麦格劳-希尔教育集团
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数据库的特色

1、数据库为医护人员最大限度地节省时间

- ClinicalAccess能够以最快的速度为一线的医护人员提供有针对性的、权威的治疗方案，帮助医生等医护从业者以最快的速度、最高的效率，为患者提供更好的治疗和护理。

2、数据库的内容得益于医学界的领袖级专家

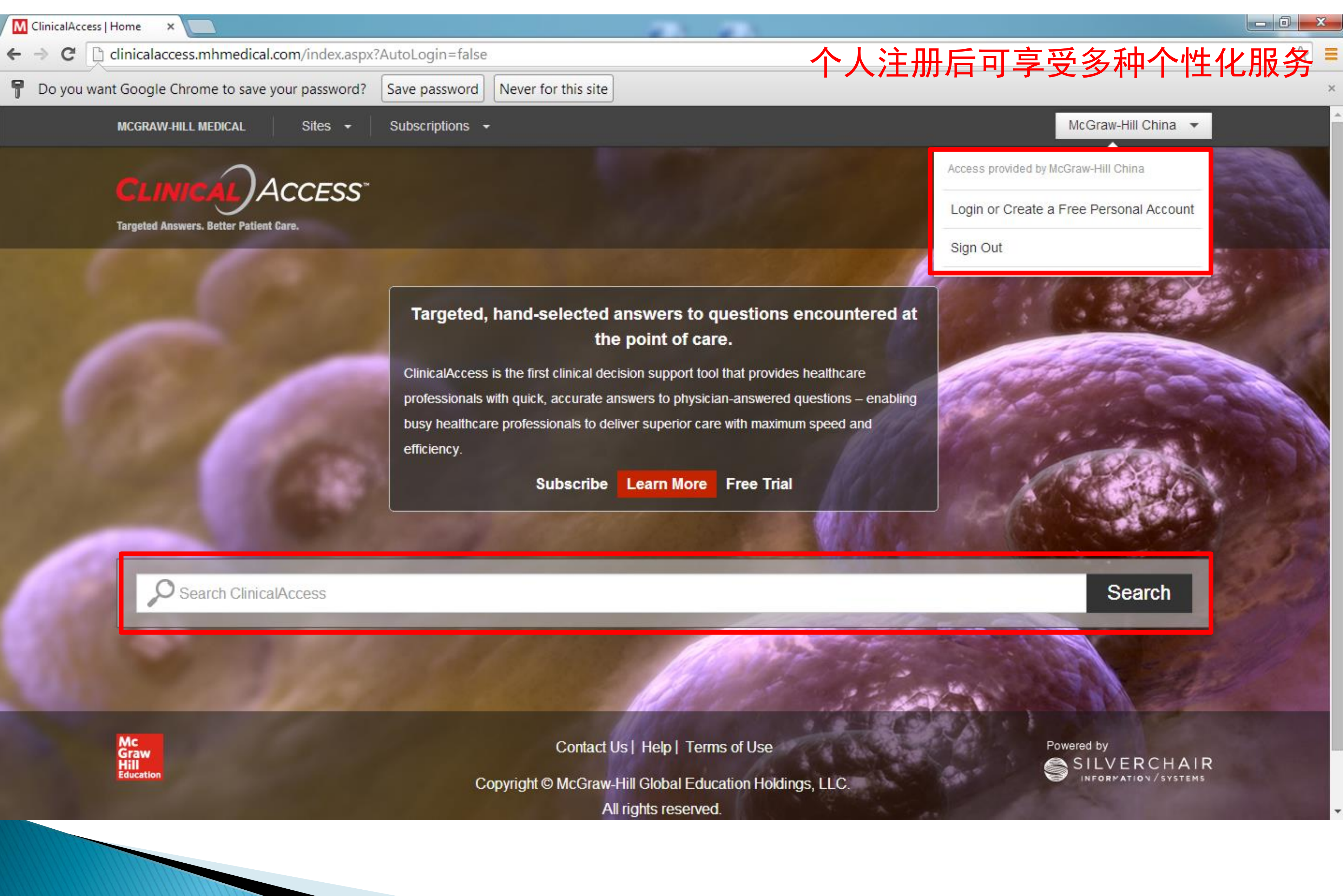
- 麦格劳-希尔教育集团拥有在全球享有盛誉的医学专家组成的编辑、顾问团队，这个团队研发出了ClinicalAccess这个数据库，它可以帮助读者在对患者进行诊断和治疗的过程中进行决策。
- 这个数据库涉及25个医学分支学科、包含超过12万个问题和相应的解决方案。
- 在问题的解决方案中包含图像、图表、视频等各种资源类型，以帮助读者更好的理解主题内容。
- 我们的编辑团队在不断的审视和更新这些内容，以确保我们所提供的信息是最新的、最准确的。

3、数据库链接权威参考信息

- ClinicalAccess引导一系列在线临床参考资源，如：AccessMedicine、AccessSurgery、AccessPediatrics、AccessEmergency Medicine等，传递给读者准确的、值得信赖的患者治疗和护理方面的信息。
- 我们提供权威的、经过大量实践检验的、来源于经典医学著作的解决方案，这些经典医学著作例如：
  - Schwartz’s Principles of Surgery
  - Tintinalli’s Emergency Medicine
  - Principles and Practice of Hospital Medicine
  - Harrison’s Principles of Internal Medicine
  - CURRENT Medical Diagnosis & Treatment
- ClinicalAccess的内容是由专业领域的领袖级专家撰写，所以这个数据库能够有效缩短用于评估患者相关信息的时间，并且快速决定这一信息是否能够被其它医护从业者所采纳和应用。ClinicalAccess提供高效的、不断提高的、专业的检索，以便适应当前所有医护从业者的需求。

数据库内容和模块介绍

1. 共有超过12万个临床问题和解决方案，且在逐步增加。从常见问题到罕见问题，ClinicalAccess为您提供值得信赖的解决方案。
2. 数据库提供必要的药物信息，药物名称可自动链接到Drug Point®，以帮助医生快速解答急性患者的治疗问题。
3. 如需获得相关主题的更多、更深入的知识，可以链接到麦格劳-希尔教育集团的其它医学电子资源，例如：AccessMedicine、AccessSurgery、AccessPharmacy、AccessPediatrics等。
4. 数据库中包含2万多张高质量图片、视频、运算程序，并且这些多媒体资源会自动整合到问题的解决方案中去，以便增强读者对某一主题和解决方案的理解。
5. 系统会自动辨认重点叙述的问题，提供更多阅读资源的快速访问方式。
6. 把相关问题进行分类，快速缩小检索范围。
7. 通过麦格劳-希尔教育集团的合作伙伴McMaster Premium Literature Service，读者可以访问到最新的、最相关的、最充分的临床证据。
8. 数据库会持续增加新的问题和解决方案，以便读者随时掌握最新进展和重大发现。
9. 浏览主题的设立方便读者搜索完整的专业目录及其所涉及的相关内容。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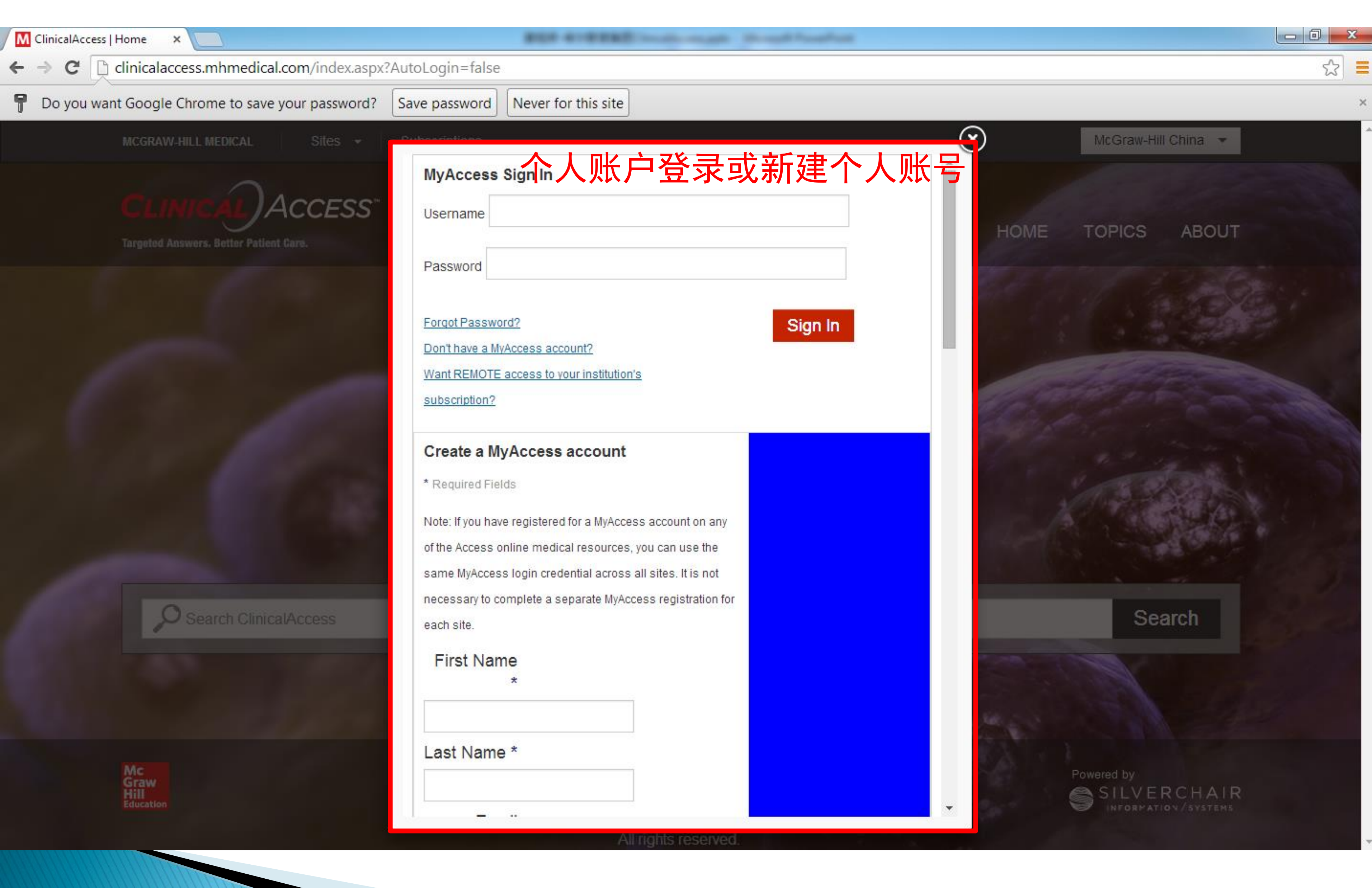
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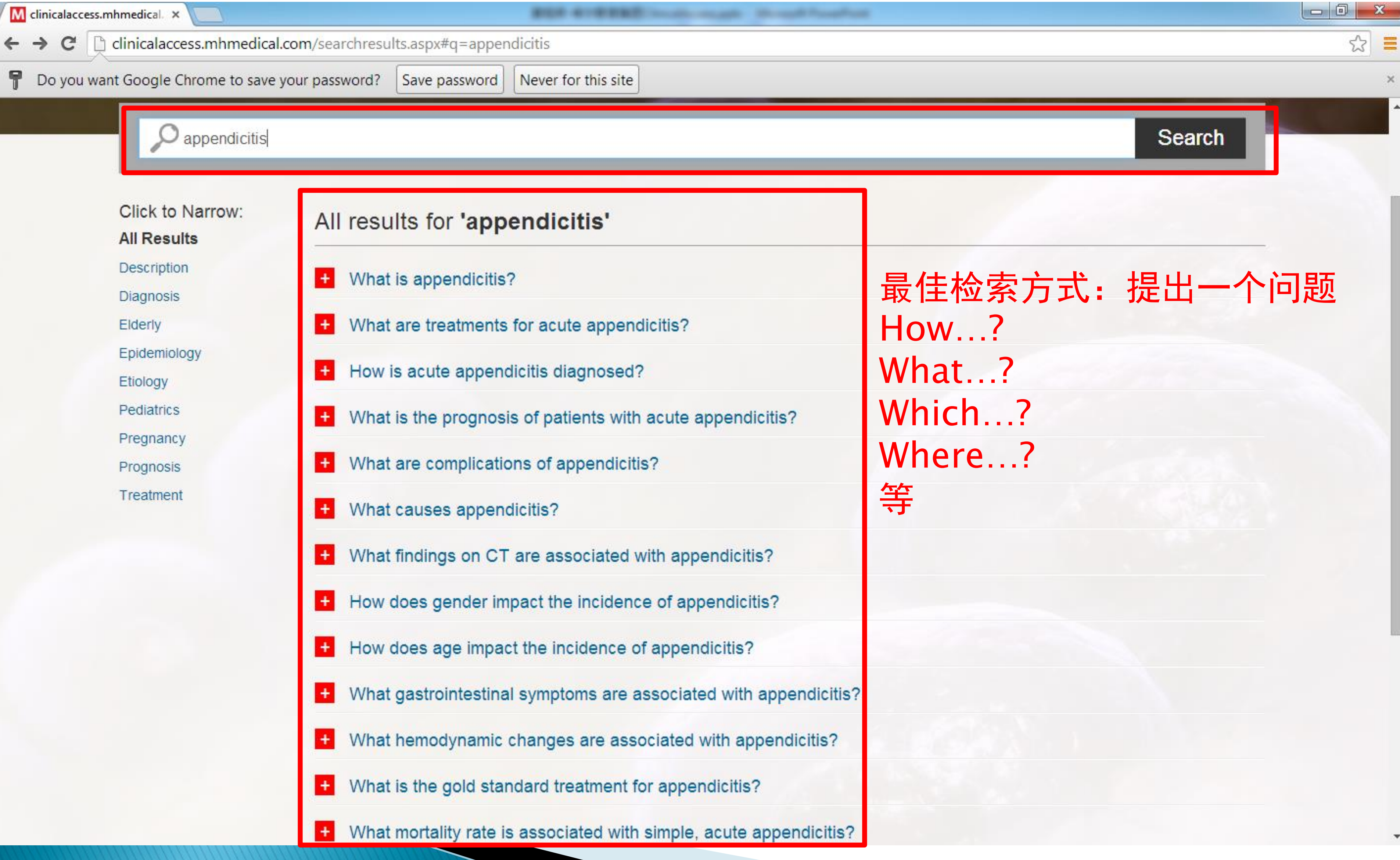
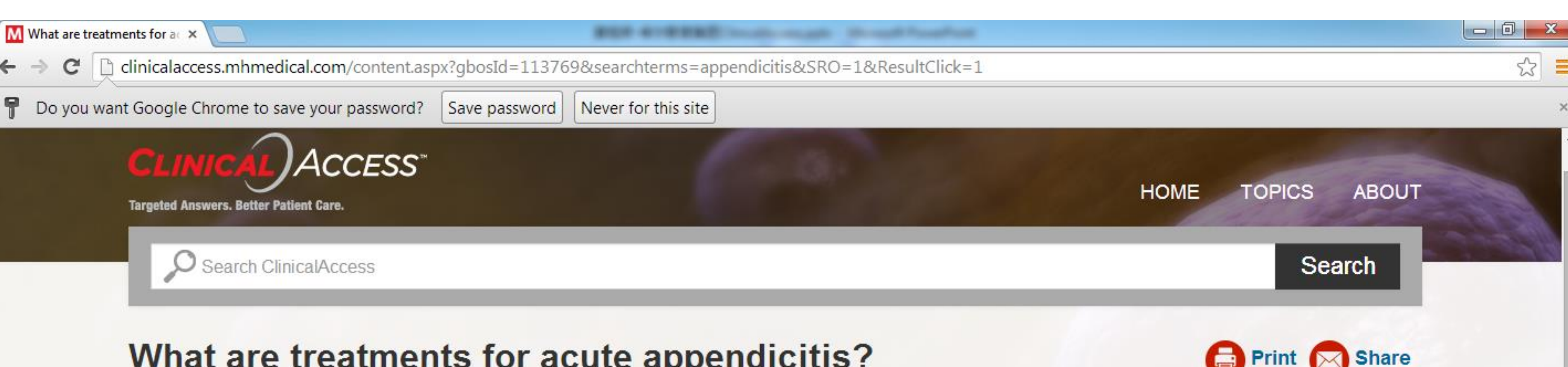
例1：appendicitis





What are treatments for acute appendicitis?

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Treatment: Acute Appendicitis

If the diagnosis is in question, 4–6 h of observation with serial abdominal exams is always more beneficial than harmful. Antibiotics should not be administered when the diagnosis is in question, since they will only mask the perforation. The treatment of presumed acute appendicitis is early operation and appendectomy as soon as the patient can be prepared. Appendectomy is frequently accomplished laparoscopically and is associated with less postoperative narcotic use and earlier discharge. It is acceptable to have a 15–20% incidence of a normal appendix at the time of appendectomy to avoid perforation. The use of early laparoscopy instead of close clinical observation has not shown a clinical benefit in the management of patients with nonspecific abdominal pain.

A different approach is indicated if a palpable mass is found 3–5 days after the onset of symptoms. This finding usually represents the presence of a phlegmon or abscess, and complications from attempted surgical excision are frequent. Such patients treated with broad-spectrum antibiotics, drainage of abscesses >3 cm, parenteral fluids, and bowel rest usually show resolution of symptoms within 1 week. *Interval appendectomy* can be performed safely 6–12 weeks later. A randomized clinical trial has demonstrated that antibiotics alone can effectively treat acute, nonperforated appendicitis in 86% of male patients. However, antibiotics alone were associated with a higher recurrence rate than when followed by surgical intervention. If the mass enlarges or the patient becomes more toxic, the abscess should be drained. Free perforation is associated with generalized peritonitis and its complications, including subphrenic, pelvic, or other abscesses, and can be avoided by early diagnosis. The mortality rate for nonperforated appendicitis is 0.1%, little more than the risk of general anesthesia; for perforated appendicitis, mortality is 3% (and can reach 15% in the elderly).

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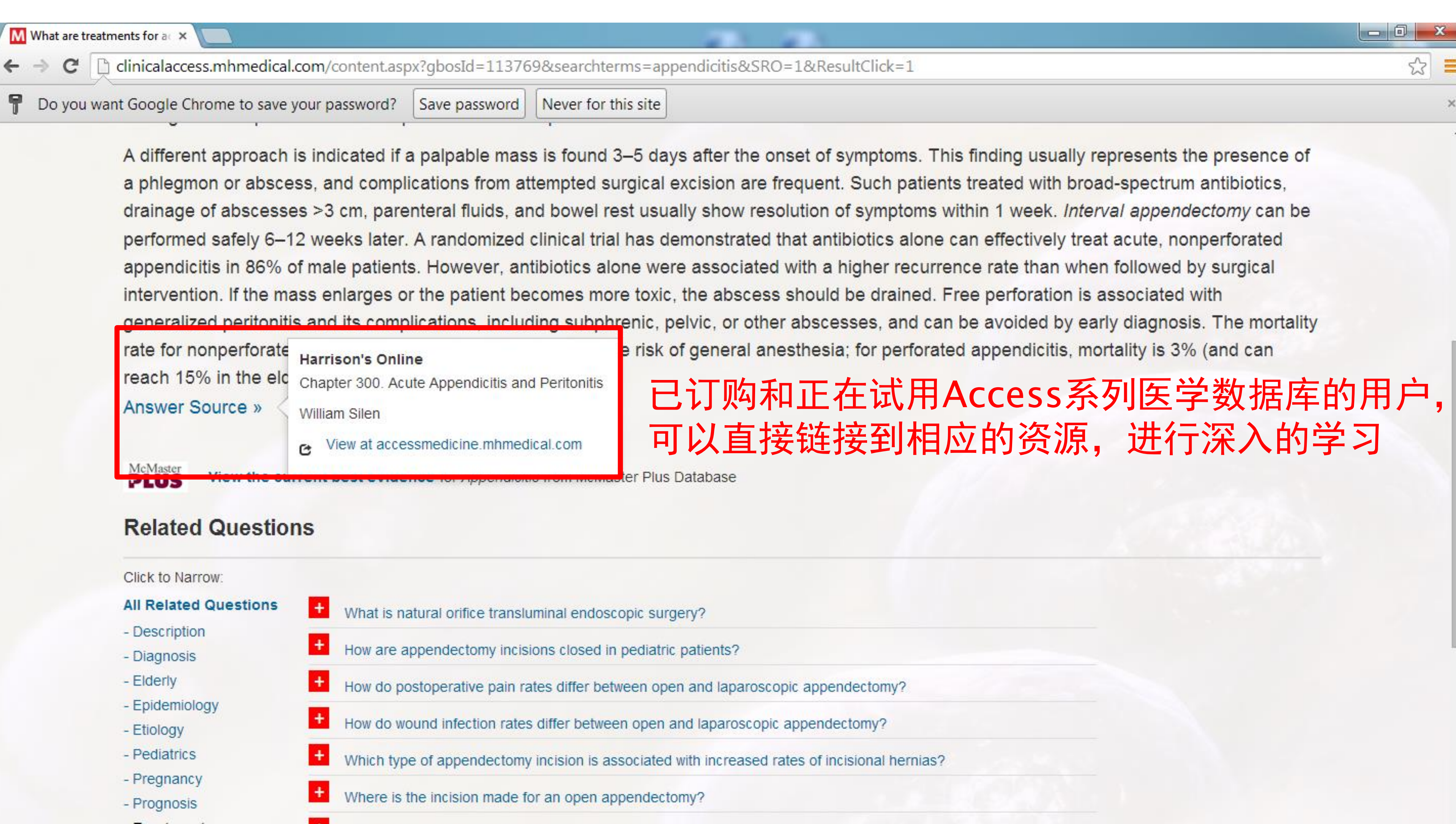
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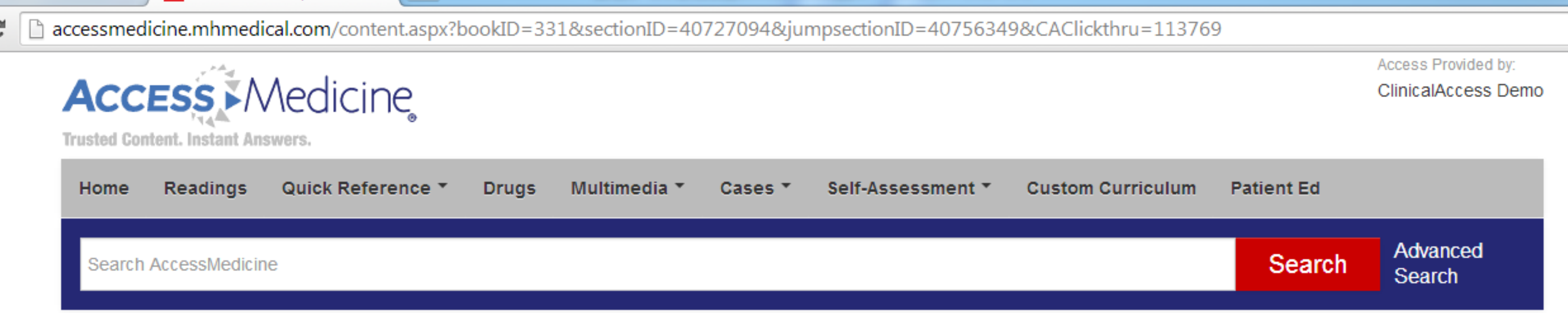
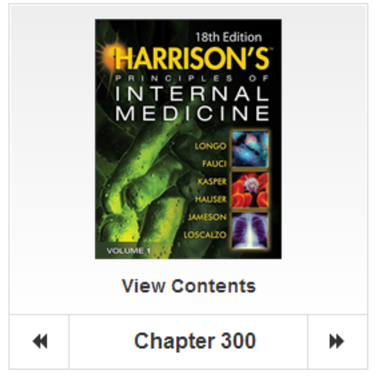
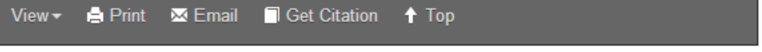
Where is the incision made for an open appendectomy?
Where is the appendectomy incision made in cases of suspected appendiceal abscess?
What surgical techniques are indicated for appendectomy during pregnancy?







Chapter 300. Acute Appendicitis and Peritonitis

William Silen

Acute Appendicitis

Incidence and Epidemiology

With more than 250,000 appendectomies performed annually, appendicitis is the most common abdominal surgical emergency in the United States. The peak incidence of acute appendicitis is in the second and third decades of life; it is relatively rare at the extremes of age. However, perforation is more common in infancy and in the elderly, during which periods mortality rates are highest. Males and females are equally affected, except between puberty and age 25, when males predominate in a 3:2 ratio. The incidence of appendicitis has remained stable in the United States over the last 30 years, while the incidence of appendicitis is much lower in underdeveloped countries, especially parts of Africa, and in lower socioeconomic groups. The mortality rate in the United States decreased eightfold between 1941 and 1970 but has remained at <1 per 100,000 since then.

Pathogenesis

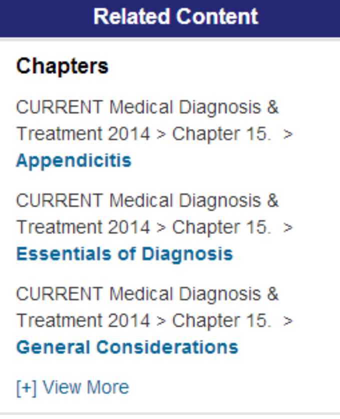
Appendicitis is believed to occur as a result of appendiceal luminal obstruction. Obstruction is most commonly caused by a fecalith, which results from accumulation and

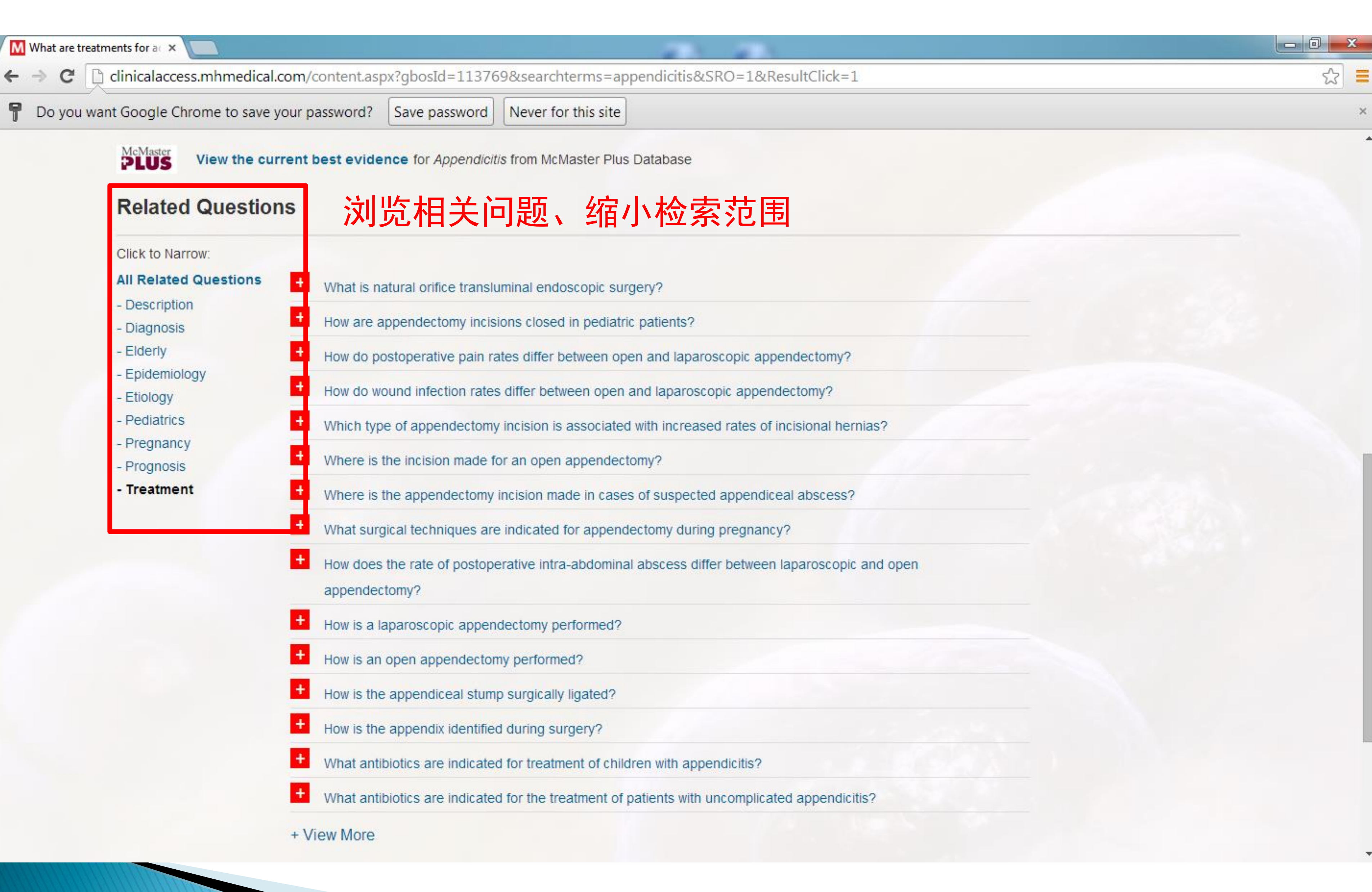
Acute Appendicitis

Clinical Manifestations

Acute Peritonitis

Further Readings

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What surgical techniques are indicated for appendectomy during pregnancy?
How does the rate of postoperative intra-abdominal abscess differ between laparoscopic and open appendectomy?
How is a laparoscopic appendectomy performed?
How is an open appendectomy performed?
How is the appendiceal stump surgically ligated?
How is the appendix identified during surgery?
What antibiotics are indicated for treatment of children with appendicitis?
What antibiotics are indicated for the treatment of patients with uncomplicated appendicitis?
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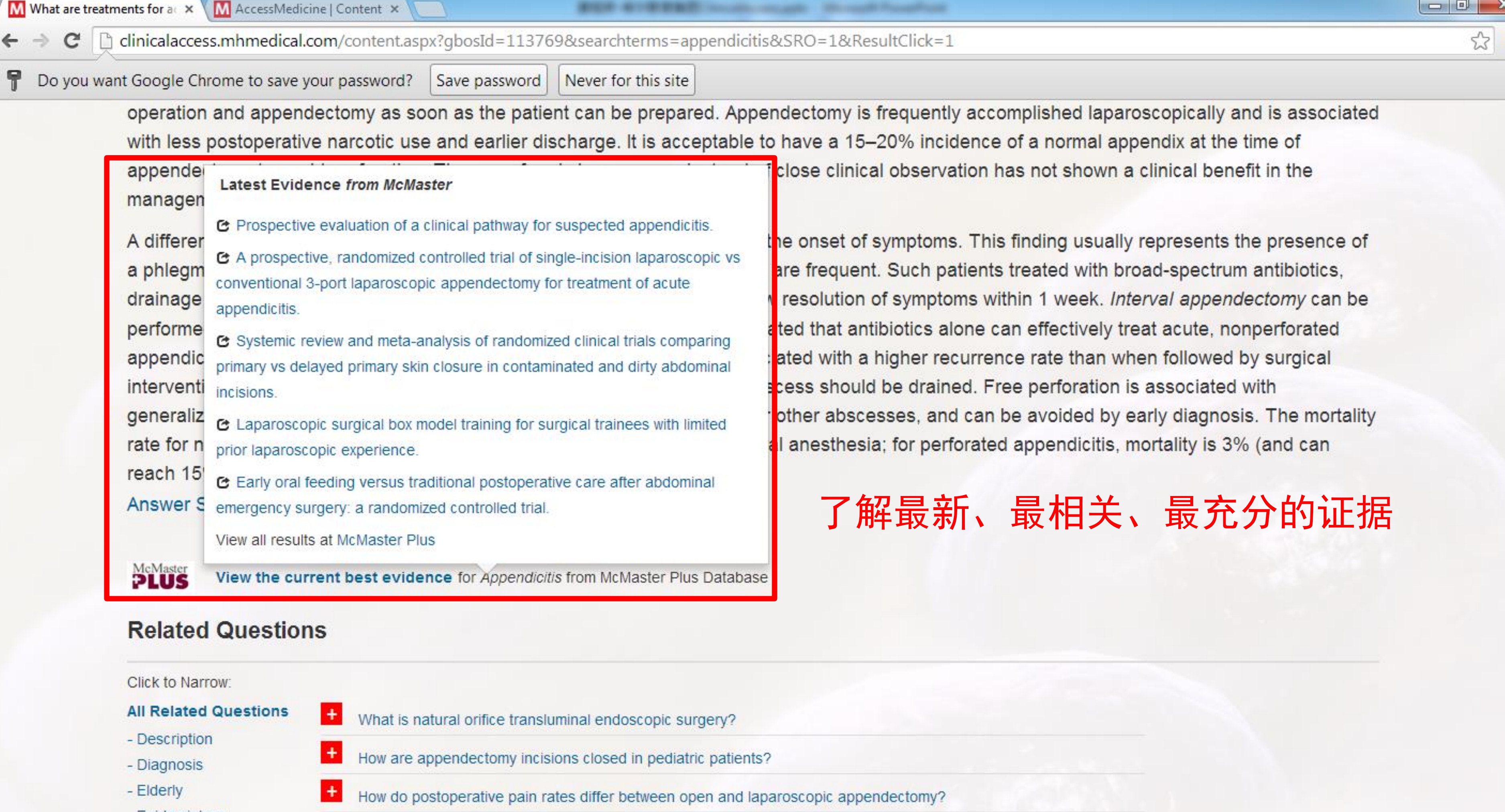

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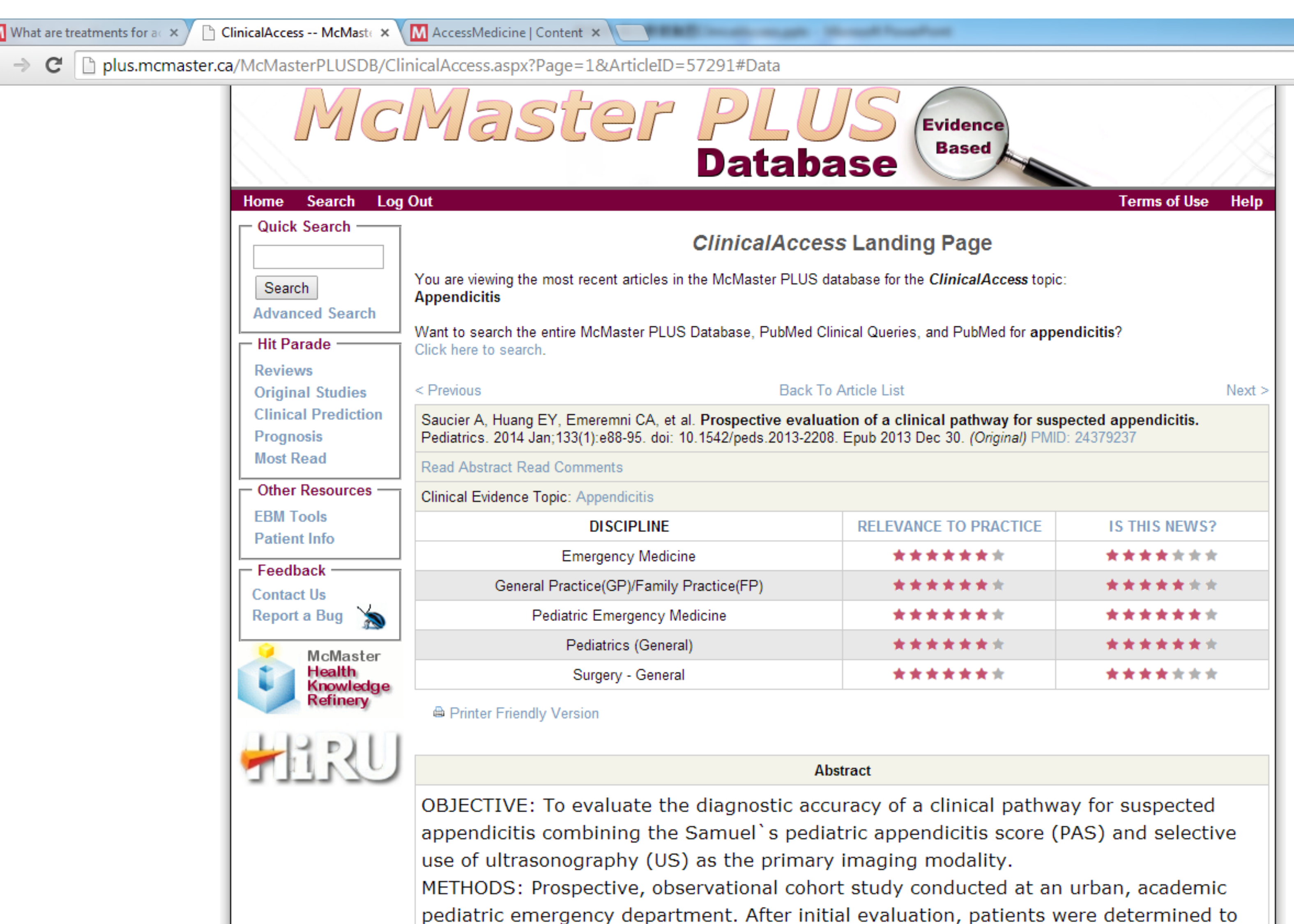
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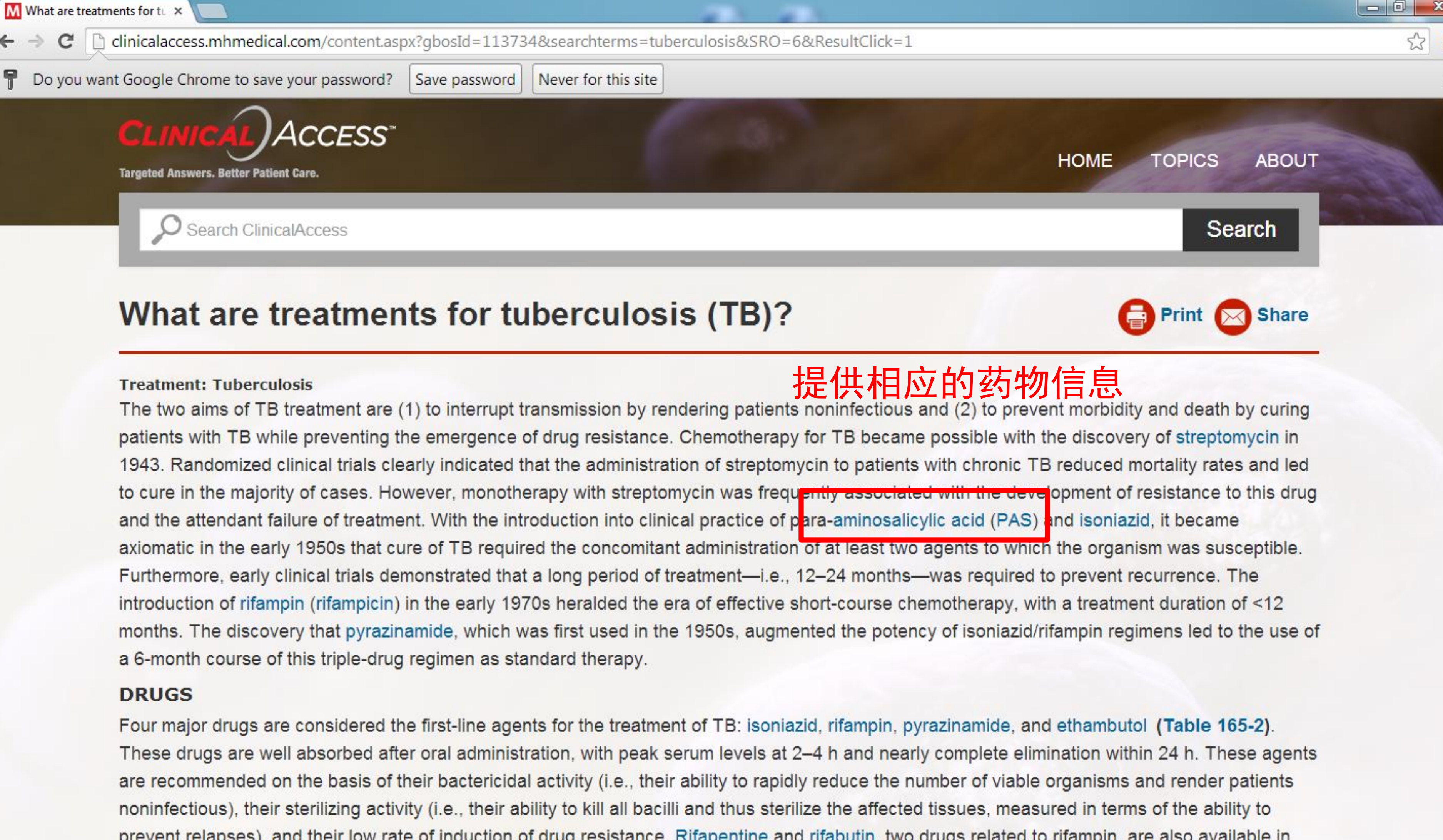
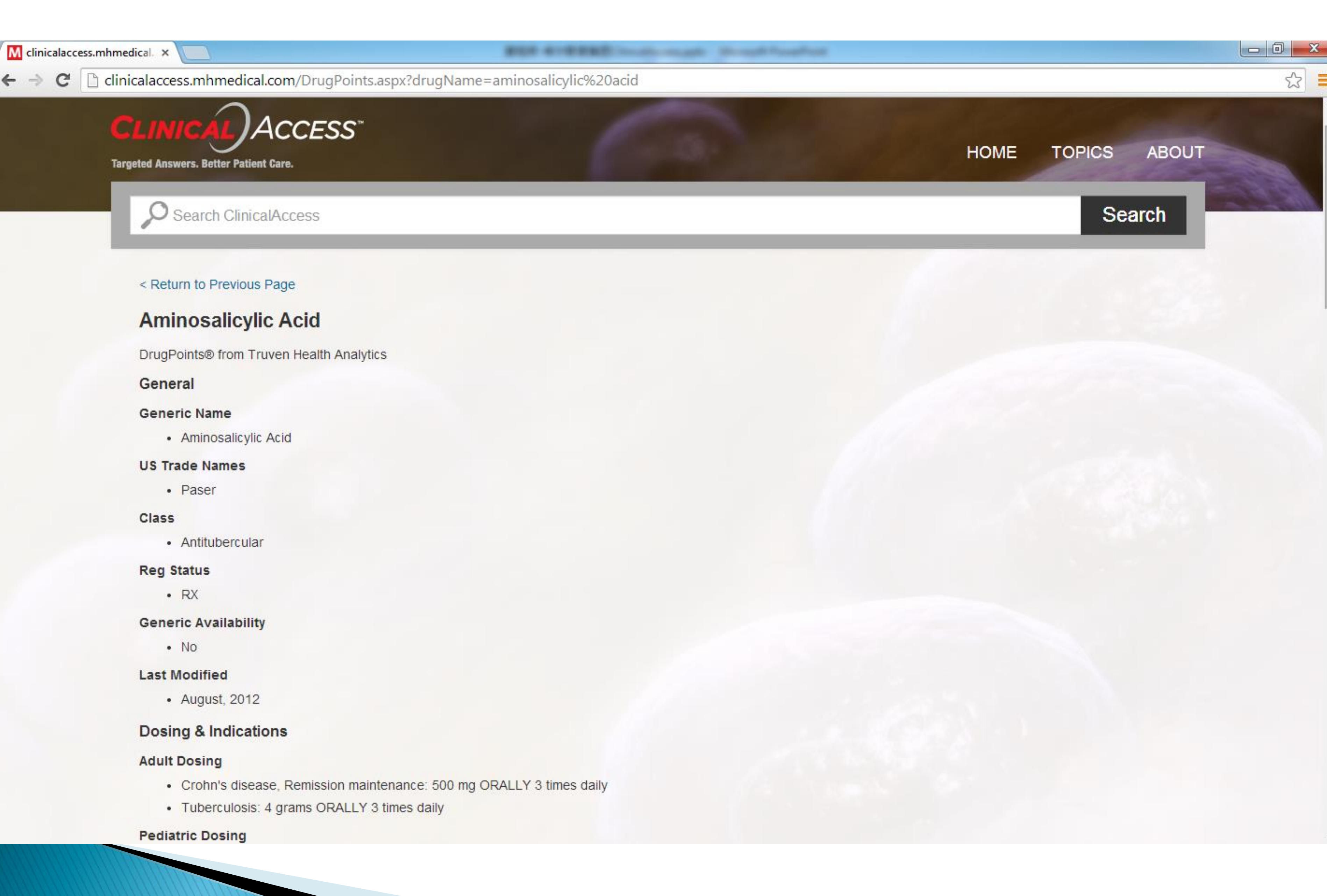
OBJECTIVE: To evaluate the diagnostic accuracy of a clinical pathway for suspected appendicitis combining the Samuel`s pediatric appendicitis score (PAS) and selective use of ultrasonography (US) as the primary imaging modality.
METHODS: Prospective, observational cohort study conducted at an urban, academic pediatric emergency department. After initial evaluation, patients were determined to be at low (PAS 1-3), intermediate (PAS 4-7), or high (PAS 8-10) risk for appendicitis.

Example2: tuberculosis(TB)





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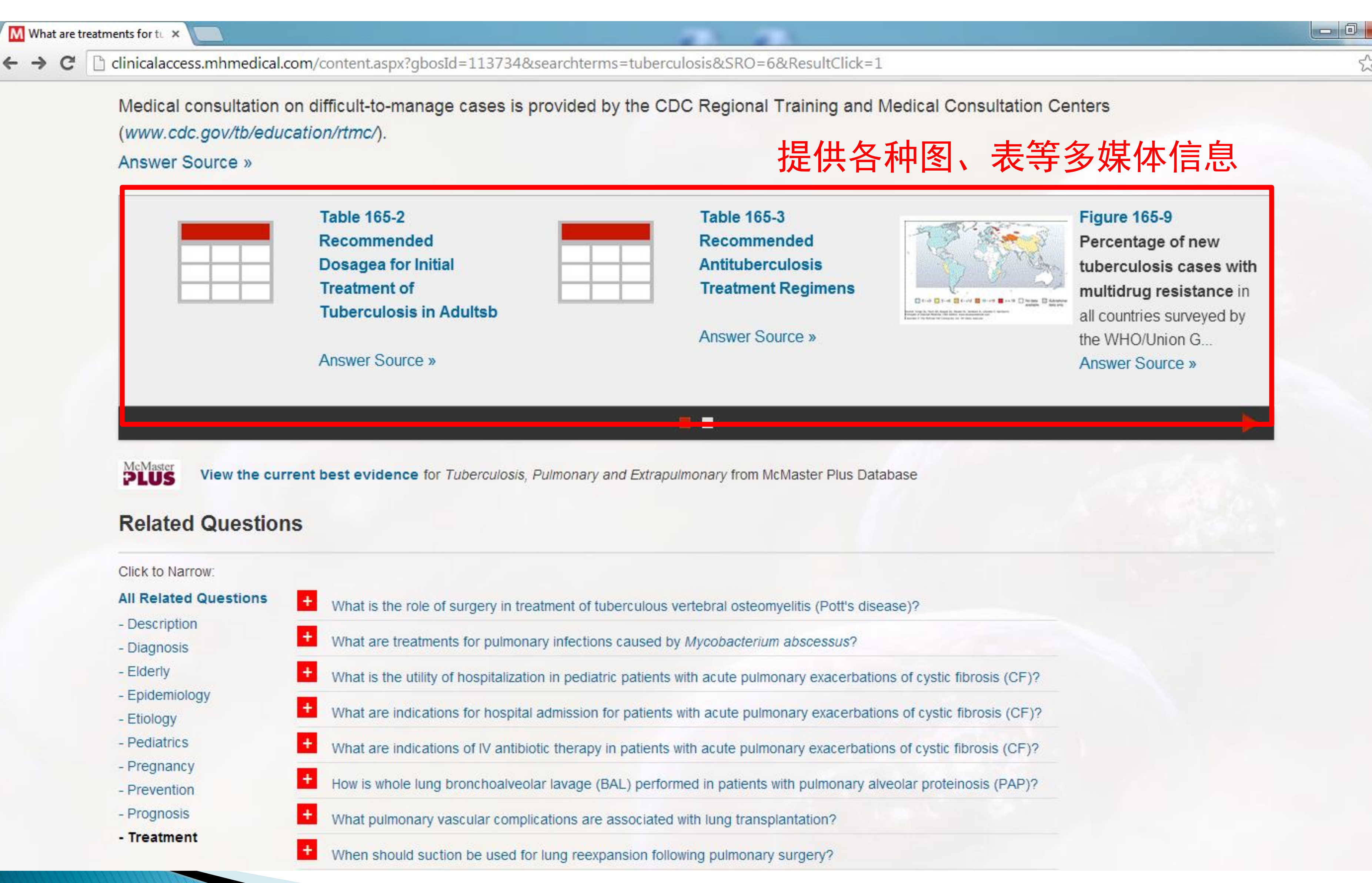
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What are treatments for pulmonary infections caused by Mycobacterium abscessus?
What is the utility of hospitalization in pediatric patients with acute pulmonary exacerbations of cystic fibrosis (CF)?
What are indications for hospital admission for patients with acute pulmonary exacerbations of cystic fibrosis (CF)?
What are indications of IV antibiotic therapy in patients with acute pulmonary exacerbations of cystic fibrosis (CF)?
How is whole lung bronchoalveolar lavage (BAL) performed in patients with pulmonary alveolar proteinosis (PAP)?
What pulmonary vascular complications are associated with lung transplantation?
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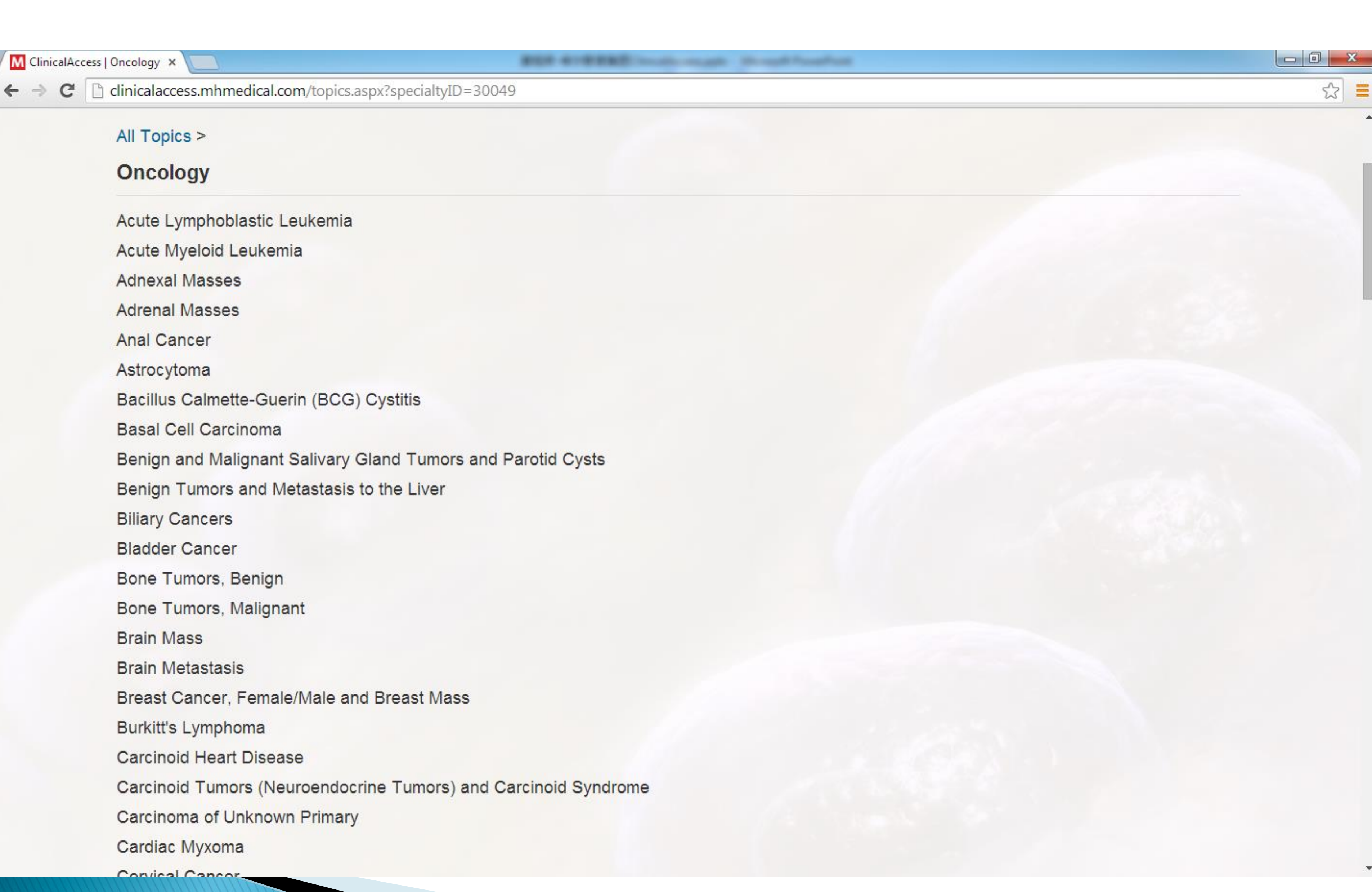
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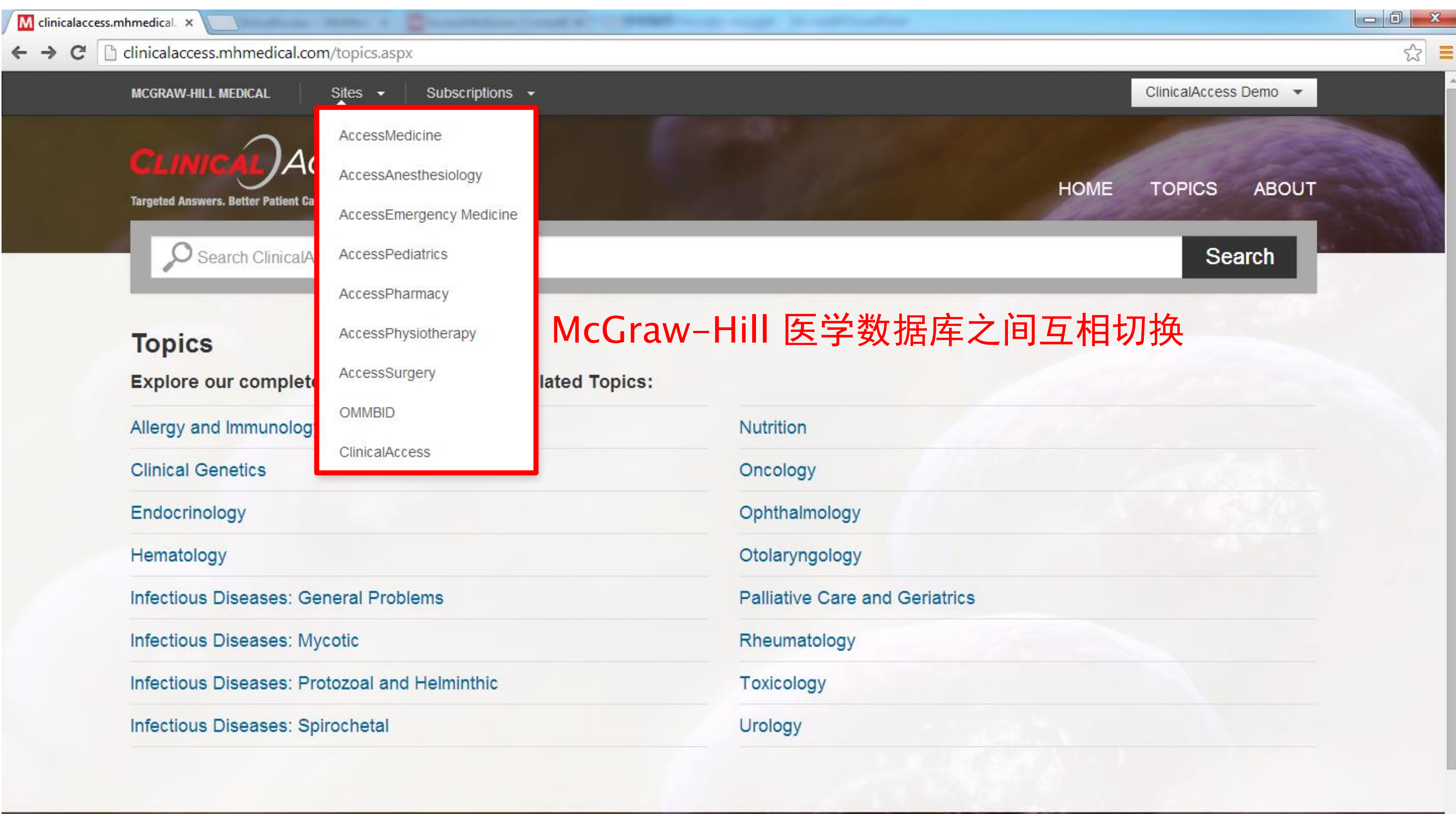
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