AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
1999

# Perplexing Pediatric Patients: Stump the Experts

Perplexing pediatric cases will be presented to a panel of pediatric emergency physicians for a lively discussion. The panelists will be challenged to determine an appropriate workup, a presumptive diagnosis, and a treatment plan.

- Recognize unusual presentations of pediatric problems.
- Discuss a systematic general approach to the ill child.

MO-28
Monday, October 11, 1999
12:30 PM - 2:25 PM
Room # N212
Las Vegas Convention Center

**FACULTY**


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(Moderator)

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# CASE: WHOLE LOTTA SHAKIN' GOING ON

## History

A 2 week old male infant is transported to your facility by ALS for seizures. Well that morning, the mother fed the child and placed him down for his usual nap. When she went into his room to check on him , he was drooling, stiff, jerking, and blue. She called EMS and applied mouth to mouth respirations. When EMS arrived they found the child to be alternatively twitching and somewhat "post ictal" at times, During transport, IV attempts failed, and rectal Valium was ordered. After a 10 minute transfer, the child arrives in the ED and you begin your care.

## Physical Examination

| | |
|---|---|
| Vital Signs: | T37C, HR 180, RR 24, BP 90/70 |
| General: | Seizing, with good capillary refill |
| HEENT: | Fontanel flat/ atraumatic |
| | Pupils mid position and reactive (sluggish) |
| | Fundi not seen |
| | TM not visualized |
| | Pharynx with secretions |
| Neck: | No adenopathy |
| Chest : | Scattered upper airway sounds |
| | Good air entry |
| | PMI normal/ no murmur |
| Abdomen: | Distended, but soft |
| | No masses |
| Rectal: | Soft guaiac neg stool |
| Pulses: | Normal |
| Extremities: | Stiff |
| Neuro : | DTR 3+ |
| | Poor response to pain |

# CASE: WHITER SHADE OF PALE

History

A previously healthy 5 year old white male arrives in the ED with a chief complaint of diarrhea and lethargy. Well until 3 days PT ED visit, he noted some abdominal cramps followed by loose stools. No emesis is noted. Over the 3 days the child has become more and more tired, with a pale appearance according to his parents. He denies fever, cough, SOB, chills, dysuria, urgency, or frequency. The stools are described as foul, dark, and frequent. No one else is ill at home. He has not travelled. PMH is unremarkable. No meds.

**Physical Examination**

| | |
|---|---|
| Vital Signs: | T38C, HR 140, RR 20, BP 70/50 |
| General: | Very pale cooperative male, alert |
| HEENT | Pale conjunctiva |
| | PERRLA, discs normal |
| | TM normal |
| | Pharynx clear |
| Neck: | Supple with shoddy adenopathy |
| Chest: | Hyperactive precordium |
| | No murmur |
| | Clear lungs |
| Abdomen: | soft |
| | Tender in all quadrants with no rebound or guarding |
| | Bowel sounds present |
| Rectal: | Soft guaiac positive stool |
| Extremities: | Full ROM, no bruising |
| Neurologic: | Intact, very dizzy when he sits up |

# CASE: OH NO, NOT ANOTHER COLICKY KID

## History

A 12 week old male is brought to the ED with a chief complaint of “seeming to be in pain”. His parents state that over the past 8 weeks the infant had frequent episodes of crying. The crying occurred more in the daytime and seemed to be related to bottle feeding. At 3 weeks, after his pediatrician diagnosed colic, he was switched to Soy formula. Over the next 6 weeks, after examination by another pediatrician and a visit to the ED, a diagnosis of severe colic was made. Donnatal drops were prescribed, as well as glycerin suppositories. The child was switched to Nutramigen without success. Birth and family history were unremarkable.

The current ED visit was prompted by the development of what the parents describe as respiratory distress. No fever, cough, N,V,D, were described.

## Physical

| | |
|---|---|
| Vital Signs: | T 37C, HR 140, RR 44, BP 80/46 |
| General: | WDWN infant in mild distress |
| HEENT: | PERRLA, discs normal |
| | TM clear |
| | Pharynx normal |
| Neck: | Supple |
| Chest: | PMI normal, no murmur |
| | Clear lungs |
| Abdomen: | Liver 3cm below RCM |
| | No masses |
| Pulses: | Equal |
| Extremities: | Full ROM |
| Neurologic: | Appropriate |
| Skin: | Sluggish capillary refill |

# CASE: YOU CAN NEVER HAVE ENOUGH DIAPERS

## History

A 4 month old infant arrives with a chief complaint of diarrhea, vomiting, and "looking ill". Well until 3 days PT ED visit, his stools are described as frequent (15-20/day), foul, green, and mostly water. No blood is noted. The emesis is sporadic, non bilious. Others in the home have similar symptoms, but are recovering. Over the past 12 hours, his activity level has decreased and his parents don't like his color. Tmax at 38C. No rash or cough is described. His urine output is inestimable due to the profuse diarrhea. Birth and PMH are normal. Immunized.

## Physical Examination

| | |
|---|---|
| Vital Signs: | T 38C, HR 140, RR 60, BP 80/46 |
| General: | Thin, tired ashen infant, barely responds to pain |
| HEENT: | PERRLA, discs normal |
| | TM clear |
| | Pharynx dry |
| Neck: | Supple |
| Chest: | PMI normal, no murmur |
| | Clear lungs |
| Abdomen: | Hyperactive bowel sounds |
| | No masses |
| Rectal: | Watery guaiac neg stool |
| Pulses: | Fair |
| Extremities: | Full ROM |
| Neurologic: | Non focal lethargy |
| Skin: | Delayed cap refill |

## CASE: LIMPING, ON A FRIDAY AFTERNOON

### History

At precisely 4:55 PM on a Friday afternoon, a 3 year old girl is referred to your ED by her private MD for evaluation of a limp (sound familiar?). Previously well, she awoke earlier that day with complaints that her right knee hurt and refused to bear weight. No antecedent trauma is described. She has had a cold for the past week, consisting of a mild cough and runny nose. No fever is described. She denies rash, sore throat or other systemic complaints with the exception of an upset stomach. No one is ill at home. PMH unremarkable.

### Physical Examination

| | |
|---|---|
| Vital Signs: | T 38.9C, HR 72, RR 16, BP 90/70 |
| General: | Well appearing young girl, very unhappy to be in the ED |
| HEENT: | PERRLA, discs normal |
| | TM clear |
| | Pharynx normal |
| Neck: | Supple |
| Chest: | PMI normal, no murmur |
| | Clear lungs |
| Abdomen: | Normal bowel sounds |
| | Mild tenderness periumbilically |
| | No masses |
| Back: | No CVAT |
| Rectal: | Normal guaiac neg stool |
| Pulses: | Normal |
| Extremities: | Left leg held flexed and abducted at the hip |
| | Decreased range of motion at the left hip |
| | No warmth or redness |
| | Rest of extremity normal |
| Neurologic: | Full normal function |
| Skin: | No rash |

# CASE: BRIGHT LIGHTS, BIG HEADACHE

## History

A 15 year old girl arrives with a chief complaint of a severe headache of 3 day's duration. The headache began mildly, bifrontal, with increasing severity over the past 24 hours. It is described as pulsatile, with worsening with position, cough, or straining. She is photophobic, and has vomited 4 times this day. No intercurrent trauma, fever, cough, URI, NVD, sore throat, or rash is described. Her PMH is negative for headaches or any chronic problems. Family history positive for migraines (mom and aunt). LMP 1 week ago. Meds include occassional NSAIDs only.

### Physical Examination

| | |
|---|---|
| Vital Signs: | T 37C, HR 72, RR 16, BP 138/85 |
| General: | WDWN adolescent in obvious pain |
| HEENT: | PERRLA, photophobic |
| | TM clear |
| | Pharynx dry |
| Neck: | Supple |
| Chest: | PMI normal, no murmur |
| | Clear lungs |
| Abdomen: | Normal bowel sounds |
| | No masses |
| Back: | No CVAT |
| Rectal: | Not done |
| Pulses: | Normal |
| Extremities: | Full ROM |
| Neurologic | AAO X 3 |
| | Motor, cerebellar normal |
| | DTRs +3 |
| Skin: | Clear |

## CASE: TURN YOUR HEAD AND . . . . . 1

### History

A 12 year old boy arrives with a chief complaint of fever and cough of 4 day's duration. The illness began with a sore throat, runny nose, mild headache, and generalized malaise. The cough is non productive, "brassy", and occurs day and night. Tmax 39C today. No NVD is described. He feels very SOB. No one is ill at home but many classmates are out "with the flu". Tylenol only. PMH unremarkable. Immunized.

### Physical Examination

| | |
|---|---|
| Vital Signs: | T 40C, HR 120, RR 60, BP 80/46 |
| General: | Thin, tired adolescent, with obvious retractions |
| HEENT: | PERRLA, discs normal |
| | TM clear |
| | Pharynx dry |
| | Lips pale |
| Neck: | Supple |
| Chest: | PMI normal, no murmur |
| | Rales all fields |
| Abdomen: | Hyperactive bowel sounds |
| | No masses |
| Rectal: | Guaiac neg stool |
| Pulses: | Fair |
| Extremities: | Full ROM |
| Neurologic: | Non focal lethargy |
| Skin: | Pale |

## CASE: I'VE GOT THE BOUNCE BACK BLUES

### History

A 10 year old boy presents for the second time in 2 days with lethargy. 2 days earlier he was referred from school for evaluation of "sleepy" behavior- drug use was suspected. History at that time was negative for trauma, drug ingestion, fever, intercurrent illness, sick contacts. At the time of the first ED visit, vitals were normal, as well as his PE. His lethargy resolved in the ED over 2 hours. Normal labs included a CBC, SMA7, and urine tox screen. A CT was considered but cancelled since he recovered spontaneously.

The 2nd visit was analogous to the first. He went to school and seemed to become progressively sleepy during classes.Over the prior night, his parents state that he slept restlessly with strange "sleeptalking".He also vomited twice (non bilious).

### Physical Examination

| | |
|---|---|
| Vital Signs: | T 37C, HR 72, RR 18, BP 100170 |
| General: | Tired child, responds to voice |
| HEENT: | PERRLA, discs normal |
| | TM clear |
| | Pharynx dry |
| | Lips normal |
| Neck: | Supple |
| Chest: | PMI normal, no murmur |
| | Clear all fields |
| Abdomen: | Hyperactive bowel sounds |
| | Mild epigastric tenderness |
| | No masses |
| Pulses: | Normal |
| Extremities: | Full ROM |
| Neurologic: | Non focal lethargy |
| Skin: | Normal |