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Chapter 1 : EPCS Questions and Answers for Prescribing Practitioners

Institutional Report A report differs from a web page because it is an official document that is often in the form of a lengthy PDF. The word report is usually in the title, and sometimes there is a document number associated with it.

Fifty-seven patients 18 years or older with postoperative defects of at least 3 cm, resulting from either Mohs micrographic surgical procedures or surgical excision, were screened for participation. Nine patients were excluded and 48 were enrolled. There was no significant difference in the total patient assessment scale score between the combination closure There was also no significant difference between the 2 closure methods in terms of mean SD scar width both methods: Our results do not support the use of adhesive strips as a means to improve cosmetic outcomes or reduce scar width. NCT Introduction Adhesive strips are commonly used for cuticular wound closure following cutaneous surgical procedures. Multiple studies have compared adhesive strips with other cuticular closure methods such as suturing, acrylate adhesives, and staples. Only a single study, performed in patients undergoing podiatric procedures, has examined the outcome of combination closure with subcuticular sutures and adhesive strips compared with subcuticular closure alone. Their study, however, was limited by both the use of alternate-day allocation instead of true randomization and lack of a validated scar assessment instrument. Furthermore, the authors compared outcomes with a running subcuticular suture rather than buried interrupted subcuticular sutures. Thus, information on whether adhesive strips improve outcomes compared with simple subcuticular wound closure with buried vertical mattress sutures alone is sparse. Our objective was to determine whether the addition of adhesive stripping to a wound closed with buried vertical mattress sutures improves outcomes following primary wound closure. Methods Study Design Between November 14, , and May 16, , we conducted a prospective, single-center, evaluator-blinded, randomized split-wound comparison trial. NCT , and written informed consent was obtained from all patients prior to enrollment. The procedures followed were in accordance with the ethical standards of the institutional review board and the Helsinki Declaration of The full study protocol synopsis can be found in the Supplement. A nurse not involved in the study generated the list prior to study participant recruitment. Allocation Assignment, Concealment, and Data Capture Allocation assignments were concealed in individual opaque envelopes that were sequentially numbered. Patient recruitment and enrollment in the study was completed by the surgeon and nurses. Following wound closure, the surgeon exited the room and the nurse requested the allocation envelope. The contents of the envelope were subsequently revealed in the presence of the patient and the instructed intervention applied to the appropriate side of the wound. The treatment method for each side was recorded for every patient at the time of the procedure in a web-based data collection form REDCap by the nurse after allocation was determined. Patients The following were the inclusion criteria for the study: Eligible patients were those who were able to provide informed consent and were willing to return for a follow-up visit 3 months after the surgical procedure. Exclusion criteria included pregnancy, incarceration, mental impairment, inability to understand English, unwillingness to return for a follow-up visit, and inability to consent. The postoperative defects were not limited by anatomic location and surgeons of different experience levels eg, residents, fellows, or faculty were included to improve external validity in the study. Interventions Following excision of the skin lesion, bevels, if present, were excised and the wound edge undermined prior to closure per surgeon preference equally on both sides. Each half of the wound was sutured using subcuticular buried vertical mattress sutures. Following placement of the subcuticular sutures, the wound was divided in half. One side was designated as side A and the other as side B. After departure of the surgeon, the allocation envelope was opened and treatment side determined. The wound half assigned to adhesive strips was coated with a supplemental adhesive Mastisol, Eloquest Healthcare Laboratories, Ferndale Pharma Group, Inc , which was allowed to dry. The adhesive strips Steri-strips, 3M Healthcare were then applied to one side of the excision and stretched across to the other side using Adson forceps, such that tension was applied toward the center of the wound. Patients were instructed to apply petroleum jelly to both sides of their wound twice daily for 1 week with a cotton-tipped applicator. It was recommended that the patient refrain from all physical activity that could result in elevation of heart rate

or blood pressure for a minimum of 1 week after the surgical procedure. Assessment Intervals and Efficacy Outcomes Patients were evaluated 3 months postoperatively, and the study concluded when no additional patients were available for follow-up. A 3-month follow-up period was selected to maximize participant retention while maintaining an appropriate postoperative interval in which to determine accurate scar evaluation, as data indicate good correlation between postoperative results at 3 and 12 months. The POSAS consists of a patient scale and an observer scale; each of 6 components is scored numerically on a scale from 1 to The component scores are then summed 12 - 14 ; the worst scar imaginable would score a 60 and the best scar a 6. Secondary outcome measures included the width of the scar measured 1 cm from midline on both sides and was measured at the 3-month follow-up visit. Scars were measured to the nearest 0. Two blinded observers performed assessments of the scar, and their scores were averaged. RedCap was used to capture and manage data. The adverse events measured were history of dehiscence, infection, hematoma, seroma, suture abscess, and other adverse events. Statistical Analysis Data were examined based on an intention-to-treat analysis. Summary statistics were used to describe the baseline demographic and clinical characteristics of the patient population. Pairwise comparisons were used at 3 months after the procedure to analyze the differences between the use of adhesive strips and no use of adhesive strips in surgical complications, investigator scar assessment, and patient scar assessment. Wilcoxon matched-pairs signed rank test was used to determine the equality of matched pairs of observations for surgical outcome variables, which were binary. The null hypothesis of this test is that both distributions are the same. For the continuous outcomes of investigator-assessed and patient-assessed scar appearance and symptoms, a paired t test was used to compare the differences between portions of the wounds treated with and not treated with adhesive strips. Results Fifty-seven patients were screened for participation. Nine patients were excluded and 48 were enrolled Figure 1. Forty-five of the 48 patients enrolled were available at the 3-month follow-up visit Figure 1. Table 1 provides complete patient demographic details. Analysis was conducted by original assigned groups. Our study population largely reflects outcomes of older and white individuals, who are representative of those who undergo most cutaneous surgical procedures at our institution.

Chapter 2 : Citing Electronic Sources | Academic Integrity at MIT

Institutional Animal Care and Use Committee Guidance Page 2 of 8 Surgery location and setâ€•up: The ideal location is a dedicated room or alcove.

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Chapter 3 : Manager of Institutional Giving | Greater Philadelphia Cultural Alliance

Several studies on sutures treated with nanoparticles, antibacterial agent and various drugs to advance the therapeutical value of surgical sutures are in consideration, drug-eluting sutures has.

In lieu of an abstract, here is a brief excerpt of the content: Brooks Landon Daniel Punday. Five Strands of Fictionality: Ohio State UP, Daniel Punday is a big-picture kind of guy. Having interrogated the relationship between two sizable concepts in his Narrative After Deconstruction and taking on still another large concept, embodiment, in Narrative Bodies , Punday has now set his sights on another expansive topic in Five Strands of Fictionality. Punday specifies that his goal in this book is "to describe the operation of fictionality in contemporary post American fiction and culture" However, Punday is more than up to meeting this challenge, [End Page] and his book is a model for thinking our way through the vagaries of fictionality and toward its productive uses. Along the way, he repeatedly reminds us of the intertwining of issues of fictionality with postmodernism. First he takes on the postmodern media culture-centered "popular perception that the fictive has somehow wormed its way into spheres of contemporary life where it traditionally was not welcome" 1. We might think of this as the "bad pomo" understanding of cultural fictionality. Punday quickly explains that his interest is not with "the apparent shift in our sense of reality," but with "the discursive uses of fiction," a potentially positive interrogation of the question of the "work" fictionality does 3. He also distinguishes fictionality from cultural myth, insofar as "fictionality, unlike myth, must have some purpose beyond itself," must serve as some form of "intellectual tool" 4. And, in what is a crucial proposition for Punday, fictionality is an inherently modern phenomenon depending on "the very precise contours of modern thinking about truth and the knowability of the world" 9. Having specified these aspects of the fictional he does not intend to engage, Punday then moves to what he will do, examining fictionality as "an occasion to rethink institutional and disciplinary boundaries" Specifically, he organizes his study around loosely bounded and frequently interpenetrating "strands" that construct fictionality primarily in terms of crafted literary myth, archive building, lying, style, and assemblage. Punday is concerned with the institutions of literary study, our ways of evaluating and assigning authority and value to fictional discursive texts, a task more and more falling to literary theory or just "theory" , which becomes a site of "a whole series of debates about the institutions that shape the creation, transmission, and reception of information" Now here comes the tricky part: These turns lead Punday back toward the postmodern issues with "reality" from which he initially distinguished his concern, but now with the crucial distinction that in place of the bad postmodern concern with media culture, simulation, and so forth, "we should see the expansion of [End Page] fictionality in contemporary culture as reflecting a variety of forces inherent to the nature of disciplines in America. You are not currently authenticated. View freely available titles:

Chapter 4 : Suture Techniques | Harvard Catalyst Profiles | Harvard Catalyst

ROZOVSKY et al Craniosynostosis, defined as the premature closure of â‰¥1 cranial sutures, is the most frequent craniofacial anomaly, occurring in 4 to 6 infants.

The regulations will also permit pharmacies to receive, dispense, and archive these electronic prescriptions. The rule was published in the Federal Register Wednesday, March 31, and becomes effective on June 1, Is the use of electronic prescriptions for controlled substances mandatory? No, the new regulations do not mandate that practitioners prescribe controlled substances using only electronic prescriptions. Nor do they require pharmacies to accept electronic prescriptions for controlled substances for dispensing. Prescribing practitioners are still able to write, and manually sign, prescriptions for schedule II, III, IV, and V controlled substances and pharmacies are still able to dispense controlled substances based on those written prescriptions. In addition, electronic prescriptions for controlled substances may be subject to state laws and regulations. Did DEA consider public comment in the development of this rule? Did DEA work with other Federal agencies in the development of this rule? When can a practitioner start issuing electronic prescriptions for controlled substances? A practitioner will be able to issue electronic controlled substance prescriptions only when the electronic prescription or electronic health record EHR application the practitioner is using complies with the requirements in the interim final rule. The application provider must either hire a qualified third party to audit the application or have the application reviewed and certified by an approved certification body. A limited set of prescriptions require information that may need revision of the basic prescription standard before they can be reliably accommodated, such as hospital prescriptions issued to staff members with an identifying suffix. Until the application is compliant with the final rule,however, the practitioner will have to print the prescription for manual signature. Such prescriptions are paper prescriptions and subject to the existing requirements for paper prescriptions. The questions and responses below assume that the practitioner is an individual practitioner e. The practitioner may be a member of a group practice. Is identity proofing of individual prescribing practitioners required. If so, who will conduct it? Yes, identity proofing is critical to the security of electronic prescribing of controlled substances. Authentication credentials used to sign controlled substance prescriptions may be issued only to individuals whose identity has been confirmed. Individual practitioners will be required to apply to certain Federally approved credential service providers CSPs or certification authorities CAs to obtain their two-factor authentication credential or digital certificate. Both in person and remote identity proofing will be acceptable. If a practitioner wants to undergo identity proofing to prescribe controlled substances, how is this accomplished? DEA expects application providers will work with CSPs or CAs to direct practitioners to one or more sources of two-factor authentication credentials that will be interoperable with their applications. Prescribing practitioners may wish to contact their application provider to determine which CSP or CA the provider recommends the practitioner use. The specifics of each application will determine what kind of two-factor credential will be needed. Is remote identity proofing permissible? Yes, the rule permits both in-person and remote identity proofing. DEA believes that the ability to conduct remote identity proofing allowed for in National Institute of Standards and Technology Special Publication Level 3 will ensure that practitioners in rural areas will be able to obtain an authentication credential without the need for travel. Once a practitioner has undergone identity proofing, will the practitioner receive something? The CSP or CA that conducted the identity proofing of the practitioner may issue a new hard token or register and provide credentials for an existing token. Regardless of whether a new token is provided and activated, an existing token is registered, or a biometric is used for the signing of controlled substance prescriptions, communications between the CSP or CA and practitioner applicant must occur through two channels e. Why is DEA requiring the use of two-factor authentication credentials? What two-factor credentials will be acceptable? Under the interim final rule, DEA is allowing the use of two of the following â€" something you know a knowledge factor , something you have a hard token stored separately from the computer being accessed , and something you are biometric information. The hard token, if used, must be a cryptographic device or a one-time password device that meets Federal Information Processing

Standard Security Level 1. What is a hard token? A hard token is a cryptographic key stored on a hardware device e. A hard token is a tangible, physical object possessed by an individual practitioner. No, the practitioner must retain sole possession of the hard token, where applicable, and must not share the password or other knowledge factor with any other person. The practitioner must not allow any other person to use the token or enter the knowledge factor or other identification means to sign prescriptions for controlled substances. If an individual practitioner wants to use a biometric as one factor of the two-factor authentication credential, does DEA have any special requirements? DEA is establishing several standards for the use of biometrics and for the testing of the software used to read the biometrics. DEA wishes to emphasize that these standards do not specify the types of biometrics that may be acceptable. Any biometric that meets the criteria DEA has specified may be used as the biometric factor in a two-factor authentication credential used to indicate that prescriptions are ready to be signed and sign controlled substance prescriptions. The use of biometrics as one factor in the two-factor authentication protocol is strictly voluntary, as is all electronic prescribing of controlled substances. Does an individual practitioner need separate authentication credentials if the practitioner has more than one DEA registration? No, a single authentication credential can be used. If an individual practitioner uses more than one application to create and sign controlled substance prescriptions, will the practitioner need to undergo identity proofing for each and obtain separate credentials for each? Whether the individual practitioner needs to undergo identity proofing and obtain separate credentials for separate applications will depend on the requirements of the applications. It is likely that if a practitioner has privileges at one or more hospitals, the hospitals will require separate credentials to use their applications. Once a practitioner possesses the two-factor credential, is the practitioner ready to sign controlled substance prescriptions? No, there is another step that must be taken. The application will determine whether access control is set by name or by role. If the logical access controls are role-based, one or more roles will have to be limited to individuals authorized to prescribe controlled substances. How are access controls set? Setting access controls requires two people. One person must determine which individuals are authorized to sign controlled substance prescriptions and enter those names or assign those names to a role that is allowed to sign controlled substance prescriptions. The access control list will need to be updated when registrants join or leave a practice. A person at the practice who is setting access control has to check to be sure that each practitioner being granted authorization to sign controlled substances prescriptions has a DEA registration, state authorization to practice and, where applicable, state authorization to dispense controlled substances that are still current and in good standing. DEA expects this will be done simply by checking the latest certificates. The questions and responses below assume that the practitioner is an institutional practitioner e. Yes, as identity proofing is critical to the security of electronic prescribing of controlled substances. Authentication credentials used to sign controlled substance prescriptions are issued only to individuals whose identity has been confirmed. Because institutional practitioners have credentialing offices, those offices may conduct in-person identity proofing as part of the credentialing process. DEA is not requiring institutional practitioners to meet the requirements of National Institute of Standards and Technology Special Publication for identity proofing. The institutional practitioner must also check State licensure and DEA registrations, where applicable. Is an institutional practitioner required to conduct identity proofing in this manner? No, institutional practitioners are allowed, but not required, to conduct identity proofing. If an institutional practitioner decides to have each practitioner obtain identity proofing and the two-factor authentication credential on his own, as other individual practitioners do, that is permissible under the rule. For an institutional practitioner, is remote identity proofing permissible? The rule only allows institutional practitioners to conduct in-person identity proofing. Remote identity proofing is not permissible for institutional practitioners. For an institutional practitioner, how is the two-factor authentication credential issued? Under the rule, the institutional practitioner may issue the two-factor authentication credentials or obtain them from a third party which will have to be a CSP or CA that meets the criteria DEA has specified. In the latter case, the institutional practitioner could have each practitioner apply for the two-factor credential himself, which would entail undergoing identity proofing by the CSP or CA. Alternatively, the institutional practitioner can serve as a trusted agent for the third party. The hard token, if used, must be a cryptographic

device or a one-time-password device that meets Federal Information Processing Standard Security Level 1. Is it permissible for a practitioner to have another staff person at the institutional practitioner maintain custody of the hard token? If an institutional practitioner wants to use a biometric as one factor of the two-factor authentication credential issued to persons prescribing controlled substances, does DEA have any special requirements? Are any additional steps needed to give practitioners the ability to sign controlled substance prescriptions? The application must have the ability to assign permissions by name or role so that only authorized practitioners are allowed to sign controlled substance prescriptions. Two individuals must be involved in setting the access controls; one will enter the data based on information from the credentialing office and the second will approve the entry. If a hard token or any other authentication factor required by the two-factor authentication protocol is lost, stolen, or compromised. Such access must be terminated immediately upon receiving notification from the individual practitioner. The individual practitioner is no longer authorized to use the electronic prescription application e. Creating and Signing Prescriptions Q. What information is an electronic prescription for a controlled substance required to contain? As with paper prescriptions, all electronic prescriptions for controlled substances are required to contain the full name and address of the patient, drug name, strength, dosage form, quantity prescribed, directions for use, and the name, address and registration number of the practitioner. Where applicable, refill information must also be included, as well as any other information required by DEA regulations. Is a practitioner required to review a prescription before signing it? All controlled substances must be reviewed by the prescribing practitioner. The practitioner must affirmatively indicate those prescriptions that are ready to be signed. A practitioner has the same responsibility when issuing an electronic prescription as when issuing a paper prescription to ensure that the prescription conforms in all respects with the requirements of the Controlled Substances Act and DEA regulations. This responsibility applies with equal force regardless of whether the prescription information is entered by the practitioner or a member of his staff. When a practitioner reviews a prescription, what information must be displayed? Must a practitioner separately attest to each prescription? No, the application must include, on the prescription review screen, the following statement or its substantial equivalent:

Chapter 5 : Investments | Insights | Franklin Templeton Institutional

While the current practice standard is a layered closure with dermal and cuticular sutures, dermal sutures plus adhesive strips have been shown to have cosmetic results similar to those with layered closure. 15 In addition, a prior study conducted with dermal sutures plus adhesive strips demonstrated excellent results. 16 Our study now shows.

The Manager will work with the Senior Managing Director, Institutional Development SMD to develop and implement key fundraising strategies and assist in translating institutional priorities into fundraising opportunities. In coordination with the SMD, emphasis is placed on activities which will retain donors, raise average giving level of donors and build a new base of donors. The Manager of Institutional Giving Manager is responsible for the identification, cultivation, solicitation and stewardship of corporate, foundation, and agencies prospects. The Manager is accountable for developing strategies to cultivate, solicit and stewardship of annual institutional donors such as corporate and foundation donors. Cultivation strategies include, but not limited to, face-to-face visits as well as proposal development. Assist in monitoring the CFR budget, the monthly reconciliation of budget transactions and any year-end closing documentation. Manage the disbursements, tracking and invoicing needs for the CFR unit. Assist and manage with preparing proposals, reports, cover letters, budgets, and letter of inquiry for current and prospective foundations, corporations, institutions, and government funders, tracking revisions and creating final packages for timely delivery Compose letters, documents, and proof and edit CFR written communication materials. Prepare correspondence and complete relevant paperwork for the acknowledgment process. Maintain an administrative filing system, both hard copy and electronic mediums for all correspondence flowing from the CFR unit. Assist in managing the VIP boxes for CFR including tracking all tickets throughout the season and ensure tickets are disbursed in a timely fashion. Assist SMD in servicing and stewarding the Collaborative Learning Council such as staffing meetings and other development-related activities. Coordinate and manage the delivery of all benefits promised to sponsors, including interim and final reports, liaising as appropriate with program staff on status updates and progress toward stated goals. Working across all departments especially Marketing to ensure appropriate sponsorship recognition provided across all collateral pieces such as social media content, print materials as well as updating the Institutional webpages as needed. Working closely with the Development Services Department, responsible for maintaining the CFR donor records, assure that all updates concerning foundation, corporate, institutional donors are recorded in database; record relationships and connections. Serve as a representative on relevant Interdepartmental Committees to provide departmental input where needed. College degree required with a minimum of two years senior level administrative experience. Minimum of three to five years of experience writing proposals and reports. Knowledge of fundraising and fundraising software and orchestral music a plus. Excellent writing, editorial, and verbal communication skills required. Must possess poise and strong interpersonal skills and the ability to work collaboratively across the Development department and the entire organization. Must possess strong organizational skills and the ability to manage more than one project simultaneously. Ability to work independently, exercise good judgement, be detailed oriented and maintain a degree of professionalism and confidentiality. Must manage high expectations, multiple demands, numerous sources of feedback and respond quickly to changing details. Strong computer literacy skills required including database management and the ability to learn new software. Knowledge of computer networks, Word, Excel, Access, PowerPoint and the Internet to manage an efficient office operation. Ability to work in a dynamic, fast-paced environment. Routine for office environment. The employee will be required to have a flexible schedule to accommodate and staff events. This position will require early mornings, late evenings, and weekends.

Chapter 6 : Suture Tutor Plus institutional licence agreement - Limbs & Things

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Objectives: The actual number of transmural sutures needed to ensure a successful fibrin-glued vasovasostomy is a key study parameter of the few experimental works already published. The present work was done to evaluate fibrin-glued vasovasostomy in rats in combination with only 2 transmural sutures.

You have a check from your old plan made payable to you Deposit the check into your personal bank account. Either make an electronic deposit or mail us a personal check. Be sure to select "day-rollover" as the contribution type. Otherwise, you may be subject to additional taxes and penalties. ACATS is a regulated system through which the majority of total brokerage account transfers are submitted. Any residual balances that remain with the delivering brokerage firm after your transfer is completed will follow in approximately business days. If you have any questions regarding residual sweeps, please contact the transferor firm directly. Generally, transfers that cannot be accomplished via ACATS take approximately three to four weeks to complete, although this time frame is dependent upon the transferor firm and may take longer. Mutual Funds Some mutual funds cannot be held at all brokerage firms. This typically applies to proprietary and money market funds. These funds will need to be liquidated prior to transfer. Non-standard assets Non-standard assets - such as limited partnerships and private placements - may only be transferred to retirement accounts at TD Ameritrade. Additional fees will be charged to transfer and hold the assets. Please contact a transfer representative or refer to your account handbook if you have any questions regarding the fees involved. Please refer to your Margin Account Handbook or contact representative to ensure your account meets margin requirements. IRA debit balances If your firm charges a fee to transfer your account, a debit balance could occur once your transfer is complete. Avoid this by contacting your delivering broker prior to transfer. To resolve a debit balance, you can either: Liquidate assets within your account. Swiftly deposit physical stock certificates in your name into an individual TD Ameritrade account.

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They suggested that adjustable sutures need not necessarily be reserved for the more unpredictable or complex cases of strabismus (that is situations in which the use of adjustable sutures is commonly thought to be advantageous).