



FADOI (Federation of the Associations of Hospital Internists)

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Insubria University, Varese

National President FADOI 2023-2025

WHO WE ARE

FADOI (founded in 1995) is a scientific society with almost **5,500** members, supporting the growth and training of internists while promoting research and innovation in internal medicine.

It is also connected to **ANIMO**, a nursing society with over **1,000** members.



WHO WE ARE II

1100 Internal Medicine Units in Italy

- 900.00 patients are admitted to Internal Medicine each year
- > 1/6 of the total hospital admissions
- 50% of the acute non surgical hospital admissions



Under 40 year Members (>50%)



OUR MISSION

- ✓ Spread advanced scientific knowledge
- ✓ Improve the quality of medical care
- ✓ Collaborate with healthcare institutions and universities





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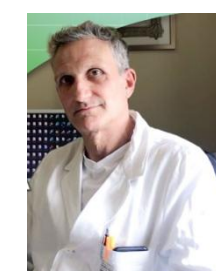
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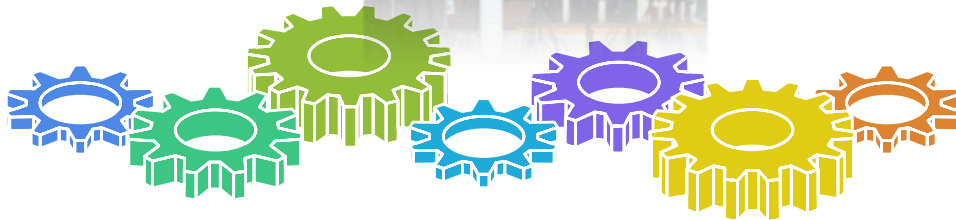
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In **2025**, the new headquarters was inaugurated — further enhanced and technologically advanced — at **MIND – Milano Innovation District**, the new Italian hub of scientific excellence.

It is a major contemporary international district, a place of knowledge and sustainable growth, open to all those who innovate, conduct research, or study — to institutions, companies, and the life of the community



2025

> 200 Educational Events (+16.3% compared to 2024)

158 In-person courses

26 Online courses

19 On-the-job training sessions

2 Blended course (FSC-RES)

2025

> 10.000 Participants

6. PATRIMONIO FORMATIVO

Categoria	Valore Triennio
Persone uniche coinvolte	835
Relatori esclusivi	578 (69%)
Moderatori esclusivi	92 (11%)
Professionisti multi-ruolo	165 (20%)

FADOI 2024-2025 Schools

SCUOLA DI NIV
NAZIONALE FADOI-ANIMO
a cura del gruppo giovani FADOI-ANIMO

Corso Teorico
FAD ASINCRONA
2 Maggio 2024 - 1° maggio 2025

Corso Pratico
FORMAZIONE SUL CAMPO
Firenze, Modica RG, Budrio BO, Cerignola FG, Torino, Varese



SCUOLA DI EPATOLOGIA
FADOI
Scuola di Epatologia
per **Internisti**
Ospedalieri

BOLOGNA, Zanhotel Europa

5-6 APRILE 2024	14-15 APRILE 2024
16-17 GIUGNO 2024	20-21 SETTEMBRE 2024




SCUOLA DI ECOGRAFIA
FADOI
XIII CORSO DI FORMAZIONE DI BASE

BOLOGNA
28-30 SETTEMBRE 2024



Scuola di Medicina Interna
FADOI Lazio Sud

**DALLE PATOLOGIE
COMUNI
ALLE MALATTIE RARE:
PARLARNE
PER RICONOSCERLE**

FROSINONE
16 OTTOBRE 2024

Sala Teatro - Ospedale Fabrizio Spaziani



2° Corso Nazionale FADOI
di ecografia clinica bedside:
come, quando e perché
Bologna 18-19 aprile 2024




3° Corso Nazionale FADOI
di ecografia clinica bedside:
come, quando e perché
Matera 14-15 novembre 2024




Ultrasound Schools (with simulators)





**Empowerment & awareness delle malattie rare in
Medicina Interna: l'importanza della diagnosi precoce**





**FAD Asincrona attiva dal
1° aprile 2025 al 31 dicembre 2025**



FAD INTERPRETAZIONE EMOGASANALISI



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DEI DIRIGENTI
OSPEDALIERI
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Italian Journal of Medicine

*A Journal of Hospital
and Internal Medicine*

The official journal of the Federation of Associations
of Hospital Doctors on Internal Medicine (FADOI)

QUADERNI dell'Italian Journal of Medicine

*A Journal of Hospital
and Internal Medicine*

The official journal of the Federation of Associations
of Hospital Doctors on Internal Medicine (FADOI)

Congresso Nazionale della Società Scientifica FADOI

13-16 maggio 2017

Presidente: A. Fontanella

Guest Editors: L. Bellesia, A. Valerio

**Comunicazione con il paziente e tra professionisti
gestione del paziente complesso in Medicina Interna**

Editors: S. Lenti, M. Felici, M. Campanini, A. Fontanella, R. Nardi, G. Gussoni

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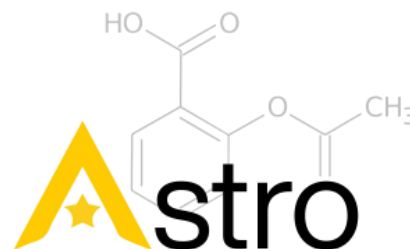
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score risk
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RICO
thromboprophylaxis
Internal Medicine
bleeding
VTE
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IMPROVE

The Use of Risk Scores for Thromboprophylaxis in Medically Ill Patients—Rationale and Design of the RICO trial

Francesco Dentali^{1,2} Mauro Campanini³ Aldo Bonaventura^{1,6} Luca Fontanella⁴
Francesca Zuretti¹ Luca Tavazzi³ Nicola Mumoli^{5,6} Paola Gennari⁷ Francesco Ventrella²
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⁷Internal Medicine, "San Paolo" Hospital, Sesto, Italy

Trials Open 2020, 6:157-168.

Abstract

Background Venous thromboembolism (VTE) in hospitalized medically ill patients is a significant cause of morbidity and mortality. Guidelines suggest that VTE and bleeding risk assessment models (RAMs) should be integrated into the clinical decision-making process on thromboprophylaxis. However, poor evidence is available comparing the use of a RAM versus clinical judgement in evaluating VTE and bleeding occurrence.

Methods Reducing Important Clinical Outcomes in hospitalized medical ill patients (RICO) is a multicenter, cluster-randomized, controlled clinical trial (ClinicalTrials.gov Identifier: NCT04207718). Acutely ill patients hospitalized in Internal Medicine wards are randomized to the use of RAMs—namely the Padua Prediction Score and the International Medical Prevention Registry on Venous Thromboembolism Bleeding Score—or to clinical judgement. The primary study outcome is a composite of symptomatic objectively confirmed VTE and major bleeding at 90-day follow-up. Secondary endpoints include the evaluation of clinical outcomes at hospital discharge and the assessment of VTE prophylaxis prescription during the study period. In order to demonstrate a 50% reduction in the primary outcome in the experimental group and assuming an incidence of the primary outcome of 3.5% in the control group at 90-day; 2,844 patients across 12 centers will be included in the study.

Discussion The RICO trial is a randomized study of clinical management assessing the role of RAMs in hospitalized medical ill patients with the aim of reducing VTE and bleeding occurrence. The study has the potential to improve clinical practice since VTE still represents an important cause of morbidity and mortality in this setting.

Keywords

- medical patients
- venous thromboembolism
- RAMs
- major bleeding
- thromboprophylaxis

Perselli et al. BMC Infectious Diseases (2021) 21:414
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BMC Infectious Diseases

RESEARCH

Open Access

Real-world use of remdesivir for the treatment of patients admitted to Italian hospitals with COVID-19: the nationwide retrospective FADOI-RECOVER study

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Abstract Remdesivir is widely used for treatment of SARS-CoV-2 pneumonia. The aim of this study was to evaluate the characteristics of patients with moderate-to-severe COVID-19 treated with remdesivir, and their outcomes during hospitalization.

Methods This retrospective observational multicenter study included consecutive patients hospitalized for moderate-to-severe COVID-19 (September 2020–September 2021), who were treated with remdesivir.

Results One thousand four patients were enrolled, all with onset of symptoms occurring less than 10 days before starting remdesivir. 17% of patients had 4 or more concurrent diseases. Remdesivir was well tolerated; adverse drug reactions (ADRs) being reported in 2.3% of patients. In-hospital death occurred in 80 patients (5.6%). The median timing of the first remdesivir dose was 5 days after symptom onset. The following endpoints did not differ according to the time span from the onset of symptoms to the first dose length of hospitalization, in-hospital death, composite outcome (in-hospital death and/or endotracheal intubation). Advanced age, number of comorbidities, A and severity of respiratory failure at admission were associated with poor in-hospital outcomes.

Conclusion In a real-world setting, remdesivir proved to be a safe and well-tolerated treatment for moderate-to-severe COVID-19. In patients receiving remdesivir less than 8 or 5 days from the onset of SARS-CoV-2 symptoms, mortality and the need for mechanical ventilation did not differ from the rest of the sample.

Keywords Remdesivir, Internal Medicine, COVID-19 pneumonia, Management of COVID-19

*Fulvio Pomeroy and Filippo Pieralli contributed equally to this work.

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Internal and Emergency Medicine (2021) 16:2001–2009
https://doi.org/10.1007/s11739-021-02935-5

IM - ORIGINAL

A new score to predict *Clostridioides difficile* infection in medical patients: a sub-analysis of the FADOI-PRACTICE study

Nicola Mumoli^{1,2}, Aldo Bonaventura², Chiara Marchesi³, Marco Cel⁴, Laura Morbidoni⁵, Ignazio Donatelli⁶, Antonino Mazzaro⁷, Francesco Dentali⁸

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Abstract

Medical divisions are at high risk of *Clostridioides difficile* infection (CDI) due to patients' frailty and complexity. This sub-analysis of the FADOI-PRACTICE study included patients presenting with diarrhea either at admission or during hospitalization. CDI diagnosis was confirmed when both enzyme immunoassay and A and B toxin detection were found positive. The aim of this sub-analysis was the identification of a new score to predict CDI in hospitalized, medical patients. Five hundred and seventy-two patients with diarrhea were considered. More than half of patients was female, 40% on antibiotics in the previous 4 weeks and 60% on proton pump inhibitors (PPIs). CDI diagnosis occurred in 103 patients (18%). Patients diagnosed with CDI were older, more frequently of female sex, recently hospitalized and bed-ridden, and treated with antibiotics and PPIs. Through a backward stepwise logistic regression model, age > 45 years, female sex, recent hospitalization, recent antibiotic therapy, active cancer, prolonged hospital stay (> 12 days), hypoalbuminemia (albumin < 3 g/dL), and leukocytosis (white blood cells > 9 × 10⁹/L) were found to independently predict CDI occurrence. These variables contributed to building a clinical prognostic score with a good sensitivity and a modest specificity for a value > 7 (79% and 58%, respectively; AUC 0.75, 95% CI 0.71–0.79, p < 0.001), that identified low-risk (score < 3, 42.5%) and high-risk (score > 3, 57.5%) patients. Although some clinical risk factors were confirmed to increase CDI occurrence, the changing landscape of CDI epidemiology suggests a reappraisal of common risk factors and the development of novel risk scores based on local epidemiology.

Keywords *Clostridioides difficile* infection · Diarrhea · Antibiotics · Risk score · Healthcare-associated infection · Internal medicine

Introduction

Clostridioides difficile infection (CDI) is a major cause of hospital-associated illness in developed countries [1]. In Europe, the incidence of CDI among hospitalized patients

ranges from 2.45 to 4.1 per 10,000 patient-days [2]. Antibiotic exposure during hospitalization is the main risk factor for CDI, however, *C. difficile* is increasingly being recognized as a cause of community-associated diarrhea [1]. Other common independent risk factors for CDI are older age (especially > 65 years), female sex, chemotherapy, prior or prolonged hospitalization, and a large number of comorbidities [3–6]. Medical divisions are reported to be at high

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Writing week end



Every two years, we train **15–20 young FADOI members** to write a scientific paper.

Over the course of two editions, we have **written and published six scientific articles** in **impact factor journals**, based on **secondary analyses of FADOI study databases**.

Organised by the EFIM Multimorbidity WG



Hospitalist Model and Co-management in Surgical Areas Across Europe

April 29th 2025
17:30 to 18:30 CET

Chair:

Ombretta Para. Internal Medicine 1 - University Hospital of Careggi, Florence Italy

17:30-17:55

Lecture 1. A travel through different co-management models in surgical settings.

Professor Francesco Dentali.

Department of Medicine and Surgery, University of Insubria, Varese, Italy

17:55-18:20

Lecture 2. Managing relevant diseases and medical complications in patients with multimorbidity

Professor Arantxa Alvarez de Arcaya Vicente.

Hospitalist Medicine Unit, Hospital Clínico San Carlos, Madrid, Spain.

18:20-18:30. Discussion and conclusions.



Original article

Competences of internal medicine specialists for the management of patients with multimorbidity. EFIM multimorbidity working group position paper

M Bernabeu-Wittel^{a,*}, O Para^b, J Voicehovska^c, R Gómez-Huelgas^d, J Václavík^e, E Battegay^f, M Holecki^g, B.C. van Munster^h, on behalf of EFIM Multimorbidity Working Group

^a Department of Medicine, Internal Medicine Department, Hospital Universitario Virgen del Rocío, University of Sevilla, Spain
^b Azienda Ospedaliera Universitaria Careggi, Firenze, Italy
^c Internal Diseases Department, Nephrology and renal replacement therapy clinic, Rigis Stradins University Hospital, Riga, Latvia
^d Internal Medicine Department, Department of Medicine, Hospital Universitario Regional de Málaga, University of Málaga, Spain
^e Department of Internal Medicine and Cardiology, University Hospital Olomouc and Olomouc University Faculty of Medicine, Olomouc, Czech Republic
^f International Center for Multimorbidity and Complexity (ICMC), University of Zurich, Zurich, University Hospital Basel (Department of Psychosomatic Medicine) and Marian Insels Klinik Basel, Switzerland
^g Department of Internal, Autoimmune and Metabolic Diseases, Medical University of Silesia, Katowice, Poland
^h Department of Geriatric Medicine, University of Groningen, Medical Medical Center Groningen, Groningen, The Netherlands

ARTICLE INFO

Keywords:
Multimorbidity
Competences
Integrated care
Internal medicine

ABSTRACT

Patients with multimorbidity increasingly impact healthcare systems, both in primary care and in hospitals. This is particularly true in Internal Medicine. This population associates with higher mortality rates, polypharmacy, hospital readmissions, post-discharge syndrome, anxiety, depression, accelerated age-related functional decline, and development of geriatric syndromes, amongst others. Internists and Hospitalists, in one of their roles as Generalists, are increasingly asked to attend to these patients, both in their own Departments as well as in surgical areas. The management of polypathology and multimorbidity, however, is often complex, and requires specific clinical skills and corresponding experience. In addition, patients' needs, health-care environment, and routines have changed, so emerging and re-emerging specific competences and approaches are required to offer the best coordinated, continuous, and comprehensive integrated care to these populations, to achieve optimal health outcomes and satisfaction of patients, their relatives, and staff. This position paper proposes a set of emerging and re-emerging competences for internal medicine specialists, which are needed to optimally address multimorbidity now and in the future.

1. The impact of multimorbidity on our health-care systems, hospitals, and different fields of internal medicine

By 2060, the number of Europeans above age 65 is projected to increase from 88 to 153 million [1]. In consequence, the true challenge for European health care systems is to prepare for this monumental change in demography. Aging is closely related to the development of chronic diseases, which cumulate during life. This relatively recent phenomenon has given rise to the term multimorbidity (MM), defined as the presence of two or more chronic diseases at the same time in the same patient or a more recent and restricted definition the complex interactions of several co-existing diseases (<https://www.ncbi.nlm.nih.gov/pubmed/3712857> term=Multimorbidity). The increasing presence of aging citizens

suffering from multiple chronic conditions requires an extensive reorganization of health care delivery systems, which ought to adapt their services to the real needs of patients: from a disease-oriented to a person-oriented approach. This is the most important and fundamental idea, that must underly all initiatives oriented towards chronic care [2, 3].

Multimorbidity is associated with a decline in many aspects of health and in consequence with an increase in hospital admissions, psychological, familial, and social distress, polypharmacy, and use of health care and social resources [3–6]. The management of patients with MM has given emphasis to the continuity of care, teamwork, holistic integral and integrated coordinated care, with the involvement of patients, families, caregivers, and social networks [9–12]. A new set of emerging

Original article

Competences of internal medicine specialists for the management of patients with multimorbidity. EFIM multimorbidity working group position paper

M Bernabeu-Wittel^{a,*}, O Para^b, J Voicehovska^c, R Gómez-Huelgas^d, J Václavík^e, E Battegay^f, M Holecki^g, B.C. van Munster^h, on behalf of EFIM Multimorbidity Working Group

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Guidelines

Acute heart failure – an EFIM guideline critical appraisal and adaptation for internists^a

Valentin A. Kokorin^a, Alvaro González-Franco^b, Antonio Cittadini^c, Oskars Kalejs^d, Vera N. Larina^e, Alberto M. Marra^f, Francisco J. Medrano^g, Zdenek Monhart^h, Laura Morbidoniⁱ, Joana Pimenta^j, Wiktoria Lesniak^k

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ARTICLE INFO

Keywords:
Acute heart failure
Clinical practice guideline
Critical assessment
Internal medicine
Consensus

ABSTRACT

Background: Over the past two decades, several studies have been conducted that have tried to answer questions on management of patients with acute heart failure (AHF) in terms of diagnosis and treatment. Updated international clinical practice guidelines (CPGs) have endorsed the findings of these studies. The aim of this document was to adapt recommendations of existing guidelines to help internists make decisions about specific and complex scenarios related to AHF.
Methods: The adaptation procedure was to identify firstly unresolved clinical problems in patients with AHF in accordance with the PICCO (Population, Intervention, Comparison and Outcome) process, then conduct a critical assessment of existing CPGs and choose recommendations that are most applicable to these specific scenarios. **Results:** Seven PICCOs were identified and CPGs were assessed. There is no single test that can help clinicians in discriminating patients with acute dyspnoea, congestion or hypoxaemia. Performing of echocardiography and natriuretic peptide evaluation is recommended, and chest X-ray and lung ultrasound may be considered. Treatment strategies to manage arterial hypotension and low cardiac output include short-term continuous intravenous isotropic support, vasopressors, renal replacement therapy, and temporary mechanical circulatory support. The most updated recommendations on how to treat specific patients with AHF and certain comorbidities and for reducing post-discharge rehospitalization and mortality are provided. Overall, 51 recommendations were endorsed and the rationale for the selection is provided in the main text.
Conclusions: Through the use of appropriate tailoring process methodology, this document provides a simple and updated guide for internists dealing with AHF patients.

Abbreviations: ABCDE staging; A: At risk; B: Beginning; C: Classic; D: Deteriorating; E: Extreme; ACEi, angiotensin-converting enzyme

^a External Reviewers: Pietro Ameri (Genova, Italy), Josep Comin-Colet (Barcelona, Spain), Maria Crespo-Leiro (La Coruña, Spain).
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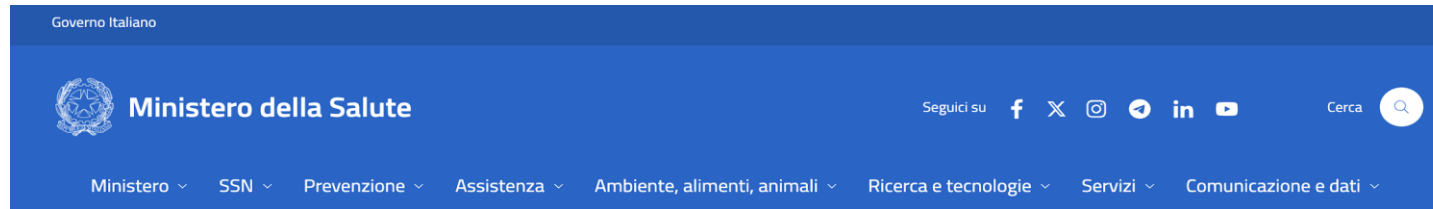


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**Valutazione del rischio cardiovascolare individuale:
esame dei calcolatori disponibili e degli strumenti
più congeniali e utilizzabili nel nostro Paese**



Valutazione del rischio cardiovascolare individuale, pubblicato il documento dell'Alleanza italiana per le malattie cardio-cerebrovascolari

[CONDIVIDI](#)

15/04/2025



Vedi anche

10/02/2025 - [Inquinamento dell'aria e malattie cardiovascolari, on line il documento dell'Alleanza italiana per le malattie cardio-cerebrovascolari](#)

11/11/2024 - [Linee di indirizzo sull'attività fisica. Revisione delle raccomandazioni per le persone con diabete mellito e per le persone sottoposte a trapianto e nuove raccomandazioni per le persone con patologie muscolo-scheletriche](#)

29/10/2024 - [29 ottobre, World Stroke Day - Giornata Mondiale dell'ictus](#)



FADOI National Day for health Prevention



Società Scientifica FADOI di Medicina Interna

ANIMO
FORMAZIONE
RICERCA
SVILUPPO
INNOVAZIONE
Associazione Nazionale Infermieri Medicina

12 APRILE 2025

Seconda Giornata Nazionale della Prevenzione

FADOI ANIMO
medici e infermieri internisti ospedalieri

#prenditicuradite



A tree for Health (One-health Project)

Collaboration with Italian Carabinieri





ESIM 2026



BARI - ITALY

Winter School

FEBRUARY 15th - 21st

European School of Internal Medicine in Puglia 2026 - Winter School
Preliminary Program

Sunday 15 feb	Monday 16 feb	Tuesday 17 feb	Wednesday 18 feb	Thursday 19 feb	Friday 20 feb	Saturday 21 feb
	7.30 – 08.30 Breakfast	7.30 – 08.30 Breakfast	7.30 – 08.30 Breakfast	7.30 – 08.30 Breakfast	7.30 – 08.30 Breakfast	
	8.30 – 9.00 Welcome and introduction	8.30 – 9.30 NIV in hypoxemic respiratory failure (pulmonary edema, pneumonia)	8.30 – 9.00 NIV in acute exacerbation of COPD including studies on high-flow oxygen therapy, etc.)	8.30 – 9.30 Unusual indications for NIV (ARDS, COVID, asthma, chest trauma, postoperative setting)	8.30 – 9.00 Palliative NIV	
	9.00 – 10.00 General principles of NIV: indications, contraindications, modes, settings, monitoring, interfaces	9.30 – 10.00 Fundamental principles of ultrasound and machine settings	9.00 – 9.30 Ultrasound signs of the thorax/lungs	9.30 – 10.00 Ultrasound signs of the heart	9.00 – 09.30 Ultrasound signs of the abdomen	
		10.00 – 11.00 Telemedicine in internal medicine: a view of the future or present reality	9.30 – 10.30 Malnutrition and sarcopenia in Internal Medicine	10.00 – 11.00 Indications for enteral and parenteral nutrition during hospitalization, with clinical case discussion	09.30 – 10.00 Meta-analyses	
			10.30 – 11.00 Observational studies		10.00 – 11.00 Novelty in management of HF patients	
	10.00 – 13.30 Guided Tour of the Castellana Caves*	11.00 – 11.30 Coffee break	11.00 – 11.30 Coffee break	11.00 – 11.30 Coffee break	11.00 – 11.30 Coffee break	
		11.30 – 12.30 Fluids and vascular access	11.30 – 12.30 Use of amines and medical-nursing monitoring in the critically ill patient	11.30 – 12.30 Clinical cases: managing the patient with shock and simulation/practical session on mannequin	11.30 – 12.30 Vaccination indications for the frail patient	
		12.30 – 13.30 Microbiological and molecular diagnostics		12.30 – 13.30 Main infections in Internal Medicine and therapeutic guidelines	12.30 – 13.30 Artificial Intelligence in Internal Medicine: A Practical Guide to Understanding the Basics	
Welcome! Residents arrive today.						Breakfast and packing.
Dinner at the Masseria.						Residents depart in the morning.
Cocktail demonstration experience*	13.30 – 15.00 Lunch at the Masseria	13.30 – 14.30 Lunch at the Masseria	12.30 – 14.00 Lunch at the Masseria	13.30 – 15.00 Lunch at the Masseria	13.30 – 15.00 Lunch at the Masseria	Have a good and safe trip home!
	15.00 – 16.00 Novelty in management of COPD patients	14.30 – 16.00 Free time to choose the Carnival costume	14.00 – 21.00 Visit to Centro di Selezione Equestre di Galeone* and Trulli of Alberobello*	15.00 – 18.00 Ultrasound Practical session	15.00 – 15.30 Ultrasound clinical patterns	
		16.00 – 17.00 Obesity: assessment and pharmacotherapy			15.30 – 16.30 Metabolic Dysfunction–Associated Steatotic Liver Disease	
	16.00 – 19.00 NIV Practical session	17.00 – 17.30 Ultrasound signs of venous vessels		18.00 – 18.30 NIV Clinical cases	16.30 – 17.30 Delivering Difficult News: Empathy, Challenges and Strategies	
		17.30 – 18.00 Randomized Controlled Trials				
		18.00 – 19.00 Clinical Cases: Primary and secondary prevention			17.30 – 19.30 A handmade Barese pasta experience*	
	19.00 – 21.00 Dinner at the Masseria	19.00 – 21.00 Dinner at the Masseria	21.00 – 22.30 Dinner at the Masseria	18.30 – 21.30 Winery with wine tasting* and light dinner	19.30 – 21.30 Dinner at the Masseria	
		Carnival party*				

Ventilation lessons

Ultrasound lessons

Nutrition in Internal Medicine lessons

Critically ill patient lessons

Primer in evaluation and revision of medical literature lessons

Antibiotic Therapy, Healthcare-Associated Infections