

## How to Use the Mobile App

The AAP Books Reader is the mobile application that allows users to download their AAP eBooks for offline reading on Apple and Android tablets and smartphones. It is a free app available in [iTunes](#) and [Google Play](#) app stores.

### Technical Specifications:

Minimum Version: [iOS 6.0](#) | [Android 4.0](#)

Storage Space: 8 MB (plus the size of the eBooks)

Includes Kindle Fire, Nook Touch, Kobo, and other Android eReaders with installation of apps from unknown sources enabled in device Settings.

### How to Log in:

The app is free, but a login is required to see and download titles. There is no device limit per login, and users can also log in online.

- AAP members and shopAAP purchasers: Log in using your regular AAP account.
- Institutional users: Use the information provided by your institution.
- Purchasers from the previous app: Log in at <http://shop.aap.org/account/my-digital-library> to see if your titles migrated automatically. If not, use the Don't See Your eBooks link on this page to enter your login from the old platform and synchronize your accounts. If this does not work, contact [mcc@aap.org](mailto:mcc@aap.org) to obtain an AAP account and add your past purchases.

Once you log in, you will see your Bookshelf.

### Downloading and Managing Your eBooks

Tap Cloud to see all titles on your account; Tap Device for only the ones you have downloaded.

For downloaded titles, tap to open or long-tap to remove from your device (they will remain on your account and Cloud screen).



If titles on your account are missing from the Cloud screen, tap the Synchronization arrow.

Tap the magnifying glass to search by author, title, etc.

Tap the Account icon to log out. This will delete download titles from your device.

Titles you have not yet downloaded will appear with a cloud icon. Tap the cover to download, long-tap to get information.

Titles you have downloaded but not opened will appear with a New banner.

### Reading Your eBooks

Swipe left/right to advance pages. Tap the screen for navigation options.

## Apple (iOS) Navigation

Tap the back arrow that looks like a bookshelf to return to your library.

For iPad, tap the split screen icon and for iPhone, tap the bulleted list icon at the bottom left to view the Table of Contents and bookmarked pages.

See highlights and notes when tap the four-cube icon at the bottom right.

Swipe or tap along the bottom panel of pages or scroll up and down.

iPad TOC:

The screenshot shows the iPad interface for the book 'Pediatric Clinical Practice Guidelines & Policies'. On the left is a 'Table of Contents' (TOC) with a list of chapters and their page numbers. On the right is the book's cover, which features a green background with a DNA helix and the text 'Pediatric Clinical Practice Guidelines & Policies' and 'A Compendium of Evidence-based Research for Pediatric Practice, 2nd Edition'. A starburst graphic on the cover says 'eBook Access Included!'. At the bottom of the iPad screen, there is a dock with several icons, including a blue icon for the book's library.

Chapter	Page
Front Matter	1
Section 1 Clinical Practice Guidelines from the...	20
Attention-Deficit/Hyperactivity Disorder	24
Brief Resolved Unexplained Events	116
Bronchiolitis	158
The Diagnosis, Management, and... Bronchiolitis Clinical Practice Guideline...	160
Diabetes	194
Dysplasia of the Hip	220
Febrile Seizures	236
High Blood Pressure	256
Hyperbilirubinemia	334
Management of Hyperbilirubinemia in... Hyperbilirubinemia Clinical Practice...	336
Hemangiomas	358
Clinical Practice Guideline for the... Infantile Hemangiomas Clinical Practice... Intravenous	362

iPhone TOC:

The screenshot shows the iPhone interface for the book 'Pediatric Clinical Practice Guidelines & Policies'. On the left is the book cover, which is smaller than the iPad version. On the right is the 'Table of Contents' (TOC) with a list of chapters and their page numbers. At the bottom of the iPhone screen, there is a dock with several icons, including a blue icon for the book's library, which is highlighted with a red box.

Chapter	Page
Front Matter	1
Section 1 Clinical Practice Guidelin...	20
Attention-Deficit/Hyperactivity...	24
Clinical Practice Guideline for...	26
Attention-Deficit/Hyperactivit...	96
Brief Resolved Unexplained Eve...	116
Brief Resolved Unexplained E...	118
Brief Resolved Unexplained...	150
Brief Resolved Unexplained...	154
Bronchiolitis	158
The Diagnosis, Management...	160
Bronchiolitis Clinical Practice...	190

For bookmarking:

- Open the Reader
- Tap on the bottom left blue icon
- Tap on the bookmark page
- Tap on the (+) icon to bookmark the page

The screenshot shows the iPhone 'Bookmarks' page. At the top, it says 'Bookmarks Done'. Below that is a list of bookmarked pages: 'Page 1', 'Page IV', and 'Page 563'. At the bottom right of the page, there is a blue '+' icon and an 'Edit' link.

Long-tap to highlight or add notes. You can drag over an area to determine what to highlight.

Hyperlinks will open in an in-app browser which you can close to return to reading.

The screenshot shows a chapter page from the book 'Medical Genetics in Pediatric Practice'. The page title is 'Section 3: Genetic Testing' and 'Chapter 10: Overview of Genetic Testing'. The author is 'Sarah L. Dugan, MD'. The page contains an 'Introduction' section with text about genetic abnormalities and diagnostic techniques. There are several highlighted areas in yellow, including the title, author name, and the end of the introduction. A blue box highlights the text 'Metabolic testing (including mitochondrial testing and dried blood spot newborn screening) is covered in Chapters 7 and 17.'.

# Android (Google) Navigation

- Tap the back arrow to return to your Bookshelf.
- Tap the magnifying glass to search within the title.
- Tap the file/gear icon for page view settings.
- Tap the pencil icon to add annotation/notes.

Tap the thumbnail view icon to navigate to pages by thumbnail preview

Tap the table of contents icon to view the Table of Contents, bookmarks or notes

← Outline

- Preface
- Part 1. Pediatric Cardiology in the Office →
- Part 2. Pediatric Cardiology in the Nursery →
- Part 3. Pediatric Cardiology in the Emergency Department →
- Part 4. Pediatric Cardiology in the Pediatric Intensive Care Unit →
- Index

Chapter 10. A New Murmur and Risk 71

**Figure 10.2.** Two-dimensional and color flow Doppler echocardiograms in the long-axis view. Panel A demonstrates a mild regurgitant jet (red jet) and P16 flutter. The color flow Doppler flow (color flow Doppler echocardiogram) during diastole in systole (not shown), there is also mild mitral regurgitation (MR), severe tricuspid regurgitation (TR), left atrial (LA) and right ventricular (RV) dilatation.

Because of the fever, rash, arthralgia, prolonged PR interval (first degree heart block), and cardiac involvement, you suspect that rheumatic fever (RF) is the most likely diagnosis, and you order antistreptolysin O (ASO) and antistreptolysin O (ASO) titers, a rapid strep test, and a throat culture. The rapid strep test is negative. The initial antistreptolysin O titer is elevated.

**Treatment**

After fulfilling the Jones criteria (major criteria: carditis and erythema marginatum; minor criteria: fever, arthralgia, prolonged PR interval, and elevated acute phase reactant levels) and establishing a diagnosis of acute RF,

Box 10.1. Summary of Jones Criteria	
Major Criteria	Minor Criteria
Carditis (clinical or subclinical)	Fever
Polyarthralgia	Arthralgia
Chorea	Elevated acute phase reactant levels (erythrocyte sedimentation rate, C reactive protein level)
Subcutaneous nodules	Prolonged PR interval on an electrocardiogram
Erythema marginatum	

Evidence of a preceding group A streptococcal infection

- Positive throat culture or rapid strep test
- Elevated or increasing antibody titer

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**71 Challenging Cases in Pediatric Cardiology**

In consultation with your pediatric cardiologist, you begin treating the patient with rest and anti-inflammatory medications. The patient has moderate carditis and receives 2 mg/kg/d of prednisone, in addition to 500 mg of penicillin V 3 times per day.

**Discussion**

The presence of a new diastolic murmur is pathological and limits the diagnosis to RF, endocarditis, or systemic lupus erythematosus. There is no family history of rheumatologic conditions. Clinical findings suggest the patient has RF; however, his ill appearance and new murmur could indicate endocarditis. Carditis is present in approximately 30% to 70% of patients with RF and is associated with clinically significant long-term morbidity and mortality. In acute rheumatic carditis, most patients develop isolated mitral regurgitation. Approximately 25% of patients have aortic valve involvement in association with mitral regurgitation. Isolated aortic valvular regurgitation is uncommon. Valvular regurgitation can be caused by a combination of verrucous vegetations on the valve leaflets, valvular prolapse, annular dilatation, chordal elongation, and even flail leaflets. The vegetations associated with RF are often not visible at echocardiography, although the valve leaflets may appear thickened. Pericarditis also may develop in patients with acute RF.

The advent of color flow Doppler echocardiography has made possible the diagnosis of aortic valve regurgitation. The presence of aortic valve regurgitation in the absence of other cardiac evidence is recurrent evidence of RF in a patient without chronic rheumatic heart disease also requires fulfillment of the Jones criteria. However, in patients with chronic rheumatic heart disease, only a minor criteria plus evidence of a preceding group A streptococcal (GAS) infection is needed to establish the diagnosis of RF recurrence. Also, the presence of chorea, without other symptoms, can establish the diagnosis of RF. Evaluating for a history of a recent GAS infection requires performing a rapid strep test, throat culture, and antibody testing. Elevated or increasing antibody titers are very reliable markers of a preceding GAS infection because the antibody response typically peaks at 1 to 4 weeks. Antistreptolysin O and antideoxyribonuclease B are the most commonly measured titers. More than 90% of patients with RF have a positive result in 1 titer when both are measured simultaneously.

Anti-inflammatory medications are the mainstay for treating acute RF to provide symptom relief; however, there is limited and conflicting evidence of their

**72 Challenging Cases in Pediatric Cardiology**

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**Discussion**

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The advent of color flow Doppler echocardiography has made possible the diagnosis of subclinical degrees of valvular regurgitation. Recent changes in the Jones criteria now provide guidance on diagnosing subclinical carditis by means of echocardiography alone (without physical findings). Evidence of carditis on an echocardiogram is now sufficient to establish the diagnosis, in the absence of other clinical evidence. A recurrent episode of RF in a patient without chronic rheumatic heart disease also requires fulfillment of the Jones criteria. However, in patients with chronic rheumatic heart disease, only 2 minor criteria plus evidence of a preceding group A streptococcal (GAS) infection are needed to establish the diagnosis of RF recurrence. Also, the presence of chorea, without other symptoms, can establish the diagnosis of RF. Evaluating for a history of a recent GAS infection requires performing a rapid strep test, throat culture, and antibody testing. Elevated or increasing antibody titers are very reliable markers of a preceding GAS infection because the antibody response typically peaks at 1 to 4 weeks. Antistreptolysin O and antideoxyribonuclease B are the most commonly measured titers. More than 90% of patients with RF have a positive result in 1 titer when both are measured simultaneously.

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