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MedOne Otolaryngology 是一種獨特的線上資源，為全球耳鼻喉科社群提供前所未有**所有Thieme耳鼻喉科學系列**資源。

MedOne Otolaryngology 專注於臨床專科應用，因此住院醫師和臨床醫師可以找到專屬的最新資訊。Thieme為世界各地的耳鼻喉科醫生帶來屢獲殊榮的內容，因此外科醫生可以為患者提供高品質的醫療。



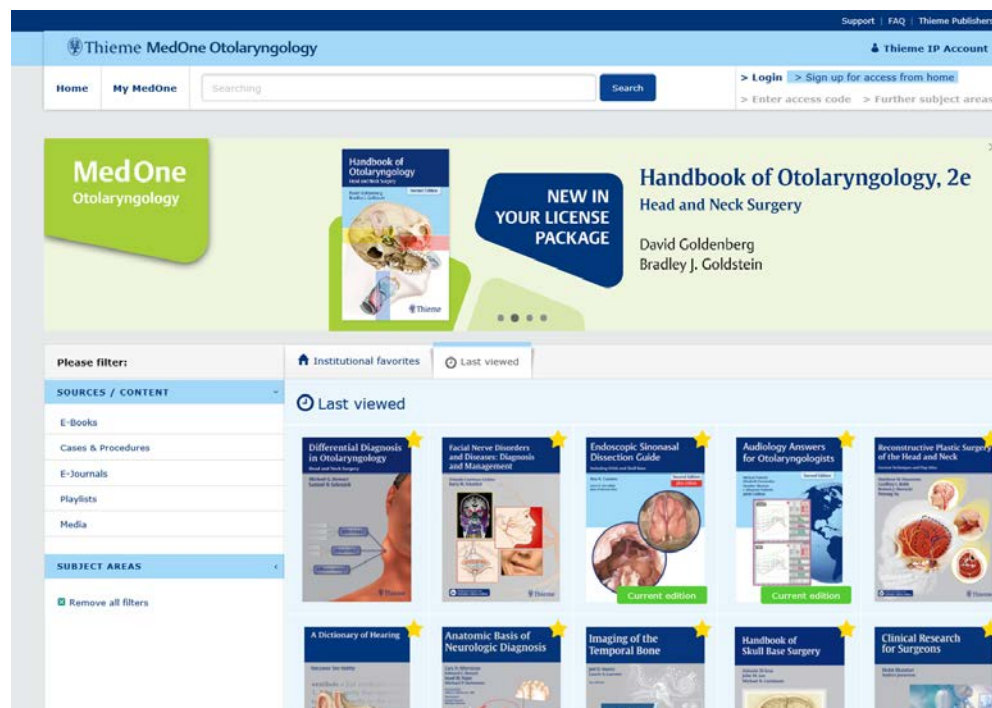
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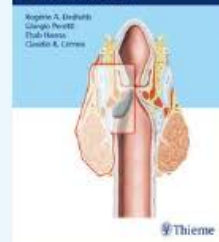
Key Topics in Otolaryngology



Neck Dissection



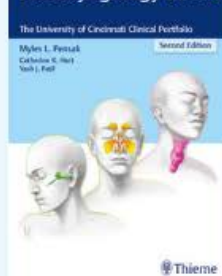
Laryngeal Cancer



The Temporal Bone: Anatomical Dissection and Surgical Approaches



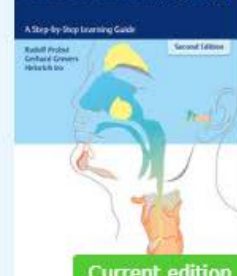
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L. Maureen Valente, Jamie Cadieux

Audiology Answers for Otolaryngologists

Source: Valente L, Cadieux J, ed. 2nd Edition. Thieme; 2017. doi:10.1055/b-006-149768

Content Images Hits

1 Psychoacoustics

2 Audiometric Testing

3 Vestibular Evaluation

4 Amplification

5 Pediatric Audiology

6 Doctoral Education in Audiology

1 Psychoacoustics

Quick access

What Is the Difference between dB HL and dB SPL?

The decibel (dB) is a logarithmic unit of measurement used to express the magnitude of a sound relative to some reference level. Decibels in hearing level, or dB HL, is commonly used in audiology because it refers to the dB level on the audiometer. The reference level for dB HL is "0," which is related to the average threshold in decibels sound pressure level (dB SPL) for the average, normal-hearing listener. In Fig. 1.1, the solid black line represents the average auditory threshold in dB SPL at each audiometric frequency. Each threshold in dB SPL, which is noted in the table at the bottom of Fig. 1.1, is equal to 0 dB HL on the audiometer for the corresponding frequency.

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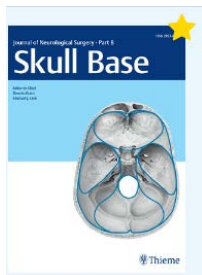
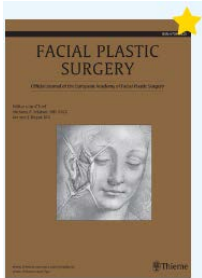
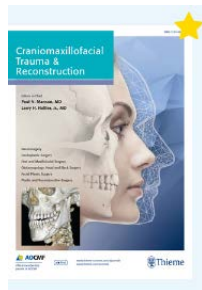


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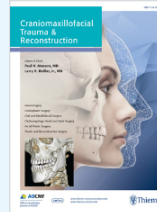
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Craniomaxillofacial Trauma & Reconstruction 02/2018

Craniomaxillofacial Trauma & Reconstruction 02/2018



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The Role of Postoperative Imaging after Orbital Floor Fracture Repair

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Craniomaxillofacial Trauma & Reconstruction 2018; 11(02): 096 - 101
DOI: 10.1055/s-0038-1625949

Original Article

Carpenter, David; Shammass, Ronnie; Honeybrook, Adam; Brown, C.; Chapurin, Nikita; Woodard, Charles

The Role of Postoperative Imaging after Orbital Floor Fracture Repair

Division of Head and Neck Surgery and Communication Sciences, Duke University Medical Center, Durham, North Carolina
Division of Plastic Surgery, Duke University Medical Center, Durham, North Carolina

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Methods | Results | Discussion | Conclusion | Disclosure | Note | References

Abstract

Obtaining postoperative images of maxillofacial fractures does not affect the clinical management of asymptomatic patients; however, few studies have evaluated the role of postoperative imaging in the context of orbital floor fractures. In this study, we evaluate current practice techniques and the role of postoperative imaging in the management of orbital floor fractures in isolation and with concomitant facial fractures. Retrospective review of patients who underwent open reduction and internal fixation of orbital floor fractures between 2005 and 2015 at a single medical institution. Operative and perioperative records were reviewed to characterize postoperative imaging as routine or as indicated by concerning clinical symptoms, and to correlate clinical outcomes to postoperative imaging patterns across all identified orbital floor fractures. A total of 139 patients underwent open reduction and internal fixation of orbital floor fractures. Of these, 75 (54%) had zygomaticomaxillary (ZMC) involvement. The remaining 64 (46%) were isolated orbital floor fractures. Overall, 54 (39%) patients underwent postoperative imaging. Of these, 38 (70%) had postoperative imaging in the absence of concerning clinical symptoms. There was no observed difference in complication rates in those who underwent postoperative imaging, and those who did not. Patients with orbital + ZMC fractures underwent a significantly higher number of postoperative imaging studies ($p < 0.001$); however, there was no observed difference in complications between isolated orbital and orbital + ZMC fractures. Routine postoperative



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收錄上百件案例的管理與追蹤提示

Tonsillitis

Case

Source: Pensak M, ed. *Otolaryngology Cases. The University of Cincinnati Clinical Portfolio*. 2nd Edition. Thieme; 2017. doi:10.1055/b-006-149761

66 Tonsillitis

- 66.1 History
- 66.2 Differential Diagnosis—Key Points
- 66.3 Test Interpretation
- 66.4 Diagnosis
- 66.5 Medical Management
- 66.6 Surgical Management
- 66.7 Rehabilitation and Follow-up
- 66.8 Questions
- Suggested Readings

Part XI General Otolaryngology > 66 Tonsillitis

Tonsillitis

Andrew J. Redmann and Reena Dhanda Patil

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66.1 History|66.2 Differential Diagnosis—Key Points|66.3 Test Interpretation|66.4 Diagnosis|66.5 Medical Management|66.6 Surgical Management|66.7 Rehabilitation and Follow-up|66.8 Questions|Suggested Readings

66.1 History

A 51-year-old man presented to the emergency department with a 2-day history of low-grade fever, worsening sore throat, odynophagia, right otalgia, and muffled voice. He denied any difficulty breathing or handling his oral secretions. He had similar symptoms 3 years ago and was diagnosed with a peritonsillar abscess. This was drained in the emergency department. Additionally he reported approximately three episodes of pharyngitis per year for the last 3 years. These had all been treated with antibiotics, which improved his symptoms. His medical history was significant for gastroesophageal reflux disease (GERD) and obstructive sleep apnea, which resolved following an intentional 40-lb weight loss. He was a prior three-pack-per-day smoker but currently only smoked eight cigarettes per day.

Physical exam revealed an adult man in no acute distress. Temperature was 101.1 °F. All other vital signs were within normal limits. Ear and nasal exams were normal. Intraoral examination revealed erythematous oropharyngeal mucosa. Tonsils were 1 + bilaterally, with the right tonsil appearing slightly larger than the left tonsil. There was no uvular deviation or soft palate fullness (► [Fig. 66.1](#)). Neck examination revealed bilateral shotty lymphadenopathy but full range of motion.



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提供125個外科手術流程的逐項說明

Deep Tongue Abscess

Procedure

Source: [Theissing J, Rettinger G, Werner J, ed. ENT Head and Neck Surgery: Essential Procedures](#). 1st Edition. Thieme; 2010.
doi:10.1055/b-002-79384

Deep Tongue Abscess

- Surgical Principle
- Anesthesia
- Surgical Technique
- Postoperative Care

9 Surgery of the Oral Cavity and Oropharynx > Surgery for Abscesses of the Oral Cavity > Deep Tongue Abscess

[Jürgen Theissing](#), [Gerhard Rettinger](#), [Jochen Alfred Werner](#)

Deep Tongue Abscess

Quick access

[Surgical Principle](#)|[Anesthesia](#)|[Surgical Technique](#)|[Postoperative Care](#)

Surgical Principle

Incision and drainage always from an external approach.

Anesthesia

Usually general endotracheal anesthesia.

Surgical Technique

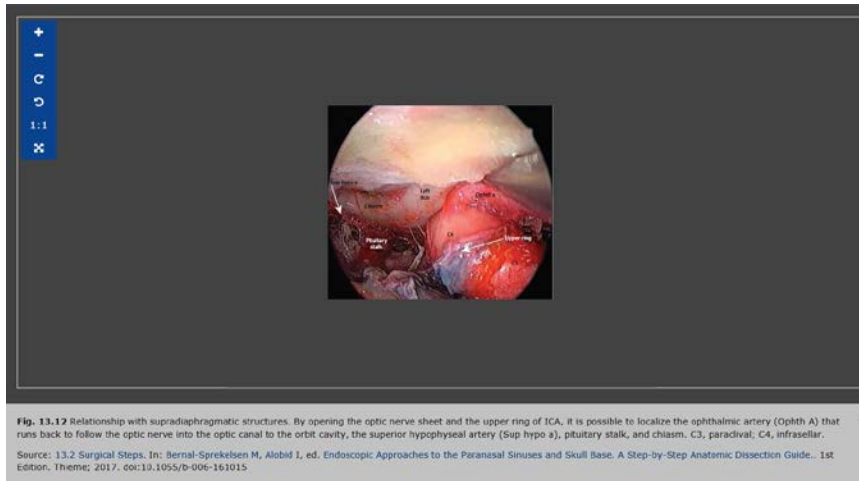


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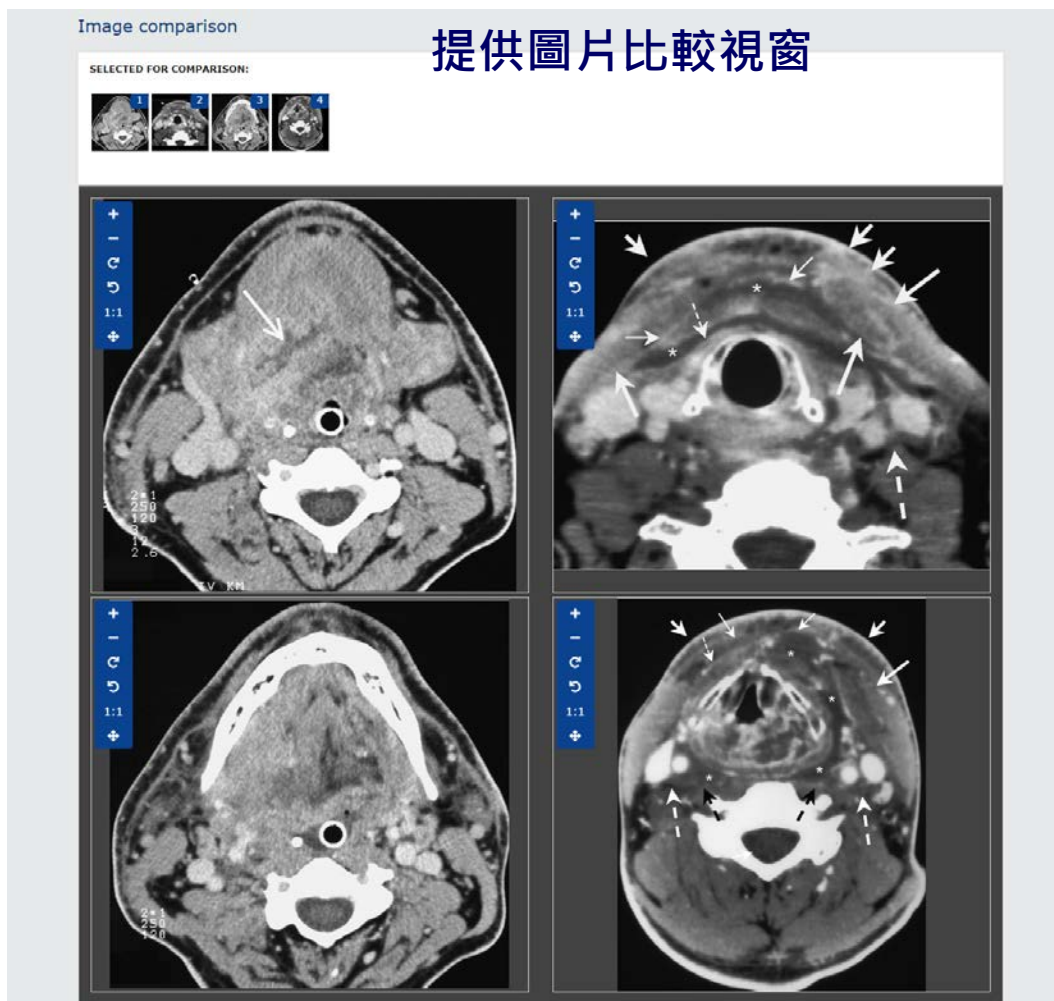
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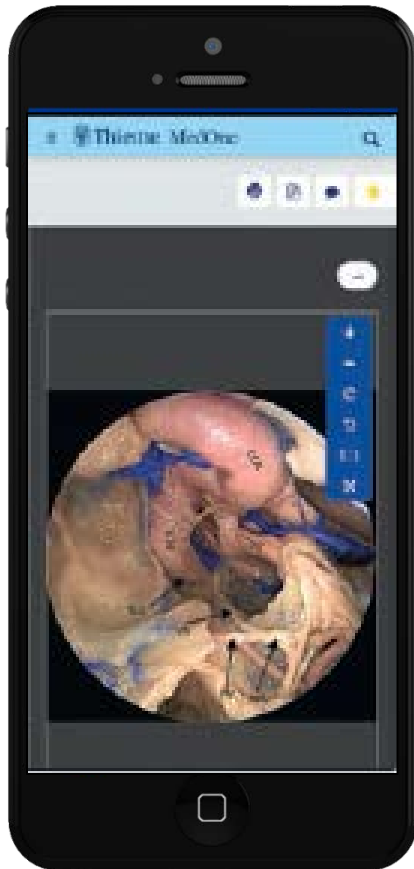
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