

PART XI | ADOLESCENT MEDICINE

Development and Clinical Assessment

Chapters 150-156

22 one-best-answer study questions with original source tables

Nelson Textbook of Pediatrics, 22nd edition, Volume 1

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A 12-year-old focuses on immediate consequences and struggles to anticipate long-term outcomes. Which developmental period in the table best fits this cognitive pattern?

- A. Late adolescence
- B. Established adulthood
- C. Postpubertal transition only
- D. Early adolescence
- E. Middle adolescence

ORIGINAL SOURCE TABLE | Table 150.1 | PDF p. 1171 | printed p. 1158

Table 150.1 Milestones in Early, Middle, and Late Adolescent Development			
VARIABLE	EARLY ADOLESCENCE	MIDDLE ADOLESCENCE	LATE ADOLESCENCE
Approximate age range	10-13yr	14-17yr	18-21yr
Sexual maturity rating*	1-2	3-5	5
Physical	- Females: secondary sex characteristics (breast, pubic, axillary hair), start of growth spurt - Males: testicular enlargement, start of genital growth	- Females: peak growth velocity, menarche (if not already attained) - Males: growth spurt, secondary sex characteristics, nocturnal emissions, facial and body hair, voice changes - Change in body composition - Acne	- Physical maturation slows - Increased lean muscle mass in males
Cognitive and moral	- Concrete operations - Egocentricity - Unable to perceive long-term outcome of current decisions - Follow rules to avoid punishment	- Emergence of abstract thought (formal operations) - May perceive future implications, but may not apply in decision-making - Strong emotions may drive decision-making - Sense of invulnerability - Growing ability to see others' perspectives	- Future-oriented with sense of perspective - Idealism - Able to think things through independently - Improved impulse control - Improved assessment of risk vs reward - Able to distinguish law from morality
Self-concept/identity formation	- Preoccupied with changing body - Self-consciousness about appearance and attractiveness	- Concern with attractiveness - Increasing introspection	- More stable body image - Attractiveness may still be of concern - Consolidation of identity
Family	- Increased need for privacy - Exploration of boundaries of dependence vs independence	- Conflicts over control and independence - Struggle for greater autonomy - Increased separation from parents	- Emotional and physical separation from family - Increased autonomy - Reestablishment of "adult" relationship with parents
Peers	Same-gender peer affiliations	- Intense peer group involvement - Preoccupation with peer culture - Conformity	Peer group and values recede in importance
Sexual	- Increased interest in sexual anatomy - Anxieties and questions about pubertal changes - Limited capacity for intimacy	- Testing ability to attract partner - Initiation of relationships and sexual activity - Exploration of sexual identity	- Consolidation of sexual identity - Focus on intimacy and formation of stable relationships - Planning for future and commitment

*See text and Figures 150.2 and 150.3.

1158

A girl has breast and areolar enlargement without contour separation; pubic hair is darker and beginning to curl. What sexual maturity rating best matches?

- A. Stage 5
- B. Stage 3
- C. Stage 1
- D. Stage 2
- E. Stage 4

ORIGINAL SOURCE TABLE | Table 150.2 | PDF p. 1173 | printed p. 1160

Table 150.2 Sexual Maturity Rating (SMR) Stages in Females		
SMR STAGE	PUBIC HAIR	BREASTS
1	Preadolescent	Preadolescent
2	Sparse, lightly pigmented, straight, medial border of labia	Breast and papilla elevated as small mound; diameter of areola increased
3	Darker, beginning to curl, increased amount	Breast and areola enlarged, no contour separation
4	Coarse, curly, abundant, but less than in adult	Areola and papilla form secondary mound
5	Adult feminine triangle, spread to medial surface of thighs	Mature, nipple projects, areola part of general breast contour

From Tanner JM. *Growth at Adolescence*, 2nd ed. Oxford, England: Blackwell Scientific; 1962.

A boy has an enlarged scrotum with altered texture, minimal penile enlargement, and scant lightly pigmented pubic hair. Which sexual maturity rating fits?

- A. Stage 1
- B. Stage 3
- C. Stage 4
- D. Stage 5
- E. Stage 2

ORIGINAL SOURCE TABLE | Table 150.3 | PDF p. 1173 | printed p. 1160

Table 150.3	Sexual Maturity Rating (SMR) Stages in Males		
SMR STAGE	PUBIC HAIR	PENIS	TESTES
1	None	Preadolescent	Preadolescent
2	Scant, long, slightly pigmented	Minimal change/enlargement	Enlarged scrotum, pink, texture altered
3	Darker, starting to curl, small amount	Lengthens	Larger
4	Resembles adult type, but less quantity; coarse, curly	Larger; glans and breadth increase in size	Larger, scrotum dark
5	Adult distribution, spread to medial surface of thighs	Adult size	Adult size

From Tanner JM. *Growth at Adolescence*, 2nd ed. Oxford, England: Blackwell Scientific; 1962.

At an annual preventive visit, a 13-year-old has no expressed mood concerns. Which assessment in the preventive-care table is still scheduled annually from age 12?

- A. Hemoglobin testing for every adolescent
- B. A diagnostic echocardiogram
- C. Depression screening
- D. Cervical cytology
- E. Tuberculin testing for every adolescent

ORIGINAL SOURCE TABLE | Table 151.1 | PDF p. 1179 | printed p. 1166

Table 151.1 Bright Futures/American Academy of Pediatrics Recommendations for Preventive Healthcare for 11- to 21-Year-Olds	
	PERIODICITY AND INDICATIONS
HISTORY	Annual
MEASUREMENTS	
Body mass index	Annual
Blood pressure	Annual
SENSORY SCREENING	
Vision	At 12yr and 15yr visits or if risk assessment positive
Hearing	Screen with audiometry, including 6,000- and 8,000-Hz high frequencies once at 11-14yr, once at 15-17yr, and once at 18-21yr.
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT	
Developmental surveillance	Annual
Psychosocial/behavioral assessment	Annual
Depression screening	Annual for 12yr and older
Tobacco, alcohol, and drug use assessment	If risk assessment positive
PHYSICAL EXAMINATION	Annual
PROCEDURES	
Immunization*	Annual
Hematocrit or hemoglobin	If risk assessment positive
Tuberculin test	If risk assessment positive
Dyslipidemia screening	Once at 9-11yr, and once at 17-21yr
STI screening	If sexually active
HIV screening†	Once between ages 15 and 18yr Discuss and offer at earlier age and annually if risk assessment positive.
Cervical dysplasia screening‡	Beginning at age 21yr
ORAL HEALTH	Annual; refer to dental home
ANTICIPATORY GUIDANCE	Annual§

*Schedules per the Advisory Committee on Immunization Practices, published annually at <http://www.cdc.gov/vaccines/schedules/hcp/index.html> and http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx.

†The CDC recommends universal, voluntary HIV screening of all sexually active people

A 16-year-old attends a preventive visit and has no symptoms of depression. Which universal screening action does the adolescent-screening table include?

- A. Annual adolescent depression screen
- B. Cervical Pap test at every visit
- C. Annual routine tuberculosis skin test
- D. Annual anemia panel for all adolescents
- E. Screening echocardiography for all adolescents

ORIGINAL SOURCE TABLE | Table 151.2 | PDF p. 1180 | printed p. 1167

Table 151.2 Adolescent Screening Recommendations				
UNIVERSAL SCREENING	11- TO 14-YR-OLD VISIT	15- TO 17-YR-OLD VISIT	18- TO 21-YR-OLD VISIT	
	ACTION	ACTION	ACTION	
Cervical dysplasia*	N/A	N/A	Pap smear all young women at 21 yr visit	
Depression	Annual adolescent depression screen beginning at 12yr visit	Annual adolescent depression screen	Annual adolescent depression screen	
Dyslipidemia	Lipid screen once at 9-11 yr	Lipid screen once at 17-21 yr	Lipid screen once at 17-21 yr	
Hearing	Once at 11-14 yr Audiometry, including 6,000- and 8,000-Hz high frequencies	Once at 15-17 yr Audiometry, including 6,000- and 8,000-Hz high frequencies	Once at 18-21 yr Audiometry, including 6,000- and 8,000-Hz high frequencies	
HIV†	Selective screening (see later)	HIV test once at 15-18yr	HIV test once at 15-18yr	
Tobacco, alcohol, or drug use	Annual tobacco, alcohol, or drug use screen	Annual tobacco, alcohol, or drug use screen	Annual tobacco, alcohol, or drug use screen	
Vision	At 12yr visit Objective measure with age-appropriate visual acuity measurement using HOTV or Lea symbols, Sloan letters, or Snellen letters	At 15yr visit Objective measure with age-appropriate visual acuity measurement using HOTV or Lea symbols, Sloan letters, or Snellen letters	N/A	
SELECTIVE SCREENING	RISK ASSESSMENT (RA)	11-14 YR OLD VISIT	15-17 YR OLD VISIT	18-21 YR OLD VISIT
		ACTION IF RA+	ACTION IF RA+	ACTION IF RA+
Anemia	Positive on risk screening questions	Hemoglobin or hematocrit	Hemoglobin or hematocrit	Hemoglobin or hematocrit
Dyslipidemia (if not universally screened at this visit)	Positive on risk screening questions and not previously screened with normal results	Lipid profile	Lipid profile	Lipid profile
HIV†	Positive on risk screening questions	HIV test	HIV test (if not universally screened at this visit)	HIV test (if not universally screened at this visit)
Oral health (through 16yr visit)	Primary water source fluoride deficient	Oral fluoridation supplementation	Oral fluoridation supplementation	N/A
STIs				
Chlamydia	Sexually active females	Chlamydia and gonorrhea NAAT (test at all sites where patient engages in sex)	Chlamydia and gonorrhea NAAT (test at all sites where patient engages in sex)	Chlamydia and gonorrhea NAAT (test at all sites where patient engages in sex)
Gonorrhea	Sexually active females			
Syphilis	Sexually active and positive on risk screening questions	Syphilis test	Syphilis test	Syphilis test
Tuberculosis	Positive on risk screening questions	Tuberculin skin test	Tuberculin skin test	Tuberculin skin test
Vision at other ages	Positive on risk screening questions at 11, 13, and 14yr visits	Objective measure with age-appropriate visual acuity measurement using HOTV or Lea symbols, Sloan letters, or Snellen letters	Objective measure with age-appropriate visual acuity measurement using HOTV or Lea symbols, Sloan letters, or Snellen letters	Objective measure with age-appropriate visual acuity measurement using HOTV or Lea symbols, Sloan letters, or Snellen letters

*Screening for Cervical Cancer. April 2012. U.S. Preventive Services Task Force.

†The Centers for Disease Control and Prevention recommends universal, voluntary HIV screening of all sexually active people beginning at age 13 yr. The American Academy of Pediatrics recommends routine HIV screening offered to all adolescents at least once by 16-18 yr of age and to those younger if at risk. The U.S. Preventive Services Task Force recommends routine HIV screening offered to all adolescents age 15 yr and older at least once and to those younger if at risk. Patients who test positive for HIV should receive

A pediatrician uses a structured psychosocial interview with a 15-year-old who reports vaping. Which additional domain belongs to the table's HEADS/SF/FIRST assessment?

- A. Only a fasting lipid profile
- B. Only birthweight and gestational age
- C. Only medication allergies
- D. Safety practices and exposure to violence
- E. Only physical examination findings

ORIGINAL SOURCE TABLE | Table 151.4 | PDF p. 1182 | printed p. 1169

Table 151.4	Adolescent Psychosocial Assessment: HEADS/SF/FIRST Mnemonic
Home. Space, privacy, frequent geographic moves, neighborhood Education/School. Frequent school changes, repetition of a grade/in each subject, teachers' reports, vocational goals, after-school educational clubs (e.g., language, speech, math), learning disabilities Abuse. Physical, sexual, emotional, verbal abuse; parental discipline Drugs. Tobacco, electronic cigarettes or vaping devices, alcohol, marijuana, inhalants, "club drugs," "rave" parties, others; drug of choice, age at initiation, frequency, mode of intake, rituals, alone or with peers, quit methods, number of attempts Safety. Seat belts, helmets, sports safety measures, hazardous activities, driving while intoxicated Sexuality/Sexual Identity. Reproductive health (use of contraceptives, presence of sexually transmitted infections, feelings, pregnancy) Family and Friends <i>Family:</i> Family constellation; genogram; single/married/separated/divorced/blended family; family occupations and shifts; history of addiction in first- and second-degree relatives; parental attitude toward alcohol and drugs; parental rules; chronically ill, physically or mentally challenged parent <i>Friends:</i> Peer cliques and configuration ("preppies," "jocks," "nerds," "computer geeks," cheerleaders), gang or cult affiliation Image. Height and weight perceptions, body musculature and physique, appearance (including dress, jewelry, tattoos, body piercing as fashion trends or other statement) Recreation. Sleep, exercise, organized or unstructured sports, recreational activities (television, video games, computer games, internet and chat rooms, church or community youth group activities [e.g., Boy (BSA)/Girl Scouts; Big Brother/Sister groups, campus groups]). How many hours per day, days per week involved? Spirituality and Connectedness. Use HOPE* or FICA† acronym; adherence, rituals, occult practices, community service or involvement Threats and Violence. Self-harm or harm to others, running away, cruelty to animals, guns, fights, arrests, stealing, fire setting, fights in school	

*HOPE, Hope or security for the future; organized religion; personal spirituality and practices; effects on medical care and end-of-life issues.

†FICA, Faith beliefs; importance and influence of faith; community support.

From Dias PJ: Adolescent substance abuse: assessment in the office. *Pediatr Clin North*

A 17-year-old with a chronic condition is preparing to transfer to adult care. Which process element in the table best supports independent self-management?

- A. Deferring all discussion until after transfer
- B. A longitudinal readiness assessment and written transition plan
- C. An unannounced transfer at the next birthday
- D. A single referral without a documented plan
- E. Stopping family involvement abruptly

ORIGINAL SOURCE TABLE | Table 152.1 | PDF p. 1184 | printed p. 1171

Table 152.1	Key Elements of the Transition of Healthcare Process
• Written transition policy to be shared with youth, families, providers, and staff, explaining the process and the responsibilities of all team members • Transitioning youth registry to track the progress of each patient through the transition process • Longitudinal readiness checklists assessing the youth’s ability for independence, self-management, and communicating with the adult healthcare system, as well as the family’s readiness to assist the patient in achieving these goals • Written transition plan documenting the steps to be conducted to meet the needs identified in the readiness assessment and identifying appropriate adult care resources • For youth with SHCN, expanded transition services, including attention to insurance, entitlements, guardianship, and vocational needs, in addition to adult subspecialty care • Appropriate communication between the pediatric and adult medical home and subspecialists, including a portable medical summary and care plan delivered to the patient and caregivers • Transfer of care, within the 18- to 21-yr-old range, to adult providers, to whom pediatric providers continue to serve as a resource until transition is complete	

An adolescent requests evaluation for pubertal suppression. Which prerequisite is specified in the source table before GnRH agonist treatment?

- A. A one-visit decision based only on pubertal stage
- B. Treatment without assessing capacity to consent
- C. A mandatory abnormal genetic test result
- D. Exclusion of family discussion in every case
- E. Assessment by a qualified mental health professional of persistent dysphoria and relevant coexisting concerns

ORIGINAL SOURCE TABLE | Table 153.1 | PDF p. 1186 | printed p. 1173

Table 153.1	Criteria for Gender-Affirming Hormone Therapy for Adolescents
Adolescents are eligible for GnRH agonist treatment if:	
1. A QUALIFIED MHP HAS CONFIRMED THAT:	
- The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed) - Gender dysphoria worsened with the onset of puberty - Any coexisting psychologic, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment - The adolescent has sufficient mental capacity to give informed consent/assent to this (reversible) treatment	
2. AND THE ADOLESCENT:	
- Has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility - Has given informed consent/assent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process	
3. AND A PEDIATRIC ENDOCRINOLOGIST OR OTHER CLINICIAN EXPERIENCED IN PUBERTAL ASSESSMENT:	
- Agrees with the indication for GnRH agonist treatment - Has confirmed that puberty has started in the adolescent (Tanner stage $\geq$G2/B2) - Has confirmed that there are no medical contraindications to GnRH agonist treatment	
Adolescents are eligible for subsequent sex hormone treatment if:	
1. A QUALIFIED MHP HAS CONFIRMED:	
- The persistence of gender dysphoria - Any coexisting psychologic, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment - The adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent/assent to this (partly) irreversible treatment	
2. AND THE ADOLESCENT:	
- Has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility) - Has given informed consent/assent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process	
3. AND A PEDIATRIC ENDOCRINOLOGIST OR OTHER CLINICIAN EXPERIENCED IN PUBERTAL INDUCTION:	
- Agrees with the indication for sex hormone treatment - Has confirmed that there are no medical contraindications to sex hormone treatment	

MHP, mental health professional.

Data from Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, Version 8. *Int J Transgend Health*. 2022;23(Suppl 1):S1-S259.

An adolescent is assessed using the DSM-5 criteria reproduced in the table. What minimum duration of marked gender incongruence is specified?

- A. At least 2 years
- B. No duration is specified
- C. At least 6 months
- D. At least 1 week
- E. At least 1 month

ORIGINAL SOURCE TABLE | Table 153.2 | PDF p. 1186 | printed p. 1173

Table 153.2	DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults
A. A marked incongruence between one’s experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following: 1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics) 2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics) 3. A strong desire for the primary and/or secondary sex characteristics of the other gender 4. A strong desire to be of the other gender (or some alternative gender different from one’s designated gender) 5. A strong desire to be treated as the other gender (or some alternative gender different from one’s designated gender) 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s designated gender)	
B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning	
Specify if: 1. The condition exists with a disorder of sex development 2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females)	

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Copyright 2013. American Psychiatric Association.

A gender-diverse adolescent reports that clinic staff repeatedly use the wrong name. Which clinical-setting strategy is listed in the table?

- A. Record and use the adolescent's affirmed name and pronouns
- B. Avoid asking how the adolescent wishes to be addressed
- C. Restrict discussion to legal documents only
- D. Discuss identity only with caregivers outside the patient's presence
- E. Use only closed questions about identity

ORIGINAL SOURCE TABLE | Table 153.3 | PDF p. 1187 | printed p. 1174

Table 153.3 Strategies for Supporting TGD Youth	
DOMAIN	STRATEGIES
Clinical settings	Use of affirmed name and pronouns in clinical spaces and inclusion of this information in the electronic medical record (EMR) Training for clinical staff Use of affirming imagery, inclusive intake forms Gender-neutral bathroom spaces Open-ended, nonjudgmental discussion about gender identity Sensitive, trauma-informed care History taking using nongendered language
Relationships with family/caregivers	Assistance with disclosure of identity to family when desired by the youth Psychoeducation on gender development and the benefits of supporting TGD youth Promoting practices such as use of affirmed name and pronouns Education about social transitioning Providing space and support for parents to express concerns without youth present Support for disclosure to extended family or other important people Referrals to support groups or family counseling
Educational settings	Education for school staff on gender concepts and zero tolerance for transphobia Advocating for the use of affirmed name and pronouns Advocacy for inclusive sexual education curriculum Advocacy for youth to use preferred bathrooms, locker rooms, and dorms and participate with desired sports teams
Public identification	Assistance with documentation for changing legal name and/or gender marker Documentation of the patient's gender identity to ensure safe passage during travel

From Voss RV, Simons L. Supporting the health of transgender and gender-diverse youth in primary care settings. *Prim Care Clin Office Pract*. 2021;48:259–270, Table 2; with data from Guss CE, Woolverton GA, Borus J, et al. Transgender adolescents' experiences in primary care: a qualitative study. *J Adolesc Health*. 2019;65:344–349.

A clinic reviews formulations listed for pubertal suppression. Which option in the table is delivered as a subcutaneous implant?

- A. Triptorelin
- B. Oral medroxyprogesterone
- C. Oral spironolactone
- D. Histrelin
- E. Leuprolide acetate

ORIGINAL SOURCE TABLE | Table 153.5 | PDF p. 1189 | printed p. 1176

Table 153.5 Available Formulations of Medications Used for Pubertal Blockade				
	MEDICATION	ROUTE OF ADMINISTRATION	DOSING FREQUENCY	DOSE
GnRH agonists	Leuprolide acetate	Intramuscular	Every 1-3 mo	11.25-30 mg
	Triptorelin	Intramuscular	Every 24 wk	22.5 mg
	Histrelin	Subcutaneous implant	Every 1-2 yr	50 mg
Progestins	Medroxyprogesterone	Oral	Daily	Up to 40 mg
		Intramuscular	Every 3 mo	150 mg
Antiandrogens	Spironolactone	Oral	1-2 times/day	25 mg initially, up to 100-300 mg divided twice daily
	Cyproterone acetate	Oral	Daily	Up to 100 mg
	Bicalutamide	Oral	Daily	50 mg

GnRH, Gonadotropin-releasing hormone.
Adapted from Allen BJ, Rosenthal SM. Care of transgender, nonbinary, and gender diverse youth. In: Allen DB, Nadeau K, Kappy MS, Geffner ME, eds. *Pediatric Endocrinology: Principles and Practice*, 3rd ed. New York: McGraw Hill; 2020.

During specialist follow-up of an adolescent receiving pubertal suppression, which longer-interval assessment appears in the source table?

- A. Monthly lumbar puncture
- B. Bone density assessment by DXA
- C. Daily head CT
- D. Weekly echocardiography
- E. Daily serum ammonia

ORIGINAL SOURCE TABLE | Table 153.6 | PDF p. 1189 | printed p. 1176

Table 153.6	Baseline and Follow-Up Protocol During Suppression of Puberty
EVERY 3-6 MO	Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
EVERY 6-12 MO	Laboratory: LH, FSH, E2/T, 25-OH vitamin D
EVERY 1-2 YR	Bone density using DXA Bone age on x-ray of the left hand (if clinically indicated)

DXA, Dual-energy x-ray absorptiometry; E2, estradiol; FSH, follicle-stimulating hormone; LH, luteinizing hormone; T, testosterone.

Adapted from Hembree WC, Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ, et al; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine

An adolescent receiving testosterone is monitored during induction of puberty. Which laboratory measurement is specifically listed with testosterone in the follow-up table?

- A. Serum troponin at every visit
- B. CSF cell count
- C. Urine organic acids
- D. Serum alpha-fetoprotein
- E. Hemoglobin and hematocrit

ORIGINAL SOURCE TABLE | Table 153.7 | PDF p. 1190 | printed p. 1177

Table 153.7	Baseline and Follow-Up Protocol During Induction of Puberty	
Anthropometry	Height,* sitting height,* weight, blood pressure, Tanner stages*	Every 3-6 mo
Laboratory studies	Testosterone: testosterone, hemoglobin/hematocrit, lipids, 25-OH vitamin D* Estrogen: estradiol, prolactin, 25-OH vitamin D*	Every 3-12 mo
Imaging*	DXA to evaluate bone mineral density† Left hand radiograph to evaluate bone age (as clinically indicated)	Every 1-2 yr

*Only indicated in individuals previously treated with pubertal blockers.
†BMD should be monitored into adulthood (until the age of 25-30 yr or until peak bone mass has been reached).
DXA, Dual-energy x-ray absorptiometry.
Adapted from Hembree WC, Cohen-Kettenis PT, Delemarre-van de Waal HA , Gooren LJ , et al; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine So

An adolescent asks about future fertility before starting gender-affirming hormone therapy. Which timing principle is listed for sperm cryopreservation?

- A. A semen sample is never used
- B. Fertility is guaranteed to recover immediately after treatment cessation
- C. Discuss and arrange preservation before hormone therapy or surgery when feasible
- D. Fertility discussion is unnecessary until after surgery
- E. Cryopreservation is possible only after years of estrogen therapy

ORIGINAL SOURCE TABLE | Table 153.8 | PDF p. 1190 | printed p. 1177

Table 153.8 Fertility Preservation Options for Transgender Patients		
FERTILITY PRESERVATION METHOD	PROCEDURE	TIMING OF INTERVENTION
ASSIGNED MALE AT BIRTH		
Sperm cryopreservation	Sperm is collected from ejaculated semen ± electrical or vibratory stimulation	1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated consider 3-mo cessation of estrogen
Surgical sperm extraction	Sperm is obtained surgically from the testis (TESE) or epididymis (PESA)	1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated consider 3-mo cessation of estrogen
ASSIGNED FEMALE AT BIRTH		
Oocyte cryopreservation	Ovarian stimulation followed by surgical egg retrieval and egg freezing	1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated consider 3-mo cessation of testosterone
Embryo cryopreservation	Ovarian stimulation followed by surgical egg retrieval, IVF, and embryo freezing	1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated consider 3-mo cessation of testosterone
Ovarian tissue cryopreservation	Surgical removal and freezing of ovarian tissue	Before gender-affirming surgery involving removal of ovaries

PESA, Percutaneous epididymal sperm aspiration; TESE, testicular sperm extraction; IVF, in vitro fertilization.
From Montoya MN, Peipert BJ, Whicker D, Gray B. Reproductive considerations for the LGBTQ+ community. *Prim Care Clin Office Pract.* 2021;48:283–297, Table 2.

to untreated TGD adolescents found no significant differences in execu- Alternative Therapy Side Effects

An adolescent considering estrogen asks which anticipated effect may not reverse without surgery. Which effect is identified in the table?

- A. Breast growth
- B. Decreased skin oiliness
- C. Reduced spontaneous erections
- D. Redistribution of body fat
- E. Reduced muscle strength

ORIGINAL SOURCE TABLE | Table 153.10 | PDF p. 1192 | printed p. 1179

Table 153.10 Timeline of Effects from Gender-Affirming Sex Hormone Therapy				
	EFFECT	ONSET	MAXIMUM	REVERSIBILITY
Estrogen	Redistribution of body fat	3-6 mo	2-3 yr	Likely
	Decreased muscle mass/strength	3-6 mo	1-2 yr	Likely
	Softening of skin/decreased oiliness	3-6 mo	Unknown	Likely
	Decreased sexual desire	1-3 mo	3-6 mo	Likely
	Decreased spontaneous erections	1-3 mo	3-6 mo	Likely
	Breast growth	3-6 mo	2-3 yr	Not possible without surgery
	Decreased testicular volume	3-6 mo	2-3 yr	Unknown
	Decreased sperm production	Unknown	>3 yr	Unknown
	Decreased terminal hair growth	6-12 mo	>3 yr	Possible
	Scalp hair	Variable		
Testosterone	Skin oiliness/acne	1-6 mo	1-2 yr	Likely
	Facial/body hair growth	6-12 mo	4-5 yr	Unlikely without electrolysis
	Scalp hair loss	6-12 mo		Unlikely
	Increased muscle mass/strength	6-12 mo	2-5 yr	Likely
	Fat redistribution	1-6 mo	2-5 yr	Likely
	Cessation of menses	1-6 mo		Likely
	Clitoral enlargement	1-6 mo	1-2 yr	Unknown
	Vaginal atrophy	1-6 mo	1-2 yr	Unknown
	Deepening of voice	6-12 mo	1-2 yr	Not possible without surgery

Adapted from Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102:3869–3903, Table 12; and from Allen BJ, Rosenthal SM. Care of transgender, nonbinary, and gender diverse youth. In Allen DB, Nadeau K, Kappy MS, Geffner ME, eds. *Pediatric Endocrinology: Principles and Practice*, 3rd ed. New York: McGraw Hill; 2020, Tables 7-11 and 7-12.

During a confidential visit, a clinician needs an accurate sexual-health history. Which approach follows the table on assumptions to avoid?

- A. Assume every adolescent is heterosexual
- B. Omit sexual-health questions if identity is not disclosed
- C. Assume bisexuality is always transient
- D. Ask about partners and practices without assuming orientation predicts behavior
- E. Infer partners solely from the adolescent's stated identity

ORIGINAL SOURCE TABLE | Table 154.1 | PDF p. 1195 | printed p. 1182

Table 154.1 Common Assumptions to Avoid When Caring for Lesbian, Gay, Bisexual, and Queer Patients	
ASSUMPTION TYPE	DO NOT ASSUME THAT...
Identity	- Lesbian, gay, or bisexual people are cisgender - A person has to identify as either male or female - A person's gender or sexual orientation is a major aspect of a person's identity - Being lesbian, gay, bisexual, or queer is always hard - LGBQ people cannot adjust to stressors
Sexual orientation	- All patients are heterosexual - People exploring their sexuality have a need to categorize into established sexual orientations - Bisexuality is a phase or that bisexual people are confused - Sexual orientation aligns with sexual behavior
Sexual behavior	- All LGBQ people are sexually active (some are celibate or asexual) - Gay men do not have sex with women or lesbian women do not have sex with men - All gay men have multiple partners and engage in high-risk behavior - Sexual behavior will remain stable over time - Lesbians are not at risk of HPV or other STIs - Bisexual people are promiscuous or are always unfaithful
Relationships and family	- Lesbian women do not want to be pregnant or are not at risk of pregnancy - Interpersonal violence does not occur in LGBQ couples - LGBQ patients do not have children or do not wish to have children - All adults of reproductive age have an interest in parenting - LGBQ people do not have strong family ties - LGBQ patients have ties to their families of origin
Anatomy	- Queer people all want to change their bodies with surgeries or hormones - Anything about the body of an LGBQ patient

HPV, Human papillomavirus; STI, sexually transmitted illness.

Adapted from Makadon HJ, Mayer KH, Potter J, Goldhammer H. *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*, 2nd ed. Philadelphia: American College of Physicians, 2015; and Suarez Lupez E, Siegel J, Streed Jr C. The annual examination for lesbian, gay, and bisexual patients. *Prim Care Clin Office Pract*. 2021;48:191–212, Table 1.

An adolescent reports multiple partners. Which question addresses the “Practices” domain of the 6 Ps sexual-history table?

- A. Have you ever had a positive STI test?
- B. What kinds of sexual contact have you had?
- C. How many partners have you had?
- D. Have you received HPV vaccination?
- E. Would you like pregnancy in the next year?

ORIGINAL SOURCE TABLE | Table 154.2 | PDF p. 1197 | printed p. 1184

Table 154.2 The 6 Ps of a Complete Sexual History		
P	OBJECTIVES	QUESTIONS
Partners	- Determine the number and gender/sex of partners - Determine partner risk factors (other partners, drug use)	“Are you currently sexually active?” “Have you ever been sexually active?” “When you have sex, what is the gender of your partners? What anatomy is used for sex?” “How do you describe your sexual orientation?” “How many partners have you had in the past 6 (or 12) months?” “Has anyone ever forced themselves on you sexually or touched you sexually in an unwanted way?”* Remember to ask about opposite-sex partners
Practices	- If a patient has had more than one partner in the past 12 mo (or has a partner who has other sex partners) - Explore their sexual practices and behaviors, because they will guide assessment of risk and determination of testing	“What types of sex are you having?” “When having sex, do you have vaginal, anal, and/or oral sex?” “If you have anal sex, do you have insertive sex, receptive sex, or both?” In colloquial words, “Are you a top, a bottom, or vers?” “Do you have any alternative sexual practices?” (i.e., kinks, BDSM, fisting) “Do you use alcohol or drugs during sex?” “Have you ever exchanged sex for money, drugs, food, or shelter?” “Do you use lubricants during sex? What kind?” “Do you use sex toys? How often? Do you share them? Do you clean them?” Put bluntly, questions should aim to answer who is putting what, where, when, and how
Protection from STI	- If a patient has had more than one partner in the past 12 mo (or has a partner who has other sex partners)[†] - Based on patient risk profile, ask these questions accordingly - Explore the patient’s use of barrier methods - Explore the patient’s use of PrEP	“How do you keep yourself safe during sex?” “Do you use condoms/dental dams when having vaginal, anal, and/or oral sex? How often? All the time? Most of the time? About half of the time? Rarely?” If no, “Why not?” “Do you and your partners use any other protection against STI?” “Do you or your partner use PrEP? Are you interested in starting PrEP?”
Past history of STI	Explore patient STI history as a risk factor for future STI	“Have you ever been tested for HIV or other STIs?” “Have you ever been diagnosed with an STI?” If yes, “When were you diagnosed? How were you treated?” “Would you like to be tested? And which parts of your body should we check?” “Has your current or any former partners ever been diagnosed with an STI?” If yes, “Have you been tested for the same STI?”
Pleasure/pain	Recognize the importance of pleasure in sexual intimacy and well-being	“Are you satisfied with your sexual life?” “Do you have any pain with sex?” “Do you have any problems with erection, lubrication, ejaculation, or orgasm?”
Prevention/planning of pregnancy	Evaluate desire for/risk of pregnancy	“Are you concerned about getting pregnant or getting your partner pregnant?” “Are you using contraception or practicing any form of birth control?” “Do you need any information on birth control?”

*For more information, please see, “Sexual Health and the LGBTQ+ Community,” by Taylor NM, King CK. *Prim Care Clin Office Pract.* 2021;48:271-282.

[†]For patients who report one or fewer partners in the last 12 mo, ask whether they have any concerns about STI.

BDSM, Bondage and discipline, dominance and submission, sadism and masochism; HIV, human immunodeficiency virus; PrEP, preexposure prophylaxis.

From Suarez S, Lupez E, Siegel J, Streed Jr C. The annual examination for lesbian, gay, and bisexual patients. *Prim Care Clin Office Pract.* 2021;48:191-212, Table 2.

A school plans a smoking-prevention intervention for adolescents. Which protective factor in the table is most relevant to strengthen?

- A. Peer smoking
- B. Disconnection from school
- C. Low academic achievement
- D. Depressive symptoms without support
- E. Family connectedness and communication

ORIGINAL SOURCE TABLE | Table 155.1 | PDF p. 1200 | printed p. 1187

Table 155.1 Identified Risk and Protective Factors for Adolescent Health Behaviors		
BEHAVIOR	RISK FACTORS	PROTECTIVE FACTORS
Smoking	Depression and other mental health problems, alcohol use, disconnectedness from school or family, difficulty talking with parents, minority ethnicity, low school achievement, peer smoking	Family connectedness, perceived healthiness, higher parental expectations, low prevalence of smoking in school
Alcohol and drug misuse	Depression and other mental health problems, low self-esteem, easy family access to alcohol, working outside school, difficulty talking with parents, risk factors for transition from occasional to regular substance misuse (smoking, availability of substances, peer use, other risk behaviors)	Connectedness with school and family, religious affiliation
Teenage pregnancy	Deprivation, city residence, low educational expectations, sexual intercourse, lack of access to sexual health services, drug and alcohol use	Connectedness with school and family, religious affiliation
Sexually transmitted infections	Mental health problems, substance misuse, exploration of sexuality and sexual identity (sexual activity)	Connectedness with school and family, religious affiliation

Adapted from McIntosh N, Helms P, Smyth R, eds. *Foafar and Arneil's Textbook of Pediatrics*, 6th ed. Edinburgh: Churchill Livingstone; 2003:1757–1768; and Viner R, Macfarlane A. Health promotion. *BMJ*. 2005;330:527–529.

A 14-year-old repeatedly steals, damages property, and bullies peers. Which disorder column in the table best captures this pattern?

- A. Adjustment to a new school without harm
- B. A specific learning disorder alone
- C. Conduct disorder
- D. Oppositional defiant disorder
- E. A normal isolated argument with parents

ORIGINAL SOURCE TABLE | Table 156.1 | PDF p. 1203 | printed p. 1190

Table 156.1 Oppositional Defiant Disorder and Conduct Disorder	
OPPOSITIONAL DEFIANT DISORDER	CONDUCT DISORDER
Often being angry or losing one’s temper Often arguing with adults or refusing to comply with adults’ rules or requests Often resentful or spiteful Deliberately annoying others or becoming annoyed with others Often blaming other people for one’s own mistakes or misbehavior	• Breaking serious rules, such as running away, staying out at night when told not to, or skipping school • Being aggressive in a way that causes harm, such as bullying, fighting, or being cruel to animals • Lying, stealing, or damaging other people’s property on purpose

tesy Centers for Disease Control and Prevention: Children’s Mental Health, <https://.cdc.gov/childrensmentalhealth/behavior.html>, accessed August 4, 2021.

A clinician uses the FISTS mnemonic to assess violence risk. Which question addresses its final “S” domain?

- A. Have you carried a weapon for self-defense?
- B. How many fights occurred last year?
- C. Have you ever been injured?
- D. Has a partner hit you?
- E. Has anyone threatened you with a weapon?

ORIGINAL SOURCE TABLE | Table 156.2 | PDF p. 1203 | printed p. 1190

Table 156.2	FISTS Mnemonic to Assess an Adolescent’s Risk of Violence
Fighting (How many fights were you in last year? What was the last?)	
Injuries (Have you ever been injured? Have you ever injured someone else?)	
Sex (Has your partner hit you? Have you hit your partner? Have you ever been forced to have sex?)	
Threats (Has someone with a weapon threatened you? What happened? Has anything changed to make you feel safer?)	
Self-defense (What do you do if someone tries to pick a fight? Have you carried a weapon in self-defense?)	

Adapted with permission from the Association of American Medical Colleges. Alpert DG, Bradshaw YS. Interpersonal violence and the education of physicians. *J Am Med Assoc*. 1997;278:1541–1550.

A community program pairs adolescents with supportive adult mentors and structured after-school activities. Which prevention strategy category is illustrated?

- A. Provide only medication for every student
- B. Eliminate parent participation
- C. Rely solely on emergency-department treatment after injury
- D. Connect youth to caring adults and activities
- E. Limit intervention to punitive school exclusion

ORIGINAL SOURCE TABLE | Table 156.4 | PDF p. 1205 | printed p. 1192

Table 156.4 Preventing Youth Violence (CDC)	
STRATEGY	APPROACH
Promote family environments that support healthy development	Early childhood home visitation Parenting skill and family relationship programs
Provide quality education early in life	Preschool enrichment with family engagement
Strengthen youth skills	Universal school-based programs
Connect youth to caring adults and activities	Mentoring programs After-school programs
Create protective community environments	Modify the physical and social environment Reduce exposure to community-level risks Street outreach and community norm change
Intervene to lessen harms and prevent future risk	Treatment to lessen the harms of violence exposures Treatment to prevent problem behavior and further involvement in violence Hospital-community partnerships

From David-Ferdon, C, Vivolo-Kantor AM, Dahlberg LL, et al. *A Comprehensive Technical Package for the Prevention of Youth Violence and Associated Risk Behaviors*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2016.

A school district wants a population-level violence-prevention approach supported by the table. Which program is listed?

- A. Removing all family-engagement programs
- B. A whole-school approach to violence prevention
- C. Expelling every student who reports anger
- D. Avoiding all social-skills education
- E. Restricting interventions to injured patients

ORIGINAL SOURCE TABLE | Table 156.5 | PDF p. 1205 | printed p. 1192

Table 156.5	Prevention of Youth Violence (WHO)
Promising prevention programs include:	
Life skills and social development programs designed to help children and adolescents manage anger, resolve conflict, and develop the necessary social skills to solve problems	
Whole-school approaches to violence prevention in educational facilities	
Programs that support parents and teach positive parenting skills	
Preschool programs that provide children with academic and social skills at an early age	
Therapeutic approaches for youths at high risk of being involved in violence	
Reducing access to alcohol	
Interventions to reduce the harmful use of drugs	
Restrictive firearm licensing	
Community and problem-oriented policing	
Interventions to reduce concentrated poverty and to upgrade urban environments	

Preventing youth violence requires a comprehensive approach that addresses the social determinants of violence, such as income inequality, rapid demographic and social change, and low levels of social protection.
Source: World Health Organization: Youth Violence. <https://www.who.int/news-events/youth-violence>

Answer key and teaching notes

01. D | Table 150.1 | PDF p. 1171, printed p. 1158

Why: Early adolescence is characterized by more concrete reasoning and limited appreciation of long-term consequences.
Closest distractor: Middle adolescence shows an emerging ability to perceive future implications, although emotions can still dominate decisions.

02. B | Table 150.2 | PDF p. 1173, printed p. 1160

Why: Stage 3 includes enlarged breast and areola without contour separation and darker curling hair.
Closest distractor: Stage 4 adds the secondary mound of areola and papilla.

03. E | Table 150.3 | PDF p. 1173, printed p. 1160

Why: Stage 2 includes early scrotal/testicular enlargement with little penile change and scant hair.
Closest distractor: Stage 3 shows penile lengthening and darker, curling pubic hair.

04. C | Table 151.1 | PDF p. 1179, printed p. 1166

Why: The preventive-care table lists annual depression screening for adolescents age 12 and older.
Closest distractor: Hemoglobin is prompted by a positive risk assessment rather than universally every year.

05. A | Table 151.2 | PDF p. 1180, printed p. 1167

Why: The 15- to 17-year visit column lists annual depression screening.
Closest distractor: Anemia testing is selective after a positive risk assessment, not universal.

06. D | Table 151.4 | PDF p. 1182, printed p. 1169

Why: The psychosocial mnemonic includes safety, including seat belts, helmets, sports safety, and violence.
Closest distractor: A laboratory profile cannot replace the broader psychosocial assessment.

07. B | Table 152.1 | PDF p. 1184, printed p. 1171

Why: The table calls for repeated readiness checks and a written plan tailored to independence and self-management goals.
Closest distractor: An isolated referral lacks assessment and preparation for adult-system communication.

08. E | Table 153.1 | PDF p. 1186, printed p. 1173

Why: The table specifies qualified mental-health assessment and attention to factors affecting treatment and decision-making.
Closest distractor: Pubertal stage alone does not address the table's broader assessment prerequisites.

09. C | Table 153.2 | PDF p. 1186, printed p. 1173

Why: The table specifies at least 6 months, with additional symptom and impairment criteria.
Closest distractor: A brief one-month history does not meet the duration in the reproduced criteria.

10. A | Table 153.3 | PDF p. 1187, printed p. 1174

Why: The table recommends an affirmed name and pronouns in clinical spaces and the electronic record.
Closest distractor: Legal documents alone do not establish the name the adolescent wants used in care.

11. D | Table 153.5 | PDF p. 1189, printed p. 1176

Why: The table lists histrelin as a subcutaneous implant.
Closest distractor: Leuprolide is listed as an intramuscular preparation.

12. B | Table 153.6 | PDF p. 1189, printed p. 1176

Why: The table lists periodic DXA bone-density evaluation alongside more frequent clinical and laboratory review.
Closest distractor: Repeated head CT does not serve the bone-health monitoring purpose.

13. E | Table 153.7 | PDF p. 1190, printed p. 1177

Why: The testosterone follow-up row lists hemoglobin/hematocrit along with testosterone and other assessments.
Closest distractor: Troponin is not a routine parameter in the table's hormone follow-up protocol.

14. C | Table 153.8 | PDF p. 1190, printed p. 1177

Why: The table places sperm cryopreservation before treatment or surgery as an available preservation option.
Closest distractor: Delaying every discussion until after surgery may remove an earlier preservation opportunity.

15. A | Table 153.10 | PDF p. 1192, printed p. 1179

Why: The source table describes breast growth as not reversible without surgery.
Closest distractor: Changes in skin oiliness are described as likely reversible.

Answer key and teaching notes

16. D | Table 154.1 | PDF p. 1195, printed p. 1182

Why: The table cautions against assuming that sexual orientation aligns with sexual behavior or that all patients are heterosexual.
Closest distractor: Identity alone does not establish exposures relevant to care.

17. B | Table 154.2 | PDF p. 1197, printed p. 1184

Why: The practices domain explores types of sexual contact to guide exposure-specific care.
Closest distractor: Partner number belongs to the Partners domain rather than Practices.

18. E | Table 155.1 | PDF p. 1200, printed p. 1187

Why: Family connectedness is listed as protective against smoking.
Closest distractor: Peer smoking is a risk factor rather than a protective factor.

19. C | Table 156.1 | PDF p. 1203, printed p. 1190

Why: Aggression causing harm, theft, and property damage appear in the conduct-disorder column.
Closest distractor: Oppositional defiant disorder emphasizes anger, argumentativeness, and defiance without these serious violations.

20. A | Table 156.2 | PDF p. 1203, printed p. 1190

Why: The final S refers to self-defense, including carrying a weapon for that purpose.
Closest distractor: Fighting, injuries, sex, and threats correspond to other letters in FISTS.

21. D | Table 156.4 | PDF p. 1205, printed p. 1192

Why: The CDC table places mentoring and after-school programs under connection to caring adults and activities.
Closest distractor: Emergency treatment after injury is not the preventive connection described.

22. B | Table 156.5 | PDF p. 1205, printed p. 1192

Why: The WHO table lists whole-school approaches among promising prevention programs.
Closest distractor: Restricting care to injured youth misses the schoolwide prevention strategy.

Table selection log

- 01. Table 150.1 | PDF p. 1171 | printed p. 1158 | Completed
- 02. Table 150.2 | PDF p. 1173 | printed p. 1160 | Completed
- 03. Table 150.3 | PDF p. 1173 | printed p. 1160 | Completed
- 04. Table 151.1 | PDF p. 1179 | printed p. 1166 | Completed
- 05. Table 151.2 | PDF p. 1180 | printed p. 1167 | Completed
- 06. Table 151.4 | PDF p. 1182 | printed p. 1169 | Completed
- 07. Table 152.1 | PDF p. 1184 | printed p. 1171 | Completed
- 08. Table 153.1 | PDF p. 1186 | printed p. 1173 | Completed
- 09. Table 153.2 | PDF p. 1186 | printed p. 1173 | Completed
- 10. Table 153.3 | PDF p. 1187 | printed p. 1174 | Completed
- 11. Table 153.5 | PDF p. 1189 | printed p. 1176 | Completed
- 12. Table 153.6 | PDF p. 1189 | printed p. 1176 | Completed
- 13. Table 153.7 | PDF p. 1190 | printed p. 1177 | Completed
- 14. Table 153.8 | PDF p. 1190 | printed p. 1177 | Completed
- 15. Table 153.10 | PDF p. 1192 | printed p. 1179 | Completed
- 16. Table 154.1 | PDF p. 1195 | printed p. 1182 | Completed
- 17. Table 154.2 | PDF p. 1197 | printed p. 1184 | Completed
- 18. Table 155.1 | PDF p. 1200 | printed p. 1187 | Completed
- 19. Table 156.1 | PDF p. 1203 | printed p. 1190 | Completed
- 20. Table 156.2 | PDF p. 1203 | printed p. 1190 | Completed
- 21. Table 156.4 | PDF p. 1205 | printed p. 1192 | Completed
- 22. Table 156.5 | PDF p. 1205 | printed p. 1192 | Completed

Skipped: 150.4 (multi-page policy matrix); 151.3 (jurisdiction-specific law); 153.4 (resource directory); 153.9 (specialist dosing protocol); 153.11 (adult-organ screening recommendations); 155.2-155.4 (dated population statistics/objectives); 156.3 (survey odds statistics).

Last completed: Table 156.5, PDF p. 1205. Next: adolescent substance use, Table 157.1 onward.

Review: gender-related treatment and screening tables reflect the source edition; check current specialist guidance and local rules before applying any protocol in patient care.