GIANCARLO PANSINI

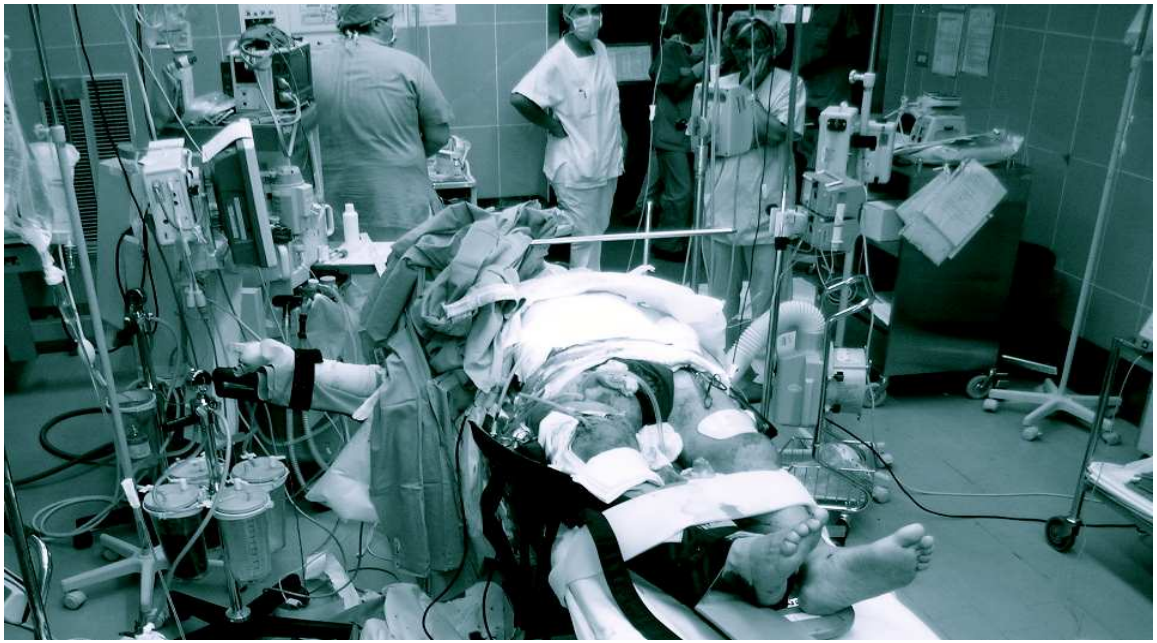
Cure ed *END STAGE*

IL PARERE DEL CHIRURGO

Pensieri iniziali

L.
Witt
gen
stein

- Di ciò che non si può dire, bisogna tacere.



- The best wear for the worst weather…
- Non c'è nulla che protegga meglio nelle condizioni peggiori.

- Nothing heals like cold cold steel...
- Non c'è nulla che faccia meglio di un bel bisturi.

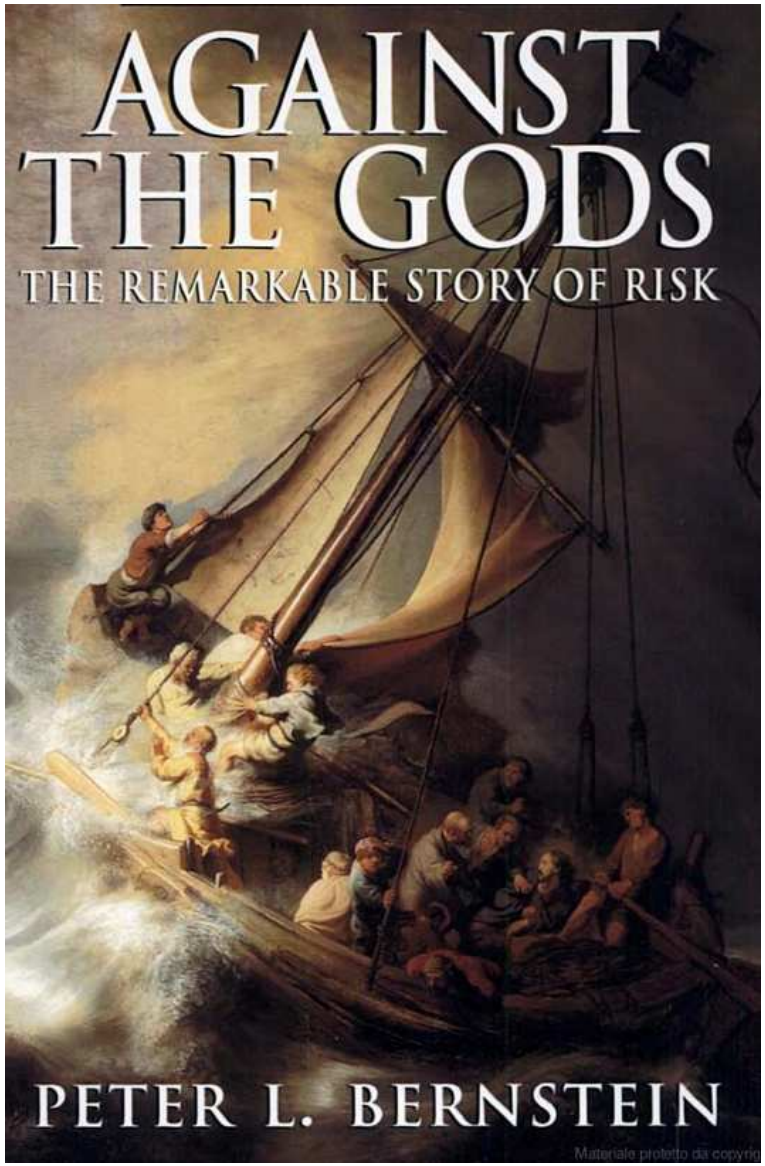
Chirurgia,
o mia
chirurgia

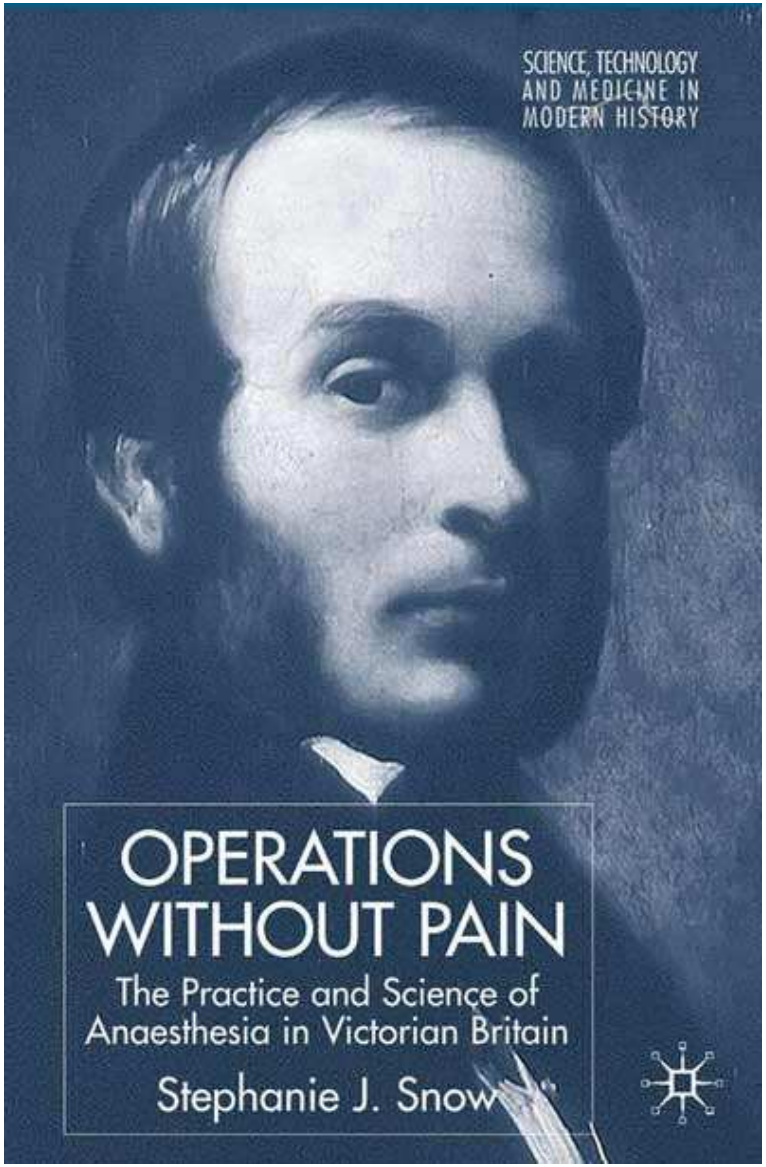
WTAPS

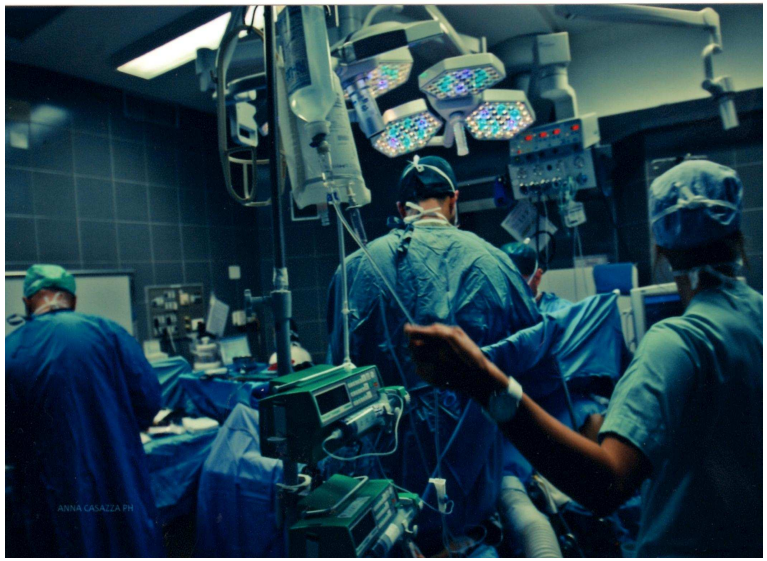
PLACING THINGS
WHERE THEY SHOULD BE.

IL RISCHIO nella PRATICA MEDICA

Il controllo del rischio è una delle idee fondamentali che animano la società moderna e la distinguono dalle civiltà arcaiche ed è diventato sinonimo di sfida e di opportunità..




SCIENCE, TECHNOLOGY AND MEDICINE IN MODERN HISTORY
OPERATIONS WITHOUT PAIN
The Practice and Science of Anaesthesia in Victorian Britain
Stephanie J. Snow



Cyto kynes for Surgeons

- Inflammatory cytokines and cell response in surgery.
- *"PATIENTS WITH SURGICAL INJURIES or infections exhibit alterations in hemodynamic, metabolic, and immune responses that are largely orchestrated by endogenous mediators referred to as cytokines."*
- *"Cells talk to each other…"*

nòva 24 IL SOLE 24 ORE

- **MISSION POSSIBLE: CURARE LA MORTALITà**
- Il nuovo business dei big della Silicon Valley è l'industria anti-età con investimenti milionari e ceo stellati.
- Il nuovo paradigma della tecnoutopia è che il processo di invecchiamento dovrebbe essere trattato come una patologia e che la **umana mortalità debba essere in qualche modo "curata".**
- 28 settembre, 2014

- **Impact of the economic crisis on healthcare resources: An European approach**

- "The financial and economic crisis period that prevailed along the first decade of 2000 was a global phenomenon, during which healthcare systems were under the risk of an increased pressure, mainly due to a **loss of operational financial resources** *and potential increases in the healthcare demand.*"

- *Centre for Heath Policy and Management, Trinity College, Dublin, 2013*

Proverbio napo letano

- In coppo poco cupo poco pepe capa.
- In un recipiente poco capiente ci entra poco pepe.

Il caso clinico

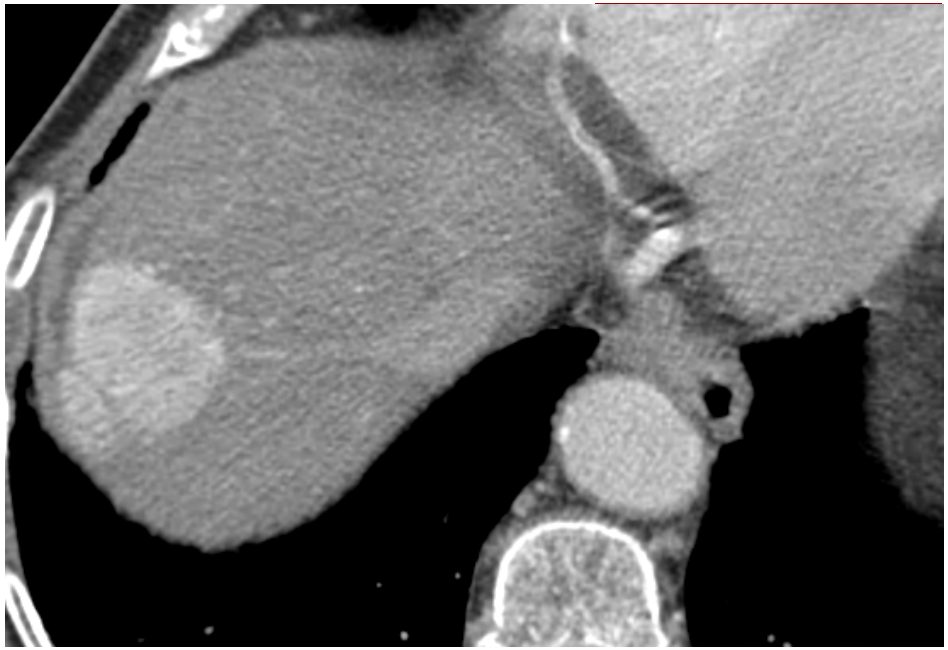
Citazione

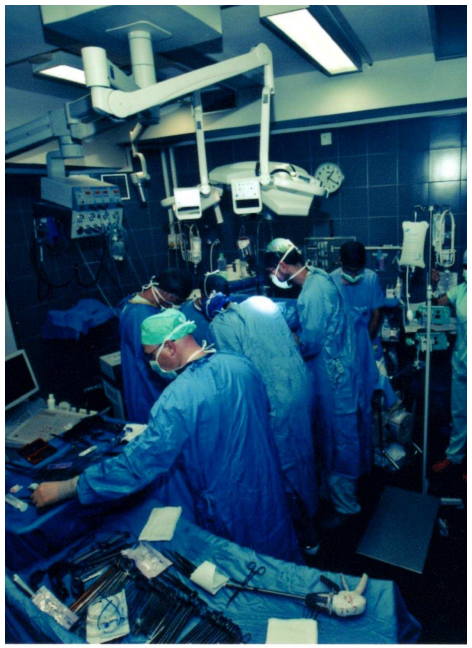
M Schein, P N Rogers
Schein's Common Sense Emergency Abdominal Surgery, 2004

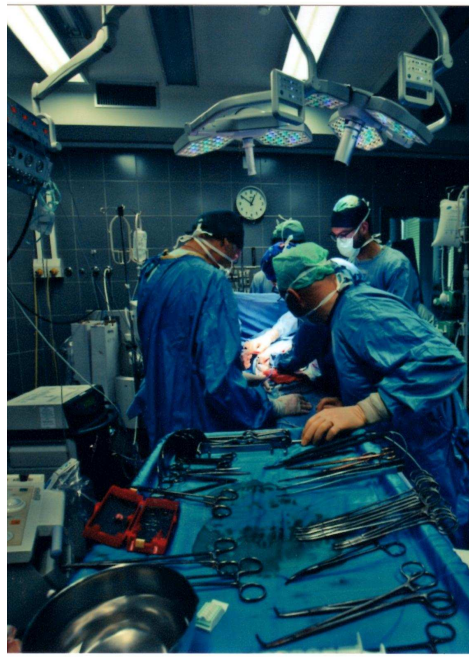
Sempre più spesso scopro che vi sono alcune cose che il sistema chirurgico tende a dimenticare velocemente, come un paziente morto.

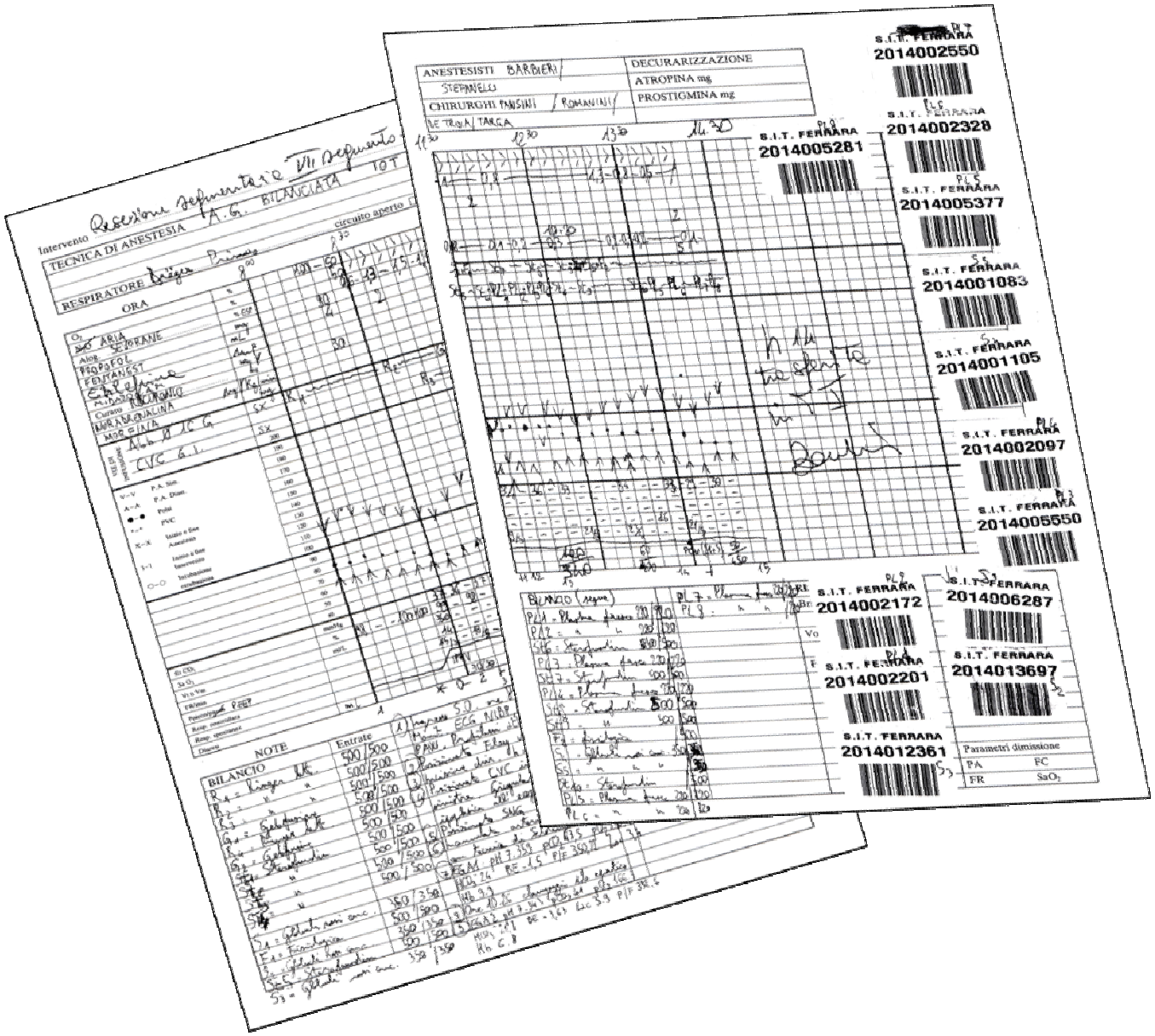
Alcuni chirurghi imparano dai propri errori, alcuni imparano dagli errori degli altri ed alcuni non imparano affatto!

- Nome simulato:
  Sign.ra Maria Rossi
- Età: 82
- Co. Mo.: ipertensione, valvulopatia lieve (S.A.), sndr ansioso-depressiva
- E.O.: SpO2: 96; FC 60
- ECG: RS 63' IV sn con sovraccario
- Farmaci: bromazepam, metroprololo, trazodone, ramipril,
- Diagnosi iniziale: HCC resecabile su cirrosi compensata HCV-correlata, leucopenia, piastrinopenia
- Opzioni di cura: resezione *epatica vs* sorveglianza
- Terapia eseguita: resezione epatica radicale








Intervento Resezione segmentaria 2° VII segmento
TECNICA DI ANESTESIA A. G. BILANCIATA TOT
RESPIRATORE Dräger Primus
ORA
CVC G.I.
NOTE
BILANCIO
ANESTESISTI BARBIERI
STEFANELLI
CHIRURGHI FANTINI / ROMANELLI
DECURARIZZAZIONE
ATROPINA mg
PROSTIGMINA mg
S.I.T. FERRARA
2014002550
2014002328
2014005377
2014005281
2014001083
2014001105
2014002097
2014005550
2014002172
2014006287
2014002201
2014013697
2014012361
Parametri dimissione
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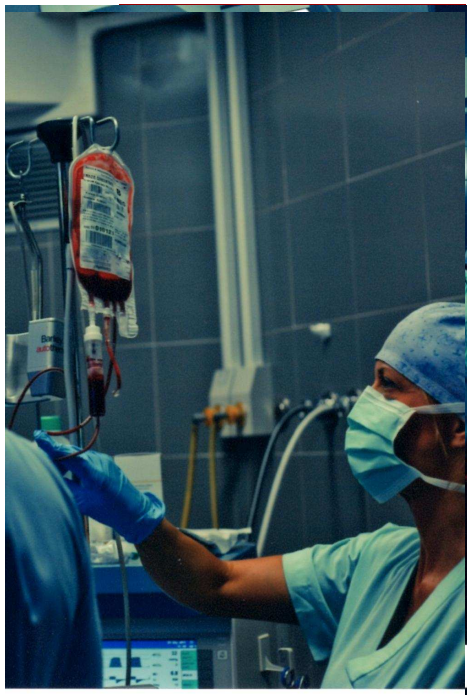
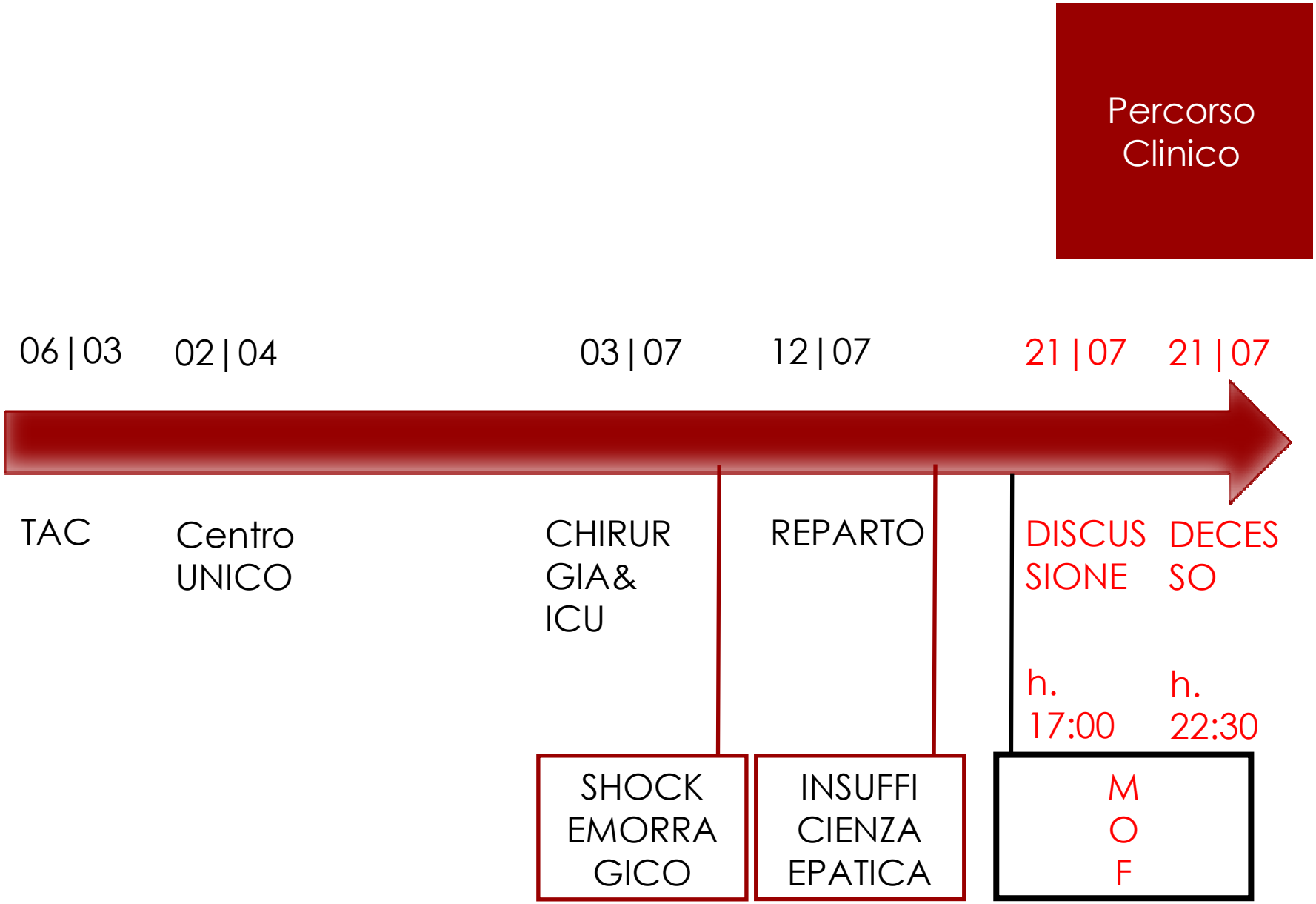
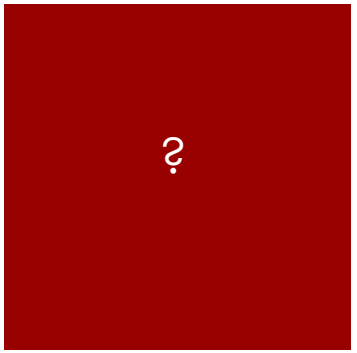
FC
FR
SaO2




Percorso Clinico
06|03
02|04
03|07
12|07
21|07
21|07
TAC
Centro UNICO
CHIRURGIA& ICU
REPARTO
DISCUSSIONE
DECESSO
h. 17:00
h. 22:30
SHOCK EMORRAGICO
INSUFFICIENZA EPATICA
MOF

Cosa si dice in giro



DNR

CHAPTER 17
The DNR Discussion

ACS Resident's Guide **USA**

- **Cardiopulmonary resuscitation: benefits vs burdens**
- Overall, 15% of in-hospital CPR attempts lead to hospital discharge. Predictors of poor outcome include metastatic cancer, sepsis, multiorgan failure, CPR event longer than 30 min.
- Burdens of CPR include permanent vegetative state (10%), chest wall trauma (25-50%), costs, **prolonging the dying process in an expected death from a chronic or an end-stage disease**.

Decisions relating to cardiopulmonary resuscitation

A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing

Resuscitation Council **UK**

- **Clinical Decision not to attempt CPR:**
- CPR should not be attempted if it will not be successful.
- **However**, the patient's individual circumstances and the most up-to-date guidance must be considered carefully before such a decision is made.

ACCCM
&
SCCM

- **Guidelines for ICU Admission, Discharge, and Triage.** *Crit Care Med 1999,27:633*

- Because of the **utilization of expensive resources**, ICUs should, in general, be reserved for those patients with reversible medical conditions who have a **"reasonable prospect of substantial recovery"** after their surgery. With recent changes in the health care environment, efficient use of ICUs has become a priority.

ACCCM
&
SCCM

- **Patients who are likely to benefit from ICU care.** *Crit Care Med 1999; 27:633*

- Selected **patients who are likely to benefit from ICU care.**
- ICU care has been demonstrated to improve outcome in severely ill, unstable patient populations.
- Defining the "too well to benefit" and "too sick to benefit" population **may be difficult solely based on diagnosis**.

ACCCM
&
SCCM

- **Conditions in which ICU care is of no greater benefit than conventional care.** *Crit Care Med 199,27:633*

- Situations involving surgical patients who are at the two extremes of the risk of death spectrum; **relatively low risk of death and exceedingly high risk of death**. These groups can be referred to as "too well to benefit" and "too sick to benefit" from critical care services.

Surgical Apgar Score **SAS**

- **The Surgical Apgar Score is strongly associated with ICU admission after hight-risk intrabdominal surgery.** *Anesth Analg 2013;117:438*
- The SAS (heart rate, MAP, EBL) is strongly associated with clinical decisions regarding immediate ICU admission after high-risk intraabdominal surgery.
- Triage of high-risk surgical patients to intensive care may impact outcomes in those with the highest likelihood of postoperative complications and death.
- **Intraoperative hemodynamics and blood loss influence ICU triage for postsurgical patients**.

Outcome primario **Sopravvi venza**

- **Mortality of patients with alchoholic liver disease admitted to critical care: a systematic review.** *J Intensive Care Society 2012,13:130*
- Relationship between outcome and their number of organ system failure.
- Mortality rate:
  - Single organ 33-34%
  - Two organs 65-75%
  - Three systems 90-100%

Liver Transplant **End-stage & Delisting**

- **Critical care of end-stage liver disease patients awaiting liver transplantation.** *Liver Transpl 2011, 17:496*

- Some illness and an end-stage liver disease necessitating ICU management **can influence transplant candidacy**.

TABLE 6. Factors that Should Lead to a Reevaluation of Transplant Candidacy

Category	Factor	Citation
Circulatory	Pulmonary hypertension	121, 122, 123
	Ischemic heart disease	
	Shock	
Central nervous system failure	Cerebral edema	124
	Stroke	
Respiratory failure	Intubation of endstage cirrhotic	119
Cancer	New diagnosis of extrahepatic malignancy	125, 126
	Evolution of HCC	
Sepsis	Bacterial infection with resistant organism	127, 128
	Fungal sepsis/Aspergillosis	
Psychosocial	Abstinence failure	129
	Noncompliance with pretransplant follow-up	
	Loss of social support	
Retransplantation	Hepatitis C	130, 131
	Renal failure	

Outcome secondario **QdV**

- **Quality of life before surgical ICU admission.** *BMC Surgery 2007,7:23*
- A study to understand how brevious QOL before admission to a surgical ICU influence postoperative outcome.
- Our objective was not to identify patients to whom surgery should be denied or postponed and we did not pretend to use QOLSS as an indicator of final outcome.
- Total QOL Severity Score was significantly **worse in elderly patients and in patients with co-morbidities and in patients more severely ill at ICU admission.**

Etica
&
Morale

- **A history of Ethics and Law in the ICU.** *Crit Care Clin 2009,25:221*

- ICU has served as an arena in which many of the ethical and legal dilemmas created by that technology have been defined and debated.

- We emphasize that advancement of the **ethical principle of respect for patient autonomy in ICUs increasingly is conflicting with physicians' concern about their own prerogatives** and with the just distribution of medical resources.

- Given the introduction of new potentially life-saving technologies, patient demand for them, and the aging of our population, such challenges will become more commonplace in the future. **So will conflicts among ethical principles in the ICU.**

Critical Care **Economics**

- **Can haelth care costs be reduced by limiting intensive care at the end of life?** *Am J Resp Crit Care Med 2002,165:750*

- High cost and high mortality make the ICU an obvious location to reduce health care costs by identifying terminally ill patients and **promptly instituting palliative rather than restorative care**.

- But, there is little evidence that terminally ill patients can be readily identified, even a few days before death in some instances.

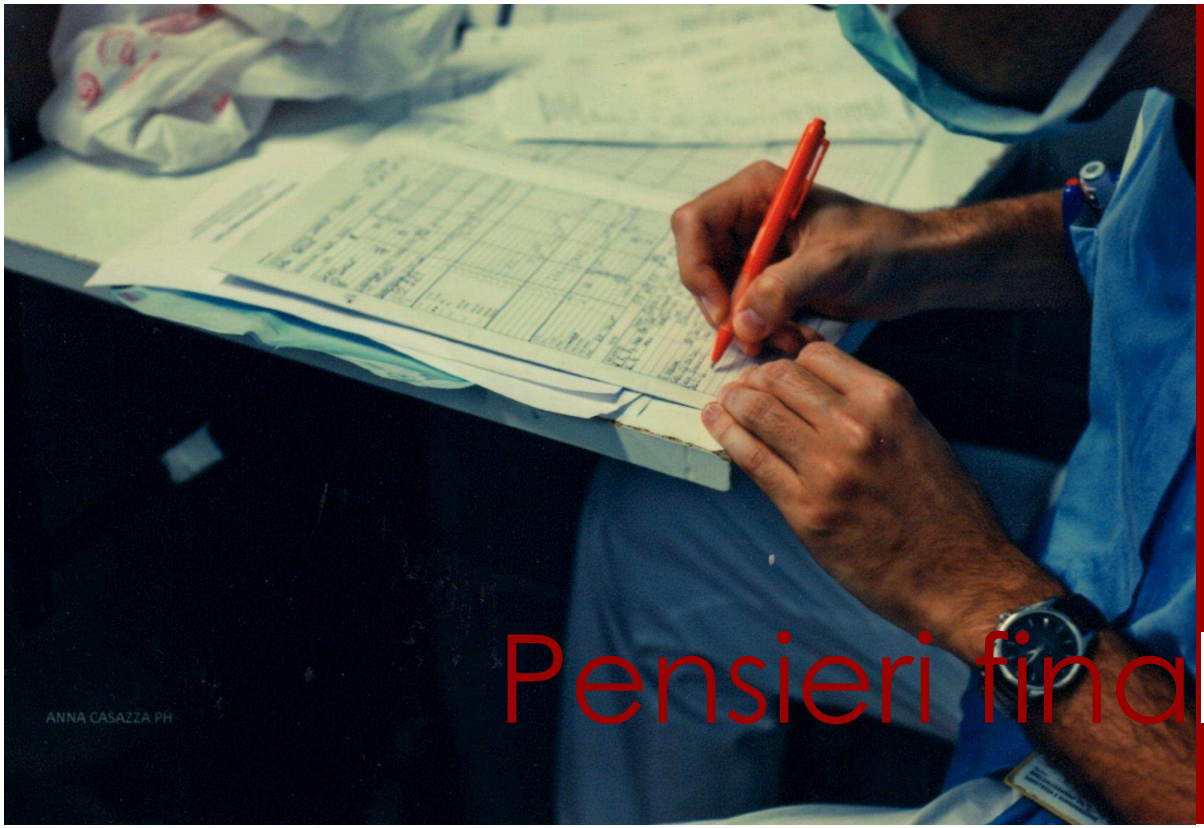
- Furthermore, even if the terminally ill could be identified, it is doubtful that significant cost savings could be realized by denying their access to the ICU.

- Finally, at least one study suggests that **indiscriminate efforts to deny access can actually increase overall mortality.**

Critical Care

- **Physician's perceptions and attitudes regarding inappropriate admissions and resources allocation in the IUC setting.** *Br J Anaesthesia 2006,96:57*

Reasons for inappropriate admissions	Percentage
Clinical doubt	33
Limited decision time	32
Assessment error	25
Pressure from superiors	13
Pressure from referring clinician	11
Pressure from patient's family	5
Threat of legal action	5
Economically advantageous DRG	1



Pensieri finali

A.
Schopen
hauer

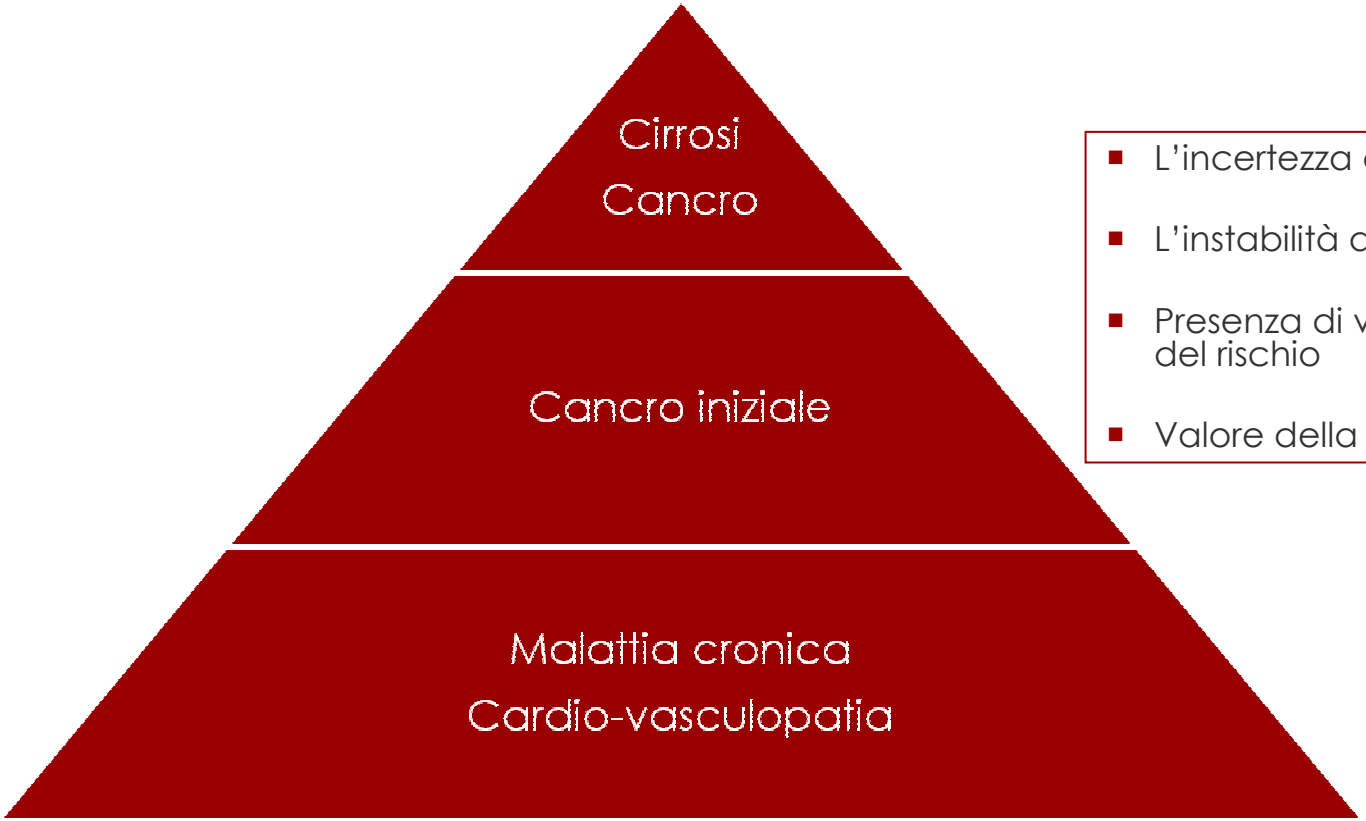
- E’ sempre meglio omettere qualcosa di buono che non aggiungere cose insignificanti.

Una decisione ?

- La decisione di ammettere un paziente chirurgico *end-stage* alle cure intensive dovrebbe dipendere dal solo concetto del "**beneficio potenziale**".
- I pazienti in condizioni troppo buone per beneficiarne e quelli troppo compromessi per trarne benefico duraturo, non dovrebbero essere ammessi.
- **Ammettere | Non-ammettere**: rimane una scelta concettualmente irrisolvibile per le scarse prove scientifiche sugli outcome, per la variabilità biologica dei singoli pazienti e per la inevitabile mancanza di una ricerca sistematica sugli outcome dei pazienti non ammessi.

Schroders Educational **An Economy Viewpoint**

La piramide rischio/rendimento



- L'incertezza del risultato atteso
- L'instabilità del risultato atteso
- Presenza di volatilità: indicatore del rischio
- Valore della "percezione"

C'è una Conclusione ?

- Difendere le scelte dettata dalla ragione umana, dall'esperienza e dai risultati della scienza, ove presenti.
- Difendere la metodologia umanistica e la regola del buon senso.
- Evitare gli eccessi di matematizzazione della scienza medica in direzione puramente quantitativa.

W.
Shake
speare

La tempesta

"tutti quanti
fummo inghiottiti da un mare in tempesta
ed i pochi di noi
che furono risospinti in terraferma
sono ora votati dal destino
a recitare un altro atto del dramma
di cui quello che è passato è appena il
prologo,
ed **il resto che si deve ancora svolgere
spetta a noi e voi d'interpretare**"