## 2023 QuickREF

**Learning Objective 03—Short Stature > Quickpoints:**
**Page 115**

| *Text currently reads:* | *Text should read:* |
|---|---|
| **Evaluate**<br>• Initial evaluation of short stature includes:<br>○ Family history—including midparental height (MPH)<br>○ Physical evaluation:<br>– Calculating MPH<br>• Males: [(paternal height) + (maternal height + 13 cm)]/2<br>• Females: [(maternal height) + (**parental** height – 13 cm)]/2 | **Evaluate**<br>• Initial evaluation of short stature includes:<br>○ Family history—including midparental height (MPH)<br>○ Physical evaluation:<br>– Calculating MPH<br>• Males: [(paternal height) + (maternal height + 13 cm)]/2<br>• Females: [(maternal height) + (**paternal** height – 13 cm)]/2 |

**Learning Objective 07—Infant HIV Exposure > Quickpoints:**
**Page 75**

| *Text currently reads:* | *Text should read:* |
|---|---|
| **Manage**<br>• Infant born to mother who is HIV-infected:<br>○ 4–6 weeks zidovudine therapy<br>○ **Zidovudine + nevirapine** if no prenatal antiretroviral therapy (ART)<br>○ Avoid breastfeeding if formula and safe water are available<br>○ Breastfeeding mothers should continue ART<br>○ Pneumocystis jiroveci pneumonia (PJP) prophylaxis with TMP-SMX or alternative | **Manage**<br>• Infant born to mother who is HIV-infected:<br>○ 4–6 weeks zidovudine therapy<br>○ **3-drug antiretroviral regimen if mother received** no prenatal antiretroviral therapy (ART)<br>○ Avoid breastfeeding if formula and safe water are available<br>○ Breastfeeding mothers should continue ART<br>○ Pneumocystis jiroveci pneumonia (PJP) prophylaxis with TMP-SMX or alternative |

**Learning Objective 07—Infant HIV Exposure > Topic Summary:**
**Page 76**

| *Text currently reads:* | *Text should read:* |
|---|---|
| Infants born to women who are HIV-positive and who received ART require 4–6 weeks of zidovudine therapy. Infants born to mothers who have not received ART are **given nevirapine (3 doses in the first week of life) in addition to zidovudine**. | Infants born to women who are HIV-positive and who received ART require 4–6 weeks of zidovudine therapy. Infants born to mothers who have not received ART are **put on a 3-drug antiretroviral regimen**. |

**Learning Objective 13—Acne Management > Quickpoints:**
**Page 1**

| *Text currently reads:* | *Text should read:* |
|---|---|
| • Other treatment options include:<br>  ○ Oral contraceptives<br>  – Approved for the management of acne in females<br>  – Only certain formulations of **ethinyl estradiol/drosperinone or ethinyl estradiol/norethindrone** | • Other treatment options include:<br>  ○ Oral contraceptives<br>  – Approved for the management of acne in females<br>  – Only certain formulations of **ethinyl estradiol/drospirenone, ethinyl estradiol/norethindrone, or ethinyl estradiol/norgestimate** |

**Learning Objective 13—Acne Management > Topic Summary:**
**Page 2**

| *Text currently reads:* | *Text should read:* |
|---|---|
| Additionally, some oral contraceptives are approved for the management of acne in females—certain formulations of **ethinyl estradiol/drosperinone or ethinyl estradiol/norethindrone**. | Additionally, some oral contraceptives are approved for the management of acne in females—certain formulations of **ethinyl estradiol/drospirenone, ethinyl estradiol/norethindrone, or ethinyl estradiol/norgestimate.** |

**Learning Objective 15—Catch-Up Immunization Schedule > Topic Summary:**
**Page 9**

| *Text currently reads:* | *Text should read:* |
|---|---|
| For pneumococcal conjugate vaccine (**PCV13**), healthy children 12–23 months of age who are not previously vaccinated should receive 2 doses separated by at least 8 weeks. Healthy children 2–5 years of age who are not previously vaccinated with **PCV13** should receive a single dose. See Table 1 on pages 10–12 for number of vaccines and minimal intervals based on age of administration of first dose. | For pneumococcal conjugate vaccine (**PCV13 or PCV15**), healthy children 12–23 months of age who are not previously vaccinated should receive 2 doses separated by at least 8 weeks. Healthy children 2–5 years of age who are not previously vaccinated with **PCV13 or PCV15** should receive a single dose. See Table 1 on pages 10–12 for number of vaccines and minimal intervals based on age of administration of first dose. |

**Learning Objective 15—Catch-Up Immunization Schedule > Topic Summary > Table 1:**
**Page 10**

*Text currently reads:*

**Table 1: Recommended Catch-Up Immunization Schedule for Children and Adolescents**

Children Age 4 Months Through 6 Years

| Vaccine | Minimum Age for Dose 1 | Minimum Interval Between Doses | | | |
|---|---|---|---|---|---|
| | | Dose 1 to Dose 2 | Dose 2 to Dose 3 | Dose 3 to Dose 4 | Dose 4 to Dose 5 |
| Hepatitis B | Birth | 4 weeks | **8 weeks and ≥ 16 weeks after 1st dose**<br>Minimum age for final dose: 24 weeks. | | |
| Rotavirus | 6 weeks<br>Maximum age for **final** dose: 14 weeks, 6 days | 4 weeks | **4 weeks**<br>Maximum age for final dose: 8 months, 0 days. | | |

*Text should read:*

**Table 1: Recommended Catch-Up Immunization Schedule for Children and Adolescents**

Children Age 4 Months Through 6 Years

| Vaccine | Minimum Age for Dose 1 | Minimum Interval Between Doses | | | |
|---|---|---|---|---|---|
| | | Dose 1 to Dose 2 | Dose 2 to Dose 3 | Dose 3 to Dose 4 | Dose 4 to Dose 5 |
| Hepatitis B | Birth | 4 weeks | **8 weeks and ≥ 16 weeks after 1st dose**<br>Minimum age for final dose: 24 weeks. | | |
| Rotavirus | 6 weeks<br>Maximum age for first dose: 14 weeks, 6 days | 4 weeks | **4 weeks**<br>Maximum age for final dose: 8 months, 0 days. | | |

**Learning Objective 31—Primary Immunodeficiency Disorders > Resource**
**Page 108**

| *Text currently reads:* | *Text should read:* |
|---|---|
| **Parente P, Pastore M, et al. Very early onset-IBD: Evidence for the need of a multidisciplinary approach.**<br>**Pathologica. 2022 114(1):3-11.**<br>**https://doi.org/10.32074/1591-951X-336** | ~~Parente P, Pastore M, et al. Very early onset-IBD: Evidence for the need of a multidisciplinary approach.~~<br>~~Pathologica. 2022 114(1):3-11.~~<br>~~https://doi.org/10.32074/1591-951X-336~~<br>incorrect reference |

**Featured Reading—Asthma Management > Quickpoints:**
**Page 141**

| *Text currently reads:* | *Text should read:* |
|---|---|
| **Know**<br>• Strong recommendations:<br>○ Fractional exhaled nitric oxide (FeNO)—indirectly measures inflammation in the airway:<br>– Should not be used to predict the future development of asthma in children < 5 years of age with recurrent wheezing<br>– Children ≥ 5 years of age<br>• Should not be used in isolation to assess asthma control, predict future exacerbations, or assess exacerbation severity<br>• If used, it should be as part of an ongoing monitoring and management strategy<br>○ SMART (Single Maintenance And Reliever Therapy)—treatment with inhaled corticosteroids (ICS) + formoterol (long-acting $\beta_2$-agonist) in single inhaler for both daily and **rescue** therapy<br>– Recommended for individuals ≥ 4 years of age with moderate to severe persistent asthma<br>• Superior to<br>○ Higher-dose ICS as daily controller therapy and short-acting $\beta_2$-agonist (SABA) for quick-relief therapy or<br>○ Same-dose ICS-LABA (long-acting $\beta_2$-agonist) as daily controller therapy and SABA for quick-relief therapy | **Know**<br>• Strong recommendations:<br>○ Fractional exhaled nitric oxide (FeNO)—indirectly measures inflammation in the airway:<br>– **May be used to support an asthma diagnosis at any age if the diagnosis is uncertain despite the use of history, physical exam, and spirometry**<br>– Should not be used to predict the future development of asthma in children < 5 years of age with recurrent wheezing<br>– Children ≥ 5 years of age<br>• Should not be used in isolation to assess asthma control, predict future exacerbations, or assess exacerbation severity<br>• If used, it should be as part of an ongoing monitoring and management strategy<br>○ SMART (Single Maintenance And Reliever Therapy)—treatment with inhaled corticosteroids (ICS) + formoterol (long-acting $\beta_2$-agonist) in single inhaler for both daily and **quick-relief** therapy<br>– Recommended for individuals ≥ 4 years of age with moderate to severe persistent asthma<br>• Superior to<br>○ Higher-dose ICS as daily controller therapy and short-acting $\beta_2$-agonist (SABA) for quick-relief therapy or<br>○ Same-dose ICS-LABA (long-acting $\beta_2$-agonist) as daily controller therapy and SABA for quick-relief therapy |

**Featured Reading—Asthma Management > Topic Summary:**
**Page 141**

| *Text currently reads:* | *Text should read:* |
|---|---|
| There is a limited role for fractional exhaled nitric oxide (FeNO) in the management of asthma. Nitric oxide in exhaled breath indirectly measures inflammation in the airway. The panel gives the following strong recommendations regarding its use:<br>• Nitric oxide in exhaled breath should also not be used to predict the future development of asthma in children < 5 years of age with recurrent wheezing. | There is a limited role for fractional exhaled nitric oxide (FeNO) in the management of asthma. Nitric oxide in exhaled breath indirectly measures inflammation in the airway. The panel gives the following strong recommendations regarding its use:<br>• **Nitric oxide in exhaled breath may be used to support an asthma diagnosis at any age if the diagnosis is uncertain despite the use of history, physical exam, and spirometry.**<br>• **It** should also not be used to predict the future development of asthma in children < 5 years of age with recurrent wheezing. |