

《Anesthesiology-麻醉学-英》

图书基本信息

书名：《Anesthesiology-麻醉学-英文版》

13位ISBN编号：9787040343373

10位ISBN编号：7040343371

出版时间：2012-07-01

出版社：田鸣 高等教育出版社 (2012-07出版)

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内容概要

Anesthesiology (麻醉学) , ISBN : 9787040343373 , 作者 : 田鸣 著

书籍目录

Chapter 1 Preanesthetic Evaluation and Preparation 1.1 Introduction 1.2 Preanesthetic Evaluation 1.3 Anesthetic and Surgical Preparation Chapter 2 Regional Block Anesthesia 2.1 Introduction 2.2 Regional Anesthesia and Local Anesthetics 2.3 Peripheral Nerve Block 2.4 Intrathecal Anesthesia Chapter 3 General Anesthesia 3.1 Concept of General Anesthesia 3.2 Related Basic Knowledge 3.3 Management of General Anesthesia 3.4 Complications Chapter 4 Monitoring and Managements during Anesthesia 4.1 Introduction 4.2 Significance and Importance of Monitoring during and after Anesthesia 4.3 The Basic Standard of Monitoring during Anesthesia 4.4 Contents of Cardiovascular System Monitoring 4.5 Principles of Circulatory Disturbance Management 4.6 Monitoring Methods and Managements of Respiration during Anesthesia 4.7 Judgments and Managements of Anesthesia Depth 4.8 Commonly Used Monitoring of Body Temperature 4.9 Monitoring and Managements during Recovery Period after Anesthesia Chapter 5 Fluid Management 5.1 Introduction 5.2 Monitoring of Fluid, Electrolytes and Osmolality 5.3 Principle to Treat Turbulence of Fluid Balance Chapter 6 Shock 6.1 Introduction 6.2 Classification of Shock 6.3 Hypovolemic Shock 6.4 Cardiogenic Shock 6.5 Distributive Shock 6.6 Obstructive Shock Chapter 7 Multiple Organ Dysfunction Syndrome 7.1 Introduction 7.2 Mechanisms of MODS 7.3 Definition of MODS 7.4 Management of MODS Chapter 8 Cardiopulmonary Resuscitation 8.1 The Concept of CPR and CPCR 8.2 Immediate Recognition and Activation of the Emergency Response System 8.3 Basic Life Support 8.4 Advanced Life Support 8.5 Post-resuscitation Treatment (PRT) Chapter 9 Nutritional Aspects 9.1 Introduction 9.2 Nutritional Requirements of Surgical Patients 9.3 Methods of Providing Nutrition Support 9.4 Nutritional Support in Special Situations Chapter 10 Pain Treatment 10.1 Introduction 10.2 The Concept, Classification and Assessing of Pain 10.3 The Body Responses of Pain 10.4 The Influence Factors of Pain 10.5 The Common Methods of Pain Treatment

章节摘录

版权页：插图：1.3.2.5 Kidney With the improvement of medical technology, life expectancy of patients with terminal kidney disease lengthens. These patients are often accompanied with other organic or systemic diseases, such as hypertension, arteriosclerosis, anemia, metabolic and endocrine disturbances. However, if combined with blood purificatory measures, such as hemodialysis, it is no longer a contraindication for elective surgery. Postoperative renal dysfunction is one of the main causes of perioperative morbidity and mortality. There are many risk factors affecting perioperative renal function, including preoperative decreased renal function reserve (e.g. the concomitant diabetes, hypertension, hypohypertonia, etc.), surgery-related factors (aortic-clamping surgeries, extracorporeal circulation, long-term surgeries, massive blood loss, etc.) and factors that may cause kidney damage during anesthesia and surgery (e.g. hypotension, hypovolemia and antibiotics, etc.). Making certain of preoperative renal function reserve, proper preoperative preparation and treatment, drawing up a plan for risk factors causing renal failure are essential for protecting renal function and improving prognosis.

1.3.2.6 Endocrine system For patients accompanied with different endocrine system disorders, the focus of preoperative preparation is different with pathological and physiological features. For hyperthyroid patients, the keypoint of preoperative preparation is to prevent intraoperative and postoperative thyroid crisis. Anti-thyroid drugs are usually administered before surgery to control the disease, and then use Lugol solution (compound iodine solution) for two weeks, so that thyroid congestion and swelling can be lightened remarkably. Iodides and propranolol or esmolol can be used compatibly to prepare for the hyperthyroidism. For patients with Cushing's syndrome, it is vital to correct the fluid and electrolyte imbalance and the acid-base disturbance before anesthesia, especially the potassium supplement, control infection and hyperglycemia and correct the negative nitrogen balance. For patients with primary aldosteronism, spironolactone or potassium can be applied before operation to correct hypokalemia. For patients with pheochromocytoma, hypertension induced by excessive secretion of catecholamine should be controlled to the greatest extent before surgery. We should use α -receptor blockers to dilate blood vessels and apply fluid therapy to expand blood volume simultaneously. For diabetic patients, preoperative fasting blood glucose should be controlled below 7.7 mmol/L (140 mg/dL) and the maximum should not exceed 12.9 mmol/L (198 mg/dL) because hyperglycemia can aggravate the cerebral ischemia causing the cerebral lesion. Patients taking oral hypoglycemic drugs previously should transfer to subcutaneous insulin or intravenous infusion of insulin before surgery. For insulin-dependent diabetic patients, operations cannot be performed unless the acetone bodies are controlled negative and the blood glucose is in normal range, except for emergency surgeries.

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编辑推荐

《医学教育改革系列教材:Anesthesiology(英文)》由高等教育出版社出版。

精彩短评

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