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**1. Bereavement support on the frontline of COVID-19: Recommendations for hospital clinicians.**

**Author(s):** Selman, Lucy E; Chao, Davina; Sowden, Ryann; Marshall, Steve; Chamberlain, Charlotte; Koffman, Jonathan

**Source:** Journal of pain and symptom management; May 2020

**Publication Date:** May 2020

**Publication Type(s):** Journal Article

**PubMedID:** 32376262

Available at  [Journal of pain and symptom management](https://auth.elsevier.com/ShibAuth/institutionLogin?entityID=https://idp.eng.nhs.uk/openathens&appReturnURL=https%3A%2F%2Fwww.clinicalkey.com%2Fcontent%2FplayBy%2Fdoi%2F%3Fv%3D10.1016%2Fj.jpainsymman.2020.04.024)  - from ClinicalKey

Available at  [Journal of pain and symptom management](https://doi.org/10.1016/j.jpainsymman.2020.04.024)  - from Unpaywall

**Abstract:** Deaths due to COVID-19 are associated with risk factors which can lead to prolonged grief disorder, post-traumatic stress and other poor bereavement outcomes among relatives, as well as moral injury and distress in frontline staff. Here we review relevant research evidence, and provide evidence-based recommendations and resources for hospital clinicians to mitigate poor bereavement outcomes and support staff. For relatives, bereavement risk factors include dying in an intensive care unit, severe breathlessness, patient isolation or restricted access, significant patient and family emotional distress, and disruption to relatives' social support networks. Recommendations include advance care planning; proactive, sensitive and regular communication with family members alongside accurate information provision; enabling family members to say goodbye in person where possible; supporting virtual communication; providing excellent symptom management and emotional and spiritual support; and providing and/or sign-posting to bereavement services. To mitigate effects of this emotionally challenging work on staff, we recommend an organisational and systemic approach which includes access to informal and professional support.

**Database:** Medline

**2. Grief and Bereavement in Parents After the Death of a Child in Low- and Middle-Income Countries.**

**Author(s):** McNeil, Michael J; Namisango, Eve; Hunt, Jennifer; Powell, Richard A; Baker, Justin N

**Source:** Children (Basel, Switzerland); May 2020; vol. 7 (no. 5)

**Publication Date:** May 2020

**Publication Type(s):** Journal Article Review

**PubMedID:** 32369937

Available at  [Children (Basel, Switzerland)](http://europepmc.org/search?query=(DOI:10.3390/children7050039))  - from Europe PubMed Central - Open Access

Available at  [Children (Basel, Switzerland)](https://www.mdpi.com/2227-9067/7/5/39/pdf)  - from Unpaywall

**Abstract:** While great strides have been made in improving childhood mortality, millions of children die each year with significant health-related suffering. More than 98% of these children live in low- and middle-income countries (LMICs). Efforts have been made to increase access to pediatric palliative care (PPC) services to address this suffering in LMICs through policy measures, educational initiatives, and access to essential medicines. However, a core component of high-quality PPC that has been relatively neglected in LMICs is grief and bereavement support for parents after the death of their child. This paper reviews the current literature on parental grief and bereavement in LMICs. This includes describing bereavement research in high-income countries (HICs), including its definition, adverse effect upon parents, and supportive interventions, followed by a review of the literature on health-related grief and bereavement in LMICs, specifically around: perinatal death, infant mortality, infectious disease, interventions used, and perceived need. More research is needed in grief and bereavement of parents in LMICs to provide them with the support they deserve within their specific cultural, social, and religious context. Additionally, these efforts in LMICs will help advance the field of parental grief and bereavement research as a whole.

**Database:** Medline

**3. The Role and Response of Palliative Care and Hospice Services in Epidemics and Pandemics: A Rapid Review to Inform Practice During the COVID-19 Pandemic.**

**Author(s):** Etkind, Simon N; Bone, Anna E; Lovell, Natasha; Cripps, Rachel L; Harding, Richard; Higginson, Irene J; Sleeman, Katherine E

**Source:** Journal of pain and symptom management; Apr 2020

**Publication Date:** Apr 2020

**Publication Type(s):** Journal Article Review

**PubMedID:** 32278097

Available at  [Journal of pain and symptom management](https://auth.elsevier.com/ShibAuth/institutionLogin?entityID=https://idp.eng.nhs.uk/openathens&appReturnURL=https%3A%2F%2Fwww.clinicalkey.com%2Fcontent%2FplayBy%2Fdoi%2F%3Fv%3D10.1016%2Fj.jpainsymman.2020.03.029)  - from ClinicalKey

Available at  [Journal of pain and symptom management](https://doi.org/10.1016/j.jpainsymman.2020.03.029)  - from Unpaywall

**Abstract:** Cases of coronavirus disease 2019 (COVID-19) are escalating rapidly across the globe, with the mortality risk being especially high among those with existing illness and multimorbidity. This study aimed to synthesize evidence for the role and response of palliative care and hospice teams to viral epidemics/pandemics and inform the COVID-19 pandemic response. We conducted a rapid systematic review according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines in five databases. Of 3094 articles identified, 10 were included in this narrative synthesis. Included studies were from West Africa, Taiwan, Hong Kong, Singapore, the U.S., and Italy. All had an observational design. Findings were synthesized using a previously proposed framework according to systems (policies, training and protocols, communication and coordination, and data), staff (deployment, skill mix, and resilience), space (community provision and use of technology), and stuff (medicines and equipment as well as personal protective equipment). We conclude that hospice and palliative services have an essential role in the response to COVID-19 by responding rapidly and flexibly; ensuring protocols for symptom management are available, and training nonspecialists in their use; being involved in triage; considering shifting resources into the community; considering redeploying volunteers to provide psychosocial and bereavement care; facilitating camaraderie among staff and adopting measures to deal with stress; using technology to communicate with patients and carers; and adopting standardized data collection systems to inform operational changes and improve care.

**Database:** Medline

**4. [Cor pulmonale].**

**Author(s):** Aubry, A; Paternot, A; Vieillard-Baron, A

**Source:** Revue des maladies respiratoires; Mar 2020; vol. 37 (no. 3); p. 257-266

**Publication Date:** Mar 2020

**Publication Type(s):** English Abstract Journal Article Review

**PubMedID:** 32088063

**Abstract:** Cor pulmonale is a disease of the heart characterised by dilatation of the right ventricle and paradoxical movement of the interventricular septum. The diagnosis depends on echocardiography even if pulmonary artery catheterisation suggests it. It is secondary to pulmonary disease or a disorder of the pulmonary circulation. These two mechanisms, which are often connected, involve pulmonary hypertension as the origin of a systolic and diastolic overload of the right ventricle, which then leads to the alterations of its structure and performance. Acute cor pulmonale is usually secondary to an acute respiratory distress syndrome or to a pulmonary embolism but it can also be seen in primary lactic acidosis, a vaso-occlusive crisis in a patient with sickle cell anaemia, severe acute asthma, and entry of air or injected crushed tablets into the circulation. Chronic cor pulmonale is the terminal stage of pulmonary hypertension. Clinically these patients are dyspnoeic with signs of chronic right heart failure. They should have an echocardiogram confirming the cardiac involvement. Certain precipitating factors, such as infection of any origin, have been reported, leading to acute on chronic cor pulmonale that has a particularly high mortality.

**Database:** Medline

**5. Biomarkers for Acute Respiratory Distress syndrome and prospects for personalised medicine.**

**Author(s):** Spadaro, Savino; Park, Mirae; Turrini, Cecilia; Tunstall, Tanushree; Thwaites, Ryan; Mauri, Tommaso; Ragazzi, Riccardo; Ruggeri, Paolo; Hansel, Trevor T; Caramori, Gaetano; Volta, Carlo Alberto

**Source:** Journal of inflammation (London, England); 2019; vol. 16 ; p. 1

**Publication Date:** 2019

**Publication Type(s):** Journal Article Review

**PubMedID:** 30675131

Available at  [Journal of inflammation (London, England)](https://journal-inflammation.biomedcentral.com/articles/10.1186/s12950-018-0202-y)  - from BioMed Central

Available at  [Journal of inflammation (London, England)](http://europepmc.org/search?query=(DOI:10.1186/s12950-018-0202-y))  - from Europe PubMed Central - Open Access

Available at  [Journal of inflammation (London, England)](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1078-7852&volume=16&issue=1&spage=1)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Journal of inflammation (London, England)](https://journal-inflammation.biomedcentral.com/track/pdf/10.1186/s12950-018-0202-y)  - from Unpaywall

**Abstract:** Acute lung injury (ALI) affects over 10% of patients hospitalised in critical care, with acute respiratory distress syndrome (ARDS) being the most severe form of ALI and having a mortality rate in the region of 40%. There has been slow but incremental progress in identification of biomarkers that contribute to the pathophysiology of ARDS, have utility in diagnosis and monitoring, and that are potential therapeutic targets (Calfee CS, Delucchi K, Parsons PE, Thompson BT, Ware LB, Matthay MA, Thompson T, Ware LB, Matthay MA, Lancet Respir Med 2014, 2:611--620). However, a major issue is that ARDS is such a heterogeneous, multi-factorial, end-stage condition that the strategies for "lumping and splitting" are critical (Prescott HC, Calfee CS, Thompson BT, Angus DC, Liu VX, Am J Respir Crit Care Med 2016, 194:147--155). Nevertheless, sequencing of the human genome, the availability of improved methods for analysis of transcription to mRNA (gene expression), and development of sensitive immunoassays has allowed the application of network biology to ARDS, with these biomarkers offering potential for personalised or precision medicine (Sweeney TE, Khatri P, Toward precision medicine Crit Care Med; 2017 45:934-939). Biomarker panels have potential applications in molecular phenotyping for identifying patients at risk of developing ARDS, diagnosis of ARDS, risk stratification and monitoring. Two subphenotypes of ARDS have been identified on the basis of blood biomarkers: hypo-inflammatory and hyper-inflammatory. The hyper-inflammatory subphenotype is associated with shock, metabolic acidosis and worst clinical outcomes. Biomarkers of particular interest have included interleukins (IL-6 and IL-8), interferon gamma (IFN-γ), surfactant proteins (SPD and SPB), von Willebrand factor antigen, angiopoietin 1/2 and plasminogen activator inhibitor-1 (PAI-1). In terms of gene expression (mRNA) in blood there have been found to be increases in neutrophil-related genes in sepsis-induced and influenza-induced ARDS, but whole blood expression does not give a robust diagnostic test for ARDS. Despite improvements in management of ARDS on the critical care unit, this complex disease continues to be a major life-threatening event. Clinical trials of β2-agonists, statins, surfactants and keratinocyte growth factor (KGF) have been disappointing. In addition, monoclonal antibodies (anti-TNF) and TNFR fusion protein have also been unconvincing. However, there have been major advances in methods of mechanical ventilation, a neuromuscular blocker (cisatracurium besilate) has shown some benefit, and stem cell therapy is being developed. In the future, by understanding the role of biomarkers in the pathophysiology of ARDS and lung injury, it is hoped that this will provide rational therapeutic targets and ultimately improve clinical care (Seymour CW, Gomez H, Chang CH, Clermont G, Kellum JA, Kennedy J, Yende S, Angus DC, Crit Care 2017, 21:257).

**Database:** Medline

**6. Minimum quality threshold in pre-clinical sepsis studies (MQTiPSS): Quality thresholds for study design and humane modeling endpoints**

**Author(s):** Chao R.; Renqi Y.; Lixue W.; Yongming Y.; Xianzhong X.

**Source:** Zhonghua Wei Zhong Bing Ji Jiu Yi Xue; 2019; vol. 31 (no. 9); p. 1061-1071

**Publication Date:** 2019

**Publication Type(s):** Review

**PubMedID:** 31657326

**Abstract:** Preclinical animal studies are mandatory before new treatments can be tested in clinical trials. However, their use in developing new therapies for sepsis has been controversial because of limitations of the models and inconsistencies with the clinical conditions. In consideration of the revised definition for clinical sepsis and septic shock (Sepsis-3), a Wiggers-Bernard Conference was held in Vienna in May 2017 to propose standardized guidelines on preclinical sepsis modeling. The participants conducted a literature review of 260 most highly cited scientific articles on sepsis models published between 2003 and 2012. The review showed, for example, that mice were used in 79% and euthanasia criteria were defined in 9% of the studies. Part I of this report details the recommendations for study design and humane modeling endpoints that should be addressed in sepsis models. The first recommendation is that survival follow-up should reflect the clinical time course of the infectious agent used in the sepsis model. Furthermore, it is recommended that therapeutic interventions should be initiated after the septic insult replicating clinical care. To define an unbiased and reproducible association between a new treatment and outcome, a randomization and blinding of treatments as well as inclusion of all methodological details in scientific publications is essential. In all preclinical sepsis studies, the high standards of animal welfare must be implemented. Therefore, development and validation of specific criteria for monitoring pain and distress, and euthanasia of septic animals, as well as the use of analgesics are recommended. A set of four considerations is also proposed to enhance translation potential of sepsis models. Relevant biological variables and comorbidities should be included in the study design and sepsis modeling should be extended to mammalian species other than rodents. In addition, the need for source control (in case of a defined infection focus) should be considered. These recommendations and considerations are proposed as "best practices" for animal models of sepsis that should be implemented.Copyright © 2019 by the Shock Society.

**Database:** EMBASE

**7. Management of altered mental status and delirium in cancer patients**

**Author(s):** Majzoub I.E.; Cheaito R.; Cheaito M.A.; Abunafeesa H.; Elsayem A.F.

**Source:** Annals of Palliative Medicine; Nov 2019; vol. 8 (no. 5); p. 737-739

**Publication Date:** Nov 2019

**Publication Type(s):** Review

Available at  [Annals of Palliative Medicine](https://doi.org/10.21037/apm.2019.09.14)  - from Unpaywall

**Abstract:** Delirium is a syndrome characterized by acute onset of changes in awareness and cognition, which fluctuate in severity during the episode. Altered mental status (AMS) and delirium have a high incidence rate among patients with cancer and this increases dramatically towards the end of life. Delirium is multifactorial, as cancer patients have an array of predisposing and precipitating factors: Metabolic disturbances, structural lesions, in addition to medications and infection. The complex nature of delirium in cancer patients and the high variability of its presentation make its diagnosis and management challenging and frequently missed. Management of delirium requires identifying and correcting the precipitating cause if feasible. Diagnosis of delirium requires a high index of suspicion, and a systematic assessment to confirm the diagnosis and identify the possible cause. This includes detailed history and comprehensive physical examination together with the use of diagnostic tools, for example: Confusion Assessment Method (CAM) tool. Given the considerable distress cancer patients suffer from, clinicians must assure safety of patients with delirium and safety of the medical team caring for the patient. Family members should be provided with counseling and support.Copyright © Annals of Palliative Medicine. All rights reserved.

**Database:** EMCARE

**8. Benzodiazepines and/or neuroleptics for the treatment of delirium in palliative care?-a critical appraisal of recent randomized controlled trials.**

**Author(s):** Gaertner, Jan; Eychmueller, Steffen; Leyhe, Thomas; Bueche, Daniel; Savaskan, Egemen; Schlögl, Mathias

**Source:** Annals of palliative medicine; Sep 2019; vol. 8 (no. 4); p. 504-515

**Publication Date:** Sep 2019

**Publication Type(s):** Journal Article Review

**PubMedID:** 30943743

Available at  [Annals of palliative medicine](https://www.zora.uzh.ch/id/eprint/183194/1/apm-08-04-504.pdf)  - from Unpaywall

**Abstract:** Delirium is a frequent condition in patients in a palliative care situation and most often associated with substantial burden or even danger for the persons concerned as well as caregivers and health-care-professionals. Despite the lack of randomized-controlled-trials (RCTs) benzodiazepines and neuroleptic agents are used extensively in palliative care for the pharmacological management of delirium. A focused review for RCTs assessing pharmacotherapy with benzodiazepines and neuroleptics for the treatment of delirium in patients treated in a palliative care or hospice setting published in 2017 was performed in PubMed. A narrative summary of the findings of the RCTs and practical recommendation are presented. Of 42 publications, two RCTs could be included. One trial assessed the use of lorazepam (in addition to haloperidol) in case of agitation, the other placebo or risperidone or haloperidol in delirious palliative care patients. Neither risperidone nor haloperidol were superior compared to placebo, but were associated with higher mortality and morbidity. Lorazepam (along with haloperidol) reduced agitation in patients with delirium compared to placebo (along with haloperidol), but was unable to reduce the severity and incidence of delirium. It is of importance to note that psychopharmacotherapy with antipsychotics is mainly indicated for the hyperactive form of delirium and psychotic symptoms (e.g., delusions or hallucinations) in the hyper- and hypoactive delirium. Severe agitation and aggressivity can be an indication for neuroleptics, when non-pharmacological interventions fail, whereas the use of benzodiazepines has to be limited to critical situations where neuroleptics cannot be applied and cases of delirium due to alcohol withdrawal. Both substances can aggravate, precipitate or mask delirium, result adverse events with substantial distress or unfavorable survival outcomes for the patients. Thus, they should only be used in severely symptomatic patients and the duration of the medication has to be limited in time. When delirium symptoms decay the psychopharmacotherapy has to be tapered. More important than psychopharmacotherapy, the thorough investigation and treatment of potentially reversible causes of delirium (e.g., pharmacotherapy, infection) and the routine identification of patients at risk for delirium along with prophylactic measures are essential. The recently published landmarks RCTs provide moderate evidence to adopt recommendations from other medical specialties (i.e., intensive care, geriatrics) to the field of palliative care.

**Database:** Medline

**9. Part I: Minimum Quality Threshold in Preclinical Sepsis Studies (MQTiPSS) for Study Design and Humane Modeling Endpoints**

**Author(s):** Zingarelli B.; Coopersmith C.M.; Drechsler S.; Osuchowski M.F.; Efron P.; Moldawer L.; Marshall J.C.; Wiersinga W.J.; Xiao X.; Thiemermann C.

**Source:** Shock; Jan 2019; vol. 51 (no. 1); p. 10-22

**Publication Date:** Jan 2019

**Publication Type(s):** Review

**PubMedID:** 30106874

Available at  [Shock (Augusta, Ga.)](https://qmro.qmul.ac.uk/xmlui/bitstream/123456789/55169/7/Thiemermann_Part%201%20Minimum%20quality%20threshold_2018.pdf)  - from Unpaywall

**Abstract:** Preclinical animal studies are mandatory before new treatments can be tested in clinical trials. However, their use in developing new therapies for sepsis has been controversial because of limitations of the models and inconsistencies with the clinical conditions. In consideration of the revised definition for clinical sepsis and septic shock (Sepsis-3), a Wiggers-Bernard Conference was held in Vienna in May 2017 to propose standardized guidelines on preclinical sepsis modeling. The participants conducted a literature review of 260 most highly cited scientific articles on sepsis models published between 2003 and 2012. The review showed, for example, that mice were used in 79% and euthanasia criteria were defined in 9% of the studies. Part I of this report details the recommendations for study design and humane modeling endpoints that should be addressed in sepsis models. The first recommendation is that survival follow-up should reflect the clinical time course of the infectious agent used in the sepsis model. Furthermore, it is recommended that therapeutic interventions should be initiated after the septic insult replicating clinical care. To define an unbiased and reproducible association between a new treatment and outcome, a randomization and blinding of treatments as well as inclusion of all methodological details in scientific publications is essential. In all preclinical sepsis studies, the high standards of animal welfare must be implemented. Therefore, development and validation of specific criteria for monitoring pain and distress, and euthanasia of septic animals, as well as the use of analgesics are recommended. A set of four considerations is also proposed to enhance translation potential of sepsis models. Relevant biological variables and comorbidities should be included in the study design and sepsis modeling should be extended to mammalian species other than rodents. In addition, the need for source control (in case of a defined infection focus) should be considered. These recommendations and considerations are proposed as "best practices" for animal models of sepsis that should be implemented.Copyright © 2018 by the Shock Society.

**Database:** EMBASE

**10. Onco-Pulmonologist**

**Author(s):** Rivera P.

**Source:** Journal of Thoracic Oncology; Oct 2018; vol. 13 (no. 10)

**Publication Date:** Oct 2018

**Publication Type(s):** Conference Abstract

Available at  [Journal of Thoracic Oncology](http://www.jto.org/article/S1556086418310402/pdf)  - from Unpaywall

**Abstract:** The majority of patients with lung cancer are diagnosed with advanced disease where the 5-year survival rate remains low. Improving survival, quality of life (QOL) and control of symptoms are pivotal goals for health care professionals caring for patients with lung cancer. Several studies have shown that symptom burden and distress are higher among patients with lung cancer 1,2. Despite advances in treatment of advanced lung cancer including targeted oral therapies which have resulted in improved survival and QOL3, and early palliative care intervention which results in improvement in symptom control and quality of life4, a recent study showed persistent significant symptom burden, distress and unmet needs in patients with advanced lung cancer5. The most common symptom in lung cancer is fatigue, reported in about 40% of patients, followed by pain (30%)5. Organ specific symptoms and complications include cough and dyspnea (20%), airway obstruction, hemoptysis, pleural effusions and tracheoesophageal fistula5,6. Providers caring for lung cancer patients need to be aware of common symptoms and interventions available, particularly non-drug interventions, and work together in multidisciplinary teams to ensure lung cancer patients are receiving the best therapeutic and non-therapeutic interventions in their cancer care in order to improve survival and QOL. Intervention(s): -Fatigue: Cancer-related fatigue, sometimes referred as cancer fatigue syndrome may be related to both the disease process and treatments, including surgery, chemotherapy and radiation therapy. Other factors that may contribute to fatigue include anemia, dyspnea, decreased nutrition, decreased exercise, pain, depression, and insomnia. Pulmonary rehabilitation (PH)/physiotherapy, shown to be very effective in patients with COPD, is an underappreciated intervention in patients with lung cancer due to lack of randomized data and low rates of referral (<25%). Although limited, existing, evidence supports PH/physiotherapy in lung cancer patients before and after surgery and that in patients receiving therapy other than surgery, may result in both ability to maintain and improve physical function, muscle strength and quality of life 7,8. -Pain: Acute and chronic pain in the lung cancer patient may be multifactorial and influenced by physical, psychosocial and spiritual factors6. Pain-assessment tools and targeted imaging as required are as first essential steps in evaluating a patient's pain symptom6. Healthcare providers should understand the WHO analgesic ladder which recommends use of analgesics (acetaminophen and NSAIDs) for mild pain, addition of weaker opioids (codeine or dihydrocodeine) for mild to moderate pain and stronger opioids (morphine, hydromorphone, oxycodone)for severe pain6. Psychologic factors contribute to increased pain and suffering among cancer patients and non-drug interventions including hypnosis, cognitive behavioral coping mechanisms, meditation and relaxation exercises have been shown to reduce pain in patients and long term survivors9. -Dyspnea: The symptom of dyspnea is complex, often multifactorial and results in worsening QOL in patients with lung cancer. Dyspnea may be due underlying COPD or cardiac disease, complications of the tumor such as airway obstruction or pleural effusion, and side effects of treatment such as anemia, muscle fatigue, infection, pneumonitis and decreased nutrition. Careful and thorough assessment is paramount in order to manage dyspnea effectively. -Airway Obstruction: Patients with symptomatic endobronchial and extrinsic airway obstruction can benefit significantly from therapeutic bronchoscopy. Therapeutic bronchoscopic interventions, often used in combination, include debulking of airway tumors mechanically, using laser, electrocautery, cryotherapy, argon plasma coagulation. Balloon dilatation and insertion of silicone or metallic airway stents may be performed to treat extrinsic stenosis or endobronchial strictures due to radiation and covered metallic airway stents are effective in the management of tracheoesophageal fistulas6. -Hemoptysis: Hemoptysis, occurring in about 7-10% of lung cancer patients, is most commonly due to endobronchial tumor involvement. Rare causes include airway-vascular fistula formation, tumor necrosis with cavity formation, and complications from treatment (bevacizumab). Hemoptysis can be minor or severe/massive, the later defined as more than 200 mL of blood in a 24-hour period and commonly requires intervention. Securing the airway with a single-lumen endotracheal tube is paramount. Bronchoscopy is an excellent tool for both diagnosis and therapeutic intervention when endobronchial disease is found as the cause of the hemoptysis and includes laser, electrocautery, and argon plasma coagulation. External beam radiation therapy may also be used for endobronchial tumors causing hemoptysis6. When hemoptysis is due to parenchymal lesion such cavitary lung lesions due to cancer or due to complications of therapy, external bean radiation therapy or bronchial artery embolization is recommended. References: 1. Cooley ME. Symptoms in adults with lung cancer. A systematic research review. J Pain Symptom Manage 2000;19:137-53 2. Graves KD, Arnold SM, Love CL, et al. Distress screening in a multidisciplinary lung cancer clinic: prevalence and predictors of clinically significant distress. Lung Cancer 2007; 55:215-24 3. Rolfo C, Passiglia F, Ostrowski M, et al. Improvement in Lung Cancer Outcomes With Targeted Therapies: An Update for Family Physicians. J Am Board Int Med 2015;28:123-33 4. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small cell lung cancer. N Engl J Med 2010;363:733-42 5. Sung MR, Patel MV, Djalalov S, et al. Evolution of Symptom Burden of Advanced Lung Cancer Over a Decade. Clinical Lung Cancer 2017;3:264-80 6. Simoff MJ, Lally B, Slade MG, et al. Symptom Management in Patients With Lung Cancer. Diagnosis and management of Lung Cancer, 3rded: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2013; 143(5) (Suppl):e455S-e497S 7. Granger CL. Physiotherapy management of lung cancer. Journal of Physiotherapy 2016; 62:60-67 8. Holland AE, Wadell K, Spruit MA. How to adapt the pulmonary rehabilitation programme to patients with chronic respiratory disease other than COPD. Eur Respir Rev 2013; 22:405-13 9.Ayrjla KL, Jensen MP, Mendoza ME, et al. Psychological and Behavioral Approaches to Cancer Pain Management. J Clin Oncol 2014; 32:1703-11 Keywords: lung cancer symptoms, hemoptysis, dyspneaCopyright © 2018

**Database:** EMBASE

**11. Management of pediatric febrile seizures**

**Author(s):** Laino D.; Mencaroni E.; Esposito S.

**Source:** International Journal of Environmental Research and Public Health; Oct 2018; vol. 15 (no. 10)

**Publication Date:** Oct 2018

**Publication Type(s):** Review

**PubMedID:** 30321985

Available at  [International journal of environmental research and public health](http://europepmc.org/search?query=(DOI:10.3390/ijerph15102232))  - from Europe PubMed Central - Open Access

Available at  [International journal of environmental research and public health](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1661-7827&volume=15&issue=10&spage=2232)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [International journal of environmental research and public health](https://www.mdpi.com/1660-4601/15/10/2232/pdf)  - from Unpaywall

**Abstract:** Febrile seizures (FS), events associated with a fever in the absence of an intracranial infection, hypoglycaemia, or an acute electrolyte imbalance, occur in children between six months and six years of age. FS are the most common type of convulsions in children. FS can be extremely frightening for parents, even if they are generally harmless for children, making it important to address parental anxiety in the most sensitive manner. The aim of this review was to focus on the management of FS in the pediatric age. An analysis of the literature showed that most children with FS have an excellent prognosis, and few develop long-term health problems. The diagnosis of FS is clinical, and it is important to exclude intracranial infections, in particular after a complex FS. Management consists of symptom control and treating the cause of the fever. Parents and caregivers are often distressed and frightened after a FS occurs and need to be appropriately informed and guided on the management of their child's fever by healthcare professionals. Due to the inappropriate use of diagnostic tests and treatments, it is extremely important to improve the knowledge of pediatricians and neurologists on FS management and to standardize the diagnostic and therapeutic work-up.Copyright © 2018 by the authors. Licensee MDPI, Basel, Switzerland.

**Database:** EMBASE

**12. Challenges in end-of-life dementia care.**

**Author(s):** Fetherston, Anne A; Rowley, Grace; Allan, Charlotte L

**Source:** Evidence-based mental health; Aug 2018; vol. 21 (no. 3); p. 107-111

**Publication Date:** Aug 2018

**Publication Type(s):** Journal Article Review

**PubMedID:** 29776973

Available at  [Evidence Based Mental Health](https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Febmh.bmj.com%2Flookup%2Fdoi%2F10.1136%2Feb-2018-102889)  - from BMJ Journals

Available at  [Evidence Based Mental Health](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1362-0347&volume=21&issue=3&spage=107)  - from ProQuest (Health Research Premium) - NHS Version

**Abstract:** Dementia is a chronic, progressive disease that is now much more widely recognised and treated. Patients with dementia may require palliative care when they reach the end stage of their illness, or they may have mild-moderate cognitive symptoms comorbid with a life-limiting illness. The variety of presentations necessitates a highly individual approach to care planning, and patients should be encouraged to set their own goals and contribute to advanced care planning where possible. Assessment and management of distressing symptoms at the end of life can be greatly helped by a detailed knowledge of the individuals' prior wishes, interdisciplinary communication and recognition of changes in presentation that may result from new symptoms, for example, onset of pain, nutritional deficits and infection. To navigate complexity at the end of life, open communication that involves patients and families in decisions, and is responsive to their needs is vital and can vastly improve subjective experiences. Complex ethical dilemmas may pervade both the illness of dementia and provision of palliative care; we consider how ethical issues (eg, providing care under restraint) influence complex decisions relating to resuscitation, artificial nutrition and treatment refusal in order to optimise quality of life.

**Database:** Medline

**13. Palliative Care for People With Hepatocellular Carcinoma, and Specific Benefits for Older Adults.**

**Author(s):** Woodrell, Christopher D; Hansen, Lissi; Schiano, Thomas D; Goldstein, Nathan E

**Source:** Clinical therapeutics; Apr 2018; vol. 40 (no. 4); p. 512-525

**Publication Date:** Apr 2018

**Publication Type(s):** Research Support, Non-u.s. Gov't Research Support, N.i.h., Extramural Journal Article Review

**PubMedID:** 29571567

Available at  [Clinical therapeutics](https://auth.elsevier.com/ShibAuth/institutionLogin?entityID=https://idp.eng.nhs.uk/openathens&appReturnURL=https%3A%2F%2Fwww.clinicalkey.com%2Fcontent%2FplayBy%2Fdoi%2F%3Fv%3D10.1016%2Fj.clinthera.2018.02.017)  - from ClinicalKey

Available at  [Clinical therapeutics](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0149-2918&volume=40&issue=4&spage=512)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Clinical therapeutics](http://www.clinicaltherapeutics.com/article/S0149291818300924/pdf)  - from Unpaywall

**Abstract:** PURPOSEHepatocellular carcinoma (HCC), the most common type of primary liver cancer, has a rapidly rising prevalence in the United States and a very poor overall rate of survival. This epidemic is driven by the cohort of aging Baby Boomers with hepatitis C viral infection and the increasing prevalence of cirrhosis as a result of nonalcoholic steatohepatitis. Because curative options are limited, the disease course creates, in patients and their families, distressing uncertainty around prognosis and treatment decisions. Older adults are disproportionately affected by HCC and have more comorbidities, adding to the complexity of the disease. This population would benefit from increased access to palliative care services, which can potentially complement the treatments throughout the disease trajectory. The purpose of this review was to use existing evidence to propose a new model of palliative care integration in patients with HCC. Thus, we focus on the HCC stage and the treatment algorithm, the ways that palliative care can offer support in this population at each stage, as well as elements that can enhance patient and family support throughout the entire disease trajectory, with an emphasis on the care of older adults with HCC.METHODSThis is a narrative review in which we identify evidence-based ways that palliative care can help younger and older adults with HCC and their families, at each stage of HCC and throughout the disease trajectory.FINDINGSWe propose ways to integrate HCC and palliative care based on the existing evidence in both fields. Palliative care offers support in symptom management, advanced care planning, and decision making in ways that are specific to each stage of HCC. We also discuss the evidence that illustrates the palliative care needs of patients with HCC that span the entire course of illness, including coping with the stigmatization of liver disease, addressing informational needs at different stages, and discussing quality of life longitudinally.IMPLICATIONSIntegrating palliative care into the treatment of patients with HCC has the potential to improve outcomes, although more research is needed to build this evidence base.

**Database:** Medline

**14. Oncological patients in the intensive care unit: prognosis, decision-making, therapies and end-of-life care.**

**Author(s):** Biskup, Ewelina; Cai, Fengfeng; Vetter, Marcus; Marsch, Stephan

**Source:** Swiss medical weekly; 2017; vol. 147 ; p. w14481

**Publication Date:** 2017

**Publication Type(s):** Journal Article

**PubMedID:** 28804862

Available at  [Swiss medical weekly](https://smw.ch/journalfile/view/article/ezm_smw/en/smw.2017.14481/4ac1da757d9555155938fa008b2e5363f6726c24/smw_2017_14481.pdf/rsrc/jf)  - from Unpaywall

**Abstract:** The effectiveness of intensive care unit (ICU) care for cancer patients remains controversial. Advances in antitumour and supportive care led to major improvements in outcomes of oncological patients in the ICU. Improved cancer therapies and supportive management of organ dysfunctions have contributed to improved survival rates. As a consequence, the number of cancer patients requiring ICU admission is rising. Frequently, cancer patients have a poor performance status and are vulnerable. It is a heterogeneous population, where the nature and curability of the neoplasm and the severity of critical illness cause a plethora of issues about ICU admissions. Therefore, oncological patients are often considered inappropriate for ICU admission. So far, no specific severity-of-illness scoring system can reliably predict the outcome of critically ill oncological patients and scoring systems or survival predictors are lacking. The major determinants of mortality and prognosis are the number of organ failures, need of mechanical ventilation (especially for acute respiratory distress syndrome), vasopressor support (>4 hours) and therapies that have preceded ICU admission. The underlying neoplasm seems to have a little impact on the outcome. The most frequent reasons leading a cancer patient to ICU are postoperative recovery, respiratory failure, infection and sepsis. To date, scientific reports suggest that acute organ dysfunction should be managed at its onset, preferably within 2 hours after the admission, whereas further aggressive ICU management should be reappraised after a few days of full support. Prognosis should be reassessed at frequent intervals with particular attention to the development of multiple organ dysfunctions. Discussing the code status is a sensitive matter and should be balanced between the patient's wish and objective medical outcome assessment. The latter can only be achieved in a multidisciplinary team of intensivists, oncologists/haematologists and potentially palliative care experts, preferably by consensus. Transition from restorative to palliative care should be made when there is no benefit from further intensive treatment, there is no trend to recovery in the first days of intensive care and where symptom palliation would improve the quality of life. Patients' autonomy and dignity should remain paramount in any decision-making. Current data do not support any absolute criteria for triaging. Establishment of clear goals and approach to admit and treatment for oncological patients in the ICU are however urgently needed. This requires further prospective studies for independent validation in different medical settings and identifying prognostic tools that can aid with decision-making and patient selection for ICU. Cancer should not be seen as an exclusion criterion and priority should be given to assure the quality of life of oncological patients.

**Database:** Medline

**15. Palliative and end of life care in solid organ transplantation**

**Author(s):** Wentlandt K.; Weiss A.; O'Connor E.; Kaya E.

**Source:** American Journal of Transplantation; Dec 2017; vol. 17 (no. 12); p. 3008-3019

**Publication Date:** Dec 2017

**Publication Type(s):** Review

**PubMedID:** 28976070

Available at  [American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons](http://www.ingentaconnect.com/openurl?genre=article&issn=1600-6135&volume=17&issue=12&spage=3008)  - from IngentaConnect - Open Access

Available at  [American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons](https://onlinelibrary.wiley.com/doi/full/10.1111/ajt.14522)  - from Wiley Online Library

Available at  [American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons](http://www.ingentaconnect.com/openurl?genre=article&issn=16006135&volume=17&issue=12&spage=3008)  - from IngentaConnect

Available at  [American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons](https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/ajt.14522)  - from Unpaywall

**Abstract:** Palliative care is an interprofessional approach that focuses on quality of life of patients who are facing life-threatening illness. Palliative care is consistently associated with improvements in advance care planning, patient and caregiver satisfaction, quality of life, symptom burden, and lower healthcare utilization. Most transplant patients have advanced chronic disease, significant symptom burden, and mortality awaiting transplant. Transplantation introduces new risks including perioperative death, organ rejection, infection, renal insufficiency, and malignancy. Numerous publications over the last decade identify that palliative care is well-suited to support these patients and their caregivers, yet access to palliative care and research within this population are lacking. This review describes palliative care and summarizes existing research supporting palliative intervention in advanced organ failure and transplant populations. A proposed model to provide palliative care in parallel with disease-directed therapy in a transplant program has the potential to improve symptom burden, quality of life, and healthcare utilization. Further studies are needed to elucidate specific benefits of palliative care for this population. In addition, there is a tremendous need for education, specifically for clinicians, patients, and families, to improve understanding of palliative care and its benefits for patients with advanced disease.Copyright © 2017 The American Society of Transplantation and the American Society of Transplant Surgeons

**Database:** EMBASE

**16. The Imperative of Palliation in the Management of Rabies Encephalomyelitis.**

**Author(s):** Warrell, Mary; Warrell, David A; Tarantola, Arnaud

**Source:** Tropical medicine and infectious disease; Oct 2017; vol. 2 (no. 4)

**Publication Date:** Oct 2017

**Publication Type(s):** Journal Article Review

**PubMedID:** 30270909

Available at  [Tropical medicine and infectious disease](https://www.mdpi.com/2414-6366/2/4/52/pdf)  - from Unpaywall

**Abstract:** The aim of this review is to guide clinicians in the practical management of patients suffering from rabies encephalomyelitis. This condition is eminently preventable by modern post-exposure vaccination, but is virtually always fatal in unvaccinated people. In the absence of any proven effective antiviral or other treatment, palliative care is an imperative to minimise suffering. Suspicion of rabies encephalomyelitis depends on recognising the classic symptomatology and eliciting a history of exposure to a possibly rabid mammal. Potentially treatable differential diagnoses must be eliminated, notably other infective encephalopathies. Laboratory confirmation of suspected rabies is not usually possible in many endemic areas, but is essential for public health surveillance. In a disease as agonising and terrifying as rabies encephalomyelitis, alleviation of distressing symptoms is the primary concern and overriding responsibility of medical staff. Calm, quiet conditions should be created, allowing relatives to communicate with the dying patient in safety and privacy. Palliative management must address thirst and dehydration, fever, anxiety, fear, restlessness, agitation, seizures, hypersecretion, and pain. As the infection progresses, coma and respiratory, cardiovascular, neurological, endocrine, or gastrointestinal complications will eventually ensue. When the facilities exist, the possibility of intensive care may arise, but although some patients may survive, they will be left with severe neurological sequelae. Recovery from rabies is extremely rare, and heroic measures with intensive care should be considered only in patients who have been previously vaccinated, develop rabies antibody within the first week of illness, or were infected by an American bat rabies virus. However, in most cases, clinicians must have the courage to offer compassionate palliation whenever the diagnosis of rabies encephalomyelitis is inescapable.

**Database:** Medline

**17. Selective Percutaneous Controlled Radiofrequency Thermocoagulation of the Gasserian Ganglion to Control Facial Pain Due to Medication-Related Osteonecrosis of the Jaw**

**Author(s):** Taniguchi A.; Fukazawa K.; Hosokawa T.

**Source:** Journal of Palliative Medicine; Oct 2017; vol. 20 (no. 10); p. 1171-1174

**Publication Date:** Oct 2017

**Publication Type(s):** Review

**PubMedID:** 28772087

**Abstract:** Background: Medication-related osteonecrosis of the jaw (MRONJ) is an important complication in patients treated with antiresorptive agents such as bisphosphonates and the receptor activator of nuclear factor kappaB ligand inhibitor (denosumab). Treatment of MRONJ is extremely difficult, which makes it a distressing long-Term complication. Objective(s): We report a case of intractable facial pain due to MRONJ that was successfully controlled with selective percutaneous controlled radiofrequency thermocoagulation of the Gasserian ganglion. Setting(s): A 68-year-old woman with breast cancer was diagnosed as having MRONJ. She was very distressed because of jaw pain and infections secondary to MRONJ. Her quality of life (QOL) was severely decreased. Since alleviation of the MRONJ could not be expected within the patient's life expectancy, it was decided to investigate the usefulness of selective percutaneous controlled radiofrequency thermocoagulation of the Gasserian ganglion to control the pain. Result(s): After the procedure, the anesthesia was obtained in the distribution of the third branch of the trigeminal nerve, and the pain completely disappeared. Although hypoesthesia was provoked as a complication, it was tolerated by the patient and she was very satisfied. Up to the time of death, there was no recurrence of pain or worsening of the MRONJ. Discussion(s): This procedure is a common technique for treating trigeminal neuralgia. Its effect is immediate and long lasting, although it provokes hypoesthesia in treated division, and it is also suited for cancer patients in terminal stage. This case suggests that the procedure was useful for improving the patient's QOL.© Copyright 2017, Mary Ann Liebert, Inc. 2017.

**Database:** EMBASE

**18. Topical Opioids and Antimicrobials for the Management of Pain, Infection, and Infection-Related Odors in Malignant Wounds: A Systematic Review**

**Author(s):** Finlayson, Kathleen, BN, MN, PhD; Teleni, Laisa, APD, BBS, MND; McCarthy, Alexandra L, PhD, MN, BN

**Source:** Oncology Nursing Forum; Sep 2017; vol. 44 (no. 5); p. 626-632

**Publication Date:** Sep 2017

**Publication Type(s):** Evidence Based Healthcare Journal Article

Available at  [Oncology Nursing Forum](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0190-535X&volume=44&issue=5&spage=626)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Oncology Nursing Forum](http://pdfs.semanticscholar.org/a79e/8d698f9114bbe9efa62cab5f07ce09c42aca.pdf)  - from Unpaywall

**Abstract:** [...]patients with malignant wounds often report pain, distress from odor and exudate, decreased self-esteem, and poor quality of life (da Costa Santos et al., 2010).
Data Synthesis All article screening, full-text review, data extraction, and risk-of-bias assessment was conducted independently by two reviewers.
Because of clinical heterogeneity, a synthesis of the studies' results is presented in narrative form.
[...]the randomized trials in this review were underpowered.
ONF, 44(5), 626-632. doi: 10.1188/17.ONF.626-632 Knowledge Translation \* No studies that evaluated opioid use with samples of greater than 10 participants were found. \* Five studies reported clinically (but generally not statistically) significant improvements in outcomes. \* Current recommendations for topical control of malignant wounds are based on case reports and observational studies in patients with breast cancer.

**Database:** BNI

**19. Systemic antibiotics for treating malignant wounds.**

**Author(s):** Ramasubbu, Darshini A; Smith, Valerie; Hayden, Fiona; Cronin, Patricia

**Source:** The Cochrane database of systematic reviews; Aug 2017; vol. 8 ; p. CD011609

**Publication Date:** Aug 2017

**Publication Type(s):** Research Support, Non-u.s. Gov't Journal Article Review Systematic Review

**PubMedID:** 28837757

Available at  [The Cochrane database of systematic reviews](http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD011609.pub2/full)  - from Cochrane Collaboration (Wiley)

Available at  [The Cochrane database of systematic reviews](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6483739)  - from Unpaywall

**Abstract:** BACKGROUNDMalignant wounds are a devastating complication of cancer. They usually develop in the last six months of life, in the breast, chest wall or head and neck regions. They are very difficult to treat successfully, and the commonly associated symptoms of pain, exudate, malodour, and the risk of haemorrhage are extremely distressing for those with advanced cancer. Treatment and care of malignant wounds is primarily palliative, and focuses on alleviating pain, controlling infection and odour from the wound, managing exudate and protecting the surrounding skin from further deterioration. In malignant wounds, with tissue degradation and death, there is proliferation of both anaerobic and aerobic bacteria. The aim of antibiotic therapy is to successfully eliminate these bacteria, reduce associated symptoms, such as odour, and promote wound healing.OBJECTIVESTo assess the effects of systemic antibiotics for treating malignant wounds.SEARCH METHODSWe searched the following electronic databases on 8 March 2017: the Cochrane Wounds Specialised Register, the Cochrane Central Register of Controlled Trials (CENTRAL; the Cochrane Library, 2017, Issue 3), Ovid MEDLINE, Ovid Embase and EBSCO CINAHL Plus. We also searched the clinical trial registries of the World Health Organization (WHO) International Clinical Trials Registry Platform (apps.who.int/trialsearch) and ClinicalTrials.gov on 20 March 2017; and OpenSIGLE (to identify grey literature) and ProQuest Dissertations & Theses Global (to retrieve dissertation theses related to our topic of interest) on 13 March 2017.SELECTION CRITERIARandomised controlled trials that assessed the effects of any systemic antibiotics on malignant wounds were eligible for inclusion.DATA COLLECTION AND ANALYSISTwo review authors independently screened and selected trials for inclusion, assessed risk of bias and extracted study data. A third reviewer checked extracted data for accuracy prior to analysis.MAIN RESULTSWe identified only one study for inclusion in this review. This study was a prospective, double-blind cross-over trial that compared the effect of systemic metronidazole with a placebo on odour in malignant wounds. Nine participants with a fungating wound and for whom the smell was troublesome were recruited and six of these completed both the intervention and control (placebo) stages of the trial. Each stage lasted fourteen days, with a fourteen day gap (washout period) between administration of the metronidazole and the placebo.The study, in comparing metronidazole and placebo, reported on two of this review's pre-specified primary outcomes (malodour and adverse effects of the treatment) and on none of the review's pre-specified secondary outcomes.MalodourThe mean malodour (smell) scores for the metronidazole group was 1.17 (standard deviation (SD) 1.60) and the mean for the placebo group was 3.33 (SD 0.82). It is unclear if systemic antibiotics were associated with a difference in malodour (1 study with 6 participants; MD -2.16, 95% CI -3.6 to -0.72) as the quality of the evidence (GRADE) was very low for this outcome. The study was downgraded due to high risk of attrition bias (33% loss to follow-up) and very serious imprecision due to the small sample size.Adverse effectsNo adverse effects of the treatment were reported in either the intervention or control group by the trial authors.AUTHORS' CONCLUSIONSIt is uncertain whether systemic metronidazole leads to a reduction in malodour in patients with malignant wounds. This is because we were only able to include a single study at high risk of bias with a very small sample size, which focused only on patients with breast cancer. More research is needed to substantiate these findings and to investigate the effects of systemic metronidazole and other antibiotics on quality of life, pain relief, exudate and tumour containment in patients with malignant wounds.

**Database:** Medline

**20. Review of evolving etiologies, implications and treatment strategies for the superior vena cava syndrome.**

**Author(s):** Straka, Christopher; Ying, James; Kong, Feng-Ming; Willey, Christopher D; Kaminski, Joseph; Kim, D W Nathan

**Source:** SpringerPlus; 2016; vol. 5 ; p. 229

**Publication Date:** 2016

**Publication Type(s):** Journal Article Review

**PubMedID:** 27026923

Available at  [SpringerPlus](http://europepmc.org/search?query=(DOI:10.1186/s40064-016-1900-7))  - from Europe PubMed Central - Open Access

Available at  [SpringerPlus](https://springerplus.springeropen.com/track/pdf/10.1186/s40064-016-1900-7)  - from Unpaywall

**Abstract:** Superior vena cava syndrome (SVCS) is a relatively common sequela of mediastinal malignancies and may cause significant patient distress. SVCS is a medical emergency if associated with laryngeal or cerebral edema. The etiologies and management of SVCS have evolved over time. Non-malignant SVCS is typically caused by infectious etiologies or by thrombus in the superior vena cava and can be managed with antibiotics or anti-coagulation therapy, respectively. Radiation therapy (RT) has long been a mainstay of treatment of malignant SVCS. Chemotherapy has also been used to manage SVCS. In the past 20 years, percutaneous stenting of the superior vena cava has emerged as a viable option for SVCS symptom palliation. RT and chemotherapy are still the only modalities that can provide curative treatment for underlying malignant etiologies of SVCS. The first experiences with treating SVCS with RT were reported in the 1970's, and several advances in RT delivery have subsequently occurred. Hypo-fractionated RT has the potential to be a more convenient therapy for patients and may provide equal or superior control of underlying malignancies. RT may be combined with stenting and/or chemotherapy to provide both immediate symptom palliation and long-term disease control. Clinicians should tailor therapy on a case-by-case basis. Multi-disciplinary care will maximize treatment expediency and efficacy.

**Database:** Medline

**21. A systematic review of prognostic factors in the final three months of life for people with a haematological malignancy**

**Author(s):** Button E.; Chan R.; Yates P.; Butler J.; Chambers S.

**Source:** Palliative Medicine; Jun 2016; vol. 30 (no. 6)

**Publication Date:** Jun 2016

**Publication Type(s):** Conference Abstract

Available at  [Palliative Medicine](https://journals.sagepub.com/doi/full/10.1177/0269216316646056)  - from SAGE A - Z

Available at  [Palliative Medicine](http://eprints.whiterose.ac.uk/102033/3/Abstract%20number%20P240.pdf)  - from Unpaywall

**Abstract:** Aim: The aim of this review was to identify 'bedside' prognostic factors associated with increased mortality in the final three months of life for people with a hematological malignancy. Method(s): A systematic review of the literature was performed across: PubMed; CINAHL; PsycINFO; and the Cochrane Library with inclusion criteria: 1) prognostic cohort studies; 2) published 2004-2014; 3) sample 18 years; 4) >50 % sample had a hematological malignancy; 5) reported 'bedside' prognostic factors; 6) median survival of < 3 months; and 7) English language. Keywords included: haematological malignancy; prognostic factors; and end of life. Result(s): The search returned 4,860 studies of which 28 met inclusion criteria. Critical appraisal was performed using the Quality in Prognostic Studies Tool. Most studies were set in the intensive care unit (n=24/28) and were retrospective (n=25/28). Forty 'bedside' prognostic factors were identified in the following broad categories: 1) demographics; 2) physiological complications or condition; 3) disease characteristics; 4) laboratory blood values; and 5) interventions. The most commonly reported factors in univariate and multivariable analyses included: mechanical ventilation; vasopressor support; sepsis/infection; older age; haemodynamic instability; elevated liver enzymes; multi-organ failure; respiratory distress; and elevated urea/urea. Performance status, symptom burden, anorexia-cachexia syndrome, quality of life, multi-morbidity and clinician judgement were not tested in any study. Conclusion(s): This review has identified factors that are useful for prognosticating for people with a hematological malignancy who have deteriorated and have been admitted to the intensive care unit. There is an urgent need for research that will identify people at risk of dying prior to acute deterioration, in a range of settings.

**Database:** EMBASE

**22. Diagnostic workup for ARDS patients**

**Author(s):** Papazian L.; Calfee C.S.; Matthay M.A.; Chiumello D.; Luyt C.-E.; Meyer N.J.; Sekiguchi H.; Meduri G.U.

**Source:** Intensive Care Medicine; May 2016; vol. 42 (no. 5); p. 674-685

**Publication Date:** May 2016

**Publication Type(s):** Review

Available at  [Intensive Care Medicine](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0342-4642&volume=42&issue=5&spage=674)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Intensive Care Medicine](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7080099)  - from Unpaywall

**Abstract:** Acute respiratory distress syndrome (ARDS) is defined by the association of bilateral infiltrates and hypoxaemia following an initial insult. Although a new definition has been recently proposed (Berlin definition), there are various forms of ARDS with potential differences regarding their management (ventilator settings, prone positioning use, corticosteroids). ARDS can be caused by various aetiologies, and the adequate treatment of the responsible cause is crucial to improve the outcome. It is of paramount importance to characterize the mechanisms causing lung injury to optimize both the aetiological treatment and the symptomatic treatment. If there is no obvious cause of ARDS or if a direct lung injury is suspected, bronchoalveolar lavage (BAL) should be strongly considered to identify microorganisms responsible for pneumonia. Blood samples can also help to identify microorganisms and to evaluate biomarkers of infection. If there is no infectious cause of ARDS or no other apparent aetiology is found, second-line examinations should include markers of immunologic diseases. In selected cases, open lung biopsy remains useful to identify the cause of ARDS when all other examinations remain inconclusive. CT scan is fundamental when there is a suspicion of intra-abdominal sepsis and in some cases of pneumonia. Ultrasonography is important not only in evaluating biventricular function but also in identifying pleural effusions and pneumothorax. The definition of ARDS remains clinical and the main objective of the diagnostic workup should be to be focused on identification of its aetiology, especially a treatable infection.Copyright © 2016, Springer-Verlag Berlin Heidelberg and ESICM.

**Database:** EMCARE

**23. Clinical effectiveness and cost-effectiveness of interventions for the treatment of anogenital warts: systematic review and economic evaluation.**

**Author(s):** Thurgar, Elizabeth; Barton, Samantha; Karner, Charlotta; Edwards, Steven J

**Source:** Health technology assessment (Winchester, England); Mar 2016; vol. 20 (no. 24); p. v-cdxcii

**Publication Date:** Mar 2016

**Publication Type(s):** Research Support, Non-u.s. Gov't Journal Article Review Systematic Review

**PubMedID:** 27034016

Available at  [Health technology assessment (Winchester, England)](https://njl-admin.nihr.ac.uk/document/download/2003405)  - from Unpaywall

**Abstract:** BACKGROUNDTypically occurring on the external genitalia, anogenital warts (AGWs) are benign epithelial skin lesions caused by human papillomavirus infection. AGWs are usually painless but can be unsightly and physically uncomfortable, and affected people might experience psychological distress. The evidence base on the clinical effectiveness and cost-effectiveness of treatments for AGWs is limited.OBJECTIVESTo systematically review the evidence on the clinical effectiveness of medical and surgical treatments for AGWs and to develop an economic model to estimate the cost-effectiveness of the treatments.DATA SOURCESElectronic databases (MEDLINE, MEDLINE In-Process & Other Non-Indexed Citations, EMBASE, The Cochrane Library databases and Web of Science) were searched from inception (or January 2000 for Web of Science) to September 2014. Bibliographies of relevant systematic reviews were hand-searched to identify potentially relevant studies. The World Health Organization International Clinical Trials Registry Platform and ClinicalTrials.gov were searched for ongoing and planned studies.REVIEW METHODSA systematic review of the clinical effectiveness literature was carried out according to standard methods and a mixed-treatment comparison (MTC) undertaken. The model implemented for each outcome was that with the lowest deviance information criterion. A de novo economic model was developed to assess cost-effectiveness from the perspective of the UK NHS. The model structure was informed through a systematic review of the economic literature and in consultation with clinical experts. Effectiveness data were obtained from the MTC. Costs were obtained from the literature and standard UK sources.RESULTSOf 4232 titles and abstracts screened for inclusion in the review of clinical effectiveness, 60 randomised controlled trials (RCTs) evaluating 19 interventions were included. Analysis by MTC indicated that ablative techniques were typically more effective than topical interventions at completely clearing AGWs at the end of treatment. Podophyllotoxin 0.5% solution (Condyline(®), Takeda Pharmaceutical Company Ltd; Warticon(®) solution, Stiefel Laboratories Ltd) was found to be the most effective topical treatment evaluated. Networks for other outcomes included fewer treatments, which restrict conclusions on the comparative effectiveness of interventions. In total, 84 treatment strategies were assessed using the economic model. Podophyllotoxin 0.5% solution first line followed by carbon dioxide (CO2) laser therapy second line if AGWs did not clear was most likely to be considered a cost-effective use of resources at a willingness to pay of £20,000-30,000 per additional quality-adjusted life-year gained. The result was robust to most sensitivity analyses conducted.LIMITATIONSLimited reporting in identified studies of baseline characteristics for the enrolled population generates uncertainty around the comparability of the study populations and therefore the generalisability of the results to clinical practice. Subgroup analyses were planned based on type, number and size of AGWs, all of which are factors thought to influence treatment effect. Lack of data on clinical effectiveness based on these characteristics precluded analysis of the differential effects of treatments in the subgroups of interest. Despite identification of 60 studies, most comparisons in the MTC are informed by only one RCT. Additionally, lack of head-to-head RCTs comparing key treatments, together with minimal reporting of results in some studies, precluded comprehensive analysis of all treatments for AGWs.CONCLUSIONSThe results generated by the MTC are in agreement with consensus opinion that ablative techniques are clinically more effective at completely clearing AGWs after treatment. However, the evidence base informing the MTC is limited. A head-to-head RCT that evaluates the comparative effectiveness of interventions used in clinical practice would help to discern the potential advantages and disadvantages of the individual treatments. The results of the economic analysis suggest that podophyllotoxin 0.5% solution is likely to represent a cost-effective first-line treatment option. More expensive effective treatments, such as CO2 laser therapy or surgery, may represent cost-effective second-line treatment options. No treatment and podophyllin are unlikely to be considered cost-effective treatment options. There is uncertainty around the cost-effectiveness of treatment with imiquimod, trichloroacetic acid and cryotherapy.STUDY REGISTRATIONThis study is registered as PROSPERO CRD42013005457.FUNDINGThe National Institute for Health Research Health Technology Assessment programme.

**Database:** Medline

**24. Development of a mnemonic assessment tool for management of malignant ulcers**

**Author(s):** Asemota E.; Larocca C.; Phillips T.

**Source:** Journal of Vascular and Interventional Radiology; Feb 2016; vol. 27 (no. 2)

**Publication Date:** Feb 2016

**Publication Type(s):** Conference Abstract

Available at  [Journal of Vascular and Interventional Radiology](https://auth.elsevier.com/ShibAuth/institutionLogin?entityID=https://idp.eng.nhs.uk/openathens&appReturnURL=https%3A%2F%2Fwww.clinicalkey.com%2Fcontent%2FplayBy%2Fdoi%2F%3Fv%3D10.1016%2Fj.jvir.2016.01.014)  - from ClinicalKey

Available at  [Journal of Vascular and Interventional Radiology](https://doi.org/10.1016/j.jvir.2016.01.014)  - from Unpaywall

**Abstract:** Purpose: Malignant wounds, also called fungating cancerous wounds, are caused by tumor infiltration from a primary skin cancer, metastatic disease to the skin, or as part of a paraneoplastic syndrome. Despite primary oncologic treatment, malignant ulcers are complicated by poor wound healing and require specialized care, especially in the palliative stage. Many articles have been written regarding best practices in care for malignant wounds. There is need for a simple mnemonic assessment tool to help providers establish goal-oriented management and a holistic approach to patients with malignant ulcers. Material(s) and Method(s): A literature search on management of malignant wounds was conducted, via Pubmed, MEDLINE, and Research Gate. Peer-reviewed original manuscripts were analyzed and significant findings synthesized. Result(s): In addition to thorough clinical assessment and evaluation of symptoms, fungating wounds should be biopsied to establish a definitive histopathologic diagnosis, to inform patients of curative and palliative oncologic treatment options, and to establish goals of care. Cancer treatments, which include surgery, chemotherapy, targeted therapies, and radiation therapy, have variable outcomes with only a proportion of patients achieving complete wound healing. In the absence of cancer treatment, malignant wounds are generally nonhealable. Malignant wounds are associated with a significant symptomatic burden from pain, mass effect, esthetic distress, exudation, malodor, pruritus, bleeding, and crusting. These multiple symptoms contribute to decreased quality of life and, as such, should be assessed for during clinical evaluation. When appropriate, debridement to control the necrotic burden can also be helpful. It is also important to identify superinfection, aided by clinical signs and microbial cultures, to guide relevant use of systemic and topical antibiotic treatments. Adequate nutrition is also a critical component of wound care. This therapeutic approach requires multi-disciplinary care, which aims to slow disease progression and optimize quality of life. Therapy of malignant wounds represents a complex problem for patients and healthcare professionals alike. Strategic management of malignant wounds can be summarized with the mnemonic COMFORT (C = care for pain and itching, O = odor control, M = manage exudate and bleeding, F = fight infection, O = optimize periwound skin integrity, R = use reparative and esthetic wound dressings, T = treat cancer). Conclusion(s): This concise article provides an assessment tool supported by evidence-based literature, which aims to enhance the clinician's competence in providing local, often palliative, wound care for malignant wounds.

**Database:** EMBASE

**25. Nausea and vomiting in palliative care**

**Author(s):** Collis, Emily; Mather, Harriet

**Source:** BMJ : British Medical Journal (Online); Dec 2015; vol. 351 ; p. n

**Publication Date:** Dec 2015

**Publication Type(s):** Review

Available at  [BMJ](http://www.bmj.com/lookup/doi/10.1136/bmj.h6249)  - from BMJ Journals

Available at  [BMJ](http://www.bartshealth.nhs.uk/education/knowledge-and-library-services/request-an-article-or-book)  - from Request from Barts Health - Whipps Cross University Hospital Local Print Collection [location] : Request from Barts Health - Whipps Cross University Hospital.

Available at  [BMJ](http://bartshealth-nhs.libsurveys.com/Barts-Health-NHS-Trust-Knowledge-and-Library-Services-Article-Request-Form)  - from Request from Barts Health - Newham University Hospital Local Print Collection [location] : Request from Barts Health - Newham University Hospital.

**Abstract:**  
Gastric stasis and chemical disturbance are the most common. 1 2 However, the aetiology is often multifactorial, and in many cases a cause cannot be confidently established. 1 Cause and triggers Key features Investigations Chemical Drugs-opioids\*, digoxin, antibiotics, antifungals, iron, SSRIs, NSAIDs, dopamine agonists Chemotherapy Metabolic-renal failure, liver failure, hypercalcaemia, hyponatraemia, ketoacidosis Toxins-ischaemic bowel, tumour products, infection Co-existent delirium may suggest metabolic cause (can also be a consequence of metabolic derangements secondary to vomiting) Polyuria and polydipsia can accompany nausea and vomiting caused by hypercalcaemia and hyperglycaemia Review drug sheet Blood sugar to exclude hyperglycaemia (all patients) Urine analysis to exclude infection (all patients) Urea and electrolytes (hyponatraemia, hypokalaemia, uraemia) Calcium and liver function (all patients who consent and for whom treatment to reverse derangements would be appropriate) Uraemia and hypercalcaemia can mimic the dying phase but may also reflect irreversible progression into the dying phase Impaired gastric emptying Drugs-opioids, tricyclics, phenothiazines, anticholinergics Tumour ascites Hepatomegaly Autonomic dysfunction Tumour infiltration Early satiety, reflux, hiccups Consider abdominal ultrasound scan or CT to investigate physical causes Visceral or serosal Bowel obstruction Severe constipation or faecal impaction Liver capsule stretch Ureteric distension Mesenteric metastases Difficult expectoration or pharyngeal stimulation Vomiting undigested food hours after ingestion suggests gastric outlet obstruction Abdominal pain and change in bowel habit suggest intestinal obstruction Progression of vomiting from stomach contents to bile to faeculent material indicates intestinal obstruction Abdominal x ray and/or CT if bowel obstruction is suspected (either gastric outlet, small or large bowel) Contrast studies may be done (such as barium meal) Suspected gastric outlet or intestinal obstruction requires inpatient admission at presentation (if in line with preferences) until symptoms have been managed Early discussion with oncologists, surgeons, and palliative care specialists is advised in all cases of suspected bowel obstruction Cranial Raised intracranial pressure-tumour, bleed, infarction Meningeal infiltration Radiotherapy Headache (especially in morning) suggests raised intracranial pressure Personality change, visual changes, depressed consciousness can occur with raised intracranial pressure CT or MRI of head should be done if new features of raised intracranial pressure or focal neurology. MRI is preferred in cases of suspected meningeal disease Discussion with patient's oncologist or palliative care specialists is advised Vestibular Drugs-opioids Motion sickness Base of skull tumour Less common cause of nausea and vomiting Symptoms are movement related (this is not pathognomic and can occur with gastric stasis) CT or MRI should be done if base of skull tumour is suspected Discussion with patient's oncologist or palliative medicine specialists is advised Cortical Anxiety Pain Anticipatory nausea Psychological or physical distress In depth psychosocial assessment SSRI=selective serotonin reuptake inhibitor, NSAID=non-steroidal anti-inflammatory drug, CT=computed tomography, MRI=magnetic resonance imaging. \*If the dose of opioid is stable, it is unlikely to be the cause of nausea and vomiting.

**Database:** BNI

**26. Literature and breastfeeding as part of "hearts and minds" strategy in health care, and health education. A preliminary study**

**Author(s):** Zafra Anta M.A.; Flores Anton B.; Temboury Molina M.C.; Munoz Calonge A.; Calonge Garcia A.; Risco Montemayor B.

**Source:** Journal of Perinatal Medicine; Oct 2015; vol. 43

**Publication Date:** Oct 2015

**Publication Type(s):** Conference Abstract

**Abstract:** Background: For some time now, many projects have been developed by academics and researchers in order to give more weight to emotional aspects in medicine using literature. Narrative medicine is helping physicians offer effective care of the sick people: mainly neurologic, oncologic, terminal, infectious diseases. Breastfeeding should be considered not only as a matter of individual and rational election but also as a choice in wich emotions play a significant role. In fact, it is difficult to find scenarios where emotional components related to nursing babies are not important. These emotions can be positive (intimacy, pleasure, joy, others) or negative (failure, grief, guilt, worry, anxiety, difficulties in a breastfeeding unfriendly culture, etc). Objective(s): To make a preliminary study about breastfeeding in the literature, and to explore its opportunities to learn and share in health care. Method(s): Searches of electronic databases, reference lists, web repositories, web portals: pubmed, dialnet, scholar google, scienceresearch, instituto Cervantes, journals (JHL, Breastfeed Med, J Med Mov). MeSH: breastfeeding, lactation, wet nurse, literature, narrative, cultural practices, medical humanities education. Language: English, Spanish. Period of time: 1985-2015. We focused on medical and history of medicine articles whose subject was the breastfeeding in 3 axes: emotional aspects, promote cooperation and reflection, academic learning or education. Result(s): We found more than 21 papers focused on breastfeeding, narrative medicine, health education, and nursing history. Most of them were narrative reviews. The reviews were targeted mainly to provide social and historical scientific knowledge, and to promote skills in the field of reflection, cooperation and empathy. Breastfeeding is discussed in various ways in Spanish and English literature: \* Ancient literature: Bible; Berceo; Cantigas-Alfonso X; "El libro de Aleixandre"-JuanManuel; \* Renaissance, Modern, Currently: "Romeo and Juliet"-Shakespeare; "La tia Tula"-Unamuno; Miguel Hernandez, Neruda, "The grapes of wrath"-Steinbeck, "El hereje"-Delibes, "Clan of the Cavebear Books"-Auel; "The most beautiful word"-Mazzantini. Conclusions Literature is a tool that allows us to gain an essential interrelationship with and interdependence on several questions on breastfeeding with: mothers, health workers (beliefs, values, attitudes, practices), health services, and surroundings. Literature offers a complementary learning model for traditional teaching contents for the items on breastfeeding. This study offers insights into narrative ways that add value to the emotional aspects of connection and engagement. Literature could raises awareness about the importance of emotional added value on breastfeeding for mothers and professionals.

**Database:** EMBASE

**27. Febrile seizures and genetic epilepsy with febrile seizures plus (GEFS+).**

**Author(s):** Camfield, Peter; Camfield, Carol

**Source:** Epileptic disorders : international epilepsy journal with videotape; Jun 2015; vol. 17 (no. 2); p. 124-133

**Publication Date:** Jun 2015

**Publication Type(s):** Journal Article Review

**PubMedID:** 25917466

Available at  [Epileptic disorders : international epilepsy journal with videotape](https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Fonlinelibrary.wiley.com%2Fdoi%2Ffull%2F10.1684%2Fepd.2015.0737)  - from Wiley Online Library Medicine and Nursing Collection 2019 - NHS

Available at  [Epileptic disorders : international epilepsy journal with videotape](http://pdfs.semanticscholar.org/d6b1/459aa0a91ee8efe38262128418b9cc3172d5.pdf)  - from Unpaywall

**Abstract:** To review the literature about febrile seizures and GEFS plus with special emphasis on management and outcome. Selected literature review. Febrile seizures are the most common convulsive event in humans, occurring in 2-6% of the population. The aetiology is complex with strong evidence for a heterogeneous genetic predisposition interacting with fever of any cause, with certain viral infections having a greater effect. A large amount of literature has established that febrile seizures have no long-term consequences on cognition or behaviour. Unfortunately, about 40% of children with a first febrile seizure will have a recurrence. The strongest predictor of recurrence is age <14-16 months at the time of the first febrile seizure. Epilepsy follows febrile seizures in ∼3% cases, with the concepts of simple and complex febrile seizures providing relatively weak prediction. Very prolonged febrile seizures may lead to mesial temporal sclerosis and temporal lobe epilepsy although the degree of risk remains uncertain. Investigations beyond establishing the cause of the provoking fever are nearly always unnecessary. Treatment is mainly reassurance and there is some evidence that parents eventually "come to grips" with the fear that their children are dying during a febrile seizure. Antipyretic medications are remarkably ineffective to prevent recurrences. Daily and intermittent prophylactic medications are ineffective or have unacceptable side effects or risks. "Rescue" benzodiazepines may prevent prolonged recurrences for selected patients with a first prolonged febrile seizure although this has not been proven. Genetic epilepsy with febrile seizures plus (GEFS+) is a complex autosomal dominant disorder usually caused by mutations in SCN1A (a voltage-gated sodium channel). One third of patients have febrile seizures only; two thirds have a variety of epilepsy syndromes, both focal and generalized. Febrile seizures may distress parents but rarely have any long-term consequences. Reassurance is the only treatment for the vast majority. Identifying patients with GEFS plus may lead to further investigations and counselling.

**Database:** Medline

**28. Outcome of patients admitted to a tertiary referral hospital ICU with acute respiratory distress syndrome-A 5 year prospective cohort study**

**Author(s):** Rajendran V.; Rangappa P.; Jacob I.; Rao K.

**Source:** Indian Journal of Critical Care Medicine; Mar 2015; vol. 19 (no. 13)

**Publication Date:** Mar 2015

**Publication Type(s):** Conference Abstract

**Abstract:** Introduction: Acute respiratory distress syndrome (ARDS) is a common cause of hypoxemic respiratory failure. Despite extensive research, no comprehensive treatment options have been defined so far. Treatment strategies, with the exception of low tidal volume mechanical ventilation, have had little impact on outcomes. This study reviewed patients with ARDS who were predominantly managed with intravenous steroids and non invasive positive pressure ventilation (NIPPV). Their outcome was assessed by ICU survival and ninety day mortality. Method(s): This was a prospective cohort study conducted in the intensive care unit of Columbia Asia tertiary referral hospital. The data was collected from an electronic database over 5 years from January 2010 to November 2014. Subjects who met the ARDS criteria as per the Berlin Definition were selected. They were all administered with intravenous Methylprednisolone as a 1 mg/kg infusion for 1 week and tapered down over the next 3 weeks. Patients who had ARDS for one week or more, terminally ill patients, major gastrointestinal bleeding within the previous 3 months or requiring a higher dose of methylprednisolone or its equivalent were excluded from this study. They were given a trial of NIPPV and intubated only if they had failed or had contraindications for NIPPV. Variables analysed were conditions precipitating ARDS, APACHE II scores, PaO2/FiO2 ratio and PEEP at presentation, change in PaO2/FiO2 ratio and PEEP on days 2, 4, 6 and 8 of admission, hemodynamic parameters, duration of mechanical ventilation, ICU survival, hospital length of stay, 90 day mortality and adverse effects. Result(s): A total of 55 patients fulfilled the criteria of ARDS as per the Berlin Definition. 22 patients (40%) had moderate ARDS and 33 patients (60%) severe ARDS. The median age was 45 years (IQR 32-65) and 55% were males. The mean APACHE II score was 15 +/- 3.5. Pneumonia (76.4%) was the common precipitating factor followed by Sepsis (16.4%). Patients treated with intravenous steroids (43 of 55) had a statistically significant better ICU survival rate of 79% [p = 0.046] and lesser ninety day mortality of 26% [p = 0.043] than those who did not receive steroids (50% and 41.6% respectively). Patients treated exclusively with NIPPV (32 of 55) had a statistically significant better ICU survival rate of 97% [p <0.01] and lesser ninety day mortality of 6% [p <0.01] than intubated patients [32% and 70% respectively]. However, patients who were intubated and mechanically ventilated had a high mean APACHE II score (23+/-2). The duration of mechanical ventilation, hospital length of stay, barotraumas, onset of new infections and steroid induced complications were similar in both groups. Conclusion(s): In this study, we observe that the use of intravenous Methylprednisolone in ARDS unless contraindicated, is associated with better ICU survival and decreased mortality. A trial of NIPPV could improve outcomes in patients with moderate ARDS than intubating them at the outset. Larger randomised controlled trials are needed to make definitive conclusions.

**Database:** EMBASE

**29. Care gaps in the inpatient management of acute exacerbations of chronic obstructive pulmonary disease: A retrospective audit**

**Author(s):** Simms T.M.; Chapman K.R.

**Source:** American Journal of Respiratory and Critical Care Medicine; 2014; vol. 189

**Publication Date:** 2014

**Publication Type(s):** Conference Abstract

**Abstract:** RATIONALE: Acute exacerbations of chronic obstructive pulmonary disease (COPD) are associated with increased mortality, accelerated decline in lung function, impaired quality of life, and substantial healthcare costs. Audits in Europe have identified wide variations in COPD inpatient care and frequent inconsistencies with practice guidelines. Such findings can inform quality improvement initiatives, with resulting declines in length of hospital stay and decreased 90 day mortality. The aim of our study was to review local practices in the inpatient management of patients with acute exacerbations of COPD and to identify areas for improvement in the quality of care delivered to this patient population. METHOD(S): We conducted a retrospective chart review of systematically sampled patients discharged from the University Health Network (Toronto General and Toronto Western Hospitals) with a most responsible diagnosis of acute exacerbation of COPD between January 1 and December 31, 2012. Patients were identified for inclusion with International Classification of Diseases (ICD) 10th revision codes and were excluded if their most responsible diagnosis was miscoded or if their philosophy of care was palliative. RESULT(S): Ninety-one charts were reviewed via sampling of every third patient. Documentation of results of prior spirometry or acknowledgement of lack of available prior spirometric data was absent in 44% of patients. Inpatient spirometry was performed in just 13% of patients with no prior documentation of airflow obstruction. Arterial blood gases were performed on admission in 36% of patients, and in only 60% of patients presenting with respiratory distress (accessory muscle use or respiratory rate > 25 breaths/minute). Non-invasive ventilation was used in 32% of patients presenting with respiratory distress or respiratory acidosis (pH <7.35 and PaCO2 >45 mmHg). Documented rates of inhaler technique teaching were 2% on admission and 10% on discharge. Among current smokers, 32% were prescribed nicotine replacement therapy and 40% received smoking cessation counselling. Pulmonary rehabilitation was extremely underutilized, with only 1% of patients referred on discharge, excluding those already participating in a program at the time of admission. Pneumococcal and/or influenza vaccination status was addressed in 13% of patients prior to discharge. In 17% of patients, important management plans were documented in the chart but not implemented or included in the discharge summary. CONCLUSION(S): Gaps in care of patients admitted with acute exacerbations of COPD were common. Further quality improvement research is required to identify the barriers to implementation of practice guidelines and to develop interventions to narrow these gaps.

**Database:** EMBASE

**30. Coronavirus virulence genes with main focus on SARS-CoV envelope gene.**

**Author(s):** DeDiego, Marta L; Nieto-Torres, Jose L; Jimenez-Guardeño, Jose M; Regla-Nava, Jose A; Castaño-Rodriguez, Carlos; Fernandez-Delgado, Raul; Usera, Fernando; Enjuanes, Luis

**Source:** Virus research; Dec 2014; vol. 194 ; p. 124-137

**Publication Date:** Dec 2014

**Publication Type(s):** Research Support, Non-u.s. Gov't Research Support, N.i.h., Extramural Journal Article Review

**PubMedID:** 25093995

Available at  [Virus research](https://doi.org/10.1016/j.virusres.2014.07.024)  - from Unpaywall

**Abstract:** Coronavirus (CoV) infection is usually detected by cellular sensors, which trigger the activation of the innate immune system. Nevertheless, CoVs have evolved viral proteins that target different signaling pathways to counteract innate immune responses. Some CoV proteins act as antagonists of interferon (IFN) by inhibiting IFN production or signaling, aspects that are briefly addressed in this review. After CoV infection, potent cytokines relevant in controlling virus infections and priming adaptive immune responses are also generated. However, an uncontrolled induction of these proinflammatory cytokines can lead to pathogenesis and disease severity as described for SARS-CoV and MERS-CoV. The cellular pathways mediated by interferon regulatory factor (IRF)-3 and -7, activating transcription factor (ATF)-2/jun, activator protein (AP)-1, nuclear factor kappa-light-chain-enhancer of activated B cells (NF-κB), and nuclear factor of activated T cells (NF-AT), are the main drivers of the inflammatory response triggered after viral infections, with NF-κB pathway the most frequently activated. Key CoV proteins involved in the regulation of these pathways and the proinflammatory immune response are revisited in this manuscript. It has been shown that the envelope (E) protein plays a variable role in CoV morphogenesis, depending on the CoV genus, being absolutely essential in some cases (genus α CoVs such as TGEV, and genus β CoVs such as MERS-CoV), but not in others (genus β CoVs such as MHV or SARS-CoV). A comprehensive accumulation of data has shown that the relatively small E protein elicits a strong influence on the interaction of SARS-CoV with the host. In fact, after infection with viruses in which this protein has been deleted, increased cellular stress and unfolded protein responses, apoptosis, and augmented host immune responses were observed. In contrast, the presence of E protein activated a pathogenic inflammatory response that may cause death in animal models and in humans. The modification or deletion of different motifs within E protein, including the transmembrane domain that harbors an ion channel activity, small sequences within the middle region of the carboxy-terminus of E protein, and its most carboxy-terminal end, which contains a PDZ domain-binding motif (PBM), is sufficient to attenuate the virus. Interestingly, a comprehensive collection of SARS-CoVs in which these motifs have been modified elicited full and long-term protection even in old mice, making those deletion mutants promising vaccine candidates. These data indicate that despite its small size, E protein drastically influences the replication of CoVs and their pathogenicity. Although E protein is not essential for CoV genome replication or subgenomic mRNA synthesis, it affects virus morphogenesis, budding, assembly, intracellular trafficking, and virulence. In fact, E protein is responsible in a significant proportion of the inflammasome activation and the associated inflammation elicited by SARS-CoV in the lung parenchyma. This exacerbated inflammation causes edema accumulation leading to acute respiratory distress syndrome (ARDS) and, frequently, to the death of infected animal models or human patients.

**Database:** Medline

**31. Year in review 2013: Critical Care--respiratory infections.**

**Author(s):** Nair, Girish B; Niederman, Michael S

**Source:** Critical care (London, England); Oct 2014; vol. 18 (no. 5); p. 572

**Publication Date:** Oct 2014

**Publication Type(s):** Journal Article Review

**PubMedID:** 25672674

Available at  [Critical care (London, England)](http://ccforum.biomedcentral.com/articles/10.1186/s13054-014-0572-3)  - from BioMed Central

Available at  [Critical care (London, England)](http://europepmc.org/search?query=(DOI:10.1186/s13054-014-0572-3))  - from Europe PubMed Central - Open Access

Available at  [Critical care (London, England)](https://ccforum.biomedcentral.com/track/pdf/10.1186/s13054-014-0572-3)  - from Unpaywall

**Abstract:** Infectious complications, particularly in the respiratory tract of critically ill patients, are related to increased mortality. Severe infection is part of a multiple system illness and female patients with severe sepsis have a worse prognosis compared to males. Kallistatin is a protective hormokine released during monocyte activation and low levels in the setting of septic shock can predict adverse outcomes. Presepsin is another biomarker that was recently evaluated and is elevated in patients with severe sepsis patients at risk of dying. The Centers for Disease Control and Prevention has introduced new definitions for identifying patients at risk of ventilator-associated complications (VACs), but several other conditions, such as pulmonary edema and acute respiratory distress syndrome, may cause VACs, and not all patients with VACs may have ventilator-associated pneumonia. New studies have suggested strategies to identify patients at risk for resistant pathogen infection and therapies that optimize efficacy, without the overuse of broad-spectrum therapy in patients with healthcare-associated pneumonia. Innovative strategies using optimized dosing of antimicrobials, maximizing the pharmacokinetic and pharmacodynamic properties of drugs in critically ill patients, and newer routes of drug delivery are being explored to combat drug-resistant pathogens. We summarize the major clinical studies on respiratory infections in critically ill patients published in 2013.

**Database:** Medline

**32. Fluoropolymer-associated illness**

**Author(s):** Hays H.L.; Spiller H.

**Source:** Clinical Toxicology; Sep 2014; vol. 52 (no. 8); p. 848-855

**Publication Date:** Sep 2014

**Publication Type(s):** Review

**PubMedID:** 25200453

**Abstract:** Context: Isolated outbreaks of respiratory illness associated with fluoropolymer-containing products, such as waterproofing agents and sealants, have occurred for many years in many different countries. Despite this, an assured mechanism of illness is not defined, representing a barrier to the prevention of future occurrences. Objective(s): To discuss the epidemiology of the respiratory illness outbreaks, proposed mechanisms of toxicity and clinical outcomes from exposure to these products. Method(s): We performed a literature review using OVID Medline (January 1946 through December 2012) and PubMed (January 1950 through December 2012) using the search terms "fluoropolymer", "fluorochemical", "leather proofing", "leather protectant", "weatherproofing agent", and "waterproofing agent". Bibliographies of identified articles were screened for additional relevant studies, including non-indexed reports. Result(s): Fluoropolymer-associated respiratory illnesses often resemble polymer fume fever: acute respiratory symptoms predominate and are accompanied by flu-like symptoms. Outbreaks occasionally follow marketing of a new or reformulated product. Treatment with basic and supportive measures is sufficient in many cases, including fresh air and supplemental oxygen. Inhaled beta-2 adrenergic agonists and corticosteroids have been used. Toxicity may result from the fluoropolymer itself or the solvent in which it is delivered. Factors which may influence toxicity include fluoropolymer particle size, emission rate, methods of application, environmental conditions, and personal health. Conclusion(s): Exposure to fluoropolymer-containing waterproofing agents can cause lung injury and usually produce abrupt onset of respiratory and flu-like symptoms. Most victims improve with supportive care and supplemental oxygen. Serious outcomes, including acute respiratory distress syndrome and death, are uncommon. Proprietary information on the exact composition of most fluoropolymer-containing products is often unavailable, and this hinders identification of an exact cause of disease. The etiology is most likely multifactorial. Future research should focus on determining the exact mechanism of illness and establishing safe exposure limits.Copyright © 2014 Informa Healthcare USA, Inc.

**Database:** EMBASE

**33. Idiopathic pulmonary fibrosis acute exacerbations: Where are we now?**

**Author(s):** Papiris S.A.; Kagouridis K.; Manali E.D.; Kolilekas L.; Bouros D.

**Source:** Expert Review of Respiratory Medicine; Jun 2014; vol. 8 (no. 3); p. 271-273

**Publication Date:** Jun 2014

**Publication Type(s):** Review

**PubMedID:** 24655104

Available at  [Expert review of respiratory medicine](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1747-6348&volume=8&issue=3&spage=271)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Expert review of respiratory medicine](https://www.tandfonline.com/doi/pdf/10.1586/17476348.2014.896206?needAccess=true)  - from Unpaywall

**Abstract:** Considerable controversy is haunting the treatment of IPF 'acute exacerbation', its most devastating complication. The consensus coined term 'acute exacerbation' implies that on an unknown etiology disease such as IPF, an unknown etiology superimposed acute lung injury/acute respiratory distress syndrome (ALI/ARDS) represents the end-life event in a consistent proportion of patients and are treated by high dose steroids despite unproven benefit. Inversely, ALI/ARDS treatment recommendations are based on the provision of excellent supportive care plus an extensive search and appropriate treatment of the etiologic precipitant and all intensive care clinicians in the absence of an obvious etiology, considering that occult infection is the most probable and also the most treatable underlying condition, universally administer extensive spectrum antimicrobials. Viewing the persistent high mortality in IPF 'acute exacerbations' treated with steroids we strongly believe that a study comparing the two arms of the steroid and non-steroid approach is greatly awaited by scientists and owed to the patients. © Informa Uk, Ltd.

**Database:** EMBASE

**34. Management of psychosis and schizophrenia in adults: summary of updated NICE guidance**

**Author(s):** Kuipers, Elizabeth; Yesufu-Udechuku, Amina; Taylor, Clare; Kendall, Tim

**Source:** BMJ : British Medical Journal (Online); Feb 2014; vol. 348 ; p. n

**Publication Date:** Feb 2014

**Publication Type(s):** Journal Article

Available at  [BMJ : British Medical Journal (Online)](http://www.bmj.com/cgi/doi/10.1136/bmj.g1173)  - from BMJ Journals

Available at  [BMJ : British Medical Journal (Online)](http://www.bartshealth.nhs.uk/education/knowledge-and-library-services/request-an-article-or-book)  - from Request from Barts Health - Whipps Cross University Hospital Local Print Collection [location] : Request from Barts Health - Whipps Cross University Hospital.

Available at  [BMJ : British Medical Journal (Online)](http://bartshealth-nhs.libsurveys.com/Barts-Health-NHS-Trust-Knowledge-and-Library-Services-Article-Request-Form)  - from Request from Barts Health - Newham University Hospital Local Print Collection [location] : Request from Barts Health - Newham University Hospital.

Available at  [BMJ : British Medical Journal (Online)](http://www.bmj.com/content/bmj/348/bmj.g2234.full.pdf)  - from Unpaywall

**Abstract:** 1 These disorders, which are characterised by distressing hallucinations and delusions, disturbed behaviour, and memory and motivation problems, present a major personal, 2 social, 3 clinical, 4 and financial 5 challenge.
[...]poor physical health is strongly associated with schizophrenia, with men dying 20 years earlier than the general population and women dying 15 years earlier, 6 7 mainly from illnesses such as cardiovascular disease, diabetes, chronic obstructive pulmonary disease, HIV infection, hepatitis C, and tuberculosis. 8 Difficulties in people with severe mental illness accessing general medical services in primary and secondary care contribute to reduced life expectancy. 9 Although many people with psychosis and schizophrenia respond to antipsychotic drugs initially, around 80% relapse within five years, partly because they discontinue medication, 10 which for many people has unacceptable side effects.
(Amended recommendation.) [Based on the experience and opinion of the GDG] Before starting antipsychotic medication Undertake and record the following baseline investigations: - Weight (plotted on a chart) - Waist circumference - Pulse and blood pressure - Fasting blood glucose, glycated haemoglobin (HbA1c), blood lipid profile, and prolactin levels - Assessment of any movement disorders - Assessment of nutritional status, diet, and level of physical activity.
[Based on the experience and opinion of the GDG] Monitoring antipsychotic medication Monitor and record the following regularly and systematically throughout treatment, but especially during titration: - Response to treatment, including changes in symptoms and behaviour - Side effects of treatment, taking into account overlap between certain side effects and clinical features of schizophrenia (such as the overlap between akathisia and agitation or anxiety) and impact on functioning - Emergence of movement disorders - Weight, weekly for the first six weeks, then at 12 weeks, at one year, and then annually (plotted on a chart) - Waist circumference annually (plotted on a chart) - Pulse and blood pressure at 12 weeks, at one year, and then annually - Fasting blood glucose, HbA1c, and blood lipid levels at 12 weeks, at one year, and then annually - Adherence to treatment - Overall physical health.
Future research and remaining uncertainties The clinical and cost effectiveness of - Peer support interventions in people with psychosis and schizophrenia - Psychological intervention alone, compared with treatment as usual, in people with psychosis or schizophrenia who choose not to take antipsychotic drugs The short and long term benefits to physical health of guided medication discontinuation or reduction in first episode psychosis and whether this can be achieved without major risks How the benefits of early intervention in psychosis services can be maintained once service users are discharged after three years The benefit of a trauma reprocessing intervention based on cognitive behavioural therapy for post-traumatic stress disorder symptoms in people with psychosis and schizophrenia The members of the Guideline Development Group were Elizabeth Kuipers (chair), Tim Kendall (facilitator), Amina Yesufu-Udechuku (systematic reviewer), Max Birchwood, Alison Brabban, Nadir Cheema (health economist), Debbie Green, Bronwyn Harrison (research assistant), Zaffer Iqbal, Sonia Johnson, Tom Lochhead, Max Marshall, Evan Mayo-Wilson (senior systematic reviewer), Jonathan Mitchell, Tony Morrison, Maryla Moulin (project manager), David Shiers, Eric Slade (health economist), Sarah Stockton (senior information scientist), Clare Taylor (senior editor), Clive Travis, Rachel Waddingham, Peter Woodhams, and Norman Young.

**Database:** BNI

**35. [Congenital cystic lung lesions--review of the literature with three clinical cases].**

**Author(s):** Slancheva, B; Hitrova, S; Markov, D; Vakrilova, L; Pramatarova, T; Yarukova, N; Brankov, O

**Source:** Akusherstvo i ginekologiia; 2013; vol. 52 (no. 2); p. 26-32

**Publication Date:** 2013

**Publication Type(s):** Case Reports English Abstract Journal Article Review

**PubMedID:** 23807978

**Abstract:** Congenital cystic lung lesions are rare. Mainly affects the lower respiratory patishta.i are congenital cystic malformation and adematozna bronchopulmonary sequestration (BPS). The pathogenesis of the occurrence of these malformations is not clear but they have a common clinical course. In most cases, the anomaly is asymptomatic and occurs with infections of the lung during the first year of life. Currently congenital lung lesions were classified into five types and is considered by most authors. The anomaly is due to the abnormal proliferation of terminal bronchioles accompanied by inhibition of alveolar development between 7-17 weeks, obstructed airway dysplasia and metaplasia of normal lung tissue. Early diagnosis is vital in making a medical decision on how to treat CCAM. Associated with abnormalities of the urinary tract, cardiovascular system, gastrointestinal atresia, diaphragmatic hernia skeletal abnormalities. In pregnancies in which prenatal lung lesions weighs registered necessary series of ultrasound examinations to track finding and using the Doppler to assess how the blood supply of the fault. The clinical presentation of malformations is respiratory distress, respiratory infection, and dyspnea. The use of CT and MRA allows better visualization of the pulmonary lesions. With its combination with arteriography and bronchoscopy are used to differentiate CCAM and pulmonary sequestration. We present three cases with lung lesions were born in Neonatologia clinic at the University Hospital of Obstetrics and Gynecology "Maternity" Sofia for the period 2010-2012 three cases CCAMs type 1, operated by 5 meters after birth with a good final outcome without complications in the postoperative period and lack of pulmonary symptoms up to 1 year after birth.

**Database:** Medline

**36. Singapore Health and Biomedical Congress, SHBC 2013**

**Author(s):** anonymous

**Source:** Annals of the Academy of Medicine Singapore; 2013; vol. 42

**Publication Date:** 2013

**Publication Type(s):** Conference Review

**Abstract:** The proceedings contain 327 papers. The special focus in this conference is on Health and Biomedicine. The topics include: Reducing the rate of postoperative endophthalmitis over 11 years-results of a new intervention using intracameral antibiotics; corpus callosum morphology in first episode and chronic schizophrenia; differences in late cardiovascular mortality following acute myocardial infarction among three major Asian ethnicities; exploring relationship of retinal thickness on optical coherence tomography and visual acuity in patients with diabetic macular edema; medication reconciliation in outpatient hospital clinics; utilising discharge planning tools in an inpatient psychiatric rehabilitation services to promote positive clinical outcomes; seven-point subjective global assessment is more time sensitive than conventional subjective global assessment in detecting nutritional changes; Singapore hospice nurses perspectives about spirituality and spiritual care; enhanced infarct stabilisation and cardiac repair with an injectable PEGylated-fibrinogen hydrogel carrying vascular endothelial growth factor (VEGF); identification of tumour suppressive MicroRNAs in multiple myeloma by pharmacologic unmasking; use of a novel stereographic projection software to calculate precise area of peripheral non-perfusion and its correlation with manual grading; a protocol to reduce inter-reviewer variability in computed tomography measurement of orbital floor fractures; impact of genome wide supported psychosis susceptibility NRGN gene on thalamocortical morphology in schizophrenia; improved outcome of myeloma patients in a tertiary hospital; femoral neck fractures-factors affecting ambulatory status in elderly patients more than 65 years old who underwent hip hemiarthroplsty; exploratory factor analysis of the Zarit burden interview in a multi-ethnic Asian community sample; prevalence, awareness, treatment and control of hypertension among Singapore elderly residential population; predictive factors of unscheduled 15-day hospital readmissions; lost in transition-newly qualified registered nurses and their transition to practice journey; national healthcare group clinical educators reflection on web2.0's application in enhancing teaching and lifelong learning in medical education; determinants of clarification studies in medical education research; hypoglycemia management of patients with type 2 diabetes in primary care setting; photograph-assisted dietary review amongst type 2 diabetics in primary care; exploring the feasibility of advanced care planning in persons with early cognitive impairment; roles of miR-186 in circulating tumour cells (CTCs)-mediated metastasis in breast cancer; characterisation of the biological and clinical relevance of RUNX genes in natural killer T-cell lymphoma; a randomised controlled trial comparing single-injection and continuous femoral nerve blocks with patient-controlled analgesia; magnetic resonance imaging (MRI) changes in lower limbs in transition to frailty; prevalence of dilutional hyponatraemia in inpatients and outpatients in Singapore; a prospective randomised study on the patency period of the plastic anti-reflux biliary stent; an academic-practice collaboration through simulation learning; a multicentre study of physiotherapists' knowledge and perceptions in palliative care; post discharge pain experiences following total knee arthroplasty; characteristics of subjective QOL of elderly people with dementia in china and Japan; audit of readmissions to a palliative care unit in a tertiary hospital; factors affecting psychological distress in informal caregivers of Singapore elderly; prevalence of anaemia in patients on aspirin medication in a primary care setting; patient satisfaction with pharmacist-managed hypertension-diabetes-lipids clinic and its relation to medication adherence and beliefs about medication; anthropometric measures and cognition in the Singapore elderly; clinical decision support for high-priority drug-drug interactions; a normative study on the national university health system aphasia screening test; a pilot study on the integration of a cognitive-behavioral therapy-based computer game in the clinical treatment of childhood anxiety; barriers of whole-grain intake among healthcare workers in national healthcare group polyclinics; a novel approach to lead screening; effects of computed tomography contrast on bone scans; prevalence and predictors of employment among the Singaporean elderly; evaluating the impact of inpatient accelerated palliative radiation therapy programme in reducing inpatient hospitalisation; socio-demographic correlates of positive mental health; unravelling the relationship between obesity, schizophrenia and cognition; relationship between measures of mental health and functional impairment in primary care; body mass index of elderly persons in Singapore; improving the influenza and pneumococcal vaccination rate of eligible patients with chronic heart failure; reducing near misses from packing errors in inpatient pharmacy; pharmacy-led smoking cessation clinic in dermatology; investigation of high platelet count in random platelet unit and its viability; public attitudes towards mentally-ill persons in Singapore; revisiting the association between parental bonding and risk for psychopathology; pharmacist reviews and outcomes in nursing homes in Singapore; evaluation of the inpatient smoking cessation programme in tan Tock Seng hospital; community forums are effective in improving osteoporosis knowledge; profile of patients referred for podiatry services in primary care; novel use of tigecycline for multiple myeloma in vitro-alternative non-mitochondrial pathways; linking human leucine-rich repeat kinase 2 (LRRK2) gene mutation to cancer development; haploinsufficiency of TP53 in multiple myeloma; bioactive and conductive collagen scaffold for wound healing augmented by electrical stimulation; systematic discovery of novel cilia and ciliopathy genes through functional genomics in the zebrafish; extracellular matrix-based biohybrid skin substitutes; enzyme sensor system for determination of total cholesterol in human serum; intestinal microbial study of gout patients; differences in gut microbiome between schizophrenic patients and healthy individuals; changes in gait associated with sarcopenia; noncultured cellular grafting for vitiligo-a three-year follow-up study; bariatric surgery and its impact on sleep; clinico-epidemiological profile of moderate to severe paediatric atopic dermatitis; influenza vaccination of healthcare workers; a snapshot of audits in the phototherapy unit; a naturalistic longitudinal study in healthy children; retrospective study on autoimmune blistering disease in paediatric patients; association between CHA65S2 score and obstructive sleep apnoea; primary localised cutaneous amyloidosis; high STOP-BANG scores herald adverse perioperative outcomes; neurobehavioral outcomes after traumatic brain injury; extended outcomes by dialysis modality selection in incident patients with end-stage renal disease and ischaemic cardiomyopathy; laparoscopic gastrectomies in gastric cancer patients; survey on factors influencing medication adherence in psychiatric patients; serum brain-derived neurotrophic factor and metabolic indices in patients with schizophrenia; outcomes of non-Tbitrauma patients in a surgical intensive care unit; evaluation of patients screened for MERS-CoV infection at tan Tock Seng hospital, Singapore; thinking twice before using the LMA for obese and older patients-a prospective observational study; comparison study between two apheresis machines; diabetes knowledge in older adults with type 2 diabetes in Singapore; establishing an intensive care unit database; necrotising fasciitis of the head and neck; diabetic chronic kidney disease patients should increase protein intake; the skin-endocrine axis in the management of dermatology patients; de

**Database:** EMBASE

**37. Pain**

**Author(s):** Johnson M.J.

**Source:** Journal of Thoracic Oncology; Nov 2013; vol. 8

**Publication Date:** Nov 2013

**Publication Type(s):** Conference Abstract

Available at  [Journal of Thoracic Oncology](https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS1556086415336261%3Fgoto%3Dsd)  - from ScienceDirect

Available at  [Journal of Thoracic Oncology](http://ovidsp.ovid.com/athens/ovidweb.cgi?T=JS&PAGE=fulltext&D=ovft&CSC=Y&NEWS=N&SEARCH=1556-0864.is+and+%228%22.vo+and+%2211%22.ip+and+%22S2%22.pg+or+%2210.1097/01.JTO.0000438438.14562.c8%22.di)  - from Ovid (Journals @ Ovid) - Remote Access

Available at  [Journal of Thoracic Oncology](http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=fulltext&D=ovft&CSC=Y&NEWS=N&SEARCH=1556-0864.is+and+%228%22.vo+and+%2211%22.ip+and+%22S2%22.pg+or+%2210.1097/01.JTO.0000438438.14562.c8%22.di)  - from Ovid (Journals @ Ovid) - London Health Libraries

Available at  [Journal of Thoracic Oncology](http://www.jto.org/article/S1556086415336261/pdf)  - from Unpaywall

**Abstract:** Pain in lung cancer Lung cancer is the most common cancer globally with 1.6 million people diagnosed with the disease during 2008; over half of them in the developing world. Nearly 90% are due to smoking, or passively smoking, tobacco. The mortality to incidence ratio is 0.86, reflecting dismal survival [http//:globocan.iarc.fr/factsheet.asp] . Therefore, the focus of care remains one of palliation despite increased options for cancer directed treatment. Optimal symptom relief must play a central role. A systematic review of pain in people in with lung cancer found an overall weighted mean prevalence of pain in 47% patients (6 - 100%); the wide variation reflecting the different patient settings (1). However, for studies in general hospitals, just over one third of lung cancer patients had pain, and the weighted mean prevalence in a cancer treatment centre was 65%. Most pain is attributed to the cancer, either directly, or due to treatment (weighted mean prevalence; 13%). Pain is most common in the chest, then, pain in the spine. Patients may have multiple sites of pain, with other symptoms such as breathlessness, cough, and fatigue; pain considered to be one of the top three most distressing. Severe pain is associated with reduced survival, and interferes with function, enjoyment of life, mood and work(2). According to surviving relatives, of the 85% patients who had pain in the last year of life, over 50% found it very distressing(3). Management Assessment. All symptom management should start with a full assessment which extends beyond physical concerns into psychosocial and spiritual domains, and treatments (and involvement of relevant team members) tailored to the needs of the individual, remembering the effect on their family and friends. There are many extensive pain assessment tools which are not easy to use in daily clinical practice. Systematic assessment of every patient attending clinic, or admitted to hospital is often overlooked, but simple aide memoirs for the busy clinician are available and effective( 4), or simple screening patient report scales. Where patient reported symptoms have been embedded in oncology clinical practice and linked to symptom management protocols, outcomes have improved(5-7). Symptom monitoring should be related to factors that patients rate as important such as effect on function and relationships with family and friends rather than a score(8). The liNKIng of assessment to education (clinician and patient) and clinical guidance is important and shown to be more effective than education alone(9). Interventions for pain control Radiotherapy. Most pain is from the primary tumour, often with haemoptysis and cough. Palliative radiotherapy is effective but not extensively documented. One RCT study in non-small cell lung cancer shows improvement in pain in three quarters. Other symptoms also improved, along with function and wellbeing(10). Bony metastases are common in lung cancer, if present over 55% lead to one or more skeletal related events. Palliative radiotherapy is the most effective treatment. Onset of relief is between a condifew days and 1 month, and lasts between 3 to 6 months(11;12). A Cochrane review in 2000 calculated a number needed to treat to give complete relief in one patient at one month as 4.2 (95% CI 3.7 - 4.7)(13). A single fraction of 8Gy is as effective as higher multifractionated doses for the acute relief of pain, although of shorter duration(14). Opioids and other analgesics. The WHO analgesic ladder remains the standard approach to analgesic use in cancer pain with morphine still the most cost-effective first line strong opioid; cheaper than the equally effective oxycodone(15;16). In the presence of significant renal dysfunction, fentanyl, alfentanil and methadone are the least likely to cause harm (17). A systematic review confirms a small further benefit with the addition of a nonsteroidal anti-inflammatory drug (NSAID), although the contributory studies were too small to comment on toxicity(18). Given the recent data on cardiovascular toxicity of NSAIDS, naproxen and low dose ibuprofen appear to be the safest in this group(19). Incident pain due to bone metastases is difficult to manage with analgesics alone because the direct relationship to periods of activity; the average duration of incident pain is 60 minutes and so may be improving before oral morphine may be fully absorbed. The newer transmucosal fentanyl preparations may be more helpful, with an onset of action of 10 minutes(20). Neuropathic pain often contributes to difficult to manage cancer pain. Opioids may provide benefit and a trial should be given. Standard adjuvant analgesics such as tricyclic antidepressants (duloxetine, amitriptyline) and anticonvulsants (gabapentin and pregabalin) and topical agents (capsaicin and lidocaine) may help but good quality trials in cancer pain are lacking(21). A recent RCT of ketamine for the palliation of refractory cancer pain found no benefit with ketamine(22). Another in patients with better performance status and where neuropathic pain is deemed to be the primary aetiology is almost closed to recruitment [ClinicalTrials. gov Identifier: NCT01316744]. Corticosteroids are commonly used for cancer pain although the evidence base is scant; a systematic review only found "low level evidence" for benefit (23). Bisphosphonates. Bisphosphonates are not routinely used for patients with lung cancer. A recent systematic review of bisphosphonate use in small cell lung cancer demonstrated improved pain control (RR 1.18; 95% CI 1.0 - 1.4), reduced skeletal related events (RR 0.81; 95% CIs 0.67 - 0.97) (24). However, many of the studies were of poor quality. Toxicity is usually restricted to transient flu-like or gastro-intestinal symptoms, but 15% of those with zoledronic acid developed renal dysfunction and 5% the distressing side-effect of osteonecrosis of the jaw. Newer agents such as denosumab may be tolerated better, but comparative trials in lung cancer are awaited. For the future In spite of these options, cancer pain, in general, is under-treated even where there is good access. Barriers include fear of, and poor education about, opioids in both patients and clinicians with consequent respective poor compliance and prescribing, and a lack of systematic screening of patient symptoms with full assessment if needed. Until assessment and management of pain is embedded into daily clinical practice, this feared symptom will remain a problem.

**Database:** EMBASE

**38. Assessment and management of delirium: a focus on hepatic encephalopathy.**

**Author(s):** Coggins, Candace C; Curtiss, Carol P

**Source:** Palliative & supportive care; Aug 2013; vol. 11 (no. 4); p. 341-352

**Publication Date:** Aug 2013

**Publication Type(s):** Journal Article Review

**PubMedID:** 23040331

Available at  [Palliative & supportive care](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1478-9515&volume=11&issue=4&spage=341)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Palliative & supportive care](http://pdfs.semanticscholar.org/3789/9fb39a052559095b83997f15bbb334000a6b.pdf)  - from Unpaywall

**Abstract:** This purpose of this article is to promote comprehensive assessment, differential evaluation and provision of care which optimizes benefit while minimizing burden. Delirium is a debilitating neuropsychiatric complication that is highly prevalent in palliative care. It is multifactorial and may be related to infection, disease progression, metabolic state or medication toxicity. There are three proposed sub-types of delirium with the hypoactive/ hypoalert variant being most often underdiagnosed and undertreated. The inadequate management of all types of delirium is associated with increased personal and family distress, lengthier hospital stays, and escalating healthcare costs. This article reviews the assessment, diagnosis and treatment for delirium in general and hepatic encephalopathy in particular. A number of valid and reliable tools are discussed, as they assist in screening, symptom appraisal, diagnosis, and treatment planning. It is recognized that nurses are particularly well positioned to make bedside observations, to document changes over time, and to educate and support patients and their families. Searching for the etiology of delirium, developing individualized plans of care consistent with patient goals, and endorsing the benefit of consultation/referral are discussed as key roles for palliative care providers from all disciplines. New and novel therapies in the management of hepatic encephalopathy are discussed, as they expand treatment options for patients at all points along the trajectory of liver disease.

**Database:** Medline

**39. Clinical course of ICU patients with severe pandemic 2009 influenza a (H1N1) pneumonia: Single center experience with proning and pressure release ventilation**

**Author(s):** Sundar K.M.; Thaut P.; Nielsen D.B.; Alward W.T.; Pearce M.J.

**Source:** Journal of Intensive Care Medicine; 2012; vol. 27 (no. 3); p. 184-190

**Publication Date:** 2012

**Publication Type(s):** Review

**PubMedID:** 21593048

**Abstract:** Background: A number of different modalities have been employed in addition to conventional ventilation to improve oxygenation in patients with severe 2009 pandemic influenza A (H1N1) pneumonia. Outcomes with ventilatory and rescue therapies for H1N1 influenza-related acute respiratory distress syndrome (ARDS) have been varied.1-6 A single intensive care unit (ICU) experience with management of laboratory-confirmed 2009 pandemic influenza A (H1N1) ARDS with a combination of proning and airway pressure release ventilation (APRV) is described. Method(s): A retrospective review of medical records of ICU patients seen at Utah Valley Regional Medical Center during the first and second waves of the H1N1 influenza pandemic was done. Result(s): Fourteen ICU patients were managed with invasive ventilation for 2009 pandemic influenza A (H1N1)-related ARDS. Hypoxemia refractory to conventional ventilation was noted in 11 of 14 patients despite application of APRV. Following proning in patients on APRV, improvement of hypoxemia and hemodynamic status was achieved. Only 2 of 11 patients on APRV and proning required continuous dialysis. Mortality in intubated patients receiving a combination of proning and APRV was 27.3% (3/11) with 2 of these dying during the first wave of the H1N1 influenza pandemic. In all, 3 of 11 patients on proning and APRV underwent tracheostomy, with 2 of these undergoing tube thoracostomy. ARDSnet fluid-conservative protocol was safely tolerated in 8 of 11 of the intubated patients following initiation of proning and APRV. Conclusion(s): Proning in combination with APRV provides improvement of hypoxemia with limitation of end-organ dysfunction and thereby facilitates recovery from severe 2009 pandemic influenza A (H1N1). © 2012 The Author(s).

**Database:** EMBASE

**40. Reconstruction of groin defects following radical inguinal lymphadenectomy: an evidence based review.**

**Author(s):** Murthy, Vijayashree; Gopinath, K S

**Source:** Indian journal of surgical oncology; Jun 2012; vol. 3 (no. 2); p. 130-138

**Publication Date:** Jun 2012

**Publication Type(s):** Journal Article

**PubMedID:** 23730102

Available at  [Indian journal of surgical oncology](http://europepmc.org/search?query=(DOI:10.1007/s13193-012-0145-3))  - from Europe PubMed Central - Open Access

Available at  [Indian journal of surgical oncology](http://europepmc.org/articles/pmc3392480?pdf=render)  - from Unpaywall

**Abstract:** Inguinal lymph node involvement is an important prognostic and predictive factor in various neoplasms of the genitalia and lower limb. As part of the multimodality approach, these patients undergo surgery and adjuvant radiotherapy. Morbidity of inguinal lymphadenectomy includes lymphedema, lymphorrhea and infection; however the most common distressing complication is skin necrosis. Myocutaneous flaps have been the most popular form of primary or delayed groin reconstruction. This paper aims to critically review the different myocutaneous flaps used in groin reconstruction, discuss evidence based data on the versatility and utility of these flaps and discuss ways in which modifications maybe incorporated in treatment and radiation planning following groin reconstruction. A comprehensive search of the scientific literature was carried out using PubMed to access all publications related to groin reconstruction. The search focused specifically on current management, technique, safety and complications of these procedures. Keywords searched included "inguinal lymphadenectomy", "primary reconstruction", "musculocutaneus flap", "myocutaneous flap", "tensor fascia lata flap", "anterolateral thigh flap", "rectus abdominis flap". Low to middle income countries witness a huge burden of locally advanced genital malignancies and melanoma of the lower extremity. Higher tumor burden both at the primary site as well as the inguinal basin requires surgery as the primary modality of treatment. Groin reconstruction is required not only to prevent femoral blowouts but also for early administration of adjuvant radiation. The versatility of tensor fascia lata, anterolateral thigh, and rectus abdominis flaps is useful to cover the defect, provide radiation, eradicate pain and achieve good palliation. Assessment of aesthetic and functional outcomes of one flap over the other and the "ideal" form of reconstruction for groin defects needs additional investigation.

**Database:** Medline

**41. POSTER PRESENTATIONS...Conference of the World Society of Arrhythmias, in Athens, Greece, 11–14 December 2011.**

**Author(s):**

**Source:** Pacing & Clinical Electrophysiology; Nov 2011; vol. 34 (no. 11); p. 1362-1451

**Publication Date:** Nov 2011

**Publication Type(s):** Academic Journal

Available at  [Pacing & Clinical Electrophysiology](https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Fonlinelibrary.wiley.com%2Fdoi%2Ffull%2F10.1111%2Fj.1540-8159.2011.03252.x)  - from Wiley Online Library Medicine and Nursing Collection 2019 - NHS

**Abstract:** ANTIARRHYTHMICS P001 THE ANTI-ARRHYTHMIC EFFECTS OF STATINS IN PATIENTS WITH CORONARY ARTERY DISEASE AND IMPLANTABLE CARDIOVERTER DEFIBRILLATORS Panattoni G; Papavasileiou LP; Della Rocca DG; Cioè R; Magliano G; Topa A; Sergi D; Santini L; Forleo GB; Romeo F Cardiology Department, University of Tor Vergata, Rome, Italy Introduction: A few studies have suggested that statins may have anti-arrhythmic effects in patients with coronary artery disease. One proposed mechanism for the antiarrhythmic effect of statins is their antioxidant properties. The aim of our study was to determine whether statin therapy could reduce mortality, the occurrence of ventricular arrhythmias and appropriate or inappropriate intervention of the device in patients with implantable cardioverter defibrillators (ICDs). Methods: We investigated 244 consecutive patients with coronary artery disease who received ICDs at our institution between April 2003 and November 2010. Patients were subdivided into "statin" (n = 177, 153 males, age 67.4 ± 10.2 years) and "no-statin" (n = 67, 56 males, age 71.4 ± 8.2 years) groups based on the use of statins. Results: Mean follow-up was 20,6 ± 17,2 months and the two groups were homogeneous regarding antiarrhythmic therapy and ejection fraction. The overall incidence of non-sustained (NSVTs) was lower among the statin group when compared with the no-statin group (44 vs 31 patients, p = 0.02). No significant differences were found in the overall mortality (25 vs 12 patients, p = ns). The use of statin did not reduced significantly the occurrence of appropriate or inappropriate intervention of the device (31 vs 20 patients, p = 0.09 and 9 vs 3 patients, p = ns respectively) and of therapy. Conclusions: In our study statin therapy is associated with a lower incidence of non-sustained ventricular tachycardias in patients with coronary artery disease and ICDs but does not influence overall mortality and appropriate or inappropriate intervention of the device. P002 QUINIDINE: AN "ENDANGERED SPECIES" DRUG APPROPRIATE FOR MANAGEMENT OF ELECTRICAL STORM IN BRUGADA SYNDROME Theofilogiannakos EK; Paraskevaidis S; Kamperidis V; Chatzizisis Y; Tsilonis K; Dakos G; Vassilikos V; Styliadis IH 1st Cardiology Department, AHEPA Hospital, Aristotle University Medical School, Thessalon The clinical manifestation of Brugada Syndrome (BS) varies from asymptomatic form to electrical storm and sudden cardiac death. We report two cases of BS that were presented with electrical storm. A 38-year-old man, who was treated with ICD implantation two years ago presented to our emergency department with electrical storm (i.e. three episodes of ventricular tachycardia in the same day) provoking shocks from the ICD. On admission, the patient was on a febrile status due to pneumonia that may was the predisposing factor that lead to the electrical instability. The second patient was a 75-year-old man, who was treated with ICD implantation nine years ago, was admitted for seven episodes of ventricular fibrillation within 24 hours that was successfully treated with ICD shocks. There was no predisposing factor that could lead to the electrical instability. Since the ICD implantation both patients did not receive any medication. Both patients were started on oral hydroquinidine (600 mg twice daily), remaining electrical stable for the rest of their hospitalization. After six months of hydroquinidine treatment the patients were also asymptomatic without any recorded ICD therapy. Recently, a discussion was initiated among electrophysiologists concerning quinidine shortage in the drug market. Quinidine is effective medical treatment for patients with short QT syndrome, BS and a subgroup of idiopathic ventricular fibrillation. Electrical storms in patients with the above syndromes should be treated with ICD. However, since ICD does not prevent the occurrence of arrhythmias, oral quinidine could be a reasonable choice for long-term prevention of life-threatening tachyarrhythmias. P003 SMALL NUMBER OF CANDIDATES FOR ANTIARRHYTHMIC DRUGS IDENTIFIED BY DATA FROM IMPLANTED PACEMAKERS Fisher JD; Yedlapati N; Rosal-Greif V Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY, USA Background: Modern pacemakers (pacers) quantify atrial fibrillation (AF) episodes and overall burden (% of time in AF). Many AF episodes are asymptomatic but still can be stroke risks. Records of 742 consecutive pacer checks were reviewed by a single investigator (JDF). Objective: To determine see how many patients (pts) had AF and might be candidates for antiarrhythmic drug (AAD) therapy. Methods: Charts were reviewed on or near the day of the in-office pacer check. Pts were considered potential candidates for AAD therapy if they had dual chamber pacers (DDD), and electrograms showing AF or flutter burden between 1% and 99%, confirmed after 1 more month. 80% of patients had dual chamber pacers. Patients with single chamber pacers were excluded because in our practice these are used in AF patients when there is no intention of restoring sinus rhythm. Other exclusions were: Severe Co-Morbidities – 9; Demented, aged – 10;Already on AAD – 8; MDs refused – 4;Patient refused – 17; AF disappeared – 8Chronic AF – 2; Language barrier – 13;Died – 1; SVT not AF – 2; Lost – 4; Moved – 2; Too Recent implant – 1 There were 11.3% non-excluded DDD Patients with 1–99% AF. The Average% AF (Burden)was 24%. Conclusion: AF can be detected and quantified in DDD pacemaker patients, but only a low percentage go on to have appropriate antiarrhythmic drugs administered. P004 CHRONIC USE OF AMIODARONE IN ICD RECIPIENTS Santini L; Cioè R; Magliano G; Viele A; Minni V; Forleo GB; Mahfouz K; Sergi D; Topa A; Romeo F Department of Cardiology, University of Rome "Tor Vergata," Rome, Italy Purpose: Amiodarone is one of the most studied and used drug to treat life-threatening ventricular arrhythmias. The aim of our study was to evaluate the influence of use of amiodarone on the outcomes of patients receiving implantable cardioverter defibrillator (ICD). Methods: We enrolled 428 consecutive patients (358 males, mean age 66,8 ± 11.3 years) who underwent ICD implantation at our Institute between September 2003 and January 2011. We subdivided patients in two groups regarding the used of amiodarone in chronic treatment. The Amiodarone + group (n = 161 patients, 139 males, 68.2 ± 10.6 years) and the Amiodarone- (n = 267, 219 males, 66.0 ± 11.6 years). Results: Groups resulted to be homogenous regarding age, sex, ejection fraction and underlying heart disease. After a mean follow-up of 22,1 ± 18.0 months, 38 patients (23.6%) in Amiodarone + group experienced appropriate discharges versus 46 patients (17.2) in the Amiodarone − group (p = ns); while the incidence of inappropriate discharges was 5% (8 pts) and 6.7% (18 pts) respectively (p = ns). The incidence of TVNS was 26% (42 pts) vs 34% (91 pts) respectively (p = ns). No significant difference was found about mortality due to cardiovascular diseases (10/161 pts vs 18/267, p = ns). Conclusions: As reported by major clinical trials only the use of ICD influence mortality when compared to antiarrhythmic treatment. The chronic use of amiodarone in ICD recipients does not influence occurrence of major arrhythmic events, nevertheless reduces total number of events per patient. P005 ATRIAL TACHYARRHYTHMIA DECREASES VENTRICULAR MICROPERFUSION DURING AMIODARONE BUT NOT DURING DRONED- ARONE TREATMENT Hammwohner M; Bukowska A; Sixdorf A; Roehl FW; Lendeckel U; Goette A St.Vincenz Hospital Paderborn, Germany Atrial fibrillation (AF) is associated with an increased risk for acute coronary syndromes. AF-induced ischemia seems to be related to disturbance of ventricular microcirculation. This study was conducted to evaluate the effects of dronedarone (DRO) and amiodarone (AMIO) infusion on ventricular macro- and microperfusion during rapid atrial pacing (RAP). Coronary flow reserve (CFR, microvascular

**Database:** CINAHL

**42. Unusual applications of noninvasive ventilation.**

**Author(s):** Ambrosino, N; Guarracino, F

**Source:** The European respiratory journal; Aug 2011; vol. 38 (no. 2); p. 440-449

**Publication Date:** Aug 2011

**Publication Type(s):** Journal Article Review

**PubMedID:** 21349915

Available at  [The European respiratory journal](http://erj.ersjournals.com/cgi/doi/10.1183/09031936.00192810)  - from HighWire - Free Full Text

Available at  [The European respiratory journal](https://erj.ersjournals.com/content/erj/38/2/440.full.pdf)  - from Unpaywall

**Abstract:** The use of noninvasive ventilation (NIV) in acute hypercapnic respiratory failure, cardiogenic pulmonary oedema, acute lung injury/acute respiratory distress syndrome (ARDS), community-acquired pneumonia and weaning/post-extubation failure is considered common in clinical practice. Herein, we review the use of NIV in unusual conditions. Evidence supports the use of NIV during fibreoptic bronchoscopy, especially with high risks of endotracheal intubation (ETI), such as in immunocompromised patients. During transoesophageal echocardiography as well as in interventional cardiology and pulmonology, NIV can reduce the need for deep sedation or general anaesthesia and prevent respiratory depression induced by deep sedation. NIV may be useful after surgery, including cardiac surgery, and, with a lower level of evidence, in patients with pulmonary contusion. NIV should not be considered as an alternative to ETI in severe communicable airborne infections likely to progress to ARDS. NIV is being used increasingly as an alternative to ETI in end-stage symptomatic patients, especially to relieve dyspnoea. The role of assisted ventilation during exercise training in chronic obstructive pulmonary disease patients is still controversial. NIV should be applied under close monitoring and ETI should be promptly available in the case of failure. A trained team, careful patient selection and optimal choice of devices, can optimise outcome of NIV.

**Database:** Medline

**43. Extracorporeal lung support technologies - bridge to recovery and bridge to lung transplantation in adult patients: an evidence-based analysis.**

**Author(s):** Medical Advisory Secretariat

**Source:** Ontario health technology assessment series; 2010; vol. 10 (no. 5); p. 1-47

**Publication Date:** 2010

**Publication Type(s):** Journal Article

**PubMedID:** 23074408

**Abstract:** UNLABELLEDFor cases of acute respiratory distress syndrome (ARDS) and progressive chronic respiratory failure, the first choice or treatment is mechanical ventilation. For decades, this method has been used to support critically ill patients in respiratory failure. Despite its life-saving potential, however, several experimental and clinical studies have suggested that ventilator-induced lung injury can adversely affect the lungs and patient outcomes. Current opinion is that by reducing the pressure and volume of gas delivered to the lungs during mechanical ventilation, the stress applied to the lungs is eased, enabling them to rest and recover. In addition, mechanical ventilation may fail to provide adequate gas exchange, thus patients may suffer from severe hypoxia and hypercapnea. For these reasons, extracorporeal lung support technologies may play an important role in the clinical management of patients with lung failure, allowing not only the transfer of oxygen and carbon dioxide (CO(2)) but also buying the lungs the time needed to rest and heal.OBJECTIVEThe objective of this analysis was to assess the effectiveness, safety, and cost-effectiveness of extracorporeal lung support technologies in the improvement of pulmonary gas exchange and the survival of adult patients with acute pulmonary failure and those with end-stage chronic progressive lung disease as a bridge to lung transplantation (LTx). The application of these technologies in primary graft dysfunction (PGD) after LTx is beyond the scope of this review and is not discussed. CLINICAL APPLICATIONS OF EXTRACORPOREAL LUNG SUPPORT: Extracorporeal lung support technologies [i.e., Interventional Lung Assist (ILA) and extracorporeal membrane oxygenation (ECMO)] have been advocated for use in the treatment of patients with respiratory failure. These techniques do not treat the underlying lung condition; rather, they improve gas exchange while enabling the implantation of a protective ventilation strategy to prevent further damage to the lung tissues imposed by the ventilator. As such, extracorporeal lung support technologies have been used in three major lung failure case types: As a bridge to recovery in acute lung failure - for patients with injured or diseased lungs to give their lungs time to heal and regain normal physiologic function.As a bridge to LTx - for patients with irreversible end stage lung disease requiring LTx.As a bridge to recovery after LTx - used as lung support for patients with PGD or severe hypoxemia. EX-VIVO LUNG PERFUSION AND ASSESSMENT: Recently, the evaluation and reconditioning of donor lungs ex-vivo has been introduced into clinical practice as a method of improving the rate of donor lung utilization. Generally, about 15% to 20% of donor lungs are suitable for LTx, but these figures may increase with the use of ex-vivo lung perfusion. The ex-vivo evaluation and reconditioning of donor lungs is currently performed at the Toronto General Hospital (TGH) and preliminary results have been encouraging (Personal communication, clinical expert, December 17, 2009). If its effectiveness is confirmed, the use of the technique could lead to further expansion of donor organ pools and improvements in post-LTx outcomes. EXTRACORPOREAL LUNG SUPPORT TECHNOLOGIES: ECMO: The ECMO system consists of a centrifugal pump, a membrane oxygenator, inlet and outlet cannulas, and tubing. The exchange of oxygen and CO(2) then takes place in the oxygenator, which delivers the reoxygenated blood back into one of the patient's veins or arteries. Additional ports may be added for haemodialysis or ultrafiltration. TWO DIFFERENT TECHNIQUES MAY BE USED TO INTRODUCE ECMO: venoarterial and venovenous. In the venoarterial technique, cannulation is through either the femoral artery and the femoral vein, or through the carotid artery and the internal jugular vein. In the venovenous technique cannulation is through both femoral veins or a femoral vein and internal jugular vein; one cannula acts as inflow or arterial line, and the other as an outflow or venous line. Venovenous ECMO will not provide adequate support if a patient has pulmonary hypertension or right heart failure. Problems associated with cannulation during the procedure include bleeding around the cannulation site and limb ischemia distal to the cannulation site. ILA: Interventional Lung Assist (ILA) is used to remove excess CO(2) from the blood of patients in respiratory failure. The system is characterized by a novel, low-resistance gas exchange device with a diffusion membrane composed of polymethylpentene (PMP) fibres. These fibres are woven into a complex configuration that maximizes the exchange of oxygen and CO(2) by simple diffusion. The system is also designed to operate without the help of an external pump, though one can be added if higher blood flow is required. The device is then applied across an arteriovenous shunt between the femoral artery and femoral vein. Depending on the size of the arterial cannula used and the mean systemic arterial pressure, a blood flow of up to 2.5 L/min can be achieved (up to 5.5 L/min with an external pump). The cannulation is performed after intravenous administration of heparin. Recently, the first commercially available extracorporeal membrane ventilator (NovaLung GmbH, Hechingen, Germany) was approved for clinical use by Health Canada for patients in respiratory failure. The system has been used in more than 2,000 patients with various indications in Europe, and was used for the first time in North America at the Toronto General Hospital in 2006. EVIDENCE-BASED ANALYSIS: The research questions addressed in this report are: Does ILA/ECMO facilitate gas exchange in the lungs of patients with severe respiratory failure?Does ILA/ECMO improve the survival rate of patients with respiratory failure caused by a range of underlying conditions including patients awaiting LTx?What are the possible serious adverse events associated with ILA/ECMO therapy?To address these questions, a systematic literature search was performed on September 28, 2009 using OVID MEDLINE, MEDLINE In-Process and Other Non-Indexed Citations, EMBASE, the Cumulative Index to Nursing & Allied Health Literature (CINAHL), the Cochrane Library, and the International Agency for Health Technology Assessment (INAHTA) for studies published from January 1, 2005 to September 28, 2008. Abstracts were reviewed by a single reviewer and, for those studies meeting the eligibility criteria, full-text articles were obtained. Reference lists were also examined for any additional relevant studies not identified through the search. Articles with an unknown eligibility were reviewed with a second clinical epidemiologist and then a group of epidemiologists until consensus was established.INCLUSION CRITERIAStudies in which ILA/ECMO was used as a bridge to recovery or bridge to LTxStudies containing information relevant to the effectiveness and safety of the procedureStudies including at least five patientsEXCLUSION CRITERIAStudies reporting the use of ILA/ECMO for inter-hospital transfers of critically ill patientsStudies reporting the use of ILA/ECMO in patients during or after LTxAnimal or laboratory studiesCase reportsOUTCOMES OF INTERESTReduction in partial pressure of CO(2)Correction of respiratory acidosisImprovement in partial pressure of oxygenImprovement in patient survivalFrequency and severity of adverse eventsThe search yielded 107 citations in Medline and 107 citations in EMBASE. After reviewing the information provided in the titles and abstracts, eight citations were found to meet the study inclusion criteria. One study was then excluded because of an overlap in the study population with a previous study. Reference checking did not produce any additional studies for inclusion. Seven case series studies, all conducted in Germany, were thus included in this review (see Table 1). Also included is the recently published CESAR trial, a mult

**Database:** Medline

**44. Dolor en hematologia clinicaPain in clinical hematology**

**Author(s):** Aguilar J.L.; Pelaez R.; Fernandez S.; Mata J.; Valenti P.; Carbayo J.; Batet C.; Guanyabens C.; Romero P.; Santamaria J.

**Source:** Revista de la Sociedad Espanola del Dolor; 2010; vol. 17 (no. 1); p. 32-50

**Publication Date:** 2010

**Publication Type(s):** Review

Available at  [Revista de la Sociedad Española del Dolor](https://doi.org/10.1016/s1134-8046(10)70006-9)  - from Unpaywall

**Abstract:** Objective: The present review aims to provide an update on the pain management and/ or palliative care provided to patients with hematological disease, whether malignant or not. In hematology, several entities may require alleviation of pain or other distressing symptoms. It is generally acknowledged that only 5% of patients with malignant hematological disease experience pain, while this percentage ranges from 70 to 80% in other types of cancer (lung, prostate and breast, which frequently lead to bone metastases). Pain may be caused by the disease itself, due to leukemic or myelomatoid infiltration, bone destruction (75-80%), the therapies administered (15-19%), mucositis in neutropenic patients, methotrexate, thalidomide (paresthesias), bortezomib (Velcade), imatinib (Glivec), bone marrow transplantation, neurotoxicity of cytostatic agents (vincristine, cisplatin) and radiotherapy. Pain is unrelated to malignant disease in 3-5% of patients (muscular weakness and myalgia, decubitus ulcers, postherpetic neuralgia, diagnostic procedures). Classically, sickle cell disease, which is not a prevalent disease in Spain, is included among the benign hematological diseases that produce pain exacerbations. According to our experience, 10 years after our previous review on the topic, the percentage of hematological patients requiring specific management of "pain" (understood as "global pain" = physical, emotional, spiritual, social, occupational, familial...) can increase if, in addition to patients with pain, we also include those with unpleasant symptoms of varying severity throughout the course of their disease. The World health Organization (WHO) estimates that 9 million new cases of cancer occur each year, that there are 6.7 million annual deaths from cancer and that almost 25 million persons are still alive 3 years after diagnosis. Pain is moderate to intense in 40- 50% of patients and very intense or intolerable in 25-30%. The WHO predicts that there will be 15 million new cases of cancer by 2020. Hematological cancer (leukemia, lymphoma and myeloma) is the fifth most frequent form of cancer and the second most frequent cause of death from cancer. Pain management and palliative care are based on symptom control (including pain) and the provision of appropriate emotional support to patients and their families. Material, methodology and results: We provide an update of the literature and summarize our experience in pain management and palliative care. The general features of symptoms in these patients are described, and the definition and classification of pain and the terms used in pain management are discussed. Next we focus on oncohematological pain, methods to measure this pain, and the therapeutic strategy still recommended by the WHO for its control. This strategy includes the "analgesic elevator", which increases the speed in moving up the steps of the analgesic ladder when required by the situation. The concept of opioid rotation is also discussed, as well as treatment of the most common adverse effects of opioids: constipation, nausea-vomiting, drowsiness and sedation, especially in older patients. The key to successful analgesia and symptom control lies in individually tailored analgesic regimens and the use of the oral route whenever possible (leading to greater patient comfort). In particular, we describe pain related to mucositis and sickle cell disease, as well as the methodological principles in which symptom control is based and the pharmacological therapies used to relieve pain. The distinct routes of administration of these drugs are described, with their benefits and drawbacks. Conclusion(s): Only 5% of patients with hematological disease experience severe pain. Oral opioid administration, according to the analgesic scale of the WHO, is the most effective, simple and efficient (cost/effectiveness) method for the management of pain in hematological disease. Conversion tables for use in opioid rotation are available. With this approach, pain can be controlled in approximately 85% of patients. Analgesic techniques with subcutaneous infusion or catheters are also excellent methods for the management of pain in these patients, but are more expensive and complex. Such techniques are generally only necessary in the remaining 15% of patients and require a normal platelet count and, in order to prevent the risk of infection, a normal granulocyte count, as well as a rigorous clinical follow-up. © 2010 Sociedad Espanola del Dolor.

**Database:** EMBASE

**45. Oncology pain in veterinary patients.**

**Author(s):** Looney, Andrea

**Source:** Topics in companion animal medicine; Feb 2010; vol. 25 (no. 1); p. 32-44

**Publication Date:** Feb 2010

**Publication Type(s):** Journal Article Review

**PubMedID:** 20188337

Available at  [Topics in companion animal medicine](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1938-9736&volume=25&issue=1&spage=32)  - from ProQuest (Health Research Premium) - NHS Version

**Abstract:** Cancer, cancer pain, and the undertreatment of cancer pain are epidemic in both the human and veterinary medical field. Concerns over recognition, assessment, and treatment of oncologic pain in our veterinary patients are multiplied when one realizes the interaction of the primary tumor, the pain itself, and even cancer treatments with fatigue, disability, dyspnea, weakness, impaired gastrointestinal motility, cognition, and urinary/defecation issues. The patient's overall health status, as well as owner psychological and spiritual distress, plays a large part in quality-of-life decisions. We will discuss classification and assessment of cancer pain, quality-of-life issues, and therapies for managing cancer pain, including pharmacologic, nonpharmacologic, and interventional techniques. The goal will be establishment of a new oncologic treatment pyramid or scale for veterinary patients, one that will guide clinicians mechanistically into thinking through the anamnesis, physical examination, and assessment of the whole patient, and on toward diagnostics and treatments available for companion animals with cancer.

**Database:** Medline

**46. Is disease management right for oncology?**

**Author(s):** Kash K.M.; Sharma S.; Goldfarb N.I.

**Source:** Population Health Management; Dec 2009; vol. 12 (no. 6); p. 337-343

**Publication Date:** Dec 2009

**Publication Type(s):** Review

**PubMedID:** 20038260

**Abstract:** The disease management (DM) model for the treatment of chronic conditions has been around for many years and has been found to be effective for diseases of high prevalence and high cost (eg, diabetes, asthma, heart disease). With an increasing number of people living with cancer and the continual escalation of treatment costs, DM vendors have begun to implement DM concepts into cancer care. However, the multitude of cancer types, treatment options, and adverse effects have all presented barriers to oncology DM, and data reflecting the effectiveness of oncology DM have remained scarce. Oncology costs, the lack of congruence between provider and patient expectations of treatment, the lack of prevention and early detection for many cancers, and, most importantly, the inability of people to adhere to healthy lifestyles are additional obstacles that must be overcome. Moreover, when designing an oncology DM program, it is imperative to look at cancers individually as the etiology, treatment, and impact of cancer can be markedly different from one patient to the next. An effective oncology DM program is one that acts to decrease fatigue, reduces nosocomial infections, deals with dehydration and pain, manages anemia, identifies and treats skin infections, recognizes and treats depression and other psychological distress, provides patients access to palliative care services, facilitates informed decision making and end-of-life transitions, and promotes communication between patients and their providers as well as between physicians. Moving forward, DM vendors and health insurance companies capable of incorporating DM with medical management will be in the best position to provide optimal cancer care. © 2009 Mary Ann Liebert, Inc.

**Database:** EMBASE

**47. Delirium in palliative care**

**Author(s):** Alici Y.; Breitbart W.

**Source:** Primary Psychiatry; May 2009; vol. 16 (no. 5); p. 42-48

**Publication Date:** May 2009

**Publication Type(s):** Review

**Abstract:** Delirium is a common and often serious neuropsychiatric complication in palliative care settings, characterized by an abrupt onset of disturbances of consciousness, attention, cognition, and perception that fluctuate over the course of the day. Delirium, frequently the harbinger of impending death, is a sign of significant physiologic disturbance, usually involving multiple medical etiologies, including infection, major organ failure, electrolyte disturbances, and medication adverse effects. Delirium is associated with increased morbidity, causing distress in patients and caregivers, and is often the final challenge of palliative care management. Unfortunately, delirium is often under-recognized and untreated in the palliative care setting. Psychiatrists, primary care physicians, oncologists, and pain specialists must be able to diagnose delirium accurately, undertake appropriate assessment of etiologies, clarify the controversies regarding the goals of management, and understand the risks and benefits of the pharmacologic and nonpharmacologic interventions currently available for managing delirium. © MBL Communications Inc.

**Database:** EMBASE

**48. LVAD destination therapy: applying what we know about psychiatric evaluation and management from cardiac failure and transplant.**

**Author(s):** Eshelman, Anne K; Mason, Shawn; Nemeh, Hassan; Williams, Celeste

**Source:** Heart failure reviews; Mar 2009; vol. 14 (no. 1); p. 21-28

**Publication Date:** Mar 2009

**Publication Type(s):** Journal Article Review

**PubMedID:** 18214674

Available at  [Heart failure reviews](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1382-4147&volume=14&issue=1&spage=21)  - from ProQuest (Health Research Premium) - NHS Version

**Abstract:** Left ventricular assist devices (LVADs) have evolved into long-term use as destination therapy for those with severe end-stage heart failure due to other medical risks. Success with LVAD depends on adherence to a complicated mechanical regimen, and acceptance of a life that is far from normal. Patients with LVADs share characteristics with other end-stage cardiac failure patients and those waiting for or receiving heart transplants. Understanding the more thoroughly studied issues of psychiatric disorders, adherence, and behavioral correlates of success in heart failure and transplantation may identify feasible strategies for optimizing care of LVAD patients and suggest directions for future research. Depression and distress complicate post-transplant care. Psychiatric morbidity is associated with poor outcomes, including graft rejection, non-adherence, hospitalizations, infection, and death. With a high risk of embolic neurological events, patients' ability for self-care may be compromised. Psychiatric symptoms are underdiagnosed and undertreated, which may impact overall survival and quality of life.

**Database:** Medline

**49. Investigator-led clinical research consortia: The Canadian Critical Care Trials Group**

**Author(s):** Marshall J.C.; Cook D.J.

**Source:** Critical Care Medicine; Jan 2009; vol. 37

**Publication Date:** Jan 2009

**Publication Type(s):** Review

Available at  [Critical Care Medicine](http://ovidsp.ovid.com/athens/ovidweb.cgi?T=JS&PAGE=fulltext&D=ovft&CSC=Y&NEWS=N&SEARCH=0090-3493.is+and+%2237%22.vo+and+%22Supplement%22.ip+and+%22S165%22.pg+or+%2210.1097/CCM.0b013e3181921079%22.di)  - from Ovid (Journals @ Ovid) - Remote Access

Available at  [Critical Care Medicine](http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=fulltext&D=ovft&CSC=Y&NEWS=N&SEARCH=0090-3493.is+and+%2237%22.vo+and+%22Supplement%22.ip+and+%22S165%22.pg+or+%2210.1097/CCM.0b013e3181921079%22.di)  - from Ovid (Journals @ Ovid) - London Health Libraries

Available at  [Critical Care Medicine](http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=fulltext&D=ovft&CSC=Y&NEWS=N&SEARCH=0090-3493.is+and+%2237%22.vo+and+%22Supplement%22.ip+and+%22S165%22.pg+or+%2210.1097/CCM.0b013e3181921079%22.di)  - from Ovid (LWW High Impact Collection) - 2017 - 2018

Available at  [Critical Care Medicine](http://www.bartshealth.nhs.uk/education/knowledge-and-library-services/request-an-article-or-book)  - from Request from Barts Health - Whipps Cross University Hospital Local Print Collection [location] : Request from Barts Health - Whipps Cross University Hospital.

Available at  [Critical Care Medicine](http://pdfs.semanticscholar.org/50ca/1872a2a939f7a81989922461931916091ec8.pdf)  - from Unpaywall

**Abstract:** Advances in the care of critically ill patients are dependent upon rigorous clinical research undertaken to characterize natural history and risk factors, and determine optimal approaches to the management of the diseases of the critically ill patient. The Canadian Critical Care Trials Group (CCCTG) was formed in 1989 to foster such research. It has grown to become a national, multidisciplinary organization with more than 100 members, and more than 3 dozen active research programs. Its members have been highly successful in obtaining funding for, completing, and publishing well-designed studies that have informed international practice in areas such as transfusion, stress ulcer prophylaxis, long term outcomes from acute respiratory distress syndrome, diagnosis and management of infection in the intensive care unit, and end-of-life care. In the process, the CCCTG has developed a highly effective culture of scientific mentoring, and has served as a model for investigator-led critical care research groups around the world. This review summarizes the history, activities, approaches, and challenges of the CCCTG, in the conviction that investigator-led groups such as ours represent the future of intensive care unit-based research. © 2009 Lippincott Williams & Wilkins, Inc.

**Database:** EMBASE

**50. Where is the evidence base? Mental health issues surrounding bereavement and HIV in children.**

**Author(s):** Sherr L; Mueller J

**Source:** Journal of Public Mental Health; Dec 2008; vol. 7 (no. 4); p. 31-39

**Publication Date:** Dec 2008

**Publication Type(s):** Academic Journal

Available at  [Journal of Public Mental Health](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1746-5729&volume=7&issue=4&spage=31)  - from ProQuest (Health Research Premium) - NHS Version

**Abstract:** Parental illness can affect child and adolescent psychosocial well-being. Mental health effects of parental bereavement generally and HIV-related bereavement specifically have been poorly explored in children. HIV-related illness has a number of specific features that may directly affect mental health considerations. Infection is clustered in families. Bereavement is often multiple. Death is often preceded by severe illness and multiple opportunistic infections. AIDS is stigmatised, which may impede disclosure, social support and adjustment. In low-income countries where HIV infection is concentrated, access to palliative care as well as medical care may be limited. This review systematically identifies studies on HIV and bereavement in children. Searches of electronic databases for relevant articles revealed 14 studies examining bereavement with sufficient measurement and controlled methodology providing standardised behavioural and emotional outcome measures. Scrutiny of the results revealed the majority (I 2:86%) recorded an adverse behavioural or emotional impact on the child. A detailed analysis of the studies provides insights to risks as well as protective factors that may inform future interventions. Only one systematic intervention was identified whereby a coping skills intervention had positive and long-lasting effects. This paper examines urgent future needs and the requirement for evidence-based policy and provision.

**Database:** CINAHL

**51. Agitation and delirium at the end of life: "We couldn't manage him"**

**Author(s):** Breitbart W.; Alici Y.

**Source:** JAMA - Journal of the American Medical Association; Dec 2008; vol. 300 (no. 24); p. 2898-2910

**Publication Date:** Dec 2008

**Publication Type(s):** Review

**PubMedID:** 19109118

Available at  [JAMA](https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Fjama.jamanetwork.com%2Farticle.aspx%3Fvolume%3D300%26issue%3D24%26page%3D2898)  - from American Medical Association Athens - NHS

**Abstract:** Delirium is the most common neuropsychiatric complication experienced by patients with advanced illness, occurring in up to 85% of patients in the last weeks of life. Using the case of Mr L, a 59-year-old man with metastatic lung cancer who developed an agitated delirium in the last week of life, we review the evaluation and management of delirium near the end of life. Although some studies have identified agitation as a central feature of delirium in 13% to 46% of patients, other studies have found up to 80% of patients near the end of life develop a hypoactive, nonagitated delirium. Both the agitated (hyperactive) and nonagitated (hypoactive) forms of delirium are harbingers of impending death and are associated with increased morbidity in patients who are terminally ill, causing distress for patients, family members, and staff. Delirium is a sign of significant physiological disturbance, usually involving multiple causes, including infection, organ failure, and medication adverse effects. Often these causes of delirium are not reversible in the dying patient, and this influences the outcomes of its management. Delirium can also significantly interfere with the recognition and control of other physical and psychological symptoms, such as pain. Unfortunately, delirium is often misdiagnosed or unrecognized and thus inappropriately treated or untreated in terminally ill patients. To manage delirium in terminally ill patients, clinicians must be able to diagnose it accurately, undertake appropriate assessment of underlying causes, and understand the benefits and risks of the available pharmacological and nonpharmacological interventions. ©2008 American Medical Association. All rights reserved.

**Database:** EMBASE

**52. The FG Syndromes (Online Mendelian Inheritance in Man 305450): Perspective in 2008**

**Author(s):** Opitz J.M.; Smith J.F.; Santoro L.

**Publication Date:** Sep 2008

**Publication Type(s):** Review

**PubMedID:** 19048730

Available at  - from ClinicalKey

**Abstract:** Rarely in the history of medicine has an X-linked mental retardation syndrome so thoroughly entered every branch of medicine, at least of pediatrics, but also of internal medicine, on account of its protean manifestations. In such countries as Zambia, malaria, tuberculosis, HIV, and other infections diseases, and many environmental and nutritional disorders still top the list of childhood morbidity and mortality. However, in the more developed nations of the Old and New Worlds, prematurity, birth defects, and genetic conditions constitute the major burden of infant mortality and chronic childhood handicaps. One of the most pervasive of these is the group of FG syndromes seen in every pediatric clinic and mental health service. A partial list includes:Peri- and neonatology: prematurity, breech and cesarean section delivery, intrauterine growth retardation, congenital hypotonia, difficulties in neonatal adaptation, feeding difficulties, reflux with or without aspiration, failure to thrive, single umbilical artery, infant deathOtology/otorhinolaryngology: severe congenital sensorineural deafness; chronic recurrent otitis; sinusitis and tonsillitis (tonsillectomy and adenoidectomy), stridor/laryngomalacia; grade 1 laryngeal cleft with or without subglottic stenosis; cleft palate; rare choanal stenosis; almost universal narrowing of ear canals with frequent need to remove wax; short lingual frenulum, labiogingival frenulum; conductive hearing lossOphthalmology: strabismus, congenital nystagmus; large corneae; stenosis of nasolacrymal ducts; lack of tearing; ptosis; blepharophimosis with inturned eyelashes and corneal irritation; errors of refraction, cobolomataAllergy: almost universal reactive airway disease; sometimes eczema, generally rather mildPulmonology: aspiration pneumonia, atelectasis; sleep apneas and other sleep disturbances that may require continuous positive airway pressure.Gastroenterology: reflux (Nissen), feeding difficulties and failure to thrive (G-button), constipation, diarrhea, pyloric stenosis, and rectal stenosisUrology [61]: hypospadias, inguinal hernia(e), cryptorchidism, hydrocele, renal anomalies, neurogenic bladder, nephrolithiasisCardiology: patent ductus arteriosus, patent foramen ovale, atrial septal defect, ventricular septal defect, (peripheral) pulmonic stenosis, left superior vena cava, conduction defects, autonomic vascular problems, postnatal hypotension, acrocyanosis/RaynaudGeneral surgery: umbilical hernia, rare diaphragmatic herniaNeurosurgery: Chiari I (beyond 10 mm [62]), syringomyelia, tethered cord, cervical vertebral malformations, rarely true hydrocephalusRadiology: for "everything," brain MRI and cine-MRI of lower cord recommended in all FGS children, boys and girlsOrthopedics: ectrodactyly, polysyndactyly, duplication of thumb, congenital clubfeet, syndactyly, patellar subluxation, hypotonic scoliosis, hypotonic pectus excavatum, unstable hipsPlastic surgery: helmet for congenital plagiocephaly/torticollis; occasional hemangiomataDermatology: pigmentary dysplasias, nevi, warts, melanoma surveillancePhysical therapy: hypotonia, hypotonic diplegia, motor delayOccupational therapy: defects of sensory integration (especially oral tactile aversion), feeding therapy, autistic manifestations.Speech therapy: virtually universal speech delayPsychology: evaluation of behavior, autism, cognitive/psychomotor development; psychologic therapyPsychiatry: evaluation for "autism," behavior and emotional problems (ADHD, oppositional defiant disorder, obsessive-compulsive disorder; bipolar disorder), psychopharmacology, psychotherapyHematology: follow-up of those with neonatal anemia, neutropenia/leucopenia, thrombocytopenia, and other platelet disordersInfectious disease and rheumatology: immune deficiencies toward potential intravenous immunoglobulin treatment [63], recurrent viral infections, respiratory syncytial virus, rotavirus, bronchiolitis.Pediatric genetics: cytogenetics, molecular genetics, FGS carrier testing, genetic counselingObstetrics and gynecology: Pregnancies in known FGS carriers require most careful surveillance and such women must be considered at high risk after a prior complicated outcome. In the process, the carrier woman may be discovered to have a uterine malformation (uterus bicornis, septate, duplex) and an unusually short perineal body. There is a much higher probability of cesarean delivery for hypotonia, cephalic dystocia, fetal distress, breech or transverse presentation, failure to progress, and other reasons. Soon molecular prenatal diagnosis will be possible.Pathology: At autopsy a stillborn male infant or fetus with evident congenital hypotonia, hypertelorism, hypospadias, broad thumbs, and halluces. Parents are not present to give a family history and the case may end up being coded "multiple congenital anomalies, chromosomes (apparently) normal," with no further causal analysis. In the fetal genetic pathology service at the University of Utah, we have begun to add the sentence: "Consider possibility of FG syndrome and referral to genetics." This takes into account the frequent note of fetal or infant death in FGS sibships evaluated in the pediatric genetics, and the findings in the last three syndromal infant cases referred by the Utah medical examiner, one dying of overwhelming sepsis with dehydration, failure to thrive, and severe constipation after formula change to Neocate with over 100 rock-hard sciboli in colon, and several affected sibs with FGS. Another male died suddenly 1 day after cochlear implant with pronounced congenital hypotonia and megalencephaly. Another was a "sudden infant death" in a male with congenital hypotonia, large head, and urethral megameatus. Thus, in our experience FGS emerges as the most common yet the least known developmental disabilities condition in our society. FGS imposes a tremendous burden of morbidity, and to some extent also of mortality, on society and families. After successful neonatal adaptation, such recurring problems as otitis, reactive airway disease, and constipation can be routinely treated symptomatically. However, the neurodevelopmental burden represents the greatest challenge that FGS presents for families and to society. Under the best of circumstances, motor and speech development catch up. However, virtually all FGS children, boys and girls, have difficulties in psychologic development, school performance, and ultimate emotional adaptation to adult life and social integration. The many such cases added to those with outright psychiatric disturbances are overwhelming social, psychologic, and psychiatric services and, above all, public and private school systems, which are understaffed, underfunded, beyond formulating individual educational plans, and helpless to deal with the enormous burden of special service needs of these children. It's time that handicapped children receive care according to needs and not according to diagnosis. However, the near absence of information on FGS available to these professionals is a handicap in arriving at a specific diagnosis (allowing state and federal support for special services) and in understanding the prognosis, natural history, and such complications as "autism," seizures, and tethered cord that affect the child's success at home, in school, and out in society. The FGS parent support group has been of enormous help in informing families about all of these "issues," and to this day remains the greatest repository of knowledge on FGS. As they say in baseball, it is time at long last for the professionals "to step up to the plate.". © 2008 Elsevier Inc. All rights reserved.

**Database:** EMBASE

**53. [Cytokine storm in avian influenza].**

**Author(s):** Us, Dürdal

**Source:** Mikrobiyoloji bulteni; Apr 2008; vol. 42 (no. 2); p. 365-380

**Publication Date:** Apr 2008

**Publication Type(s):** English Abstract Journal Article Review

**PubMedID:** 18697437

**Abstract:** The most dramatic example of defining the pathogenicity of influenza virus A/H5N1 strains is the higher fatality rate of avian influenza epidemic (>50%) occured in Southeast Asia in 1997 comparing to the pandemic caused by influenza virus A/H1N1 in 1918 (5-10%) which was recorded as the most destructive pandemic in the world. When considering the fatal/total case numbers (208/340) reported by World Health Organization in respect of December 14th, 2007, the mortality rate has now reached to 61 percent. Recent studies have shown that the high fatality rate of avian influenza virus infections is a consequence of an overactive inflammatory response and the severity of infection is closely related with virus-induced cytokine dysregulation. The most important feature of A/H5N1 immunopathogenesis is the appearence of hypercytokinemia ("cytokine storm") which is characterized by the extreme (exaggerated) production and secretion of large numbers and excessive levels of pro-inflammatory cytokines. This phenomenon is blamed on the emergence of lethal clinical symptoms such as extensive pulmonary oedema, acute bronchopneumoniae, alveolar haemorrhage, reactive haemophagocytosis, and acute respiratory distress syndrome, associated with necrosis and tissue destruction. Numerous in vitro, in vivo and clinical studies have pointed out that A/H5N1 viruses are very strong inducers of various cytokines and chemokines [Tumor Necrosis Factor (TNF)-alpha, Interferon (IFN)-gamma, IFN-alpha/beta, Interleukin (IL)-6, IL-1, MIP-1 (Macrophage Inflammatory Protein), MIG (Monokine Induced by IFN-gamma), IP-10 (Interferon-gamma-Inducible Protein), MCP-1 (Monocyte Chemoattractant Protein), RANTES (Regulated on Activation Normal T-cell Expressed and Secreted), IL-8], in both humans and animals. The privileged cells of cytokine storm are macrophages and CD8+ T-lymphocytes, while the primary contributor cytokines are TNF-alpha, IL-6 and IFN-gamma. It has been detected that, mutations of some viral genes (NS1, PB2, HA and NA) are responsible for the cytokine storm, by increasing the viral replication rate, expending the tissue tropism, facilitating the systemic invasion and emerging of resistance against the host antiviral response. It has been shown that Glu92 and Ala149 mutations, and carboxyl-terminal ESEV/EPEV motif of NS1 protein have been implicated as determinants of virulence for A/H5N1 strains. In addition, Lys627 mutation in PB2 protein, polybasic aminoacid mutations in the cleavage region of hemagglutinin (HA) polyprotein, and glycosylation and sialylation mutations in HA and neuraminidase (NA) proteins were found to enhance the immune-mediated patology of highly virulent A/H5N1 strains. In this review article, the immunopathogenesis of influenza infection and the mechanisms of cytokine storm caused by influenza A/H5N1 viruses have been discussed under the light of recent literature.

**Database:** Medline

**54. Ulceras tumorales en cuidados paliativos. A proposito de un casoTumoral ulcers in palliative care. Review of one case**

**Author(s):** Pozo Villa R.; Lapeira Cabello J.M.

**Source:** Medicina Paliativa; 2007; vol. 14 (no. 2); p. 66-68

**Publication Date:** 2007

**Publication Type(s):** Article

**Abstract:** We presented a clinical case in which the care of a tumoral ulcer made a great improvement on the quality of life of a terminally ill patient with lung cancer. Going trough the bibliography it describes the usefulness of non-invasive measures and emphasize the need of care better than cure. Giving analgesia for breakthrough pain by using morphine sulphate prior to any physical manipulation and applying metronidazole gel to control de odour related with anaerobe infections were the most important needs we have to focus on. The choice of an appropriate dressing reduced the patient and family distress. Regarding the bleeding control we recommended the use of towels damped with tranexamic acid, and also we advised the carers about what to do in the case of heavy bleeding (to cover the area with green and dark towels) and how to clean the non bleeding areas by irrigation with warm saline solution. Copyright © 2007 AraN Ediciones, S.L.

**Database:** EMBASE

**55. Hidratacion en cuidados paliativos: Cuando, como, por queHydration in palliative care: When, how and why**

**Author(s):** Puerta Ardiz M.D.; Bruera E.

**Source:** Medicina Paliativa; 2007; vol. 14 (no. 2); p. 104-120

**Publication Date:** 2007

**Publication Type(s):** Review

**Abstract:** Background: a great majority of patients with end-stage disease experience a severily reduced oral intake before death, which is due to a variety of causes related to their cancer or its treatment. Reduced oral intake is perceived by patients and their families with distress because of implications related to eating and hydration. This perception and the fact that there is no evidence-based research to determine how it is best to proceed sourround this issue of much controversy even among palliative care professionals. Objective(s): to review the existing literature regarding the assessment of hydration in cancer patients, the process of decision making regarding hydration, and the methods and outcomes of artificial hydration. Material(s) and Method(s): we conducted a narrative review using the Pubmed database as well as references within the identified papers, chapters in textbooks of pallaitive medicine and oncology, and previous issues of Medicina Paliativa. The review was conducted both in English and Spanish. Result(s): terminal cancer patients need less fluid for adequate hydration; however, they are at increased risk for fluid deficiency, often precipitated by minor variations in fluid intake, infection, and other conditions. Conclusion(s): the main symptoms of dehydration are difficult to interpret due to the presence of multiple symptoms related to cancer and cancer therapy. A careful assessment is needed before a decision is made regarding fluid administration. In unclear cases a brief trial of parenteral hydration may be useful. The subcutaneous and rectal routes are useful alternatives to the intravenous route, particularly in the community setting. If hydration is not considered appropriate a progressive reduction of drugs likely to accumulate in the presence of dehydration - including opioids - is indicated. Copyright © 2007 Aran Ediciones, S.L.

**Database:** EMBASE

**56. Cancer-related fatigue clinical practice guidelines in oncology**

**Author(s):** Mock V.; Eisenberger M.A.; Abernethy A.P.; Atkinson A.; Barsevick A.M.; Berger A.M.; Piper B.F.; Cella D.; Wagner L.I.; Cimprich B.; Cleeland C.; Escalante C.P.; Hinds P.; Jacobsen P.B.; Kaldor P.; O'Connor T.; Otis-Green S.A.; Pirl W.F.; Rugo H.S.; Sabbatini P.; Stewart F.M.

**Source:** JNCCN Journal of the National Comprehensive Cancer Network; Nov 2007; vol. 5 (no. 10); p. 1054-1078

**Publication Date:** Nov 2007

**Publication Type(s):** Review

**PubMedID:** 18053429

**Abstract:** These guidelines propose a treatment algorithm in which patients are evaluated regularly for fatigue using a brief screening instrument and are treated as indicated by their fatigue level. The algorithm's goal is to identify and treat all patients with fatigue that causes distress or interferes with daily activities or functioning. Management of fatigue begins with primary oncology team members who perform the initial screening and either provide basic education and counseling or expand the initial screening to a more focused evaluation for moderate or higher levels of fatigue. At this point, the patient is assessed for current disease and treatment status and undergoes a review of body systems and an in-depth fatigue evaluation. In addition, the patient is assessed for the presence of 7 treatable factors known to contribute to fatigue: pain, emotional distress, sleep disturbance, anemia, alteration in nutrition, deconditioning, and comorbidities. If any of these conditions are present, they should be treated according to practice guidelines, with referral to other care professionals as appropriate, and the patient's fatigue should be reevaluated regularly. If none of the 7 factors is present or if the fatigue is unresolved, appropriate fatigue management and treatment strategies are selected within the context of the patient's clinical status (e.g., undergoing active cancer treatment, disease-free long-term follow-up, or care at end of life). Management of fatigue is cause-specific when conditions known to cause fatigue (e.g., infection, fluid and electrolyte imbalances, cardiac dysfunction) can be identified and treated. When specific causes of fatigue cannot be identified and corrected, the fatigue can still be treated with nonpharmacologic and pharmacologic interventions. Nonpharmacologic interventions may include a moderate exercise program to improve functional capacity and activity tolerance, psychosocial programs to manage stress and increase support, attention-restoring therapies to decrease cognitive alterations and improve mood state, energy conservation to maintain energy, and nutritional and sleep interventions for patients with disturbances in eating or sleeping. Pharmacologic therapy may include drugs, such as antidepressants for depression or erythropoietin for anemia. A few clinical reports on the use of psychostimulants suggest the need for further research on these agents as potential treatment modalities in managing fatigue. Effective management of cancer-related fatigue involves an informed and supportive oncology care team that assesses patients' fatigue levels regularly, counsels and educates patients on strategies for coping with fatigue,194 and uses institutional experts for referral of patients with unresolved fatigue.43. © Journal of the National Comprehensive Cancer Network.

**Database:** EMBASE

**57. Psychiatric disorders in advanced cancer**

**Author(s):** Miovic M.; Block S.

**Source:** Cancer; Oct 2007; vol. 110 (no. 8); p. 1665-1676

**Publication Date:** Oct 2007

**Publication Type(s):** Review

**PubMedID:** 17847017

Available at  [Cancer](https://onlinelibrary.wiley.com/doi/full/10.1002/cncr.22980)  - from Wiley Online Library

**Abstract:** BACKGROUND. Emotional distress and psychiatric disorders are common among patients with advanced cancer. Oncologists play an important role in screening for these conditions, providing first-line treatment and referring patients for further evaluation and treatment when indicated. METHODS. The literature on psycho-oncology was reviewed, focusing on the epidemiology, assessment, and treatment of psychiatric disorders (adjustment disorders, major depression, anxiety and post-traumatic stress, personality disorders, substance abuse, and major mental disorders such as schizophrenia and bipolar disorder) in patients with advanced cancer. Communication skills and the role of the oncologist in dealing with end-of-life issues were also reviewed. Relevant data were summarized from the most recent systematic reviews, epidemiological studies, and intervention trials. Clinical recommendations are provided. RESULTS. About 50% of patients with advanced cancer meet criteria for a psychiatric disorder, the most common being adjustment disorders (11%-35%) and major depression (5%-26%). Both psychosocial and pharmacological treatments are effective for anxiety and depression, although existing studies have methodological limitations. Collaboration with mental health specialists is recommended for patients with personality disorders, major mental illness, and substance abuse problems. Effective communication involves active listening, exploring emotion and meaning, addressing prognosis, and discussing end-of-life issues when relevant. CONCLUSIONS. Treating psychiatric conditions improves quality of life in patients with advanced cancer. Oncologists play a key role in screening for psychiatric disorders, initiating first-line treatments for depression and anxiety, and communicating with patients and caregivers about prognosis and end-of-life issues. © 2007 American Cancer Society.

**Database:** EMBASE

**58. Review of gaseous methods of killing poultry on-farm for disease control purposes.**

**Author(s):** Raj, A B M; Sandilands, V; Sparks, N H C

**Source:** The Veterinary record; Aug 2006; vol. 159 (no. 8); p. 229-235

**Publication Date:** Aug 2006

**Publication Type(s):** Research Support, Non-u.s. Gov't Journal Article Review

**PubMedID:** 16921011

Available at  [The Veterinary record](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0042-4900&volume=159&issue=8&spage=229)  - from ProQuest (Health Research Premium) - NHS Version

**Abstract:** Poultry may need to be culled in the event of an outbreak of disease. Gassing has advantages over mechanical and electrical methods or overdoses of anaesthetics because large numbers can be killed simultaneously and little or no handling of the birds is required. However, gaseous killing methods may have welfare implications for the birds, which may find various gases more or less aversive, may undergo respiratory distress and/or experience convulsions, and may remain conscious for a considerable time before they die. In addition, the gases used may present health and safety risks to human operators, and be difficult to supply and deliver.

**Database:** Medline

**59. Emerging approaches for prophylaxis and management of oropharyngeal mucositis in cancer therapy.**

**Author(s):** Epstein, Joel B; Klasser, Gary D

**Source:** Expert opinion on emerging drugs; May 2006; vol. 11 (no. 2); p. 353-373

**Publication Date:** May 2006

**Publication Type(s):** Journal Article Review

**PubMedID:** 16634706

**Abstract:** Oral mucositis is a common treatment-limiting side effect of cancer therapy that may have a significant impact on quality of life and on the cost of care. Oral mucositis is the most distressing complication of cancer therapy as reported by head and neck cancer patients, in patients receiving dose-dense myelosuppressive chemotherapy and in patients receiving haematopoietic stem cell transplant. Mucositis may increase the risk of local and systemic infection, particularly in myelosuppressed patients. Severe oral mucositis can lead to the need to interrupt or discontinue cancer therapy, and thus may impact cure of the primary disease. Current care of patients with mucositis is essentially palliative, and includes appropriate oral hygiene, nonirritating diet and oral care products, topical palliative mouth rinses, topical anaesthetics and use of systemic opioid analgesics. Emerging approaches for prevention and treatment of oral mucositis are developing based on an increasing understanding of the pathobiology of mucosal damage and repair. New interventions are expected to be administered based on the mechanisms of initiation, progression and resolution of the condition. The approval by the FDA of keratinocyte growth factor (palifermin; Amgen) in 2004 represents a new step in prevention of oral mucositis in stem cell transplant patients based on the increasing understanding of the pathogenesis of mucositis. Progress in the prevention and management of mucositis will improve quality of life, reduce cost of care and facilitate completion of more intensive cancer chemotherapy and radiotherapy protocols. Improved management of mucositis may allow implementation of cancer treatment protocols that are currently excessively mucotoxic, but have potentially higher cure rates of the malignant disease.

**Database:** Medline

**60. Management of oral mucositis in patients with cancer.**

**Author(s):** Stone, Rebecca; Fliedner, Monica C; Smiet, Antoine C M

**Source:** European journal of oncology nursing : the official journal of European Oncology Nursing Society; 2005; vol. 9

**Publication Date:** 2005

**Publication Type(s):** Journal Article Review

**PubMedID:** 16202654

**Abstract:** Oral mucositis (OM) is a distressing toxic effect of chemotherapy and radiotherapy. It can increase the need for total parenteral nutrition and opioid analgesics, prolong hospital stays, increase the risk of infection, and greatly diminish a patient's quality of life. Nurses play a critical role in the assessment and management of OM. However, nurses face several significant challenges in effectively managing OM. First, the assessment and management of OM is inconsistent across Europe. Second, available treatment options for OM are largely ineffective, aimed at palliation of symptoms, and do not target the underlying pathophysiology. Nursing care has focused primarily on symptom management and pain control. With recent advances in the understanding of the pathobiology of OM and the development of interventions, it is hoped that the quality of care provided to patients will improve dramatically as new agents should allow the goal of OM management to shift from symptom relief to protection and prevention. Nurses should be educated about these novel options for the management of OM.

**Database:** Medline

**61. Pain management of sickle cell disease**

**Author(s):** Ballas S.K.

**Source:** Hematology/Oncology Clinics of North America; Oct 2005; vol. 19 (no. 5); p. 785-802

**Publication Date:** Oct 2005

**Publication Type(s):** Review

**PubMedID:** 16214644

**Abstract:** The clinical manifestations of SCD fall into four major categories: (1) pain, (2) anemia and its sequelae, (3) organ failure, including infection, and (4) comorbid conditions. Advances in the pathogenesis of SCD focused on the sequence of events that occur between polymerization of deoxyhemoglobin S and vaso-occlusion. Cellular dehydration, inflammatory response, and reperfusion injury appear to be important pathophysiologic mechanisms. Management of SCD continues to be primarily palliative in nature, including supportive, symptomatic, and preventive approaches to therapy. There are three major types of sickle cell pain: acute, chronic, and neuropathic pain. The acute painful episode is the insignia of the disease and the most common cause of hospitalization. Its management entails the use of nonpharmacologic and pharmacologic modalities. Pain management should follow certain principles that include an assessment stage, treatment stage, reassessment stage, and adjustment stage. Chronic sickle cell pain may be due to certain complications of the disease, such as leg ulcers and avascular necrosis; intractable chronic pain may be due to central sensitization. Management of chronic pain should take a multidisciplinary approach. The ultimate goals of management of sickle cell pain should be pain relief, improved physical functioning, reduced psychosocial distress, and improved quality of life. © 2005 Elsevier Inc. All rights reserved.

**Database:** EMBASE

**62. Living-related liver transplantation in pediatric patients.**

**Author(s):** Dalgic, A; Ozcay, F; Arslan, G; Emiroglu, R; Sozen, H; Moray, G; Karakayali, H; Bilgin, N; Haberal, M

**Source:** Transplantation proceedings; Sep 2005; vol. 37 (no. 7); p. 3133-3136

**Publication Date:** Sep 2005

**Publication Type(s):** Journal Article

**PubMedID:** 16213328

**Abstract:** INTRODUCTIONMany developments in surgical technique, immunosuppression, and patient selection criteria have led to improved long-term patient and graft survival in pediatric patients receiving liver transplants. In this study, we examined the early results of 26 pediatric recipients who underwent 26 liver transplantations between January 2003 and December 2004 at our institution.MATERIALS AND METHODSThe most common indications for liver transplantation were cholestasis in 10 patients (38.5%) and Wilson's disease in 8 (30.8%). Other indications were fulminant hepatic failure (4 patients, 15.4%), tyrosinemia (2 patients, 7.7%), Caroli disease (1 patient, 3.8%), and cryptogenic cirrhosis (1 patient, 3.8%). One recipient with Byler disease and two with tyrosinemia also had incidental hepatocellular carcinoma.RESULTSOf 26 patients, 24 (92.3%) underwent living-related liver transplantation and 2 (7.7%) underwent cadaveric transplantation. The medical records of all patients were retrospectively reviewed. Twenty-two of 26 survived with excellent graft function, showing 91.2%, 86.4%, and 81.6% at 3, 12, and 24 months graft and patient survival rates, respectively. Sixteen patients (61.5%) developed various morbidities with biliary and vascular complications being the most common. Four patients (15.3%) developed bile leaks. Four patients (15.3%) developed hepatic artery thromboses. Five patients (19.2%) developed life-threatening infections. Four patients (15.4%) died during the study period, three owing to infectious complications. The other patient died due to acute respiratory distress syndrome.CONCLUSIONDespite technical difficulties and a donor organ shortage, the results of liver transplantation in pediatric patients with end-stage liver disease have demonstrated promising results at our institution.

**Database:** Medline

**63. Kezeles az elet vegenEnd-of-life care**

**Author(s):** Hedvig G.; Tamas M.

**Source:** Lege Artis Medicinae; Jun 2003; vol. 13 (no. 5); p. 360-363

**Publication Date:** Jun 2003

**Publication Type(s):** Review

**Abstract:** Recently, physicians and medical literature are more concerned about end-of-life care. A review is given of studies dealing with the rights of the dying patient, with advance directives and with possible treatments in the last days of life. A survey was done in author's department on medical therapy of the terminal period of 103 inpatients, died between 01. 10. 2001. and 31. 03. 2002. Comparing these data with those of American, Finnish etc. authors, the treatments seem to be more generous - probably because in Hungary it is not (yet?) usual to "declare" end-of-life care and to withdraw active therapy. However, indication of antibiotics seems to be more clinical (28.1%, vs. 42%-88% given by similar foreign data). Antibiotics are not palliative means, however, they may be administered in the last days, if the patient is suffering from a terminal infection. Indications and choice of antibiotics are suggested in these cases; medical and ethical problems discussed. Physicians can relieve the physical and mental distressing symptoms of the dying patient and ensure human dignity and peace of the last days.

**Database:** EMBASE

**64. New approaches to respiratory infections in children: Bronchiolitis and croup**

**Author(s):** Wright R.B.; Pomerantz W.J.; Luria J.W.

**Source:** Emergency Medicine Clinics of North America; 2002; vol. 20 (no. 1); p. 93-114

**Publication Date:** 2002

**Publication Type(s):** Review

**Abstract:** Croup is a disease that is commonly seen in children younger than the age of 6 years. The cause is viral, with parainfluenza viruses and RSV being the two most common pathogens. Treatment consists primarily of supportive care, and parents usually have tried humidification and cool air exposure before the child presents to the ED. Children with moderate to severe croup are usually seen in the ED. The use of steroids in an oral preparation results in a clinical improvement of outpatients with mild to moderate croup and reduces the need for hospitalization. The dosage range for oral dexamethasone is 0.15 mg/kg to 0.6 mg/kg. Nebulized budesonide may also be used. Racemic or L-epinephrine, both of which are equally effective, can be used for symptomatic treatment in severe croup. After administration of racemic or L-epinephrine, hospitalization is not automatic and patients can be discharged safely from the ED after a 3-hour of observation period. There should be no respiratory distress, and the patient should have access to follow-up and emergency care if needed.

**Database:** EMCARE

**65. Carcass disposal: lessons from Great Britain following the foot and mouth disease outbreaks of 2001.**

**Author(s):** Scudamore, J M; Trevelyan, G M; Tas, M V; Varley, E M; Hickman, G A W

**Source:** Revue scientifique et technique (International Office of Epizootics); Dec 2002; vol. 21 (no. 3); p. 775-787

**Publication Date:** Dec 2002

**Publication Type(s):** Journal Article Review

**PubMedID:** 12523714

Available at  [Revue scientifique et technique (International Office of Epizootics)](http://pdfs.semanticscholar.org/7cb7/6b12629b7f769a44699241e031be4ee563f2.pdf)  - from Unpaywall

**Abstract:** The foot and mouth disease (FMD) outbreak that occurred in the United Kingdom in 2001 was of an unprecedented scale and severity and presented a massive logistical challenge to Government. Over 6.5 million animals were slaughtered and disposed of, over 4 million as a direct result of disease and a further 2.5 million on welfare grounds. On-farm burial and on-farm burning were the principal routes for disposal at the commencement of the outbreak. On-farm burial was limited by legislation to protect groundwater supplies and pyre burning came increasingly under attack from local communities concerned about health risks from smoke and emissions. Burning also painted a vivid but distressing picture of the war against disease. Increasingly, rendering capacity made an important contribution to disposal. The peak of the outbreak could only be managed by the development of a new disposal route--mass burial in engineered sites and by using licensed landfill where available. During the course of the outbreak, a disposal hierarchy was developed to reflect environmental and public health concerns, namely: rendering and incineration ranked first, licensed landfill next, followed by burning with mass burial or on-farm burial as the least preferred options. However, the campaign against the disease could not have been won without the tactical use of mass burial in addition to all the other available disposal routes. The authors describe the development and deployment of the disposal routes used in the 2001 outbreak.

**Database:** Medline

**66. The flagellin-TLR5 axis: Therapeutic opportunities**

**Author(s):** Liaudet L.; Deb A.; Pacher P.; Mabley J.G.; Murthy K.G.K.; Salzman A.L.; Szabo C.

**Source:** Drug News and Perspectives; Sep 2002; vol. 15 (no. 7); p. 397-409

**Publication Date:** Sep 2002

**Publication Type(s):** Review

**Abstract:** Motile bacteria synthesize large-sized surface structures known as flagella through the ordered polymerization of protein subunits. Flagellin, a protein of 40-60 kDa, is the principal constituent of the flagellum; each flagellum consists of approximately 20,000 flagellin molecules. An alignment of the amino acid sequences from different Gram-negative species shows a high degree of similarity in the amino and carboxy terminal domains. In contrast, the central hypervariable regions of these proteins are quite divergent. Recent work reveals that - in addition to playing a role in bacterial adhesion - monomeric flagellin, a protein component of flagellated bacteria, can also act as a soluble immunostimulatory and proinflammatory factor, activating the immune/inflammatory axis via the Toll-like receptor 5-nuclear factor-kappaB axis. Monocytes and macrophages, as well as intestinal and pulmonary epithelial cells, respond to monomeric flagellin at low concentrations. Administration of flagellin at doses comparable to or lower than that of bacterial lipopolysaccharide (endotoxin) can induce prominent local and systemic immune/inflammatory responses in vivo. Recognition of the flagellin-TLR5 pathway offers novel opportunities for the experimental therapy of various forms of shock, sepsis, acute respiratory distress syndrome, bacterial inflammation and infection. © Prous Science 2002. All rights reserved.

**Database:** EMBASE

**67. Immunosuppressive therapy of childhood idiopathic nephrotic syndrome.**

**Author(s):** Abeyagunawardena, A; Brogan, Paul A; Trompeter, R S; Dillon, Matthew J

**Source:** Expert opinion on pharmacotherapy; May 2002; vol. 3 (no. 5); p. 513-519

**Publication Date:** May 2002

**Publication Type(s):** Journal Article Review

**PubMedID:** 11996630

**Abstract:** Childhood nephrotic syndrome (NS) is a distressing chronic renal disorder with potentially life threatening complications. Over 80% of cases in children are due to minimal change disease and the majority will respond to corticosteroid therapy. Steroid-sensitive NS is considered a relatively benign condition, since progression to end stage renal failure (ESRF) is extremely rare and > 80% will enter spontaneous long-term remission in later childhood. However, the disease is characterised by a relapsing course, placing the child at risk of acute complications, such as infection, hypovolaemia and thrombosis. Frequent relapses can result in a not inconsequential corticosteroid burden or prescription of cytotoxic immunosuppressive therapy to control the disease. In contrast, steroid-resistant and -refractory NS has an unfavourable outcome with a propensity to progress to ESRF. While these clinical entities have an unpredictable response to cytotoxic immunosuppressive therapy, the favourable long-term renal survival associated with children who enter sustained remission has revived the enthusiasm to treat steroid-resistant NS with more aggressive immunosuppressive regimens.

**Database:** Medline

**68. Management of disability in lymphatic filariasis--an update.**

**Author(s):** Shenoy, R K

**Source:** The Journal of communicable diseases; Mar 2002; vol. 34 (no. 1); p. 1-14

**Publication Date:** Mar 2002

**Publication Type(s):** Journal Article Review

**PubMedID:** 12718336

**Abstract:** The global lymphatic filariasis elimination programme incorporates disability management along with transmission control, to ensure 'a visible impact' on those who are already affected by the disease. The common manifestations of lymphatic filariasis like lymphoedema; elephantiasis and hydrocele result from irreversible damage caused to the lymphatics by the adult worms. Only palliative treatment in the form of physical methods and surgery is available for lymphoedema and elephantiasis. Hydrocele can be corrected by surgery. The most distressing aspect of lymphatic filariasis is the attacks of acute adenolymphangitis, which cause considerable short-term and also long-term disability by worsening the lymphoedema. Since each episode prevents the person from attending his work for several days, the economic loss is substantial. The precipitating cause of these attacks is secondary infection, the bacteria entering the tissues through 'entry lesions' in the skin. These episodes can very well be prevented by proper 'local-hygiene' of the affected limbs, which is a simple, effective, cheap and sustainable method that can be carried out even in the patient's house. These subjects and the providers of 'home care' should be trained in foot-hygiene programme, so that the message percolates to various levels in the affected communities, ultimately benefiting the patient.

**Database:** Medline

**69. AIDS-related death: A review of how bereaved gay men are affected**

**Author(s):** Campbell, Tomás

**Source:** Counselling Psychology Quarterly; Sep 1999; vol. 12 (no. 3); p. 245-252

**Publication Date:** Sep 1999

**Publication Type(s):** Journal Peer Reviewed Journal Journal Article

Available at  [Counselling Psychology Quarterly](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0951-5070&volume=12&issue=3&spage=245)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Counselling Psychology Quarterly](http://openurl.ebscohost.com/linksvc/linking.aspx?authtype=athens&genre=article&issn=0951-5070&volume=12&issue=3&spage=245&date=1999)  - from EBSCO (Psychology and Behavioral Sciences Collection)

**Abstract:** Reviews the literature in relation to how gay men are affected by AIDS related bereavement. The author explores how coping is affected by the experience of multiple loss within the gay community, concerns regarding one's own HIV status, the perception of stigma or discrimination, and the experience of caring and supporting friends and lovers dying from AIDS. Findings suggest that bereavement reactions have changed as the AIDS epidemic has progressed in that gay men are less affected in the long term than was previously thought. This change is placed within a cultural and political context and this context is used to consider current bereavement reactions. (PsycINFO Database Record (c) 2016 APA, all rights reserved)

**70. Stents in the management of malignant airway obstruction.**

**Author(s):** Stöhr, S; Bolliger, C T

**Source:** Monaldi archives for chest disease = Archivio Monaldi per le malattie del torace; Jun 1999; vol. 54 (no. 3); p. 264-268

**Publication Date:** Jun 1999

**Publication Type(s):** Journal Article Review

**PubMedID:** 10441984

**Abstract:** Surgical resection is feasible in only 20% of patients with lung cancer: less than 30% of these patients survive > 5 yrs and almost 95% of them require palliative treatment. During the course of disease, 30% of lung cancers cause obstruction of the trachea and main bronchi with subsequent respiratory distress, bleeding and infection. Similar problems arise through secondary pulmonary malignancies. There are several types of central airway obstruction; this influences the modality used for their treatment. The three basic types of stenosis are endoluminal, extraluminal and a combination of both. A mainly endoluminal stenosis can be treated with various resection techniques, such as laser, electrocautery or cryotherapy; for an extraluminal compression the only option is placement of stents, which results in efficient palliation and may prolong survival. Various stent models have been developed for the treatment of inoperable airway stenoses. They consist mainly of two types: metal and silicone devices, or combinations of both (hybrid models). The choice of a specific stent depends on the nature of the airway obstruction, the endoscopist's preference and the overall costs of the procedure. The best treatment results are usually obtained using a combination of stent placement followed by tumour-specific treatment such as irradiation or chemotherapy.

**Database:** Medline

**71. Subcutaneous fluid administration--better than the intravenous approach?**

**Author(s):** Jain, S; Mansfield, B; Wilcox, M H

**Source:** The Journal of hospital infection; Apr 1999; vol. 41 (no. 4); p. 269-272

**Publication Date:** Apr 1999

**Publication Type(s):** Journal Article Review

**PubMedID:** 10392332

Available at  [The Journal of hospital infection](https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0195670198905370%3Fgoto%3Dsd)  - from ScienceDirect

**Abstract:** Hypodermoclysis is a method of subcutaneous fluid administration particularly useful in elderly patients and in palliative care settings where intravenous access may be difficult. Subcutaneous fluid delivery is an effective method of rehydration and of opioid administration, and can prevent the need for intravenous catheterization and consequently hospitalization. It is a simple procedure to initiate, safe, less distressing to the patient, and does not predispose to intravascular related infections. The reported incidence of infection at the delivery site is extremely low. However, local guidelines should be agreed so that a standardized protocol is operated and risks of localized infection are minimized.

**Database:** Medline

**72. The catastrophic antiphospholipid syndrome, 1998. A review of the clinical features, possible pathogenesis and treatment.**

**Author(s):** Asherson, R A

**Source:** Lupus; 1998; vol. 7

**Publication Date:** 1998

**Publication Type(s):** Comparative Study Journal Article Review

**PubMedID:** 9814675

Available at  [Lupus](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0961-2033&volume=7&issue=2&spage=S55)  - from ProQuest (Health Research Premium) - NHS Version

**Abstract:** A review of 50 patients who manifest features of the catastrophic antiphospholipid syndrome (CAPS) is presented. The clinical features comprise mainly organ involvement as opposed to large-vessel venous or arterial occlusions as is seen in patients with 'simple' antiphospholipid syndrome (APS), which makes the pathogenesis of this unusually rare complication perhaps somewhat different from that of patients with the APS. The mortality of the condition is 50%, most patients dying as a result of a combination of cardiac and respiratory failure. Fifteen patients (28%) suffered from disseminated intravascular coagulation (DIC) as well, which may have contributed to the multiorgan thrombotic microangiopathy characteristic of the CAPS. Although most patients were treated with high-dose i.v. steroids, heparin, cyclophosphamide and other modalities of therapy (such as i.v. globulin), plasmapheresis (advocated for TTP, a similar microangiopathic condition) seemed to offer some benefit (68% recovery). The systemic inflammatory response syndrome (SIRS) was responsible for some of the clinical manifestations such as adult respiratory distress syndrome (ARDS) seen in 15 patients. Pathogenesis of the CAPS seems dependent on a 'two-hit' or even 'three-hit' hypothesis in patients already suffering from a hypercoagulable state. Precipitating factors include infections, trauma (surgical), drug administration and warfarin withdrawal. A recent view that the multiple thrombotic lesions themselves may contribute to further thrombosis ('thrombotic storm') is also discussed.

**Database:** Medline

**73. From fate to tragedy: The changing meanings of life, death, and AIDS**

**Author(s):** Selwyn P.A.; Arnold R.

**Source:** Annals of Internal Medicine; Dec 1998; vol. 129 (no. 11); p. 899-902

**Publication Date:** Dec 1998

**Publication Type(s):** Review

**PubMedID:** 9867733

**Abstract:** The advent of highly active antiretroviral therapy (HAART) and quantitative viral load assays has revolutionized the care of HIV-infected patients. However, this paradigm shift has also had unexpected, sometimes adverse consequences that are not always obvious. Before antiretroviral therapy, physicians learned how to accompany patients through their illness; to bear witness to sickness and dying; and to help patients and their families with suffering closure, and legacy. Since we have become better at treating the virus, a new temptation has emerged to dwell on quantitative aspects of HIV management and monitoring, although the skills that we learned earlier in the epidemic are no less necessary for providing good care. Our new-found therapeutic capabilities should not distract us from the sometimes more difficult and necessary task of simply 'being there' for patients for whom HAART is no longer effective. The definition and practice of end-of- life care for patients with AIDS will continue to evolve AIDS comes to resemble other chronic, treatable, but ultimately fatal illnesses, such as end-stage pulmonary disease and metastatic cancer, in which clinicians must continually readdress with their patients the balance of curative and palliative interventions as the disease process unfolds over time. The coming challenge in HIV care will be to encourage the maintenance of a 'primary care' mentality-with attention to the larger psychosocial tissues, and-of- life care, bereavement, and a focus on the patient as opposed to the illness- alongside our new antiretroviral paradigm. Otherwise, we run the risk of forgetting what we learned about healing, from a disease that we could not cure.

**Database:** EMBASE

**74. Manaing HIV. Part 5: Treating secondary outcomes. 5.17 HIV, weight loss and wasting syndrome.**

**Author(s):** Kelly, M D; Lloyd, A R; Kemp, R J

**Source:** The Medical journal of Australia; May 1996; vol. 164 (no. 9); p. 549-550

**Publication Date:** May 1996

**Publication Type(s):** Journal Article Review

**PubMedID:** 8649294

**Abstract:** Weight loss in HIV infection can be severe and distressing. Management must address the likely combination of causes by excluding opportunistic infection, monitoring drug effects, palliating diarrhoea, supporting a healthy diet and using drug therapy to improve appetite or weight gain.

**Database:** Medline

**75. Anticipatory grief and AIDS: strategies for intervening with caregivers.**

**Author(s):** Walker, R J; Pomeroy, E C; McNeil, J S; Franklin, C

**Source:** Health & social work; Feb 1996; vol. 21 (no. 1); p. 49-57

**Publication Date:** Feb 1996

**Publication Type(s):** Journal Article Review

**PubMedID:** 8626158

Available at  [Health & social work](http://openurl.ebscohost.com/linksvc/linking.aspx?genre=article&issn=0360-7283&volume=21&issue=1&spage=49)  - from EBSCO (Health Business FullTEXT Elite)

Available at  [Health & social work](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48421&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0360-7283&volume=21&issue=1&spage=49)  - from ProQuest (Health Research Premium) - NHS Version

Available at  [Health & social work](http://openurl.ebscohost.com/linksvc/linking.aspx?authtype=athens&genre=article&issn=0360-7283&volume=21&issue=1&spage=49&date=1996)  - from EBSCO (Psychology and Behavioral Sciences Collection)

**Abstract:** Anticipatory grief may have beneficial effects for caregivers of people with HIV infection or AIDS. However, the duration of the illness and the stigmatization and multiple losses associated with the disease may impede the caregiver's ability to effectively engage in the grief process. This article discusses the impact of these aspects of the disease on the anticipatory grief process and mourning tasks for caregivers at each stage of the illness. Intervention strategies developed to help the caregiver remain actively involved with the patient and simultaneously grieve losses and prepare for death are specified.

**Database:** Medline

**76. Death and AIDS: a review of the medico-legal literature.**

**Author(s):** Huber, J T

**Source:** Death studies; 1993; vol. 17 (no. 3); p. 225-232

**Publication Date:** 1993

**Publication Type(s):** Journal Article Review

**PubMedID:** 10126140

**Abstract:** As there is still neither a known cure for the acquired immunodeficiency syndrome (AIDS) nor any vaccine to prevent infection with the human immunodeficiency virus (HIV), an AIDS diagnosis continues to denote a death sentence. One might think that approaching dying, death, and bereavement in the AIDS pandemic would be the same as with other terminal illnesses. However, that is not the case. No other single disease in the history of the American legal system has generated more litigation than this disease. This article examines some of the medico-legal issues associated with AIDS-related death such as estate planning, discrimination, insurance, long-term care, the right to die, and suicide as detailed in medical and legal discourse.

**Database:** Medline

**77. AIDS and the family: implications for counselling.**

**Author(s):** Lippmann, S B; James, W A; Frierson, R L

**Source:** AIDS care; 1993; vol. 5 (no. 1); p. 71-78

**Publication Date:** 1993

**Publication Type(s):** Journal Article Review

**PubMedID:** 8461363

Available at  [AIDS care](http://openurl.ebscohost.com/linksvc/linking.aspx?authtype=athens&genre=article&issn=0954-0121&volume=5&issue=1&spage=71&date=1993)  - from EBSCO (Psychology and Behavioral Sciences Collection)

**Abstract:** The presence of HIV spectrum illness stimulates a powerful emotional reaction from a patient's family and friends. Grief and shock over the infection, and its implications are frequent observations. Sadness, anxiety, helplessness and anger are also common. Health care staff should address these responses in order to strengthen coping skills and maximize interpersonal comfort. Stigmatization and isolation are major stressors. Bereavement is complicated by fear, shame, dependency and hopelessness. Therefore, a task in counselling is to maintain the integrity and supportiveness of the patient's social unit by encouraging open communications between those involved and by educating about AIDS. Information should be provided on HIV transmission, self-protection, and illness progression as well as the safety of causal contacts and the practices of 'safer sex'. The significant others should retain outside interests and be encouraged to seek help for patients from supportive social agencies. Instillation of hope lends benefit to patient, family and friends. Kind, non-judgmental counselling and good quality medical care should be made available, especially since HIV-related disorders are increasingly becoming a chronic disease. Advocacy for the significant others translates into better adjustment and it enhances the patient's medical prognosis.

**Database:** Medline

**78. Trauma and its relationship to the adult respiratory distress syndrome and the multi-organ dysfunction syndrome: Part one**

**Author(s):** Boghossian B.P.

**Source:** Clinical Intensive Care; 1993; vol. 4 (no. 2); p. 67-72

**Publication Date:** 1993

**Publication Type(s):** Review

**Abstract:** It was as a complication of trauma that Adult Respiratory Distress Syndrome (ARDS) was first recognised in wounded soldiers during the Second World War. 1-3 Years later, another grave syndrome, Multi-Organ Dysfunction Syndrome (MODS), was also recognised as an almost terminal complication of trauma in its broader sense. 4 By the time both conditions were clearly defined and their pathophysiological mechanisms sufficiently understood, many other causative agents were discovered that were directly or indirectly responsible for the production of ARDS and MODS eg severe fulminating infections, such as peritonitis and pancreatitis; shock, viral influenza5 aspiration of gastric contents, and others. However, trauma, in its wider meaning, with sepsis, remains the most important aetiological factor in the genesis of ARDS and MODS. 6 It is the aim of this review to discuss briefly the chronological sequence of events in the development of our knowledge of these two syndromes. I shall highlight the salient features with emphasis on selected, pertinent experimental and clinical information that defines our present concept of the role of trauma in the development of acute lung injury ie ARDS and the closely associated MODS. Several important animal experiments related to trauma are described and evaluated in some detail in this issue. The clinical implications in patients will be discussed in Part Two of this review, as well as future challenges facing researchers in traumatology and intensive care.

**Database:** EMBASE

**79. [The psychological impact of HIV infection and the "burn-out" syndrome amongst health care workers dealing with HIV seropositive and AIDS patients].**

**Author(s):** Gala, C; Pergami, A; Invernizzi, G

**Source:** Minerva psichiatrica; Jun 1993; vol. 34 (no. 2); p. 75-84

**Publication Date:** Jun 1993

**Publication Type(s):** English Abstract Journal Article Review

**PubMedID:** 8412580

**Abstract:** HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immunodeficiency Syndrome) health care personnel is faced with a life threatening disease and with problems concerning fear of contagion and sense of professional inadequacy in dealing with chronically and terminal patients who may be suffering from psychosocial and neuropsychiatric problems. Therefore, HIV/AIDS health care workers may develop the "burn-out syndrome" (BOS) that is characterized by emotional distress, lowered job productivity and spread of work problems to family and conjugal relationships. BOS aetiology involves individual, organizational and socio-cultural factors and its consequences may negatively affect quality of care of HIV/AIDS patients. BOS prevention includes continuing staff training and education on HIV-related issues and support groups for health workers.

**Database:** Medline

**80. L'impatto psicosociale dell'infezione da HIV sul personale sanitario e la sindrome del "burn-out" nel corso dell'assistenza ai pazienti sieropositivi e AIDSThe psychological impact of HIV infection and the "burn-out" syndrome amongst health care workers dealing with HIV seropositive and AIDS patients**

**Author(s):** Gala C.; Pergami A.; Invernizzi G.

**Source:** Minerva psichiatrica; Jun 1993; vol. 34 (no. 2); p. 75-84

**Publication Date:** Jun 1993

**Publication Type(s):** Review

**PubMedID:** 8412580

**Abstract:** HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immunodeficiency Syndrome) health care personnel is faced with a life threatening disease and with problems concerning fear of contagion and sense of professional inadequacy in dealing with chronically and terminal patients who may be suffering from psychosocial and neuropsychiatric problems. Therefore, HIV/AIDS health care workers may develop the "burn-out syndrome" (BOS) that is characterized by emotional distress, lowered job productivity and spread of work problems to family and conjugal relationships. BOS aetiology involves individual, organizational and socio-cultural factors and its consequences may negatively affect quality of care of HIV/AIDS patients. BOS prevention includes continuing staff training and education on HIV-related issues and support groups for health workers.

**Database:** EMBASE

**81. The hidden victims of AIDS: healthcare workers and families.**

**Author(s):** Rinella, V J; Dubin, W R

**Source:** The Psychiatric hospital; 1988; vol. 19 (no. 3); p. 115-120

**Publication Date:** 1988

**Publication Type(s):** Journal Article Review

**PubMedID:** 10303697

**Abstract:** With the realization that acquired immune deficiency syndrome (AIDS) is an epidemic, the focus on prevention and treatment of the AIDS patients has intensified. However, there has been a lack of recognition of other potential victims. Specifically, little attention has been paid to the psychological impact of AIDS on healthcare workers who care for AIDS patients and on families of AIDS victims. In addition to confronting the premature dying of a young patient, both healthcare workers and families must confront their own conflicts regarding the stigmatizing nature of AIDS as it relates to the patient's sexuality or drug abuse. Failure to resolve these issues often serves as a major obstacle to the provision of effective medical care and prevents families from providing the essential emotional support that can help patients cope with their illness. Furthermore, failure to resolve family conflicts about the patient's life-style may significantly impair the grieving process and may lead to family disengagement and dissolution. The purpose of this paper is to review the literature on the impact of AIDS on healthcare workers and families, and to propose intervention strategies which will alleviate stress and facilitate appropriate psychological adaptation. "....this dreadful disease is not only killing young people in the prime of life and destroying their familial and social relationships. It is also damaging the bond between the care giver and the patient with AIDS as well."

**Database:** Medline

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| 3 | Medline | exp "DISEASE OUTBREAKS"/ | 95706 |
| 4 | Medline | (1 OR 2 OR 3) | 1638075 |
| 5 | Medline | (palliati\* AND (car\* OR nurs\* OR surge\* OR therap\* OR treat\*)).ti,ab | 64780 |
| 6 | Medline | exp "PALLIATIVE CARE"/ | 53314 |
| 7 | Medline | exp "PALLIATIVE MEDICINE"/ | 336 |
| 8 | Medline | exp "HOSPICE AND PALLIATIVE CARE NURSING"/ | 816 |
| 9 | Medline | (5 OR 6 OR 7 OR 8) | 88796 |
| 10 | Medline | exp "TERMINAL CARE"/ | 50687 |
| 11 | Medline | ((terminal\* OR end of life OR EOL OR dying) AND (car\* OR nurs\* OR therap\* OR treat\*)).ti,ab | 201559 |
| 12 | Medline | (10 OR 11) | 235696 |
| 13 | Medline | (9 OR 12) | 305249 |
| 14 | Medline | (4 AND 13) | 13930 |
| 15 | Medline | exp BEREAVEMENT/ | 13120 |
| 16 | Medline | (bereav\* OR grief\* OR griev\* OR mourn\* OR distress\* OR sorrow\*).ti,ab | 133664 |
| 17 | Medline | (15 OR 16) | 138487 |
| 18 | Medline | (14 AND 17) | 187 |
| 19 | CINAHL | (COVID\* OR Coronavir\* OR Corona OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS OR ncov OR "2019-ncov" OR "novel betacov" OR "novel betacoronavirus" OR infection\* OR infectious disease\* OR pandemic\* OR "Spanish flu" OR "bird flu" OR "avian flu" OR "H1N1" OR influenza OR flu OR disease\* outbreak\* OR epidemic\*).ti,ab | 286896 |
| 20 | CINAHL | exp CORONAVIRUS/ OR exp "CORONAVIRUS INFECTIONS"/ | 3365 |
| 21 | CINAHL | exp "DISEASE OUTBREAKS"/ | 28646 |
| 22 | CINAHL | (19 OR 20 OR 21) | 298535 |
| 23 | CINAHL | (palliati\* AND (car\* OR nurs\* OR surge\* OR therap\* OR treat\*)).ti,ab | 37436 |
| 24 | CINAHL | exp "PALLIATIVE CARE"/ | 38813 |
| 25 | CINAHL | exp "HOSPICE AND PALLIATIVE NURSES ASSOCIATION"/ | 295 |
| 26 | CINAHL | exp "HOSPICE AND PALLIATIVE NURSING"/ | 5238 |
| 27 | CINAHL | (23 OR 24 OR 25 OR 26) | 55559 |
| 28 | CINAHL | exp "TERMINAL CARE"/ | 68728 |
| 29 | CINAHL | ((terminal\* OR end of life OR EOL OR dying) AND (car\* OR nurs\* OR therap\* OR treat\*)).ti,ab | 48517 |
| 30 | CINAHL | (28 OR 29) | 97217 |
| 31 | CINAHL | (27 OR 30) | 109212 |
| 32 | CINAHL | (22 AND 31) | 2449 |
| 33 | CINAHL | exp BEREAVEMENT/ | 14977 |
| 34 | CINAHL | (bereav\* OR grief\* OR griev\* OR mourn\* OR distress\* OR sorrow\*).ti,ab | 71957 |
| 35 | CINAHL | (33 OR 34) | 77352 |
| 36 | CINAHL | (32 AND 35) | 85 |
| 37 | EMBASE | (COVID\* OR Coronavir\* OR Corona OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS OR ncov OR "2019-ncov" OR "novel betacov" OR "novel betacoronavirus" OR infection\* OR infectious disease\* OR pandemic\* OR "Spanish flu" OR "bird flu" OR "avian flu" OR "H1N1" OR influenza OR flu OR disease\* outbreak\* OR epidemic\*).ti,ab | 1973215 |
| 41 | EMBASE | exp CORONAVIRINAE/ OR exp "CORONAVIRUS INFECTION"/ | 21514 |
| 42 | EMBASE | exp PANDEMIC/ OR exp EPIDEMIC/ OR exp "PANDEMIC INFLUENZA"/ | 118057 |
| 43 | EMBASE | (37 OR 41 OR 42) | 2011932 |
| 45 | EMBASE | ((terminal\* OR end of life OR EOL OR dying) AND (car\* OR nurs\* OR therap\* OR treat\*)).ti,ab | 260299 |
| 46 | EMBASE | exp "TERMINAL CARE"/ | 67941 |
| 47 | EMBASE | (45 OR 46) | 304323 |
| 48 | EMBASE | (palliati\* AND (car\* OR nurs\* OR surge\* OR therap\* OR treat\*)).ti,ab | 107089 |
| 49 | EMBASE | exp "PALLIATIVE THERAPY"/ | 108714 |
| 50 | EMBASE | exp "PALLIATIVE NURSING"/ | 853 |
| 51 | EMBASE | (48 OR 49 OR 50) | 148183 |
| 52 | EMBASE | (47 OR 51) | 422755 |
| 53 | EMBASE | (43 AND 52) | 20133 |
| 54 | EMBASE | (bereav\* OR grief\* OR griev\* OR mourn\* OR distress\* OR sorrow\*).ti,ab | 187522 |
| 55 | EMBASE | exp GRIEF/ | 12592 |
| 57 | EMBASE | exp BEREAVEMENT/ OR exp "BEREAVEMENT SUPPORT"/ | 9399 |
| 58 | EMBASE | (54 OR 55 OR 57) | 193488 |
| 59 | EMBASE | (53 AND 58) | 349 |
| 60 | EMCARE | (COVID\* OR Coronavir\* OR Corona OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS OR ncov OR "2019-ncov" OR "novel betacov" OR "novel betacoronavirus" OR infection\* OR infectious disease\* OR pandemic\* OR "Spanish flu" OR "bird flu" OR "avian flu" OR "H1N1" OR influenza OR flu OR disease\* outbreak\* OR epidemic\*).ti,ab | 333197 |
| 61 | EMCARE | exp CORONAVIRINAE/ OR exp "CORONAVIRUS INFECTION"/ | 4836 |
| 62 | EMCARE | exp PANDEMIC/ OR exp EPIDEMIC/ OR exp "PANDEMIC INFLUENZA"/ | 35208 |
| 63 | EMCARE | (60 OR 61 OR 62) | 342644 |
| 64 | EMCARE | ((terminal\* OR end of life OR EOL OR dying) AND (car\* OR nurs\* OR therap\* OR treat\*)).ti,ab | 41747 |
| 65 | EMCARE | exp "TERMINAL CARE"/ | 25915 |
| 66 | EMCARE | (64 OR 65) | 55281 |
| 67 | EMCARE | (palliati\* AND (car\* OR nurs\* OR surge\* OR therap\* OR treat\*)).ti,ab | 33967 |
| 68 | EMCARE | exp "PALLIATIVE THERAPY"/ | 43140 |
| 69 | EMCARE | exp "PALLIATIVE NURSING"/ | 394 |
| 70 | EMCARE | (67 OR 68 OR 69) | 49608 |
| 71 | EMCARE | (66 OR 70) | 89982 |
| 72 | EMCARE | (63 AND 71) | 2765 |
| 73 | EMCARE | (bereav\* OR grief\* OR griev\* OR mourn\* OR distress\* OR sorrow\*).ti,ab | 72830 |
| 74 | EMCARE | exp GRIEF/ | 7684 |
| 75 | EMCARE | exp BEREAVEMENT/ OR exp "BEREAVEMENT SUPPORT"/ | 5809 |
| 76 | EMCARE | (73 OR 74 OR 75) | 75217 |
| 77 | EMCARE | (72 AND 76) | 87 |
| 78 | BNI | (COVID\* OR Coronavir\* OR Corona OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS OR ncov OR "2019-ncov" OR "novel betacov" OR "novel betacoronavirus" OR infection\* OR infectious disease\* OR pandemic\* OR "Spanish flu" OR "bird flu" OR "avian flu" OR "H1N1" OR influenza OR flu OR disease\* outbreak\* OR epidemic\*).ti,ab | 42117 |
| 79 | BNI | CORONAVIRUSES/ OR "COVID-19"/ | 610 |
| 80 | BNI | PANDEMICS/ OR EPIDEMICS/ | 3860 |
| 81 | BNI | (78 OR 79 OR 80) | 42993 |
| 82 | BNI | ((terminal\* OR end of life OR EOL OR dying) AND (car\* OR nurs\* OR therap\* OR treat\*)).ti,ab | 14688 |
| 83 | BNI | "PALLIATIVE CARE"/ | 20092 |
| 84 | BNI | (palliati\* AND (car\* OR nurs\* OR surge\* OR therap\* OR treat\*)).ti,ab | 14273 |
| 85 | BNI | (82 OR 83 OR 84) | 28160 |
| 86 | BNI | (81 AND 85) | 486 |
| 87 | BNI | (bereav\* OR grief\* OR griev\* OR mourn\* OR distress\* OR sorrow\*).ti,ab | 17353 |
| 88 | BNI | GRIEF/ | 3566 |
| 89 | BNI | (87 OR 88) | 18249 |
| 90 | BNI | (86 AND 89) | 27 |
| 91 | PsycINFO | (COVID\* OR Coronavir\* OR Corona OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS OR ncov OR "2019-ncov" OR "novel betacov" OR "novel betacoronavirus" OR infection\* OR infectious disease\* OR pandemic\* OR "Spanish flu" OR "bird flu" OR "avian flu" OR "H1N1" OR influenza OR flu OR disease\* outbreak\* OR epidemic\*).ti,ab | 52936 |
| 92 | PsycINFO | exp EPIDEMICS/ | 3406 |
| 93 | PsycINFO | (91 OR 92) | 53174 |
| 94 | PsycINFO | ((terminal\* OR end of life OR EOL OR dying) AND (car\* OR nurs\* OR therap\* OR treat\*)).ti,ab | 24506 |
| 95 | PsycINFO | exp "PALLIATIVE CARE"/ | 13845 |
| 96 | PsycINFO | (palliati\* AND (car\* OR nurs\* OR surge\* OR therap\* OR treat\*)).ti,ab | 10678 |
| 97 | PsycINFO | (94 OR 95 OR 96) | 32970 |
| 98 | PsycINFO | (93 AND 97) | 554 |
| 99 | PsycINFO | (bereav\* OR grief\* OR griev\* OR mourn\* OR distress\* OR sorrow\*).ti,ab | 94740 |
| 100 | PsycINFO | exp BEREAVEMENT/ | 14641 |
| 101 | PsycINFO | exp "GRIEF COUNSELING"/ | 157 |
| 102 | PsycINFO | (99 OR 100 OR 101) | 95997 |
| 103 | PsycINFO | (98 AND 102) | 50 |
| 105 | Medline | exp "SYSTEMATIC REVIEW"/ OR exp "SYSTEMATIC REVIEWS AS TOPIC"/ | 3221 |
| 106 | Medline | exp "META-ANALYSIS"/ OR exp "META-ANALYSIS AS TOPIC"/ | 19124 |
| 107 | Medline | ((systematic\* OR evidence OR scoping OR rapid\*) ADJ3 (overview\* OR review\*)).ti,ab | 237767 |
| 111 | Medline | (Pubmed OR medline OR embase).ti,ab | 200081 |
| 112 | Medline | (search\* strateg\* OR search\* criteria OR systematic\* search\*).ti,ab | 180106 |
| 113 | Medline | (study selection OR selection of studies OR (data ADJ3 extract\*)).ti,ab | 240165 |
| 114 | Medline | (meta analys\* OR metaanalys\*).ti,ab | 172777 |
| 115 | Medline | (handsearch\* OR hand-search\*).ti,ab | 9095 |
| 116 | Medline | (PRISMA OR preferred reporting).ti,ab | 15346 |
| 117 | Medline | (relevant journals OR reference list\* OR bibliograph\*).ti,ab | 51783 |
| 118 | Medline | (105 OR 106 OR 107 OR 111 OR 112 OR 113 OR 114 OR 115 OR 116 OR 117) | 655852 |
| 119 | Medline | (18 AND 118) | 9 |
| 120 | Medline | (14 AND 17) [Document type Meta-analysis OR Review] | 35 |
| 121 | CINAHL | exp "SYSTEMATIC REVIEW"/ | 94376 |
| 123 | CINAHL | ((systematic\* OR evidence OR scoping OR rapid\*) ADJ3 (overview\* OR review\*)).ti,ab | 127284 |
| 124 | CINAHL | (Pubmed OR medline OR embase).ti,ab | 82824 |
| 125 | CINAHL | (search\* strateg\* OR search\* criteria OR systematic\* search\*).ti,ab | 75783 |
| 126 | CINAHL | (study selection OR selection of studies OR (data ADJ3 extract\*)).ti,ab | 60123 |
| 127 | CINAHL | (meta analys\* OR metaanalys\*).ti,ab | 73180 |
| 128 | CINAHL | (handsearch\* OR hand-search\*).ti,ab | 4599 |
| 129 | CINAHL | (PRISMA OR preferred reporting).ti,ab | 6629 |
| 130 | CINAHL | (relevant journals OR reference list\* OR bibliograph\*).ti,ab | 23723 |
| 131 | CINAHL | exp "META ANALYSIS"/ | 50363 |
| 132 | CINAHL | (121 OR 123 OR 124 OR 125 OR 126 OR 127 OR 128 OR 129 OR 130 OR 131) | 269338 |
| 133 | CINAHL | (36 AND 132) | 2 |
| 134 | CINAHL | (36 AND 132) [Publication types Meta Analysis OR Meta Synthesis OR Review OR Systematic Review] | 1 |
| 135 | EMBASE | exp "SYSTEMATIC REVIEW"/ OR exp "SYSTEMATIC REVIEW (TOPIC)"/ | 264060 |
| 136 | EMBASE | exp "META ANALYSIS"/ OR exp "META ANALYSIS (TOPIC)"/ | 224402 |
| 137 | EMBASE | ((systematic\* OR evidence OR scoping OR rapid\*) ADJ3 (overview\* OR review\*)).ti,ab | 279838 |
| 138 | EMBASE | (Pubmed OR medline OR embase).ti,ab | 254113 |
| 139 | EMBASE | (search\* strateg\* OR search\* criteria OR systematic\* search\*).ti,ab | 52470 |
| 140 | EMBASE | (study selection OR selection of studies OR (data ADJ3 extract\*)).ti,ab | 92892 |
| 141 | EMBASE | (meta analys\* OR metaanalys\*).ti,ab | 220301 |
| 142 | EMBASE | (handsearch\* OR hand-search\*).ti,ab | 11064 |
| 143 | EMBASE | (PRISMA OR preferred reporting).ti,ab | 17249 |
| 144 | EMBASE | (relevant journals OR reference list\* OR bibliograph\*).ti,ab | 49917 |
| 145 | EMBASE | (135 OR 136 OR 137 OR 138 OR 139 OR 140 OR 141 OR 142 OR 143 OR 144) | 653533 |
| 146 | EMBASE | (59 AND 145) | 18 |
| 147 | EMBASE | (53 AND 58) [Publication types Review] | 46 |
| 148 | EMBASE | (53 AND 58) [Evidence based medicine Meta Analysis OR Systematic Review] | 10 |
| 149 | EMCARE | exp "SYSTEMATIC REVIEW"/ OR exp "SYSTEMATIC REVIEW (TOPIC)"/ | 126759 |
| 150 | EMCARE | exp "META ANALYSIS"/ OR exp "META ANALYSIS (TOPIC)"/ | 76239 |
| 151 | EMCARE | ((systematic\* OR evidence OR scoping OR rapid\*) ADJ3 (overview\* OR review\*)).ti,ab | 116008 |
| 152 | EMCARE | (Pubmed OR medline OR embase).ti,ab | 96997 |
| 153 | EMCARE | (search\* strateg\* OR search\* criteria OR systematic\* search\*).ti,ab | 21190 |
| 154 | EMCARE | (study selection OR selection of studies OR (data ADJ3 extract\*)).ti,ab | 35355 |
| 155 | EMCARE | (meta analys\* OR metaanalys\*).ti,ab | 73718 |
| 156 | EMCARE | (handsearch\* OR hand-search\*).ti,ab | 4881 |
| 157 | EMCARE | (PRISMA OR preferred reporting).ti,ab | 7064 |
| 158 | EMCARE | (relevant journals OR reference list\* OR bibliograph\*).ti,ab | 18377 |
| 159 | EMCARE | (149 OR 150 OR 151 OR 152 OR 153 OR 154 OR 155 OR 156 OR 157 OR 158) | 239144 |
| 160 | EMCARE | (77 AND 159) | 5 |
| 161 | EMCARE | (72 AND 76) [Publication types Review] | 18 |
| 162 | EMCARE | (72 AND 76) [Evidence based medicine Meta Analysis OR Systematic Review] | 1 |
| 163 | BNI | ((systematic\* OR evidence OR scoping OR rapid\*) ADJ3 (overview\* OR review\*)).ti,ab | 16659 |
| 164 | BNI | (Pubmed OR medline OR embase).ti,ab | 8688 |
| 165 | BNI | (search\* strateg\* OR search\* criteria OR systematic\* search\*).ti,ab | 8816 |
| 166 | BNI | (study selection OR selection of studies OR (data ADJ3 extract\*)).ti,ab | 5188 |
| 167 | BNI | (meta analys\* OR metaanalys\*).ti,ab | 6460 |
| 168 | BNI | (handsearch\* OR hand-search\*).ti,ab | 657 |
| 169 | BNI | (PRISMA OR preferred reporting).ti,ab | 814 |
| 170 | BNI | (relevant journals OR reference list\* OR bibliograph\*).ti,ab | 2287 |
| 171 | BNI | "SYSTEMATIC REVIEW"/ OR "META-ANALYSIS"/ | 5908 |
| 172 | BNI | (163 OR 164 OR 165 OR 166 OR 167 OR 168 OR 169 OR 170 OR 171) | 29339 |
| 173 | BNI | (90 AND 172) | 2 |
| 174 | BNI | (86 AND 89) [Document type Literature Review OR Review] | 1 |
| 175 | PsycINFO | ((systematic\* OR evidence OR scoping OR rapid\*) ADJ3 (overview\* OR review\*)).ti,ab | 52912 |
| 176 | PsycINFO | (Pubmed OR medline OR embase).ti,ab | 22667 |
| 177 | PsycINFO | (search\* strateg\* OR search\* criteria OR systematic\* search\*).ti,ab | 32842 |
| 178 | PsycINFO | (study selection OR selection of studies OR (data ADJ3 extract\*)).ti,ab | 45155 |
| 179 | PsycINFO | (meta analys\* OR metaanalys\*).ti,ab | 36540 |
| 180 | PsycINFO | (handsearch\* OR hand-search\*).ti,ab | 1241 |
| 181 | PsycINFO | (PRISMA OR preferred reporting).ti,ab | 2406 |
| 182 | PsycINFO | (relevant journals OR reference list\* OR bibliograph\*).ti,ab | 23896 |
| 183 | PsycINFO | exp "META ANALYSIS"/ OR exp "LITERATURE REVIEW"/ | 27351 |
| 184 | PsycINFO | (175 OR 176 OR 177 OR 178 OR 179 OR 180 OR 181 OR 182 OR 183) | 180446 |
| 185 | PsycINFO | (103 AND 184) | 0 |
| 186 | PsycINFO | (98 AND 102) [Methodology Literature Review OR Meta Analysis OR Systematic Review] | 1 |