

Fall 2008

Issue 3 Volume 1

## PCRS is expanding!

We've added three new faculty members over the past few months: Shaida Ziari, MD; Lisa Clewner, MD and Jennifer Lai, MD. As we try to get you accustomed to our website, please follow the instructions below to their faculty bios and pictures. As you may be aware, we also use our ambulatory faculty and chief residents to help with weekend coverage. This year, our chief residents are Mark Tabarrok, MD and Lynn Thoreson, DO. We also welcome a new ambulatory faculty member, Stephen Pont, MD, who will join in the weekend rotation with Michelle Gallas, DO; Roberto Rodriguez, MD and Marilyn Doyle, MD.

Instructions for accessing PCRS bios and pics: Please visit the Dell Children's Medical Center of Central Texas website at [www.dellchildrens.net](http://www.dellchildrens.net). Click on the "For Healthcare Professionals" link and you will see a link to PCRS, "Pediatric Consultation and Referral Service." From there, "Our Physicians" will provide you access to our up-to-date faculty bios and pictures. The "For Healthcare Professionals" page also has lots of other great information, including the Grand Rounds schedule, the Central Texas Asthma Action Plan, as well as the most recent version of this LINK Letter.

## Case Report: Fever, Cough and Mouth sores

by James Goodman, MD

A previously healthy six-year old male presents for admission from his pediatrician with several days of fever and cough. The fever started eight days prior to admission, was persistent daily, and consistently high - reaching as high as 105° F. Parents used Tylenol and Motrin for the fever, which provided only temporary relief. Two to three days later, the patient developed a cough that was occasionally productive of phlegm. He was taken to his pediatrician four days prior to admission where a chest x-ray was done. He was diagnosed with pneumonia and given Omnicef. After receiving three doses of the antibiotics, he continued to cough, developed increasing throat pain leading to difficulty swallowing, swelling of his eyelids and lips, and bilateral eye redness. He was taken to an outside ER two days prior to presentation, where it was thought he was having a reaction to Omnicef. He was given Benadryl and steroids and sent home with instructions to stop taking the Omnicef. The next day, he was seen again by the PCP and switched to amoxicillin because of continued, persistent coughing. At this time, mom noticed that he had "sores" inside his mouth. Due to his painful throat and lips, he was unable to take solids by mouth, but was able to drink liquids. He began having post-tussive emesis the day prior to admission. He had normal urine output.

On physical exam, the patient was ill-appearing with bilaterally erythematous conjunctivae. His eyelids were swollen bilaterally, with exudates. His lips were markedly erythematous and swollen and he had several ulcerative lesions on the inside of his lower lip, with possible pseudomembrane formation. The remainder of the oral exam was deferred due to the patient's pain and inability to open his mouth. The lungs were clear bilaterally and there was no increased work of breathing. The remainder of his exam, including skin exam, was unremarkable.

He quickly deteriorated over the next 24 hours, with progressively worsening eye and throat pain, and then respiratory distress. He was

transferred to the intensive care unit where he was subsequently intubated. During the course of his hospitalization, the patient had a positive *Mycoplasma* PCR and positive cold agglutinins. His final diagnoses included Stevens-Johnson Syndrome (SJS) and *Mycoplasma* infection.

This was a unique presentation of Stevens-Johnson Syndrome in that it involved severe mucositis and exudative conjunctivitis, but no skin manifestations. A review of the literature describes very few reported cases of SJS with the absence of skin involvement (1). These reported cases appear to be related to infection with *M. pneumoniae*, which has an incubation period of 1 to 4 weeks, is predominant in children from the ages of five to 14, and is the most frequent infectious cause of SJS in pediatric patients (2, 3). In fact, the term Stevens-Johnson Syndrome may not be the best to describe this patient's condition, especially since skin involvement is required to make the diagnosis of SJS. Two different terms that have been proposed to describe this condition included "atypical Stevens-Johnson Syndrome" or "*M. pneumoniae*-associated mucositis" (1). The ultimate cause of this patient's mucositis was not completely clear. This was because the patient had two possible etiologies, antibiotics and *Mycoplasma* infection. When questioned as to whether or not the patient had received Omnicef in the past, the patient's parents were unsure. In addition, the patient's clinical presentation was not typical of the progression of SJS. Skin and mucosal changes typically emerge one to three weeks after exposure to the offending agent (3). Given this timeframe, it might have been less likely for the prescribed Omnicef to have produced the patient's mucositis after only three doses.

There has been no reported mortality of "atypical SJS," although several patients have been admitted to the ICU (1), much as with our patient. It is well known that the pathophysiology of SJS seems to be a spectrum of disease, and the exact mechanism is still not clear. This case

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# Working Together -

## DIRECT ADMITS AND COMMUNICATION PROBLEMS

by Richard Holt, MD

Most of us spend a good part of our day trying to avoid conflict. We know that many of you get frustrated around getting us to take direct admits and about how to easily communicate with us.

It seems that no matter how many cell phones, pagers, computers or faxes one has, getting to talk to the right person is harder, not easier. In an effort to provide more oversight at night and on weekdays, we now have a day-call hospitalist (8 a.m. to 4 p.m.) and a night-call hospitalist (4 p.m. to 8 a.m.). The single, nearly foolproof way to get in touch with one of us is to call the Dell Children's main number, 512-324-0000, and ask for the PCRS on-call attending. Put the ball in our court to help you get someone admitted or get information about a patient. If your call is more routine and doesn't need a quick answer, or involves more than just the on-call attending, call our office, 512-324-0164 for assistance.

Communication is a two-way process. We commonly encounter frustration when trying to call and discuss a case with you. If we don't have a back-line number, that's a problem, as is the common question, "He's in a room, do you want me to interrupt him?" If your group prefers email, pages or even text messages, please let us know. Anything you can do to help us with would be greatly appreciated.

The decision to take direct admits onto the floor is very complex. There are so many variables, including the acuity of the case, and thus the safety; available beds at that moment; plus, the number of cases already here that haven't yet been adequately staffed (which, in turn, are a function of both numbers and acuity). For these reasons, we cannot always do what you want us to do. I promise that we listen and try. Your "not sick" neonatal fever still requires urgent assessment, LP and antibiotic administration, something the system (unit, nurses, residents and attendings) may not be able accomplish safely if the last two kids admitted have unresolved issues.

One last thing: we could learn so much from our community colleagues. Please know that we'd welcome any of you that might want to round with us. We'll even get you a parking place! Call us and come on down. It really is fun.

*Editor's note: I asked Richard to comment on this important topic. Increasingly, the safety of the hospital system is being scrutinized. Without timely and effective communication within this complex system, our patients suffer. Your feedback is important to us and welcome. You may contact me, Mark Shen, at mshen@seton.org or Richard at rholt@seton.org.*

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provides an example of both the spectrum and limited understanding of Stevens-Johnson Syndrome.

#### References

1. Schalock P, Dinulos J et al. Erythema Multiforme due to Mycoplasma pneumoniae Infection in Two Children. *Pediatric Dermatology* 2006; 23: 546-555.
2. Latsch K, Girschick H.J., Abele-Horn M. Stevens-Johnson syndrome without skin lesions. *J of Medical Microbiology* 2007; 56: 1696-1699.
3. Ravin K, Rappaport L, et al. *Mycoplasma pneumoniae* and Atypical Stevens-Johnson Syndrome: A Case Series. *Pediatrics* 2007; 119e; e1002-e1005.

James Goodman is a third-year pediatric resident. He attended medical school at the University of Texas Southwestern Medical Center in Dallas and received his undergraduate degree from the University of Notre Dame. He is planning to go into private practice and hoping to stay in the Austin area.

## IMPORTANT UPCOMING DATES

### Thursday, October 30, 2008

Dell Children's Annual Medical Staff Meeting

6 – 8:30 p.m.

Sig Auditorium

Dell Children's

### Upcoming Grand Rounds Schedule:

#### Friday, October 24, 2008

7:30-8:30 a.m.

Sig Auditorium, Dell Children's

"Alternative Therapies in Children: Precautions and Contraindications"

Dr. Susan Gerik

Director of the Division of Children's Special Services, Assistant Professor, UTMB Galveston

#### Friday, November 7, 2008

7:30-8:30 a.m.

Sig Auditorium, Dell Children's

"Syncope"

Dr. Arnold Fenrich

Pediatric Cardiologist, Specialist in Electrophysiology, Children's Cardiology Associates

#### Friday, November 14, 2008

7:30-8:30 a.m.

Sig Auditorium, Dell Children's

"Research in a Children's Hospital"

Dr. Karla Lawson

Research Scientist, Dell Children's Medical Center

#### Thursday, December 11, 2008

12:15-1:15 p.m.

Sig Auditorium, Dell Children's

"OOOO, Baby, Baby: Teens, Sex, and the Media"

Dr. Victor Strasburger

Chief of Adolescent Medicine, University of New Mexico School of Medicine