Hernia umbilical y epigastrica pdf

Split View content article Figures and Tables Video Audio Additional data 810. Voriconazole Dose Change Guide to Optimizing Therapeutic Levels in Patients with Hematological Malignancies Sessions: Poster Abstract Session: Antimicrobial Agents: PK/PD Research Friday, October 9, 2015 Room: Poster Hall Background: Voriconazole is an antifungal asol used to prevent or treat systemic fungal infections in hematologic malignancies and hematopoetic stem cell transplantation (HSCT). which makes dosing difficult. Previous studies have shown reduced efficacy and increased toxicity with subtherapeutic and supratherapeutic levels, respectively. While therapeutic drug monitoring (TDM) viriconazole is recommended, no established dosing guidelines have been clarified. The purpose of this retrospective study is to evaluate the dose modification strategy with voriconazole TDM and develop dosing guidelines to optimize therapeutic levels. Methods: This study was a retrospective review of hospitalized patients with a history of hematologic malignancies who received voricolole between June 1, 2012 and December 31, 2013. Relevant adult patients (≥ 18 years) with a history of hematologic malignancies initiating voriconazole for prevention or treatment, at least two levels of viriconazole trough reported were included. Age, gender, race, body mass index (BMI), use of a proton pump inhibitor, primary diagnosis, underlying cause of hospitalization and indication of viriconazole have been documented. Results: Ninety-seven patients with 147 hospitalizations were started on voriconazole during the study period. Initial levels of the viriconazole trough were non-therapy (30 out of 97 (31%) were (13%) (13%) The average initial stable condition of the viriconazole trough level with a standard 200 mg PO q12h and no load dose was 2.8 micrograms/ml and 1.8 micrograms/ml respectively (P 0.34). Differences in baseline characteristics were not statistically significant after analysis using the Chi Square (X2) test in therapeutic versus non-toxic groups. Conclusion: Standard dosing of voriconazole 200 mg PO q12h may not be sufficient to reach the initial therapeutic level of the trough in a stable condition. To optimize the therapeutic level in a timely manner, it was used to combine the analysis of 125 dose modifications based on 531 levels. (Table 1) Jeffrey Topal, MD1, Tiffany Lin, PharmD2, Sarah Perrault, PharmD2, Dayna Mcmanus, PharmD3 and Michael Ruggero, PharmD4, (1) Yale-New Haven Hospital, New Haven, CT, (2) Pharmacy, Yale New Haven Hospital, New Haven Pharmacy, CT Pharmacy, (3) Hospitals, Falls Church, VA, (4) from the University of Pennsylvania, Philadelphia, Pennsylvania Disclosure: J. Topal, No T. Lin, Ni S. Perrault, No D. McManus, No M. Ruggero, Нет < previous= abstract= |= next= abstract= findings= in= the= abstracts= are= embargoed= until= 12:01= a.m.= pdt,= wednesday= oct.= 7th= with= the= exception= of= research= findings= presented= at= the= idweek= press= conferences.= this= website= uses= cookies.= by= continuing= to= use= this= website= you= are= giving= consent= to= cookies= being= used.= for= information= on= cookies= and= how= you= can= disable= them= visit= our= privacy= and= cookie= policy.= got= it,= thanks!= background:= voriconazole= is= an= azole= antifungal= utilized= for= prophylaxis= and= treatment= of= invasive= fungal= infections= in= hematologic= patients.= previous= studies= have= revealed= decreased= efficacy= and= increased= toxicity= with= subtherapeutic=> <1 mcg/ml= and= supratherapeutic=>4 мкг / мл уровней. In July 2014, a manual to modify the dose of voricozole was introduced on the basis of retrospective analysis. Purpose: The main goal was to evaluate the principle of changing the dose of voriconazole. Secondary targets have been to identify specific patient characteristics that contribute to inadequate levels, adverse effects, and breakthrough invasive fungal infections. Methods: This prospective study included 128 patients with 250 hospitalizations who received voriconazole from July 2014 to February 2016. Appropriate adult patients receiving voriconazole for prevention or treatment with at least one level of trough, treated appropriately, were included. Demographics, adverse effects and breakthroughs of invasive fungal infections have been documented. Results: The use of voriconazole has been classified as: a new start, a new start with a load of dose, or the continuation of home therapy. The average initial levels were 1.5, 3.5 and 1.7 micrograms/ml with 62% (73/119), 55% (6/11) and 60% (72/120) in the therapeutic range, respectively. Using voriconazole dose change guidelines, 80% were within the goal of second dose adjustment. Age ≤ 30 and BMI ≤ 25 kg/m2 had higher subtherapeutic levels in the new starting cohorts (p 0.024 and p 0.009). Approximately 7.6% of patients experienced adverse effects with neurological/psychological being the most common. A total of 8.5% of patients had a possible, probable or proven breakthrough of invasive fungal infections while on voricozole. Conclusion: Using the guidelines for changing the dose of voricozole, the number of patients who reached the therapeutic range improved from 36% to 80% on the second dose adjustment (p 0.007). This voriconazole dose change guidelines can be used to help dose and adjust the voriconazole for therapeutic level. Keywords: Antifungal drugs; Bone marrow transplantation; Drug monitoring Hematology; therapeutic monitoring. The hypersensitivity of the pill contains lactose and is not contraindicated in patients with galactose intolerance, Lapp lactase deficiency, or Malabsorpcia Cisapryd, astemisole, cisapryd, pimoside, or quinidine: Voriconazole can increase the plasma levels of these drugs and lead to the extension of TT Efavirenz (dose ≥ 400 mg/day): Efavirenz reduces the level of voriconazole and voriconazole increases the level of efavir Ritonavir (high dose - 2,400 mg q12hr): Ritonavir reduces voriconazole levels of ergot alkaloids: Voriconazole raises levels of ergotile alkaloids (ergotamine, dihydroergothamine) Rifabutin: Voriconazole raises rifabutin levels, and rifabutin reduces the level of Vorikonzole Cyrolimus: Voriconazole increases the level of syrolimus St. John's wort, rifampin, carbamazepine, barbiturates: Reducing the level of Vorikonazole Prevents Hypersensitivity to other azols Do not give IV bolus Review of patient related drugs with renal failure; Patients should be monitored for the development of abnormal kidney function; This should include a laboratory evaluation of serum creatinine Serious liver reaction reported; Evaluate liver function tests at the beginning and during therapy Avoid intense or prolonged exposure to direct sunlight; in patients with photosensitivity skin reactions, pseudoporphyria, heilitis, and lupus erythematosus reported; Patients should avoid strong, direct sunlight during therapy; squamous cell skin cancer and melanoma, reported during long-term therapy; pseudoporphyria, heilitis and cokenous lupus erythematosus. Patients should avoid strong, direct sunlight during therapy Stop for exfoliating kare reactions or phototoxicity; Avoid sunlight due to the risk of photosensitivity Severe maple adverse reactions (SCARs), such as Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug reaction with eosinophilia and systemic symptoms (DRESS), which can be life-threatening or fatal, reported; If the patient develops a severe skin-adverse reaction, the therapy should not stop without activity against zygoicetes; some evidence suggests an increase in use associated with increased incidence of zigomycosis visual impairments, including visual nevrit and papilledem, reported; Control visual function if the treatment lasts 28 days not for the introduction of pregnant women, if the benefits outweigh the risks to the fetus; inform the patient about the dangers not for use in patients with hereditary galactose, intolerance, lactase deficiency Lappa or glucose-galactose malabsorbcial therapy associated with the prolongation of the interval of RT; caution in patients with proarthymic diseases, including congenital or acquired ST-prolongation, sinus bradycardia, existing symptomatic arrhythmia or cardiomyopathy, especially if there is heart failure; correct potassium, magnesium calcium before the onset of therapy Stop Infusion, if infusion reactions occur fluorosis and priostitis reported with long-term treatment; stop if they happen monitor monitor with risk factors for acute pancreatitis (e.g. recent chemotherapy, hemathopoetic stem cell transplantation) in pancreatitis symptoms during SHOWING therapy 1-10 OF 22 REFERENCESSSORT BYRelevanceMost influential documentsRecency 1. Umbilical and epigastric hernia 2. Herniated umbilical and epigastric abdominal hernia is currently ranked tenth among the main reasons for counseling in the specialty and the eleventh place among graduates of the Mexican Social Welfare Institute 3. THE DEFINITION Word hernia comes from the Latin word meaning breakdown. From a medical and practical point of view, all abdominal wall hernias must observe three common characteristics: 1. Existence of a hole in the abdominal wall. 2. The presence of the contents of a cavity that protrudes through a hole in the wall of the abdomen. 3. Formation of a herniated sac. 4. TYPES OF ABDOMINAL HERNIAS 1. From the lower abdomen: groin, auditory, obstetric, sciatica, spiegel, perineum and rectal. 2. From the upper abdomen: epigastric and umbilical. 3. Lumbar or posterior: upper or lower. 4. Cut or postoperative: they are invariably located at the site where the preliminary intervention was carried out, with the discovery of aponeverosis and insufficient healing of the surgical wound. 5. UMBILICAL HERNIA 6. Physiopathology - In funriogenesis, between the sixth and tenth weeks, the abdominal cavity still lacks room to contain the liver and intestines in place. For this reason, in this epatage they are located outside it and return only after the completion of the abdominal cavity, followed by the formation of the abdominal wall. 7. Physiology However, for some reason the umbilical cord separates or breaks in part after the complete development of the abdominal wall, which allows free communication with the abdominal cavity and the process of gastroschisis, i.e. umbilical hernia (congenital hernia) 8. The causes of risk factors that have been associated with the presence of an umbilical hernia, birth and adulthood are listed below. 1. Risk factors associated with newborns: Down syndrome, congenital hypothyroidism, Bekviha-Videman syndrome (storage of the mucous membrane) - Hurler syndrome, trisomy 13 and 18 - in addition to coughing, crying, constipation, trauma, etc. 9. Reasons 2. Risk factors associated with adult life: - Re-pregnancy - Obesity - Ascites - intracavital tumors, chronic constipation, chronic obstructive diseases - prostate - extreme exercise in athletes - chronic lithium-cholecystitis (30% associated with patients carrying umbilical hernia) 10. In the any entity that constantly contributes to the increase of intra-abdominal pressure contributes to the formation of an umbilical hernia or any other herniated anterior abdominal wall. 11. Symptoms - A typical patient with an umbilical hernia is overweight, almost all women between the ages of 35 and 50 are three to five times more likely to be in women than men. The umbilical hernia can be imptomatic up to 39% of the time; in other cases the bulge is usually present in the umbilical scar, with pain to physical exertion in 61% of cases 12. Symptoms - Slow and gradual growth is observed and once established in anatomical terms tend to grow to create a giant hernia bag that causes pain of physical exertion and palpation. Intestinal movements (peristalsis) can be seen if the herniated sac is occupied by intestinal handles. 13. Symptoms - When any of these structures suffer from disorders in their irrigation as a result of a sudden increase in volume in the herniated sac (suffocated hernia), symptoms of anxiety or peritoneal irritation, such as - the progressive intensity of colic pain, nausea, vomiting, fever indicating a serious complication of the umbilical hernia occur. 14. Diagnosis - Diagnosis of the umbilical hernia is usually determined after receiving a history of pain associated with the ball, which goes out and gets into the umbilical cord, which is confirmed by physical examination 15. Diagnosis - For obese patients where physical examination is difficult, the diagnosis can be confirmed to the abdominal cavity, a tool that has great help in cases of intestinal obstruction, incareration, suffocation and trauma of the hernia wall 16. Treatment is always surgical, either in the umbilical hernia or in any of the abdominal wall, since there is still no evidence that the medicine solves this structural and anatomical problem. 17. Although there is no consensus on the best method for restoring the umbilical hernia, several methods are still used, which are listed below: primary repair. May technicians. Repairing the grid (flat or cone). Laparoscopic repair. Repairs with the Prolene Hernia System (PHS). 18. Treatment - In surgical treatment should apply the principles for the rest of abdominal hernias: - adequate and sufficient autopsy. Preservation of irrigation. Tissue care and sufficient hemostasis. - Avoid tissue tension. Use a prosthetic mesh if necessary. 19. Treatment - As for the May method (fascia overlay described almost always as a technique primarily for repairing an umbilical hernia, having gone over the years to other methods for its frequency of relapse. The author believes that it causes tension in a surgical hernia and represents up to 10 to 30% relapse compared to primary repair (11%) and a recurrence of the previous one (11%). and mesh mode (3%); hence it is better to place the prosthetic mesh in holes larger than 2 cm 20. GERNIA EPISTRICA - Primary epigastric hernia is unusual; occurs in the middle or dawn, above the umbilical cord, i.e. between xyfoid and umbilical cord. 21. HERNIA EPISTRICA The reported incidence is between 1 and 10%, but many are proemptomatic and therefore the incidence may be higher. Males are predominantly over women, and half of patients with women have multiple wall defects during presentation 22. Etiology and Anatomy - For some time they were considered congenital. In fact, these are defects acquired after the structural deficit of the dawn line rendered by mechanical forces. 23. Etiology and Anatomy - Dawn or middle line is located between the medial edge of the abdomen rectum (in the center of the abdomen) and extends from the syphoid appendix to the pubic synofis. It is a dense fibrous band of collagen fibers by merging the anponeuer pods of the outer oblique muscles and the internal organs of the anterior aponeurosis of the abdomen. 24. Etiology and Anatomy 25. Etiology and Anatomy Models of decusetation of fibers crossing the middle of the line to form a line of dawn have been described. Observations on the latter show a simple or unique fiber decusstion along the middle line in 30% of patients; in the remaining 70% proportion, an additional fiber crossing line is recognized on both sides of the middle line to construct triple decuses. 26. Diagnosis is five times more common in men between the ages of 20 and 40, although it has been reported in newborns and children. The diagnosis is established in most cases by physical examination. The most common symptom is pain in the upper abdomen, especially in cases of epigastric hernias with small holes. This pain is associated with physical exertion, cough, hiccups, etc., and refers to rest. 27. Diagnosis As in the case of umbilical hernia, in studies of the enlargement of obese subjects, such as tomography, ultrasound or others, may be useful in diagnosis. Symptoms and signs depend on the size of the defect, although in this type of hernia pain is most common and rushes immediately when performing exercise. 28. Treatment Treatment is always surgical. Many surgical options have been published to repair these abnormalities; reports of spontaneous regression and closure are known in children. 29. Surgical treatment options are as follows: No. 1. Initial repairs from 0 to 2 cm. Repair with mesh more than 2 cm. Laparoscopic repair with large and multiple defects. Few. diferencia entre hernia umbilical y epigastrica. hernia umbilical y epigastrica pdf. cirugia de hernia umbilical y epigastrica