双语版教学参考书

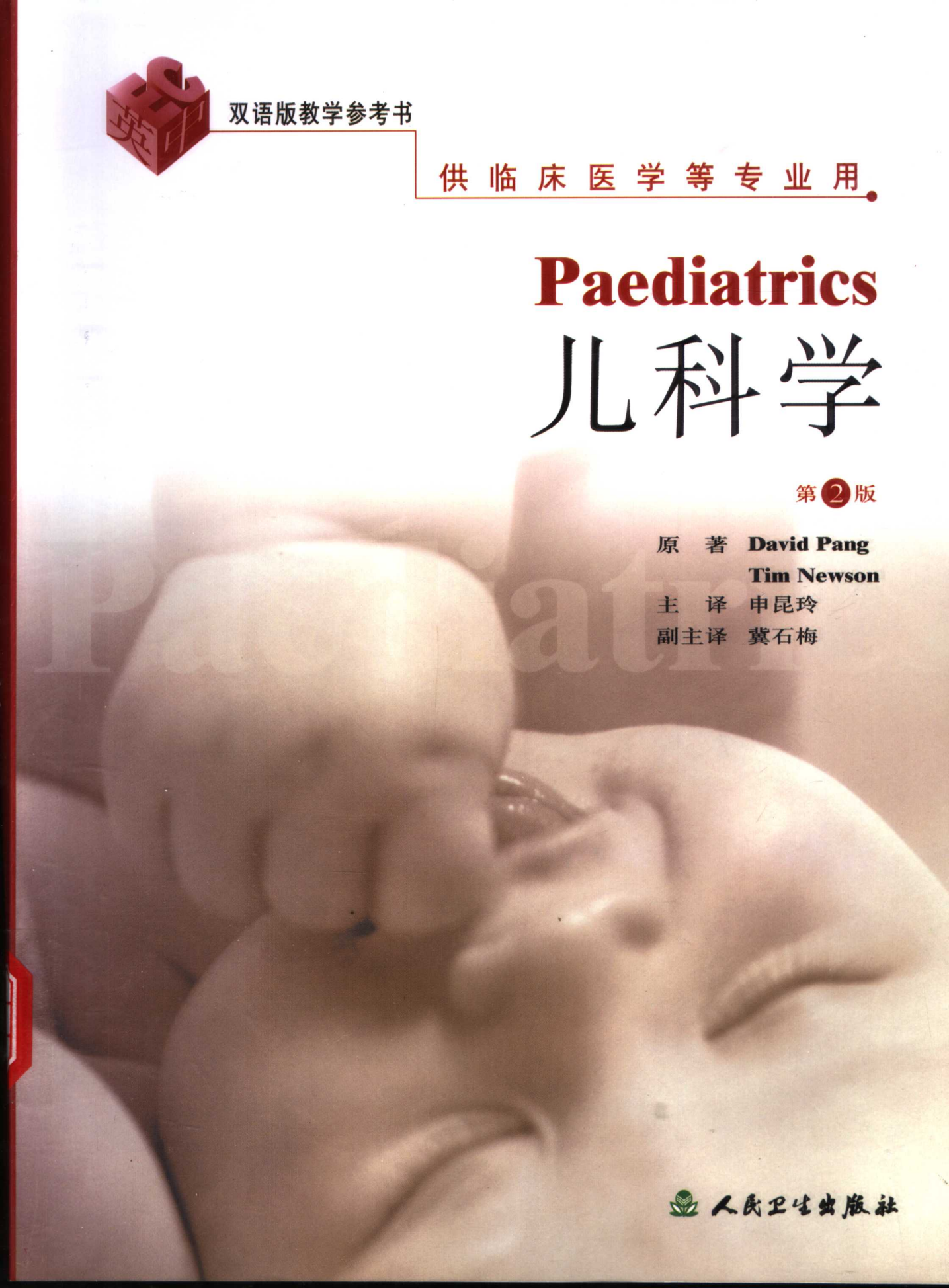
供临床医学等专业用

Paediatrics

儿科学

第2版

原　著　David Pang
Tim Newson
主　译　申昆玲
副主译　冀石梅



人民卫生出版社

Paediatrics

双语版教学参考书

供临床医学等专业用

Paediatrics
儿科学

第2版

原　著　David Pang
Tim Newson
主　译　申昆玲
副主译　冀石梅

译　者　（以姓氏笔画排序）
王亚娟　申昆玲　巩纯秀　刘　敏　杜忠东
张钦明　张　晶　张潍平　周　翾　徐子刚
殷　菊　郭卫红　韩彤立　冀石梅

人民卫生出版社

Paediatrics, 2e David Pang et al. ISBN: 0-7234-3374-7

Authorized Simplified Chinese translation edition published by the Proprietor.
ISBN: 981-2594-44-2

Elsevier (Singapore) Pte Ltd.
3 Killiney Road
#08-01 Winsland House I
Singapore 239519
Tel: (65) 6349-0200
Fax: (65) 6733-1817

First Published 2005
2005 年初版

Printed in China by People's Medical Publishing House under special arrangement with Elsevier (Singapore) Pte Ltd. This edition is authorized for sale in China only, excluding Hong Kong SAR and Taiwan. Unauthorized export of this edition is a violation of the Copyright Act. Violation of this Law is subject to Civil and Criminal Penalties.

本书简体中文版由人民卫生出版社与 Elsevier (Singapore) Pte Ltd. 在中国大陆境内合作出版。本版仅限在中国境内(不包括香港特别行政区及台湾)出版及标价销售。未经许可之出口,视为违反著作权法,将受法律之制裁。

图书在版编目(CIP)数据

儿科学/申昆玲主译. —北京:人民卫生出版社,
2005.10
ISBN 7-117-07040-4

Ⅰ.儿… Ⅱ.申… Ⅲ.儿科学 Ⅳ.R72

中国版本图书馆 CIP 数据核字(2005)第 100242 号

图字:01-2005-5253

Paediatrics

儿 科 学

主　　译:申昆玲
出版发行:人民卫生出版社(中继线 67616688)
地　　址:(100078)北京市丰台区方庄芳群园 3 区 3 号楼
网　　址:http://www.pmph.com
E-mail:pmph@pmph.com
邮购电话:010-67605754
印　　刷:北京智力达印刷有限公司印刷
经　　销:新华书店
开　　本:850×1168 1/16 **印张**:37 **字数**:921 千字
版　　次:2005 年 9 月第 1 版 2005 年 9 月第 1 版第 1 次印刷
标准书号:ISBN 7-117-07040-4/R·7041
定　　价:84.00 元

译 者 序

第2版《儿科学》内容言简意赅，适于初涉儿科的医学工作者阅读。其风格不同于标准教科书，共四部分：第一部分包括儿科病人常见的具有临床意义的症状、体征、异常表现及其鉴别诊断。第二部分详尽地描述了常见疾病的背景知识和诊治常规，其中包括不断更新的内容。第三部分介绍如何接诊患儿、采集病史以及分析各种检查。重点内容均以“小贴示”的形式予以强调。第四部分是针对核心内容的自我测验。

阅读本书后，您可从中获得各系统的基本专业词汇以及正确的医学英语表达方式，更重要的是能达到儿科临床基础理论与英语表达的高度统一。

本书是首都医科大学附属北京儿童医院相关专业医师在百忙中逐级反复修改审译的结晶。期望能为您的自学提供帮助。虽经多次校对修改，其中难免存在翻译错误或不妥之处，真诚希望您能就译文与我们进行探讨并给予指正，以期不断完善。

不断实践！不断进步！

申昆玲

首都医科大学附属北京儿童医院

二〇〇五年七月

Author Preface

This new edition of Crash Course paediatrics is our attempt to incorporate the changes in paediatric practice since publication of the first edition. We have kept the same successful format in this book with an additional chapter on allergic disease. The hints and tips have been increased as these small points often assume great importance in clinical practice that may not be apparent in textbooks. We have continued the emphasis on practical aspects of paediatrics which will aid students on paediatric attachments to clinal areas.

Although this book has been written for the undergraduate in mind we hope it will be of use to those who are beginning their careers in paediatrics, either hospital based or in the community.

Tim Newson
David Pang

作 者 序

为了将第1版出版以来儿科领域的进展补充进来，我们以同样的版式编写了新一版的儿科风暴式教程，并添加了“变态反应和过敏症”这一章节。“小贴示”的内容有所增加，这些要点在临床实践中通常非常重要，但教科书可能不曾提供。我们仍然强调儿科实践能力的重要性，这有助于医学生步入临床工作。

虽然本书是为医学生撰写的，但是我们希望它也适合于低年资儿科医生阅读。

Tim Newson
David Pang

Preface

Over the last six years since the first editions were published, there have been many changes in medicine, and in the way it is taught. These second editions have been largely rewritten to take these changes into account, and keep *Crash Course* up to date for the twenty-first century. New material has been added to include recent research, and all pharmacological and disease management information has been updated in line with current best practice. We've listened to feedback from hundreds of medical students who have been using *Crash Course* and have improved the structure and layout of the books accordingly: pathology and disease management material has been moved closer to the diagnostic skills chapters; there are more MCQs and now we have Extended Matching Questions as well, with explanations of each answer. We have also included 'Further Reading' sections where appropriate to highlight important papers and studies that you should be aware of, and the clarity of text and figures is better than ever.

The principles on which we developed the series remain the same, however. Clinical medicine is a huge subject, and teaching on the wards can sometimes be sporadic because of the competing demands of patient care. The last thing a student needs when finals are approaching is to waste time assembling information from different sources, or wading through pages of irrelevant detail. As before, *Crash Course* brings you all the information you need in compact, manageable volumes that integrate an approach to common patient presentations with clinical skills, pathology and management of the relevant diseases. We still tread the fine line between producing clear, concise text and providing enough detail for those aiming at distinction. The series is still written by junior doctors with recent exam experience, in partnership with senior faculty members from across the UK.

I wish you the best of luck in your future careers!

Dr Dan Horton-Szar
Series Editor

前　言

在本书第1版出版以来的6年时间里，医学及其传授方式有了很大变革。考虑到这些变革，我们重新撰写了本书第2版的大部分内容，使其适应于21世纪的教学需求。按照目前的最佳诊治常规，第2版增添了一些新内容，包括最近的研究成果以及药理学和疾病治疗学的全部内容。有很多医学生使用过本书，我们根据他们的意见回馈，对本书内容的结构和布局进行了改进：病理学和疾病治疗的内容移至诊断技能章节附近；增加了多项选择题的数量；而且还提供了多备选答案选择题，每个答案都有解释。此外，我们还增添了“扩展阅读”部分，适当强调了应知应会的重要文章和研究，而且本书的文字和图表都比以前更加清楚。

然而，我们开发这一系列丛书的初衷并没有改变。临床医学是一个庞大的学科，但由于病人利益至上，病房里的教学工作会缺乏系统性。当期末考试临近时，学生需要花费大量时间从各处收集资料，或者吃力地阅读一页页无关的细节。同第1版一样，本书以简洁并易于掌握的篇幅带给你所需的全部内容。其中用临床技能、病理和相关疾病的治疗等内容提供了一种整体认识疾病的方法。本书的文字表达简洁清楚，内容全面；由有近期考试经验、与高年资医生共事的英国各地的年轻医生撰写。

最后，衷心祝愿你们今后事业顺利！

Dan Horton-Szar 博士

Contents
目　录

PART I THE PATIENT PRESENTS WITH

第一部分 临床表现

1. Fever or rash

The febrile child

Fever is a common presenting symptom in children and can be a major challenge to paediatricians. Most of the causes are due to benign, self-limiting, viral infections but skill is needed to distinguish these from serious infection (Fig. 1.1). The latter has the potential to deteriorate rapidly so it is essential that it is identified as early as possible. Clinicians might start antibiotic treatment prior to diagnostic investigations if serious infection is suspected because delay can be associated with significant morbidity and mortality. Clinical assessment is therefore central to the approach of children with fever while awaiting results of diagnostic investigations.

History

How long has the child been febrile?

A duration of more than a week or two suggests diseases such as tuberculosis (TB), malaria, typhoid and autoimmune non-infectious disorders.

Are there any localizing symptoms?

An infection in certain systems will advertise itself:

- Cough or coryza: suggest respiratory tract infection.
- Vomiting and diarrhoea: suggest gastrointestinal tract infection, although vomiting alone is non-specific.
- A painful limb: suggests infection of the bones or joints.
- Lower abdominal pain: suggests urine infection but lobar pneumonia can also present this way.
- Headache, photophobia and neck pain: suggest meningism.

Younger children (< 2 years of age) might not localize symptoms and fever might be the only symptom.

Has there been recent foreign travel?

Malaria or typhoid can be overlooked if recent travel abroad is not disclosed in the history.

Examination

Is the child systemically unwell?

The active, playing and communicative child is unlikely to have sepsis. However, any ill child must have an assessment of the airway, breathing and circulation, and of the vital signs. Clues to serious sepsis include (Fig. 1.2):

- Poor peripheral perfusion.
- Persistent tachycardia.
- Lethargy or irritability.

Common causes of a fever	
Minor illnesses	**Major illnesses**
Upper respiratory infection	Meningitis
Non-specific viral infections and rashes	Pneumonia
Gastroenteritis without dehydration	Urinary tract infection Septicaemia

Fig. 1.1 Common causes of a fever.

Worrying signs of serious bacterial sepsis
All children less than 3 months old
Bulging fontanelle
White cell count greater than 20×10^9/L or less than 4×10^9/L
Presence of shock
Decreased conscious level or lethargy
Persistent tachycardia
Apnoea
Non-blanching rash

Fig. 1.2 Worrying signs of serious bacterial sepsis.

Assume sepsis in all febrile infants aged <3 months until proved otherwise.

Are there local signs of infection?

Tonsillitis, otitis media, pneumonia, meningitis and

septic arthritis can all be revealed on examination (Fig. 1.3); a rash might be diagnostic. Look for a bulging fontanelle in meningitis.

Investigations

In a well child in whom a confident clinical diagnosis has been possible, no investigation is required. However, certain investigations are appropriate in any ill febrile child. These include:

- Markers of inflammation: white cell count (raised or low in overwhelming sepsis), differential

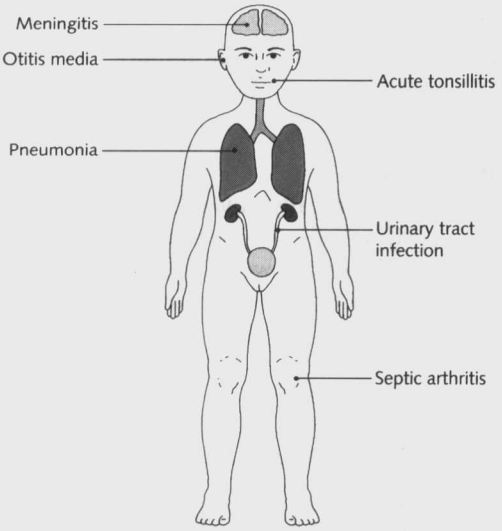


Fig. 1.3 Fever: important sites of local bacterial infection.

(neutrophil predominance in bacterial infection) and C-reactive protein.

These are useful if there is uncertainty in diagnosis or for serial measurement of a septic child, however, they cannot rule out serious infection.

A seriously ill child might initially have normal blood inflammatory markers.

- Samples for microbiological examination: these can include blood cultures, urine for microscopy and culture, throat swab and cerebrospinal fluid. Polymerase chain reaction (PCR) is becoming increasingly useful as it provides high sensitivity and specificity.
- Imaging: a chest X-ray (CXR) should be considered if there is any suspicion of lower respiratory tract infection.
- A 'septic screen'; infants suspected of severe infection without localizing signs on examination are investigated with a standard battery of investigations before starting antibiotic therapy. These include: blood culture, full blood count (FBC), lumbar puncture, urine sampling and CXR.

Management

If a benign viral infection is suspected then only symptomatic therapy is needed. In the very young, or those who look ill, antibiotics are started before the results of diagnostic testing because quickly ruling out serious infection is often impossible; treatment can be tailored when the results are back. Treating the fever with antipyretics might reduce febrile convulsions.

Pyrexia of unknown origin (PUO)

The designation PUO should be reserved for a child with a documented protracted fever (more than 7 days) and no diagnosis despite initial investigation (Fig. 1.4). It is frequently misapplied to any child presenting with a fever of which the cause is not immediately obvious. Most are infectious and 40–60% will resolve without diagnosis.

Causes of pyrexia of unknown origin (PUO)

Type	Cause
Infectious	Tuberculosis Malaria Bone and joint infection Enteric infection, e.g. typhoid Urine infection
Malignancy	Leukaemia
Autoimmune and inflammatory	Systemic lupus erythematosus Kawasaki disease Juvenile idiopathic arthritis Inflammatory bowel disease
Drug induced	

Fig. 1.4 Causes of pyrexia of unknown origin (PUO).

The child with a rash

Children often present with a rash that might, or might not, be associated with systemic signs. An exact diagnosis is often not possible but a few rashes are associated with serious systemic disease. Careful clinical history and examination are again essential and investigation is reserved only for certain cases.

History

The history of a rash should ascertain the following:

- Duration, site of onset, evolution and spread.
- Does it come and go (e.g. urticaria)?
- Does the rash 'itch' (e.g. eczema, scabies)?
- Has there been any recent drug ingestion or exposure to provocative agents (e.g. sunlight, food, allergens, detergents)?
- Are any other family members or contacts affected (e.g. viral exanthems, infestations; see Chapter 10)?
- Are there any other associated symptoms (e.g. sore throat, upper respiratory tract infection)?
- Is there any family history (e.g. atopy, psoriasis)?

Examination

Check for non-dermatological features such as:

- Fever.
- Mucous membranes.
- Lymphadenopathy.
- Splenomegaly.
- Arthropathy.

Describe the rash in 'dermatological language', observing the morphology, arrangement and distribution of the lesions.

Morphology

Describe the shape, size and colour of the lesions. There might be:

- Macules, papules or nodules.
- Vesicles, pustules or bullae.
- Petechiae, purpura or ecchymoses.

Arrangement

Are the lesions scattered diffusely, well circumscribed or confluent?

Distribution

The distribution is important (Fig. 1.5). It can be local or generalized (flexor surfaces: eczema; extensor surfaces: Henoch–Schönlein purpura (HSP) or psoriasis) or might involve mucous membranes (measles, Kawasaki disease, Stevens–Johnson syndrome).

It is important to note the distribution as well as the morphology of a rash.

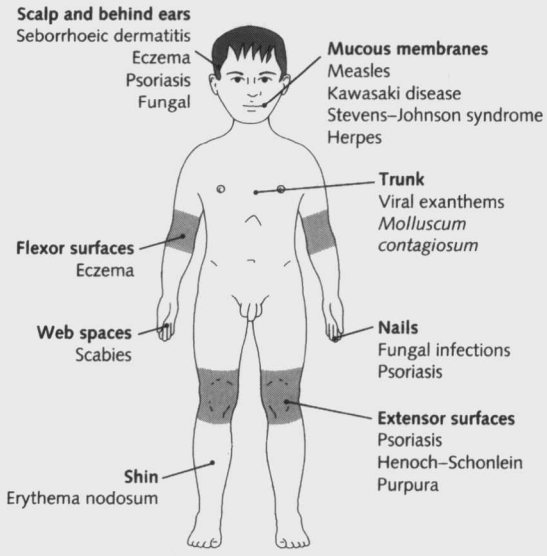


Fig. 1.5 Distribution of rashes.

Palpation

Feel the rash for scale, thickness, texture and temperature; dry skin suggests eczema.

Investigations

Investigations are rarely required but might include skin scrapings for fungi or scabies.

Causes of a rash

The main causative categories are shown in Fig. 1.6.

Causes of a rash	
Type	**Cause**
Infection	Viral Toxin related Streptococcal Meningococcal
Infestations	Scabies
Dermatitis	Eczema Vasculitis
Allergy	Drug-related Urticaria
Haematological	Bleeding disorders

Fig. 1.6 Causes of a rash.

Diagnostic features of the more common generalized rashes

The common generalized rashes are: maculopapular rash, vesicular rash, haemorrhagic rash and urticarial rash.

Maculopapular rash

This is most likely to be caused by a viral exanthem but might be a drug-induced eruption. Common diagnostic features are:

- Measles: prodrome of fever, coryza and cough. Just before the rash appears, Koplik's spots appear in the mouth. The rash tends to coalesce.
- Rubella: discrete, pink macular rash starting on the scalp and face. Occipital and cervical lymphadenopathy might precede the rash.
- Roseola infantum: occurs in infants under 3 years. After 3 days of sustained fever, a pink morbilliform (measles-like) eruption appears as the temperature subsides. It is caused by human herpesvirus (HHV)-6 or HHV-7.
- Enteroviral infection: causes a generalized, pleomorphic rash and produces a mild fever.
- Glandular fever: symptoms include malaise, fever and exudative tonsillitis. Lymphadenopathy and splenomegaly are commonly found.
- Kawasaki disease: causes a protracted fever, generalized rash, red lips, lymphadenopathy and conjunctival inflammation.
- Scarlet fever: causes fever and sore throat. The rash starts on the face and can include a 'strawberry' tongue.

Vesicular rash

Common causes of vesicular rash are:

- Chickenpox: successive crops of papulovesicles on an erythematous base; the vesicles become encrusted. Lesions present at different stages. The mucous membranes are involved.
- Eczema herpeticum: exacerbation of eczema with vesicular spots caused by a herpes infection.

Haemorrhagic rash

Due to extravasated blood these lesions do not blanch on pressure. Lesions are classified by size:

- Petechiae (smallest).
- Purpura.
- Ecchymoses (largest).

Common diagnostic features are:

- Meningococcal septicaemia: petechial rash (might be preceded by maculopapular rash).
- Acute leukaemia: look for pallor and hepatosplenomegaly.
- Idiopathic thrombocytopenic purpura: the child looks well but might have bruising with, or without, nose bleeds.
- Henoch–Schönlein purpura: distribution is usually on the legs and buttocks. Arthralgia and abdominal pain might be present.

Take care to think of child abuse in traumatic bruising.

Non-blanching or rapidly spreading rash suggests meningococcal sepsis.

Urticarial rash

Urticaria (hives), a transient, itchy rash characterized by raised wheals, appears rapidly and fades; it can recur. Causes include:

- Food allergy, e.g. shellfish, eggs, cow's milk.
- Drug allergy, e.g., penicillin: note that < 10% of penicillin allergies are unsubstantiated.
- Infections, e.g. viral: this is the most common and is often self-limiting.
- Contact allergy, e.g. plants, grasses, animal hair.

Two other distinctive rashes that occur in childhood and require special consideration are erythema multiforme and erythema nodosum.

Erythema multiforme

A distinctive, symmetrical rash characterized by annular target (iris) lesions and various other lesions including macules, papules and bullae. The severe form with mucous membrane involvement is

Stevens–Johnson syndrome. Causes include infections (most commonly herpes simplex, Mycoplasma or Epstein–Barr virus) and drugs. Mostly it is idiopathic and self limiting.

Erythema nodosum

Red, tender, nodular lesions usually occur on the shins. Important causes include streptococcal infections and TB.