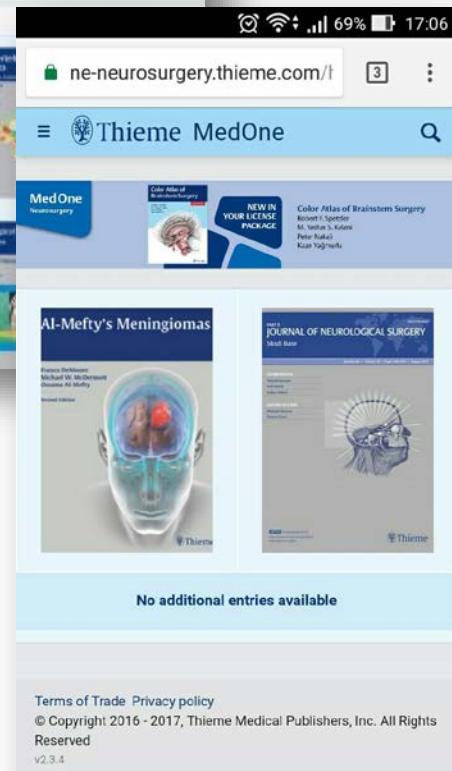


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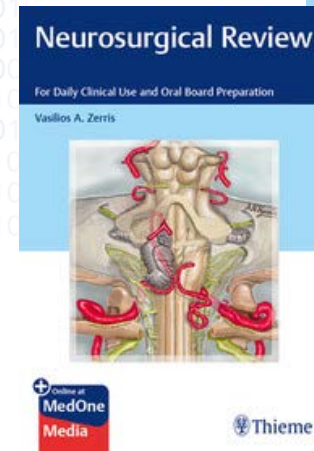
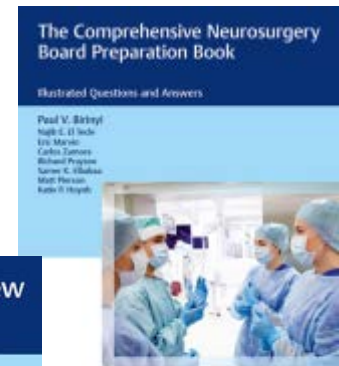
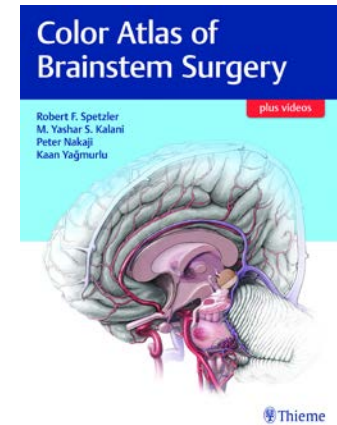
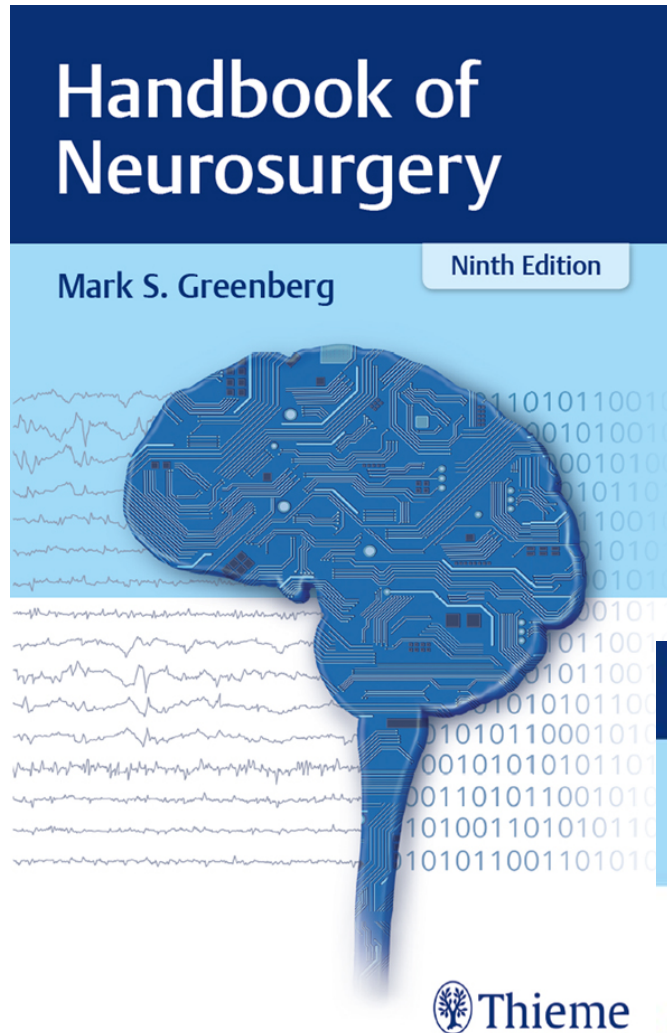
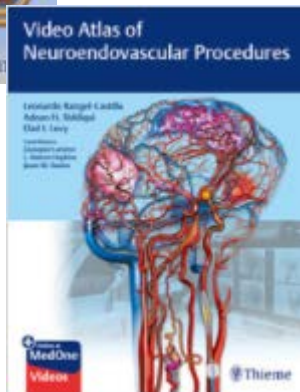
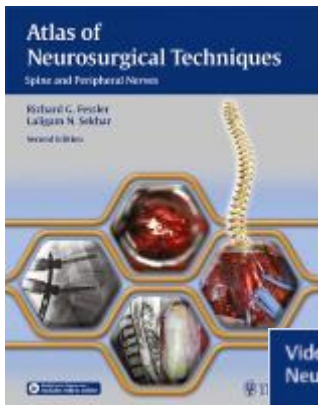
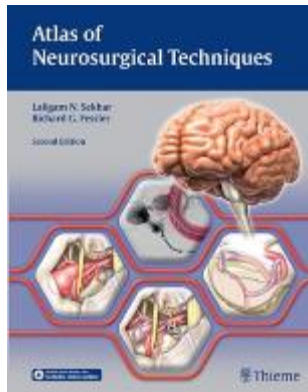


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- Cases 案例說明
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檢索

先進的搜索機制，並依據與關鍵字的關聯度排列檢索結果。

The screenshot displays the MedOne Neurosurgery search results page. At the top, there is a search bar with the text 'Neurosurgery' and a 'Search' button. To the right of the search bar are links for 'Login', 'Sign up for access from home', 'Enter access code', and 'Further subject are'. The search results are organized into several categories, each highlighted with a red oval:

- Playlist Collections**: Includes 'MedOne SAP Neurosurgery'.
- E-Journals**: Includes 'Current issue 04/20 Arquivos Brasileiros de Neurocirurgia: Brazilian Neurosurgery' and 'Current issue 01/21 Indian Journal of Neurosurgery'.
- E-Books**: Includes 'Kaloostian, Ordookhanian Neurosurgery Outlines: Surgical Outlines' and 'Nader, Sabbagh, Elbabaa, Al-Jehan... Neurosurgery Case Review: Questions and Answers'.
- Chapter**: Includes '1 Anatomy, Embryology, and Normal and Abnormal Development of the Craniovertebral Junction and Cervical Spine' and 'Anatomy of the Subaxial Cervical Spine'.

Other visible categories include 'Content Collections' (with 'Cases: Functional Neurosurgery' and 'Greenberg's Handbook of Neurosurgery'), 'Playlists' (with 'Team MedOne Neurosurgery'), and 'Search all' (with 'Authors').

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2. 期刊
3. 電子書
4. 特定章節
5. 文章

Procedures: 提供418個外科手術流程Step-by-step 指引

Endoscopic Approach to Craniopharyngioma

Nancy McLaughlin, Leo F. S. Ditzel Filho, Daniel M. Prevedello, Daniel F. Kelly, Ricardo Carrau, Amin Kassam



Quick access

Introduction and Background | Operative Detail and Preparation | Outcomes and Postoperative Course | References

Introduction and Background

Definition, Pathophysiology, Epidemiology, and Histology

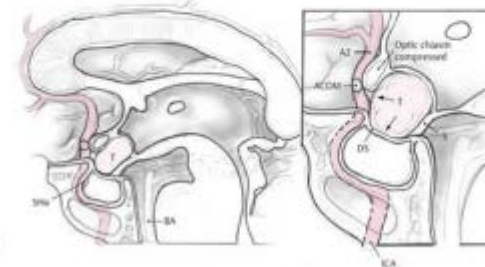
- ▶ Craniopharyngiomas are rare tumors of the central nervous system that occur at a rate of 1.3 per million person-years. Overall, they account for 2–5% of all primary intracranial neoplasms. Although they can be diagnosed at any age, craniopharyngiomas typically present a bimodal age distribution with a first peak in children 5–14 years old and a second peak in adults 50–74 years old.
- ▶ Craniopharyngiomas arise along the path of the craniopharyngeal duct, a canal connecting the stomodeal ectoderm with the evaginated Rathke pouch. Some authors have proposed that these tumors arise from neoplastic transformation of embryonic squamous cell rests of the involuted craniopharyngeal duct. Others have suggested that craniopharyngiomas result from metaplasia of adenohypophyseal cells in the pituitary stalk or gland.
- ▶ Craniopharyngioma are benign grade I tumors according to the World Health Organization classification. Histologically, two subtypes have been recognized, the adamantinomatous (most common, predominantly in young patients) and the papillary (almost exclusively in adults). Transitional or mixed forms have also been reported.
- ▶ Despite its benign histology, craniopharyngiomas tend to adhere and infiltrate surrounding structures. This characteristic accounts for their aggressive behavior and potentially significant morbidity and mortality. Rarely, craniopharyngiomas may present a malignant transformation, potentially and questionably induced by radiation therapy.

Clinical Presentation

- ▶ As craniopharyngiomas grow within the sellar/parasellar region, they may exert mass effect on critical structures of the nervous system including the optic apparatus, pituitary stalk and gland, floor of the third ventricle, hypothalamus, and cerebral vasculature of the circle of Willis.
- ▶ Headache, nausea/vomiting, visual disturbances, and symptoms related to hypothalamopituitary dysfunction are among the most commonly reported clinical manifestations. Less common presenting features include motor weakness, seizures, psychiatric symptoms, autonomic disturbances, and precocious puberty.
- ▶ Symptomatic elevated intracranial pressure may occur in any age population, resulting from obstruction of the foramen of Monro or of the aqueduct of sylvius by the tumor.

Staging

- ▶ To date, authors have proposed various classification systems depending on their relation to the sella turcica, diaphragm sellae, optic chiasm, and third ventricle. The infundibulum is the key anatomic landmark that helps guide the modular exposure of endoscopic endonasal approaches (EEA) for craniopharyngioma resection (Fig. 60.1), as previously described by Kassam et al.
- ▶ *Type I craniopharyngiomas* are preinfundibular, located immediately anterior to the pituitary stalk (most accessible). They are located in the suprasellar space, guarded inferiorly by the diaphragm, superiorly by the displaced chiasm, posteriorly by the pituitary stalk, and laterally by the carotid arteries. Preinfundibular lesions are the most direct craniopharyngiomas to approach through an endonasal route.
- ▶ *Type II craniopharyngiomas* are transinfundibular lesions that grow within the long axis of the infundibulum, widening it circumferentially. Such lesions often create a component in the subchiasmatic space and extend rostrally through the tuber cinereum and into the third ventricle. In these cases, the stalk forms the capsule of the tumor.
- ▶ *Type III craniopharyngiomas* are retroinfundibular lesions, located posterior to the pituitary stalk (most challenging). They are bounded anteriorly by the pituitary stalk and posteriorly by the mammillary bodies and basilar apex. The tumor may extend rostrally (type 3a), through the membrane of Lilliequist, to ultimately encroach or invade the third ventricle. It may also extend caudally (type 3b) to fill the interpeduncular fossa, potentially encroaching on the posterior circulation. Laterally, retroinfundibular craniopharyngiomas are bounded by the oculomotor nerves as they travel forward toward the cavernous sinus and the posterior communicating arteries as they travel between the posterior cerebral artery (P1) and the internal carotid artery (ICA).
- ▶ *Type IV craniopharyngiomas* are pure intraventricular tumors. These tumors may best be approached by a transcranial route as the endonasal corridors are often limited by the stalk and chiasm.



Cases: 收錄225個案子的管理與追蹤提示

Brain Abscess

Pedro M. Ramirez and Martina Stippler

Quick access

[Case Presentation](#) | [Questions](#) | [Overview](#) | [Answers](#) | [Summary](#) | [Annotated References](#)

Case Presentation

A 52-year-old man with no previous medical history was brought to the emergency department with tonicoclonic seizure on the right side. The patient was afebrile, postictal at examination, but had no focal neurological deficit. He had a history of alcohol abuse (12-pack of beer a day). Laboratory workup showed: white blood cell (WBC) count 18.6×10^3 (neutrophil 91%); erythrocyte sedimentation rate (ESR) 10 (0–25); C-reactive protein (CRP) 1.4 (< 0.3), and blood glucose is 148 mg/dL. Noncontrast computed tomographic (CT) scan and enhanced magnetic resonance imaging (MRI) were obtained (Fig. 140.1). Blood cultures were negative and the patient is started on empirical antibiotic therapy. Two weeks after empirical therapy was the patient continued having headaches, the WBC count was 3.4×10^3 , ESR was 15, and CRP was 0.5. A follow-up MRI scan was obtained (Fig. 140.2). The patient undergoes stereotactic needle aspiration, which showed a positive culture for *Nocardia*. Antibiotic therapy was titrated with ceftriaxone for 6 weeks and trimethoprim/sulfamethoxazole for 12 months.

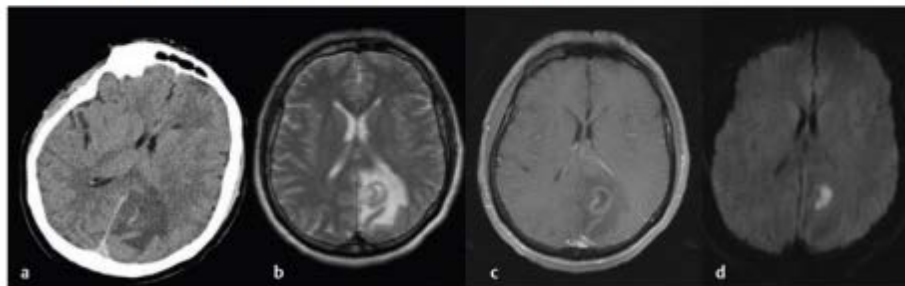


Fig. 140.1 Imaging studies at the time of admission. (a) Computed tomographic scan without contrast showing left parietal edema with a central rim. (b) T2-weighted magnetic resonance imaging (MRI) demonstrating the hyperintense lesion in the left parietal lobe with surrounding vasogenic edema. (c) Contrast-enhanced T1-weighted MRI demonstrating a left parietal ring-enhancing lesion. (d) Diffusion-weighted imaging revealing restricted diffusion.

Images/Videos/Audios

95,361 包含圖註影像

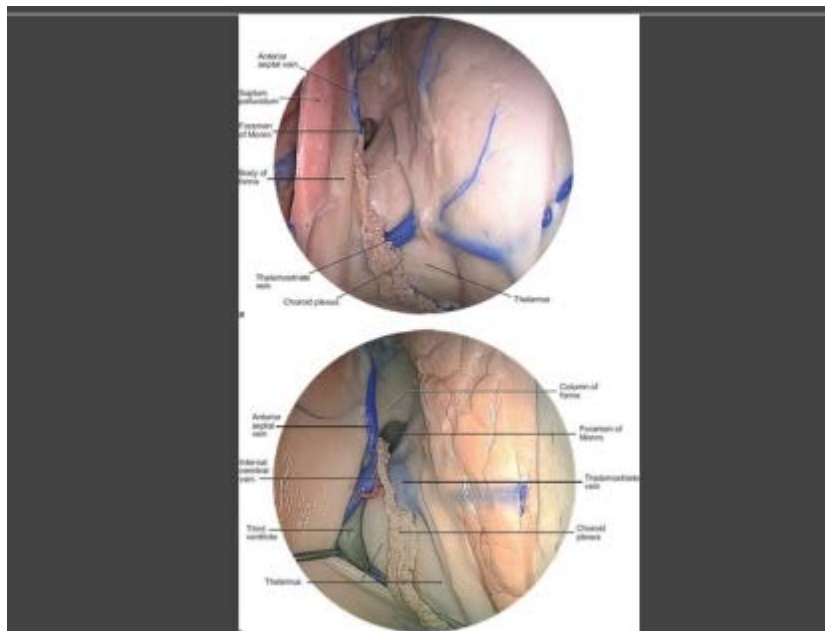


Figure 1.12. (a,b) Endoscopic views of the exposure of the third ventricle.
Source: Color Atlas of Brainstem Surgery > Internal Anatomy of the Brainstem

1,865影片



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Questions and Answers

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Treatment

Statistics of learning progress

1788 / 2387



Question
1788

True or False. Patients who undergo decompressive laminectomies are likely to develop lumbar instability?

Answer

True or False. Patients who undergo decompressive laminectomies are likely to develop lumbar instability?

false -
Less than
1%

Greenberg 8th
edition, Chapter
72.8.4

Correctly answered repeat

◀ Previous question

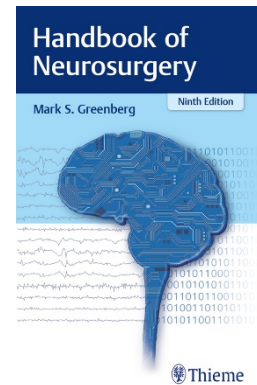
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Treatment

From: The Greenberg Rapid Review: A Companion to the 8th Edition

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E-Journals: 可閱讀期刊全文內容



Journal of Neurological Surgery Part B Skull Base 02/2017

Journal of Neurological Surgery Part B Skull Base 02/2017

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Journal of Neurological Surgery Part B Skull Base 2017; 78(02): 132 - 138
DOI: 10.1055/s-0036-1593469

Original Article

Shahid, Saman; Hussain, Kamran

Role of Glioblastoma Craniotomy Related to Patient Survival: A 10-Year Survey in a Tertiary Care Hospital in Pakistan

Department of Sciences and Humanities, National University of Computer and Emerging Sciences (NUCES), Foundation for Advancement of Science and Technology (FAST), Lahore, Pakistan
Department of Neurosurgery, Federal Post Graduate Medical Institute, Sheikh Zayed Hospital, Lahore, Pakistan

Quick access

[Abstract](#) | [Introduction](#) | [Patients and Methods](#) | [Results](#) | [Discussion](#) | [Concluding Remarks](#) | [Acknowledgment](#) | [References](#)

Abstract

A total of 270 glioblastoma patients were treated for tumor resection during 2004 to 2014. The following variables were examined: patient age group (PAG) and percent of the extent of resection (EOR) in four types of resections: gross total resection (GTR), subtotal resection (STR), partial resection (PR), and biopsy/decompression (BD). The Karnofsky performance scale (KPS) was used and the average survival time noted. The least survival time (7 months) was noticed in the patient age group 18 to 35 years with biopsy only, whereas, the maximum survival time (14.3 months) was noted with the patient age group 54 to 71 years by gross tumor resection. The largest number of (n = 76) patients had PR (80%) and these patients had an average survival time of 10.3 months. Total 190 patients out of 270, with EOR (100–80%) had a KPS score "0" (80 and above) and total 80 patients out of 270 patients, with EOR (50%) had a KPS score "1" (below 80). The correlation was statistically significant at (p < 0.050) for EOR (%) and KPS score (0/1) only. Correlation analysis showed that the maximum resection has a strong impact on the glioblastoma patient's survival. A lesser EOR correlated with poor quality of life and also a decreased survival of patients.

Introduction

閱讀電子書

The screenshot displays the MedOne Neurosurgery website interface. At the top left, the author's name 'Alan R. Cohen' and the title 'Pediatric Neurosurgery' are visible. A search bar at the top center contains the text 'ischemic stroke', which is highlighted with a red box and labeled '檢索詞' (Search term). Below the search bar, the page title 'Section I Introduction' is shown, along with the section editor's name 'Tae Sung Park'. The main content area provides a detailed overview of the section, covering fundamental issues in pediatric neurosurgery, including preoperative and operative planning, surgical techniques, and management of various conditions. A table of contents on the left side of the page lists chapters from '1 Basic Surgical Technique' to '9 Neurologic Examination of the Child and Adolescent'. A red arrow points to this table of contents, labeled '完整目錄' (Complete table of contents). Another red arrow points to the 'Images' tab in the navigation bar, labeled '圖解文字包含到檢索字詞的相關圖片' (Diagrammatic text includes related images to the search term). A third red arrow points to the 'Hits' tab, labeled '檢索詞相關的章節' (Chapter related to the search term). On the right side of the page, there is a 'RELATED CONTENT' section with a list of related articles, such as 'Critical Illness of Patients with CNS Tumors' and '57.3 Outcomes and Postoperative Course'. A red arrow points to this section, labeled '其他電子書有關資訊' (Other electronic book information).

完整目錄 →
圖解文字包含到檢索字詞的相關圖片
檢索詞相關的章節

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電子書功能

« Back to overview

Alan B. Cohen
Pediatric Neurosurgery

ischemic stroke

6 Intraoperative Neurophysiological Monitoring During Pediatric Neurosurgical Procedures > 6.1 Introduction and Background

6.1 Introduction and Background

The goal of pediatric neurosurgery is to cure or meliorate disease of the nervous system using surgical methods that maximize benefit to the child while minimizing risk. Intraoperative neurophysiological monitoring is one of the most important modalities used to achieve these goals. The history of what can be done, how it can be done, and its utility for the surgeon has evolved along with other technical and conceptual advances in the procedural specialties. Intraoperative monitoring is a relatively young field, and neurosurgeons in general, and pediatric neurosurgeons in particular, may have varying experiences with different sorts of monitoring modalities and practitioners.

One of the earliest uses of intraoperative monitoring, which had as its aim minimizing potentially preventable damage to neural structures, was cranial nerve monitoring during cerebellopontine angle and otologic surgery. The professionals involved in this aspect of the emerging field often came from backgrounds in audiology. Another early use of monitoring in the general sense was intraoperative corticography to assess epileptogenic tissue during seizure surgery, most often performed by neurologists or neurophysiologists specializing in epilepsy. As somatosensory and later motor evoked potentials came into use in scoliosis and spine tumor surgery, the field of intraoperative monitoring began to expand, becoming an independent specialty, arising from these various lineages. As its use in children may

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Otology, Neurotology, and Lateral Skull Base Surgery. An Illustrated Handbook > 4 Disease-Specific Diagnostics and Medical Management > Central Neurologic Disorders
- Neuropathological Mechanisms of Injury at the Craniovertebral Junction
Surgery of the Craniovertebral Junction > I Foundations for Surgical Treatment > 5 Neurological Findings of Craniovertebral Junction Disease >

註記

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The screenshot displays the MedOne Neurosurgery interface. At the top, it shows the authors "Jamie S. Ullman, Patricia B. Raksin" and the title "Atlas of Emergency Neurosurgery". Below this is a search bar with the text "Search within this E-book" and a magnifying glass icon. The main content area is titled "Closing" and is part of a navigation path: "I Cerebral Trauma and Stroke > 7 Invasive Neuromonitoring Techniques > Closing". The text describes the procedure for closing an incision, including irrigation, suturing, and dressing. A specific paragraph about EVD calibration is highlighted in blue. The interface also features a table of contents on the left side, listing various surgical procedures under the heading "I Cerebral Trauma and Stroke".

Atlas of Emergency Neurosurgery
2015; 1st Edition

Search within this E-book

I Cerebral Trauma and Stroke > 7 Invasive Neuromonitoring Techniques > Closing

Closing

- The incision site is irrigated. The skin incision is closed with 3.0 nylon sutures.
- A sterile transparent dressing is placed over the incision site (or around the bolt apparatus).
- Calibration
 - **EVD:** after catheter placement, the drain height is selected (in on H₂O). The drainage system is set with the zero point level to the top of the patient's ear. This corresponds to the approximate level of the foramen of Monro—the midpoint of the ventricular system. The pressure waveform may be recorded by attachment to an external strain gauge or by insertion of a fiberoptic pressure probe or micro strain gauge device into the EVD lumen (and connection to a stand-alone monitor box).
 - **Parenchymal ICP monitor:** the fiberoptic pressure probe is attached to a stand-alone monitor box and zeroed with respect to air prior to insertion into the seated bolt apparatus.
 - **Brain tissue oxygen monitor:** Calibration is achieved through the use of a smartcard.
 - **Cerebral blood flow monitor:** To ensure that the probe is optimally placed, the K value on the monitor should be between 4.8 and 5.6 and the probe position assistant (PPA) below 2. The K value varies depending on the conductivity of the tissue. The K value of white matter is between 4.8 and 5.9. PPA indicates the artifact created by the pulsation of the brain tissue (if the probe is close to a vessel). A value of 0 indicates no artifact.
 - **Jugular venous saturation monitor:** Once correct probe position has been verified, light intensity calibration of the oximetry system can be performed. A blood sample from the tip of the catheter is also sent for analysis to confirm the value on the oximetry system. Frequent recalibration is required and should be prompted by any sudden change in the jugular venous saturation—prior to any alteration of medical management.

Source:
[Closing](#)
From: [Atlas of Emergency Neurosurgery](#)

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Indications
Atlas of Emergency Neurosurgery » I Cerebral Trauma and Stroke » 4 Decompressive Craniectomy for Intracranial Hypertension and Stroke, Including Bone Flap Storage in Abdominal Fat Layer » Indications
Source: Atlas of Emergency Neurosurgery

Closing
If mechanical failure is suspected, the EVD collection system may need to be changed. If cellular debris is suspected, catheter irrigation using a small volume (less than 2 ml) of sterile isotonic normal saline is used to restore flow and is performed under strict sterile conditions.
Atlas of Emergency Neurosurgery » I Cerebral Trauma and Stroke » 7 Invasive Neuromonitoring Techniques » Closing
Source: Atlas of Emergency Neurosurgery

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Note (required)

If mechanical failure is suspected, the EVD collection system may need to be changed. If cellular debris is suspected, catheter irrigation using a small volume (less than 2 ml) of sterile isotonic normal saline is used to restore flow and is performed under strict sterile conditions.

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Cases > Cerebrovascular > Vasculitis > Temporal Arteritis

Temporal Arteritis

Hits Case

Temporal Arteritis
From: *Neurosurgery Knowledge Update, A Comprehensive Review*
(2015; 1st Edition)

40 Temporal Arteritis

- Case Presentation
- Questions
- Overview**
- Answers
- Summary
- Annotated References

Temporal Arteritis

Joseph G. Adel

Quick access

Case Presentation | Questions | Overview | Answers | Summary | Annotated References

Case Presentation

A 67-year-old woman presented with a 10-day history of right-sided headaches resistant to over-the-counter analgesics. Her examination was significant for mild fever, right scalp tenderness, and a visual field deficit in the right eye. Laboratory testing revealed an erythrocyte sedimentation rate (ESR) of 90 mm/h and a C-reactive protein (CRP) of 40 mg/dL. Given the suspicion of giant cell arteritis (GCA), the patient was started on high-dose steroids and referred for temporal artery biopsy. Biopsy results were consistent with GCA. The patient improved clinically and serologic inflammatory markers normalized.

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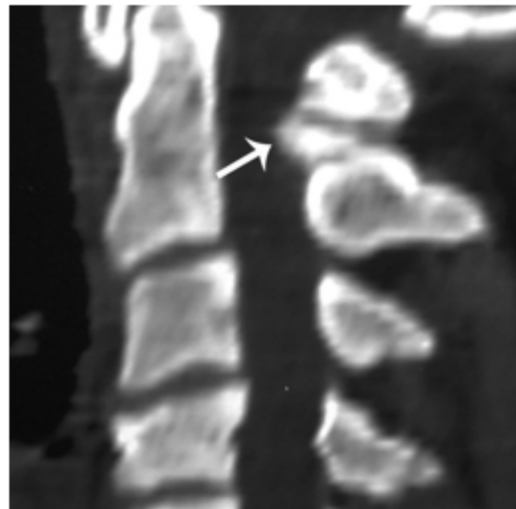


Figure 2 Fig 1 Axial (arrowheads) and Fig 2 sagittal CT demonstrate an expansile lesion (arrow) of the posterior arch of C1. It is contained within the cortex with no soft tissue extension. The bony margins appear smooth, homogeneous and sclerotic.

Source: Elias I, Pahl M, Zoga A, et al. [Recurrent burner syndrome due to presumed cervical spine osteoblastoma in a collision sport athlete – a case report.](#) *Journal of Brachial Plexus and Peripheral Nerve Injury.* 2007; 02(01): 61 - 65 doi:10.1186/1749-7221-2-13

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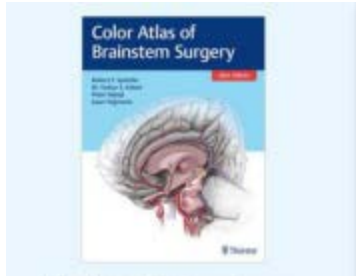
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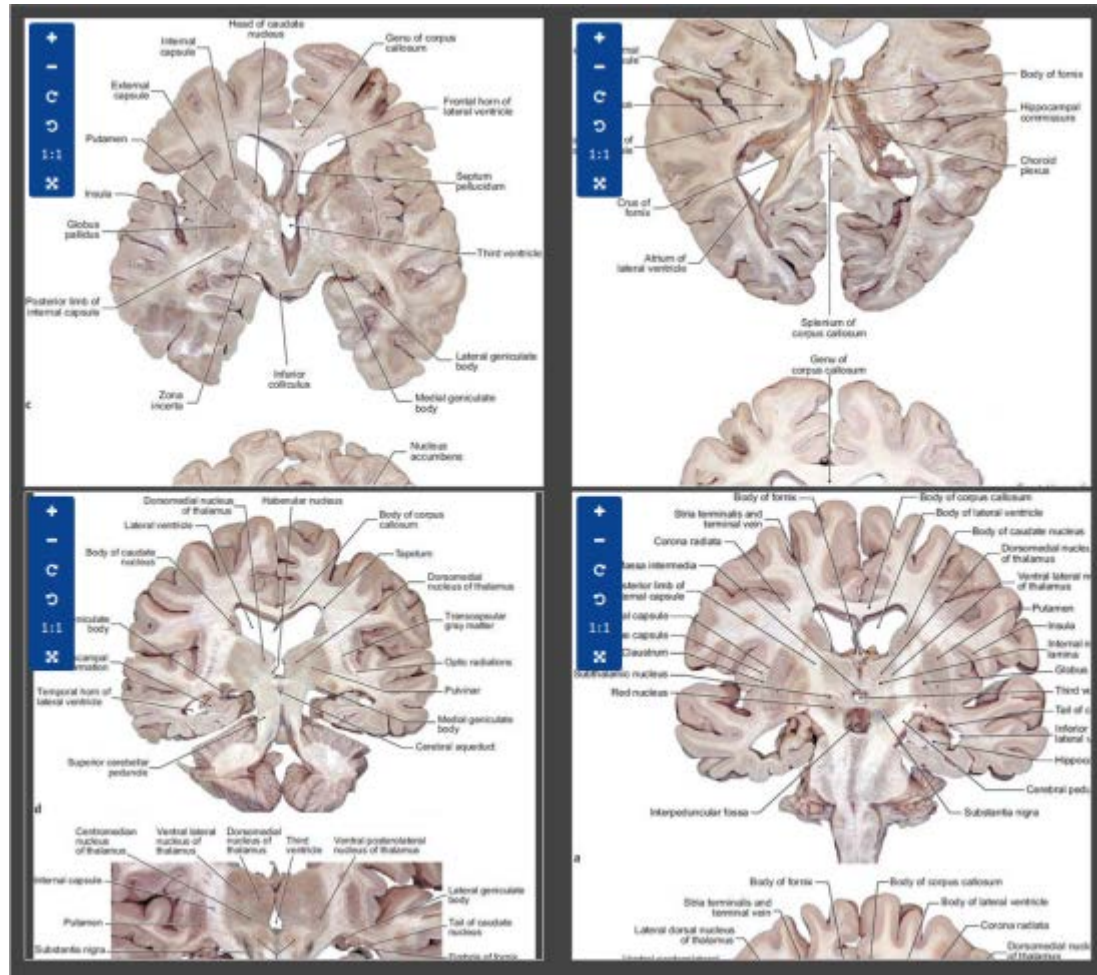
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