

## Pediatrics– H&P #2

Chief Complaint: “rash” since last night

### HPI

18-month-old male with no significant past medical history and UTD immunizations presents with a rash that began last night. Mother reports the rash was first noticed last night on his back, torso, and belly, and has persisted into today. The patient was recently seen in the ED on 02/13/2026 due to a fever (Tmax 101.2) and was diagnosed with acute otitis media with a prescription of a 10-day course of amoxicillin suspension. Mother has been administering amoxicillin to the infant ever since and states that the fever has resolved since yesterday and has been administering Tylenol and Motrin. Mother also denies a prior history of similar rashes. The patient has otherwise been acting at baseline, playful and interactive. Appetite and oral intake are unchanged. Parent denies any fever, facial swelling, lip or tongue swelling, cough, nasal congestion, shortness of breath, wheezing, itching, vomiting, diarrhea, change in urine output, sick contacts, or recent travel. There have been no new foods, soaps, detergents, or lotions introduced. Patient is tolerating oral intake and has a normal appetite.

### Birth Hx

- Born at 38 weeks of gestation via normal spontaneous vaginal delivery at 7 lbs 10 oz, the mother received all necessary prenatal care without abnormalities, no complications with the birth process, and went home on the same day of delivery without a NICU stay

### PMHx

- No known medical history

### PSHx

- ED visit on 02/13/2026, diagnosed with AOM, discharged with Amoxicillin suspension for 10 days.
- No known past hospitalizations, surgeries, or transfusions.

### Medications

- Amoxicillin suspension 400 mg/5 mL, 6mL PO BID for 10 days
- Pediatric Multivitamin Chewables

### Allergies

- No known drug, food, or environmental allergies.

### FHx:

- Maternal Grandfather → alive and well, no known medical conditions
- Maternal Grandmother → alive and well, no known medical conditions
- Mother → alive and well, HLD
- Father → alive and well, HTN, HLD
- Older sister → 5 years old, alive and well, no known medical history

### SHx

- K. G. lives with mother and father in an apartment. Parents are active and involved in care. No pets in the home. Parents deny smoking, alcohol use, or illicit drug use in the home. Child does not attend daycare.

ROS

**General** – Denies fever, decreased activity, or unusual weight gain or weight loss.

**Skin** – Admits to rash. Denies pruritus, bruising, cyanosis, or skin sloughing

**HEENT** – Denies sore throat, sneezing, conjunctivitis, discharge, or ear pain

**Neck** – Denies any neck pain, neck swelling, or stiffness.

**Chest/Cardiovascular** – Denies any palpitations.

**Pulmonary** – Denies cough, wheezing, or shortness of breath.

**Gastrointestinal** – Denies abdominal pain, nausea/vomiting/diarrhea, or constipation.

**Genitourinary** – Denies urinary frequency, hematuria, or changes in urination.

**Neurological** – Denies headaches or dizziness.

**Musculoskeletal** – Denies trauma/injuries or decreased movement

**Hematologic** – Denies any bruising or abnormal bleeding.

Vital Signs

<b>Vitals</b>	<b>11:10 AM</b>
<b>BP</b>	90/55 mmHg
<b>P</b>	112 bpm
<b>RR</b>	24 breaths/min
<b>T (rectal)</b>	98.4 F
<b>O2 Sat</b>	99% on room air

**Height:** 33 in | **Weight:** 11.2 kg | **BMI:** 16.3

Physical Exam

**General:** Patient is well-appearing, playful, in no acute distress

**Skin:** Diffuse erythematous maculopapular rash noted on the trunk and back. No vesicles, pustules, petechiae, or purpura. No mucosal involvement. Skin warm and intact.

**HEENT:** Head normocephalic and atraumatic. PERRL. Conjunctiva pink without injection. Mucous membranes moist. Oropharynx clear without erythema or lesions. No tenderness with manipulation of the pinna or tragus. Tympanic membranes are erythematous with loss of the cone of light and bulging bilaterally

**Cardiac:** RRR. Radial pulses are 2+ bilaterally. No murmurs heard.

**Lungs:** Lungs are clear to auscultation bilaterally without stridor, wheezing, rhonchi, or rales. Normal breathing effort without retractions, belly breathing, or nasal flaring.

**Abdomen:** Abdomen is soft, flat, and nondistended. Bowel sounds are normoactive in all 4 quadrants. There is no abdominal tenderness throughout.

### Assessment

18-month-old male with no significant past medical history presented with an acute onset of diffuse maculopapular rash following recent consumption of amoxicillin therapy for acute otitis media. Patient is afebrile, well-appearing, and hemodynamically stable with no systemic symptoms or mucosal involvement. Presentation is most consistent with a benign drug-related rash or viral exanthem.

### D/Dx

1. Drug Allergic Reaction
  - a. Rationale: Recent exposure to amoxicillin with delayed-onset rash that is maculopapular may appear after starting the antibiotic.
2. Roseola
  - a. Rationale: This condition presents with high fever that resolves suddenly within 3 days, followed by a fine, pink maculopapular rash starting on the trunk and spreading to extremities similar to rash seen on exam. Patient was only febrile for 2 days, making this less likely but still possible if fever was very brief or unnoticed at home.
3. Infectious Mononucleosis
  - a. Rationale: Can present with a diffuse maculopapular rash, sometimes after antibiotic exposure (amoxicillin). Usually associated with fever, lymphadenopathy, and pharyngitis. Patient is currently afebrile and without lymphadenopathy or sore throat, so less likely.
4. Contact Dermatitis
  - a. Rationale: Rash appears after exposure to new soaps, detergents, lotions, or environmental irritants. Rash is typically localized that is sometimes pruritic. Mother denies new exposures and the rash distribution is diffuse, making this less likely.
5. SJS/TEN
  - a. Rationale: Caused by delayed hypersensitivity reaction to medications (including antibiotics like amoxicillin) characterized by widespread erythematous or purpuric rash, mucosal involvement, and epidermal detachment. Patient currently has no mucosal involvement, no skin sloughing, and is well-appearing, making SJS/TEN unlikely, but important to rule out.

### Problem Lists & Plan

**Problem:** Acute rash in an infant due to a suspected allergic reaction to amoxicillin & bilateral acute otitis media

#### **Plan**

- Discontinue any remaining amoxicillin (already completed course)

- Initiate azithromycin suspension 200 mg/5 mL: 3 mL PO once on Day 1 (given in the ED), then 1.5 mL PO once daily on Days 2–5 for bilateral acute otitis media
- Supportive care for rash and AOM: ensure adequate hydration, maintain comfort, use acetaminophen or ibuprofen PRN for any pain or fever
- Educate parents on warning signs: fever, worsening rash, lips/tongue involvement, facial swelling, difficulty breathing, persistent ear pain, or irritability
- Follow up with pediatrician within 1–2 days for reassessment of rash and ear exam
- Return to ED if any symptoms worsen or new systemic signs develop

#### Labs/Imaging Results

**COVID/Flu/RSV Liat** – all negative

#### Disposition

Patient is stable to be discharged home. Parents were educated on the likely nature of the rash and advised on supportive care and ED return precautions. Follow-up with the primary pediatrician is recommended.