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Malaria ppt free

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Lauran won the Nobel Prize for his discovery in 1907 on August 20, 1897, Ronald Ross, a British officer at the Indian Medical Service, became the first to show that the malaria parasite could be transmitted from mosquito-infected patients, Ross won the Nobel Prize in 1902. The first time it was revealed that malaria parasites can be transmitted from mosquito-infected patients, malaria is an infectious disease transmitted from vectors caused by prosthesis parasites. It is widespread in the tropics and sub-tropics, including parts of the Americas, Asia, and Africa. The most dangerous of these four is. P.falciparum A is the fifth species, Plasmodium knowlesi, causing malaria in macaco but can also infect humans. Warm, humid and therefore vulnerable and vulnerable tropical regions for malaria transmission. Malaria remains the world's most devastating human parasitic infection. Malaria affects more than 40% of the world's population. WHO, estimates that there are 350 - 500 million cases of malaria worldwide, in india 2 million cases and 1000 deaths annually .which 270 - 400 million are Falciparum malaria, the most severe form of the disease. Of those 270 - 400 million malaria falciparum, the most severe form of the disease). Malaria's life cycle is a complex system with both sexual and asy bisexual aspects. The cycle of all species that infect humans is essentially the same. There is an exogenous sexual phase in a mosquito called sporgonial, during which the parasite is animenxed. There is also an endogenous asexual phase that takes place in vertebrates or human hosts called schizogeny. This phase involves the development of a parasitic that takes place in the red blood cell, called the erythrocytic cycle, and phase thate is carried out in paransmal cells in the liver, called the exo-retrostic phase. The oxo-orthrocytic phase is also called tissue phase. The schizogeny that takes place here can occur without delay during the initial infection or can be delayed in the case of malaria recurrence. I'm focusing on the development of parasites. Human host. . Sporozoites injected during mosquito feeding attack exoerythrocytic schizogony (merozoites) merozoites attack RBCs repeating erythrocytic schizogony cycles of infectious gametocytes for mosquito fusion of gametes in the sporogony intestines in the intestinal wall in hemoquely sporozoites attacking the goat liver. There is also an endogenous asexual phase that takes place in vertebrates or human hosts called schizogeny. This phase involves the development of a parasitic that takes place in the red blood cell, called the erythrocytic cycle, and phase thate is carried out in paransmal cells in the liver, called the exo-retrostic phase. The oxo-orthrocytic phase is also called tissue phase. The schizogeny that takes place here can occur without delay during the initial infection or can be delayed in the case of malaria recurrence. I will focus on the development of parasites in human hosts. Red rip cells release Merozoites that attack new red cells continue with frequent cycles of Schizogony in P.falciparum - erythrocytes contaminated with serpent Schizonts in brain capsules and other internal organs only ring forms Seen in blood smears macrogamites are also called female microgametocytes also referred to as male gametocytes 20 marked by acute fever attacks (malaria paroxism) periodic episodes of intermittent fever with manifestations Asymptomatic periods and intensity depend on species and safety of host status, general health, nutritional state, genetics recrudescences and relapses can occur over months or years can develop severe complications (especially P. falciparum) 24 26 This is a life threaten manifestation of malaria, and is defined as the detection of P. falciparum in the peripheral blood in the presence of any or more of the clinical laboratory features listed : Regret -(Disability or difficulty sitting right, standing or walking without support in a child is normally able to do this, or the inability to drink in children too young to sit) 28 33 34 rapid diagnostic tests (RDTs) are imagochromatography tests based on the detection of specific parasite antigens. Experiments that detect histidine-rich protein 2 (HRP2) are specific to P.falciparum while experiments that detect lactate di hydrogenase (pLDH) or aldolase have the ability to distinguish between P.falciparum and non-P.falciparum malaria (viva, malaria and early). With proper training, RDTs are simple to use and sensitive in the diagnosis of low-use parasite RDTs however it is not recommended for follow-up as many tests remain positive between 2 and 3 weeks after effective anti-mattarial treatment and parasite clearance. They cannot be used to determine the density of parasites. When using RDTs, it is important to strictly adhere to manufacturer guidelines, especially when reading results. Remember to view safe medical waste disposal at all times. The RDTs for use in Kenya will be based on the recommendations of the WHO produced annually. Treatment is available to reduce the chances of such recurrences and should follow the first attack treatment. Severe malaria that is often caused by P. falciparum Quinine should never be given by intravenous bolus injections, as a reduction in fatal blood pressure may result. Kinetin diederochloride should be given by controlled injection at a rate in saline or dextrose solutions at a rate of more than 5 mg/kg of body weight per hour. to antimalarial parents in the treatment of severe malaria for at least 24 hours, once started (regardless of the patient's ability to tolerate the earlier opening drug), and, then, Complete treatment by giving a full course of: - artemmeter plus lumefantrine, - artesunate plus amodiaquine, – dihydroartemisinin plus piperaquine, - artesunate plus sulfadeucin-pyrimethamine, artesunate plus clindamycin or doxycycline, – quinine plus clindamycin or doxycycline. Riamet: Whenever possible, the dosage should be taken immediately after meals. Patients with acute malaria often oppose food. Patients should be encouraged to resume natural eating as soon as they endure food because this improves artemmeter and lomfntriene uptake (see pharmacokinetic–absorption). In case of vomiting within 1 hour of administration, a repeat dose should be taken. Quinine: This drug may cause headache, sweating, dizziness, blurred vision, diarrhea, nausea, and vomiting. [3] Instruct the patient to report symptoms/symptoms of hypersensitivity reactions, thrombocytopenia, or unusual bleeding and/or bruising. [3] Advise the patient to take medication with food to reduce heartburn. [3] Train an infected patient to complete the course of treatment. Don't stop taking the medication unless approved by your doctor, even if the symptoms have improved. [3] Patient recommendations there are several significant drug and drug interactions for this drug. Consult health professionals before using new drugs (including over-the-counter and herbal remedies). [3] In the event of a missed dose, the patient will not consult to double the dose. If more than 4 hours of missed doses are passed, skip the missed dose and maintain a regular dosage plan. [3] Quinine (oral track, capsules, tablets, tablets, extended release) artmeter plus lumefantrine, ■ artesunate plus amodiaquine, ■ artesunate plus mefloquine, ■ artesunate plus sulfadeoxin-pyrimethamine,7 ■ dihydroartemisinin plus piperaquine. Rimette Chloroquine: This drug may cause diarrhea, loss of appetite, nausea, stomach cramps, amnesia, or vomiting. Instructs patients to report muscle weakness or symptoms/symptoms of retinopathy, especially if in long-term treatment. The patient should not use anthaside or kaolin within 4 hours before or after chloroquine phosphate. Tell the patient to take ampicillin within 2 hours before or after chloroquine phosphate. If a patient missed the dose at once this week, the patient's order to be missed As soon as possible then wait 7 days before taking the next dose. primaquine: Patients should report recent use of quinacrin before beginning treatment. This drug may cause abdominal pain. Advise the patient to report symptoms/symptoms of leukopenia or hemolytic anemia. Tell the patient to take medication with food to minimize heartburn. Because primaquine can cause hemolytic anemia in people with G6PD deficiency, G6PD screening should occur before primaquine treatment begins. Primaquine should not be used for P. vivax and P. ovale infections during pregnancy, primaquine phosphate should not be given for the radical treatment of hypnosvites during pregnancy. Pregnant patients with P. vivax and P. ovale infections should be retained on chloroquine prevention for the duration of their pregnancy. The chloroquine phosphate dose is 300 mg baseline (=500 mg salt) once a week. After childbirth, pregnant patients who do not have G6PD deficiency should be treated with primaquine. Pregnant women diagnosed with severe malaria should be treated aggressively with parental antimalarial therapy. The use of artemisinin derivatives does not require adjustment in vital organ dysfunction. Levels of kinidine (and kinidine) may accumulate in severe vital organ impairment. If the patient remains in acute renal failure or has hepatic dysfunction, then the dose should be reduced by a third after 48 hours. If patients receive either hemodialysis or hemofiltration, dazage settings are not required. brainular . Severe malaria of P. falciparum with brain manifestations usually involves coma (Glasgow Coma Scale < 11, Bluntier Coma Scale < 3). Malaria with a coma for > 30 minutes after seizure is considered as brain malaria. Mefloquine is available as a 274mg mefloquine hydrochloride tablet containing a baseline of 250mg or a 250mg mefloquine hydrochloride tablet containing a baseline of 228mg (US Only). Meflokin is administered as a weekly dose of 250 mg for adults or 5 mg/kg of body weight for people under 36 kg. Side effects of nausea, vomiting, abdominal pain and diarrhea. It is the most common but dose-related and self-limiting. Other cns-related disorders include disturbances, dizziness, ataxia, headache, some visual and hearing impairments, sleep disorders and nightmares, seizures. Contraindications Š. The first trimester of pregnancy Š. Is not prescribed to patients less than 5 kg. Š. Avoid use in the history of seizures and in severe neuropsychology disorder Š. Do not administer simultaneously with quinine and avoid using quinine after administering mefloquine caution Š. Mefloquine can compromise adequate immunization with live typhoid vaccine. Mefloquine should be taken 12 hours after administration of the last dose of quinine Š. Care should be taken when prescribing companion medications that interfere with the patient's cardiac function should be recommended that any live vaccine should be completed at least 3 Before starting treatment. The patient should avoid activities that require mental alertness or coordination until the drug effects are realized. It may cause bradycardia, diarrhea, nausea, dizziness, drowsiness, or mental disorder. Instruct the patient to report depression, anxiety, psychosis or unusual changes in behavior. The patient should take the pill with food and a glass of 8 ounces of water. The patient should not treat or follow the treatment of the most hadofanthane. The patient should avoid using kinidine, kinidine or chloroquine at the same time. Instruct the patient to repeat the full dose if vomiting occurs within 30 minutes of the dose, or to repeat the dose of 1/2 if vomiting occurs within 30 to 60 minutes of the dose. Side effects of GIT stimulation, increased vulnerability to sunburn (phototoxic reaction), transient depression bone growth and tooth discoloration, vaginal candidate. Doxycycline Contraindications should not be used in Š. Children under 8 years of age Š. Pregnant mothers and lactant Š. People with hepatic Š. People with hypersensitivity known to take tetracycycline caution Doxycycline should not be used for prevention for periods over 4 months. Avoid anthacides and milks in absorption of tetracycline and its coincidence. Instruct the patient to report severe diarrhea and consult health professionals before taking anti-diarrhea medications. The drug causes sensitivity to the sun. Advise the patient to use sunscreen and avoid tanning beds. Medication may reduce the effectiveness of birth control pills with simultaneous use. Recommend an additional form of birth control. This drug may cause a digestive disorder. Advise the patient to take the drug with sufficient fluid to prevent esophageal irritation or ulseration. The patient may take the pill and suspension with food, milk, or a fingling drink in case of heartburn. Doxycycline (span path, capsule, capsule, wide release, powder for suspension, syrup, tablets, tablets, delayed release) Doxycycline (venous pathway, powder for solution) Doxycycline (Subgingival pathway, kit) 1. Malaria Pre-Mane Infections 2. Lauran 3. Malaria remains the world's most devastating human parasitic infection. Malaria affects more than 40% of the world's population. WHO, estimates that there are 350 - 500 million cases of malaria worldwide. In India, 2 million cases and 1,000 deaths per year 4. Malaria life cycle is a complex system with both sexual and assym non-sexual aspects. The cycle of all species that infect humans is essentially the same. There is an exogenous sexual phase in a mosquito called sporgonial, during which the parasite is animenxed. There is also an endogenous asexual phase that takes place in vertebrates or human hosts called schizogeny 5. Complex Life Cycle 6. Human Cycle 1 pre-erythrocytic schizogony 2 Erythrocytic Schizogony 3 Gametogony 4 Exoerythrocytic schizogony 7. Events in humans start with mosquito bites ➔ male – medium host. ➔ – Definitive Host – Sporozoites Infectious Forms Currently, in the saliva of anophle mosquitoes, ➔ are introduced after the bite of the mosquito sporesuit infected with circulation. 8. Pre-erythrocytic cycles ➔ Sprozoites developmental stage in hepatic cells ➔ numerous nuclear divisions developed into Schozonts➔ Schizont containing 20,000 - 50,000 mesotics. 9. Period before erythrocytic cycle ➔ 1 P.vivax 8 days ➔ 2 P.falciparum – 6 days ➔ 3 P.malariae - 13 – 16 days, ➔ 4 P.ovale 9 days in the maturation of ruptured liver cells free merozoites into the bloodstream 10. Erythrocyte cycle ➔ Merozoites released invade red cells ➔ P.vivax infects young erythrocytes ➔ P.malariae Infects old erythrocytes ➔ P.falcipar ARE RBC infections of all ages ➔ pear merozoites in the form of 1-5 microns during ➔ receptors for Merozoites on red cells in glycoprotein 11. Erythrocytic Schizogony ➔ Liberated Merozoites penetrate RBC ➔ Three stages occur 1 Trophozoites 2 Schizont 3 Merozoite 12. The exo-erythrocytic phase (tissue) of ➔ P. malaria or P. falciparum does not form hypnosis sporozoites, developed directly into pre-erythrocytic schizonts in the liver ➔ Schizonts rupture, releasing merozoites that attack red blood cells (RBC) in liver 13. Gametogony ➔ Merozoites differentiate into Male and female gametocytes ➔ They develop in the red cells ➔ Found in the peripheral blood smears ➔ Microgametocyte of all species are similar in size ➔ Macro gametocytes are larger in size. 14. Mosquito cycle sex cycle ➔ sex cycle will begin in humans by forming Gametocytes ➔ further development occurs in female anophlex mosquitoes ➔ conception occurs when microgymetocytes penetrate macroga ➔ ➔ ZYGOTE matured into OOKINETE ➔ OOKINETE to OOCYST ➔ OOCYST matured with a large number of 15 Sporozoites (several hundred to thousands). Mosquito Definitive Host Cycle – Mosquito 16. Malaria has the disease ➔ 9 to 14 days of incubation 17 days. Early symptoms ➔ common first symptoms - fever, headache, chills and vomiting - usually appear 10 to 15 days after the person is infected. If not immediately treated with effective drugs, malaria can cause severe illness and is often fatal. 18. How malaria is now clinically ➔ stage 1 (cold stage) ➔ shivering for 15 tons to 1 hour ➔ caused by rupture of host red cells escaping into the blood ➔ pre-onset with nausea, vomiting, headaches ➔ step 2 (hotstage) ➔ fever may reach up to 400c may take several hours to start attacking newer red cells. 19. Clinical malaria ➔ step 3 (sweating stage) patent begins to sweat, concluding the often asynchronous cycle part of Paroxysms occurs every 48 - 72 hours in P.malariae pyrexia may last for 8 hours or more and my temperature exceeds 410c 20. Malaria stages of the disease 21. More commonly, the patient presents with a combination of symptoms following ➔ fever ➔ shivering ➔ sweat ➔ headaches ➔ nausea and vomiting ➔ body ➔ general weakness. 22. Periodic can provide clues in the diagnosis and species of ➔ tertiana: 48h between fever (P. vivax and ovale) ➔ malaria quartana: 72h between fever (P. malaria) ➔ malaria tropica: irregular high fever (P. falciparum) 23. Severe complex malaria • Changes in consciousness levels (ranging from drowsiness to deep coma) • Brain malaria (an indidable coma not attributable to any other cause in a patient with Falciparum malaria) • Respiratory distress (metabolic acidosis bi-carb less than 15 meq/l) • Multiple general seizures (2 or more episodes in a 24-hour period) • shock (circulatory breakdown, septicaemia) • pulmonary oedema • abnormal bleeding (dlated intra vascular coagulopathy) • Jaundice • Haemoglobinuria (black water fever) • Acute renal failure - presented as oligoria or anuri • severe anemia (hemoglobin < 5g/dl or Haematocrit < 15%) • High fever • Hypoglycemia (blood sugar level < 2.2.mmol/l) confusion, or drowsiness with severe weakness (weakness). : Defined as diagnosis of P. falciparum in peripheral blood 24. Malaria Disease 25. Why Falciparum infection is ➔ can produce fatal complications, 1.Brain malaria 2.Hyperpyrexia malaria 3.Digestive disorders. 4.Algide malaria (SHOCK) 5 black water fever can lead to 26 deaths. Dangerous malaria ➔ a life-threatening complication in acute Falciparum malaria ➔ it is heavy due to parasites ➔ obvious with 1 brain malaria - it is presented with hyperperix, coma and paralysis. The dense brain has 2 algide malaria – provided with oyster skin leading to peripheral circulatory failure. 27. Malignant brain malaria can affect the brain and the rest of the central nervous system. Changes in the level of consciousness, seizures and paralysis are identified. 28. Cerebral ➔ in patients with hyperpericosis ➔ can lead to coma ➔ paralysis and other complications. ➔ looks dense 29. Pathogens of brain ➡ high cytokine levels can be toxic on their ➡ high levels of cytokine also enhance the second process thought to be responsible for brain malaria: sequences of infected RBCs 30. Sequestration & cytoadherence ➔ Rosetting (sticking INFECTED RBCs to other RBCs) and clumsy (sticking between infected cells) were first observed in laboratory culture 31. Black water fever ➔ in malignant malaria a large number of red blood corpuscles are lost. Hemoglobin is removed from the blood corpuscles in the urine, which is why it is dark and almost color cola 32. How long malaria infection can be lost in humans ➔ without P.falciparum treatment will end in less than 1 year. ➔ but in P.vivax and P.ovale continues to be hypnotized after parasites are cut from the blood. ➔ can periodic recurrence of prodce last up to 5 years ➔ in P.malariae may last for 40 years (called relapse X) parasites survive in the liver erythrocytes ? 33. Laboratory diagnosis of malaria 34. Diagnostic tools for humans With Malaria ➔ Blood film examination(Microscopy) ➔ QBC system ➔ Rapid Diagnostic Tests (RDTs) ➔ PCR 35. Thin and thick smear 36. Microscopes ➔ malaria parasites can be identified by examining under the microscope of a drop of the patient's blood, spreading as a blood smear on the microscope slide. Before examination, the sample is stained (often with Giemsa stains) to make the parasite appear distinctive. The technique remains the gold standard for laboratory malaria verification. 37. The QBC system has evolved as a fast and accurate method in diagnosis ➔ the QBC malaria method is the easiest and most sensitive method for diagnosing the following diseases. ➡ malaria ➡ Babziosis ➡ Trypanosomiasis (Chagas disease, sleep disease) ➡ filariasis (phylliasis, loa-loa) ➡ recurrent fever (Beverlyosis) 38. The appearance of malaria parasites in the QBC 39 system. Rapid and accurate antigen detection methods are ➔ different test kits are available to detect antigens derived from malaria parasites and provide results in 2 to 15 minutes. These rapid diagnostic tests (RDTs). Rapid diagnostic tests (RDTs) are imagonocratographic tests based on the detection of parasite-specific antigens. Experiments that detect histidine-rich protein 2 (HRP2) are specific to P.falciparum while experiments that detect lactate di hydrogenase (pLDH)-OptiMAL ➔ or aldolase have the ability to distinguish between P.falciparum and non-P.falciparum 40 malaria. Newer diagnostic methods for ➔ detection of parasite nuclear acids are detected using polymerase chain reaction (PCR). This technique is more accurate than microscope. However, it is expensive, and requires a specialized laboratory (even if technical advances are likely to result in field-action PCR machines). 41. Sensitivity tool for diagnosis of malaria infection 1. Most sensitive: Antibody detection 2. PCR 3. Blood film examination 42. Malaria recurrent ➔ in P. vivax and P. ovale infections, patients who have recovered from the first part of the disease may suffer several additional attacks (recurrence) after months or even years without symptoms. Relapse occurs because P. vivax and P. ovale are dormant liver stage parasites (hypnosis) that may be reactivation. 43. Pharmacology antiMALARIALS class definition example class definition class definition schizonticidal blood law drugs in the (erythrostic) stage of the parasite resulting in the termination of clinical disease Quinine, artemisinins, amodiaquine, chloroquine, lumefantrine, tetracyclinea , atovaquone, sulphadoxine, clindamycina, proguanila tissue schizonticidal drugs Act on tissue primary forms of plasmodia which initiate the erythrocytic stage. They prevent the further development of Primaquine infections, pyrimethamine, proguanyl, tetracycline gametocytocid al-drugs removing sexual forms of parasites thereby preventing the transmission of infection to primaquine mosquitoes, artemisinin, slow acting quinineb, cannot مورد استفاده به تنهایی برای جلوگیری از علائم بالینی ب ضعیف gametocytocidal 44. فارماکولوژی ANTIMALARIALS (cont.) کلاس تعریف مثال کلاس تعریف کلاس نمونه های تعریف داروهای هیپنوتیزم این عمل در مراحل کبد مداوم P.ovale و P.vivax که باعث بیماری مکرر Primaquine، tafenoquine Sporozontocidal به مواد مخدر این عمل با تاثیر بر توسعه بیشتر گیمتوسیت oocytes در داخل پشه در نتیجه abating انتقال Primaquine، (60 پروگوانیل، کلرگوانیل 45. 1. درمان شدید فالسیپاروم مالاریا رژیم رژیم ترجیحی رژیم جایگزین چهارم آرتسونات (mg): 2.4mg/kg 2.4 در پذیرش، و به دنبال آن 12 mg/kg در 24h، & و سپس یک بار در روز به مدت 7 روز. •هنگامی که بیمار می تواند درمان شفاهی را تحمل، درمان باید به یک دزدی کامل از Riamet (artemether / lumefantrine) به مدت 3 روز تعویض IV Quinine 7 کیلوگرم بیش از 1 / mg بارگذاری نمک hr 10 کینه و به دنبال آن تزریق mg 10 کیلوگرم / نمک / کیلوگرم بیش از 4 ساعت، سپس نمک mg / کیلوگرم Q8H یا چهارم Quinine 20mg/kg 10 بیش از 4 ساعت، سپس mg/kg Q8H. Plus Gt Adult & child >8yrs old: Doxycycline (3.5mg/kg once daily) or •Pregnant women & child < 8yrs= old:= clindamycin= (10mg/kg= twice= daily).= both= drug= can= be= given= for= 7= days.= ▲reconstitute= with= 5%= sodium= bicarbonate= &= shake= 2-3min= until= clear= solution= obtained.= then= add= 5ml= of= d5%= or= 0.9%nacl= to= create= total= volume= of= 6ml.= ▲slow= iv= injection= with= rate= of= 3-4ml/min= or= im= injection= to= the= anterior= thigh.= ▲the= solution= should= be= prepared= freshly= for= each= administration= &= should= not= be= stored.= ▲dilute= injection= quinine= in= 250ml= od= d5%= and= infused= over= 4hrs.= ▲infusion= rate= should= not= exceed= 5= mg= salt/kg= per= hour.= 46.= 2.= treatment= of= uncomplicated= p.falciparum= preferred= regime= alternative= regime= artemether= plus= lumefantrine(riamet)= (1= tab := 20mg= artemether/120mg= lumefantrine)= quinine= sulphate= (300mg/tab)= weight= group= day= 1= day= 2= day3= day= 1-7:= quinine= 10mg= salt/kg= po= q8h= plus= *doxycycline= (3.5mg/kg= once= a= day)= or= *clindamycin= (10mg/kg= twice= a= day)= *any= of= these= combinations= should= be= given= for= 7= days.= doxycycline:= children=> 8yr Clindamycin: Children<8yr 5-14kg= 1= tab= stat= then= 8hr= later= 1= tab= q12h= 1= tab= q12h= 15-24kg= 2= tab= stat= then= 8hr= later= 2= tab= q12h= 2= tab= q12h= 25-34kg= 3= tab= stat= then= 8hr= later= 3= tab= q12h= 3= tab= q12h=>34kg 4 tab stat then 8hr later 4 tab Q12H 4 tab Q12H Take immediately after a meal or drink containing at least 1.2g fat to enhance 47. دارو و دارو <5 kg ** IM first dose Artesunate 1.2 mg/kg or IM Arthemeter 1.6 mg/kg) ***Oral Artesunate 2mg/kg/day day 2 to day 7 Oral Quinine 10 mg/kgTDS for 4 days then 15-20 mg/kg TDS for 4 days Source: Malaria in Children, Department of tropical Pediatrics, Faculty of Tropical Medicine, Mahidol University. ** Preferably Artesunate/Artemether IM on day 1 if available *** When Artesunate/Artemether IM is unavailable, give oral Artesunate from day 1 to day 7 * Treat the young infant Quinine when oral Artesunate > پلاسمودیوم</8yr> فالسیپاروم برای گروه سنی جوان گروه وزن آرتسونات یا *Quinine 0 - 4 ماه در دسترس 5 کیلوگرم یا زیر 4 ماه ماه کودکان زیر نیست نباید به Riamet عفونت از ناشی مالاریا درمان. 3 .48 (نگاه کنید به جدول) به جای درمان با رژیم زیر شود داده p.knowlesi & mixed (p. falciparum + p. vivax) ➔Treat as p. falciparum 49. 4. از ناشی مالاریا درمان p.vivax، p. ovale یا p. مالاریا. CHLOROQUINE (150 میلی 25 (میلی گرم پایه / زیانه) 3 روز / کیلوگرم پایه / گرم PRIMAQUINE (7.5 با همزمان شروع• 3 روز 2 روز 1 روز (زیانه / پایه گرم میلی CHLOROQUINE 0.5 گرم میلی base/kg Q24H for 2 weeks •Take with food •Check G6PD status before start primaquine •In mild-to-moderate G6PD defifiency, primaquine 0.75 mg base/kg body weight given once a week for 8 weeks. •شدید کمبود در G6PD، 10 مورد استفاده قرار گیرد و نباید شود می پیشگیری پریماکین mg 5 پایه، سپس استات، کیلوگرم / کیلوگرم / پایه mg کیلوگرم پایه / کیلوگرم Q24H 5 پایه mg / کیلوگرم Q24H 1 250 کلروکین فسفات زیانه mg 150 معادل پایه mg. دوز محاسبه برای کلروکین بر اساس پایه است، نه فرم SALT. 1 زیانه از فسفات primaquine 7.5 شامل پایه mg. 50. درمان در جمعیت خاص & موقعیت های خاص جمعیت ترجیح رژیم جایگزین رژیم بارداری Quinine به علاوه clindamycin به مدت 7 روز Artesunate به علاوه Clindamycin به مدت 7 روز داده می شود نشان داد اگر درمان خط اول با شکست مواجه زنان (از جمله Lactating باید درمان استاندارد ضد مالاری ACTs) به جز dapsone دریافت خواهید کرد, primaquine نظارت از نزدیک, تنظیم دوساژ مناسب مورد نیاز است, توسط کبد اصلاح 30-50%: محروم و تتراسیکلین, که باید در طول لاکتاسیون اختلال کبدی کلروکین Quinine : کلروکین اختلال مصرف کلیه بدون تنظیم دوساژ، مانیتور از نزدیک. آرتمیسینین ها : بدون تنظیم دوساژ در هپاتیک اختلال متوسط تا خفیف : ClCr 40 اسفنجی تحت درمان (درجه سانتی گراد، <10ml in-50%= of= normal= dose.= hemodialysis,= peritoneal= dialysis:= 50%= of= normal= dose.= continuous= renal= replacement= therapy(crrt)= :100%= of= normal= dose.= quinine= := .clcr= 10-50ml/min= := administer= q8-12h,=></10ml> <10ml in= := administer= q24h,severe= chronic= renal= failure= not= on= dialysis= := initial= dose:= 600mg= followed= by= 300mg= q12h,= hemo-= or= peritoneal= dialysis:= administer= q24h= ,continuous= arteriovenous= or= hemodialysis:= administer= q8-12h.= artemisinin= := no= dosage= adjustment.= 51.= treatment= of= complications= of= malaria= ➔= severe= &= complicated= falciparum= or= knowlesi= malaria= is= a= medical= emergency= that= requires= intervention= and= intensive= care= as= rapidly= as= possible.= ➔= fluid,= electolyte= glucose= &= acid-base= balance= must= be= monitored.intake= &= output= should= be= carefully= recorded.= 52.= immediate= clinical= management= of= severe= manifestations= and= complications= of= p.= falciparum= malaria= definitive= clinical= features= immediate= management/treatment= come= (cerebral= malaria)= monitor= &= record= level= of= consciousness= using= glaslow= coma= scale ,= temperature,= respiratory,= and= depth,= bp= and= vital= signs.= hyperpyrexia= (rectal= body= temperature=>fanning &with an antipyretic drug. پاراستامول</10ml> رکتال بر داروهای The more preferred (such as NSAIDs) seizures are a slow IV injection than from Maximum 20mg for adults). hypoglycemia (glucose. <2.8mmol)= correct= with= 50% = dextrose= (as= infusion = fluids).= check = blood = glucose = q4-6h = in= the= the first = 48hrs.= severe= anaemia= (hb=>>lt;/2.8mmol> lt; 7g/dl)= transfuse= with= packed= cells.= monitor= carefully= to avoid = fluid = overload.= give = small = iv = dose = of = frusemide,= 20mg,= as= necessary = during = blood = transfusion = to= avoid = circulatory = overload.acute = pulmonary = oedema = prop = patient = upright = (45°), = give = oxygen,= give = iv = diuretic= (but= most= patient = response = poorly = to = diuretics), stop= intravenous = fluids.= early = mechanical = ventilation = should = 53.= immediate = clinical = management = of severe = manifestations = and = complications = of = p.= falciparum = malaria = (cont.) = definitive = clinical features = immediate = management treatment= acute = renal = failure = (urine = output=> 265μmol/L) • Elimination of pre-renal causes with <400ml in= 24hrs= in= adults = or = 0.5ml/kg/hr ,= failing= to= improve= after= rehydration = &= a= serum = creatinine = of=>Evaluation of hydration status. • Rejection of urinary tract obstruction by abdominal examination or ultrasound. • Intravenous normal salin • If you add hemophilimetric or hemodialysis in stabilized renal failure, or intravenous dialysis if unavailable. Coagulopathy is released intra-vascular (DIVC) • Transmission packed with cells, clotting agents or platelets. • Routine regimen: Cryoprecipitate 10units,Platelet 4-8units, Fresh Frozen Plasma(10-15ml/kg). • For long-term PT, vitamin K, 10mg with slow IV injection. Metabolic acidosis • Sodium bicarbonate 8.4% 1mg/kg over 30min and repeat if needed. • If it's severe, add hemodialysis to it. Shock (hypotension with systolic blood pressure 'suspects septicemia, blood for culture; to waldral broad antimicrobial spectrum, just 54. Monitoring & follow-up ➔ Blood smear should be repeated daily (twice daily in severe infection). Within 48 to 72 hours of treatment, patients usually go afebrile and recover clinically except in complex cases. ➔ patients should be checked with repeated blood footage of the malaria parasite a month after the malaria infection improves, to ensure no correction. 55. Prevention of ➔ avioid bites: • Wear long sleeves, pants. • Bednets treatment insecticide • Repellent cream or spray. 56. Chemoprophylaxis ➔ for travelers travelling to indigenous areas. ➔ Mefloquinine 250mg weekly (up to 1 year) or doxycycline 100mg daily (up to 3 months), to start 1 week before and continue for up to 4 weeks after leaving the area. 57. < 5= kg=> < 3= months= not= recommended= 5= -= 12= kg= 3= -= 23= months= 1/4= 13= -= 24= kg= 2= -= 7= yrs= 1/2= 25= -= 35= kg= 8= -= 10= yrs= 3/4= 36= and= above= 11= yrs= and= above= 1= 58.= dosing= schedule= for= doxycycline= weight= in= kg= age= in= years= no= of= tablets=> < 25=> < 8 Contraindicated 25 - 35 8 - 10 ½ 36 - 50 11 - 13 ¾ 50+ 14+ 1 1 8= contraindicated= 25= -= 35= 8= -= 10= ½= 36= -= 50= 11= -= 13= ¾= 50+= 14+= 1= 1=></ 8 Contraindicated 25 - 35 8 - 10 ½ 36 - 50 11 - 13 ¾ 50+ 14+ 1 1 > برنامه مصرف برای Weight age no pills per week

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