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QUESTION 1

In January, you see an 18-month-old boy in the middle of the night in the pediatric emergency department. The father relates that 1 hour ago his son started coughing. The father describes the cough as barking ("seal" like). The child has mild stridor at rest, but otherwise is not in respiratory distress. His RR is 45 breaths per minute. He has a temperature of 103.4°F .

What is the most likely diagnosis?

A. epiglottitis

B. croup

C. pneumonia

D. sinusitis

E. bronchiolitis

Correct Answer: B Section: (none)

Explanation: This case is a common presentation for viral croup, with the symptoms of a seal-barking cough, stridor, tachypnea, and fever in the winter. Pneumonia must also be considered with tachypnea, cough, and fever, but it is less likely to cause stridor and may not have the seal-bark type of cough. Sinusitis may cause cough and fever, but would be more likely to have a purulent nasal discharge and less likely to have the typical croupy cough. Bronchiolitis due to RSV is a common cause of wintertime cough and fever. It is less likely to have stridor and more likely to have wheezing. Children with epiglottitis are typically found in the "tripod position" and may be drooling. It is, fortunately, becoming rare with the widespread use of the H. influenzae vaccine. Parainfluenza types 1 and 2 account for 6070% of all viral croup. HIB was a common cause of epiglottitis, but is now rare because of widespread vaccinations. Influenza B and RSV can cause croup, but not as commonly as parainfluenza types 1 and 2. S. pneumoniae would be the most common bacterial cause of pneumonia or sinusitis. (American Academy of Pediatrics, 2003, pp. 454455) The steeple sign is subglottic narrowing of the trachea seen on an AP view of the trachea or a CXR. The trachea is seen to narrow, almost to a point, like the steeple of a church. Swollen adenoids are difficult to identify in lateral neck x-rays. The presence of swollen adenoids is unrelated to the airway narrowing seen in croup. The thumb sign is a swollen epiglottis seen with epiglottitis. Alobar pulmonary infiltrate may be seen with a typical bacterial pneumonia.

QUESTION 2

A74-year-old male with a history of hypertension, CAD, and a 50 pack-year history of smoking presents with complaints of pain and cramping sensation of the thigh and buttock areas for the past 2 months. On detailed history, patient reports that the pain is usually during ambulation and relieves with sitting down. The pain does not change with respect to sitting or supine position. He denies any recent trauma, weakness of the legs, or paresthesias. He takes his prescription medications regularly and denies using alcohol, drugs, or any herbs/ supplements. Which of the following should be performed as an initial test to help confirm your clinical impression?

A. ankle-brachial index (ABI)

B. x-ray of the lumbar spine

C. electromyelography and nerve conduction studies of the lower extremities

D. lower extremity venous ultrasound with Dopplers

E. angiography of the aorta and lower extremities

Correct Answer: A Section: (none)

Explanation: Peripheral arterial disease (PAD) affects roughly 12% of the U.S. population with higher prevalence rates in persons over the age of 70. The classic symptoms of PAD are intermittent claudication which is usually described by patients as cramping pain in the calf, legs, thighs, or buttocks during any type of exercise that quickly relieves with rest. This scenario of worsening with activity and relief with rest is consistent with the disease process, as the pain results from ischemia. The ischemia is worse during periods of increased oxygen demand where the vascular insufficiency fails to meet the demand. Not all patients with PAD are symptomatic, thus an assessment of risk factors and a thorough physical examination are usually key to making the diagnosis in asymptomatic patients. The ABI is an easy, inexpensive, noninvasive test with a high correlation to angiography that can be done in the office. ABI is the usual initial test to screen for PAD.

TABLE 1-2 CLASSIFICATION OF ASTHMA SEVERITY

Classification	Days with symptoms	Nights with symptoms	PEF or FEV_1 (PEF is % of personal best; FEV_1 is % of predicted)	PEF variability	Treatment
Severe persistent	Continual	Frequent	≤60%	>30%	Preferred: high dose inhaled steroid and long-acting beta agonist AND, if needed, corticosteroid tablets or syrup
Moderate persistent	Daily	≥5/month	>60–<80%	>30%	Preferred: low-to-medium dose inhaled steroid and long-acting beta agonist Alternative: increase inhaled steroid within medium dose range OR low-to-medium dose inhaled steroid and leukotriene modifier or theophylline If needed (particularly in patients with recurring severe exacerbations): Preferred: increase inhaled steroid within medium dose range and long-acting beta agonist Alternative: increase inhaled steroid within medium dose range and add leukotrienemodifier or theophylline
Mild persistent	3–6/ week	3–4/month	≥80%	20–30%	Preferred: low dose inhaled steroid Alternative: cromolyn, nedocromil, leukotriene modifier, or theophylline
Mild intermittent	≤2/week	≤2/month	≥80%	<20%	No daily medication needed severe exacerbations may occur, separated by long periods of normal function and no symptoms. A course of systemic corticosteroids is recommended

All patients: Short-acting bronchodilator as needed for symptoms
Source: (Reproduced from) Practical Guide for the Diagnosis and Management of Asthma, NIH: National Heart, Lung and Blood Institute, 1997; NAEPP Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma–Update on Selected Topics, 2002; NIH: National Heart, Lung and Blood Institute, 2002.

A value of greater than 1.0 is considered normal, whereas values less than 0.9 are consistent with varying grades of PAD: · 1.0 or greater: normal · 0.810.9: mild PAD · 0.510.8: moderate PAD ·