

Bp guidelines for fibrinolytic therapy

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You are on a swing shift in a remote, island community hospital when a 58-year-old man poses with a sudden onset of chest pain. The pain began at rest, radiated into the jaw, and is associated with diaphoresis and nausea. He has a history of coronary heart disease (CAD), and during his last cardiac catheterization in 2008, the stent was placed in his proximal left anterior descending coronary artery. His medical history is also important for diabetes, chronic obstructive pulmonary disease, hyperlipidemia and hypertension. He's an active smoker. In the exam, he is not only diaphoretic and squeezing his chest, but also describes the pain as an elephant sitting on my chest. Initial life signs: P 110, BP 175/100, RR 20, PO2 98% on RA, T 98.9 F. You give him aspirin 324 mg and nitroglycerin sublingual 0.4 mg, and his chest pain improves from 10/10 to 8/10. His initial electrocardiogram (ECG) is below. Figure 1: Patient ECG presentation. ST Altitude Myocardial Infarction (STEMI) Management Options You call an ambulance transporting critical care as well as the nearest cardiac catheterization team to warn them about your patient. Unfortunately, it is a stormy evening in the middle of winter, and all bridges from the island are closed; helicopters grounded because of the storm. Your patient currently has no translation options. What else can you do? Indications to fibrinolytic therapy Acces data from the American Heart Association, there are several considerations when it comes to fibrinolytic therapy for myocardial infarction: Class I recommendation: STEMI Symptom began in the last 12 hours Perutonic cardiac intervention (PCI) cannot be performed within 120 minutes of arriving at the emergency room. Below) Class II Recommendation: Evidence of current ischemia 12-24 hours after the onset of symptoms Large area of my On hemodynamic instability Absolute Contraindications: Any previous intracranial hemorrhage Signs/Signies of structural vascular lesions of the brain q1t;3 months suspected aortic' dissection know Malignancy active's bleeding or bleeding diathesis significant' closed head trauma Oral anticoagulants Relieve Contraindication: Significant HTN on arrival (pressure of 180 mmHg) ischemic stroke of qgt;3 months Dementia O 10 min Major Surgery intracranial Pathology of traumatic peddy surgery of zlt;3 weeks of bleeding transfer the patient to a hospital with PCI capability within 1 hour of presentation or they have contraindications to fibrinolytic it is recommended that you transfer the patient as soon as possible. Otherwise, the goal is fibrinolytic infusion weeks non-compressible= vascular= punctures pregnancy active= peptic= ulcer= disease= pci= versus= systemic= fibrinolytic= therapy if= you= are= able= to= transfer= the= patient= to= a= hospital= with= pci= capability= within= 1= hour= of= presentation= or= they= have= contraindications= to= fibrinolytic= therapy.= it= is= recommended= that= you= transfer= the= patient= as= soon= as= possible.= otherwise.= the= goal= is= fibrinolytic= infusion= </3 weeks Non-compressible vascular punctures Pregnancy Active peptic ulcer disease PCI versus Systemic Fibrinolytic Therapy If you are able to transfer the patient to a hospital with PCI capability within 1 hour of presentation or they have contraindications to fibrinolytic therapy, it is recommended that you transfer the patient as soon as possible. Otherwise, the goal is fibrinolytic infusion < </2> </2> 30 minutes of arrival in the ambulance. In any case, simultaneously initiate maximum medical management, including a full dose of aspirin, Plavix or Brilinta, and anticoagulation (unfractured heparin or lovenox). Tenetelaze is usually the preferred fibrin of specific agents, given its ease of use and lower rates of non-cerebral bleeding compared to other agents. Reassess after Fibrinolysis If your patient has a resolution of chest pain and a 70% reduction in ST height, or ST height decodes within 60-90 minutes, you will probably have a restored flow. If you see a 50% decrease in STE and no reperfusion arrhythmia (see below) for 2 hours after fibrinolytic dosing, you have partially improved the flow but not fully restored it. Criteria for transmission after fibrinolytic therapy Immediate transmission: acute heart failure or cardiogenic shock Unint transmission: unsuccessful reperfusion or abdication 3-24 hours: hemodynamically stable, successful reperfusion Epepeus arrhythmia You plan to take a VIP because you are not able to transfer the patient to the PCI center when the nurse hands you the following EKG: Figure 2: This is an example of an accelerated idioventricular rhythm. It is a normal symptom of reperfusion after STEMI and does not require treatment. In fact, such a rhythm is generally seen as a positive response to fibrinolytic therapy, as indicated by reperfusion. Criteria: Regular Rhythm Rate 50-110bpm (slower ventricular escape, faster VT) Three or more ventricular complexes Fusion (F) and capture (C) beats (see below) Figure 3: Fusion and capture strokes after successful reperfusion. The overall goal of care after fibrinolytic therapy should be transmission for diagnostic angiography and percutaneous coronary evaluation, which is quickly performed for your patient the day after the storm decides. Faculty Reviewer: Dr. Christina McAteer O'Gara PT, Kushner FG, Ascheim DD, et al. 2013 ACCF/AHA Guide to Managing ST-Height Myocardial Infarction: Summary: Report by the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. 2013 draw: 127:e362. White HD. Thrombolytic therapy in the elderly. The Lancet 2000; 356:2028. Armstrong PW, Gershlik AH, Goldstein P, et al. Fibrinolysis or primary PCI in the ST segment of high-altitude myocardial infarction. N Engl J Med 2013; 368:1379. Effectiveness of intravenous thrombolytic treatment in acute myocardial infarction. Gruppo Italiano per lo Studio della Streptochinasi nell'Infarto Miocardico (GISSI). 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Karnash SL, Granger CB, White HD, et al. Treatment of menstruating women with thrombolytic therapy: analyses of the global use of streptococaine and tissue plasminogen activator for the study of occluded coronary arteries (GUSTO-I). J Am Coll Cardiol 1995; 26:1651. Woodfield SL, Lundergan CF, Rainer JS, et al. Angiographic findings and results in diabetic patients, treatment with thrombolytic therapy for acute myocardial infarction: experience gustO-I. J Am Coll Cardiol 1996; 28:1661. Mak KH, Moliterno DJ, Granger CB, et al. Effect of diabetes on the clinical outcome in the thrombolytic era of acute myocardial infarction. GUSTO-I Investigators. The global use of streptokinase and plasminogen activator tissue for occluded coronary arteries. J Am Coll Cardiol 1997; 30:171. Home Free ACLS Algorithms Suspected Stroke Algorithm to identify signs and symptoms of a possible stroke and activate an emergency response. Watch the patient for signs of a stroke. Use F-A-S-T to remember warning signs: face drooping, hand weakness, speech difficulties, and time. Call 911 immediately or call someone else to activate the emergency response system. Critical assessments and actions of EMS. Support ABCs by giving the patient oxygen if necessary, and perform pre-hospital stroke assessments. Determine when a stroke onset and sort a patient into a stroke center by alerting the hospital in advance so they can activate the stroke team. Consider sending a patient to a CT, and, if possible, check glucose levels. Immediate overall assessment and stabilization. Once the patient arrives at the emergency room, and within 10 minutes of arrival, assess the vital, providing oxygen if the patient is hypoxicemic. Get IV access, run labs, glucose, activate stroke commands, perform neurological screening with emerging CT scans or BRAIN MRI, and get a 12-year-leading ECG. Immediate neurological assessment by the team of stroke or or A 25 minute arrival at the emergency room, stroke team or designee should review a patient's history, set a timeline for symptoms, and perform a neurological examination using either the NIH stroke scale or the Canadian Neurological Scale. Does CT show hemorrhage? Determine whether THE CT shows a hemorrhage within 45 minutes of the patient's arrival in the emergency room. Probable acute ischemic stroke; consider fibrinolytic therapy. If the CT scan shows no signs of hemorrhage, it is likely that the patient has suffered an ischemic stroke and is a candidate for fibrinolytic therapy. Check for fibrinolytic exceptions such as significant head injuries or strokes in the previous 3 months, a history of intracranial hemorrhage, high blood pressure, active internal bleeding, or blood glucose concentrations of less than 50 milligrams per deciliter. Then repeat the neurological exam. Consult a neurologist or neurosurgeon. If a CT scan indicates a hemorrhage, contact neurologists and neurosurgeons and start a stroke or hemorrhage. Administering aspirin. If the patient is not a candidate for fibrinolytic therapy, take aspirin and start a stroke or hemorrhage pathway. Start a stroke or hemorrhage path. Start a stroke or hemorrhage path and take the patient to the stroke department or intensive care unit. Risk/benefits review with the patient and family. If the patient remains a candidate for fibrinolytic therapy, consider the risks and benefits of therapy with the patient and their family within 1 hour of arrival and 3 hours of symptoms. If they agree to treatment, administer rPA and do not give the patient anticoagulants or anti-pay within 24 hours. Start post-rPA to stroke the path. Start after an rPA stroke path within 3 hours of the patient's arrival in the emergency room. Take the patient to the stroke department or intensive care unit and aggressively control blood pressure and neurological deterioration. Deterioration.

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