



ATEŞLİ ÇOCUĞA YAKLAŞIM

Prof. Dr. Ergin ÇİFTÇİ

**Ankara Üniversitesi Tıp Fakültesi
Çocuk Enfeksiyon Hastalıkları Bilim Dalı**

www.erginciftci.com

Prof. Dr. Ergin ÇİFTÇİ

Çocuk Sağlığı ve Hastalıkları Uzmanı
Çocuk Enfeksiyon Hastalıkları Uzmanı

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Anasayfa Özgeçmiş Yayınlar Dersler Bilimsel Toplantılar Bilimsel Dergiler Basın Fotoğraflar Ulaşım Edebiyat Satranç Sinema

Saat

Anasayfa

Beni Takip Et!



Duyurular



Korsanlar Seyir Defteri Tutmaz



Takvim

Aralık 2018						
P	S	Ç	P	C	C	P
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Hava Durumu

Anlık Yarın

3° 11° 1°

Ankara



Prof. Dr. Ergin ÇİFTÇİ

Çocuk Sağlığı ve Hastalıkları Uzmanı

Çocuk Enfeksiyon Hastalıkları Uzmanı

John F. Kennedy Caddesi 24/5

(Tunalı Hilmi Caddesi Kavşağı)

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Saat

A. Öğren

A. Öğrenci Dersleri

B. Asistan Dersleri

Ankara Üniversitesi Tıp Fakültesi Dönem 5 ve 6 öğrencileri kendilerine Prof. Dr. Ergin Çiftçi tarafından anlatılan derslerin güncel sunumlarına buradan ulaşabilirler.

DÖNEM 5

1. Çocukluk çağı döküntülü hastalıkları
2. Çocuklarda akut gastroenterit
3. Çocukta ağızdan sıvı tedavisi

DÖNEM 6

1. Dehidrasyon: Vaka temelli interaktif tartışma

Yorumlar - Yorum Yaz

Beni Takip Et!



Duyurular



Korsanlar Seyir Defteri Tutmaz



Agust 2020

Takvim

Aralık 2018						
P	S	Ç	P	C	C	P
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Hava Durumu

Anlık Yarınlık

3° 11° 1°

ATEŞ NEDİR?

Vücut sıcaklığının kontrollü bir biçimde normalin üstüne çıkmasıdır.

TERMOREGÜLASYON

Vücut iç sıcaklığının dengeli bir şekilde sabit tutulmasıdır

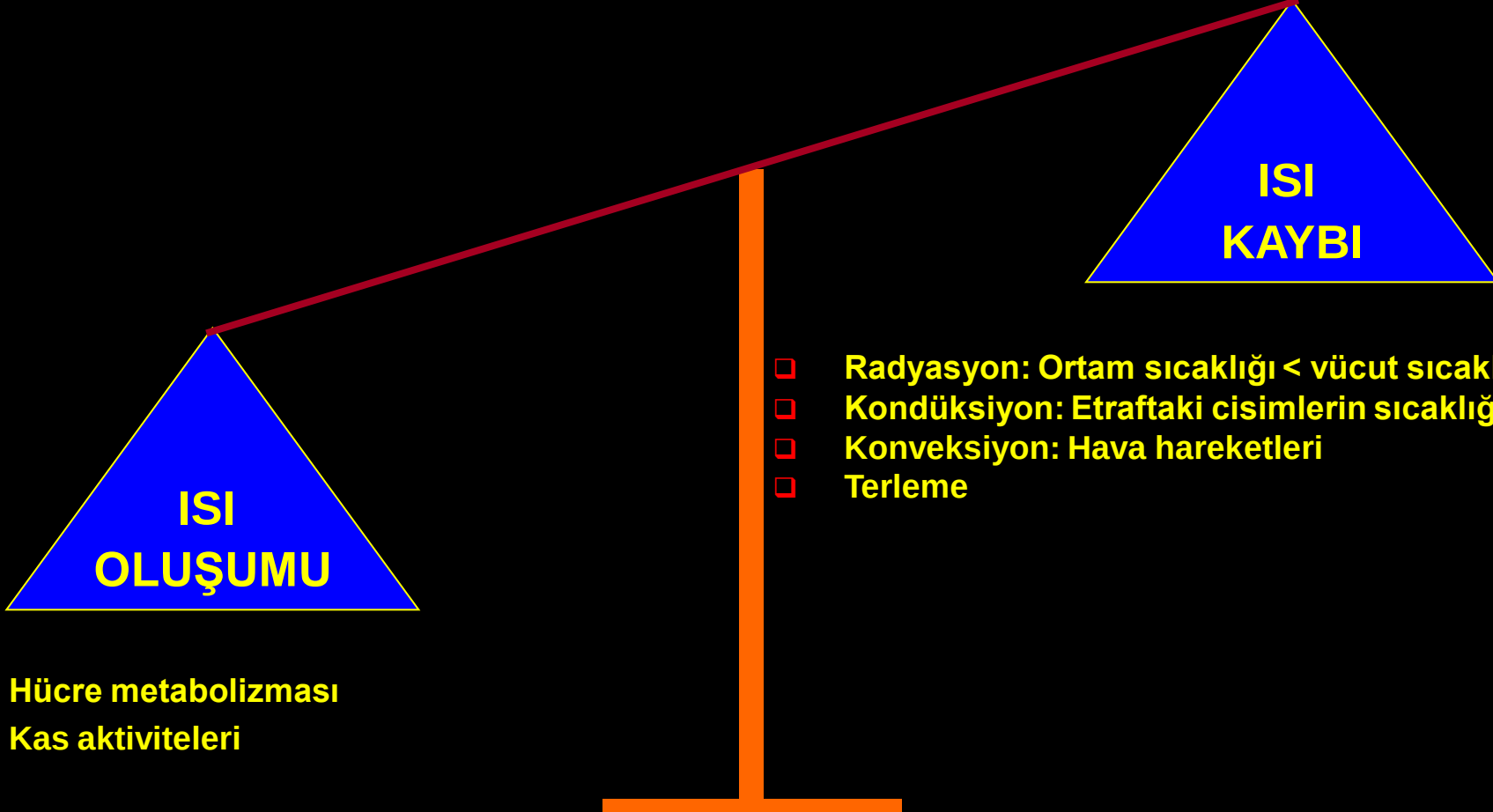


- ❑ Hücre metabolizması
- ❑ Kas aktiviteleri

- ❑ Radyasyon: Ortam sıcaklığı < vücut sıcaklığı
- ❑ Kondüksiyon: Etraftaki cisimlerin sıcaklığı < vücut sıcaklığı
- ❑ Konveksiyon: Hava hareketleri
- ❑ Terleme

ATEŞ

Ateş dengenin ısı oluşumu lehine bozulmasıdır.

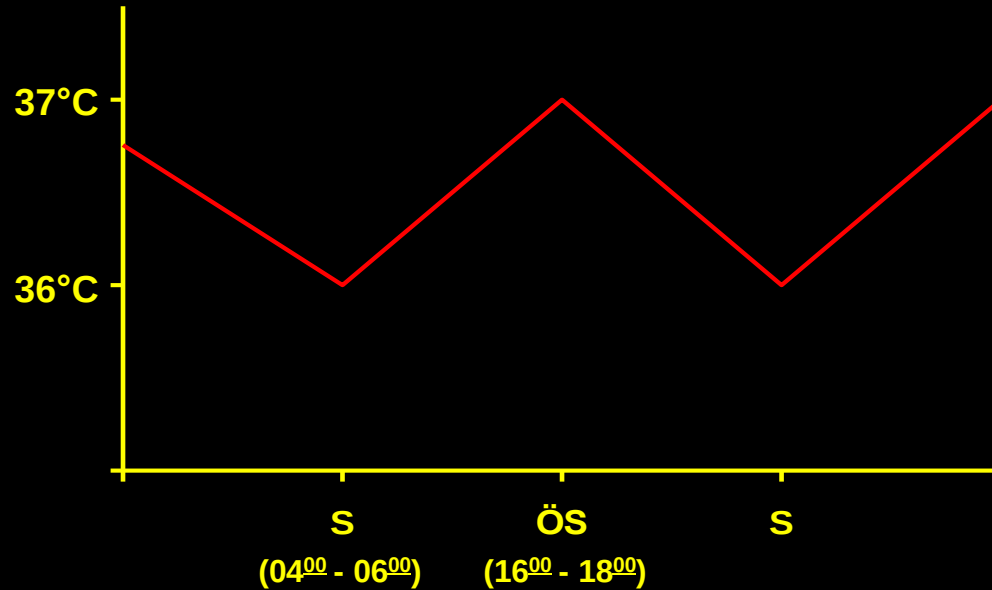


VÜCUT SICAKLIĞININ DİURNAL RİTMİ

Sabah-akşam saatleri arasındaki fark ortalama: $0.9-1.1^{\circ}\text{C}$

İlk 2 yaşta bu fark belirgin değil

6 ay-2 yaş $\rightarrow 0.6^{\circ}\text{C}$ fark



Oğlum
cennete
geldik
galiba!

Kesin
cennetteyiz
lan!

Sıcak.

Ooof
of—



VÜCUT SICAKLIĞININ HANGİ DEĞERLERİN ÜSTÜNE ÇIKMASI ATEŞ OLARAK KABUL EDİLİR?

- Aksiller $> 37.2^{\circ}\text{C}$
- Oral $> 37.8^{\circ}\text{C}$
- Rektal $\geq 38^{\circ}\text{C}$
- Timpanik $> 38^{\circ}\text{C}$ (Rektal mod) $> 37.5^{\circ}\text{C}$ (Oral mod)
- Alın $> 38^{\circ}\text{C}$



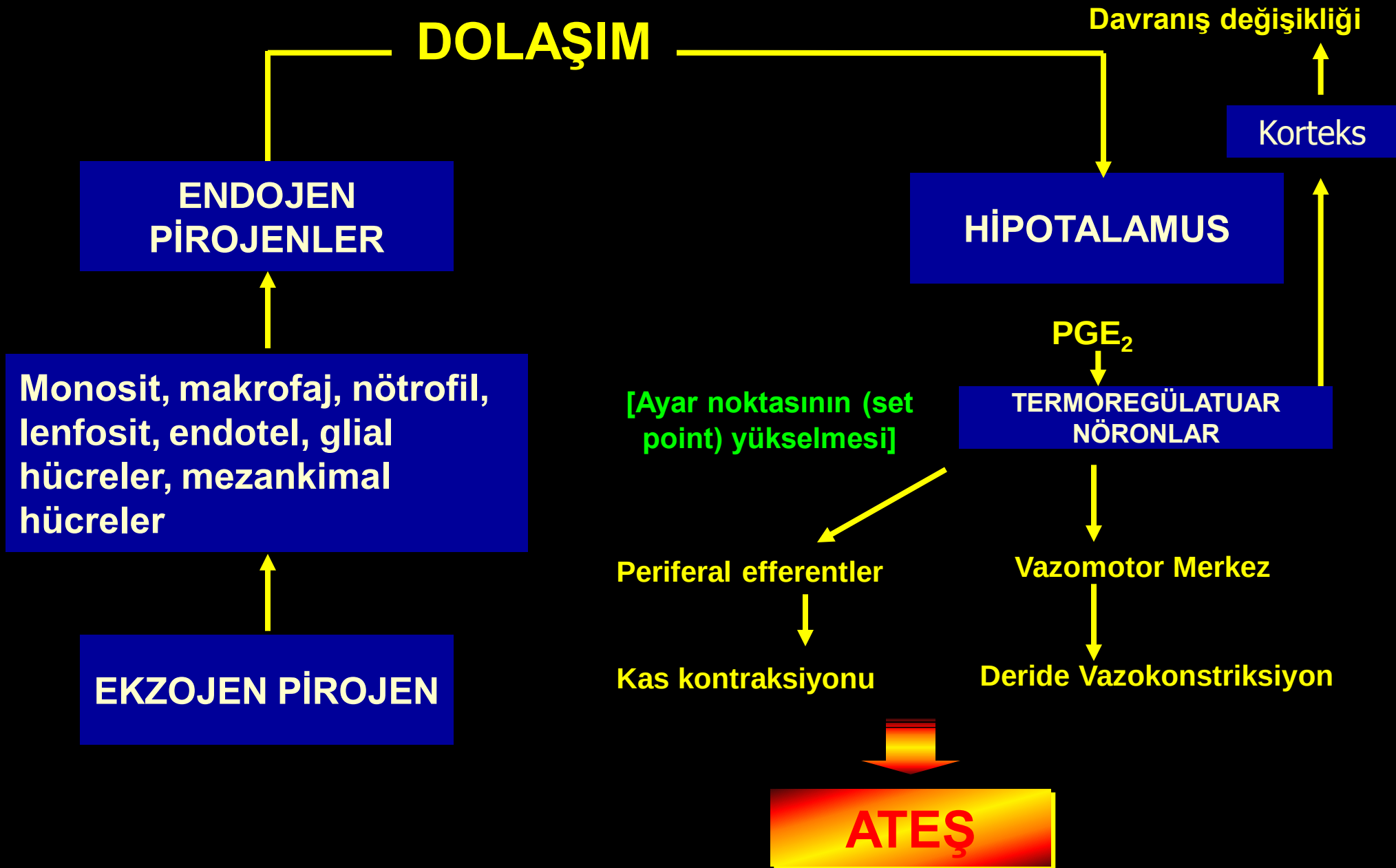
HEMŞİRELİK BÖLÜMÜNDEN
DERECE İLE MEZUN OLDUM.

BALTAYLA MI
MEZUN OLACAKTIN?..
HEMŞİRESİN, DERECEYLE
OLACAN TABİ HAH HAH
HAH!

BANA DAHA İYİ
KALPLI, TATLI Bİ KIZ
LAZIM... BU KÜFREDİYOR

TERMOMETRELER

- 1. Civalı termometre**
- 2. Elektronik termometre**
- 3. Kızıl ötesi kulak termometresi**
- 4. Temassız termometre**
- 5. Plastik termometre**



Ateş, vücudun zararlı etkenlere karşı geliştirdiği adaptif bir yanıttır

Vücut sıcaklığı arttığında;

- 1. İnflamasyon sistemi daha iyi çalışır**
- 2. Mikrobiyal çoğalma hızı azalır**

ATEŞ, ORGANİZMANIN YARARINA İŞLEV GÖRÜR

BU DÜNYAMIZ
CEHENNEMİN TA KENDİSİ
DOSTUM...

Kabullenemedi
bi türlü!



ATEŞİN NEDEN OLDUĞU DEĞİŞİKLİKLER

Metabolik hızda artma

Oksijen tüketimde artma

Karbondiyoksit üretiminde artma

Kardiyak output artışı

Solunum iş yükünde artma

Konvülsiyon eşiğinde düşme



ATEŞİN TEDAVİSİ

DESTEK TEDAVİSİ

Ortam ısısının ayarlanması

İnce ve gevşek giysi giydirilmesi

Bol su verilmesi



ATEŞİN TEDAVİSİ

DESTEK TEDAVİSİ

Ortam ısısının ayarlanması

İnce ve gevşek giysi giydirilmesi

Bol su verilmesi

Yeterli kalori alımının sağlanması

Ilık su ile pansuman ve banyo

Söylee! Nasıl soktun
bunu içeri?!



ATEŞİN TEDAVİSİ

ANTİPİRETİK İLAÇ TEDAVİSİ

Parasetamol 10-15 mg/kg/doz, 4-6 saatte bir

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ANTİPİRETİK İLAÇ TEDAVİSİ

Parasetamol 10-15 mg/kg/doz, 4-6 saatte bir

İbuprofen 5-10 mg/kg/doz, 6-8 saatte bir

ATEŞİN TEDAVİSİ

ANTİPİRETİK İLAÇ TEDAVİSİ

Parasetamol 10-15 mg/kg/doz, 4-6 saatte bir

İbuprofen 5-10 mg/kg/doz, 6-8 saatte bir

Ketoprofen

Aspirin

Metamizol

Nimesulid



ATEŞİN TEDAVİSİ

NEDENE YÖNELİK TEDAVİ

Enfeksiyonun tedavisi

Hastalığa özgü tedavi

ODAĞI BİLİNMEYEN AKUT ATEŞ

ATEŞLİ HASTA

Odak belli

Anamnez ve fizik muayene

Odak belli değil

Tedavi

Ciddi bakteriyel enfeksiyon yönünden risk taşıyor mu?

Toksik görünüm

**Yaş
Altta yatan hastalık**

**Laboratuvar
incelemeleri**

TOKSİK GÖRÜNÜM

Bilinç değişikliği

Etrafa ilgisizlik

Letarji

İrritabilite

Anneyi tanımama

Teskin edilemeyen ağlama

Beslenme bozukluğu

Emmeme

Kusma

Taşikardi ve takipne, periferik dolaşım bozukluğu

Deride kirli-gri renk, cutis marmoratus

Peteşiyal döküntü

Titremeye yükselen ateş

Ateş $\geq 40^{\circ}\text{C}$

Yenidoğan reflekslerinde azalma

RİSK GRUPLARI

YAŞ

<1 ay bebekler

1-3 ay arası bebekler

3-36 ay arası bebekler

ALTTA YATAN HASTALIK

Ağır beslenme bozukluğu

Orak hücre anemisi

Aspleni

İmmun yetmezlik

Konjenital kalp hastalığı

Nötropenik hastalar

Malignite

Santral ven kateteri - İdrar sondası vs.

Total parenteral beslenme uygulanan hastalar

Geniş spektrumlu antibiyotik kullanan hastalar

CİDDİ BAKTERİYEL ENFEKSİYON RİSKİNE İŞARET EDEN LABORATUVAR BULGULARI

TKS ve formül

BK: $<5.000 - >15.000/\text{mm}^3$

Çomak sayısı: $>1.500/\text{mm}^3$

Band/Total nötrofil: >0.2

Tam idrar incelemesi

BK $>10/\text{HPF}$

Lökosit esteraz pozitifliği

Nitrit pozitifliği

İdrar kültürü $\pm$ (Erkek < 6 ay, sünnetsiz erkek < 24 ay, bütün kızlar, TİYE

Akciğer grafisi $\pm$ (Solunum sistemi semptomu varsa)

Dışkı incelemesi $\pm$ (İshal varsa)

BK $>5/\text{HPF}$

BOS incelemesi $\pm$ (Değerlendirme güçlüğü veya şüphe varsa)

BK $>5-10/\text{mm}^3$

CİDDİ BAKTERİYEL ENFEKSİYON RİSKİNE İŞARET EDEN LABORATUVAR BULGULARI

BOSTON CRITERIA

Infants are at low risk if they appear well, have a normal physical examination, and have a caretaker reachable by telephone and if laboratory tests are as follows:

- CBC: $<20,000$ WBC/ μ L
- Urine: negative leukocyte esterase
- CSF: leukocyte count less than $10 \times 10^6/L$

ROCHESTER CRITERIA

Infants are at low risk if they appear well and have a normal physical examination and if laboratory findings are as follows:

- CBC: 5,000-15,000 WBC/ μ L; absolute band count $\leq 1,500/\mu$ L
- Urine: <10 WBC/HPF at 40x
- Stool: <5 WBC/HPF if diarrhea

PITTSBURGH GUIDELINES

Infants are at low risk if they appear well and have a normal physical examination and if laboratory tests are as follows:

- CBC: 5,000-15,000 WBC/ μ L; peripheral absolute band count $<1,500/\mu$ L
- Urine (enhanced urinalysis): 9 WBC/ μ L and no bacteria on Gram stain
- CSF: 5 WBC/ μ L and negative Gram stain; if bloody tap, then WBC:RBC $\leq 1:500$
- Chest radiograph: no infiltrate
- Stool: 5 WBC/HPF with diarrhea

PHILADELPHIA PROTOCOL

Infants are at low risk if they appear well and have a normal physical examination and if laboratory tests are as follows:

- CBC: $<15,000$ WBC/ μ L; band: total neutrophil ratio <0.2
- Urine: <10 WBC/HPF; no bacteria on Gram stain
- CSF: <8 WBC/ μ L; no bacteria on Gram stain
- Chest radiograph: no infiltrate
- Stool: no RBC; few to no WBC

GİZLİ BAKTERİYEMİ

Genel durumu iyi görünen bir çocukta, sıklıkla bakteriyemi ile seyreden bir enfeksiyon olmadan, pozitif kan kültürü olmasıdır.

En sık görüldüğü yaş grubu 0-36 aydır

Ateşin yükseklik derecesi arttıkça sıklığı artar

Riskli ateş (Rektal): 3 aydan küçük bebekler için $\geq 38^{\circ}\text{C}$
3-36 ay arası bebekler için $\geq 39^{\circ}\text{C}$

GİZLİ BAKTERİYEMİ

ALIŞILMIŞ ETKENLER

Streptococcus pneumoniae

Neisseria meningitidis

Haemophilus influenzae Tip b

Salmonella spp.

Staphylococcus aureus

< 3 AY BEBEKLER

B grubu Streptokoklar

Listeria monocytogenes

Enterik Gram (-) basiller

GİZLİ BAKTERİYEMİ

Kendiliğinden düzelebilir.

S. pneumoniae: %30-40

H. influenzae: %5

Lokal bir enfeksiyon biçimine dönüşebilir.

Menenjit, septik artrit, osteomyelit, pnömoni...

Sebat edebilir.

Sepsis (SIRS) şekline dönüşebilir.

GROUP	MANAGEMENT
Any toxic-appearing child 0-36 mo and temperature $\geq 38^{\circ}\text{C}$ (100.4°F)	Hospitalize, broad cultures plus other tests,* parenteral antibiotics
Child <1 mo and temperature $\geq 38^{\circ}\text{C}$ (100.4°F)	Hospitalize, broad cultures plus other tests,* parenteral antibiotics
Child 1-3 mo and temperature $\geq 38^{\circ}\text{C}$ (100.4°F)	Two-step process - Determine risk based on history, physical examination, and laboratory studies. Low risk: - Uncomplicated medical history - Normal physical examination - Normal laboratory studies - Urine: negative leukocyte esterase, nitrite and <10 WBC/HPF - Peripheral blood: $5,000$-$15,000$ WBC/mm^3; $<1,500$ bands or band: total neutrophil ratio <0.2 - Stool studies if diarrhea (no RBC and <5 WBC/HPF) - CSF cell count (<8 WBC/μL) and negative Gram stain - Chest radiograph without infiltrate - If child fulfills all low-risk criteria, administer no antibiotics, ensure follow-up in 24 hr and access to emergency care if child deteriorates. Daily follow-up should occur until blood, urine, and CSF cultures are final. If any cultures are positive, child returns for further evaluation and treatment. If child does not fulfill all low-risk criteria, hospitalize and administer parenteral antibiotics until all cultures are final and definitive diagnosis determined and treated
Child 3-36 mo and temperature 38 - 39°C (100.4 - 102.2°F)	Reassurance that diagnosis is likely self-limiting viral infection, but advise return with persistence of fever, temperatures $>39^{\circ}\text{C}$ (102.2°F), and new signs and symptoms
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Child 3-36 mo and temperature $>39^{\circ}\text{C}$ (102.2°F)	Two-step process: - Determine immunization status - If received conjugate pneumococcal and <i>Haemophilus influenzae</i> type b vaccines, obtain urine studies (urine WBC, leukocyte esterase, nitrite, and culture) for all girls, all boys <6 mo old, all uncircumcised boys <2 yr, all children with recurrent urinary tract infections If did not receive conjugate pneumococcal and <i>H. influenzae</i> type b vaccines, manage according to the 1993 Guidelines (see Baraff et al. <i>Ann Emerg Med</i> 22:1198-1210, 1993.)

*Other tests may include chest radiograph, stool studies, herpes simplex polymerase chain reaction.
CSF, cerebrospinal fluid; HPF, high-powered field; RBC, red blood cell; WBC, white blood cell.

Practice guideline for the management of infants and children 0 to 36 months of age with fever without source. Agency for Health Care Policy and Research.

Baraff LJ¹, Bass JW, Fleisher GR, Klein JO, McCracken GH Jr, Powell KR, Schriger DL.

+ Author information

Erratum in

Ann Emerg Med 1993 Sep;22(9):1490.

Abstract

STUDY OBJECTIVE: To develop guidelines for the care of infants and children from birth to 36 months of age with fever without source.

PARTICIPANTS AND SETTING: An expert panel of senior academic faculty with expertise in pediatrics and infectious diseases or emergency medicine.

DESIGN AND INTERVENTION: A comprehensive literature search was used to identify all publications pertinent to the management of the febrile child. When appropriate, meta-analysis was used to combine the results of multiple studies. One or more specific management strategies were proposed for each of the decision nodes in draft management algorithms. The draft algorithms, selected publications, and the meta-analyses were provided to the panel, which determined the final guidelines using the modified Delphi technique.

RESULTS: All toxic-appearing infants and children and all febrile infants less than 28 days of age should be hospitalized for parenteral antibiotic therapy. Febrile infants 28 to 90 days of age defined at low risk by specific clinical and laboratory criteria may be managed as outpatients if close follow-up is assured. Older children with fever less than 39.0 C without source need no laboratory tests or antibiotics. Children 3 to 36 months of age with fever of 39.0 C or more and whose WBC count is 15,000/mm³ or more should have a blood culture and be treated with antibiotics pending culture results. Urine cultures should be obtained from all boys 6 months of age or less and all girls 2 years of age or less who are treated with antibiotics.

CONCLUSION: These guidelines do not eliminate all risk or strictly confine antibiotic treatment to children likely to have occult bacteremia. Physicians may individualize therapy based on clinical circumstances or adopt a variation of these guidelines based on a different interpretation of the evidence.

3-36 ay arası

Ateş $\geq 39^{\circ}\text{C}$

Toksik değil

Odak yok

**BK sayısı $\geq 15\ 000/\text{mm}^3$ olan hastalara (veya tüm hastalara?)
1 doz seftriakson yapıp ayaktan izlenir**

KAN KÜLTÜRÜ NEGATİF

Ateş düşmüşse

Genel durumu iyi ise ayaktan takip

KAN KÜLTÜRÜ POZİTİF

Ateş devam ediyor

Hastaneye yatır

Sepsis yönünden değerlendir (BOS dahil)

KAN KÜLTÜRÜ NEGATİF

Ateş devam ediyor

**Yeniden değerlendirilip çocuğun
durumuna göre ayaktan ya da yatarak
izlenmeli**

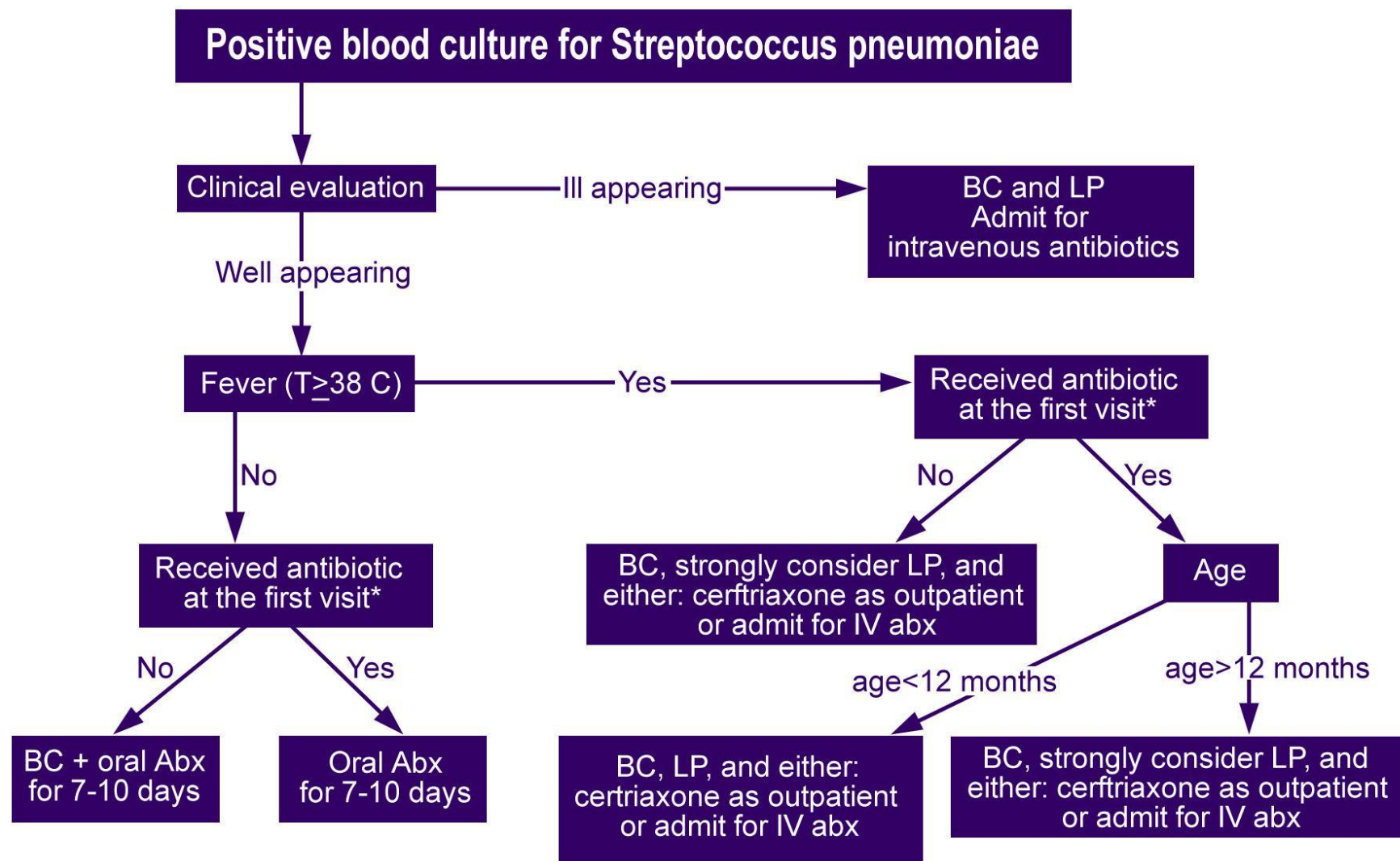
KAN KÜLTÜRÜ POZİTİF

Ateş düşmüş (antipiretik almadan)

**Yeniden değerlendir, gerekirse LP yap,
tekrar kan kültürü al.**

Seftriaksonu sürdür

**Ateş düşük devam ediyor ve diğer
incelemeler normal ise, tedaviyi oral
antibiyotikle 7-10 güne tamamla**



All patients need close follow-up.
Consider obtaining a chest radiograph in any child with cough or respiratory symptoms.

Abbreviations:

Abx= antibiotics

BC= blood culture

LP= lumbar puncture

*Abx given at initial visit with efficacy against *Streptococcus pneumoniae*



NEDENİ BİLİNMEYEN **UZAMIŞ** ATEŞ

İlk kez **1961** yılında Petersdorf ve Beeson

1. En az üç hafta süren
2. Bir hafta süreyle hastanede yapılan incelemelere karşın nedeni belirlenemeyen
3. Belgelenmiş 38.3 °C üzerinde ateş



NEDENİ BİLİNMEYEN UZAMIŞ ATEŞ

TABLE 56-1 Summary of Definitions and Major Features of the Four Subtypes of Fever of Unknown Origin (FUO)

	CLASSIC FUO	NOSOCOMIAL (HEALTH CARE-ASSOCIATED) FUO	NEUTROPENIC (IMMUNE-DEFICIENT) FUO	HIV-RELATED FUO
Definition	>38.3° C (100.9° F), >3 wk, >2 visits or 3 days in hospital	>38.3° C (100.9° F), >3 days, not present or incubating on admission	>38.3° C (100.9° F), >3 days, negative cultures after 48 hr	>38.3° C (100.9° F), >3 wk for outpatients, >3 days for inpatients, HIV infection confirmed

Table 177-4 Summary of Definitions and Major Features of the 4 Subtypes of Fever of Unknown Origin

FEATURE	CLASSIC FUO	HEALTHCARE-ASSOCIATED FUO	IMMUNE-DEFICIENT FUO	HIV-RELATED FUO
Definition	>38°C (100.4°F), >3 wk, >2 visits or 1 wk in hospital	≥38°C (100.4°F), >1 wk, not present or incubating on admission	≥38°C (100.4°F), >1 wk, negative cultures after 48 hr	≥38°C (100.4°F), >3 wk for outpatients, >1 wk for inpatients, HIV infection confirmed

NEDENİ BİLİNMEYEN **UZAMIŞ** ATEŞİN NEDENLERİ

1. **Enfeksiyonlar**
2. **Kollajen-vasküler hastalıklar**
3. **Maligniteler**
4. **Diğer hastalıklar**
5. **Tanı konulamayanlar**



NEDENİ BİLİNMEYEN UZAMIŞ ATEŞ

Çocuklarda Nedenler

YAZAR Hasta sayısı	Enfeksiyonlar	Malignite	KDH	Diğer	Tanı konulamayan
Pizzo 100	%52	%6	%20	%10	%12
McLung 99	%29	%8	%11	%19	%33
Lohr 54	%33	%13	%20	%15	%8
Mouaket 221	%78	%2	%3	%0	%15
Steele 109	%22	%2	%6	%3	%67
Çiftçi 102	%44.2	%11.7	%6.8	%24.5	%12.8

Pyrexia of unknown origin in children: a review of 102 patients from Turkey

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(Accepted July 2003)

Summary Pyrexia of unknown origin (PUO) has not been appropriately investigated in Turkish children and therefore a study was undertaken to determine the causes of PUO and to evaluate which clinical procedures are useful in establishing a diagnosis. A total of 102 children fitting the classical PUO criteria seen in our clinic between 1995 and 2002 were investigated retrospectively. Infections, collagen vascular disorders, malignancy and miscellaneous conditions constituted 44.2%, 6.8%, 11.7% and 24.5% of cases, respectively, while 12.8% of the cases remained undiagnosed. Enteric fever, brucellosis and respiratory tract infections were the most commonly encountered infections, whereas familial Mediterranean fever was the commonest non-infectious disorder. Biopsy, aspiration, serology, bacteriology, radiology and observation of the clinical course were the most useful diagnostic procedures.

NEDENİ BİLİNMEYEN **UZAMIŞ** ATEŞ

İlk kez **1961** yılında Petersdorf ve Beeson

1. En az üç hafta süren
2. Bir hafta süreyle hastanede yapılan incelemelere karşın nedeni belirlenemeyen
3. Belgelenmiş 38.3 °C üzerinde ateş



Ateş $\geq$ 8 Gün

Hasta iyi görünüyor

Evet

Hayır

İLK ETAP

HASTANEYE YATIR

Gereksiz tedavileri kes

Kan sayımı ve formül

BFT, elektrolitler, glukoz

Transaminazlar

İdrar incelemesi

Gerekiyorsa görüntüleme yap

Gözlem ve muayeneye devam et

Gereksiz tedavileri kes

Kan sayımı ve formül

BFT, elektrolitler, glukoz

Transaminazlar

İdrar incelemesi

Gerekiyorsa görüntüleme yap

Gerekiyorsa BOS

CRP bakmayı düşün

Kültürler

Ampirik antibiyotik (kültür sonrası)

Gözlem ve muayeneye devam et

**Ateş düştü
Neden saptandı**

Evet

Hayır

Nedeni tedavi et

Kategorik araştırma yap

Kategorik araştırma yap

ENFEKSİYON

Kültürler
BOS (gerekirse)
Spesifik serolojik test
Spesifik PCR
CRP/ESH (abse, endokardit,
osteomyelit şüphesi varsa)
Görüntüleme (gerekirse)
Amprik antibiyotik
(kültürler alındıktan sonra)

ONKOLOJİ

Ürik asit
LDH
Ferritin
Periferik yayma
Akciğer grafisi
Steroid kesilmesi

OTOİMMÜN-KVH

ANA
RF
C3, C4, CH50
TFT
CRP, ESH, Ferritin

İMMÜN YETMEZLİK

İmmünglobulinler
Lenfosit markerları
Antikorlar (aşılarla karşı)

Neden saptanamadı

Uzmanla danış
Üçüncü basamak merkeze sevk

Kültürleri tekrarla
Ek serolojik testler
Kemik iliği aspirasyonu
Görüntüleme
Kemik sintigrafisi
PET
Gastrointestinal

Common Causes of Pediatric FUO

Infectious			Non-Infectious		
Bacterial	Viral	Other	Oncologic	Autoimmune	Other
Abscess	Adenovirus	Blastomycosis	Leukemia	Behcet Disease	Diabetes
Bartonella	Arbovirus	Cryptosporidium	Lymphoma	Inflammatory Bowel Disease	Insipidus
Brucellosis	Cytomegalovirus	Ehrlichiosis	Langerhans Cell Histiocytosis		Drug Fever
Leptospirosis	Enterovirus	Histoplasmosis	Neuroblastoma	Hyperthyroidism	Factitious Fever
Mastoiditis	Epstein-Barr Virus	Leishmaniasis	Hemophagocytic Lymphohistiocytosis	Granulomatosis (with polyangitis)	Familial Dysautonomia
Mycoplasma	Hepatitis Viruses	Venereum		Juvenile Idiopathic Arthritis	Periodic Fever Syndromes
Osteomyelitis	Herpes Simplex Virus	Malaria			Pancreatitis
Pyelonephritis		Psittacosis			Serum Sickness
Rat Bite Fever	Human	Q Fever		Kawasaki Disease	Cyclic neutropenia
Salmonellosis	Immunodeficiency	Rocky Mountain Spotted Fever		Polyarteritis Nodosa	Kikuchi-Fujimoto Disease
Sinusitis	Virus	Toxoplasmosis		Sarcoidosis	
Tuberculosis	Picornavirus	Visceral larva migrans		Systemic Lupus Erythematosus	
Tularemia				Antiphospholipid Antibody Syndrome	
Non-Tuberculous Mycobacteria				Subacute thyroiditis	

BİZ DE ALDIK
ÇOCUĞU HASTANEYE
GÖTÜRDÜK. 40
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ÇIKMIŞTI!

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