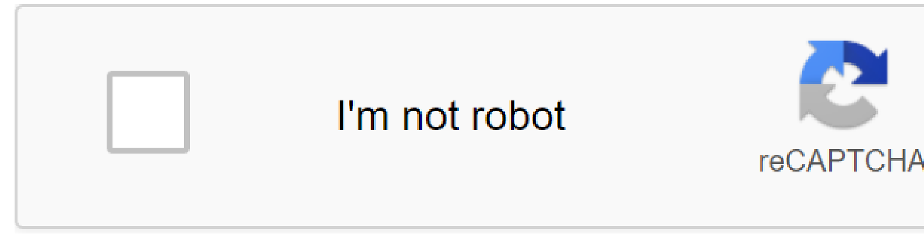
Warfarin adjustment guidelines aha



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MIRABELLI, MD, University of Rochester Medical Center, Rochester, New YorkAm Pham Physician. 2013 April 15;87(8):568-573.Article Sections With Wrist Pain are usually present with acute trauma or spontaneous onset of pain without a specific traumatic event. Falling on an outstretched arm can cause a fracture of scaphoid, which is the most commonly broken cyst bone. Conventional radiography itself can miss up to 30 percent of scaphoid fractures. Specialized presentations (such as posteroanterior in ulnar deviation, overnated oblique) and repeat radiography in 10 to 14 days can improve sensitivity for scaphoid fractures. If the alleged fracture of the scafoide cannot be confirmed by a simple Bone scans or magnetic resonance imaging can be used. Podopower or chronic wrist usually develops gradually with or without prior traumatic events. In these cases, differential diagnosis is wide and includes tendinopathy and nerve seizure. Excessive use of the muscles of the forearm and wrist can lead to tendinopathy. Radial pain involving basically the first extensor compartment is usually de quinven tenosinovitis. The diagnosis is based on the history and results of the Finkelstein positive test and negative test. Nervous grip on the wrist presents with pain as well as with sensory and sometimes motor symptoms. In the ulnar neuropathy of the wrist, a typical presentation of wrist discomfort with sensory changes in the fourth and fifth digits. Activities that include repetitive or prolonged wrist extensions, such as cycling, karate and baseball (particularly catchers), may increase the risk of ulnar neuropathy. Electrodiagnostic tests determine the area of nerve capture and the degree of pathology. Musculoskeletal cancer problems cause up to 20 percent of all visits to primary care units in the United States.1 Family doctors are often the first to assess and treat wrist pain. Wrist pain is traditionally classified as acute pain caused by a particular injury or as sub-acute/chronic pain not caused by a traumatic event (tables 1 and 2). Injuries that cause acute pain can lead to concussions, fractures, sprains or tears, and instability. Subacute or chronic pain may result from overuse, have neurological or systemic causes, or be a continuation from an old injury. Patients with these injuries may have a history of repetitive wrist movements, both professionally and recreationally. Adding sensory disorders, such as numbness or tingling, indicates nerve involvement. History and physical examination lead to the correct diagnosis in most cases. Location, nature, timing and pain quality are important keys to narrowing differential diagnosis. In acute injuries, the wrist should be given a simple radiography with anteroposteral, lateral and oblique views. When the diagnosis remains unclear, further imaging, such as bone scans, ultrasonography, computed tomography or magnetic resonance imaging (MRI), can help determine the cause. Since non-traumatic wrist pain has a wide differential diagnosis, the patient's history should include a review of systems with neurological or constitutional symptoms, as well as a social history of professional recreational activities. The following case studies discuss the background and presentation of three causes of wrist pain, as well as diagnostic tests and strategies. The 21-year-old man poses with a dorsal left wrist pain after falling on his outstretched arm during a stand-up He noted immediate swelling and painful extension of the wrist. Physical examination shows swelling of soft tissues with limited movement, mainly in expansion, secondary secondary Pain. There is bony tenderness along the distal radius as well as anatomical snuff. The results of his sensory and vascular examination are unremarkable. BACKGROUNDThe wrist consists of eight carpal bones (figure 12), but only the sleepwalk and scaphoid form with the radius and absorb a significant effect during the fall on the outstretched hand. Scaphoid is the most common fracture of the cystic bone. The primary vascular supply of scafoide comes from the retrograde branches of the distal radial artery, which makes the proximal pole of the scafoid relatively vascular and with a higher risk of non-union and vascular necrosis. The fractures of the proximal and distal scaphoid parts each account for 20 percent of scaphoid fractures, and the middle portion falls on the remaining 60 percent.3Pic frequency of scafoide fractures occurs around 15 years.4 Due to weakness of the distal radius compared to scaphoid, scaphoid fractures are not common in older adults. In young children, the supporting cartilage surrounding the deriding nucleus of an immature scafoid creates protection, making the physio injuries of the radius more common. PRESENTATION A typical story of a patient with a scaphoid fracture is a fall on an outstretched hand with his wrist dorsiflexed and radially deflected. Most patients with scaphoid fracture are present shortly after the fall, but in some cases, the initial pain improves, causing a delay in submission. Physical examination can reveal swollen wrists. Tenderness is usually located dorsally around the distal radius. Patients may have painful wrist extensions and loss of grip strength if they pose a few days after the injury. There are no reliable clinical tests to rule out a fracture of the scafoide. Swelling of the anatomical snuffer (Figure 25) increases the likelihood of scaphoid texture. The combination of snuffbox swelling, scaphoid tuber tenderness, and pain with axed pressure on the first metacarpal bone has a sensitivity of approximately 100 percent.6 However, the specificity of each test is 9, 30 and 48 percent, Accordingly.6 Reduced grip strength compared to the contralateral side increases the positive prognosing value for fracture scaphoid.7 Differential diagnosis of the alleged fracture of the scafide indicated in Table 3.DIAGNOSTIC TESTSConventional radiography (anteroposterior, lateral, and oblique views) can only miss up to 30 percent of scaphoid fractures.8 Based on retrospective studies , sensitivity is improved if additional opinions are added (i.e. posteroanterior in the ulnar devation, protate oblique, and supinated oblique).8 In many cases, re-radiography is needed in 10 to 14 days to observe sclerosis, which indicates the healing of the fracture. If the diagnosis cannot be confirmed by simple radiography, it may be bone scans or MRI scans. Bone scan has sensitivity sensitivity 100 percent, but produces false results up to 25 percent of the time.9 MRI in one day after the injury has a sensitivity of 80 percent.10 but later examination (more than 10 days after the injury) has sensitivity and specificity, Comparable to bone scanning.11DIAGNOSTIC STRATEGYIf scaphoid fracture suspected based on history and physical examination, simple radiography must be performed, including specialized opinions such as posteroanterior in elbow deviation and pronated oblique. If radiography is negative for a fracture but clinical suspicions are high, the wrist should be protected in the thumb spica thrown with the possibility of repeating simple radiography in 10 to 14 days or bone scans one to two days after injury.4.5 If repeated simple radiography is negative, but the pain in the wrist is retained, MRI should be performed to clarify the diagnosis. The 39-year-old right-hander has a four-week history of wrist pain and numbness and tingling in his right hand. There is no history of injury or injury to the neck, elbow or wrist. She works mainly in the workplace, but there was no change in her work schedule. Physical examination of the wrist did not reveal swelling of soft tissues, muscle atrophy or skin changes. It has painful wrist extensions as well as a tingling sensation in the fifth finger with tapping on the pisiform. The power of the capture is normal and no other bony tenderness is appreciated. BACKGROUNDThe ulnar nerve comes from C8 and T1 nerve roots (Figure 312), and extends from the medial cord of the brachial plexus through the armpit arm, inertial of the muscles of the forearm and arm. Proximal to the wrist, dorsal and palm skin branches separated, while the rest of the nerve courses through the Guyon canal (figure 4) to the surface of the palmar arm. This triangular canal borders medially on the pisiform, lateral hamat, anterior flexor tendon of carpi ulnaris, and posterior transverse carpal ligament. In the channel, the ulnar nerve breaks down into a superficial sensory branch that delivers a sense of hypotenaral arrogance, and onto a deep motor branch that inertiates hypotenar muscles, adductor pollicis, and a flexor. The ulnar nerve can be compressed anywhere in the Gaion canal, causing an engine, sensory or mixed deficiency. Compression is usually caused by ganglion cysts or recurring injuries. Elbow nerve capture is the second most common upper limb neuropathy, surpassed only by average nerve grip (i.e. carpal tunnel syndrome).13 Although the true incidence of ulnar neuropathy on the wrist is not well documented, it is considered the second most common site after compression on the elbow. Ural neuropathy is slightly more common in men than in women. The peak of the disease men over 35 years of age.14PRESENTATIONAs presentation in ulnar neuropathy neuropathy discomfort of the wrist with sensory changes in the fourth and fifth digits. Weakness of seizure may be present in chronic cases. History usually shows no specific injuries. Activities that include repetitive or prolonged wrist enlargement such as cycling, karate and baseball (particularly catchers) may increase the risk of ulnar neuropathy.15 Physical examination of the patient, presenting with these neurological symptoms should include cervical spine, shoulder and elbow examinations to rule out proximal lesion. Reproduction of neck pain may indicate cervical disc disease; shoulder pain movement may indicate brachial plexus problem; and the reproduction of symptoms when the nerve compression on the ulnar groove may indicate elbow compression. The compression of the ulnar nerve in the Guillon canal should cause weakness of the hypotenoar muscles, innervated by the deep motor branch, and sensory disturbances of the fifth digit, an innervated superficial sensory branch. Clinical tests include Tinel's positive mark on the percussion of the ulnar nerve above the Guyon canal, as well as Falen's positive sign (maximum passive wrist flexion for more than one minute) with paresthesia in the fourth and fifth fingers. Unlike carpal tunnel syndrome, the sensitivity and specificity of these tests on the ulnar neuropathy on the wrist are not known. The differential diagnosis of suspected ulnar neuropathy on the wrist is indicated in Table 4.DIAGNOSTIC TESTSPlain radiography assesses the anatomy of the wrist well, and can identify fractures, dislocations, or soft tissue masses that may have led to nerve compression. Ultrasonography of peripheral nerves is useful in detecting compressed etiology of nerve damage and in the visualization of structural nerve changes. It is non-invasive, relatively inexpensive, and well-tolerated by patients. Studies of electromyography and nerve conduction can be useful in determining the area of capture and documenting the degree of pathology. Motor and sensory conduction speeds are more useful for acute seizures, while electromyography is the best choice for chronic neuropathy because it shows axonal degeneration more clearly. The sensitivity and specificity of these electrodiagnostic tests in primary health care settings is unknown, as existing studies are limited to a small number of patients with known neuropathy. MRI scans can detect abnormalities in the ulnar nerve, tendon flexors, vascular structures and transverse cystic ligaments around the Guillon canal. Neurogenic swelling can be seen as early as 24-48 hours after denervation compared to electromyography, in which changes after denervation are not visible within one to three weeks.16 The criteria for imaging neuropathy on MRI are not very clearly defined, and several found MRI abnormalities in healthy, asimamatic patients.17DIAGNOSTIC STRATEGYIf ulnar neuropathy neuropathy neuropathy simple radiography should be ordered first. If no obvious mass or lesion is detected, an electrodiagnosis should be ordered to localize the lesion, measure its severity and assist in the prognosis. In the conditions of inconclusive or non-localizing results of an electrodiagnostic test, ultrasonography or MRI may be useful. The 31-year-old woman is presenting with several months of worsening radial pain in her left wrist, which began insidiously. She denies any specific injury. She has no numbness or tingling in her wrist, hand or fingers. Her pain worsens with grabbing and clinging, and picking up her nine-month-old daughter. Physical examination did not reveal bleaching and minimal swelling of soft tissues along the radial stiloid and anatomical snuffbox. There is a soft tissue tenderness about the anatomy of a snuffber and a radial stilide. It has limited movement of the thumb, with pain mostly in expansion and abduction. Her sensory and vascular research is unremarkable. BACKGROUNDTwo major spinal tendons of the thumb involved: extensor pollicis brevis and kidnapper pollicis longus (Figure 5). Fixed. These tendons make up the lateral boundary of the anatomical snuffbox, with the extender pollicis longus medially and scaphoid the bone at the bottom. The two tendons have a similar function resulting in a thumb in radial abduction. These tendons work in the synovial shell in the first stretched arm compartment. Inflammatory changes in the shell and tendons lead to tenosinovitis. Recurrent or persistent inflammation can lead to stenosizing tenosinovitis. PRESENTATIONTypical presentation includes undersionable radial pains in the wrist at the base of the thumb and in the dystal radius. In hindsight, patients may identify new or repetitive manual activities as the cause, but etiology is often idiopathic. De Kverven Tenosinovitis is more common in women, especially those in their 30s to 50s.18 New mothers particularly noted that this problem from raising a child.19 Physical examination can reveal minimally swollen wrists. Tenderness is usually located above the radial tubers, and sometimes around the soft tissues of the anatomical snuffbox. The movement of the thumb is invariably painful. Neurovascular examination should be unremarkable. Finkelstein's test is a confirmation because it has good sensitivity and specificity.18.20 This is performed by taking a fist over the thumb and then moving the hand into an elbow deflection that passively stretches the tendons of the thumb over the radial styloid.20,21 Grind test of the thumb, which is performed by wasp compression and a slight rotation of the metacarophalanja joint, should be negative in those with de kverven teninositis, but positive in those with de kverveno. , with the first Osteoarthritis. The differential diagnosis of the suspected tenosinovit de quanwen is listed in Table 5.DIAGNOSTIC TESTSSSamia is a clinical clinical clinical history and expertise. In cases where osteoarthritis of the carpomekarpal joint is considered, pain with a diagnostic lidocaine (Xilocain) injection of the first stretched compartment eliminates the arthritis cause. X-rays, electromyography/nerve conduction studies, blood tests, MRI or ultrasonography can be used to assess alternative diagnoses. DIAGNOSTIC STRATEGYIf history and examination are consistent, further diagnostic testing is required. If suspected of a fracture or arthritis, X-rays are a suitable first step. If suspected, radial nerve abnormalities can be ruled out with electromyography or study of neural conduction. If there is concern about infectious tenosinovitis, a full blood test and measurement of inflammatory markers, such as red blood cell deposition levels and C-reactive protein levels, are appropriate. If the patient does not respond to treatment or if the diagnosis is in question, MRI or musculoskeletal ultrasonography may be ordered to further assess the first extensor compartment.19.22Data Sources: PubMed search has been completed in clinical enquiries using key terms shocapid fracture, ulnar neuropathy, and de kovvena. The search included meta-analyses, randomized controlled trials, clinical trials and reviews. They also searched for basic evidence, the Cochrane Database, the National Guidelines Coordination Center, and UpToDate. Search date: August 2011.Page 3Clinical Evidence HandbookA Publishing BMJ Publishing GroupSANDEEP VIJAN, University of Michigan Health System, Ann Arbor, MichiganAm Fam Physician. 2013 Apr 15;87(8):574-575.Among people with diabetes, about 40 percent of people aged 45 years, and more than 60 percent of those 75 years of age and older, will have blood pressure greater than 140/90 mmHg. Major cardiac events occur in about 5 percent of people with diabetes and untreated hypertension each year, and the risk is higher in those with other risk factors such as diabetic nephropathy. We can't be sure how different treatments compare in people with diabetes and hypertension. However, the evidence suggests that either angiotensin enzyme conversion (ACE) inhibitors or diuretics are effective first-line treatments. ACE inhibitors reduce the risk of kidney disease compared to placebo, and they seem to reduce cardiovascular events compared to calcium channel blockers. However, they can cause coughing and angioedema. Diuretics such as chlortalidon reduce cardiovascular events compared to placebo, but they can increase glucose, cholesterol and uric acid levels. Diuretics seem to be just as effective as ACE inhibitors when preventing cardiovascular events, and they can more effective than calcium channel blockers while reducing the risk of heart failure. Beta blockers can be just as effective as ACE inhibitors in reducing the onset of kidney disease and other diabetes-related diabetes and microvascular phenomena, or death associated with diabetes. However, they can cause weight gain and increase the need for glucose reduction treatment. Calcium channel blockers seem as effective as diuretics, more effective than beta blockers, and less effective than ACE inhibitors when reducing cardiovascular events in general, and amlodipine may be less effective in preventing heart failure compared to chlortalidone. We found conflicting data on long-term outcomes with angiotensin II receptor antagonists. It seems likely that more intensive treatment to achieve greater blood pressure reduction leads to a greater reduction in cardiovascular events and overall mortality. However, it is difficult to determine targeted blood pressure in people who have diabetes and hypertension. Hypertension in diabetes is classically defined as systolic blood pressure of 140 mmHg. art or more, or diastolic blood pressure of 90 mmHg. Art. and more. Hypertension is divided into three stages. Pregipertension is a systolic blood pressure of 120 to 139 mmHg. or diastolic blood pressure of 80 to 89 mm Hg. Stage 1 hypertension is systolic blood pressure from 140 to 159 mmHg. 90 to 99 mmHg. Stage 2 hypertension is a systolic artery with a pressure of 160 mmHg. art. and above, or diastolic artery pressure of 100 mmHg. Art. and above. However, guidelines now suggest that drug therapy should be administered to anyone with diabetes and hypertension, regardless of the stage of the disease. This review focuses on adults with diabetes and stage 1 or stage 2 hypertension, but without a diagnosis of coronary heart disease, diabetic retinopathy, or nephropathy. Most studies on this issue do not distinguish between type 1 diabetes and type 2, but basic epidemiology and age of the studied population show that more than 95 percent of the study participants are likely to have type 2 diabetes. Hypertension is widespread among people with diabetes. This is about 1.5-3 times more common in people with type 2 diabetes than in the general age population. Using a diagnostic threshold of 140/90 mm Hg. About 40 percent of people with diabetes have hypertension at 45, and more than 60 percent have hypertension by the age of 75. About 30 percent of people with type 1 diabetes end up developing hypertension, usually after they develop diabetic nephropathy. The prevalence of hypertension varies depending on the population studied. The cause of hypertension is multifactorial, complex and not fully understood. In the general population, there are several Risk factors for hypertension; specific risk factors are clearly not different in people who have diabetes. Age is the predominant factor; evidence suggests that the prevalence of With age. Individuals with at least one parent with hypertension are about twice as likely to develop hypertension. In the United States, blacks have a 7 to 10 percent increase in prevalence compared to non-Hispanic whites. Obese people also have a greater risk: for each unit, the body mass index increases by about 1 to 1.5 percent. Insulin resistance is associated with the development of hypertension. Untreated hypertension in people with diabetes is associated with high rates of cardiovascular disease (such as myocardial infarction, heart failure and stroke) and microvascular diseases (such as kidney disease (including albuminuria, renal failure and end-stage renal diseases) and diabetic retinopathy). In placebo groups of major hypertension control trials in type 2 diabetes, major cardiac events occurred in approximately 4 to 6 percent of people per year, and were significantly higher in populations with additional risk factors such as diabetic nephropathy. Page 4Puting Prevention in PracticeAn Evidence is based on approachAILEEN BUCKLER, MD, MPH, CDR, USPHS, Medical Officer, U.S. Preventive Services Task Force Program, Health Research Agency and JASON BERNHARD, MD, LCDR, USN, General Preventive Medicine Residence, Unified University of Medical SciencesAm Fam. 2013 Apr 15;87 (8):577-578. Related: U.S. Preventive Services Task Force Recommendation StatementA 22-year-old woman primigravid at 20 weeks pregnant gifts to your office with her boyfriend for a routine obstetric examination. She was having an uneven pregnancy. She states that everything is fine at home, although she was fired from her job shortly before she found out she was pregnant. Although the pregnancy was not planned, she is happy to be a mother. Because intimate partner violence (IPV) is common in the United States, but often goes unnoticed, you have decided to screen for possible signs of abuse. The U.S. Preventive Services Task Force (USPSTF) reports that one of the following statements about IPV screening is correct? A: Evidence suggests that existing screening tools cannot accurately identify current or past abuse or an increased risk of abuse. The Hurt, Insult, Threaten, Scream (HITS) tool consists of four questions, can be used in primary care and is available in English and Spanish. The USPSTF has found adequate evidence to recommend screening women at risk at the annual intervals.D. Slapped, Threatened, and Throw (STaT) is a clinician-driven, three-point tool that has been tested at a high-risk obstetric clinic. If screening show that this patient has experienced IPV, it is at risk, which of the following? A. Premature birth.B. Low birth weight.C. Depression.D. Reducing gestational age. Which of the following allegations is IPV correct? A: Adequate evidence suggests that screening and interventions in IPV moderately increase the risk of harm to a person. The USPSTF concluded with moderate confidence that screening of women of childbearing age at IPV is of no use.C. Activities for IPV supported by evidence include counseling, home visits, information cards, referrals to community services and support for mentoring.D. Studies show that only IPV-activities provided by social workers are effective.1 There is sufficient evidence that the available screening tools may detect current and past abuse or an increased risk of abuse. Several of the tools used in more than one study were found to be highly sensitive and specific. Those with the highest level of sensitivity and specificity for detecting IPV are HITS; Permanent Abuse Screen/Ongoing Violence Assessment Tool (OAS/OAT); STaT; Humiliation, Fear, Rape, Punch (HARK); Modified pediatric traumatology - short form (CTC-SF); and the Woman Abuse Screen Tool (WAST). The HITS tool includes four issues that can be used in primary health care, and is available in English and Spanish. He can be self-governing or a clinician. HARK is a self-driving four-point tool. STaT is a three-point self-reporting tool that has been tested in the emergency department. The USPSTF found no evidence of appropriate screening intervals. It should be noted, however, that one of the main limitations of the evidence on screening is the lack of a established first-line method; all studies compared the screening tool with the second tool, which was usually tested and often more detailed.2 Correct answers: A, B, C and D. Possible health effects, in addition to injuries and deaths, include sexually transmitted diseases, pelvic inflammatory diseases, unintended pregnancies, chronic pain, neurological disorders, gastrointestinal disorders, migraine headaches and other disorders. IPV in pregnant women is also associated with preterm birth, low birth weight and decreased gestational age. People experiencing IPV often develop chronic mental illnesses such as depression, post-traumatic stress disorder, anxiety disorders, substance abuse and suicidal behavior3. The correct answer - C. USPSTF has found sufficient evidence that effective action on IPV can reduce violence, abuse, and physical or mental for women of reproductive age. Evidence of randomized trials supports a variety of interventions, including counselling, home visits, information cards, referrals to community services and mentoring support. Depending on the type of intervention, these services may be provided by doctors, nurses, social workers, non-clinical mentors or community workers. Advice usually includes information about security behavior and community In addition to counseling, home visits can include emotional support, education on problem-solving strategies and parental support. The USPSTF has also found adequate evidence that the risk of harm to a person from screening or intervention is no greater than that of a small one. Of all the studies assessing potential harm, there were no significant differences between screening compared to lack of screening and intervention compared to non-interventionist groups. Thus, the USPSTF has concluded with moderate certainty that screening of women of childbearing age for IPV has a moderate net benefit. To see the full article, log in or buy access. Disclosure of the author: There is no appropriate financial affiliation. The conclusions and conclusions in this example are the conclusions of the author (s) who are responsible for its content and do not necessarily reflect the views of the Ministry of Defence. No statement in this report should be construed as the official position of the Ministry of Defence or the University of Medical Sciences in uniform. Preventive Services Task Force. Intimate partner violence and abuse of elderly and vulnerable adults: Recommendation statement from the U.S. Preventive Services Task Force. Ann Intern Med. 2013;158(6):478-486.Nelson HD, Bougatsos C, Blazina I. Screening of women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force's recommendations. Ann Intern Med. The case study and answers to the questions are based on recommendations from the U.S. Preventive Care Task Force (USPSTF), an independent group of experts in primary health care and prevention that systematically analyzes evidence of efficacy and develops recommendations for clinical preventive services. For more information, please visit the USPSTF Recommendation Statement and the generalization of evidence . Recommendations for practice in this activity can be a collection of prevention quizzes published in the AFP on . The ©, 2013 by the American Academy of Family Physicians. This content is owned by AAFP. A person browsing it on the Internet can make one printout of the material and can only use this printout for their personal, non-commercial reference. Otherwise, this material cannot be downloaded, copied, printed, stored, transferred or reproduced in any environment, regardless of whether it is known or later invented, except where it is permitted in writing by AAPP. Contact afpserv@aafp.org copyright issues and/or requests for 5BENSON KOON WEE YEO, MBBS, and HONG LIANG TEY, MBBS, MRCP, National Skin Center, SingaporeAm Fam Physician. 2013 Apr 15;87(8):579-580.A 46-year-old woman is presented with a facial rash that worsened more Months. She was treated with several topical corticosteroids and topical antibiotics that improved her symptoms only temporarily. She didn't take any other medication. There were no specific triggers or contacts and she did not have a significant medical history. Examination revealed ring-shaped plaques with raised erythema border on the forehead (figure 1) and both cheeks (Figure 2). Other parts of her body were not injured. Based on the patient's history and the results of a physical examination, which one of the following is the most likely diagnosis?A. Acne rosacea.B. Acute lupus erythematosus.C. Atopic dermatitis.D. Dermatomyositis.E. Tinea acey. Answer E: tinea faciei. Tinea faciei, or dermatophytosis, is a common condition that result in a dermatophytic infection of surface epidermis. Papulosquamous plaques with ring-shaped scaly edge should increase clinical suspicion of horde infections, especially if they persist despite steroid treatment. After the use of steroids, scaling and other clinical features of the ordyn infection may disappear, leading to incognito ordyns. Tinea pedis and tinea cruris are the most common superficial fungal infections. However, tinea faciei accounts for about 3 to 4 percent of cases of tinea corporis. It is more common in women and children, accounting for

about 19 percent of all superficial fungal infections in children.1A fungal infection can be confirmed by skin scraping the boundaries of lesions. Culture can identify specific types of dermatophyte, although treatment is usually the same. Fungal scraping and culture can produce false-negative results, and sensitivity decreases after treatment with steroids and antifungal drugs.2 Rarely, a biopsy punch is required to diagnose an infection or evaluate for other possible causes. Most horde infections can be treated with topical antifungal drugs. Systemic therapy should be considered for resistant, chronic or extensive cases. Oral antifungal drugs should be used if the infection involves hair or folliculitis, because topical applications cannot reach the depth of the hair follicles where dermatophytes live. Pergre rosacea is a chronic inflammatory disease affecting the cheeks, forehead and nose. The condition usually causes papules, pustules, and telangiectasias. Flushing and redness often occur when eating spicy food or alcohol. Acute cococenotic lupus erythema usually involves erythematous spots or plaques on the bumps and nasal bridge, resulting in a typical butterfly configuration. Systemic signs and symptoms of lupus erythematosus may also be present. The rash is most common in sun-prone areas. Atopic dermatitis, or endogenous eczema, is instead of papulosquamous and is most common on the surfaces of limb flexors. Patients with often have a history of other atopic diseases such as asthma or allergic rhinitis. The rash should respond to topical corticosteroids. Dermatoyositis usually causes periorbital, symmetrical, altical spots (heliotrope rash), as well as symmetrical weakness of proximal muscles. To see the full article, log in or buy access.1. Lari AR, Ahlagi L, Falahati M., Alagebandan R. Characteristics of dermatophytos among children in an area south of Tehran, Iran. Mycoses. 2005;48(1):32–37.2. Levitt I.O., Levitt BH, Ahavan A., Janofsky H. Sensitivity and specificity of potassium hydroxide smear and fungal culture in relation to clinical evaluation in the evaluation of tinea pedis: combining the analysis. Dermatol Pres. June 22, 2010. . Access to January 28, 2013. The author of the photovisa is John E. Delzell Jr., MD, MSPH. A collection of photo quizzes published by AFP is available on . AFP editors welcome the materials for the photo quiz. Guidelines for the preparation and dispatch of the Photovisation manuscript can be found in the authors' Guide to . In order to be considered for publication, submissions must comply with these guidelines. Emailing afpphoto@aafp.org. The ©, 2013 by the American Academy of Family Physicians. This content is owned by AAFP. A person browsing it on the Internet can make one printout of the material and can only use this printout for their personal, non-commercial reference. Otherwise, this material cannot be downloaded, copied, printed, stored, transferred or reproduced in any environment, regardless of whether it is known or later invented, except where it is permitted in writing by AAPP. Contact afpserv@aafp.org copyright issues and/or requests for permission. Page 6Am Fam Doctor. 2013 Apr 15;87(8):584-585.Research shows that more than a third of people with migraines need preventive therapy; however, only 3 to 13 percent use it. The American Academy of Neurology (AAN) and the American Headache Society (AHS) recently reviewed studies published since 2000 to determine which therapies reduce the frequency of migraines or severity, or reduce the number of days with migraine. These guidelines do not apply to onabotulinumtoxinA (Botox), which AAN described in 2008 as probably ineffective for treating episodic migraines. Evidence to support pharmacological strategies for migraine treatment shows which treatments may be effective but insufficient to create optimal therapies. Thus, treatment regimens should be individualized on the basis of the effectiveness and adverse effects of drugs, diseases and personal considerations. EFFECTIVEDivalproex (Depakote), metoprolol, propranolol, thymolol, topiramate (Topamax) and valproate (Depacon) are effective and should be offered for Prevent. Frovatriptan (Frova) should be offered for short-term prevention of menstrual migraine. PROBABLY EFFECTIVEAmitriptyline, Atenolol (tenormin), nadolol (Corgard) and venlafaxine (Effexor) are probably effective and should be considered for migraine prevention. Solmitriptan and naratriptan (Amerge) should be considered for short-term prevention of menstrual migraines. POSSIBLY EFFECTIVECandesartan (Atacam), Carabamazepine (Tegretol), clonidine (Catapres), guanfacin (Tenex), lysinopril (Zestil), nebivolol (bystolic) and pindolol can be considered for migraine prevention. NOT ADEQUATE OR CONFLICTING DATA ON EFFECTIVENESS There are insufficient or conflicting data on the effectiveness of the following drugs for migraine prevention: acetummarole (not available in the U.S.), acetazolamide, bisoprolol (Sebeta), cyclandate (not available in the U.S.), fluoxetine (Prozac), fluvoxamine, gabapentin (Neurontin), nicardipine (Cardion), nifedipine (Procardia), nimodipine (Nimo-top), picotamid (not available in the U.S.), PROBABLY OR Clomipramin (Anafranil) is probably ineffective and should not be offered. The following drugs may also be ineffective for migraine prevention: acebutolol (Sectral), clonazepam (Klonopin), nabumethone, oxcarbazepine (trileptal) and telmisartan (Micardis). Studies show that some medications used for migraines may offer long-term protection against the progression of headaches, while other agents may increase the risk of progression. Epidemiological studies have shown that aspirin or ibuprofen can protect against progression from episodic to chronic headaches. However, studies evaluating the effectiveness of non-steroidal anti-inflammatory drugs and complementary migraine treatments are limited and should be considered compared to other available pharmacological treatments. EFFECTIVEPetasites, a purified extract from the butterbur plant, is effective in reducing the frequency of migraine attacks, and should be offered for prevention. PROBABLY EFFECTIVEFenoprofen, histamine, ibuprofen, ketoprofen, magnesium supplements, miG-99 (fever extract), naproxen (naproxin), naproxen sodium (Anaprox), and riboflavin supplements are likely effective and should be considered for migraine prevention. POSSIBLY EFFECTIVECoenzyme No10 supplements, ciprogeptadine, estrogen therapy, flurbiprofen, and mefenamic acid (Ponstel) may be considered for migraine prevention. NOT ADEQUATE OR CONFLICTING DATA ON EFFECTIVENESS No insufficient or contradictory data on the effectiveness of the following migraine prevention methods: aspirin, hyperbaric oxygen, indomethacin (indocin) and omega-3 supplements. PROBABLY, OR EFFECTIVEMontelukast (Singulair) is not effective in reducing the incidence, frequency or severity of migraines, and should not be offered. Page 7 Am Fam Doctor. 2013 April 15;87(8):536.TO EDITOR: This article does not mention a valuable method to help in diagnosing scabies: ink burrows test.1.2 When ink is applied over suspicious areas of the skin, it is absorbed where tick nods exist under the skin. Wiping the surface ink shows the remaining ink that has penetrated the burrows. In addition, microscopic identification of ticks, eggs and fecal pellets can be performed by pausing the skin scraping in mineral oil.3 Ticks will stick to the oil, and the skin scales will be mixed with oil. Differences in refraction will be greater between tick and oil. The oil does not dissolve fecal pellets. Although there are studies describing the use of potassium hydroxide (KOH) instead of mineral oil,4 KOH can dissolve fecal pellets, thus preventing the identification of Sarcoptes scabiei.5.6 For this reason, mineral oil is preferred in relation to the KOH solution. Author disclosure: Dr. de Caprariis previously worked at Pfizer as Medical Director for Antifungal Drugs from 2009 to February 2011. Dr. Della-Latta does not have the relevant financial affiliations.show all links1. Spaylman A. Arthropod. In: Gorbachev SL, Bartlett JG, Blacklow NR, eds. Infectious diseases. 2nd o. Philadelphia, Pennsylvania: Saunders; 1998:2500–2501....2. Sarwat M.A. et al. Parasitological and Clinical Studies of Human Scabies in Cairo. J Egypt Soc Parasitol. 1993;23(3):809–819.3. Jarrell A., Schalok PC. Procedures of dermatology and therapy. In: Shalom PC, Hsu JT, Arndt SA, eds. Lippincott Primary Health Dermatology. Philadelphia, Pennsylvania: Lippincott Williams and Wilkins; 2011.4. Hicks MI, Elston DM. Scabies. Dermatol Tr. 2009;22(4):279–292.5. Garcia L.S. Diagnostic Medical Parasitology. 5th o.p. Washington: ASM Press; 2007:704.6. Diaz JH. Scabies. In: Mundell GL, Bennett JE, Valley R, Ed. Principles and Practice of Infectious Diseases. 7th Ed. Philadelphia, Pennsylvania: Churchill Livingston; 2010: 3633-3636.IN REPLY: We appreciate the mention of testing the ink burrow for the diagnosis of scabies. Also known as test ink burrows, this method consists of rubbing the bottom of the pen cartridge on the suspected scabies of papules and then wiping out excess ink with an alcohol pad. Although a pen cartridge (with free-flowing ink) is a simple and inexpensive tool, ballpoint pens are more common in the United States, limiting the practicality of this dough due to the lack of cartridge handles. Furthermore, although the test appears to be a valid diagnostic tool, a long search is sometimes required to find a positive lesion even in patients who have Scabies is highly suspected.1 Because prolonged examination can be impractical in the tense environment of the office, office, Recommended empirical treatment for patients with itching, typical lesions and a history of itching in close contacts.2 We agree that mineral oil is superior to KOH drugs for microscopic skin scraping studies when diagnosing scabies, and have included recommendations for the use of mineral oil in testing. Disclosure of the author: There is no appropriate financial affiliation.1. Woodley D, Saurat JH. Burrow ink tests and scabies mite. J Am Akade Dermatol. 1981;4(6):715–722.2. Page TL, Aiff MP, Judkins DM, Walker B. Clinical Inquiries. When should we treat scabies empirically? Jay Pham Practical. To see the full article, log in or access the purchase. Send emails to afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Lywood, KS 66211-2680. Include your full address, email address and phone number. Letters must be less than 400 words and are limited to six links, one table or a figure and three authors. Letters submitted for publication to THE AFP should not be submitted in any other publication. Possible conflicts of interest should be disclosed at the time of submission. The submission of the letter will be interpreted as granting AAFP permission to publish the letter in any form of the letter. Editors can edit letters to meet the requirements of style and space. This series is coordinated by Kenny Lin, MD, MPH, Deputy Editor of AFP Online. The ©, 2013 by the American Academy of Family Physicians. This content is owned by AAFP. 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