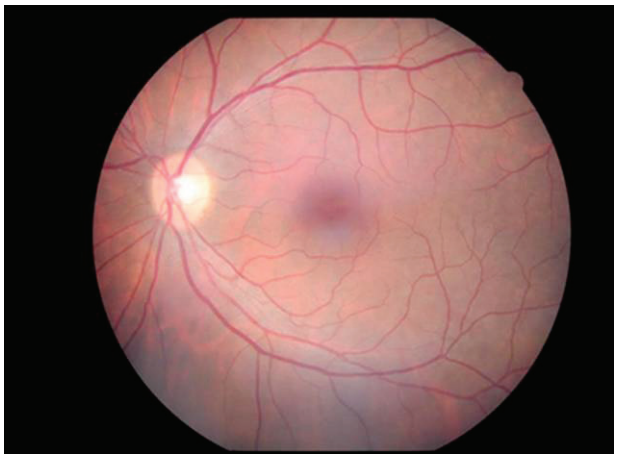
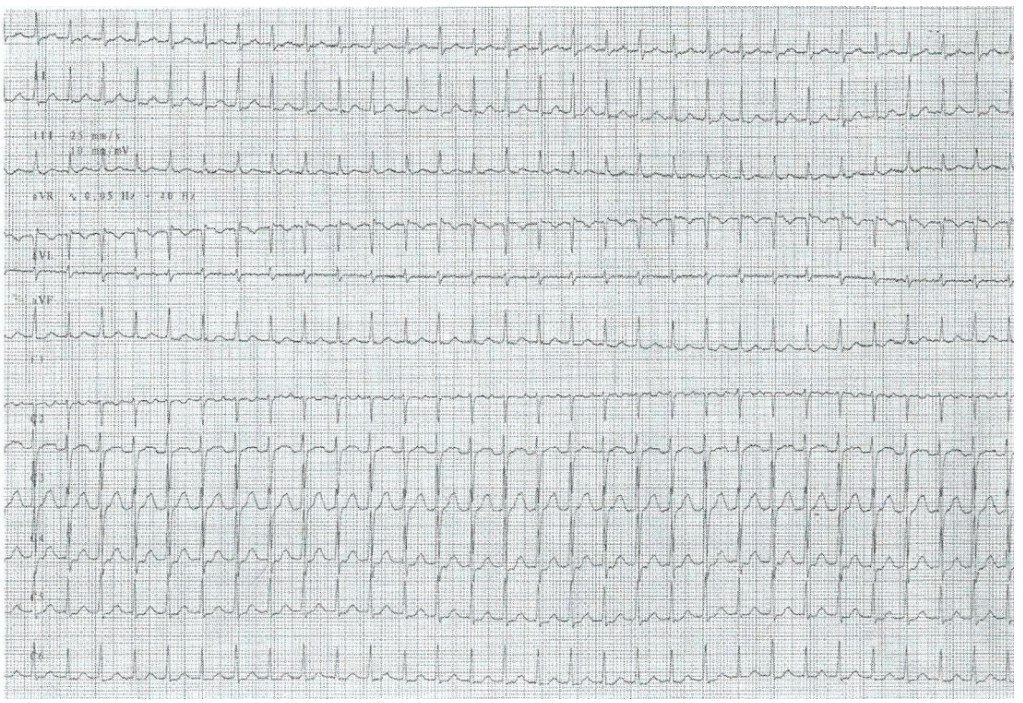
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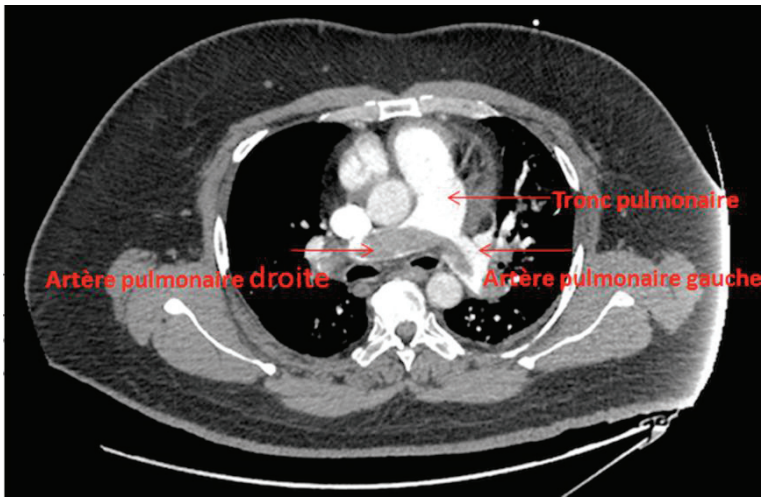
DOSSIER 33 - p.278



DOSSIER 31 - p. 262 (question 7)



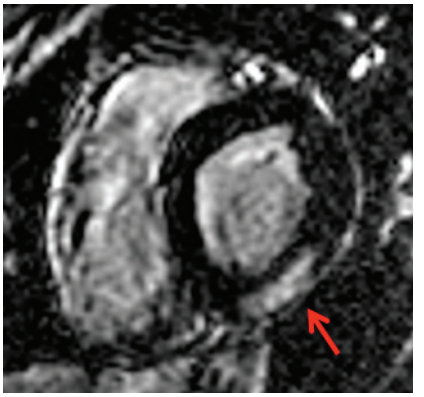
DOSSIER 11 - p. 97



DOSSIER 26 - p. 224 (réponse 8)



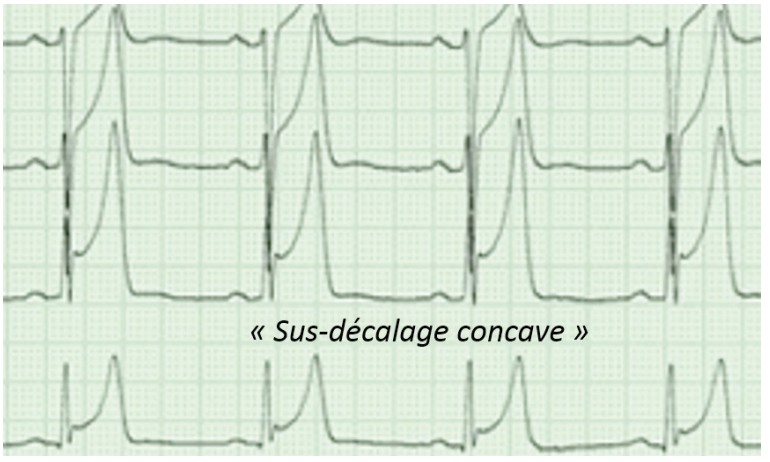
DOSSIER 2 - p. 23



DOSSIER 31 - p. 266



DOSSIER 6 - p. 59



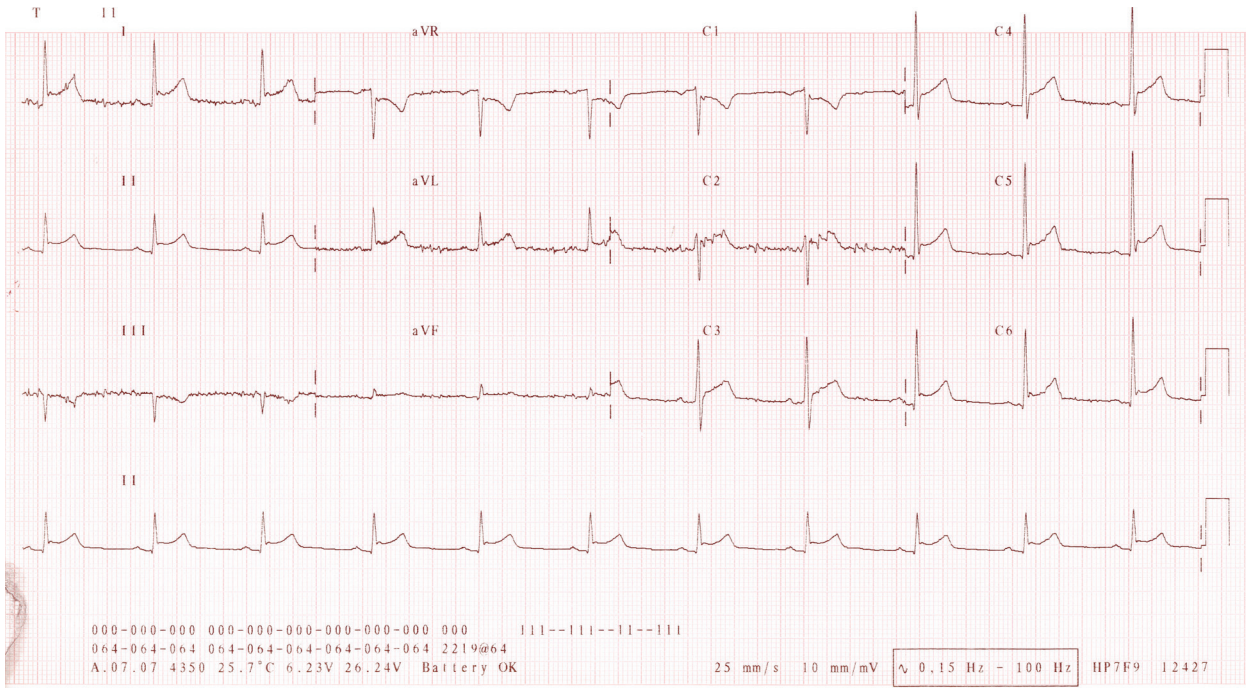
DOSSIER 31 - p. 265 (réponse 3 bas)



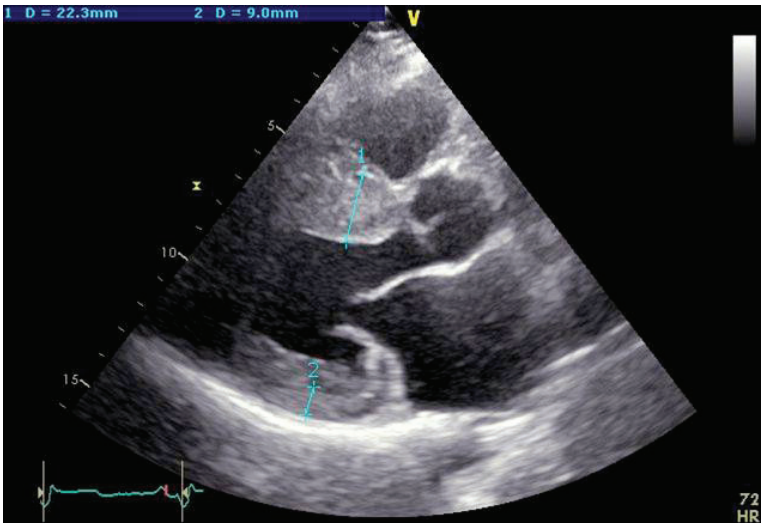
DOSSIER 26 - p. 220



DOSSIER 18 - p. 155 (question 3)



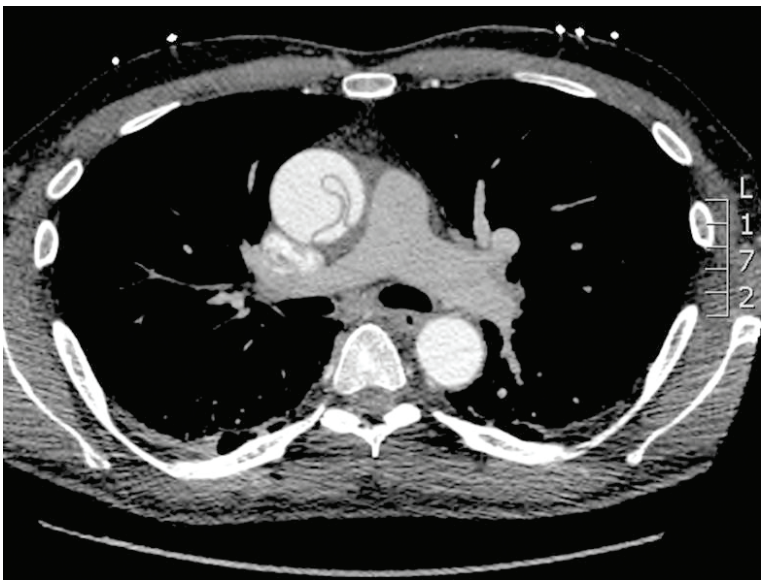
DOSSIER 10 - p. 89



DOSSIER 36 - p. 303

D-dimer measurement is not recommended in patients with high clinical probability, as a normal result does not safely exclude PE, even when using a highly sensitive assay.	III	B

DOSSIER 26 - p. 223

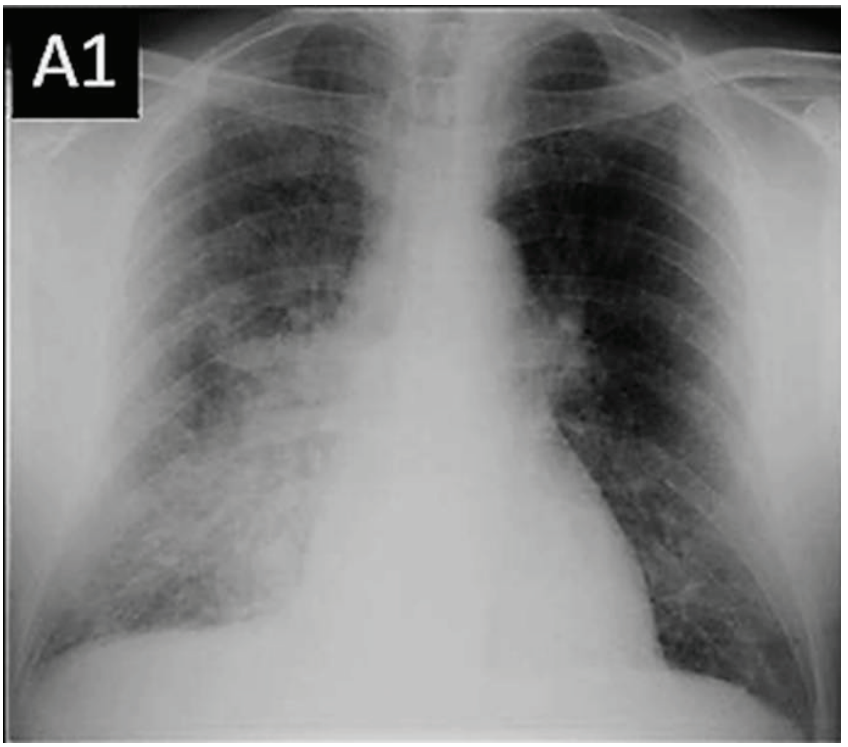


DOSSIER 21 - p. 180

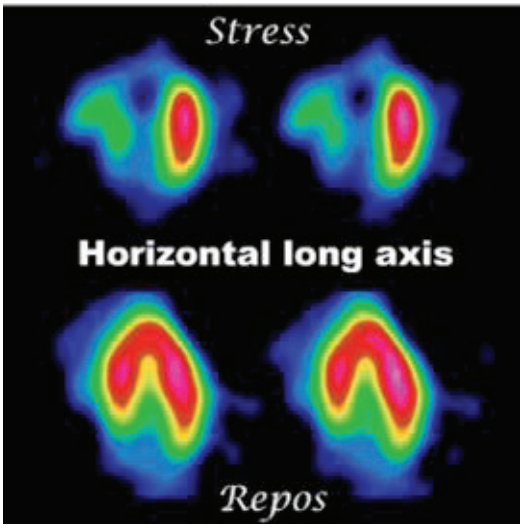
Fondaparinux (2.5 mg subcutaneously daily) is recommended as having the most favourable efficacy–safety profile with respect to anticoagulation.	I	A	Enoxaparin (1 mg/kg twice daily) is recommended when fondaparinux is not available.	I	B
			If fondaparinux or enoxaparin are not available, UFH with a target aPTT of 50–70 s or other LMWHs at the specific recommended doses are indicated.	I	C

ESC 2011 sur la PEC des SCA ST-

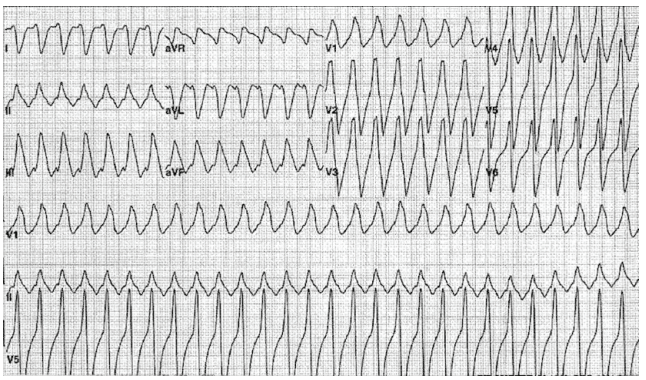
DOSSIER 17 - p. 151 (réponse 2)



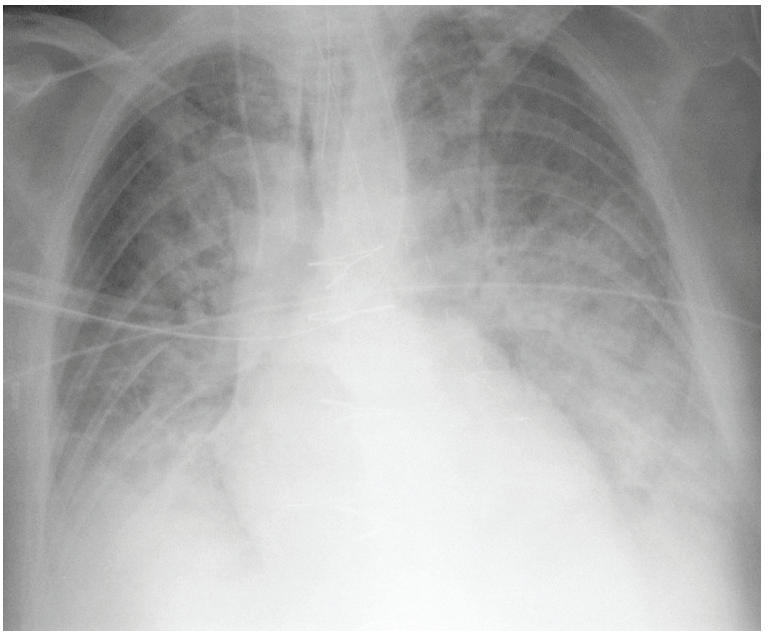
DOSSIER 25 - p. 211



DOSSIER 7 - p. 66



DOSSIER 17 - p. 147



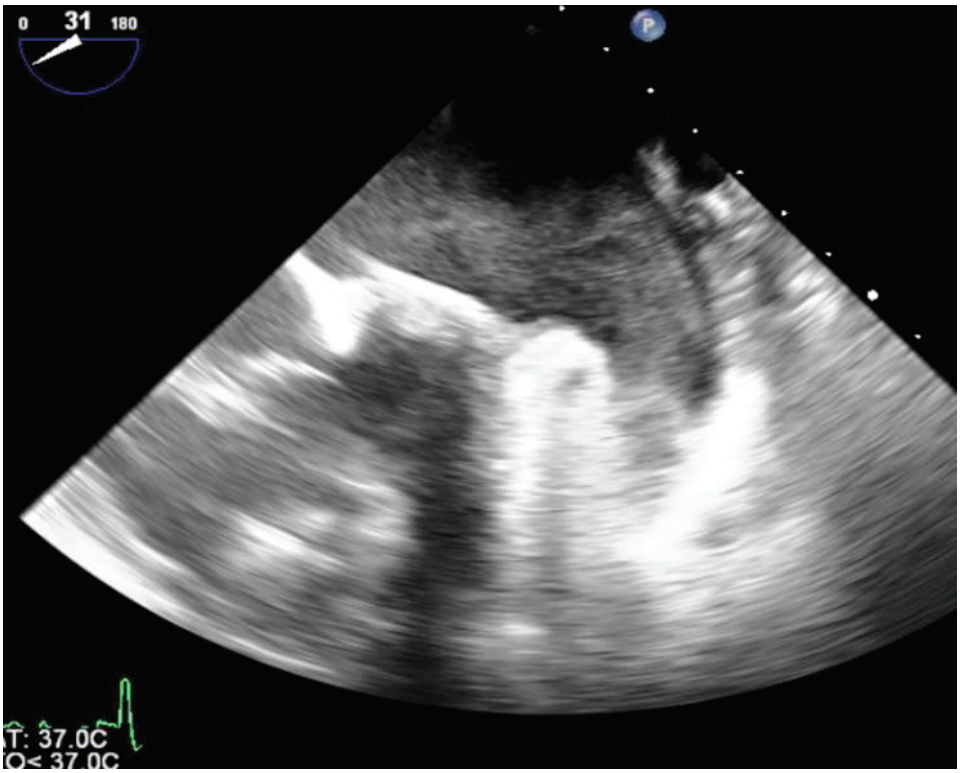
DOSSIER 27 - p. 226



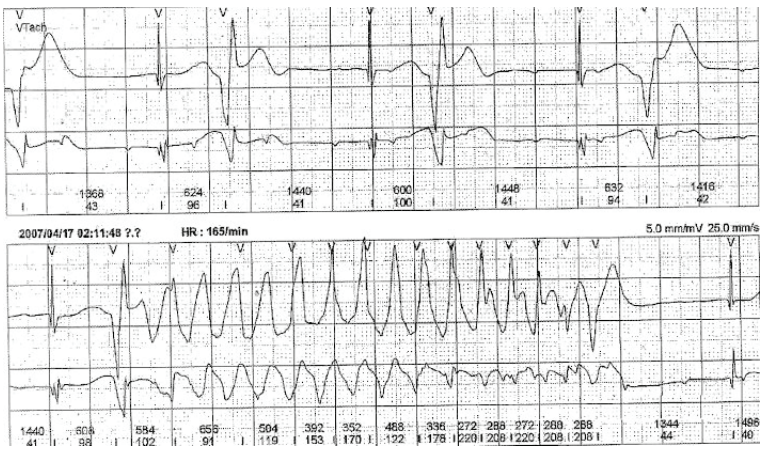
DOSSIER 36 - p. 305



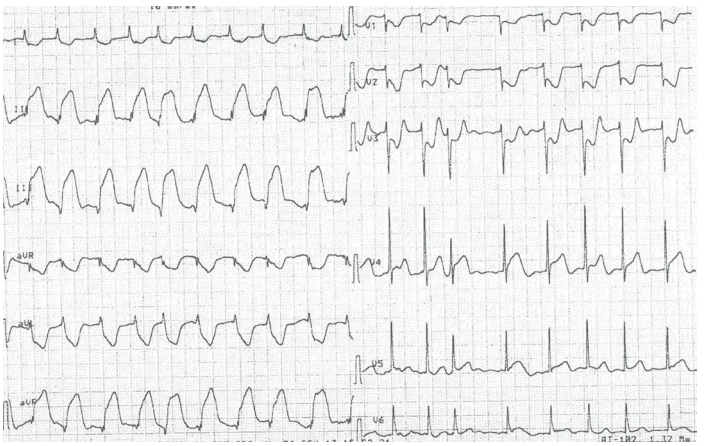
DOSSIER 19 - p. 164



DOSSIER 8 - p. 72 (question 6)



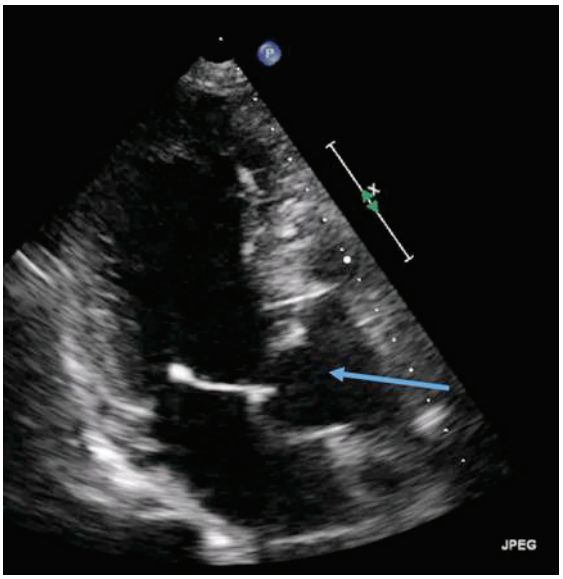
DOSSIER 13 - p. 115



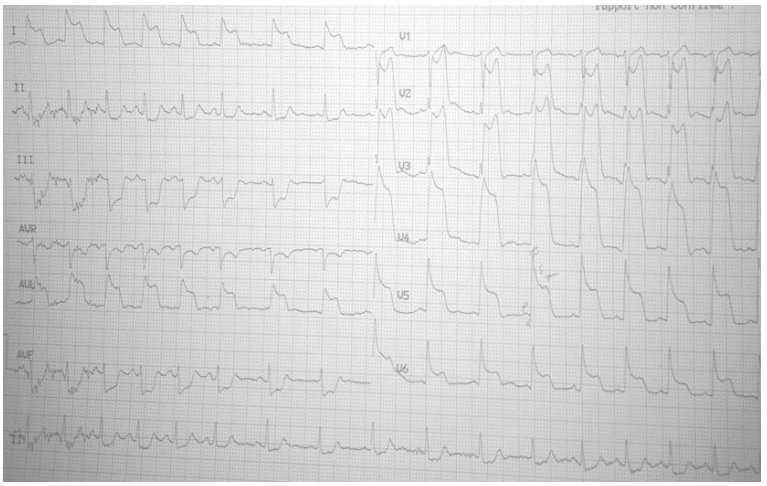
DOSSIER 6 - p. 56



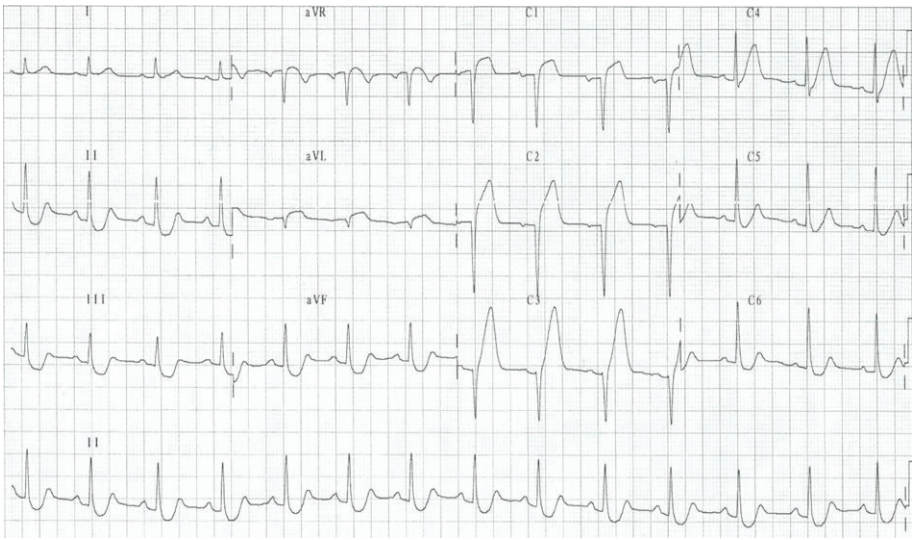
DOSSIER 18 - p. 156 (question 4)



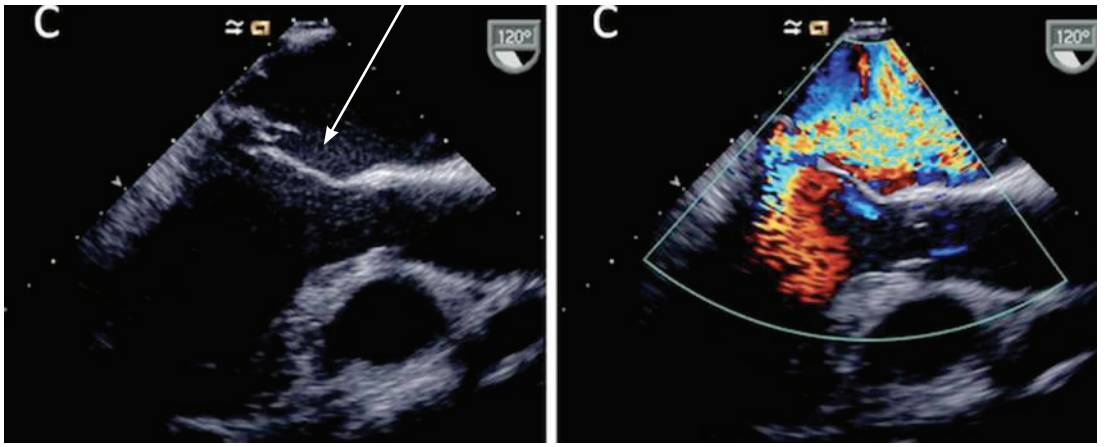
DOSSIER 34 - p. 287



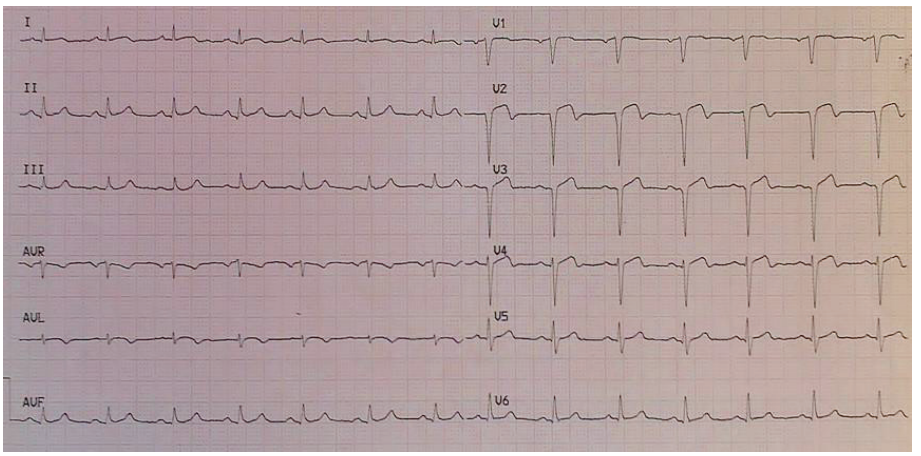
DOSSIER 15 - p. 129 (énoncé)



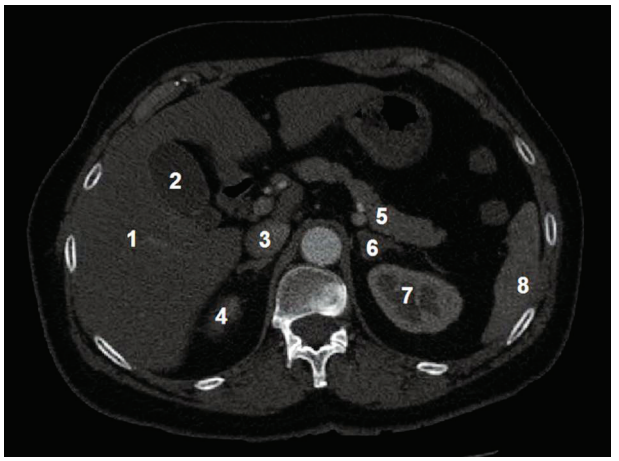
DOSSIER 17 - p. 148 (question 9)



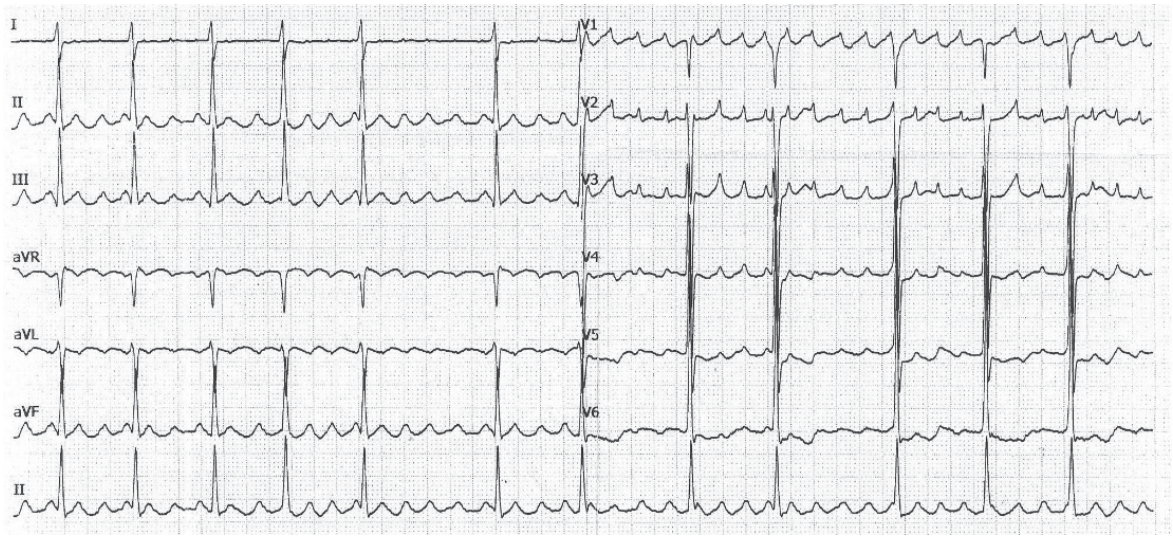
DOSSIER 25 - p. 212 (questions 5 et 6)



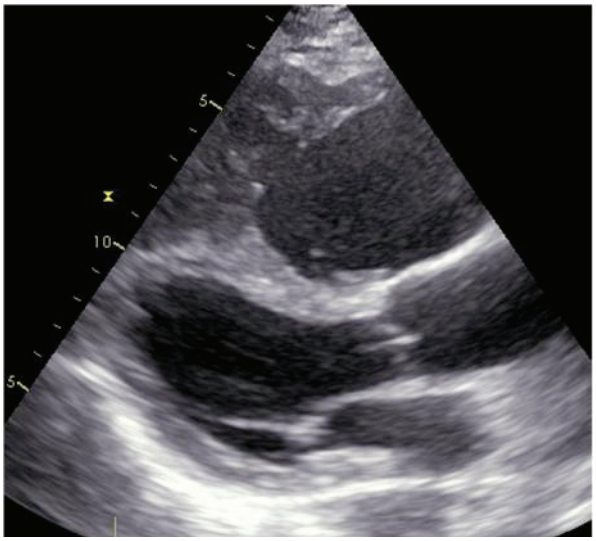
DOSSIER 15 - p. 131



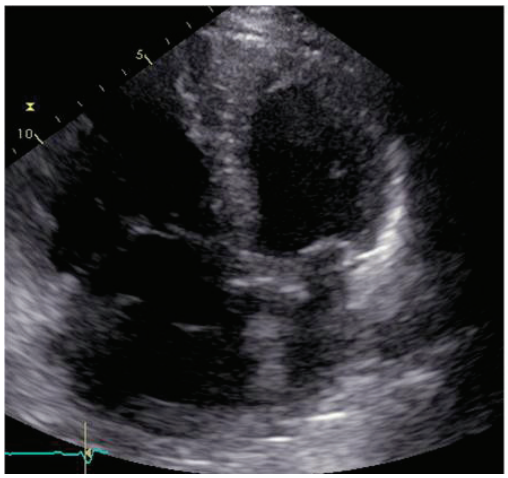
DOSSIER 1 - p. 16



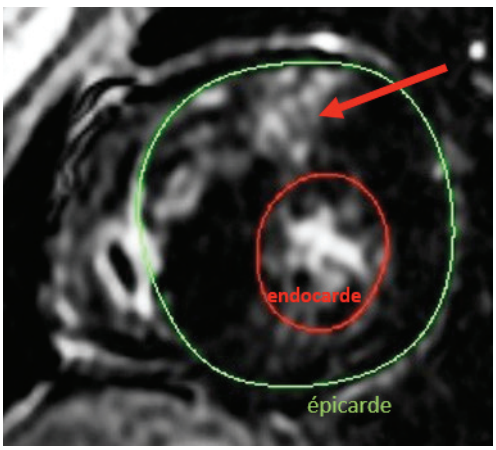
DOSSIER 11 - p. 100



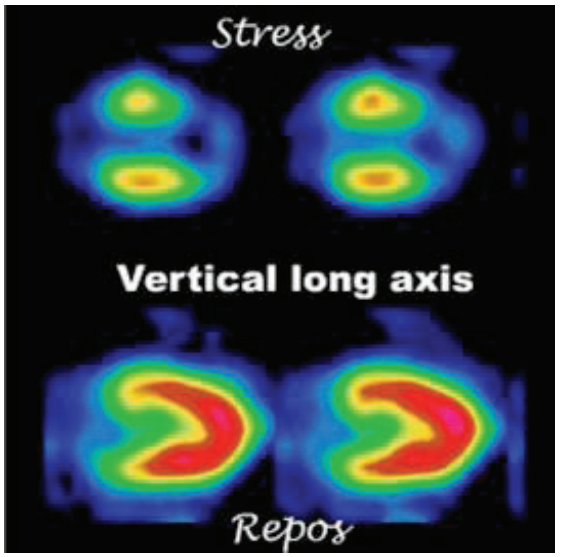
DOSSIER 18 - p. 156 (question 5)



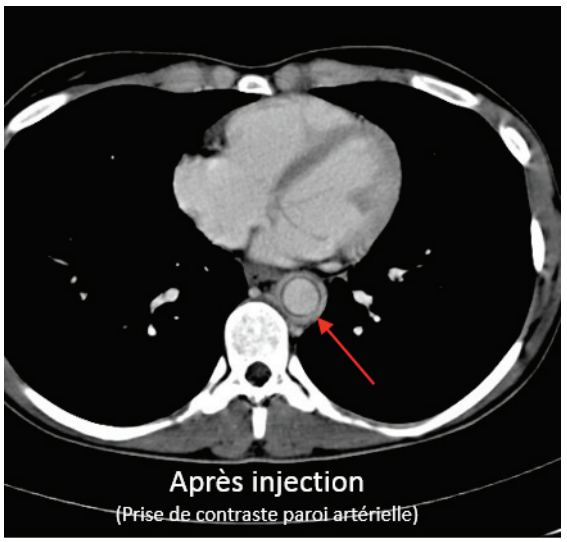
DOSSIER 18 - p. 156 (question 5)



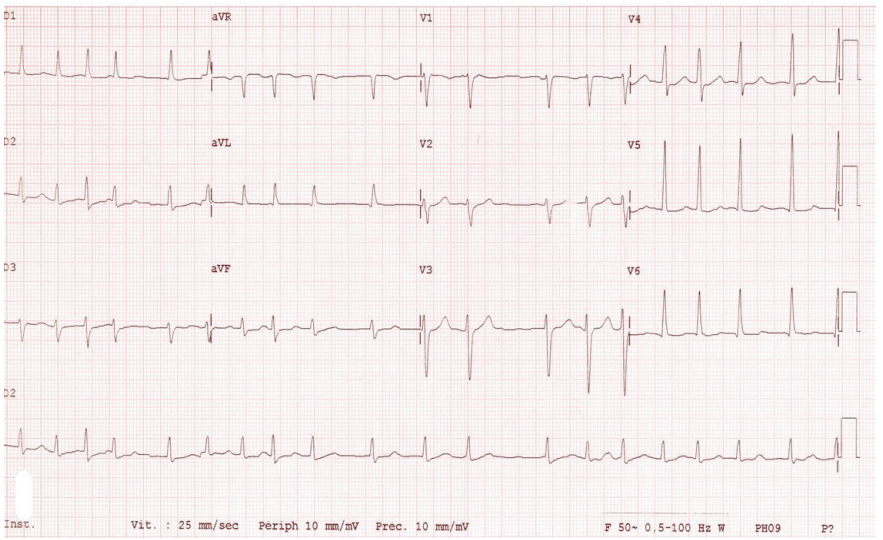
DOSSIER 36 - p. 307



DOSSIER 7 - p. 66



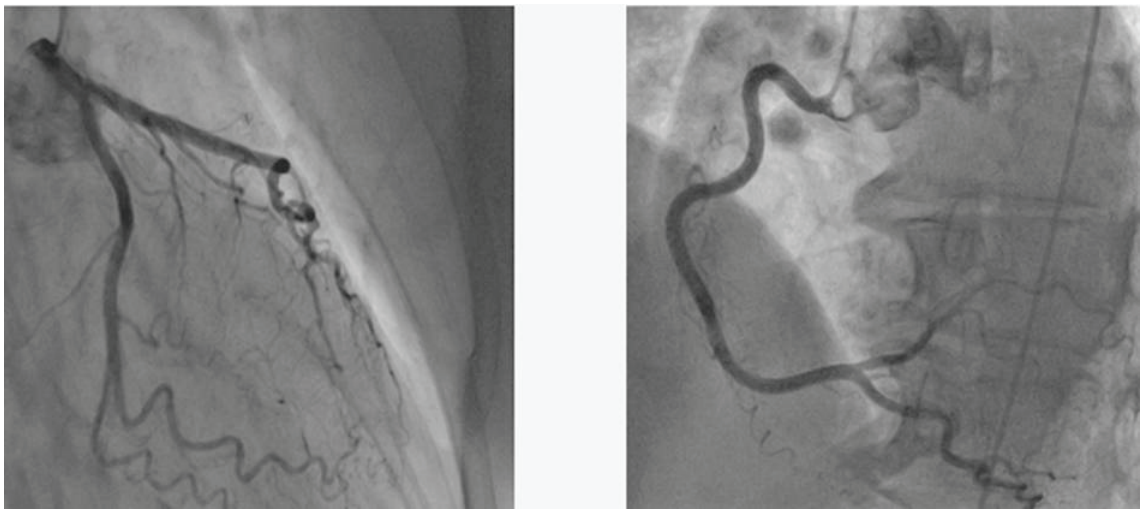
DOSSIER 33 - p. 283



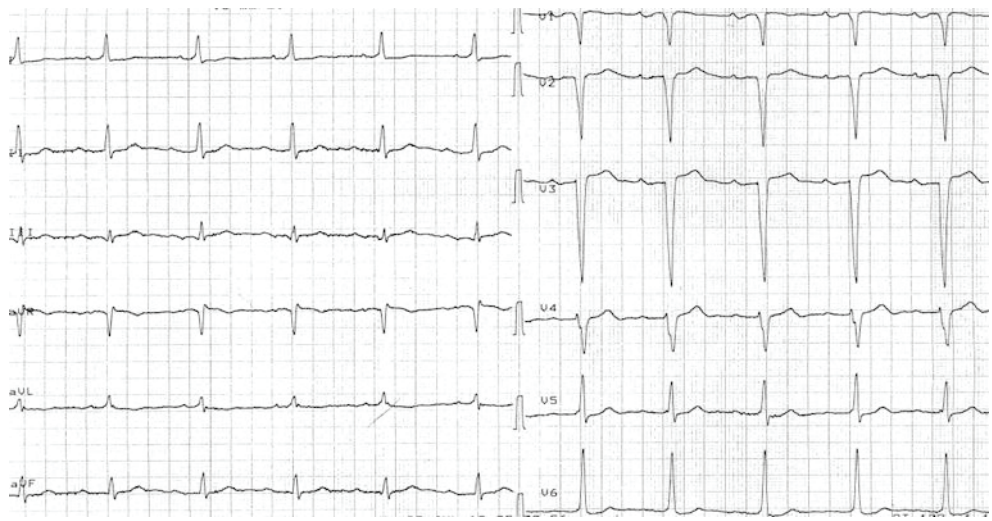
DOSSIER 1 - p. 15

Recommendations	Class[a]	Level[b]	Ref[c]			
PE without shock or hypotension (intermediate-or low-risk)[d]						
Anticoagulation: combination of parenteral treatment with VKA				As an alternative to the combination of parenteral anticoagulation with a VKA, anticoagulation with apixaban (10 mg twice daily for 7 days, followed by 5 mg twice daily) is recommended.	I	B
Initiation of parenteral anticoagulation is recommended without delay in patients with high or intermediate clinical probability of PE while diagnostic work-up is in progress.	I	C	352			
LMWH or fondaparinux is the recommended form of acute phase parenteral anticoagulation for most patients.	I	A	273, 274, 281, 353	As an alternative to VKA treatment, administration of dabigatran (150 mg twice daily, or 110 mg twice daily for patients ≥80 years of age or those under concomitant verapamil treatment) is recommended following acute-phase parenteral anticoagulation.	I	B[e]
In parallel to parenteral anticoagulation, treatment with a VKA is recommended, targeting an INR of 2.5 (range 2.0–3.0).	I	B	352, 354			
Anticoagulation: new oral anticoagulants						
As an alternative to the combination of parenteral anticoagulation with a VKA, anticoagulation with rivaroxaban (15 mg twice daily for 3 weeks, followed by 20 mg once daily) is recommended.	I	B	296	As an alternative to VKA treatment, administration of edoxaban[e] is recommended following acute-phase parenteral anticoagulation.	I	B

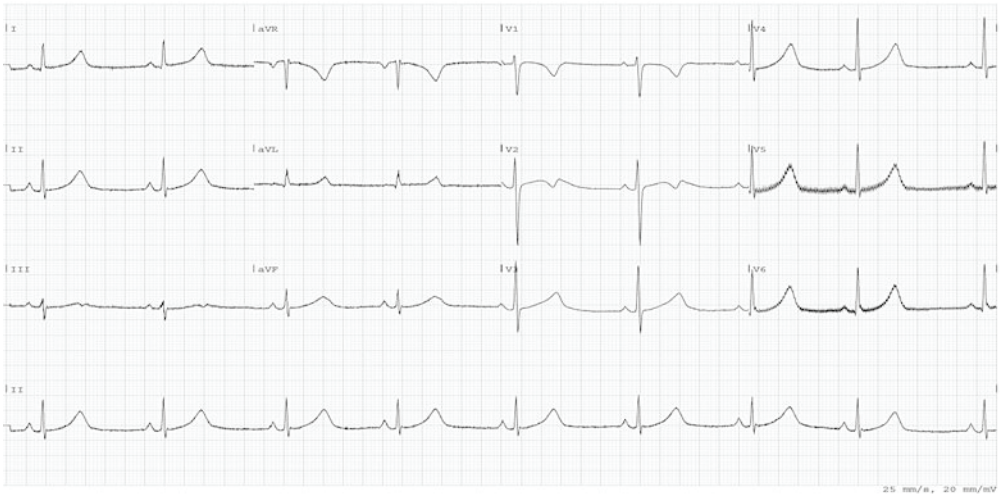
DOSSIER 26 - p. 224 (réponse 11)



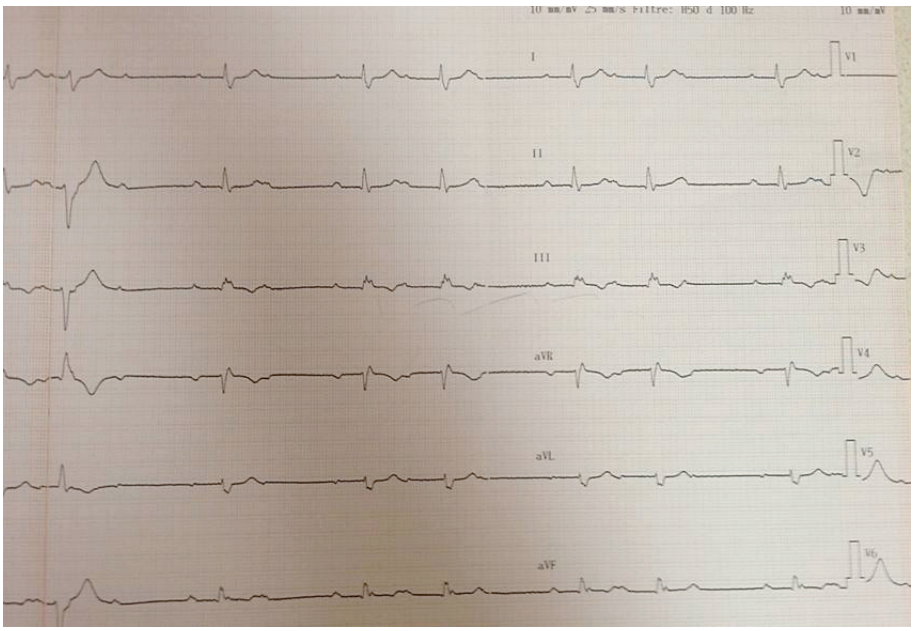
DOSSIER 31 - p. 262 (question 6)



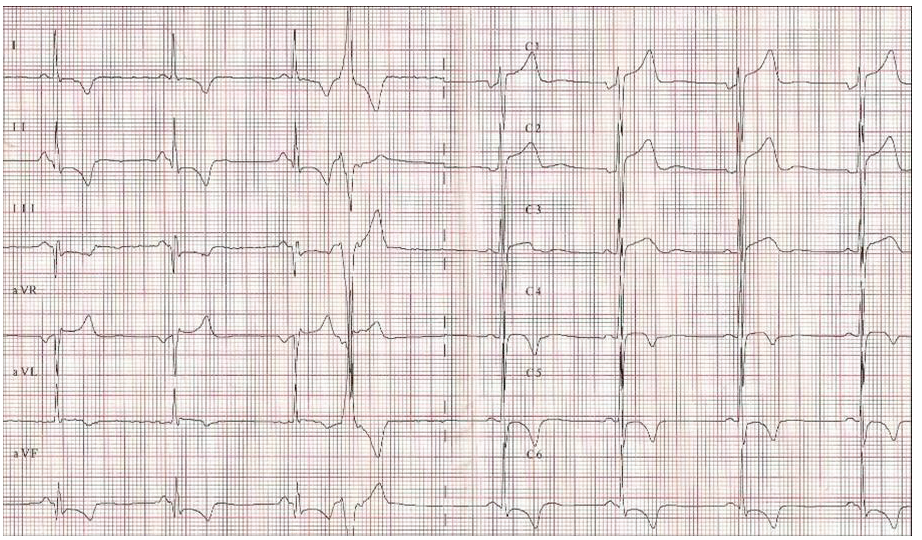
DOSSIER 27 - p. 227



DOSSIER 29 - p. 247



DOSSIER 20 - p. 173 (question7)



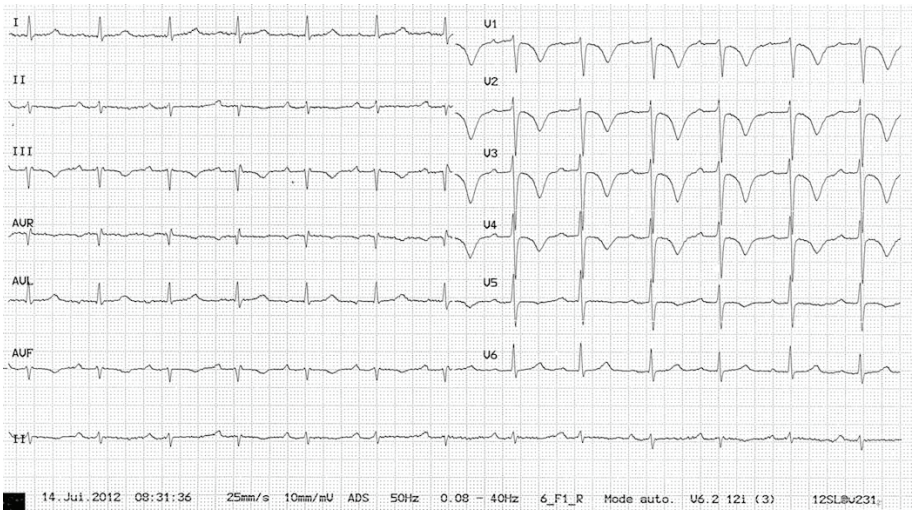
DOSSIER 36 - p. 302

***Tableau* 8 :** *Stades de la BPCO d'après GOLD (Global Initiative for Chronic Obstructive Lung Disease)*

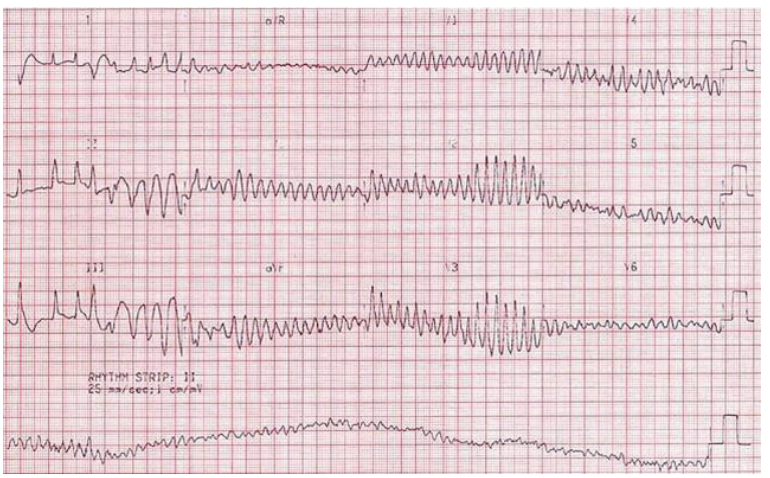
Stades	Caractéristiques	Equivalence clinique*
Stade I : BPCO légère	VEMS/CV < 70% VEMS ≥ 80% des valeurs prédites	Absence de dyspnée
Stade II : BPCO modérée	VEMS/CV < 70% 50% ≤ VEMS < 80% des valeurs prédites	Dyspnée d'effort inconstante
Stade III : BPCO sévère	VEMS/CV < 70% 30% ≤ VEMS < 50% des valeurs prédites	Dyspnée d'effort
Stade IV : BPCO très sévère	VEMS/CV < 70% VEMS < 30% des valeurs prédites ou VEMS < 50% des valeurs prédites en présence d'insuffisance respiratoire (PaO2 < 60 mmHg) ou de signes cliniques d'insuffisance cardiaque droite	Dyspnée au moindre effort ou dyspnée de repos

* En association aux symptômes chroniques (toux et expectoration). La proposition d'une équivalence clinique ne dispense pas d'une confirmation fonctionnelle par EFR en dehors des poussées

DOSSIER 35 - p. 300 (réponse 14)



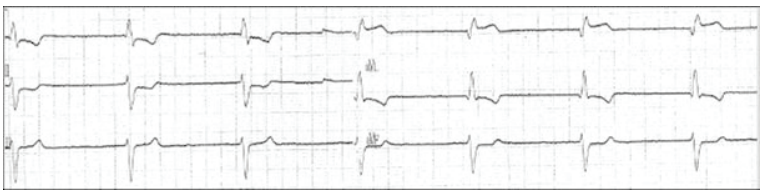
DOSSIER 35 - p. 294



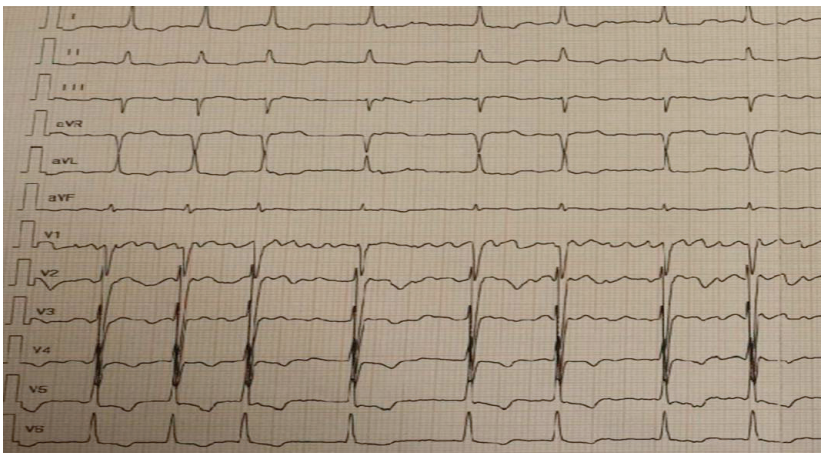
DOSSIER 15 - p. 129 (question 3)
DOSSIER 31 - p. 263 (question 13)



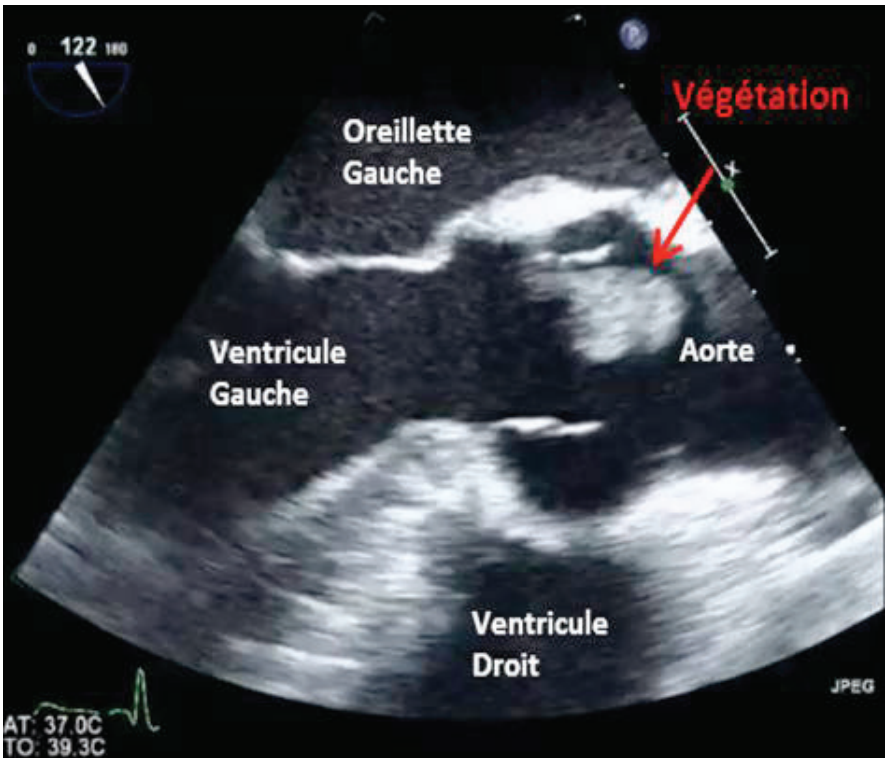
DOSSIER 21 - p. 179



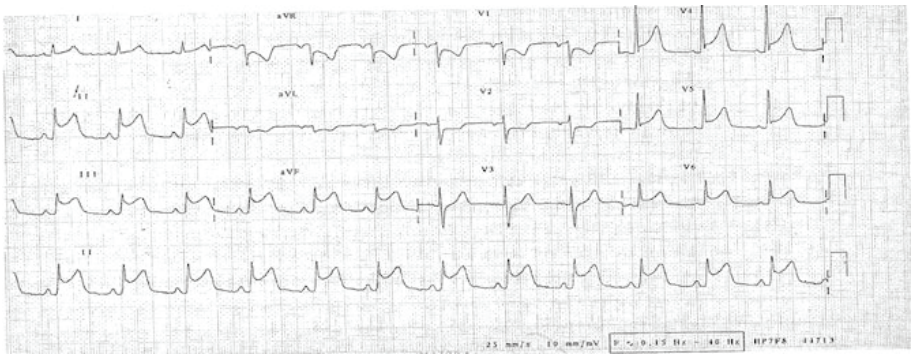
DOSSIER 17 - p. 149



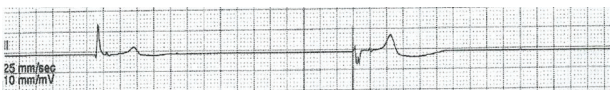
DOSSIER 8 - p. 72 (question3)



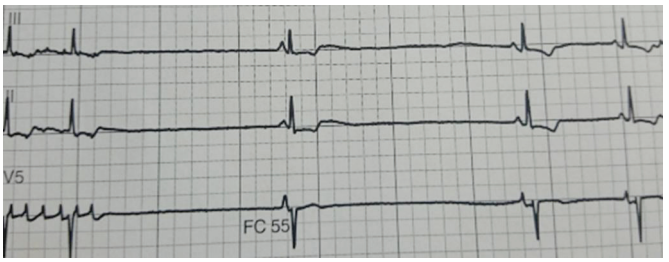
DOSSIER 19 - p. 167



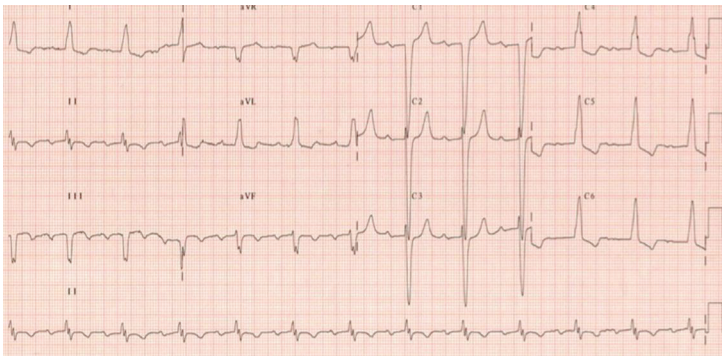
DOSSIER 31 - p. 261



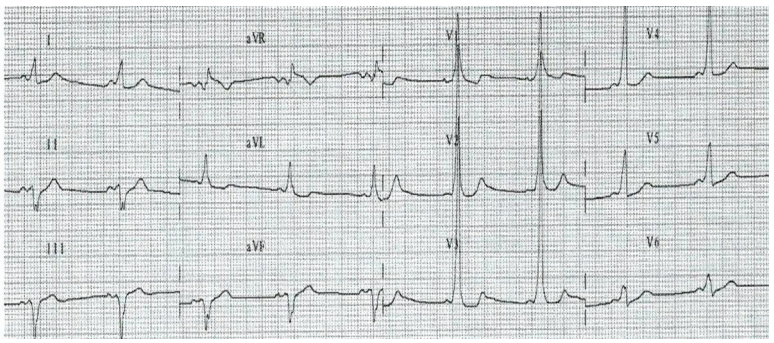
DOSSIER 11 - p. 99 (question 10)



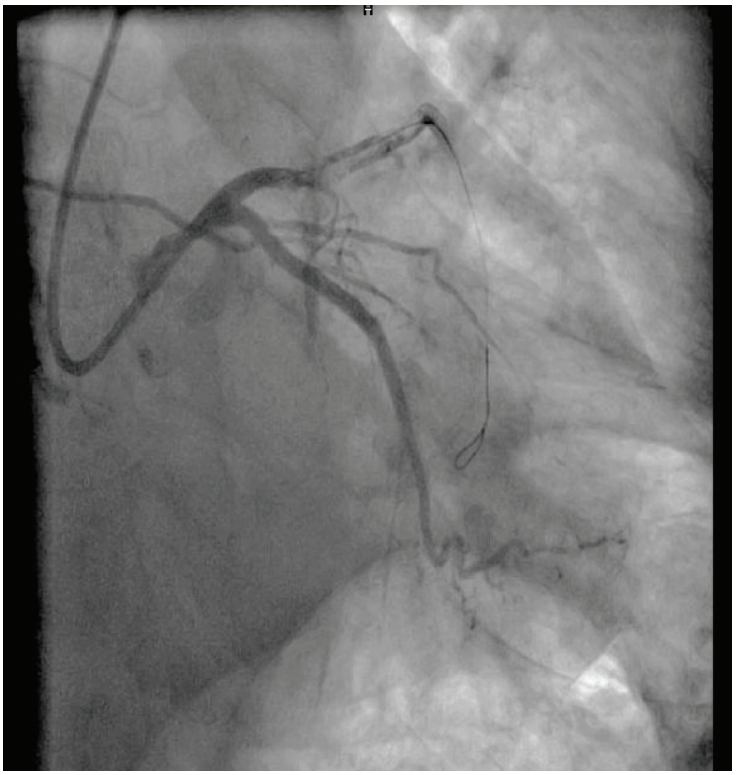
DOSSIER 8 - p. 74



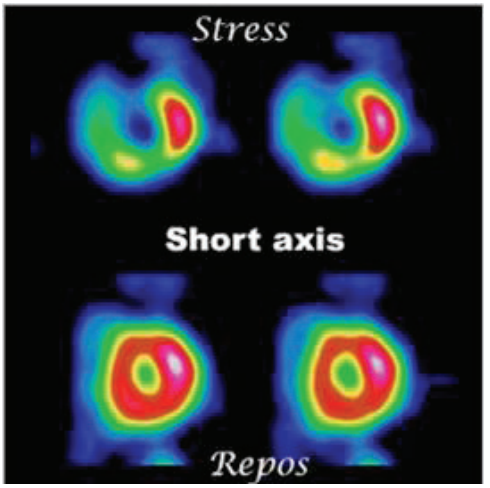
DOSSIER 2 - p. 24



DOSSIER 11 - p. 98



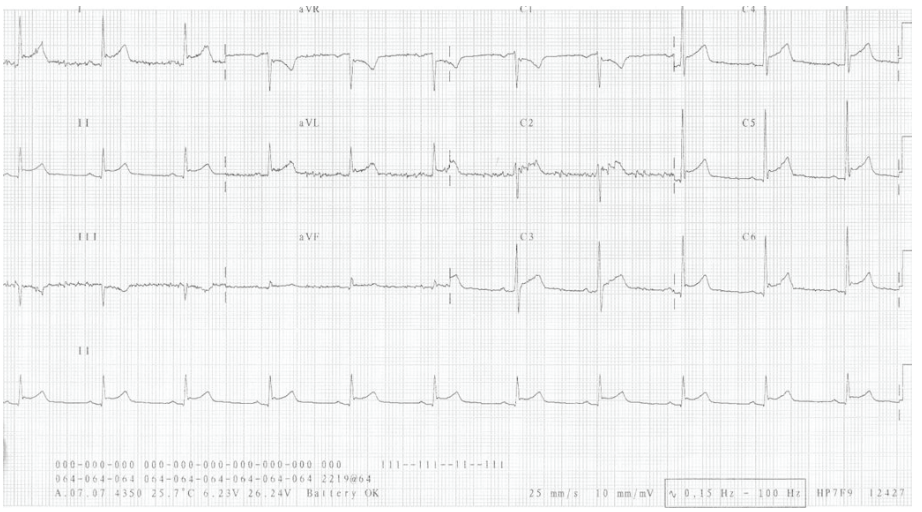
DOSSIER 17 - p. 148 (question 10)



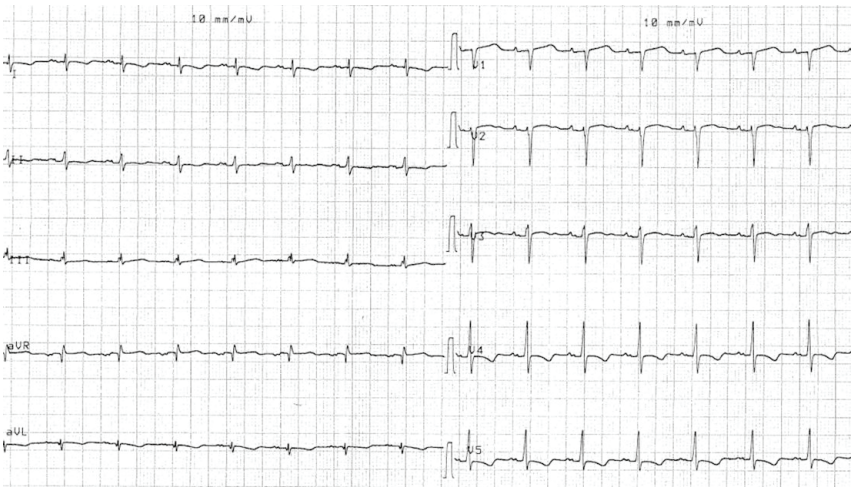
DOSSIER 7 - p. 66



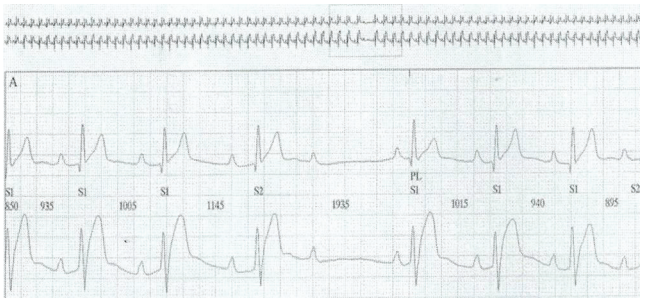
DOSSIER 36 - p. 307 (réponse 7)



DOSSIER 23 - p. 195



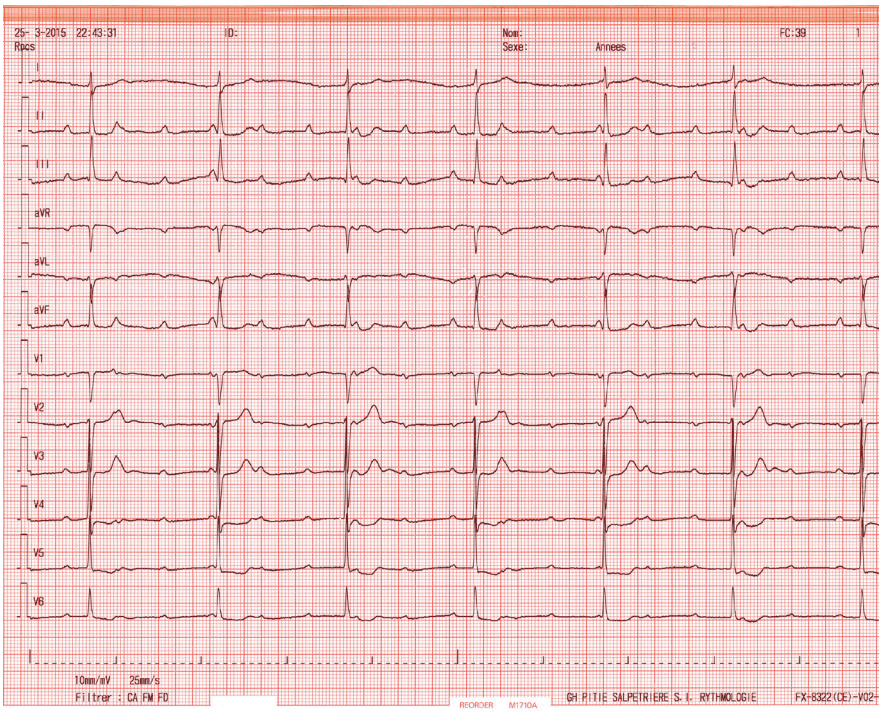
DOSSIER 16 - p. 137



DOSSIER 11 - p. 99 (question 9)



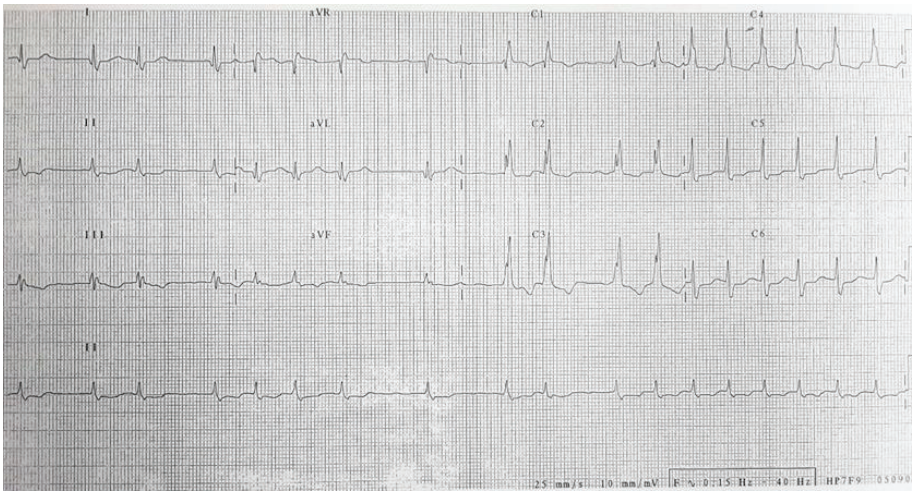
DOSSIER 13 - p. 114



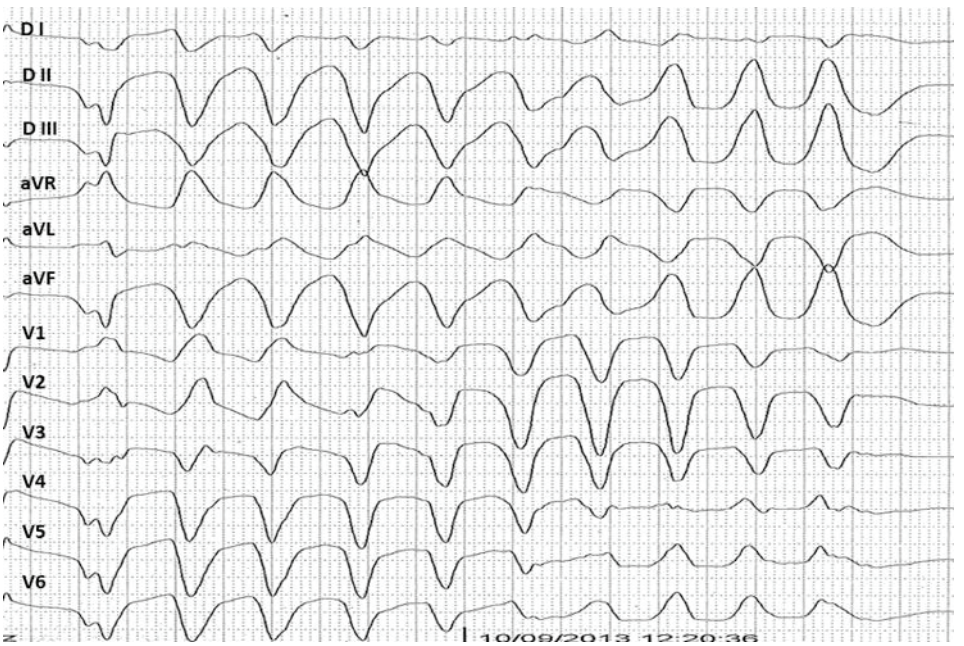
DOSSIER 20 - p. 173 (question 9)

	Class [a]	Level [b]
A. Indications for surgery in severe aortic regurgitation		
Surgery is indicated in symptomatic patients.	I	B
Surgery is indicated in asymptomatic patients with resting LVEF ≤50%.	I	B
Surgery is indicated in patients undergoing CABG or surgery of ascending aorta, or on another valve.	I	C
Surgery should be considered in asymptomatic patients with resting EF >50% with severe LV dilatation: LVEDD >70 mm, or LVESD >50 mm or LVESD >25 mm/m² BSA.[d]	IIa	C
B. Indications for surgery in aortic root disease (whatever the severity of AR)		
Surgery is indicated in patients who have aortic root disease with maximal ascending aortic diameter[e] ≥50 mm for patients with Marfan syndrome.	I	C
Surgery should be considered in patients who have aortic root disease with maximal ascending aortic diameter: ≥45 mm for patients with Marfan syndrome with risk factors[f] ≥50 mm for patients with bicuspid valve with risk factors[g] ≥55 mm for other patients	IIa	C

DOSSIER 34 - p. 292 (réponse 10)

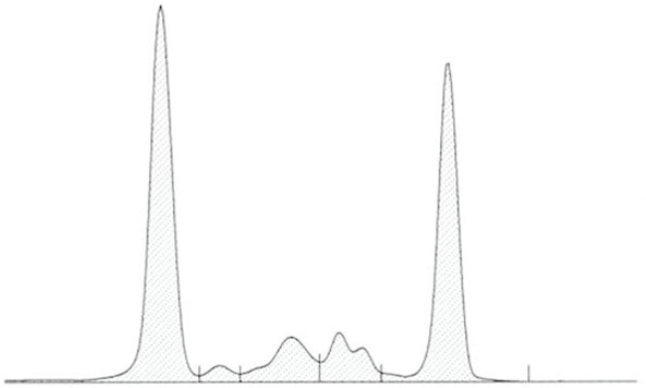


DOSSIER 32 - p. 269



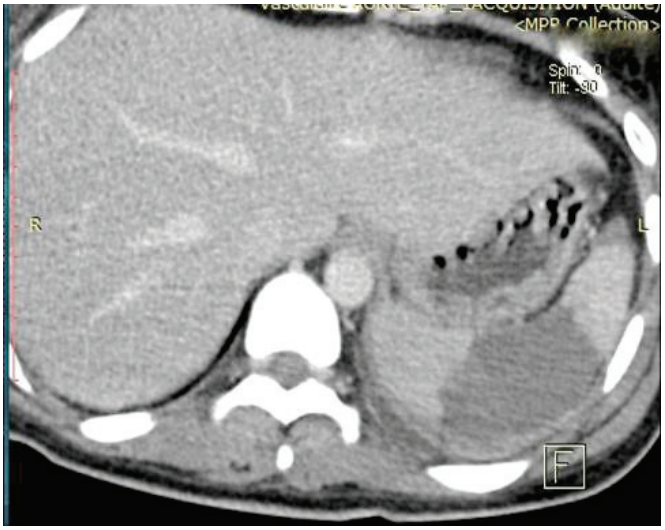
DOSSIER 29 - p. 246

PROTEINES SERIQUES

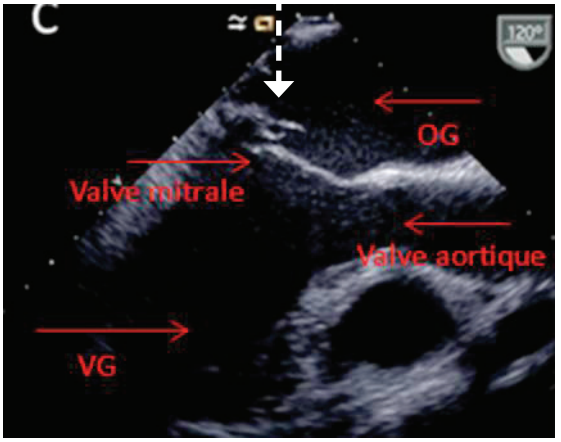


FRACTION	%	G/L	*NORMALES EN G/L*
ALBUMINE	46.1	30.0	*32.0 - 50.0*
ALPHA 1	2.2	1.4	*1.0 - 4.0*
ALPHA 2	9.1	5.9	*5.0 - 11.0*
BETA	8.3	5.4	*6.0 - 13.0*
GAMMA	34.3	22.3	*7.0 - 15.0*
PROTEINES TOTALES		65.1	

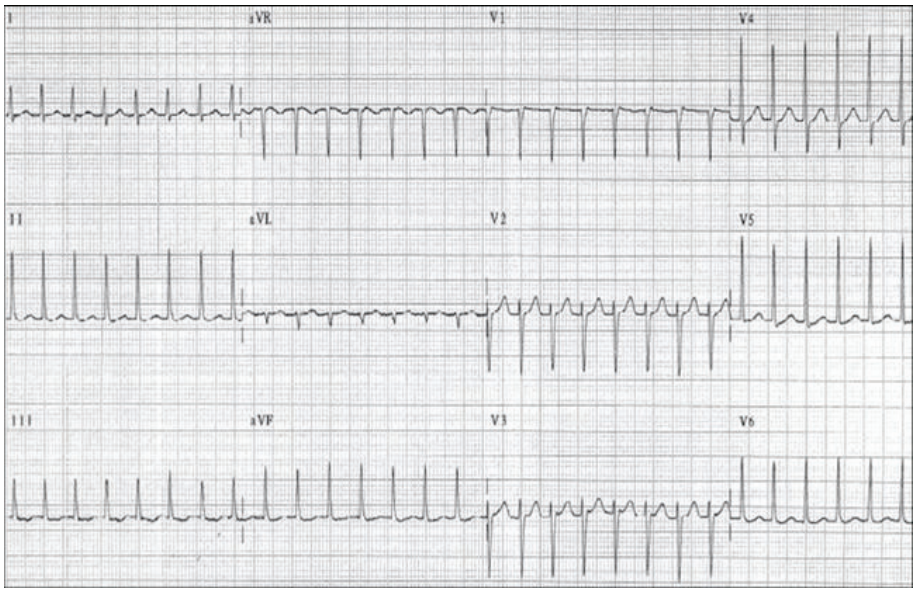
DOSSIER 16 - p. 139



DOSSIER 19 - p. 165



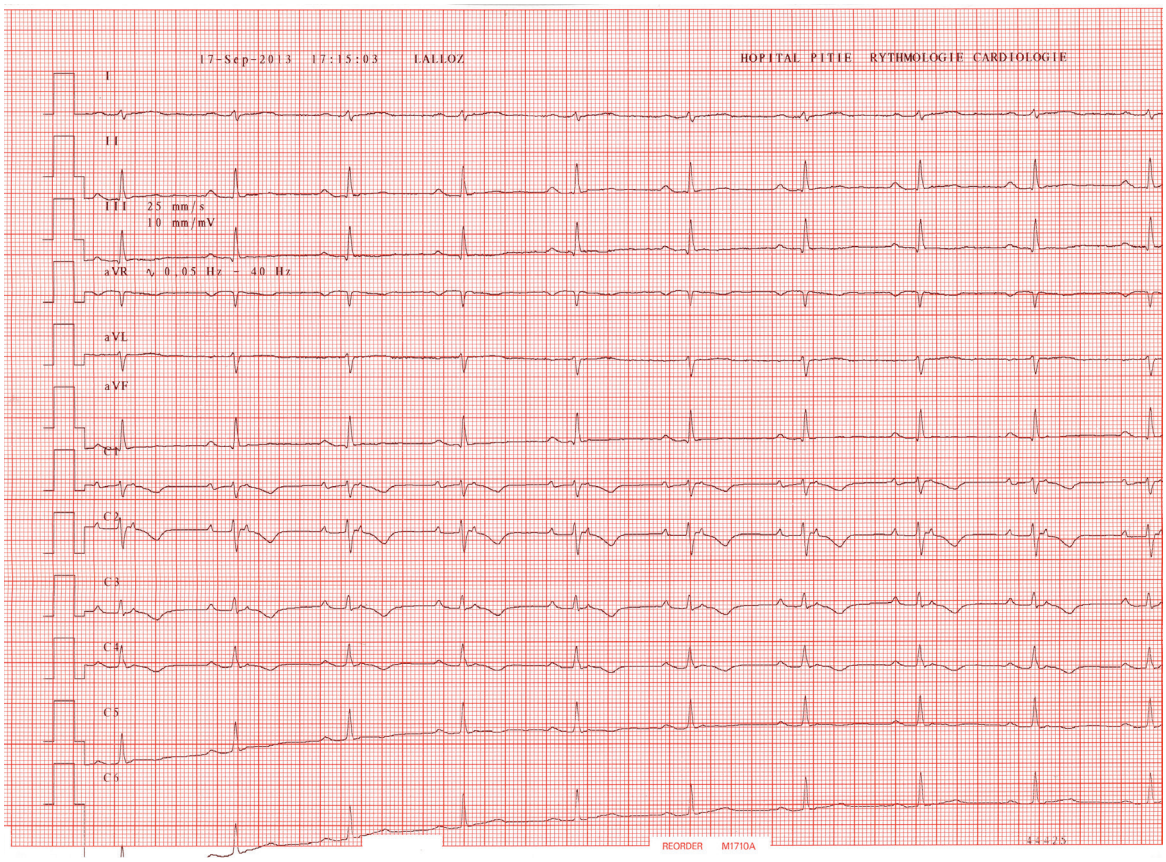
DOSSIER 25 - p. 215 et 216 (réponses 5 et 7)



DOSSIER 22 - p. 188



DOSSIER 2 - p. 25



DOSSIER 18 - p. 155 (question 1)

Inotropic/vasopressor agents should be considered: • Dopamine	IIa	C
• Dobutamine	IIa	C
• Norepinephrine (preferred over dopamine when blood pressure is low).	IIb	B

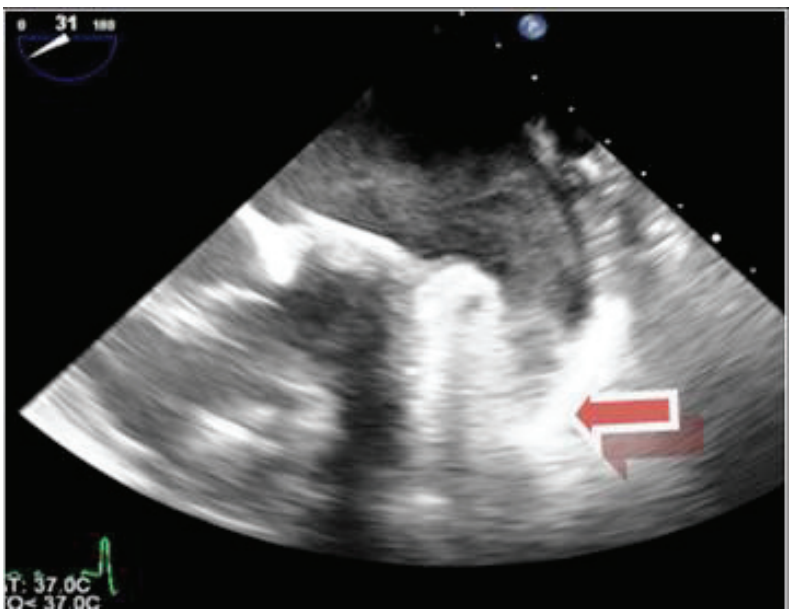
DOSSIER 6 - p. 62 (répone 12)



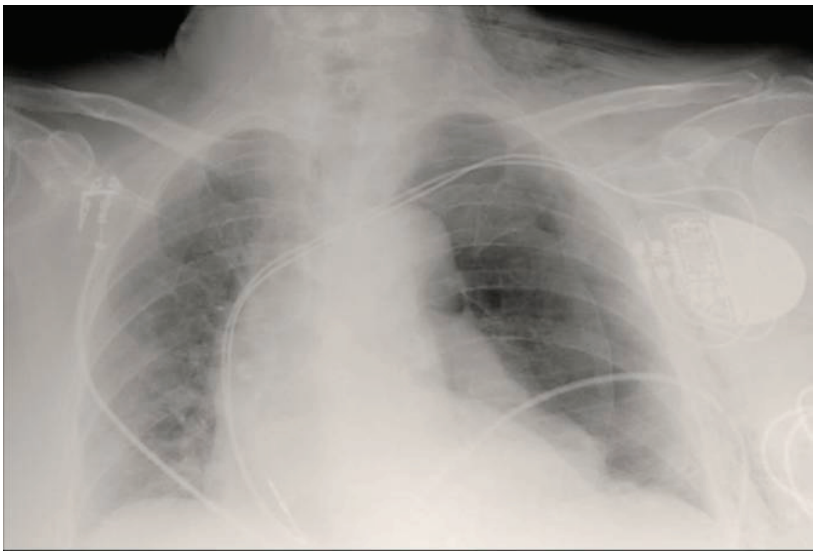
DOSSIER 15 - p. 132



DOSSIER 12 - p. 108



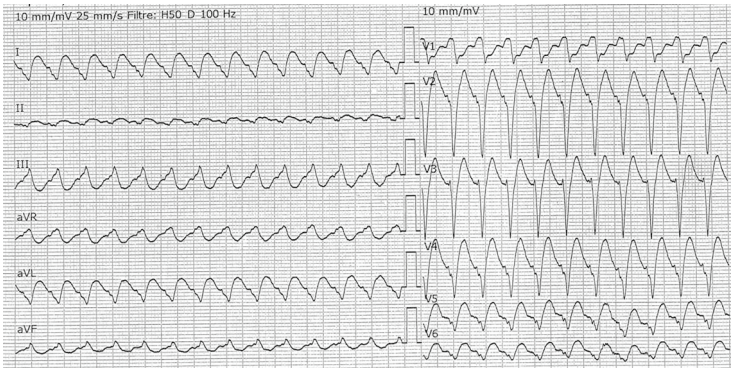
DOSSIER 8 - p. 77



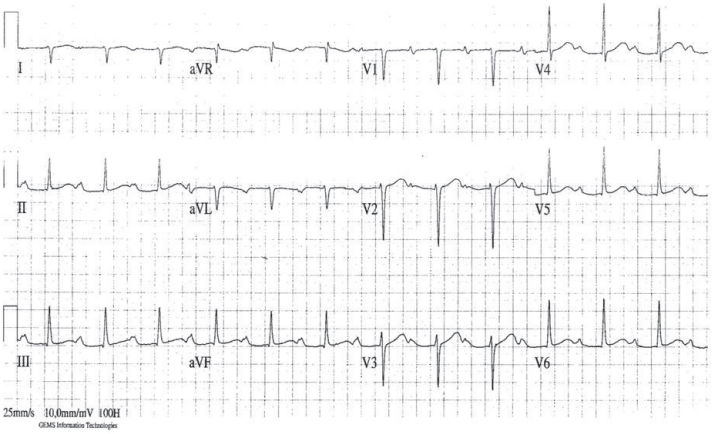
DOSSIER 20 - p. 174

Recommendations	Class [a]	Level [b]
Statin therapy is recommended in patients with T1DM and T2DM at very high-risk (i.e. if combined with documented CVD, severe CKD or with one or more CV risk factors and/or target organ damage) with an LDL-C target of <1.8 mmol/L (<70 mg/dL) or at least a ≥50% LDL-C reduction if this target goal cannot be reached.	I	A
Statin therapy is recommended in patients with T2DM at high risk (without any other CV risk factor and free of target organ damage) with an LDL-C target of <2.5 mmol/L (<100 mg/dL).	I	A

DOSSIER 7 - p. 69 (réponse 15)



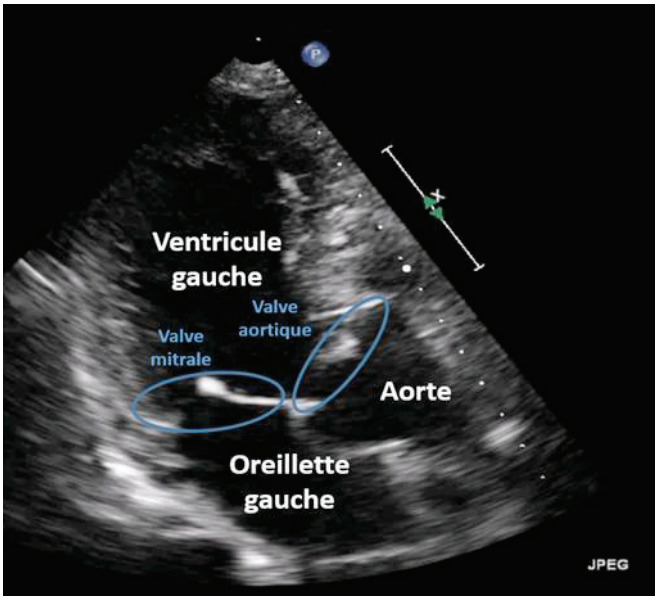
DOSSIER 9 - p. 82



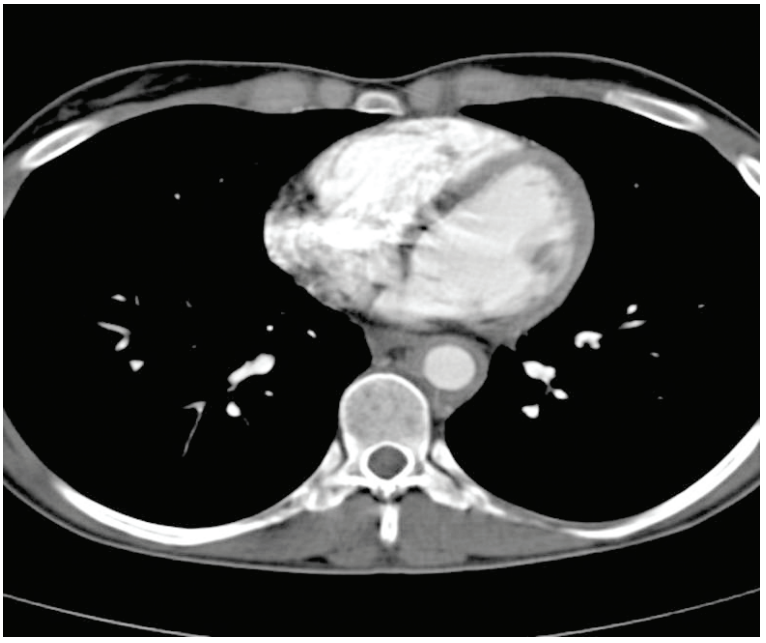
DOSSIER 24 - p. 206



DOSSIER 19 - p. 166



DOSSIER 34 - p. 291



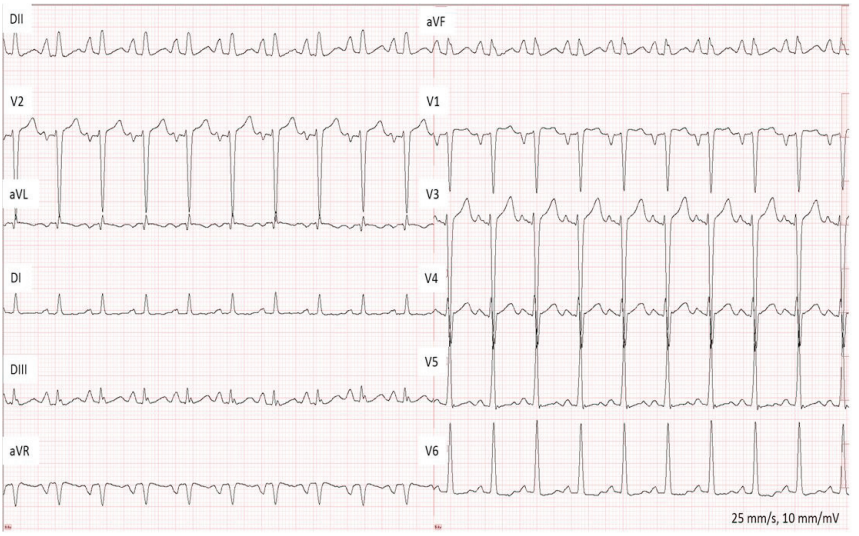
DOSSIER 33 - p. 283



DOSSIER 33 - p. 280



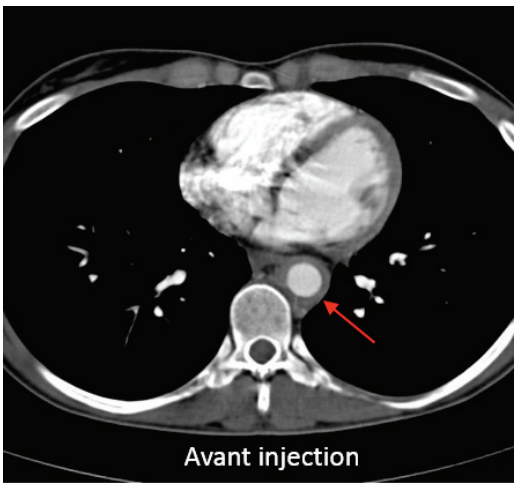
DOSSIER 13 - p. 116



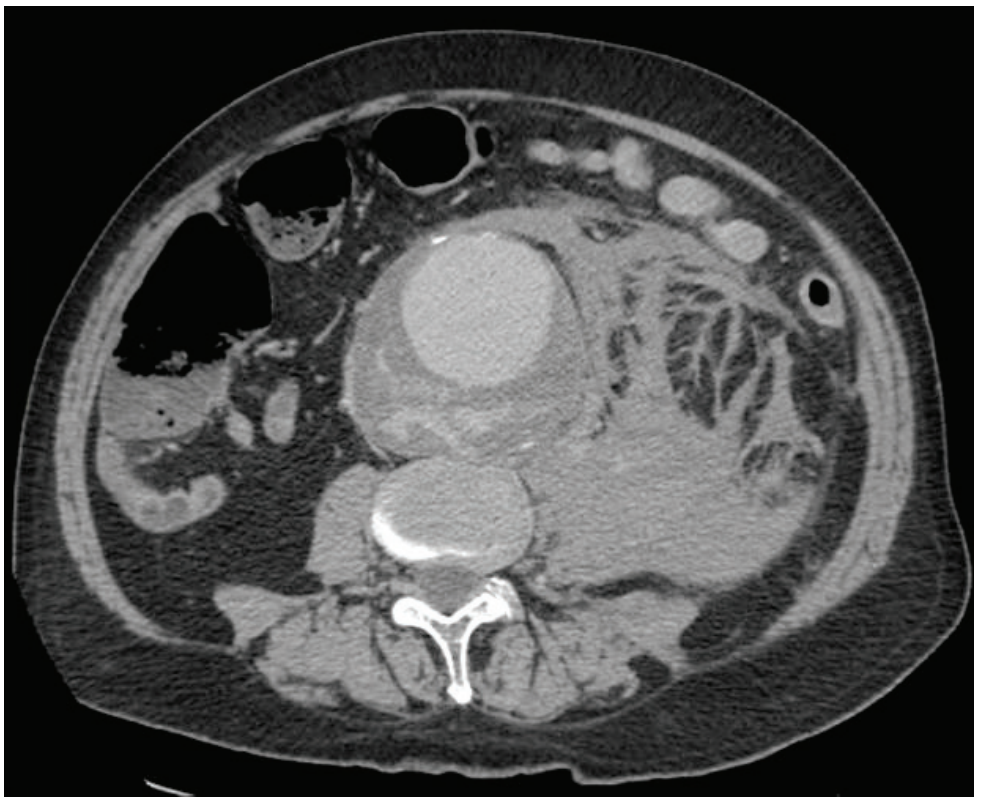
DOSSIER 9 - p. 83



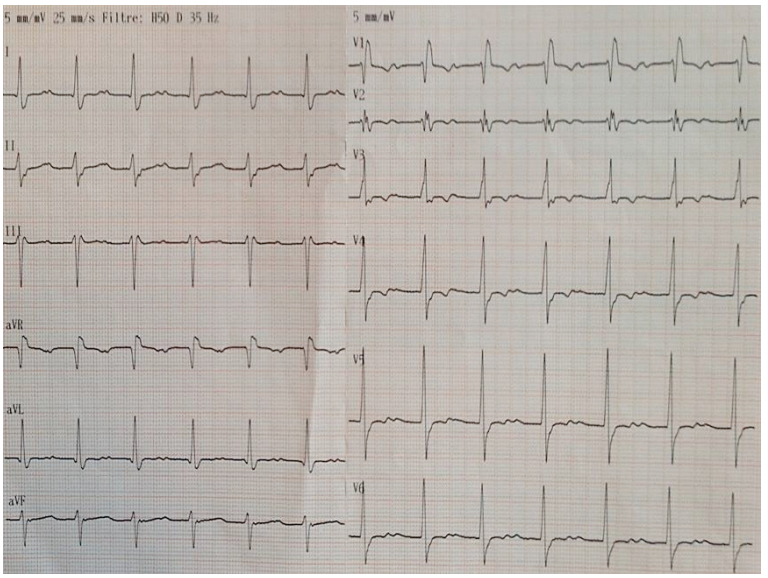
DOSSIER 3 - p. 34



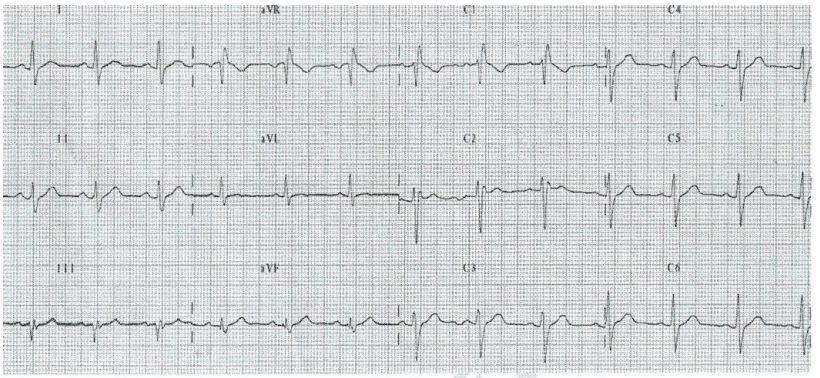
DOSSIER 33 - p. 283



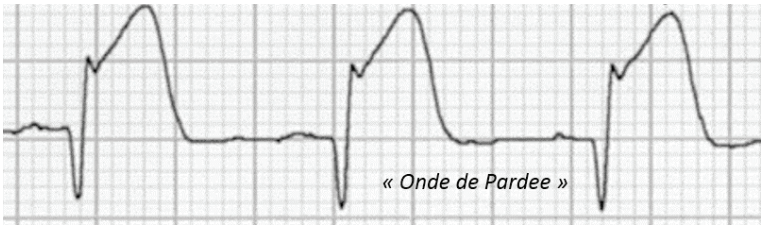
DOSSIER 4 - p. 42



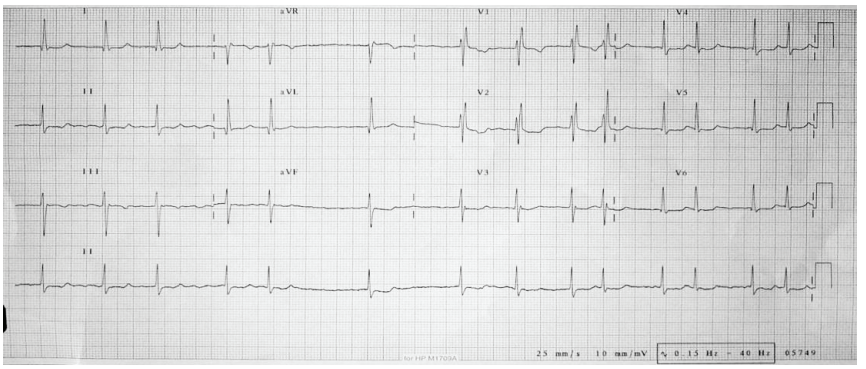
DOSSIER 20 - p. 172



DOSSIER 11 - p. 99 (question 8)



DOSSIER 31 - p. 265 (réponse 3 haut)

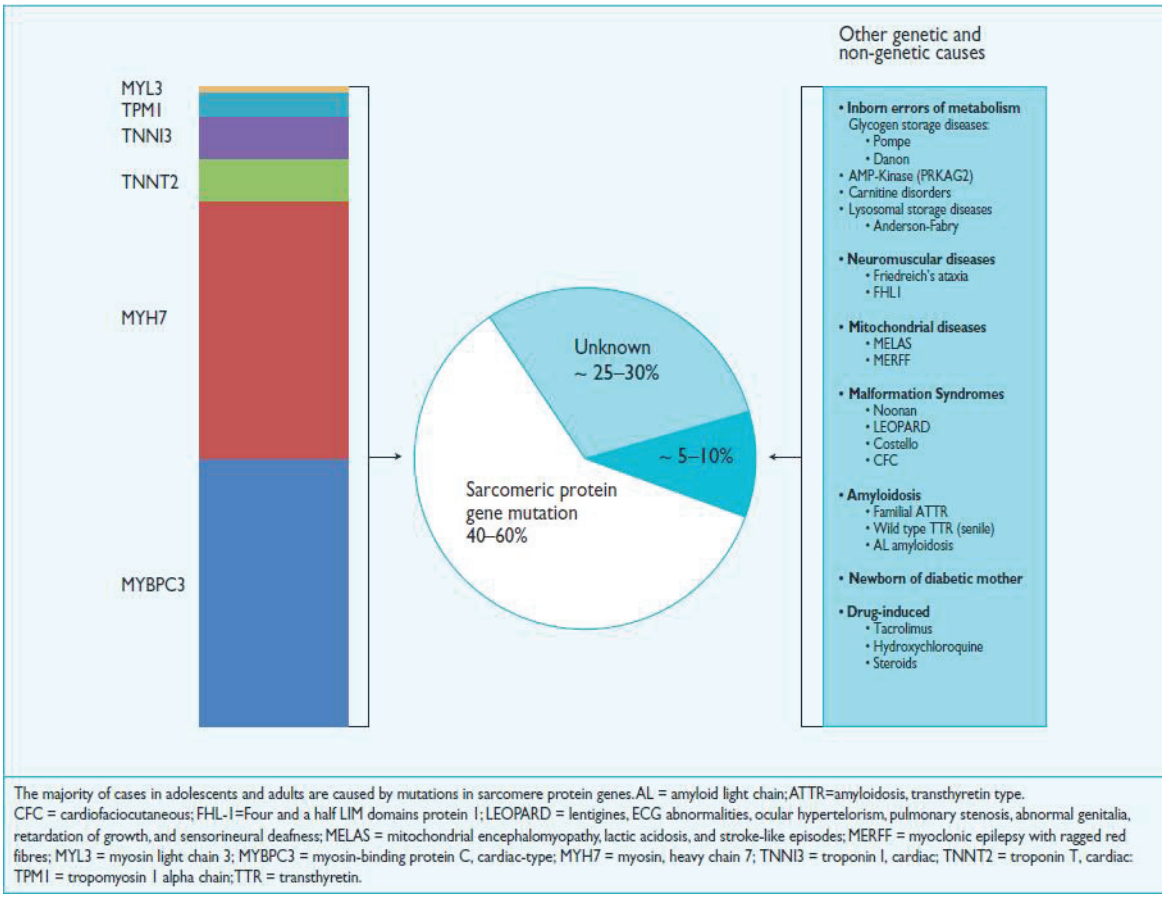


DOSSIER 12 - p. 105

Recommendations	Class[a]	Level[b]	Primary
An invasive strategy (within 72 h after first presentation) is indicated in patients with: • at least one high-risk criterion (*Table 9*); • recurrent symptoms.	I	A	• Relevant rise or fall in troponin[a] • Dynamic ST- or T-wave changes (symptomatic or silent)
			Secondary
Urgent coronary angiography (<2 h) is recommended in patients at very high ischaemic risk (refractory angina, with associated heart failure, life-threatening ventricular arrhythmias, or haemodynamic instability).	I	C	• Diabetes mellitus • Renal insufficiency (eGFR <60 mL/min/1.73 m²) • Reduced LV function (ejection fraction <40%) • Early post infarction angina • Recent PCI • Prior CABG • Intermediate to high GRACE risk score (*Table 5*)
An **early** invasive strategy (<24 h) is recommended in patients with a GRACE score >140 or with at least one primary high-risk criterion.	I	A	

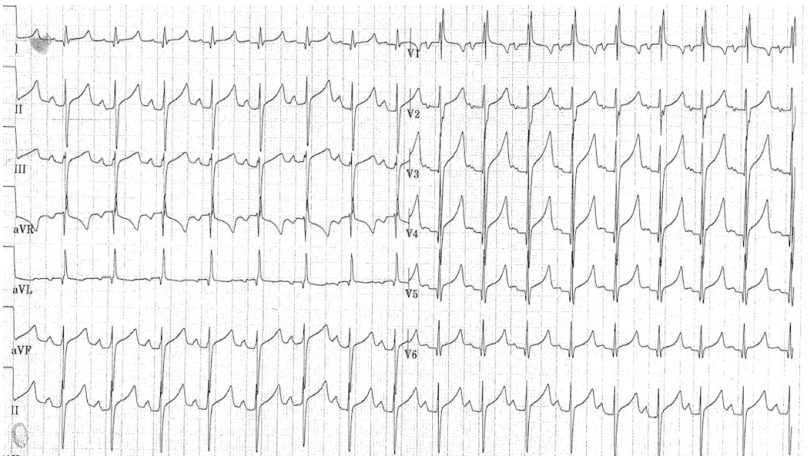
ESC 2011 sur le PEC des SCA ST-

DOSSIER 17 - p. 151 (réponse 1)

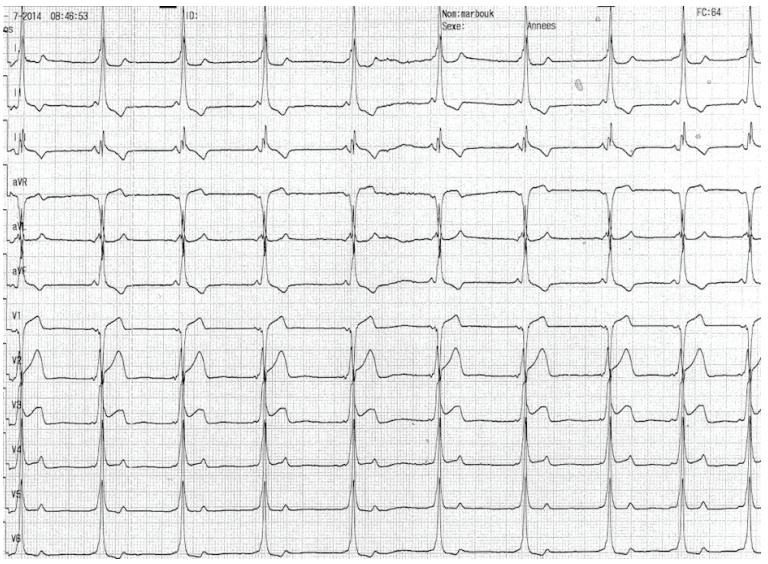


The majority of cases in adolescents and adults are caused by mutations in sarcomere protein genes. AL = amyloid light chain; ATTR=amyloidosis, transthyretin type. CFC = cardiofaciocutaneous; FHL-1=Four and a half LIM domains protein 1; LEOPARD = lentigines, ECG abnormalities, ocular hypertelorism, pulmonary stenosis, abnormal genitalia, retardation of growth, and sensorineural deafness; MELAS = mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes; MERFF = myoclonic epilepsy with ragged red fibres; MYL3 = myosin light chain 3; MYBPC3 = myosin-binding protein C, cardiac-type; MYH7 = myosin, heavy chain 7; TNNI3 = troponin I, cardiac; TNNT2 = troponin T, cardiac: TPM1 = tropomyosin 1 alpha chain; TTR = transthyretin.

DOSSIER 36 - p. 306 (réponse 6)



DOSSIER 28 - p. 238



DOSSIER 22 - p. 189