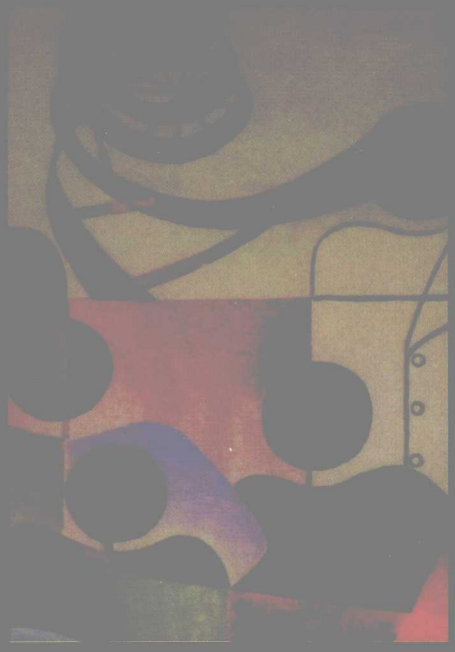
第 6 版

临床药物治疗学
病例分析

PHARMACOTHERAPY CASEBOOK
A PATIENT-FOCUSED APPROACH

原　著　Terry L. Schwinghammer

主　译　陈东生　　副主译　吕迁洲　陈志良



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译者序

《临床药物治疗学病例分析》（Pharmacotherapy Casebook-A Patient-Focused Approach）是美国《临床药物治疗学》第6版的补充教材，由人民卫生出版社引进，委托华中科技大学附属协和医院陈东生教授主译。由来自华中科技大学附属协和医院（武汉）、复旦大学附属中山医院（上海）和南方医科大学附属南方医院（广州）的13位译者共同商议编译。

在译著中我们尽量忠实原著内容，力求反映原著通俗易懂、用词准确的语言风格，并对其中非国际通用的药名、计量单位等按照国际标准进行了统一。

该书与《临床药物治疗学》相对应，收录了148例独立病例，并按照人体器官系统分类，覆盖了医药学各学科领域，不仅包括了医药学的最新信息，而且知识融会贯通。书中依据病例病情的复杂程度分三个等级，引导读者通过具体的案例分析，收集更多的信息，得出更优化的解决问题的方案，同时重点突出了如何有效地对患者进行宣教，如何建立正确的临床思维方法。本书旨在通过病例分析对所列疾病的病理生理状态和药物治疗学有全面的了解，培养医药学学生及临床药师独立学习、分析问题、解决问题以及医、药、护沟通和团队协作的能力，提高临床药学服务的水平。我们希望本书能协助医药工作者进行安全有效的药学服务，在满足社会需求方面发挥更大的作用。

本书在翻译过程中得到了华中科技大学附属协和医院王泽华教授、成蓓教授的帮助，华中科技大学第一临床医学院彭义香主任、伍三兰、翟学佳同志做了大量的辅助工作，对此深表谢意！译著虽经多次审校，但因为水平有限，错误在所难免，欢迎广大同仁对本书提出宝贵意见。

编译组于武汉

前言

《临床药物治疗学病例分析》旨在通过病例分析，帮助医疗卫生专业学生提高鉴别和解决药物治疗问题的技能。通过病例分析，让学生在学习过程中培养自信心，提高学生独立学习、分析问题、解决问题以及沟通和团队协作的能力。同时，病例分析也可作为病理生理学、药物化学、药理学、药物治疗学等各学科个体案例讨论的重点内容。通过对生物医学和药物治疗学的整合，病例分析可以帮助学生在进行实践准备时认识基础科学的关联性和重要性。

本书是美国第6版教材《临床药物治疗学》的补充教材。本书包含148个独立病例，与第一版相比多33个；按照人体的器官系统进行编排，并与《临床药物治疗学》相对应。在参阅本书中病人病情诊断前，学生应该阅读相关的教科书，从而对每种疾病的病理生理状态和药物治疗学有全面的了解。针对具体病例建立和实施药学监护方案，可以增强学生在以后的专业实践工作中所必需的技能和自信心。

病例分析中解决患者呈现问题所需的知识和经验是不同的，某些病例仅涉及到单一疾病，另一些则涉及到多种疾病以及药物相关的问题。作为教材指南，本书中的病例按照复杂程度分为3个级别，此分类方法将在第1章中详细叙述。

第6版含有5章概述：

第1章介绍了病例分析的格式及学生和教师最大限度利用本书的方法。每一个病例都遵循一定的系统处理方法。所涉及的步骤包括：

（1）鉴别存在的或潜在的药物治疗问题

（2）确定预期的治疗效果

（3）确定治疗方案

（4）最佳个体药物治疗方案的制定

（5）鉴别结果评价的参数

（6）对患者进行宣教

（7）药物治疗方案的沟通与实施

第2章介绍了有效学习策略的基本原理和具体实施方法。本章描述了如何利用这些实施方法提高学习能力，还为教师提供了大量的有价值的有效学习策略，并为学生在有效的学习环境中如何充分利用学习机会提出了宝贵建议。

第3章介绍了由美国印第安纳卫生事务署提出的一种有效的患者咨询方法。这些方法可以作为患者询问方法应用到相关患者个案中。

第4章描述了患者监护过程，并给出了建立监护方案所必需的步骤，这些监护方案有助于患者药物相关性需求的满足。在本节的结尾给出了一张空白的监护计划表格作为范例，在完成病例研究的过程中，应鼓励学生尽量运用此表（或类似的表格）。

第5章描述了记录临床干预的两种方法，以及与其他医疗保健人员沟通的方法。包括传统的SOAP记录法和更专业的FARM记录法。学习为患者制作SOAP或FARM记录，会为以后的实际工作打下坚实的基础。

需要强调的是：课上针对病例的讨论应该集中于解决患者问题的过程和找出实际问题的答案。知识更新的速度之快，会导致今天学到的知识明天可能就已经是过时或错误的了。只有那些能够识别患者问题，并用合理治疗方法解决这些问题的医疗工作者才能够跟上人体知识更新的步伐，这对提高患者生活的质量意义深远。

我们十分感谢各界对本书的广泛认同，尤其是本书被许多药学和护理专业学校广泛采用。本书还受到福利院工作人员和欲提高药学服务技巧的药师等人员的欢迎。我们希望新的版本将协助医疗卫生工作者在满足患者对安全有效的药物治疗的社会需求方面发挥更大的作用。

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以患者为中心的治疗原则

第1章

导论：用书指南

Terry L. Schwinghammer

通过病例分析提高学习能力

病例分析的首要目的是提高自学、判断和决策的能力。无论是在专业课上还是在自学中，病例分析的重点都是学习药物治疗问题的分析、解决方法，而不仅仅是简单地找到问题答案。通过对病例问题的解答，学生的确可以学到知识，但通过自学和小组讨论通常会有更大的收获。学生可以通过处理相似的病例来巩固相关知识。传统医药卫生专业课程的学习主要依赖于学科内容的讲述和机械的背诵，而不是在高层次技能方面的提高。

医疗学科中的病例研究包括：患者的病史以及需要解决的单个或多个健康问题。学生的任务是：通过获知病例的具体情况、分析已有数据、收集更多信息、提出假设、考虑可行的方法、提出最优的解决方案以及考虑该方案的疗效。老师的角色是给予学生指导和引导，而不仅仅是“答案”的来源。老师不必持有唯一正确答案或是在相关领域讨论中担当专家的角色。事实上，在许多病例中，解决问题的方法往往不止一个。学生可以直接参与到病例的讨论中，并在讨论中相互学习。

病例的内容安排

背景介绍

本书中的病例可以作为学生课下自学的重点，也可以作为课上学生和老师一起讨论的重点。如要开展重要的学习讨论会，学生必须在讨论之前通过自学，准备参与讨论会的病例材料、提出合理的方案、给出药物治疗的依据。这本书中的病例与第6版《临床药物治疗学》的内容相对应。为此，可以推荐学生对应课本中的相关章节的详尽内容进行准备。书中的大部分病例是全科药学实习者遇到的常见疾病，而不是所有有关药物疗法的病例都可以在本书中找到。其他的一级和三级参考书也应可以作为本书的补充读物来查阅。另一方面，某些章节讨论的复杂病例，本书中也有与之多个对应的病例。

病例复杂性的等级

每个病例首先标明了病例等级。老师可以按照分类来因材施教。分类等级如下：

Ⅰ级——简单的病例：病例中的问题只需用教科书中单独章节就可解答。基本上不需要具备该疾病的临床经验。

Ⅱ级——较复杂的病例：完成此病例的学习需要参考教科书中的多个章节或其他参考书。学生在回答病例中的问题时，可能需要具备前期临床经验。

Ⅲ级——复杂的病例：需要查阅教科书中多个章节以及具备大量的临床经验才能解决患者给药方案中的所有问题。

能力的培养

对每个病例进行分析需要学生具备多种能力。这些能力是在临床实践中培养起来的，而不是仅仅依靠单独的科学知识。学生可以通过理论与临床实践相结合、研究病例、给出药物治疗方案并提供方案的依据等方式来提高自己的能力。以上方式

主要是指引学生积极思考，而不是要求学生必须做到上述的每个环节。事实上，针对每个病例，学生应该有自己的能力培养和学习目标。这样学生才能自主学习，从而激发学习的主动性和能动性。

病例介绍

病例的格式和结构与临床通常所见格式一致。患者的用药史和体检结果在以下的规范病例中都有所体现。

主诉

主诉是患者用自己的语言对医师简要讲述就诊的原因。为了精确地表达患者症状，一般不使用医学术语及诊断名词。

现病史

现病史是对患者症状更为完整的描述。通常现病史包括以下几个方面：

（1）发病时间
（2）具体部位
（3）疾病的性质、程度和持续时间
（4）是否恶化或减轻
（5）现有治疗方案的效果
（6）相关的其他症状、身体机能或活动（如活动能力、饮食）
（7）日常活动的影响程度

既往史

既往病史包括严重疾病、外科手术和既往损伤。较轻的病情（如流行性感冒、感冒）通常均省略。

家族史

家族史包括父母、兄弟姐妹和子女的年龄及健康状况。对于已故亲戚，应当记录其死亡的年龄和原因。遗传病和具有遗传趋向的疾病（如糖尿病、心血管疾病、恶性肿瘤、类风湿性关节炎、肥胖症）也应记录在案。

个人史

个人史包括可能导致疾病的社会、环境和行为因素。通常包括患者的婚姻情况、子女数目、教育背景、职业、身体状况、嗜好、饮食习惯以及烟、酒和用药情况。

药物史

药物史应当详尽记录患者目前处方药和非处方药的用药情况。药师掌握了丰富的处方药和非处方药的知识，通过获得完整的药物史：所有药物的药名、剂量、用药时间和治疗持续时间及饮食和其他替代疗法，可以为医疗团队提供有价值的服务。

过敏史

过敏史包括对药物、食物、宠物和环境因素（如草、灰尘、花粉）的过敏反应。并对所发生的过敏反应进行精确的描述。医生应当仔细区分药物毒副作用（肠胃不适）与过敏反应（荨麻疹）。

系统回顾

系统回顾，医生询问患者与身体有关的各个系统的症状。在许多病例中，仅仅只记录相关的阳性或阴性结果。在一个完整的系统回顾中，身体从头到脚全部被记录，包括皮肤、头、眼、耳、鼻、口和咽、颈、心血管、呼吸系统、胃肠系统、生殖泌尿系统、内分泌系统、肌肉骨骼系统和神经系统。系统回顾的目的是衡量身体各个系统的状态，避免疏忽了相关信息。现病史中包括的信息在此就不再赘述。

体格检查

行体格检查的具体过程主要取决于患者的陈述和医疗史。在某些情况下，只须履行几项主要的体检项目即可。对于精神病患者，检查的项目主要集中在患者症状的类型和严重程度，而不是体检结果。一本好的体格评估教科书应当遵循特定的程序，以检查身体各个系统。体格检查一般包括如下内容：

- 一般状况
- 生命体征——血压、脉率、呼吸频率、体温（体重和身高通常也会记录在案，尽管它们不是重要的生命体征）
- 皮肤
- 五官（头、眼、耳、鼻、喉）
- 胸部
- 心血管系统
- 腹部
- 生殖器官/直肠
- 肌肉骨骼/四肢
- 神经系统

实验室检查

本书中几乎所有病例均包括实验室检查结果。附录A包含常用的转换因子和人体测量数据，这些信息对解决病例中的许多问题是有帮助的。附录B包含整本书中的实验室检查的正常范围。实验室检查的正常范围通常由样本群中具有代表性的样本测得。数值的上限和下限为平均值 ± 标准差，具有95%的可信度。“正常范围”这个词是具有一定的误导性，对于某一个体检结果即使是在“正常”范围内，但仍然有可能是不正常的。此外，采用所给的统计学方法计算该范围，大约20个健康个体中有1人的检测结果会在正常范围之外。基于以上原因，建议采用“参考范围”这个术语而不采用“正常范围”。参考范围因实验室不同而有差异，因此附录B中给定的数值仅供大家参考。在实际临床工作中应当使用实验室特定的参考范围。

所有病例中包括了一些在正常范围之内的体格检查和实验室检查结果。例如，心脏检查描述为最强搏动点在第五肋间隙；实验室检查结果为血清钠140mEq/L。实际的检查结果（除了简单陈述心脏检查和血清钠正常）会直接反映临床工作中发现的问题。更重要的是，同时列出正常和异常数值，要求学生仔细评价所有数据并独立鉴别阳性和阴性结果。如果仅仅