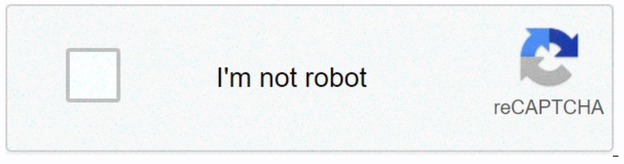

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Lab report on calorimetry

Clinical Practice Guidelines: Adult Middle Disease.Rosenfeld RM, Andes D, Batatariya N, Chong D, Eisenberg S, Ganiatz TG, Gelzer A, Hamiros D, Heydon RC 3rd, Hajins PA, Jones S, Cruz HJ, Lee LH, Mahoney MC, Marple BF, Mitchell CJ, Nathan R, Schiffman RN Smith, Wissel DL. Rosenfeld RM, and others. Otra Ringol Headneck Sarg. September 2007; 137 (3 Suppl): S1-31.Doi: 10.1016/j.otohns.2007.06 .726.Otralingol Headneck Sarg 2007.PMID: 17761281 About 6% to 7% of children with respiratory symptoms have acute middle disease. Updating the 2001 guidelines, this practice guideline from the American Academy of Pediatrics (AAP) discusses the diagnosis and management of acute bacterial new disease in children ages 1 to 18. Acute bacterial sinusitis can be diagnosed in children with persistent acute upper respiratory tract infections (nasal discharge or daytime cough lasting more than 10 days without improvement), aggravation (exacerbation or new nasal discharge, daytime cough after initial improvement, or fever), or severe (at least 102.2°F [39°C] and purulent nasal purulentness). Plain X-rays, contrast-enhanced computed tomography, magnetic resonance imaging, and ultrasound imaging should not be performed to distinguish acute bacterial new tracheitis from viral upper respiratory tract infections. However, magnetic resonance imaging using contrast-enhanced computed tomography or contrast media of the sinuses should be performed in children who are considered to have orbital or central nervous system complications. The most common orbital complications of acute bacterial genesis include children under the age of 5 with etmoid sanusis. These complications should be suspected in children with swollen eyes, especially if there is protosis or if extraocular muscle function is impaired. Intracranial complications (e.g., subdural and epidural embolism, venous thrombosis, cerebral abscesses, meningitis) are less common, but are more severe and have higher morbidity and mortality than orbital complications. These complications should be suspected in children with severe headaches, photophobias, seizures, or other focal neurological findings. Antibiotics should be prescribed to children with severe, aggravated or persistent acute bacterial malignancies. Three days of outpatient care is also an option in children with persistent illnesses. Amoxicillin alone or in combination with clavrat is the choice of the first line of antibiotics. Intravenous or intramuscular ceftriaxon (Rocephin) can be given to children vomiting at 50 mg per kg, children who are unable to take oral medication, or who are less likely to take prescribed early antibiotic doses. After clinical improvement, the treatment can be changed to oral treatment. Children with hypersensitivity to amoxicillin (type 1 and non-type 1)Treated with cefudinil (omnisef), cefloxim (ceftin), or cefpodoxim. Surveillance studies have shown resistance to trimethoprim/sulfamethoxazole and azithromax in pneumococcal and hemophilia influenza, indicating that it should not be used to treat acute bacterial parauria in people with penicillin hypersensitivity. Recommendations for the optimal duration of treatment vary from 10-28 days. Alternatively, it is recommended to avoid individual treatment, treatment for at least 10 days, continuous treatment of asymptic patients for 7 days after the symptoms subside. If acute bacterial malignant infections are confirmed in children with worsening symptoms or 72 hours later that have not improved, antibiotics are changed (if the child is already on antibiotics) or initiated (if the child has been observed). If the parent indicates that the child's illness is getting worse (the first signs or symptoms are progressing, or new signs or symptoms are occurring), or if they do not improve after 72 hours of treatment (signs and symptoms persist), the administrative decision should be reevaluated. There are no recommendations for adjuvant therapy for acute bacterial sinusitis, but intranasal corticosteroids, physiological nasal irrigation or cleaning, topical or oral decingents, mucus degrading agents, and topical or oral antihistamines may be an option. One Cochrane review found no well-designed study to establish the effectiveness of decingentry, antihistamines and nasal irrigation for acute sinusitis in children. Since the 2001 guidelines were published, only a small number of high-quality studies have been published on the diagnosis and treatment of acute bacterial new disease in children. Therefore, the evidence underlying the recommendations is limited and further research is needed in many areas. Page 2 Note: This information was up-to-date at the time of release. However, medical information is constantly changing, and some of the information given here may be outdated. For regular information on a variety of health topics, visit the AAFP patient education website familydoctor.org. Dr. Amfam. April 15, 2014, 89(8): Online. Most people who see related articles about headaches have headaches at some point in their lives. Chronic daily headaches are headaches that last a long time, usually at least 15 months or more per month. Chronic daily headaches are more common in whites and women. Other risk factors are obesity, taking too many medications, stress, sning, drinking too much caffeine, and other causes of chronic pain. Chronic daily headaches are not usually life-threatening. Sometimes they are caused by pressure or bleeding in the brain, which is rare. Your doctor will order a test if you believe there is an infection or problem with the bone, muscle, or tissue.You don't need a test to find out what type of headache you have. Headaches often last longer when people take too many medications to treat them. This can occur with over-the-counter medications, such as acetaminophen (one brand: Tylenol), or with prescription drugs. Doctors may suggest taking fewer medications or trying medications that stop medications from coming back completely or prevent headaches from returning. This includes taking medications such as antidepressants, anticonvulsants and muscle relaxants. Other treatments include cognitive behavioral therapy, relaxation techniques, and acupuncture. It is rare for a single drug or treatment to completely stop chronic daily headaches. Talk to your doctor to see which treatment or combination of treatments is best for you. See the full article at your Doctor National Headache Foundation , login or purchase access. This handout is provided by your family physician and the American Academy of Family Physicians. More health-related information is available at AAFP Online at . This information provides a general overview and does not apply to everyone. Find out if this information applies to you and talk to your doctor for more information on this subject. Copyright of 2014 by the American Academy © Physicians. This content is owned by AAFP. Those watching online can create a printout of one of the materials, and that print can only be used for his or her personal, non-commercial references. This material may not be downloaded, copied, printed, stored, transmitted or reproduced in any medium, whether currently known or later invented, except as approved in writing by AAFP. If you have any copyright questions or requests for permission, please contact afpserv@aafp.org. Do you want to use this article elsewhere?The latest issue of permissions December 1, 2020 Read the latest issue of American Family Physicians Read the problem Don't miss a single problem. Sign up for a free AFP email TOS. Sign up © the 2020 American Academy of Family Physicians. All right reservations. The American Academy of Pediatrics 2001 September (Revised 2013 Jul) Definition of the quality of evidence (A-D, X) and strength of recommendations (strong recommendations, recommendations, options) is provided at the end of the key recommendations field. Key Action Statement (KAS)1 Clinicians should make an estimated diagnosis of acute bacterial resanopathy when a child with acute upper respiratory tract infection (URI) presents: persistent disease (i.e., persistent disease) nasal discharge (any quality) or daytime cough or both last more than 10 days without improvement) or aggravation course (i.e., fever after worsening or initial improvement of nasal discharge, or new onset) or severe onset (i.e., simultaneous fever [temperature])And at least 3 consecutive days of purulent nasal discharge (evidence quality: grade B; recommendation) KAS profile 1 Total evidence quality: B Benefits: Diagnosis can make management decisions. Children who are likely to benefit from antimicrobial therapy are identified. Harm: Improper diagnosis can lead to unnecessary treatment. Missing a diagnosis can cause persistent infections and complications. Cost: Improper diagnosis can lead to unnecessary costs of antibiotics. Missing a diagnosis can lead to the cost of care for persistent illnesses (loss of time from school or work) and complications. Benefits - Harm Assessment: Ahead of Profit Value Judgment: No Role of Patient Preference: Limited Intentional Ambiguity: No Exclusion: Children 1+; Over 1 Year Old, Strength with Underlying Conditions: Recommendation Key Action Statement 2 AClinicirns should not obtain imaging studies (plain film, contrast enhanced computed tomography [CT], magnetic resonance imaging [MRI], or ultrasound imaging to distinguish between acute bacterial malignantitis and viral URIs (evidence quality: grade B). Strong recommendation). KAS Profile 2A Total Evidence Quality: B; Overwhelmingly consistent evidence benefits from observational studies: Avoid radiation exposure and research costs. Avoid unnecessary treatment for false positive diagnosis. Harm: No Cost: Benefit Harm Assessment To Avoid The Cost of Imaging: Exclusive Profit Value Judgment: Unnecessary Radiation and Cost Concerns Patient Preference Role: Limited. Parents may rate negative studies and antibiotic avoidance as radiation-deseds, but the panel disagrees. Intentional ambiguity: non-exclusion: patient strength with complications of sinusitis: Strong recommendation Key action statement 2BClinicans should obtain enhanced CT scans of contrasting anti-nasal sinuses and/or MRI if the child is suspected of having orbital or central nervous system complications of acute bacterial sinusitis (evidence quality: Grade B; strong recommendation). KAS Profile 2B Aggregates the quality of evidence: B; Overwhelmingly consistent evidence benefits from observational studies: determining the presence of abscesses that may require surgical intervention. Avoid sequels for proper active management. Harm: exposure to edolysing radiation for CT scans; The need for sedation of MRI costs: direct cost benefit value assessment of research: ahead of profit value judgment: concerns of serious complications that may not be recognized, and therefore not treating the appropriate role of patient preferences: limited intentional ambiguity: strength without: strong recommendation key action statement 3 Initial management of acute bacterial newness 3A: Initial management clinicians of acute bacterial synassisisAntibiotic therapy (evidence quality: grade B; strong recommendation) for acute bacterial badness (signs, symptoms, or both) in children with severe onset or worsening course. KAS Profile 3A Total Evidence Quality: B; Restricted randomized controlled trial benefits: May increase clinical healing, shorten disease duration, and prevent nutritional complications in high-risk patient populations. Harm: Adverse effects of antibiotics Cost of treatment Direct cost of treatment Profit damage assessment: Ahead of profit value judgment: Concern over morbidity and possible complications in case of patient's preferred unedided role: Limited intentional ambiguity: No exclusion: Strong recommendation 3B: Persistent disease clinicians prescribe antibiotic therapy or persistent illness (nose secretion of quality or cough for at least 10 days without evidence of improvement, or both) should provide 3 days of additional outpatient observation (evidence quality: grade B; recommended). KAS Profile 3B Total Evidence Quality: B; Restricted randomized controlled trial benefits: Antibiotics increase the chances of improvement or healing in 10-14 days (number required for treatment, 3-5). Additional observations can avoid incidental costs and side effects and the use of antibiotics. Harm: Antibiotics can have harmful effects (the number that need to be harmed, 3) and increase bacterial resistance. Observation may prolong the disease and delay the start of necessary antibiotic therapy. Cost: the direct cost of antibiotics, as well as the cost of adverse reactions; the indirect cost of delay recovery when using observations. Benefit harm assessment: profit lien (since both antibiotic therapy and additional observations with rescue antibiotics are appropriate management as needed). Value judgment: the role of an additional short observation period for new children with persistent illness, as well as those recommended for acute otitis otitis, as well as those recommended for acute otitis otitis, comparing additional observations with immediate antibiotic therapy and longer periods of disease before presentation. The role of patient preferences: the severity of the disease, the quality of life of the child, the substantial role in shared decision-making that should incorporate the values and concerns of the caregiver. Intentional ambiguity: No exclusion: Children excluded from randomized clinical trials of acute bacterial lysitis, as defined by text intensity: Recommendation Key Action Statement 4 Clinicians should prescribe amoxicillin as a first-line treatment with or without creclanate if a decision is made to start antibiotic treatment for acute bacterial lysitis (evidence quality: grade B; recommended). KAS Profile 4 Total Evidence Quality: B; Restricted Randomized Controlled Trial Benefits: Increase Clinical HealingSpectrum drugs; gradual increase in spectrum spread as a risk factor for tolerance increases harm: adverse effects of antibiotics, including the development of hypersensitivity costs Costs: Benefit value assessment: Possible role of patient preferences: Possible ambiguity of shared decision-making that should incorporate caregiver experience and value: No exclusion: It may not contain allergy or intolerance intensity: recommendation key action statement 5AClinicians recommended within 72 hours of the initial management of deterioration (progression of initial signs/symptoms or appearance of new signs/symptoms) or failure of improvement (reduction of all presenting signs/symptoms). KAS Profile 5A Total Evidence Quality: C; Benefits of Observational Studies: Identify patients who may have been misdiagnosed, who are at risk of complications, and who need changes in management harm: Changes in treatment if patients do not improve costs Delays of up to 72 hours to: Benefit harm assessment of additional providers and caregivers' time and resources: Benefit value judgment advantage: 72 hours of use to assess progress can, in early cases, lead to excessive classification as a treatment failure. Emphasize the importance of exacerbating the disease in defining treatment failures. The patient's preferred role: The caregiver decides whether the severity of the patient's illness legitimates the report to the clinician of the patient's worsening or failure to improve. Intentional ambiguity: No exclusion: patients with serious diseases, poor general health, complex adrenalitis, immunodeficiency, previous adrenal disease strength, or coexisting bacterial disease strength: Recommendation Key Action Statement 5B Symptoms worsen or if a diagnosis of acute bacterial adrenalitis is confirmed in children who fail to improve in 72 hours, clinicians may initially change antibiotic therapy in children managed with antibiotics. options based on expert opinions, case reports, and inferences from first principles). KAS Profile 5B Total Evidence Quality: D; Expert Opinions and Inferences from the First Principles Benefits: Prevention of Complications, Management of Preventive Harms of Effective Treatment: Toxicity of Secondary Antibiotic Therapy Costs: Direct Cost of Drugs, Often Benefit Damage Assessment of Second Line Drugs: Profit Lien Value Judgment: Clinicians need to determine whether the costs and adverse effects associated with antibiotic changes can be given the severity of the disease. Patient preference roles:In patients who have severe or worsened symptoms, but who may have mildly affected children who are failing to improve, may reasonably postpone changes in antibiotics. Intentional ambiguity: None Exclusion: Strength without: Option definition: Definition of a statement definition based on evidence Strong recommendation Recommendations are made when the expected benefits of the recommended intervention clearly exceed the harm (because strong recommendations for action are made when the expected harm clearly exceeds the benefit). In some clearly identified situations, strong recommendations may be made when high-quality evidence cannot be obtained and the expected benefits strongly outweigh the harms. Clinicians should follow strong recommendations unless there is a clear and compelling basis for alternative approaches. Recommendation Recommendation Recommendations are made to support a particular action when the expected benefits exceed the harms but the quality of the evidence is not so strong. Again, in some clearly identified situations, recommendations may be made if it is impossible to obtain high-quality evidence, but the expected benefits outweigh the harms. Clinicians will be wise to follow the recommendations, but they should remain vigilant and sensitive to patient preferences for new information. Optional options define courses that can be taken when the quality of evidence is questionable or carefully conducted studies have shown little clear advantage in one approach over another. Clinicians should consider decision-making options, and patient preferences may have a substantial role. No recommendations The recommendations indicate that there is a lack of relevant published evidence and that the expected balance of benefits and harm is currently unknown. Clinicians should be aware of new published evidence that clarifies the balance between benefits and harm. Quality of evidence Preemption of harm balance between profit or benefit A. Well-designed randomized controlled trial (RCT) or diagnostic study on related populations Strong recommendation option B. Diagnostic studies with RCT or minor limitations; observational research recommendations / strong recommendations C. overwhelmingly consistent evidence recommendations from observational studies / strong recommendations C. recommendations D. Expert opinions, case reports, inferences from first principles from first principles Inference Recommendation X. The type of supporting evidence for a recommendation that cannot conduct validation research and has a clear preemption of evidence with a clear preemption of benefit or harm recommendations is specifically described in each recommendation (see Key Recommendations).Implementation strategy description Implementation strategy was not provided. Accurate diagnosis of acute bacterial malignancies, proper use of imaging procedures, and adverse effects of antibiotic therapy, including proper use of antibiotic hypersensitivity, allergic reactions and bacterial resistance observations, can prolong the disease and delay the start of necessary antibiotic therapy. It can lead to unnecessary treatment, such as exposure to ionizing radiation for computed tomography (CT) scans and the need for sedation of magnetic resonance imaging (MRI). Missing a diagnosis can cause persistent infections and complications. Definition of evidence-based statements Definition of statements Strong recommendations Strong recommendations If the expected benefits of the recommended intervention clearly exceed the harm (strong recommendations for action are made if the expected harm clearly exceeds the benefits), strong recommendations are made to support a particular action when the quality of the supporting evidence is excellent. In some clearly identified situations, strong recommendations may be made when high-quality evidence cannot be obtained and the expected benefits strongly outweigh the harms. Clinicians should follow strong recommendations unless there is a clear and compelling basis for alternative approaches. Recommendation Recommendation Recommendations are made to support a particular action when the expected benefits exceed the harms but the quality of the evidence is not so strong. Again, in some clearly identified situations, recommendations may be made if it is impossible to obtain high-quality evidence, but the expected benefits outweigh the harms. Clinicians will be wise to follow the recommendations, but they should remain vigilant and sensitive to patient preferences for new information. Optional options define courses that can be taken when the quality of evidence is questionable or carefully conducted studies have shown little clear advantage in one approach over another. Clinicians should consider decision-making options, and patient preferences may have a substantial role. No recommendations The recommendations indicate that there is a lack of relevant published evidence and that the expected balance of benefits and harm is currently unknown. Clinicians should be aware of new published evidence that clarifies the balance between benefits and harm. The recommendations in this statement do not indicate an exclusive course of treatment and do not function as a standard of medical care. Taking into account individual circumstances, variations may be appropriate. The method used to collect/select evidence searches in PubMed for electronic databases was performed using the same search terms as in the 2001 report. All searches were restrictedEnglish and human studies. Three separate searches were carried out to maximize the search for the latest and highest quality evidence of pediculousnovaitis. The third limited results of randomized controlled trials (RCT) from 1966 to 2009, total meta-analysis from 1966 to 2009, and all pediatric studies since the last technical report (1999-2009) (age < limited to 18 years). In addition, the web of science was queried to identify studies that cited the original American Academy of Pediatrics (AAP) guidelines. The literature search was replicated in July 2010 and November 2012 to capture recently published studies. The full results of the literature review are published separately in the technical report (see Availability of Companion Documents). Only three trials met the inclusion criteria. Due to significant heterogeneity in these studies, formal meta-analysis was not pursued. A number of source documents 17 randomized studies of this problem in children have been identified and reviewed. Only three trials met the inclusion criteria. Methods used to assess the quality and intensity of evidence weighting based on the strength of evidence quality evidence Evidence quality quality superiority benefits or harm balance A. Well-designed randomized controlled trials (RCT) or diagnostic studies on related populations Strong recommended options B. Diagnostic studies with RCT or minor limitations; observational research recommendations / strong recommendations C. Overwhelmingly consistent evidence recommendations from observational studies C. Recommendations D. Expert opinions, case reports, first principles of reasoning from the first principles No Recommendation X. Verification studies cannot be conducted, and these action statements are exceptional circumstances where there is a clear preemption of recommendations/strong recommendation methods used to analyze evidence. It was generated using BRIDGE-Wiz (Developer Guidelines Editor, Yale School of Medicine, Newhaven, CT building recommendations). BRIDGE-Wiz also incorporates the quality of evidence available in the final decision of the strength of each recommendation. The method used to formulate recommendations for methods used to formulate recommendations in June 2009, the American Academy of Pediatrics (AAP)Review and revise the clinical practice guidelines published by AAP in 2001. It was developed by a subcommittee of the Steering Committee on Quality Control Management, which includes physicians with expertise in the fields of primary care pediatrics, academic general pediatrics, family practice, allergy, epidemiology and informationology, pediatric infectious diseases, pediatric otolaryngology, radiology, and pediatric emergency medicine. The AAP policy statement, Classification of Recommendations in clinical practice guidelines, was followed in specifying the level of recommendations. An evidence-based statement definition is provided (see Rating Scheme for Recommendation Strength). Guidelines Developers reviewed the published cost analysis. Description of internal peer review guidelines for guideline verification external peer review This guideline was reviewed by the American Academy of Pediatrics (AAP) and multiple groups of two external organizations. The comments were compiled and reviewed by the subcommittee and relevant changes were incorporated into the guidelines. Clinical practice guidelines for the diagnosis and management of acute bacterial stench in children aged 1-18 years old, Waldo ER, Applegate KE, Baudry C, Darrow DH, Grode MP, Mercy SM, Nelson CE, Rosenfeld RM, Shaikh N, Smith MJ, Williams PV, Weinberg ST. Pediatrics. July 132, 2013 (1): e262-80. [See 104] PubMed Not Applicable: The guidelines were not applied from another source. The American Academy of Pediatrics (AAP) has not solicited or accepted commercial involvement in the development of the publication's content. Only funds from AAP were used to fund the development of the guidelines. Subcommittee on managing the subnasitis configuration of the group that created the guideline committee members: Ellen R. Wald, MD, FAAP; Kimberly E. Applegate, MD, MS, FAAP; Clay Baudry, MD, MPH, FAAP; David H. Darrow, MD, FAAP; Mary P. Grode, MD, FAAP;S. Michael Murthy, MD, FAAP; NaderShaikh, MD, FAAP; Michael J. Smith, MD, MSCE, FAAP; Paul V. Williams, MD, FAAP; Stuart T. Weinberg, MD, FAAP; Carrie E. Nelson, MD, MS; Richard M. Rosenfeld, MD, MPH, FAAPConsultant: Richard N. Schiffman, MD, FAAPStaff: Caryn Davidson, author of ma financial disclosure/conflict of interest all, filed a conflict of interest statement with the American Academy of Pediatrics. The dispute was resolved through a process approved by the Board of Directors. This is the current release of the guidelines. This guideline updates an earlier version: Clinical Practice Guidelines: Management of The Function of Synables.Pediatrics. September 108, 2001 (3): 798-808. [See 79] All clinical practice guidelines of the American Academy of Pediatrics automatically expire five years after publication, unless reconfirmed.or retired before that time. These guidelines meet the NGC's 2013 (Revised) Inclusion Standards. Companion Doc Availability: Print Copy: American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, available from IL 60009-0927. This summary was completed by ECRI on November 16, 2001. This information was verified by guideline developers as of December 5, 2001. This overview was updated by the ECRI Institute on September 13, 2013. This summary was updated by the ECRI Institute on May 18, 2016, following recommendations from the U.S. Food and Drug Administration on fluoroquinolone antimicrobials. This NGC overview is based on the original guidelines subject to copyright restrictions for guideline developers. Contact permission editor, American Academy of Pediatrics (AAP), 141 Northwest Point Blvd., Elk Grove Village, IL 60007. Acute Bacterial Sub-Nasopharyngeal Evaluation Management Allergy and Immunology Family Practice Infectious Diseases Otolaryngology Pediatric Preventive Medicine Senior Medical Nurses Union Medical Human Nurse Physician Assistant Physician Update American Academy of Pediatrics Clinical Practice Guidelines for Diagnosis and Management of Acute Bacterial Paranitis in Children and Adolescents 1 to 18 years old, acute bacterial sinusitis note: This guideline does not take into account respaints and children under 1 year of age or children with sinuses, immunodeficiency, cystic fibrosis, or anatomical abnormalities of primary herophylosis. Diagnosis and Practice by Examination of Diagnosis/Evaluation Physical examination and evaluation of diagnosis Antibiotic therapy amoxicillin or levofloxacin in cases of suspected diagnosis contrast or central nervous system complications in cases where a child is suspected of having orbital or central nervous system complications does not improve the main results considering the severity of the symptoms and the severity of the possible symptoms Reevaluate initial controls Ease of quality of life cost administration of antibiotics Caregivers are concerned about the potential adverse effects of antibiotics The persistence of respiratory symptoms, or the development of complications FDA warning/regulatory warning notes from the National Guidelines Clearinghouse: This guideline refers to drugs that refer to drugs for which important regulatory and/or warning information has been published. May 12, 2016 - Fluoroquinolone antimicrobials: The U.S. Food and Drug Administration (FDA) advises that serious side effects associated with fluoroquinolone antimicrobials generally outweigh the benefits of patients with parasymitis, bronchitis, and uncompinable urinary tractsThose who have other treatment options. For patients with these conditions, fluoroquinolone should be reserved for those who do not have alternative treatment options. Efficacy Patient Centrality National Guidelines Clearinghouse (NGC) does not develop, create, approve or support the guidelines set out on this site. All guidelines compiled by the NGC and hosted on our site are created under the auspices of medical professional associations, related professional organizations, public or private organizations, other government agencies, medical institutions or plans, and similar organizations. The guidelines set out on the NGC website are submitted by the Guidelines Developer and reviewed only to determine that they meet the NGC inclusion criteria that can be found at NGC, AHRQ and its contractor ECRI Institute make no warranties as to the content or clinical efficacy or efficacy of the clinical practice guidelines and related materials described on this site. In addition, the views or opinions of the developers or authors of the Guidelines posted on the Site do not necessarily reflect the views or reflections of the NGC, AHRQ, or its contractor ECRI Institute, and the inclusion or hosting of NGC's guidelines may not be used for advertising or commercial warranty purposes. Readers who have questions about the content of the guidelines will be instructed to contact the developer of the guidelines. Developers.

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