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Cover: Breton Girls, Dancing, Pont Aven, by Paul GAUGUIN (Copyright, National Gallery of Art, Washington, DC; Collection of Mr and Mrs Paul Mellon). Gauguin was a French Symbolist and lived from 1848 to 1903. Gauguin traveled the world as a seaman and pursued a career in banking in Paris and Copenhagen before concentrating on his skills as a painter and sculptor. He was determined to develop a new approach to painting through which to symbolically express a thought or mood, in contrast to the impressionist approach which sought to reproduce a scene through the exact recording of every nuance of color and light. Completed in 1888, Breton Girls Dancing, Pont Aven is one of Gauguin's earliest works in this new style. The themes of friendship, community, exercise, and appreciation of nature depicted here are important elements in the total health and development of every child.

Commentary
Pediatrician and School Readiness

Editor's note: A reader wrote to ask whether or not the battery of tests for school readiness he uses is appropriate and adequate. We asked Dr Dworkin to respond with the following commentary.

The pediatrician, as the professional concerned with monitoring the growth and development of children during the preschool years, is well suited to contribute to the assessment of children's readiness to begin the task of academic learning, as well as participate in the early identification of children at risk for school dysfunction. Pediatricians view the early identification of children with potential learning disabilities as an important component of primary care. Parents and educators regard such issues as school readiness as being within the pediatrician's area of responsibility. Yet, despite this consensus of opinion, there is no agreement as to how pediatric health care providers can optimally participate in the process of determining a child's readiness for school and identify, as early as possible, children at increased risk for learning problems.

A variety of developmental screening tests are presently used in child health programs in an attempt to determine, before school entry, children's educational readiness. The relatively large number of such tools reflect their problems with reliability, validity, and lack of well-established norms. In brief, the ideal screening test for school readiness does not exist. Furthermore, given the multiple factors (i.e., competencies in various areas of development, characteristics of the child's temperament and behavioral style, social, and environmental circumstances that influence a child's readiness to learn within the classroom, the optimal screening test may never be devised.

Given the limitations inherent to screening children for educational readiness, how can the pediatrician meaningfully and effectively participate in the identification of children at risk for school problems? Ideally, years of skilled observation within the office setting should enable the pediatrician to determine the child's competency in the various developmental areas that influence school functioning. Familiarity with social factors such as family composition, social support, socioeconomic status, and stresses in the home should be helpful in identifying children at increased environmental risk for school dysfunction. Eliciting and attending to the concerns of parents regarding children's school readiness is crucial. Such concerns have been found to be accurate predictors of developmental problems.

For children who have participated in preschool programs, the opinions of teachers are extremely valuable in predicting subsequent school performance. This emphasis on making accurate and informative developmental observations of children, eliciting and attending to parental concerns, and obtaining relevant historical observation is most consistent with the process of developmental surveillance.

A variety of specific techniques may be used by the pediatrician during developmental surveillance to perform skilled observation of children. Many pediatricians use an informal collection of age-appropriate tasks. The child's performance on such tasks must not be viewed in isolation but rather considered within the context of the child's overall well-being. Developmental screening tests

Self-Evaluation Quiz—CME Credit

As an organization accredited for continuing medical education, the American Academy of Pediatrics certifies that completion of the self-evaluation quiz in this issue of Pediatrics in Review meets the criteria for two hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association and two hours of PREP credit.

The questions for the self-evaluation quiz are located at the end of each article in this issue. Each question has a SINGLE BEST ANSWER. To obtain credit, record your answers on your quiz reply cards (which you received under separate cover), and return the cards to the Academy. On each card is space to answer the questions in five issues of the journal: CARD 1 for the July through November issues and CARD 2 for the December through April issues. To receive credit you must currently be enrolled in PREP or a subscriber to Pediatrics in Review—and we must receive both cards by June 30, 1990.

Send your cards to: Pediatrics in Review, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927.

The correct answers to the questions in this issue appear on the inside front cover.
Hellerstein S. Urinary tract infections in children. Chicago, IL: Year Book Medical; 1982


Self-Evaluation Quiz

1. Cases of acute pyelonephritis in children are most commonly due to infection with:
   A. Type I fimbriated Escherichia coli.
   B. P-fimbriated E. coli.
   C. Staphylococcus aureus.
   D. Staphylococcus epidermidis.

2. It is recommended that after every first instance of urinary tract infection in an infant or child the follow-up include each of the following except:
   A. A radionuclide scan of kidneys and ureters.
   B. Intravenous pyelography.

EDUCATIONAL OBJECTIVE

12. The pediatrician should have an appropriate appreciation for the significance of infant bonding and the potential for problems from parent’s misconceptions about the essential nature of immediate contact after delivery (Recent Advances, 88/89).

Skin to Skin Contact


Separation between mothers and very low birth weight infants is often prolonged with subsequent psychologic distress, behavior problems, and lactation failure. Babies as small as 700 g, who no longer require oxygen, can be safely and enjoyably held naked, except for a diaper, between the mother’s breasts for as many as 4 h/d. The authors carried out a randomized trial among 71 babies weighing <1500 g. The mothers of 35 infants were helped to hold their babies in skin to skin contact and encouraged to do so whenever they visited the babies. The mothers of 36 infants were encouraged to handle their babies but without skin to skin contact. Mothers using skin to skin contact lactated for 4 weeks longer on average than the control group. At 6 months of age, the infants who had skin to skin contact cried significantly less than the control group. Skin to skin contact can safely and enjoyably be offered to very low birth weight infants, especially in developing countries where the mother’s lactation is vital. (RJH)
Jaundice

choledochal cyst: the concept of infantile obstructive cholangiopathy. Prog Pediatr Surg. 1974;6:113
Maisels MJ, Gifford K, Antle CE, Leib GR.
McDonagh AF, Lightner DA. 'Like a shrivelled blood orange'-bilirubin, jaundice, and phototherapy. Pediatrics. 1981;67:368

Self-Evaluation Quiz

5. In which of the following would a more extensive evaluation for the cause of jaundice be least likely to be indicated?
A. A 12-hour-old newborn girl with mild jaundice.
B. A 3-day-old boy whose serum bilirubin concentration has increased 7 mg/dL in the last 24 hours.
C. A 4-day-old Oriental male breast-fed infant of a diabetic mother with a serum bilirubin value of 12 mg/dL.
D. A full-term formula-fed infant who is jaundiced at 12 days of age.
E. A 6-day-old term boy with a serum bilirubin value of 10 mg/dL (40% conjugated).

6. Which of the following would be a contraindication to home phototherapy?
A. Healthy term infant.
B. Infant older than 48 hours of age.
C. Unconjugated hyperbilirubinemia.
D. Serum bilirubin between 14 and 18 mg/dL.
E. Phototherapy unit designed for hospital use.

7. Each of the following is correct association, except:
A. Hepatocellular damage—serum transaminase.
B. Hepatobiliary ductal disease—serum alkaline phosphatase or 5'-nucleotidase.
C. Hepatocellular synthetic function—prothrombin time or serum albumin.
D. Neonatal hepatitis vs biliary atresia—percutaneous cholangiogram.
E. Choledochal cyst—ultrasonography.

8. A 4-week-old apparently healthy boy has yellow skin and pale stools. He appears moderately jaundiced and has hepatomegaly. Each of the following would be consistent with biliary atresia, except:
A. Percutaneous liver biopsy—bile duct proliferation, cholestasis, peripoortal fibrosis.
B. Serum bilirubin 10 mg/dL with 90% unconjugated.
C. Duodenal string device—absence of bile pigment color.
D. Hepatobiliary scintigraphy—absent excretion into intestine.
E. Normal α1-antitrypsin level.

9. Which of the following should not be supplemented in the diet of infants with cholestasis?
A. Medium-chain triglycerides.
B. Copper.
C. Vitamin A.
D. Vitamin D.
E. Vitamin E.

DEPARTMENT OF CORRECTIONS

In the article by Parrott in the January 1989 issue of Pediatrics in Review, "Cystitis and Urethritis," Table 3 on page 222 outlined the 1982 MMWR guidelines for treatment of gonococcal urethritis. New guidelines were issued in 1985. Readers should check the revised schedules for details. Major changes include: (1) oral tetracycline alone is no longer acceptable therapy, (2) ceftriaxone (adult dose of 250 mg, IM) is one of the new acceptable regimens, and (3) the increasing incidence of penicillinase-producing Neisseria gonorrhoeae warrants community monitoring.
Rowe MI, Clatworthy HW. The other side of the pediatric inguinal hernia. Surg Clin North Am. 1971;51:1371–1376
Steward DJ. Preterm infants are more prone to complications following minor surgery than are term infants. Anesthesiology. 1982;56:304–306
Wilson-Storey D. Scrotal swelling in the under 5’s. Arch Dis Child. 1987;62:50–52

Self-Evaluation Quiz
10. Each of the following is a true statement about inguinal hernias, except:
   A. Premature infants have an increased incidence.
   B. More than two thirds of incarcerated hernias occur in the first year of life.
   C. Most incarcerated hernias can be reduced by gentle manipulation.
   D. Repair is not mandatory because some resolve spontaneously.
   E. After a surgical repair about 20% of children will later have an indirect inguinal hernia on the other side.

11. Regarding hydroceles, which of the following is not true?
   A. Most hydroceles resorb during the first 18 months of life.
   B. They readily transilluminate.
   C. Diagnostic aspiration is recommended if the diagnosis is questionable.
   D. Unlike a hernia, a typical hydrocele does not extend into the inguinal canal.
   E. Hydrocelectomy should generally be deferred until the child is 2 years old.

12. Each of the following is a true statement pertaining to testicular torsion, except:
   A. Peak incidence is at 13 years of age.
   B. Diagnosis should be confirmed preoperatively by sonography and Doppler stethoscope.
   C. Scrotal pain is first symptom in two thirds of patients.
   D. Prompt surgery is essential.
   E. Torsion in utero results in an absent testis at birth

13. Which of the following is least likely to be associated with redness of the overlying scrotum?
   A. Acute hydrocele.
   B. Incarcerated hernia.
   C. Torsion of testis.
   D. Inguinal lymphadenitis.
   E. Acute epididymitis.

14. Which of the following requires immediate surgical attention?
   A. Torsion of the appendix testis.
   B. Irreducible incarcerated inguinal hernia.
   C. Acute hydrocele.
   D. Inguinal lymphadenitis.
   E. Acute varicocele.

EDUCATIONAL OBJECTIVE
128. The pediatrician should have an appropriate understanding of the relationship of parvovirus B-19 infections and hypoplastic crises in children with chronic hemolytic anemias (Recent Advances, 1989/90).

Fifth Disease

Forty-two pregnant women infected with human parvovirus B-19 were studied. All had contact with erythema infectiosum (fifth disease). Thirty-eight percent of the women were in their first trimester, 40% were in their second trimester, and 21% were in their third trimester. Clinical fifth disease developed in 64% of the women. Hydrops fetalis developed in 26%, and 7 of 10 hydropic fetuses died. "Three of 10 pregnancies with hydrops fetalis occurred in women working in kindergartens during an outbreak of erythema infectiosum . . . ."

Comment: Human parvovirus B-19 is the cause of fifth disease. It also causes aplastic crises in persons with hemolytic anemia. It also causes hydrops fetalis. The question is how frequently? (RHR)