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Figure 1. “Currant jelly” stool.



Figure 2. Abdominal obstructive series, including posteroanterior chest radiograph. Used with permission of the Department of Radiology, Mercy Hospital, as associated with the University of Illinois at Chicago Radiology and Emergency Medicine Residency Programs, University of Illinois College of Medicine, Chicago, IL.

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A previously healthy 11-month-old girl presented to the emergency department with repeated episodes of bilious emesis during the previous day. Just before arrival, the mother observed a bloody bowel movement, which she saved in the child's diaper (Figure 1).

Vital signs included a temperature of 38.6°C (101.5°F) and a pulse of 168 beats/min. The child appeared listless, with dry mucous membranes and a protuberant, tympanitic abdomen. An abdominal radiograph was obtained (Figure 2).

*For the diagnosis and teaching points, see page 312.
To view the entire collection of Images in Emergency Medicine, visit www.annemergmed.com*

scattered throughout the book. In fact, there is an entire section dedicated to reading a head CT with corresponding cases demonstrating brain pathology.

The book is organized into 7 distinct sections based on anatomical regions of the body. The 7 sections are chest, abdomen, upper extremity, lower extremity, cervical spine, head and face. Each section begins with an overview of appropriate imaging modalities based on the suspected diagnosis for that area of the body, a review of radiographic anatomy and views, a discussion of potential pathology and what one would expect it to look like radiographically. After the brief yet very helpful overview, the author presents an array of cases to reinforce the material presented at the beginning of the section. Each case presentation ends with a question for the reader to ponder before the author describes the radiographic findings and suggested subsequent diagnostic and treatment plan. The images overall are excellent and really highlight the key teaching points. There are multiple tables used throughout the book to emphasize key points. At the end of each section, there is a list of suggested readings that includes classic articles and textbook chapters on the topic being discussed as well as clinical guidelines published on the diagnosis.

The case approach with an enormous number of images definitely makes the book more appealing than the traditional radiology textbook. The reader can even skip the introductory material in each section and test their knowledge in the various cases or go straight to a case about a topic they are interested in learning more about. The author lists the various cases at the beginning of the book by presenting complaint as well as by diagnosis. Dr. Schwartz's latest textbook, *Emergency Radiology: Case Studies*, should be a part of every emergency medicine resident's personal library. In addition to residents, I would highly recommend this book to medical students, midlevel providers and any other physician who is interested in improving their ability to interpret radiographic studies necessary to diagnose common emergency medicine patient complaints.

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Intussusception. Guaiac testing of the "currant jelly" stool was markedly heme positive. The patient was resuscitated with intravenous fluids and broad spectrum antibiotics. Reduction was attempted unsuccessfully with a barium enema. Ultimately, the child underwent successful open reduction in the operating room.

Intussusception is the most common cause of intestinal obstruction in children between 3 months and 6 years of age, with a peak incidence at 6 to 11 months of age.¹ It is caused by a prolapse or "telescoping" of one part of the intestine into the lumen of an adjacent segment, most commonly at the ileocecal valve. The exact cause is often unclear but may involve a pathologic "lead point" in the intestine caused by a polyp, lymphoma, or enlarged lymph nodes.² The classic triad of symptoms is abdominal pain, vomiting, and bloody stool.³ The criterion standard for diagnosis remains barium or air enema because it is often both diagnostic and therapeutic.³ Surgical reduction is necessary in cases of failed reduction by enema and in those cases with clinical signs of perforation or peritonitis.⁴

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