Dr. Abeer Assaf online lecture

Aseel N. Abdeen

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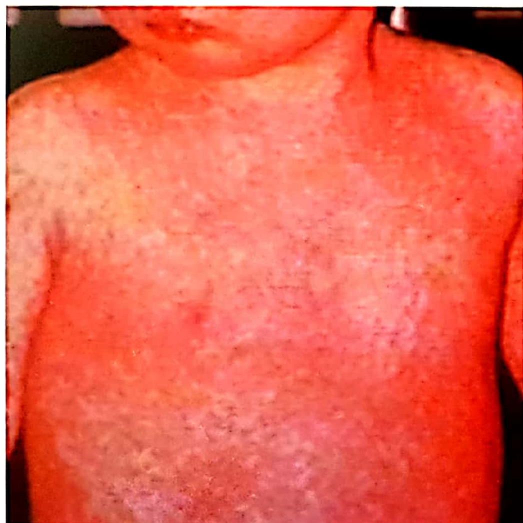
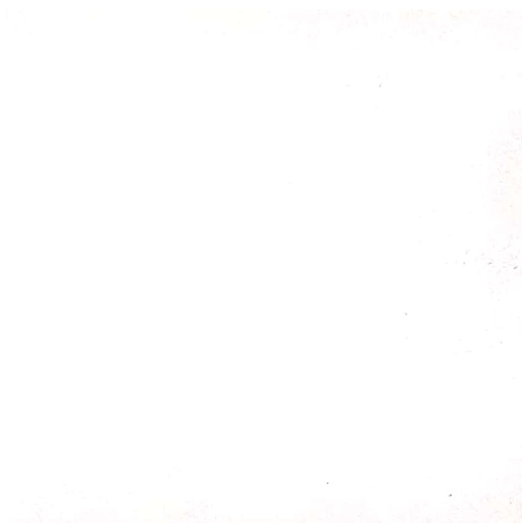
Measles

3 c's

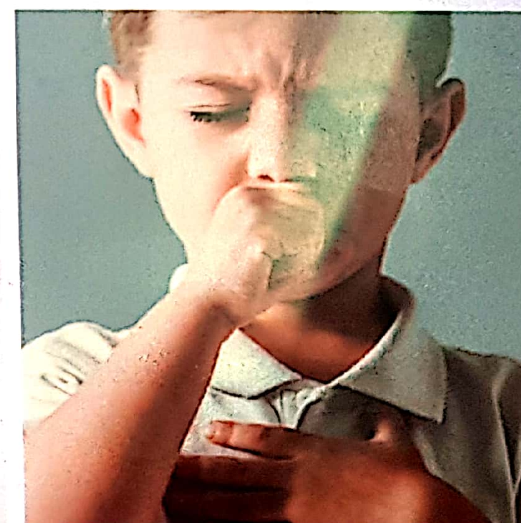


maculo(change in color)papular (rasied) rash

purulent conjunctiva



corrisa (crusted nose)



high grade fever and cough

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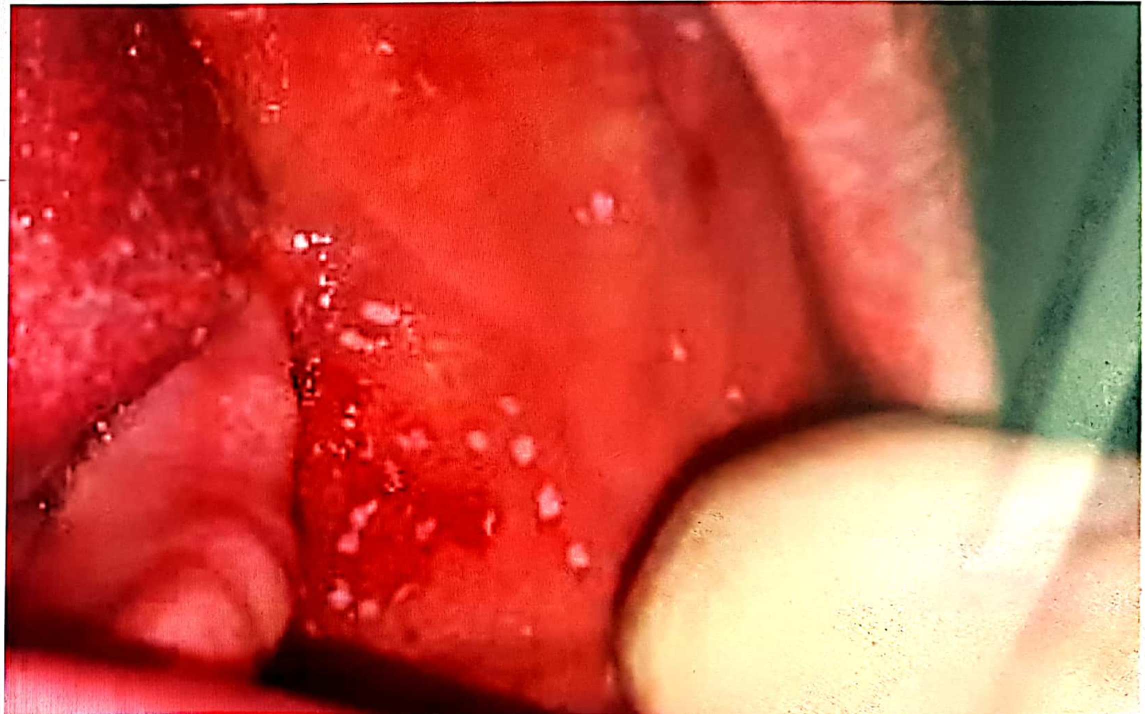
cont

- most common complication(or associated morbidity) of measles?

otitis media , encephalitis

-supplement of vitamin A decrease morbidity in these patients- not known why- theory: increase integrity of mucus membrane --> decrease mortality

- incubation period - 7-14 days



koplik spots(in mouth) -pathognomic for measles.
if not seen doesn't mean not measles. why?
appear in first 24 hrs then disappear after few hours .

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Erythema Infectiosum AKA 5th Disease

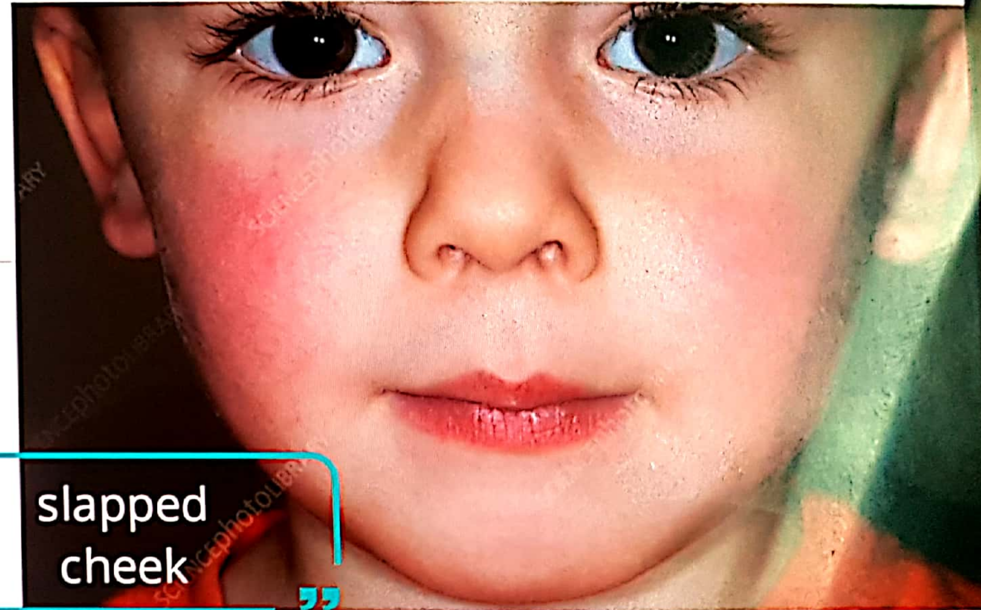
- cause by pardo virus (benign infection)

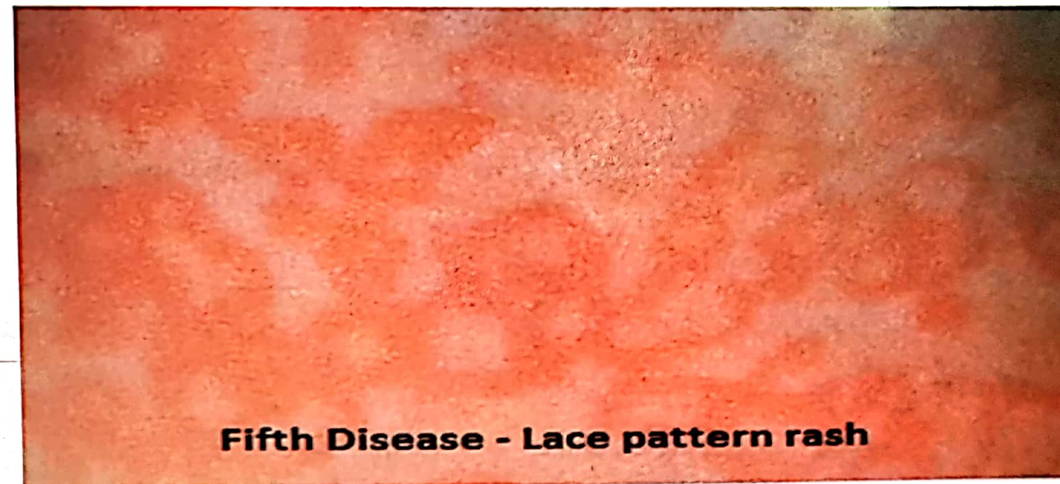
symptoms appear for a few days then disappear, usually no complications

- 2 groups of people may have serious complications if got this infection?

1- sickle cell (any hemolytic anemia) -- if exposed, will cause infection in bone marrow --> aplastic crisis

2- pregnant women --> fetal hydrops





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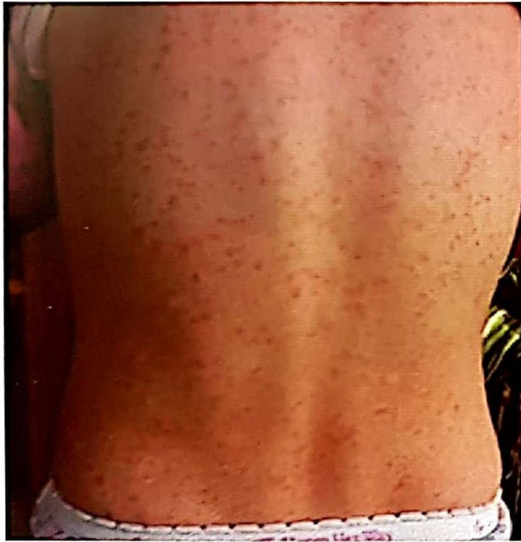
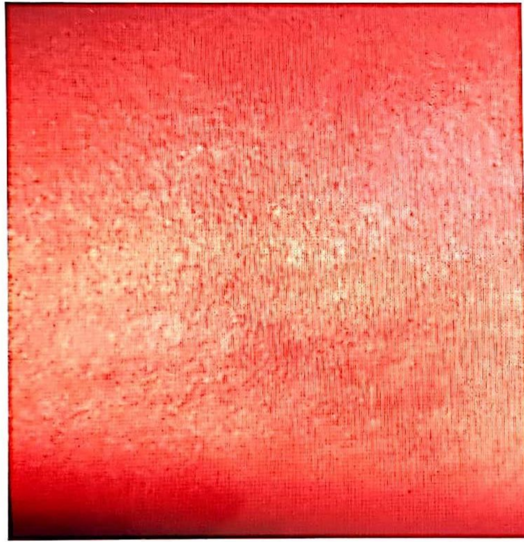
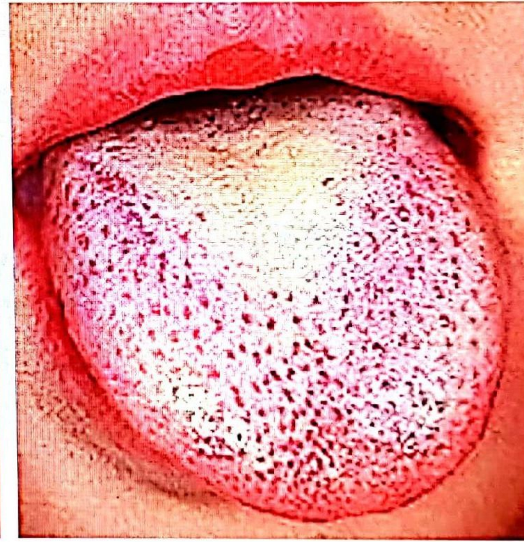
Scarlet fever - beta hemplytic group A strep



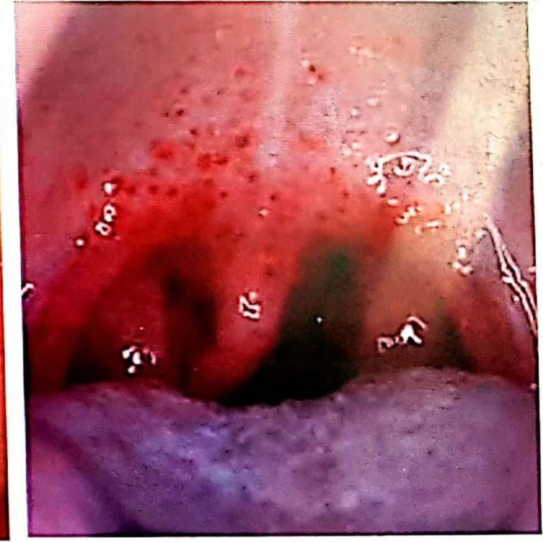
maculopapular rash



rough skin -sand paper like



white strawberry tongue then red strawberry tongue



tonsillitis

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cont ..

- ***group A strep (pyogens) :***
- - tonsilitis of scarlet fever
- - impetigo
- - post strep GN
- -- (if complicated may cause rheumatic fever)
- ***group B Strep (agalctia) :***
- - vaginal tract esp. in pregnant women
- - STD
- - neonatal meningitis and sepsis

- any patient with scarlet fever we have to check for
- 1. heart - rheumatic fever (if we suspect RF we have to ask was it preceeded by URTI by 3-4 weeks ?)
- 2. kidney - post strep GN
- pt with hematurea.. put ddx .. one of them should be post strep GN .. must ask was there proceeding URTI before 2 weeks ?
- pt with recurrent hematurea, always after each URTI in 2-3 days? IgA nephropathy

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- Major criteria of Rheumatic fever
- 1. Erythema Marginatum
- 2. subcutaneous nodules (if present, must have #3)
- 3. carditis (not necessarily occur with #2)
- 4. arthritis
- 5. sydenham chorea - appear late after 4 months

- * in rheumatic fever, we have to have evidence of strep infection either high ASO titre or throat swab positive culture for strep group A. Exception: sydenham chorea , appear after 4 months, so we wont have evidence of infection at that time

ıemonic: *"JONES CAFE PAL"*

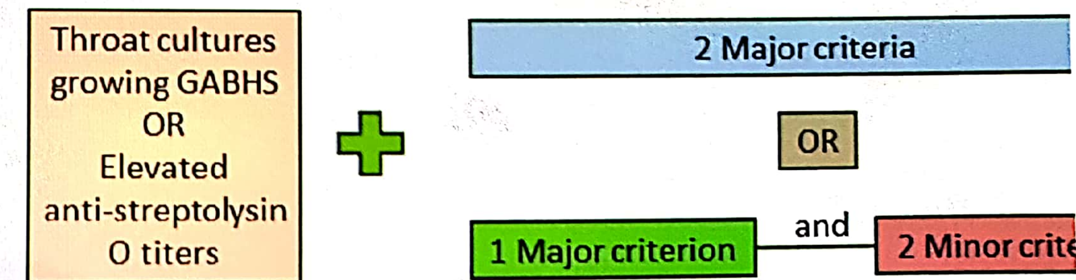
Major Criteria

J	Joint Involvement
O	**O looks like a heart = myocarditis**
N	Nodules, subcutaneous
E	Erythema marginatum
S	Sydenham chorea

Minor Criter

C	CRP Increased
A	Arthralgia
F	Fever
E	Elevated ESR
P	Prolonged PR Inte
A	Anamnesis of Rhe
L	Leukocytosis

Diagnosis



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Impetigo - honey crust

- significant rash but good looking patient

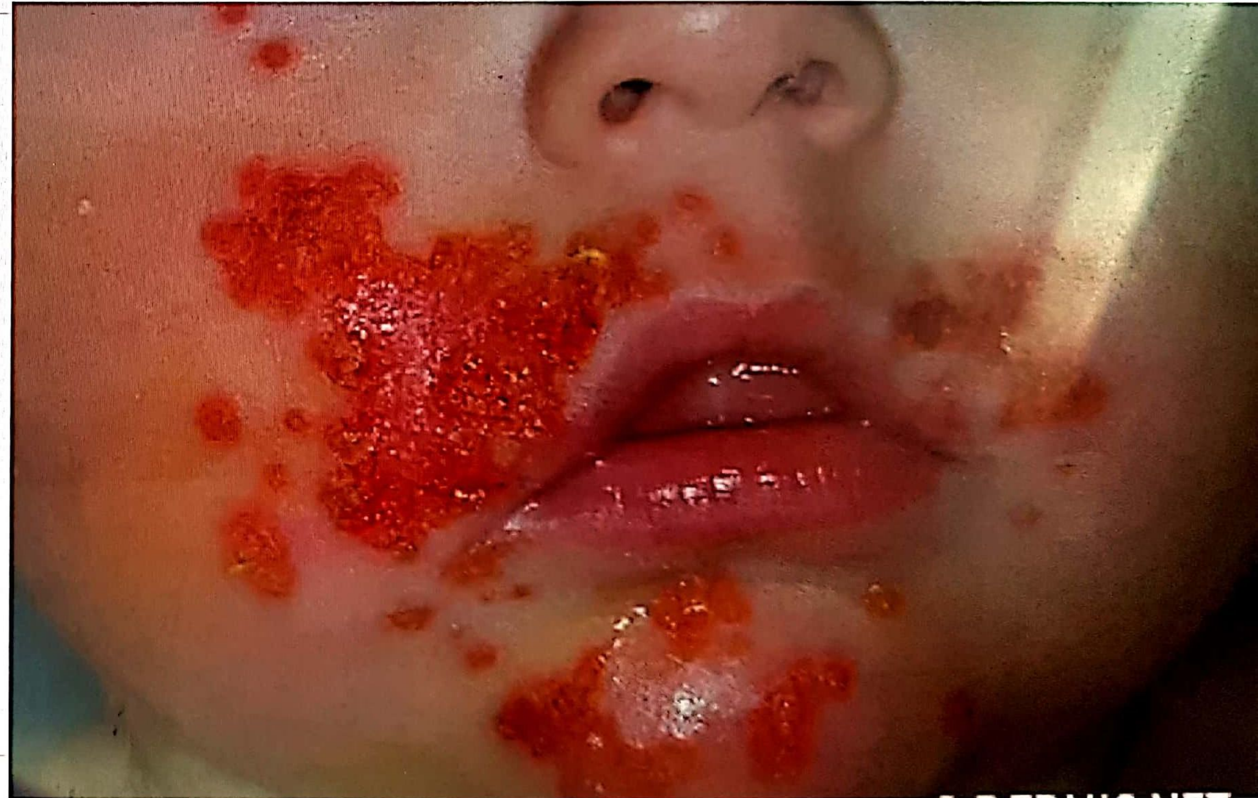
- caused by group a strep and sometimes staph aureus

- if it was caused by group a strep (most common) and caused skin infection, will it cause rheumatic fever as a complication? **no,** but may cause post strep GN after 2-3 weeks of skin rash

- treatment of choice for group A strep?

penicillin, if allergic we give macrolides (erythromycin)

- when we give penicillin, we prevent rheumatic fever as a complication but not post strep GN.



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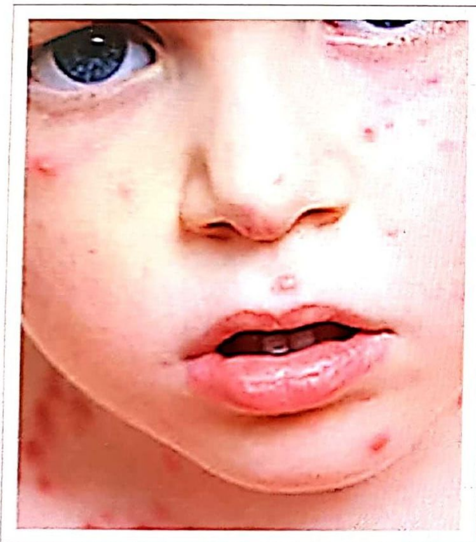
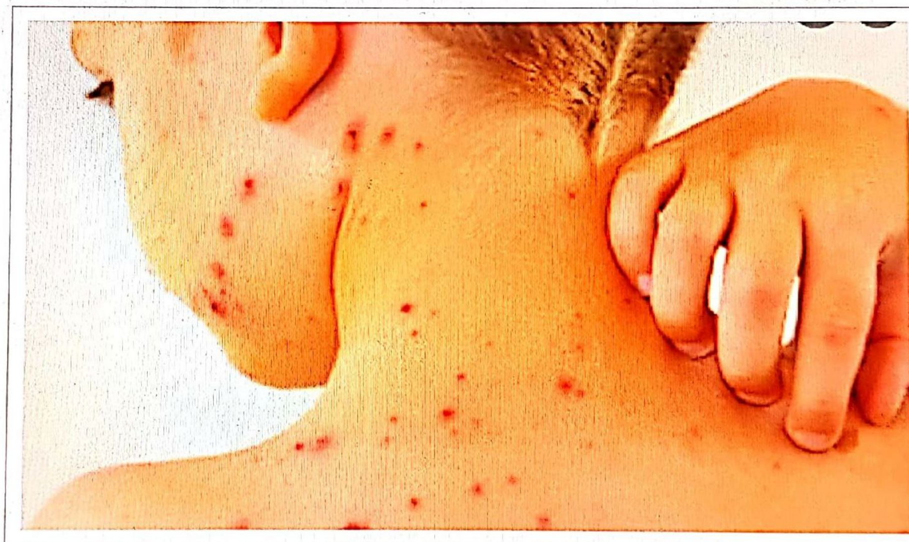
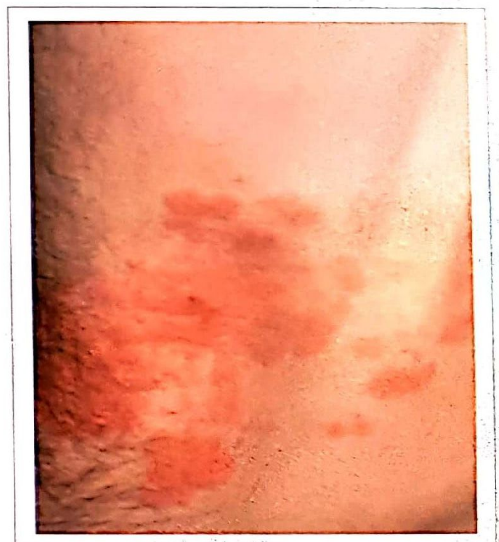
Chicken pox -HZH



macule then papular then vesicles then vehicular rash



highly itchy



reactivation in adults cause shingles on certain dermatomes

incubation period : 2-3 weeks

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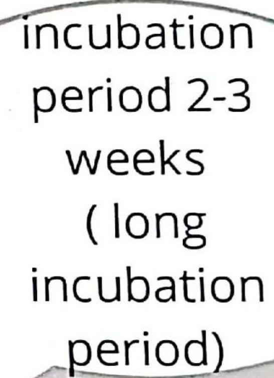

MaRCH

M: mumps
R: rubella
CH: chicken pox

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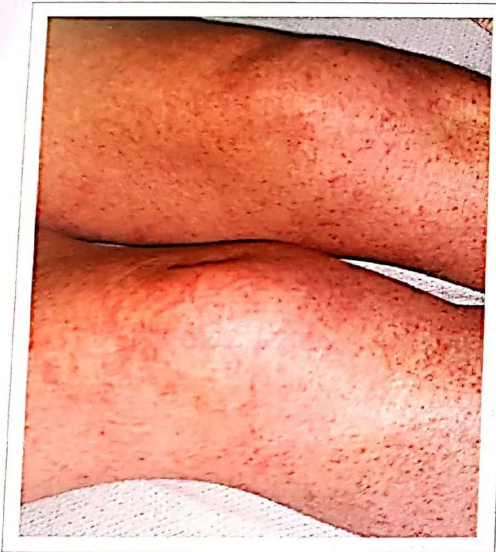
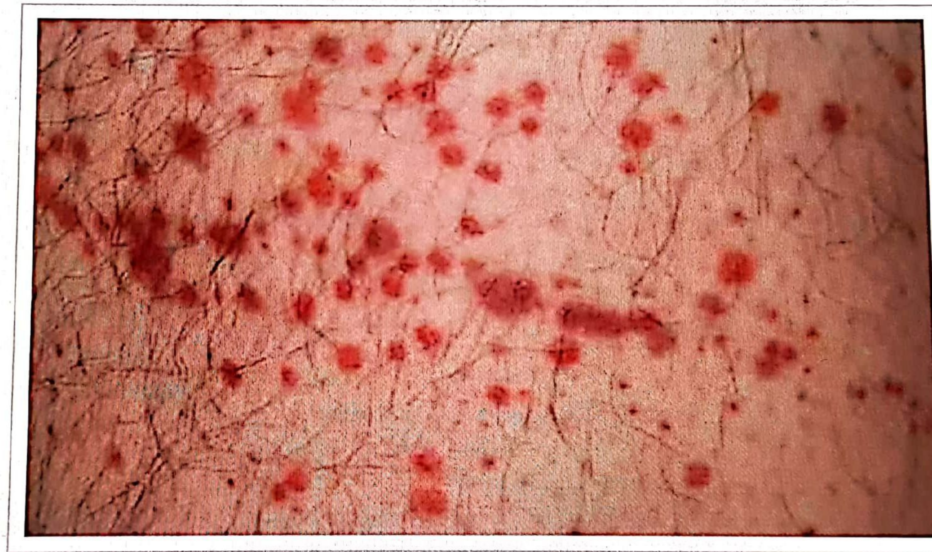
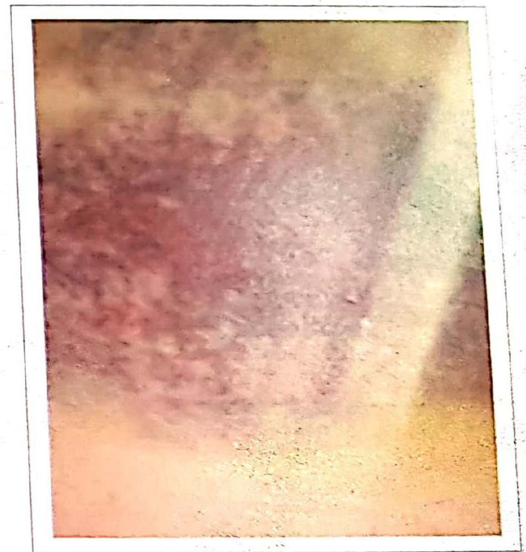


petichia



purpura



eccymosis

"Same pathophysiology (bleeding under skin) but different size"

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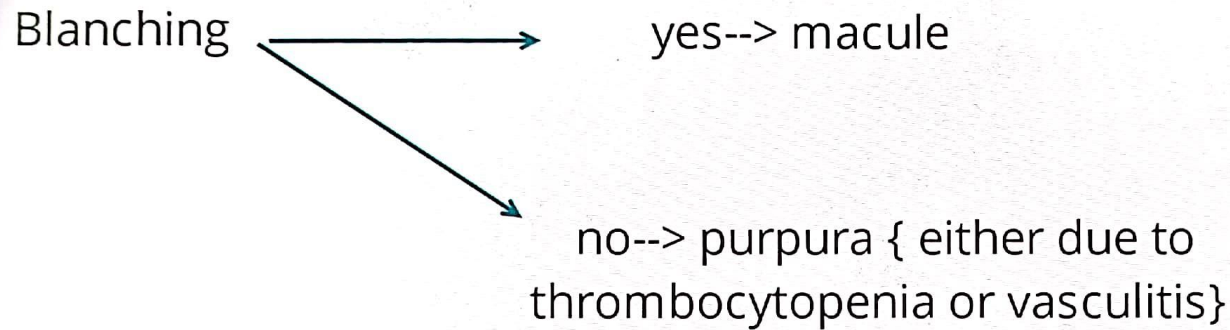

> most common cause of vasculitis purpura?
> henoch schonlein purpura
> (has predilection for small vessel disease)

> child with non blanching purpura, fever, and sick looking. what is the cause?
> (bacterial infection)
> Nisseria Meningitidis

> most common cause of thrombocytopenic purpura?
> ITP (well looking, no fever, low platelet, only purpura)

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how to differentiate through physical examination that this non blanchable purpura is due to ITP or due to vasculitis?

we see if there is palpation (palpable or not)

if yes --> vacultits

if not palbaple --> ITP

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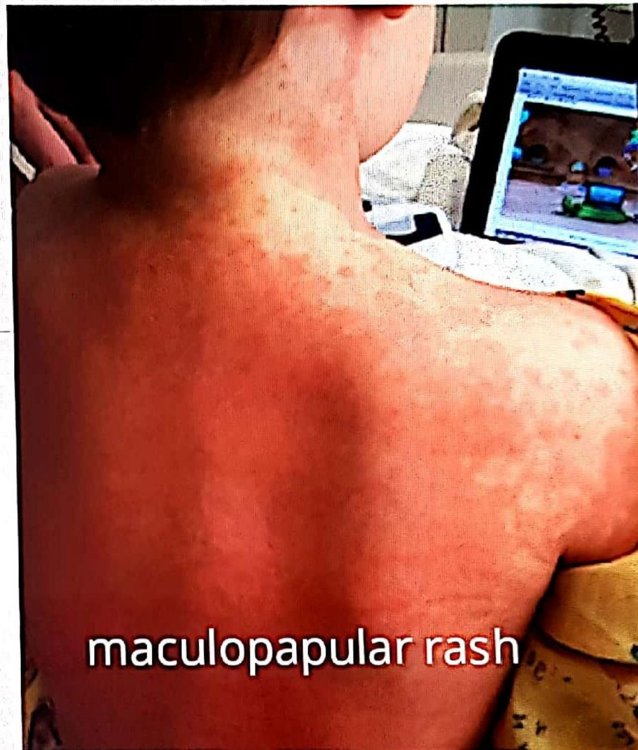
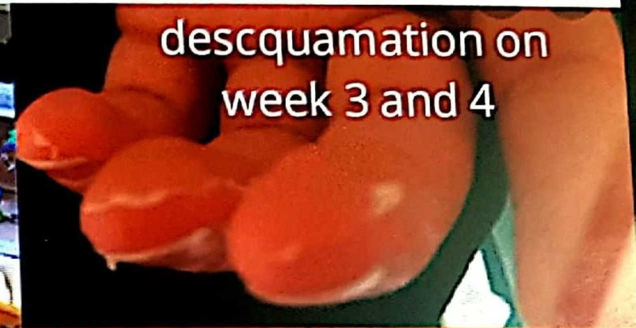
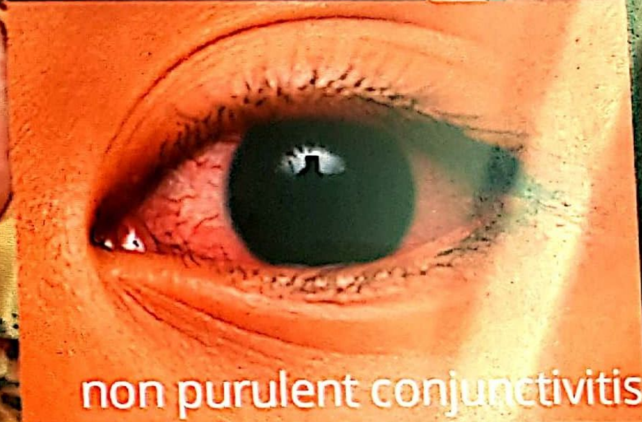
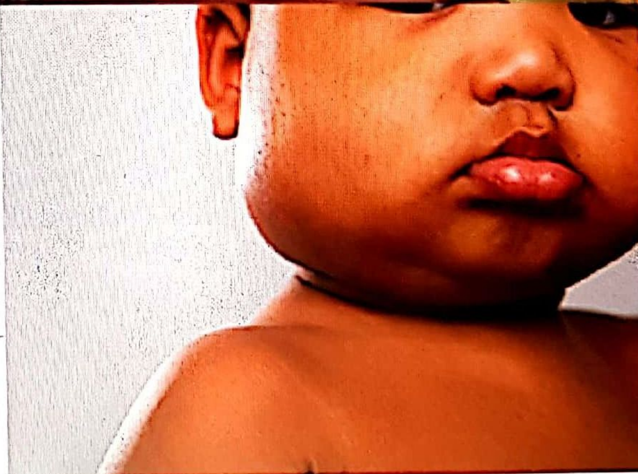
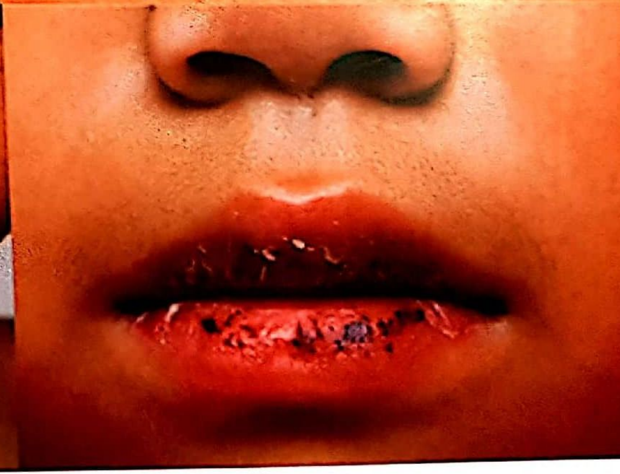
kawasaki disease











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*high grade fever for more than 5 days.
* Major criteria :
-2 things affect the skin (rash, swelling in hands and feet, desquamation of skin)
-2 things affect the mucos membrane (conjunctivitis, strawberry tongue, fissured tips)
-1 LN involvement (cervical lymphadenopathy, usually unilateral)
* acute phase: first 2 weeks
* sub acute phase: weeks 3 and 4
* drug of choice for Kawasaki?
gamma globulin IV { IVIg} - to prevent serious complications like coronary aneurysm.
* sometimes we give aspirin, in acute phase we give high dose (anti-inflammatory dose) first week
* on week 3 and 4 { subacute phase }, 3 things happen:
1. desquamation
2. coronary aneurysm if it will form
3. thrombocytosis (we give low dose aspirin - antiplatelet dose)

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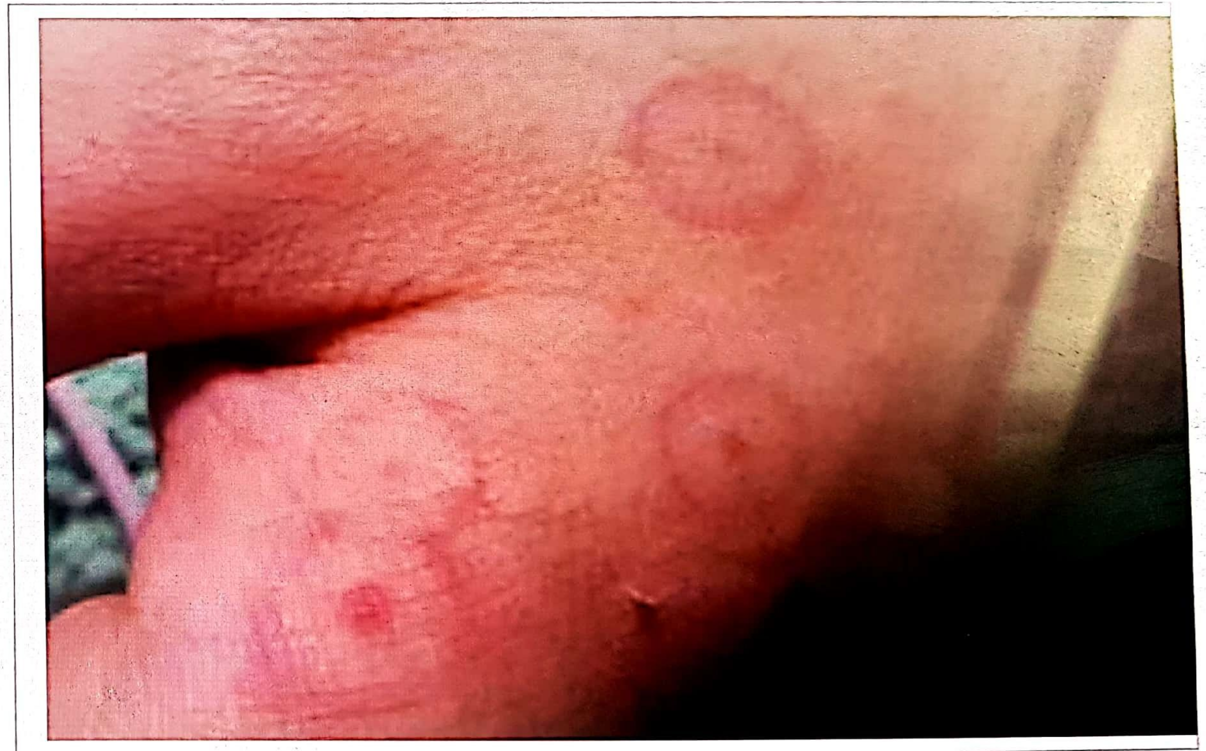
Erythema Multiforme - target lesion

- if erythema multiforme with mucus membrane involvement? Steve-Johnson disease - as a complication of this disease the patient may develop corneal ulcerations.

* causes:

viral infections (herpes, mycoplasma)

drugs (sulfa, penicillin)



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2 common anti epileptic drugs, when given together , we have to adjust the dose; give lower doses (if we didn't adjust the dose and gave high doses we may cause Steven Johnson disease)
valpruic acid and lamotrigen

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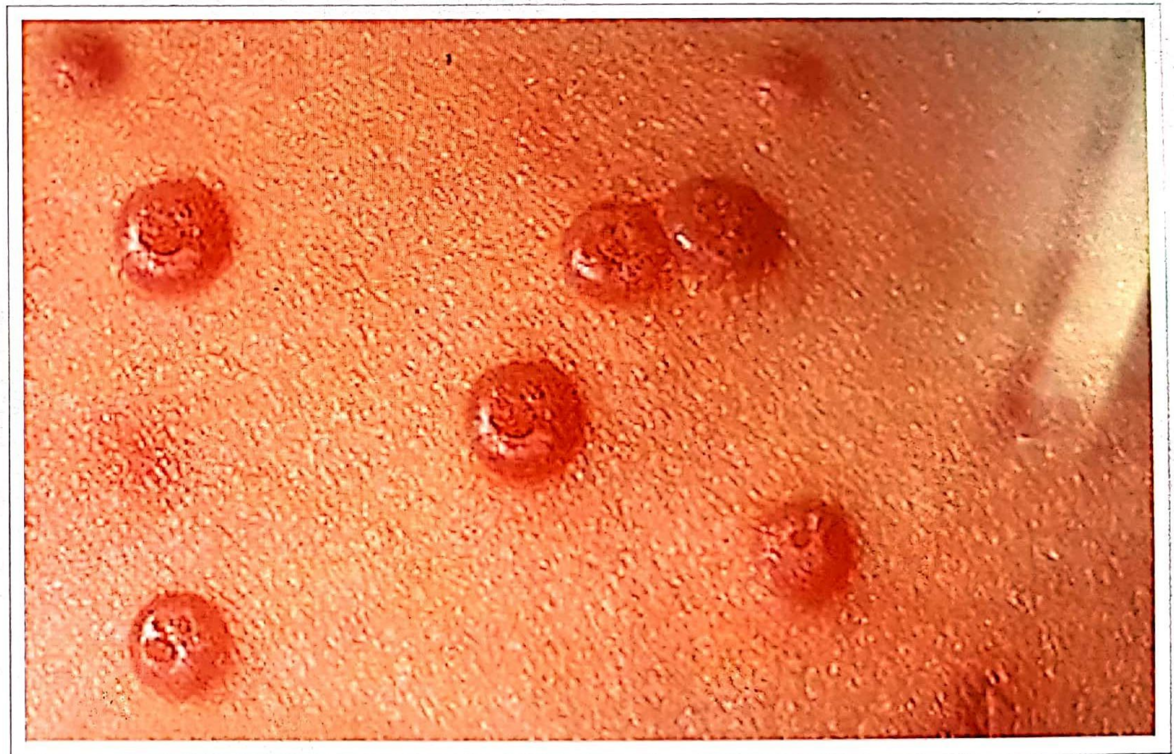
Molloscum Contagiosum

- caused by benign strains of pox virus
- central depression inside lesion
- mostly seen in chin and eyelids
- self limiting, takes time to disappear
- cosmetic problem
- highly infectious
- we may use cryotherapy



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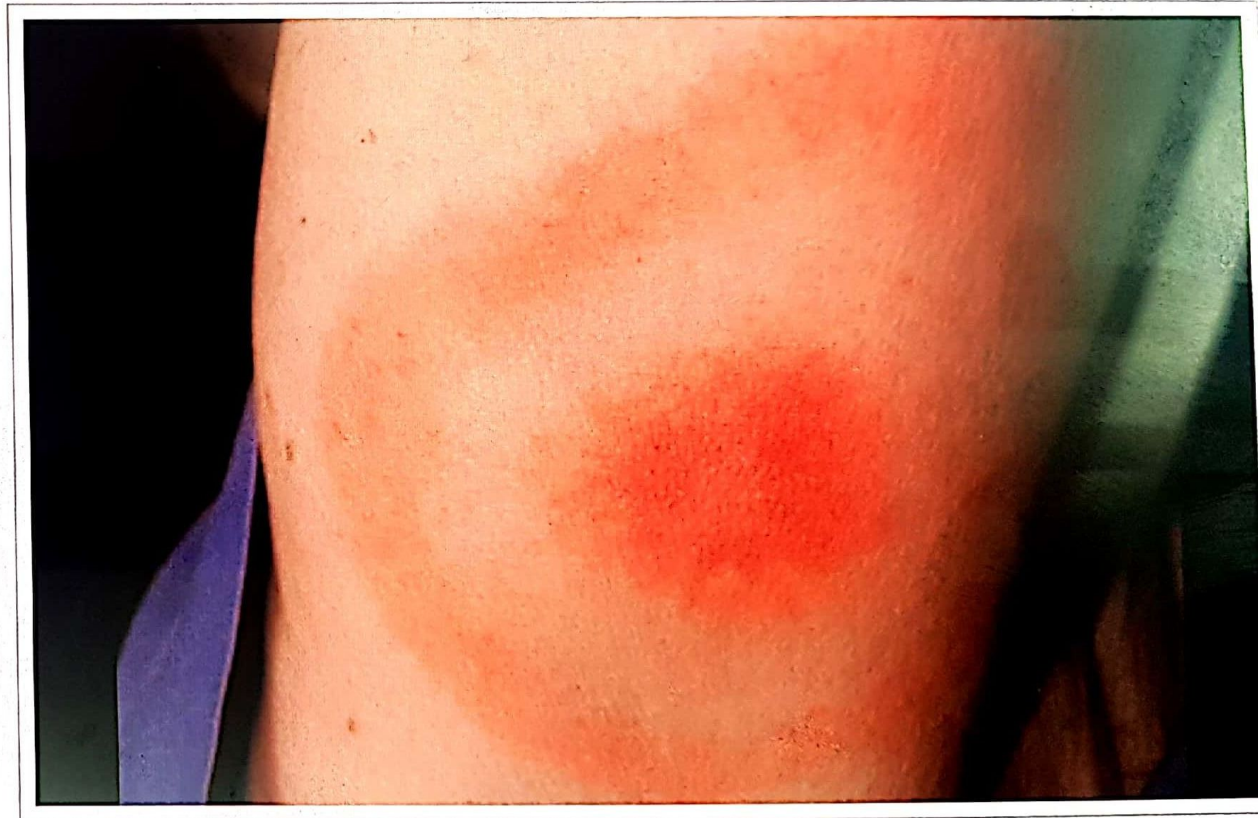
Erythema Migrans -Bulls eye - lyme disease

- caused by borrelia bugrdolefi



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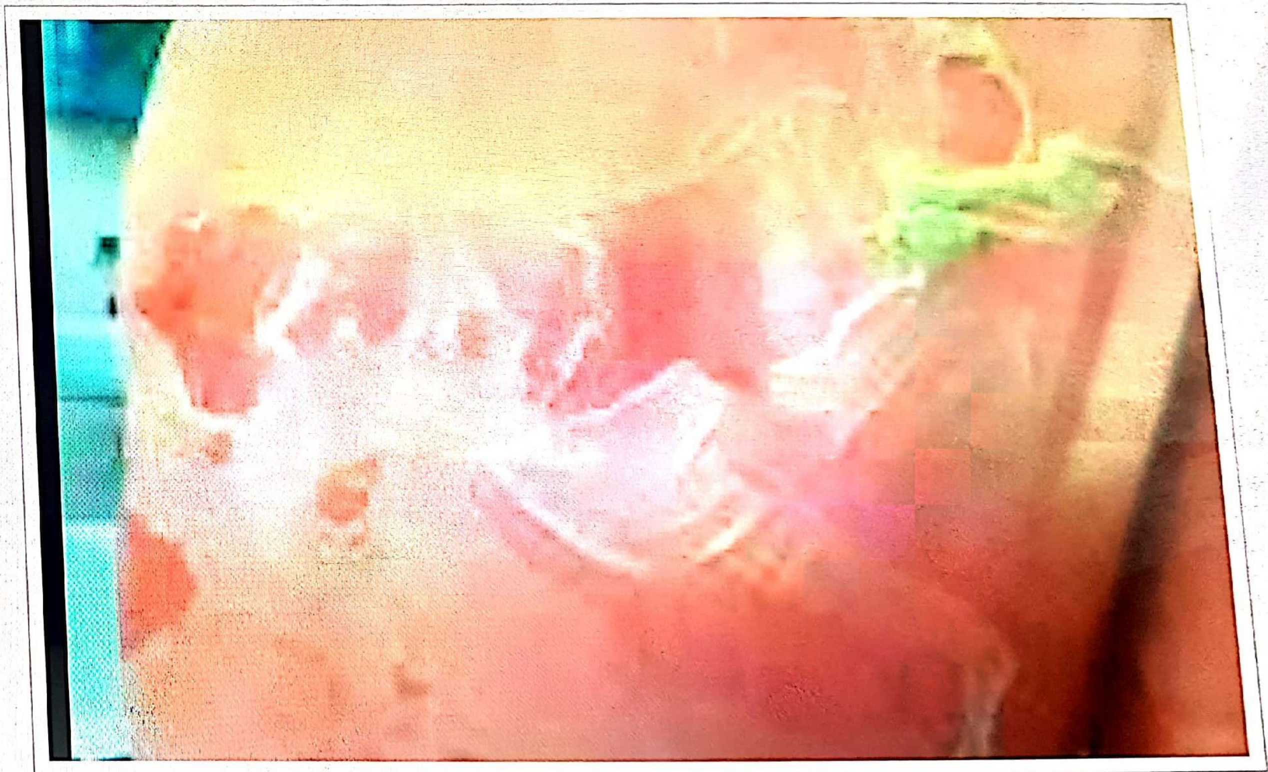
Scaleded skin syndrome

- significant desquamation



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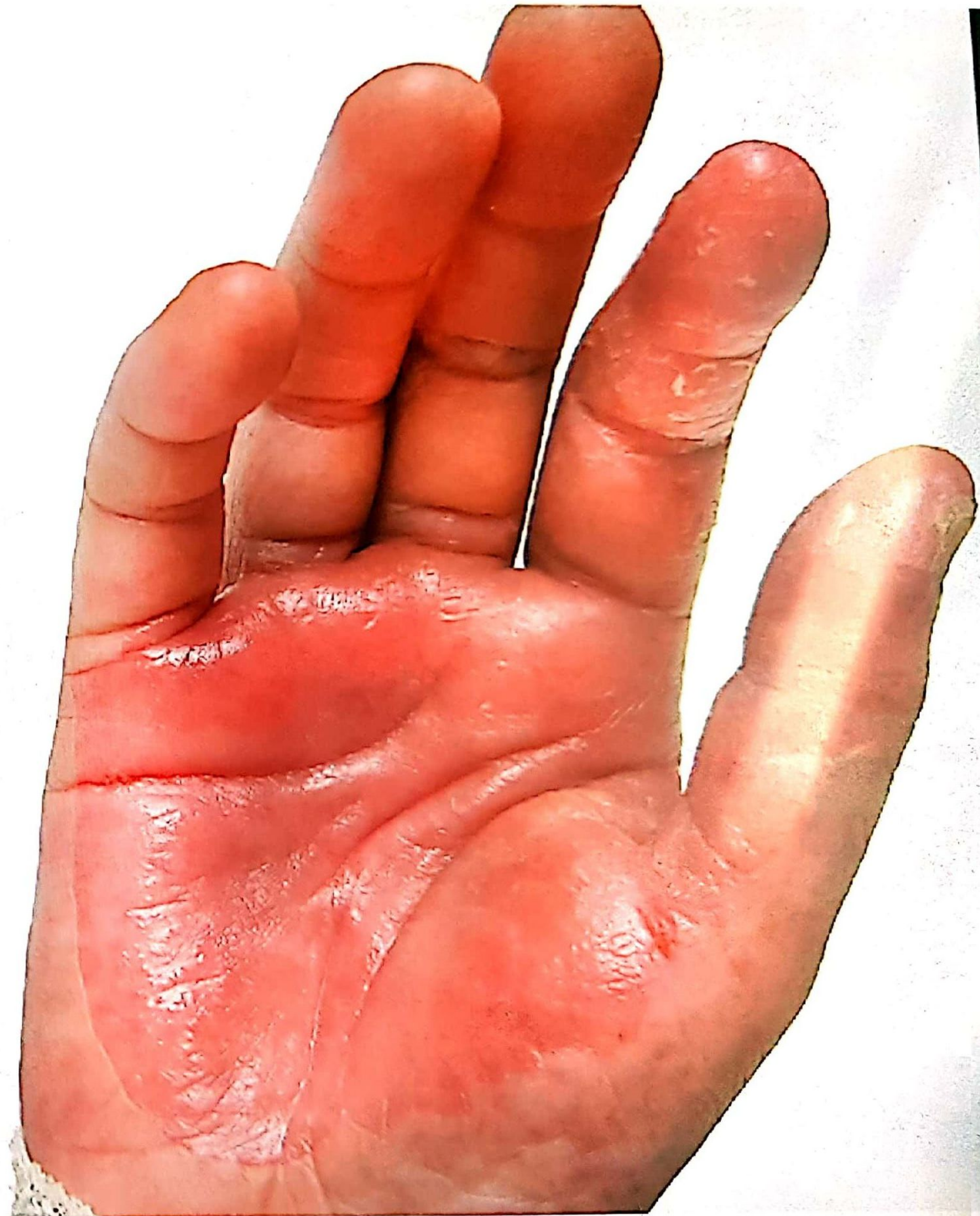
Toxic shock syndrome

mostly caused by staph aureus

tx (anti staph) : vancomycin

-** we also give another drug to shut down toxin production--> clindamycin which may cause pseudomembranous colitis as a complication



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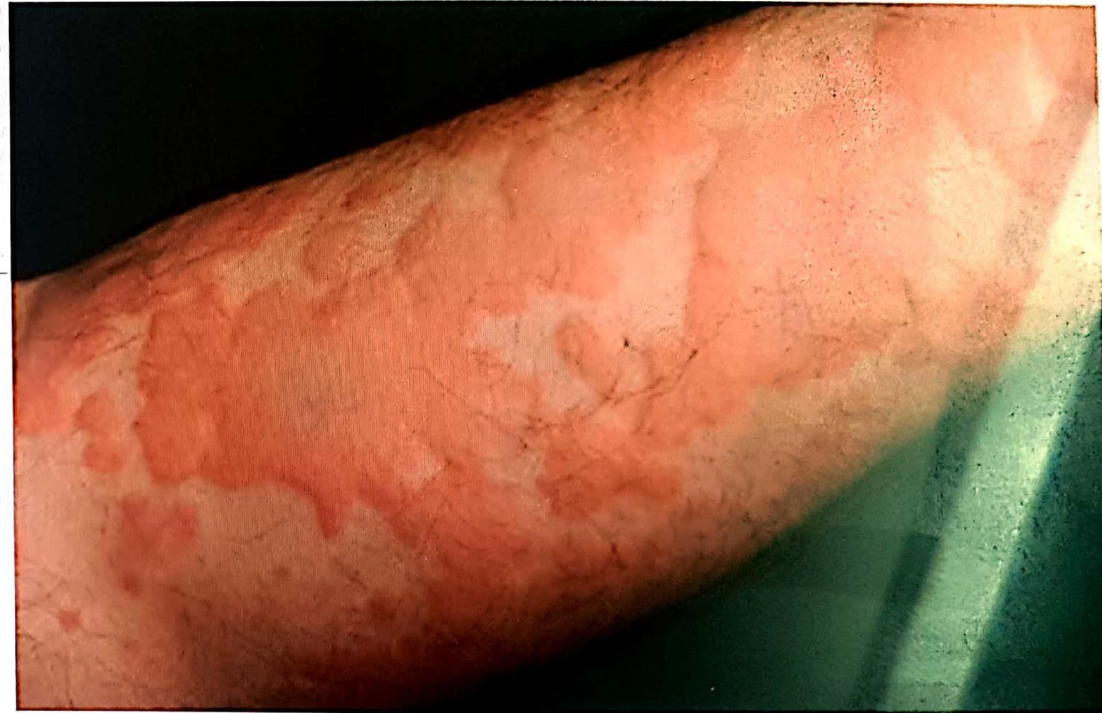
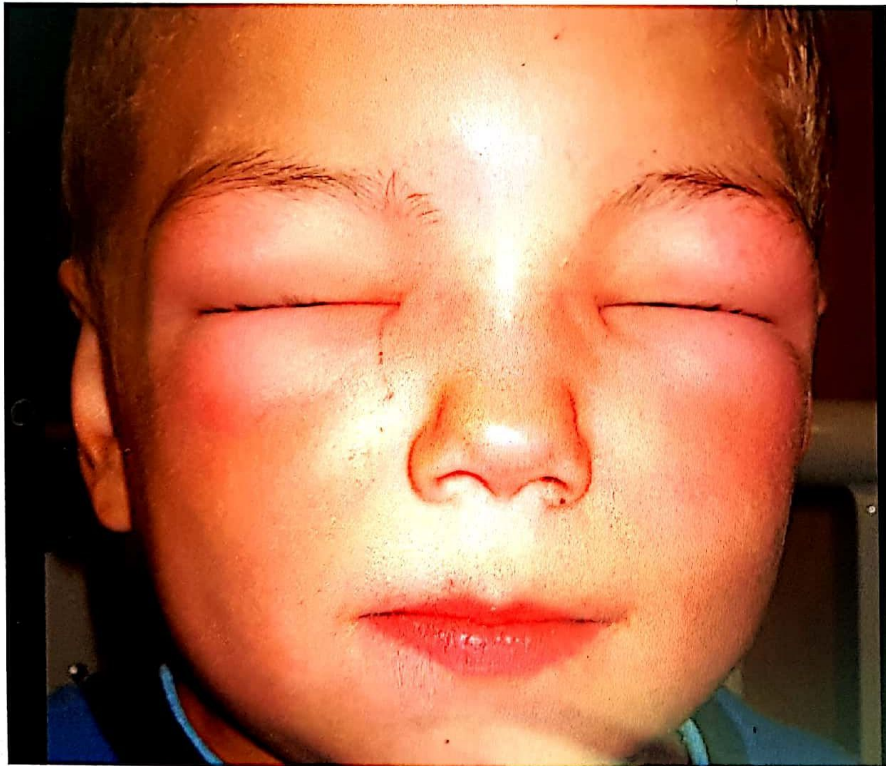
-itchy rash, allergy--> urticaria

-angioedema (if we had a question about someone with bilateral periorbital oedema, we must include allergy rxn in our ddx along with nephrotic syndrome, liver disease...





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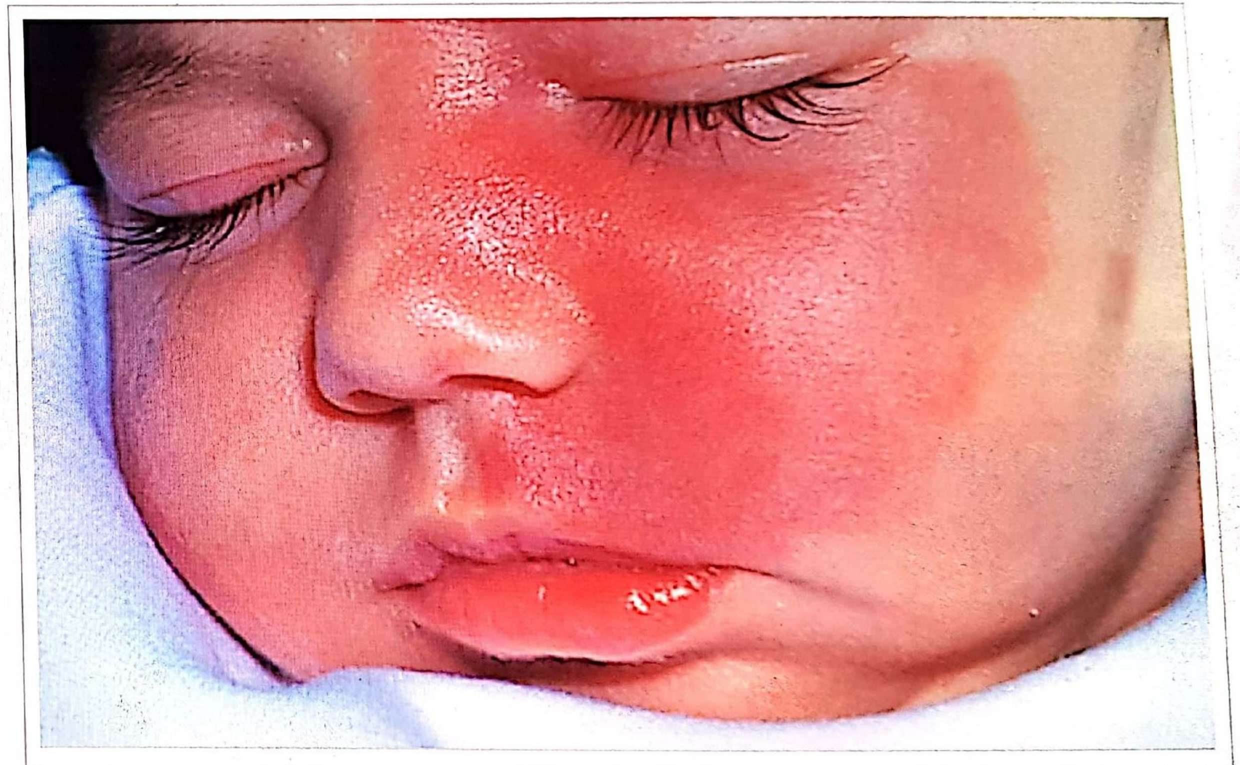
Port wine stain

- if associated with vascular proliferation and compressing ipsilateral part of brain causing contralateral side weakness and seizure??

neurocutaneous syndrome -- ***Sturge Weber syndrome***



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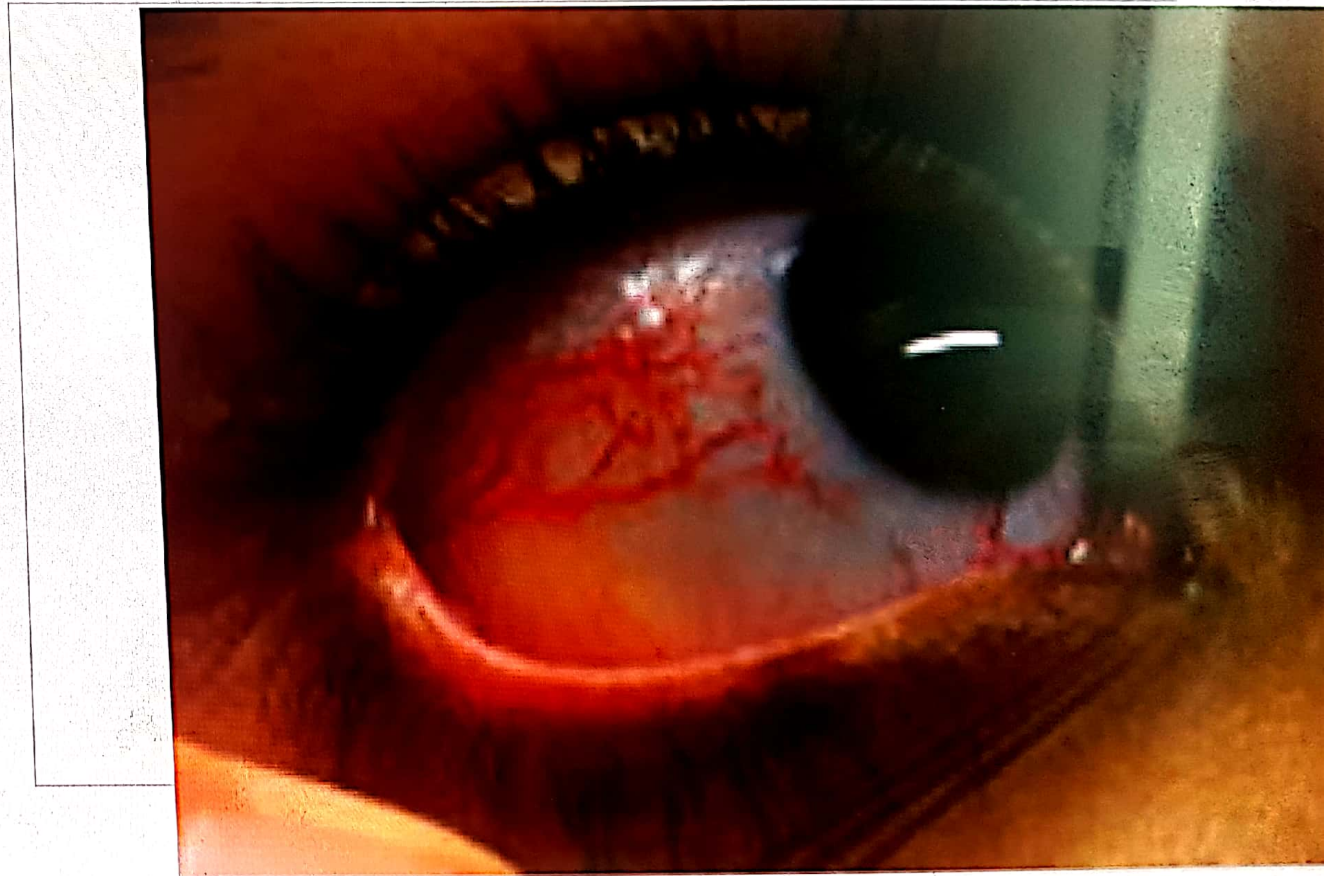
ataxia telangiectasia

- recurrent sinuoulmonary infection

-with telegenictasia

* one of immunodeficiency disorders, therefore these patients are more prone to ***leukaemia and lymphomas .***



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Fragile X syndrome

- most common cause of mental retardation in boys ?

fragile X syndrome

elongated face

broad forehead

large prominent ears

congenital heart disease esp mitral valve prolapse

enlarged testis

> Tall stature and atrophied testis?
> kleinfilter syndrome

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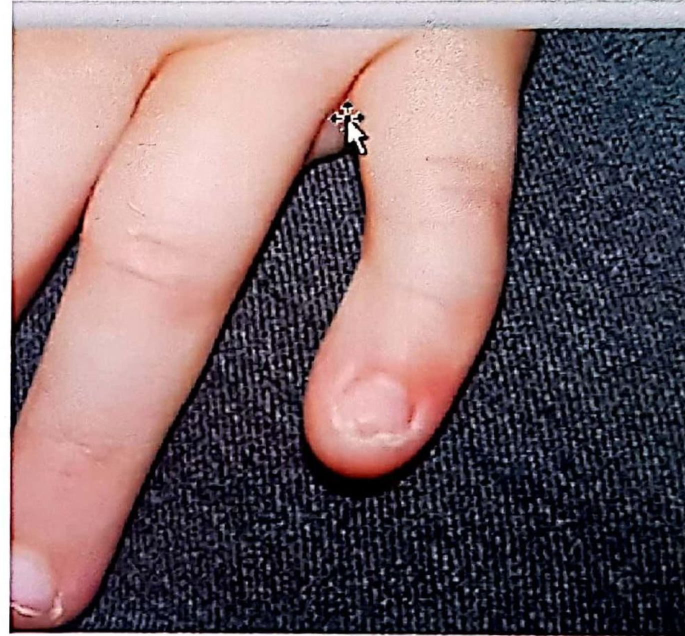
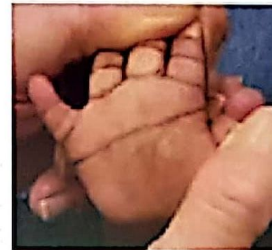
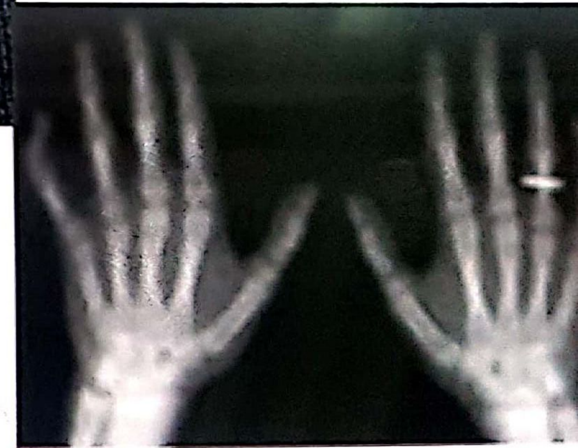
clinodactyly

- inward curve of little finger
- characteristic of down syndrome and others







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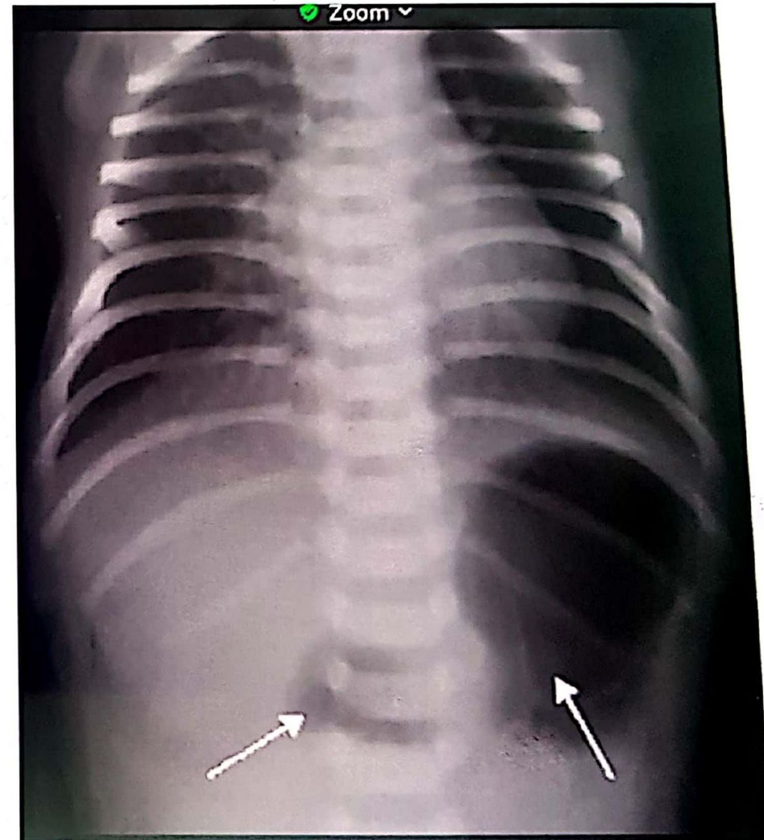
double bubble sign

- in duodenal artesia
- olive sign in pyloric stenosis



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epiglottitis -upper airway emergency

hx and pe:

sick looking , acute prsentation

high grade fever , respiratory distress

bending forward gasping for air

drooling saliva

when you see this quickly send pt to operating room and under anaesthesia we do laryngoscopy and diagnose

dx:

swollen and red

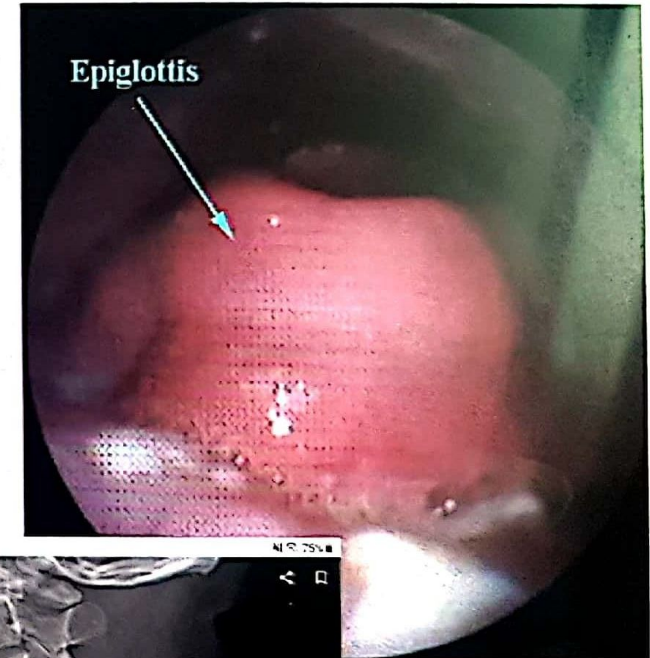
mc organism: h.influenza type b

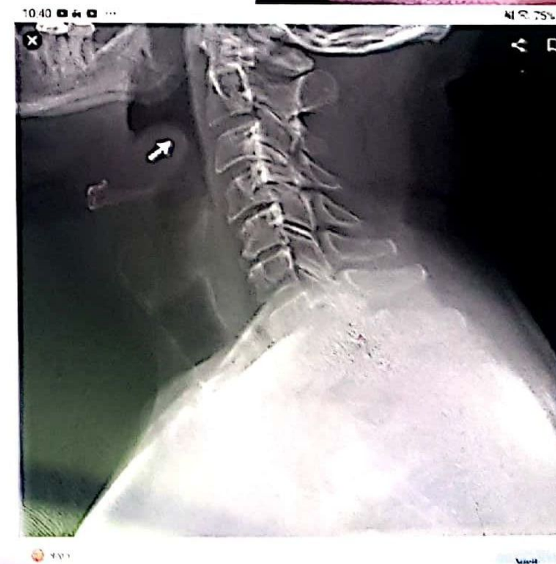
Mgx:

fluid and rehydration and abx

imagine when you did laryngocopy you didn't find inflammation(normal epiglottis) instead, you found pus secretion from trachea. do suction and send to histology or lab (bacterial trachitis --> staph aureus

if you made an lateral x- ray (we usually dont; We sent OR directly), well find thumb sign





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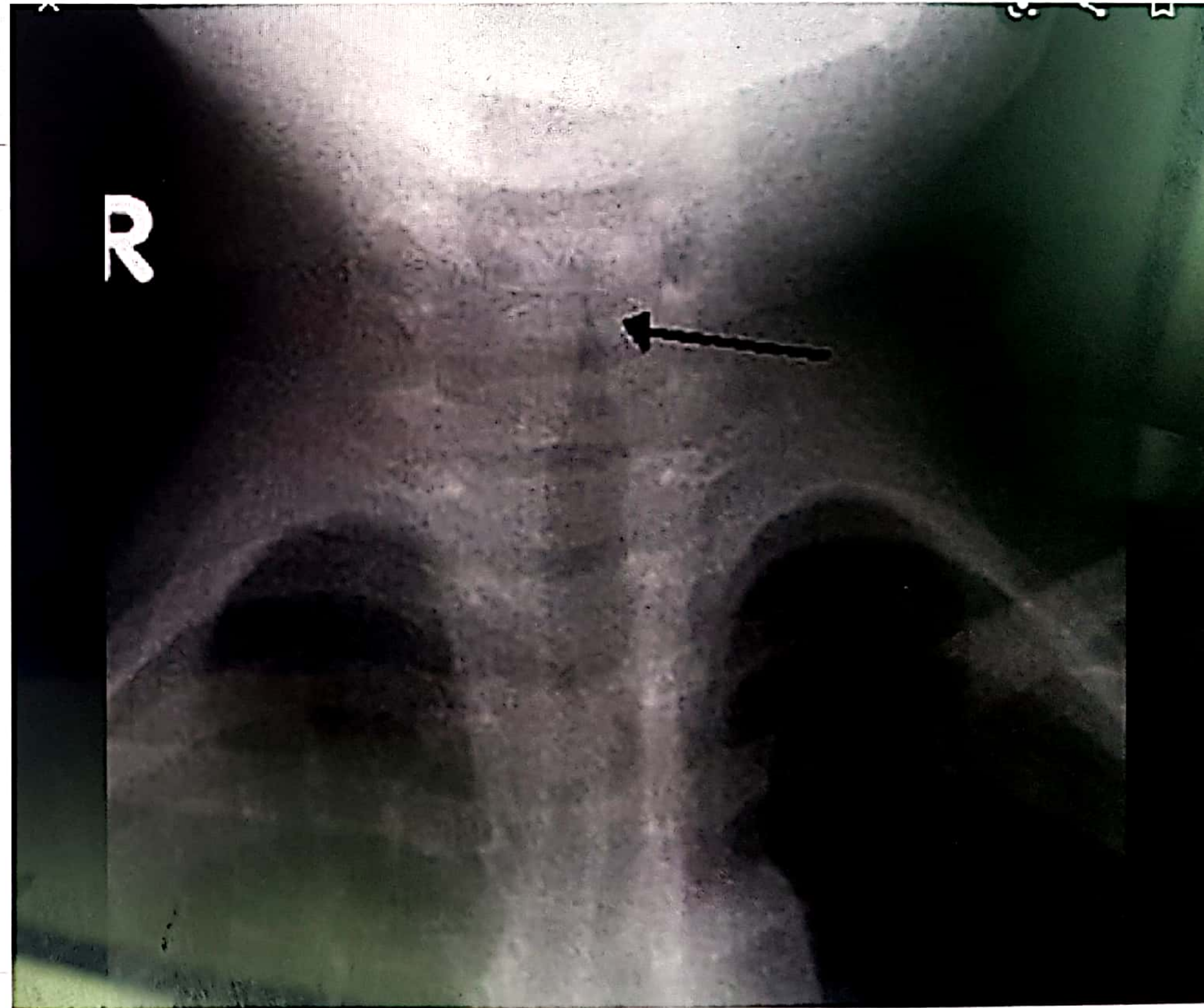
steeple sign also seen in epiglottitis- narrowing in upper airway



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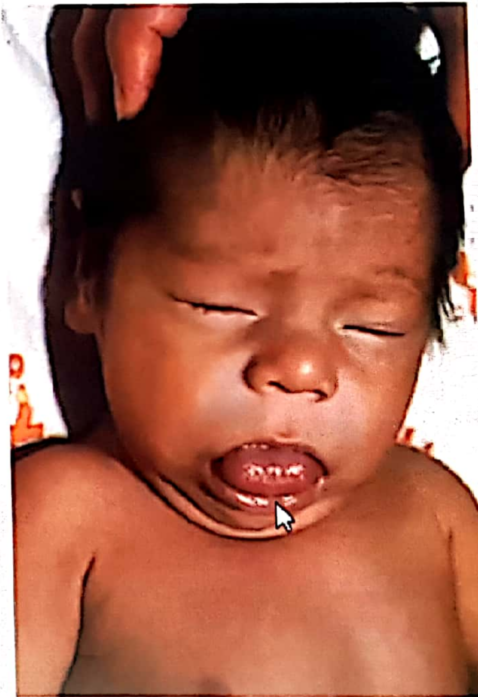
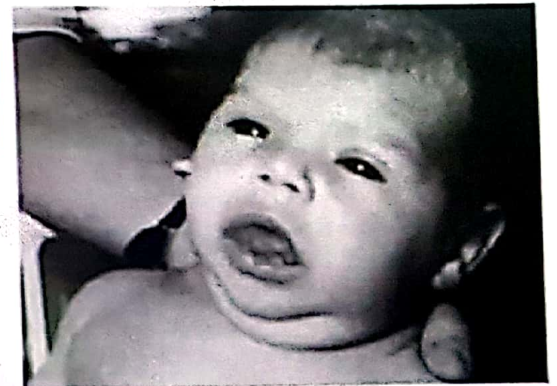
untreated congenital hypothyroidism

coarse features and large tongue





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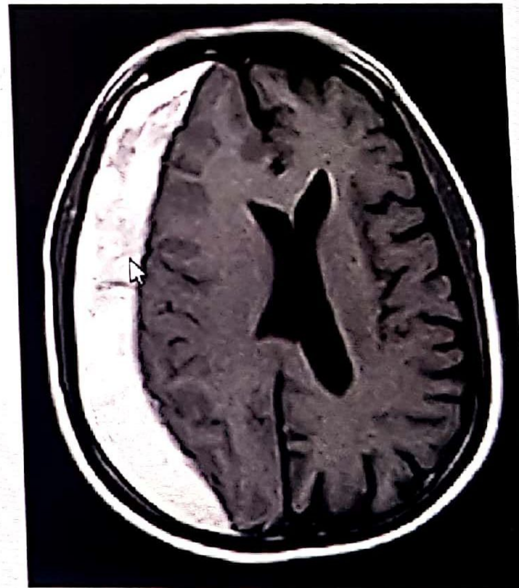
subdural hemorrhage(crescent shape) --> veins (cortical bridging veins)

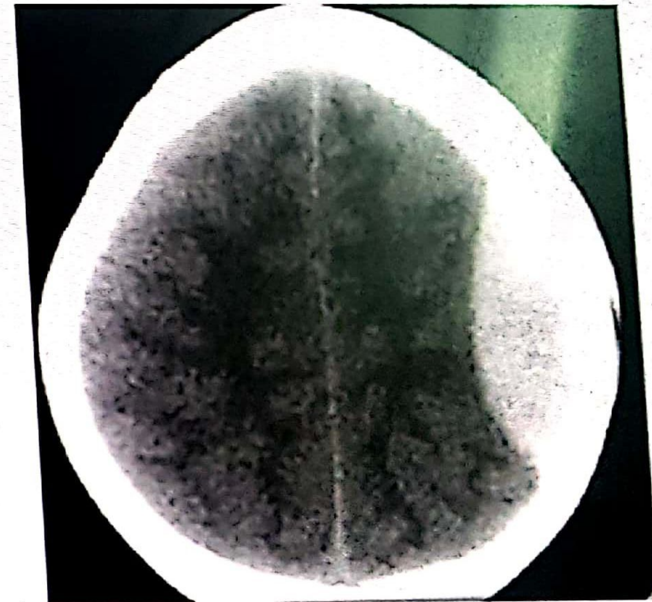
epidural hemorrhage--> middle meingeal artery

{ trauma , loss of consciousness, wake up, LOC ,, and so on..) -->

(poor prognosis)

lucid interval





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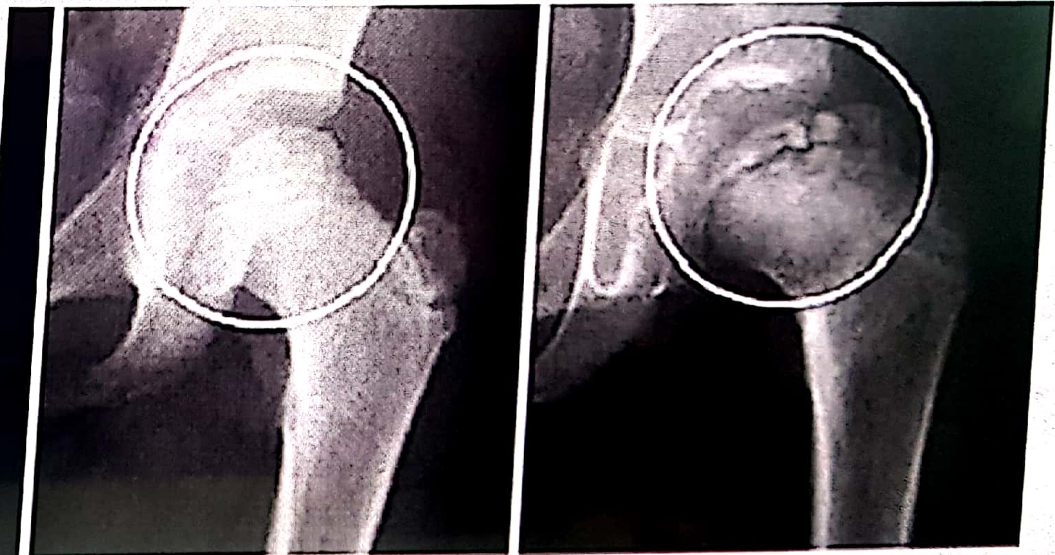
perthes disease

necrosis of femoral head

painless limbing is the most important sign



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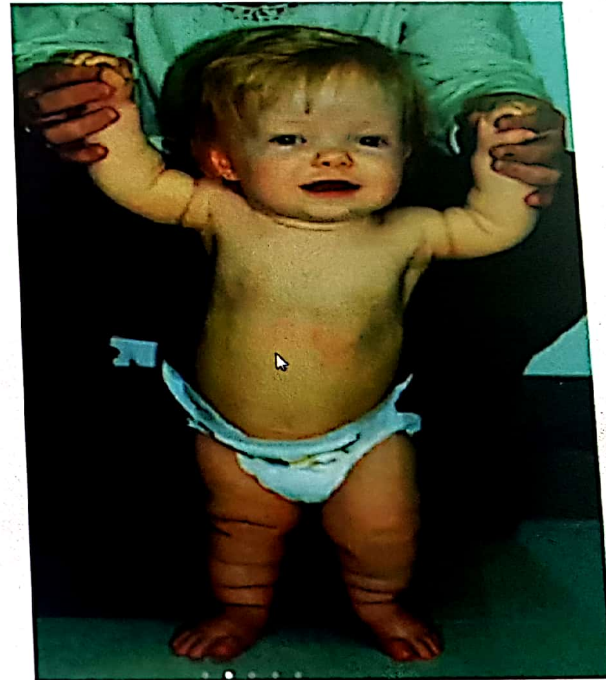
achondroplasia

autosomal dominant or denovo

severe short stature, normal trunk but short limbs



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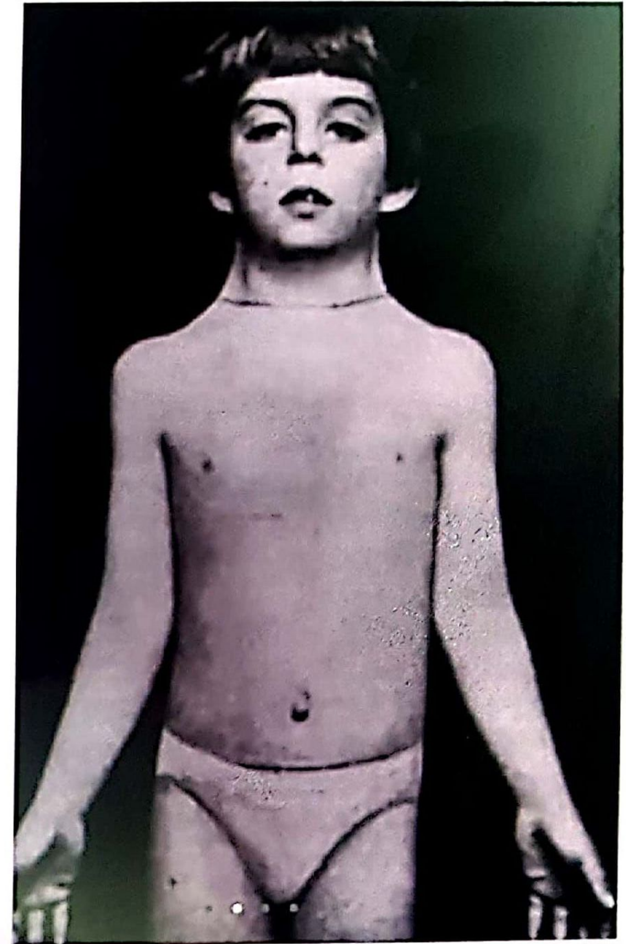
Noonan syndrome

- widely spread nipples
- braod neck
- cupitus valgus
- male
- high risk for pulmonary stenosis
- ☆☆ differentiate from Turner syndrome (females, has high risk for 2 congenital heart disease mostly : bicuspid aortic valve and coarctaion of aorta)*



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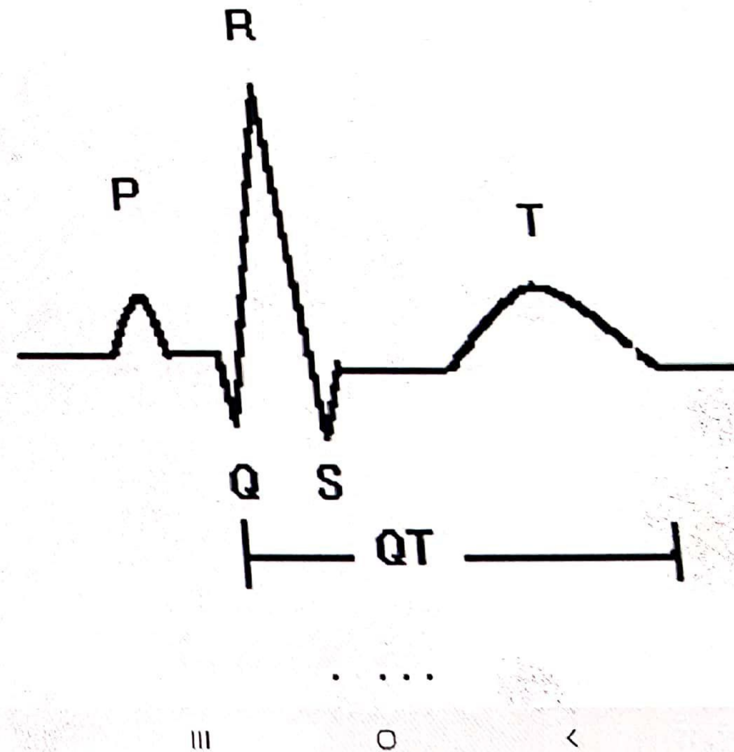
prolonged QT interval

from the begging of q till the end of t .

could be secondary to hypocalcemia or hypokalemia, hypothermia, intracranial bleeding or due to some certain syndromes like Romano ward syndrome?



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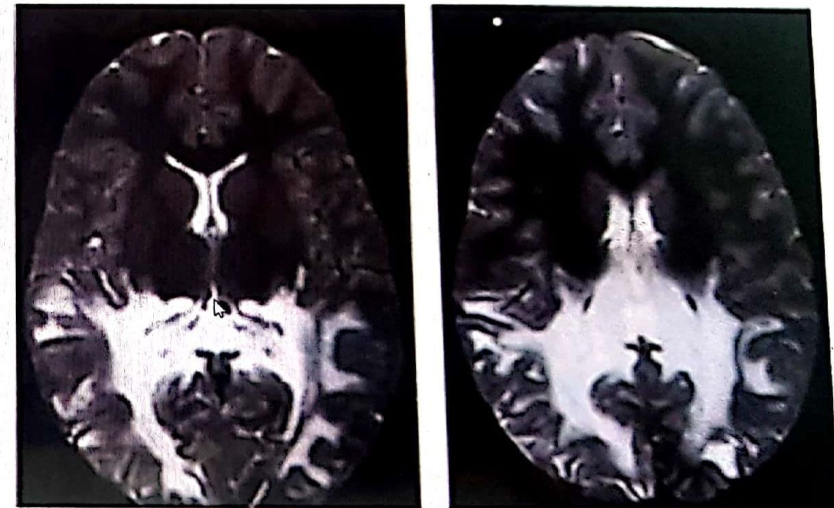
white matter disease (adrenal leukodystrophy)

MRI T2 (white matter dark, grey matter lighter, csf white)

T1 --> csf black

white matter 3aks il spinal cord..

white matter inner and grey matter outer



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tetralogy of fallout

abnormal shape - boot shape

four things

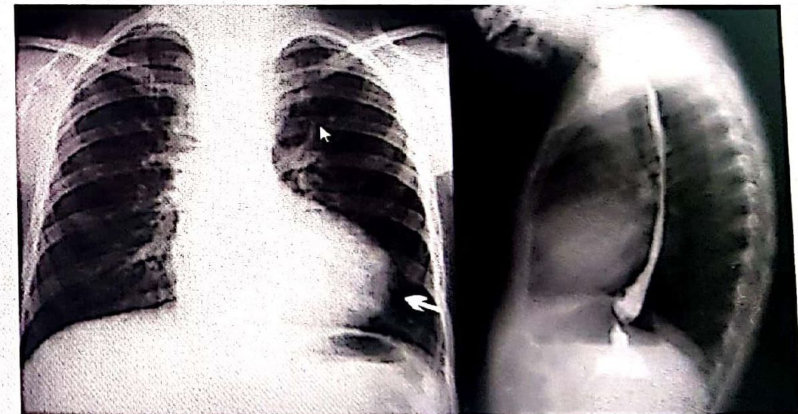
VSD, LV hypertrophy, overriding aorta, pulmonary stenosis

we predict to be oligaemic lung field due to pulmonary stenosis

lung field:

1- oligaemic lung field - dark lung field- -decreased pulmonary blood flow

2- plethiric lung field -(white lung field due to good vasculature)-- increased pulmonary blood flow going to the lung



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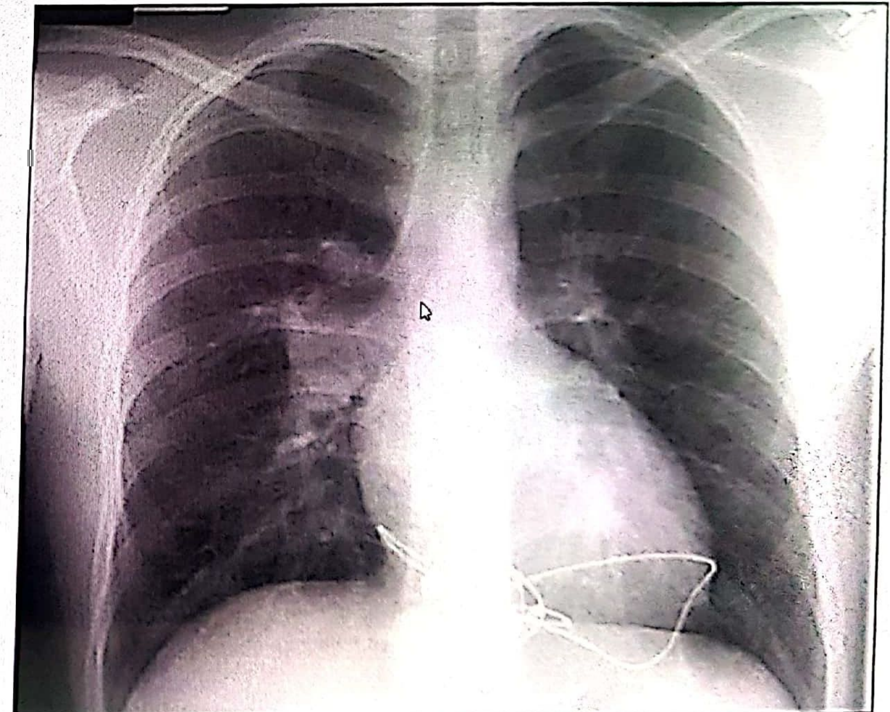
transposition of great arteries

egg on string --TGA

plethoric lung field

cardiomegaly and narrow mediastinum



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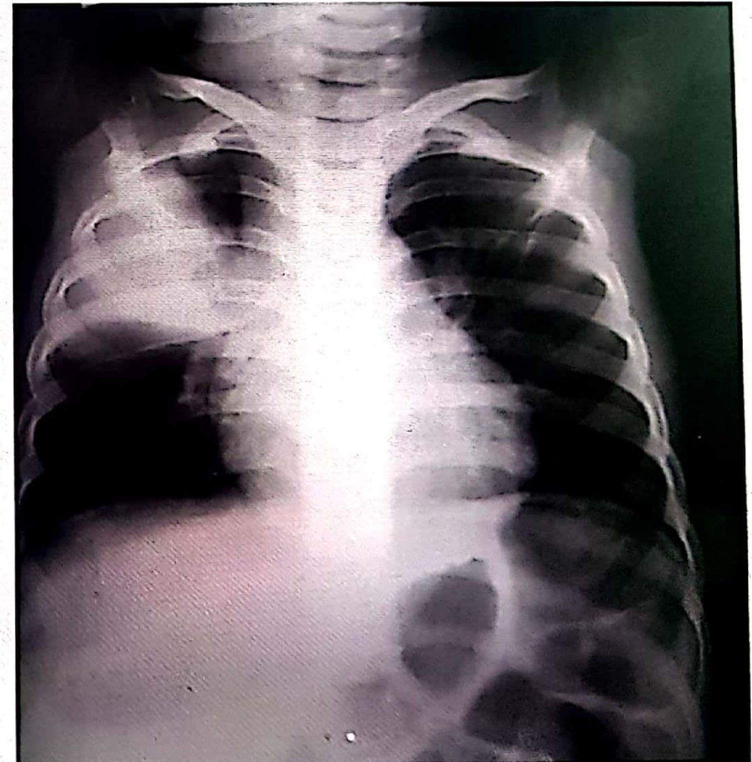
lobar pnemonia

high grade fever, cough,
crepitations on right lung



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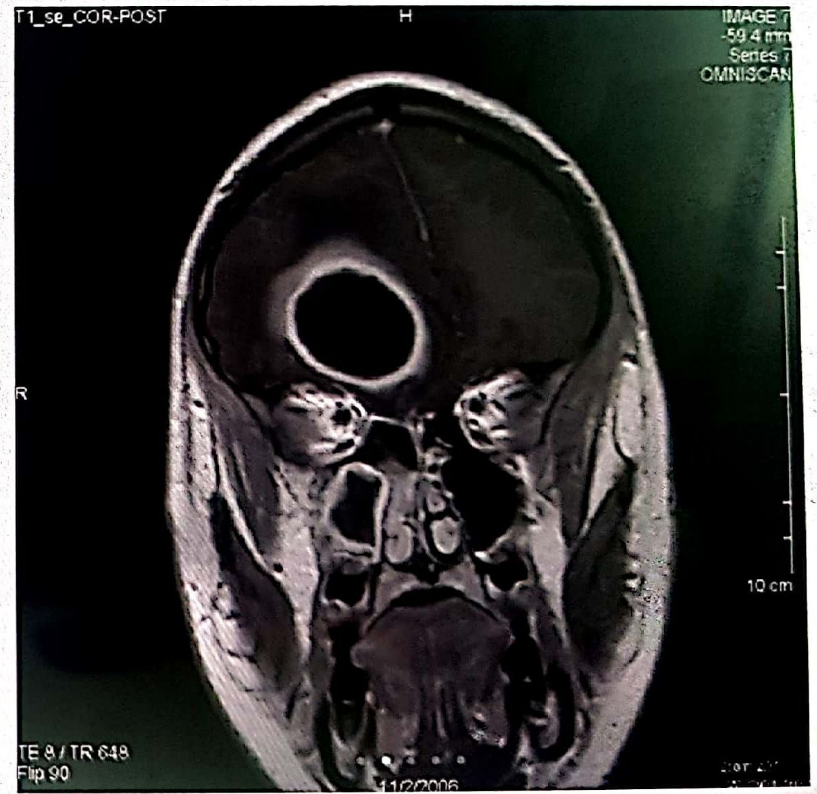
brain abscess



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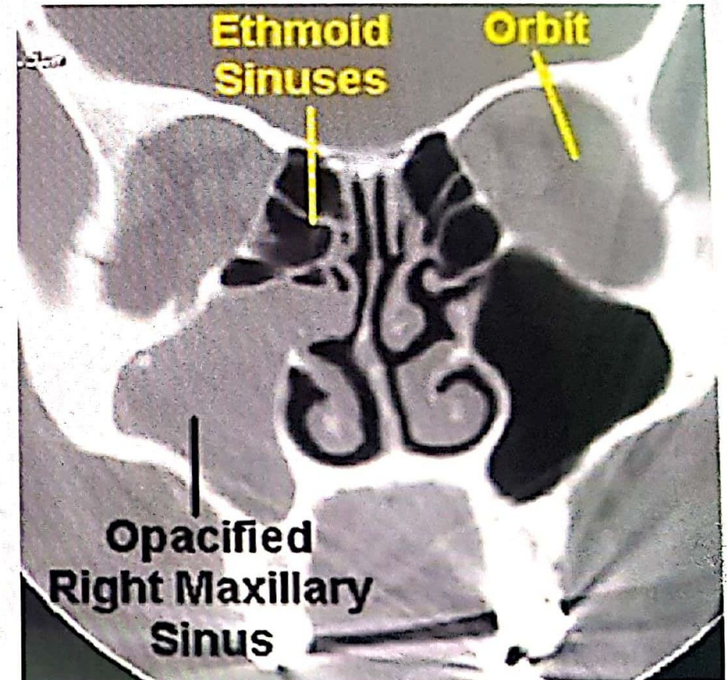
2 sinuses apparent in children : ME

maxillary sinus and ethnmoid sinus

sphenoid sinus apparent at 7 years



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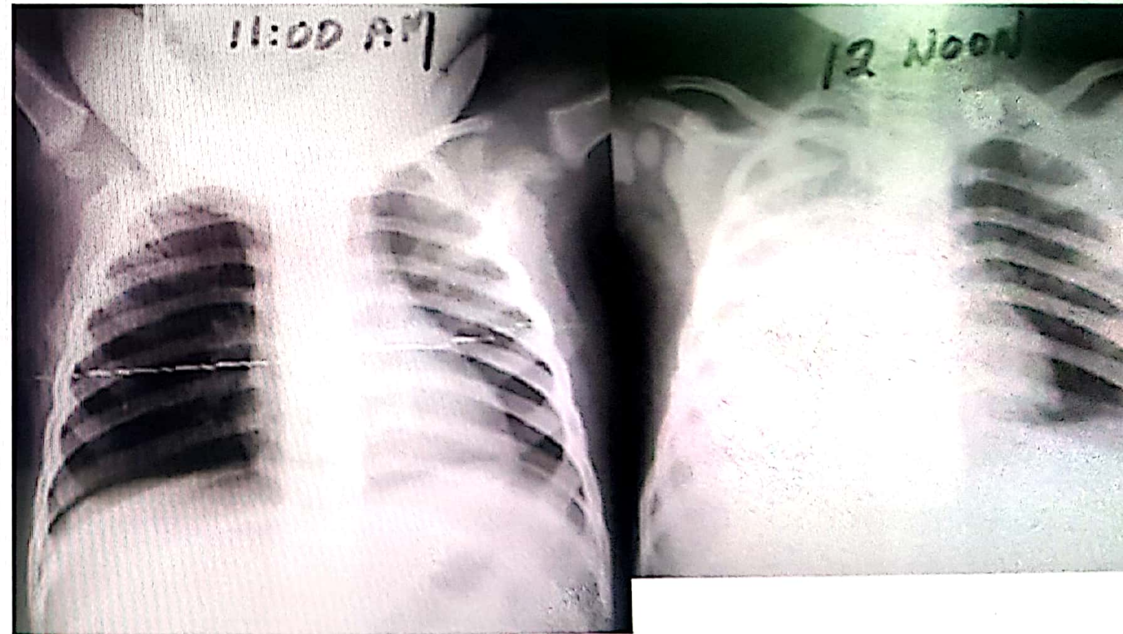
foreign body aspiration

- came with respiratory distress, child was playing with his toys
- lung collapse



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omphalocele

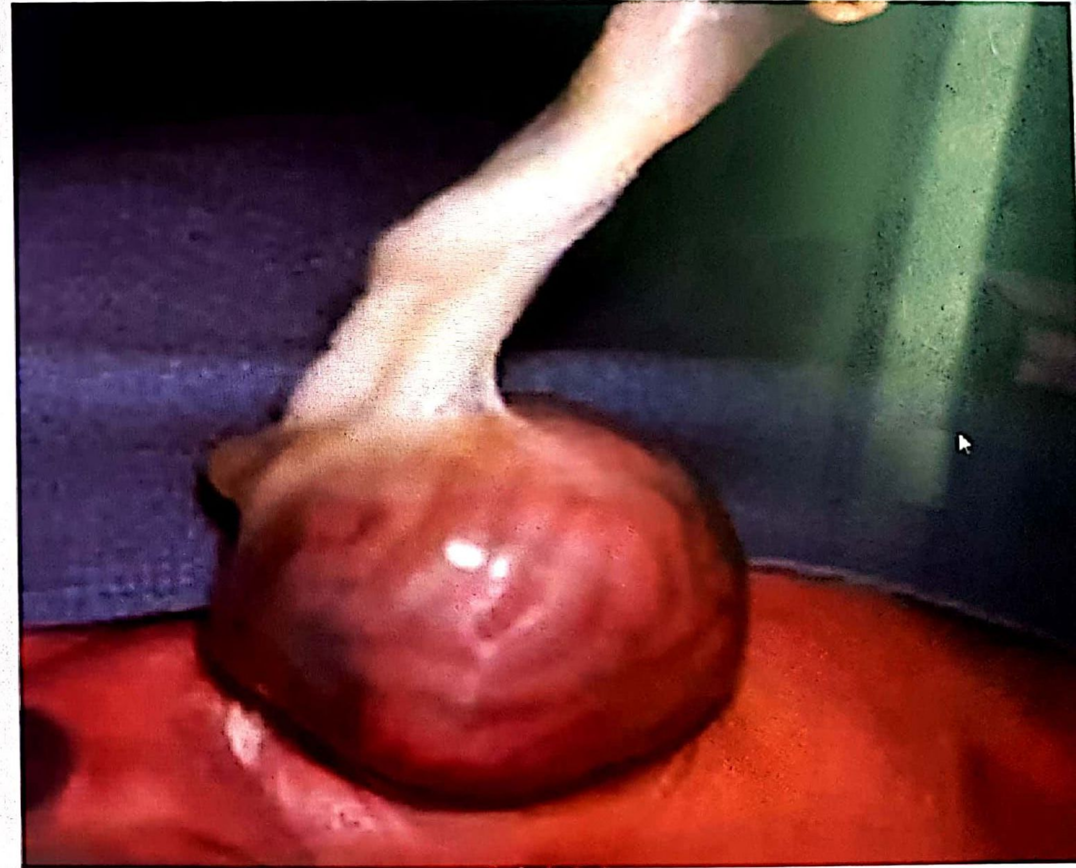
vescera covered with protrusion from umbulicus and covered by membrane

even when surgery is done he will not go back to normal..

associated with other morbididtes mainly part of syndrome :

macrosomnia, omphalocele, transverse ear crease , hypoglycemia due to beta cell ...(excess insulin) .. ***dx?beckwith weisman syndrome***

if not covered by membrane -- gastroschisis



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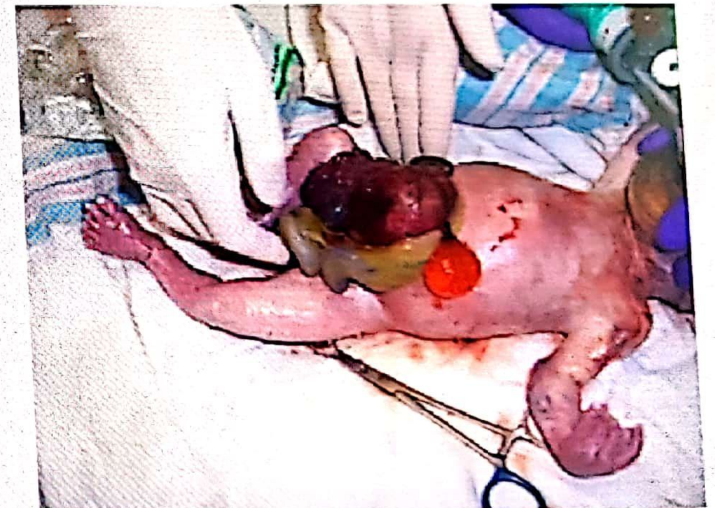
gastroschisis

better prognosis than omphalocele

once correction surgery is done everything will go back to normal. (no associated anomalies)



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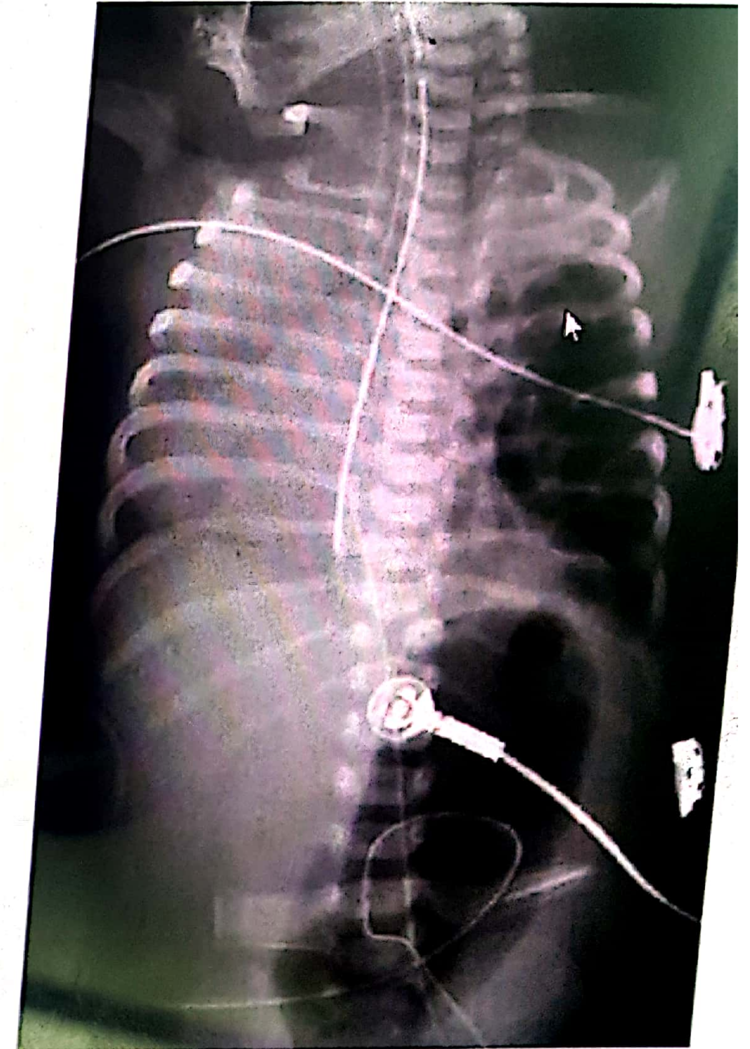
diaphragmatic hernia

has respiratory distress

bowel in chest



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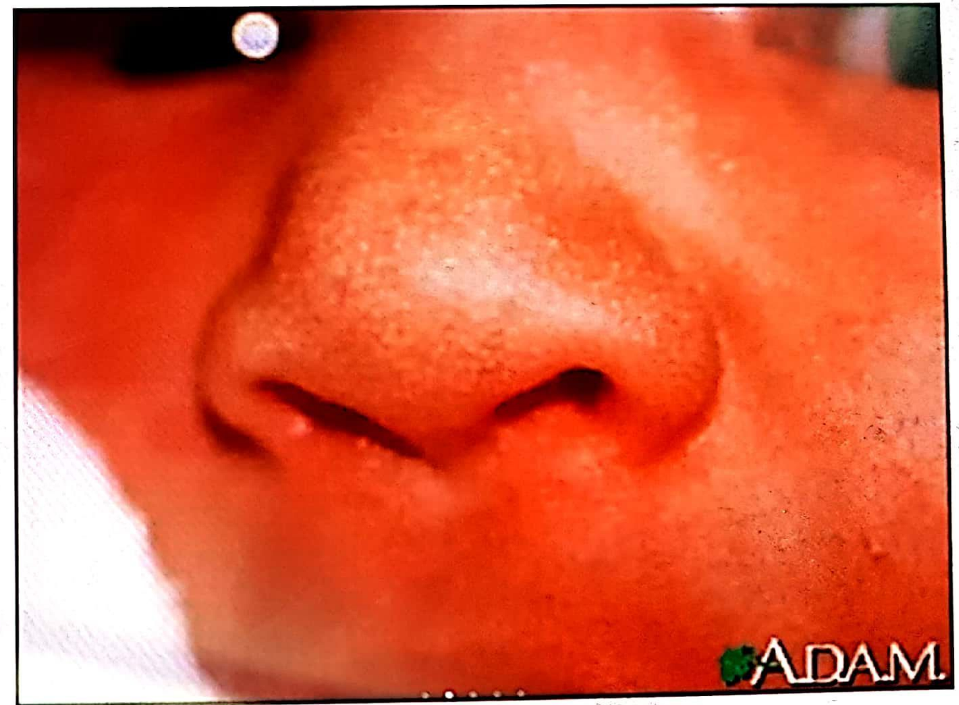
sebaceous retention cyst

normal variant

small dots on nose



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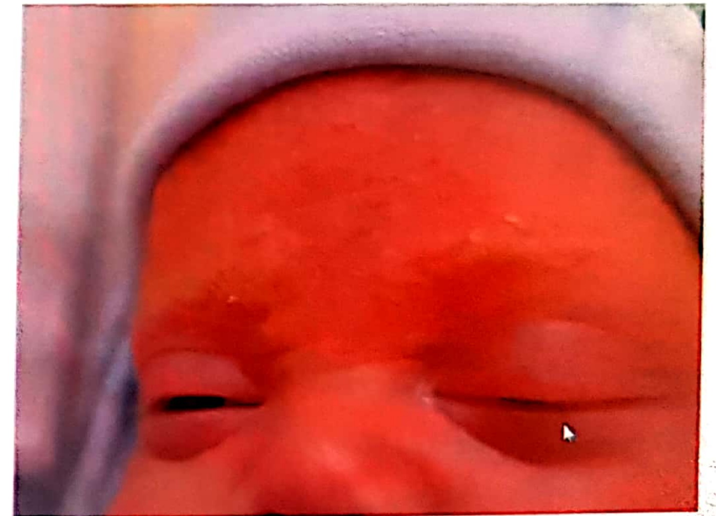
erythema toxicum

normal finding in neonates

background erythema on skin with patches and papules

self limited - dissapears on 7 days



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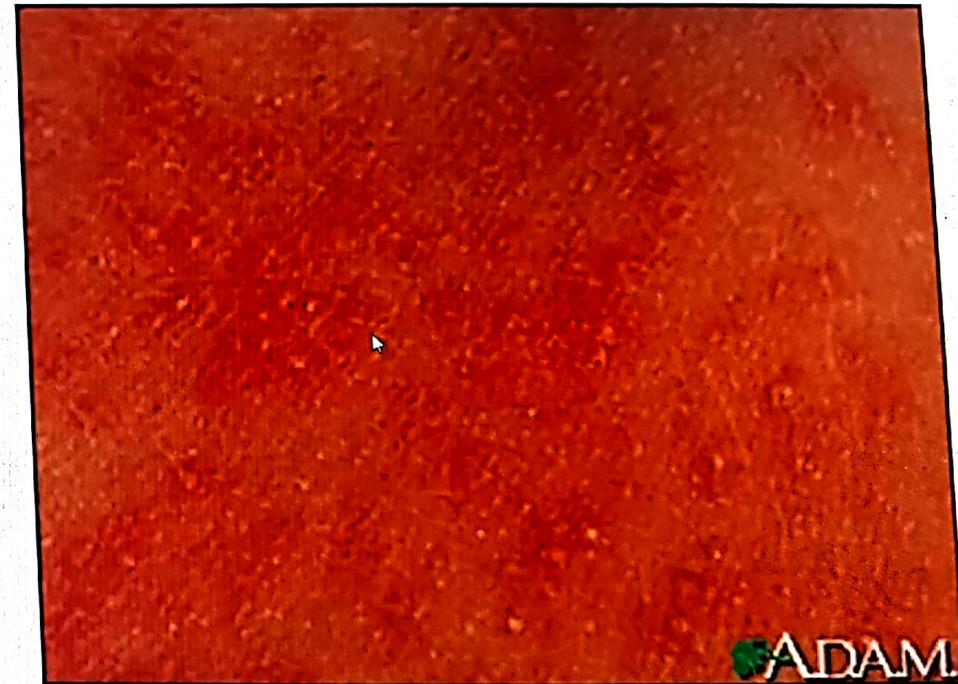
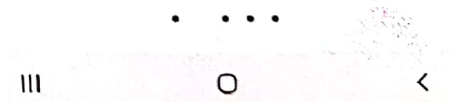
seborhheoic dermatitis





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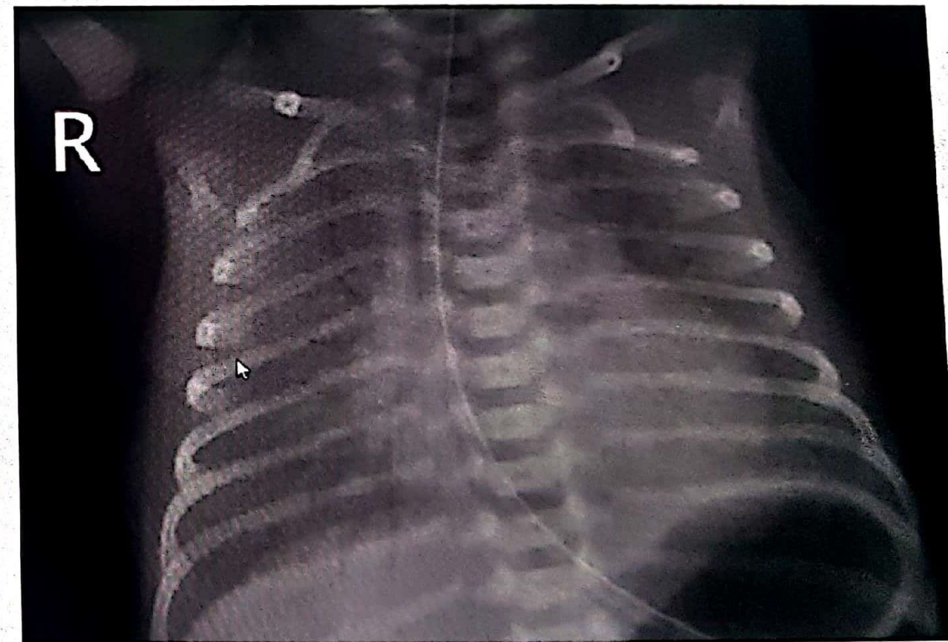
premature , reticuloglandular infiltration bilateral -- this is seen in two cases

1. respiratory distress syndrome -- we will find air bronchogram

2. congenital pnemonia .. that's why any premature baby we start on prophylactic antibiotic



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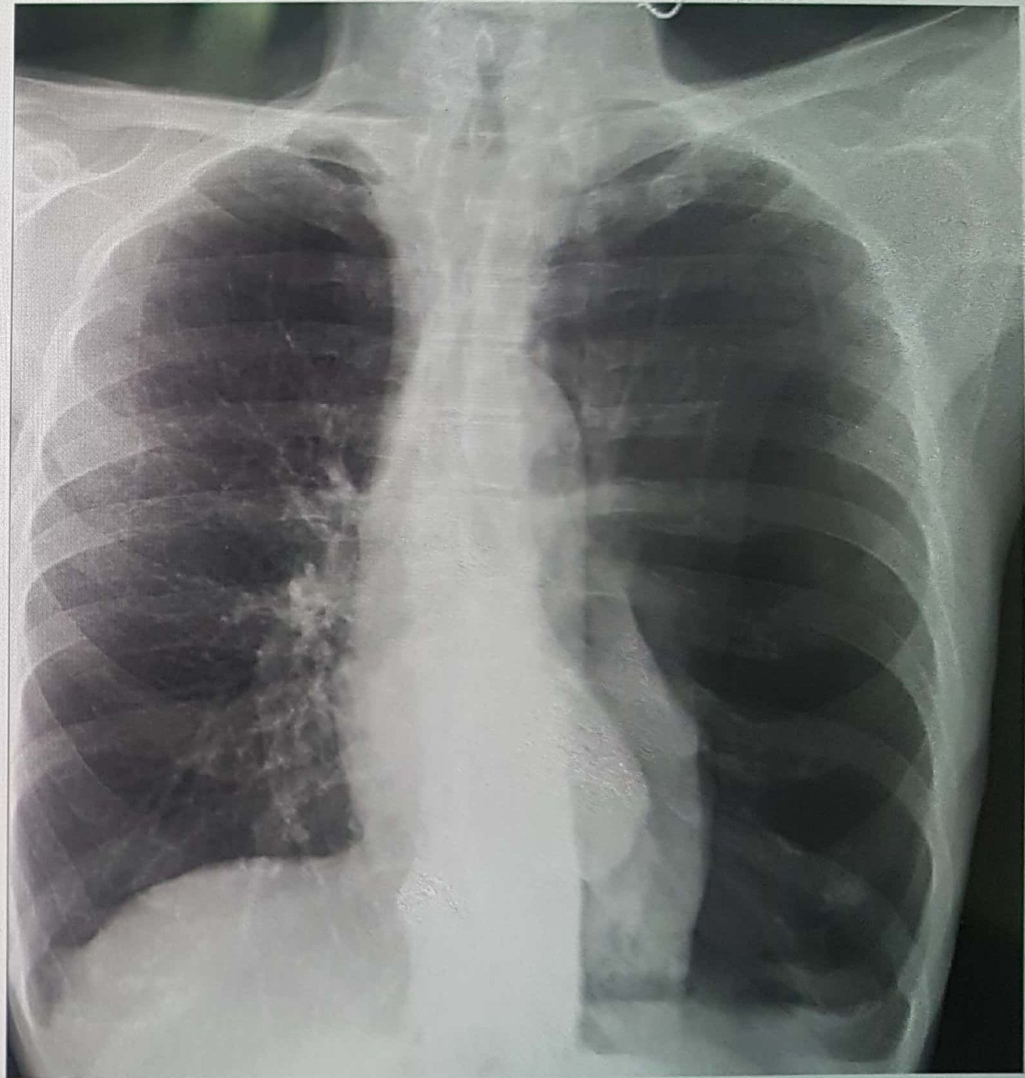
pneumothorax



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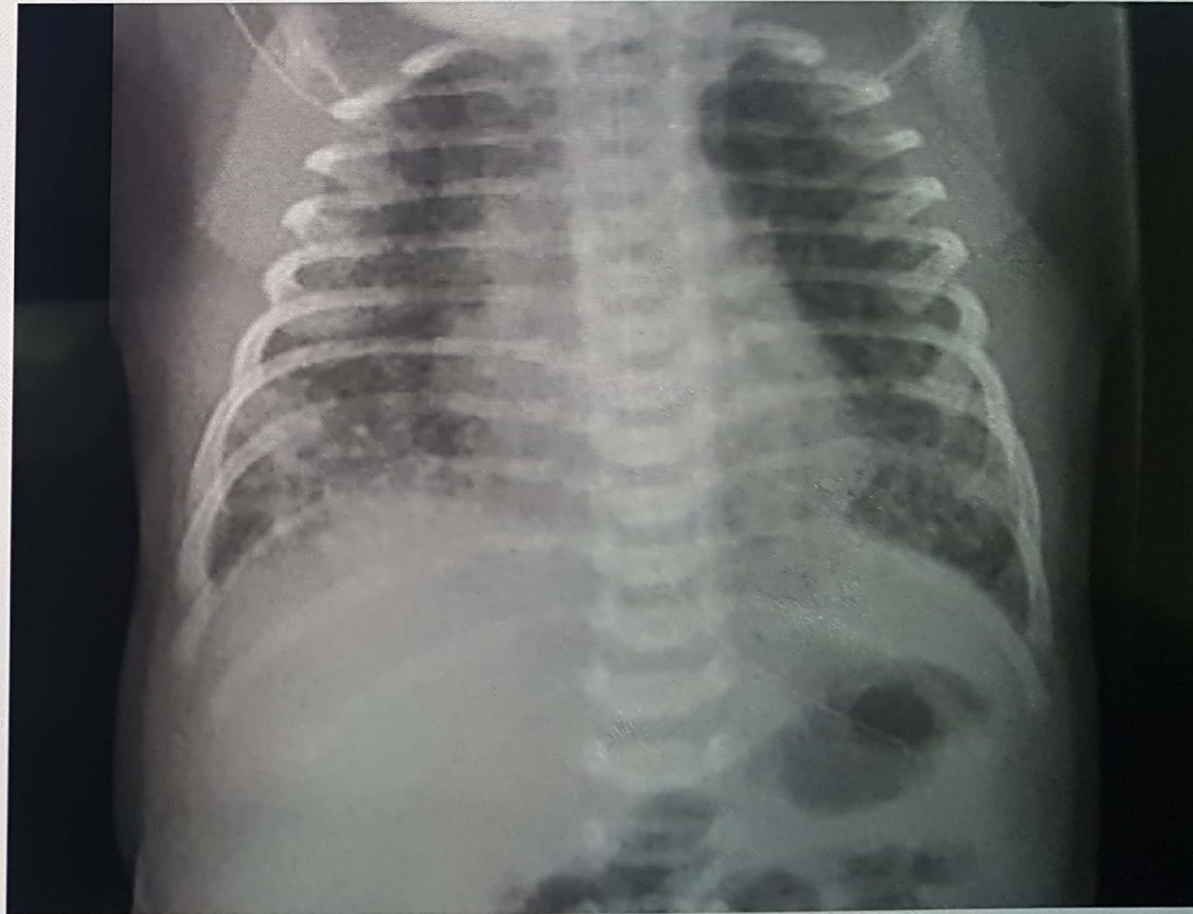
meconium aspiration

bilateral infiltration but not reticuloglandular, fluffy infiltrate , more coarse infiltrate



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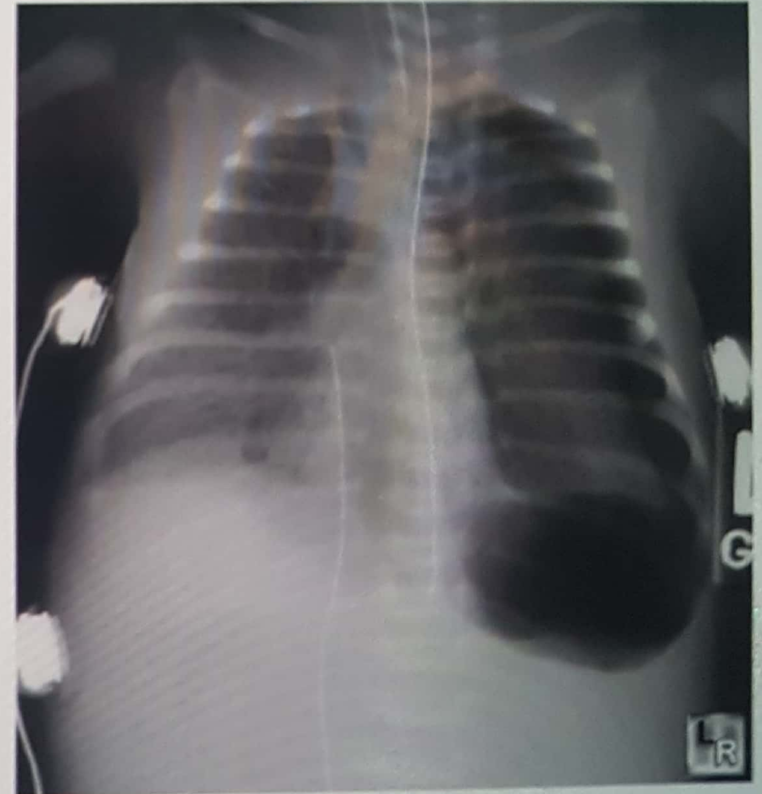
transient tacypnea of newborn

pulmonary oedema, fissure edema

usually borns CS, have retention of fluids in lung mo2aqat , just need respiratory support like oxygen for 2 days max.



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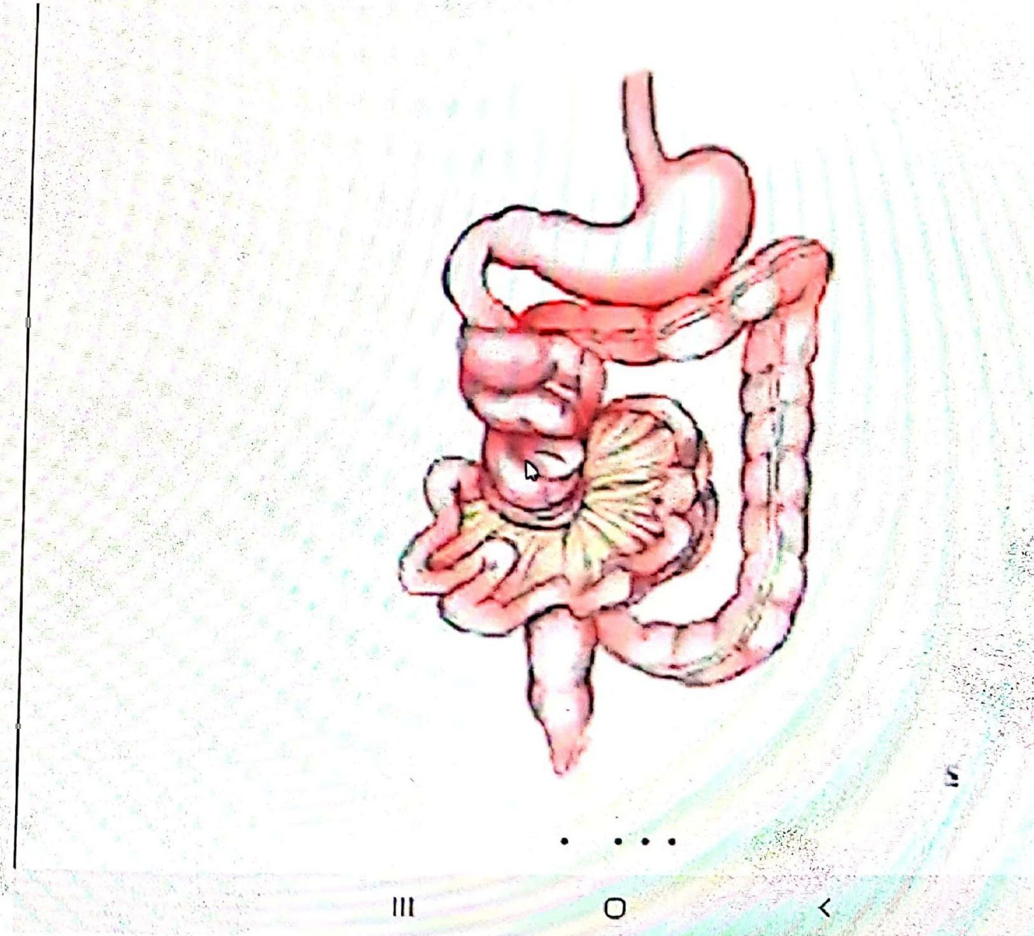
volvulus

malrotation around superior mesenteric artery

in adult due to high fiber diet



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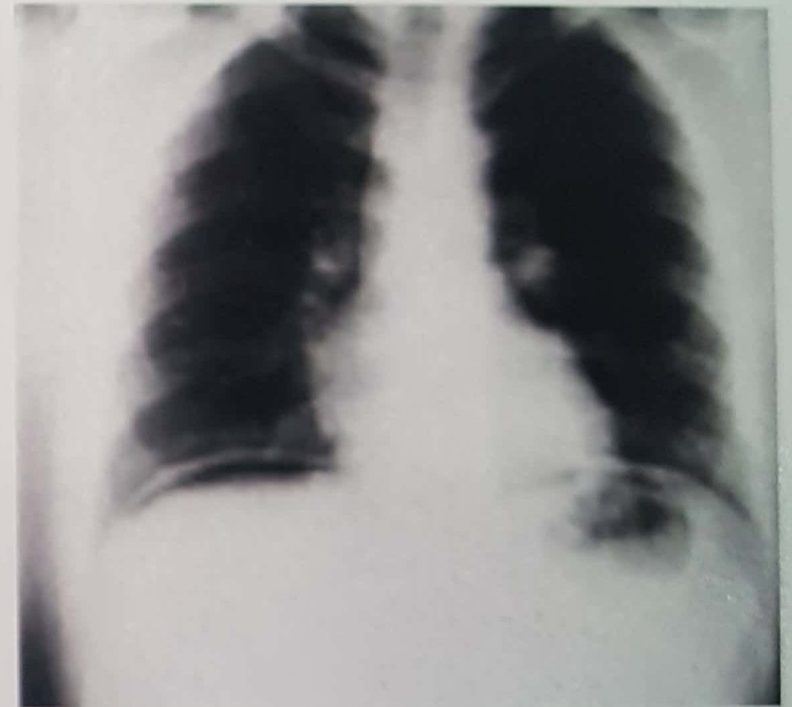
air under diaphram

probably has perforation



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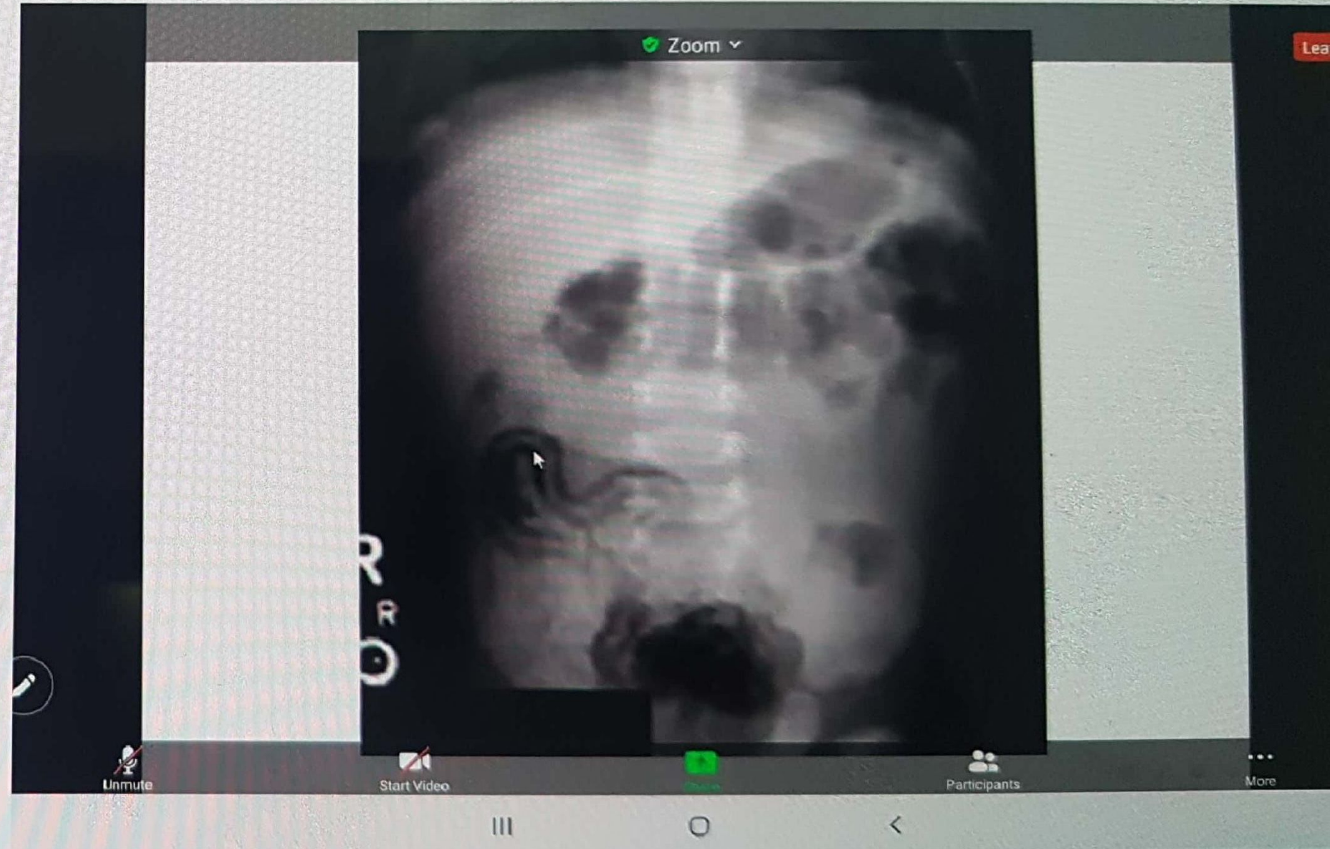
pnematosis intestinalis

premature, complication of gi system of premature, has this sign



common complication in premature children : ARDS, necrotizing interocolitis

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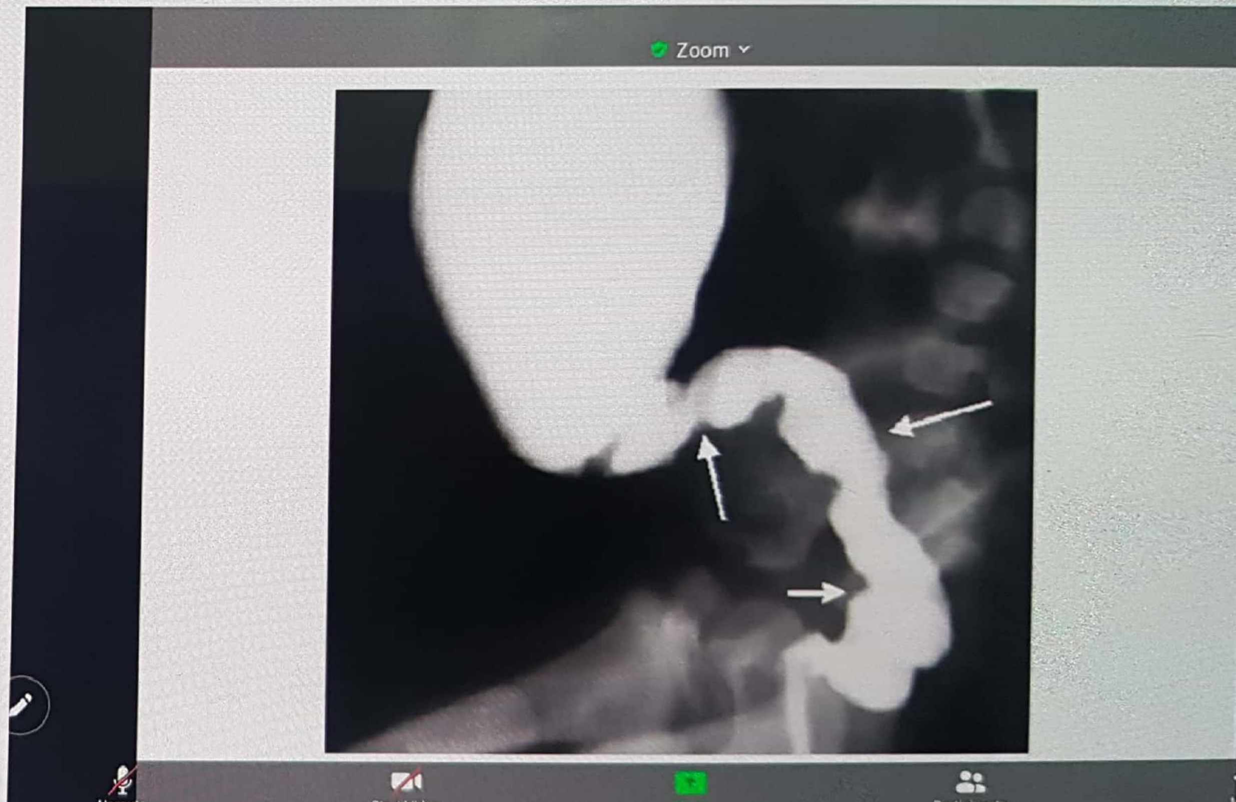
hurschprung disease

delayed passage of meconium, has some sort of intestinal obstruction , he is a neonate



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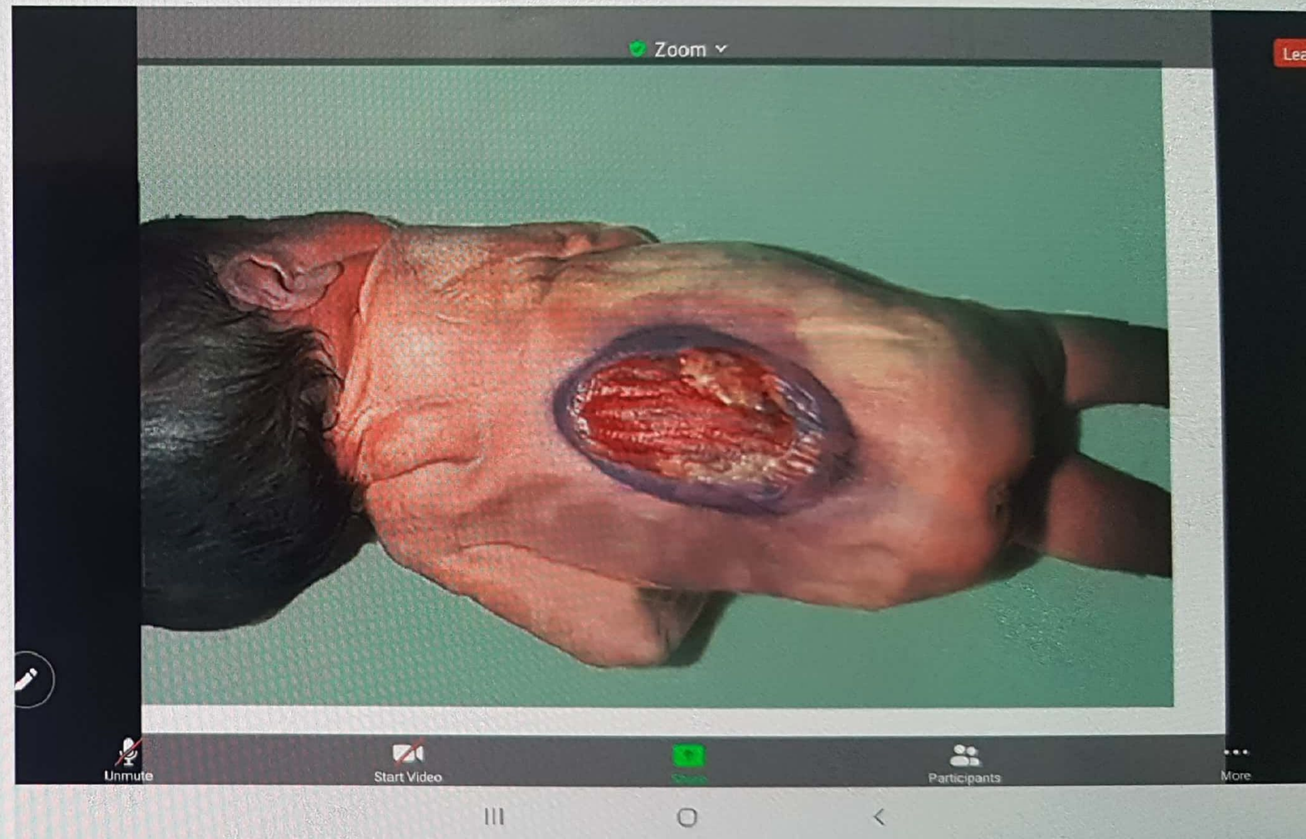
meningiomyolocele



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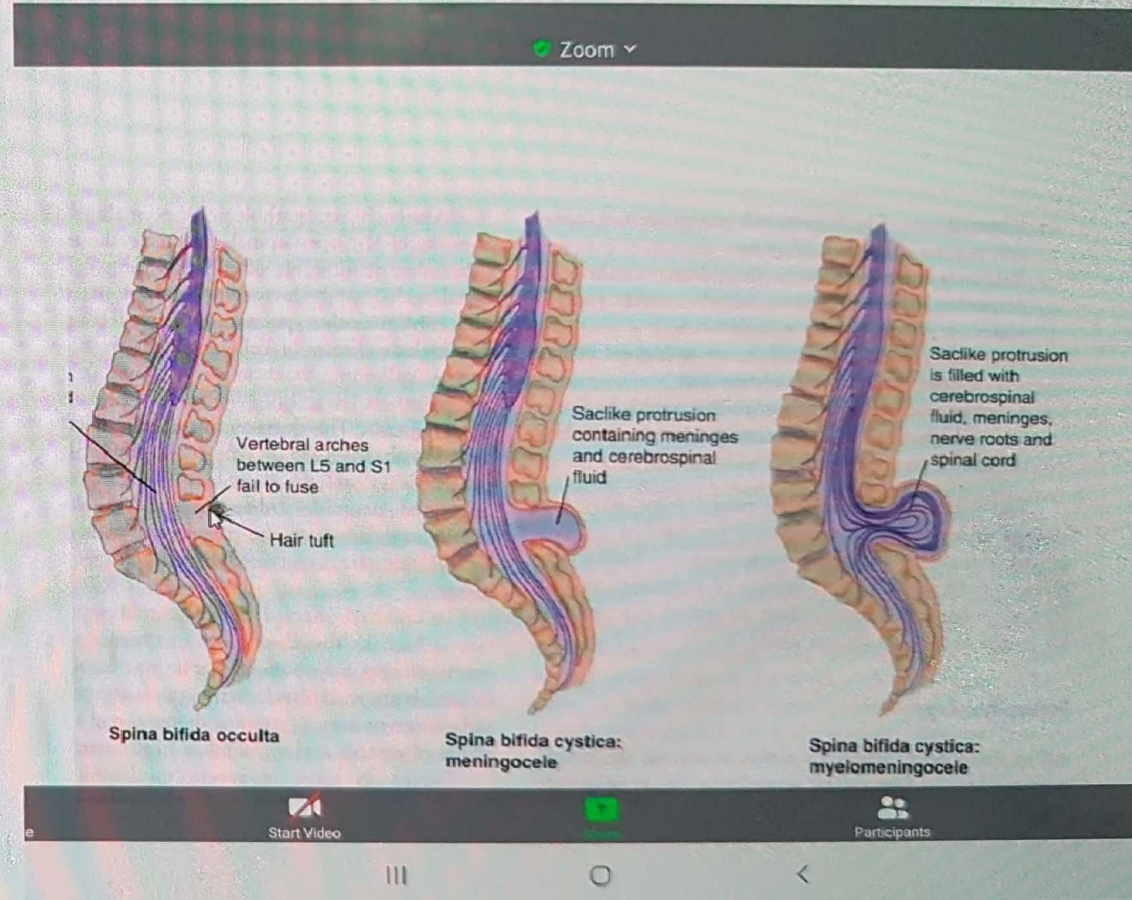
just spina bifida without dimples and hair tuft--- oculta

just meningeal membrane -- meningiocele

with tissues-- menigiomyelocele



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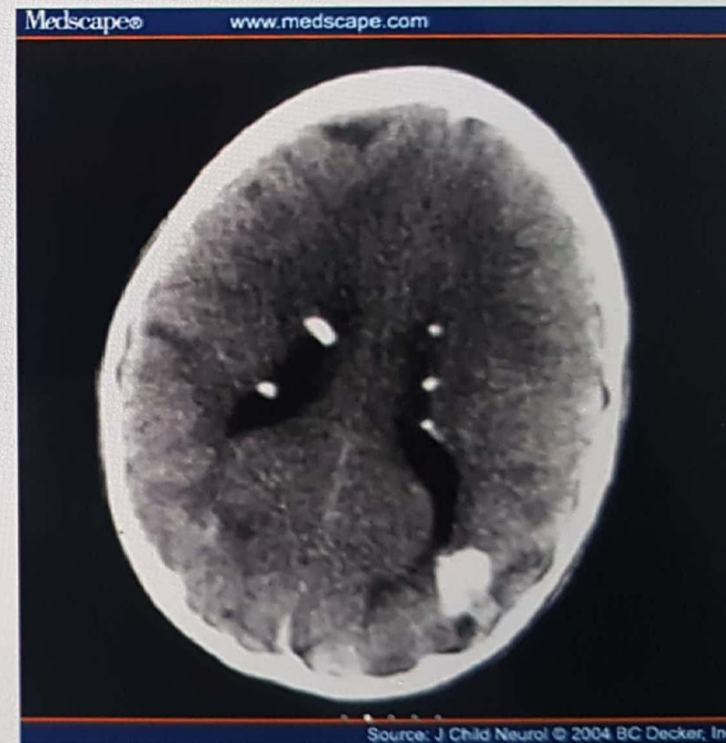
tuberous sclerosis

one of the neurocutaneous syndromes , periventricular calcification, findings: edematious and schagreen patch - thick skin on orange peel texture and angual fibrosis



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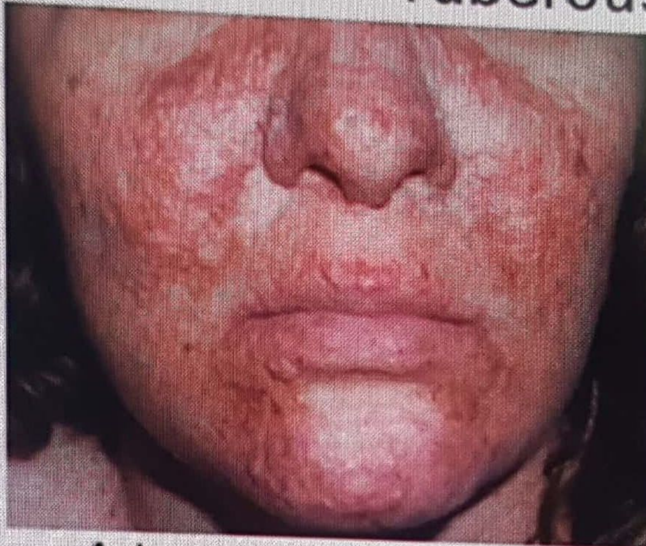
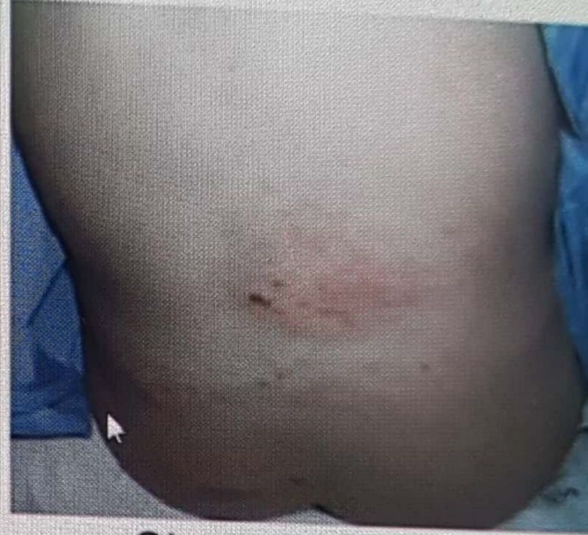
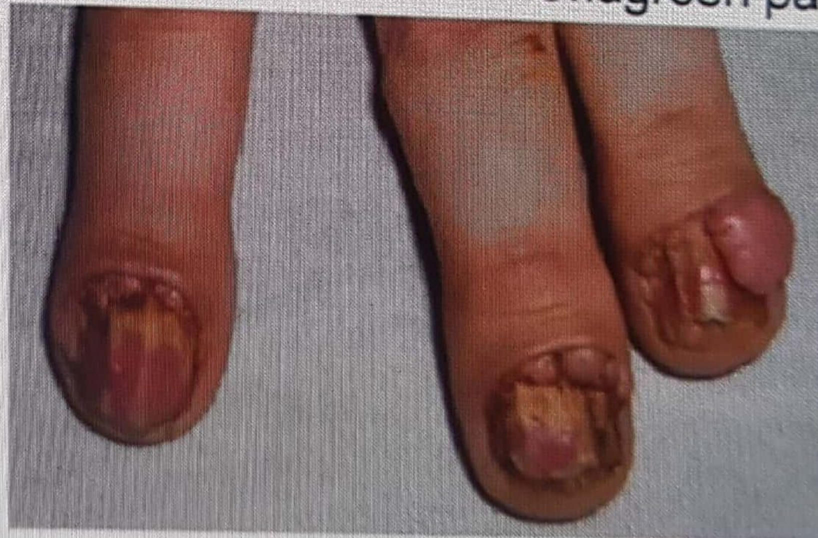
Tuberous sclerosis



Adenoma sebaceum



Shagreen patch



Ungual fibromas

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anti reflux

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lactose free

for patients with galactosemia or lactase deficiency

HA-- hypoallergenic .. for patients with cow milk allergy

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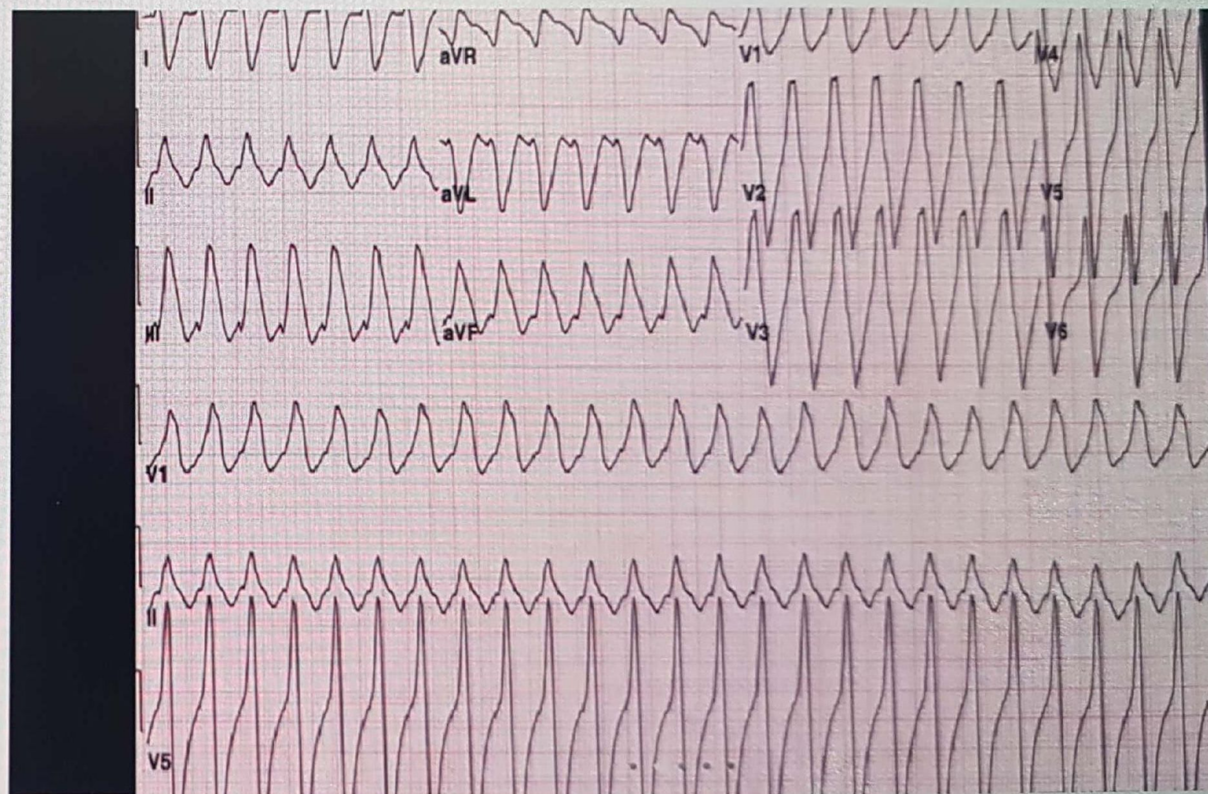
v tach

wide qrs interval

tachycardiq



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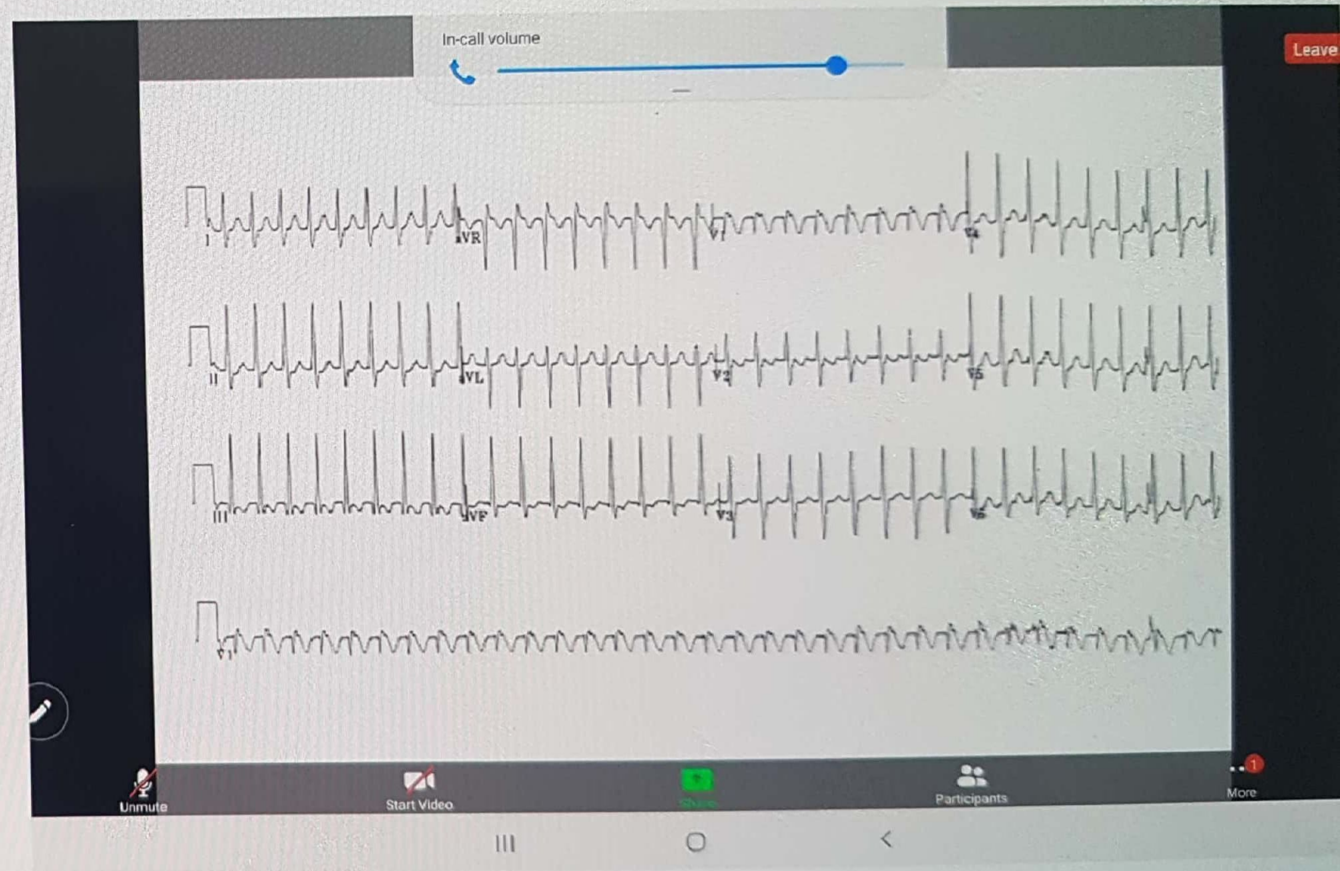
svt

narrow qrs and absent p wave

treated by adenosine



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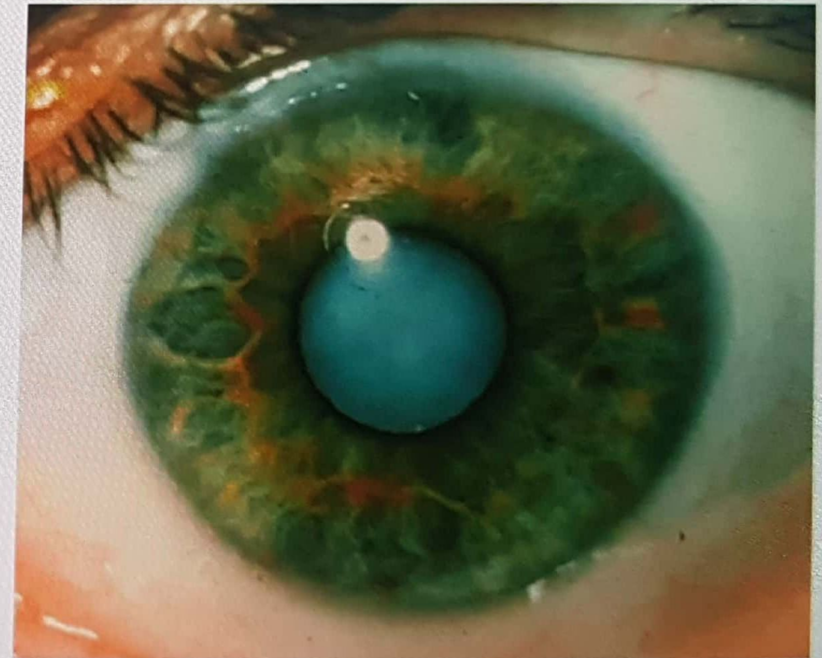
cataract



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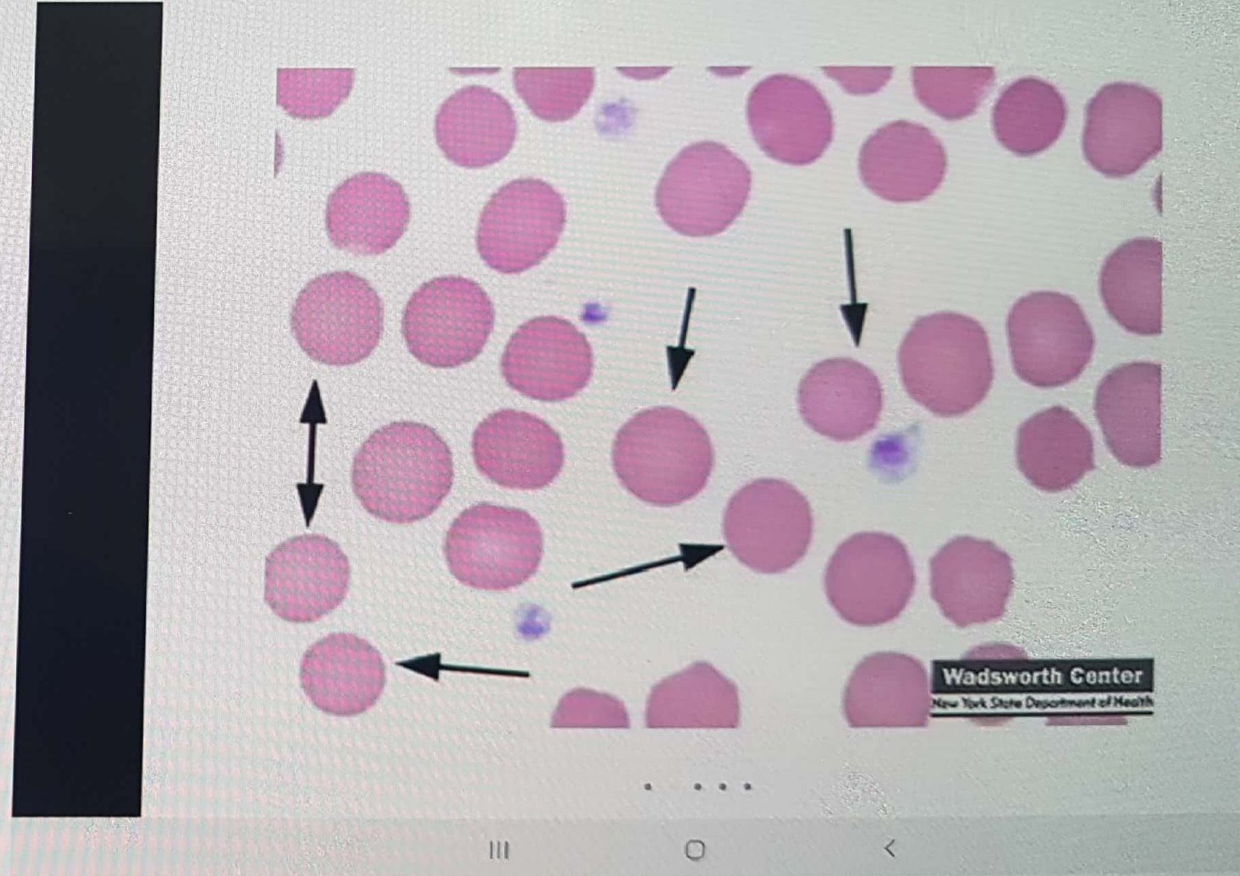
spherocytosis

hemolytic anemia

aut. dominant



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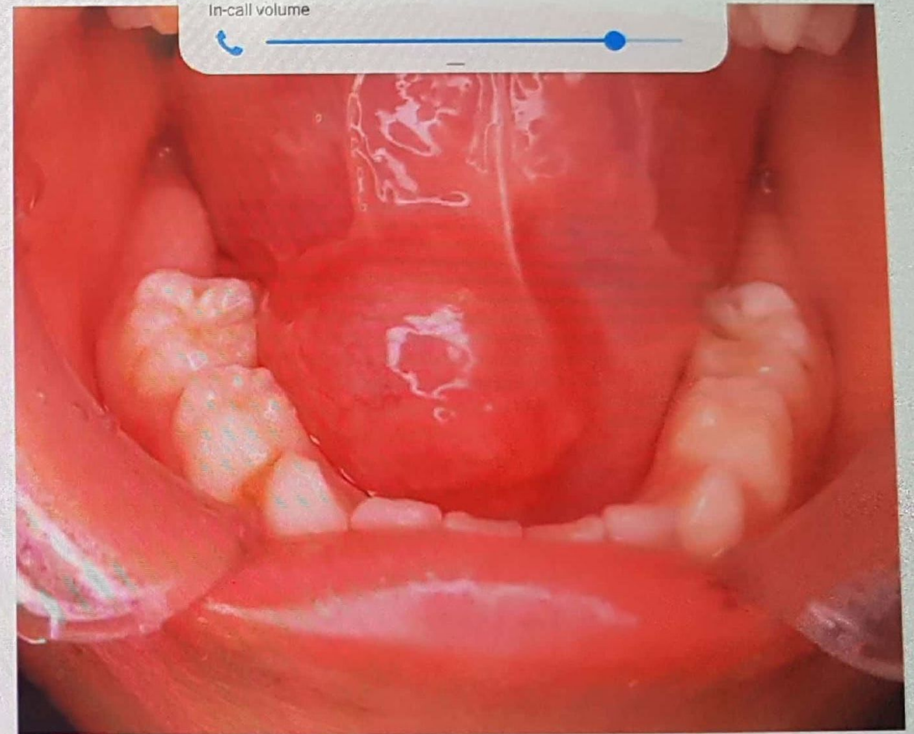
Ranula

mucus retention cyst

sublingual



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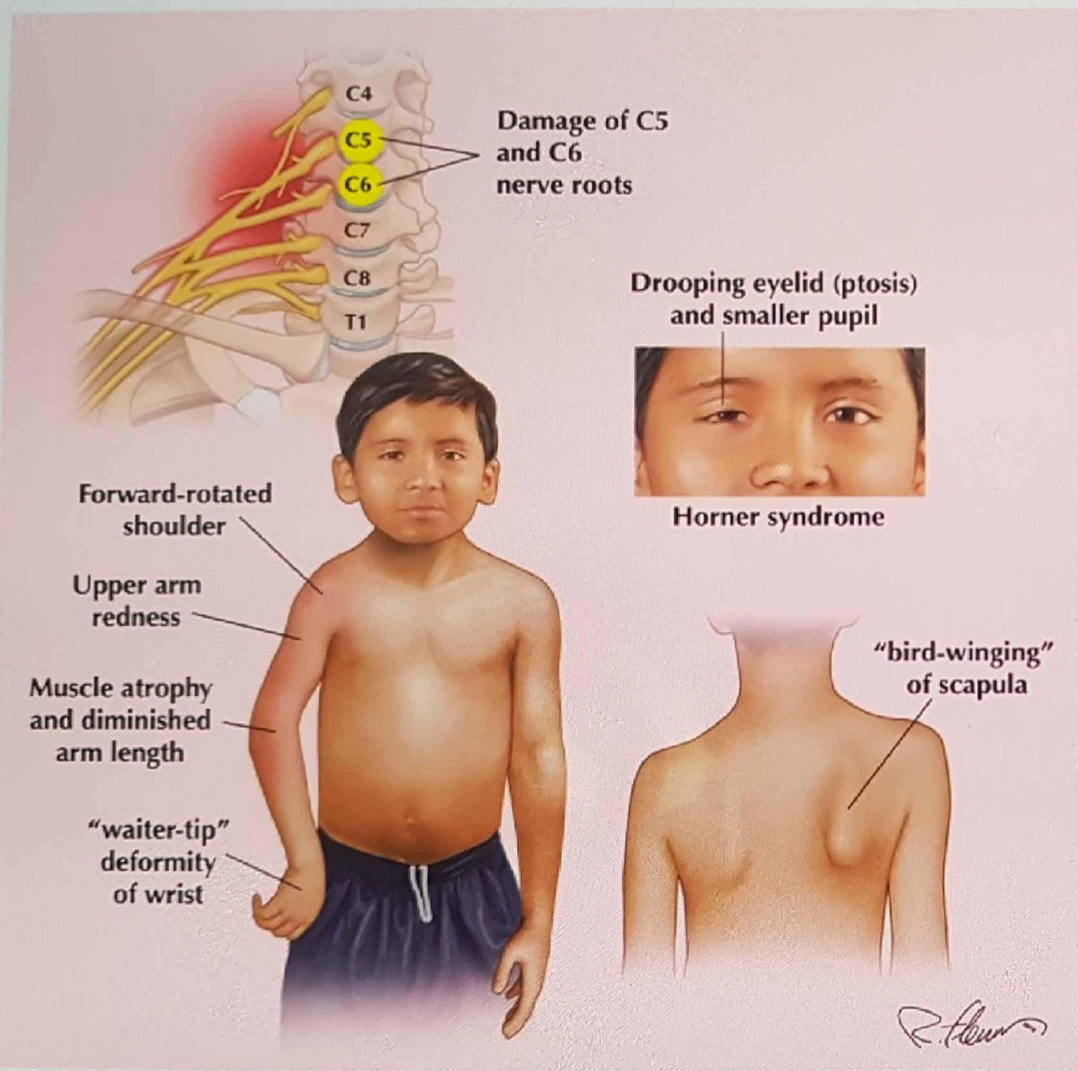
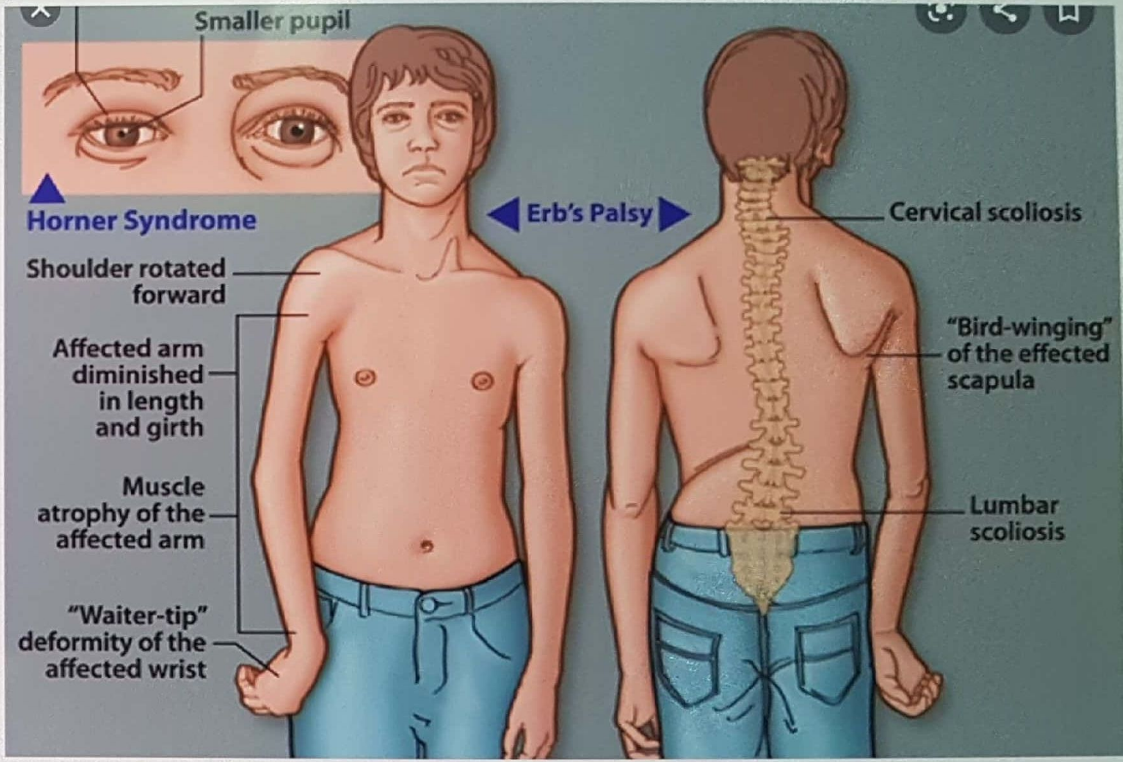


Erb's palsy



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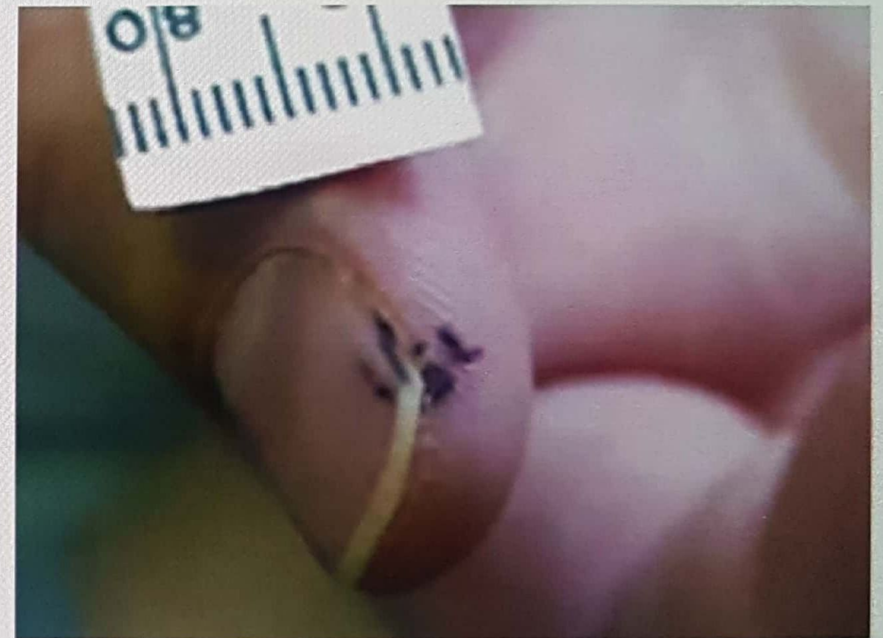
splinter hemorrhage

seen in subacute bacterial endocarditis



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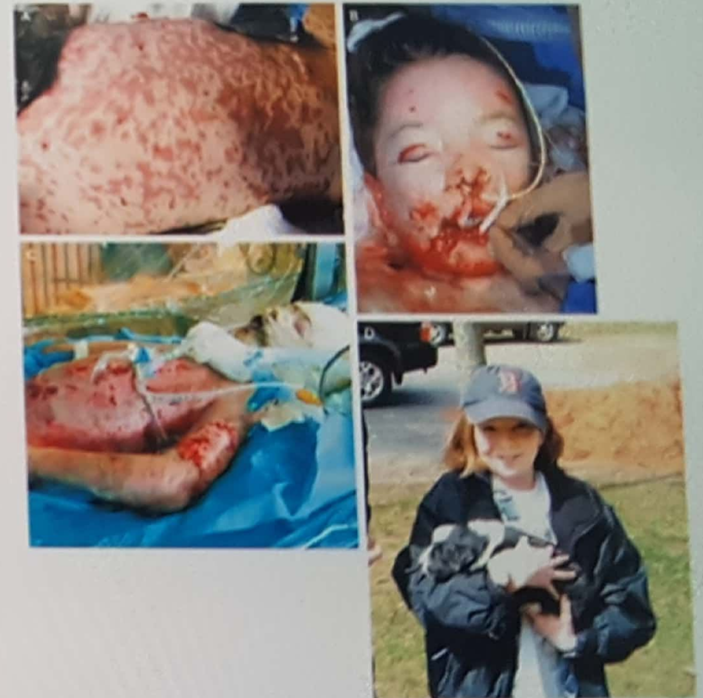
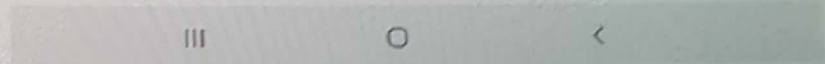
purpura, fever, (think of Nisseria mengitidis) so she has meningitis

intubated

took rocephen

complete recovery





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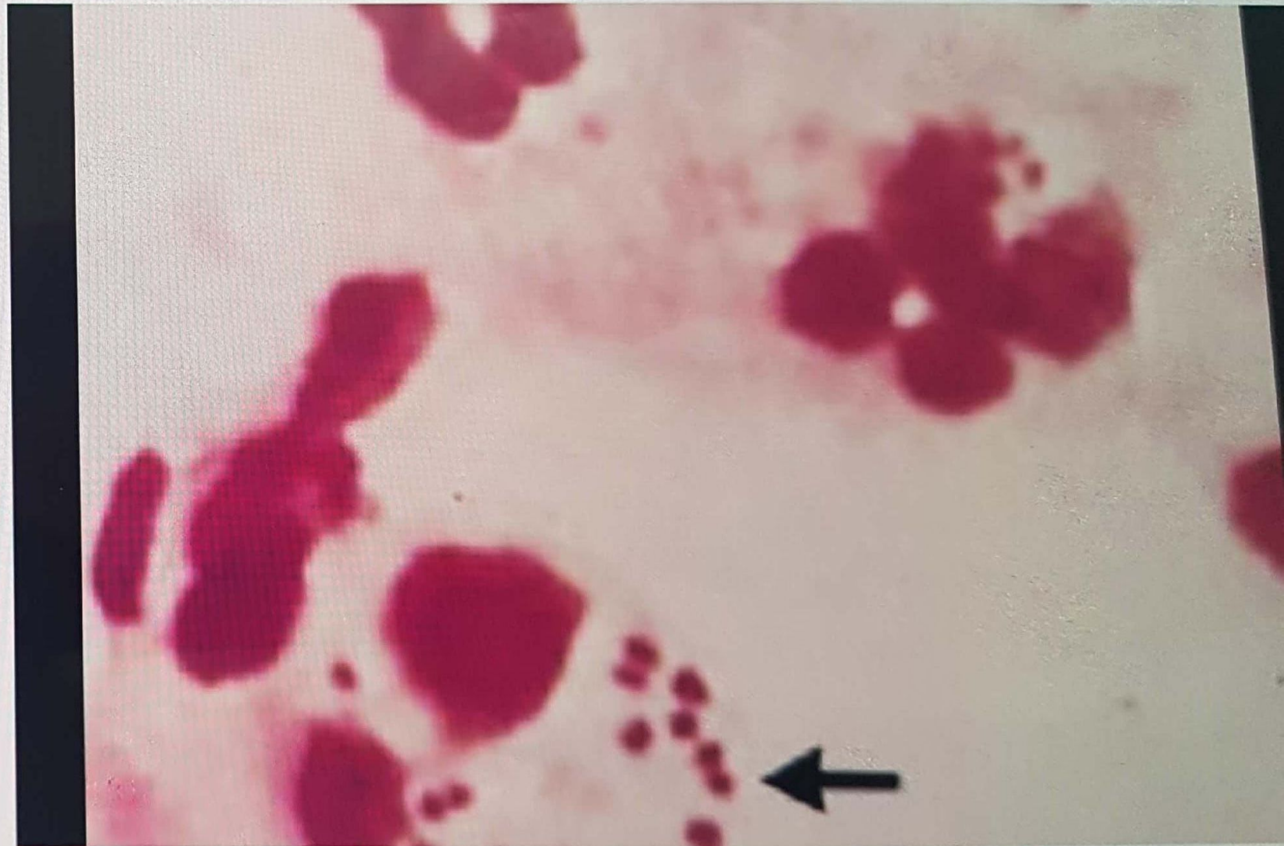
gram stain for nisseria
mengidiitz

color: grame negative , red



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