Caduceus

A Publication of the Medical Division of the American Translators Association

SUMMER 2008

CONTENT: Part One

Enjoy the Summer

Summer 2008

Caduceus is a quarterly publication of the Medical Division of the American Translators Association, a non-profit organization dedicated to promoting the recognition of translating and interpreting as professions.

Please mail all correspondence and contributions to: bukrak@bellsouth.net

Elizabeth Abraham leads off our Summer 08 issue with a detailed personal view of what the Canadian medical system, within which she works, is like.

Dr. José R. Martí's topic for his **Surgical Perspectives** column is dedicated to cancer of the breast. In a separate note, he also tells us about Anesthesia Awareness, a topic recently in the news.

A review by M. Eta Trabing of the very successful medical seminar held in Houston under the auspices of ATA and HITA appears in this issue followed by a cardiovascular terminology glossary in English, Spanish and German.

Alzheimer's is on everyone's mind: those who have it, those who don't and those who wonder if AD will befall them. The incidence figures keep rising. Two separate notes on the subject appear in this issue.

Dr. Jim McAninch is on vacation. I have used this space for an Infection Glossary. Dr. Elena Sgarbossa continues her search for interesting emerging terms and acronyms.

Suzanne Couture completes her series on Health Care with: **WHERE**.

Stay well,

Rafael

Instructions to Authors

Submissions for publications must be sent electronically in Word format. The deadline for submissions for the Fall/Winter issue of ***Caduceus*** is 1 September, 2008.

Caduceus carefully reviews its content in order to eliminate any textual errors. Nevertheless, we apologize for any errors in grammar, punctuation, typography and the like which may inadvertently appear on our pages.

Caduceus

A PUBLICATION OF THE MEDICAL DIVISION OF ATA

by Esther Diaz

Boy is it hot outside! Especially in Atlanta, where the National Council on Interpreting in Health Care (NCIHC) held its annual meeting in June, followed by the 1st Southeast Regional Medical Interpreter Conference. In the next few months, other local organizations will hold their conferences, too. This is an excellent opportunity to earn CE points at low cost. And there's so much to learn at these events! For example, at the NCIHC meeting we heard about the National Coalition on Health Care Interpreter Certification and were treated to a fun and lively debate on the conduit role. The Southeast Regional Medical Interpreter Conference featured presentations on Interpreting at the End of Life, and Improved Interviewing Skills for Interpreters. The fun continues into the fall. The upcoming Midwest Association of Translators and Interpreters (MATI) Conference will be held this September. I will present several medical terminology topics at the Tennessee Association of Professional Interpreters and Translators (TAPIT) Conference, September 12-14, and there will also be a presentation on Interpreting for Children in Medical, Forensic, and Legal Settings. The conference of the International Medical Interpreters Association (IMIA) will be held October 10-12 in Boston. It is the largest and best known medical interpreter conference. And, certainly, the biannual conference on Quality Healthcare for Diverse Populations —September 21-24 in Minneapolis— is a must-see!

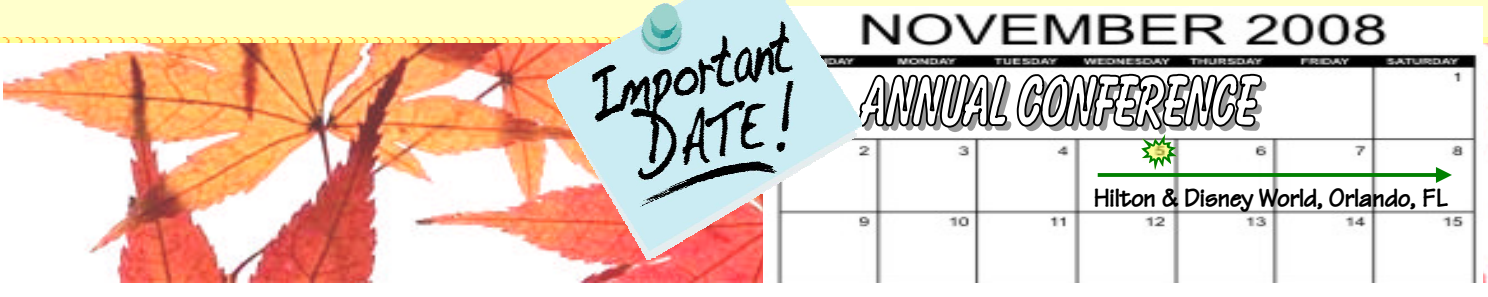
Of course, some of you got ahead of the game by attending ATA's Medical Professional Development Seminar in Houston in February. To find out what you missed there, see the related article by Eta Trabing in this issue of Caduceus. As a special bonus, this issue also features a glossary of cardiovascular terms in English, Spanish, and German. For a list of medical translation and interpreting organizations and related conferences and seminars, visit our website at www.ata-divisions.org/MD.

As we sit here sipping iced tea, it's not too early to start planning for the ATA Conference in Orlando this November. We have quite a lineup of sessions for you, including a pre-conference workshop on mental health with language-specific breakout groups, and a session on abused and battered children by a visiting pediatrician. Stay tuned to the MD listserv for more information. Also, be on the lookout for a survey asking what you would like the Medical Division to do for you, including your preference for the location of our 2009 mid-year conference.

PLANNING AHEAD : Fall/Winter 08

In the Fall/Winter, 08 issue of ***Caduceus***

- Breast Cancer Part II
- Preview of the Medical Division's activities during the ATA Conference in Orlando
- A proposed Medical Division survey of members' needs and interests is currently under review at ATA HQ.



Caduceus
A PUBLICATION OF THE MEDICAL DIVISION OF ATA

by Elizabeth Abraham

Community Interpretation in Canada's largest city: a snapshot of the present and a vision of the road ahead

When I first came to Canada from the U.S. in 1984, the phenomenon of universal access to health care seemed surreal to me.

Almost all hospitals are public, funded and administered by the individual provinces and supplemented by federal funding. Through this system, citizens and landed immigrants (the Canadian equivalent of green card status) receive a provincial health card which allows them to visit a doctor or get an MRI or a brain tumor removed or a hip replaced, for free. While there are waits for elective surgeries, emergency surgeries are usually accommodated through extended OR time or by bumping the electives.

Refugee claimants also receive free health care coverage from a federal insurance program. Whereas undocumented residents of Canada (referred to as "illegal aliens" in the U.S.) must pay for medical treatment (about $35 for a physician consult, a few hundred dollars for an emergency visit in Toronto), no one can be refused emergency treatment, regardless of their ability to pay for services. Imagine.

It's a remarkable system, although continually struggling towards a seemingly unattainable goal of sustainability. Notwithstanding perpetual budgetary constraints, it ensures that the health needs of the majority are met most of the time.

On the flip side, there are health disparities, particularly among the marginalized populations: the indigenous communities (particularly in the North), undocumented residents, the underhoused (homeless), and anyone who doesn't speak English or French.

Canada is known as a bilingual country, in that it has two official languages; contrary to popular belief abroad, only a very small percentage (0.3%) speak both. As in the U.S., however, the linguistic landscape has evolved significantly over the last 25 years following immigration trends.

The 2006 Census reveals that one in five residents report a mother tongue other than English or French, an 18% increase over the 2001 Census. These individuals are referred to as "allophones."

Of the 6.2 million allophones living in Canada (total population 31 million), 3.1 million reside in Ontario, 1.1 million in British Columbia and almost 900,000 in the province of Quebec. In several urban centers, and in many indigenous communities in Northern Canada, 80% or more of the residents are allophones. What was once a bilingual country could be described today as multilingual.

Canada's linguistic diversity is a strength, on the one hand, for all the reasons that diversity of any kind (cultural, gender, ability/disability) enriches a society; and on the other hand, a challenge for non-English or French speakers who need services, and for the providers serving this population.

The most challenged urban centers are Toronto, with 213,000 individuals with "no knowledge of English or French," equivalent to 4% of the city's population. Vancouver comes in second with 108,000 (5%), followed by Montreal with almost 60,000 (1.6%). I believe these numbers are highly underestimated, given the undocumented population, most of them allophones, that reside in Canada without status, and therefore unlikely to be represented in the Census.

Furthermore, note the term "no knowledge" as opposed to "limited knowledge." Unfortunately, the Census did not count individuals with *limited* English (or French) proficiency, which would have been useful in determining the number of

individuals who require interpretation in order to access services in the community.

Despite the sharp increase in allophone immigration, no specific funding from the federal or provincial governments is allocated for interpretation services to those cities, or the organizations within those cities, serving LEP/LFP patients. In contrast to the U.S., where LEP population is predominantly Spanish, the sheer diversity of languages in Canadian cities presents a challenge. Over 200 mother tongues were reported in the 2006 Census, with 145 languages spoken in Toronto.

Professionalization of community interpreters in Canada

Throughout Canada, advocacy groups have moved their agenda towards the broader field of Community Interpretation (CI), which covers the sectors of health, law and social services. These organizations are dedicated to raising the profile of the profession and lobbying government agencies to fund this essential need for its residents, particularly in cities highly populated with allophone immigrants.

A significant challenge is the fact that community interpretation lacks recognition as a profession. In Ontario, the Association of Translators and Interpreters of Ontario is the only body in Canada legislated by the provincial government to regulate the professions of translators, court interpreters and conference interpreters through a certification process. Only recently have they started to dialogue at the Board level and with the membership on the possibility of broadening their mandate to include community interpreters.

In addition to the recent interest within ATIO, the Canadian media brought community interpreting into focus with articles in both *The Toronto Star* and the *Vancouver Sun* in December 2007. In response to the former article, entitled "The City of Babel," the Canadian Translators, Terminologists and Interpreters Council issued a media release, stating:

"CTTIC is eager to assist [community interpreters] by letting them draw on the expertise already built in other segments of the profession. With the proper tools in place, they will be in a position to achieve professional certification, which in turn should allow for due recognition of the real value of their work in the community and in the judicial, health and other sectors of public service."

In the absence of a certification process, finding qualified interpreters to work in the healthcare sector is another challenge. Like the unregulated title of "therapist," many untrained bilingual individuals practice as community interpreters, placing the individuals receiving the service at risk.

Minimum standards for community interpreters should include a passing a CILISAT (Cultural Interpreter Language and Interpreting Skills Assessment Tool, visit www.cisoc.net) or ILSAT (Interpreter Language and Skills Assessment Tool, visit www.acrosslanguages.org). Both tests assess proficiency in English and a second language, the ability to interpret in both directions, and sight translation skills.

In addition, throughout Toronto various agencies offer a 70-hour training course in core competencies

for community interpreters (which costs approximately $500-600, depending on whether it contains a medical terminology component). For those recruiting interpreters, a passing CILISAT or ILSAT test score and a certificate from such a course is almost guaranteed a green light.

In 2004, the Toronto-based Healthcare Interpretation Network published *A Handbook for Trainers: Language Interpreting in the Healthcare Sector.* (www.healthcareinterpretationnetwork.ca)

In September 2006, seven Ontario community colleges launched the Language Interpreter Training Program - a180-hour program consisting of six modules. This was a great leap forward toward professionalization. Graduation from this program is the ideal qualification for community interpreters.

The Canadian-based group, Critical Link (*www.criticallink.org*), is a non-profit organization committed to the advancement of the field of community interpreting. It began in 1992 when it organized the first international conference on community interpreting. It continues to hold a conference every three years. A national conference will take place in Vancouver, British Columbia in 2009.

Late in 2007, the Healthcare Interpretation Network published the *National Standard Guide to Community Interpreting Services*, which includes a Code of Ethics. These *Standards* have been ratified by Critical Link Canada.

Lack of adequate funding

Canadian hospitals fare much the same way as hospitals do in the U.S., with a wide range of language service provision modalities, depending on support from senior management to fund the service—and buy-in from risk management departments. Even in Toronto, there are hospitals offering only well-meaning but untrained "volunteer interpreters" and hospitals with a combination of trained staff, contract and agency interpreters.

Most hospitals also employ telephonic interpretation services. Usage of these fee-for-service modalities varies among institutions, depending on the culture of the hospital and the providers' awareness of the importance of communication in diagnosis and treatment. The money comes from the lump sum, "global funding" provided annually to the hospital by the provincial ministry of health.

There is no reporting or recognition for the number of LEP/LFP patients serviced, only the number of medical services provided to all patients by the hospital during the previous fiscal period.

Patients are not charged for language services, where these are available. Moreover, I don't know of any hospital language department that charges the clinics that use an interpreter for patient encounters.

For hospitals that provide language services, managers have to decide between serving fewer patients with professional interpreters, or more patients with untrained interpreters. Given the high risk to patient safety in the event of communication error, the support of the hospital's legal department is critical.

Language rights in Canada—the road ahead

Section 15(1) of The Charter of Rights and Freedoms of Canada guarantees all residents of Canada, regardless of status, equal access to services:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, *national or ethnic origin*, colour, religion, sex, age or mental or physical disability. [*italics mine*]

Like Title VI in the U.S., it is a mandate without a legislative directive for funding to ensure that it is fulfilled.

Sign language interpreters enjoy a different status than their spoken language counterparts, due to a landmark decision of the federal Supreme Court in 1997, which obligated healthcare providers to supply sign language interpreters for Deaf, deafened and hard of hearing patients. Three Deaf patients in British Columbia filed a claim against a hospital for denying them access to services, charging discrimination based on physical disability, and challenging the Charter of Rights. The case ended up at the Supreme Court of Canada.

The Eldridge Decision (1997) states that, "where sign language interpreters are necessary for effective communication in the delivery of medical services, the failure to provide them constitutes a denial of the Charter of Rights."

While there was no specific funding in place to support this practice, the ruling itself empowered the deaf community, to the point where the patients themselves can and do book their interpreters through their local branch of the Canadian Hearing Society, and the CHS sends the invoice to the doctor's office, clinic or hospital.

While spoken language interpreters are not regulated, nor is their use explicitly legislated, these interpreters are still considered a frill, rather than a necessity. The burden of language facilitation continues to fall on family members that have to take off time from work not only to accompany their loved ones to medical appointments, but also to communicate serious diagnoses. Many family members lack the skills required for this work, but are not empowered, within the medical encounter, to disclose their limitations.

Within the increasingly multilingual landscape of Canada, the need for regulated community interpreting becomes more acute each year. We cannot continue to recruit close to a quarter of a million newcomers to Canada annually, hand out the golden health card and then turn our backs because, well, it's not our problem if they don't speak the language.

Similarly, we cannot embrace the concept of diversity without due concern for the groups that constitute our diverse population, which is more evident in Toronto than anywhere in Ontario. Denial of access to services, by failing to provide professional interpretation, is a violation of the Charter. A claim of this nature has yet to reach the Supreme Court.

Regulation of community interpreting, through ATIO and/or legislative reform, would enhance services provided to immigrants and refugees and mitigate the inherent risks of communication error in these sensitive fields. Professional community interpreters, and agencies that employ them, seek the support of regulating bodies to help enforce standards that guarantee clients a fair trial, a meaningful visit with a social worker or a safe visit to the doctor.

Language services are an intrinsic cost of healthcare to the Canadian population, more so today than even five years ago. Just as there is a cost to providing the physician, nurse, resident and diagnostic exams. Hopefully, one day, publicly funded services will include, for those in need, the provision of professional interpreters. This may not happen before a human rights claim for discrimination based on national origin makes its way to the Supreme Court of Canada.

Readers interested in the evolution of CI, or in the recent articles in the media, can visit the HIN website: *www.healthcareinterpretationnetwork.ca*.

by José R. Martí, MD

BREAST CANCER -- Part I

A brief review about the history and treatment of breast cancer

This year approximately 180,000 American women will develop breast cancer and 41,000 will die from it. Alarming, as this may seem, the outcomes and treatment options for this disease have, in fact, improved. Let's look at the history of breast cancer.

The breast cancer saga started towards the end of the Victorian era in Great Britain. England was bouncing back from the industrial revolution, machines were replacing humans and people were being laid off (*does it sound familiar?*). England started to shift from a pragmatic utilitarian philosophy, towards a more humanistic way of thinking (*remember Oliver Twist?*). The awareness of mental illness, increased though it was, considered it an incurable disease. Those patients were admitted to psychiatric institutions where they received a kind and humanitarian type of care; but they were denied of any form of medical treatment; they were considered incurable. However, true to British tradition, their clinical records were precise and meticulous. Several decades later, around the turn of the century, Dr. Bloom, a statistician in England, discovered a cluster of women in those mental hospitals who were also diagnosed with breast cancer. Their mental illness *de facto* had rendered them incurable; therefore, they did not get any medical treatment for their breast cancer. However, they received generous humanitarian care for their symptoms, similar to that in hospices today. Most of the women were in their 60's when they were diagnosed with breast cancer and the records showed that breast cancer patients **left untreated** had an average life span of 2 years!

Around 1920, Dr. William Halstead, a prominent surgeon in America, Chief of Surgery at the Johns Hopkins University Hospital, came across these facts. He decided that any form of breast cancer treatment was better than no treatment at all and went on to design the first surgical approach to treat breast cancer. This efficient, but aggressive surgical procedure entailed removal of the entire breast, including the chest wall muscles and the axillary lymph nodes in one block. The procedure took 5 hours of surgery and required a skin graft to cover the chest wall defect; he called it a **Radical Mastectomy**. The mutilation and morbidity of this procedure was enormous. Nevertheless, women with breast cancer undergoing this type of radical surgery survived for more than 5 years for the first time; this was unprecedented.

During the same period, British physicians also started to approach breast cancer but with a different therapeutic plan - combining surgery with radiation therapy. Their surgery, though less radical, still required removal of the breast, but without removing the chest wall muscles or the axillary lymph nodes, and it did not require a skin graft either. It was called a **Simple Mastectomy**. Radiation therapy was a new specialty beginning to emerge and it complemented this less aggressive surgical approach.

The survival rate of women with breast cancer receiving either treatment - Radical or Simple Mastectomy - was very similar; so, this generated an international study measuring the risks and benefits of both treatment modalities. Both required sacrifices, but this was the first time in history that treatment for breast cancer offered any hope for women with this illness.

Several years later, another surgeon in Boston (Patey), recognized the significance of removing the entire breast gland along with the axillary lymph nodes in one block to control (*cure*?) breast cancer; but he questioned the need for removing the chest wall muscles and a large area of skin around the breast. He modified the classic approach, leaving the chest wall muscles intact and removing a smaller portion of skin around the breast, avoiding the need for a skin graft. He called this a **Modified Radical Mastectomy**.

The survival of women with breast cancer receiving either one of these two surgical treatments appeared to be similar, but the benefits and risks between both

procedures were clearly different. The American College of Surgeons initiated a national study trying to answer this question, but it was not only until **1980**, that they declared the Modified Radical Mastectomy as the gold standard for breast cancer treatment. Both surgical procedures had similar survival outcomes, but the Modified Radical Mastectomy did so with less destruction and suffering.

It was also around 1980, that another surgeon in Italy (Umberto Veronesi) questioned the need for amputating the entire breast and suggested a partial removal of the breast only. He called this procedure a **quadrantectomy**. Thus, from the start, Europe was treating breast cancer with a more conservative approach than America and they continued with this temperate way of thinking. The quadrantectomy went under scrutiny triggering yet another international study that generated an even more conservative approach - the **lumpectomy**, which is now a viable option. The European philosophy of preserving the breast, instead of removing it, combining lesser surgery with radiation therapy to the breast and adjacent regional lymph nodes continued to grow. Investigators began to understand the **significance of the regional axillary lymph nodes** as **prognostic markers**, rather than localized "filters". These concepts lead to the conclusion that breast cancer was not a localized disease attacking the breast only. It was recognized that other external factors could change a woman's immune system affecting her internal milieu eventually causing breast cancer; thus, the concept of breast cancer as a systemic disease continued to grow.

Part II, in our next issue, will cover the Staging System, use of chemotherapy and adjuvant chemotherapy, the influence and use of hormones, genetics, early detection and screening.

Benefits of surgery for obesity extend to cancer prevention

In a previous entry on bariatric surgery (Spring 08 ***Caduceus***), we mentioned the reduction in diabetes, hypertension and heart disease that follows this approach to morbid obesity. Canadian researchers at McGill University in Toronto, have now reported that the incidence of two of the most common cancers - breast and colon - was reduced by 85 % and 70 % respectively, following surgical treatment of obesity. The study confirms the findings reported in two scientific papers published last August showing an overall reduction in cancer deaths associated with surgery for obesity.

An estimated 205,000 Americans underwent bariatric surgery last year according to the American Society for Metabolic & Bariatric Surgery. The number is expected to rise by 5% this year. It is now common practice for bariatric surgery candidates to undergo mammograms, colonoscopies and upper GI endoscopies to screen for cancer in preparation for the weight-loss surgery.

Sun Sentinel.com, Florida. June 20, 2008
Associated Press

Caduceus
A PUBLICATION OF THE MEDICAL DIVISION OF ATA

WHO WHAT WHEN WHERE

by Suzanne Couture and
Rafael A. Rivera, M.D., FACP

ABBR	ENGLISH	ABREV	ESPAÑOL	REF
	academic medical center		centro médico académico	3
	acute bed		cama para enfermos agudos	1
	acute care hospital		hospital para enfermedades agudas, hospital de agudos	1
	adult day care: "Adult day care centers provide a break (respite) to the caregiver while providing health services, therapeutic services, and social activities for people with Alzheimer's disease and related dementia, chronic illnesses, traumatic brain injuries, developmental disabilities, and other problems that increase their care needs. Some adult day care centers are dementia specific, providing services exclusively to that population. Other centers serve the broader population."		centro ambulatorio de supervisión y cuidados para adultos/personas mayores	8,18,19
	ambulatory surgical facility, *Surgicenter*		centro quirúrgico para pacientes ambulatorios, centro ambulatorio de cirugía – "Inicialmente una marca registrada, *Surgicenter* ha pasado a utilizarse en los Estados Unidos como sustantivo común."	1,8
	assisted living facility		residencia de cuidados asistidos	8
	authorized health agency		agencia autorizada de salud	8
CMTU	Cardiomyopathy and Transplant Unit		unidad de cardiomiopatía y trasplantes	11
CRU	Cardiovascular/Cardiothoracic Recovery Unit	URC	unidad de recuperación quirúrgica - cardiovascular / cardiotorácica	9, 12
CMS	Centers for Medicare & Medicaid Services		Centros de Servicios de Medicare y Medicaid	8

ABBR	ENGLISH	ABREV	ESPAÑOL	REF
CCU	Coronary Care Unit	UC	Unidad de atención coronaria, unidad coronaria	9, 11, 13
	daycare center, day-care centre		Puede tener dos significados: 1) centro de cuidado para adultos ambulatorios 2) guardería infantil, centro de cuidado de niños	1,8
	doctor's office		consultorio médico	1
	emergency		**emergencia**: en los sistemas norteamericano y canadiense de cuidados inmediatos se usa el sistema de triage. La emergencia es el nivel mas alto que requiere atención inmediata para salvar la vida o evitar daño corporal irreparable. La **urgencia** requiere tratamiento cuan pronto sea posible.	1, 16
	emergency area		zona de emergencias, servicio de emergencias; zona catastrófica	1
	emergency care		atención de emergencias	1, 2
ECC	Emergency Care Center		servicio/sala de emergencias	1
ED	Emergency Department		Departamento (hospitalario) de Emergencias	1, 2
	emergency laboratory		laboratorio de emergencias	1
ER	Emergency Room		laboratorio de emergencias	1
	emergency room* vs. *urgent care center		"En los Estados Unidos y Canadá es muy clara la diferencia entre *Emergency Room* y *Urgent Care Center*. No debe confundirse este último con el *Urgent Care* integrado en el servicio hospitalario de emergencias, pero que se encarga de atender de forma ambulatoria a las urgencias."	1
	emergency theatre		quirófano de urgencias	1
	emergency* vs. *urgency		"...en inglés distinguen...claramente entre ***emergency*** (proceso que exige atención urgente por poner en peligro la vida del paciente...) y ***urgency*** (proceso que exige atención urgente pero menos grave y que no pone en peligro la vida del paciente...)"	1

ABBR	ENGLISH	ABREV	ESPAÑOL	REF
	emergency ward		servicio de emergencias	1
	extended care facility		centro de asistencia prolongada	1
	Fast Track Emergency Care (part of many large US hospitals): "The Fast Track program is designed to operate when physician offices are closed for medical conditions that may not be life threatening but still needs immediate medical attention. The Fast Track program is located right in the Emergency Department."		servicio rápido de emergencias	1, 14
G-ICU	General Intensive Care Unit	UCI-G	unidad de cuidados intensivos generales	11
	halfway house		centro domiciliario de rehabilitación	8
	home health care/agency		agencia de servicios de salud en el hogar	8
	homemaker services		servicios de ayuda en el hogar	8
	inpatient		paciente interno/internado/ ingresado/hospitalizado	
ICU	intensive care unit	UCI UTI UVI	unidad de cuidados intensivos, unidad de terapia intensiva, unidad de vigilancia intensiva	1, 17
InCU	intermediate care unit	UCIN UTIN UVIN	unidad de cuidados intermedios: "Es un área adjunta y con el mismo nivel de la Unidad de Cuidados Intensivos, con la finalidad de proveer continuidad en el tratamiento de un paciente que ha estado hospitalizado en la Unidad de Terapia Intensiva y que, por la adecuada evolución de su enfermedad, ya no requiere de una vigilancia tan estrecha." Unidad de terapia intermedia Unidad de vigilancia intermedia	17
	Level I – Regional Resource Center: Level I Trauma Centers generally serve large cities or population-dense areas. A Level I Trauma Center is responsible for providing leadership in research, professional and community education.		centro de trauma de primer nivel	15

ABBR	ENGLISH	ABREV	ESPAÑOL	REF
	Level II – Regional Trauma Centers – Level II Trauma Centers provide comprehensive trauma care and serves as a lead trauma facility for a geographical area. A Level II Trauma Center provides educational outreach and prevention programs and assumes responsibility for trauma system leadership. There are emergency physicians and nurses in-house to initiate resuscitation and stabilization, with surgical teams on call and promptly available.		centro de trauma de segundo nivel	15
	Level III – Area Trauma Center – Level III Trauma Centers provide assessment, resuscitation, emergency surgery, and stabilization and, for the most critically injured patients, arranges for transfer to a Level I or Level II trauma center that can provide further definitive care. A general surgeon must be promptly available and the facility must be involved with prevention and have an active outreach program for its referring communities		centro de trauma de tercer nivel	15
	Level IV – Local Trauma Stabilization Center – Level IV		centro de trauma de cuarto nivel	15
	local county assistance office		oficina local de bienestar público del condado	8
	long-term care facility		centro de asistencia a largo plazo	1
	medical center, medical centre	CS CAP	centro médico, centro de salud, centro de atención primaria	1,4,5,6
MICU	Medical Intensive Care Unit	UCIM	unidad médica de cuidados intensivos, unidad de cuidados médico intensivos	9.11
NICU	Neonatal Intensive Care Unit	UCIN	unidad de cuidados intensivos neonatológicos	11
NICU	Neurosurgical Intensive Care Unit	UCIN	unidad neuroquirúrgica de cuidados intensivos, unidad de cuidados intensivos neuroquirúrgicos	9,11
	nursing home		asilo/institución de cuidado de ancianos	8
	outpatient		paciente externo/ambulatorio	1
	outpatient physical therapy services		servicio de fisioterapia para paciente externo/ambulatorio	8

ABBR	ENGLISH	ABREV	ESPAÑOL	REF
PCRU	Pediatric Cardiovascular Recovery Unit	URCI	unidad pediátrica de recuperación cardiovascular	12
PICU	Pediatric Intensive Care Unit	UCIP	unidad pediátrica de cuidados intensivos	11
PACU	post-anesthesia care unit	URPA	unidad de recuperación postanestésica	13
PARU	post-anesthesia recovery unit	URPA	unidad de recuperación postanestésica	13
RCFEs	residential care facilities for the elderly		centro residencial de cuidado para ancianos	7
	residential health care facility		centro residencial de cuidados de salud	8
RCU	Respiratory Care Unit	UCR	unidad de atención respiratoria	9
	rest home		casa de reposo	8
	rural health clinics		clínicas rurales de salud	8
	skilled nursing facility		centro especializado de enfermería, institución de enfermería especializada	1,8
SICU	Surgical Intensive Care Unit	UCIQ	unidad quirúrgica de cuidados intensivos, unidad de cuidados intensivos quirúrgicos	9,10,11
	trauma center		centro para el tratamiento de traumas, centro de traumatología	1,15
UC	Urgent Care		servicio de urgencias ambulatorias (a nivel hospitalario)	1,2
	urgent care		atención de urgencias	
UCC	Urgent Care Center		centro de socorro de atención de urgencias	1,2

REFERENCES

AUTHOR / ORGANIZATION	TITLE / WEBSITE	REF
Navarro, F. A	Diccionario crítico de dudas inglés-español. 2da edición. McGraw-Hill	1
Saladrigas, M. V.	Fichas de MedTrad: *emergency care*, *urgent care*. http://tremedica.org/panacea/IndiceGeneral/n7_FichasEmergency.pdf (con acceso el 15 de febrero del 2008)	2
LexJuris Puerto Rico	http://www.lexjuris.com/LEXLEX/Leyes2006/lexl2006136.htm (con acceso el 18 de febrero del 2008)	3
CatSalut (España)	http://www10.gencat.net/catsalut/esp/servcat_primaria.htm (con acceso el 18 de febrero del 2008)	4
Wikipedia	http://es.wikipedia.org/wiki/Centro_de_Atenci%C3%B3n_Primaria (con acceso el 18 de febrero del 2008)	5
semFYC (España)	http://www.cap-semfyc.com/fCap.php (con acceso el 18 de febrero del 2008)	6
California Advocates for Nursing Home Reform (USA)	http://www.canhr.org/factsheets/spanish_fs/sp_index.htm (con acceso el 15 de febrero del 2008)	7
Social Security Administration (USA	http://www.ssa.gov/espanol/EN-SP.pdf (con acceso el 15 de febrero del 2008)	8
St. Vincent Catholic Medical Centers (USA)	http://stvincentes.convertlanguage.com/stvincent/enes/24/_www_svcmc_org/body.cfm?id=800 (con acceso el 18 de febrero del 2008)	9
Revista chilena de infectología (Chile)	http://www.scielo.cl/scielo.php?pid=S0716-10182003020100012&script=sci_arttext (con acceso el 15 de febrero del 2008)	10
E. Sgarbossa, MD	Assistant Editor, ***Caduceus***, ATA Medical Division Newsletter	11
EACTS Congenital Database	http://www.eactscongenitaldb.org/index.php?LANG=en&level=2&struct=4_4 (con acceso el 18 de febrero del 2008)	12
Hospital de la Candelaria (España)	http://www.aseedar-td.org/pdfs/05-22.pdf (con acceso el 18 de febrero del 2008)	13
Fulton County Health Center (USA)	http://www.fultoncountyhealthcenter.org/services.aspx?service_id=fabcd036-e0c2-4c08-9149-907b0e70d820 (con acceso el 18 de febrero del 2008)	14
Trauma-Emergency Medical Services System in Alaska (USA)	http://www.chems.alaska.gov/EMS/Trauma_system.htm (con acceso el 18 de febrero del 2008)	15
Real Academia Española	http://buscon.rae.es/draeI/SrvltConsulta?TIPO_BUS=3&LEMA=emergencia (con acceso el 18 de febrero del 2008)	16
Hospital Angeles Lomas (México)	http://www.hospitalangeleslomas.com/servicios/unidad-intermedios.php (con acceso el 18 de febrero del 2008)	17
Office of Minority Health (USA)	http://www.omhrc.gov/espanol/templates/browse.aspx?lvl=1&lvlid=19 (con acceso el 18 de febrero del 2008)	18
ARCH National Respite Network & Resource Center (USA)	http://www.archrespite.org/archfs54.htm (con acceso el 18 de febrero del 2008)	19

Caduceus

A PUBLICATION OF THE MEDICAL DIVISION OF ATA

INFECTION TERMINOLOGY | 16

by Rafael A. Rivera, M.D., FACP

INFECTION is the **localized** tissue invasion and proliferation of microorganisms: bacteria, virus, others.

INFLAMMATION, or **inflammatory response**, is the host's (human or animal) response to infection.

Infection and inflammation are often used interchangeably. The presence of infection is suspected when, somewhere in the body, the signs and symptoms of inflammation are evident - pain, heat, redness, tenderness, increased vascularity, perhaps presence of pus. Pus is usually a sign of infection of bacterial origin.

PAIN AND TENDERNESS

PAIN is what you feel.

TENDERNESS is abnormal sensitivity to touch or pressure.

- **Direct tenderness**, the most common, is pain elicited upon applying pressure directly over an area
- **Rebound tenderness** is pain that occurs upon releasing applied pressure over a painful area, typically the abdomen. It is a sign of peritoneal irritation; the peritoneum is the lining of the abdominal cavity.
- **Pencil tenderness** is tenderness to pressure applied by the rubber tip of a pencil, pointing to the precise location of underlying pathology.

An inflammatory response ALSO takes place as a result of **other** injurious processes that **do not** involve microorganisms; for example an inflamed knee (arthritis) or an inflamed eye (uveitis) and similar tissue responses.

SIRS is an acronym that stands for **Systemic Inflammatory Response Syndrome**. When **local** infection reaches a critical level of severity, the inflammatory response may be activated at a **systemic (see below)** level.

LOCAL or localized means the inflammatory process remains in a specific area.

SYSTEMIC means widespread throughout the body.

BACTER/EMIA or VIR/EMIA. When whole microorganisms disseminate into the rest of the body from the primary site via the circulation, this is known as **bacteremia** (in the case of bacteria) and **viremia** (in the case of viruses) **(the suffix "hemia", means blood**.

SEPSIS. When **SIRS, the systemic response** to bacterial infection occurs, the resulting clinical state is called **sepsis**.

FEVER is a rise in body temperature above the normal. Most often, fever is a sign of infection. Fever can also be due to normal physiologic stresses like ovulation, vigorous exercise, excess of thyroid hormone (these elevations of body temperature are small).

PYREXIA is a technical term for fever.

ANTIPYRETICS are chemical substances, like aspirin, that reduce fever.

TOXINS are toxic (injurious) substances produced by bacteria. If these toxins remain inside the bacterial cell they are called **endotoxins**. If toxins are released into the circulation they are known as **exotoxins**.

TOXIC SHOCK SYNDROME is what happens **when exotoxins disseminate systemically**. This is a most serious situation, it may give rise to **circulatory collapse** (drop in blood pressure) which leads to organ failures (loss of function).

ANTIBIOTICS are chemical substances capable of killing or inhibiting growth of bacteria, very limited effectiveness against viruses

ANTIPYRETICS are chemical substances that lower elevated temperatures, like aspirin

ENDEMIC is present or usually prevalent in a population or geographical area at all times

EPIDEMIC is a disease outbreak occurring suddenly in numbers clearly in excess of the normal expectancy; said especially of infectious diseases but applicable to any disease, injury or health related event

PANDEMIC is a widespread of a disease. Wildly epidemic; distributed or occurring widely throughout a region, country or continent; globally

For more advanced terminology of viral infections please see the article by Dr. Jim McAninch in our Spring 08 issue

Infection vs **infestation.** The latter is an invasion by parasites which live and propagate in the skin and its appendages (hair, nails, sebaceous glands, sweat glands)

Signs and Symptoms

Symptoms are what the patient feels - subjective sensations such as aches, pain, loss of appetite, tenderness, tiredness, malaise, headaches, etc.

Signs are the objective evidence of disease - fever, redness, swelling, enlarged lymph nodes and whatever the physician finds on physical examination or by means of diagnostic testing.

Bacterial (B) or Viral (V)

Can you tell which of the following infections are bacterial (B) and which are viral (V)?

1. Anthrax
2. Chickenpox
3. Measles
4. Plague
5. Tuberculosis
6. SARS
7. Whooping Cough
8. Mononucleosis
9. Mumps
10. Rabies

Answers on page 28

Words about words and related words

"LOOK-ALIKE WORDS":

A. cardiac and cardia Cardiac means pertaining to the heart; cardia refers to the upper part of the stomach as it meets the esophagus; between the lowermost esophagus and the cardia there is a sphincter called the lower esophageal or cardiac sphincter. The opening in the diaphragm through which the lower esophagus goes through to meet the stomach is the cardiac opening of the diaphragm.

B. colon, colonic, colic, cholic Colon is the anatomical name of the large intestine, colonic means pertaining to the colon. Colic is an acute, severe abdominal pain that seems to oscillate in intensity, not necessarily related to the colon. It could be a biliary colic arising from gallstones lodged in the biliary system or an appendicial colic due to appendicitis. Cholic acid is one of the primary bile acids found in humans, it facilitates fat absorption and cholesterol excretion.

C. amygdala and *amígdalas* Generally speaking, an amygdala is an almond shaped structure; however, amygdala is a specific area of the brain which has to do with emotional learning. In Spanish, *amígdalas* are the pharyngeal tonsils, which are removed when enlarged and chronically infected. There are other tonsils higher up in the throat, the nasopharynx, called 'adenoids'. These may or may not be removed at the time of a pharyngeal tonsillectomy

glycemic index is a term that stands for how fast and how high our blood sugar level rises after eating carbohydrates. Foods high on the glycemic index cause a higher blood sugar spike than those classified as low. Fruits,vegetables, fiber containing and less processed foods are categorized as low glycemic.

positive and negative symptoms Ever heard of that? This is terminology used typically in schizophrenia, a mental illness characterized by impairments in perception, cognition as well as social and occupational functioning, a form of psychosis. Positive symptoms are those that appear to reflect an excess or distortion of normal functions such as delusions and hallucinations, disorganized speech (frequent derailment or incoherence). Negative symptoms are those that appear to reflect a diminution or loss of normal functions such as poverty of speech, a flat affect, low energy, social isolation, avolition or the difficulty to initiate and persist in goal directed behaviors, lack of interest in anything. There is no other area of medicine where symptoms are categorized in this manner.
http://www.schizophrenia.com/diag.php http://www.medscape.com/viewarticle/560657

sign language dictionary American Sign Language (ASL) has no written form. A National Science Foundation grant is funding a first of a kind ASL dictionary currently being developed at a Boston University laboratory. Researchers are capturing thousands of words on video. The goal is to develop a lexicon of 3,000 signs. There are 20 million Americans classified as deaf or hard of hearing, almost 1 million are children, according to Gallaudet University, a leading school for the deaf located in Washington, D.C. Presently, there are print and video ASL dictionaries, but one needs to know the meaning of the word to look up the sign. That is like trying to figure out the meaning of a foreign word by looking it up under its English equivalent.
Associated Press / Sun Sentinel, Ft Lauderdale, Fl May 26,2008

retail care centers The most recent community health care options, these are convenient walk-in centers located inside retail stores, such as Wal-Mart, and are open 7 days a week. Staffed by nurse practitioners these centers can perform physical examinations, treat and prescribe medications for common problems. They also perform EKGs and routine blood tests at affordable prices.