*Seu modelo de prova está na página seguinte

Curso de Inglês Instrumental Online

preparatório para Provas de Proficiência do Mestrado e Doutorado com Certificado de Proficiência

SAIBA MAIS

TEXTO 1

SHOULD I EAT BREAKFAST?

Breakfast, we are told, is the most important meal of the day. Over the last 50 years, we have been bombarded with messages extolling the health benefits of processed cereals and porridge oats. We are told breakfast helps us reduce weight by speeding up our metabolism. These are not just marketing messages, they are core to nutritional guidelines in developed countries, such as in the US, UK and Australia, prepared by expert scientific panels. These messages are mirrored in the media and websites worldwide. But what if the benefits of breakfast are just another diet myth?

It's popular these days to follow the nutritional regimes of our ancient ancestors, but no one seems to be studying whether or not they ate breakfast. The Hadza people in Tanzania are the last true hunter-gatherers in East Africa who we believe live much like our ancestors. Living with them, we noticed a definite lack of a breakfast routine. They also have no regular word to describe "breakfast". After waking up, the men usually leave on a hunting or honey-gathering trip without eating, maybe grabbing some berries a few hours later, en route. If they stay in camp in the morning or even all day, a handful of honey late morning —or even consumed as late as early afternoon— may be all they eat until a larger, evening meal. That said, there is no routine and eating patterns are highly variable, depending on the camp size and season. The women stay close to the camp and on some days make simple food, like baobab porridge, or they eat some stored honey, but rarely before 9 to 10am, giving them a fasting time since their evening meal of over 15 hours. Lacking a regular breakfast routine has not made them fat or unhealthy and they lack most Western diseases. Perhaps **we should take a leaf from their book**. At least, that's what the latest scientific evidence suggests.

The health benefit of breakfast has now been completely debunked by a new systematic review and meta-analysis of 11 randomized trials that investigated the impact of skipping breakfast on weight and metabolic rate. The studies vary widely in duration and quality, and seven looked at changes in weight as well as changes in energy usage. Their conclusion is the same as in recent reviews that have been largely ignored, **namely**, there is no evidence to support the claim that skipping meals makes you put on weight or adversely reduces your resting metabolic rate. There is now considerable evidence from these studies that skipping breakfast can be an effective way to reduce weight for some people. So why has the field got it so wrong in the past? One reason is the belief in "grazing" rather than "gorging" to avoid "stress" on the body from having to digest large meals, especially later in the day when glucose and insulin peaks are higher and metabolic rate lower. The flawed rationale was based on lab rodents and a few short-term human studies. While the concept of over-compensation later in the day was correct—breakfast skippers do eat more lunch and slightly reduce their activity—it is not nearly enough to make up the energy deficit in a real-world setting outside a lab.

Scientists were honestly misled in the past by many observational studies showing that obese people skipped meals more often than thin people. This mindset became ingrained in nutritional dogma. But these observational studies were seriously biased. Breakfast skippers were more likely, on average, to be poorer, less educated, less healthy and have a poorer diet. Overweight people were more likely to diet and, after a binge, more likely to feel guilty and skip a meal.

Evidence is also accumulating that restricted eating times and increasing fasting intervals can help some people lose weight. Some of these recent developments that seem counterintuitive to traditional thinking, make sense when we consider the importance of the gut microbiome on our health and metabolism. The community of 100 trillion gut microbes have a circadian rhythm and vary in composition and function in fasting and fed states. Data suggests microbial communities could benefit from short periods of fasting. They, like us, may need to rest and recuperate. Some of us are programmed to prefer eating food earlier in the day and others later, which may suit our unique personal metabolism. Around a third of people in developed countries regularly skip breakfast while many others enjoy it. This does not mean that everyone overweight would benefit from skipping breakfast. **There is no one size fits all**, and prescriptive diet guidelines filled with erroneous information look increasingly counterproductive and detract from important health messages. Different populations have their own varied breakfast habits, but before you next go hunting, why not try your own personal breakfast skipping experiments—**it may suit you**.

Fonte: Adaptado de: **Shoul I Eat Breakfast? Why Skipping The Meal Could Help Us Lose Weight And Stay Healthy.** Disponível em: https://www.newsweek.com/should-i-eat-breakfast-why-skipping-meal-could-help-us-lose-weight-stay-1312722 Acesso em: 09 fev 2019.

TEXTO 2

IDIOPATHIC THROMBOCYTOPENIC PURPURA (ITP)

Idiopathic thrombocytopenic purpura is an immune disorder in which the blood does not clot normally. ITP can cause excessive bruising and bleeding. An unusually low level of platelets, or thrombocytes, in the blood results in ITP.

ITP remains a diagnosis of exclusion. The essential elements include an otherwise healthy individual who presents with isolated thrombocytopenia, an otherwise unremarkable peripheral smear, a physical examination that only shows evidence of bleeding consistent with the platelet count, and the exclusion of other causes of thrombocytopenia if grounds for suspicion exist. These include exposure to drugs, herbs, foods, or other substances (eg, quinine) associated with thrombocytopenia; pseudothrombocytopenia; giant platelets; family history consistent with inherited thrombocytopenia; or symptoms/signs suggestive of an underlying disorder that may cause secondary immune thrombocytopenia. We only perform bone marrow examinations as a

matter of routine in otherwise typical patients if they are over 60 years of age when the incidence of MDS becomes significant, in those who do not show a robust response (> 50 000 × 10^9/L) to treatment, and often prior to splenectomy if not previously performed. Response to treatment, especially intravenous immune globulin (IVIG) or intravenous anti-D (IV anti-D), even if transient, is the single best diagnostic test. Conversely, a poor response to treatment may necessitate re-evaluation of the diagnosis, including a bone marrow examination.

Although rare, major bleeding has been reported at platelet counts between 20 000 and 30 000 × 10^9/L. Furthermore, counts may drop suddenly at any time. A worrisome number of patients who developed intracerebral hemorrhage (ICH) did so after acute and often unpredictable events such as viral infection or head trauma, or after inadvertently taking medications that impair platelet function. We would argue that the goal of therapy must be individualized on the basis of signs and symptoms, tolerance of treatment, lifestyle, and patient preference. Our usual practice is to maintain a somewhat higher platelet count initially (eg, 30 000 × 10^9/L) while we get to know the patient, with the goal of establishing a track record of bleeding, compliance, and risk management that allows us to modify the threshold for treatment over time.

Patients typically present with petechiae or purpura that develop over several days accompanied by platelet counts less than 20 000 × 10^9/L, although the onset is often more insidious than previously appreciated. Severe cutaneous bleeding, prolonged epistaxis, gingival bleeding, overt hematuria, or menorrhagia may develop at platelet counts less than 10 000 × 10^9/L. Spontaneous or posttraumatic ICH or bleeding at other internal sites is uncommon, but not without precedence, at platelet counts between 10 000 and 20 000 × 10^9/L. Those with platelet counts between 30 000 and 50 000 × 10^9/L may note easy bruising, whereas platelet counts above 50 000 × 10^9/L are usually discovered incidentally. Rarely, do patients present with bleeding disproportionate to the platelet count because of antibody-induced platelet dysfunction. Some patients experience untoward and otherwise unexplained fatigue when their platelet count is low.

Management is predicated primarily on the severity of thrombocytopenia and bleeding. Drugs that interfere with platelet function are discontinued. Alternatives are substituted for drugs deemed necessary but potentially causal. The initial goal of treatment is to attain a hemostatic platelet count (≥ 30 000 × 10^9/L) while minimizing the toxicity of treatment. Therapy is indicated in all patients who present with bleeding and those with platelet counts less than 20 000 × 10^9/L because fewer than 10% of adults rapidly attain spontaneous remission. Those with platelet counts more than 50 000 × 10^9/L can almost always be observed, although some require treatment later. In general, immediate therapy is not required for patients with platelet counts between 20 000 and 50 000 × 10^9/L in the absence of bleeding or predisposing comorbid conditions such as uncontrolled hypertension, active peptic ulcer disease, anticoagulation, recent surgery, or head trauma. We recommend maintaining platelet counts above 40 000 to 50 000 × 10^9/L for patients requiring aspirin, nonsteroidal anti-inflammatory drugs, warfarin, or other antithrombotics.

Thrombocytopenia recurs in most patients when corticosteroids are tapered. We treat patients with persistent ITP with the goal of maintaining the platelet count more than 20 000 to 30 000 × 10^9/L while avoiding steroid-induced osteoporosis, cataracts, and other toxicities. The major decision is whether to temporize with medical therapy or to proceed swiftly to splenectomy. For those in whom the former is chosen, our preference is to infuse IV anti-D as needed. In the largest series to date, 25% to 30% of patients showed responses lasting longer than 1 year. Alternatives, including anti-CD20 (rituximab) or danazol are discussed. For those whose disease does not abate by 1 year after diagnosis, who do not show a durable response, or who are intolerant of therapy, we recommend splenectomy.

Fonte: Adaptado de: How I Treat Idiopathic Thrombocytopenic Purpura (ITP). Disponível em:
https://www.healthline.com/health/idiopathic-thrombocytopenic-purpura-itp
http://www.bloodjournal.org/content/106/7/2244?sso-checked=true. Acesso em: 09 fev 2019.

QUESTÕES

As questões de 1 a 5 referem-se ao TEXTO 1:

1) Analise as seguintes afirmativas:

I. O argumento de que o desjejum contribui para redução de peso é somente mercadológico.

II. A convivência do autor com o povo Hadza revelou um tempo longo de jejum entre o jantar e o desjejum.

III. A conclusão dos estudos na Tanzânia diverge das evidências científicas mais recentes.

IV. Os impactos saudáveis de 'pular' o desjejum foram comprovados através de experimentos recentes.

São VERDADEIRAS:

(A) apenas I e III.

(B) apenas II e IV.

(C) apenas I, II e III.

(D) TODAS.

2) O que induziu ao erro os resultados dos estudos observacionais a favor do desjejum?

3) Quais são as evidências recentes que fortalecem os argumentos a favor de se 'pular' o desjejum?

4) O principal objetivo do texto é

(A) criticar as pessoas que seguem os hábitos alimentares de seus antepassados.

(B) convencer o leitor de que o desjejum é um hábito prejudicial à saúde.

(C) comparar os hábitos da dieta matinal do passado com os da sociedade atual.

(D) expor a opinião dos autores sobre a cultura atual do desjejum.

5) É CORRETO o que se afirma em:

(A) *we should take a leaf from their book,* destacado no 2º parágrafo, tem sentido literal.

(B) *namely*, destacado no 3º parágrafo, é usado para corrigir uma ideia anterior.

(C) *There is no one size fits all*, destacado no 5º parágrafo, é usado pelos autores para dizer que suas

ideias não se aplicam a todos os casos.

(D) *it may suit you*, destacado no 5° parágrafo, é usado para dizer que o desjejum deve ser evitado

por todos.

As questões de 6 a 10 referem-se ao TEXTO 2:

6) Sobre o diagnóstico de Púrpura Trombocitopênica Idiopática (PTI), é CORRETO afirmar

que

(A) o exame da medula óssea faz parte da rotina de investigação em todos os casos.

(B) o melhor é a resposta do paciente ao tratamento com imunoglobulina.

(C) a trombocitopenia isolada e o esfregaço de sangue periférico são aspectos secundários à

investigação.

(D) o exame da medula óssea é sugerido para pacientes esplenectomizados.

7) NÃO é sintoma de PTI mencionado no texto:

(A) Sangramento.

(B) Hematoma.

(C) Infecção viral.

(D) Fadiga.

8) Segundo o autor, como deve ser o tratamento de pacientes com contagem de plaquetas

entre 20 e 30 mil e com qual finalidade?

9) É CORRETO o que se afirma em:

(A) Pacientes com contagem de plaquetas superior a 50 mil não necessitam de tratamento

imediato.

(B) Pacientes com contagem de plaquetas inferior a 20 mil necessitam de tratamento somente

em caso de sangramento.

(C) Medicamentos associados à causa da PTI precisam ser interrompidos somente em pacientes

com contagem de plaquetas inferior à 20 mil.

(D) Pacientes com redução de corticosteroide permaneceram estáveis, com contagem de plaquetas

entre 20 e 30 mil.

10) Para quais casos a esplenectomia é indicada?

RASCUNHO