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The book is intended for independent revision on topics related to the heart and large vessels, as well as the lung and chest wall. Fundamental science questions include developmental disabilities, normal anatomy and physiology, microbiology and pharmacology. Clinical issues include those related to the management of conditions affecting the heart and lungs and mainly refer to the phase between medical and surgical management and their final surgical management. The book gives an insight into how heart, lung and thoracic wall diseases are managed surgically and can provide a useful understanding of the surgical management of these conditions by a non-union professional surgeon. This is definitely a useful companion study for the surgeon in training, especially those interested in cardiac or thoracic surgery. While a specialist intern in cardiothoracic surgery will be a big beneficiary of general internists will find useful topics on which revision issues are based. The Fundamental Sciences Section can be useful even for junior doctors and medical students. The structure of the questions was developed mainly as a type of plural choice, as the author believes that they are more useful as an assistant for revision. The last two chapters are in the form of Type One Best Answer and Advanced Matching item-type questions for readers to familiarize themselves with these kinds of questions. Delivery Associate will place the order on your doorstep and step back to keep the 2-meter distance. Customer signatures are not required at the time of delivery. To pay for delivery orders, we recommend paying with a credit card/debit card/netbanking via a paid link sent via SMS at the time of delivery. To pay in cash, place the cash on top of the delivery box and step back. Amazon directly manages the delivery of this product. Tracking the delivery of an order to your doorstep is available. ANSWER 1 and 3 IABP remains the first mechanical line of defense for LV perioperative dysfunction. IABP reduces cardiac function (MVO₂) by deflating during the blue, thereby reducing after load, and increasing coronary perfusion with inflation during diastole. IABP counterpulsation is designed to increase myocardial oxygen during diastole and reduce the demand for myocardial oxygen during the systole. The main effects of IABP are: 1. High diastolic blood pressure 2. Decrease in systolic blood pressure - note that the peak of systolic pressure is lower than that of unaided systolic pressure peak 3. Reducing the consumption of systolic labor LV, voltage and myocardial oxygen 4. Decrease after load - note the pre-systolic pressure with IABP lower than the unaided end of diastolic pressure 5. Improved RV function (2 increase) myocardial and pressure discharge LV Balloon inflation: balloon inflated with helium, in volume from 20-40 ml. Sets (8.5, 9.5 Fr) have a lower frequency of complications than older (50 to 80 ml) sets. The goal is not to occlude the aorta, but simply to displace the blood during the diastole. 85% occlusion is optimal. Gases for inflation: Carbon dioxide: Dense and therefore slowly inflate the balloon - Requires a large line of drive diameter with an increase in artery injury, but quickly dissolves in the blood if accidentally introduced. Helium: Low density has therefore reduced the number of Reynolds and is therefore able to quickly inflate and deflate a balloon: only a narrow diameter drive line is required, but the source of the embolism is if accidentally entered into the bloodstream. The helium in volumes used in IABP is released into the descending aorta quickly distributed across the brain and coronary vessels - quickly fatal. Location: The balloon is usually located only distal to the left subclave takeoff. Device can also be placed in the proximal downward aorta (placed intraoperative) Timeline: Inflation should be synchronised with a dirotic notation on the blood pressure trail. Basically balloon inflation is set automatically to start in the middle of Wave T and deflate before the end of the set of readings. Torchiana and colleagues reviewed the Massachusetts Hospital's experience of 4,756 IABP patients from 1968 to 1995. In their series, the use of IABP intraoperative or postoperative was associated with 35.7% and 35.9% mortality, respectively, along with a tendency to increase preoperative use. Gall and his colleagues studied the use of IABP in 12 Massachusetts hospitals. In CASES, CABG used 13.4%. Many reports show an increase in preoperative IABP placement in patients with reduced LV function. This does not include failed PTCA/stenting, postinfarction of fire-resistant angina, or cardiogenic shock patients undergoing urgent or emergency placement. Holman and his colleagues did not show survival benefits with preoperative IABP, but showed improved recovery and reduced hospitalization. The overall use of IABP was reviewed by the Verification Results Register. Between June 1996 and August 2000, 203 hospitals worldwide (90% in the United States) examined 16,909 patient records. Indications for the use of IABP included: support during or after cardiac catheterization (20.6%), cardiogenic shock (18.8%), cpB weaning (16.1%), preoperative placement of patients at high risk of cardiac surgery (13.0%) and patients at high risk of cardiac surgery (13.0%), and fire-resistant unstable angina (12.3%). The two main signs for IABP placement are: 1. myocardial ischemia, which is insoluble for maximum medical therapy 2. LV dysfunction is under-managed with inotropic therapy When common femoral artery percut or open approach is not possible, or ankle-brachial ankle-brachial (ABI) is less than 0.9 (severe peripheral vascular disease), the aorta arch placement of IABP is considered. This requires re-surgery to remove and is associated with a higher incidence of postoperative neurological events. Absolute contraindications for IABP are few: 1. Severe aortic valve disease 2. Aortic dissection 3. Severe peripheral valve disease Complications: Cx-related femoral IABP placements occur in 8% to 25% of patients. Aortic perforation, aortoiliac dissection, retroperitoneal hematoma, limb ischemia, compression of the roots of the local nerve, av fistulas, pseudo-aneurysms and hematoma wounds. Sex of women, increasing the age of patients and peripheral vascular disease (PVD) are independent risk factors for morbidity. 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