

S.C. Gestione e Sviluppo delle Risorse Umane

CONCORSO PUBBLICO, PER TITOLI ED ESAMI, PER LA COPERTURA A TEMPO INDETERMINATO DI N.1 POSTO DELL'AREA DEI PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI - RUOLO SANITARIO - PROFESSIONI SANITARIE DELLA RIABILITAZIONE: LOGOPEDISTA.

Domanda attinente al profilo

1. La valutazione logopedica nel caso di un bambino di 9 anni con sospetto di dislessia
2. Il bambino con Sindrome di Down in età prescolare: pianificazione dell'intervento
3. La presa in carico logopedica del bambino disfonico
4. Otorinolaringoiatra, Ortodontista e Logopedista: quali possibili interazioni
5. Ruolo del logopedista nella disfagia dell'anziano
6. Ruolo del logopedista nell'equipe per la certificazione di DSA
7. Il trattamento logopedista nei disturbi fonetico – fonologici in età evolutiva
8. Valutazione della comprensione verbale in età prescolare
9. Valutazione e trattamento indiretti di un bambino parlatore tardivo in 30 mesi
10. Intervento logopedico nel paziente con afasia non fluente
11. Paralisi cordale: intervento logopedico
12. Intervento logopedico nel bambino con labio -palato-schisi
13. I disturbi alimentari del bambino con autismo: ruolo del logopedista
14. Bambino di 5 anni con sordità trasmissiva: possibili conseguenze sullo sviluppo del linguaggio e degli apprendimenti
15. Ruolo del logopedista con il paziente con esiti di trauma encefalico
16. Intervento logopedico delle funzioni facio-oro-deglutorie nel bambino prematuro
17. Impiego e possibile utilizzo di pratiche di CAA nel bambino con disturbo dello spettro Autistico
18. Principi di riabilitazione del sistema lessicale nell'afasia
19. Strumenti testistici per valutare le competenze fonetico-fonologiche nel Disturbo Primario del linguaggio nel bambino di 4 anni
20. Intervento del logopedista nel paziente con Paralisi Cerebrale infantile
21. La raccolta del campione di linguaggio spontaneo del bambino: modalità, analisi e scopi
22. L'insufficienza velo-faringea: quadri clinici e possibili interventi del logopedista
23. Il trattamento logopedico nella presa in carico dei disturbi di lettura nel bambino
24. Il trattamento logopedico nella presa in carico dei disturbi specifici di scrittura
25. Insegnante di 40 anni con noduli cordali: counselling e trattamento
26. Relazione tra disturbi di linguaggio e di apprendimento
27. Le norme di igiene vocale nella presa in carica dell'adulto disfonico
28. Strumenti compensativi e misure dispensative in un bambino di 10 anni con diagnosi di dislessia

Domanda di informatica

1. Qual è la differenza tra Hardware e Software?
2. Qual'è la differenza tra input e output? Fare un esempio di periferiche di input e di output.
3. Che cos'è una rete LAN?
4. Che cos'è un sistema operativo?
5. È possibile ripristinare un file che errore è stato spostato nel cestino?
6. In cosa consiste il backup?
7. Che cos'è un browser?
8. Cosa si intende per stampante multifunzione?
9. A cosa serve il programma Excel o Calc? Che tipo di programma è?



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10. Che differenza c'è tra file e cartella?
11. Cos'è un programma freeware? Fare un esempio.
12. Che cos'è l'hard disk?
13. Cosa significa WI-FI?
14. Quali sono le combinazioni rapide da tastiera per i comandi Copia Incolla Taglia?
15. Cosa rappresenta l'icona a lucchetto accanto ad un indirizzo internet del browser?
16. Che cos'è un motore di ricerca? Farne qualche esempio
17. Che cos'è un Database?
18. Che cos'è l'estensione di un file?
19. Cos'è quella che viene definita comunemente penna usb?
20. Che cos'è un font?
21. Che cos'è un client di posta elettronica?
22. Che cos'è la PEC?
23. Nella posta elettronica cosa è lo Spam?
24. Nell'invio di una mail cosa significa il campo "ccn"? A cosa serve?
25. In informatica che cos'è il "PHISHING"
26. Che cos'è la firma digitale?
27. Cosa significa il termine quarantena?
28. Che cosa significa "zippare" un file?

Sistema Socio Sanitario



Regione
Lombardia

ASST Cremona

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Domanda lingua inglese

1- Post-stroke dysphagia (PSD) is present in more than 50% of acute stroke patients, increases the risk of complications, in particular aspiration pneumonia, malnutrition and dehydration, and is linked to poor outcome and mortality.

2- The aim of this guideline is to assist all members of the multidisciplinary team in their management of patients with PSD. These guidelines were developed based on the European Stroke Organisation (ESO) standard operating procedure and followed the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach. An interdisciplinary working group identified 20 relevant questions, performed systematic reviews and meta-analyses of the literature, assessed the quality of the available evidence and wrote evidence-based recommendations.

3- Expert opinion was provided if not enough evidence was available to provide recommendations based on the GRADE approach. We found moderate quality of evidence to recommend dysphagia screening in all stroke patients to prevent post-stroke pneumonia and to early mortality and low quality of evidence to suggest dysphagia assessment in stroke patients having been identified at being at risk of PSD. We found low to moderate quality of evidence for a variety of treatment options to improve swallowing physiology and swallowing safety.

4- These options include dietary interventions, behavioural swallowing treatment including acupuncture, nutritional interventions, oral health care, different pharmacological agents and different types of neurostimulation treatment. Some of the studied interventions also had an impact on other clinical endpoints such as feedings status or pneumonia. Overall, further randomized trials are needed to improve the quality of evidence for the treatment of PSD.

5- The oropharyngeal swallow involves a rapid, highly coordinated set of neuromuscular actions beginning with lip closure and terminating with upper oesophageal sphincter closure when the bolus has passed through. The central coordination of this complex sensorimotor task uses a widespread network of cortical, subcortical and brainstem structures

6- Stroke is the most frequent disease leading to disruption of this swallowing network thereby causing an impairment of deglutition, that is, post-stroke dysphagia (PSD).⁵ Depending on the diagnostic criteria, timing and method of assessment, alongside stroke features, PSD is found in 29–81% of acute stroke patients.

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7- Although many stroke patients recover swallowing within the first weeks after the ictus, 11–50% still suffer from dysphagia at 6 months.^{7,8} PSD broadly affects swallowing safety leading to an increased risk of aspiration and subsequent pneumonia, and swallowing efficacy with the related danger of insufficient nutrition and hydration.

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8- Apart from these physical consequences, dysphagia has a significant impact on the psychological well-being and level of independence for the affected individuals, and dysphagia has been linked to low mood and depression.

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9- Because of its large epidemiological burden and hazardous clinical complications, the European Stroke Organization (ESO) and the European Society for Swallowing Disorders (ESSD) have decided to compile guidelines on the management of PSD.

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10- These recommendations are based on findings from randomized controlled trials (RCTs) and observational studies. They were agreed through consensus with the involved authors using the grading of recommendations, assessment, development and evaluation (GRADE) approach and the ESO standard operating procedure (SOP) for guidelines development¹⁰ and have the approval of the ESO Executive Committee.

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11- The aim of this guideline document is to inform physicians, speech-and-language therapists (SLTs) as well as stroke-nurses, and all the members of the multidisciplinary team on how to screen, assess and treat patients with PSD to avoid dysphagia-related complications and to facilitate recovery of swallowing function.

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12- Due to the European-wide approach, stakeholders in terms of the target patient population were not included in this guideline project. The working group (WG) was confirmed by the ESO Executive Committee. Standardized steps, which were undertaken by the WG, are summarized as follows.

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13-The group identified all available publications published in English related to the PICO questions in 4 separate searches. These were guided by the 2011 Centre for Evidence Based Medicine's levels of evidence.¹¹ We searched the databases such as MEDLINE, EMBASE, CINAHL and Cochrane database of systematic reviews (CDSR), the Cochrane central register of controlled trials (CENTRAL) (1990 through August 2018). Furthermore, we searched the reference lists of review articles and clinical trials on PSD for further appropriate studies.

14-The group selected eligible studies. Due to the high number of PICO questions different WG members were responsible for the 4 separate topics and screened the respective articles. As we identified relatively few RCTs and systematic reviews or meta-analyses of RCTs, we also included observational and epidemiological studies that might facilitate the recommendations or proposals.

15-Meta-analysis was performed using the Review Manager (RevMan, version 5.3) Cochrane Collaboration software. The risk ratio (RR), odds ratio (OR), mean difference (MD) or standard mean difference (SMD) and 95% confidence interval (CI) were calculated with a random effects model for all outcomes.

16-Where appropriate, subgroup analyses based on different treatment modalities within a given main category were performed. Results were then summarized in GRADE evidence profiles and summary of findings tables (Supplement 4, Supplement 6). Directness refers to the extent by which patient populations, interventions and outcomes are similar to those of interest.

17-The components of GRADE system, such as Study design, Risk of bias, Inconsistency, Indirectness, Imprecision and other considerations, were considered in grading the evidence. The study design specified the basic design of the study (RCT or non-RCT).

18-The final summaries of the quality and strength of evidence and recommendations for each PICO question were discussed by the whole group, recommendations were agreed on by the authors.¹⁴ The strength of recommendations was graded as strong when the desirable effects of an intervention clearly outweighed the undesirable effects or weak when the trade-off was less certain, either because of low-quality evidence, or because the evidence suggested that desirable and undesirable effects were more closely balanced.

19-The WGs who completed this guideline will be reviewing the evidence on a regular basis, with the first anticipated partial review in 2024. We envisage that this period after the publication of these guidelines will further increase the number of clinical studies published in the next few years.

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20-Due to the impact of PSD on specific complications and global outcome post stroke, many hospitals throughout the world use dysphagia screening protocols to identify patients at risk of aspiration and to guide subsequent diagnostic and therapeutic procedures. In addition, dysphagia screening has also been implemented in various guidelines⁵⁸⁻⁶² and is part of auditing systems for stroke units

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21-This guideline does not review evidence for the accuracy and reliability of different dysphagia screening protocols compared with gold standard assessments, in particular the Videofluoroscopic Swallowing Study (VFSS) and Flexible Endoscopic Evaluation of Swallowing (FEES).

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22-*In patients with acute stroke does screening compared to no screening for dysphagia improve functional outcome and/or survival, reduce aspiration risk, reduce length of hospital stay, reduce adverse events and complications, have an effect on nutritional status and have an effect on quality of life?*

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23-In spite of the methodological differences between water-swallow tests and multiple-consistency tests, there are to date no comparative studies that help to determine which approach might work better in the context of stroke. Therefore, no specific recommendation with regards to this PICO question could be made.

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24-Malnutrition is present in about one quarter of stroke patients with studies reporting prevalence between 6 and 62% depending on the timing of assessment, patients' characteristics and methods used.⁹⁶ Commonly, patients will present with malnutrition on admission, while in others malnutrition develops during the further course of the disease.

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25-Malnutrition has been shown to be associated with an excess in mortality, bad functional outcome, prolonged length of stay in hospital and increased healthcare costs.^{60,100-102} The aetiology of malnutrition in the context of stroke is heterogeneous and includes, apart from dysphagia, functional disability, impaired consciousness, perception deficits, cognitive dysfunction and depression.

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26-Our literature search did not find any comparative studies pertinent to this question. However, with regards to the applicability in the clinical routine the Nutritional Risk Screening (NRS 2002)¹⁰⁴ and the Malnutrition Universal Screening Tool (MUST)¹⁰⁵ are proposed by two different guidelines^{59,60} and have been used extensively in stroke patients in prospective cohort studies.

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27-Following the suggestion of other guidelines,^{59,60} stroke patients should be subjected to a dysphagia assessment if they have failed the dysphagia screen. Regardless of the outcome of the initial screening, a dysphagia assessment is also recommended in patients presenting with pertinent clinical risk factors for PSD or its complications, in particular severe dysarthria, aphasia, facial palsy, cognitive impairments and increased stroke severity (NIH-SS ≥ 10 points).

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28-The use of texture-modified foods and thickened liquids has become a cornerstone of clinical practice to address PSD. The principle behind this approach arises from the assumption that modifying the properties of normal foods and liquids will make them safer and easier to swallow.

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