



Clinical logbook for Simon Downes

Pediatrics, Saint Anthony Hospital, 2020

Chief attending: Mohammad Chaudhary, MD

Duration: from Jan 20th to March 14th, 2020

Student details:

Name: Simon Downes
130838

OUM ID No:

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(Signatures are on separate attachments)

Clinical procedures performed/observed

**The clinic was extremely fast-paced, and therefore, we were able to observe and participate great deal. I will present some examples below.*

Clinical procedure #1

Name of the procedure:

Newborn baby exam

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**Principle of the procedure:**

When a baby is born on the wards, the attending is called up from the clinic to perform a newborn exam. If we were lucky enough to be working that day, were able to go together and assist in the exams.

Indication(s) for the procedure:

All babies receive newborn exams. Following the exam, the parent /mother must come to the clinic for a follow up newborn exam where she will be screened for depression and asked many questions about her baby and how the mother/parents are coping.

Associated risk(s) with the procedure:

The newborn exam is very important because certain things must be confirmed before the baby can go home. For example, if the child has jaundice, it must be determined what type of jaundice it is, and the levels must be confirmed before sending the child home. If the levels are high for example, the baby will be put under special lights which will reduce the jaundice. It is essential that the baby is not sent home with high levels of bilirubin as the baby can die at home. On the way home, levels are checked, and the number is recorded. If the attending notices abnormalities, the baby cannot go home.

Also, there are several essential examination points that must be done so that problems can be dealt with immediately.

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Method:

One example of an essential part of the newborn exam is examination of the fontanelles, not only the front but also the back, to confirm that they are not fused, which would be craniosynostosis. The attendings kindly taught us how to do this.

Another important component is the baby's weight. After birth, the baby will lose quite a bit of weight, but will gain it back during the first few weeks.

The umbilical cord should be examined for infection as well as palpating the entire body to check for abnormalities.

Looking at the baby's back, we can sometimes see a Mongolian spot, or look at the spine to see whether there are any neural tube defects. In addition, there are many types of temporary skin conditions that the parent may be concerned about such as milia, which will also go away on its own.

Expected outcome/ advantage/ interpretation:

Medical malpractice due to missing important clues can be avoided by following simple guidelines. I saw many exams, and I noticed that the attendings followed a certain order and covered the same areas with each baby exam.

In one instance, a mother was preparing to go home but the baby had a very high bilirubin level, and therefore, she was asked to stay in the hospital with her baby, or to go home and leave the baby here for another day.

Certain protocols must be followed exactly in order to avoid trouble. I noticed, however that the physicians did not seem stressed regarding the exams and in fact looked to be enjoying their work. So to summarize, the greatest advantage of following the protocols is the happy parent and healthy child.

Clinical procedure #2

Name of the procedure:

Nebulizer for child with breathing difficulty

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**Principle of the procedure:**

A nebulizer treatment will relieve tightness and distress, by delivering a liquid medicine to the lungs in the form of a mist. This is done by sending oxygen through the tube at a certain number of liters. We observed that when about 8 liters are sent through the tubing, the liquid becomes a mist.

Indication(s) for the procedure:

Some examples for nebulizing treatments are asthma, bronchiolitis, sinusitis, and emphysema. When a child comes in with tightness and irritation, they are often in a panicked state. While the parent may understand that the treatment will provide relief, the child/infant does not. The respiratory therapist is often the person called to conduct the procedure.

Associated risk(s) with the procedure:

If the medicine is not delivered properly through the mist, there is a possibility of worsening symptoms, or death. However, some of the common side effects might be sneezing or a stuffy nose, a cough, or wheezing.

From observing the procedure, I could see that even though the mist was achieved, if it is not delivered to the patient, then there will be no effect.

Method:

Using either a portable oxygen tank or an air compressor, liquid medicine, for example, albuterol is sent directly to the lungs in the form of a mist. A spacer is often added to mix more air with the treatment. It is possible to use either a mask or a mouth piece extension where the child may hold it, which seems to give the child

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some control, and could possibly assist in calming them down. In the case I saw in the clinic, the mother of a 2-year-old said he preferred to hold the mouthpiece rather than to wear the mask.

Expected outcome/ advantage/ interpretation:

It may take 5 to 15 minutes for the treatment to begin working, and the patient may sit for 30 minutes or more with the treatment until a comfortable breathing condition can be achieved.

The nebulizer may be administered every 3 to 4 hours depending on the lung condition of the child. In an allergic asthmatic reaction, for example, one treatment may be all that is needed. However, with a child who has cystic fibrosis, breathing treatments may be a daily occurrence.

Seminars presented/attended

The rotation was set up in a way that allowed us to train in the clinic and attend weekly/daily lectures. Some were mandatory attendance for all, and for others, we took turns, even leaving the clinic for the lecture, and returning to the clinic after the lecture.

On Tuesdays, we all went to the Access Clinic to hear general lectures by Dr. Chaudhary before the presentation was given by a student. Not all students presented, but there was always a great deal of questions after and during presentations, so we had to be on our toes!

On some days, we had both Access Clinic lectures and inpatient lectures as listed in the activity table in this document.

This rotation contained the most seminars/lectures of all my rotations, and it was a great experience!

Example:

1. Seminar topic: Types of shock and how to treat pts

Duration: 1hr (6:30 am to 7:30am)

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Copy of the slides: N/A (Dr. Lavani wrote on a whiteboard while we were all in the pediatric critical care unit.

Our group was mixed with about 15 people including students from St. George's and students completing externships and also pediatric residents.

Other activities*

Provide details of any other activities. Examples of other activities include medical research, medical counseling, and health education

When a student becomes a physician, they bring with them the wealth of their life experience when they begin treating patients.

Because I am a child psychologist, the attendings sometimes asked me to talk with patients or parents regarding child psychological development or issues relating to maintaining stability at home. I found the experience rewarding, and realized that a great deal of knowledge can be shared with patients in order to improve their outcomes – and that doctors can draw on the experience of consultants and members of the team to provide the best services possible.

Case history #1: Well child visit + viral syndrome

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(Example images)

The well child visit is a very important part of pediatrics. During this period, children will receive all their immunizations, be screened for certain conditions, and be followed to make sure they meet their developmental milestones.

At the scheduled well-child visit, sometimes the child will present with viral syndrome symptoms.

Patient details

Age: 4

Sex: F

Date: 1-22-20

Seen at: Saint Anthony Pediatrics Clinic

Chief complaint(S):

A 4 yo girl was seen for a well-child visit and presented with fever, cough, post-tussive emesis, earache and a runny nose. The fever had a TMAX of 100, 7.5 ml ibuprofen was given, with last dose at 7am. The cough started 3 days ago, and 1 tsp of Mucinex was given, with the last dose at 7 am of the clinic visit. Post-tussive emesis started one day ago, it was clear and not

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voluminous, and no medicine was given. The runny nose started 2 days ago, the discharge was clear, and saline nasal spray was given. This improved the condition. The earache started two days ago, and no medicine was given. There are no appetite changes, no sleep changes, no abdominal pain and no headaches.

History of present illness (HPI):

Past history:

Pt is up to date on all of her vaccinations.

Family history:

Mother has asthma, father not alive.

Personal and social history:

Child living at home with normal diet and developmental milestones.

Review of systems:

NEURO –no dizziness or Hx of neuro Dx, HEENT – No allergies, no glasses, no throat pain, RESP - No wheezing, CV – no hx chest pain or orthopnea, no PND, atypical chest pain, GI- no report of abnormalities, MSK – WNL, GU – WNL, Endo – normal function, hormonal WNL, HEME/IMM– not anemic

Physical examination

General survey:

Child looks lethargic and irritable

Vital signs:

T: 98.6, BP: 85/55, P: 90, RR: 30, O2: 99, Pain: 0

Skin:

Clear skin on face, no scars, bruises, rash or edema

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**Head, eyes, ears, nose, throat (HEENT):**

NC/AT, nontender, PERRLA, EOMI, pharynx red and inflamed, clear nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged, no pain with turning

Back:

No discoloration or scars

Thorax and lung:

Lungs – clear, some wheezing, no crackles, rales, no rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Very thin, soft, not distended not tender. BS + in all quads. No bruits noted. No rebound tenderness. Liver WNL no hepatosplenomegaly, No Rovsing sign. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis, no edema.

Nervous system:

A&Ox3 (no pain), CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

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Hb/Hct, Lead taken as part of well child visit

Differential diagnoses:

Influenza, strep throat

Provisional diagnosis:

Viral syndrome

Investigations and result:

Rapid strep, rapid flu

Final diagnosis:

Viral syndrome

The child's symptoms are of an infection most likely caused by a virus

Treatment and follow-up:

The child was sent home to await the results of the rapid tests. Pedialyte was recommended to maintain fluids, and OTC eardrops, and continue cough medicine as needed.

The 4 year-old immunizations were not given as the child is sick. Normally these would be: MMR#2, VZV #2, IPV #4, Dtap #5. The eye test and hearing tests were also not performed.

Final outcome:

The outcome of the rapid strep and influenza tests may bring the child back into the clinic. The nurses will call with the results.

Review of case:

The pediatric clinic is full of this type of presentation. We became very used to seeing children coming in for well-child visits who presented with cold symptoms. This is to be expected in the flu season. The students were encouraged to examine the child, and when the doctor examined the child, a

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thorough explanation was made regarding the care and follow-up for the sick child, as well as questions asked regarding development.

1. Correct protocol:

Detection of Viruses in Young Children With Fever Without an Apparent Source

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3507256/>

The common cold in children: Management and prevention

<https://www.uptodate.com/contents/the-common-cold-in-children-management-and-prevention>

2. Relevant research articles:

Viral Syndrome in Children

<https://www.drugs.com/cg/viral-syndrome-in-children-discharge-care.html>

Case history #2: Sexual disease



(example image)

Patient details

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Age: 17

Sex: M

Marital status: S

Occupation: High school student

Date: 3-7-20

Pediatric clinic: Saint Anthony Hospital

Admitted to Med/Surg ward: n/a

Chief complaint(S):

Pt. complained of penile discharge after unprotected sex 4 days ago. He has some lesions on shaft of penis.

History of present illness (HPI):

Pt. has a new partner, and has not had unprotected sex with another partner.

Past history:

No previous history of sexual disease.

Family history:

No cancer or major diseases in family.

Personal and social history:

Single, no children, does not drink, no tobacco, no marijuana

Review of systems:

NEURO – No dizziness, never had any head issues, HEENT – Throat is clear, no infections, RESP – breathes with ease, not SOB, CV – no MI, no orthopnea, no PND, denies chest pain, GI- WNL, MSK – no pain or abnormalities, no leg swelling, no numbness in toes, GU – BPH, Endo – WNL, HEME/IMM- no coagulopathies

Physical examination

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**General survey:**

Alert and oriented x 3, no difficulty communicating, thin

Vital signs:

T: 98, BP: 120/86, P: 92, RR: 20, O2: 97, Pain: 2

Skin:

Supple, no scars, some bruises, rash on shaft of penis, no edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx soreness, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

Denies any pain, can touch toes, stretch with no difficulty

Thorax and lung:

Lungs – clear to auscultation, no crackles, rales, no rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

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**Extremities:**

No cyanosis clubbing or edema

Nervous system:

A&Ox3, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

No additional tests performed

Differential diagnoses:

- Gonorrhea
- Chlamydia
- Syphilis

Provisional diagnosis:

Gonorrhea

Investigations and result:

A swab was taken from his urethra and his gave a urine sample

Final diagnosis:

Gonorrhea

Gonorrhea is caused by Neisseria gonorrhea and can attack the warm, moist areas of the body. For example: urethra, eyes, throat, vagina, and anus.

Final outcome:

The patient went home and waited for the result which was positive for gonorrhea. Upon coming back, he received the results and was ceftriaxone

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and and azithromycin (Zithromax, Zmax). In addition, he was informed that he should notify his girlfriend so that she may be tested too. For women, the fear is that she may not notice and it will lead to pelvic inflammatory disease. This can develop into chronic pain and then infertility. The young man was given the choice either to tell her directly or to have the clinic call her and say that someone she was with tested positive for gonorrhea.

Review of case:

This was my first experience having to collect a specimen for a sexually transmitted disease. I could see that it was traumatic or embarrassing for the boy and he was afraid about the outcome. I learned that in these situations, it is good to educate the patient of the risks and expectations to allay fears, and to bring him into the treatment plan.

Unprotected sex can lead to a variety of complications including pregnancy. Moreover, exposure to HSV1 or HSV2, or HIV makes choosing to wear protection the right answer until testing for both partners can be completed.

As one of the protocols at Saint Anthony Hospital, I was asked to provide a HEADSS interview to the boy. This interview would cover:

Home & Environment

Education & Employment

Activities

Drugs

Sexuality

Suicide/Depression

1. Correct protocol:

One of the best things that came about with the invention of the internet was access to information. As a result, patients can have some reasonable expectations regarding treatment for a particular condition. However,

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sometimes internet publications lead patients to fear the worst about their condition.

CDC Treatment Guidelines

<https://www.cdc.gov/std/tg2015/gonorrhea.htm>

STD Basics

[https://www.freestdcheck.org/std-basics/?](https://www.freestdcheck.org/std-basics/?gclid=Cj0KCQjwplLfzBRCRARIsAHuj6qVhdgahr7uFpjHLMHXOwoXoObdCPkoKI7PSED544cINy3HEWeTQTdIaAu_YEALw_wcB)

[gclid=Cj0KCQjwplLfzBRCRARIsAHuj6qVhdgahr7uFpjHLMHXOwoXoObdCPkoKI7PSED544cINy3HEWeTQTdIaAu_YEALw_wcB](https://www.freestdcheck.org/std-basics/?gclid=Cj0KCQjwplLfzBRCRARIsAHuj6qVhdgahr7uFpjHLMHXOwoXoObdCPkoKI7PSED544cINy3HEWeTQTdIaAu_YEALw_wcB)

2. Relevant research articles:

New antibiotic for gonorrhea advances in trials

<https://www.nih.gov/news-events/nih-research-matters/new-antibiotic-gonorrhea-advances-trials>

Prevalence and factors associated with gonorrhea infection with respect to anatomic distributions among men who have sex with men

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0211682>

Risk factors associated with gonorrhea and chlamydia transmission in selected health facilities in Ghana

<https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-019-4035-y>

Case history #3: Ventricular septal defect

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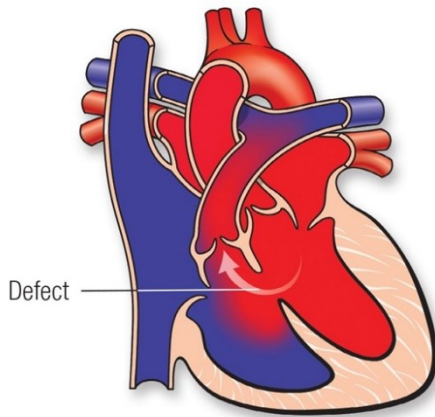
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Ventricular Septal Defect



Patient details

Age: 2

Sex: M

Date: 01-25-2020

Clinic visit: Pt. was brought in by his mother to Saint Anthony Hospital, Pediatric Clinic

Chief complaint(S):

2 yo boy came for a sick visit (up to date with immunizations) in order to receive a referral for a pediatric cardiologist. The mother was concerned that the VSD may not have closed, but stated that the child was not having any circulation/respiratory problems.

History of present illness (HPI):

Pt. was born with a ventricular septal defect and told the defect would probably close on its own by about 2 years of age.

Past history:

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The patient has a history of over ten years being in an out of the psych ward, incarceration, and ant-social behavior.

Family history:

No significant heart defects in the family. Mother's brother has type 2 diabetes.

Personal and social history:

The child lives at home with his parents and has no significant personal history. Neither parents smokes, does drugs or uses alcohol.

Review of systems:

NEURO – no abnormal signs, no dizziness, alert and oriented x 3 HEENT – no nodules, pain erythema, RESP – no lung abnormalities, CV – no Hx of chest pain, GI- WNL, MSK – no pain or abnormalities, no leg swelling, no numbness in toes, GU – WNL, Endo – no Hx of problems, HEME/IMM– no coagulopathies

Physical examination:**General survey:**

Pt appears healthy, with no apparent skin lesions, or discoloration of skin. A&O x3. Mother states the child has no difficulty with daily activities or playing at home, no trouble sleeping or eating, and no toilet difficulties. In general, the mother thinks there are no concerns but wants to confirm everything is ok.

Vital signs:

T: 98.0, BP: 86/70, P: 85, RR: 30, O2: 99, Pain: 0

Skin:

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No bruises, no rash cyanosis or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL

Thorax and lung:

Lungs – clear to auscultation, no rales, no rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis or clubbing or edema in legs, or arms

Nervous system:

A&Ox3, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups,

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DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

No other labs were taken

Differential diagnoses:

Atrial septal defect, Tetralogy of Fallot. Tricuspid regurgitation, pulmonic stenosis, PDA

Investigations and result:

The students were first asked to auscultate the heart, to listen for the murmur. The clinic was noisy, and the child's breathing sometimes made it difficult to know whether we were hearing the murmur (ejection systolic murmur and a fixed split of S2) or the breathing.

Final diagnosis:

The students were not able to hear any murmur, but the attending said while she thinks the VSD has closed, she can hear innocent murmurs. The innocent heart murmurs are non-pathologic sounds made by the blood as it circulates in a normal pattern. This can be caused by the blood travelling more rapidly than usual through the vessels of the heart.

Treatment and follow-up:

The patient was told the doctor's guess regarding the diagnosis, but was referred to pediatric cardiology to receive an official examination and possible diagnosis that the VSD had in fact closed, and no other pathology remains in the heart.

Final outcome:

In order to provide a referral, we either send them to a physician in the hospital or an outside location. The student prepares the referral not including all of the details of the case, and then the doctor will sign it. The

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patient then will carry the referral letter to the department to make an appointment.

Review of case:

When we were asked to listen to the child's heart and the mother was asking us "do you still hear the murmur?", I felt very inadequate in my clinical skills as I could not hear anything, or I was confusing the breathing sounds with the sounds of a VSD. When the attending came in, the child was playing with a video game, yet she was still able to clearly and confidently make out the sounds in the heart as a result of her experience.

If the VSD does not close, the child could be at risk for developing endocarditis. One option is to close the VSD through surgery, although it is a controversial operation as some say it should be left alone. Closing the VSD may not be the only way to prevent endocarditis, and a more effective way maybe to prevent dental infection in these children and wait longer for it to close.

1. Correct protocol:

American Heart Association: Ventricular Septal Defects

<https://www.heart.org/en/health-topics/congenital-heart-defects/about-congenital-heart-defects/ventricular-septal-defect-vs>

VSD surgery for children

<https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/ventricular-septal-defect-surgery-for-children>

2. Relevant research articles:

Should we close small ventricular septal defects?

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<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5241834/>

Ventricular Septal defects

<https://ojrd.biomedcentral.com/articles/10.1186/s13023-014-0144-2>

Case history #4: COVID-19 infection



Patient details

Age: 16

Sex: M

Marital status: S

Occupation: no work, no income

Date: 03-09-20

Attended out-patient pediatrics department: Saint Anthony Hospital

Chief complaint(S):

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The boy presented with a sudden high fever, TMAX 102 F, non-productive cough, sore (scratchy) throat and runny nose for one day. There was no wheezing or shortness of breath.

History of present illness (HPI):

The patient was up to date on his immunizations and had presented for all of his well-child visits. He receives a yearly influenza shot, and his last winter cold was in December 2019.

Past history:

No viral syndrome since 12/2019, no respiratory illness or sinusitis

Family history:

Both parents alive, no siblings, no significant family history

Personal and social history:

Single with no children, no tobacco, no drugs, no alcohol

Review of systems:

NEURO – slightly dizzy, normal mentation, HEENT – no neck problems or hoarseness, RESP – lungs clear CV – WNL, no PND, no chest pain, GI- WNL, MSK – some weakness in legs, stable, walks slowly, GU – WNL, Endo – denies abnormalities, HEME/IMM– no coagulopathies

Physical examination

General survey:

Normal weight, athletic physique, lethargic, viral syndrome-like appearance

Vital signs:

T: 100.1, BP: 130/75, P: 78, RR: 20, O2: 99, Pain: 3

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**Skin:**

No dryness, no scars, no marks on arms or legs, no bruises, rash or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx scratchy/itchy/sore, slight clear nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL, no scoliosis, slight kyphosis

Thorax and lung:

Lungs – clear, no wheezing on expiration, no crackles, rales, or rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses wnl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis clubbing or edema, no marks from needles or erythema

Nervous system:

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A&Ox3, slightly dizzy, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L, Motor 5/5 in all muscle groups (some weakness walking), DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

No other lab values available prior to visit, but COVID-19 test was ordered.

Differential diagnoses:

Common cold (viral syndrome), Influenzas A or B

Provisional diagnosis:

Corona virus

Investigations and result:

The boy was sent to the lab for a corona virus test. The results were confidential.

Final diagnosis:

Unknown (the boy did not come back into our clinic, and we cannot ask about the result)

Treatment and follow-up:

There is no specific treatment for the corona virus. Self-care and supportive care are all that is recommended. In addition, adequate rest, and plenty of fluids are recommended. In recent days, those who suspect they have the corona virus are advised to contact their doctor and stay at home. If symptoms worsen, then they should go to the emergency room.

Final outcome:

I remember seeing the patient leave the clinic on the way to the lab for testing. As the results of the testing will not be shared with anyone not

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directly related to the case (and this is the protocol for all of medicine), this is the last we heard of this person. Hopefully they are doing well.

Review of case:

Chicago is presently in a state of lockdown due to the COVID-19, and we are still learning about the pathogenesis and possible treatment for the virus. Social distancing and washing hands (and never touching your face) have been the instructions given to us, but I expect we will see other updates regarding how to avoid it in the near future.

This person's case is representative of the state of understanding for the virus at this time. People are scared, and do not know what to do when there is a possibility of infection. Specifically, people do not have a clear understanding of the symptoms associated with COVID-19.

One of the most significant symptoms is a dry cough that includes difficulty breathing. While the other possible symptoms of a high sudden fever, runny nose, fatigue, chills & muscle aches could mimic the common cold or influenzas, respiratory symptoms seem to set this virus apart. Patients are advised to stay home if they have mild symptoms or call 911 / visit the closest emergency department if they think they may be infected with the COVID-19 virus and have serious symptoms.

1. Correct protocol:

CDC- Coronavirus Disease 2019 (COVID-19)

<https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html>

Dept of Labor: COVID-19, Control and Prevention

<https://www.osha.gov/SLTC/covid-19/controlprevention.html>

2. Relevant research article:

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First known person-to-person transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in the USA

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30607-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30607-3/fulltext)

Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30566-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext)

Case history #5: Measles (Rubeola)



(sample image)

Patient details

Age: 4

Sex: F

Date: 2-26-20

Attended pediatrics department: Saint Anthony Hospital

Chief complaint(S): Fever, dry cough, runny nose, red blotchy skin rash, koplik spots in mouth

History of present illness (HPI):

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Pt. has not received any vaccines and until now, only had the common cold.

Past history:

Pt mother stated that she intentionally exposed her child to measles at a measles party in her neighborhood.

Family history:

No other member of the family has measles. All have been vaccinated.

Personal and social history:

Pt lives at home with older brother who had been vaccinated. This girl was the first have not been vaccinated out of fear from the mother of developing autism from the MMR vaccine.

Review of systems:

NEURO – no mental abnormalities, no dizziness or bumps on head, HEENT – sore throat, no nodules, RESP no history of asthma or breathing diff / trauma, CV – orthopnea, sleeps with no difficulties, no chest pain, GI- WNL, MSK – no numbness or difficulty with gait, GU – WNL, Endo – no reported abnormalities, HEME/IMM– no coagulation or bleeding problems

Physical examination:**General survey:**

Pt has a rash over her torso and part of face, she looks tired and irritable with cold-like symptoms of a dry cough, runny nose and a fever.

Vital signs:

T: 99.0, BP: 85/40, P: 98, RR: 20, O2: 99, Pain: 3

Skin:

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Blotchy rash over part of face and trunk & extremities, no scars, bruises, or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, slight nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL, no scars

Thorax and lung:

Lungs – clear, no wheezing, crackles, rales, or rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non sensitive, BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis clubbing or edema.

Nervous system:

A&Ox3 (no communication difficulties), CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor

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5/5 in all muscle groups (no difficulty with gait), DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

The patient will have a fever of more than three days to be diagnosed with measles. In addition, the pt must have at least one of these: cough, coryza, or conjunctivitis. It is said to be diagnostic if Koplik's spots are seen.

Differential diagnosis:

Similar symptoms may be seen with parvovirus, dengue fever, Kawasaki disease, and scarlet fever.

Provisional diagnosis:

Measles

Investigations and result:

Koplik spots were observed, so with the accompanying dry cough, fever, rash and runny nose, measles was suspected, given that the parent refused the MMR vaccine.

Final diagnosis:

Measles due to intentional exposure and refusal of the MMR vaccine.

Treatment and follow-up:

No specific antiviral drug is available. However: Measles vaccine is the biologic of choice if given within 72 hours of exposure. Vitamin A is given to boost the antibody response and to prevent a superinfection. Also, adequate hydration is recommended plus pain medicine such as acetaminophen or ibuprofen.

Final outcome:

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The child's mother was counseled on the benefits of the MMR vaccine for her child's future, but the mother refused and said there was no need for it. The child went home with the mother and will come back for a follow up in two weeks or if the symptoms worsen.

Review of case:

I had read about parents who refuse vaccination for their children but had never seen one up close. At first I felt anger towards the parent, but then came to understand her choice about how she raised her child. Later in the rotation I saw another parent with these values and it seems that more and more parents are believing that the MMR and other vaccinations are not necessary despite evidence to the contrary.

1. Correct protocol:

CDC: Measles for healthcare professionals

<https://www.cdc.gov/measles/hcp/index.html>

Managing measles exposures in healthcare workers

<https://www.health.state.mn.us/diseases/measles/hcp/control.html>

2. Relevant research articles:

Measles immunization research: a review

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2491276/>

How measles wipes out the body's immune memory

<https://www.sciencedaily.com/releases/2019/10/191031204630.htm>

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Date	Activity	Details
Jan 18 (Sat)	Orientation	I was paired with one of the students and trained from 12:30 to 5pm
Jan 20 (Mon)	Clinic 12:30 – 5pm	+ Best way to present cases review
Jan 21 (Tues)	Lecture peds 3 rd floor Lecture at Access Clinic	Well-child examinations vs sick visit
Jan 22 (Wed)	Clinic 12:30 – 5pm	+ how to fill in school physical exam forms
Jan 23 (Thurs)	Clinic 12:30 – 5pm	+ Reading and explaining growth charts
Jan 24 (Fri)	Inpatient lecture	Dr. Co, USMLE CK, CS peds
Jan 25 (Sat)	Clinic 12:30 – 5pm	+ newborn exam, hip examination technique
Jan 27 (Mon)	Clinic 12:30 – 5pm	+ Develop milestones qu for mother and scoring
Jan 28 (Tues)	Lecture at Access Clinic	Dehydration and diarrhea
Jan 29 (Wed)	Clinic 12:30 – 5pm	+ Types of asthma, Dx and Tx options
Jan 30 (Thurs)	Clinic 12:30 – 5pm	Peds ICU GI issues / epiglottitis, intubation
Jan 31 (Fri)	Inpatient lecture	Kawasaki disease
Feb 1 (Sat)	Clinic 12:30 – 5pm	+ Eye and hearing exams
Feb 3 (Mon)	Clinic 12:30 – 5pm	+ Rapid strep / flu tests
Feb 4 (Tues)	Lecture at Access Clinic Inpatient lecture	Newborn examinations Dr. Singh
Feb 5 (Wed)	Clinic 12:30 – 5pm	+ Types of viral

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		syndrome presentations
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Feb 6 (Thurs)	Clinic 12:30 – 5pm Inpatient lecture	Dr. Lavani – Common skin rashes
Feb 7 (Fri)	Inpatient lecture Grand rounds / lecture	Dr. Lavani, newborns Dr. Noronha / Dr. Co, neonatal syndromes
Feb 8 (Sat)	Clinic 12:30 – 5pm	+ Postnatal depression screenings (Edinburgh) and CRAAFT screenings
Feb 10 (Mon)	Clinic 12:30 – 5pm	+ How to make referrals to other depts
Feb 11 (Tues)	Lecture at Access Clinic Inpatient lecture	(cancelled - inspection) Dr. Noronha
Feb 12 (Wed)	Clinic 12:30 – 5pm (off)	-
Feb 14 (Fri)	Clinic 12:30 – 5pm (off) Inpatient lecture	Dr. Co, USMLE CK, CS peds
Feb 15 (Sat)	Clinic 12:30 – 5pm	+ listening to heart murmurs
Feb 18 (Tues)	Lecture at Access Clinic	Immunizations
Feb 19 (Wed)	Clinic 12:30 – 5pm	+ Making better pt presentations (review)
Feb 22 (Sat)	Clinic 12:30 – 5pm	+ how to collect specimen from boy w poss sexual disease
Feb 24 (Mon)	Lecture	Intro to neonatology
Feb 25 (Tues)	Lecture at Access Clinic Inpatient lecture	Bilirubinemia types Dr. Co, hyperbilirubinemia (2 nd)
Feb 26 (Wed)	Clinic 12:30 – 5pm Inpatient lectures	Dr. Lavani
Feb 27 (Thurs)	Clinic 12:30 – 5pm Inpatient lecture Grand rounds	Dr. Co, USMLE CK, CS peds Gallstones
Feb 28 (Fri)	Inpatient lecture	Dr. Co, USMLE CK, CS

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		peds
March 2 (Mon)	Inpatient lecture	Dr. Co, USMLE CK, CS peds
March 3 (Tues)	Lecture at Access Clinic	Otitis media
March 4 (Wed)	Clinic 12:30 – 5pm	+ ointments vs creams for dry skin
March 5 (Thurs)	Clinic 12:30 – 5pm	+ fontanel inspect skills
March 7 (Sat)	Clinic 12:30 – 5pm	+ HEADS interview
March 9 (Mon)	Clinic 12:30 – 5pm	+ Mother child counseling /runaway
March 10 (Tues)	Lecture at Access Clinic	Gastroenteritis and diarrhea
March 11 Wed)	Clinic 12:30 – 5pm	Cardio ischemic shock and diff types of shock
March 12 (Thurs)	Inpatient lecture	Dr. Co, USMLE CK, CS peds
March 13 (Fri)	Inpatient lecture	Dr. Co – USMLE CK, CS peds

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