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Pubblico concorso per titoli ed esami, per la copertura a tempo indeterminato di n.1 posto di Dirigente Medico

- disciplina Ginecologia e ostetricia -

da assegnare alla S.C. Ginecologia e ostetricia
nell'ambito del Dipartimento Area di Chirurgia Addominale dell'Ente

TEST INGLESE

#1
Vulvar cancer is the fourth most common gynecologic malignancy in the United States, accounting for 2–5% of all gynecologic cancers. In 2023, an estimated 6470 patients will be diagnosed with new cases of vulvar cancer while 1670 patients will succumb to vulvar cancer related death. Vulvar cancer is a disease most commonly affecting postmenopausal patients after the 7th decade of life]. The incidence of vulvar cancer has been gradually increasing in recent years in the United States.

#2
The starting point was chosen to limit the study period to contemporaneous times, and the study endpoint was chosen due to the transition to the 10th revision of the International Classification of Disease codes schema in the National Inpatient Sample. This decision was based on the characteristics of International Classification of Disease, 10th revision of Procedure Coding Schema that is not surgical procedure specific (i.g., radical vulvectomy).

#3
The first step of the analysis was to describe the cohort-level characteristics. Temporal trends in patient characteristics of interest were also assessed (age, obesity, Charlson Comorbidity Index, history of radiotherapy, and history of chemotherapy). The Cochran-Armitage trend test was used to assess the statistical significance using the 5-year increments. Relative percentage rate changes from the first-third to the last-third of study period were examined.

#4
The second step of the analysis was to assess the characteristics related to the measured perioperative morbidities. A frequency table was generated to estimate the incidence of each perioperative morbidity, displayed from most to least frequent. The incidence of perioperative morbidities was examined across the study covariates, and statistical significance was assessed with chi-square tests in univariable analyses.

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#5
The third step of the analysis was to assess the rate of failure-torescue following perioperative morbidity. In this analysis, the study population was restricted to the patients who had the diagnosis of any of the measured perioperative morbidities. The rate of failure-torescue was assessed within the measured study covariates and perioperative morbidities in the univariable analysis

#6
Private health insurance usually covers a wide range of healthcare services, such as doctor visits, prescriptions, mental health care, hospitalization, and emergency care. Depending on the plan, private health insurance might include coverage for vision and dental care, alternative medicine, and other services.
These plans can vary significantly in cost and coverage, from basic plans that cover essential services like doctor visits and prescription drugs to more comprehensive plans that can cover costly treatments like surgery.

#7
Key results of this study are the following: first, vulvar cancer patients undergoing surgical treatment had increased comorbidity over time. Second, the rate of failure-to-rescue from a perioperative complication was 1.2% overall, but mortality following cardio-pulmonary and infectious morbidities (high-risk morbidities) was significantly high (5.7%).

#8
A recent study in 2017 showed that overall hospital mortality for critical care patients decreased during the period of the current study, which likely results in improved rates of failure-to-rescue for gynecologic cancer patients [48]. The risk of mortality after cardiopulmonary and infectious morbidities in this study remain disproportionately high and may also reflect the increasing frailty of the patient population receiving vulvectomy.

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#9
There are several limitations in this study. Patient performance status, details of the vulvar cancer (e.g., histology, tumor size, location, and cancer stage), the type of lymph node evaluation (e.g., sentinel lymph node biopsy), surgeon characteristics, use of an enhanced recovery system, detail of the measured individual comorbidity indicator (e.g., glycemic control of diabetes mellitus), and the level of postoperative hospital care (e.g, intensive care unit) were not available in the National Inpatient Sample, but these unmeasured confounders may have impacted the results of the analysis.

#10
Surgeons and the entire multi-disciplinary perioperative care team may consider the clinical impact of high-risk morbidities have on the risk of perioperative mortality. Special attention needs to be paid to the management of any patient with these high-risk morbidities after vulvectomy. Future investigations may describe best practices in hospital-based perioperative care that may decrease risk of failure-torescue.

#11
Our current data have several limitations, namely this study's single institution, retrospective design. The lack of racial and ethnic diversity in our cohort limits the generalizability of the findings. Given the significant heterogeneity of endometrial cancer, further understanding of the prevalence and risk factors for T2DM in more diverse cohorts is necessary to assess the needs of individual populations.

#12
Disparities in maternal morbidity and mortality remain vivid reminders of the role of racism in obstetrics and gynecology. If a serious attempt is to be made to purge medicine of its ongoing role in unequal care, then departments must commit the same intellectual and material resources as they would to the other health challenges in their remit.

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#13
Natural language processing—the branch of artificial intelligence concerned with the interaction between computers and human language—has advanced markedly in recent years with the introduction of sophisticated deep-learning models. Improved performance in natural language processing tasks, such as text and speech processing, have fueled impressive demonstrations of these models' capabilities.

#14
A large rose-tree stood near the entrance of the garden: the roses growing on it were white, but there were three gardeners at it, busily painting them red.
Alice thought this a very curious thing, and she went nearer to watch them, and just as she came up to them she heard one of them say, "Look out now, Five ! Don't go splashing paint over me like that !"

#15
Dr Nelson is an Associate Professor at The University of Texas Southwestern Medical Center and the Chief of Obstetrics for Parkland Health. He received a Bachelor of Science degree with honors (summa cum laude) in Chemical Engineering from the University of Arkansas. After graduation from medical school at the University of Arkansas for Medical Sciences, Dr Nelson completed a residency in obstetrics and gynecology at Parkland Hospital and a fellowship in maternal-fetal medicine at The University of Texas Southwestern Medical Center.

#16
There are 140 million births per year worldwide, and childbirth is a defining moment in anyone's life.1 Largely a physiologic process, parturition does come with risks; one mother dies every two minutes.2 These deaths occur mostly in healthy women and are often considered preventable.2,3 For each death, 20 to 30 mothers experience complications that compromise their short- and long-term health.

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#17
The articles in this first supplement address birth plans, birth settings, the role of midwives in intrapartum care, methods to assess labor progress, the diagnosis of labor disorders in the first stage, the nature of pain during labor, and the pharmacologic and nonpharmacologic means for pain relief. Authors also review methods of monitoring uterine contractility and frequent complications such as intrapartum fever and abruptio placenta.

#18
The opening article of this issue discusses "the importance of listening to mothers to transform maternity care" and is authored by the leadership of "Every Mother Counts," an organization dedicated to making pregnancy and childbirth safe, respectable, and equitable for every mother, everywhere. This choice reflects my view that mothers should be at the center of any conversation related to childbirth.

#19
To ensure that information about parturition reaches as many people as possible, we have made all articles freely available to subscribers and non-subscribers, thanks to the generosity of our publisher, Elsevier, Inc. Articles are accompanied by videos summarizing the key concepts and are posted to AJOG's social media channels—Twitter, Instagram, Facebook, and a dedicated YouTube channel.

#20
In the United States, 98.3% of patients give birth in hospitals, 1.1% give birth at home, and 0.5% give birth in freestanding birth centers. This review investigated the impact of birth settings on birth outcomes in the United States. Presently, there are insufficient data to evaluate levels of maternal mortality and severe morbidity according to place of birth. Out-of-hospital births are associated with fewer interventions such as episiotomies, epidural anesthesia, operative deliveries, and cesarean deliveries.

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#21
These differences increased further when patients were stratified by recognized risk factors such as breech presentation, multiple gestations, nulliparity, advanced maternal age, and postterm pregnancy. Causes of the increased perinatal morbidity and mortality include deliveries of patients with increased risks, absence of standardized criteria to exclude high-risk deliveries, and that most midwives attending out-of-hospital births in the United States do not meet the gold standard for midwifery regulation, the International Confederation of Midwives' Global Standards for Midwifery Education.

#22
There have been no significant studies that compared maternal mortality or severe morbidity between planned home births, birth-center births, and hospital births. Currently, the data compiled in the United States are insufficient for delineating and interpreting levels of maternal mortality and severe morbidity as compared according to site of birth.

#23
A major obstacle when comparing outcomes is that dangerous situations that begin outside the hospital (in homes and/or birth centers) and are then transferred to a hospital setting for intervention result in faulty data compilation, with the ultimate results (adverse or otherwise) attributed to the receiving hospital rather than the intended out-of-hospital birth location. The delay in care during transfer and the fact that the patient is likely unknown to the hospital also potentially affect the ability of the hospital to respond appropriately to reduce morbidity and mortality and improve outcomes.

#24
Even if the absence of high-risk factors may make a pregnant patient "low-risk," there is never "zero" risk. Although birth is usually an uneventful occurrence requiring little intervention, it can be interrupted by a pathologic or emergency event with little warning, which would require the activation and cooperation of many individuals from different professions, with little time to spare to prevent the pregnant

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patient and/or the soon-to-be-born child from being negatively affected.

#25

Fetus' and newborns' health and lives can be saved by delivering in the hospital, where many interventions can be life-saving and are unavailable at out-of-hospital births. Such interventions include risk-reducing inductions, treating serious infections, timely prevention of cerebral palsy, treatment of obstetrical hypertension, ultrasonographic examination, and management of umbilical cord prolapse and shoulder dystocia.

#26

According to ACOG, pregnant patients attempting a vaginal delivery after previous cesarean delivery (VBAC) have increased maternal and neonatal risks and require in-hospital deliveries with precautions, and therefore a previous cesarean delivery is an absolute contraindication for out-of-hospital birth.

#27

Pregnant patients who choose a home birth with their first pregnancy are at markedly increased risks for adverse pregnancy complications. The Birthplace in England study confirmed that nulliparous women have poorer perinatal outcomes in planned home births, which led Buekens and Keirse58 to recommend that pregnant patients with their first pregnancies should not deliver at home.

#28

A recent study concluded that planned home births in the state of Washington have good neonatal outcomes when first excluding high-risk deliveries. When the significant number of high-risk patients in that study was included, however, there was an increased neonatal mortality rate of >8 times compared with low-risk patients.

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#29
With increased success, ovarian tissue cryopreservation has recently become a standard technique for fertility preservation. However, malignant cell introduction through ovarian tissue transplantation remains a major concern for patients with acute leukemias.

#30
Our long-term follow-up demonstrated no evidence of disease relapse after ovarian tissue transplantation in patients with acute leukemia who received allogenic hematopoietic stem cell transplantation. This safety profile may be explained by the fact that these patients are induced into remission by non-gonadotoxic induction chemotherapy before undergoing ovarian tissue cryopreservation.