Bedside clinical paediatric teaching:

1. Introduce the emergency triage (a process of quick assessment for screening).

   If any of the following complaints or signs are present do not proceed to take the detailed history but provide emergency care and stabilize the patient.

   General condition of the child: convulsion, unconsciousness, drowsy or lethargic, continually irritable or restless and cyanosis.
   Respiration: grunting, head nodding, respiratory distress.
   Circulation: features of shock.
   Temperature: hyperpyrexia.

2. If not in emergency continue to take the history. History taking starts from the identification points (name, age, sex etc). For a child with the presenting complaint of acute onset of cough or difficulty in breathing emphasize on:
   a. In history: age of the child, place of residence, parental occupation, who cares the child, cough (numbers of days present, paroxysms with whoops or vomiting present), wheeze (previous episodes, response to bronchodilators), seasonal occurrence, exposure to someone with TB or chronic cough in the family, risk factors (smoking parents, domestic smoke pollution, persons sleeping in the same room, cooking in the same room), immunizations history, history of choking or sudden onset of symptoms and known HIV infections.
   b. In general examination: respiratory rate, cyanosis, head nodding, nasal flaring, severe pallor, oedema, wheeze, and stridor.
   c. In the examination of chest: chest indrawing, hyper expanded chest, prolonged expiration, prolonged inspiration, apex beat displaced/ trachea shifted from the midline, percussion signs of pleural effusion (stony dullness) or pneumothorax (hyper-resonance).
   d. In auscultation: ronchi, coarse crepitations, bronchial breath sounds and gallop rhythm.
   e. Abdominal examination: palpable enlarged liver.

Differential diagnosis:
1. Pneumonia. 2. Bronchiolitis. 3. Asthma. 4. Severe anaemia. 5. Cardiac failure. 5. Tuberculosis. 6. Pertussis. 7. Foreign body. 8. Viral croup. 9. Bacterial tracheitis and acute epiglottitis. 10. Empyema. 11. Pneumothorax. 12. Congenital heart disease. 13. Acute naso-pharyngitis. 14. Post nasal drip. 15. Gastro-oesophageal reflux.

Morning Bedside Clinical Class

Wednesday, May 05, 1999

1. Selection of patients in the morning at 8.30 AM, selected cases were: right pleural effusion, PUO, right upper lobe consolidation, pneumonia.

2. Student's notebooks were checked. Purpose of writing history was discussed. Most of the cases were very short.
3. Objective of the morning session was: to observe whether after passing the half mile stones if they could finish history taking, examination within one hour. Patients were allotted.
4. Two cases were discussed; pleural effusion and PUO. Signs of pleural effusion were shown. Bronchial breath sound listened.
5. Different type of fluid were shown chylous, straw coulur, pyogenic and serous. These fluid were prepared by diluting milk, diluting savlon, clean water and diluting tincture benzoin.
6. Day's activity was discussed.

Wednesday, June 02, 1999

1. Four cases of abdominal pain (tuberculous) were selected. They had different presentations: intestinal, ascitic, omental and iliocaecal.
2. Students were divided in four groups. They are allotted these four cases. They were asked to take history and exam their respective cases in one hour.
3. Students presented their cases to the group. Individual students were asked to write four causes that can have such presentations..
4. Teacher led the discussion by asking individual student to highlight the information that was sufficient to make the specific diagnosis. In case of unusual diagnosis teacher asked the students to make questions that should be asked to the parent, which may be positive in the history.
5. The teacher confirmed examination findings and missed findings were shown.
6. Day's activities were summarized. Four different presentation of abdominal tuberculosis shown. A. Intestinal: stricture, alternate constipation and diarrhoea, fever with weight loss, distention of abdomen, blood in the stool, difference between the ulcer of tuberculosis and typhoid, why stricture occurs, why a child with intestinal obstruction becomes dehydrated inspite of not having diarrhoea. B. Omental tuberculosis: rolled on omentum as a mass in the upper abdomen. C. Ascitic: causes of ascitis, difference in the presentation of cirrhosis, kwashiorkor, nephrotic syndrome, inferior venacaval obstruction. D. Ileocaecal tuberculosis: mantoux 13-mm +ve, history of contact, distended intestine in one side only, duplication of the bowel. Result of ascitic tap: increased lymphocytes..

Wednesday

1. Four cases of meningitis with following neurological complications were selected: hydrocephalus, subdural effusion, facial palsy and right lower limb paresis.
2. Brief discussion was done on the pathophysiology of meningitis.
3. Students were divided in four groups and were asked to:
    - formulate questions for the parents to find out the symptoms.
    - Formulate questions for the history of present and past illnesses.
    - Formulate other questions that are relevant for the other medical history.
4. Students were asked to present their work and brief discussion was done.
5. Students were asked to list the signs that may be seen in a child with meningitis including the complications.
6. These signs were discussed briefly relating to skills of eliciting the signs: specially neck stiffness, kernig.s sign, drowsy, bulging fontanalle and focal neurological signs.
7. Students were asked to list investigations for meningitis.
8. Students were allotted cases in-group of two and they were asked to take history and do clinical examination.
9. Students presented the cases and discussion was done.
10. Students were shown the following investigation:
    CT Scan, CSF findings.

2059.2.8

First class in Bedside Clinical Teaching

Objectives: At the end of the session the students will be able to:

a. list the common presenting complaints for which parents bring their children in the OPD
b. identify the common age group of children attending the OPD
c. formulate the leading questions to identify different disease of the respiratory tract specially
d. formulate questions on important risk factors for ARI
e. count the respiratory rate
f. identify the different types of respiratory sounds.
g. list the steps in performing the respiratory system examination
h. perform a complete respiratory system examination.

Activities:

1. divide the group each consisting of two students.
2. ask them to go the OPD and interview 5 parents by asking following two questions: a. why have you brought your child to-day? B. what is the age of your child. Total time is 10 minutes.
3. supervise while students perform the activities.
4. Lead a group discussion by writing the presenting complaints from each group and age group of children. Emphasize the cough/ diarrhea/fever/ear infection and malnutrition. Children less than 5 years age.
5. Divide the students in three groups. Three groups will formulate the questions that should be asked to identify the respiratory disease in history, list the different organs that form the respiratory system and leading questions to identify the disease of the specific organ; clinical findings in inspection, palpation, percussion and auscultation of the different organs
6. lead the group discussion and summarize. Emphasize on respiratory rate, chest indrawing, breath sounds.
7. Demonstrate the examination technique of the respiratory system examination.
8. Allot patient in group of two and ask students to examine patient.
9. Summarize the days activity.

Wednesday (2059.3.26)
Task oriented bed side clinical class (TOCC)
!.Discuss the entry questions and threading questions

Entry questions:
Does the child has difficulty in breathing?
Threading questions:

For how long? Is the child able to drink.

Emphasis was made on not to ask the type of questions for which observation will be made during examination. Example: Does the child has fast breathing is not a good question because we will count the respiratory rate during examination. Only those questions should be asked which can not be seen at present.

Students were asked to formulate Entry questions to be asked during history taking for a child aged 9 years old with the presenting complaints of abdominal pain. Time allocated 20 minutes. Students were divided in group of three.

At the end brief discussion was done.

Students were asked to make threading questions for a child complaining of pain in the R upper quadrant of the abdomen. Time given for this task was 15 minutes. Brief discussion was done at the end.

Students were asked to brain storm the signs for the disease that can cause abdominal pain in the right upper quadrant of the abdomen. Then group them under the inspection, palpation, percussion and auscultation. The time given for this task was 15 minutes

Students were divided in group of two and two patients ((342 Liver abscess and 772 Infective hepatitis) were allotted to them to complete history and examination. Time allocated was 30 minutes for this group work. One student from each group took the history and another one student examined the patient. Discussion was done to make the diagnosis, correlating the historical and examination findings. Investigations and treatment were discussed.(child with jaundice diagnosed as infective hepatitis: important investigations were blood glucose and prothrombin time not sgot and sgpt) At the end summary of the session was done.