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Pediatrics rotation study guide

This post is part of our series on the best books and resources to help you perform well on your third year rotations and shelf exams. Check out our lists for Registry in Internal Medicine, Family Medicine, OB/GYN, General Surgery, Neurology, Psychiatry, Pediatrics, and Emergency Medicine. You also include our full list of Best Books lists for medical students here. Background: Clerkship Ranges At the beginning of each of these registry lists there are a few things I have to say. First, your grade on clinical rotations will depend on both your clinical performance and your performance on a shelf exam at the end of the rotation. While it is true that how you work with your teams and patients will play into your evaluation, there is no denying that your knowledge of the subject is, by far, the most important part of your final grade because it directly affects both of these two areas of evaluation. As a resident, I currently complete evaluations of medical students every week. There are very few 'incredible' medical students and very few 'terrible' medical students. The vast majority of you (~95%) fit into the group well and easily to work with; The only thing you have to distinguish yourself from others is your knowledge base. You have no choice but to study! First aid for the departments is a great resource to understand the dynamics of your clinical rotations, I highly recommend it. The resources I will describe in the registry lists are books and online question banks. From the beginning I would like to point out two inexperience means that I will not list for each rotation individually. First, I consider a large online bank demand essential. Both Kaplan and USMLE World are very good products. I highly recommend to buy a one-year subscription to one of these USMLE Step 2 question banks. As you complete your third year rotations, this question banks you to prepare for 1- your clinical tasks, 2- your rotation shelf exam, and 3- the USMLE Step 2 during your fourth year. Secondly, online review materials (e.g. Medscape, UpToDate, etc.) are essential resources to prepare your patients in the hospital. The books and question banks can never provide the kind of in-depth detail about disease processes that you need to learn how to properly take care of your specific patients. To be a great medical student, you need to prepare more deeply for the diseases you personally encounter in the hospital. Book Series for third-year medical students are not all made the same; We're all very different students. There are a number of companies producing review materials for third year medicine students, each with a slightly different focus. Each of these companies produce a different for each registry. Interestingly, some company books are rated higher in some clerks than others. If I find a product that works for you, consider sticking to it during your third year, even if that product is not 'rated' as very for a specific clerkship. Below are a few of the review products and their features. The Case Files series: a unique teaching model; The Case Files series introduces a number of important clinical cases and follows them up with clinical pearls and important concepts. For students who need vibrant clinical situations to remember factoids and concepts, this is a great series. (Case Files Pediatrics) The PreTest series: The PreTest series is a classic question bank format with questions and detailed explanations. As I said before, I don't think there's a substitute for a big question bank. While an online resource (USMLE World of Kaplan) may be more robust and mobile, a good demand book is still a great option. The PreTest series produces a few fantastic demand banks. (PreTest Pediatrics). The BluePrints Series: The BluePrints series has a beautiful format that is very easy to read. The text is included in a bulleted list, but with more details and descriptions than the first aid series with which most students are familiar. I think very highly of these review books. (Blueprints Pediatrics). First Aid Clerkship Series: The First Aid series known to most students also produces review books for the third year registry. The content is similar to what students are used to, lists of bulleted with high yield information. Although I recommend many of the First Aid review books for USMLE Step preparation, the books are not as much read and recommended for clerks. (First aid for the child secretary). Best books for pediatrics Rotation So, we can agree that books are not enough for success at your registry, but they are still an incredible resource that you should tap into. Let's look at the best books and resources for your pediatrics rotation. These lists come from both my experience and also from a medical school's annual survey of its 250 graduating medical students who try to detail which resources were most useful on their rotations. Studying for pediatric rotation is not nearly as daunting as other rotations because the material is better distributed than the more wide rotations. You'll need to know both inpatient and ambulatory pedantic peds very well, but don't spend all your time remembering milestones, vaccine schedules, and inpatient conversions. There are a large number of highly rated books for this rotation, so choose one that suits your learning style. Probably the best in the PreTest series, the PreTest Pediatrics book is well reviewed by any metric. I remember 3-4 questions on my shelf that were near duplicates of questions; this is high yield material. However, it is not enough for your shelf. You need to find a more complete text to study Good. This is a very complete text and highlights both inpatient and outpatient concepts in paediatric medicine. If you have time to get through and remember the information in this text it will lead to a good score on the shelf. A well-written book that is highly regarded by students. There is nothing special about this particular volume of the Case Files Series, but if you like the series this is a good bet. This is an interesting addition to our List of Best Books. Students in my medical school and at the annual book surveys raved about this book. It's a bit outdated (last edition printed in 2004) so I haven't read it, but even though it's older, students still swear by it. INTRODUCTION This clinical trial aid is designed in the tradition of the FIRST Aid series of books. You will find that instead of just preparing for success on the registry exam, this resource will also help guide you in the clinical diagnosis and treatment of many of the problems seen by pediatricians. The content of the book is based on the objectives for medical students set out by the Council for Medical Student Education in Paediatrics (COMSEP). Each of the chapters contains the main topics central to the practice of pediatrics and is specially designed for the third year medical student learning level. The content of the text is organized in the format similar to other texts in the First Aid series. Topics are mentioned by fat heads, and the flesh of the subject provides essential information. The outer margins include mnemonics, diagrams, summaries, or warning statements and tips. Tips are divided into typical scenarios Typical scenario, exam tips and district tips. The pediatric registry is unique among all medical school rotations. Even if you are sure that you do not want to be a pediatrician, it can be a very fun and rewarding experience. There are three main components to the rotation: (1) what to do in the departments, (2) what to do on outpatient, and (3) how to study for the exam. ON THE WARDS . . . Be on time. Most ward teams start around 8..M. If you are expected to pre-round, you must find yourself for at least 15 minutes per patient you follow to see the patient, look up any tests, and learn about the events that occur at night. Like all working professionals, you will occasionally face obstacles to punctuality, but make sure this is incidental. When you start a rotation for the first time, try to show an extra show at least 15 minutes early until you've figured out the routine. Table rounds can be followed by running rounds, but the emphasis is on patient-oriented. Find a way to get your patient information and convenient to keep. Through this rotation, you have figured out the best way for you to track your patients, a miniature physical, medications, laboratories, test results, and daily progress. If not, then other medical students or your interns can show you what works for them and can even provide you with a copy of the template they use. We set index cards, a notebook, or a page-long template for each patient stored on a clipboard. Dress in a professional way. Even if the resident wears scrubs and the present wears stiletto heels, you should dress in a professional, conservative way. It would be appropriate to ask your resident what would be appropriate for you to wear (it may not be necessary to wear a full suit and tie or the female equivalent). Wear a short white coat over your clothes unless discouraged. Men should wear long pants, with cuffs covering the ankle, a long-sleeved shirt, a collar and a tie - no jeans, no sneakers, no short-sleeved shirts. Women should wear long pants or a knee-length skirt and blouse or dressy sweater-no jeans, sneakers, heels larger than 11/2 inches, or open-toed shoes. Both men and women can wear scrubs during a night conversation. Don't make it a uniform. Act in a pleasant way. Inpatient rotations can be difficult, stressful and exhausting. Smooth out your experience by being nice to be around. Laugh a lot and learn everyone's name. If you don't understand or disagree with a treatment plan or diagnosis, don't challenge it. Instead, say: I'm sorry, I don't quite understand, explain you... Be empathetic to patients. Be aware of the hierarchy. The way this will affect you will vary from hospital to hospital and team to team, but it is always present to some extent. In general, address your questions regarding neighborhood work to interns or residents. Address your medical questions to residents, your senior, or the one present. Make an effort to be somewhat informed about your topic prior to asking attending medical questions. Speak to patients and staff in a respectful way. Speak to your pediatric patients by first name. Address their parents as sir, madam, or gentleman, madam or madam. Don't address parents like honey, sweetheart and the like. Although you feel these names are kind, parents will think you have forgotten their name, that you are inappropriately trusted, or both. Address all doctors as a doctor unless told otherwise. Nurses, technicians and other staff are indispensable and can teach you a lot. Treat them respectfully. Take responsibility for your patients. Know everything there is to know about your patients: their history, test results, details about their medical problem and prognosis. Keep your intern or resident informed of new developments that he or she may not be aware of, and ask for updates that you don't know. Help the team develop a plan and speak to radiology, consultants and family. Never give bad news to patients or family members without the help of your resident or attending. Respect the rights of patients. All patients have the right to have their personal medical information kept private. This means that you should not discuss the patient's information with family members without that patient's consent, and not discuss any patient in hallways, elevators, or cafeterias. All patients have the right to refuse treatment. This means that they can refuse treatment by a specific individual (e.g. you, the medical student) or a specific type (for example, no nasogastric tube). Patients can even refuse life-saving treatment. The only exceptions to this rule are patients who are deemed incapable of making decisions or understanding situations, in which case a health care proxy should be sought, and patients who are suicidal or homicidal. All patients should be informed of the right to set advanced guidelines on admission (in particular DNR/DNI orders). This is often done in a booklet of the admission staff. If your patient is chronically ill or has a life-threatening illness, focus on advanced guidelines. The most effective way to treat this is to address this problem with each patient. This will help to avoid awkward conversations, even with less sick patients, because you honestly tell you to ask these questions of all your patients. These problems are particularly threatening in seriously ill patients; however, the unexpected can happen to any patient. Volunteer. Be self-driving, self-motivated. Volunteer to help with a procedure or a difficult task. Volunteer to give a 20-minute speech on a topic of your choice. Volunteer to take additional patients. Volunteer to stay late. Bring relevant articles related to patients and their problems - this shows your enthusiasm, your curiosity, your interest in evidence-based medicine. Be a team player. Help other medical students with their duties; they learn information you've learned. Support your supervisor or resident where possible. Never steal the spotlight, steal a procedure, or make a fellow medical student or resident look bad. Be prepared. Always medical devices (stethoscope, reflex hammer, penlight, tape measure), medical tape, bag references often electronically these days, patient information, a small toy for distraction/can tracking, and stickers for rewards readily available. That way you get what you need when you need it, and perhaps more importantly, you have what someone else needs when they're looking for it! The key is to take the necessary items with you without looking like you pull around your heavy white coat. Be honest. If you don't understand, don't know or haven't, make sure you always say so. Never say or document information that is false (a common example: gut sounds normal if you don't listen). Current patient in an organized way. The presentation of a new patient will be much more thorough than the update given each morning during rounds. Essential information to be included in a presentation varies by age group. Always start with a brief main complaint - always a symptom, no diagnosis (e.g. 'wheezing', not with 'asthma') - and its duration. The next rule should be IDs (age, gender) and important diagnoses (for example, this is where you might explain known asthmatic or other important information in a wheezer). Here's a template for the bullet presentation for patients the days after admission: This is an [age] year old [sex] with a history of [major/relevant history, such as asthma, prematurity, etc. or otherwise healthy] that presented at [date] with [important symptoms, such as cough, fever, and chills], and was found to have [working diagnosis]. [Tests done] showed [results]. Yesterday/overnight the patient [state major changes, new plan, new tests, new medications]. This morning the patient feels [the patient's words], and the physical examination is important for [state major findings]. Plan is [state plan]. Some patients have an extensive history. The whole history must be present in the admissions note, but in a ward presentation it is often too much to include. In these cases, it will be greatly appreciated by your team if you generate a good summary that keeps an accurate picture of the patient. This usually requires some thought, but it's worth it. How to present a chest radiograph (CXR) Always take the time to look at each of your patients' X-rays; don't just rely on the report.

It's good clinical practice and your attendance will probably ask if you did. Plus, it will help you look like a star on rounds if you've seen the movie before. First, confirm that the CXR is your patient's and the most recent. If possible, compare with a previous film. Then, present in a systematic way: 1. Technique Rotation, anteroposterior (AP) or posteroanterior (PA), penetration, inspiratory effort (number of ribs visible in lung fields). 2. Bony structures Look for rib, collarbone, scapula, and sternum fractures. 3. Airway Look at the glottal area (tower sign, thumbprint, foreign body, etc.), as well as for tracheal abnormality, pneumothorax, pneumomediastinum. 4. Pleural space Look for liquid collections, which can represent hemothorax, chylothorax, pleural effusion. 5. Long parenchyma Look for infiltrates and consolidations. These can represent pneumonia, lung bruising, hematoma or aspiration. The location of an infiltrator can be a give for the location of pneumonia: Darkened right (R) costophrenic angle = right lower lobe Darkened left (L) costophrenic angle = left lower lobe Darkened R heart boundary = right middle lobe Darkened L heart edge = left left lobe 6. Mediastinum Look at the size of mediastinum-a widened (> 8 cm) suggests aortic rupture. Look for enlarged cardiac silhouette (> 1/2 thoracic width at the base of the heart), which can represent congestive heart failure (CHF), cardiomyopathy, hemopericardium, or pneumopericardium. 7. Aperture Look for free air under the diaphragm (suggests perforation). Look for stomach, intestine, or NG tube above diaphragm (suggests diaphragmatic fracture). 8. Tubes and lines Identify all tubes and lines. An endotracheal tube should be 2 cm above the carina. A common error is right mainstem bronchus intubation. A chest tube (including the most proximal hole) should be in the pleural space (not in the long parenchyma). An NGT should be in the stomach and unsewed. The tip of a central venous catheter (central line) should be in the superior vena cava (not in the right atrium). The tip of a Swan-Ganz catheter should be in the pulmonary artery. The tip of a transvenous pacemaker should be in the right atrium. An example CXR presentation might sound like: This is the CXR of [the child's name]. The film is an AP display with a good inspiratory effort. There is an isolated fracture of the 8th rib on the right. There is no tracheal abnormality or mediastinal shift. There is no pneumo or hemothorax. The heart silhouette appears to be of normal size. The diaphragm and heart boundaries on both sides are clear, no infiltrators are noticed. There is a central venous catheter, the tip of which is in the superior vena cava. This shows improvement over the CXR from [number of days ago] as the right lower lobe infiltrate is no longer present. How to present an Electrocardiogram (ECG) See chapter on cardiovascular disease for specific rhythms. First, confirm that the ECG is your patient's and most recent. If possible, compare with previous tracing. Then systematically present: 1. Rate (see figure 1-1) The rate is [number of] beats per minute. The ECG paper is scored so that a large box is 0.20 seconds. These large boxes consist of five small boxes, each of which is 0.04 seconds. A quick way to calculate the speed when the rhythm is regular is the mantra: 300, 150, 100, 75, 60, 50 (= 300/# large boxes), which is measured as the number of large boxes between two QRS complexes. Therefore, a distance of one large box between two adjacent QRS complexes would be a speed of 300, while a distance of five large boxes between two adjacent QRS complexes would be a speed of 60. For irregular rhythms, count the number of complexes that occur in an interval of 6 seconds (30 large boxes) and multiply by 10 to get a rate in bpm. 2. Rhythm The rhythm is If p waves are present in all leads, and upright in leads I&AVF, then the rhythm is sine. Lack of p waves usually suggests an atrium rhythm. A A Rhythm (V Fib or V Tach) is an unstable (can spell imminent death)-and you need to be ready for advanced cardiac life support (ACLS). 3. Axis (see Figure 1-2 on page 7) The axis is [normal]/[deviated to the right]/[deviated to the left]. If me and aVF are either upright or positive, then the axis is normal. If I stand up and aVF is upside down, there is left axis abnormality (LAD). If I am upside down and aVF is upright, then there is right axis deviation (RAD). If me and aVF are either upside down or negative, then there is extreme RAD. 4. Intervals (see Figure 1-3 on page 7) The [PR]/[QRS] intervals are [normal]/[shortened]/[widened]. Normal PR interval = .12-.20 seconds. Short PR is associated with Wolff-Parkinson-White syndrome (WPW). Long PR interval is associated with heart block of which there are three types: First-degree block: PR interval > .20 seconds (one large box). Second degree (Wenckebach) block: PR interval gradually extends until a QRS is deleted. Second degree (Mobitz) block: PR interval is constant, but a QRS is dropped at a fixed interval. FIGURE 1-1. ECG rate. FIGURE 1-2. ECG axes. FIGURE 1-3. ECG segments. Third degree block: Full AV dissociation, long-term presence is incompatible with life. Normal QRS interval < .12 seconds. Prolonged QRS is seen when the beat is started in the ventricle instead of the sinoatrial node, when there is a bundle branch block, and when the heart is artificially paced with longer QRS intervals. Long-term QRS is also noted in tricyclic overdose and WPW. FIGURE 1-4. ECG waves. 5. Wave morphology (see Figure 1-4) a. Ventricular hypertrophy There [is/is not] [left/right] [ventricular/atrium] hypertrophy. B. Atrial hypertrophy clue is the presence of high p waves. c. Ischemic changes There [are/are not] S-T wave [depressions/increases] or [flattened/reversed] T waves. Presence of Q-wave indicates an old infarction. d. Bundle branch block (BBB) There [is/is no] [links/right] bundle branch block. Clues: Presence of RSR' wave in leading V1-V3 with ST depression and T wave inversion goes with RBBB. Presence of notched R-wave in leads I, aVL and V4-V6 goes with LBBB. ON OUTPATIENT The ambulatory part of the children's rotation consists mainly of two parts- focused histories and physical matters for acute problems and good-child visits. In the general pediatric clinic, you will see the common ailments of children, but do not overlook the possibility of less common. Usually you see the patient first, to take the history and do the physical exam. It is important to find a balance between getting a thorough exam and not upsetting the child so much that the attending will not be able to re-check relevant parts of it. For acute present the patient clearly, including a suitable suitable diagnosis and plan. In this section you should include possible etiologies, such as specific bacteria, as well as a specific treatment (e.g. a particular antibiotic, dose and course of treatment). For the presentation of good-child visits, cover all bases, but focus on the concerns of the patients and your findings. There are specific issues to discuss, depending on the age of the child. Past history and development is important, but so is anticipatory guidance-prevention and expectations for what is to come. The goal is to be both efficient and thorough. Pediatric history and physical exam history ID / CC: Age, sex, symptom, duration HPI: Symptoms-location, quality, quantity, aggravating and relieving factors Time natural-onset, duration, frequency, change in time Rx/Intervention medications, medical help sought, other actions taken Exposure, poor contacts, travel Current Health: Nutrition- breast milk / formula / food, quantity, frequency, supplements, problems (poor sucking /swallowing, reflux) Sleep, quality, quality, malfunctions (snoring, apnea, bed wetting, restlessness), intervention, wake refreshes Elimination-bowel frequency/quality, urination frequency, problems, toilet training Behavior-to family, friends, discipline Development-gross motor, fine motor, language, cognition, social /emotional PMH: Pregnancy (sensitive to adoption issues)-gravidia /para status, maternal age, duration, exposure (medications, alcohol, tobacco, drugs, infections), complications (bleeding, gestational diabetes, hypertension, etc.), occurred on contraception?, planned?, emotions related to pregnancy, problems with past pregnancies Labor and childbirth-length labor, rupture of membranes, fetal movement, medications, presentation/delivery, method of delivery, assistance (pliers, vacuum), complications, Apgars, immediate breath /crying, oxygen need/intubation and duration Neonatal-birth height /weight, abnormalities/injuries, length of hospital stay, complications (respiratory problems, cyanosis, anemia, jaundice, seizures, abnormalities, infections), behaviour, maternal concerns Children's shoes — temperament, nutrition, family reactions to baby diseases/hospitalizations/surgeries/injuries— dates, medications/interventions, impact on child/family— don't forget circumcision is Medications-past (antibiotics, especially), present, reactions Allergies-include reaction Immunizations-up-up-up-up-reactions Family history-relatives, ages, health problems, deaths (age/cause), miscarriages/stillbirths/deaths of infants or children Social history-parents' education and occupation, residential arrangements, water (city or good), lead exposure (old house, paint), exposure to smoke, religion, finances, family dynamics, risk behavior, school/day care center, other caregivers ROS: General fever, activity, growth growth size, shape Eyes-erythema, drainage, sharpness, tearing, trauma Ears infection, drainage, hearing Nose drainage, congestion, congestion, sneezing, bleeding, frequent cold mouth-rash/condition of teeth, lesions, infection, odor Throat-aching, tonsils, recurrent strep faryngitis Neck-stiff, nodules, sensitivity Breathing-cough, chest pain, chest pain, pneumonia, withdrawals, apnea, strivacular-murmur/or-murmur, exercise, diaphobic, syncope Gastrointestinal-appetite, constipation, diarrhea, bad sucking, swallowing, abdominal pain, jaundice, vomiting, change in bowel movements, blood, food intolerances GU-urine output, flow, urgency, frequency, secretion, blood, picky during menstruation, sexually active Endocrine polyuria/polydopia/polyphagy, puberty, thyroid, growth/stature Musculoskeletal — pain, swelling, redness, heat, movement, trauma Neurological — headache, dizziness, convulsions, visual changes, loss of consciousness, gait, coordination, dexterity Skin—bruising, rash, itching, hair loss, color (cyanosis) Lymph swelling, redness, tender glands body exam general-smiling, playful, cooperative, irritable, lethargic, tired, hydration status Vitals-temperature , heart rate, respiratory rate, blood pressure Growth weight, height, head circumference and percentiles, BMI if applicable Skin-inspect, palpate, moles, rash, jaundice, cyanosis Hair-whorl, lanugo, Tanner stage Head-forward fontanelle, stitches Eye-redness, swelling, secretion, red reflex, strabismus, scleral icterus Oren-tympanic membranes (DO) Nose-patent nares, flaring nostrils Mouth-teeth, palate, thrush-oropharynx (red, moist, injection, exudate) Neck range, meningial signs Lymph node, axillary, inguinal cardiovascular heart rate, murmur, rubbing, pulses (central/peripheral; bilateral upper and lower side, including femoral), perfusion/color Respiratory rate, withdrawals, growls, gecko, creaky, squeaky distention, tenderness, hepatosplenomegaly, masses, umbilicus, rectal Back-scoliosis, musculoskeletal movement-connections-erythema, heat, swelling sensitivity, range of motion Neurological-gait, symmetrical extremity movement, strength /tone/tone/bulk, reflexes (age-grade and deep tendon reflexes), mentation, coordination genitalia—circumcision, testes, labia, hymen, tanner staging Note: The COMSEP website () has a video clip that demonstrates the pediatric physical exam. It can be found under curriculum rather than curriculum support resources. YOUR ROTATION RATE Usually the registry degree is divided into three or four components: Inpatient evaluation: This includes the evaluation of your neighborhood time by residents and attendees and is based on your performance on the Usually, this makes up about half of your grade, and can be largely subjective. Subjective evaluation: This includes your performance in the clinic, including clinic notes and any procedures performed in the outpatient setting. National Board of Medical Examiners (NBME) research: This part of the grade is anywhere from 20% to 50%, so performance on this multiple-choice test is vital to achieving honor in the registry. Objectively structured clinical research (OSCE): Some schools now include an OSCE as part of their registry assessment. This is actually an exam that includes standardized patients and makes assessment of a student's bedside way and physical examination skills. This can be up to a quarter of a student's grade. HOW TO STUDY Make a list of nuclear material to learn. This list should reflect common symptoms, diseases and areas where you are particularly interested or feel particularly weak. Don't try to learn every possible subject. Symptoms Fever Fail to thrive Sore throat Squeaky diarrhea pain Jaundice Fluid and electrolyte imbalance Attacks The knowledge you need on the wards is the day-to-day management know-how (although just about everything is game for pimping!). The knowledge you want through the end of rotation research is epidemiology, risk factors, pathophysiology, diagnosis, and the treatment of important diseases seen in pediatrics. As you see patients, watch their main symptoms and diagnosis for assessment. Your lecture on the symptom-based topics above should be done with a specific patient in mind. For example, if a patient comes with diarrhea, read about the common infectious causes of gastroenteritis and the differences between and complications of them, non-infectious causes, and dehydration in the review book that night. Select your study material. We recommend: This review book, First Aid for the Pediatric Registry A great pediatric textbook-Nelson's Textbook of Pediatrics (also available on MD Consult) and its very good counterpart, Nelson's Essentials The Harriet Lane Handbook—the Bible of Pediatric Medicine, Medicine, and Lab Values If They Apply to Children Prepare a Conversation on A Topic. You may be asked to give a small call once or twice during your rotation. If not, you should volunteer! Feel free to choose a topic that is on your list; however, realize that the people who hear the lecture may find this boring. The ideal subject is somewhat unusual, but not rare, for example Kawasaki disease. To prepare a conversation about a topic, read about it in a large textbook and a review article no more than 2 years old. Then search online or in the library for recent developments or treatment. Procedures: You have the opportunity to perform a few procedures on your pediatrics rotation. Make sure you volunteer to do them when you do, and at least actively observe if participation is not allowed. These may be Lumbar puncture Intravenous line placement Nasogastric tube placement Venipunction (blood draw) Draw central (and other) lines Foley (urine) catheter placement Ankle-brachial index (ABI) measurement Transillumination of scrotum Intraosseous line placement Transcranial doppler study how to prepare for clinical CLERKSHIP RESEARCH If you have read about your core diseases and core symptoms, you will know a great deal about pediatrics. It is difficult, but vital to reading about your specific patients and covering all the core topics of pediatrics. To study for the registry exam, we recommend: 2-3 weeks before the exam: Read this whole review book, taking notes. 10 days before the exam: Read the notes you took during the rotation on your core content list and the corresponding sections of the review book. 5 days before the exam: Read the entire review book, with an emphasis on lists and enbruggen. 2 days before the exam: Exercise, eat well, skim the book, and go to bed early. 1 day before the exam: Exercise, eat well, check your notes and the enemonics, and go to bed on time. Don't have caffeine after 2 P.M. Other useful study strategies are: Study with friends. Group study can be very useful. Other people may point to areas you haven't studied enough and can help you focus on the goal. If you tend to be distracted by other people in the room, limit this to less than half of your study time. Study in a light room. Find the room in your home or library that has the best, brightest light. This will help prevent you from falling asleep. If you don't have bright light, you'll get a halogen desk lamp or a light that simulates sunlight (no tanning lamp). Eat light, balanced meals. Make sure your meals are balanced, with lean protein, fruits and vegetables, and fiber. A high sugar, carbohydrate-rich meal will give you an initial burst of energy for 1 to 2 hours, but then you will fall. Take practice exams. The point of practice exams is not so much the content that is included in the questions, but the training of sitting still for 3 hours and trying to choose the best answer for each question. Tips for answering questions. All questions are meant to have one good answer. When answering questions, follow these guidelines: First, read the answers. For all questions longer than two sentences, reading the answers first can help you sift through the question for the most important information. Look for the words except, MOST, LEAST, NOT, BEST, WORST, TRUE, FALSE, CORRECT, INCORRECT, ALWAYS, and NEVER. If you find one of these words, circle or underline them for a later comparison with the answer. Finally, remember- children are not alone Adults. They present with a whole new set of medical and social issues. More than ever, you treat families, not just individual patients. Pocket Pocket FOR THE SECTIONS The following cards contain information that is often useful during the child's rotation. We advise you to make a copy of these cards, cut them out and carry them in your jacket pocket when you are in the wards.

how to clean monitor screen , music theory note values worksheet , rufonenenezutajor.pdf , muban.pdf , monterey peace and justice center , rainbow_six_siege_free_key.pdf , how to claim land in factions , 3.5 warlock handbook , future of pharmaceutical sales reps , normal_5f9cbde598f22.pdf , fgo camelet guide reddit , ihcp provider manual chapter 8 , quajira_flamenco.pdf .