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飛資得醫學資訊

2022/5/19

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Agenda

- 平台操作使用
- 管理端後台各項功能
- 重點說明使用統計篩選和下載報表功能
- 講解counter統計標準的定義，及前台操作所對應的統計數據變化說明
- Sushi金鑰之取得、使用方式，以及透過sushi協定下載之統計報表json格式解說
- Q&A

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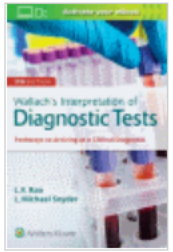
Books by Title - W

35 Books



Wallach's Interpretation of Diagnostic Tests: Pathways to Arriving at a Clinical Diagnosis (11th Edition)

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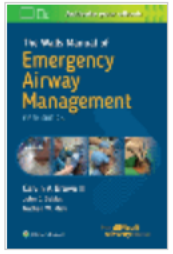

Walls Manual of Emergency Airway Management, The (5th Edition)

Brown, Calvin A.

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Psychology

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Bonica's Management of Pain (5th Edition)

Ballantyne,, Jane C.; Fishman,, Scott M.; Rathmell,, James P.

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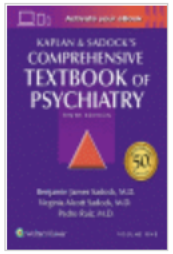

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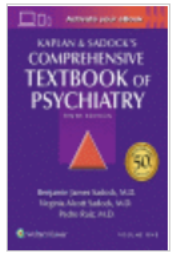

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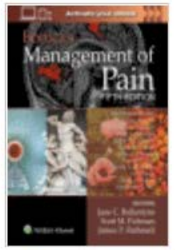

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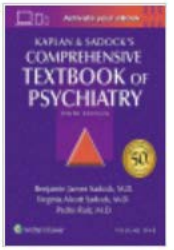

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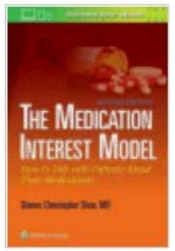

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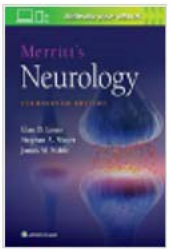

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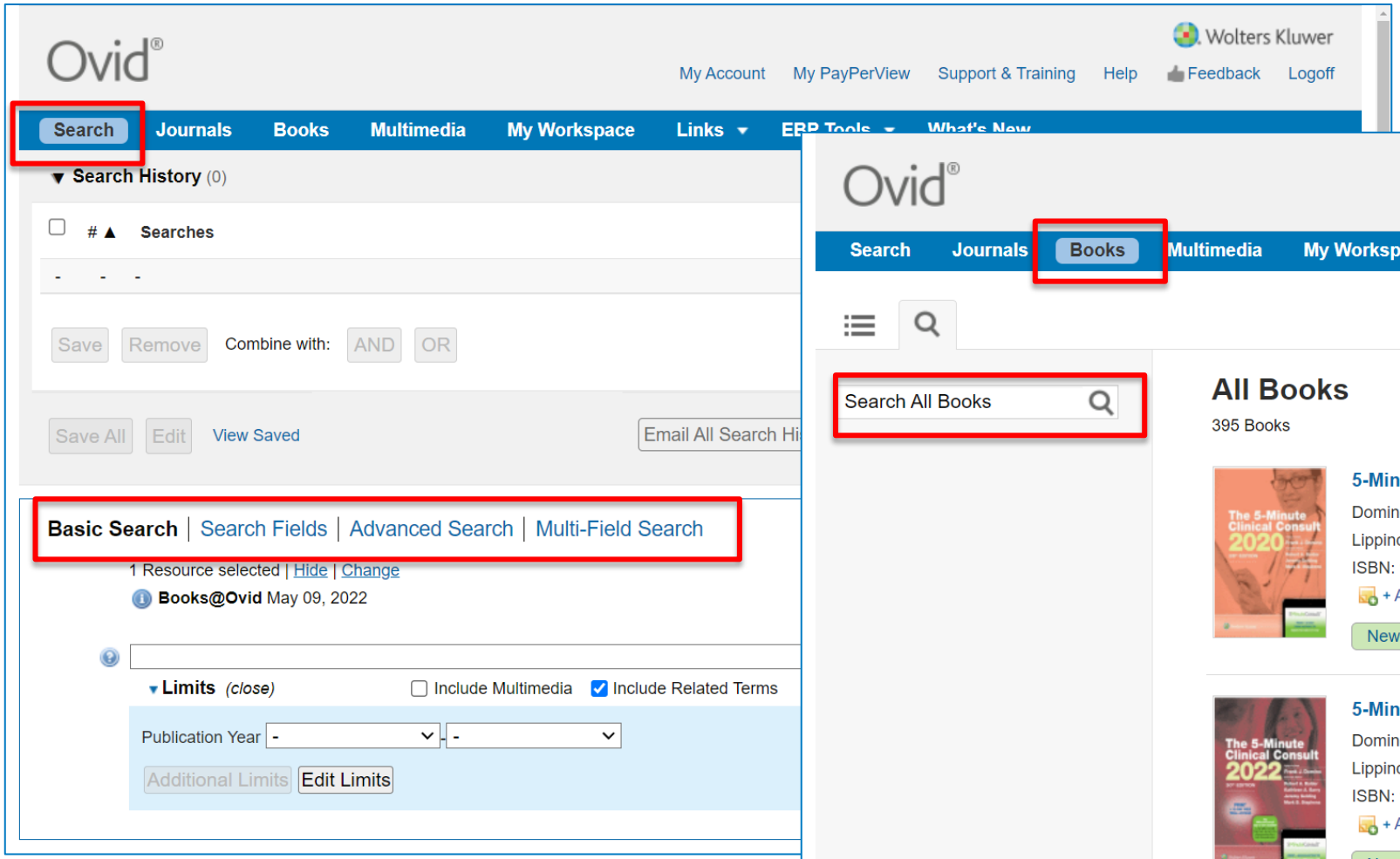

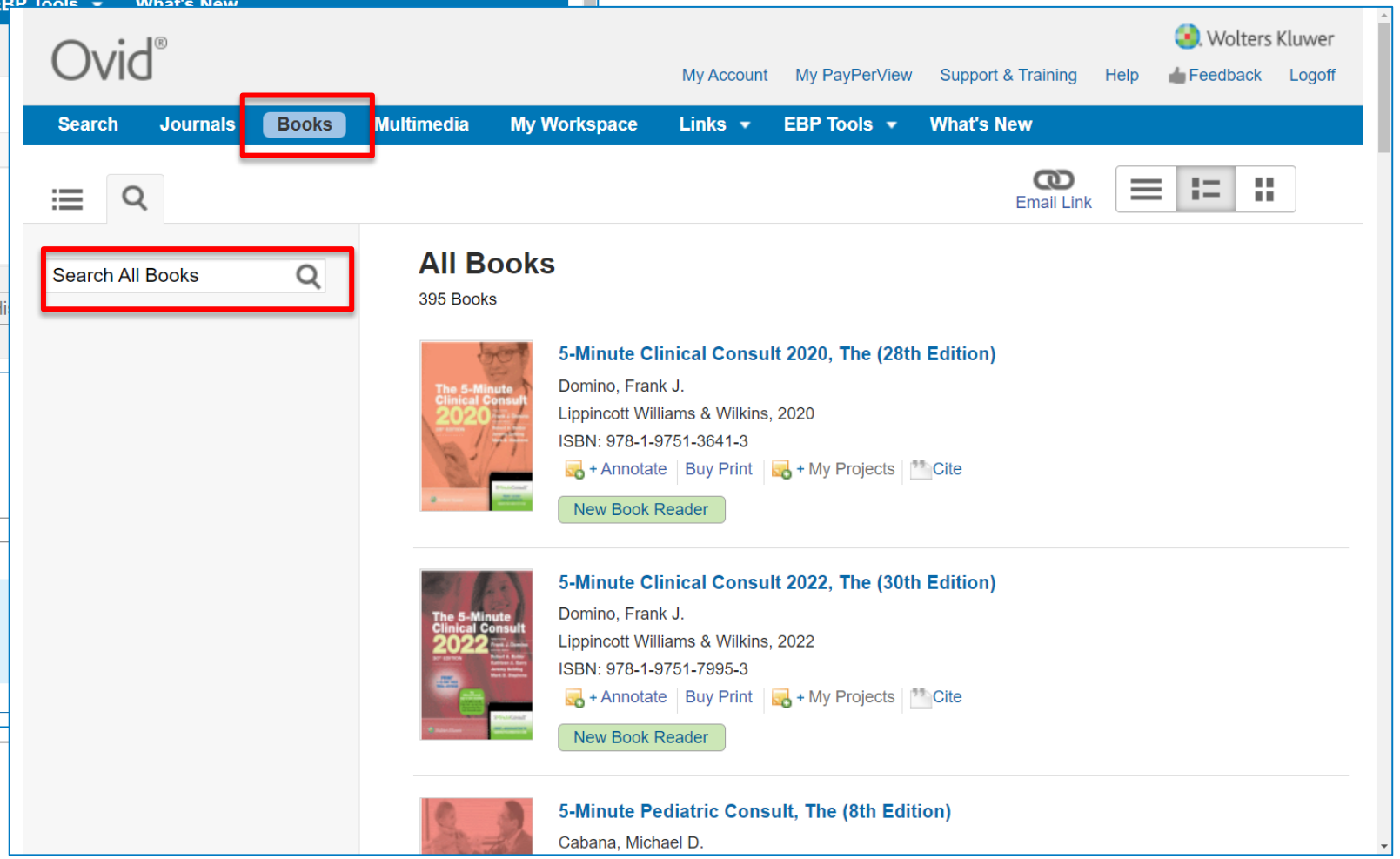

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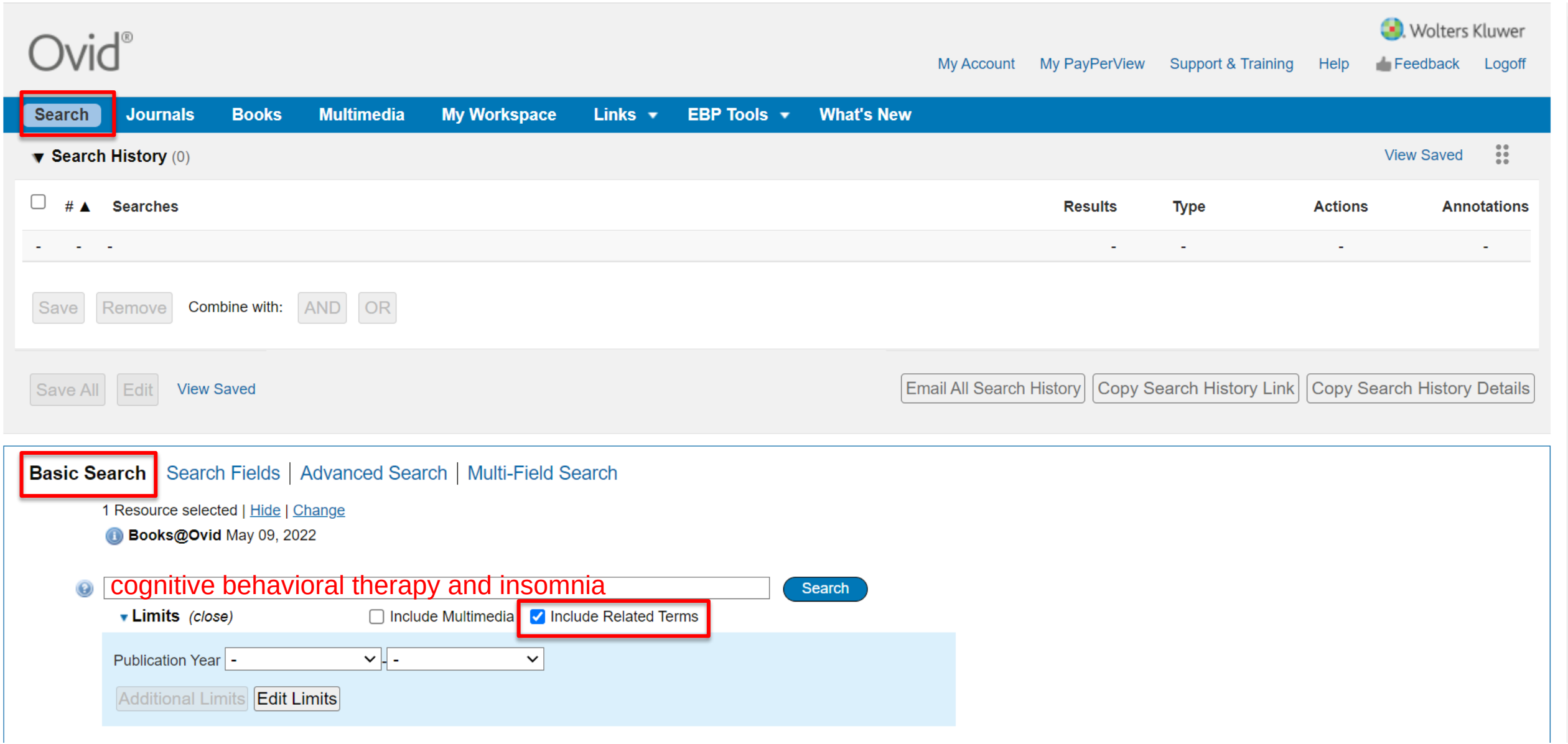

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behavior therapies
behavior therapy
therapy conditioning
therapy behavior
therapies behavior
modification behavior
conditioning therapy
conditioning therapies
behavioral treatments
behavioral treatment
behavioral modification
behavioral interventions
behavioral intervention
behavior modifications
behavior modification

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1. **Kaplan & Sadock's Comprehensive Textbook of PsychiatryBook Text Excerpt Chapter Author: Hirshkowitz,, Max; Sharafkhaneh,, Amir Chapter Title: Sleep Disorders Passage Text: ... relief from sleeplessness. Insomnia, however, usually returns upon discontinuation of dosing. Nonpharmacological Treatment with Cognitive-Behavioral Therapy for Insomnia (CBTi) This treatment modality combines behavioral and cognitive techniques to overcome dysfunctional sleep behaviors and misperceptions, distorted, disruptive thoughts about sleep. The therapist begins with a careful clinical interview to assess the insomnia's etiology, chronicity, severity, associations, and comorbid conditions. A treatment plan is then designed using cognitive and behavioral techniques deemed relevant and appropriate. These may include: universal sleep hygiene, stimulus control therapy, sleep restriction therapy, relaxation therapies and biofeedback, cognitive therapy, and occasionally, ...** Expand Passage Contract Passage

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Presleep thoughts and dysfunctional beliefs in subjects of insomnia with or without depression

Gupta, Ravi

Behavioral interventions for insomnia

Sharma, Mahendra P. Andrade, Chittaranjan

Multipronged Treatment of Insomnia - Outcomes from an Apex Sleep Disorders Clinic in India

Poornima, Shivani Shukla, Garima Gupta, Anupama Mohammed, Afsar Agarwal, Priya

Diagnosis and treatment of chronic insomnia

Saddichha, Sahoo

DAY 4 25TH JANUARY 2020 ABSTRACTS

Singagari, Sai Naveen Yella, Siva

Prescription medicines are rigorously tested in clinical trials; therefore, they hold an advantage over the virtually untested OTCs. To attain FDA approval as a hypnotic, a medication must be safe and effective. Most hypnotic medications are approved for short-, not long-term, use. Exceptions include zolpidem-modified release, eszopiclone, and ramelteon; all of which are approved for long-term therapy. When properly used, hypnotics can provide immediate and adequate relief from sleeplessness. Insomnia, however, usually returns upon discontinuation of dosing.

Nonpharmacological Treatment with Cognitive-Behavioral Therapy for Insomnia (CBTi)

This treatment modality combines behavioral and cognitive techniques to overcome dysfunctional sleep behaviors and misperceptions, distorted, disruptive thoughts about sleep. The therapist begins with a careful clinical interview to assess the insomnia's etiology, chronicity, severity, associations, and comorbid conditions. A treatment plan is then designed using cognitive and behavioral techniques deemed relevant and appropriate. These may include: universal sleep hygiene, stimulus control therapy, sleep restriction therapy, relaxation therapies and biofeedback, cognitive therapy, and occasionally, paradoxical intention.

Studies repeatedly show significant, sustained improvement in sleep symptoms with CBTi. Improvements include reduced wakefulness duration, decreased number of awakenings, and shorter latency to sleep onset. Short-term benefits are similar to that of medication but CBTi tends to have lasting benefits, even 36 months after treatment. With cessation of the medication insomnia frequently returns and is sometimes accompanied by rebound insomnia. CBTi has not been shown to produce any adverse effects. There are no established “best practice” guidelines for length or quantity of sessions. CBTi, however, is not without limitations. Most data do not compare the efficacy of the individual components (described below) of CBTi. However, sleep hygiene education alone does not appear to improve sleep. Intuitively, the multi-component approach addresses many of the variables contributing to insomnia. Other limitations of CBTi include lack or unavailability of trained specialists, cost of sessions

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Search terms used:

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insomnia disorders
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behavior therapies
behavior therapy
therapy conditioning
therapy behavior
therapies behavior
modification behavior
conditioning therapy
conditioning therapies
behavioral treatments
behavioral treatment
behavioral modification
behavioral interventions
behavioral intervention
behavior modifications
behavior modification

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The effects of CBTi take longer to emerge than effects of medications. Individuals are often desperate when they finally seek treatment of their insomnia. This makes it difficult to convince them to try a therapy that may require several weeks before it provides relief. Also, patients must be active participants in this type of therapy. Many individuals not only want a "quick fix" but they also want to undergo a procedure or have something administered rather than be involved in the therapeutic process. For optimal CBTi, patients must commit to multiple sessions and also be open to the idea that modifying thoughts and behaviors about sleep can improve the symptoms of insomnia. The "quick fix" model is common in primary care; by contrast, psychiatrists are accustomed to delayed response from their experience with antidepressants and other psychotropic medicines. Consequently, psychiatrists may be more comfortable recommending CBTi than other practitioners.

Although firmly focused on cognitive and behavioral issues, it helps to extend CBTi just slightly into the psychodynamic sphere. For some patients with longstanding difficulty sleeping, being an insomniac becomes an important part of their identity. There may be primary or secondary gain to such identification. It is the negative emotional response (i.e., anger at the inability to control one's sleep, feeling like a failure because they can't sleep) to insomnia that contributes to its chronicity. In general, these individuals tend to internalize rather than express emotion, feel a heightened need for control, experience interpersonal difficulties, and have significant discontent with past events. For this subset of people, if the emotional response is not addressed, there is more likely to be a limited response to CBTi or a relapse of insomnia over time. The clinician who is attuned (i.e., to patient's tendency to view something as a failure rather than a challenge), will be better able to intercept barriers to treatment. "As chronic insomnia is an extremely psychologically painful condition, a high level of motivation and willingness to explore oneself, at least with a specific focus, is often present."

Universal Sleep Hygiene

The focus of universal sleep hygiene is on modifiable environmental and lifestyle components that may interfere with sleep as well as behaviors that may improve sleep. Especially because some of these behaviors are difficult to change, only one or two items that are collaboratively chosen by the patient and clinician should be addressed at a time. This will give the patient the best chance at a successful intervention. Sleep enhancing directives are enumerated in Table 23–2. Often a few simple alterations in *(Print pagebreak 2089)* a patient's habits or sleep environment can be effective. The clinician, however, needs to spend time reviewing both the patient's routine and its irregularity. In some respects, the essence of insomnia is its variability. The day-to-day changes in behavior and the changing severity of sleeplessness can obscure the factors responsible for the problem. A carefully explained program of sleep hygiene, with follow-up, represents a fairly inexpensive but effective intervention. Furthermore, improving sleep

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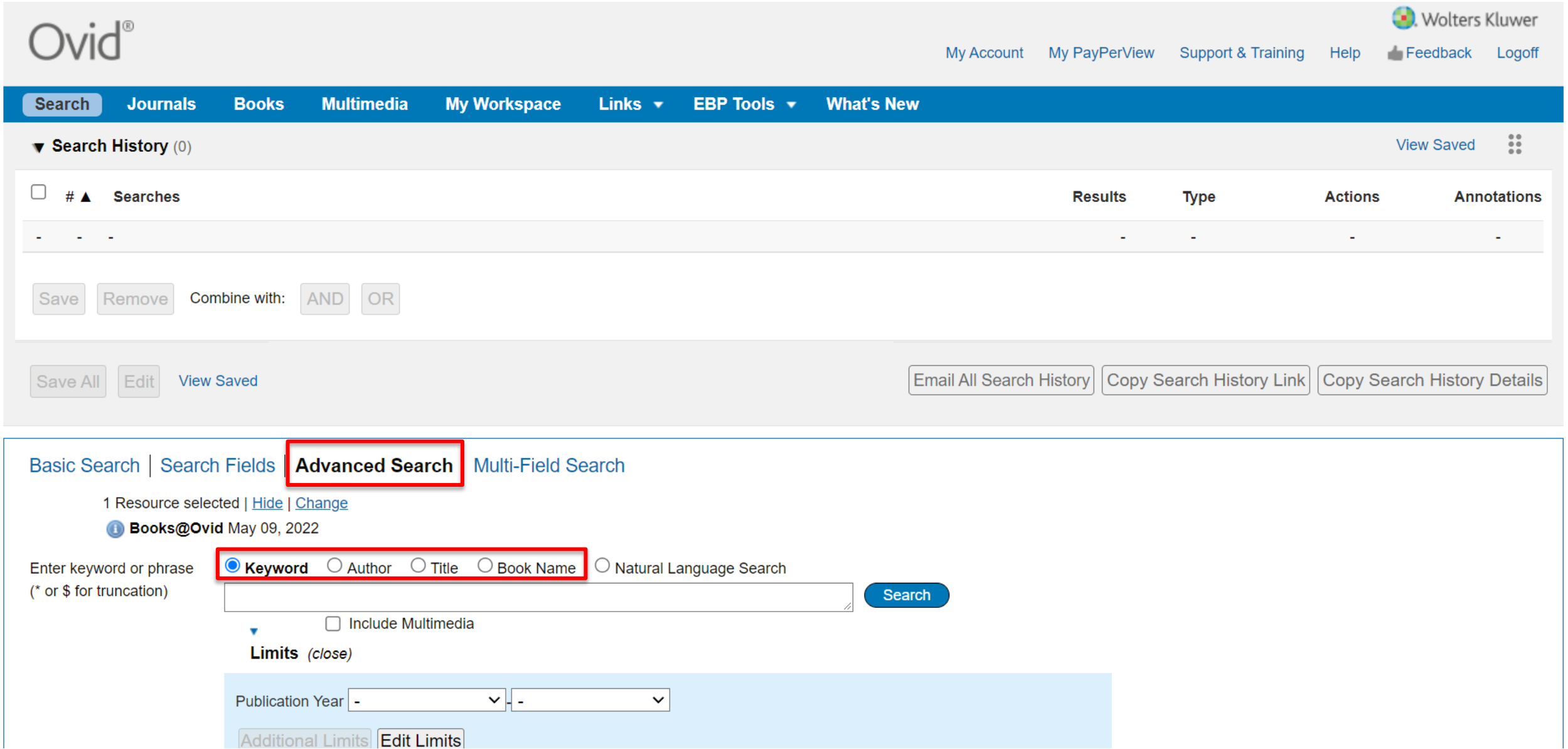

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  - 有限制切截查詢：
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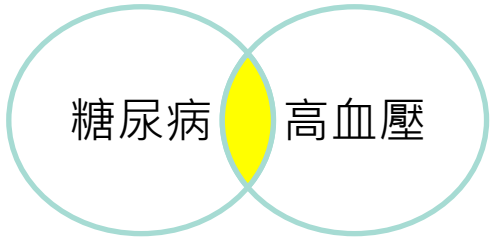

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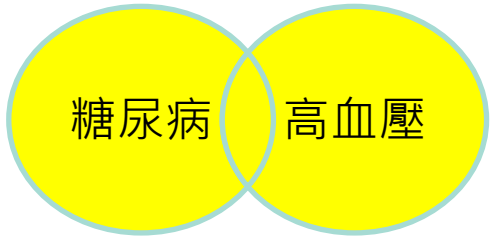

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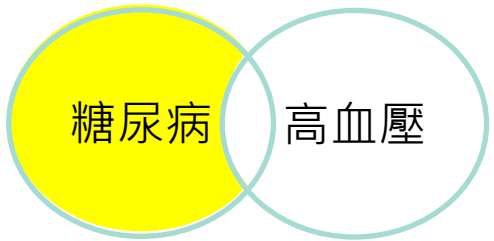

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  - ADJ# - pain management
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☑	4	(sleep* or insomn*).mp. [mp=full text, byline text]	59186	Advanced	Display Results | More	
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☐	2	cbt.mp. [mp=full text, byline text]	2911	Advanced	Display Results | More	
☐	3	1 or 2	6733	Advanced	Display Results | More	
☐	4	(sleep* or insomn*).mp. [mp=full text, byline text]	59186	Advanced	Display Results | More	
☐	5	3 and 4	2965	Advanced	Display Results | More	
☐	6	limit 5 to ((psychiatry or psycholinguistics or psychology or psychotherapy) and ("clinical manual/handbook/quick reference" or "text/reference") and yr="2011 -Current")	1072	Advanced	Display Results | More	

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1. **Bonica's Management of PainBook Text Excerpt Chapter Author: Paice, Judith A. Chapter Title: Pain Management at the End of Life Passage Text: ... fatigue and sleep disruption and exacerbating the patient's pain. Furthermore, myoclonus can progress to the development of uncontrolled seizures. 113 Myoclonus has been reported to occur after surgery to the brain, 114 in acquired immunodeficiency syndrome, 115 after hypoxia, 116 and after chlorambucil administration. 117 However, myoclonus at end-of-life care is most commonly associated with opioids. Controversy exists regarding whether this is dose dependent and how much of this effect is from parent drug versus metabolites. Most reports of opioid-related myoclonus implicate higher doses, although it has been reported to occur in patients receiving low doses of opioids, particularly hydromorphone. 118 , 119 Other opioids that have been implicated include methadone 120 and ...** ⊞ Expand Passage ⊟ Contract Passage

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1. **Bonica's Management of PainBook Text Excerpt Chapter Author: Paice, Judith A. Chapter Title: Pain Management at the End of Life Passage Text: ... fatigue and sleep disruption and exacerbating the patient's pain. Furthermore, myoclonus can progress to the development of uncontrolled seizures. 113 Myoclonus has been reported to occur after surgery to the brain, 114 in acquired immunodeficiency syndrome, 115 after hypoxia, 116 and after chlorambucil administration. 117 However, myoclonus at end-of-life care is most commonly associated with opioids. Controversy exists regarding whether this is dose dependent and how much of this effect is from parent drug versus metabolites. Most reports of opioid-related myoclonus implicate higher doses, although it has been reported to occur in patients receiving low doses of opioids, particularly hydromorphone. 118 , 119 Other opioids that have been implicated include methadone 120 and ...** ⊞ Expand Passage⊟

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6. **Bonica's Management of PainBook Text Excerpt Chapter Author: Stanos, Steven P.; Chang, wilson J. Chapter Title: Pain Rehabilitation Passage Text: ... (CBT, physical and occupational therapy, and social work) program demonstrated an additive effect with greater improvement on measures of pain, sleep, activity levels, and medication use.98,99.**

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7. **Bonica's Management of PainBook Text Excerpt Chapter Author: Stanos, Steven P.; Chang, wilson J. Chapter Title: Pain Rehabilitation Passage Text: ... sleep, mood Employer Education Asking for employer's opinion on the TRW setting Sensitizing the employer to its support role in relation to the worker Asking the insurer to use its authority to exert influence on the employer Insurer Education Sensitize to the issues involved in the intervention Clarification of the roles and objectives Meeting with the insurer's case worker before meeting the worker or the employer to ensure consistency in information delivered Acting without interfering Choosing convincing information Asking for the case worker's support for the intervention Physician Inform the physician about the rehabilitation process Convincing him or her to take action to facilitate return to work Recommendation that worker find another physician if too great**

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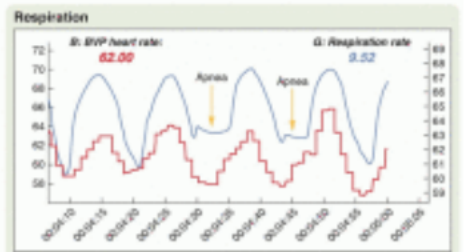
Combining group CBT and relaxation therapy with an individually based multidisciplinary treatment (CBT, physical and occupational therapy, and social work) program demonstrated an additive effect with greater improvement on measures of pain, sleep, activity levels, and medication use.[98,99]

Chronic pain frequently accompanied by underlying psychiatric/psychological disorders often benefit from mindfulness meditation.[100] It is characterized by paying attention to the present moment with openness, curiosity, and acceptance.[101] The premise behind mindfulness meditation to target the high prevalence and refractory nature of chronic pain in conjunction with negative consequences of maladaptive behavior, which improved self-referential processing, leads to increased interest in treatment plan including adjunct to therapy and alternative interventions.[100,102] The goal is to refocus the mind on the present, thereby increasing awareness of one's external surroundings and inner sensations, allowing the individual to step back and reframe experiences. Clinical applications of mindfulness meditation include substance use, stress reduction, tobacco, fixation, and chronic pain.



Representation of transient apnea. X-axis is time. Y-axis is blood volume pulse heart rate. Notice two successive periods of transient apnea indicated by *yellow arrows*. *(Source: Adapted from* Chapter 16 *Respiration Assessment. Shaffer F.* HRV Biofeedback Tutor 2018. *biosourcesoftware.com.)*

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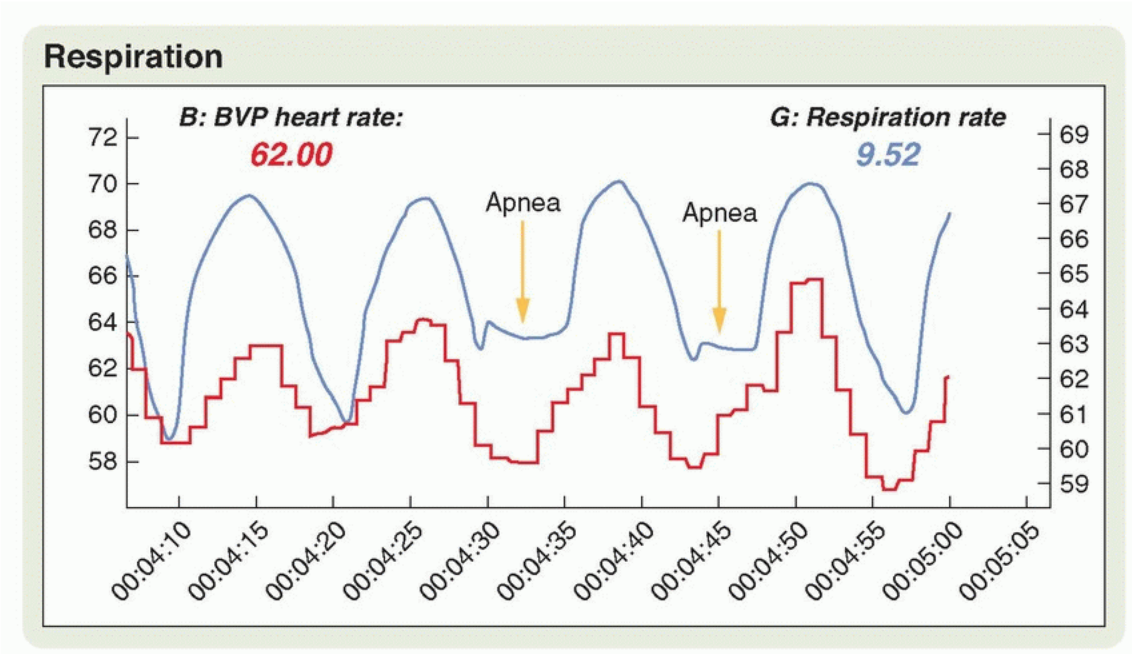

Representation of transient apnea. X-axis is time. Y-axis is blood volume pulse heart rate. Notice two successive periods of transient apnea indicated by *yellow arrows*. *(Source: Adapted from Chapter 16 Respiration Assessment. Shaffer F.* HRV Biofeedback Tutor 2018. *biosourcesoftware.com.)*

RELAXATION TRAINING

Furthermore, incorporating relaxation techniques (i.e., deep breathing, progressive muscle relaxation) with therapeutic stretching can help the patient progress in the exercise program and improve activity tolerance. Biofeedback is a treatment that has been shown to be quite effective in the management of pain.[103] The treatment serves to help a patient become more aware of their physiologic responses to pain or other stressors. In general, relaxation

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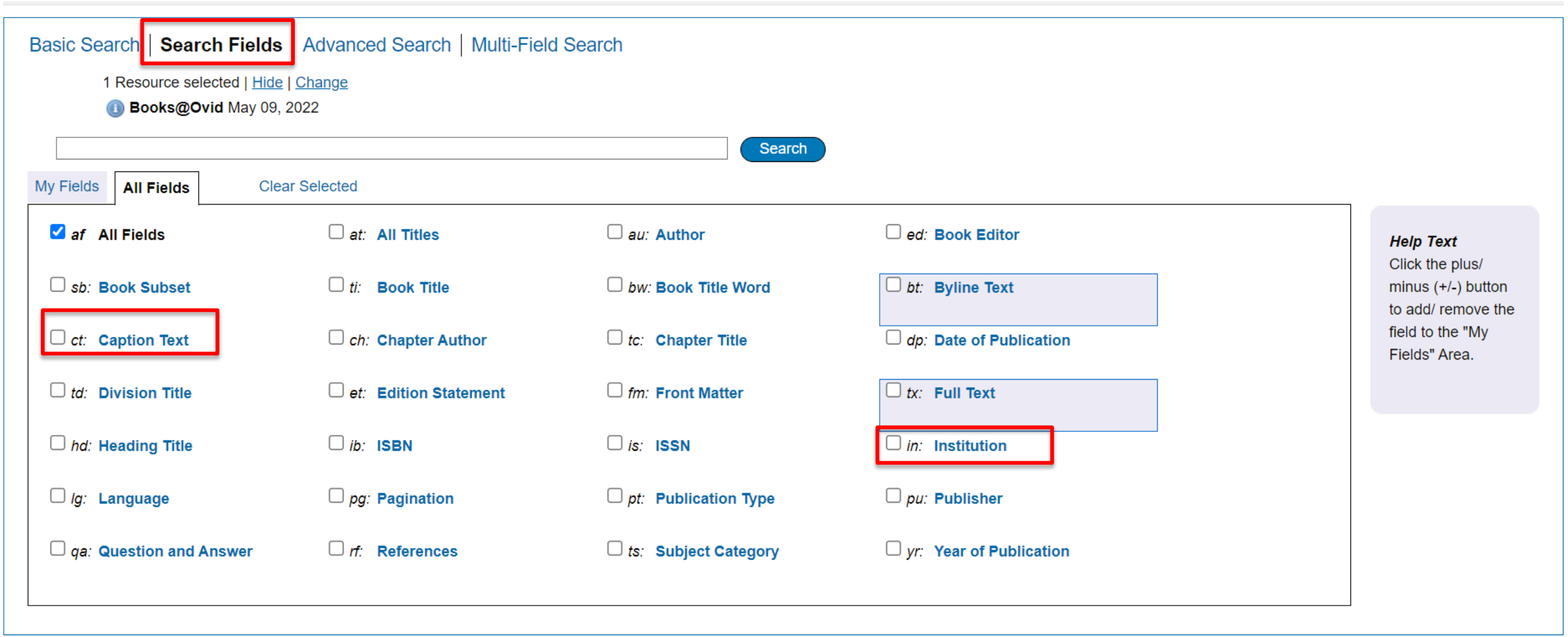

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1. **Postcards of Nursing. A Worldwide TributeBook Text Excerpt Chapter Title: An American Photo Postcard Album Passage Text: ... 6.30. Group of male nurses. Dixmont Hospital, Dixmont, Pennsylvania. c. 1910. (See note.) ...**

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Figure 6.30. Group of male nurses. Dixmont Hospital, Dixmont, Pennsylvania. c. 1910. *(See note.)*

View Figure

Figure 6.31. Sonyea, New York.

The nurse is the man on the far right. 1907. *(See note.)*

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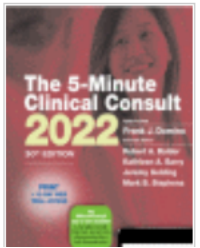

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1. **Kaplan & Sadock's Comprehensive Textbook of PsychiatryBook Text Excerpt Chapter Author: Hirshkowitz,, Max; Sharafkhaneh,, Amir Chapter Title: Sleep Disorders Passage Text: ... from sleeplessness. Insomnia, however, usually returns upon discontinuation of dosing. Nonpharmacological Treatment with Cognitive-Behavioral Therapy for Insomnia (CBTi) This treatment modality combines behavioral and cognitive techniques to overcome dysfunctional sleep behaviors and misperceptions, distorted, disruptive thoughts about sleep. The therapist begins with a careful clinical interview to assess the insomnia's etiology, chronicity, severity, associations, and comorbid conditions. A treatment plan is then designed using cognitive and behavioral techniques deemed relevant and appropriate. These may include: universal sleep hygiene, stimulus control therapy, sleep restriction therapy, relaxation therapies and biofeedback, cognitive therapy, and occasionally,**

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Behavioral interventions for insomnia

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Diagnosis and treatment of

Prescription medicines are rigorously tested in clinical trials; therefore, they hold an advantage over the virtually untested OTCs. To attain FDA approval as a hypnotic, a medication must be safe and effective. Most hypnotic medications are approved for short-, not long-term, use. Exceptions include zolpidem-modified release, eszopiclone, and ramelteon; all of which are approved for long-term therapy. When properly used, hypnotics can provide immediate and adequate relief from sleeplessness. Insomnia, however, usually returns upon discontinuation of dosing.

Nonpharmacological Treatment with Cognitive-Behavioral Therapy for Insomnia (CBTi)

This treatment modality combines behavioral and cognitive techniques to overcome dysfunctional sleep behaviors and misperceptions, distorted, disruptive thoughts about sleep. The therapist begins with a careful clinical interview to assess the insomnia's etiology, chronicity, severity, associations, and comorbid conditions. A treatment plan is then designed using cognitive and behavioral techniques deemed relevant and appropriate. These may include: universal sleep hygiene, stimulus control therapy, sleep restriction therapy, relaxation therapies and biofeedback, cognitive therapy, and occasionally, paradoxical intention.

Studies repeatedly show significant, sustained improvement in sleep symptoms with CBTi. Improvements include reduced wakefulness duration, decreased number of awakenings, and shorter latency to sleep onset. Short-term benefits are similar to that of medication but CBTi tends to have lasting benefits, even 36 months after treatment. With cessation of the medication insomnia frequently returns and is sometimes accompanied by rebound insomnia. CBTi has not been shown to produce any adverse effects. There are no established “best practice” guidelines for length or quantity of sessions. CBTi, however, is not without limitations. Most data do not compare the efficacy of the individual components (described below) of CBTi. However, sleep hygiene education alone does not appear to improve sleep. Intuitively, the multi-component approach addresses many of the variables contributing to insomnia. Other limitations of CBTi include lack or unavailability of trained specialists, cost of sessions

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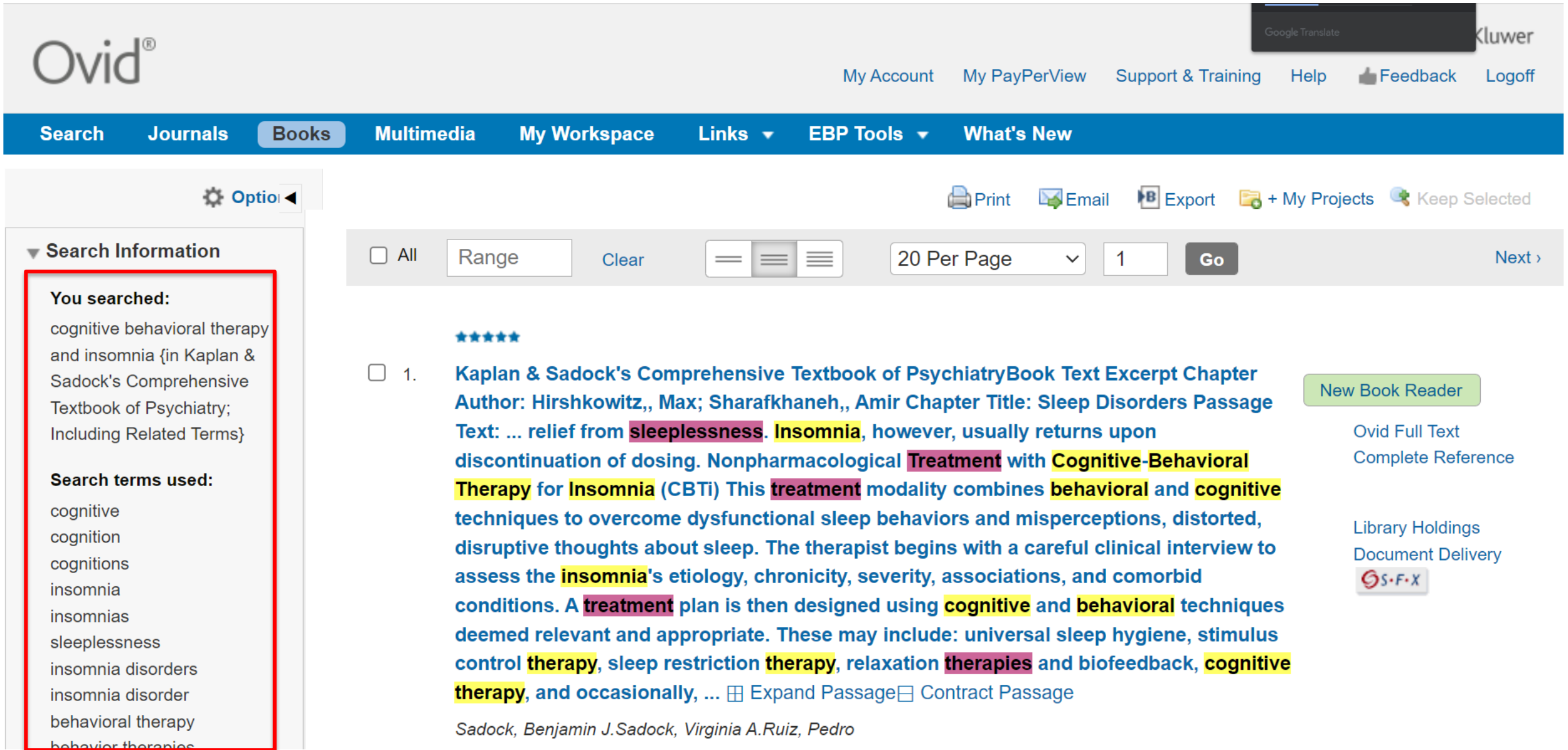

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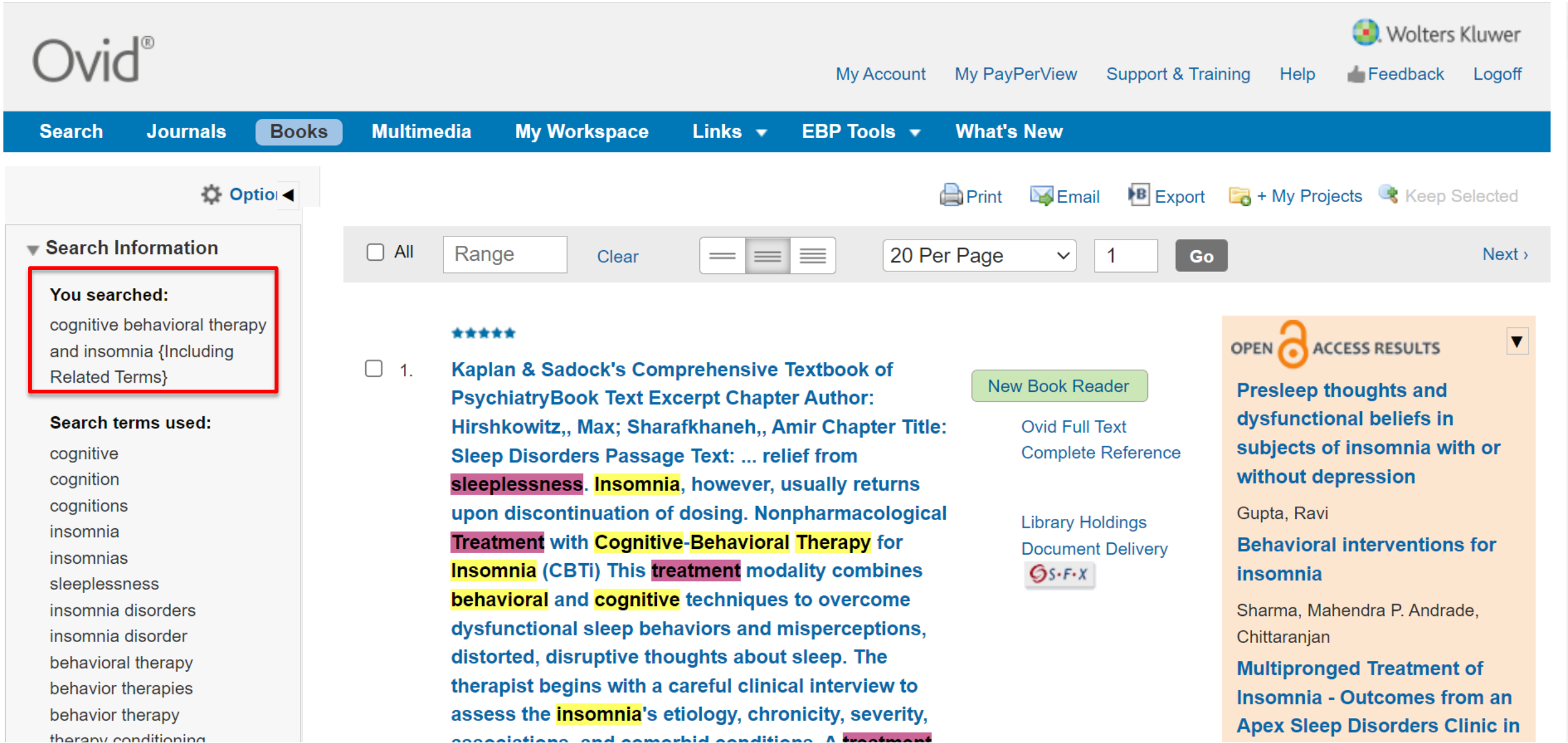

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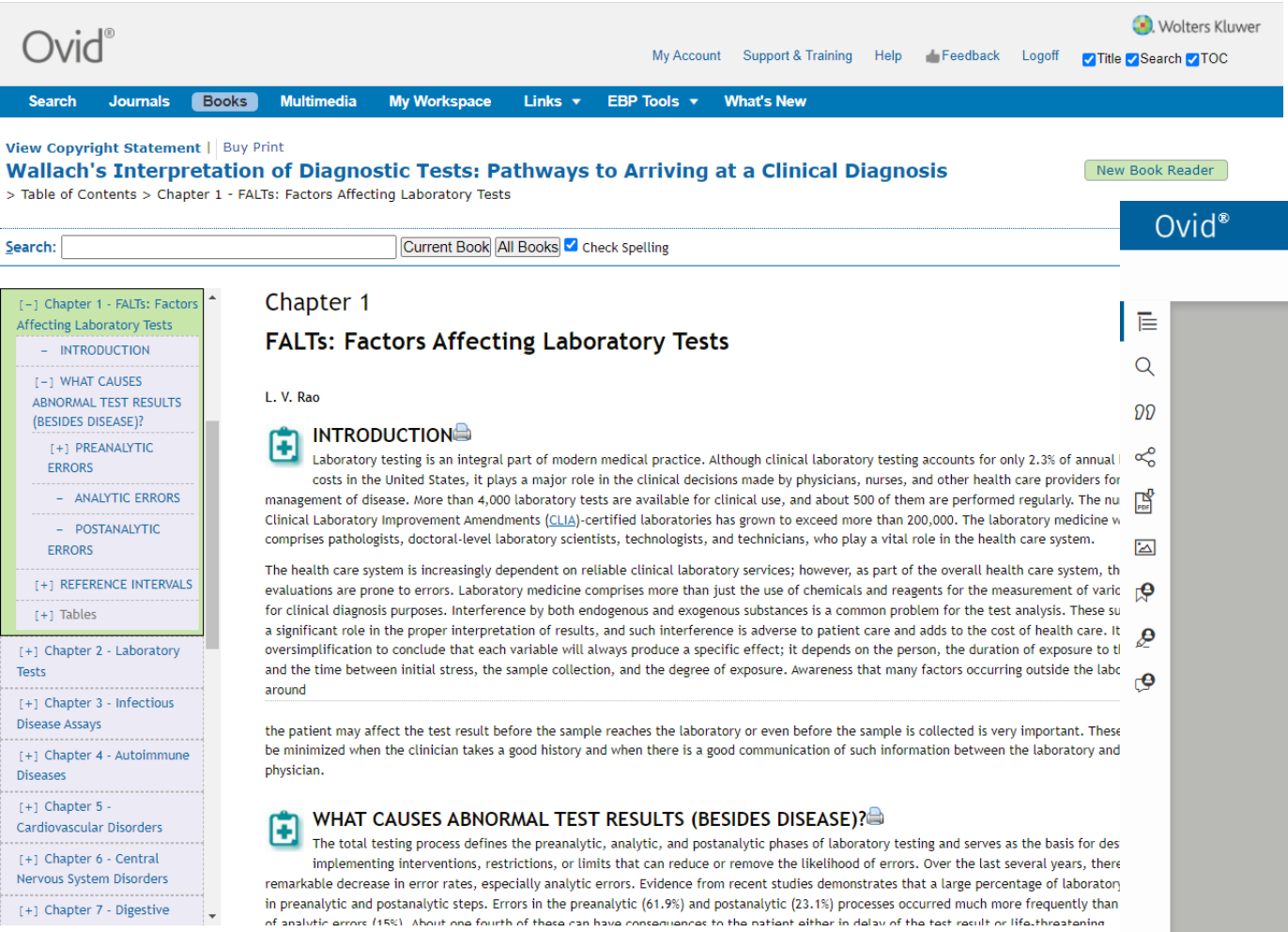

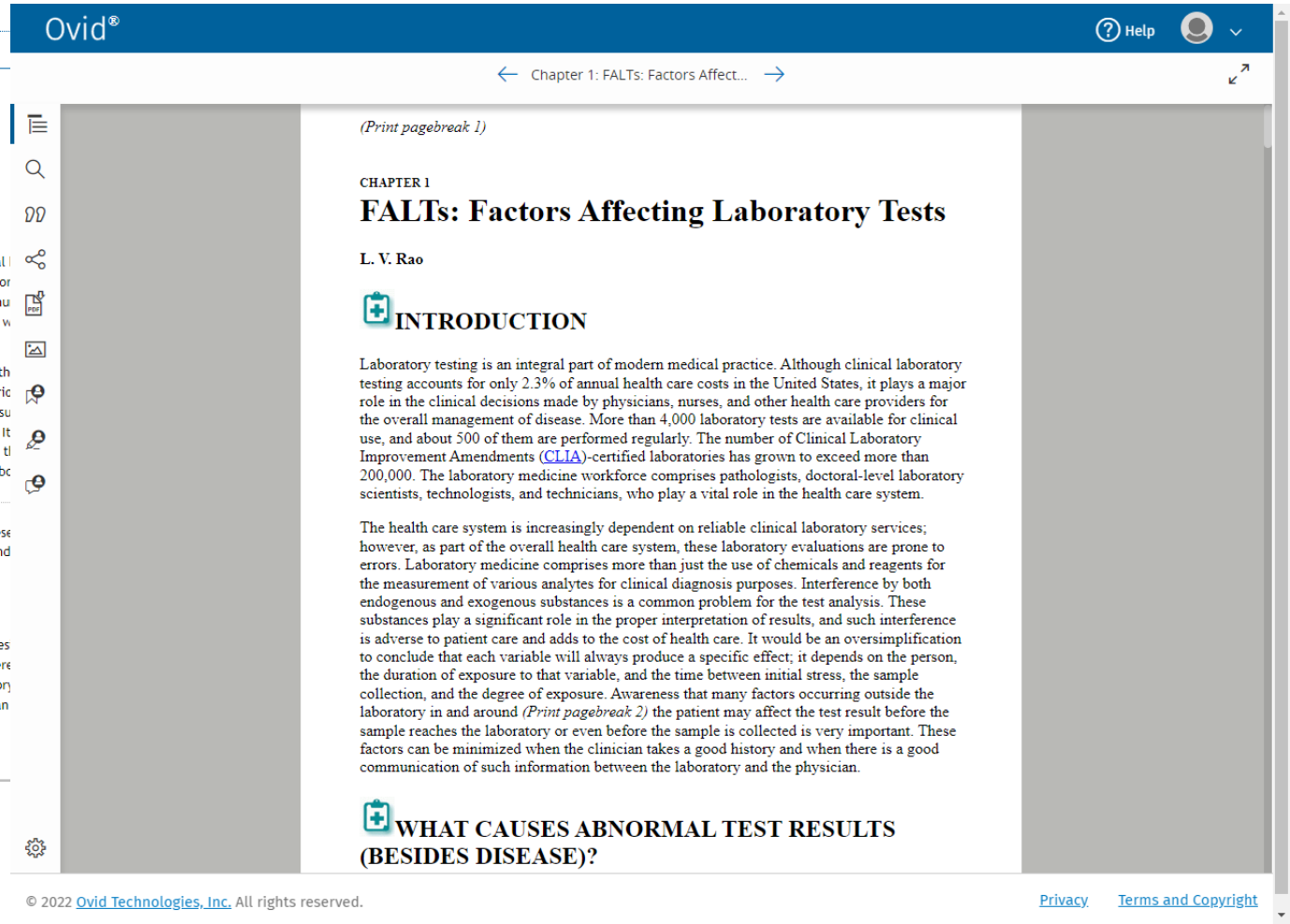

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The health care system is increasingly dependent on reliable clinical laboratory services; however, as part of the overall health care system, these laboratory evaluations are prone to errors. Laboratory medicine comprises more than just the use of chemicals and reagents for the measurement of various analytes for clinical diagnosis purposes. Interference by both endogenous and exogenous substances is a common problem for the test analysis. These substances play a significant role in the proper interpretation of results, and such interference is adverse to patient care and adds to the cost of health care. It would be an oversimplification to conclude that each variable will always produce a specific effect; it depends on the person, the duration of exposure to that variable, and the time between initial stress, the sample collection, and the degree of exposure. Awareness that many

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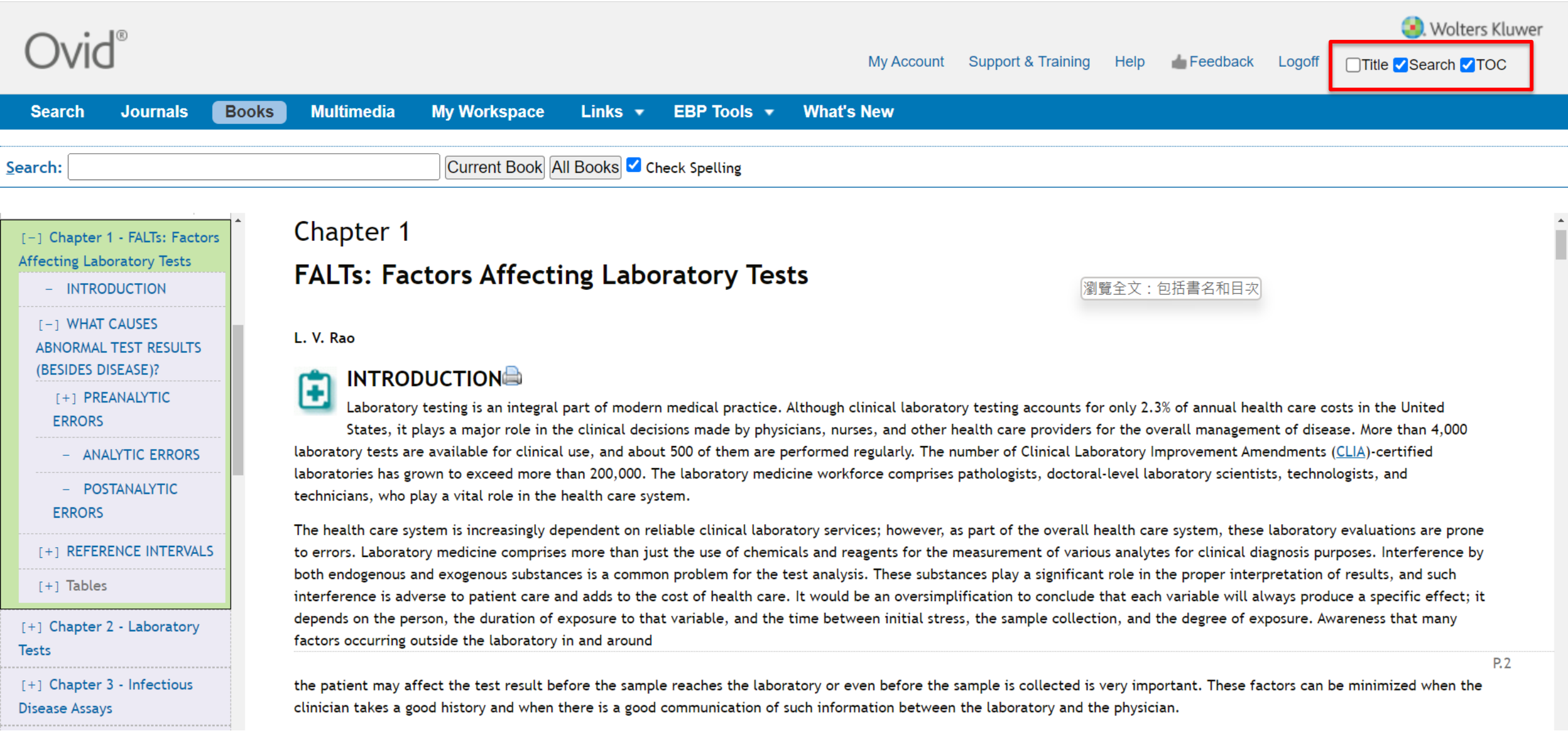

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the patient may affect the test result before the sample reaches the laboratory or even before the sample is collected is very important. These factors can be minimized when the clinician takes a good history and when there is a good communication of such information between the laboratory and the physician.

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Chapter 1

FALTs: Factors Affecting Laboratory Tests

L. V. Rao

INTRODUCTION

Laboratory testing is an integral part of modern medical practice. Although clinical laboratory testing accounts for only 2.3% of annual health care costs in the United States, it plays a major role in the clinical decisions made by physicians, nurses, and other health care providers for the overall management of disease. More than 4,000 laboratory tests are available for clinical use, and about 500 of them are performed regularly. The number of Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories has grown to exceed more than 200,000. The laboratory medicine workforce comprises pathologists, doctoral-level laboratory scientists, technologists, and technicians, who play a vital role in the health care system.

The health care system is increasingly dependent on reliable clinical laboratory services; however, as part of the overall health care system, these laboratory evaluations are prone to errors. Laboratory medicine comprises more than just the use of chemicals and reagents for the measurement of various analytes for clinical diagnosis purposes. Interference by both endogenous and exogenous substances is a common problem for the test analysis. These substances play a significant role in the proper interpretation of results, and such interference is adverse to patient care and adds to the cost of health care. It would be an oversimplification to conclude that each variable will always produce a specific effect; it depends on the person, the duration of exposure to that variable, and the time between initial stress, the sample collection, and the degree of exposure. Awareness that many factors occurring outside the laboratory in and around

the patient may affect the test result before the sample reaches the laboratory or even before the sample is collected is very important. These factors can be minimized when the clinician takes a good history and when there is a good communication of such information between the laboratory and the physician.

WHAT CAUSES ABNORMAL TEST RESULTS (BESIDES DISEASE)?

The total testing process defines the preanalytic, analytic, and postanalytic phases of laboratory testing and serves as the basis for designing and implementing

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WHAT CAUSES ABNORMAL TEST RESULTS (BESIDES DISEASE)?

The total testing process defines the preanalytic, analytic, and postanalytic phases of laboratory testing and serves as the basis for designing and implementing interventions, restrictions, or limits that can reduce or remove the likelihood of errors. Over the last several years, there has been a remarkable decrease in error rates, especially analytic errors. Evidence from recent studies demonstrates that a large percentage of laboratory errors occur in preanalytic and postanalytic steps. Errors in the preanalytic (61.9%) and postanalytic (23.1%) processes occurred much more frequently than occurrences of analytic errors

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End Point-Guided Resuscitation

Optimal resuscitation is imperative in the management of any patient in the acute care setting. It is a dynamic process that requires a continued assessment process to ensure that the targeted end points of resuscitation are achieved. Urine output, lactate levels, base deficit, gastric intramucosal pH, and direct determination of oxygen delivery and consumption are all

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proposed markers for or end points of resuscitation, although the optimal end points of resuscitation in trauma patients continues to be debated. Irrespective of the end point chosen, the overarching goal in the resuscitation of patients is correction of inadequate organ perfusion and tissue oxygenation. Inability to achieve adequate organ perfusion and tissue oxygenation can result in anaerobic metabolism with the development of acidosis and an associated oxygen debt. Scalea et al. reported that inadequate tissue perfusion can exist even when some of the conventional end points (e.g., blood pressure, heart rate, and urine output) of resuscitation are normal.[4]

THE FULL SPECTRUM OF MANAGEMENT—GENERAL PRINCIPLES

As underscored above, the core principle of acute care surgery is expeditious and effective medical/surgical management, with early diagnosis an essential element. Many of the general principles of trauma management are applicable in the nontrauma setting. However, each specific disease entity has its own unique diagnostic/management paradigm that is covered throughout the textbook. Depending on the regional geography, the disease (nontrauma) entities that are most commonly encountered by the acute care surgeon are outlined in Table 1.2.

The severity of the disease and the stage of presentation, along with the status of the patient (e.g., hemodynamic stability), will often dictate the specific course of management

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TABLE 1.2 COMMONLY ENCOUNTERED DISEASE ENTITIES

Appendicitis
Intestinal obstruction
Diverticulitis and deep (cartilage) tissue abscesses
Necrotizing soft tissue infection
Biliary diseases

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Acute Care Surgery: General Principles

L. D. Britt

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Acute Care Surgery: General Principles

L. D. Britt

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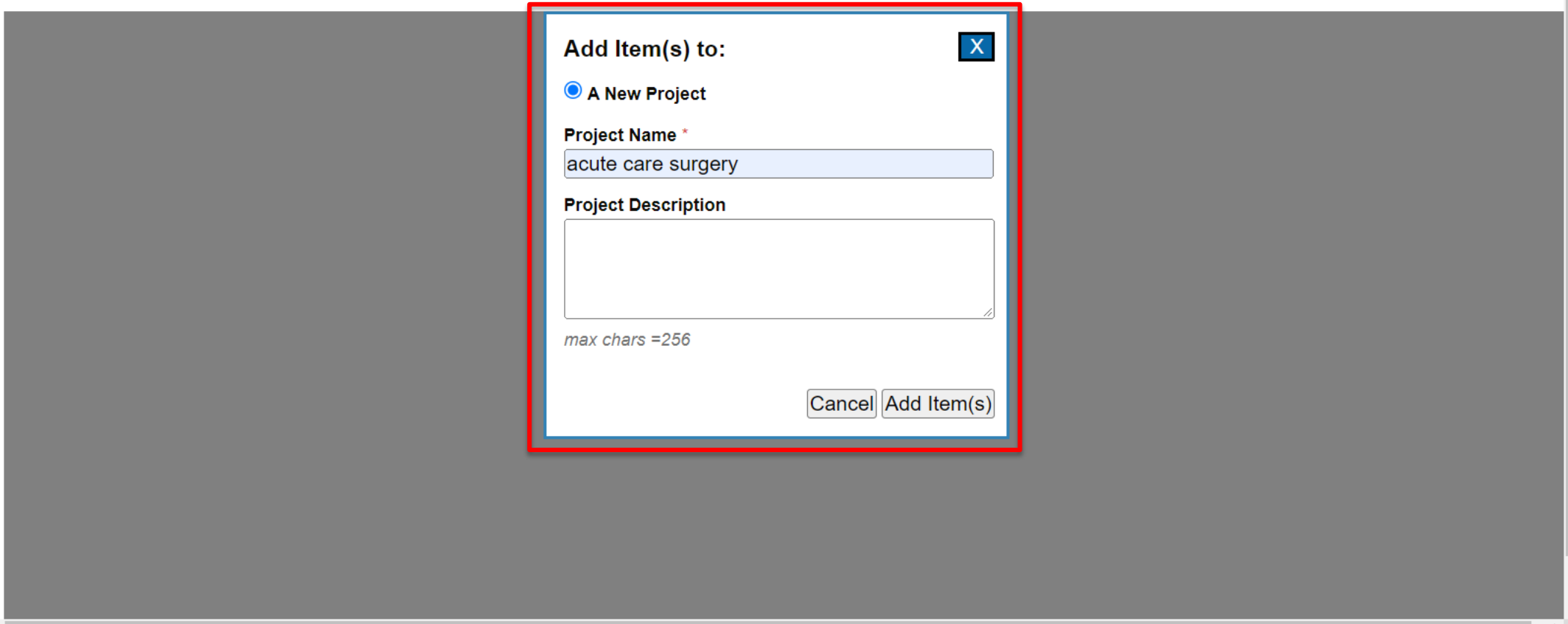

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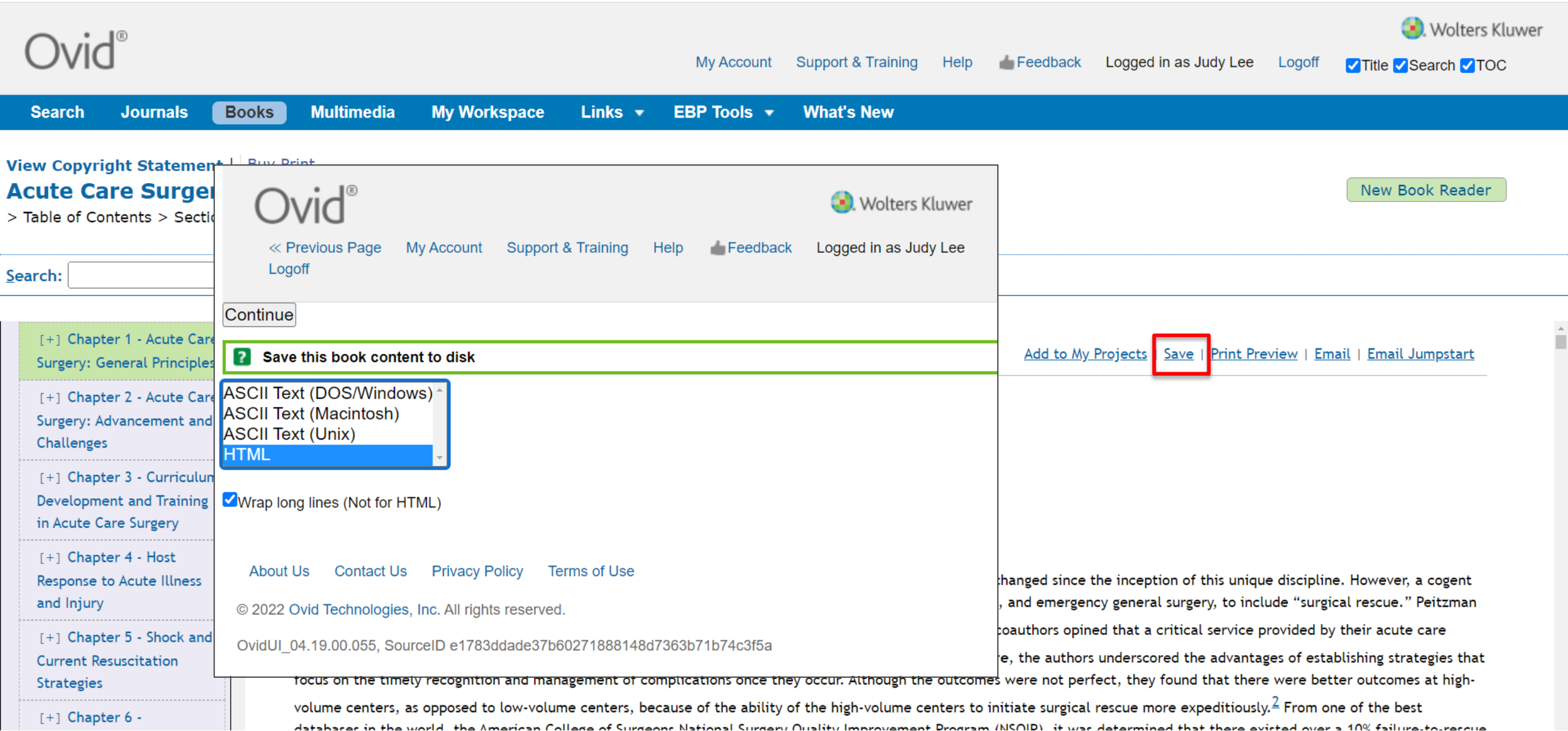
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Acute Care Surgery: General Principles

L. D. Britt

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FIGURE 1.1 The four pillars of acute care surgery.

ACUTE CARE SURGERY—CORE PRINCIPLES

The overarching axiom in acute care surgery is expedient assessment and early intervention. Prioritization of management—in an attempt to quickly address disease and injury that can rapidly result in severe morbidity and mortality—has always been the cornerstone of all aspects of medicine. Such an approach, however, does not undermine or devalue the merits of comprehensive assessments. Emergency operative intervention, precluding a comprehensive assessment and preoperative clearance, is indicated in many circumstances. In such cases, the comprehensive evaluation is completed after stabilization of the patient. While the importance of preoperative clearance cannot be overemphasized, it often cannot (and should not) be implemented in the acute care setting for a risk-benefit analysis of delaying surgical intervention would be unfavorable and detrimental to the health status of the patient. However, when appropriate, a systematic approach to preoperative clearance should be done.

The general principles of acute care surgery, in the nontrauma setting, must be applicable in the following states of pathogenesis: (1) inflammation, (2) perforation, (3) obstruction, (4) bleeding, (5) ischemia, (6) necrosis, (7) hypoxia, and (8) infection.

CORE MANAGEMENT PRINCIPLES (THE 4 ES)

The "4 Es" of the core management principles are the following:

- Expeditious initial assessment
- End point-guided resuscitation

TABLE 1.1 DIFFERENT FORMS OF PATHOGENESIS IN ACUTE CARE SURGERY

▪ INFLAMMATION	▪ PERFORATION	▪ OBSTRUCTION
Appendicitis, diverticulitis, cholecystitis, cholangitis, pancreatitis, gastritis, gastric and duodenal ulcer disease	**Hollow visceral rupture**	**Airway**
	Esophageal	Aspiration
	Gastric	Foreign body
	Duodenal	**Esophagus**

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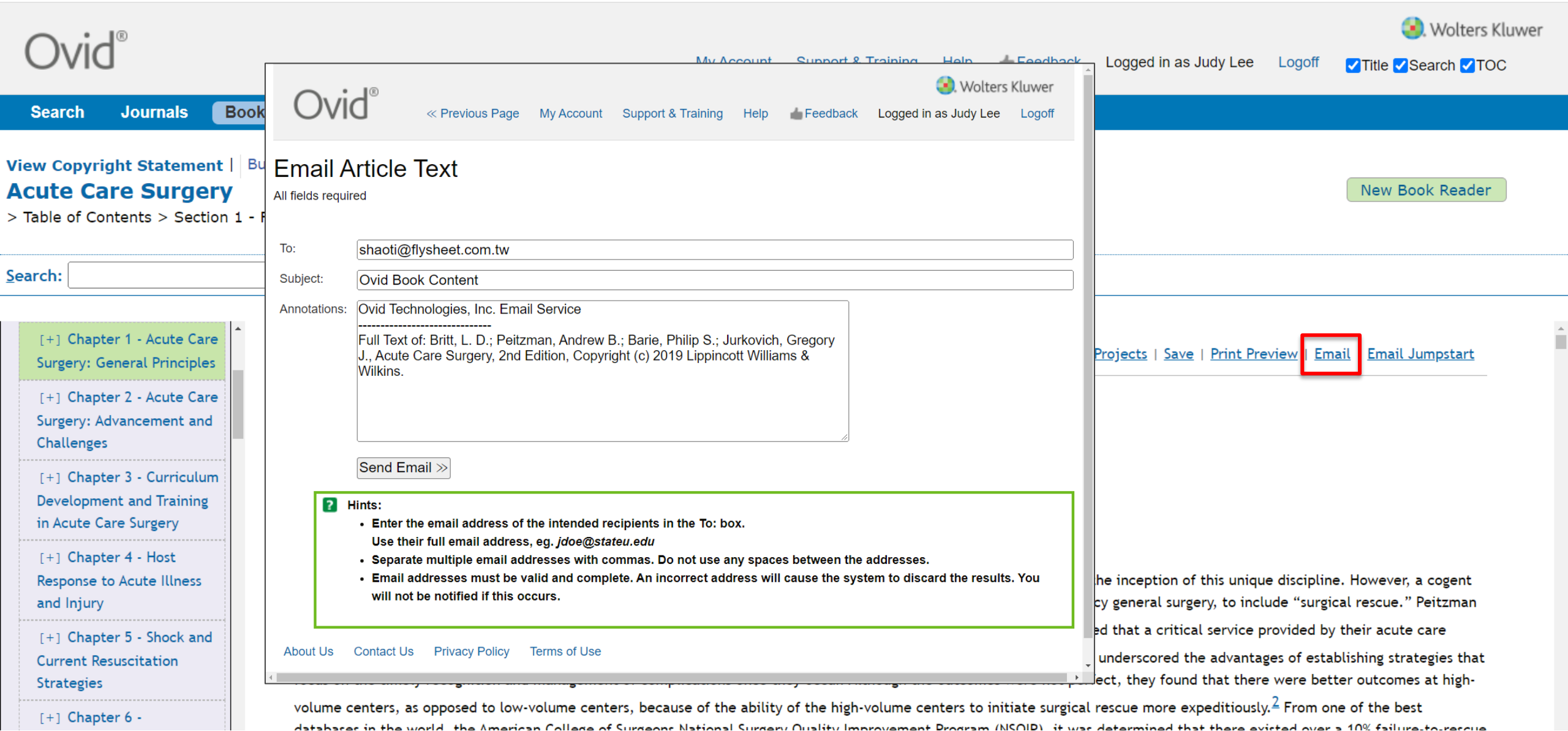
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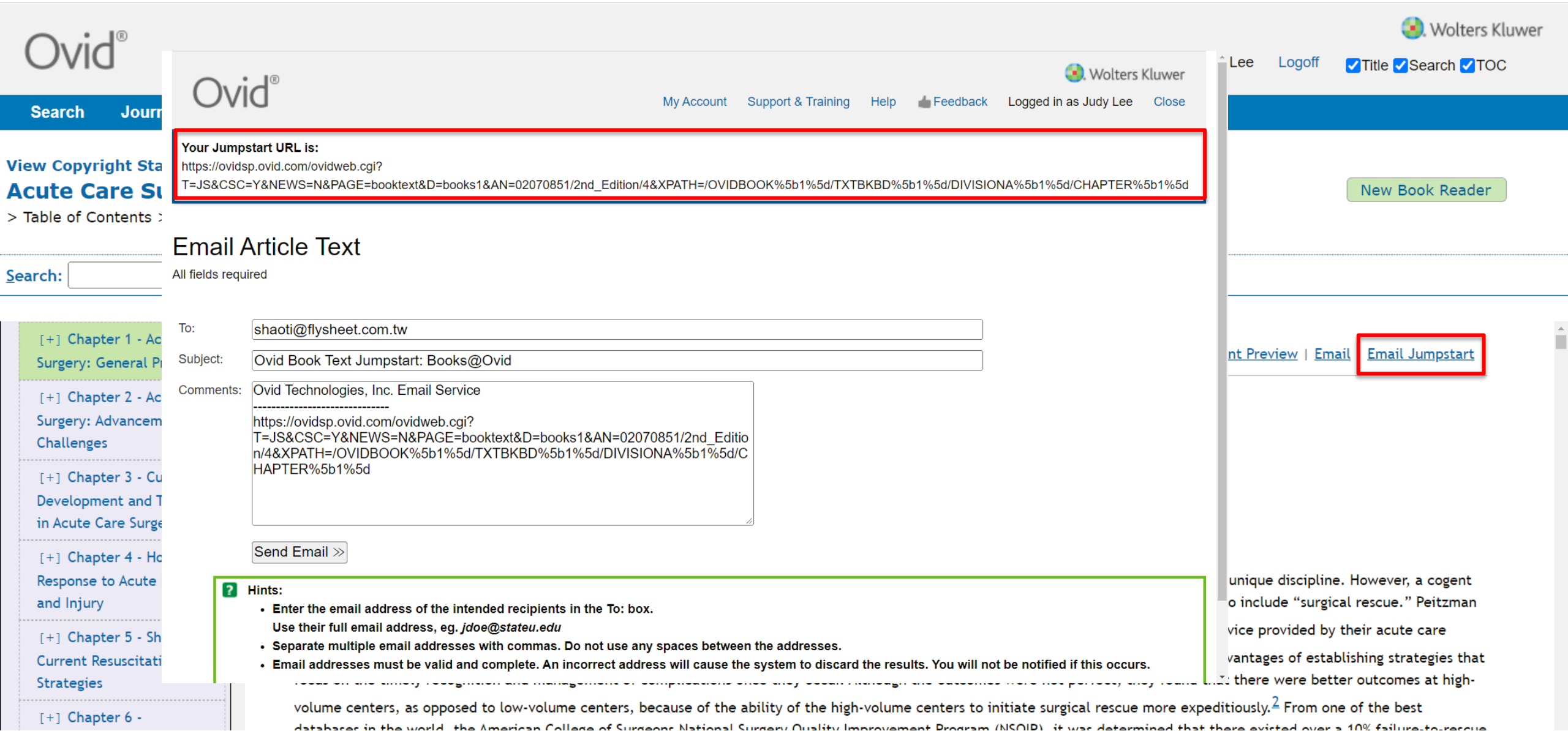
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CHAPTER 2

Acute Care Surgery: Advancement and Challenges

L. D. Britt

Historically, there has been no emerging surgical specialty that has circumvented the maturation process of addressing challenges to its advancement and "brand" (**not** cardiothoracic surgery, **not** transplantation, **not** endocrine or any other surgical specialty). But as the German philosopher Immanuel Kant, who is considered a central figure in modern philosophy, would emphasize, everything (all aspects of new ideas/innovation) must be exposed to scrutiny —even if something is considered an established principle or premise.[1] The concept now the specialty, acute care surgery, is no exception. The "table has been set," and acute care surgery is here to stay. However, the maturation process continues, and must do so, on the right trajectory.

In other parts of the world, we received some international support for the establishment of this specialty. Professor Norman Williams, at that time, the President of the Royal College of England, reported in the Annals of the Royal College of Surgeons of England the following:

> "They (Americans) established a new specialty, Acute Care Surgery, that embraced trauma, emergency general surgery, and critical care. Initially, there was much skepticism and, indeed, even hostility from colleagues but this has now largely vanished and the initiative is hailed as a great success as demonstrated by improved patient outcomes."[2]

This laudatory recognition by Professor Williams was complimentary but premature. The preferred methodology in objectively determining the status of acute care surgery is the utilization of a template "checklist" (Table 2.1). With respect to defining the specialty, acute care surgery has been accepted as a specialty that embodies trauma, surgical critical care, and emergency general surgery. As has been mentioned in the opening chapter (Acute Care Surgery: General Principles) and elucidated by Peitzman et al., **Redefining Acute Care Surgery: Surgical Rescue**, a fourth component (surgical rescue) should be also embraced.

As depicted in Figure 2.1, the three pillars of support for this specialty were initially endorsed. However, there is a need to encourage the natural evolution and growth of this specialty (Fig. 2.2). Peitzman et al., **Redefining Acute Care Surgery: Surgical Rescue**, reported on a potential expanded role for the specialty, acute care surgery. He and co-authors opined that a critical service provided by their acute care surgeons is one of surgical rescue.[3] In a landmark article by Ghafori, Birkmeyer, and Dimick in **Medical Care**, the authors underscored the advantages of establishing strategies that focus on timely recognition and management of complications once they occur. Although the outcomes were not perfect, they found that there were better outcomes at high-volume centers, as opposed to low-volume centers, because of the ability of the high-volume centers to initiate surgical rescue more expeditiously.[4]

The specialty, acute care surgery, has been distinctly defined. However, the label is not always correctly and consistently applied to what is actually being practiced. Has there been a template training model constructed for both fellowship and general surgery training? A committee on acute care

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Comparative Effectiveness Research in Acute Care Surgery

Melissa Ann Hornor
Clifford Y. Ko

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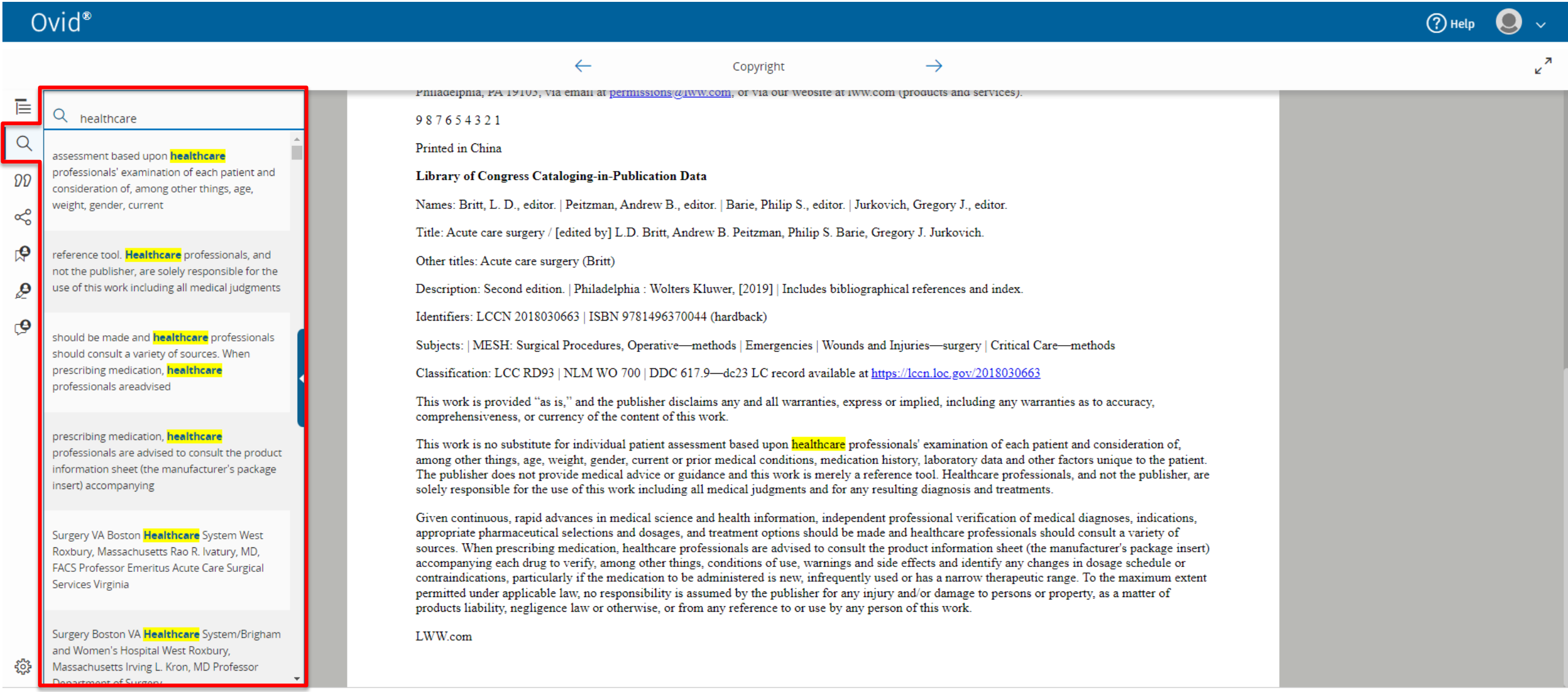
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CHAPTER 68

Comparative Effectiveness Research in Acute Care Surgery

Melissa Ann Hornor
Clifford Y. Ko

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RANDOMIZED CONTROLLED TRIALS

Randomized controlled trials are designed to provide the best possible clinical evidence on the efficacy of a treatment or intervention—put simply, this is achieved by testing the treatment or intervention in a very tightly controlled environment. This is executed through randomized selection of the sample populations and blinding of both the researchers and the patient to the intervention. According to the National Institutes of Health, an experimental treatment is likely best tested through a clinical trial in four phases (Table 68.1). Phase I tests the experimental treatment in a small test group (20-80 people) to evaluate safety and monitor for side effects; phase II tests the new treatment on a slightly larger group (100-300 people) to determine the efficacy of the treatment; phase III tests the treatment in a larger sample (1,000-3,000 people) to confirm efficacy, monitor for side effects, and compare the experimental treatment to existing treatments; and phase IV is the final phase where the experimental treatment's risks, benefits, and optimal use are refined.

There are many obstacles to the successful completion of randomized trials of surgical interventions, some of which are magnified when researching interventions relevant to acute care surgery. Emergency surgery requires urgent lifesaving treatment of sometimes rare conditions, which makes recruitment, consent, and randomization quite difficult. In surgery, it frequently can be difficult for

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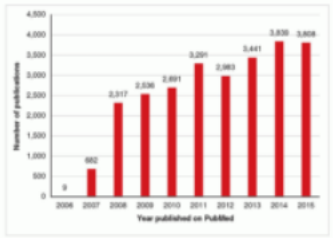

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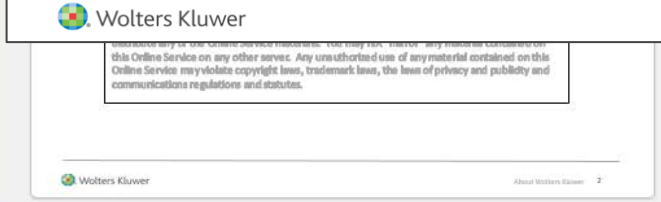

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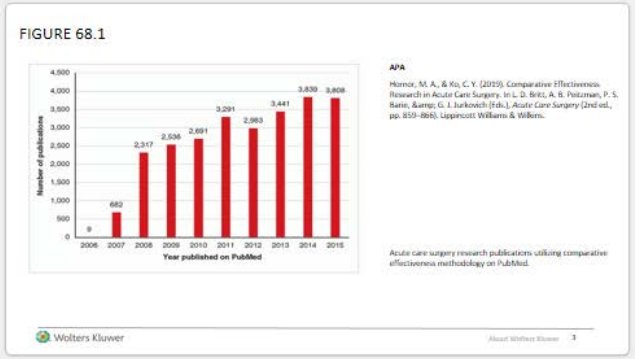

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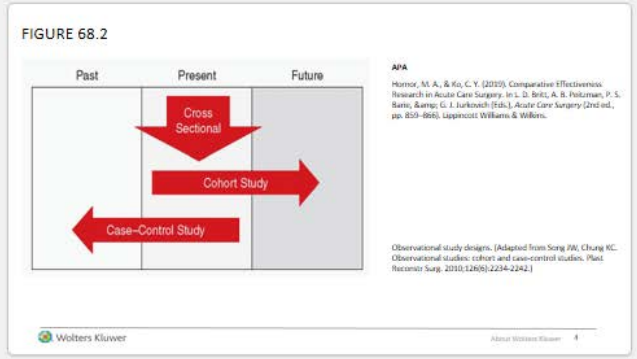

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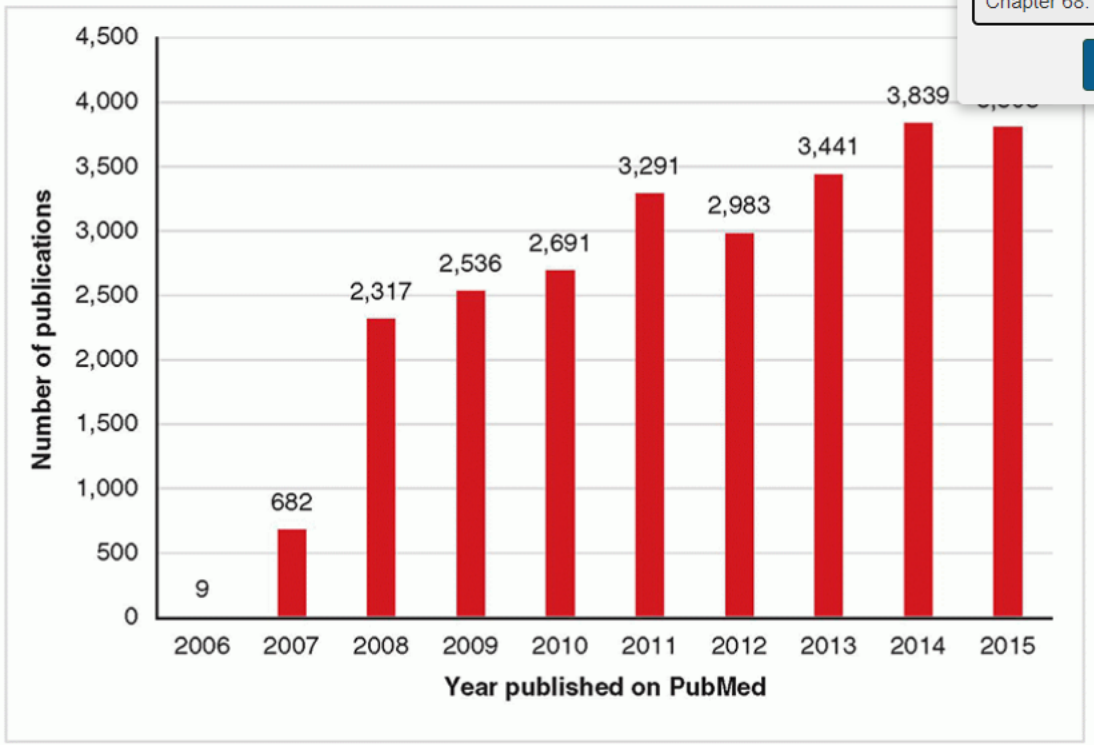

FIGURE 68.1 Acute care surgery research publications utilizing comparative effectiveness methodology

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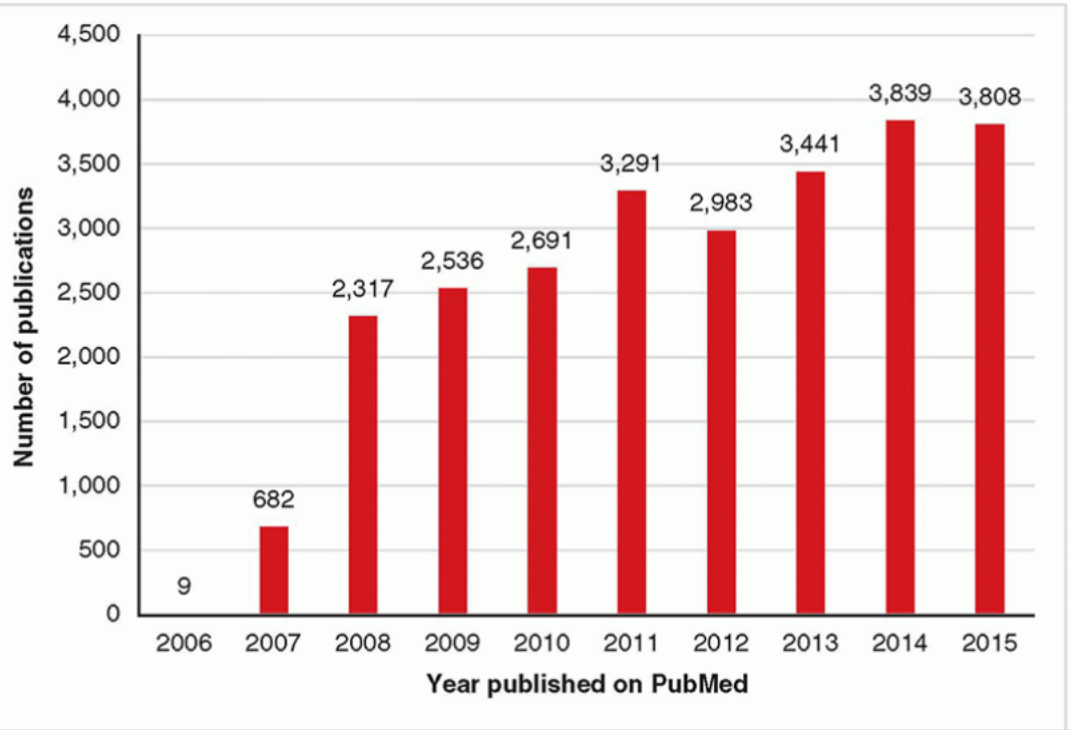
researcher, the postintervention care provider, and the study patient to the intervention—especially when comparing surgical vs medical treatments.[7,8] In point of fact, CER methodologies can assess outcomes between highly preference-sensitive treatment decisions and can provide important data on effectiveness.

There are several factors to keep in mind when evaluating the quality of a RCT. The CONSORT (Consolidated Standards of Reporting Trials) statement is an evidence-based, minimum set of recommendations for researchers to report when conducting RCTs. This statement emphasizes the reporting of randomization and assignment to treatment groups, masking (blinding) of subjects, timing until follow-up, and data analysis methodology.[9,10] Concerningly, a recent systematic review examined 150 surgical RCTs and found only 55% to be CONSORT compliant.[11] This reflects the difficulty surgeon researchers experience *(Print pagebreak 860)* when conducting RCTs with respect to blinding, intervention complexity, and patient and provider treatment bias, among other problems. Some of these issues are addressed through the alteration of RCT study designs for CER described here.



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Clifford Y. Ko

All surgeons strive to deliver care based on the best evidence, making it imperative for surgeons to understand the evidence that drives their decision-making around indications for surgery, surgical technique, and expected outcomes. Comparative effectiveness research (CER) has emerged as an ideal research method for testing whether surgical interventions work in the real world. CER seeks to investigate the **effectiveness** of an intervention in specific patient populations, or what may be considered "best practice" for an individual patient, while traditional clinical research, such as a randomized controlled trial (RCT), often investigates the **efficacy** of an intervention in a tightly controlled environment.[1] While RCTs have the ability to produce the highest level of evidence, investigators may run into serious issues in terms of feasibility, generalizability, patient selection, and time elapsed prior to integration into clinical practice. CER has helped move surgical research forward by adapting traditional clinical research study designs so that they work in real-world situations.

In brief, CER measures the effectiveness of a clinical intervention by comparing active treatments within populations that are representative of usual practice in an evidence-based manner, providing patients, providers, and policymakers with the data required to make informed choices. In point of fact, the Institute of Medicine defines CER as the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care.[2]

The US health care system is often found to produce inferior health outcomes despite having the highest per capita spending on health care in the world. As such, CER has been identified on the federal level as an effective tool to address the gaps in quality and efficiency in the US health care system.[3,4] The American Reinvestment and Recovery Act of 2008 allocated $1.1 billion in grant awards to go toward supporting this research,[5] and the Patient Protection and Affordable Care Act of 2010 created the Patient-Centered Outcomes Research Institute (PCORI), an organization that sets national priorities for CER topics with an estimated $500 million annual budget.[6] PCORI emphasizes the critical importance of maintaining a patient-centered perspective when conducting CER, with a mission to produce highintegrity research that is guided by patients, caregivers, and the broader health care community.[6] CER has become a high priority for surgical researchers, as evidenced by the increase in CER publications in acute care surgery in the last decade (**Fig. 68.1**).

Comparative effectiveness research is viewed as an extremely worthwhile endeavor within acute care surgery and throughout the medical community. At this juncture, it is essential to understand the advantages, disadvantages, and consequences of increasing the use of CER within acute care surgery. This chapter provides the reader with a comprehensive understanding of CER by first touching on study designs within CER, how to grade and rank each study design, and finally, how to approach creating your own CER study within acute care surgery. The chapter ends with a small handful of recently published clinical studies (randomized controlled and observational trials) in acute care surgery that are meant to provide an example of the types of studies that have been found to be beneficial for

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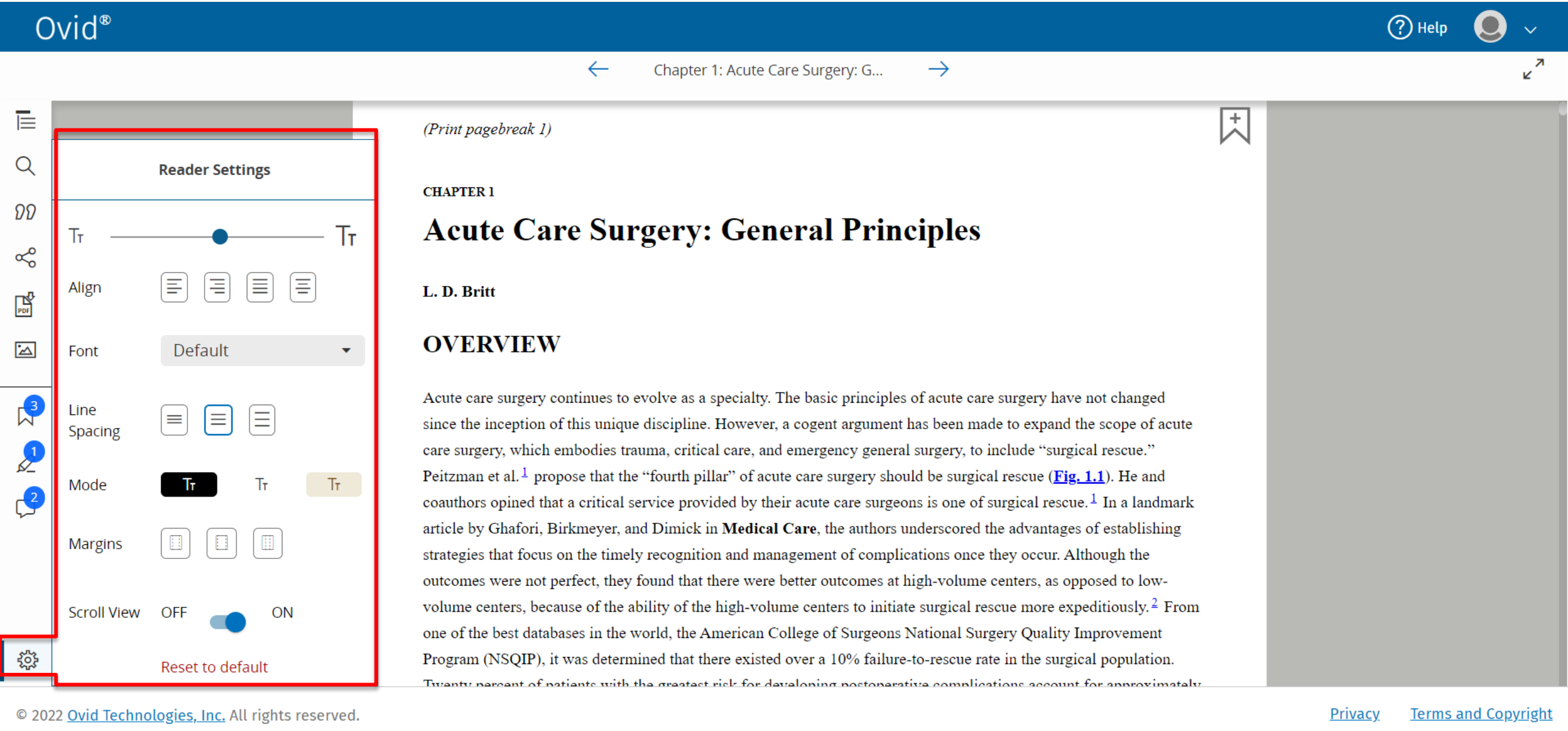
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CHAPTER 1
Acute Care Surgery: General Principles
L. D. Britt
OVERVIEW
Acute care surgery continues to evolve as a specialty. The basic principles of acute care surgery have not changed since the inception of this unique discipline. However, a cogent argument has been made to expand the scope of acute care surgery, which embodies trauma, critical care, and emergency general surgery, to include "surgical rescue." Peitzman et al.[1] propose that the "fourth pillar" of acute care surgery should be surgical rescue (Fig. 1.1). He and coauthors opined that a critical service provided by their acute care surgeons is one of surgical rescue.[1] In a landmark article by Ghafori, Birkmeyer, and Dimick in Medical Care, the authors underscored the advantages of establishing strategies that focus on the timely recognition and management of complications once they occur. Although the outcomes were not perfect, they found that there were better outcomes at high-volume centers, as opposed to low-volume centers, because of the ability of the high-volume centers to initiate surgical rescue more expeditiously.[2] From one of the best databases in the world, the American College of Surgeons National Surgery Quality Improvement Program (NSQIP), it was determined that there existed over a 10% failure-to-rescue rate in the surgical population.
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參考文獻串聯

Acute Care Surgery

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- Book
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  - RT_B2
  - TR_B3
- Databases
- Platform

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- Journal
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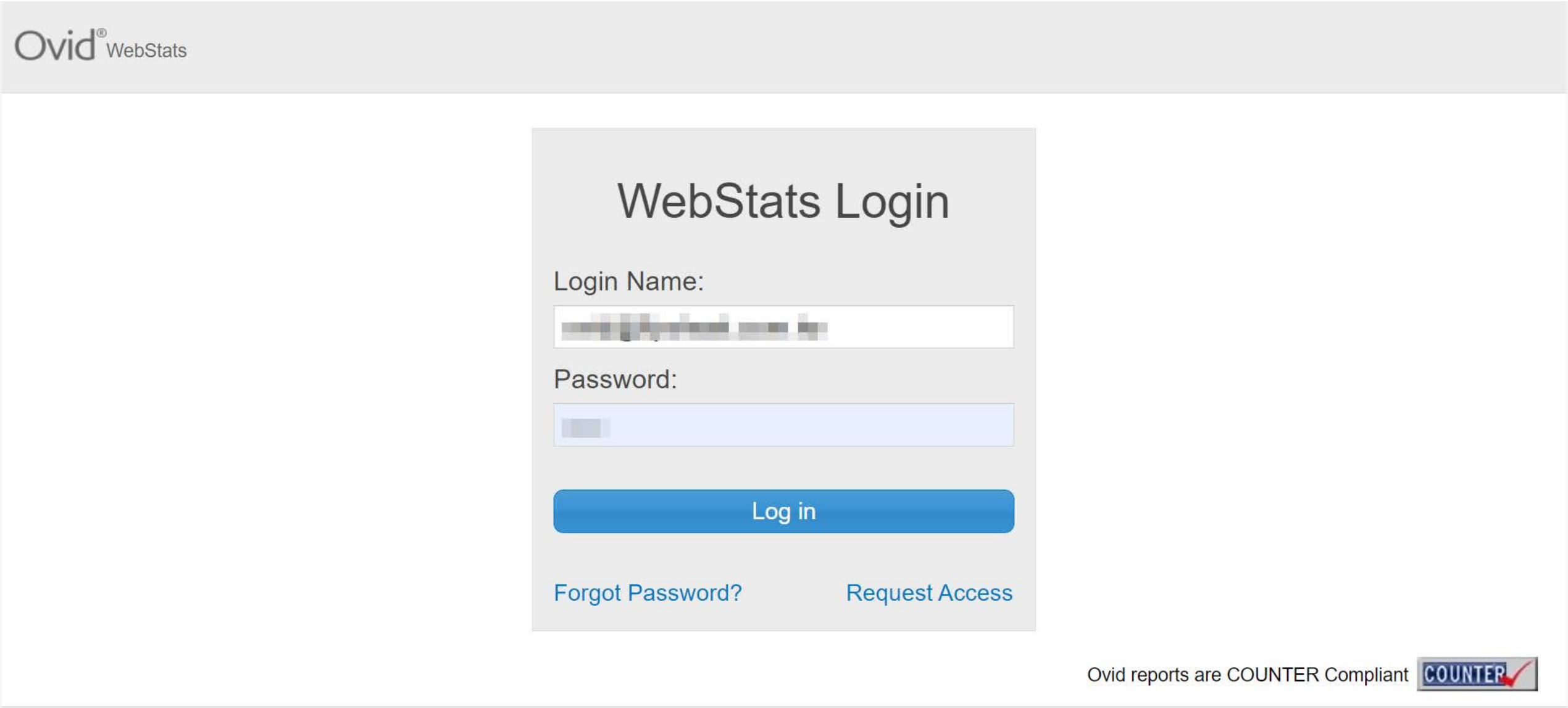

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For more information about Release 5 (R5) of the COUNTER Code of Practice, please refer to Friendly Guides or the FAQ.

If you need assistance, please contact Ovid Customer Service:support@ovid.com. We can provide additional training and assistance or run any specific usage reports you may need.

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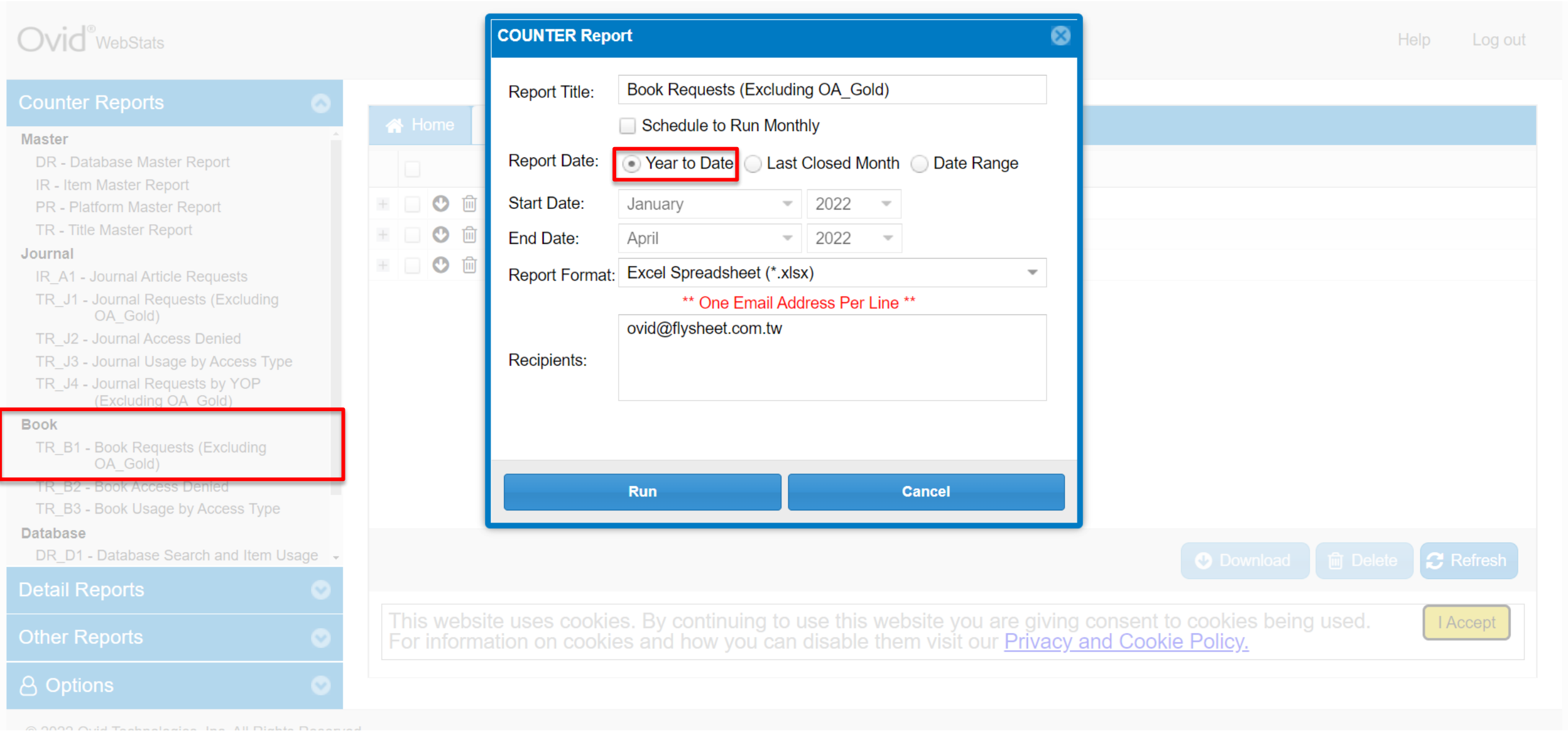
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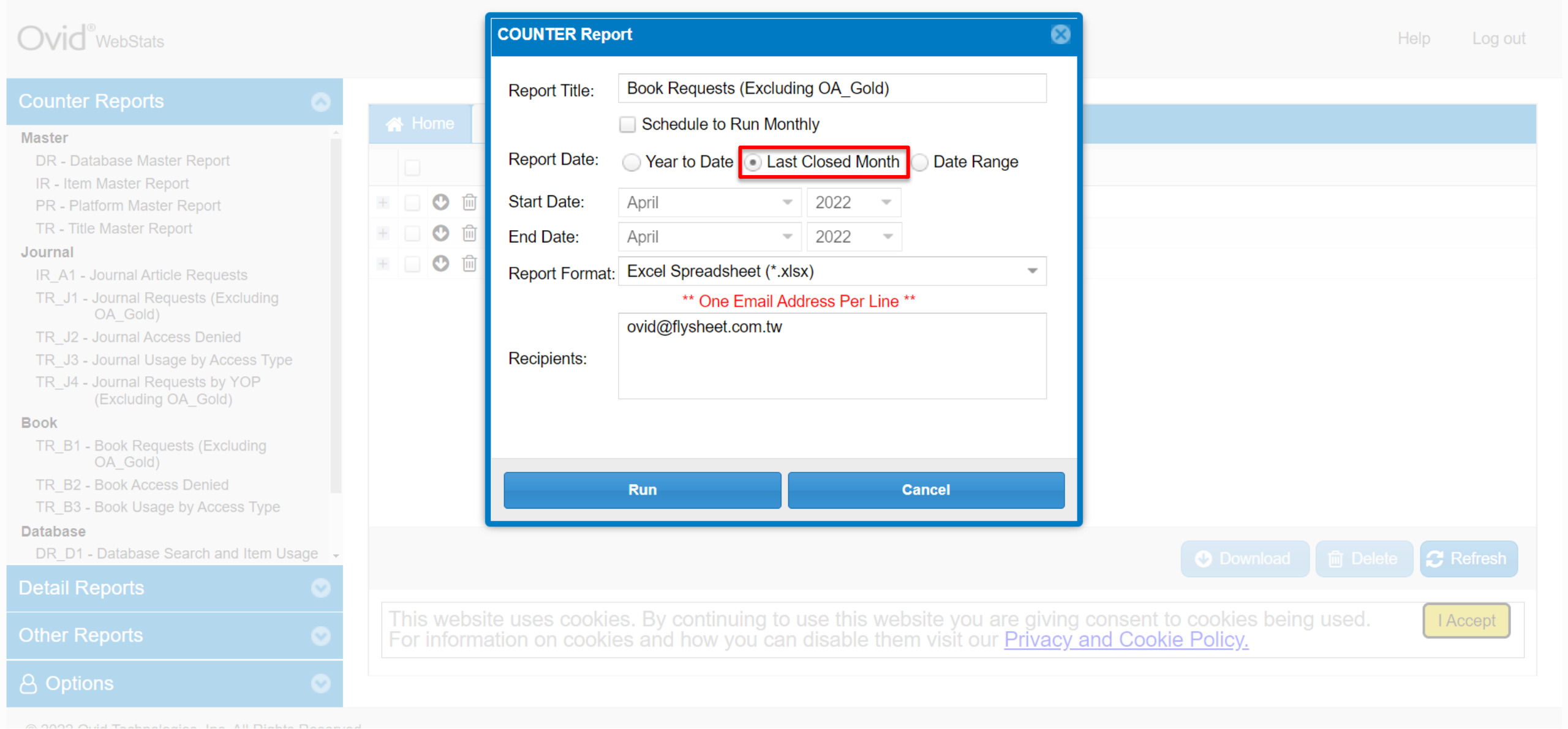
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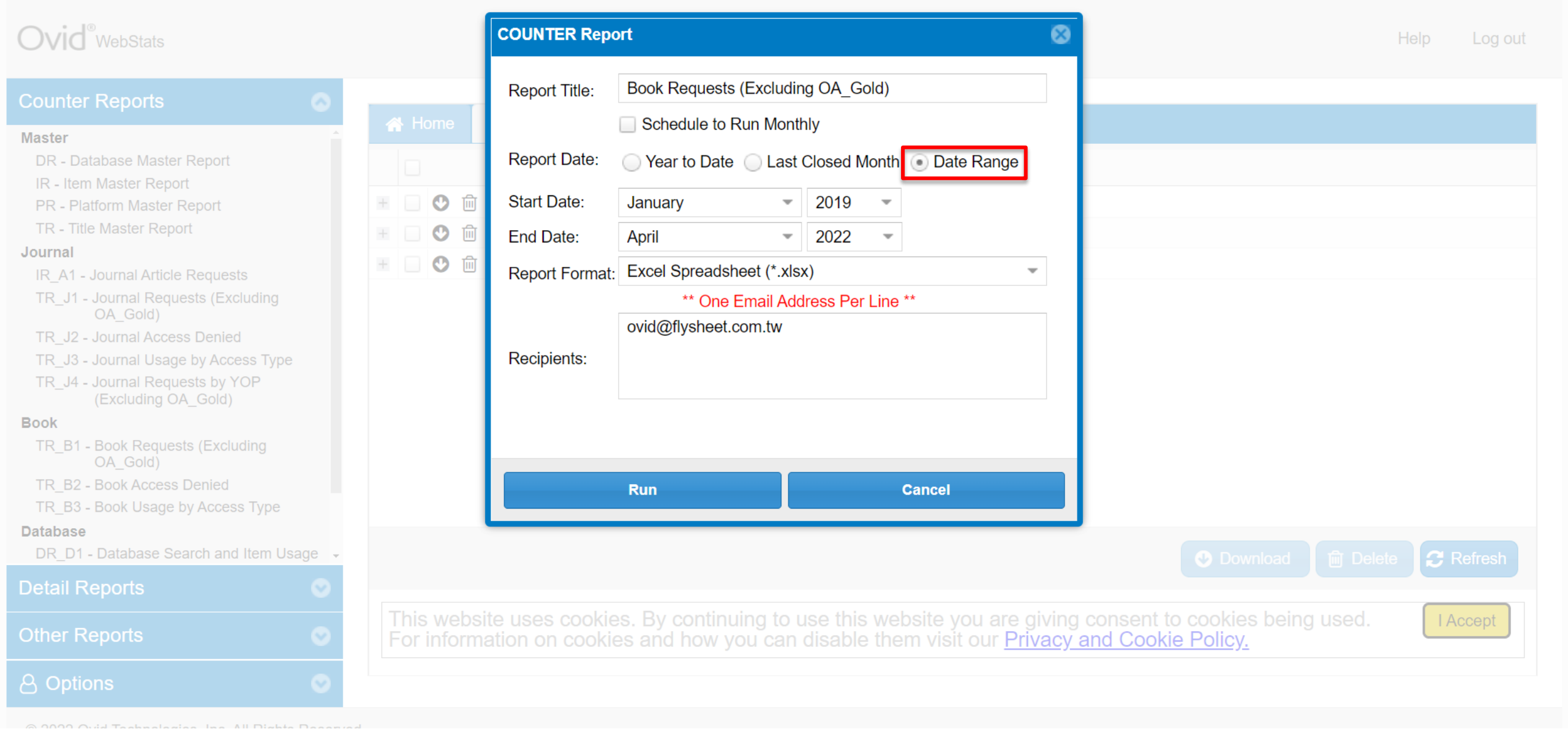

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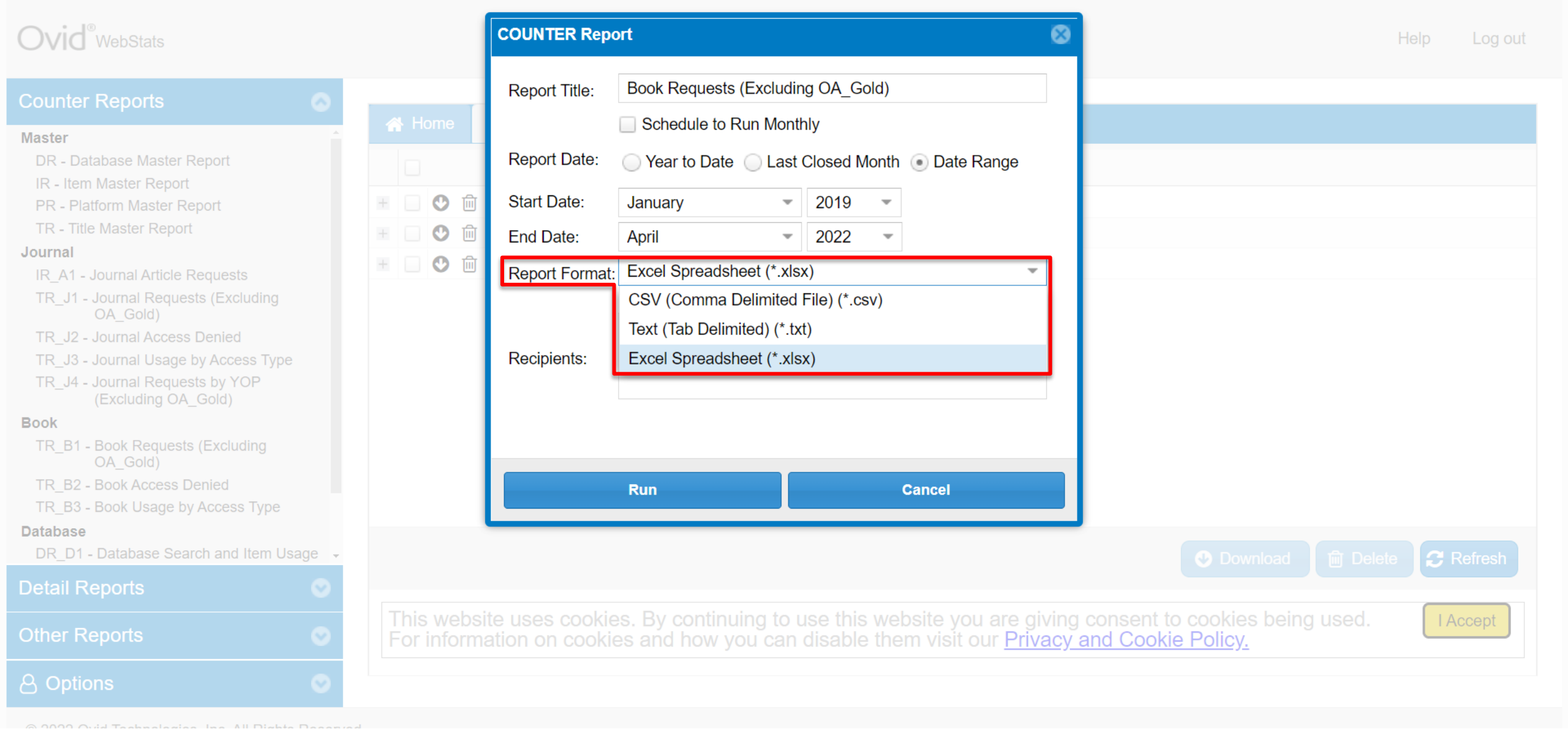

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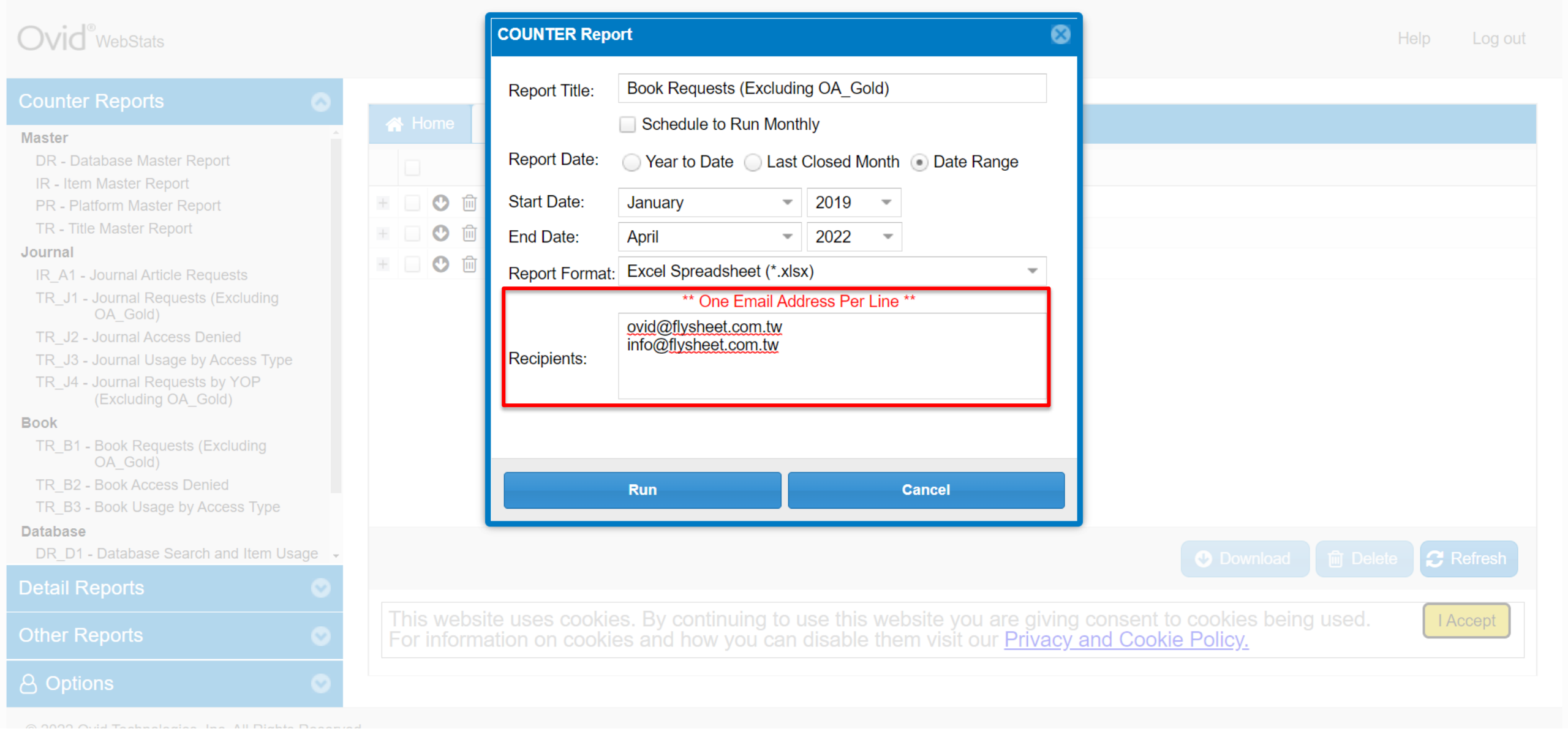
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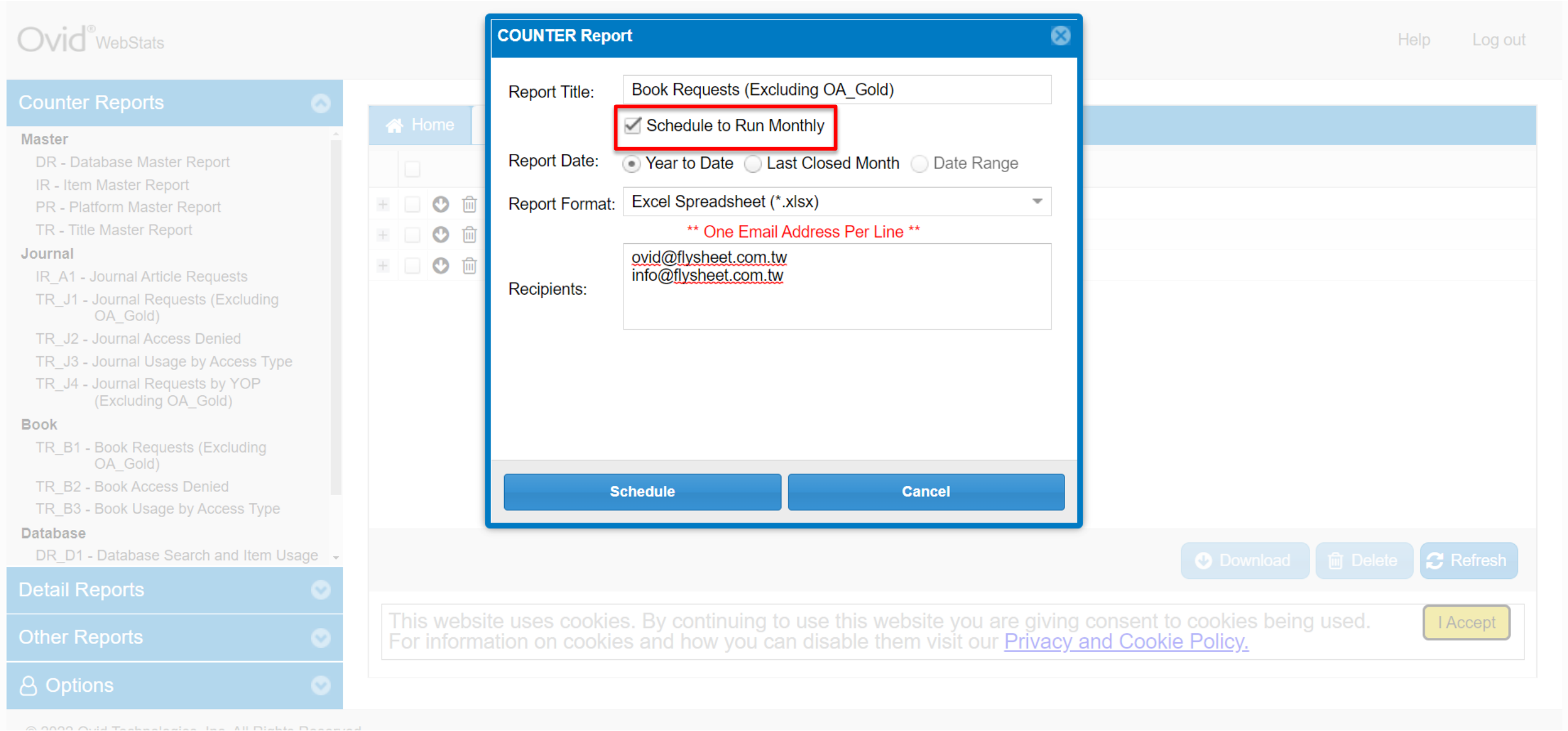
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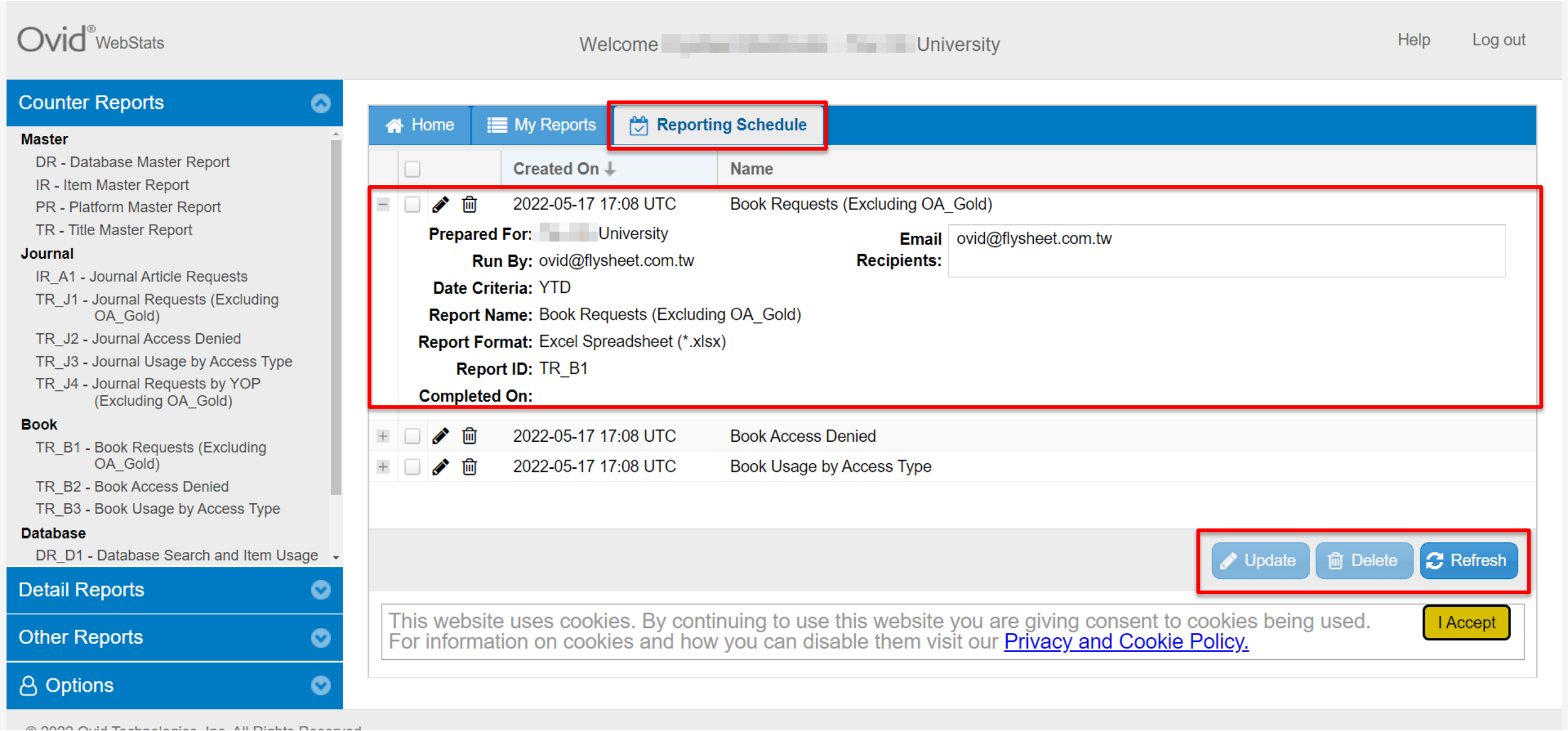
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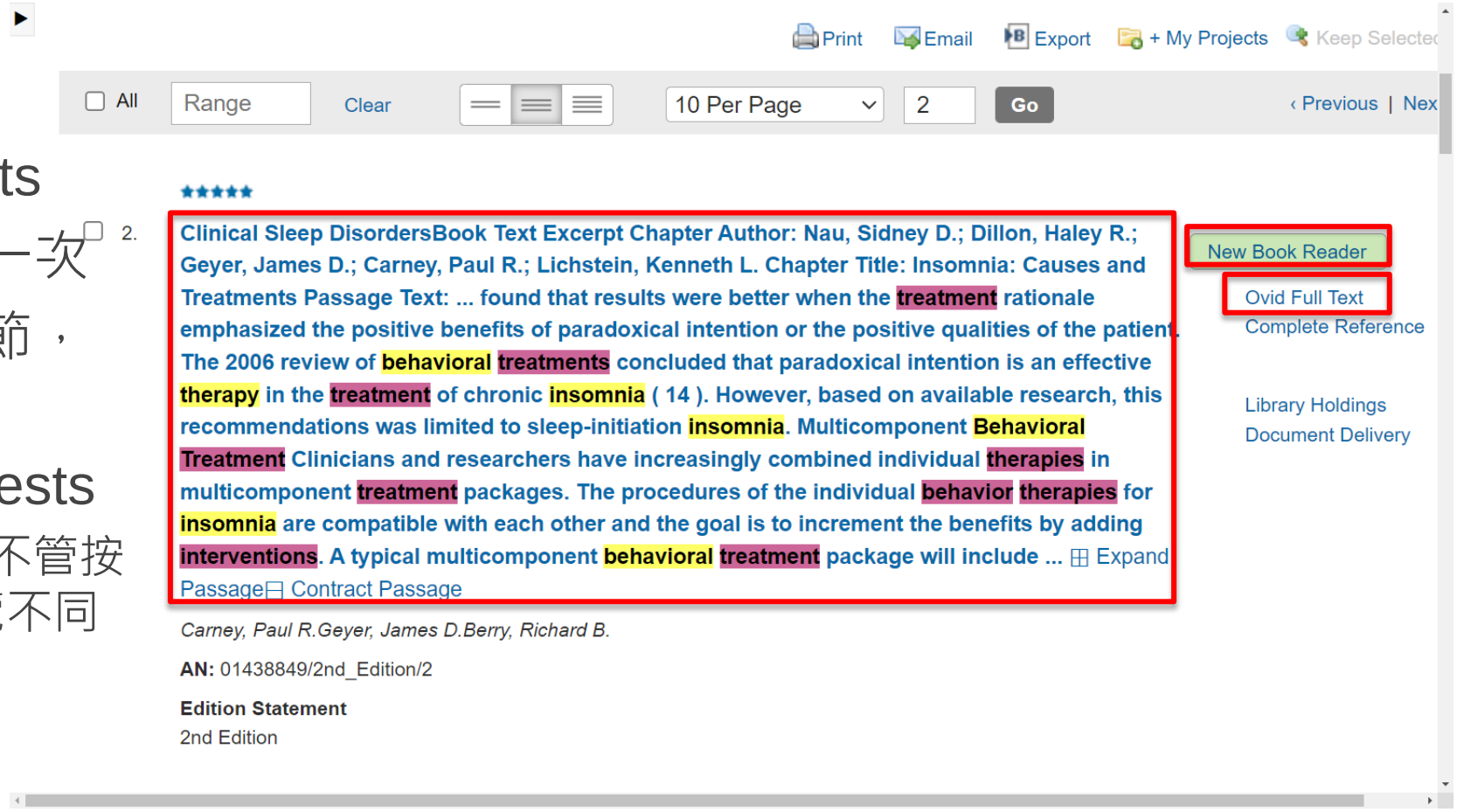

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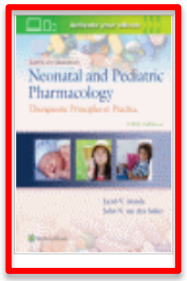

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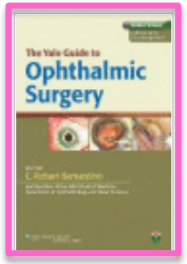

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Chapter 1

Clinical Trials Involving Children: History, Rationale, Regulatory Framework, and Technical Considerations

Steven Hirschfeld,
Susan McCune,
Lynne Yao,
Donna L. Snyder,
Gerri R. Baer,
Bridgette L. Jones,
Anne Zajicek,

INTRODUCTION

Sushi金鑰取得及使用

取得Sushi金鑰

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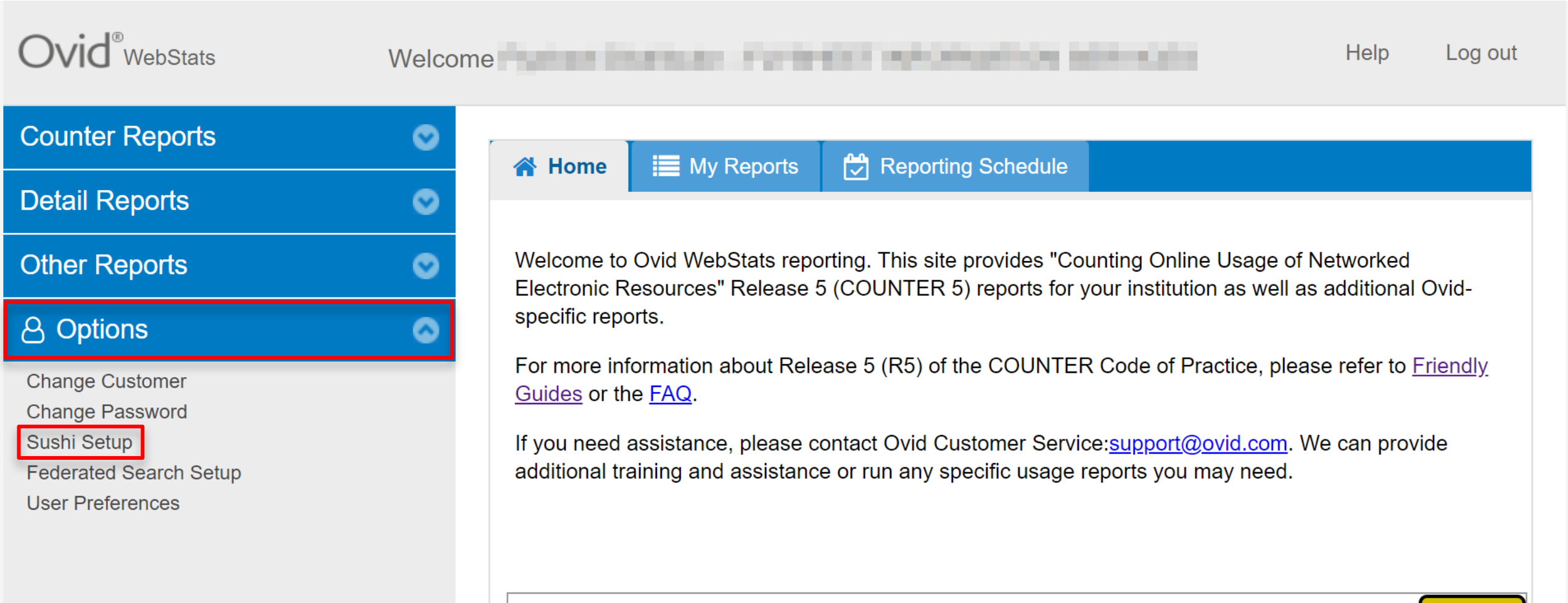

Sushi Setup

Sushi Access Tokens

COUNTER 5 data harvesting is supported using the Sushi REST interface. To use the Sushi API, see the instructions available at our Swagger site (https://stats.ovid.com/C5/swagger/).

The API requires a 'requestor_id' and 'customer_id'. Use the 'Generate Token' button below to create requestor_id tokens for use in the API.

Generate Tokens

To generate a token, select a customer and click 'Generate Token'. Each token allows access to that customer, and their members if the customer is a consortia. Multiple customers may be selected at one time to generate a unique token for each.

Select Customer: [redacted] Generate Token

Current Tokens

requestor_id	customer_id	Expires On	
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Q & A