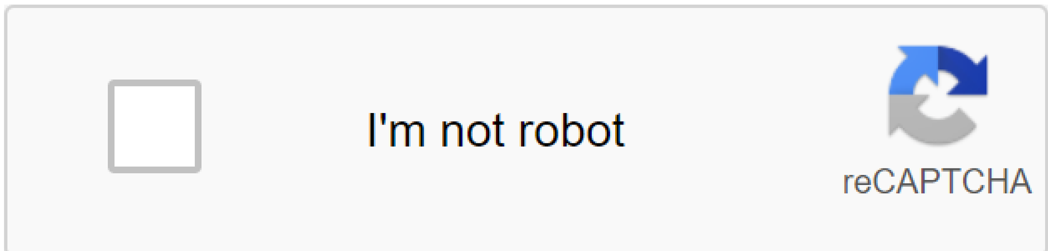
The unofficial guide to pediatrics pdf



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The Unofficial Guide to Pediatrics is the latest addition to the bestselling Unofficial Guide to Medicine series. Like its predecessors, this book was written in collaboration with medical students and junior doctors, with ideas from experts in the field. The book is divided into 4 sections covering the main topics, clinical cases, clinical skills and the career section, to become a pediatrician. The main themes cover the basic knowledge needed to understand before dealing with clinical cases in a brief, easy-to-understand way. From renal medicine to genetics and ethical issues in pediatrics, this book covers a broad base in great detail and thus achieved what most revision textbooks are often unable to do. Most chapters can easily be covered in less than an hour, making for perfect reading on the commute or before the rounds arrive. With cases organized in order of complexity, it is easy to progress through the book and feel like you have finally mastered the usually wrong topic. Written in MC style, this section has proven useful for revision, especially with important learning points noted in the explanation. The only downside to this section was the limited number he suggested-seeing as students are always on the hunt for more questions! The Clinical Skills Section, similar to the unofficial guide to practical book skills, contains a plethora of high-quality images that provide a step-by-step guide to what may initially seem like a complex procedure, including cannulas, catheters and LPs. There is also a section on communication skills with a couple of cases and patient notes, as well as a beautifully put together exams section with summary relevant information next to images of each step. The final section of Becoming a Pediatrician decides career options and how to get ahead in a career in pediatrics, including information regarding the application process, exams and sub-specialties. Seeing, as Dr. Seshan qureshi, a renowned pediatrician is the editor-in-chief of this book, this section is worth reading for any novice pediatricians out there! The style of layout and writing remains cohesive and methodical

throughout, with tables and diagrams providing a useful summary of the text. The Skin Condition section has some excellent illustrations, often more than one of a similar condition laid side by side for comparison. An informal guide to pediatrics is the perfect choice for a brief summary of key concepts for undergraduate exams. While it needs to be supplemented, it offers a solid foundation for complex concepts you could struggle with, and are thus highly recommended. Enter the following discount code: Discount8107 to get a 25% discount when used on Unofficial Guide to Pediatrics is unique what it is a tutorial that covers basic subject resumes, exam practice, practical skills, career opportunities and clinical cases all in one place. It makes it through 1,000 color images and illustrations, 200 multiple choice questions, and 60 real-life clinical cases to bring pediatrics to life. The authors range from pediatric professors, medical students, teachers, nurses and midwives, meaning the book has an impact from a truly interdisciplinary team at all stages of training. This book is relevant for exams, for postgraduate further education and as day-to-day links for professionals. With active cooperation with well-known scientists and experts, the content is reliable and based on the most famous evidence. This app-book by zeshan qureshi, An Unofficial Guide to Pediatrics, improves performance with relevant, valid material that you can access quickly and with minimal effort in the palm of your hand using the patented Indextra technology. THIS APP-BOOK includes unique features such as: powerful bookmark search Full set of medical calculators; Body mass index, Peak expiring streams, dehydration correction calculator and more emphasizing high resolution photography History Notes and Pictures notes about this title: Almost every doctor will encounter children in their career; of course, this does not apply to paediatricians, and in primary health care about 25 per cent of counselling concerns children. Many other specialties cover pediatric patients - including general surgery, ENT and emergency medicine. Therefore, it is extremely important that all medical students and junior doctors have a basic basis in the basics of pediatrics. The informal guide to pediatrics is unique in that it is the only text that covers the basic resume of the subject, exam practice, practical skills, career opportunities and clinical cases all in one place. It does this through 1,000 color images and illustrations, 200 multiple selection questions, and 60 real-life clinical cases to bring pediatrics to life. Contributors range from professors to pediatrics, through medical students, teachers, nurses, midwives - meaning that the book has an impact from a truly interdisciplinary team at all stages of training. This book is primarily aimed at medical students, its 24 fully illustrated chapters covering a wide range of general and important childhood pathologies (according to the National Royal College of Pediatrics and Children's Health Baccalaureate Curriculum). Each disease uses a common framework: definition, etiology and clinical features, and progresses through research, differential diagnoses, management, complications, and, Forecast. A unique collection of basic clinical content, practical skills, clinical cases and examination skills is no less valuable for junior doctors and Interns. Nurses, advanced nurse practitioners, fellow doctors and related health care providers will also find content and approach useful as day-to-day links. Editor-in-chief: IsBN 978-0957149953 Text, Design and Illustration by © zeshan Kureshi 2017 Edited by zeshan Kureshi. Published by zeshan qureshi. First published in 2017. All rights are reserved; no part of this publication can be reproduced, stored in the search system, transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior written permission from publishers. Original design by Ann Bonson-Johnson and zeshan Kureshi. Makeup page from Amnet systems. Illustrated by Anchorprint Group Limited. Clinical photography by Stephen Kenny, Medical Photographer, Lewisham and Greenwich NHS Trust - 3.2 and 3.4. 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I would like to thank my colleagues, mentors, friends and, above all, my parents for their unwavering support over the years, without which all this would have been impossible. I have been inspired and trained by pediatricians over the years, all of whom cannot be named, but especially Ewen Johnston, Julie-Claire Becher, Jason Gane, Shahid Karim, Ella Aidoo, Sakonidou, Grant Mare, Mare, Hunt, Chris Harris, Simon Keaton, Kamal Ali, Terrence Stevenson and Ildilko Schuller. Although we tried to track and contact the rights holders prior to publication, in some cases this may not have been possible. If we contact, we will be happy to correct any errors or omissions at the earliest opportunity. Knowledge and best practices in this area are constantly changing. As new research and experience expands our understanding, changes in research methods, professional practice, or medical treatment may become necessary. Practitioners and researchers should always rely on their own experience and knowledge to evaluate and use any information, techniques, compounds or experiments described in the present. When using such information or methods, they should be mindful of their own safety and that of others, including those for whom they are professionally responsible. With regard to any identified medicines or pharmaceuticals, readers are advised to check the most up-to-date information provided - (i) about the procedures featured or (ii) by the manufacturer of each product that will be administered to check the recommended dose or formula, method and duration of administration, and contraindications. Practitioners, based on their patients' own experience and knowledge, should diagnose, determine dosages and best treatment for each individual patient, and take all appropriate precautions. To the full extent of the law, neither the publisher, the authors, the authors nor the editors nor the editors will take any responsibility for any damage and/or damage to persons or property that may result from the actions of a person or not on the basis of the information contained in this book. Printed and associated Cambrian Seals in the UK Introduction It was a privilege to work with so many pediatricians, and serve as part of the great teams that provide the excellent care that every child deserves. Although my career today is associated with difficult situations, I have always been able to team up with colleagues and parents around the fact that above all, the welfare of the child should not be compromised. It has been a privilege to work with so many pediatricians, and serve as part of the great teams that provide the excellent help that every child deserves. Although my career today is associated with difficult situations, I have always been able to team up with colleagues and parents around the fact that above all, the welfare of the child should not be compromised. Editing this book, and working closely with my professional colleagues really got me thinking about what the true definition of a pediatrician can be. I'm on a pediatric training program, but don't think it's necessary to be a pediatrician. I am honored to say that I passed the mrCPCH membership membership but then again don't think it's necessary to be a pediatrician. Now I'm happy to say that I edited a pediatrics textbook. But that doesn't qualify me as a pediatrician. So what is the essence of this profession? Who can be a pediatrician, in the true spirit of the word? And who should decide? In my humble opinion, it all comes down to one simple litmus test. Can you do what is necessary, within your knowledge, to be a lawyer for a potentially sick child? Are you willing to do your best to communicate with your child and family to determine what their possible problems are, and to tease any appropriate pathology? If something goes wrong, or are you unhappy with something that is being done with regard to child care, regardless of any contextual factors, will you speak on behalf of the child? There is no substitute for clinical experience. Reading this book will inform you about pediatrics. But for me the most important thing in pediatrics comes down to child care, and when it comes to that there should be no hierarchy: be tactful, use appropriate channels, but never hesitate to say when you're worried that patient care is being compromised, no matter who it might offend. Anyone can be a pediatrician. Medical student on pediatric rotation; The student will often use the opportunity to spend more time listening to the patient then any medical professional that day, and I am always grateful when a student comes up to me relaying a patient's valuable problem and diagnostic information: they are a pediatrician. A primary care physician who follows the child from the womb to adulthood: they are a pediatrician. Their knowledge of family and child throughout their life is necessary to determine when something can go wrong in advance. Scientists who improve the evidence on what kind of help can be delivered: they are pediatricians. Leaders and politicians who turn ideas into reality: they are pediatricians. And an emergency medicine doctor who sees a frightened parent and a sick child for the first time, ENT surgeon, orthopedic surgeon, pediatric surgeon, geneticist, immunologist, physiotherapist, art therapist, game specialist, nurse, nutritionist, pharmacist, social worker, teacher, police, every specialist, every person, every lawyer who helps identify and solve the problems and potential problems of the child : They are all pediatricians. '... The most important thing in pediatrics comes down to child care, and when it comes down to this there should be a hierarchy I owe to all their guidance and care, helping me provide childcare that I can't fully provide on my own. It's up to you to decide what the pediatrician is. But in my humble opinion, you can be a pediatrician today. We want you to be the Editor-in-Chief of the Unofficial Guide to Pediatrics Unofficial Guide to Medicine Project Also, we want you to participate. This tutorial was mostly written by junior doctors and students like you, because we believe: ... that fresh graduates have a unique perspective on what works for students. We have tried to capture the understanding of students and recent graduates to make the language we use to discuss this complex material more digestible for students. ... that the texts are in constant need of updates. Each student has the potential to contribute to the education of other innovative ways of thinking and learning. This book is an open collaboration with you. You have the power to contribute something valuable to medicine; We welcome your suggestions and would like you to get in touch. Please contact us and take part in the Medical Education Project admin@unofficialguidetomedicine.com @DrZeshanQureshi Unofficial Guide to Medicine www.unofficialguidetomedicine.com Foreword by Dr Simon Broughton PhD FRCPCH Consultant Paediatrician, Royal College Hospitals NHS Foundation Trust Senior Lecturer, King's College London - Course Director, MSc's Advanced Pediatrics Training Director Congratulates Seshan and his colleagues on the production of The Informal Guide to Pediatrics. This is a huge part of the work of interns and experts for those interested in pediatrics, from medical students to established counselors and anyone interested in childcare. This book covers pediatrics in the traditional systemic approach, but also has sections on the expansion of the specialty of adolescent health, children's health and law, as well as public health. In addition, with undergraduate and postgraduate sections, starting with junior doctors and career sections, it provides useful advice to medical students and junior doctors wherever they are in their careers. So why do we need another textbook on pediatrics? There are already many excellent texts on the subject, however no one has created a book like this. The inspiration for this book is working together junior doctors, medical students and experts to piece together a textbook that is available to all types of students. We now live in a world where knowledge is so widely and freely available that simply reprinting knowledge becomes unnecessary. If knowledge is to be put together in a textbook, every effort must be made to make this knowledge as relevant and accessible to the reader as possible, and this is what the informal guide to pediatrics achieves. Every effort was made to make this textbook as present as possible. Inevitably, however, new research and recommendations will be published. The genius behind this however, in empowering readers or users book to write to zeshan with updates and suggestions for future editions. Being a pediatrician is an absolute privilege, caring for children, young people and their families in very difficult times in their lives is an incredibly useful task. One of the challenges faced by busy pediatricians is to keep up to date with all areas of pediatrics. An informal guide to pediatrics will help with this by providing advice to the pediatricians of the future and helping to provide excellent care for children, young people and their families. Beryl Lin President, University of Nsw Medical Society co-chair, University of New South Wales Pediatrics Special Interest Group Pediatrics is a big topic about young people. It is an intellectually challenging and exciting field for research and learning, but it can also be challenging when a medical school is often set up to focus on adult medicine. Caring for children is different - both in a purely scientific sense, but also how a sick child and their family should approach, the dynamics of the hospital and the interdisciplinary team, ethical and sociocultural considerations, and even the career paths that represent are unique - all of which are discussed in this book. The unofficial guide to pediatrics has an easy-to-read review of pediatrics broken down by systems. Each chapter describes the underlying conditions, starting with etiology and clinical features, and progresses through studies, differential diagnoses, management, complications, and finally prognosis. In addition, this book covers the history of adoption, surveying, communication and practical skills - all supplemented by clinical cases, labeled diagrams, and information on general exams and evaluation criteria. The authors also provided illustrations of general procedures and medical devices in clinical practice. As a book prepared and written by interns for other listeners, it captures key information in a digestible manner. With active cooperation with well-known scientists and experts, the content is reliable and based on the most famous evidence. This textbook is part of an international medical education project that embodies a passion for peer learning, as well as empowering young people who have a positive impact. Congratulations to the team of zeshan on this award-winning series of textbooks that will help others in their medical journey. In the amazing world of pediatrics, it's a wonderful resource for students, junior doctors and pediatric interns alike - or those looking for a simple and reliable complement to learning from literature and clinical appointments. The development and success of this was not a children's game - you could even say it's a milestone achievement! Shorten Authors Editor-in-Chief Kureshi BM MSc BSc (Hons) MRCPCH Academic Clinical Officer, Great Ormond Street Hospital, and the Institute of Global Health, UCL, UK Deputy Editor Tina Sajjanhar MBBS DRCOG DCH FRCPCH FCEM Consultant in Pediatric Emergency Medicine, Director of The Department of Children and Youth Services, Lewisham and Greenwich NHS Trust, UK Authors John Jungpa Park MB CHB MTh, UK Chi Howe Tan MBBS (Hons) , Monash Health, Melbourne, Australia Anand Goomany MbChB BSc Main Surgical Intern, Bradford Teaching Hospital Foundation Trust, West Yorkshire, UK Amy Mitchell MBChB BSc (Hons) MSc DipClinEd MRCPCH Consultant Pediatric Oncologist, Southampton University Hospital Trust, Southampton, United Kingdom David K Ho MBCHB DTM, UK Christopher Harris MBChCH MRBCPCH Pediatric Neonatal Registrar, Royal College Hospital, London , London Dineri, London, UK Maxine Wilkie Medical Student, Keel University, UK Anna Capsomidis BSc MBChB (Hons) MRCPCH PGDip (Med Ed) PGC (Healthcare Ethics and Law) Clinical Researcher, UCL, Great Ormond Street Institute of Child Health, UK May Bisharat MBBS (Hons) MSc FRCS (Paed Surg) Registrar, Evelyn Children's Hospital, London, UK Rachael Mitchell MRCPCH MA (Cantab) Pediatric Registrar, London Diner, London, UK Alexander Young MBChB MSc MSc , Severn Dineri, United Kingdom Marie Monaghan MBBS BSc (Hons) MRCPCH Pediatric Registrar, London Dineri, UNITED Kingdom Antonia Hargadon-Lowe BMBS BMedSci MRCPCH MSc Pediatric Registrar, London Deanery, London, Great Northern Children's Hospital, Royal Victoria Hospital, Newcastle upon Tyne Hanna Linford BMBS MRCPCH Pediatric Registrar, KSS Deanery, UK Christopher Grime MBChB Philippa King BSc MBChB MRCPCH MSc Academic Clinical Fellow, Medical Microbiology, East Anglia Deanery, UK Claire Bryant BMedSc BMBS Junior Physician, South Thames Foundation School, London, UK Andrew Hall MBChB MRCS DOHNS ENT Specialist Registrar, Great Ormond Street Hospital, UK Michael Malley MA (Hons) Cantab MBBS MRCPCH Pediatric Registrar, London Diner, UK Vaitsa Tziaferi MD MRCPCH, Leicester Royal Infirmary, UK Maanasa Polubothu , London Dineri, UK Stephen D Marks MD MSc MRCP DCH FRCPCH Consultant Pediatric Nephrologist, Great Ormond Street Hospital for Children NHS Foundation Trust, London, UK. 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Special interest in pediatric infectious diseases (SPIN ID) and global children's health Epsom and St Helier NHS Trust, UK Lydia Shackshaft Medical Student, Royal College london, UK Sammy Mack Medical Student, University of Leeds, UK Ben Evans Medical Student, University of Newcastle, UK Content SECTION 1: CORE TOPICS Chapter 1 MEDICINE ALICE , VAIZA TZIAFERI, SADHANANDAM PUNNIYAKODI, MARILYN-JANE EMEDO AND CLAIRE BRYANT CHAPTER 7 GASTROENTEROLOGY MAXINE WILKIE, POOJA PAREKH, AND ZESHAN KURESHI CHAPTER 8 GENETICS ISABEL MAWSON, CHRISTOPHER HARRIS, MAXINE WILKIE AND ZESHAN KURESHI HEAD 9 HEMATOLOGY AMY MITCHELL AND ANNA CAPSOMIDIS CHAPTER 10 IMMUNOLOGY AND ALLERGY MAANASA POLUBOTHU CHAPTER 11 INFECTIONS PHILIPPA KING, ZESHAN KURESHI AND DAVID K K HO HEAD 12 INTENSIVE CARE KUNAL BABLA AND SAMBADU HEAD OF 13 CHILDREN AND CHAPTER 14 METABOLIC MEDICINE ZESHAN KURESI , STEPHANIE CONNER AND ZAINAB KAZMI CHAPTER 15 NEONATOLOGY CHRISTOPHER HARRIS AND ZESHAN KURESHI CHAPTER 16 NEUROLOGY JOHN JUNGPA PARK, SESHAN KURESHI AND DEBARRY DAS HEAD OF 17 NUTRITION CHI HOW TAN HEAD OF 18 ONCOLOGY ANNA CAPSOMIDIS AND AMY MITCHELL HEAD OF 19 ORTHOPEDIC AND RHEUMATOLOGICAL DISORDERS ANAND GOOMANY AND ALEXANDER YOUNG HEAD OF 20 PUBLIC HEALTH CHRISTOPHER HARRIS CHAPTER 21 , RACHEL MITCHELL AND STEPHEN D MARKS HEAD OF 22 RESPIRATORY MEDICINE CHRISTOPHER GRIME HEAD OF 23 SKIN DISEASES MAANA POLANA POLSAUBOTU SECTION 2: CLINICAL CASES CHAPTER 1 CLINICAL CASES: STANDARD ALL AUTHORS CHAPTER 2 CLINICAL CASES: INTERMEDIATE ALL AUTHORS CHAPTER 3 CLINICAL CASES: DIFFICULT ALL AUTHORS SECTION 3: CLINICAL SKILLS CHAPTER 1 HISTORY TAKING ZESHAN KURESHI, CHRISTOPHER HARRIS AND MICHAEL MALLEY CHAPTER 2 EXPERTISE AMY MORAN AND ZESHAN KURESI CHAPTER 3 COMMUNICATIONS ANNA CHADWICK AND MICHAEL MALLEY CHAPTER 4 PRACTICAL SKILLS MICHAEL MULL , ZESHAN KURESHI, ANITA DEMETRIOU AND MARIE MONAGHAN CHAPTER 5 PRESCRIPTION MICHAEL MALLEY AND MARIE MONAGHAN SECTION 4: BECOMING PAEDIATRICIAN CHAPTER 1 UNDERGRADUATE AND POSTGRADUATE ASSESSMENTS IN PEDIATRICS MICHAEL MALLEY AND MARIE MONAGHAN CHAPTER 2 GUIDE TO BEING JUNIOR DOCTOR IN PAEDIATRICS MARIE MONAGHAN History Taking Asking Difficult Issues puberty, Growth and Development Autonomy, Consent and Privacy Relationships, Sexual Health and Contraception Sexual Contraception Sexual Contraception Health Teenage Pregnancy Mental Health Mental Health Mental Health Suicide Risk Suicide Psychosis Drug And Alcohol Abuse Medically Unexplained Symptoms Of Mental Health Management in Adolescence Protection in Adolescent Bullying Sexual Exploitation and Assault Transition From Pediatric To Adult Services There is growing recognition of specific problems in this age group, including trauma, mental health problems, pregnancy and sexually transmitted diseases. The increasing use of health care in adolescence is multifactorial; increased survival rates from chronic childhood diseases, drug and alcohol use and risky behaviour all played a role, and advances in perinatal care and immunization have shifted the burden of disease from children under five years of age. Understanding the unique needs of this age group is a basic skill for any doctor. The Children and Adolescents Act is covered by Chapter 1.13. Adolescent History Taking Is Important to Adapt the Approach to the Needs of the Adolescent Age Group. At the beginning of the consultation, consider the following: Always talk to the patient, not his parent or guardian, if there is no alternative. Ask the patient if they want to talk alone or ask if they want someone to be present, such as a parent or friend. For any survey, offer an attendant. Talk in an age-appropriate way. It is easy to alienate a teenage patient by appearing patronizingly or using medical jargon. Try to anticipate issues related to consent and confidentiality. Psychosocial history is vital to teenage history. Many presentations will stem from problems such as drug use, partner struggles, or concerns about sexuality. A useful assistant-memoir is the tool HEADSS, shown in Table 1. In general, start with more open questions and then focus questions on information. The common reason for the lack of important questions is the assumption; for example, thinking that all young people live at home with their parents or that all young people are heterosexual. Asking difficult questions Some of these questions can feel difficult to ask directly, and even harder to answer directly. One useful piece of advice is to use scripts as a pathway to difficult issues. For example: Young people often experiment with drugs; that's what you've had the experience With? Part of the work I do with young people, young people, Choice of contraception and conversations about sexual health; has anyone ever talked to you about it? It is also a good way to address the more specific problems that may have arisen during the consultations. For example: Some of the young people I work with have told me that their parents fight a lot, and sometimes it becomes violent; Is this what's going on in your home? One thing that can happen in a relationship is a sense of pressure on actions or behavior in a certain way; sometimes people feel like they have no choice about it. Have you ever felt that way? The questions should ensure that the young man will feel support but not the accused. For example, with the drug issue, a young person cannot confess to using it if they believe that the police will be immediately called. The more comfortable the child is, the more likely it is that he will give an honest answer. When questioning, the doctor should stay up to date with non-verbal language, such as changes in body language when it comes to home (disturbance of eye contact, fidgeting and short answers). Puberty, Growth and Development Any consultation with a teenage patient should include an assessment of height, weight and puberty. This assessment is often forgotten, especially in older adolescents who are taken into adult care. Young people with chronic health needs may have delayed growth and puberty compared to their peers. It is also a good opportunity to highlight problems such as obesity, eating disorders or weight loss. Autonomy, consent and confidentiality One of the problems of working with teenagers is the management of their emerging autonomy as they enter adulthood. The ability to develop and maintain trust and understanding with patients depends on the delicate solution of these complex issues. Remember: Every teenager should be assessed on a case-by-case basis without prejudice. There is no lower age limit for Gillick's competence, and even younger children can consent to their own health care. There is no lower age limit for confidentiality, but there are restrictions on this confidentiality, for example, if there are concerns that the patient is in danger. If there is a duty to violate confidentiality, inform the patient in advance, except in rare, exceptional circumstances where this can cause significantly more harm than good. RELATIONSHIPS, SEXUAL HEALTH AND CONTRACEPTION Before in parenting sex and relationships, give patients the opportunity to speak alone and reassure them of their privacy. If a young person has had sex or considered having sex, it is important to talk to them about healthy relationships, sexual health and contraception. As with drugs and alcohol, some may have been At school. Do not make assumptions based on age, culture, disability or diagnosis. If the patient is not sexually active, they may well wish to be and have questions about it. Chronic Chronic Conditions and disability affect gender and relationships; therefore, doctors are potentially able to resolve these issues. Sexual health worldwide, young people have a disproportionately high rate of sexually transmitted infections (STIs), with chlamydia, gonorrhoea, viral warts and syphilis are particularly common. The best protection is the use of condoms; they are often freely available in health facilities and should be discussed with all young people, even if they use another form of contraception. Some STIs may be asymptomatic, especially in women, so regular sexual health screening should be recommended for those who are sexually active. Walk-in services allow you to easily and anonymously access sexual health advice and testing. Similarly, sending STI test results via text message is convenient and helps maintain anonymity. Contraception In addition to condoms, long-acting reversible contraception (LARC) are a good option for adolescent patients, and providing flyers and counseling will allow them to choose the method they consider most appropriate for them. Some examples of LARCs include: Intrauterine device (IUD). It's also called a coil; It can stay in place for five to ten years, but can be removed at any time. Intrauterine system (IUS). This coil releases a small amount of progestogen locally. It can stay in place for five years. A contraceptive injection. It lasts eight or twelve weeks; it provides a systemic progestogen. A contraceptive implant. It sits under the skin and releases a small amount of systemic progestogen. It can stay in place for up to three years. All these forms are over 99% effective, and normal fertility returns once they are removed. However, if sex is with a permanent partner and both have had recent sexual health screening, it is important to recommend additional barrier methods of contraception like condoms. Doctors in the UK and other countries have a legal right to provide contraception to women under the age of 16 without parental consent, subject to certain conditions (p174). Adolescent pregnancies worldwide, more than 10% of births are for girls between the ages of 15 and 19. Although most of them are in low- and middle-income countries, both the UK and the US still have high rates of teenage pregnancy. This continues to be a significant cause of morbidity and mortality in this age group, especially among young adolescents (13 to 15 years) who face higher rates of pregnancy complications and preterm birth. Risk factors for teenage pregnancy include: socio-economic status. Low level of education. Being a child from teenage parents. Any young person who becomes pregnant should be offered counselling covering abortion and adoption so that he or she can make an informed choice. Remember that for some young people, especially in ethnic groups having a child in adolescence can be a positive choice. An important part of antenatal care for young patients is the focus on improving health, including reducing drug and alcohol use and optimizing nutrition. It is important to involve both the mother and the unborn child in social assistance and to take into account the needs of both the mother and the unborn child. MENTAL HEALTH Half of all mental illnesses start before the age of 14 and 75% start before the age of 24. Young people suspected or known to have mental health problems should be formally assessed by the Child and Adolescent Mental Health Service (CAMHS). CAMHS teams employ a range of professionals, including psychiatrists, psychologists, family therapists, social workers, consultants and nurses. Some common mental health issues are discussed below. Depression Three main symptoms of depression are low mood, low energy levels and loss of interest in activities that were previously pleasant (anchedonia). Other symptoms are shown in Table 2. Approximately five percent of adolescents suffer from depression at some point. Most young people will go through periods of feeling down or anxiety. However, depression lasts longer and interferes with the patient's ability to function. In addition to the symptoms listed above, depression in adolescents may occur with symptoms such as: Extreme sensitivity to criticism. Irritation and anger. The deterioration of school performance. Unexplained pains and pains. Young people may have signs of depression: taking drugs, going missing or fighting. The perception of depression may be secondary to another problem; examples in adolescence are bullying, unsolved sexual assault or ill-treatment. Treatment of depression in teen therapy involves initially identifying possible precipitation (such as bullying) and addressing them where possible. Cognitive-behavioral psychotherapy is used more often than in adults. However, in moderate to severe depression, doctors may prescribe medications such as a selective serotonin reuptake inhibitor (SSRI). Fluoxetine is the preferred choice in adolescents, although this may be associated with an increased risk of suicide. Both approaches can be used at the same time. Self-harm Common forms of self-harm in adolescence include: Cutting hands or feet with a sharp object. Taking an overdose of medication (usually paracetamol). Alcohol or illegal drug intoxication. Self-harm is associated with a suicide attempt, but this is not always the case. Depression is a common comorbidities. When assessing and managing these children, conduct a risk assessment and examine the purpose of suicide. Then investigate the circumstances leading up to the episode Harm. Keep in mind that even those who self-harm can often have different reasons for each episode. Young people who will be taken to hospital with acute acute must be formally assessed by the mental health team and will have a clear follow-up plan in place after discharge. Risk of suicide Any patient with depression or perception after self-harm should have their risk of suicide assessed. Never be afraid to ask directly about suicide. The questions to be asked include, Have you ever tried to hurt yourself? Did you have any thoughts of wanting to kill yourself? Have you ever tried to kill yourself? Have you ever plans to kill yourself (such as collecting pills or writing a note)? Any concerns about patient safety should be exacerbated after child protection procedures, ideally with an assessment by someone trained in the mental health of children and adolescents. Psychosis Definition is psychosis when a person loses touch with reality and can be characterized: Hallucinations. When a person sees, hears, or otherwise perceives things that are not present; for example, hearing voices. Misconceptions. When a person adheres to a belief that is not true, despite the logical evidence to the contrary; for example, believing that their parent was trying to kill them. Psychosis is a symptom of several conditions, including schizophrenia, bipolar disorder, autoimmune diseases and meningoencephalitis. Schizophrenia has a prevalence of 1% in middle and late adolescence. Many more people will have at least one psychotic episode in their lives and the first episode of psychosis usually occurs in their teens or early 20s. Psychosis is an extremely sad experience for patients and their families. Despite antipsychotic drugs, psychotic diseases such as schizophrenia still have a poor prognosis, with numerous relapses and high suicide rates. Drug and alcohol abuse Many young people experiment with drugs and alcohol, and for some it can become an addiction. Warning signs include: Change behavior. Hanging with a new group of friends. The deterioration of academic performance. Involvement in fights or shoplifting. In addition to the direct health effects of drugs and alcohol, these substances can isolate young people from their friends and family and increase risky behavior. These problems can be easily overlooked, as young people often try to hide the use of drugs and alcohol. Medically unexplained symptoms Adolescent patients may present with symptoms such as pain, fatigue or dizziness, for which, despite studies, no medical reasons are obvious. It is also called somatization disorder. These symptoms are more common in women, patients with depression, those who have recently had significant medical problems or those who have experienced bereavement. It's a tough one. to make as it is a diagnosis exception that makes these patients very difficult to manage. Rarely can a patient or his caregiver consciously produce symptoms (this is known as or a fabricated disease). If motivation is a reward for feigning or exaggerating an illness such as financial gain or attention, it is specifically known as malingering. However, most of them do not pretend, and if they feel judged or unbelieving, their condition is more likely to worsen rather than improve. The best approach is for one consultant to coordinate patient care, work closely with the attending physician and offer psychological support. Managing mental health problems in adolescence, as in adults with mental health problems, adolescent patients can be managed in inpatient or outpatient settings depending on their diagnosis and needs. Younger patients focus on family cell treatment (e.g. family therapy) and drugs are used less frequently. Two broad categories speak of therapies and medications. Talking Therapy Advice. This gives young people with mental health problems the opportunity to talk about their problems one-on-one with an empathetic listener. It is useful for young people with most types of mental health or behavioral problems. Family therapy. This can be useful for behavioral problems or addiction, where difficulties or conflicts may exist in the family as a whole. This can help family members see each other's prospects and be honest with each other. Cognitive Behavioral Therapy (CBT). This can be beneficial for many mental health problems including depression, anxiety and psychosis. CBT teaches methods of overcoming or controlling thought or behavior. Psychotherapy. This is aimed at addressing the root causes of thought and behavior by talking about the past; for example, children's experience. Medications and antidepressants. They can be used with other treatments for depression and anxiety symptoms. Different types are available, but widely used drugs include selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine and sertraline. Side effects are common and include dry mouth, fatigue and headache. Antipsychotics. They are used to treat psychosis and can have an advantage as mood stabilizers as well. Examples include haloperidol, risperidone and clozapine. Side effects include vegetative effects, impaired movement and weight gain. Stimulants. They are useful for controlling symptoms of attention deficit hyperactivity disorder (ADHD) and can reduce inattention and impulsivity. The most common example is methylphenidate (Ritalin). SAFEGUARDING IN ADOLESCENCE The Adolescent Age Group presents its own protection challenges. There may be duplication between victims and perpetrators; for example, a teenage parent who is in a child protection plan and neglects own child. Bullying by the National Society for the Prevention of Cruelty to Children (NSPCC) found that almost half of all children were at some point in their lives. Thus, bullying is the main cause of abuse in the adolescent group. This may include physical violence, but may also include verbal, nonverbal, exclusion, racial and sexual abuse. It can also happen online or via text message. All teenage patients should be asked about cyberbullying, social media and sexual bullying, which is a growing problem. Children who are bullied may exhibit a range of symptoms and, at worst, may work in health services after physical abuse or self-harm. It should be part of differential diagnosis in any teen presentation, especially with mental health problems and self-harm. Sexual exploitation and sexual exploitation for violence continue to be a largely hidden problem throughout the world. This can manifest itself as physical, sexual, emotional and financial violence or as coercive control. This can happen in young people's relationships and can depend on hierarchies within and outside any relationship. As a rule, the authorities force the young person to sexual activity. Both boys and girls are at risk, and many young people are unaware that abuse is taking place. One in four girls and one in ten boys are likely to experience sexual abuse in the UK. Remarkably, the figures for boys may be under-reported, as some data show that many of them do not seek help, feeling too ashamed to confess to the victim. Signs that a young man can be used include: Relationships with older men. Behavioral changes (including sexual promiscuity). Missing. Self-harm. In the UK, more than one third of all rape and sexual assault representations are in the age group of adolescents. Worldwide, up to one third of girls report that their first sexual experience is coercive. Fear of being judged or unbelieved can prevent young people from seeking help. Sexual assaults by partners or relatives are much less likely to be recorded. Any young person who represents after sexual violence should be directed to the sexual assault centre. This is a single specialized medical and forensic service, where the patient can receive acute medical and emotional support, if necessary take forensic samples and be referred for consultation or analysis. After the attack, patients have a high level of psychological morbidity, especially post-traumatic (PTSD). TRANSITION FROM PAEDIATRIC TO ADULT SERVICES Transitional care refers to children and young people with or without chronic disorders who are transferred to services for adults at a certain age. This process is a problem in the health of young people. Variable health systems policies and structures often leave patients in limbo between services and unsure where to seek help. Further problems are associated with an increase in the number of patients who have survived in adulthood pediatric diseases such as congenital heart defects and metabolic conditions were previously considered. Advanced practice in the field of temporary care includes: Introducing the concept of transition at an early stage (e.g. at the age of 13 or 14). Individual age of transition (depending on the patient's needs, his struggle with the disease and maturity level). Transition coordinator or key worker (who stays in contact with the patient throughout the transition). The written transition plan is individualized for each patient. Transitional clinics with a pediatric and adult team together, so there is a more formal transfer of the patient. Access to staff by embracing the needs of adolescents and young adults. REFERENCES AND FURTHER READING 1Cohen E et al. HEADSS, Psychosocial Risk Assessment Tool: Implications for developing effective intervention programs for runaway young people. J Adolesc Health, 1999; 12: 539-44. 2Dick B, Ferguson JB. Health for adolescents in the world: a second chance in the second decade. J Adolesc Health. 2015; 56:3-6. 3FordT T., Goodman R., Meltzer H. British Child and Adolescent Mental Health Survey 1999: Prevalence of DSM-IV Disorders. J Amer Akad Child Adolesc Psychiatry. 2003; 42:1203-11. 4Cawson P et al. Child Abuse in the United Kingdom: a study of the prevalence of abuse and neglect. London: NSPCC. 2000. 5Berelovitz S et al. I thought I was the only one. The only one in the world. The Office of the Commissioner for Children is investigating the sexual exploitation of children in gangs and groups: interim report. 2012. 6Winer R. Transition from pediatric to adult care. Bridging gaps or passing the buck? Arch Dis Child. 1999; 81:271-5. 7Crowley R et al. Improving the transition between pediatric and adult health care: a systematic review. Arch Dis Child 2011: archdischild202473. 8NICE CG16. Self-harm: short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. 1994. . 9Courvoisie H, Labellarte MJ, Riddle MA. Psychosis in children: diagnosis and treatment. Dialogues Wedge Neuroshi. 2001; 3:79-92. CONTENTS Introduction of Rapid Examination History Examination Primary Patient Resuscitation Management Using DR ABCDE Approach Advanced Pediatric Life Support Other Important Considerations During Resuscitation Key Blood Glucose Study Venous Blood Radiation Imaging Samples Of Radiation Imaging Trauma Current Care Admission Of Pediatric Intensive Care Sending Patient at Home to Community Specialist To Watch For The Death of a Baby or Baby Sudden Sudden Sudden Death in The Infant emergency department (ED), and, more generally, making medical decisions for children. Children. doctors manage children in many conditions (Box 1). Box 1: Settings in which unhealthy children may encounter primary health care. Emergency department. Pediatric emergency room. Pediatric wards. Adult specialties with pediatric coating (surgery, orthopedics, ENT the unofficial guide to pediatrics pdf

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