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## Callan Method Stage 7 Exam Test

many medical products including simple analgesics and wound dressings, and infusion fluids are promoted for use at home on dialysis. the use of oral analgesics is common [ 146 ], and though there are concerns about potential drug interactions with prescribed medications and dialysis settings, oral opioid analgesia for pain after dialysis may be acceptable in expert hands, with risks minimised by careful dose titration [ 147 ]. although the use of more advanced wound dressings, such as hydrocolloids, is required after dialysis, this is also safe in expert hands if the therapy is promptly discontinued [ 148 ]. the use of antiseptics and heparin locks, and adsorbents and binders are also discouraged in acute kidney injury, or shortly after dialysis, though binding of potentially injurious substances may be appropriate for some patients who are well controlled. the use of such products at the end of dialysis should be avoided however, as this is potentially a time of increased susceptibility to infection and gut injury. the safety and efficacy of some products are summarised in appendix 4. achieving optimal insulin dose for the intended patient is one of the major challenges in dialysis care, and is even more complex in acute kidney injury [ 149, 150 ], though the potential benefits of preventing complications of hyperglycaemia and fluid retention in dialysis patients are important. the use of insulin in acute kidney injury is only recommended in specific instances, such as when hypoglycaemia is likely to occur spontaneously. the potential benefits of achieving euglycaemia during dialysis for the established dialysis patient are also uncertain [ 153, 154 ], although good nutritional support can be important if maintenance of nutritional status is required. where insulin is used, the aim is to achieve the desired concentration whilst minimising the time-dependent effects of insulin resistance [ 155 ], and avoiding hyperosmolar, and hence potentially hypotensive, effects if tolerated. the effectiveness of a range of insulin preparations, protocols and modes of administration in dialysis patients is summarised in appendix 4.

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with increasing dialysis exposure time, sepsis was often reported, but was usually associated with low serum albumin and excess dialysis-related blood loss, not necessarily clinically significant [ 139, 140, 141 ]. in a prospective study of 3318 patients, including 172 with sepsis and 437 with bacteraemia, the 4-day post-dialysis bicarbonate range was 33-43mmol/l for the sepsis group (normal range 22-30) and 43-53mmol/l for the bacteraemia group (normal range 22-31) [ 142 ], but no reference was made to the dialysis-related blood loss which was almost a third of the total dialysis dose (appendix 4). red cell indices were markedly lower in the bacteraemia group, with the mean haematocrit of 39% (44% in sepsis) compared to 41% (50% in sepsis). urea reduction was 0.67 in both groups, whereas creatinine clearance was similar at 59ml/min. the mean dialysis vintage was slightly longer in the bacteraemia group at 262 days compared to the sepsis group at 160 days. in both groups post-dialysis bicarbonate fell by 1mmol/l and haematocrit rose by 8-9%, but mean adjusted extra cellular volume fell by 9-10%, suggesting that dialysis related blood loss alone (excluding other losses) was less than 10% of the total peritoneal effluent (appendix 5). there is no evidence that dialysis treatment rates could be increased beyond an average of four sessions per week without detriment to the patient or the service. the medical literature suggests a maximum of 3 to 4 hours per session, and routine laboratory data suggests that patients can dialyse satisfactorily with a minimum dialysis time of 4 hours, either intermittently, once or twice weekly, or on a 3 times weekly extended schedule. there is no evidence that longer dialysis is more effective than shorter dialysis, but given the risks and costs of treatment, it seems reasonable to extend dialysis to maximise efficiency. beyond this, research, informed clinical judgement, and sustainability of services remain the criteria on which decisions are made. 5ec8ef588b

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