Pediatrics in Review

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"The Knitting Lesson" (ca 1860) by Jean Francois Millet (1814–1875).
Renowned for his peasant paintings, Millet in this painting illustrates the
cycles of life and the passing on of skills from one generation to another.
One of the major tasks of pediatricians is to teach parents and children
skills to promote health. May we do it as gently and lovingly as this
mother teaches her daughter knitting. (From the Museum of Fine Arts,
Boston, Massachusetts.)

ANSWER KEY


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innocence of the perpetrator will be assessed.

Testifying in court is frequently stressful and anxiety-provoking. To facilitate the process, the physician should review medical notes with the attorney who issued the subpoena. It is also helpful for the physician to remember that he or she is not the one on trial; rather, the physician is there to relate the medical findings in a complex case in which undoubtedly there will be other experts. Although the physician usually is assigned the role of child advocate, it is important not to get caught up in the legal battle, but to remain neutral and advocate for the truth.

Prognosis

The prognosis for sexually abused children varies. Studies on adolescent suicide, depression, and eating disorders show a high prevalence of sexual abuse in these populations. The medical problems are addressed readily by the use of antibiotics when appropriate; the psychological trauma is more enduring. Appropriate referrals for counseling should be initiated in all abused children. It is hoped that cessation of the abuse and involvement with therapy will improve the long-term outlook for these children.

REFERENCES


PIR QUIZ

1. Each of the following statements about child sexual abuse is true except:
   A. The perpetrator is usually known to the child.
   B. Perpetrators are predominantly male.
   C. Developmentally delayed and physically disabled children are at increased risk.
   D. Less than 1% of sexual abuse victims are male.
   E. Accusations of sexual abuse arising within custody disputes are particularly difficult to resolve.
2. A 6-year-old girl is brought to your office after disclosing to her teacher that her mother’s boyfriend “touches my privates.” To obtain the most reliable information from the girl, you would do each of the following except:
   A. Explore the allegations privately with the child.
   B. Carefully validate the child’s responses in a series of separate interviews.
   C. Use open-ended, nonleading questions.
   D. Record the child’s responses verbatim.
   E. Suggest that the girl draw her memory of the event(s).
3. A 9-year-old girl alleges that her stepfather had vaginal and anal intercourse with her 6 months ago. Anatomic findings consistent with penetration by an adult penis include each of the following except:
   A. Normal anus.
   B. Perianal scarring.
   C. Normal hymen.
   D. Markedly distorted hymen.
   E. Imperforate hymen.
4. Assuming you encounter the clinical situations listed below, for which one is sexual abuse the only acceptable explanation?
   A. A 6-year-old girl with a positive VDRL test and fluorescent treponemal antibody tests.
   B. A 12-month-old boy with perineal warts.
   C. A 9-year-old girl with bacterial vaginosis.
   D. A 4-year-old girl with Trichomonas vaginalis.
   E. An 18-month-old girl with Chlamydia conjunctivitis.
5. You strongly suspect a 7-year-old boy has been sexually abused. Each of the following statements regarding your responsibility for reporting and testifying about child sexual abuse is true except:
   A. You are legally required to report your concerns.
   B. You do not need to be certain that sexual abuse actually occurred.
   C. Failure to report suspected sexual abuse may result in civil action against you.
   D. In most states, you can be successfully sued by the reported parties or parents if sexual abuse of the child is not confirmed.
   E. You may be obliged to provide future court testimony.
GROWTH AND DEVELOPMENT
Failure to Thrive

PIR QUIZ
6. True statements about growth deficiency in infants and children include each of the following except:
A. Organic causes should be rigorously excluded first, because appropriate therapy will quickly reverse the growth deficiency.
B. Growth deficiency typically is defined as a child below the fifth percentile on standardized growth charts for both height and weight in the absence of constitutional delay.
C. Parental growth should be considered in determining whether a child is growth deficient.
D. Chronic malnutrition usually is the immediate cause of growth deficiency.
E. Rarely is a single factor entirely responsible for growth deficiency.

7. Each of the following has been identified as a risk factor for growth deficiency except:
A. Poverty.
B. Single parent.
C. Feeding problems.
D. Prematurity.
E. Parental neglect.

8. The clinical assessment of children with growth deficiency properly includes which one of the following?
A. Hospitalization of all children for close observation and assessment of feeding patterns.
B. The detailing, by history, of a typical week's diet.
C. Careful administration of a Denver Developmental Screening Test.
D. Careful assessment of the child's nutritional status, including triceps skinfold and midarm circumference measurements.

9. Which one of the following would be inappropriate for the successful management of the child with growth deficiency?
A. Initially attempting to manage the problem with frequent visits on an outpatient basis.
B. Administering a multivitamin preparation that includes zinc and iron.
C. Instituting behavioral training, especially with regard to nutrition and feeding techniques.
D. Instituting family counseling and intervention as appropriate, with a goal of maintaining an intact family.
E. Addressing all factors simultaneously that contribute to the child's growth deficiency.

ABSTRACT

Inheritance Patterns in Tourette Syndrome


The spectrum of tic disorders in children is neither so uncommon nor transient that pediatricians can disregard or take lightly a parent’s or teacher’s observations about a child’s involuntary motor movements or vocal utterances. Rather, such information warrants a more detailed history about the child and family, especially as it pertains to other members who have tics or obsessive-compulsive disorders, particularly when they are chronic.

The combination of an uncontrollable chronic motor tic disorder with vocal tics that are manifested by echolalia, coprolalia, or echokinesis suggests Tourette syndrome. This is by far the most serious of the chronic tic disorders, with a prevalence of 1 in 2000. Boys are affected three to four times more often than girls.

As more families are identified who have a variety of chronic tic disorders, an autosomal dominant pattern of inheritance with sex-specific expressions and variable penetrance is evident. Of interest is that in such family pedigrees, more fathers are affected with chronic motor tics than are mothers, who more often manifest obsessive-compulsive disorders. In the instance of a homozygous individual, the penetrance is about 94% for Tourette syndrome, about 50% for the heterozygous individual, and less than 0.3% for normal individuals.

Observations of the Tourette disorder in monozygotic twins suggest a concordance rate of 53% and for dizygotic twins a rate of only 85%. Further evidence for the inherited predisposition of chronic tic disorders in twins is supported by a concordance rate of 77% in monozygotic twins and 23% in dizygotic twins.

Comment: Recognizing that such patterns of inheritance exist in the spectrum of chronic tic disorders seen in children demands a careful history and physical examination of the affected individual and near relatives within the family. To ascertain better the risk of subsequent children being affected with Tourette syndrome or the need to provide other reassuring and appropriate recommendations, a careful pedigree analysis must be done.

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PREVENTION

Lead Poisoning


Centers for Disease Control. Preventing Lead Poisoning in Young Children: A Statement by the Centers for Disease Control. Atlanta, GA: US Department of Health and Human Services/Public Health Service; 1991


Cory-Slechta DA, Weiss B, Cox C. Mobilization and redistribution of lead over the course of calcium disodium ethylene-diamine tetracetic acid chelation therapy. J Pharmacol Exp Ther. 1987;243:804-813


Weinberger HL, Post EM, Schneider T, Helu B, Friedman J. An analysis of 248 initial mobilization tests performed on an ambulatory basis. Am J Dis Child. 1987;146:1266-1270


PIR QUIZ

10. True statements about the significance of blood lead levels include each of the following, except:
   A. Lead does not cross the placenta unless the maternal blood lead level exceeds 60 µg/dL.
   B. The blood lead level may not accurately reflect the total body burden of lead.
   C. Children with blood lead levels greater than 60 µg/dL are usually asymptomatic.
   D. Children with toxic lead levels may not show adverse effects for some time.
   E. The prevalence of toxic blood levels in children in the United States exceeds that of any other chronic disease.

11. Important sources of lead in the environment that may contribute to childhood poisoning include each of the following, except:
   A. Paint used in house interiors prior to 1977.
   B. City water sources.
   C. Old houses undergoing rehabilitation.
   D. Airborne emissions from smelters and refineries.
   E. Lead gasoline.

12. The following are false statements about the long-term effects of lead on children, except:
   A. They do not correlate with the magnitude of the blood lead level.
   B. They are negligible for blood lead levels less than 25 µg/dL.
   C. They may be significant after fetal exposure to a maternal level of 10 to 15 µg/dL.
   D. They can be prevented with appropriate treatment of symptomatic children.
   E. They are rare if the child has been asymptomatic.

13. An ideal program for screening children for lead poisoning should include:
   A. Screening all children in elementary school.
   B. Measuring blood lead levels only if the erythrocyte protoporphyrin level is less than 35 µg/dL.
   C. Ensuring that all children are screened once at age 6 months regardless of risk factors.
   D. Recognizing that elevated erythrocyte protoporphyrin levels due to iron-deficiency anemia rule out the probability of lead poisoning.
   E. Confirming screening tests by blood lead levels performed serially.

14. Appropriate management of children with elevated blood lead levels include each of the following, except:
   A. Identifying the source of lead exposure.
   B. Providing a diet rich in iron, calcium, and zinc.
   C. Removing all lead-based paint only after the child can be removed from the site.
   D. Controlling household dust with frequent wet-mopping using a high-phosphate detergent.
   E. Administering chelation therapy only for asymptomatic children.
particularly true in children whose upper airways are obstructed or those who have obstructive sleep apnea. A normal sleep state generally is associated with decreased ventilation. Breathing frequently is irregular and unaffected by environmental factors—much different from the waking state. Studies of normal sleep indicate a significant decrease in the ventilatory response to CO₂ inhalation when compared with the conscious state. Therefore, sleeping states may exacerbate hypoxia and increase right ventricular pressure in any situation where cor pulmonale exists. Conditions causing upper airway obstruction may especially worsen during sleep.

Cor pulmonale is reversible if the contributory and causative factors can be relieved. If the chronic problem cannot be managed primarily, then methods to ensure or improve oxygen levels or pulmonary vascular resistance should be attempted. Supplemental oxygen not only decreases the level of hypoxemia, but also acts as a pulmonary vasodilator and will lower pulmonary vascular resistance. Direct pulmonary vasodilators also may be tried. Digitalis and diuretics also have been prescribed where evidence for right ventricular failure exists.

The clinical diagnosis of cor pulmonale is made by the auscultatory finding of a very loud, narrowly split or single second heart sound. This may be associated with a palpable impulse. In advanced cases there may be murmurs of pulmonary or tricuspid insufficiency. Hepatomegaly and peripheral edema may occur.

The EKG is frequently used for the diagnosis of cor pulmonale. However, it may lag significantly behind the development of the clinical picture. With the onset of cor pulmonale, EKGs are frequently normal. In time, however, right ventricular hypertrophy develops and the frontal plane axis shifts rightward. Right atrial hypertrophy with typical peaked P waves (P pulmonale) may be seen. One should not, however, rely on the EKG for the diagnosis. Similarly, electrocardiographic changes toward normal lag in those in whom cor pulmonale has reversed.

**Comment:** Pediatricians need to become sensitive to the early diagnosis of cor pulmonale in children who exhibit upper airway obstruction primarily as a result of large tonsils and adenoids. After the initial report by Kravath et al (Pediatrics 1977;6: 865-871), it became clear that significant enlargement of tonsils and adenoids resulting in upper airway obstruction can precipitate chronic hypoxia, hypercarbia and, as a result, increased pulmonary vascular resistance resulting in the potential for cor pulmonale and significant congestive failure. Pediatricians, therefore, must be sensitive to this condition, and if the diagnosis of significant upper airway obstruction is made on this basis, early surgical intervention should be considered in light of the potential serious sequelae. In the most severe cases cited in the literature, children have presented as early as 2 and 3 years of age.

**Steven P. Shelov, MD**

Abstracts Editor
ABSTRACT

Exercise Intolerance


The most common and yet occasionally overlooked cause of exercise intolerance in pediatrics is exercise-induced asthma (EIA). Most susceptible individuals require at least 5 to 6 minutes of strenuous exercise to precipitate an attack. Activities that require short bursts of energy, such as baseball, rarely cause EIA. The symptoms classically occur shortly after completion of the activity and include excessive dyspnea, wheezing, or cough. Symptoms reach their peak within 5 to 10 minutes and recovery is usually complete by 30 to 90 minutes. Cold, dry air induces more severe attacks than warm, humid air. The patient’s current state of airway reactivity also will influence the severity of response to a similar exercise stimulus. Inhaled beta agonists, given 10 minutes before exercise, are the treatment of choice. Cromolyn sodium is the preferred second-line agent.

Just as “all that wheezes is not asthma,” all that is exercise-limited cannot always be attributed to asthma. The child’s aerobic exercise capacity is determined by both the availability of oxygen to the exercising muscle and the muscle’s capacity to use the delivered oxygen. In addition to the lung’s ability to provide oxygen to the blood, other critical factors for oxygen delivery include the heart’s ability to pump oxygenated blood to the working muscles (stroke volume x heart rate) and the oxygen-carrying capacity of the blood (ie, normal hemoglobin concentration). Bar-Or nicely illustrates, using the Fick principle, the various mechanisms leading to reduced aerobic power.

When a patient presents with a history of exercise intolerance, a careful history must be obtained. If atypical symptoms are present, such as chest pain or syncope, a thorough evaluation for cardiac etiologies should be performed, including exercise testing. Although rare, exercise may be life-threatening in this group of patients.

In addition to the physiologic causes of exercise limitation, deconditioning, either habitual, psychological, or secondary to disease states, must be considered. A group of asthmatic children studied by Orenstein et al demonstrated reduced working capacity compared with nonasthmatic controls. The subgroup of subjects who participated in a 4-month running program showed significant increases in work tolerance and cardiovascular fitness compared with the asthma patients who did not participate in the training program.

In summary, the most common cause of exercise limitation in pediatrics is exercise-induced asthma. However, a much wider variety of etiologies must be considered in the patient who complains of exercise intolerance. An atypical history mandates an evaluation that should include exercise testing. Exercise testing also may be used to provide proper training regimens to patients with disease (ie, cystic fibrosis, asthma). Exercise testing is an underutilized tool in pediatrics. When ordering an exercise test, it is important to communicate the purpose of the test beforehand, because a progressive test is not the optimal test for EIA, and tests directed at the diagnosis of EIA will not be a reliable estimate of cardiovascular fitness.

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The American Academy of Pediatrics is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. As an organization accredited for continuing medical education, completion of the PIR Quiz meets the criteria for 2 hours of credit, per issue, of the American Academy of Pediatrics’ PREP Education Award.

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The questions for the PIR 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 the PIR Quiz Card found in the January issue, and return the card to the Academy. (PREP group participants will receive the PIR Quiz Card and Self-Assessment Credit Reply Sheet under separate cover.) To receive CME credit on the 1992 annual credit summary, you must be enrolled in PREP or subscribe to Pediatrics in Review and return the PIR Quiz Card by February 28, 1993. PIR Quiz Cards received after this deadline will be recorded in the year it is received; with cards from the 1992 PIR journals, accepted through December 31, 1994.

The PIR Quiz card is bound into the January issue. Complete the quizzes in each issue and send it to: American Academy of Pediatrics, PREP Office, PO Box 927, Elk Grove Village, IL 60009-0927.

The correct answers to the questions in this issue appear on the inside front cover.
CUMULATIVE SUBJECT INDEX

The following index covers subjects in Pediatrics in Review in Volumes 11 (1989-1990), 12 (1990-1991), and 13 (1992). Each entry includes the volume and page number of the article in which the subject appears. (abs) = abstract

Additionally, the index includes subjects addressed in the Self-Assessment (SA) Exercise for 1992. Each entry includes the question number and year in which the subject appears.

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Erratum

The Answer Key in the November 1992 issue inadvertently included answers to questions that are included in the December 1992 issue. Answers 26 through 30 in the November issue should be ignored.

The Answer Key correctly identified F as the answer for question #12. However, no place was provided on the PIR Quiz card for an F answer. Therefore, everyone who sent in the Quiz card will be credited for #12 regardless of their answer and will receive CME credit.