Outline of the Pediatric History:

Chief Complain
History of Present Illness
Past Medical History
Pregnancy and Birth History
Developmental History
Feeding History
Review of Systems
Family History
Social History
Immunisation History
Differences of a Pediatric History Compared to an Adult History:

I. Content Differences
   A. Prenatal and birth history
   B. Developmental history
   C. Social history of family - environmental risks
   D. Immunization history

II. Parent as Historian
Pregnancy and Birth History

Maternal health during pregnancy: bleeding, trauma, hypertension, fevers, infectious illnesses, drugs, alcohol, smoking, rupture of membranes, gestational age at delivery

Labor and delivery - Type of delivery (vaginal, cesarean section), use of forceps, breech delivery.

Neonatal period - Apgar scores, breathing problems, use of oxygen, need for intensive care, hyperbilirubinemia, birth injuries, feeding problems, length of stay, birth weight.
Birth History

- Born at 34 weeks
- Emergency Section, 3.250 kg, foetal distress
- Spontaneous labour and PROM
- Pregnancy and scans fine
- Was on SCBU for 3 weeks
- Needed CPAP for 1 day and then some oxygen for a while
- No oxygen when went home
Developmental History

A. **Ages at which milestones were achieved and current developmental abilities** - smiling, rolling, sitting alone, crawling, walking, running, 1st word, toilet training, riding tricycle, etc (see developmental charts)

B. **School** - present grade, specific problems, interaction with peers

C. **Behavior** - enuresis, temper tantrums, thumb sucking, pica, nightmares etc.
Developmental History

★ Smiled at 10 weeks
★ Sat at 6 months
★ Never crawled
★ Walked at 13 months
★ Started talking around 18 months
★ No problems with hearing or vision
★ Average progress at school
Feeding History

A. Breast or bottle fed, types of formula, frequency and amount, reasons for any changes in formula
B. Solids - when introduced, problems created by specific types.
Family History

- Dad got eczema and hay fever
- Maternal grandma has diabetes
- Paternal Grandfather had TB
- Mum and Dad separated
- Younger 2 year old brother also has eczema
- No consanguinity
Immunisation History

* ‘up to date’
* didn’t have MMR – cousin with autism
PHYSICAL EXAMINATION-
Differences in Performing A Pediatric Physical Examination Compared to an Adult:

"Of course I know what he wants when he cries. He wants you."
General Principles & Tips

- Get down to their level
- A lot of information can be gained by INSPECTION alone, before you lay an hand on the patient
- Beware of asking the child’s permission
- Know a conversation topic / latest craze / TV characters / films relating to different age groups
- Examination needs to involve play and be opportunistic but thorough
Keep Mum close at hand and in child’s view or reach

Keep child in the position in which they are comfortable. No need to lie them down unless you have to - children are very vulnerable in this position

Save the nasty things to the end so that you don’t lose trust (eg ENT)
Techniques of Physical Assessment

- Inspection
- Palpation
- Percussion
- Auscultation

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Vital signs

Normals differ from adults, and vary according to age
See charts of age-adjusted normals

A. Temperature
Tympanic vs. oral vs. axillary vs. rectal

B. Heart rate
1. Auscultate or palpate apical pulse.
2. Palpate antecubital or femoral pulse in infant and radial pulse in older child
C. Respiratory rate
Observe for a minute. Infants normally have periodic breathing so that observing for only 15 seconds will result in a skewed number.

D. Blood pressure
Appropriate size cuff - 2/3 width of upper arm

E. Growth parameters - must plot on appropriate growth curve:
   1. Weight
   2. Height/length
   3. OFC: Across frontal-occipital prominence so greatest diameter
Developmental assessment

- Gross Motor
- Fine Motor
- Language
- Social

These are normal stages of development in children. If any child is late by one or two months in doing any of these activities, send to a doctor.
Basic Newborn Assessment
Skin

• PE of the skin, what does and *can* it mean?
  – Cutis Marmorata
  – Harlequin Color Change
  – Ecchymosis
  – Macule
  – Petechiae
  – Vesicle
  – Pustule
Cutis Marmorata
Harlequin Color Change
Ecchymosis (Bruising) Increases Risk for Jaundice
Macule
Petechiae
Vesicle
Head to Toe Assessment!
Head

- Measurement: Microcephaly? Macrocephaly?
- Shape: molding?
Skull: fontanels and sutures
Pustule
Nose
Mouth
Ears

Preauricular Sinus
**Observing retractions**

When you observe retractions in infants and children, be sure to note their exact location—an important clue to the cause and severity of respiratory distress. For example, subcostal and substernal retractions usually result from lower respiratory tract disorders; suprasternal retractions, from upper respiratory tract disorders.

Mild intercostal retractions alone may be normal. However, intercostal retractions accompanied by subcostal and substernal retractions may indicate moderate respiratory distress. Deep suprasternal retractions typically indicate severe distress.
Heart

- Murmur?
- 4 limb Blood Pressure
- Pulses
Abdomen

- Size
- Shape
- Movement
Abdomen
Genitourinary
Hymenal Tag

Figura 1. Formación poliposa de superficie lisa, color carnoso y consistencia blanda (tag himenéal)
Musculoskeletal
Hip Examination
Barlow
Primitive Reflexes
Background

- Primitive reflexes start to emerge during the **late foetal period**, e.g. Rooting and sucking reflex.

- Most of these reflexes are already **present at birth**, e.g. Rooting and sucking reflex.

- These reflexes are of **sub-cortical origin**, arising mainly in the **brainstem** and to some degree in the **Spinal Cord**.
The majority reflexes are integrated/disappear by the age of 6/12 (at latest by 12/12) due to the increasing inhibitory effect of the maturing cortex. Those with protective value tend to persist throughout life.

The persistence or reappearance of these primitive reflexes after the age of 6/12 is abnormal and usually indicative of cortical or cerebral damage. These reflexes lock the child in a “holding pattern” and their development becomes stuck, significantly impair their development of postural control, achievement of milestones and volitional movement.
Primitive Reflexes ~ Palmar Grasp

- The palmar grasp reflex one of the most reflexes to
- Appears in utero
- Endures through the 4th month
- Negative palmer grasp: neurological problems; spasticity
- Leads to voluntary reaching and grasping

May predict handedness in adulthood
Primitive Reflexes ~ Sucking

• Occurs pre-and postnatally
  – Babies are born with blisters on lips
• Stimulated by touching the lips
Primitive Reflexes ~ Search

- Helps the baby locate nourishment
- Baby turns head toward the food
- Usually works in conjunctions with sucking reflex
- Contributes to head- and body-righting reflexes

Stimulus ~ touching the cheek
Primitive Reflexes ~ Moro Reflex

- Palm of hand lifts back of head
- Hand is removed suddenly so that head begins to fall
  - Head is supported
- Moro reflex precedes the startle reflex and causes the arms and legs to extend immediately rather than flex
- Disappears at 4-6 months
Primitive Reflexes ~
Asymmetric Tonic Neck Reflex

- Causes flexion on one side and extension on the other
- Not always seen in newborn
- Facilitates the development of bilateral body awareness
Primitive Reflexes ~ Plantar Grasp

- The toes appear to be grasping
- Stimulus is touching the ball of the foot
- This reflex must disappear before the baby can stand or walk
Parachute reflex

- Elicited by holding the baby in ventral suspension with the head down, extension of the arms should occur to protect the head.

- This is a protective reflex and appears at six months and never disappears.
Landau reflex

- Elicited by holding the baby in ventral suspension
- The child will extend his head and legs.
- This reflex appears at 3 months and disappears by 1 year of age.
Primitive Reflexes ~ Babinski Reflex

• Elicited by a stimulus similar to plantar grasp, but response is different
• Test of the pyramidal tract activity for later motor movement
Postural Reflexes Stepping

Stepping reflex is a forerunner to walking
Parachuting Reflexes

- Propping reflexes
- Related to upright posture
- This reflex is a conscious attempt to break a potential fall
SUMMARY

* Good Paediatric history taking needs to be thorough and takes practice
* 70% of diagnoses can be made on the history alone
* ALWAYS listen to the mother
* Children are quite often unco-operative and examinations can be difficult
* Be prepared to PLAY
Questions?