临床证据资源及检索方法

2014.9 研究生课程

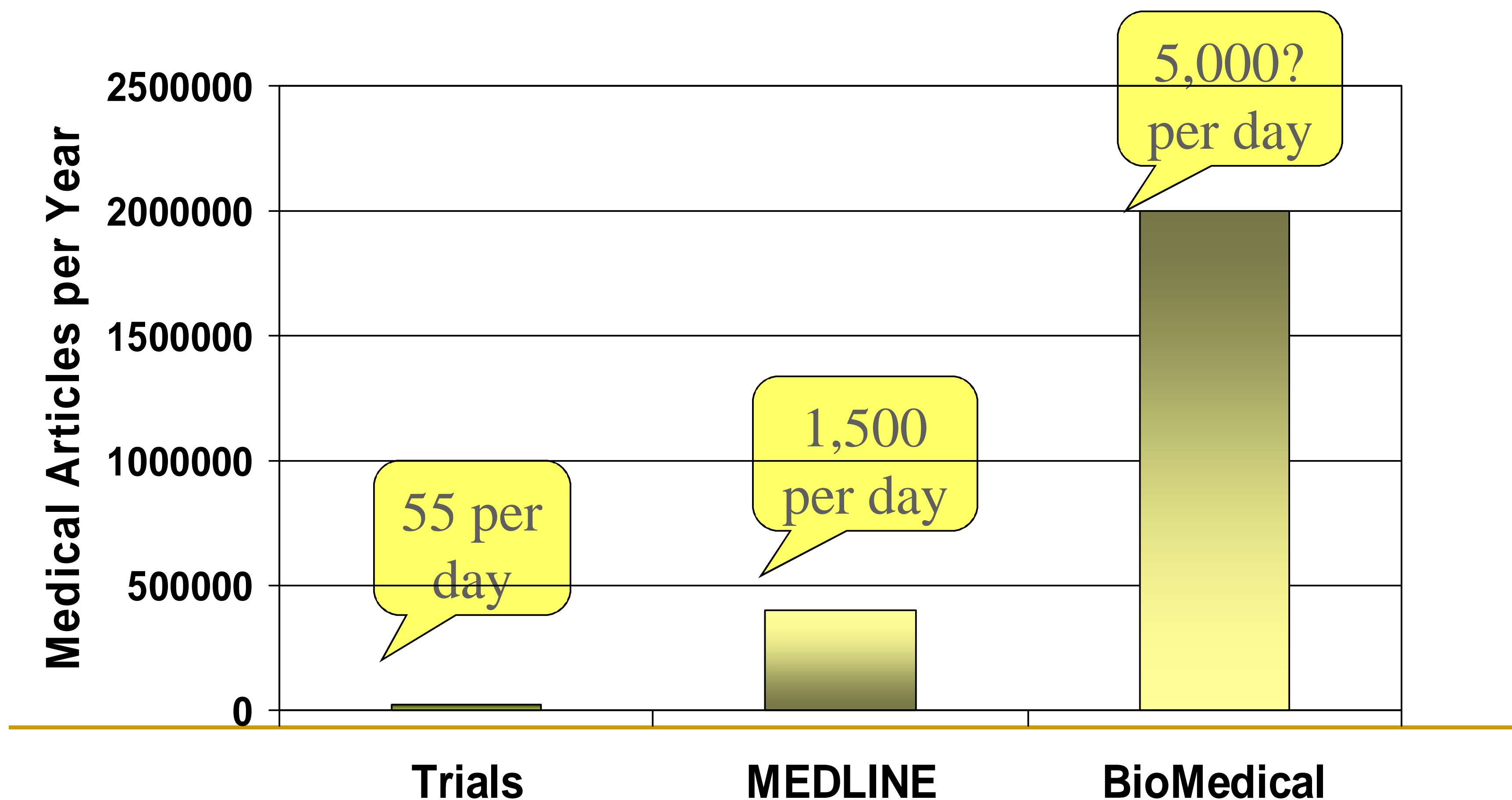
主要内容

- 循证医学检索的基本知识
- 认识循证医学几个重要数据库

循证医学实施步骤

- 提出临床问题
- 寻找回答上述问题的最佳证据，收集有关问题的资料
- 评估文献的真实性、有效性和适用性，从而得出科学证据
- 在临床上应用科学证据
- 对所做的工作进行评价

全世界医学文献发表量



选用最快捷的检索途径发现循证资源

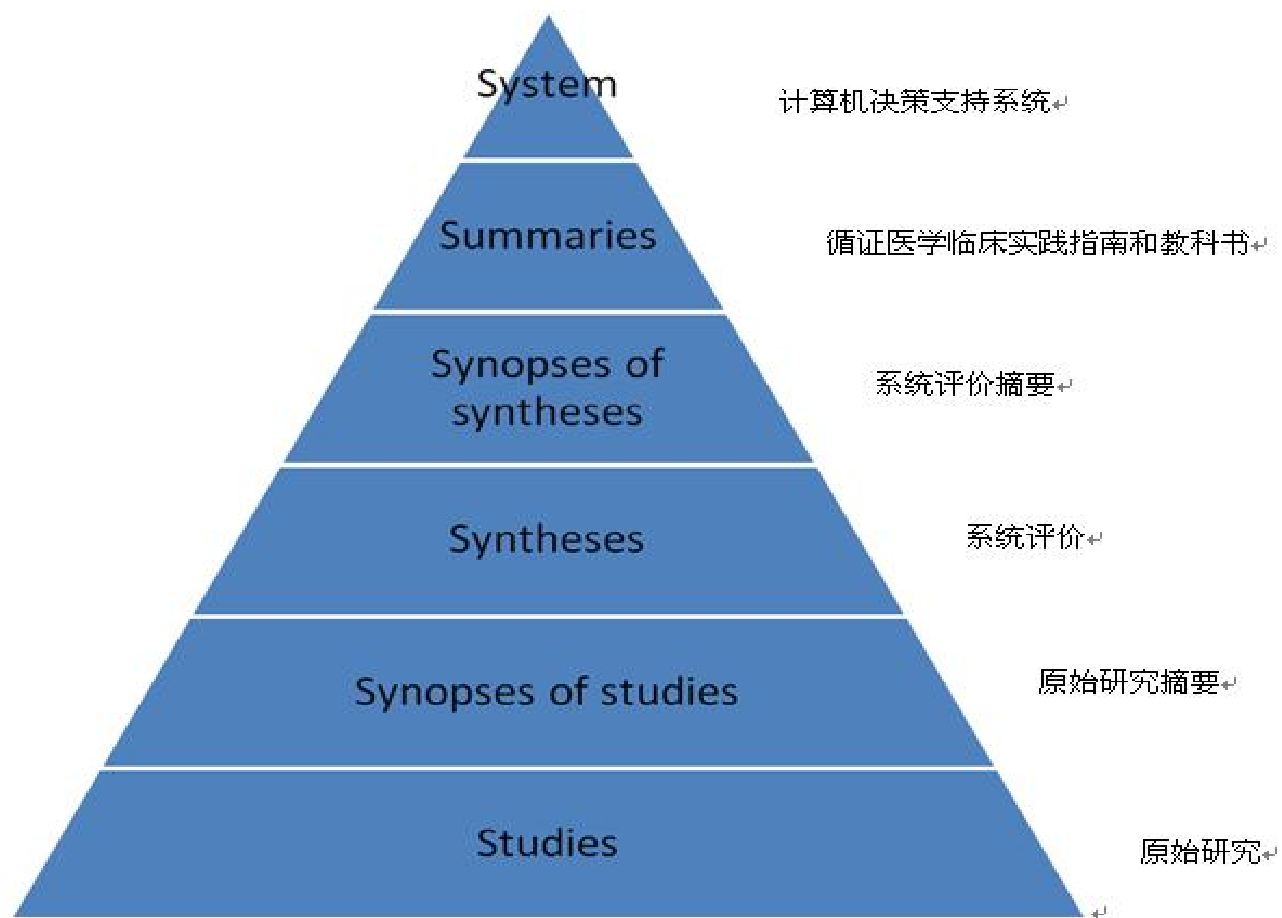


图 1 “6S”循证医学资源分布示意图

计算机决策支持系统

- 针对某个临床问题，概括总结所有相关和重要的研究证据，并通过电子病例系统与特定患者的情况自动联系起来，为医生提供决策信息
- 一个完善的基于实证的临床信息系统应能综合某一临床问题的所有重要的相关实证研究，并通过电子病历将特定病人情况自动链接至相关信息，从而使医生在制定医疗决策时，可随时通过此系统获得相关参考。
-

计算机决策支持系统

- Best Practice（http://bestpractice.bmj.com/）
- UpToDate(http://www.uptodate.com)

证据总结

- 循证医学临床实践指南

  由各级政府、医药卫生管理部门、专业学会、学术团体等针对具体临床问题，分析评价已有的科学研究证据，提出的标准或推荐意见，可作为临床医生处理临床问题的参考性文件，用于指导临床医生的医疗行为。

- 循证医学教科书

证据总结

- Clinical Evidence(www.clinicalevidence.com)
- Dynamed(dynamed.ebscohost.com)
- Physicians’Information and Education Resource(PIER)(pier.acponline.org)
- NGC（National Guideline Clearinghouse, www.guideline.gov)

证据摘要

- 由专家从所有相关期刊中发现最好的论文、选择最好的研究，提供结构式摘要和概要评述或总结。一个评估报告通常包括**4**个方面的内容:
- 问题性质：评估证据的背景材料和依据;
- 证据来源：原始研究或综述性二次研究;
- 评估标准：评估证据质量、可靠性和适用性的标准;
- 评估结果：报告形式可以是证据摘要、证据评述和特定文献评估报告

系统评价摘要

- ACP Journal Club（www.acpjc.org）
- Evidence-Based Medicine（ebm.bmj.com）
- Database of Abstracts of Reviews of Effectiveness (DARE)（www.crd.york.ac.uk/CRDWeb/）

系统评价

- 系统综述（Systematic Reviews）是针对某一具体临床问题、系统全面地检索文献，按照科学标准筛选出合格的研究，通过统计学处理和综合分析，得出可靠的结论，用于指导临床实践。系统综述有别于传统的文献综述，系统综述收集文献的全面程度、质量以及综合资料的定量分析方法均优于传统综述，从而较少了偏倚和错误程度。

系统评价

- The Cochrance Database of Systematic Reviews

原始研究摘要

- ACP Journal Club（www.acpjc.org）

原始研究

- 经过严格评估的研究:ACPJC PLUS，EvidenceUpdates和Nursing+
- 综合的生物医学文献数据库文献数量大，质量参差不齐:MEDLINE、EMBASE和CBM
- PubMed设有Clinical Queries

正在进行的科学研究

正在进行的科学研究所涉及的问题往往是带有普遍性的重要问题，近年来，临床试验已逐渐引起医学专业人员的重视。Cochrane Controlled Trials Register收录和登记了世界各国的临床试验，这些研究不仅是已完成并发表的，还包括已启动但尚未完成和发表的研究。

临床医生实际应用角度

考虑时效性

临床指南：

指南一般分布在

- 专业数据库中的指南（Best Practice、MDC）
- 发表在专业期刊中的指南
- 学协会网站（专业网站）发布

系统综述和Meta分析：Cochrane系统综述

期刊中的系统综述

RCT：发表在期刊中的原始研究

未发表的原始研究

检索方案的制定

- 明确被检索的问题/主题
- 制定纳入和排除标准
- 确定特定专题资源
- 编制特定资源的检索策略

明确被检索的问题/主题

- Population 病人/人群
- Intervention 干预/暴露
- Comparator 对照
- Outcome 结局

采用PICO程式阐明问题

抗菌薇乔缝线是否可以降低阑尾切除术切口感染率？

- Population 人群：阑尾切除术病人
- Intervention 干预：抗菌薇乔缝线
- Comparator 对照：丝线
- Outcome 结局：切口感染率

制定纳入和排除标准

- 研究设计
- 研究环境
- 语种限定
- 文献所涉及的时间限制

确定特定专题资源

信息资源应尽可能全面，通常包括:

已出版的文献、灰色文献、手工检索期刊、与专家互通信息，以及跟踪相关论文的参考文献等一系列信息资源。

检索范围的选择

- 电子数据库
- 手工检索
- 参考文献检索
- 网络搜索
- 引文检索
- 个人交流

编制特定资源的检索策略

- 不同的信息资源需制定不同的检索策略
- 必须遵循特定数据库的检索规则，正确选用描述主题特征的检索词和逻辑组配符
- 在检索策略中还应包括相关的研究设计（如随机对照试验，Meta分析等）

检出结果的选择和评价

- 初筛：浏览检出文献的标题或文摘，筛除明显不合格的文献，对不能肯定的文献则阅读全文。
- 阅读全文：对每一篇相关文献都应进行严格的质量评估。
- 与作者联系：对文中观点有疑问或分歧，或提供信息不全、可与作者联系获取有关信息后再决定取舍。

认识循证医学相关数据库

- Best Practice
- NGC
- The Cochrane Library
- PubMed
- CBM

復旦大學圖書館 医科馆
FUDAN UNIVERSITY MEDICAL LIBRARY

望道溯源 | 馆藏目录 | 数据库 | 电子期刊 | 我的图书馆

说明：查找馆藏纸本图书、期刊和部分电子图书，还可以利用 更多途径 进行查询。

所有词 检索

古籍 哈佛和MIT教材 欧盟赠书 复旦人著作

01. 资源

- 馆藏目录
- 学术信息资源门户
- 常用数据库
- 试用数据库
- 电子图书
- 特藏资源
- 医学期刊联合目录
- 中外文核心期刊查...
- 电子资源使用管理...
- 电子资源访问方式

02. 服务

03. 指南

通知公告 | 资源动态

- 逾期未还"已预约"图书读者名单 2013-10-10
- 医科馆各部门电话恢复正常使用的通知 new 2014-09-25
- 医科馆临时书刊库开放时间及服务内容 new 2014-09-16
- ClinicalKey数据库试用 HOT new 2014-09-04
- Informa出版社Expert Opinion药学专辑电子期刊试用 new 2014-07-09
- 复旦大学医学图书馆联盟系列讲座——上海市公共卫生临床中心站PPT new 2014-06-20

- 复旦大学
- 复旦大学上海医学院
- 复旦大学图书馆
- 全国医学文献检索教研会
- 中华医学会医学信息学分会

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本站地图 联系我们 English

复旦大學图书馆 医科馆
FUDAN UNIVERSITY MEDICAL LIBRARY

首页 资源 服务 指南 新闻动态 关于医科馆 怀念旧版

资源

- 馆藏目录
- 学术信息资源门户
- 常用数据库
- 试用数据库
- 电子图书
- 特藏资源
- 医学期刊联合目录
- 中外文核心期刊查询系统
- 电子资源使用管理办法
- 电子资源访问方式

常用数据库

MetaLib/SFX学术资源门户	Web of Knowledge-Web of Science
BestPractice	OVID平台
EMBASE (OVID)	EBM Reviews (OVID)
BIOSIS Previews (OVID)	JBI 循证护理数据库 (OVID)
Primal 3D人体解剖模型库 (OVID)	Nursing Consult
Amirsys影像学图片数据库	Amirsys病理学图片数据库
McGraw-Hill Access Medicine	McGraw-Hill Access Surgery
MICROMEDEX (医药知识数据库)	Scifinder
EBSCO	Proquest
Kluwer	Elsevier
Scopus数据库	JSTOR
国家科技图书文献中心(NSTL)	EI（工程索引）
PQDT	MedicinesComplete
NoteExpress文献管理软件2.0版	更多数据库...

Science Online	Nature
The New England journal of medicine (OVID)	LWW Journals (OVID)
BMJ Journals	BioMed Central
Springer Link	Karger
Informa Healthcare	Wiley-Blackwell
独立学术出版集团（ISPG）	SAGE Journals

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Clinical Evidence 临床证据

- Clinical Evidence 是一本权威性的临床证据大全，提供常见临床问题的最佳证据，由英国医学杂志出版社出版。该书以提问形式解答临床医学各专业中有关疗效及预防方面的问题，内容涉及干预手段、疾病概述，治疗要点及疗效利弊，以利于临床医生在选择治疗方案时做出正确的决策。

Clinical Evidence 临床证据

- 收录650 余种临床病症和3100 余种治疗方案
- 证据来源于10,000余种同行评审期刊中的文献
- 提供干预手段、疾病概述、治疗要点及疗效利弊
- 参考文献可链接至PubMed 和Cochrane 等资源
- 提供用药安全通报、实践指南和最新研究证据

BMJ Best Practice

权威

- 全新的临床诊疗（辅助）系统
- 全球**5000+**知名临床专家执笔撰写
- 提供国际权威指南和可以定制国内标准和指南
- **NIH**，**NHS**认证，**WHO**认证中

高效

- 直达所需内容，免去查找过程
- 与药物数据库系统**Martindale**实时对接
- 每月更新，每年重审

实用

- 涵盖超过**10000**种诊断方法，**3000**项诊断性检测和**4000**多篇诊断和治疗指南
- 包括基础，预防，诊断，治疗和随访等各个关键环节的内容
- 整合了**BMJ** **Clinical Evidence**

ClinicalEvidence

A full list of *Clinical Evidence* sections.

- Blood and lymph disorders
- Cardiovascular disorders
- Care of the elderly
- Child health
- Diabetes
- Digestive system disorders
- Ear, nose, + throat disorders
- Endocrine and metabolic disorders
- Eye disorders
- HIV and AIDS
- Infectious diseases
- Kidney disorders
- Lifestyle
- Men's health
- Mental health
- Musculoskeletal disorders
- Neurological disorders
- Oncology
- Oral health
- Perioperative care
- Poisoning
- Pregnancy and childbirth
- Respiratory disorders (acute)
- Respiratory disorders (chronic)
- Sexual health
- Skin disorders
- Sleep disorders
- Social and community health
- Supportive and palliative care
- Travel health
- Women's health
- Wounds

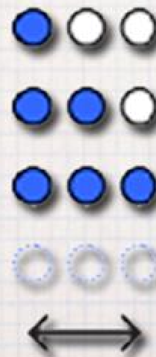
- Chronic fatigue syndrome (updated)

Summary of all updates

Guest editorial

Since 2004, Clinical Evidence has undergone multiple changes to enhance the accessibility of the content and maximise the transparency and usefulness of the evidence presented. Key initiatives include the creation of a key points section and addition of a GRADE system. Now, as Karen Pettersen highlights in her Editorial, we are pleased to announce the launch of a new tabulated format for presentation of the data in half of our reviews (please see our review on heart failure as an example). We hope you find the new data display helpful in understanding the benefits and harms of interventions and, most importantly, in making better decisions, together with patients.

Read the Editorial



The Clinical Evidence Userguide, available in over a dozen languages (now including Finnish), features illustrations and examples of how to get the most out of our site.

Swine flu patient leaflet now free online

Swine flu patient leaflet

Articles and Research section

Access the latest independent research on *Clinical Evidence*

Clinical Evidence Research Report

Read the latest opinions from users of *Clinical Evidence* and why evidence-based medicine is so important in medical practice

Our methods

The systematic reviews in *Clinical Evidence* result from a rigorous process

Consultancy reviews

Palliative care

Our latest review synthesises the evidence

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搜索题名 | 按疾病浏览

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What's new or updated?

Anaemia of chronic disease	Chronic renal failure
Conversion and somatic symptom disorders	Erythema multiforme
Hepatoma	Pertussis

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In the spotlight

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Overviews
Allergy and immunology
Cardiothoracic surgery
Cardiovascular disorders
Critical care medicine
Dermatology
Ear, nose and throat
Emergency medicine

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

AAT deficiency
Abdominal aortic aneurysm
Abdominal compartment syndrome
Abdominal injury
Abdominal pain, chronic (Assessment of)
Abdominal pain in children (Assessment of)
Abdominal pain in pregnancy (Assessment of)
Abdominal pain in children (Assessment of)

Search results

acute lymphoblastic leuk

BMJ Clinical Evidence 患者教育 Drug database BMJ Por

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搜索题名 按疾病浏览

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What's new or updated?

Assessment of abdominal pain in children

Coxiella burnetii infection

Dyssomnias in children

Assessment of hypocalcaemia

Acanthosis nigricans

Assessment of back pain

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Title	分类	Last updated	Update changes i
Assessment of abdominal pain in children	症状分析	19 九月 2014	
Coxiella burnetii infection	Infectious diseases	19 九月 2014	
Dyssomnias in children	Ear, nose and throat	9 九月 2014	
Assessment of hypocalcaemia	症状分析	19 九月 2014	
Acanthosis nigricans	Dermatology	17 九月 2014	
Assessment of back pain	症状分析	17 九月 2014	
Barrett's oesophagus	Gastroenterology and hepatology	17 九月 2014	
Cholangiocarcinoma	Gastroenterology and hepatology	17 九月 2014	
Assessment of elevated creatinine	症状分析	17 九月 2014	
Familial adenomatous polyposis syndromes	Gastroenterology and hepatology	17 九月 2014	
Gestational hypertension	Obstetrics and gynaecology	17 九月 2014	
Haemochromatosis	Endocrinology and metabolic disorders	17 九月 2014	
Hypertrophic cardiomyopathy	Cardiothoracic surgery	17 九月 2014	
Iliotibial band syndrome	Orthopaedics	17 九月 2014	
Patellofemoral pain syndrome	Orthopaedics	17 九月 2014	
Peutz-Jeghers syndrome	Gastroenterology and hepatology	17 九月 2014	

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Best Practice主要提供两种标准结构界面

- 疾病诊治标准界面 从“疾病”入手

精粹	基础	预防	诊断	治疗	随访	文献资料
总结	定义	一级预防	病史与检查	具体方法	推荐	参考文献
概览	流行病学	筛检	实验室检查	治疗步骤	并发症	图像
	病原学	二级预防	鉴别诊断	新疗法	预后	网站资源
	病理生理		诊断步骤	治疗指南		患者教育
	分类		诊断标准	证据		致谢
			诊断指南			
			病史			

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- 症状分析 从“症状”入手

Clinical Evidence 患者教育 药物数据库 Help 中文（中国）

BestPractice 按疾病浏览 Search Best Practice Search All

Assessment of peripheral oedema

概览	急诊	诊断	文献资料
总结	应急考虑	诊断步骤	参考文献
病原学		鉴别诊断	图像
			网站资源
			患者教育
			致谢

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搜索题名 按疾病浏览

Search BMJ Best Practice

搜索结果

acute appendicitis

提示：使用标签来帮助过滤搜索。

搜索结果

全部结果 (8404) 疾病 (177) 诊断 (1431) 治疗 (2577) 证据 (710) 药物数据库 (0) 指南 (198)

结果 **1**到**50**的**8404**

保存此搜索

疾病	Acute appendicitis 精粹 | 基础 | 诊断 | 治疗 | 随访 | 文献资料
证据	Appendicitis > Clinical Evidence

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精粹 | 基础 | 诊断 | 治疗 | 随访 | 文献资料

Appendicitis > Clinical Evidence

Assessment of acute abdomen

概览 | 急诊 | 诊断 | 文献资料

Assessment of abdominal pain in pregnancy

概览 | 急诊 | 诊断 | 文献资料

Assessment of gait disorders in children

概览 | 急诊 | 诊断 | 文献资料

Assessment of abdominal pain in children

概览 | 急诊 | 诊断 | 文献资料

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Acute appendicitis

最后更新于：九月 05, 2014

精粹	基础	诊断	治疗	随访	文献资料
总结	定义	病史与检查	具体方法	推荐	参考文献
概览	流行病学	实验室检查	治疗步骤	并发症	图像
	病原学	鉴别诊断	治疗指南	预后	网站资源
	病理生理	诊断步骤	证据		患者教育
		诊断标准			致谢
		诊断指南			Related BMJ content
		病史			

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Acute

Patient group	Treatment line	Treatment show all
uncomplicated acute appendicitis	1st	› appendectomy + supportive care
	adjunct	› IV antibiotic therapy
unwell with perforation or abscess	1st	› IV antibiotic therapy + supportive care
perforation	plus	› appendectomy
abscess	plus	› drainage ± interval appendectomy

uncomplicated acute appendicitis	1st

appendectomy + supportive care

→ Once the diagnosis of acute appendicitis is made, patients should be given nil by mouth. Maintenance IV fluids, such as lactated Ringer's solution, should be started.

→ Appendectomy should be performed without delay, as early appendectomy reduces the chances of perforation and intra-abdominal abscess.

→ Laparoscopic appendectomy carried out by an expert has better cosmetic results and decreases the length of hospital stay, postoperative pain, and overall complication rate, including intra-abdominal abscess intra-abdominal abscess is and postoperative ileus, when compared with open appendectomy. Evidence B

→ Open appendectomy is considered to be the safest approach in pregnant women, [54] whereas a laparoscopic approach is considered safest in obese patients. [55]

→ Intra-abdominal abscesses have previously been noted to be more common in adult patients who undergo laparoscopic appendectomy, [60] Evidence B but other factors such as the level of contamination, possible stump leak, use of preoperative antibiotic, and the patient's own immune response to infection may be involved. However, one study suggests that intra-abdominal abscess is less frequent in patients undergoing laparoscopic surgery. [33]

→ Patients with higher APACHE (Acute Physiology and Chronic Health Evaluation) scores seem to be at higher risk of development of postoperative complications. [APACHE II calculator] The APACHE score is commonly used to establish illness severity in the ICU and predict the risk of death. In this context, there is a high risk of death if the score is 25 or above.

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Patient group Treatment line Treatment show all

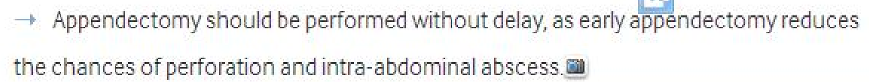
uncomplicated acute appendicitis

1st

appendectomy + supportive care

→ Once the diagnosis of acute appendicitis is made, patients should be given nil by mouth. Maintenance IV fluids, such as lactated Ringer's solution, should be started.

→ Appendectomy should be performed without delay, as early appendectomy reduces the chances of perforation and intra-abdominal abscess.



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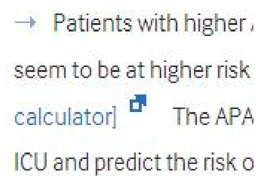

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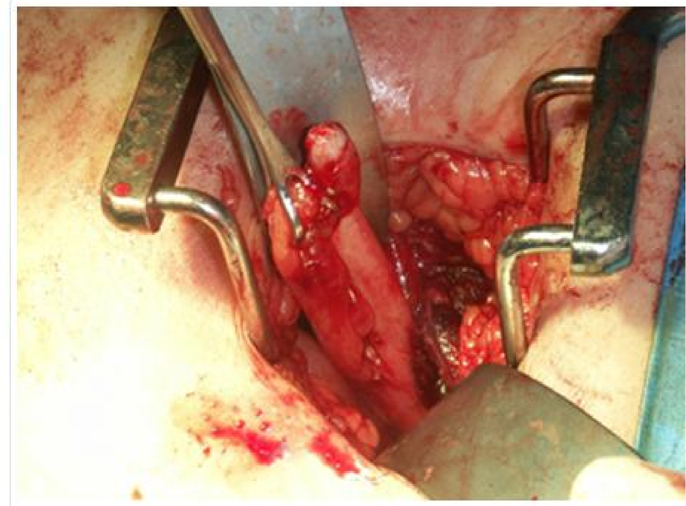

Acute appendicitis - intraoperative specimen

Nasim Ahmed, MBBS, FACS

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uncomplicated acute appendicitis	**1st**	**appendectomy + supportive care**

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→ Appendectomy should be p[illegible] appendectomy reduces the chances of perforation and i[illegible]

Randomized controlled trials (RCTs) of <200 participants, methodologically flawed RCTs of >200 participants, methodologically flawed systematic reviews (SRs) or good quality observational (cohort) studies.

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→ Patients with ation) scores seem to be at hig ACHE II calculator] T erity in the ICU and predict th the score is 25 or above.

Evidence score Close

Wound infection rates in adults with acute appendicitis: there is medium-quality evidence that, compared with open surgery in adults, laparoscopic surgery seems more effective than open surgery at reducing wound infections.

Evidence level B
Randomized controlled trials (RCTs) of <200 participants, methodologically flawed RCTs of >200 participants, methodologically flawed systematic reviews (SRs) or good quality observational (cohort) studies.

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Reference Close

54. Wilasrusmee C, Sukrat B, McEvoy M, et al. Systematic review and meta-analysis of safety of laparoscopic versus open appendicectomy for suspected appendicitis in pregnancy. Br J Surg. 2012;99:1470-1478.

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Meta-Analysis

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Systematic review and meta-analysis of safety of laparoscopic *versus* open appendicectomy for suspected appendicitis in pregnancy

C. Wilasrusmee[1,2], B. Sukrat[2,3], M. McEvoy[4], J. Attia[4] and A. Thakkinstian[2,*]

Article first published online: 21 SEP 2012

DOI: 10.1002/bjs.8889

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British Journal of Surgery

Volume 99, Issue 11, pages 1470–1478, November 2012

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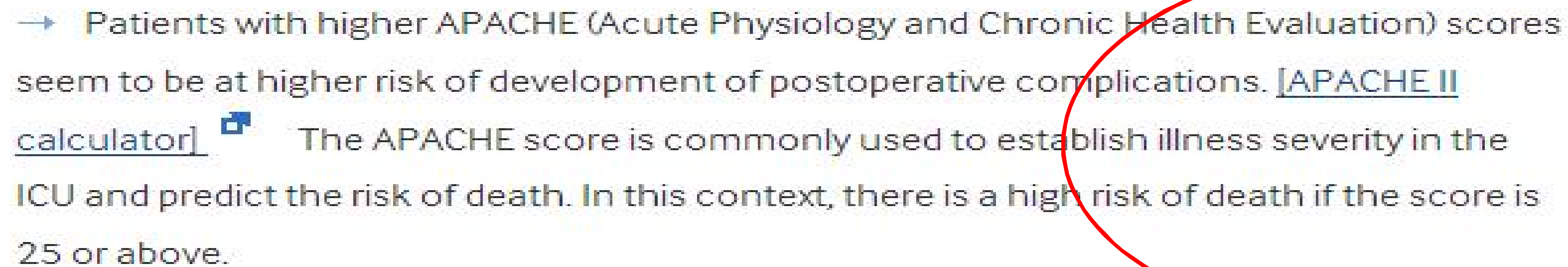

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› IV antibiotic therapy

⌄ **IV antibiotic therapy + suppo**

→ These patients have evidence of perforation, mass, or abscess

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Scoring systems for ICU and surgical patients:

APACHE II (Acute Physiology And Chronic Health Evaluation)

Temperature (°C) 0	Mean Arterial Pressure (mmHg) 0	Heart Rate 0
Respiratory Rate 0	If FIO2 >= 0,5 : (A-a) O2 (Help) 0	If FIO2 < 0,5 : PaO2 0
If no A.B.Gs : Serum HCO_3^- (mmol/L) 0	Arterial pH 0	Serum Sodium (mmol/L) 0
Serum Potassium (mmol/L) 0	Serum Creatinine With Acute Renal Failure 0	Serum Creatinine Without Acute Renal Failure 0
Ht (%) 0	W.B.C ($x10^3$/ mm^3) 0	Glasgow Coma Score (Help) 0
Age 0	Apache II 0 Clear	Chronic Organ Insufficiency (Help) immuno-compromised 0

Predicted death rate 0

Logit = -3,517+(Apache II) * 0,146

Predicted Death Rate $=e^{Logit}/(1+e^{Logit})$

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最后更新于： 九月 05, 2014

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	病原学	鉴别诊断	治疗指南	预后	网站资源
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Treatment approach

The goal of treatment is to remove the infected appendix.

Uncomplicated presentation

Once the diagnosis of acute appendicitis is made, patients should be given nil by mouth.

Maintenance IV fluids, such as lactated Ringer's solution, should be started. Use of prophylactic IV antibiotics postoperatively is controversial; however, the use of cefoxitin is recommended for uncomplicated appendicitis to reduce the risk of wound infection. [48] Evidence B Appendectomy should be performed without delay.

Complicated presentation

Complications of acute appendicitis occur in 4% to 6% of patients and include gangrene with subsequent perforation or intra-abdominal abscess. [11]

Initial management includes keeping the patient nil by mouth and starting maintenance IV fluids. If the patient is in shock, they should be given a bolus of IV fluid, such as 0.9% normal saline or lactated Ringer's solution, in order to maintain a stable pulse rate and BP.

IV antibiotics with cefoxitin or ticarcillin/clavulanate should be started immediately and continued until the patient becomes afebrile and the leukocytosis is corrected. For more severe infections, a carbapenem antibiotic may be used as a single agent or a combination of a third-generation cephalosporin, a monobactam, or aminoglycoside plus anaerobic coverage with clindamycin or metronidazole. [11]

In patients with acute peritonitis, appendectomy should be performed without delay.

Patients presenting with right lower quadrant abscess should be managed with IV antibiotics and drainage either by interventional radiology (CT-guided drainage) or by operative drainage. If there is clinical improvement and the signs and symptoms are completely resolved, then there is no need for interval appendectomy. [49] [50] [51] Interval appendectomy is performed after 6 weeks if the symptoms are not completely resolved. [52]

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Acute appendicitis

最后更新于： 九月 05, 2014

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Treatment guidelines

International show all

2013 WSES guidelines for management of intra-abdominal infections

Published by: World Society of Emergency Surgery

Last published: 2013

Summary

These guidelines provide evidence-based recommendations for the management of patients with intra-abdominal infections.

- Discuss this topic on the **Stroke Medicine** forum at **doc2doc**
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This is a collection of guidelines, position papers and study group articles from the World Society of Emergency Surgery

Collection published: 18 April 2014

Review Open Access

Acute appendicitis: position paper, WSES, 2013

Ferdinando Agresta, Luca Ansaloni, Fausto Catena, Luca Verza, Daniela Prando

World Journal of Emergency Surgery 2014, **9**:26 (7 April 2014)

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Correction Open Access

Correction: emergency surgeon: "last of the mohicans" 2014-2016 editorial policy WSES-WJES: position papers, guidelines, courses, books and original research; from WJES impact factor to WSES congress impact factor

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This article is part of the series WSES guidelines, position papers and study group articles: 2010 to 2014.

Review

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Acute appendicitis: position paper, WSES, 2013

Ferdinando Agresta[1]*, **Luca Ansaloni**[2], **Fausto Catena**[3], **Luca Andrea Verza**[1] and **Daniela Prando**[1]

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World Journal of Emergency Surgery 2014, **9**:26 doi:10.1186/1749-7922-9-26

The electronic version of this article is the complete one and can be found online at: http://www.wjes.org/content/9/1/26

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- What are the effects of treatments for acute appendicitis?

View this review's GRADE table, the basis of our judgements about evidence quality. Read more

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What are the effects of treatments for acute appendicitis?

Category		Interventions
Beneficial		• Surgery plus antibiotics
Likely to be beneficial		• Laparoscopic surgery versus open surgery in children • Stapling versus endoloops in laparoscopic appendicectomy
Trade off between benefits and harms		• Antibiotics versus surgery • Laparoscopic surgery versus open surgery in adults
Unknown effectiveness		• Antibiotics versus no treatment/placebo • Surgery versus no treatment • Natural orifice surgery versus laparoscopic surgery
Likely to be ineffective or harmful		• Stump inversion at open appendicectomy versus simple ligation

Web publication date: 7 Jan 2011 (based on February 2010 search)

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Treatments

Stump inversion at open appendicectomy versus simple ligation

In this section:

Key points | Benefits and harms | Comment

Key points

Top

- For GRADE evaluation of interventions for Appendicitis, see table.
- There is limited evidence to suggest that stump inversion has an increased rate of wound infection compared with simple ligation, and no difference in rate of intra-abdominal abscess formation.

Benefits and harms

Top

Stump inversion versus simple ligation:

We found no systematic review, but found two RCTs.[24][25]

Hospital stay

Compared with simple ligation We don't know how effective stump inversion at open appendicectomy is compared with simple ligation at reducing hospital stay (**moderate-quality evidence**).

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This table summarises the results of our GRADE analysis that forms the basis of our judgements about evidence quality. Read more

GRADE Evaluation of interventions for Appendicitis.

Important outcomes	Hospital stay, Intra-abdominal infection, Mortality (from appendicitis), Operation duration, Pain, Postoperative mortality (from surgery), Quality of life, Return to normal activities, Wound infection									
Studies (Participants)	**Outcome**	**Comparison**	**Type of evidence**	**Quality**	**Consistency**	**Directness**	**Effect size**	**GRADE**	**Comment**	
What are the effects of treatments for acute appendicitis?										
at least 35 (8812)[12]	Wound infection	Surgery plus antibiotics versus surgery plus placebo or surgery alone in adults	4	–1	0	0	0	Moderate	Quality point deducted for randomisation flaws	
10 (4468)[12]	Intra-abdominal infection	Surgery plus antibiotics versus surgery plus placebo or surgery alone in adults	4	–1	–1	0	0	Low	Quality point deducted for randomisation flaws. Consistency point deducted for different results for subgroup analyses	
7 (1198)[12][14]	Wound infection	Surgery plus antibiotics versus surgery plus placebo or surgery alone in children	4	–1	–1	0	0	Low	Quality point deducted for randomisation flaws. Consistency point deducted for different results for subgroup analyses	
6 (1003)[12]	Intra-abdominal infection	Surgery plus antibiotics versus surgery plus placebo or surgery alone in children	4	–2	0	0	0	Low	Quality points deducted for randomisation flaws and uncertainty about statistical significance of result	
2 (120)[7][5]	Pain	Antibiotics versus surgery	4	–2	0	–1	0	Very low	Quality points deducted for sparse data and incomplete reporting of results. Directness point deducted for uncertainty about diagnosis	
1 (252)[15]	Return to normal	Antibiotics versus surgery	4	–1	0	–1	0	Low	Quality point deducted for analysis flaw. Directness points deducted for narrow	

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Assessment of abdominal pain in children

Summary

Paediatric abdominal pain is often a diagnostic dilemma. It is a common problem and, although the vast majority of these episodes are benign and self-limiting, persistent abdominal pain may signify an underlying pathology requiring urgent intervention. Timely assessment and intervention are critical in preventing untoward sequelae in children presenting with abdominal pain.

Because of the spectrum of aetiologies that manifest as abdominal pain, the differential remains broad and diagnosis can be challenging. In most cases, a thorough history and physical examination can narrow the broad differential. However, depending on the age of the child, additional investigations may be required to delineate diseases that present with similar symptoms. Furthermore, even with the assistance of parents or guardians, a comprehensive history is often difficult to obtain, and diagnosis therefore relies heavily on the clinical acumen of the practitioner.

Differential diagnosis

Sort by: common/uncommon or category

Common

- Constipation
- Acute appendicitis
- Gastroenteritis
- Urinary tract infection
- Abdominal trauma (blunt or penetrating)
- Cholelithiasis/cholecystitis
- Primary dysmenorrhoea
- Pneumonia
- Functional abdominal pain

Uncommon

- Intussusception
- Meckel's diverticulum
- Mesenteric adenitis
- Hirschsprung's disease
- Ulcerative colitis
- Crohn's disease
- Small bowel obstruction
- Volvulus
- Large bowel obstruction
- Necrotising enterocolitis
- Peptic ulcer disease
- Viral hepatitis
- Biliary dyskinesia

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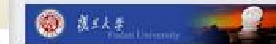

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Assessment of abdominal pain in children

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Urgent considerations

See Differential Diagnosis for more details

Although the causes of abdominal pain in children are frequently benign (e.g., constipation), there is always the potential for life- or organ-threatening conditions, which require urgent intervention.

GI emergencies

Acute appendicitis resulting in perforation

- Untreated acute appendicitis may progress to ischaemia, necrosis, and eventually perforation. The clinician may encounter a range of presentations. Patients often complain of abdominal pain localised to the right lower quadrant (RLQ); in more severe cases the pain may be diffuse (e.g., if a large perforation results in generalised peritonitis). Perforation should be considered when a patient presents with a long duration of symptoms and/or suspected appendicitis with marked systemic signs of illness (e.g., high fever [>38.3° C, >101°F]), tachycardia, and anorexia). Evidence A A CT scan of the abdomen may be useful in determining the extent of the inflammatory response as well as the presence of any collections that may be amenable to percutaneous drainage. Appendectomy should be performed in all cases. Procedure can be done by open surgery or by laparoscopy.

Intestinal obstruction

- Urgency of intervention is dependent on the clinical severity of the obstruction. Non-

Red flags

- Acute appendicitis
- Urinary tract infection
- Abdominal trauma (blunt or penetrating)
- Intussusception
- Small bowel obstruction
- Volvulus
- Large bowel obstruction
- Necrotising enterocolitis
- Peptic ulcer disease
- Viral hepatitis
- Acute pancreatitis
- Splenic infarction/cysts
- Testicular torsion
- Ovarian torsion
- Pregnancy complications
- Empyema

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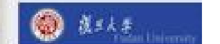

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Assessment of abdominal pain in pregnancy

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Summary

Abdominal pain throughout pregnancy is common. Many adaptive or physiological changes of pregnancy affect the presentation. Women tend to visit doctors often as they are concerned about the health of their fetus. Patients require a careful assessment in order to reduce anxiety and give reassurance. If the clinical picture is unclear, a specialist should be consulted. [1] [2]

Diagnostic challenges and pitfalls

The physiological and anatomical changes of various organs during the course of pregnancy result in major diagnostic challenges for the clinician. Reproductive organs share the same visceral innervations as the lower ileum, sigmoid colon, and rectum. It is therefore often difficult to differentiate between pain of gynaecological and GI origin. Pain may be due not only to pregnancy-specific causes or gynaecological conditions, but to many other diseases whose symptoms and signs may be altered significantly by the pregnant state. This is particularly true from the late second trimester onwards.

Evaluation is based on 2 patients: the mother and the fetus. The potential adverse effects of anaesthesia, drugs, and radiation on the fetus often complicate the traditional diagnostic approach. As a result, the presence of the fetus may lead to delayed intervention or invasive diagnostic tests. Furthermore, there is a general reluctance to operate unnecessarily on a gravid patient.

The acute abdomen in pregnancy remains a diagnostic dilemma. As pregnancy stretches the anterior abdominal wall, the resulting peritoneal signs are often different from what is expected in the non-pregnant patient owing to lack of contact with the underlying inflammation. In addition, the clinical picture may be distorted by the uterus obstructing the movement of the omentum to the area of inflammation. [3] Laboratory parameters can be non-specific and are often altered due to physiological changes in pregnancy.

Despite advances in medical technology, pre-operative diagnosis of acute abdominal conditions can still be inaccurate, increasing the rate of exploratory laparotomy, caesarean section, premature delivery, and perinatal death.

Differential diagnosis

Sort by: common/uncommon or category

Common

- Miscarriage
- Ectopic pregnancy
- Pre-term labour
- Adnexal mass
- Acute cystitis
- Placental abruption
- Uterine rupture
- Acute pyelonephritis
- Nephrolithiasis
- Acute hydronephrosis
- Ruptured ovarian cyst
- Haemorrhagic ovarian cyst
- Adnexal torsion
- Appendicitis
- Cholecystitis
- Acute pancreatitis
- Intestinal obstruction
- Uterine fibroids

Uncommon

- Chorioamnionitis
- Haemolysis, elevated liver enzymes, and low platelet count (HELLP) syndrome
- Acute fatty liver of pregnancy
- Ovarian hyper-stimulation syndrome
- Splenic rupture
- Rectus sheath haematoma

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Common

Miscarriage

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History	Exam	1st test	Other tests
usually presents before 12th week of pregnancy; supra-pubic pain due to uterine contractions; vaginal bleeding; clots often passed	cervix dilated with products protruding in cases of inevitable miscarriage; if miscarriage complete, cervical os may be closed	• **transvaginal ultrasound:** confirms viability of pregnancy More	• **type and screen:** variable More

Ectopic pregnancy

see our comprehensive coverage of Ectopic pregnancy

History	Exam	1st test	Other tests
commonly presents in first trimester; lower abdominal pain with or without vaginal bleeding; shoulder tip pain may indicate haemoperitoneum; although presence of risk factors (hx of PID, previous ectopic pregnancy, previous tubal surgery, use of IUD, IVF) is highly indicative, many patients have none	minimal abdominal tenderness and/or vaginal bleeding; pelvic examination may reveal a mass, eliciting cervical motion tenderness if haemoperitoneum is present; tubal rupture can cause haemodynamic instability	• **transvaginal ultrasound:** no intrauterine pregnancy detected More • **serum beta-hCG measurement:** positive More	• **type and screen:** variable More

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American Society of Clinical Oncology - Medical Specialty Society. *View all guidelines by the developer(s)*

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- ☐ Aged (65 to 79 years)
- ☐ Aged, 80 and over

Methods Used to Assess the Quality and Strength of the Evidence:

- ☐ Expert Consensus
- ☐ Expert Consensus (Committee)
- ☐ Expert Consensus (Delphi Method)
- ☐ Subjective Review

Clinical Specialty:

- ☐ Allergy and Immunology
- ☐ Anesthesiology
- ☐ Cardiology
- ☐ Chiropractic

Methods Used to Formulate the Recommendations:

- ☐ Balance Sheets
- ☐ Expert Consensus
- ☐ Expert Consensus (Consensus Development Conference)
- ☐ Expert Consensus (Delphi)

Guideline Category:

- ☐ Diagnosis
- ☐ Evaluation
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Heart and Stroke Foundation of Ontario - Medical Specialty Society; Registered Nurses' Association of Ontario - Professional Association. *View all guidelines by the developer(s)*

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Medical Services Commission, British Columbia - National Government Agency [Non-U.S.]. *View all guidelines by the developer(s)*

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9. **Guide to management of hypertension 2008. Assessing and managing raised blood pressure in adults.** 2008. NGC:006724
National Heart Foundation of Australia - Disease Specific Society. *View all guidelines by the developer(s)*

10. **Best evidence statement (BESt). Screening of hypertension in pediatric patients with diabetes.** 2011 Apr 5. NGC:008545
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11. **Medical management of adults with hypertension.** 2003 Aug (revised 2009 Aug). **[NGC Update Pending]** NGC:007527
Michigan Quality Improvement Consortium - Professional Association. *View all guidelines by the developer(s)*

12. **Essential hypertension.** 1997 (revised 2009 Feb). NGC:007260
University of Michigan Health System - Academic Institution. *View all guidelines by the developer(s)*

13. **Adapting your practice: treatment and recommendations for homeless patients with hypertension, hyperlipidemia & heart failure.** 2004 (revised 2009 Dec). NGC:007679
Health Care for the Homeless (HCH) Clinician's Network - Medical Specialty Society; National Health Care for the Homeless Council, Inc. - Nonprofit Organization.

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Guideline Comparison

Guideline Title	Clinical practice guidelines on arterial hypertension. 2007 update.	2007 guidelines for the management of arterial hypertension.
Date Released	2002 (revised 2008)	2003 Jun (revised 2007)
Adaptation	Three previously published guidelines formed the base of this guideline: • Hypertension. Management of hypertension in adults in primary care. Clinical Guideline 18. National Institute for Clinical Excellence. 2004;Clinical Guideline 18. • Khan NA, McAlister FA, Rabkin SW, Padwal R, Feldman RD, Campbell NR, et al. The 2006 Canadian Hypertension Education Program recommendations for the management of hypertension: Part II - Therapy. Can J Cardiol. 2006;22(7):583-93. • Williams B, Poulter NR, Brown MJ, Davis M, McInnes GT, Potter JF, et al. British Hypertension Society guidelines for hypertension management 2004 (BHS-IV): summary. BMJ. 2004;328(7440):634-40.	Not applicable: The guideline was not adapted from another source.
Guideline Developer(s)	Basque Health System - Osakidetza - State/Local Government Agency [Non-U.S.]	European Society of Hypertension - Disease Specific Society European Society of Cardiology - Medical Specialty Society
Source(s) of Funding	These Guidelines were financed by Osakidetza and the Department of Health of the Basque Government. A fellowship for commissioned research in the evaluation of health technologies, managed by Osteba, was received in 2005.	European Society of Cardiology
Composition of Group That Authored the Guideline	*Coordinator*: Rafael Rotaeche del Campo, family doctor, UAP Alza (Gipuzkoa Ekialde district) *Authors*: José Ramón Aguirrezabala Jaca, family doctor, UAP Rekalde (Bilbao District); Laura Balagué Gea, nurse, UAP Iztieta (Gipuzkoa Ekialde District); Ana Gorroñogoitia Iturbe, family doctor, UAP Rekalde (Bilbao District); Ina Idarreta Mendiola, family doctor, UAP Tolosa (Gipuzkoa Mendebalde District); Carmela Mozo Avellaned, pharmacist (Gipuzkoa Ekialde District); Rafael Rotaeche del Campo, family doctor, UAP Alza (Gipuzkoa Ekialde District); Eulali Mariñelarena Mañeru, family doctor, UAP Pasajes Antxo (Gipuzkoa Ekialde District); Elena Ruiz de Velasco Artaza, pharmacist (Bilbao District); Jesús Torcal Laguna, family doctor, UAP Basauri-Kareaga (Interior District) *Collaborating Experts*: Fernando Arós Borau, cardiologist, Hospital de Txagorritxu; Mónica Ausejo Segura, Deputy Director-General of Pharmaceutical Assistance, Directorate General of Pharmacy and Health Products, Department of Health and Consumption (Madrid Region); Julián Bajo García, family doctor, UAP Kueto (Ezkerraldea-Enkarterri District); Alfonso Casi Casanellas, family doctor, UAP Lakua Aranbizkarra (Araba District); Juan Antonio Divisón Garrote, family doctor, Casas	*Task Force Members*: Giuseppe Mancia, Co-Chairperson (Italy); Guy De Backer, Co-Chairperson (Belgium); Anna Dominiczak (UK); Renata Cifkova (Czech Republic); Robert Fagard (Belgium); Giuseppe Germano (Italy); Guido Grassi (Italy); Anthony M. Heagerty (UK); Sverre E. Kjeldsen (Norway); Stephane Laurent (France); Krzysztof Narkiewicz (Poland); Luis Ruilope (Spain); Andrzej Rynkiewicz (Poland); Roland E. Schmieder (Germany); Harry A.J. Struijker Boudier (Netherlands); Alberto Zanchetti (Italy) *European Society of Cardiology (ESC) Committee for Practice Guidelines Members*: Alec Vahanian, Chairperson (France); John Camm (United Kingdom); Raffaele De Caterina (Italy); Veronica Dean (France); Kenneth Dickstein (Norway); Gerasimos Filippatos (Greece); Christian Funck-Brentano (France); Irene Hellemans (Netherlands); Steen Dalby Kristensen (Denmark); Keith McGregor (France); Udo Sechtem

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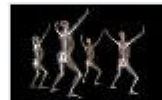

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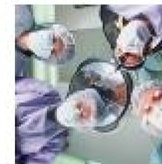

Advances in medicine have resulted in increasingly complex care pathways and individualisation of care. As a result, medicine has become subspecialised in many areas, and there is evidence for improved outcomes for patients treated by multidisciplinary teams. The 1995 Calman-Hine report, which aimed to improve cancer survival in the UK, recommended setting up co-ordinated care within cancer networks.

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Tip No. 1:
Boolean operators AND, OR, and NOT can be selected from the pulldown selection boxes or entered directly within the search text boxes. Use parentheses to separate components when entering complex search directly in text box with mixed Boolean operators.

Example: *(colchicine AND liver) AND (fibrosis OR cirrhosis)*

Tip No. 2:
The AND operator is used by default between search terms. The string *brain stem* will match records where both words are included in any order or proximity. Search for exact phrases by enclosing a string in quotation marks.

Example: *"clodronate therapy"* matches that exact term

Tip No. 3:
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Infection control strategies for preventing the transmission of meticillin-resistant *Staphylococcus aureus* (MRSA) in nursing homes for older people

Carmel Hughes[1,*], Michael Smith[2], Michael Tunney[1], Marie C Bradley[1]

Database Title

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Editorial Group: Cochrane Wounds Group

Published Online: 7 DEC 2011

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Abstract

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Background

Nursing homes for older people provide an environment likely to promote the acquisition and spread of meticillin-resistant *Staphylococcus aureus* (MRSA), putting residents at increased risk of colonisation and infection. It is recognised that infection prevention and control strategies are important in preventing and controlling MRSA transmission.

Objectives

To determine the effects of infection prevention and control strategies for preventing the transmission of MRSA in nursing homes for older

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- 3．EBM Reviews - Cochrane Database of Systematic Reviews（CDSR，系统评价资料库），收录由Cochrane协作网系统综述专业组在统一工作手册指导下完成的系统综述，包括系统综述全文和研究方案。
- 4．EBM Reviews - Cochrane Methodology Register（CMR， 方法学评价数据库）
- 5．EBM Reviews - Database of Abstracts of Reviews of Effects（DARE， 疗效评价文摘库），由英国York大学国家卫生服务系统（NHS）评价与传播中心建立的疗效综述文摘数据库。它提供结构式摘要，即对以往发表的高质量系统综述做概要性摘要，并提供系统综述参考文献的索引）。
- 6．EBM Reviews - Health Technology Assessment（HTA，卫生技术评估数据库，Cochrane图书馆卫生技术评估数据库收录国际卫生技术评估网络成员单位和其他卫生技术评价机构提供的结构式摘要，其中一些记录是正在进行研究的项目。
- 7．EBM Reviews - NHS Economic Evaluation Database（NHS EED英国国家卫生保健服务（系统）卫生经济评价数据库），该库是按一定规范，系统收录各种相关数据库和杂志中卫生保健干预措施的经济学评价记录，记录有详有略，摘要为结构式摘要。

8．EBM Reviews Full Text-CDSR，ACP Journal Club，and DARE（EBM全文数据库）。

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Intravenous enoxaparin versus unfractionated heparin in unselected patients undergoing percutaneous coronary interventions: the Zurich enoxaparin versus unfractionated heparin in PCI st [EuroIntervention. 2010]

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Low-molecular-weight heparins vs. unfractionated heparin in the setting of percutaneous coronary intervention for ST-elevation myocardial infarction: a meta-analysis. [J Thromb Haemost. 2011]

The Role of Apixaban for Venous and Arterial Thromboembolic Disease (October). [Ann Pharmacother. 2011]

A critical review of the efficacy and safety in the use of low-molecular-weight heparin in acute ST-elevation myocardial infarction: a Bayesan approach. [Eur Rev Med Pharmacol Sci. 2011]

Factor Xa inhibitors for acute coronary syndromes. [Cochrane Database Syst Rev. 2011]

Comparison of bivalirudin versus heparin plus glycoprotein IIb/IIIa inhibitors in patients undergoing an invasive strategy: A meta-analysis of randomized clinical trials. [Int J Cardiol. 2010]

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