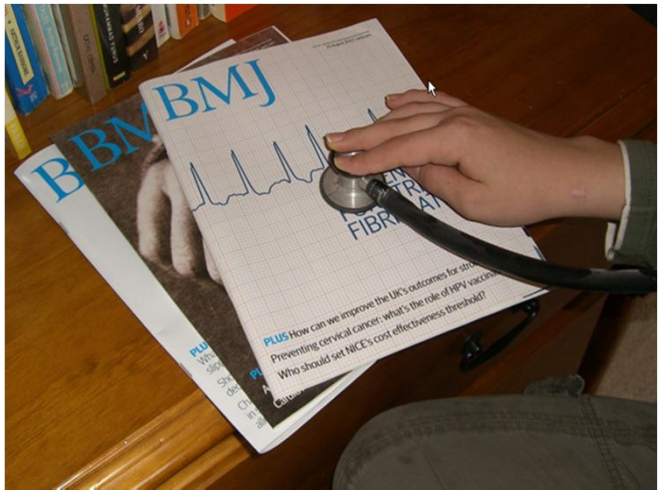
Uz Pierādījumiem Balstīta Prakse Ginekoloģijā/Dzemdniecībā

Ilze Vīberga, MD PhD

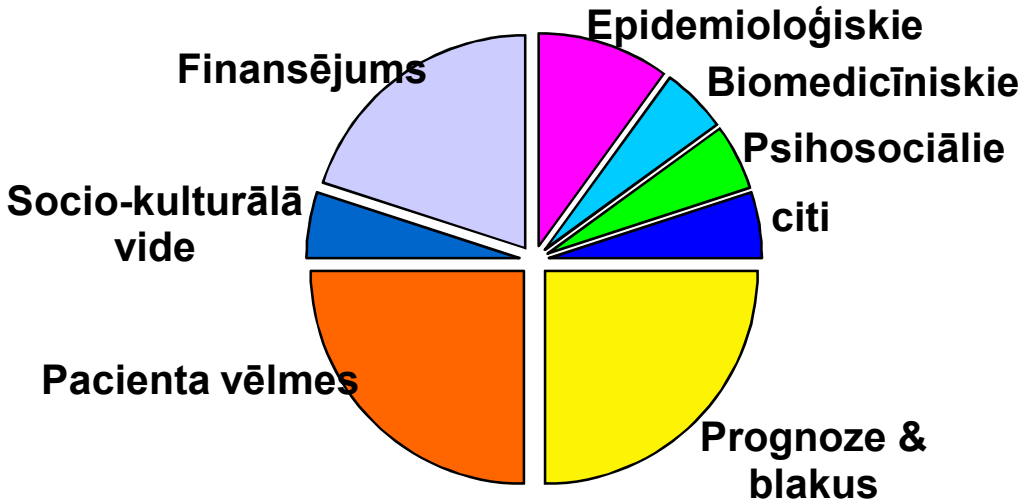
19.01.2013.



Kas ir uz Pierādījumiem Balstīta Prakse (PBP)?

Veselības aprūpe sistēma

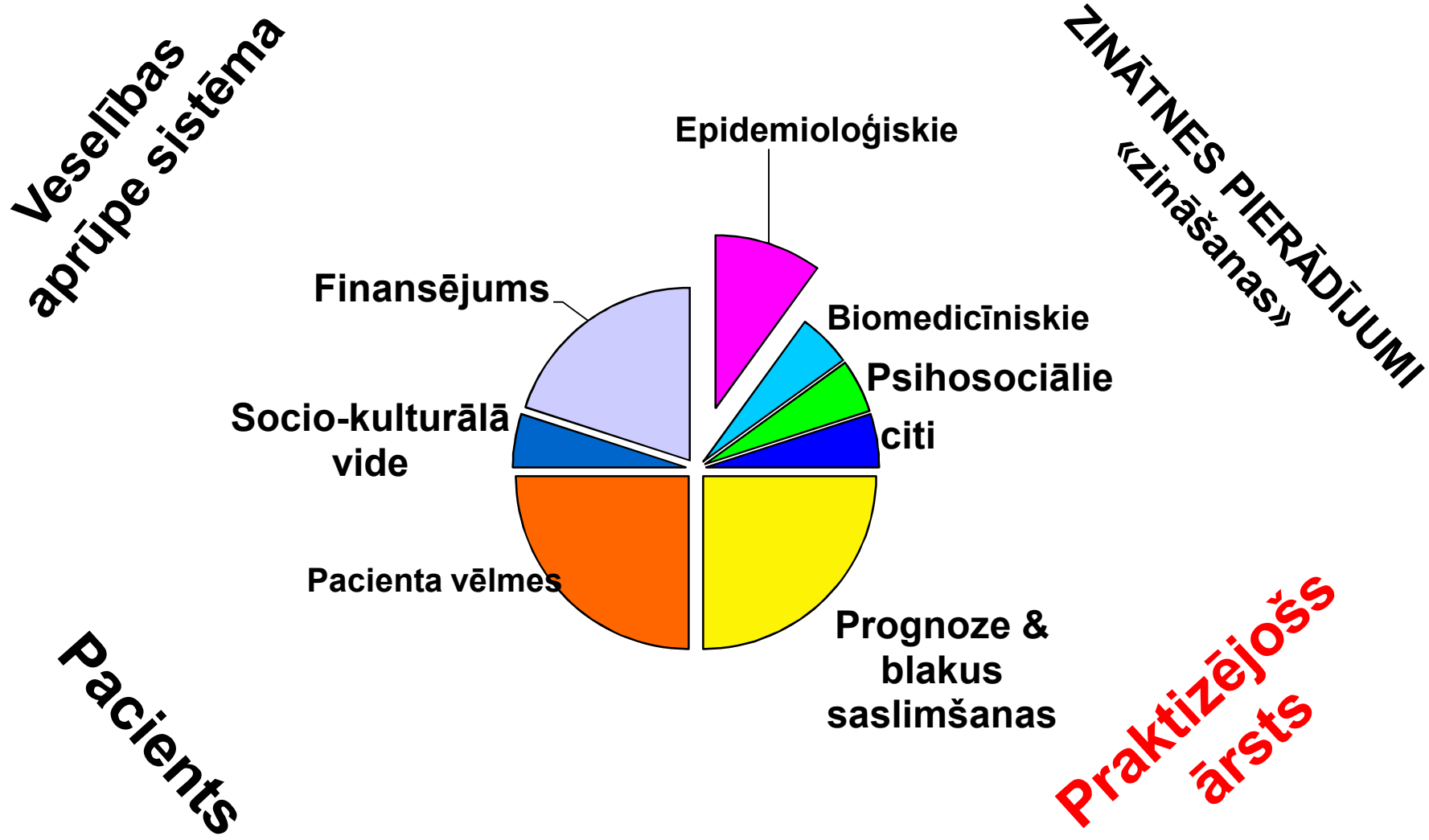
ZINĀTNES PIERĀDĪJUMI «zināšanas»



Pacients

Praktizējošs ārsts

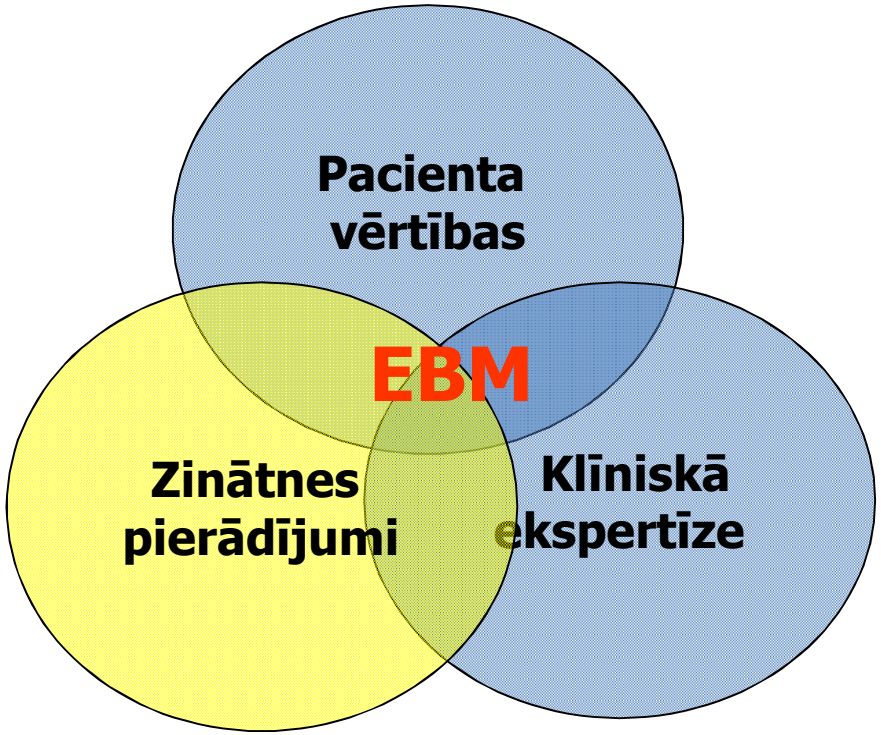
Kas ir uz Pierādījumiem Balstīta Prakse (PBP)?



KAS IR EBM (uz Pierādījumiem Balstīta Medicīna = PBM)?

"**Evidence-based medicine** is the integration of **best *research evidence*** with ***clinical expertise*** and ***patient values***"

- *Dave Sackett*



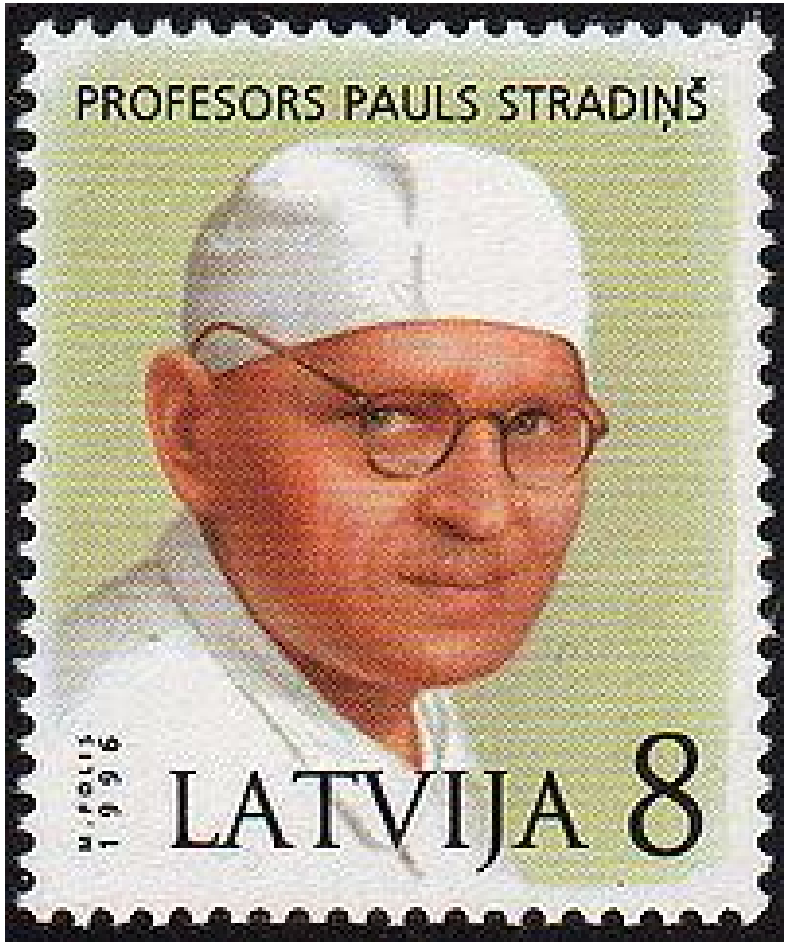
Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. BMJ 1996;312:71-2.

Lekcijas mērķi

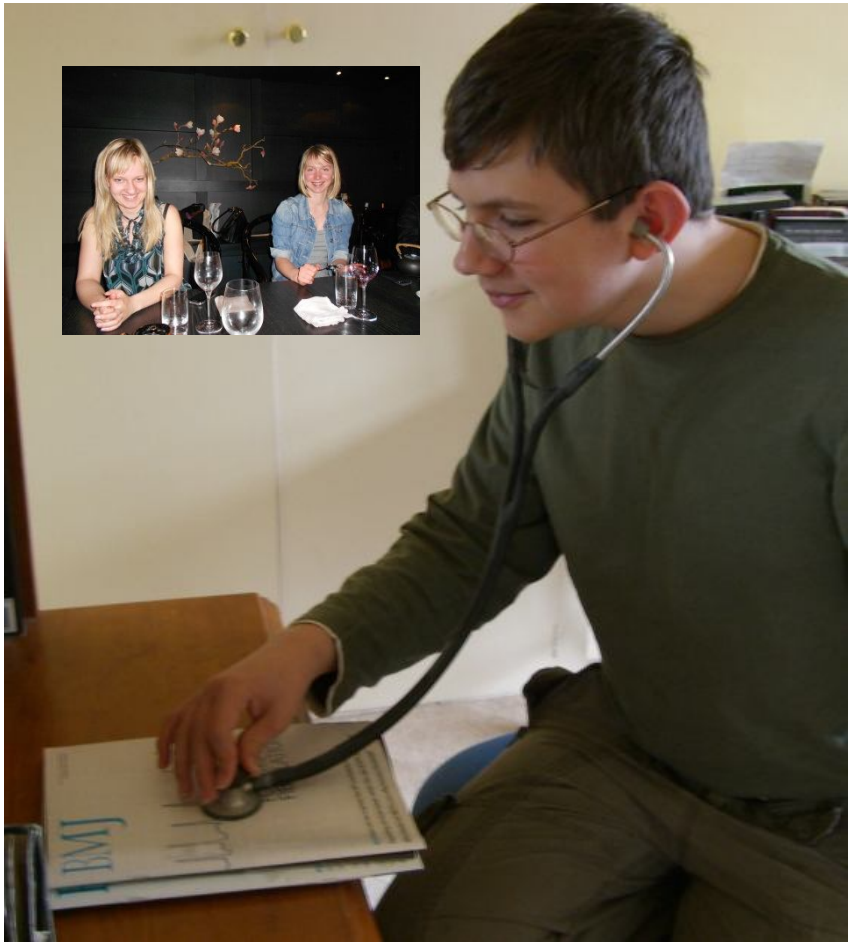
1. **KĀ praktizēt EBM/PBM, kas arī ir PBP?**
   - Kā tas «izskatās» realitātē?

2. **KĀ**
   - **Formulēt klīnisku jautājumu**
     1. Meklēt pierādījumus = EBM/PBM
     2. Novērtēt «pierādījumus – pētījumus»
     3. Pielietot klīniskai praksei

Kuru Jūs izvēlētos ārstu?

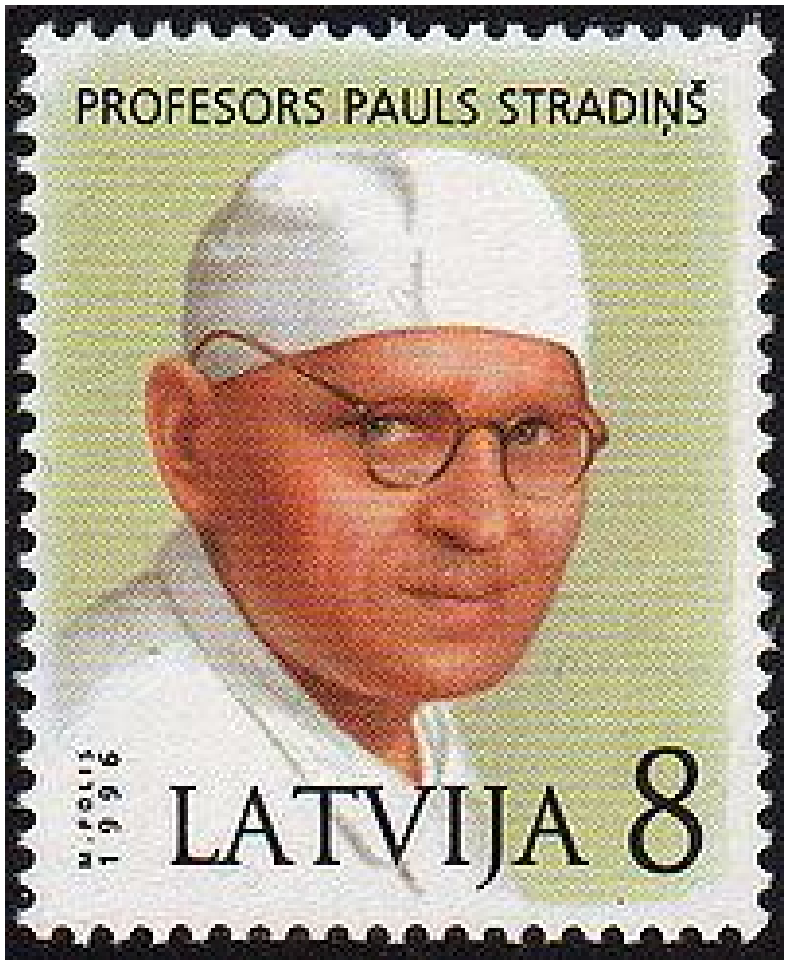


Pauls Stradiņš, 1896
gudrs un pieredzējis



apķērīgs jauns ārsts, 1986

Kuru Jūs izvēlētos ārstu?

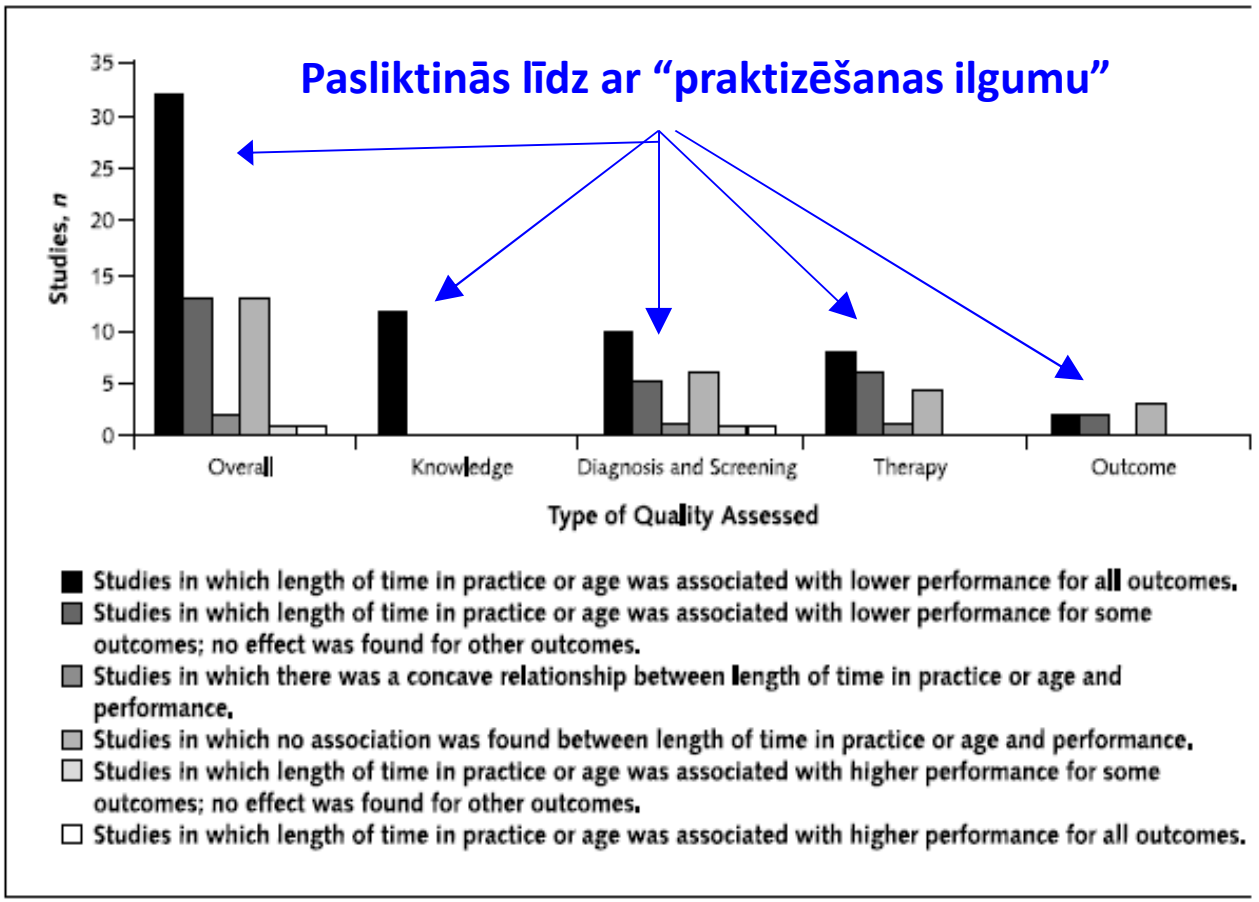


Gudru & pieredzējušu un apķērīgu jaunu ārstu

Systematic Review: The Relationship between Clinical Experience and Quality of Health Care

Niteesh K. Choudhry, MD; Robert H. Fletcher, MD, MSc; and Stephen B. Soumerai, ScD

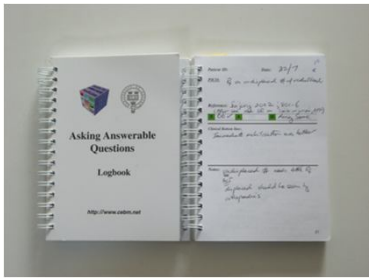
Figure 2. Distribution of study results relating physician age to clinical performance in various domains.



Palūkosimies pēdējos 12, 24, 36….. mēnešus atpakaļ

- Ko Jūs **savā praktizēšanā esat mainījis**?
- Kas to ir ietekmējis?
- No kā/ no kurienes Jūs to esat pārņēmis/ iemācījies?
- Kādi Jums bija **pierādījumi, lai mainītu** …… ?

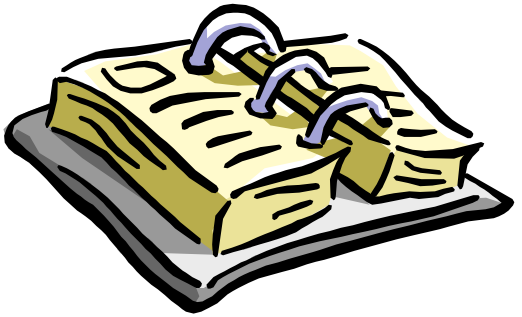
Kā to izdarīt tik ļoti noslogotajā ikdienā?: trīs ***iespējamas*** lietas varētu darīt



A. Lasīt EBM medicīnas periodiku, kas publicē medicīnas zinātnē notiekošo

B. Veidot Jūs interesējošo jautājumu materiālu kompilācijas

C. Dalīties ar savām jauniegūtām atziņām ar tuvākiem kolēģiem un pārspriest tās



Palūkosimies vēl uz sevi…..

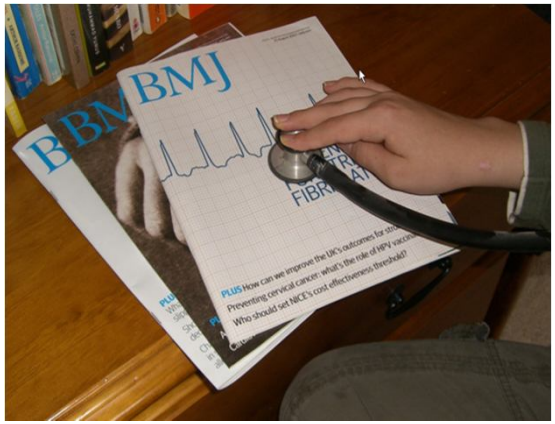
- Vai es vispār domāju/atceros par to, ka man vajadzētu pasūtīt (kādu) profesionālo žurnālu?
- Vai pieķeru sevi pie domas, ka man uznāk «dusmas» lasot «visgudros» rakstus?
- Vai es lasu profesionālo literatūru, lai labāk iemigtu?
- Vai man uz galda ir «kaudzēm» profesionālo žurnālu?
- Vai es ar nepacietību gaidu nākamo pasūtītā žurnāla izdevumu?

Vai iespējams **visu izlasīt, kas būtu noderīgs un būtisks man?**

Kā tomēr varētu «veikt **NEISPĒJAMO MISIJU**»?

PROCESS: 6-12 profesionāļi

- **120+** žurnālu
  - **60 000** rakstu
- Cik daudz bija **derīgi**?
  < 5%
- Cik daudz bija **būtiski**?
  < 0,5%



Kā izfiltrēt, cik daudz konkrētais publicētais avots ir noderīgs un būtisks Jums Jūsu PBP??

Jāievēro **ČETRI** soļi/etapi:

1. Formulējiet JAUTĀJUMU, uz kuru vēlaties rast atbildi.
2. Meklējiet PIERĀDĪJUMUS.
3. Kritiski NOVĒRTĒJIET pierādījumus.
4. INDIVIDUALIZĒJIET tos, balstoties uz klīnisko ekspertīzi/pieredzi un pacientes vēlmēm

www.evidence-basedmedicine.com

1. Formulējiet **JAUTĀJUMU**, uz kuru vēlaties rast atbildi.

- **Pētāmā jautājuma/u struktūras veidošana !**

PICO-T

- **P**opulation/**P**atient/**P**roblem
- **I**ntervention
- (**C**omparison)
- **O**utcome
- (**T**ime)

Sicily statement on evidence-based practice. BMC Med Educ. 2005 Jan 5;5(1):1.

PICO

1. piemērs

- Bakteriālā vaginoze
- Terapija
- (Metranidazols, Klindamicīns)
- Novērst priekšlaika dzemdības

2. piemērs

- Endometrioze
- Ķirurģija
- Neaugības ārstēšana

Patient Problem

Describe the ones that you come into contact with and are relevant to your practice.

Intervention

Interventions can be types of dressings, drug therapies, placebos or counselling. Also they can be about the provision of differing environmental factors or deal with the way in which information is given to patients. They can also be diagnostic tests.

Comparison Intervention

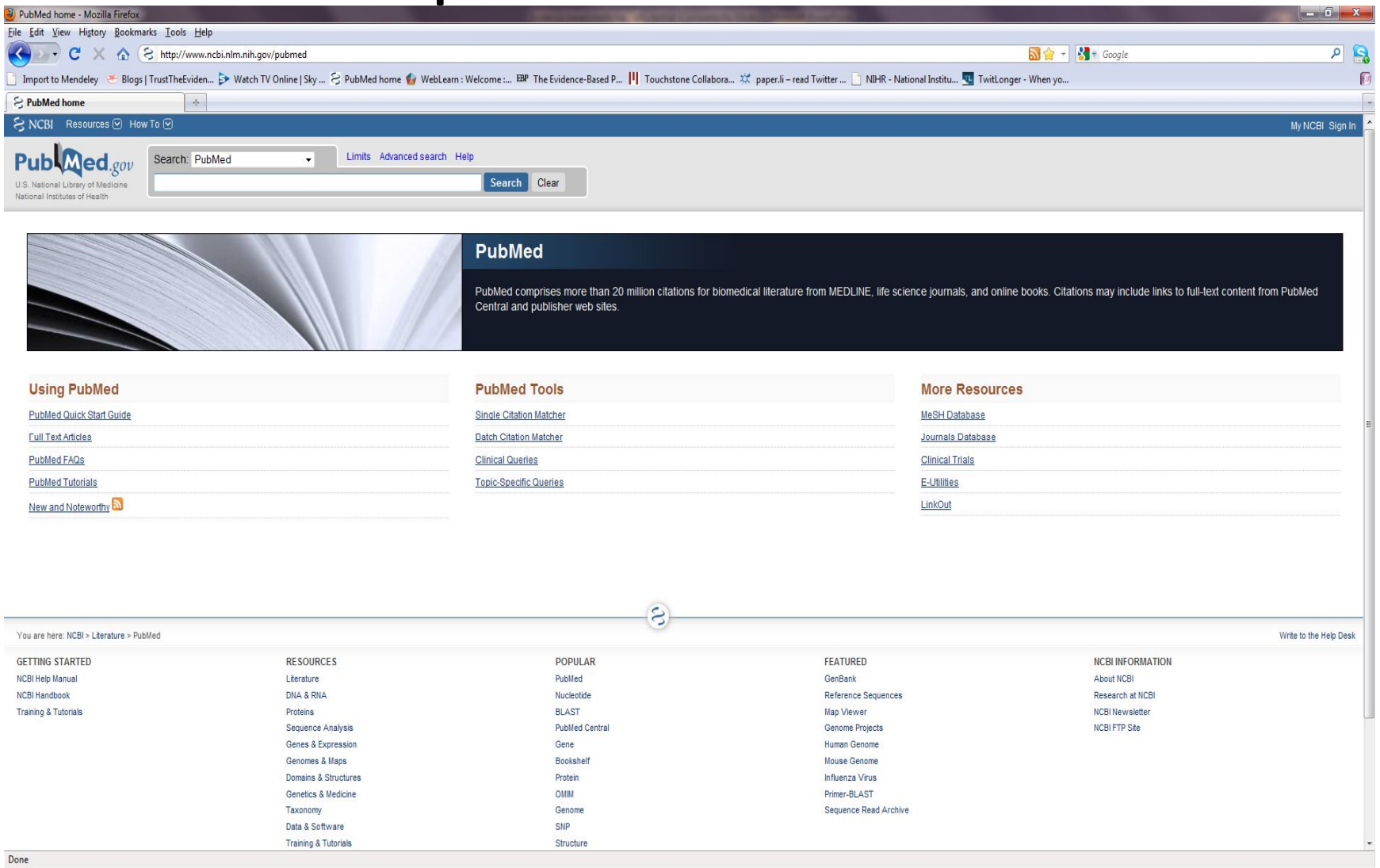
This can be a standard therapy, though it may also be no intervention a placebo or an alternative treatment, exposure or diagnostic test.

Outcomes

Make a distinction between the outcome which is relevant to your patient or problem and the outcome measures deployed in studies. Spend some time working out exactly what outcome is important to you, your patient, and the time-frame which is appropriate.

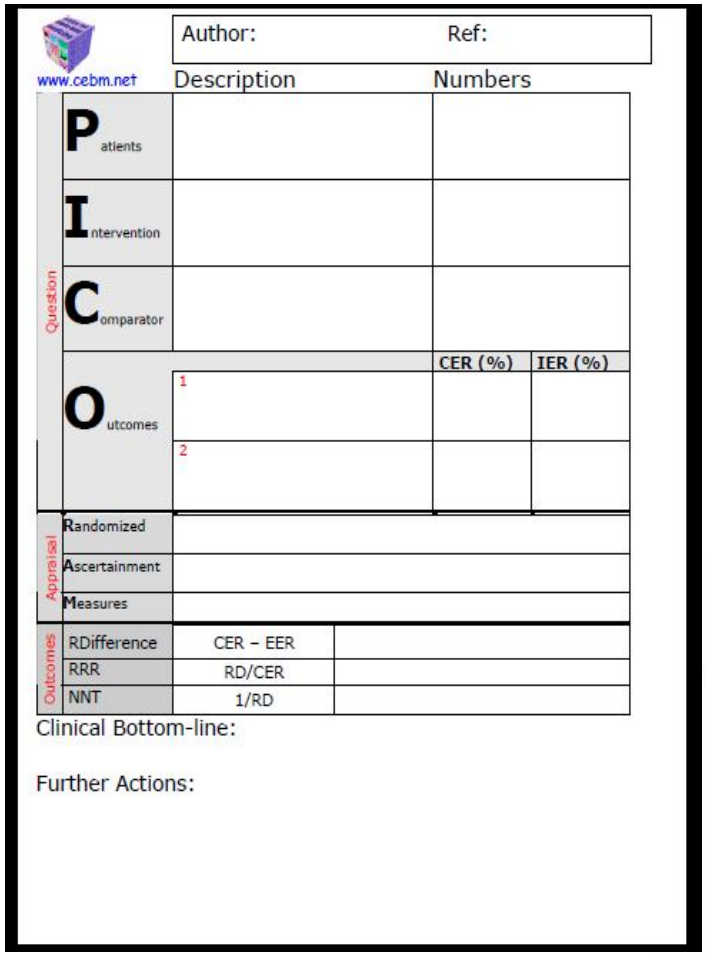
2. Meklējiet PIERĀDĪJUMUS.

Neko nevar darīt – tas jāmācās, kaut vai saprast kā tas notiek!!!



3. Kritiski NOVĒRTĒJIET pierādījumus.

Kā novērtēt, vai Jūs atradāt kvalitatīvu avotu PIERĀDĪJUMIEM?



www.cebm.net

	Author:		Ref:
	Description		Numbers
Question	**P** atients		
	I ntervention		
	C omparator		
	O utcomes		CER (%) / IER (%)
	1		
	2		
Appraisal	Randomized		
	Ascertainment		
	Measures		
Outcomes	RDifference	CER – EER	
	RRR	RD/CER	
	NNT	1/RD	

Clinical Bottom-line:

Further Actions:

DIVI «soļi»

1. PICO
2. RAMBO

GATE

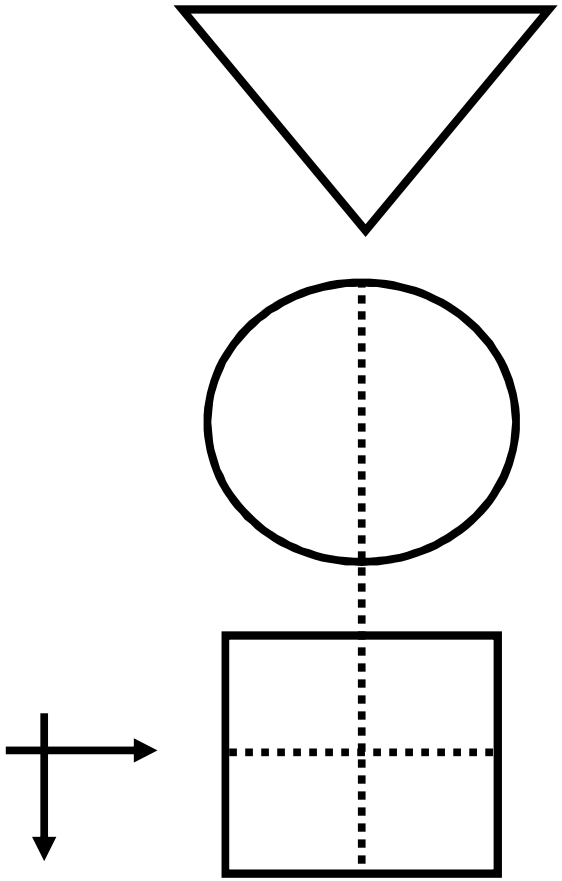
Graphic Approach To Epidemiology

Graphic Appraisal Tool for Epidemiology

Graphic Architectural Tool for Epidemiology

www.epiq.co.nz

GATE «rāmis»



Jebkuram klīniski-epidemioloģiskam ir pētījuma «rāmis»!

PECOT: jebkuram klīniski-epidemioloģiskam pētījumam ir jābūt **PIECĀM** sastāvdaļām

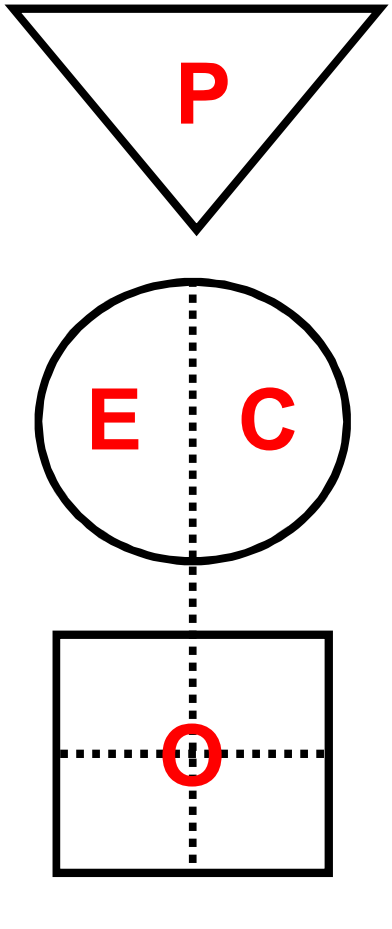
Participants

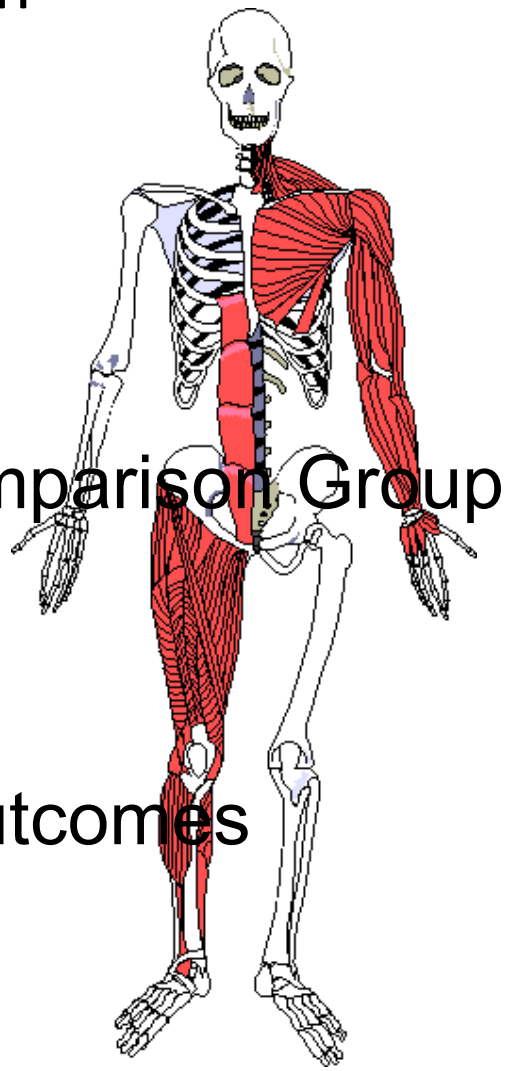
Exposure Group

Comparison Group

Outcomes

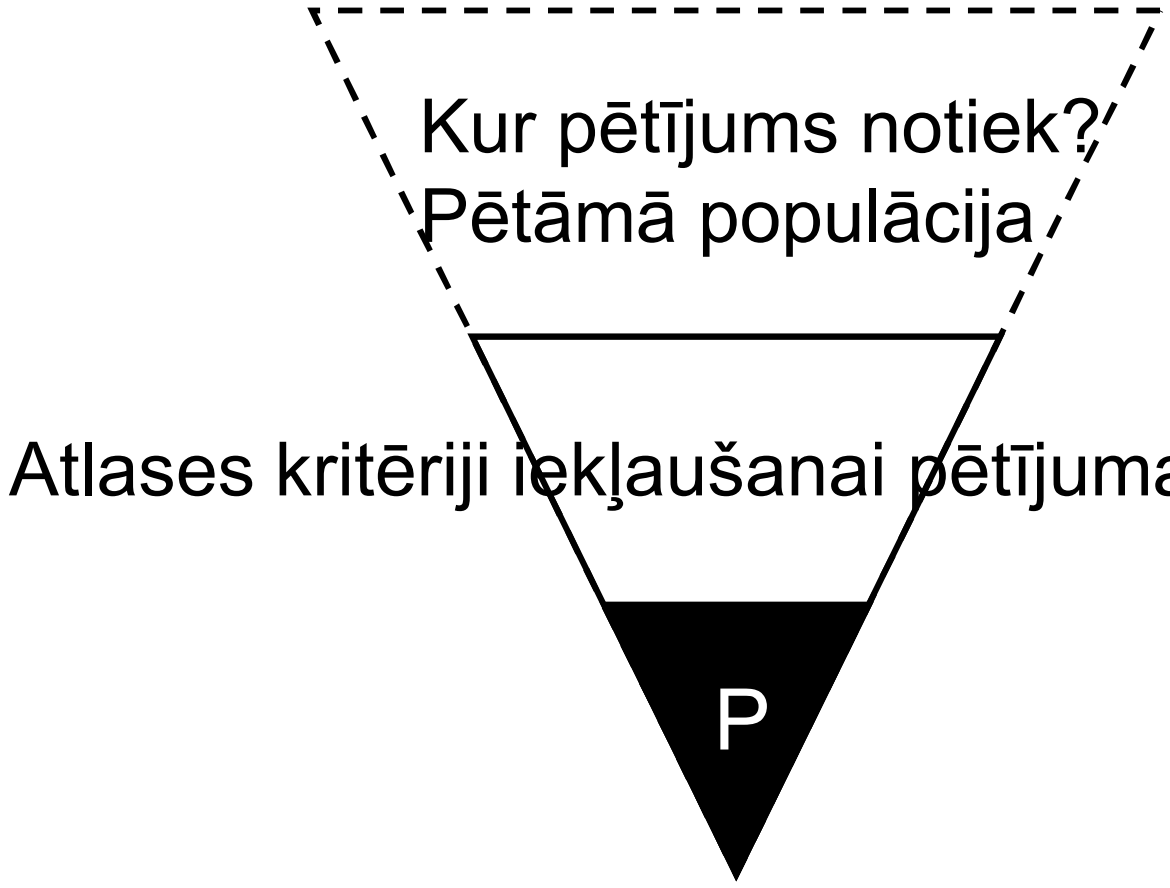
Time





Jebkuram pētījumam ir jāiekļaujas šajā GATE rāmī!

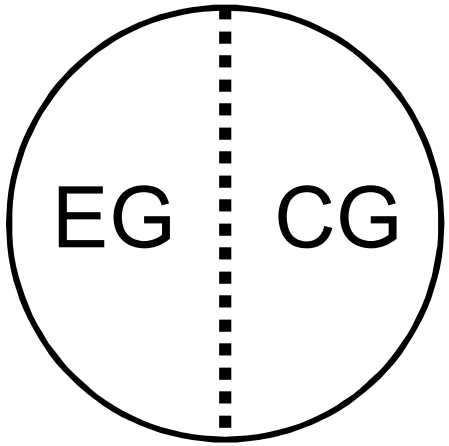
Pētījuma grupa



Participants=Iekļautie dalībnieki

«Ekspozīcijas» & «Salīdzināmā» Grupas

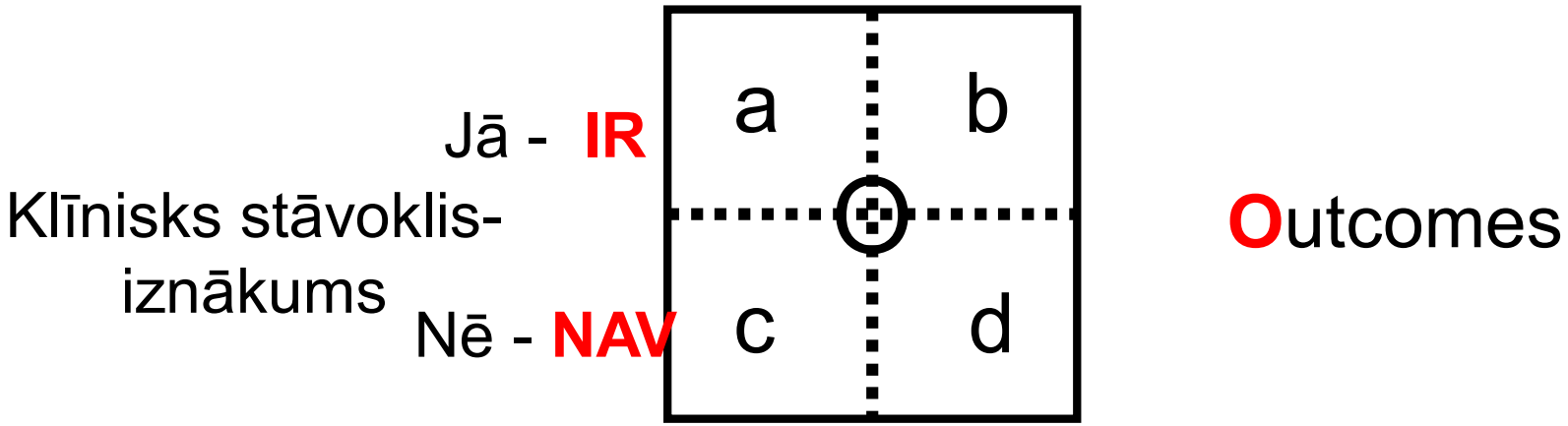
Exposure or Intervention Group (EG)



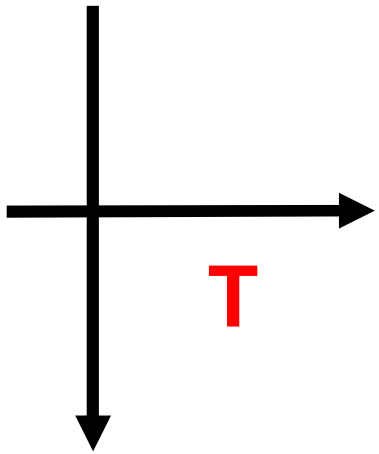
Comparison or Control Group (CG)

Vai vispār ir salīdzināmas ?!

Rezultāts/Iznākums



Laika komponente



Incidence

Prevalence

EBP & PECOT = zināma korelācija pastāv starp klīnisku-epidemioloģisku pētījumu un reālo praksi, un tāpēc jau tiek veikts pētījums, lai rastu atbildi labai praksei!

1. **Participants** (paciente/s, ko Jūs gribat ārstēt, viņai ieteikt lietot, operēt, veikt izmeklējumu….)
2. **Exposure** (Jūsu konkrētā aktivitāte, ……)
3. **Comparison** (Vienmēr ir alternatīva! – cita terapija, izmeklējums, var nedarīt neko ….)
4. **Outcome** (parasti saslimšana, stāvoklis …, ko jūs vēlaties novērst, sasniegt)
5. **Time frame** (cik ātri jūs domājat sagaidīt rezultātu)

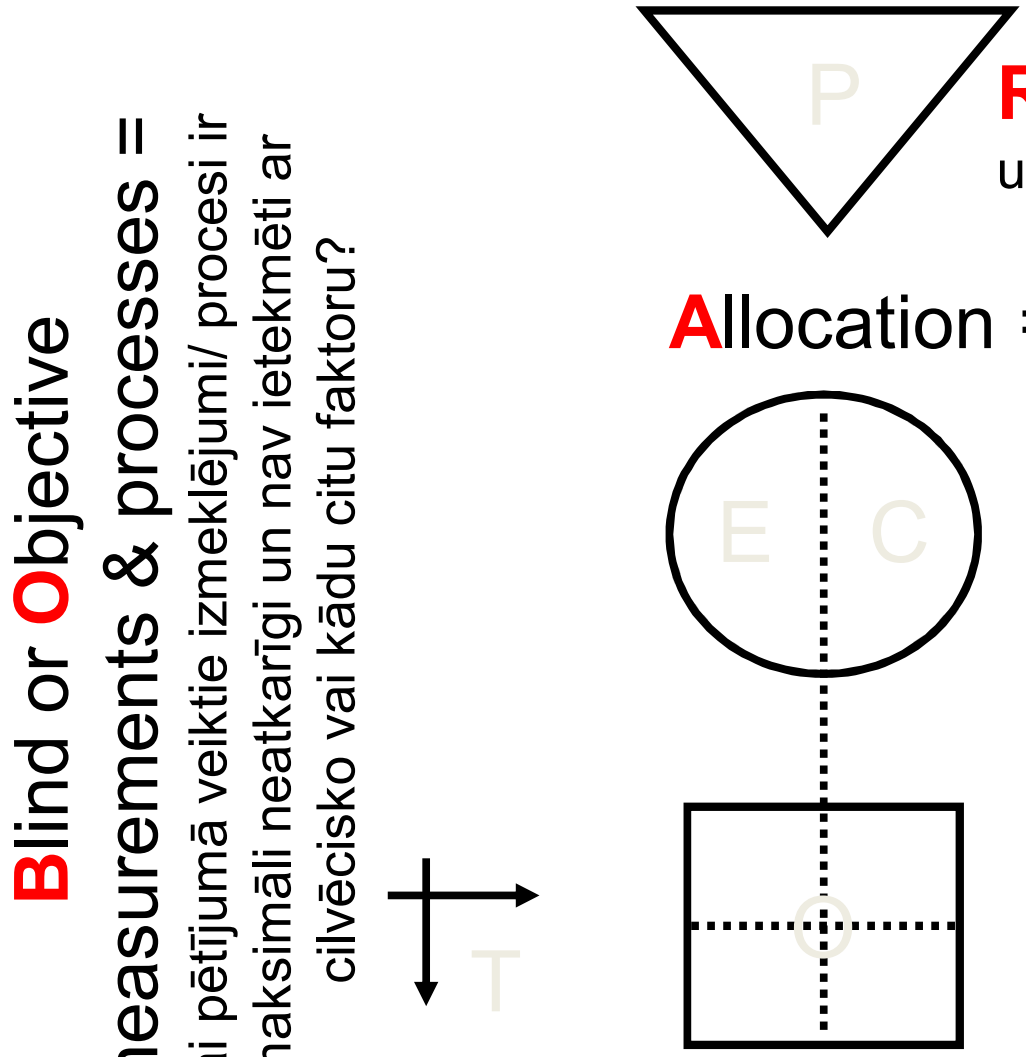
Pētījuma (PIERĀDĪJUMU) izvērtējums

Cik labi (ticami) pētījums ir veikts?

Vai visas «rāmja» sastāvdaļas ir pētījumā ir ticamas un tās savstarpēji ir sakarīgas?

‘NAV PILNĪGI PERFEKTU/IDEĀLU PĒTĪJUMU!’

Pētījuma GATE izvērtējums = **RAMBO**

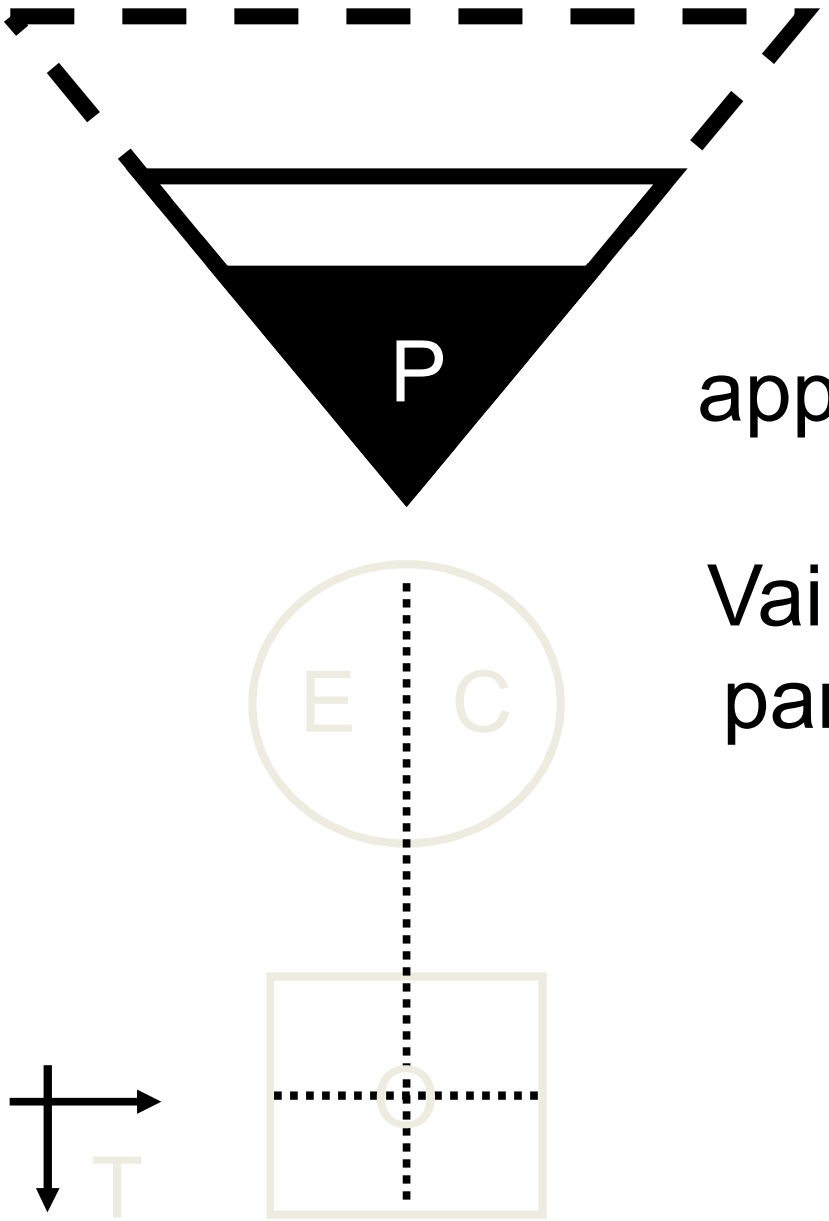


Recruitment = kā izvēlēti un iesaistīti dalībnieki?

Allocation = kas ar ko tiek salīdzināts?

Maintenance = vai pētījuma gaita ir uzturēta nemainīga?

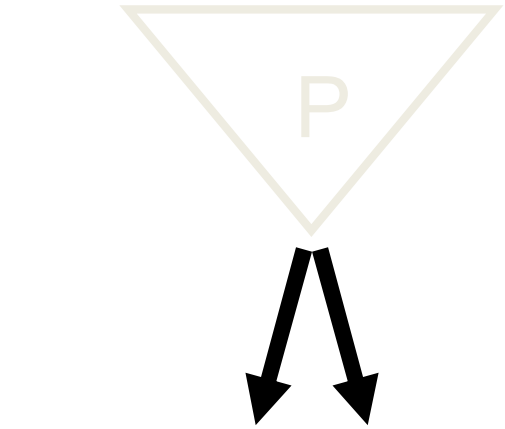
Blind or **O**bjective measurements & processes = vai pētījumā veiktie izmeklējumi/ procesi ir maksimāli neatkarīgi un nav ietekmēti ar cilvēcisko vai kādu citu faktoru?



RAMBO

appropriate **Recruitment** =

Vai pētījuma grupa atlasīta pareizi un reprezentē visu pētāmo populāciju?

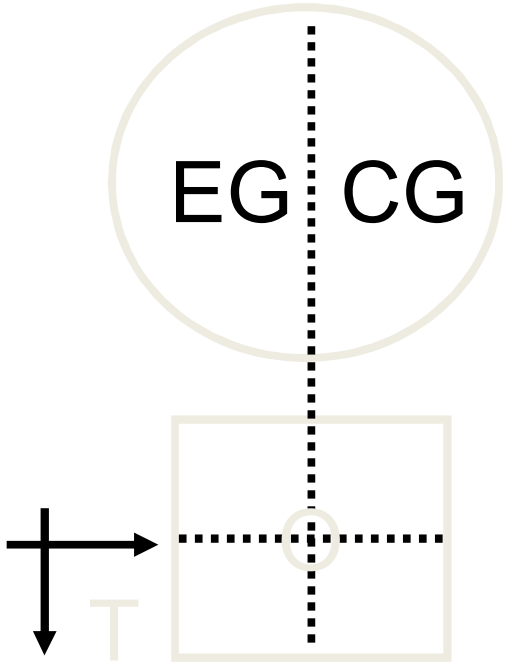


Allocate

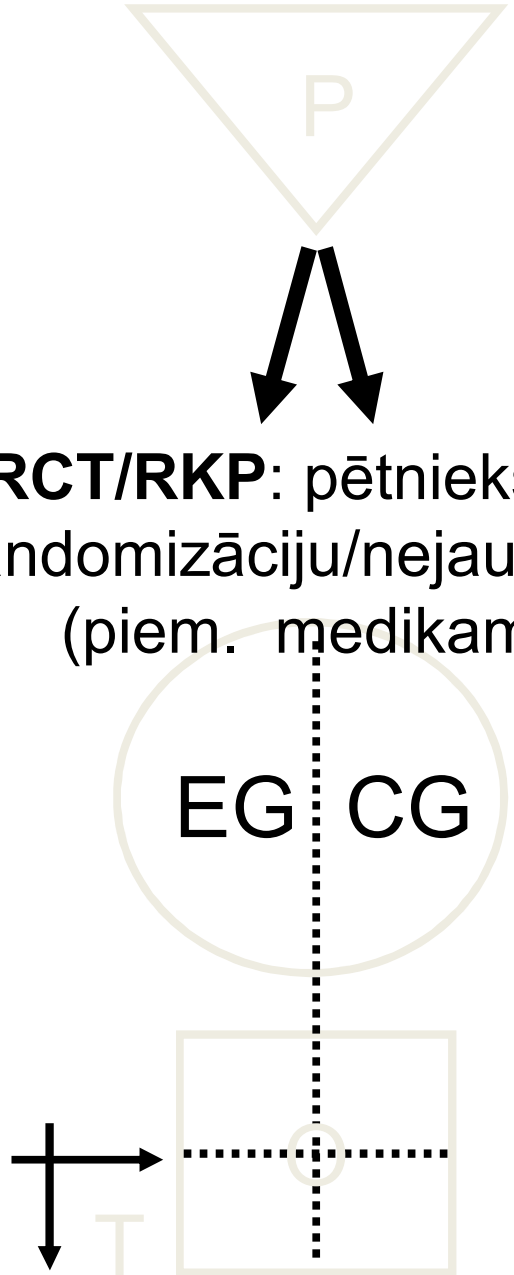
RAMBO

appropriate **Allocation** =

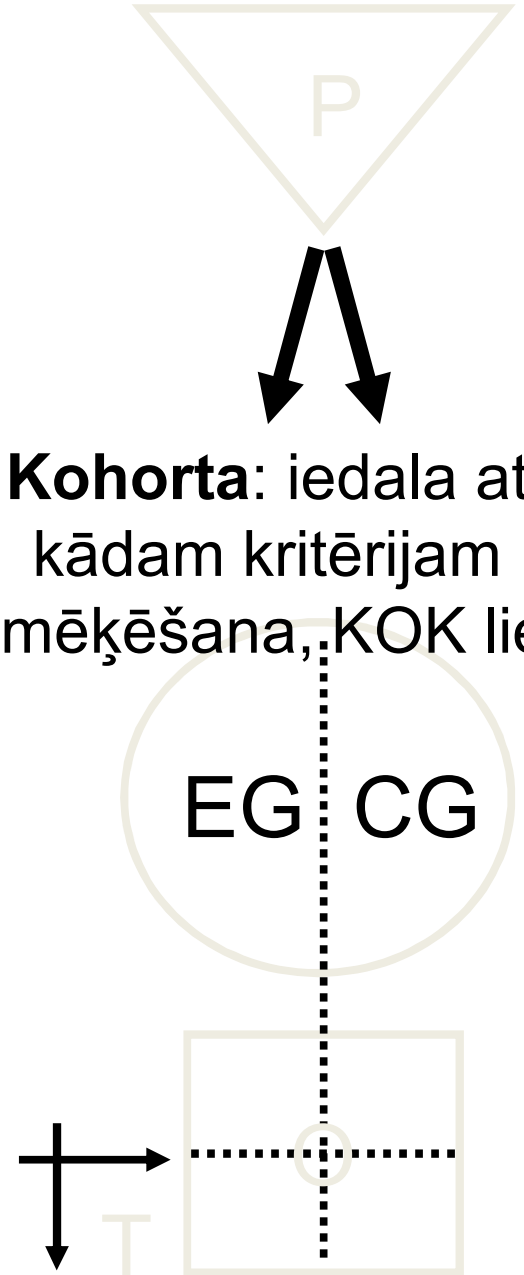
Vai EG & CG ir salīdzināmas?

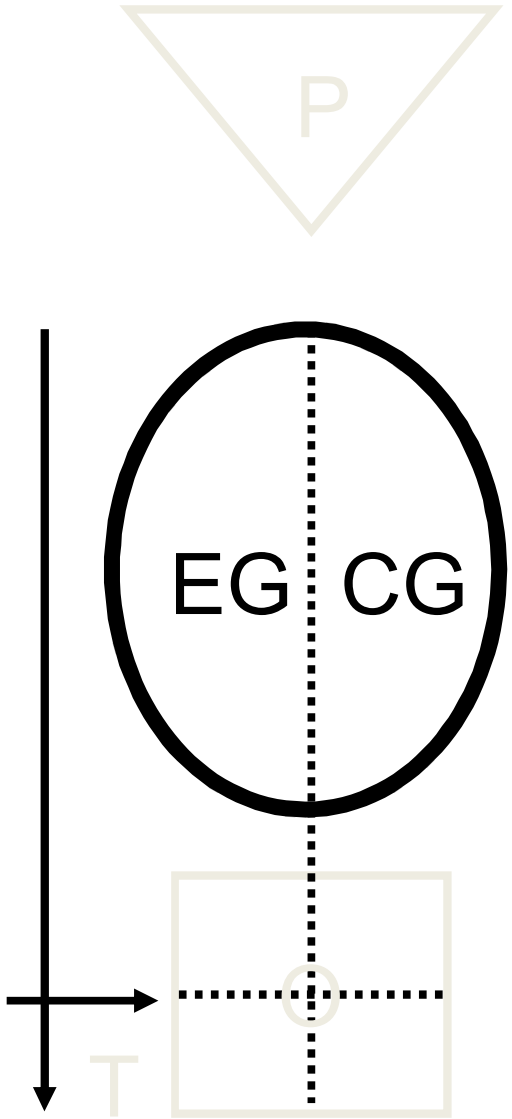


RCT/RKP: pētnieks/ki veic randomizāciju/nejaušināšanu (piem. medikamenti)



Kohorta: iedala atbilstoši kādam kritērijam (piem. smēķēšana, KOK lietošana)

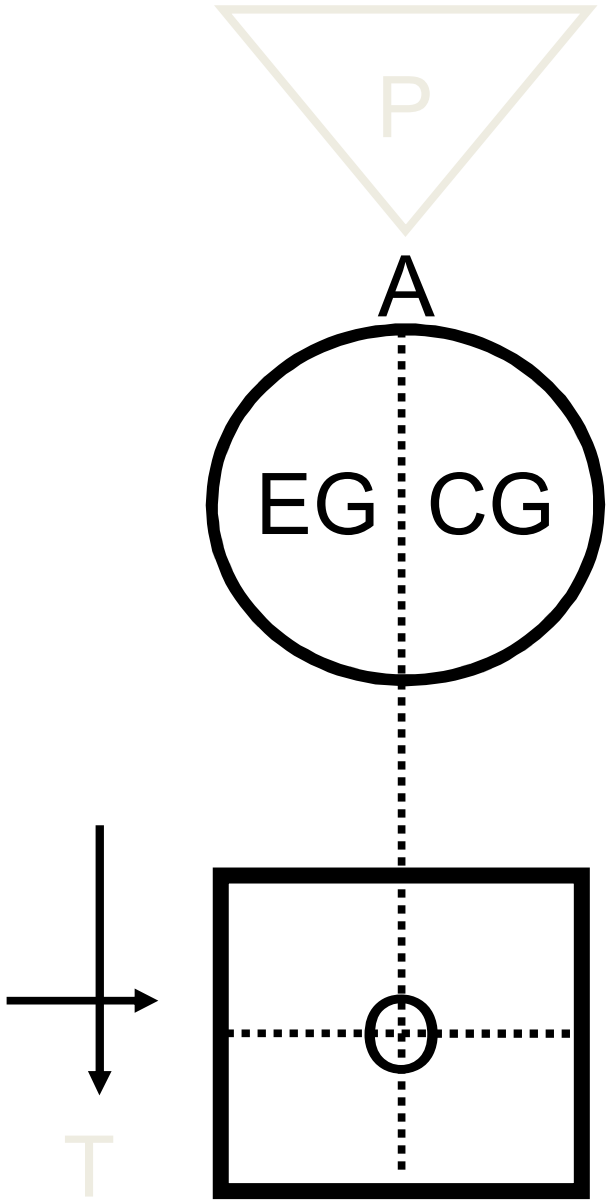




RAMBO

good **Maintenance** =

Vai pētījuma grupas paliek vienādas visu pētījuma laiku?



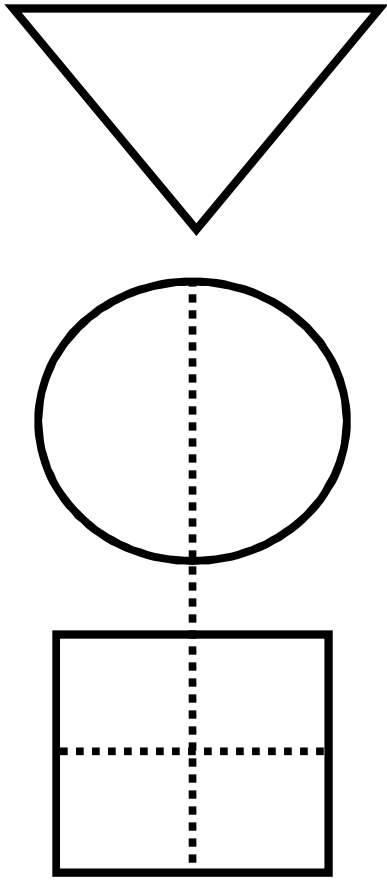
RAMBO

Blind or Objective

measurements & processes =

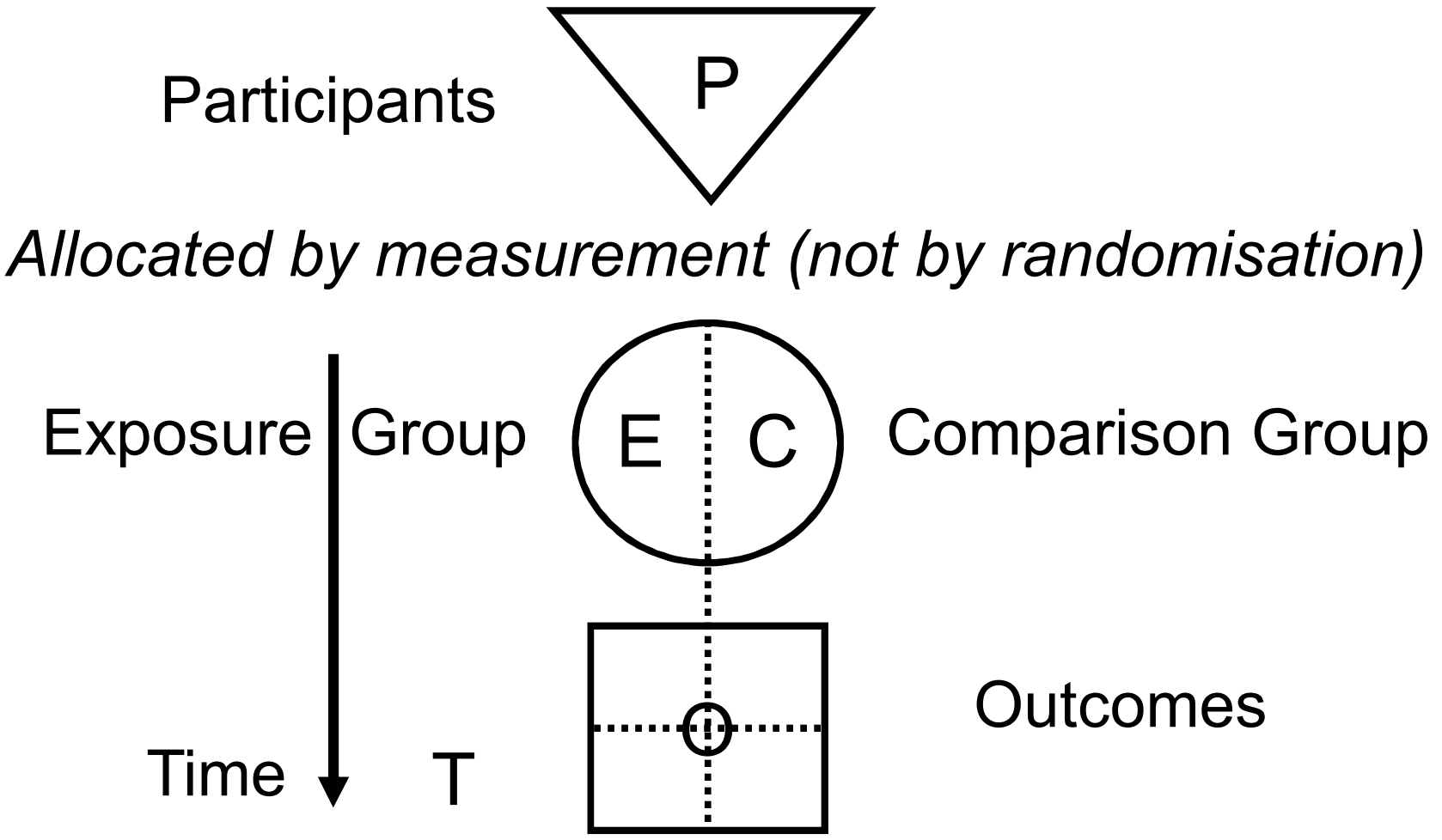
Vai visi novērtējumi un pats pētījuma process nav kaut kā ietekmēts?

Pētījumu pamatveidi



- **Kohortas pētījums** (& gadījuma-kontroles) – vērsts uz etioloģiju/prognozi/aktivitāti
- **RKP** (**randomizētas kohortas pētījums**) – vērsts uz aktivitāti
- **Šķērsgriezuma** pētījums – vērsts uz diagnozi

KOHORTAS pētījums



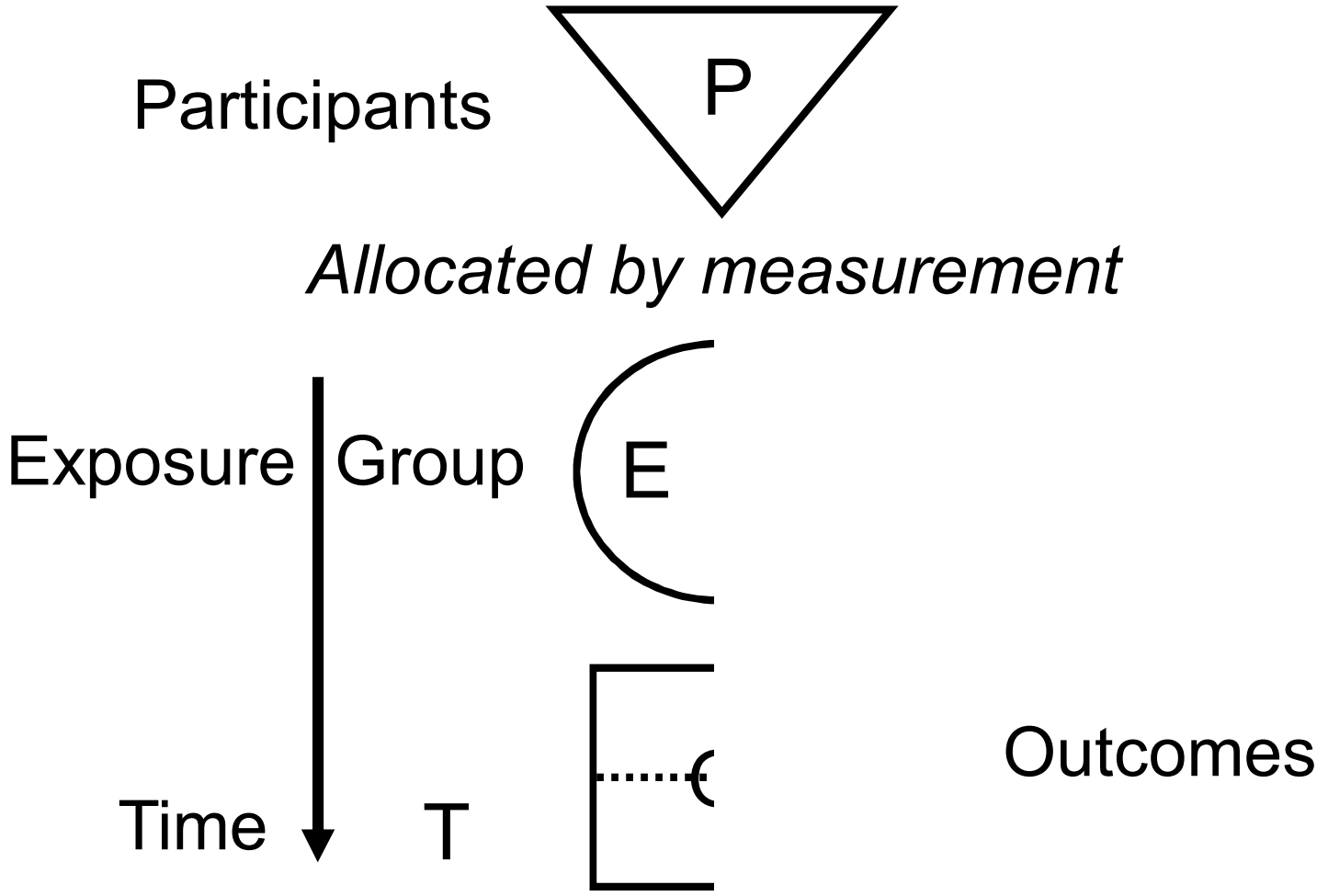
Labākais veids pētīt etioloģiju, riskus, prognozi

Gadījuma-kontroles pētījumi

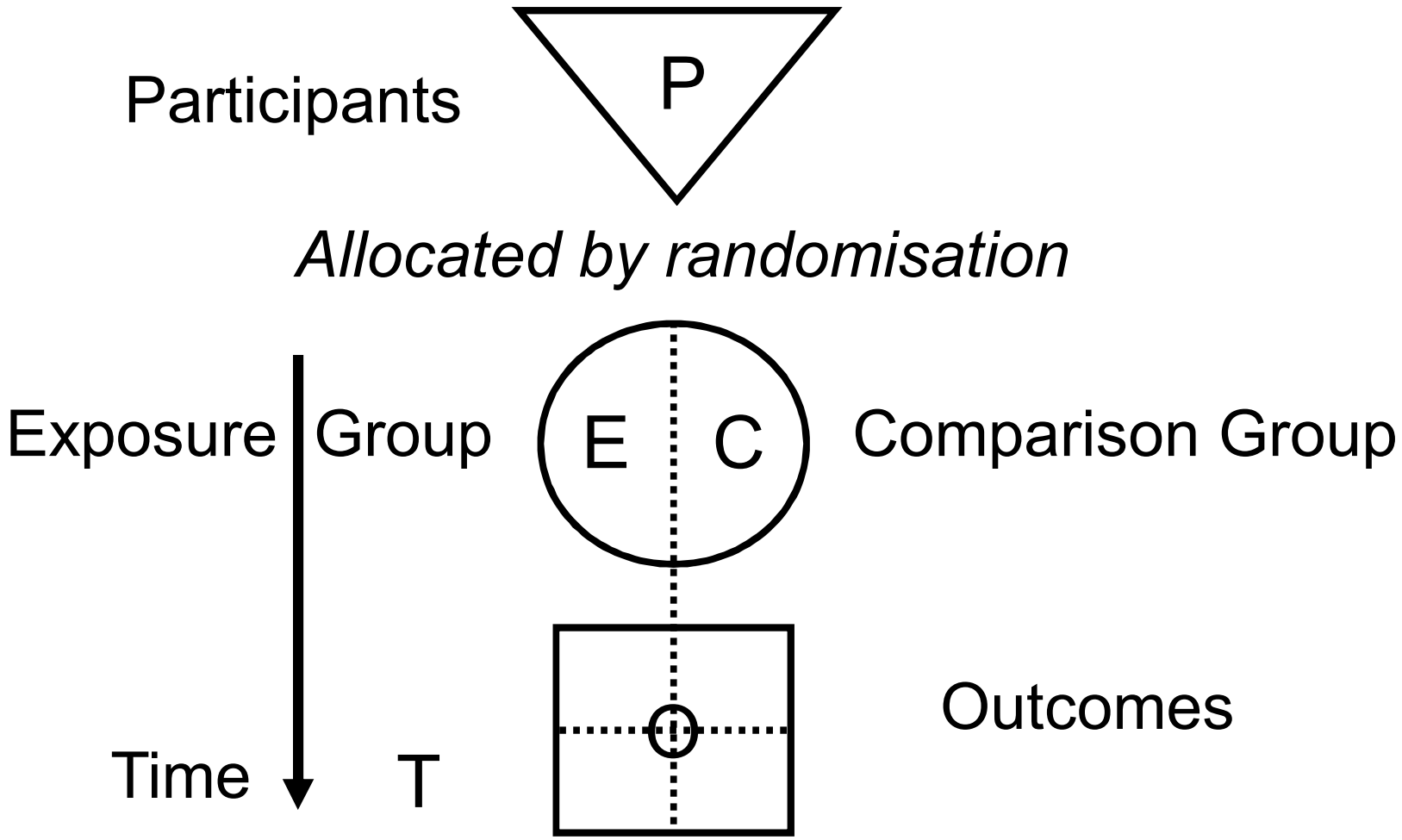
	Exposed	Not Exposed
Cases	a	b
Controls	c	d

Etioloģijas un prognozes - risku pētījumos, ja iznākums ir sastopams reti un laiks priekš kohortas pētījuma būtu ļoti garš

Gadījumu sērija ir Kohortas pētījums bez salīdzinošās grupas

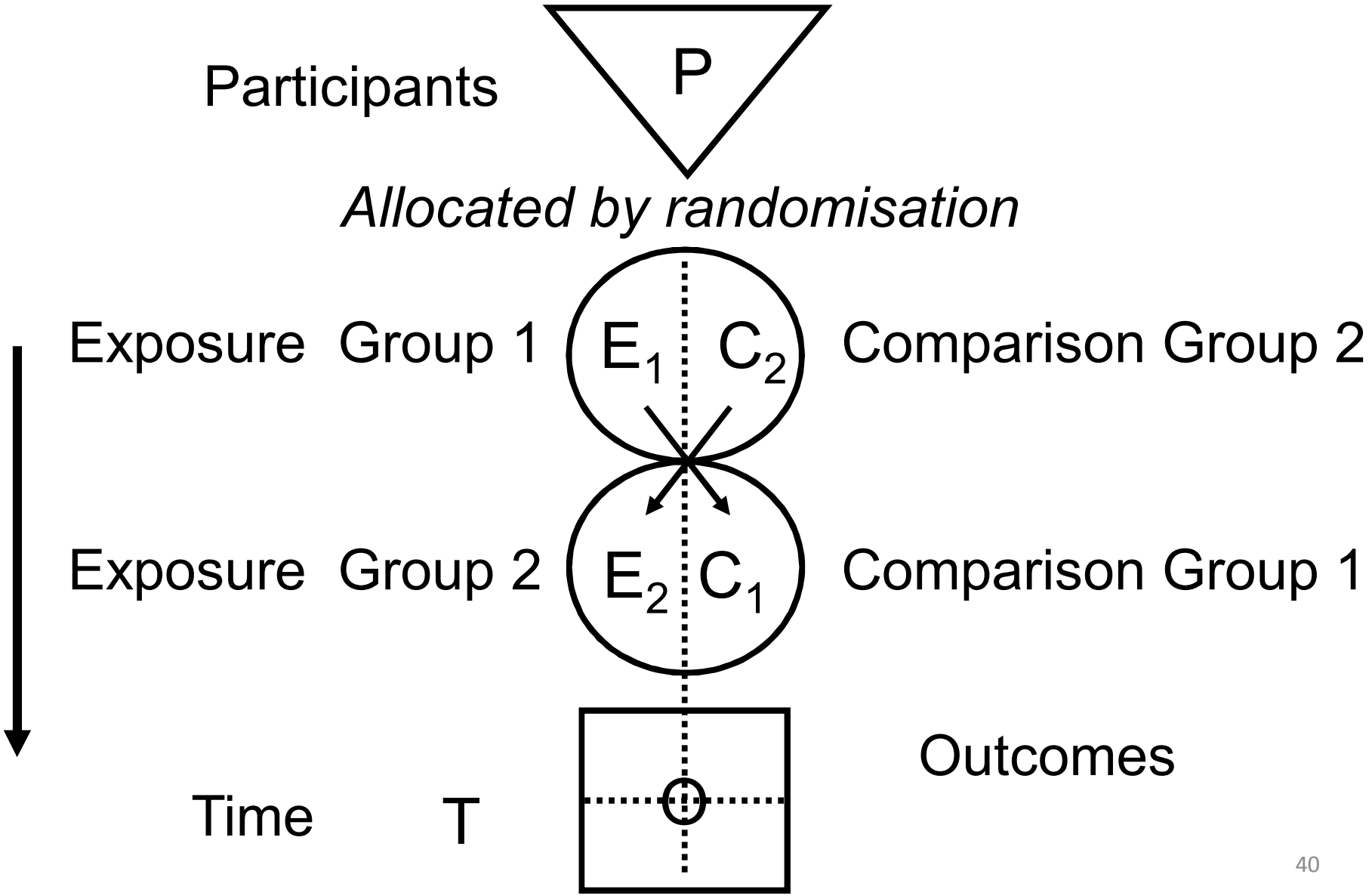


RKP

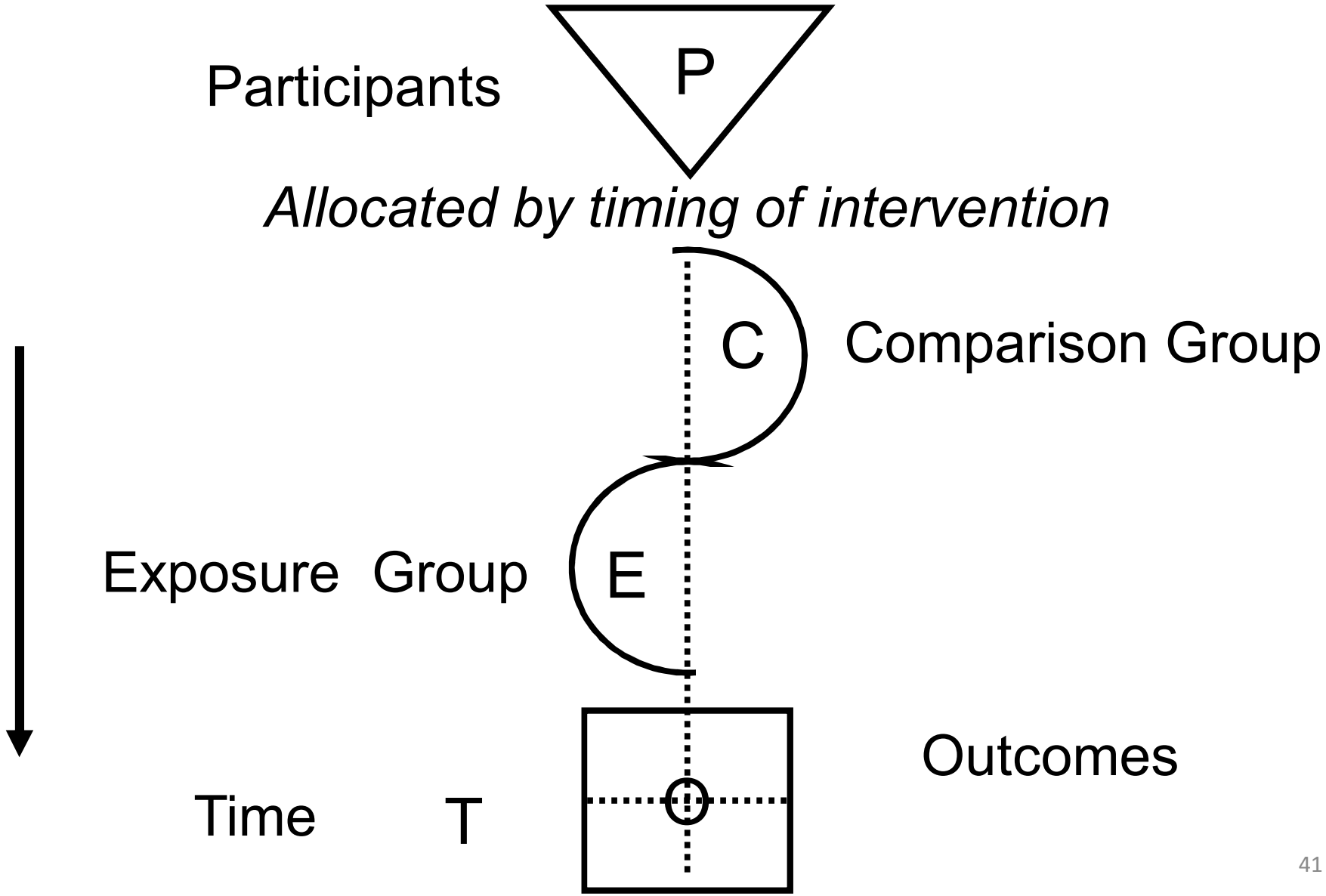


Labākais pētījuma veids pētīt terapijas iespējas

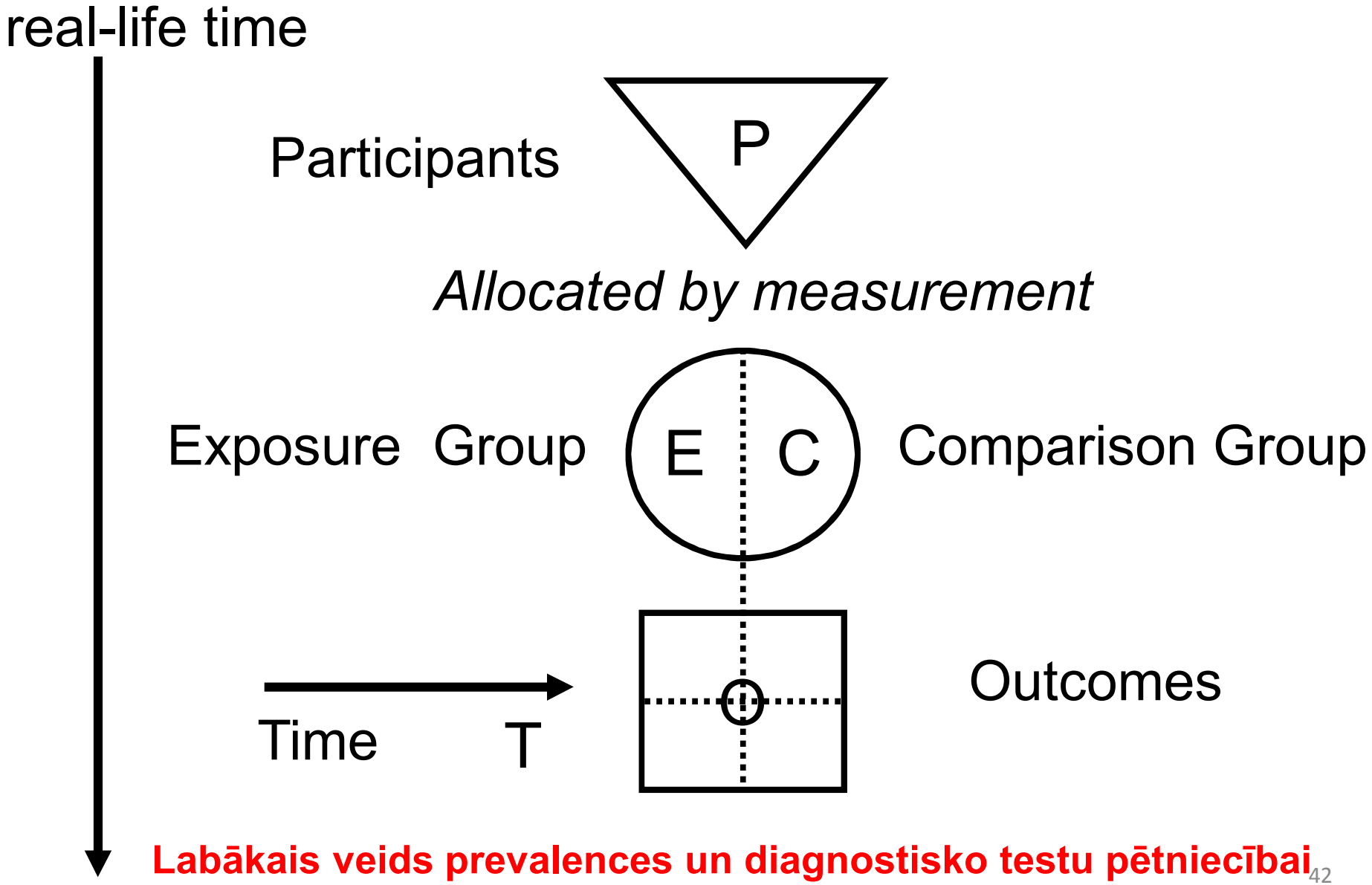
Krustenisks pētījums



Prospektīvs/perspektīvs vai retrospektīvs pētījums



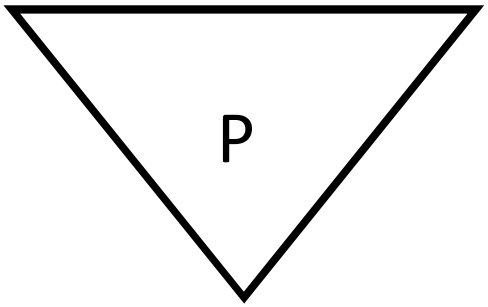
Sķērsgriezuma pētījums



Labākais veids prevalences un diagnostisko testu pētniecībai

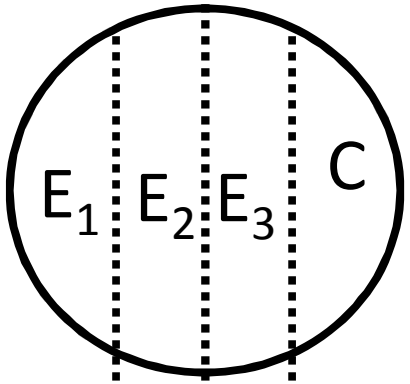
Multiplu kategoriju pētījumi

Participants

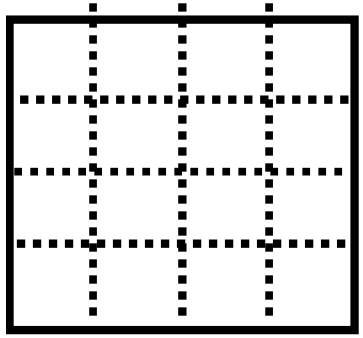


Multiple Exposure categories

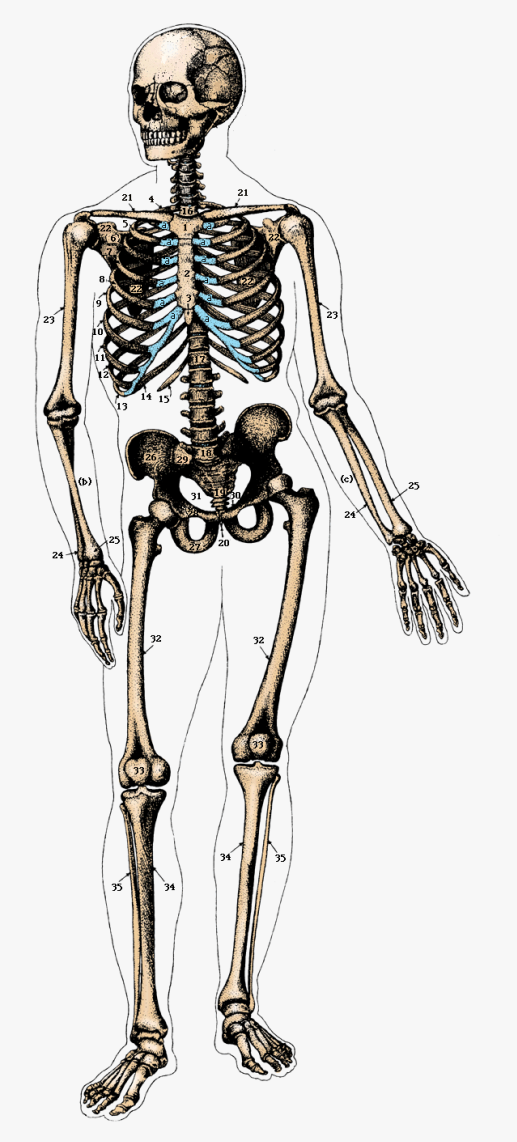
Comparison

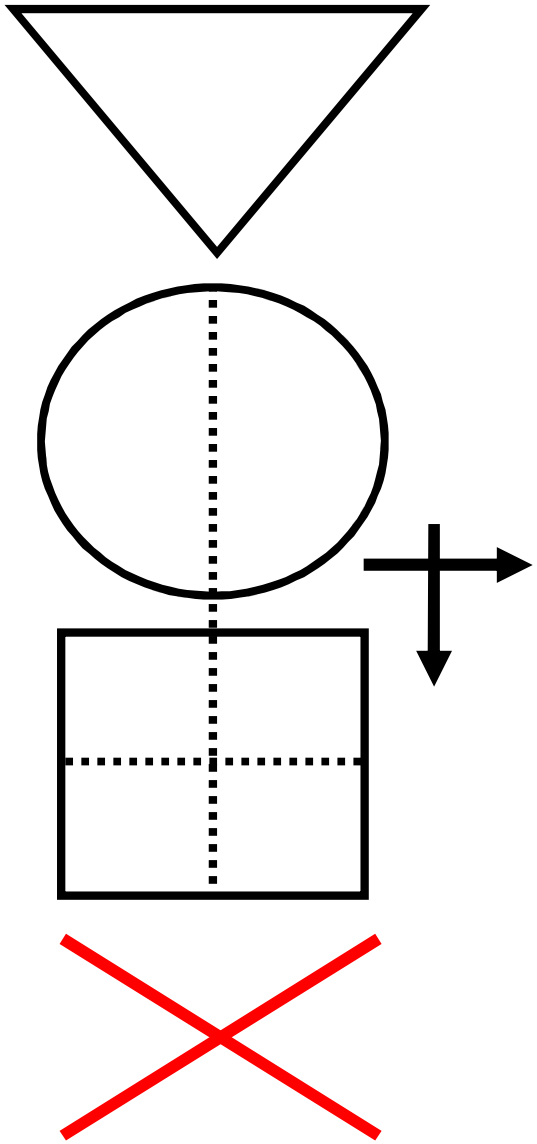


Multiple Outcome categories

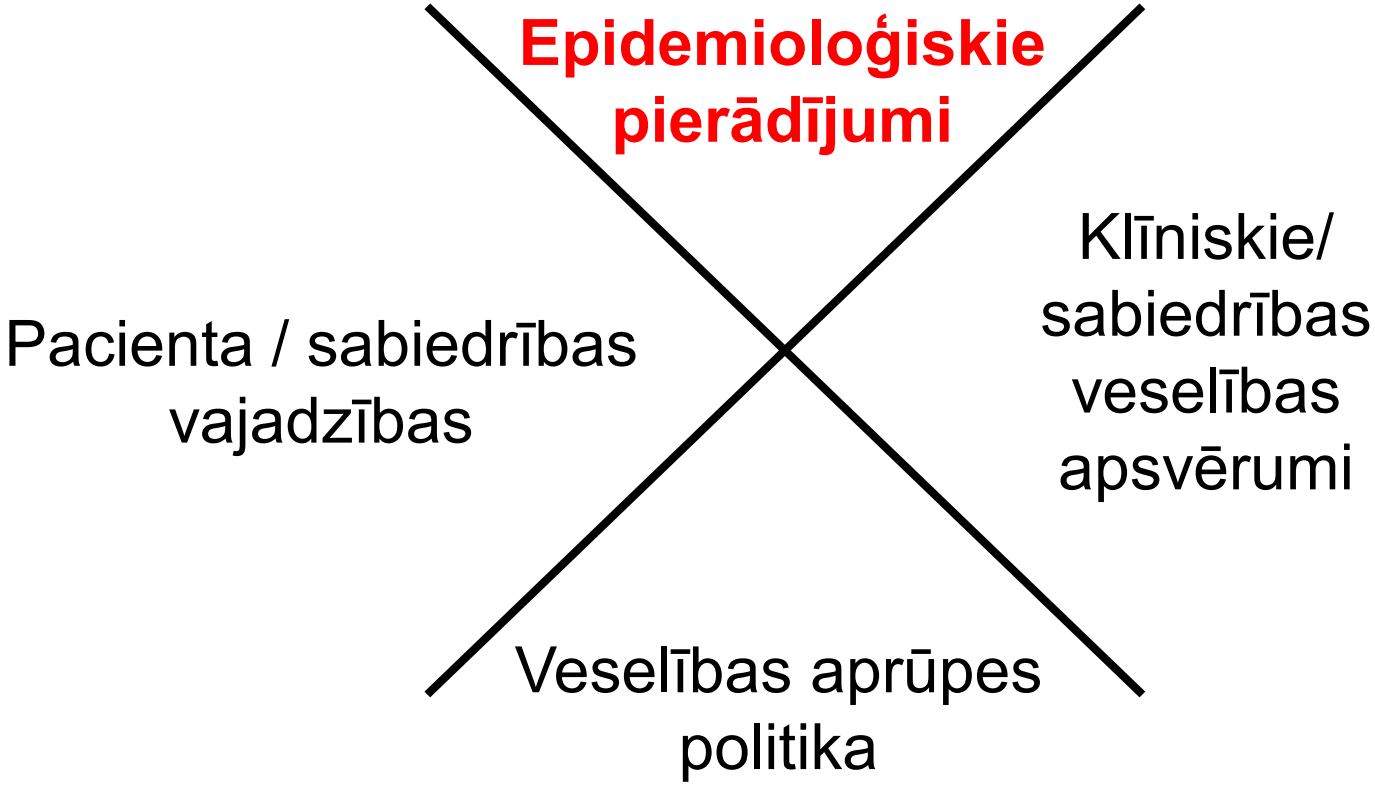


EBP: KONDENSĒJAM ticamu un būtisku informāciju, tad izdarām uz **<u>pierādījumiem balstītus lēmumus</u>**: **X-faktors**





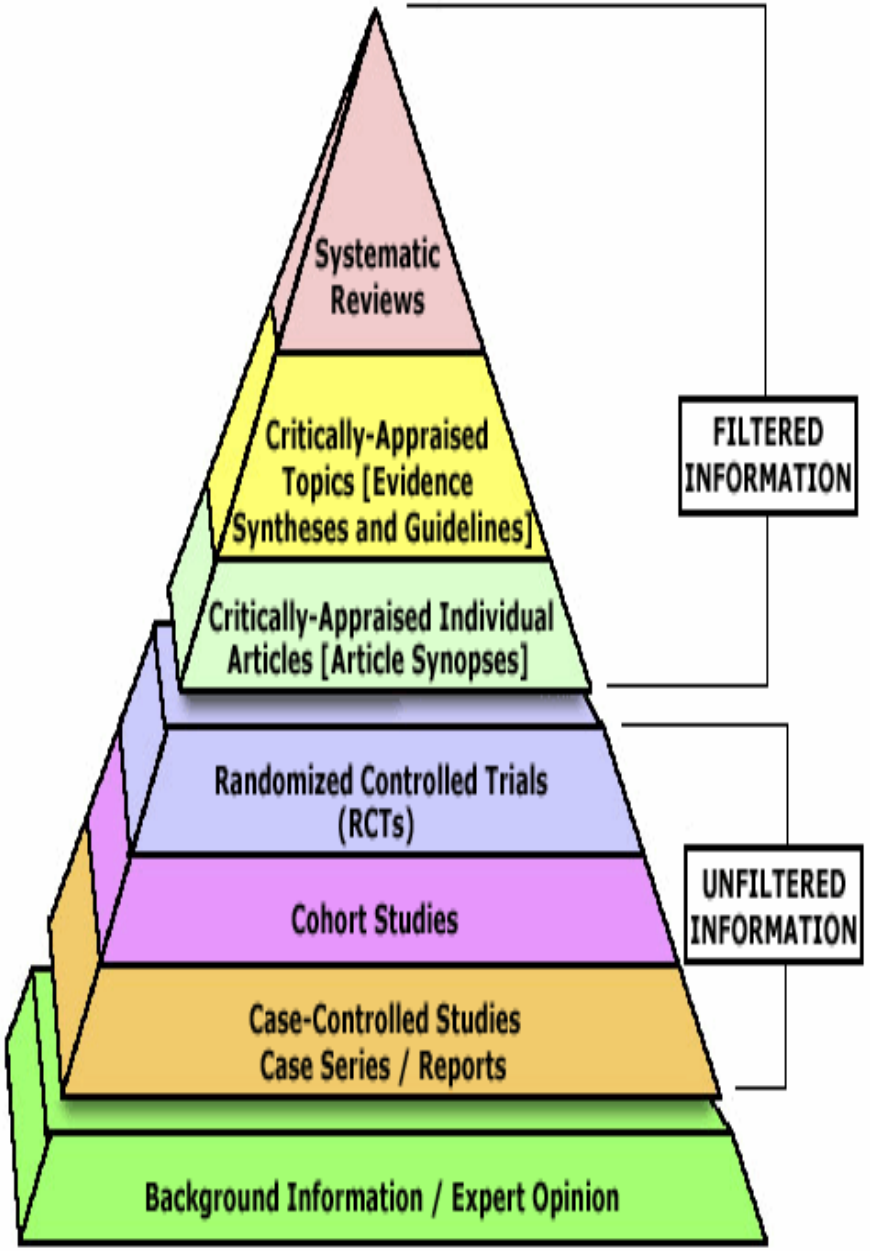
X - FAKTORS



Saliekot to visu kopā, nonākam katrs personīgi pie PBP jeb X-faktora konkrētā vidē

Pierādījumu vākšanas process

- Lasa ..... Analizē ..... Apkopo .....
- ..... Sintezē .....
- ..... Ekspertu komentāri .....
- ..... Ekspertu viedokļi .....
- ..... Rekomendācijas .....
- ..... Pierādījumu gradācija .....
- ..... Apkopojumi un slēdzieni .....



- **Systematic Review** jeb **Sistemātisks pārskats** ir kā atbilde uz skaidri formulētu jautājumu, lietojot sistēmiskas un stingri izstrādātas metodes, lai kritiski novērtētu un atlasītu atbilstošus pētījumus, un apkopotu un analizētu datus no tiem, nonākot pie konkrēta secinājuma-slēdziena

- **Meta-analīze** (***meta-analysis***) ir Statistisko metožu lietojums, lai apkopoti analizētu iekļauto pētījumu rezultātus, i.i., lai rastu ar matemātisku metodi apstiprinājumu vai noliegumu rezultātu ticamības pakāpei.

Gradācija

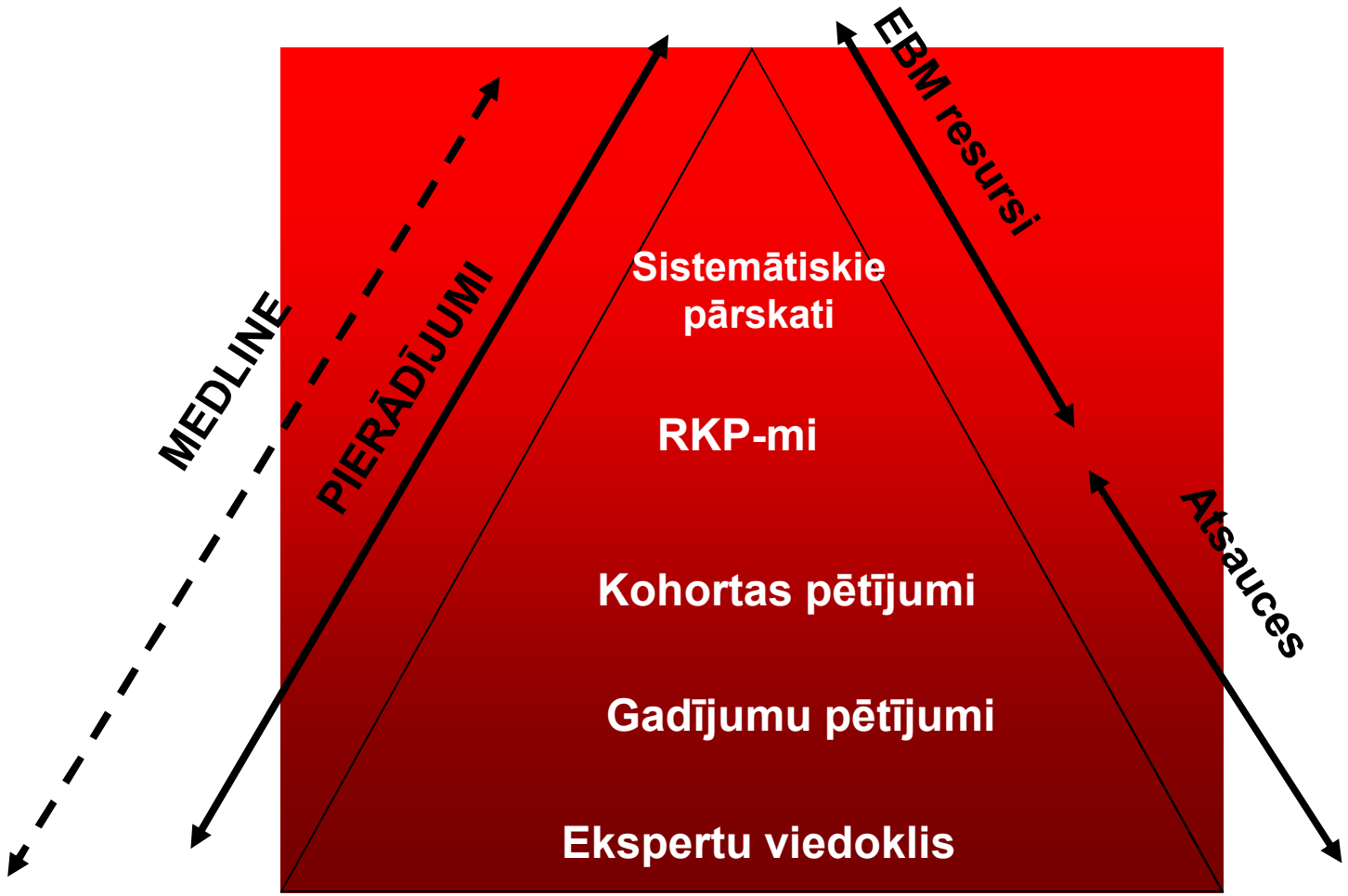
- **A līmenis** – pierādījumi ar augstu ticamību, kas iegūti vairākos labas kvalitātes nejaušinātos klīniskos pētījumos, par kuriem veikta meta-analīze.

- **B līmenis** – pierādījumi ar vidēju ticamību, kas iegūti atsevišķos labas kvalitātes nejaušinātos klīniskos pētījumos vai meta-analīzē par vairākiem labi organizētiem pētījumiem ar kontroles grupu (klīniski pētījumi bez nejaušināšanas, gadījuma – kontroles pētījumi, kohortu pētījumi).

- **C līmenis** – pierādījumi ar zemu ticamību, kas iegūti atsevišķos pētījumos ar kontroles grupu (klīniski pētījumi bez nejaušināšanas, gadījuma – kontroles pētījumi, kohortu pētījumi).

- **D līmenis** – nepietiekami pierādījumi, kas iegūti gadījumu sēriju novērojumos vai par kuriem saņemts vienprātīgs ekspertu ieteikums.

UZ PIERĀDĪJUMIEM BALSTĪTS LĒMUMS



The Cochrane Library

- *The Cochrane Library* is a collection of six databases that contain different types of high-quality, independent evidence to inform healthcare decision-making, and a seventh database that provides information about groups in The Cochrane Collaboration.

1. *Cochrane Database of Systematic Reviews*
2. Cochrane Central Register of Controlled Trials
3. Cochrane Methodology Register
4. Database of Abstracts of Reviews of Effects
5. Health Technology Assessment Database
6. NHS Economic Evaluation Database
7. About The Cochrane Collaboration

THE COCHRANE COLLABORATION®

GINEKOLOĢIJA: 383 pārskati

- Cancer (64)
- Contraception (57)
- Excessive menstrual bleeding (19)
- Hirsutism/acne (3)
- Menopause (11)
- Menstrual cycle disorders/oligo-amenorrhoea (10)
- Pelvic organ prolapse (4)
- Pelvic pain (28)
- Premenstrual syndrome (4)
- Sexually transmitted disease (32)
- Subfertility (85)
- Surgery (12)
- Therapeutic abortion (11)
- Urinary incontinence (52)

THE COCHRANE COLLABORATION®

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- Black cohosh (Cimicifuga spp.) for menopausal symptoms
- Exercise for vasomotor menopausal symptoms
- Hormone therapy for endometriosis and surgical menopause
- Hormone therapy in postmenopausal women and risk of endometrial hyperplasia
- Local oestrogen for vaginal atrophy in postmenopausal women
- Long term hormone therapy for perimenopausal and postmenopausal women
- Oestrogen and progestogen hormone replacement therapy for peri-menopausal and post-menopausal women: weight and body fat distribution
- Oral oestrogen and combined oestrogen/progestogen therapy versus placebo for hot flushes
- Phytoestrogens for vasomotor menopausal symptoms
- Short and long term effects of tibolone in postmenopausal women
- Testosterone for peri and postmenopausal women

Centralisation of services for gynaecological cancer (Review)

Woo YL, Kyrgiou M, Bryant A, Everett T, Dickinson HO

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2012, Issue 3

http://www.thecochranelibrary.com

Background

Gynaecological cancers are the second most common cancers among women. It has been suggested that centralised care improves outcomes but consensus is lacking.

Objectives

To assess the effectiveness of centralisation of care for patients with gynaecological cancer.

Search methods

We searched the Cochrane Gynaecological Cancer Group Trials Register, CENTRAL (*The Cochrane Library, Issue 4, 2010*), MEDLINE, and EMBASE up to November 2010. We also searched registers of clinical trials, abstracts of scientific meetings, and reference lists of included studies.

Selection criteria

We included randomised controlled trials (RCTs), quasi-RCTs, controlled before-and-after studies, interrupted time series studies, and observational studies that examined centralisation of services for gynaecological cancer, and used multivariable analysis to adjust for baseline case mix.

Data collection and analysis

Three review authors independently extracted data, and two assessed risk of bias. Where possible, we synthesised the data on survival in a meta-analysis.

Main results

Five studies met our inclusion criteria; all were retrospective observational studies and therefore at high risk of bias.

PLAIN LANGUAGE SUMMARY

Centralisation of care may prolong survival in women with ovarian cancer, and possibly more generally, gynaecological cancer

Gynaecological cancers are cancers affecting the ovaries, uterus, cervix, vulva, and vagina. They are the second most common cancers among women, after breast cancer. It is often suggested that outcomes are improved by centralising care within highly specialised services that include expert surgeons, radiologists, pathologists, oncologists who specialise in chemotherapy and radiotherapy, specialist nurses and other health professionals. However, consensus is lacking on whether centralisation of care for gynaecological cancer helps patients to live longer. This review investigated this issue by comparing the survival of women diagnosed with gynaecological cancer who received care from specialised and unspecialised centres.

We used a set of tests to ensure that the evidence the five studies identified reached the quality standard for our analysis.The analysis of three studies combined (meta-analysis), assessing over 9000 women, suggested that institutions with gynaecologic oncologists (specialists in the field of gynaecological cancer treatment) on site may prolong the lives of women with ovarian cancer compared to community or general hospitals. Similarly, another meta-analysis of three studies which assessed well over 50,000 women, found evidence to suggest that teaching centres or regional cancer centres (specialised centres) may prolong the lives of women with gynaecological cancer compared to community or general hospitals. The largest study in this meta-analysis assessed all gynaecological cancers in 48,981 women, so it had major influence on the final result; this means that our findings are likely to be relevant to other gynaecological cancers, besides ovarian cancer.

Overall, the findings suggest that centralisation of care may prolong the lives of women with gynaecological cancer, and in particular ovarian cancer. However, the results should be interpreted with caution as all of the studies included in the review could be biased. For example, it is possible that the patients who were treated in specialised centres were less ill to begin with. Another weakness of the review is that only one of the studies included women with gynaecological cancers other than ovarian cancer.

Ideally, further studies in this area are needed. New studies should be designed to avoid the possibility of bias due to the treatment of women at specialist and non-specialist centres being systematically different. Additionally, studies should assess the impact of centralisation of care on the quality of life of patients.

Most of the available evidence was about ovarian cancer in developed countries; future studies should be extended to other gynaecological cancers and to less developed countries.

Steroid hormones for contraception in men (Review)

Grimes DA, Lopez LM, Gallo MF, Halpern V, Nanda K, Schulz KF

THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2012, Issue 3

http://www.thecochranelibrary.com

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Background

Male hormonal contraception has been an elusive goal. Administration of sex steroids to men can shut off sperm production through effects on the pituitary and hypothalamus. However, this approach also decreases production of testosterone, so 'add-back' therapy is needed.

Objectives

To summarize all randomized controlled trials (RCTs) of male hormonal contraception.

Search methods

In January and February 2012, we searched the computerized databases CENTRAL, MEDLINE, POPLINE, and LILACS. We also searched for recent trials in ClinicalTrials.gov and ICTRP. Previous searches included EMBASE. We wrote to authors of identified trials to seek additional unpublished or published trials.

Selection criteria

We included all RCTs that compared a steroid hormone with another contraceptive. We excluded non-steroidal male contraceptives, such as gossypol. We included both placebo and active-regimen control groups.

Data collection and analysis

The primary outcome measure was the absence of spermatozoa on semen examination, often called azoospermia. Data were insufficient to examine pregnancy rates and side effects.

PLAIN LANGUAGE SUMMARY

Hormones for contraception (birth control) in men

Researchers have tried to develop contraceptives for men that would be like birth control pills for women. Hormone birth control for men has been hard to achieve. Giving sex hormones to men can lower the sperm produced. However, this approach also lowers the male hormone testosterone in the body, so some testosterone has to be 'added back.' This review looks at the randomized controlled trials of giving hormones to men to prevent their sexual partners from becoming pregnant.

In January and February 2012, we did a computer search for studies of hormones tested for contraception in men. We also looked at reference lists of articles. We considered randomized controlled trials in any language. We wrote to trial authors to find other studies we may have missed.

We found 33 studies. The focus of the trials was having no sperm found in semen. The percent of men who achieved no sperm varied widely. We found a few major differences and list them here. 1) Implants plus injected testosterone worked better than a pill plus testosterone patch. 2) Adding a hormone pill improved the effect of testosterone injected weekly. 3) A hormone pill also improved the effect of a testosterone injection with more injections at 6 and 12 weeks. 4) A lower dose pill did not work as well as a higher dose when testosterone was put under the skin (implant). 5) When used with implants, a lower dose of injected testosterone led to no sperm more often than a higher dose. 6) An injected hormone plus injected testosterone led to no sperm more often when given every 8 weeks versus 12 weeks. 7) Four implants of a male hormone worked better than two implants.

Several trials showed good results for the percent with no sperm. Five trials studied testosterone and another hormone. The other hormones were desogestrel, etonogestrel, and levonorgestrel.

No hormonal birth control for men is ready for general use. Most trials were small pilot studies trying out different hormone treatments. Larger trials with better methods are needed to test good leads in this area.

PVO EBM VADLĪNIJAS

CIRE sistēma ir pastāvīgs process, indentificējot, kritiski izvērtējot un sintezējot kopā jaunāko pētniecībā, gūstos jaunus PIERĀDĪJUMUS.

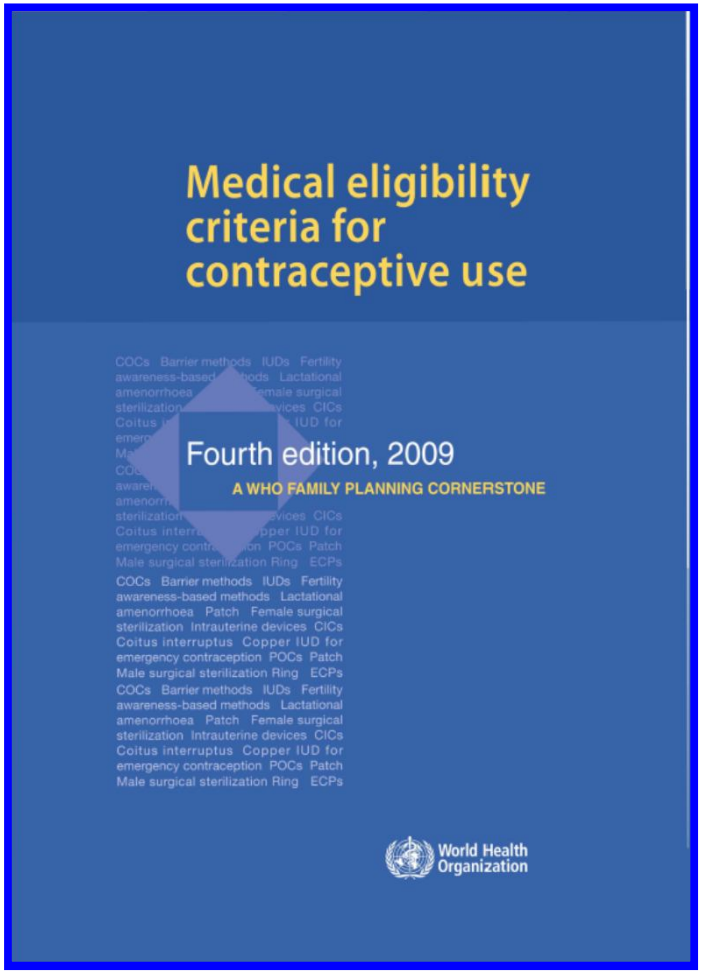
Continuous Identification of Research Evidence system CIRE

Sistemātiska analīze

Ekspertu grupa/s

Atjaunota informācija www.who.int/reproductive-health/family_planning

MEDICĪNISKĀS PIEMĒROTĪBAS KRITĒRIJI KONTRACEPCIJAS LIETOŠANAI



- 1700 rekomendācijas – kas un kad un kādu kontracepciju var lietot
- 4.izdevums, 2010.
- Kā pamats vadlīniju izstrādei 50 valstīs

ČETRAS KATEGORIJAS

1 = Stāvoklis, kas metodes lietošanai **nav nekādu ierobežojumu**.

2 = Stāvoklis, kad, lietojot metodi, **ieguvumi ir daudz nozīmīgāki** kā pār teorētisko vai pierādīto risku.

3 = Stāvoklis, kad, lietojot metodi, **ieguvumi tomēr ir nozīmīgāki** kā pār teorētisko vai pierādīto risku.

4 = Stāvoklis, kad lietojot metodi, pastāv nepieņemams risks.

CONDITION * additional comments at end of table	CATEGORY I = initiation, C = continuation				CLARIFICATIONS/EVIDENCE
	COC	P	R	CIC	
COC = combined oral contraceptives **P** = combined contraceptive patch **R** = combined contraceptive vaginal ring **CIC** = combined injectable contraceptives					
PAST ECTOPIC PREGNANCY*	1	1	1	1	
HISTORY OF PELVIC SURGERY	1	1	1	1	
SMOKING					**Evidence**: COC users who smoked were at increased risk of cardiovascular diseases, especially myocardial infarction, compared with those who did not smoke. Studies also showed an increased risk of myocardial infarction with increasing number of cigarettes smoked per day.(174-185)
a) Age < 35 years	2	2	2	2	
b) Age ≥ 35 years					
(I) < 15 cigarettes/day	3	3	3	3	
II) ≥ 15 cigarettes/day	4	4	4	4	
KNOWN THROMBOGENIC MUTATIONS (e.g. factor V Leiden; prothrombin mutation; protein S, protein C, and antithrombin deficiencies)	4	4	4	4	**Clarification**: Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. **Evidence**: Among women with thrombogenic mutations, COC users had a two to twenty-fold higher risk of thrombosis than non-users. (191;222-244)

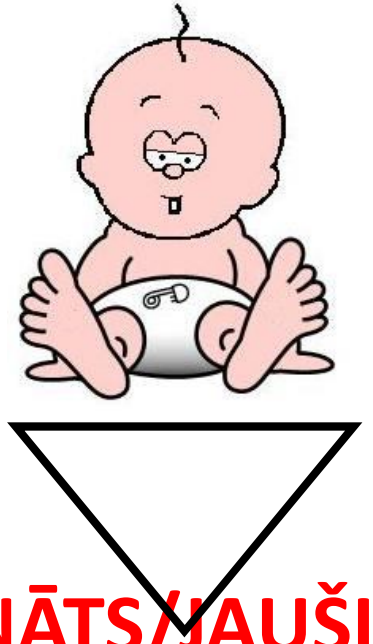
4. INDIVIDUALIZĒJIET PIERĀDĪJUMUS, balstoties uz Jūsu klīnisko ekspertīzi/pieredzi un pacienta vēlmēm!!!

- KO PIERĀDĪJUMI IZSAKA un NOZĪMĒ KOPUMĀ?
- KĀ PIERADĪJUMI PIEMĒROJAMI <u>ŠAJĀ KONKRĒTAJĀ GADĪJUMĀ</u>?

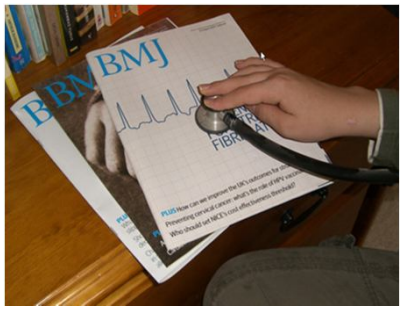
Varbūt tomēr kaut kas ir jāmaina?!

- VISU EKSISTĒJOŠO PIERĀDĪJUMU LIETOJUMS ARĪ VEIDO LABU PRAKSI →→ PACIENTAM!!!
- TĀPĒC ARĪ TIEK VEIDOTAS VADLĪNIJAS UN KLĪNISKĀS REKOMENDĀCIJAS, NOTEIKUMI, LAI VARĒTU ESOŠOS PIERĀDĪJUMUS IEDZĪVINĀT IKDIENAS PRAKSĒ!!!

PALDIES PAR UZMANĪBU!



PRAKTIZĒSIM PBP GINEKOLOĢIJĀ!



DZĪVE IR NEJAUŠINĀTS/JAUŠINĀTS VISU VEIDU PĒTĪJUMS MUMS IKVIENAM?!