**Bibliografia que pode interessar**

### Varizes e úlcera venosa


### Trombose venosa


Venous thromboembolism event (VTE) is a common and morbid complication in cancer patients. Patients with gastrointestinal cancers often suffer from symptomatic or incidential saphenous vein thrombosis, impaired liver function and/or thrombocytopenia. These characteristics require a thorough risk/benefit evaluation for individual patients. Considering the risk factors for the development of VTE and bleeding events in addition to recent study results may be helpful for correct initiation of primary pharmacological prevention and treatment of cancer-associated thrombosis (CAT), preferably with low molecular weight heparins (LMWH). Whereas thromboprophylaxis is most often recommended in hospitalized surgical and non-surgical patients with malignancy, there is less agreement as to its duration. With regard to ambulatory cancer patients, the lack of robust data results in low grade recommendations against routine use of anticoagulant drugs. Anticoagulation with LMWH for the first months is the evidence-based treatment for acute CAT, but duration of secondary prevention and the drug of choice are unclear. Based on published guidelines and literature, this review will focus on prevention and treatment strategies of VTE in patients with gastrointestinal cancers.


Infection / Pediabético


Introduction: The ischaemic diabetic foot is associated with a faster evolving atherosclerosis affecting preferentially the below knee arteries. This distal ischemia associated with a wide distribution of multiple stenosis and occlusions throughout lower limb arteries, makes revascularization very hard or even impossible. This represents a major factor responsible for non-healing diabetic foot ulcer. In these cases all efforts should be made to find treatment alternatives that can promote ulcer healing.

Case presentation: Male patient with neuroischaemic diabetic foot ulcer with exposure tendon, without possibility for endovascular or surgical revascularization, was treated unsuccessfully with prostaglandin and several types of dressings for 7 months. Skin graft failed. Weekly dressings with collagen implant impregnated with gentamicin sulphate were then started and continued in an outpatient setting. Evolution was very positive, with 99% of epithelisation in 9 months. No pain or infection since the beginning of this treatment.

Discussion: Successful treatment of a neuroischaemic diabetic foot ulcer rests with the possibility of increasing the perfusion to the foot. Whether or not a revascularization procedure is possible will set the tone for the ensuing treatment. Using collagen implant with gentamicin sulphate, collagen is delivered to the wound bed helping in the granulation tissue formation, will increase microcirculation, and topic gentamicin will decrease bacterial load, exudate and proteases production, increasing cicatrisation.

Conclusion: In neuroischaemic diabetic foot溃疡 weekly dressings with collagen implant impregnated with gentamicin sulphate can be a good option for ulcer healing.


Negative pressure wound therapy with instillation (NPWTi) and dwell time is an adjunctive treatment modality for selected complex wounds. Because of the greater amount of research now available, a multidisciplinary expert panel comprising the fields of podiatry, plastic and general surgery, burn treatment, infectious diseases, and orthopedics was convened on July 11, 2015, to produce a summary of the data and recommendations on the use of NPWTi. The panel members each reviewed available published literature on NPWTi in the PubMed, Cochrane, and Google Scholar databases from 1 January 2012 up until 20 July 2015 using the string search term negative pressure wound therapy instillation provided by the panel moderator; there were no restrictions on the language or type of publication. Panel members discussed their experiences and worked to reach consensus on several predefined topics. NPWTi was found to be most appropriate for properly selected complex hosts or wounds such as patients with multiple comorbidities, patients with an American Society of Anesthesiology Classification ≥ 2, severe traumatisms wounds, diabetic foot infections, and wounds complicated by invasive infection or extensive biofilm.

NPWTi should not be used routinely to treat simple wounds or hosts without comorbidities. There is evidence that when NPWTi is added to standard of care in properly selected cases it provides better overall clinical outcomes than standard of care alone, even when including NPWT. Based on published evidence and panel member experience, the Panel recommends a dwell time fluid briefly instilled into the wound and allowed to diffuse for a user-specified time - of 10-20 minutes followed by 2-4 hours of negative pressure at -125 mmHg, although larger wounds may need times of up to 6 hours. Normal saline (0.9%) is the preferred solution for NPWTi, except in special situations. NPWTi with dwell time is an adjunct to other standard principles of appropriate wound assessment and treatment (e.g., debridement, pressure offloading, systemic antibiotic therapy, vascular assessment and revascularization when needed, or glycemic control).


Objective: To report a case of ertapenem-induced hallucinations and delirium in an elderly, morbidly obese patient.

Setting/Case description: A 71-year-old male was receiving intravenous antibiotics at an outside nursing facility through our Outpatient Parenteral Antimicrobial Therapy (OPAT) program, which has enrolled more than 800 patients since 2009. He was admitted to our medical center, a 673-bed tertiary health care facility, which provides care to more than 100,000 veterans in Northeast Ohio.

Main Outcome/Results: Our patient was admitted with an acute heart failure exacerbation after being discharged four weeks prior with a plan to complete six weeks of intravenous daptomycin 1 g daily and ertapenem 1 g daily for a left-calcaneal diabetic foot osteomyelitis. On initial exam, in addition to volume overload, he was noted to have fluctuating orientation, hallucinations, and suicidal ideations, which were all a significant change from his baseline mentation. A physical, laboratory, and radiologic workup revealed no conclusive etiology for his symptoms, at which point drug-induced toxicity was suspected. Upon discontinuation of ertapenem, the patient rapidly improved over the next 72 hours, including return to baseline mentation and absence of any suicidal thoughts. Use of the Naranjo probability scale indicated a probable relationship between ertapenem and the adverse effects experienced by our patient.

Conclusion: This case report and literature review demonstrates the potential severity of non-seizure-related neurotoxicity associated with ertapenem. As this toxicity can be life-threatening if unrecognized, it is crucial that clinicians across all practice settings be proactive in detecting and preventing it.

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AGENDA

Varizes e úlcera venosa – o que pode correr mal?

Organização local: Serviço de Cirurgia Geral, Hospital de Santa Maria Maior, EPE, Barcelos
Local: Auditório da Santa Casa da Misericórdia de Barcelos
Data: 18 de Junho de 2016

08,30h - Abertura do secretariado

09,00h - CERIMÓNIA DE ABERTURA – Presidente da SPC, Presidente do CA do Hospital, Provedor da Santa Casa da Misericórdia de Barcelos, Presidente do Colégio de Cirurgia Geral, Director Clínico do Hospital, Director do Serviço de Cirurgia Geral, Coordenador do Capítulo.

Introdução - O que pode correr mal?...– Costa Almeida
Presidente – Costa Almeida
Moderadores – Pereira Alves, Pratas Balhau

Comentadores – Aida Paulino, Luís Gasparinho, Luís Silveira, Luís Carvalho

9,10h – No diagnóstico de varizes primárias dos membros inferiores – Cristina Aniceto
9,20h – Na escleroterapia – Pratas Balhau
9,30h – No tratamento por radioablação – Amélia Estêvão
9,40h – No tratamento cirúrgico – Luís Reis
9,50h – Apresentação de casos clínicos

10,30h – Discussão

11,00h – Intervalo para café

Comentadores – Augusto Lourenço, Conceição Marques, Eduardo Oliveira, Pedro Vaz, Daniel Cartucho

11,30h – No diagnóstico de úlcera venosa da perna – Natália Santos
11,40h – No tratamento médico da úlcera venosa – José Neves Antunes
11,50h – No tratamento interventivo da úlcera venosa – C E Costa Almeida
12,00h – Apresentação de casos clínicos
12,30 – Discussão
13,00h – Encerramento

Inscrição grátis, mas obrigatória, para:
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