A 12-year-old renal transplant recipient taking tacrolimus begins using an over-the-counter herbal product. Two weeks later, the tacrolimus trough concentration falls. Which supplement is most likely responsible?

A. Aloe vera
B. Grapefruit
C. Licorice
D. St. John's wort
E. Valerian

Original table 7.2 | Nelson printed p. 57 | PDF p. 100

Table 7.2 Common Herbal Dietary Supplement (HDS)–Drug Interactions

HDS	DRUGS	POTENTIAL CONSEQUENCES/REACTIONS
Aloe vera	Glibenclamide (glyburide)	↑ Oral aloe vera gel can cause additive glycemic-lowering effects when taken concurrently with a hypoglycemic agent
Bitter orange	Phenelzine	↑ Risk of hypertensive crisis
Garlic	Ritonavir	↓ Effect of ritonavir
	Saquinavir	↓ Effect of saquinavir
Licorice	Warfarin	↑ Risk of bleeding
Grapefruit	Calcium channel blockers	Grapefruit juice has been found to increase the bioavailability of certain drugs by inhibition of the cytochrome P450 (CYP) 3A4 isozyme in the liver and gut wall
Melatonin	Zolpidem	↑ Sedative effects
Valerian	Alprazolam, phenobarbital	↑ Central nervous system depression
Goldenseal	Inhibition of CYP2D6 and CYP3A4	May affect approximately 50% of common pharmaceutical agents
St. John's wort	Cyclosporine, tacrolimus, warfarin, protease inhibitors, digoxin, theophylline, venlafaxine, oral contraceptives	May decrease drug effectiveness

↓, Decreasing; ↑, increasing.

A 9-year-old with progressive Tay-Sachs disease has recurrent distressing symptoms. Which characterization most strongly supports pediatric palliative care involvement?

A. A curative option is expected after brief treatment
B. A progressive condition without a curative option
C. A transient and fully reversible illness
D. An isolated uncomplicated developmental delay
E. A stable disease without symptom burden

Original table 8.1 | Nelson printed p. 59 | PDF p. 103

Table 8.1 Conditions Appropriate for Pediatric Palliative Care

CONDITIONS FOR WHICH CURATIVE TREATMENT IS POSSIBLE BUT MAY NOT SUCCEED
Advanced or progressive cancer or cancer with a poor prognosis
Complex and severe congenital or acquired heart disease
CONDITIONS FOR WHICH THERE IS INTENSIVE LONG-TERM TREATMENT AIMED AT PROLONGING LIFE AND MAINTAINING QUALITY OF LIFE, BUT PREMATURE DEATH IS STILL POSSIBLE
Cystic fibrosis
Severe immunodeficiency
High-risk solid-organ transplant candidates and/or recipients (e.g., lung, multivisceral)
Chronic or severe respiratory failure
Muscular dystrophy
Complex multiple congenital malformation syndromes
Primary pulmonary hypertension
Severe chromosomal disorders (aneuploidy, deletions, duplications)
PROGRESSIVE CONDITIONS FOR WHICH THERE IS NO CURATIVE OPTION AND IN WHICH TREATMENT IS ALMOST EXCLUSIVELY PALLIATIVE AFTER DIAGNOSIS
Progressive metabolic disorders (Tay-Sachs disease)
Batten disease
Severe forms of osteogenesis imperfecta
CONDITIONS INVOLVING SEVERE, NONPROGRESSIVE DISABILITY, CAUSING EXTREME VULNERABILITY TO HEALTH COMPLICATIONS
Severe cerebral palsy with recurrent infection or difficult-to-control symptoms
Severe neurologic sequelae of infectious disease
Hypoxic or anoxic brain injury
Brain malformations (e.g., holoprosencephaly, lissencephaly)

Adapted from The Together for Short Lives (formerly the Association for Children's Palliative Care [ACT]) Life-limiting/Life-threatening Condition Categories. http://www.togetherforshortlives.org.uk/professionals/childrens_palliative_care_essentials/approach.

A 4-year-old receiving palliative care says, "I became sick because I was bad." Which response best matches the child's developmental understanding?

A. Explain that death is an irreversible biologic event using detailed physiology
B. Avoid discussing illness until adolescence
C. Reassure the child that they did nothing to cause the illness
D. Ask the child to calculate the probability of recovery
E. Tell the child that no one in the family will be affected

Original table 8.3 | Nelson printed p. 63 | PDF p. 107

Table 8.3 Developmental Questions, Thoughts, and Concepts of Dying, with Responsive Strategies

TYPICAL QUESTIONS AND STATEMENTS ABOUT DYING	THOUGHTS THAT GUIDE BEHAVIOR	DEVELOPMENTAL UNDERSTANDING OF DEATH	STRATEGIES AND RESPONSES
MONTHS TO 3 YR OF AGE "Mommy, don't cry." "Daddy, will you still tickle me when I'm dead?"	Child has limited understanding of events, future and past, and of the difference between living and nonliving.	Child may have "sense" that something is wrong. Death is often viewed as continuous with life (analogous to being awake and being asleep).	Optimize comfort and consistency; familiar persons, objects, routines. Use soothing songs, words, and touch. "I will always love you." "I will always take care of you." "I will tickle you forever."
AGE 3-5 YR "I did something bad and so I will die." "Can I eat anything I want in heaven?"	Concepts are simple and reversible. Variations between reality and fantasy.	Child may see death as temporary and reversible and not universal. Child may feel responsible for illness. Death may be perceived as an external force that can get you.	Assure child that illness is not their fault. Provide a consistent care team. Promote honest, simple language. Use books to explain the life cycle and promote questions and answers. "You did not do anything to cause this." "You are so special to us, and we will always love you." "We know (God, Jesus, Grandma, Grandpa) are waiting to see you."
AGE 5-10 YR "How will I die?" "Will it hurt?" "Is dying scary?"	Child begins to demonstrate organized, logical thought. Thinking becomes less esoteric. Child begins to problem-solve concretely, reason logically, and organize thoughts coherently. However, child has limited abstract reasoning.	Child begins to understand death as real and permanent. Death means that your heart stops, your blood does not circulate, and you do not breathe. It may be viewed as a violent event. Child may not accept death could happen to himself or herself or to anyone he or she knows, but starts to realize that people they know will die.	"Tell me why you are asking." Be honest and provide specific details if they are requested. Help and support the child's need for control. Permit and encourage the child's participation in decision-making. "We will work together to help you feel comfortable. It is very important that you let us know how you are feeling and what you need. We will always be with you, so you do not need to be afraid."
AGE 10-18 YR "I'm afraid if I die my mom will just break down." "I'm too young to die. I want to get married and have children." "Why is God letting this happen?"	Abstract thoughts and logic possible. Body image is important. Child needs peer relationships for support and for validation. Child expresses altruistic values, such as staying alive for family (parents, siblings) and donating organs/tissue. Disbelief that they are dying.	Understand death as irreversible, inevitable, and universal. Child needs reassurance of continued care and love. Search for meaning and purpose of life.	Reinforce child's/adolescent's self-esteem, sense of worth, and self-respect. Allow need for privacy, independence, access to friends and peers. Tolerate expression of strong emotions and permit participation in decision-making. "I can't imagine how you must be feeling. Despite it all, you are doing an incredible job. I wonder how I can help?" "What's most important to you now?" "What are your hopes … your worries?" "You have taught me so much; I will always remember you."

Adapted from Hurwitz C, Duncan J, Wolfe J. Caring for the child with cancer at the close of life, *JAMA*. 2003;292:2141–2149.

A child with a life-limiting illness has distressing air hunger despite disease-directed care. Which nonpharmacologic measure is specifically listed for relief of dyspnea?

A. Restrict all oral fluids regardless of thirst
B. Use a fan to provide cool moving air
C. Require vigorous exercise during each episode
D. Place the child in tight clothing for chest support
E. Eliminate caregiver presence during episodes

Original table 8.5 | Nelson printed p. 69 | PDF p. 113

Table 8.5 Nonpharmacologic Approach to Symptoms Commonly Experienced by Children with Life-Threatening Illness

SYMPTOM	APPROACH TO MANAGEMENT
Pain	Prevent pain when possible by limiting unnecessary painful procedures, providing sedation, and giving preemptive analgesia before a procedure (e.g., including sucrose for procedures in neonates). Address coincident depression, anxiety, sense of fear, or lack of control. Consider guided imagery, relaxation, hypnosis, art/pet/play therapy, acupuncture/acupressure, cognitive behavioral therapy (CBT), physical therapy, biofeedback, massage, heat/cold, yoga, transcutaneous electric nerve stimulation, and distraction.
Dyspnea or air hunger	Wipe and/or suction oral secretions if present; positioning; comfortable loose clothing; fan to provide cool, blowing air. Limit volume of intravenous fluids; consider diuretics if fluid overload/pulmonary edema present. Behavioral strategies, including breathing exercises, guided imagery, relaxation, music, and distraction.
Fatigue	Sleep hygiene (establish a routine, promote habits for restorative sleep). Regular, gentle exercise; prioritize or modify activities. Address potentially contributing factors (e.g., anemia, depression, side effects of medications). Aromatherapy*: peppermint, rosemary, basil.
Nausea/vomiting	Consider dietary modifications (bland, soft, adjust timing/volume of foods or feeds). Aromatherapy*: ginger, peppermint, lavender, acupuncture/acupressure.
Constipation	Increase fiber in diet, encourage fluids, ambulation (if possible).
Oral lesions/ dysphagia	Oral hygiene and appropriate liquid, solid, and oral medication formulation (texture, taste, fluidity). Treat infections, complications (mucositis, pharyngitis, dental abscess, esophagitis).
	Oropharyngeal motility study and speech (feeding team) consultation.
Anorexia/cachexia	Manage treatable lesions causing oral pain, dysphagia, or anorexia. Support caloric intake during phase of illness when anorexia is reversible. Acknowledge that anorexia/cachexia is intrinsic to the dying process and may not be reversible. Prevent/treat coexisting constipation.
Pruritus	Moisturize skin. Trim child's nails to prevent excoriation. Try specialized anti-itch lotions. Apply cold packs. Counterstimulation, distraction, relaxation.
Diarrhea	Evaluate/treat if obstipation. Assess and treat infection. Dietary modification.
Depression	Psychotherapy, behavioral techniques, setting attainable daily goals. Aromatherapy*: bergamot, lavender.
Anxiety	Psychotherapy (individual and family), behavioral techniques. Aromatherapy*: clary sage, angelica, mandarin, lavender.
Agitation/terminal restlessness	Evaluate for organic or drug causes. Educate family. Orient and reassure child; provide calm, nonstimulating environment; use familiar music, verse, voice, touch. Aromatherapy*: frankincense, ylang.

*Best if aromatherapy is administered by a practitioner trained in aromatherapy use and safety and if child has choice of essential oil aroma that stimulates positive response.
From Sourkes B, Frankel L, Brown M, et al. Food, toys, and love: Pediatric palliative care. *Curr Probl Pediatr Adolesc Health Care*. 2005;35:345–392.

A child develops fever and jaundice 5 days after returning from an area with active mosquito-borne disease. Which infection is listed in the short-incubation group (<10 days) and is a plausible consideration?

A. Filariasis
B. Schistosomiasis
C. Dengue
D. Tuberculosis
E. Secondary syphilis

Original table 11.2 | Nelson printed p. 80 | PDF p. 124

Table 11.2 Incubation Periods of Common Travel-Related Infections*

SHORT INCUBATION (<10 DAYS)	MEDIUM INCUBATION (10-21 DAYS)	LONG INCUBATION (>21 DAYS)
Malaria	Malaria	Malaria
Arboviruses including dengue, yellow fever, Japanese encephalitis, Zika, chikungunya	Flaviviruses: tick-borne encephalitis and Japanese encephalitis	Schistosomiasis
Hemorrhagic fevers: Lassa, Ebola, South American arenaviruses	Hemorrhagic fevers: Lassa, Ebola, Crimean-Congo	Tuberculosis
Respiratory viruses including severe acute respiratory syndrome	Acute HIV infection	Acute HIV infection
Typhoid and paratyphoid	Typhoid and paratyphoid	Viral hepatitis
Bacterial enteritis	*Giardia*	Filariasis
Rickettsia: spotted fever group—Rocky Mountain spotted fever, African tick typhus, Mediterranean spotted fever, scrub typhus, Q fever	*Rickettsia*: flea-borne, louse-borne, and scrub typhus, Q fever, spotted fevers (rare)	*Rickettsia:* Q fever
Bacterial pneumonia including *Legionella*	Cytomegalovirus	Secondary syphilis
Relapsing fever	*Toxoplasma*	Epstein-Barr virus including mononucleosis
Amoebic dysentery	Amoebic dysentery	Amoebic liver disease
Meningococcemia	Histoplasmosis	Leishmaniasis
Brucella (rarely)	*Brucella*	*Brucella*
Leptospirosis	Leptospirosis	Bartonellosis (chronic)
Fascioliasis	Babesiosis	Babesiosis
Rabies (rarely)	Rabies	Rabies
African trypanosomiasis (acute), East African (rarely)	East African trypanosomiasis (acute)	West African trypanosomiasis (chronic)
	Hepatitis A (rarely)	Cytomegalovirus
	Measles	

*Diseases that commonly have variable incubation periods are shown more than once. However, most diseases may rarely have an atypical incubation period, and this is not shown here.
HIV, Human immunodeficiency virus.
From Freedman DO. Infections in returning travelers. In: Bennett JE, Blaser MJ, Dolin R, et al (eds): *Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases*, 8th ed. Philadelphia: Saunders;2015: Table 324-2.

A toddler has paired, parallel linear bruises with intervening central sparing across the posterior thighs. Which mechanism best matches the pattern described in the table?

A. Accidental fall onto a flat floor
B. Blunt impact with a belt or electrical cord
C. Bilateral pressure from a blood pressure cuff
D. Spontaneous petechiae from thrombocytopenia
E. Normal skin pigmentation

Original table 17.1 | Nelson printed p. 115 | PDF p. 159

Table 17.1 Injury Patterns

METHOD OF INJURY/ IMPLEMENT	PATTERN OBSERVED
Grip/grab	Relatively round marks that correspond to fingertips and/or thumb
Closed-fist punch	Series of round bruises that correspond to the knuckles of the hand
Slap	Parallel, linear bruises (usually petechial) separated by areas of central sparing
Belt/electrical cord	Loop marks or parallel lines of petechiae (the width of the belt/cord) with central sparing, may see triangular marks from the end of the belt, small circular lesions caused by the holes in the tongue of the belt, and/or a buckle pattern
Rope	Areas of bruising interspersed with areas of abrasion
Other objects/ household implements	Injury in shape of object/implement (e.g., rods, switches, and wires cause linear bruising)
Human bite	Two arches forming a circular or oval shape, may cause bruising and/or abrasion
Strangulation	Petechiae of the head and/or neck, including mucous membranes; may see subconjunctival hemorrhages
Binding/ligature	Marks around the wrists, ankles, or neck; sometimes accompanied by petechiae or edema distal to the ligature mark
Punishment by kneeling on salt or other rough substance	Abrasions/burns, especially to knees
Hair pulling	Traumatic alopecia; may see petechiae on underlying scalp or swelling or tenderness of the scalp (from subgaleal hematoma)
Tattooing or intentional scarring	Abusive cases have been described but can also be a cultural phenomenon (e.g., Māori body ornamentation); may also be a symbol of ownership in a youth being sexually trafficked

A healthy infant has a flat blue-gray patch over the lower back, present since birth and unchanged over several weeks. Which listed condition is the most likely mimic of bruising?

A. Dermal melanocytosis
B. Factor XIII deficiency
C. Osteogenesis imperfecta
D. Glutaric aciduria type I
E. Hemophilia A

Original table 17.2 | Nelson printed p. 117 | PDF p. 161

Table 17.2 Mimics of Nonaccidental Trauma

CUTANEOUS LESIONS
Accidental trauma
Congenital coagulation defects (hemophilia, von Willebrand disease)
Acquired coagulation defects (aplastic anemia, ITP, leukemia, vitamin K deficiency)
Ehlers-Danlos syndrome
Vitamin C deficiency
Impetigo
Vasculitis (IgA vasculitis: Henoch-Schönlein purpura)
Dermal melanocytosis (Mongolian spots)
Cupping
Coining
Spooning
SKELETAL LESIONS
Osteogenesis imperfecta
Obstetric trauma
Caffey disease
Rickets (not just low 25-hydroxy-vitamin D levels)
Hyper-IgE syndrome
Recurrent multifocal osteomyelitis
Skeletal dysplasias
HEAD TRAUMA
Birth trauma
Hemophilia
Factor XIII deficiency
Vitamin K deficiency (malabsorption)
Cobalamin C defect
Osteogenesis imperfecta
Ehlers-Danlos syndrome
Glutaric aciduria type I
Menkes syndrome
Vasculitis (primary CNS, systemic)
Benign enlargement of subarachnoid spaces

ITP, Immune thrombocytopenic purpura; IgA, immunoglobulin A; IgE, immunoglobulin E; CNS, central nervous system.

An 8-month-old with an unclear injury history undergoes a skeletal survey. Which finding in the table has high specificity for inflicted injury in an infant?

A. Isolated linear skull fracture
B. Isolated clavicular fracture
C. Posteromedial rib fractures
D. Single long-bone shaft fracture
E. Subperiosteal new bone formation

Original table 17.3 | Nelson printed p. 118 | PDF p. 162

Table 17.3 Specificity of Radiologic Findings

HIGH SPECIFICITY*
Classic metaphyseal lesions
Rib fractures, especially posteromedial
Scapular fractures
Spinous process fractures
Sternal fractures
MODERATE SPECIFICITY
Multiple fractures, especially bilateral
Fractures of different ages
Epiphyseal separations
Vertebral body fractures and subluxations
Digital fractures
Complex skull fractures
Pelvic fractures
COMMON BUT LOW SPECIFICITY
Subperiosteal new bone formation
Clavicular fractures
Long bone shaft fractures
Linear skull fractures

*Highest specificity applies in infants

From Kleinman PK. *Diagnostic imaging of child abuse*, 3rd ed. Cambridge, UK: Cambridge University Press;2015: 24.

A 10-month-old has unexplained bruising and suspected physical abuse. Which chest imaging set is part of the skeletal survey described for children under 2 years?

A. Single portable anteroposterior chest radiograph only
B. Anteroposterior chest plus right and left posterior oblique rib views
C. Lateral chest only
D. Chest fluoroscopy without radiographs
E. Bilateral decubitus views only

Original table 17.4 | Nelson printed p. 119 | PDF p. 163

Table 17.4 Radiologic Skeletal Survey for Infants and Children under 2 Years of Age*

- Anteroposterior (AP) and lateral views of skull (Townes view optional; add if any fracture seen)
- Lateral spine (cervical spine [C-spine] may be included on skull radiographs; AP spine is included on AP chest and AP pelvis views to include entire spine)
- AP view, right posterior oblique, left posterior oblique view of chest-rib technique
- AP pelvis
- AP view of each femur
- AP view of each leg
- AP view of each humerus
- AP view of each forearm
- Posteroanterior (PA) view of each hand
- AP (dorsoventral) view of each foot

*Images are checked by a radiologist before the patient leaves. Poorly positioned or otherwise suboptimal images should be repeated. Lateral views are added for positive or equivocal findings in the extremities. Coned views of positive or equivocal findings (i.e., at ends of long bones, ribs) may be obtained.

Adapted from Coley BD. *Caffey's pediatric diagnostic imaging,* 12th ed. Philadelphia: Mosby;2013: Box 144-1, p. 1588.

A fracture is seen with hard callus on follow-up radiographs. According to the table, during which interval does hard callus typically peak?

A. 0-3 days
B. 4-10 days
C. 10-14 days
D. 21-42 days
E. More than 1 year

Original table 17.5 | Nelson printed p. 119 | PDF p. 163

Table 17.5 Timetable of Radiologic Changes in Children's Fractures*

CATEGORY	EARLY	PEAK	LATE
1. SPNBF	4-10 days	10-14 days	14-21 days
2. Loss of fracture line definition, days		10-14 days	14-21 days
3. Soft callus		10-14 days	14-21 days
4. Hard callus	14-21 days	21-42 days	42-90 days

The time points tend to increase from early infancy into childhood.
*Repetitive injuries may prolong all categories.
SPNBF, Subperiosteal new bone formation.
From Kleinman PK. *Diagnostic imaging of child abuse*, 3rd ed. Cambridge, UK: Cambridge University Press;2015: p. 215.

A prepubertal child is evaluated for possible sexual abuse. Which finding independently meets an indication for STI testing in the table?

A. A parent asks for STI testing
B. The child has no symptoms and no known exposure
C. The child has a normal external examination
D. The child is too young to give a detailed history
E. The child has received routine vaccinations

Original table 17.6 | Nelson printed p. 125 | PDF p. 169

Table 17.6 Indications for STI Screening in Children with Suspected Sexual Abuse

1. The child has experienced penetration or has evidence of recent or healed penetrative injury to the genitals, anus, or oropharynx.
2. The child has been abused by a stranger.
3. The child has been abused by an assailant known to be infected with an STI or at high risk for STIs (e.g., injecting drug user, men who have sex with men, persons with multiple sexual partners, or person with a history of STIs).
4. The child has a sibling, other relative, or another person in the household with an STI.
5. The child lives in an area with a high rate of STIs in the community.
6. The child has signs or symptoms of STIs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, or genital lesions or ulcers).
7. The child or parent requests STI testing.
8. The child is unable to verbalize details of the assault.

STI, Sexually transmitted infection.
From Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. *MMWR Recomm Rep*. 2021;70(4):1–184.

An 8-year-old prepubertal child has laboratory-confirmed gonorrhea, and perinatal transmission has been excluded. Which interpretation best follows the table?

A. It is inconclusive and needs only routine follow-up
B. It is expected from nonsexual contact
C. It is diagnostic evidence for sexual abuse and should be reported
D. It becomes relevant only if genital warts are also present
E. It excludes the need for a safety assessment

Original table 17.7 | Nelson printed p. 126 | PDF p. 170

Table 17.7 Implications of Commonly Encountered Sexually Transmitted or Sexually Associated Infections for Diagnosis and Reporting of Sexual Abuse Among Infants and Prepubertal Children

INFECTION	EVIDENCE FOR SEXUAL ABUSE	SUGGESTED ACTION
Gonorrhea*	Diagnostic†	Report†
Syphilis*	Diagnostic	Report†
HIV§	Diagnostic	Report†
*Chlamydia trachomatis**	Diagnostic†	Report†
*Trichomonas vaginalis**	Diagnostic	Report†
Anogenital herpes	Suspicious	Consider report†,¶
Condylomata acuminata (anogenital warts)*	Suspicious	Consider report†,¶,**
Anogenital molluscum contagiosum	Inconclusive	Medical follow-up
Bacterial vaginosis	Inconclusive	Medical follow-up

*If unlikely to be perinatally acquired and vertical transmission, which is rare, is excluded.
†Reports should be made to the local or state agency mandated to receive reports of suspected child abuse or neglect
§If unlikely to have been acquired perinatally or through transfusion.
¶Unless a clear history of autoinoculation exists.
**Report if evidence exists to suspect abuse, including history, physical examination, or other identified infections. Lesions appearing for the first time in a child aged >5 yr are more likely to have been caused by sexual transmission.
From Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. *MMWR Recomm Rep*. 2021;70(4):1–184. Adapted from Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics*. 2005;116:506–512; Adams JA, Farst KJ, Kellogg ND. Interpretation of medical findings in suspected child abuse: An update for 2018. *J Pediatr Adolesc Gynecol*. 2018;31:225–231.

At a well-child visit, a 4-month-old infant is pulled gently to sit. Which observation best matches the age-specific pattern in the table?

A. Marked persistent head lag
B. No head lag with a steady head
C. Independent walking
D. A tower of four cubes
E. Using two-word sentences

Original table 23.2 | Nelson printed p. 154 | PDF p. 199

Table 23.2 Emerging Patterns of Behavior During the First Year of Life*

NEONATAL PERIOD (0-4 WK)	
Prone:	Lies in flexed attitude; turns head from side to side; head sags on ventral suspension
Supine:	Generally flexed and a little stiff
Visual:	May fixate face on light in line of vision; doll's eye movement (oculocephalic reflex) of eyes on turning of the body
Reflex:	Moro response active; stepping and placing reflexes; grasp reflex active
Social:	Visual preference for human face
AT 1 MO	
Prone:	Legs more extended; holds chin up; turns head; head lifted momentarily to plane of body on ventral suspension
Supine:	Tonic neck posture predominates; supple and relaxed; head lags when pulled to sitting position
Visual:	Watches person; follows moving object
Social:	Body movements in cadence with voice of other in social contact; beginning to smile
AT 2 MO	
Prone:	Raises head slightly farther; head sustained in plane of body on ventral suspension
Supine:	Tonic neck posture predominates; head lags when pulled to sitting position
Visual:	Follows moving object 180 degrees
Social:	Smiles on social contact; listens to voice and coos
AT 3 MO	
Prone:	Lifts head and chest with arms extended; head above plane of body on ventral suspension
Supine:	Tonic neck posture predominates; reaches toward and misses objects; waves at toy
Sitting:	Head lag partially compensated when pulled to sitting position; early head control with bobbing motion; back rounded
Reflex:	Typical Moro response has not persisted; makes defensive movements or selective withdrawal reactions
Social:	Sustained social contact; listens to music; says "aah, ngah"
AT 4 MO	
Prone:	Lifts head and chest, with head in approximately vertical axis; legs extended
Supine:	Symmetric posture predominates, hands in midline; reaches and grasps objects and brings them to mouth
Sitting:	No head lag when pulled to sitting position; head steady, tipped forward; enjoys sitting with full truncal support
Standing:	When held erect, pushes with feet
Adaptive:	Sees raisin, but makes no move to reach for it
Social:	Laughs out loud; may show displeasure if social contact is broken; excited at sight of food
AT 7 MO	
Prone:	Rolls over; pivots; crawls or creep-crawls (Knobloch)
Supine:	Lifts head; rolls over; squirms
Sitting:	Sits briefly, with support of pelvis; leans forward on hands; back rounded
Standing:	May support most of weight; bounces actively
Adaptive:	Reaches out for and grasps large object; transfers objects from hand to hand; grasp uses radial palm; rakes at raisin
Language:	Forms polysyllabic vowel sounds
Social:	Prefers mother; babbles; enjoys mirror; responds to changes in emotional content of social contact
AT 10 MO	
Sitting:	Sits up alone and indefinitely without support, with back straight
Standing:	Pulls to standing position; "cruises" or walks holding on to furniture
Motor:	Creeps or crawls
Adaptive:	Grasps objects with thumb and forefinger; pokes at things with forefinger; picks up pellet with assisted pincer movement; uncovers hidden toy; attempts to retrieve dropped object; releases object grasped by other person
Language:	Repetitive consonant sounds ("mama," "dada")
Social:	Responds to sound of name; plays peek-a-boo or pat-a-cake; waves bye-bye
AT 1 YR	
Motor:	Walks with one hand held; rises independently, takes several steps (Knobloch)
Adaptive:	Picks up raisin with unassisted pincer movement of forefinger and thumb; releases object to other person on request or gesture
Language:	Says a few words besides "mama," "dada"
Social:	Plays simple ball game; makes postural adjustment to dressing

*Data are derived from those of Gesell (as revised by Knobloch), Shirley, Provence, Wolf, Bailey, and others.
Data from Knobloch H, Stevens F, Malone AF. *Manual of Developmental Diagnosis*. Hagerstown, MD: Harper & Row;1980.

A typically developing 18-month-old is assessed during play. Which adaptive skill matches the table?

A. Copies a circle
B. Makes a tower of four cubes
C. Reads simple words
D. Ties shoelaces
E. Draws a recognizable person

Original table 24.1 | Nelson printed p. 163 | PDF p. 208

Table 24.1 Emerging Patterns of Behavior from 1-5 Years of Age

15 MO	
Motor:	Walks alone; crawls up stairs
Adaptive:	Makes tower of 3 cubes; makes a line with crayon; inserts raisin in bottle
Language:	Jargon; follows simple commands; may name a familiar object (e.g., ball); responds to his/her name
Social:	Indicates some desires or needs by pointing; hugs parents
18 MO	
Motor:	Runs stiffly; sits on small chair; walks up stairs with 1 hand held; explores drawers and wastebaskets
Adaptive:	Makes tower of 4 cubes; imitates scribbling; imitates vertical stroke; dumps raisin from bottle
Language:	10 words (average); names pictures; identifies 1 or more parts of body
Social:	Feeds self; seeks help when in trouble; may complain when wet or soiled; kisses parent with pucker
24 MO	
Motor:	Runs well, walks up and down stairs, 1 step at a time; opens doors; climbs on furniture; jumps
Adaptive:	Makes tower of 7 cubes (6 at 21 mo); scribbles in circular pattern; imitates horizontal stroke; folds paper once imitatively
Language:	Puts 3 words together (subject, verb, object)
Social:	Handles spoon well; often tells about immediate experiences; helps to undress; listens to stories when shown pictures
30 MO	
Motor:	Goes up stairs alternating feet
Adaptive:	Makes tower of 9 cubes; makes vertical and horizontal strokes, but generally will not join them to make cross; imitates circular stroke, forming closed figure
Language:	Refers to self by pronoun "I"; knows full name
Social:	Helps put things away; pretends in play
36 MO	
Motor:	Rides tricycle; stands momentarily on 1 foot
Adaptive:	Makes tower of 10 cubes; imitates construction of "bridge" of 3 cubes; copies circle; imitates cross
Language:	Knows age and gender; counts 3 objects correctly; repeats 3 numbers or a sentence of 6 syllables; most of speech intelligible to strangers
Social:	Plays simple games (in "parallel" with other children); helps in dressing (unbuttons clothing and puts on shoes); washes hands
48 MO	
Motor:	Hops on 1 foot; throws ball overhand; uses scissors to cut out pictures; climbs well
Adaptive:	Copies bridge from model; imitates construction of "gate" of 5 cubes; copies cross and square; draws man with 2-4 parts besides head; identifies longer of 2 lines
Language:	Counts 4 pennies accurately; tells story
Social:	Plays with several children, with beginning of social interaction and role-playing; goes to toilet alone
60 MO	
Motor:	Skips
Adaptive:	Draws triangle from copy; names heavier of 2 weights
Language:	Names 4 colors; repeats sentence of 10 syllables; counts 10 pennies correctly
Social:	Dresses and undresses; asks questions about meaning of words; engages in domestic role-playing

Data derived from those of Gesell (as revised by Knobloch), Shirley, Provence, Wolf, Bailey, and others. After 6 yr, the Wechsler Intelligence Scales for Children (WISC-IV) and other scales offer the most precise estimates of cognitive development. To have their greatest value, they should be administered only by an experienced and qualified person.

A toddler grew 8 cm between the second and third birthdays. How should this annualized velocity be interpreted against the table?

A. Far below the table value for 24-36 months
B. Approximately the listed velocity for 24-36 months
C. Equal to the listed birth-to-12-month velocity
D. Equal to the listed pubertal peak for boys
E. Evidence of a growth spurt expected only in adolescence

Original table 27.1 | Nelson printed p. 175 | PDF p. 220

Table 27.1 Growth Velocity and Other Growth Characteristics by Age

INFANCY	CHILDHOOD	ADOLESCENCE
Birth-12 mo: 24 cm/yr 12-24 mo: 10 cm/yr 24-36 mo: 8 cm/yr	6 cm/yr Slowly decelerates before pubertal onset Height typically does not cross percentile lines	Sigmoid-shaped growth Adolescent growth spurt accounts for about 15% of adult height Peak height velocity Girls: 8 cm/yr Boys: 10 cm/yr

A 9-year-old with falling height velocity, abdominal discomfort, and iron-deficiency anemia has no pubertal delay. Which listed cause of short stature best unifies these findings?

A. Familial short stature
B. Celiac disease
C. Constitutional tall stature
D. Growth hormone excess
E. Precocious puberty

Original table 27.2 | Nelson printed p. 177 | PDF p. 222

Table 27.2 Common Causes of Decreased Growth and Short Stature

Variation of normal
- Familial short stature
- Constitutional delay
- Delayed puberty

Nutrition and gastrointestinal conditions
- Malnutrition
- Celiac disease
- Inflammatory bowel disease

Genetic conditions
- Turner syndrome
- Prader-Willi syndrome
- 22q deletion syndrome
- Trisomy 21
- Skeletal dysplasias: achondroplasia, SHOX haploinsufficiency, osteogenesis imperfecta

Endocrine conditions
- Hypothyroidism
- Growth hormone deficiency
- Poorly controlled diabetes mellitus
- Poorly controlled diabetes insipidus
- Metabolic bone disease: rickets, hypophosphatasia
- Glucocorticoid excess

Psychosocial causes

Renal conditions
- Renal tubular acidosis
- Nephrotic syndrome

Medications
- Glucocorticoids
- Inappropriate sex steroid exposure
- Antiepileptic medications

A tall adolescent has arachnodactyly, joint hypermobility, and aortic root dilatation. Which listed cause of increased growth is most likely?

A. Marfan syndrome
B. Familial short stature
C. Turner syndrome
D. Celiac disease
E. Hypothyroidism

Original table 27.3 | Nelson printed p. 177 | PDF p. 222

Table 27.3 Common Causes of Increased Growth and Tall Stature

Variation of normal
Constitutional tall stature
Familial tall stature
Endocrine conditions
Growth hormone excess
Precocious puberty (ultimate height may be decreased)
Congenital adrenal hyperplasia
Obesity
Genetic conditions
Marfan syndrome
Klinefelter syndrome
Sotos syndrome

A 6-year-old begins erupting a permanent tooth behind the primary dentition without loss of a primary tooth at that site. Which tooth most closely matches the age and pattern in the table?

A. Third molar
B. First permanent molar
C. Permanent canine
D. Second permanent premolar
E. Primary second molar

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Table 27.4 Chronology of Human Dentition of Primary (Deciduous) and Secondary (Permanent) Teeth

	CALCIFICATION		AGE AT ERUPTION		AGE AT SHEDDING	
	BEGINS AT	COMPLETE AT	MAXILLARY	MANDIBULAR	MAXILLARY	MANDIBULAR
PRIMARY TEETH						
Central incisors	5th fetal mo	18-24 mo	6-8 mo	5-7 mo	7-8 yr	6-7 yr
Lateral incisors	5th fetal mo	18-24 mo	8-11 mo	7-10 mo	8-9 yr	7-8 yr
Cuspids (canines)	6th fetal mo	30-36 mo	16-20 mo	16-20 mo	11-12 yr	9-11 yr
First molars	5th fetal mo	24-30 mo	10-16 mo	10-16 mo	10-12 yr	10-12 yr
Second molars	6th fetal mo	36 mo	20-30 mo	20-30 mo	10-12 yr	11-13 yr
SECONDARY TEETH						
Central incisors	3-4 mo	9-10 yr	7-8 yr	6-7 yr		
Lateral incisors	Max, 10-12 mo Mand, 3-4 mo	10-11 yr	8-9 yr	7-8 yr		
Cuspids (canines)	4-5 mo	12-15 yr	11-12 yr	9-11 yr		
First premolars (bicuspids)	18-21 mo	12-13 yr	10-11 yr	10-12 yr		
Second premolars (bicuspids)	24-30 mo	12-14 yr	10-12 yr	11-13 yr		
First molars	Birth	9-10 yr	6-7 yr	6-7 yr		
Second molars	30-36 mo	14-16 yr	12-13 yr	12-13 yr		
Third molars	Max, 7-9 yr Mand, 8-10 yr	18-25 yr	17-22 yr	17-22 yr		

Mand, Mandibular; max, maxillary.
Adapted from a chart prepared by P.K. Losch, Harvard School of Dental Medicine, who provided the data for this table.

A 20-month-old who previously used several words and gestures has stopped using both over 2 months. Which next step best follows the developmental red-flag table?

A. Reassure the family that regression is expected during toddlerhood
B. Wait until school age before screening
C. Arrange prompt developmental evaluation and assessment for hearing loss
D. Assess only height and weight
E. Defer assessment unless a parent reports fever

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Table 28.2 Red Flags in Developmental Screening and Surveillance

These indicators suggest that development is significantly delayed or disordered and that the child should be referred to a developmental pediatrician or pediatric neurologist. Any delay in achieving a milestone at the 75th percentile may be considered a red flag and merits further evaluation, vigilant surveillance, or repeat screening.

POSITIVE INDICATORS
Presence of any of the following:
Loss of developmental skills at any age
Parental or professional concerns about vision, fixing, or following an object or a confirmed visual impairment at any age (simultaneous referral to pediatric ophthalmology)
Hearing loss at any age (simultaneous referral for expert audiologic or ear, nose, and throat assessment)
Persistently low muscle tone or floppiness (check creatine kinase)
No speech by 15 mo, especially if the child does not try to communicate by other means, such as gestures (simultaneous referral for urgent hearing test)
Asymmetry of movements or other features suggestive of cerebral palsy, such as increased muscle tone
Persistent toe walking
Multiple organ involvement
Head circumference above the 99.6th centile or below 0.4th centile; also, if circumference has crossed 2 centiles (up or down) on the appropriate chart or is disproportionate to parental head circumference
NEGATIVE INDICATORS
Activities that the child cannot do:
Sit unsupported by 12 mo
Walk by 18 mo (check creatine kinase)
Walk other than on tiptoes
Run by 24 mo
Hold object placed in hand by 4 mo (corrected for gestation)
Reach for objects by 6 mo (corrected for gestation)
Points to show you something interesting by 18 months

Adapted from Horridge KA. Assessment and investigation of the child with disordered development. *Arch Dis Child Educ Pract Ed*. 2011;96:9–20; Zubler JM, Wiggins LD, Macias MM, et al. Evidence-informed milestones for developmental surveillance tools. Pediatrics. 2022;149(3):e2021052138.

A child with trisomy 21 has loud habitual snoring and obstructive events during sleep. Which anatomic feature in the table can contribute directly to upper-airway obstruction?

A. Macroglossia
B. Long femurs
C. Scoliosis without thoracic restriction
D. Small spleen
E. Delayed tooth eruption

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Table 31.4 Anatomic Factors That Predispose to Obstructive Sleep Apnea Syndrome and Hypoventilation in Children

NOSE
Anterior nasal stenosis
Choanal stenosis/atresia
Deviated nasal septum
Seasonal or perennial rhinitis
Nasal polyps, foreign body, hematoma, mass lesion
NASOPHARYNGEAL AND OROPHARYNGEAL
Adenotonsillar hypertrophy
Macroglossia
Cystic hygroma
Velopharyngeal flap repair
Cleft palate repair
Pharyngeal mass lesion
CRANIOFACIAL
Micrognathia/retrognathia
Midface hypoplasia (e.g., trisomy 21, Crouzon disease, Apert syndrome)
Mandibular hypoplasia (Pierre Robin, Treacher Collins, Cornelia de Lange syndromes)
Craniofacial trauma
Skeletal and storage diseases
Achondroplasia
Storage diseases (e.g., glycogen; Hunter, Hurler syndromes)

airway patency (upper airway obstruction and/or decreased upper air-

A 7-year-old snores most nights and has witnessed pauses in breathing. According to the guideline summarized in the table, which is the most appropriate next diagnostic step?

A. Reassurance without evaluation
B. Obtain polysomnography or refer for specialist evaluation
C. Routine chest radiography
D. Immediate long-term oxygen without diagnosis
E. An empiric antibiotic course

Original table 31.5 | Nelson printed p. 208 | PDF p. 253

Table 31.5 American Academy of Pediatrics Clinical Practice Guideline: Diagnosis and Management of Childhood Obstructive Sleep Apnea Syndrome

Key Action Statement 1: Screening for OSA
As part of routine health maintenance visits, clinicians should inquire whether the child or adolescent snores. If the answer is affirmative or if a child or adolescent presents with signs or symptoms of OSA, clinicians should perform a more focused evaluation. (Evidence Quality: Grade B; Recommendation Strength: Recommendation.)

Key Action Statement 2A: Polysomnography
If a child or adolescent snores on a regular basis and has any of the complaints or findings of OSA, clinicians should either (1) obtain a polysomnogram (Evidence Quality: Grade A; Recommendation Strength: Recommendation) *or* (2) refer the patient to a sleep specialist or otolaryngologist for a more extensive evaluation. (Evidence Quality: Grade D; Recommendation Strength: Option.)

Key Action Statement 2B: Alternative Testing
If polysomnography is not available, clinicians may order alternative diagnostic tests, such as nocturnal video recording, nocturnal oximetry, daytime nap polysomnography, or ambulatory polysomnography. (Evidence Quality: Grade C; Recommendation Strength: Option.)

Key Action Statement 3: Adenotonsillectomy
If a child is determined to have OSA, has a clinical examination consistent with adenotonsillar hypertrophy, and does not have a contraindication to surgery, the clinician should recommend adenotonsillectomy as the first line of treatment. If the child has OSA but does not have adenotonsillar hypertrophy, other treatment should be considered (see Key Action Statement 6). Clinical judgment is required to determine the benefits of adenotonsillectomy compared with other treatments in obese children with varying degrees of adenotonsillar hypertrophy. (Evidence Quality: Grade B; Recommendation Strength: Recommendation.)

Key Action Statement 4: High-Risk Patients Undergoing Adenotonsillectomy
Clinicians should monitor high-risk patients undergoing adenotonsillectomy as inpatients postoperatively. (Evidence Quality: Grade B; Recommendation Strength: Recommendation.)

Key Action Statement 5: Reevaluation
Clinicians should clinically reassess all patients with OSA for persisting signs and symptoms after therapy to determine whether further treatment is required. (Evidence Quality: Grade B; Recommendation Strength: Recommendation.)

Key Action Statement 5B: Reevaluation of High-Risk Patients
Clinicians should reevaluate high-risk patients for persistent OSA after adenotonsillectomy, including those who had a significantly abnormal baseline polysomnogram, have sequelae of OSA, are obese, or remain symptomatic after treatment, with an objective test (see Key Action Statement 2), or refer such patients to a sleep specialist. (Evidence Quality: Grade B; Recommendation Strength: Recommendation.)

Key Action Statement 6: CPAP
Clinicians should refer patients for CPAP management if symptoms/signs or objective evidence of OSA persists after adenotonsillectomy or if adenotonsillectomy is not performed. (Evidence Quality: Grade B; Recommendation Strength: Recommendation.)

Key Action Statement 7: Weight Loss
Clinicians should recommend weight loss in addition to other therapy if a child/adolescent with OSA is overweight or obese. (Evidence Quality: Grade C; Recommendation Strength: Recommendation.)

Key Action Statement 8: Intranasal Corticosteroids
Clinicians may prescribe topical intranasal corticosteroids for children with mild OSA in whom adenotonsillectomy is contraindicated or for children with mild postoperative OSA. (Evidence Quality: Grade B; Recommendation Strength: Option.)

CPAP, Continuous Positive Airway Pressure; OSA, obstructive sleep apnea.
Adapted from Marcus CL, Brooks LJ, Draper KA, et al. Diagnosis and management of childhood obstructive sleep apnea syndrome. *Pediatrics*. 2012;130:576–584.

A 6-year-old awakens fully after a frightening dream in the latter part of the night and describes it clearly. Which event best matches the comparison table?

A. Sleep terror
B. Confusional arousal
C. Sleepwalking
D. Nightmare
E. Nocturnal seizure

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Table 31.6 Key Similarities and Differentiating Features Between Non-REM and REM Parasomnias as Well as Nocturnal Seizures

	CONFUSIONAL AROUSALS	SLEEP TERRORS	SLEEPWALKING	NIGHTMARES	NOCTURNAL SEIZURES
Time	Early	Early	Early-mid	Late	Any
Sleep stage	SWA	SWA	SWA	REM	Any
EEG discharges	–	–	–	–	+
Scream	–	++++	–	++	+
Autonomic activation	+	++++	+	+	+
Motor activity	–	+	+++	+	++++
Awakens	–	–	–	+	+
Duration (min)	0.5-10; more gradual offset	1-10; more gradual offset	2-30; more gradual offset	3-20	5-15; abrupt onset and offset
Postevent confusion	+	+	+	–	+
Age	Child	Child	Child	Child, young adult	Adolescent, young adult
Genetics	+	+	+	–	±
Organic CNS lesion	–	–	–	–	++++

CNS, Central nervous system; EEG, electroencephalogram; REM, rapid eye movement; SWA, slow-wave arousal.
From Avidan A, Kaplish N. The parasomnias: epidemiology, clinical features and diagnostic approach. *Clin Chest Med.* 2010;31:353–370.

A 13-year-old has unpleasant leg sensations that begin when resting in the evening, improve while walking, and disturb sleep. Which condition is most consistent with the table?

A. Restless legs syndrome
B. Sleep terror
C. Narcolepsy
D. Obstructive sleep apnea
E. Circadian rhythm delay alone

Original table 31.7 | Nelson printed p. 210 | PDF p. 255

Table 31.7 Diagnostic Criteria for Restless Legs Syndrome

A. An urge to move legs, usually accompanied by or in response to uncomfortable and unpleasant sensations in the legs, characterized by the following:
   1. The urge to move the legs begins or worsens during periods of rest or inactivity.
   2. The urge to move the legs is partially or totally relieved by movement.
   3. The urge to move the legs is worse in the evening or at night than during the day, or occurs only in the evening or at night.
B. The symptoms in Criterion A occur at least 3 times per week and have persisted for at least 3 mo.
C. The symptoms in Criterion A are accompanied by significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
D. The symptoms in Criterion A are not attributable to another mental disorder or medical condition (e.g., arthritis, leg edema, peripheral ischemia, leg cramps) and are not better explained by a behavioral condition (e.g., positional discomfort, habitual foot tapping).
E. The symptoms are not attributable to the physiologic effects of a drug or abuse or medication (e.g., akathisia).

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed, Arlington, VA: American Psychiatric Association; 2013. p 410.

A 14-year-old has months of daytime sleep attacks and brief episodes of bilateral loss of muscle tone when laughing, without loss of consciousness. Which diagnosis best fits the table?

A. Absence epilepsy
B. Narcolepsy with cataplexy
C. Sleep terror
D. Restless legs syndrome
E. Obstructive sleep apnea

Original table 31.8 | Nelson printed p. 212 | PDF p. 257

Table 31.8 Diagnostic Criteria for Narcolepsy

A. Recurrent periods of an irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day. These must have been occurring at least 3 times per week over the past 3 mo.
B. The presence of at least one of the following:
   1. Episodes of cataplexy, defined as either (a) or (b), occurring at least a few times per month:
      a. In individuals with long-standing disease, brief (seconds to minutes) episodes of sudden bilateral loss of muscle tone with maintained consciousness that are precipitated by laughter or joking.
      b. In children or individuals within 6 mo of onset, spontaneous grimaces or jaw-opening episodes with tongue thrusting or a global hypotonia, without any obvious emotional triggers.
   2. Hypocretin deficiency, as measured using CSF hypocretin-1 immunoreactivity values (less than or equal to one third of values obtained in healthy subjects tested using the same assay, or ≤110 pg/mL). Low CSF levels of hypocretin-1 must not be observed in the context of acute brain injury, inflammation, or infection.
   3. Nocturnal sleep polysomnography showing REM sleep latency ≤15 min, or a multiple sleep latency test showing a mean sleep latency ≤ 8 min and two or more sleep-onset REM periods.

Specify whether:

Narcolepsy without cataplexy but with hypocretin deficiency: Criterion B requirements of low CSF hypocretin-1 levels and positive polysomnography/multiple sleep latency test are met, but no cataplexy is present (Criterion B1 not met).

Narcolepsy with cataplexy but without hypocretin deficiency: In this rare subtype (<5% of narcolepsy cases), Criterion B requirements of cataplexy and positive polysomnography/multiple sleep latency test are met, but CSF hypocretin-1 levels are normal (Criterion B2 not met).

Autosomal dominant cerebellar ataxia, deafness, and narcolepsy: This subtype is caused by exon 21 DNA (cytosine-5)-methyltransferase-1 mutations and is characterized by late-onset (age 30-40 yr) narcolepsy (with low or intermediate CSF hypocretin-1 levels), deafness, cerebellar ataxia, and eventually dementia.

Autosomal dominant narcolepsy, obesity, and type 2 diabetes: Narcolepsy, obesity, and type 2 diabetes are low; CSF hypocretin-1 levels have been described in rare cases and are associated with a mutation in the myelin oligodendrocyte glycoprotein gene.

Narcolepsy without cataplexy but with hypocretin deficiency: This subtype is for narcolepsy that develops secondary to medical conditions that cause infectious (e.g., Whipple disease, sarcoidosis), traumatic, or tumoral destruction of hypocretin neurons.

Severity:

Mild: Infrequent cataplexy (less than once per week), need for naps only once or twice per day, and less disturbed nocturnal sleep.

Moderate: Cataplexy once daily or every few days, disturbed nocturnal sleep and need for multiple naps daily.

Severe: Drug-resistant cataplexy with multiple attacks daily, nearly constant sleepiness, and disturbed nocturnal sleep (i.e., movements, insomnia, and vivid dreaming).

CSF, Cerebrospinal fluid; REM, rapid eye movement.
From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed, Arlington, VA: American Psychiatric Association; 2013. pp 372–373.

During a sleep screen, a parent reports that a 9-year-old snores loudly each night. Which domain of the BEARS algorithm directly captures this concern?

A. Bedtime problems
B. Excessive daytime sleepiness
C. Awakenings at night
D. Regularity and duration
E. Snoring

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Table 31.10 BEARS Sleep Screening Algorithm

The BEARS instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children 2-18 yr old. Each sleep domain has a set of age-appropriate "trigger questions" for use in the clinical interview.
B = Bedtime problems
E = Excessive daytime sleepiness
A = Awakenings during the night
R = Regularity and duration of sleep
S = Snoring

	DEVELOPMENTALLY APPROPRIATE TRIGGER QUESTIONS		
	TODDLER, PRESCHOOL (2-5 YR)	**SCHOOL-AGE (6-12 YR)**	**ADOLESCENT (13-18 YR)**
1. Bedtime problems	Does your child have any problems going to bed? Falling asleep?	Does your child have any problems at bedtime? (P) Do you any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C)
2. Excessive daytime sleepiness	Does your child seem overtired or sleepy a lot during the day? Does your child still take naps?	Does your child have difficulty waking in the morning, seem sleepy during the day, or take naps? (P) Do you feel tired a lot? (C)	Do you feel sleepy a lot during the day? In school? While driving? (C)
3. Awakenings during the night	Does your child wake up a lot at night?	Does your child seem to wake up a lot at night? Any sleepwalking or nightmares? (P) Do you wake up a lot at night? Do you have trouble getting back to sleep? (C)	Do you wake up a lot at night? Do you have trouble getting back to sleep? (C)
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? What are they?	What time does your child go to bed and get up on school days? Weekends? Do you think your child is getting enough sleep? (P)	What time do you usually go to bed on school nights? Weekends? How much sleep do you usually get? (C)
5. Snoring	Does your child snore a lot or have difficulty breathing at night?	Does your child have loud or nightly snoring or any breathing difficulties at night? (P)	Does your teenager snore loudly or nightly? (P)

C, Child; P, parent.

At a routine visit, a 15-year-old says they have made a specific plan to kill themself. Which classification best matches the mental-health action-sign table?

A. Expected adolescent distress requiring no action
B. A mental-health action sign requiring immediate safety assessment
C. A normal response to academic pressure
D. A symptom that should be revisited only at the next annual visit
E. Evidence of a sleep disorder alone

Original table 32.1 | Nelson printed p. 217 | PDF p. 262

Table 32.1 Mental Health Action Signs

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involvement in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in your behavior or personality

From The Action Signs Project. *Center for the Advancement of Children's Mental Health* at Columbia University.

A child with new psychotic symptoms has episodic vomiting, encephalopathy, and marked hyperammonemia. Which listed medical cause merits particular evaluation?

A. Oppositional defiant disorder
B. Ornithine transcarbamylase deficiency
C. Specific phobia
D. Primary insomnia
E. Uncomplicated adolescent adjustment

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Table 32.4 Medical (Secondary) and Psychiatric (Primary) Causes of Psychosis and/or Depression

CATEGORY	DISORDERS
Psychiatric	Schizophrenia Schizoaffective Schizophreniform Brief psychotic Major depression Bipolar Postpartum
Head trauma	Traumatic brain injury Subdural hematoma
Infectious	Viral infections/encephalitides (HIV infection/encephalopathy, herpes encephalitis, cytomegalovirus, Epstein-Barr virus, COVID-19) Lyme disease Cerebral malaria Endocarditis Neurosyphilis Whipple disease
Inflammatory	Autoimmune encephalitis: NMDAR, limbic, others (see Table 32.5) Systemic lupus erythematosus Sjögren syndrome Hashimoto encephalopathy (steroid-responsive encephalopathy associated with autoimmune thyroiditis [SREAT]) Sydenham chorea Sarcoidosis Celiac disease
Neoplastic	Primary or secondary cerebral neoplasm Paraneoplastic encephalitis: ovarian teratoma-associated autoimmune encephalitis Systemic neoplasm Pheochromocytoma
Endocrine or acquired metabolic	Hepatic encephalopathy Uremic encephalopathy Hypo/hyperparathyroidism Hypo/hyperthyroidism Addison disease Cushing disease Vitamin deficiency: vitamin B_{12}, folate, niacin, vitamin C, thiamine Gastric bypass–associated nutritional deficiencies Hypoglycemia Hyponatremia
Vascular	Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL) Other vasculitis syndromes Stroke
Degenerative	Idiopathic basal ganglia calcifications, Fahr disease Neuroacanthocytosis Neurodegeneration with brain iron accumulation (NBIA) Tuberous sclerosis Huntington disease Corticobasal ganglionic degeneration Multisystem atrophy, striatonigral degeneration, olivopontocerebellar atrophy
Demyelinating, dysmyelinating	Multiple sclerosis Acute disseminated encephalomyelitis Adrenoleukodystrophy Metachromatic leukodystrophy
Inherited metabolic	Wilson disease Posterior horn syndrome Tay-Sachs disease (adult onset) Neuronal ceroid lipofuscinosis Niemann-Pick disease type C Acute intermittent porphyria Mitochondrial encephalopathy, lactic acidosis, and stroke-like episodes (MELAS)
Inherited metabolic (cont'd)	Mitochondrial neurogastrointestinal encephalopathy (MNGIE) Cerebrotendinous xanthomatosis Homocystinuria Ornithine transcarbamylase deficiency Phenylketonuria
Syndromes	Williams Prader-Willi Marfan Fragile X Deletion 22q11.2 Rapid-onset obesity with hypothalamic dysfunction, hypoventilation, autonomic dysregulation (ROHHAD) Klinefelter
Epilepsy	Ictal Interictal Postictal Postepilepsy surgery Lafora progressive myoclonic epilepsy Complex partial (temporal lobe)
Substance induced (medications)	Analgesics Acyclovir Androgens (anabolic steroids) Antiarrhythmics Anticonvulsants Anticholinergics Antihypertensives Antineoplastic agents β-Blocking agents Cefepime Clarithromycin Cyclosporine Dextromethorphan Dopamine agonists Ketamine Fluoroquinolones Metronidazole Sulfamethoxazole-trimethoprim Oral contraceptives Sedatives/hypnotics Selective serotonin reuptake inhibitors (SSRIs) (serotonin syndrome) Steroids
Substance induced	Alcohol Amphetamines Cocaine LSD Marijuana and synthetic cannabinoids Methylenedioxymethamphetamine (MDMA, Ecstasy) Phencyclidine Mescaline Psilocybins (mushrooms)
Drug withdrawal syndromes	Alcohol Barbiturates Benzodiazepines Amphetamines SSRIs
Toxins	Heavy metals: lead, mercury, arsenic Carbon monoxide Inhalants Organophosphates St. John's wort
Other	Normal-pressure hydrocephalus Ionizing radiation Decompression sickness Narcolepsy

A previously healthy adolescent develops new agitation, bizarre behavior, orofacial dyskinesias, and fluctuating consciousness after encephalitis. Which antibody target listed in the table is most likely?

A. N-methyl-D-aspartate receptor (NMDAR)
B. Aquaporin-4
C. Acetylcholine receptor at the neuromuscular junction
D. Thyroid peroxidase alone
E. Platelet glycoprotein IIb/IIIa

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Table 32.5 Antigenic Targets in Autoimmune Encephalitis with Associated Psychiatric Features

COMMONLY TARGETED ANTIGENS	ANTIGEN DESCRIPTION OR EPITOPE	MAIN ENCEPHALOPATHY SYNDROME AND PSYCHIATRIC FEATURES	OTHER ASSOCIATED NEUROLOGIC DISORDERS	MAIN PSYCHIATRIC FEATURES
NMDAR	Ligand-gated ion channel	Encephalopathy (frequently extralimbic manifestation)	Post–herpes simplex encephalitis relapse with chorea; pediatric dyskinetic encephalitis lethargica; idiopathic epilepsy; immunotherapy-responsive dementia	Anxiety, agitation, bizarre behavior, catatonia, delusional or paranoid thoughts, and visual or auditory hallucinations; also movement disorder, seizures, autonomic instability
LGI1	VGKC-associated and AMPAR-associated secreted molecule	Limbic encephalitis with or without faciobrachial dystonic seizures; prominent hyponatremia	Morvan syndrome, neuromyotonia, epilepsy, REM sleep behavior disorder; rarely isolated movement disorder (parkinsonism, dystonia, chorea)	Confusion, hallucinations, depression
CASPR2	VGKC-associated adhesion molecule	Morvan syndrome: peripheral nerve hyperexcitability, autonomic instability, encephalopathy	Limbic encephalitis, neuromyotonia, epilepsy; rarely isolated movement disorder (chorea, myoclonus)	Confusion, hallucinations, agitation, delusions
AMPAR	Ligand-gated ion channel	Limbic encephalitis	NA	Personality change, psychosis, apathy, agitation, confabulation
$GABA_AR$	Ligand-gated ion channel	Limbic encephalitis with refractory seizures	Varied presentations	Confusion, anxiety, affective changes (including depression), hallucinations, catatonia
$GABA_BR$	Ligand-gated ion channel	Limbic encephalitis with refractory status epilepticus	Opsoclonus-myoclonus; cerebellar ataxia; PERM	Psychosis, agitation, catatonia
Hu	Intracellular RNA-binding protein	Limbic encephalitis or limbic encephalomyelitis occurring with small cell lung cancer	Painful sensory neuropathy; cerebellar ataxia	Confusion, depression, less commonly hallucinations
Ma2	Intracellular protein involved in mRNA processing or biogenesis	Limbic encephalitis occurring with testicular germ cell tumors; REM sleep disorder is common; frequent short-term memory problems	Visual dysfunction, gait disturbance, hypokinesia	Confusion and anxiety, including obsessions and compulsions
D2R	Metabotropic receptor	So-called basal ganglia encephalitis with prominent movement disorder (i.e., dystonia, parkinsonism, chorea, tics)	Sydenham chorea, PANDAS	Agitation, depression, psychosis, emotional lability
DPPX	Auxiliary subunit of Kv4.2 potassium channels	Limbic encephalitis with enteropathy	PERM	Amnesia, delirium, psychosis, depression
MGluR5	Metabotropic glutamate receptor	So-called Ophelia syndrome: limbic encephalitis in association with Hodgkin lymphoma	Paraneoplastic limbic encephalitis without lymphoma, or nonparaneoplastic limbic encephalitis; immunotherapy-responsive prosopagnosia	Depression, anxiety, delusions, visual and auditory hallucinations, personality change, anterograde amnesia
GFAP	Intracellular (cytosolic) glial intermediate filament protein	Corticosteroid-responsive meningoencephalitis or encephalitis, with or without myelitis; presents with subacute onset of memory loss and confusion	NA	Occurred in 29% in one study but not described in detail; psychosis and behavioral changes reported

AMPAR, α-Amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid receptor; CASPR2, contactin-associated protein-like 2; D2R, dopamine receptor D2; DPPX, dipeptidyl-peptidase-like protein-6; $GABA_AR$, γ-aminobutyric acid type A receptor; $GABA_BR$, γ-aminobutyric acid type B receptor; GFAP, glial fibrillary acidic protein; LGI1, leucine-rich glioma-inactivated 1; MGluR5, metabotropic glutamate receptor 5; NA, not applicable; NMDAR, N-methyl-D-aspartate receptor; PANDAS, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections; PERM, progressive encephalomyelitis with rigidity and myoclonus; REM, rapid eye movement; VGKC, voltage-gated potassium channel.
Modified from Pollak TA, Lennox BR, Muller S, et al. Autoimmune psychosis: an international consensus on an approach to the diagnosis and management of psychosis of suspected autoimmune origin. *Lancet Psychiatry*. 2020;7(1):93–108.

An adolescent starts an antipsychotic and develops rapid weight gain and dyslipidemia. Which listed medication has the highest relative frequency of weight gain and lipid abnormalities?

A. Aripiprazole
B. Lurasidone
C. Olanzapine
D. Haloperidol
E. Risperidone

Original table 33.6 | Nelson printed p. 229 | PDF p. 274

Table 33.6 Relative Side Effects for Select Antipsychotic Medications

ADVERSE EFFECT	ARIPIPRAZOLE [ABILIFY]	OLANZAPINE [ZYPREXA]	QUETIAPINE [SEROQUEL]	RISPERIDONE [RISPERDAL]	PALIPERIDONE [INVEGA]	LURASIDONE [LATUDA]	HALOPERIDOL [HALDOL]
Akathisia	++	++	+	++	++	++	+++
Parkinsonism	+	++	+	++	++	++	+++
Dystonia	+	+	+	++	++	++	+++
Tardive dyskinesia	+	+	+	++	++	++	+++
Hyperprolactinemia	+	++	+	+++	+++	+	+++
Anticholinergic	+	++	+/++	++	+	+	+
Seizures	+	++	++	+	+	+	+
Orthostasis	+	++	++	++	++	+	+
QT interval	+	++	+	+	+	+	++
Weight gain	+	+++	++	++	++	+	+
Hyperlipidemia	+	+++	++	+++	++	++	+
Glucose abnormalities	+	+++	++	++	+	+	+
Sedation	+	++	++	+	+	++	+

+= Seldom; ++ = sometimes; +++ = often.
Adapted from Keepers GA, Fochtmann LJ, Anzia JM, et al. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. *Am J Psychiatry*. 2020;177(9):868–872.

A 15-year-old with depression is able to engage in psychotherapy. Which intervention is listed as well-established for adolescent depression?

A. Individual cognitive behavioral therapy
B. Individual psychodynamic therapy alone
C. Exposure and response prevention
D. Habit reversal training
E. Applied behavior analysis

Original table 34.1 | Nelson printed p. 232 | PDF p. 277

Table 34.1 Effective Psychotherapies for Specific Behavioral Health Disorders

DISORDER	WELL-ESTABLISHED*	PROBABLY EFFICACIOUS†
Anorexia	Family therapy: behavioral	Family therapy: systemic Individual psychodynamic psychotherapy
Anxiety, children under 8	Family-based CBT	Group parent CBT ± group child CBT
Anxiety	CBT ± parent component ± medication	Family psychoeducation Parent/child CBT Relaxation, assertiveness training
Attention-deficit/hyperactivity	BPT Behavioral classroom management Behavioral peer interventions Organization (executive function) training	Combined training interventions
Autism	Individual, comprehensive ABA Teacher-implemented focused ABA + DSP	Individual, focused (communication) ABA ± DSP Focused DSP parent training
Behavior, child	Group BPT Individual BPT with child component	Modifications of Group BPT‡ Individual BPT alone or with other modifications Self-directed parent behavior therapy Group child behavior therapy ± teacher training Individual child behavior therapy ± parent component Group/individual child-centered play therapy
Behavior, adolescent	Behavioral therapy + CBT + family therapy	CBT
Bipolar	Family skill building + psychoeducation	DBT
Depression, child	None	None
Depression, adolescent	Individual/group CBT Individual IPT	Group IPT
Obsessive-compulsive	Family-focused CBT	Individual CBT
Posttraumatic stress	Individual/group trauma-focused CBT ± parent component	Group CBT + parent component EMDR
Substance use	Individual/group/family CBT ± MET Family-based treatment, ecologic ± CBT ± MET	Family-based treatment, behavioral Motivational interviewing/MET Family-based treatment, ecologic + contingency management Family-based treatment, behavioral, ecologic, contingency management + MET MET + CBT + contingency management
Self-injurious thoughts and behaviors	DBT-adolescents (deliberate self-harm, suicidal ideation)	DBT—adolescents (nonsuicidal self-injury, suicide attempt) Individual/family CBT (suicide attempt) Family therapy (suicide attempt) Interpersonal therapy—adolescents (suicidal ideation) Individual psychodynamic therapy (deliberate self-harm) Parent training (self-injurious thoughts and behaviors (suicidal and nonsuicidal)

*Two or more consistent randomized controlled trials demonstrating superiority of treatment over control groups; conducted by independent investigators working at different research settings.
†Same as in the previous footnote, but lacking independent investigator criterion.
‡Modifications of Group Behavioral Parent Training that are probably efficacious include adding child components or family problem-solving strategies
CBT, Cognitive-behavioral therapy; BPT, behavioral parent training; ABA, applied behavioral analysis; DSP, developmental social-pragmatic; DBT, dialectical behavioral therapy; IPT, interpersonal psychotherapy; EMDR, eye movement desensitization and reprocessing; MET, motivational enhancement treatment.
Adapted from Society of Clinical Child and Adolescent Psychology. Concerns, symptoms and disorders. https://effectivechildtherapy.org/concerns-symptoms-disorders/. Accessed July 13, 2021.
Criteria derived from Southam-Gerow MA, Prinstein MJ. Evidence base updates: The evolution of the evaluation of psychological treatments for children and adolescents. *J Clin Child Adol Psychol*. 2014;43(1):1–6.

Answer key and teaching notes

01. D | Table 7.2 | printed p. 57, PDF p. 100

Why: The table lists St. John's wort as decreasing the effectiveness of tacrolimus and several other drugs.
Closest distractor: Grapefruit is listed for increased bioavailability of certain calcium channel blockers, a different interaction.

02. B | Table 8.1 | printed p. 59, PDF p. 103

Why: The table places progressive metabolic disorders such as Tay-Sachs disease among conditions with no curative option for which care is predominantly palliative.
Closest distractor: A curative treatment is not the expected course described for this condition.

03. C | Table 8.3 | printed p. 63, PDF p. 107

Why: Children aged 3-5 years may attribute illness to their actions; the table recommends simple, honest reassurance that the child did not cause it.
Closest distractor: Detailed abstract physiology is less suitable for this age group.

04. B | Table 8.5 | printed p. 69, PDF p. 113

Why: The table includes cool moving air from a fan, positioning, and attention to oral secretions among nonpharmacologic dyspnea measures.
Closest distractor: Vigorous exercise can worsen air hunger and is not listed for an acute episode.

05. C | Table 11.2 | printed p. 80, PDF p. 124

Why: Dengue is an arboviral infection listed in the short-incubation column.
Closest distractor: Schistosomiasis is in the long-incubation column in this table. Incubation alone does not establish a diagnosis.

06. B | Table 17.1 | printed p. 115, PDF p. 159

Why: A belt or electrical cord can leave parallel or looped marks with central sparing.
Closest distractor: A flat-surface fall does not typically reproduce the parallel patterned marks described.

07. A | Table 17.2 | printed p. 117, PDF p. 161

Why: Dermal melanocytosis is listed as a cutaneous mimic of inflicted bruising and is consistent with a stable congenital blue-gray patch.
Closest distractor: A coagulation defect can cause bruises but does not explain a stable congenital pigmented patch.

08. C | Table 17.3 | printed p. 118, PDF p. 162

Why: Posteromedial rib fractures are among the high-specificity findings, especially in infants.
Closest distractor: An isolated linear skull fracture is in the common but low-specificity group.

09. B | Table 17.4 | printed p. 119, PDF p. 163

Why: The table specifies an AP chest and both posterior oblique views using a chest-rib technique.
Closest distractor: A single AP image can miss rib injuries and does not constitute the listed chest series.

10. D | Table 17.5 | printed p. 119, PDF p. 163

Why: The table places peak hard callus at 21-42 days.
Closest distractor: The 10-14-day interval is associated with earlier changes. These ranges should not be used to assign a precise injury date.

11. A | Table 17.6 | printed p. 125, PDF p. 169

Why: A request for STI testing from the child or parent is explicitly listed as an indication.
Closest distractor: A normal examination does not, by itself, provide the specific indication tested here.

12. C | Table 17.7 | printed p. 126, PDF p. 170

Why: The table categorizes gonorrhea, when unlikely to be perinatally acquired, as diagnostic evidence and recommends reporting.
Closest distractor: Anogenital warts have a different, less specific interpretation in the table.

13. B | Table 23.2 | printed p. 154, PDF p. 199

Why: At 4 months the table describes no head lag when pulled to sit and a steady head.
Closest distractor: Persistent head lag fits younger age descriptions and prompts closer developmental assessment at this age.

14. B | Table 24.1 | printed p. 163, PDF p. 208

Why: The 18-month entry includes stacking four cubes.
Closest distractor: Copying a circle develops later than the table's 18-month example.

15. B | Table 27.1 | printed p. 175, PDF p. 220

Why: The table lists approximately 8 cm/year from 24 to 36 months.
Closest distractor: Birth-to-12-month growth is substantially faster at approximately 24 cm/year.

16. B | Table 27.2 | printed p. 177, PDF p. 222

Why: Celiac disease is a nutritional/gastrointestinal cause of impaired growth in the table and fits the accompanying gastrointestinal symptoms and anemia.
Closest distractor: Familial short stature alone would not explain a falling velocity with gastrointestinal and hematologic findings.

17. A | Table 27.3 | printed p. 177, PDF p. 222

Why: Marfan syndrome appears among genetic conditions associated with tall stature and fits the cardiovascular and skeletal findings.
Closest distractor: Turner syndrome and celiac disease are listed with decreased rather than increased growth.

Answer key (continued)

18. B | Table 27.4 | printed p. 178, PDF p. 223

Why: The first permanent molars typically erupt around 6-7 years without replacing primary molars.
Closest distractor: Third molars erupt much later.

19. C | Table 28.2 | printed p. 179, PDF p. 224

Why: Loss of previously acquired skills at any age is a red flag; the table also highlights urgent hearing assessment for speech concerns.
Closest distractor: Waiting until school age would miss a significant developmental warning sign.

20. A | Table 31.4 | printed p. 206, PDF p. 251

Why: Macroglossia is listed among nasopharyngeal/oropharyngeal factors predisposing to obstructive sleep apnea.
Closest distractor: Delayed tooth eruption is not an upper-airway obstructive factor in the table.

21. B | Table 31.5 | printed p. 208, PDF p. 253

Why: The table advises polysomnography or specialist referral for regular snoring plus symptoms or signs of obstructive sleep apnea.
Closest distractor: Observation without evaluation does not address the witnessed breathing pauses.

22. D | Table 31.6 | printed p. 209, PDF p. 254

Why: Nightmares are associated with REM sleep, later-night occurrence, awakening, and no postevent confusion.
Closest distractor: Sleep terrors typically arise earlier from slow-wave sleep and the child generally does not fully awaken.

23. A | Table 31.7 | printed p. 210, PDF p. 255

Why: Rest-related urge to move the legs, relief with movement, and evening predominance are core features listed for restless legs syndrome.
Closest distractor: Circadian delay can disrupt sleep timing but does not explain the movement-responsive leg symptoms.

24. B | Table 31.8 | printed p. 212, PDF p. 257

Why: The table describes recurrent daytime sleepiness plus emotion-triggered cataplexy with preserved consciousness as a narcolepsy pattern.
Closest distractor: Absence seizures impair awareness and are not typically triggered by laughter with preserved consciousness.

25. E | Table 31.10 | printed p. 215, PDF p. 260

Why: The S in BEARS represents snoring and includes questions about loud or nightly snoring.
Closest distractor: Awakenings address nighttime waking rather than the reported respiratory symptom.

26. B | Table 32.1 | printed p. 217, PDF p. 262

Why: Planning suicide is explicitly included among mental-health action signs and requires immediate assessment of safety.
Closest distractor: Deferring assessment to an annual visit would miss a serious current safety concern.

27. B | Table 32.4 | printed p. 219, PDF p. 264

Why: The table includes ornithine transcarbamylase deficiency among inherited metabolic causes of psychiatric manifestations; hyperammonemia supports a urea-cycle disorder.
Closest distractor: A primary phobia would not explain hyperammonemia and encephalopathy.

28. A | Table 32.5 | printed p. 220, PDF p. 265

Why: The NMDAR row includes psychiatric changes and associated neurologic features, including a post-herpes-encephalitis syndrome and dyskinesias.
Closest distractor: Aquaporin-4 is associated with a different inflammatory CNS disorder and is not the described row.

29. C | Table 33.6 | printed p. 229, PDF p. 274

Why: Olanzapine is rated +++ for both weight gain and hyperlipidemia in the comparative table.
Closest distractor: Risperidone is rated ++ for weight gain and +++ for hyperlipidemia, making olanzapine the stronger match for both effects.

30. A | Table 34.1 | printed p. 232, PDF p. 277

Why: The table lists individual/group cognitive behavioral therapy and individual interpersonal therapy among well-established options for adolescent depression.
Closest distractor: Exposure and response prevention is associated with obsessive-compulsive symptoms rather than the adolescent depression row.

Table selection log

Thirty single-page tables selected in book order. Printed folios and PDF page numbers are both shown.

Excluded examples: dated statistics/history (Tables 1.1-1.4, 2.1-2.4, 14.1); continued tables (3.2, 8.4, 13.1).
Other tables before 34.1 were omitted when they offered limited clinical board value. Resume after Table 34.1.

01. **Table 7.2 | PDF 100 | printed 57 | Completed**
    Table 7.2 Common Herbal Dietary Supplement (HDS)–Drug Interactions
02. **Table 8.1 | PDF 103 | printed 59 | Completed**
    Table 8.1 Conditions Appropriate for Pediatric Palliative Care
03. **Table 8.3 | PDF 107 | printed 63 | Completed**
    Table 8.3 Developmental Questions, Thoughts, and Concepts of Dying, with Responsive Strategies
04. **Table 8.5 | PDF 113 | printed 69 | Completed**
    Table 8.5 Nonpharmacologic Approach to Symptoms Commonly Experienced by Children with Life-Threatening Illness
05. **Table 11.2 | PDF 124 | printed 80 | Completed**
    Table 11.2 Incubation Periods of Common Travel-Related Infections*
06. **Table 17.1 | PDF 159 | printed 115 | Completed**
    Table 17.1 Injury Patterns
07. **Table 17.2 | PDF 161 | printed 117 | Completed**
    Table 17.2 Mimics of Nonaccidental Trauma
08. **Table 17.3 | PDF 162 | printed 118 | Completed**
    Table 17.3 Specificity of Radiologic Findings
09. **Table 17.4 | PDF 163 | printed 119 | Completed**
    Table 17.4 Radiologic Skeletal Survey for Infants and Children under 2 Years of Age
10. **Table 17.5 | PDF 163 | printed 119 | Completed**
    Table 17.5 Timetable of Radiologic Changes in Children's Fractures
11. **Table 17.6 | PDF 169 | printed 125 | Completed**
    Table 17.6 Indications for STI Screening in Children with Suspected Sexual Abuse
12. **Table 17.7 | PDF 170 | printed 126 | Completed**
    Table 17.7 Implications of Commonly Encountered Sexually Transmitted or Sexually Associated Infections for Diagnosis and Reporting of Sexual Abuse Among Infants and Prepubertal Children
13. **Table 23.2 | PDF 199 | printed 154 | Completed**
    Table 23.2 Emerging Patterns of Behavior During the First Year of Life*
14. **Table 24.1 | PDF 208 | printed 163 | Completed**
    Table 24.1 Emerging Patterns of Behavior from 1-5 Years of Age
15. **Table 27.1 | PDF 220 | printed 175 | Completed**
    Table 27.1 Growth Velocity and Other Growth Characteristics by Age
16. **Table 27.2 | PDF 222 | printed 177 | Completed**
    Table 27.2 Common Causes of Decreased Growth and Short Stature
17. **Table 27.3 | PDF 222 | printed 177 | Completed**
    Table 27.3 Common Causes of Increased Growth and Tall Stature
18. **Table 27.4 | PDF 223 | printed 178 | Completed**
    Table 27.4 Chronology of Human Dentition of Primary (Deciduous) and Secondary (Permanent) Teeth
19. **Table 28.2 | PDF 224 | printed 179 | Completed**
    Table 28.2 Red Flags in Developmental Screening and Surveillance
20. **Table 31.4 | PDF 251 | printed 206 | Completed**
    Table 31.4 Anatomic Factors That Predispose to Obstructive Sleep Apnea Syndrome and Hypoventilation in Children
21. **Table 31.5 | PDF 253 | printed 208 | Completed**
    Table 31.5 American Academy of Pediatrics Clinical Practice Guideline: Diagnosis and Management of Childhood Obstructive Sleep Apnea Syndrome
22. **Table 31.6 | PDF 254 | printed 209 | Completed**
    Table 31.6 Key Similarities and Differentiating Features Between Non-REM and REM Parasomnias as Well as Nocturnal Seizures
23. **Table 31.7 | PDF 255 | printed 210 | Completed**
    Table 31.7 Diagnostic Criteria for Restless Legs Syndrome
24. **Table 31.8 | PDF 257 | printed 212 | Completed**
    Table 31.8 Diagnostic Criteria for Narcolepsy
25. **Table 31.10 | PDF 260 | printed 215 | Completed**
    Table 31.10 BEARS Sleep Screening Algorithm
26. **Table 32.1 | PDF 262 | printed 217 | Completed**
    Table 32.1 Mental Health Action Signs
27. **Table 32.4 | PDF 264 | printed 219 | Completed**
    Table 32.4 Medical (Secondary) and Psychiatric (Primary) Causes of Psychosis and/or Depression
28. **Table 32.5 | PDF 265 | printed 220 | Completed**
    Table 32.5 Antigenic Targets in Autoimmune Encephalitis with Associated Psychiatric Features
29. **Table 33.6 | PDF 274 | printed 229 | Completed**
    Table 33.6 Relative Side Effects for Select Antipsychotic Medications
30. **Table 34.1 | PDF 277 | printed 232 | Completed**
    Table 34.1 Effective Psychotherapies for Specific Behavioral Health Disorders