Case #1 (Pediatric fever):
A 30day old infant was sent from the Pediatrician office because she was found to have a fever of 102.5F. Child has no medical history, born full term , spontaneous vaginal delivery. Mother does not recall the child having any recent illness. Denies URI symptoms. Child has decreased appetite, but still taking breast milk and wetting the same amount of diapers.
V/S: 80/35 P:190, RR:33, O2 Sat: 100%
Child is non-toxic appearing, awake and active. Physical exam is unremarkable

1) What is the diagnostic work up for this child?
2) Should the child receive antibiotics?
3) What is the disposition?

Case #2 (Peds/Tox): It is 5am and you are in the Pediatric Emergency department when they bring a 4 year old boy in for ingestion of unknown amount of household cleaning product about 30 minutes ago. The mother shows you a bottle that reads " Spray-on glass cleaner ". You look it up and find out that it contains ammonia. Mother states the child gagged several times and brought up some saliva, but no vomiting.
The child is breathing comfortably. On physical exam you don't see any oral lesions and there is no pharyngeal erythema. You give the child some apple juice and he refused to drink V/S: BP: 110/65, P:150, RR:23, O2 sat:100%, T:98.7F

1) Does the absence of oral burn make it unlikely that this child may have esophageal injury?
2) What are the predictors of the severity of injury
3) Does this child required esophagoscopy
4) What is the disposition for the child?

Case#3(AMS/Tox) : A 32 year old males is brought into by EMS for agitation. Patient was found on the side walk displaying aggressive behavior towards bystander. During your examination you find a pack of K2 in his pocket in his pocket. He admits to smoking K2, and denies use of any other drug. V/S: 145/90, P:95, RR: 20, O2 sat:94%

1) What is the K2?
2) What is the typical presentation?
3) How do you manage patients with K2