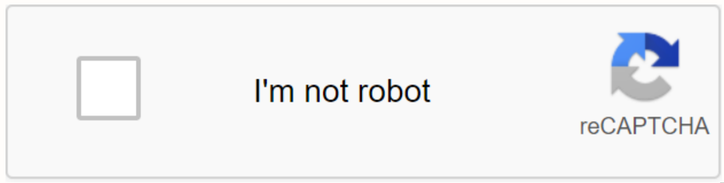

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Chronic sinusitis guidelines 2020

成人における急性中鼻炎の管理に関するガイドラインは、次の組織によって発表されました: 米国耳鼻咽喉科頭頸部外科財団 (AAO-HNSF) (2015) 米国アレルギー・喘息・免疫学会 (AAAAI)/米国アレルギー大学, 喘息・免疫学(ACAAI)(2014)アメリカ感染症学会(IDSA)(2012)ミシガン大学ヘルスシステム(2011)2014 AAAAI/ACAAIプラクティスパラメータは、サイ鼻炎に対して次の分類を提供します[13] : 急性サイ 患者は12ヶ月以内にARSの少なくとも3エピソードを有する必要があります: 持続性上気道感染症膿性鼻後鼻腔鼻腔鼻腔閉塞性疼痛頭痛熱咳再発性急性鼻炎(RARS)慢性鼻鼻炎(CRS)患者は、12週間以上続いた様々 MUST have ARS symptoms of severe severity. AAO-HNSF Guidelines In the Clinical Practice Guidelines for the Management of Rhinitis in Adults updated in 2015, AAO-HNSF made a strong recommendation that clinicians should distinguish between acute rhinitis caused by bacterial sources and episodes caused by viral upper respiratory tract infections and non-infectious conditions. Symptoms or signs of acute bacterial rhinitis (ABBRS) include either of the following [14]: purulent runny nose cut with nasal obstruction facial pain fullness A clinician evidence that ARS symptoms or signs improved for at least 10 days beyond the onset of ARS The AAO-HNSF guideline, which persists without (no evidence of improvement) worsens after the first improvement (double) (double) recommends for radiation imaging for patients who meet ARS diagnostic criteria, unless complications or alternative diagnostics are suspected. [14] IDSA Guidelines 2012 IDSA Guidelines APRS diagnosis is carried out in the presence of the following clinical presentation [15] : signs of severe symptoms or high fever (≥39 degrees C) and purulent nasal discharge or facial pain without evidence of improvement that lasts at least 3-4 days at the beginning of the onset of a new headache, Onset with symptoms or signs compatible with ARS lasting at least 10 days Signs and symptoms that first showed improvements in the University of Michigan health system guidelines increased nasal discharge following a typical viral upper respiratory tract infection that showed the University of Michigan Health System Guidelines 2011 University of Michigan Health System Guidelines recommend that patients perform sinus tomography (CT) scans while symptoms are available. In the case of symptoms ofAntibiotics and more than three weeks in spite of recurrence more than three times a year. A simple Cynus X-ray series is not recommended because CT scanning provides a much better definition. [16] AAO-HNSF Guidelines Recommendations for AAO-HNSF Treatment include [14] : Viral and Bacterial Rhinitis, Analgesics, Intranasal Steroids, and/or Nasal Physiological Yarn Irrigation Symptom relief may provide the patient with symptom relief if the patient's condition has not improved within seven days of diagnosis, or if ABS is treated with antibiotics, careful waiting time should be provided only if there is a follow-up guarantee so that antibiotic therapy can be started at any time if it worsens. Amoxicillin, with or without clarinate, receives first-line treatment for 5-10 days in most adults, confirmS ABBRS, exclude the cause of other diseases, detect complications if the patient does not improve in 7 days or initial management options after diagnosis. If ABBRS is confirmed in patients who are managed by observation, antibiotic therapy should be started. If the patient is already managed with antibiotics, antibiotics should be changed to evaluate patients with multiple chronic conditions that change the management of chronic rhinitis or RACS chronic rhinitis or RARS, which distinguishes chronic rhinitis from isolated episodes of ABBRS and other causes of by-nose symptoms, As opposed to the AAO-HNSF guidelines, such as asthma, cystic fibrosis, immunodeficiency, and ceroid pigmentation IDSA guidelines, the IDSA Guidelines recommend the start of antimicrobial therapy with amoxicillin-Clavrate rather than amoxicillin alone as soon as a clinical diagnosis of AVRS is established. Doxycycline or respiratory fluoroquinolone (levofloxacin or moxifroxacin) is recommended as an alternative to experienced antibacterial therapy in adults who are allergic to penicillin. However, in 2016, the U.S. Food and Drug Administration (FDA) issued a recommendation that serious side effects associated with fluoroquinolone antimicrobials generally outsce the benefits of patients with sideitis and that fluoroquinolone should be reserved for patients without alternative treatment options. [17] Patients clinically deteriorated after 3 days of experience antibacterial therapy after 3 days using the first line agent, or patients that do not improve after 3-5 days, resistant pathogens, non-infected pathogens, structural abnormalities, or therapeutic failure it should be evaluated for the possibility of other causes. [15] In addition, the IDSAAs an advable treatment, menstrual stimulation and intranasal corticosteroids. [15] The practical parameters of AAAI/AAAI Guidelines 2014 AAAAI/ACAAI recommend the use of intranasal corticosteroids with monotherapy or antibiotics for the treatment of ABBRS. [13] The University of Michigan Heath System ABBRS Treatment Recommendation includes [16] : Amoxicillin and trimetrom/sulfametoxazole as a frontline alternative (e.g., doxycycline, azithromycin) Antibiotics to be given only to patients allergic to both first-line drugs The first course should be 10-14 days, except for azithromycin, a solution after the first course of partial but incomplete antibiotics, extend the duration of antibiotic therapy for a total of three weeks, minimize or no improvement in the initial treatment, reevaluation of the diagnosis, consider changing to an antibiotic with broader coverage, including resistant strains. High doses of amoxicillin, amoxicillin-clublanate, levofloxacin, and moxifroxacin ciprofloxacin should be avoided for limited activity against pneumococcal. In 2013, the American Academy of Pediatrics (AAP) published clinical practice guidelines for the diagnosis and management of acute bacterial new disease in children. According to the guidelines, the diagnosis of acute bacterial sinusitis should last for more than 10 days without improvement if a child with an acute upper respiratory tract infection (URI) has a persistent disease (i.e., nasal discharge and /or daytime cough). Discharge of the nose after the initial improvement, daytime cough, or worsening course or new onset of fever; or severe onset (i.e., fever and purulent nasal discharge) for at least three consecutive days. [18] Other major behavioral statements include the following [18]: imaging studies (plain film, contrasting enhanced CT scans, magnetic resonance imaging [MRI] scans, or ultra-sonograms), contrasting CT scans of the sinuse sinuses and / or contrasting MRI scans of the sinuse sinuses that are not recommended to distinguish acute bacterial sinusitis from viral URIs, or central nervous system complications should be performed if there is a suspicion of prescribing antibiotic therapy in children with acute bacterial sinusitis symptoms, or both) prescribing antibiotic therapy or providing additional outpatient observations for children with persistent diseases (quality of at least 10 days without evidence of improvement and / or nasal secretion of cough) with or without water Prescription of amoxicillin as a first-line treatmentIf the diagnosis of acute bacterial malignancies is confirmed in children with worsening symptoms, or if the diagnosis of acute bacterial malignancies is confirmed in children who fail to improve in 72 hours, if there are reports of deterioration of initial management or failure of improvement caregivers, re-evaluate the initial management of the decision to start antibiotic therapy. Thereafter, 2014 AAAI / AAAI practice parameters that may first observe and manage antibiotic therapy that can first start antibiotic therapy for patients first managed by antibiotic or antibiotic treatment, clinicians when evaluating rhinitis patients it is recommended to look for the presence of otitis media. AAAI/ACAAI also points out that there is no evidence to support the use of nasal irrigation, antihistamines, hyperchotopoietics, or mucus-degrading drugs as admal therapy in the treatment of ABS in children. In 2017, the Korean Center for Disease Control and Prevention issued guidelines on the use of antibiotics in adults aged 19 and over associated with acute upper respiratory tract infections. [19] In patients with acute bacteriosis, antibiotics may be prescribed early after diagnosis of acute bacterial malignancies. You should start antibacterial therapy that does not indicate or indicate worsening symptoms If the patient shows the following serious symptoms or laboratory opinions, treatment should be initiated: 39 degrees C (102 degrees F) Fever, facial pain, or purulent nasal secretions that last for 3-4 days, amoxicillin or amoxicillin / clavicle is recommended for the first experience therapy of acute bacterial infaccessia in adults high doses of amoxicillin or amoxicillin / clavlanate should be considered for patients in areas with a high rate of penicillin-resistant S pneumonia, patients with severe symptoms, elderly patients, Recently hospitalized patients, patients with a history of antimicrobial therapy within the past month, and type IV hypersensitivity to immunodeficiency patients penicillin (e.g., rash), doxycycline or fluoroquinolone or third-generation Farosporin or clindamycin, type I hypersensitivity to penicillin (e.g., anacraxis), should not be used all β-lac antibiotics (eg, cephalosporin). Non β-lactam antibiotics, unless the patient has severe acute malignancy, short periods of time (within 5-10 days or within 4-7 days of symptom / symptom improvement), or when the patient's symptoms worsen within 72 hours of the first experience therapy, or unless the patient needs to consider not showing improvement after 3-5 days, short period of time (within 4-7 days of symptom / symptom improvement) should be maintained. Ceftriaxon, cefotaxim, levofloxacin, and moxifroxacin can be used for the required severe conditionsSurgical treatment may be considered if recurrent acute new inflammation does not respond to appropriate drug therapy