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COVER

"Le Gourmet," painted in 1901 by Picasso (1881-1973) during his "Blue Period," demonstrates the natural appetite of the small child, who appears well nourished and even is eating standing up. Eating problems in children are not inherent in their stage of development but are their response to adverse environments. The blue color, however, suggests a threat to this healthy state. Child health professionals must balance this innate healthy aspect of childhood against the environmental threats to their well-being and be advocates for the healthy development of children. (This painting is from the National Gallery of Art's Chester Dale collection and is reproduced with permission.)

ANSWER KEY

**Table 6. Approach to the Patient Who Has Persistent Diarrhea (ie, 14+ Days)**

**STEP**

1. **Assess child for degree of dehydration**
   -宜适当的补液

2. **Question and Examine Patient for:**
   -**Bloody stool**
     -Invasive organism, particularly *Shigella* and *Entamoeba histolytica*
   -**Malnutrition**
     -Weight-for-age, weight-for-height, arm circumference
     -Inadequate diet, decreased resistance, poor healing
   -**Dietary changes, especially addition of milk or formula**
     -Possible milk or protein hypersensitivity
   -**Problems following milk ingestion**
     -Lactose malabsorption
   -**Antibiotic treatment**
     -Antibiotic-associated enterocolitis or resistant organism
   -**Poor appetite; less than 3 meals daily**
     -Feeding problems, progressive malnutrition, healing problems
   -**Poor dietary management during previous 14 days of diarrhea**
     -Delayed healing and recovery

3. **Examine Stool:**
   -**Look at specimen**
     -**Finding:** Bloody stool
     -**Suggests:** History confirmed; invasive organism
   -**Examine stool microscopically, including search for ova, parasites, and *Cryptosporidium***
     -Red and white blood cells
     -E. histolytica cysts
     -*Giardia, E histolytica* trophozoites
     -**Suggests:** *Shigella*, other invasive organism
     -Etiologic role unclear
     -Etiologic role more likely; specific treatment indicated
   -**Determine stool pH, reducing substances**
     -pH <5.5 and ++ reducing substances
     -**Suggests:** Lactose or other carbohydrate malabsorption*
     -Etiology and potentially effective antibiotic treatment
   -**Determine stool culture and sensitivity**
     -Pathogens present

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*Sucrose is not a reducing substance; it needs hydrolysis to be detected.*

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**PIR QUIZ**

1. Which one of the following factors tends to decrease the incidence of acute gastroenteritis in children?
   -A. Bottle feeding.
   -B. Breastfeeding.
   -C. Malnutrition.
   -D. Participation in well-run child care.
   -E. Previous antibiotic use.

2. Acute onset of watery, large-volume diarrheal stools is most consistent with disease caused by:
   -A. *Campylobacter.*
   -B. Enteroinvasive *Escherichia coli.*
   -C. Rotavirus.
   -D. *Salmonella.*
   -E. *Shigella.*

3. *Giardia* infections most likely are:
   -A. Acquired by the ingestion of contaminated water.
   -B. Characterized by bloody dysenteric stools.
   -C. Devoid of trophozoites in stool specimens.
   -D. Not influenced by drug therapy.
   -E. Responsible for most outbreaks of gastroenteritis in child care centers.

4. Principles of oral rehydration therapy include which one of the following?
   -A. A child who has no tears, sunken eyes, and a rapid pulse is a candidate for oral rehydration.
   -B. Approximately 25% of children who have acute gastroenteritis will require intravenous rehydration.
   -C. Intractable vomiting and moderate dehydration usually can be managed with oral rehydration.
   -D. Sodium solutions containing glucose decrease bowel uptake of fluid.
   -E. Solutions that have approximately 60 mm sodium per liter are best for restoring volume.
medical and nonmedical. Sensitive, knowledgeable discussion of the etiologic and developmental diagnoses and their implications for treatment and outcome will aid parents in adapting to their child who has a handicap. The pediatrician should be objective about the child’s current performance without removing realistic hope for future change.

Treating and monitoring developmental progress must begin with a basic understanding of the child’s developmental rate (DQ) and its importance in establishing realistic short- and long-term treatment goals. The pediatrician, with his or her appreciation of the child’s neurodevelopment in the context of the specific family, is in an excellent position to evaluate goals and treatment. Such ongoing evaluation is a key component of pediatric support to families who have mentally retarded children.

**SUGGESTED READING**


Grossman HJ, ed. *Classification in Mental Retardation*. Washington, DC: American Association on Mental Deficiency; 1983


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**PIR QUIZ**

5. Among the following, the most common presenting symptom of mental retardation is:
   A. Abnormal motor milestones.
   B. Auditory deficit.
   C. Language delay.
   D. Neurobehavioral disorder.
   E. Seizure disorder.

6. By definition, children who have a learning disability have an IQ:
   A. Above the retarded range.
   B. In the mildly retarded range.
   C. In the moderately retarded range.
   D. In the severely retarded range.
   E. In the profoundly retarded range.

7. Most children who have mental retardation:
   A. Cannot be classified.
   B. Are classified as mildly retarded.
   C. Are classified as moderately retarded.
   D. Are classified as severely retarded.
   E. Are classified as profoundly retarded.

8. The etiologies of the majority of cases of moderate-to-severe mental retardation:
   A. Cannot be determined.
   B. Are perinatal influences.
   C. Are postnatal influences.
   D. Are prenatal influences.

9. Which of the following is most useful in establishing the etiology of mental retardation?
   A. Cranial computed tomography.
   B. Cranial ultrasoundography.
   C. Full karyotype.
   D. Magnetic resonance imaging of the brain.
   E. Patient’s history and findings on physical examination.
and never have been asked about the need. Clinicians tend to view teens who have intellectual or mobility impairments as asexual. As with any adolescent, screening regarding sex education needs as well as contraceptive and other sexual health concerns should be standard for the adolescent who has myelomeningocele.

Conclusion
Today, the vast majority of children born having myelomeningocele live at least until the age of 20, and many are reaching the age of 30 and beyond. Because myelodysplasia historically has been a ‘‘children’s disease,’’ the needs of affected adults have been considered only recently. To continue to treat adults in a pediatric setting only continues to infantilize them. We need to develop mechanisms to transfer care to adult providers as part of overall transition planning. Because children and adolescents who have myelomeningocele frequently are followed by a variety of specialists, pediatricians play a vital role in coordinating care as well as attending to general health and psychosocial concerns. Our goal is to help these children achieve their maximum physical, social, and intellectual functioning.

SUGGESTED READINGS
Shurtleff D, ed. Myelodysplasias and Exstrophies: Significance, Prevention and Treatment. Orlando, Fla: Grune and Stratton; 1986
PIR QUIZ

13. Each of the following life circumstances can be used to designate an individual as an emancipated minor except:
   A. Living independently.
   B. Marriage.
   C. Military service.
   D. Parenthood.
   E. Sexual activity.

14. Poor nutrition among adolescents is most likely to cause:
   A. Folate deficiency.
   B. Hypoalbuminemia.
   C. Hypocalcemia.
   D. Iron deficiency.
   E. Vitamin C deficiency.

15. The leading cause of death among adolescents is:
   A. Autoimmune disorders.
   B. Cardiovascular disease.
   C. Diabetes mellitus.
   D. Injuries.
   E. Malignancies.

16. The most common sexually transmitted disease among adolescent girls is:
   A. Chlamydia trachomatis infection.
   B. Herpes simplex infection.
   C. Neisseria gonorrhoea infection.
   D. Trichomonas vaginalis infection.
   E. Treponema pallidum infection.

17. Among the following, the issue most likely to be discussed by the pediatrician interviewing an adolescent patient is:
   A. Contraceptive usage.
   B. Depression.
   C. Peer relationships.
   D. Physical health.
   E. Substance abuse.

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