

Pediatric Clerkship



Seattle Children's[®]
HOSPITAL • RESEARCH • FOUNDATION

UW Medicine
SCHOOL OF MEDICINE

Sites

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PEDS 643 Spokane, WA (Kaiser)
PEDS 668 Spokane, WA (Providence)
PEDS 656 Wenatchee, WA
PEDS 644 Wasilla, AK

PEDS 630 WRITE Sites (various)
PEDS 631 LIC Centralia/Olympia, WA

Core Pediatric Clerkship Manual Directory (Website)

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OVERVIEW

Educational Objectives

The practice of Pediatrics involves addressing the health needs of children. Every child should have the opportunity to grow and develop to achieve his or her maximum potential; the job of the Pediatrician is to assist in that process by treating and preventing illness, guiding children and their families toward good health choices, and offering information and interventions that support the overall well-being of the child.

Goals of the core pediatric clerkship: Provide foundational skills and knowledge about the fundamental issues of childhood health and illness in order to prepare UW SOM medical students to provide safe and compassionate care to children.

Learning Objectives:

1. Collect both focused and comprehensive, developmentally appropriate patient histories using triadic interviewing skills.
2. Perform an age appropriate physical examination on newborns, infants and older children.
3. Construct an appropriate approach to common pediatric clinical problems by:
 - a. Identifying essential clinical features.
 - b. Outlining natural history of disease processes.
 - c. Creating a stratified differential diagnosis.
 - d. Formulating evidence-based diagnostic and therapeutic approaches.
 - e. Discussing how age and development influence our thinking.
4. Conduct healthcare maintenance visits that include the following components: childhood immunizations, assessment of child development and nutrition, and the principles of anticipatory guidance.
5. Discuss the effects of growth and maturation on pharmacokinetics and use this knowledge to select the appropriate treatment regimens of commonly used fluids and medications in patients of different ages.
6. Analyze common professional and ethical dilemmas in pediatrics.
7. Deliver well-organized, appropriately focused, and accurate oral patient presentations.
8. Write well-organized, appropriately focused, and accurate patient notes, including admission, progress and outpatient visit notes.
9. Demonstrate relationship building skills in each clinical encounter and interprofessional exchange.
10. Work effectively as a member of the healthcare team.
11. Elicit and recognize the perspectives and needs of families and provide care for patients within their social and cultural context.
12. Set personal and professional goals for learning.

Pediatric Clinical Skills:

After completing your Pediatrics clerkship, we expect that you will have gained knowledge and developed skills in the following areas related to the care of children:

1. Health Supervision/Anticipatory Guidance (includes poisoning/injury prevention)
2. Growth
3. Development and Behavior (includes issues of normal development and also concerns about behavior)
4. Nutrition for Children
5. Issues Unique to Adolescents
6. Newborn Care (includes newborn anticipatory guidance and the newborn physical exam)
7. Fluid/Electrolyte Management and Pediatric Therapeutics
8. Assessment of the Acutely Ill Child

For each area, we will describe the skills you are expected to learn and methods to demonstrate your capabilities.

Minimal Competency Outline for Pediatric Clinical Skills

Health Supervision/Anticipatory Guidance (includes poisoning/injury prevention)

Health supervision requires asking about nutrition, elimination, activity and preventative strategies.

“Anticipatory guidance” means providing information to parents and patients to maintain health, predict normal processes, and avoid problems. Appropriate nutrition and preventative care is of paramount importance so that children can achieve their goals of growth and development. See also subsequent sections in this Outline on Growth, Development and Behavior. You should be able to discuss anticipatory guidance in several areas:

Specific Skills	Minimum achievement
Obtain an appropriate dietary history in children of different ages and counsel on basic healthy practices	<ul style="list-style-type: none"> • Infants - List at least two benefits of breastfeeding; discuss avoiding initiation of solid foods before 4-6 months of age;. Address at least one principle of vitamin or mineral supplementation. • Toddler - Address eliminating bottle feeding and limiting sugary beverage consumption. Ask about milk consumption • Preschooler/School Age- Address at least one principle of a healthy diet, such as limiting sugary beverages and junk food and encouraging fruits and vegetables. •
Demonstrate ability to address immunizations according to CDC guidelines	<ul style="list-style-type: none"> • Ask about immunization record. • Discuss risks and benefits of routine immunizations
Discuss personal safety/Injury prevention related to issues including: <ul style="list-style-type: none"> • Motor vehicle safety • Infant sleeping position • Falls • Burns • Poisoning • Fire safety • Choking • Water safety • Bike safety • • Firearms and weapons 	<ul style="list-style-type: none"> • Address at least two age-appropriate safety concerns during a health maintenance visit. • Counsel about the appropriate storage of potential toxins; e.g. cabinet locks, safety caps. • Discuss the appropriate intervention in the event of an exposure; this must include advice about calling poison control.

Learning Activities: <ul style="list-style-type: none"> • Participate in outpatient health supervision clinic visits for infants, toddlers and school aged children • Aquifer Pediatrics cases 2, 3, 4, 5 • COMSEP Physical Examination Video • Physical Examination Benchmarks • Stanford Breastfeeding video • Textbook (optional) 	Assessment: <ul style="list-style-type: none"> • Final examination • Clinical Performance Assessment • Evaluation of written H&P
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Growth

Normal growth is a marker of child health and well-being. Abnormal growth can be an indicator of chronic illness, genetic disorders, malnutrition, psychosocial problems, or other issues which require intervention. You should be able to address growth issues for children as follows:

Specific Skills	Minimum achievement
Demonstrate ability to measure and assess growth including height/length, weight, head circumference, and body mass index in patient encounters using standard growth charts.	<ul style="list-style-type: none">• If growth data are abnormal, recheck plot.• Recognize normal and abnormal growth patterns.

<p>Learning Activities:</p> <ul style="list-style-type: none">• Interpret growth data on all physical examinations• Growth Chart Problem Set• Textbook (optional)	<p>Assessment:</p> <ul style="list-style-type: none">• Final examination• Evaluations of written H&P• Clinical Performance Assessment• Completion and discussion of Growth Chart Problem Set
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Development and Behavior (includes issues of normal development and also concerns about behavior)

Although there is variation for each individual, childhood development and behavior should follow a generally recognized pattern. Abnormalities of development or behavior may suggest organic or psychosocial problems that require intervention; many problems can be avoided with appropriate guidance. You should be able to recognize and address development and behavior issues in children as follows:

Specific Skills	Minimum achievement
<p>Demonstrate an ability to assess normal childhood development and behavior within the following domains:</p> <ul style="list-style-type: none"> • Psychosocial development • Language development • Physical maturation • Motor development • Cognitive development 	<ul style="list-style-type: none"> • Describe at least one aspect of psychosocial development in a specific patient. • Describe at least one aspect of language development in a specific patient. • Describe at least one aspect of physical development in a specific patient. • Describe at least one aspect of motor development in a specific patient. • Describe at least one aspect of cognitive development in a specific patient. • Demonstrate an appropriate exam. • Recognize at least one sign of puberty. •
<ul style="list-style-type: none"> • Identify behavioral and psychosocial problems of childhood using the medical history and physical examination 	<ul style="list-style-type: none"> • Identify common abnormal behaviors seen in either infancy, childhood or adolescence such as sleep issues, toilet training. • Identify at least one common psychosocial problem in either infancy, childhood or adolescence such as limited family resources.

<p>Learning Activities:</p> <ul style="list-style-type: none"> • Aquifer Pediatrics cases 2, 3, 4, 5 • Patient care • OPEN Pediatrics "Developmental Milestones" video • Textbook (optional) 	<p>Assessment:</p> <ul style="list-style-type: none"> • Final Examination • Clinical Performance Assessment • Evaluation of written H&P • CEX
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Issues Unique to Adolescents

The changes of adolescence present unique health issues and new challenges for the patient, family, and pediatrician. You should be able to recognize and address these issues when caring for adolescents:

Specific skills	Minimum achievement
<ul style="list-style-type: none"> Interview an adolescent patient with emphasis on sensitive questions about behaviors that affect health and safety (e.g. sexuality, drug, tobacco and alcohol use) 	<ul style="list-style-type: none"> Separate (or attempt to) patient from parent/guardian for part of the interview. Address confidentiality with patient. Ask a psychosocial history (e.g. HEADSS or other appropriate tool) that includes screening for at least two risk-taking behaviors.
<ul style="list-style-type: none"> Conduct a physical exam of an adolescent that demonstrates respect for privacy and modesty, employing a chaperone when appropriate 	<ul style="list-style-type: none"> Identify the need for chaperone when appropriate. Utilize appropriate draping techniques. Assess SMR (sexual maturity rating, formerly "Tanner stage") of breast, pubic hair, and genitalia. Describe how to assess for scoliosis.
<ul style="list-style-type: none"> Provide information and guidance for issues related to adolescents with appropriate screening and preventive measures 	<ul style="list-style-type: none"> Give basic preventive counseling for common adolescent issues (e.g. diet, exercise, sexuality, substance use, safety).

<p>Learning Activities:</p> <ul style="list-style-type: none"> Aquifer Pediatrics case 5,6 COMSEP Physical Examination Video Physical Examination Benchmarks Patient Care "Scoliosis Screening Exam" video (optional) Textbook (optional) 	<p>Assessment:</p> <ul style="list-style-type: none"> Final examination Clinical Performance Assessment
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Newborn Care (includes newborn anticipatory guidance and the newborn physical exam)

Pediatric care begins at birth, with careful evaluation of the newborn and support to the parents; this holds true for the normal infant and for those with health challenges. You should be able to assess and provide guidance for a newborn as follows:

Specific skills	Minimum achievement
Give anticipatory guidance to parents of a newborn for the following issues: <ul style="list-style-type: none"> • Feeding • Normal bowel and urinary elimination patterns • Jaundice • Appropriate car seat use • SIDS prevention • Health maintenance/prevention • Identifying illness 	<ul style="list-style-type: none"> • Ask about plans for feeding. • Ask about duration, frequency and volume of feeding. • List 2 benefits of breastfeeding/breast milk. • Display nonjudgmental attitude. • Ask about frequency of urine and stool output. • Ask if parents have a car seat; ask about car seat positioning (e.g. rear-facing, front vs. back seat). • Inquire about sleep position. • Ask about smoke exposure. • Ask about plan for follow-up care. • Ask if newborn received Hepatitis B vaccine. • Verify that hearing and newborn screening done before discharge. • Give at least 2 reasons to call health care provider.
Perform or observe a complete physical exam of the newborn infant	As outlined in Physical Examination Benchmarks

Learning Activities: <ul style="list-style-type: none"> • Aquifer Pediatrics cases 1, 2, 7, 8, 9 • Newborn nursery experience • COMSEP Physical Examination Video • Open Pediatrics "Newborn exam" video • • Textbook (optional) 	Assessment: <ul style="list-style-type: none"> • Final examination • CEX (Newborn/Toddler) • Clinical Performance Assessment
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Fluid/Electrolyte Management and Pediatric Therapeutics

Maintaining effective circulating volume is necessary to assure organ perfusion. Children may be at increased risk for volume depletion due to their smaller size and higher propensity to develop volume-depleting ailments. Assessment of volume status and correction of fluid/electrolyte abnormalities are core pediatric skills. Since children come in many sizes, understanding how to address fluid or medication management that is appropriately scaled to the individual patient is of paramount importance. You should understand and be able to address the issues listed below:

Specific skills	Minimum achievement
<p>Fluid/electrolyte management:</p> <ul style="list-style-type: none"> • Obtain history and physical finding information necessary to assess the volume status of a child. • Calculate intravenous maintenance fluids for a child considering daily water and electrolyte requirements. • Calculate the fluid therapy to achieve euolemia for a child with volume depletion • Explain how to use oral rehydration therapy for mild to moderate volume depletion. 	<ul style="list-style-type: none"> • Ask about intake and output. • Assess at least 2 physical exam findings and 1 vital sign relevant to intravascular volume status. • Choose appropriate intravenous fluid (water, sodium, glucose, other additives as indicated). • Calculate maintenance fluid delivery correctly using weight or BSA. • Choose isotonic fluid at 10-20 mL/kg for volume expansion ("rescue" IV bolus). • Reassess patient after intervention. • Choose appropriate oral rehydration solution and recognize when it is indicated.
<ul style="list-style-type: none"> • Calculate a drug dose and select a formulation for a child based on patient size. 	<ul style="list-style-type: none"> • Identify "per kg" or "per body surface area" doses for common pediatric medications (antipyretics, antibiotics) • • Create an appropriate medication order or prescription including name of medication, formulation, dose, dosing schedule, route, and duration.. • Assure that recommended dosing regimen scaled to patient size does not exceed adult maximum dose.
<p>Learning Activities:</p> <ul style="list-style-type: none"> • Aquifer Pediatrics case 15 (and various other cases that have medication administration) • Patient care • Required Problem Sets • Textbook (optional) 	<p>Assessment:</p> <ul style="list-style-type: none"> • Final examination • Clinical Performance Assessment • Completion and discussion of Required Problem Sets

Assessment of the Acutely Ill Child

You may be called upon to provide emergency care to a patient at any time. One must be able to recognize and rapidly assess a sick child and understand how the presentation of illness may differ from that seen in an adult. Basic topics in pediatric acute assessment and emergency care, with which you should be familiar, include the following:

Specific skills	Minimum achievement
<ul style="list-style-type: none"> Describe vital signs and other clinical clues to acute illness are different for children as compared to adults, and will vary for children of different ages. Develop a framework to identify a child who needs acute, urgent, or emergent care. 	<ul style="list-style-type: none"> Recognize signs of circulatory compromise (tachycardia, bradycardia, weak pulse, prolonged capillary refill). Recognize signs of respiratory distress (retractions, cyanosis, apnea, tachypnea) Note mental status as a marker of overall illness (calm, fussy, inconsolable, agitated, somnolent, obtunded). Note general appearance as a marker of overall illness (alert, floppy, weak cry, etc.).

Learning Activities: <ul style="list-style-type: none"> Aquifer Pediatrics Cases 7, 10, 11, 12, 19, 14, 15, 23, 25, 30 OPENPediatrics "Recognizing Respiratory Distress and Failure" video Acute Care in/out patient experience Textbook (optional) 	Assessment <ul style="list-style-type: none"> Final Examination Clinical Performance Assessment
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The previous section outlined specific **skills** that you are expected to obtain during your rotation. In addition, you are expected to obtain core medical knowledge related to the care of pediatric patients and their medical conditions. Specific objectives related to these activities include:

- Construct an appropriate approach to common pediatric clinical problems by:
 - Identifying essential clinical features
 - Outlining natural history of disease processes
 - Creating a stratified differential diagnosis
 - Formulating evidence-based diagnostic and therapeutic approaches
 - Discussing how age and development influence essential clinical features, natural history of disease processes, differential diagnosis as well as diagnostic and therapeutic approach

Learning Activities:

- Aquifer Pediatrics Cases (1-32)
- Didactics
- Required Problem Sets
- Patient Care (inpatient/outpatient settings)
- Written H&P
- [Online MedED videos](#) (optional)
- [MedEdOnTheGo videos](#) (optional)
- [OPENPediatrics videos](#) (optional)
- Textbook (optional)

Assessment:

- Final Examination
- Evaluation of written H&P
- Clinical Performance Assessment
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Grading and Evaluation

Pediatric Clerkship Grading Rubric

To pass the Pediatric Clerkship you must:

- Complete all assignments
- Meet professionalism standards
- Perform at a passing level or higher on your clinical performance (Clinical Grade)
- Receive a passing grade of 60% or higher on the final examination (Exam Grade)

Your Final Grade is determined from a combination of your Clinical Grade and your Exam Grade.

CLINICAL GRADE

Your Clinical Grade is determined by the Site Director, who reviews the information provided by each evaluator with whom you worked during the clerkship. The Site Director assigns a numerical Clinical Grade based on the submitted values for Recommended Level of Evaluation for Time Spent, weighted appropriately for the level of time spent by each evaluator who observed your work and interacted with you.

Evaluators indicate Time Spent with Student and provide a Recommended Level of Evaluation for Time Spent:

TIME SPENT WITH STUDENT
Little or no contact
Sporadic and superficial contact
Infrequent but in-depth contact
Frequent and in-depth contact

RECOMMENDED LEVEL OF EVALUATION FOR TIME SPENT	
Exceptional Performance (Honors)	5
Exceeds Expectations (High Pass)	4
Meets Expectations (Pass)	3
Below Expected Performance for Level (Marginal)	2
Unacceptable Performance (Fail)	1

Please note that the Recommended Level of Evaluation from each evaluator, and thus the numerical Clinical Grade assigned by the Site Director, is not a simple average of values reported in the 12-item evaluation form. Rather, since each domain in the 12-item evaluation form may be considered differently depending on the types of patients you see and the environments where you work, the Recommended Level of Evaluation and the resultant numerical Clinical Grade represent overall assessments of your performance as a doctor-in-training.

All evaluations are reviewed *regardless of the level of contact* for comments that may be included in your final evaluation to provide specific feedback on your performance, to highlight areas of strength or to identify areas of concern. Significant areas of concern may constitute special circumstances which require individualized review.

EXAM GRADE

Your Exam Grade is the final percent correct score as reported on the standardized exam used in the clerkship. For the Pediatric Clerkship, the standardized exam is the Aquifer Pediatrics exam. Please note that you must score 75% or higher on your Exam Grade to be eligible for a Final Grade of Honors.

FINAL GRADE

Your Exam Grade adjusts your Clinical Grade giving an Adjusted Total Grade. The Final Grade is based on the Adjusted Total Grade with consideration also of your Exam Grade for Honors eligibility. Note that to receive Honors, you must achieve the appropriate Adjusted Total Grade and also score 75% or higher on your Exam Grade; if your Adjusted Total Grade is Honors eligible but your Exam Grade is <75%, your Final Grade is High Pass.

EXAM GRADE and ADJUSTMENT		ADJUSTED TOTAL GRADE, RANGE, and FINAL GRADE		
90% and above	+ 0.15	<i>Adjusted Total Grade is the Sum of Clinical Grade and Adjustment from Exam Grade</i>	Greater than 4.5 and Exam \geq 75%	Honors
70%-89%	No Adjustment		3.75 – 4.5 or >4.5 but Exam <75%	High Pass
60%-69%	- 0.10		3.0 – 3.74	Pass
Less than 60%	Fail		Less than 3.0 or Exam Fail	Fail

GRADING PHILOSOPHY

There is no curve and no forced normal distribution of grades for the Pediatric Clerkship. Each student is evaluated individually on the merits of clinical performance, knowledge of pediatric medicine, assignment completion and professionalism. Therefore, any student is eligible for any grade based on demonstrated performance.

We believe that every student who participates in the Pediatric Clerkship will be able to demonstrate the knowledge, skills and attitudes necessary to achieve a passing grade. Given our faith in you we assume that every student starts the Pediatric Clerkship at the level of Pass. If you participate fully, complete all assignments, act in the appropriately professional manner, and demonstrate the expected clinical skills, you will have met expectations and will achieve a Clinical Grade with a numerical value in the range of Pass. If you exceed the expected level of performance in multiple areas you will be eligible for a Clinical Grade with a numerical value in the range of High Pass. If you do not meet the minimum expectations for knowledge, skills, attitudes or professionalism you may receive a Clinical Grade of Fail; students who appear to be at risk for a failing grade will meet with the Site Director promptly to review performance and develop a plan for improvement.

A Clinical Grade in the numerical range of Honors is awarded to students who consistently perform at an exceptionally high level throughout the Pediatric Clerkship in all clinical settings. To be eligible for a Clinical Grade in the numerical range of Honors we would expect you to demonstrate the following attributes, consistently over time, in multiple settings:

- Show an exceptional dedication to patients and their care
- Exhibit superior clinical skills, collecting data (History/Physical/Medical record review) with ease, precision and accuracy
- Have appropriate, intuitive, facile engagement with patients and families
- Synthesize and prioritize data with the development of patient specific differential diagnoses and assessments
- Offer logical, cogent, thoughtful, and comprehensive patient care plans and provide organized, thorough, concise presentations
- Demonstrate a high level of engagement that exemplifies self-directed learning
- Seek, accept and implement feedback in an iterative manner
- Engage in collaborative and respectful interactions with all team members
- Assume responsibility for the care of patients and serve as an active member of the team

To receive a Final Grade of Honors, we believe that a student must demonstrate a high level of clinical skill and engagement as noted above along with showing mastery of the knowledge base related to Pediatric medicine. This is why a minimum performance level on the standardized exam is also required to receive the Final Grade of Honors. Please note that to receive a Final Grade of Honors, you must achieve the appropriate Adjusted Total Grade and also score 75% or higher on your Exam Grade; if your Adjusted Total Grade is Honors eligible but your Exam Grade is <75%, your Final Grade is High Pass (see above).

Questions regarding the grading rubric, grading philosophy or your final grade should be directed to the clerkship director, Dr. Jordan Symons (jordan.symons@seattlechildrens.org).

SPECIAL CIRCUMSTANCES

Final Grade of Fail or other special circumstances will be referred to the Associate Dean for Student Affairs and/or Student Progress Committee in accordance with UWSOM policy.

ASSIGNMENTS

Checklist for Core Pediatric Clerkship (WWAMI Region Sites and LIC Program)

The following list is an outline of the assignments you will need to complete to pass your clerkship. You will be using the Pediatric Tracker to upload and log all of your completed assignments throughout the course of your clerkship. Your site coordinator/director will provide information about completion of assignments at your WWAMI or LIC site.

Required Assignments:

- Pediatric Assignment Tracker (<https://courses.washington.edu/fmclerk/wordpress/pedsclerk/tracker>)
 - UW Net ID required
 - PDFs of all required forms can be found linked on the Tracker
 - Upload and log all of your completed assignments throughout the course of your clerkship, all assignments due by the last day.
- Aquifer Pediatrics cases (<https://aquifer.org/>)
- E-Value Clinical Encounters Program (<https://sites.uw.edu/medevalu/clinical-encounters/>)
 - UW Net ID required
 - Log the patients you see using the 8 required domains. (required: one of each domain)
- Mid-Clerkship Feedback form: 1st half of clerkship as directed by your site.
- History and physical examination write-up: Submit 1 complete write-up for evaluation and feedback
 - Note: Upload this document to the tracker with required feedback comments included.
- Infant/Toddler Observed physical examination (Mini-CEX)

Required Problem Set Exercises:

- Volume Depletion Problem Set
- Maintenance Fluids Problem Set
- Medication Ordering Problem Set
- Growth Chart Problem Set
- Perform full H&Ps on inpatients, new to the service or “new to you”, 2-3/week while on inpatient service (adjusted as per your site)
- Ethics in Pediatrics (as directed by your site director)
- Work as an integral part of the care team during your rotation
- If applicable: All electronic notes signed and sent to your direct supervisor BEFORE you leave on your last day.
- Pass the final examination for the course.

Checklist for Core Pediatric Clerkship (Seattle Children's Hospital / 4-week rotation)

The following list is an outline of the assignments you will need to complete to pass your clerkship. You will be using the Pediatric Tracker to upload and log all of your completed assignments throughout the course of your clerkship. PDFs all of all required forms can be found linked on the Tracker. Access to the Pediatric Tracker is assigned to each user by their UW net ID. Here's the link: <https://courses.washington.edu/fmclerk/wordpress/pedsclerk/tracker>

Required Assignments:

Items to be completed during Orientation:

- Medication Ordering Problem Set

Items to be completed during Inpatient 2-weeks:

- Complete one full history and physical examination write-up for evaluation and feedback.
 - Turn in this write-up to your attending AND to the clerkship director indicated on your personal calendar/schedule you received at orientation.
 - Note: Upload this H&P to the Tracker with feedback comments included.
- Perform full H&Ps on inpatients, new to the service or "new to you", 2-3/week while on inpatient service
- Save and forward all electronic notes to your direct supervisor BEFORE you leave on your last day.
- Return SCH inpatient pager so that the next student on your team will have it

Items to be completed during Outpatient week:

- Growth Charts Problem Set
- Clinic specific checklist—Obtain this on your first day of outpatient clinic
 - Complete and return the checklist as directed by your outpatient site coordinator.

Items to be completed during "Mixed Tape" week:

- Volume Depletion Problem Set: complete in the ED
- Infant/Toddler observed physical examination (Mini-CEX): complete with a resident or attending in the Newborn Nursery

Items to be completed by the end of your clerkship:

- Aquifer Pediatrics cases (<https://aquifer.org/>)
- Maintenance Fluids Problem Set
- Ethics Assignment (see UW PEDS Patient Care Phase website for instructions on how to complete this self-study assignment: <http://www.peds.uw.edu/students/current/third-year>)
- Mid-Clerkship Feedback form
- Log patients using the EValue Clinical Encounters Program. There are 8 domains; log one patient per domain. (<https://sites.uw.edu/medevalu/clinical-encounters/>)
- Work as an integral part of the care team during your rotation
- Final examination for the course
- Return SCH badge to Medical Student Program Office at the end of your clerkship.

Checklist for Core Pediatric Clerkship (WRITE Program)

The following list is an outline of the assignments you will need to complete to pass your clerkship. You will be using the Pediatric Tracker to upload and log all of your completed assignments throughout the course of your clerkship. PDFs all of all required forms can be found linked on the Tracker. Access to the Pediatric Tracker is assigned to each user by their UW net ID. Here's the link: <https://courses.washington.edu/fmclerk/wordpress/pedsclerk/tracker>

Required Assignments

To be completed by the end of your clerkship:

- Aquifer Pediatrics Cases (<https://aquifer.org/>)
- Log the patients you see using the EValue Clinical Encounters Program (<https://sites.uw.edu/medevalu/clinical-encounters/>)
- Final examination for the course

To be completed during your inpatient 2-week experience

- Mid-Clerkship Feedback form (during the last week on inpatient)
- Complete one full history and physical examination write-up for evaluation and feedback.
 - Turn in this write-up to your attending AND to the clerkship director indicated on your personal calendar/schedule you received at orientation.
 - Note: Upload this H&P to the Tracker with feedback comments included.
- Medication Ordering Problem Set (Everett self-study; Seattle see schedule)
- Maintenance Fluids Problem Set (self-study)
- Volume Depletion Problem Set (Everett self-study; Seattle see schedule)
- Perform full H&Ps on inpatients, new to the service or "new to you", 2-3/week while on inpatient service
- Save and Forward all electronic Notes to your direct supervisor BEFORE you leave on your last day.

To be completed during the WRITE outpatient experience

- Growth Chart Problem Set (self-study)
- Ethics Assignment (self-study)
- Infant/Toddler observed physical examination (Mini-CEX): complete with a resident or attending

At the end of your clerkship, please turn in your ID badge and return borrowed books and/or pagers.

Pediatric Core Medical Knowledge: Online Cases and Problem Sets

Aquifer Pediatrics Online Cases: During the course of the clerkship, you will learn about common pediatric illnesses/problems in all age groups as well as approach to healthcare maintenance for children. This material is covered in the Aquifer Pediatrics cases:

Go to <https://aquifer.org/>

Sign in/Register: Follow the instructions to sign in or register. You must use your UW email account to sign up (the program won't recognize domains like @gmail or @hotmail). If you have used the Aquifer cases in the past (SIMPLE and fmCASES), you will use your previous login information.

Cases: Under "Courses", open "Aquifer Pediatrics". You do not have to do the cases all at once. When you quit the program, the website will save the place where you stopped. You can return to the case at that progress point. You are expected to complete all the Aquifer Pediatrics cases during the course of the clerkship.

Please contact the Medical Student Office if you need additional login assistance.

Required Problem Sets: There are 4 problem sets for you to complete:

1. Maintenance Fluids Problem Set
2. Volume Depletion Problem Set
3. Medication Ordering Problem Set
4. Growth Charts Problem Set

To facilitate learning, we have developed a series of assignments and corresponding didactic sessions. To help you prepare for didactics, we created the materials on the website here:

<http://depts.washington.edu/uwpeds/medstudents/?p=401>

Collectively, this content will provide you with a solid foundation for caring for common pediatric problems and prepare you for your final examination.

To further prepare for the USMLE Step II CK, we recommend thorough review of the content presented in the clerkship, completion of additional practice questions, use of review books as appropriate, adequate study time and following the guidance of the learning specialists at UW School of Medicine.

Inpatient Experience - Pediatric H&Ps

Performing H&Ps in the inpatient setting helps you both improve and demonstrate your skills of gathering, organizing and synthesizing information about pediatric patients, developing assessments of the patient's status and then building a plan. Depending on your site, there will be different opportunities for patients with varied complaints and complexity. Challenge yourself to do full evaluations on the patients newly admitted or transferred to your service, or a patient who has been there for a while but is "new to you". The more you do the more practice you get, and the more your preceptors can observe your skills and provide feedback.

We expect you to complete 2-3 full H&Ps for every week that you participate on the inpatient service. Since the number of weeks on inpatient service, inpatient census, or the nature of the experience, may differ at the various sites (inpatient-only at some sites vs. blended inpatient/outpatient at others), the exact number of full H&Ps by the end of the rotation may vary. Please remember that the more you engage in this activity, the more you learn and improve, and the more your preceptors can observe your skills.

You are required to write up and submit to your site director/preceptor at least one of your H&Ps for formal review and feedback. Your local site will clarify the method. Make sure that you upload the H&P that shows the feedback and comments to the Pediatric Clerkship Assignment Tracker.

Required Problem Set Exercises

Volume Depletion Problem Set - Fluid Management for Pediatric Patients How to Address the Volume Deplete Patient

Some things to remember:

- Always evaluate your patient's volume status
- Use weight changes and your clinical judgment to assess a volume deficit
- The goal in volume replacement is to improve effective circulating volume
- Oral therapy and IV therapy both have a place in treating children with volume depletion
- Ongoing monitoring and review of your patient's progress is required

Complete Fluid Management:

Full instructions and further materials

here: <http://depts.washington.edu/uwpeds/medstudents/?p=401>

Clinical Problems

1. A normally healthy 18-month-old girl who weighed 11kg two weeks ago comes to the ER with the complaint of "the flu". She had emesis four times this morning and now has had two loose stools. She weighs 10.8kg on admission to the ER; her physical exam is significant for a weepy, unhappy appearing child.

What would you do to assess and treat this child's fluid and electrolyte abnormality?

2. A normally healthy 18-month-old girl who weighed 11kg two weeks ago comes to the ER with the complaint of "the flu". She has only been taking water and juice; now she refuses all fluids. She weighs 10.2kg on admission to the ER; her physical exam is significant for tachycardia and dry mucous membranes.

What would you do to assess and treat this child's fluid and electrolyte abnormality?

3. A normally healthy 18-month-old girl who weighed 11kg two weeks ago comes to the ER with the complaint of "the flu". She has only been taking water and juice for several days; now she refuses all fluids and her parents say she is lethargic. Her parents do not remember the last time she made any urine. She weighs 9.2kg on admission to the ER; her physical exam is significant for tachycardia, dry mucous membranes, cool extremities and tenting skin. She is afebrile. She arouses to noxious stimuli.

What would you do to assess and treat this child's fluid and electrolyte abnormality?

Required Problem Set Exercises

Maintenance Fluids Problem Set - Fluid Management for Pediatric Patients How to Provide Maintenance Fluids

Things to remember:

- The volume of fluid required to keep a patient in normal balance is often called “maintenance”
- Maintenance needs may differ from person to person or from day to day
- Based on assumptions of normal physiology, it is possible to calculate maintenance needs
- The assumptions about maintenance needs do not always hold in the setting of illness

Complete Fluid Management:

Full instructions and further materials

here: <http://depts.washington.edu/uwpeds/medstudents/?p=401>

Required Problem Set Exercises

Medication Ordering Problem Set

Some things to remember:

1. Medications and other therapeutics need to be dosed in a manner appropriate for children. This most often requires scaling a drug dose to body weight or body surface area. Accurate weight and height are therefore necessary to both evaluate and treat a pediatric patient.
2. In some rare circumstances (e.g., extremes of abnormal weight, fluid excess, etc.), measured body weight/height may not be appropriate for dosing calculations. Rather, “ideal” weight/height would be used.
3. Not all medications come in forms that are usable in all children (e.g., liquids for oral use in a small child who cannot swallow a pill) and not all medications are acceptable for use in children. These issues must be considered when prescribing.

Complete Medication Ordering:

Website: <http://depts.washington.edu/uwpeds/medstudents/?p=401>

Using a pediatric formulary reference, determine the appropriate dose of medications for the following clinical situations. Write the dose, route, frequency, and if necessary the duration, formulation (tablets, liquid, etc.) and/or the “as needed” (PRN) indication.

Clinical Situation	Medication
18-month-old boy admitted for fever and respiratory distress Weight: 12kg Height: 82cm	Rx: ACETAMINOPHEN
4-year-old girl admitted for pyelonephritis Weight: 16kg Height: 100cm	Rx: CEFTRIAXONE
16-year-old girl seen in the clinic with probable UTI Weight: 72kg Height: 155cm	Rx: TRIMETHOPRIM-SULFAMETHOXAZOLE
7-year-old boy treated in the ER for acute asthma exacerbation Weight: 21 kg Height: 122 cm	Rx: ALBUTEROL
3-year-old girl with new-onset nephrotic syndrome Weight: 14 kg Height: 95 cm	Rx: PREDNISONE

Required Problem Set Exercises

Growth Charts Problem Set Study Guide

The purpose of this exercise is to practice interpreting growth charts and develop assessment and management plans for problems with growth and development.

There are two parts of the exercise that you will complete:

- 1) Background reading about normal growth- Weintraub B. Growth. Pediatrics in Review 2011; 32, 404-06, can be found using the link: <http://pedsinreview.aappublications.org/content/32/9/404>
- 2) Using the growth charts on [this PDF file](#) and this study guide to interpret the growth charts (scenarios A-D). You will identify the pattern and create a differential diagnosis. Think about how to explain your rationale for each choice. Finally, for each scenario, outline a strategy for assessment and management of the patient. Remember, some scenarios may represent normal growth!

The exercise addresses the following core competencies and minimal expected skills:

Growth

Normal growth is a marker of child health and well-being. Abnormal growth can be an indicator of chronic illness, genetic disorders, malnutrition, psychosocial problems, or other issues which require intervention. You should be able to address growth issues for children as follows:

Specific Skills	Minimum achievement
<ul style="list-style-type: none">• Demonstrate ability to measure and assess growth including height/length, weight, and head circumference and body mass index in patient encounters using standard growth charts	<ul style="list-style-type: none">• Identify normal and abnormal growth patterns

Key Points

You cannot interpret growth charts without a history and physical. Plotting the height for weight charts for younger children and BMI for older children is important, especially if using an electronic medical record (the growth charts are not necessarily side by side). Growth charts are an important tool and should prompt a conversation with the parent/patient about general health, diet, and social factors.

Reflection Questions

- For each growth chart, answer the following set of questions. What growth changes/abnormalities are you seeing?
- What would you include on your differential diagnosis for this patient and why?
- What other information from the history or physical may be helpful?
- What work up and or treatment would you suggest?

Answer Key

Scenario A: normal growth (normal variant)

Growth pattern- length is crossing percentiles in a downward trend but weight and length for weight are tracking

DDx—familial short stature, constitutional growth delay, genetic abnormality, growth hormone deficiency

Other information- How tall are the patient's biologic parents? Any abnormal findings on exam?

Management- remeasure parameters, complete PE, obtain a detailed dietary history, calculate mid-parental height. If growth hormone deficiency remains on the DDx: consider bone age, IGF-1, IGF-BF3 (but usually done later...so probably not indicated at this point).

Scenario B: Faltering Growth

Growth pattern- both weight and length are crossing percentiles in a downward trend suggesting significant decreasing velocity of growth. Weight for length continues to track since both weight and length are being affected in a similar fashion.

DDx-- Psychosocial factors (neglect, lack of resources, parental education, etc.), cystic fibrosis, heart disease, kidney disease, infection, malignancy, endocrinopathy

Other information- What is the child's typical diet? Are there any limitations/restrictions with diet? Does the family have any difficulty accessing food? Have there been any other health concerns or issues?

Management: Recognize pathological growth pattern, detailed history and exam. Different approaches depending on the specific case, but should include detailed dietary history, screening labs as indicated by history and physical (electrolytes, BUN/creatinine, LFTs, albumin, CBC, TSH, UA), check newborn screen and if indicated hospitalization for trial of feeding.

Scenario C: Obesity

Growth pattern- weight is crossing percentiles in an upward fashion while height continues to track. BMI, both absolute and percentile, therefore is increasing.

DDx- Due to disproportional caloric intake to activity level, genetic causes (Turner syndrome, Prader-Willi, etc.), endocrinopathy (hypothyroidism; Cushing syndrome, etc.), medications

Other information- Does the patient have any symptoms of a possible endocrine reason for their weight gain? Are there any physical exam findings that would suggest an underlying cause?

Management- History (including detailed dietary...may need food log and activity log); family history; PE; screening for complications related to obesity; counseling and lifestyle intervention

Scenario D: Anorexia nervosa or other eating disorder

Growth pattern- Minimal weight gain between evaluations while height has continued to track appropriately. Consequently, BMI, both absolute and percentile, has decreased significantly.

DDx—eating disorder, diabetes, malignancy, inflammatory bowel disease, malabsorption, chronic kidney disease, chronic infection (TB, HIV), social stressors and inability to obtain sufficient calories, medications/drugs.

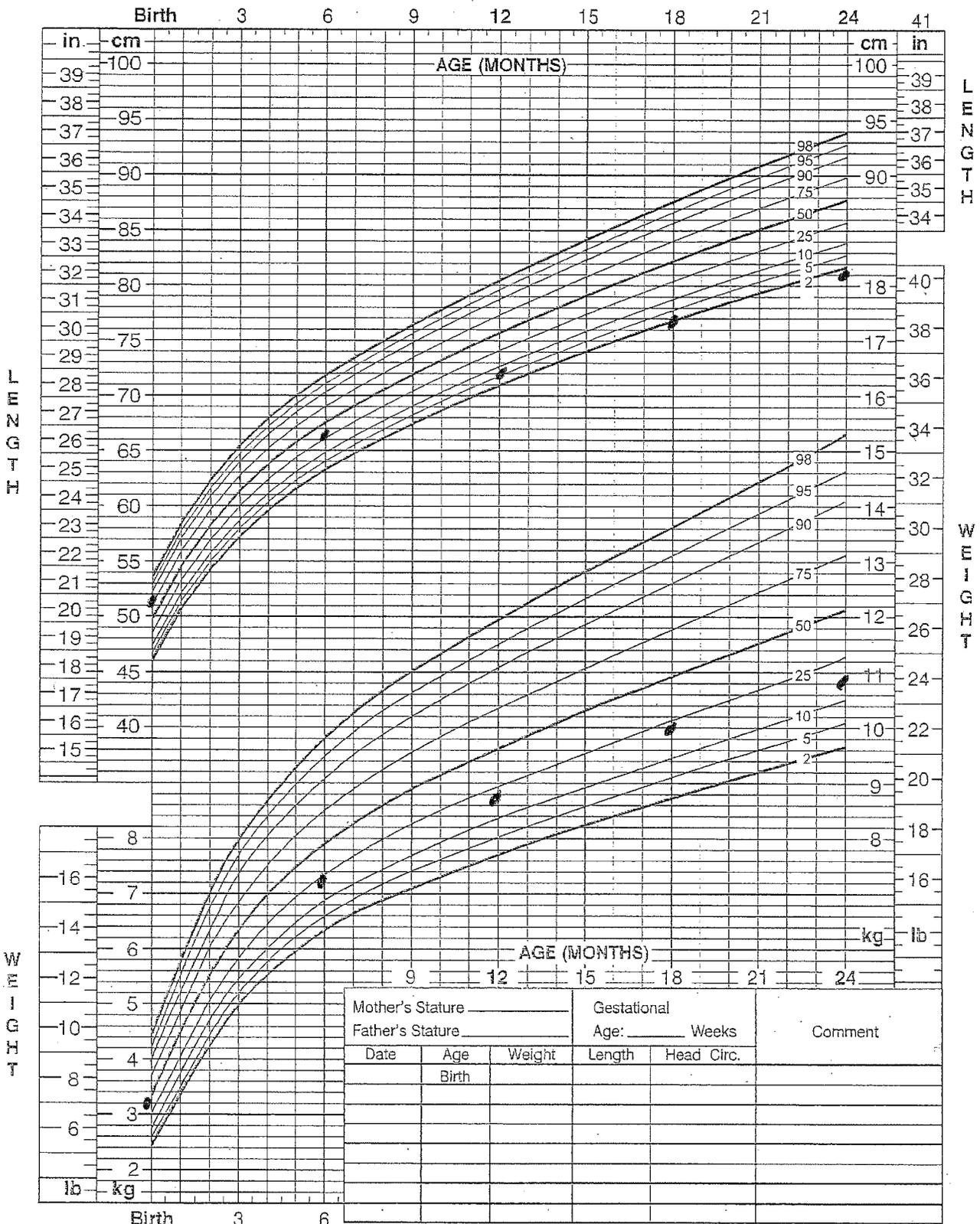
Other information- Does the patient have any other concerning findings on review of systems or physical exam? Is the weight loss intentional? What is their diet like?

Management- Detailed history including HEADSS questions and physical with particular attention for specific physical examination finding suggestive of eating disorder, screening for physiological stability, screening tests for suspected underlying diseases like Crohn's or celiac if concerning history, screening questions for HIV risk, eating disorder work up including electrolytes, CBC, UA, EKG.

Birth to 24 months: Boys
 Length-for-age and Weight-for-age percentiles

NAME CASE 1 / Scenario A

RECORD # _____



Mother's Stature _____		Gestational Age: _____ Weeks		Comment
Father's Stature _____		Length	Head Circ.	
Date	Age	Weight		
	Birth			

Published by the Centers for Disease Control and Prevention, November 1, 2009
 SOURCE: WHO Child Growth Standards (<http://www.who.int/childgrowth/en>)

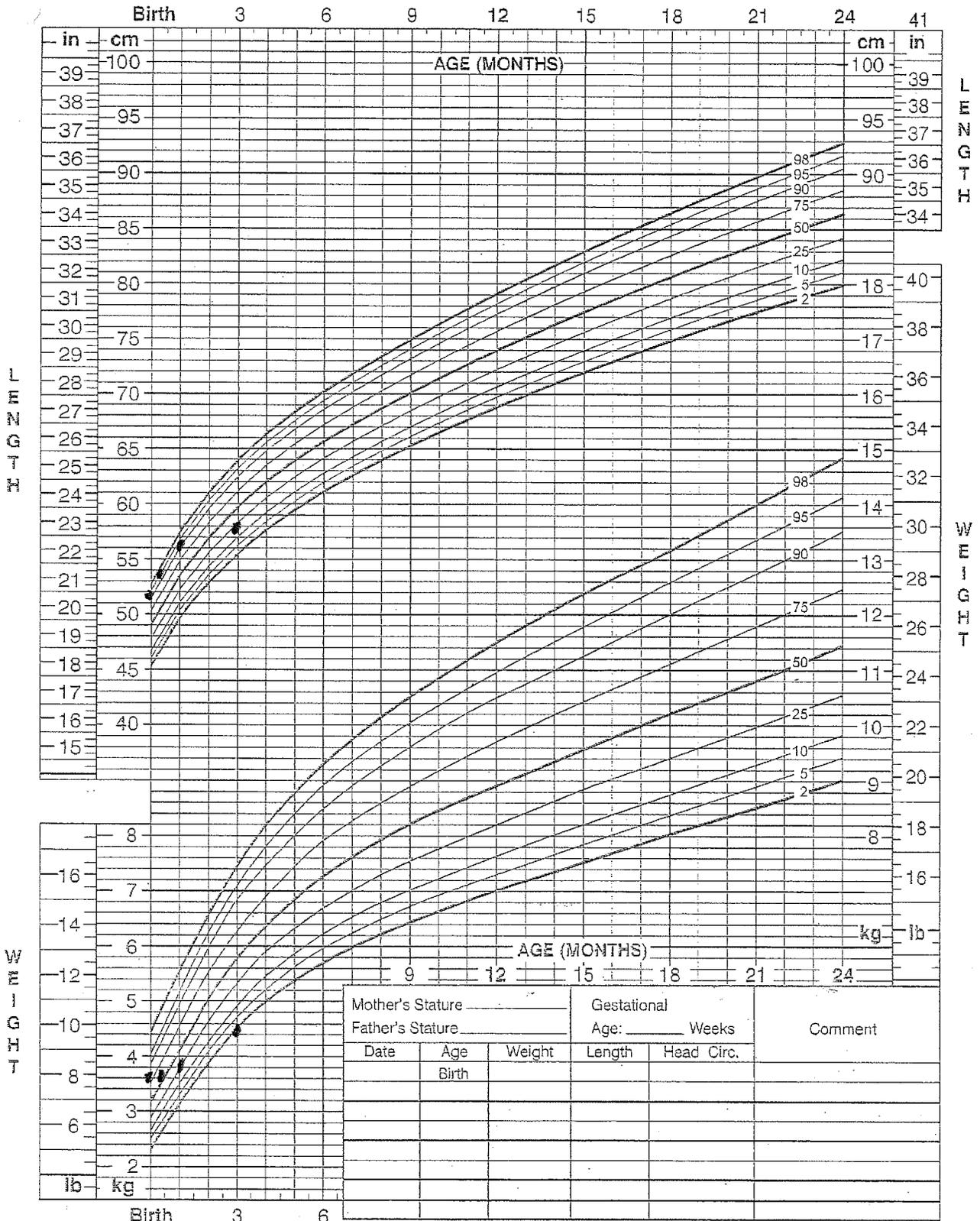
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Birth to 24 months: Girls
 Length-for-age and Weight-for-age percentiles

NAME CASE2/Scenario B

RECORD #



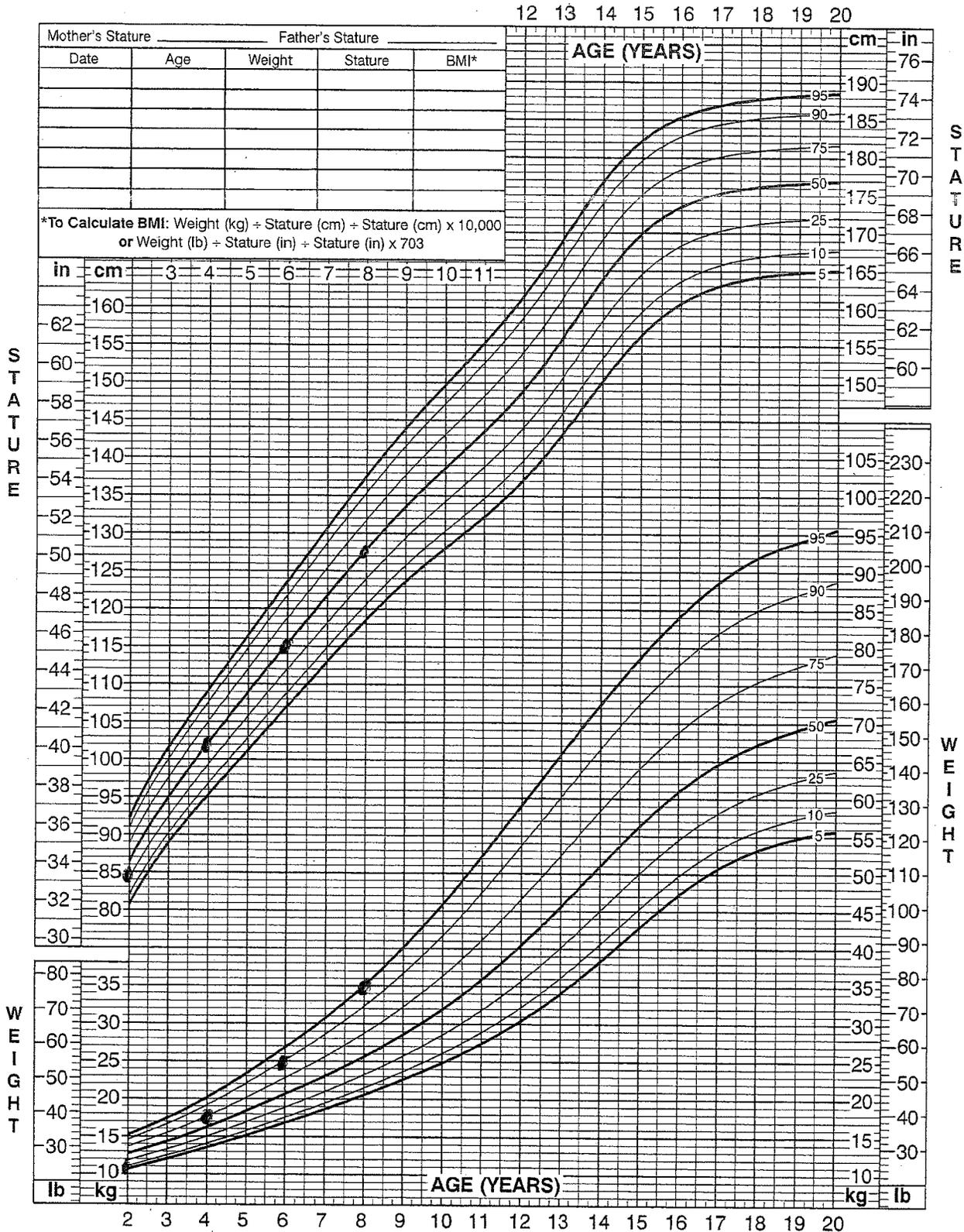
Mother's Stature _____		Gestational Age: _____ Weeks		Comment
Father's Stature _____		Length	Head Circ.	
Date	Age Birth	Weight		

Published by the Centers for Disease Control and Prevention, November 1, 2009
 SOURCE: WHO Child Growth Standards (<http://www.who.int/childgrowth/en>)



2 to 20 years: Boys
 Stature-for-age and Weight-for-age percentiles

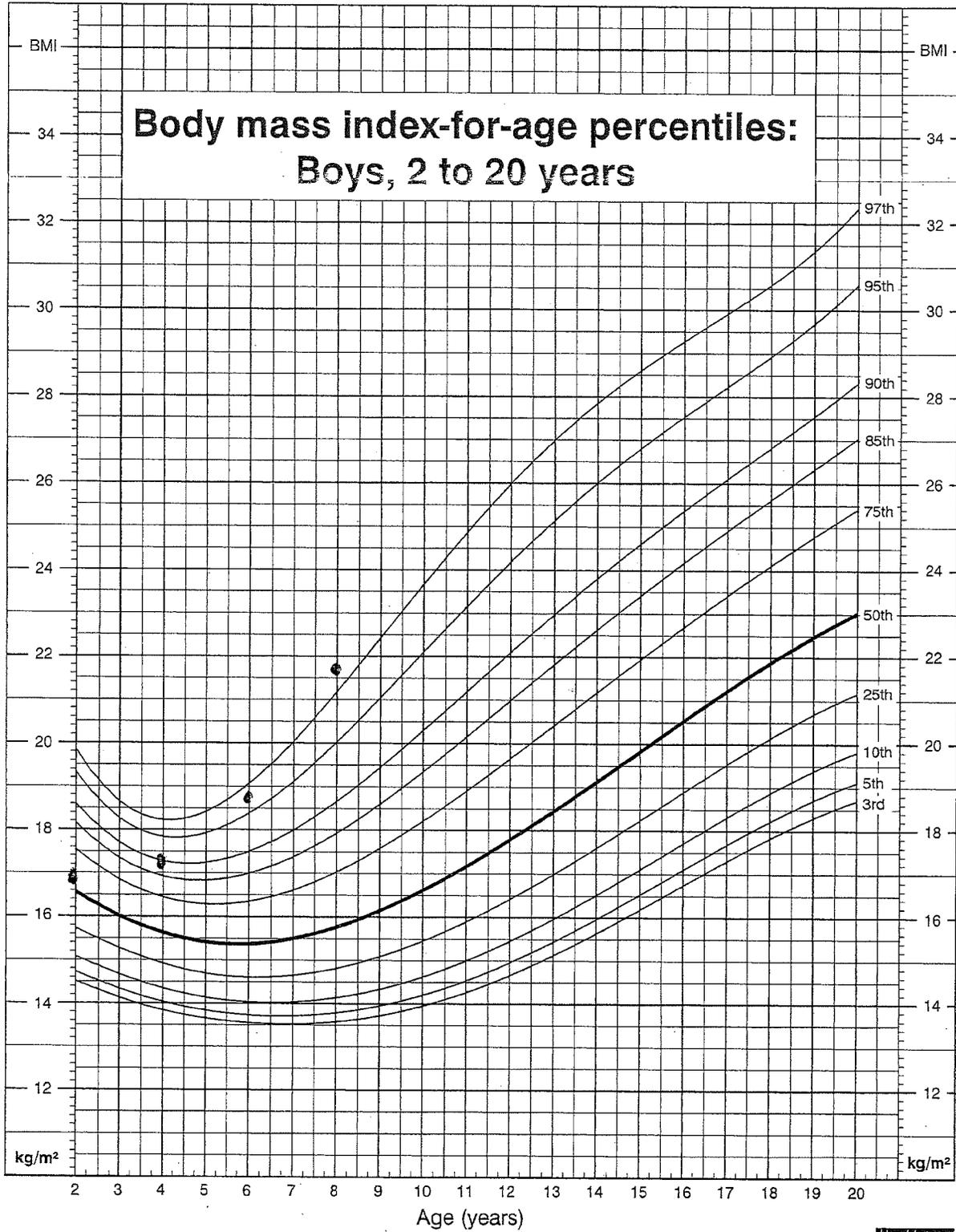
NAME Case 3 / Scenario C
 RECORD # _____



Published May 30, 2000 (modified 11/21/00).
 SOURCE: Developed by the National Center for Health Statistics in collaboration with
 the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>



CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



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Tools, References and Resources

Communication Skills Learning Tools for the Pediatric Clerkship

One important goal of your pediatric training is to learn to gather histories from parents and patients in a variety of settings. The resource presented here will help you to learn and improve on these skills, building on experiences you have had working with adult patients.

Practicing with real patients is the core part of learning and developing these skills. Depending on your experiences prior to your clerkship, you may find it useful to use some or all of the resource presented here.

1. Observe your preceptor doing different types of pediatric interviews and note their approach. Directed observation and then discussion afterwards will help you notice specific skills we want you to practice during the clerkship. Communication skills may differ for well child exams or for new/acute visits. We have developed a Communication Checklist that identifies areas for review when speaking to patients and families in these settings. You can find the checklist on the clerkship website:

<http://www.washington.edu/medicine/pediatrics/students/current/third-year>

While observing your preceptor performing a well child exam and an acute care visit, fill out the appropriate checklist (“Medical Interviewing Rating Tool Established Well Child Care” or “Medical Interviewing Rating Tool Acute care/sick visit”). Afterwards, discuss with your preceptor how to approach different aspects of communication and any elements about which you have questions. As you know, the clinical encounter is complex, and there is no “right way” to conduct patient histories.

2. Review teaching materials about pediatric communication
 - a. There is a general overview of how to communicate with children in your clerkship manual.
 - b. There is a short video (<https://www.youtube.com/watch?v=zOF6Zfol7Ws>) that models how to conduct a well-child visit.
 - c. Aquifer Pediatrics cases 1-5 also cover well child visits.

Review as much as you need to before conducting the visits to make sure you are comfortable and confident with your patients.

3. Ask your preceptor to observe part/all of a well-child and/or acute care visit. They can use the SAME checklist you did when you observed them. Review your technique with your preceptor, using the checklist as a guide for your discussion.
4. Get feedback on your skills – this should be continuous throughout the clerkship – from patients, faculty and your own self-feedback. The checklist on the observed patient interactions is there to guide you on our expectations for minimal competency and to make sure feedback happens.

Approach to the Pediatric Patient in the Medical Setting

Taking a history & physical exam from toddlers, children, or adolescents & their caregivers

What is a “Pediatric Patient-Centered” Approach?

- Takes into account the patient's **previous experience** with medical illness
- Considers the patient's **cognitive ability & developmental stage**
- Involves the patient in **age-appropriate** ways
- Views the patient and caregiver as “**the expert(s)**” on the patient, including **historical details** and how the patient may **cope** with illness

Why does a “Pediatric Patient-Centered” Approach Matter?

- Improves collection of historical data & physical exam findings
- Enhances the patient & family's ability to **cope** with illness
- Improves **adherence** in-house & with out-patient regimens
- It will **SAVE time** because it improves care!

Common Reactions of Pediatric Patients in the Hospital Setting

- **Overt or Active:** crying, resisting treatment, destructive to the environment
- **Passive:** decreased eating, decreased communication & activity
- **Regressive:** temper tantrums, toileting accidents, dependency on parents

General Principles When Communicating with Pediatric Patients

- **Get their attention** before speaking: engage the patient with a non-judgmental, non-specific comment about surroundings, TV, interests, etc.
- **Get on the child's eye-level** when speaking with him/her. (i.e., avoid standing over the bed.)
- **Always introduce yourself and explain who you are (including your role on the team, i.e. as medical student).** Don't be shy about showing your name on your badge.
- Don't ask if you are not ok with the possible answer. (e.g., Can I come in? Can I examine you?)
- **Don't minimize or ignore** the patient's experience or feelings (i.e., don't say “it's okay!”)
- Ask children to **repeat** what you said in order to correct misunderstandings.
- **BE HONEST!**
 - Always **answer questions truthfully** (i.e., It's okay to say “I don't know”)
 - Use honest, simple, minimally threatening explanations that are developmentally appropriate.
 - Avoid reassurance with potentially false/vague statements. (e.g., Don't promise it won't hurt!)
 - In being honest, you avoid creating mistrust between the patient and the medical team.

When Communicating with Patients: Developmental Stage Considerations

Toddlers/Preschoolers

- Are afraid of being away from their parents
- Have difficulty sitting still
- May conceptualize illness as a punishment
- Engage in concrete and “magical” thinking (e.g., “I am in the hospital because I didn't listen to mommy last night.”)
- Often rely on imitation and look to others, especially parents, for how they should respond

Childhood/School Age

- Begin to understand their bodies and how they work
- Will likely have many questions
- May be afraid that their bodies won't work or they will look different

Adolescents

- Are very worried about privacy and how they look
- Want to feel competent and have their opinions validated
- Can cognitively understand most things about their care, but behaviorally they continue to require monitoring. Adherence difficulties are common, often due to poor education/transfer of skills and desire to fit-in.
- Can fail to see long-term consequences (e.g., explaining that poor diabetes control can lead to dialysis is not often a convincing way to improve adherence in teenagers with diabetes)
- Will often not be forthcoming with sensitive topics unless asked directly

* * *

Involving and Interacting with Parents/Caregivers

- ***Always introduce yourself in full, including role on team.*** Again, don't be shy showing your name on your badge.
- With younger children, try to meet with one or both parents alone first (although this can be challenging in the in-patient setting).
- With adolescents, it is often better – when possible – to meet with them first. Better yet: give adolescents the choice!
- Remember that caregivers have a ***unique understanding*** of their child's medical experiences and therefore provide key details of the medical history including:
 - Patient's experience of and expression of pain or discomfort
 - Patient's knowledge of or understanding of diagnosis
 - Treatment regimen
 - Medication dosage and tolerance
 - Previous hospitalizations & frequency of outpatient care
 - Previous degree of cooperation with each aspect of the regimen
 - Patient's previous level of involvement in care
 - Developmental history, school history, and cognitive functioning

* * *

Tips on Entering the Room & Doing the Physical Exam

- If you need to gown/glove, introduce yourself first with face visible then dress and enter.
- Seat yourself to include patient *and* caregiver at patient's eye-level.
- With toddler/school-age patients, demonstrate use of the stethoscope or other instruments on yourself, a caregiver, a toy or a non-threatening body part (e.g. hand) first.
- If the child appears intimidated by you, try providing distance from the child and visibly engage with the caregiver(s) first before turning to the child. It allows the child to see a positive interaction between you and caregiver making the child more amenable to approaching you.
- Leave the most invasive or painful parts of the physical examination to the end.
- Use distraction as much as possible.

Explanation of Pediatric H&Ps/Pediatric Database

History:

CC: *Same as for adults*

HPI:

The information is the same for any medical problem. A careful and complete description of the presenting problem, with appropriate chronology is key. Always include pertinent positives/negatives and relevant family history or social history items. An important distinction is that much of the history will be observations from a third party (parent/caregiver). Important questions include: mood, activity level, eating pattern, urine output (specific as possible), sleep pattern and a description in the parent's words what the problem is, how it has changed, what they have tried to alleviate the symptoms and what they think is causing the child's illness.

Past Medical History:

Birth/Pregnancy History:

For infants, this component is particularly important. Often birth/pregnancy history is either relevant to the chief complaint or represents the majority of the PMH. Make sure to include these questions on all infants and any child with a problem that might be related to perinatal/neonatal issues.

Maternal: Mother's age, gravida, para, health problems and medications

Pregnancy: Complications, prenatal care/labs/tests

Labor: Duration of membrane rupture and complications

Delivery: Gestational age (at a minimum whether term or premature), Mode (vaginal/C-section/forceps/vacuum), Apgars.

Neonatal: Duration of hospitalization and any events that occurred shortly after birth.

Medical history:

*Any medical problems or hospitalizations with a brief summary and dates.
Specifically ask about the last health supervision visit.*

Surgical history:

Any surgeries and dates

Allergies:

Allergies and reactions

Medications:

*Any prescription medications, over the counter medications or herbs/supplements.
Include doses when known.*

Diet:

Description of diet. Particularly important in the first year of life or if growth is abnormal. In infants comment whether breast feeding (frequency, duration and volume if known) or formula feeding (type of formula, volume and frequency) in infants. In older children ask about typical diet or about concerns the parents may have.

Growth and Development:

This should be part of every history.

The way you ask the questions will change over time. Start with an open ended question to parents like “tell me what types of things your child is doing now”. Childhood development is often categorized into 4 domains (social, fine motor, gross motor and language) and screening questions in each domain should be explored. In older children, make sure to ask about their hobbies, activities, school and friends. Assess academic achievement from parents/patient.

Immunizations:

In every patient ask about receipt of immunizations; there are standard immunizations given at specific ages. Parents sometimes have the immunization record. If the child has not received immunizations, explore the reasons why. Saying “up to date” without checking actual documents or registries is an insufficient response. Try to document what immunizations were given and when.

Family history (include genogram):

Explore any diseases that are in the family (e.g. hypertension, diabetes, or other problems resembling the child’s problem). Also gently explore any miscarriages or childhood deaths in the family.

Social history:

Ask who lives in the home and whether there are other siblings and the state of the siblings’ health. Explore childcare arrangements—whether it is the family, an in-home setting or center-based (larger classrooms). Inquire about what languages are spoken at home. If the child is verbal, directly ask them about school/daycare, friends, and favorite pastimes/toys, pets and siblings/family members. Identify sources of stress for the parents.

Environmental History:

Ask about smokers in the house, firearms, seatbelts, hot water heaters and car seats. Also ask about travel history, pets and exposures to ill people.

Review of Systems:

This section is similar to that for adult patients. Remember that preverbal children cannot report many of the symptoms, so parental observation is the main source of information. A sample review of systems:

<i>General: fever, weight loss, activity</i>	<i>GU: frequency, dysuria ,urine output, hematuria</i>
<i>Endocrine: change in habitus, weight gain</i>	<i>Skin: rashes</i>
<i>Eyes: crossing, pain, redness, drainage</i>	<i>Neuro: seizures, loss of consciousness</i>
<i>HEENT: ear pain, drainage, hearing loss Nose: drainage, discharge, sinusitis Throat: tooth pain, sore throat, hoarseness</i>	<i>GI: feeding/appetite, vomiting, diarrhea, constipation, blood in the stool, abdominal pain</i>
<i>Resp: cough, wheezing, apnea, cyanosis, difficulty breathing</i>	<i>Musculoskeletal: joint swelling, tenderness, weakness</i>
<i>CV: murmurs, chest pain</i>	<i>Psych: mood changes, sleep problems</i>
<i>Heme/lymph: bleeding, anemia, jaundice, swollen glands</i>	

Physical Examination:

The approach to the physical examination will vary with the age of the child. There are special maneuvers that are done at each age. There are specific benchmarks and appendices available in the clerkship manual and on the pediatric student website.

Vital Signs: HR RR Temp BP

Height _____ % Weight _____ % OFC _____ % BMI _____

General: Describe the state of alertness, mood, and willingness to cooperate with the exam and whether the child is in distress

Head: For infants and children feel for the fontanelle. Comment on the shape of the head

Eyes: Note presence of the red reflex in **all** children. Check pupillary reaction, lids/conjunctiva

NB: Fundoscopic exam is difficult to perform on infants but can usually be done in children over 5-6 years of age. (The examination in this age group provides an excellent opportunity to see the optic disc and vessels.)

Ears: Check for tenderness of pinna, discharge and gross assessment of hearing. Check tympanic membranes bilaterally with insufflation.

Nose: Check for discharge, turbinate color.

Mouth/Throat: Check for teeth/caries. Inspect the tongue, buccal mucosal and the posterior pharynx for erythema, enlarged tonsils. Feel for submucosal cleft palate.

Neck: Gently palpate neck for masses and assess range of motion (often by observation).

Lymphatic: Check lymph nodes in neck, axilla and groin.

Chest: Observe for signs of respiratory distress (nasal flaring, retractions and grunting). Normal respiratory rate varies with age. Palpate for tactile fremitus then auscultate anterior and posterior lung fields. Note the inspiratory:expiratory ratio (I:E ratio).

Cardiovascular: Observe for cyanosis, respiratory distress and hyperdynamic precordium. Palpate the precordium (for thrills). Auscultate as in adults---pediatric heart rates are faster than adults thus distinguishing systole and diastole is more difficult. An S3 may be found in normal children (represents rapid ventricular filling). Many children will have benign murmurs (of no medical importance) ---train your ears to hear them! Palpate the peripheral pulses as in adults. (Femoral pulses are particularly important to check in neonates when screening for coarctation of the aorta).

Abdomen: observe, auscultate and palpate as in adults. Children often have a palpable liver edge...always palpate from the pelvic brim up.

GU: See Sexual Maturity Rating (SMR) information in the Aquifer Pediatric cases and physical exam benchmarks in the clerkship manual and on the medical student website.

Musculoskeletal: Much of this portion of the examination is observation for tone and strength. In neonates, observe for increased or decreased tone...both are pathological. When children are older and can follow directions, the approach is similar to an adult exam. There are also special maneuvers to screen for congenital hip dysplasia (Barlow/Ortolani maneuvers).

Neurological: Much of this exam is by observation (especially the cranial nerves). Children have deep tendon reflexes just like adults that should be tested. Neonates have primitive reflexes that are considered normal (like an upgoing toe with a Babinski test).

Example H&P (Older Patient)

CC: AB is a 16-year-old female presenting to the Emergency Department with 4 days of bloody diarrhea, abdominal pain and fever.

HPI: AB was in her usual state of health until 7 days prior to admission when she started experiencing nasal congestion, clear rhinorrhea and low-grade fever (maximum temperature 99-100). She went to her primary care provider, had a CT scan of her sinuses done, was diagnosed with a sinus infection and was treated with a nasal spray (patient not sure what type). Five days prior to admission, she began having intermittent fevers to 101.9, which have continued until the time of admission. Four days prior to admission, AB started having severe (7/10) generalized abdominal pain, worse in her subgastrium. She describes the pain as constant, dull, non-migratory, not relieved by anything, including acetaminophen, and exacerbated by eating. During the three days prior to admission, she has also had 3-4 episodes of bloody red diarrhea with the abdominal pain. She says that having a bowel movement makes her abdominal pain worse. AB has also had 2 episodes of nonbloody, nonbilious emesis in the past two days. She has noticed increased fatigue and has lost 2 lbs in the last week, though she still has a good appetite.

Notably, AB was seen approximately 5 months ago in the Emergency Department in Everett with abdominal pain. She had no diarrhea or emesis at that time. Her stool guaiac was negative, but was diagnosed with iron deficient anemia with a hemoglobin of 12.2 g/dL. She was sent home on iron supplements and no clear diagnosis for her abdominal pain. Since that episode she has noticed intermittent abdominal pain, fatigue and has lost 10 lbs.

She denies any rashes, arthralgias or myalgias, eye discharge or inflammation, oral lesions, cough, jaundice, petechiae or easy bruising. She has normal urine output. Her past medical history is also remarkable for cholecystitis requiring cholecystectomy at the age of 10. Her travel history is significant for being in N. Europe on a cruise 3 months before the onset of symptoms. She has two dogs and one cat. Her LMP was last week and was normal in volume and duration. AB does not have a family history of inflammatory bowel disease or rheumatological diseases.

Past Medical History:

BH: Term, vaginal delivery, no complications

PMH: Abdominal pain, cholecystitis and anemia described in the HPI. Otherwise negative.

GPO, regular menses

Immunizations: Up to date, including HPV and influenza (checked online vaccine registry)

Past Surgical History: Cholecystectomy, 6 years prior to admission (see HPI)

Medications: Ferrous sulfate for anemia
Multi-vitamin
No over the counter meds or alternative therapies

Family History: No history of inflammatory bowel disease (Crohn's or ulcerative colitis); No history of childhood rheumatological diseases or systemic lupus erythematosus. Paternal grandmother has psoriasis. Maternal grandmother with osteoarthritis. Paternal grandfather with heart disease and diabetes. No sick contacts.

Social History: Lives in Marysville with Mother, Step-Father, 15 mo brother

Is in the 11th grade, same school as last year; good grades (A's and B's).
Plays soccer and tennis; sings in the school choir
Denies EtOH, nicotine, and other drug use.
Is not and has not been sexually active. No current partner (boyfriend or girlfriend).

Review of systems:

General: See HPI
Endocrine: Weight loss as in HPI. No polyuria/polydipsia
Eyes: see HPI; no redness, no blurred vision or double vision.
Ears, Nose, Throat:
Ears: ear pain or drainage, no hearing loss.
Nose: see HPI
Throat: no tooth pain, sore throat or hoarseness
Cardiovascular: no chest pain or murmurs
Genitourinary: normal urine output, no frequency, dysuria, hematuria
Gastrointestinal: see HPI
Musculoskeletal: See HPI
Hematology/Lymphatic: see HPI; no jaundice or swollen glands
Psychiatric: no mood changes or sleep problems

Admitting PE:

Vitals: T 37.8 HR 110 RR 18 SaO₂ 97% on RA BP 113/82 Pain 5/10

Weight 42.5 Kg (< 3%) Height: 158 cm (25%)

General: well developed but thin young female, looks fatigued w/o significant distress

Skin: pale skin, no rashes or erythema, no petechiae or bruising

HEENT:

Eyes: PERRLA, full EOM, conjunctiva without exudates; sclera anicteric without injection, no periorbital edema

Ears: pinna and canals normal; TMs gray w/o erythema

Nose: nasal turbinates are slightly swollen and mildly pale with some clear rhinorrhea

Oropharynx: dry lips, mildly dry oral MM, 2+ tonsils w/o exudates or crypts, no pharyngeal erythema.

Neck: Supple with full range of motion; non tender to palpation. Thyroid soft and without nodules.

Lymphatic: no cervical, supraclavicular, axillary, inguinal adenopathy.

Chest: Symmetric inspiration, clear to auscultation bilaterally with no wheezes, crackles or rhonchi.

Breasts: SMR stage V

CV: Tachycardic, regular rhythm, prominent PMI over 5th intercostal space ~ MCL, normal S1 and S2, I-II/VI systolic ejection murmur over L sternal border, < 5cm CVP; 1+ radial and pedal and inguinal pulses which are symmetric, capillary refill 2-3 seconds.

GI: several small well healed scars from previous lap cholecystectomy, active bowel sounds, tenderness on light palpation in all 4 quadrants and worse in LLQ and RLQ, + guarding in LLQ, + peritoneal signs by moving the patient and rebound tenderness in LLQ, negative obturator and psoas signs, liver edge and spleen not felt. Liver span estimated to be 7 cm. No masses palpated.

Rectal examination: normal tone, no masses; no fissures; guaiac positive.

GU: 3 skin tags in the peri-anal region, no abscesses, erythema or fistulas in perineal region, SMR stage V genitalia and pubic hair.

MS: full ROM w/o pain, no erythema or increased warmth over joints, no effusions. No clubbing

Neuro: CN II-XII intact, Muscle strength 4-5+ throughout, 1+ and symmetric patellar reflexes, sensation to light touch intact in all extremities

Laboratory:

CBC: 8.1 WBC (28%pmns, 33%lymphs, 12%mono, 23%bands); Hemoglobin 9.1, Hct 27.4; MCV 89; RDW 13; RBC morphology is normal; Platelets 622K
U/A: pH 6.5; 1.025 sp gravity; tr protein; 0-5 WBC; 0-5 RBC; LE neg; Nitrite neg
Chemistry: Na 143, K 3.8, Cl 103, HCO₃ 29, BUN 11, Cr 0.7, Glu 97
CRP 4.3
ESR 114

Assessment:

AB is a 16 y.o. female with several month history of intermittent diffuse abdominal pain, fatigue, ten pound weight loss, with an acute course of profuse bloody diarrhea with low-grade fever. Her physical examination is remarkable for signs of peritonitis and volume depletion without signs of shock. Notable laboratory data include elevated inflammatory markers, anemia, normal platelet count and a left shift on her CBC.

AB's bloody diarrhea with fever and abdominal pain can be from infectious enterocolitis (parasite and bacteria), inflammatory bowel disease (IBD), malabsorptive (celiac), vasculitis (HSP, PAN), carcinoma of ileum or colon, carcinoid tumor, intestinal lymphoma as well as other less likely diseases. Given AB's long standing illness course with weight loss and anemia it is likely that she has a chronic illness thus making inflammatory bowel disease (IBD) the most likely diagnosis. Other chronic illnesses such as carcinoma, lymphoma or carcinoid tumors are unlikely in this age group. There are no specific signs/symptoms that differentiate ulcerative colitis (UC) and Crohn's disease (CD). Weight loss, bloody diarrhea, abdominal pain, fever and anemia can occur in both CD or UC. Given her skin tags, and past cholecystitis, it is more likely that she has CD than UC. In addition, she has significant elevation of CRP and ESR, and a left shift on her CBC indicating severe acute inflammation, which is all consistent with inflammatory bowel disease.

An infectious agent is less likely because of the chronic course, no significant travel risks, lack of suspicious foods eaten and no sick contacts. While she did travel before the onset of the symptoms, the travel was not temporally related to her symptoms. Possible agents could include E. coli O157:H7, E. coli (other pathogenic strains), Shigella, Salmonella, Yersinia enterocolitica, C. jejuni, C. difficile, amebiasis, giardiasis and cryptosporidium. Stool culture and O&P exams are necessary to diagnose an infection. Celiac disease rarely presents with bloody stools, but could explain her weight loss and abdominal pain. She has no other features of vasculitis, such as rash, swollen joints or kidney dysfunction to suggest these possibilities as the cause of her symptoms. However, if no unifying diagnosis is determined, further consideration and testing of these causes of her symptoms should be pursued.

AB's anemia is normocytic with an MCV of 89 and a Hct of 27.4. Typically iron deficiency anemia is microcytic making this diagnosis less likely. Her RBC morphology is normal, making intravascular hemolysis less likely. The anemia is most likely due to acute blood loss, and/or anemia due to chronic inflammatory state and poor iron utilization. Her anemia can also be complicated by B12 or folate deficiencies due to poor absorption. Her RDW is within normal range. If needed, a ZPPH, iron studies, B12 and folate levels, and reticulocyte count can be ordered to work up a continued anemia. Since she is likely volume depleted as suggested by her tachycardia, she may be more anemic than she appears to be at the time of admission.

Plan:

Bloody Diarrhea:

1. Abdominal x-ray for focal abdominal pain. Monitor abdominal exam for increased pain, nausea, continued bloody diarrhea and signs of obstruction (bilious emesis, severe abdominal pain, leukocytosis, SIRS, sepsis).
2. Consider H2 or PPI for gastritis.
3. Consult gastroenterology for consideration of diagnostic endoscopy.
4. Obtain Stool Cx, stool O&P, C. difficile toxin screen. No empirical antibiotics but monitor closely for clinical deterioration or signs of sepsis. If C. difficile toxin positive, initiate treatment.

Anemia:

1. Recheck CBC x 2 if she continues to have bloody diarrhea
2. Consider transfusion if Hgb < 8.5 gm/dL. It is very possible that she will need a transfusion because she is volume depleted and has on going hematochezia which will make her hematocrit lower.

Fluids/Electrolytes/Nutrition:

1. FEN: D5 + NS + KCl 20meq/L @ 100cc/hr. Monitor urine output to determine if additional normal saline boluses will be needed to correct volume depletion. Continue IV fluids until she is taking adequate PO and vitals are stable. Monitor vitals for orthostasis. Optimize fluids to maintain normal heart rate for age.
2. Clear diet, ad lib.

Example H&P (infant)

ID/CC: 7 mo old ex-40 week AGA healthy infant male presents w/ a 3 month history of faltering growth and a 1 mo history of recurrent upper respiratory symptoms

HPI

TS's mother believed her infant to be in good health until earlier today when during a routine primary care visit his pediatrician was alarmed by his thin appearance and fall in his weight for age from the 30th percentile to the 2nd over the past 3 months. His length and head circumference for age also dropped across percentiles during this period but have remained on the normal curve. The mother denies any recent changes in TS's appetite and explains that he eagerly breastfeeds every 2-3 hours for 5-10 minutes at a time during the day (without nighttime feedings from 10 pm to 7 am) plus soft baby foods 1-2 times per day. She believes that this "is approximately the same amount that her two older daughters ate at that age". She also believes that her milk supply is "good" because she is easily able to express milk by squeezing her breast. She is also currently 16 weeks pregnant.

She denies TS having symptoms of fatigue, diaphoresis or rapid breathing during feeding as well as post-feeding fussiness, emesis or diarrhea. He has 2-3 wet or mixed diapers per day and his stools are brown in color without melena, clay color or bright red blood, and they are not particularly foul smelling. TS's development thus far has been appropriate for age and growth was following a normal curve at least until 4 months of age. Neither parent has a known history of HIV or other sexually transmitted infections nor any high risk behaviors. There is no history of recent travel or exposure to persons infected with TB. He has had one newborn metabolic screen at 1 day old which was normal; the second screen was not obtained.

Of note, TS has also experienced approximately 1 month of recurring fever, cough and rhinorrhea that lasts for 3-4 days at a time. He is having some of these symptoms today with a transient fever to 101.2 earlier today but no wheezing, stridor or increased work of breathing. He has had all of his childhood immunizations up to the age of 4 months with the exception of rotavirus and influenza. Several family members have also had these symptoms all of which have self-resolved. The mother describes no changes in TS's appetite or feeding frequency/duration while ill.

ED Course

On arrival to SCH ED, TS was afebrile and all vital signs were within normal limits. He was given a 300 ml NS bolus via peripheral IV. CBC, electrolytes, CRP and a viral panel were obtained. He arrived to the floor shortly thereafter.

Birth Hx

Born at 40 +3/7 AGA to G3P2 mother via uncomplicated vaginal delivery. APGARs at birth were 7 at one minute, 8 at five minutes. The mother's screening was remarkable only for lack of Rubella immunity. Neonatal course remarkable for mild jaundice (Tbili max = 6.8) which required no intervention and initial difficulty latching. Both resolved prior to discharge.

PMH

Stable/Resolved Problems

1. Neonatal jaundice: see Birth Hx
2. Difficulty breastfeeding: see Birth Hx

PSH

None

Allergies

None known

Medications

No medications or supplements

Diet

See HPI.

Growth and Development

Weight for age: 30th percentile (age 4 months) -- 2nd percentile (age 7 months)

Length for age: 85th percentile (age 4 months) --15th percentile (age 7 months)

Head circumference: 70th percentile (age 4 months)--40th percentile (age 7 months)

TS is able to sit up on his own with good head control, starting to crawl, reaching for objects, stacking blocks and babbling. His mother reports that he is developing similarly to his sisters, even during the time he has lost weight.

Immunizations

Routine vaccinations up to age 4 months with the exception of Rotavirus and Influenza

Family Hx

Hyperthyroidism: paternal grandfather and cousins

Type II DM: maternal grandmother

Both parents and 2 older siblings with no significant PMH

Social/Environmental Hx

Lives in home in Everett, WA with mother, father and two sisters (ages 2 and 4). Mother stays at home while father works outside of the home as an engineer during the day. No additional care providers. TS does not attend day care. Mother does not have any concerns for safety in the home.

Exposures: both parents are non-smokers, cleaning supplies and toxins out of reach, pets include 2 Guinea pigs.

ROS

Gen: +transient fevers over past month (see HPI), no chills or sweats, activity at baseline,

Endo: no change in habitus, + weight loss (see HPI)

HEENT: no head trauma, + stork bites over bilateral eyelids, no eye crossing, no rhinorrhea, +moderate clear nasal drainage, no ear pain, drainage, or hearing loss, + thick white coating on tongue and lips, no hoarseness.

Resp: + intermittent wet cough (see HPI), no snoring, apnea, increased work of breathing, cyanosis or wheezing

CV: no murmurs, no fatigue, sweating or tachypnea with feeding, no cool extremities

Heme/Lymph: no easy bruising or bleeding, anemia, jaundice or lymphadenopathy

GI: no signs of abdominal pain, normal appetite, no dysphagia or choking, no hematemesis, diarrhea, melena or hematochezia, no constipation

GU: no change in frequency, urine output or urine color, no hematuria

Neuro: no seizures or LOC

MSK: no joint swelling or erythema, no asymmetry or weakness

Skin: erythematous papules in diaper region

Psych: no changes in sleep pattern or appetite

Physical Examination:

Vital Signs (on admission)

Weight: 6.322 kg (2%); Height 65cm (15%); Head Circumference 42.5 cm (40%)

HR: 148

BP: 81/67

RR: 32

SpO2: 100% on RA

Temp: 37.6

Gen: pale and thin appearing, alert and interactive, consolable when fussy

HEENT

Head: NC/AT, anterior fontanelle 1 cm and flat, sutures normal with no overriding.

Eyes: normal position, normal red reflex, PERRLA, EOMI, conjunctiva somewhat pale, no scleral icterus

Ears: pinna normally positioned; no drainage, external canal without erythema or exudate, TMs slightly red bilaterally but no bulging or pus.

Nose: non-purulent drainage, nares patent, no nasal flaring

Throat: 2 erupting bottom teeth, palate intact, posterior pharynx without erythema or exudate, normal appearing tonsils without pus, tongue, buccal mucosa and soft palate with thick white plaque

Neck: no masses; thyroid normal size and consistency

Lymphatic: shotty anterior cervical lymphadenopathy; no inguinal or axillary lymphadenopathy

Chest: normal inspiratory: expiratory ratio, symmetrical chest expansion, no wheezing, rales, ronchi or stridor, no increased WOB

CV: RRR, no murmurs, rubs or gallops, brachial, femoral and dorsalis pedis pulses full and symmetrical, no cyanosis

Abdomen: soft, non-tender, non-distended, no masses, 1 cm reducible umbilical hernia, normoactive bowel tones, liver edge is palpable 2 cm below the right costal margin; no spleen tip is palpable.

Back: normal curvature, no sacral dimples or hair tufts

MSK: normal ROM, joints without erythema or swelling

GU: SMR stage 1, normal genitalia, testes descended bilaterally, anus patent, erythematous patch with satellite lesions along inguinal folds and beneath scrotum

Neuro: alert and interactive

Cranial nerves: II-X and XII intact by gross examination

Motor: 5/5 strength upper and lower extremities

Tone: normal, no fasciculation

Sensory: responsive to light touch

Reflexes: 1+ patellar reflexes, +Babinski, no moro, rooting, palmar or plantar grasp

Cerebellar: unable to assess

Gait: unable to assess

Labs/Studies

CBC w/diff

WBC: 8.6

Hb: 10

Hct: 30 (L) MCV 72 (L)

Plts: 167K

Electrolytes: Na 139 K 3.9 Cl 110 HCO₃ 25 BUN 10 Cr 0.3

CRP: 1.4 (H)

Viral PCR: + for RSV

Assessment/Plan

7 month old previously healthy and developmentally normal breastfed male presents with poor growth since last assessed by PCP at age 5 months. He has a normal appetite without vomiting or diarrhea, no loss of developmental milestones but 1 month of recurring URI symptoms of fever, cough and rhinorrhea. Physical examination is remarkable for white plaques on his tongue/buccal mucosa, rhinorrhea, and erythematous diaper rash. Viral PCR positive for RSV.

Problem 1: Faltering Growth

TS meets faltering growth criteria due to a decrease in weight from 7.0 kg at age 4 months to 6.32 kg at age 7 months (from approximately 30th percentile to 2nd percentile on weight for age). His length and head circumference have also crossed percentiles but remain on the normal curve. The DDx for faltering growth broadly includes nutritional causes (neglect, abuse, inadequate feeding) vs metabolic/increased demand causes (CHD, diabetes, RTA, malignancy, inborn errors of metabolism, etc) vs infectious (UTI, HIV, TB) vs malabsorption causes (CF, cow-milk-protein intolerance, IBD, GERD, pyloric stenosis, etc).

The most likely cause of faltering growth in this previously healthy and developmentally normal 7 mo male is inadequate nutrition both because it is epidemiologically most likely and because there are no obvious signs/symptoms of organic causes. There is also some suggestion from his mother's lactation history and current 16 week pregnancy that her breast milk may be inadequate to support this infant. In addition, TS is being offered only once daily table foods which is likely too little to make up for deficiencies in breast milk. Poor latching and inadequate frequency of feeding are unlikely given the mother's ability to provide detailed history of his feeding schedule. UTI and prolonged URI are also possible given the recent fevers and accompanying symptoms, however these would be unlikely to cause such a dramatic change in growth over a 1 month period in the setting of normal PO intake.

The report of recurrent URI symptoms, mouth plaques c/w thrush, and yeast infection also raises suspicion for possible congenital immune deficiencies such as severe combined immune deficiency (SCID), selective IgA deficiency or x-linked agammaglobulinemia. SCID commonly presents with faltering growth and thrush but usually also includes chronic diarrhea which TS has not had. I would also not expect normal growth for the first 4 months of life with this etiology. Agammaglobulinemia fits TS's age (decreased maternal IgG by 6 months) but he has not experienced recurrent bacterial infections and tonsils are present. Selective IgA deficiency is possible in the setting of recent recurrent URI symptoms but usually doesn't present as faltering growth as the first symptom; I would expect more sinopulmonary symptoms. HIV and TB are much less likely given no maternal or paternal h/o HIV infection or risky sexual behavior and lack of travel or exposure to contacts with TB. Malignancy should also be considered given his recent pattern of fevers and weight loss; however this is also less likely than inadequate feeding. Neglect and/or abuse should be considered although there are no overly concerning findings on social history or physical exam to raise significant suspicion.

Other possibilities including CHD, CF, milk protein intolerance, IBD, GERD, pyloric stenosis, diabetes, inborn errors of metabolism, and RTA are least likely given the lack of suggestive history and physical exam findings. CHD would likely present as fatigue, diaphoresis, tachypnea during feeding. CF would present with greasy, foul smelling stools and possibly rickets. He has no h/o high blood glucoses or polyuria to suggest diabetes. Milk protein intolerance and IBD would be suggested by bloody stools of which there is no history. GERD and pyloric stenosis would present with significant post-feeding symptoms (projective vomiting, fussiness, tachypnea). Inborn errors of metabolism would have likely been discovered on his newborn screen (although he did not have a 2nd screen) and presented earlier in infancy. I would also expect developmental delays with this etiology. RTA or chronic renal insufficiency would be considered if urinalysis and/or electrolyte abnormalities were present (elevated BUN, creatinine), but there is no e/o this currently.

- Pre- and post-feeding weights to determine adequacy of breast feeding
- Calorie counts
- Strict I&O's

- Nutrition and lactation consults
- Social work consult to evaluate for psychosocial contributors
- UA to r/o UTI and renal causes
- Stool elastase to r/o malabsorption
- Q6 vital signs
- No maintenance fluids at this time, reassess if become tachycardic or hypotensive
- Nutrition and lactation consults as above
- Consider re-feeding labs

Problem 2: Anemia

TS's anemia is most likely secondary to combined iron and possibly folate deficiencies given current state of malnutrition. Will want to reassess as outpatient if does not resolve with improved nutrition.

- Multivitamin supplementation
- Consider infant formula if breastfeeding determined to be inadequate
- F/u CBC as outpatient

Problem 3: URI symptoms (low grade fever, cough, rhinorrhea)

TS has been afebrile since arrival to the ED but most likely etiologies of transient low grade fever, cough and rhinorrhea in this 7 month old infant w/viral panel positive for RSV and no increased WOB is URI. Recent contacts with similar, self-resolving symptoms support this diagnosis. UTI or other bacterial infections are also possible but less likely given the long duration and self-resolving nature of symptoms.

- UA as above to screen for other common causes of fever

Problem 4: Elevated CRP

Likely 2/2 a combination of malnutrition and current respiratory illness.

- Address malnutrition as above
- Monitor for signs of worsening illness

Problem 5: Diaper rash/ mouth plaques

Likely 2/2 yeast, such as Candida, given the location and satellite lesions. Mouth/tongue plaques also c/w oral candidiasis.

- Oral and topical nystatin

Disposition

-home, pending ability to gain weight in hospital and parental education regarding adequate intake or determination of organic cause.

Pediatric Physical Examination

Students often feel intimidated about performing the pediatric physical examination.

We have provided some tools to make learning this skill easier and hopefully fun for you!

A few pearls for the examination:

- You may have to do the physical examination out of order in many children. Be flexible.
- You can't stop and write down your findings as you go. You have to remember what you saw/heard/felt. Write it down afterwards.
- Save the most invasive parts for last (ears and mouth).
- Children over 5 can usually follow directions, so their examination is similar to adults.
- Enlist the caregiver's help as needed!
- Have fun and think of how to make this a game (for yourself and your patient).

Review the following video that provides additional tips for performing physical examinations in children. The video is found on the COMSEP website (Council of Medical Student Education in Pediatrics—the national pediatric clerkship organization).

<https://www.comsep.org/multimedia-teaching-resources/>

After you have watched the video, look through the Physical Examination Benchmarks and Appendices.

Watch your preceptor/faculty member/resident do an exam and then go for it!

Use the Physical Exam CEX as a way to track your progress.

Remember, the more you practice, the better you will become. Ask the people you work with to show you how to do the physical examination. Be honest if you don't hear or see a physical exam finding. And remember, the more you practice....

Benchmarks for the Pediatric Physical Examination

General Approach

One should be flexible when examining children. You must establish rapport with the child and the parent before starting the exam. In general, children between the ages of 8 months and 4 years require the most flexible approach. For younger children you should perform the most “invasive” part of the examination (e.g. the head and neck examination) last.

Do

Use an age appropriate approach to the examination

- Newborn: Place the newborn on the examination table. Conduct a general assessment by observing the child and then listen to the heart and lungs. Once those are accomplished proceed with the remainder of the exam.
- Infant/Toddler: You may examine the child in the caregivers lap. Begin slowly with a non-threatening part of the examination, perhaps the hands. Then move to the heart and lung exam. End with the head and neck examination, focusing on the ears and throat last.
- Older child/adolescent: The sequence of the examination is the same as that of the adult. Pay particular attention to modesty and whether parents will remain in the room.

Assess the child’s growth

- Review the child’s height/weight (and head circumference for infants) and percentiles. Determine BMI if not done.
- Plot/review growth measurements:
 - Assessing growth is a part of each pediatric encounter because this is a sensitive measure of overall health of the child. There are growth curves available for different age groups (0-36 months, 2-20 years). Review growth curves generated by an electronic health record or plot the data yourself for review.
- Weight:
 - Infants should be weighed naked or in a diaper only. If the weight is too high/low recheck the weight and accuracy of the scale. Fluctuations in weight influence management of children, especially those who are hospitalized.
- Height:
 - Most children younger than 2 years cannot/will not stand by themselves so their length is measured instead of their height. There are measuring devices to assist with accurate assessment. If there is any concern about growth, measure the length at least twice.
- Head circumference:
 - The tape should encircle the most prominent portions of the head. For increased accuracy, measure three times; it is easy to make an error. Do not start your examination with this measurement as the infant may start crying!
- Body mass index (BMI)
 - BMI should be calculated in all children and followed in addition to height and weight. To calculate BMI:
 - $Wt (kg) / stature (cm) / stature (cm) \times 10,000$
 - Or $Wt (lb) / stature (in) / stature (in) \times 703$
- Special situations:

- Premature infants: the growth of premature infants is typically “corrected” for their premature birth. Although special growth charts are available, many pediatricians plot the current weight at the “chronological” age and then subtract the months/weeks of prematurity (e.g. if the child was born at 30 weeks they subtract 10 weeks) and plot the growth parameters at the “corrected” age. Plotting the corrected age usually continues until age 2 years.
- Other populations: there are special growth charts available to plot the growth for children with Down syndrome, Turner syndrome and achondroplasia.

Know

- Be alert to the possibility of a problem when the head circumference is at one extreme or the other.
- Sequential measurements of growth are sensitive measures of overall health.
- Alteration in the rate of growth “crossing percentiles” should alert you to possible underlying problems.
- Typical weight gain in the newborn period: 20-30 grams/day.
- Typical height velocity:
 - In children 5years –puberty, normal growth velocity is ≥ 5 cm/year;
 - < 5 cm/year should be investigated; <4 cm/year is pathologic.
- Patterns of growth:
 - Growth hormone deficiency: high weight-to-height ratio.
 - Chronic disease (e.g. inflammatory bowel disease):(low weight-to-height ratio).
 - Constitutional growth delay: normal weight-to-height ratio.

The maneuvers you use in the adult physical examination are also used when examining children with appropriate adjustment for age and size. It is expected that you will be able to correctly execute the basic physical examination maneuvers commonly used for all patients.

Newborn Examination

You should be able to conduct a complete examination of all organ systems in a newborn using an age appropriate approach. These examination techniques are the same as for adults with adjustments for age and size. Specific maneuvers that are a part of the neonatal examination that you should be able to demonstrate include:

Fontanel assessment:

Do

- Palpate the anterior fontanel, assessing size and firmness
 - Place the infant in an upright position (and hopefully she/he will remain calm!)
 - Gently place your fingers over the anterior fontanel, located midline on the superior temporo-frontal portion of the skull.
 - Gently palpate for the edges of the fontanel.
- Palpate the posterior fontanel (closes earlier than anterior)
 - Repeat the same procedure outlined above, feeling for the posterior fontanel, located in the midline occipital region.

Know

- The posterior fontanel usually closes by 6 weeks of age. The anterior fontanel closes by 18 months in most infants.
- Changes in intracranial pressure or hydration status are reflected in changes of the palpable tension of the fontanel (increased with increased intracranial pressure, decreased with dehydration).
- Fontanel size varies tremendously; persistent delays in closure or unusually large size of fontanels (particularly the posterior fontanel) may indicate pathologic bone growth delay.
- Craniosynostosis: premature closure of cranial sutures. It may result from a primary defect of ossification (primary craniosynostosis) or, more commonly, from a failure of brain growth (secondary craniosynostosis).
- Conditions associated with a large anterior fontanel (greater than 3 cm) include hydrocephaly, achondroplasia, hypothyroidism, osteogenesis imperfecta, and vitamin D deficient rickets.

Eye Exam:

Do

- Assess whether the red reflex is present
 - Set the ophthalmoscope lens power to "0". Turn on the lamp and look through the ophthalmoscope into both eyes of the child simultaneously from approximately 18 inches away.
 - The newborn infant spontaneously opens his/her eyes if the head is gently tipped forward/backward. This is easier than trying to force open tightly shut eyelids!
- Test corneal light reflex
 - Shine your ophthalmoscope or penlight in the newborn's eyes; you are assessing whether the light symmetrically reflects from the corneas bilaterally.

Know

- A normal red reflex emanates from both eyes and is symmetric.

- Leukocoria (white pupillary reflex) suggests cataracts, chorioretinitis, retinopathy of prematurity, persistent hyperplastic vitreous or retinoblastoma. Leukocoria mandates an urgent ophthalmologic evaluation.
- Many newborns appear to be “cross eyed” because of prominent epicanthal folds. A normal (symmetric) corneal light reflex suggests normal alignment (no strabismus).
- Asymmetric corneal light reflex is a sign of strabismus, an imbalance of ocular muscle tone. Uncorrected strabismus can lead to blindness. Proper coordination of eye movements should be achieved by 3-6 months. Persistent eye deviation requires evaluation.
- Visual acuity of a newborn is approximately 20/400; this rapidly normalizes and by 2-3 years of age is 20/30-20/20.

Hip Exam:

Do

- Assess the neonate for developmental dysplasia of the hip by performing the Barlow maneuver and Ortolani test:
 - Place the baby on a firm surface in the supine position.
 - Flex the thighs to a right angle to the abdomen and the knees at right angles to the thighs.
 - (Barlow maneuver)
 - Grasp each thigh with your forefinger along the outside shaft of the femur, with your middle finger on the greater trochanter and thumb medially.
 - Adduct the femora fully and push down toward the bed.
 - (Ortolani test)
 - Gently abduct each leg from the position of full adduction so that the knees come to lie laterally on the table.
 - During abduction, push the greater trochanters medially and forward with your fingers.

Know

- The infant may have a congenitally dislocated or subluxable hip if:
 - You feel or hear a click during either adduction or abduction.
 - There is spasm or discomfort of the adductor muscles of the femur.
- Developmental dysplasia of the hip:
 - 1/100 infants have clinically unstable hips; 1/800-1000 experience true dislocation. There is a positive family history in 20% of patients and associated generalized ligamentous laxity. 9:1 female-to-male ratio.
 - Developmental dysplasia typically presents after birth in most infants. If it is present at birth, you should look for an underlying neuromuscular disorder. This type of developmental dysplasia of the hip is called teratologic DDH.

Newborn reflexes:

Do

- As part of your newborn exam, elicit the following primitive reflexes:
 - Asymmetric tonic neck reflex (Fencer’s position).
 - Place the infant on his/her back.
 - Turn the newborn’s head to one side.
 - Observe the gradual extension of the arm on the side to which the head is turned.
 - Observe the flexion of the other arm.

- Moro reflex (startle response)
 - Hold the infant supine and support the infant's head with one hand.
 - Gently move the infant's head (while supporting it) below the level of the rest of the body.
 - Observe the infant extend both arms suddenly and rapidly with open hands.
 - Observe the infant bring both hands back to midline in an "embrace" movement.
- Palmar grasp
 - Place your index fingers in each of the infant's open hands.
 - Observe the infant's fingers close around your fingers in a firm grasp.
- Plantar grasp
 - Place your thumb on the sole of the infant's foot under the toes.
 - Observe the toes curl around your thumb.

Know

- Reflexes should be symmetric. Asymmetry suggests weakness in a particular muscle group.
- Primitive reflexes disappear as the infant matures; persistence of these reflexes is a signal of underlying neurological dysfunction.
 - Asymmetric tonic neck reflex (Fencer's position)
 - Appears by 35 wks gestation, is fully developed at 1 month & lasts 6-7 months.
 - Moro reflex (startle response)
 - Appears by 28-30 wks gestation; is fully developed at term & lasts 5-6 months.
 - Palmar grasp
 - Appears by 28 wks, is fully developed by 32 wks gestation & lasts 2-3 months.

Skin exam

Do

- Inspect all of the infant's skin (including diaper area).
- Describe (size, shape, color, distribution) any rashes.
- Note any areas lacking skin.

Know

- Benign lesions that parents may have questions about include:
 - Small angiomas present on the eye lids, nape of the neck, forehead.
 - Milia: small white spots on the skin, particularly on the nose and cheeks.
 - Erythema toxicum: yellowish/white pustules on an erythematous base that occur singly or in groups.
 - Hyperpigmented macules or slate gray macules (previously called Mongolian spots): blueish-green to black in color, more common in people of color, can be mistaken for bruises.
- Concerning changes include large angiomatous lesions, vesicles, pustules or areas lacking skin.
- Midline abnormalities (dimple, hair tuft, moles) on the back may indicate an underlying abnormality in the bones/nervous system.

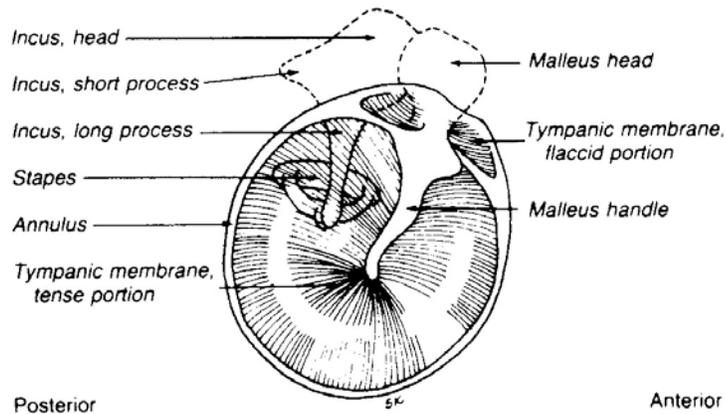
Infant/Toddler Examination

You should be able to conduct a complete examination of all organ systems in all infants/toddlers using an age appropriate approach. These examination techniques are the same as for adults with adjustments for age and size. Specific maneuvers that are a part of the infant/toddler examination include:

Ear examination

Do

- Ask about hearing concerns
 - Inquire about infant's response to noises, voice
 - Observe an older infant's/toddler's speech pattern
- Inspect the ears
 - Assess the shape of the ears
 - Determine if both ears are well formed
 - Assess the position
 - Examine the child from the front, with the child's head held erect and the eyes facing forward.
 - Draw an imaginary line between the inner canthi and extend it around the head.
 - This line should be below the top of the pinnae
- Palpate the tragus and posterior auricular area
- Otoscopic exam including insufflation
 - Position the child for an ear examination
 - This part of the exam can be performed either on the examination table or in the caregiver's lap. The head should be stabilized to prevent movement during otoscopy.
 - A parent or assistant can help with the examination by folding the child's wrists and arms over the child's abdomen with one hand and then holding the child's head against the parent's/assistant's chest with the other.
 - Visualize the external canal
 - Gently hold the tragus and insert the otoscope while visualizing the canal. In contrast to adults, gentle posterior traction may help you visualize the canal and eventually the tympanic membrane.
 - Visualize the tympanic membrane
 - Identify the landmarks starting with the long handle of the malleus then moving to the "cone of light" in the pars tensa.
 - Carefully visualize the pars flaccida.



Courtesy of M. Whipple, MD

- Perform pneumatic otoscopy
 - Hold the otoscope and bulb with one hand and retract the pinna with the other.
 - Gently apply a small “puff” of air to the tympanic membrane.
 - Normal movement: medially (away from you) with the application of air and laterally (toward you) when the bulb is released.

Know

- Hearing:
 - Any delay in language acquisition or loss of language milestones should prompt a referral for formal hearing testing.
 - Hearing impairment is estimated to occur in 1-2/1000 live births.
 - Some etiologies of hearing loss in childhood:
 - Sensorineural: cochlear malformation, damage to hair cells (due to noise, disease, ototoxic agents) or 8th nerve damage.
 - Conductive (most common): ear canal atresia, cerumen impaction, otitis media with effusion.
- Position/Shape of the ears
 - Malformed external and middle ears may be associated with serious renal or other craniofacial malformations.
- Palpation:
 - Tenderness to palpation of the tragus is indicative of otitis externa.
 - You will also typically see white cheesy material in the external auditory canal.
 - Treatment is aural toilet and topical antibiotics.
 - Tenderness to palpation and/or redness in the posterior auricular area may suggest mastoiditis.
- Otoscopy:
 - Areas of retraction in the pars flaccida may represent a cholesteatoma and should be further evaluated. A cholesteatoma acts as a benign tumor causing local bone destruction and is a nidus for bacteria to grow and cause chronic infections.
 - The most common reason for an immobile tympanic membrane (TM) with pneumatic otoscopy is a poor seal between the otoscope and ear canal.
 - You must assess the movement of the TM to determine if a patient has otitis media. In addition to pneumatic otoscopy, acoustic tympanometry can be used.

- Changes in the appearance of the TM that are highly suggestive of acute infection include bulging or purulent material visualized behind the tympanic membrane. Guidelines for the diagnosis and treatment of otitis media: www.aap.org
- Removal of cerumen is difficult but sometimes necessary to adequately see the TMs. The external auditory canal bleeds easily with minor trauma so ask for help if you need to clear out cerumen. It can be done by gentle irrigation with warm water, H₂O₂ or with direct visualization and use of a wire/plastic loop.

Mouth examination

Do

- The approach
 - In young children save the mouth exam for the very last.
 - Ask child to open the mouth and show you their teeth (appropriate for an older toddler/child). If this doesn't work, be prepared to be fast with your tongue blade.
 - An alternative is to be flexible and look in the mouth when the child is crying for some other reason!!!
- Inspect the teeth
 - Count the number of teeth and note position.
 - Note any defects or discolorations.
- Inspect gums, mucosal surfaces and posterior pharynx
 - Inspect the buccal mucosal and gums looking for ulcers, candida or trauma.
 - To see the posterior pharynx, you may have to use the tongue blade and gag the child. Alternative tricks you can use include asking the child to "roar like a lion", "pant like a dog", have their parents model what you would like to child to do or have the child look in your mouth.

Know

- The numbering system for primary teeth is different than the system used in adults.
 - There are 20 primary teeth
 - Time for first tooth eruption is variable. Delayed eruption may be familial or associated with other syndromes/conditions (like hypothyroidism)
 - There may be developmental anomalies associated with tooth development.
- Dental caries is the most common chronic illness in the United States. More than half of children within the U.S. have dental caries. *Streptococcus mutans* is associated with the development of dental caries.
 - Early childhood caries may occur on the smooth surfaces of upper/lower incisors because of prolonged exposure to sugar containing substances.
 - Sites for caries in older children (> 3 years) include pits/fissures of biting (occlusal) surfaces.
- Using a tongue blade in this population is challenging. Inserting it along the side of the mouth and then gagging the child will allow for an unobstructed view of the posterior pharynx in most children.
- The size of tonsils are described in the following way:

Grade	Appearance
0	Absent
1	Visible between the tonsillar pillars
2	Easily visible outside of the tonsillar fossae
3	Enlarged and occupying >75% of posterior pharynx

- The diagnosis of streptococcal pharyngitis is a laboratory, not clinical diagnosis. Other infections that can cause tonsillar exudates include EBV infections, CMV infections, *S. aureus* infections, adenoviral infections.

Heart Examination

The approach to the pediatric heart examination is the same as in an adult. Included here is a brief discussion of murmurs in children.

- Newborn period
 - As the pulmonary vascular resistance decreases, flow through the ductus arteriosus or foramen ovale stops as these structures close. Some murmurs heard shortly after birth will disappear.
 - However, as the pulmonary vascular resistance decreases, this may allow left to right shunting and new murmurs may appear (such as seen with a VSD).
 - Presence of central cyanosis is an important clue for congenital heart disease. Those lesions associated with cyanotic heart disease are the “Ts”: tetralogy of Fallot, tricuspid atresia, transposition of the great arteries, total anomalous venous return and truncus arteriosus (there are others but these are easy to remember).
- Beyond the newborn period
 - 50% of children have innocent murmurs.
 - Non-pathologic murmurs include:
 - Peripheral pulmonary flow murmur:
 - Soft (1-2/6) systolic ejection murmur heard at L upper sternal border with radiation to the axilla and back.
 - Venous hum:
 - Soft (1-2/6) continuous murmur heard in 1st or 2nd intercostal space.
 - Innocent murmur:
 - Soft (<3/6) early systolic murmur heard along the L sternal border between the 2nd/3rd or 4th/5th ribs. Intensity varies with position & might be heard with the bell. “Vibratory/blowing/musical” in quality.
 - Hemic murmur (flow murmur):
 - Heard in states with increased physiologic need (fever, anemia). Heard at base of the heart, soft (<3/6) and often associated with tachycardia.

Musculoskeletal Examination

Do

- Observe the child closely, noting in particular range of motion and limb use
 - An excellent time to get this information is before the examination while the child is playing or interacting with their parents.
- Inspect the joints for redness or swelling
 - Start with the hands or some non-threatening part of the examination; examine the affected joint last.
- Palpate methodically and in a systematic manner the involved area and all other areas that influence the involved area.

- Note muscles, bony prominences, other important landmarks, and joints of the involved body part.
 - Be observant for pain or warmth.
- Assess active and passive range of motion for each major joint.
 - Young children may not cooperate with this part of the examination; you may have to range their joints and gauge how much they resist you to judge function.

Older child/Adolescent Examination

You should be able to conduct a complete examination of all organ systems in all adolescents using an age appropriate approach. The physical examination in an older child/adolescent is very similar to that done in adults. Pay particular attention to patient modesty. Specific maneuvers that are a part of the older child/adolescent examination include:

Sexual maturity rating (Tanner staging)

Do

Assess sexual maturity rating for both male and female patients. You should assess and report pubic hair development separately from breast or genitalia development.

Girls	Hair (Pubic/Axillary)	Breasts
Stage I	No coarse/pigmented hair	Papilla elevated only
Stage II	Scant course pigmented hair on labia	Breast buds palpable, areola enlarge
Stage III	Course, curly hair over mons pubis; Axillary hair develops	Elevation on contour, areola enlarge
Stage IV	Hair of adult quality, not on lateral thigh	Areola forms a secondary mound on the breast
Stage V	Spread of hair to lateral thigh	Adult breast contour

Boys	Hair (Pubic/Axillary)	Testes length	Penis
Stage I	No coarse/pigmented hair	<2.5 cm	No growth
Stage II	Scant course pigmented hair at base of penis	2.5-3.2 cm	Earliest increase length/width
Stage III	Course, curly hair over pubis	3.6cm	Increased growth
Stage IV	Hair of adult quality, not on lateral thigh Axillary hair develops	4.1-4.5	Continued growth
Stage V	Spread of hair to lateral thigh	>4.5 cm	Mature genital size

Know

Pubertal changes typically occur between the ages of 8 and 14 in girls and 9 and 16 in boys. Occurrence of pubertal changes outside these ranges should be evaluated.

- Precocious puberty:
 - Benign precocious adrenarche: may occur in boys before age 9 and girls before age 8. Absence of penile enlargement in boys or of clitoral enlargement in girls distinguishes this from pathologic virilization.
 - Precocious thelarche: isolated premature breast development in girls.
 - Other causes include: CNS tumors, ovarian cysts, gonadal tumors, congenital adrenal hyperplasia, exogenous sources.
- Delayed puberty:
 - Constitutional (physiologic): most common, occurs in boys more often and is associated with delayed growth and bone age; ask about family history.
 - Other causes: Malnutrition (including anorexia nervosa), chronic disease, central causes (hypothalamic/pituitary abnormality, tumors, drugs, other endocrine problems like hypothyroidism), gonadal causes (chromosomal—XXY, XO, anatomic abnormalities, immunologic).

Musculoskeletal exam

An excellent demonstration of the 2 minute orthopedic examination in an older child can be found in Aquifer Pediatrics case # 6 (Mike pre-sports physical); also Chapter 17 in Goldbloom's Pediatric Clinical Skills (p 311).

Do

- Be able to perform a basic musculoskeletal examination (see Foundations-level resources).
- Additional techniques:
 - Assess the strength of the upper and lower extremities' major muscle groups.
 - Be able to test pelvic girdle strength: Ask the patient to sit on the floor and then stand up.
 - Lower extremity strength/joint function: Ask the child to squat and walk like a duck across the room.
 - Back examination
 - Inspect the back for spinal dimples & midline abnormalities such as a tuft of hair, midline nevi or central dimple. This should be done beginning in infancy.
 - Assess whether the spinal dimples are level
 - Inspect the patient back from behind when they stand. If the spinal dimples are at the same level there is not significant leg length discrepancy.
 - Assess symmetry/screening for scoliosis:
 - Shoulders should be at the same level, as should posterior superior iliac crest.
 - Inspect the patient's back when they are facing away from you.
 - Have the child bend forward at the waist keeping knees straight and allowing arms to hang freely; ribs/thorax should be symmetric.

Know

- Gowers' sign occurs when a child is unable to rise from a sitting to standing position without assistance. This sign indicates proximal muscle weakness.
- Midline abnormalities may indicate an underlying spinal cord or vertebral abnormality.
- Scoliosis is common in children and screening is a part of the adolescent examination.
- Excessive thoracic kyphosis that persists when the child lies down is pathologic.

Ethics Assignment and Additional Resources and Cases in Pediatric Bioethics

Introduction:

Ethics is an important concept in Pediatrics, as many patients are not able to legally consent for care and do not have the ability to advocate for themselves. At times during the practice of Pediatrics, clinicians must make difficult ethical and moral decisions to serve the best interest of their patients.

You can find all of the referenced materials on the UWSOM Pediatric Patient Care Clerkship website here: <http://www.washington.edu/medicine/pediatrics/students/current/third-year>

Assignment:

Review the [Ethical Decision-Making in Pediatrics](#) video as an introduction to how ethical concepts are uniquely considered and applied in the care of Pediatric patients.

Optional:

For a more in-depth learning opportunity, we have included a lecture on [Pediatric Palliative Care](#)

Group Discussion

The scenarios described below are real cases that highlight ethical issues unique to Pediatric patients and provide opportunities to develop practical approaches to these situations. We have also included a list of online resources to introduce you to broader materials available in Pediatric bioethics. For the cases, be prepared to discuss the following:

- The ethical issues raised by each case;
- How you would weigh the various sides of the conflicts/view the different arguments;
- How you would develop a plan to resolve the problem and the ethical conflicts;
- Basic ethical principles that would guide your plans.

Ethics Cases

Case 1

You are a primary care physician who is assuming the care of a family. Upon review of the past medical history of the 1-year-old daughter, you find that she has had no immunizations although she received several well child examinations with their homeopathic caregiver. Her current medications include Chinese herbal supplements and the family follows a vegan diet. You ask the parents why your patient hasn't received immunizations and they state, "We don't believe in immunizations".

Case 2

A 14 year-old boy is admitted to the Hematology-Oncology ward with acute lymphoblastic leukemia. He presented to the Emergency Department with pallor and dizziness and was found to have a hematocrit of 14.9%. The oncologist would like to start best available chemotherapy immediately, but the patient and his legal guardians (aunt and uncle) have made it clear both verbally and in writing that, as Jehovah's Witnesses, they will refuse all blood products. His chemotherapy is myeloablative and will cause a further decline in his hematocrit. There is virtually a 100% chance of death with this leukemia if it is not treated and an approximately 75% chance of survival with best available chemotherapy.

Case 3:

A 7-week old previously healthy full term Hmong female infant presents to your clinic with 24 hours of fever, mild cough, nasal congestion and irritability. Mom measured an axillary temperature of 104.5

degrees Fahrenheit this morning. On physical exam, you find the infant sleeping comfortably in no acute distress in her mother's arms but who begins to whimper when you try to move her. Overall, her exam is non-focal with a full but soft anterior fontanelle. Initial labs show a normal white blood cell count but with a left shift, a negative urinalysis, and an elevated C-reactive protein. Mom declines any further work-up—including a lumbar puncture—saying she is “against any more invasive tests”.

Resources in Pediatric Bioethics

University of Washington School of Medicine

(1) Pediatric Clerkship UW
<https://depts.washington.edu/bhdept/ethics-medicine> This website presents core materials about ethics and professionalism for each clerkship at UW. Go to the pediatric clerkship section for specific information.

(2) Treuman Katz Center for Pediatric Bioethics
<http://www.seattlechildrens.org/research/initiatives/bioethics/>
The Treuman Katz Center for Pediatric Bioethics at Seattle Children's Hospital and the University of Washington offers a number of helpful resources for pediatric bioethics. You may also access past conferences and videos of the presentations. Check the calendar for grand rounds presentations on ethics, guest speakers, and other educational activities.

National Resources in Pediatric Bioethics:

(3) American Academy of Pediatrics
<https://www.aap.org/en-us/continuing-medical-education/Bioethics-Cased-Based-Teaching-Guides/Pages/Bioethics-Case-Based-Teaching-Guides.aspx>
American Academy of Pediatrics has been at the forefront of ethical policy development for the Pediatrics profession. While AAP policy statements are not legally binding, they reflect the considered wisdom and consensus of leadership in the profession. Follow the link above to the AAP Section on Bioethics and Committee on Bioethics Case Based Teaching Guides for Resident Training.

(4) American Medical Association's Journal of Ethics is a terrific resource sponsored by the AMA. It offers case scenarios, brief discussions and helpful presentations. Enter: "child" as the search word to bring up additional discussions in pediatric ethics.

Immunization Information

(5) Information for providers from the CDC: <http://www.cdc.gov/vaccines/>

AAP Policy Immunization Hesitancy: <http://pediatrics.aappublications.org/content/138/3/e20162146>

Ethics and Professionalism Benchmarks for Pediatrics

Many of the ethical principles that apply to caring for adults also apply to caring for children. These benchmarks outline several topics unique to pediatric patients that are highlighted in your clerkship. This is not an all-inclusive list. Useful links to additional cases are also included in the final section of the document.

ETHICS:

Parental rights to guide care

Know

Parental rights:

Society has given the right of making medical care decisions to parents because they are viewed as uniquely capable of determining the child's best interest. This included authorizing treatments AND refusing treatments (even life sustaining treatments).

Limitations to parental rights:

If the parents' actions appear not to be in the child's best interest, the parents' rights can be challenged. You have the ethical responsibility to advocate for the patient if you believe the parents' actions are imminently dangerous, neglectful or abusive.

Do

Fully elicit parents' reasons for therapeutic decisions.

Explore perceived differences in an open and accepting manner (even if you really disagree).

Assess whether parents are capable/competent to make medical decisions.

Determine (through conversations with your resident and faculty supervisors) whether there are concerns about the parents advocating for the child's best interests.

Child abuse reporting

Know

Caregivers' legal responsibility:

Physicians who care for children have a legal obligation to report suspected child abuse. As a student, you are responsible to report concerns to supervisors but it is NOT your responsibility to determine whether the abuse occurred, what person may have perpetrated the abuse or any other specific details. There are often complicated social interactions and caring for abused children is a team effort. We work with nurses, social workers, other physicians and child protective services as a team to help determine what happened. If you suspect child abuse and you do NOT report it, you may be legally liable. Please seek guidance in these complex cases.

Do

Be vigilant about this issue.

Be non-judgmental—just because you suspect abuse doesn't mean it happened OR you know who the abuser might be.

Be honest about what you see with the parents and ask for their explanation of your findings.

Discuss your observation with your faculty supervisor.

Clearly document what you see and what you are told.

You SHOULD NOT disclose your concerns to the family before discussing this with your supervisors. Discussing these issues is the faculty/attendings' responsibility.

Care of adolescent patients

Know

General approach:

Adolescent patients are capable of participating and guiding their medical therapy. The extent of each patient's ability will depend on the developmental maturation of the patient. In general, parents retain the responsibility to direct care for patients less than 18 years of age unless there is disagreement about the course of therapy.

Special considerations:

As a caregiver for pediatric patients you should be able to define the following special categories of patients:

1. Emancipated minor:
There are specific categories of adolescents who are legally capable of directing their medical care. The categories include: 1) married, 2) pregnant/parent, 3) in the military, 4) self-supporting.
2. Mature minor:
Courts can grant decision-making capacity to minors; this may be limited to specific categories of care (see below) or in some cases of chronic illness when the PHYSICIAN has determined that the patient is capable of informed consent.
3. Specific categories of care:
Decision-making capacity is given to minors for the treatment/care of pregnancy, drug or alcohol abuse and sexually transmitted infection. Laws vary by state.

As a caregiver for pediatric patients you should be able to define the difference between:

1. Informed consent: requires that the patient be competent to make health care decisions, physician disclosure of relevant information, patient understanding of the information and a voluntary, un-coerced patient decision.
2. Parental permission: parents give permission for therapy provided to their children. The same standards and procedures for giving informed consent to a competent patient apply.
3. Child Assent: helps patients acquire a developmentally appropriate understanding of patients' condition, telling the patient what patient can expect for the treatment, assessing the patient's understanding of the situation, including determining whether the patient felt pressured to accept/reject the treatment. It also includes soliciting the patient's willingness to undergo the procedure (you can see how this is probably a team effort with the parents!). This approach is not limited to adolescent patients but is appropriate for ALL pediatric patients.

Do

Use appropriate language for the patient's developmental level when explaining medical care options.

Respect the patient's privacy.

Discuss sensitive issues when you are alone with older patients (e.g. drug or alcohol use, sexual practices/preferences, suicide risk etc.).

Obtain parental permission about therapeutic interventions.

Obtain child assent from patients about therapeutic interventions.

PROFESSIONALISM:

Admitting Mistakes

Know

A medical error or mistake is a preventable or unexpected outcome of a medical treatment. An adverse event is a side effect that may occur in a certain percentage of cases that are treated.

Medical mistakes are usually not due to negligence. They arise from incomplete knowledge base, an error of judgment, lapse in attention or a “systems” error. You have a professional responsibility as a health care provider to disclose errors to your patients. Although it is difficult and uncomfortable disclosing errors, most patients appreciate honesty (wouldn't you?). Loss of trust usually arises from nondisclosure of errors.

Do

When you identify a medical error:

- Determine the effect (actual or potential) on the patient.

- Investigate/identify possible causes.

- Explain in a calm, unhurried, truthful and apologetic manner that an error has occurred.

- Answer all questions the patient has and be open for additional questions in the future

- Provide information about follow up of the incident.

- Accept responsibility and apologize as (or if) necessary.

Balancing Learning and Care for the patient

Know

As a student it is a common dilemma and each case should be approached on an individual basis. The primary conflict in these cases is the care for THIS patient vs. the need to learn to care for FUTURE patients. Balancing the risk to the patient you are caring for presently compared to what you will learn must be determined. There is an adage “see one, do one, teach one”, that may or may not be appropriate based on the risk to the patient and your own unique abilities. You must be honest and provide adequate informed consent. An additional stressor for most students is also balancing care for the patient and being evaluated.

Do

Provide informed consent:

- You should clearly indicate who will be doing the procedure and what the level of training is. You must answer additional follow up questions (like...how many of these have you done?).

Know your limitations.

Communicate your abilities clearly with your supervisors.

First do no harm to your patients.

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Pediatrics Career Advisors

Our career advisors are happy to provide individualized help with your decision making. These advisors are excellent resources and are happy to meet with you at various points throughout the long application process. With your initiative, your advisor will become acquainted with you and your record, and will be able to provide you with individual feedback to help you with these important decisions.

The current Department of Pediatrics faculty members who serve as advisors for aspiring pediatricians:

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