
護理與UpToDate

- Nursing Program and UpToDate

林幼婕(Yoyo)

Customer Success Specialist

 Wolters Kluwer



內容 Content

- 護理師2025年願景 (Goal of International Council of Nurses (ICN) in 2025)
- UpToDate介紹 (Introduction of UpToDate)
- 護理課程與UpToDate的結合 (How to Engage Nursing Program and UpToDate)
 - 利用案例實際操作UpToDate (UpToDate Demo by using clinical case)
- 使用UpToDate回答問題 (Search answer by using UpToDate)
- 總結 (Summary)
- Q&A



護理師2025年願景 (Goal of ICN in 2025)

護理師2025年願景 (Goal of ICN in 2025)

- 2025年國際護理師節主題：「*Our Nurses. Our Future. Caring for nurses strengthens economies*」(有護理師才有未來，關懷護理師促進經濟成長)。
 - The importance of supporting the health and wellbeing of nurses, who are vital to the functioning of health systems globally.
(支持護理人員的健康和福祉的重要性，護理人員對於全球衛生系統的運作至關重要。)
 - Calling for all organizations and governments to value, protect, respect and invest in our nurses for a sustainable future for nursing and health care.
(呼籲所有組織和政府重視、保護、尊重和投資我們的護士，為護理和醫療保健創造可持續的未來) (ICN;2025)



- 要如何達到 (How to Achieve) ?
 - 將護理價值量化 (Quantifying the value of nursing)(馮等，2017)



護理師2025年願景 (Goal of ICN in 2025)

- 醫院病安目標 (Hospital safety goals)

-2025年衛生福利部醫院病安目標：

- * 促進醫療人員間團隊合作及有效溝通

(Promote teamwork and effective communication among medical staff)

- * 營造病人安全文化、建立醫療機構韌性及落實病人安全事件管理

(Create a patient safety culture, build institutional resilience and implement patient safety incident management)

- * 提升

(Impr

- * 預防

(Prev

- * 落實

(Impl

- * 提升

(Impr

- * 改善醫病溝通並鼓勵病人及家屬參與病人安全工作

(Improve doctor-patient communication and encourage patient and family involvement in patient safety efforts)

- * 維護孕產兒安全

(Protect the safety of pregnant women and infants)

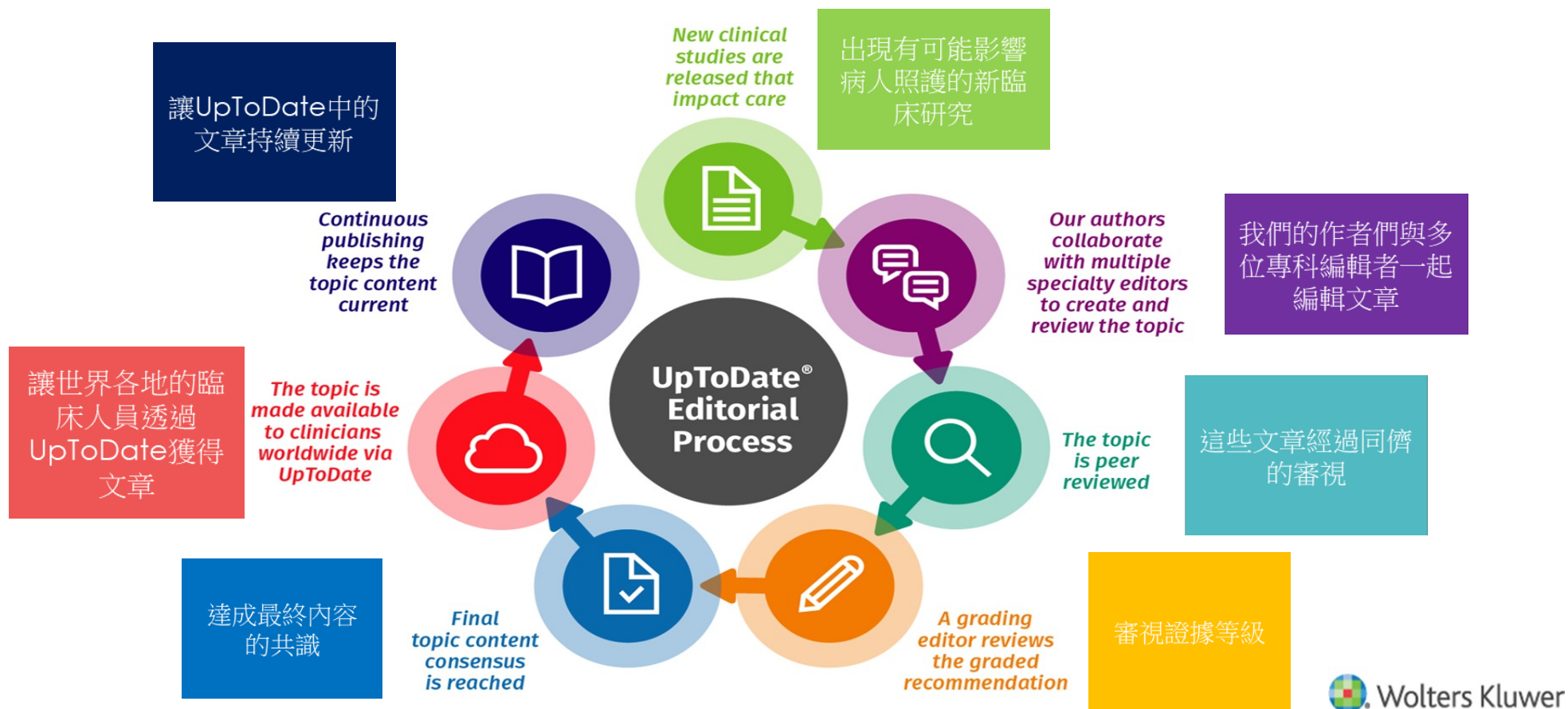
臨床實證醫學
(Evidence-based medicine, EBM)

衛生福利部(2025)

UpToDate 介紹 (Introduction of UpToDate)

UpToDate 介紹 (Introduction of UpToDate)

-文章如何產生? (How the articles have been produced?)



UpToDate 介紹 (Introduction of UpToDate) -資料來源(Resources)

- **Journals:**

- 426 peer reviewed journals:

<https://www.wolterskluwer.com/en/solutions/uptodate/about/journals-reviewed-by-uptodate>

- **Electronic searching of databases:**

Medline and Cochrane Library

- **Guidelines**

- **Published information regarding clinical trials**

- Such as reports from the US Food and Drug Administration (FDA), clinicaltrials.gov, and the European Medicines Agency, as well as other sources of information produced by governmental and nongovernmental agencies such as the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO).

- **Proceedings of major national and international scientific meetings**

- **The clinical experience and observations of our authors, editors, and peer reviewers**

UpToDate® Enterprise Suite



10,400+
主題
topics



1900+
病患衛教單張
Patient education topics



420+
人工檢索的期刊
journals hand-searched



9,800+
分級建議
Graded recommendations



>850
醫學指南
Society Guidelines



7,600+
獨立藥品條目
unique drug entries



38,000
圖像內容 (表格、圖片、演算法)
graphics (tables, images, algorithms)



200+
計算器
calculators

✓ **KLAS Clinical Adoption**

- Broadest adoption among physicians; high satisfaction

✓ **Frost & Sullivan**

- Top 2 CDS Growth and Innovation 2023

✓ **Market validation**

Who uses UpToDate

- 100% of top 20 U.S. News Best Hospitals Honor Roll
- 80% of Healthgrades America's 100 Best Hospitals™
- 80% of U.S. hospitals selected for the 2022 inaugural Best Hospital Award by Money and The Leapfrog Group

護理課程與UpToDate的結合 (How to Engage Nursing Program and UpToDate)

護理課程與UpToDate的結合

(How to Engage Nursing Program and UpToDate)

- **使用實際案例報告**
(Incorporate actual case studies)

- 利用案例報告內容，指引學生使用可性度高的資料庫找尋資料
(Utilize case report content to guide students in searching for information using high-credibility databases)
- 使用UpToDate延伸，學習更多相關新醫學知識
(Utilize UpToDate to further explore and learn about the latest advancements in medical knowledge)

- **使用不明確之病人狀況結合心智圖**
(Apply mind mapping techniques to interpret unclear clinical scenarios)

- 給學生一個狀況不明確的病人狀況，利用UpToDate找尋答案
(Use an ambiguous clinical scenario and guide them to use UpToDate to search for appropriate answers)
- 並使用心智圖輔助學習及整理思路
(Incorporate mind mapping as a tool to facilitate learning and organize processes)

- **結合客觀結構式臨床測驗(OSCE)**
(Incorporate Objective Structured Clinical Examinations (OSCEs))

- 給學生一個醫囑，評估其是否能用UpToDate確認醫囑是否正確
(Provide students with a medical order and assess their ability to verify its accuracy using UpToDate)
- 若不正確/需要討論，該如何利用查到的資料與其他醫療團隊溝通
(If the order is incorrect or requires further discussion, guide students on how to use the information they have found to effectively communicate with other members of the healthcare team)

護理課程與UpToDate的結合(How to Engage Nursing Program and UpToDate) -使用實際案例報告 (Incorporate actual case studies)

• 慢性阻塞性肺病(COPD)急性惡化病患之臨床辨別與處置

住院日期	2023/9/18	姓名：C 先生
年齡：82 y/o	性別：男	宗教信仰：民間信仰
身高：170cm	體重：52Kg	過敏史：無
過去病史：：高血壓，肺心症		
此次入院主述及情況：		
此次入院主述及情況： C 先生今早因呼吸喘、痰液多又稠，無法自咳，由家屬送至急診室。CXR 初步診斷有肺氣腫(emphysema bullae)，沒有肺炎 (pneumonia)、敗血肺(septic lung)、肺水腫(pulmonary edema)、或氣胸(pneumothorax)等現象。C 先生沒有發燒，雖已接受 A+B inhalation 及持續 aminophylline 20 mg/hr IVF 治療，並給予氧氣鼻套管 O ₂ Mask FiO ₂ 40% 使用。但他仍抱怨呼吸不順暢，理學檢查也發現他雙側肺葉有明顯喘鳴音(wheezing)，因此安排住院治療。		

小夜班(21:00)，C 先生呼吸費力，咳嗽不止，呼吸的喘鳴音更明顯了。同時主訴冒冷汗、心悸。護理師測量生命徵象，體溫 37.6°C，心跳 125bpm，呼吸 36 bpm，血壓 90/60mmHg，請值班醫師來視，依醫囑給予抽血 ABG 及 CBC/DC。 值班醫師囑咐繼續給予 O₂ 與 bronchodilator，就回值班室睡覺了。

大夜班 2 點鐘，病人突然嚴重咳血，你到 bedside 時已經量不到 BP，評估意識狀況 E1V2M4，通知值班醫師來後，給予插入 7.5# oral Endo with Ventilator support (Mode: A/C、rate:12 bpm、PEEP: 5 cmH₂O、FiO₂:40%)、on 16# foley、on 14# NG with decompression。 並給予大量輸液及緊急輸血，追蹤 CXR 後發現，C 先生疑似左側氣血胸，緊急插 32# chest tube with one bottle system drainage with low

pressure suction 10 cmH₂O，並於 2:30 轉入 ICU 治療。 2:40 C 先生顯得非常躁動，SaO₂ 78%，抽血 ABG PH:7.26、PaO₂: 48mmHg、PaCO₂:76 mmHg、SaO₂:88%、HCO₃⁻: 27 meq/L。且 C 先生呈現持續休克狀況，BP:70/40mmHg。

護理課程與UpToDate的結合(How to Engage Nursing Program and UpToDate)

-使用實際案例報告 (Incorporate actual case studies)

慢性阻塞性肺病(COPD)急性惡化病患之臨床辨別與處置

- 呼吸喘、痰液多又稠

-針對這個症狀學生可以在UpToDate上先了解呼吸喘/呼吸困難(Dyspnea)初步處置要做什麼?

The screenshot displays the UpToDate interface for a search on 'Dyspnea'. The left sidebar shows a 'Contents' menu with sections: SUMMARY AND RECOMMENDATIONS, INTRODUCTION, PATHOPHYSIOLOGY, EPIDEMIOLOGY, OVERVIEW OF APPROACH, INITIAL RAPID ASSESSMENT AND STABILIZATION, Clinical danger signs, Emergency stabilization of patients with danger signs, and a 'Prenatal car' section. The main content area is divided into three columns. The first column lists 'Clinical danger signs' and 'Emergency stabilization of patients with danger signs', with sub-points for 'General measures' (Options for oxygenation or ventilatory support, Patients with inadequate respiratory effort), 'Targeted measures based on signs and symptoms' (Stridor, Unilateral diminished breath sounds, Rales), and 'Wheezing'. The second column is titled 'EVALUATION OF STABLE AND STABILIZED PATIENTS' and lists 'History', 'Physical examination', 'General measures' (Supplemental oxygen), and 'Diagnostic testing' (Overview, Studies for almost all patients, Plain chest radiograph). The third column lists 'History', 'Physical examination', 'General measures' (Supplemental oxygen), 'Diagnostic testing' (Overview, Studies for almost all patients, Plain chest radiograph), and 'Role of bedside ultrasound'. A 'Showing results' bar at the top indicates 'Showing results'.

護理課程與UpToDate的結合(How to Engage Nursing Program and UpToDate)

-使用實際案例報告 (Incorporate actual case studies)

慢性阻塞性肺病(COPD)急性惡化病患之臨床辨別與處置

- 接下來學生能診斷在UpToDate查詢診斷名稱

 - 肺氣腫(emphysema bullae)、肺炎 (pneumonia)、敗血肺(septic lung)、肺水腫(pulmonary edema)、或氣胸(pneumothorax)

- 再來是學習到藥物資訊，藥物的副作用、如何使用及使用後的注意事項？以及是否有和其他藥物的交互作用？

 - 什麼是Atrovent 和 Bricanyl?

 - aminophylline怎麼使用?

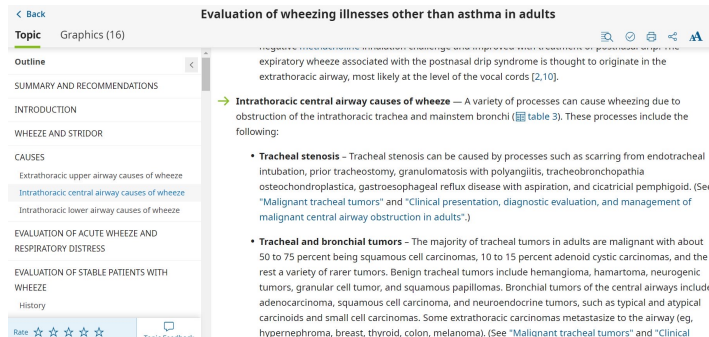
The screenshot shows the UpToDate interface for "Aminophylline: Drug information". On the left, there is a navigation menu with sections: Outline, Pharmacologic Category, Dosing (Adult, Pediatric), and Adverse Reactions. The main content area includes a copyright notice for UpToDate Lexidrug, contributor disclosures, and a note to see "Aminophylline: Patient drug information" and "Aminophylline: Pediatric drug information" for more details. Below this, the "Pharmacologic Category" is listed as "Phosphodiesterase Enzyme Inhibitor, Nonselective". The "Dosing: Adult" section contains a note: "All dosages expressed as aminophylline; use ideal body weight to calculate dose (theophylline has limited distribution into body fat); individualize dose based on steady-state serum theophylline concentrations. Theophylline dose is ~80% of aminophylline dose."

The screenshot shows search results for "Atrovent (Ipratropium)". The search results include: "Showing results for Atrovent (Ipratropium)", "Search instead: Anticholinergic drugs, Bronchodilators", and three UpToDate Pathways: "Chronic obstructive pulmonary disease: Severity assessment and selection of initial therapy in adults", "Acute bacterial rhinosinusitis: Evaluation and management for adults who have failed initial antibiotic treatment", and "Acute rhinosinusitis: Initial management and...". On the right side, there is a sidebar with filters for "Ipratropium", including "Ipratropium: Drug information", "Ipratropium: Pediatric drug information", and "Ipratropium: Patient drug information", each with sub-links for "Oral Inhalation" and "Nasal". At the bottom of the sidebar is a button for "Launch drug interactions program" with a right-pointing arrow.

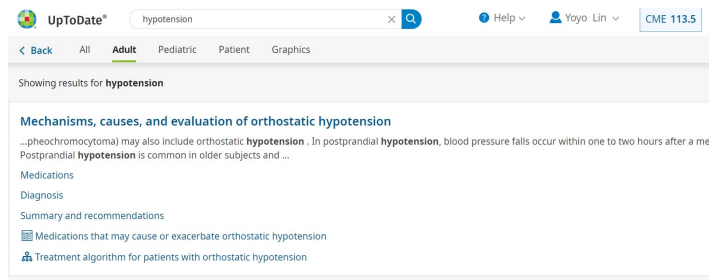
護理課程與UpToDate的結合(How to Engage Nursing Program and UpToDate) -使用實際案例報告 (Incorporate actual case studies)

慢性阻塞性肺病(COPD)急性惡化病患之臨床辨別與處置

- Wheezing 是什麼? 需要注意什麼? 什麼樣的疾病會有Wheezing?



- 心跳快、血壓掉的處置?



Evaluation of and initial approach to the adult patient with undifferentiated hypotension and shock

...that raise the suspicion for shock include the following: **Hypotension** – **Hypotension** occurs in the majority of patients with shock. **Hypotension** may be absolute (eg, systolic blood pressure <90 mmHg; mean ...

Features of shock

Summary and recommendations

👤 Patient with undifferentiated shock (initial approach)

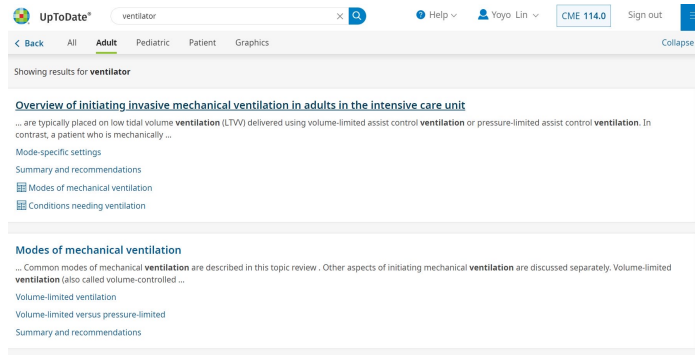
👤 Patient with undifferentiated shock (ongoing resuscitation)

護理課程與UpToDate的結合(How to Engage Nursing Program and UpToDate)

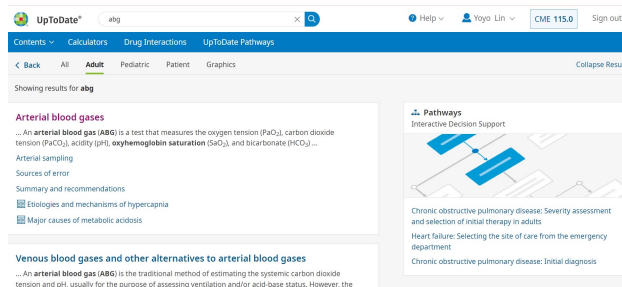
-使用實際案例報告 (Incorporate actual case studies)

• Ventilator 的設定?

-A/C mode是什麼? 還有什麼mode?



• ABG的正常值是什麼?病人是呼吸性酸重度?代謝性酸中毒?



asia, neglect, agnosia, or apraxia?
the face involved (eg, facial droop)?
were a myotomal pattern to the
distribution of weakness?
the description of weakness
consistent with a particular peripheral
nerve?

-Patient's History

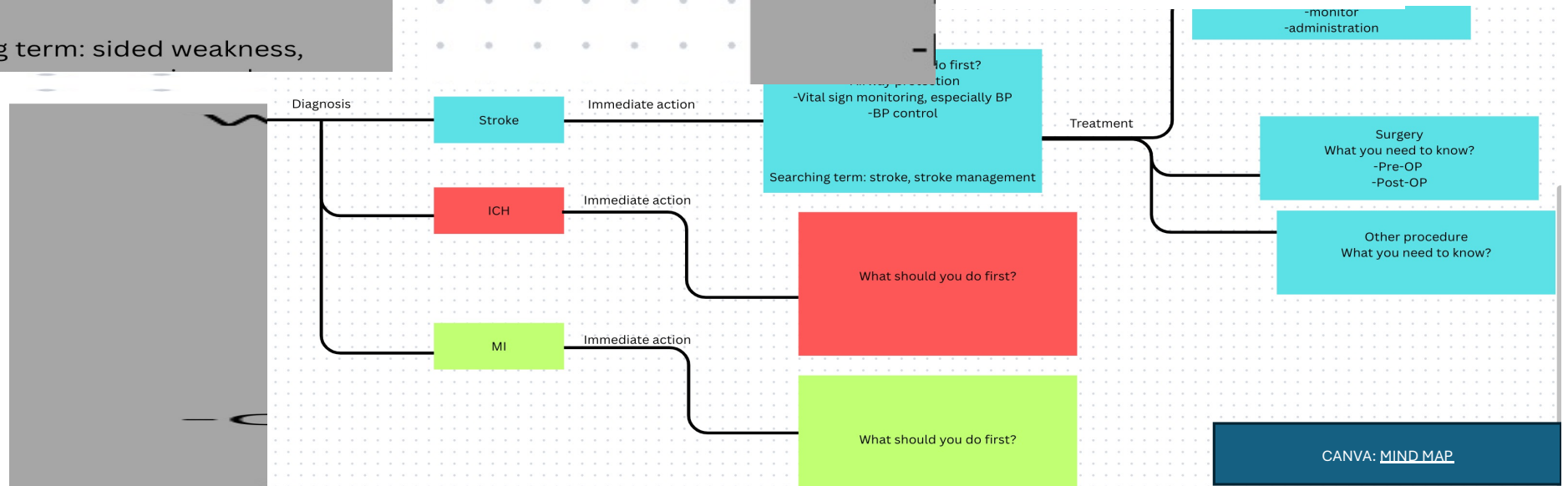
What diseases might cause it?

- Infection
- Brain disease
- Abnormal Lab Data

searching term: sided weakness,

合 (How to Engage Nursing Program) 智圖 (Apply mind mapping techniques)

enarios)

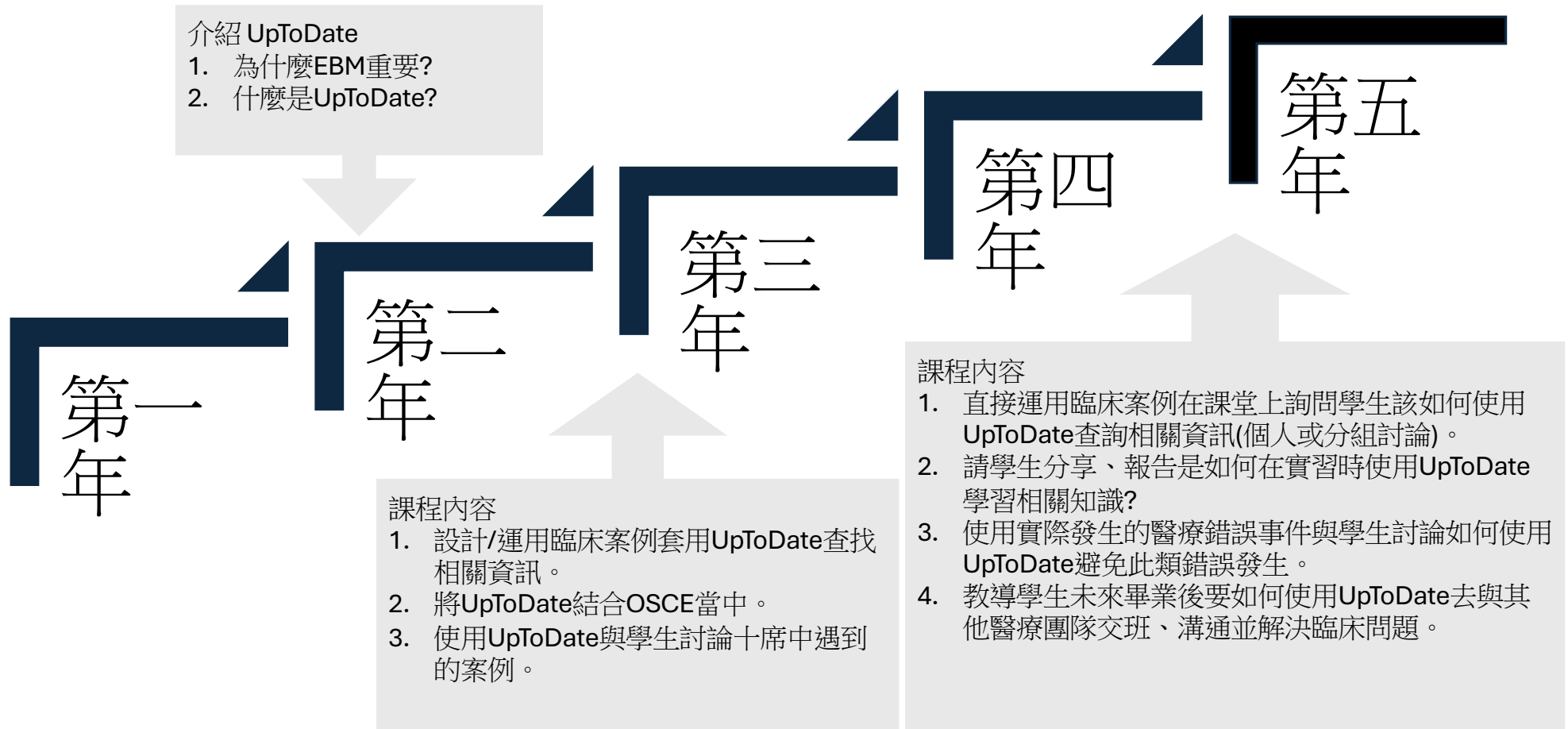


護理課程與UpToDate的結合(How to Engage Nursing Program and UpToDate)

-結合客觀結構式臨床測驗(OSCE)(Incorporate Objective Structured Clinical Examinations (OSCEs))

- 65歲男性，剛動完膝關節置換術(total knee replacement; TKR)，您是小夜班的主護，看到醫囑“Propofol 50mg IVP ST”，請執行相關護理措施。

護理課程與UpToDate的結合(How to Engage Nursing Program and UpToDate) -與護理課程設計



使用UpToDate回答問題 (Search answer by using UpToDate)

- 請問，若哺乳期的媽媽服用Acetaminophen 後，此藥物會出現在母乳嗎？
-會
- 中風的病人(ischemic stroke)在血栓溶解劑治療(thrombolytic therapy)前血壓要維持在多少？
-systolic blood pressure is ≤ 185 mmHg and diastolic blood pressure is ≤ 110 mmHg
- $\leq 185/110$ mmHg
- 請問，warfarin 可以和以下哪些藥物一起使用，毋須擔心交互作用？
A. Alteplase B. Oxatomide C. Digoxin D. Streptokinase
- 請問，病人體重98kg，身高185cm，請問他：
A. 過輕 (Below normal weight) B. 正常 (Normal weight) C. 過重 (Overweight) D. 一級肥胖 (Class I Obesity)

總結(Summary)

- 2025年國際護理師節主題：「Our Nurses. Our Future. Caring for nurses strengthens economies」(有護理師才有未來，關懷護理師促進經濟成長)。
- 利用護理與實證醫學提升護理師的專業性
- 利用UpToDate提升醫學知識及臨床思考
- 使用實際個案案例培養學生查詢資料及批判性思考的相關技能

出處來源 (Reference)

- ICN puts wellbeing of nurses at centre of International Nurses Day 2025(2025, January 9). ICN's newsletter. <https://www.icn.ch/news/icn-puts-wellbeing-nurses-centre-international-nurses-day-2025>
- 馮容莊, 黃露萩, 呂文娟, 黃鶯滿, 吳燕麗, 林帝芬, 簡瑩佩, 韓國菁, 袁美珍(2017). 以價值為基礎的護理照護 *北市醫學雜誌*, 14(SP), 96-106
- 醫院病安目標(2025, February 25).台灣病人安全資訊網
<https://www.patientsafety.mohw.gov.tw/xcdocb/cont?xsmsid=0M069415939762306582&sid=0O024613642710580442>

Q & A



Customer Success Specialist

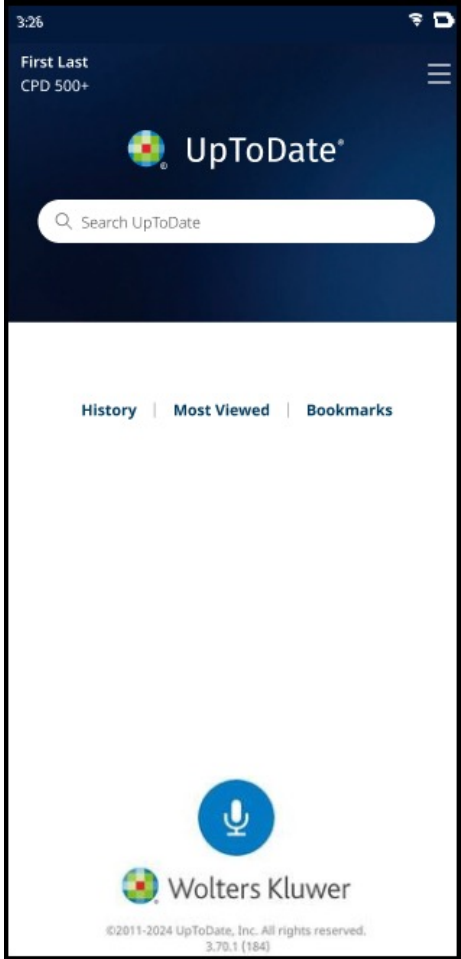
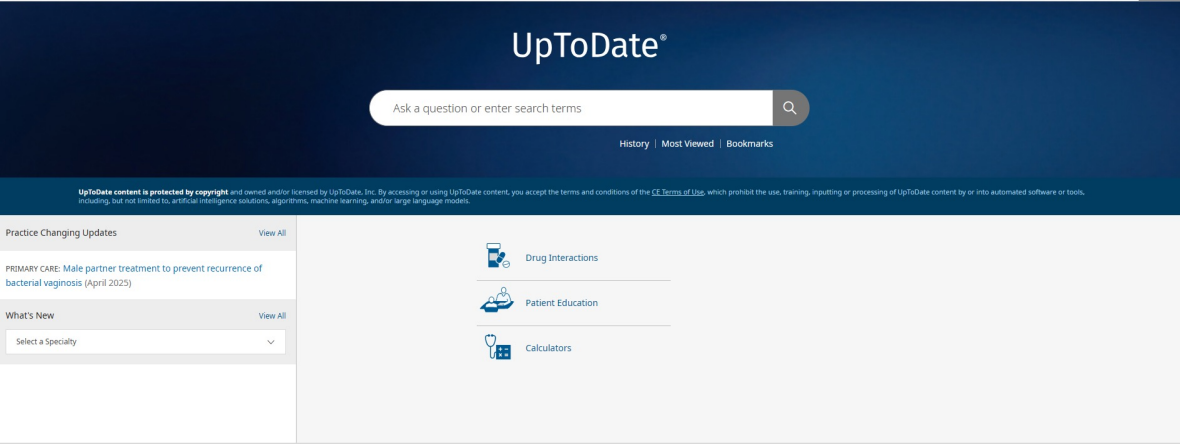
Name: 林幼婕 (Yoyo)

Email: yoyo.lin@wolterskluwer.com

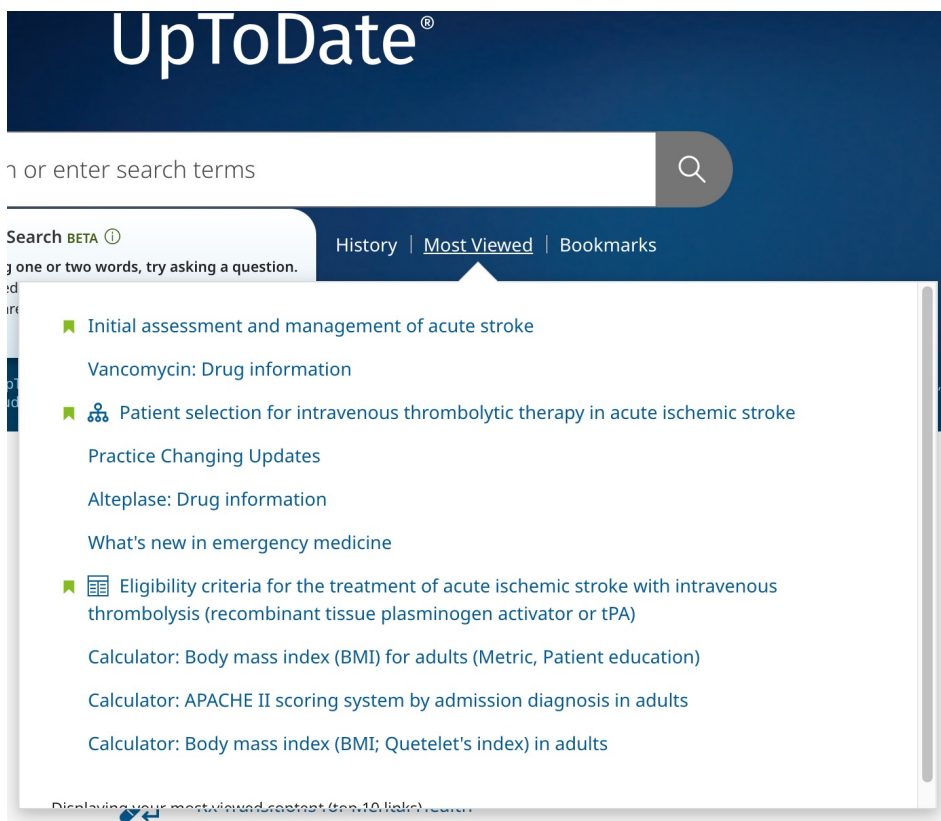


註冊相關步驟及問題

頁面介紹-網頁版及行動裝置版



註冊的好處



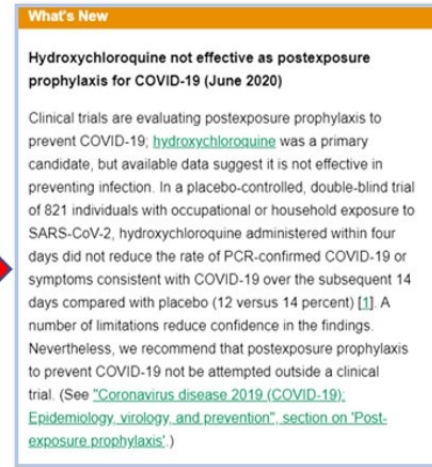
💡 只要完成 [UpToDate 行動版帳號登錄](#)

- ✓ 可以回家繼續查詢 UpToDate
- ✓ 可以建立個人檢索紀錄
- ✓ 可以透過手機 APP 隨時隨地使用 UpToDate

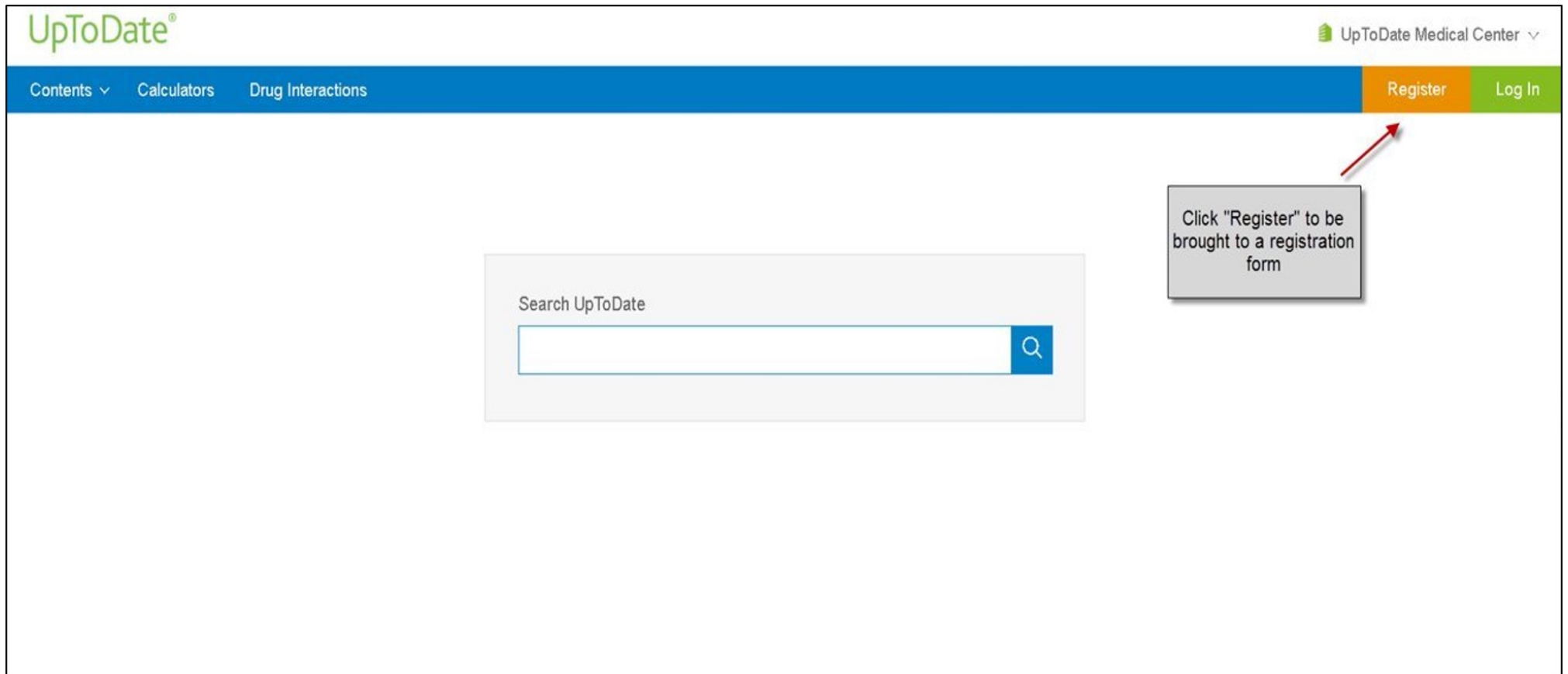
最重要的是，由個人帳號框，告訴你最新更新內容

✍ 立刻註冊取得個人帳戶，讓您三個願望一次滿足！

完成註冊後，每一次登入個人帳號，若在已書籤過或是曾經閱覽過的主題前看到一個小橘點，則表示該主題有更新內容，點下小橘點就會顯示更新內容



註冊步驟 (Registration processes)



註冊資料填寫

Registration form with fields for:

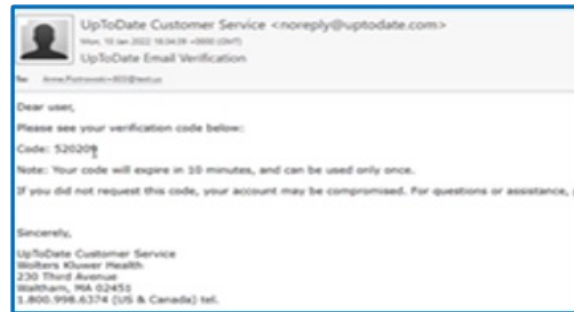
- First Name
- Last Name
- Email
- Country (dropdown)
- ZIP/Postal Code (optional)
- City
- Specialty (dropdown)
- Role (dropdown)
- Create your username and password section:
 - Username
 - Password (with rules: 8 to 24 characters, at least 1 uppercase letter, cannot match username, at least 1 number or special character)
 - Verify Password

Send Verification Code button

按下送出驗證碼按鈕

接收驗證碼郵件

驗證碼會由noreply@uptodate.com寄出



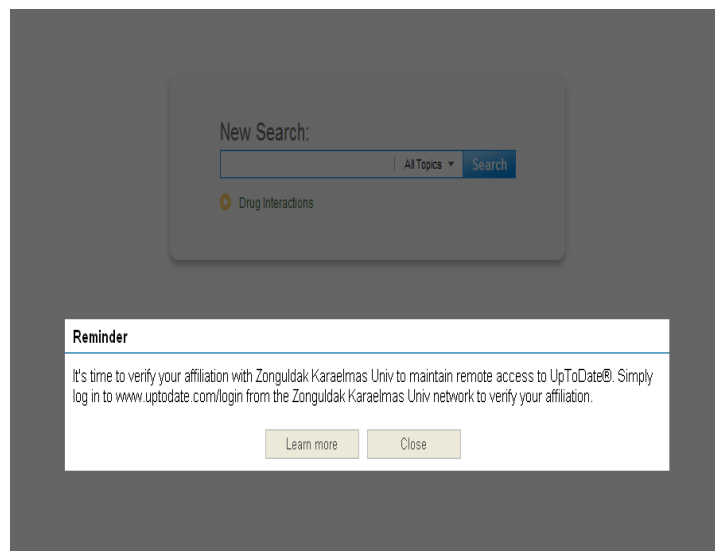
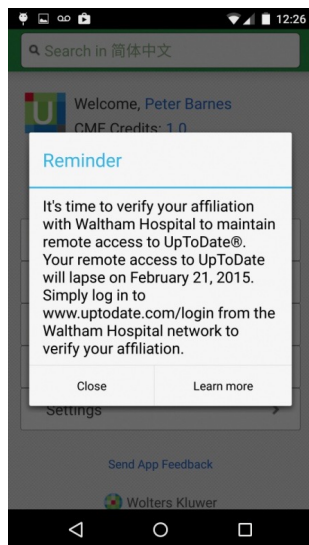
填寫驗證碼

Verification code entry screen with:

- Send New Code button
- Text: Check the email account you submitted for a message containing a verification code. If you don't see the email, please check your spam folder. Paste or type the code below. The code is valid for 10 minutes. **No account data will be saved until the code is accepted.**
- Verification Code input field
- Submit Verification Code button

推送通知

- 每90天內您必須在醫院網域內使用電腦登入您的帳號, 以延展您的帳號使用有效期, 只要您有下載App, 當您打開App時會出現提醒。



肺炎(pneumonia)合併胸腔積水病患之臨床辨別與處置

住院日期	2023/9/12	姓名：Y 女士
年齡：78 歲	性別：女	宗教信仰：佛教
身高：165cm	體重：80Kg	過敏史：無
過去病史：高血壓、心臟肥大、痛風		
此次入院主述及情況： Y 女士自訴一周前感冒了，這周來斷斷續續出現發燒、咳嗽及喉嚨痛，3 天前到 LMD 看診，看診前 COVID-19 快篩陰性，LMD 醫師給開立止咳及祛痰劑，已服用 3 天，症狀未獲得改善。今早她開始咳嗽不止、且痰液中帶血絲，主訴呼吸喘(SOB)及呼吸困難，由家屬送至急診室。 到院時，Y 女士 GCS：E4V5M6，主訴呼吸困難，觀察呼吸淺快，臉色蒼白。CXR 初步診斷追蹤胸部 X 光發現有明顯的兩側肺葉有瀰漫性浸潤，ER 立即進行 COVID-19 PCR 檢測，結果還在 Pending，胸部超音波發現右肺部分肺節塌陷(lung collapse)。胸部電腦斷層發現雙下肺葉有多個囊腫，疑似為間質性肺炎合併胸腔積水。醫囑給予 A+B inhalation，並使用 O ₂ mask FiO ₂ 40% 使用。但 Y 女士仍抱怨呼吸不順暢，聽診發現雙側肺葉有明顯喘鳴音(wheezing)，故安排轉入 ICU。 小夜班，Y 女士仍咳嗽不止，呼吸喘鳴音更明顯了，主訴冒冷汗、心悸，生命徵象：體溫 39.6℃，心跳 125bpm，呼吸 36 bpm，血壓 90/60mmHg，您請值		

班醫師來視，依醫囑給予抽血 ABG 及 CBC/DC，並做血液及痰液培養。

大夜班 2:00 病人顯躁動，主訴呼吸困難加重，SpO₂: 78%，ABG PH:7.26、PaO₂:58 mmHg、PaCO₂:76mmHg、SaO₂:84%、HCO₃⁻: 28meq/L，值班醫師給予插入 7.5# oral Endo with Ventilator support (Mode: A/C、rate:16 bpm、PEEP: 5 cmH₂O、FiO₂:60%)、on 16# foley、on 14# NG with decompression。

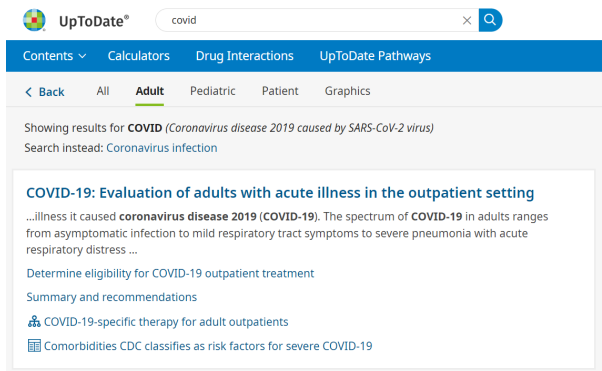
2:40 出現皮膚濕冷，生命徵象：體溫 39℃，心跳 130bpm，呼吸 22 bpm，血壓 BP:70/40mmHg。您是 Y 女士的主護理師，請您與您的團隊討論完成學習單的內容？

1. 依 Y 女士在急診室的呼吸狀況，你覺得急診室的評估重點是？
2. 依照 CXR、胸部超音波、及胸腹部電腦斷層檢查結果，Y 女士肺浸潤及肺塌陷，雙側肺葉出現喘鳴音，您認為急診室的緊急處置重點是？
3. 大夜班 2:00 時 Y 女士顯得躁動及呼吸困難加重時，您認為處理的優先次序是？
4. 依大夜班 2:00 插管後，使用呼吸器(A/C)，您認為適當嗎？如果是，理由是？如果不是，您的建議是？
5. 2:40 Y 女士出現全身冒冷汗、心跳加速及血壓下降症狀，您認為她怎麼了？請

肺炎(pneumonia)合併胸腔積水病患之臨床辨別與處置

-UpToDate能協助的地方

- COVID-19治療方向?診斷方式?



UpToDate® covid

Contents Calculators Drug Interactions UpToDate Pathways

< Back All **Adult** Pediatric Patient Graphics

Showing results for **COVID** (Coronavirus disease 2019 caused by SARS-CoV-2 virus)
Search instead: Coronavirus infection

COVID-19: Evaluation of adults with acute illness in the outpatient setting

...illness it caused **coronavirus disease 2019 (COVID-19)**. The spectrum of **COVID-19** in adults ranges from asymptomatic infection to mild respiratory tract symptoms to severe pneumonia with acute respiratory distress ...

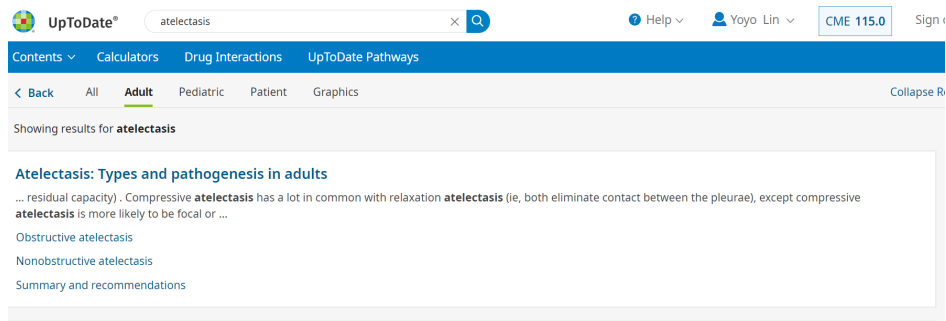
Determine eligibility for COVID-19 outpatient treatment

Summary and recommendations

COVID-19-specific therapy for adult outpatients

Comorbidities CDC classifies as risk factors for severe COVID-19

- 肺塌陷的原因?



UpToDate® atelectasis

Help Yoyo Lin CME 115.0 Sign

Contents Calculators Drug Interactions UpToDate Pathways

< Back All **Adult** Pediatric Patient Graphics Collapse R

Showing results for **atelectasis**

Atelectasis: Types and pathogenesis in adults

... residual capacity) . Compressive **atelectasis** has a lot in common with relaxation **atelectasis** (ie, both eliminate contact between the pleurae), except compressive **atelectasis** is more likely to be focal or ...

Obstructive atelectasis

Nonobstructive atelectasis

Summary and recommendations

胸腹部鈍傷合併敗血症病患之臨床辨別與處置

住院日期	2023/9/18	姓名：P 先生
年齡：52 y/o	性別：男	宗教信仰：基督教
身高：175cm	體重：86 Kg	過敏史：penicillin 類藥物
過去病史：高血壓史 10 年、糖尿病史 10 年，心臟病史 5 年		
此次入院主述及情況：		
<p>P 先生在傾盆大雨中騎重型機車，在行經急轉彎下坡路段時，因車速過快，失速撞上護欄。瞬間碰撞下，P 先生連車帶人撞向對向車道護欄。他頓時覺得頭昏眼花，並且出現胸悶、腹痛、想吐、及冒冷汗等症狀，他看到自己右前臂及右手肘則有一個開放性創傷大約 5*10 cm²，正在冒出鮮血。目擊民眾緊急 call 119。救護車到達急診室時，檢傷發現，P 先生右大腿股骨中段有閉鎖性骨折導致變形血腫；雙腳有多處擦傷及挫傷，右前臂及右手肘的傷口約 5*10 cm²，仍有明顯出血。P 先生主訴右前胸及右腹部持續明顯悶痛，腹部電腦斷層攝影顯示：肝臟有撕裂傷 grade III，腹腔大量出血，因此緊急轉入 ICU 治宜先生意識仍清醒，生命徵象：體溫：35.4°C，脈動微弱：102 bpm，血壓 160/100mmHg，呼吸淺：22 bpm，主訴前胸及右腹疼痛，急診醫師緊急做了血液及生化檢查，並照了頸椎、胸部 X 光及腹部電腦斷層攝影，檢查結果：血糖：189mg/dl，頸椎、胸部 X 光發現，Left side clavical fracture，CT 則顯示肝臟有一個撕裂傷 grade III，在急診室給予緊急輸液 L-R1500 ml，並安排入觀察室觀察。</p> <p>進觀察室後，宜先生仍主訴胸腹部持續疼痛，小夜班 20:00 時，宜先生臉色蒼白、全身冰冷、冒汗、躁動不安，他主訴腹部疼痛加劇、且感覺喘不過氣來了。你為宜先生測量生命徵象，體溫：35.8°C，脈搏：112 bpm，血壓：86/50mmHg，呼吸 28 bpm，呼</p>		


果如下：PH 7.32、PaCO₂ 46.1mmHg、PaO₂ 60 mmHg、HCO₃⁻：20.3 meq /L
aO₂：91.6 %。依醫囑給予 O₂ MASK FIO₂ 40 %使用。12 導程心電圖檢查顯示 sinus Tachycardia，胸部 X 光顯示：兩側肺水腫，聽診肺部呼吸音呈濕囉音，痰液

紅色泡沫狀。轉 MICU 觀察。

大夜班，病人意識改變，血壓過低：70/40 mmHg，心跳：128bpm，呼吸：36 bpm，ABG：PH 7.24、PaCO₂ 70 mmHg、PaO₂：48 mmHg、HCO₃⁻：18.3 meq /L、SaO₂：78%

你是他的主護理師，請您與您的團隊討論完成學習單的內容？

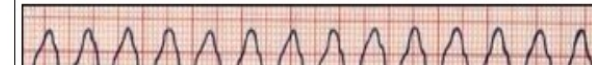
- 在急診室，宜先生主訴前胸及腹部疼痛，你的評估及照護重點為何？
- 在觀察室時，宜先生 12 導程心電圖檢查顯示如下圖，你判讀的結果是？接下來你的處理重點是？



- 針對宜先生在急診室的表現，你覺得處置重點為何？值班醫師與您討論病患後續的治療計畫，您的建議是？

4. 小夜班 8 點鐘時，您覺得宜先生怎麼了？您認為應該給值班醫師的處置建議是？

5. 大夜班，宜先生出現生命徵象改變及明顯的臨床症狀，處理後，Lead II EKG



胸腹部鈍傷合併敗血症病患之臨床辨別與處置

-UpToDate能協助的地方

- 車禍的病人需要做的評估及檢查?

The screenshot shows the UpToDate search interface. The search bar contains 'car accident'. The top navigation bar includes 'Contents', 'Calculators', 'Drug Interactions', and 'UpToDate Pathways'. Below the navigation bar, there are tabs for 'All', 'Adult', 'Pediatric', 'Patient', and 'Graphics', with 'Adult' selected. The search results are displayed under the heading 'Showing results for car accident'. The first result is 'Initial management of trauma in adults', with a brief description: '...other special populations Trauma is a leading cause of mortality globally. Worldwide, road traffic injuries are the leading cause of death between the ages of 18 and 29, while in the United States, ...'. Below the title, there are links for 'Mechanism', 'Epidemiology', and 'Summary and recommendations'. A small icon indicates that there is a table of contents for this article.

- 大腿骨骨折需要注意的地方?

The screenshot shows the UpToDate search interface. The search bar contains 'femoral fractures'. The top navigation bar includes 'Contents', 'Calculators', 'Drug Interactions', and 'UpToDate Pathways'. Below the navigation bar, there are tabs for 'All', 'Adult', 'Pediatric', 'Patient', and 'Graphics', with 'All' selected. The search results are displayed under the heading 'Showing results for femoral fractures'. The first result is 'Midshaft femur fractures in adults', with a brief description: '... art of femoral fracture care involves a balancing act between anatomic alignment and early functional rehabilitation of the limb. The diagnosis and nonoperative management of midshaft femur fractures in adults ...'. Below the title, there are links for 'Surgical and nonsurgical interventions', 'Splinting and traction', and 'Summary and recommendations'. Two small icons indicate that there are images associated with this article.

胸腹部鈍傷合併敗血症病患之臨床辨別與處置

-UpToDate能協助的地方

- 肝撕裂傷的等級是什麼?

UpToDate® liver laceration grading

Management of hepatic trauma in adults

Topic Graphics (12)

Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

MECHANISM OF INJURY

TRAUMA EVALUATION

History and physical examination

Associated injuries

Laboratory studies

DIAGNOSIS

HEPATIC INJURY GRADING

APPROACH TO MANAGEMENT

NONOPERATIVE MANAGEMENT

Rate ☆☆☆☆ Topic Feedback

intrahepatic arterial hemorrhage. (See 'Hepatic embolization' below.)

HEPATIC INJURY GRADING

We use the American Association for the Surgery of Trauma (AAST) classification system, the most widely accepted injury grading scale, to grade hepatic injuries (table 1) [3,12]. Another hepatic injury grading system has been proposed by the World Society of Emergency Surgery that reflects both the hemodynamic status of the patient as well as the AAST anatomic grade of the injury [13,14].

The imaging criteria of the AAST grades of hepatic injury are as follows:

- Grade I - Subcapsular hematoma <10 percent surface area. Parenchymal laceration <1 cm in depth (image 1).
- Grade II - Subcapsular hematoma 10 to 50 percent surface area (image 2); intraparenchymal hematoma <10 cm in diameter (image 3). Laceration: 1 to 3 cm parenchymal depth and ≤10 cm in length (image 4).
- Grade III - Subcapsular hematoma >50 percent of surface area; ruptured subcapsular or parenchymal hematoma. Intraparenchymal hematoma >10 cm. Laceration >3 cm in depth (image 5). Any injury in

- 外傷後血壓低的原因?需要做的檢查處置?

UpToDate® low blood pressure after trauma

Contents Calculators Drug Interactions UpToDate Pathways

Initial management of moderate to severe hemorrhage in the adult trauma patient

Topic Graphics (10)

Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

CLASSIFICATION OF HEMORRHAGE

INITIAL ASSESSMENT AND INTERVENTIONS

INITIAL MANAGEMENT OF HEMORRHAGE

Control of compressible or extremity bleeding

- Hemorrhage from pelvic fracture

Control of non-compressible bleeding

Early determination of disposition

RESUSCITATION AND TRANSFUSION

Rate ☆☆☆☆ Topic Feedback

AUTHOR: Christopher Colwell, MD
SECTION EDITOR: Anil Aydin, MD, FACEP
DEPUTY EDITOR: Michael Garescky, MD
Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: Apr 2024.
This topic last updated: Apr 23, 2024.

INTRODUCTION

In the setting of trauma, loss of circulating blood volume from hemorrhage is the most common cause of shock. Inadequate oxygenation, mechanical obstruction (eg, cardiac tamponade, tension pneumothorax), neurologic dysfunction (eg, high-spinal cord injury), and cardiac dysfunction represent other potential causes or contributing factors [1]. Hemorrhagic shock is a common and frequently treatable cause of death in injured patients and is second only to traumatic brain injury as the leading cause of death from trauma [2,3].

This topic will review the initial management of hemorrhagic shock in the adult trauma patient. General management of the adult trauma patient, subsequent management of trauma-related hemorrhage, and

胸腹部鈍傷合併敗血症病患之臨床辨別與處置

-UpToDate能協助的地方

- 什麼是sinus Tachycardia?這個心律需要注意什麼?初步處置?

The screenshot shows the UpToDate search results for "sinus tachycardia". The search bar at the top contains "sinus tachycardia" and the user is logged in as "Yoyo Lin". The page is titled "Sinus tachycardia: Evaluation and management". The main text discusses the evaluation of sinus tachycardia, mentioning that it can be due to a physiologic insult such as infection, pulmonary embolus, or blood loss. It also mentions differential diagnosis and treatment of the underlying cause. There are sections for "Overview of the acute management of tachyarrhythmias" and "Sinus tachycardia".

The screenshot shows the "Graphics" section of the UpToDate search results for "sinus tachycardia". It contains four panels: 1. "Sinus tachycardia" showing a normal ECG trace. 2. "Electrocardiogram (ECG) showing sinus tachycardia at a rate of 150 beats/min" showing a significantly elevated heart rate. 3. "Sinus tachycardia with ST segment changes due to fever in an 11-month-old child with dengue fever" showing an ECG trace with ST segment depression. 4. "Algorithm for the evaluation of narrow QRS complex tachycardias in unstable patients" showing a flowchart for clinical decision-making.

- 病人意識改變需要做什麼檢查?

The screenshot shows the UpToDate search results for "conscious change". The search bar at the top contains "conscious change" and the user is logged in as "Yoyo Lin". The page is titled "Diagnosis of delirium and confusional states". The main text discusses the diagnosis of delirium and confusional states, mentioning that it is often a sign of acute illness. It also mentions the importance of a thorough history and physical examination. There are sections for "Disturbance of consciousness", "Summary and recommendations", "Bedside tests of attention", and "Causes of delirium and confusion".

討論

- 三個案例都是急診常見的狀況，案例一及案例二能學到的內容稍微有點重複，其中案例一能學到的東西較廣較深，我會建議**保留案例一及案例三**(剛好一內科一外科)報告即可。
- 日後有關教學上我會建議，急診還是會有處置觀察後返家的病人，可以詢問學生，若遇到一般非檢傷分類**1-2級**的病人治療完畢後回家可以給予什麼樣的衛教？

例如:氣喘的病人診治觀察過後可以回家，那需要注意什麼？

胸悶痛的病人診治觀察過後可以回家，那需要注意什麼？

- 課堂中，老師可以出一些醫療給藥疏失的案例給學生思考，若護理師使用**UpToDate**查詢相關藥物資訊，是否可以避免一些醫療錯誤？

例如:案例三，醫囑上醫生開立**Amoxicillin**使用，結果造成病人嚴重過敏，請問要如何使用**UpToDate**避免這類的醫療疏失？

或者若洗腎的病人(**60KG**)，因下肢局部紅腫入院，後診斷蜂窩性組織炎，醫囑**Vancomycin 900mg IVD Q12H**，這個劑量對洗腎的病人是否合適？

婦產科護理學案例分析

案例分析

個案基本資料

姓姓名：張○美 性別：女 年齡：39 歲 職業：工
教教育程度：大學 使用語言：國語 婚姻狀況：已婚 宗教信仰：無
住住院日期：112/4/11 護理期間：112/4/11~112/4/13
最最近三個月內旅遊史/接觸史：無
住住院診斷(中英文)：pelvic adhesion 骨盆腔沾黏
手術日期：112/4/12
手術名稱(中英文)：laparoscopic adhesionolysis 婦產科腹腔鏡分離沾黏手術
Hysteroscopic Excision of Polyps 子宮鏡子宮內膜息肉切除術

現現在病史：求醫過程及主訴〔PQRST〕

求醫過程：個案在準備胚胎植入時發現子宮內有沾黏，在2023/01/03有做過子宮內
沾黏清除，但胚胎植入仍未成功，所以這次安排入院來做腹腔鏡沾黏清除手術
主訴：在胚胎植入過程中發現有子宮沾黏。

三、過去病史

(一) 是否罹患何種疾病?及相關治療?

疾病：Pelvic adhesion 骨盆腔沾黏。

治療：laparoscopic pelvic adhesiolysis 婦產科腹腔鏡分離沾黏手術(子宮)。

Hysteroscopic lysis of uterine adhesion 子宮鏡子宮內膜息肉切除術。

(二) 是否曾住院或接受何種手術或特殊治療?

- 2015年因子宮外孕做腹腔鏡切除輸卵管手術。
- 2023年子宮鏡子宮內膜沾黏清除。

(三) 是對何種食物或藥物過敏?過敏反應為何?

皆無。

婦產科護理學案例分析

- 什麼是Pelvic adhesion?術後需要注意什麼?

UpToDate® pelvic adhesion

Contents Calculators Drug Interactions UpToDate Pathways Rx Transitions for Mental Health

< Back All Adult Pediatric Patient Graphics

Showing results for **pelvic adhesion**

Postoperative peritoneal adhesions in adults and their prevention
...adhesions, and 3.8 percent required operation. Infertility – Infertility in women can result from **pelvic adhesions**, which can alter pelvic anatomy and interfere with ovum capture and transport, or from tubal ...
Indications for adhesiolysis
Incidence and burden
Summary and recommendations

Chronic pelvic pain in adult females: Evaluation
...sacral Tarlov cysts, cauda equina syndrome, pelvic varicosities entrapping sacral nerve roots, or **pelvic adhesions** at the site of symptoms have been implicated as causes of CPP. The role of these entities in...
Poorly understood causes
Summary and recommendations

Endometriosis: Surgical management of pelvic pain
...for evaluation or urinary symptoms or colonoscopy for evaluation of hematochezia. Extensive **pelvic adhesions** are difficult to diagnose with imaging, although the "sliding sign" at time of imaging may be ...
Hysterectomy
Adhesiolysis
Summary and recommendations

- laparoscopic adhesionolysis是什麼? 需要注意什麼? Laparoscopic跟Open surgery 的差異?

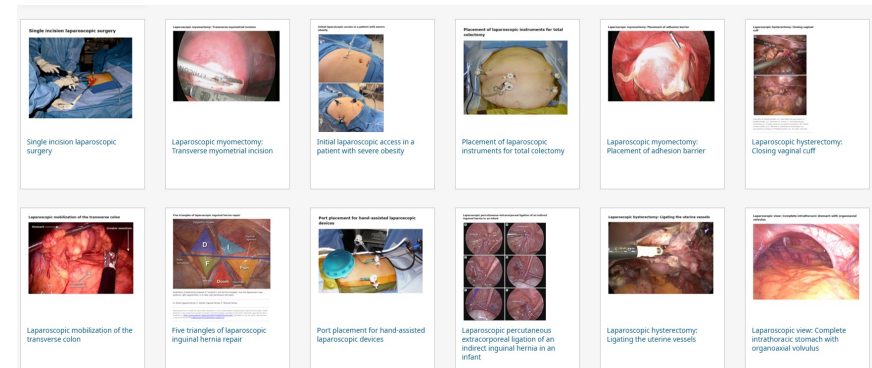
UpToDate® laparoscopic adhesionolysis

Contents Calculators Drug Interactions UpToDate Pathways Rx Transitions for Mental Health

< Back All Adult Pediatric Patient Graphics

Showing results for **laparoscopic adhesionolysis**
Search instead: laparoscopic adhesionolysis

Postoperative peritoneal adhesions in adults and their prevention
...11 and 16 percent, respectively, in control subjects. **Laparoscopic adhesionolysis** as a therapy for chronic pain is controversial. **Adhesiolysis** for reducing chronic pain has been studied in two small trials ...
Lessening chronic pain
Liquid barriers (instillates)
Summary and recommendations



婦產科護理學案例分析

- Hysteroscopic Excision是什麼?

The screenshot shows the UpToDate search results for 'Hysteroscopic Excision'. The search bar at the top contains the text 'Hysteroscopic Excision'. Below the search bar, there are navigation tabs for 'Contents', 'Calculators', 'Drug Interactions', 'UpToDate Pathways', and 'Rx Transitions for Mental Health'. The main content area displays two search results. The first result is titled 'Hysteroscopy: Instruments and procedure' and includes a snippet: '...hysteroscopy to a 3.7 mm rigid or 3.6 mm flexible hysteroscope. Both groups received topical cervical anesthesia. Compared with flexible hysteroscopes, use of a rigid hysteroscope was associated with significanceity ...'. Below this snippet are links for 'Rigid versus flexible', 'Optics', and 'Summary and recommendations'. The second result is titled 'Uterine fibroids (leiomyomas): Hysteroscopic myomectomy and other transcervical procedures' and includes a snippet: '...procedure. Hypotonic solutions (ie, glycine) are used when a resectoscope with monopolar electrical wire loop technique is employed. Bipolar resectoscopes are used with isotonic fluids. Tissue extraction (morcellation) ...'. Below this snippet are links for 'Instrumentation', 'Procedure', and 'Summary and recommendations'.

- Uterus Polys 是什麼? 要怎麼預防?

The screenshot shows the UpToDate article for 'Endometrial polyps'. The search bar at the top contains the text 'uterus Polyps'. The article title 'Endometrial polyps' is displayed prominently. Below the title, there is a section for 'Authors' and 'Section Editor' with their names and credentials. A note indicates that all topics are updated as new evidence becomes available and that the literature review is current through March 2025. The article is divided into sections: 'INTRODUCTION', 'HISTOPATHOLOGY', and 'DIAGNOSTIC EVALUATION'. The 'INTRODUCTION' section discusses the etiology of abnormal genital tract bleeding in both premenopausal and postmenopausal patients. The 'HISTOPATHOLOGY' section describes localized hyperplastic overgrowths of endometrial glands and stroma. A table of contents on the left side of the page lists various sections including 'SUMMARY AND RECOMMENDATIONS', 'INTRODUCTION', 'HISTOPATHOLOGY', 'PATHOGENESIS', 'PREVALENCE', 'RISK FACTORS AND PREVENTION', 'NATURAL HISTORY', 'CLINICAL PRESENTATION', 'DIAGNOSTIC EVALUATION', and 'DIAGNOSIS'.

The screenshot shows the 'Endometrial polyps' article page with a focus on 'Graphics (8)'. The graphics section contains three panels: 'Causes of abnormal genital tract bleeding in females', 'Indications for endometrial polyp removal in pre- and postmenopausal patients', and 'Risk factors for endometrial cancer'. Below the graphics section is a 'Pictures' section with three panels: 'Endometrial polyp: Histology', 'Hysteroscopic view of endometrial polyps', and 'Endocervical polyp'. Each panel includes a small image and a caption. The 'Endometrial polyp: Histology' panel shows a microscopic view of a polyp. The 'Hysteroscopic view of endometrial polyps' panel shows a hysteroscopic view of a polyp. The 'Endocervical polyp' panel shows a hysteroscopic view of a polyp on the cervix.

其他產科相關疾病

- 妊娠糖尿病，要如何衛教病人控制血糖？

The screenshot shows the UpToDate interface for the topic "Gestational diabetes mellitus: Glucose management, maternal prognosis, and follow-up". The page includes a navigation menu on the left with sections like "Outline", "SUMMARY AND RECOMMENDATIONS", "WHAT'S NEW", "INTRODUCTION", "RATIONALITY FOR TREATMENT", "MEDICAL NUTRITIONAL THERAPY", "EXERCISE", "GLUCOSE MONITORING", and "MONITORING FOR KETONURIA". The main content area features a "What's New" section with a highlighted update: "Oral antihyperglycemics are less effective than insulin in pregnancy (February 2025)". Below this is the "INTRODUCTION" section, which discusses the treatment of gestational diabetes mellitus (GDM) and its impact on pregnancy outcomes. The "RATIONALITY FOR TREATMENT" section is also visible at the bottom of the page.

- **Prevention of future diabetes** – Patients should be informed that breastfeeding may decrease their long-term risk of developing type 2 diabetes. (See "Gestational diabetes mellitus: Obstetric issues and management", section on 'Breastfeeding'.)

Lifestyle interventions are beneficial for reducing the incidence of type 2 diabetes in persons with prediabetes [149] and these interventions (diet and exercise, achieving a normal body mass index, avoiding smoking and excessive alcohol intake) also appear to be beneficial in patients with a history of GDM, whether or not they meet criteria for prediabetes [150]. The annual incidence of diabetes may be reduced by 30 to 50 percent or more compared with no intervention [151,152].

Pharmacotherapy (eg, [metformin](#), [pioglitazone](#)) may also have a role in preventing future type 2 diabetes. In a multicenter randomized trial, both intensive lifestyle and metformin therapy reduced the incidence of future diabetes by approximately 50 percent compared with placebo in patients with a history of GDM; metformin was much more effective than lifestyle intervention in parous patients with previous GDM [151]. This topic is discussed in detail separately. (See "Prevention of type 2 diabetes mellitus".)

- **Follow-up laboratory testing** – Long-term follow-up is essential. Reassessment of glycemic status should be undertaken at a minimum of every three years (eg, every one to three years) [24]. More frequent assessment may be important in patients who may become pregnant again, since early detection of diabetes is important to preconception and early prenatal care. More frequent screening (every one or two years) may also be indicated in patients with other risk factors for diabetes, such as family history of diabetes, obesity, and need for pharmacotherapy during pregnancy.

The best means of follow-up testing has not been defined. The two-hour 75 g oral GTT is the more sensitive test for diagnosis of diabetes and impaired glucose tolerance in most populations, but the fasting plasma glucose is more convenient, specific, and reproducible, and less costly. A1C is convenient and the preferred test for patients who have not fasted overnight. (See "Screening for type 2 diabetes mellitus and prediabetes", section on 'Screening tests'.)

- **Prevention of future cardiovascular disease** – Given increasing evidence of an association between GDM and future CVD [153], even in the absence of progression to type 2 diabetes, it is reasonable to discuss healthy lifestyle behaviors (eg, heart-healthy diet, maintenance of a healthy weight, tobacco avoidance, and physical activity) with all patients who have had GDM [154]. (See "Overview of primary prevention of cardiovascular disease in adults".)

其他產科相關疾病

- 子癲前症(Pre-eclampsia)，符合子癲前症的標準是？

The screenshot shows the UpToDate interface with the search term 'Pre-eclampsia'. The navigation bar includes 'Contents', 'Calculators', 'Drug Interactions', 'UpToDate Pathways', and 'Rx Trans'. Below the navigation bar, there are tabs for 'All', 'Adult', 'Pediatric', 'Patient', and 'Graphics'. The main content area displays the search results for 'preeclampsia (instead of Pre-eclampsia)'. The first result is titled 'Preeclampsia: Clinical features and diagnosis' and includes sub-sections for 'Typical presentation', 'Summary and recommendations', and 'Diagnostic criteria for preeclampsia'. The second result is titled 'Preeclampsia: Antepartum management and timing of delivery' and includes sub-sections for 'Preterm pregnancies: Expectant management', 'Monitoring blood pressure and treatment of hypertension', and 'Summary and recommendations'.

Diagnostic criteria for preeclampsia

Systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg on at least 2 occasions at least 4 hours apart after 20 weeks of gestation in a previously normotensive patient AND the new onset of 1 or more of the following*:

- Proteinuria ≥ 0.3 g in a 24-hour urine specimen or protein/creatinine ratio ≥ 0.3 (30 mg/mmol) in a random urine specimen or dipstick $\geq 2+$ if a quantitative measurement is unavailable
- Platelet count $< 100,000/\text{microl}$.
- Serum creatinine > 1.1 mg/dL (97.2 micromol/L) or doubling of the creatinine concentration in the absence of other kidney disease
- Liver transaminases at least twice the upper limit of the normal concentrations for the local laboratory
- Pulmonary edema
- New-onset and persistent headache not accounted for by alternative diagnoses and not responding to usual doses of analgesics[†]
- Visual symptoms (eg, blurred vision, flashing lights or sparks, scotomata)

Preeclampsia is considered superimposed when it occurs in a patient with chronic hypertension. Superimposed preeclampsia is characterized by worsening or resistant hypertension (especially acutely), the new onset of proteinuria or a sudden increase in proteinuria, and/or significant new end-organ dysfunction in a patient with chronic hypertension. It typically occurs after 20 weeks of gestation or postpartum.

Definitions/diagnostic criteria for preeclampsia are generally similar worldwide except the International Society for the Study of Hypertension in Pregnancy (ISSHP) definition also includes signs of uteroplacental dysfunction (eg, fetal growth restriction, abnormal angiogenic markers, abnormal umbilical artery Doppler, abruption, fetal demise). The ISSHP also considers a platelet count $< 150,000/\text{microl}$ rather than $< 100,000/\text{microl}$ consistent with preeclampsia.

* If systolic blood pressure is ≥ 160 mmHg and/or diastolic blood pressure is ≥ 110 mmHg, confirmation within minutes is sufficient.

[†] Response to analgesia does not exclude the possibility of preeclampsia.

Adapted from:

- American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin No. 222: Gestational Hypertension and Preeclampsia. *Obstet Gynecol* 2020; 135:e237.
- Magee LA, Brown MA, Hall DR, et al. The 2021 International Society for the Study of Hypertension in Pregnancy classification, diagnosis & management recommendations for international practice. *Pregnancy Hypertens* 2022; 27:148.

其他產科相關疾病

- 前置胎盤(Placenta praevia)，要如何衛教病人？

This screenshot shows the UpToDate article titled "Placenta praevia: Management". The page includes a navigation bar with "Contents", "Calculators", "Drug Interactions", "UpToDate Pathways", and "Rx Transitions for Mental Health". A left sidebar lists various topics under "Placenta praevia: Management", including "SUMMARY AND RECOMMENDATIONS", "INTRODUCTION", "ASYMPTOMATIC PATIENTS", and "ACUTE CARE OF BLEEDING PATIENTS". The main content area features an "INTRODUCTION" section with text explaining placenta praevia and its management. At the top of the main content, there is a box with author information: "AUTHOR: Charles J Lockwood, MD, MChM, Karen Russo-Slegitz, MD; SECTION EDITOR: Vincenzo Berghella, MD; DEPUTY EDITOR: Vanessa A Baris, MD, FACOG; Contributor Disclosures". A note states: "All topics are updated as new evidence becomes available and our peer review process is complete. Literature review current through: Mar 2025. This topic last updated: Apr 19, 2024."

This screenshot shows the UpToDate article titled "Patient education: Placenta praevia (The Basics)". The page includes a navigation bar with "Contents", "Calculators", "Drug Interactions", "UpToDate Pathways", and "Rx Transitions for Mental Health". A left sidebar lists various topics under "Patient education: Placenta praevia (The Basics)", including "Outline", "What is placenta praevia?", "What are the symptoms of placenta praevia?", "Is there a test for placenta praevia?", "How is placenta praevia treated?", "Is there anything I can do on my own?", "When should I call the doctor?", "When will I give birth?", "More on this topic", "GRAPHICS", "RELATED TOPICS", and "Patient education: Bleeding in late pregnancy (The Basics)". The main content area features a "What is placenta praevia?" section with text explaining the condition and its symptoms. A note states: "Written by the doctors and editors at UpToDate. Please read the Disclaimer at the end of this page." The text reads: "Placenta praevia is a condition that happens during pregnancy when the placenta covers the opening of the cervix. Normally, the placenta is not near the cervix (see figure 1). Placenta praevia can cause severe bleeding from the vagina. Placenta praevia is more likely in people who had: • A c-section in an earlier pregnancy – A c-section is surgery to get the baby out. It is also called a "cesarean birth." • Placenta praevia in a previous pregnancy. Other things that can make placenta praevia more likely are: • Smoking • Giving birth several times before • Being pregnant with more than 1 baby at a time." The "What are the symptoms of placenta praevia?" section states: "Most people leak blood from the vagina. In some, the uterus also tightens. Doctors call this "contractions." The belly can feel hard during contractions."

產科用藥相關資訊查詢

- Acetaminophen 會出現在母乳嗎? 會透過胎盤影響胎兒嗎?

Acetaminophen (paracetamol): Drug information

Food Interactions
Rate of absorption may be decreased when given with food. Management: Administer without regard to food.

→ **Pregnancy Considerations**
Acetaminophen crosses the placenta (Naga Rani 1989; Nitsche 2017; Towers 2018).

Based on epidemiological data, an increased risk of major congenital malformations has not been observed following maternal use of acetaminophen during pregnancy. The use of acetaminophen in recommended doses during pregnancy has not been associated with an increased risk of miscarriage or still birth; however, an increase in fetal death or spontaneous abortion may be seen following maternal overdose if treatment is delayed (Li 2003; Rebordosa 2009; Riggs 1989). A possible association between prenatal constriction of the ductus arteriosus following maternal use during the third trimester has been investigated. Based on available data, an increased risk is not likely associated with short-term use of acetaminophen at recommended doses (Allegaert 2019; Dathe 2019; Hauben 2021; Hutson 2021). Additional adverse events such as wheezing and asthma in early childhood, adverse effects on male reproductive development, and adverse neurodevelopmental effects such as attention-deficit/hyperactivity disorder (ADHD) or autism spectrum disorder following in utero acetaminophen exposure have been evaluated in multiple studies; outcome data are inconclusive due to study limitations (variety of evaluation methods and/or indications for acetaminophen use, recall bias, etc), and causal associations have not been established (Kwok 2022; Lourido-Cebreiro 2017; Patel 2022; Scialli 2010; Singh 2021; SMFM 2017; Sznajder 2022; Tadokoro-Cuccaro 2022).

Maternal fever is associated with adverse fetal outcomes, including neural tube defects, oral clefts, and congenital heart defects. Treatment of maternal fever with an antipyretic may reduce these risks (Dreier 2014).

Due to pregnancy-induced physiologic changes, some pharmacokinetic properties of acetaminophen may be altered. Dose adjustments are not recommended (Brookhuis 2021; Kulo 2014).

Acetaminophen is the preferred initial treatment for acute migraine headache in pregnant patients (ACOG 2022). Acetaminophen is considered appropriate for the treatment of pain and fever in pregnancy (SMFM 2017) and is recommended for the treatment of fever in pregnant patients diagnosed with influenza (ACOG 2018). Acetaminophen may be used as part of a multimodal approach to pain relief following cesarean delivery (ACOG 2019).

Acetaminophen is recommended to be used at the lowest effective dose for the shortest duration of time to effectively treat the mother and protect the health of the fetus (Kilcoyne 2017).

Breastfeeding Considerations
Acetaminophen is present in breast milk.

婦產科相關計算器

Obstetrics, Gynecology and Women's Health Calculators

Clinical Criteria

[Trial of labor after cesarean \(TOLAC\) for use at entry to prenatal care](#)

Medical Equations

[Conventional \(gravimetric, imperial, US\) unit to SI unit conversions: Chemistry and endocrine tests](#)

[Estimated 24-hour urine protein excretion in pregnancy \(from spot urine protein to creatinine ratio\) \(conventional and SI units\)](#)

[Estimated Date of Delivery \(EDD\)](#)

[Estimated date of delivery \(EDD\) \(Patient education\)](#)

[Gestational age from estimated date of delivery \(EDD\)](#)

[Nuchal translucency \(NT\) percentile for measured crown-rump length \(CRL\)](#)

[SI unit to conventional \(gravimetric, imperial, US\) unit conversions: Chemistry and endocrine tests](#)

兒科相關疾病

• 小兒發燒，造成發燒原因?該如何處置?需做哪些檢查?

UpToDate® child fever

Help | CME 321.5 | Sign out

Topic: Graphics (3)

Outline: (See "Fever in children with chemotherapy-induced neutropenia".)

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

TEMPERATURE MEASUREMENT

Site and method of measurement — The most common sites of temperature measurement in clinical practice are the rectum, mouth, and axilla; in addition, parents and caregivers may measure temperature at the tympanic membrane or forehead (temporal artery). Each of these sites has its own range of normal values [1].

Rectal thermometry — Rectal thermometry is generally considered the reference standard for measurement of core body temperature [2], but there is a lag between changes in core body temperature and temperature in the rectal vault [3]. Rectal thermometry is usually performed in infants and young children if the result has clinical implications. The majority of studies establishing the risk of serious infections in febrile infants and young children have relied on rectal temperatures. Rectal thermometry is contraindicated in patients with neutropenia.

Oral thermometry — Oral thermometry generally is preferred in children who are old enough to cooperate. Oral temperature is typically 0.6°C (1.0°F) lower than rectal temperature because of mouth breathing, which is particularly important in patients with tachypnea. Oral temperatures also may be affected by recent ingestion of hot or cold liquids [1,4].

Opinions differ about the best site of temperature measurement for young children who cannot cooperate with oral thermometry. The Bright Futures Guidelines for Health Supervision suggest rectal thermometry for children younger than four years of age [5]. In contrast, the National Institute for Health and Care Excellence recommends electronic axillary thermometry for children younger than four weeks, and axillary (electronic or chemical dot) or infrared tympanic membrane (TM) thermometry for children four to five years of age because these methods are quicker, easier to use, and better accepted by children and their caregivers [6].

Axillary thermometry — Axillary temperature is consistently lower than rectal temperature, but the absolute difference varies too widely for a standard conversion [7]. Axillary temperature may be measured in neutropenic patients who are unable to use an oral thermometer.

Contact and noncontact infrared thermometry — Infrared TM thermometers measure the amount of heat produced by the TM. Temperature readings are close to core temperature, although the infrared TM reflective devices commonly used in homes, hospitals, and offices are less accurate than TM thermometers used in research and by anesthesiologists [3,8–12]. Individ studies comparing TM and rectal temperatures in children have had contradictory results. Although newer-generation infrared TM thermometers appear to have improved accuracy compared with older models (vision rectal thermometer as the standard) [13], results should be verified in situations where detection of fever has clinical implications (an laboratory evaluation of the

UpToDate® child fever

Help | CME 321.5 | Sign out

Contents | Calculators | Drug Interactions | UpToDate Pathways | Rx Transitions for Mental Health

Topic: Graphics (32)

Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

DEFINITIONS

CAUSES

OVERVIEW OF EVALUATION

Setting

Pace

Approach

INITIAL EVALUATION

History

- Fever history
- Associated complaints
- Exposures
- Ethnic or genetic background

Examination

Initial diagnostic testing

- Basic tests for all patients
- Additional targeted tests

INTRODUCTION

Fever is a common presenting complaint in children. Most febrile illnesses either resolve before a diagnosis can be made or develop distinguishing characteristics that lead to a diagnosis. Fever of unknown origin (FUO) refers to a prolonged febrile illness without an established etiology despite thorough evaluation.

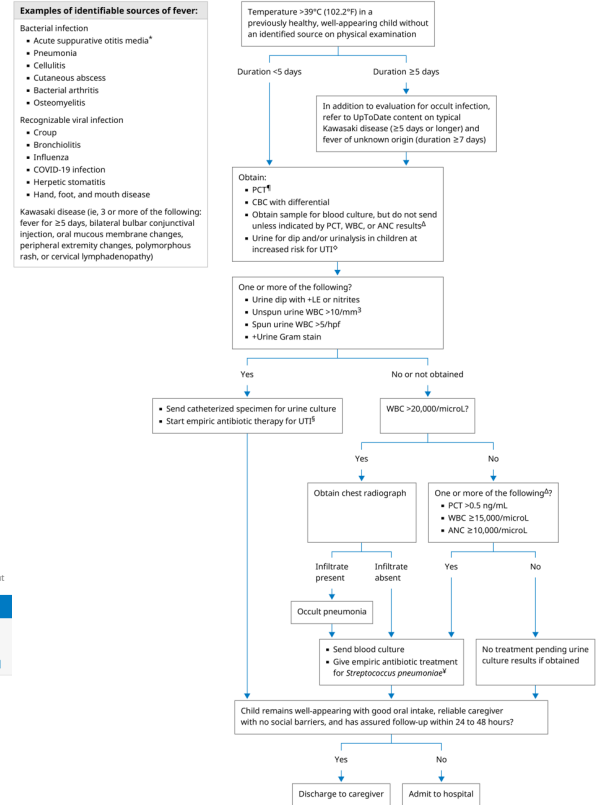
An approach to the evaluation of FUO in children will be reviewed here. Causes of FUO in children, fever without a source, and fever in specific pediatric populations are discussed separately:

- (See "Fever of unknown origin in children: Etiology".)
- (See "Fever without a source in children 3 to 36 months of age: Evaluation and management".)
- (See "The febrile infant (29 to 90 days of age): Outpatient evaluation" and "The febrile infant (29 to 90 days of age): Management".)
- (See "Fever in children with chemotherapy-induced neutropenia".)
- (See "Management of children with non-chemotherapy-induced neutropenia and fever".)

DEFINITIONS

A consensus definition for FUO in children is lacking [1]. For clinical purposes, we define FUO in children as fever >38.3°C (101°F) at least once per day for ≥8 days with no apparent diagnosis after

Emergency department evaluation and management of fever without a source in children 3 to 36 months of age, either unimmunized or incompletely immunized



This algorithm provides the evaluation and management of fever without a source in children 3 to 36 months of age who are unimmunized or incompletely immunized. Important exceptions mean that the child has not received the primary series of all heat-stable immunizations with intragastric vaccine against Streptococcus pneumoniae (Pneumovax® [PPV23]) and/or oral rotavirus (Rotarix® or RotaTeq®) are not applicable. (See "UpToDate content on fever without a source in children.")

ANC, absolute neutrophil count; CBC, complete blood count; LE, leukocyte esterase; PCT, procalcitonin; UTI, urinary tract infection; WBC, white blood cell count.

* For patients with acute suppurative otitis media, oral and topical neomycin/polymyxin B/mupirocin ointment applied to the affected ear(s) should address current patterns of resistance. Evaluation for occult bacteremia is not routinely necessary.

† If results are negative available (eg, within 60 minutes), a serum procalcitonin level identifies patients with higher sensitivity and specificity than WBC or ANC. A procalcitonin level <0.5 ng/mL warrants the same management as a WBC <10,000/microL or ANC <10,000/microL. Refer to UpToDate topic on fever without a source in children 3 to 36 months of age.

‡ In a child with multiple blood draws, the blood culture may be drawn with the CBC and sent if the PCT, WBC, or ANC is elevated. Recognizing that these studies are not ideal screening tools, some clinicians may prefer to always send a blood culture in these patients.

§ Young children at increased risk for UTI include:

- Female CAH patients aged
- Discharge from 48 months old
- Discharge from 60 months old
- Discharge from 72 months old
- Discharge from 84 months old
- Discharge from 96 months old
- Discharge from 108 months old
- Discharge from 120 months old
- Discharge from 132 months old
- Discharge from 144 months old
- Discharge from 156 months old
- Discharge from 168 months old
- Discharge from 180 months old
- Discharge from 192 months old
- Discharge from 204 months old
- Discharge from 216 months old
- Discharge from 228 months old
- Discharge from 240 months old
- Discharge from 252 months old
- Discharge from 264 months old
- Discharge from 276 months old
- Discharge from 288 months old
- Discharge from 300 months old
- Discharge from 312 months old
- Discharge from 324 months old
- Discharge from 336 months old
- Discharge from 348 months old
- Discharge from 360 months old
- Discharge from 372 months old
- Discharge from 384 months old
- Discharge from 396 months old
- Discharge from 408 months old
- Discharge from 420 months old
- Discharge from 432 months old
- Discharge from 444 months old
- Discharge from 456 months old
- Discharge from 468 months old
- Discharge from 480 months old
- Discharge from 492 months old
- Discharge from 504 months old
- Discharge from 516 months old
- Discharge from 528 months old
- Discharge from 540 months old
- Discharge from 552 months old
- Discharge from 564 months old
- Discharge from 576 months old
- Discharge from 588 months old
- Discharge from 600 months old
- Discharge from 612 months old
- Discharge from 624 months old
- Discharge from 636 months old
- Discharge from 648 months old
- Discharge from 660 months old
- Discharge from 672 months old
- Discharge from 684 months old
- Discharge from 696 months old
- Discharge from 708 months old
- Discharge from 720 months old
- Discharge from 732 months old
- Discharge from 744 months old
- Discharge from 756 months old
- Discharge from 768 months old
- Discharge from 780 months old
- Discharge from 792 months old
- Discharge from 804 months old
- Discharge from 816 months old
- Discharge from 828 months old
- Discharge from 840 months old
- Discharge from 852 months old
- Discharge from 864 months old
- Discharge from 876 months old
- Discharge from 888 months old
- Discharge from 900 months old
- Discharge from 912 months old
- Discharge from 924 months old
- Discharge from 936 months old
- Discharge from 948 months old
- Discharge from 960 months old
- Discharge from 972 months old
- Discharge from 984 months old
- Discharge from 996 months old
- Discharge from 1008 months old
- Discharge from 1020 months old
- Discharge from 1032 months old
- Discharge from 1044 months old
- Discharge from 1056 months old
- Discharge from 1068 months old
- Discharge from 1080 months old
- Discharge from 1092 months old
- Discharge from 1104 months old
- Discharge from 1116 months old
- Discharge from 1128 months old
- Discharge from 1140 months old
- Discharge from 1152 months old
- Discharge from 1164 months old
- Discharge from 1176 months old
- Discharge from 1188 months old
- Discharge from 1200 months old
- Discharge from 1212 months old
- Discharge from 1224 months old
- Discharge from 1236 months old
- Discharge from 1248 months old
- Discharge from 1260 months old
- Discharge from 1272 months old
- Discharge from 1284 months old
- Discharge from 1296 months old
- Discharge from 1308 months old
- Discharge from 1320 months old
- Discharge from 1332 months old
- Discharge from 1344 months old
- Discharge from 1356 months old
- Discharge from 1368 months old
- Discharge from 1380 months old
- Discharge from 1392 months old
- Discharge from 1404 months old
- Discharge from 1416 months old
- Discharge from 1428 months old
- Discharge from 1440 months old
- Discharge from 1452 months old
- Discharge from 1464 months old
- Discharge from 1476 months old
- Discharge from 1488 months old
- Discharge from 1500 months old
- Discharge from 1512 months old
- Discharge from 1524 months old
- Discharge from 1536 months old
- Discharge from 1548 months old
- Discharge from 1560 months old
- Discharge from 1572 months old
- Discharge from 1584 months old
- Discharge from 1596 months old
- Discharge from 1608 months old
- Discharge from 1620 months old
- Discharge from 1632 months old
- Discharge from 1644 months old
- Discharge from 1656 months old
- Discharge from 1668 months old
- Discharge from 1680 months old
- Discharge from 1692 months old
- Discharge from 1704 months old
- Discharge from 1716 months old
- Discharge from 1728 months old
- Discharge from 1740 months old
- Discharge from 1752 months old
- Discharge from 1764 months old
- Discharge from 1776 months old
- Discharge from 1788 months old
- Discharge from 1800 months old
- Discharge from 1812 months old
- Discharge from 1824 months old
- Discharge from 1836 months old
- Discharge from 1848 months old
- Discharge from 1860 months old
- Discharge from 1872 months old
- Discharge from 1884 months old
- Discharge from 1896 months old
- Discharge from 1908 months old
- Discharge from 1920 months old
- Discharge from 1932 months old
- Discharge from 1944 months old
- Discharge from 1956 months old
- Discharge from 1968 months old
- Discharge from 1980 months old
- Discharge from 1992 months old
- Discharge from 2004 months old
- Discharge from 2016 months old
- Discharge from 2028 months old
- Discharge from 2040 months old
- Discharge from 2052 months old
- Discharge from 2064 months old
- Discharge from 2076 months old
- Discharge from 2088 months old
- Discharge from 2100 months old
- Discharge from 2112 months old
- Discharge from 2124 months old
- Discharge from 2136 months old
- Discharge from 2148 months old
- Discharge from 2160 months old
- Discharge from 2172 months old
- Discharge from 2184 months old
- Discharge from 2196 months old
- Discharge from 2208 months old
- Discharge from 2220 months old
- Discharge from 2232 months old
- Discharge from 2244 months old
- Discharge from 2256 months old
- Discharge from 2268 months old
- Discharge from 2280 months old
- Discharge from 2292 months old
- Discharge from 2304 months old
- Discharge from 2316 months old
- Discharge from 2328 months old
- Discharge from 2340 months old
- Discharge from 2352 months old
- Discharge from 2364 months old
- Discharge from 2376 months old
- Discharge from 2388 months old
- Discharge from 2400 months old
- Discharge from 2412 months old
- Discharge from 2424 months old
- Discharge from 2436 months old
- Discharge from 2448 months old
- Discharge from 2460 months old
- Discharge from 2472 months old
- Discharge from 2484 months old
- Discharge from 2496 months old
- Discharge from 2508 months old
- Discharge from 2520 months old
- Discharge from 2532 months old
- Discharge from 2544 months old
- Discharge from 2556 months old
- Discharge from 2568 months old
- Discharge from 2580 months old
- Discharge from 2592 months old
- Discharge from 2604 months old
- Discharge from 2616 months old
- Discharge from 2628 months old
- Discharge from 2640 months old
- Discharge from 2652 months old
- Discharge from 2664 months old
- Discharge from 2676 months old
- Discharge from 2688 months old
- Discharge from 2700 months old
- Discharge from 2712 months old
- Discharge from 2724 months old
- Discharge from 2736 months old
- Discharge from 2748 months old
- Discharge from 2760 months old
- Discharge from 2772 months old
- Discharge from 2784 months old
- Discharge from 2796 months old
- Discharge from 2808 months old
- Discharge from 2820 months old
- Discharge from 2832 months old
- Discharge from 2844 months old
- Discharge from 2856 months old
- Discharge from 2868 months old
- Discharge from 2880 months old
- Discharge from 2892 months old
- Discharge from 2904 months old
- Discharge from 2916 months old
- Discharge from 2928 months old
- Discharge from 2940 months old
- Discharge from 2952 months old
- Discharge from 2964 months old
- Discharge from 2976 months old
- Discharge from 2988 months old
- Discharge from 3000 months old
- Discharge from 3012 months old
- Discharge from 3024 months old
- Discharge from 3036 months old
- Discharge from 3048 months old
- Discharge from 3060 months old
- Discharge from 3072 months old
- Discharge from 3084 months old
- Discharge from 3096 months old
- Discharge from 3108 months old
- Discharge from 3120 months old
- Discharge from 3132 months old
- Discharge from 3144 months old
- Discharge from 3156 months old
- Discharge from 3168 months old
- Discharge from 3180 months old
- Discharge from 3192 months old
- Discharge from 3204 months old
- Discharge from 3216 months old
- Discharge from 3228 months old
- Discharge from 3240 months old
- Discharge from 3252 months old
- Discharge from 3264 months old
- Discharge from 3276 months old
- Discharge from 3288 months old
- Discharge from 3300 months old
- Discharge from 3312 months old
- Discharge from 3324 months old
- Discharge from 3336 months old
- Discharge from 3348 months old
- Discharge from 3360 months old
- Discharge from 3372 months old
- Discharge from 3384 months old
- Discharge from 3396 months old
- Discharge from 3408 months old
- Discharge from 3420 months old
- Discharge from 3432 months old
- Discharge from 3444 months old
- Discharge from 3456 months old
- Discharge from 3468 months old
- Discharge from 3480 months old
- Discharge from 3492 months old
- Discharge from 3504 months old
- Discharge from 3516 months old
- Discharge from 3528 months old
- Discharge from 3540 months old
- Discharge from 3552 months old
- Discharge from 3564 months old
- Discharge from 3576 months old
- Discharge from 3588 months old
- Discharge from 3600 months old
- Discharge from 3612 months old
- Discharge from 3624 months old
- Discharge from 3636 months old
- Discharge from 3648 months old
- Discharge from 3660 months old
- Discharge from 3672 months old
- Discharge from 3684 months old
- Discharge from 3696 months old
- Discharge from 3708 months old
- Discharge from 3720 months old
- Discharge from 3732 months old
- Discharge from 3744 months old
- Discharge from 3756 months old
- Discharge from 3768 months old
- Discharge from 3780 months old
- Discharge from 3792 months old
- Discharge from 3804 months old
- Discharge from 3816 months old
- Discharge from 3828 months old
- Discharge from 3840 months old
- Discharge from 3852 months old
- Discharge from 3864 months old
- Discharge from 3876 months old
- Discharge from 3888 months old
- Discharge from 3900 months old
- Discharge from 3912 months old
- Discharge from 3924 months old
- Discharge from 3936 months old
- Discharge from 3948 months old
- Discharge from 3960 months old
- Discharge from 3972 months old
- Discharge from 3984 months old
- Discharge from 3996 months old
- Discharge from 4008 months old
- Discharge from 4020 months old
- Discharge from 4032 months old
- Discharge from 4044 months old
- Discharge from 4056 months old
- Discharge from 4068 months old
- Discharge from 4080 months old
- Discharge from 4092 months old
- Discharge from 4104 months old
- Discharge from 4116 months old
- Discharge from 4128 months old
- Discharge from 4140 months old
- Discharge from 4152 months old
- Discharge from 4164 months old
- Discharge from 4176 months old
- Discharge from 4188 months old
- Discharge from 4200 months old
- Discharge from 4212 months old
- Discharge from 4224 months old
- Discharge from 4236 months old
- Discharge from 4248 months old
- Discharge from 4260 months old
- Discharge from 4272 months old
- Discharge from 4284 months old
- Discharge from 4296 months old
- Discharge from 4308 months old
- Discharge from 4320 months old
- Discharge from 4332 months old
- Discharge from 4344 months old
- Discharge from 4356 months old
- Discharge from 4368 months old
- Discharge from 4380 months old
- Discharge from 4392 months old
- Discharge from 4404 months old
- Discharge from 4416 months old
- Discharge from 4428 months old
- Discharge from 4440 months old
- Discharge from 4452 months old
- Discharge from 4464 months old
- Discharge from 4476 months old
- Discharge from 4488 months old
- Discharge from 4500 months old
- Discharge from 4512 months old
- Discharge from 4524 months old
- Discharge from 4536 months old
- Discharge from 4548 months old
- Discharge from 4560 months old
- Discharge from 4572 months old
- Discharge from 4584 months old
- Discharge from 4596 months old
- Discharge from 4608 months old
- Discharge from 4620 months old
- Discharge from 4632 months old
- Discharge from 4644 months old
- Discharge from 4656 months old
- Discharge from 4668 months old
- Discharge from 4680 months old
- Discharge from 4692 months old
- Discharge from 4704 months old
- Discharge from 4716 months old
- Discharge from 4728 months old
- Discharge from 4740 months old
- Discharge from 4752 months old
- Discharge from 4764 months old
- Discharge from 4776 months old
- Discharge from 4788 months old
- Discharge from 4800 months old
- Discharge from 4812 months old
- Discharge from 4824 months old
- Discharge from 4836 months old
- Discharge from 4848 months old
- Discharge from 4860 months old
- Discharge from 4872 months old
- Discharge from 4884 months old
- Discharge from 4896 months old
- Discharge from 4908 months old
- Discharge from 4920 months old
- Discharge from 4932 months old
- Discharge from 4944 months old
- Discharge from 4956 months old
- Discharge from 4968 months old
- Discharge from 4980 months old
- Discharge from 4992 months old
- Discharge from 5004 months old
- Discharge from 5016 months old
- Discharge from 5028 months old
- Discharge from 5040 months old
- Discharge from 5052 months old
- Discharge from 5064 months old
- Discharge from 5076 months old
- Discharge from 5088 months old
- Discharge from 5100 months old
- Discharge from 5112 months old
- Discharge from 5124 months old
- Discharge from 5136 months old
- Discharge from 5148 months old
- Discharge from 5160 months old
- Discharge from 5172 months old
- Discharge from 5184 months old
- Discharge from 5196 months old
- Discharge from 5208 months old
- Discharge from 5220 months old
- Discharge from 5232 months old
- Discharge from 5244 months old
- Discharge from 5256 months old
- Discharge from 5268 months old
- Discharge from 5280 months old
- Discharge from 5292 months old
- Discharge from 5304 months old
- Discharge from 5316 months old
- Discharge from 5328 months old
- Discharge from 5340 months old
- Discharge from 5352 months old
- Discharge from 5364 months old
- Discharge from 5376 months old
- Discharge from 5388 months old
- Discharge from 5400 months old
- Discharge from 5412 months old
- Discharge from 5424 months old
- Discharge from 5436 months old
- Discharge from 5448 months old
- Discharge from 5460 months old
- Discharge from 5472 months old
- Discharge from 5484 months old
- Discharge from 5496 months old
- Discharge from 5508 months old
- Discharge from 5520 months old
- Discharge from 5532 months old
- Discharge from 5544 months old
- Discharge from 5556 months old
- Discharge from 5568 months old
- Discharge from 5580 months old
- Discharge from 5592 months old
- Discharge from 5604 months old
- Discharge from 5616 months old
- Discharge from 5628 months old
- Discharge from 5640 months old
- Discharge from 5652 months old
- Discharge from 5664 months old
- Discharge from 5676 months old
- Discharge from 5688 months old
- Discharge from 5700 months old
- Discharge from 5712 months old
- Discharge from 5724 months old
- Discharge from 5736 months old
- Discharge from 5748 months old
- Discharge from 5760 months old
- Discharge from 5772 months old
- Discharge from 5784 months old
- Discharge from 5796 months old
- Discharge from 5808 months old
- Discharge from 5820 months old
- Discharge from 5832 months old
- Discharge from 5844 months old
- Discharge from 5856 months old
- Discharge from 5868 months old
- Discharge from 5880 months old
- Discharge from 5892 months old
- Discharge from 5904 months old
- Discharge from 5916 months old
- Discharge from 5928 months old
- Discharge from 5940 months old
- Discharge from 5952 months old
- Discharge from 5964 months old
- Discharge from 5976 months old
- Discharge from 5988 months old
- Discharge from 6000 months old

¶ Refer to UpToDate content on empiric treatment of UTI in children. Consider chest radiograph for children with WBC >20,000/microL.

* Cellulitis (20 mg/kg); intravenous is preferred because of the antimicrobial spectrum and prolonged duration of action. Refer to UpToDate content on treatment of children with fever without a source.

兒科相關疾病

- 小兒氣喘，如何衛教家屬? 相關影片可提供學生了解?

The screenshot shows the UpToDate search results for "asthma children". The search bar contains "asthma children". The results are filtered by "Pediatric". The main result is "An overview of asthma management in children and adults", which includes links to "Classification of asthma severity", "Initial assessment", "Summary and recommendations", "Simplified approach to initial asthma therapy", and "Assessment of asthma symptom control and future risk". Below this, there are two more results: "Asthma in children younger than 12 years: Overview of initiating therapy and monitoring control" and "Acute asthma exacerbations in children younger than 12 years: Overview of home/office management planning".

The screenshot shows the UpToDate article page for "患者衛教：兒童氣喘（基礎知識）". The page is in Chinese. The main content area contains a message: "There is a newer version of this topic available in English. 本主題有新的中文版本。" Below this, there is a section titled "什麼是氣喘?" (What is asthma?) with a sub-section "氣喘症狀可以輕微的，也可以是嚴重的。" (Asthma symptoms can be mild or severe). The article also includes a section titled "氣喘的症狀有哪些?" (What are the symptoms of asthma?) with a list of symptoms: "喘鳴或呼吸有雜音", "經常在夜間、清晨或運動時咳嗽", "感覺胸悶", and "呼吸困難". The page also features a sidebar with a table of contents and a "Videos" section with two video thumbnails.

兒科相關疾病

川崎氏症(Kawasaki disease), 如何診斷?如何治療?

UpToDate Kawasaki disease

Contents Calculators Drug Interactions UpToDate Pathways Rx Transitions for Mental Health

Kawasaki disease: Clinical features and diagnosis

Topic Graphics (9)

Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

CLINICAL MANIFESTATIONS

LABORATORY FINDINGS

Full Text with ePillars

Author: Mary Beth F. Soti, MD
 SECTION EDITORS: Maria Klein-Goldman, MD, MPH, Sheldon L. Kaplan, MD
 REVIEW EDITOR: Philip Seo, MD, MHS
 Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.
 Literature review current through: Mar 2025.
 This topic last updated: Jul 08, 2024.

INTRODUCTION

Kawasaki disease (KD), previously called mucocutaneous lymph node syndrome) is one of the most common forms of systemic vasculitis in children [1]. KD also occurs, rarely, in adults. It is typically a self-limited condition, with fever and manifestations of acute inflammation lasting for an average of 12 days without therapy [2].

The most common complication of KD is the development of coronary artery (CA) aneurysms, which can lead to significant morbidity and mortality. Less common but potentially devastating complications include depressed myocardial contractility and heart failure, myocardial infarction, arrhythmias, and peripheral arterial occlusion. (See "Cardiovascular sequelae of Kawasaki disease: Clinical features and evaluation".)

The clinical manifestations and diagnosis of KD are discussed in this topic review. The epidemiology, etiology, treatment, and complications of KD, including cardiac sequelae, and unique features in infants and adults are reviewed separately. (See "Kawasaki disease: Pathogenesis, epidemiology, and etiology" and "Kawasaki disease: Initial treatment and prognosis" and "Cardiovascular sequelae of Kawasaki disease: Clinical features and evaluation".)

CLINICAL MANIFESTATIONS

The clinical manifestations of Kawasaki disease (KD) are often not present at the same time, and for most features, there is no typical order of appearance. Thus, repeated histories and physical

Kawasaki disease: Initial treatment and prognosis

Topic Graphics (5)

Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

IDENTIFICATION OF PATIENTS AT HIGH RISK FOR IVIG RESISTANCE

INITIAL THERAPY

ADVERSE EFFECTS

ADDITIONAL THERAPY FOR PATIENTS AT HIGH RISK FOR IVIG RESISTANCE

Author: Mary Beth F. Soti, MD
 SECTION EDITORS: Maria Klein-Goldman, MD, MPH, Sheldon L. Kaplan, MD
 REVIEW EDITOR: Philip Seo, MD, MHS
 Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.
 Literature review current through: Mar 2025.
 This topic last updated: Mar 05, 2025.

INTRODUCTION

Kawasaki disease (KD), formerly called mucocutaneous lymph node syndrome, is one of the most common vasculitides of childhood [1]. It is typically a self-limited condition with fever and manifestations of acute inflammation lasting for an average of 12 days without therapy. However, KD may cause cardiovascular complications, particularly coronary artery (CA) aneurysms. These, in turn, can lead to coronary occlusion and cardiac ischemia and result in significant morbidity or even mortality. (See "Cardiovascular sequelae of Kawasaki disease: Clinical features and evaluation".)

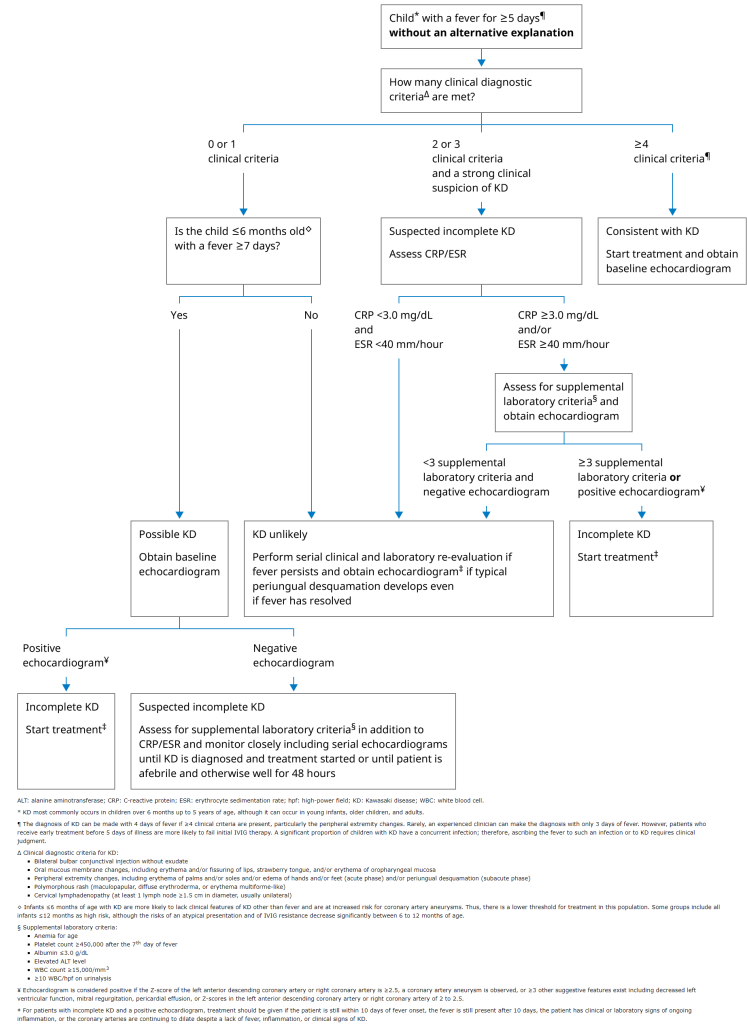
The frequency of CA aneurysm development and associated morbidity and mortality have dramatically decreased as a result of treatment with intravenous immune globulin (IVIG). This therapy is effective for preventing CA abnormalities, but the benefits in children who have already developed CA aneurysms are more equivocal. Thus, expeditious diagnosis and timely treatment are critical to achieve the optimal clinical outcome. The initial treatment of KD is discussed in this topic review. The clinical manifestations, diagnosis, cardiovascular sequelae, and treatment of refractory KD are reviewed elsewhere. (See "Refractory Kawasaki disease" and "Kawasaki disease: Clinical features and diagnosis" and "Cardiovascular sequelae of Kawasaki disease: Clinical features and evaluation".)

IDENTIFICATION OF PATIENTS AT HIGH RISK FOR IVIG RESISTANCE

Once the diagnosis of KD has been made (see algorithm 1), the next step is to determine the risk of intravenous immune globulin (IVIG) resistance since it is associated with a higher risk of coronary artery (CA) abnormalities (see algorithm 2). Patients who do not respond to IVIG treatment may benefit from more aggressive initial therapy for KD.

The first retrospective study to look at risk factors for refractory KD used the database of the 2003 to 2004 nationwide survey of KD in Japan [2]. Of the 15,940 patients with KD, 20 percent did not respond to initial IVIG therapy. These nonresponders had a dramatically higher risk for CA aneurysms (odds ratio [OR] 10.38, 95% CI 6.98-15.45) and giant CA aneurysms (OR 54.06, 95% CI 12.84-227.65) compared with responders. One of the risk factors identified was initial treatment at or before the fifth day of illness (OR 1.89, 95% CI 1.66-2.15). However, a review of data from the 1997

Evaluation of suspected Kawasaki disease



ALT: alanine aminotransferase; CRP: C-reactive protein; ESR: erythrocyte sedimentation rate; IgG: high-power field; KD: Kawasaki disease; WBC: white blood cell.

* KD most commonly occurs in children over 6 months up to 5 years of age, although it can occur in young infants, older children, and adults.

† The diagnosis of KD can be made with 4 days of fever if 3-4 clinical criteria are present, particularly the periorbital edema changes. Rarely, an experienced clinician can make the diagnosis with only 3 days of fever; however, patients who receive early treatment before 5 days of illness are more likely to fail initial IVIG therapy. A significant proportion of children with KD have a concurrent infection; therefore, ascertaining the fever to such an infection or to KD requires clinical judgment.

‡ Clinical diagnostic criteria for KD:

- Bilateral bulbar conjunctival injection without exudate
- Oral mucosa membrane changes, including erythema and/or fissuring of lips, strawberry tongue, and/or erythema of oropharyngeal mucosa
- Peripheral extremity changes, including erythema of palms and/or soles and/or edema of hands and/or feet (acute phase) and/or periorbital desquamation (subacute phase)
- Polymorphous rash (maculopapular, diffuse erythroderma, or erythema multiforme-like)
- Cervical lymphadenopathy (at least 1 lymph node ≥1.5 cm in diameter, acutely enlarged)

§ Infants <5 months of age with KD are more likely to lack clinical features of KD other than fever and are at increased risk for coronary artery aneurysms. Thus, there is a lower threshold for treatment in this population. Some groups include all infants <12 months at high risk, although the risks of an azygos presentation and of IVIG resistance decrease significantly between 6 to 12 months of age.

¶ Supplemental laboratory criteria:

- Anemia for age
- Platelet count >450,000 after the 7th day of fever
- Albumin <3.0 g/dL
- Elevated ALT level
- WBC count ≥15,000/mm³
- ≥10 WBC/HPF on urinalysis

‡ Echocardiogram is considered positive if the Z-score of the left anterior descending coronary artery or right coronary artery is ≥2.5, a coronary artery aneurysm is observed, or ≥3 other suggestive features exist including decreased left ventricular function, mitral regurgitation, pericardial effusion, or Z-scores in the left anterior descending coronary artery or right coronary artery of 2 to 2.5.

§ For patients with incomplete KD and a positive echocardiogram, treatment should be given if the patient is still within 10 days of fever onset; the fever is still present after 10 days, the patient has clinical or laboratory signs of ongoing inflammation, or the coronary arteries are continuing to dilate despite a lack of fever, inflammation, or clinical signs of KD.

兒科相關疾病

- 小兒燒燙傷，如何計算面積?如何處置?

UpToDate® burn injury children

Contents ▾ Calculators Drug Interactions UpToDate Pathways Rx Transitions for Mental Health

Moderate and severe thermal burns in children: Emergency management

Topic Graphics (13)

Outline

- SUMMARY AND RECOMMENDATIONS
- INTRODUCTION
- PATHOPHYSIOLOGY
- CLASSIFICATION
- PREHOSPITAL CARE
- EVALUATION
 - Initial rapid assessment
 - History
 - Physical examination
 - General examination
 - Evaluation of burn injury
 - Diagnostic studies
- MANAGEMENT
 - Initial management decisions
 - Fluid resuscitation
 - Estimating fluid requirements
 - Choice of fluid
 - Monitoring fluid status
 - Pain control

AUTHOR: Mark D Joffe, MD
SECTION EDITOR: Richard G Bachur, MD
DEPUTY EDITOR: James F Wiley, II, MD, MPH
Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.
Literature review current through: Mar 2025.
This topic last updated: Jul 14, 2023.

INTRODUCTION

This topic will review the emergency management of moderate to severe thermal burns in children (see table 1).
The care of minor thermal burns, smoke inhalation, chemical burns to the skin and eye, electrical injuries, and ongoing burn management, are discussed separately.

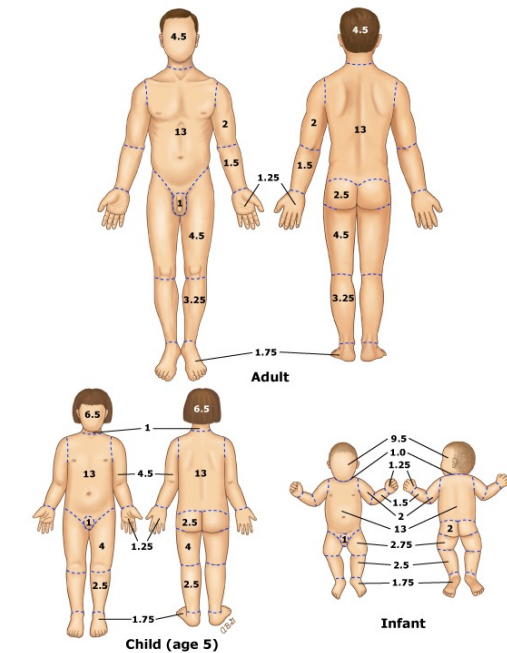
- (See "Treatment of minor thermal burns".)
- (See "Inhalation injury from heat, smoke, or chemical irritants".)
- (See "Topical chemical burns: Initial evaluation and management".)
- (See "Electrical injuries and lightning strikes: Evaluation and management".)
- (See "Overview of the management of the severely burned patient".)

PATHOPHYSIOLOGY

Local injury, systemic response, and metabolic changes combine to determine the severity of a burn injury as follows:

- **Burn wound** – Significant thermal energy transferred to skin denatures and coagulates protein, resulting in irreversible tissue destruction. Surrounding this zone of coagulation is an at-risk area of decreased perfusion [1]. Tissue in this zone is salvageable, provided that resuscitative efforts are successful in restoring perfusion. Perfusion is increased at the outer margins of the burn. Tissue in this zone can recover as long as the patient does not experience prolonged hypoperfusion.

Modified Lund-Browder chart



Numbers refer to the percentage body surface area burned.

兒科相關計算器

Pediatrics Calculators

Clinical Criteria

Apgar score in newborns

Corrected/adjusted age of preterm infants

Newborn hyperbilirubinemia assessment for infants born at ≥ 35 weeks gestation

Pediatric ulcerative colitis activity index (PUCAI)

Westley croup severity score (appropriate for use in children ≤ 6 years of age)

Medical Equations

Absolute eosinophil count

Assessment of malnutrition in females, 0 to 24 months (WHO)

Assessment of malnutrition in females, 2 to 5 years (WHO)

Assessment of malnutrition in males, 0 to 24 months (WHO)

Assessment of malnutrition in males, 2 to 5 years (WHO)

Basal metabolic rate (BMR) using Schofield equations in children and adolescents

Blood pressure percentiles, 0 to 17 years (2017 standard)

Body mass index (BMI) percentiles and Z-scores, females 2 to 20 years (CDC)

Body mass index (BMI) percentiles and Z-scores, females 2 to 20 years (CDC) (Patient education)

Body mass index (BMI) percentiles and Z-scores, males 2 to 20 years (CDC) (Patient education)

Body surface area (BSA) (Mosteller, square root method) in children and adults

Conventional (gravimetric, imperial, US) unit to SI unit conversions: Chemistry and endocrine tests

Estimated energy requirement (EER) for females, birth to 18 years (revised 2023)

Estimated energy requirement (EER) for males, birth to 18 years (revised 2023)

Glomerular filtration rate estimate for children by Schwartz formula

Glomerular filtration rate estimation (eGFR) by CKID U25 equations with creatinine and/or cystatin C in children and adults ≤ 25 years old (2021)

Head circumference-for-age percentiles and Z-scores, 0 to 24 months (WHO)

Head circumference-for-age percentiles and Z-scores, 0 to 36 months (CDC)

Height-for-age percentiles and Z-scores, females 2 to 20 years (CDC)

Height-for-age percentiles and Z-scores, males 2 to 20 years (CDC)

Length-for-age percentiles and Z-scores, 0 to 24 months (WHO)

MELD 3.0 score EXCLUDING serum albumin (for patients 12 years and older)

MELD 3.0 score including serum albumin (for patients 12 years and older)

Maintenance fluid calculation for children based on daily fluid requirements

Maintenance fluid calculation for children based on hourly fluid requirements

PELD-Cr score for end-stage liver disease (patients less than 12 years old)

PFT predicted values in children and adults (2022, race-neutral GLI equations)

PFT predicted values in children and adults (2022, race-neutral GLI equations)

Peak expiratory flow prediction in females (5 to < 18 years)

Peak expiratory flow prediction in males (5 to < 18 years)

Prediction of child's target height (height potential) based on midparental height

SI unit to conventional (gravimetric, imperial, US) unit conversions: Chemistry and endocrine tests

Spot urine albumin-to-creatinine ratio in adults (conventional and SI units)

Spot urine protein-to-creatinine ratio in adults

Spot urine protein-to-creatinine ratio in children (6 months to 18 years of age)

Urine potassium-to-creatinine ratio in adults and children ≥ 1 year of age

Weight-for-age percentiles and Z-scores, 0 to 24 months (WHO)

Weight-for-age percentiles and Z-scores, females 2 to 20 years (CDC)

Weight-for-age percentiles and Z-scores, males 2 to 20 years (CDC)

Weight-for-length percentiles and Z-scores, 0 to 24 months (WHO)

社區護理學相關

- 失智症評估，目前診斷標準是什麼?處置有哪些?如何衛教?

The image shows a screenshot of the UpToDate website. The top navigation bar includes 'Contents', 'Calculators', and 'Drug Interactions'. The search bar contains the word 'dementia'. Below the search bar, there are tabs for 'All', 'Adult', and 'Pediatric'. The main content area displays search results for 'dementia', including 'Evaluation of cognitive impairment', 'Treatment of Alzheimer disease', and 'Early-onset dementia in...'. A sidebar on the left lists related topics such as '什麼是失智症?', '我們應該為未來制訂什麼計畫?', and '如何防止家人走失?'. The main article page is titled '患者衛教：照顧阿茲海默症或失智症患者（基礎知識）' and contains text about dementia, including a definition and a list of recommendations for future planning.

UpToDate® dementia

Contents Calculators Drug Interactions

< Back All Adult Pediatric

Showing results for dementia
Search instead: Vascular dementia, Alzheimer disease

Evaluation of cognitive impairment
... vascular dementia and vascular cognitive impairment
dementias (eg, metabolic dementias) tend ...
Criteria for dementia
Laboratory testing
Summary and recommendations
DSM-IV and DSM-5 criteria for dementia
Drugs that cause or prolong cognitive impairment

Treatment of Alzheimer disease
...about the diagnosis of an early Alzheimer dementia is likely (early-onset Alzheimer disease)
Cholinesterase inhibitors
Neuropsychiatric symptoms
Summary and recommendations
Cholinesterase inhibitors
Anticholinergic activity of medications

Early-onset dementia in
...factors for early-onset dementia

UpToDate® dementia

Help CME 323.5 Sign in

Contents Calculators Drug Interactions UpToDate Pathways Rx Transitions for Mental Health

患者衛教：照顧阿茲海默症或失智症患者（基礎知識）

Select Language

由 UpToDate 的醫師與編輯撰寫
請參閱本頁尾的免責聲明。

什麼是失智症？
失智症是一個總稱，指一組會導致記憶和思考問題的腦部疾病。失智症最常見的原因是阿茲海默症。但還有其他形式的失智症。得知親人患有阿茲海默症或另一種形式的失智症，可能會讓人感到恐懼和壓力。本文提供可以幫助照護者的資訊。

我們應該為未來制訂什麼計畫？
當得知家人被診斷出患有阿茲海默症（或其他形式的失智症）後，需要為他們制訂計畫，例如：

- 居住情況—如果家人獨居，請確保他們的安全並獲得自理所需的幫助。他們終將無法獨自生活，因此做好這方面的計畫很重要。您可以讓他們住在有人協助的家裡，或搬到安養院。
- 決策制訂—家人應盡早選出一位「委任代理人」。委任代理人是指當事人無法自行做決定時可以代為決定的人。委任代理人與當事人交談以了解他們在不同情況下的需求非常重要，尤其是在臨終時。例如，有些人如果無法自行呼吸，會希望裝設呼吸器，但有些人則不願意。進行這些對話很困難，但務必在當事人仍然能夠自行決定時儘早執行。
- 金錢—隨著疾病的惡化，家人在理解如何管理金錢方面遇到困難。如果您的家人想要自己管理錢財，務必確保他們正確處理金錢。您還需要制訂計畫以應對他們無法獨自管理金錢的情況。
- 駕駛—如果家人仍然能夠駕駛，請詢問醫師他們何時應該停止。每個人停止的適當時間都不同。
- 醫療保健—需要有人帶家人去看醫師並遵循醫師的指示。如果他們使用藥物，您可以在需要時幫助他們建立用藥習慣。

阿茲海默症的症狀會隨著時間的經過而惡化。請務必注意並根據需要定期修改計畫。

社區護理學相關

- 鼻胃管/鼻腸管照護，營養補充?腸造口更換及衛教

Inpatient placement and management of nasogastric and nasoenteric tubes in adults

Topic Graphics (5)

Outline

- SUMMARY AND RECOMMENDATIONS
- INTRODUCTION
- INDICATIONS
- CONTRAINDICATIONS
- TYPES OF TUBES
- AREAS OF CONTROVERSY
- PROPHYLACTIC PLACEMENT
- GASTRIC LAVAGE
- ENTERAL NUTRITION
- TUBE PLACEMENT
- Placement for decompression
- Altered patient
- Intubated patient
- Placement for feeding
- Confirmation of placement
- Radiographic confirmation
- Clinical confirmation tubes used only for decompression
- Tube fixation

INTRODUCTION

Nasogastric and nasoenteric tubes are flexible double or single-lumen tubes that are passed proximally from the nose distally into the stomach or small bowel. Enteric tubes that will be removed within a short period can also be passed through the mouth (orogastric). This topic will review the indications, contraindications, placement, management, and complications of nasogastric and nasoenteric tubes in the adult inpatient.

INDICATIONS

Nasogastric tubes are indicated for the following reasons:

- **Treatment of ileus or bowel obstruction** – Gastrointestinal decompression using nasogastric tubes is important for the treatment of patients with bowel obstruction or prolonged ileus. Nasogastric decompression improves patient comfort, minimizes or prevents recurrent vomiting, and serves as a means to monitor the progress or resolution of these conditions. (See “Postoperative ileus” and “Management of small bowel obstruction in adults”.)
- **Administration of medications** – A nasogastric tube may be needed to administer medications or oral contrast for computed tomography to patients who cannot swallow or who are neurologically impaired.
- **Enteral nutrition** – Nasogastric and nasoenteric tubes are used to deliver enteral nutrition into the stomach (gastric feeding) or into the small intestine (postpyloric). (See “Enteral nutrition” below.)

Nutrition support in critically ill adult patients: Enteral nutrition

Topic Graphics (3)

Outline

- SUMMARY AND RECOMMENDATIONS
- INTRODUCTION
- PHASES OF CRITICAL ILLNESS
- INDICATIONS AND CONTRAINDICATIONS
- ROUTE OF DELIVERY
- GASTRIC
- POST-PYLORIC
- FORMULATIONS
- Choosing a formulation
- Standard
- Formulations for special circumstances
- Concentrated formulas
- Blend
- Predegested
- COMPOSITION
- Carbohydrate
- Protein
- Other (vitamins, minerals, trace elements, fiber)
- Extra supplements of no proven benefit
- DELIVERY STRATEGY

INTRODUCTION

Enteral nutrition (EN) support refers to the provision of calories, protein, electrolytes, vitamins, minerals, trace elements, and fluids via an intestinal route. EN is the most common mode of delivery for nutrition support in intubated critically ill patients. To initiate EN, appropriate access must be obtained and the prescription needs to be determined.

Typical access used, available formulations and their composition, delivery route, and monitoring of EN in critically ill patients are reviewed in this topic. The indications, contraindications, timing, and prescription of calories and protein are discussed separately. (See “Nutrition support in critically ill adult patients: Initial evaluation and prescription”.)

PHASES OF CRITICAL ILLNESS

The phases of critical illness include the acute (early and late) and chronic phases. Further details are provided separately. (See “Nutrition support in critically ill adult patients: Initial evaluation and prescription”, section on “Phases of critical illness”.)

INDICATIONS AND CONTRAINDICATIONS

Clinical practice guidelines suggest that EN protocols be designed and implemented in each institution [1,2]. The indications and contraindications (table 1) for EN are described elsewhere. (See “Nutrition support in critically ill adult patients: Initial evaluation and prescription”, section on “Assess indications and contraindications”.)

ROUTE OF DELIVERY

In critically ill patients, EN is most commonly delivered into the stomach (gastric feeding) (see “Gastric” below). However, in select patients it can also be administered into more distal parts of the alimentary tract (eg, post-pyloric feeding) (see “Post-pyloric” below). Feeding through an enteral tube should not begin until its proper position has been confirmed radiographically.

Gastric — Gastric feeding is typically delivered via an orogastric or nasogastric tube (table 2). Oro- or nasogastric tubes are available in two varieties, sump or feeding tubes, the placement of which are discussed separately (see “Inpatient placement and management of nasogastric and nasoenteric tubes in adults”).

- Sump tubes – Sump tubes are larger and stiffer than feeding tubes. They are generally inserted for gastric decompression but may be used for short periods to deliver EN when gastric

患者衛教：如何照護造口 (基礎知識)

Topic Graphics (7)

Outline

- SUMMARY AND RECOMMENDATIONS
- INTRODUCTION
- PATIENT EDUCATION
- POUCH SYSTEMS AND ROUTINE OSTOMY CARE
- Pouch systems
- Pouch placement
- Pouch emptying and care
- DIET AND CONTROL OF GAS
- ILEOSTOMY PATIENTS
- Dehydration
- High ostomy output
- Food blockage
- Drug malabsorption
- COLOSTOMY PATIENTS
- Colon irrigation
- PHYSICAL ACTIVITY
- Sex

INTRODUCTION

Ileostomy or colostomy creation may be required temporarily or permanently for the management of a variety of pathologic conditions, including congenital anomalies, colon obstruction, inflammatory bowel disease, intestinal trauma, or gastrointestinal malignancy [1].

The anatomic location and type of stoma construction have an impact on management. Loop colostomies tend to be larger and somewhat more difficult to manage than end colostomies. The type and volume of output (effluent), and therefore fluid loss, is determined by the location of the stoma relative to the ileocecal valve. Fluid loss is primarily a factor with end or loop ileostomies.

With proper stoma care and attention to nutrition and fluid management, most ostomy patients are able to have full, healthy, active social and professional lives and normal sexual activity. In many cases, quality of life can be improved, even in the context of a permanent ostomy, with treatment of the underlying disease.

The routine care and management of common issues and complications of stoma creation are reviewed here. The types and indications, and principles of ostomy construction and reversal, are discussed separately. (See “Overview of surgical ostomy for fecal diversion” and “Parastomal hernia”.)

PATIENT EDUCATION

Patient preparation for adaptation to life with a temporary or permanent ostomy begins in the preoperative period, whenever possible. (See “Overview of surgical ostomy for fecal diversion”, section on “Preparation and counseling”.)

檢查保護皮的貼合度。將保護皮的開口置於造口中央。請確保其所有邊緣都貼合。自標度盡量減少暴露的皮膚量。如有需要，請修剪保護皮。

- 進行皮膚防護。醫師或護理師可能會讓您使用皮膚防護薄片、保護皮粉或造口膏。
- 從保護皮上取下保護背墊。將保護皮放在造口周圍的皮膚上。用手或溫熱的乾毛巾接觸至少 30 至 60 秒，或長達數分鐘。將保護皮保持在適當位置數分鐘可以讓它在皮膚上粘得更牢固。
- 如果使用兩件式系統，可以在保護皮貼到皮膚上之前或之後將袋子連接到保護皮上。
- 您可能想把保護背襯作為膠板保存，以便下次更換造口袋時使用。
- 封住造口袋的底部，或安裝夾子。

如何照護皮膚？

如果糞便接觸到皮膚，皮膚可能會受到刺激和疼痛。取下舊保護皮也會導致皮膚發紅或疼痛。一些有助於保持造口周圍皮膚健康的建議：

- 在更換造口前後洗手。
- 每次更換造口袋或保護皮時，請用溫水輕輕清潔皮膚。不要使用含有油或香水的產品來清潔造口。
- 如果造口周圍的皮膚疼痛或如果出現滲漏，醫師或護理師可能會建議使用皮膚防護薄片、造口粉、造口膏或使用不同類型的造口系統。
- 僅使用專為造口周圍使用的粉末或其他產品。

如何照護造口？

您不需要做任何特別的事情來照護造口。它應該呈深粉紅色或紅色。由於造口含有許多微小的血管，因此造口有少量出血是正常的。如果造口處有臭味，請用軟毛刷或衛生紙輕輕擦拭。

Ileostomy or colostomy care and complications

Topic Graphics (7)

Outline

- SUMMARY AND RECOMMENDATIONS
- INTRODUCTION
- PATIENT EDUCATION
- POUCH SYSTEMS AND ROUTINE OSTOMY CARE
- Pouch systems
- Pouch placement
- Pouch emptying and care
- DIET AND CONTROL OF GAS
- ILEOSTOMY PATIENTS
- Dehydration
- High ostomy output
- Food blockage
- Drug malabsorption
- COLOSTOMY PATIENTS
- Colon irrigation
- PHYSICAL ACTIVITY
- Sex

INTRODUCTION

Ileostomy or colostomy creation may be required temporarily or permanently for the management of a variety of pathologic conditions, including congenital anomalies, colon obstruction, inflammatory bowel disease, intestinal trauma, or gastrointestinal malignancy [1].

The anatomic location and type of stoma construction have an impact on management. Loop colostomies tend to be larger and somewhat more difficult to manage than end colostomies. The type and volume of output (effluent), and therefore fluid loss, is determined by the location of the stoma relative to the ileocecal valve. Fluid loss is primarily a factor with end or loop ileostomies.

With proper stoma care and attention to nutrition and fluid management, most ostomy patients are able to have full, healthy, active social and professional lives and normal sexual activity. In many cases, quality of life can be improved, even in the context of a permanent ostomy, with treatment of the underlying disease.

The routine care and management of common issues and complications of stoma creation are reviewed here. The types and indications, and principles of ostomy construction and reversal, are discussed separately. (See “Overview of surgical ostomy for fecal diversion” and “Parastomal hernia”.)

PATIENT EDUCATION

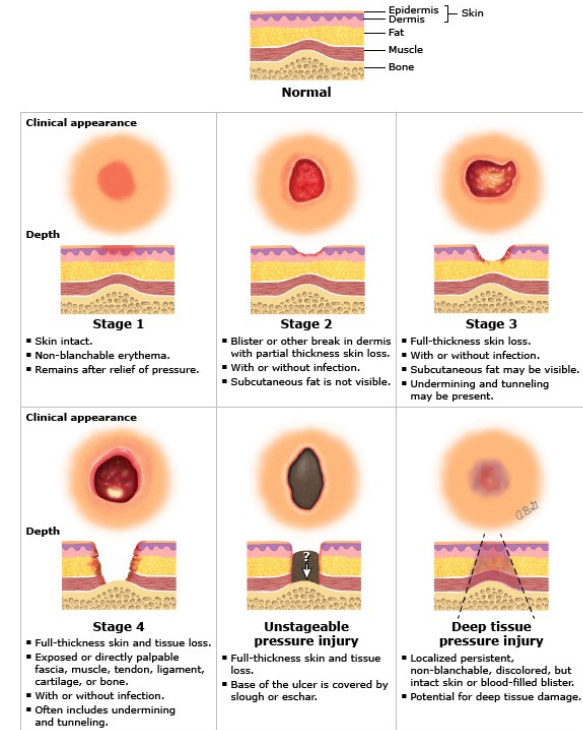
Patient preparation for adaptation to life with a temporary or permanent ostomy begins in the preoperative period, whenever possible. (See “Overview of surgical ostomy for fecal diversion”, section on “Preparation and counseling”.)

社區護理學相關

- 壓瘡，風險等級?傷口等級評估? 如何衛教?

The screenshot shows the UpToDate website interface. At the top, there's a search bar with 'bedsore treatment' entered. Below the search bar, there are navigation tabs for 'Contents', 'Calculators', 'Drug Interactions', 'UpToDate Pathways', and 'Rx Transitions for Mental Health'. The main content area displays search results for 'bedsore treatment', including a link to 'Clinical staging and general management of pressure-induced skin and soft tissue injury'. Below this, there are sections for 'Local care of pressure-induced skin and soft tissue injury' and 'Wound management dressing guide'. The bottom part of the screenshot shows a detailed article page for '患者衛教：壓瘡（基礎知識）' (Patient Education: Pressure Ulcers (Basic Knowledge)). The article includes a language selection dropdown, a notice about a newer version available in English, and a list of related topics such as '什麼是壓瘡?' (What are pressure ulcers?), '壓瘡是什麼樣子?' (What do pressure ulcers look like?), '誰容易有壓瘡?' (Who is at risk for pressure ulcers?), and '壓瘡是什麼樣子?' (What do pressure ulcers look like?).

Characteristics of pressure-induced injury by stage



These illustrations highlight the characteristics of the stages of pressure-induced injuries as defined by the National Pressure Ulcer Advisory Panel. Each panel demonstrates the clinical appearance of the involved skin as well as the cross section of the depth of injury. Most pressure-induced injuries are associated with an underlying bony prominence. There is always the potential for deeper tissue damage than appreciated on clinical examination, as illustrated by the panel "Deep tissue pressure injury."

Adapted from definitions by the National Pressure Ulcer Advisory Panel. **UpToDate**

社區護理學相關

- 老年憂鬱症

UpToDate® elderly depression

Contents Calculators Drug Interactions UpToDate Pathways Rx Transitions for Mental Health

Diagnosis and management of late-life depression

Topic Graphics (9)

Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

EPIDEMIOLOGY AND PATHOGENESIS

COMORBIDITY

CLASSIFICATION

SCREENING

DIAGNOSIS

UpToDate® elderly depression

Help v CME 325.0 Sign out

Authors: Randall T Espinoza, MD, MPH, Jürgen Unützer, MD, MPH
Section Editors: Peter P Roy-Byrne, MD, Kenneth E Schmader, MD
Deputy Editors: Sara Swenson, MD, David Solomon, MD
Literature review current through: Mar 2025.
This topic last updated: Apr 07, 2025.

INTRODUCTION

The term late-life depression includes both aging patients whose depressive disorder presented in earlier life, and patients whose disorder presents for the first time in later life. Depressive illness in the older population is a common and serious health concern that is associated with impaired functioning, medical comorbidity, excessive use of health care resources, and increased mortality (including suicide) [1].

Late-life depression remains underdiagnosed and inadequately treated [2-5]. In the United States, older men, especially older African Americans and Hispanic Americans, are at even greater risk of unrecognized depression [6-8]. The public health consequences of inadequately treated depression in late life will increase over time as the population continues to age.

Most mental health treatment for older adults with depression is delivered in the primary care setting. Depression often goes undiagnosed in primary care [9], and is often left untreated, even when diagnosed [10]. Recognition and management of late-life depression is an important responsibility for the primary care clinician. Either pharmacotherapy or psychotherapy can benefit

Screening for depression in adults

Topic Graphics (8)

Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

DEFINITIONS

WHO TO SCREEN

BENEFITS AND HARMS OF SCREENING

SCREENING TESTS

UpToDate® elderly depression

Help v CME 325.0 Sign out

Authors: John Williams, MD, Jason Nieuwma, PhD
Section Editors: Joann G Elmore, MD, MPH, Peter P Roy-Byrne, MD
Deputy Editors: Sara Swenson, MD
Literature review current through: Mar 2025.
This topic last updated: Feb 21, 2025.

INTRODUCTION

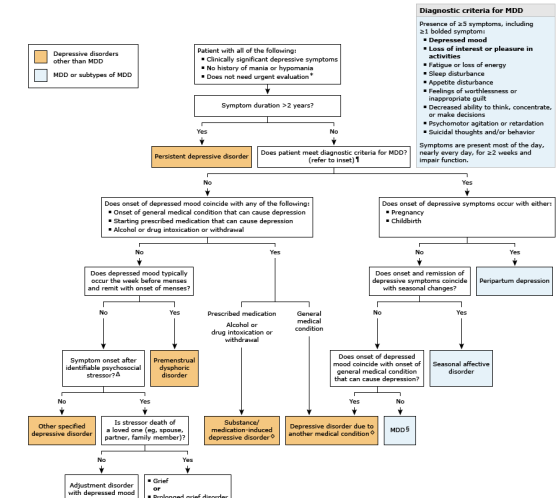
Depression is the most common psychiatric disorder in the general population [1] and the most common mental health condition in patients seen in primary care [2,5]. Undiagnosed, depression is associated with decreased quality of life as well as risks for mortality and other adverse health outcomes. Thus, systematic screening carries the potential for substantial benefit.

This topic will review the rationale for screening for depression, including the evidence for its benefits, harms, and cost-effectiveness. It will also address who to screen, screening instruments, and implementation of screening into primary care practices.

The epidemiology, risk factors, clinical presentation, diagnosis, and management of unipolar major depression are discussed elsewhere:

- (See "Major depression in adults: Epidemiology".)
- (See "Depression in adults: Clinical features and diagnosis".)
- (See "Approach to the adult patient with suspected depression".)
- (See "Major depressive disorder in adults: Approach to initial management".)

Diagnostic approach to adult outpatients with a likely depressive disorder



This algorithm should be used in conjunction with UpToDate topics on clinical symptoms, evaluation, and diagnosis of depression. This algorithm outlines the diagnostic approach to the adult with a likely depressive disorder and is intended to guide the user to the most likely possible diagnosis.

Definitive diagnosis requires a comprehensive evaluation and confirmation via diagnostic interview, particularly since patients may meet criteria for multiple psychiatric and general medical disorders.

For an overall approach to the patient with suspected depression, refer to UpToDate topics on the approach to the adult patient with suspected depression.

Orange boxes are depressive disorders other than MDD. Blue boxes are MDD or subtypes of MDD. Refer to UpToDate topics on clinical features and diagnosis of depression in adults for details.

DSM-5-TR: Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision; MDD: major depressive disorder; PHQ-9: 9-item Patient Health Questionnaire; WHO: World Health Organization.

* Individuals who require urgent evaluation include those at imminent risk of self-harm or harming others and those with life-threatening functional impairment, acute mania, or psychosis. Refer to UpToDate topics on the approach to the adult patient with suspected depression for details on the assessment of features that require urgent evaluation.

† To assess for clinical symptoms of depression, clinicians can use structured instruments (eg, PHQ-9) and/or direct questioning about symptoms. We typically use diagnostic criteria from the DSM-5-TR or the WHO's International Classification of Diseases. Refer to UpToDate topics on the clinical features and diagnosis of depression in adults for details.

Δ Individuals with an acute psychosocial stressor who meet diagnostic criteria for MDD have that diagnosis, not adjustment disorder.

◊ Coincidental onset of depressive symptoms with the medical condition or medication is necessary, but not sufficient, to establish this diagnosis. Clinicians should additionally use clinical judgement to determine if the timing and types of depressive symptoms suggest that the new-onset medical condition, new medication, or alcohol or drug use is causing the depressive symptoms.

§ After establishing the diagnosis of MDD, clinicians should evaluate for depression subtypes that may affect prognosis and/or treatment (eg, anxious, catatonic, mixed, and psychotic). Refer to UpToDate topics on the clinical features and diagnosis of depression in adults for details.

References:

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR). American Psychiatric Association 2022.
2. World Health Organization. Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders (CDD). World Health Organization 2024.