against the RAP in order to expel the blood from the cavity into the radial artery and collapse it (using this simple digital compression, it can be observed that the swelling disappears completely). Once the RAP has collapsed (it is now flat), we recommend applying a semicompressive bandage directly over it. After proximal occlusive compression of the RAP for 3 to 4 hours, we then recommend a semicoclusive compression (of the RAP and proximally) for an additional 24 hours. Due to the risk of external breakage, we recommend hospitalization for the following 24 hours.

3. If the above is ineffective, we recommend treatment with ultrasound-guided injection of thrombin (1 mL, 500 IU).

4. Surgery should be reserved for cases in which this more conservative management strategy has not been effective.

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and orientation of myocardial fibers at the apex. According to the Torrent-Guasp model, the left segment acts as a chassis that supports the apical loop when it contracts, which leads to atrioventricular union and expulsion of the blood volume accumulated in the left ventricle. This idea is based on the rearrangement of the apical muscle as 2 helical bands, which generate torsional movements they slide on the longitudinal axis; because this movement brings the base and apex together, the ventricular cavity is compressed and the blood is pushed toward the exit tract of the left ventricle. This model thus assigns the apical fibers a central role in left ventricle contraction. We propose this hypothesis for testing in future studies of the correlation between apical deformation and LEVF in different clinical contexts, with a larger number of patients and a wider age range.

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