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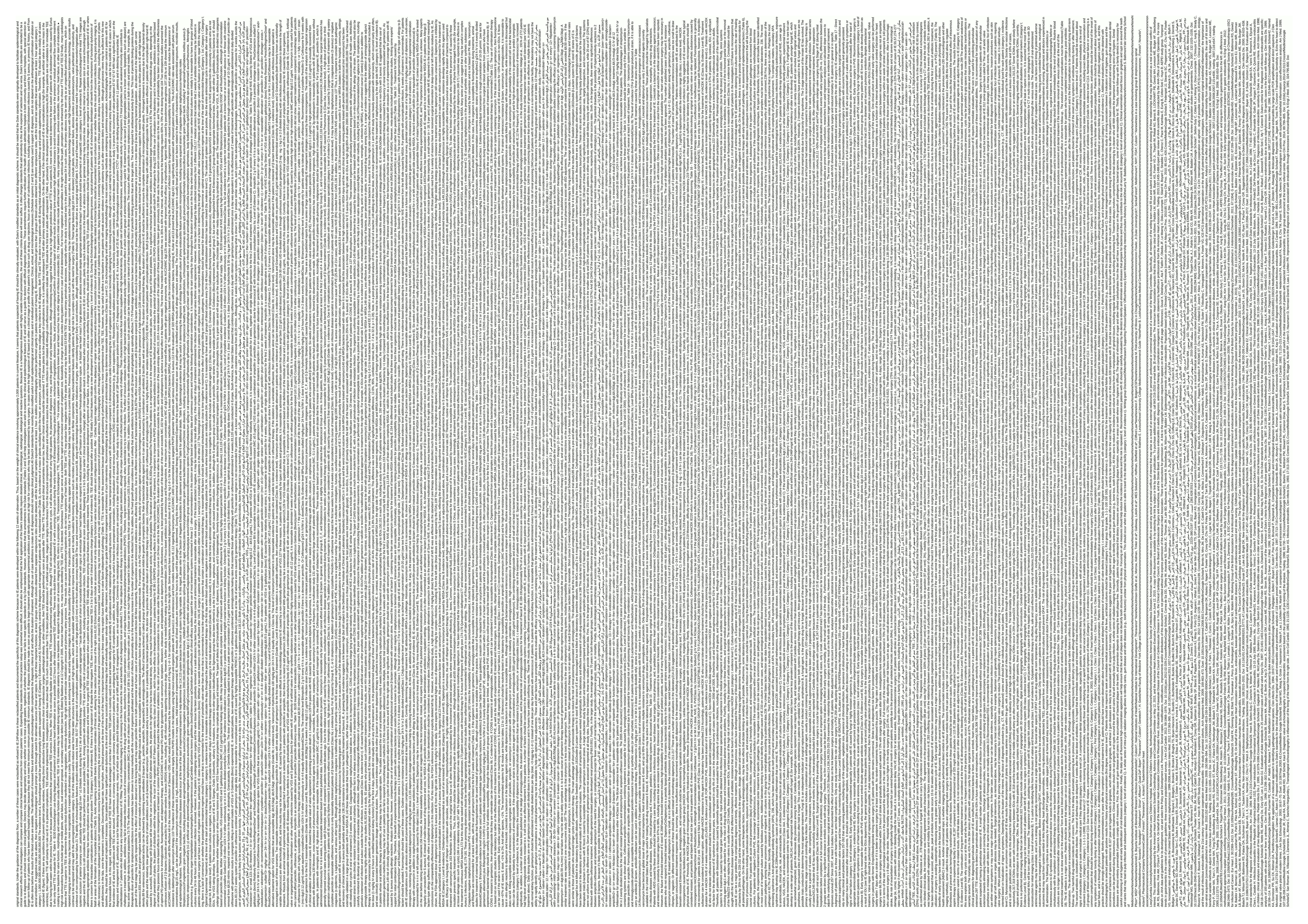
Deficiencia de vitamina c en cuyes pdf

Abstract endocarditis is a potentially fatal disease that has undergone significant changes in both the host and the pathogen. Epidemics of infectious endocarditis have become more complex with countless health care-related factors today that are susceptible to infection. Moreover, changes in the prevalence of diseases, particularly the most common staphylococcus origin, have affected the results, which have not improved despite medical and surgical advances. Methods and Results - This 2005 update update of the iteration, both developed by the American Heart Association under the auspices of the Rheumatic Fever Committee, endocarditis, and Kawasaki disease, the Youth Cardiovascular Council. It includes an evidence-based system of diagnostic and treatment recommendations used by the American College of Cardiology and the American Heart Association to obtain treatment recommendations. Conclusions — Infectious endocarditis is a complex disease, and patients with this disease generally require management by a team of doctors and health providers allied with a variety of areas of expertise. The purpose of the recommendations in this document is to help manage this uncommon but potentially fatal infection. However, the clinical variation and complexity of gastroenteritis dictate that these recommendations be used to support rather than replace decisions in individual patient management. Infectious endocarditis is an uncommon infectious disease with an annual prevalence rate of 3 to 7 per 100,000 people in the most contemporary population surveys.1-3 Although relatively rare, disease and mortality is still the third or fourth most life-threatening syndrome, after sepsis, pneumonia and intra-abdominal abscess. Globally, in 2010, disability was associated with 1.58 million years of life or healthy years adjusted for disability or years of health lost as a result of death, illness or non-fatal disability.4 The peed-in surveys from France and international cooperation on the inflammation of the chorisa have confirmed that the epidemiological features of IE have changed significantly. Although the overall IE infection rate remained stable,1,2,5-9 the rate of IE infection caused by Eurasian staphylococcus has increased, and S aureus is now the most common causative organism in most of the industrialized world. The emergence of S aureus IE is partly due to the increasing importance of healthcare communication as a leading risk associated with infection. The characteristics of IE patients have also shifted towards an increase in the patient's average age, a higher proportion of artificial valves and other heart devices, and a lower rate of rheumatic heart disease. Furthermore, the proportion of IE patients undergoing surgery over time has increased to >50%1,10,11 in addition to these time epidemiological changes, and the main new results of multiple diagnosis, prognosis, and therapeutic Since the last iteration of the American Heart Association (AHA) has published a statement on the diagnosis and management of IE complications published in 2005.12 For example, the rapid detection of etiology of valve tissue has been verified by patients undergoing IE surgery by polymerase chain reaction (PCR). In addition, diagnostic innovations have emerged through new imaging techniques such as 3D echocardiography(3D), head-to-toe ct and mri. Furthermore, the role of cerebral MRI and MRI in the diagnosis and management of IE has been better identified in many studies. In addition, many risk division models have been developed to determine morbidity and mortality rates in patients in IE in general, especially in those undergoing valve surgery that have been developed and validated. Finally, diptamicin was evaluated in the treatment of S aureus and IE bacteria in a controlled randomized trial.13 Several monitoring studies conducted with accuracy 11,14-16 and a randomcontrolled trial 17 the effect and timing of valve surgery in IE management were examined. In addition, recent guidelines for international management have been published.18.19 The current AHA IE writing committee has conducted comprehensive and focused reviews of literature published between January 2005 and October 2013 to update the previous version of the guidelines. Research has been carried out in the literature for pubMed/MEDLINE databases to identify relevant materials. The searches were limited to English. The main research terms included endocarditis, gastric endocarditis, intracardiac, falafi, mural, infection, diagnosis, bacteria, case definition, epidemiology, risks, demographics, substance abuse, addressing drug use, cardiology, microbiology, negative culture, treatment, antibiotics, antifungals, antimicrobials, antimicrobial resistance, and effects Negative pharmacological, drug monitoring, result, meta-analysis, complications, abscess, heart failure, embolic events, stroke, behavior abnormalities, survival, pathogens, organisms, treatment, surgery, indicators, valve replacement, valve repair, ambulance care trials, in addition, this statement includes a new branch, is surgical treatment. This work primarily deals with IE in adults; a more detailed review of the unique properties of IE in children is available in another statement from the AHA Committee on Rheumatic Fever, Endocarditis, and Kawasaki Disease.20 The Committee also published data on endocarditis that complicates The electrical device (pacemakers, intracardiac defibrillator), 21 ventricular assist, and other non-luscious heart devices.22 Certificate system of diagnostic and treatment recommendations tasked the writing group with the task of conducting an evidence-based evaluation of the data and providing a class of recommendations and a level of evidence for each According to the American College of Cardiology/AHA Classification System (. The category of recommendation is an estimate of the magnitude of the treatment effect, taking into account risks versus benefits, in addition to evidence or agreement that a particular treatment or procedure is beneficial, unhelpful, ineffective or in some cases may cause harm. The level of evidence is an estimate of certainty or accuracy in the effect of treatment. The writing team and the strength values of the evidence supporting each recommendation were reviewed with the level of evidence classified As a, B and C in accordance with the specific definitions in Table 1. For some circumstances where data were unavailable or insufficient, the recommendations were based on expert consensus and clinical expertise, and were classified as evidence level C. A summary of the recommendation class system and evidence levels in Table 1, which also contains suggested terms for writing recommendations in each category of recommendations, is summarized. Table 1- Emissions 1000 application classification recommendations and the level of EvidenceDiagnosis diagnosis of IE is evident in a minority of patients who provide with consistent history and classic oslerian manifestations: persistent bacteria or fungi, evidence of active fotal inflammation, peripheral polypolina, and immune vascular phenomena. In most patients, however, the history of the textbook and the results of the physical examination may be few or absent. Cases with limited manifestations of IE may occur early during IE, especially among patients who inject drugs (IDUs), which is often IE as a result of acute S aureus infection of the heart valves of the right side. Acute IE may develop very rapidly for the development of immune vascular phenomena, which are more characteristic of later stages of the cunning form than an untreated a. Additionally, valve lesions on either side usually do not create peripheral emboli phenomena and immune blood vessels that can result from the involvement of the left valve side. However, IE from the right side can cause emboli lung rot. The variation in IE's clinical presentation and the importance of early accurate diagnosis require a sensitive diagnostic strategy for disease detection and specific to exclude them across all forms of the disease. In 1994, Durak and his colleagues23 from Duke University Medical Center proposed a diagnostic scheme that categorizes patients suspected of having IE in three categories: specific, possible and rejected cases (Tables 2 and 3). Table 2- Definition of IE in accordance with Duke's modified standards * Specific IE pathological standards of microorganisms shown by culture or tissue examination of plants, plants that have been embolous, or an abscess sample within the heart. Or pathological lesions; Clinical standards 2 main criteria, 1 main criteria and 3 secondary criteria, or 5 secondary standards IE 1 main standard and standard 1 secondary, or 3 secondary criteria Rejected alternative diagnostic company explaining IE evidence; or the decision of IE syndrome with antibiotic therapy ≤4 d; Or there is no pathological evidence of IE in surgery or autopsy with antibiotic therapy ≤4 D; Or do not meet the standards for ie potential as aboveTable 3. Definition of terms used in Duke's modified standards for IE diagnosis * Key standards positive blood culture for typical IE micro-organisms consistent with IE of 2 separate blood cultures: Viridans streptococci, Streptococcus bovis, HACEK group, aureus staphylococc; Or the community acquired enterococci in the absence of basic focus, or microorganisms that agree with ie of blood cultures constantly positive knowledge as follows: at least 2 positive cultures of blood samples drawn >12 h or all 3 or majority of ≥4 separate cultures of blood (with the first and last sample that was drawn at least 1 h apart) and one positive blood culture of cocosi burnellaetii or anti-stage 1G teter antibodies ≥1:80 evidence implicated Cardiac positive echo for IE (TEE recommended for patients with artificial valves, rated at least as possible IE by clinical standards, or IE complex [semi-lukewarm abscess]; TTE as the first test in other patients) is defined as follows: the intra-heart mass oscillates on a valve or supporting structures, in the course of cream jets, or on substances implanted in the absence of an alternative anatomical interpretation; Abscess, or new partial dehiscence of artificial valve or new glycetic waltz (exacerbation, alteration or pre-existing insufficient puff) secondary readiness criteria, prepared heart condition, or IDU fever, temperature >38°C vascular phenomena Emboli main arteries, pulmonary septum rot, fungal aneurysm, intracranial bleeding, conjunctivitis bleeding, genuai lesions immune phenomena: pellet inflammation, osler nodes, rothold spots, microbiological rheumatoid factor evidence : Positive blood culture but does not meet the main criterion as noted above (except for single positive cultures of negative coagulase-cluster and organisms that do not cause endocarditis) or serological evidence of active infection with the organism consistent with secondary standards echo IE eliminating the IE diagnosis with the original Duke criteria was based on the existence of any of the main or secondary clinical criteria (Tables 2 and 3). Duke's criteria gave diagnostic weight to bacteria with staphylococcus or primary aphorists only, based on the acquisition location and without a clear initial concentration; Six common but less specific Included in the Duke's original scheme (Tables 2 and 3) of the IE system as secondary criteria. In the mid to late 1990s, direct analyses of Duke's standards were conducted in 12 major studies27-38 including approximately 1,700 patients consisting of geographically and clinically diverse groups (adults, children, and older adults [≥60 years of age] patients; IDU and non-IDU patients; And those with both the original valves and prostheses). Studies 27-38 confirmed the high sensitivity, specificity of duke standards and the diagnostic benefit of echo imaging in identifying clinically identifiable cases. Furthermore, a retrospective study of 410 patients showed a good agreement (72%-90%) between Duke standards and clinical evaluation by blind infectious disease experts to underlying IE risk factors.39 Improvements were made to both major and minor Duke criteria. In duke's original standards, bacteremia resulting from S aureus or enterococci was considered to meet a key criterion only if society gained because ample literature suggested that this parameter was an important alternative sign for IE.27 Thaben, however, a growing number of more contemporary studies documented IE in patients with staphylococcus bacteria nosocomial. For example, of the 59 consecutive patients with S aureus IE, 45.8% had infection infection infection infection, 50.8% had a removable concentration of infection.39 In the analysis of 262 patients at Duke University Medical Center who received Saureus bacteria in hospital, 34 (13%) She was later diagnosed with ie specific. Therefore, duke's amended standards (Tables 2 and 3) recommend that S aureus bacteria be included as the main criterion, regardless of whether the infection is the hospital gained (with or without a removable source of infection) or the acquired community.24 Specific serological data are included in the Duke IE diagnostic scheme to more accurately identify pathogens of IE negative to culture (i.e., as an alternative to positive blood cultures). These serological criteria will be applied in conditions in which the pathogenic organism grows slowly in routine blood cultures (for example, prosila species) or requires the media's own blood culture (for example, bartonella species, legionnaires, Legionspecies, Tropheryma whipplei, fungi, mecotobacteria) or in which the organism is not suitable for agriculture (for example, Coxiella burnetii, agent of Keo fever). For example, in duke's original standards, the positive serum for Q fever was considered a simple microbiological criterion. Later, Fournier et al studied 40 confirmed cases of Ie Fever Q. When the original Duke criteria were used, 4 of the 20 patients were rated as having ie possible. When the serological results of Q fever and one blood culture were positive for C burnetii was considered a major criterion, however, each of these 4 possible IE cases was reclassified to ie specific. On the basis of this Specific serological data as an alternative marker of positive blood cultures have now been included in Duke's standards. Thus, anti-phase I immunosuppressive G antibody ≥1:800 or a blood culture one positive for C burnetii should be a key criterion in modifying the DUKE scheme.24PCR-based tests for other difficult organisms for agriculture such as Quintana Bartonella or Trophery whippelii have also been discussed as key criteria in the future. At present, there are significant systemic problems associated with the suggestion of antibody tter that are positive for bartonella and breast-based types or pcr-based testing on T-Wibely as a key criterion in the Duke scheme. For example, low sensitivity caused by bartonella and often refractive types cannot be selected in serotest results due to occasional reactions.41 Low sensitivity is a major constraint of PCR unless cardiac fibrilious tissue is available for testing.42-45 Few timely PCR tests are available for these rare causes of IE. Therefore, the inclusion of these measurements as key criteria should be deferred until the serological and PCR approaches can be standardized and validated in a sufficient number of cases of these rare male species, the solution of the above-mentioned technical problems, and the widespread availability of such measures. It has also been proposed to expand secondary standards to include high rate of dethroscopic deposition or c reactive protein, the presence of newly diagnosed clubs, slynomegaly, and microscopic blood scope. In a study of 100 consecutive cases of proven original VALVE patients IE (NVE), the inclusion of these additional parameters with the duke-based simple criteria led to a 10% increase in the frequency of cases considered clinically specific, with no loss of privacy. The main limitations of the sedimentation rate in contaminated pellets and reactive C protein are that they are not specific and particularly difficult to interpret in patients with comorbid patient conditions. These additional parameters are not officially incorporated into Duke's amended standards,24 however, which are universally accepted. One secondary standard of Duke's original chart, echocardiography consistent with IE but not met the main criterion, has been reassessed. This standard was originally used in cases where unspecified thickness was detected through a cross-thoracic echocardiography (TTE). In the reanalysis of patients in the Duke University database (which contains records collected in the future on >800 specific and possible cases since 1984), this echocardiogram was used in only 5% of cases and was not used in the final analysis of any patient who underwent an transesophageal echocardiography (TEE). Therefore, this secondary standard was excluded in Duke's amended criteria.24Final research, amending duke standards requiring a minimum of 1 grand plus 1 secondary standard or 3 secondary criteria as minimum Set a possible IE case (rather than results that are consistent with IE that do not amount to a specific but not 'rejected' case) has been included in the revised criteria for reducing the proportion of patients assigned to the IE category as possible. This approach was used in a series of patients initially classified as IE possible by duke's



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