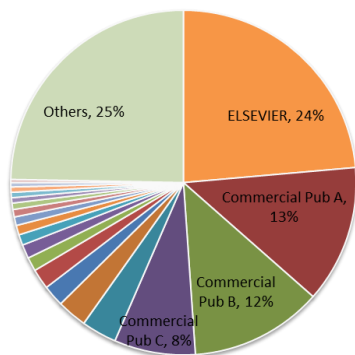


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## 权威循证医学

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Source Type

- ☐ Journal Articles 29503
- ☒ Full Text Only
- ☐ Full text and MEDLINE
- ☐ Systematic Reviews 335
- ☐ Meta-analyses 304
- ☐ Randomized Control Trials 1122
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- ☒ Guidelines 690
- ☐ Clinical Trials 644
- ☒ First Consult/Clinical Overviews 239
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Specialties ☒ Date ☒

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☐ **FIRST CONSULT**  
**Hypertension in children**  
Charles Kwon, MD, Director  
Ruben Nazario, MD, MA

☐ **CLINICAL OVERVIEW**  
**Hypertension**  
Updated November 1, 2017

☐ **FULL TEXT ARTICLE**  
**Hypertension Diagnosis, Risk**  
Canadian Journal of Cardiology  
Leung, Alexander A., MD,  
Cardiovascular Society of Canada


Searches related to hypertension edema p  
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hypertension of pregn  
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☐ **FULL TEXT ARTICLE**  
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Canadian Journal of Cardiology

Selected Content (13) ☒ BETA

What are the stages of hypertension?  
*Hypertension: A Companion to Braunwald's Heart Disease* • January 2018

Books Journals Drug Monographs Guidelines Patient Education First Consult/Clinical Overviews Multimedia

Cardiology Clinics 

Volume 35, Issue 2  
2017-5-1, Pages i-305  
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Articles in this issue:

- ☐ **Hypertension: Pre-Hypertension to Heart Failure**  
Pages i-ii. Jamerson, Kenneth A., and Byrd, James Brian.  
CARDIOLOGY CLINICS www.cardiology.theclinics.com Consulting Editors JORDAN M. PRUTKIN, MD, MHS, FHRP Assistant Professor of Medicine, University of Washington Medical Center, Seattle, Washington  
TERRENCE D. WELCH AUDREY H. WU May 2017 • Volume 35 • Number 2
- ☐ **Copyright**  
Pages iii-iv.  
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http://www.theclinics.com CARDIOLOGY CLINICS Volume 35, Number 2 May 2017 ISSN 0883-5963  
49645-2 Editor: Stacy Eastman Developmental ...
- ☐ **Contributors**  
Pages iii-iv.  
Editorial Board JORDAN M. PRUTKIN, MD, MHS, FHRP Assistant Professor of Medicine, University of Washington Medical Center, Seattle, Washington  
FACC, FSCAI Associate Professor, Keck School of Medicine, University of California, Los Angeles
- ☐ **Contents**  
Pages v-vii.

涵盖全部临床专科的权威指南和循证医学，确保医疗规范安全

北美临床期刊-心脏病学

本期邀请业内权威专家围绕高血压前期到心衰相关临床问题进行论述

# 以症状入手-提供全面准确的诊疗思路防止漏诊误诊

All Types abdominal pain Saved Searches Search History

Filter By:

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- ☐ Journal Articles 16788
- ☒ Full Text Only
- ☐ Full text and MEDLINE
- ☐ Systematic Reviews 219
- ☐ Meta-analyses 89
- ☐ Randomized Control Trials 526
- ☐ Narrative Reviews 4108
- ☐ Books 6404
- ☐ Images 1208
- ☐ Patient Education 476
- ☐ Clinical Trials 403
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☐ **FIRST CONSULT**  
**Functional abdominal pain in children**  
Maim Alkhouri, MD, Joseph E. Scherger, MD, MPH... Show all. Published October 29, 2011. Last updated October 28, 2011.

☐ **BOOK**  
**Signs**  
Abdominal Pain > Diagnostic Approach > Pivotal Findings  
The objective evaluation begins with measurement of the vital signs. Significant tachycardia and hypotension are indicators that hypovolemia or sepsis may be present. Tachypnea in the absence of hypoxemia may be an indication of metabol acidosis...  
Rosen's Emergency Medicine: Concepts and Clinical Practice.  
Smith, Kurt A.. Published January 1, 2018. © 2018.

☐ **BOOK**  
**Ancillary Testing**  
Abdominal Pain > Diagnostic Approach > Pivotal Findings  
Urinalysis and testing for pregnancy are perhaps the most time- and cost-effective adjunctive laboratory tests available. Urinalysis results are interpreted within the context of the patient's clinical picture. Pyuria, with or without bacteri...  
Rosen's Emergency Medicine: Concepts and Clinical Practice.  
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Searches related to abdominal pain  
abdominal pain characteristic

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**Intussusception**  
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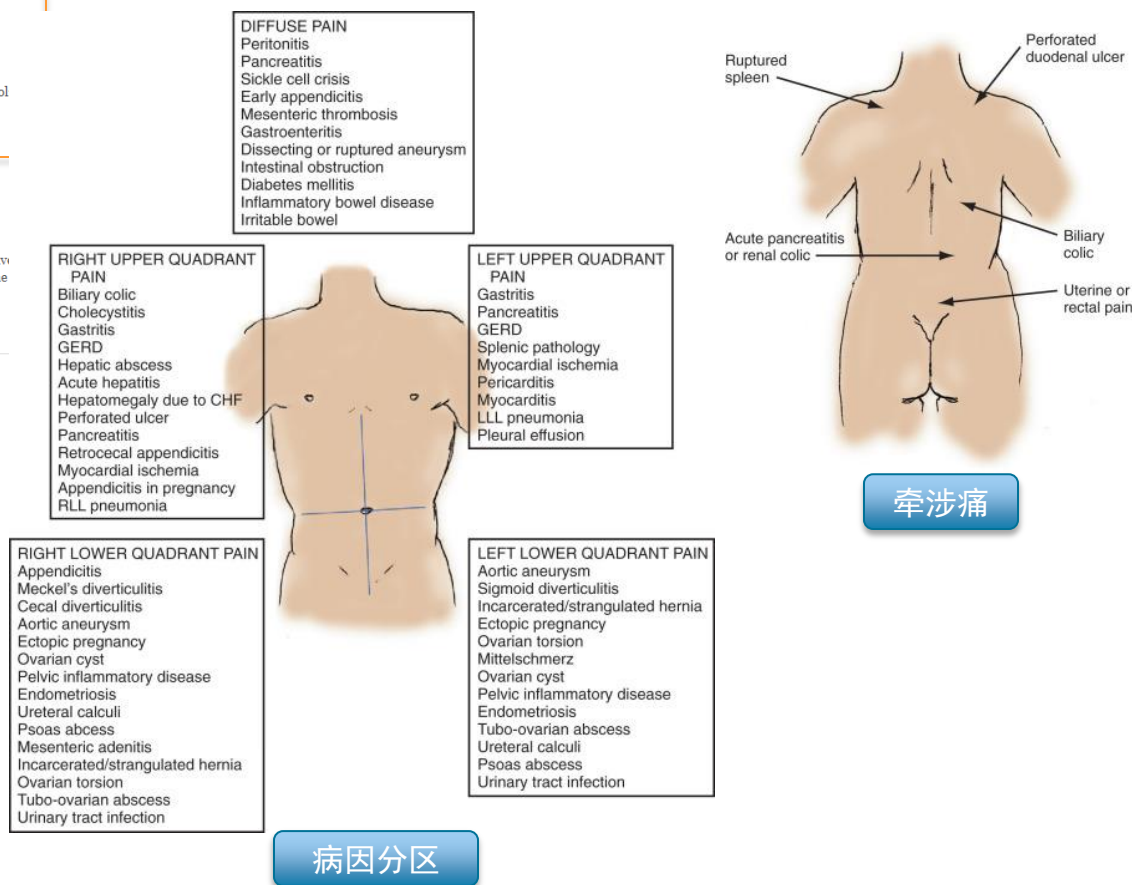
☐ **CLINICAL OVERVIEW**  
**Campylobacter infections**  
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**Chronic diarrhea**  
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☐ **CLINICAL OVERVIEW**  
**Gastroenteritis in children**

以“腹痛”检索，可得到诊断建议，供参考：

非器质性腹痛、腹痛临床可能情况、急性阑尾炎、阿米巴病、肠套叠、宫外孕、慢性腹泻、慢性胰腺炎等



# 如何进一步判断病因？

## Diagnostic Approach

### Differential Diagnosis Considerations

The differential diagnosis of abdominal pain is divided into abdominopelvic (intraoperative, retroperitoneal, and pelvic) causes (eg, appendicitis, cholecystitis, pancreatitis) and non-abdominopelvic processes (eg, pneumonia, myocardial infarction, ketoacidosis, toxicologic, abdominal wall pain). Table 24.1 lists important potentially life-threatening nontraumatic causes of abdominal pain. This group represents the major causative disorders likely to be associated with hemodynamic compromise and for which early therapeutic intervention is critical. More common emergent conditions t

TABLE 24.1  
Critical Causes of Abdominal Pain

CAUSE	EPIDEMIOLOGY
Ruptured ectopic pregnancy	Occurs in females of childbearing age. No method of contraception prevents ectopic pregnancy. Approximately 1 in every 100 pregnancies.

## 鉴别诊断

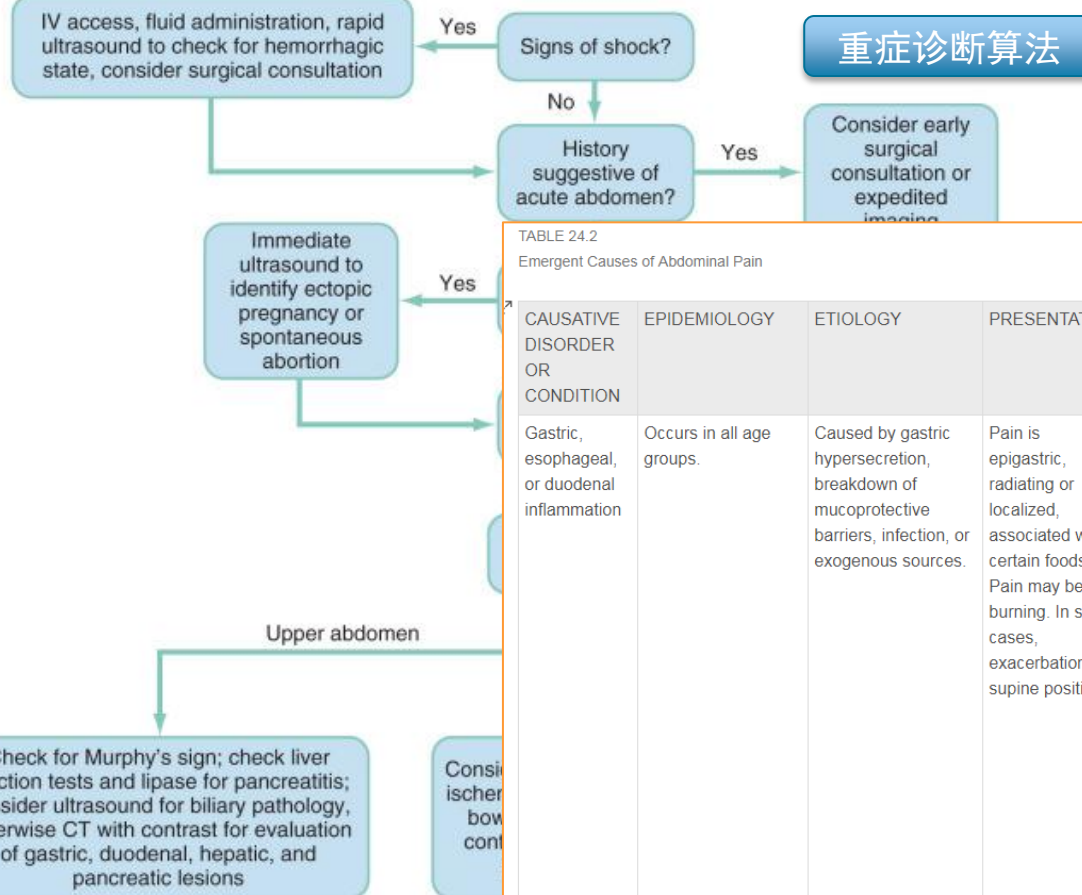


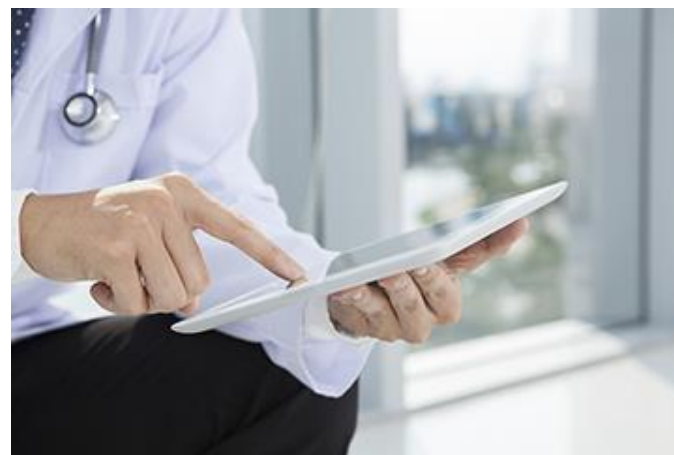
TABLE 24.2  
Emergent Causes of Abdominal Pain

CAUSATIVE DISORDER OR CONDITION	EPIDEMIOLOGY	ETIOLOGY	PRESENTATION	PHYSICAL EXAMINATION	USEFUL TESTS
Gastric, esophageal, or duodenal inflammation	Occurs in all age groups.	Caused by gastric hypersecretion, breakdown of mucoprotective barriers, infection, or exogenous sources.	Pain is epigastric, radiating or localized, associated with certain foods. Pain may be burning. In some cases, exacerbation in supine position.	Epigastric tenderness without rebound or guarding. Perforation or bleeding leads to more severe clinical findings.	Uncomplicated are treated with antacids or histamine H <sub>2</sub> blockers by invasive studies contemplated. Gastrointestinal is valuable in diagnosis and testing for <i>Helicobacter pylori</i> with blood or stool specimens. If perforation is suspected, a chest radiograph obtained early out free air. CT be beneficial.
Acute appendicitis	Peak age in adolescence and young adulthood; less common in	Appendiceal lumen obstruction leads to swelling, ischemia, infection, and	Epigastric or periumbilical pain migrates to RLQ over 8 to 12	Mean temperature 38° C (100.5° F). Higher	Leukocyte count nonspecific and be normal or elevated. If ele

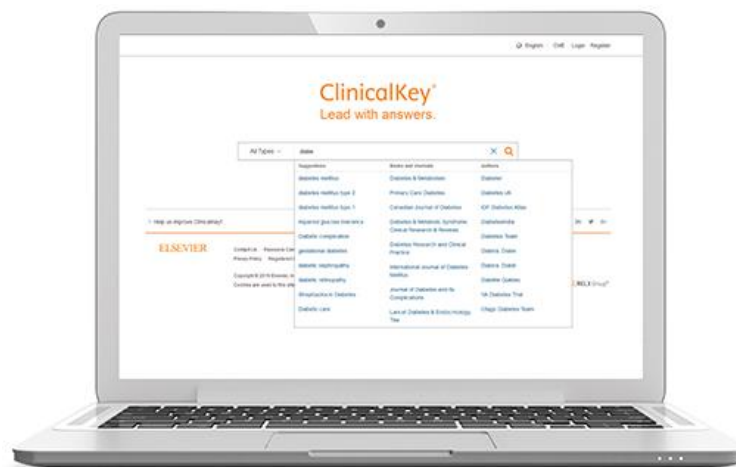
## 急症病因

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继续 >

疑难复杂病—助力诊断

## 辅助医生破解复杂病情

**ClinicalKey**语义分析后台，像医生一样思考，根据医生输入的线索，寻找各种可能病因，并根据关联度排序，助力疑难复杂病的诊断。

以症状、检查结果等入手，通过**多症状**、**检查结果**联合检索，为疑难复杂病诊断提供思路，降低误诊率、减少会诊和住院日，同时为多科诊疗模式（MDT）提供有效支持。

例1：患者出现双侧听力下降至耳聋，辗转半年就诊，检查现**MRI**脑膜强化、脑脊液**CA19-9**升高、脑神经受累等主要阳性症状和结果，经多次专家会诊后，无明确诊断，看**ClinicalKey**能否提供有效线索？

The image displays two screenshots of the ClinicalKey search interface, illustrating the process of finding relevant medical literature for a complex case.

**Top Screenshot:** The search query is "bilateral hearing loss meningeal CA19-9". The results show 1 result. The highlighted article is titled "Sudden onset sensorineural hearing loss caused by meningeal carcinomatosis secondary to occult...". The authors are Auris Nasus Larynx, Marchese, Maria Raffaella; La Greca, Carmelo... Show all. The article is published in Issue 4, Pages 515-518, © 2009.

**Bottom Screenshot:** The search query is "hearing loss meningeal". The results show 705 results. The highlighted article is titled "Sudden onset sensorineural hearing loss caused by meningeal carcinomatosis secondary to occult...". The authors are Auris Nasus Larynx, Marchese, Maria Raffaella; La Greca, Carmelo... Show all. The article is published in Issue 4, Pages 515-518, © 2009. The article includes a brain MRI image (Fig. 4) and an audiogram (Fig. 3).

**Figure 4:** Brain MRI with contrast enhancement revealed tumor in both internal auditory canals and cerebellar pontine angle (white arrows). More

**Figure 3:** Audiogram recorded at the beginning of the symptoms (A) and 2 months later (B) (symbols: circle : right ear air-conduction; open tip of the arrow to the right : right ear bone-conduction; square with little arrow : masked left ear air-conduction, ... More

## 例2：35岁原发性不孕女性患者拟行输卵管通液术和宫腔镜检查

- 曾有甲硝唑过敏史，否认其他系统疾病和手术史
- 术前访视正常，入室后生命体征平稳
- 静脉输注1.5g头孢呋辛后，给予乳酸钠林格液。行丙泊酚、芬太尼和顺阿曲库铵麻醉诱导后3分钟内插管
- 插管后3分钟，血压降至33/20mmHg；呼气末CO<sub>2</sub>分压从30cmH<sub>2</sub>O降至14cm H<sub>2</sub>O，患者出现皮肤荨麻疹

问题：围手术期过敏如何防治？患者过敏性休克的原因是什么？

The screenshot displays two search results from Elsevier. The top result is for 'perioperative anesthesia anaphylaxis prevention' with 143 results. The bottom result is for 'Cisatracurium' with 1160 results.

**Search 1: perioperative anesthesia anaphylaxis prevention**

- Filter By:** Source Type (Journal Articles: 109, Full Text Only: 1, Full text and MEDLINE: 1, Randomized Control Trials: 1, Narrative Reviews: 53, Books: 27, Guidelines: 8, First Consult/Clinical Overviews: 4, Images: 1, Specialties: 1, Date: 1, Subscribed Content: 1).
- Key points:** Introduction, Case 1, Case 2, Evaluation, Risk factors, Commonly implicated agents, Neuromuscular Blocking Agents, Latex, Antibiotics, Hypnotics, Opioids, Colloids, Hemostatics, Chlorhexidine, Blue Dyes, Nonsteroidal Antiinflammatory Drugs, Other Agents.
- Full Text Article:** Perioperative Anaphylaxis, Jennifer A. Immunology, Elsevier Inc.

**Search 2: Cisatracurium**

- Filter By:** Source Type (Journal Articles: 644, Full Text Only: 1, Full text and MEDLINE: 1, Systematic Reviews: 2, Randomized Control Trials: 79, Narrative Reviews: 112, Books: 412, Clinical Trials: 69, Images: 31, First Consult/Clinical Overviews: 3, Drug Monographs: 1, Specialties: 1, Date: 1, Subscribed Content: 1).
- Drug Monograph:** Cisatracurium, Gold Standard. Published September 8, 2017.
- Book:** Cisatracurium, Neuromuscular Blocking Drugs > Intermediate-Acting Nondepolarizing Neuromuscular Bl..., Gold Standard. Published September 8, 2017.
- Book:** Cisatracurium, Antiepileptic drugs > Drug-drug interactions, Gold Standard. Published September 8, 2017.
- Book:** Cisatracurium, Basics of Anesthesia, Miller, Ronald D., Published January 1, 2018. © 2018.
- Book:** Cisatracurium, Antiepileptic drugs > Drug-drug interactions, Aronson, J.K., MA, DPhil, MBChB, FRCP, HonFBPhS, HonFFPM. Published January 1, 2016. © 2016.
- Searches related to cisatracurium:** cisatracurium besilate.
- Full Text Article:** Cisatracurium-induced proliferation impairment and death of colorectal cancer cells, HCT116 is...

**Cisatracurium Adverse Reactions:** anaphylactoid reactions, angioedema, apnea, bradycardia, bronchospasm, dyspnea, flushing, hypotension, laryngospasm, muscle paralysis, myasthenia, myopathy, urticaria.

疑难复杂状况—助力方案制定

## 例2：如何实施孕妇巨大垂体瘤切除术麻醉？

- 女性，25岁，孕24周。二年前，月经出现紊乱，未接受治疗。2016年，临床症状加重，才于上海华山医院就诊，显示泌乳素（PRL）高达3640uIU/ml（正常值102-496uIU/ml），脑部核磁共振检查显示：垂体瘤大小1.4\*1.1cm。
- 给予溴隐亭治疗，直到2017年1月30日被确认怀孕。正规服药期间，泌乳素降到168.4uIU/ml，肿瘤也缩小到0.6\*1.1cm。
- 2017年5月，她因左眼视物模糊到瑞金医院就诊。脑部核磁共振显示，肿瘤达到2.1\*1.8cm，泌乳素超过200ng/ml（正常值为5.18-26.53ng/ml）。检查还发现左眼视野缺失3/19。右眼也开始模糊。
- 为减轻肿瘤压迫和阻止进行性视野缺损，神经外科医生准备进行经蝶垂体瘤切除术。患者是孕妇，还必须考虑腹中胎儿，所以手术和麻醉风险非常大。

问题：这类手术的麻醉风险？术中如何进行严密的麻醉监测和相关处理？

The screenshot displays a search results page for the query "nonobstetric surgery pregnancy anesthesia". The search results are filtered by "Source Type" (Journal Articles, Full Text Only, MEDLINE, etc.) and "Specialties" (Obstetrics, Surgery, etc.). The results list includes several books and articles, with the top result being "Anesthesia during Nonobstetric Surgery" by Schwartz, Nadav, and Jack P. The detailed view of this book chapter shows the table of contents, including sections on "Anesthesia and Teratogenicity", "Anesthesia and Pregnancy Physiology", "Nonobstetric Surgery and Pregnancy Outcome", "Fetal Monitoring", "Laparoscopy in Pregnancy", "Laparoscopic Entry Techniques in Pregnancy", "Laparoscopy and Pregnancy Outcome", "Adnexal Masses in Pregnancy", "Obesity, Bariatric Surgery, and Pregnancy", "Cardiac Surgery in Pregnancy", "Neurosurgery in Pregnancy", "Key Points", and "References". The "Key Points" section highlights several important considerations for anesthesia during pregnancy, such as the need for a multidisciplinary approach, the expansion of maternal blood volume, the risk of maternal hemorrhage, the delay in surgical intervention, the risk of preterm labor and fetal loss, the use of radiation, the risk of congenital malformations, the risk of preterm birth, low birthweight, and neonatal death, the use of laparoscopy, and the risk of adnexal masses.

**Search Results:**

- Filter By: 4979 results
- Source Type:
  - Journal Articles: 4288
  - Full Text Only
  - Full text and MEDLINE
  - Systematic Reviews: 40
  - Meta-analyses: 31
  - Randomized Control Trials: 298
  - Narrative Reviews: 1009
  - Books: 521
  - Clinical Trials: 67
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  - Patient Education: 28
  - Procedures Consult: 14
  - Videos: 14
  - Drug Monographs: 4
  - Images: 1
- Specialties:
  - Obstetrics: Normal and Problem Pregnancy
  - Surgery During Pregnancy
  - Anesthesia during Nonobstetric Surgery
  - Anesthesia and Teratogenicity
  - Anesthesia and Pregnancy Physiology
  - Nonobstetric Surgery and Pregnancy Outcome
  - Fetal Monitoring
  - Laparoscopy in Pregnancy
  - Laparoscopic Entry Techniques in Pregnancy
  - Laparoscopy and Pregnancy Outcome
  - Adnexal Masses in Pregnancy
  - Obesity, Bariatric Surgery, and Pregnancy
  - Cardiac Surgery in Pregnancy
  - Neurosurgery in Pregnancy
  - Key Points
  - References

**Book Chapter: Anesthesia during Nonobstetric Surgery**

**Neurosurgery in Pregnancy**

Neurosurgical anesthesia often involves several techniques aimed at regulating cerebral blood flow, but these may also impact uteroplacental perfusion. For example, controlled hypotension can lead to reduced placental perfusion and transient FHR abnormalities. Similarly, whereas pregnancies can usually tolerate hypothermia, hyperventilation, and diuresis, potential fetal effects cannot be disregarded.<sup>104</sup> In most cases, maternal health should be the primary focus and should supersede potential fetal effects. Nonetheless, a basic understanding of these effects can help the obstetrician guide the surgical and anesthesia teams caring for the patient.

**Key Points**

- Care of the pregnant surgical patient requires a multidisciplinary approach with an understanding of the physiologic changes that accompany normal pregnancy.
- Expansion of maternal blood volume during pregnancy may mask signs of maternal hemorrhage, and clinically significant blood loss can occur before hemodynamic changes are evident.
- Delay in surgical intervention can result in increased maternal and fetal morbidity and mortality, which significantly increases the risk for preterm labor and fetal loss.
- Diagnostic doses of radiation (<5 cGy) from radiographs and CT scans are unlikely to pose any significant harm to the developing fetus. MRI and ultrasound can be safely used when appropriate to further minimize radiation exposure.
- No significant increased risk is apparent for congenital malformations in women who require nonobstetric surgery during pregnancy. Although the risk for preterm birth, low birthweight, and neonatal death may be increased, this may be due to the underlying illness rather than the surgical procedure.
- Although laparoscopy as a first approach to abdominal surgery in pregnancy seems reasonable, its safety continues to be studied. Abdominal insufflation pressures should be kept below 15 mm Hg whenever possible, and the SAGES guidelines should be followed. The use of a laparoscopic approach in the latter stages of pregnancy should be individualized based on indications and experience of the surgeon.
- Adnexal masses are commonly encountered in pregnancy, although most ovarian masses are benign. Pregnant women diagnosed with an adnexal mass should be counseled about the signs and symptoms of

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Fetal Heart Rate Categories

Evaluation of the Neonate and Neonatal Resuscitation

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Questions of the Day

Anesthesia for Nonobstetric Surgery During Pregnancy

The overall incidence of nonobstetric surgery during pregnancy is 1% to 2%, with trauma, appendicitis, and cholecystitis being the most frequent causes. <sup>100 101</sup> In addition to management of maternal awareness, hemodynamic before, anesthetic prevention of early in pregnancy delayed until, however, none on the fetus by for intervention timing should surgery during surgery in pre

For operation plan that optimize plan in the event planned, the with cesarean available to in general anesthetic of regional technique anesthesia. <sup>10</sup>

Avoidance

There is always undiagnosed pregnancy tes

Obstetrics

Key Evaluation Components

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Key Evaluation Components

Based on a 2008 National Institutes of Health (NIH) report, the assessment of FHR interpretation involves evaluation of (1) uterine contractions, (2) baseline FHR, (3) baseline FHR variability, (4) presence of accelerations, (5) periodic or episodic decelerations, and (6) changes or trends of FHR patterns over time. <sup>111</sup>

Uterine Contractions

Uterine contractions can be monitored externally or internally. External monitors only relay contraction frequency, but internal monitoring allows for both frequency and measurement of intrauterine pressure (in Montevideo units). Uterine activity and definitions are detailed in Box 33.4. If a tonic contraction or period of tachysystole occurs during labor, treatment with IV nitroglycerin can briefly relax the uterus and restore fetal perfusion. In addition, the obstetrician can administer subcutaneous terbutaline.

BOX 33.4

- Normal: ≤5 contractions in 10 minutes, averaged over a 30-minute window
- Tachysystole: >5 contractions in 10 minutes, averaged over a 30-minute window
- Characteristics of uterine contractions: tachysystole should be always qualified as to presence or absence of associated fetal heart rate decelerations.
  - Tachysystole applies to either spontaneous or stimulated labor. The clinical response to tachysystole may differ depending on whether contractions are spontaneous or stimulated.
  - Hyperstimulation and hypercontractility are not defined and should be abandoned.

Uterine Activity Terminology

Data from Macones GA, Hankins GD, Spong CY, et al. The 2008 National Institute of Child Health and Human Development workshop report on electronic fetal monitoring: update on definitions, interpretation, and research guidelines. *J Obstet Gynecol Neonatal Nurs.* 2008;37(5):510-515.

Baseline Fetal Heart Rate

Baseline FHR is determined by approximating the mean FHR rounded to increments of 5 beats/min during a 10-

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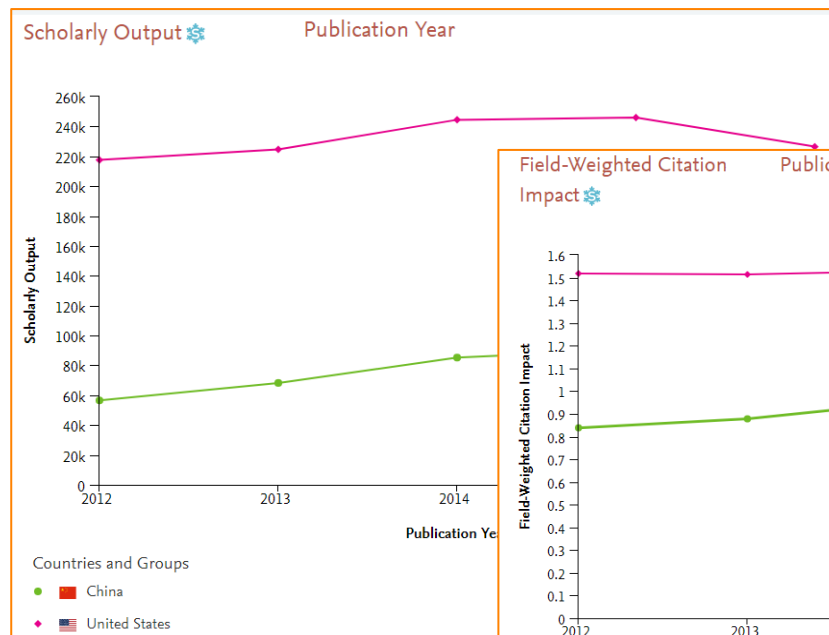
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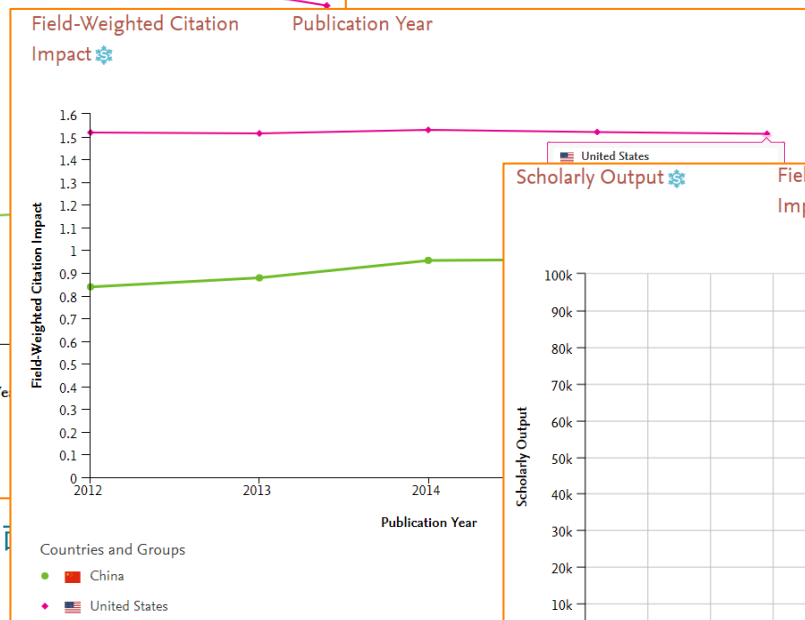
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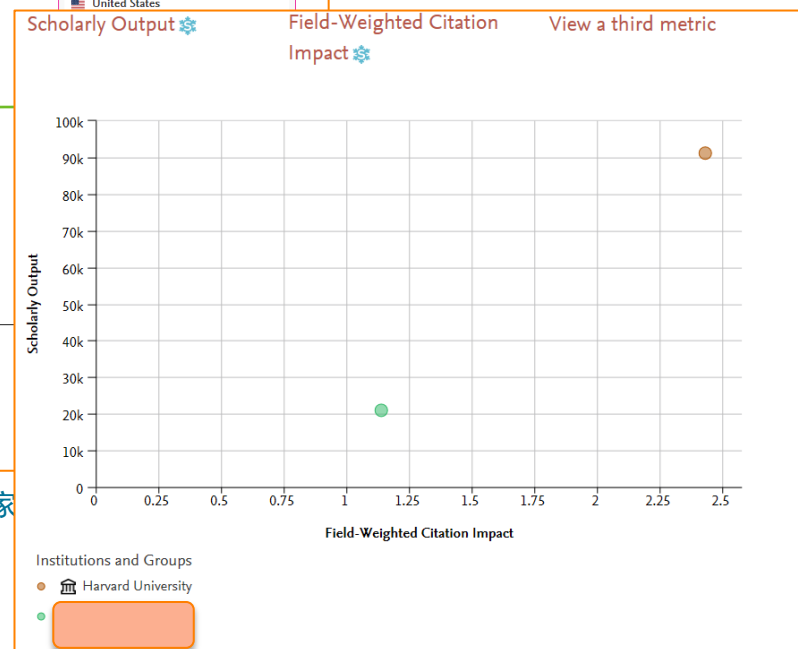
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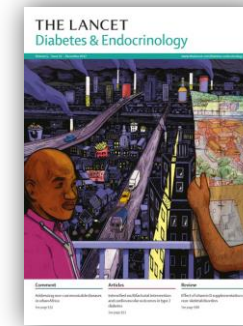
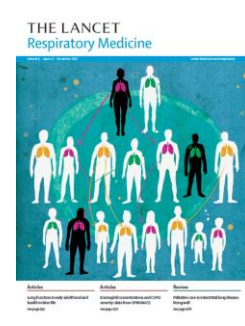
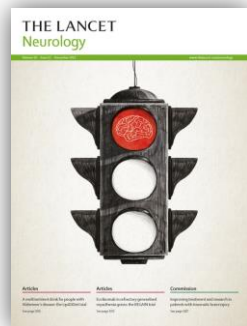
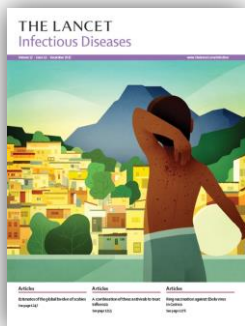
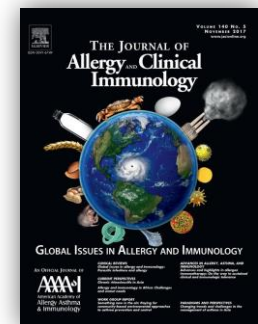
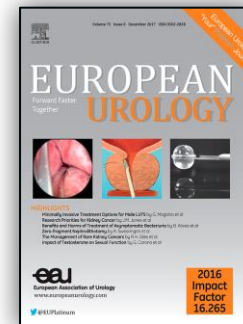
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Lancet Oncology, The. Tammemagi, Martin C, Prof; Schmidt, Heidi,... 显示全部. 出版 November 1, 2017. Volume 18, Issue 11. 页 1523-1531. © 2017.

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European position statement on lung cancer screening

Lancet Oncology, The. Oudkerk, Matthijs, Prof; Devaraj, Anand, MD,... 显示全部. 出版 December 1, 2017. Volume 18, Issue 12. 页 e754-e766. © 2017.

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Lung cancer screening and its continuous risk assessment

Lancet Oncology, The. de Koning, Harry J.. 出版 November 1, 2017. Volume 18, Issue 11. 页 1434-1436. © 2017.

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Low-dose CT for lung cancer screening

Lancet Oncology, The. Ruano-Ravina, Alberto; Pérez-Ríos, Mónica,... 显示全部. 出版 March 1, 2018. Volume 19, Issue 3. 页 e131-e132. © 2018.

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Low-dose CT for lung cancer screening

Lancet Oncology, The. Bach, Peter B; Brawley, Otis W; Silvestri, Gerard A.. 出版 March 1, 2018. Volume 19, Issue 3. 页 e133-e134. © 2018.

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**Phase I Study of the Administration of T Lymphocytes Expressing the CD30 Chimeric Antigen Receptor for Relapsed CD30+ Hodgkin's Lymphoma and CD30+ Non-Hodgkin's Lymphoma (CART CD30)**  
Published March 2, 2017. Conditions: Non-Hodgkin's Lymphoma; Hodgkin's Lymphoma. Interventions: Drug: CAR-CD30 T cells.

☐ **CLINICAL TRIAL**  
**Phase I/II Study of EGFR CART Cells for Patients With Metastatic Colorectal Cancer.**  
Published August 13, 2017. Conditions: EGFR-positive Colorectal Cancer. Interventions: Biological: EGFR CART.

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**Chemoradioresistance in Prospectively Isolated Cancer Stem Cells in Esophageal...**  
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## CLINICAL TRIAL

### Administration of T Lymphocytes for Hodgkin's Lymphoma and Non-Hodgkin's Lymphoma (CART CD30)

First received on March 4, 2011. Last updated on March 2, 2017.

#### Purpose

The body has different ways of fighting infection and disease. No single way seems perfect for fighting cancer. This research study combines two different ways of fighting disease: antibodies and T cells. Antibodies are proteins that protect the body from diseases caused by germs or toxic substances. They work by binding those

#### Detailed Description

When the patient enrolls on this study, they will be assigned a dose of CD30 chimeric receptor-activated T cells. The dose level of cells that they will receive will not be based on a medical determination of what is best for the patient, instead the dose is based on the order in which the patient enrolled on the study relative to other participants. Subjects enrolled earlier in the study will receive a lower dose of cells than those enrolled later in the study. The risks of harm and discomfort from the study treatment may bear some relationship to the dose level.

#### Criteria

**INCLUSION CRITERIA: PROCUREMENT:** Referred patients will initially be consented for procurement of blood for generation of the transduced ATL. Eligibility criteria at this stage include: - Diagnosis of recurrent CD30+ HL or CD30+ NHL, or newly diagnosed patients unable to receive or complete standard therapy OR

#### Contacts and Locations

Please refer to this study by its ClinicalTrials.gov identifier: NCT01316146

#### Locations

University of North Carolina Chapel Hill

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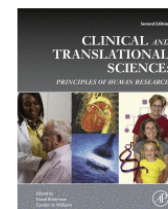
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## 以胶质瘤为例探讨解决科研问题

### Definition from *Goldman-Cecil Medicine*

Astrocytomas, which are the most common glioma, are classified into one of four World Health Organization categories: grade I, the pilocytic astrocytoma; grade II, the fibrillary astrocytoma; grade III, the anaplastic astrocytoma; and grade IV, the glioblastoma. Pilocytic astrocytomas (grade I) are extremely low-grade focal tumors that are more common in children and may be associated with neurofibromatosis type 1; they are often cured by complete surgical excision. Fibrillary astrocytomas, anaplastic astrocytomas, and glioblastomas are diffuse tumors that infiltrate widely into brain; even grade II tumors progress over time, and most acquire the histologic features and growth patterns of grade III and IV tumors.

星形胶质细胞瘤是最常见的神经胶质瘤，根据世界卫生组织的分类分为四级：I级，毛细胞性星形细胞瘤；II级，原纤维型星形细胞瘤；III级，间变性星形细胞瘤；IV级，胶质母细胞瘤。嗜酸细胞星形细胞瘤（I级）是极低级别的局灶性肿瘤，在儿童中更常见，可能与1型神经纤维瘤病相关，他们通常通过完整的手术切除来治愈。纤维化星形细胞瘤，间变性星形细胞瘤和胶质母细胞瘤是弥漫性肿瘤，广泛渗入脑内，甚至II级肿瘤也会随着时间的推移而进展，并且大部分获得III级和IV级肿瘤的组织学特征和生长模式。



### 分析：

纤维化星形细胞瘤，间变性星形细胞瘤和胶质母细胞瘤是弥漫性肿瘤，广泛渗入脑内，针对这一状况，要想手术尽可能的切除肿瘤组织，改善患者预后，就需要精确识别肿瘤的边界，并且要顾及脑组织的功能保护，因此如何通过各种先进的技术手段尽可能**确认肿瘤边界**就是一个关键的问题。

## 问题：胶质瘤边界如何识别？


胶质瘤边界的精确识别对于此病的精准诊断、治疗和改善预后意义重大，那么当前国际上在解决此棘手问题有哪些最新的研究进展？

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

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**CLINICAL TRIAL**

**Multimodality Imaging Combined With Multiple Targets Pathological Examination for Detecting of Biological Borders of Gliomas: a Clinical Application Study**

First received on October 17, 2016. Last updated on October 19, 2016.

**Purpose**

Knowledge of the spatial extent of gliomas is an essential prerequisite for the treatment planning. In particular, the localization of the border zone between tumor infiltrated and normal brain tissue is one of the major problems to be solved before beginning therapy. However, it is a well known problem that, in conventional magnetic resonance imaging (MRI), it often is difficult to detect areas with low tumor infiltration, especially in gliomas, because of their infiltrative and often diffuse nature. The study has two purpose: I. To correlate the imaging border zone with pathological grade of different tumor site following surgery in patients with newly diagnosed intracranial gliomas, work out the biological border zone, and complete resect the tumor. II. To determine the feasibility of defining the optimal target volume for radiation therapy using MR spectroscopy, diffusion, perfusion and functional imaging.

Status	Recruiting
Condition	Glioma
Phase	N/A
Study Type	Interventional

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**Resecting diffuse low-grade gliomas to the boundaries of brain functions: a new concept in surgical neuro-oncology.**

**Abstract**

The traditional dilemma making surgery for diffuse low-grade gliomas (DLGGs) challenging is underlain by the need to optimize tumor resection in order to avoid permanent neurological morbidity. Development of tumor resection according to the oncological limits provided by preoperative or intraoperative structural and metabolic imaging. However, this principle is not coherent, neither with the infiltrative nature of DLGGs nor with the limited resolution of current neuroimaging. Indeed, despite technical advances, MRI still underestimates the actual spatial extent of gliomas, since tumoral cells are present several millimeters to centimeters beyond the area of signal abnormalities. Furthermore, cortical and subcortical structures may be still crucial for brain functions despite their invasion by this diffuse tumoral disease. Finally, the lack of reliability of functional MRI has also been demonstrated. Therefore, to talk about "maximal safe resection" based upon neuroimaging is a non-sense, because oncological MRI does not show the tumor and functional MRI does not show critical neural pathways. This review proposes an original concept in neuro-oncological surgery, i.e. to resect DLGG to the boundaries of brain functions, thanks to intraoperative electrical mapping performed in awake patients. This paradigmatic shift from image-guided resection to functional mapping-guided resection, based upon an accurate study of brain connectomics and neuroplasticity in each patient throughout tumor removal has permitted to solve the classical dilemma, by increasing both survival and quality of life in DLGG patients. With this in mind, brain surgeons should also be neuroscientists.

**Citation**

*Resecting diffuse low-grade gliomas to the boundaries of brain functions: a new concept in surgical neuro-oncology.*

Duffau H - J Neurosurg Sci - December 1, 2015; 59 (4); 361-71

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- Brain Neoplasms /surgery \*
- Glioma /surgery \*
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**J Neurosurg Sci**

Published December 1, 2015.

Volume 59, Issue 4; Pages 361-71

Duffau H<sup>1</sup>.

**Author information**

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Format: Abstract

J Neurosurg Sci. 2015 Dec;59(4):361-71. Epub 2015 Apr 24.

**Resecting diffuse low-grade gliomas to the boundaries of brain functions: a new concept in surgical neuro-oncology.**

Duffau H<sup>1</sup>.

**Author information**

**Abstract**

The traditional dilemma making surgery for diffuse low-grade gliomas (DLGGs) challenging is underlain by the need to optimize tumor resection in order to significantly increase survival versus the risk of permanent neurological morbidity. Development of neuroimaging led neurosurgeons to achieve tumor resection according to the oncological limits provided by preoperative or intraoperative structural and metabolic imaging. However, this principle is not coherent, neither with the infiltrative nature of DLGGs nor with the limited resolution of current neuroimaging. Indeed, despite technical advances, MRI still underestimates the actual spatial extent of gliomas, since tumoral cells are present several millimeters to centimeters beyond the area of signal abnormalities. Furthermore, cortical and subcortical structures may be still crucial for brain functions despite their invasion by this diffuse tumoral disease. Finally, the lack of reliability of functional MRI has also been demonstrated. Therefore, to talk about "maximal safe resection" based upon neuroimaging is a non-sense, because oncological MRI does not show the tumor and functional MRI does not show critical neural pathways. This review proposes an original concept in neuro-oncological surgery, i.e. to resect DLGG to the boundaries of brain functions, thanks to intraoperative electrical mapping performed in awake patients. This paradigmatic shift from image-guided resection to functional mapping-guided resection, based upon an accurate study of brain connectomics and neuroplasticity in each patient throughout tumor removal has permitted to solve the classical dilemma, by increasing both survival and quality of life in DLGG patients. With this in mind, brain surgeons should also be neuroscientists.

PMID: 25907410  
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**Publication type, MeSH terms**

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**PubMed Search Results:**

- Search query: ((COPD[Title/Abstract]) AND treatment) AND "Clinics in chest medicine"[Journal]
- Format: Summary, Sort by: Most Recent, Per page: 20
- Search results list:
  1. **Managing Respiratory Failure in Obstructive Lung Disease.**  
Bergin SP<sup>1</sup>, Rackley CR<sup>2</sup>.  
Clin Chest Med. 2016 Dec;37(4):659-667. doi: 10.1016/j.ccm.2016.07.006. Epub 2016 Sep 8.
  2. [Abstract text: Exacerbations of obstructive lung disease are common causes of acute respiratory failure. Short-acting bronchodilators and systemic glucocorticoids are the foundation of pharmacologic management. For patients requiring ventilator support, use of noninvasive ventilation reduces the risk of mortality and progression to invasive mechanical ventilation. Challenges associated with invasive ventilation include ventilator dyssynchrony, air trapping, and dynamic hyperinflation. Careful monitoring and adjustment of ventilatory support parameters helps to optimize the patient-ventilator interaction and minimizes the risk of associated morbidity. Extracorporeal life support is an emerging treatment for refractory hypercapnic respiratory failure associated with obstructive lung disease.]
  3. KEYWORDS: Asthma; COPD; Hypercapnia; Mechanical ventilation; Noninvasive ventilation; Ventilator dyssynchrony.
  4. Publication type, MeSH terms

**ClinicalKey Article View:**

- Article title: **Managing Respiratory Failure in Obstructive Lung Disease**
- Authors: Stephen P. Bergin MD and Craig R. Rackley MD
- Journal: Clinics in Chest Medicine, 2016-12-01, 卷号 37, 期 4, 页 659-667, Copyright © 2016 Elsevier Inc.
- Abstract: Exacerbations of obstructive lung disease are common causes of acute respiratory failure. Short-acting bronchodilators and systemic glucocorticoids are the foundation of pharmacologic management. For patients requiring ventilator support, use of noninvasive ventilation reduces the risk of mortality and progression to invasive mechanical ventilation. Challenges associated with invasive ventilation include ventilator dyssynchrony, air trapping, and dynamic hyperinflation. Careful monitoring and adjustment of ventilatory support parameters helps to optimize the patient-ventilator interaction and minimizes the risk of associated morbidity. Extracorporeal life support is an emerging treatment for refractory hypercapnic respiratory failure associated with obstructive lung disease.
- Table of Contents (Left):
  - Key points
  - Introduction
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  - Noninvasive ventilation
  - Invasive mechanical ventilation
  - Indications
  - Initiation
  - Identifying Air Trapping
  - Managing Air Trapping
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**LinkOut - more resources:**

- Full Text Sources:
  - Elsevier Science
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  - ClinicalKey** (highlighted)

**Clinics in Chest Medicine:**

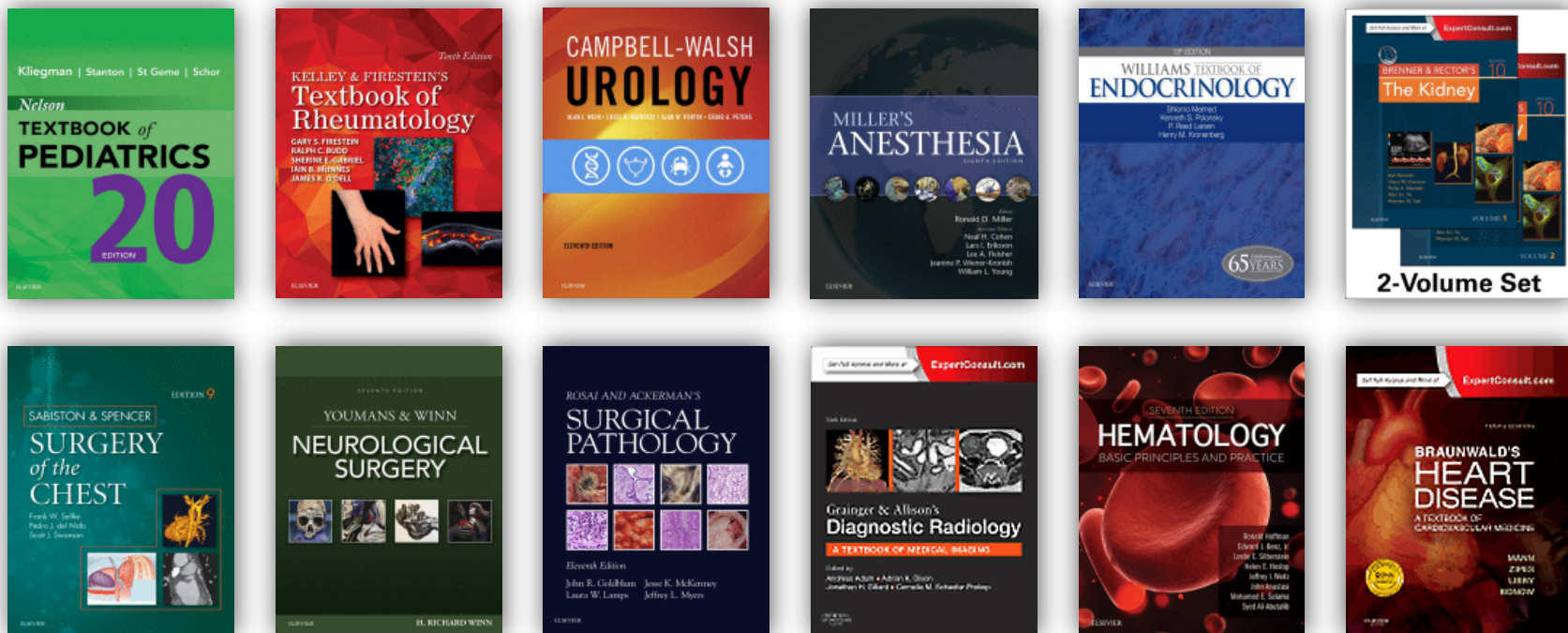
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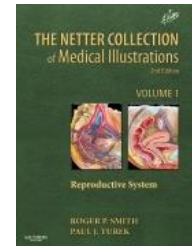
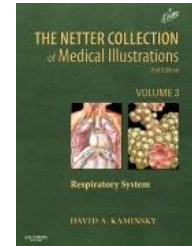
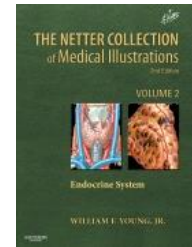
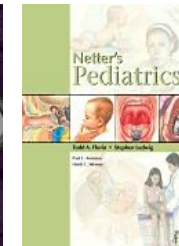
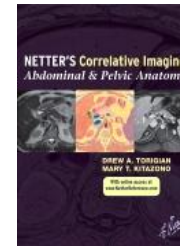
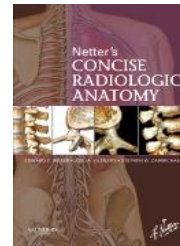
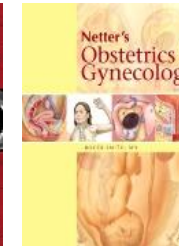
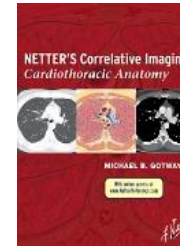
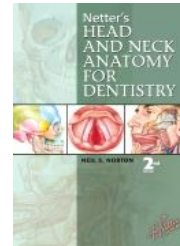
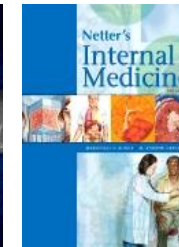
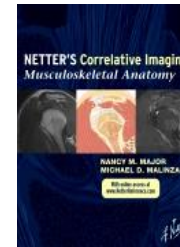
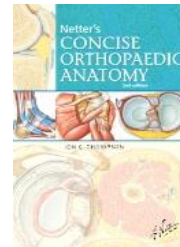
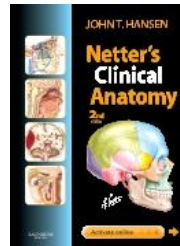
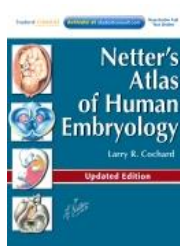
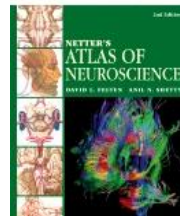
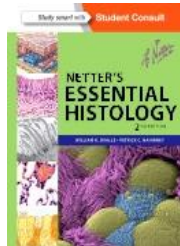
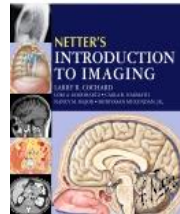
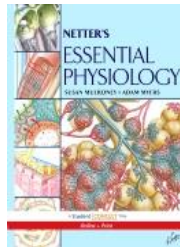
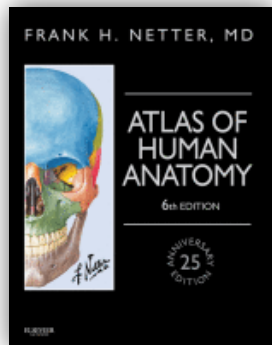
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## ROUTINE EXAMINATION (see )

Top of

image magnified and annotated.

### TESTS OF PULMONARY FUNCTION

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## CONTRAST EXAMINATIONS

Top of

### RADIOLOGIC EXAMINATIONS OF THE LUNGS

#### RADIOLOGIC EXAMINATION OF THE LUNGS

NORMAL POSTEROANTERIOR (PA) AND LATERAL VIEWS OF CHEST

Plate 3-7

LEFT BRONCHIAL TREE AS REVEALED BY BRONCHOGRAMS

Go to: [Outline](#)

## Pulmonary Angiography

Top

### ROUTINE EXAMINATIONS (see Plates 3-4 to 3-6)

### COMPUTED TOMOGRAPHY (see Plate 3-6)

### CONTRAST EXAMINATIONS

### RADIONUCLIDE EXAMINATIONS

### MAGNETIC RESONANCE IMAGING

### SONOGRAPHY

### INTERPRETATION OF RADIOGRAPHIC PATTERNS

### EXHALED BREATH ANALYSIS

### FLEXIBLE BRONCHOSCOPY

#### ROUTINE EXAMINATION (see Plates 3-4 to 3-6)

#### COMPUTED TOMOGRAPHY (see Plate 3-6)

#### CONTRAST EXAMINATIONS

#### RADIONUCLIDE IMAGING

#### MAGNETIC RESONANCE IMAGING

#### SONOGRAPHY

#### INTERPRETATION OF RADIOGRAPHIC PATTERNS

#### EXHALED BREATH ANALYSIS

#### FLEXIBLE BRONCHOSCOPY

#### EQUIPMENT

#### RADIOLOGIC EXAMINATION OF THE LUNGS

#### ROUTINE EXAMINATION (see Plates 3-4 to 3-6)

#### COMPUTED TOMOGRAPHY (see Plate 3-6)

#### CONTRAST EXAMINATIONS

#### RADIONUCLIDE IMAGING

#### MAGNETIC RESONANCE IMAGING

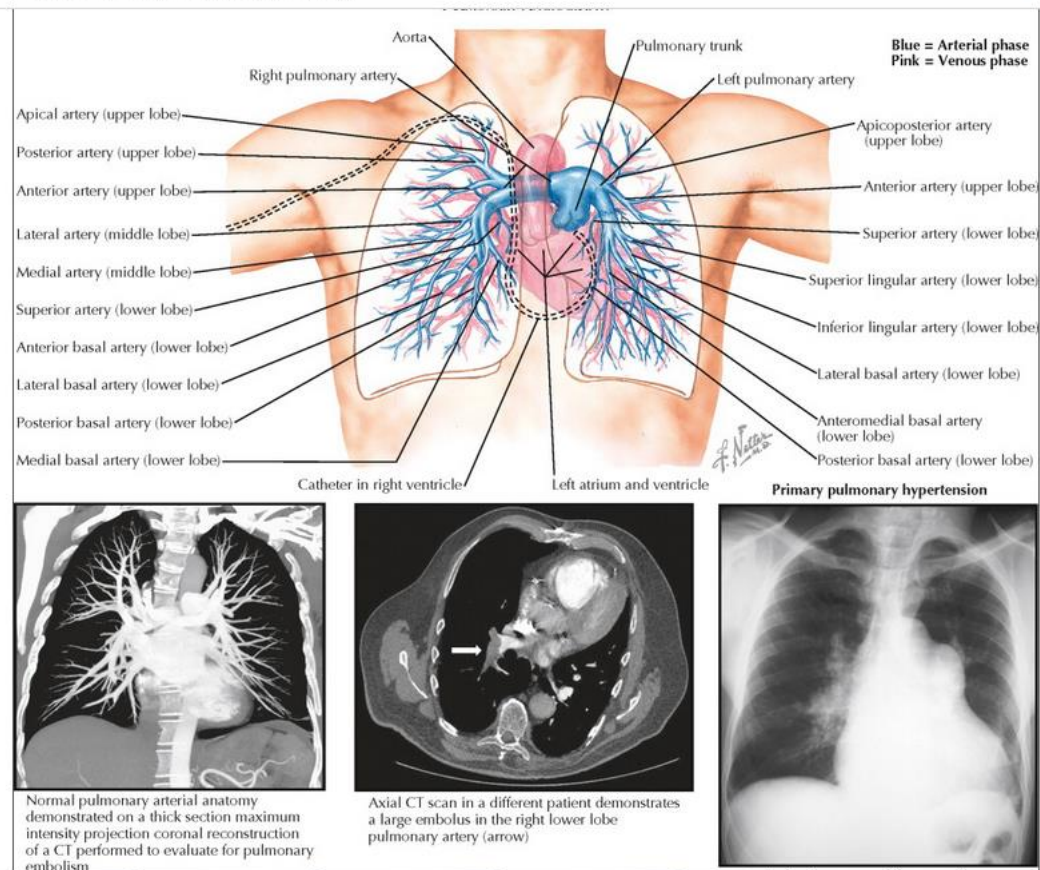
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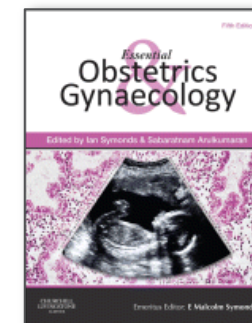
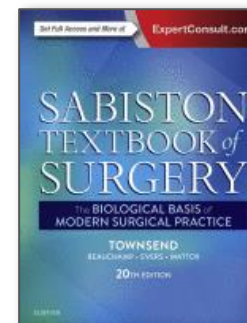
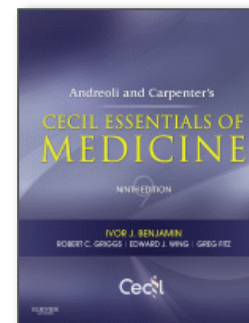
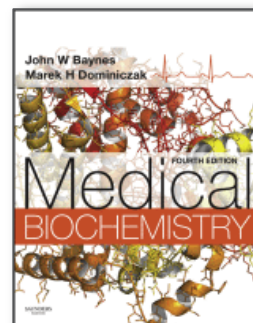
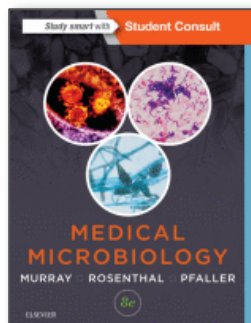
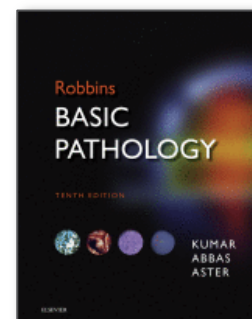
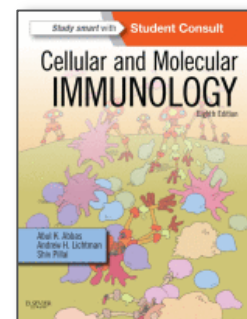
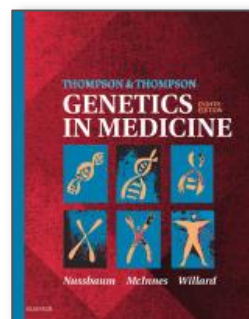
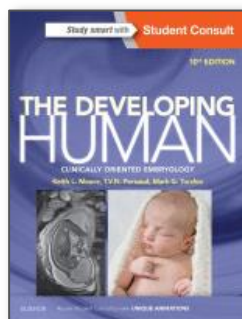
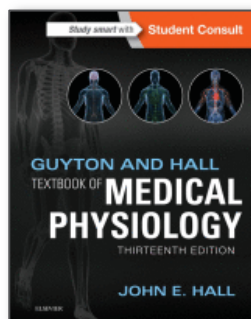
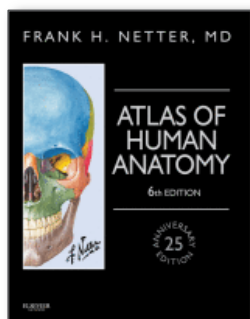
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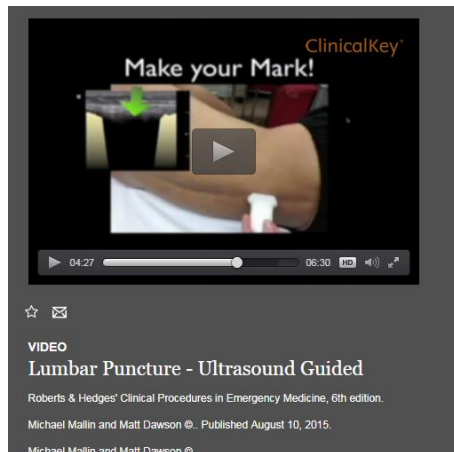
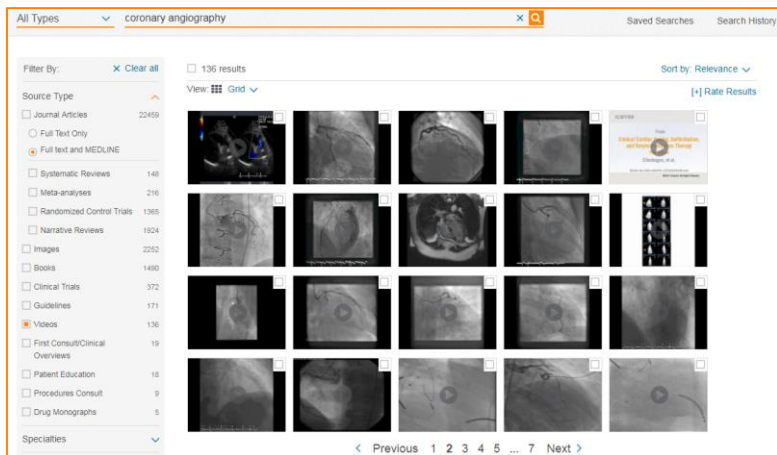
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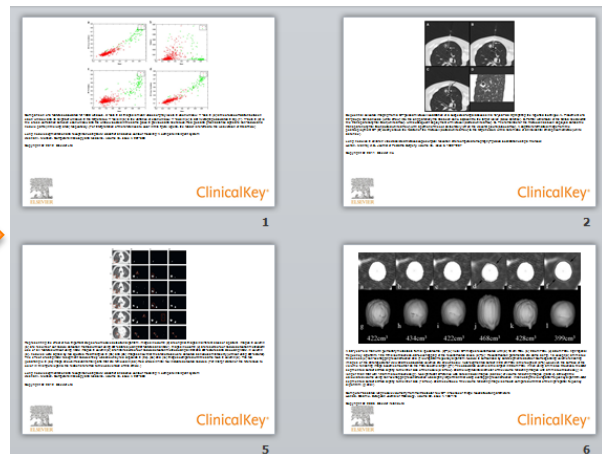
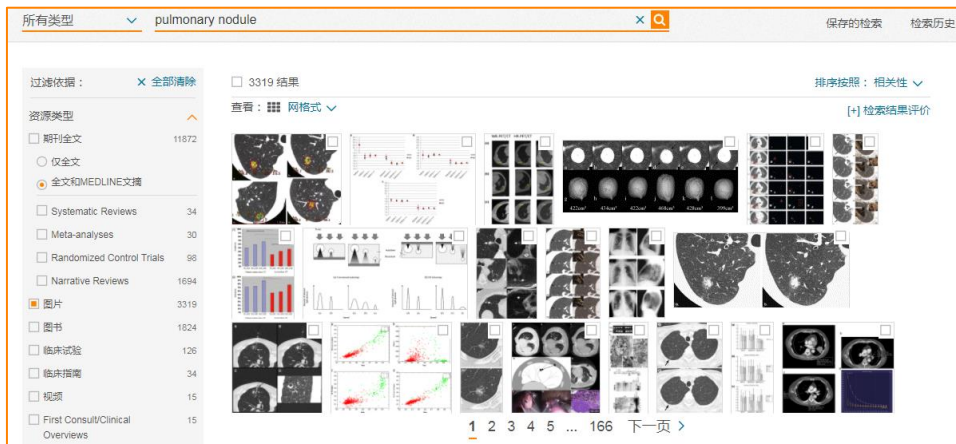
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