2026–2027 Edition

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- Your shortcut to mastering USMLE Step 2 CK
- Crafted with ultra-concise, high-yield Gems

USMLE 2 GEMS

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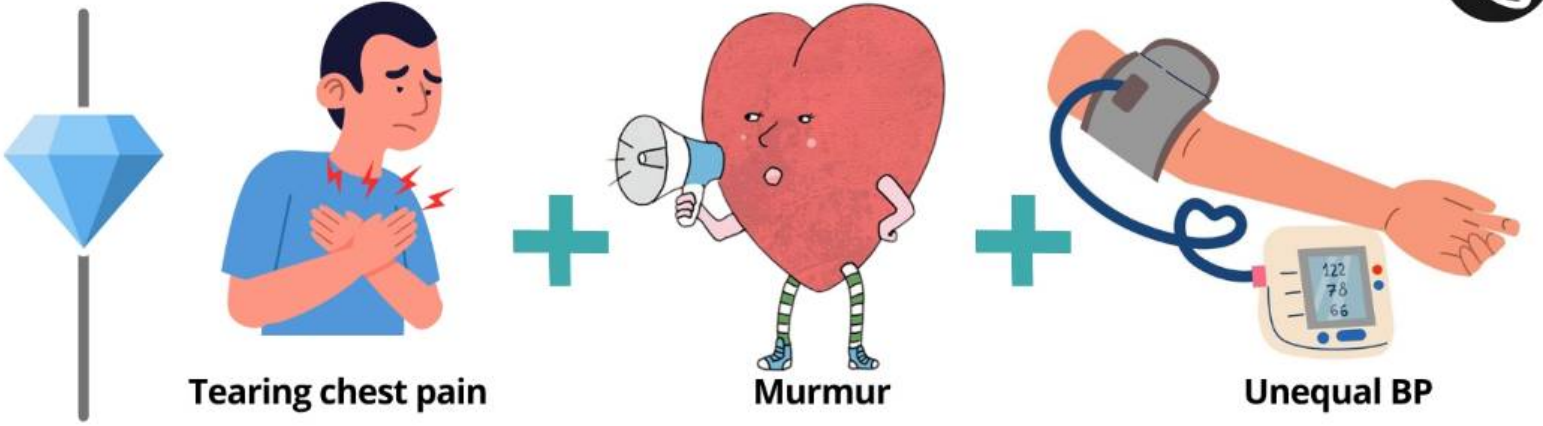
USMLE 2 GEMS



Tearing chest pain + Murmur + Unequal BP

= Aortic Dissection

Scenario Summary

A 70-year-old male presents with ***severe chest pain*** radiating to the back, ***unequal BP*** between arms, and a ***diastolic murmur***. Creatinine is elevated.

Diagnosis

Type A Aortic Dissection

Why?

Tearing pain, aortic regurgitation murmur, and pulse differential are hallmark signs of ascending dissection

Best step★

Transesophageal Echocardiography (TEE) → Preferred in unstable patients or those with renal dysfunction due to no contrast need.

Treatment

- First-line imaging → ***TEE*** (safe with renal insufficiency).
- Emergency ***surgical repair*** if confirmed.
- ***IV B-blockers*** to control BP.

Takeaway Points

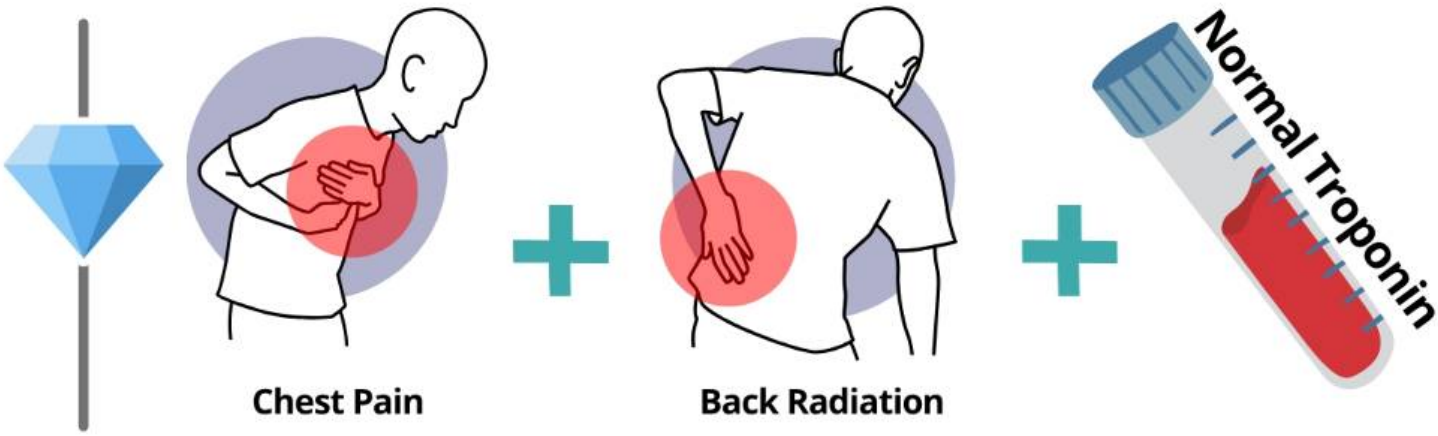
TEE is preferred in suspected aortic dissection with ***renal impairment*** or ***hemodynamic instability.***

Pitfall to Avoid⊘

Avoid CT angiography in patients with renal dysfunction or unstable vitals.

USMLE tip

In a hypertensive patient with back pain, murmur, and high creatinine, ***TEE is the ideal first test*** for suspected type A aortic dissection.



= Suspect Aortic Dissection

Scenario Summary

A 65-year-old man presents with **sudden chest pain** followed by brief syncope.
BP is ***high bilaterally***, D-dimer is elevated, troponin is normal, and CT shows dissection.

Diagnosis

Acute Ascending Aortic Dissection (Type A)

Why?

Sudden tearing pain, high BP, and widened mediastinum in an older hypertensive patient with normal troponin fits Type A dissection.

Best step

Emergent Surgical Repair

Treatment

- First-line management → ***Urgent surgical repair*** of the ascending aorta.
- **Pre-op BP control** using IV beta blockers to reduce shear stress.
- **Avoid thrombolytics or antiplatelets**.

Takeaway Points

Type A dissections can **mimic MI** but require emergent surgery, not anticoagulation.

Pitfall to Avoid

Don't give **aspirin, heparin, or thrombolytics**—these increase bleeding in dissection.

USMLE tip

A patient with chest pain, syncope, and mediastinal widening needs emergency surgery for Type A dissection, even with normal troponin.

Penetrating Limb Injury + Cool Extremity + Feeble Pulse

= Immediate Surgery

Scenario Summary

A 34-year-old male with a **gunshot wound** to the **thigh** has a **cool leg and faint distal pulses.**

Diagnosis

Vascular Injury with Distal Ischemia

Why?

Penetrating trauma + signs of ischemia (coolness, weak pulses) = hard sign of vascular injury.

Best step

Urgent Surgical Exploration

Treatment

⚡ ***Immediate surgery*** without delay for imaging.
📌 **Arteriography** can be done intraoperatively if needed.
📌 Restore perfusion + repair vessel.

Takeaway Points

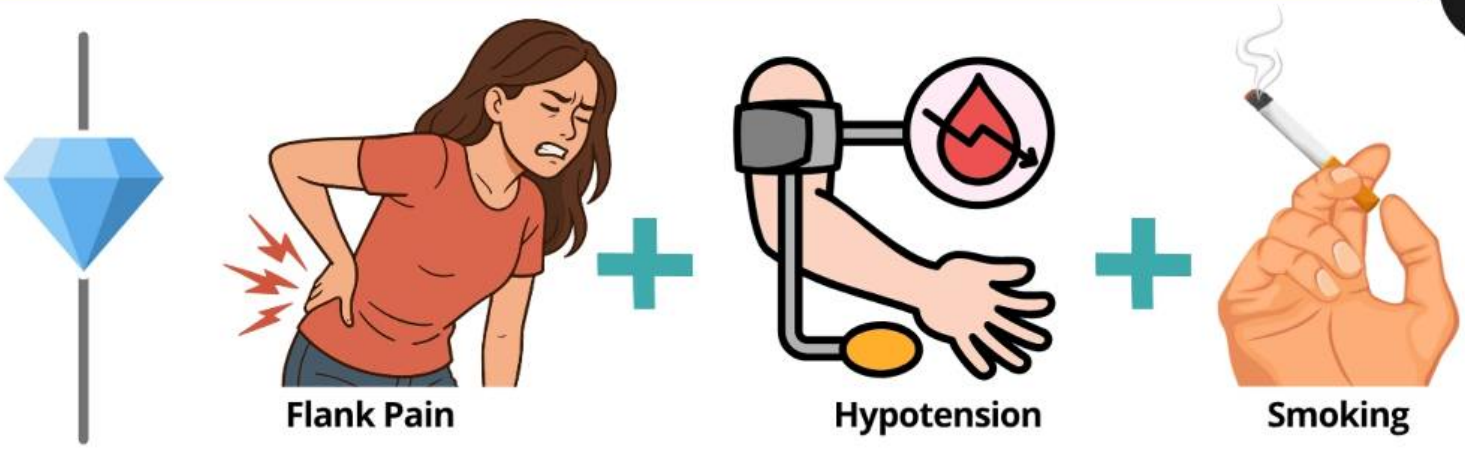
Hard signs of vascular injury = ***go to OR now***.

Pitfall to Avoid

Don't delay for imaging in unstable or ischemic limbs.

USMLE tip

Gunshot + cool limb + weak pulses = ***surgical exploration is the next step***, not Doppler or CT angiography.



= Suspect AAA Rupture

Scenario Summary

An 84-year-old man with HTN and smoking history presents with **sudden left flank pain**, **hypotension**, and CVA tenderness.

Diagnosis

Ruptured Abdominal Aortic Aneurysm (AAA)

Why?

Elderly smoker with **sudden flank pain, hypotension, and cool extremities** → classic signs of retroperitoneal AAA rupture.

Best step

Focused Abdominal Ultrasound (if unstable)

Treatment

- ***Emergency surgical repair*** is required.
- Initiate fluid resuscitation and consult vascular surgery immediately.
- Avoid delays—AAA rupture has **high mortality**.

Takeaway Points

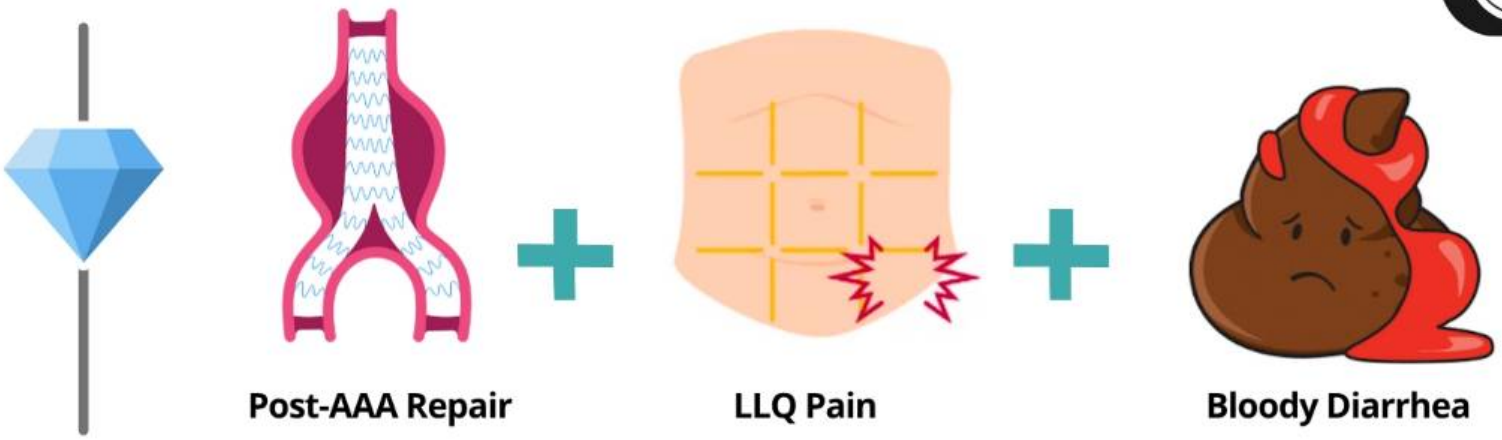
AAA rupture should be high on the differential in elderly patients with sudden flank pain + hypotension.

Pitfall to Avoid

Don't confuse with **renal colic or pyelonephritis**—those don't cause shock or decreased pulses.

USMLE tip

In an elderly male with flank pain and hypotension, AAA rupture is the most likely cause—even without known aneurysm history.



= Bowel Ischemia

Scenario Summary

A 72-year-old man develops **left lower quadrant pain** and **bloody diarrhea** on day 1 after infrarenal abdominal aortic aneurysm (AAA) repair.
WBC is elevated. Femoral pulses are symmetric.

Diagnosis

Bowel Ischemia due to Graft-Related Hypoperfusion

Why?

Compromised perfusion to the sigmoid colon due to IMA loss post-AAA repair leads to ischemic colitis.

Best Diagnostic Test ★

CT Abdomen with Contrast

Treatment

- ***Supportive care*** with IV fluids and bowel rest if no signs of necrosis.
- **Surgical resection** if signs of peritonitis or gangrene.
- Monitor hemodynamics closely post-vascular surgery.

Takeaway Points

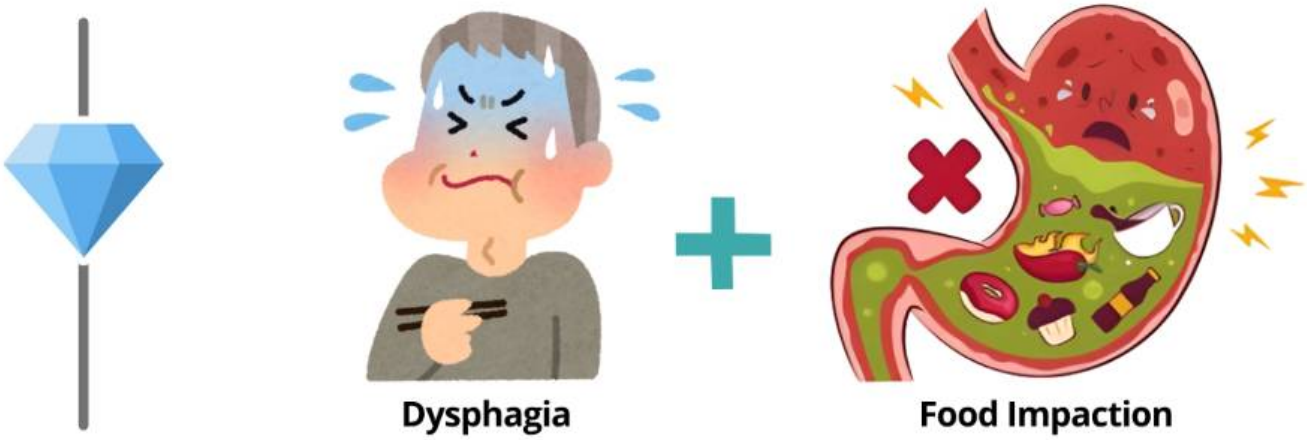
Post-op bloody diarrhea + LLQ tenderness = think **ischemia after aortic surgery.**

Pitfall to Avoid ⊘

Don't assume C. difficile just because the patient received antibiotics—presentation and timing matter.

USMLE tip

In patients with **abdominal pain and hematochezia** after aortic surgery, suspect bowel ischemia, not pseudomembranous colitis.



= Vascular Ring

Scenario Summary

A 2-year-old girl has recurrent **solid food impactions** and **growth delay**. Barium esophagram shows **posterior esophageal compression** near T4.

Key features

Recurrent food impaction, difficulty swallowing solids, history of **middle-lobe pneumonia**, posterior impression on esophagus.

Overview

These findings suggest a **congenital vascular ring** compressing the esophagus.

Most likely cause

Congenital vascular malformation encircling the esophagus and/or trachea.

Takeaway Points

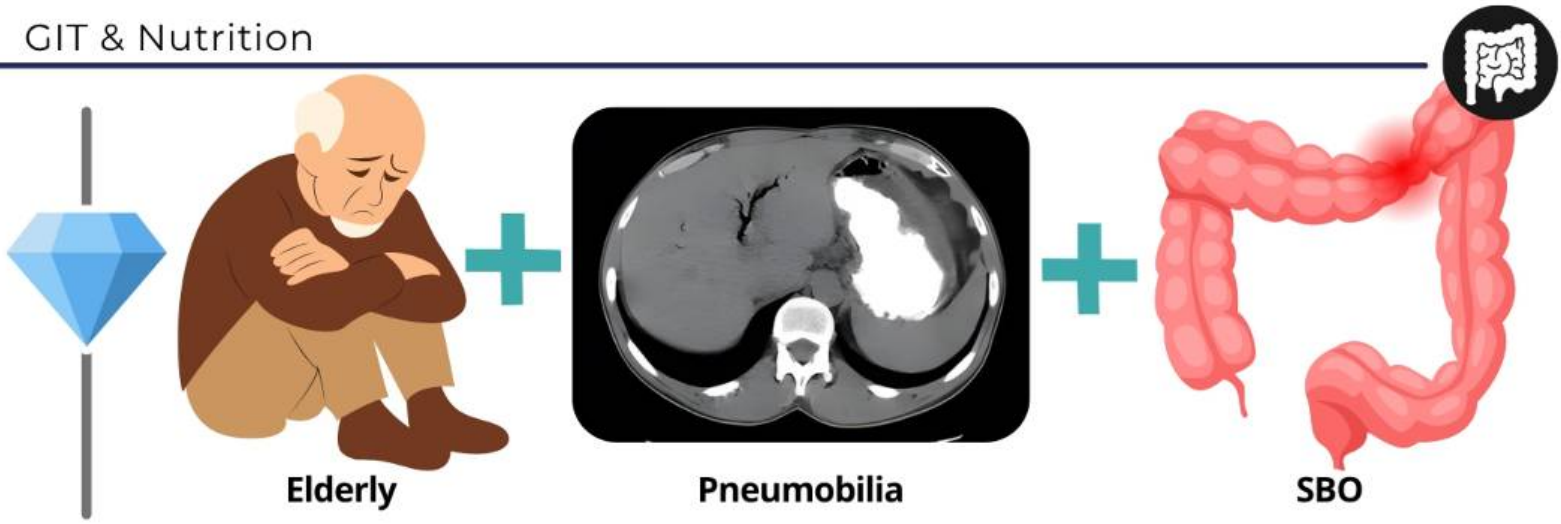
Vascular rings can cause chronic dysphagia and **recurrent respiratory infections** due to **tracheoesophageal compression**.

Pitfall to Avoid

Don't mistake this for **eosinophilic esophagitis or achalasia** — those wouldn't cause posterior esophageal compression.

USMLE tip

In a child with recurrent **food impaction** and **esophageal compression** on barium imaging, suspect a **vascular ring** as the underlying cause.



= Gallstone Ileus

Scenario Summary

An 82-year-old woman with a history of gallstones presents with **abdominal distension**, **vomiting**, and **air in the biliary tree** on imaging.

Key features

Pneumobilia, bowel obstruction, **colicky pain**, elderly woman.

Overview

This is **gallstone ileus**, caused by stone migration through a **biliary-enteric fistula.**

Definitive management

Surgical stone extraction + cholecystectomy.

Takeaway Points

In elderly patients with **SBO** and air in the biliary tree, always **suspect gallstone ileus.**

Pitfall to Avoid

Don't confuse with **paralytic ileus** — this is mechanical.

USMLE tip

Gallstone ileus presents with small bowel obstruction and **pneumobilia**; treat with surgical stone removal and **cholecystectomy.**

= Acute Cholangitis

Scenario Summary

A 39-year-old woman with **type 1 diabetes** presents with **RUQ pain**, **confusion, fever**, and vomiting. Labs show **high direct bilirubin**, **elevated ALP**, and normal lipase.

Key features

Fever, confusion, **hypotension, hyperbilirubinemia**, and **leukocytosis** = **Reynolds Pentad** (suggestive of severe cholangitis).

Overview

This is likely **acute cholangitis**, caused by ascending infection through an **obstructed biliary tract**.

Key intervention

Start IV antibiotics and perform biliary drainage via ERCP within 24–48 hours.

Takeaway Points

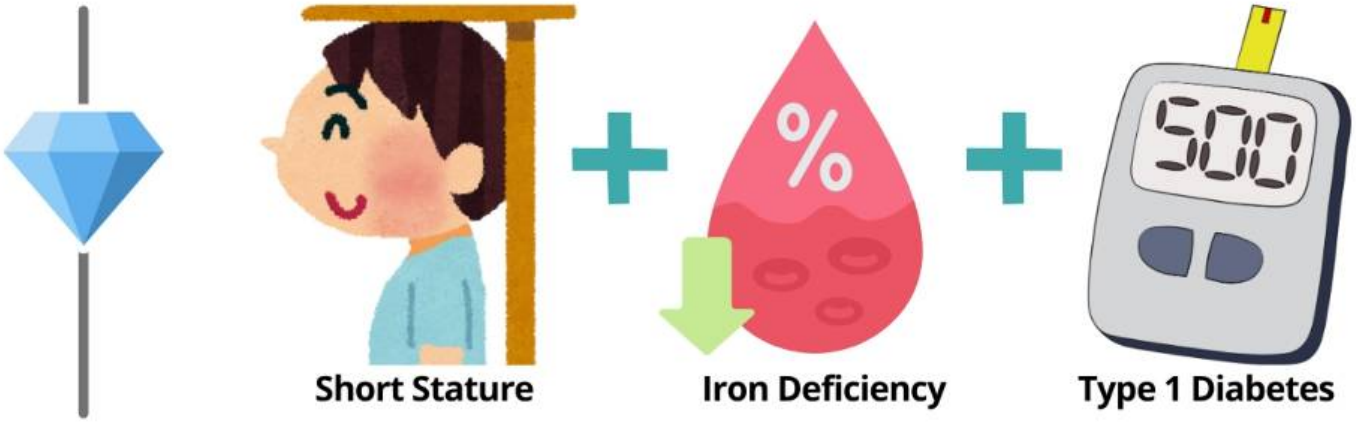
Charcot Triad = **fever, RUQ pain, jaundice.** Add hypotension and AMS = **Reynolds Pentad** = severe disease.

Pitfall to Avoid

Normal urinary ketones and glucose >400 do **NOT equal DKA** if mental status change is better explained by sepsis. Don't be misled by diabetes alone.

USMLE tip

When a patient has **RUQ pain**, **jaundice, fever**, and **mental status changes**, think of **acute cholangitis** due to biliary obstruction and **manage urgently with ERCP.**



= Screen for Celiac

Scenario Summary

A 13-year-old boy with **type 1 diabetes** and **growth delay** has **microcytic anemia** and **recurrent hypoglycemia** despite good appetite.

Key features

Growth delay, iron deficiency anemia, abdominal bloating, **autoimmune comorbidity**.

Overview

Consider **celiac disease** in any child with type 1 diabetes and signs of malabsorption, especially with unexplained anemia or poor growth.

Best next step

Order anti–tissue transglutaminase IgA antibodies.

Takeaway Points

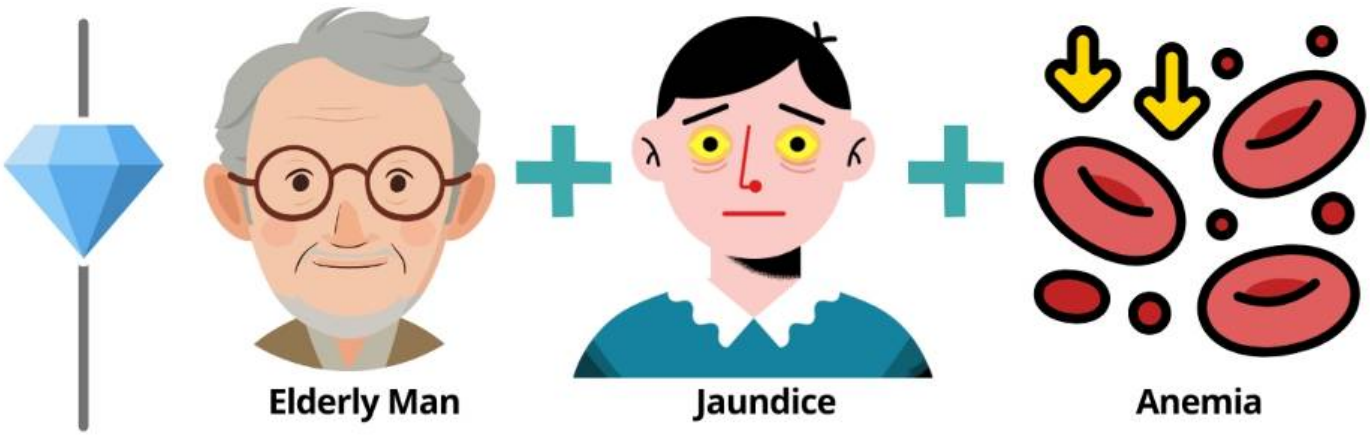
Celiac disease is a common **autoimmune comorbidity in type 1 diabetes**. GI symptoms may be subtle or absent.

Pitfall to Avoid

Don't jump to imaging or fecal tests **without** first screening for celiac serology in this context.

USMLE tip

In a diabetic child with microcytic anemia and poor growth, always screen for **celiac disease** with **anti–tissue transglutaminase IgA.**



= Cholangiocarcinoma

Scenario Summary

A 75-year-old man presents with **jaundice**, **weight loss** (15 lbs), and **pallor**. Labs show **conjugated hyperbilirubinemia** (total bilirubin 8.0 mg/dL, direct 6.5 mg/dL) and **anemia** (Hb 9.0 g/dL). MRCP shows **biliary stricture**.

Key features

Painless jaundice, weight loss, cholestatic pattern, **biliary stricture**, elderly patient, no gallstones.

Overview

This is likely **cholangiocarcinoma** causing biliary obstruction.

Best test

Perform MRCP and ERCP with biopsy to confirm malignancy.

Takeaway Points

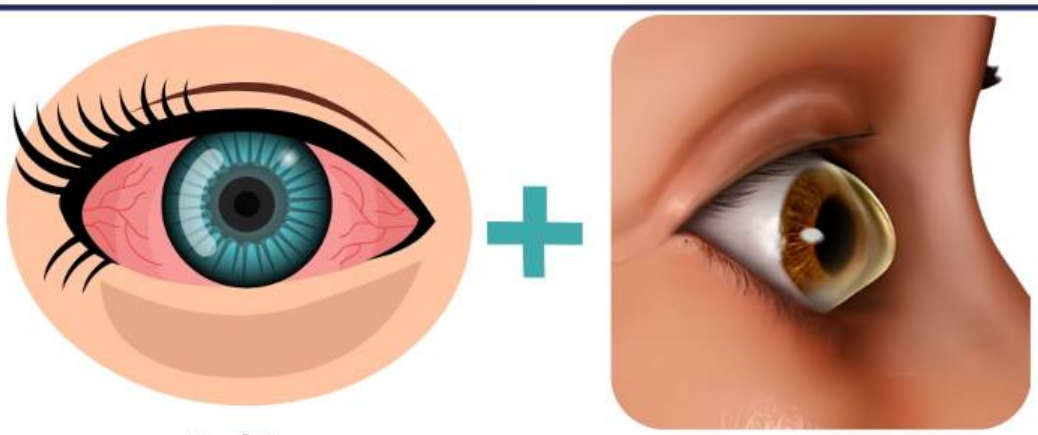
Cholangiocarcinoma presents with jaundice, weight loss, and biliary strictures. **MRCP/ERCP is diagnostic**; staging guides treatment.

Pitfall to Avoid

Do not confuse with **pancreatic cancer** (pancreatic mass) or **PSC** (IBD history, younger patients). **Avoid** delaying biopsy.

USMLE tip

In an elderly patient with jaundice, weight loss, and biliary stricture, cholangiocarcinoma is diagnosed with **MRCP/ERCP**, guiding biopsy.



Red Eye

Enlarged Cornea in a Baby

= Test for Glaucoma

Scenario Summary

A 9-month-old has **tearing and eye redness**. Exam shows an **enlarged left cornea** and globe, **photophobia**, and a **port-wine stain** over the left face.

Key features

Unilateral tearing, **photophobia**, globe enlargement, **port-wine stain** (suggestive of Sturge-Weber).

Overview

This is likely **congenital glaucoma**, commonly associated with Sturge-Weber syndrome.

Best test

Use **tonometry to assess intraocular pressure (IOP).**

Takeaway Points

Infantile glaucoma presents with **corneal edema**, enlargement, and **photophobia**. It can cause vision loss if not promptly treated.

Pitfall to Avoid

Don't misdiagnose as **conjunctivitis** or **blocked tear duct** — enlarged cornea/globe is key.

USMLE tip

A baby with **unilateral photophobia**, **eye tearing**, and a **port-wine stain** should have tonometry to check for elevated intraocular pressure due to **glaucoma**.

= Central Vertigo (Possible Stroke)

Scenario Summary

A 64-year-old woman develops sudden **headache**, **vertigo**, nystagmus, and **falls toward the left**.

Key features

Persistent **vertigo**, **central nystagmus**, inability to walk, **headache**.

Overview

Red flags for **central vertigo**, especially **cerebellar stroke**.

Best next step

Noncontrast CT scan of the head (to rule out cerebellar stroke/bleed).

Takeaway Points

Inability to walk + **persistent vertigo** = **suspect central cause (stroke)**, not benign peripheral vertigo.

Pitfall to Avoid

Do not *reassure* and *treat symptomatically* until stroke is ruled out.

USMLE tip

Persistent vertigo + **inability to walk** → order **head CT urgently**.

Acute Ataxia + Left-Sided Dysmetria + Normal CT

= Acute Stroke → Alteplase

Scenario Summary

A 62-year-old woman develops **sudden vertigo, left-sided dysmetria, and headache**, but CT is normal.

Key features

Persistent vertigo, dysmetria, posterior headache, normal initial CT.

Overview

Cerebellar infarct (posterior circulation stroke) should be treated as ischemic stroke.

Best next step

Administer intravenous alteplase.

Takeaway Points

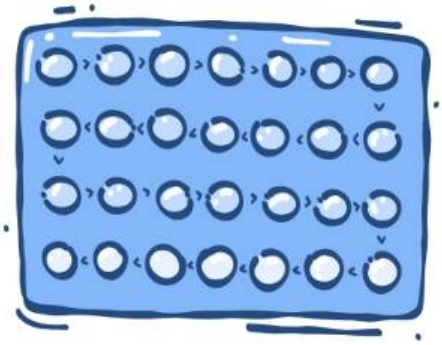
Posterior circulation strokes can initially appear like peripheral **vertigo** — beware!

Pitfall to Avoid

Don't miss window for ***thrombolysis*** — treat within 4.5 hours even if CT is normal.

USMLE tip

Central vertigo + ataxia + normal CT early → **still thrombolyse**!



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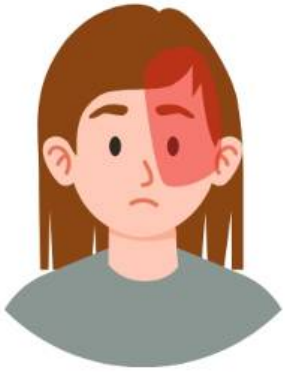


Migraine With Aura

= STOP Estrogen!

Scenario Summary

An 18-year-old woman with **classic migraines with aura** (paresthesia before headache) is using **combined oral contraceptives**.

Key features

Unilateral **throbbing headache**, **nausea**, **aura with tingling/numbness**, on combined hormonal contraceptives.

Overview

Migraine with aura + estrogen-containing contraceptives = ↑ **risk of ischemic stroke**. Estrogen must be discontinued.

Best next step

Discontinue estrogen-containing contraceptives immediately.

Takeaway Points

Aura = **contraindication to estrogen**. Consider switching to progestin-only methods.

Pitfall to Avoid

Don't initiate migraine prophylaxis before addressing the stroke risk from estrogen.

USMLE tip

In any patient with **migraine with aura**, avoid or **stop estrogen-based contraceptives** to minimize **thrombotic stroke risk.**

= Radiculopathy

Scenario Summary

A 37-year-old male develops **neck and arm pain** radiating to the thumb with decreased sensation. **No motor weakness** is noted.

Key features

Pain **radiates to thumb and index finger**, pinprick loss, no weakness, likely C6 nerve root involvement.

Overview

: This is a **cervical radiculopathy**, likely caused by acute disc herniation at C5–C6.

Initial management

NSAIDs and avoidance of provocative activity.

Takeaway Points

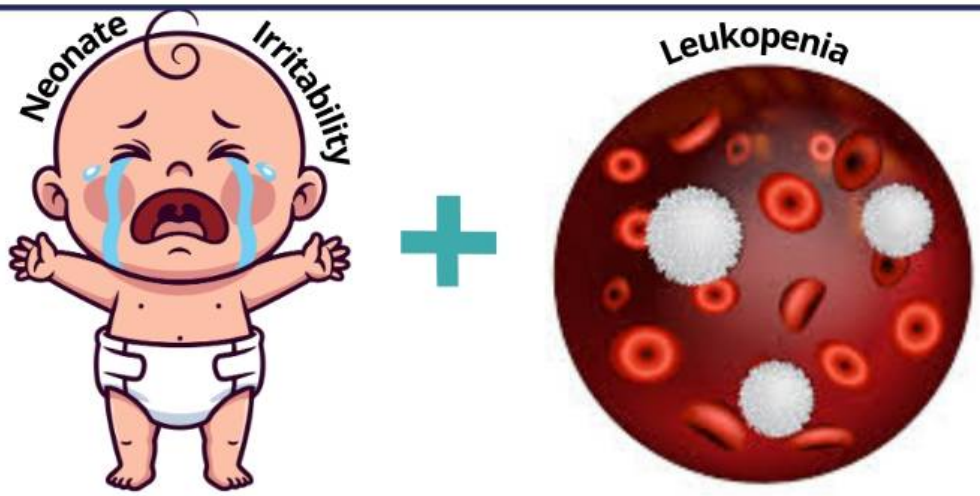
Most cervical radiculopathies resolve with **conservative management** unless there are red flags.

Pitfall to Avoid

Don't jump to imaging unless there's **progressive neurologic decline** or red flag symptoms.

USMLE tip

In a healthy patient with radiating neck pain and C6 pattern sensory loss, initial management is **NSAIDs and avoiding neck strain.**



= Empiric Ampicillin + Gentamicin

Scenario Summary

A 3-day-old newborn becomes ***irritable and refuses feeding***. Temp is normal, but WBC is low. Exam reveals inconsolable ***crying*** and no specific findings on cardiorespiratory or abdominal exam.

Key features

- Age **under 7 days**
- ***Poor feeding***, irritability
- **Leukopenia**
- ***No fever***, but tachycardic

Overview

This is suspected early-onset ***neonatal sepsis***, most likely due to **GBS**, **E. coli**, **or Listeria.**

Best treatment approach

Start ***IV ampicillin and gentamicin*** immediately while obtaining cultures.

Takeaway Points

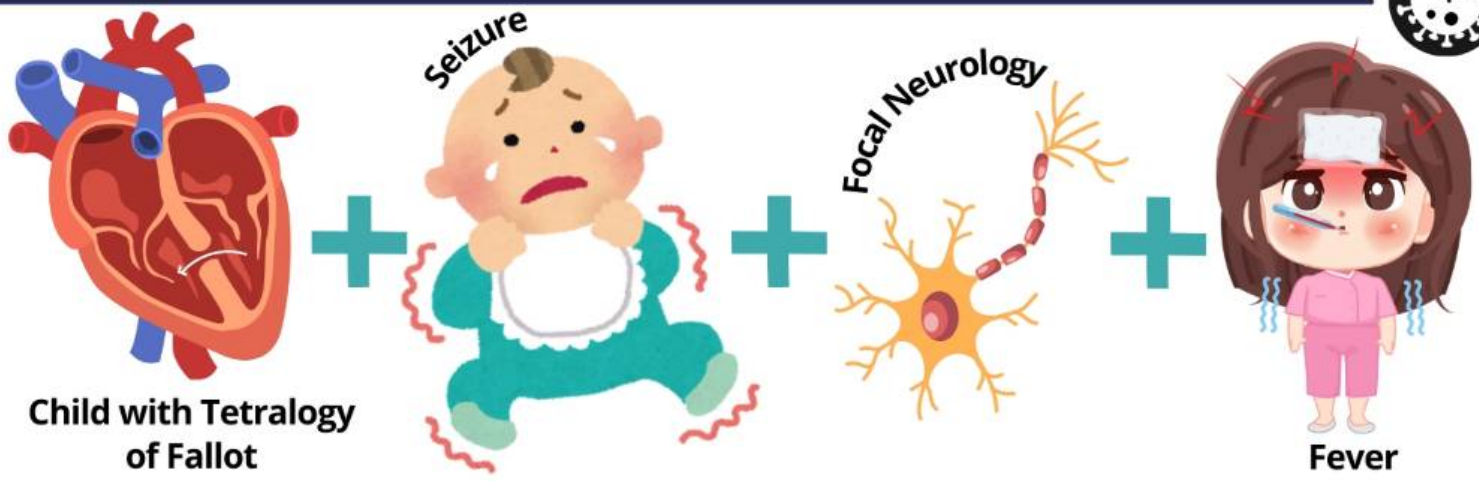
- Early-onset sepsis is often **subtle**.
- Even in normothermic neonates, signs like lethargy, poor feeding, or irritability should prompt concern.
- **Low WBC** can be a ***red flag.***

Pitfall to Avoid

- Don't wait for fever.
- ***Avoid ceftriaxone*** in neonates — risk of ***kernicterus*** and no Listeria coverage.

USMLE tip

In neonates with ***poor feeding and leukopenia***, use ***ampicillin and gentamicin*** as first-line empiric treatment to cover GBS, E. coli, and Listeria monocytogenes.



= Brain Abscess

Scenario Summary

A 3-year-old boy with ***DiGeorge syndrome*** and ***unrepaired tetralogy of Fallot*** (TOF) presents with **morning** headaches, vomiting, ***right leg*** weakness, and a generalized **tonic-clonic seizure**.

Key features

Cyanotic congenital heart disease, fever, morning headache, vomiting, ***focal neurologic*** deficit, and seizure.

Overview

Children with ***right-to-left shunt*** (e.g., TOF) are at risk of **brain abscess** due to hematogenous spread of organisms that ***bypass pulmonary filtration***. The **classic triad:** headache, fever, and focal neurologic findings.

Diagnosis

Initial step: ***Neuroimaging (CT/MRI)***. **Definitive**: ***Aspiration or biopsy of lesion.***

Takeaway Points

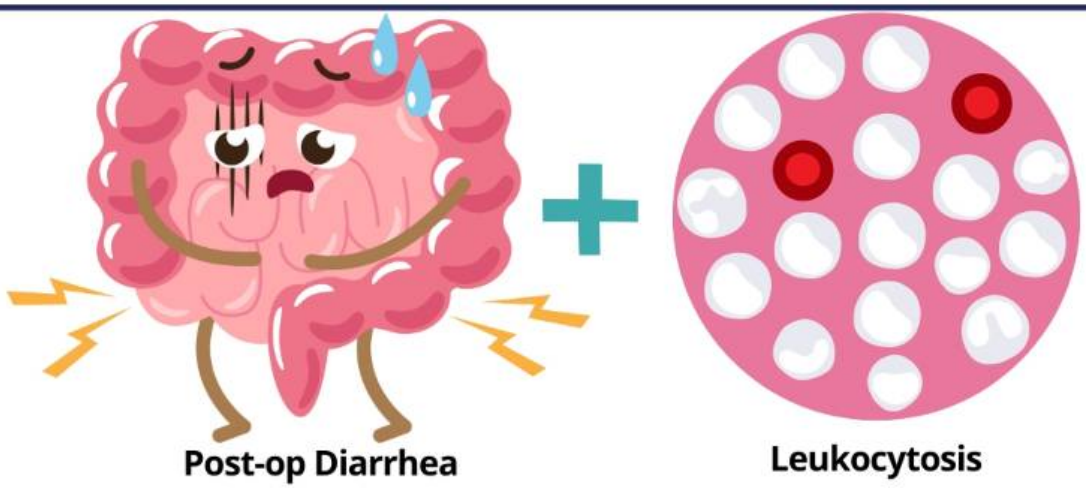
In any **cyanotic** heart disease patient with **neurologic** changes, think ***brain abscess***. These kids skip the lung's natural defense against circulating bacteria.

Pitfall to Avoid

Don't misdiagnose as stroke or meningitis. Brain abscess has progressive, localized symptoms and fever.

USMLE tip

TOF + new **focal deficit** + fever + seizure = ***brain abscess***, especially in a child from a developing country.



= Suspect C. difficile

Scenario Summary

A 50-year-old man develops ***watery diarrhea*** and fever on day 7 after abdominal ***surgery***. He previously received ***antibiotics*** for post-op infection. Labs show ***leukocytosis***.

Key features

Recent antibiotics, watery diarrhea, fever, leukocytosis, and recent hospitalization.

Overview

This is classic ***Clostridioides difficile infection (CDI)*** in a postoperative patient after recent antibiotic exposure.

Best next step

Order ***stool toxin*** testing or ***PCR*** for C. difficile to confirm diagnosis and begin treatment.

Takeaway Points

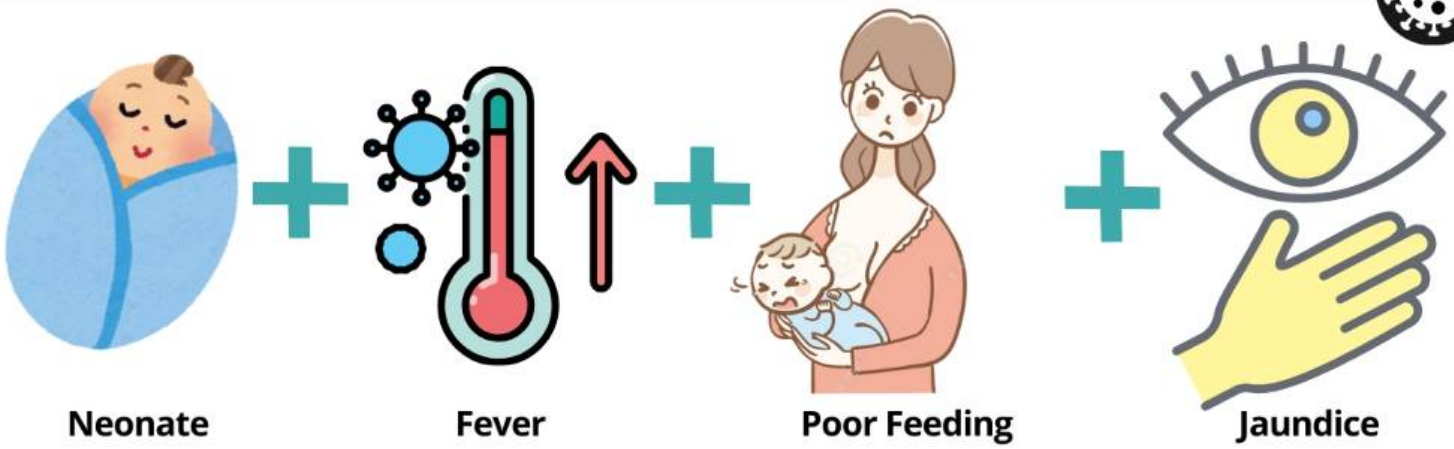
Always suspect CDI in hospitalized patients with new-onset diarrhea and leukocytosis, especially after antibiotic exposure.

Pitfall to Avoid

Don't treat empirically without confirming the diagnosis via ***stool assay*** unless the patient is critically ill.

USMLE tip

In a hospitalized patient with diarrhea and leukocytosis after antibiotic exposure, confirm ***C. difficile infection*** with stool toxin testing or PCR and initiate appropriate treatment.



= Full Sepsis Workup

Scenario Summary

A 21-day-old girl presents with ***poor feeding***, ***hypothermia***, ***lethargy***, and ***jaundice***. She has a full fontanelle and reduced tone.

Key features

Hypothermia, weak suck, jaundice, full fontanelle, and lethargy in a neonate under 28 days.

Overview

These are classic signs of ***neonatal sepsis and meningitis***, which can be subtle but rapidly ***fatal*** if missed.

Best initial step

Immediately ***obtain*** blood, urine, and CSF cultures, then ***start*** empiric ampicillin and gentamicin.

Takeaway Points

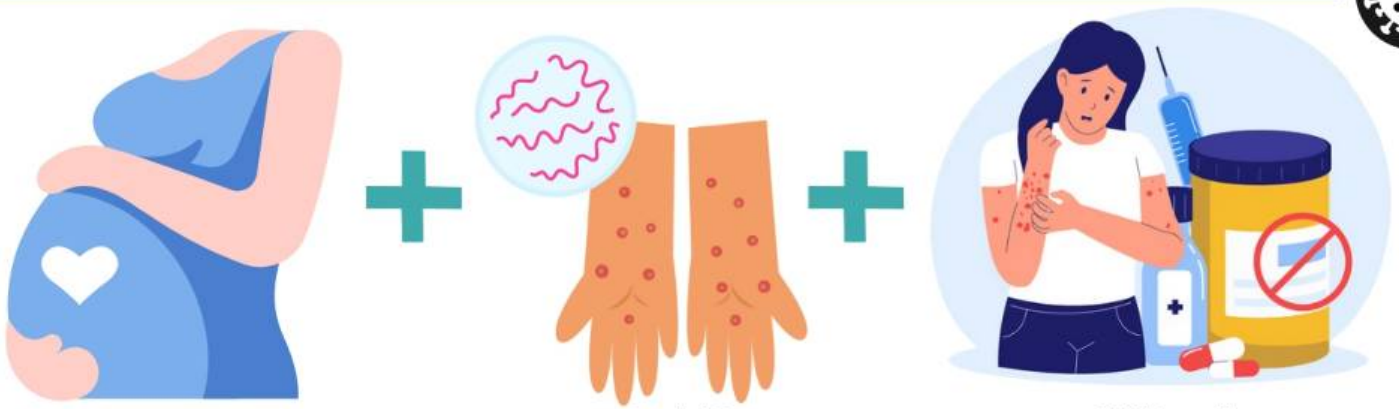
Neonates with poor feeding, temperature instability, or irritability need a ***full sepsis evaluation*** even if afebrile.

Pitfall to Avoid

N***ever assume a benign cause*** for poor feeding in neonates. Delay in cultures or antibiotics can be fatal.

USMLE tip

In neonates with hypothermia and altered behavior, always obtain blood, urine, and CSF cultures before empiric antibiotics to diagnose ***sepsis or meningitis***.



= Penicillin Desensitization

Scenario Summary

An 8-week ***pregnant*** woman with ***confirmed syphilis*** and a reported ***penicillin allergy*** (pruritic rash).

Key features

Pregnant, early syphilis, non-severe penicillin allergy (no anaphylaxis), no HIV, rash-based allergy history.

Overview

In pregnancy, penicillin is **essential** for treating syphilis, even with a mild allergy history.

Best step

Skin testing and ***desensitization***, then treat with ***benzathine penicillin G***.

Takeaway Points

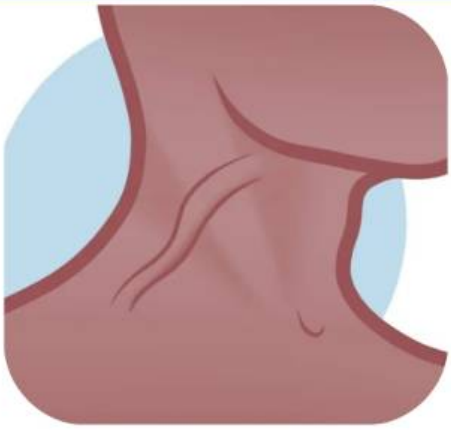
Only penicillin effectively treats maternal and fetal syphilis. Allergy evaluation and desensitization is mandatory.

Pitfall to Avoid

Avoid using macrolides or doxycycline in pregnancy. They are ineffective or **contraindicated.**

USMLE tip

A pregnant woman with ***syphilis*** and ***non-anaphylactic penicillin allergy*** needs skin testing followed by desensitization before penicillin treatment.



Penetrating Chest Trauma + Hypotension + Distended Neck Veins

= Tension Pneumothorax

Scenario Summary

A 22-year-old man presents after a **stab wound to the right chest**. He is ***hypotensive, tachypneic, and in respiratory distress.*** Breath sounds are ***absent on the right, and neck veins are distended***. He becomes **obtunded** during the exam.

Key features

Right-sided **absent** breath sounds, **distended** neck veins, hypotension, tachycardia, **midline trachea**, and **altered** mental status.

Overview

This is likely a case of **tension pneumothorax** due to ***penetrating chest trauma*** causing a *one-way valve effect* and *cardiovascular compromise*.

Most appropriate next step

Immediate **needle thoracostomy** should be performed **without delay** to decompress the tension.

Takeaway Points

Tension pneumothorax presents with **unilateral** absent breath sounds, hypotension, and neck vein distension. It is a clinical diagnosis and requires **immediate decompression**.

Pitfall to Avoid

Do not delay for imaging or intubation. ***Positive pressure ventilation*** can worsen the collapse and precipitate arrest.

USMLE tip

In patients with penetrating trauma and signs of obstructive shock, needle thoracostomy must be performed **immediately** to **relieve** a tension pneumothorax and **prevent** cardiovascular collapse.

Alcoholic + Foul Sputum + Cavitary Lesion

= Anaerobic Lung Abscess

Scenario Summary

A disheveled, **homeless** man with **poor dentition** presents with ***fever, chills, weight loss, and a cough productive of foul-smelling sputum***. Chest imaging shows a **right-sided cavitary infiltrate** with an **air-fluid level**.

Key features

Subacute onset, **poor** oral hygiene, aspiration risk (**alcohol use**, **homelessness**), **cavitary** lesion with **air-fluid level**.

Overview

This is a classic presentation of a **lung abscess** caused by ***aspiration of anaerobic bacteria from the oropharynx.***

Best management approach

Start **empiric antibiotics** with **ampicillin-sulbactam** or **clindamycin** to cover anaerobes.

Takeaway Points

Anaerobic organisms like ***Fusobacterium, Bacteroides, and Peptostreptococcus*** are the usual culprits in lung abscess. Imaging shows a **thick-walled cavity** with an **air-fluid level**.

Pitfall to Avoid

Do not rely on sputum cultures — anaerobes are hard to grow. **Avoid** attributing all cavitary lesions to TB or cancer without considering aspiration.

USMLE tip

In a homeless, alcoholic patient with foul-smelling sputum and cavitary infiltrate, think ***anaerobic bacterial infection*** due to **aspiration**.

Smoker + Chronic Cough + Mild Hemoptysis

= Chronic Bronchitis

Scenario Summary

A 55-year-old construction worker with long-term morning cough and recent ***blood-streaked sputum,*** no systemic symptoms.

Key features

Chronic ***daily cough for >2 years***, smoking history, and mild hemoptysis.

Overview

This is a classic presentation of ***chronic bronchitis,*** a form of COPD, primarily caused by smoking.

Etiology note

Chronic inflammation of bronchi → mucus hypersecretion → daily sputum production.

Takeaway Points

Chronic bronchitis is the most common cause of ***hemoptysis in smokers*** with long-standing cough.

Pitfall to Avoid

Don't jump to TB or cancer without weight loss, fever, or systemic signs. Always ***rule out malignancy*** with imaging if hemoptysis persists.

USMLE tip

In smokers with longstanding morning cough and recent hemoptysis, the likely cause is ***chronic bronchitis***, unless red flags suggest otherwise.

Pleuritic Chest Pain + OCP Use + Long Flight =

= Pulmonary Infarction

Scenario Summary

A 34-year-old woman develops ***pleuritic chest pain*** and mild hemoptysis after flying from Central Asia. She uses ***oral contraceptives*** and is tachypneic.

Key features

Acute pleuritic chest pain, tachypnea, hemoptysis, recent flight, OCP use.

Overview

Classic ***pulmonary embolism*** with peripheral infarction causing pleuritic pain and bleeding.

Mechanism

Thrombus blocks peripheral artery → ischemia → ***infarction and pleuritis.***

Takeaway Points

PE can cause infarction in distal arteries → ***sharp pain and hemoptysis.***

Pitfall to Avoid

Don't assume it's pericarditis or pneumonia. No fever or systemic signs, and pericarditis rarely causes hemoptysis.

USMLE tip

In a woman with pleuritic chest pain and hemoptysis after a long flight + OCP use, the likely cause is ***pulmonary infarction due to PE.***

Term Neonate + Tachypnea + Fluid in Fissures

= TTN

Scenario Summary

A term baby develops ***tachypnea*** shortly after C-section. CXR shows *hyperinflated lungs and interlobar fluid.*

Key features

Term delivery, cesarean birth, mild respiratory distress, fluid in fissures.

Overview

This is ***Transient Tachypnea of the Newborn (TTN)*** due to delayed clearance of fetal lung fluid.

CXR hallmark

Fluid in interlobar fissures and hyperinflation confirm TTN.

Takeaway Points

TTN resolves ***spontaneously*** within 1–3 days. Supportive care only is needed.

Pitfall to Avoid

Avoid unnecessary antibiotics or surfactant. TTN is ***self-limited.***

USMLE tip

Newborns with tachypnea and interlobar fluid after C-section likely have Transient Tachypnea of the Newborn, ***not infection or RDS.***

Hypertension + Hypokalemia

= Primary Hyperaldosteronism

Scenario Summary

Young hypertensive man with ***diuretic-induced hypokalemia*** (**muscle cramps**, **weakness**).

Key features

Resistant hypertension, hypokalemia, **metabolic alkalosis**, adrenal **mass** on CT.

Overview

Conn syndrome (aldosterone-secreting adenoma) or **bilateral adrenal hyperplasia**.

Best test

Plasma **aldosterone/renin ratio** (PAC/PRA >20 + aldosterone >15 ng/dL confirms diagnosis).

Takeaway Points

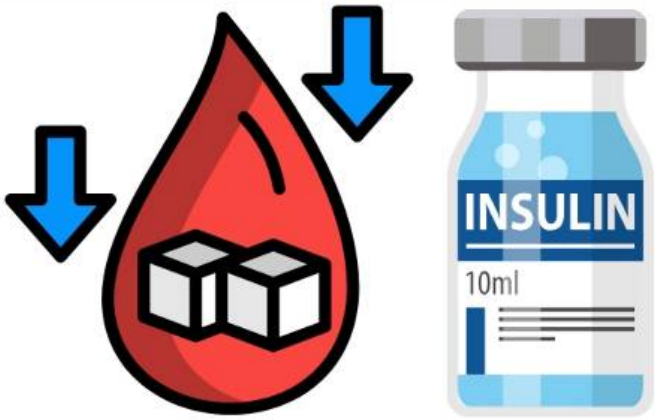
Hypokalemia + hypertension = screen for **hyperaldosteronism**. Adrenal venous sampling differentiates **adenoma** (surgical cure) from **hyperplasia** (medical therapy).

Pitfall to Avoid

Starting spironolactone before testing (***falsely lowers aldosterone***).

USMLE tip

Epicernone/spironolactone (mineralocorticoid antagonists) are ***first-line*** for hyperplasia or nonsurgical candidates.



Hypoglycemia + Inappropriately Elevated Insulin

= Insulinoma

Scenario Summary

Young adult presents with episodic palpitations, tremors, and confusion. Lab shows hypoglycemia with inappropriately high insulin, C-peptide, and proinsulin levels. Symptoms **resolve with glucose**.

Key features

Whipple's triad (hypoglycemia, symptoms, relief with glucose), elevated insulin/C-peptide/proinsulin, negative sulfonylurea screen.

Overview

Beta-cell tumor (insulinoma) is most likely due to autonomous insulin secretion despite hypoglycemia.

Best test

Supervised fasting test with serial glucose/insulin levels.

Takeaway Points

Insulinoma is the **most common pancreatic neuroendocrine tumor**. Elevated proinsulin >5 pmol/L is highly suggestive.

Pitfall to Avoid

Don't confuse with ***exogenous insulin use*** (low C-peptide) or sulfonylureas (positive drug screen).

USMLE tip

In hypoglycemia with **elevated insulin, C-peptide, and proinsulin**, the diagnosis is insulinoma. Non-beta cell tumors (e.g., IGF-II-secreting) suppress insulin/C-peptide.

Child with Polyuria + Visual Field Defects

= Craniopharyngioma

Scenario Summary

Young child with polydipsia, polyuria, and frequent collisions due to **peripheral vision loss**. Imaging shows a **suprasellar mass**.

Key features

Diabetes insipidus (dilute urine, high sodium), bitemporal hemianopsia, growth failure.

Overview

Craniopharyngioma **compresses the optic chiasm** (vision loss) and pituitary stalk (ADH deficiency).

Best test

MRI brain (cystic/calcified suprasellar mass).

Takeaway Points

Derived from Rathke pouch remnants. **Treatment**: surgery + radiation.

Pitfall to Avoid

Don't miss **pituitary adenoma** (no calcifications) or Rathke cleft cyst (no visual defects).

USMLE tip

A **calcified suprasellar mass** in a child with DI and visual field defects is craniopharyngioma.

Secondary Adrenal Insufficiency from Steroid Withdrawal

Scenario Summary

A patient on **chronic prednisone for polymyalgia rheumatica develops fatigue, nausea, and hypotension after abrupt cessation.** Labs show hyponatremia and hypoglycemia.

Key features

- HPA axis suppression → low ACTH/cortisol
- No hyperpigmentation or hyperkalemia (aldosterone intact).

Overview

Exogenous glucocorticoids suppress CRH/ACTH → **adrenal atrophy.**

Best test

Morning cortisol (low) + **ACTH stimulation test** (blunted response).

Takeaway Points

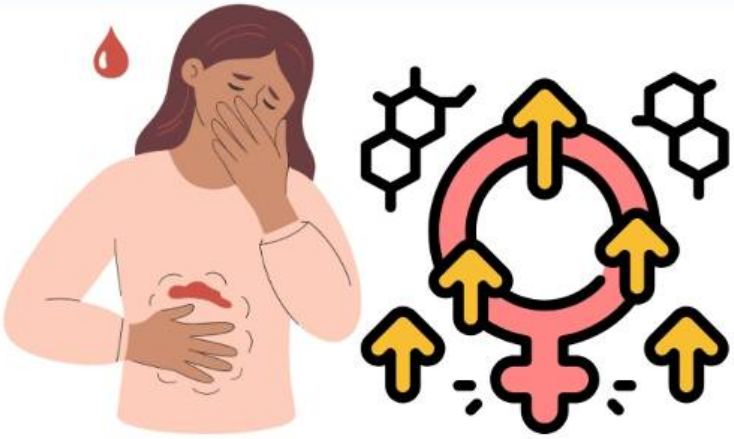
- Taper steroids slowly to allow HPA axis recovery.
- Stress-dose steroids needed for illness/surgery.

Pitfall to Avoid

:Missing **primary adrenal insufficiency** (expect hyperkalemia and hyperpigmentation).

USMLE tip

Hyponatremia and hypoglycemia after **steroid withdrawal** indicate secondary adrenal insufficiency.



Postmenopausal Bleeding + Unopposed Estrogen

= Endometrial Cancer Risk

Scenario Summary

Obese postmenopausal woman with **new vaginal bleeding** and history of PCOS.

Key features

- **Chronic anovulation** → unopposed estrogen → endometrial hyperplasia
- PCOS is a **major risk factor** for endometrial adenocarcinoma

Overview

Estrogen stimulation without progesterone leads to uncontrolled endometrial proliferation.

Best test

Transvaginal ultrasound (endometrial thickness >4mm warrants biopsy).

Takeaway Points

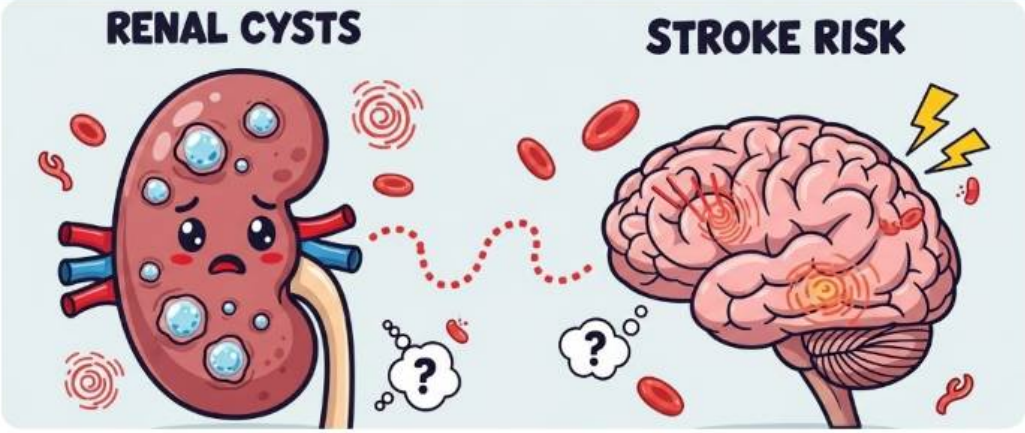
- **Progestin therapy** for hyperplasia without atypia.
- PCOS patients need **endometrial surveillance** after age 40.

Pitfall to Avoid

Attributing bleeding to **atrophy** without imaging.

USMLE tip

Postmenopausal bleeding in a PCOS patient requires evaluation for **endometrial cancer**.



Renal Cysts and Stroke Risk

= Watch the Brain

Scenario Summary

A 33-year-old man with no comorbidities is evaluated for **flank pain**. Renal ultrasound reveals **bilateral cysts**.

Key features

Bilateral renal cysts on ultrasound in a young adult, no significant medical history, positive family history of early sudden death.

Overview

This is consistent with **ADPKD**, which carries increased risk of intracranial aneurysms and subarachnoid hemorrhage, especially with **family history**.

High-risk complication

Patients with ADPKD have an increased risk of **intracranial bleeding from ruptured berry aneurysms**, often presenting as sudden death or stroke.

Takeaway Points

Consider brain imaging for aneurysm screening in ADPKD patients with family history of aneurysm or stroke.

Pitfall to Avoid

Do not overlook the **neurologic risks of ADPKD** — screening can be life-saving in the right context.

USMLE tip

In patients with ADPKD, the most feared complication is **intracranial hemorrhage from a ruptured cerebral aneurysm** — especially with a family history of sudden death.

Severe Hypercalcemia

= Hydration First, Always

Scenario Summary

An older man presents with confusion, nausea, and abdominal pain. Labs reveal **serum calcium of 14.1 mg/dL,** acute kidney injury, and signs of dehydration.

Key features

Severe hypercalcemia, confusion, vomiting, dehydration, elevated creatinine.

Overview

This is likely **hypercalcemia of malignancy**, which requires immediate volume resuscitation due to renal vasoconstriction and polyuria-induced volume loss.

First-line intervention

Normal saline infusion is the most important initial step to correct volume status and promote renal calcium excretion.

Takeaway Points

Severe hypercalcemia **(>14 mg/dL)** presents with neuro and GI symptoms. Start with saline, then consider calcitonin and bisphosphonates.

Pitfall to Avoid

Avoid **immediate use of loop diuretics** unless volume overload exists. Also, don't delay hydration while arranging bisphosphonate therapy.

USMLE tip

In patients with severe symptomatic hypercalcemia, the priority is **aggressive saline hydration to correct volume depletion** and enhance renal calcium clearance.

Dark Urine + HTN + Proteinuria in Teen

= Glomerular

Scenario Summary

A 16-year-old girl presents with **dark brown urine**, fatigue, and elevated BP. Urinalysis shows **proteinuria and RBCs**.

Key features

Cola-colored urine, proteinuria, hypertension, elevated creatinine — all suggest **glomerular hematuria.**

Overview

This is likely **glomerulonephritis, possibly post-infectious or lupus nephritis**.

Best next step

Order serum complement levels (C3, C4) to evaluate glomerular injury.

Takeaway Points

Dark urine with proteinuria + RBCs + HTN needs **complement evaluation** to rule out PSGN, lupus, MPGN.

Pitfall to Avoid

Avoid imaging or waiting; this is not a lower UTI. Do not order urine culture unless infection is suspected.

USMLE tip

A teen with brown urine, HTN, proteinuria, and elevated creatinine should be evaluated for **glomerulonephritis** by checking serum complement levels.

Aniridia + Genitourinary Anomalies in Newborn

= WAGR Syndrome

Scenario Summary

A newborn boy has **bilateral aniridia**, **hypospadias**, and left undescended testis. Vitals are stable, and growth is appropriate.

Key features

Absent irises, **genitourinary anomalies**, normal delivery, no dysmorphic facial features.

Overview

This is likely **WAGR syndrome**, a genetic deletion disorder (11p13) with risk of Wilms tumor, Aniridia, Genitourinary abnormalities, and intellectual disability.

Next step

Begin abdominal ultrasound screening every 3 months in infancy to detect early Wilms tumor.

Takeaway Points

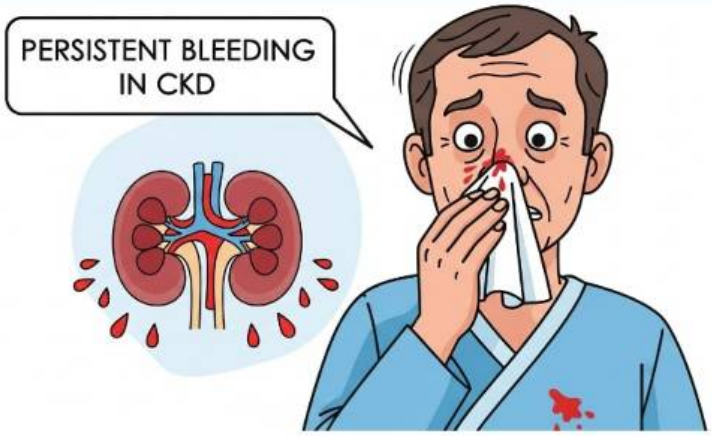
Suspect WAGR syndrome in newborns with aniridia and genitourinary defects.
WT1 gene deletion raises Wilms tumor risk.

Pitfall to Avoid

Don't confuse with **Down syndrome** (which may have Brushfield spots, not aniridia) or **neurofibromatosis** (which shows café-au-lait spots, not genitourinary anomalies).

USMLE tip

In a newborn with aniridia and GU abnormalities, always evaluate for WAGR syndrome, and initiate regular ultrasound screening for **Wilms tumor** due to WT1 gene deletion.



Persistent Bleeding in CKD

= Platelet Dysfunction

Scenario Summary

A 69-year-old diabetic man with **ESRD** experiences persistent bleeding after a blood draw. Labs show normal platelet count, normal PT/aPTT, and **elevated creatinine**.

Key features

Normal labs but **prolonged bleeding**, baseline CKD, and dialysis access history.

Overview

This is **classic uremic platelet dysfunction**, a common cause of bleeding in chronic kidney disease (CKD).

Pathophysiology

Impaired platelet adhesion and **aggregation** due to uremic toxins like guanidinosuccinic acid.

Takeaway Points

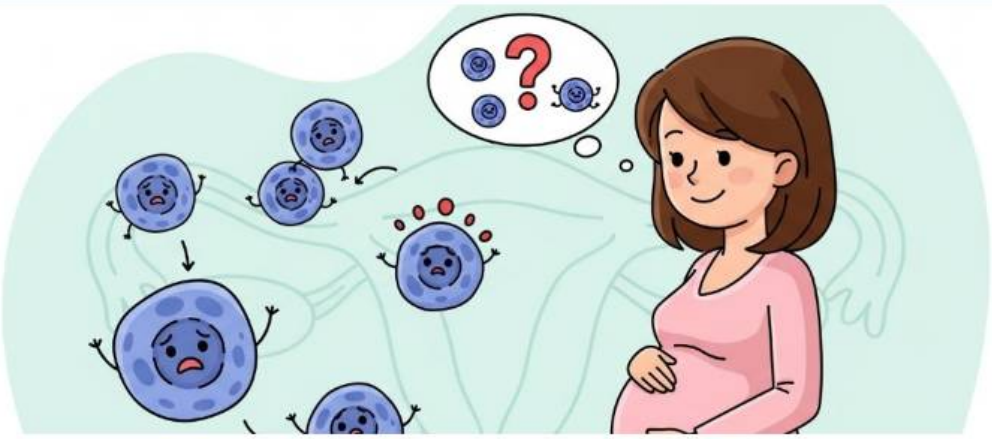
In CKD patients, bleeding despite normal counts and coagulation = suspect ***platelet dysfunction***.

Pitfall to Avoid

Do not **transfuse platelets unnecessarily**. They rapidly become inactive in uremic plasma.

USMLE tip

In patients with CKD and normal platelet counts who develop unexpected bleeding, the most likely cause is **platelet dysfunction**, not thrombocytopenia or coagulopathy.



Gestational Thrombocytopenia

= Benign & Self-Limited

Scenario Summary

A 29-year-old woman at 29 weeks has **fatigue, leg edema, and platelets** 115K/mm^3 (down from 140K). No bleeding.

Key features

Mild thrombocytopenia, no HTN/proteinuria. **Exclusion diagnosis (**normal coagulation, no HELLP/TTP).

Overview

Gestational thrombocytopenia (platelets 100–150K/mm^3) from hemodilution.

Takeaway Points

No treatment needed; resolves postpartum. **Differentiate** from ITP (platelets <100K, petechiae).

USMLE tip

Isolated mild thrombocytopenia in an **asymptomatic** pregnant woman is likely **gestational thrombocytopenia,** requiring **no intervention**.

Cracked Nipples and Blood

= Check That Latch

Scenario Summary

A woman 7 days postpartum has **severe nipple pain**, **bloody discharge**, and is **unable** to breastfeed.

Key features

Bloody nipple discharge, bilateral nipple abrasions, **breast engorgement**, **worsened pain** with feeds.

Overview

Improper latch-on technique is the most common cause of nipple trauma in early breastfeeding.

Key intervention

Assess infant latch and positioning, and **provide education** on proper breastfeeding technique.

Takeaway Points

Cracked, painful nipples with bleeding are usually from poor latch. Early intervention can **prevent** complications and **promote** breastfeeding **success**.

Pitfall to Avoid

Don't assume mastitis or infection if there is no fever, redness, or localized breast tenderness. Also, **don't stop** breastfeeding unless medically necessary.

USMLE tip

Painful, cracked, and bleeding nipples in a breastfeeding mother without signs of infection point toward **poor infant latch technique**, not infection or cancer.

Facial Pigmentation in Pregnancy

= It's Just Melasma

Scenario Summary

A 32-year-old woman at 28 weeks has **light brown facial macules on cheeks** and **nose** that spare the nasolabial folds. No other symptoms.

Key features

Symmetric hyperpigmented macules in malar distribution, normal vitals and labs, **no proteinuria**.

Overview

This is **melasma**, a benign pigmentation disorder in pregnancy due to hormonal stimulation of melanocytes and sun exposure.

Best action

No further evaluation needed. **Reassure** and **recommend sun protection**.

Takeaway Points

Melasma is **common** in pregnancy, **resolves** postpartum, and is **diagnosed** clinically.

Pitfall to Avoid

Don't confuse melasma with lupus rash — lupus is typically erythematous and scaly with systemic signs.

USMLE tip

Symmetric facial hyperpigmentation in pregnancy *without systemic signs* is melasma, and the correct approach is **clinical diagnosis without further workup.**

Heavy Bleeding + Nonviable Fetus

= Suction Curettage

Scenario Summary

A 29-year-old woman at 10 weeks gestation presents with **massive vaginal bleeding**, low BP, and a **nonviable fetus** on ultrasound.

Key features

Hemodynamic **instability**, open cervix, large **clots**, no fetal **cardiac activity**.

Overview

This is an **inevitable abortion** in a hemodynamically unstable patient requiring urgent evacuation.

Immediate management

Perform **suction curettage** to **control** bleeding and **evacuate** retained tissue.

Takeaway Points

Suction curettage is **first-line** in unstable patients with **heavy** bleeding and **inevitable** abortion.

Pitfall to Avoid

Don't delay with expectant or medical management — these are for stable cases only.

USMLE tip

In early pregnancy with heavy bleeding, open cervix, and nonviable fetus, the right approach in an unstable patient is **suction curettage**.

Claw Hand + Ptosis

= Think Klumpke Palsy

Scenario Summary

A newborn boy after **forceps delivery** with **shoulder dystocia** shows right-hand weakness, "**claw hand**" and right-sided **ptosis**.

Key features

Macrosomic baby, forceps delivery, **absent grasp reflex**, **intact** biceps reflex, **ipsilateral** ptosis.

Overview

This is **Klumpke palsy** due to lower brachial plexus (C8-T1) injury during shoulder dystocia.

Pathophysiology

Nerve root traction causing motor loss in hand + **sympathetic** fiber disruption → **Horner syndrome.**

Takeaway Points

Claw hand + Horner's syndrome = **Klumpke palsy**. Often resolves with physiotherapy.

Pitfall to Avoid

Don't confuse with Erb's palsy (C5-C6, "waiter's tip") or fractures. This is lower plexus + sympathetic.

USMLE tip

A newborn with a **claw-like hand**, absent grasp reflex, and ptosis/miosis following shoulder dystocia likely has injury to the C8 and T1 nerves, consistent with **Klumpke palsy**.

High FSH + Streak Ovaries

=Turner Syndrome

Scenario Summary

A 15-year-old girl with **no breast development** is found to have a prepubertal uterus and **high FSH**/LH on labs.

Key features

Primary amenorrhea, absent secondary sex characteristics, **short stature**, **elevated FSH**/LH.

Overview

This is consistent with **gonadal dysgenesis** from **Turner syndrome** (45,X), leading to **primary ovarian insufficiency**.

Pathophysiology clue

Loss of the second X chromosome → **streak ovaries** → **low estrogen** → **elevated FSH** from lack of **negative feedback**.

Takeaway Points

Turner syndrome presents with **short stature**, **primary amenorrhea**, and elevated gonadotropins. Karyotyping confirms 45,X.

Pitfalls to Avoid

Don't confuse with **hypothalamic causes** of **amenorrhea** — **low FSH** would be expected in those.

USMLE tip

A girl with **primary amenorrhea**, **high FSH**, and small prepubertal ovaries likely has **Turner syndrome** due to congenital absence of an X chromosome.

Breast Abscess

=Fluctuant + Erythematous + Febrile

Scenario Summary

A 32-year-old **breastfeeding woman** presents with a week of worsening left breast pain, **erythema**, and **fever**. Exam shows a fluctuant 4-cm mass with surrounding **erythema** and axillary lymphadenopathy.

Key features

Fluctuant, tender breast mass with **fever**, localized **erythema**, and axillary lymph nodes following untreated **mastitis**.

Overview

This is a **breast abscess**, a complication of **mastitis** when **milk stasis** and infection progress into localized purulent collection.

Next step

Perform **needle aspiration** and prescribe **antibiotics** to cover methicillin-sensitive **Staphylococcus aureus**.

Takeaway Points

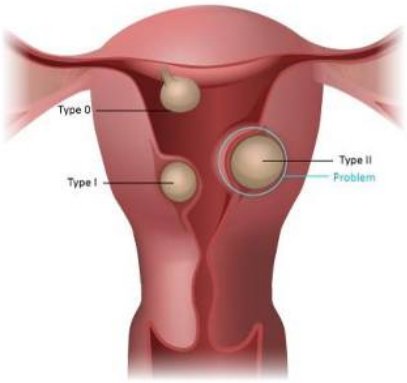
Breast abscess typically requires drainage + **antibiotics**, not just conservative therapy. Continued breastfeeding is encouraged.

Pitfalls to Avoid

Don't confuse this with **mastitis** alone — fluctuation indicates abscess. Breast binding worsens stasis.

USMLE tip

In breastfeeding women with **focal erythema**, **fever**, and a **fluctuant mass**, the proper next step is **needle aspiration** and antibiotic therapy to treat a **breast abscess**.



Submucosal Fibroids

=Cause Recurrent Miscarriage

Scenario Summary

A 35-year-old woman with three **early pregnancy** losses is found to have a 2-cm **submucosal fibroid** on ultrasound.

Key features

Recurrent first-trimester losses, normal cycles, negative thrombophilia workup, **intracavitary fibroid**.

Overview

The fibroid is disrupting the endometrial cavity, impairing implantation or placental development, and causing early miscarriage.

Best treatment

Hysteroscopic myomectomy to remove the **submucosal fibroid** and restore normal uterine anatomy.

Takeaway Points

Submucosal fibroids that distort the endometrial cavity are a well-known cause of **recurrent pregnancy loss** and must be surgically removed.

Pitfalls to Avoid

Don't use clomiphene or heparin unless the problem is hormonal or thrombotic. This is a structural cause.

USMLE tip

When recurrent **early pregnancy** loss is linked to a **submucosal fibroid** on imaging, the next step is **hysteroscopic myomectomy** to improve uterine environment and outcomes.

Simple Ovarian Cyst in Postmenopause

=Check CA–125

Scenario Summary

A 62-year-old woman has an incidental 5-cm **ovarian cyst** found on routine **pelvic ultrasound**. No symptoms or **family history** of cancer.

Key features

Asymptomatic, **postmenopausal**, normal Pap test, simple **ovarian cyst** on imaging.

Overview

In **postmenopausal women**, even benign-looking **adnexal mass**es warrant further evaluation due to higher **malignancy risk**.

Best next step

Serum CA-125 level to risk-stratify the cyst before deciding between observation or further imaging/surgery.

Takeaway Points

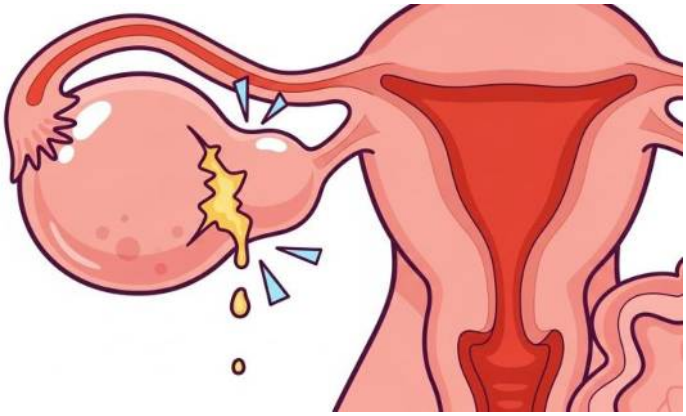
Postmenopausal women with **adnexal mass**es need CA-125 testing, even if the cyst appears benign, due to higher cancer risk.

Pitfalls to Avoid

Never aspirate **ovarian cyst**s — risk of peritoneal seeding. Don't observe without checking CA-125 in **postmenopausal** cases.

USMLE tip

In asymptomatic **postmenopausal women** with a simple-appearing **ovarian cyst**, the next best step is to assess **malignancy risk** with a serum CA-125 level.



Ovarian Cyst Rupture

=Observe if Stable

Scenario Summary

A 32-year-old woman with recent discontinuation of OCPs has sudden LLQ pain and ultrasound showing a simple **ovarian cyst** and free fluid.

Key features

Acute-onset unilateral pain, recent ovulation, negative pregnancy test, thin-walled cyst, moderate pelvic fluid.

Overview

This is likely ruptured physiologic **ovarian cyst**, which can cause sudden **pelvic pain** post-ovulation..

Management decision

If hemodynamically stable and no **fever**, observation and **reassurance** is appropriate

Takeaway Points

Ovarian cyst rupture is often self-limiting. Manage conservatively if the patient is stable.

Pitfalls to Avoid

Avoid unnecessary imaging or surgery if the ultrasound and vitals support benign rupture.

USMLE tip

In a reproductive-aged woman with sudden unilateral pain and pelvic free fluid after stopping contraceptives, the best approach is observation and **reassurance**, indicating **ruptured ovarian cyst**.

Uneven Hair Loss + Sparse Brows

=Trichotillomania

Scenario Summary

An **adolescent girl** presents with **irregular patches** of hair loss, sparse eyebrows, and a habit of **wearing hats**. She enjoys her school play role.

Key features

Patchy hair loss with **broken hairs**, sparse eyebrows, emotionally stable, **compulsive behavior**.

Overview

This presentation is typical of **trichotillomania** (**hair-pulling disorder**), a **compulsive behavior**al condition often triggered by stress or **performance pressure**.

Best treatment

Begin **habit reversal training**, a type of **CBT**.

Takeaway Points

Hair pulling leads to irregular, **non-scarring hair loss** with hairs of different lengths. Eyebrows and **eyelashes** may also be affected.

Pitfalls to Avoid

Don't confuse with **alopecia areata**, which presents as **smooth**, completely **hairless patches** without **broken shafts**. Avoid misdiagnosing as **tinea** or **lupus**.

USMLE tip

When a young female presents with irregular hair loss and sparse eyebrows without **inflammation**, the diagnosis is **trichotillomania**, best treated with **habit reversal CBT**.

MAOI + SSRI

= Serotonin Syndrome

Scenario Summary

A woman with depression develops agitation, tremor, fever, and hypertension after starting phenelzine one week after stopping escitalopram.

Key features

Recent MAOI use, hyperthermia, tremors, dilated pupils, hyperreflexia, altered mental status.

Overview

This is a case of serotonin syndrome due to insufficient washout between SSRI and MAOI.

Likely cause

Serotonin toxicity from phenelzine following recent SSRI (escitalopram).

Takeaway Points

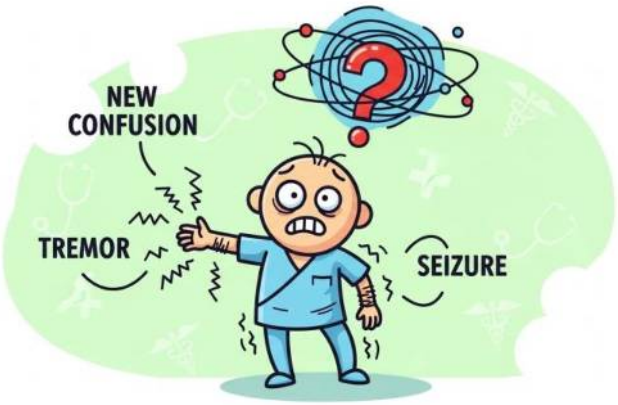
Serotonin syndrome features mental status change, autonomic instability, and neuromuscular hyperactivity. Allow 2 weeks (5 for fluoxetine) before switching to MAOI.

Pitfalls to Avoid

Do not confuse with tyramine hypertensive crisis or NMS. Hyperreflexia and dilated pupils favor serotonin syndrome.

USMLE tip

When a patient on phenelzine presents with agitation, tremor, hyperthermia, and recent SSRI use, the cause is serotonin syndrome due to poor medication transition.



New Confusion + Tremor + Seizure

=Lithium Toxicity

Scenario Summary

A 73-year-old man with **bipolar** disorder becomes confused, tremulous, and ataxic after starting hydrochlorothiazide. He then has a **seizure**.

Diagnosis

Chronic **lithium** toxicity

Why

Symptoms + recent thiazide (↓ **lithium** clearance) point to **accumulation** and **neurotoxicity**.

Most Likely Culprit

Lithium ▪ Common triggers: thiazides, NSAIDs, ACE inhibitors. ▪ Watch for signs: **ataxia**, confusion, GI upset, seizure.

Takeaway Points

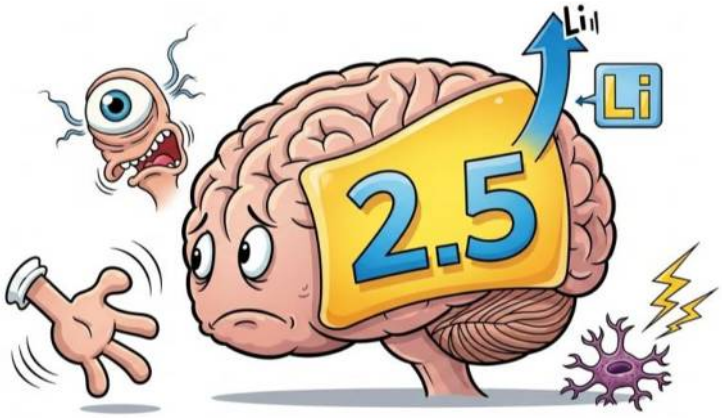
Lithium levels rise with renal clearance reduction—especially with thiazide diuretics.

Pitfalls to Avoid

Don't attribute new neurologic symptoms in **bipolar** patients to aging—check meds first.

USMLE tip

In bipolar patients on **lithium** with ataxia and confusion, suspect toxicity, especially if taking thiazides or NSAIDs.



Lithium Level >2.5 + Neurologic Signs?

= Dialysis Now

Scenario Summary

A 31-year-old woman with **bipolar** disorder is somnolent and confused with fasciculations, **vomiting**, and a **seizure**. Her **lithium** level is 2.8 mEq/L.

Diagnosis

Acute **lithium** toxicity

Why

Classic signs (GI upset, **altered mental status**, neuromuscular symptoms) and a toxic **lithium** level >2.5 mEq/L.

Best Next Step

Hemodialysis

Management Details

▪ **First-Line Treatment** → Hemodialysis for **lithium** level >2.5 + significant symptoms. ▪ Avoid activated charcoal—ineffective for **lithium**. ▪ Monitor renal function and electrolytes during treatment.

Takeaway Points

Hemodialysis is **indicated** in **lithium** toxicity with high levels or severe neurologic symptoms.

Pitfalls to Avoid

Don't waste time on gastric decontamination—**lithium** is poorly absorbed by charcoal.

USMLE tip

In any patient with neurologic signs + **lithium** level >2.5, the next step is hemodialysis—no exceptions.

Stopped Paroxetine + Flu-like Symptoms?

=It's ADS

Scenario Summary

A 35-year-old woman reports **chills**, tremor, **myalgias**, and **insomnia** after **missing several doses** of **paroxetine** during travel.

Diagnosis

Antidepressant discontinuation syndrome (**ADS**)

Why

Short half-life **SSRI** (**paroxetine**) + flu-like symptoms, tremor, irritability = classic **ADS**.

First-Line Treatment

Restart the **SSRI**

Management Details

▪ Restart **paroxetine** → symptoms usually resolve within 24–48 hours. ▪ Consider switching to **fluoxetine** if recurrent **ADS** occurs, due to its long half-life. ▪ Warn patients to avoid abrupt discontinuation.

Takeaway Points

ADS can mimic viral illness—especially with short half-life SSRIs like **paroxetine** and **venlafaxine**.

Pitfalls to Avoid

Don't give antibiotics or antivirals—this is not an **infection**.

USMLE tip

If a patient develops tremor, restlessness, and flu-like symptoms after stopping **paroxetine**, the next step is to restart the **SSRI**.

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USMLE 2 GEMS