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ステロイド 副作用

▼ 全てのトピック

Q

▶ コンテンツ

患者向け情報 | 最新情報 | PCUs | 計算ツール | 薬物相互作用

"ステロイド 副作用 (steroid side effects)"の検索結果
訳語の正しさを評価してください。

steroid で意図する語を次からクリックして下さい: topical glucocorticoids, glucocorticoids, anabolic steroids

● 全てのトピック

● 成人

● 小児

● 患

● 画

この全身投与の主な副作用

ステロイド抵抗性特発性ネフローゼ症候群

潰瘍性大腸炎に対するアプローチ

成人におけるフィラデルフィア染色体陽性急性リンパ芽球性白血病に対する導入療法

全身性ステロイドに対する過敏反応

小児および思春期における性同一性障害のマネージメントの概要

原発性巣状分節性糸球体硬化症の治療

先天性代謝異常:個々の障害の発見

女性の転移性乳癌に対する全身療法:化学療法

骨転移、多発性骨髄腫、およびリンパ腫における完全および切迫病的骨折の評価およびマネージメント

小児における急性肝不全:病因および評価

下垂体腺腫およびその他の鞍部腫瘍に対する経蝶形骨洞手術

肝肥大:鑑別診断および評価

女性における思春期後のび瘡

心血管疾患および癌の一次予防におけるアスピリン

アルコール性肝炎:自然経過およびマネージメント

胃瘻チューブ:造設および定期的なケア

小児に対する手術室外での鎮静処置に使用する薬剤

子宮摘出時の選択的卵巣摘出術または卵巣保全

内因性および外因性ステロイドの尿中排泄の測定

結果を展開する

トピックの概要を表示する

新機能 1

こちらをクリックすると、トピックごとによく読まれている代表的な項目が表示されます

新機能 2

こちらをクリックすると、トピック概要が表示されます

ここに表示される英語表記で検索しておりますので、この英語表記が正しいかご確認ください

「全てのトピック」で検索した場合
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新機能 1: トピック項目の展開機能について

ステロイド 副作用

「ステロイド 副作用 (steroid side effects)」の検索結果
誤語の正しさを評価してください。

steroid で意図する語を次からクリックして下さい: [topical glucocorticoids](#), [glucocorticoids](#), [anabolic steroids](#)

全てのトピック

成人

小児

患者向け

画像

ステロイドの全身投与の主な副作用

- ⇒ Toxicity of systemic glucocorticoids by organ system or symptom complex
- ⇒ Monitoring and prevention of adverse effects
- ⇒ Summary
- ⇒ Glucocorticoid side effects (Tables)
- ⇒ Steroid side effects time dose (Figures)

小児におけるステロイド抵抗性特発性ネフローゼ症候群

- ⇒ Summary and recommendations
- ⇒ Etiology
- ⇒ Management approach
- ⇒ Therapeutic interventions

ステロイドの中断

- ⇒ Indications for withdrawing glucocorticoids
- ⇒ Glucocorticoid preparations
- ⇒ Summary and recommendations
- ⇒ Other forms of glucocorticoid dependence
- ⇒ Hypothalamic-pituitary-adrenal axis suppression

小児における特発性ネフローゼ症候群の治療

- ⇒ Steroid-sensitive nephrotic syndrome
- ⇒ Summary and recommendations
- ⇒ Steroid-resistant nephrotic syndrome
- ⇒ Initial pharmacologic therapy
- ⇒ Complications

成人におけるステロイド抵抗性およびステロイド依存性の潰瘍性大腸炎に対するアプローチ

- ⇒ Steroid-dependent ulcerative colitis
- ⇒ Summary and recommendations
- ⇒ Evaluation of a patient with steroid-dependent or steroid-refractory ulcerative colitis
- ⇒ Steroid-refractory ulcerative colitis
- ⇒ Experimental agents

緩和ケア:悪液質と食欲不振の評価および管理

- ⇒ Summary and recommendations

結果を折りたたむ

トピックの概要を表示する

代表的な項目表示が必要ない場合は再度クリックすると元の表示に戻ります

トピックごとによく読まれている代表的な項目が表示され、クリックすると該当の項目までジャンプします
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ステロイド 副作用

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ステロイドの全身投与の主な副作用
小児におけるステロイド抵抗性特発性ネフローゼ症候群
ステロイドの診断
小児におけるステロイド抵抗性特発性ネフローゼ症候群の治療
小児におけるステロイド抵抗性特発性ネフローゼ症候群に対する治療

カーソルを動かすとトピックアウトラインが右側に表示されます

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成人におけるフィラデルフィア染色体陽性急性リンパ芽球性白血病に対する導入療法
全身性ステロイドに対する過敏反応
小児および思春期における性同一性障害のマネジメントの概要
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肝肥大: 鑑別診断および治療
女性における思春期後の骨密度の低下
心血管疾患および癌の一次予防におけるアスピリン
アルコール性肝炎: 自然経過およびマネジメント
胃瘻チューブ: 造設および定期的なケア
小児に対する手術室外での鎮静処置に使用する薬剤
子宮摘出時の選択的卵巣摘出術または卵巣保全
内因性および外因性ステロイドの尿中排泄の測定

- Lipids
• Gastrointestinal tract
- Pancreatitis
• Kidney and systemic hemodynamics
• Genitourinary and reproductive system
- Pregnancy
• Musculoskeletal
- Osteoporosis
- Vertebral fractures
- Osteonecrosis
- Growth in children
- Muscle weakness
• Central nervous system
• Glucose metabolism
• Infection and immune response
• Neutrophilia
• Vaccination
MONITORING AND PREVENTION OF ADVERSE EFFECTS
HYPOTHALAMIC-PITUITARY-ADRENAL AXIS SUPPRESSION
INFORMATION FOR PATIENTS
SUMMARY
GRAPHICS
FIGURES
• Steroid side effects time dose

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Anaphylaxis: Rapid recognition and treatment

anaphylaxis

Find

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新機能 3

トピック内の検索機能が
使いやすくなりました

TOPIC OUTLINE

SUMMARY & RECOMMENDATIONS

INTRODUCTION

DEFINITION AND DIAGNOSIS

TRIGGERS AND MECHANISMS

CONTRIBUTORY FACTORS

LABORATORY TESTS

DIFFERENTIAL DIAGNOSIS

IMMEDIATE MANAGEMENT

PHARMACOLOGIC TREATMENTS

Anaphylaxis: Rapid recognition and treatment

Authors

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Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.
Literature review current through: Mar 2014. | This topic last updated: 11 12, 2013.

INTRODUCTION

INTRODUCTION — Anaphylaxis is a potentially fatal disorder. The rate of occurrence is increasing in industrialized countries [1-6]. Anaphylaxis is not always recognized as such because it can mimic other conditions and is variable in its presentation.

This topic will review the recognition and treatment of anaphylaxis by healthcare professionals working in settings such as an emergency department (ED), surgical unit, hemodialysis facility, hospital ward, clinic, or clinician's office [7-11]. Unique features of anaphylaxis in pregnant women and infants are presented separately, as is the pathophysiology of anaphylaxis. (See "Anaphylaxis in pregnant and breastfeeding women" and "Anaphylaxis in infants" and "Pathophysiology of anaphylaxis".)

DEFINITION AND DIAGNOSIS

DEFINITION AND DIAGNOSIS — Anaphylaxis is defined as a serious allergic or hypersensitivity reaction that is rapid in onset and may cause death [12,13]. The diagnosis of anaphylaxis is based primarily upon clinical symptoms and signs, as well as a detailed description of the acute episode, including antecedent activities and events occurring within the preceding minutes to hours.

Anaphylaxis is underrecognized and undertreated [1-3,5]. This may partly be due to failure to appreciate that it can present without obvious skin symptoms and signs and without shock. Anaphylaxis is a much broader syndrome than "anaphylactic shock," and the goal of therapy should be early recognition and treatment with epinephrine to prevent progression to life-threatening respiratory and/or cardiovascular symptoms and signs, including shock.

Diagnostic criteria

Diagnostic criteria — Diagnostic criteria for anaphylaxis were published by a multidisciplinary group of experts in 2005 and 2006 [12,13]. These criteria were intended to help clinicians recognize the full spectrum of symptoms and signs that comprise anaphylaxis. Recognition of the variable and atypical presentations of anaphylaxis is critical to providing effective therapy in the form of epinephrine, as well as reducing overreliance on less effective medications such as antihistamines and glucocorticoids [14]. In a retrospective cohort study of 214 emergency department patients, these criteria were found to have a sensitivity of 97 percent compared with an allergist's diagnosis upon review of the case, as well as a specificity of 82 percent, a positive predictive value of 69 percent, and a negative predictive value of 98 percent [15].

There are three diagnostic criteria, each reflecting a different clinical presentation of anaphylaxis (table 1) [12]. Anaphylaxis is highly likely when any ONE of the following three criteria is fulfilled:

Criterion 1

Criterion 1 — Acute onset of an illness (minutes to several hours) involving the skin, mucosal tissue, or both (eg, generalized hives, pruritus or flushing, swollen lips-tongue-uvula) and at least one of the following:

Respiratory compromise (eg, dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia).

OR

Reduced blood pressure (BP) or associated symptoms and signs of end-organ dysfunction (eg, hypotonia [collapse], syncope, incontinence).

Topic Feedback

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SUMMARY & RECOMMENDATIONS ➡

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Find in Topic

anaphylaxis Find

229 ☒ Find Synonyms ◀ ▶

The search expression is based on "アレルギー" which was translated to "anaphylaxis".

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Criterion 1 — Acute onset of an illness (minutes to several hours) involving the skin, mucosal tissue, or both (eg, generalized hives, pruritus or flushing, swollen lips-tongue-uvula) **and at least one of the following:**

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OR
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Practice Changing UpDates

TOPIC OUTLINE

INTRODUCTION

HEMATOLOGY (FEBRUARY 2014)

- Ibrutinib for relapsed chronic lymphocytic leukemia

GASTROENTEROLOGY AND HEPATOLOGY (DECEMBER 2013)

- Sofosbuvir and simeprevir for genotype 1 chronic hepatitis C infection

GASTROENTEROLOGY AND HEPATOLOGY (DECEMBER 2013)

- Sofosbuvir for genotype 2 and 3 chronic hepatitis C infection

HEMATOLOGY (DECEMBER 2013)

- Obinutuzumab plus chlorambucil for previously untreated chronic lymphocytic leukemia

ONCOLOGY, GENERAL SURGERY (OCTOBER 2013)

- New ASCO/CAP criteria for HER2 positivity

RHEUMATOLOGY, ADULT PRIMARY CARE, FAMILY MEDICINE, CARDIOLOGY (AUGUST 2013)

- Cardiovascular risk of NSAIDs

INFECTIOUS DISEASES (AUGUST 2013)

- Treatment of AIDS-related CMV retinitis

INFECTIOUS DISEASES, ADULT PRIMARY CARE, FAMILY MEDICINE (JULY 2013)

- Pre-exposure prophylaxis against HIV infection for injecting drug users

GYNECOLOGY, ADULT PRIMARY CARE, FAMILY MEDICINE (MAY 2013, MODIFIED JUNE 2013)

- HPV triage for women ages 30 and older with LSIL on cervical cytology

GYNECOLOGY, ADULT PRIMARY

Practice Changing UpDates

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Disclosures

All topics are updated as new evidence becomes available and our [peer review process](#) is ongoing. [Review current through:](#) Mar 2014. | [This topic last updated:](#) 1 14, 2014.

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HEMATOLOGY (FEBRUARY 2014)

Ibrutinib for relapsed chronic lymphocytic leukemia

- For most patients with refractory chronic lymphocytic leukemia (CLL) we suggest a trial of ibrutinib ([Grade 2C](#)).

For patients with refractory chronic lymphocytic leukemia (CLL), potential chemotherapy regimens include nucleoside analogs, ibrutinib, bendamustine, corticosteroids, or rituximab based therapy. For most patients, we suggest a trial of ibrutinib. This preference is based largely upon its favorable side effect profile and dramatic responses seen in heavily pretreated patients, including those with 17p deletions [1]. The overall response rate was 71 percent, and an additional 18 percent had a partial response with lymphocytosis. Ibrutinib has been approved by the US Food and Drug Administration for the treatment of patients with CLL who have received at least one prior therapy [2]. (See "[Treatment of relapsed or refractory chronic lymphocytic leukemia](#)", section on 'Ibrutinib'.)

GASTROENTEROLOGY AND HEPATOLOGY (DECEMBER 2013)

Sofosbuvir and simeprevir for genotype 1 chronic hepatitis C infection

- Most patients with chronic genotype 1 HCV infection who are candidates for and desire therapy should be treated with peginterferon, weight-based ribavirin, and a direct-acting antiviral (DAA). For these patients, we recommend the DAAs sofosbuvir or simeprevir rather than telaprevir or boceprevir ([Grade 1B](#)).

Sofosbuvir, a hepatitis C virus (HCV) polymerase inhibitor, and simeprevir, a HCV protease inhibitor, are currently becoming available in the United States and elsewhere for treatment of chronic genotype 1 HCV infection. Regimens that include these agents offer high sustained virological response (SVR) rates, more favorable adverse effect profiles than earlier regimens, ease of administration, and relatively short treatment durations [3-6]. However, regimens for genotype 1 infection generally continue to include interferon. Interferon-free regimens are expected in the near future, and it is reasonable for many patients to defer treatment while awaiting newer therapies. Most patients with chronic genotype 1 HCV infection who are candidates for and desire therapy at this time should be treated with peginterferon, weight-based ribavirin, and a direct-acting antiviral (DAA). If available, we recommend the DAAs sofosbuvir or simeprevir rather than telaprevir or boceprevir. Choice of regimens for specific populations of patients are further discussed in the topic. A joint panel from the American Association of the Study of Liver Diseases and the Infectious Diseases

新機能 4

Practice Changing UpDates (PCUs)

こちらをクリックすると、大きな変更があったトピックを領域ごとに更新月とともに表示します