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The American College of Obstetricians and Gynecologists (ACOG) recently published clinical management guidelines for cervical insufficiency. The complete directive, ACOG Practice Bulletin No. 48, appeared in the November 2003 issue of *Obstetrics and Gynecology*. This report contains evidence for screening asymptomatic women at risk and offers guidance on the procedure. According to the National Center for Health Statistics, 23,000 discharge records from short-term hospitals included a diagnosis of cervical incapacity in 2000. Diagnostic criteria remain elusive and several surgical and non-surgical treatments have been proposed. Is there a role for routine ultrasound examination of the cervix? Serial ultrasound evaluations of the cervix in women at low risk showed low sensitivity and low positive predictive values, which means that ultrasonography lacks enough discriminatory performance to recommend routine use. What is the role of ultrasonography in the evaluation of women who have had a previous loss of pregnancy? The results of the study suggest that serial transvaginal ultrasound may be considered in women with a history of second or early third trimester delivery. Since the upper part of the cervix is not easily distinguished from the lower uterine segment in early pregnancy, these reviews should not begin before 16 to 20 weeks of pregnancy. According to ACOG, there is no reason to conduct ultrasound screening for cervical insufficiency in women with a history of first trimester pregnancy loss. In which cerclage is stated? In the past, the choice of patients for elective cerclage was based on congenital or acquired visible defects of ectocervix or classic features of cervical incompetence, which include a history of two or more pregnancy losses of the second trimester (except those resulting from premature labor or secession); history of loss of each pregnancy at an earlier gestational age; history of painless dilation of the cervix up to 4 to 6 cm; absence of clinical findings corresponding to placental abruption; and history of cervical trauma caused by a biopsy of the cone, intrapartum cervical lacerations and excessive forced dilation of the cervix during the termination of pregnancy. Based on limited clinical information, elective cerclage for historical factors should generally be limited to patients with three or more otherwise unexplained pregnancy losses in the second trimester or premature births. Cerclage should be performed after 13 to 16 weeks of pregnancy after ultrasound examination showed the presence of a live fetus without obvious anomalies. Urgent, or therapeutic, cerclage is often recommended for women who have ultrasonographic changes consistent with short cervix or evidence of funnels. The management of this group remains speculative due to the limited number of well-designed randomised studies. The decision to proceed with cerclage should be made with caution. In the past, women who present themselves with advanced cervical dilation in the absence of work and secession candidates for emergency cerclage. No randomised studies have been conducted in this area and retrospective studies are limited by selection bias, insufficient patient numbers and inconsistent selection criteria. How should a short cervix be treated in the second trimester? According to ACOG, if transvaginal ultrasonography before 16 to 20 weeks of pregnancy identifies a short cervix, the examination should be repeated due to the inability to adequately distinguish the cervix from the lower uterine segment in early pregnancy. Identification of the short cervix at 20 weeks of pregnancy or after it should lead to an immediate examination of fetal anomalies, uterine activity that excludes premature birth, and maternal factors that exclude chorioamnionitis. Regular evaluation can be carried out (especially in patients with pelvic pressure, back pain or increased mucoid discharge) every few days to prevent missing rapid changes in cervical expansion or until a trend in the length of the cervix is characterized. In patients with a history of less than three second trimester pregnancy losses, urgent cerclage is not supported by evidence-based studies, and additional transvaginal ultrasound surveillance may be a more judicious approach. Treatment of cervical shortening or funnel is unclear, and the decision to proceed with urgent cerclage should be done with caution. The cervical change recorded before the viability of the foetus is a better indication for cerclage than when it is identified after the viability of the foetus has been achieved. Emergency cerclage can be considered in women if clinical chorioamnionitis or signs of childbirth are not present. In the third trimester, how should a short cervix be treated? If the length of the patient's cervix is less than 10 percentile (25 mm) for gestational age at or after the viability of the fetus, the evaluation should include ultrasound assessment of fetal anatomy to exclude anomalies, tocodynamometry to detect the presence of uterine contractions and assessment of maternal factors to exclude chorioamnionitis. If the patient is at work, thiscolytic therapy can delay delivery long enough to promote the ripening of the lungs of the fetus with maternal glucocorticoid therapy. The presence of chorioamnionitis is the reason for the immediate delivery and use of broad-spectrum antibiotics. If work or chorioamnionitis is not present, a change in activity, pelvic rest, tobacco quitting and upcoming proceedings may be considered. Cerclage has not been adequately evaluated in the treatment of women with cervical insufficiency after determining fetal viability. Is there a role for the planned early or first trimester cerclage in patients with a suspicious clinical history? The evidence-based risk-benefit ratio does not support cerclage in the first trimester, even in transabdominal procedures. Is the location of cerclage associated with an increase in morbidity? Suture displacement, membrane rupture and chorioamnionitis are the most common complications associated with the location of cerclage and the timing and indications for cerclage. Urgent and emergency cerclages are associated with a higher incidence of morbidity due to cervical shortening and exposure of amniotic membranes to the vaginal ecosystem. Transabdominate cerclage can be complicated by rupture of membranes and chorioamnionitis. It carries an increased risk of intraoperative bleeding from the uterine veins when the cerclage band is tunneled between the dissections of the uterine artery, as well as the known risks associated with laparotomy. Life-threatening complications of uterine rupture and maternal septicemia are extremely rare, but have been reported in all types of cerclage. Should perioperative antibiotics and tocolytics be used in connection with the location of cerclage? Studies with perioperative antibiotics were small, undisturbed and inconclusive. The use of unnecessary antibiotics can lead to the development of resistant strains of bacteria and other morbidity for the patient and her fetus. No randomized studies have shown that the use of tocolytic therapy after cerclage is effective. The lack of a clear benefit for these supplement treatments suggests that these drugs should be used with caution. Does a patient who has been exposed to diethylstilbestrol require cerclage? To date, no definitive epidemiological studies have shown that cervical insufficiency is more common in women exposed to diethylstilbestrol than in comparable control subjects. There are no randomized cerclage studies in these patients. A woman who has been exposed can be evaluated according to the same criteria as a patient without use. When is cerclage removal indicated in a patient with premature work or premature rupture of membranes? Since the available studies are small and undisturbed, the optimal timing of cerclage removal is unclear, according to ACOG. Page 2Carrie Morantz, Brian TorreyAm Fam Doctor. 2004 Jan 15;69(2):440-441.ACOG Opinion paper on elective surgeryCommittee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) has released a new opinion paper dealing with the dispute over elective caesarean section. Surgery and Patient Choice. The ethics of decision-making is available online at and the right of patients to refuse unwanted surgery is well known, less clear is the right of patients to have surgery done when the scientific evidence to support it is incomplete, poor quality, or completely absent. According to ACOG, when supporting evidence is limited, there is no single answer to the correct ethical response of a doctor considering a patient's request for surgery. This means that the decision on whether to perform an elective Caesarean section (also known as a patient's caesarean section or caesarean section on demand) comes down to a number of ethical factors, including concerns about the patient and the doctor's understanding of the risks and benefits of the procedure. In case of elective caesarean section if the doctor believes that caesarean section promotes the overall health and well-being of the woman and her fetus more than vaginal birth, then he is ethically entitled to perform a Caesarean section. Similarly, if the doctor believes that performing a Caesarean section would be harmful to the overall health and well-being of the woman and her fetus, he is ethically obliged to refrain from performing the operation. Referral to another doctor would be appropriate if the patient and her doctor can not agree on the method of delivery. As regards the policy change in support of elective caesarean section, the ACOG states that the burden of proof should fall on those who advocate change. Therefore, doctors are not required to start a discussion about a procedure such as an elective Caesarean section, which is scientifically unproved or that an individual doctor may not consider medically acceptable. A growing number of women are asking for an elective Caesarean section instead of vaginal delivery in the belief that surgery will prevent future pelvic support problems, or sexual dysfunction problems, or for other reasons. A number of doctors believe that such an operation should not be selected through a natural process without immediate and convincing medical needs. ACOG warns that evidence to support the benefit of elective caesarean section is still incomplete and that there are no extensive morbidity and mortality data to compare elective caesarean section delivery with vaginal birth in healthy women. With better data, there could be a shift in clinical practice. Cdc Report on Physical Activity Among ChildrenAdmi, although most children between the ages of nine and 13 engage in certain levels of free-time physical activity, increased participation rates in both free-time and organized physical activity are needed, especially for non-Hispanic black and Hispanic children, according to a report by the Centers for Disease Control and Prevention (CDC). Physical Activity Levels Among Children 9-13 Years-United States, 2002 appears in the August 22, 2003, issue of the *Morbidity and Mortality Weekly Report* and is available online and to promote at healthy, more active lifestyle among U.S. youth, the CDC has developed the Youth Media Campaign (YMC), at national initiative to encourage children of nine to 13 years of age to engage in and maintain high levels of regular physical activity. The CDC conducted the YMC Longitudinal Survey (YMCLS) to provide a baseline assessment of physical activity levels in children in this age group. According to the report, 61.5 percent of children between the ages of 9 and 13 do not participate in any organized physical activity during extracurricular hours; 22.6 percent do not engage in any free physical activity. The CDC notes that improving the level of physical activity in this population will require innovative solutions that motivate children and obstacles that prevent their children from physical activity. Fewer children reported engaging in organized sports (38.5 percent) than in free physical activity (77.4 percent). Non-Hispanic black and Hispanic children were significantly less likely than non-Hispanic white children to report an engaging in organized activities, as were children with parents who had lower incomes and education levels. Although parents generally perceived the same barriers to participating in physical activities regardless of the child's gender and age, concerns about transportation, opportunities in their area, and costs were reported significantly more frequently by non-Hispanic black and Hispanic parents than non-Hispanic white parents. Neighborhood safety concerns were reported more frequently in girls (17.6 percent) than in boys (14.6 percent) and were reported more frequently by Hispanic parents (41.2 percent) than non-Hispanic whites (8.5 percent) and non-Hispanic black (13.3 percent) parents. Overall, parents with lower incomes and education levels reported more perceived barriers. The AHRQ report on prescription drug spending and the Health Care Research Agency and the Panel Health Expenditure Survey (MEPS) released a new report on prescription drug use and spending. Statistical Brief Number 21: Trends in Outpatient Prescription Drug Use and Spending: The 1997-2000 available online at MEPS found a significant increase in total outpatient prescription spending between 1997 and 2000-from \$72.3-3 billion to \$103 billion. Outpatient prescription drugs accounted for a larger share of total health care spending, increasing from about 13 percent of total spending in 1997 to more than 16 percent in 2000.Average out-of-pocket spending for people 65 and older was more than three times higher than for people under 65 each year of the study period. Between 1997 and 2000, the average cost for people 65 years and older with prescription drug costs increased by 35 percent, from \$819 to \$1,102. For people under 65, the amount increased by 40 percent, from \$347 to \$485.Finally, the average number of prescriptions for people aged 65 and older was more than double the average number of prescriptions for people under 65 each year of the study period. Page 3Discoignite note: This information was up to date at the time of publication. But medical information is constantly changing, and some information here may be outdated. Regularly updated information on various health topics can be found familydoctor.org, on the AAFP patient education website. Am Fam doctor. 2004 Jan 15;69(2):375-376.Antibiotics are powerful drugs that can stop some infections and save lives. But antibiotics can cause more harm than good if not used in the right way. You can protect yourself and your family by knowing when use antibiotics and when you should not. No. Antibiotics act only against infections caused by bacteria. They do not work against infections caused by viruses. Viruses cause colds, flu and most coughs and sore throats. When bacteria are repeatedly exposed to the same antibiotics, the antibiotic can no longer fight the bacteria. Being exposed to the same antibiotic for a long time can change some bacteria. And sometimes bacteria change on their own. Some changes make bacteria so powerful that they can fight antibiotics and win the fight. Then they say that these bacteria are resistant to this antibiotic. Antibiotic resistance is becoming a common problem in many parts of the United States. Resistant bacteria develop faster when antibiotics are used too often or are not used properly. Resistant bacteria can sometimes be treated with antibiotics to which the bacteria have not yet become resistant. These drugs can be administered intravenously (through a vein) in a hospital. Several types of resistant bacteria are incurable. If you take antibiotics that can't fight the bacteria you have to kill, your infection may take longer. Instead of doing better, your infection can get worse. You may need to make several visits to your doctor's office. You may need to take various medications or go to the hospital for antibiotics in the veins. At the same time, your family members or other people you come into contact with may catch the resistant bacteria you have. Then they would also get infections that are hard to cure. Every time you take antibiotics when you don't really need it, you can increase the likelihood that you will get the disease one day, which is caused by bacteria that are resistant to antibiotics. The answer depends on what is the cause of the infection. Below are the following some basic guidelines:Colds and flu. Viruses cause these diseases. They can not be cured with antibiotics. Cough or bronchitis. Viruses almost always cause these. However, if you have a problem with the lungs or a disease that lasts a long time, bacteria can be the cause. Your doctor may decide to try to use an antibiotic. Sore throat. Most sore throats are caused by viruses and do not need antibiotics. However, strep throat is caused by bacteria. A cervical swab and laboratory test are usually needed before your doctor prescribes an antibiotic for strep throat. Infection. There are several types of ear infections. Antibiotics are used for some, but not all of them. Sinus infection. Antibiotics are often used to treat sinus infections. Runny nose and yellow or green mucus do not necessarily mean that you need an antibiotic. Carefully follow your doctor's instructions. Your doctor will tell you to take all antibiotics. Do not hide some medications for the next time you are sick. Wash your hands with soap and water before meals and after using the bathroom. Regular hand washing during the day will help keep you healthy and prevent the spread of if you have all the vaccinations (injections), you need to protect yourself from the disease. Page 4 Note: This information was up-to-date at the time of publication. But medical information is constantly changing, and some information here may be outdated. Regularly updated information on various health topics can be found familydoctor.org, on the AAFP patient education website. Am Fam doctor. 2004 Jan 15;69(2):379-380.Influenza (also called influenza) is a viral infection in the nose, throat and lungs. About 10 to 20 percent of Americans get the flu each year. Some people are very sick. Every year, about 130,000 people go to the hospital with the flu, and 20,000 people die due to flu and complications. Influenza can cause fever, cough, sore throat, runny nose or stuffy nose, headache, muscle aches and fatigue. Some people describe the flu as the worst cold of their lives. Most people feel better after one or two weeks, but for some people, the flu leads to serious, even life-threatening diseases such as pneumonia. The flu vaccine (flu shot) is recommended for people who are more likely to get really sick and need to be protected from getting the flu. You have a higher risk of complications of influenza, such as pneumonia, if: They are 50 years of age or olderAre a health workerYou have a lung problem, such as asthma or emaciated lungsYou have a suppressed immune systemYou have diabetes, heart disease, or other long-term health problemsYou are in any of these groups, you should probably get the flu vaccine every year. Other people should also get the vaccine because they could spread the flu to high-risk people. You should receive the vaccine if you are working in a long-term care facility. Even if you're not at higher risk, you may want to get the flu vaccine so you don't get sick with the flu. There are two types of flu vaccine. The first species is a shot that contains slain viruses. You can't get the flu out of a shot because the viruses are dead. Your body makes antibodies to the virus to protect you from the flu. When a live virus appears, your defenses are ready. These defenses are stopping you from getting the flu. The second species is the liquid that you spray into the nose (nasal mist). Nasal fog contains live viruses. These viruses have been altered so that they do not grow well at body temperature, but cause your body to produce antibodies to the real flu virus. Only healthy people between the ages of five and 49 can use nasal fog. Since flu viruses change from year to year, you need to get a shot or use nasal fog every year to be protected. Yes. Even with the flu or nasal fog, you are not completely protected. Each year the flu vaccine contains three different strains (types) of the virus. The selected strains are the ones that scientists believe are most likely to appear in the United States that year. If their choice is correct, the vaccine is 70 to 90% effective in preventing influenza under the age of 65. If you are older than 65 years, the vaccine is less likely to prevent flu. If you get the flu after the vaccine, however, your flu symptoms should be milder than when you didn't get the vaccine. You will also be less likely to get complications from the flu. Yes. Flu vaccination is safe for people over six months of age. The shot has few side effects. Your hand can be sore for several days. You may have a fever, feel tired, or have aching muscles for a short period of time. Nasal fog is safe for people over five years of age. However, people who have asthma or other respiratory diseases, and diseases with a lack of immunity or immunosuppression should not use nasal fog. Nasal fog has several side effects, including runny nose, nasal congestion, sore throat, and cough. Some people are allergic to the flu vaccine. If you have a severe allergy to eggs, you should not get a shot or use nasal fog. You should consult your doctor about your egg allergy. He or she will tell you if it's okay for you to get the flu vaccine. Some pregnant women should not get the flu vaccine. If you are pregnant and want to get a flu vaccine, talk to your doctor. For more information, you can call the National Immunization Information Line of the Centers for Disease Control and Prevention at the following numbers: 1-800-232-2522 (English)1-800-232-0233 (Spanish)To view the full article, log in or buy access. This leaflet is provided by your family physician and the American Academy of Family Physicians. More health-related information is available in AAFP online at . This information provides a general overview and may not apply to everyone. Consult your family doctor to see if this information applies to you and get more information on the subject. Image copyright © 2004 by the American Academy of Family Physicians This content is owned by AAFP. A person viewing it online can make one copy of the material and can only use it for their personal, non-commercial references. 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