



Tutorial UpToDate

Biblioteca Hospital Universitario de Burgos

1-Qué es.

2-Cómo buscar.

- Los resúmenes de Medline.
- Enlazar con Pubmed o con la Biblioteca online.
- Los gráficos y las imágenes relacionadas.
- Movernos por el contenido relacionado.
- Summary and Recommendations.
- Imprimir, o enviar un enlace por correo del contenido.
- Imprimir, exportar a power point o enviar un enlace por correo de los gráficos.
- Educación para el paciente.
- Novedades.
- Actualizaciones que Cambian la Práctica Clínica.
- Calculadoras.
- Interacciones de Fármacos

3-UpToDate móvil.

- Registro.
- Funcionamiento
- Mantener acceso

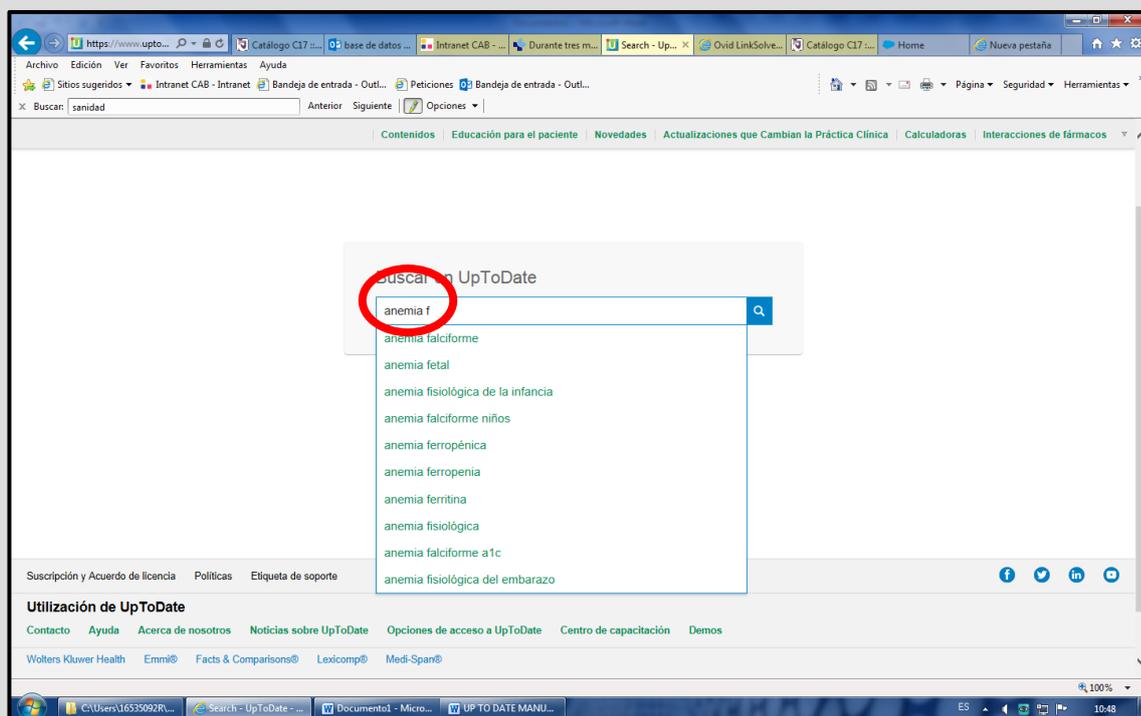
1-Qué es.

- UpToDate es una aplicación desarrollada por Wolters Kluwer que proporciona información bibliográfica muy actualizada sobre cualquier tema médico.
- Es una herramienta de apoyo para la toma de decisiones clínicas
- Su contenido se renueva cada cuatro meses.
- Está elaborada por Más de 6.700 autores, editores y revisores médicos.

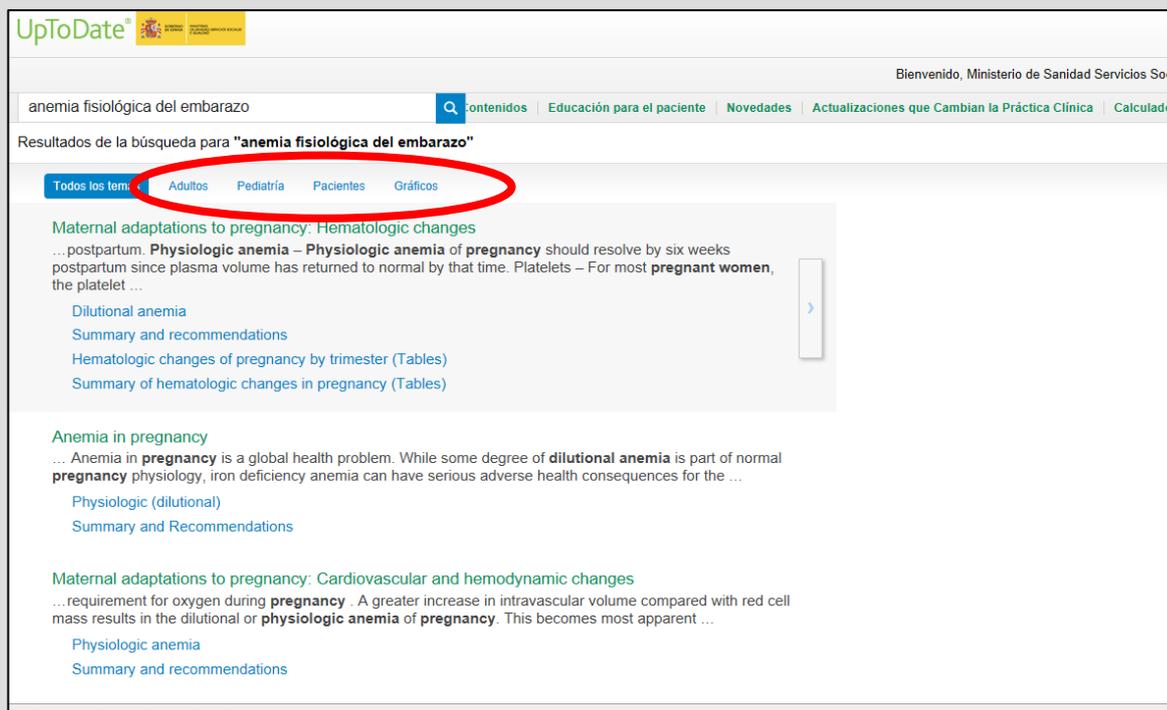
2-Cómo buscar.

Introducimos un término de búsqueda.

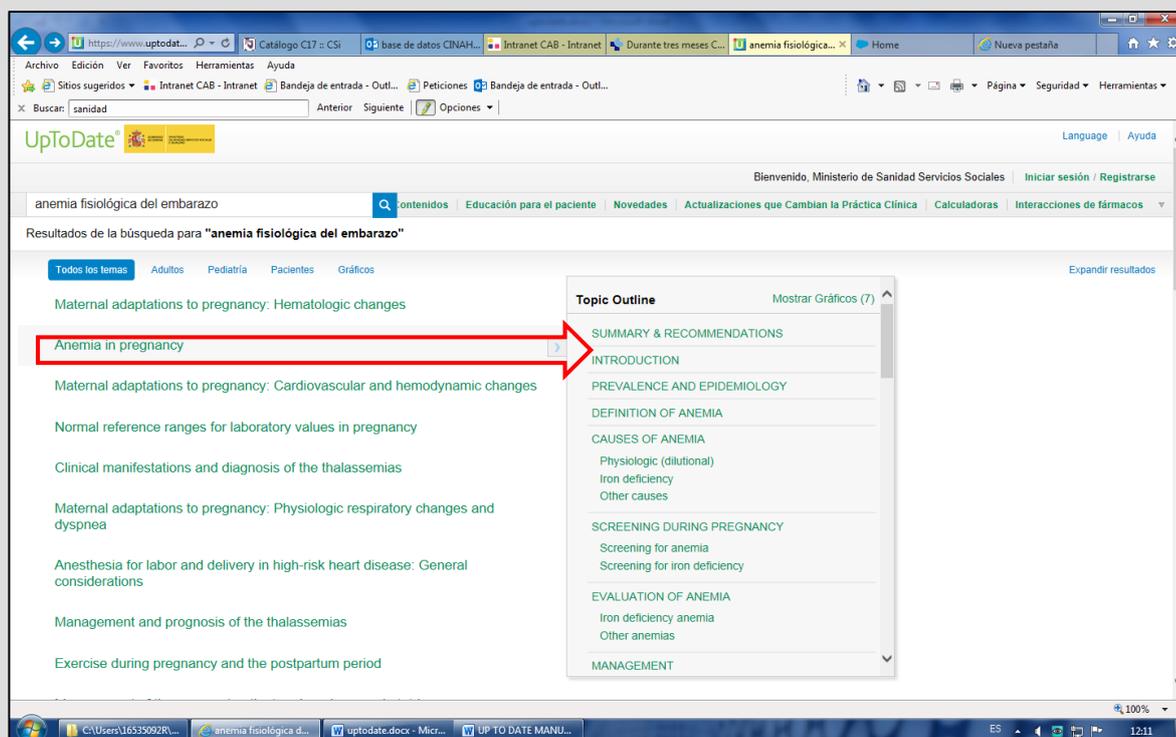
Podemos realizar la búsqueda en español, aunque los resultados van a aparecer en inglés.



Se obtiene así una lista de temas por orden de relevancia, en función de los criterios de búsqueda, que podemos priorizar por: adultos, pediatría, pacientes o gráficos.



Haciendo clic en la flecha que aparece al pasar el ratón por encima de cada tema nos aparece a su derecha un esquema de cada uno de ellos.



Si hacemos clic en el mismo tema, se accede al contenido.
 En primer lugar aparecen los autores y editores, y seguidamente la última fecha de revisión

The screenshot shows the UpToDate interface for the topic 'Anemia in pregnancy'. On the left is a 'Topic Outline' with categories like 'SUMMARY & RECOMMENDATIONS', 'INTRODUCTION', 'PREVALENCE AND EPIDEMIOLOGY', etc. The main content area is titled 'Anemia in pregnancy' and includes the following information:

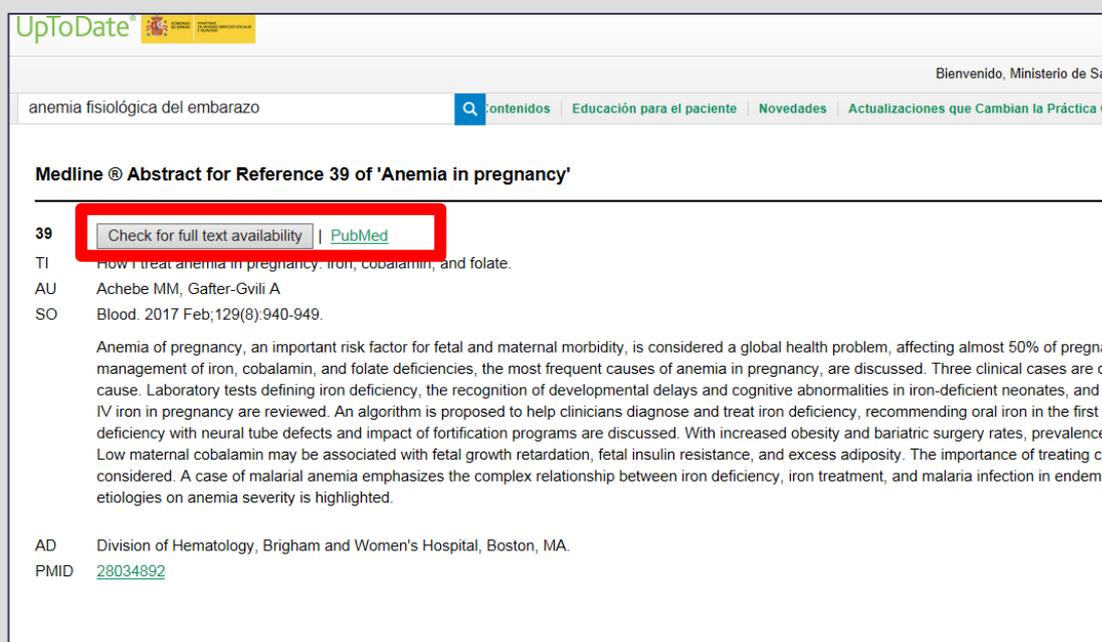
- Section Editors:** Lynn L Simpson, MD, Stanley L Schrier, MD
- Deputy Editors:** Jennifer S Tirnauer, MD, Vanessa A Barss, MD, FACOG
- Contributor Disclosures**
- Literature review current through:** Aug 2018. | **This topic last updated:** Sep 10, 2018.
- INTRODUCTION** — Anemia in pregnancy is a global health problem. While some degree of dilutional anemia is part of normal pregnancy physiology, iron deficiency anemia can have serious adverse health consequences for the mother and child. Thus, it is critical to distinguish iron deficiency anemia from physiologic anemia, as well as to identify other less common causes of anemia that may require treatment.
- This topic discusses an approach to evaluating and treating anemia during pregnancy. The general approach to anemia in adults and children and the diagnosis of iron deficiency in other populations are discussed in separate topic reviews:
- General approach to anemia – (See "[Approach to the adult with anemia](#)" and "[Approach to the child with anemia](#)".)
- Diagnosis of iron deficiency in children and adolescents – (See "[Iron deficiency in infants and children <12 years: Screening, prevention, clinical manifestations, and diagnosis](#)" and "[Iron requirements and iron deficiency in adolescents](#)".)
- Diagnosis of iron deficiency in adults – (See "[Causes and diagnosis of iron deficiency and iron deficiency anemia in adults](#)".)

Vamos a ver **los resúmenes de Medline** utilizados (Números entre paréntesis), los cuales, al pinchar en ellos,

The screenshot shows the UpToDate article for 'Iron deficiency anemia'. The text includes the following information:

- Iron deficiency anemia** — All women with anemia should have prompt testing for iron deficiency because it is the most common cause of nonphysiologic anemia in pregnancy. Microcytosis may be present, but microcytosis is a late finding of iron deficiency ([table 2](#)) and may also be caused by thalassemia. Thus, the absence of microcytosis does not eliminate the possibility of iron deficiency and the presence of microcytosis does not confirm it. (See "[Causes and diagnosis of iron deficiency and iron deficiency anemia in adults](#)", section on 'Stages of iron deficiency' and "[Microcytosis/Microcytic anemia](#)", section on 'Causes of microcytosis'.)
- When testing for iron deficiency, most women without comorbidities can be tested with a serum ferritin level alone. If low (eg, <30 ng/mL [<30 mcg/L]), this is sufficient to confirm the diagnosis of iron deficiency; levels ≥ 30 ng/mL are sufficient to eliminate the possibility of iron deficiency in the majority of cases ([39](#)).
- Borderline levels of serum ferritin may be in the range of 30 to 40 ng/mL with chronic illnesses such as diabetes, or up to 100 ng/mL with chronic kidney diseases or active collagen vascular diseases such as systemic lupus erythematosus or rheumatoid arthritis. This occurs because ferritin is an acute phase reactant. These borderline levels should prompt testing of a full set of iron studies including ferritin, serum iron, total iron binding capacity, and calculation of transferrin saturation (TSAT).
- The United States Preventive Services Task Force (USPSTF) noted that serum ferritin may have limited use during pregnancy because its concentration often decreases in late pregnancy as maternal iron stores are used to supply iron to the placental and fetal circulations ([figure 1](#)), but using hemoglobin or hematocrit measurement alone to determine iron deficiency status is indirect and imprecise ([21](#)). Other than iron deficiency, no other causes of a low serum ferritin have been identified. Iron studies as well as other tests for iron deficiency and their interpretation are discussed in more detail separately. (See "[Causes and diagnosis of iron deficiency and iron deficiency anemia in adults](#)", section on 'Iron studies (list of available tests)').
- Other anemias** — We promptly evaluate for other causes of anemia if there are any features of the anemia that suggest another condition or if testing for iron deficiency is negative (ie, if iron stores are adequate). Examples of features that suggest another cause include:
 - Extreme microcytosis (eg, mean corpuscular volume [MCV] <80 fL), suggestive of thalassemia

nos van a **enlazar con Pubmed**, o con la **Biblioteca online**, para ver si tenemos el contenido completo.



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anemia fisiológica del embarazo

Contenidos | Educación para el paciente | Novedades | Actualizaciones que Cambian la Práctica Clínica

Medline ® Abstract for Reference 39 of 'Anemia in pregnancy'

39 [Check for full text availability](#) | [PubMed](#)

TI How I treat anemia in pregnancy: iron, cobalamin, and folate.

AU Achebe MM, Gafter-Gvili A

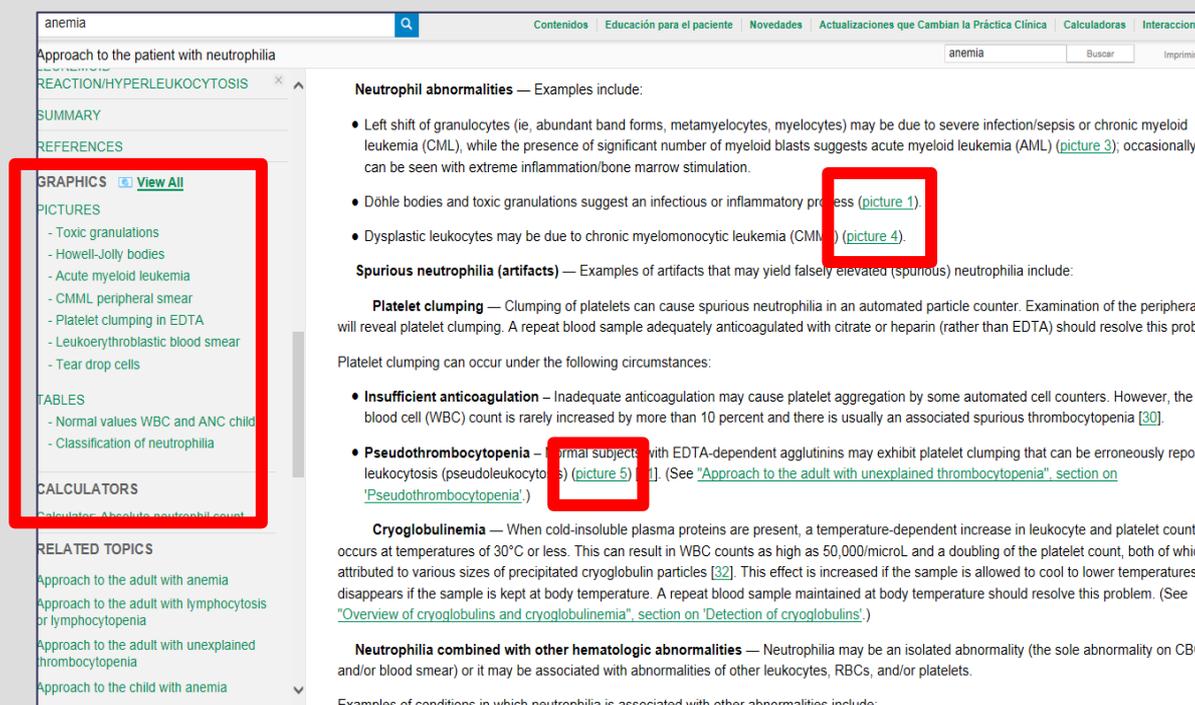
SO Blood. 2017 Feb;129(8):940-949.

Anemia of pregnancy, an important risk factor for fetal and maternal morbidity, is considered a global health problem, affecting almost 50% of pregnant women. The management of iron, cobalamin, and folate deficiencies, the most frequent causes of anemia in pregnancy, are discussed. Three clinical cases are presented. Laboratory tests defining iron deficiency, the recognition of developmental delays and cognitive abnormalities in iron-deficient neonates, and the use of intravenous (IV) iron in pregnancy are reviewed. An algorithm is proposed to help clinicians diagnose and treat iron deficiency, recommending oral iron in the first trimester and IV iron in the second and third trimesters. The prevalence of iron deficiency with neural tube defects and impact of fortification programs are discussed. With increased obesity and bariatric surgery rates, prevalence of iron deficiency is increasing. Low maternal cobalamin may be associated with fetal growth retardation, fetal insulin resistance, and excess adiposity. The importance of treating cobalamin deficiency is considered. A case of malarial anemia emphasizes the complex relationship between iron deficiency, iron treatment, and malaria infection in endemic areas. Etiologies on anemia severity is highlighted.

AD Division of Hematology, Brigham and Women's Hospital, Boston, MA.

PMID [28034892](#)

Podemos ver los **gráficos y las imágenes relacionadas** con el tema bien desde el panel de la izquierda, o bien en el mismo texto, señalado entre paréntesis:



anemia

Contenidos | Educación para el paciente | Novedades | Actualizaciones que Cambian la Práctica Clínica | Calculadoras | Interacciones

Approach to the patient with neutrophilia

REACTION/HYPERLEUKOCYTOSIS

SUMMARY

REFERENCES

GRAPHICS [View All](#)

PICTURES

- Toxic granulations
- Howell-Jolly bodies
- Acute myeloid leukemia
- CMMML peripheral smear
- Platelet clumping in EDTA
- Leukoerythroblastic blood smear
- Tear drop cells

TABLES

- Normal values WBC and ANC child
- Classification of neutrophilia

CALCULATORS

Calculator: Absolute neutrophil count

RELATED TOPICS

- Approach to the adult with anemia
- Approach to the adult with lymphocytosis or lymphocytopenia
- Approach to the adult with unexplained thrombocytopenia
- Approach to the child with anemia

Neutrophil abnormalities — Examples include:

- Left shift of granulocytes (ie, abundant band forms, metamyelocytes, myelocytes) may be due to severe infection/sepsis or chronic myeloid leukemia (CML), while the presence of significant number of myeloid blasts suggests acute myeloid leukemia (AML) ([picture 3](#)), occasionally can be seen with extreme inflammation/bone marrow stimulation.
- Döhle bodies and toxic granulations suggest an infectious or inflammatory process ([picture 1](#)).
- Dysplastic leukocytes may be due to chronic myelomonocytic leukemia (CMML) ([picture 4](#)).

Spurious neutrophilia (artifacts) — Examples of artifacts that may yield falsely elevated (spurious) neutrophilia include:

Platelet clumping — Clumping of platelets can cause spurious neutrophilia in an automated particle counter. Examination of the peripheral smear will reveal platelet clumping. A repeat blood sample adequately anticoagulated with citrate or heparin (rather than EDTA) should resolve this problem.

Platelet clumping can occur under the following circumstances:

- **Insufficient anticoagulation** — Inadequate anticoagulation may cause platelet aggregation by some automated cell counters. However, the white blood cell (WBC) count is rarely increased by more than 10 percent and there is usually an associated spurious thrombocytopenia [30].
- **Pseudothrombocytopenia** — Normal subjects with EDTA-dependent agglutinins may exhibit platelet clumping that can be erroneously reported as leukocytosis (pseudoleukocytosis) ([picture 5](#)) [31]. (See "Approach to the adult with unexplained thrombocytopenia", section on "Pseudothrombocytopenia".)

Cryoglobulinemia — When cold-insoluble plasma proteins are present, a temperature-dependent increase in leukocyte and platelet counts occurs at temperatures of 30°C or less. This can result in WBC counts as high as 50,000/microL and a doubling of the platelet count, both of which disappear if the sample is kept at body temperature. A repeat blood sample maintained at body temperature should resolve this problem. (See "Overview of cryoglobulins and cryoglobulinemia", section on "Detection of cryoglobulins".)

Neutrophilia combined with other hematologic abnormalities — Neutrophilia may be an isolated abnormality (the sole abnormality on CBC and/or blood smear) or it may be associated with abnormalities of other leukocytes, RBCs, and/or platelets.

Examples of conditions in which neutrophilia is associated with other abnormalities include:

Podemos **movernos por el contenido relacionado**, de un lugar a otro del documento, pinchando encima del texto subrayado.

been described. The percentage of CD4 + lymphocytes is generally unchanged.

G-CSF side effects — G-CSF is generally well-tolerated, although musculoskeletal complaints (especially bone pain) occur in as many as 10% of patients. Other side effects include dysuria and local reactions at the administration site. Mild elevations in serum aminotransferases, lactate dehydrogenase, and uric acid have also been described. Tachyphylaxis does not accompany long-term use. (See ["Introduction to recombinant hematopoietic growth factors"](#), section on 'Toxicity of colony-stimulating factors'.)

Stimulation of HIV replication or an acceleration of disease progression during therapy has generally not been observed. However, a preliminary report from a study in which G-CSF was given to mobilize stem cells found transient HIV RNA increases in approximately 50 percent of patients [30]. This appears to be a more important issue with GM-CSF. (See ["Possible stimulation of HIV replication"](#), below.)

Dose — The typical starting dose of rG-CSF is 1 to 5 mcg/kg per day subcutaneously; the dose can be escalated every three days to a maximum of 10 mcg/kg per day. Response in ANC is generally evident in 48 hours. After the ANC reaches the targeted range of 1000 to 2000/microL, maintenance therapy with 300 mcg three times each week is common; however, the dose required to maintain the target ANC varies markedly among patients from one to seven doses per week.

[Pegfilgrastim](#), a long-acting colony stimulating factor formed by the conjugation of G-CSF with a 20-kD polyethylene glycol moiety, is used for the prophylaxis of chemotherapy-induced neutropenia; its role in the management of HIV-associated neutropenia has not been defined.

Treatment with GM-CSF — GM-CSF is not used as often as G-CSF because of theoretical concern that GM-CSF may increase HIV replication. The beneficial impact of recombinant GM-CSF on neutropenia has been well described among patients with HIV. Given its effects on a broad range of cells, increases in neutrophils, monocytes, eosinophils, and, least commonly, lymphocytes are characteristic of therapy. Like G-CSF, GM-CSF has demonstrated efficacy in improving the hematologic tolerance of many therapies, including AZT [31], [ganciclovir](#) [32], and combination chemotherapy regimens for non-Hodgkin lymphoma [33] and Kaposi sarcoma [34].

The starting dose of GM-CSF is generally 250 mcg/day. Dose modifications and maintenance schedules are identical to those for G-CSF (with doses between 5 to 10 mcg/kg per day administered one to seven days a week, titrated to patient response and tolerance).

Possible stimulation of HIV replication — The major concern with GM-CSF therapy is the potential for stimulation of HIV replication. This phenomenon was initially demonstrated during in vitro experiments with mononuclear phagocytes exposed to GM-CSF or IL-3 [35]. Later in vitro studies revealed upregulation of CCR5 coreceptor expression and enhanced HIV infectivity in fresh human monocytes exposed to GM-CSF [36].

En “**Summary and Recommendations**” encontramos el resumen de las recomendaciones más importantes que necesitamos conocer para tomar una decisión.

reumatoide artritis

Contenidos Educación para el paciente Novedades Actualizaciones que Cambian la Práctica Clínica Calculadoras Interacciones de fármacos

Initial treatment of rheumatoid arthritis in adults

SUMMARY & RECOMMENDATIONS

- In all patients with active rheumatoid arthritis (RA), we recommend treatment with a disease-modifying antirheumatic drug (DMARD), rather than use of antiinflammatory agents and/or glucocorticoids alone and delay of DMARD therapy. (Grade 1B) Additional principles for the treatment of RA include achievement and maintenance of tight control of disease activity with the ideal goal of remission; use of antiinflammatory agents, including glucocorticoids, only as adjunctive agents; and participation of a rheumatologist in the evaluation and ongoing care of the patient. (See ["General principles"](#) above and ["General principles of management of rheumatoid arthritis in adults"](#).)
- Patient education and other nonpharmacologic and preventive therapies are needed for all patients with RA. (See ["Nonpharmacologic and preventive therapies"](#) above and ["Nonpharmacologic therapies and preventive measures for patients with rheumatoid arthritis"](#).)
- In patients with active RA we suggest methotrexate (MTX) as the initial DMARD, rather than another single nonbiologic or biologic DMARD or combination therapy. (Grade 2B) Doses are increased as tolerated and as needed, up to 25 mg/week, to control symptoms and signs of arthritis. Subcutaneous administration may be of benefit in patients with an inadequate response to orally administered MTX at a dose of 15 to 25 mg/week of MTX. (See ["Initial therapy with methotrexate"](#) above.)
- In patients who are unable or unwilling to take MTX, we use an alternative nonbiologic or biologic DMARD therapy. (See ["Alternatives to MTX"](#) above.)
- In patients with active RA, we use antiinflammatory drug therapy with nonsteroidal antiinflammatory drugs (NSAIDs) or glucocorticoids, preferably on a temporary basis, to quickly achieve control of signs and symptoms of disease. We use NSAIDs in all patients without contraindications to their use. In patients with more severe disease or with moderate disease resistant to a brief course of NSAIDs, we suggest the use of glucocorticoids (Grade 2B). We then taper and withdraw these medications once DMARDs have taken effect. We use intraarticular injection of low-dose glucocorticoids to reduce synovitis in particular joints that are more inflamed than others. When clinically indicated, joint fluid should be obtained to exclude infection. (See ["NSAIDs"](#) above and ["Glucocorticoids"](#) above.)

Las recomendaciones pueden estar graduadas según la fortaleza de la evidencia, y de su calidad. Lo vemos si pinchamos encima de la gradación.

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Grade 1B recommendation

A Grade 1B recommendation is a strong recommendation, and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.

Explanation:

A Grade 1 recommendation is a strong recommendation. It means that we believe that if you follow the recommendation, you will be doing more good than harm for most, if not all of your patients.

Grade B means that the best estimates of the critical benefits and risks come from randomized, controlled trials with important limitations (eg, inconsistent results, methodologic flaws, imprecise results, extrapolation from a different population or setting) or very strong evidence of some other form. Further research (if performed) is likely to have an impact on our confidence in the estimates of benefit and risk, and may change the estimates.

Recommendation grades

1. Strong recommendation: Benefits clearly outweigh the risks and burdens (or vice versa) for most, if not all, patients
2. Weak recommendation: Benefits and risks closely balanced and/or uncertain

Evidence grades

- A. High-quality evidence: Consistent evidence from randomized trials, or overwhelming evidence of some other form
- B. Moderate-quality evidence: Evidence from randomized trials with important limitations, or very strong evidence of some other form
- C. Low-quality evidence: Evidence from observational studies, unsystematic clinical observations, or from randomized trials with serious flaws

For a complete description of our grading system, please see the UpToDate editorial policy.

También haciendo clic en los hipervínculos de los fármacos a utilizar,

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Initial treatment of rheumatoid arthritis in adults Buscar Paciente Imprimir Cor

SUMMARY AND RECOMMENDATIONS

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vemos la información relacionada con ese fármaco.

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Methotrexate: Drug information

reumatoid arthritis | Buscar

Language

Topic Outline

- ALERT: US Boxed Warning
- Brand Names: US
- Brand Names: Canada
- Pharmacologic Category
- Dosing: Adult
- Dosing: Renal Impairment: Adult
- Dosing: Hepatic Impairment: Adult
- Dosing: Pediatric
- Dosing: Renal Impairment: Pediatric
- Dosing: Hepatic Impairment: Pediatric
- Dosing: Geriatric
- Dosing: Obesity
- Dosing: Adjustment for Toxicity
- Dosage Forms

Methotrexate: Drug information Lexicomp®

[Access Lexicomp Online here.](#)
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(For additional information see "[Methotrexate: Patient drug information](#)" and see "[Methotrexate: Pediatric drug information](#)")

For abbreviations and symbols that may be used in Lexicomp ([show table](#))

ALERT: US Boxed Warning

Intrathecal and high-dose therapy:

Use only preservative-free methotrexate formulations and diluents for intrathecal and high-dose therapy. Do NOT formulations or diluents containing preservatives for intrathecal and high-dose therapy because they contain benz alcohol.

Appropriate use:

Because of the possibility of serious toxic reactions (which can be fatal), methotrexate should be used only in life

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anemia | Buscar | Imprimir | Compartir

estations of HIV infection: Neutropenia

Hematologic manifestations of HIV infection: Neutropenia

Authors: Timothy J Friel, MD, David T Scadden, MD
Section Editor: Peter Newburger, MD
Deputy Editor: Alan G Rosmarin, MD
Contributor Disclosures

All topics are updated as new evidence becomes available and our [peer review process](#) is complete.
Literature review current through: Aug 2018. | **This topic last updated:** Nov 22, 2017.

INTRODUCTION — Shortly after the first description of the acquired immunodeficiency syndrome (AIDS), cytopenias of all major blood cell lines were increasingly recognized in patients with human immunodeficiency virus (HIV) infection. As an example, in one early series of patients with AIDS, anemia was noted in approximately 70 percent, lymphopenia in 70 percent, neutropenia in 50 percent, and thrombocytopenia in 40 percent [1].

The incidence of the various cytopenias correlates directly with the degree of immunosuppression. As an example, the incidence of neutropenia varies from 5 to 10 percent in the early, asymptomatic stages of infection to as high as 50 to 70 percent of patients with advanced disease. The degree of neutropenia may be overestimated from the total white blood cell count due to the associated lymphopenia (as evidenced by the low CD4 cell count).

However, isolated abnormalities, including neutropenia, may be encountered as the initial presentation of HIV infection. As a result, HIV infection should be considered in the assessment of patients presenting with any type of cytopenia. In fact, in one large series of more than 370,000 Danish patients, baseline neutropenia was identified in approximately 1 percent of all patients; during four years of follow-up, the presence of neutropenia had a stronger association with the incident diagnosis of HIV than any other viral infection [2].

This topic review will discuss the causes, clinical impact, and treatment of neutropenia in patients with HIV infection. HIV-associated anemia, thrombocytopenia, coagulation defects, and lymphopenia are discussed separately. (See "[Hematologic manifestations of HIV infection: Anemia](#)" and "[Hematologic manifestations of HIV infection: Thrombocytopenia and coagulation abnormalities](#);" and "[Techniques and interpretation of measurement of the CD4 cell count in HIV-infected patients](#)".)

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Mean corpuscular volume in children

Age (years)	Hemoglobin (g/dL)		Hematocrit (%)		MCV (fL)	
	Lower limit*	50 th percentile	Lower limit*	50 th percentile	Lower limit*	Upper limit*
1	11	37	32	80	71	89
2	11	36	31	77	63	88
3	11	37	33	82	74	89
4	11	36	32	80	64	89
5	11.7	38	34	84	77	91
6	11	37	33	83	67	91
7	12	40	35	85	78	91
8	11.2	38	34	84	72	92
9	12.3	40	36	87	80	94
10	12.6	42	36	87	80	94
11	10.6	38	33	86	71	95

También tenemos acceso a **Educación para el paciente**, donde podemos elegir ver “lo básico”, o lo “más allá de lo básico”

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Patient Education

UpToDate offers two levels of content for patients:

- The Basics** are short reviews. They are written in accordance with plain language principles and answer the four or five most important questions a person might have about a medical problem.
- Beyond the Basics** are longer, more detailed reviews. They are best for readers who want detailed information and are comfortable with some medical terminology.

This site complies with the HONcode standard for trustworthy health information: [verify here](#).

To browse the available patient education topics in UpToDate, click on a category below.

Allergies and asthma	Ear, nose, and throat	Lung disease
Arthritis	Eyes and vision	Men's health issues
Autoimmune disease	Gastrointestinal system	Mental health
Blood disorders	General health	Pregnancy and childbirth
Bones, joints, and muscles	Heart and blood vessel disease	Senior health
Brain and nerves	HIV and AIDS	Skin, hair, and nails
Cancer	Hormones	Sleep
Children's health	Infections and vaccines	Surgery
Diabetes	Kidneys and urinary system	Travel health
Diet and weight	Liver disease	Women's health issues

“Lo básico” podemos verlo también en castellano. Lo “Más allá de lo básico” solo en inglés.

The screenshot shows the UpToDate website interface. At the top, there is a search bar with the text "Buscar en UpToDate" and a magnifying glass icon. To the right of the search bar are navigation links: "Contenidos", "Educación para el paciente", and "Nov". Below the search bar, the page title is "Allergies and asthma". There are two tabs: "The Basics" (selected) and "Beyond the Basics". A paragraph explains: "The Basics" are short (1 to 3 page) articles written in plain language. They answer the 4 or 5 most important questions a person might have about a medical problem. These articles are categorized into "Allergies" and "Anaphylaxis". Under "Allergies", there are six articles listed, each with a "View in English" button. Under "Anaphylaxis", there are three articles listed, each with a "View in English" button. At the bottom, under "Angioedema", there is one article listed with a "View in English" button.

En “**Novedades**” encontramos las novedades y actualizaciones que el equipo editorial considera más importantes dentro de cada especialidad.

The screenshot shows the UpToDate website interface. At the top, there is a search bar with the text "Buscar en UpToDate" and a magnifying glass icon. To the right of the search bar are navigation links: "Contenidos", "Educación para el paciente", "Novedades" (highlighted with a red box), and "Actualizaciones que Cambian la Práctica Clínica". Below the search bar, the page title is "What's New". A paragraph explains: "Our editors select a small number of the most important updates and share them with you via What's New." Below this, there is a section titled "Find Out What's New In:" followed by a grid of medical specialties. The specialties are listed in three columns:

Practice Changing UpDates	Gastroenterology and hepatology	Oncology
Allergy and immunology	General surgery	Palliative care
Anesthesiology	Geriatrics	Pediatrics
Cardiovascular medicine	Hematology	Primary care
Dermatology	Hospital medicine	Psychiatry
Drug therapy	Infectious diseases	Pulmonary and critical care medicine
Emergency medicine	Nephrology and hypertension	Rheumatology
Endocrinology and diabetes mellitus	Neurology	Sleep medicine
Family medicine	Obstetrics and gynecology	Sports medicine (primary care)

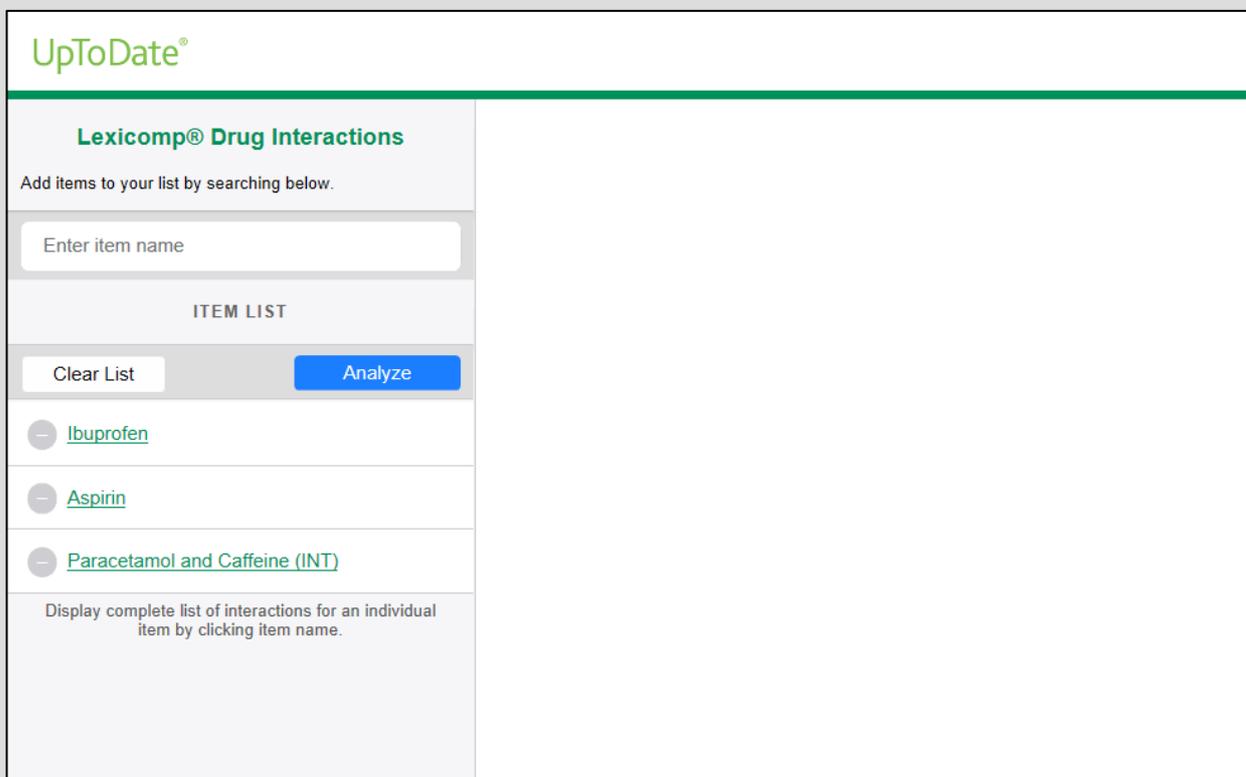
Las “**Actualizaciones que Cambian la Práctica Clínica**” son cambios que el equipo editorial considera tan importantes que pueden tener un impacto inmediato y cambiar la práctica clínica. Estos cambios los vemos en el índice de la izquierda en orden cronológico.

The screenshot shows the UpToDate website interface. At the top, there is a search bar and a navigation menu. The 'Actualizaciones que Cambian la Práctica Clínica' link is highlighted with a red box. Below the navigation, the main content area displays 'Practice Changing Updates' with authors, contributor disclosures, and a list of updates. A sidebar on the left provides a 'Topic Outline' with categories like 'CARDIOVASCULAR MEDICINE; HOSPITAL MEDICINE; GENERAL SURGERY (August 2018)', 'GASTROENTEROLOGY AND HEPATOLOGY; PEDIATRICS; ALLERGY AND IMMUNOLOGY (July 2018)', 'ONCOLOGY (July 2018)', 'HEMATOLOGY (July 2018)', 'NEPHROLOGY AND HYPERTENSION; HOSPITAL MEDICINE; PULMONARY AND CRITICAL CARE MEDICINE; EMERGENCY MEDICINE (ADULT AND PEDIATRIC) (June 2018)', and 'INFECTIOUS DISEASES; OBSTETRICS, GYNECOLOGY AND WOMEN'S HEALTH (June 2018)'. Each category lists specific updates.

La opción “**Calculadoras**”, está disponible por lista alfabética, por especialidad, o también tenemos una caja de búsqueda:

The screenshot shows the UpToDate website interface for the 'Calculadoras' section. At the top, there is a search bar and a navigation menu. The 'Calculadoras' link is highlighted with a red box. Below the navigation, the main content area displays 'View By Specialty' and 'List Alphabetically' buttons, along with a search box for calculators. The content area lists various calculators under categories like 'ALLERGY AND IMMUNOLOGY CALCULATORS' and 'ANESTHESIOLOGY CALCULATORS'. The 'ALLERGY AND IMMUNOLOGY CALCULATORS' section includes 'Clinical Criteria', 'Temperature unit conversions', 'Weight unit conversions', 'Medical Equations', 'Absolute eosinophil count', 'Conventional (gravimetric, imperial, US) unit to SI unit conversions: Chemistry and endocrine tests', 'Conventional (gravimetric, imperial, US) unit to SI unit conversions: Immunology lab values', 'SI unit to conventional (gravimetric, imperial, US) unit conversions: Chemistry and endocrine tests', and 'SI unit to conventional (gravimetric, imperial, US) unit conversions: Immunology lab values'. The 'ANESTHESIOLOGY CALCULATORS' section includes 'Clinical Criteria'.

En “**Interacciones de Fármacos**” Podemos introducir una lista ilimitada de fármacos para analizar las posibles interacciones entre ellos, o de productos naturales, como té verde, ajo, etc. (Los nombres deben estar en inglés)



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Add items to your list by searching below.

Enter item name

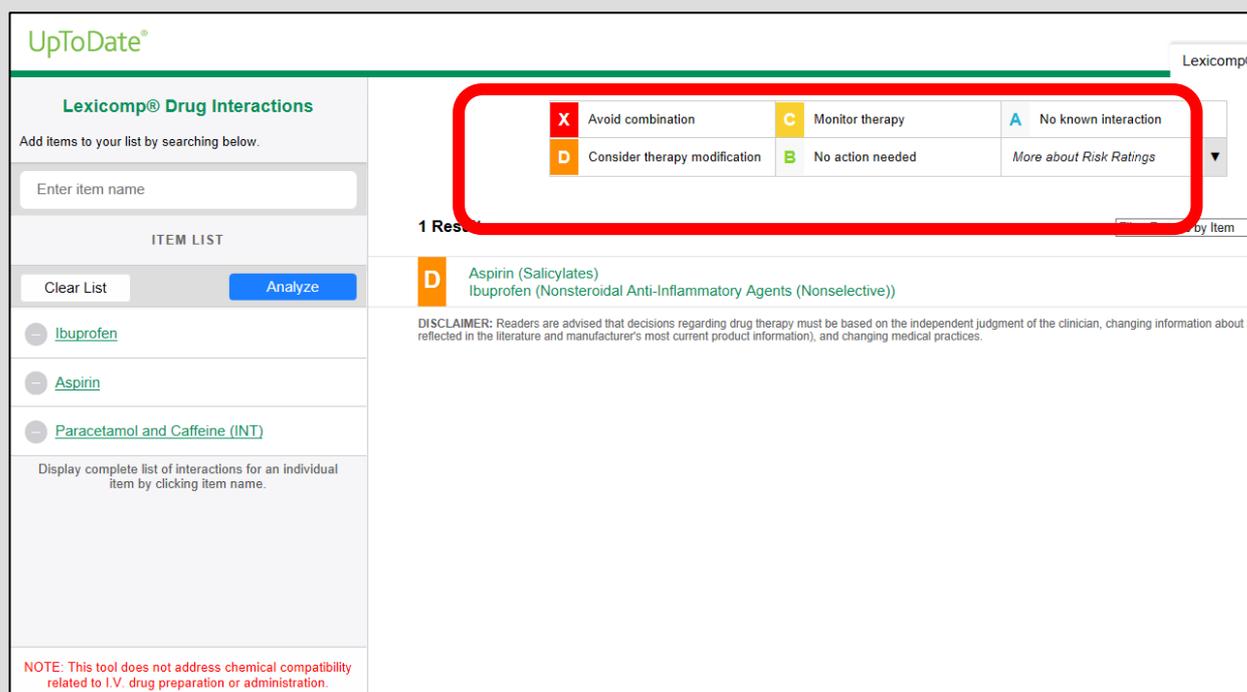
ITEM LIST

Clear List Analyze

- Ibuprofen
- Aspirin
- Paracetamol and Caffeine (INT)

Display complete list of interactions for an individual item by clicking item name.

Nos va a mostrar el resultado de las interacciones entre ellos, según una gradación de la A la X.



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Lexicomp® Drug Interactions

Add items to your list by searching below.

Enter item name

ITEM LIST

Clear List Analyze

- Ibuprofen
- Aspirin
- Paracetamol and Caffeine (INT)

Display complete list of interactions for an individual item by clicking item name.

1 Result

X Avoid combination	C Monitor therapy	A No known interaction
D Consider therapy modification	B No action needed	More about Risk Ratings

D Aspirin (Salicylates)
Ibuprofen (Nonsteroidal Anti-Inflammatory Agents (Nonselective))

DISCLAIMER: Readers are advised that decisions regarding drug therapy must be based on the independent judgment of the clinician, changing information about a reflected in the literature and manufacturer's most current product information), and changing medical practices.

NOTE: This tool does not address chemical compatibility related to I.V. drug preparation or administration.

Si queremos tener más información sobre alguna de éstas interacciones hacemos clic sobre ella, y veremos una explicación de esa interacción, y que podemos hacer para tratar a ese paciente (reducir la dosis, o sustituir uno de los fármacos).

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Lexicomp® Drug Interactions

Add items to your list by searching below.

ITEM LIST

Clear List Analyze

- [Ibuprofen](#)
- [Aspirin](#)
- [Paracetamol and Caffeine \(INT\)](#)

Display complete list of interactions for an individual item by clicking item name.

NOTE: This tool does not address chemical compatibility related to I.V. drug preparation or administration.

Title Salicylates / Nonsteroidal Anti-Inflammatory Agents (Nonselective) [Print](#)

Risk Rating D: Consider therapy modification

Summary Nonsteroidal Anti-Inflammatory Agents (Nonselective) may enhance the adverse/toxic effect of Salicylates. An increased risk of bleeding may be associated with use of this combination. Nonsteroidal Anti-Inflammatory Agents (Nonselective) may diminish the cardioprotective effect of Salicylates. Salicylates may decrease the serum concentration of Nonsteroidal Anti-Inflammatory Agents (Nonselective). **Severity** Major **Reliability Rating** Good

Patient Management Monitor for increased risk of bleeding during concomitant use of nonselective NSAIDs and salicylates. Ibuprofen, and possibly other nonselective NSAIDs, may reduce the cardioprotective effects of aspirin. It seems prudent to avoid regular, frequent use of ibuprofen in patients receiving aspirin for its cardioprotective effects. Alternative analgesics (e.g., acetaminophen) may be a safer choice. Patients may require counseling about the appropriate timing of ibuprofen and aspirin dosing. Ibuprofen should be administered 30-120 minutes after immediate release aspirin, 2 to 4 hours after extended release aspirin, or at least 8 hours before aspirin.

Nonsteroidal Anti-Inflammatory Agents (Nonselective) Interacting Members Aceclofenac, Acemetacin, Dexibuprofen, Dexketoprofen, Diclofenac (Systemic), Diclofenac (Topical), Diflunisal, Dipyrrone, Etodolac, Etofenamate, Fenoprofen*, Floctafenine, Flurbiprofen (Systemic), Ibuprofen*, Ibuprofen (Topical), Indomethacin*, Ketoprofen, Ketorolac (Nasal), Ketorolac (Systemic), Lomoxicam, Loxoprofen, Meclofenamate*, Mefenamic Acid, Meloxicam, Nabumetone, Naproxen*, Oxaprozin, Pelubiprofen, Phenylbutazone, Piroxicam (Systemic)*, Piroxicam (Topical), Propyphenazone, Sulindac*, Tenoxicam, Tiaprofenic Acid, Tolfenamic Acid, Tolmetin*, Zaltoprofen

Salicylates Interacting Members Aminosalicilyc Acid, Aspirin*, Bismuth Subsalicylate, Choline Salicylate, Magnesium Salicylate, Salsalate, Sodium Salicylate, Triflusal

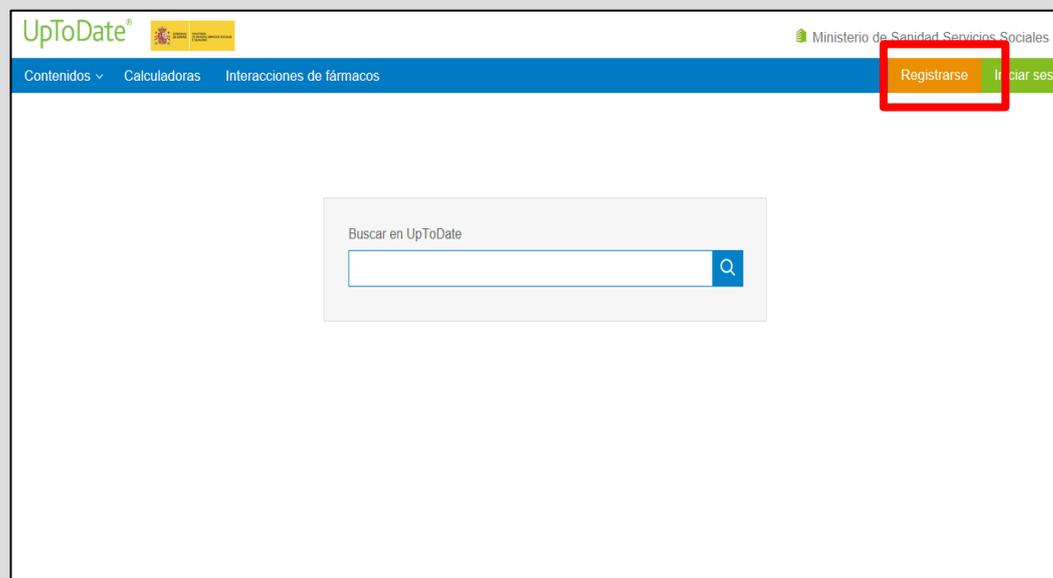
Exception Choline Magnesium Trisaliclyate

* Denotes agent(s) specifically implicated in clinical data. Unmarked agents are listed because they have properties similar to marked agents, and may respond so within the context of the stated interaction.

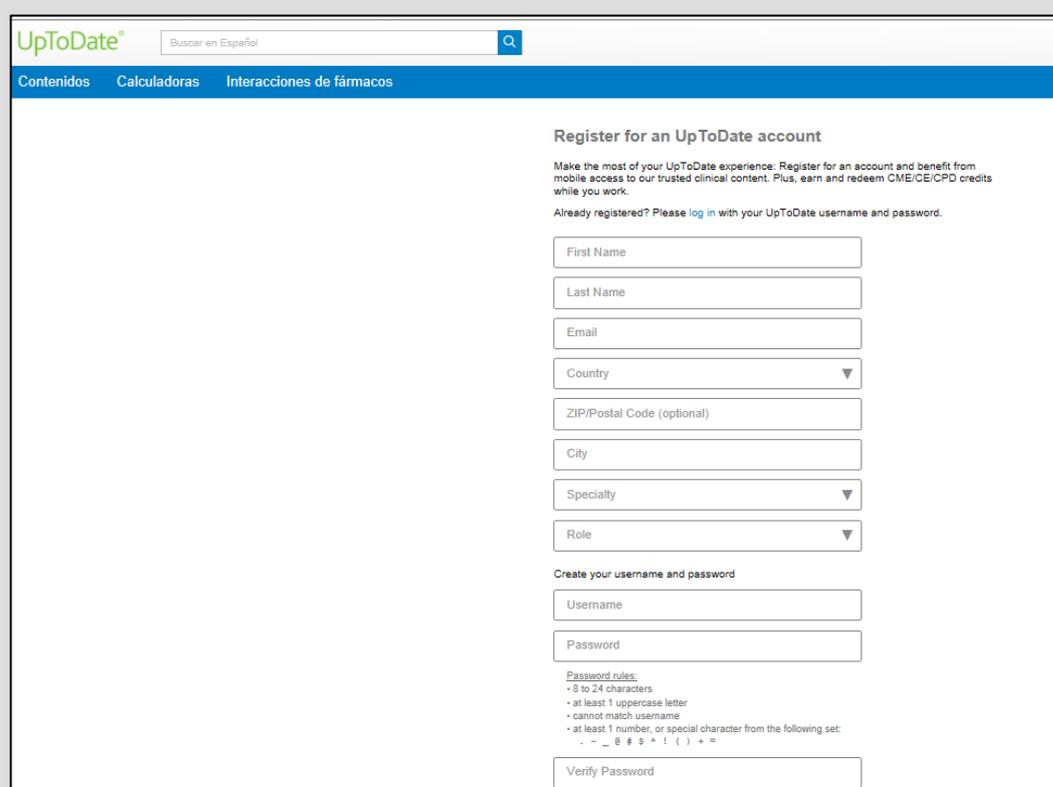
Discussion The combination of a salicylate and an NSAID may increase the risk of gastrointestinal bleeding. Further, aspirin has been noted to decrease serum concentrations of a variety of nonsteroidal anti-inflammatory agents (NSAIDs), sometimes by more than 50% (e.g., flurbiprofen).^{1,2,3,4,5,6,7,8,9,10,11,12} The interactions appear to be of minimal clinical significance. The mechanism(s) for these

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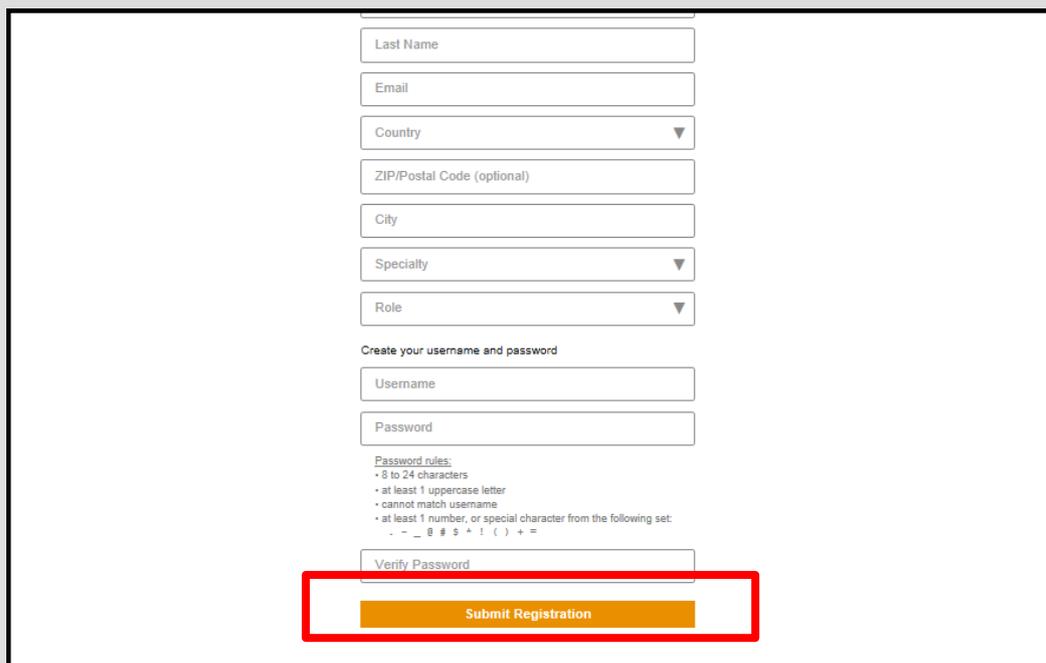
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Haremos clic en “Submit Registration”:



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 Specialty
 Role
 Create your username and password
 Username
 Password

Password rules:
 • 8 to 24 characters
 • at least 1 uppercase letter
 • cannot match username
 • at least 1 number, or special character from the following set:
 . - _ @ # \$ % ^ & * ! () + =

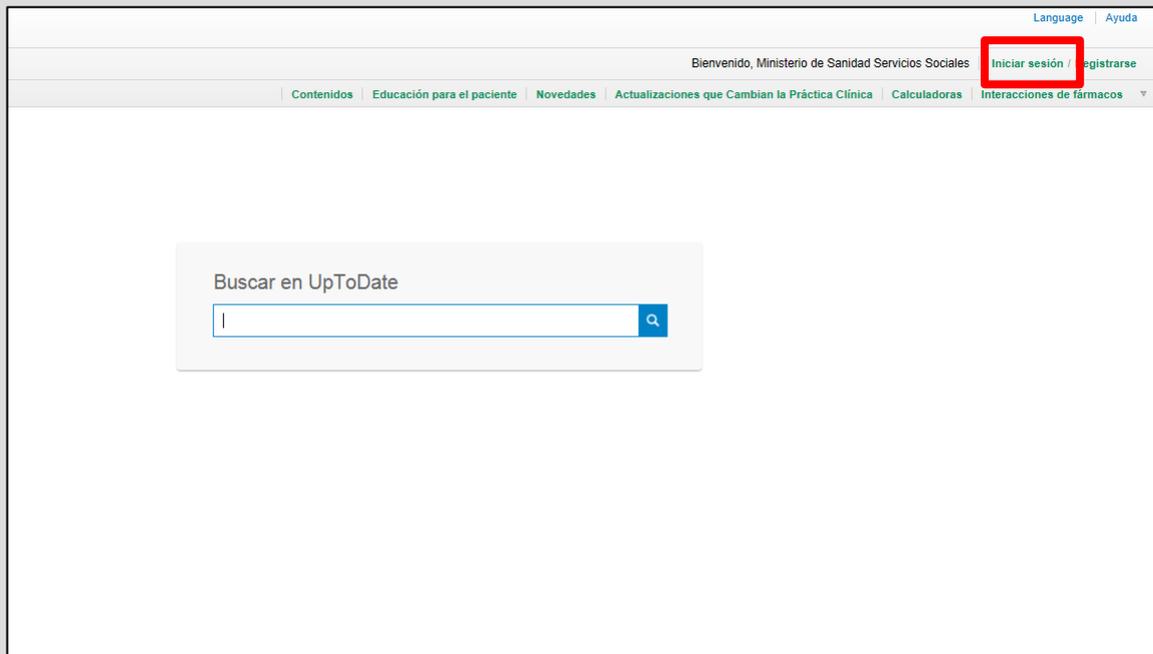
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