Pocket Picture Guides
to Clinical Medicine

Pediatrics

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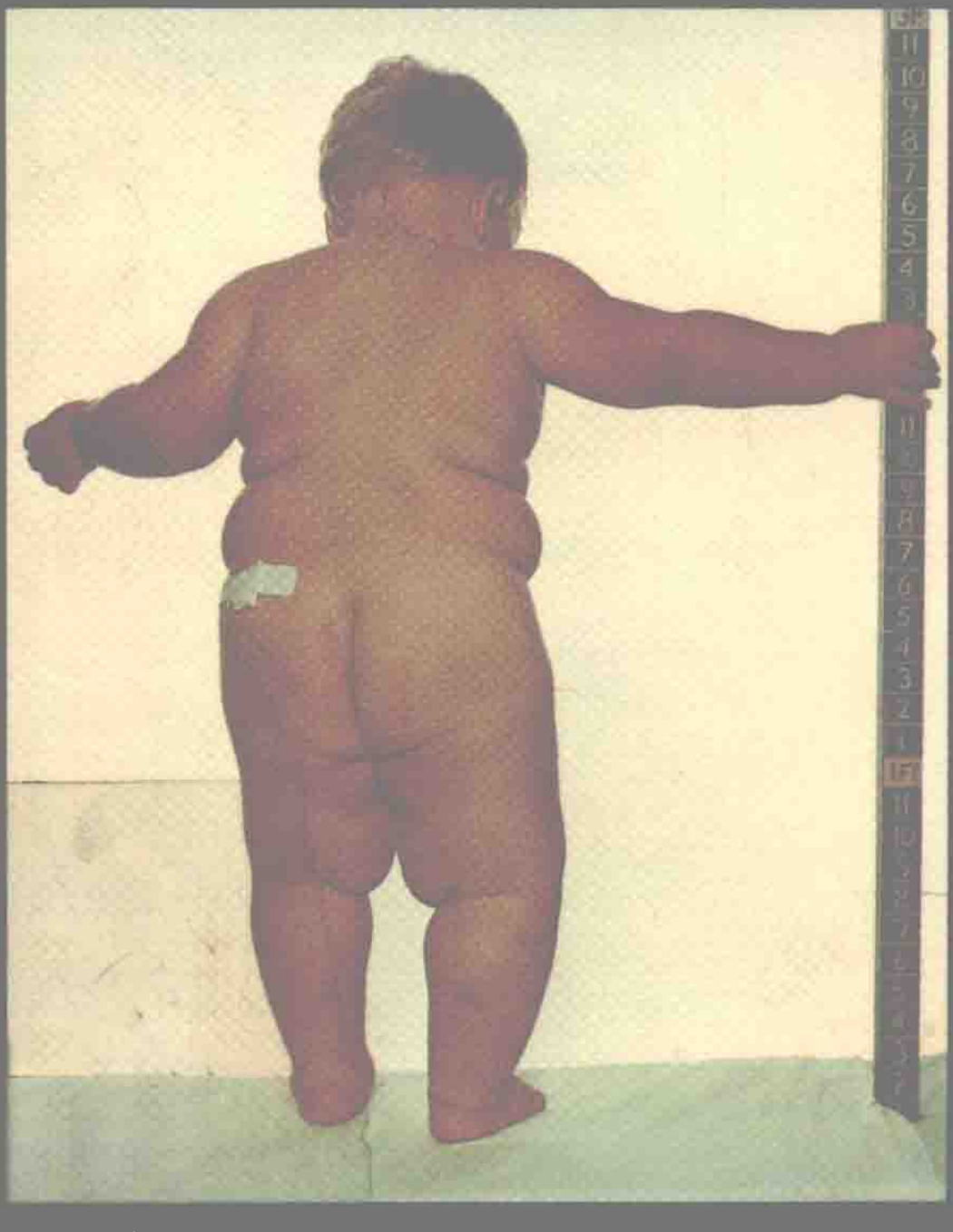

Williams & Wilkins

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Pocket Picture Guides to Clinical Medicine

The purpose of this series is to provide essential visual information about commonly encountered diseases in a convenient practical and economic format. Each Pocket Picture Guide covers an important area of day-to-day clinical medicine. The main feature of these books is the superbly photographed colour reproductions of typical clinical appearances. Other visual diagnostic information, such as X-rays, is included where appropriate. Each illustration is fully explained by a clearly written descriptive caption highlighting important diagnostic features. Tables presenting other diagnostic and differential diagnostic information are included where appropriate. A comprehensive and carefully compiled index makes each Pocket Picture Guide an easy to use source of visual reference.

An extensive series is planned and other titles in the initial group of Pocket Picture Guides are:

Infectious Diseases
Rheumatic Diseases
Sexually Transmitted Diseases
Skin Diseases

To Chloe and Alexander; Hannah and Michael

Introduction

This collection of colour clinical photographs is intended as a supplement to standard paediatric texts. Within the limitations of its size, we have tried to include as many common childhood conditions as possible. Several uncommon conditions have been included; those which demonstrate particular physical signs and those in which early recognition will influence management. We hope that this book will therefore be useful to undergraduate and postgraduate students of paediatrics and paediatric nursing.

We are grateful to the staff of the Hospital for Sick Children, Great Ormond Street, London and in particular Mr. R. Lunnon and Mr. M. Johns in the Department of Medical Illustration for providing an extensive library of high quality clinical photographs from which all these photographs were taken, except where indicated. Our thanks go to those who have kindly provided additional photographs.

Contents

The Neonate

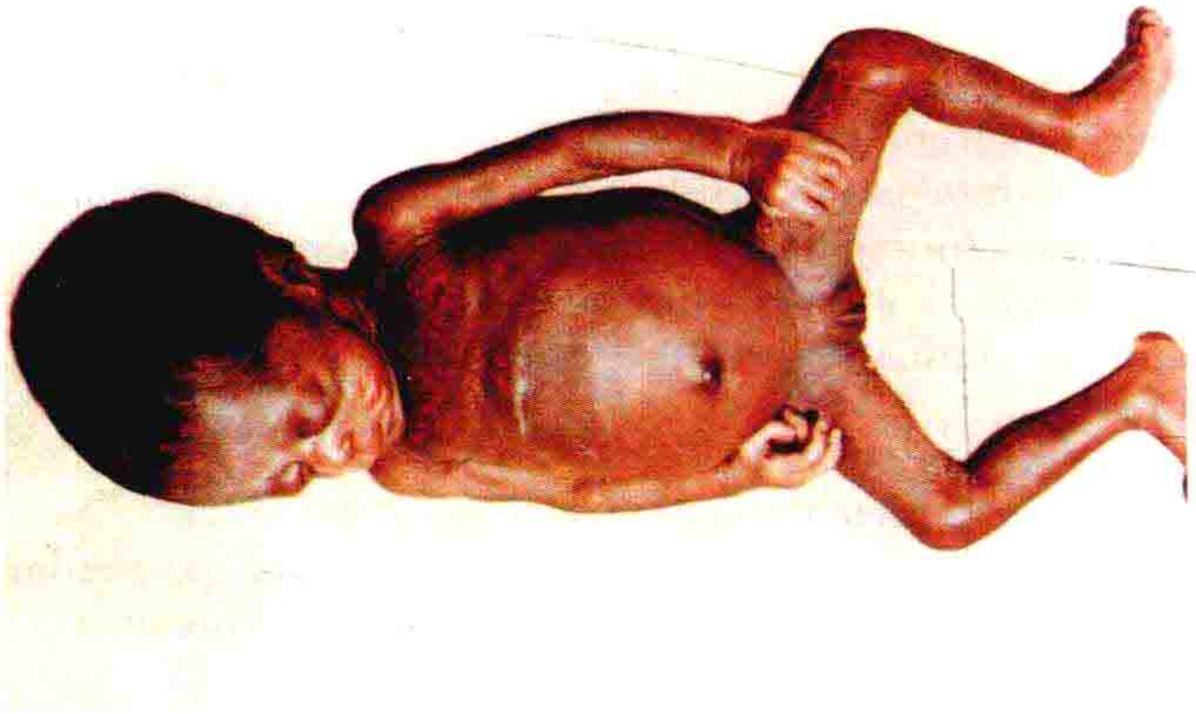

Fig. 1 Pre-term infant. The upper limbs are extended with frog-like flexion of the lower limbs. The labia majora are separated with the labia minora protruding. The skin is thin and translucent. By courtesy of TALC, Institute of Child Health.

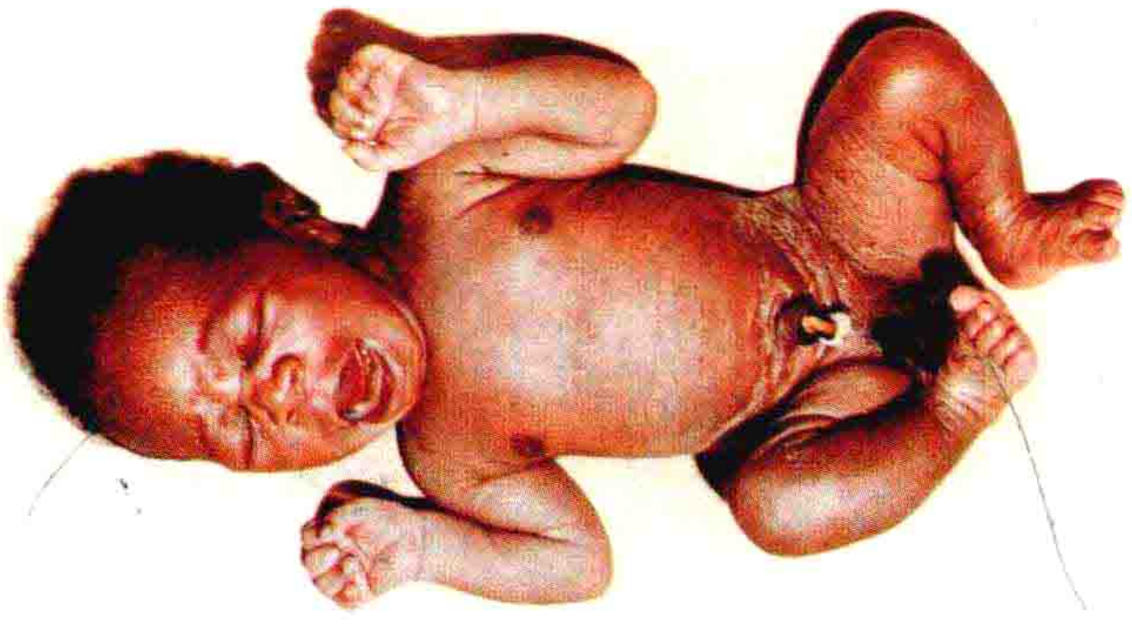

Fig. 2 Full term infant. In contrast to the pre-term infant there is full flexion of the knees, hips and elbows and the genitalia are mature. The skin is thicker and more subcutaneous fat is present. By courtesy of TALC, Institute of Child Health.

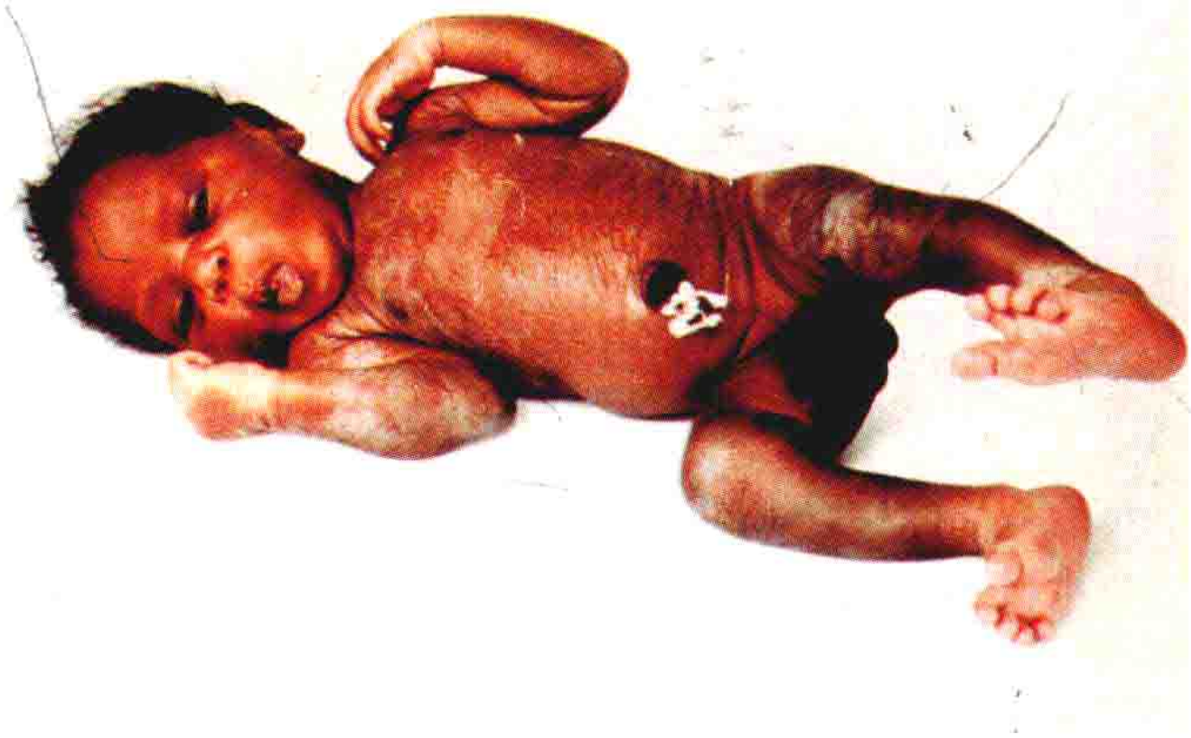

Fig. 3 Post-mature infant. The gestation period is over 42 weeks and the infant has characteristically dry, peeling skin. By courtesy of TALC, Institute of Child Health.

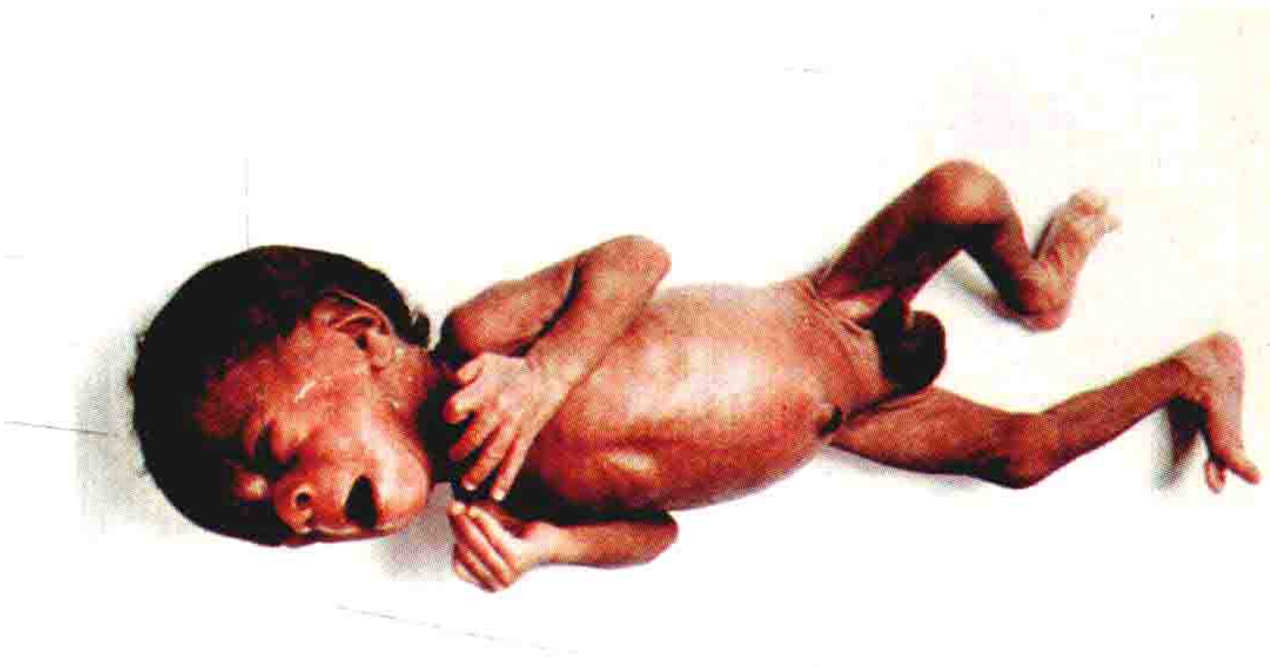

Fig. 4 Light-for-dates infant. This term baby weighed only 1.7 kg. The head appears disproportionately large for the thin, wasted body. This results from placental insufficiency late in pregnancy. Hypoglycaemia may be a complication. By courtesy of TALC, Institute of Child Health.

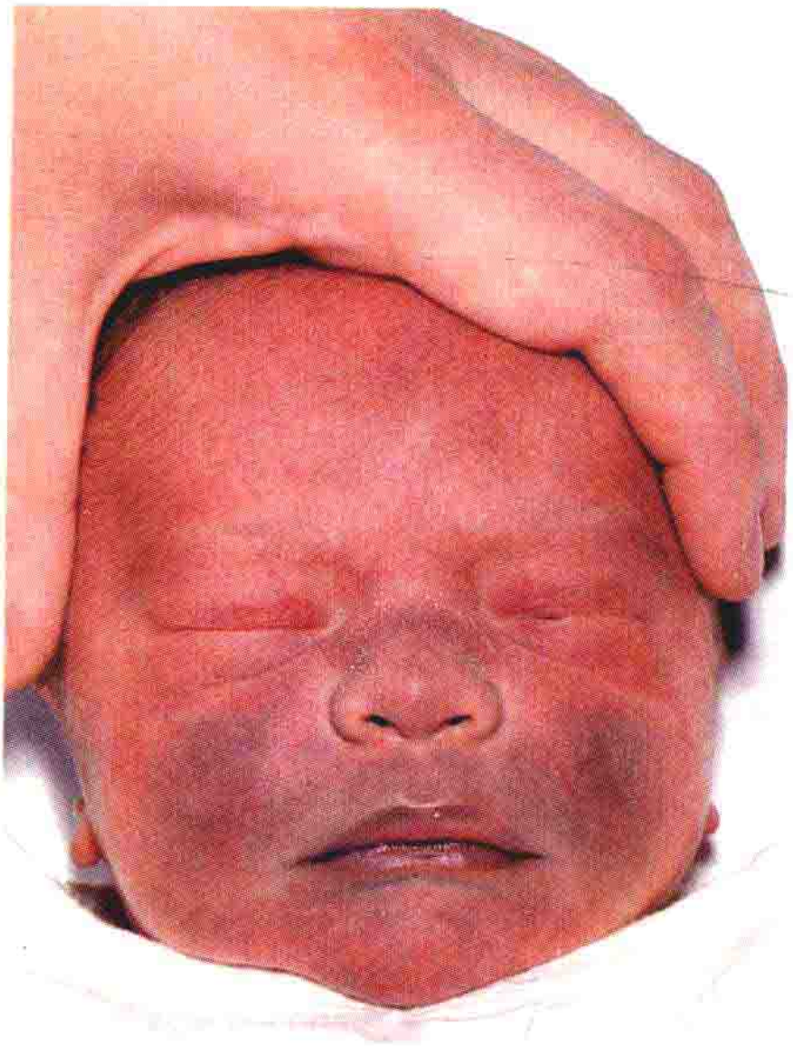

Fig. 5 Face to pubes presentation. There is extensive bruising and petechiae of the presenting part. The infant is not cyanosed. Extensive neonatal bruising may result in jaundice.

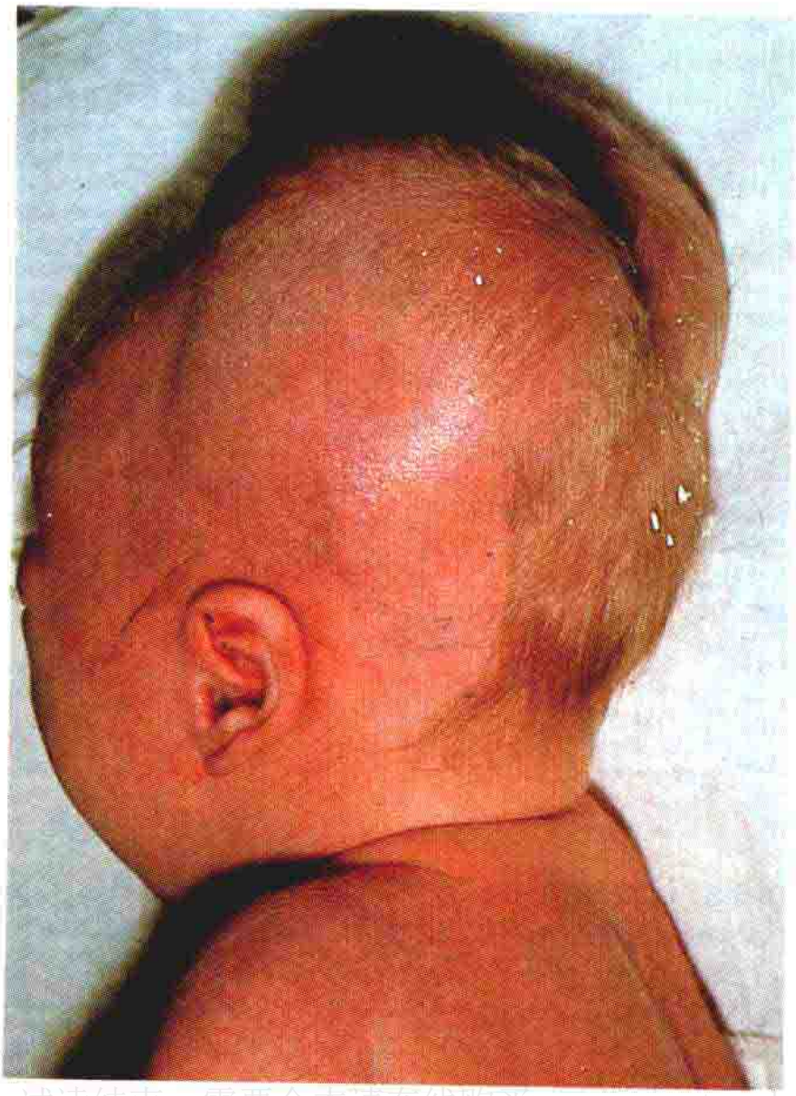

Fig. 6 Cephalhaematoma. Swellings are present over both parietal bones. These are subperiosteal haemorrhages which may be associated with skull fracture. Jaundice may develop. Spontaneous resolution occurs, sometimes with calcification. By courtesy of Dr. P. Daish and by kind permission of Dr. P.M. Dunn.

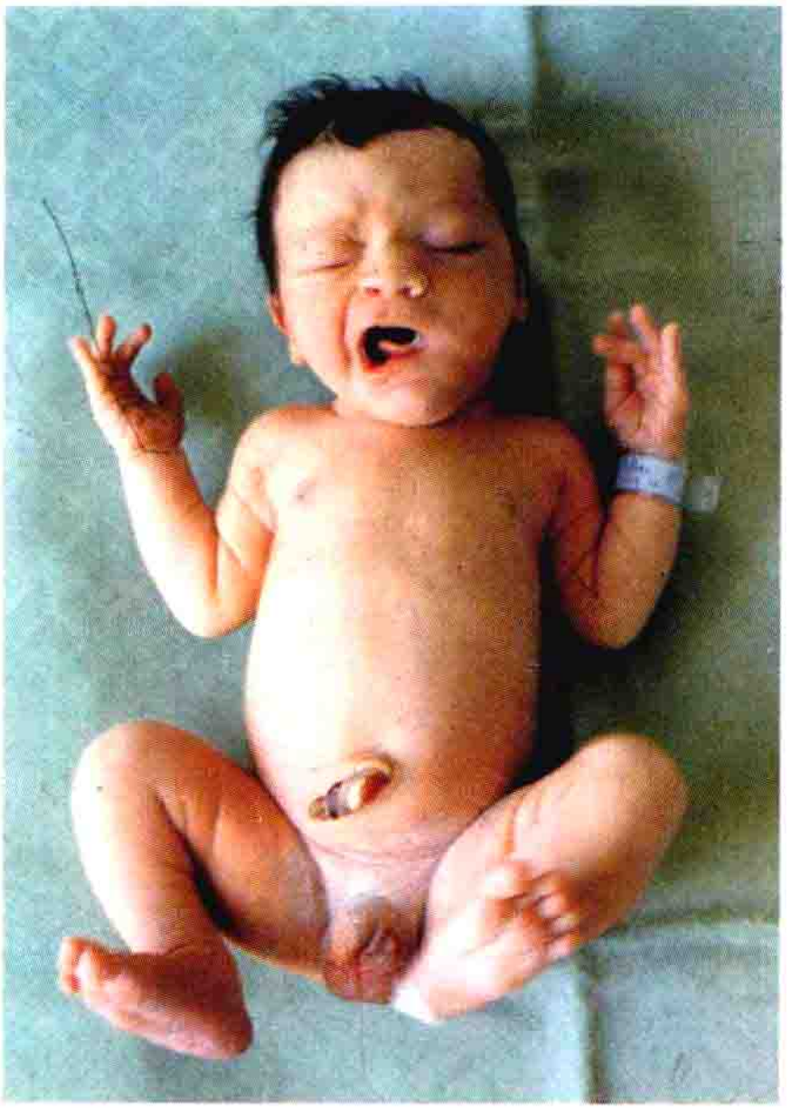

Fig. 7 Facial palsy. A left facial palsy is present in this term baby. This is a lower motor neurone lesion which may result from pressure *in utero* or following forceps delivery. If the nerve fibres are not torn, recovery occurs after a few weeks but the eye may need special care during this time. By courtesy of Dr. P. Daish and by kind permission of Dr. P.M. Dunn.

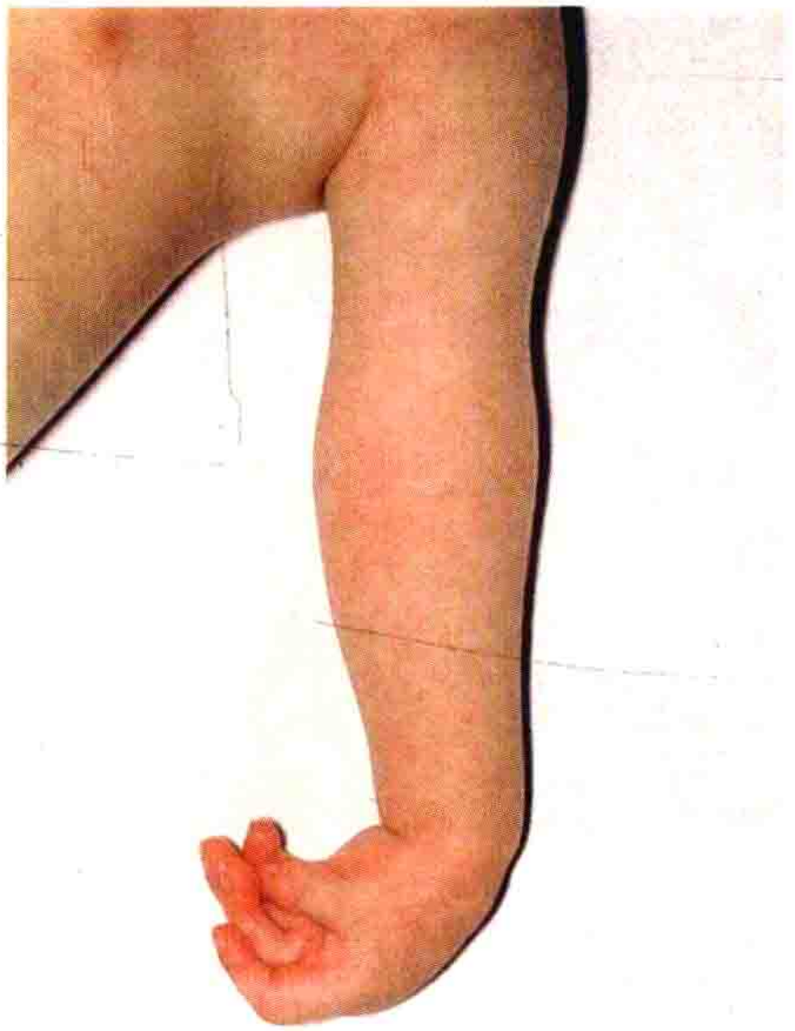

Fig. 8 Erb's palsy. The arm is internally rotated, with pronation of the forearm and the characteristic 'waiter's tip' position of the hand. This C5-6 branchial plexus lesion is often due to shoulder traction during delivery.

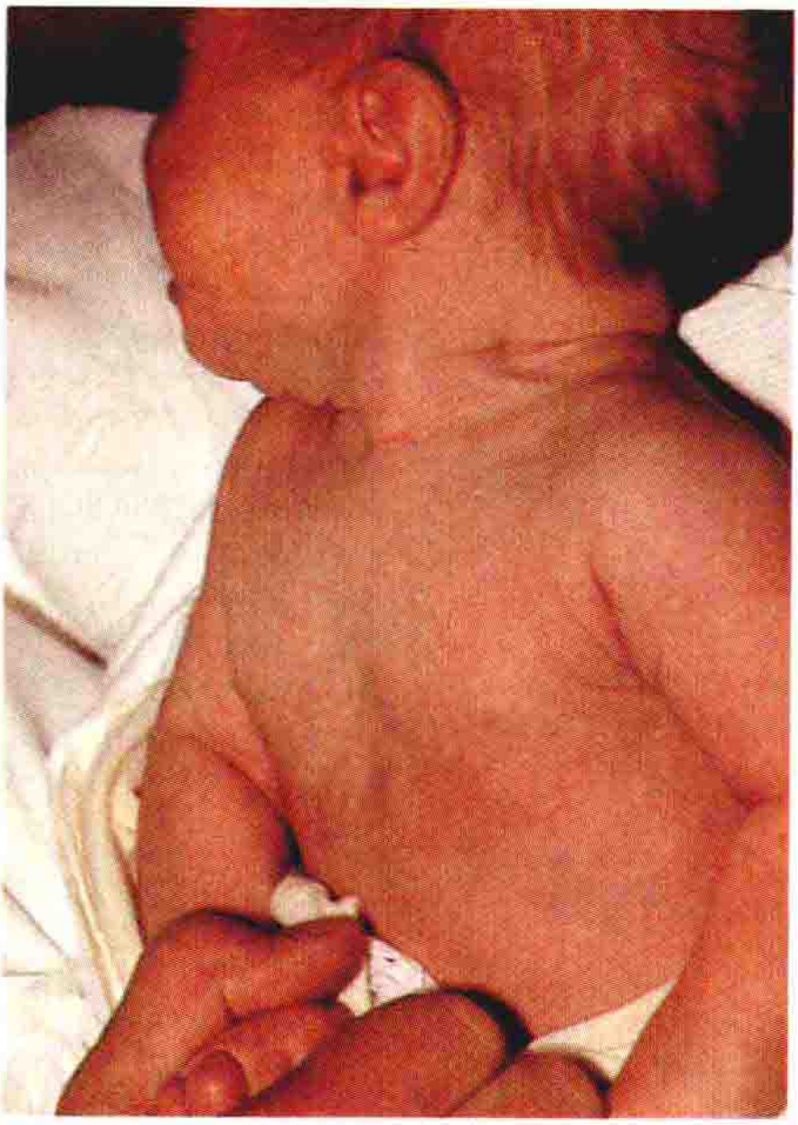

Fig. 9
Sternomastoid tumour. There is shortening of the left sternocleidomastoid with swelling in its mid portion. The condition is of unknown aetiology and is associated with torticollis if untreated.

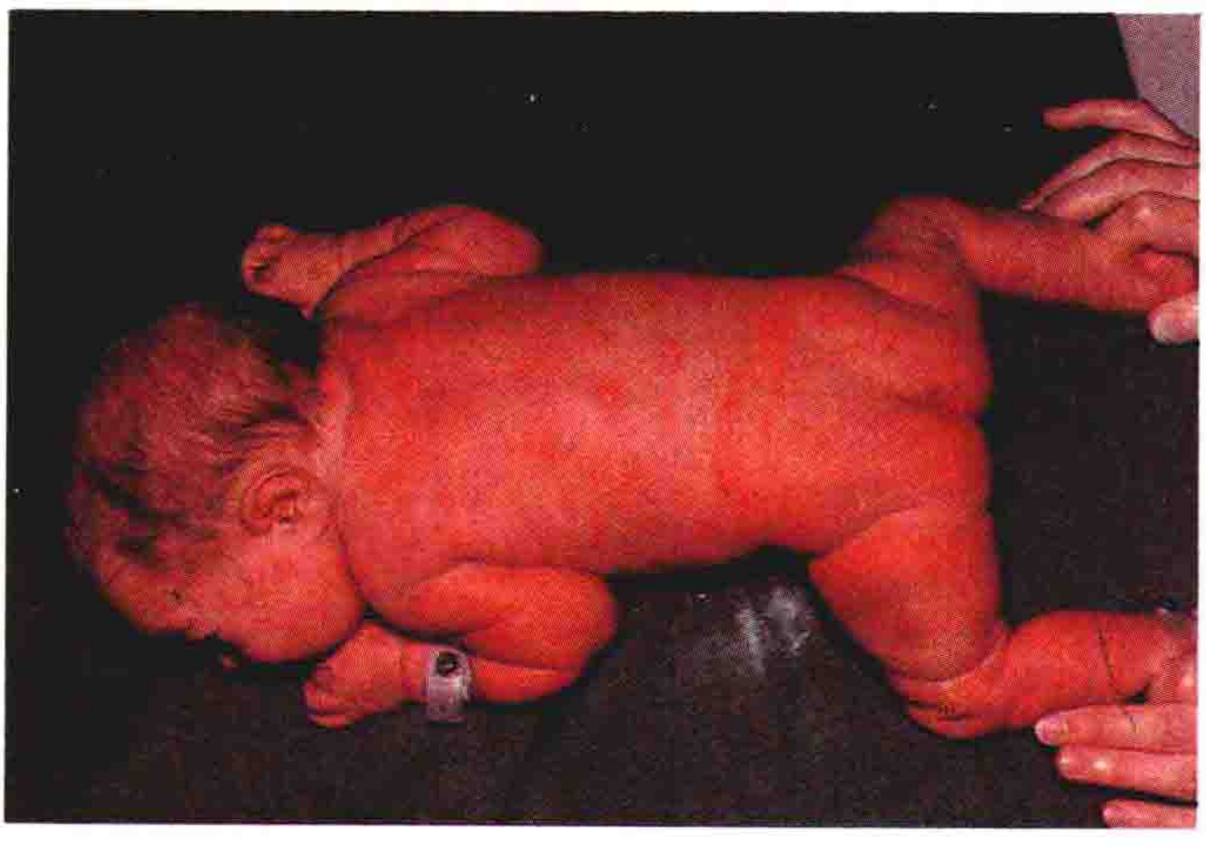

Fig. 10 Toxic erythema (neonatal urticaria). Blotchy erythema occurs with firm yellow-white pustules. These contain eosinophil-rich fluid which is sterile on culture. This condition is common, benign and self-limiting and usually appears around the second day of life.

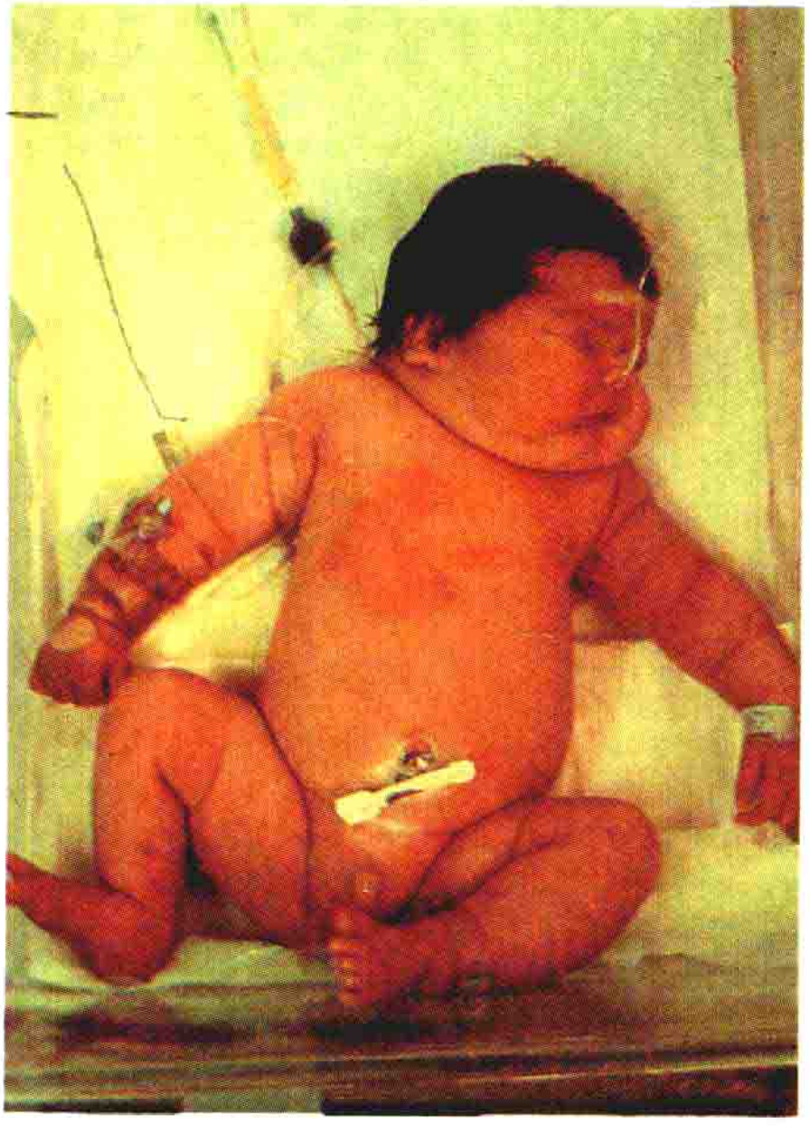

Fig. 11 Infant of diabetic mother. These babies are large and fat, often over 4 kg, and all look remarkably similar. Visceromegaly may be present. Early hypoglycaemia is common and there is an increased incidence of hyaline membrane disease, cardiac failure and hypocalcaemia. By By courtesy of Dr. P. Daish and by kind permission of Dr. P.M. Dunn.

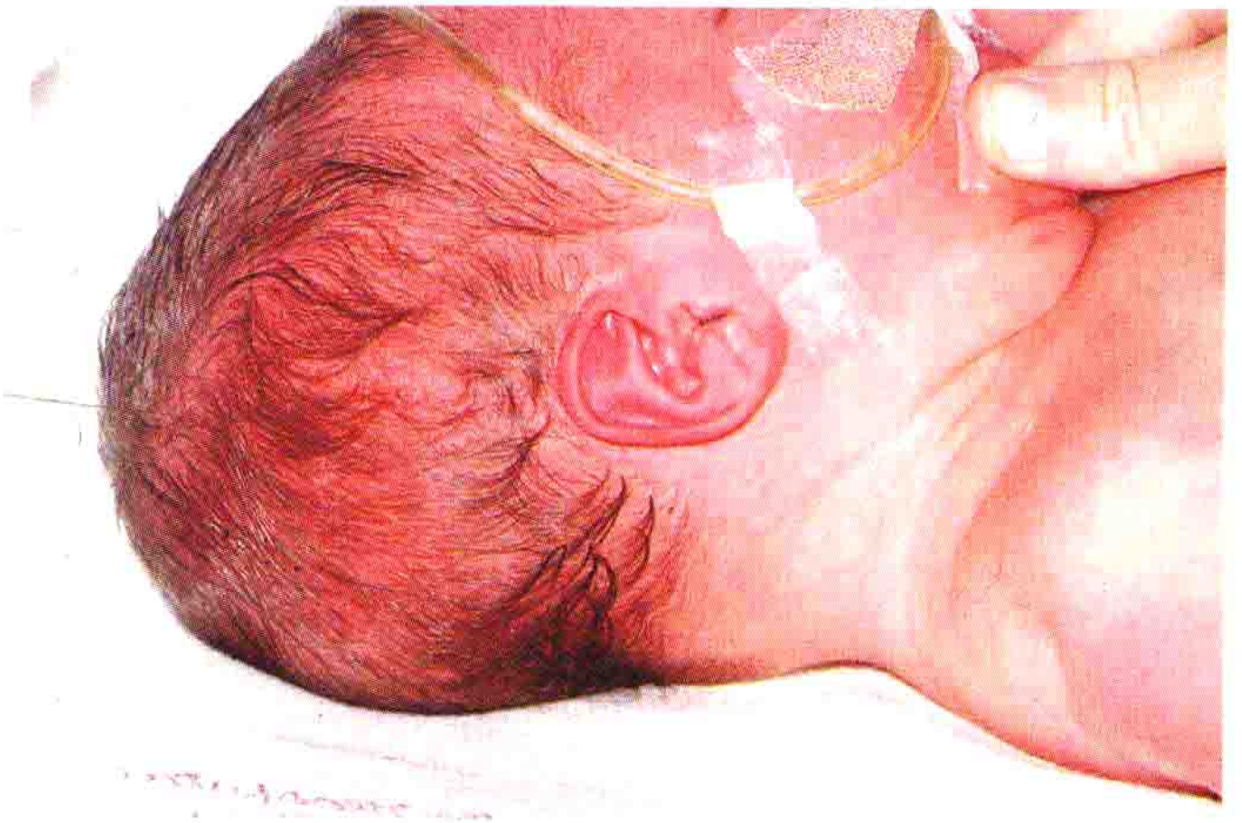

Fig. 12 Beckwith's syndrome. These infants are of high birth weight with macroglossia, exomphalos (see Fig. 178) and visceromegaly. Characteristic linear creases are present in the ear lobe. Hypoglycaemia is common and may be severe and persistent.

Fig. 13 Potter's syndrome. Bilateral renal agenesis results in oligohydramnios with fetal compression. Pulmonary hypoplasia is present. There are characteristically low-set ears, a receding chin and beaked nose. Such infants are frequently stillborn, or die in the early neonatal period.

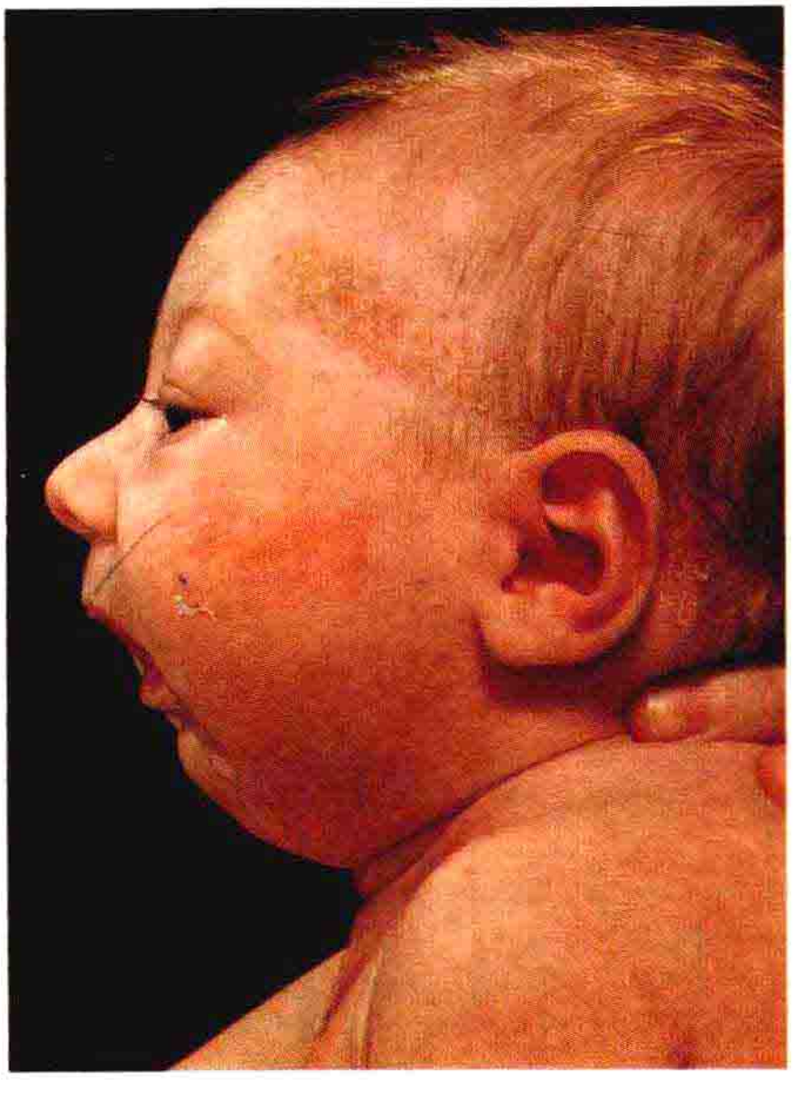

Fig. 14 Pierre-Robin syndrome. Mandibular hypoplasia leads to posterior displacement of the tongue, and a rounded palatal cleft. Obstruction of the upper airways may occur but this can be relieved by bringing the tongue forward. Feeding requires extra patience. Growth results in a normal profile.

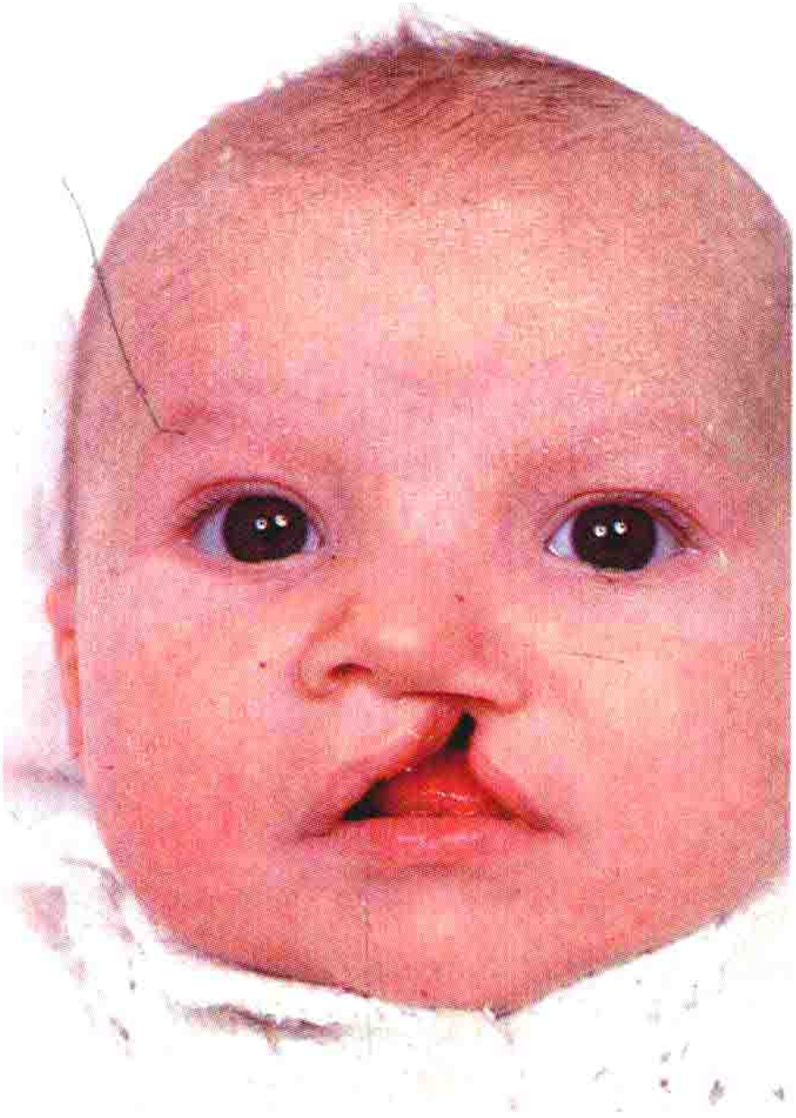

Fig. 15 Unilateral cleft lip. The alveolar margin is usually involved, and the nose is displaced and deformed. This condition may be associated with a cleft palate. The lip is usually repaired at around two months of age.

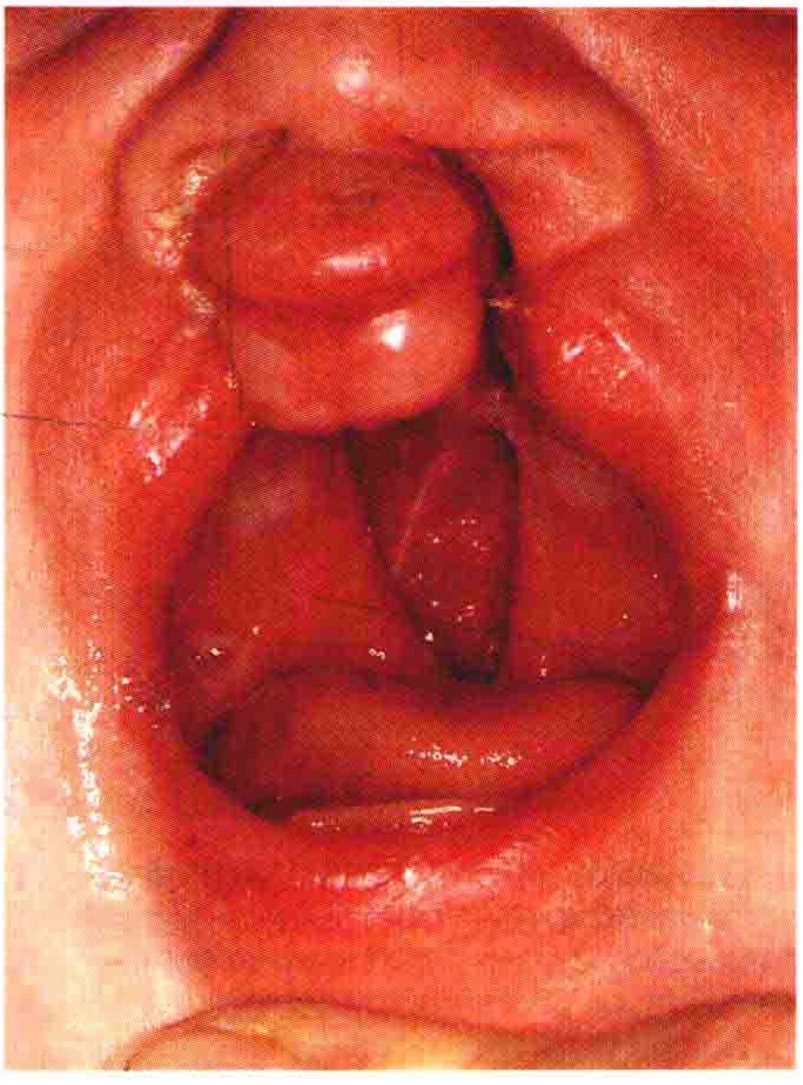

Fig. 16 Bilateral cleft lip and palate. The cleft extends from the soft to the hard palate, exposing the nasal cavity. Protrusion of the intermaxillary process is present. A multidisciplinary approach to management is important, as speech and dental problems arise in addition to the obvious cosmetic ones.

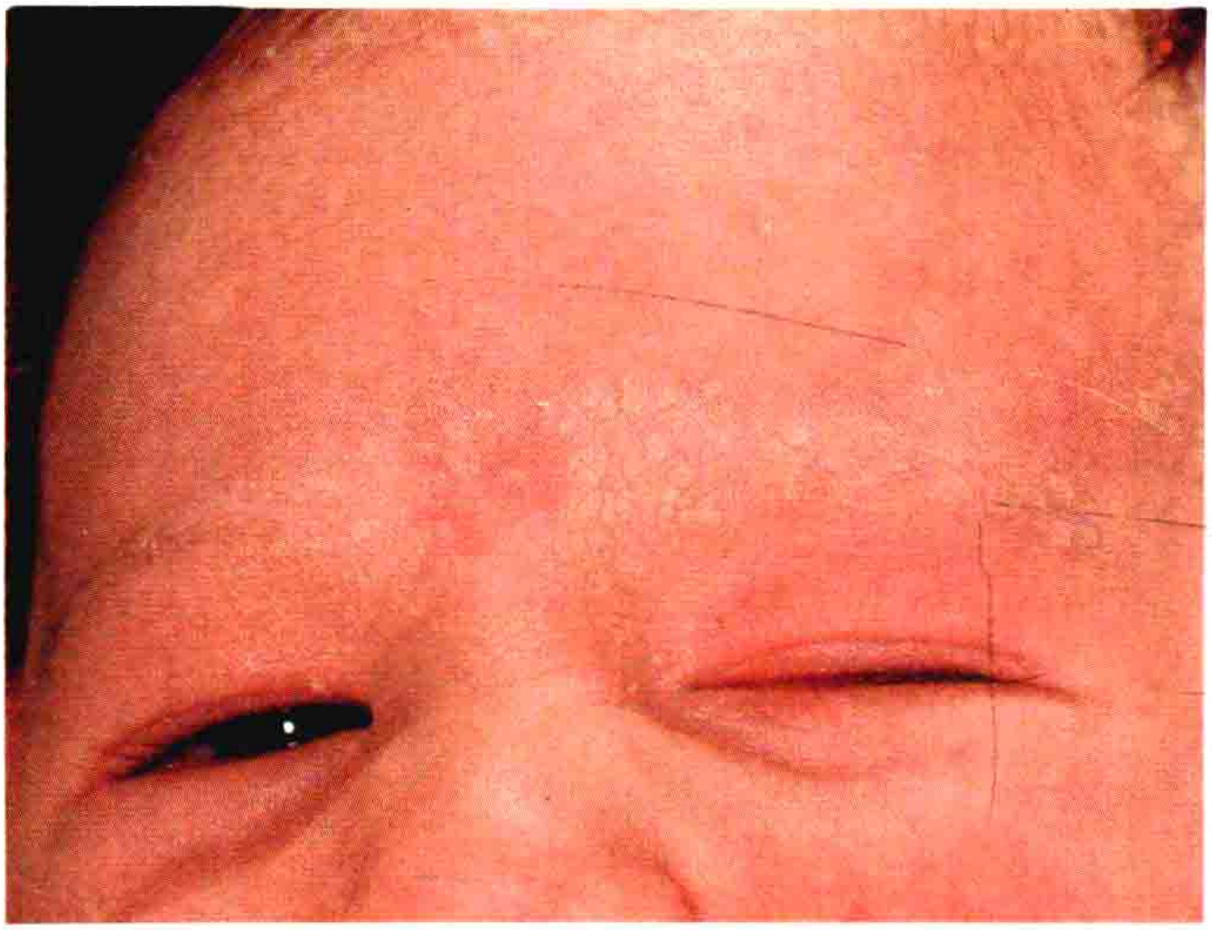

Fig. 17 Seborrhoeic dermatitis. A dry, scaly, non-pruritic erythematous dermatitis is seen, which may begin in the first month of life and is common throughout the first year. It affects the scalp (see Fig. 153), face, neck and napkin area.

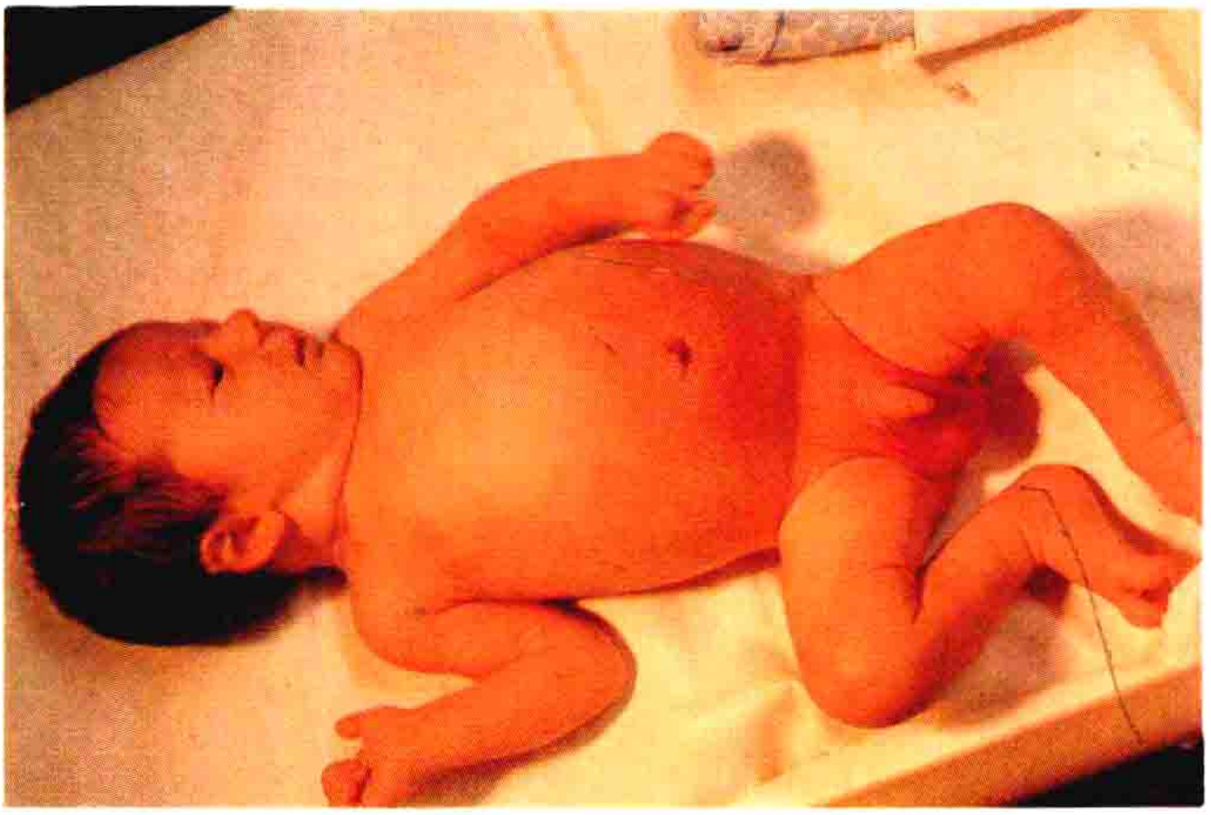

Fig. 18 Omphalitis. This is an umbilical infection due to pyogenic bacteria and is a serious complication of the neonatal period. Spread of infection to the liver or haematogenous spread are potentially serious complications which can be prevented by correct umbilical care. By courtesy of Dr. P. Daish.