

# Medical Reference Cards

[github.com/alping/medical-reference-cards](https://github.com/alping/medical-reference-cards)

# Adrenal Venous Sampling

**Introduction:** Primary aldosteronism (PA) is more common than previously thought. Up to 15% of all hypertension is due to PA. PA can be caused by bilateral or unilateral hyperplasia, an adenoma, or by mutations in genes coding for enzymes involved in aldosterone (AS) synthesis. **Adrenal venous sampling (AVS)** is a procedure used to diagnose the **source** of the excess aldosterone (i.e. whether it is uni- or bilateral). Why is this important? Because unilateral PA is treated surgically, whereas bilateral PA is managed medically. AVS is, by far, the most reliable way of establishing the source of excess AS.

**The procedure:** With AVS, the difference between left and right adrenal AS excretion is measured by sampling blood from each **adrenal vein (AV)**. This is more complicated than it sounds, mostly for anatomical reasons. The **right adrenal vein** is very short and originates directly from the **inferior vena cava (IVC)**, making it very difficult to cannulate. The **left AV** originates from a common trunk with the inferior phrenic vein (IPV), which, in turn, originates from the left renal vein. The common trunk is easier to cannulate than the left AV itself, but dilution from the IPV must then be compensated for when interpreting the AS level (in the common trunk, left AV blood is mixed with IPV blood, which obviously has a lower AS concentration).

# Adrenal Venous Sampling

**Execution:** The **right AV**, **IVC**, and **left AV** are cannulated, and blood is sampled for analysis of **AS** and **cortisol** levels. The AVs are catheterized through the percutaneous femoral vein approach. Gentle contrast injections are used to verify the position of the catheter tip.

- Why is blood sampled from the IVC? Why is the cortisol level analyzed? Aren't we only interested in the AS levels? These questions are answered in the interpretation section.

**Interpretation:** Ultimately, we're interested in whether there's a significant difference between AS levels in the two adrenal veins. So why cannulate the IVC? Because comparing the right AV and IVC cortisol levels tells us whether or not the difficult cannulation was successful – the cortisol level should be **≥3 higher** in the right AV. If this is the case, we can trust subsequent measurements.

Before AS levels are compared, we must account for dilution. This is done by dividing the AS level with the cortisol level in each AV – the ratio will be the same regardless of dilution. These **corrected** values (A/C ratios) are the ones used in the final comparison.

If the A/C ratio of one adrenal vein is  $\geq 4$  times higher than that of the other, the source of AS is unilateral and should be treated **surgically**.

# C-ABCDE

## **C** Catastrophic bleeding / Cardiac arrest

### **A** Airways

Check airway  
Thorax movement  
See, listen, feel  
Paradox. breathing?  
Stridor?

1. Chin lift/Jaw thrust
2. Naso/Oropharyngeal airway
3. Suction
4. Laryngeal mask airway
5. Intubation
6. Coniotomy

### **B** Breathing

Respiratory rate  
Thorax movement  
Auscultation  
Cyanosis

1. Oxygen
2. Ventilation
3. Decompression
4. Chest tube

### **C** Circulation

Colour (Pale)  
Cold/Sweaty  
Pulse (Rad / Fem / Car)  
Abdomen/Pelvis

1. Tilt bed
2. Fluids (PVC, IO, CVC)
3. Vasoactive drugs  
(Adrenalin IM)

### **D** Disability

AVPU/GCS  
Pupils  
Movement of extrem.

1. Support ABC
2. Glucose
3. Antidote

### **E** Exposure

Check whole body  
Prevent hypothermia  
Prevent further injury

1. Log roll
2. Warm blankets
3. Warm fluids

# SBAR

## **S** Situation

Own name, title, and unit

Patients name, sex, and age

Patients social security / identification number

Describe situation briefly

*I'm contacting you to...*

## **B** Background

Previous and current illness

Relevant medical history

Allergies

Contagiousness

## **A** Assessment

A: Airway

B: Breathing, saturation

C: Heart rate, blood pressure

D: Consciousness, pain, oriented to time / place / person

E: Temperature, skin, colour, abdomen, urine production

***Brief assessment***

## **R** Recommendation

Immediate action (Care, monitoring, transfer, treatment)

Further examinations (Radiology)

Time frame (How often...? How long...? Next contact...?)

**Confirmation of communication**

*Questions / Agreement*

# Lab reference (Swe)

Sys.	Component	Subgroup	Ref. interval	Unit
P/S	ALAT	Male	0,15 – 1,1	µkat/L
		Female	0,15 – 0,75	µkat/L
P/S	ALP		0,60 – 1,8	µkat/L
P/S	Amylas		0,40 – 2,0	µkat/L
P/S	Albumin	18 – 40 y.	36 – 48	g/L
		41 – 70 y.	36 – 45	g/L
		>70 y.	34 – 45	g/L
P/S	ASAT	Male	0,25 – 0,75	µkat/L
		Female	0,25 – 0,60	µkat/L
P/S	Bilirubin		5 – 25	µmol/L
P/S	Calcium		2,15 – 2,50	mmol/L
P/S	CK	Male 18 – 50 y.	0,80 – 6,7	µkat/L
		Male >50 y.	0,70 – 4,7	µkat/L
		Female	0,60 – 3,5	µkat/L
P/S	Fosfat	Female	0,80 – 1,5	mmol/L
		Male 18 – 50 y.	0,70 – 1,6	mmol/L
		Male >50 y.	0,75 – 1,4	mmol/L
fP	Glukos		4,2 – 6,3	mmol/L
P/S	GT	Male 18 – 40 y.	0,15 – 1,3	µkat/L
		Male >40 y.	0,20 – 1,9	µkat/L
		Female 18 – 40 y.	0,15 – 0,75	µkat/L
		Female >40 y.	0,15 – 1,2	µkat/L
P/S	Järn		9 – 34	µmol/L
P/S	Järnmättnad	Male	0,15 – 0,60	
		Female 18 – 50 y.	0,10 – 0,50	
		Female >50 y.	0,15 – 0,50	
P	Kalium		3,5 – 4,4	mmol/L
S	Kalium		3,6 – 4,6	mmol/L
P/S	Kolesterol	18 – 30 y.	2,9 – 6,1	mmol/L
		31 – 50 y.	3,3 – 6,9	mmol/L
		>50 y.	3,9 – 7,8	mmol/L
P/S	HDL-Kolesterol	Female	1,0 – 2,7	mmol/L
		Male	0,80 – 2,1	mmol/L

# Lab reference (Swe)

Sys.	Component	Subgroup	Ref. interval	Unit
P/S	LDL-Kolesterol	18 – 30 y.	1,2 – 4,3	mmol/L
		31 – 50 y.	1,4 – 4,7	mmol/L
		>50 y.	2,0 – 5,3	mmol/L
P/S	Kreatinin	Male	60 – 105	µmol/L
		Female	45 – 90	µmol/L
P/S	LD	18 – 70 y.	1,8 – 3,4	µkat/L
		>70 y.	1,9 – 4,2	µkat/L
P/S	Magnesium		0,70 – 0,95	mmol/L
P/S	Natrium		137 – 145	mmol/L
P/S	Pankreasamylas		0,15 – 1,10	µkat/L
P/S	Protein		64 – 79	g/L
P/S	TIBC		47 – 80	µmol/L
P/S	Triglycerider		0,45 – 2,6	mmol/L
P/S	Urat	Male	230 – 480	µmol/L
		Female 18 – 50 y.	155 – 350	µmol/L
		Female >50 y.	155 – 400	µmol/L
P/S	Urea	Male 18 – 50 y.	3,2 – 8,1	mmol/L
		Male >50 y.	3,5 – 8,2	mmol/L
		Female 18 – 50 y.	2,6 – 6,4	mmol/L
		Female >50 y.	3,1 – 7,9	mmol/L
B	Hemoglobin	Female	117 – 153	g/L
		Male	134 – 170	g/L
B	EVF	Female	0,350 – 0,458	
		Male	0,393 – 0,501	
B	Erythrocyter	Female	3,94 – 5,16	1012/L
		Male	4,25 – 5,71	1012/L
B	MCV		82 – 98	fL
Erc	MCH		27,1 – 33,3	pg
Erc	MCHC		317 – 357	g/L
B	Leukocyter		3,5 – 8,8	109/L
B	Trombocyter	Female	165 – 387	109/L
		Male	145 – 348	109/L

# Atrial Fibrillation

## Types

**Paroxysmal** spontaneous termination within 7 days

**Persistent** requires cardioversion to restore sinus rhythm

**Permanent** sinus rhythm cannot be restored

## Treatment

**Freq. control** *goal <110/min*

T Bisoprolol 2.5-5 mg

T Digoxin 0.13-0.25 mg *if heart failure*

**Rhythm control** *if symptomatic*

**Paroxysmal** T flekainid (Tambocor) 50-100 mg x2

**Persistent** Electrical cardioversion

AF <48 h → no anticoagulants needed

AF >48 h → anticoagulants > 3 weeks  
before procedure (alternative: TEE)

**Anticoagulants** *If  $CHA_2DS_2-VASc > 2$*

1. NOAK, ex. dabigatran (Pradaxa)

2. Warfarin (Waran)

3. Long-term treatment with LMH





# NYHA

**Mortality % (untreated) after 1 resp. 5 years**

NYHA	Symptoms	1 y	5 y
I	Impaired heart function without symptoms	5	20
II	Shortness of breath and fatigue only during strenuous exercise	10	30
III a	Shortness of breath and fatigue during light to medium exercise	25	60
III b	III a, and cannot walk >200m	Same as III a	
IV	Shortness of breath and fatigue at rest. Often confined to bed.	50	80

New York Heart Association (NYHA) Functional Classification

## Diagnostics modalities for heart failure (HF)

**Heart ultrasound** (confirms the diagnosis)

**ECG** (normal ECG speaks strongly against HF)

**Plain film X-ray** (heart/lung, to exclude other conditions)

**NT-proBNP** (if low + ok ECG, rules out HF w. high certainty)

**Lab tests** (Hb, Na, K, Crea., PK, B-glucose, TSH, CRP, iron)

# Heart Failure Treatment

## NYHA Treatment when EF <45%

### **ACE inhibitor\***

- I** *If symptomatic oedema*  
**Diuretic**

### **Beta-blocker** (slow increase in dose)

*If EF <35%*

- II Aldosterone receptor antagonist**

*If EF <35% and QRS >120 ms*

### **Assess need for CRT and/or ICD**

## **III + IV** Advanced treatment/palliative care.

\*If not tolerated → Angiotensin II receptor antagonist, EF = Ejection Fraction

Drug class	Example	Start (mg)	Target (mg)
<b>ACE-Inhibitor</b>	Enalapril	2.5 x 2	10-20 x 2
<b>Diuretic</b>	Furix	20 - 40	40 - 240
<b>Beta-blocker</b>	Bisoprolol	1.25 x 1	10 x 1
<b>Aldosterone antagonist</b>	Spironolakton	25 x 1	25-50 x 1
<b>Angiotensin II antagonist</b>	Candesartan	4-8 x 1	32 x 1

## **Acute heart failure (left ventricle)**

### **Heart position**

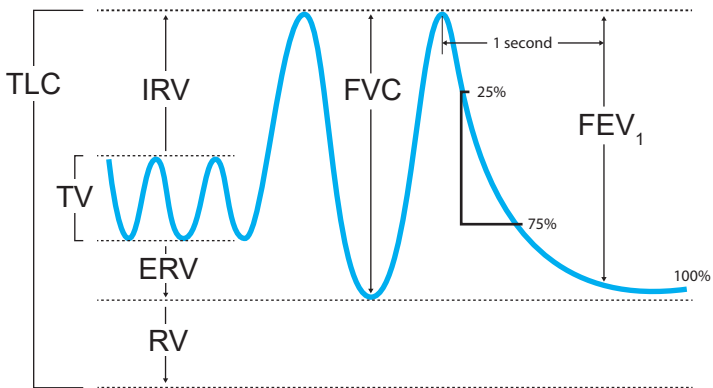
**Oxygen** (target SaO<sub>2</sub> >90%) or **CPAP** *if severe lung oedema*

**Furosemid** (10 mg/ml 2-4 ml i.v.)

**Nitroglycerin i.v.** (0.25-0.5 mg) or

**spray** (0.4 mg) sublingually *if systolic BP >100*

# Spirometry





# CHA2DS2VAS

<b>C</b>	Cardiac - Heart failure	<b>1</b>
<b>H</b>	Hypertension	<b>1</b>
<b>A</b>	Age $\geq 75$ years	<b>2</b>
<b>D</b>	Diabetes	<b>1</b>
<b>S</b>	Stroke / TIA / Embolism	<b>2</b>
<b>V</b>	Vascular Atherosclerotic disease	<b>1</b>
<b>A</b>	Age 65-74	<b>1</b>
<b>S</b>	Sex - Female*	<b>1</b>

\*No indication for antithrombotic treatment if only risk factor

**AF and score  $\geq 2 \rightarrow$  Antithrombotic treatment**  
**IF low-medium risk of bleeding (HAS-BLED  $< 3$ )**

*See local guidelines for specific antithrombotic drugs*

*Example of initial Warfarin treatment, 2.5mgx1 p.o.*

Day 1: 2-4 | Day 2: 2-3 | Day 3: 1-4 (dep. on INR)

# HAS-BLED

<b>H</b>	Hypertension >160 mmHg	<b>1</b>
<b>A</b>	Abnormal liver or kidney*	<b>1-2</b>
<b>S</b>	Stroke	<b>1</b>
<b>B</b>	Bleeding Previous tendency or anaemia	<b>1</b>
<b>L</b>	Labile INR High / Unstable INR or <60% time in therapeutic range	<b>1</b>
<b>E</b>	Elderly (>65 years)	<b>1</b>
<b>D</b>	Drugs E.g. ASA, NSAID or high alcohol consumption	<b>1-2</b>

\* Kidney: Creatinine >200, dialysis, or transplant  
Liver: Chronic liver disease, Bilirubin 2x ref, or  
ALAT/ASAT/ALP 3x ref.

**High risk of bleeding if  $\geq 3$  points**

# Neurological exam.

## Higher cerebral functions

Wakefulness, oriented to time/place/self, comprehension, attention, spatial function, dysarthria, dysphasia, dyslexia, dyspraxia, neglect, amnesia, right or left handed

## Standing

Walking	Symmetry	<b>Strength</b>
	Pattern	Squat and rise
	Normal/Toes/Heels	Jump on one leg
	Arm movements	<b>Coordination</b>
	Step length	Romberg's test
	Turning	Finger nose test

**Sensory:** Visual acuity, hearing

## Sitting

Eyes	Fundus examination (papillary stasis)	Face	Symmetry
	Visual field (Donder's test)		Facial expressions
	Movement (nystagmus, paresis, diplopia)		Sensibility
	Pupil (symmetry, size, reaction to light)		Motor function
	Corneal reflex		Ptosis
Tests	Muscle strength (arm/finger/shoulder)	Mouth	Symmetry
	Reflexes (brach.rad/bic/tric/patel./achill.)		Tongue motor function
	Grasset's test		Swallow reflex
	Dysdiadochokinesis, finger play		Gingival hyperplasia

## Lying down

**Important: Neck stiffness**

Muscles	Strength – proximal, distal	Sensibility	Light touch
	Tonus* – hand/elbow/knee joint		Vibration
	Atrophies		Temperature
	Fasciculation		Pain
	Tremor		Proprioception
Tests	Heel-knee test	Prim. reflex	Grasping reflex
	Reverse Barré's test		Glabellar
	Straight leg raise		Palmomental
	Babinski's sign		Sucking

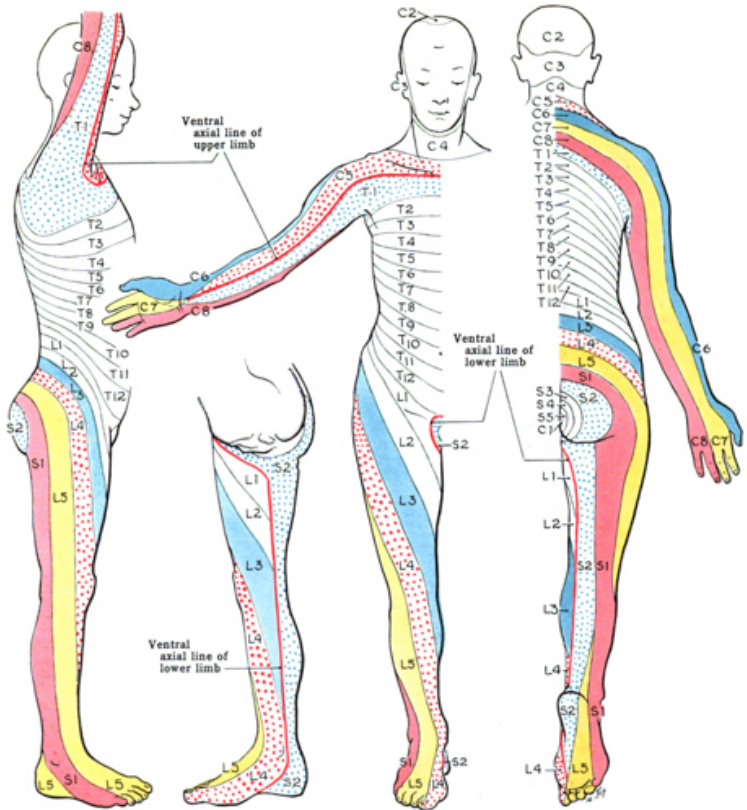
\*Rigidity, gear phenomenon, spasticity



# Glasgow Coma Scale

	Response	Score
Eye opening response	Spontaneously	4
	To speech	3
	To pain	2
	No response	1
Best verbal response	Oriented to time, place, and person	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No response	1
Best motor response	Obeys commands	6
	Moves to localized pain	5
	Flexion withdrawal from pain	4
	Abnormal flexion (decorticate)	3
	Abnormal extension (decerebrate)	2
	No response	1
Total score	Best response	15
	Comatose patient	≤8
	Totally unresponsive	3

# Dermatomes



# Myotomes

Segment	Function
<b>C1/C2</b>	Neck flexion/extension
<b>C3</b>	Neck lateral flexion
<b>C4</b>	Shoulder elevation
<b>C5</b>	Shoulder abduction
<b>C6</b>	Elbow flexion/wrist extension
<b>C7</b>	Elbow extension/wrist flexion
<b>C8</b>	Finger flexion
<b>T1</b>	Finger abduction
<b>L2</b>	Hip flexion
<b>L3</b>	Knee extension
<b>L4</b>	Ankle dorsi-flexion
<b>L5</b>	Great toe extension
<b>S1</b>	Ankle plantar-flexion/ankle eversion/ hip extension
<b>S2</b>	Knee flexion
<b>S3–S4</b>	Anal wink

# Bishop's index

	0	1	2
Station	Above or at pelvis entrance	Above spinae	At or below spinae
Diameter (cm)	$\leq 0,5$	$0,5 < d < 1,5$	$\geq 1,5$
Effacement (%)	0	$< 50$	$\geq 50$
Consistency	Firm	Medium	Soft
Position	Posterior	Middle	Anterior

*Bishop's index is a modified Bishop's score*

Score  $< 6$  = Immature cervix →

High probability of long labour if induced

## Techniques used to induce labour

Intravenous prostaglandin  $E_1$  or  $E_2$  (Cytotec)

Vaginal prostaglandin  $E_2$

Amniotomy

Intrauterine balloon putting pressure on the cervix

Oxytocin i.v. to potentiate contractions (Syntocinon)

*Local guidelines on which method to use differ between hospitals*

# CTG

	Base HR	Variability + Acc.	Decelerations	Contractions
Normal	110-150	5-25	None	≤5/10min
		≥2 acc/60 min	Uniform early	
			Variable uncompl. <30 s, <60 beats	
Abnormal*	100-110	<5 for >40 min, with no acc	Variable uncompl. 30-60 sec OR >60 beats	>5/10min
	150-170	>25		
	<100 for <3 min	<2 acc/60 min		
Pathologic	>170	<5 for >60 min, with no acc	Variable complicated >60 sec	
	<100 for >3min	Sinusoidal pattern	Uniform late	
			Combined	

**Preterminal** No variability (<2/min) and no accelerations

\* ≥2 = suspected pathological

<b>Acceleration</b>	Increase in heart rate of >15, for >15 s
<b>Uniform deceleration</b>	Shaped like a U
<b>Early</b>	With the contraction
<b>Late</b>	After the contraction
<b>Variable</b>	Variable form (see above table)

# Acute abdominal pain

**Check vital signs, ABCDE**

**Lab: u-hCG, CRP, Hb, urinary dipstick**

**Gynaecological exam. and vaginal ultrasound (VU)**

## u-hCG positive

**Spontaneous abortion:** Localized pain over the uterus in combination with larger vaginal bleeding

**Ectopic pregnancy (EctP):** Localized pain over one side  
Occasionally minor vaginal bleeding  
Risk of intraabdominal haemorrhage

**Non gynaecological:** Appendicitis, urinary tract infection, gallstones

*High probability of EctP if S-hCG does not double in 2 days or unable to find intrauterine pregnancy with VU when s-hCG >1000*

## u-hCG negative

**Ovarian torsion:** Acute onset of severe pain in intervals  
Often with cysts  $\approx$  5cm. Acute laparoscopic surgery

**Rupture of cyst/Ovulation pain:** Generalized pain in the lower abdomen (subsides within a few hours)

**Infection:** Pathological fluor/bleeding  $\rightarrow$  Chlamydia sample + Wet smear. Doxycycline + Metronidazole

**Endometriosis:** Dysmenorrhea.

Clinical diagnosis (laparoscopic verification if needed)

Combined contraceptive hormone therapy

(Neovletta/Prionelle), 2-4 menstruations/year

# Fever Post Partum

<b>Mastitis</b>	<p><i>Redness, tenderness, and increased heat, in a localized area. Palpable resistance. High fever. CRP↑</i></p> <p>Breast feeding (empty the breast) pump if needed Culture if wound Flukloxacillin (Heracillin) 1g x3 If abscess: Ultrasound drainage and culture.</p>
<b>Endometritis</b>	<p><i>Abd. pain. Tender uterus. Malodorous bloody discharge. CRP↑</i></p> <p>Cervical culture (streptococcus), blood culture Methergin + antibiotics: Within days: pip/tazo 4g x4 Late: amoxi/klav 500mg/125mg x3 + metronidazol 400mg x3 5-10d</p>
<b>Wound infection</b>	<p><i>Redness, pus</i></p> <p>Wound culture Debridement</p>
<b>Pneumonia</b>	<p><i>Coughing, pleural pain</i></p> <p>Clinical examination, X-ray if needed If uncomplicated: PcG</p>
<b>Urinary tract inf.</b>	<p><i>Urinary urgency and tenderness over kidneys or bladder</i></p> <p>Urine culture Antibiotics, e.g. Selexid (CAVE Furadantin)</p>
<b>Thrombosis</b>	<p><i>Signs of pulmonary embolus or DVT</i></p> <p>Ultrasound legs Pulmonary CT if needed</p>

Swedish BESLUT = Bröst, Endometrit, Sårinfektion, Lunginflammation, Urinvägsinfektion, Trombos

# Distal Status - Hand

## Inspection

Hematomas / Wounds

Malalignment / Tonus

## Palpation

Fossa tabatière

Distal radioulnar joint

## Circulation

Allen's test – Ulnar / Radial loss of circulation

Capillary refill Dig I-V

## Passive movement (tendons)

Finger extension, each separately

Flexor digitorum superficialis et profundus, separately

## Neurology

1. *Radialis* 2. *Medianus* 3. *Ulnaris*

Sensory			Motor
	1. Dig I, radially	1. Extension of fingers	
	2. Dig II, distal of PIP	2. Opposition, Dig I & V	
	3. Dig V, ulnar side	3. F.spread / Dig V flex.	

## Stability

Dig I, MCP, UCL, Distal radioulnar joint

Watson's test – Instability, scaphioidum - lunatum

## Specific tests

Tinel's and Phalen's tests: carpal tunnel syndrome

Finkelstein's test: Morbus de Quervain

**Pain in wrist should result in plain film x-ray**



- Orthopedics -

- **Empty** -

# Ottawa Ankle Rule

## 1 Pain around the malleolus AND

---

Palpation tenderness over the dorsal ridge of the lateral or medial malleus

**OR**

Inability of the foot to support four steps

---

## 2 Pain around the mid part of the foot AND

---

Palpation tenderness over the base of the 5th metatarsal bone OR the Navicular bone

**OR**

Inability of the foot to support four steps

---

**X-ray of foot and lower leg if 1 or 2 are met**

**Otherwise:** Elastic wrap, tape, possibly orthosis, information (proprioceptive exercises e.g. stand on one leg while brushing teeth)

**Acute care (PRICE)**

Protection, Rest, Ice, Compression, Elevation

*Only applicable on adults (>18 years) with isolated injury*

# Well's DVT Score

Sign	Point
Active cancer last 6 months	1p
Paralysis, paresis, newly casted	1p
Immobilized >3 d. or large surgery last 4 w.	1p
Localized tenderness along the deep venous system	1p
Whole leg swelling	1p
Calf circumference >3 cm, compared to asymptomatic side	1p
Pitting oedema on symptomatic side	1p
Collateral flow in superficial veins (non-varicose)	1p
Similar likelihood of alternative diagnosis	-2p

**Low points <2 + negative D-dimer**  
= low probability for DVT

**High points  $\geq 2 \rightarrow$  Ultrasound whole leg**

*Risk of false negative D-dimer when  
symptoms >1w or anticoagulation therapy*

# Normal Physiology

Age	RR (/min)	HR (/min)	SBP (mmHg)
0-1 m	30 - 60	110 - 160	65 - 90
1-12 m	30 - 40	110 - 160	70 - 90
1-2 y	25 - 35	100 - 150	85 - 95
2-5 y	25 - 30	95 - 140	80 - 110
5-12 y	20 - 25	80 - 120	90 - 110
>12 y	15 - 20	60 - 100	100 - 120

Age	♀ W. (kg)	♀ H. (cm)	♂ W. (kg)	♂ H. (cm)
0 m	2.8 - 4.2	46 - 54	2.9 - 4.4	47 - 55
3 m	4.6 - 7.0	56 - 64	4.8 - 7.5	57 - 66
6 m	6.0 - 9.3	62 - 71	6.4 - 10	63 - 73
1 y	8.0 - 12	70 - 80	8.5 - 13	71 - 82
5 y	15 - 25	102 - 120	15.5 - 25	110 - 112
18 y	46 - 80	156 - 180	55 - 94	167 - 194

Age (m)	1-2	2-4	4-6	6-8	8-10	10-12
W. gain (g/w)	175	150	125	100	75	50

	W. (kg)	Fluids (ml/kg/24h)
	2-8	150
	6-10	110 - 125
Holiday-Segar	0-10	100
	10-20	50
	>20	20

A. (y)	ml/kg/hour
0-1	2-4
>1	1-2
▲ Urine / Oliguri ▼	
0-1	<1
>1	<0.5

# Physical examination

## General condition / appearance

- Tiredness / Movement / Speech / Adeq. devel. for age / Temperature
- Pallor / Cyanosis / Icterus / Petechiae / Turgor

## Head

- Size / Shape / Fontanelle (<8-12 months) / Sutures

## Eyes and Ears

- Movement / Pupil size/reflex/ Red reflex / Squint / Sunset gaze

## Mouth and Throat

- Cleft lip/palate / Teeth / Tongue / Tonsils / Sucking

## Lymph nodes

- Neck / Axilla / Groin

## Circulation

- Heart rate & rhythm / Murmurs / Capillary refill time / Femoral pulses

## Respiration

- Resp. rate / Recessions / Nasal flaring / Wheezing / Crackling / Stridor

## Neurology

- Spontaneous movement / Tonus / Neck stiffness / Babinski's sign
- Reflexes: Moro / Suck / Grasp

## Abdomen

- Liver (<1 cm below costal ridge) / Kidneys / Spleen / Umbilicus

## Genitalia

- Outer genitalia / Discharge / Testicles / Cremaster reflex

## Hips

- Symmetry / Ortolani's test / Barlow's test / Abduction test (>60-70°)

## Back: Entire spinal column and Anus

<2-3 months: supine position / otherwise in parents lap / **Remember growth charts**

# Developmental Milestones

Age (m)	Gross motor	Fine motor	Cogn. & Comm.
1-2	Lift head when prone	-	Smile in resp. to face/voice, visual preference for human face
2-3	Head steady in sitting	-	-
3-4	Lift head & chest w. ext. arms	Grasp rattle	Sustain contact, displeasure if soc. contact broken, "aah, ngah"
5-6	Roll over	Transfer objects hand to hand	Monosyllabic babble
6-7	Sit with support	-	Polysyllabic babble, vowel sounds, enjoys mirrors
7-8	Sit without support, crawl	Thumb-finger grasp	Suspicious/afraid of strangers
9-10	Pull to standing, walk holding furniture	Pincer grip, bang objects together	Play peek-a-boo, wave bye-bye, respond to own name
12-18	Walk alone	Turn pages in book, scribble, build 2-cube tower	Speak a few words
4 yrs.	Walk in a straight line, jump on one leg	Button clothes	Answer questions, understand prepositions

# Reflexes

Primitive	Postural
<b>Moro</b> Sudden extension of the head causes symmetrical extension, followed by flexion of the arms	<b>Labyrinthine rigthing</b> Head moves in opposite direction to which the body is tilted
<b>Grasp</b> Flexion of fingers when an object is placed in the palm	<b>Postural support</b> When held upright, legs take weight and may push up (bounce)
<b>Rooting</b> Head turns to the stimulus when touched near the mouth	<b>Lateral propping</b> In sitting, the arm extends on the side to which the child falls as a saving mechanism
<b>Stepping response</b> Stepping movements when held vertically and dorsum of feet touch a surface	<b>Parachute</b> When suspended face down, the arms extend as though to save themself
<b>Assym. tonic neck reflex</b> Lying supine, the infant adopts an outstretched arm to the side to which the head is turned	

*The primitive reflexes present at birth gradually disappear as postural reflexes develop, which are essential for independent sitting and walking*

- Pediatrics -

# Nutrition

## 0-4 months

Breast milk or formula

---

## 4-6 months

Breast milk or formula

Start to introduce small amounts of vegetables, cereals

---

## 6-8 months

Breast milk or formula or gruel or cereals

Complete meal (potatoes, meat, vegetables, fruit, berries)

Cow's milk can be used in cooking, but not as a beverage

---

## 8-12 months

Two cooked meals a day

From 10-12 months of age milk as a beverage

---

## 1-2 years

Regular food

No low-fat products and/or high-fibre foods

---

## Vitamin D supplement

5 drops every day (400 IE/day)

All children from 1 month up to at least 2 years of age

Low intake/sun exposure may need suppl. till school age

---

## Salt intake

No extra salt added to food for children below 1 year

---

## Food items *not suitable* for children below 1 year

Spinach, mangold, and beetroot – high levels of nitrate

Honey – may contain C. Botulinum spores



# Apgar score

Apgar Sign	2	1	0
<b>Heart Rate</b> Pulse	>100/min	>100/min	Absent
<b>Breathing</b> Rate and effort	Cries well	Irregular	Absent
<b>Grimace</b> Responsiveness or reflex irritability	Pulls away, sneezes, coughs, or cries with stimulation	Facial movement only with stimulation	Absent
<b>Activity</b> Muscle tone	Active, spontaneous movement	Arms and legs flexed with little movement	No movement, floppy tone
<b>Appearance</b> Skin colouration	Normal colour (also hands and feet are pink)	Normal colour (but hands and feet are bluish)	Bluish-grey or pale all over

This test is done to determine whether a newborn needs help breathing or is having heart trouble

## Normal Results: 7-10

10 is unusual, almost all newborns lose 1 point for blue hands and feet

## Abnormal results: 0-6

Signals that the baby needs medical attention

## Low Apgar score is often caused by:

Difficult birth, C-section, Fluid in the baby's airway

## A baby with a low Apgar score may need:

- Oxygen and clearing out the airway to help with breathing
- Physical stimulation to get the heart beating at a healthy rate

**Most of the time, a low score at 1 minute is near-normal by 5 minutes**

*A lower Apgar score does not mean a child will have serious or long-term health problems  
The Apgar score is not designed to predict the future health of the child*

# Vaccinations (Swe)

Age	Vaccination	Dose
<b>3 m</b>	Diphtheria, Tetanus, Pertussis, Polio, Hib, S. Pneumoniae	<b>I</b>
<b>5 m</b>	Diphtheria, Tetanus, Pertussis, Polio, Hib, S. Pneumoniae	<b>II</b>
<b>12 m</b>	Diphtheria, Tetanus, Pertussis, Polio, Hib, S. Pneumoniae	<b>III</b>
<b>18 m</b>	Measles, Mumps, Rubella	<b>I</b>
<b>5–6 y</b>	Diphtheria, Tetanus, Pertussis, Polio	<b>IV</b>
<b>6–8 y</b>	Measles, Mumps, Rubella	<b>II</b>
<b>10–12 y</b>	HPV (girls born 1999 or later)	<b>I,II,III</b>
<b>14–16 y</b>	Diphtheria, Tetanus, Pertussis	<b>V</b>
<b>Risk patients</b>	Hepatitis B x 3 Tuberculosis at 6 m	<b>-</b>

Children born before and during 2001 follow another schedule from 5–6 years of age

# Check-ups (Swe)

Age	Profession	Assessment/Action
<b>0-10 d</b>	Nurse	Home visit
<b>2-8 w</b>	Nurse	Growth assessment and counselling, once a week
<b>6-8 w</b>	Doctor, nurse	Psychomotor development
<b>3 m</b>	Nurse	Vaccination
<b>3-5 m</b>	Nurse	Growth assessment and counselling, every other week
<b>5 m</b>	Nurse	Vaccination
<b>6 m</b>	Doctor	Check-up
<b>6-12 m</b>	Nurse	Growth assessment and counselling, once a month
<b>10/12 m</b>	Doctor	Check-up
<b>12 m</b>	Nurse, dentist	Vaccination Dental health care information
<b>18 m</b>	Nurse	Vaccination
<b>3 y</b>	Nurse	Language development Child security information
<b>4 y</b>	Nurse	Vision, hearing, language, and psychomotor development Child security information
<b>5.5 y</b>	Doctor, nurse	Vaccination School assessment Child security information

# - Pharmacology - Addiction

	Drug	Half-life	Equivalent dose (mg)
Benzo. Equivalents	Oxazepam (Sobril)	Short	15.0 - 25.0
	Zopiklon / Zolpidem	Short / Short	7.5 / 10.0
	Nitrazepam (Mogadon)	Short	2.5
	Lorazepam (Temesta)	Short	1.0
	Flunitrazepam	Short	0.5
	Alprazolam (Xobril)	Short	0.25-0.5
	Triazolam (Halcion)	Short	0.25
	Diazepam (Stesolid)	Long	5.0
	Klonazepam (Iktorivil)	Long	0.25

## Principles for dose-lowering

Benzodiazepines	Change drug to equivalent dose of Oxazepam (Sobril)
	Split previous total daily dose into 5 evenly distributed doses over one day
	Decrease total daily dose by 10% per week
	Start by reducing the middle-of-the-day dose, leave morning/evening till last
	<b>Never increase the dose!</b> If there is an increase of withdrawal symptoms, stay on the current dose until the symptoms have stabilised
Opioids	Change drug to equivalent dose of Kodein (Citodon)
	Split previous total daily dose into 5 evenly distributed doses over one day
	Decrease total daily dose by 20% / week
	Start by reducing the middle-of-the-day dose, leave morning/evening till last
	<b>Never increase the dose!</b> If there is an increase of withdrawal symptoms, stay on the current dose until the symptoms have stabilised
	When only 4 pills left, terminate treatment

- Pharmacology -

- **Empty** -