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Dr Roman Cregg MB BS FRCA

UCL Centre for Anaesthesia

September 2009 for BUS2

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(By Dr Irina Kisileva, Kyiv)



Другий Британсько-Український Симпозіум

Анестезіологія, Інтенсивна Терапія та Медицина Болю

головна програма розміщення реєстрація партнери контакти

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17-18 вересня

Відкритий лист до британських лекторів та учасників Першого Британсько-Українського симпозіуму

З боку Українського оргкомітету і делегатів Першого Британсько-Українського симпозіуму з анестезії інтенсивної терапії та медицини болю ми висловлюємо глибоку подяку всім Британським лекторам за проведену велику роботу по проведенню цього форуму. Ми високо цінуємо високий рівень презентацій і плідотворні дискусії по практичним аспектам лікування хворих, які перебувають у критичному стані. Цей симпозіум допоміг Українським анестезіологам зрозуміти сучасні тенденції в анестезії, інтенсивній терапії і медицині болю в Великобританії. Це спонукає нас до покращення нашої практики лікування пацієнтів, а також навчання наших анестезіологів і допомагає бути ближче до міжнародних стандартів. Ми будемо вдячні за можливість організації навчально-тренувальної поїздки для 2-3 наших лікарів в Британських Відділеннях IT і бачимо це наступним кроком нашого співробітництва. Це дозволить їм безпосередньо спостерігати за Вашою щоденною практикою і розділити отриманий досвід з іншими лікарями. Ми сподіваємось на те що тісні зв'язки з українськими лікарями були також цікавими для Британських делегатів і таке міжнародне співробітництво буде продовжуватись та розвиватись і у майбутньому.

Успіх Першого симпозіуму був можливий не тільки завдяки високому професійному рівню Британських лекторів та наполегливій роботі, українського та британського оргкомітетів, а й завдяки великому інтересу та зацікавленості з боку українських делегатів та учасників цього форуму.

Висловлюємо сподівання, що плідним буде і Другий Британсько-Українського симпозіуму, який відбудеться 17-18 вересня 2009 на клінічних базах кафедри анестезіології та інтенсивної терапії НМАПО ім. П.Л. Шупика в Київському міському центрі серця та Київській клінічній лікарні швидкої медичної допомоги.



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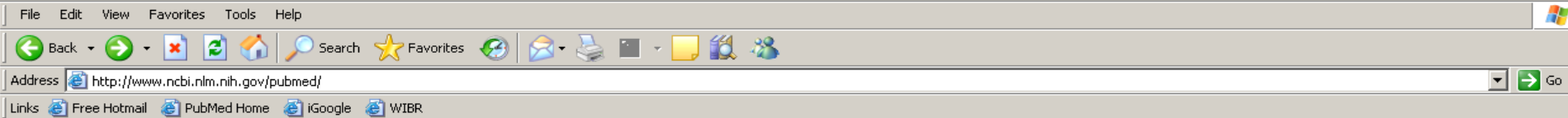
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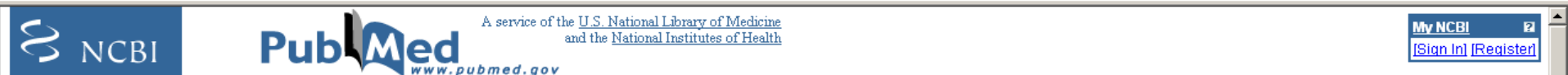
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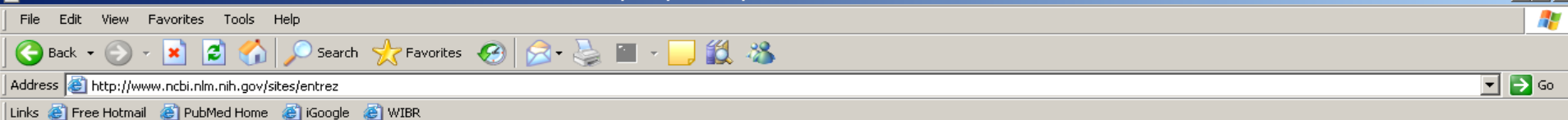
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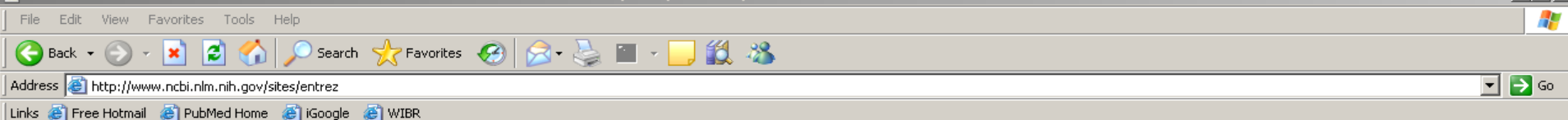
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Our Current Concepts Review committee has published an outstanding series of review articles on various current topics of interest in orthopaedic foot and ankle surgery over the past few years, with one on rheumatoid forefoot problems in this issue. The authors of these articles, along with the CCR committee members, especially Brian Toolan and Chris Chiodo, perform an extensive literature review, assign a level of evidence to each article, and make recommendations regarding the strength of evidence supporting or not supporting given treatments (Levels A to C). The American Journal of Bone and Joint Surgery began assigning levels of evidence ratings to each of their articles beginning in January 2003.² In order to assist our readers in assessing the scientific quality of a study, a level of evidence will now be included as part of the abstract for all clinical articles in *Foot & Ankle International*.

There are five levels of evidence generally accepted for a scientific study.² The table included here outlines the levels of evidence for different types of clinical studies. Level I (prospective randomized clinical trials) studies are certainly the best method for answering a specific clinical question. We will continue to publish Level IV (retrospective case reviews) and Level V (case reports/expert opinion) studies, as there is significant information to be gained from these studies. Most current orthopaedic practice is still predicated upon Level IV and V evidence from previous years. However, our goal as physicians and scientists should be improving the quality of evidence whenever possible.

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DOI: 10.3113/FAL2008.0881

Editorial: Levels of Evidence, Evidence-Based Medicine, and *Foot & Ankle International*

Our Current Concepts Review committee has published an outstanding series of review articles on various current topics of interest in orthopaedic foot and ankle surgery over the past few years, with one on rheumatoid forefoot problems in this issue. The authors of these articles, along with the CCR committee members, especially Brian Toolan and Chris Chiodo, perform an extensive literature review, assign a level of evidence to each article, and make recommendations regarding the strength of evidence supporting or not supporting given treatments (Levels A to C). The American Journal of Bone and Joint Surgery began assigning levels of evidence ratings to each of their articles beginning in January 2003.² In order to assist our readers in assessing the scientific quality of a study, a level of evidence will now be included as part of the abstract for all clinical articles in *Foot & Ankle International*.

There are five levels of evidence generally accepted for a scientific study.² The table included here outlines the

Table 1: Level of evidence and grades of recommendation

Level of Evidence

- Level I: High-quality prospective randomized clinical trial
- Level II: Prospective comparative study
- Level III: Retrospective case control study
- Level IV: Case series
- Level V: Expert opinion

Grades of Recommendation (given to various treatment options based on Level of Evidence supporting that treatment)

- Grade A: Treatment options are supported by strong evidence (consistent with Level I or II studies)
- Grade B: Treatment options are supported by fair evidence (consistent with Level III or IV studies)

Table 1: Level of evidence and grades of recommendation

Level of Evidence

- **Level I:** High-quality prospective randomized clinical trial
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Grades of Recommendation (given to various treatment options based on Level of Evidence supporting that treatment)

- **Grade A:** Treatment options are supported by strong evidence (consistent with Level I or II studies)
- **Grade B:** Treatment options are supported by fair evidence (consistent with Level III or IV studies)
- **Grade C:** Treatment options are supported by either conflicting or poor quality evidence (Level IV studies)
- **Grade I:** When insufficient evidence exists to make a recommendation



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Evidence-based medicine

From Wikipedia, the free encyclopedia



This article has been nominated to be checked for its **neutrality**. Discussion of this nomination can be found on the [talk page](#).

(May 2009)

Evidence-based medicine (EBM) aims to apply the best available [evidence](#) gained from the [scientific method](#) to medical decision making.^[1] It seeks to assess the quality of evidence, weigh the risks and benefits of [treatments](#) (including lack of treatment).^[2]

EBM recognizes that many aspects of medical care depend on individual factors such as [quality-](#) and [value-of-life](#) judgments, which are only partially subject to scientific methods; however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best [prediction](#) of outcomes in a given medical treatment, even as debate continues about which outcomes are desirable.

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1.1 Evidence-based guidelines

1.2 Evidence-based individual decision making

2 Process and progress

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7.6 Populations, clinical experience, and dubious diagnoses

8 History

US Preventive Services Task Force

[\[edit\]](#)

Systems to stratify evidence by quality have been developed, such as this one by the [U.S. Preventive Services Task Force](#) for ranking evidence about the effectiveness of treatments or screening:

- Level I: Evidence obtained from at least one properly designed [randomized controlled trial](#).
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- Level III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

National Health Service

[\[edit\]](#)

The UK [National Health Service](#) uses a similar system with categories labeled A, B, C, and D. The above Levels are only appropriate for treatment or interventions; different types of research are required for assessing diagnostic accuracy or natural history and prognosis, and hence different "levels" are required. For example, the Oxford Centre for Evidence-based Medicine suggests levels of evidence (LOE) according to the study designs and critical appraisal of prevention, diagnosis, prognosis, therapy, and harm studies:^[9]

- Level A: Consistent [Randomised Controlled Clinical Trial](#), [cohort study](#), all or none (see note below), clinical decision rule validated in different populations.
- Level B: Consistent Retrospective Cohort, Exploratory Cohort, Ecological Study, Outcomes Research, [case-control study](#); or extrapolations from level A studies.
- Level C: [Case-series study](#) or extrapolations from level B studies.
- Level D: Expert opinion without explicit critical appraisal, or based on [physiology](#), bench research or first principles.

Grade Working Group

[\[edit\]](#)

A newer system is by the Grade Working Group and takes in account more dimensions than just the quality of medical evidence.^[10] "Extrapolations" are where data is used in a situation which has potentially clinically important differences than the original study situation. Thus, the quality of evidence to support a clinical decision is a combination of the quality of research data and the clinical 'directness' of the data.^[11]

Despite the differences between systems, the purposes are the same: to guide users of clinical research information about which studies are likely to be most valid. However, the individual studies still require careful critical appraisal.

Note: The all or none principle is met when all patients died before the Rx became available, but some now survive on it; or when some patients died before the Rx became available, but none now die on it.

Categories of recommendations

[\[edit\]](#)

In guidelines and other publications, recommendation for a clinical service is classified by the balance of risk versus benefit of the service *and* the level of evidence on which this information is based. The [U.S. Preventive Services Task Force](#) uses:^[12]

- Level A: Good scientific evidence suggests that the benefits of the clinical service substantially outweighs the potential risks. Clinicians should discuss the service with eligible patients.
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Доказательная медицина

Материал из Википедии — свободной энциклопедии

Доказа́тельная медици́на (англ. *Evidence-based medicine* — *медицина, основанная на доказательствах*) — термин описывает такой подход к медицинской практике, в котором решения о применении профилактических, диагностических и лечебных мероприятий принимаются исходя из полученных доказательств их эффективности и безопасности, и предполагающий поиск, сравнение, обобщение и широкое распространение полученных доказательств для использования в интересах больных (Evidence Based Medicine Working Group, 1993).

Содержание [убрать]

- История
- Принципы доказательной медицины
- Развитие идей доказательной медицины
- Внешние ссылки
- Литература

История

Известно, что многие, даже существующие длительное время медицинские традиции и «общепризнанные методы», до сих пор не были подвергнуты адекватной научной проверке. Постепенно в медицине возникали идеи, повышающие её эффективность — например, «**Золотой стандарт терапии**» и «**Препарат выбора**»

Термин **Доказательная медицина** был предложен группой канадских учёных из **Университета Мак-Мастера** (1990).

Хотя общепринятого определения термин пока не имеет, но концепции, стоящие за ним, быстро распространяются.

Принципы доказательной медицины

В основе доказательной медицины лежит проверка эффективности и безопасности методик диагностики, профилактики и лечения в **клинических исследованиях**. Под принципами доказательной медицины понимают *использование данных, полученных из клинических исследований в повседневной клинической работе врача*.

В большинстве стран стали общепризнанными некоторые правила проведения клинических исследований, изложенные в стандарте *GCP* (*Good Clinical Practice*, «Надлежащая клиническая практика»), а также правила производства лекарственных средств (стандарт *GMP*) и выполнения лабораторных исследований (стандарт *GLP*).

Развитие идей доказательной медицины

Международная система доказательной медицины развивается в геометрической прогрессии: с момента её становления в начале 90-х годов и по настоящее время число центров, монографий и форумов по проблеме исчисляется десятками, количество публикаций — сотнями. Агентство политики здравоохранения и науки США субсидирует в 1997 сроком на 5 лет 12 таких центров, созданных при ведущих университетах и научных организациях различных штатов; растёт число центров по отдельным проблемам (здоровье детей, первичная помощь, общая практика, психическое здоровье и др.). Общим для всего направления является использование принципа доказательности на любом уровне принятия решений — от государственной программы до назначения индивидуальной терапии.

US Preventive Services Task Force

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Internet health searches could lead to dangerous results

16 January 2008

A new report from the US Center for Medicine in the Public Interest (CMPI) says that Google searches for health information may be leading to dangerous medical decisions by the public(1).

"What we found was not only disturbing, but dangerous to public health," said Robert Goldberg, Vice President, CMPI.

"For millions of Americans, Google has replaced the family physician. People trust, and make decisions, based on the information they find online," said Goldberg. "With few exceptions, the information we found appeared legitimate but had no medical authority whatsoever. In many cases, we found lawyers posing as medical experts."

The analysis of search results revealed that online real estate was dominated by websites paid for and sponsored by either class action law firms or legal marketing sites searching for plaintiff referrals. Other sites were sponsored by groups or individuals selling 'alternatives'.

- 65% of the first three pages of search results came from sites that were biased or contained unverified information:

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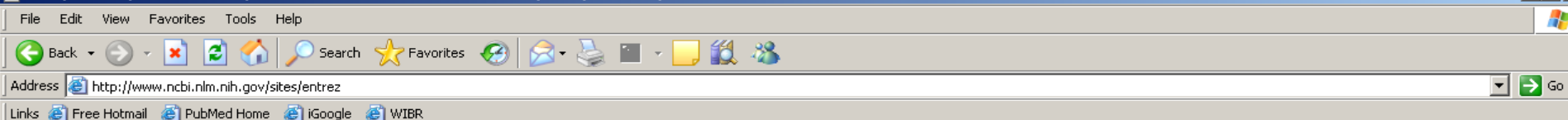
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Polenceusz W, Kupisiak J, Goch R, Paczkowski D.
Anestezjol Intens Ter. 2008 Oct-Dec;40(4):249-52. Review. Polish.
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☐ 3: [Lipid emulsion combined with epinephrine and vasopressin does not improve survival in a swine model of bupivacaine-induced cardiac arrest.](#)
Hicks SD, Salcido DD, Logue ES, Suffoletto BP, Empey PE, Poloyac SM, Miller DR, Callaway CW, Menegazzi JJ.
Anesthesiology. 2009 Jul;111(1):138-46.
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Evaluation of the Association of Anaesthetists of Great Britain and Ireland lipid infusion protocol in bupivacaine induced cardiac arrest in rabbits.

[Cave G](#), [Harvey MG](#), [Winterbottom T](#).

Wellington School of Medicine & Health Sciences, University of Otago, Wellington, New Zealand.

Infusion of lipid emulsion has been demonstrated to facilitate return of spontaneous circulation in animal models and human cases of local anaesthetic induced cardiac arrest. Guidelines for lipid application exist; however, experimental evidence of efficacy at recommended dosing is lacking. In 20 sedated, mechanically ventilated, and invasively monitored New Zealand White rabbits, asystole was induced via bolus bupivacaine injection. Animals were randomised to receive either 20% Intralipid administered according to Association of Anaesthetists of Great Britain and Ireland guidelines, or identical volumes of 0.9% saline solution, in addition to standard Advanced Cardiac Life Support resuscitative measures. Seven lipid treated rabbits developed return of spontaneous circulation vs four saline treated animals ($p = 0.370$). A trend toward sooner return of spontaneous circulation in the lipid treated group was observed (2.4 (0.53) vs 3.8 (1.7) min; $p = 0.082$). Five animals in the lipid treated group survived to protocol termination vs nil animals from the saline treated group ($p = 0.033$). The current Association of Anaesthetists of Great Britain and Ireland lipid infusion protocol provides a useful beginning for lipid emulsion administration.

PMID: 19624627 [PubMed - indexed for MEDLINE]

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Evaluation of the Association of Anaesthetists of Great Britain and Ireland lipid infusion protocol in bupivacaine induced cardiac arrest in rabbits

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Intralipid

From Wikipedia, the free encyclopedia

Intralipid is a brand name for the first safe fat emulsion for human use, approved in 1962 and invented by Professor Arvid Wretling, Sweden. It is given intravenously to patients who are unable to get enough fat in their diet. It is an emulsion of soy bean oil and egg phospholipids. Some preparations of the anaesthetic drugs [propofol](#) and [etomidate](#) are supplied using Intralipid as a vehicle.

Weinberg et al. have published data indicating Intralipid is effective in treating experimental models of severe cardiotoxicity secondary to intravenous overdose of local anaesthetic drugs such as [bupivacaine](#) (Picard & Meek 2006, Weinberg et al. 1998, 2003 and 2004). Recent case reports have been published of the successful use of lipid emulsion in this way (Rosenblatt 2006, Litz 2006, Foxall 2007) to save patients who were unresponsive to the usual resuscitation methods. All patients recovered completely shortly after intravenous injections of lipid.

Intralipid is also widely used in optical experiments to simulate the scattering properties of biological tissues (Driver et al. 1989). Solutions of appropriate concentrations of intralipid can be prepared that closely mimic the response of human or animal tissue to light at wavelengths in the red and infrared ranges where tissue is highly scattering but has a rather low absorption coefficient.

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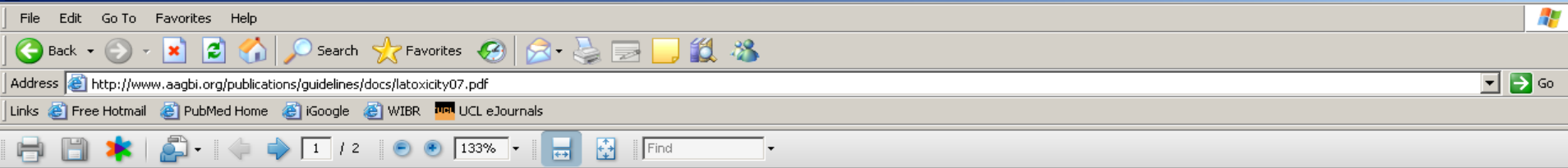
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THE ASSOCIATION OF ANAESTHETISTS *of Great Britain & Ireland*

Guidelines for the Management of Severe Local Anaesthetic Toxicity

Signs of severe toxicity:

- Sudden loss of consciousness, with or without tonic-clonic convulsions
- Cardiovascular collapse: sinus bradycardia, conduction blocks, asystole and ventricular tachyarrhythmias may all occur
- Local anaesthetic (LA) toxicity may occur some time after the initial injection

Immediate management:

- Stop injecting the LA
- **Call for help**
- Maintain the airway and, if necessary, secure it with a tracheal tube
- Give 100% oxygen and ensure adequate lung ventilation (hyperventilation may help by increasing pH in the presence of metabolic acidosis)
- Confirm or establish intravenous access
- Control seizures: give a benzodiazepine, thiopental or propofol in small incremental doses
- Assess cardiovascular status throughout

Management of cardiac arrest associated with LA injection:

- Start cardiopulmonary resuscitation (CPR) using standard protocols
- Manage arrhythmias using the same protocols, recognising that they may be very refractory to treatment
- Prolonged resuscitation may be necessary; it may be appropriate to consider other options:



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Beta adrenoceptor blockers are among the most widely used cardiovascular drugs today. Propranolol is a highly lipophilic, nonselective beta-blocker with additional local anesthetic properties. In severe overdose bradycardia, seizures, and intractable cardiovascular collapse are common. While the amount of propranolol prescriptions issued has declined with the advent of more cardioselective beta-blockers, this agent remains a cause of mortality in human poisoning [1].

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Accuracy of emergency medical information on the web

Presented at the Society for Academic Emergency Medicine Mid-Atlantic Regional Meeting, April 2002, Wilmington, DE.

[Leslie S Zun](#), MD*[†], [Douglas N Blume](#)*, [Joseph Lester](#)*, [Giles Simpson](#), MD*, [Lavonne Downey](#), PhD*

Received 11 October 2002; accepted 23 May 2003.

Abstract

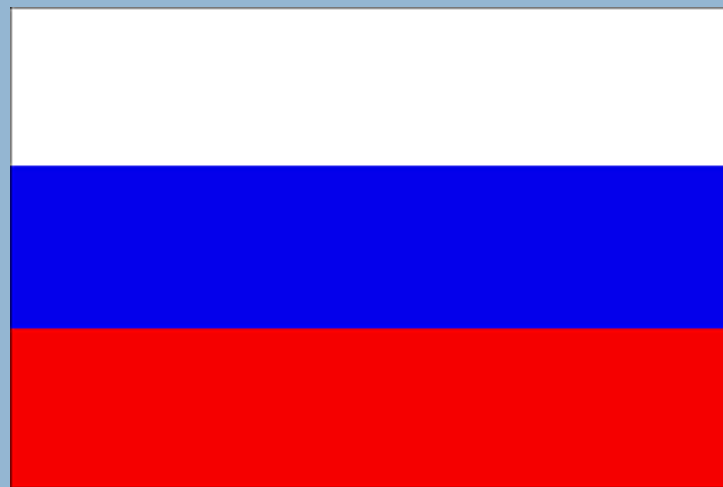
A large amount of EM information can be found on the Internet, but the accuracy of this information has not been determined. This study compares the "gold standards" of EM information on four common emergencies with top healthcare web sites. The study also examines the relationship of web sites' credentials and certification on content. Checklists were developed for four emergency medical topics: influenza, febrile child, chest pain, and stroke from the "gold standards" promoted by the American Stroke Association, the American Heart Association, the National Heart, Lung and Blood Institute, and the American College of Emergency Physicians. Information found at the 20 most visited health information web sites were compared with the "gold standards." Completeness of the information, certification, and credentials were used to judge the accuracy of the web sites. Inaccurate or incorrect information from these web sites were noted. Correlations between the site's credentials and its content were also measured. This study, conducted from January 18, 2002, to January 31, 2002, excluded eight of the top 20 health web sites because they did not cater to the lay public. MEDLINEplus was the most complete web site with 74.8% of the items noted contained in the web site; [MayoClinic.com](#) had 54.5% and Medscape had 50.9%. Half of the web sites fell between 35% and 50%, including WebMD at 46.9%, IntelliHealth at 45.5%, HealthWorld Online at 44.8%, Yahoo! Health at 41.3%, [AllHealth.com](#) at 40.6%, and [Health.excite.com](#) at 36.4%. [Healthcentral.com](#) at 35%, [Drkoop.com](#) at 35%, and AskDrWeil at 26.8% were the bottom three sites. Information on stroke was the most complete overall in 11 of 12 web sites. Four web sites contained questionable or concerning information. No correlation was found between possession of certification and the completeness of content (Pearson correlation -0.264 with a two-tailed significance of .406). Despite recent efforts to improve web site content through certification, few web sites contained a significant amount of EM information on all four topics investigated. In fact, some of the information provided on these health information web sites has the potential to be dangerous. Thus, most web sites are not good sources of reference for the public to find out what to do in the case of a medical emergency.

Keywords: [Emergency](#), [Internet](#), [accuracy](#)

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Paul Marino - The ICU book



The third edition of The ICU Book marks its 15m year as a fundamental sourcebook in critical care. This edition continues the original intent to provide a generic textbook that presents fundamental concepts and patient care practices that can be used in any intensive care unit, regardless of the specialty focus of the unit. Highly specialized areas, such as obstetrical emergencies, thermal injury, and neurocritical care, are left to more qualified authors and their specialty textbooks. Most of the chapters in this edition have been completely rewritten (including 198 new illustrations and 178 new tables), and there are two new chapters on infection control in the ICU (Chapter 3) and disorders of temperature regulation (Chapter 38). Most chapters also include a final section (called A Final Word) that contains an important take-home message from the chapter. The references have been extensively updated, with emphasis on recent reviews and clinical practice guidelines. The ICU Book has been unique in that it reflects the voice of one author. This edition welcomes the voice of another, Dr. Kenneth Sutin, who added his expertise to the final 13 chapters of the book. Ken and I are old friends who share the same view of critical care medicine, and his contributions add a robust quality to the material without changing the basic personality of the work.

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[Закрытые повреждения живота](#) Романенко А.Е.

[Опыт проведения реинфузии у больных с политравмой при повреждении паренхиматозных органов.](#)

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- [Гельфанд Б.Р., Кириенко П.А., и др. "Анестезиология и интенсивная терапия". \(2003\) \(открывается в новом окне\)](#)
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 - [Марино П.Л. "Интенсивная терапия".](#)
 - [Морган Дж.Э "Клиническая анестезиология" \(три тома\).](#)
- [Моше Шайн "Здравый смысл в неотложной абдоминальной хирургии" \(2003г\)\(2,60Mb\)](#)
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- [Чепкий Л.П., Новицька-Усенко Л.В., Ткаченко Р.О. "Анестезіологія та інтенсивна терапія" \(2003\)\(12Mb\)\(укр.яз\).](#)
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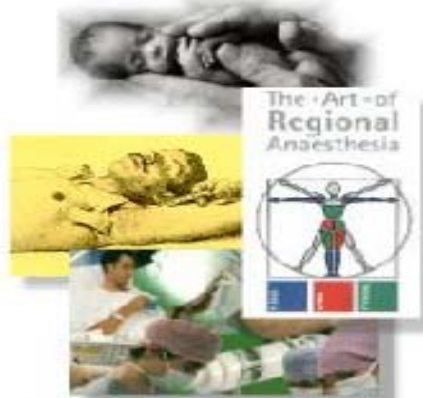
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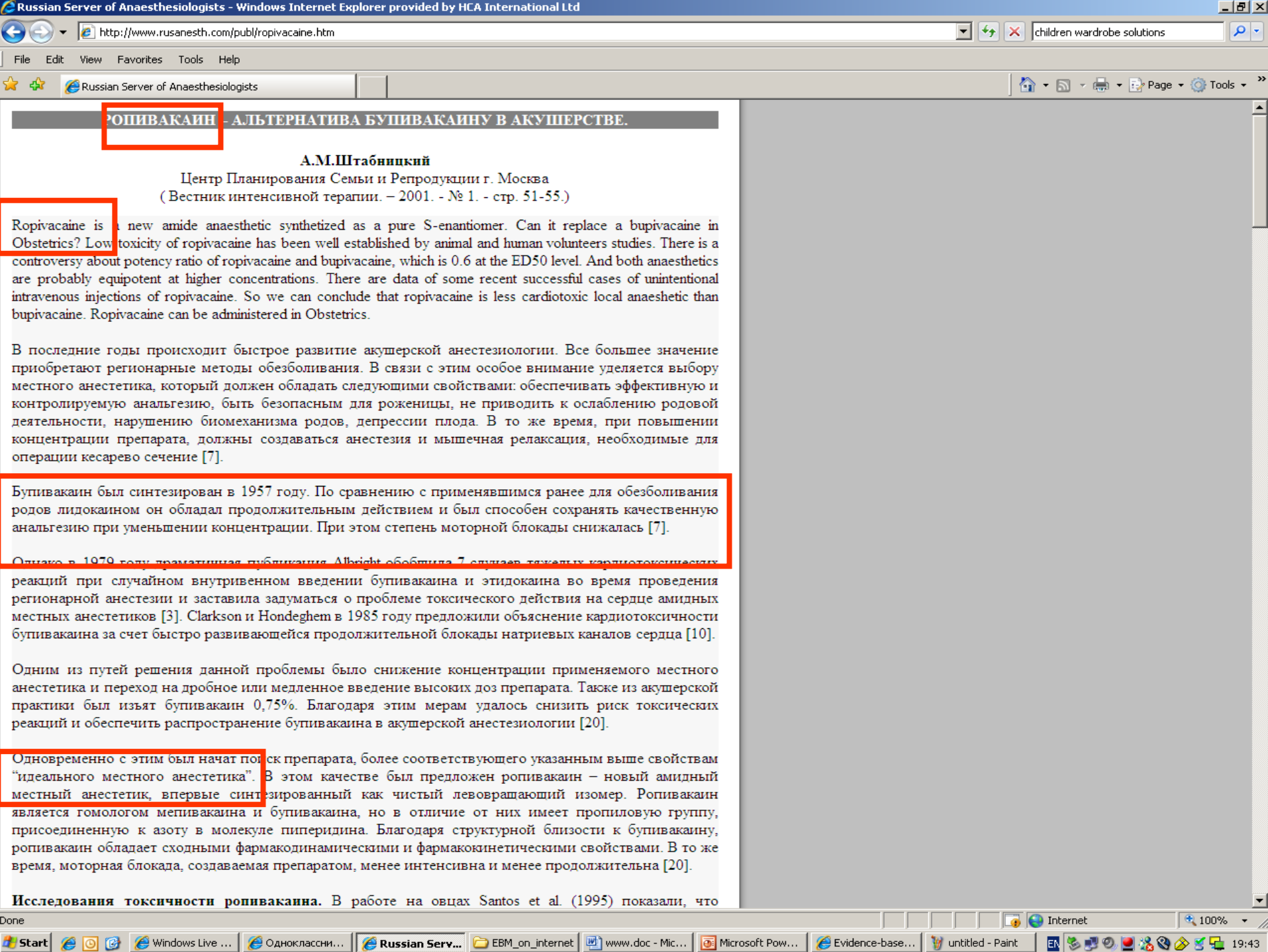
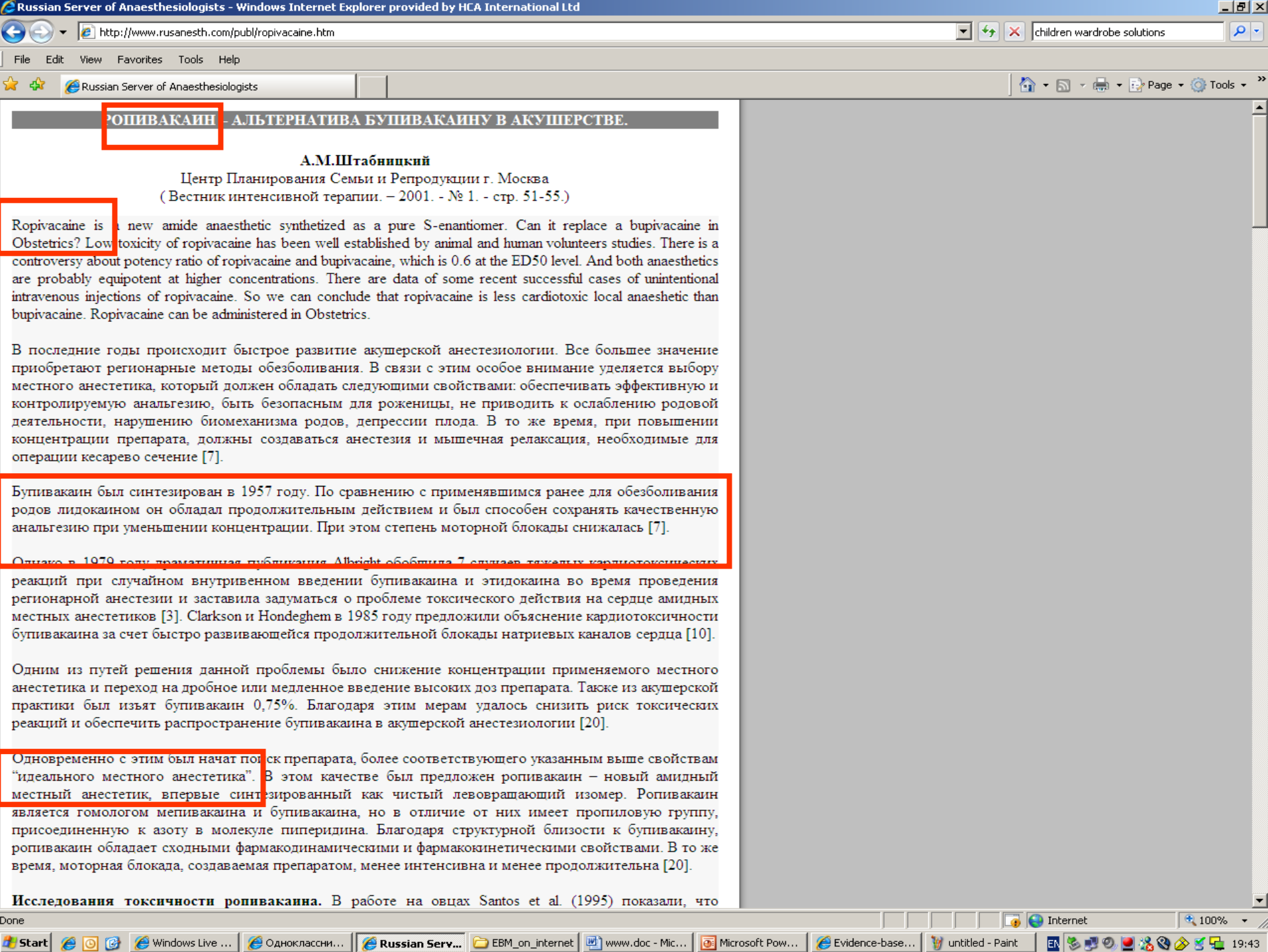
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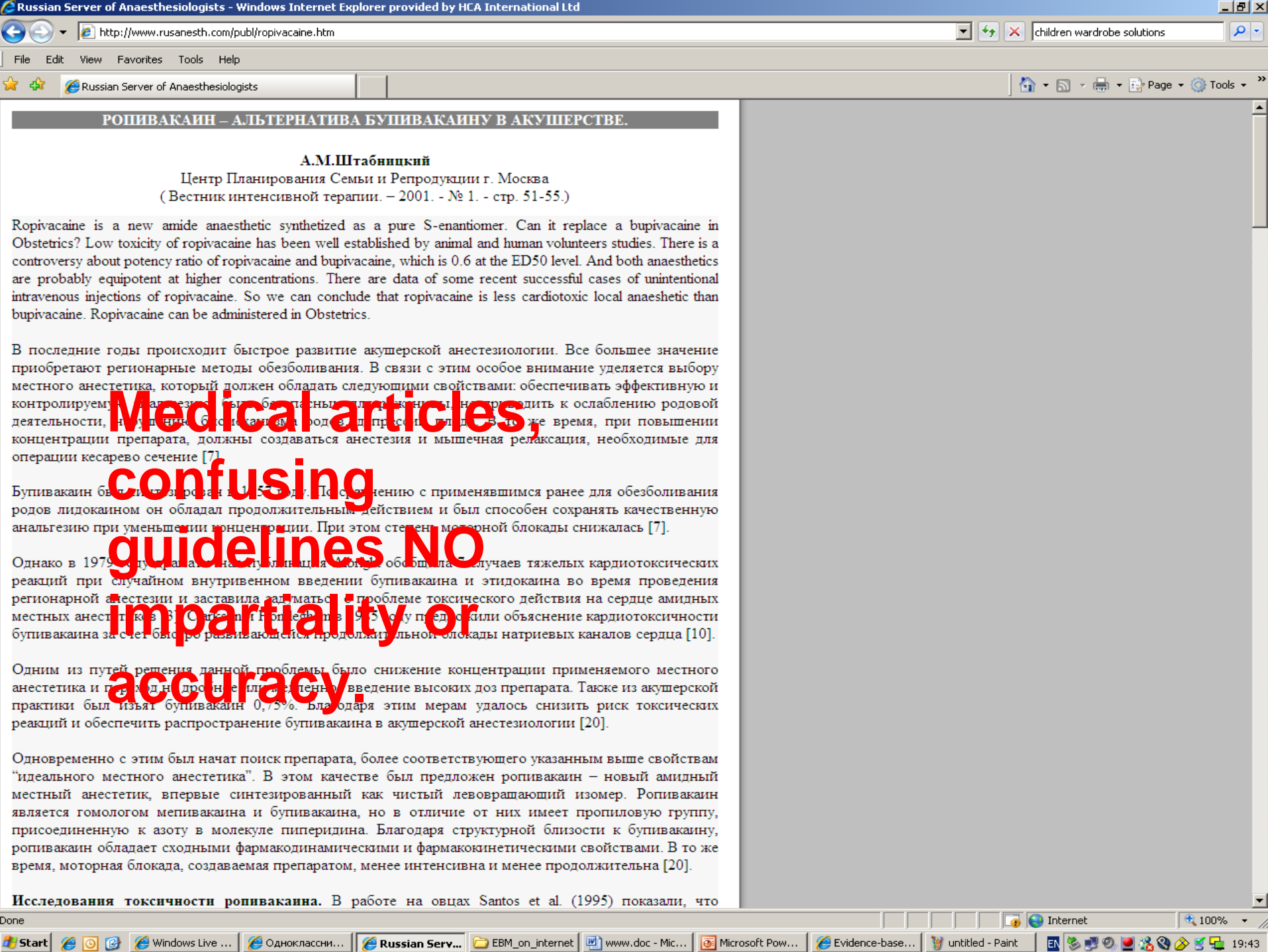
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Как изменилась ваша зарплата после перехода на новую систему оплаты труда

- ☐ Увеличилась
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ФЕДЕРАЦИЯ АНЕСТЕЗИОЛОГОВ И РЕАНИМАТОЛОГОВ РОССИИ

КРАСНОЯРСКОЕ КРАЕВОЕ РЕГИОНАЛЬНОЕ ОТДЕЛЕНИЕ

И
ПРОКН

ПРОТОКОЛ ВЕДЕНИЯ БОЛЬНЫХ

ДИАГНОСТИКА И ИНТЕНСИВНАЯ ТЕРАПИЯ СИНДРОМА ОСТРОГО ПОВРЕЖДЕНИЯ ЛЕГКИХ И ОСТРОГО РЕСПИРАТОРНОГО ДИСТРЕСС-СИНДРОМА

Исправленная и переработанная редакция для обсуждения на II-м Международном конгрессе по респираторной поддержке

(по решению Девятого съезда Федерации анестезиологов и реаниматологов России)

18-20 августа 2005 года

г. Красноярск

Данный проект подготовлен Красноярским краевым региональным отделением Федерации анестезиологов и реаниматологов России:

Грицан Алексей Иванович – д.м.н., проректор по последипломному образованию ГОУ ВПО КрасГМА Росздрава, профессор кафедры анестезиологии и реаниматологии №2 ФПК и ППС

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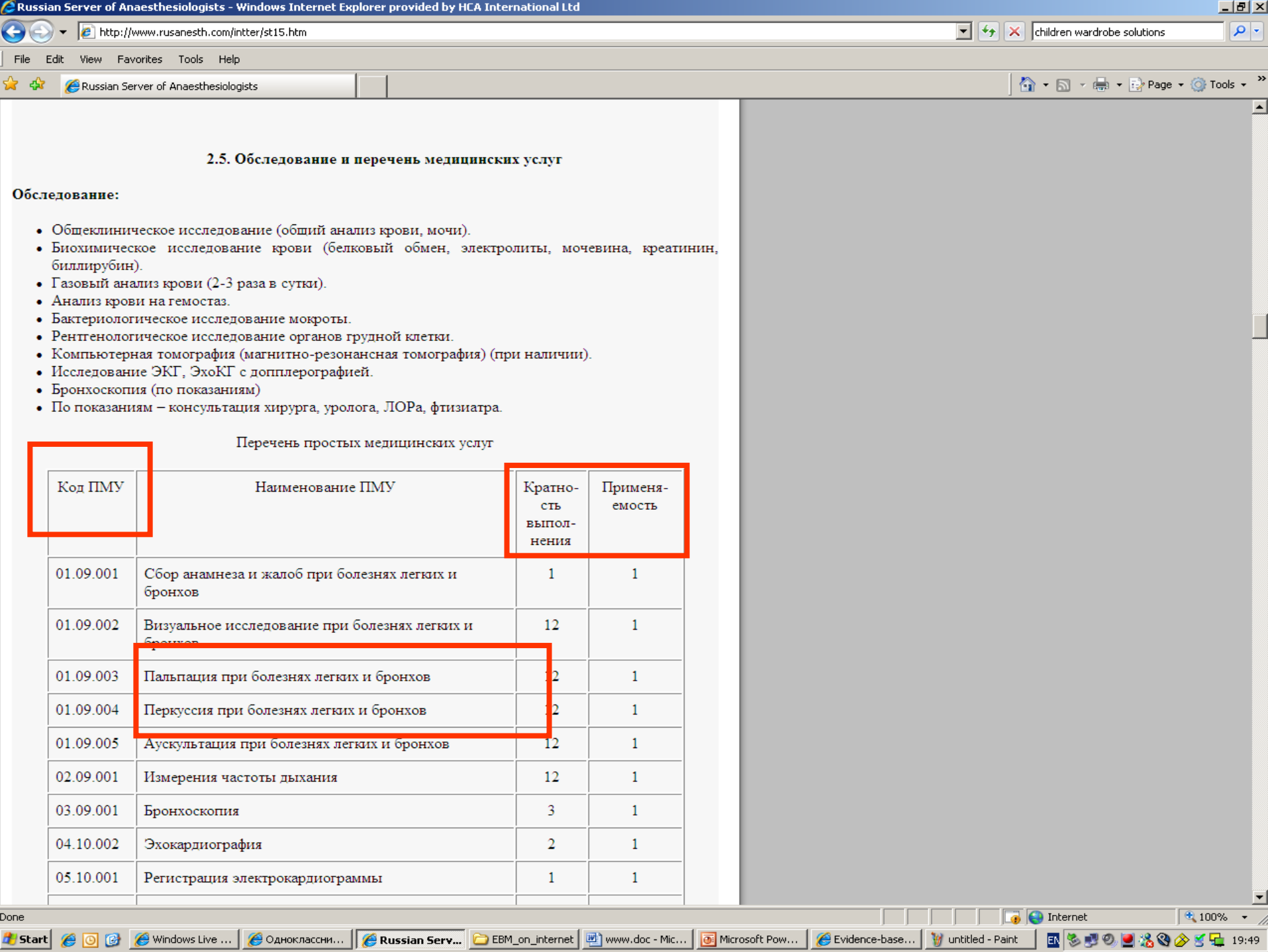
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Введение

Синдром острого повреждения легких (СОПЛ) является постоянным спутником любой острой хирургической и соматической патологии и во многом определяет течение и исходы при жизнеугрожающих состояниях, так как летальность при тяжелых формах острого респираторного дистресс-синдрома (ОРДС) составляет более 50%.

В то же время следует признать, что в Российской Федерации нет единых подходов по определению понятия, диагностике и интенсивной терапии СПОЛОРДС.

Протокол ведения больных «Диагностика и интенсивная терапия синдрома острого повреждения



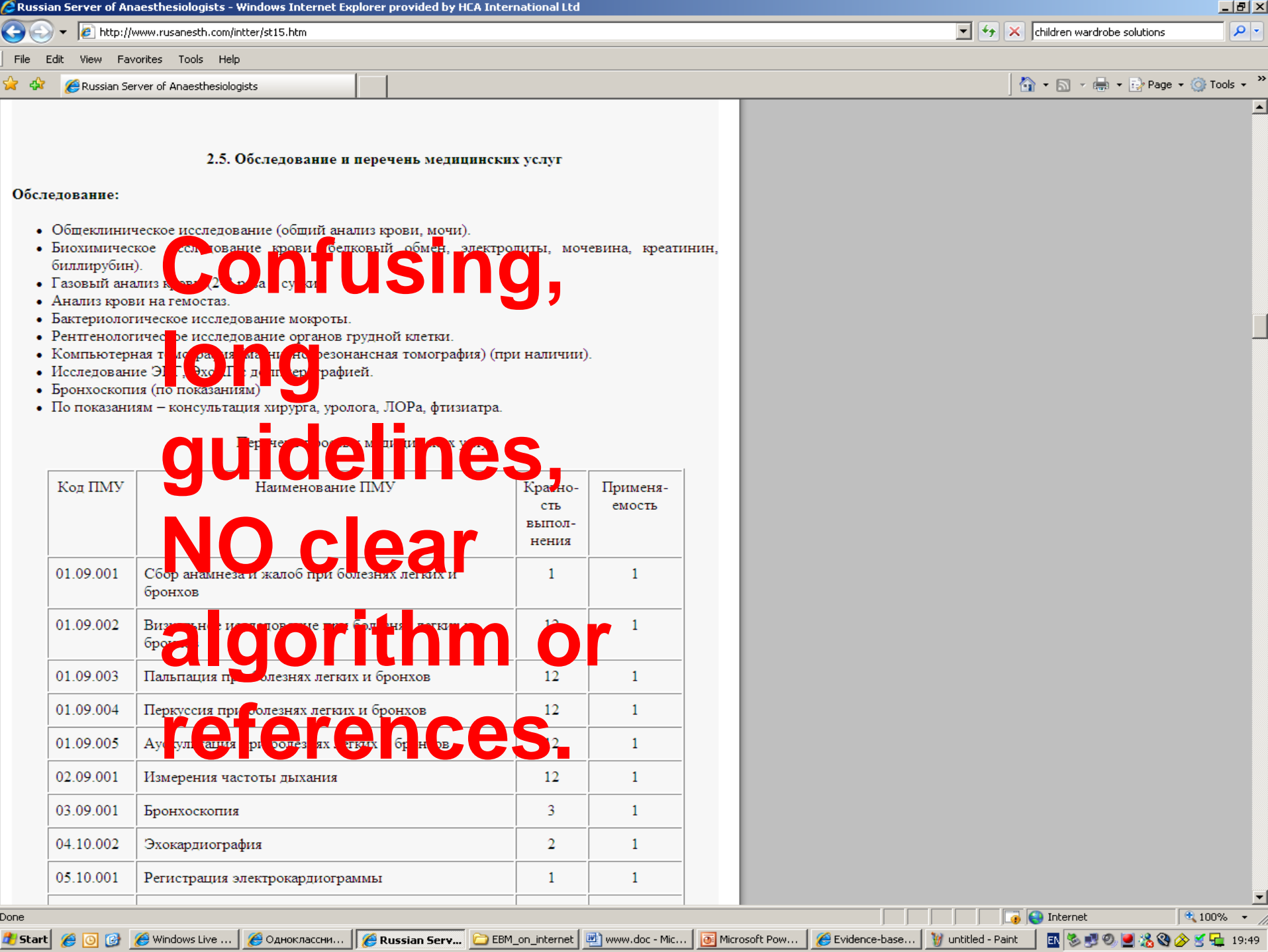
2.5. Обследование и перечень медицинских услуг

Обследование:

- Общеклиническое исследование (общий анализ крови, мочи).
- Биохимическое исследование крови (белковый обмен, электролиты, мочеви́на, креатинин, билирубин).
- Газовый анализ крови (2-3 раза в сутки).
- Анализ крови на гемостаз.
- Бактериологическое исследование мокроты.
- Рентгенологическое исследование органов грудной клетки.
- Компьютерная томография (магнитно-резонансная томография) (при наличии).
- Исследование ЭКГ, ЭхоКГ с доплерографией.
- Бронхоскопия (по показаниям)
- По показаниям – консультация хирурга, уролога, ЛОРа, фтизиатра.

Перечень простых медицинских услуг

Код ПМУ	Наименование ПМУ	Кратность выполнения	Применяемость
01.09.001	Сбор анамнеза и жалоб при болезнях легких и бронхов	1	1
01.09.002	Визуальное исследование при болезнях легких и бронхов	12	1
01.09.003	Пальпация при болезнях легких и бронхов	12	1
01.09.004	Перкуссия при болезнях легких и бронхов	12	1
01.09.005	Аускультация при болезнях легких и бронхов	12	1
02.09.001	Измерения частоты дыхания	12	1
03.09.001	Бронхоскопия	3	1
04.10.002	Эхокардиография	2	1
05.10.001	Регистрация электрокардиограммы	1	1



2.5. Обследование и перечень медицинских услуг

Обследование:

- Общеклиническое исследование (общий анализ крови, мочи).
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- Компьютерная томография (магнитно-резонансная томография) (при наличии).
- Исследование ЭКГ, ЭхоКГ, доплерография.
- Бронхоскопия (по показаниям).
- По показаниям – консультация хирурга, уролога, ЛОРа, фтизиатра.

Перечень медицинских услуг

Код ПМУ	Наименование ПМУ	Кратность выполнения	Применяемость
01.09.001	Сбор анамнеза и жалоб при болезнях легких и бронхов	1	1
01.09.002	Визуальное исследование при болезнях легких и бронхов	12	1
01.09.003	Пальпация при болезнях легких и бронхов	12	1
01.09.004	Перкуссия при болезнях легких и бронхов	12	1
01.09.005	Аускультация при болезнях легких и бронхов	12	1
02.09.001	Измерения частоты дыхания	12	1
03.09.001	Бронхоскопия	3	1
04.10.002	Эхокардиография	2	1
05.10.001	Регистрация электрокардиограммы	1	1

Приклад англійського керівництва

LONDON BRIDGE HOSPITAL

DEPARTMENT: Day Surgery Unit - Main Building and St Olaf House.

TITLE OF POLICY: Operational Policy

EFFECTIVE DATE: 01.09.2004

POLICY NUMBER:E.DS.25.01

VERSION DATE: 01.10.05

REPLACES POLICY:E.TH.25.02

APPROVED BY:



DATE: 01.10.05

AUTHORISED BY: Suzy Jones, Day Surgery Unit Manager

REVIEW DATE: 01.10.08

OVERVIEW

This operational policy covers the Day Surgery Unit which incorporates a 10 bedded ward area in the main hospital, a 15 bedded ward in St Olaf House, an Endoscopy and processing suite in St Olaf House and a Theatre, Anaesthetic Room and Recovery room in the main building.

9. STAFF

The overall unit establishment comprises:

- Day Surgery Manager
- Day Surgery Sister
- Ward Clerk/Administration assistant

Ward (St Oiaf House and Main building rotation)

- Sister
- Junior Sister x2
- Staff Nurse x8
- HCA x3

Endoscopy (St Olaf house primary location)

- Staff Nurse x3

19. EQUIPMENT SERVICING, EVALUATION AND TESTING

All electro-medical equipment is checked at regular intervals under service contract in liaison with the manufacturer and/or hospital engineering department.

A planned programme for routine maintenance is carried out during weekdays by a member of the Bio-Medical Team (G.E). Service and Maintenance records are retained by G.E.

All repairs, however minor, are carried out by qualified engineering staff only.

Any new/loan equipment delivered to the department is checked and tested by a member of the Bio-Medical team prior to use.

Prior to purchasing new equipment, an evaluation process involving staff, consultant users and engineering department is carried out.

Expensive items of equipment coming to the end of their life are replaced on a planned basis following trial and evaluation (by users) of replacement items.

Staff are inducted into use of new equipment by company representatives and a record retained by the DSU Manager in the office of the main building.

REFERENCES / RELATED POLICIES:

Day Surgery Admission Criteria

Day Surgery Admission Procedure

Day Surgery Preoperative Preparation and Transfer to Theatre Procedure

Day Surgery Transfer of Patients between Day Surgery and Endoscopy

Day Surgery Post operative Procedure

Day Surgery Transfer from Theatre to Ward

Day Surgery Discharge Criteria

Day Surgery Discharge Procedure

Day Surgery Theatre Procedures

Day Surgery Endoscopy Procedures.

Day Surgery Food Ordering Procedure

Day Surgery Trolley Cleaning Procedure

LBH Hospital Policy folder

LBH Infection Control policy folder

Theatre Policy and Procedures

LBH Fire Policy

www.modern.nhs.uk/theatreprogramme/preop

www.bads.co.uk

www.doh.gov.uk/daysurgery

? Чи можна це застосувати
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Іноземні керівництва

27 чоловік, колоті рани



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Розробка та реалізація
керівництв та протоколів

ОСНОВИ

- Визначення
 - Порівняння медичних керівництв та протоколів
 - Проблеми доказової медицини, які стосуються анестезіології
 - Надійні джерела
-

http://en.wikipedia.org/wiki/Medical_guideline

- **Медичні керівництва** це документи, які мають за ціль керувати рішеннями та критеріями у визначенні діагнозу, ведення хворого та лікування у різних областях медицини.
 - Використовується тисячі років.
 - Первісні підходи - засновані на традиціях, чи авторстві
 - Сучасні медичні керівництва основані на доказах та принципах доказової медицини.
 - Звичайно включають до себе об'єднанні положення та рішення практичних питань.
-

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- Медичні керівництва це документи, які мають за ціль керувати рішеннями та критеріями у визначенні діагнозу, ведення хворого та лікування у різних областях медицини.
 - Використовується тисячі років.
 - Первісні підходи - засновані на традиціях, чи авторстві
 - Сучасні медичні керівництва основані на доказах та принципах доказової медицини.
 - Звичайно включають до себе об'єднанні положення та рішення практичних питань.
-

Визначення практичних керівництв

Zarin, 1993

- Практичне керівництво направлено на визначення стратегії ведення пацієнта. Та розроблені для надання допомоги в визначенні клінічних рішень (Zarin, 1993).
 - Ефективне лікування і спектр відповідного лікування доступні для пацієнтів (Zarin, 1993).
 - Систематично розвинені положення медичної практики допомагають лікарю чи пацієнту у прийнятті рішень про належну медичну допомогу по конкретних захворюваннях (United Healthcare, 1994).
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-

http://en.wikipedia.org/wiki/Medical_guideline

1. Виявлення, узагальнення та оцінка кращих доказів та найбільш сучасної інформації о діагнозі, лікуванні включаючи дози ліків,
 - Ризк/одужання
 - Ціна-якість
 2. Деякі керівні принципи містять рішення або алгоритми розрахунку, яких слід дотримуватися .
Таким чином, вони об'єднують у собі визначенні точки прийняття рішень і відповідні напрями діяльності з клінічними судженнями й досвідом практиків
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 - Ризк/одужання
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-

Чи можна це застосувати в Україні ?

- Багато керівництв містять альтернативні рішення та допомагають у провадженні лікування
-

Компоненти моделі:

1 ціна-якість

- Ґсновується на економічному аналізі
 - Порівнює ціну та ефект від застосування
 - Зазвичай МЦЯ (модель ціна-якість) виражається в співвідношенні, де в знаменнику поліпшення здоров'я і в чисельнику стоїть здоров'я населення. Найбільш часто використовувалися результати міри якості життя з поправкою на роки (QALY).
-

Компоненти аналізу: 2 - ризк/одуження, (risk/benefit)

- Порівняння ризку при різних ситуаціях з користю
-

Risk/benefit analysis of activated protein C in patients with intra-abdominal sepsis

E Borthwick, D Stewart, E Mackle and C McAllister

Craigavon Area Hospital, Co. Armagh, UK

from 27th International Symposium on Intensive Care and Emergency Medicine
Brussels, Belgium. 27–30 March 2007

Critical Care 2007, **11**(Suppl 2):P61 doi:10.1186/cc5221

Published: 22 March 2007

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Introduction and objective

To establish whether activated protein C (APC) is safe in surgical patients with intra-abdominal sepsis (IAS). APC has been used in the treatment of IAS in our hospital since 2003. Fears persist regarding the potential for clinically significant bleeding in this surgical subgroup of patients.

Methods

Forty-four patients with IAS received APC as a standardized regime between March 2003 and August 2006. A retrospective medical and ICU chart review was undertaken. Data collected included clinically significant bleeding episodes and mortality. Descriptive subgroup analysis of unexpected non-survivors (died in the ICU with APACHE II (APACHE II) > 50%) and unexpected survivors (survived to ICU discharge with APACHE II predicted mortality > 50%) was performed as a small patient numbers was inappropriate.

Протокол \Leftrightarrow Алгоритм

- Медичні протоколи це (локальні) застосування керівництв
-

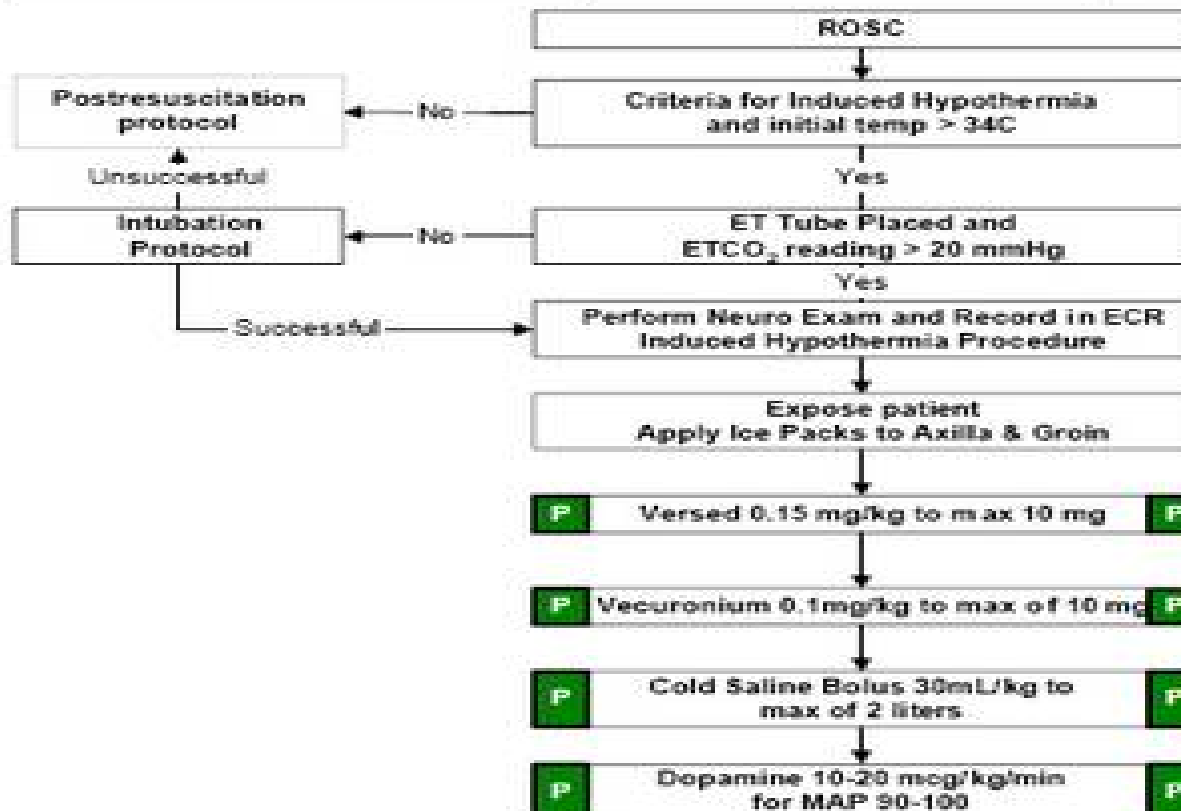
Протокол (алгоритм)



Induced Hypothermia



History: <ul style="list-style-type: none"> Non-Traumatic Cardiac arrest 	Signs/Symptoms: <ul style="list-style-type: none"> Return of pulse 	Differential: <ul style="list-style-type: none"> Continue to address specific differentials associated with the original dysrhythmia
--	--	--



Legend		
	EMT	
I	EMT- I	I
P	EMT- P	P
M	MC Order	M

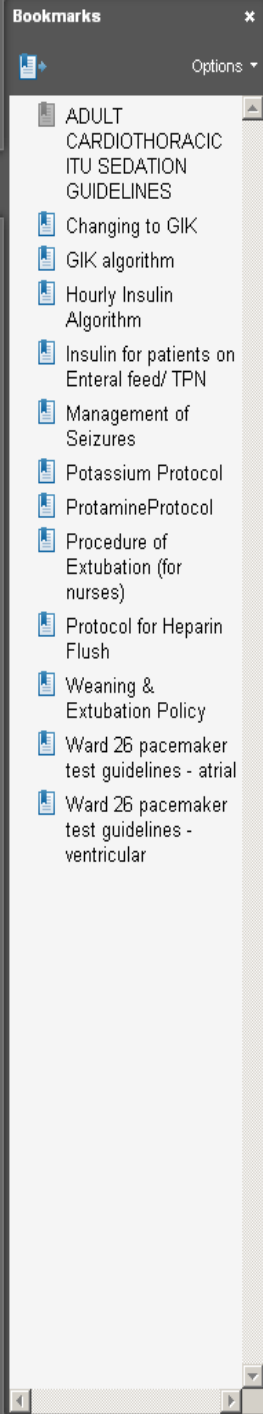
AT ANY TIME
Loss of Spontaneous Circulation:
Discontinue cooling and go to appropriate protocol

Monitor ETCO₂ Target 40 mmHg
DO NOT
HYPERVENTILATE

Abstract *Abstracted from the Journal of the American Academy of Child and Adolescent Psychiatry, 35:10, 1996, pp 1201-1210.*



Приклад керівництва



Newcastle upon Tyne Group of Hospitals

ADULT CARDIOTHORACIC ITU SEDATION GUIDELINES

(American College of Critical Care Medicine (ACCM) and the Society of Critical Care Medicine (SCCM) recommendation)

RATING SYSTEM FOR RECOMMENDATION

Classification of information.

- (a) Randomised controlled prospective trials
- (b) Non-randomised trials, concurrent or cohort investigations
- (c) Peer review articles, editorials or substantiated case reports.
- (d) Non-peer review articles such textbooks.

Level 1 recommendation

Convincingly justified on scientific evidence alone

Level 2 recommendation

Reasonably justified scientific evidence and strongly supported by expert critical care opinion

Level 3 recommendation

Scientific evidence is lacking but widely supported by available data and expert critical care opinion.

ANALGESIC AGENTS RECOMMENDED FOR ROUTINE USE IN THE INTENSIVE CARE

Recommendation 1—(Level 2 evidence): Morphine Sulfate is the preferred analgesic agent for critically ill patients.

Morphine sulfate is the most frequently used intravenous analgesic agent in the ICU, mainly because of low cost, potency, analgesic efficacy, and euphoric effect. Morphine has a half-life of 1.5 to 2 hrs after intravenous administration in normal subjects. In the ICU patient, distribution volume and protein binding may be abnormal, resulting in either an exaggerated or diminished response

Recommendation 2—(Level 2 evidence): Fentanyl or alfentanil are the preferred analgesic agents for critically ill patients with hemodynamic instability

Intravenous infusions have a relatively short half-life of 30 to 60 mins due to rapid redistribution to peripheral compartments. However, prolonged administration leads to accumulation in peripheral compartments and can result in a progressive increase in half-life to 9 to 16 hrs

SEDATIVE AGENTS RECOMMENDED FOR USE IN ITU

Sedation (calming or allaying excitement) is indicated in the ICU setting for the primary treatment of anxiety (psycho-physiologic response to the anticipation of real or imagined danger) and agitation (excitement accompanied by motor restlessness). The prototype intravenous sedative agent is diazepam. Intravenous diazepam is not recommended for routine use in the ICU for the following reasons:

- a) pain and thrombophlebitis are common when administered by peripheral vein injection;
- b) a scheduled intermittent dosing regimen may lead to excessive sedation unless an objective monitor of the level of sedation is utilized before each dose

SEDATIVE AGENTS RECOMMENDED FOR ROUTINE USE IN THE INTENSIVE CARE

Recommendation 3—(Level 2 evidence): Midazolam and Propofol are the preferred agents for the Short-Term (less than 24 Hrs) treatment of anxiety in the critically ill adult.

The greater cost of these drugs is balanced by the rapidity with which their pharmacological effects

A Constraint-based Approach to Medical Guidelines and Protocols

Arjen Hommersom and Perry Groot and Peter Lucas¹
Mar Marcos and Begoña Martínez-Salvador²

Abstract. Medical guidelines and protocols are documents aimed at improving the quality of medical care by offering support in medical decision making in the form of management recommendations based on scientific evidence. Whereas medical guidelines are intended for nation-wide use, and thus omit medical management details that may differ among hospitals, medical protocols are aimed at local use within hospitals and, therefore, include detailed information. Although a medical guideline and protocol concerning the management of a particular disorder are related to each other, one question is to what extent they are different. Formal methods are applied to shed light on this issue. A Dutch medical guideline regarding the treatment of breast cancer, and a Dutch protocol based on it, are taken as an example.

1 Introduction

Medical management is increasingly based on recommendations from the medical scientific community, summarised in medical

and optimal. In the research described in this document we investigate whether this is really possible using a combination of informal and formal, in particular model checking, methods.

2 Medical Guidelines and Protocols

A medical guideline is an extensive document, developed by a working group of professionals involved in the management of the disorder covered by the guideline. By definition, a protocol is seen as a local version of a guideline, meant to be useful as a guide for daily clinical care. The need for a protocol in conjunction with a guideline is twofold: firstly, a guideline is an extensive document (e.g., the breast-cancer guideline is 121 pages in A4 format), and, therefore, it is not easy to locate relevant information; secondly, detailed recommendations about duration, dose, or actual procedure have been omitted from the guideline, and, thus, are added in a protocol to complement the information that is in the guideline. Hence, basically, a medical protocol is a summary of the most important sections that

On the origins and development of evidence-based medicine and medical decision making

A. S. Elstein

Department of Medical Education, University of Illinois at Chicago, Chicago, USA, e-mail: aelstein@uic.edu

Abstract. The aims of this paper are to identify the issues and forces that were the impetus for two recent developments in academic medicine, evidence-based medicine (EBM) and medical decision making (MDM); to make explicit their underlying similarities and differences; and to relate them to the fates of these innovations. Both developments respond to concerns about practice variation; the rapid growth of medical technology, leading to a proliferation of diagnostic and treatment options; the patient empowerment movement; and psychological research that raised questions about the quality of human judgment and decision making. Their commonalities include: use of Bayesian principles in diagnostic reasoning, and the common structure embedded in an answerable clinical question and a decision tree. Major differences include: emphasis on knowledge or judgment as the funda-

based medicine (EBM) [5, 6] and medical decision making (MDM) [7, 8]. In the 1980s and '90s, both communities published extensively to illustrate and advocate these approaches [e.g., 9–13]. Both emphasize a quantitative approach to provide guidance to clinical decision makers and they have common conceptual foundations.

Despite these similarities, the response of the academic medical community has been quite different. EBM has become a major curricular movement within academic medicine while MDM has remained the interest of a relatively small scholarly community. Its core technique, decision analysis (DA), is used primarily by health policy analysts. This paper explores why this has happened. It has three goals:

1. To identify the problems in clinical practice that provided the impetus for developing both EBM and MDM.

Анестезія та доказова медицина

- NSEPOD
 - “Чому помирають матері” доклад
 - Токсичність Бупівакаїну та Інтраліпід
 - Труднощі у лікуванні повітряних шляхів
 - Клінічна криза
-

Українська модель

- Лікування засновано на матеріальних можливостях пацієнта?
 - Не наша робота вирішувати скільки коштує лікування
 - Дилема
-

Українська модель

- Лікування засновано на матеріальних можливостях пацієнта?
 - Не наша робота вирішувати скільки коштує лікування
 - Дилема
-



Current opinion

Medical Practice Guidelines

Separating science from economics

Silvia G. Priori, (Chairman, ESC Committee for Practice Guidelines 2002–2004)*, Werner Klein, (Chairman, ESC Committee for Practice Guidelines 2000–2002), Jean-Pierre Bassand, (President, European Society of Cardiology 2002–2004)

Received 16 June 2003; accepted 17 July 2003

Introduction

Over the past twenty years, practice guidelines have become an increasingly popular tool for synthesis of clinical information.

The objectives of guidelines are to enhance the appropriateness of practice, improve quality of cardiovascular care, lead to better patient outcomes, improve

'seems logical', comes from the assumption made in the seventies and in the eighties that reducing premature ventricular contractions would lower arrhythmic deaths. To our surprise, we learnt from the Cardiac Arrhythmias Suppression Trial (CAST), that drugs highly 'effective' in reducing premature ventricular beats actually *increased* patient mortality due to *proarrhythmia*.³ There are of course many more examples of how carefully collected

Українська модель ?

- Лікування засновано на матеріальних можливостях пацієнта?
 - Не наша робота вирішувати скільки коштує лікування
 - Дилема
-

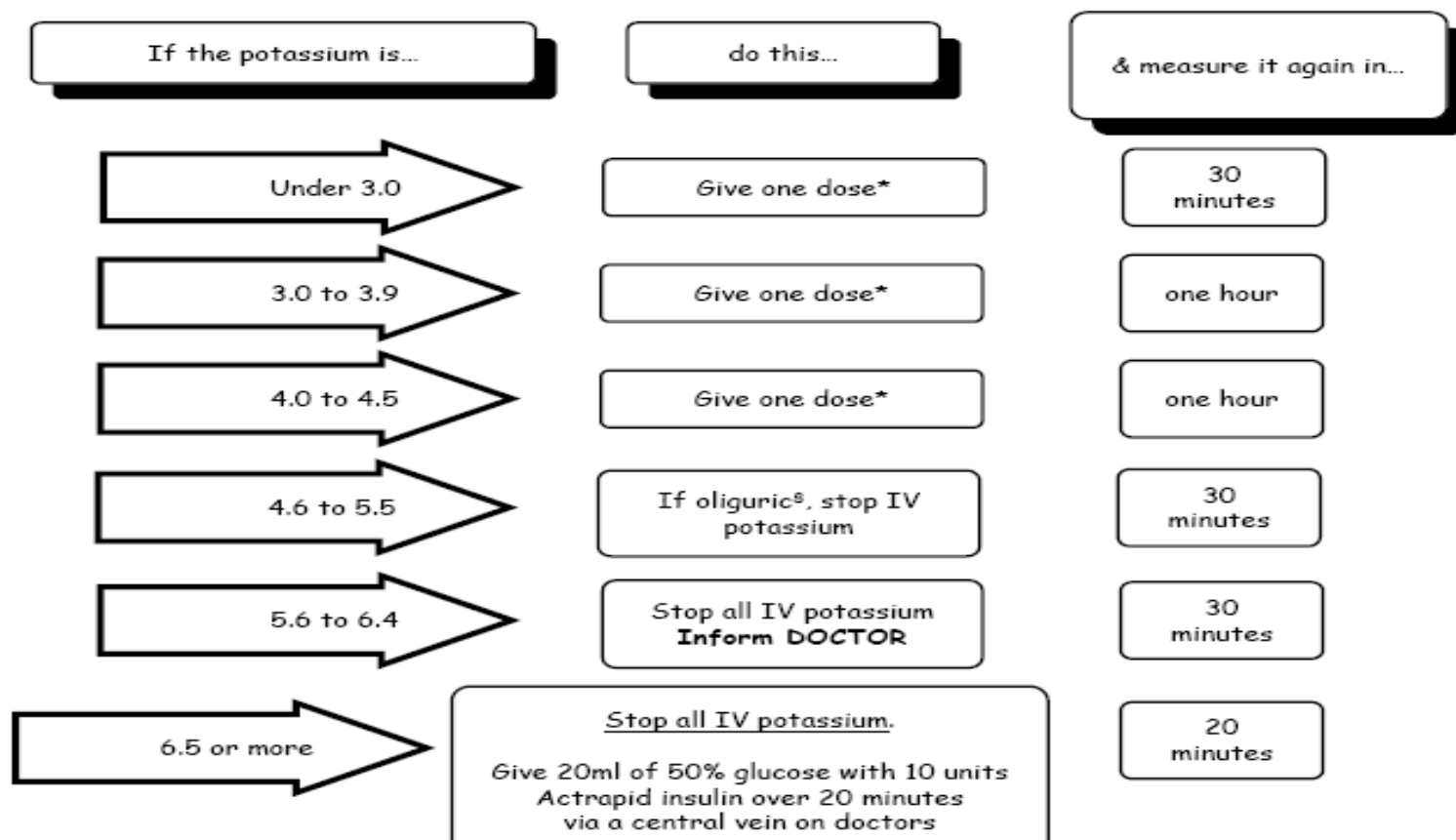
Іноземні керівництва/протоколи

Застосування в Україні

Приклад застосування протоколу

Potassium Protocol

Use this as a guide to how to give potassium to patients in the ITU.



Приклади **не** - застосування протоколів В Україні

Technology Appraisal Guidance - No. 49



*National Institute for
Clinical Excellence*

Guidance on
the use of
ultrasound
locating devices
for placing central
venous catheters

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вступ

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"75 years advancing patient safety"



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- AAGBI LINKMAN CONFERENCE 2009 - BT Convention Centre, Liverpool. 22nd September 2009 - Linkmen please login to the [Linkman Portal](#) for more information and to register.
- Propofol - A statement from the Association of Anaesthetists of Great Britain & Ireland (AAGBI) [More Information](#)
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Read the Safety and Human Factors virtual issue online today [MORE INFO](#)



The AAGBI produces guidelines on issues affecting anaesthetists or anaesthesia -



Care of the critically ill child in Irish Hospitals (2005) (An Irish Standing Committee Publication)

Other Irish Standing Committee Publications



Catastrophes in Anaesthetic Practice (2005) (Review date 2010)



Checking anaesthetic equipment 3 (2004) (being reviewed)

Checklist for anaesthetic equipment (2004) A4 Laminated Sheet (being reviewed)



Consent for Anaesthesia (2006) (Review date 2011)

Consultant trainee relationships – a guide for consultants (2001)
(Review date 2010) **WEBSITE ONLY**



Contract and Job Planning for Consultant Anaesthetists. (2005)



Controlled Drugs in Perioperative Care (2006)

Additional Notes for practitioners in the Republic of Ireland from The Irish Standing Committee.

www.aagbi.org/publications/guidelines.htm



AAGBI SAFETY GUIDELINE

Suspected Anaphylactic Reactions

Associated with Anaesthesia

4

www.aagbi.org/publications/guidelines.htm



**Recommendations for the Safe Transfer of
Patients with Brain Injury**

2006

Published by
The Association of Anaesthetists of Great Britain and Ireland,
21 Portland Place, London W1B 1PY
Telephone: 020 7631 1650 Fax: 020 7631 4352
www.aagbi.org

May 2006

http://www.nice.org.uk/




Welcome to the National Institute for Health and Clinical Excellence

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

NHS Evidence

NHS Evidence helps you find, access, and use high quality clinical information



Consultations

- ▶ Donor breast milk banks (draft guideline consultation)
- ▶ School-based interventions to prevent smoking: consultation on the draft guidance
- ▶ Hypertensive disorders during pregnancy: draft guideline consultation
- ▶ Male lower urinary tract symptoms (LUTS): guideline consultation

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- ▶ Renal cell carcinoma
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[Patient safety solutions pilot](#)

Ultrasound-guided regional nerve block



Guidance issued Number: **IPG285**

Summary

The National Institute for Health and Clinical Excellence (NICE) has issued full guidance to the NHS in England, Wales, Scotland and Northern Ireland on ultrasound-guided regional nerve block.

Description

There are a number of conditions for which regional anaesthesia to allow surgery is required for a specific part of the body. This technique aims to provide accurate placement of local anaesthetic by using ultrasound guidance to position needles that deliver the local anaesthetic in the correct place next to the nerves.

Details

Arrangement:

Other (see guidance)

Topic area:

**Surgical procedures
Therapeutic procedures**

Specialty:

Neurology

Specialist advice has been sought from:

- **Association of Anaesthetists of Great Britain and Ireland**
- **Royal College of Anaesthetists**
- **British Pain Society**

Date notified to NICE:

27 October 2007

Provisional consultation date:

June 2008

IP Pub Date:

28 January 2009

Contact details:

For patient

NHS

*National Institute for
Health and Clinical Excellence*

Understanding NICE guidance

Information for people who use NHS services

**Using ultrasound guidance to
place a needle tip near a nerve to
give anaesthetic and/or pain relief**

For doctor

Ultrasound-guided regional nerve block

1. **Introduction**

- 10.10. Currents and voltages are not the same thing and are not easily confused. Currents are quantities measured in amperes (amps) and voltages are quantities measured in volts. Currents are the flow of electrons and voltages are the force that causes the flow. Currents are measured in amperes and voltages are measured in volts.
- 10.11. Currents and voltages are not the same thing and are not easily confused. Currents are quantities measured in amperes (amps) and voltages are quantities measured in volts. Currents are the flow of electrons and voltages are the force that causes the flow. Currents are measured in amperes and voltages are measured in volts.

2. The procedure
indications and our needs must match.

- [illegible]

Abstract

- [illegible]

patients did not show significant efficacy and safety outcomes from the published literature, that the committee considered aspects of the evidence sufficient to proceed. For more detailed information on the evidence, see the overview available at www.nice.org.uk/guides/cg160.

Abstract

- [illegible]

For more information, contact: www@hawaii.edu or 808-955-2222

© 2004 Blackwell Publishing Ltd, *Journal of Internal Medicine* 255: 103–110

- [illegible]

References

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[illegible]

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Methoden: Die Daten wurden über 24 Stunden und 240 Minuten mit einem 12-Kanal-PC aufgezeichnet. Die Daten wurden mit einem 12-Kanal-PC aufgezeichnet. Die Daten wurden mit einem 12-Kanal-PC aufgezeichnet.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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NHS

***National Institute for
Health and Clinical Excellence***

Quick reference guide

Issue date: May 2009

Low back pain

Early management of persistent non-specific
low back pain

http://www.bma.org.uk/health_promotion_ethics/health_developing_world/Evidencebasedhealthinformationon.jsp



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Free evidence-based health information

29 August 2007

July 2006

This information sheet is aimed primarily at health professionals in low and middle income countries and other areas where information for health workers is in short supply. The resources referred to below are peer-reviewed, evidence-based and available, free of charge, via the Internet.

Some publishers/websites provide free access to all users (some of these ask users to register, but without requiring a fee). Other schemes, such as HINARI (below), provide free access mainly to not for profit healthcare institutions, such as hospitals, health libraries, research organisations. (This usually covers all health staff working in them).

We refer here to resources in English, but many of the websites mentioned below include, or link to, material in other languages too.

[BIOMED Central](#) provides access to over 140 open access journals covering all areas of biology and medicine. It is an independent publishing house committed to providing immediate open access to peer-reviewed biomedical research. All original research articles published by BioMed Central are made freely and permanently accessible online immediately they are published. BioMed Central views open access to research as essential in order to ensure fast and efficient communication of research findings.

British National Formulary

The [BNF](#) provides healthcare professionals with practical information on the selection and clinical use of medicines (users are asked to register, but do not have to pay for access).

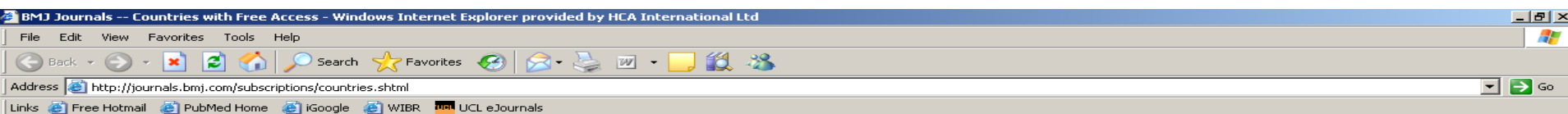
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The low income and low-middle income countries detailed below are entitled to FREE access to our sites. They include the 113 developing countries, areas and territories included in [the HINARI initiative](#). There is no need to subscribe to access the full text – countries in the list below will automatically qualify for free access.

To continue onto the full-text of our journals, please go to [BMJ Journals](#).

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Countries whose institutions are eligible for free access (GNP per capita \$1000-\$3000):

Algeria	Belarus	Belize
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<http://www.nda.ox.ac.uk/wfsa/>



World Anaesthesia — Online —



Advancing Anaesthesia Throughout the Developing World

Produced by World Anaesthesia (WA) & the World Federation of Societies of Anaesthesiologists ([WFSA](#)). Please feel free to copy any of the articles for teaching purposes - we only request that the source of the material is acknowledged.



The Glostavent
for anaesthetists in
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Update in Anaesthesia

An educational journal aimed at providing practical advice for those working in isolated or difficult environments.

News:

'Update in Anaesthesia' is now only published in Adobe PDF.

[Update 23](#) is now available in [PDF](#).

- [Update in Anaesthesia Issue Index](#) issues 1-19 only.
- [Update in Anaesthesia Section Index](#) (incomplete)
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World Anaesthesia

The newsletter of the WFSA, for the exchange of views & ideas on advancing the specialty of anaesthesia in the developing world.

[Volume 11, Issue 1](#), added August 2009.

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Educating, Training and Setting Standards in Anaesthesia,
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Anaesthesia is the largest single
hospital specialty in the NHS.
The College is the professional body
responsible for the specialty of
anaesthesia throughout the UK, and
ensures the quality of patient care
through the maintenance of
standards in anaesthesia, critical
care and pain management.



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Advisory Appointments Committees: Guidance for College Representatives
August 2006



Annual Report and Financial Statements of the College
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ANZCA and Faculty of Pain Medicine - Acute Pain Management: Scientific Evidence
Second Edition, June 2005



Bulletin
The bi-monthly Bulletin of the Royal College of Anaesthetists



Cardiopulmonary Resuscitation: Standards for clinical practice and training
October 2004



CCT in Anaesthetics I: General Principles
April 2009



CCT in Anaesthetics II: Competency Based Basic Level (ST Years 1 and 2) Training and Assessment
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CCT in Anaesthetics III: Competency Based Intermediate Level (Years 3 and 4) Training and Assessment
April 2009



CCT in Anaesthetics IV: Competency Based Higher and Advanced Level (Years 5, 6 and 7) Training and Assessment
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Fellowship of the Royal College of Anaesthetists

http://www.frca.co.uk/



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AnaesthesiaUK is an educational site with training resources for anaesthetic professionals. It provides interactive practice questions, journal abstracts and reference articles for the Primary FRCA, Final FRCA, Irish FCARCSI, European Diploma of Anaesthesiology, American Board examinations, and currently receives over 30,000 page views daily.



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e-Learning Anaesthesia
Integrated Anaesthesia Learning Portal

A peer reviewed web based education resource that follows the Anaesthesia curriculum, helping trainees prepare for the Primary Examination



Menu

- ☐ Project home
- ☐ More information
- ☐ Sample session
- ☐ Meet the team
- ☐ Register

Home

e-LA is a web-based educational resource produced by the Royal College of Anaesthetists in partnership with e-Learning for Healthcare (e-LfH).

Available for free to all UK anaesthetists practising in the NHS, e-LA delivers the knowledge and key concepts that underpin the anaesthetic curriculum and will help trainees prepare for the FRCA examination.

e-LA offers the following components:

- **e-Learning Sessions** – Over 1,000 knowledge and scenario based sessions covering the first two years of the anaesthetic curriculum. Each session takes around 20-30 minutes to complete.
- **e-Library** – free and direct access to thousands of full-text journal articles which have been cross-referenced and mapped to the anaesthetic curriculum
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Partners



The Royal College of Anaesthetists



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- ☐ Register

More information

Key elements of the anaesthesia curriculum are arranged into seven academic blocks of e-learning sessions designed to support clinical modules allocated in the first two years of anaesthetic training.

Each e-session lasts about 20 minutes.

To find out how e-learning complements existing teaching methods, view the [ITN Video](#)

Project structure

You can find out more about each module by rolling over the blocks below.

Block 1

Block 2

Block 3

Block 4

Block 5

Block 6

Block 7

Project structure details

Block 1

An introduction to clinical anaesthesia

Editors:

Iain Wilson - Exeter

Fred Roberts - Exeter

Tom Clutton-Brock - Birmingham

Partners



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Menu

- ☐ Project home
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More information

Key elements of the anaesthesia curriculum are arranged into seven academic blocks of e-learning sessions designed to support clinical modules allocated in the first two years of anaesthetic training.

Each e-session lasts about 20 minutes.

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Project structure

You can find out more about each module by rolling over the blocks below.

Block 1

Block 2

Block 3

Block 4

Block 5

Block 6

Block 7

Project structure details

Block 2

Consolidating basic clinical practice

Editors:

Keith Allman - Exeter

K-L Kong - Birmingham

Aidan O'Donnell - Livingston, West Lothian

David Murray - Middlesbrough

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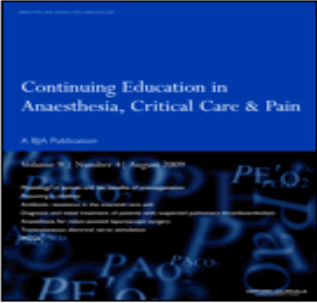
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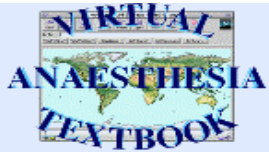
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<http://www.virtual-anaesthesia-textbook.com/vat/medline.html>



The Virtual Anaesthesia Textbook

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Many Universities and hospitals provide Medline access to their employees; check first.

Journals

[AJ Wright's ACCRI](#) Anaesthesia Resource provides a detailed list of anaesthesia journals and newsletters.

<http://www.white-clouds.com/iclc/cliej/cl7hu.htm>

Anesthesia Resources on the Internet

Qianli Hu
Anesthesia Library
SUNY Health Science Center at Brooklyn
450 Clarkson Ave., Box 6
Brooklyn, NY 11203
U.S.A.
hu@hscbklyn.edu

ABSTRACT. This article presents results of a search for Anesthesia resources on the Internet. It is useful to faculty, physicians, residents, medical students and librarians in this field. A comprehensive list like this saves time for other researchers. The article sums up the author's experience, provides useful information and makes a few suggestions for more efficient use of the resources available.

I. Introduction

This article presents the results of a search for Anesthesia resources on the Internet. Searching information on the Internet is time-consuming. The author would like to share his experience, provide useful information and make a few suggestions for more efficient use of the resources available. It is the author's hope that the information included in this article will be useful to faculty, physicians, residents, medical students and librarians in the field.

II. Search Methodology

Criteria used in search

The topics focused on in my search were: Neurosurgical Anesthesia, Pain Management, Ambulatory Anesthesia, Cardiac Anesthesia, Critical Care Medicine, Obstetric Anesthesia, and Pediatric Anesthesia.

In addition to the above topics, fellowships and scholarships, professional societies, associations and foundations, and employment were also included.

Databases used

V. Fellowships and Scholarships

SUNY at Buffalo. Anesthesiology.

<http://wings.buffalo.edu/academic/departments/medicine/anest/critcare.html>

This site lists two one-year fellowship positions. It links to the residency brochure, and the higher level is SUNYAB Anesthesiology homepage.

Scholarship Program. American Society of PeriAnesthesia Nurses.

<http://www.aspan.org/scholar.htm>

This site lists two \$1000 scholarships for postanesthesia, preanesthesia and ambulatory surgery nurses.

Respiratory Sciences Center, AHSC. Arizona.

<http://www.ahsc.arizona.edu/~cbittel/recfellows.html>

This site lists the Adult Pulmonary and Critical Care Medicine Fellowships. Fellowships of three years' duration provide clinical and research experiences.

Stanford University of Medicine. California.

<http://www.med.stanford.edu/school/anesthesia/fellowships.html>

This five-page homepage offers information on critical care medicine, cardiovascular anesthesia, obstetrical anesthesia, neurosurgical anesthesia, pain management, pharmacokinetics and pharmacodynamics, neurobiology of anesthesia and analgesia, anesthetics and adrenergic mechanisms, metabolism and toxicity of anesthetics, physical chemistry of anesthetic agents. It links to the Anesthesia, Stanford University of Medicine homepage.

VI. Professional Societies, Associations, and Foundations

American Society of Anesthesiologists (ASA).

<http://www.asahq.org>

This is a good homepage which provides much information, e.g. professional information, continuing education, related organizations, and placement. It links to education at home and abroad, other anesthesia societies, publications, anesthesia history, anesthesia software, etc. It also lists to top sites, such as Physicians' Online, Medical Society of Anesthesiologists, Critical Care resources, and the online version of the peer review journal Anesthesiology. On its employment page, it lists twenty-three links. In its mailing lists, it lists

SurgiNet Foundation.

<http://www.surginet.org/online/asmth.htm>

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HIGHLIGHTS



IRIN

Conflict, flooding pose health risks in the Philippines

7 September 2009 -- Battered by conflict and flooding, hundreds of thousands of people on the southern Philippines island of Mindanao have been displaced and face multiple health risks. In the current episode of our podcast, we focus on how WHO is working to respond to the enormous health challenges faced by many.

[Listen to the podcast](#)[More about the situation](#)

Supporting fair access to pandemic (H1N1) 2009 vaccine

4 September 2009 -- Though it is not yet ready for use, WHO is working to ensure that developing countries have access to the pandemic (H1N1) 2009 vaccine when it is available, says an article in the *WHO Bulletin*.

First doses are expected to be available to governments later this month.

[Read the article in the WHO Bulletin](#)

Pandemic (H1N1) 2009

[Preparing for the second wave](#)
28 August 2009

[Recommended use of antivirals](#)
21 August 2009

[Full coverage](#)

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Director-General and senior management

[Governance of WHO](#)
WHO Constitution, Executive Board and World Health Assembly

[Media centre](#)
News, events, fact sheets, multimedia and contacts

[International travel and health](#)
Publication on travel risks, precautions and vaccination requirements

[World Health Report](#)
Annual report on global public health and key statistics

WHO Regional Committee for South-East Asia



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<http://www.anaesthesiaconference.kiev.ua/ebmresurs.html>



Другий Британсько-Український Симпозіум

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**Association of Anaesthetists of Great
Britain&Ireland**

www.aagbl.org
www.aagbl.org/publications/guidelines.htm

**National Institute for Health and Clinical
Exellence**

www.nice.org.uk

British Medical Association

www.bma.org.uk
http://www.bma.org.uk/health_promotion_ethics/health_developing_world/Evidencebasedhealthinformationon.jsp

**National Institute of Health Research,
RDFunding**

<http://rdfunding.org.uk/>



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












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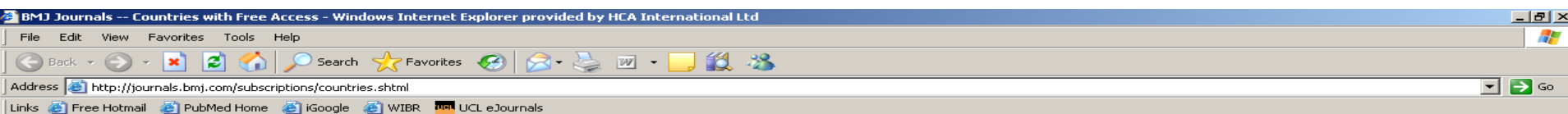
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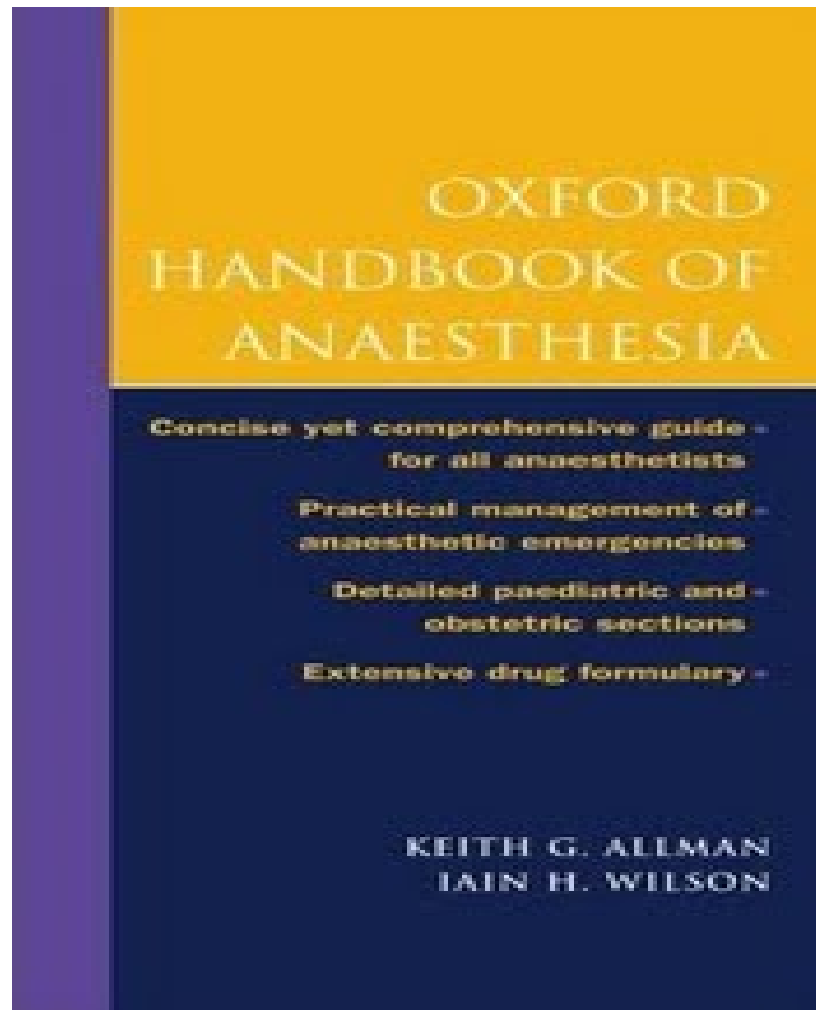
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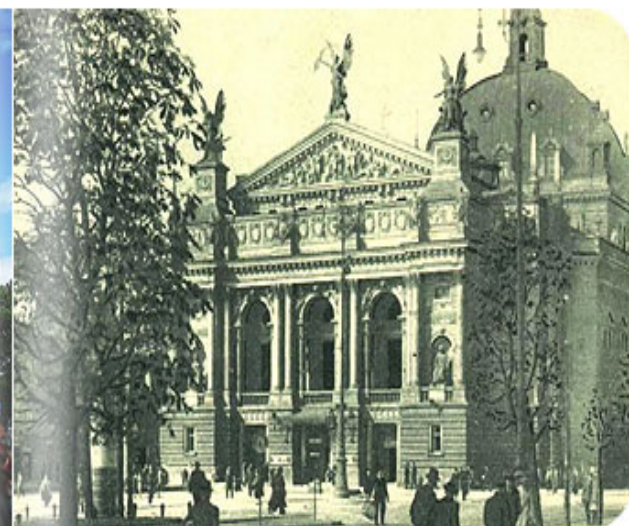
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Pain Medicine: Present and Future



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