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Discussion of some of the questions follows:

(1-3) Persistent pulmonary hypertension occurs in term infants who were asphyxiated at birth. The heart and lungs are normal on chest roentgenogram. Metabolic acidosis follows the hypoxemia. Normal temperature will reduce oxygen needs. Hyperviscosity is common and will reduce perfusion. Tolazoline is used to dilate the pulmonary vasculature. The patient is not in cardiac failure, and ventilation without oxygen is of little value. Reducing ductal shunting is counterproductive.

(4, 5) In severe RDS, there is hyperventilation, minimal response to ventilation, and hypercarbia. There often is ductal shunting as well as impaired diffusion, alveolar hypoventilation, and perfusion differences. Due to the acidosis, the dissociation curve will be shifted to the right (lower saturation).

(6) Pneumonia, hypoglycemia, and CNS hemorrhage may all produce cyanosis. PDA with persistence and subsequent cardiac failure is more common in low-birth-weight infants. Transient tachypnea in term infants occurs by 3 to 4 days of life, and is due to slow resorption of lung fluid.

(7) You would anticipate a response to breathing 100% oxygen in conditions due to alveolar hypoventilation (cardiac failure, CNS hemorrhage). Paco2 would not be normal in pneumonia. Methemoglobinemia would respond to oxygen administration but a cardiac shunt would not!

(8) In iron deficiency anemia the red blood cells are microcytic and hypochromic, the bone marrow shows erythroid hyperplasia. the serum iron is reduced while Coombs test is negative and hemoglobin electrophoresis is normal. The findings in TEC are presented on pages 25-26.