SUBSEQUENT EXAMINATIONS AND PROCEEDINGS AFTER THE RELAPSE 147 pdf

1: Opiate and opioid withdrawal: MedlinePlus Medical Encyclopedia

SUBSEQUENT EXAMINATIONS AND PROCEEDINGS AFTER THE RELAPSE Examination of Witnesses Scanner Internet Archive HTML5 Uploader

This article has been cited by other articles in PMC. Abstract Solitary rectal ulcer syndrome SRUS is a chronic, multiform, non-cancerous disorder of the rectum, the final diagnosis of which is based upon histopathological criteria. This disorder is often accompanied by latent proctoptosis. In the years â€" the same patient underwent 15 APC sessions at monthly intervals obtaining full recovery from SRUS, although she had been treated unsuccessfully for 17 years prior to that. Six-year observation did not show any relapse. In SRUS diagnosis one should consider the clinical symptoms and the course of the disease, supplemented by the results of defecography, anorectal manometry, and endoscopic biopsies. The final diagnosis is set on the basis of histopathological criteria. It is often accompanied by evident or latent proctoprosia, and in cases like this the therapeutic possibilities and prognosis are slightly better. The SURS is a rare disease, with an estimated incidence of 1â€"3. In most observations, differences between genders are minor but it is reported in a slightly higher proportion of women. The diagnosis of SRUS is usually late, mainly because of its common asymptomatic initial course [1 , 2 , 5]. Later symptoms are the same as in other â€" more common â€" disorders of the anorectum and are often ignored. Treating SRUS is difficult and includes a variety of strategies, starting with conservative methods up to various surgery techniques. Despite numerous articles on SRUS and relatively large interest in the disease, the pathogenesis is still not known precisely and no effective treatment of solitary rectal ulcer syndrome has been established. The aim of the study is to present an effective treatment of solitary rectal ulcer syndrome without proctoptosis with the pioneering use of argon plasma coagulation APC. Case report A female, year-old patient, presently 79 years old was admitted in to the University Ward of General Surgery and Gastroenterology in Bytom, Silesian Medical University for diagnosis and treatment of rectal ulceration. The interview and documents showed that since the patient had disorders in the form of idiopathic, acute pains of the stomach, in the region of the anus and rectum, and diarrhoea alternating with constipation, mucus and blood in stools and decreased body mass. The colonoscopy performed in another hospital 10 cm from the anus showed the presence of rectum ulceration. Histopathology of a specimen was as follows: Adenocarcinoma bene differentiatum exulceratum. As a result, in the patient had exploratory laparotomy performed, which did not show any pathologic changes in the abdominal cavity. Subsequently, the patient used conservative treatment in the form of a diet. She felt quite well and did not report serious pain or constipation. In , however, the pain appeared again. The patient was still treated by conservatory treatment plus sulphasalazine and neomycin enemas, and control colonoscopies with samples taken for histopathological examinations were also carried out. However, each time the presence of rectal ulceration covered with fibroma with tiny polyp lesions on its edges was shown, the primary diagnosis of neoplastic change was never confirmed again. In the years â€", seven colonoscopies were done, which did not show any significant macroscopic and size changes of the ulceration. As well as exploratory laparotomy done in , she had an appendectomy in and a hysterectomy with perineoplasty in At that time the diagnosis was as follows: The histopathology results were as follows: In she had a benign ischaemic cerebral stroke. At admission the patient did not report any pain; the reason for admission was the presence of large amount of blood and mucus in stools. The patient was in good general condition. Apart from obesity body mass index BMI Rectoscopy and colonoscopy with samples for histopathology, panendoscopy, contrast infusion, hydrosonography, cystoscopy, and abdominal cavity USG were performed. The rectoscopy showed a cm bleeding ulceration, and colonoscopy showed dolichocolon and two benign polyps, which were removed in the descending colon â€" adenoma tubulare of 0. Contrast infusion showed numerous additional colon flexures, slight atrophy of large intestinal haustration and elongation of the transverse colon. Hydrosonography confirmed the atrophy of large intestinal haustration. Abdominal cavity ultrasound showed

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discreet urinary retention in the kidneys and cholecystolithiasis. No other deviations were observed. Laboratory tests done during hospitalisation showed anaemia â€" Hgb The blood glucose curve was pathologic. The remaining tests showed no deviations. Six APC sessions were done during colonoscopy every 2 days, with the result of ulceration decrease and no bleeding after the fifth session. The patient was dismissed in a good condition, with the recommendation of using high-fibre diet and outpatient check-ups. The patient did not follow the recommendations because at the time she had no pain or bleeding. In March the patient was admitted to hospital due to recurrence of pain and considerable bleeding from the anus. Colonoscopy showed the presence of large ulceration surrounded by congested mucosa, covered with clots up to the sigmoid-rectal bend. The surgical procedure of transversostomy was performed, excluding the changed part of the rectum from the passage, and in the postoperative period, local treatment of ulceration with hydrocortisone enemas was applied. The subsequent retroscopies and colonoscopies showed slow regression of the lesions. The examination of May confirmed the lack of ulceration, so the decision to remove the transversostomy was taken. In March , which is 10 months after the reconstruction of the alimentary duct continuity, the patient was readmitted to the hospital due to rectal bleeding. The colonoscopy showed an irregular ulceration with bleeding, congested edges in the rectum on the front wall. The histopathology result revealed ulceratio chronica. At that time, the patient did not suffer any pain, but periodically she had slight bleeding from the rectum. The patient was on a high-fibre diet. Histopathology showed ulceratio chornica. The results were as follows: In fluorescence light â€" ulceration edges locally of diffuse reddish fluorescence congestion , 1 cm distally from the ulceration irregular brownish fluorescence field. Histopathology results were as follows: Epithelium sine dysplasia; 2. Epithelium without dysplasia; 3. Dysplasia epithelii glandularis LG. Prolific inflammatory infiltrations, mainly eosinophilia. In January the patient was offered argon therapy in our hospital. The patient suffered from diabetes mellitus, arterial hypertension, ischaemic heart disease, general atherosclerosis, degeneration of L-S spine joints, left hip and knee joints, cholecystolithiasis, and lower limbs varices. The patient had suffered ischaemic brain stroke with a slight left-side paresis and no distinct defect symptoms of CNS. The patient was offered a method with the use of argon beamer by EMED, which had given promising treatment results so far; the recommendations of Stoppino et al. The method of local application was modified by extending the periods between argon coagulation, and the target was full healing of the ulceration. Fifteen APC sessions were done at monthly intervals, stopping the ulceration bleeding after the second session and decreasing the extensive ulceration constantly, and consequently obtaining full recovery from SRUS after 20 months of treatment. Further check-ups in a surgery clinic were recommended. The patient is still under surgical supervision. The observation has currently been ongoing for 6 years, with no relapse. The latest colonoscopy was performed on Aug 10, , during which the colonoscope was inserted into the caecum. The observations were as follows: Discussion Patient noticed the first symptoms at the age of 56 years, which is later than the most common cases of SRUS in women usually between 40 and 50 years; however, there is a wide age-range for the disease: The SRUS aetiology, despite many studies and observations, has not been discovered. The most popular hypothesis claims that this is a secondary disease following rectal prolapse overt or latent, mucosal or complete prolapse and it is a result of defecation disorders. Another hypothesis related to defecation disorders draws attention to the oversensitivity of rectal mucosa, leading to a continuous feeling of incomplete defecation and excessive rectal tenestmus [2]. The influence of atherosclerotic changes on mucosal ischaemia is also suggested [5], as well as disorders in cholinergic synapses of the autonomous nervous system, which can be related to diabetic polyneuropathy [7]. It is also suspected that SRUS can be an innate malformation of the hamartoma type. There are other factors that are taken into consideration in the pathogenesis, such as an injury caused by a patient while initiating defecation with a finger or while using rectal enemas, the influence of radiotherapy, and the effects of some drugs applied per rectum. The coexistence of several factors in SRUS pathogenesis is also possible. A distinctive element that might be important in SRUS pathogenesis in this patient was the atherosclerotic component, dementia, diabetes mellitus and temporal relation with the perineoplasty done 5 years before. In

this case, SRUS did not coexist with rectal prolapse, which considerably limits treatment options when conservative treatment is ineffective. The patient had diabetes mellitus, ischaemic disease, and hypertension. At the age of 62 she had already had a cerebral stroke with apparent dementia, which made introduction of a proper diet and effective psychotherapy difficult. Lack of uniform agreements about procedures in SRUS also results from non-homogenous and poorly recognised pathogenesis. The therapy initially consists of conservative methods and is usually the end of therapy if there is some improvement or if patients are asymptomatic. Subsequently, it is recommended that patients follow a high-fibre diet to regulate defecation rhythm, perform relaxation exercises of the sphincter muscles, and avoid mechanical procedures leading to local injuries of rectal mucosa. Good results were achieved by using behavioural therapy: The aim is to improve defecation technique, to decrease rectal oversensitivity to stimuli, to recover normal mechanism of defecation and thus to make clinical symptoms disappear, to normalise the frequency and quality of defecation, and to heal the lesions in the rectum. Most probably the feedback influences autonomic innervation and, as a result, improves mucous flow and provides favourable conditions for rectal wound healing [1 , 7 , 8]. However, some authors claim that feedback is effective in short-term observations, but in the long-term perspective this method is ineffective. In our patient the only form of psychotherapy was the recommendation to follow the diet and to defecate regularly. It seems that the diagnostic histopathology mistake and probably the overly eager decision to perform a laparotomy did not influence the natural course of the disease. It is usually a long time from the first symptoms to a diagnosis from 3 months to 30 years, with a mean of 5 years [1]. In our case, the diagnosis was established 6 years after the first symptoms. Late diagnosis is usually the result of ignoring symptoms typical for common anorectal diseases.

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2: Statutes & Constitution :View Statutes : Online Sunshine

CONTENTS PART Iâ€" THE TRIAL I FIRST PROCESS: THE LAPSE TRIAL EX OFFICIO i Six Public Examinations i Nine Private Examinations 55 THE TRIAL IN ORDINARY Skip to main content Search the history of over billion web pages on the Internet.

General Secretary, International Military Tribunal. Amnesia at beginning of trial. There can be no doubt that Hess was in a state of virtually complete amnesia at the beginning of the trial. The opinions of the psychiatric commissions in this regard and with respect to his sanity have only been substantiated by prolonged subsequent observation. On the day of the special hearing in his case, 30 November , Rudolf Hess did, in fact, recover his memory. The cause of his sudden recovery is an academic question, but the following event probably played a part: Just before the hearing f told Hess as a challenge that he might be considered incompetent at that time and excluded from the proceedings, but I would sometimes see him in his cell. Hess seemed startled and said he thought he was competent. Then he gave his declaration of malingering in court, apparently as a face-saving device. In later conversations he admitted to me that he had not been malingering, and that he knew he had lost his memory twice in England. During the months of December , and January , his memory was quite in order. At the end of January I began to notice the beginnings of memory failure. This increased progressively during February, until he returned to a state of virtually complete amnesia again about the beginning of March, and he has remained in that state ever since. At the beginning of relapse, Hess expressed anxiety over it, saying that no one would believe him this time after he had said he had faked his amnesia the first time. At present his memory span is about one-half day, and his apprehension span has dropped from 7 to 4 digits repeated correctly immediately after hearing. I have teed the application of Dr. Seidl both in German and in English, and wish to make the following comment: Lay discussion of psychiatric concepts does not help throw any light on this case, because psychiatrists themselves are not in agreement on the definition of terms like "psychopathic constitution", "hysterical reaction", etc. The psychiatric commissions have agreed, and my further observations have confirmed, that Hess is not insane in the legal sense of being incapable of distinguishing right from wrong or realizing the consequences of his acts. Hess did recover his memory for a sufficient period of time months to give his counsel ample cooperation in the preparation of his defense. If he failed to do so, it was the result of a negativistic personality peculiarity, which I have also observed, and not incompetence. There has been no indication in his case history or present behavior that he was insane at the time of the activities for which he has been indicted. His behavior throughout the trial has also shown sufficient insight and reason to dispel any doubts about his sanity. He may have gone through a psychotic episode in England, but that in no way destroys the validity of the previous two statements. He has exhibited signs of a "persecution complex" here too, but these have not been of psychotic proportions. In my opinion, another examination by a psychiatric commission at this time would not throw any further light on the case, because the clinical picture is the same and the conclusions would necessarily be the same as those of the original psychiatric commissions, to wit: Hess is not insane but suffering from hysterical amnesia. I have discussed this case with the present prison psychiatrist,. This motion, which reviewed at length the previous examinations and psychiatric history of Defendant Hess, was a request "to subject the Defendant Hess once more.

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3: The Avalon Project : Nuremberg Trial Proceedings Vol. 1

Morphologic examinations of bone marrow and cerebrospinal fluid (CSF) are considered routine in the assessment of children who complete therapy for ALL. 5 To determine the usefulness of such studies in identifying or predicting relapse, we reviewed the medical records of children with ALL at two US medical institutions.

The health and safety of the children served shall be of paramount concern. The prevention and intervention should engage families in constructive, supportive, and nonadversarial relationships. The prevention and intervention should intrude as little as possible into the life of the family, be focused on clearly defined objectives, and keep the safety of the child or children as the paramount concern. The prevention and intervention should be based upon outcome evaluation results that demonstrate success in protecting children and supporting families. All placements shall be in a safe environment where drugs and alcohol are not abused. It is the further intent of the Legislature that, when children are removed from their homes, disruption to their education be minimized to the extent possible. A volunteer who assists on an intermittent basis for less than 10 hours per month need not be screened if a person who meets the screening requirement of this section is always present and has the volunteer within his or her line of sight. The department is authorized to adopt rules, policies, and procedures necessary to implement this paragraph. The department shall collaborate with all relevant state and local agencies to provide needed services. The children at greatest risk of being sexually exploited are runaways and throwaways. Many of these children have a history of abuse and neglect. The vulnerability of these children starts with isolation from family and friends. Traffickers maintain control of child victims through psychological manipulation, force, drug addiction, or the exploitation of economic, physical, or emotional vulnerability. Children exploited through the sex trade often find it difficult to trust adults because of their abusive experiences. These children make up a population that is difficult to serve and even more difficult to rehabilitate. To ensure the safety of children. To provide for the treatment of such children as dependent children rather than as delinquents. To sever the bond between exploited children and traffickers and to reunite these children with their families or provide them with appropriate guardians. To enable such children to be willing and reliable witnesses in the prosecution of traffickers. It is the intent of the Legislature that this state provide such care and services to all sexually exploited children in this state who are not otherwise receiving comparable services, such as those under the federal Trafficking Victims Protection Act, 22 U. To prevent and remediate the consequences of mental illnesses and substance abuse disorders on families involved in protective supervision or foster care and reduce the occurrences of mental illnesses and substance abuse disorders, including alcohol abuse or related disorders, for families who are at risk of being involved in protective supervision or foster care. To expedite permanency for children and reunify healthy, intact families, when appropriate. To support families in recovery. Participation in treatment, including a mental health court program or a treatment-based drug court program, may be required by the court following adjudication. Participation in assessment and treatment before adjudication is voluntary, except as provided in s. The state further recognizes that the ability of parents, custodians, and guardians to fulfill those responsibilities can be greatly impaired by economic, social, behavioral, emotional, and related problems. The impact that abuse, abandonment, or neglect has on the victimized child, siblings, family structure, and inevitably on all citizens of the state has caused the Legislature to determine that the prevention of child abuse, abandonment, and neglect shall be a priority of this state. To further this end, it is the intent of the Legislature that an Office of Adoption and Child Protection be established. The Governor shall appoint a Chief Child Advocate for the office. Assist in developing rules pertaining to the promotion of adoption, support of adoptive families, and implementation of child abuse prevention efforts. Develop a strategic program and funding initiative that links the separate jurisdictional activities of state agencies with respect to promotion of adoption, support of adoptive families, and child abuse prevention. The office may designate lead and contributing agencies to develop such initiatives. Advise the Governor and the Legislature on statistics related

to the promotion of adoption, support of adoptive families, and child abuse prevention trends in this state; the status of current adoption programs and services, current child abuse prevention programs and services, the funding of adoption, support of adoptive families, and child abuse prevention programs and services; and the status of the office with regard to the development and implementation of the state strategy for the promotion of adoption, support of adoptive families, and child abuse prevention. Develop public awareness campaigns to be implemented throughout the state for the promotion of adoption, support of adoptive families, and child abuse prevention. Oversee the preparation and implementation of the state plan established under subsection 10 and revise and update the state plan as necessary. Provide for or make available continuing professional education and training in the prevention of child abuse and neglect. Work to secure funding in the form of appropriations, gifts, and grants from the state, the Federal Government, and other public and private sources in order to ensure that sufficient funds are available for the promotion of adoption, support of adoptive families, and child abuse prevention efforts. Make recommendations pertaining to agreements or contracts for the establishment and development of: Programs and services for the promotion of adoption, support of adoptive families, and prevention of child abuse and neglect. Training programs for the prevention of child abuse and neglect. Multidisciplinary and discipline-specific training programs for professionals with responsibilities affecting children, young adults, and families. Efforts to promote adoption. Postadoptive services to support adoptive families. Monitor, evaluate, and review the development and quality of local and statewide services and programs for the promotion of adoption, support of adoptive families, and prevention of child abuse and neglect and shall publish and distribute an annual report of its findings on or before January 1 of each year to the Governor, the Speaker of the House of Representatives, the President of the Senate, the head of each state agency affected by the report, and the appropriate substantive committees of the Legislature. The report shall include: A summary of the activities of the office. A summary detailing the timeliness of the adoption process for children adopted from within the child welfare system. Recommendations, by state agency, for the further development and improvement of services and programs for the promotion of adoption, support of adoptive families, and prevention of child abuse and neglect. Budget requests, adoption promotion and support needs, and child abuse prevention program needs by state agency. The Department of Children and Families, the Department of Corrections, the Department of Education, the Department of Health, the Department of Juvenile Justice, the Department of Law Enforcement, and the Agency for Persons with Disabilities shall participate and fully cooperate in the development of the state plan at both the state and local levels. Furthermore, appropriate local agencies and organizations shall be provided an opportunity to participate in the development of the state plan at the local level. Appropriate local groups and organizations shall include, but not be limited to, community mental health centers; guardian ad litem programs for children under the circuit court; the school boards of the local school districts; the Florida local advocacy councils; community-based care lead agencies; private or public organizations or programs with recognized expertise in working with child abuse prevention programs for children and families; private or public organizations or programs with recognized expertise in working with children who are sexually abused, physically abused, emotionally abused, abandoned, or neglected and with expertise in working with the families of such children; private or public programs or organizations with expertise in maternal and infant health care; multidisciplinary child protection teams; child day care centers; law enforcement agencies; and the circuit courts, when guardian ad litem programs are not available in the local area. The state plan to be provided to the Legislature and the Governor shall include, as a minimum, the information required of the various groups in paragraph b. The office shall establish a Child Abuse Prevention and Permanency Advisory Council composed of an adoptive parent who has adopted a child from within the child welfare system and representatives from each state agency and appropriate local agencies and organizations specified in paragraph a. The advisory council shall serve as the research arm of the office and shall be responsible for: Assisting in developing a plan of action for better coordination and integration of the goals, activities, and funding pertaining to the promotion and support of adoption and the prevention of child abuse, abandonment, and

neglect conducted by the office in order to maximize staff and resources at the state level. The plan of action shall be included in the state plan. Assisting in providing a basic format to be utilized by the districts in the preparation of local plans of action in order to provide for uniformity in the district plans and to provide for greater ease in compiling information for the state plan. Providing the districts with technical assistance in the development of local plans of action, if requested. Assisting in examining the local plans to determine if all the requirements of the local plans have been met and, if they have not, informing the districts of the deficiencies and requesting the additional information needed. Assisting in preparing the state plan for submission to the Legislature and the Governor. Such preparation shall include the incorporation into the state plan of information obtained from the local plans, the cooperative plans with the members of the advisory council, and the plan of action for coordination and integration of state departmental activities. The state plan shall include a section reflecting general conditions and needs, an analysis of variations based on population or geographic areas, identified problems, and recommendations for change. In essence, the state plan shall provide an analysis and summary of each element of the local plans to provide a statewide perspective. The state plan shall also include each separate local plan of action. Working with the specified state agency in fulfilling the requirements of subparagraphs 2. The plan for accomplishing this end shall be included in the state plan. The office, the department, the Department of Law Enforcement, and the Department of Health shall work together in developing ways to inform and instruct appropriate local law enforcement personnel in the detection of child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect. Within existing appropriations, the office shall work with other appropriate public and private agencies to emphasize efforts to educate the general public about the problem of and ways to detect child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect. The office, the department, the Department of Education, and the Department of Health shall work together on the enhancement or adaptation of curriculum materials to assist instructional personnel in providing instruction through a multidisciplinary approach on the identification, intervention, and prevention of child abuse, abandonment, and neglect. The curriculum materials shall be geared toward a sequential program of instruction at the four progressional levels, K-3, , , and Strategies for encouraging all school districts to utilize the curriculum are to be included in the state plan for the prevention of child abuse, abandonment, and neglect. Each district of the department shall develop a plan for its specific geographical area. The plan developed at the district level shall be submitted to the advisory council for utilization in preparing the state plan. The district local plan of action shall be prepared with the involvement and assistance of the local agencies and organizations listed in this paragraph, as well as representatives from those departmental district offices participating in the promotion of adoption, support of adoptive families, and treatment and prevention of child abuse, abandonment, and neglect. In order to accomplish this, the office shall establish a task force on the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect. The office shall appoint the members of the task force in accordance with the membership requirements of this section. The office shall ensure that individuals from both urban and rural areas and an adoptive parent who has adopted a child from within the child welfare system are represented on the task force. The task force shall develop a written statement clearly identifying its operating procedures, purpose, overall responsibilities, and method of meeting responsibilities. The district plan of action to be prepared by the task force shall include, but shall not be limited to: Documentation of the magnitude of the problems of child abuse, including sexual abuse, physical abuse, and emotional abuse, and child abandonment and neglect in its geographical area. A description of programs currently serving abused, abandoned, and neglected children and their families and a description of programs for the prevention of child abuse, abandonment, and neglect, including information on the impact, cost-effectiveness, and sources of funding of such programs. Information concerning the number of children within the child welfare system available for adoption who need child-specific adoption promotion efforts. A description of programs currently promoting and supporting adoptive families, including

information on the impact, cost-effectiveness, and sources of funding of such programs. A description of a comprehensive approach for providing postadoption services. The continuum of services shall include, but not be limited to, sufficient and accessible parent and teen support groups; case management, information, and referral services; and educational advocacy. A continuum of programs and services necessary for a comprehensive approach to the promotion of adoption and the prevention of all types of child abuse, abandonment, and neglect as well as a brief description of such programs and services. A description, documentation, and priority ranking of local needs related to the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect based upon the continuum of programs and services. A plan for steps to be taken in meeting identified needs, including the coordination and integration of services to avoid unnecessary duplication and cost, and for alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, contracting with local universities for services, and local government or private agency funding. A description of barriers to the accomplishment of a comprehensive approach to the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect. Recommendations for changes that can be accomplished only at the state program level or by legislative action. Such revisions shall be submitted to the Speaker of the House of Representatives and the President of the Senate no later than June 30 of each year divisible by 5. At least biennially, the office shall review the state plan and make any necessary revisions based on changing needs and program evaluation results. An annual progress report shall be submitted to update the state plan in the years between the 5-year intervals. In order to avoid duplication of effort, these required plans may be made a part of or merged with other plans required by either the state or Federal Government, so long as the portions of the other state or Federal Government plan that constitute the state plan for the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect are clearly identified as such and are provided to the Speaker of the House of Representatives and the President of the Senate as required under this section. The amendment by s. This paragraph does not deny the child access to his or her records. Such agreement shall be designed to provide educational access to children known to the department for the purpose of facilitating the delivery of services or programs to children known to the department. The agreement shall avoid duplication of services or programs and shall provide for combining resources to maximize the availability or delivery of services or programs.

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4: Chapter - Trial And Proceedings After Conviction

cure after CNS relapse is the duration of initial remission. to By definition, all patients having treatment electively disÂ-continued have been in prolonged remission and would be.

Symptoms usually start within 12 hours of last heroin usage and within 30 hours of last methadone exposure. Exams and Tests Your health care provider will perform a physical exam and ask questions about your medical history and drug use. Urine or blood tests to screen for drugs can confirm opiate use. Blood chemistries and liver function tests such as CHEM CBC complete blood count, measures red and white blood cells, and platelets, which help blood to clot Chest x-ray EKG electrocardiogram, or heart tracing Testing for hepatitis C , HIV , and tuberculosis TB , as many people who abuse opiates also have these diseases Treatment Withdrawal from these drugs on your own can be very hard and may be dangerous. Treatment most often involves medicines, counseling, and support. You and your health care provider will discuss your care and treatment goals. Withdrawal can take place in a number of settings: At-home, using medicines and a strong support system. This method is difficult, and withdrawal should be done very slowly. Using facilities set up to help people with detoxification detox. In a regular hospital, if symptoms are severe. It is also used as a long-term maintenance medicine for opioid dependence. After a period of maintenance, the dose may be decreased slowly over a long time. This helps reduce the intensity of withdrawal symptoms. Some people stay on methadone for years. Buprenorphine Subutex treats withdrawal from opiates, and it can shorten the length of detox. It may also be used for long-term maintenance, like methadone. Buprenorphine may be combined with Naloxone Bunavail, Suboxone, Zubsolv , which helps prevent dependence and misuse. Clonidine is used to help reduce anxiety, agitation, muscle aches, sweating, runny nose, and cramping. It does not help reduce cravings. Help with sleep Naltrexone can help prevent relapse. It is available in pill form or as an injection. People who go through withdrawal over and over should be treated with long-term methadone or buprenorphine maintenance. Most people need long-term treatment after detox. Self-help groups, like Narcotics Anonymous or SMART Recovery Outpatient counseling Intensive outpatient treatment day hospitalization Inpatient treatment Anyone going though detox for opiates should be checked for depression and other mental illnesses. Treating these disorders can reduce the risk of relapse. Antidepressant medicines should be given as needed.

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5: International Criminal Court - Wikipedia

after discontinuation of ATD therapy, except for two patients who became pregnant at and months follow-up and were then excluded. Relapse was deï¬•ned as FT.

This section needs additional citations for verification. Please help improve this article by adding citations to reliable sources. Unsourced material may be challenged and removed. June Learn how and when to remove this template message The establishment of an international tribunal to judge political leaders accused of international crimes was first proposed during the Paris Peace Conference in following the First World War by the Commission of Responsibilities. The issue was addressed again at a conference held in Geneva under the auspices of the League of Nations in , which resulted in the conclusion of the first convention stipulating the establishment of a permanent international court to try acts of international terrorism. The convention was signed by 13 states, but none ratified it and the convention never entered into force. Following the Second World War , the allied powers established two ad hoc tribunals to prosecute axis power leaders accused of war crimes. In the United Nations General Assembly first recognised the need for a permanent international court to deal with atrocities of the kind prosecuted after the Second World War. Ferencz , an investigator of Nazi war crimes after the Second World War, and the Chief Prosecutor for the United States Army at the Einsatzgruppen Trial , became a vocal advocate of the establishment of international rule of law and of an international criminal court. In his first book published in , entitled Defining International Aggression: The Search for World Peace, he advocated for the establishment of such a court. Robinson revived the idea of a permanent international criminal court by proposing the creation of such a court to deal with the illegal drug trade. The International Criminal Tribunal for the former Yugoslavia was created in in response to large-scale atrocities committed by armed forces during Yugoslav Wars , and the International Criminal Tribunal for Rwanda was created in following the Rwandan Genocide. The creation of these tribunals further highlighted the need for a permanent international criminal court. In January , the Bureau and coordinators of the Preparatory Committee convened for an Inter-Sessional meeting in Zutphen in the Netherlands to technically consolidate and restructure the draft articles into a draft. On 17 July , the Rome Statute of the International Criminal Court was adopted by a vote of to 7, with 21 countries abstaining. They were sworn in at the inaugural session of the Court on 11 March There they adopted two amendments to the Statute. The second amendment defined the crime of aggression and outlined the procedure by which the ICC could prosecute individuals. However, the conditions outlined in the amendment have not yet been met and the ICC can not yet exercise jurisdiction over crimes of aggression. The Court itself, however, is composed of four organs: Some of them, including China and India , are critical of the Court. The Assembly meets in full session once a year, alternating between New York and The Hague , and may also hold special sessions where circumstances require. Any person being investigated or prosecuted may request the disqualification of a prosecutor from any case "in which their impartiality might reasonably be doubted on any ground". You need a political agreement. Policy Paper[edit] A Policy Paper is a document published by the Office of the Prosecutor occasionally where the particular considerations given to the topics in focus of the Office and often criteria for case selection are stated. Policy Paper on the Interest of Justice [54] 12 April Policy Paper on Preliminary Examinations [56] 20 June Policy paper on case selection and prioritisation [58] Environmental crimes[edit] On the Policy Paper published in September it was announced that the International Criminal Court will focus on environmental crimes when selecting the cases. The Statute contains three jurisdictional requirements and three admissibility requirements. All criteria must be met for a case to proceed. There are three jurisdictional requirements in the Rome Statute that must be met before a case may begin against an individual. The requirements are 1 subject-matter jurisdiction what acts constitute crimes , 2 territorial or personal jurisdiction where the crimes were committed or who committed them , and 3 temporal jurisdiction when the crimes were committed. Individuals can only be prosecuted for crimes that are listed in the Statute. The primary crimes are

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listed in article 5 of the Statute and defined in later articles: Genocide[edit] Article 6 defines the crime of genocide as "acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group". Crimes against humanity[edit] Article 7 defines crimes against humanity as acts "committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack".

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6: Effective treatment of solitary rectal ulcer syndrome using argon plasma coagulation

The residence of an offeree or purchaser that is a legal entity (e.g. corporation, partnership or trust) is the location where, at the time of the sale, the entity has its principal place of business.

The disease is one of the most commonly diagnosed neurological disorders of horses in the United States. While great strides have been made throughout the last decade in an effort to understand EPM, many questions remain unanswered concerning its etiology, pathogenesis, occurrence, treatment, and diagnosis. Unfortunately, infection with these other protozoan species is clinically indistinguishable from infection with Sarcocystis neurona. For the purpose of this paper, only infection with Sarcocystis neurona as a causative agent of EPM will be described. The definitive host of Sarcocystis neurona is the opossum. Infected opossums shed sporocysts in feces which are in turn infective to the intermediate host when ingested. Many intermediate hosts are currently recognized in the life cycle of this protozoan, and the full range of hosts has yet to be identified. Current species implicated include cats, armadillos, skunks, raccoons, and sea otters. Once the intermediate host is infected, it goes on to develop sarcocysts in its skeletal muscle. When this muscle is ingested by the opossum, the life cycle is completed. The horse is considered an aberrant or dead-end host of Sarcocystis neurona. While the horse is presumably infected by ingestion of sporocysts in contaminated feed and water, there are many unanswered questions concerning the pathogenesis of this protozoan once it actually infects the horse. It is suggested that sporozoites released from the ingested sporocysts are able to penetrate the intestinal wall and enter arterial endothelial cells. Schizonts then develop in these cells until they rupture releasing merozoites into the bloodstream. This stage of the life cycle may be repeated several times producing large amounts of merozoites. At this point, the infection can be cleared leading to seropositivity but no clinical signs or the protozoan can progress to the central nervous system. It is unknown how S. It has been suggested that merozoites enter the CNS via infected leukocytes or through the cytoplasm of endothelial cells. Schizonts and daughter merozoites in the neural tissue remain uninfective and, therefore, transmission from the infected horse to other animals is not possible. Although several theories have been developed concerning why only some horses develop clinical disease, the reason is unknown. Theoretical contributing factors to the development of this disease include stress and other unrelated health events that occur before the onset of clinical EPM. In addition, little is known concerning the incubation period between exposure to the protozoan and development of clinical disease. Clinical Pathology and Necropsy Findings: No characteristic changes are seen in the hemogram or serum chemistries found in horses affected with equine protozoal myeloencephalitis. Cytological examination of cerebral spinal fluid typically does not reveal significant changes. Gross pathological changes are apparent in the affected portions of the brain and spinal cord, and include multifocal areas of hemorrhage and malacia or both grey and white matter. Gross changes of muscular atrophy may also be seen in the skeletal muscle of affected horses. Histological examination of affected nervous tissue reveals neuronal necrosis and loss in addition to marked mononuclear perivascular cuffing. Infiltration of monocytes, lymphocytes, some eosinophils, and rare neutrophils can also be observed. Direct visualization of the organism is often not achieved because they are often present in very low numbers. This is especially true if the animal has been previously treated with antiprotozoal medications. A definitive diagnosis of EPM in a live horse is challenging. Simple seropositivity toward S. In other words, a seropositive horse has been exposed to the organism, but may or may not have EPM. While there are several tests available to diagnose EPM, all of them are problematic. The most recent major advance in diagnosis is the introduction of the immunoblot test for detection of IgG antibodies against Sarcocystis neurona. However, if the CSF is accidentally contaminated with blood during the procedure, a false positive can result. This could also result in a false positive immunoblot test result. These results, as well as the risk of a false positive test, suggest that the use of immunoblot analysis is most useful in ruling out EPM rather than diagnosing the disease. The albumin quotient test was developed to detect contamination of the CSF sample with blood. However, subsequent

studies have found little difference between index values of EPM-affected horses and normal control horses. The detection of characteristic lesions on necropsy is considered the gold standard of diagnosis by some. Due to the small number of organisms needed to cause the disease, however, the diagnosis can be missed even with a full neurologic necropsy. In general for the live animal, a clinical diagnosis is best established in horses with neurological disease consistent with EPM and a positive immunoblot test or an uncontaminated CSF sample. Another clue for diagnosis is an improvement of clinical signs in response to treatment of EPM. Overall, it is imperative that the diagnosis be based not only on test results, but in conjunction with a thorough diagnostic examination that rules out other causes of neurological disease. Treatment of equine protozoal myeloencephalitis is expensive, and even mildly affected horses can require prolonged therapy. The standard treatment for many years has been combinations of antifolate drugs including sulfadiazine and pyrimethamine with or without trimethoprim. The use of folic acid supplements in conjunction with this therapy has been recommended by some in an effort to reduce the risk of folic acid deficiency. A recent case report showed that supplementation failed to prevent the development of folic acid deficiency, however. The use of nonsteroidal anti-inflammatory medi-cations in conjunction with traditional therapy has been routinely used for many years. Supplementation with various vitamins has been recommended by some as well as the use of acupuncture in an effort to treat EPM; however, the efficacies of these practices have not been proven in clinical trials. The most recent breakthrough in the treatment of EPM is the development of triazine-derivative drugs. These medications were initially developed as herbicides and have historically been used as coccidiostats in poultry and swine. Other drugs in this class include diclazuril and toltrazuril. Ponazuril is a primary metabolite of toltrazuril, and has shown anticoccidial activity against several parasites, including Sarcocystis neurona. Treatment regimen requires once a day dosing for days. While studies show ponazuril can effectively rid horses of S. The mechanism of this relapse is unknown, but reemergence of a latent stage parasite, persistence of a small focus of infection despite treatment, and reexposure to S. Due to the lifestyle and eating habits of the definitive host of Sarcocystis neurona the opossum , prevention and control of EPM are potentially problematic. Current recommendations include preventing access of opossums to hay, grain, pasture, and water sources. This may be difficult, especially if food and water are in short supply for the opossum. The most reasonable and simple precaution for horse owners to take is to deny access of stored hay and grain bins to the opossum. The opossum is considered a scavenger and will consume whatever is available to it, including road-kill. Recommendations to prevent EPM commonly include picking up road-kill in the immediate area. This suggestion may be somewhat ineffective, however, since there are likely many other unknown intermediate hosts that are perpetuating the lifecycle. A killed vaccine against Sarcocystis neurona has been developed using merozoites. Overall, there are few suggestions to aid in the prevention of Sarcocystis neurona exposure. Detection of antibodies against Sarcocystis neurona in cerebro-spinal fluid from clinically normal neonatal foals. Sensitivity and specificity of western blot testing of cerebrospinal fluid and serum for diagnosis of equine protozoal myeloencephalitis in horses with and without neurologic abnormalities. Clinical diagnosis of equine protozoal myeloencephalitis. J Vet Internal Med J Equine Vet Sci Folate deficiency during treatment with orally administered folic acid, sulphadiazine and pyrimethamine in a horse with suspected equine protozoal myeloencephalitis. Equine Vet J

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After BMT, 23 patients had cytogenetic studies; the outcome of the cytogenetic events is summarized in Figure www.enganchecubano.com initial testing, 19 patients had normal karyotypes, 16 of whom continued to have a normal karyotype during subsequent studies.

Patient records were registered prospectively in successive patients with NHL admitted to the Norwegian Radium Hospital from to A total of patients had no CNS involvement at diagnosis and were treated according to standard protocols. The incidence and risk factors for CNS progression or relapse were examined retrospectively. The risk of CNS involvement in this study is comparable with the results from other large series. Patients with other types of H-NHL should receive adequate CNS prophylaxis if at least four of the five risk factors identified are present. In general, time to CNS involvement is short [7]. At some centers, CNS prophylaxis is also administered to patients with other high-grade lymphomas at sites presumed to be associated with CNS recurrence, such as the bone marrow, skeleton, testicles and paranasal sinuses [8 , 10 , 13 , 14]. Central nervous system recurrence is considered rare in low-grade lymphomas [10 , 15 , 16]; however, only a few studies have examined its incidence in these types of lymphoma. Whether CNS prophylaxis should include both systemic CNS-active and intraspinal chemotherapy is unclear, although lessons learnt from the treatment of lymphoblastic leukemia [17] favor the use of both lines of treatment, although the risk of neurotoxicity may increase [3 , 18]. Numerous studies [7 , 10 , 16 , 19â€”23] have examined risk factors associated with CNS involvement, but some of the results are contradictory. The main objective of this study was to identify the risk factors for developing CNS involvement during primary treatment or at relapse, and to establish a risk model that can guide clinicians in the identification of high-risk patients and decide when CNS prophylaxis should be given. Thirty patients with CNS disease at presentation were excluded from the analysis. There were males and females with a median age of 62 years range 15â€”93 years. Median observation time was 94 months range 13â€” months for the survivors. Among these patients with NHL, patients 4. The percentage CNS recurrence according to the Kiel classification [24]were as follows: One patient with unclassified lymphoma relapsed in the CNS. Standard staging procedures were performed. Examinations of the cerebrospinal fluid CSF was performed on all patients given CNS prophylactic chemotherapy see section on Treatment. The prevalence of HIV positivity in Norway during the â€”s was extremely low. HIV positivity was routinely assessed from Clinical stage at presentation was classified according to the Ann Arbor system [25]. Among the 22 patients with intracerebral involvement, a biopsy to confirm the lymphoma diagnosis was only performed in one patient. Other explanations such as CNS-associated infection, hemorrhage or infarction were excluded. Distribution of the various histological subtypes amongst the patients is shown in Table 1. Histological diagnosis was not reviewed specifically for this analysis, but the great majority of cases were diagnosed by one of two experienced hematopathologists. Treatment The treatment of systemic disease followed standard protocols at the institution. Patients with advanced L-NHL disease received cyclophosphamide, vincristine and prednisone COP until , and thereafter chlorambucil and prednisone. Transformed lymphomas were treated as H-NHL. Intrathecal CNS prophylaxis with MTX 12 mg was after given to most patients with H-NHL with involvement of the bone marrow, epidural space, skeleton, testicles or paranasal sinuses. In addition, the latter group received high-dose MTX with folic acid rescue. Analysis of potential risk factors The following factors were registered as potential risk factors for CNS involvement and entered into univariate analysis. Lymph node involvement at the following sites including the spleen: The Kaplanâ€”Meier method was used for estimating the probability of CNS involvement during primary treatment or at relapse [29], and the time to CNS recurrence for different groups were compared by the log-rank test [30]. Patients with no CNS recurrence were treated as censored. Only variables maintaining a statistically significant effect were kept in the model. Results Median time to CNS recurrence for those 36 patients who progressed during primary treatment was 5 months range 2â€”45 and for

those 70 who relapsed, 16 months range 3â€” The median time from CNS involvement to death for patients with primary progression and for those who relapsed was 2. The site of CNS involvement was diffuse meningeal involvement 74 patients , intracerebral location 22 patients or epidural one patient , and in eight patients the CNS involvement was clinically diagnosed. The description of the patients according to their histology is listed in Table 2. Prophylaxis was only given to 70 of patients with either involvement of the bone marrow, testicles, skeleton or head-and-neck sites close to the CNS. The risk of isolated or systemic CNS involvement was similar, but isolated CNS recurrence seemed to take place somewhat earlier. Risk factors for CNS involvement in the different histological groups Low-grade histology A total of 33 2. In multivariate analysis, B-symptoms, involvement of the bone marrow or skin were independent prognostic factors, and the relative risk of CNS involvement was 2. Only three patients had all three risk factors; one of these three developed CNS involvement. Analysis of the different low-grade histologies did not reveal any difference in the risk of developing CNS involvement. However, five patients with aggressive centrocytic mantle cell lymphoma according to the WHO classification received CNS prophylaxis. The time to CNS involvement was 2â€”50 months. Testicular involvement at diagnosis was seen in only 25 patients, of whom two patients with stage IV disease de-veloped CNS involvement. Skeletal involvement was present in 80 patients, of whom five developed CNS involvement one patient with stage I and four patients with stage IV. Risk factors from the univariate analyses were entered into the Cox regression model, by both forward selection and backward elimination, and the same prognostic factors were found to be important by all modeling strategies. Five variablesâ€”age, LDH, albumin, retroperitoneal glands and number of extranodal sitesâ€”were shown to have an independent impact on subsequent CNS involvement. Figure 1 shows Kaplanâ€”Meier estimates for the risk of CNS involvement in groups representing the number of the five risk factors age, LDH, albumin, retroperitoneal lymph node involvement, more than one extranodal site present at diagnosis. As the estimated hazard ratios are not identical, the curves only give a general picture. The probability of CNS recurrence within 5 years is listed in Table 4. Discussion We report the overall risk of secondary CNS involvement following a diagnosis of NHL in patients consecutively accrued and followed up from a single institution. Why some lymphomas spread to the CNS is not clear. Bloodâ€”brain dissemination from the retroperitoneal glands or bone marrow to the leptomeninges through the intervertebral venous plexa may play a role [2 , 8 , 14], as may adhesion molecules expressed by tumor cells, since CD56 expression is associated with CNS infiltration in peripheral T-cell lymphomas [32]. Gene expression profiling using microarray techniques [33] may uncover more powerful biological variables for predicting CNS recurrence in the future. However, one should not forget that PCR rearrangement studies of Ig rearrangements in late CNS relapses indicate that they may also represent a second unpredictable de novo neoplasm [34]. The overall risk of CNS dissemination following a primary diagnosis of lymphoma was 4. Central nervous system recurrence occurred in 96 of patients within 5 years, median time 10 months. The risk is reported to range from 1. The latency time to CNS involvement varied from 6 to 8 months [7 , 21 , 23 , 36]. Factors previously reported to be associated with increased risk of CNS recurrence include: Factors associated with advanced disease: Factors showing an influence of the disease on the patient: B-symptoms [1 , 7 , 16 , 22] or performance status [7]. A combination of factors associated with an inferior prognosis, such as IPI [20 , 35]. Young age defined differently in various studies is often associated with a higher risk for CNS recurrence [5 , 16 , 19 , 21]. Involvement of specific sites were the prominent risk factors in previous studies when analyzed by either univariate or multivariate analyses. However, in more recent studies that include a higher number of patients [7 , 20 , 35], other risk factors have turned out to be more important LDH, IPI, number of extranodal sites. Our data are partly in line with these findings, but we did not find IPI to be an independent risk factor. This may be due to an increased risk for CNS recurrence in younger, not older, patients, while the opposite is the case for IPI score. Furthermore, we found retroperitoneal lymph node infiltration to be an independent factor, which may be due to the vicinity of these glands especially when bulky to the intervertebral venous plexa and thereby to the leptomeninges [2]. A fifth independent risk factor, serum albumin, has not been included as a

potential risk factor for CNS recurrence by other investigators. Many authors recommend CNS prophylaxis for those with bone marrow involvement [1 , 2 , 16 , 19 â€” 23 , 36 , 39]. However, recent data have not confirmed the association between bone marrow involvement and CNS disease [7 , 35]. The few investigations performed in indolent lymphomas describe the risk in general to be low [10 , 15 , 16]. The few cases of CNS involvement were reported to be associated with a transformation to high-grade malignancy [15]. Nevertheless, they consider the role of CNS prophylaxis in reducing CNS recurrence as doubtful, because CNS infiltration in MCL is almost invariably part of a disseminated disease or a systemic relapse, and because the prognosis is poor anyway. High-grade histology was diagnosed in patients, of whom 52 4. The patients with H-NHL could be divided in two risk groups: A high risk group in which patients possess four or five risk factors In our view, CNS prophylaxis should be given to patients with at least a two- to three-fold increased risk of CNS recurrence. We thus recommend that the patients in the high-risk group should receive CNS prophylaxis. We could not confirm a significantly higher risk for CNS recurrence for patients with involvement of the testicles, paranasal sinuses or skeleton in the univariate analyses. Notably, skeletal 80 patients and testicular 25 patients involvement with stage IE and IIE disease had a very low risk of CNS involvement in our study [42]. Those with involvement of the bone marrow had a significantly higher risk of CNS recurrence in univariate analysis, but not in multivariate analysis. Reasons for not giving the more intensive chemotherapy regimen including CNS prophylaxis were increased age or poor performance status in most patients, and the groups were therefore not directly comparable. Inclusion of age and performance status in the analysis did not, however, change the effect of prophylaxis. No independent risk factors for developing CNS involvement could be found in these histological groups. As indicated from the treatment of childhood leukemias [44] and lymphomas [45], systemic control seems to reduce the likelihood of CNS recurrence. Prospective randomized studies in which one [10 , 47] or several study arms [48] contain CNS-active regimens could have clarified the importance of CNS prophylactic treatment. However, the incidence of CNS recurrence is not reported in any of these studies. Frequencies of CNS recurrence derived from these studies, especially if the data were put together in a meta analysis, might clarify whether CNS-active treatment really protects against CNS involvement. As our study was not a randomized intervention study, patients receiving CNS prophylaxis were not comparable to those not receiving prophylaxis, and the effect of prophylaxis could not be estimated. However, based on pharmacological studies and data from the treatment of acute lymphoblastic leukemias and lymphomas, as well as studies from the GELA group, intensive systemic therapy including systemic high-dose MTX and MTX i. Our study is retrospective in nature, and ideally the results should be confirmed in a prospective study.

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The relapse-free survival of all patients except those with stage IA1disease was % at 1 year after diagnosis of the dysgerminoma, % at 2 years, and % at 4 years. The earliest relapse was 4 1/2 months after diagnosis, and the latest observed relapse was at years.

List of Titles Sec. Attendance of witnesses in criminal proceedings. The following words, when used in this section, have the meaning specified, unless the context otherwise indicates: If a judge of a court of record in any state which by its laws has made provision for commanding persons within that state to attend and testify in this state certifies, under the seal of such court, that there is a criminal prosecution pending in such court, or that a grand jury investigation has commenced or is about to commence, that a person being within this state is a material witness in such prosecution or grand jury investigation and that the presence of such witness will be required for a specified number of days, upon presentation of such certificate to any judge of a court of record in the judicial district in which such person is, such judge shall fix a time and place for a hearing and shall make an order directing the witness to appear at such time and place for such hearing. If, at such hearing, the judge determines that the witness is material and necessary, that it will not cause undue hardship to the witness to be compelled to attend and testify in the prosecution or a grand jury investigation in the other state and that the laws of such other state and the laws of any other state through which the witness may be required to pass by ordinary course of travel will give to such witness protection from arrest and from the service of civil or criminal process, the judge shall issue a summons, with a copy of the certificate attached, directing the witness to attend and testify in the court where the prosecution is pending, or where a grand jury investigation has commenced or is about to commence at a time and place specified in the summons. At any such hearing, the certificate shall be prima facie evidence of all the facts stated therein. If such certificate recommends that the witness be taken into immediate custody and delivered to an officer of the requesting state to assure the attendance of the witness in such state, such judge may, in lieu of notification of the hearing, direct that such witness be forthwith brought before such judge for such hearing, and, being satisfied, at such hearing, of the desirability of such custody and delivery, of which desirability such certificate shall be prima facie proof, may, in lieu of issuing a subpoena or summons, order that such witness be forthwith taken into custody and delivered to an officer of the requesting state. If such witness, after being paid or tendered by an authorized person the same amount per mile as provided for state employees pursuant to section c for each mile by the ordinary traveled route to and from the court where the prosecution is pending and five dollars each day that such witness is required to travel and attend as a witness, fails, without good cause, to attend and testify as directed in the summons, the witness shall be punished in the manner provided for the punishment of any witness who disobeys a summons issued from a court of record in this state. If a person in any state, which by its laws has made provision for commanding persons within its borders to attend and testify in criminal prosecutions or in grand jury investigations commenced or about to commence in this state, is a material witness in a prosecution pending in a court of record in this state, or in a grand jury investigation which has commenced or is about to commence, a judge of such court may issue a certificate under the seal of the court, stating such facts and specifying the number of days the witness will be required. Such certificate may include a recommendation that the witness be taken into immediate custody and delivered to an officer of this state to assure the attendance of the witness in this state. Such certificate shall be presented to a judge of a court of record in the judicial district in which the witness is found. If the witness is summoned to attend and testify in this state, the witness shall be tendered the same amount per mile as provided for state employees pursuant to section c for each mile by the ordinary traveled route to and from the court where the prosecution is pending, and five dollars for each day that such witness is required to travel and attend as a witness. A witness who has appeared in accordance with the provisions of the summons shall not be required to remain within this state a longer period of time than the period mentioned in the certificate, unless otherwise ordered by the court. If

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such witness, after coming into this state, fails, without good cause, to attend and testify as directed in the summons, the witness shall be punished in the manner provided for the punishment of any witness who disobeys a summons issued from a court of record in this state. If a person comes into this state in obedience to a summons directing him to attend and testify in this state, he shall not, while in this state pursuant to such summons, be subject to arrest or the service of process, civil or criminal, in connection with matters which arose before his entrance into this state under such summons. If a person passes through this state while going to another state in obedience to a summons to attend and testify in that state or while returning therefrom, he shall not, while so passing through this state, be subject to arrest or the service of process, civil or criminal, in connection with matters which arose before his entrance into this state under such summons. This section shall be so interpreted and construed as to effectuate its general purpose to make uniform the laws of the states which enact it. Annotations to former section Annotations to present section: Habeas corpus petitioner, incarcerated in Arizona, could not prevail on claim that trial court should have invoked provisions of Subsec.

9: Equine Protozoal Myeloencephalitis

Amended Rule and new Rule A will be effective days after publication in the Federal Register. Amended Rule will be effective 60 days after publication in the Federal Register. The repeal of Rule will be effective days after publication in the Federal Register.

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