Medical Narration corporate & narration scripts

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How Statins Work

Mechanism of action, animation · Adult (30-45) · Neutral American · 90 seconds

[Pronunciation: atherosclerosis = ath-er-oh-skler-OH-sis; HMG-CoA reductase = H-M-G co-A reh-DUCK-tace; lipoprotein = lip-oh-PRO-teen]

Your liver is a busy factory. Among its many jobs, it makes cholesterol, a waxy molecule the body uses to build cell membranes and hormones.

But when too much low-density lipoprotein, or LDL, circulates in the bloodstream, it can slip into the walls of the arteries. Over years, those deposits build into plaque. This process is called atherosclerosis, and it narrows the vessels that carry blood to the heart and brain.

Statins work at the source.

Inside liver cells, cholesterol is produced through a chain of chemical steps. One early step is controlled by an enzyme called HMG-CoA reductase. Statins block that enzyme.

With less cholesterol being made inside the cell, the liver responds by moving more LDL receptors to its surface. Those receptors act like hooks, pulling LDL particles out of the blood.

The result: lower levels of LDL cholesterol circulating through the arteries. Statins may also help stabilize existing plaque, making it less likely to rupture.

Like any medicine, statins can have side effects, including muscle aches in some people. Your prescriber will weigh the benefits and risks for you, and may check your blood tests over time.

Statins. Working inside the liver, to help protect the arteries.

Beta Blockers: Slowing the Signal

Mechanism of action, animation · Adult (40-55) · Neutral American · 60 seconds

[Pronunciation: metoprolol = meh-TOE-pro-lol; atenolol = ah-TEN-oh-lol; adrenergic = ad-ren-ER-jik; angina = an-JYE-nuh]

When you're stressed, your body releases adrenaline and noradrenaline. These hormones bind to beta-adrenergic receptors on the heart, telling it to beat faster and squeeze harder.

That's useful in an emergency. But for a heart that's already working too hard, constant stimulation adds strain.

Beta blockers, such as metoprolol and atenolol, occupy those receptors and block the signal. The heart rate slows. Each contraction is a little less forceful. Blood pressure comes down, and the heart needs less oxygen to do its job. The result is a calmer, more efficient heartbeat.

That's why clinicians use beta blockers for conditions including high blood pressure, angina, certain heart rhythm problems and heart failure.

Because they slow the heart, beta blockers can cause tiredness, dizziness or cold hands. And they shouldn't be stopped suddenly. Any change should be made with your prescriber.

Your Insulin Pump: Day-to-Day Basics

Device training, patient · Adult (30-45) · Neutral American · 2 minutes

[Pronunciation: subcutaneous = sub-kyoo-TAY-nee-us; cannula = CAN-yoo-luh; hypoglycemia = high-po-gly-SEE-mee-uh; occlusion = oh-KLOO-zhun]

Welcome to your insulin pump training. In the next two minutes, we'll look at how the

pump delivers insulin, and what you'll do each day to keep it working well.

An insulin pump is a small, computerized device that delivers rapid-acting insulin through thin tubing to a soft cannula placed just under the skin, in the subcutaneous tissue. Together, the tubing and cannula are called the infusion set.

The pump gives insulin in two ways.

First, basal insulin: a small, steady trickle delivered throughout the day and night, to cover your body's background needs.

Second, a bolus: an extra amount you request before meals, or to correct a high glucose reading. Your pump's settings are programd with your diabetes care team. Don't change them on your own.

Each day, check your infusion site for redness, swelling, or leaking. Change the infusion set and rotate the site on the schedule your care team gives you. Using the same spot over and over can cause lumps under the skin that affect how insulin is absorbed.

Pay attention to alarms. An occlusion alarm means insulin isn't flowing, often because the tubing is kinked or the cannula is blocked. Because a pump uses only rapid-acting insulin, an interruption can lead to high blood glucose quickly.

Know the signs of low blood glucose, or hypoglycemia: shakiness, sweating, confusion, a racing heart. Keep fast-acting sugar with you, and follow the plan your team has given you.

Finally, always carry backup supplies, and keep a backup plan for insulin injections in case the pump stops working.

Your pump is a powerful tool. Your care team is your guide. Let's get started.

ACE Inhibitors and the Renin-Angiotensin System

Mechanism of action, animation · Adult (30-45) · Neutral American · 90 seconds

[Pronunciation: angiotensin = an-jee-oh-TEN-sin; angiotensinogen = an-jee-oh-ten-SIN-oh-jen; aldosterone = al-DOSS-ter-own; lisinopril = lye-SIN-oh-pril; enalapril = en-AL-uh-pril; bradykinin = brad-ee-KYE-nin; angioedema = an-jee-oh-eh-DEE-muh]

When blood pressure or blood flow to the kidneys drops, the body has a system for pushing it back up. It's called the renin-angiotensin-aldosterone system.

It starts in the kidneys, which release an enzyme called renin. Renin converts a protein made by the liver, angiotensinogen, into angiotensin one.

Angiotensin one is fairly inactive. But as it passes through blood vessels, especially in the lungs, another enzyme converts it into angiotensin two. That enzyme is angiotensin-converting enzyme, or ACE.

Angiotensin two is powerful. It constricts blood vessels, and it signals the adrenal glands to release aldosterone, which makes the kidneys hold on to sodium and water. Both effects raise blood pressure. That's helpful in a crisis. But over the long term, it adds strain.

ACE inhibitors, such as lisinopril and enalapril, block that conversion step. Less angiotensin two is produced. Blood vessels relax, less fluid is retained, and blood pressure falls.

ACE also breaks down a substance called bradykinin. When the enzyme is blocked, bradykinin can build up, which is thought to explain the dry cough some patients develop. Rarely, it's linked to swelling of the face, lips or throat, called angioedema, which needs urgent medical attention.

ACE inhibitors. One enzyme, one blocked step, and a cascade of effects.

Proton Pump Inhibitors: Switching Off the Pumps

Mechanism of action, animation · Adult (25-40) · Neutral American · 60 seconds

[Pronunciation: parietal = puh-RYE-uh-tul; ATPase = A-T-P-ase; omeprazole = oh-MEP-ruh-zole; pantoprazole = pan-TOE-pruh-zole; esophagus = ih-SOF-uh-gus]

Lining the stomach are millions of parietal cells. Their job is to produce acid, which helps break down food and defends against swallowed microbes.

The final step happens at a tiny molecular pump on the surface of each cell: the hydrogen-potassium ATPase, often called the proton pump. It pushes hydrogen ions into the stomach in exchange for potassium.

Proton pump inhibitors, such as omeprazole and pantoprazole, switch those pumps off. They bind to the pump and inactivate it. Acid production drops sharply, and stays low until the cell builds new pumps.

Less acid gives irritated tissue in the esophagus and stomach a chance to heal. That's why clinicians use these medicines for reflux disease, ulcers, and some other acid-related conditions.

Like any medicine, they work best when taken exactly as your prescriber or pharmacist directs. Ask them before starting, stopping or combining them with other medicines.

SSRIs and the Synapse

Mechanism of action, animation · Adult (30-45) · Neutral American · 90 seconds

[Pronunciation: serotonin = sair-oh-TOE-nin; synapse = SIN-aps; presynaptic = pree-sin-AP-tik; neurotransmitters = noor-oh-TRANS-mit-ers; sertraline = SER-truh-leen; fluoxetine = floo-OX-uh-teen]

Nerve cells in the brain don't touch. Between them is a tiny gap called the synapse. To pass a message across, one neuron releases chemical messengers, called neurotransmitters, into that gap.

One of those messengers is serotonin. It's involved in regulating mood, sleep, appetite and more.

After serotonin crosses the synapse and binds to receptors on the next neuron, the signal needs to end. So the first neuron, the presynaptic neuron, pulls serotonin back inside using a transporter protein. This recycling process is called reuptake. It keeps the system tidy and responsive.

Selective serotonin reuptake inhibitors, or SSRIs, such as sertraline and fluoxetine, block that transporter. Serotonin stays in the synapse longer, and more is available to bind to receptors.

That's the immediate effect. But the benefits for depression and anxiety usually take several weeks to appear, which suggests that longer-term adaptations in the brain are part of the story. Researchers are still learning exactly how these medicines help.

Side effects can include nausea, sleep changes and sexual side effects. Some people, especially younger people, may have changes in mood or thinking when starting treatment, which is why regular follow-up matters.

SSRIs shouldn't be stopped abruptly. Any change should be planned with the prescriber.

The Nephron and Glomerular Filtration

Anatomy, physiology explainer · Adult (30-45) · Neutral American · 2 minutes

[Pronunciation: glomerulus = glow-MAIR-yoo-lus; glomerular = glow-MAIR-yoo-lur; afferent = AF-er-ent; efferent = EF-er-ent; arteriole = ar-TEER-ee-ole; Bowman's capsule = BOW-munz CAP-sool; Henle = HEN-lee; creatinine = kree-AT-ih-neen]

Each of your kidneys contains around a million tiny filtering units called nephrons. Together, they filter the body's entire plasma volume dozens of times a day, keeping what the body needs and removing what it doesn't.

Let's follow the path.

Blood arrives through a small artery called the afferent arteriole. It flows into the glomerulus, a tight knot of capillaries that sits inside a cup-shaped structure called Bowman's capsule.

Here, pressure pushes water and small molecules, such as sodium, glucose and urea, out of the capillaries and into the capsule. Blood cells and most proteins are too large, and stay behind. This is glomerular filtration. The blood then leaves through the efferent arteriole.

The rate of filtration across both kidneys is called the glomerular filtration rate, or GFR. It's one of the most important measures of kidney function, and it's usually estimated from a blood test for creatinine.

The filtered fluid, now called filtrate, moves into the renal tubule. In the proximal convoluted tubule, most of the water and sodium, and nearly all of the glucose, are reabsorbed into the blood.

Next comes the loop of Henle, which dips down into the medulla. Its descending limb lets water out. Its ascending limb pumps salt out. Together, they build a concentration

gradient that lets the kidney produce concentrated urine.

In the distal convoluted tubule and the collecting duct, final adjustments are made, guided by hormones such as aldosterone and antidiuretic hormone.

What remains flows on as urine.

Filter. Reabsorb. Fine-tune. Every minute of every day, the nephron balances the body's water, salt and waste.

The Heart's Electrical Pathway

Anatomy, cardiac conduction · Adult (30-45) · Neutral American · 90 seconds

[Pronunciation: sinoatrial = sigh-no-AY-tree-ul; atrioventricular = ay-tree-oh-ven-TRICK-yoo-lur; bundle of His = BUN-dul of HISS; Purkinje = pur-KIN-jee; repolarize = ree-POH-luh-rize; arrhythmias = uh-RITH-mee-uz]

Every heartbeat begins with an electrical spark, and that spark starts in a small cluster of specialized cells in the wall of the right atrium: the sinoatrial node, or SA node.

The SA node is the heart's natural pacemaker. In a healthy adult at rest, it typically fires around sixty to one hundred times a minute.

Its impulse spreads across both atria, causing them to contract and push blood down into the ventricles. On an ECG, this appears as the P wave.

The impulse then reaches the atrioventricular node, or AV node. Here, the signal is deliberately delayed for a fraction of a second. That pause gives the ventricles time to fill.

From the AV node, the impulse travels down the bundle of His, which divides into the right and left bundle branches along the septum. Finally, it spreads through the Purkinje fibers, a network that carries the signal rapidly through the ventricular walls.

The ventricles contract from the apex upward, squeezing blood out to the lungs and the body. On the ECG, this is the QRS complex. As the ventricles recover, or repolarize, we see the T wave.

SA node. AV node. Bundle of His. Bundle branches. Purkinje fibers.

When any part of this pathway is disrupted, the rhythm can change. And that is where the study of arrhythmias begins.

The Brachial Plexus in Sixty Seconds

Anatomy, medical student revision · Adult (25-40) · Neutral British · 60 seconds

[Pronunciation: brachial = BRAY-kee-ul; plexus = PLEK-sus; rami = RAY-my; axillary = AK-sih-lair-ee; musculocutaneous = MUSS-kyoo-loh-kyoo-TAY-nee-us; Klumpke = KLUMP-kee]

The brachial plexus is a network of nerves that supplies the shoulder, arm and hand. It's formed from the anterior rami of the spinal nerves C5 to T1.

Students often remember its organisation as roots, trunks, divisions, cords and branches.

The five roots join to form three trunks: superior, middle and inferior. Each trunk splits into an anterior and a posterior division. The divisions then regroup into three cords, named for their position around the axillary artery: lateral, posterior and medial.

Finally, the cords give rise to five major terminal branches: the musculocutaneous, axillary, radial, median and ulnar nerves.

Injury at different levels produces different patterns. Damage to the upper roots, as in Erb's palsy, mainly affects the shoulder and elbow. Damage to the lower roots, as in Klumpke's palsy, affects the small muscles of the hand.

Roots, trunks, divisions, cords, branches. Learn the map, and the clinical picture follows.

Gas Exchange in the Alveoli

Anatomy, respiratory physiology · Adult (25-40) · Neutral American · 90 seconds

[Pronunciation: alveoli = al-VEE-oh-lye; alveolus = al-VEE-oh-lus; bronchioles = BRONG-kee-oles; pneumocytes = NOO-moh-sites; surfactant = sur-FAK-tunt; emphysema = em-fuh-ZEE-muh]

Take a breath.

Air travels down the trachea, into the bronchi, and through smaller and smaller bronchioles. At the very end are the alveoli: hundreds of millions of tiny air sacs, clustered like bunches of grapes.

Each alveolus is wrapped in a mesh of capillaries. And the barrier between the air inside and the blood outside is remarkably thin, in places less than a micrometer across.

Gas exchange happens by diffusion. Gases move from areas of higher partial pressure to areas of lower partial pressure.

Air in the alveoli is rich in oxygen. Blood arriving from the pulmonary arteries is low in oxygen. So oxygen diffuses across the membrane into the blood, where most of it binds to hemoglobin in red blood cells.

At the same time, carbon dioxide moves the other way: from the blood, where its level is higher, into the alveoli, to be breathed out.

Two kinds of cells line the alveoli. Type one pneumocytes are thin and flat, forming most of the surface for gas exchange. Type two pneumocytes produce surfactant, which lowers surface tension and helps keep the alveoli from collapsing.

Anything that thickens the barrier, fills the air sacs with fluid, or destroys alveolar walls,

as in emphysema, makes gas exchange less efficient.

One breath. Millions of tiny exchanges. Repeated around twenty thousand times a day.

Laparoscopic Cholecystectomy: The Critical View of Safety

Procedure, surgical training · Adult (40-55) · Neutral American · 2 minutes

[Pronunciation: cholecystectomy = koh-lee-sis-TEK-toh-mee; laparoscopic = lap-uh-roh-SKOP-ik; pneumoperitoneum = noo-moh-pair-ih-toh-NEE-um; Trendelenburg = tren-DEL-en-burg; cephalad = SEF-uh-lad; infundibulum = in-fun-DIB-yoo-lum; hepatocystic = HEP-uh-toh-SIS-tik]

This module reviews the key steps of laparoscopic cholecystectomy, with an emphasis on achieving the critical view of safety.

The patient is positioned supine under general anesthesia. Pneumoperitoneum is established, and ports are placed: typically one at the umbilicus for the camera, with additional working ports in the epigastrium and right upper quadrant.

The patient is placed in reverse Trendelenburg and rotated slightly to the left, allowing the bowel to fall away from the operative field.

The fundus of the gallbladder is grasped and retracted cephalad over the liver. The infundibulum is retracted laterally, opening the hepatocystic triangle.

Dissection begins. The peritoneum is incised on both the anterior and posterior aspects of the triangle, and fatty and fibrous tissue are cleared.

Before any structure is clipped or divided, the critical view of safety must be established. Three criteria must be met.

One. The hepatocystic triangle is cleared of fat and fibrous tissue.

Two. The lower third of the gallbladder is separated from the liver bed, exposing the cystic plate.

Three. Two structures, and only two, are seen entering the gallbladder: the cystic duct and the cystic artery.

Only when all three criteria are confirmed are the cystic duct and artery clipped and divided. Many teams document the view with a photograph or video capture.

If the critical view cannot be achieved, because of severe inflammation or unclear anatomy, consider a bailout strategy, such as subtotal cholecystectomy, or conversion to an open procedure. Choosing a bailout is a sign of good judgment, not failure.

The gallbladder is then dissected from the liver bed, placed in a retrieval bag, and removed through a port site.

The critical view of safety. In every case.

Ultrasound-Guided Central Line Insertion

Procedure, clinical skills · Adult (30-45) · Neutral American · 90 seconds

[Pronunciation: internal jugular = in-TUR-nul JUG-yoo-lur; chlorhexidine = klor-HEX-ih-deen; Trendelenburg = tren-DEL-en-burg; Seldinger = SEL-din-jer; lumen = LOO-men; pneumothorax = noo-moh-THOR-ax]

In this section, we'll walk through ultrasound-guided insertion of a central venous catheter at the internal jugular vein.

Begin with the essentials: confirm the indication, obtain consent, and perform a time-out. Use full barrier precautions: cap, mask, sterile gown, sterile gloves and a full-body sterile drape. Prepare the skin with chlorhexidine and allow it to dry.

Position the patient in slight Trendelenburg, if tolerated, to distend the vein. Using a probe in a sterile sheath, identify the internal jugular vein and the carotid artery. The vein is typically larger, compressible, and lateral to the artery.

Under real-time ultrasound guidance, advance the needle into the vein, watching the needle tip throughout. Once you have free flow of venous blood, pass the guidewire through the needle. This is the Seldinger technique.

Before dilating, confirm with ultrasound that the wire is in the vein, not the artery. Remove the needle, dilate the tract, and advance the catheter over the wire. Never let go of the wire.

Aspirate and flush each lumen, secure the catheter, and apply a sterile dressing.

Finally, confirm tip position and rule out pneumothorax, according to your institution's protocol, before the line is used.

Real-time guidance. Wire control. Confirmation before use. Three habits that protect your patient.

Inside a Coronary Angioplasty

Procedure, clinician and patient overview · Adult (40-55) · Neutral American · 2 minutes

[Pronunciation: percutaneous = per-kyoo-TAY-nee-us; ostium = OSS-tee-um; stenosis = steh-NO-sis; atherosclerotic = ath-er-oh-skler-OT-ik; angioplasty = AN-jee-oh-plas-tee; restenosis = ree-steh-NO-sis; antiplatelet = an-tee-PLATE-let]

Percutaneous coronary intervention, or PCI, is a procedure used to open narrowed or blocked coronary arteries. It's performed in the cardiac catheterization lab, usually with the patient awake and lightly sedated.

Access is gained through an artery, most often the radial artery at the wrist, or the femoral artery in the groin. A sheath is placed, and a guiding catheter is advanced to the opening, or ostium, of the coronary artery.

Contrast dye is injected, and X-ray images called angiograms show the vessel in real time. The team identifies the stenosis: the narrowed segment caused by atherosclerotic plaque.

Next, a very thin guidewire is steered across the stenosis.

Over that wire, a balloon catheter is advanced to the narrowed segment and inflated. The balloon compresses the plaque and widens the channel. This is balloon angioplasty.

In most cases, a stent is then placed. The stent is a small mesh tube mounted on a balloon. As the balloon inflates, the stent expands against the vessel wall, and it stays in place as a scaffold when the balloon is withdrawn.

Most stents used today are drug-eluting. They release medication slowly into the vessel

wall to reduce the growth of scar tissue that can narrow the artery again. That re-narrowing is called restenosis.

Final angiograms confirm that blood is flowing freely. The catheters are removed, and the access site is closed or compressed.

After PCI, patients are usually prescribed antiplatelet medicines to lower the risk of a clot forming inside the stent. Taking them as prescribed is critical. Stopping them early, without guidance from the cardiology team, can be dangerous.

PCI. A single puncture. A wire, a balloon, a stent. And blood flow restored to the heart muscle.

Programming the Ostlund LX Infusion Pump

Device training, nursing · Adult (30-45) · Neutral American · 90 seconds

[Pronunciation: Ostlund = OST-lund; occlusion = oh-KLOO-zhun]

Welcome to device training for the Ostlund LX infusion pump. In this module, you'll learn to program a primary infusion safely using the pump's drug library.

Start at the bedside. Perform hand hygiene and verify the patient's identity using two identifiers. Confirm the order against the medication label.

Power on the pump and select the clinical care area for your unit. This loads the drug library limits set by your pharmacy.

Prime the administration set, removing all air from the line, and load it into the pump channel. Close the door until it clicks.

Now select Drug Library, and choose the medication by name and concentration. Never bypass the library to program a basic infusion unless your policy specifically allows it. The library is your safety net.

Enter the rate and the volume to be infused, exactly as ordered. If a value falls outside a soft limit, the pump will alert you. Stop and double-check. If it falls outside a hard limit, the pump won't accept it.

Before starting, trace the line from the bag all the way to the patient, and confirm you're connected to the right access point.

Press Start, and confirm the infusion is running.

If an occlusion alarm sounds, check for closed clamps, kinked tubing, or a problem at

the access site, and resolve the cause before restarting.

Verify. Program. Trace. Then start.

Glucose Meter Quality Control Check

Device training, point-of-care testing · Adult (25-40) · Neutral American · 60 seconds

Before you test a patient with the Peregrine point-of-care glucose meter, the meter needs to pass its quality control check.

QC confirms that the meter and the test strips are giving accurate results. Your facility sets how often, typically each day the meter is used, and whenever results seem questionable.

First, check the expiration dates on the test strips and the control solutions. Make sure each vial shows the date it was opened.

Scan your badge, then select Quality Control from the main menu. Scan the strip lot, then the control solution lot.

Insert a test strip. Apply the level one control solution, and wait for the result. Then repeat with level two.

If both results fall within the ranges printed for that lot, the meter is ready for patient testing.

If a result fails, don't test patients. Repeat the check with fresh solution. If it fails again, remove the meter from service and notify your point-of-care coordinator.

Ventilator Alarms: Patient First

Device training, critical care · Adult (40-55) · Neutral American · 2 minutes

[Pronunciation: endotracheal = en-doh-TRAY-kee-ul; bronchospasm = BRONG-koh-spaz-um; pneumothorax = noo-moh-THOR-ax; extubation = ex-too-BAY-shun]

This module covers alarm response on the Arden V7 critical care ventilator. Alarms are your early warning system. Responding quickly and systematically keeps your patient safe. Alarm fatigue is real, but every alarm deserves a response.

The V7 sorts alarms by priority. High-priority alarms show in red, with a repeating tone. Medium-priority alarms show in yellow. Never silence an alarm without assessing the patient first.

Start with the patient, not the screen. Is the patient safe right now? Look at chest rise, skin color, oxygen saturation and the patient's comfort.

Let's look at two of the most common alarms.

High peak pressure. The ventilator is meeting more resistance as it delivers a breath. Common causes include secretions in the airway, a kinked or bitten endotracheal tube, coughing, bronchospasm, or the patient breathing against the ventilator. More serious causes include a pneumothorax. Assess, suction if indicated, and check the tubing from the patient back to the machine.

Low pressure, or low exhaled volume. This usually means a leak or a disconnection somewhere in the circuit. Check every connection, and listen for an audible leak. Check the cuff of the endotracheal tube. Consider unplanned extubation, and check the tube's position at the lips.

If you can't quickly identify and fix the problem, and your patient is in distress, disconnect the patient from the ventilator and begin manual ventilation with a bag-valve

device connected to oxygen. Call for the respiratory therapist and the medical team.

Remember the order. The patient first. Then the circuit. Then the machine.

In the next section, you'll practice responding to these alarms on the simulator.

Getting Ready for Your MRI

Patient education, imaging · Adult (30-45) · Neutral American · 90 seconds

[Pronunciation: gadolinium = gad-oh-LIN-ee-um; technologist = tek-NOL-uh-jist]

Your doctor has asked for an MRI scan. MRI stands for magnetic resonance imaging. It uses a strong magnet and radio waves, not X-rays, to create detailed pictures inside your body.

Because the magnet is very strong, metal can be a safety concern. Before your scan, you'll be asked about any metal in or on your body. Please tell the team about pacemakers or other implanted devices, metal fragments, joint replacements, or any surgery you've had. Some implants are safe in an MRI, and some are not, so the team needs the full picture.

On the day, leave jewelry and watches at home. You may be asked to change into a gown.

Some scans use a contrast dye, often containing gadolinium, given through a small IV in your arm. If you've had a reaction to contrast before, or have kidney problems, let the team know.

During the scan, you'll lie still on a padded table that slides into the scanner. The machine makes loud knocking and buzzing sounds. That's normal. You'll be given earplugs or headphones, and you can talk to the technologist at any time.

If you feel anxious in small spaces, tell your care team ahead of time. They can talk with you about ways to help you feel more comfortable.

Follow any instructions you're given about eating, drinking or taking your medicines before the scan. And if you have questions, ask. We're here to help.

Your Recovery After Knee Replacement

Patient education, orthopedics · Mature (55+) · Neutral American · 2 minutes

[Pronunciation: arthroplasty = AR-throh-plas-tee; quadriceps = KWOD-rih-seps; anticoagulant = an-tee-koh-AG-yoo-lunt]

You've had a total knee replacement, also called a total knee arthroplasty. The worn surfaces of your knee joint have been replaced with smooth metal and plastic parts. Now your recovery begins, and you are a big part of it.

Your care team will give you instructions that fit your surgery and your health. Always follow them first. This video will help you understand why they matter.

Movement is medicine. You'll probably be up and walking, with help and a walker, soon after surgery. Your physical therapist will teach you exercises to bend and straighten your knee and to strengthen your quadriceps, the large muscles at the front of your thigh. Do them as often as you're asked, even when they're uncomfortable. Regaining your range of motion early makes a real difference later.

Manage your pain so you can move. Take your pain medicine exactly as prescribed. Ice and elevation can help with swelling. Let your team know if your pain isn't under control.

Protect against blood clots. After joint surgery, there's a higher risk of clots in the legs. Your team may prescribe an anticoagulant, compression stockings or simple ankle exercises. Call your care team right away if you notice new pain, warmth or swelling in your calf. Call emergency services if you have sudden shortness of breath or chest pain.

Watch your incision. Keep it clean and dry, and follow your instructions for bathing. Call your surgeon if you see increasing redness or drainage, or if you have a fever.

Make your home safe. Clear walkways, remove loose rugs, and keep the things you use most within easy reach.

Recovery takes time. Many people see steady progress over the first few months. Be patient with yourself, keep moving, and stay in touch with your care team. They're with you every step of the way.

Preparing for Your Colonoscopy

Patient education, gastroenterology · Adult (40-55) · Neutral American · 60 seconds

[Pronunciation: colonoscopy = koh-lon-OSS-kuh-pee; polyps = POL-ips; sedation = seh-DAY-shun]

A colonoscopy lets your doctor look at the inside lining of your large intestine, or colon, using a thin, flexible tube with a camera. It's an important way to find polyps, small growths that can be removed during the exam.

For your doctor to see clearly, your colon needs to be completely empty. That's the job of the bowel prep.

Your care team will give you written instructions. Follow them exactly. They'll explain when to switch to clear liquids, how and when to take your prep, and what to do about any medicines you take, especially blood thinners or diabetes medicines.

Your instructions will list which clear liquids are allowed. Many ask you to avoid anything colored red or purple.

You'll usually be given sedation, so arrange for a responsible adult to take you home.

A good prep means a better exam. If anything in your instructions is unclear, call us before your procedure day.

Living With Atrial Fibrillation

Patient education, cardiology · Mature (55+) · Neutral American · 90 seconds

[Pronunciation: fibrillation = fib-rih-LAY-shun; atria = AY-tree-uh; palpitations = pal-pih-TAY-shunz; anticoagulant = an-tee-koh-AG-yoo-lunt; cardioversion = KAR-dee-oh-VER-zhun; ablation = ab-LAY-shun]

Atrial fibrillation, often called AFib, is the most common type of irregular heartbeat.

Normally, each heartbeat starts with an orderly electrical signal in the upper chambers of the heart, called the atria. In AFib, that signal becomes chaotic. The atria quiver instead of contracting fully, and the heartbeat can become irregular and often fast.

Some people feel palpitations, a fluttering or pounding in the chest. Others feel tired, short of breath or lightheaded. And some feel nothing at all.

The biggest concern with AFib is stroke. When the atria don't squeeze properly, blood can pool and form clots. If a clot travels to the brain, it can cause a stroke.

That's why many people with AFib are prescribed an anticoagulant, sometimes called a blood thinner, to lower that risk. Your care team will decide whether it's right for you, based on your age and your other health conditions.

Treatment may also include medicines to control your heart rate or rhythm, or procedures such as cardioversion or ablation.

Here's what you can do. Take your medicines exactly as prescribed. Don't stop a blood thinner without talking to your care team. Tell any doctor or dentist that you take one. And keep your follow-up appointments.

Know when to get help. Call emergency services right away for chest pain, fainting, or signs of a stroke, such as face drooping, arm weakness or difficulty speaking.

CME Module Opener: Antimicrobial Stewardship

CME, module opener · Adult (40-55) · Neutral American · 60 seconds

[Pronunciation: antimicrobial = an-tee-my-KROH-bee-ul; Clostridioides difficile = kloss-trid-ee-OY-deez dif-ih-SEEL; empiric = em-PEER-ik; de-escalation = dee-ess-kuh-LAY-shun]

Welcome to this continuing medical education module on antimicrobial stewardship in the inpatient setting. It's designed for physicians, pharmacists and advanced practice providers who prescribe or review antibiotics.

Antimicrobial resistance is one of the most serious threats to global public health. Every antibiotic course carries a cost: to the patient, in adverse effects and Clostridioides difficile infection, and to the wider population, in the selection of resistant organisms.

Stewardship isn't about withholding treatment. It's about getting treatment right: the right drug, at the right dose, by the right route, for the right duration.

Over the next forty minutes, we'll cover four areas. Obtaining cultures before starting empiric therapy. The antibiotic time-out at forty-eight to seventy-two hours. De-escalation based on culture results. And evidence-based treatment durations for common infections.

At the end of the module, you'll complete a short case-based assessment.

Let's begin.

Recognising Sepsis Early

CME, acute care module · Adult (40-55) · Neutral British · 90 seconds

[Pronunciation: dysregulated = dis-REG-yoo-lay-tid; lactate = LAK-tate; hypotensive = high-poh-TEN-siv; vasopressors = vay-zoh-PRESS-erz]

Welcome to this module on the early recognition and management of sepsis.

Sepsis is a life-threatening organ dysfunction caused by a dysregulated host response to infection. That definition matters. Sepsis isn't simply infection. It's what happens when the body's response to infection begins to damage its own tissues and organs.

It's common, it's time-critical, and it can be hard to spot. Early signs are often subtle: a raised respiratory rate, new confusion, a fall in blood pressure, reduced urine output, or a patient who simply looks unwell.

Early warning scores help, but they don't replace clinical judgement. If you're worried, ask the question: could this be sepsis?

Once it's suspected, the priorities are clear. Escalate early to a senior clinician. Take blood cultures, ideally before antibiotics, but without delaying them. Measure lactate. Give appropriate antibiotics promptly, following local guidance. Assess fluid status, and give intravenous fluids where indicated. Monitor urine output closely.

Patients who remain hypotensive despite fluids may need vasopressors and critical care input.

In this module, you'll work through three case studies, each with a patient whose deterioration could easily be missed. For each one, you'll decide when to escalate, and why.

Recognise it. Escalate it. Treat it. Every hour counts.

Understanding the GLP-1 Receptor Agonist Class

Pharma sales training, therapeutic area · Adult (30-45) · Neutral American · 2 minutes

[Pronunciation: incretin = in-KREE-tin; glucagon = GLOO-kuh-gon; agonist = AG-uh-nist; semaglutide = sem-uh-GLOO-tide; liraglutide = lir-uh-GLOO-tide; pancreatitis = pan-kree-uh-TYE-tis]

Welcome to module three of your therapeutic area training: understanding the GLP-1 receptor agonist class.

Before you can talk confidently with health care professionals about any product in this space, you need to understand the physiology behind it. Let's start there.

When we eat, cells in the gut release hormones called incretins. One of the most important is glucagon-like peptide one, or GLP-1.

GLP-1 does several things. It stimulates the pancreas to release insulin, but mainly when blood glucose is raised. That glucose-dependent action is a point clinicians will ask you about. It also reduces the release of glucagon, a hormone that raises blood glucose. It slows gastric emptying, so nutrients enter the bloodstream more gradually. And it acts on the brain to increase feelings of fullness.

The challenge is that natural GLP-1 is broken down within minutes by an enzyme called DPP-4.

GLP-1 receptor agonists, such as semaglutide and liraglutide, are designed to mimic the hormone while resisting that breakdown. They activate the same receptors, for much longer.

Clinicians use this class in type 2 diabetes, and some agents are also approved for chronic weight management. Certain agents have shown cardiovascular benefits in outcome trials.

You'll also need to know the safety profile. The most common side effects are gastrointestinal: nausea, vomiting and diarrhea, often most noticeable when treatment starts. The class carries warnings you'll study in detail, including pancreatitis and, for some agents, a warning about thyroid C-cell tumors.

One reminder. In every conversation, you'll discuss only approved uses, and you'll present benefits and risks with fair balance, as covered in your compliance training.

In module four, we'll look at the clinical evidence.

On-Label Promotion and Fair Balance

Pharma sales training, compliance · Adult (40-55) · Neutral American · 2 minutes

[Pronunciation: pharmacovigilance = FAR-muh-koh-VIJ-ih-lunss; adverse = AD-verse]

Welcome to compliance essentials for field representatives. In this module, we'll cover two principles that shape every conversation you have with a health care professional: on-label promotion and fair balance.

Let's start with on-label promotion. Every prescription medicine is approved for specific uses in specific patient populations. Those uses are described in the product's prescribing information, often called the label. As a representative, you may only promote a product for its approved uses. Promoting an unapproved use, known as off-label promotion, is prohibited, even if a clinician raises it first.

So what do you do if a physician asks about an unapproved use? You don't answer it yourself. Explain that you can only discuss approved uses, and offer to submit a request to Medical Information, so a qualified medical colleague can respond directly.

Now, fair balance. Whenever you present a product's benefits, you must also present its important risks, with comparable prominence. That means the risks aren't rushed, minimized, or left for the end of a meeting that runs short. If there's no time to cover the

risks, there's no time to cover the benefits.

Use only approved promotional materials. Don't create your own charts, summaries or comparisons.

Finally, adverse events. If a health care professional mentions a side effect or problem experienced by a patient taking one of our products, you must report it to pharmacovigilance within the time frame set by company policy. You don't need to judge whether the product caused it. Just report it.

On-label. Fair balance. Report adverse events.

These aren't just rules. They protect patients, they protect clinicians' trust in you, and they protect your career.

Now let's look at a scenario.

Welcome to Harlow Ridge Medical Center

Hospital orientation, new staff · Adult (30-45) · Neutral American · 60 seconds

Welcome to Harlow Ridge Medical Center. We're glad you're here.

This week, you'll meet your unit leaders, complete your training, and get to know your new colleagues.

A few things to know from day one.

Your badge is your key. Wear it above the waist, photo facing out, at all times. It opens secure doors and tells patients who you are.

Hand hygiene is everyone's job. Clean your hands on the way into every patient room, and on the way out.

Learn our emergency codes. A card listing every code is attached to the back of your badge. If you hear a page you don't understand, ask.

If you see something unsafe, speak up. Anyone can pause care to raise a safety concern, and you'll never be penalized for raising one in good faith.

And when you get lost, which you will, ask anyone wearing a green lanyard. They're our wayfinding volunteers.

Welcome to the team.

Taking Part in a Clinical Trial

Clinical trial, participant information · Adult (30-45) · Neutral American · 2 minutes

[Pronunciation: placebo = pluh-SEE-boh; investigational = in-vess-tih-GAY-shun-ul; randomized = RAN-duh-mized]

Thank you for your interest in the ALDER-2 study. This video explains what taking part in a clinical trial means, so you can make an informed choice. It doesn't replace your conversation with the study team. Please ask them anything.

A clinical trial is a research study that tests whether a treatment is safe and whether it works. This study is testing an investigational medicine. Investigational means it is not yet approved for this use.

This is a randomized, double-blind, placebo-controlled study. Let's take those words one at a time.

Randomized means a computer will assign you, by chance, to one of two groups. You won't choose your group, and neither will your doctor. This keeps the comparison fair.

One group will receive the investigational medicine. The other will receive a placebo: something that looks the same, but contains no active medicine.

Double-blind means that neither you nor the study team will know which group you are in until the study ends. This helps make sure the results aren't influenced by what anyone expects. If there's a medical need, the team can find out quickly.

Taking part may involve extra visits, blood tests and questionnaires. The study team will explain the schedule, the possible risks and discomforts, and any possible benefits. You may not benefit directly, but the information gathered could help others in the future.

Before you join, you'll be asked to read and sign an informed consent form. Take your

time. Take it home if you like. Talk it over with family, or with your own doctor.

Your participation is entirely voluntary. You can leave the study at any time, for any reason, and it won't affect the care you would normally receive.

If you have questions now, or at any point during the study, contact your study team. Their details are on your information sheet.

Thank you for considering it.

Hip Dysplasia in Dogs

Veterinary, client education · Adult (30-45) · Neutral American · 60 seconds

[Pronunciation: dysplasia = dis-PLAY-zhuh; acetabulum = as-eh-TAB-yoo-lum; osteoarthritis = OSS-tee-oh-arth-RYE-tis; orthopedic = or-thoh-PEE-dik]

Hip dysplasia is one of the most common orthopedic conditions in dogs, especially in large and giant breeds.

The hip is a ball-and-socket joint. The ball is the head of the femur, and the socket is a cup in the pelvis called the acetabulum. In a healthy hip, the two fit snugly and glide smoothly.

In hip dysplasia, the joint develops abnormally. The fit is loose, and the ball shifts within the socket. Over time, that instability wears down the cartilage and leads to osteoarthritis.

Owners may notice stiffness after rest, a reluctance to climb stairs or jump, or a swaying, bunny-hopping gait.

Genetics play a major role, but growth rate, body weight and exercise also contribute.

Diagnosis is based on a physical exam and X-rays. Management may include weight control, controlled exercise, physical rehabilitation, pain relief and, in some cases, surgery.

If you notice changes in how your dog moves, talk to your veterinarian.

Colic in Horses

Veterinary, equine · Adult (40-55) · Neutral British · 60 seconds

[Pronunciation: colic = KOL-ik; borborygmi = bor-boh-RIG-my; nasogastric = nay-zoh-GAS-trik]

Colic isn't a single disease. It's a general term for abdominal pain in the horse, and it remains one of the most common reasons for an emergency veterinary call.

Horses are particularly vulnerable. They can't vomit, and their long, mobile intestine can become impacted, displaced or twisted.

Signs include pawing at the ground, looking round at the flank, repeatedly lying down and getting up, rolling, sweating, and a reduced or absent appetite.

On examination, the vet will assess heart rate, mucous membrane colour, capillary refill time and gut sounds, known as borborygmi. A rising heart rate and absent gut sounds are concerning signs.

Further assessment may include a rectal examination, passing a nasogastric tube to check for reflux, and abdominal ultrasound.

Most cases respond to medical treatment. A smaller number need surgery, and in those cases, time is critical.

If you suspect colic, call your vet straight away, remove any feed, and follow their advice until they arrive.

From Gingivitis to Periodontitis

Dental, patient education · Adult (25-40) · Neutral American · 60 seconds

[Pronunciation: gingivitis = jin-jih-VYE-tis; periodontitis = pair-ee-oh-don-TYE-tis; periodontal = pair-ee-oh-DON-tul]

Healthy gums fit snugly around each tooth, like a cuff. But when plaque, a sticky film of bacteria, builds up along the gumline, the gums can become inflamed. This is gingivitis. The gums may look red and puffy, and bleed when you brush.

At this stage, the damage can be reversed with thorough brushing, cleaning between the teeth, and regular professional care.

If gingivitis isn't treated, it can progress to periodontitis. The inflammation spreads below the gumline. The gums pull away from the teeth, forming spaces called periodontal pockets. Bacteria collect in those pockets, and the body's own immune response begins to break down the bone and connective tissue that hold the teeth in place.

Over time, teeth can loosen, and may eventually be lost.

Periodontitis is linked with smoking and diabetes, and it's a leading cause of tooth loss in adults.

Your dental team can measure your gums and help you build a plan to keep them healthy.

Root Canal Treatment: A Step-by-Step Overview

Dental, procedure for dental teams · Adult (40–55) · Neutral British · 2 minutes

[Pronunciation: endodontic = en-doh-DON-tik; apical foramina = AY-pih-kul for-AM-ih-nuh; pulpitis = pul-PYE-tis; necrotic = neh-KROT-ik; periapical = pair-ee-AY-pih-kul; hypochlorite = high-poh-KLOR-ite; obturated = OB-tyoo-ray-tid; gutta-percha = GUT-uh PUR-chuh]

This module provides an overview of conventional endodontic treatment, more commonly known as root canal treatment, for dental nurses and dental students.

Inside every tooth, beneath the enamel and dentine, is the pulp: soft tissue containing nerves and blood vessels. The pulp extends from the pulp chamber in the crown, down through the root canals, to openings at the root tips called the apical foramina.

When the pulp becomes irreversibly inflamed, a condition called irreversible pulpitis, or when it becomes necrotic and infected, root canal treatment can preserve the natural tooth.

Treatment begins with diagnosis, including clinical tests and a periapical radiograph. Once local anaesthesia is achieved, the tooth is isolated with a rubber dam. This keeps the field clean and dry, and protects the patient's airway from small instruments and irrigants.

An access cavity is prepared through the crown to reach the pulp chamber, and the canal openings, or orifices, are located.

Next, the working length is determined, using an electronic apex locator and radiographs. Files are then used to clean and shape each canal to that length.

Throughout shaping, the canals are irrigated, commonly with sodium hypochlorite, to dissolve organic tissue and disinfect the canal system. Careful technique is essential, to

avoid forcing irrigant beyond the root tip.

Once the canals are shaped and dried, they're obturated, or filled, usually with gutta-percha and a sealer. The access cavity is then sealed with a temporary or permanent restoration.

Many teeth, especially back teeth, will later need a crown to protect them from fracture.

Accurate length, thorough disinfection, and a good seal. Those three goals guide every case.

Practice with these, record them, post them as demos or reels, use them in auditions. Please do not resell them as scripts. © VO Journey Academy · avosjourney.com