1- El descenso de la presión arterial media depende de alteraciones en el gasto cardiaco y la resistencia vascular sistémica:

Falso_____ Verdadero _____

2-La presión venosa central presenta una deficiente correlación con respecto diferenciar entre respondedores y no respondedores a fluidoterapia:

Falso_____ Verdadero _____

3-El índice de variabilidad del volumen sistólico y del gasto cardiaco, superan al test de elevación de piernas al momento de diferenciar entre respondedores y no respondedores a fluidoterapia:

Falso_____ Verdadero _____

4-Por cada gramo de albumina humana que se administra, se provoca una autotransfusión de 18ml de liquido intersticial hacia el espacio intravascular.

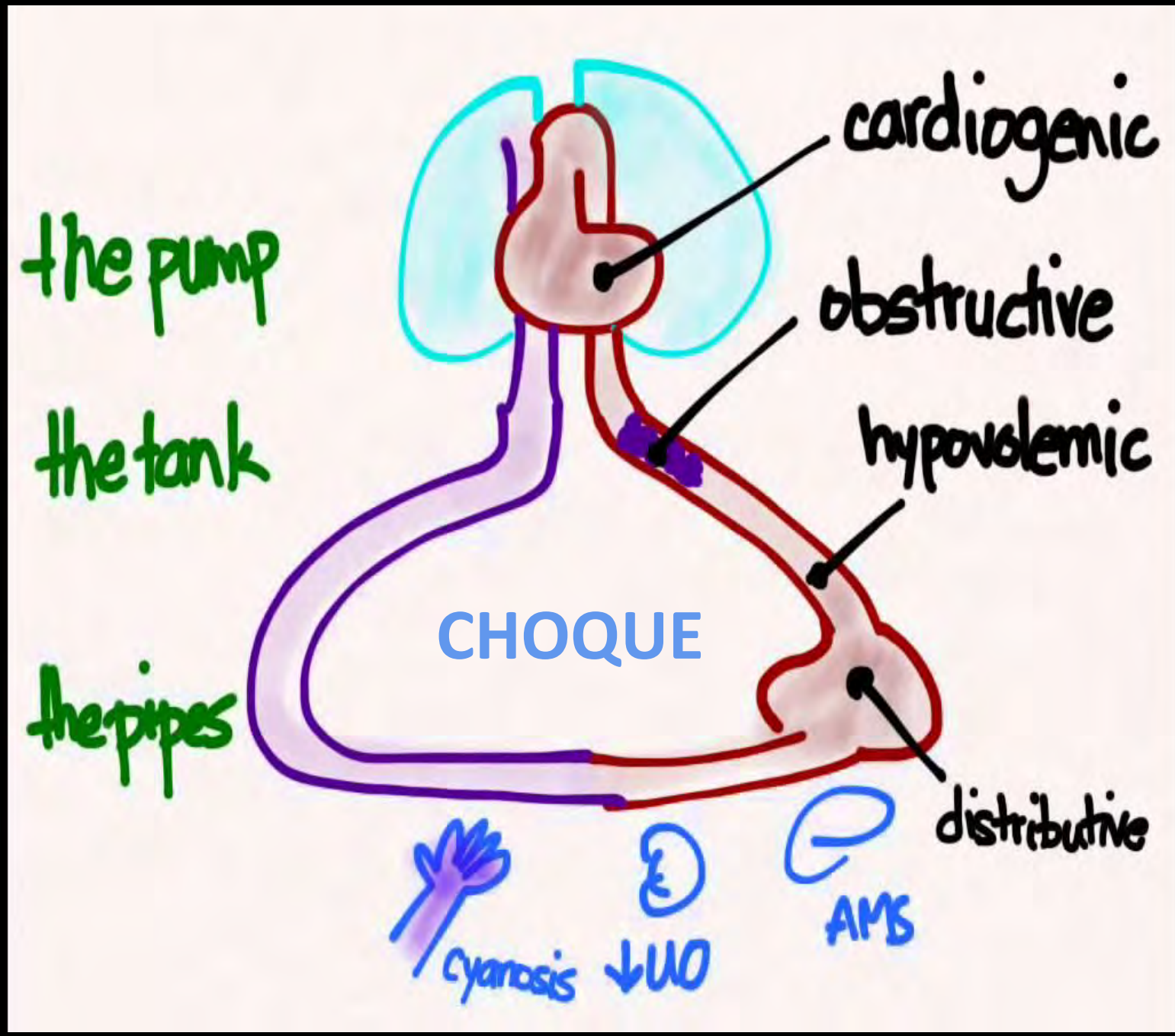
Falso_____ Verdadero _____

5-En el choque séptico, en caso de refractariedad a norepinefrina, se recomienda utilizar dopamina y no se recomienda emplear epinefrina:

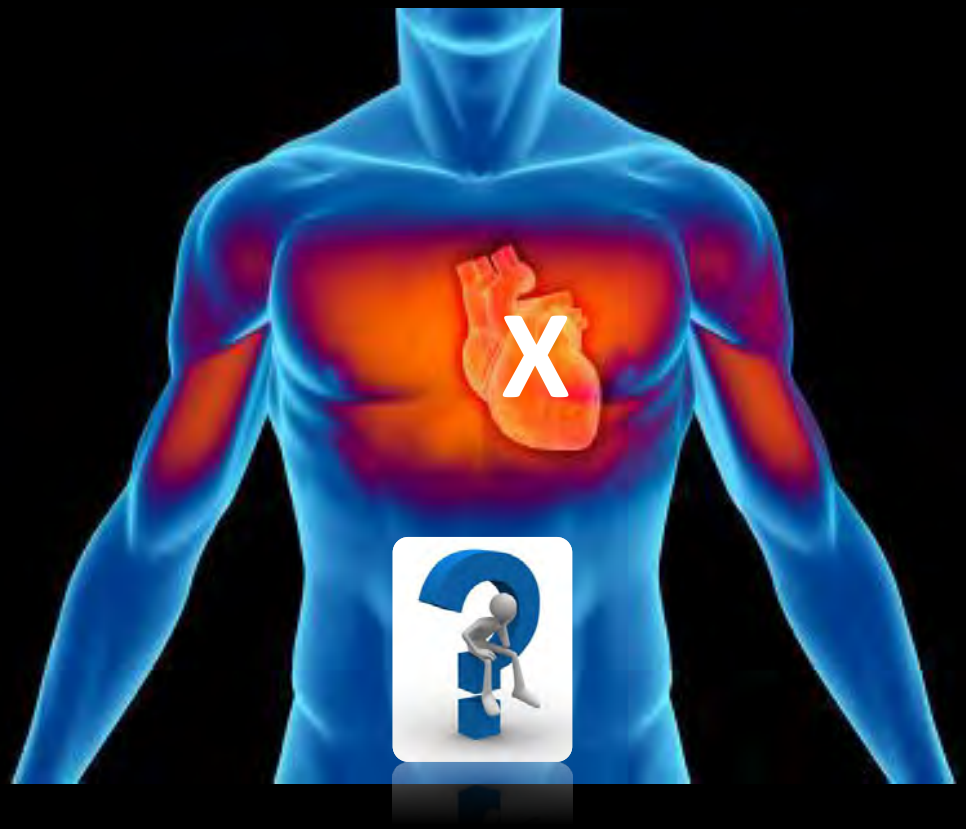
Falso_____ Verdadero _____

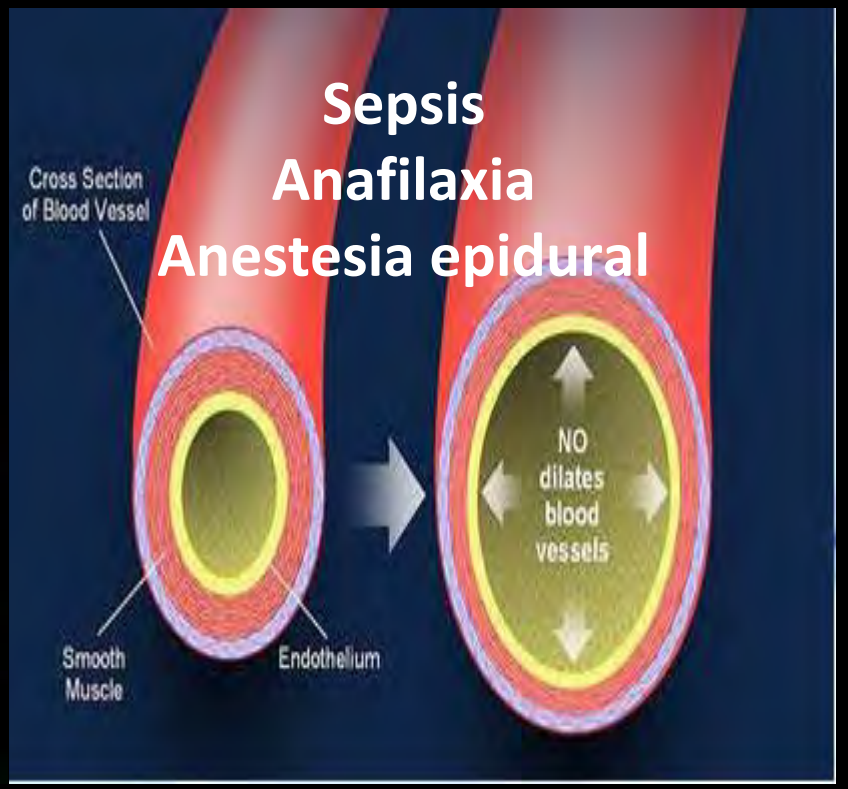
Fisiopatología y manejo del Choque circulatorio

Dr. Víctor Segura Lemus


the pump
the tank
the pipes
CHOQUE
cardiogenic
obstructive
hypovolemic
distributive
cyanosis
↓UO
AMS

PAM = GC × RVS


X


Sepsis
Anafilaxia
Anestesia epidural
Cross Section of Blood Vessel
NO dilates blood vessels
Smooth Muscle
Endothelium

GC= VS 70ml x FC 30x´= 2.1lts x´

GC = VS × FC

VS

PRECARGA

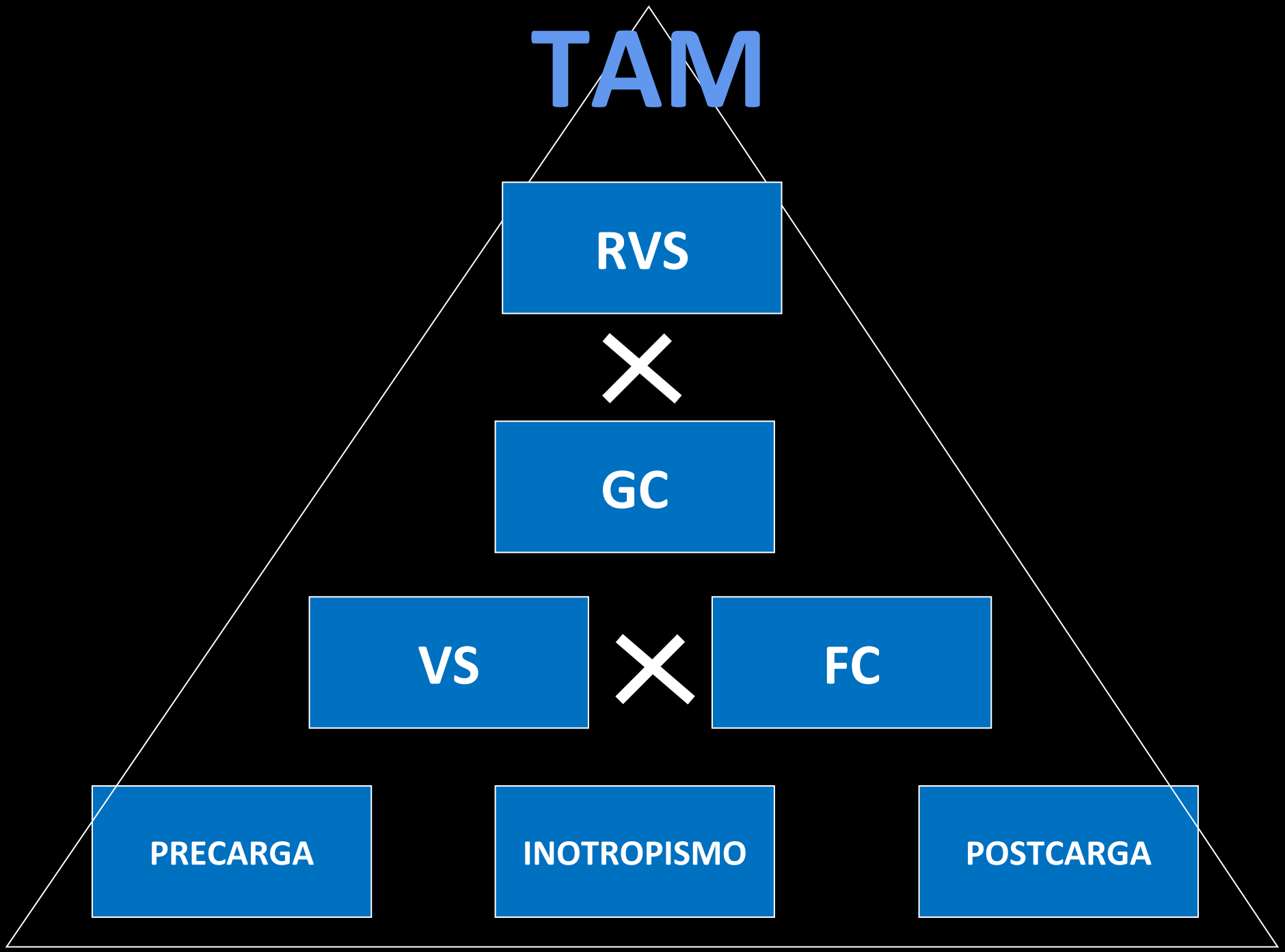
HEMORRAGIA

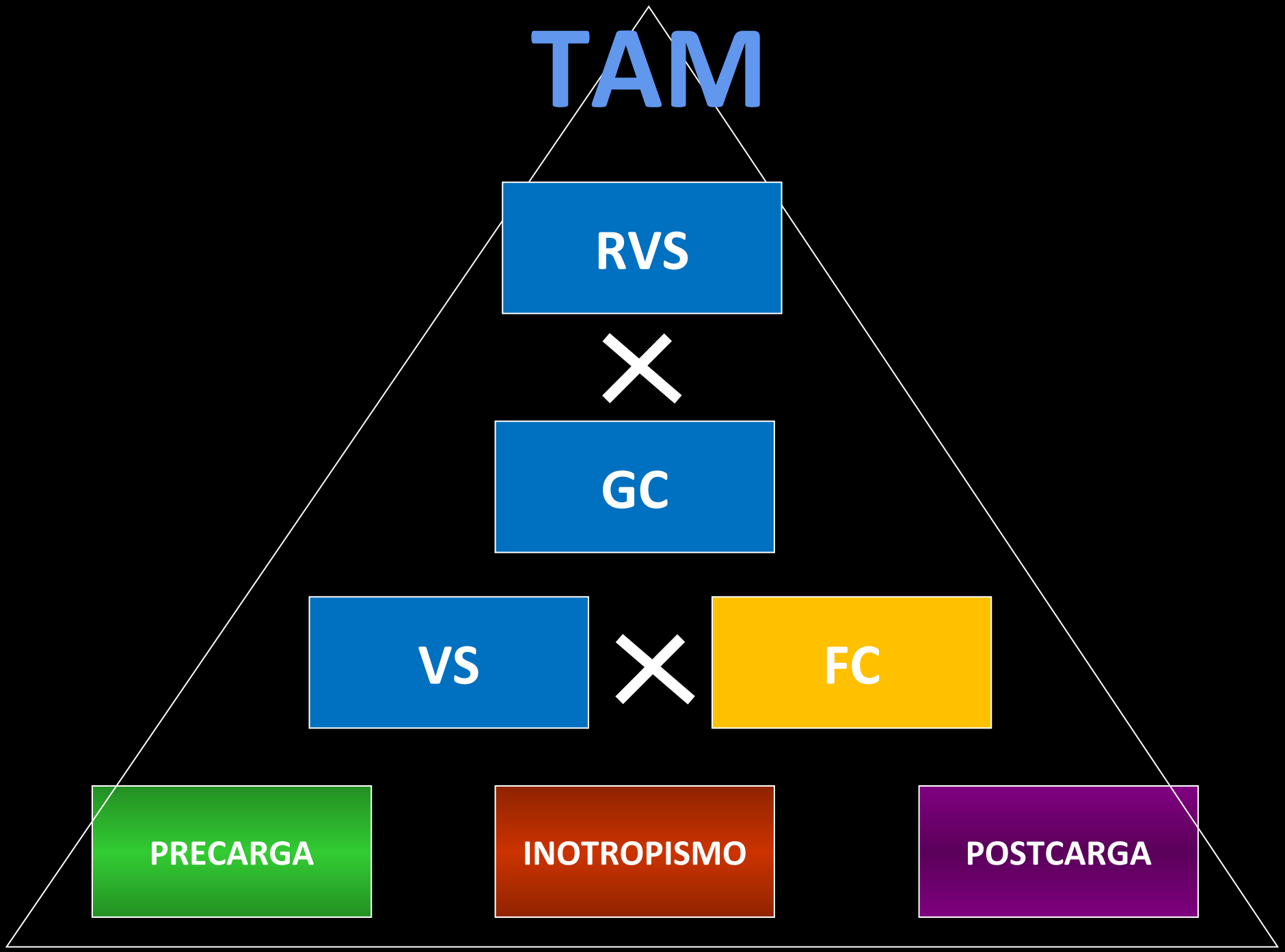
INOTROPISMO

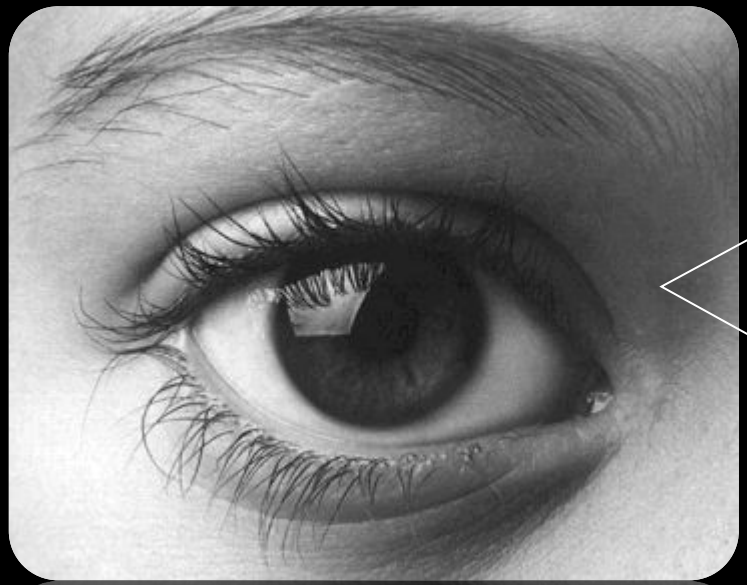
CONTUSION CARDIACA

POSTCARGA

ANESTESIA


TAM
RVS
GC
VS
FC
PRECARGA
INOTROPISMO
POSTCARGA


TAM
RVS
GC
VS
FC
PRECARGA
INOTROPISMO
POSTCARGA

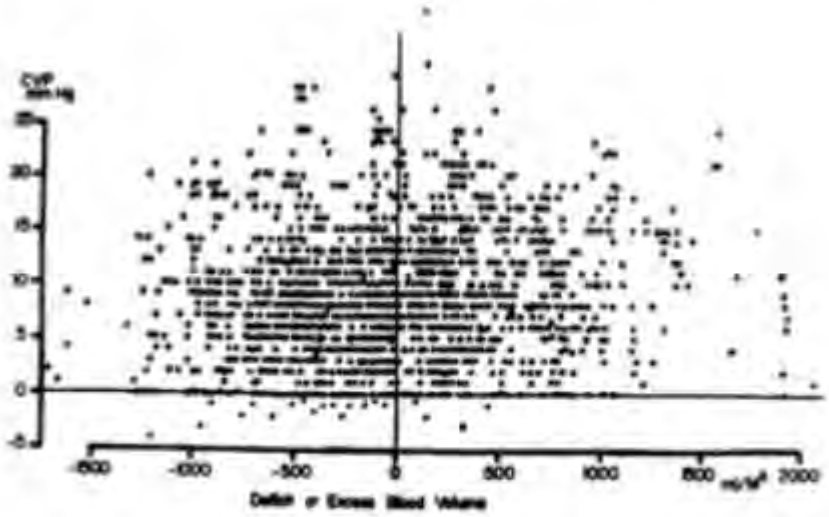


TAM

- PRECARGA
- INOTROPISMO
- FC
- POSTCARGA

PRECARGA

CVP

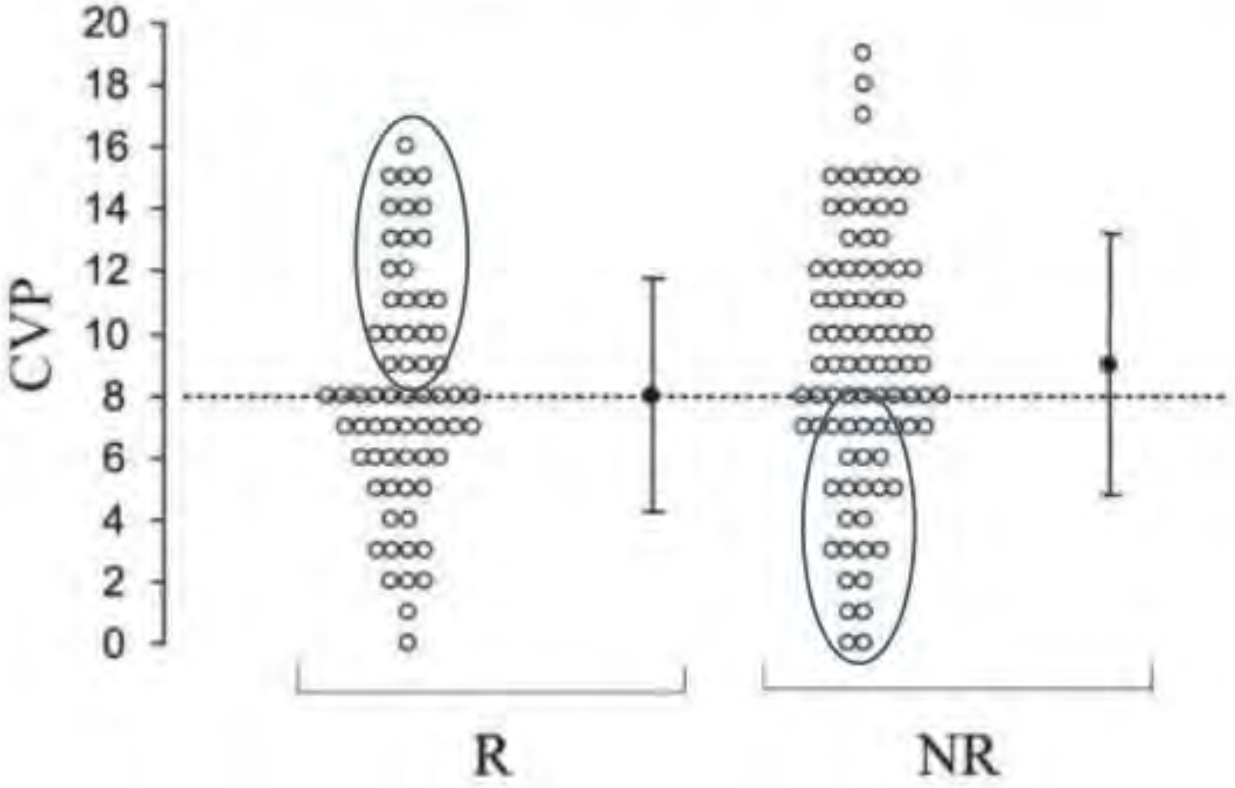


- CVP : poor predictor of fluid volume

CHEST. July 2008;134(1):172-178.

Cardiac filling pressures are not appropriate to predict hemodynamic response to volume challenge*

David Osman, MD; Christophe Ridel, MD; Patrick Ray, MD; Xavier Monnet, MD, PhD; Nadia Anguel, MD; Christian Richard, MD; Jean-Louis Teboul, MD, PhD



Hemodynamic parameters to guide fluid therapy

Paul E Marik[1*], Xavier Monnet[2], Jean-Louis Teboul[2]

Annals of Intensive Care 2011, 1:1

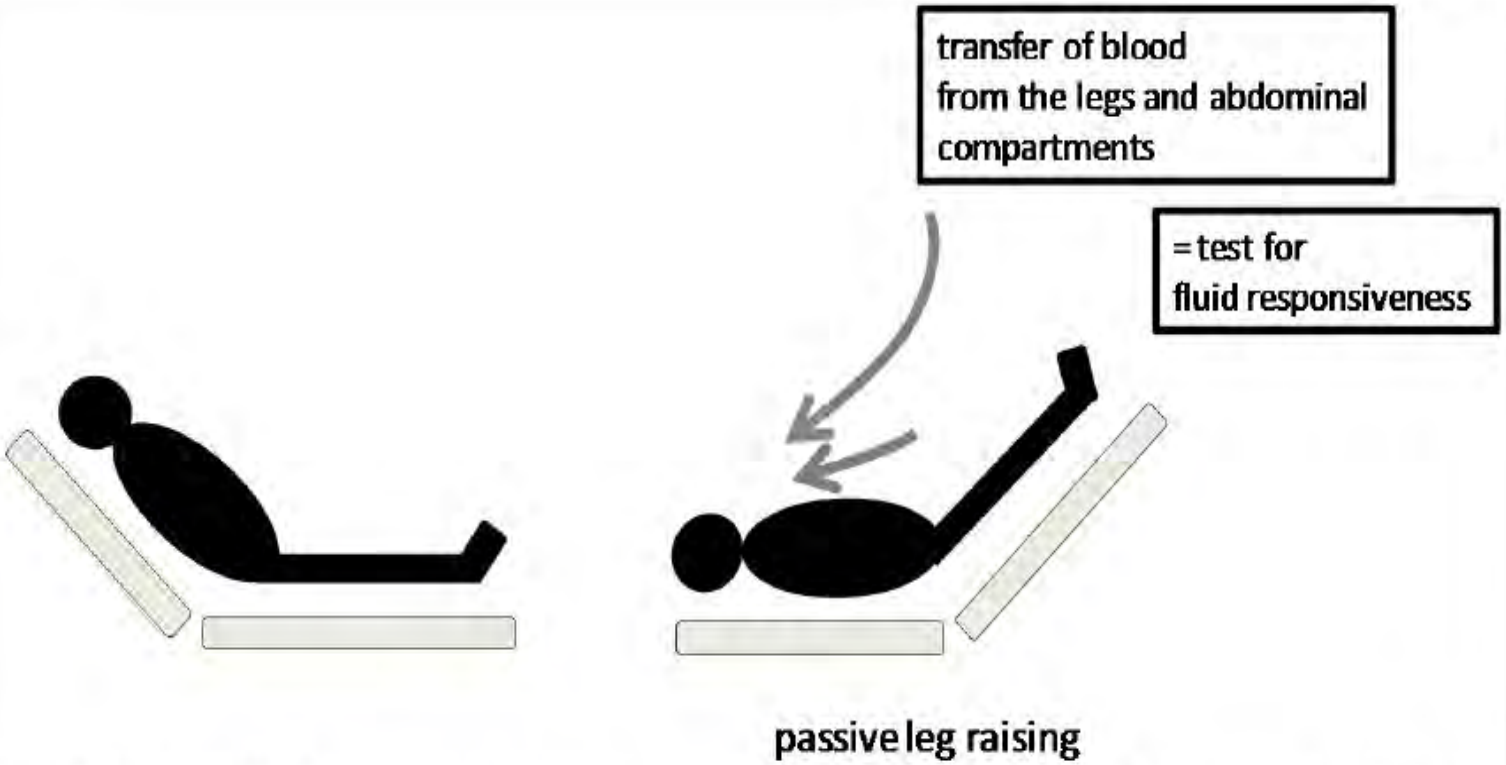
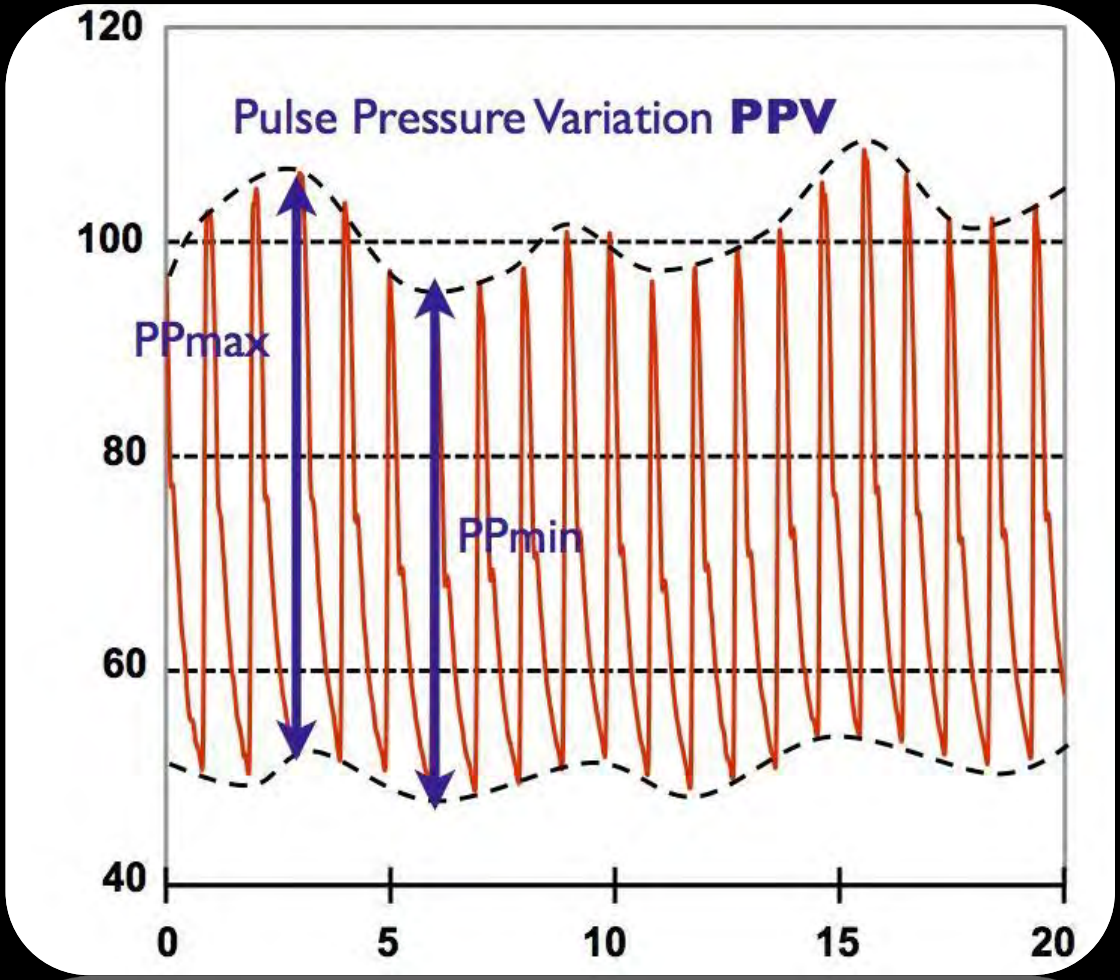
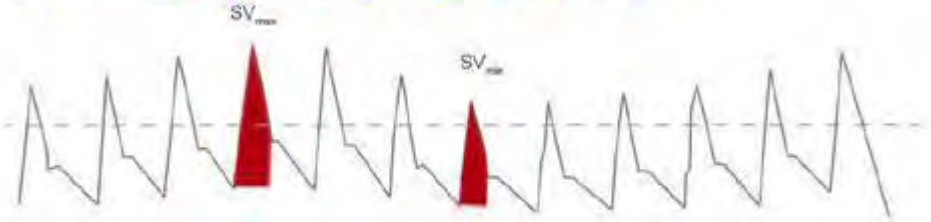


Figure 4 Passive leg raising. The passive leg raising test consists in measuring the hemodynamic effects of a leg elevation up to 45°. A simple way to perform the postural maneuver is to transfer the patient from the semirecumbent posture to the passive leg raising position by using the automatic motion of the bed.

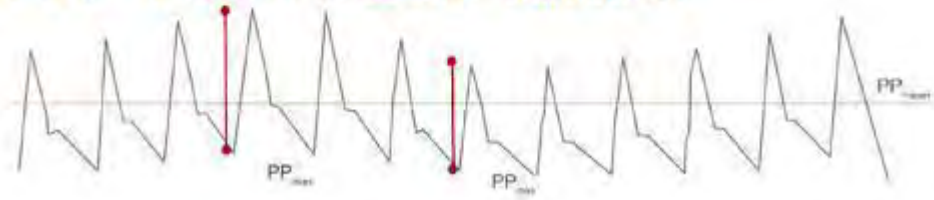
PPV= [(PPmax – PPmin)/ (PPmax + Ppmin/2)] x 100



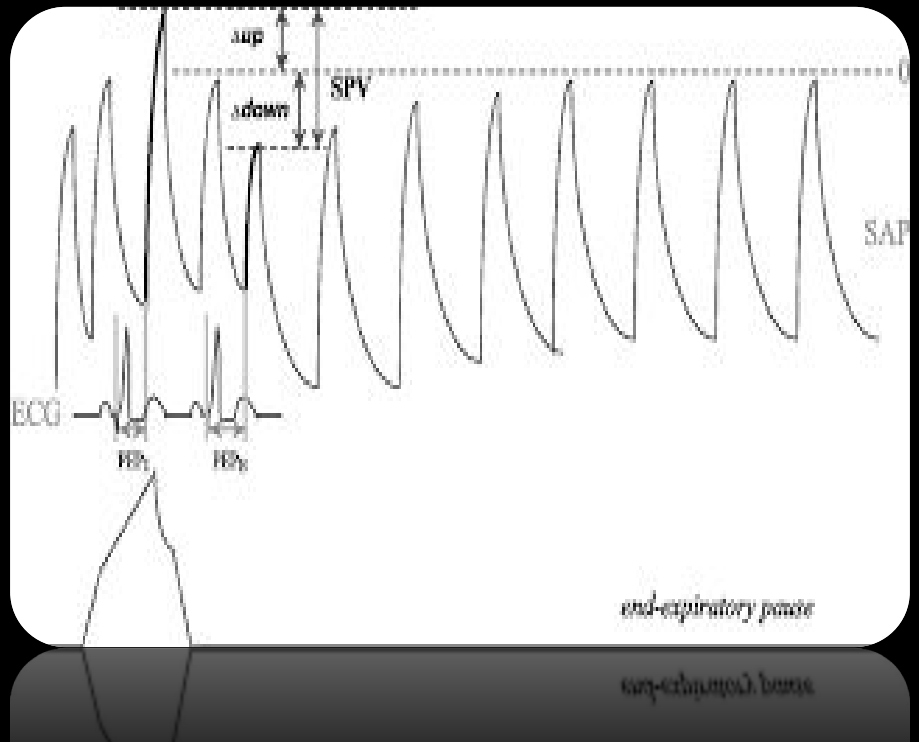
SVV - Stroke Volume Variation



PPV - Pulse Pressure Variation



$$SPV = 100 \times \left\{ \frac{(SP_{max} - SP_{min})}{\left[\frac{1}{2}(SP_{max} + SP_{min}) \right]} \right\}$$

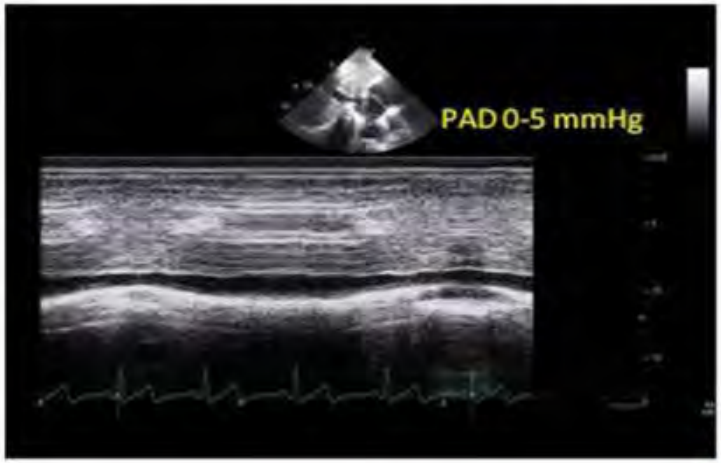


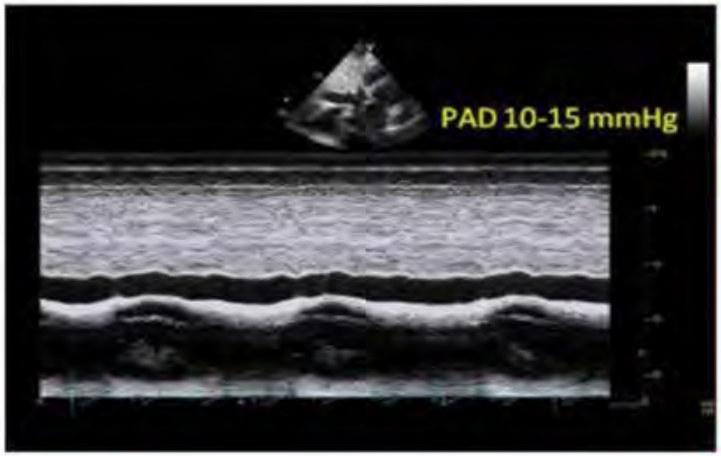

B
C
A

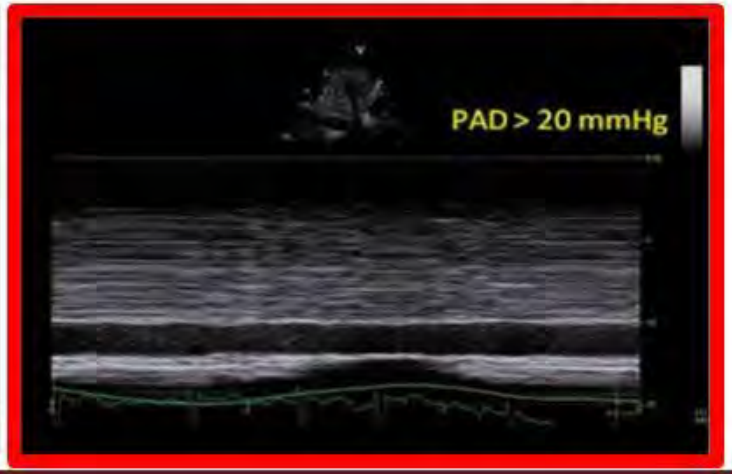

VCI
RA

TP: Signos ecocardiográficos

Dilatación VCI y colapso inspiratorio reducido:





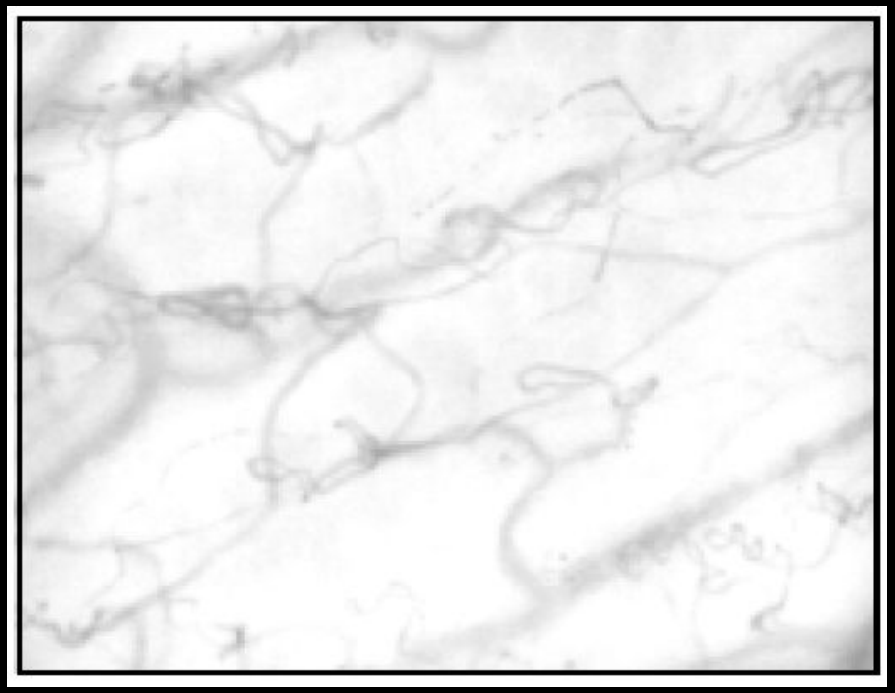


INOTROPISMO

	ALTO GASTO SEPTICO	BAJO GASTO CARDIOGENICO
TEMPERATURA	CALIENTE	FRIO
PIEL	HIPEREMICO	CIANOTICO
LLENADO CAPILAR	RAPIDO	LENTO
PRESION DE PULSO	AMPLIA	ESTRECHA


A.D.A.M.

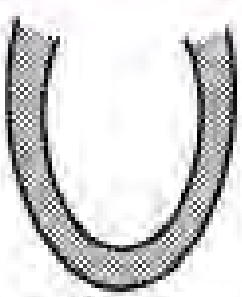

La sangre regresa al tejido
Se aplica presión al lecho ungueal hasta que se vuelva blanco
A.D.A.M.



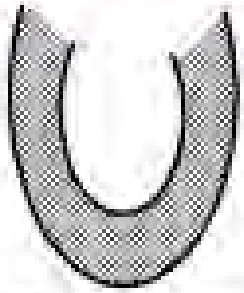
NORMAL

SEPSIS

ACUTE PHASE OF SEPTIC SHOCK



Left Ventricular End Diastolic Volume = 200 ml

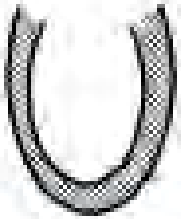


Left Ventricular End Systolic Volume = 150 ml

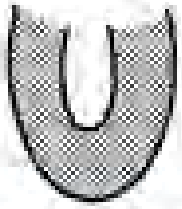
Stroke Volume = 50 ml

$$\text{Ejection Fraction} = \frac{200\ \text{ml} - 150\ \text{ml}}{200\ \text{ml}} = 25\%$$

RECOVERY PHASE OF SEPTIC SHOCK



Left Ventricular End Diastolic Volume = 100 ml

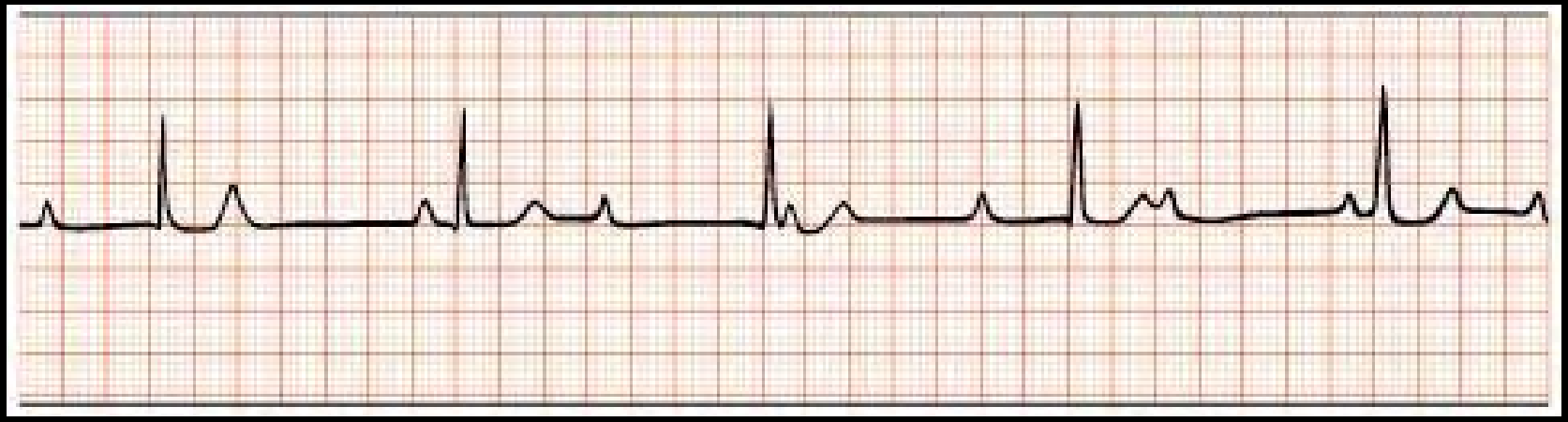


Left Ventricular End Systolic Volume = 50 ml

Stroke Volume = 50 ml

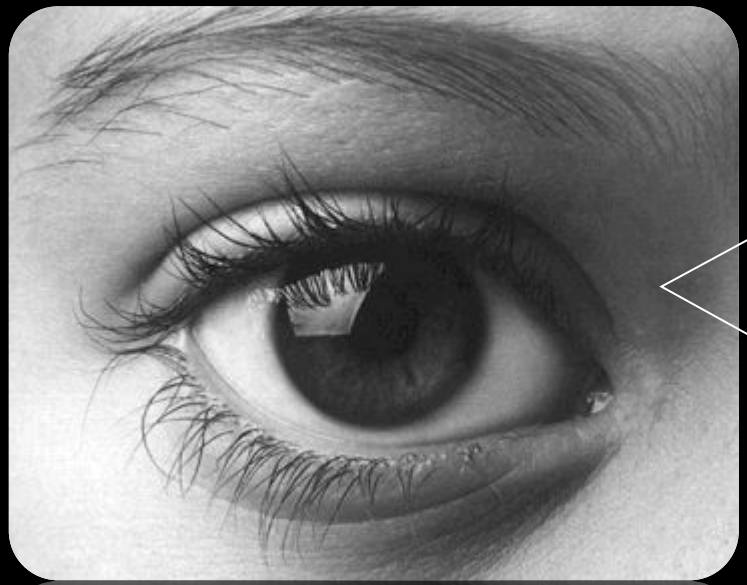
$$\text{Ejection Fraction} = \frac{100\ \text{ml} - 50\ \text{ml}}{100\ \text{ml}} = 50\%$$

FC



POSTCARGA

POSTCARGA



TAM

- PRECARGA
- INOTROPISMO
- FC
- POSTCARGA

PRECARGA	Volumen
INOTROPISMO	Inotrópicos
FC	Cronotrópicos Marcapaso Antiarrítmico Cardioversión Desfibrilación
POSTCARGA	Vasopresor Vasodilatador Calor

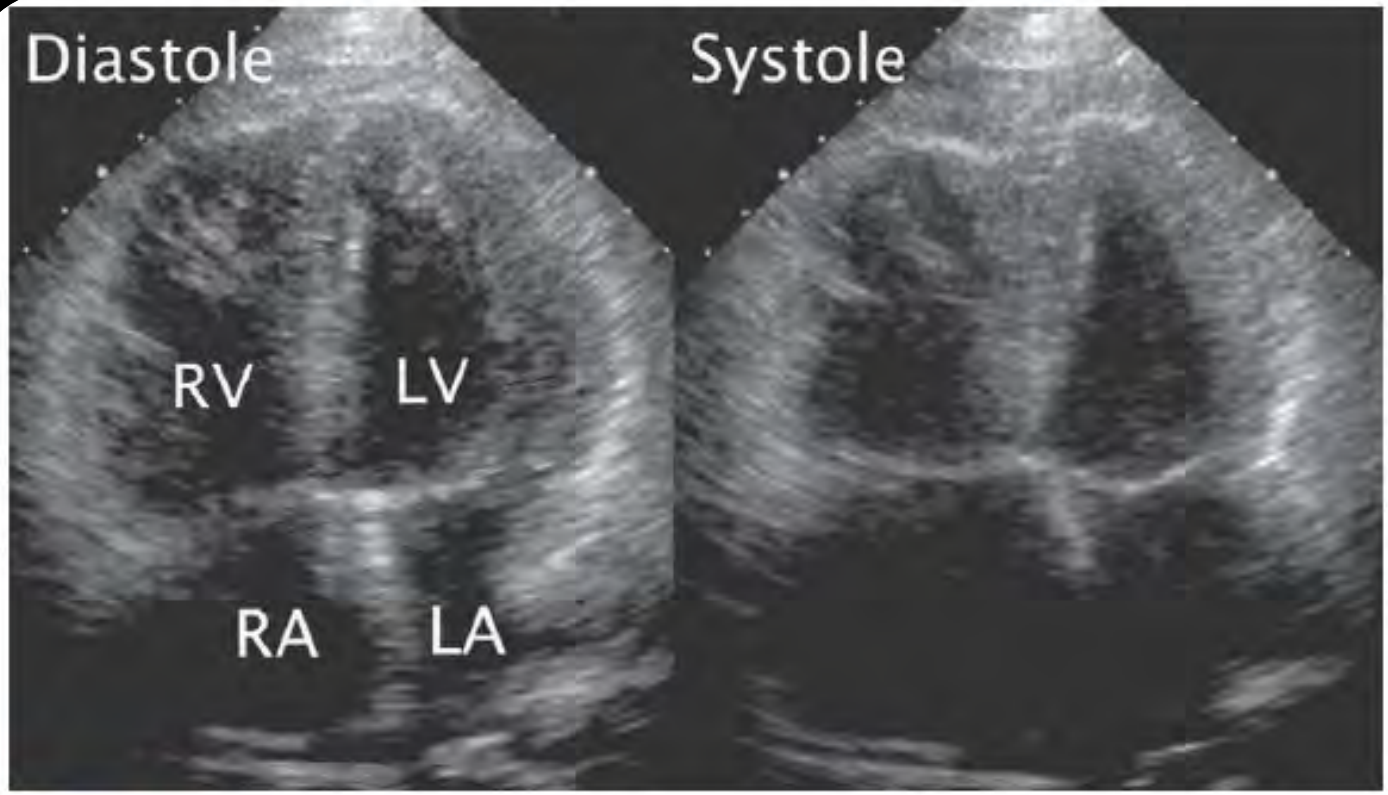
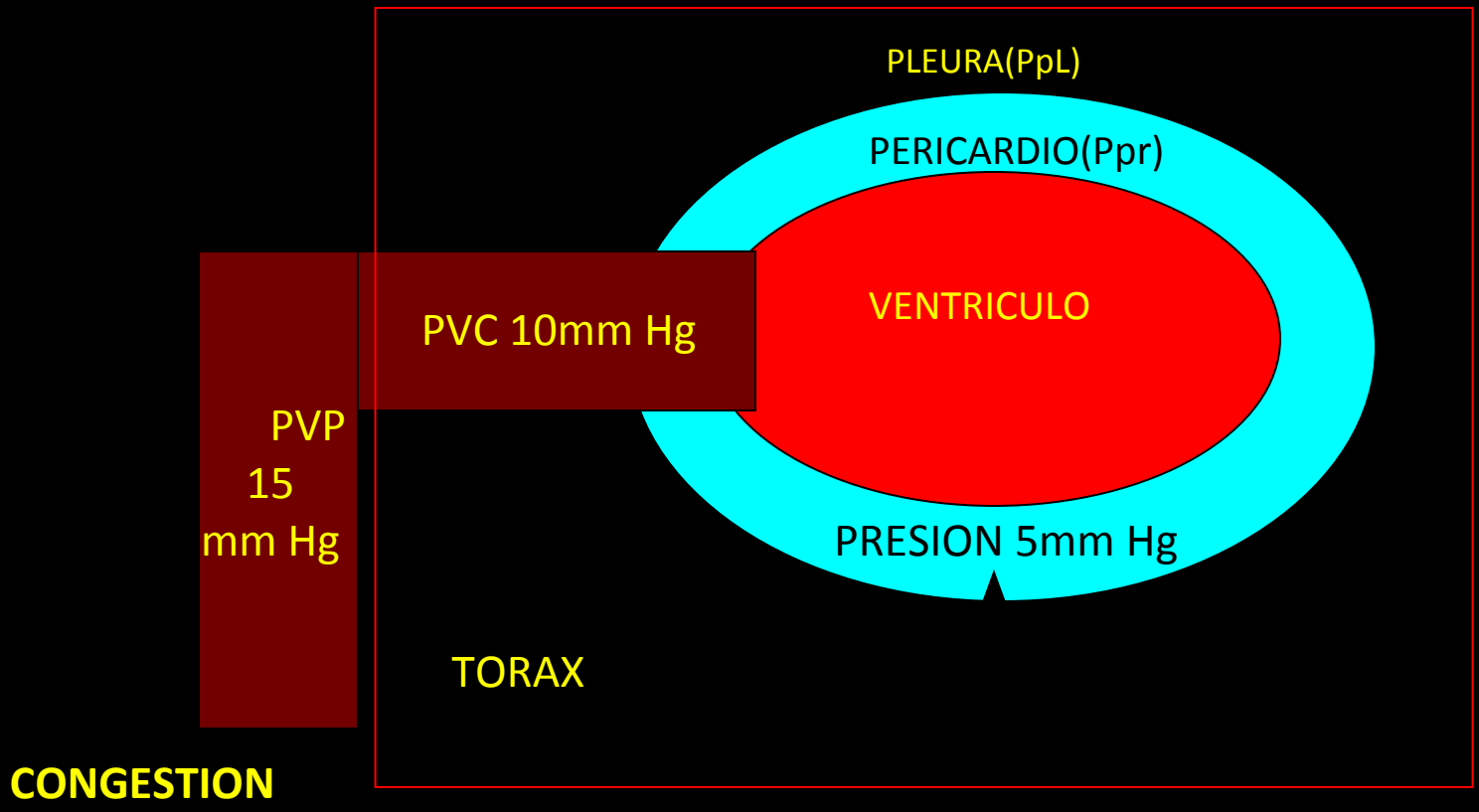


Figure 35–23. *Apical four-chamber view in diastole and systole in a patient with acute and massive pulmonary embolism. The right ventricle (RV) is severely diastolic image demonstrates severe dilatation. The interatrial septum deviates to the left consistent with right atrial hypertension. In systole, the RV does not appear to contract. However, there is motion at the right ventricular apex. This is a demonstration of "McConnell's sign" and should raise the suspicion of acute pulmonary embolism. LA, left atrium; LV, left ventricle; RA, right atrium.*

TAMPONADA CARDIACA



SI LA Ppr > 10 mmHg LA PVC Y LA PVP SE EQUILIBRAN
EL FLUJO ENTRE COMPARTIMENTOS SE VE ALTERADO.

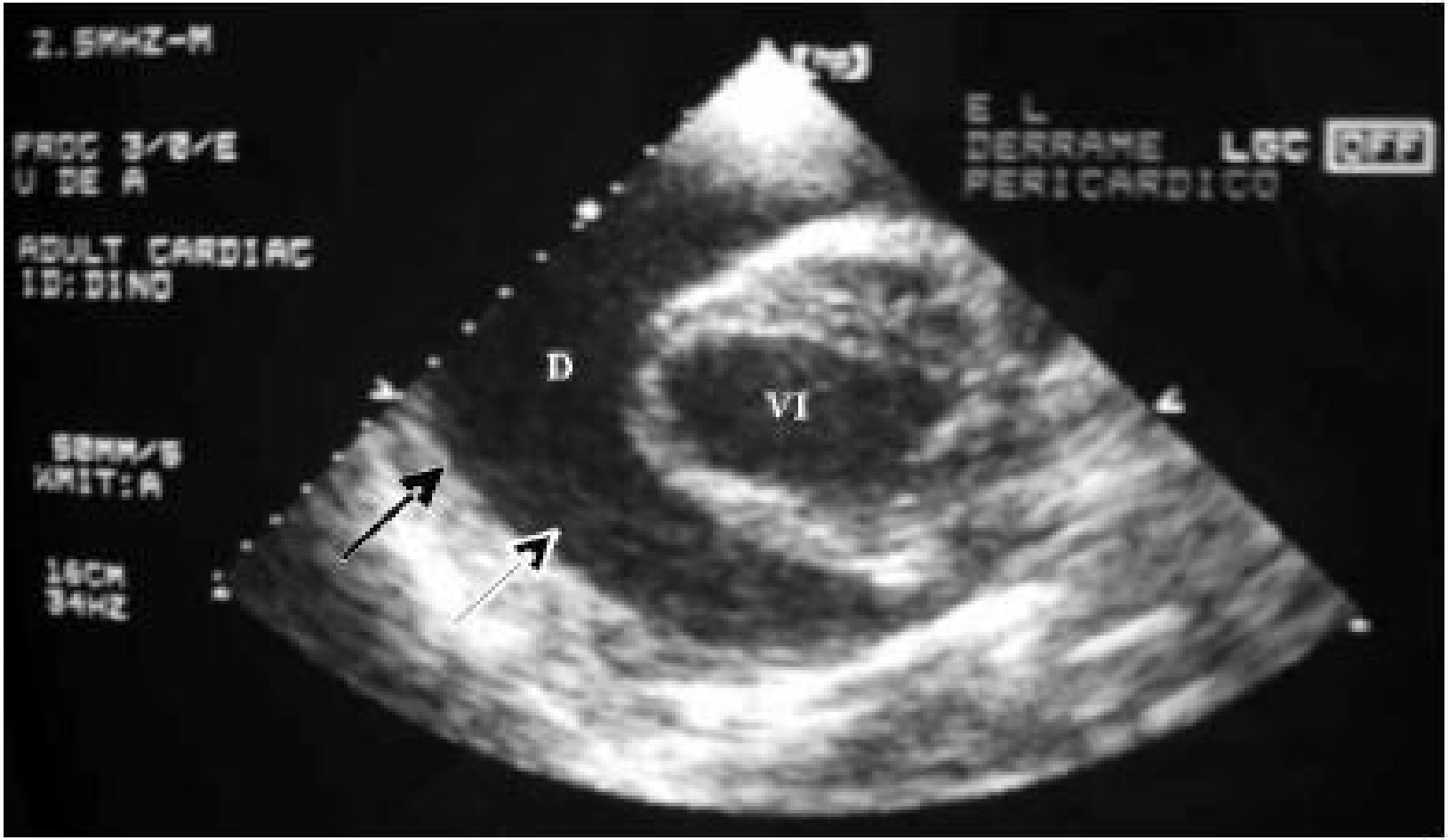
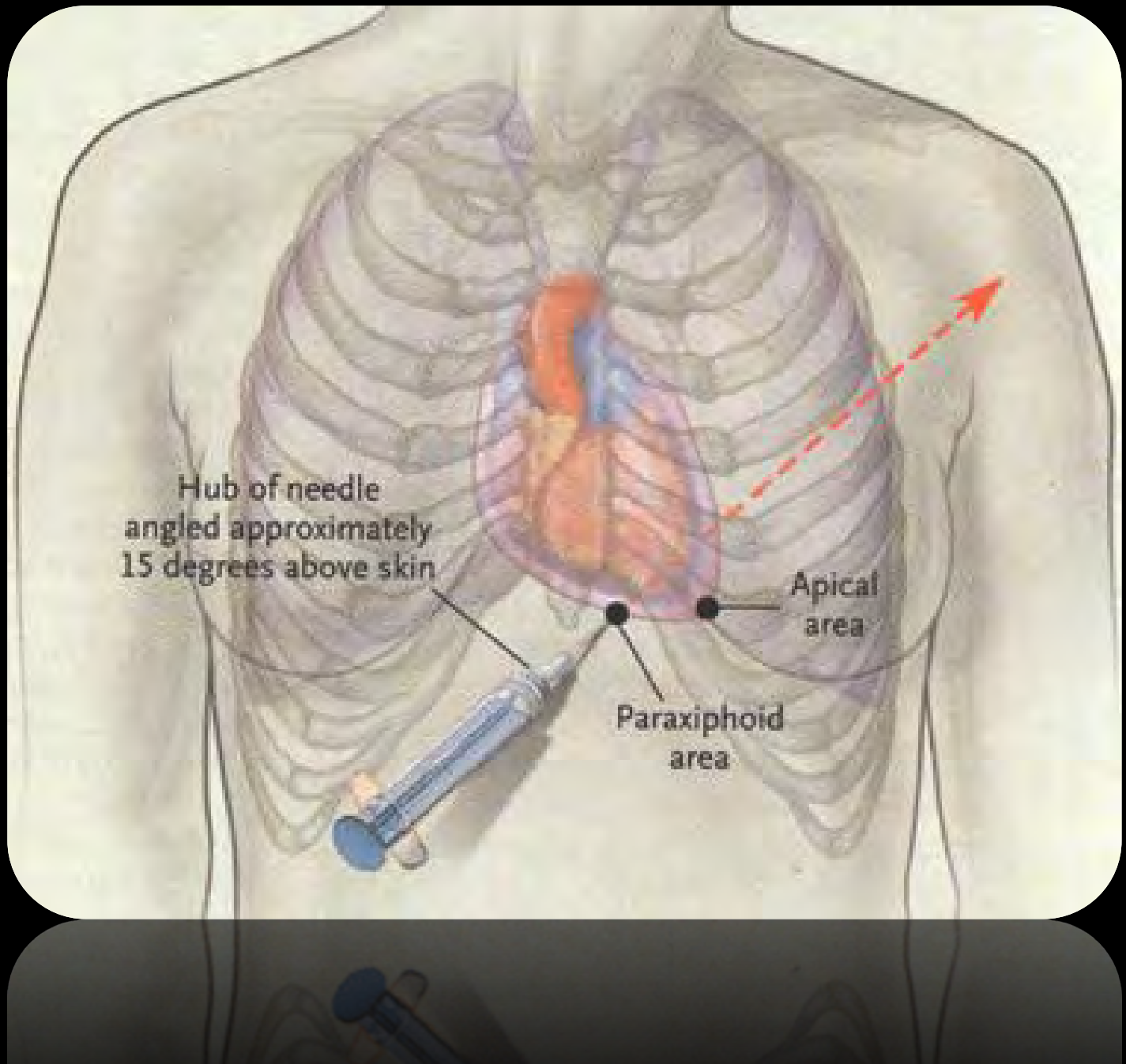
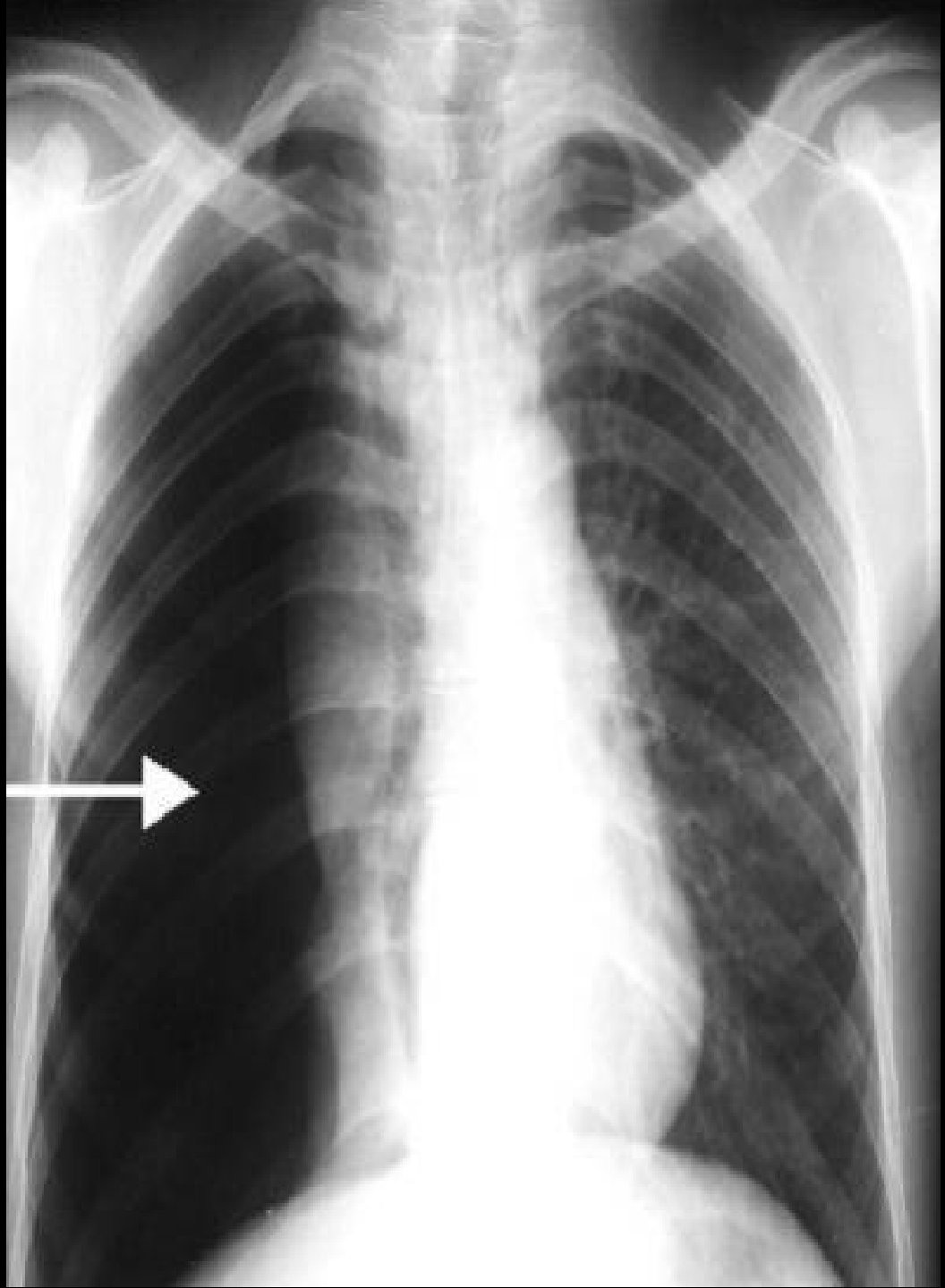


Figura 3. Ecocardiografía del eje largo. Una acumulación severa de líquido pericárdico (letra D) se aprecia como un espacio anecoico entre el ventrículo izquierdo (VI) y el saco pericárdico (flecha negra).


Hub of needle
angled approximately
15 degrees above skin
Apical
area
Paraxiphoid
area

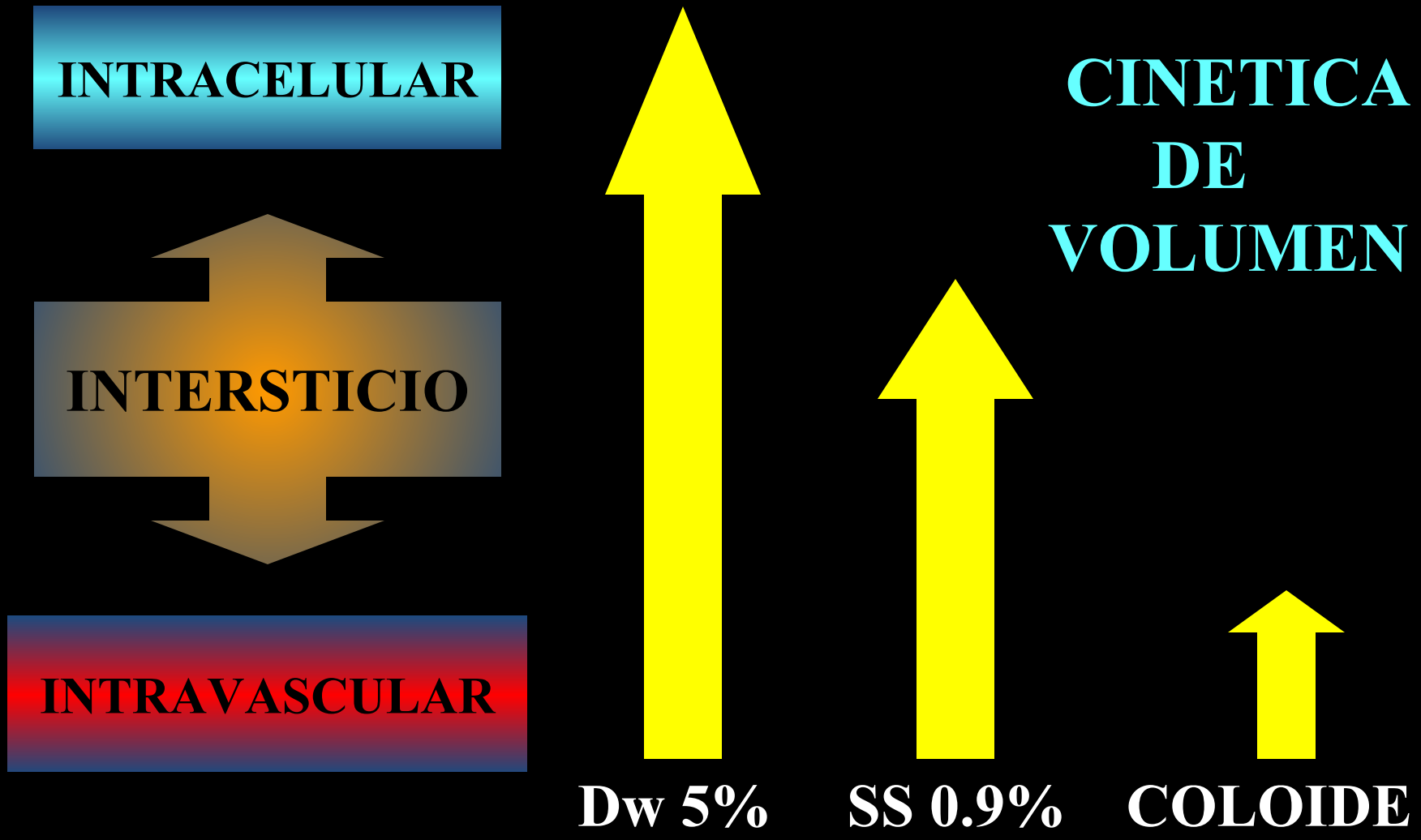


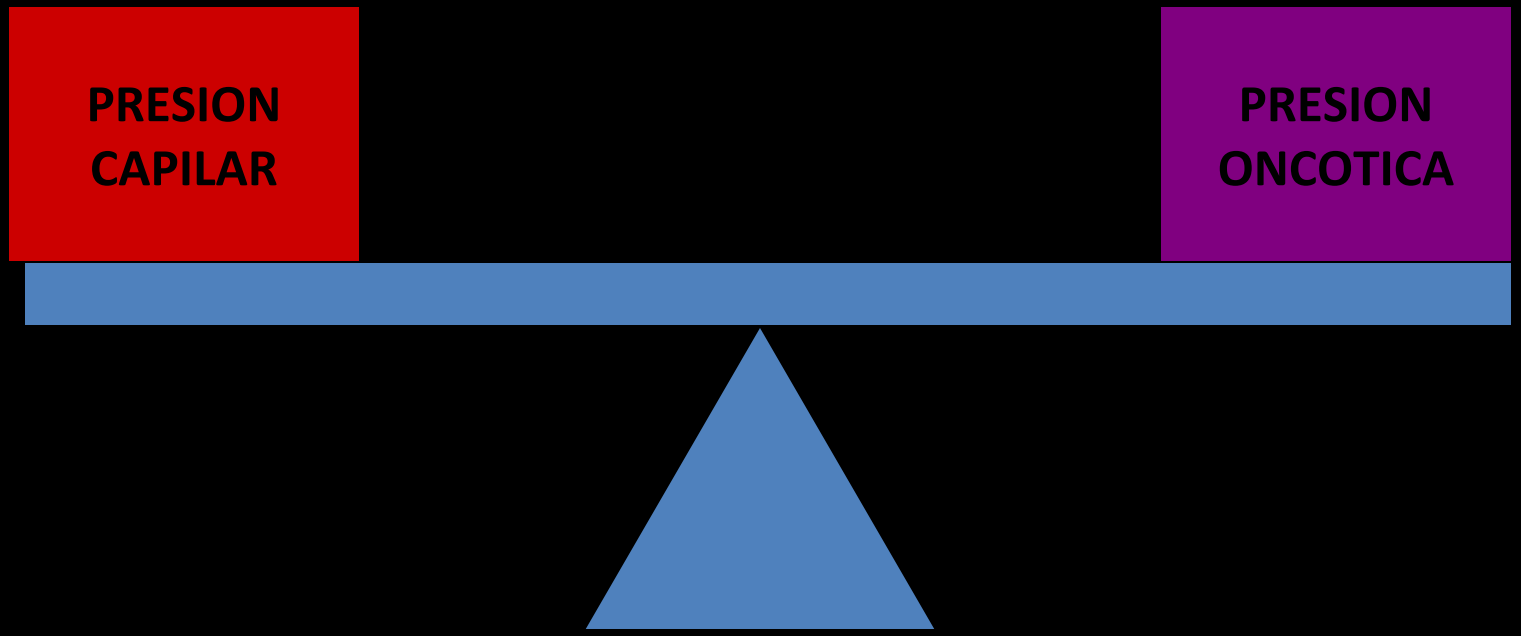
DISTRIBUCION DE LIQUIDOS CORPORALES

CINETICA DE FLUIDOS

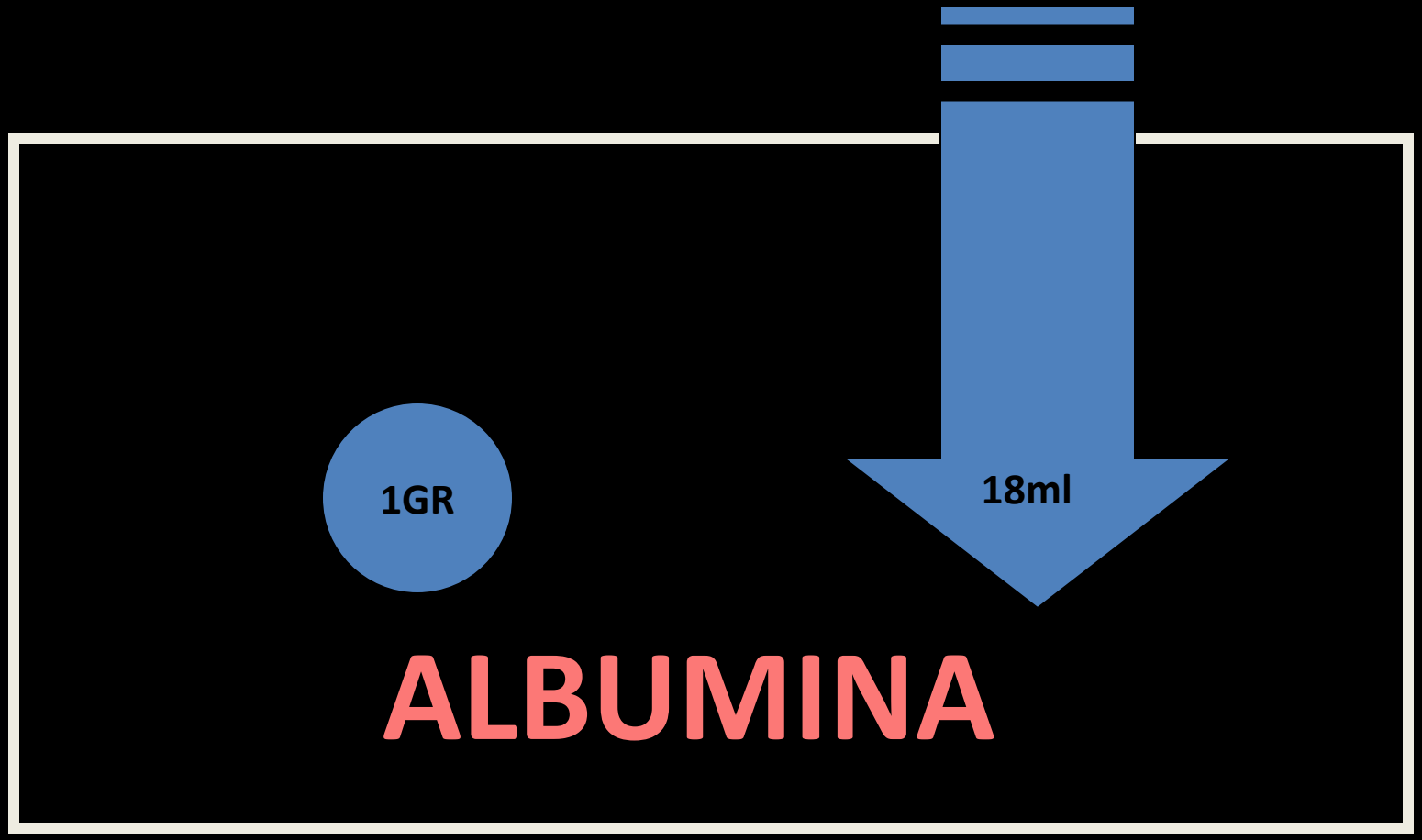
Shires GT, Ann Surg 176: 288 - 295 1972

DISTRIBUCION DE LIQUIDOS CORPORALES




PRESION
CAPILAR
PRESION
ONCOTICA

DISTRIBUCION DE LIQUIDOS CORPORALES



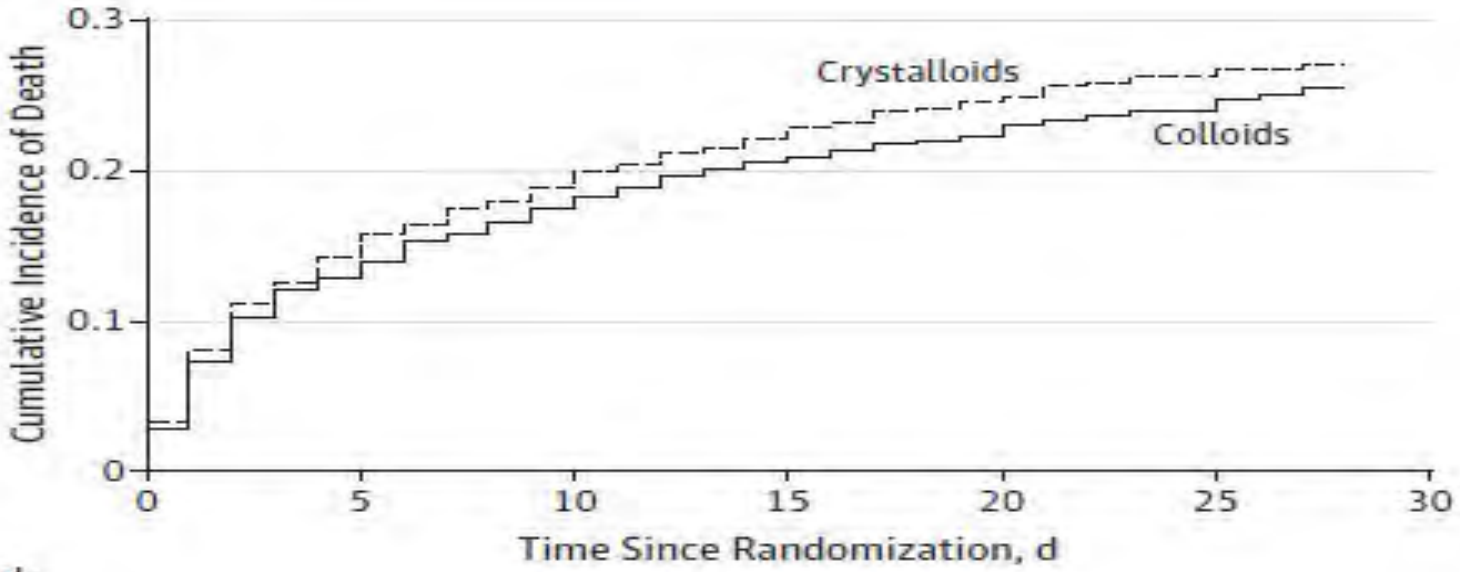
Effects of Fluid Resuscitation With Colloids vs Crystalloids on Mortality in Critically Ill Patients Presenting With Hypovolemic Shock

The CRISTAL Randomized Trial

JAMA November 6, 2013 Volume 310, Number 17

Djillali Annane, MD, PhD; Shidasp Siami, MD; Samir Jaber, MD, PhD; Claude Martin, MD, PhD; Souheil Elatrous, MD; Adrien Descorps Declère, MD;

Figure 2. Cumulative Incidence of Death Within First 28 Days After Randomization

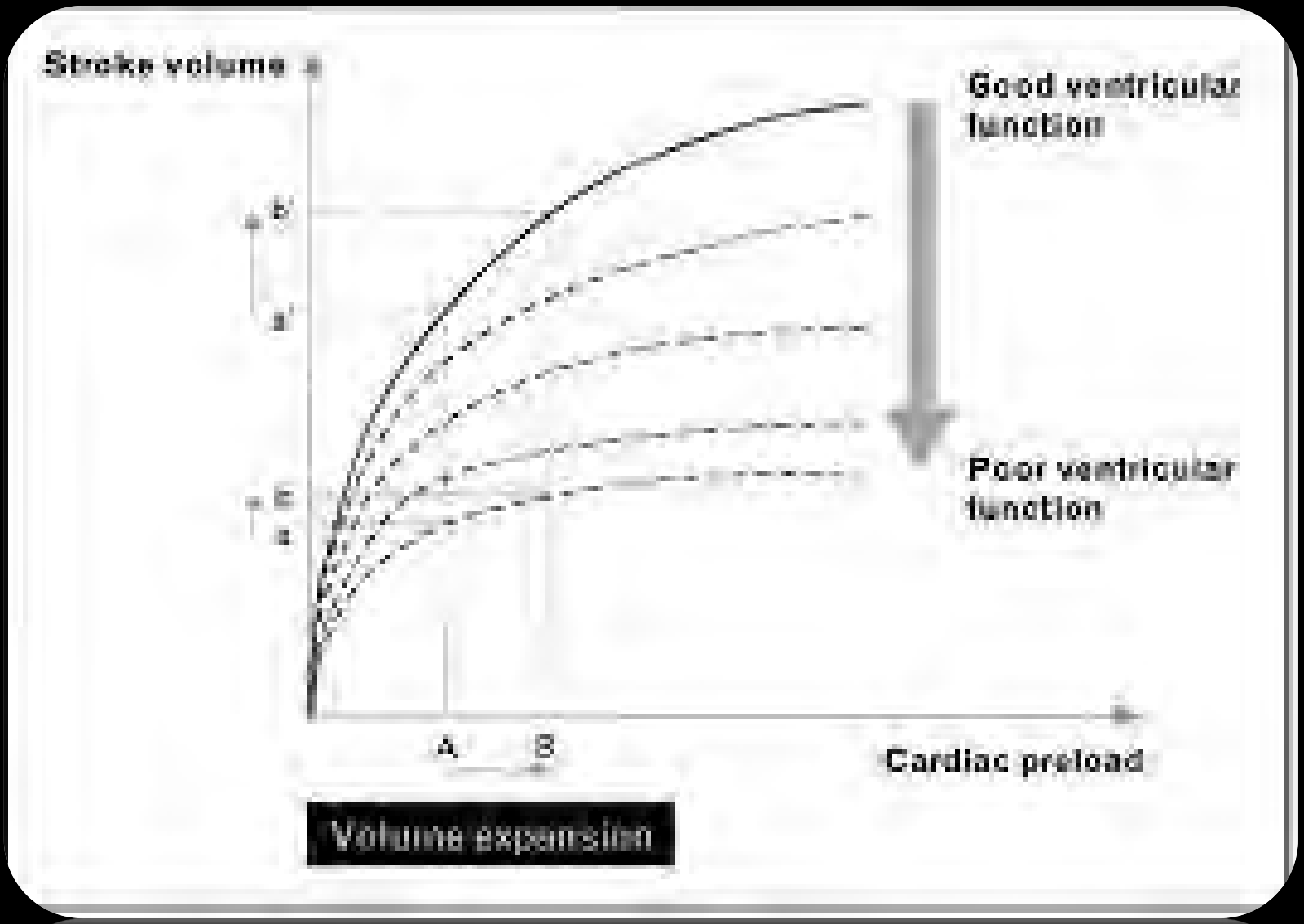


No. at risk

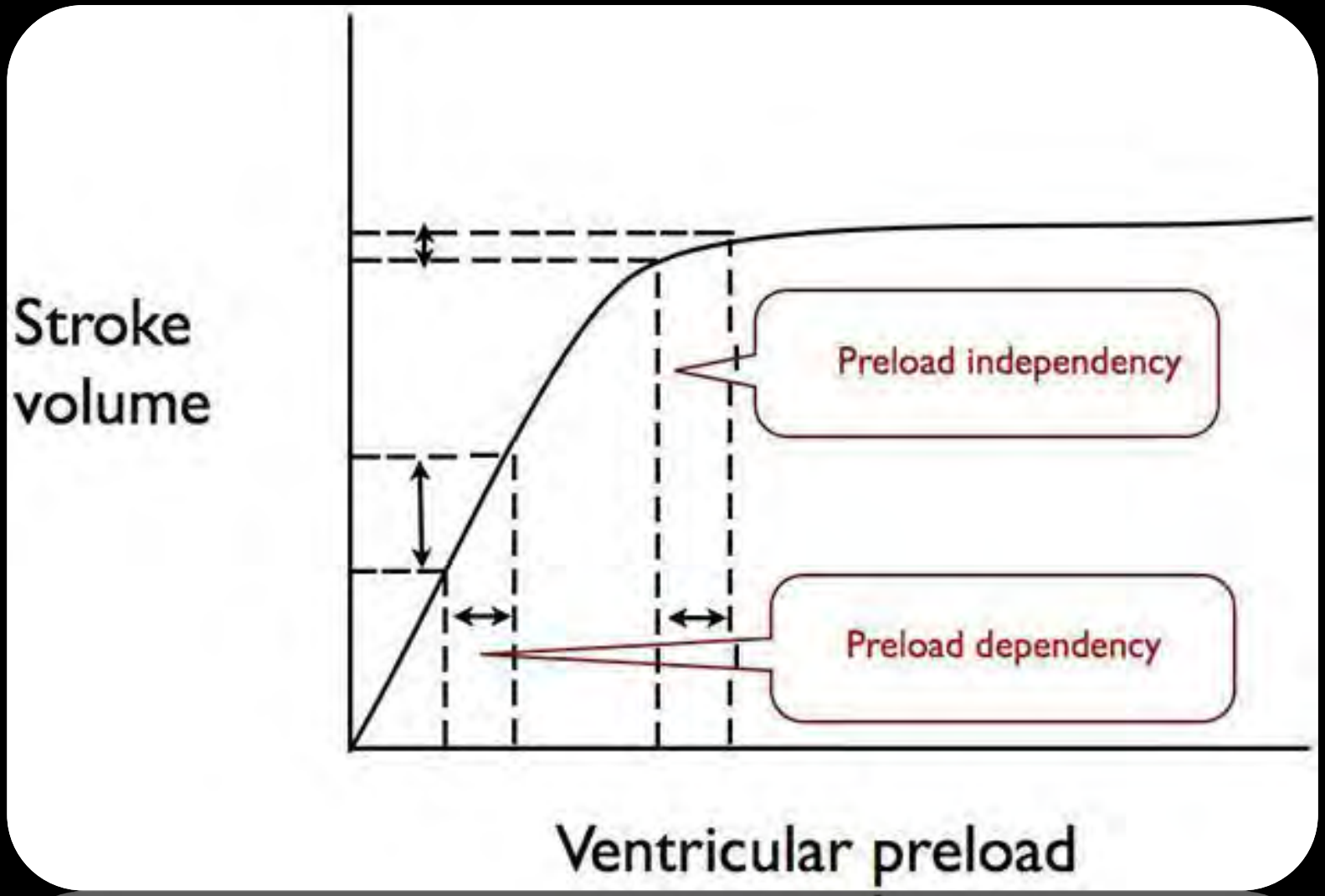
Colloids	1414	1233	1167	1124	1099	1076
Crystalloids	1443	1239	1172	1124	1089	1064

El inicio de la Fluidoterapia debe de hacerse de preferencia con **cristaloides**.

Respuesta a la fluidoterapia

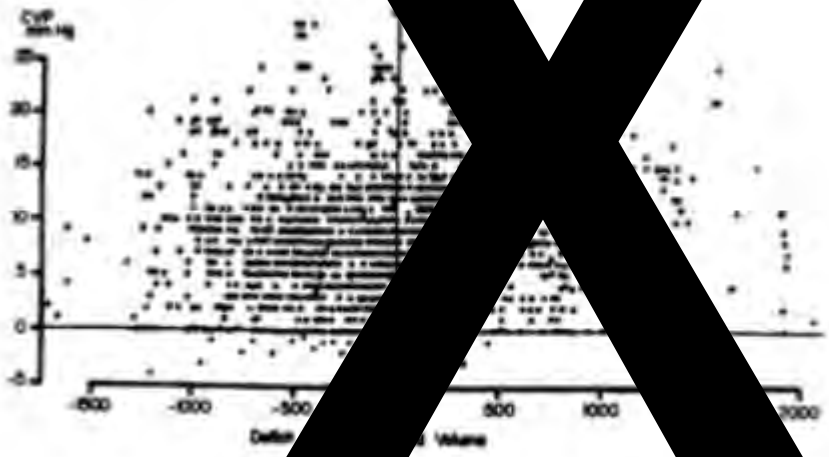


Respuesta a la fluidoterapia



PRECARGA

CV



- CVP : poor predictor of fluid volume

- CVP : poor predictor of fluid volume

CHEST. July 2008;134(1):172-178.

Hemodynamic parameters to guide fluid therapy

Paul E Marik[1*], Xavier Monnet[2], Jean-Louis Teboul[2]

Annals of Intensive Care 2011, 1:1

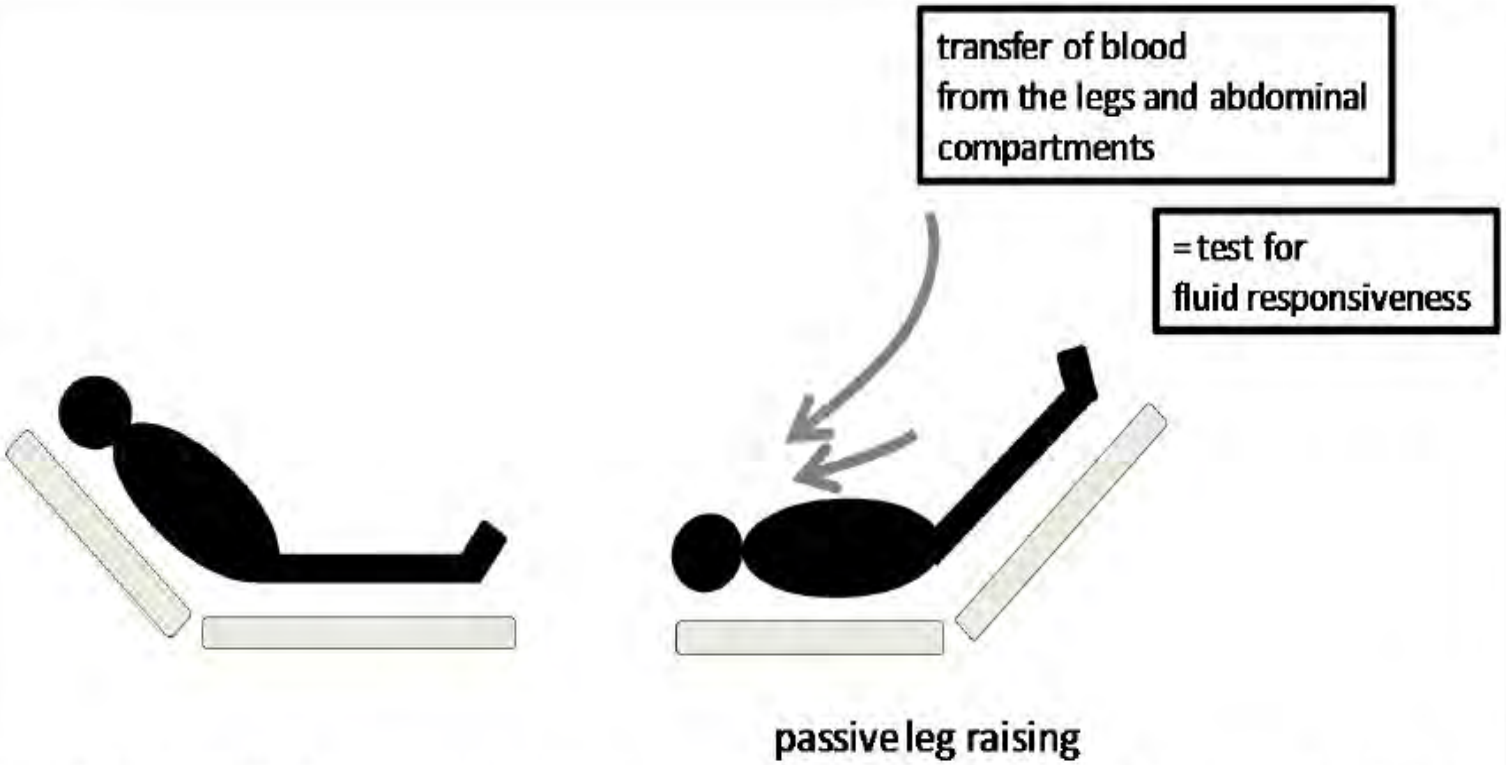
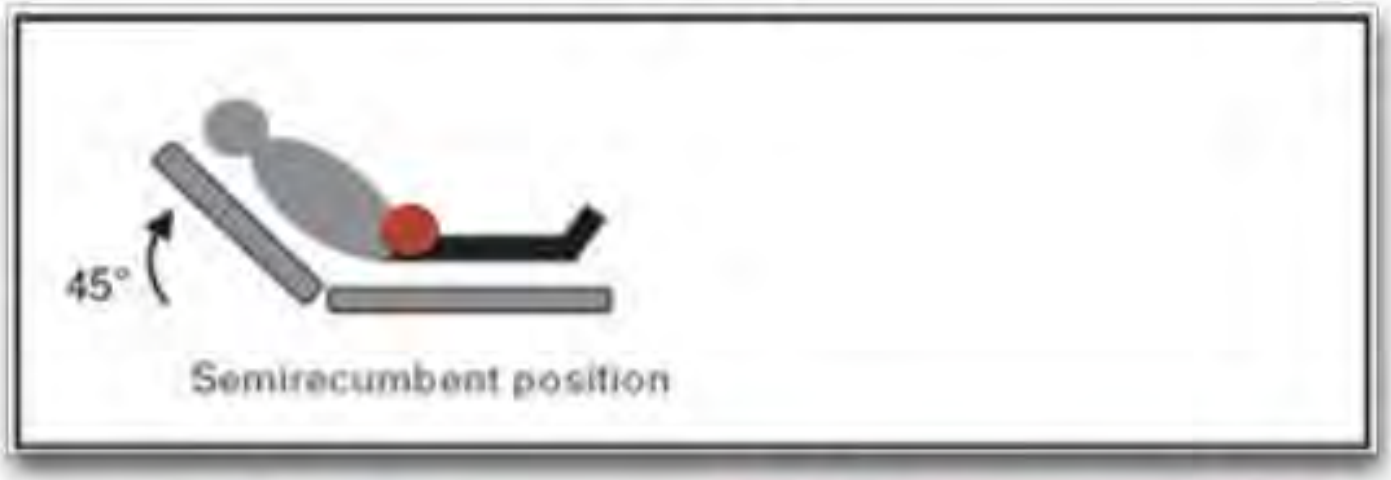


Figure 4 Passive leg raising. The passive leg raising test consists in measuring the hemodynamic effects of a leg elevation up to 45°. A simple way to perform the postural maneuver is to transfer the patient from the semirecumbent posture to the passive leg raising position by using the automatic motion of the bed.

Passive Leg Raising Test
(PLRT)

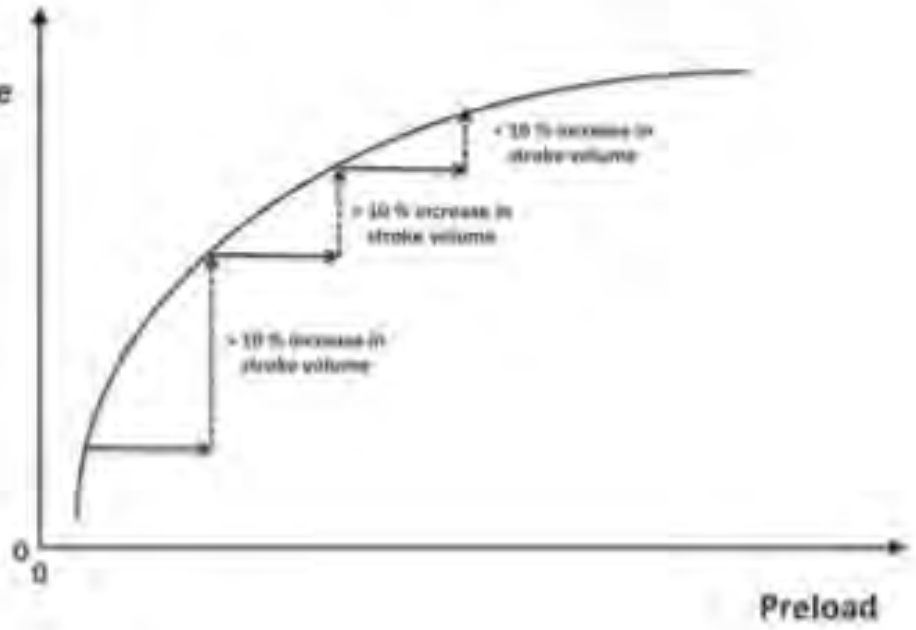


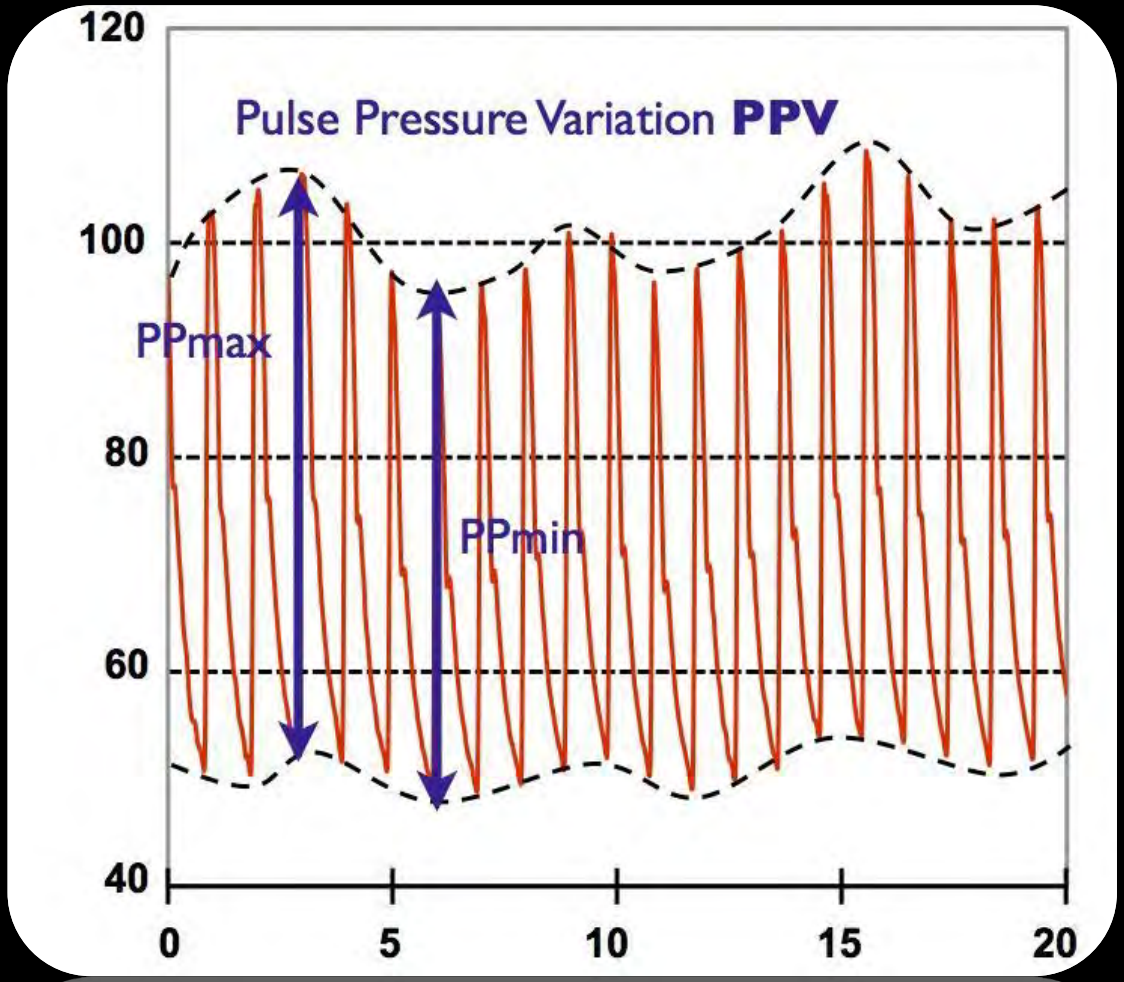
CO increase >10%
Sensitivity 97%
Specificity 94%
(for predict fluid responsiveness)

Monnet X, et al. Crit Care Med 2006;34:1402-7

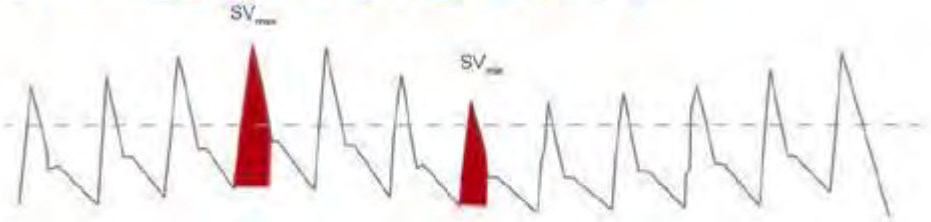
Fluid optimization concept based on stroke volume monitoring.

The concept of cardiac output maximization based on fluid administration and stroke volume monitoring.
Small boluses of fluid are administered intravenously (200 to 250 ml at a time) until the stroke volume increases by <10%.

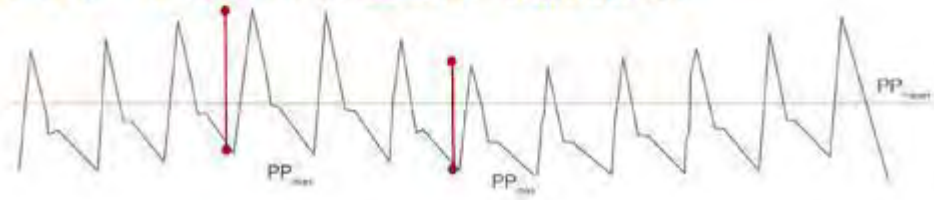



Pulse Pressure Variation PPV
120
100
80
60
40
PPmax
PPmin
0
5
10
15
20

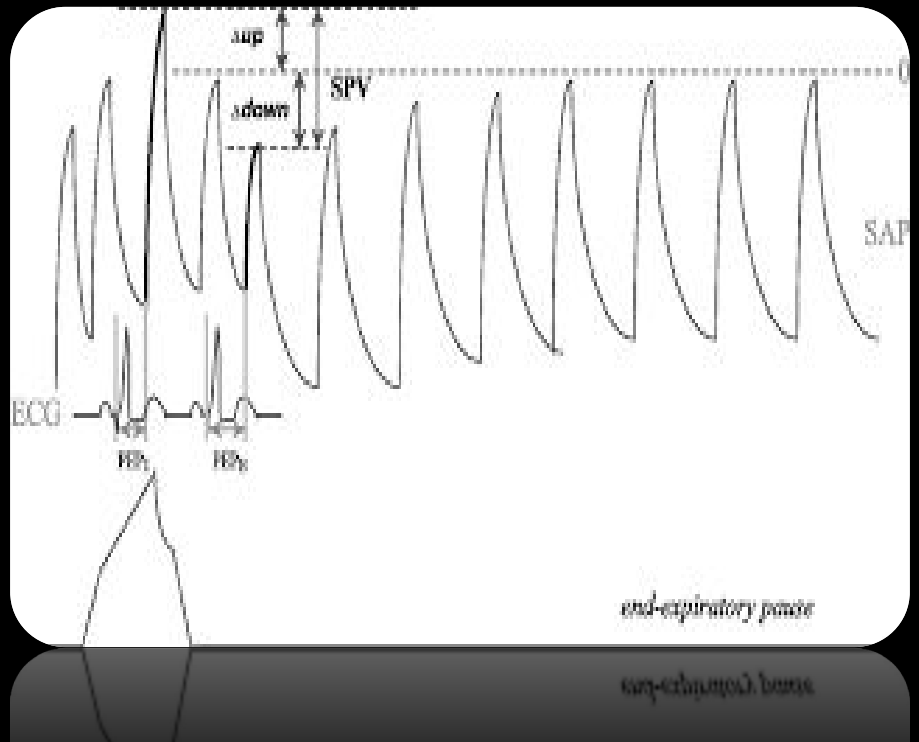
SVV - Stroke Volume Variation



PPV - Pulse Pressure Variation



$$SPV = 100 \times \left\{ \frac{(SP_{max} - SP_{min})}{\left[\frac{1}{2}(SP_{max} + SP_{min}) \right]} \right\}$$

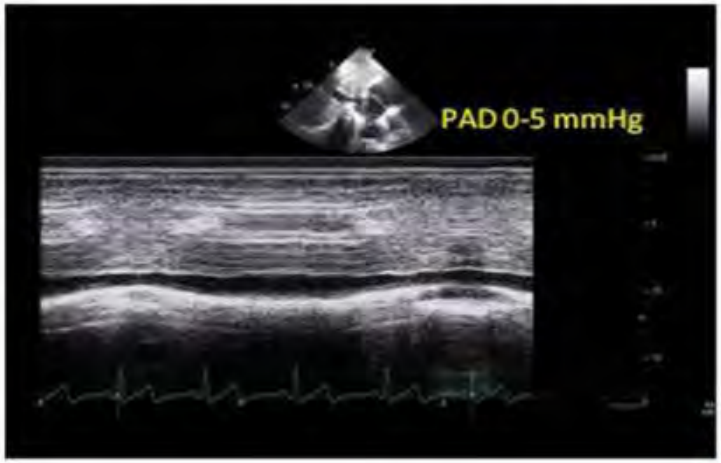


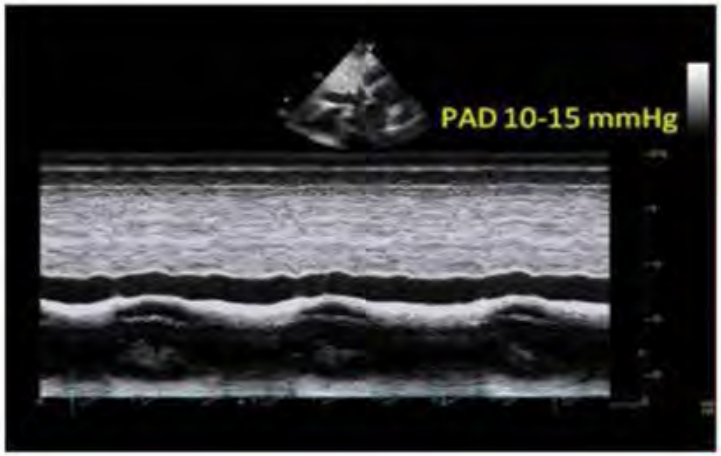

B
C
A

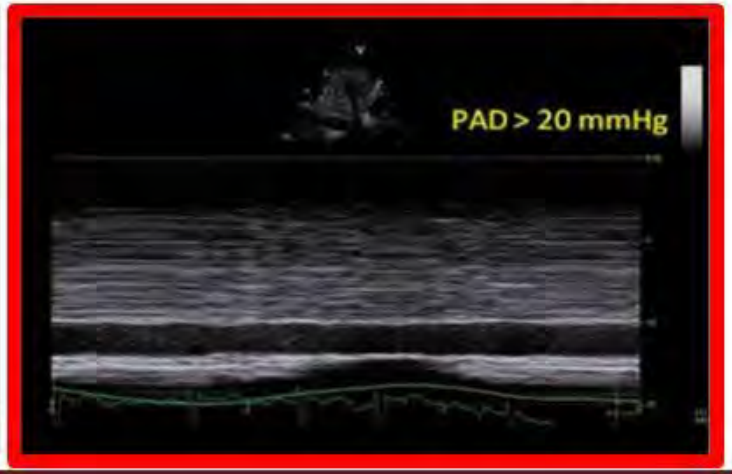

VCI
RA

TP: Signos ecocardiográficos

Dilatación VCI y colapso inspiratorio reducido:







Hemodynamic parameters to guide fluid therapy

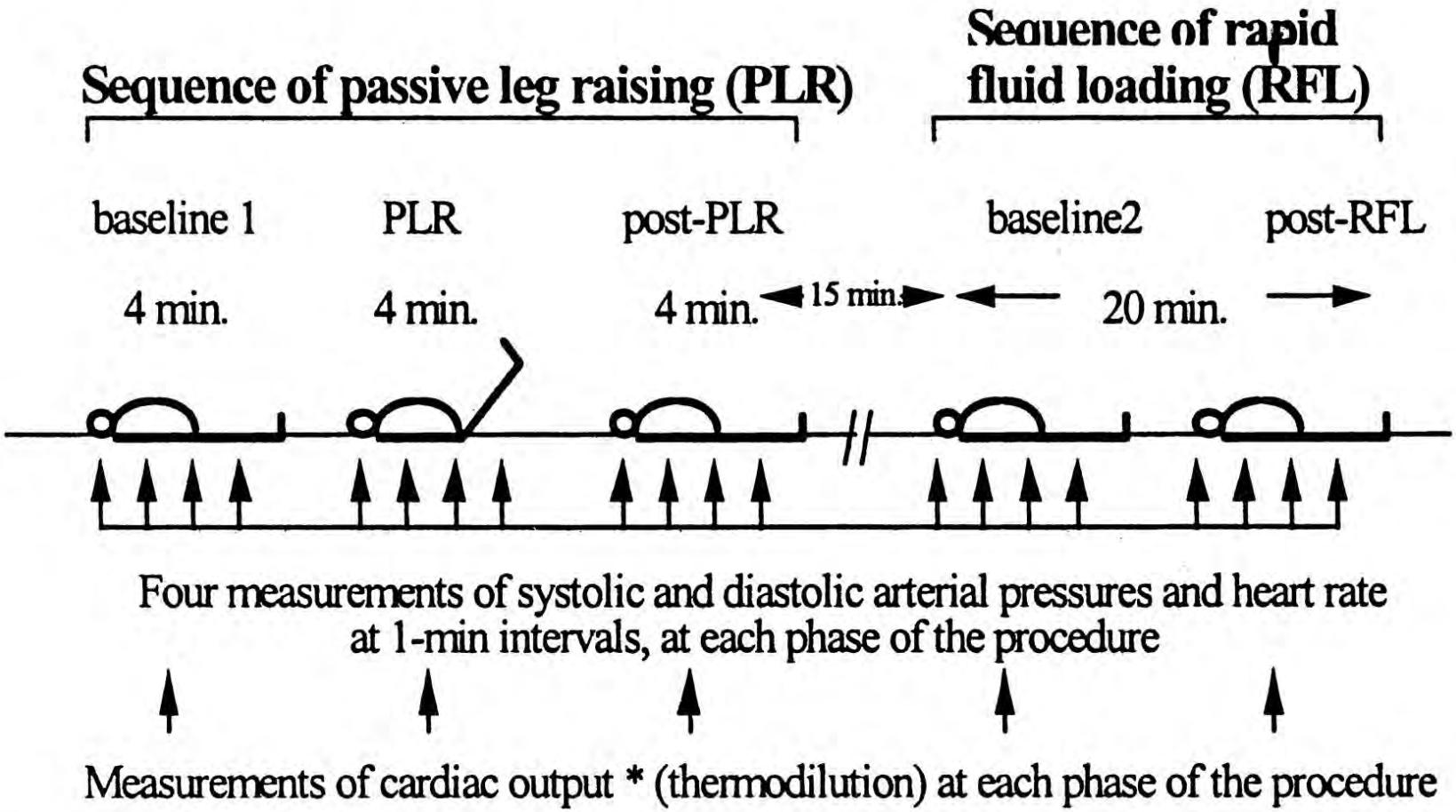
Paul E Marik[1*], Xavier Monnet[2], Jean-Louis Teboul[2]

Annals of Intensive Care 2011, 1:1

Table 2 Predictive value of techniques used to determine fluid responsiveness [15]

Method	Technology	AUC*
Pulse pressure variation (PPV)	Arterial waveform	0.94 (0.93-0.95)
Systolic pressure variation (SPV)	Arterial waveform	0.86 (0.82-0.90)
Stroke volume variation (SVV)	Pulse contour analysis	0.84 (0.78-0.88)
Left ventricular end-diastolic area (LVEDA)	Echocardiography	0.64 (0.53-0.74)
Global end-diastolic volume (GEDV)	Transpulmonary thermodilution	0.56 (0.37-0.67)
Central venous pressure (CVP)	Central venous catheter	0.55 (0.48-0.62)

*AUC = area under the curve with 95% confidence intervals.


Sequence of passive leg raising (PLR)
Sequence of rapid fluid loading (RFL)
baseline 1
PLR
post-PLR
baseline2
post-RFL
4 min.
4 min.
4 min.
15 min.
20 min.
Four measurements of systolic and diastolic arterial pressures and heart rate at 1-min intervals, at each phase of the procedure
Measurements of cardiac output * (thermodilution) at each phase of the procedure

La fluidoterapia es una piedra angular del tratamiento del choque séptico, PERO la sobrecarga hídrica puede ser deletérea.

Fluid accumulation, survival and recovery of kidney function in critically ill patients with acute kidney injury

Josée Bouchard[1], Sharon B. Soroko[1], Glenn M. Chertow[2], Jonathan Himmelfarb[3], T. Alp Ikizler[4], Emil P. Paganini[5] and Ravindra L. Mehta[1], Program to Improve Care in Acute Renal Disease (PICARD) Study Group

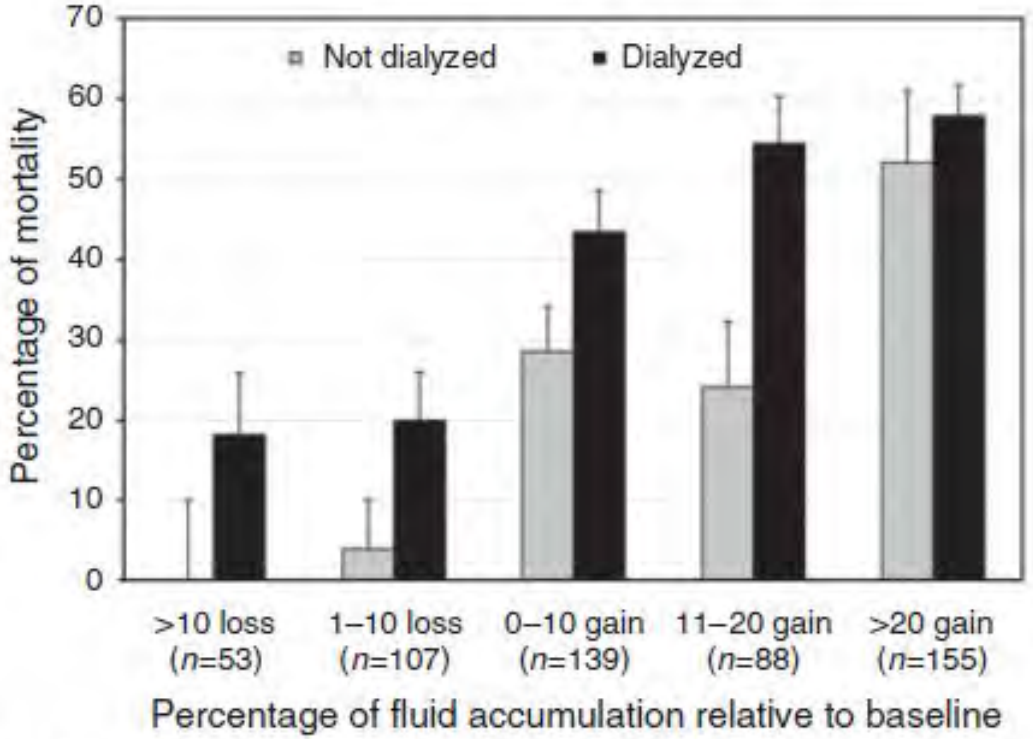
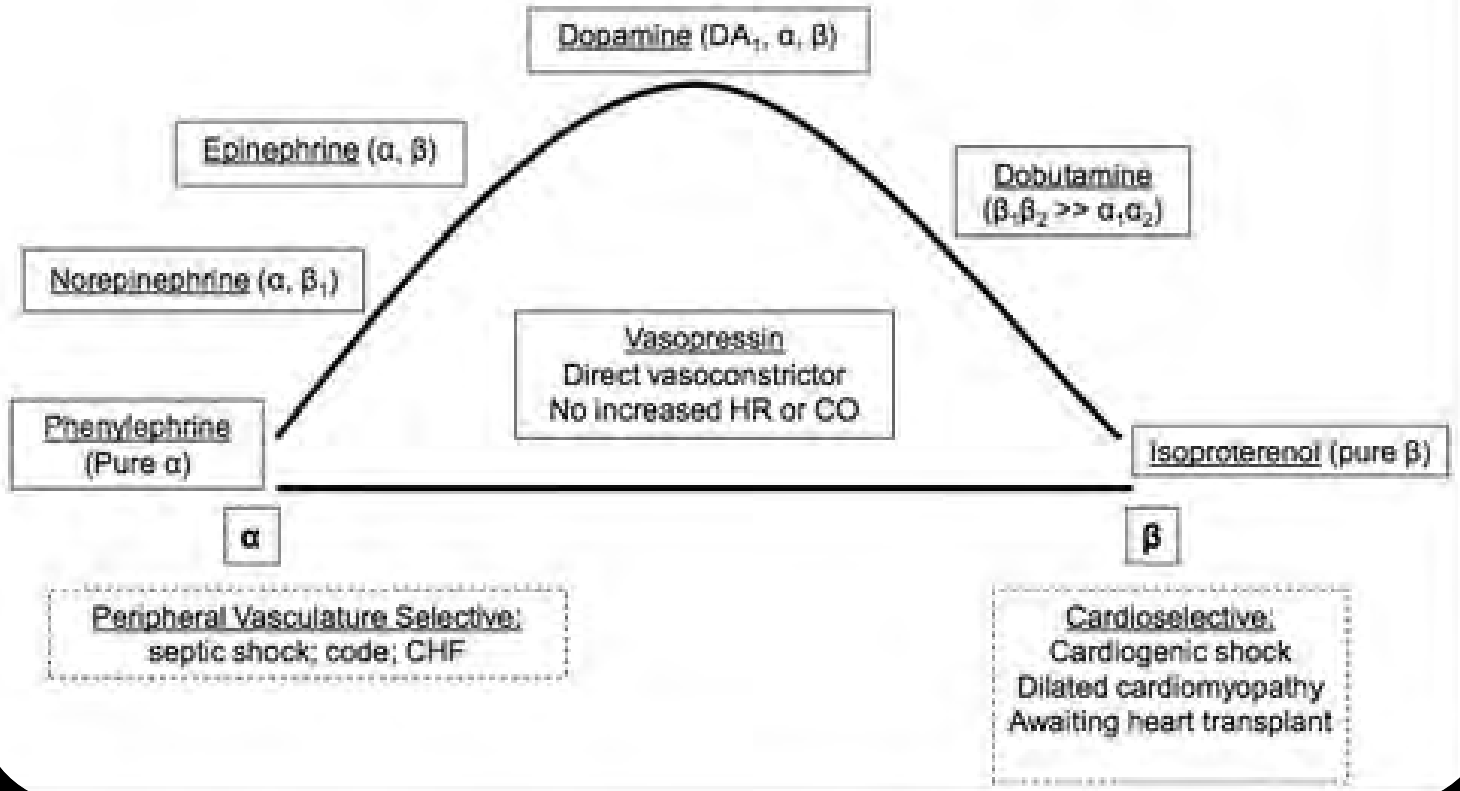


Figure 2 | Mortality rate by final fluid accumulation relative to baseline weight and stratified by dialysis status.

Kidney International (2009) **76,** 422–427; doi:10.1038/ki.2009.159;

Vasopressors/Inotropes



Timing of vasopressor initiation and mortality in septic shock: a cohort study

Critical Care 2014, **18**:R97 doi:10.1186/cc13868

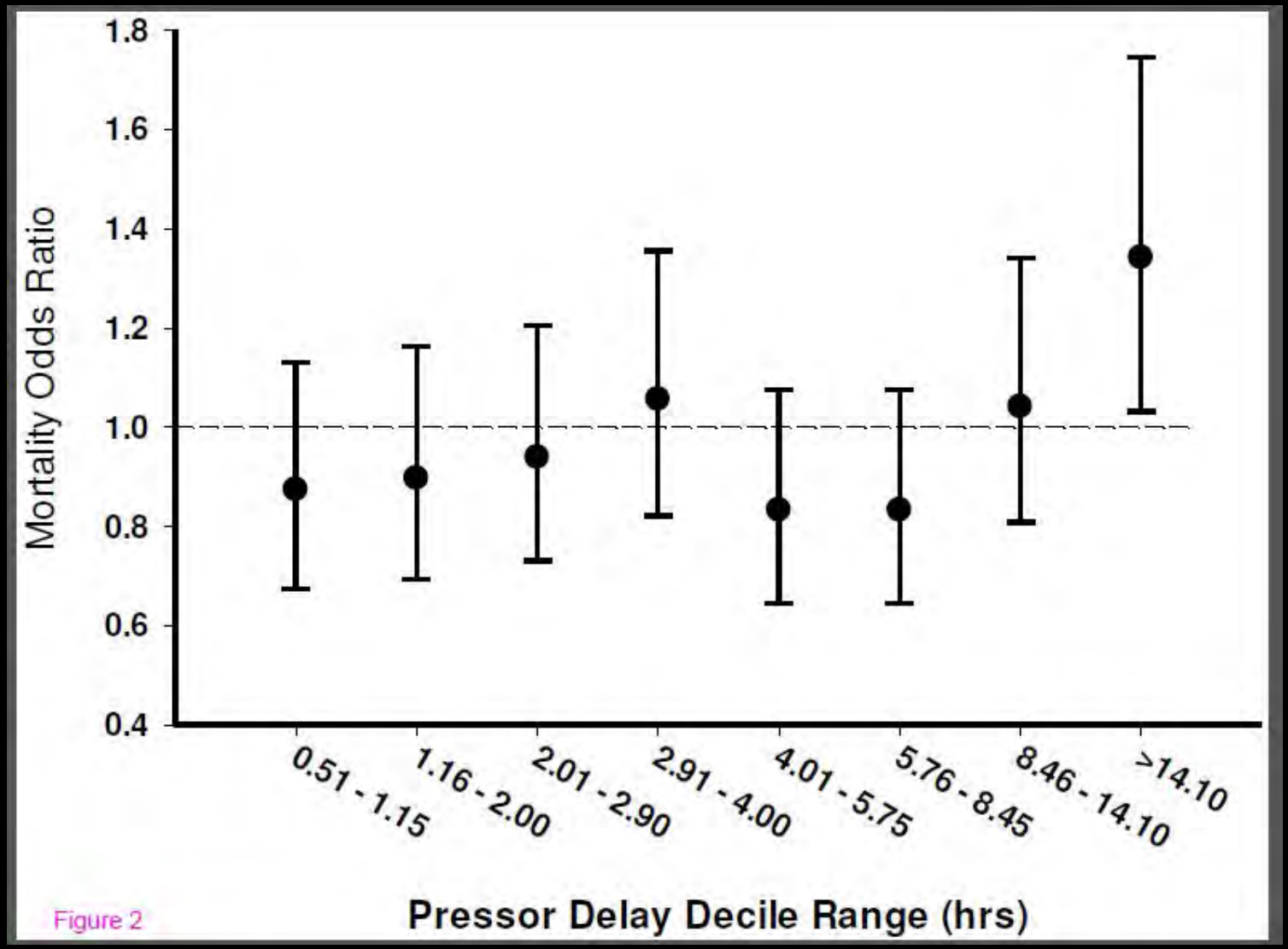


Figure 2

Journal club critique

CORTICUS: The end of unconditional love for steroid use?

Phillip E. Mason[1], Ali Al-Khafaji[2], Eric B. Milbrandt[2], Brian P. Suffoletto[3], and David T. Huang[4]

[1] Clinical Fellow, Department of Critical Care Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA
[2] Assistant Professor, Department of Critical Care Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA
[3] Assistant Professor, Department of Emergency Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA
[4] Assistant Professor, Departments of Critical Care Medicine and Emergency Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA

Published online: 7th August 2009
This article is online at http://ccforum.com/content/13/4/309

Critical Care 2009, 13:309 (DOI: 10.1186/cc7986)

Characteristic	Annane	CORTICUS
SAPS II mean (placebo/treatment)	57/60	49/50
Control group mortality	61%	32%
Corticotropin non-responders	77%	47%
Admission category - medical	60%	35%
Hospital-acquired infection	21%	47%
Post-surgical infection	16%	61%
Abdominal infection	16%	49%

Table 1: Comparison of patient characteristics in CORTICUS and the study by Annane and colleagues.

Early initiation of low-dose corticosteroid therapy in the management of septic shock: a retrospective observational study

Hye Yun Park[1], Gee Young Suh[1], Jae-Uk Song[1], Hongseok Yoo[1], Ik Joon Jo[2], Tae Gun Shin[2], So Yeon Lim[1], Sookyoung Woo[3] and Kyeongman Jeon[1*]

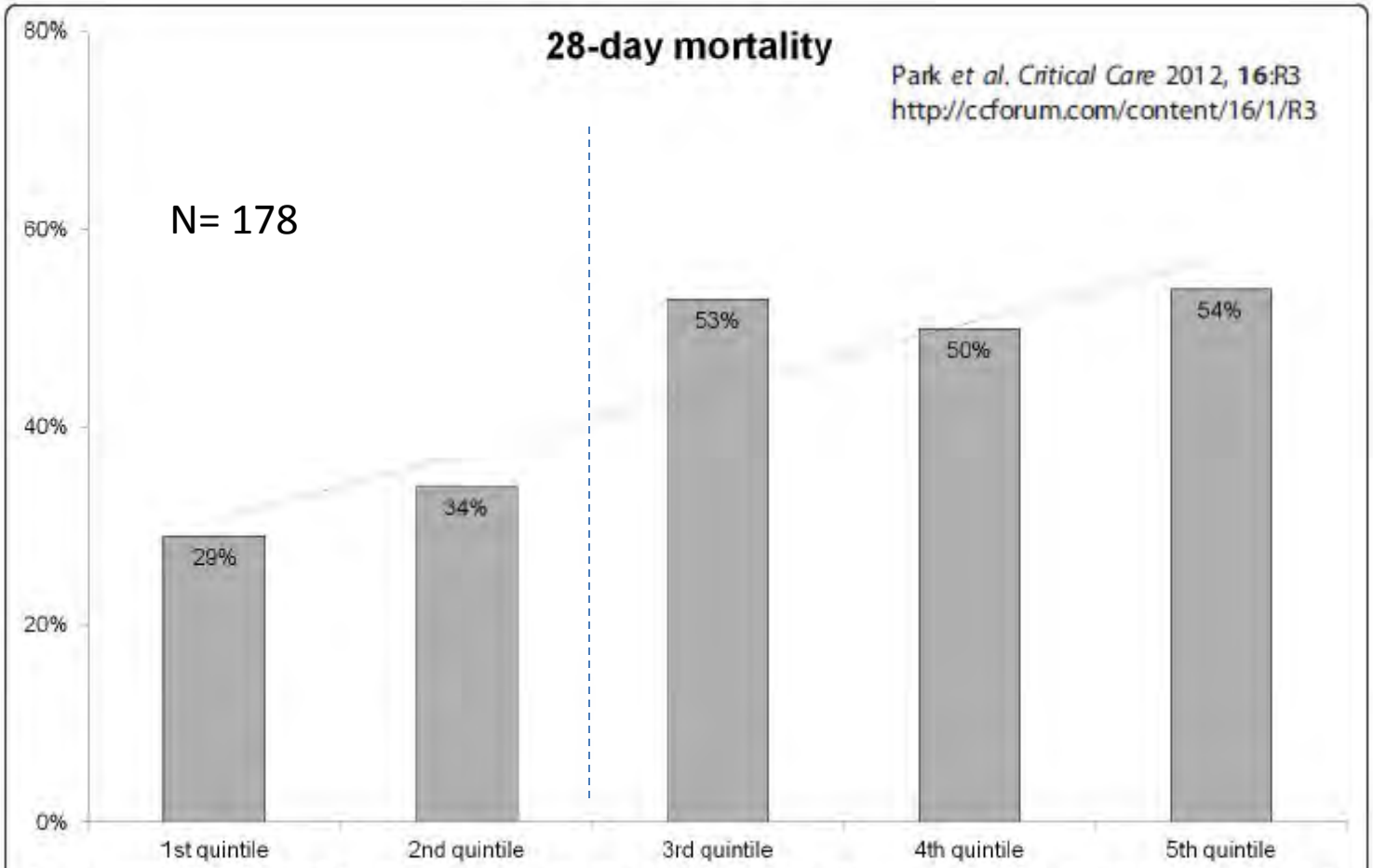


Figure 1 Trend of 28-day mortality rate according to the time to initiation of low-dose corticosteroid therapy in quintiles (1st quintile, 0 to 3.0 hours; 2nd quintile, 3.1 to 6.3 hours; 3rd quintile, 6.4 to 11.3 hours; 4th quintile 11.4 to 24.5 hours; 5th quintile, ≥ 24.6 h) (P = 0.0107, test for trend).

Early initiation of low-dose corticosteroid therapy in the management of septic shock: a retrospective observational study

Hye Yun Park[1], Gee Young Suh[1], Jae-Uk Song[1], Hongseok Yoo[1], Ik Joon Jo[2], Tae Gun Shin[2], So Yeon Lim[1], Sookyoung Woo[3] and Kyeongman Jeon[1*]

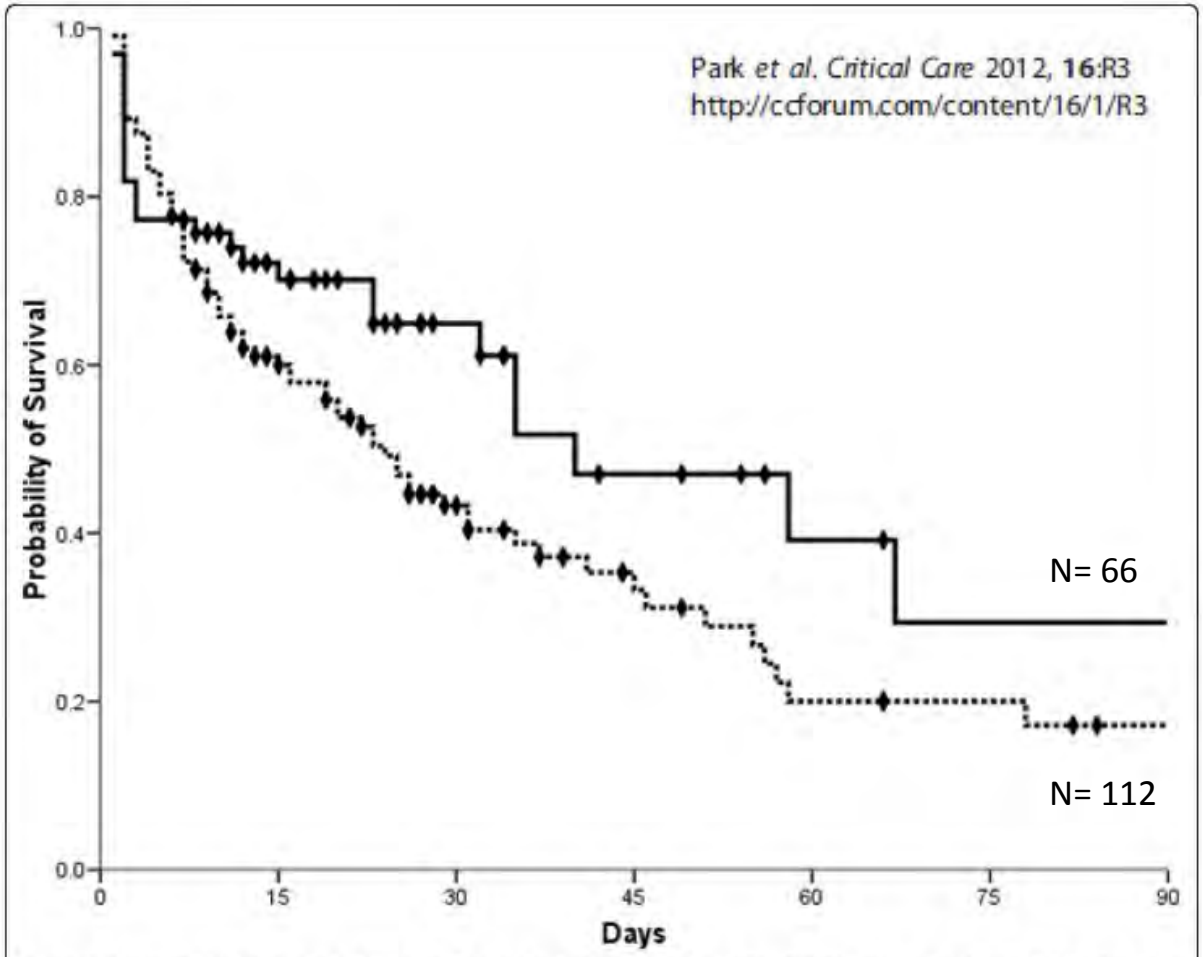


Figure 2 Kaplan-Meier survival analysis comparing patients treated with low-dose corticosteroid therapy within six hours after development of septic shock and those treated later (solid line represents the early therapy group, who received the therapy within six hours; dotted line represents the late therapy group, who received the therapy after six hours).

La hidrocortisona puede revertir el choque refractario a vasopresores, PERO su impacto en la mortalidad todavía puede estar en discusión.

El impacto del uso de hidrocortisona en pacientes con choque séptico podría estar marcado por la prontitud de su indicación.

La aplicación de hidrocortisona en pacientes con choque séptico puede ayudar a reducir la dosis requeridas de vasopresores para revertir el choque .

Effects of Epinephrine on Hemodynamics and Oxygen Metabolism in Dopamine-Resistant Septic Shock*

Pierre Edouard Bollaert, M.D.; Philippe Bauer, M.D.; Gérard Audibert, M.D.; Henri Lambert, M.D.; and Alain Larcan, M.D.

Table 2—*Hemodynamic and Metabolic Parameters in 13 Patients with Septic Shock Before (H0) and One Hour after Starting Epinephrine (H1) Therapy

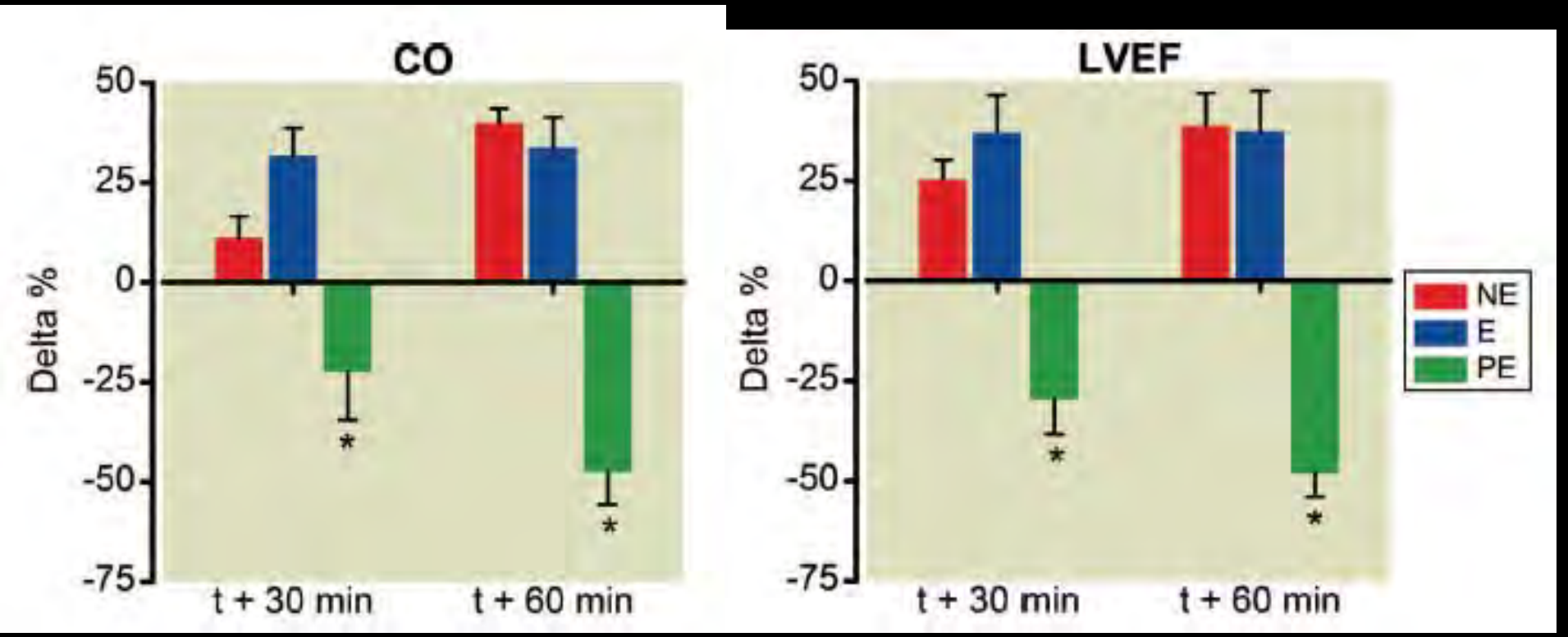
Variable	H0 (Baseline)	H1	p
HR, beats/min	121 ± 29	129 ± 25	NS
SAP, mm Hg	73 ± 15	120 ± 27	<0,01
DAP, mm Hg	34 ± 8	52 ± 13	<0,01
MAP, mm Hg	46 ± 11	72 ± 21	<0,01
MPAP, mm Hg	21 ± 9	26 ± 11	<0,05
PWP, mm Hg	9 ± 3	10 ± 4	NS
CI, L/min·m²	5,5 ± 2,3	6,7 ± 2,1	<0,05
SVI, ml/m²	44 ± 16	52 ± 14	<0,05
LVSWI, g/m²	24 ± 11	45 ± 17	<0,01
SVRI, dynes·s/cm⁵·m²	771 ± 347	935 ± 333	<0,05
PVRI, dynes·s/cm⁵·m²	372 ± 249	351 ± 225	NS
$\dot{D}o_2$, ml/min·m⁻²	621 ± 306	807 ± 313	<0,01
$\dot{V}o_2$, ml/min·m⁻²	224 ± 150	249 ± 157	<0,05
ER,†%	38 ± 14	30 ± 10	<0,05
Lactate, mg/L	570 ± 410	738 ± 530	<0,01

(Chest 1990; 98:949-53)

En caso de choque refractario a norepinefrina, se recomienda el uso de **epinefrina** a **dosis de 15 µg x minuto** .

Comparison of Equipressor Doses of Norepinephrine, Epinephrine, and Phenylephrine on Septic Myocardial Dysfunction

Nicolas Ducrocq, M.D.,* Antoine Kimmoun, M.D.,* Anna Furmaniuk, M.Sc.,† Zerin Hekalo, M.Sc.,† Fatiha Maskali, Ph.D.,‡ Sylvain Poussier, Ph.D.,‡ Pierre-Yves Marie, M.D., Ph.D.,§ Bruno Levy, M.D., Ph.D.‖



Anesthesiology 2012; 116:1083–91

Fenilefrina solo si:

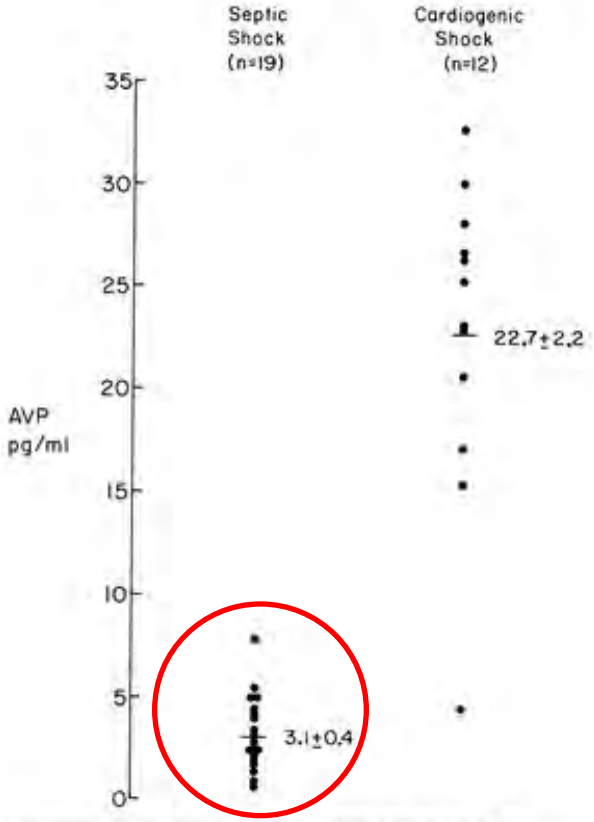
-Arritmias graves por NE.

-GC alto con PAM baja a pesar de NE + AD/VP.

Vasopressin Deficiency Contributes to the Vasodilation of Septic Shock

Donald W. Landry, MD, PhD; Howard R. Levin, MD; Ellen M. Gallant, MD; Robert C. Ashton, Jr, MD; Susan Seo, BA; David D'Alessandro, BA; Mehmet C. Oz, MD; Juan A. Oliver, MD

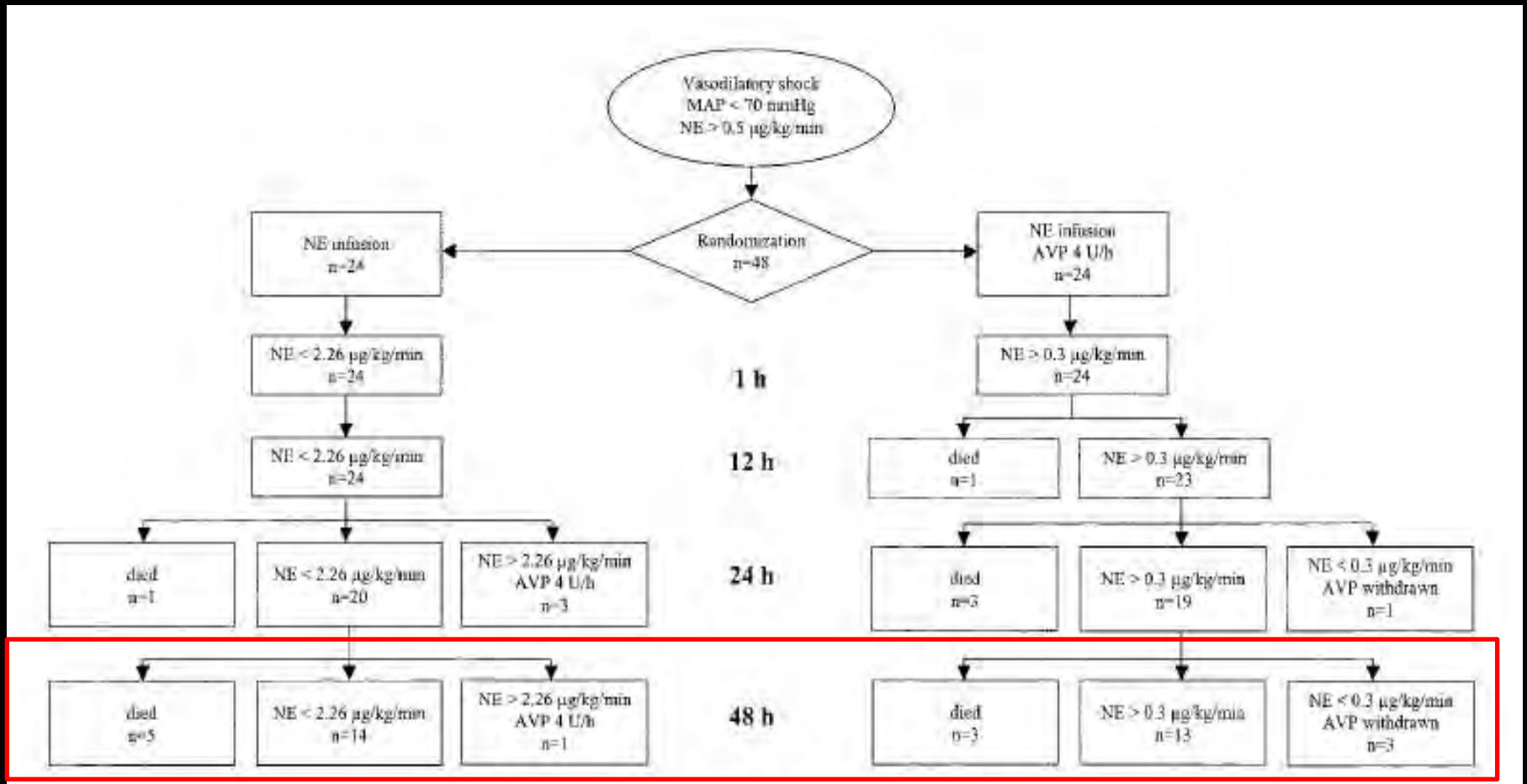
Plasma vasopressin levels (AVP) of patients in septic shock and cardiogenic shock.



Landry D W et al. Circulation. 1997;95:1122-1125

Arginine Vasopressin in Advanced Vasodilatory Shock: A Prospective, Randomized, Controlled Study

Martin W. Dünser, Andreas J. Mayr, Hanno Ulmer, Hans Knotzer, Günther Sumann, Werner Pajk, Barbara Friesenecker and Walter R. Hasibeder



Overview of patient enrollment and study design.

Circulation. 2003;107:2313-2319

Vasopresina a dosis de 0.03 – 0.04U x minuto solo en caso de choque refractario

Terlipressin for norepinephrine-resistant septic shock

Alastair O'Brien, Lucie Clapp, Mervyn Singer

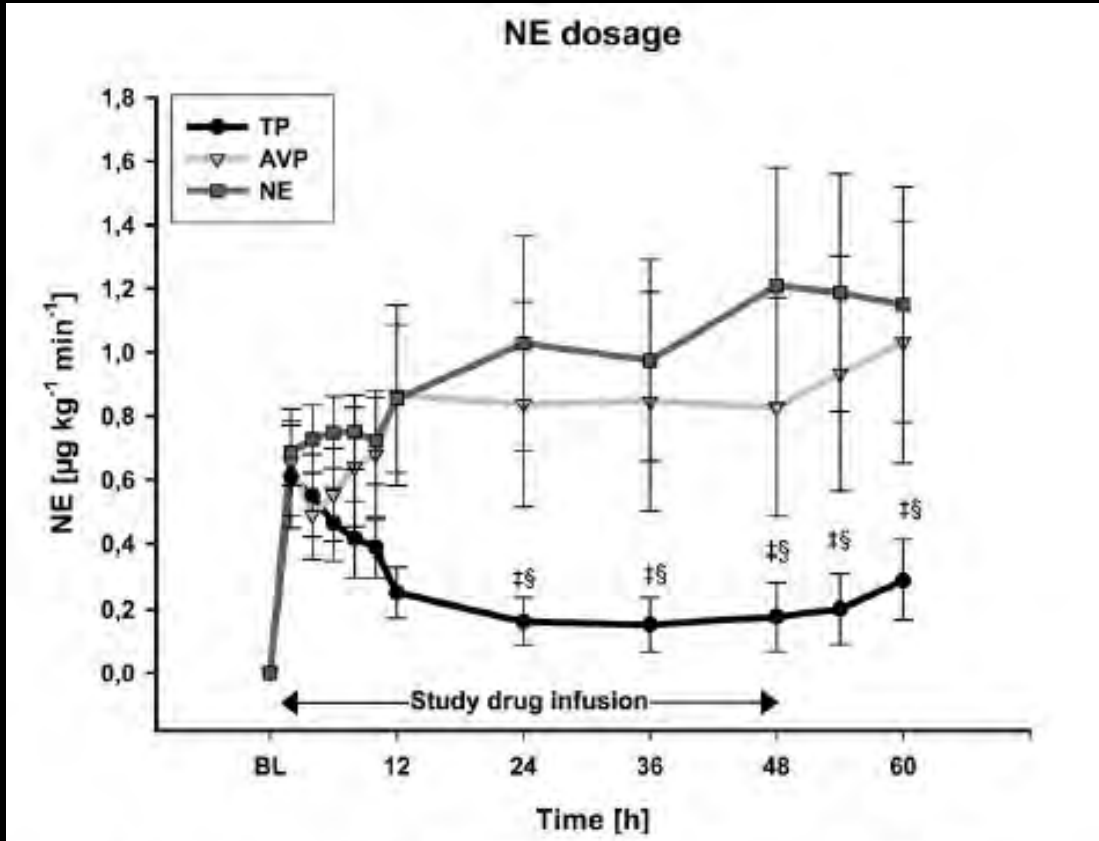
Cause of septic shock	Age (years)	Apache II score	Terlipressin (mg)	Initial norepinephrine (μg/kg/min)	Further norepinephrine requirements	Outcome
Dog bite	56	25	2·0	0·41	None, needed glyceryl trinitrate to lower mean arterial pressure	Discharged to ward after 1 month
Unknown cause	68	25	1·0	0·34	Unchanged dose though good pressor response	Died 10 days later
Streptococcal pneumonia	50	25	1·0	0·85	Weaned off over 24 h	Discharged to ward after 2 months
Staphylococcal septicaemia	52	37	2·0	0·53	Effect lasted 5 h then steady increase in norepinephrine	Died within 24 h
Streptococcal septicaemia	40	30	1·0	0·30	Effect lasted for 5 h then steady increase in norepinephrine to 0·7 μg/kg/min over next 15 h*	Died within 24 h
Faecal peritonitis	68	31	1·0	0·73	Weaned off over 24 h	Discharged to ward 2 weeks later
Salmonella gastroenteritis	82	25	2·0	0·73	Weaned off over 2 days	Discharged to ward 17 days later
Meningococcal septicaemia	62	28	1·5	0·82	Continued on low dose norepinephrine for 4 days, then gradual deterioration	Died after 6 days

*Given a 2nd dose of terlipressin at 5 h; the effect was similar but only lasted 3 h.

Lancet 2002; **359:** 1209–10

Continuous terlipressin versus vasopressin infusion in septic shock (TERLIVAP): a randomized, controlled pilot study

Andrea Morelli[1], Christian Ertmer[2], Sebastian Rehberg[2], Matthias Lange[2], Alessandra Orecchioni[1], Valeria Cecchini[1], Alessandra Bachetoni[3], Mariadomenica D'Alessandro[3], Hugo Van Aken[2], Paolo Pietropaoli[1] and Martin Westphal[2]



Norepinephrine requirements. AVP = arginine vasopressin; NE = norepinephrine; TP = terlipressin. ‡ $P < 0.05$ vs. AVP (significant group effect); § $P < 0.05$ vs. NE (significant group effect).

Critical Care 2009, **13**:R130 (doi:10.1186/cc7990)

Rescue treatment with terlipressin in children with refractory septic shock: a clinical study

Antonio Rodríguez-Núñez[1], Jesús López-Herce[2], Javier Gil-Antón[3], Arturo Hernández[4], Corsino Rey[5] and the RETSPED Working Group of the Spanish Society of Pediatric Intensive Care

Evolution of hemodynamic variables and catecholamine infusion rates after terlipressin therapy

	Before terlipressin therapy	Time after terlipressin therapy					
		30 min	60 min	4 hours	12 hours	24 hours	48 hours
Systolic blood pressure (mmHg)	77 (50–140)	108 (61–154)*	102.5 (61–137)*	99 (65–147)	91 (70–120)	107 (55–118)	105 (65–130)
Mean blood pressure (mmHg)	50.5 (37–93)	77 (42–100)**	69.5 (41–104)*	74 (40–95)	62 (40–90)	68 (35–90)	73 (40–103)
Diastolic blood pressure (mmHg)	38 (25–70)	57 (32–72)*	55.5 (31–90)*	48 (25–86)	50 (20–80)	48 (26–77)	53 (30–90)
Heart rate (beats/min)	155 (80–205)	149 (114–186)	148 (85–190)	148 (110–190)	146 (114–185)	142 (102–170)	148 (101–170)
Central venous pressure (mmHg)	14 (4–23)	13 (3–23)	12.5 (3–17)	13 (3–27)	12 (4–24)	12 (5–18)	13.6 (5–22)
Catecholamines (μg/kg/min)							
Noradrenaline	2 (1–4)	1 (0–3)	1.15 (0–3)	1.4 (0–2)	1 (0–2.6)*	1 (0–2.5)**	0.1 (0–1)**
Adrenaline	1.2 (0.4–4)	1 (0.5–6)	1 (0.3–4)	0.7 (0.2–3)	0.6 (0.1–2)	1 (0.2–2)	0.5 (0–2.5)
Dopamine	21.5 (10–52)	16.3 (3–40)	17.5 (0–52)	10 (0–40)	15.8 (0–40)	20 (3–40)	11.6 (0–45)
Dobutamine	22.5 (5–40)	20 (0–40)	20 (0–40)	20 (0–40)	20 (0–40)	20 (0–40)	22.5 (10–30)
Inotropic equivalent[a]	176 (141–552)		153.5 (67–460)		128.5 (57–340)	117.5 (20–340)*	82 (0–371)**

[a]Inotropic equivalent: (noradrenaline × 100) + (adrenaline × 100) + dopamine + dobutamine + (milrinone × 15) [25].
* $P < 0.05$ versus baseline. ** $P < 0.01$ versus baseline.

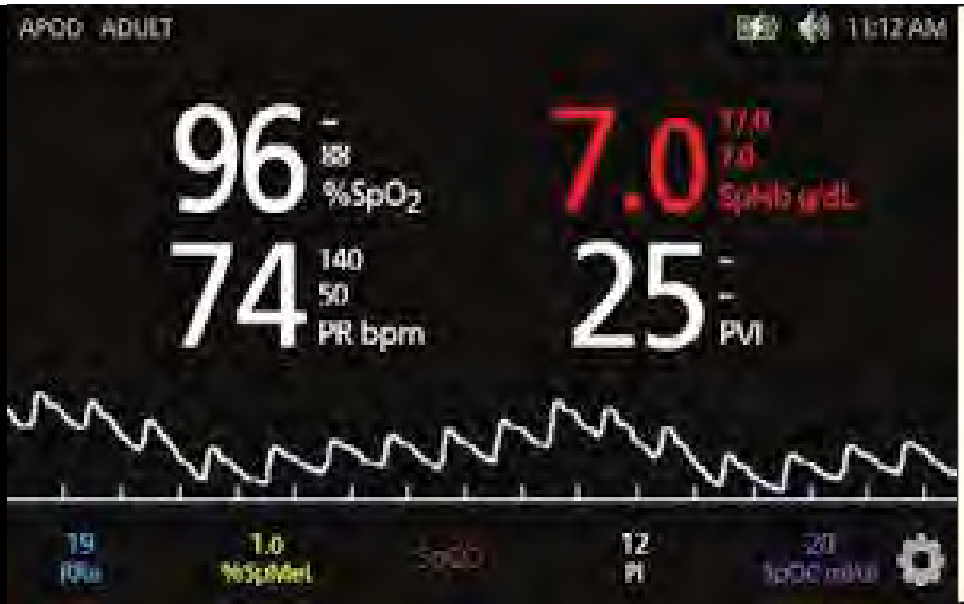
Critical Care 2006, **10**:R20 (doi:10.1186/cc3984)

Existe evidencia temprana que propone la posibilidad de **Terlipresina** como una alternativa en choque séptico refractario a **dosis de 1.3µg x Kg x hr.**


83
95
1


7.0
20
4.0
97
74
15


80
118 76
91
98
12
38


APOD ADULT
11:12 AM
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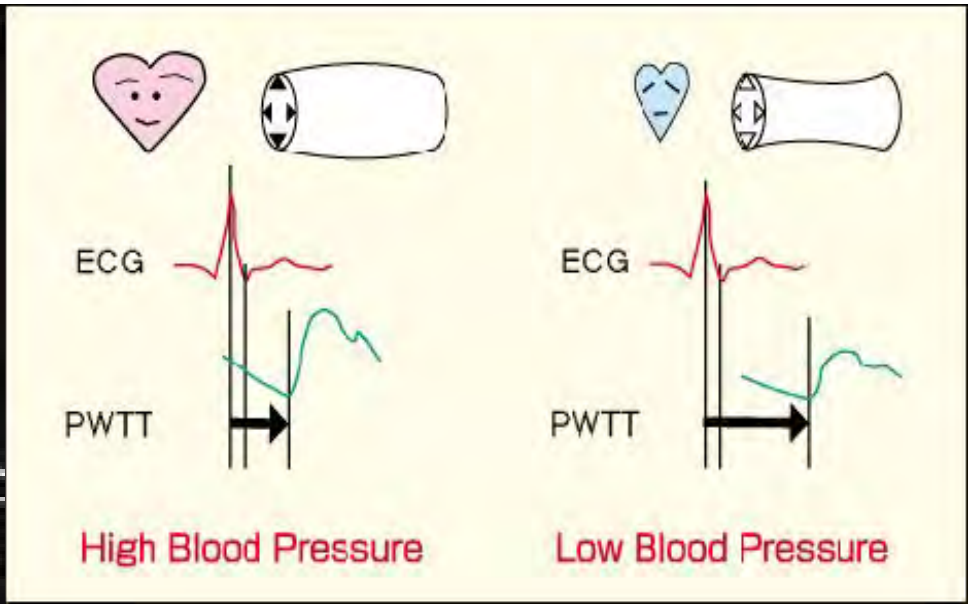
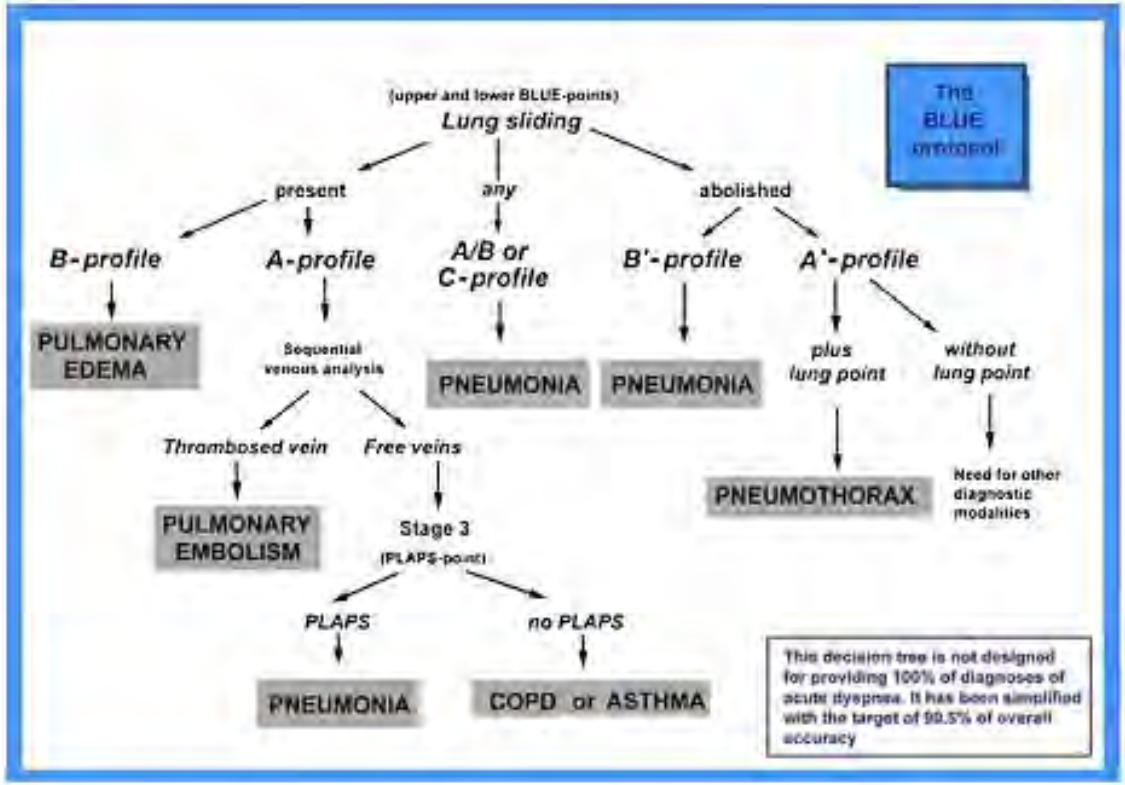
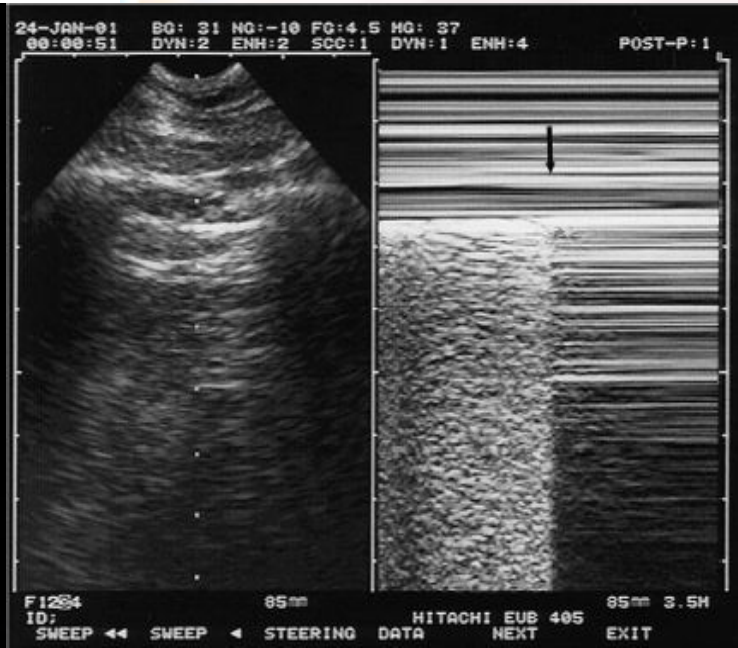

ECG
PWTT
High Blood Pressure
ECG
PWTT
Low Blood Pressure


The BLUE protocol
(upper and lower BLUE-points)
Lung sliding
present
any
abolished
B-profile
A-profile
A/B or C-profile
B'-profile
A'-profile
PULMONARY EDEMA
Sequential venous analysis
PNEUMONIA
PNEUMONIA
plus lung point
without lung point
Thrombosed vein
Free veins
PNEUMOTHORAX
Need for other diagnostic modalities
PULMONARY EMBOLISM
Stage 3
(PLAPS-point)
PLAPS
no PLAPS
PNEUMONIA
COPD or ASTHMA
This decision tree is not designed for providing 100% of diagnoses of acute dyspnea. It has been simplified with the target of 99.5% of overall accuracy


VCI
RA


24-JAN-01 BG: 31 NG:-10 FG:4.5 MG: 37
00:00:51 DYN:2 ENH:2 SCC:1 DYN:1 ENH:4 POST-P:1
F1284
ID:
HITACHI EUB 405
SWEEP ◀◀ SWEEP ◀ STEERING DATA NEXT EXIT


RVD3
LV
RVD2
RV
RVD1
LA
RA

TEST DE ELEVACIÓN DE PIERNAS

U C I

Hospital Nacional San Rafael

SR

SantaTecla, La Libertad

1- El descenso de la presión arterial media depende de alteraciones en el gasto cardiaco y la resistencia vascular sistémica:

Falso_____ Verdadero _____

2-La presión venosa central presenta una deficiente correlación con respecto diferenciar entre respondedores y no respondedores a fluidoterapia:

Falso_____ Verdadero _____

3-El índice de variabilidad del volumen sistólico y del gasto cardiaco, superan al test de elevación de piernas al momento de diferenciar entre respondedores y no respondedores a fluidoterapia:

Falso_____ Verdadero _____

4-Por cada gramo de albumina humana que se administra, se provoca una autotransfusión de 18ml de liquido intersticial hacia el espacio intravascular.

Falso_____ Verdadero _____

5-En el choque séptico, en caso de refractariedad a norepinefrina, se recomienda utilizar dopamina y no se recomienda emplear epinefrina:

Falso_____ Verdadero _____

1- El descenso de la presión arterial media depende de alteraciones en el gasto cardiaco y la resistencia vascular sistémica:
Verdadero

2-La presión venosa central presenta una deficiente correlación con respecto diferenciar entre respondedores y no respondedores a fluidoterapia:
Verdadero

3-El índice de variabilidad del volumen sistólico y del gasto cardiaco, superan al test de elevación de piernas al momento de diferenciar entre respondedores y no respondedores a fluidoterapia:
Falso

4-Por cada gramo de albumina humana que se administra, se provoca una autotransfusión de 18ml de liquido intersticial hacia el espacio intravascular.
Verdadero

5-En el choque séptico, en caso de refractariedad a norepinefrina, se recomienda utilizar dopamina y no se recomienda emplear epinefrina:
Falso