日本の診療ガイドライン整備への基礎研究

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日本医師会総合政策研究機構
（日医総研）

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目次

まえがき

この報告書は既に診療ガイドラインを数多く作成し、医療現場で広く実践している英語圏とくに米国の実状を調査紹介し、これから診療ガイドラインを整備しようとしている日本が参考とすることを目的としたものである。英語圏では医療のあらゆる領域で日々刻々と新しい診療ガイドラインがつくられデータベースに収載されている。本調査は常に変貌を遂げ続けるデータベースを一時点で捉えたものであり、動画撮影ではなくいわばスナップショットに相当する。こうすることで、診療ガイドライイン整備状況の全体像がむしろ理解しやすくなったと考える。添付資料として各学会等の団体ごとに整理した診療ガイドライン一覧を掲載するので、日本の各学会が診療ガイドラインを作成していく際の参考にしていただければ幸いである。また、偏った価値判断で特定の目的のためのみに診療ガイドラインが作られていくことを避け、国民にとって真に有益な診療ガイドラインを作成していくための診療ガイドライン作成機構の設立も本文中に提唱させていただく。この報告書の原文は日医総研主任研究員の桑間が、データベースの整理等は同主任研究員の上野が担当した。尚、この報告書の内容は日医総研ホームページ（http://www.jmari.med.or.jp/）からも近日電子媒体として閲覧可能となる予定である。この報告書が良質な日本版診療ガイドライン整備に役立つことを希望する。

1999 年 3 月

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Ⅰ．総論

医学の急速な進歩と情報化社会の到来によって、医療を取り巻く環境が急速に変化している。多くの異なる情報が多数発表されるようになり、医療従事者は溢れる情報の中から重要で正しいものだけを選択しながら日々の診療に役だてることを求められるようになった。一説によれば、最新の医療水準を維持するために医師は毎日２０近い論文に目を通す必要があるといわれるくらいである。しかし、現実には各医師個人がこのような努力をし続けることは不可能であり、何らかの効率の良い方法で重要な情報を抽出し、この情報を便利な形で共有することが必須となってきた。

日々の診療ではありとあらゆる状況に対して医師は最良の診療判断を下さなければならないが、診療判断の助けになるような標準的医療行為指針が現在の日本では整備されておらず、各医師個人レベルで試行錯誤を繰り返しながら判断をし続けなければならない現状である。多くの医師が、正しい治療をしているのか否か確信が持ちにくい不安を抱えた状況である。

そこで、診療で想定される代表的な状況に対しては、標準的対処法を決めておくことが重要となり、これがガイドラインと呼ばれるものである。ガイドライン作成の過程では、現時点で最も信頼性の高い情報を見つけて根拠とし、その根拠に様々な立場の人の価値観を反映させて最終的な合意を形成することが基本となる。また、ある一定期間を経た後には、新しい情報や社会の価値観の変化を加味してガイドラインの改定がなされつづけることも重要だ。

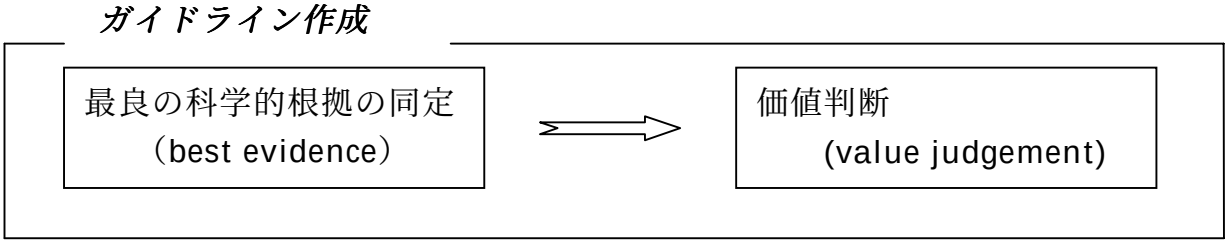
今回の研究では、ガイドライン作成の先進国である英語国圏の現状を分析し、日本のガイドライン作成で取り入れるべき点と、米国が経験したマイナス面を整理し、これから日本がガイドライン整備をしていく際の参考になることを期待するものである。

Ⅱ．診療ガイドライン作成過程の理念

ガイドライン作成の基本理念は、最近になって急速にその考えが広がりつつある Evidence Based Medicine(科学的根拠に基づいた医療学)の体系の中に整理されている。Evidence Based Medicine とは、「臨床研究データから得られる現時点での最良の科学的根拠を誠実かつ思慮深く臨床判断に用いながら医療を実践すること」と定義さる。この定義は二つの重要なプロセスを意味している。第一のプロセスは、「臨床研究データから得られる現時点での最良の科学的根拠」を探し出すことで、第二のプロセスは

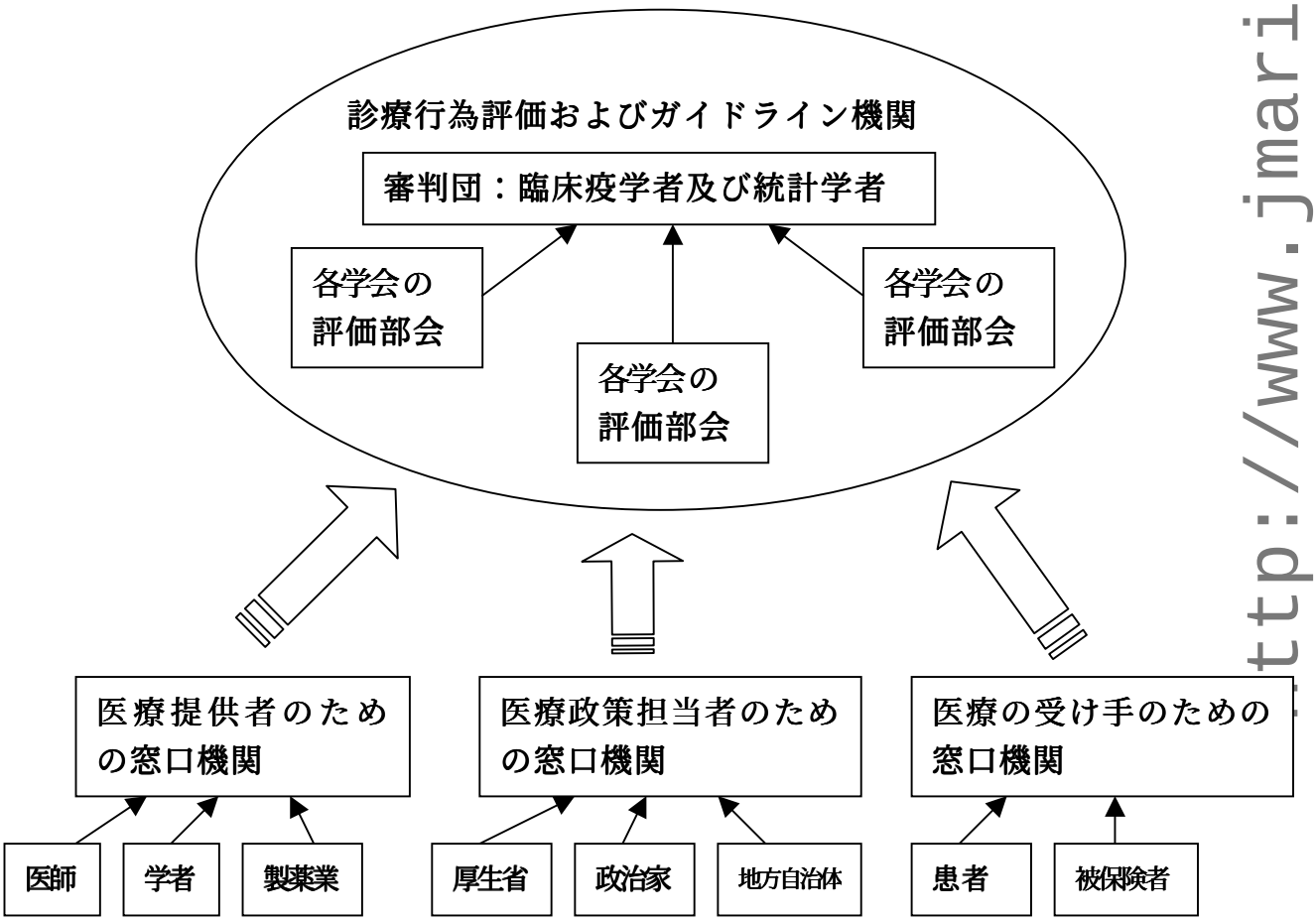
得られた科学的根拠を「誠実かつ思慮深く臨床判断に用いながら医療を実践」することを指す。

ガイドライン作成における第一のプロセスでは、ガイドラインを作成するために収集された様々な臨床研究データを信頼性の高い順番に並べ、最も信頼性の高いデータを基に、事実を把握する。たとえば、これこれの検査をこれこれのタイプの人に施行することで期待できる利益と、この際に発生する検査の苦痛や副作用、さらには経済的費用といった損失を具体的に把握する。そして第二のプロセスでは、第一のプロセスで得られた事実に、価値判断を加えてガイドラインを作成していく。たとえば、1 兆円の治療費をかけると一人の癌を治癒せしめる治療法が第一のプロセスで明らかにされたとする。癌を治して 1 人を救命するという大きな利益と、1 兆円もの巨額の費用がかかるという損失が事実として捉えられたことになるが、この癌の治療法を一般に薦めるべき標準的治療法としてガイドラインにするかは議論を要するところだ。なぜならば、この癌を 500 人も治療した場合には国内総生産をほとんど使い果たし、500 人が治癒しても日本の総人口 1 億 2 千万人が餓死する結果につながるからだ。逆に第一のプロセスで、年間一人当たり 5 万円を要する健康増進プログラムを 40 年続ければ健康寿命（仕事を続けたり、老後の生活を活発に楽しめる生産的期間）が平均で 2 年間延長することが医学的事実として捉えられたとする。この場合、5 万円ｘ40 年＝200 万円で 2 年間の健康寿命つまり健康寿命 1 年分が 100 万円で得られることになるが、この費用は寝たきり状態の介護や疾病治療に要する費用よりも十分に小さいと考えられ対費用効果は高いので、第 2 のプロセスでほとんどの人が長期的な視点から積極的導入に賛意を持つであろう。純粋な医学だけで片づけられない社会的要素や個人的要素が存在し、最終的な医療判断にはいつでもこれらを考慮する必要がある。これが第二のプロセスである。何がなんでも命を救ってもらいたい患者の価値観、治せるものならば何とか治してあげたい医療従事者の価値観、国家財政といった視野から医療費の分配を重視する行政の価値観といった、様々な価値観を調整して最終的なガイドラインを決めることになる。



Ⅲ. 理想の診療ガイドライン作成過程

理想のガイドライン作成過程では、Ⅱで述べた第一のプロセスと第二のプロセスのそれぞれが、公正になされる必要がある。恣意的に造られたデータを根拠にガイドラインが作成されたり、ある偏った価値判断のみでガイドラインが作成されるようなことがあると、国民の大きな不利益につながる。第一のプロセスでは、Evidence Based Medicine(科学的根拠に基づいた医療学)の体系に精通した臨床疫学者や統計学者が、恣意的バイアスを極力排除する目的で参加しつづけなければならないし、第二のプロセスには医師、患者、医療政策決定者といった様々な立場のそれぞれの価値観（value）が十分に反映されなければならない。つまり、ガイドライン作成には様々な価値感を公正に調整する裁判所のような機構の存在が必要となる。



上記の図は、様々な価値感が公正に反映されるガイドライン作成機関の仕組みの一案である。このような仕組みにより偏りのない透明性の高いガ

イドラインが供給されれば、国民の価値感を十分に反映する医療政策の推進に役立つであろう。

Ⅳ．英語圏の診療ガイドラインの現状

多くの人種が共存する米国はマニュアルが充実した社会であるといわれいている。ありとあらゆる職場の、ありとあらゆる職務にマニュアルが完備されている状況には驚かされる。ここでは、医療におけるマニュアル、そしてマニュアルがより一般化されて広く紹介されるまで高まったガイドラインが、米国でどれほど充実しているかの現状を分析し紹介させていただくことで、英語圏の診療ガイドラインの現状を分析したい。

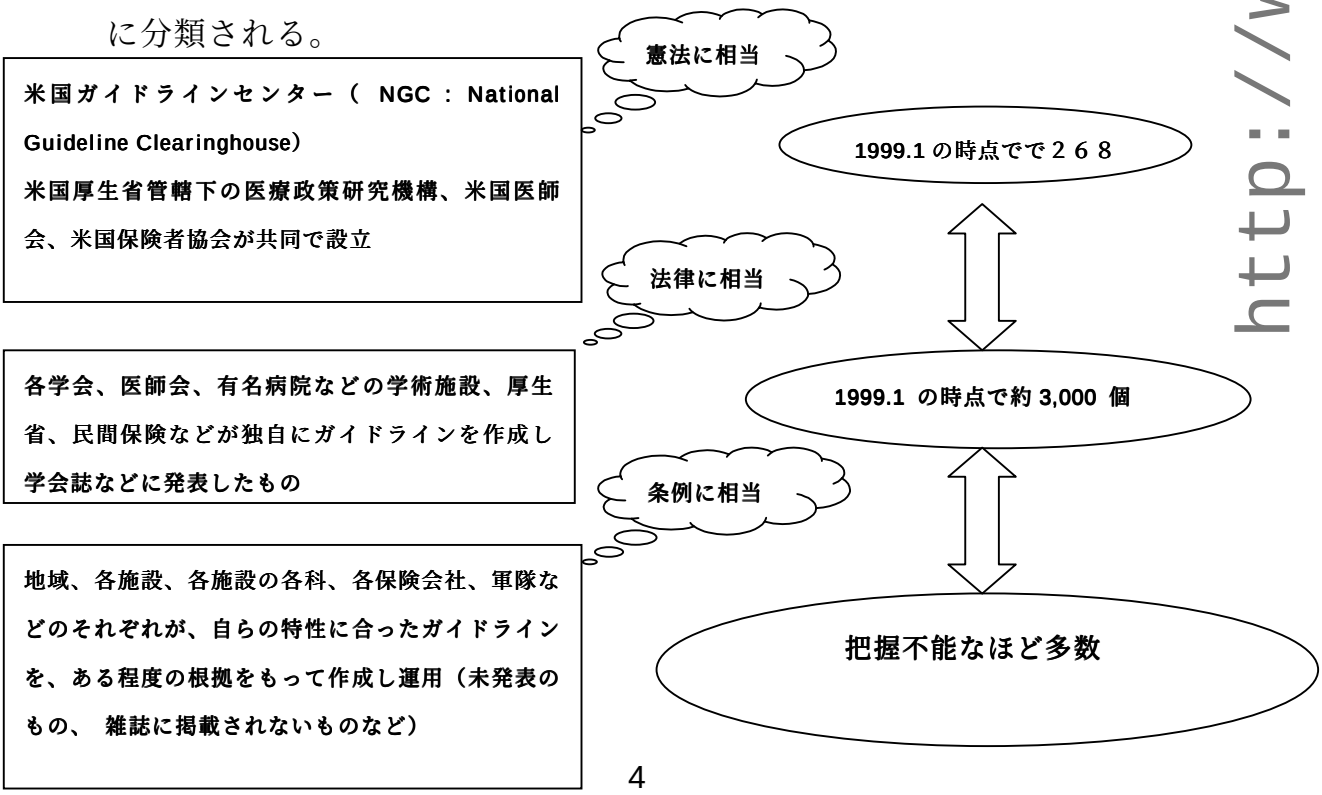
マニュアルまたはガイドラインは、

Ａ．各施設、各施設の各科、各保険会社、軍などのそれぞれが、自らの特性に合ったガイドラインを、ある程度の根拠をもって作成し運用するレベルのもの（未発表のもの、 雑誌に掲載されないものなど）

Ｂ．各学会、医師会、有名病院などの学術施設、厚生省、民間保険などが独自にガイドラインを作成し、学会誌などを通じて広く一般に発表されているもの

Ｃ．主としてＢタイプのガイドラインの中から、米国ガイドラインセンター（ NGC : National Guideline Clearinghouse）：米国厚生省管轄下の医療政策研究機構、米国医師会、米国保険者協会が共同で 1998 年 12 月から運営しているガイドライン評価センターの手続きを経て公表されるにいたったもの

に分類される。



以上のＡ．Ｂ．Ｃ．について、それぞれ例を挙げて説明する。

Ａ．各施設、各施設の各科、各保険会社、軍などのそれぞれが、自らの特性に合ったガイドラインを、ある程度の根拠をもって作成し運用するレベルのもの（未発表のもの、 雑誌に掲載されないものなど）―― 数多く存在

ここでは例として約３０床を有するニューヨークベスイスラエル病院シルバー病棟８階で１９９６年時点に使用されていたガイドラインを紹介する。この病棟は心疾患の患者さんが主として入院するところだったので、整備されているガイドラインも心疾患のものが多かった。

常備されていたガイドラインの全ての題名をここに掲載し、全日本語訳を添付資料として紹介する（添付資料 １）。それぞれのガイドラインは添付資料にあるように、Ａ４用紙１ページ 1 枚に収まる程度の短いものであり、簡潔で実践的である。学会が発表するありとあらゆる状況に対応する目的で作成された数１０ページにも及ぶガイドラインと比較すれば、医療現場で典型的な患者さんを普通に診療する際にはこのような簡略版が存在して初めてガイドラインが有効利用されることになる。

27 種類のガイドラインのテーマの一覧を下記に示す。各ガイドラインの添え字から推測されるように、この 27 種類はあくまでもニューヨークベスイスラエル病院シルバー病棟８階に常備されていたものであり、病院全体では更に多くのガイドライン簡略版が存在した。

- 拡張型心筋症による鬱血性心不全 （循環器 - 1）
- ペースメーカー挿入 （循環器 - 2）
- 胸痛患者の管理 （循環器 - ３）
- 持続性心室性頻拍 （循環器 - ５）
- 非持続性心室性頻拍 （循環器 - ６）
- 心室性期外収縮 （循環器 - ７）
- 心臓血管造影検査後の管理 （循環器 - ８）
- 心臓血管ステント挿入後の管理 （循環器 - ９）
- 心臓冠状動脈処置（PTCA、内膜摘除、ロタブレーダー）後の管理 （循環器-１０）
- 菌血症／敗血症症候群 （感染症 - 1）
- 尿路感染症（免疫正常者、非手術患者） （感染症 － ２）
- 蜂巣炎 （感染症 － ３）

- 骨髄炎 （感染症 － ４）
- 急性脳梗塞 （神経内科－１）
- 痙攣（コントロール不良の） （神経内科 －２）
- 院外で発症した肺炎
- 喘息患者の入院治療
- 悪性胸水 （胸部外科－３）
- 肺気腫増悪の入院治療 （呼吸器 - 3）
- 自然気胸 （呼吸器 - 4）
- 高齢失神者（原因不明）の診療
- 下部消化管手術 (外科 - 1)
- 右上腹部痛患者の診療（胆嚢炎疑い）(外科 - 3)
- 透析用血管グラフト感染の入院治療 （腎臓 - 3）
- 終末期患者の管理（ホスピスの役割） (ホスピス - 1)
- 薬剤使用ガイドライン（バンコマイシン）
- 薬剤使用ガイドライン（シプロキサン）

これらは医療従事者が実践的かつ簡単に参照できるようにまとめられたものだが、この簡略版の作成に際しては学会等が作成する数１０ページにもわたる重厚なガイドラインが参考にされる。数 10 ページの重厚なガイドラインを参考にしながら、病院の実情に合った形で、さらには最新の知見も加味しながら、病院内各医学領域の専門医チームが実践用簡略版を作成するのだ。

では次の B 項では、簡略版を作成するためのインフラストラクチャーである学会等が作成するガイドラインについて検討する。

B．各学会、医師会、有名病院などの学術施設、厚生省、民間保険などが独自にガイドラインを作成し、学会誌などを通じて広く一般に発表されているもの —— 約 3000 件

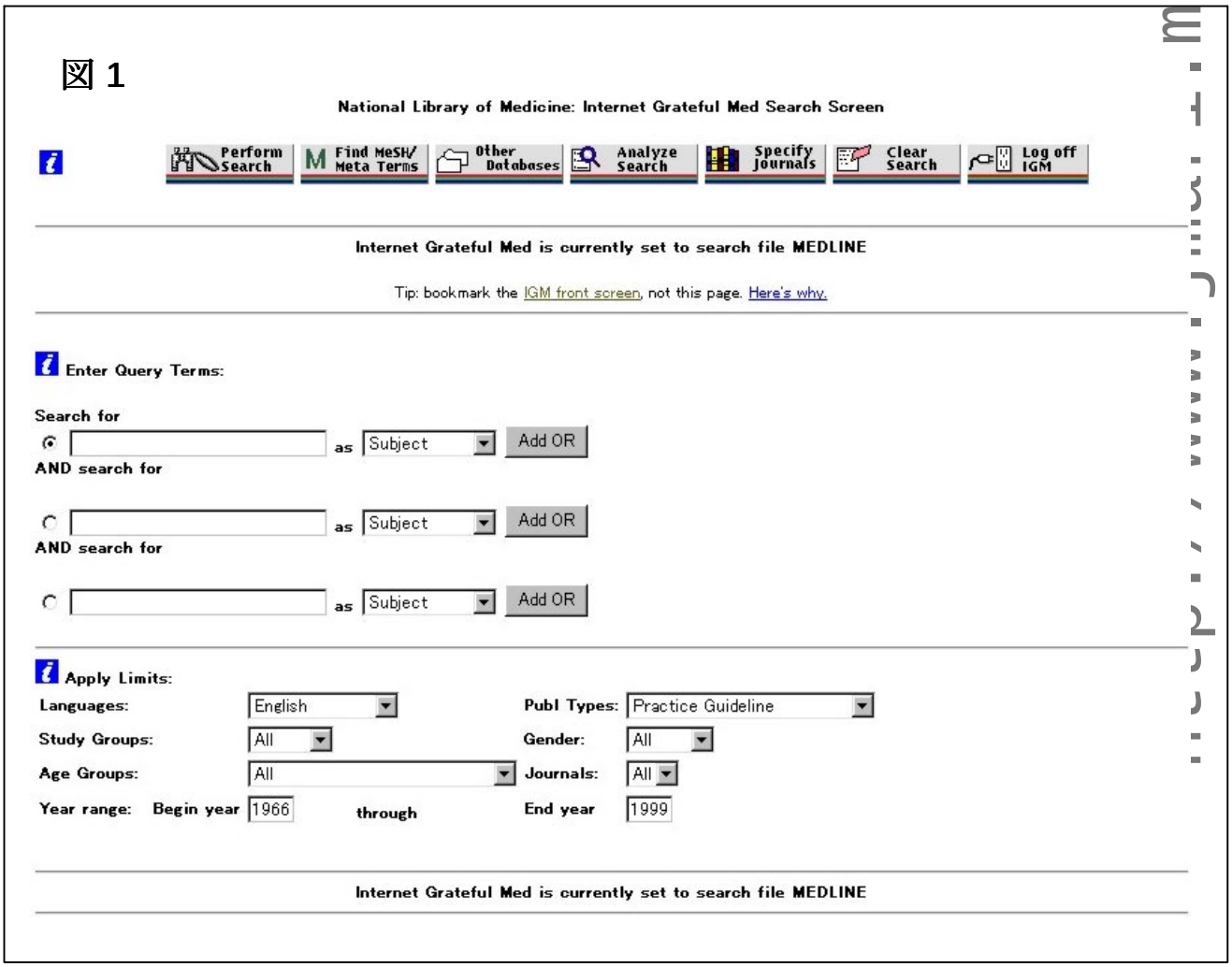
米国国立図書館が作成している医療情報のデータベースである MEDLINE を用いて、医学雑誌などに公に発表されているガイドラインを検索した。

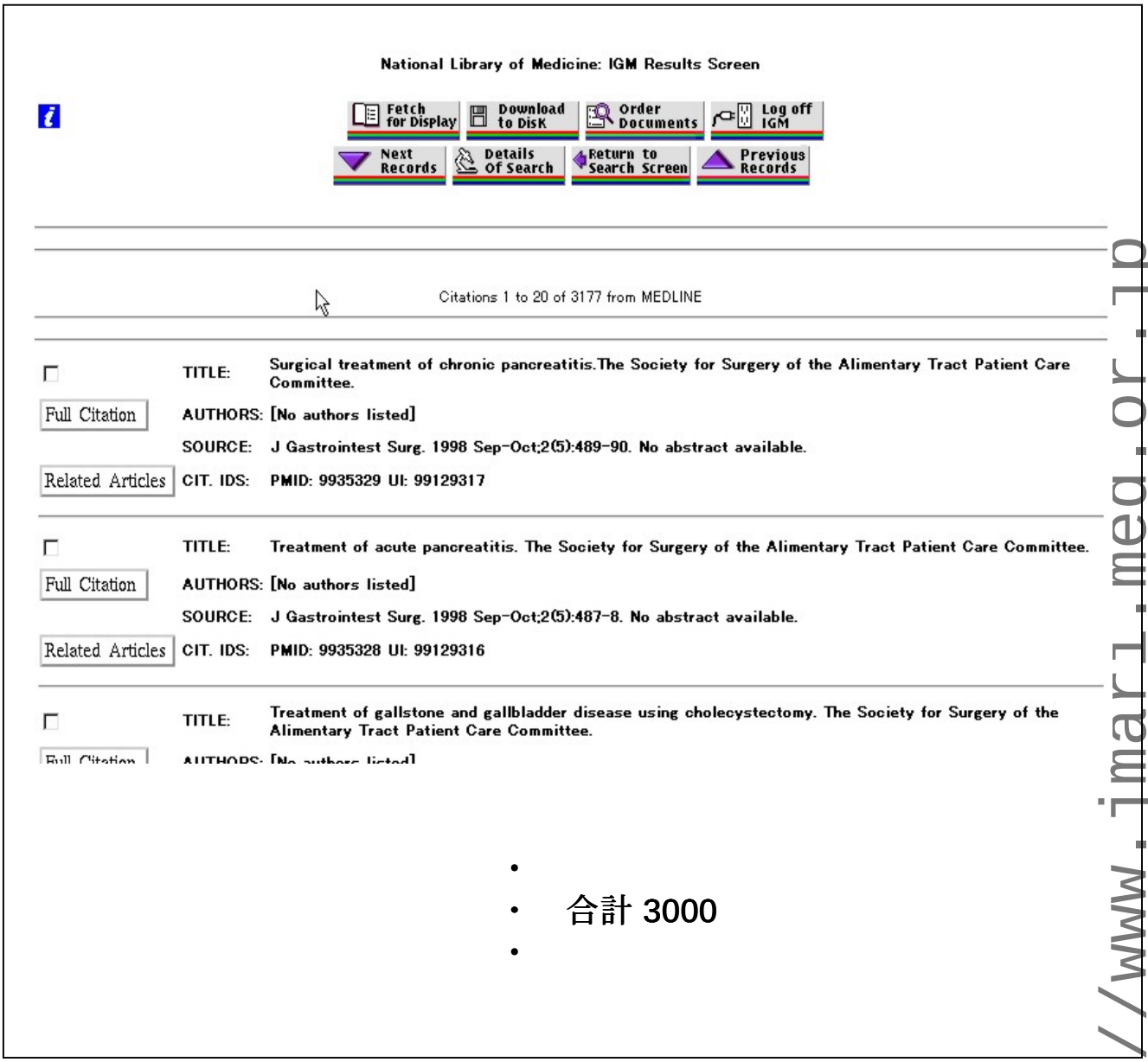
米国国立図書館は 1966 年以来の医学文献を巧妙な規則で分類し、キーワードを入力するだけで欲しい情報を含む文献が容易に入手できるデータベース（MEDLINE）を作成しつづけている。現在までに合計 950 万件の文献が蓄積し、１年あたり約 40 万件の新文献が MEDLINE に新情報

として蓄積されつづけている。インターネットが普及した最近になって、この MEDLINE を医師から患者まで誰もが簡単に無料でインターネット上で検索できるようなサービスが始められた。

次に掲げる MEDLINE の検索画面(図 1)に、診療ガイドライン(practice guideline）と英語文献（English）というキーワードを入力し、この条件を満たす文献を調べたところ、1999.11.18 までのデータで 3177 件が存在した(図 2)。同一のガイドラインが論説（editorial)、解説（comment）といった形で別件として重複して掲載されていたり、複数の学会が共同で作成したガイドラインがそれぞれの学会誌に別件として掲載されたり、更には何回か改訂されたものが全て掲載されることなどの重複分を考慮すると、実存のガイドライン数は 3177 件よりは少ないことにはなるが、発表されたガイドライン数が膨大であることに変わりはない。

図 1





- 合計 3000

MEDLINE にデータベースとして登録されるようなガイドラインは、しっかりとした委員会や学会が医学雑誌にまとめあげるものであるから、ガイドラインを作成するために使用された参考文献の数も非常に多く、多くの人々のコンセンサスを得たものといえ、このようなガイドラインは報告書の形でまとめあげられて、何十ページもの重厚なものになることも少なくない。このガイドライン約 3000 件全ての題名、参照ジャーナル名を学会などの開発団体ごとに集計を試みた（添付資料３）。この表を見る際の一方法は、関心事の医学領域を担当する学会名等をガイドライン作成団体一覧（添付資料２）にて確認後、この団体の英名が添付資料３でアルファベット順に並べてあることろから探し出す、という手順が勧められる。たとえば糖尿病に関するどのようなガイドラインがあるかが関心事であれ

ば、ヨーロッパ糖尿病研究会、米国糖尿病学会、米国糖尿病教育者協会、英国糖尿病協会といった団体名を見つけ、この英名を資料 3 よりアルファベット順に見つければ、糖尿病関連のガイドラインにどのようなものがあるかを調べることができる。

MEDLINE は米国に限らず、世界中の様々な国で発表された文献もデータベースとして収載している。1999.3 までの MEDLINE のデータでは、ガイドラインの登録数は英語文献という制限を加えなければ３６１０件であった。ガイドライン掲載数を国別に調査してみると下記のようになる(図 3 および表 1)。ガイドライン作成国と異なる国のジャーナルに発表されて、あたかもその国の作成したガイドラインとして扱われるものも混在するし、Medline が米国のデータベースで他国製のガイドライン数が少なくなることなど分析には注意を要するが、この分野で米国が圧倒的優位にあることには疑いの余地はない。

図 3

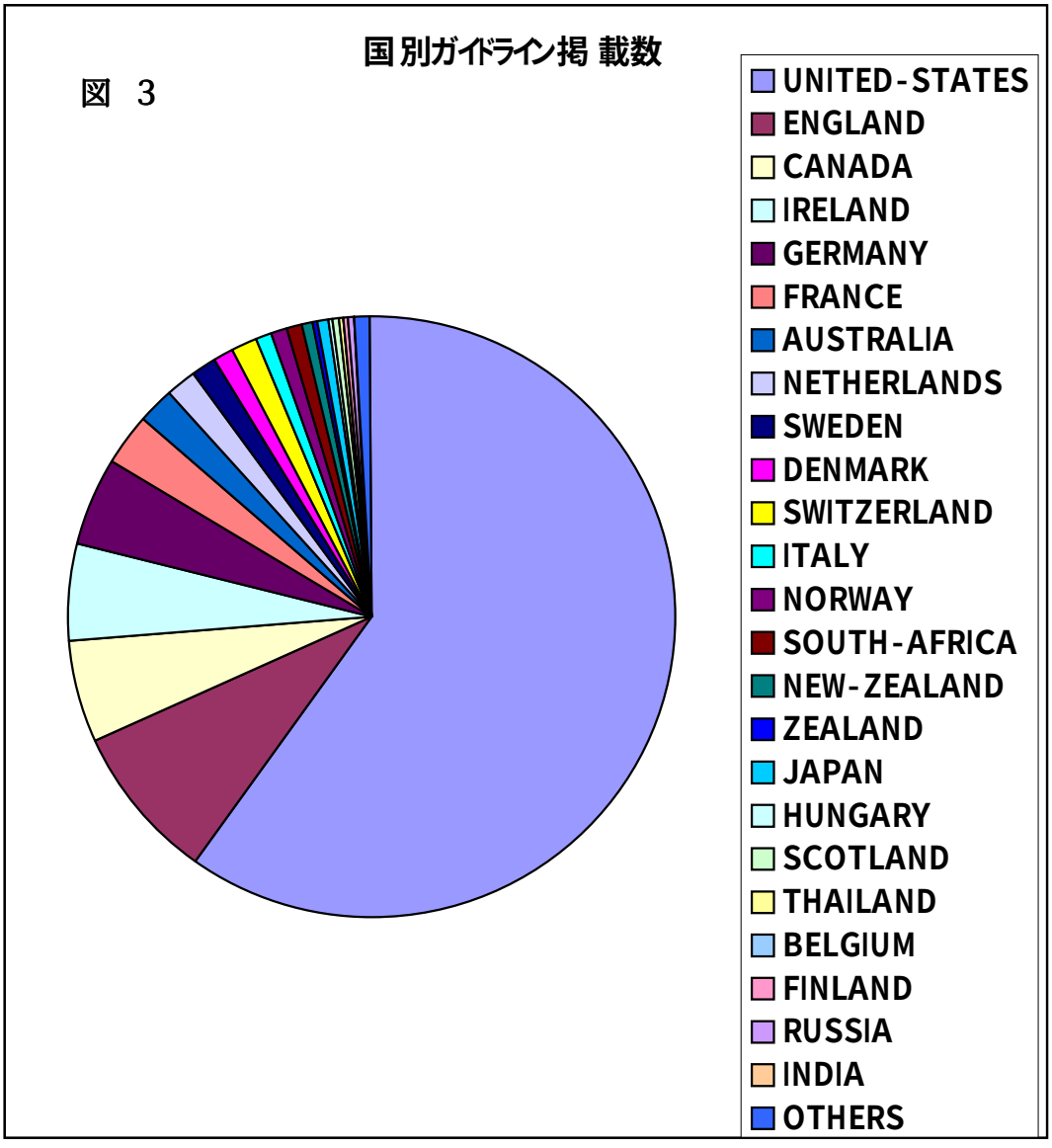


表 1

UNITED-STATES	2142	NEW-ZEALAND	16	ARGENTINA	2
ENGLAND	299	ZEALAND	16	CHILE	2
CANADA	201	JAPAN	14	ISRAEL	2
IRELAND	194	HUNGARY	11	PUERTO-RICO	2
GERMANY	166	SCOTLAND	10	GUINEA	1
FRANCE	104	THAILAND	9	LEBANON	1
AUSTRALIA	63	BELGIUM	8	MEXICO	1
NETHERLANDS	62	FINLAND	7	PAPUA-NEW-GUINEA	1
SWEDEN	49	RUSSIA	7	PHILIPPINES	1
DENMARK	47	INDIA	5	PORTUGAL	1
SWITZERLAND	43	AUSTRIA	4	SINGAPORE	1
ITALY	34	CZECH	4	ZIMBABWE	1
NORWAY	32	BRAZIL	3	OTHERs	11
SOUTH-AFRICA	28	POLAND	3	TOTAL	3610

さてＢ．のガイドライン例をここで述べさせていただいてもよいが、Ｂ．の約３０００のガイドラインがＮＧＣ（下記）の手続きを経て掲載されたものが次のＣ．項のガイドラインであるから、B.のガイドライン例は C. 項と重複するのでＣ項を参考にしていただきたい。

Ｃ．Ｂタイプのガイドラインの中から、米国ガイドラインセンター（ NGC：National Guideline Clearinghouse）：米国厚生省管轄下の医療政策研究機構（AHCPR)、米国医師会（AMA)、米国保険者協会 (AAHP) が共同で 1998 年 12 月から運営しているガイドライン評価センターで選ばれて公表されるにいたったもの

「Ⅲ．理想の診療ガイドライン作成過程」の項目で述べたように、Evidence Based Medicine(科学的根拠に基づいた医療学)の体系に精通した臨床疫学者や統計学者が参加し、医師、患者、医療政策決定者といった様々な立場のそれぞれの価値観（value）が公正に反映するためにの裁判所のようなガイドライン作成機構が 1998 年 12 月より米国ガイドラインセンター（ NGC : National Guideline Clearinghouse 、http://www.guideline.gov/）として活動を開始した。ここには、各学会、健康保険会社、政府機関などが独自に作成したガイドラインが、それぞれのガイドラインが作られた根拠、その根拠として引用された医学研究の一

覧および信頼度、ガイドラインを作成する際に要した研究費を誰が負担したか、ガイドラインが使用された場合に起こりうる効用や害といった分析を添えた形で、インターネットを通じて広く一般に公開されている。同一項目に複数のガイドラインが掲載される場合もあり、この際には 2 つのガイドラインの性質が容易に比較できるようになっている。このことによって、ある特定の価値観のみが強く反映するガイドラインだけが作られていく事を防止するねらいがある。

様々な団体が提出してくるガイドランを公平に分析して情報を公開する実務は、米国ガイドラインセンターが ECRI（以前は、Emergency Care Research Institute と呼ばれていたが現在は頭文字を取ったアルファベット 4 文字が正式名称：http://www.healthcare.ecri.org/site/frame4.html）という 30 年以上続く非営利の医療研究所に依頼している。ECRI は WHO の協力機関としても機能していて 250 人以上の常勤研究員を擁している。研究員は医師、生命科学者、統計学者、生物統計学者、エレクトロニクス技術者などで、職員が特定の団体との癒着を生じないために職員の収入を厳密にチェックするなどの（特定の団体から研究費をもらう事などがないように）チェック機構を有している。

ECRI の活動を支え監視するのが、米国厚生省管轄下の医療政策研究機構（the Agency for Health Care Policy and Research；AHCPR)、米国医師会（the American Medical Association；AMA)、米国保険者協会（the American Association of Health Plans；AAHP）というわけだ。

1）参加団体

1999 年 2 月 22 日時点で米国ガイドラインセンターのガイドラインデータベースに少なくとも 1 つ以上のガイドラインを登録した学会、政府機関、健康保険会社などの参加団体の数は 47 団体にのぼる。そのリストを表 2 に掲載する。現在、刻々と参加団体は増えている。

表 2

1999年2月22日までにガイドライン提出をした参加団体

Agency for Health Care Policy and Research - 11 guidelines
American Academy of Allergy, Asthma and Immunology - 6 guidelines
American Academy of Child and Adolescent Psychiatry - 11 guidelines
American Academy of Family Physicians - 3 guidelines

American Academy of Ophthalmology - 11 guidelines
American Academy of Pediatrics - 5 guidelines
American Association for Respiratory Care - 44 guidelines
American Association of Clinical Endocrinologists - 8 guidelines
American College of Allergy, Asthma and Immunology - 6 guidelines
American College of Cardiology - 8 guidelines
American College of Endocrinology - 8 guidelines
American College of Physicians - 12 guidelines
American College of Preventive Medicine - 9 guidelines
American College of Radiology - 1 guideline
American College of Sports Medicine - 1 guideline
American Diabetes Association - 5 guidelines
American Gastroenterological Association - 7 guidelines
American Heart Association - 8 guidelines
American Medical Association - 1 guideline
American Psychiatric Association - 9 guidelines
American Society of Addiction Medicine - 2 guidelines
American Society of Clinical Oncology - 4 guidelines
American Society of Health-System Pharmacists - 1 guideline
American Society of Nuclear Cardiology - 1 guideline
American Urological Association, Inc. - 1 guideline
Centers for Disease Control and Prevention - 6 guidelines
Children's Hospital Medical Center (Cincinnati, OH) - 3 guidelines
College of American Pathologists - 3 guidelines
Consortium for Spinal Cord Medicine - 3 guidelines
Council on Chiropractic Practice - 1 guideline
Daniel Freeman Hospitals, Inc - 1 guideline
Diabetes Treatment Centers of America - 1 guideline
Horizon Healthcare - 2 guidelines
Institute for Clinical Systems Integration - 7 guidelines
Institute for Healthcare Quality, Inc - 4 guidelines
Joint Council of Allergy, Asthma and Immunology - 6 guidelines
Kaiser Permanente Health Plan, Inc. Mid-Atlantic Permanente Medical Group - 5 guidelines
National Abortion Federation - 1 guideline
National Heart, Lung, and Blood Institute - 5 guidelines
National Institute of Diabetes and Digestive and Kidney Diseases - 1 guideline
National Kidney Foundation - 4 guidelines
Nutrition Screening Initiative - 2 guidelines
Office of Medical Applications of Research - 17 guidelines
Paralyzed Veterans of America - 3 guidelines
PinnacleHealth - 1 guideline
United States Preventive Services Task Force - 70 guidelines
University of Iowa Gerontological Nursing Interventions Research Center - 5 guidelines

2）ガイドライン集計表

ある団体が作成したガイドラインを米国ガイドラインセンターに採用してもらうためには、下記の集計表にあるデータをまとめて提出することから手続きが始まる。この集計表には、ガイドラインの信頼度が容易に判断できるためのガイドラインの客観的な情報が網羅されている。（表 3）

表 3

ガイドライン集計表

属性	詳細
ガイドライン・タイトル	ガイドラインの完全なタイトルを記載。
著書目録出所	ガイドライン開発者によってガイドラインが公表される際の完全な著書目録。
参考文献の数	ガイドライン・ドキュメントに引用された参考文献の数。
ガイドラインの入手方法	ガイドラインの利用性に関する情報。電子(ハイパーテキスト・リンクによる全文テキスト)コピーおよび印刷コピーに関する情報
関連ドキュメント	NGC 内で必ずしも利用可能でないガイドラインで、適切なガイドライン開発者によって生産された関連ドキュメント。例えば、ヘルスケア政策研究所(AHCPR)で作成されたガイドラインに伴う、消費者ガイドライン(Consumer Guidelines)、クイック・リファレンス・ガイド(Quick Reference Guides)および技術的報告書(Technical Reports)などは全てここにリストされる。
ガイドライン・ステータス	ガイドラインが以前に出されたドキュメントの改訂版か、あるいは最新バージョンかを記載。
最新版情報	次のバージョンが出されると予想される場合、ガイドライン開発者の調査および修正プロセスに関する一般的な情報、および(または)ガイドラインが現在改定中かを記載。
ガイドライン長さ	公表されたガイドライン全文のページ数。
ガイドライン発行者	ガイドライン開発者と異なる場合は、ガイドラインを出すことに責任を負う組織。
ガイドライン開発者	ガイドラインの開発を担当した組織。
ガイドライン開発者コメント	ガイドライン開発者が複数組織の共同で作られた場合は、その個々の組織の名称を記載。
ガイドライン賛同者	ガイドラインの中で賛同者として具体的に述べられている、組織や団体があればこれを記載。
改変	もしも、ガイドラインが別のガイドラインの改作である場合、その出所を記載。
組織または団体のタイプ	組織や団体のタイプを下記の NGC 分類スキーム(NGC Classification Scheme)の適切な概念から選択して記載する。 学術団体、医学専門協会、疾病特定協会、連邦政府機関(米国)、国際機関、メーカー、政府機関(U.S 以外)、私的非営利団体、私的非営利的研究機構、私的営利機構、私的営利研究機構、専門協会、州/地方自治体機関(米国)、州/地方自治体機関(U.S 以外)
ガイドライン作成のための資金の出所	ガイドラインの中で具体的に述べられている、ガイドライン作成費用の資金提供者を記載。
出所資金の源泉	ガイドラインの中で具体的に述べられている助正金（ファンド）番号。
ガイドライン委員会	ガイドライン開発者内の委員会/小委員会があれば、その名前を公表。
ガイドラインを著したグループの構成メンバー	ガイドラインを著したグループ/委員会の構成メンバーの、専門、学位、肩書きをリスト。
ガイドライン発表の日付	ガイドラインが公表された日付。
ガイドライン・カテゴリー	ガイドラインを下記の NGC 分類スキーム(NGC Classification Scheme)の適切な概念から選んで分類する。 治療効能の評価、カウンセリング、診断、診療方針、予防、危険予測/予後、スクリーニング、治療

臨床の専門分野	ガイドラインの専門分野を下記の NGC 分類スキーム(NGC Classification Scheme)の適切な概念を用いて分類。 思春期健康、アレルギーと免疫学、麻酔学、行動健康、心臓学、心血管看護、脊椎矯正指圧療法医学、臨床検査-微生物学、臨床検査-病理学、臨床検査、大腸および直腸外科、集中治療看護、集中治療、歯科学、皮膚科、救急医療、内分泌学、疫学と公衆衛生、家族医療、消化器病学、一般的な外科、老人医学、感染症、内科、医学遺伝学、メンタル・ヘルスおよび薬物中毒、新生児学、脳神経外科、神経病学、核医学、看護、栄養、産婦人科、腫瘍学、眼科、検眼学、整形学、整形外科、耳鼻咽頭学、小児科、薬物学、物療医学とリハビリテーション、形成外科、足病治療、予防医学、プライマリーケヤー、精神医学、呼吸器学、エックス線学、社会福祉事業、スポーツ医学、胸の外科、泌尿器科、血管外科
病気や健康分野	ガイドラインで論じられている医学の主な領域を、ガイドラインに述べられた言葉で記載する。
ガイドライン目的	ガイドラインの中に述べられた、ガイドライン作成の目的。
ガイドライン推薦の調査の方法	ガイドラインを有効にするためになされた方法を要約。ガイドラインを有効化するということは、あらゆる外部からのガイドライン評価、他のガイドラインとの比較、実際にガイドラインを使用してみる研究で得られた効果と定義する。(Hayward RSA ら．臨床実行ガイドラインを分析してより有用な情報を得る方法．内科学会誌;118:731-737)。 NGC 分類スキーム(NGC Classification Scheme)の適切な分類から選択する。 他のガイドラインとの比較、臨床的パイロットテスト、施行期間を設けた臨床確認実験、外部医療従事者による検討、内部医療従事者による調査、医療従事者による調査。
ガイドライン推薦の調査の方法の記述	前項に補足するような、細かな説明。パイロット試験あるいは臨床試行期間などの説明。
臨床試行計画は作られているか?(はい、/いいえ、)	臨床試行計画が作られているか、ユーザーが臨床試行計画を実行できるようになっているかを述べる。
臨床試行計画の説明	ガイドラインの中で示されているのならば、ガイドラインを試行するための特定の戦略、目的、実行手段あるいは計画についての記載。
ユーザー対象	ガイドラインの使用者を下記の NGC 分類スキーム(NGC Classification Scheme)から選び表示する。 医療従事者グループ、臨床検査技師、栄養士、医療供給者、健康保険、病院、正看護婦、看護婦、作業療法士、患者、理学療法士、内科医助手、内科医、呼吸セラピスト、スピーチセラピスト。
ガイドライン対象者	ガイドラインに述べられた、ガイドラインを適応する患者対象。 HMO 内であるとか、何々地域内であるとか、具体的に記述。
ガイドライン対象者の年齢層	ユーザが特定の年齢集団にターゲットを絞り込むことができるような、ガイドライン対象者の年齢層の記載。
ガイドライン対象者の性別	ユーザが特定の性集団にターゲットを絞り込むことができるような、ガイドライン対象者の性別の記載。
考察対象となった診療行為	ガイドラインの中で考察対象となった特定の診療行為を、ガイドラインに使われた言葉を用いて記述。
ガイドライン作成で関心のあった健康指標	ガイドライン作成で重要と捉えられた健康指標を記述。治療のガイドラインであれば治癒率とか死亡率が、検査のガイドラインであれば疾病発見率など。
コスト分析がなされたか(はい、/いいえ、)?	
証拠を集めるのに使用された方法	証拠を集めるために使用される方法を下記の NGC 分類スキーム(NGC Classification Scheme)の適切な概念から選び分類する。 発表文献を手作業で検索(原著) 発表文献を手作業で検索(孫引き論文) 電子的なデータ・ベースの検索 患者登録データの探索 未発表データの探索
証拠を集めるのに使用された方法の細かな記載	ガイドライン中で述べられた証拠収集方法の要約説明。詳細な検索方法、検索されたジャーナルの一覧、キーワード、データ・ベースなど。
引用ドキュメントの数	上記の証拠収集で得られた引用ドキュメントの数。ドキュメントの数は参照文献の数ではない。

集めた証拠の質と証拠力の検証方法	集めた証拠の質や重要度を下記の NGC 分類スキーム(NGC Classification Scheme)の適切な概念から選び分類する。 決定分析、個々の患者のメタ分析、観測研究のメタ分析、無作為化試験のメタ分析、患者データ要約研究のメタ分析、まとめの論文、系統的なまとめ論文、証拠テーブルを備えた系統的なまとめ論文。
証拠力を表す格付け方法	証拠力を分類してあらわす方法があれば、これを記載。
証拠を分析するのに使用された方法	得られた証拠をを評価するための方法を下記の NGC 分類スキーム(NGC Classification Scheme)の適切な概念から選び、記載する。 エキスパート見解、エキスパートの見解(委員会)、エキスパートの見解(デルファイ法)、主観的なまとめ、格付けスキーム(格付け方法あり)によって格付ける、格付けスキーム(格付け方法記載なし)によって格付ける。
証拠を分析するのに使用された方法の詳細な記載	前項のやや詳しいまとめ。
警告文	ガイドライン開発者によって強調されたガイドラインに関係するステートメントあるいは重要な警告。不確実な部分を認識し、ガイドラインでどのように不確実性を強調したか。
主な提言	主な提言を述べる。
臨床アルゴリズム	アルゴリズムの形でまとめたものがあれば、これを記載。
提言を支える証拠のタイプ	提言を支える証拠のタイプについて記述。
潜在的な利益	ガイドラインを施行した場合に予想される、患者またはガイドライン施行者への潜在的利益。
利益をもっとも享受しそうなグループ	ガイドライン対象者の中で、利益をもっとも手にするであろうグループ。
潜在的な害	ガイドラインを施行した場合に予想される、患者またはガイドライン施行者への潜在的害。
害をもっとも享受しそうなグループ	ガイドライン対象者の中で、害をもっとも受けるであろうグループ。

NGC にガイドラインを掲載するには、上記のフォーマットに従った情報を提出しなければならず、この情報が別の団体から出された同じ医学領域のガイドラインとの比較にも用いられる。添付資料４に、米国心臓病学会と米国心臓協会が共同で作成した「術前検査」に関するガイドラインと、米国内科学会が別に作成した「術前検査」に関するガイドラインを比較する表を示す。読者は、この表を判断材料として、より信頼できる方のガイドラインを選択して使用することになる。

3）エビデンスの質と証拠力

ガイドライン整備は近年盛んな EBM （Evidence Based Medicine：科学的根拠に基づいた医療）の手法によるのが一般的となってきた。つまり、ガイドラインを作成するためには、質と信頼度のなるべく高いデータを集め、質と信頼度の客観的な評価をしながら、データを採用していくというものだ。表３には「証拠を集めるのに使用された方法」という項目があり、文献をどのように収集して選択したかの理由が述べられている。また、「証拠力を表す格付け方法」という項目では、エビデンスの質と証拠力を評価する方法として等級付けシステムを推奨している。このようにして、ガイドラインに述べられる勧告の重要性および信頼性が格付けされているものが多くなってきた。

ここでは、エビデンスの質と根拠力の等級付けとは何かを具体的なガイドラインの一部を紹介しながら説明させていただく。

図 4

タイトル

無症状の虚血性心疾患のスクリーニング

原著：

Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. 3-14 [85 references]

引用：

Not applicable: Guideline was not adapted from another source.

発行日：1996

主な勧告：スクリーニングをするかしないかの勧告の程度は、以下の等級に分類して評価します。

等級付けのランク

A. 定期検診に行うことをしっかりした証拠を根拠に勧める行為。
B. 定期検診に行うことをまあまあの証拠を根拠に勧める行為。
C. 定期検診に行うことを薦めるには十分な証拠がないが、別の理由があれば勧めることもありうる行為。
D. 定期検診には行わないほうがよいと、まあまあの証拠を根拠として断定できる行為。
E. 定期検診には行わないほうがよいと、しっかりとした証拠を根拠として断定できる行為。

診療行為

中年や高齢者の無症候性虚血性心疾患をスクリーニングするために、安静時心電図、歩行心電図、負荷心電図をとることを勧める十分な証拠は存在しない（勧告度 C)。心電図検査の感受性は低く、無症状者に異常心電図所見が得られても本当に異常であることは少ないこと、さらには心電図検査のコストも考えると、虚血性心疾患のリスクの高くない人にはスクリーニングをしない方が良いと言えそうだ。リスクの高い人に心電図検査を行なう時は、心電図検査の結果によってはアスピリン投与や高脂血症治療薬投与を検討する場合のみである。パイロットやトラックの運転手など特殊な職業の場合は、公共の安全を考えて心電図を施行すべきとの意見はありうる。無症状の虚血性心疾患のスクリーニングで、どの検査を選択すべ

きかは臨床判断によるが、負荷心電図の方が安静時心電図よりも正確としてもかなり高価な検査である。無症状の小児、若者、若年成人に対する定期健康診断やスポーツクラブ参加前検診は勧められない（勧告度 D)。医師は検査よりも虚血性心疾患にならないような一次予防のことを、全受診者に考えるべきである。

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NGC STATUS ：
This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998.

上記のように、あるガイドラインで推奨する特定の医療行為に対する意義が、臨床データの質と根拠力に基づいて等級化（上の例では A から E）されている。この等級化は、いわばガイドライン文言の信頼度の格付けを意味しており、ガイドラインが作成された後に新たな更に証拠力の高い臨床研究結果が発表されれば、各医療従事者の判断で診療行為をアップデートする判断の大きな助けになる。つまり、レストランの星の数による格付けと同様で、「あるガイドラインの勧告は 2 つ星程度の証拠力に基づくものだ。今回新たに発表された臨床研究の証拠力は４つ星に相当してより良いデータであるから、新たな臨床研究の知見に基づく診療方針へ変更しよう」などというように、異なる研究結果や見解がある際に、医療従事者が容易に判断を下せるようになる。また、様々な医療行為の意義も比較検討することさえ可能となり、限られた医療資源の範囲内でどの医療行為を選択していくかといった場合に、より格付けの高い診療行為から優先させていくなどの判断材料としても役立つ。

４）ガイドライン一覧表

米国ガイドラインセンターは1998年12月に活動を開始して間もなく、毎週新たなガイドラインが 10 件以上のペースでデータベースが蓄積している。1999 年 1 月中旬時点での登録ガイドライン数は 266 件であり、病気や検査および治療ごとに分類される形で、誰もが容易にガイドラインにアクセスできるようにインターネット上のホームページで公開されている。

添付資料として、1999 年 1 月時点での掲載全ガイドライン 266 件の一覧表を添付資料５として示す。

５）B.項および C.項のガイドラインの一例

MEDLINE 上にデータベースとして収載されているガイドラインが約 3000 件、1999 年 1 月中旬時点でこれらのうち 266 件が米国ガイドラインセンターに登録されている。心臓超音波検査の適応に関するガイドライン要約を一例として示す（添付資料６）。ガイドラインの原文は約 60 ページもの膨大なものだが、これを約 15 ページに要約して米国ガイドラインセンターはインターネット上に公開している。添付資料６の一部分は翻訳したので、是非参考にしていただきたい。心臓超音波検査をするのが適当と考えられる医学的状況から、検査をする必要のない医学的状況まで、驚くほど詳細な分類がなされている。しかし、このようなガイドラインの内容全てを医療従事者が理解し記憶しなければならないものではない。実地医家は日常診療で自らが遭遇する少数の典型的状況についてのみの理解を深めれば良いわけで、理解するのが困難な様々な特殊な状況であれば、専門家へ患者の診療を依頼するのが適当ということであろう。このような詳細なガイドラインが出そろうことがインフラ整備となり、簡略版が病院内で作られたり、医学雑誌に紹介されたりしながら、医療の標準化が進んでいくことになる。

Ⅴ．ガイドラインの問題点

- ガイドラインは全ての状況を規定するものではない。ある特定の患者さんにガイドラインを応用する際には、患者さんの特性、患者さんの希望、社会的影響、経済的負担など、ガイドラインでは必ずしも細かく検討されてはいない value judgement（価値判断）を組み合わせて個別の対応をすることになる。患者の個別性をガイドラインによって安易に否定するべきでないし、個別性を無理に排除することがガイドラインの目的ではない。ガイドラインと個別の患者の状況の橋渡しをするプロセスは医師のアートの領域として決してなくならないといえる。
- ガイドラインの作成に当たっては、エビデンスを comprehensive（包括的）に採用するべきで、決してある目的に偏ったエビデンスのみが

使用されるようなことに陥ってはならない。例えば、ＥＢＭ手法により得られるエビデンスのうち、医療費削減に都合のよいものだけが選ばれることは、ＥＢＭが最も忌み嫌うバイアスであり、ＥＢＭの精神に大きく反する。医療費が増えてしまうエビデンスであっても、社会にとって必要との判断が得られれば、積極的にこれを採用することが必要である。バイアスがなく、様々な立場や価値観が十分に反映される形でガイドラインが作られることが大前提である。

- 「効果がエビデンスとして証明されない」ことと「効果がないことが証明された」ことは全く別のことであり、これを区別することは重要である。「効果がエビデンスとして証明されない」ということは、効果が否定されたことではないのだから、その診療行為を簡単に否定したガイドラインを作るべきではない。米国の管理医療では医療費抑制の価値観のみでガイドラインが作成されたことも多かったようだ。
- ガイドラインの作成には、バイアスのない良質なデータを多数集めることが前提となる。診療時間が十分に確保できない現在の医療提供体制では、十分な説明とインフォームドコンセントが前提となる、ランダム化比較試験といった臨床研究は不可能に近い状況である。ガイドラインを整備しながら医療の標準化と効率化を図るためには、臨床研究が可能になるような診療環境や医学教育などの整備を先行投資することが不可欠だ。米国の医療費を見れば明らかなように先行投資はかなりの額に上ることが想像されるが、医療の標準化による大きなメリットを得るためには賢明な投資と考えるべきであろう。
- 医療の提供者のみでなく、医療の受け手にもガイドラインを整備していくことの重要性を理解してもらう必要がある。ランダム化比較試験は効果の有無がはっきりしないから施行するのであり、仮に自分がプラセボ（偽薬）群に割り当てられても不利益を被るのではないことを理解して、積極的に協力する姿勢を期待したい。

VI. まとめ

英語圏の診療ガイドライン整備はかなり充実していて、診療のありとあらゆる領域をガイドラインが細かく規定する状況まで近づいていることが明らかになった。この膨大なガイドライン整備は、ガイドライン作成の歴史が長いからこそできたものであり、ガイドライン作成に用いられたエビデンスも何年もの期間を要する臨床研究データの蓄積によるものである。この現実を目のあたりにすると、臨床研究、特に臨床疫学的研究をこれから充実させる日本が英語圏並みの診療ガイドラインを整備できるのは先の

時代にならざるを得ない。しかし、日本人の診療ガイドラインは日本人の遺伝的特性、社会的状況、日本人の価値観をもとに作られるのが望ましいことは明白で、かなり出遅れたのは事実としても日本人のための独自のガイドラインを作成するために作業を開始しなければならない。日本の臨床研究、特に臨床疫学的研究を充実させるための環境整備を早急に整える必要がある。

では、かなり先の時代になるまでの移行期への対策はどうするか。どうやら既に充実した英語圏のガイドラインを日本の価値観に合う形に調整して用いる以外はないように思われる。遺伝子や、社会環境などが違うとはいえ、英語圏の人間もやはり同じ人類である。日本にはデータがないからどうしようもないと諦めるよりは、英語圏のガイドラインを参考にすることは非常に有益と思われる。とりあえずは、英語圏のガイドラインを参考にしながら、日本のデータがそろった分野から徐々に日本版ガイドラインへ移行していけばよい。

本研究で作成したガイドライン一覧は、各学会ごとにまとまる形で整理した。今後、日本の学界等がガイドラインを作成していく際に、担当医学領域を同じにする外国の学会がどのようなガイドラインを作成してきたかを参考にすることができれば、少しでも早く日本の患者さんのためのガイドライン整備につながるのではないだろうか。今後のガイドライン整備の進展を期待する。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：拡張型心筋症による鬱血性心不全　循環器１　　1995. 9. 27

目的	鬱血性心不全の治療および管理のガイド ***注意：***このガイドラインは下記の診断には適さない ● 新たな心筋梗塞 ● 重症の大動脈弁狭窄 ● 拡張不全を伴う肥大型心筋症 ● 透析療法を必要とする腎不全 ● 重度の僧帽弁狭窄
入院前の検討事項	十分な監視ができる体制で管理が可能であれば、外来管理とする。 今回の心不全悪化は、食事療法が不良だったからか、新たな心不全によるものか、不整脈の発生によるものか、腎機能不全によるものかの検討。
治療／対処方法	● 胸部Ｘ線写真、腎機能評価。 ● 最近なされていなければ超音波検査による心機能評価または核医学検査による心機能評価を施行。 ✓ 毎日の体重測定 ✓ 塩分および水分制限 ✓ 薬物療法（全ての適応について考察、各患者にあった薬物療法を） ➢ 利尿剤 ➢ ジギタリス ➢ ＡＣＥ阻害剤 ➢ 亜硝酸剤 ➢ 抗凝固療法 ***注意：***臨床所見と検査成績により薬剤の投与量を調整すること。適正な治療の目安は、呼吸苦や疲労感の軽減、日々の体重が理想体重へ減少していくこと。
退院可能な状況	● 呼吸苦の軽減 ● 呼吸音上の所見が軽快 ● 体重減少、理想体重への接近 ● 普段の運動能の回復 ● 経口薬剤で安定した管理可能 投薬内容、塩分制限、適切な運動量、心不全悪化の症状や兆しを患者が十分に理解し、外来管理への準備ができた状況。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：ペースメーカー挿入　　循環器２　　1996．1．4

目的	● ペースメーカー挿入が必要な患者の評価および管理の支援を目的とする
入院前の検討事項	● ペースメーカーの必要性を次の事項で検討 ➢ 病歴 ➢ 身体所見 ➢ 心電図 ➢ 必要ならばホルター心電図 *注意：* 次のページに掲げるメディケア版のペースメーカーガイドラインを参照のこと
治療／対処方法	● ペースメーカー適応が判然としないが、ペースメーカーを必要とするかもしれない症状がある場合は、24 時間の心電図モニターを考慮する。 ● 24 時間の心電図モニターでもペースメーカー適応となる不整脈が捉えられないが場合： ➢ ＥＰＳ検査を考慮（内線 2806 番へ連絡） ➢ 患者の状態が安定していれば、退院の後に外来でのホルター心電図やイベント心電図で評価を計画する。 ● ペースメーカー植え込みが必要と判断されれば： ➢ 外科へ連絡 ➢ ペースメーカーのモード（VVI、DDD 等）を検討 ● ペースメーカー挿入後は： ➢ ペースメーカー機能チェックを外来で担当する医師を確認し、またはペースメーカー外来の予約を行う。（内線 2806 番） ➢ ペースメーカー業者へのペースメーカー使用開始届の提出。 ● 患者教育 ➢ 患者および家族とペースメーカー使用説明書を用いた勉強会を開く。 ➢ 医者へ連絡をとるべき症状の確認。
退院可能な状況	● 状態が落ち着けば、ペースメーカー挿入手術日当日または翌日には退院。 ● 退院先の環境が、今後のケアに適するかの評価。

メディケア版のペースメーカーガイドラインの概要

第１ｸﾞﾙｰﾌﾟ：ペースメーカー適応症例

1. 後天性完全房室ブロック
2. 先天性完全房室ブロックで著明な徐脈を呈するもの（年齢換算で）
3. 有症状のモービッツ２型房室ブロック
4. 有症状のモービッツ１型房室ブロック
5. （失神などの）主症状を呈する洞性徐脈（もしくは 50 以下の脈拍数）
6. めまい感やごく短期の意識障害を伴う、軽度の（脈拍数 50 から 59 の）洞性徐脈
7. 中止できない薬物療法の副作用による洞性徐脈で有症状のもの
8. 頻脈を伴う/伴わない洞結節機能不全または房室結節機能不全で有症状のもの
9. 上室性頻脈に関連する徐脈
10. 失神症状を伴う頚動脈洞過敏症

第２ｸﾞﾙｰﾌﾟ：病歴や今後の見通し次第ではペースメーカー適応のある症例

１．無症状の後天性完全房室ブロック
２．先天性完全房室ブロックで、ある程度の徐脈を呈するもの（年齢換算で）
３．失神を生じる２肢ブロックまたは３肢ブロック
４．一時的な完全房室ブロックや、モービッツ２型房室ブロックを生じた急性心筋梗塞後に、予防的にペースメーカーを装着する場合
５．無症状のモービッツ２型房室ブロック
６．中止できない薬物療法の副作用による洞性徐脈で無症状のもの
７．再発性あるいは頑固な心室性頻脈に対し、オーバードライブペーシングをする場合

注：トロポニン値やミオグロビン値が検査に広く応用される前のものですので、現在はアップグレードされているものと思われます。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：胸痛患者の管理　　循環器３　　１９９６．２．２

目的	● 狭心痛が典型的でない患者さんの評価を速やかに行って早期退院を導くことを目的とする
治療／対処方法	● １８～２４時間の間に３回の CPK, CK-MB を測定して心筋梗塞を除外。 ● 入院時心電図、翌日の心電図、さらには過去の心電図を入手して比較する。 ● 入院翌日に心臓超音波検査で、心機能や心筋壁の運動性を評価。 ● もしも、心電図や心臓超音波検査で虚血性心疾患のサインがなければ、負荷検査を申し込む。（できれば入院翌日中に実施） ➢ （患者が運動可能な場合）安静時心電図が正常であれば負荷心電図 ➢ （負荷タリウム/超音波/MUGA/PET などの）負荷画像診断を、安静時心電図が異常であれば、もしくは臨床的に虚血性心疾患が強く疑われれば最初から検査する **注：**もしも、患者が運動できないような場合は、薬物による負荷試験を予定するので負荷検査室へ連絡を入れること。
退院可能な状況	もしも重篤な虚血性心疾患が除外され、または軽度の虚血性心疾患に対する適切な内服治療が始められ： ● 状態が安定 ● 歩行可能 ● 外来での検査計画や生活指導がなされる ならば、更なる精密検査は外来にて行うこととする。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：持続性心室性頻拍　　循環器５　　1996. 2. 2

目的	持続性心室性頻拍（３０秒以上の心室性頻拍または３０秒以下でもカウンターショックを要するもの）の管理を医師が適切に行えることを目的とする。このような患者は通常は救急外来にて遭遇するものや、心疾患を有する入院患者であるが、正しい治療にて状態が落ち着くまでは CCU またはモニターベッドのある循環器病棟で管理しなければならない。
入院前の検討事項	器質性心疾患の有無を次の事項で検討する ➢ 病歴および身体所見 ➢ 心筋梗塞の既往歴または狭心症の既往歴の有無 ➢ 心電図 ➢ 心臓超音波検査 ➢ 心臓血管造影検査
治療／対処方法	● 器質性心疾患がなかった場合は原因不明の持続性心室性頻拍として抗不整脈薬で治療、または原因が判明すればこれを除去。 ● 虚血性心疾患が発見されたならば： ➢ 心臓血管造影検査の後に適切な冠状動脈再建（CABG、PTCA など）を行う。 ➢ もしも、冠状動脈再建が不可能な場合は EPS（電気生理検査）を施行し、適切な内科的治療または外科的治療を行う。 ● もしも虚血性心疾患でない器質性心疾患（心筋症など）が見つかった場合： ➢ EPS（電気生理検査）を考慮し、適切な薬物療法を行う。 ➢ 除細動器の植え込みを考慮。
退院可能な状況	● 心室性頻拍の危険を適切な治療と観察で除去 ● 予防、経過観察、救急外来受診が必要な場合を患者および家族と話し合う。 そして ● 薬剤の適切な内服法、薬剤相互作用や副作用に関する患者教育 ● 退院先の環境が治療に適するかの評価

ベスイスラエルメディカルセンター　　診療ガイドライン

題：非持続性心室性頻拍　　循環器 6　　1996. 2. 2

目的	非持続性心室性頻拍（３秒以上で脈拍数１００/分以上の心室性頻拍）の管理を医師が適切に行えることを目的とする
入院前の検討事項	ほとんどの患者が胸痛、鬱血性心不全、失神または頻脈の検査や治療で心拍モニター病床に入院している場合に生じる不整脈である。ホルター心電図や外来での心電図検査でたまたま発見される患者もいる。
治療／対処方法	● 器質性心疾患がなく有症状であれば（動機、めまい、失神など)、ベーターブロッカー投与で治療する。 ● 虚血性心疾患が発見されたならばシグナルアベレージ心電図を施行： ➢ もしも異常ありならば、ＥＰＳ（電気生理検査）を考慮。 ➢ もしも正常ならば、それ以上の検査は不要。 ● もしも虚血性心疾患でない器質性心疾患（心筋症など）が見つかった場合： ➢ 有症状の患者さんのみを薬物治療にて対処。 ➢ どの治療法を始めるにしてもＥＰＳを前もって施行することを考慮。
退院可能な状況	● 予防、経過観察、救急外来受診が必要な場合を患者および家族と話し合う。 **そして** ● 薬剤の適切な内服法、薬剤相互作用や副作用に関する患者教育。 ● 退院先の環境が治療に適するかの評価。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：心室性期外収縮　　循環器 7　　1996. 2. 2

目的	心電図、心電図モニター、ホルター心電図などで 1 時間あたり 10 回以上の心室性期外収縮を生じた患者の管理を医師が適切に行えることを目的とする。
入院前の検討事項	● 外来患者であれば既に動悸などの症状に対して何らかの検査がなされているかも知れない。 ● 入院患者であれば、心電図、心電図モニターなどで既に心室性不整脈が捉えられていたかもしれない。
評価／検査方法	● 病歴および身体所見で器質性心疾患（虚血性ｖｓ非虚血性）を示唆するもの： ➢ 心筋梗塞または狭心症の既往 ➢ 弁膜症 ➢ 心筋症 ● 器質性心疾患を見つけるための非侵襲的検査： ➢ 心臓超音波検査 ➢ 負荷心電図 ➢ もしも負荷心電図検査が微妙な結果の場合は負荷核医学検査（SPECT、タリウム検査、PET） ● 器質性心疾患を見つけるための非侵襲的検査： ➢ 負荷心電図や核医学負荷検査が異常であった場合は、心臓血管造影
治療	● 薬物治療ならばベータブロッカー ➢ 鬱血性心不全を伴わない虚血性/非虚血性器質性心疾患で有症状の場合 ➢ 器質性心疾患が明らかでないが、頑固に症状が持続する場合で下記が効果ない場合 — 医学的に心配しなくて良いとの説明 — カフェイン摂取量の軽減 — 減煙または禁煙 — 減酒または禁酒 ● （器質性心疾患がないもの、虚血性心疾患または非虚血性心疾患があるものでも）無症状患者は治療の必要なし。
退院可能な状況	● 予防、経過観察、救急外来受診が必要な場合を患者および家族と話し合う。 **そして** ● 薬剤の適切な内服法、薬剤相互作用や副作用に関する患者教育 ● 退院先の環境が治療に適するかの評価

ベスイスラエルメディカルセンター　　診療ガイドライン

題：心臓血管造影検査後の管理　　循環器 8　1996. 2. 26

目的	心臓血管造影検査後の管理を補助することを目的とする。
治療／管理	● 診察および血液検査： ➢ 血圧、脈拍数、カテーテル刺入部、末梢動脈の脈拍を、検査後 15 分おきに 4 回、30 分おきに 4 回、１時間おきに４回、毎４時間おきに４回と観察していく。 **注：**カテーテル刺入部に血腫や出血を認めたら、用手圧迫をして循環器専修医を呼ぶこと。血腫外縁にペンで印をつけ、新たな血管雑音がないかをチェックし、ヘマトクリット値とヘモグロビン値を患者が安定するまで少なくとも毎４時間おきに測定する。（重度の血腫や出血では、もっと頻回のチェックを要する） ➢ ２４時間にわたる体液量管理（IN＆OUT）を続け、その後は適宜とする。 ➢ 検査後直ちに心電図を検査し、翌朝の心電図検査、もしも胸痛を生じた場合はその都度心電図を検査する。 ➢ 検査直後、翌朝、後は必要に応じて電解質、BUN、クレアチニン、血算を検査する。 ● 歩行許可 ➢ カテーテル挿入側の脚は真っ直ぐに伸ばしたままとし、頭を３０°挙上することは許可する。 ➢ カテーテルシース除去後６時間は圧迫器具を使用する。もしも血腫や出血を生じなければ、患者の体動を徐々に許可する。(寄りかかり歩行から、補助歩行から、独立歩行へと) ● 患者教育 ➢ 検査医から得た検査結果情報をもう一度しっかり教える。（最終報告がなくても、検査速報レポートを参照のこと） ➢ 動脈硬化危険因子をおさらいし、患者に生活指導をする。 ➢ 適切な専門家（栄養士、ソーシャルワーカー、生活改善療法プログラムなどへ）紹介する。 ● 今後の内服薬摂取方法のおさらいをし、その他教育すべきことを話す。
退院可能な状況	● 歩行可能状態。 ● 血液検査上問題となる異常値なし。 ● 心臓血管造影検査の結果と今後の治療方針を患者が理解。 ● ７日以内に外来で経過観察をする予約を取る。 ● 退院先の環境が治療に適するかの評価

ベスイスラエルメディカルセンター　診療ガイドライン

題：心臓血管ステント挿入後の管理　循環器 9　1996. 3. 6

目的	心臓血管ステント挿入後の管理を補助することを目的とする。
治療／管理	● 診察および血液検査： ➢ 血圧、脈拍数、カテーテル刺入部、末梢動脈の脈拍を、検査後 15 分おきに 4 回、30 分おきに４回、１時間おきに４回、毎４時間おきに４回と観察していく(バイタルサインプロトコール)。 **注：**カテーテル刺入部に血腫や出血を認めたら、用手圧迫をして循環器専修医を呼ぶこと。血腫外縁にペンで印をつけ、新たな血管雑音がないかをチェックし、ヘマトクリット値とヘモグロビン値を患者が安定するまで少なくとも毎４時間おきに測定する。（重度の血腫や出血では、もっと頻回のチェックを要する）もしも、偽動脈瘤や動静脈ろうが疑われれば、血管超音波検査を考慮する。 ➢ ２４時間にわたる体液量管理（IN&OUT）を続け、その後は適宜とする。 ➢ 検査後直ちに心電図を検査し、翌朝の心電図検査、もしも胸痛を生じた場合はその都度心電図を検査する。 ➢ 検査後直ちに、翌朝、あとは必要に応じて電解質、BUN、クレアチニン、血算を検査する。 ➢ ROMI：検査後直ちに、さらに毎８時間おきに２回、CPK、CK-MB を測定。もしも上昇していれば、下降するまで毎８時間おきの測定を続ける。その場合は、循環器医師と相談しながら心筋梗塞の患者として扱う。 ➢ 胸痛、不整脈、ST 変化の際には、循環器専修医に連絡。 ● シース除去/運動 ➢ カテーテル挿入側の脚は真っ直ぐに伸ばしたままとし、頭を３０°挙上することは許可する。 ➢ 更なる検査の予定がなければ ACT が１８０以下となった時点でカテーテルシース除去となる。 ➢ 圧迫器具を使用開始後は上記のバイタルサインプロトコールに従う。圧迫器具はシース除去後１０時間着用する（ヘパリン、ワーファリン、血栓溶解療法後の患者ではもっと長く）。もしも血腫や出血を生じなければ、患者の体動を徐々に許可する。(寄りかかり歩行から、補助歩行から、独立歩行へと) ● 投薬 ➢ アスピリン３２５mg/毎日 ➢ チクロピジン２５０ｍｇｘ２回/毎日(ワーファリン使用者は不要) ➢ もしもワーファリン投与予定であれば、ヘパリン投与を続け PTT が 60 から８０になるような調節を、ワーファリンによる抗凝固作用が INR 2.0～3.0 となるまで続ける。 ➢ 全例にアスピリンを、ワーファリンまたはチクロピジンと併用する。 ➢ カルシウムブロッカー投与を循環器科担当医と協議して決める。 ➢ シースが除去され循環動態が安定すれば、経静脈投与のニトログリセリンを減量中止する。他にも病変がない限り、大抵はニトログリセリンの投与を中止できる。 ➢ 患者ごとに必要な他の薬を再開する。 ● 患者教育 ➢ アンギオ専門看護婦（ポケベル５２７７）を呼び管理を始める。 ➢ 検査医から得た検査結果情報をもう一度しっかり教える。（検査速報レポートを参照のこと） ➢ 動脈硬化危険因子をおさらいし、患者に生活指導をする。 ➢ 適切な専門家（栄養士、ソーシャルワーカー、生活改善療法プログラムなどへ）紹介する。 ➢ 今後の内服薬摂取方法のおさらいをし、その他教育すべきことを話す。
退院可能な状況	● 歩行しても胸痛がなく、循環動態安定状態。 ● 血液検査上問題となる異常値なし。 ● 心臓血管造影検査の結果と今後の治療方針を患者が理解。 ● ７日以内に外来で経過観察の予約を取る。 ● チクロピジン使用例では 14 日以内に血算および分画をチェック。 ● ワーファリン投与患者では 2 日以内にＰＴ/ＩＮＲ測定が必要で、ＩＮＲを適宜検査することが必要。 ● 退院先の環境が治療に適するかの評価 **注：**全ての疑問はアンギオ循環器チームへ質問すること。

ベスイスラエルメディカルセンター　　診療ガイドライン　　1996．2．27

題：心臓冠状動脈処置（PTCA、内膜摘除、ロタブレーダー）後の管理　循環器 10

目的	心臓冠状動脈処置（PTCA、内膜摘除、ロタブレーダー）後の管理を補助する目的
治療／管理	● 診察および血液検査： ➢ 血圧、脈拍数、カテーテル刺入部、末梢の脈拍を、検査後 15 分おきに 4 回、30 分おきに 4 回、１時間おきに４回、毎４時間おきに４回と観察していく(バイタルサインプロトコール)。 **注：**カテーテル刺入部に血腫や出血を認めたら、用手圧迫をして循環器専修医を呼ぶこと。血腫外縁にペンで印をつけ、新たな血管雑音がないかをチェックし、ヘマトクリット値とヘモグロビン値を患者が安定するまで少なくとも毎４時間おきに測定する。（重度の血腫や出血では、もっと頻回のチェックを要する）もしも、偽動脈瘤や動静脈ろうが疑われれば、血管超音波検査を考慮する。 ➢ ２４時間にわたる体液量管理（IN&OUT）を続け、その後は適宜とする。 ➢ 検査後直ちに心電図を検査し、翌朝の心電図検査、もしも胸痛を生じた場合はその都度心電図を検査する。 ➢ 検査後直ちに、翌朝、あとは必要に応じて電解質、BUN、クレアチニン、血算を検査する。 ➢ ROMI：検査後直ちに、さらに毎８時間おきに２回、CPK、CK-MB を測定。もしも上昇していれば、下降するまで毎８時間おきの測定を続ける。その場合は循環器医師と相談しながら、心筋梗塞の患者として扱う。 ➢ 胸痛、不整脈、ST 変化の際には、循環器専修医に連絡。 ● シース除去/運動 ➢ カテーテル挿入側の脚は真っ直ぐに伸ばしたままとし、頭を３０°挙上することは許可する。 ➢ 更なる検査の予定がなければ ACT が１８０以下となった時点でカテーテルシース除去となる。 ➢ 圧迫器具を使用開始後は上記のバイタルサインプロトコールに従う。圧迫器具はシース除去後１０時間着用する（ヘパリン、ワーファリン、血栓溶解療法後の患者ではもっと長く）。もしも血腫や出血を生じなければ、患者の体動を徐々に許可する。(寄りかかり歩行から、補助歩行から、独立歩行へと) ● 投薬 ➢ アスピリン３２５mg/毎日 ➢ カルシウムブロッカー投与を循環器科担当医と協議して決める。 ➢ シースが除去され循環動態が安定すれば、経静脈投与のニトログリセリンを減量中止する。他にも病変がない限り、大抵はニトログリセリンの投与を中止できる。 ➢ 患者ごとに必要な他の薬を再開する。 ● 患者教育 ➢ アンギオ専門看護婦（ポケベル５２７７）を呼び管理を始める。 ➢ 検査医から得た検査結果情報をもう一度しっかり教える。（検査速報レポートを参照のこと） ➢ 動脈硬化危険因子をおさらいし、患者に生活指導をする。 ➢ 適切な専門家（栄養士、ソーシャルワーカー、生活改善療法プログラムなどへ）紹介する。 ➢ 今後の内服薬摂取仕方のおさらいをし、その他教育すべきことを話す。
退院可能な状況	● 歩行しても胸痛がなく循環動態安定状態。 ● 血液検査上問題となる異常値なし。 ● 心臓血管造影検査の結果と今後の治療方針を患者が理解。 ● ７日以内に外来で経過観察の予約を取る。 ● 退院先の環境が治療に適するかの評価。 **注：**全ての疑問はアンギオ循環器チームへ質問すること。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：菌血症/敗血症症候群　　感染症 1　1995. 7. 12

目的	● 菌血症/敗血症症候群の患者の適切な診断及び治療を確保するのが目的。心内膜炎、髄膜炎、免疫不全患者（つまりＨＩＶ患者や白血球減少症患者）は本ガイドラインの対象外。
定義	● **菌血症**：血液培養陽性（コンタミネーションは除外） ● **敗血症/敗血症症候群** ➢ 頻脈、呼吸数増加、高熱、低体温などの全身反応の存在 ➢ 低酸素血症、乏尿、意識障害、乳酸アシドーシス、かつ/またはＤＩＣの存在 注：敗血症/敗血症症候群であればＭＩＣＵ管理、かつ/また感染症科コンサルテーションを考慮。
治療／対処方法	● **検査およびアセスメント：感染巣の同定のために下記を行う** ➢ 感染巣同定のために注意深い病歴聴取と症状 ➢ 危険因子の同定－基礎疾患、最近の手術、入院、人工異物の有無など ➢ 身体所見 ➢ 検査－2 セット以上の血液培養（10ｃｃの血液を別の部位から採血）、尿検査、尿培養、血算および分画、胸部Ｘ線写真、その他 **注：**ベスイスラエル病院の敗血症患者からランダムに検体を採取したところ、その多くが尿路感染を感染源としていたことは参考になる。 ● 抗生物質治療（細菌同定前の）：選択の際の考慮 ➢ 最近の抗生物質使用 ➢ プロテーゼや血管内留置器具の有無 ➢ 最近の入院、手術、またはナーシングホームなどの施設入所者 ➢ 過去の抗生物質に対する副作用歴、アレルギー歴 ➢ 抗生物質治療は（大腸菌、クレブシエラなどの）グラム陰性桿菌と、（黄色ブドウ球菌、連鎖球菌などの）グラム陽性球菌をカバーしなければならない ➢ ベスイスラエル病院で検出される菌の感受性に基づけば（ベスイスラエル抗生物質マニュアル参照のこと）、アミノグリコシドとセファロスポリンまたは広域ペニシリンを初めに投与する。 注：バンコマイシンはＭＲＳＡの危険の高い症例(プロテーゼや血管内留置器具の患者)のみに使用 注：抗生物質使用箋は完全に埋めること。これにより適正な使用量と副作用を最小限に押さえるように努める ➢ 培養検査結果が明らかになれば、抗生物質を適宜変更する ● 下記の場合には自宅での点滴療法や経口抗生物質による治療を考慮： ➢ 体温が正常に近づいていく時 ➢ 白血球数が正常化していく時 ➢ 感染の症状と所見が軽快していく時 ➢ 経口抗生物質が内服できる時 ➢ 検査結果が尿路感染症や肺炎球菌を疑わせ、内服治療に変更できそうな時
退院可能な状況	経口抗生物質に変更後 24 時間以内に退院を考慮し始める。

ベスイスラエルメディカルセンター　診療ガイドライン　1995．11．21

題：尿路感染症（免疫正常者、非手術患者）　感染症 2

目的	● 入院の基準を設定する ● 経静脈投与抗生物質から経口抗生物質へ変更する際の基準を設定する ● 診断方法の提案
入院前の考察	● **外来治療を考慮する：**単純な尿路感染症で下記のものは、経口抗生物質で外来治療を考慮する ➢ 発熱 37.８℃以下 ➢ 白血球増加のないもの ➢ 全身感染のサインのないもの 培養結果が出る前の抗生物質投与：ST 合剤、アンピシリン、ノフロキサシン ● **入院を考慮する：**複雑尿路感染症で下記のもの ➢ 発熱 37.8℃以上 ➢ 白血球増加があるもの ➢ 排尿時痛、頻尿、側腹部痛や腹部の圧痛のあるもの、嘔吐または経口抗生物質を内服できないもの。 注：複雑尿路感染症：腎盂腎炎または尿路結石の既往歴のある患者、上部尿路感染症の症状のあるもの（側腹部/腹部の疼痛、嘔気/嘔吐）、感染再発、既知の尿路奇形、最近の抗生物質使用歴がある患者
治療／ 対処方法	● **腎盂腎炎/複雑尿路感染症** ➢ 血液培養検査ｘ2 回、尿検査/尿培養検査を全員に施行 菌同定前の抗生物質投与。投与薬剤は、セファロスポリン、ST 合剤、アンピシリン/ゲンタマイシン、その他。 ● 下記の場合は経静脈投与抗生物質から経口抗生物質へ変更 ➢ 体温が低下して落ち着いた時 ➢ 白血球数が正常化していく時 ➢ 感染の症状が軽快していく時 ➢ 経口抗生物質が内服できる時 ● 下記の場合は更なる検索を必要とする ➢ 尿路感染症を再発する患者 ➢ 男性の尿路感染症は泌尿器科コンサルテーションを要す ➢ ４８～７２時間の経静脈投与抗生物質投与でも解熱しない場合 ― 尿培養検査の再検 ― 培養検査の結果にあわせて抗生物質を変更 ― 膿瘍や尿路閉塞のないことを超音波検査で確認 ― 感染症科/泌尿器科コンサルテーションを考慮
退院 可能な状況	経口抗生物質に変更しても症状の悪化がなく、入院しつづけなければならない理由がない状況で、外来フォローができる場合。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：蜂巣炎　　感染症 3　1995. 11. 21

目的	蜂巣炎を診断し治療すること。
定義	下記のいずれかを伴う局所軟部組織の炎症 発熱、局所の発赤、腫脹、熱感、疼痛または圧痛、水疱、リンパ管炎とリンパ節炎
入院前の考察	● **病歴聴取上重要な点** 基礎疾患：　例）糖尿病、末梢血管障害、外傷、違法薬物注射、皮膚潰瘍、悪性腫瘍、手術、腎不全、　鬱血性心不全 ➢ 最近の抗生物質投与。 ➢ 主な症状および身体所見。敗血症の兆候はあるか。 ➢ 経口の抗生物質を内服できないのか。 **注）　多くの蜂巣炎の患者さんは経口抗生物質で外来治療が可能**
治療／対処方法	● **検査** ➢ 血算および分画、血沈 ➢ 体温が３８．４度以上で血液培養検査ｘ2回（２カ所の別部位より） ● 骨髄炎や軟部組織内ガスを除外するために、これらが疑われるときは画像診断の施行を考慮する。 ● もしも筋壊死、軟部組織ガス、筋膜炎の所見があれば、感染症科／外科へのコンサルトを考慮する。 ● 抗生物質投与（起因菌が判明する前の） 抗生物質選択における考察 ➢ 抗生物質の副作用／アレルギーの既往歴確認。薬物の名前と生じたアレルギーの種類記載。 ➢ 最近の抗生物質の使用歴。 ➢ 最近の入院／手術。 ● 起因菌判明前の治療 注）ほとんどの蜂巣炎はA群溶連菌によるが、黄色ブドウ球菌によるケースもある。静脈内投与から経口に切り替える際の経口抗生物質も列挙する。 ➢ ペニシリン、ナフシリン（経口ジクロキサシリン）などの合成ペニシリンまたはセファゾリン（経口セファレキシンやセフラジン）などの第１世代セファロスポリンを使用。もしも隆起した境界など連鎖球菌のみが疑われた場合はペニシリン単独使用もあり得る。 ➢ 組織壊死の所見がある重症の糖尿病性足感染症では、外科的治療やグラム陰性菌や嫌気性菌をカバーする抗生物質の追加を考慮する。 ➢ 重篤なペニシリンアレルギー患者では、クリンダマイシン（経口または経静脈）またはバンコマイシンを投与。もしも連鎖球菌のみが疑われるならばエリスロマイシン（経口または経静脈）でもよい。 ➢ バンコマイシンはＭＲＳＡのハイリスク患者（静脈カテーテルや人工物のある患者）にのみ使用するようにする。 注）　治療開始後４８時間経過してもよくならなかった場合は、感染症科／外科コンサルテーションのこと。 ➢ 下記のように感染が軽快する場合は経静脈投与から経口投与へ切り替える。 － 発赤、腫脹、圧痛が減少するとき。 － 患者の体温が正常化していくとき。 － 白血球数が正常化するとき。 － 経口の抗生物質を内服できるとき。
退院可能な状況	静脈内投与から経口抗生物質に変更して問題なければ２４時間以内に退院可能。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：骨髄炎　　感染症 4　1995. 11. 21

目的	骨髄炎を診断し治療すること
定義	下記のいずれかを伴う骨の炎症 発熱、局所の発赤、腫脹、熱感、疼痛または圧痛、水疱、リンパ管炎とリンパ節炎
入院前の考察	● **病歴聴取上重要な点** ➢ 基礎疾患：　例）糖尿病、外傷、違法薬物注射、鎌状赤血球症、人工異物、手術、末梢血管障害、床ずれ。 ➢ 最近の抗生物質投与。 ➢ 主な症状および身体所見。敗血症の兆候はあるか。 ➢ 検査成績－血算および分画、血小板、血沈、血液培養２回（１０ＣＣを２カ所から)、病変部のＸ線写真 ➢ Ｘ線検査で異常がなくても骨髄炎が疑われるならば、３相骨シンチまたはＭＲＩ施行。 **注）　臨床所見と骨シンチ所見が骨髄炎に合致すれば、ガリウムシンチは必要ないかもしれない。** ➢ 長期的な抗生物質投与が必要となるので、精密な細菌学的診断をすることが非常に重要。もしも血液培養検査が陰性で、画像診断が骨髄炎を疑わせ、まだ抗生物質が投与されていなければ、骨生検／デブリドメントを検討。
治療／対処方法	● **抗生物質の選択は血液培養または骨生検で見つかった細菌の種類による。もしも、細菌が同定されなかった場合、少なくともブドウ球菌をカバーするものを含めること。** ● **感染症科コンサルトを考慮** 次に関する病歴を聴取 ➢ 抗生物質の副作用／アレルギー歴の確認。薬物の名前と生じたアレルギーの種類を記載。 ➢ 最近の抗生物質の使用歴。 ➢ 最近の入院／手術。 ● 骨髄炎は長期にわたる経静脈的抗生物質投与を要するので、 ➢ 家庭での点滴投与が可能であるかの心理社会学的検討が必要。 ➢ 長期静脈アクセス法への検討を入院早期に開始する。
退院可能な状況	家庭での治療継続が可能であれば、退院後に家庭での静脈内抗生物質投与療法が可能。慢性骨髄炎では、長期経口抗生物質療法も可能。

ベスイスラエルメディカルセンター　診療ガイドライン

題：急性脳梗塞　神経内科 1　1995. 7. 12

目的	➢ 急性脳梗塞患者の診療を助けるため。 ➢ 効率的な診断を進めるため。 ➢ 脳梗塞の再発予防のために、適切な内科的そして／または外科的治療をするため。
入院前の考察	● 脳梗塞とＴＩＡは入院が必要な神経内科における救急疾患である ● 神経内科病棟への入院が望ましい（意識低下のある患者、循環動態または呼吸状態が不安定な患者は集中治療室への入院） 脳梗塞の危険因子：高齢、男性、黒人／アジア人、高血圧、心疾患（冠動脈疾患、心不全、心房細動など）、糖尿病、高脂血症、末梢血管障害、喫煙、アルコール中毒、過去の脳梗塞、ＴＩＡまたは既知の頸動脈狭窄、凝固能亢進状態
治療／対処方法	**検査及び診断** ● 血液検査：血算、血小板、電解質、血糖、クレアチニン、ＢＵＮ、心筋酵素, 心疾患危険因子、凝固検査、心電図、胸部Ｘ線 ➢ ５０歳以下の症例や危険因子のない症例では、血沈、ＡＮＡ、梅毒検査、Ｃ蛋白、Ｓ蛋白、アンチトロンビンⅢ, 抗カージオリピン抗体、ルーパス抗凝固因子を測定。 ● 頭部ＣＴ検査：脳内出血及び他の頭蓋内疾患を除外するために、全例にコントラストなしの頭部ＣＴを至急施行。 ➢ （特に椎骨動脈系の梗塞が疑われる場合など）頭部ＣＴ検査が診断に有用でない場合はＭＲＩを考慮。 ● ほとんどの患者に頸動脈ドップラー超音波検査が必要：椎骨動脈及び経頭蓋ドップラー超音波検査が施行できる患者もいる ➢ ドップラー超音波検査が中等度から高度の狭窄を示唆し、患者が外科手術適応ならば、もしくは動脈解離とか血管炎が疑われるときは、血管造影検査を考慮。（ＭＲＡをスクリーニングとして代用したり、造影剤アレルギー者に実施） ● 心臓からの塞栓が疑われるときは、心臓超音波検査（経胸壁または経食道）を考慮。 ➢ 注：診断のための検査は入院第３病日までに全て終えること。 **治療** ― 血圧が 220/110mmHg 以上の時、心不全があるとき、大動脈解離のあるときは、血圧を下げる治療をおこなう。 ― 低血糖または高血糖（170mg/dl 以上）の治療 ― 酸素投与を必要に応じて ― 心機能のモニター ― 以下のものを可及的に予防する：　誤飲、低栄養、肺炎、深部静脈血栓症、肺塞栓、床ずれ、拘縮および関節の問題 ― 進行性の梗塞、動脈または心源性の軽から中等度の塞栓では（初回のワンショット投与を伴わない）ヘパリン持続投与を開始し、ＰＴＴをコントロールの１．５倍になるよう調整。 ― 抗凝固療法がなされないのなら（アスピリン、チクロピヂン）などの抗血小板剤を投与。 ― 早期離床と早期のリハビリテーションへのコンサルト。 ― 高度の頸動脈狭窄または血管操作を考慮する場合は外科（血管外科または脳血管外科）にコンサルト 注：入院３日目までに（抗血小板薬、抗凝固療法、外科手術）の長期的視野に立った治療方針を決定する
退院可能な状況	障害の程度により、家、短期または長期のリハビリテーション施設、特別介護施設への退院となる。 ― 神経内科的に安定　― 内科的に安定 ― 診断が完了　― （抗血小板薬、抗凝固療法、外科手術）の治療が開始 ― 患者／家族への教育が終了　― 適切なフォローアップの準備

ベスイスラエルメディカルセンター　　診療ガイドライン

題：痙攣（コントロール不良の）神経内科２　1995. 9. 11

目的	てんかんの既往症がある患者で、痙攣を再発した場合のマネージメント
入院前の考察	● てんかん症例の全員が入院する必要はない。 ● 入院を考慮しなければならないのは次の通りである。 ➢ ３０分以内に２回以上の痙攣を生じた場合。 ➢ 痙攣発作が長引いたもの。 ➢ 意識障害などが元通りになるまで時間を要した場合。 ➢ いつもと違ったパターンの痙攣を生じた場合。 ● 痙攣重積は入院が必要。（痙攣重積：複数の痙攣が連続して生じその間に神経学的に完全な回復を見ないもの、または３０分以上にわたり痙攣症状が持続するもの）
診断および検査	痙攣再発の原因をつきとめるのがねらい ● 血液検査：血算、血小板、電解質、血糖、クレアチニン、ＢＵＮ、抗痙攣剤の血中濃度 必要に応じて：違法薬物検査、アルコール濃度、マグネシウム ● もしも下記の場合は頭部ＣＴまたはＭＲＩ、脳波、髄液検査 ➢ いつもの痙攣と頻度やタイプが異なる場合 ➢ 神経学的所見が持続する場合 ➢ （髄膜炎、硬膜下血腫、頭蓋骨骨折などの）他の診断がありそうな場合
治療／対処方法	● 抗痙攣剤を補充する。この際に薬剤の薬理をしっかり考慮し、他の薬との相互作用、肝臓代謝ｖｓ腎臓代謝をチェックする。 ● 痙攣が持続するとき以外はベンゾジアゼピン不要。痙攣重積は集中治療室へ入院の上、速やかに痙攣を止めるため積極的な治療をする。 ● 発作後のもうろう状態には酸素を投与する。 ● 痙攣時の身体損傷に注意する。 ● 身体損傷を生じないように痙攣用の注意事項を実施する。 **注：**舌をかみきらないようにとの目的で使われるバイトブロックは、有用ではなく不必要性であることが判明した。 ● 既往のてんかん以外の痙攣の原因が判明した場合はその治療を行う。たとえば、抗生物質投与、脳外科的治療など。 痙攣のコントロールが難しかったり、第２病日に至っても痙攣の原因が判然としない場合は、神経内科へのコンサルテーションが望ましい。新たな診断や今までの抗痙攣剤の見直しなどが必要となる。
退院可能な状況	下記の場合は退院可能となる。 －　痙攣の停止 －　抗痙攣剤の血中濃度の安定 －　患者／家族の教育が完了 －　外来での経過観察計画が完了

ベスイスラエルメディカルセンター　　診療ガイドライン

題：院外で発症した肺炎の治療　1995．4．10

目的	● 抗生物質の選択方法 ● 静脈内投与の抗生物質から経口の抗生物質への変換
入院前の検討事項	基礎疾患を持たない若年者など多くの患者は、経口のエリスロマイシン投与で治療可能。 クラリスロマイシン、アジスロマイシンは高価な代替薬である。肺気腫の患者さんにお勧め。
治療／対処方法	<u>入院患者：比較的軽症な肺炎</u> ● 最初の抗生物質はセフロキシム（マイコプラズマ肺炎、レジオネラ肺炎、クラミジア肺炎が疑われるときは、エリスロマイシンを追加） **老人ホーム患者はセフタジジムまたはチカルシリン／クラブラン酸をセフロキシムの代わりに投与。もしも、えん下性肺炎で嫌気性菌を疑うならばチカルシリン／クラブラン酸を考慮。** <u>入院患者：重症肺炎</u> 次の条件の何れかを満たすもの ― 呼吸数３０回/分以上 ― PaO2／FIO2 が２５０以下 ― 人工呼吸器の必要なもの ― 両側／多葉性肺炎 ― X 線写真での肺炎陰影が４８時間以内に５０％以上増加するもの ― ショックを伴うもの ― 乏尿 ― 昇圧剤の必要なもの ● 最初の抗生物質は、[セフロキシム または セフタジジム または チカルシリン／クラブラン酸] と バンコマイシン と エリスロマイシンの３剤併用。 **非耐性ブドウ球菌の場合はバンコマイシンを可及的にナフシリンに変更すること。細菌培養検査および抗生物質感受性検査の結果で、適宜抗生物質を変更すること。** <u>次の全てが満たされた場合には経口抗生物質へ変更</u> ➢ ２４時間以上にわたり、持続して 0.5℃以上の解熱効果が認められた時 ➢ 血液中の白血球が減少した場合 ➢ 呼吸器系の症状／所見が軽快した時 ➢ 経口抗生物質が内服可能 **このような状況は、比較的軽症な肺炎では入院２日目から５日目に訪れるのが普通。**
退院可能な状況	<u>退院</u> 経口抗生物質に変更後 24 時間にわたり病状の悪化がなく、特に入院でなければできない治療が不必要になれば退院となる。 **このような状況は、比較的軽症な肺炎では入院３日目から６日目に訪れるのが普通。** **胸部 X 線写真上の所見改善は病状改善より遅れるのが普通なので、病状軽快を胸部 X 線写真上で確認する必要は初期１週間にはない。（胸部X線写真上の軽快がなくても退院とし、退院してからしばらく期間が経過してから胸部X線写真を再検する。）**

ベスイスラエルメディカルセンター　　診療ガイドライン

題：喘息患者の入院治療　　1995．4．10

目的	入院が必要な喘息患者の管理を補助するのが目的。
入院前の検討事項	普通はベーター刺激剤とステロイドの吸入療法にて外来での治療が可能。ピークフローの改善が少なく１００Ｌ／分未満であったり、呼吸数が多かったり、呼吸補助筋を使うなどの呼吸不良を示す他の症状があれば入院治療とする。
治療／対処方法	● ピークフロー ➢ 少なくとも毎日１回は測定。 ● 薬剤 ➢ メチルプレドニゾロン４０ｍｇIV 毎６時間を、少なくとも２４時間。症状が軽怪したらば速やかに経口のプレドニゾン４０ｍｇ／日へ変更。 ➢ 急性期にはアルブテロールのネブライザーを使用し、その後はアルブテロール吸入剤をスペーサーを用いて４吸入、必要に応じて４時間の間隔をあけて使用。 ➢ 退院後に吸入ステロイド使用が必要と予測される場合はトリアムシノロン吸入剤をスペーサーを用いて１０吸入毎日２回を直ちに開始。（急性喘息ではフルニソリドやベクロメタゾンは使用しないこと） **注：**アミノフィリンの静脈内投与はしないこと ● 歩行 ➢ 毎日積極的に歩くように指導。 ● 患者教育 ➢ 入院初日より開始 ➢ スペーサーを用いた正しい吸入剤の使用方法 ➢ 病気のメカニズムの説明 ➢ 異なる種類の薬剤効用の説明 ➢ 生じうる副作用の説明
退院の適応	● 呼吸苦が解消して十分歩ける程度になった場合。 ● ピークフロー値の改善。 ● 吸入療法を自分で正しくできるようになること。 ● 退院後７日以内の外来予約。

ベスイスラエルメディカルセンター　　診療ガイドライン　　１９９５．９．１１

題：悪性胸水

胸部外科　３

目的	胸水穿刺、診断、胸水再発予防、呼吸困難対策
入院前の検討事項（救急室及び入院での診療）	血算、電解質、生化学、凝固系、尿検査、心電図、胸部Ｘ線写真（過去１０日以内になされていなければ）
治療／対処方法 ― 手術前	**注：**何種類かの治療法が存在するが、そのうちのどれがよいかはっきりわかっていない ● **方法１** ✧ 胸部Ｘ線で胸水貯留側を確認後、局所麻酔を使って胸部チューブをベッドサイドで挿入する。 ✧ 滲出胸水が１日に１００ｃｃ以下となり、肺が十分に広がったことを確認後、タルク（または他の物質）を注入して、胸膜癒着術を行う。 ✧ 滲出胸水が１日に１００ｃｃ以下となったら、チューブを抜去。 ✧ 滲出胸水が１日に１００ｃｃ以下にならない時は、胸膜癒着術を繰り返すことを考慮。 ● **方法２** ✧ 呼吸苦軽減のために胸腔穿刺を外来診療で行う。 ✧ 胸腔穿刺後の胸部Ｘ線写真で肺が完全に膨らんでいれば、次の日に入院して胸腔鏡下胸膜切除術またはタルク（または他の物質）を注入して胸膜癒着術を行う。 滲出胸水が１日に１００ｃｃ以下となったら、チューブを抜去。 **注：**胸腔穿刺や胸腔チューブ挿入で肺が完全に膨らまない場合は、胸膜癒着術の効果はない。 その際には２つの方法を考慮。 １．　胸腔チューブを抜去し、再度胸水のたまった段階で再治療。 ２．　胸腔腹腔シャント術を考慮
退院可能な状況	次の場合は退院可能と判断 ― 平熱 ― 介助なしで歩行できるようになる ― 経口投与薬剤のみで疼痛コントロール可能 ― 十分な食事摂取可能状態 ― 家で退院後のケアができる状態であることの確認

ベスイスラエルメディカルセンター　診療ガイドライン　1995．8．15

題：肺気腫増悪の入院治療　呼吸器 3

目的	入院が必要な肺気腫増悪患者の管理を補助するのが目的。
入院前の検討事項	人工呼吸器を使用しなければならない状況が十分に懸念される場合は入院管理が妥当。外来治療にて適切にベーター刺激剤、抗コリン剤、経口テオフィリン製剤、経口抗生物質を使用していけば多くの場合で入院は回避できるはず。
治療／対処方法	● 酸素 ➢ ルームエヤーでの動脈血ガス分析を入院時に測定 ➢ 低分量の酸素（２４%～２８%のベンチマスクか１～２Ｌ／分の鼻カニュラ）で高二酸化炭素血症を生じない範囲で動脈血酸素を上昇させる。（動脈血酸素６０mmＨｇ以上、酸素飽和度９０%以上を確認。） ➢ 初めの動脈血二酸化炭素濃度が高いときは、酸素投与量が変わる度に酸素飽和度に加えて動脈血ガス分析が必要。 ➢ もしも酸素投与で高二酸化炭素血症が生じるならば、動脈血酸素分圧を６０～７０mmHg にてコントロール。 ● 集中治療室または呼吸治療ユニットでの管理が必要かの評価 人工呼吸器を使用しなければならない状況が十分に懸念される場合や、既に人工呼吸器がつながれた状況では、上記の特別病室の医師による評価を受けて転棟を考慮。つまり、高度の低酸素血症、治療抵抗性の高二酸化炭素血症、意識レベルの低下、呼吸筋疲労のサイン（奇異性呼吸や呼吸補助筋を用いた呼吸）。 ● 薬剤 ➢ 状態の悪いときはベーター刺激剤（アルブテロール）をネブライザーで毎１～２時間おきに投与。その後はスペーサーを用いたベーター刺激吸入剤を４吸入毎４～６時間に変更。大抵は２４時間以内にネブライザーから吸入剤に変更可能。 ➢ 抗コリン剤（イプラトロピウム）をネブラザイー投与毎４～６時間、後に吸入剤４吸入毎４～６時間へ変更。 **注：**アルブテロールとイプラトロピウムは一緒に投与してよい。虚血性心疾患や頻脈性不整脈がある場合の治療ではイプラトロピウムに重点を置く。特に問題なければ両薬剤を用いること。 ➢ ほとんどのケースでステロイドと抗生物質を経口にて投与。 **注：**抗生物質は呼吸苦とともに痰の量が増えて膿性痰となっている場合に最も有用。肺炎がなくても使用効果あり。喘息と異なり吸入ステロイドは効果がない。 ➢ 安定していない患者にはテオフィリンの点滴等与はしないこと。使用による危険の方が、得られる利益より少ない。使用するとすれば落ち着いた後で徐々に投与。 ● 呼吸器科へのコンサルト ➢ 高二酸化炭素血症や呼吸器の使用をしている場合。 ➢ 入院後３日以内に改善しないときも呼吸器科へのコンサルト。 ● 患者教育 ➢ 入院直後から開始 ➢ スペーサーを用いた正しい吸入剤の使用方法 ➢ 病気のメカニズムの説明 ➢ 異なる種類の薬剤効用の説明 ➢ 生じうる副作用の説明 人工呼吸器の装着や心肺蘇生を受けたいか否かの意志表示は急性増悪になる前に行うのがよい。入院直後に患者の希望を確認することが重要。
退院可能な状況	― 今回の増悪前の状態に基づいた自宅療養プランと、外来での経過観察計画が完了。 ― 吸入療法が毎４時間以上の間隔でも呼吸苦のない状態にコントロール可能となること。 ― 入院前に歩行可能であった患者は、病室内を歩行可能になること。 ― 頻回の呼吸困難で食事や睡眠が妨害されることがなくなる。 ― 静脈内投与薬剤なしでも安定している状況を 12～24 時間は観察確認。 ― 患者、または退院後患者の面倒を見る人に投薬の説明。 注：退院後、増悪状態から脱して元通りになった際、薬剤の一部は減量もしくは中止を検討する。 注：家庭での酸素投与療法の適応 ― 吸入療法が不可能ならばネブライザー治療を要す。経口薬剤での治療も選択肢の一つである。 ― 退院前の動脈血液ガスで酸素分圧が 55mmＨｇ以下の時（肺性心または赤血球増多症がある場合は 60 以下）で自宅酸素療法が必要と判断。退院後は徐々に改善が期待できるので６～８週後に再評価。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：自然気胸

呼吸器　４　　１９９５．１０．２６

目的	虚脱肺の再膨張と気胸再発防止を目的とする。
入院前の検討事項	患者は普通は救急室経由で入院することになる。入院時血液検査と胸部Ｘ線検査が必要。
治療／対処方法	● **小さな自然気胸でＨＩＶ陽性またはＨＩＶ陰性の場合** ➢ もしも虚脱率が２５％以下で呼吸困難がない場合は、２４時間の観察入院とする。 ➢ 入院中に２回の胸部Ｘ線写真を撮影のこと。 ➢ もしも、胸部Ｘ線写真上の悪化がなく、呼吸状態も悪くならなければ退院可能。 ➢ 経過観察は退院後外来で４８時間以内に行うこと。 ➢ 患者に判断力がなかったりで信頼がおきにくい時は観察のみでは不十分で、安全のために胸腔チューブを挿入すること。 ● **初回発作、ＨＩＶ陰性、胸腔チューブ挿入を要する場合** ➢ 胸腔チューブを挿入する。２０ｃｍ水柱で吸引すること。 ➢ 肺が完全に膨張し、空気漏れがなければ２４時間後に吸引を中止。胸部Ｘ線写真撮影。 ➢ もし肺が膨張していれば、吸引を止めたまま２４時間観察し、再度胸部Ｘ線写真を撮影。 ➢ 吸引を中止すると肺が虚脱するようであれば、吸引を再開。 ➢ もしも、空気漏れが４８時間以上となるか肺虚脱が生じるようであれば、胸腔鏡下の肺のう胞切除術とするか、物理的な胸膜癒着術か、薬物による胸膜癒着術を計画する。 ● **再発例でＨＩＶ陰性の場合** ➢ 胸腔チューブを挿入する。２０ｃｍ水柱で吸引すること。 ➢ もしも、空気漏れが４８時間以上となるか肺虚脱が生じるようであれば、胸腔鏡下で肺のう胞を切除するか、物理的な胸膜癒着術か胸膜切除術を計画する。 ● **初回発作、ＨＩＶ陽性、胸腔チューブ挿入を要する場合** ➢ 呼吸器内科コンサルテーション（カリニ肺炎が多い） ➢ 胸腔チューブを挿入する。２０ｃｍ水柱で吸引すること。 ➢ 肺が完全に膨張し、空気漏れがなければ２４時間後に吸引を中止。胸部Ｘ線写真撮影。 ➢ もし肺が膨張を保っていれば、胸腔チューブを抜く。 もしも、空気漏れが７２時間以上となるか肺虚脱が生じるようであれば、 ➢ 化学物質による胸膜癒着術を、空気漏れの有無にかかわらず施行。 注：　その他の方法として、患者が手術に十分耐えられるのなら胸腔鏡下の肺のう胞切除と物理的な胸膜癒着術を併用する。 ● **再発例、ＨＩＶ陽性の場合** ➢ 呼吸器内科コンサルト。 ➢ 胸腔チューブを挿入し、２０ｃｍ水柱で吸引。 患者の状況により ➢ 胸腔鏡下の肺のう胞切除と物理的な胸膜癒着術または胸膜切除術を併用する。 ➢ 胸腔チューブから化学物質による胸膜癒着術を、空気漏れの有無にかかわらず施行。
退院の適応	胸腔チューブを抜いて、胸部Ｘ線写真上で気胸が消滅したとき。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：高齢者失神（原因不明）の診療　　1995．4．10

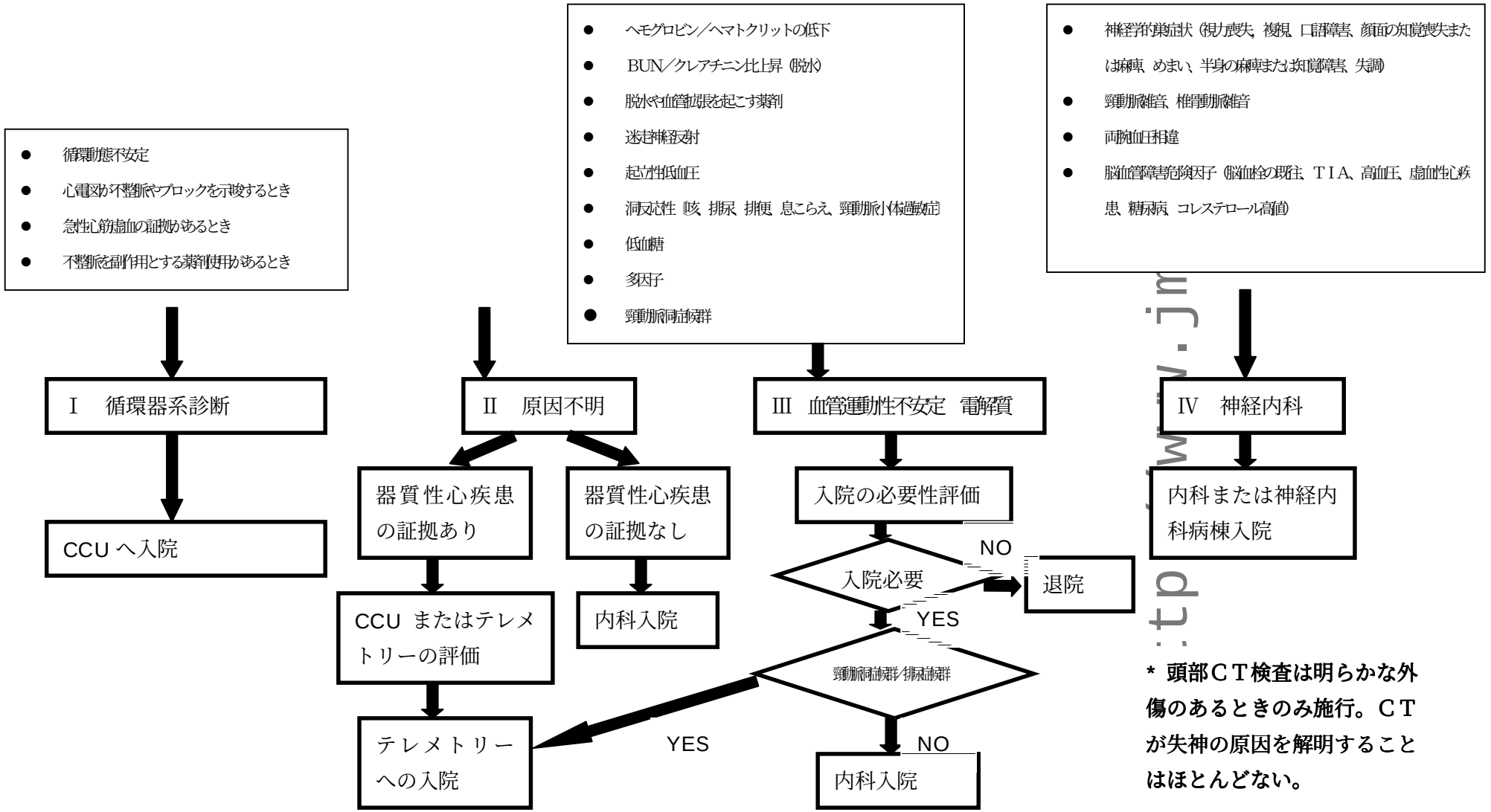
目的	原因が明らかでない高齢者失神の入院後の対処方法
入院前の検討事項	診断フローチャート（＊）にあるように、全ての患者が入院しなければならないのではない。原因が明らかで、容易に修正可能または予防可能であれば、退院させて家での経過観察でよい。
治療／対処方法	**注：**器質性心疾患の既往または証拠のない高齢者の失神は、大抵は大がかりな検査は必要ない。老人ホームでの臨床研究で、転倒する高齢者と転倒しない高齢者の不整脈を調べたところ、一過性不整脈の頻度は両群で違わなかった。高齢者での抗不整脈薬療法の意義は疑わしい。 ● 失神－迷走神経反射が原因として疑われるもの ✧ 内科病棟へ入院 ✧ 循環器科へコンサルトするのが好ましい ✧ 起立傾斜台試験で診断できる可能性あり ✧ 入院後４８時間以内に検査を終了すること ● 失神－原因が判然としないが心疾患ではなさそうなもの ✧ 内科病棟へ入院 ✧ 初めての失神であれば：ホルター心電図、起立傾斜台試験を考慮 ✧ 失神の再発例であれば：ホルター心電図、心電図イベント記録、起立傾斜台試験を考慮 ● 失神－原因が判然としないが心疾患の既往や器質性心疾患の証拠があるもの ✧ 心臓集中治療室または心電図モニター病棟へ入院 ✧ 循環器科へコンサルトする ✧ ２４時間以上の連続モニター モニターで異常が捉えられ必要ならば、ペースメーカー挿入、信号平均化心電図、誘発電位検査を施行
退院可能な状況	● 原因不明のもので、入院中に失神の再発がない例では、検査が終了したらば退院とする。 ● 原因が判明して、治療で治った場合。 ● 適切な経過観察の準備ができた場合。

（＊）次ページに記載

高齢者の失神：初期評価

定義　突然の一過性意識低下と姿勢保持力の低下で、自然に回復するもの。

全患者に
- ＊　詳細な問診と現場を目撃した人の証言
- ＊　身体所見、臥位と起立での血圧測定、両腕での血圧測定
- ＊　電解質、ＢＵＮ、クレアチニン、血糖、血算、心電図、尿検査
- ＊　家へ退院させることができるかの退院計画



＊ 頭部ＣＴ検査は明らかな外傷のあるときのみ施行。ＣＴが失神の原因を解明することはほとんどない。

ベスイスラエルメディカルセンター　　診療ガイドライン　　１９９５．７．１２

題：下部消化管手術　　外科　Ｓ１

目的	１．　下部消化管手術（大腸、直腸手術）で在宅術前処置を行う手術当日入院の適応と禁忌を明らかにする ２．　周術期管理のキーポイント
入院前の検討事項	手術や大腸内視鏡のための在宅術前処置は、一般的に安全に施行できる。しかし、ある特定の患者群には水分と電解質バランスの変化が危険を生じることもあり、このような場合は手術前日の入院とする。 ● 手術前日入院が必要な場合 ✧ 心不全、心筋梗塞、不安定狭心症、重度の狭心症の既往 ✧ コントロール不良の高血圧、電解質異常、腎不全、重度のインスリン依存性糖尿病 ✧ ステロイド依存喘息または重度肺気腫、脳血管障害の既往、肺塞栓または深部静脈血栓症の既往者で予防治療を要するもの ✧ 出血傾向、消化管閉塞 ✧ 高齢、身体および精神上の問題、自己術前処置ができない他の理由がある場合 ✧ 他の何らかの主病名より軽度の疾患が存在
治療／対処方法 ***－　手術前***	● **大腸術前処置および水分補給** ✧ 大腸術前処置は次のいずれかで行う：ゴライテリー、フリート燐酸ソーダキット、クエン酸マグネシウム、タップ水浣腸。 ✧ それぞれの術前処置剤にはきちんとした説明書を添付。もしも、前処置を行う際に何らかの問題があれば手術の２４時間前までに患者が主治医に報告を入れるようにする。 ✧ 手術前の経口または全身投与の抗生物質 **注：**在宅では水分を多くとるようにし、入院後は点滴による水分補給が望ましい。 ***－　手術後*** ● **歩行－**手術翌日午前中に介助にて歩行。 ● **胃減圧－**胃管よりの流出が 250cc 以下であるか 100cc 以下の胃内容残量であれば、手術後２４～３６時間で胃管抜去。胃ろうの場合も同じ条件でクランプ。 ● **食事－**胃管抜去または胃ろうクランプ後 24～36 時間で薄い流動食を開始し、濃い流動食へ同日のうちに上げていく。さらにその翌日には濃い流動食から常食へと変えていく。 ● **疼痛管理－**全ての患者に疼痛の患者自己管理を考慮する。必要に応じてペインチームのコンサルテーションをする。
退院可能な状況	次の場合退院可能と判断 －　常食を食べれらるようになる －　介助なしで歩行できるようになる －　発熱がなく他の合併症もない －　経口投与薬剤のみになる －　退院時のパンフレットや指示書の準備完了

ベスイスラエルメディカルセンター　　診療ガイドライン　　１９９５．９．１１

題：透析用血管グラフト感染の入院治療　　腎臓　３

目的	血液透析グラフト感染患者の管理を補助する目的
入院前の検討事項	血液培養検査陽性またはグラフト部位の発赤、腫脹、滲出物、疼痛の患者で、他に明らかな感染源がない、発熱または白血球増多を認める（または認めない）者
治療／対処方法	● 全ての患者は直ちに外科医に診察してもらう。 ● 入院に際し２セットの血液培養を提出。グラフト部の末梢およびグラフトより透析時に採血（またはパーマキャスより）。入院後４８～７２時間で再度採血。 ● （培養結果がでる前の）抗生物質投与は次の通り。 － バンコマイシン 1.0ｇとゲンタマイシン 1.5mg/kg をローディングとして初回静脈投与。 － 血液培養の結果にあわせて抗生剤を適宜変更。 注：細菌培養の結果バンコマイシンを継続することになった場合は、各回透析の後に投与する。同定された細菌にもよるが、血液中バンコマイシン濃度が 10～15 μg/ml 以下でバンコマイシンの追加投与を行う。 ● グラフトを除去するか否かは入院後２４時間以内に決定 ✧ もしもグラフトを残す判断であれば、治療方針はそれぞれのケースで考える。 ✧ もしもグラフトを除去する判断であれば、直ちに除去。 － グラフト除去後２４時間後に血液培養再検。 － 患者が菌血症でなければグラフト除去後２日以内にパーマネントカテーテルを挿入。 － 患者が菌血症であった場合、他の感染源を除外し、グラフト除去部に感染が残存していないか診察。感染症科コンサルトを考慮。 － 菌血症が治癒すれば、パーマネントカテーテルを挿入して加療を続ける
退院可能な状況	菌血症が治癒し、傷の感染がコントロール可能となれば、傷の管理と外来での抗生物質投与とする。

題：終末期患者の管理　（ホスピスの役割）　ホスピス　1

目的	下記の場合にはホスピスサービスへの依頼を考慮 ● 治癒目的の治療または延命治療が病状の進行を止められずに、苦痛が増大していることが懸念される場合。 ● 余命が何ヶ月という単位で推測される場合。（何年という単位ほど長くなく、何週間という単位ほど短くない時が好ましい。） ● 看病する家族が疲労症候群を呈し始めたとき。
入院前の検討事項	● ホスピスへ依頼をする最適な時期を探る（限られた余命）。 ● 患者、家族と供に、治療目標の変更について協議する。（病気そのものの治療から、苦痛緩和、尊厳ある死亡のプロセスの確保へと目標を変更することを意味する）
治療／対処方法	**主治医の役割** ● 多角的な苦痛緩和医療の必要性を認識する。 ● 各患者に即した療養計画を作り、必要に応じてアップデートする。 ● 苦痛緩和へのプライマリーケアを提供する。 ● 家族へのサポートも考慮する。 **ホスピスの役割** 最高レベルの癒し、満足のいく QOL の確保、家族へのサポートを実現するために、身体的、心理社会的、家族的、精神的な総括的治療に主眼をおく。 ● 終末期の初期の段階でホスピスサービスを開始。そうすることで状態が悪化した際に生じうるパニック的な入院治療、死の苦痛を引き延ばすだけの意味のない医療、看護する家族が疲弊して家族が崩壊することを未然に防ぐ。 ● ホスピスの主任医師やスタッフが、疼痛症状緩和療法の技術面でのアセスメントを行う。 ● 在宅医療、外来医療、入院医療の連携で終末期の様々な問題に対処していく。 ● ありとあらゆる状況で、多くの専門家によるチーム医療の経験と技術を生かす。 ● ナーシングホームで療養する場合は、ホスピスサービスを出張して行う。 ● 最後の時間を共同で有意義に高め、満足いく終末期医療を行う。
ホスピスサービスの開始	● ホスピスサービス依頼がなされてから４８時間以内にサービスの開始が可能。 ホスピス受付（２１２）－４２０－３３７０へ連絡のこと。

ベスイスラエルメディカルセンター　診療ガイドライン　1996．2．2

題：右上腹部痛患者の診療（胆嚢炎疑い）　外科　3

目的	急性の右上腹部痛で入院した患者（胆嚢炎疑い）の診断および診療の補助を目的とする。
入院前の検討事項（救急室及び入院での診療）	● 完全な病歴聴取と身体所見（直腸診と内診を含む） ● 血算、生化学セット、アミラーゼ、凝固系検査、胸部X線写真 ● 腹部X線写真（臥位および立位）：右上腹部痛を生じうる他の疾患の除外に役立つかもしれない。 ● 外科コンサルトを至急に行う。 ● シンチグラム（HIDA/DISIDA スキャン）が胆嚢炎の診断には最も正確。 　－ 胆嚢管閉塞で胆嚢が見えなければ急性胆嚢炎 　－ 描出が遅延し肝細胞相が持続する場合は慢性胆嚢炎および／または総胆管閉塞 **注：**無石胆嚢炎、エイズ患者、多疾患で集中治療室に入院している患者ではシンチグラムの診断力は落ちる。 ● 超音波検査：原因が判然としない右上腹部痛では超音波検査の方が有用。急性胆嚢炎としては非典型的な場合、シンチグラムの前に超音波検査をすることを考慮。 **注：**HIDA スキャンで所見がなく、超音波検査でも胆嚢壁肥厚がない場合、胃十二指腸病変のないことを確認しなければならない。
治療／対処方法 ***－　手術前***	● **発熱／白血球増多症例は静脈内抗生物質投与** ✧ 抗生物質に反応すれば、経口抗生物質へ切り替えて１０日間投与。その後、腹腔鏡下胆嚢摘出術のスケジュールを組む。 ✧ 入院２日目までに反応しなければ、３日目に胆嚢摘出術施行。 ● **発熱／白血球増多がない症例では、待機的な腹腔鏡下胆嚢摘出術のスケジュールを組む** ● **手術後管理（胆嚢摘出術）**
－　手術後	✧ 術前の消化管閉塞がない限り、経鼻胃管は手術室または術後回復室で抜去。 ✧ 十分な疼痛管理。開腹胆嚢摘出術症例の全例に患者自己疼痛管理を考慮する。 ✧ 患者が糖尿病であったり、胆嚢炎が壊死性もしくは穿孔性であった場合を除き、抗生物質は２４時間以内に中止。 ✧ 手術後１２時間で歩行。 ✧ 食事；術前の消化管閉塞がなければ、薄い流動食を術後２４時間以内に開始。問題なければ、その後２４時間以内に常食へと進めていく。
退院可能な状況	次の場合は退院可能と判断 － 平熱 － 介助なしで歩行できるようになる － 経口投与薬剤のみで疼痛コントロール可能 － 十分な食事摂取可能状態 － 家で退院後のケアができる状態であることの確認

ベスイスラエルメディカルセンター　　診療ガイドライン

題：薬剤使用ガイドライン（バンコマイシン）

Adapted from the Revised Recommendation of the Hospital Infection Control Practice Advisory Committee (HICPAC) 1995.11.13　（病院感染制御諮問委員会の勧告をもとに作成）

バンコマイシン　ー　使用基準／勧告

Ⅰ．バンコマイシンの使用が適切または認められる場合

1．ベータラクタム抵抗性グラム陽性細菌による重大な感染症の治療。ベータラクタム感受性ブドウ球菌においてバンコマイシンはベータラクタム剤よりも殺菌速効性に欠けることを理解しなければならない。

2．ベータラクタム剤に対し強いアレルギーがある患者の、グラム陽性菌感染の治療。

3．米国心臓協会の推奨する心内膜炎リスクの高い患者での、特定の処置に際する予防的抗生物質投与。

4．ＭＲＳＡ院内感染率の高い病院での、人工物挿入の大手術に際する予防的投与。たとえば、弁置換心臓手術、血管グラフト手術、人工股関節置換手術など。手術前の１回投与で十分とされるが、６時間以上の手術ではもう１回の投与のみ追加投与する。３回投与はしない。

Ⅱ．バンコマイシンの使用が不適切な場合

1．ベータラクタム抵抗性グラム陽性細菌が検出されていない状況で、感染疑いに対して漫然と長期間投与すること。

2．ただ１回だけのコアグラーゼ陰性ブドウ球菌検出（他の培養検査が一貫して陰性であるとき）に対してバンコマイシンの投与を行うこと。つまり、表皮ブドウ球菌に対して不適切にバンコマイシンが投与されることがある。コンタミネーションを最小限におさえるために採血技師や血液培養を採取する他の医療従事者を訓練しなければならない。

3．ベータラクタム剤に対し強いアレルギーがある以外の患者に、手術時感染予防目的にルーチン投与をすること。

4．ＭＲＳＡコロナイゼーション（細菌がただ常在しているだけで感染を生じていないもの）への投与。

5．腎不全患者のベータラクタム感受性グラム陽性細菌感染治療に用いること。

ベスイスラエルメディカルセンター　　診療ガイドライン

題：薬剤使用ガイドライン（シプロフロキサシン）

シプロフロキサシン　ー　使用基準／勧告

Ⅰ．経口シプロフロキサシン投与は下記のいずれかの適応のみに使用。

1．シプロフロキサシンに感受性のあるグラム陰性細菌感染で、他により安価な代替抗生剤がない場合。
2．浸潤性腸細菌（赤痢やサルモネラなど）による感染性腸炎による下痢。
3．キノロン感受性結核菌で多剤耐性のもの。
4．浸潤性非定形抗酸菌症へのセカンドライン治療。
5．または、他の抗生物質にアレルギーのある患者さんへの使用。

Ⅱ．経静脈投与のシプロフロキサシンは、経口摂取をしていない患者のみに用いる。

＊抗生物質監視委員会は細菌同定ができていない状況でのシプロフロキサシン使用を勧めていない。

ガイドライン作成団体	日本語訳	掲載数
AAON		1
Academy of Prosthodontics.		1
Academy of Psychosomatic Medicine.		1
Acne Subgroup, Task Force on Standards of Care.		1
Ad Hoc Committee for Cardiothoracic Surgical Practice Guidelines.	胸部外科診療ガイドライン アドホック委員会	4
Ad Hoc Committee of the Western Vascular Society.		1
Ad Hoc Committee on Acquired Immunodeficiency Syndrome and Hepatitis.		1
Ad Hoc Committee on Cancer Pain of the American Society of Clinical Oncology.		1
Ad Hoc Committee on Occupational and Environmental Hearing Conservation.		1
Ad Hoc Group on Osteoporosis.		1
Ad Hoc Paediatric Group.		1
Ad Hoc Working Group for the Development of Standards for Pediatric Immunization Practices.		1
Ad Hoc Working Party on Biotechnology/Pharmacy and Working Party on Safety Medicines.		2
Advisory Committee for Elimination of Tuberculosis.	結核撲滅諮問委員会	3
Advisory Committee on Epidemiology.		1
Advisory Committee on Immunization Practices	予防接種諮問委員会	32
Advisory Council for the Elimination of Tuberculosis.	結核撲滅諮問協議会	12
Aerospace Medical Association, Air Transport Medicine Committee, Alexandria, Va.		1
Agency for Health Care Policy and Research	医療政策研究局	79
Agency for Toxic Substances and Disease Registry. United States department of Health and Human Services, Public Health Service, Atlanta, Georgia.		1
AIDS Advisory Group on Strategies for HIV Testing.		1
Alberta Association of Registered Nurses.		1
Alberta Children's Hospital, Calgary, Alberta, Canada.		1
Alberta Society of Gastroenterology consensus statement		1
Alzheimer's Association.		1
American Academy of Allergy, Asthma, and Immunology	米国アレルギー喘息免疫学会	23
American Academy of Child and Adolescent Psychiatry, AACAP.	米国小児思春期精神科学会	24
American Academy of Clinical Toxicology; European Association of Poisons Centres and Clinical Toxicologists.	米国臨床中毒学学会	5
American Academy of Dermatology	米国皮膚科学会	40
American Academy of Family Physicians	米国家庭医学会	9
American Academy of Head, Neck and Facial Pain.	米国頭頸部痛学会	2
American Academy of Implant Dentistry. Position paper.		1
American Academy of Neurology	米国神経内科学会	31
American Academy of Nursing		1
American Academy of Ophthalmology.	米国眼科学会	3
American Academy of Oral and Maxillofacial Radiology.		1
American Academy of Orthopedic Surgeons.		1
American Academy of Otolaryngic Allergy.		1
American Academy of Otolaryngology	米国耳鼻科学会	2
American Academy of Pain Medicine	米国疼痛医学学会	4
American Academy of Pediatric Dentistry.	米国小児歯科学会	5
American Academy of Pediatrics	米国小児科学会	145
American Academy of Periodontology.		1
American Academy of Physical Medicine and Rehabilitation.		1
American Association for Cancer Education		1
American Association for Thoracic Surgery	米国胸部外科協会	5
American Association of Cardiovascular and Pulmonary Rehabilitation		1
American Association of Clinical Endocrinologists		1

American Association of Colleges of Nursing.		1
American Association of Diabetes		1
American Association of Diabetes Educators	米国糖尿病教育者協会	8
American Association of Electrodiagnostic Medicine	米国電子診断医学協会	4
American Association of Endodontists.		1
American Association of Equine Practitioners' Vaccination Guidelines		1
American Association of Kidney Patients (AAKP).		1
American Association of Mental Retardation		1
American Association of Neurological Surgeons.		1
American Association of Occupational Health	米国産業医協会	12
American Association of Occupational Health Nurses		1
American Association of Oral and Maxillofacial Surgeons.	米国口腔外科協会	3
American Association of Physicists in Medicine.	米国医学物理療法士協会	4
American Association of Spinal Cord Injury Nurses.		1
American Board of Forensic Odontology.		1
American Board of Orthodontics.		1
American Brachytherapy Society, Philadelphia, PA.,Clinical Research Committee.		1
American Burn Association.		1
American Cancer Society	米国対癌協会	12
American Cleft Palate-Craniofacial Association.		1
American Clinical Neurophysiology Society		1
American College of Allergy, Asthma and Immunology.		1
American College of Cardiology.	米国循環器病学会	40
American College of Chest Physicians.	米国胸部内科学会	4
American College of Clinical Pharmacy, 1985-86.	米国臨床薬剤学会	2
American College of Critical Care Medicine	米国集中治療医学学会	5
American College of Emergency Physician.	米国救急医学会	31
American College of Gastroenterology.	米国消化器学会	14
American College of Medical Genetics.		1
American College of Nurse-Midwives		1
American College of Obstetricians and Gynecologists	米国産婦人科学会	154
American College of Physicians.	米国内科学会	43
American College of Preventive Medicine.	米国予防医学学会	6
American College of Prosthodontists		1
American College of Radiology	米国放射線学会	5
American College of Rheumatology	米国リウマチ学会	12
American College of Sports Medicine	米国スポーツ医学協会	9
American College of Veterinary Anesthesiologists.		1
American Dental Association	米国歯科医師会	8
American Diabetes Association	米国糖尿病学会	20
American Diet Association	米国栄養士会	6
American Electroencephalographic Society	米国脳波協会	13
American Endocurietherapy Society.		1
American Federation of Clinical Oncologic Societies.		1
American Fertility Society.		1
American Gastroenterological Association	米国消化器病協会	9
American Geriatrics Society	米国老年病協会	12
American Heart Association	米国心臓協会	96
American Holistic Nurses' Association.		1
American Medical Association	米国医師会	11
American Nephrology Nurses' Association	米国腎臓病看護協会	5
American Nurses Association	米国看護婦協会	11
American Occupational Therapy Association.		1
American Opthalmology Association		1
American Pain Society		1

American Pharmaceutical Association	米国薬業協会	3
American Physical Therapy Association.	米国物理療法協会	2
American Psychiatric Association	米国精神科協会	20
American Public Health Association		1
American Rheumatism Association.		1
American Sleep Disorders Association.	米国睡眠障害協会	5
American Society for Artificial Internal Organs		1
American Society for Blood and Marrow Transplantation		1
American Society for Dermatologic Surgery.	米国皮膚外科協会	4
American Society for Gastrointestinal Endoscopy	米国消化器内視鏡協会	26
American Society for Parenteral and Enteral Nutrition.	米国経管経腸栄養協会	9
American Society for Therapeutic Radiology and Oncology	米国治療放射線科協会	2
American Society of Addiction Medicine.	米国薬物中毒協会	3
American Society of Anesthesiologists	米国麻酔医協会	9
American Society of Clinical Oncology	米国臨床腫瘍医協会	13
American Society of Clinical Pathologists.	米国臨床病理協会	2
American Society of Colon and Rectal Surgeons.	米国大腸肛門病協会	6
American Society of Colon and Rectal Surgeons.	米国大腸肛門外科協会	5
American Society of Echocardiography.	米国心臓超音波協会	3
American Society of Health-System Pharmacists	米国医療システム薬剤師協会	20
American Society of Hematology.	米国血液病協会	4
American Society of Hospital Pharmacists.	米国病院薬剤師協会	4
American Society of Human Genetics	米国人類遺伝学協会	5
American Society of Hypertension	米国高血圧協会	3
American Society of Nuclear Cardiology.	米国循環器核医学協会	8
American Society of Pain Management Nurses.		1
American Society of Parenteral and Enteral Nutrition		1
American Society of Pediatric Hematology/Oncology.		1
American Society of Plastic and Reconstructive Surgical Nurses.		1
American Society of Post Anesthesia Nurses.		1
American Society of Temporomandibular Joint Surgeons.		1
American Society of Transplant Physicians.	米国移植医協会	4
American Society Parenteral and Enteral Nutrition.		1
American Speech-Language-Hearing Association.		1
American Student Dental Association	米国歯科医学生協会	2
American Thoracic Society	米国胸部学会	21
American Thyroid Association.	米国甲状腺協会	2
American Urological Association	米国泌尿器協会	8
American Uveitis Society.		1
American Venous Forum, Ad Hoc Committee.		1
American Veterinary Medical Association	米国獣医協会	4
AmericanAcademy of Otolaryngology-Head and Neck Surgery Ffoundation, Inc.		1
American-European Consensus Conference on ALI/ARDS.		1
Angelman Syndrome Foundation.		1
Anticoagulation Guidelines Task Force.		1
Arthritis Foundation.		1
Association for Improvements in the Maternity Services		1
Association for Professionals in Infection Control and Epidemiology,	米国感染予防疫学専門家協会	5
Association of Chartered Physiotherapists in Women's Health.		1
Association of Clinical Pathologists.		1
Association of Directors of Anatomic and Surgical Pathology	米国解剖外科病理管理医協会	22
Association of Hemophilia Clinic Directors of Canada.		1
Association of Nurses in AIDS care.		1
Association of Operating Room Nurses	米国手術室勤務看護婦協会	82
Association of Reptilian and Amphibian Veterinarians		1

Association of State and Territorial Dental Directors		1
Australasian College of Physical Scientists and Engineers in		1
Australasian College of Rehabilitation Medicine.		1
Australasian Society for the Study of Hypertension in Pregnancy.	オーストラリア妊婦高血圧研究協会	2
Australasian Society for Ultrasound in Medicine		1
Australasian Society of Blood Transfusion consensus symposium.		1
Australia and New Zealand Intensive Care Society		1
Australian Association of Clinical Biochemists		1
Australian Association of Neurologists (AAN).		1
Australian College of Midwives Inc.	オーストラリア助産婦学会	2
Australian College of Paediatrics	オーストラリア小児科学会	9
Australian Council of Community Nursing Services		1
Australian Diabetes Society position statement.		1
Australian Resuscitation Council.	オーストラリア蘇生術委員会	2
Australian Society of Critical Care Nurses.		1
B virus Working Group.		1
BC Office of Health Technology Assessment.		1
Belgian Lipid Club. Consensus of the Belgian Lipid Club.		1
Belgian Society of Anesthesia		1
Belgian Working Group of Invasive Cardiology.		1
Bethesda conference 24th		1
Blood Management Practice Guidelines Conference.		1
Brain Trauma Foundation.	脳外傷財団	15
British Andrology Society		1
British Association for Accident and Emergency Medicine guidelines.	英国事故救急医療ガイドライン	3
British Association for the Study of Community Dentistry (BASCD)		1
British Association of Critical Care Nurses		1
British Association of Dermatologists		1
British Association of Perinatal Medicine	英国新生児医学協会	2
British Association of Surgical Oncology		1
British Cardiac Society.	英国心臓協会	6
British Committee for Standards in Haematology	英国血液学標準委員会	20
British Dental Association		1
British Diabetic Association	英国糖尿病協会	4
British Fertility Society.		1
British Geriatrics Society		1
British Heart Foundation Working Group.		1
British HIV Association.	英国HIV協会	2
British Hyperlipidaemia Association.	英国高脂血症協会	2
British Hypertension Society.		1
British Orthopaedic Association		1
British Pacing and Electrophysiology Group (BPEG).		1
British Paediatric Association		1
British Paediatric Haematology Group.		1
British Photodermatology Group		1
British Prostate Group.		1
British Society for Antimicrobial Chemotherapy.	英国抗生物質治療協会	5
British Society for Haematology.	英国血液病協会	3
British Society for Medical Mycology.		1
British Society for Restorative Dentistry.		1
British Society for Rheumatology	英国リウマチ協会	3
British Society for Surgery of the Hand.		1
British Society for the Study of Infection.	英国感染症研究協会	6
British Society of Gastroenterology		1
British Society of Gastroenterology	英国消化器病協会	5
British Society of Gynaecological Endoscopy.		1

British Society of Paediatric Dentistry		1
British Thoracic Society.	英国胸部協会	12
British Trauma Society.		1
California Board of Registered Nursing		1
California Department of Health Services.		1
Canadian Association of Emergency Physicians		1
Canadian Association of Gastroenterology	カナダ消化器病協会	6
Canadian Association of General Surgeons		1
Canadian Association of Nephrology Nurses and Technicians		1
Canadian Association of Neuroscience Nurses		1
Canadian Association of Nurses in Oncology		1
Canadian Association of Radiation Oncologists	ｶﾅﾀﾞ放射線科腫瘍学協会	6
Canadian Association of Radiologists.		1
Canadian Cardiovascular Society	カナダ循環器病協会	8
Canadian Coalition for High Blood Pressure Prevention and Control.	カナダ高血圧予防協会	3
Canadian College of Medical Geneticists.	カナダ遺伝学会	2
Canadian College of Neuropsychopharmacology.		1
Canadian Dental Association.	カナダ歯科医師会	2
Canadian Diabetes Advisory Board.		1
Canadian Diabetes Association.	カナダ糖尿病協会	2
Canadian Headache Society.	カナダ頭痛協会	2
Canadian HIV Trials Network Antiretroviral Working Group.		1
Canadian Hypertension Society	カナダ高血圧協会	5
Canadian Infectious Disease Society	カナダ感染症協会	3
Canadian Medical Association.	カナダ医師会	6
Canadian Neurosurgical Society.		1
Canadian Nurses Association.		1
Canadian Pediatric Society.	カナダ小児科協会	8
Canadian Psychiatric Association.	カナダ精神科協会	2
Canadian Rhinitis Symposium.		1
Canadian Society of Allergy and Clinical Immunology.		1
Canadian Society of Cytology.		1
Canadian Society of Palliative Care Physicians		1
Canadian Society of Surgical Oncology		1
Canadian Task Force on the Periodic Health Examination.	カナダ予防医療研究班	13
Canadian Thoracic Society	カナダ胸部学会	6
Canadian Urological Association		1
Canadian Workshop on the Evaluation of Current Recommendations Concerning Fluorides.		1
Cancer Center of Boston.	ボストン癌センター	2
Cancer Genetics Studies Consortium.	癌遺伝子共同研究協会	2
Capital Health Authority Regional Palliative Care Program.		1
Cardiac Care Network of Ontario Expert Panel on Intracoronary		1
Cardiac Society of Australia and New Zealand.		1
Cardiological Society of India.		1
Cataract Management Guideline Panel.		1
Center for Disease Control	米国疾病予防センター	63
Central Audit Group in Genitourinary Medicine.		1
Central Sydney Health Service.		1
Childrens Cancer Study Group.		1
Cleveland Clinic Foundation.		1
Clinical and Scientific Committee.		1
Clinical Genetics Society.		1
Clinical Guidelines Recommendation		1
Clinical Quality Improvement Network (CQIN) Investigators.		1
College of American Pathologists	米国病理医師学会	31

College of Family Physicians of Canada		1
College of Optometrists.		1
College of Physicians and Surgeons of Alberta.		1
Colorado Medical Society.		1
Colorectal Cancer Practice Guideline Committee.		1
Colorectal Surgical Society of Australia.	オーストラリア大腸肛門病協会	2
Commission of Accreditation of Rehabilitation Facilities.		1
Commission on European Affairs		1
Committee on Adolescent Health Care.		1
Committee on Guidelines of Care.		1
Committee on Gynecologic Practice.		1
Committee on Hearing and Equilibrium		1
Committee on Infectious Diseases.		1
Committee on Practice and Ambulatory Medicine.		1
Committee to Advise on Tropical Medicine and Travel (CATMAT).	熱帯医学旅行医学諮問委員会	11
Committee to Develop Criteria for Evaluating the Outcomes of Approaches to Prevent and Treat Obesity.		1
Community and Hospital Infection Control Association of Canada.		1
Confederation of Australian Critical Care Nurses Inc.		1
Connecticut Department of Health Services.		1
Connecticut Department of Public Health and Addiction Services		1
Connecticut State Medical Society		1
Consensus Committee on Diuresis Renography.		1
Consensus Committee.		1
Consensus Conference on Prosthetic Valve Thrombosis.		1
Consensus Group on ACEI Renography.		1
Consensus Initiative of the Coalition for Improving Maternity Services (CIMS).		1
Consensus Study Group on Risperidone Dosing.		1
Consortium for Spinal Cord Medicine.		1
Consortium for spinal cord.		1
Consultant in Communicable Disease Control, England.		1
Consultants in Paediatric Dentistry Group of United Kingdom and		1
Contact Lens Association of Ophthalmologists -Canada		1
Coronary Prevention Group.		1
Council for Learning Disabilities (CLD)		1
Council for Myocardial Ischemia and Infarction.		1
Council of Regional Networks for Genetic Services (CORN).		1
Council of the National Osteoporosis Foundation.		1
Council of the Royal Australasian College of Surgeons.		1
Council of the Society of Thoracic Surgeons.		1
Council on Acute Coronary Care of the Irish Heart Foundation.		1
Council on Dental Research.		1
Council on Dental Therapeutics.		1
Council on Scientific Affairs.		1
Danish Neurological Society		1
Danish Nurses' Organization.		1
Delphi Panel and the Consulting Group.		1
Department of Health and Human Services	米国厚生省	11
Department of Health, South Africa.		1
Dermatology Nurses' Association	皮膚科看護婦協会	3
Deutsche AIDS-Gesellschaft (DAIG)	ドイツオーストリア エイズガイド	2
Deutsche Gesellschaft fur Kieferothopadie.		1
Dialysis Outcomes Quality Initiative.		1
Dietitians' Association of Australia		1
Division of Industrial Accidents, State of California.		1

Division of Public Health, Delaware Health and Social Services.		1
DNA standards and certification committee.		1
Drugs and Pregnancy Study Group.		1
DYNARAD		1
Early Identification of Alzheimer's Disease and Related Dementias		1
Early Treatment Diabetic Retinopathy Study Research Group.		1
Eastern Association for the Surgery of Trauma.	東海岸外傷手術協会	2
Eastern Cooperative Oncology Group.		1
EC-Clearinghouse on Oral Problems Related to HIV Infection		1
Ehlers-Danlos National Foundation (USA)		1
Emergency Cardiac Care Committee members.		1
Emergency Nurses Association	救急看護協会	5
Endocarditis Working Party for Antimicrobial Chemotherapy.		1
Endovascular Graft Committee.		1
Epilepsy Association of Maryland, Inc.		1
Epilepsy Foundation of America		1
Esophageal Cancer Practice Guideline Committee.		1
ESPGAN Working Group.		1
Ethical Practice Board.		1
Europe against cancer programme.		1
European Academy of Allergology and Clinical Immunology(EAACI).	ヨーロッパアレルギー臨床免疫協会	13
European and other Societies on coronary prevention.	ヨーロッパおよびその他の国の冠動脈疾患協会	2
European Association for Palliative Care.	ヨーロッパ苦痛緩和医療協会	2
European Association for the Study of Diabetes.	ヨーロッパ糖尿病研究協会	2
European Atherosclerosis Society.	ヨーロッパ動脈硬化協会	3
European Brain Injury Consortium.		1
European Breast Cancer Working Group.		1
European Charcot Foundation Working Group for Treatment Trials.		1
European Clinical Heavy Particle Dosimetry Group (ECHED).		1
European Committee for Clinical Laboratory Standards (ECCLS).		1
European Committee for Medical Ultrasound Safety		1
European Community (EUROEYE).		1
European conference.		1
European Consensus Conference, Windsor, U.K., November, 1991.		1
European Endosonography Club Working Party.		1
European FALS Collaborative Group.		1
European Foundation for Osteoporosis and Bone Disease.	ヨーロッパ骨粗鬆症および骨疾患基	2
European Group for Blood and Marrow Transplantation (EBMT).	ヨーロッパ血液骨髄移植ｸﾞﾙｰﾌﾟ	2
European Group for Breast Cancer Screening.		1
European Group of Bone Marrow Transplantation (EBMT)		1
European Helicobacter Pylori Study Group.	ヨーロッパピロリ菌研究団	2
European IDDM Policy Group 1993.		1
European NIDDM Policy Group.		1
European Organization for Research and Treatment of Cancer.	ヨーロッパ癌研究治療機構	2
European Pressure Ulcer Advisory Panel.		1
European Research Network on Congenital Toxoplasmosis.		1
European Respiratory Society.	ヨーロッパ呼吸器協会	6
European Resuscitation Council	ヨーロッパ蘇生術会議	21
European Society for Human Reproduction and Embryology.	ヨーロッパ人類生殖胎児協会	3
European Society for Pediatric Endocrinology	ヨーロッパ小児内分泌協会	2
European Society for Therapeutic Radiology and Oncology Advisory Report to the Commission of the European Union for the 'Europe Against Cancer Programme'.		1
European Society of Cardiology.	ヨーロッパ心臓病協会	16
European Society of Clinical Pharmacy.		1

European Society of Contact Dermatitis.	ヨーロッパ接触性皮膚炎協会	2
European Society of Endodontology		1
European Society of Gastrointestinal Endoscopy (E.S.G.E.).	ヨーロッパ消化器内視鏡協会	3
European Society of Human Reproduction and Embryology.		1
European Society of Intensive Care Medicine.	ヨーロッパ集中治療医学協会	2
European Society of Pediatric Allergy and Clinical Immunology.		1
European Society of Pediatric Gastroenterology and Nutrition.	ヨーロッパ小児消化器栄養協会	4
European Society of Pneumology		1
European Society of Surgical Oncology.	ヨーロッパ癌外科協会	2
European Study Group for Antireflux Surgery (ESGARS).		1
European Thyroid Association.		1
European Union.		1
European Working Party of the European Society of Clinical Microbiology and Infectious Diseases.		1
Expert Committee on Clinical Guidelines for Overweight in Adolescent Preventive Services.		1
Expert Committee on the Diagnosis and Classification of Diabetes Mellitus.		1
Expert Consensus Panel for obsessive-compulsive disorder.		1
Expert Panel on the Identification, Evaluation, and Treatment of Overweight in Adults.		1
Expert Scientific Committee.		1
Eye Care Technology Forum.	眼治療技術フォーラム	3
Federation Dentaire Internationale.		1
Federation Internationale Dentaire	国際歯科連盟	4
FIGO (International Federation of Gynecology and Obstetrics)	国際産婦人科連盟	2
Food and Drug Administration	米国食品医薬品局	7
French College of Obstetricians and Gynaecologists		1
French Federation of Cardiology.		1
French National Ad Hoc Committee.		1
French Society for Infectious Diseases.		1
French Society of Anesthesia and Intensive Care.		1
French-American-British Cooperative Leukaemia Group.		1
Gastric Cancer Practice Guideline Committee.		1
General Dental Council.		1
General Medical Council.		1
German Gastric Cancer Study Group.		1
German Hypertension League.		1
German Society of Angiology.		1
German Society of Thoracic Surgery.		1
German Working Group for Gene Therapy.		1
Gestosis--Consensus Conference		1
Glaxo-Wellcome Research, UK. The Working Team of Glaxo-Wellcome Research, UK.		1
Great Lakes Regional Genetics Group.		1
Groupement pour le Depistage, l'Etude et la Prevention des Infections Hospitalieres--Groep ter Opsporing, Studie en Preventie van de Infecties in de Ziekenhuizen (GDEPIH - GOSPIZ).		1
Guidelines on psychotropic drugs for the EC.		1
Harry Benjamin International Gender Dysphonia Association.		1
Harvard Medical School.		1
Health and Policy Committee.		1
Health Canada. Dyslipidemia Working Group of Health Canada.		1
Health Care Financing Administration		1
Health Services Utilization and Research Commission.		1
Hepatology Working Group.		1
Hines VA Medical Center.		1
HIV Epidemiologic Research Study Group.		1

Horizon Healthcare, Inc.		1
Hospital Infection Control Group of Thailand.	タイ病院感染対策ｸﾞﾙｰﾌﾟ	9
Hospital Infection Control Practices Advisory Committee (HICPAC).	米国病院感染対策諮問委員会	9
Hypertension Society of Southern Africa		1
ICH		1
Illinois State Dental Society.	イリノイ州歯科医師会	2
Immigration and Overseas Health Services and the Bureau of Communicable Disease Epidemiology.		1
Indian Academy of Pediatrics.		1
Indian Consensus Group for the Prevention of Diabetes.		1
Indian Society of Gastroenterology.		1
Infectious Diseases Society of America	米国感染症協会	54
Institute for Clinical Systems Integration.	医療システム統合研究所	11
Institution of Physics and Engineering in Medicine and Biology.	医療生物物理エンジニアリング研究	2
Interagency Committee on New Therapies for Pain and Discomfort, February 16, 1979.		1
International AIDS Society-USA.	国際エイズ協会	3
International Association of Enterostomal Therapy.	国際人工肛門協会	3
International Board of Lactation Consultant Examiners.		1
International Chronic Fatigue Syndrome Study Group.		1
International Collaborative Group on Oral White Lesions.		1
International Commission on Microbiological Specifications for Foods.		1
International Committee of Dermatology.		1
International Committee on Wound Management.		1
International Confederation of Midwives	国際助産婦連合	3
International Conference on sinus Disease.		1
International Consensus Group on Depression and Anxiety.	国際鬱病不安症ｺﾝｾﾝｻｽｸﾞﾙｰﾌﾟ	2
International consensus recommendations.		1
International Continence Society		1
International Council for Standardization in Haematology.	国際血液学標準化議会	2
International Council of Nurses.		1
International Diabetes Center.		1
International Federation for the Surgery of Obesity.	国際肥満手術連合	2
International Federation of Anti-leprosy Associations (ILEP)		1
International Federation of Clinical Neurophysiology committee.		1
International Federation of Gynecology and Obstetrics.	国際産婦人科連合	4
International Headache Society Committee on Clinical Trials.		1
International Huntington Association.	国際ハンチントン病連合	2
International League Against Epilepsy.	国際対てんかん連盟	4
International League of Societies for Persons with Mental Handicap (ILSMH).		1
International Liaison Committee on Resuscitation (ILCOR)	国際蘇生合同委員会	12
International Lymphoma Study Group		1
International Prostate Cancer Screening Trial Evaluation Group.		1
International Radiation Protection Association.		1
International Red Cross		1
International Respiratory Care Club (IRCC).		1
International Society for Analytical Cytology.		1
International Society for Burn Injuries in collaboration with the World Health Organization.		1
International Society for Clinical Electrophysiology of Vision.	国際眼科電気生理学協会	2
International Society for Heart and Lung Transplantation	国際心肺移植協会	2
International Society for Peritoneal Dialysis.	国際腹膜透析協会	2
International Society of Andrology (ISA).		1
International Society of Thrombosis and Hemostasis	国際血栓止血協会	2
International Symposium on Insulin-like Growth Factors. 3rd		1
International Symposium on Veterinary Oral Care		1

International Task Force on Safety in the Intensive Care Unit.		1
International Union Against Tuberculosis and Lung Disease	国際対結核及び肺疾患連合	5
International Union of Nutritional Sciences/WHO		1
International union of pharmacology (IUPHAR).	国際薬学連合	3
International Working Group in Colorectal Cancer (IWGCRC)	国際大腸肛門病ﾜｰｸｸﾞﾙｰﾌﾟ	2
International Working Group on Vaginal Microbicides.		1
Intersociety Working Group for Cytology Technologies.	国際細胞診技術ﾜｰｸｸﾞﾙｰﾌﾟ	3
Intravenous Nurses Society.	静脈注射看護婦協会	6
Irish Helicobacter Pylori Study Group.		1
Irish Society of Surgical Oncology.		1
Italian Association of Hospital Gastroenterologists (AIGO)		1
Italian Federation of Anticoagulation Clinics.		1
Italian League against Cancer.		1
Italian Society for Neurosurgery.		1
Italian Society for the Study of Headache (SISC).	イタリア頭痛研究協会	2
Italian Society of Neurosurgery.		1
Italian Society of Pneumology.		1
Italy Society for the study of Fertility and Sterility		1
IUPAC Commission of Toxicology.		1
Japan Industrial Safety and Health Association.		1
Japan Society of Obstetrics and Gynecology.		1
Japanese Circulation Society (JCS) Task Force Committee on Chronic Myocarditis.		1
Japanese National Cancer Center.		1
Japanese Society of Allergology.		1
Japanese Society of Hyperthermic Oncology.		1
Johns Hopkins Dementia Research Clinic.		1
Joint American Preventive Services Task Force. Canadian Task Force on Health Care Screening.		1
Joint Commission on Accreditation of Hospitals.		1
Joint Committee on Phase IV Clinical Trial Guidelines.		1
Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure	国際高血圧診断評価治療合同会議	5
Joint United Nations programme on HIV/AIDS (UNAIDS).		1
Kaiser Permanente Medical Group.		1
Kentucky Board of Nursing.		1
Kentucky Department for Mental Health		1
Kentucky Diabetic Retinopathy Group.		1
Kids Neuro-Oncology Workshop (KNOWS).		1
Laboratory Centre for Disease Control.	疾病予防検査センター	8
Latex allergy.		1
Lawson Wilkins Pediatric Endocrine Society.		1
Loma Linda University Institutional Review Board.		1
London School of Hygiene and Tropical Medicine.		1
Los Angeles Ethics Committee		1
Macular Photocoagulation Study Group.		1
Malaria Control Technical Subcommittee on Case Management and Drug Sensitivity.		1
Malaria Reference Laboratory of the Public Health Laboratory Service, London.		1
Maternal and Neonatal haemostasis Working Party of the Haemostasis and Thrombosis Task.		1
Medical Association of Georgia		1
Medical Association of South Africa.	南アフリカ医師会	3
Medical Center of Central Georgia.		1
Medical Research Council Working Party on Phenylketonuria.		1
Medical Society of New Jersey.		1
Members of the Working Party on Cervical Screening.		1

Ministry of Health and Welfare, Japan.		1
Mississippi State Department of Health.		1
Mississippi State Medical Association	ミシシッピー州医師会	2
NANN		1
NAON Standards Task Force.		1
NAPNAP		1
NASPHV Committee.		1
National Academy of Clinical Biochemistry.	米国臨床生化学学会	12
National Academy of Sciences		1
National Advisory Committee on Immunization (NACI)	米国予防接種諮問委員会	13
National Advisory Group on Standards and Practice Guidelines for Parenteral Nutrition.		1
National Association Directors of Nursing Administration		1
National Association for Medical Direction of Respiratory Care (NAMDRC)		1
National Association of Emergency Medical Services Physicians.		1
National Association of EMS Physicians.	米国救急医師協会	2
National Association of Medical Examiners.		1
National Association of Neonatal Nurses.	米国新生児看護婦協会	2
National Association of Pediatric Nurse Associates and Practitioners.	米国小児看護助手医療従事者協会	2
National Association of State Public Health Veterinarians	米国州公衆衛生獣医協会	6
National Association of State School Nurse Consultants.	米国州看護コンサルタント協会	2
National Association of Theatre Nurses.		1
National Asthma Education Program		1
National Belgian consensus meeting. 1998		1
National Blood Transfusion Council.		1
National Cancer Institute	米国国立癌研究所	7
National Childbirth Trust.		1
National Cholesterol Education Program.	米国コレステロール教育プログラム	5
National Comprehensive Cancer Network.	米国癌包括ネットワーク	14
National Consensus of the "Belgian Bone Club", November 1996.		1
National Coordinating Committee for Breast Cancer Screening Pathology.		1
National Coordinating Committee for Nutrition Standards		1
National Coordinating Network (National Cervical Screening		1
National Diabetes Advisory Board.		1
National Diabetes Commission, Singapore.		1
National Emergency Medical Services for Children Resource Alliance.	米国小児救急医療資源同盟	2
National Epilepsy Association of Australia		1
National Fragile X Foundation.		1
National Headache Foundation.		1
National Health and Medical Research Council.	米国健康医学研究委員会	4
National Health Research and Development Program.		1
National Health Service		1
National Health Service Executive Nursing Directorate.		1
National Heart Foundation of New Zealand.	ニュージーランド心臓財団	3
National Heart, Lung and Blood Institute.	米国心肺血液研究所	6
National Hospice Organization.		1
National Institute for Nursing		1
National Institute of Allergy and Infectious Diseases		1
National Institute of Child Health and Human Development	米国小児健康発達研究所	2
National Institute of Dental Research		1
National Institute on Aging.	米国老化研究所	2
National Institutes of Health.	米国国立健康研究所	15
National Joint Committee for the Communicative Needs of Persons with Severe Disabilities.		1
National Kidney Foundation	米国腎臓財団	13

National Multiple Sclerosis Society	米国多発性硬化症協会	3
National Nurses Society on Addictions.	米国中毒者看護協会	4
National Pediatric HIV Resource Center.		1
National Poison Information Service.		1
National Society of Genetic Counselors.		1
National Vaccine Advisory Committee.	米国ﾜｸﾁﾝ諮問委員会	2
National Workshop on Screening for Cancer of the Cervix.		1
NATO Advanced Study Institute.		1
Netherlands Heart Foundation.		1
New classification permits multiple diagnoses.		1
New Hampshire Sexual Assault Medical Examination Protocol Project Committee.		1
New Hampshire-Dartmouth Psychiatric Research Center.		1
New Jersey State Department of Health.		1
New South Wales Nurses' Association	オーストラリアサウスウェールズ看護協会	3
New South Wales Therapeutic Assessment Group.		1
New Zealand College of Anaesthetists		1
New Zealand Nephrologists Consensus Group.		1
New Zealand Nurses' Organisation.		1
New Zealand Society for the Study of Diabetes.		1
NINCDS-ADRDA Work Group		1
Nordic Clinical Chemistry (NORDKEM) Project.		1
Nordic Myeloma Study Group Laboratories.		1
North American Association for the Study of Obesity.		1
North American Society of Pacing and Electrophysiology.	北米ペーシング電気生理学協会	2
North American Society of Phlebology.		1
North Carolina Cardiopulmonary Rehabilitation Association.		1
North Flight Emergency Medical Services.		1
North of England Aspirin Guideline Development Group.		1
North of England Asthma Guideline Development Group.		1
North of England Stable Angina Guideline Development Group.		1
North Staffordshire Hospital Trust, Staffordshire Social Services and Staffordshire Police.		1
Northern Regional Head Injury Group.		1
NSW Cancer Council Cancer Education Research Program.		1
Ochsner Clinic. Department of Surgery and Ochsner Clinic Quality Assurance Committee.		1
Ohio Department of Health.		1
Ohio State Dental Board.		1
ONA (Oregon Nursing Association)		1
Oncology Nursing Society	癌看護協会	5
Ontario Medical Association.		1
Oregon Nurses Association.		1
Osteoporosis Australia.		1
Osteoporosis Global Medical Conference		1
Osteoporosis Society of Canada. Scientific		1
Otitis Media Guideline Panel.		1
Paediatric Society of New Zealand.	ニュージーランド小児科協会	2
Pan American Health Organization		1
Pancreatic Cancer Practice Guideline Committee.		1
Panel for the Prediction and Prevention of Pressure Ulcers in Adults.		1
Papanicolaou Society of Cytopathology Task Force on Standards of Practice.	パパニコロー細胞診協会	4
Parkinson's Disease Consensus Working Group.		1
PCS Committee.		1
Pennsylvania Public Health Association.		1

Pressure Ulcer Guideline Panel.		1
Prostate Cancer Alliance of Canada.		1
Provincial Breast Disease Site Group.	州乳癌疾病対策ｸﾞﾙｰﾌﾟ	2
Provincial Gastrointestinal Disease Site Group.	州消化管悪性腫瘍対策ｸﾞﾙｰﾌﾟ	2
Provincial Genitourinary Cancer Disease Site Group.		1
Provincial Lung Cancer Disease Site Group.	州肺癌対策ｸﾞﾙｰﾌﾟ	5
Provincial Lung Disease Site Group.		1
Psychiatry Committee on Alcoholism and the Addictions.		1
Public Health Laboratory Service Salmonella Committee.	公立臨床検査サービス	6
Public Health Service	公衆衛生院	3
Quality Standards Subcommittee.		1
RACDS and ANZCA		1
Radiation Therapy Oncology Group		1
Radionuclides in Nephrourology Committee on renal clearance.		1
Regional Networks for Genetic Services.		1
Registered Nurses Association of British Columbia.	カナダブリチッシュコロンビア看護	5
Renal Association and the Royal College of Physicians.		1
Renal Physicians Association Working Committee on Clinical	腎臓医協会	2
Respiratory Committee of the Paediatric Society of New Zealand.		1
Respiratory paediatricians of Australia and New Zealand.		1
Rhode Island Department of Health.		1
Roual Australian College of Practitioners.		1
Roundtable of Experts in Surgery Blood Management.		1
Royal Australasian College of Physicians	オ-ストラリア内科学会	2
Royal Australian College of General Practitioners.	オーストラリア家庭医学会	3
Royal College of General Practitioners.		1
Royal College of Midwives		1
Royal College of Nursing		1
Royal College of Ophthalmologists and the British Association of Perinatal Medicine.		1
Royal College of Pathologists of Australasia.	オーストラリア病理医学会	3
Royal College of Physicians.	英国内科学会	21
Royal College of Physicians.	英国放射線医学会	2
Royal College of Surgeons	英国外科学会	4
Saskatchewan Registered Nurses' Association.		1
Scientific Advisory Board and the Board of National Societies.		1
Scientific Advisory Group of Experts (SAGE). Part II. Recommendations from the Scientific Advisory Group of Experts		1
Scientific Committee of the European Association for Endoscopic Surgery (E.A.E.S.).		1
Scottish Lipid Consensus Group.		1
SCVIR Technology Assessment Committee.		1
SEMDSA (National Diabetes Advisory Board (SEMDSA))		1
SIOP (International Society of Pediatric Oncology)	国際小児癌協会	4
Sioux Falls Task Force on Antimicrobial Resistance.		1
SMS Board of Directors		1
Societa Italiana di Diabetologia		1
Society for Academic Emergency Medicine (SAEM)		1
Society for Adolescent Medicine	思春期医学協会	5
Society for Cardiac Angiography &amp	心臓血管造影治療協会	5
Society for Clinical Densitometry.		1
Society for Fetal Urology		1
Society for Healthcare Epidemiology of America.	米国健康疫学協会	3
Society for Magnetic Resonance Imaging Safety Committee.	ＭＲI協会	2
Society for Minerals and Trace Elements.		1
Society for Surgery of the Alimentary Tract	消化管外科管理協会	3
Society for Vascular Nursing.		1

Society for Vascular Surgery	血管外科協会	4
Society of American Gastrointestinal Endoscopic Surgeons (SAGES).	米国消化管内視鏡外科協会	5
Society of Cardiovascular and Interventional Radiology.	心血管治療放射線科協会	7
Society of Critical Care Medicine.	集中治療医学協会	9
Society of Gastroenterology Nurses and Associates, Inc.	消化器看護看護助手協会	3
Society of Gynecologic Oncologists	婦人科癌協会	8
Society of Hospital Epidemiologists of America.	米国病院疫学協会	2
Society of Infectious Diseases Pharmacists.	感染症薬剤師協会	2
Society of Nuclear Medicine.	核医学協会	28
Society of Obstetricians and Gynaecologists of Canada		1
Society of Operating Room Nurses.	耳鼻咽喉科看護婦協会	9
Society of Otorhinolaryngology and Head-Neck Nurses.		1
Society of Paediatric Nursing of the Royal College of Nursing.		1
Society of Rural Physicians of Canada (SRPC)		1
Society of Surgical Oncology	腫瘍外科協会	10
Society of Thoracic Surgeons.		1
Society of Toxicology.	胸部外科協会	3
South African Childhood Asthma Working Group (SACAWG).	南アフリカ小児喘息ﾜｰｸｸﾞﾙｰﾌﾟ	2
South African Gastro-enterology Society	南アフリカ消化器協会	3
South African Medical Association Heart Failure Working Group.		1
South African Pulmonology Society.	南アフリカ呼吸器協会	4
South African Society of Anaesthetist.		1
South African Society of Cardiac Practitioners		1
South African Society of Endoscopic Surgeons (SASES).		1
South African Tuberculosis Control Programme.		1
South Auckland Community Diabetes Planning Group.		1
South Carolina Hospital Association		1
South Carolina Pediatric AIDS Advisory Committee.		1
Southeastern Regional Genetics Group (SERGG).		1
SSC		1
Standards and Certification Committee.		1
State Board of Nursing for South Carolina.		1
State of California Alzheimer's Disease Diagnostic and Treatment Centers.		1
State of Florida Agency for Health Care Administration		1
STD Treatment Guidelines Project Team and Consultants.		1
Steering Committee for the Revision of the Clinical Practice Guidelines for the Management of Diabetes in Canada.		1
Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer.	乳がん診療ガイドライン委員会	3
Surgical Eye Expeditions international.		1
Surgical Infection Society.		1
Surgical Infection Study Group.		1
Surgical Society of Great Britain and Ireland.		1
Swedish National Road Administration.		1
Swiss Academy of Medical Sciences (SAMS).		1
Systemic Treatment Program Committee.		1
Task Force on Adaptive Diabetes for Visually Impaired Persons.		1
Task Force on Support Personnel.		1
Task Group on Mucoactive Drugs.		1
Temporomandibular Joint Implant Surgery Workshop.		1
Tennessee Department of Health.		1
Texas Pediatric Society.	テキサス小児科医会	2
Texas State Board of Medical Examiners.		1
The Consortium on Respiratory Monitoring on the General Care		1
Third International Workshop-Conference on Gestational Diabetes Mellitus.		1

Thoracic Society of Australia and New Zealand.	オーストラリアニュージーランド胸部学会	9
Thrombocythemia Vera Study Group.		1
Toronto Working Group on Cholesterol Policy.		1
Transcultural Nursing Society.		1
U.S. Preventive Services Task Force	米国予防医療研究班	12
U.S. Public Health Service	米国公衆衛生局	12
UCLA Division of Geriatric Medicine.		1
UK Haemophilia Centre Directors' Organisation		1
UK NGO AIDS Consortium Working Group on Access to Treatment for HIV in Developing Countries.		1
UK Regional Haemophilia Centre Directors Committee.		1
United Kingdom Central Council	英国中央委員会	3
United Kingdom Haemophilia Centre Director's Organization.		1
United Kingdom Health Ministers' Gene Therapy Advisory Committee.		1
United Nations Programme on HIV/AIDS (UNAIDS)-WHO.		1
United Ostomy Association		1
United States Occupational Safety and Health Administration.		1
University Hospital Consortium Expert Panel for Off-Label Use of Polyvalent Intravenously Administered Immunoglobulin Preparations.		1
University of Connecticut Health Center.		1
University of Pavia Medical school		1
University of Pennsylvania.		1
University of Texas. Houston Health Science Center.		1
Urodynamic Society.		1
US National MS Society Task Force.		1
Usher Syndrome Consortium.		1
Victoria Declaration.		1
Visually Impaired Persons Specialty Practice Group.		1
Voluntary euthanasia: the council's view.		1
Women's and Children's Hospital.		1
Working Group on Critical Care, Ontario Ministry of Health.		1
Working Group on Flow Cytometry and Image Analysis.		1
Workshop Consensus Conference		1
Workshop on Quality Assurance in Dentistry.		1
World Association for the Advancement of Veterinary Parasitology		1
World Federation of Neurology:	世界神経内科連合	3
World Health Organization	世界保険機関	25
World Marrow Donor Association		1
World Medical Association Declaration of Helsinki.		1
Wound Ostomy Continence Nurs		1

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The Academy of Psychosomatic Medicine practice guidelines for psychiatric consultation in the general medical setting. The Academy of Psychosomatic Medicine.	Academy of Psychosomatic Medicine.	Psychosomatics. 1998 Jul-Aug;39(4):S8-30.
Guidelines for prescribing isotretinoin (Accutane) in the treatment of female acne patients of childbearing potential.	Acne Subgroup, Task Force on Standards of Care.	J Am Acad Dermatol. 1988 Nov;19(5 Pt 1):920.
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Practice guidelines in cardiothoracic surgery.	Ad Hoc Committee for Cardiothoracic Surgical Practice Guidelines.	Ann Thorac Surg. 1995 Jun;59(6):1613-9.
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ACIP releases new recommendations on immunization.	Advisory Committee on Immunization Practices (ACIP)	Am Fam Physician. 1994 Jun;49(8):1975-8.
ACIP revises typhoid immunization recommendations.	Advisory Committee on Immunization Practices (ACIP)	Am Fam Physician. 1995 Mar;51(4):969-70.
ACIP issues recommendations on the prevention of varicella.	Advisory Committee on Immunization Practices (ACIP)	Am Fam Physician. 1996 Dec;54(8):2578, 2581.
Advisory Committee on Immunization Practices issues recommendations for the 1997-98 influenza season.	Advisory Committee on Immunization Practices (ACIP)	Am Fam Physician. 1997 Jul;56(1):279-82.
ACIP releases recommendations for the immunization of health care workers.	Advisory Committee on Immunization Practices (ACIP)	Am Fam Physician. 1998 Mar 15;57(6):1426, 1429.
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Immunization of adolescents: recommendations of the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Medical Association.	Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Medical Association.	J Sch Health. 1997 Sep;67(7):298-303.

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National
Guideline
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Guideline Comparison

TITLE:

1) Am Coll Physicians 1996 Oct 25: Guidelines for assessing and managing the perioperative risk from coronary artery disease associated with major noncardiac surgery.

2) Am Coll Cardiol/Am Heart Assoc 1996 Mar 15: Guidelines for perioperative cardiovascular evaluation for noncardiac surgery. Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Perioperative Cardiovascular Evaluation for Noncardiac Surgery).

ADAPTATION:

1) Am Coll Physicians 1996 Oct 25: Not applicable: Guideline was not adapted from another source.

2) Am Coll Cardiol/Am Heart Assoc 1996 Mar 15: Not applicable: The guideline was not adapted from another source.

LENGTH:

1) Am Coll Physicians 1996 Oct 25: 4 pages (guideline); 16 pages (background paper)

2) Am Coll Cardiol/Am Heart Assoc 1996 Mar 15: 38 pages

DEVELOPER(S):

1) Am Coll Physicians 1996 Oct 25: American College of Physicians - Medical Specialty Society

2) Am Coll Cardiol/Am Heart Assoc 1996 Mar 15: American College of Cardiology - Medical Specialty Society
American Heart Association - Professional Association

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1) Am Coll Physicians 1996 Oct 25: Clinical Efficacy Assessment Subcommittee, Health and Public Policy Committee

2) Am Coll Cardiol/Am Heart Assoc 1996 Mar 15: Committee on Perioperative Cardiovascular Evaluation for Noncardiac Surgery

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2) Am Coll Cardiol/Am Heart Assoc 1996 Mar 15: The committee consisted of experts representing various disciplines of cardiovascular care, including general cardiology, noninvasive testing, vascular medicine, vascular surgery, anesthesiology, and arrhythmia management. *Names of Committee Members:* Kim A. Eagle, MD, FACC, Chair; Bruce H. Brundage, MD, FACC; Bernard R. Chaitman, MD, FACC; Gordon A. Ewy, MD, FACC; Lee A. Fleisher, MD, FACC; Norman R. Hertzer, MD; Jeffrey A. Leppo, MD, FACC; Thomas Ryan, MD, FACC; Robert C. Schlant, MD, FACC; William H. Spencer III, MD, FACC; John A. Spittell, Jr, MD, FACC; Richard D. Twiss, MD, FACC

DISEASE/CONDITION:

1) Am Coll Physicians 1996 Oct 25:

Coronary Artery Disease

Myocardial Infarction

2) Am Coll Cardiol/Am Heart Assoc 1996 Mar 15: CARDIOVASCULAR DISEASE
Coronary artery disease
Myocardial infarction
Angina pectoris
Congestive heart failure
Arrhythmias and Conduction Defects
Hypertension
Cardiomyopathy
Valvular heart disease
Pulmonary vascular disease

CATEGORY:

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米国ガイドライン評価センター

要約

（原文は 60 ページだが、ガイドラインセンターが 15 ページに要約したもの）

タイトル:

超音波心臓検査適用の ACC/AHA ガイドライン:臨床ガイドライン(Practice Guidelines)(超音波心臓検査の臨床適応(Clinical Application)委員会)に関する米国循環器病学会/米国心臓病協会特別対策本部による報告。

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改作：

本ガイドラインは他のガイドラインを参考にして作られたものではなく、オリジナルです。

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主な勧告:

ドップラー超音波心臓検査の使用に関するガイドラインは、他の ACC/AHA ガイドラインの中で使用される表示分類システム(例えばクラス I、II および III)を用います:

クラス I: その処置や治療が有用で効果があるとの証拠が存在したり一般的な見解の合意が得られているもの。

クラス II: その処置や治療の有用性/効能に関する複数の相反するデータや証拠が存在して見解が分かれているもの。

クラス IIa: その処置や治療の有用性/効能性に関する証拠や意見が、どちらかといえばこれを支持しているもの。

クラス IIb: その処置や治療の有用性/効能性に関する証拠や意見が不十分なもの。

クラス III:その処置や治療の効果はない、あるいは有害であるとの証拠や一般的な見解合意が得られているもの。

心疾患を見つけるための検診としての超音波心臓検査の適応

	クラス
1. 遺伝性心疾患家系の患者。	I
2. 心臓移植提供者になる可能性のある場合。	I
3. マルファン症候群やこれに類する結合組織疾患と思われる患者。	I
4. 心毒性のある抗癌剤治療に入る前の癌患者の心機能評価。	I
5. 心機能障害を生じる恐れのある全身疾患を持つ患者。	IIb
6. 一般人。	III
7. 臨床所見のない運動選手。	III

心雑音評価での超音波心臓検査の適応

	クラス
1. 心肺機能の有症状患者の心雑音。	I
2. 無症状の心雑音ではあるが、臨床所見上で器質的心疾患を中等度以上疑わせるものがある場合。	I
3. 無症状の心雑音で器質的心疾患の可能性が低いものの、臨床所見では十分に器質的心疾患を除外することができない場合。	IIa
4. 大人の無症状の心雑音で、経験を十分に積んだ医師が機能性雑音と判断するもの。	III

高血圧患者での超音波心臓検査の適応

	クラス
1. 安静時左室機能、心肥大、または求心性リモデリングの評価が治療方針の決定に必要と考えられる場合。(左室機能の項参照)	I
2. 虚血性心疾患による機能評価が必要な場合。(虚血性心疾患の項参照)	I
3. 臨床症状の変化や投薬治療の調整の際に行うフォローアップ検査としての左室のサイズ測定と機能評価。	I
4. 収縮期異常の有無にかかわらず、左室の拡張期機能障害を調べるための検査。	IIa
5. 心電図で左室肥大の所見を伴わない境界型高血圧症例で、高血圧治療開始を考察する場合。この目的には、簡略化した検査のみで十分。	IIa
6. 予後推定のために左室機能を調べること。	IIb
7. 左室心筋量の減少を目安に高血圧を治療する場合の、再評価。	III
8. 無症状の高血圧患者の左室機能再評価。	III

弁狭窄での超音波心臓検査の適応

	クラス
1. 診断;心血管動態の評価。	I
2. 左心室(LV)および右心室(RV)のサイズ、機能および(または)血行動態の評価。	I
3. 既知の弁狭窄患者の症状や徴候が変化した場合の再評価。	I
4. 既知の弁狭窄妊婦の血行動態や心室機能評価。	I
5. 高度の弁狭窄をもった無症候性患者の再評価。	I
6. 軽度あるいは中等度の弁狭窄患者の血行動態評価。	IIa
7. 左室機能不全または心肥大を合併する無症状の軽度あるいは中等度の大動脈弁狭窄患者の再評価。	IIa
8. 症状と徴候が安定している軽度あるいは中等度の大動脈弁狭窄患者の再評価。	IIa
9. 徴候が安定し無症状の軽度の大動脈弁狭窄患者で、左室の機能とサイズが正常の症例に対するルーチン検査。	III
10. 徴候が安定し無症状の軽度および中等度の僧帽弁狭窄患者に対するルーチン検査。	III

(さらに「心臓弁膜症および人工弁(Prosthetic　Valves)に関する治療での超音波心臓検査の適応を参照のこと)

失神患者の超音波心臓検査の適応

	クラス
1. 臨床上心原性の失神が疑われる場合。	I
2. 運動負荷がかかった際に生じた失神。	I
3. パイロットなどのリスクの高い職業者の失神。	IIa
4. 病歴および身体所見で原因が不明の失神。	IIb
5. 以前の心臓超音波検査や他の検査で原因が判明している失神が繰り返された場合。	III
6. 心疾患が疑われない患者の失神。	III
7. 典型的な神経性の失神。	

以下同様の形式で、臨床上遭遇するありとあらゆる場合が想定されて、約３０項目に分類された超音波検査の適応が論じられている。上記の５項目も含めて英文のまま掲載する。

Indications for Echocardiography in the Evaluation of Heart Murmurs

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1. A murmur in a patient with cardiorespiratory symptoms. I
2. A murmur in an asymptomatic patient if the clinical features indicate at least a moderate probability that the murmur is reflective of structural heart disease. I
3. A murmur in an asymptomatic patient in whom there is a low probability of heart disease but in whom the diagnosis of heart disease cannot be reasonably excluded by the standard cardiovascular clinical evaluation. IIa
4. In an adult, an asymptomatic heart murmur that has been identified by an experienced observer as functional or innocent. III

Indications for Echocardiography in Valvular Stenosis

---

1. Diagnosis; assessment of hemodynamic severity. I
2. Assessment of left ventricular (LV) and right ventricular (RV) size, function, and/or hemodynamics. I
3. Reevaluation of patients with known valvular stenosis with changing symptoms or signs. I
4. Assessment of changes in hemodynamic severity and ventricular compensation in patients with known valvular stenosis during pregnancy. I
5. Reevaluation of asymptomatic patients with severe stenosis. I
6. Assessment of the hemodynamic significance of mild to moderate valvular stenosis by Doppler echocardiography. IIa
7. Reevaluation of patients with mild to moderate aortic stenosis with LV dysfunction or hypertrophy even without clinical symptoms. IIa
8. Reevaluation of patients with mild to moderate aortic valvular stenosis with stable signs and symptoms. IIb
9. Routine reevaluation of asymptomatic adult patients with mild aortic stenosis having stable physical signs and normal LV size and function. III
10. Routine reevaluation of asymptomatic patients with mild to moderate mitral stenosis and stable physical signs. III

(See also "Indications for Echocardiography in Interventions for Valvular Heart Disease and Prosthetic Valves.")

Indications for Echocardiography in Native Valvular Regurgitation

---

1. Diagnosis; assessment of hemodynamic severity. I
2. Initial assessment and reevaluation (when indicated) of LV and RV size, function, and/or hemodynamics. I
3. Reevaluation of patients with mild to moderate valvular regurgitation with changing symptoms. I
4. Reevaluation of asymptomatic patients with severe regurgitation. I
5. Assessment of changes in hemodynamic severity and ventricular compensation in patients with known valvular regurgitation during pregnancy. I
6. Reevaluation of patients with mild to moderate regurgitation with ventricular dilation without clinical symptoms. I
7. Assessment of the effects of medical therapy on the severity of regurgitation and ventricular compensation and function. I
8. Reevaluation of patients with mild to moderate mitral regurgitation without chamber dilation and without clinical symptoms. IIb
9. Reevaluation of patients with moderate aortic regurgitation without chamber dilation and without clinical symptoms. IIb
10. Routine reevaluation in asymptomatic patients with mild valvular regurgitation having stable physical signs and normal LV size and function. III

(See also "Indications for Echocardiography in Interventions for Valvular Heart Disease and Prosthetic Valves.")

Indications for Echocardiography in Mitral Valve Prolapse

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1. Diagnosis; assessment of hemodynamic severity, leaflet morphology, and/or ventricular compensation in patients with physical signs of MVP. I
2. To exclude MVP in patients who have been diagnosed but without clinical evidence to support the diagnosis. IIa
3. To exclude MVP in patients with first-degree relatives with known myxomatous valve disease. IIa
4. Risk stratification in patients with physical signs of MVP or known MVP. IIa
5. Exclusion of MVP in patients with ill-defined symptoms in the absence of a constellation of clinical symptoms or physical findings suggestive of MVP or a positive family history. III
6. Routine repetition of echocardiography in patients with MVP with no or mild regurgitation and no changes in clinical signs or symptoms. III

Indications for Echocardiography in Infective Endocarditis: Native Valves

---

1. Detection and characterization of valvular lesions, their hemodynamic severity, and/or

ventricular compensation.* I
2. Detection of vegetations and characterizations of lesions in patients with congenital heart disease suspected of having infective endocarditis. I
3. Detection of associated abnormalities (e.g., abscesses, shunts, etc).* I
4. Reevaluation studies in complex endocarditis (e.g., virulent organism, severe hemodynamic lesion, aortic valve involvement, persistent fever or bacteremia, clinical change, or symptomatic deterioration). I
5. Evaluation of patients with high clinical suspicion of culture-negative endocarditis.* I
6. Evaluation of bacteremia without a known source.* IIa
7. Risk stratification in established endocarditis.* IIa
8. Routine reevaluation in uncomplicated endocarditis during antibiotic therapy. IIb
9. Evaluation of fever and nonpathological murmur without evidence of bacteremia. III
*TEE may provide incremental value in addition to information obtained by TTE. The role of TEE in first-line examination awaits further study.

Indications for Echocardiography in Interventions for Valvular Heart Disease and Prosthetic Valves

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1. Assessment of the timing of valvular intervention based on ventricular compensation, function, and/or severity of primary and secondary lesions. I
2. Selection of alternative therapies for mitral valve disease (such as balloon valvuloplasty, operative valve repair, valve replacement).* I
3. Use of echocardiography (especially TEE) in performing interventional techniques (e.g., balloon valvotomy) for valvular disease. I
4. Postintervention baseline studies for valve function (early) and ventricular remodeling (late). I
5. Reevaluation of patients with valve replacement with changing clinical signs and symptoms; suspected prosthetic dysfunction (stenosis, regurgitation) or thrombosis.* I
6. Routine reevaluation study after baseline studies of patients with valve replacements with mild to moderate ventricular dysfunction without changing clinical signs or symptoms. IIa
7. Routine reevaluation at the time of increased failure rate of a bioprosthesis without clinical evidence of prosthetic dysfunction. IIb
8. Routine reevaluation of patients with valve replacements without suspicion of valvular dysfunction and unchanged clinical signs and symptoms. III
9. Patients whose clinical status precludes therapeutic interventions. III
*TEE may provide incremental value in addition to information obtained by TTE.

Indications for Echocardiography in Infective Endocarditis: Prosthetic Valves

---

1. Detection and characterization of valvular lesions, their hemodynamic severity, and/or

ventricular compensation.* I
2. Detection of associated abnormalities (e.g., abscesses, shunts, etc).* I
3. Reevaluation in complex endocarditis (e.g., virulent organism, severe hemodynamic lesion, aortic valve involvement, persistent fever or bacteremia, clinical change, or symptomatic deterioration).* I
4. Evaluation of suspected endocarditis and negative cultures.* I
5. Evaluation of bacteremia without known source.* I
6. Evaluation of persistent fever without evidence of bacteremia or new murmur.* IIa
7. Routine reevaluation in uncomplicated endocarditis during antibiotic therapy.* IIb
8. Evaluation of transient fever without evidence of bacteremia or new murmur. III
*TEE may provide incremental value in addition to that obtained by TTE.

Indications for Echocardiography in Patients With Chest Pain

---

1. Diagnosis of underlying cardiac disease in patients with chest pain and clinical evidence of valvular, pericardial, or primary myocardial disease (see sections II, IV through VI, VIII, and IX). I
2. Evaluation of chest pain in patients with suspected acute myocardial ischemia, when baseline ECG is nondiagnostic and when study can be obtained during pain or soon after its abatement (see section IV). I
3. Evaluation of chest pain in patients with suspected aortic dissection (see section VIII). I
4. Chest pain in patients with severe hemodynamic instability (see section XIII). I
5. Evaluation of chest pain for which a noncardiac etiology is apparent. III
6. Diagnosis of chest pain in a patient with electrocardiographic changes diagnostic of myocardial ischemia/infarction. III

Indications for Echocardiography in the Diagnosis of Acute Myocardial Ischemic Syndromes

---

1. Diagnosis of suspected acute ischemia or infarction not evident by standard means. I
2. Measurement of baseline LV function. I
3. Patients with inferior myocardial infarction and bedside evidence suggesting possible RV infarction I
4. Assessment of mechanical complications and mural thrombus.* I
5. Identification of location/severity of disease in patients with ongoing ischemia. IIa
6. Diagnosis of acute myocardial infarction already evident by standard means. III
*TEE is indicated when TTE studies are not diagnostic.

Indications for Echocardiography in Risk Assessment, Prognosis, and Assessment of Therapy in Acute Myocardial Ischemic Syndromes

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1. Assessment of infarct size and/or extent of jeopardized myocardium. I
2. In-hospital assessment of ventricular function when the results are used to guide therapy. I
3. In-hospital or early postdischarge assessment of the presence/extent of inducible ischemia whenever baseline abnormalities are expected to compromise electrocardiographic interpretation.* I
4. In-hospital or early postdischarge assessment of the presence/extent of inducible ischemia in the absence of baseline abnormalities expected to compromise ECG interpretation.* IIa
5. Assessment of myocardial viability when required to define potential efficacy of revascularization.** IIa
6. Reevaluation of ventricular function during recovery when results are used to guide therapy. IIa
7. Assessment of ventricular function after revascularization. IIa
8. Assessment of long-term prognosis (> 2 years after acute myocardial infarction). IIb
9. Routine reevaluation in the absence of any change in clinical status. III

*Exercise or pharmacological stress echocardiogram.
**Dobutamine stress echocardiogram.

Indications for Echocardiography in Diagnosis and Prognosis of Chronic Ischemic Heart Disease

---

1. Diagnosis of myocardial ischemia in symptomatic individuals.* I
2. Assessment of global ventricular function at rest. I
3. Assessment of myocardial viability (hibernating myocardium) for planning revascularization.** I
4. Assessment of functional significance of coronary lesions (if not already known) in planning percutaneous transluminal coronary angioplasty.* I
5. Diagnosis of myocardial ischemia in selected patients with an intermediate or high pretest likelihood of coronary artery disease.* IIb
6. Assessment of an asymptomatic patient with positive results from a screening treadmill test. IIb
7. Assessment of global ventricular function with exercise.* IIb
8. Screening of asymptomatic persons with a low likelihood of coronary artery disease. III
9. Routine periodic reassessment of stable patients for whom no change in therapy is contemplated. III
10. Routine substitution for treadmill exercise testing in patients for whom ECG analysis is

expected to suffice. III
*Exercise or pharmacological stress echocardiogram.
**Dobutamine stress echocardiogram.

Indications for Echocardiography in Assessment of Interventions in Chronic Ischemic Heart Disease

---

1. Assessment of LV function when needed to guide institution and modification of drug therapy in patients with known or suspected LV dysfunction. I
2. Assessment for restenosis after revascularization in patients with atypical recurrent symptoms.* I
3. Assessment for restenosis after revascularization in patients with typical recurrent symptoms.* IIa
4. Routine assessment of asymptomatic patients after revascularization. III

*Exercise or pharmacological stress echocardiography.

Indications for Echocardiography in Patients With Dyspnea, Edema, or Cardiomyopathy

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1. Assessment of LV size and function in patients with suspected cardiomyopathy or clinical diagnosis of heart failure.* I
2. Edema with clinical signs of elevated central venous pressure when a potential cardiac etiology is suspected or when central venous pressure cannot be estimated with confidence and clinical suspicion of heart disease is high.* I
3. Dyspnea with clinical signs of heart disease. I
4. Patients with unexplained hypotension, especially in the intensive care unit.* I
5. Patients exposed to cardiotoxic agents, to determine the advisability of additional or increased dosages. I
6. Reevaluation of LV function in patients with established cardiomyopathy when there has been a documented change in clinical status or to guide medical therapy. I
7. Reevaluation of patients with established cardiomyopathy when there is no change in clinical status. IIb
8. Reevaluation of patients with edema when a potential cardiac cause has already been demonstrated. IIb
9. Evaluation of LV ejection fraction in patients with recent (contrast or radionuclide) angiographic determination of ejection fraction. III
10. Routine reevaluation in clinically stable patients in whom no change in management is contemplated. III
11. In patients with edema, normal venous pressure, and no evidence of heart disease. III

*TEE is indicated when TTE studies are not diagnostic.

Indications for Echocardiography in Pericardial Disease

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1. Patients with suspected pericardial disease, including effusion, constriction, or effusive-constrictive process. I
2. Patients with suspected bleeding in the pericardial space, e.g., trauma, perforation, etc. I
3. Follow-up study to evaluate recurrence of effusion or to diagnose early constriction. Repeat studies may be goal directed to answer a specific clinical question. I
4. Pericardial friction rub developing in acute myocardial infarction accompanied by symptoms such as persistent pain, hypotension, and nausea. I
5. Follow-up studies to detect early signs of tamponade in the presence of large or rapidly accumulating effusions. A goal-directed study may be appropriate. IIa
6. Echocardiographic guidance and monitoring of pericardiocentesis. IIa
7. Postsurgical pericardial disease, including postpericardiotomy syndrome, with potential for hemodynamic impairment. IIb
8. In the presence of a strong clinical suspicion and nondiagnostic TTE, TEE assessment of pericardial thickness to support a diagnosis of constrictive pericarditis. IIb
9. Routine follow-up of small pericardial effusion in clinically stable patients. III
10. Follow-up studies in patients with cancer or other terminal illness for whom management would not be influenced by echocardiographic findings. III
11. Assessment of pericardial thickness in patients without clinical evidence of constrictive pericarditis. III
12. Pericardial friction rub in early uncomplicated myocardial infarction or early postoperative period after cardiac surgery. III

Indications for Echocardiography in Patients With Cardiac Masses and Tumors

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1. Evaluation of patients with clinical syndromes and events suggesting an underlying cardiac mass. I
2. Evaluation of patients with underlying cardiac disease known to predispose to mass formation for whom a therapeutic decision regarding surgery or anticoagulation will depend on the results of echocardiography. I
3. Follow-up or surveillance studies after surgical removal of masses known to have a high likelihood of recurrence (ie, myxoma). I
4. Patients with known primary malignancies when echocardiographic surveillance for cardiac involvement is part of the disease staging process. I
5. Screening persons with disease states likely to result in mass formation but for whom no clinical evidence for the mass exists. IIb
6. Patients for whom the results of echocardiography will have no impact on diagnosis or clinical decision making. III

Indications for Echocardiography in Suspected Thoracic Aortic Disease

	TTE	TEE
1. Aortic dissection.	IIa	I
2. Aortic aneurysm.	I*	I
3. Aortic rupture.	IIb	I
4. Aortic root dilatation in Marfan or other connective tissue syndromes.	I	IIb
5. Degenerative or traumatic aortic disease with clinical atheroembolism.	IIb	I
6. Follow-up of aortic dissection, especially after surgical repair without suspicion of complication or progression.	I	IIa
7. Follow-up of aortic dissection especially after surgical repair when complication or progression is suspected.	IIa	I
8. First-degree relative of a patient with Marfan syndrome or other connective tissue disorder.	I	IIb

*Especially for aortic root aneurysm.

Indications for Echocardiography in Pulmonary Disease

1. Suspected pulmonary hypertension.	I
2. Pulmonary emboli and suspected clots in the right atrium or ventricle or main pulmonary artery branches.*	I
3. For distinguishing cardiac versus noncardiac etiology of dyspnea in patients in whom all clinical and laboratory clues are ambiguous.*	I
4. Follow-up of pulmonary artery pressures in patients with pulmonary hypertension to evaluate response to treatment.	I
5. Lung disease with clinical suspicion of cardiac involvement (suspected cor pulmonale).	I
6. Measurement of exercise pulmonary artery pressure.	IIa
7. Patients being considered for lung transplantation or other surgical procedure for advanced lung disease.*	IIa
8. Lung disease without any clinical suspicion of cardiac involvement.	III
9. Reevaluation studies of RV function in patients with chronic obstructive lung disease without a change in clinical status.	III

*TEE is indicated when TTE studies are not diagnostic.

Indications for Echocardiography in Hypertension

1. When assessment of resting LV function, hypertrophy, or concentric remodeling is important in clinical decision making (see LV function).	I
2. Detection and assessment of functional significance of concomitant coronary artery disease (see coronary disease).*	I

3. Follow-up assessment of LV size and function in patients with LV dysfunction when there has been a documented change in clinical status or to guide medical therapy. I
4. Identification of LV diastolic filling abnormalities with or without systolic abnormalities. IIa
5. Assessment of LV hypertrophy in a patient with borderline hypertension without LV hypertrophy on ECG to guide decision making regarding initiation of therapy. A limited goal-directed echocardiogram may be indicated for this purpose. IIa
6. Risk stratification for prognosis by determination of LV performance. IIb
7. Reevaluation to guide antihypertensive therapy based on LV mass regression. III
8. Reevaluation in asymptomatic patients to assess LV function. III
*Stress echocardiography.

Indications for Echocardiography in Patients With Neurological Events or Other Vascular Occlusive Events

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1. Patients of any age with abrupt occlusion of a major peripheral or visceral artery. I
2. Younger patients (typically <45 years) with cerebrovascular events. I
3. Older patients (typically >45 years) with neurological events without evidence of cerebrovascular disease or other obvious cause. I
4. Patients for whom a clinical therapeutic decision (anticoagulation, etc) will depend on the results of echocardiography. I
5. Patients with suspicion of embolic disease and with cerebrovascular disease of questionable significance. IIa
6. Patients with a neurological event and intrinsic cerebrovascular disease of a nature sufficient to cause the clinical event. IIb
7. Patients for whom the results of echocardiography will not impact a decision to institute anticoagulant therapy or otherwise alter the approach to diagnosis or treatment. III

Indications for Echocardiography in Patients With Arrhythmias and Palpitations

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1. Arrhythmias with clinical suspicion of structural heart disease. I
2. Arrhythmia in a patient with a family history of a genetically transmitted cardiac lesion associated with arrhythmia such as tuberous sclerosis, rhabdomyoma, or hypertrophic cardiomyopathy. I
3. Evaluation of patients as a component of the workup before electrophysiological ablative procedures. I
4. Arrhythmia requiring treatment. IIa
5. TEE guidance of transseptal catheterization and catheter placement during ablative procedures. IIa
6. Arrhythmias commonly associated with, but without clinical evidence of, heart disease. IIb

7. Evaluation of patients who have undergone radiofrequency ablation in the absence of complications. (In centers with established ablation programs, a postprocedural echocardiogram may not be necessary.) IIb
8. Palpitation without corresponding arrhythmia or other cardiac signs or symptoms. III
9. Isolated premature ventricular contractions for which there is no clinical suspicion of heart disease. III

Indications for Echocardiography Before Cardioversion

---

1. Patients requiring urgent (not emergent) cardioversion for whom extended precardioversion anticoagulation is not desirable.* I
2. Patients who have had prior cardioembolic events thought to be related to intra-atrial thrombus.* I
3. Patients for whom anticoagulation is contraindicated and for whom a decision about cardioversion will be influenced by TEE results.* I
4. Patients for whom intra-atrial thrombus has been demonstrated in previous TEE.* I
5. Evaluation of patient for whom a decision concerning cardioversion will be impacted by knowledge of prognostic factors (such as LV function, coexistent mitral valve disease, etc). I
6. Patients with atrial fibrillation of <48 hours' duration and other heart disease.* IIa
7. Patients with atrial fibrillation of <48 hours' duration and no other heart disease.* IIb
8. Patients with mitral valve disease or hypertrophic cardiomyopathy who have been on long-term anticoagulation at therapeutic levels before cardioversion.* IIb
9. Patients undergoing cardioversion from atrial flutter. IIb
10. Patients requiring emergent cardioversion. III
11. Patients who have been on long-term anticoagulation at therapeutic levels and who do not have mitral valve disease or hypertrophic cardiomyopathy before cardioversion. III
12. Precardioversion evaluation of patients who have undergone previous TEE and with no clinical suspicion of a significant interval change. III

*TEE only.

Indications for Echocardiography in the Patient With Syncope

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1. Syncope in a patient with clinically suspected heart disease. I
2. Periexertional syncope. I
3. Syncope in a patient in a high-risk occupation (e.g., pilot). IIa
4. Syncope of occult etiology with no findings of heart disease on history or physical exam. IIb
5. Recurrent syncope in a patient in whom previous echocardiographic or other testing demonstrated a cause of syncope. III
6. Syncope in a patient for whom there is no clinical suspicion of heart disease. III

7. Classic neurogenic syncope. III

Indications for Echocardiography to Screen for the Presence of Cardiovascular Disease

---

1. Patients with a family history of genetically transmitted cardiovascular disease. I
2. Potential donors for cardiac transplantation. I
3. Patients with phenotypic features of Marfan syndrome or related connective tissue diseases. I
4. Baseline and reevaluations of patients undergoing chemotherapy with cardiotoxic agents. I
5. Patients with systemic disease that may affect the heart. IIb
6. The general population. III
7. Competitive athletes without clinical evidence of heart disease. III

Conditions and Settings in Which Transesophageal Echocardiography Provides the Most Definitive Diagnosis in the Critically Ill and Injured

The hemodynamically unstable patient with suboptimal TTE images.
The hemodynamically unstable patient on a ventilator.
Major trauma or postoperative patients (unable to be positioned for adequate TTE).
Suspected aortic dissection.
Suspected aortic injury.
Other conditions in which TEE is superior (see section on valvular disease).

Indications for Echocardiography in the Critically Ill

---

1. The hemodynamically unstable patient. I
2. Suspected aortic dissection (TEE). I
3. The hemodynamically stable patient not expected to have cardiac disease. III
4. Reevaluation follow-up studies on hemodynamically stable patients. III

Indications for Echocardiography in the Critically Injured*

---

1. Serious blunt or penetrating chest trauma (suspected pericardial effusion or tamponade). I
2. Mechanically ventilated multiple-trauma or chest trauma patient. I
3. Suspected preexisting valvular or myocardial disease in the trauma patient. I
4. The hemodynamically unstable multiple-injury patient without obvious chest trauma but with a mechanism of injury suggesting potential cardiac or aortic injury (deceleration or crush). I

5. Widening of the mediastinum, postinjury suspected aortic injury (TEE). I
6. Potential catheter, guidewire, pacer electrode, or pericardiocentesis needle injury with or without signs of tamponade. I
7. Evaluation of hemodynamics in multiple-trauma or chest trauma patients with pulmonary artery catheter monitoring and data disparate with clinical situation. IIa
8. Follow-up study on victims of serious blunt or penetrating trauma. IIa
9. Suspected myocardial contusion in the hemodynamically stable patient with a normal ECG. III
*The use of TTE or TEE includes Doppler techniques when indicated and available and with appropriately trained and experienced sonographer and interpreter.
TEE is indicated when TTE images are suboptimal. TEE often provides incremental information.

Indications for Echocardiography in the Adult Patient With Congenital Heart Disease

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1. Patients with clinically suspected congenital heart disease, as evidenced by signs and symptoms such as a murmur, cyanosis, or unexplained arterial desaturation, and an abnormal ECG or radiograph suggesting congenital heart disease. I
2. Patients with known congenital heart disease on follow-up when there is a change in clinical findings. I
3. Patients with known congenital heart disease for whom there is uncertainty as to the original diagnosis or when the precise nature of the structural abnormalities or hemodynamics is unclear. I
4. Periodic echocardiograms in patients with known congenital heart lesions and for whom ventricular function and atrioventricular valve regurgitation must be followed (e.g., patients with a functionally single ventricle after Fontan procedure, transposition of the great vessels after Mustard procedure, l-transposition and ventricular inversion, and palliative shunts). I
5. Patients with known congenital heart disease for whom following pulmonary artery pressure is important (e.g., patients with moderate or ventricular septal defects, atrial septal defects, single ventricle, or any of the above with an additional risk factor for pulmonary hypertension). I
6. Periodic echocardiography in patients with surgically repaired (or palliated) congenital heart disease with the following: change in clinical condition or clinical suspicion of residual defects, LV or RV function that must be followed, or when there is a possibility of hemodynamic progression or a history of pulmonary hypertension. I
7. To direct interventional catheter valvotomy, radiofrequency ablation valvotomy interventions in the presence of complex cardiac anatomy. I
8. A follow-up Doppler echocardiographic study, annually or once every 2 years, in patients with known hemodynamically significant congenital heart disease without evident change in clinical condition. IIb
9. Multiple repeat Doppler echocardiography in patients with repaired patent ductus arteriosus, atrial septal defect, ventricular septal defect, coarctation of the aorta, or bicuspid aortic valve without change in clinical condition. III
10. Repeat Doppler echocardiography in patients with known hemodynamically insignificant

congenital heart lesions (e.g., small atrial septal defect, small ventricular septal defect) without a change in clinical condition. III

Indications for Neonatal Echocardiography

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1. Cyanosis, respiratory distress, congestive heart failure, or abnormal arterial pulses. I
2. Chromosomal abnormality or major extracardiac abnormality associated with a high incidence of coexisting cardiac abnormality. I
3. Lack of expected improvement in cardiopulmonary status in a premature infant with a clinical diagnosis of pulmonary disease. I
4. Systemic maternal disease associated with neonatal comorbidity. I
5. Loud or abnormal murmur or other abnormal cardiac finding in an infant. I
6. Presence of a syndrome associated with cardiovascular disease and dominant inheritance or multiple affected family members. I
7. Presence of a syndrome associated with heart disease, with or without abnormal cardiac findings, for which an urgent management decision is needed. I
8. Cardiomegaly on chest radiograph. I
9. Dextrocardia, abnormal pulmonary or visceral situs by clinical, electrocardiographic, or radiographic examination. I
10. Arrhythmias or other abnormalities on standard ECG suggesting structural heart disease or peripartum myocardial injury. I
11. Clinical suspicion of residual or recurrent abnormality, poor ventricular function, pulmonary artery hypertension, thrombus, sepsis, or pericardial effusion after cardiovascular surgical therapy for congenital heart disease. I
12. Nonimmunologic fetal hydrops. I
13. Follow-up assessment of a neonate with patent ductus arteriosus who has undergone medical or surgical intervention. I
14. Short, soft murmur at the lower left sternal border in the neonate. IIa
15. Failure to thrive in the absence of definite abnormal clinical findings. IIa
16. Presence of a syndrome associated with a high incidence of congenital heart disease for which there are no abnormal cardiac findings and no urgency of management decisions. IIb
17. History of nonsustained fetal ectopy in the absence of postpartum arrhythmias. III

Indications for Echocardiography in the Infant, Child, and Adolescent

---

1. Atypical or pathological murmur or other abnormal cardiac finding in an infant or older child. I
2. Cardiomegaly on chest radiograph. I
3. Dextrocardia, abnormal pulmonary or visceral situs on clinical, electrocardiographic, or radiographic examination. I
4. Patients with a known cardiac defect to assess timing of medical or surgical therapy. I

5. Immediate preoperative evaluation for cardiac surgery of a patient with a known cardiac defect to guide cardiac surgical management and inform the patient and family of risks of surgery. I
6. Patient with known cardiac lesion and change in physical finding. I
7. Postoperative congenital or acquired heart disease with clinical suspicion of residual or recurrent abnormality, poor ventricular function, pulmonary artery hypertension, thrombus, sepsis, or pericardial effusion. I
8. Presence of a syndrome associated with cardiovascular disease and dominant inheritance or multiple affected family members. I
9. Patients with a family history of genetically transmitted myocardial disease, with or without abnormal cardiac finding. I
10. Phenotypic findings of Marfan syndrome or Ehlers-Danlos syndrome. I
11. Baseline and follow-up examinations of patients with neuromuscular disorders having known myocardial involvement. I
12. Presence of a syndrome associated with a high incidence of congenital heart disease when there are no abnormal cardiac findings. I
13. Exercise-induced precordial chest pain or syncope. I
14. "Atypical," "non-vasodepressor" syncope without other cause. I
15. Failure to thrive in the absence of definite abnormal clinical findings. IIb
16. In a child or adolescent, an asymptomatic heart murmur identified by an experienced observer as functional or an insignificant cardiovascular abnormality. III
17. In an otherwise asymptomatic child or adolescent, chest pain identified by an experienced observer as musculoskeletal in origin. III

Indications for Echocardiography in Pediatric Patients With Arrhythmias/Conduction Disturbances

---

1. Arrhythmia in the presence of an abnormal cardiac finding. I
2. Arrhythmia in a patient with a family history of a genetically transmitted cardiac lesion associated with arrhythmia, such as tuberous sclerosis or hypertrophic cardiomyopathy. I
3. Complete atrioventricular block or advanced second-degree atrioventricular block. I
4. Complete or high-degree secondary atrioventricular block. I
5. Arrhythmia requiring treatment. I
6. Ventricular arrhythmia in a patient referred for evaluation for competitive sports. IIa
7. Evidence of preexcitation on ECG. IIa
8. Preexcitation on ECG in the absence of abnormal cardiac findings. IIb
9. Recurring arrhythmia not requiring treatment in the presence of normal findings on examination. IIb
10. Sinus arrhythmia or isolated extrasystoles in a child with otherwise normal cardiac findings and no family history of a genetically transmitted abnormality associated with arrhythmia. III

Indications for Echocardiography in Pediatric Acquired Cardiovascular Disease

---

1. Baseline studies and reevaluation as clinically indicated on all pediatric patients with suspected or documented Kawasaki disease, myopericarditis, HIV, or rheumatic fever. I
2. Postcardiac or cardiopulmonary transplant to monitor for signs of acute or chronic rejection, thrombus, and cardiac growth. I
3. Baseline and reevaluation examinations of patients receiving cardiotoxic therapeutic agents. I
4. Patients with clinical evidence of myocardial disease. I
5. Patients with severe renal disease and an abnormal cardiac finding. I
6. Donors undergoing evaluation for cardiac transplantation. I
7. An acutely ill child with suspected bacterial sepsis or rickettsial disease. IIa
8. Follow-up examinations after acute rheumatic fever in patients with normal cardiac findings. IIb
9. A single late follow-up study after acute pericarditis with no evidence of recurrence or chronic pericardial disease. IIb
10. Long-term follow-up studies in patients with Kawasaki disease who have no coronary abnormalities during the acute phase of the disease process. III

Indications for Echocardiography in Pediatric Cardiopulmonary Disease

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1. Any patient with clinical findings of pulmonary artery hypertension. I
2. Baseline study of patients with cystic fibrosis and no findings of cor pulmonale. IIa

Indications for Echocardiography in Pediatric Thromboembolic Disease States

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1. Thromboembolic event in an infant, child, or adolescent. I
2. Finding or family history of tuberous sclerosis. I
3. Appearance of sepsis, cyanosis, or right-heart failure in a patient with a long-standing indwelling catheter. I
4. Systemic embolization or acute-onset hypertension in a patient with right-to-left-shunting and an indwelling catheter. I
5. Superior vena caval syndrome in the presence of central venous catheter. I
6. Patient with indwelling catheter and fever but without evidence of pulmonary or systemic embolization. IIb
7. Routine surveillance of asymptomatic patients with indwelling catheter. III

Indications for Transesophageal Echocardiography in Pediatric Patients

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1. Any patient with congenital or acquired heart disease needing echocardiography when significant diagnostic information cannot be obtained by TTE. I

2. Monitoring and guidance during cardiothoracic procedures when there is a risk for residual shunting, valvular insufficiency, obstruction, or myocardial dysfunction. I
3. Guidance of catheter/device placement during interventional catheterization/radiofrequency ablation in patients with congenital heart disease. I
4. Study of patients with intra-atrial baffle in whom the potential for thrombus is of concern because of elevated central venous pressures, atrial chamber dilation, increasing cyanosis, or the appearance of arrhythmia. I
5. Patients with long-term placement of intravascular devices in whom thrombus or vegetation is suspected. I
6. Patients with a prosthetic valve in whom thrombus or vegetation is suspected. I
7. Any patient with suspected endocarditis and inadequate transthoracic acoustical window. I
8. Performing TEE in a patient who has not previously had careful study by TTE. III
9. Patients with structural esophageal abnormality. III

Indications for Fetal Echocardiography

---

1. Abnormal-appearing heart on general fetal ultrasound examination. I
2. Fetal tachycardia, bradycardia, or persistent irregular rhythm on clinical or screening ultrasound examination. I
3. Maternal/family risk factors for cardiovascular disease, such as a parent, sibling, or first-degree relative with congenital heart disease. I
4. Maternal diabetes. I
5. Maternal systemic lupus erythematosus. I
6. Teratogen exposure during a vulnerable period. I
7. Other fetal system abnormalities (including chromosomal). I
8. Performance of transplacental therapy or presence of a history of significant but intermittent arrhythmia. Reevaluation examinations are required in these conditions. I
9. Fetal distress or dysfunction of unclear etiology. IIa
10. Previous history of multiple fetal losses. IIb
11. Multiple gestation. IIb
12. Low-risk pregnancies with normal anatomic findings on ultrasound examination. III
13. Occasional premature contractions without sustained tachycardia or signs of dysfunction or distress. III
14. Presence of a noncardiovascular system abnormality when evaluation of the cardiovascular system will not alter either management decisions or fetal outcome. III

CLINICAL ALGORITHM(S):
None provided.

DEVELOPER(S):
American College of Cardiology (ACC) - Medical Specialty Society

American Heart Association (AHA) - Professional Association

COMMITTEE:
Committee on Clinical Application of Echocardiography

GROUP COMPOSITION:

The committee was composed of both university-affiliated and practicing physicians and those with specific echocardiographic expertise and senior clinicians who use the technique. Two general physicians (one general internal medicine and one family practitioner) also served on the committee.

Names of Committee Members: Melvin D. Cheitlin, MD, FACC, Chair; Joseph S. Alpert, MD, FACC; William F. Armstrong, MD, FACC; Gerard P. Aurigemma, MD, FACC; George A. Beller, MD, FACC; Fredrick Z. Bierman, MD, FACC; Thomas W. Davidson, MD, FAAFP; Jack L. Davis, MD, FACC; Pamela S. Douglas, MD, FACC; Linda D. Gillam, MD, FACC; Richard P. Lewis, MD, FACC; Alan S. Pearlman, MD, FACC; John T. Philbrick, MD, FACP; Pravin M. Shah, MD, FACC; Roberta G. Williams, MD, FACC

ENDORSER(S):
American Society of Echocardiography (ASE) - Professional Association

GUIDELINE STATUS:
Update -- This guideline updates a previous guideline (ACC/AHA guidelines for the clinical application of echocardiography. A report of the American College of Cardiology/American Heart Association Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures [Subcommittee to Develop Guidelines for the Clinical Application of Echocardiography]. J Am Coll Cardiol 1990 Dec;16[7]:1505-28 and Circulation 1990 Dec;82[6]:2323-45).

These guidelines will be reviewed 2 years after publication and yearly thereafter and considered current unless the task force revises or withdraws them from distribution.

GUIDELINE AVAILABILITY:
Electronic copies: Available from the American College of Cardiology (ACC) Web site and the American Heart Association (AHA) Web site.

Print copies: Available from ACC, Educational Services, 9111 Old Georgetown Road, Bethesda, MD 20814-1699. Also available from AHA, Public Information, 7272 Greenville Avenue, Dallas, TX 75231-4596 (Reprint No 71-0102)

COMPANION DOCUMENTS:
The following is available:

ACC/AHA guidelines for the clinical application of echocardiography: executive summary. J Am Coll Cardiol 1997 Mar 15;29(4):862-79.

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NGC STATUS:
This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998.

最後の部分は再度日本語訳を添付する。

臨床アルゴリズム:

なし

開発者:

米国循環器病学会
米国心臓病協会

委員会:

心臓超音波検査の適応に関する委員会

グループ構成:

委員会は、大学に勤務する医師および開業医師の両方、ならびに超音波心臓検査法の専門知識および技術を有する上級の臨床医、さらに一般的な 2 人の内科医(一般的な 1 人の内科医および 1 人の家庭医)も参加した。

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超音波心臓検査(ASE)協会

ガイドライン・ステータス:

更新--このガイドラインは前のガイドライン(超音波心臓検査の臨床適応のための ACC/AHA ガイドライン)を更新したものです。診断および治療の心血管処置(Therapeutic Cardiovascular Procedures)[超音波心臓検査の臨床適応(Clinical Application)のためのガイドラインを開発する小委員会]の評価に関する循環器病学会/米国心臓病協会特別対策本部の報告書。J、Coll of Cardiol 1990 年 12 月;16[7]:1505-28 および循環 1990 年 12 月;82[6]:2323-45。
これらのガイドラインは、出版後 2 年後に見直され、そしてその後は毎年見直し、特に特別対策本部が改訂しない場合は、最新版として扱うことにする

ガイドライン本文の入手先:

電子版あり:循環器病学会(ACC)ウェブサイトおよび米国心臓病協会(AHA)のウェブサイトから利用可能です。
印刷したガイドラインは:ACC、教育のサービス(Educational Services)、9111 Old Georgetown Road、ベテスダ、MD 20814-1699 から利用可能です。
さらに、AHA、公開情報、7272 Greenville Avenue、ダラス、TX 75231-4596(71-0102 を再版しない)から利用可能です。

関連ドキュメント:

下記が利用可能です:超音波心臓検査の臨床適応のための ACC/AHA ガイドライン:実行の要約。J、Coll Cardiol 1997 年 3 月 15;29(4):862-79)
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