



ATEŞLİ HASTAYA YAKLAŞIM

Prof.Dr.Ergin Çiftçi

Ankara Üniversitesi Tıp Fakültesi
Çocuk Enfeksiyon Hastalıkları BD

www.erginciftci.com

15 Ocak 2019

Prof. Dr. Ergin ÇİFTÇİ

Çocuk Sağlığı ve Hastalıkları Uzmanı
Çocuk Enfeksiyon Hastalıkları Uzmanı

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Anasayfa Özgüçmiş Yayınlar Dersler Bilimsel Toplantılar Bilimsel Dergiler Basın Fotoğraflar Ulaşım Edebiyat Satranç Sinema

Saat

Anasayfa

Beni Takip Et!



Duyurular



Korsanlar Seyir Defteri Tutmaz



Prof. Dr. Ergin ÇİFTÇİ

Çocuk Sağlığı ve Hastalıkları Uzmanı

Çocuk Enfeksiyon Hastalıkları Uzmanı

John F. Kennedy Caddesi 24/5

(Tunalı Hilmi Caddesi Kavşağı)

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Takvim

<< Aralık 2018 >>

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Hava Durumu

Anlık Yarınlık



3°

11° 1°

Ankara

Prof. Dr. Ergin ÇİFTÇİ

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Saat

A. Öğren

A. Öğrenci Dersleri

B. Asistan Dersleri

Ankara Üniversitesi Tıp Fakültesi Dönem 5 ve 6 öğrencileri kendilerine Prof. Dr. Ergin Çiftçi tarafından anlatılan derslerin güncel sunumlarına buradan ulaşabilirler.

DÖNEM 5

1. Çocukluk çağı döküntülü hastalıkları
2. Çocuklarda akut gastroenterit
3. Çocukta ağızdan sıvı tedavisi

DÖNEM 6

1. Dehidrasyon: Vaka temelli interaktif tartışma

Yorumlar - Yorum Yaz

Beni Takip Et!



Duyurular



Korsanlar Seyir Defteri Tutmaz



Korsanlar Seyir Defteri Tutmaz

Takvim

<< Aralık 2018 >>

P	S	Ç	P	C	C	P
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31						

Hava Durumu

Anlık

Yanı



3°

11° 1°

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ODAĐI BİLİNMEYEN
AKUT ATEŐ

NEDENİ BİLİNMEYEN
ATEŐ

ATEŐ TEDAVİSİ

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TERMOREGÜLASYON

Vücut iç sıcaklığının dengeli bir şekilde sabit tutulmasıdır

**ISI
OLUŞUMU**

- ❑ Hücre metabolizması
- ❑ Kas aktiviteleri

**ISI
KAYBI**

- ❑ Radyasyon: Ortam sıcaklığı < vücut sıcaklığı
- ❑ Kondüksiyon: Etraftaki cisimlerin sıcaklığı < vücut sıcaklığı
- ❑ Konveksiyon: Hava hareketleri
- ❑ Terleme

ATEŞ

Dengenin ısı oluşumu lehine bozulmasıdır

ISI
OLUŞUMU

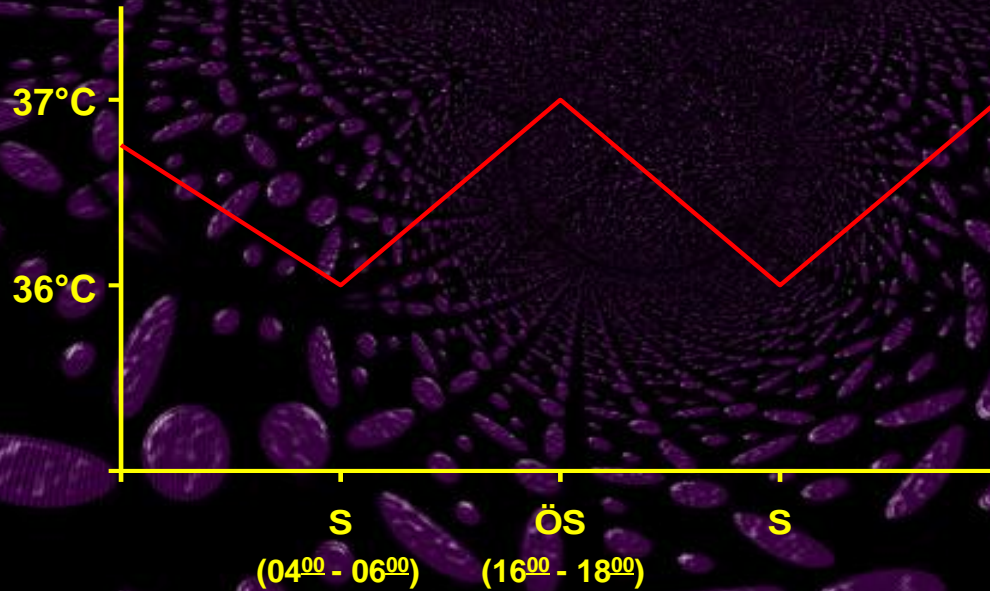
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VÜCUT SICAKLIĞININ DİJURNAL RİTMİ

- Sabah-akşam saatleri arasındaki fark ortalama: $0.9-1.1^{\circ}\text{C}$
- İlk 2 yaşta bu fark belirgin değil
- 6 ay-2 yaş $\rightarrow 0.6^{\circ}\text{C}$ fark



VÜCUT SICAKLIĞININ HANGİ DEĞERLERİN ÜSTÜNE ÇIKMASI ATEŞ OLARAK KABUL EDİLİR?

- Aksiller $> 37.2^{\circ}\text{C}$
- Oral $> 37.8^{\circ}\text{C}$
- Rektal $\geq 38^{\circ}\text{C}$
- Timpanik $> 38^{\circ}\text{C}$ (Rektal mod) $> 37.5^{\circ}\text{C}$ (Oral mod)
- Alın $> 38^{\circ}\text{C}$

BİZ DE ALDIK
ÇOCUĞU HASTANEYE
GÖTÜRDÜK. 40
DERECE ATEŞİ
ÇIKMIŞTI!

BİZ BÖYLE
DERECE DEDİĞİMİZ
İÇİN BOZULMALIYO -
SUN DI MI
FAHRENAYT?



CIK!



ATEŞE NEDEN OLAN MEKANİZMALAR

1. Pirojen

Enfeksiyon

Malignite

İnflamatuvar hastalıklar

2. Aşırı ısı üretimi

Salisilat zehirlenmesi

Malign hipertermi

3. Isı kaybında defekt olması

Ektodermal displazi

Sıcak çarpması

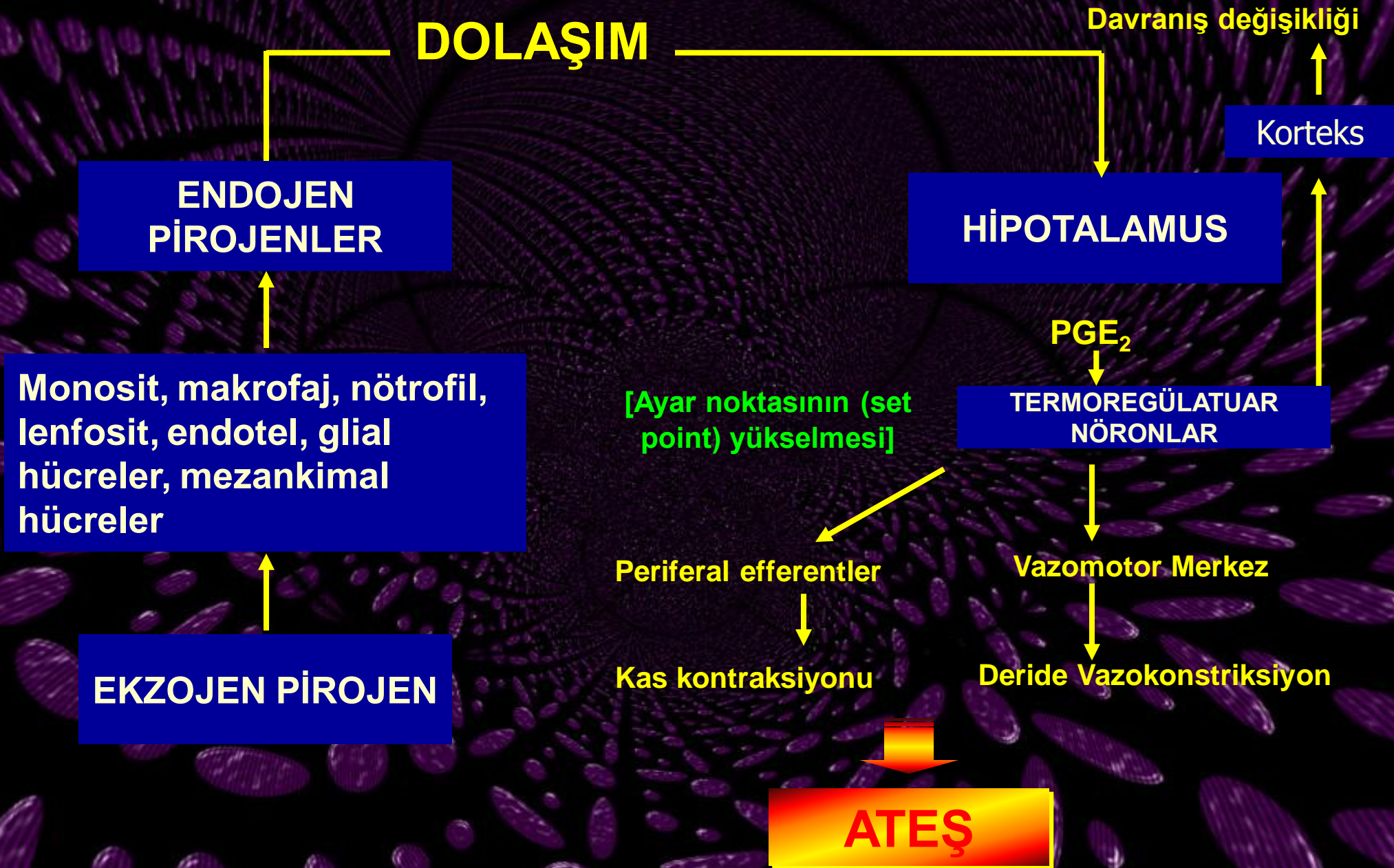
ENDOJEN PİROJENLER

- **IL-1**
- **IL-6**
- **TNF α**
- **İnterferonlar (IFN- α , IFN- β , IFN- γ)**

EKZOJEN PİROJENLER

- **Mikroorganizmalar**
 - Gram (-) → lipopolisakkarid
 - Gram (+) → peptidoglikan...
- **Mikrobiyal toksinler**
 - Endotoksin
 - Enterotoksinler
 - Eritrojenik toksinler
- **İlaçlar**
 - Vankomisin
 - Amfoterisin B
 - Allopürinol
 - Bleomisin
 - Daunorubicin
 - L-asparaginaz

DOLAŞIM



Ateş, vücudun zararlı etkenlere karşı geliştirdiği adaptif bir yanıttır

Vücut sıcaklığı arttığında;

- 1. İnflamasyon sistemi daha iyi çalışır**
- 2. Mikrobiyal çoğalma hızı azalır**

ATEŞ, ORGANİZMANIN YARARINA İŞLEV GÖRÜR

TERMOMETRELER

- 1. Civalı termometre**
- 2. Elektronik termometre**
- 3. Kızıl ötesi kulak termometresi**
- 4. Temassız termometre**
- 5. Plastik termometre**



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AKUT ATEŐ

NEDENİ BİLİNMEYEN
ATEŐ

ATEŐ TEDAVİSİ

Ateşli hasta

Odak belli

Anamnez ve fizik muayene

Odak belli değil

Tedavi

Ciddi bakteriyel enfeksiyon yönünden risk taşıyor mu?

Toksik görünüm

**Yaş
Altta yatan hastalık**

**Laboratuvar
incelemeleri**

TOKSİK GÖRÜNÜM

- ❑ **Bilinç değişikliği:** etrafa ilgisizlik, letarji, irritabilite, anneyi tanımama, teskin edilemeyen ağlama
- ❑ **Beslenme bozukluğu:** emmeme, kusma
- ❑ **Taşikardi ve takipne, periferik dolaşım bozukluğu**
- ❑ **Deride kirli-gri renk, cutis marmoratus**
- ❑ **Peteşiyal döküntü**
- ❑ **Titremeyele yükselen ateş**
- ❑ **≥ 40°C ateş**
- ❑ **Yenidoğan reflekslerinde azalma**

RİSK GRUPLARI

YAŞ

<1 ay bebekler

1-3 ay arası bebekler

3-36 ay arası bebekler

ALTTA YATAN HASTALIK

Ağır beslenme bozukluğu

Orak hücre anemisi

Aspleni

İmmun yetmezlik

Konjenital kalp hastalığı

Nötropenik hastalar

Malignite

Santral ven kateteri - İdrar sondası vs.

Total parenteral beslenme uygulanan hastalar

Geniş spektrumlu antibiyotik kullanan hastalar

CİDDİ BAKTERİYEL ENFEKSİYON RİSKİNE İŞARET EDEN LABORATUVAR BULGULARI

TKS ve formül: BK: $<5.000 - >15.000/mm^3$, Çomak sayısı: $>1.500/mm^3$

Tam idrar incelemesi

İdrar kültürü \pm (Erkek < 6 ay, sünnetsiz erkek < 24 ay, bütün kızlar)

Akciğer grafisi \pm (Solunum sistemi semptomu varsa)

Dışkı incelemesi \pm (İshal varsa)

BOS incelemesi \pm (Değerlendirme gücü veya şüphe varsa)

BOSTON CRITERIA

Infants are at low risk if they appear well, have a normal physical examination, and have a caretaker reachable by telephone and if laboratory tests are as follows:

- CBC: $<20,000$ WBC/ μ L
- Urine: negative leukocyte esterase
- CSF: leukocyte count less than $10 \times 10^6/L$

ROCHESTER CRITERIA

Infants are at low risk if they appear well and have a normal physical examination and if laboratory findings are as follows:

- CBC: 5,000-15,000 WBC/ μ L; absolute band count $\leq 1,500/\mu$ L
- Urine: <10 WBC/HPF at 40 \times
- Stool: <5 WBC/HPF if diarrhea

PITTSBURGH GUIDELINES

Infants are at low risk if they appear well and have a normal physical examination and if laboratory tests are as follows:

- CBC: 5,000-15,000 WBC/ μ L; peripheral absolute band count $<1,500/\mu$ L
- Urine (enhanced urinalysis): 9 WBC/ μ L and no bacteria on Gram stain
- CSF: 5 WBC/ μ L and negative Gram stain; if bloody tap, then WBC:RBC $\leq 1:500$
- Chest radiograph: no infiltrate
- Stool: 5 WBC/HPF with diarrhea

PHILADELPHIA PROTOCOL

Infants are at low risk if they appear well and have a normal physical examination and if laboratory tests are as follows:

- CBC: $<15,000$ WBC/ μ L; band: total neutrophil ratio <0.2
- Urine: <10 WBC/HPF; no bacteria on Gram stain
- CSF: <8 WBC/ μ L; no bacteria on Gram stain
- Chest radiograph: no infiltrate
- Stool: no RBC; few to no WBC

GİZLİ BAKTERİYEMİ

Genel durumu iyi görünen bir çocukta, sıklıkla bakteriyemi ile seyreden bir enfeksiyon olmadan, pozitif kan kültürü olmasıdır.

En sık görüldüğü yaş grubu 0-36 aydır

Ateşin yükseklik derecesi arttıkça sıklığı artar

Riskli ateş (Rektal): 3 aydan küçük bebekler için $\geq 38^{\circ}\text{C}$
3-36 ay arası bebekler için $\geq 39^{\circ}\text{C}$

GİZLİ BAKTERİYEMİ

ALİŞILMIŞ ETKENLER

S. pneumoniae

N. meningitidis

H. influenzae tip b

Salmonella spp.

S. aureus

< 3 AY BEBEKLER

B grubu Streptokoklar

L. monocytogenes

Enterik Gram (-) basiller

GİZLİ BAKTERİYEMİ

Kendiliğinden düzelebilir

***S. pneumoniae*: %30-40**

***H. influenzae*: %5**

Lokal bir enfeksiyon biçimine dönüşebilir

**Menenjit, septik artrit, osteomyelit,
pnömoni vs...**

Sebat edebilir

Sepsis (SIRS) şekline dönüşebilir.

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Child 1-3 mo and temperature $\geq 38^{\circ}\text{C}$ (100.4°F)	Two-step process 1. Determine risk based on history, physical examination, and laboratory studies. Low risk: <ul style="list-style-type: none"> • Uncomplicated medical history • Normal physical examination • Normal laboratory studies • Urine: negative leukocyte esterase, nitrite and <10 WBC/HPF • Peripheral blood: $5,000-15,000$ WBC/mm^3; $<1,500$ bands or band: total neutrophil ratio <0.2 • Stool studies if diarrhea (no RBC and <5 WBC/HPF) • CSF cell count (<8 WBC/μL) and negative Gram stain • Chest radiograph without infiltrate 2. If child fulfills all low-risk criteria, administer no antibiotics, ensure follow-up in 24 hr and access to emergency care if child deteriorates. Daily follow-up should occur until blood, urine, and CSF cultures are final. If any cultures are positive, child returns for further evaluation and treatment. If child does not fulfill all low-risk criteria, hospitalize and administer parenteral antibiotics until all cultures are final and definitive diagnosis determined and treated
Child 3-36 mo and temperature $38-39^{\circ}\text{C}$ ($100.4-102.2^{\circ}\text{F}$)	Reassurance that diagnosis is likely self-limiting viral infection, but advise return with persistence of fever, temperatures $>39^{\circ}\text{C}$ (102.2°F), and new signs and symptoms
Child 3-36 mo and temperature $>39^{\circ}\text{C}$ (102.2°F)	Two-step process: 1. Determine immunization status 2. If received conjugate pneumococcal and <i>Haemophilus influenzae</i> type b vaccines, obtain urine studies (urine WBC, leukocyte esterase, nitrite, and culture) for all girls, all boys <6 mo old, all uncircumcised boys <2 yr, all children with recurrent urinary tract infections If did not receive conjugate pneumococcal and <i>H. influenzae</i> type b vaccines, manage according to the 1993 Guidelines (see Baraff et al. <i>Ann Emerg Med</i> 22:1198-1210, 1993.)

*Other tests may include chest radiograph, stool studies, herpes simplex polymerase chain reaction.

CSF, cerebrospinal fluid; HPF, high-powered field; RBC, red blood cell; WBC, white blood cell.

Practice guideline for the management of infants and children 0 to 36 months of age with fever without source. Agency for Health Care Policy and Research.

[Baraff LJ](#)¹, [Bass JW](#), [Fleisher GR](#), [Klein JO](#), [McCracken GH Jr](#), [Powell KR](#), [Schriger DL](#).

+ Author information

Erratum in

Ann Emerg Med 1993 Sep;22(9):1490.

Abstract

STUDY OBJECTIVE: To develop guidelines for the care of infants and children from birth to 36 months of age with fever without source.

PARTICIPANTS AND SETTING: An expert panel of senior academic faculty with expertise in pediatrics and infectious diseases or emergency medicine.

DESIGN AND INTERVENTION: A comprehensive literature search was used to identify all publications pertinent to the management of the febrile child. When appropriate, meta-analysis was used to combine the results of multiple studies. One or more specific management strategies were proposed for each of the decision nodes in draft management algorithms. The draft algorithms, selected publications, and the meta-analyses were provided to the panel, which determined the final guidelines using the modified Delphi technique.

RESULTS: All toxic-appearing infants and children and all febrile infants less than 28 days of age should be hospitalized for parenteral antibiotic therapy. Febrile infants 28 to 90 days of age defined at low risk by specific clinical and laboratory criteria may be managed as outpatients if close follow-up is assured. Older children with fever less than 39.0 C without source need no laboratory tests or antibiotics. Children 3 to 36 months of age with fever of 39.0 C or more and whose WBC count is 15,000/mm³ or more should have a blood culture and be treated with antibiotics pending culture results. Urine cultures should be obtained from all boys 6 months of age or less and all girls 2 years of age or less who are treated with antibiotics.

CONCLUSION: These guidelines do not eliminate all risk or strictly confine antibiotic treatment to children likely to have occult bacteremia. Physicians may individualize therapy based on clinical circumstances or adopt a variation of these guidelines based on a different interpretation of the evidence.

3-36 ay arası, ateş > 39°C, toksik değil, TANI YOK

Tüm hastalara veya BK sayısı >15 000/mm³ olan hastalara 1 doz seftriakson yapıp ayaktan izlenir

KAN KÜLTÜRÜ NEGATİF

Ateş düşmüşse

Genel durumu iyi ise ayaktan takip

KAN KÜLTÜRÜ NEGATİF

Ateş devam ediyor

Yeniden değerlendirilip çocuğun durumuna göre ayaktan ya da yatarak izlenmeli

KAN KÜLTÜRÜ POZİTİF

Ateş devam ediyor

Hastaneye yatır

Sepsis yönünden değerlendir (BOS dahil)

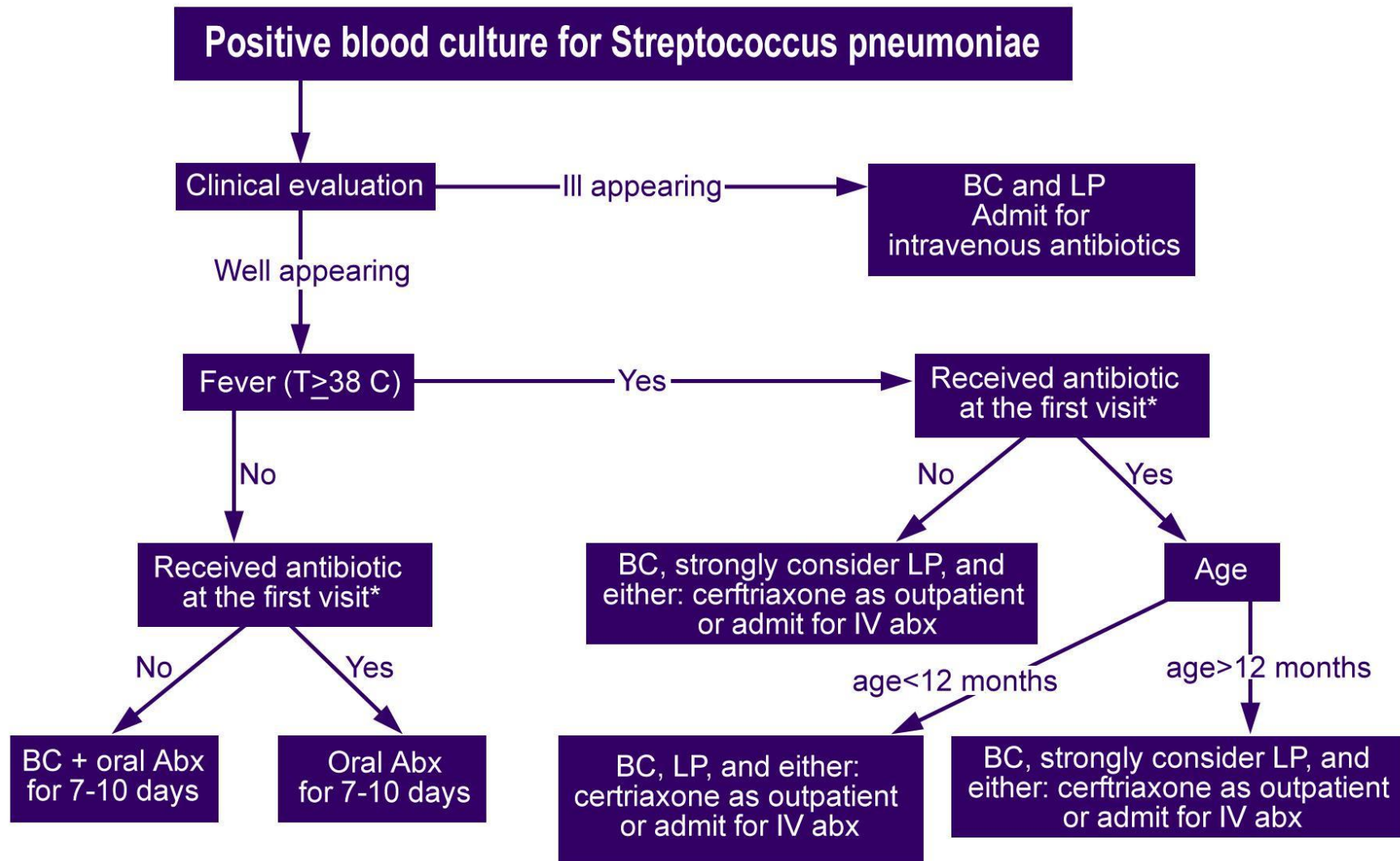
KAN KÜLTÜRÜ POZİTİF

Ateş düşmüş (antipiretik almadan)

Yeniden değerlendir, gerekirse LP yap, tekrar kan kültürü al.

Seftriaksonu sürdür

Ateş düşük devam ediyor ve diğer incelemeler normal ise, tedaviyi oral antibiyotikle 7-10 güne tamamla



All patients need close follow-up.
Consider obtaining a chest radiograph in any child with cough or respiratory symptoms.

Abbreviations:
Abx= antibiotics
BC= blood culture
LP= lumbar puncture

*Abx given at initial visit with efficacy against Streptococcus pneumoniae



KONU BAŐLIKLARI

ATEŐ BİLGİSİ

ODAĐI BİLİNMEYEN
AKUT ATEŐ

NEDENİ BİLİNMEYEN
ATEŐ

ATEŐ TEDAVİSİ

NEDENİ BİLİNMEYEN ATEŞ

İlk kez 1961 yılında Petersdorf ve Beeson

- 1. En az üç hafta süren**
- 2. Bir hafta süreyle hastanede yapılan incelemelere karşın nedeni belirlenemeyen**
- 3. Dokumante edilen 38.3 °C üzerinde ateş**

NEDENİ BİLİNMEYEN UZAMIŞ ATEŞ

TABLE 56-1 Summary of Definitions and Major Features of the Four Subtypes of Fever of Unknown Origin (FUO)

	CLASSIC FUO	NOSOCOMIAL (HEALTH CARE-ASSOCIATED) FUO	NEUTROPENIC (IMMUNE-DEFICIENT) FUO	HIV-RELATED FUO
Definition	>38.3° C (100.9° F), >3 wk, >2 visits or 3 days in hospital	>38.3° C (100.9° F), >3 days, not present or incubating on admission	>38.3° C (100.9° F), >3 days, negative cultures after 48 hr	>38.3° C (100.9° F), >3 wk for outpatients, >3 days for inpatients, HIV infection confirmed

Table 177-4 Summary of Definitions and Major Features of the 4 Subtypes of Fever of Unknown Origin

FEATURE	CLASSIC FUO	HEALTHCARE-ASSOCIATED FUO	IMMUNE-DEFICIENT FUO	HIV-RELATED FUO
Definition	>38°C (100.4°F), >3 wk, >2 visits or 1 wk in hospital	≥38°C (100.4°F), >1 wk, not present or incubating on admission	≥38°C (100.4°F), >1 wk, negative cultures after 48 hr	≥38°C (100.4°F), >3 wk for outpatients, >1 wk for inpatients, HIV infection confirmed

NEDENİ BİLİNMEYEN UZAMIŞ ATEŞİN (NBUA) NEDENLERİ

1. Enfeksiyonlar
2. Kollajen-vasküler hastalıklar
3. Maligniteler
4. Diğer hastalıklar
5. Tanı konulamayanlar

 Onur Canik ▶ Tıpçı Yaylası - GRUP ...
Dün, 22:47 • 🗨️

← Tweet

 canik ^_(\ツ)_/~
@onurcanik10

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NEDENLERİ" diye ders var. tweet
bitti bu kadar

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10 Retweet 185 Beğeni

👍👎❤️ Sen, Halil Ibrahim Kurgan ve 149 diğer kişi

Pyrexia of unknown origin in children: a review of 102 patients from Turkey

ERGİN ÇİFTÇİ, ERDAL İNCE & ÜLKER DOĞRU

Department of Paediatric Infectious Diseases, University of Ankara Medical School, Ankara, Turkey

(Accepted July 2003)

Summary Pyrexia of unknown origin (PUO) has not been appropriately investigated in Turkish children and therefore a study was undertaken to determine the causes of PUO and to evaluate which clinical procedures are useful in establishing a diagnosis. A total of 102 children fitting the classical PUO criteria seen in our clinic between 1995 and 2002 were investigated retrospectively. Infections, collagen vascular disorders, malignancy and miscellaneous conditions constituted 44.2%, 6.8%, 11.7% and 24.5% of cases, respectively, while 12.8% of the cases remained undiagnosed. Enteric fever, brucellosis and respiratory tract infections were the most commonly encountered infections, whereas familial Mediterranean fever was the commonest non-infectious disorder. Biopsy, aspiration, serology, bacteriology, radiology and observation of the clinical course were the most useful diagnostic procedures.

Ateş \geq 8 Gün

Hasta iyi görünüyor

Evet

Hayır

İLK ETAP

HASTANEYE YATIR

Gereksiz tedavileri kes

Kan sayımı ve formül

BFT, elektrolitler, glukoz

Transaminazlar

İdrar incelemesi

Gerekiyorsa görüntüleme yap

Gözlem ve muayeneye devam et

Gereksiz tedavileri kes

Kan sayımı ve formül

BFT, elektrolitler, glukoz

Transaminazlar

İdrar incelemesi

Gerekiyorsa görüntüleme yap

Gerekiyorsa BOS

CRP bakmayı düşün

Kültürler

Ampirik antibiyotik (kültür sonrası)

Gözlem ve muayeneye devam et

**Ateş düştü
Neden saptandı**

Evet

Hayır

Nedeni tedavi et

Kategorik araştırma yap

Kategorik araştırma yap

ENFEKSİYON

Kültürler
BOS (gerekirse)
Spesifik serolojik test
Spesifik PCR
CRP/ESH (abse, endokardit, osteomyelit şüphesi varsa)
Görüntüleme (gerekirse)
Ampririk antibiyotik (kültürler alındıktan sonra)

ONKOLOJİ

Ürik asit
LDH
Ferritin
Periferik yayma
Akciğer grafisi
Steroid kesilmesi

OTOİMMÜN-KVH

ANA
RF
C3, C4, CH50
TFT
CRP, ESH, Ferritin

İMMÜN YETMEZLİK

İmmünglobulinler
Lenfosit markerları
Antikorlar (aşılara karşı)

Neden saptanamadı

Uzmanla danış
Üçüncü basamak merkeze sevk

Kültürleri tekrarla
Ek serolojik testler
Kemik iliği aspirasyonu
Görüntüleme
Kemik sintigrafisi
PET
Gastrointestinal

ÇOCUKLARDA NBUA (FUO) NEDENLERİ

Common Causes of Pediatric FUO					
Infectious			Non-Infectious		
Bacterial	Viral	Other	Oncologic	Autoimmune	Other
Abscess	Adenovirus	Blastomycosis	Leukemia	Behcet Disease	Diabetes
Bartonella	Arbovirus	Cryptosporidium	Lymphoma	Inflammatory Bowel Disease	Inspidus
Brucellosis	Cytomegalovirus	Ehrlichiosis	Langerhans Cell Histiocytosis		Drug Fever
Leptospirosis	Enterovirus	Histoplasmosis	Neuroblastoma	Hyperthyroidism	Factitious Fever
Mastoiditis	Epstein-Barr Virus	Leishmaniasis	Hemophagocytic Lymphohistiocytosis	Granulomatosis (with polyangitis)	Familial Dysautonomia
Mycoplasma	Hepatitis Viruses	Lymphogranuloma Venereum			Periodic Fever Syndromes
Osteomyelitis	Herpes Simplex Virus	Malaria		Juvenile Idiopathic Arthritis	Pancreatitis
Pyelonephritis		Psittacosis			Serum Sickness
Rat Bite Fever	Human Immunodeficiency Virus	Q Fever		Kawasaki Disease	Cyclic neutropenia
Salmonellosis		Rocky Mountain Spotted Fever		Polyarteritis Nodosa	Kikuchi-Fujimoto Disease
Sinusitis		Toxoplasmosis		Sarcoidosis	
Tuberculosis	Picornavirus	Visceral larva migrans		Systemic Lupus Erythematosus	
Tularemia					
Non-Tuberulous Mycobacteria				Antiphospholipid Antibody Syndrome	
				Subacute thyroiditis	

KONU BAŐLIKLARI

ATEŐ BİLGİSİ

ODAĐI BİLİNMEYEN
AKUT ATEŐ

NEDENİ BİLİNMEYEN
ATEŐ

ATEŐ TEDAVİSİ

Ateş enfeksiyona karşı geliştirilen savunma yanıtının bir parçasıdır.

Aileyi ve hastayı huzursuz eden bir semptomdur

Ateşin neden olduğu deęişiklikler

Metabolik hızda artma

Oksijen tüketimde artma

Karbondiyoksit üretiminde artma

Kardiyak output artışı

Solunum iş yükünde artma

Konvulsiyon eşğinde düşme

ATEŞLİ ÇOCUĞA TEDAVİ YAKLAŞIMI

1. DESTEK TEDAVİSİ

- Ortam ısısının ayarlanması
- İnce ve gevşek giysi giydirilmesi
- Bol sıvı verilmesi
- Yeterli kalori alımının sağlanması
- Ilık su ile pansuman ve banyo

2. ANTİPİRETİK İLAÇ TEDAVİSİ

- Asetaminofen 10-15 mg/kg/doz olarak her 4-6 saatte bir
- İbuprofen 5-10 mg/kg/doz olarak her 6-8 saatte bir
- Aspirin 30-65 mg/kg/gün 4-6 dozda, Antipretik olarak kullanma
- Metamizol Asla kullanma

3. NEDENE YÖNELİK TEDAVİ

FAHRENHEIT 451 (1966)
DEĞİŞEN DÜNYANIN İNSANLARI

