## Diary of daily activities

**Name of trainee**: Dr. Kinga André

**Name of internship**: General Paediatrics (General training on Paediatric Ward)

**Place**: Children’s Unit, St. Mary’s Hospital Isle of Wight

**Period**: 01/02/2014 – 31/05/2014

## 1st February (Saturday)

Introduction to the daily life of the Children’s Unit.

Getting to know the daily routine on the Children’s Ward.

Prescribing drugs, how to use the British National Formulary.

How to order blood tests, imaging studies, how to make interconsultant referrals.

Getting to know the administrative tasks: writing discharge summaries, clerking in new patients.

## 3rd February

Monday Grand Round in Neonatal Unit& Children’s Ward.

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples, siting cannulas.

* 5 y/o: R side pneumonia. Not tolerating oral ABx – admitted for iv. ABx + fluids.
	+ iv. Augmentin
* 2 y/o: admitted because of wheezy episode
	+ therapy: Salbutamol + Atrovent inhalers, prednisolone p.o.
* 8 y/o: presented with acute abdominal pain
	+ ? appendicitis – surgical review. Iv. antibiotics. Iv. fluids. Observation.

## 4th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples, siting cannulas.

## 11/12 known MCADD patient, vomiting – oral rehydration according to „emergency regime”.

* 2/52: ALTE.
	+ floppy, cold and barely responsive episode. IO access, fluid bolus. Commenced on Ceftriaxon for possible sepsis. Ophthalmolgy and US head scan: NAD. CXR NAD. Bloods all within normal limits. Blood cultures negative. Baby was discharged home.
* 4/12: laryngomalacia, feeding and breathing problems
	+ reassurance given, Gaviscon for possible reflux

## 5th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples, siting cannulas.

* 2 y. old: minor head injury.
	+ No LOC, 1x vomit. 6 hours of observation.
* 11/52: severe hypoxic brain injury, feeding problems. Presented with ? aspiration of formula milk. - ? aspiration pneumonia.
	+ Observation. Therapy: oral antibotics.
* 13/12 girl: pneumonia, tonsillitis; salbutamol nebs 4 hourly, Augmentin Duo + Azithromycin
	+ discharged home on oral abx + Salbutamol reducing plan.

## 6th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 6 y/o: Known epileptic. Currently on oral antibiotics for tonsillitis. Presented with increased frequency of fits.
	+ Overnight observation. Continue regular medication + antibiotics.
* 3 y/o.: adenotonsillotomy. Observation.
* 8 y/o: OD paracetamol.
	+ Bloods – paracetamol under treatment level. Observation, CAMHS review.

## 7th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 16 y/o: 1/7 hx of abdominal pain. Temp. 38C. CRP 95. RV- ed by surgeons. Improved following day in the hospital. Commenced on oral Augmerntin for 5 days. Dgn.: Mesenteric adenitis.
* 6 y/o: Lymphangitis on L elbow.
	+ Therapy: iv Flucloxacillin and Benzylpenicillin for 24 houra. Switch to oral Flucloxacillin (7 days course), discharge home.
* 1 y/o: Investigation for food allergy. ?Egg, ? milk.
	+ Observation. Referral to Asthma and Allergy Clinic for further tests.

## 2nd week – 10-14/02/14

## 10th February 2014

Monday grand round in NICU& Children’s Ward. Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 15 y/o male, known ulcerative colitis. Medication: Mesalazine. Passing more blood in stools recently. Anemia in FBC. Impression: Flare of ulcerative colitis.
* Plan: Abdominal USS. Abdominal X-ray. Mesalazine + iv. hydrocortizone.
* 9 y/o male, 4 days hx of increasing pain and torticollis in the R side of neck. Afebrile.
	+ Dg.: unilateral cervical lymphadenitis. ? abscess. Plan: Blood tests, blood culture, iv. antibiotics (Augmentin + Metronidazole), paracetamol + diclofenac. ENT referral.
* 20/12 old, diagnosed with ALL 3 months ago. Receiving chemotherapy. Admission with vomiting. Iv. fluids + antiemetics.

## 11th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 4 ys old boy with a 1 year history of headaches and papillaedema, (benign intracranial hypertension?), now presented with headache
	+ painkillers, observation – d/w Paed. Neurolgy in SGH.
* 7 y/o girl with abdominal pain, dg.: viral URTI, mesenterial lymphadenitis
* 17/12 girl, repeated vomiting, decreased oral intake. History of hydronephrosis.
* Th: oral rehydration via NG tube.

## 12th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 ys old with 3 days hx of fever. Dg: AOM, Th.: co-amoxiclav p.o. 7 days.
* 8,5/12 boy, chronic constipation
	+ discharged with Movicol and dietary changes
* 2 ys: wheezing, tachypnea, low sats
	+ Th: salbutamol nebs 1-4 °, prednisolone p.o.

## 13th February

Taking part in regular Thursday morning meeting: physiotherapy (topics: management of children with cerebral palsy, toe walking, abnormal muscle tone)

Taking part in ward round, reviewing patients admitted the previous day:

* 16 y/o, took 20 x 500 mg paracetamol tablets 1 day earlier(no suicidal intention). Nauseaous.
* Investigations: blood test (inc. ALT, INR, paracetamol level - after 24 hours not informative). ALT was very high, on control higher (200). Therapy: Parvolex .
* 3 weeks old girl with high fever, some URTI symptoms
	+ Investigations: full septic screen + CXR. Th: iv. cefotaxime, O2
* 2 ys. old boy with Down syndrome, p/c: bronchiolitis
	+ supportive therapy

## 14th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GP or A&E.

* 16 ys old girl with a 3 ys. history of recurrent faints. ECG done by GP: normal. Microcyter anemia (due to heavy periods?). Referred to Cardiology in Southampton.
* 5 weeks old, ? vomiting.
* 5 months old, with a history of epilepsy, now referred by GP due to feeding problem.

## 3rd week – 17-21/02/14

## 17th February

Monday Grand Round in NICU and Children’s Ward.

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 9 ys old girl, with sudden onset of headache and blurred vision, disorientation
	+ CT scan normal. next day feeling better, but diplopia still present
	+ ophtalmology: NAD. refer to SGH paed. neurology: LP, MRI
* 2 ys old girl, bronchopneumonia
	+ th: ceftriaxone iv. + azithromycin
* 15 ys: anorexia nervosa
	+ CAMHS follow-up. Medically stable, but still losing weight.
	+ decision to insert NG tube
* 13 ys: OD Paracetamol
	+ bloods: ALT, Bi, INR mildly elevated
	+ iv. Parvolex

## 18th February

Taking part in ward round in Children’s Ward, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples, siting cannulas.

* 2 y/o girl: bronchopneumonia, th: ceftriaxone iv. + azithromycin
	+ repeated vomiting, dehydration → iv. fluids (full maintenance)
	+ cont. iv. antibiotics
* 5 y/o: pneumonia
	+ admitted because of vomiting
	+ iv. fluids → improving, now oral intake is better
	+ still low grade fever
	+ cont. iv. antibiotics (Augmentin), add p.o. azithromycin
* 5 y/o : known haemophilia A, awaiting factor VIII half-life study
	+ fever without focus. Possible infection of port-a-cath?
	+ iv. antibiotics: Tazocin + Gentamycin

## 19/02/14

Taking part in ward round in Children’s Ward, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples, siting cannulas.

Wednesday morning teaching. Topic: „Shaken baby syndrome” and „Non-accidental injuries”

* 5 y/o: pneumonia
	+ no vomiting, no fever
	+ d/c home on oral antibiotics
* 2 y/o: bronchopneumonia
	+ no vomiting, better general condition
	+ discharge on oral antibiotics
* 2 yo wheezy: dyspnea resolved, apyrexial, without oxygen
	+ o/e: mild crackles over R lung base
	+ discharge home on oral Azithromycin (3 days) and Salbutamol

## 20th February

Taking part in ward round in Children’s Ward, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples, siting cannulas.

* 11 y/o boy, mild-moderate croup: p.o. dexamethasone (12 mg as max. dose) → 4 hr observation→ discharge
* 16 y/o: OD atomoxetine (Strattera) + paracetamol
	+ bloods: negative. ECG: normal.
* 1 y/o: simple febrile seizure.
* Underlying diagnosis: tonsillitis. Therapy: oral co-amoxiclav. Discharged home once the temperature settled.

## 21st February

Taking part in ward round in Children’s Ward, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 6 y/o: impetigo like lesion on thigh. Therapy: oral Flucloxacilline.
* 4 y/o: Brought in by ambulance following an episode of focal seizure involving the L arm. No LOC. Blurred speech after the event, slow recovery. Neurology examination: grossly normal, very subtle signs of L sided hemiplegia.
* Investigations: ECG - NAD. Head MRI: periventricular and deep white matter regions of parenchymal loss with gliotic change in the watershed areas of both cerebral hemispheres. – probably perinatal hypoxic injury
* 20/12: First wheezy episode. On admission Sats of 91%. Prolonged expiration and sub-intercostal recession. Therapy: nebulisers – good response

## 4th week – 24-28/02/14

## 24th February

 Monday grand round in NICU& Children’s Ward. Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

This day’s most interesting case:

* 9 y/o girl, with a history of : 5 days fever,  4 days diffuse erythema/rash all over the body (incl genitals),  5 days non-purulent conjunctivitis,

swollen & red  palms, cracked lips + strawberry tongue

Diarrhoea/vomiting 4 days earlier. 2 days prior to admission was seen, scarlet fever suspected, throat swab + penicillin V. Symptoms didn’t improve.

Throat swab: negative. Lab findings on admission: CRP, ESR ↑, ALT ↑, WBC 16. ECG normal.

Dg: **Kawasaki sy.**

 Th: IVIG 2 g/kg iv. in one dose+ Aspirin 10 mg/kg QDS.Referred to SGH Cardiology for echocardiography.

## 25th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. This day’s most interesting case:

* 21 month old boy

  Brought in by ambulance to A&E with 1 seizure.   D & V last 2 days. No fever.  In A & E another seizure, stopped by buccal midazolam 2.5 mg.  Iv access → bloods NAD.  Th: ceftriaxone 80 mg/kg, acyclovir 250 mg/m2 until cultures negative.

On the ward another seizure (GTCS), 30 secs, stopped spontaneously. CT scan done after that: normal. LP: NAD.

##  27th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. This day’s most interesting case:

* 18/12 girl: urticariform rash + puffy eyes for 2 days. No fever, good general condition. Mild URTI symptoms. Because of puffy eyes → urine dipstick : nad (no proteiniuria). No bloods done. Dg: allergic rash possibly due to viral infection. Th: piritone p.o. D/c home with open access.

##  27th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 13 y/o: unwell, fever, abdominal pain, currently treated for tonsillitis with ab
	+ Bloods: CRP 180. Surgical review: not surgical abdomen. Mesenterial lymphadenitis. Supportive therapy.
* 13/12: pneumonia.
	+ Iv. ceftriaxone for 48 hours. Discharge home on oral ab.
* 3 y/o: known epileptic. For observations after fit.

## 28th February

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2/12: brought in by ambulance for an unresponsive episode, shortly turned blue around lips. ALTE?

Bloods: raised ALT, otherwise unremarkable. ECG: normal. Observation. Discharge home with follow-up. To repeat ALT in 1 month.

* 1/12: noisy breathing, difficulty feeding, especially during feeds and lying flat

Diagnosis: laryngomalacia (“floppy larynx”) +/- reflux

No further investigations needed. Advice given re feeding and positioning.

* 5/52: fever, positive urine dipstick

Treated as pyelonephritis, iv. ceftriaxone 48 hours. Discharge home on Trimethoprim. Abdominal USS: no VUR.

## 5th week – 03-07/03/14

## 3rd March

Monday ward round in NICU + Children’s Ward.

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 4/12 old, presented with vomiting. Moderate dehydration. Not tolerating NG fluids - iv fluids.
* 20/12 mo.: presented with shortness of breath, fever, low sats. Diagnosed with pneumonia. Started on Vapotherm. Therapy: iv. ceftriaxone, p.o. azithromycin.
	+ teaching point: hi-flow oxygen therapy, use of steroid in pneumonia with wheeze
* NICU:32 gest.week boy, nvg. Steroid prophylaxis done.

Bloods: routine tests, cultures: blood, rectal, ear, nasal, umbilical. Blood gas. Blood glucose.

Iv. fluids: 10% Glucose @ 60 mls/kg/day. Iv. antibiotics: Cefotaxime.

## 4th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Most interesting case of the day:

* 6 y/o: Investigation for polydipsia + polyuria in known ADHD child. Bloods, urine osmolality, overnight fluid deprivation: NAD. Possibly psychogenic polydipsia.

## 5th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 y/o: simple febrile convulsion: observation
* 5 y/o: L side pneumonia. Therapy: iv antibiotics + azithromycin.
* 7 y/o: one-sided swelling of face = cellulitis, iv flucloxacillin + metronidazole. 24 hours of iv., then switch to oral (Augmentin + Fluclox.)

## 6th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 10 y/o: presented with a few days hx of not passing stools. Previous history of chronic constipation. Treatment: Movicol disimpaction regime. Follow-up by community nurses.
* 2 y/o: 1st simple febrile seizure. Viral URTI as focus. Observation.
* 4 y/o: 2nd wheezy episode. Treatment: Prednisolone p.o. , Salbutamol nebulisers, then inhalers. Discharge home on Salbutamol reducing plan.

## 7th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 yr old: minor head injury. No LOC, NO vomiting. 6 hours of observation.
* 15/12: URTI, fever. Therapy: Iv. ceftriaxone.
* 13 y/o: acute asthma exacerbation. Known asthmatic & allergic patient.
	+ Therapy: O2, Salbutamol, Atrovent nebulisers, Prednisolone p.o., Azithromycin.

## 6th week – 10-14/03/14

## 10th March

Monday Grand Round in NICU and Children’s Ward. Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 8 y/o: Presented with gross haematuria. History of tonsillitis 2-3 weeks before. Dg: poststreptococcal GN. Therapy: Penicillin p.o. Contacted SGH Nephrology Unit.
* 15 days old: bronchiolitis. Supportive therapy: NG feeding, oxygen as needed.
* 5 y/o. Hx of epilepsy (DOOSE sy.), presented with fever and maculopapular, nonblanching rash on the face and trunk. Bloods NAD. Covered with Azithromycin.

## 11th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 8 y/o: ? cellulitis on both legs. Injury to L shin 2 days earlier. Atypical presentation.
	+ Iv. penicillin, iv. flucloxacillin
* 17/12 old: simple febrile convulsion. Viral URTI as focus.
	+ Observation
* 14 y/o: moderately severe DKA in known diabetic patient. Treatment as per DKA protocol.

## 12th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 3 y/o: Down`s syndrome. P/C Fever, cough, petechial spots on legs and trunk.
	+ Bloods: NAD. Observation for 4 hours – no more petechiae. Treatment: azithromycin p.o.
* 2,5 y/o headaches for 2 weeks, nosebleeds, occasionally high blood pressure. BP normal on the ward. No neurological signs or red flags. Previous hx of viral URT infection.
	+ Observation. Head imaging not needed at the moment.
* 7/12: ex-premature, faltering growth + social issues
	+ Feeding problems. Change of formula to high energy formula.

## 13th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 7 y/o: known epileptic. Brought in by ambulance following a fit. Increased frequency of seizures over the last month.
	+ Observation. Increase dose of AED.
* 16 y/o: deliberate overdose of codein and paracetamol. Paracetamol level under treatment level.
	+ Observation. Bloods.
* 15 y/o male: 2/12 history of recurrent vomiting, loss of appetite. Started with D&V episode. Symptoms now improving.
	+ Bloods: NAD. Chest X-ray to exclude mediastinal mass: negative. H. pylori: pending. Follow-up in clinic.

## 14th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 4/12: bronchiolitis, varicella
	+ Supportive therapy (O2), observation.
* 8 y/o: patient earlier the week treated for cellulitis on lower limbs. Still pyrexial, limbs painful. Erythemal areas increasing.
	+ Diagnosis: Erythema nodosum (EN). Cause: possible streptococcal throat infection 2-3 weeks earlier. Teaching point: clinical presentation and investigation of EN.
* 1,5 y/o: fever, rash: Rash consistent with paediatric viral illness (? Slapped cheek disease and hand-foot-mouth disease). After period of observation and unremarkable blood results d/c home.

## 7th week – 17-21/03/14

## 17th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 7 y/o: constipation & secondary urinary retention. Reluctant to take the Movicol & drink fluids. Becoming increasingly uncomfortable. No success with Movicol yet, overflow diarrhoea. Difficulty passing urine.
* glycerol enema – result + + +. Continue with Movicol
* 3/12: fever, ? focus → positive urine dipstick
* Treated as pyelonephritis, iv. ceftriaxone 48 hours. Urine grew fully sensitive E. coli (significant). Discharge home on Trimethoprim. Kidney + urinary USS: normal.
* 4 y/o: wheezy episode. Previous wheeze, atopic. Tachypnea, prolonged expiration, sub-intercostal recession. Therapy: Salb + Atrovent nebulisers – moderate response. + Prednisolone p.o. for 3 days

## 18 th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 16 y/o: ? meningitis
	+ Admitted via GP with fever, ? stiff neck and photophobia. Im. penicillin prior to admission by GP. On admission pyrexial, but no signs of photophobia or stiff neck. Bloods, blood culture taken. All normal. Urinalysis NAD. In view of history given 2 doses of ceftriaxone. Blood cultures -ve at discharge.
* 22/12: CHARGE sy., previously had pacemaker. Brought in by ambulance after a seizure, with bradycardia
	+ Dg.: Reflex anoxic seizure – which triggered the bradycardia – resolved spontaneously. Transfer to SHG Cardiology, to put pacemaker back.
* 16 y/o: overdose of amitryptilin
	+ Monitoring, iv. fluids, bloods

## 19th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 y/o: wheezy episode.
	+ Good response to Salbutamol and Atrovent nebulisers.
* 3 y/o: pyrexia. ? focus – under investigation
* 20/12: severe wheeze
	+ 3 days hx of URTI symptoms, 1 day hx of wheeze – deteriorated
	+ Salbutamol and Atrovent nebulisers, Hydrocortizone iv., Vapotherm for 2 days

## 20th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 6 y/o: ALL patient, presented with fever and D&V
	+ Febrile neutropenia protocol (Tazocin + Gentamycin).
* 15 y/o: head injury (bike accident). LOC, 1 minute seizure. Injury to the maxilla and orbital region.
	+ CT head. – fractures to the maxilla and the orbital wall
	+ Surgical repair of lacerations. Maxillofacial care.
* 15 y/o: Bleeding after tonsillectomy.

## 21th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 5 y/o: brought in by ambulance after a fit
	+ Known epileptic, now has fever and is on ab therapy
* 2 y/o: cerebral palsy. Presented with vomiting & diarrhoea. Blood in the bile bag.
	+ Bloods: showed high urea and creatinine - prerenal failure. Iv. fluids.
* 8 y/o: Hit by a car. Suffered minor head injury, knee and foot injury. Observations, monitoring.

## 8th week – 24-28/03/14

## 24th March 2014

Monday grand round in NICU& Children’s Ward. Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 16 y/o : admitted because of intentional co-codamol overdose and allergic reaction to codein.
	+ Paracetamol level below treatment line. Observation.
* 16 y/o: known type 1 DM with DKA
	+ treatment according to DKA protocol
* 7/12: ex-preterm with faltering growth, social issues. Observation of feeding.

## 25th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 y/o: cerebral palsy, fed via PEG. P/C: diarrhoea, bloody stools, fever, cough: HUS excluded, bloods NAD. ( CRP 0.8) Chest X-ray: R sided patchy infiltration. (consistent with local findings).
* 2 y/o: bronchopneumonia.
	+ Therapy: Iv. ceftriaxone.
* 15 y/o: end-stage renal failure, with nausea/dizziness. Awaiting dialysis in 2 days.
	+ creatinine, urea ↑

## 26th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 1 y/o: presented with fever and vomiting. On examination: acute otitis media.
	+ therapy: Co-amoxiclav per os
* 5 y/o: leukaemia patient, post bone marrow tx, with line infection
* 16 y/o: minor head injury, no LOC, no vomiting
	+ for observation

## 27th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 8/12: ex-preterm, faltering growth. Observation of feeding. Change to different formula.
* 1 y/o: previous UTI (diagnosed with VUR), now presents with discomfort and fever.
	+ still on Trimethoprim prophylaxis. Urine negative. Possibly viral infection.
* 4 y/o: presented with constipation + lower UTI
	+ Movicol regime+ Nitrofurantoin p.o.

## 28th March

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 y/o: wheezy episode
	+ Salbutamol + Atrovent nebulisers – good response. D/C home on Salbutamol reducing plan.
* 4 y/o: focal seizure at home, now back to normal, subtle neurol. signs (L sided latent hemiparesis?) → MRI
* 4/12: growing head circumference for several weeks+ sunsetting eyes→ acute head CT : acute + subacute subdural haematoma
	+ shaken baby sy. suspected, transfer to SGH Neurosurgery

## 9th week – 31/03- 04/04/14

## 31st March 2014

Monday grand ward round in NICU & Children’s Ward.

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 4/12: allergic reaction to ready-made porridge –at time of admission symptoms resolved. Possible cow’s milk allergy.
* 5/52 girl: ?viral meningitis, awaiting CSF viral screen and cultures, on IVAB until then
* 9/52 boy: ?viral meningitis, awaiting CSF viral screen and cultures, on IVAB + aciclovir
* 17 y/o meningococcus B infection: last day of iv. ceftriaxone, discharge.

## 1st April 2014

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 5/52 girl: viral meningitis, parechovirus detected in CSF
* 9/52 boy: viral meningitis, enterovirus detected in CSF
* 2 y/o: non-blanching rash and pyrexial, covered with iv. ceftriaxone, but looks like viral infection
* 15 y/o: spontaneous pneumothorax, under surgeons. Chest drain inserted because of progression.

##  2nd April

Wednesday teaching in Paediatrics. Presentation by myself about ALTE (Apparent Life Threatening Events).

Taking part in regular Wednesday medical teaching for foundation doctors/juniors.

## 3rd April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 17 days old girl: ? sepsis ?viral meningitis. LP done: negative. NPA: parechovirus detected!
* 12 y/o girl: brought in by 999 because of collapse at home. Probably vasovagal (?psyhological factors), dicharged home in the afternoon after 6 hours of observation. Blood pressure, ECG normal. No further complaints.
* 6 y/o boy: AML patient under chemotherapy. Treated for febrile neutropenia according to protocol.

## 4th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 5 y/o: croup+wheeze.
	+ Dexamethason as per protocol (0.6 mg/kg p.o.), nebulisers
* 3/12: chest infection.
	+ Therapy: Oral Augmentin, Salbutamol + Atrovent nebulisers.
* 21/12: for MRI under sedation. Indication: recurrent febrile convulsions.
	+ Sedation protocol: Chloralhydrate p.o.
	+ successul sedation. Result: Normal brain anatomy.

## 10th week – 07-11/04/14

## 7th April

Grand ward round in NICU & Children’s Ward.

Taking part in ward round, reviewing inpatients. Admitting new patients referred by GP or A&E.

Taking blood samples from inpatients and/or outpatients, siting cannulas.

* 2 y/o male: wheezy episode, therapy: salbutamol nebulizers + prednisolone p.o.
* 4 y/o male: fever, cough

2 day history of low-grade fever + cough for 1 week. CXR shows mild patchiness – consistent with viral infection. On admission well in himself, afebrile, no respiratory distress. RR 28/min. Chest: bilateral crackles. No wheeze. Nasal congestion. Rest of examination negative.

Other problems: parental concerns re ? poor weight gain, feeling tired and being more sleepy lately. **Plan**: chest symptoms due to viral infection, no treatment. Weight is between 2nd and 9th centile. Height: 25th- 9th centile. Growth chart does not suggest failure to thrive.

Investigations while he is acutely ill should not be done (especially not iron and ferritin studies). Follow-up in clinic in 3 months, check of weight and growth .

* 3 y/o male : sedation for MRI
	+ sedation with p.o. chloralhydrate(50 mg/kg) as per protocol
* 14 y/o female: peritonsillar abscess
	+ therapy: iv. ceftriaxone + metronidazole

## 08 April

* **3/52:** male infant, referred from Beacon Centre. Perinatal history: term baby, IUGR (2.4 kg), low sats (no reading above 93%) in NICU, treated for possible sepsis. No follow-up. Poor weight gain, poor feeding, parents occasionally noted blue lips at home. On the day of admission was seen by health visitor who was concerned about the weight (2.7 kg).

On admission SatO2 46% !!! Blood gas: acidosis (? metabolic), lactate 8.

On oxygen sats gradually improved. Started on amoxicillin, cefotaxime, acyclovir in case of possible sepsis. Bloods were non-contributory, CRP 0.2, FBC OK. Blood culture, NPA sent. NPA negative for RSV, sent for other viruses.

Chest X-ray: lungs OK, no cardiomegaly, ? shape of heart

Commenced on Vapotherm. (8 L, 100 %, then 60%) Blood gas improved quickly.

? Cardiac cause

## 09 April

Morning teaching in Paediatrics: Topic: allergy priming in utero.

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 3 y/o: first wheezy episode, no O2 requirement, therapy: Salbutamol & Atrovent nebs, then inhalers
* 8 y/o: first wheezy episode, hx of eczema. Th: Salbutamol & Atrovent nebs, then inhalers, Prednisolone per os
* 2/52: swelling of the head, ? cephalhaematoma, ? intracranial abnormality. USS: ? subdural haemorrhage → cranial CT

## 10th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2,5 y/o: constipation (faecal impaction)
	+ management: Movicol disimpaction regime, follow-up by Community Nursing Team
* 14 y/o female: tonsillitis, ? peritonsillar abscess.
	+ Th: iv. metronidazole, iv. benzylpenicillin
	+ ENT referral

## 11th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 3/52 infant: ↓SatO2 (70-90%) on 8L, 50% Vapotherm. Echo: TAPVR , ASD R→L shunting. Emergency transfer to SHG for correction.
* 2 y/o boy: CHARGE syndrome, now presenting with vomiting
	+ U&E’s: normal, therapy: ORS via gastrostomy
* 13 y/o male : known patient with mediastinal B-cell lymphoma; febrile neutropenia
	+ therapy: management as per febrile neutropenia protocol, iv. Tazocyn and Gentamycin

## 11th week – 14-18/04/14

## 14th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 y/o: periorbital cellulitis
	+ th.: therapy: iv. ceftriaxone + metronidazole
* 8/12 months old: respiratory distress, wheeze
	+ not improving despite bronchodilators – put on Vapotherm
* 1 y/o: simple febrile convulsion
	+ observation

## 15th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 6 y/o: fever, lymphadenitis in L groin, cat sratch in hx
	+ Bartonella serolgy sent, bloods done (elevated CRP), started on clarithromycin
* 3 y/o: fever, positive urine dipstick
	+ treat as pyelonephritis, iv. ceftriaxone
* 12 y/o: presented with abdominal pain
	+ bloods: NAD, USS: NAD.
	+ constipation in hx

## 16th April

Wednesday morning teaching in Paediatrics. Topic: Case presentation about a recent case of cyanotic heart disease in an infant.

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 10 months old: minor head injury. No LOC, 1x vomit. 6 hours of observation.
* 23 months old: fever, tonsillitis
	+ penicillin
* 6 y/o: fever, lymphadenitis in L groin
	+ developed redness around a large haemangioma on the L thigh
	+ possibly infected haemangioma as source of infection
	+ therapy: iv. ceftriaxone + flucloxacillin

## 17th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 15 y/o: known DM, vomiting, blood sugar 16, admitted yesterday afternoon
	+ DKA protocol started despite normal blood gas
	+ today morning iv fluids & iv insulin stopped, back to sc. insulin
* 10/52 baby with “cough” and occasional ? cyanosis. Started on Gaviscon, little effect. Breastfed. No fever. O/E: NAD. During observation 1x episode: looked like reflux.
	+ Investigation: NPA for RSV: negative
	+ Diagnosis: possible reflux. Therapy: Ranitidine. Follow up in 1 week.
* 15 y/o with juvenile RA. For Tocilizumab infusion. Siting cannula and taking bloods.

## 18th April: Good Friday- Bank Holiday

## 12th week – 21-25/04/14

## 21st April – Easter

## 22nd April 2014

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 16 y/o: holidaymaker on IOW, on insulin pump, high blood sugars & ketones
	+ well in herself, no vomiting. Blood gas: normal pH, HCO3 18.9, BE -4
	+ oral rehydration
* 1 y/o: Down syndrome, chest infection, fever, wheeze
	+ therapy: co-amoxiclav p.o. + salbutamol
* 9 y/o girl: fever, abdominal pain → high CRP, leukocytosis, positive urine
	+ treated as pyelonephritis with iv. Augmentin.

## 23rd April

Morning teaching in Peadiatrics. Topic: case presentation of elevated alkalic phosphatase and neutropenia.

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 y/o: CHARGE sy., presented with fever and respiratory symptoms
	+ chest X-ray: infiltration on L side. Bloods: WBC 15.6, neu 8, CRP 17
	+ therapy: ceftriaxone iv.
* 6 y/o : first wheezy episode
	+ Salbutamol, Atrovent nebs overnight, required O2
	+ peak flow 140 L/min

## 24th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 5/12 girl: 1 day hx of high fever, several weeks hx of resp. symptoms

 - chest X-ray: no consolidation, some patchiness

 - bloods: WBC 15, neu 50% . Started on iv. cefotaxime.

* 6/12 girl: fever , cough
	+ chest X-ray done in A&E: NAD. On examination: bilateral AOM. Oral Co-amoxiclav.
* 2 y/o: minor head injury, no neurological signs, no LOC/vomiting
	+ 6 hours observation

## 25th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* + 4 y/o: cervical lymphadenitis for 3 weeks, no acute symptoms/fever. Bloods NAD.
	+ 2 y/o: acute onset respiratory distress
	+ 2 y/o: CHARGE sy., still spiking temperature, repeat bloods – NAD.

## 13th week – 28/04-02/05/14

## 28th April

Monday grand round in NICU& Children’s Ward. Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* A&E: 8/12 girl: scalded on the chest and L arm with hot tea
	+ 2nd degree burn, approx. 15%
	+ Paracetamol and ibuprofen, iv. Fluids
	+ Transport to Salisbury Burn Unit
* 2 y/o boy: admitted previous night with fever, cough and SOB. R sided pneumonia.
	+ Therapy: p.o. co-amoxiclav, discharge home
* 4/52 baby: Referred by GP because of an umbilical ? cyst or ? granuloma. 4 days ago parents noticed a small, pea-sized, red, cyst-like mass in the umbilicus. USS needed.

## 29th April

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 14 y/o CF patient. Sputum culture: S. aureus. Cough +++. Regularly on Flucloxacillin. Admitted for iv. Abx. (tobramycin, ceftazidime) for 14 days. (via port-a-cath).
* 13 y/o: infection triggered asthma attack. On ceftriaxone iv. and azithromycin, Salbutamol nebs. Oxygen via face mask. Improving.
* 1,5 y/o: febrile convulsion 2x in 24 hours, started on Augmentin Duo p.o., then switched to iv. Ceftriaxone. Completed 2 days of iv. Ab and azithromycin. Spiked a temperature again, but well in himself, active. No rash. No conjunctivitis, no cervical lymphadenopathy. Can go home, review next day.

## 30th April

Morning teaching. Topic: epilepsy

Regular Wednesday medical teaching for junior doctors.

Taking part in Children’s ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 3,5 y/o: newly diagnosed DM type 1 in severe DKA. Several weeks history of polydipsia, polyuria, weight loss. Few days hx of increased drowsiness. Treatment acc. to protocol.
* 4/12: petechial rash on legs in a well baby. Bloods (incl. clotting) NAD. Discharge home.

## 1st May

Taking part in Children’s ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 6 weeks old: rash and vomiting after changing breastmilk to formula. Possible cow’s milk allergy.
* 7 y/o presented with 6 months hx of occasional dizziness, 1 month hx of occasional headaches. No red flags, no neur. signs. On presentation no complaints. ENT referral and f/u in 4-6 weeks in clinic by consultant.
* 14/12: 2nd simple febrile convulsion. Observation.

## 2nd May

Taking part in Children’s ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 12 y/o: abdominal pain. Bloods NAD. Probable mild irritative gastritis due to the consumption of irritant foods.
* 13 weeks old: P/C occasional bluish discoloration of hands and feet. Sine morbo.
* 6 y/o: T-cell ALL, previous cord blood stem cell tx, p/c unwell, conjunctivitis, lethargic
	+ investigations & treatment according to Oncologist’s advice

## 14th week – 05-09/05/14

## 5th May – Bank holiday

## 6th May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 16 y/o female: 1 week hx of jaundice, RUQ pain, vomiting. Serum Bi, ALT, ALP raised.
	+ USS confirmed gallstones. Clinical condition improving. Surgical team involved.
* 2 y/o: recent surgery for abdominal tumour (awaiting histology), presented with fever and diarrhoea. Not oncology patient. Good general condition. Probably viral gastroenteritis.
* 9/12: chest infection. Th: Oral co-amoxiclav.

## 7th May

Wednesday morning teaching. Topic: Recent case of erythema nodosum.

* 4 y/o pyelonephritis: on ceftriaxone + trimethoprim, still spiking temperature
	+ Urine: E. coli fully sensitive. Th: single-shot gentamicin added to therapy.
* 2 y/o MSUD (maple syrup urine disorder), presented with PEG site oozing
	+ Swab taken, p.o. flucloxacillin started (awaiting surgery next week)
* 15 y/o: post kidney transplant. Presented after a collapse. Observation. Probably vasovagal collapse. D/C home.

## 8th May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 15/12: dizziness, wobbly walking. Under treatment for AOM. Dg: labyrinthitis. To finish co-amoxiclav course. ENT referral.
* 5 y/o severe CF patient: 2 weeks treatment iv. antibiotics (imipenem). Physiotherapy.
* 6 y/o ALL patient. Under oncology treatment. Neutrophilia, line infection (Coagulase negative Staphylococcus). Therapy: 10 days Teicoplanin.

## 9th May:

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 14 y/o fever, lethargy, R flank pain. On examination R sided crepitations. Dg: pneumonia. Th.: iv. ceftriaxone.
* 17 y/o: presented with non-epileptic seizures. CT head negative. Bloods unremarkable. Possible psychogenic seizures. Transported to SGH for EEG.
* 2 y/o: presented with being unwell, fever, 1x vomit. Operated for abdominal tumour (awaiting histology) recently. Observation, oral rehydration.

## 15th week – 12-16/05/14

## 12th May:

Grand round. Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples.

* 3 y/o: constipation, refuses to drink

o   Glycerol enema, discharge home on Movicol regime

* 6 y/o: brain stem glioma, VP shun.   Increase in vomiting, increase in ataxia, fever
* Emergency head CT, bloods, blood cultures. VP shunt tap not done.   Iv. ceftriaxone. Urgent transfer to SGH Neurosurgery.
* 10 y/o: sudden onset dizziness, chest pain, slurred speech, slow recovery. Now back to normal, no neur. signs.
	+ CT head NAD. ECG normal. Ophthalmology ref.

## 13th May:

Taking part in ward round, reviewing patients admitted in the previous days. Admitting patients referred by GPs or A&E.

* 8 y/o: erythema multiforme minor, pt. in good general condition
	+ antihistamine p.o., d/c home
* 3/12: referred because of episodes of abnormal eye movements. (one episode recorded by Mum by camera)
	+ ? epileptic →referral to SGH Neurology
* 5 y/o: severe CF patient, fever, cough +++, unwell
	+ Bloods, CXR →worse than before
	+ Imipenem changed to Meropenem

## 14th May:

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 2 weeks old girl: mastitis. On p.o. flucloxacillin. Not improving. No systemic signs of infection.
	+ USS planned + surgical revision.
* 5 y/o: Hx of spina bifida, hydrocephalus, VP shunt. P/C 1x vomit, fever.
	+ ?raised ICP. Head CT: no change. Bloods: ↑↑lymphocytes, ↑ALT, GGT
		- Hepatitis serology: neg., EBV, CVM: pending.
* 2 y/o: Henoch-Schönlein purpura
	+ urine: NAD. No abdominal complaints. D/C home. To check urine at home with dipstick every week for 4 weeks, then 2 weekly.

## 15th May:

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 6 y/o: ALL patient. 1 day hx of fever, unwell, vomit. Not neutropenic. ? sepsis
	+ started on Taz+Gent.
* 15 y/o: mixed OD Buscopan+ Pregabalin.
	+ ECG monitoring.
* 3 y/o: simple febrile convulsion
	+ source of fever: viral URTI. Observation.

## 16th May:

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Today’s most interesting case:

15/12 boy: Readmission due to deteriorating/regressing walking over the last 3-4 weeks. PMHx: Recurrent ear infections and tonsillitis. Was diagnosed with (possible) labyrinthitis 10 days earlier, treated with Co-amoxiclav. Readmitted because parents feel that his walking is getting worse every day. Previously was walking normally (since 10 months of age).

On admission neurolgical examination was abnormal. Muscle hypotonia. Absent reflexes on lower limbs. Unable to walk on his own. Unsteady crawling. ? underlying neurological/neuromuscular condition. ? Gullain-Barré sy , ? neuromuscular. Transported for further investigations to SGH.

MRI was performed. Dg.: Guillain-Barré sy. Therapy: IVIG.

## 16th week – 19-23/05/2014

## 19th May

Grand round. Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples.

* 8 y/o: known benign intracranial hypertension, papillaedema . P/C increased headaches
* Ophthalmology review re visual acuity.
* 5 y/o: severe eczema, infected – p.o. Augmentin. Contact SGH re hospitalization there.
* 10 y/o: newly diagnosed possible ALL - pale, presented with petechiae on lower limbs – WCC 110, Hgb 75, Plt 28
	+ Iv. fluids, allopurinol overnight. Plt transf. Morning transfer to SGH Haematology.
* 4 y/o: viral induced wheeze
	+ Salbutamol, Atrovent nebs

## 20th May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples.

* 2 y/o: excessive crying when trying to pass stools, abdominal pain. PMHx constipation.
	+ Dg.: constipation. To start Movicol.
* 6/12: Presented with cough, shortness of breath, tachypne. No fever. Dg.: Bronchiolitis, no O2 requirements, feeding as usual
	+ discharge with open access. NPA done.
* 8/12: fever, cough, unwell
	+ CXR: patchy shadowing on R side
	+ therapy: p.o. Azithromycin

## 21st May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples.

Wednesday afternoon teaching for junior doctors. Topics: Hyponatremia. X-ray tutorial.

* 16 y/o: anorexia nervosa, under psychiatric care. Losing weight.
* for medical assessment (anorexia nervosa assessment chart) and bloods
* 15 y/o: presenting with R arm numbness and ? weakness
	+ hx of similar episode – dg.: hemiplegic migraine, MRI, MRA normal
* 20/12: review for ? haematochezia. Hx reviewed – possible constipation.
	+ Movicol ½-1 sachet/day, follow-up

## 22nd May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E.

* 4 y/o boy: admission for simple febrile seizure. Source of fever: acute otitis media – th: Augmentin. PMHx: autism, 2x grand mal in the past – EEG negative, MRI failed to perform. Frequent absence episodes.
* 1,5 y/o: readmission due to wheezy episode, does not cope with 4 hourly inhalers
	+ Salbutamol nebs, prednisolone p.o.
* 3 y/o: fever, acute otitis media + conjunctivitis, ? swollen testicles
	+ th.: Co-amoxiclav p.o.

## 23rdMay

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples.

* 3 y/o: readmission. 2 days ago discharged with wheezy episode, to continue Salbutamol at home. Yesterday evening worsening. Atrovent + Salbutamol nebs, Prednisolone p.o.
* 5 y/o: underlying condition: SMA. Presented with fever, cough. Bloods: CRP 100.
	+ Therapy: Iv. ceftriaxone.
* 6 y/o: Brought in by ambulance because of prolonged seizure. Still unresponsive on arrival, slow recovery. Afebrile.
	+ PMHx: Previous seizure. MRI head: left posterior fossa arachnoid cyst. Awaiting neurology appt. in SGH.
* 15/12 pt. with confirmed Guillain-Barré sy. transported back to the Ward. Received IVIG. On Gabapentin therapy. Improving symptoms, now walking. Needs physiotherapy.

## 17th week – 26-31/05/2014

## 26th May – Monday, Bank holiday

## 27th May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples. Hours completed 6th May.

* 10 y/o: Down’s syndrome, with fever and URTI symptoms
	+ complaining of knee pain. Reactive arthritis.
* 9/12: pneumonia. Th: iv. ceftriaxone, p.o. azithromycin. CXR: diaphragmatic lump ? eventration → d/w SGH Paed. Surgery.
* 3/12: Presented with a fever 38.4. URTI symptoms. Well in himself. Admitted for observation. No more temperatures.

## 28th May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples. Hours completed 7th May.

* 1,5 y/o: Fever, rash, some of them petechial, but well in herself→ bloods (incl. clotting): NAD.
* 10/12: A&E: possible foreign body aspiration
	+ CXR: NAD. Transported to SGH for bronchoscopy. (Tinfoil removed from subglottis)
* 16 y/o: Presented with a collapse. Previous hospitalization swith abd. pain. Observation overnight, BP monitoring. Possibly vasovagal.

## 29th May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples. Hours completed 13th May.

* 4,5 y/o: GP referral. Cervical lymphadenopathy for 2 weeks. Previous URTI. No fever, well.
	+ Bloods: Normal. Possibly reactive. Follow-up in 2 months.
* 15 y/o: Presented with peritonsillar abscess. ENT: incision.
	+ th.: Iv. metronidazol, iv. penicillin.
* 2/12 o.: P/c 2.5 weeks cough. No temperature or cold symptoms. Tried Gaviscon: no effect.
	+ dg.: GERD. Th.: Ranitindine. Follow-up in 1 week.

## 30th May

Taking part in ward round, reviewing patients admitted the previous day. Admitting patients referred by GPs or A&E. Taking blood samples. Hours completed 20th May.

* 7 y/o girl: Referred by GP. 6-7 months hx of episodic dizziness +- headaches. No vomiting. No concerning neurological findings on examination. No complaints on examination.
	+ Dg.: ? benign paroxysmal vertigo. → ENT referral. Follow-up in clinic.
* 3 y/o boy: presented with fever
	+ on examination: L side of chest: decreased breath sounds, on percussion dull
	+ chest X ray: infiltration on L side.
	+ th: iv. Ceftriaxone for 48 hours, then switch to oral abx
* 15 y/o: Known to CAMHS. Brought in by ambulance, intentional ingestion of 6 g Paracetamol, 27 mg Pizotifen.
	+ Bloods: paracetamol level below treatment line. Observation overnight. ECG: Normal. CAHMS review.

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