NUGGETS

PEDIATRICS MEDICINE

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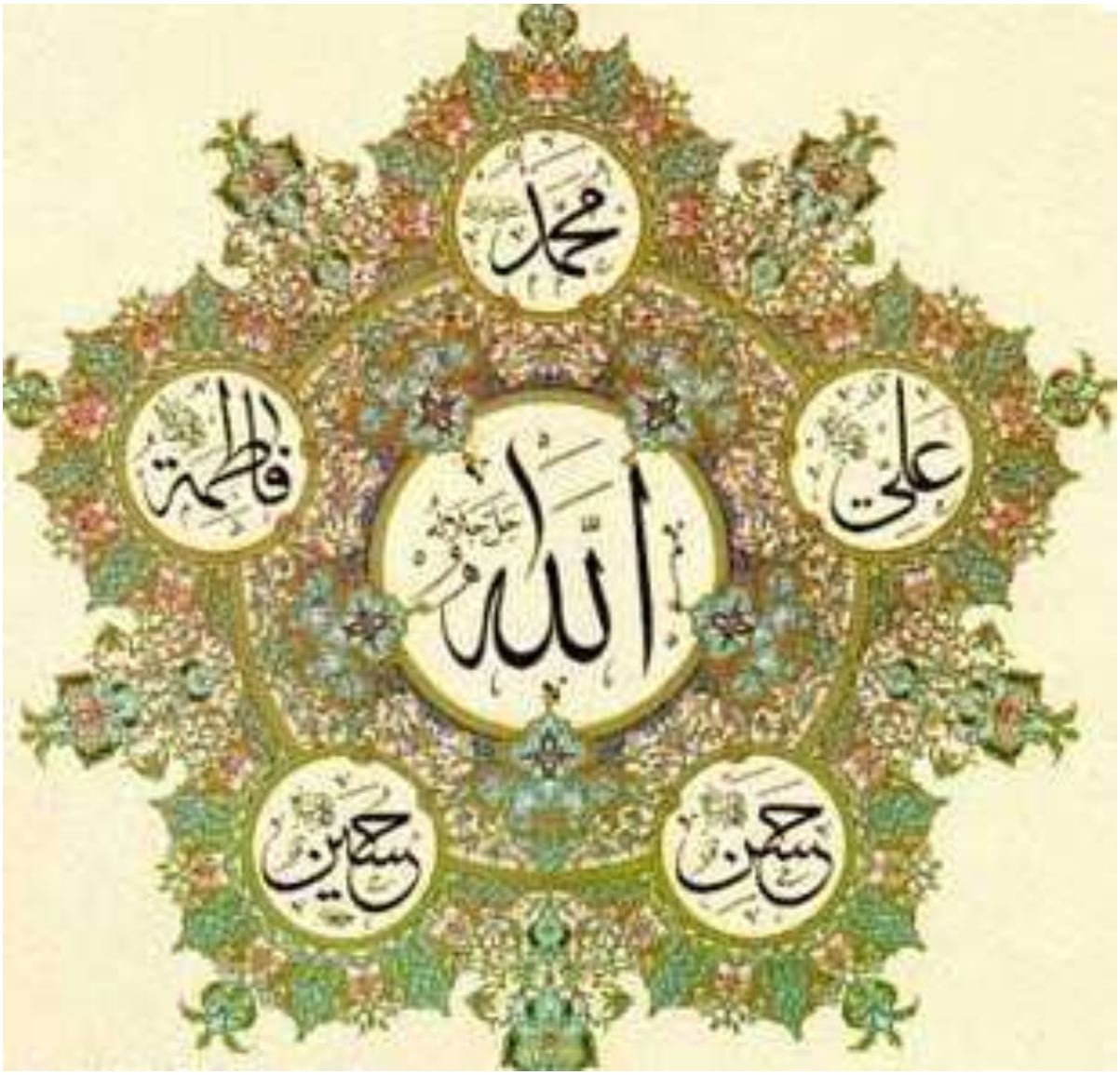
DEDICATED TO……



RICKETS NUGGETS.....

1) Most common cause of rickets is nutritional deficency of vitamin D..... Low Calcium----->High PTH----->Low Phosphate.... : <2 years.

2) Most common non-nutritional cause of rickets = VITAMIN D-RESISTANT RICKETS.... X-linked dominant.....Everything is normal but PHOSPHATE LEVEL IS VERY VERY VERY LOW..... >2 years

3) X-linked dominant diseases: xd rickets, incontentia pigmenti, fragile-x, charcot-marrie tooth disease, Rett disease

4) Spnie and teeth abnormalities are more prominent in VIT-D RESISTANT RICKETS; whereas head and thorax (rosary) deformities are more common in Nutritional rickets.....

5) Vitamin D-dependant rickets is AUTOSOMAL RECESSIVE disease having two types :

type-1 (Renal deficincy of 1-a-hydroxylase)

type-2: end organ resistance everywhere and increased 1-25 d3

6) VITAMIN D-RESISTANT RICKETS and Type-2 vitamin D dependant = both have end organ resistance but the difference is k VIT-D-R has resistance mostly in kidney leading to LOW PHOSPHATE while Type-2 vit.d.dpndt has resistance in

every part of body and it also leads to ALOPECIA. while vit-d-resistant leads to teeth and spine abnormalities (kyphosis, lordosis, scoliosis)

7) Best site to do X-RAY for findings of rickets is WRIST..... IN ACTIVE RICKETS: CUPPING, FRAYING, FLARING ; decreased bone density; ..... IN HEALING RICKETS: preparatory line of calcification, calcification of osteoid

8) For treatment of RICKETS..... give Inj Vit.D3 2 lac unit i/m..... after 2 weeks: do x-ray and see improvement : if no improvement....again repeat.... after that.. maintenance dose of 400 IU daily

9) If after 2 injections of vit-d there is no improvement = VIT-D RESISTANT RICKETS.....Rx by Oral PHOSPHATE SUPPLEMENTS and 1,25 vit-d3

10) Rosary (prominent costocondral junction) is also found in SCURVY as well..... but scurvy has other findings as well which are = PARAFOLLICULAR HEMORRHAGES; FROG POSITION OF LEGS and leg pain; ..... X-RAY: Ground glass, Pencil point cortex, White line of Ferenkel....."

INFECTIOUS DISEASES NUGGETS.....

1) Streptococcus pharyngitis can lead to both RHEUMATIC FEVER and GLOMERULONEPHRITIS but streptococcal skin infection only leads to GLOMERULONEPHRITIS not rheumatic fever

2) Pharyngitis leads to rheumatic/glomerulonephritis after 2-3 weeks of primary infection but after skin infection; glomerulonephritis happens after 3-6 weeks

3) In rheumatic fever; if JOINTS are involved = heart will be minimally involved but if heart is involved Chorea would be there..... remember: C=C (Carditis = chorea)..... but A not = C.... means arthritis not with chorea..... and remember: RHEUMATIC FEVER LICKS THE JOINTS; BUT BITES THE HEART..... so carditis is severe but arthritis is not severe..... in severe carditis = subcutaneous nodules would be there (on extensors , scapula and mastoid)

4) Signs of chorea (favorite question of Prof.Tariq Bhatti).... i) Milkmaid sign ii) Pronator drift iii) Darting tongue

5) Chorea = Rapid, jerky, involuntary purposless movement of proximal limbs...Treated by Haloperidol

Athetosis = Slow, writhing movements of distal limbs

6) In acute rheumatic fever = MITRAL REGURGITATION and AORTIC REGURGITATION..... MR = pansystolic murmur AR = early diastolic murmur.....

but sometimes due to EDEMA/Nodules of mitral valve; there happens functional mitral stenosis which gives MID-DIASTOLIC MURMUR known as CAREY COOMB MURMUR

7) Primary prophylaxis = Treatment of sore-throat by Benzathiane penicillin

2ndry prophylaxis = Prevent recurrence by continous prophylaxis

8) Acute diarrhea : < 2 weeks

Persistant diarrhea: > 2 weeks (infectious)

Chronic diarrhea: > 2weeks (Non-infectious)

9) Common causes of ACUTE BLOODY DIARRHEA in children = Food poisoning, Bacillary dysentry, Amebic dysentry....

10) Bacillary dysentry caused by shigella; Acute onset; Frequent stools; blood mixed with mucus; Very very very high fever (104) leading to dehydration and fits and CNS signs; pus cells in stools; confirmed by isolating organism on stool culture.....Rx: Ampicillin, TMP-SMX; cipro = 5 days + FLUID AND ORS

11) Amebic dysentry caused by E.histolytica; Subacute onset; Less and small frequent stools; Just blood in feces; Fever may or may not be; Mobile trophozites in stools; detect organism in stool culture also ELISA and IHA.....Rx: Metronidazole in 3 divided doses

12) As Shigella gives high grade fever ....leading to marked dehydration and CNS signs including fits and meningitis and TOXIC ENCEPHLOPATHY known as EKIRI SYNDROME.

Eg: scenario could be: A child comes with generalized tonic clonic fits..... high grade fever..... h/o blood and mucus in stools..... Dx: It is SHIGELLA /BACILARY DYSENTRY;..... never chose here amebic dysentry...

13) Most common cause of non-bloody diarrhea in chlidren is ROTAVIRUS..... other include: Cholera; Giardia...

14) Rotavirus leads to shedding of mucosal cells causing deficiency of dissaharides leading to LACTOSE INTOLERANCE= OSMOTIC DIARRHEA..

15) Diarrhea may be Osmotic or Secretoy.....

16) Osmotic diarrhea is more common; it stops when patient stops taking food; Calculated osmolarity of stools is > observed osmolarity..... Example include Rotavirus, lactose intolerance... acidic pH of stool

17) Secretory diarrhea is less common than osmotic; it does not stops when patient stops taking food ; calculated osmolarity of stools = observed osmolarity....example include CHOLERA..

18) Evaluate degree of dehydration by 6 signs (4 star signs and 2 non-star signs)

Star signs: Consicous level, Skin pinch, Sunken-ness of eyes, Drinking ability

Non-star: Eye dryness, Tongue dryness

If any ONE star sign is positive = categorize dehydration by that sign..... For example if skin pinch goes back very slowly >2sec = SEVERE DEHYDRATION.

19) Example: A child with diarrhea..... Sunken eyes, and skin pinch goes back very slowely..... How will u classify this dehydration?? SEVERE DEHYDRATION.....

20) Follow PLAN C for severe dehydration.....<1 year = slowly rehydrate (5 hours)..... >1 year = rapidly rehydrate (3 hours)

21) As ORS contains 20g glucose and 3.5 g NaCl..... it can itself cause OSMOTIC DIARRHEA..... so to prevent its this side effect a new formulation is there = LOW OSMOLARITY O.R.S .....contains 13g Glucose and 2.7 gram NaCl (Favourtie question of DR.JUNAID)

22) Zinc is very important in treatment of DIARRHEA.....IMPORTANT: ZINC DEFICIENCY LEADS TO ACRODERMATITIS ENTEROPATHICA

23) Mumps causes painful enlargment of parotid glands; redness and swelling of stenson ducts; causes edema of soft palate, larynx and even UPPER CHEST..... Dx by Lymphocytosis, Inc . Amylase, IgM and IgG.... Complications include MENINGIOENCEPHLITIS, EPIDIDYMO-ORCHITIS, PANCREATITIS, DEAFNESS.....

Meningitis can occur along with parotitis or after 10 days of parotitis.... ORCHITIS is seen in POST-PUBERTAL MALES not pre-pubertal.....

If mumps to fetus in intra-uterine life = leads to SUBENDOCARDIAL FIBROELASTOSIS

24) In measels ....

i) Prodromal phase = 3C(Cough, croyza, conjunctivitis) Koplik spots.

ii) Eruptive phase: Maculopapular confluent rash from ear downwards,

Complications: Giant cell pneumonia, otitis media, diarrhea, encephlitis, SSPE, Hemorrhagic meseals, Thrombocytopenia, Cancrum oris, Corneal ulcer, Myocarditis., VITAMIN A DEFICENCY

25) As measels lead to VITAMIN A DEFICENCY = So give vitamin A to measel patient to decrease morbidity and mortality

26) When rash of measels appear = fever rises abruptly, rash desends rapidly within 2-3 days and fades rapidly in same sequence as it appeared..... and severity of rash depends upon CONFLUCENCE OF RASH....rash is itching..... if severe measels = DISFIGURED AND SWOLLEN FACE.....

27) Measels vaccine given SUB.CUTANEOUSLY.....Contraindications: ANaphylactic reaction to NEOMYCIN/ GELATIN; Immunodeficency..... S/E: Morbiliform rash, febrile fits, encephlitis

28) Polio can occur as

i) Asymptomatic (95%)

ii) Abortive (febrile, sore throat)

iii) Non-paralytic ASEPTIC MENINGITIS...

iv) Paralytic (Assymetric paralysis).... Spinal , bulbur, Encephlitic

Confirmatory test for POLIO = STOOL CULTURE... 2 sample ; 24 hour apart....

29) A 3 year old unvaccinated child with febrile illness and lower motor neuron signs of lower limbs.....D/D.....gullian barrie, Paralytic polio....

30) An unvaccinated child with meningitis = D/D = Tuberculous meningitis ; Non-paralytic polio, H.Influenza

31) Infectious diseases especially ROSEOLA INFANTUM can lead to FEBRILE FITS.....

32) Febrile fits = Seizure +fever + No CNS infection

33) Febrile fits may be TYPICAL or ATYPICAL...sometimes family history is positive

34) Typical: >12 months of age; generalized tonic clonic; <10 mins; Brief/no post-ictal period; once/24 hours; no focal findings; normal CSF exam

35) Atypical: <12 months of age; focal seizure; >10 mins; Prolonged post-ictal; >1/24 hours; focal findings may be there....

36) Atypical febrile fits can transform into EPILEPSY in later life....the other risk factors for epilepsy in a patient with febrile fits include..... i) Some

neurological disease (cerebral palsy, mental retardation)..... ii) Family history of epilepsy... iii) <1 year seizure

37) When to do L.P in a patient of febrile fits? ATYPICAL febrile fits.. or IF SLOW RECOVERY, PUO, FOLLLOW UP NOT POSSIBLE.....

38) Mangemtn of febrile fits..... ABC, Tempreature regulation, seizure control by diazepam, cause of fever, ...

39) Childhood exanthems....

i) 1st disease = measels (rubeola)

ii) 2nd disease = Scarlet fever

iii) 3rd disease = Rubella (germen measels)

iv) 5th disease = Erythema infectiousm (parvoB19) = Slapped cheek rash

v) 6th disease = Roseola infantum.....Leads to febrile fits

40) A child with fever, hoarsness, barking cough = LARYNGOTRACHEOBRONCHITIS/CRUOP..... caused by PARAINFLUENZA VIRUS....

41) <2 years child with WHEEZE, DYSPNEA, COUGH = Bronchiolitis= most common cause RESPIRATORY SYNCYTIAL VIRUS .....other ADENOVIRUS, PARAINFLUENZa

42) There are just 2 contraindications of PERTUSSIS VACCINE:

i) Anaphylactic reaction to previous dose of vaccine

ii) Encephlopathy within 7 days of previous dose manifesting as gen/focal seizure without recovery within 24 hours.....NOte : FAMILY history of any thing is not contraindication...

NUTRITION NUGGETS.....

1) Daily requirement of Vitamin A = 400ug (1500 IU)..... Deficency causes Eye abnormalities and skin abnormalities..... Eye signs appear when serum retinal <0.35mol/L.....Vitamin A deficency also leads to Iron deficency anemia.....Rx of def:

>1 year: 2 lac IU single dose

6-12 months: 1 lac IU single dose

<6 months = no need but if measels = give 50 thousand IU

2) Vitamin E (tocopherol) is found in green leafy vegetables.... it is antioxidant.... Deficency causes MUSCLE BREAKDOWN & PROXIMAL MYOPATHY; Creatinuria; Premature hemolytic anemia; Increased platelets; anemia in Kwashikor.....Excessive iron administration exxagerates signs and symptoms of vit.E deficency

3) Vitamin C causes increased absorption of IRON whereas Increased Iron exaggerates signs and symptoms of VIT.E toxicity

4) Vitamin K1 = naturally occuring..... K2= formed by intestinal bacteria..... deficency causes hemorrhagic disease of newborn; rise in PT ..... PT is corrected after injection of vit.K witin 24 hours.....All Infants should be given vit.K 1mg I/M within 2 hours of birth.. it is given to infant b/c:

i) Low transport of vit.K across placenta

ii) Bacterial colonization of gut in infant occurs gradually

iii) Protein synthesis has not yet reached full capacity

5) Vitamin K in breast milk is 3 TIMES less as compared to COW milk..... but the absorption of Vitamin K from breast milk is higher..... Similarly Sodium, P, Ca are less in breast milk than cow but absorption is effective

6) IgA in breast milk provides passive immunity to baby and protect from gastroenteritis, otitis-media and PNEUMONIA....

7) Breast milk has greater vitamin D, C as compared to cow milk.. but still infants exclusively breast fed can develop vitamin D deficency b/c quantitatively vitamin D is deficient in breast milk... so proper sun exposure and prophylactic vitamin D should be given to exclusively breast fed children...

8) If an Infant is on goat's milk = always give FOLIC ACID supplement.

9) Only absoulte contra-indications of breastfeeding are PHENYLKETONURIA and GALACTOSEMIA

10) Calories, water and fat content is same in breast and cow milk

11) Breast milk has less protein than cow milk but main protein is WHEY...

12) Cow milk has more protein thant breast milk but main protien is CAESIN...

Remember WOMEN = WHEY..... COW = CAESIN

13) Daily requirement of vitamin D = 400 IU (10ug)

14) Daily protein requirement for adult/ school going child = 1g/kg/day and the daily requirement of calcium = 1 g / day...

15) Weight for age = Gomez classification

Height and weight = Waterlow classification

Weight for age + Edema = Welcome classification

Midarm circumference = Cut off <75%

Quac teest

16) Hair and skin changes are found in KWASHIKOR and Flaky paint dermatitis is characterstic skin finding

17) A child 1 years of age with weight 5 kg and edema = Marasmo-kwashikor

18) A child 1 years of age with weight 8 kg and edema = Kwashikor

19) A child 1 year of age with weight 8 kg but no edema = Pondreal retardtion

20) A child 1 year of age with weight 5 kg but no edema = Marasmus

21) Normal weight at birth = 2.5 kg

6 months = 5 kg

1 year = 10 kg

2 year = 12 kg

3 year = 14 kg

22) Head circumference at birth = 35 cm

3 month = 41cm

6 month = 44cm (MCQ IMP)

9 month= 46cm

1 year = 47 cm

2 year = 49 cm

3 year = 51 cm

23) A child comes with short stature = do wrist X-RAY.....

i) If bone age = chronological age : Familial short starue, IUGR, turner, skeletal dysplasia, chromosomal abnormalities

ii) If bone age < chronological age : Constitutinal short stature, Endocrine problems (Hypothyroid, hypercortisol, GH deficney, chronic diseses)

iii) If bone age > chronological age: Obesity, precociuos puberty, CAH, hyperthyroid

RHEUMATOLOGY NUGGETS...

1) Morning stiffness and gradual loss of motion leading to limp in child persisting for 6 weeks = Juvenile Rheumatoid Arthritis....

2) Oligoarticular JRA = <5 joints involved; No systemic manifestations; no rash; no polyserositis; no lymph nodes; ANA STRONGLY POSITIVE; RF negative; STRONG EVIDENCE OF UVEITIS (20%); Excellent prognosis.....Rx: give NSAID 4-6 wk + I.A steroids..... Repeat I.A steroids..... if not..... Oral methotrexate

3) Polyarticular JRA = >5 joints involved; No systemic manifestations; No polyserositis; no lymph nodes; ANA positive; RF POSITIVE; uveitis positive 5%; prognosis 50%.....NSAID +IA STEROIDS..... Oral methotrexate..... Subcutaneous methotrexate

4) Systemic onset JRA (still disease)= Any joint involved; Systemic manifestations common FEVER + SKIN RASH (sALMON PINK); Polyserositis present; Lymphadenopathy/Hepatospleno present; ANA NEGATIVE; RF negative; uveitis positive 5% ; prognosis is variable

5) Note: i) UVEITIS AND ANA ARE STRONGLY POSITIVE IN OLIGOARTICULAR JRA

ii) RF is only positive is POLYARTICULAR

iii) JRA causes PERICARDITIS while Rheumatic fever causes PANCARDITIS

6) Investigations to be done for JRA:

CBC, ESR, RF, ANA, Slit lamp examination for uveitis, XRAY , MRI

7) Diagnostic criteria of KAWASAKI disease: (Temperature 5 days + 4/5 other features)

My HEART

i) Mucosal involvement (craked lips, strawberry tongue, injected pharynx)

ii) Hand and feet (edema, desquemation, redness)

iii) Eyes involvemnt (non purulent bilateral conjunctivitis)

iv) Adenopathy (unilateral cervical lymphadenopathy)

v) Rash (polymorphous truncul scarlet fever like rash)

vi) Temperature 5 days

Treat with high dose IVIG and aspirin.....Complications: CORONARY ARTERY ANEURYSM and CORONARY ARTERY VASCULITIS leading to m.i

8) Child with coliky abdominal pain; bloody diarrhea; joint pain; palpable purpura; rash on legs and buttocks after respiratory infection = HENOCH SCHLOEIN PURPURA..... Other features: intussusception, cutanous nodules, edema of forehead, spine, genitalia, feet, large joints arthritis, testicular torsion.....Increased ESR and IgA..... skin biopsy shows LEUKOERHTYROCLASTIC VASCULITIS WITH IGA AND C3..... Complications include INTUSSUSCEPTON, TESTICULAR TORSION, GLOMERULONEPHRITIS.....Rx supprotive."

CVS NUGGETS.....

1) Congenital CYANOTIC HEART DISEAES = Rule of T's = TOF, TGA, TAPVR, Tricuspid atresia, Truncus arteriosis, Ebstein anamoly

2) ACYANOTIC HEART DISEASE= 3 letter abbreviation except T..... VSD, ASD, PDA, COA.....

3) Most common cyanotic heart disease at birth = TGA....Diabetic mother & Di-george syndrome are risk factor.....Cardiomegaly and Egg on side apperaence on X-RAY; Increased vascular markings on lungs; Palliative shunt is RASHKIND; Corrective surgery at 2weeks by TOTAL REPAIR BY ARTERIAL SWITCH TECHNIQUE...

Conservative management of TGA is TGA = Temperature regulation, Glucose maintenance, Acidosis correction..... moreover treat CCF and give PGE1 to keep ductus arteriosis open at birth....

4) Most common cyanotic heart disease with onset 3 months = TOF..... No cardiomegaly but BOOT SHAPE HEART on X-RAY; reduced vascular markings on lungs (Oligemic lung fields); Palliative shunt is BLALOCK-TAUSSAIG; corrective surgery done at 3month - 2year.....

COnservative management include = Nutrition, iron, hydration, vaccination, beta blockers

coMPLICATIONS OF TOF: Infective edno, CCF, Brain abscess, Stroke, Tet spell

5) In babies with TOF = Tet spell is problem within 1st 2 years : Stress leads to Infundibular spasm----> worsening of cyanosis--->metabolic acidosis---->shock.....

Note: in tet spell = murmur may disappear on auscultation.....

Rx of spell = Hospitalization, Squatting position (knee chest); Oxygen; Morphine ; Bicarbonate; Beta-blocker (0.1mg/kg), IV fluids, phenylephrine

6) Rapidly Signs of heart failure in child with PULSE >200-250 = Supraventricular Tachycardia = Most common cause in child: WPW syndrome..... Treat SVT by carotid massage and valsalva ; immerse face in cold water; ..... I/v adenosine

Long term SVT leads to heart failure and hepatomegaly; while SVT during fetal life leads to HYDROPS FETALIS

7) Rapidly Signs of heart failure in child with PULSE <200 = Myocarditis = most common cause COXAKIE B virus.....Treat heart failure and Heart transplant if fail

8) Quaduple rhythm on ECG with murmur of T.R; Right atrial hypertrophy; History in mother of Lithium use = EBSTEIN ANOMOLY

9) Newborn with signs and symptoms of heart failure and MACHINERY MURMUR on left sternal border below clavicle ; radiating to back = PATENT DUCTUS ARTERIOSIS..... Bounding pulse and wide pulse pressure.....Risk factors are FEMALE SEX, PREMATURITY, MATERNnal RUBELLA..... Dx by Echo.....Rx : Indomethacin, Rx heart failure, Surgery : <1 year Ligation and division..... >1 year=Coil closure via cardiac catheter

10) D/D of machinery murmur : PDA, A-V fistula, Ruptured sinus of valsalva, A-P window

11) Child with pansystolic murmur , wide splitting.... and signs of heart failure = VSD..... If VSD is large: loud diastolic murmur..... it is most common congenital heart disese..... Rx heart failure ..... do surgery if resistant...

Most VSD close spontaneously"

NEONATOLOGY NUGGETS.....

1) Perinatal mortality : from 28 weeks to 7 days after birth = 60/1000

2) Neonatal mortality = 44/1000

3) IMR: 95 / 1000

4) Small for date: Weight <10 percentile of gestational age...IUGR is predisposing

5) Care of newborn: CEASR-BB-2.5

i) Care of cord

ii) Eye care

iii) Abnormalities detection

iv) APGAR score

v) Skin care

vi) Resucitation

vii) Breast feeding within an hour

viii) Body temperature regulation

ix) 2.5kg birth weight

6) Perinatal asphyxia leads to HYPOXIC ISCHEMIC ENCEPHLOPATHY..... leads to..... CEREBRAL PALSY

7) Newborn can never have generalized tonic clonic seizure

8) Most common cause of respiratory distress in newborn = TRANSIENT TACHYPNEA OF NEWBORN.... found in term infants esp those with c-section... Chest X-ray = hyperexpansion of lungs; good air entry on auscultation; minimal or no cyanosis; ABG almost normal

9) Child with respiratory distress and tachypnea ; chest retraction and cyanosis= Respiratory distress syndrome.... Prematurity is risk factor..... Chest-XRAY... 3 stages

Stage 1 = Reticulonodular densities

Stage 2 = Air bronchograms

Stage 3 = ground glass appearence

Rx with warm oxygen, CPAP, IPPV, surfactant replacement therapy

10) Premature baby with bloody stool after feed; abdominal distention; X-RAY= pneumatosis intestinalis = NECROTIZING ENTEROCOLITIS (Transmural intestinal necrosis) = Rx: NG, cessation of food..... Resection of necrotic segment

11) Early onset sepsis <7 days ..... mostly caused by maternal factors: GBS, LISTERIA, E.COLI

12) Late onset sepsis >7 days ..... mostly caused by environmental factors: coagulase -ve staph, klebsilla

13) Jaundice appearing on 2nd day of life and subsiding within a week; daily rise of bilirubin <5mg/dl/day; peak bilirubin upto 12mg/dl = PHYSIOLOGIC JAUNDICE... due to immaturity in Conjugation enzyme in liver..... If physiologic jaundice is prolonged..... think abt CONGENITAL HYPOTHYROIDISM and DOWN SYNDROME

14) Jaundice appearing on 1st day of life; daily rise of bilirubin >5mg/dl/day; peak bilirubin >12mg/dl = PATHOLOGICAL UNCONJUGATED HYPERBILIRUBINEMIA..... many causes:

i) COOMB POSITIVE = Rh/ABO, Thalasemia minor

ii) COOMB NEGATIVE = Polycythemia, hemolytic anemias, breast milk jaundice.

15) Breast milk jaundice is UNCONJUGATED HYPERBILIRUBENIMA but it appears in 2ND WEEK OF LIFE..... CAUSE: breast milk has Glucuronidase, pregnanediol, FFA, steroids.....Stop breast milk and give formula for 1-2 days.....restart breast milk

16) If bilirubin 5mg/dl, baby low birth weight, Hemolytic disease of newborn = Start PHOTOTHERAPY

17) If at birth: Bili=>5mg/dl, hemoglobin <12g/dl, Coomb+ve, Retic>10% = Start EXCHANGE TRANSUSION

18) If within 1st week: Bili>20mg/dl, progressive anemia, family history of kernictures, failure of phototherapy, = start EXCHANGE TRANSFUSION

19) in PHOTOTHERAPY= Blue visible light (425-475 nm is used)..... U.V is not used..... Blue light causes conversion of BILIRUBIN into LUMIRUBIN (remember Lumbi Rabia)

20) Complications of phototherapy = Loose stool, Macular rash, hyperthermia, dehydration, Bronze baby syndrome, Masking of cyanosis

21) Newborn with SCAPHOID ABDOMEN and tachypnea; auscultation reveals diminished breath sounds and bowel sounds in left chest= CONGENITAL DIAPHRAGMATIC HERNIA = cause: b.c of failure of fusion of FORAMEN OF BOCHDALEK.....Rx: Pass NG, low pressure ventilation..... DO NEVER USE AMBO-BAG..... Prognosis depends upon degree of pulmonary hypoplasia

22) Newborn who fails to pass stool after birth; no anal opening visible = IMPERFORATE ANUS.....Dx by INVERTOGRAM..... Rx by surgical repair/defunctioning colostomy

LIVE LIKE MUHAMMAD (S.A.W.W) & ALI (A.S)

DIE LIKE HUSSAIN (A.S)

☺ STAY BLESSED ☺