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Cover: Two Young Girls at the Piano, by Pierre August RENOIR (© 1989 The Metropolitan Museum of Art; Robert Lehman Collection, 1975. (1975.1.201)). Two Young Girls at the Piano is one of at least five versions of the same scene by Renoir, including a lovely pastel recently sold at auction. Renoir was 51 years of age at the time he did this work in 1892, and at the height of his popularity. This lovely presentation evokes a former era when adolescents, at least those in favored economic status, spent their leisure learning skills such as playing the piano and singing. One of the major tasks of adolescence is to develop one's identity and sense of competence. Whether it is the charming skills so beautifully depicted in this painting or others, the task of pediatricians is to assist young people in developing skills of which they can be proud.

The printing and production of Pediatrics in Review is made possible, in part, by an educational grant from Ross Laboratories.

In this volume we have brought together all twelve issues of the twelfth year of publication of Pediatrics in Review. This includes three Guides for Record Review, published by the American Board of Pediatrics, which served as supplements to the journal. The articles and abstracts were developed to help readers achieve educational objectives set for the continuing education program of the American Academy of Pediatrics. We believe that they contain material of use to a wider readership than members of the Academy who subscribe to the Pediatrics Review and Education Program (PREP) such as residents, nurses, family physicians, and other clinicians. We hope that you find them useful.

Robert J. Haggerty, MD
Editor
Commentary
PREP 2 - YEAR 6: An End and a New Beginning

It does not seem possible that 12 years have passed since the launching of PREP. The first issue of Pediatrics in Review appeared in July 1979, preceded by several years of planning. The exact origin of the joint efforts of the American Academy of Pediatrics and the American Board of Pediatrics to develop a continuing education program tied to recertification is not clear to me today. Suffice to say that Dr Olmstead (then Director of the Academy’s Department of Education), Dr Fraser (the Executive Director of the Academy), and Dr Brownlee of the Board worked together to form a Coordinating Committee made of representatives from both organizations and from pediatric practice and academia. Committees were formed to develop two sets of educational objectives each year. One set was devoted to 25 to 35 particular content areas or “Topics” within four or five subspecialty areas. For instance, hematology/oncology and gastroenterology are among the topics in 1990 to 1991. The second set of objectives was composed of some 125 to 150 items and based on “Recent Advances” within the field. Recent Advances objectives encompassed the entire field of pediatrics but were limited to new information from the previous 7 years. (Information on “Topics” objectives had no time limit.) Working from these objectives, separate groups of pediatricians developed questions for the recertification examination of the Board and the self-assessment questions of the Academy. With the able assistance of the Editorial Board of Pediatrics in Review, I recruited the articles and abstracts for the journal based upon the educational objectives.

I do not believe that the continuing education program of any medical specialty has been developed more rationally. Although the recertification aspect of the program was greeted with a good deal of hostility, cooperation between the Board and the Academy has continued unhindered throughout the 12 years. I have always believed that the recertification portion is an important and integral part of the whole program, both to increase motivation for education and to ensure public confidence in pediatricians’ competence. But I also agree with those who oppose recertification that there is more to being a good pediatrician than passing a paper-and-pencil cognitive examination. However, it is hard to conceive that one can be a good pediatrician without a specific knowledge base. The development of an educational program to address what was considered by both practitioners and academicians to be important knowledge, not esoterica, has been the primary goal of PREP. The PREP process has ensured that the information provided through the program and the knowledge base required to pass the Board’s examination is relevant to practice. In Pediatrics in Review, I have attempted to publish articles and abstracts to provide up-to-date information pertinent to the objectives. Pediatrics in Review has been well accepted as a reliable source of continuing education information for pediatricians. This 1990 to 1991 PREP 2 - Year 6, which begins with the July 1990 issue, marks the end of this phase. I have enjoyed the process of editing the journal because, for me as well as for our readers, it has been a wonderful continuing education process.

THE NEW BEGINNING

The next phase of PREP presents an exciting challenge. Those pediatricians who became certified by the American Board of Pediatrics in 1988 now have a time-limited certification and will be required to participate in the Program for Renewal of Certification in Pediatrics (PRCP) if they wish to remain certified. There will be four parts to this program: 1) an examination drawn from a comprehensive list of “core content” statements of knowledge; 2) a record review; 3) an examination to assess diagnostic processes; and 4) an examination to assess skills in the management of clinical problems. Pediatrics in Review will concentrate on providing pediatricians with information relating to the core content and record review.

THE CORE CONTENT

Task forces similar to those which developed the educational objectives for PREPs I and II have begun to develop hundreds (eventually thousands) of core content statements.

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 I 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 six issues of the journal: CARD 1 for the July through December issues and CARD 2 for the January through June 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 August 31, 1991.

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.
Infect from tations cent appropriate practice of Henderson school-aged the Yearbook 1988:112-116. The human Advances, care pediatrics analysis. D, new MC. Asia Quiz Pediatrics. children? Accidental OBJECTIVE pharyngitis. Detection J Infect Dis. Comparison of a Latex Agglutination Test and Four Culture Methods for Identification of Group A Streptococci in a Pediatric Office Laboratory. Roddey OF et al. J Pediatr. 1986;108:347–351. Performance of an Enzyme Immunoassay Test and Anaerobic Culture for Detection of a Group A Streptococci in a Pediatric Practice Versus a Hospital Laboratory. Kellog JA et al. J Pediatr. 1987;III:18–21. Identification of Streptococcal Pharyngitis in the Office Laboratory: Reassessment of New Technology. Radefsky M et al. Pediatr Infect Dis J. 1987;6:556–563. Streptococcal Pharyngitis in the 1980’s. Dillon HC. Pediatr Infect Dis J. 1987;6:123–130. Resurgence of Acute Rheumatic Fever in the Intermountain Area of the United States. Veasy LG et al. N Engl J Med. 1987;316:421–427. Since 1954, the use of office throat cultures has been the gold standard in the detection of Group A β-hemolytic streptococcal pharyngitis. In recent years, rapid diagnostic tests based on detection of bacterial antigen or other microbial constituents have become available. These tests have a positive test correlation with positive cultures in more than 90% of cases. False negatives occur if there is sparse growth on culture (fewer than 10 colonies), and there is considerable test-to-test variability. The advantages of these rapid diagnostic tests include symptomatic benefit of early treatment, the possible earlier return of the child to day care or school, reduced transmission to family and close contacts, and the decreased use of unnecessary antibiotics. The disadvantages are the bacteriological inaccuracy, the effect on office-laboratory routine, and the increased cost. These rapid diagnostic tests are an optional adjunct to throat cultures. A positive test result is generally reliable and justifies antimicrobial therapy. A negative test result does not exclude the possibility of group A streptococcal pharyngitis, and a concomitant throat culture should be obtained when clinical findings suggest streptococcal infection. With the resurgence of acute rheumatic fever in some areas of the United States, the importance of proper bacteriologic diagnosis of pharyngitis has been reiterated. In this diagnostic regime, rapid diagnostic tests have a role. However, their limitations must be recognized, and the physician must remember that the throat culture remains the standard by which all other means of diagnosis should be measured.

Comment: In our office practice, the value of the rapid diagnostic test has been in determining whether immediate treatment of the child is indicated, thus decreasing the use of unnecessary antibiotics and increasing parental compliance with treatment regimen. (Kurt Metzl, MD, Editorial Board)
required for specific antibacterial therapy.

REFERENCES

16. Langman MJ. Epidemiologic evidence and the association between peptic ulceration and antiinflammatory drug use. Gastroenterology. 1989;96:640s–646s

Self-Evaluation Quiz

4. The major factor in causing stress-related ulcer is:
   A. Increased gastric acid secretion.
   B. Ischemia.
   C. Fever.
   D. Inhibition of prostaglandin synthase.
   E. Decreased bicarbonate production.

5. Which of the following is more frequent in primary than secondary peptic ulcer disease?
   A. Abdominal pain.
   B. Melena.
   C. Hematemesis.
   D. Perforation.
   E. Death.

6. Each of the following is true about non-steroidal anti-inflammatory drugs (NSAIDs) and peptic ulcer disease, except:
   A. They are associated with the development of both gastric and duodenal ulcers.
   B. Most have been implicated as a cause of peptic ulcers.
   C. A personal or family history of ulcers is apparently a risk factor for NSAID-induced ulcers.
   D. Even with antacid or H2-receptor antagonist treatment, a NSAID-induced peptic ulcer will not heal unless the drug is discontinued.
   E. They act as both local and systemic irritants to the gastric mucosa.

7. Which of the following is least likely to be a true statement pertaining to primary peptic ulcer disease in children?
   A. Initial symptoms in young children often include feeding problems or vomiting.
   B. Gastric ulcers are more common than duodenal ulcers in children less than 6 years of age.
   C. After 10 years of age, the majority of ulcers are found in boys and are duodenal.
   D. Pain in young children often has no association with meals.
   E. Children with duodenal ulcers rarely have pain at night.

8. The most accurate test(s) for establishing the diagnosis of peptic ulcer disease associated with Helicobacter pylori or Campylobacter pylori is (are):
   A. Special stain and/or culture of biopsied gastric tissue.
   B. Culture of gastric juice.
   C. Qualitative identification of ammonium ion in agar-incubated tissue.
   D. C14 urea breath test.
   E. Observation of motile organisms in fresh tissue specimen.

DEPARTMENT OF CORRECTIONS

In the article by Ginsberg-Fellner in the February 1990 issue of Pediatrics in Review, "Insulin-Dependent Diabetes Mellitus," the blood concentration at which the kidneys excrete glucose was stated incorrectly. On page 242, the 22nd line of the section on the management of children and adolescents with diabetes should indicate that this occurs only when the blood glucose concentration is greater than 180 mg/dL.
spection of the surface of the scalp or palpation of it may give the necessary clues to the correct diagnosis.

LOOSE ANAGEN SYNDROME

This syndrome is included in the discussion of disorders with alopecia for two reasons: (1) it was only described recently, and (2) it may be much more common than recognized previously. Prominent areas of alopecia do not seem to be a characteristic feature, although areas of marked scalp hair loss may be present. The primary complaint concerns easy pulling out of hair without pain. The disorder is most commonly described in children, particularly blonde girls. On inspection of the hair that is easily epilated, the bulbs appear to be anagen in nature, although they are commonly misshapened and lack an outer root sheath. Parents may note that their children's hair does not grow or grows very slowly, and almost never requires cutting. The cause of this disorder is not known. Although no treatment is available, the parents can be comforted to know that the appearance of the hair improves with time.

SUMMARY

The differential diagnosis of alopecia in the pediatric age group is simplified by the fact that 90% to 95% of the cases are caused by four major entities: alopecia areata, telogen effluvium, tinea capitis, and trichotillomania. Careful examination of the scalp, hair, and historical pattern of the loss will usually be rewarded by the correct diagnosis.

REFERENCES


SUGGESTED READING


Self-Evaluation Quiz

9. The four disorders responsible for 90% to 95% of alopecia in children include each of the following except:
   A. Tinea capitis.
   B. Alopecia areata.
   C. Seborrheic dermatitis.
   D. Telogen effluvium.
   E. Trichotillomania.
10. A 7-year-old epileptic boy on valproic acid develops diffuse thinning of his hair. His scalp appears normal, but plucked hairs show an increased telogen count. The most likely diagnosis is:
   A. Telogen effluvium.
   B. Alopecia areata.
   C. Tinea capitis.
   D. Trichotillomania.
   E. Loose anagen syndrome.
11. Each of the following is a true statement about kerions except:
   A. They are caused by a hypersensitivity reaction to a dermatophyte.
   B. They form a boggy inflammatory mass on the scalp.
   C. They are associated with cervical lymphadenopathy.
   D. Their presence indicates a need for incision and drainage.
   E. The recommended therapy is oral griseofulvin.
12. An 11-year-old girl has scaling of her scalp, patchy hair loss, and broken hairs. A fungal infection is suggested by a KOH mount, but examination with Wood light shows no fluorescence. The most likely diagnosis is:
   A. Tinea capitis.
   B. Trichotillomania.
   C. Traumatic alopecia.
   D. Telogen effluvium.
   E. Alopecia areata.
13. Typical findings in the loose anagen syndrome include each of the following except:
   A. Hair pulls out easily.
   B. Epilation is not painful.
   C. No prominent areas of alopecia are found.
   D. Hair does not grow or grows slowly.
   E. The appearance of the hair worsens with time without treatment.

DEPARTMENT OF CORRECTIONS

In the article on "Hemangiomas and Spitz Nevi" published in the March 1990 issue of Pediatrics in Review, the authors' titles were reversed. Dr Rasmussen is a Professor of Dermatology and Pediatrics in the Department of Dermatology at The University of Michigan-Ann Arbor, and Dr Hartley is a private practitioner.