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## What is the cure for acute respiratory distress syndrome

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Spironolactone against placebo or in combination with steroids for hysteria and/or acne. Cochrane Database Syst Rev. 2009;(2): CD000194. Page 3DAHLIA HASSAN, MD; ROBERT H. WILLIAMS, MD; and SWATI SHARMA, MD, Howard University Hospital, Washington, District of ColumbiaAm Fam Physician. 2012 Feb 15;85(4):383-384. A man ofyears presented with the lack of breath and vomiting of three threeduration. The vote occurred without notice and consisted of undigested food. The morning of this presentation, he woke up with food remains in the nostrils and persistent cough. The patient reported progressive difficulties with swallowing solids and liquids. He had occasional shortness of breath, constipation, and a weight loss 50-lb in the previous two years. His medical history was significant for chronic obstructive pulmonary disease and gastroesophageal reflux disease. He had smoked a pack of cigarettes a day for more than 50 years, but he didn't abuse alcohol. The physical examination showed mild respiratory stress and dry mucosa. His respiratory sounds were coarse bilaterally, with a slight scapegoat. He had moderate epogastric tenderness. Barium esophagography and computerized chest tomography were performed (Figures 1 and 2). Based on patient history, physical examination and imaging results, what is the most likely diagnosis below? A. Achalasia exophic. B. Esophageal carcinoma. C. Spasma esophageal. D. Rigorous pettico. E. Scleroderma. The correct answer is A: exophic achalasia. Exophical achalasia affects one for 100,000 people every year. 1 It is a motor disorder of the lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenteric plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the myenter plex of neurons.2 The lower esophagus that is caused by a loss of the mye liquids from moving into the stomach. Most people with this condition are diagnosed between 25 and 60 years of age. Increase ingestion difficulty is usually the symptom of presentation. The regurgitation of undigested food is an important diagnostic feature of exophic achalasia, and rarely causes suction pneumonia. Some patients may also have heartburn, weight loss, cough, or chest pain. 3A barium esophagogram showing persistent shrinkage at the intersection that produces a "bird beak" or " rat tail" appearance, is characteristic of exotic achalasia. He's exotic tomography often shows a level of air flow in the dilated esophagus over shrinkage. The esophageal manometria demonstrates the incomplete relaxation of the LES, a high basal pressure of the LES, and the absence of peristaltic contractions in the thoracic esophagus. The treatment of exophic achalasia includes drugs such as nitrates, anticholinergics and calcium channel blockers to reduce LES pressure. OnabotulinumtoxinA (Botox) injections in the sphincter can produce temporary paralysis of the muscles of LES.4 Balloon expansion (pneumatic) or surgical mytomy can be used if the most conservative therapies are ineffective.5 Early treatment can help prevent complications, such as drilling, mega-esophagus, severe esophageal and cancer. All patients undergoing treatment for esophageal atalasia should receive follow-up with endoscopy, due to increased risk of squamous carcinoma and adenocarcinoma usually occurs in older people. Defagy is the most common presentation symptom followed by weight loss. Barium esophagography is sensitive to mucous irregularities. If clinical suspicion is high and mucous membrane abnormalities are present, endoscopy is essential for visualization and chest pain. The esophagus and manometry of Bario can demonstrate widespread and uncoordinated contractions of the esophagus ("corkscrew"). In patients with severe peptics, dysphagia initially includes solids and advances to involve both solids and liquids. The strict pettics are associated with heartburn, and pH monitoring is positive for acid reflux. There is regular narrowing of the distal esophagus, usually at the squamocle junction, on the barium esophagus. 7 The main clinical characteristics of scleroderma are heartburn,8 Esophageal geometry and barium esophagus, andis freely open. Multiorgan involvement with a positive antibody panel is characteristic of scleroderma. Page 4Clinical Evidence HandbookA Publication of BMJ PALLAVI LATTHE, Birmingham Women's National Health Service Foundation Trust, Birmingham, United KingdomAm Fam Physician. The dismenorrea is very common, and can be severe enough to interfere with daily activities up to 20 percent of women. Dismenorrhea is most likely in smoking women, and in women with a previous age at menarches or longer periods of menstruation. Non-steroidal anti-inflammatory drugs reduce moderate to severe pain in women with primary dysmenorrhea compared to placebo, but we do not know if any non-steroidal anti-inflammatory drug is superior to others. Simple analgesic such as aspirin and paracetamol can reduce short-term pain, although few studies have been of good quality. The Chinese herbal remedy toki-shakuyaku-san and an Iranian herbal remedy made by saffron, celery and anise can reduce pain compared to the placebo. We do not know if Chinese herbal remedies are advantageous compared to placebo, but there is limited evidence that can be effective compared to other dysmenorrhea. Combined oral contraceptives can be more effective in reducing pain in women with effective than ibuprofen. Actress can be more effective than sham or no treatment to relieve dysmenorrhea. Spinal manipulation cannot be more effective than placebo to reduce pain after a month in women with primary dysmenorrhea. relaxation can be better than no treatment to relieve dysmenorrhea. we do not know whether acupuncture, fish oil, vitamin b12, magnets or intrauterine progestigen reduce dismenorrea. surgical interruption of the pelvic nerve routes is not beneficial in the treatment of dysmenorrhea, and may be associated with adverse effects including constipation. dysmenorrhea is painful menstrual cramps of uterine origin. is commonly divided into primary dysmenorrhea (organic pathology-free paina) and secondary dysmenorrhea (revich pain associated with an identifiable pathological condition, such as endometriosis or ovarian cysts.) the initial start of the primary dysmenorrea usually occurs within six-12 months after the menarche, when ovulator cycles are established. the duration of pain is commonly eight to 72 hours and is usually associated with the beginning of the menstrual flow. Secondary dysmenorrhea may occur even at any time after menarche, but may arise as a new symptom during the fourth and fifth decade of a woman, after the beginning of a underlying causative condition. in this review we consider only studies of women with primary dysmenorrhea. However, results can also be generalized to women with secondary dysmenorrhea. studies of women with primary dysmenorrhea. However, results can also be generalized to women with secondary dysmenorrhea. Studies of women with primary dysmenorrhea. Studies of women with primary dysmenorrhea. determine precise prevalence rates. Studies tend to report on prevalence in teenage girls, and the type of dysmenorrhea is not always specified. teenage girls tend to a greater prevalence of primary dysmenorrhea is not always specified. teenage girls tend to a greater prevalence of primary dysmenorrhea is not always specified. Dysmenorrheheamay be lower in teens, because the beginning of causal conditions may not yet occur. Therefore, the results of prevalence studies of adolescents cannot always be extrapolated to older women, or be accurate estimates of the prevalence of secondary dysmenorrhea. However, various types of studies have found a consistently high prevalence in women of different ages and nationalities. A systematic review (1996 research date) of the prevalence of chronic pelvic pain, summarizing Community and hospital surveys from developed countries. (2002 research date) found that 25 to 50 per cent of adult women, and about 75% of adolescents, experienced pain with menstruation, with 5 to 20 per cent reporting the severe dysmenorrhea or pain that prevents them from participating in their habitual activities. A third systematic review and meta-analysis of the prevalence rates between high-quality studies with representative samples of the general global population (2004 research date) found that the prevalence range, from 49 to 71 percent). The prevalence rates reported in the United Kingdom were between 45 and 97 percent for any dismenorrhea in community-based studies, and between 41 and 62 percent in hospital studies. A systematic review (2004 research date) of cohort and case control studies concluded that the younger age of 30 years, low body mass index, smoking, menarches before (younger than 12 years), longer menstrual cycles, heavy menstrual flow, nulliparity, premenstrual syndrome, sterilization, clinically suspected inflammatory disease, sexual abuse and psychological risk have been associated with increasedPrimary dysmenorrhea is a chronic recurring condition that affects most young women. Studies on the natural history of this condition are radi. A longitudinal study in Scandinavia found thatdysmenorrhea often improves in the third decade of a woman's reproductive life, and is also reduced after childbirth. We did not find studies that reliably examined the relationship between the prognosis of secondary dysmenorrhea and the severity of underlying pathology, such as endometriosis. Page 51. Sheffield JS, Hill JB, Hollier LM, et al. Valacyclovir's prophylaxis to prevent recurring herpes at delivery: a randomized clinical trial [the published correction appears in Obstet Gynecol. 2006;108(3 pt 1):695]. Obstet Gynecol. 2006;108(1):141–147....2. Watts DH, Brown ZA, Money D, et al. A double blind, randomized, placebo-controlled aciclovir test in late pregnancy for reduction of herpes simplex virus shedding and delivery cesarea. Am J Obstet Gynecol. 2003;188(3):836-843.3. Hollier LM, Wendel GD. Terze trimester antiviral prophylaxis to prevent recurrent genital herpes simplex virus (HSV) and neonatal infection. Cochrane Database Syst Rev. 2008;(1):CD004946.4. Brown ZA, Wald A, Morrow RA, Selke S, Zeh J, Corey L. 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Obstet. 6The USPSTF Task Force Preventive Services (USPSTF) concludes that the current test is insufficient to assess the balance of benefits and screening damage for bladder cancer in asymptomatic adults (Table 1). I declare. Importance. The bladder cancer in asymptomatic adults (Table 1). I declare in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1). I declare in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in asymptomatic adults (Table 1) and the ninth most commonly diagnosed cancer in adults (Table 1) and the ninth most commonly diagnosed cance women in the United States. It is the seventh major cause of death related to solid cancer. In 2009 70,980 new cases in men and 18,170 cases in women), and about 14.330 people died of the disease (10,180 men and 4,150 women). More than 90 percent of all bladder cancer cases are classified as transitional cell carcinomas. Most recently diagnosed transient cell carcinomas present as superficial tumors (50 - 70 percent) will be repeated after treatment, with a risk of 10-20 percent of the tumor that progresses to the invasive phase. A quarter of all cases of bladder cancer and from 20 to 40% of all invasive bladder cancer is associated with poor prognosis. Detection. The evidence is insufficient with regard to the diagnostic accuracy of potential tests (i.e., urine analysis for microscopic hemateria, urine cytology or urine biomarkers test) to identify bladder cancer in asymptomatic people without bladder canc improvement in disease morbidity or mortalityor general. Early detection and intervention. The projection can produce false positive results. Fake-positive results can lead to anxiety, labelling, pain and additional complications resulting indiagnostic cystoscopy and biopsy (for example, bladder drilling, bleeding, infection) or imaging. USPSTF found inadequate evidence of bladder cancer screening. Damage tests associated with early treatment, which may occur more often with increased detection of first-stage cancer cases, are also insufficient. Evaluation USPSTF. The USPSTF concludes that evidence is insufficient to determine the balance of benefits and screening damage for bladder cancer in asymptomatic adults. This recommendation applies to asymptomatic adults with slight symptomatic, these symptomatic, these symptoms are common and are not considered to be associated with an increase in the risk of bladder cancer. The USPSTF considered it reasonable to include these people in the symptoms of the lower urinary tract are not included in this population. CREENING TEST Primary-fessible screening tests for bladder cancer include the identification of hematuria with a urinary dipstick or a microscopic urinary analysis, urine cytology and urine biomarkers test. TREATMENTAfter the diagnosis of bladder cancer, several factors determine the treatment, including the degree of cancer, the stage of cancer (superficial versus invasive), if the tumor is recurrent, the age of the patient and the general state of health, and the preferences of the patient and physician. The main treatment for superficial bladder cancer, which can be combined with adjuvant radiotherapy, intravesic chemotherapy, immunotherapy or photodynamic therapies. The radical cysttectomy, with adjuvant or neoadjuvant systemic chemotherapy, it is used in cases of surgically recitable invasive bladder cancer, doctors should consider below: Preventive potential Burden. The cancer of the bladder is similar to many other types of cancer as it is a heterogeneous condition. Approximately 70 percent of all cases of newly diagnosed transient cell carcinomas present as superficial tumors (including in situ); some of these tumors can never progress in advanced disease. However, some cases of bladder cancer invade muscle tissue, progress and metastasis; treatment has a limited effectiveness in these cases. Early detection of tumors with malignant potential may have an important effect on the mortality rate of bladder cancer. A screening challenge for bladder cancer is to accurately identify the cases of first stage cancer (subepitelial and situ) with a high risk of progression. Another area of uncertainty is determining whether to provide a first, less toxic treatment (e.g. immunotherapy) with the intention of preventing symptomatic progression causes less overall damage to the patient than providing a more toxic treatment (e.g. radical cystectomy) only to patients who develop symptomatic or advanced tumors. People at greater risk of bladder cancer include those who work in the rubber, chemical or skin industries, as well as those who smoke, are males, are older, or have a family or personal history of bladder cancer. Potential weapons. The results of the false-positive test can lead to unnecessary anxiety and evaluations, diagnostic damage from cystoscopy and biopsy, labelling damage or unnecessary treatments (e.g., trans-uretral resection of a bladder tumor, intravesic chemotherapy, biological therapies), and overdiagnosis. Current practice. Screening tests possible for use in primary care include urinary dipstick or microscopic urine analysis for ematter, urinary cytology and for urine biomarkers. Tests for urine biomarkers are not commonly used in primary care partly because of their cost, although this varies substantially. Patients with positive screening results are typically urologist for further evaluations, which may include cystoscopy (and biopsy if you find a tumor), imaging and other studies. Page 7Puting Prevention in Practice An ApproachJENNIFER CROSWELL, MD, MPH, Medical Officer, U.S. Preventive Services Task Force Program, Health Care Agency BINETOU FALL, MD, Resident Family Medicine, University of Maryland Medical CenterAm Fam Physician. 2012 Feb 15;85(4):401-402. U.S. Preventive Services Task Force Recommendation DeclarationK.J., a 62-year-old white man, presents for a prior visit. He hasn't seen a doctor for three years because he's generally healthy. After his 65-year-old meighbor was diagnosed with bladder cancer, K.J.'s wife convinced him to be projected. K.J. says he had mild symptoms of urinary hesitation and nocturia for about five years. He smoked a pack of cigarettes a day for the last 20 years, and he drinks alcohol from time to time. It has been used in a tyre factory over the last 15 years. Based on the recommendations of the Task Force US Preventive Services (USPSTF), which one of the following is the most appropriate approach to use with this patient? A. Plan a cystoscopy for bladder cancer screen. B. Informi K.J. that should not be projected for bladder cancer because there is convincing evidence that the damage of the projection exceeds the benefits. C. Order urine cytology because it has been shown to have superior accuracy as a screening test for bladder cancer compared to urine analysis or urine biomarkers test. Q. Explain to K.J. its risk factors for bladder cancer, and discuss potential benefits and screening damage. E. Inform K.J. that should not be projected for bladder cancer because it has no gross hematuria. Which of the followingis it correct on bladder cancer? A. In the United States, most cases of transient cell carcinoma of the bladder have already invaded muscleat the time of diagnosis. B. If not treated, all superficial tumors progress to invasive cancer. C. Few superficial tumors of the bladder will be repeated after appropriate treatment. Q. The main treatment for surface bladder cancer is cystectomy. E. A. screening challenge for bladder cancer is the ability to accurately identify first-stage injuries that have a high risk of progression. Which of the characteristics of K.J. are considered risk factors for bladder cancer? A. His story of working in a tire factory. B. Its history of urinary hesitation and nocturia. C. Its use of alcohol. D. His story of smoking.1. The correct answer is D. Explain to K.J. its risk factors for bladder cancer, and discuss what is known about potential benefits and screening damages for bladder cancer in the adult asymptomatic population because there is insufficient to assess the balance of benefits and screening damages for bladder cancer in the adult asymptomatic population because there is insufficient to assess the balance of benefits and screening damages for bladder cancer in the adult asymptomatic population because there is insufficient evidence that screening for bladder cancer or treatment of bladder cancer detected by the screen leads to better specific results of the disease or general mortality. Tests are also insufficient for early screening or treatment damage to bladder cancer. Screening tests for bladder cancer that are feasible for use in primary care include urine dipstick or microscopic urinalysis for hematuria, urine cytology and evidence for urine biomarkers; However, the USPSTF has found inadequate evidence regarding the diagnostic accuracy of these tests. Patients with positive screening results are typically referred to a urologist for further evaluations, which may include cystoscopy. USPSTF recommendation for bladder cancer screening applies to adults not included adults with gross hematuria would be considered diagnosis, not screening. 2. The correct answer is E. A screening challenge for bladder cancer is to accurately identify cases ofcancer (subepitelial and situ) with a high risk of progression. Approximately 70 percent of all cases of newly diagnosed transient cell carcinomas present as superficial tumors (including in situ); some of these tumors can never progress in advanced disease. Many superficial tumors (50 - 70 percent) will be repeated after treatment, with a risk of 10-20 percent of the tumor that progresses to the invasive phase. The main treatment for surface bladder cancer, which can be combined with adjuvant radiotherapy, chemotherapy, biological therapies or photodynamic therapies. Radical cystectomy, often with adjuvant chemotherapy, is used in cases of invasive bladder cancer surgically re-removable. The correct answers are the risk factors of A and D. K.J. for bladder cancer include those who work in the rubber, chemical or skin industries, as well as those who smoke, are males, are older, or have a family or personal history of bladder cancer. The symptoms of the lower urinary frequency, hesitation, urgency, disuria, nocturia) are common, and it is not believed to be associated with an increase in the risk of bladder cancer. Alcohol consumption is not considered a risk factor for bladder cancer. To see the full article, log in or buy access. Moyer VA. Screening for bladder cancer: U.S. Preventive Services Task Force Recommendation Declaration [the published correction appears in Ann Intern Med. 2011;155(6):408]. Ann Intern Med. 2011;155(4):246–251. Chou R, Dana T. Adult Screening for bladder cancer: a review of the trials for the Task Force Preventive Services U.S. (USPSTF), an independent panelexperts in primary care and prevention that systematically review the evidence of effectiveness and develop recommendation on this subject is available in the USPSTF Recommendation, in the summary of the tests and in the systematic review of the tests on the USPSTF website () Practical recommendations in this activity are available at . A compilation of practical articles published in AFP is available at Copyright © 2012 of the American Academy of Family Physicians. This content is owned by AFP. A person who displays it online can do a print of the material and can use that print only for his personal, non-commercial reference. This material may not otherwise be downloaded, copied, printed, memorized in writing by AFP. Page 8AMBER RANDELAm Fam Physician. 2012 Feb 15;85(4):403-404. The use of long-term reversible contraceptives (LARC) increased from 1.3 to 5.5 percent in the previous decade. There are three LARCs available in the United States: single-rod etonogestrel intrauterine system [Mirena.)] Unwilled pregnancy rates are lower and contraceptive continuation is higher in women using LARC than other methods (see accompanying table.) LARCs are also less expensive than other methods and do not require continuous efforts by the patient for long-term effectiveness. Encourage appropriate patients to use LARCs can helpthe rate of non-intentional pregnancy in the United States especially in high-risk women. There are fewfor the oo of larc, also in women and adolescents null. the American college of obstetricians and gynecologists has issued a practice bulletin to guide doctors on the larc's oo. Although larcs have traditionally been placed during the meses, they can be placed at any time during the menstrual cycle until pregnancy can be reasonably excluded, the immediate post-partum period (within 10 minutes of place larcs because most of these women are motivated to oate contraception, are known for not being pregnant, and the hospital is a convenient environment for positioning. However, larcs are contraindicated in women with peripartum chorioamnionitis, endometritis, or puerperal sepsis. Although copper iud may be preferred because it does not contain hormones, limited evidence has shown that the intrauterine system of levonorgestrel and the etonogestrel plant do not affect the duration of breastfeeding or the growth of the child. larc oo affects menstrual bleeding, and patients must be educated on these effects. abnormal bleeding again onset should be assessed as in women using non-LARC. There is no evidence that larc affects weight, acne, or bone mineral density, the benefits of the larc or oo exceed the risks in patients with diabetes mellitus. iuds should be removed in women who become pregnant, if this can be achieved without an invasive procedure. the risks of not removing the device include miscarriage and septic abortion. larcs do not increase the risk of ectopic pregnancy, and can be used in patients with a history of ectopic pregnancy, it is recommended to wait for a year of amenorrea before removing a copper jud. levels of inspiring mad hormonebe measured to confirm menopause in those using the levonorgestrel intrauterine system because amenorrhea can be a secondary effect of this method. However, there is no convincing evidence thatmust be removed after menopause. Endometrial biopsy, cervical couphoscopy, cervical ablation or ecision, and endometrial sampling can be performed with an IUD in position. The IUD string can be hidden in the cervical channel or cut during these procedures. The expected management is appropriate if Actinomyces is detected on cervical cytology in asymptomatic patients with an IUD. This includes education regarding the small risk of actinomycosis. Randomized controlled trials were not conducted to compare IUDs with emergency contraception medical systems, and the levonorgestrel intrauterine system was not studied for this use. Copper IUD is the most effective method of emergency contraception when inserted up to five days after unprotected sex. Routine screening for sexually transmitted infections (STIs) is recommended before IUD placement in high-risk women, but not in low-risk women. The projection can be performed on the same day as the IUD positioning. Although the risk of pelvic inflammatory disease is higher in women with an STI at the time of IUD placement, this risk is low. Women with mucopurulent discharge or with known chlamydia or cervicite gonorrhea must be treated before an IUD is placed. The routine use of antibiotics to prevent pelvic infections is not recommended before IUD placement. Randomized controlled studies show that antibiotic prophylaxis does not reduce the risk of pelvic infection or the need to remove IUD in the first three months after placement. Page 9 Note: This information has been updated at the time of publication. But medical information is always changing, and some information provided here can be out of date. For regularly updated information on a variety of health topics, visitthe AAFP patient education website. Am Fam Physician. 2012 Feb 15;85(4): 365. See the relevant article on acute respiratory stress syndrome. Acute respiratory stress syndrome, or ARDS, is a serious disease that causes the lack offast breathing and difficulty getting oxygen from the lungs to the rest of the body. ARDS occurs when air-filled bags in the lungs can be wounded by a disease, such as pneumonia or blood infection, inhaling water or vomiting, or trauma. These injuries are believed to inflate the lungs. ARDS can be life threatening, so it must be treated in the hospital intensive care unit. Most patients with ARDS are put on a machine called a fan who breathes for them, until they are able to breathe alone. Other treatments include pain medicine and infection treatments include pain medicine and infection treatments recovering from the ADS will have to use an oxygen machine to help with the shortness of breath. Some will be weak or have problems such as depression or posttraumatic stress disorder. Your doctor can help you handle these problems. To see the full article, log in or buy access. This delivery is provided by your family doctor and the American Academy of Family Doctors. Other health information is available from AFP online at . This information provides a general overview and cannot apply to all. Talk to your family doctor to find out if this information applies to you and to get more information about this topic. Copyright © 2012 of the American Academy of Family Physicians. This content is owned by AFP. A person who displays it online can do a print of the material and can use that print only for his personal, non-commercial reference. This materialmay otherwise be downloaded, copied, printed, memorized, transmitted or reproduced in any medium, now known or subsequently invented, unless authorisation requests. Do you want to use this article elsewhere? Get MOST RECENT ISSUE permissions 15 May 2021 Login to the latest issue of American Family Physician Read the problem Don't miss a single number. Subscribe to the free AFP e-mail content table. Subscribe now is acute respiratory distress syndrome. how to treat acute respiratory distress. syndrome. how to treat respiratory distress syndrome

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