Symposium 6
改變行醫模式的急診醫學新知
The Update of Emergency Medicine to Change Medical Practice

時間：2026 年 6 月 26 日(五) 13:30~15:00
會議室：401 會議廳
座長：賴佩芳醫師(花蓮慈濟醫院)、薛承君醫師(土城醫院)
13:30~13:50 史帝芬.強森症候群及毒性表皮壞死溶解症
Stevens-Johnson syndrome and toxic epidermal necrolysis
主講人：蘇則聿醫師(高醫附醫)
13:50~14:10 不怕風雨的醫院怎麼蓋？醫院如何挺過氣候風暴
Hospital Resilience in the Era of Climate Extremes
主講人：賴佩芳醫師(花蓮慈濟醫院)
14:10~14:30「肺全白了！」-談急性呼吸窘迫症候群全球定義更新與急診初期應對管理
"White Lungs" – Updates on the Global Definition of ARDS and Initial Management in the Emergency Department
主講人：李豐佑醫師(台中慈濟醫院)
14:30~14:50 腹部腔室症候群：急診醫師不可不知的隱形殺手
Abdominal Compartment Syndrome: The Invisible Killer Emergency Physicians Must
主講人：李凌遠醫師(三軍總醫院)
14:50~15:00 綜合討論

課程簡介

- **史帝芬.強森症候群及毒性表皮壞死溶解症**

毒性淋巴細胞、Fas-Fas 配體(FasL)的凋亡 (apoptosis)途徑、顆粒介導的胞吐作用(exocytosis)及腫瘤壞死因子-α (TNF) –α)死亡受體途徑等。

史帝芬.強森症候群及毒性表皮壞死溶解症的盛行率每百萬人口中約有 2-7 人且史帝芬.強森症候群的發生率是毒性表皮壞死溶解症的三倍。此病有遺傳傾向尤其和人類白血球抗原 (HLA)的同種異型有關。它們有可能發生在任何年齡、性別和種族，但在老年人和女性中比較常見。它們更有機會發生在感染人類免疫缺陷病毒 (HIV) 的病人中，其發病率約為 1/1000，但跟感染黴漿菌、巨細胞病毒、登革熱及注射疫並無明顯相關。在疾病早期，毒性表皮壞死溶解症的表現為廣泛的觸痛性紅皮病(erythroderma)及皮膚糜爛(erosion)並可能伴隨靶樣皮疹(targetoid rash)；而史帝芬.強森症候群綜合徵的特徵更多是靶樣皮疹但剝蝕作用(denudation)區域較少。黏膜潰瘍

和糜爛可能涵蓋唇、口腔、咽、食道和胃腸道、眼睛、生殖器、上呼吸道，且大約一半的患者有三個以上之黏膜部位被侵犯。當疾病進展到很嚴重時，典型症狀包括：發燒、倦怠、頭痛、厭食、咽喉炎及因眼、肺、心血管、胃腸、腎臟和血液系統的急性功能障礙而引起的相關症狀。史帝芬.強森症候群及毒性表皮壞死溶解症的治療主要是以支持療法為主，如停止服用可能的致病藥物、晶體溶液補充、保持環境溫暖及止痛藥物使用、保持無菌每日換藥並小心去除壞死的皮膚和黏膜及建議每兩天在腋下和鼠蹊的皮膚做細菌培養以提供抗生素使用之參考。至於疾病的預後部分，根據 2009-2012 年美國全國住院病患的平均死亡率，史帝芬.強森症候群為 4.8%，兩者之混和型為 9.4%，毒性表皮壞死溶解症則為 14.8%；至於在法國，361 名診斷為史帝芬.強森症候群或毒性表皮壞死溶解症的患者中有 66 名死亡(18%)：2%死於史帝芬.強森症候群，12%死於兩者之混和型，而有 26% 死於毒性表皮壞死溶解症。近年來，死亡率呈下降趨勢，這主要歸功於比前幾十年更好品質的支持性療法。至於最常見的長期併發症是眼部 (包括失明)、皮膚 (色素改變和疤痕) 和腎臟病，黏膜受累出現水泡和糜爛則可能導致狹窄和疤痕。大部分的皮膚病灶約在 12 到 16 週後癒合。

- **不怕風雨的醫院怎麼蓋？醫院如何挺過氣候風暴**

  Climate change is increasing the frequency and intensity of extreme weather events, placing hospitals at risk of functional disruption at the very moment they are most needed. For emergency physicians, the failure of hospital infrastructure is not a theoretical concern but a direct threat to patient care capacity and surge response.

- **「肺全白了！」-談急性呼吸窘迫症候群全球定義更新與急診初期應對管理**

  Acute respiratory distress syndrome (ARDS) is a rapidly progressive and life-threatening clinical syndrome characterized by diffuse inflammatory lung injury and severe hypoxemia. Despite advances in critical care medicine, ARDS continues to carry a high mortality rate and imposes substantial long-term health burdens on survivors. Over the past decades, the definition of ARDS has evolved from early clinical descriptions to more standardized diagnostic criteria. Following the widely adopted Berlin definition in 2012, a new global consensus definition was proposed in 2023 to address several limitations identified in clinical practice. The updated definition expands diagnostic applicability by incorporating patients receiving high-flow nasal oxygen therapy, allowing the use of oxygen saturation–based indices when arterial blood gas is unavailable, and recognizing lung ultrasound as an acceptable imaging modality. In addition, modifications were introduced for resource-limited settings to improve diagnostic feasibility worldwide.

  For emergency physicians, early recognition and timely management of ARDS are

crucial, particularly when encountering patients with acute hypoxemic respiratory failure. Although no pharmacologic therapy has been proven to cure ARDS, early supportive strategies play a key role in improving outcomes. These include lung-protective ventilation with low tidal volume and controlled plateau pressure, the use of high-flow nasal oxygen or noninvasive ventilation in selected patients, conservative fluid management, and consideration of prone positioning or extracorporeal membrane oxygenation in severe cases. From the perspective of emergency critical care, prompt identification of ARDS, initiation of appropriate respiratory support, and early treatment of underlying etiologies remain essential components of initial management and may significantly influence patient prognosis.

- **腹部腔室症候群：急診醫師不可不知的隱形殺手**

以臨床案例為引子，深入探討腹部腔室症候群(Abdominal Compartment Syndrome, ACS)的診斷與處置。標準測量方法為經膀胱測壓法，建議高風險患者每 6 小時監測。ACS 對心血管、呼吸、腎臟、消化道及神經系統均有嚴重影響，例如 IAP 達 15 mmHg 即可引起少尿，30 mmHg 可能導致無尿。危險因子包括大量輸液復甦、嚴重創傷或燒傷、重度急性胰臟炎及大量腹水。治療策略包含減少腹腔容積(胃管、腹腔引流)、改善腹壁順應性(鎮靜、肌肉阻斷)、謹慎輸液，以及必要時緊急開腹減壓術。雖然 ACS 在 ICU 發生率僅 0.17%，但院內死亡率高達 58.1%，且臨床人員對 IAP 測量的認知不足，導致診斷延誤。