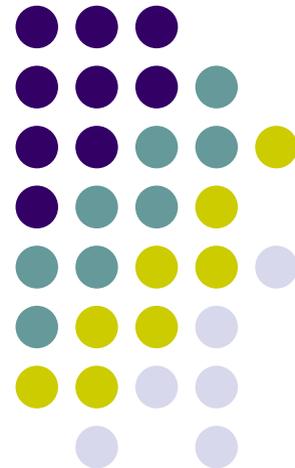


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Guida di utilizzo



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1. Type 1 Diabetes (includes abstract) Wood D; Sinnott B; Health Library: Evidence-Based Information, EBSCO Publishing, November 2009 (patient education - condition) CINAHL AN: 2009544693 Testo completo in HTML	Aggiungi
2. Type 2 Diabetes (includes abstract) Wood D; Sinnott B; Health Library: Evidence-Based Information, EBSCO Publishing, November 2009 (patient education - condition) CINAHL AN: 2009543325 Testo completo in HTML	Aggiungi
3. diabetes Venes D; Taber's Cyclopedic Medical Dictionary, 20th ed, F.A. Davis Company, 2005 (book - book chapter) CINAHL AN: t0hD05-242140 Testo completo in HTML	Aggiungi
4. Type 1 diabetes: diagnosis and management of type 1 diabetes in children and young people: complete summary US National Guideline Clearinghouse, 2006 Feb 20 (other - practice guidelines) CINAHL AN: 5000006843 Testo completo in PDF (101KB)	Aggiungi
5. Diabetes management in correctional institutions: complete summary US National Guideline Clearinghouse. 2008 Oct 20 (other - practice guidelines) CINAHL AN: 5000009670	Aggiungi

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▶ Argomento: titolo principale		
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	<p>1. Diabetes Mellitus, Type 1, in Adolescents Schub T; Pravikoff D; CINAHL Nursing Guide, Cinahl Information Systems, 2010 Feb 19. (2p) (quick lesson - CEU, exam questions) CINAHL AN: 5000010425 CE Module: Diabetes Mellitus, Type 1, in Adolescents--CE Module Testo completo in HTML Testo completo in PDF (188K)</p>	Aggiungi
	<p>2. Diabetes Mellitus, Type 2 Strayer DA; Pravikoff D; CINAHL Nursing Guide, Cinahl Information Systems, 2010 Jan 22. (2p) (quick lesson - CEU, exam questions) CINAHL AN: 5000001606 CE Module: Diabetes Mellitus, Type 2--CE Module Testo completo in HTML Testo completo in PDF (190K)</p>	Aggiungi
	<p>3. Diabetes Mellitus, Gestational Strayer DA; Pravikoff D; CINAHL Nursing Guide, Cinahl Information Systems, 2010 Mar 12. (2p) (quick lesson) CINAHL AN: 5000000890 Testo completo in HTML Testo completo in PDF (183K)</p>	Aggiungi
	<p>4. Diabetes Mellitus, Type 2 in Adolescents Schub T; Pravikoff D; CINAHL Nursing Guide, Cinahl Information Systems, 2010 Feb 19. (2p) (quick lesson - CEU, exam questions) CINAHL AN: 5000010426 CE Module: Diabetes Mellitus, Type 2 in Adolescents--CE Module Testo completo in HTML Testo completo in PDF (184K)</p>	Aggiungi
	<p>5. Diabetes Mellitus: Pregnancy in Patients with Preexisting Diabetes Strayer DA; Pravikoff D; CINAHL Nursing Guide, Cinahl Information Systems, 2008 Nov 11. (2p) (quick lesson) CINAHL AN: 5000004666</p>	Aggiungi

Selezionando ad esempio la sezione **Lezioni Rapide**, si visualizzano una serie di documenti in testo completo che descrivono tutti gli aspetti della patologia correlata al termine ricercato

Titolo: *Diabetes Mellitus, Type 1* Di: Strayer DA, Schub T, Pravikoff D, CINAHL Nursing Guide, November 11, 2008

Database: *Nursing Reference Center*

Diabetes Mellitus, Type 1

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Quick Lesson

By: Darlene A. Strayer, RN, MBA; Tanja Schub, BS
Edited by: Diane Pravikoff, RN, PhD, FAAN
Cinahl Information Systems

Description/Etiology

Diabetes mellitus, type 1 (DM1; formerly known as insulin-dependent **diabetes** and juvenile-onset **diabetes**) is a life-threatening, multisystem, metabolic disease of abrupt onset characterized by severe insulin deficiency as a result of autoimmune destruction of insulin-producing pancreatic β -cells. Without appropriate treatment, the ensuing disruption in the normal regulation of carbohydrate, fat, and protein metabolism leads to chronic hyperglycemia (i.e., increased blood sugar), systemic acid-base imbalance, insufficient glucose delivery to the brain and retina, inadequate blood supply to the tissues, widespread vascular degeneration, and neuropathy.

Current research links the cause of DM1 to the synergistic effects of genetic susceptibility, environmental (e.g., viral) factors, and a dysfunctional immune process. Diagnosis of DM1 is based on clinical presentation and laboratory studies demonstrating elevated fasting glucose levels. Treatment of DM1 involves administration of exogenous insulin, as well as exercise and diet control. Strict adherence to conventional (1-2 insulin injections/day) or intensive (3-4 insulin injections/day) treatment regimens is essential to maintaining quality of life and increasing life expectancy. The long-term quality of blood glucose control plays a major role in delaying or preventing the onset of complications such as heart attack, stroke, end-stage kidney disease, blindness, and gangrene of the limbs since chronic hyperglycemia is associated with both macrovascular and microvascular complications. Regular screening for nephropathy, hypertension, dyslipidemia, neuropathy, and retinopathy is indicated in patients with DM1.

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Titolo: *Diabetes Mellitus, Type 1* Di: Strayer DA, Schub T, Pravikoff D, CINAHL Nursing Guide, November 11, 2008

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- Diseases & Conditions includes:*
- **Quick Lessons**
Clinically-organized nursing overviews that are designed to map the nursing work flow
 - **Evidence-Based Care Sheets** 
Evidence-based summaries on key topics incorporating the best available evidence through rigorous systematic surveillance

La sezione **Patologie e Condizioni** offre la possibilità di cercare e accedere alle Lezioni Rapide e alle Schede Evidence-Based relative a specifiche patologie e condizioni.

quickLESSON
about...

Abdominal
Cancer

Description/Etiology

Abdominal cancers may be found as primary tumors in any of the abdominal organs, including the principal digestive tract organs (e.g., stomach, small intestine, colon, rectum), accessory digestive tract organs (e.g., liver, pancreas, gallbladder), pelvic organs (e.g., uterus, ovaries), and retroperitoneal organs (e.g., kidneys, adrenal glands). Cancers of the lymph nodes (e.g., non-Hodgkin's and Hodgkin's lymphomas), nervous system, blood vessels, surrounding bones (e.g., vertebrae, ribs), and peritoneum may be classified as abdominal cancers. Secondary cancers (i.e., metastasis from an abdominal or distant primary tumor) may develop in the abdomen.

Diagnostic confirmation of abdominal cancer is based on tumor biopsy; samples are usually obtained using image-guided percutaneous sampling. Many tumors of the abdomen are not resectable at diagnosis because their characteristics preclude safe or complete surgical removal. More than half of patients with liver tumors undergo surgery only to learn from the surgeon that their tumor(s) are not resectable.

In addition to surgical resection (e.g., laparotomy, laparoscopic procedures, endoscopic mucosal resection), abdominal cancers may be treated with chemotherapy, radiation therapy, photodynamic therapy (e.g., used in treatment of small metastases), laser ablation, cryosurgical destruction, hypo- or hyperbaric therapy, or alcohol injection. Biologic therapy, a term often used in reference to targeted, non-chemotherapeutic agents (e.g., monoclonal antibodies, growth factors, angiogenesis inhibitors, interferon, interleukin 2, gene therapy), is increasingly being used as a treatment strategy for various types of abdominal cancer. The individualized treatment plan may include combination treatment modalities (e.g., chemotherapy and/or radiation therapy may be given to shrink the tumor prior to surgery). Abdominal tumors considered unresectable because of location, size, or degree of metastasis are often treated by nonsurgical modalities. Many of these treatments are used as palliation in patients with a poor prognosis due to advanced disease. Complications vary depending on the type and localization of tumor, and may include obstruction/compression of blood vessels and gastrointestinal structures, regional or distant metastasis, and carcinomatosis (i.e., disseminated spread of cancerous tumors).

Facts and Figures

In 2008, it is estimated that there were 148,810 new cases of colorectal cancer and about 49,960 deaths from colorectal cancer in the United States. In as many as half of these cases, the tumor had already metastasized at diagnosis; about 77% of these metastases were to the liver. The liver is the second most common site for metastasis from solid tumors, following the lymph nodes. Only a small percentage of liver metastases are resectable, but if they are successfully resected, 25–35% of these patients will survive long term.

It is estimated that in 2008, there were 37,690 new cases of pancreatic cancer and 34,200 deaths from pancreatic cancer in the U.S. Five-year survival in pancreatic cancer in the U.S. is 5%. Patients with distant metastasis have a 1.9% 5-year survival rate. Pancreatic cancer is the fourth leading cause of cancer death in the U.S.

Gastric cancer was diagnosed in approximately 21,500 people in the U.S. in 2008, and caused death in 10,880 individuals. In parts of Latin America and Asia, it is the most common cancer in men and the second most common cancer in women. Gastric cancer is curable by surgery if diagnosed early, but in the West, it usually is diagnosed in a late stage when half of all tumors are unresectable, and nearly two-thirds of patients have lymph node metastasis. Gastric cancer can result in small, difficult-to-find metastases in the peritoneum and liver.

It is estimated that 21,370 people were diagnosed with liver or intrahepatic bile duct cancer in the U.S. in 2008; 18,410 died of these cancers. Hepatic cancers are much more common in males than in females; in the U.S. they are the sixth most common cause of cancer death in men and the tenth most common cause in women.

In the U.S. in 2008, cancer of the gallbladder was diagnosed in 9,520 people and 3,340 died of the disease. It affects men and women equally. Worldwide, it is the fifth most common type of gastrointestinal cancer. Although only 1% of patients who undergo cholecystectomy for cholelithiasis have carcinoma of the gallbladder, 90% of patients with cancer of the gallbladder have cholelithiasis.

Ovarian cancer is the fourth most common cancer and ovarian cancer the eighth most common cancer in women in the U.S.; respectively, they represent the eighth and fifth most common causes of cancer deaths.

Risk Factors

Risk factors depend upon the age of the patient and the type of tumor. Helicobacter pylori infection, gastritis, and peptic ulcer disease are thought to predispose to gastric cancer.

Signs and Symptoms/Clinical Presentation

Patients may present with ascites, complain of a swollen abdomen, or refer to symptoms of gastrointestinal tract disease, such as constipation, presence of blood in stool, or have nonspecific symptoms of malignancy, such as fatigue, weight loss, night sweats, and/or anorexia. In many cases, the cancer is asymptomatic, or the first sign or symptom may be jaundice, skin nodules, bone fracture, or hepatomegaly, all of which may indicate metastatic disease.

Assessment

- ▶ **Laboratory Tests That May Be Ordered**
 - Specific tumor markers may be elevated (e.g., CA-125 increased levels may indicate liver or other abdominal cancer)
- ▶ **Other Diagnostic Tests/Studies**
 - Abdominal ultrasound, MRI, PET, CT scan, or diffusion-weighted imaging may be performed to visualize abnormalities
 - In some cases, small metastases that are not visible by standard imaging methods can be identified via laparoscopy using fluorescent visualization
 - Diagnostic laparoscopy may be performed after ultrasound, CT scans, and/or MRI to identify, stage, biopsy, remove, or treat tumors; laparoscopy is often done if the patient has ascites
 - Endoscopy and endoscopic ultrasound may be used to diagnose, biopsy, or remove tumors of the gastrointestinal tract

Treatment Goals

- ▶ **Provide Symptomatic Relief, Monitor, and Provide Supportive Care**
 - Monitor vital signs, assess all physiologic systems, and review laboratory results; immediately report abnormalities and treat, as ordered
 - Follow facility pre- and posttreatment protocols if patient becomes a candidate for surgical intervention, radiation therapy, or chemotherapy; reinforce education and ensure completion of informed consent documentation
 - Assess for pain and nausea, administer analgesics and antiemetics, as ordered
 - Monitor treatment site for bleeding, infection, and skin breakdown; treat, as ordered
- ▶ **Provide Emotional/Psychological Support and Educate**
 - Assess anxiety level and coping ability; educate and encourage discussion of the disease process, potential complications, treatment risks and benefits; posttreatment care (e.g., wound care, adverse effects of chemotherapy or radiotherapy, infection prevention strategies), ongoing medical surveillance, and individualized prognosis

Food for Thought

- ▶ With the advent of new molecular therapies for abdominal cancers, it is likely that the role of PET scanning will grow because PET visualizes molecular and cellular processes

Red Flags

- ▶ Monitor for signs and symptoms of metastasis (see *Signs and Symptoms/Clinical Presentation*, above); at least one quarter of patients with gastric carcinoma are under-staged as a result of using standard preoperative imaging modalities, and metastases are not visible by CT in more than half of patients with metastases

What Do I Need to Tell the Patient/Patient's Family?

- ▶ Encourage attending a cancer support group to benefit from contact with others who face similar health challenges
- ▶ Emphasize the importance of ongoing medical surveillance and seeking immediate medical attention for new or worsening signs and symptoms

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Le Lezioni Rapide forniscono la descrizione, i segnali e i sintomi, I test diagnostici e terapeutici normalmente prescritti e le attività nelle quali l'infermiere è coinvolto nel processo di cura del paziente.

EVIDENCE-BASED CARE SHEET

Pain, Postoperative: Epidural Analgesia

What We Know

- Epidural analgesia (EA; also called neuraxial analgesia) is a form of regional analgesia. EA involves injecting medication—most commonly opioids such as morphine, fentanyl, sufentanil, hydromorphone hydrochloride, and meperidine—through a catheter placed by a neuroanesthesiologist into the epidural or intrathecal space between the dura mater (i.e., the tough, fibrous membrane that forms the outer covering of the CNS) and the vertebral bones of the spine^(1, 3, 6)
- EA causes anesthesia (i.e., loss of sensation) and analgesia (i.e., loss of pain) by blocking transmission of signals from nerves in or near the spinal cord to the brain
- EA is most suitable for surgical procedures involving the thorax, abdomen, pelvis, and lower limbs because the epidural space is increasingly more difficult to access as one ascends the spine. EA is less commonly used for analgesia for the neck or arms and is not possible following cranial surgery because sensory interventions for the head are intertwined with the cranial nerves
- When EA is used postoperatively for pain control, it can be administered by continuous epidural infusion (CEI), by individual doses on demand, or by a combination of both methods. Patient-controlled epidural analgesia (PCEA) refers to patient self-administration of EA by a computerized infusion pump (most commonly used for IV delivery of patient-controlled analgesia [PCA]). PCEA permits the delivery of specific doses of medication within a prescribed period of time. The PCA pump is typically programmed to deliver a low dose CEI and to give the patient the option of adding “demand doses.” The clinician’s order for the “demand doses” includes the amount of medication to be administered in the “demand dose” and a lockout time (i.e., the period of time during which the PCA pump will not release more medication). The PCA pumps used for PCEA can be programmed to deliver any combination of both dose (i.e., a relatively large, single quantity of a subdose), CEI, and/or “demand doses” for break-through pain or in preparation for increased activity such as physical therapy^(1, 3, 7)
- PCEA is particularly effective in reducing patient sensory pain control because the patient does not have to rely on healthcare staff for administration of analgesia
- Compared IV opioids, CEI has been found superior in relieving pain for up to 72 hours following surgery and in reducing duration of endotracheal intubation
- Drugs commonly used for pain control via postoperative EA are combinations of an opioid and a local anesthetic such as bupivacaine and ropivacaine. The different mechanisms of the two types of drugs create a synergy that yields effective pain control and minimizes the potential for toxicity from a large dose of a single agent^(1, 4, 5, 7)
- Morphine infuses extended-release liposome injections (DepoDur) is a type of EA that was developed as an alternative to an indwelling epidural catheter. DepoDur provides up to 48 hours of analgesia with a single-dose administration, after which the catheter is removed
 - DepoDur is particularly beneficial to patients with impaired hepatic or renal function because it reduces the accumulation of morphine metabolites
- In addition to improved pain control, postoperative use of PCEA has demonstrated the following benefits compared to analgesia administered IV or IM^(1, 3, 4, 6, 7)
 - Increased shivering, less nausea, improved sleep pattern, and less use of medication
 - Improved pulmonary function and a reduced incidence of pulmonary infection
 - Decreased incidence of myocardial infarction due to a moderate reduction in heart rate and afterload (i.e., impeded flow of blood out of the heart)
 - Decreased incidence of nausea thresholds
 - Reduced incidence of ileus (i.e., adynamic gastrointestinal tract)
 - Fewer medication errors
- Common side effects of EA include respiratory depression, nausea, vomiting, pruritus, urinary of the face and chest, sedation, dizziness, and orthostatic hypotension^(1, 4, 5)
 - Bladder catheterization is routine in order to prevent urinary retention in patients receiving EA
- The most common complications are benign—spinal block/analgesia (e.g., inadequate pain relief due to poorly placed catheter) is reported in up to 17% of patients, and postural puncture headache (PPH) caused by accidental puncture of the dura is reported in up to 56% of patients. Less common complications are neurologically related and include radicular pain (i.e., pain at the root of a spinal nerve) and peripheral nerve lesions
 - PPH is characterized by pain at the back of the head and neck and a tight pulling and throbbing sensation
 - Unilateral lower extremity numbness with occasional weakness or motor block may occur, usually as the

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- result of the tip of the epidural catheter migrating along a nerve root so that the infused medication is intrathecally concentrated in one area
- Potentially catastrophic complications of EA are epidural hematoma (i.e., an accumulation of blood in the subdural or epidural space) and epidural abscess (i.e., an accumulation of pus in the epidural space), both of which can mechanically compress the spinal cord and lead to permanent paraplegia
- Mortality in cases of EA-induced abscess can be as high as 18%⁽¹⁾
 - Cardinal signs of an epidural hematoma or an abscess are ipsilateral lower extremity neurologic changes and loss of bowel and bladder control, especially if accompanied by back pain and tenderness. These signs may be difficult to assess if the patient is using CEI. The incidence of epidural hematomas after catheter placement, injection of medication, or catheter removal is estimated to be 1:190,000 cases
 - Additional complications may arise if the catheter moves out of the epidural space, resulting in intrathecal or intravascular delivery of anesthetic and cardiotoxicity
- Contraindications to the use of EA include^(1, 3, 4, 6)
 - uncorrected hypotension
 - coagulopathy or taking anticoagulants (e.g., low molecular weight heparin)
 - cardiomyopathy or aortic aneurism, because the vasodilation induced by the anesthetic may lead to excessive hypotension in patients who have either of these conditions
 - spinal deformity (e.g., scoliosis or spina bifida)
 - neurologic disease, including neuropathy due to diabetes mellitus, because if there is a change in neurologic status—which is common following surgery—diagnosis of a deterioration can be confused with the effect of the EA
 - abnormalities of the CNS (e.g., multiple sclerosis, syringomyelia [i.e., spinal cord disease characterized by the development of cysts or cavities within the cord])
- Ongoing management of patients using a PCEA pump is usually overseen by a neuroanesthesiologist. Nursing responsibilities include^(1, 3, 5)
 - evaluation of pain and location, and treatment for medication side effects
 - inspection of the catheter for migration and inspection of the insertion site for drainage, erythema (i.e., redness), inflammation, tenderness, and dressing integrity. Many facility protocols specify that the dressing remains intact, with changes made only when an opaque dressing prevents clinician observation. Aseptic technique is recommended
 - inspection of the PCA pump for malfunction, inspection of the catheter and tubing for kinks and cracks, and review of the medication and infusion regimen. Many facility protocols require that PCA tubing be dedicated solely to EA and that tubing and connection ports be labeled appropriately
- If the catheter is inadvertently removed from the insertion site, the site should be cleaned and dressed, the catheter saved, especially if any form of mixing or purulent drainage is present, the neuroanesthesiologist notified, and any unused medication discarded pursuant to facility protocols^(1, 3, 6)
- When the insertion and management of the epidural catheter has been uncomplicated, removal of the catheter upon discontinuation of treatment is generally a benign, painless procedure similar to the removal of central venous and pulmonary artery catheters^(1, 3, 4, 6)

What We Can Do

- Become knowledgeable about EA and its use in the postoperative setting so you can accurately assess your patients’ needs; there is information with your colleagues
- Collaborate with the education department and/or the pain control service at your facility, if available, to develop educational programs and informational materials on postoperative EA for clinicians of all specialties
- Monitor your patients for complications related to the use of epidural catheters and PCEA pumps, and for any side effects of related medication
- Collaborate with your patients and their meeting clinicians (if) to develop a pain management plan
- Advise the patient of the importance of pain management to recovery
- Instruct the patient on the use of pain rating scales and the importance of advising clinical staff of breakthrough pain. Advise the patient of the availability of supplemental analgesia
- Inform the patient of the potential side effects of the analgesia
- Discuss the level and types of permitted activity while the epidural catheter is in place

Coding Matrix

- References are listed in order of strength**
- A Published meta-analysis
 - SR Published evidence or integrated literature review
 - RCT Published research (randomized controlled trial)
 - R Published research (non-randomized controlled trial)
 - C Case-control, case series
 - G Published guideline
 - RV Published review of the literature
 - IRV Published research abstract report
 - QF Published quality improvement report
 - L Legislation
 - PCR Published government report
 - PRR Published linked report
 - WF Written procedure, protocol
 - X Theoretical expertise, clinical opinion
 - GJ General or background information/observational
 - U Unpublished research, reviews, posters, presentations or other such materials
 - CP Conference proceedings, abstracts, presentations

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Le Schede Evidence-Based forniscono invece le migliori evidenze, ovvero cosa si sa di una specifica patologia e come questa può essere curata.

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Key Content

Skills & Procedures includes:

- **Skills/Procedures**
Clinical papers detailing the necessary steps to achieve proficiency in a specific nursing task or defining the key considerations to providing culturally competent care to a specific group

Nella sezione **Skills & Procedures** si trovano documenti clinici che descrivono i passaggi necessari a raggiungere una buona conoscenza su una specifica attività infermieristica o a definire la principali azioni da compiere per fornire un valido supporto culturale ad un gruppo specifico di persone.

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- A-Methapred **Use:** [MethylPREDNISolone](#)
- A-Spas S/L **Use:** [Hyoscyamine](#)
- [Abacavir](#)
- [Abarelix](#)
- [Abatacept](#)
- Abbokinase **Use:** [Urokinase](#)
- [Abciximab](#)
- Abelcet **Use:** [Amphotericin B deoxycholate](#)
- Abenol **Use:** [Acetaminophen](#)
- Abilify **Use:** [Aripiprazole](#)
- Abraxane **Use:** [Paclitaxel](#)
- Abreva **Use:** [Docosanol](#)
- [Acamprosate calcium](#)
- [Acarbose](#)
- Accolate **Use:** [Zafirlukast](#)

Contenuti principali

Drug Information includes:

Davis's Drug Guide for Nurses:

- Latest coverage of over 5,000 trade and generic drugs
- 50 comprehensive drug classes
- IV therapy tips organized by Direct IV, Intermittent Infusion, and Continuous Infusion
- Comprehensive Patient/Family Teaching and Home Care Tips

AHFS Drug Information Essentials:

- Over 11,700 represented medicines plus manufacturers of drug products
- Separate drug monographs for systemic topical and EENT drug formulations
- Drug interactions, cautions and toxicity
- Extensive dosage and methods of administration

Le **Informazioni sui Medicinali** consentono di cercare dettagliate informazioni su specifici farmaci all'interno di monografie dedicate: *Davis's Drug Guide for Nurses* e *AHFS Drug Information Essentials*

- Ricerca di base
- Patologie e condizioni
- Skills & Procedures
- Informazioni sui medicinali
- Educazione dei pazienti**
- Risorse per l'utilizzo
- Formazione professionale

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- [Abortion, Threatened](#)
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TITOLO: Riparazione dell'aneurisma dell'aorta addominale Di: Fucci MJ, Consumer Health Information Language Database, November 1, 2008
DATABASE: Consumer Health Information -- Italian

Riparazione dell'aneurisma dell'aorta addominale

(AAA)

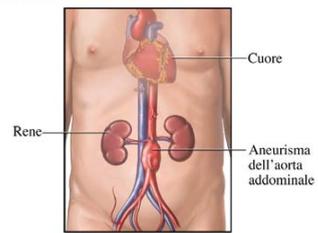
del: Personale editoriale e collaboratori

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Definizione

L'aorta è l'arteria più grande del corpo. La porzione addominale dell'aorta porta il sangue all'addome, al bacino e alle gambe. A volte le pareti dell'aorta si indeboliscono e si gonfiano in un'area. Ciò crea un aneurisma dell'aorta addominale (AAA). Spesso l'AAA deriva dall'aterosclerosi (indurimento delle arterie) unita a pressione alta. L'intervento chirurgico è necessario quando l'AAA diventa troppo grande o si rompe.

Aneurisma dell'aorta addominale



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Parti del corpo interessate

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Motivi per l'intervento
Fattori di rischio per le complicazioni durante l'intervento
Cosa aspettarsi
Prima dell'intervento
Anestesia
Descrizione dell'intervento
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Quanto tempo ci vorrà?
Sentirò male?
Possibili complicazioni
Durata media del ricovero in ospedale
Cure post-operatorie
Esito
Chiama il medico se noti una delle seguenti cose

- Torso
- Area addominale

Motivi per l'intervento

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La sezione **Educazione dei Pazienti** contiene schede informative, basate sulla medicina dell'evidenza, dedicate ai pazienti. Ad oggi le schede sono principalmente in inglese, ma ne sono incluse anche circa 200 in lingua italiana.

Gestore stampa

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E' possibile stampare la scheda per il paziente aggiungendo delle note specifiche, ovvero personalizzando l'informazione per l'utente finale.

- Ricerca di base
- Patologie e condizioni
- Skills & Procedures
- Informazioni sui medicinali
- Educazione dei pazienti
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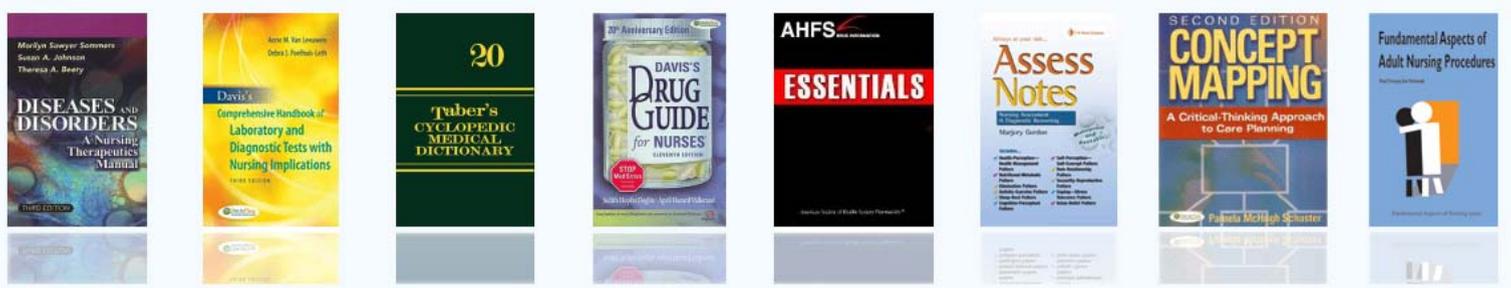
Risorse per l'utilizzo

Pubblicata da CINAHL Information systems, la CINAHL Nursing Guide è una raccolta di informazioni di riferimento e assistenza per personale paramedico basate su prove di efficacia realizzata da Nurses for Nurses.

Funzionalità chiave:

- [Legal Cases](#)
- [Practice Guidelines](#)
- [Research Instruments](#)

Libri consigliati



La **Risorse per l'Utilizzo** fornisce l'accesso a specifiche risorse, come manuali sui farmaci, linee guida, casi legali e strumenti di ricerca

- Ricerca di base
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The course material links to the CE module which consists of the course materials, Interactive Review, and final test.

In fine, nella sezione **Formazione Professionale**, si trovano moduli per valutare l'auto-apprendimento su specifici argomenti trattati dalla banca dati.

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Per memorizzare questi documenti nella cartella per sessioni successive, [Accedi](#).

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- 2. [Crohn's Disease](#) Strayer DA; Pravikoff D; CINAHL Nursing Guide, Cinahl Information Systems, 2010 Apr 09. (2p) (quick lesson - CEU, exam questions) CINAHL AN: 5000000244
CE Module: [Crohn's Disease--CE Module](#)
 [Testo completo in HTML](#)  [Testo completo in PDF](#) (198K)
- 3. [Imaging recommendations for patients with Crohn's disease: complete summary](#) US National Guideline Clearinghouse, 2006 Mar 21 (other - practice guidelines, tables/charts) CINAHL AN: 5000006610
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