

For bronchospasm

Oxygen at least 40%.

- salbutamol, nebulised, 2.5–5 mg undiluted given over 3 minutes
Repeat 4–6 hourly.

OR

salbutamol 100 mcg, MDI, 2–4 puffs every 3 minutes

For severe allergic reaction, after resuscitation:

- prednisone, oral 0.5 mg/kg daily for 10 days

For urticaria, after resuscitation:

- chlorpheniramine, oral, 4 mg as a single dose

Observe all patients for at least 4–6 hours after stabilisation.

20.1.2 SHOCK

R57

20.1.2.1 HYPOVOLAEMIA

R57.1

DESCRIPTION

Loss of intravascular fluid, e.g. dehydration, haemorrhage or fluid shifts.

NON-DRUG TREATMENT

Control obvious bleeding with direct pressure. **Do not use tourniquets.**
Insert one or two large bore IV catheters, peripheral lines are adequate.

DRUG TREATMENT**INITIAL VOLUME RESUSCITATION**

- sodium chloride 0.9%, IV, 1–2 L
Monitor blood pressure, pulse and clinical response.

Most patients will respond to the initial fluid bolus.

If they respond initially and subsequently deteriorate, there may be an ongoing occult haemorrhage.

If no response occurs, consider:

- occult exsanguinating haemorrhage: intra-abdominal, retroperitoneal and intrapleural
- non-hypovolaemic shock: tension pneumothorax, myocardial contusion or myocardial infarct.

CONSIDERABLE HAEMORRHAGE

Blood transfusion is indicated.

Transfer to a specialist unit once stable.

20.1.2.2 TENSION PNEUMOTHORAX, SUSPECTED

J93.8

DESCRIPTION

Patient presents with decreased or absent breath sounds, tracheal shift and elevated JVP.

NON-DRUG TREATMENT

If clinical signs are present:

- 1: Emergency management: insert a large bore needle into the 2nd interspace, mid-clavicular line, then
- 2: place an intrathoracic drain.

Obtain a chest X-ray as soon as possible and a control chest X-ray after intrathoracic drain insertion.

**DRUG TREATMENT
PRECORDIAL PAIN**

Refer urgently if myocardial infarction is suspected and confirmed on ECG and the patient remains hypotensive.

Initiate therapy with:

- aspirin, soluble, oral, 300 mg immediately

PLUS

Assuming adequate central venous pressure, **inotropic drugs** e.g.:

- dobutamine, IV, 2–10 mcg/kg/minute as needed to achieve desired response
Dilute in dextrose 5% or in sodium chloride 0.9%. Lower doses may be given initially.

Administer under constant ECG monitoring.

20.1.2.3 NEUROGENIC SHOCK

R57.8

**DRUG TREATMENT
MILD TO MODERATE HYPOTENSION**

For patients requiring a vasopressor agent:

- phenylephrine, IM, 25 mg, immediately

SEVERE HYPOTENSION

- phenylephrine, continuous IV infusion, 100–150 mcg/minute
After blood pressure has stabilised, give maintenance rate of 40–60 mcg/minute.
Dilute 10 mg or more in 200 mL sodium chloride 0.9% or dextrose 5% to make desired concentration.

OR

For cardiac arrest, asystole and pulseless ventricular tachycardia:

Administer CPR and/or cardioversion, with tracheal tube in place and vascular access, together with:

- adrenaline 1:1 000, **IV**, every 3 minutes until patient's arrest has resolved

OR

adrenaline, endotracheal, 3–5 mL of 1:10 000 solution every 3 minutes until patient's arrest has resolved

To make a 1:10 000 solution: dilute 1 mL in 9 mL sodium chloride 0.9%.

Restore blood volume adequately.

20.1.2.4 SEPTIC SHOCK

A41.9

DRUG TREATMENT

The following may be required:

- adequate fluid resuscitation of up to 6 L in the first 6 hours
- additional inotropic support
- a central venous line to monitor fluid administration.

- adrenaline, IV infusion, 2–10 mcg/minute
Dilute 4 ampoules of adrenaline (1 mg/mL) in 200 mL sodium chloride 0.9% and infuse at 5 mL/hour (= 2 mcg/minute).

PLUS

appropriate antibiotics

20.1.2.5 PULMONARY OEDEMA, ACUTE

J81

DESCRIPTION

A life-threatening condition with abnormal accumulation of fluid in the lungs. Acute heart failure is a common cause.

NON-DRUG TREATMENT

Maintain open airway.

Administer oxygen.

Bed rest in Fowler's position, unless hypotensive or comatose.

Correct electrolyte disturbances.

Determine and correct any arrhythmias.

Venesection may be required if other interventions do not succeed, but to be effective must be done quickly by using a large bore needle, withdrawing 500 mL within 10 minutes.

DRUG TREATMENT

- furosemide, IV, 20–80 mg initial dose
May be repeated 15 minutes later if symptoms persist.
- morphine, IV, 10 mg
Dilute 10 mg up to 10 mL with sodium chloride 0.9% and administer 1 mg/minute up to a maximum of 10 mg.

Nitrates

- isosorbide dinitrate, SL, 5 mg 6 hourly or more frequently
Monitor closely.

OR

glyceryl trinitrate, IV, 1–2 mcg/kg/minute diluted in sodium chloride 0.9%
Titrate according to response.

If hypotensive consider inotropic support, e.g. :

- dobutamine, IV infusion, 2–20 mcg/kg/minute
Dilute in dextrose 5% in water or sodium chloride 0.9%.

Administer under constant ECG monitoring.

20.2 INJURIES

T14

20.2.1 BURNS

T30.0

DESCRIPTION

Skin and tissue damage caused by:

- exposure to extremes of temperature
- contact with an electrical current
- exposure to a chemical agent
- radiation

ASSESSMENT OF BURNS

Depth of burn	Degree	Surface/ colour	Pain sensation
Superficial (Partial loss of skin)	1 st	Dry, minor blisters, erythema	Painful
Partial A (Superficial dermal)	2 nd A	Blisters	Painful
Partial B (Deep dermal)	2 nd B	Moist white slough, red mottled	Painful
Full thickness (Deep/complete loss of skin)	3 rd	Dry, charred whitish	Painless

NON-DRUG TREATMENT

Remove smouldering or hot clothing.

Immerse the burnt area in cold tap water to limit the extent of the burn.

Clean and dress wounds appropriately.

Early intubation if hypoxic or drop in oxygen saturation and ventilation or if soft tissue swells, as these patients frequently tend to develop respiratory failure.

Support vital organ function.

IV access should be obtained to administer intravenous fluids in e.g. shocked patients.

Look for aggravating comorbidities, e.g. seizures, hypokalaemia and renal failure.

Clean superficial burns can be managed by occlusive dressings. Do not use “burnshield” on full thickness wounds and on extensive surface area wounds.

While waiting transfer to a major burn centre, cover wound with cling wrap.

Deeper wounds may have to be excised and grafted.

Rehabilitation.



CHAPTER 20

EMERGENCIES AND INJURIES

DRUG TREATMENT

Intravenous fluids

If required, as soon as possible:

- sodium chloride 0.9%, IV

Anlagesia

Ensure adequate analgesia particularly at change of dressing, i.e.:

- morphine, IV, 0.1 mg/kg as a bolus
Thereafter titrated according to effect with a maximum of 10–15 mg every 3–4 hours.

Immunisation, primary or booster:

- tetanus toxoid vaccine, IM, 0.5 mL immediately

Burn dressing

- povidone iodine 5% cream

OR

silver sulfadiazine cream 1%

Cover with paraffin gauze.

- gentamicin, ophthalmic drops, instil 1 drop 4–6 hourly during the day

GASTRIC ULCER PROPHYLAXIS

- sucralfate, oral, 1 g 6 hourly

Note:

The pharmacokinetic profile of certain drugs may be altered and will require appropriate dose adjustments.

REFERRAL CRITERIA

- burns > 15% body surface area (BSA) or > 10% BSA if over 50 years
- burns of face, hands, feet, genitalia, perineum or involving joints
- electrical burns, including lightning burns
- chemical burns
- inhalation injury or burns
- burns associated with major trauma



CHAPTER 21 DRUGS USED FOR CERTAIN CONDITIONS

21.1 ANAESTHESIOLOGY

DRUGS FOR INDUCTION

- diazepam
- etomidate
- ketamine
- midazolam
- propofol
- thiopental sodium

INHALANTS

- halothane
- isoflurane

ANALGESICS

- fentanyl
- morphine

MUSCLE RELAXANTS AND RELATED DRUGS

- atracurium besylate
- glycopyrronium bromide
- neostigmine
- suxamethonium chloride
- vecuronium bromide

LOCAL ANAESTHETICS

- bupivacaine
- bupivacaine 5 mg/mL plus dextrose
- lidocaine 1%
- lidocaine 2%
- lidocaine 2% plus adrenaline
- lidocaine jelly
- lidocaine topical spray

OTHER DRUGS

- adenosine:
 - For rapid reversion to sinus rhythm of paroxysmal supraventricular tachycardias. Beware of atrial fibrillation or flutter with accessory pathway. Contra-indicated in 2–3 AV block. Cardiac monitoring is essential.
 - Dose: 6 mg by rapid IV injection over 1–2 seconds. If ineffective after 2 minutes, follow with 12 mg over 1–2 seconds. Follow immediately with sodium chloride 0.9%.

- adrenaline
 - antacid mixture
 - atropine
 - calcium, IV
 - dantrolene:
 - For malignant hyperthermia.
 - Dose: 1 mg/kg by rapid IV injection.
 - Repeat as necessary to cumulative maximum of 10 mg/kg. Avoid extravasation.
 - dextrose 50%, IV
 - dobutamine
 - esmolol
 - furosemide, IV
 - glyceryl trinitrate
 - heparin, 5 000 units/mL
 - hydrocortisone, IV
 - insulin, soluble, short acting
 - isosorbide dinitrate
 - isosorbide mononitrate
 - lanolin eye ointment, liquid
 - magnesium, IV
 - mannitol, IV
 - metoclopramide, IV
 - naloxone
 - neostigmine (post op)
 - oxytocin
 - phenylephrine:
 - For acute hypotension, i.e. systolic < 70 mmHg, where other measures have failed, or where a tachycardia may be undesirable.
 - May decrease kidney perfusion.
 - Dose: 180 mcg/minute by IV infusion, reduced to 30–60 mcg/minute according to response.
- OR**
- In theatre: slow IV infusion of a 1 mg/mL solution; 100–500 mcg, repeated as necessary after at least 15 minutes.
 - potassium, IV
 - promethazine, IV
 - salbutamol, inhaler
 - salbutamol, IV
 - sodium bicarbonate 4.2%

21.2 TOTAL PARENTERAL NUTRITION SOLUTIONS

Normally, nourished patients will not be severely affected by going without food for as long as 7–10 days. Hence parenteral nutrition should not be considered under these circumstances unless there is a hypercatabolic state and the enteral route is not appropriate. Early consultation with a dietician is recommended for patients.

"If the gut works, use it" is useful. The gastrointestinal tract is always the preferred route.

Potential benefits of enteral nutrition include:

- prevention of gut atrophy
- reduction in bacterial translocation
- enhanced immunomodulation of antigens
- attenuation of the metabolic response to various cytokines and endotoxin.

GENERAL INDICATIONS FOR TPN

- in patients with small-bowel obstruction secondary to inflammatory adhesions
- when adequate enteral nutrition cannot be established within 1 week of hospitalisation
- in patients with enterocutaneous fistulas, both high and low

It is recommended that a TPN preparation that can be reconstituted in the ward be used in preference to those that need to be mixed in a sterile pharmacy unit.

Relative contraindications to early enteral feeding:

- bowel obstruction (absolute)
- small bowel ileus (absolute)
- short-bowel syndrome
- high-output gastrointestinal fistulas
- necrotising pancreatitis
- intra-abdominal sepsis

21.3 ORAL MICRONUTRIENTS

- ascorbic acid
- thiamine
- pyridoxine
- folic acid
- niacin
- vitamin B complex
- multivitamin (RDAs and/or selenium and zinc)

21.4 DRUGS USED IN INTENSIVE CARE UNIT

It is advisable that the following drugs are available in ICU

- adrenaline
- aminophylline, IV
- amiodarone IV and oral
- atracuronium besylate
- atropine
- β -blocker, IV, long acting, e.g. atenolol
- calcium gluconate, IV
- diazepam
- dihydropyridine calcium channel blocker, long acting, e.g. amlodipine
- dobutamine
- furosemide, IV
- glyceryl trinitrate, IV
- heparin
- hydrocortisone, IV
- ipratropium bromide solution for nebulisation
- isosorbide dinitrate
- lidocaine 2%
- magnesium, IV
- mannitol
- metoclopramide, IV
- morphine
- naloxone
- neostigmine
- nifedipine
- phenylephrine
- phenytoin, IV
- potassium IV
- promethazine, IV
- salbutamol solution for nebulisation
- sodium bicarbonate 4.2%
- sodium nitroprusside
- suxamethonium chloride
- thiopental sodium
- verapamil IV

21.5 DIAGNOSTIC CONTRAST AGENTS AND RELATED SUBSTANCES

- antacid mixture
- bowel preparation, e.g. sodium phosphate
- barium sulphate suspension enema
- barium sulphate powder
- hyoscine butylbromide
- iohexol
- iopamidol
- iopromide
- ioversol 300 and 350
- lidocaine 1% jelly
- meglumine amidotrizoate plus sodium amidotrizoate
- meglumine iothalamate
- metoclopramide
- sennosides A and B mixture
- sodium bicarbonate
- sodium iopodate capsules
- sodium iothalamate infusion

21.6 INTRAVENOUS FLUID THERAPY

AIMS OF FLUID THERAPY

Aims of fluid therapy include:

- to restore blood volume
- to restore an effective circulation by correcting a contracted ECF volume
- to correct true “dehydration” i.e. expand a contracted ICF volume
- to provide for ongoing losses or “maintenance” requirements

It is important to decide at the outset which body fluid compartment has the fluid deficit so that fluid which preferentially expands that compartment may be selected. In healthy males total body water (TBW) is 60% of mass, and 50% in females. Of this, $\frac{2}{3}$ is inside cells (ICF) and $\frac{1}{3}$ outside (ECF) in plasma and interstitial fluid.

Clinical assessment of ECF volume is difficult. A typical history, and signs of low JVP, BP, and tachycardia, with marked postural changes should be sought but are often absent. Useful laboratory tests to support or confirm a clinical suspicion include a rise in haematocrit or plasma protein concentrations, and a “pre-renal” ratio of plasma urea (mmol/L) to creatinine (micromol/L), which approaches 1:10 rather than the usual 1:20. To guide therapy, an estimate should then be made of the deficit e.g. 10% or 15% of an ECF volume of \pm 10 L or 15 L.

Contraction of the ICF compartment (“shrunken cells”) is present when there is hypernatraemia. As a rough guide, the percentage increase in plasma Na concentration is equal to the percentage of the ICF water deficit.



CHAPTER 21

DRUGS USED FOR CERTAIN CONDITIONS

SELECTION OF INTRAVENOUS FLUID

In general, infusion of hypotonic fluids should be avoided.

Firstly, most hospitalised patients who are ill will have non-osmotic release of ADH. They may therefore be unable to deal with a water load and are prone to develop acute hyponatraemia. The clinical effects will be most severe in patients with small muscle mass (females, malnutrition) or high brain-to-skull volume (children, young adults).

Secondly, the water requirements to replace "insensible losses" in inactive, hospitalised patients are often over-estimated, unless there is clearly fever and increased sweating.

Note:

Most patients with hyponatraemia on presentation will have chronic hyponatraemia (duration > 48 hours). The major danger here is that of serious brain damage from too-rapid correction of plasma Na concentration.

When there are "swollen cells" in the setting of acute hyponatraemia (< 48 hours duration), therapy in the symptomatic patient is to raise the ECF osmolality rapidly by administration of hypertonic saline. Most of these cases will develop in hospital or will be seen in the setting of psychogenic polydipsia, marathon running or "ecstasy" use.

If the ECF volume is being expanded, isotonic fluid is required.

The default choice in most circumstances is isotonic saline, i.e.:

- sodium chloride 0.9%

There should be a good reason for selecting another option.

When it is necessary to infuse alkali as well as re-expand the ECF volume, e.g. in patients with cholera whose stool losses contain significant amounts of bicarbonate:

- Ringer-Lactate

Volumes infused must be based on the estimated deficit in the ECF volume (see above) and an assessment of ongoing losses.

Note:

Some glucose-containing fluids like rehydration fluid are initially "isotonic" but once the dextrose is metabolised it is really hypotonic (sodium chloride 0.45%). If glucose is needed, use:

- sodium chloride 0.9% with dextrose 5%

If there is hypernatraemia due to water deficit and therefore "shrunken cells", hypotonic fluids, e.g.:

- sodium chloride 0.45%

OR

dextrose 5%

Avoid over-correction by quantifying the deficit as stated above.



CHAPTER 21

DRUGS USED FOR CERTAIN CONDITIONS

21.7 MALIGNANCIES

The aim of this section is to ensure a seamless drug availability of oncostatic chemotherapy at secondary level.

- bleomycin
- busulfan
- chlorambucil
- cyclophosphamide
- dacarbazine
- doxorubicin
- epirubicin
- fludarabine
- 5-fluorouracil
- folinic acid
- hydroxyurea
- mechlorethamine
- mitoxantrone
- procarbazine
- tamoxifen
- vinblastine
- vincristine

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GUIDELINE ON EDL REVIEW PROCESS AND SUBMISSION FOR AMENDMENTS

The National Essential Drugs selection process is based upon a well-developed network of provincial, district and institutional Pharmacy and Therapeutics committees.

Motivations for inclusion in the list will only be considered if:

- The prescribed form has been fully completed.
- The motivators' contact details are complete.
- The drug name has been stated.
- The submission has been evaluated and approved by the provincial Pharmacy and Therapeutics Committee (PTC).
- The indication has been clearly stated.
- All relevant comparator drug/s have been listed.
- There is sufficient evidence to support the proposed amendment.

Motivations may address major or minor amendments.

Major amendments include:

- new indications
- new therapeutic entities
- new therapeutic classes

All major amendments must be supported by evidence reflecting safety, efficacy and cost of the medicine compared to an already listed drug for the same indication.

A major amendment may also include motivations for drugs not listed and for conditions not addressed in the EDL. In such cases submissions must be supported by demographic data.

Minor amendments include:

- new formulations
- combination therapies of existing essential drugs

For minor amendments the supporting evidence should be relevant to the nature of amendment.

Screening

Motivations are screened by the Rational Selection Group (RSG) at the National Department of Health to ensure that:

- the submission has been approved by the provincial PTC
- the motivators' contact details are included
- the drug can be identified in terms of the INN
- an indication has been included
- relevant comparator drug/s have been identified with their corresponding dosing regimens
- there are supporting references to substantiate the request



GUIDELINE ON EDL REVIEW PROCESS AND SUBMISSION FOR AMENDMENTS

RSG will compile a review of the prevailing cost of therapy.

Submissions that have been accepted by RSG are tabled at the relevant technical subcommittee for allocation to a suitably qualified reviewer who compiles a technical report. This technical report summarizes a review of the submitted data in terms of the following:

- relative safety
- relative efficacy
- practice environment - the focus here being efficacy relative to current EDL drugs
- pharmacoeconomic evaluation

The report is then presented to the technical subcommittee. The committee may request further information from the applicant through the province or commission a literature search and review.

The technical subcommittee will make recommendations to the National Essential Drug List Committee (NEDLC) for approval or rejection. Where the NEDLC is of the opinion that further review is required the decision will be sent back to the technical subcommittee for further review.

The data elements of the submission form

The motivation form is divided into 5 sections.

SECTION 1: PROPOSAL

The proposal consists of:

- a) The International Nonproprietary Name (INN) of the medicine – this identifies a pharmaceutical substance or active pharmaceutical ingredient by a unique name that is globally recognized and is public property. A nonproprietary name is also known as a generic name.
- b) Level of Care - indicate whether the proposed medicine should be listed for use at primary care (PHC) or hospital level (Note drugs at PHC level are automatically included at the hospital level).
- c) Prescriber level - indicate the level of competency required to prescribe the drug.

SECTION 2: MOTIVATORS' DETAILS

The NEDLC will acknowledge all submissions and communicate decisions with supporting arguments where appropriate. This section therefore forms a vital link between the motivator and the decision making process.



GUIDELINE ON EDL REVIEW PROCESS AND SUBMISSION FOR AMENDMENTS

SECTION 3: PROPOSED INDICATIONS

a) Indication

Points to consider:

- The EDL targets those conditions that are the most prevalent in South Africa. Where the motivator suggests an indication not currently reflected in the EDL, a brief motivation based upon South African epidemiological data must be included as an annexure.
- The indication allows for the identification of the appropriate comparator in the current EDL.
- Many drugs have multiple indications. However, not all are equally cost effective.

b) Proposed Regimen

This data will be used for cost comparison and is very important for pharmacoeconomic evaluation.

c) Cost assessment

The information is necessary for the determination of affordability. It is expected that the provincial PTC will deliberate about the affordability during their review prior to submission to NEDLC. For this reason, this data is considered mandatory at the national level.

SECTION 4: DRUGS ON THE CURRENT EDL FOR THE SAME INDICATION

As a principle, the addition of an EDL item should replace an existing item. This is of particular importance when safety and economic implications are taken into account.

Evidence

Evidence is a vital component of the submission and review process. Evidence does not constitute a drug decision and merely informs the strength of the argument. It forms the basis upon which the decision is made and allows for transparent scrutiny of the decision as well as facilitating the review.

Evidence is required in support of:

- relative efficacy
- relative safety
- pharmacoeconomic benefits

Note

Evidence needs to be relevant to the South African context. Multinational or foreign studies must be supported by a motivation of the relevance of both the outcome measures as well as socio-economic facets to the South African context.

The inclusion of at least one relevant reference is mandatory. A copy of the full journal article should be included in order to expedite the review process.

SECTION 5: FOR USE AT NATIONAL LEVEL ONLY

This section is intended to ensure that the submissions have followed the proper process.



DEPARTMENT OF HEALTH
Republic of South Africa

Motivation Form for the Inclusion of a Drug on the National Essential Drugs List

Please complete Sections 1 to 4 in full

SECTION 1

NB - Only use INN (International Nonproprietary Name/Generic names) on this form

Proposed Drug

For Inclusion on the Essential Drug List for PHC Hospital *Check all appropriate blocks*

Prescriber Level Primary Health Care - 1 Medical Officer -2 Specialist -3 Designated Specialist - 4

Submission Date

PTC Title

SECTION 3

Proposed Indication

See reverse side for the level of evidence schedule

Indication	Proposed Regimen		
	Dose	Route	Interval
			hour
			hour
			hour

Level Of Evidence Ia Meta-analysis Ib Randomized Controlled Trial II Control
 IV Expert committee V Clinical experience

SECTION 4

Drugs on the Current EDL for the Same Indication

Drug	Indication <i>as per list above</i>			
		Dose	Route	Interval
1				hour
2				hour
3				hour

SECTION 5

FOR NATIONAL USE ONLY

Correspondence Date received / / Acknowledged / /

Evidence No of articles submitted:

For National Evaluation Yes No Further evidence Motivation New

Decision Accepted / Rejected /



SECTION 2							
Motivator's Details							
Title		Name					
Tel No	Code		Number				
Fax No	Code		Number				
Postal Address							
						Code	
E Mail							

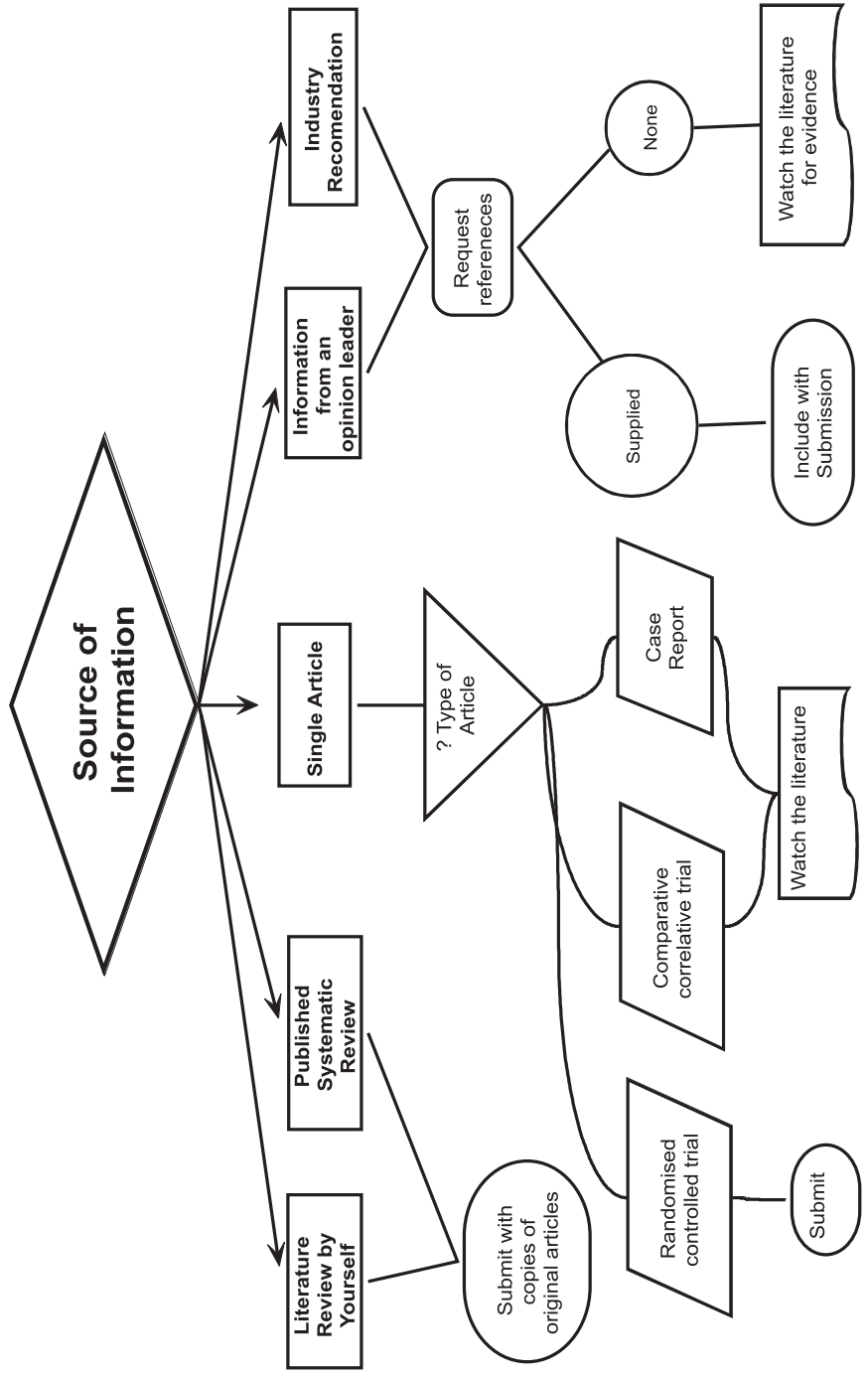
Cost assessment					Level of Evidence
	Duration	Cost/Unit	Cost per Day	Cost per Course / Month	
hourly	Days	R /	R	R	
hourly	Days	R /	R	R	
hourly	Days	R /	R	R	

II Controlled study with no randomization III Comparative, correlation or case control
NB The literature review on the reverse side must support this

Cost Assessment						Can Be Replaced by Proposed Drug
Route	Interval	Duration	Cost/Unit	Cost per Day	Cost Per course /month	
	hourly	Days	R /	R	R	Yes / No
	hourly	Days	R /	R	R	Yes / No
	hourly	Days	R /	R	R	Yes / No

/ /	Request for more evidence	/ /
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New Drug	Standard Therapeutic Guideline New/Change	Prescriber level
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Levels of Evidence **Ia** Meta-analysis **Ib** Randomized Controlled Trial **II** Controlled study with no randomization. **III** Comparative correlation or case study
IV Expert committee **V** Clinical experience

Evidences (articles or abstracts) included with your submission

Heading					
Journal name	Vol.	Date	Pages	Level of evidence	-
Included	Full article	Abstract			

Heading					
Journal name	Vol.	Date	Pages	Level of evidence	-
Included	Full article	Abstract			

Heading					
Journal name	Vol.	Date	Pages	Level of evidence	-
Included	Full article	Abstract			

Heading					
Journal name	Vol.	Date	Pages	Level of evidence	-
Included	Full article	Abstract			

Heading					
Journal name	Vol.	Date	Pages	Level of evidence	-
Included	Full article	Abstract			

Comments
