

## CASE STUDY TWO FOR ED COURSE

### History of present illness:

DJ, a seven year old female, is brought by her mother for a severe sore throat and a croupy sounding cough. The child started with this illness yesterday. She came home from school with a fever and with a sore throat. The child refused to eat dinner but did drink Gatorade during the evening. At 2 a. m., she woke up complaining of a sore throat and had a barking cough, she was able to drink tea and was given advil 3 teaspoon for her fever. The child slept on four pillows during the early a.m. The mother decided to bring the child to the ed since she didn't look right and refused to drink. The mother thought the child was dehydrated. She has voided yesterday and during the night. The last urine output was two hours ago. The rest of the house is well. There is no exposure to sick friends and there have been no known severe illnesses at school.

### Review of systems:

#### Remarkable for:

Other than the symptoms associated with present illness, the following is reported with regard to recent health:

General: No recent fever

HEENT: had a mild running nose for two days prior to the illness

Heart: no chest pain

GI: no constipation, abdominal pain

GU: no problems with UTI

Neuro: no generalized weakness

Psychiatric illness: none reports

Past medical History: The child was a full term baby born via NSVD weighing 7 pound to 26 year old mother. The child went home with mother. The child has never been hospitalized. Has had an episode of croup every year until age 4 years. She never needed any medication for the croup. The mother was told by the doctor that her child seemed prone to croup. The child has hay fever with allergic rhinitis as the main symptoms. She has had no surgeries or intercurrent serious health problems. She had varicella at age one year. No other significant illness.

Family history: The child lives with her parents who are now 33 years old. There are no siblings. There is a pet cat and an iguana. The parents are healthy. The maternal grandmother is 63 and has hypertension but is in excellent health. The paternal grandmother has mitral valve prolapse but the father does not have MVP. There is no diabetes, asthma or kidney disease in the family.

Social: Both parents work. The child gets picked up at the after school center around 4:30. They are active Born Again Christians and religion is a major factor in their lives. The family is very active in the community. There is no exposure to household smoke.

The house is about 10 years old and there is no exposure to any environmental hazards. There is a smoke and carbon monoxide detector in the house.

Immunizations: up to date

Medications: The child take Zrytec one teaspoon at hs with good control of her allergies. Last dose two days ago. The child is on motrin for fever control.

Allergies: No medications allergies. The child has dust and pollen allergies.

Physical examination:

Appearance: Alert child sitting in a position of comfort at 60 degree angle. Needs help to move her head around to get her into just the right position. The child is not afraid of the examiner

Vital signs: T 103 AR 142 RR 32 oxygenation 97% BP 128/84

Skin: warm, slightly flushed cheeks, without any rashes.

TM: pearly grey

Nose clear

Throat: not examined

Lymph: cervical adenopathy

Chest: Mild stridorous sounds noted. Air movement good in and out. No rales, rhonchi or wheezes noted

Thorax: Slight suprasternal retractions noted

Abdomen: soft examined while child was in 60 degree position

Rest of exam deferred

Based on the above history, You need to go to the bulletin board by Friday with:

Initial differential diagnosis

Initial actions

Initial plans

Initial tests

On Friday, I will post on the bulletin board the results of the tests. Then you get to decide what you give this patient to manage further including IV fluid rate, medications.

I would be happy to answer any e-mails regarding IV fluid rate as that lecture is one week out.