Esperienze del paziente dopo un lungo periodo in terapia intesiva

S. Livigni

Table 2 EQ-5D results for patients responding at 6 and 12 months (*n* = 293)

	Pre-admission %	6 months %	12 months %
Mobility			
N: I have no problems in walking about	66%	41%	45%
M: I have some problems in walking about	32%	58%	54%
E: I am confined to bed	2%	1%	1%
Self-care			
N: I have no problems with self-care	87%	72%	74%
M: I have some problems washing or dressing myself	12%	26%	25%
E: I am unable to wash or dress myself	1%	2%	1%
Usual activities			
N: I have no problems	65%	31%	35%
M: I have some problems	30%	58%	54%
E: I am unable to perform my usual activities	5%	11%	11%
Pain/discomfort			
N: I have no pain or discomfort	49%	27%	31%
M: I have moderate pain or discomfort	41%	62%	59%
E: I have extreme pain or discomfort	10%	11%	11%
Anxiety/depression			
N: I am not anxious or depressed	70%	54%	56%
M: I am moderately anxious or depressed	26%	41%	37%
E: I am extremely anxious or depressed	4%	5%	7%
EuroQol UK Tariff			
Median	0.796	0.691	0.691
25th percentile	0.673	0.516	0.516
75th percentile	1	0.804	0.814
EQ-5D VAS			
Median		64	66
25th percentile		46	44
75th percentile		80	80

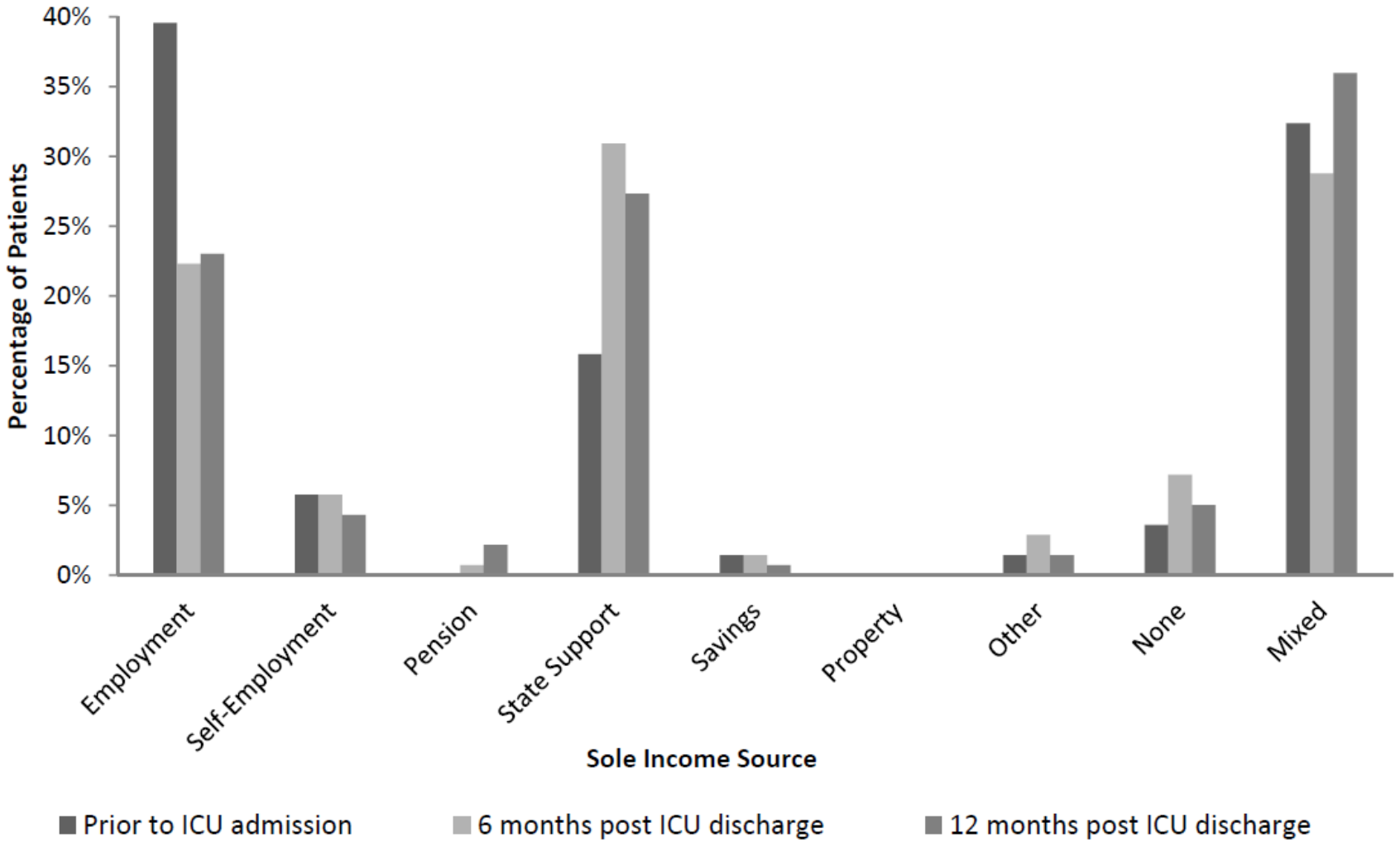


Figure 2 Sources of income prior to admission and at 6 and 12 months post-ICU discharge. Mixed income is where the patient has reporting having more than one source of income at any point in time.

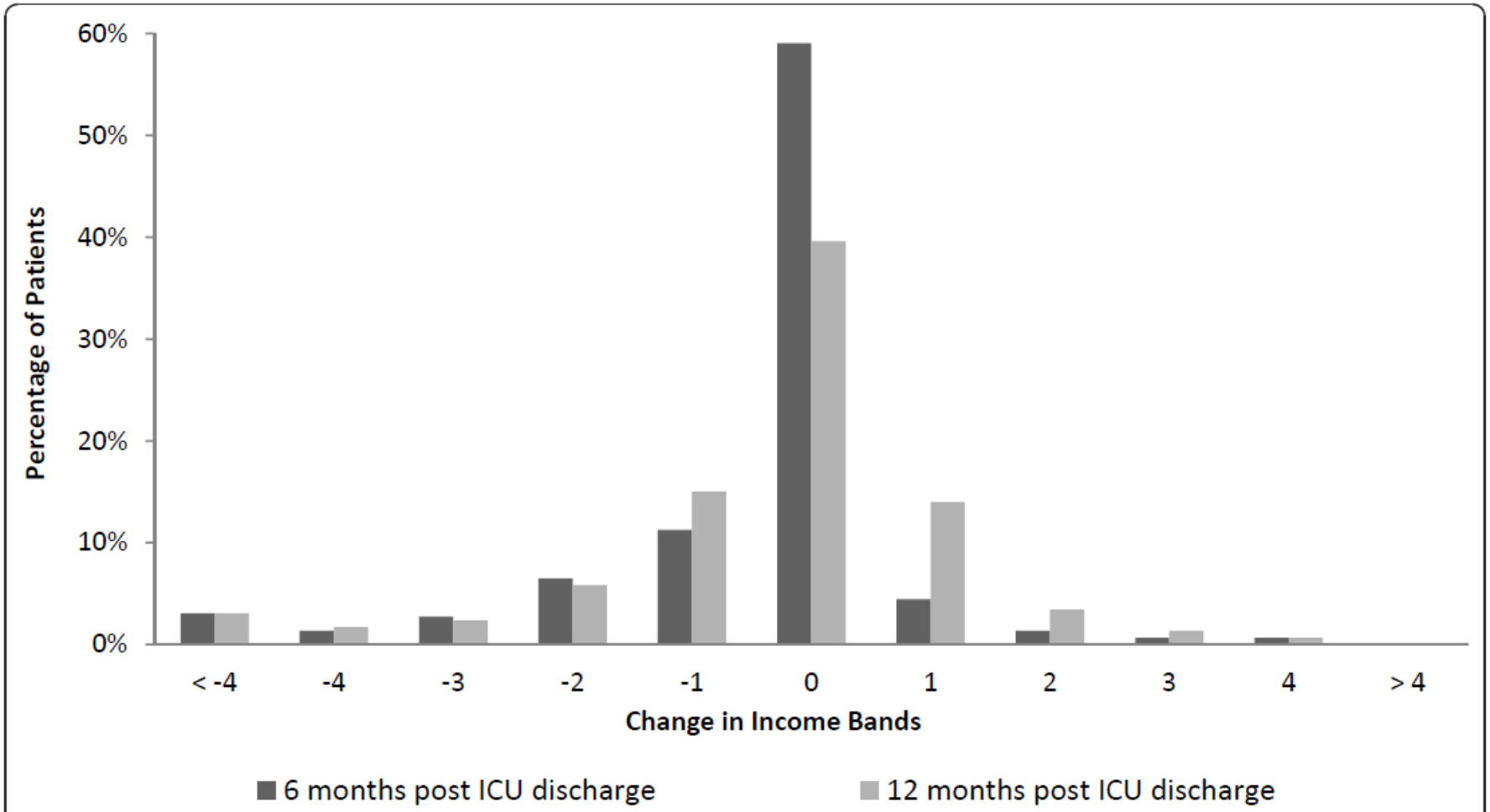


Figure 3 Changes in financial income brackets. Income shift at 6 and 12 months compared with pre-admission expressed in terms of changes in income brackets (from question 10 derived from Reference 25).

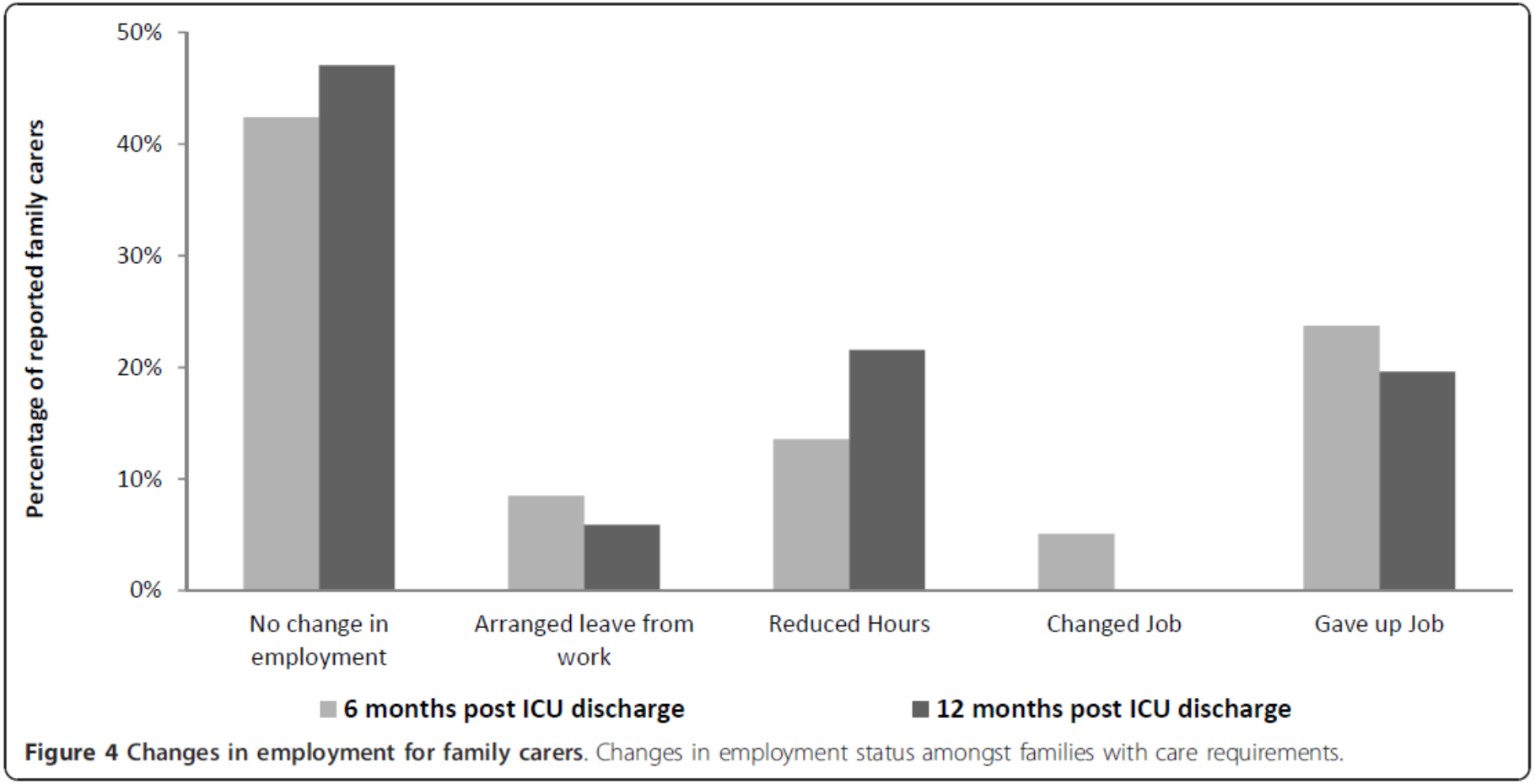


Figure 4 Changes in employment for family carers. Changes in employment status amongst families with care requirements.

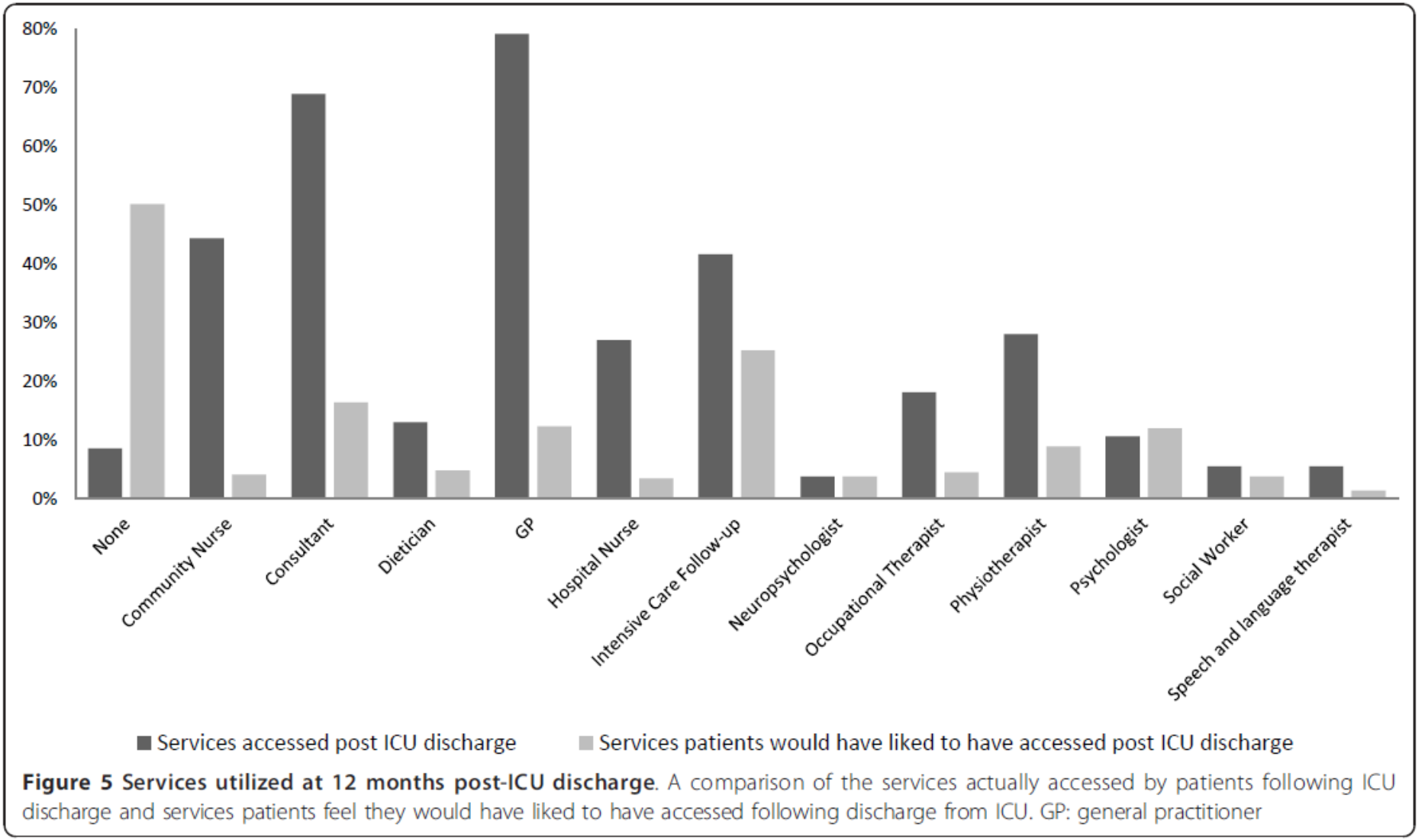


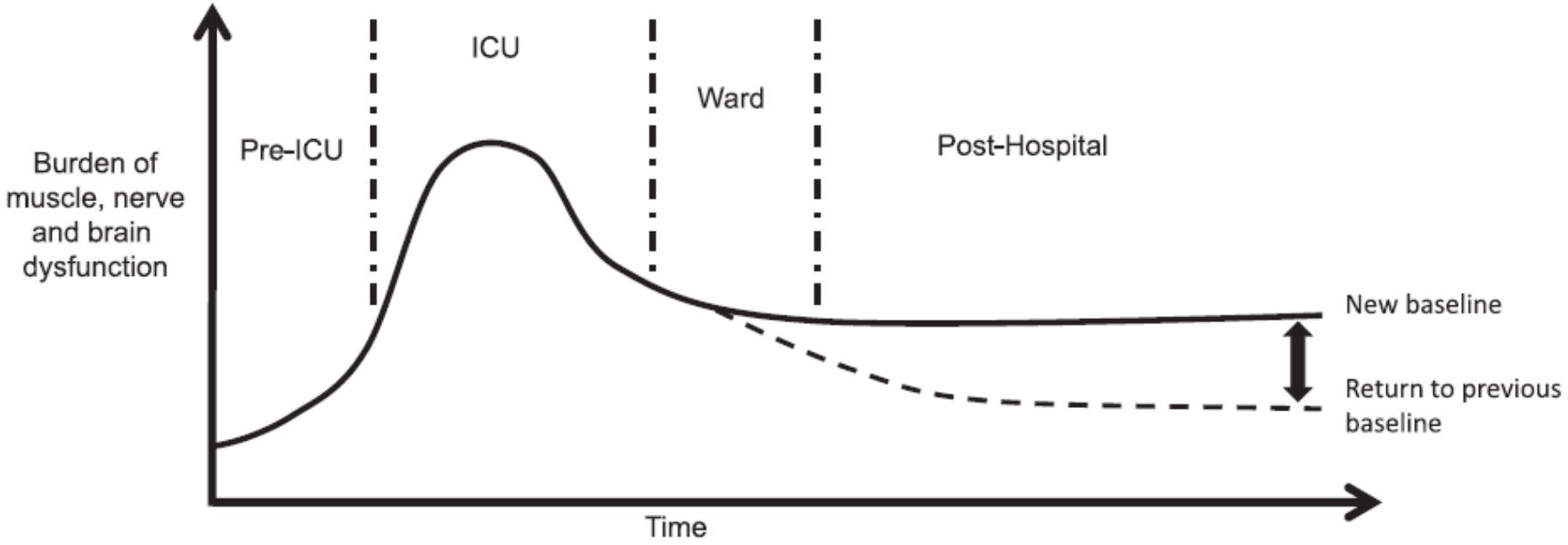
Figure 5 Services utilized at 12 months post-ICU discharge. A comparison of the services actually accessed by patients following ICU discharge and services patients feel they would have liked to have accessed following discharge from ICU. GP: general practitioner

Pre-ICU
Risk factors: age, sex, pre-existing cognitive impairment, multiple comorbidities, baseline functional status, vision/hearing impairment, chronic drug or alcohol use, malnutrition, immunosuppression (HIV), genetics (APOE)
Measures of muscle/nerve function: ADLs, IADLs
Measures of brain function: IQ-CODE
Goal: discuss advance directives as appropriate

ICU
Risk factors: admission diagnosis (ARDS, TBI, other), need for resuscitation, lung protective ventilation strategy, use of steroids and neuromuscular blockade, glycemic control, metabolic derangement (sodium disorders, uremia, hepatic failure), sleep disorder, delirium monitoring and its management (choice of sedatives, pain control, anxiety, physical restraints), wakefulness (sedation stewardship), early mobilization, cognitive and physical therapy
Measures of muscle/nerve function: EMG, MRC, physical strength and function
Measures of brain function: RASS, CAM-ICU
Goal: reduce iatrogenic risk exposure

Ward
Risk factors: Disordered sleep, delirium monitoring and its management, mobilization, inadequate intensity of cognitive and physical therapy, neurotransmitter abnormalities, persistent cytokine mediated inflammation
Measures of muscle/nerve function: 6MWD, FIM, MRC, ADLs, HRQOL (SF-36 or EQ-5D)
Measures of brain function: Neuropsychological testing, BDI-II, HAD, IES
Goal: reduce iatrogenic risk exposure, risk stratify inpatient versus outpatient physical or cognitive rehabilitation

Post-Hospital
Risk factors: Disordered sleep, unrecognized need for ongoing cognitive and physical therapy, neurotransmitter abnormalities, persistent cytokine mediated inflammation
Measures of muscle/nerve function: 6MWD, FIM, MRC, ADLs, IADLs, HRQOL (SF-36 or EQ-5D)
Measures of brain function: Neuropsychological testing, BDI-II, HAD, IES, sleep study (polysomnography, actigraphy)
Goal: ongoing physical or cognitive rehabilitation, maintain or achieve functional independence, identify and treat new psychiatric impairment, return to work (job re-training)



(*Crit Care Med* 2013; 41:S81–S98)

Ambulatorio di follow-up

- contatto telefonico ad un anno dal ricovero in TI per i pazienti con degenza > 72 h
- visita con intervista strutturata (SF-12/SF-36, HADS, GOS-E, Barthel Index, eventuale testimonianza video)
- richiesta eventuale di consulenze specialistiche (fisiatra, psicologo, neurologo-neurochirurgo, radiologo, cardiologo, dietologo, ecc…)
- lettera al curante
- database dedicato

Follow up (da gennaio 2010 a giugno 2012)

240 pazienti contattati (permanenza > 72h in TI)

131 visti in ambulatorio (55%)

39 deceduti (16%)

47 non in grado di venire (20%), di questi

13 ricoverati in altre strutture

20 non rintracciati (8%)

3 non interessati

2 altro

2 pz ricoverati in altre strutture sono stati visitati

Ricordi del ricovero

- 62 hanno ricordi della Terapia Intensiva
- 61 non ricordano nulla
- 10 non sanno rispondere

- ansia e paura: 35
- dolore: 31
- incubi: 43

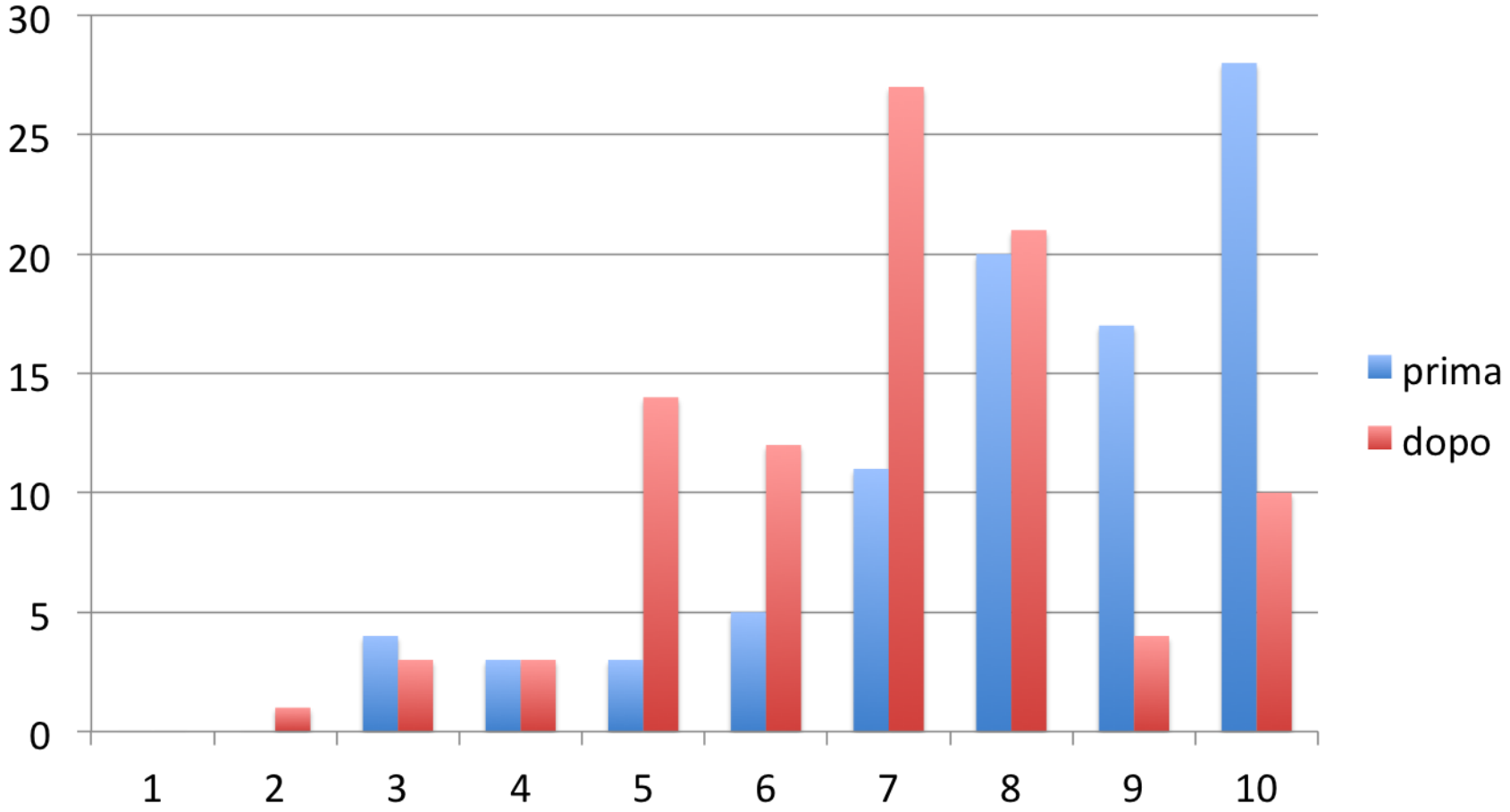
14 pazienti non sono in grado di rispondere ad un'intervista strutturata per afasia o problemi cognitivi

Limitazioni funzionali

- Limitazioni per moderato sforzo fisico: 39 parecchio
  39 parzialmente
  33 per nulla

- 71 (54%) hanno ripreso un'attività lavorativa (41% delle cerebrolesioni e 71% dei restanti)
- 60 (46%) NON hanno ripreso
- Oltre la metà dei pazienti che hanno ripreso lamentano limitazioni di vario grado
- Il ruolo della famiglia nei pazienti con limitazioni è importantissimo

“la mia salute da zero a dieci”:



“il mio carattere è cambiato”:

- Sì 56% (31% in peggio, 21% in meglio, 2% entrambi)
- No 24%
- Non sanno rispondere: 6%

“sento che la vita non ha più valore”:

- Mai 57%
- Quasi mai 8%
- Qualche volta 22%
- Spesso 9%

Life after intensive care: it's life…
…but not as we know it!

B Cuthbertson – Critical Care Medicine 2008

- la malattia di un paziente non termina con la dimissione dalla Terapia Intensiva
- tra il 10% e il 20% dei pazienti dimessi vivi dalla TI muoiono in ospedale
- la mortalità si mantiene più elevata e la qualità di vita è inferiore nei 5 anni successivi rispetto alla popolazione generale

problemi più comuni post TI

Ansia e depressione

PTSD o sintomi correlabili (fuga, evitamento, pensieri intrusivi)

Insonnia

Dolore

Irritabilità

Debolezza, affaticabilità

Limitazioni fisiche

Disturbi cognitivi

Critical Care

CRITICAL CARE

Health-related quality of life scores after intensive care are almost equal to those of the normal population: a multicentre observational study

Critical Care 2013, **17**:R236 doi:10.1186/cc13059

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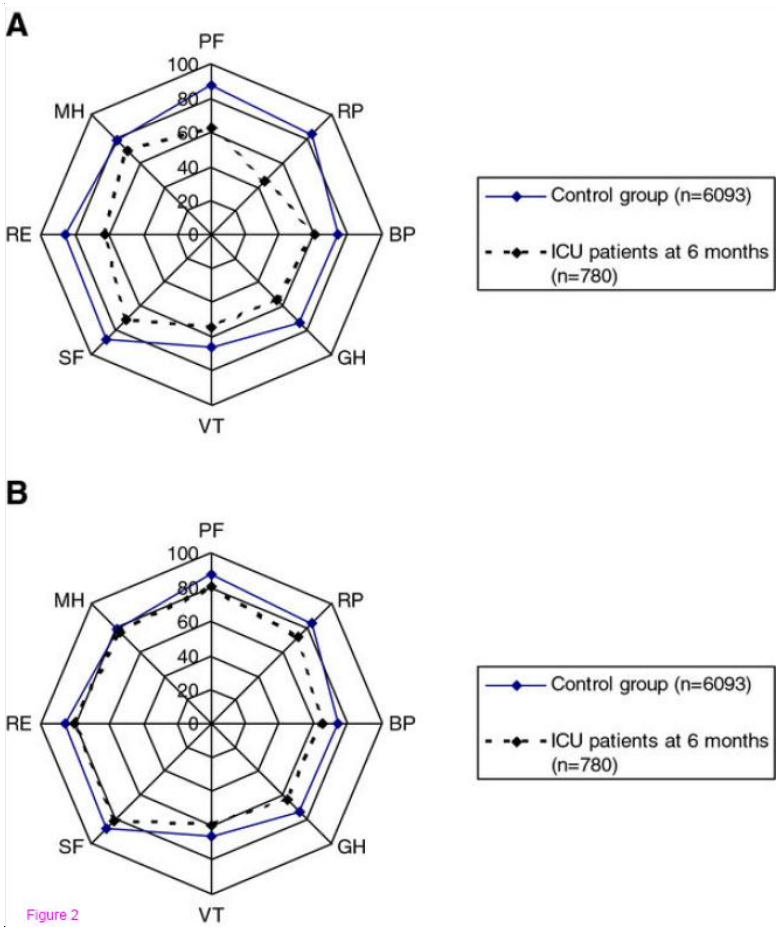


Figure 2

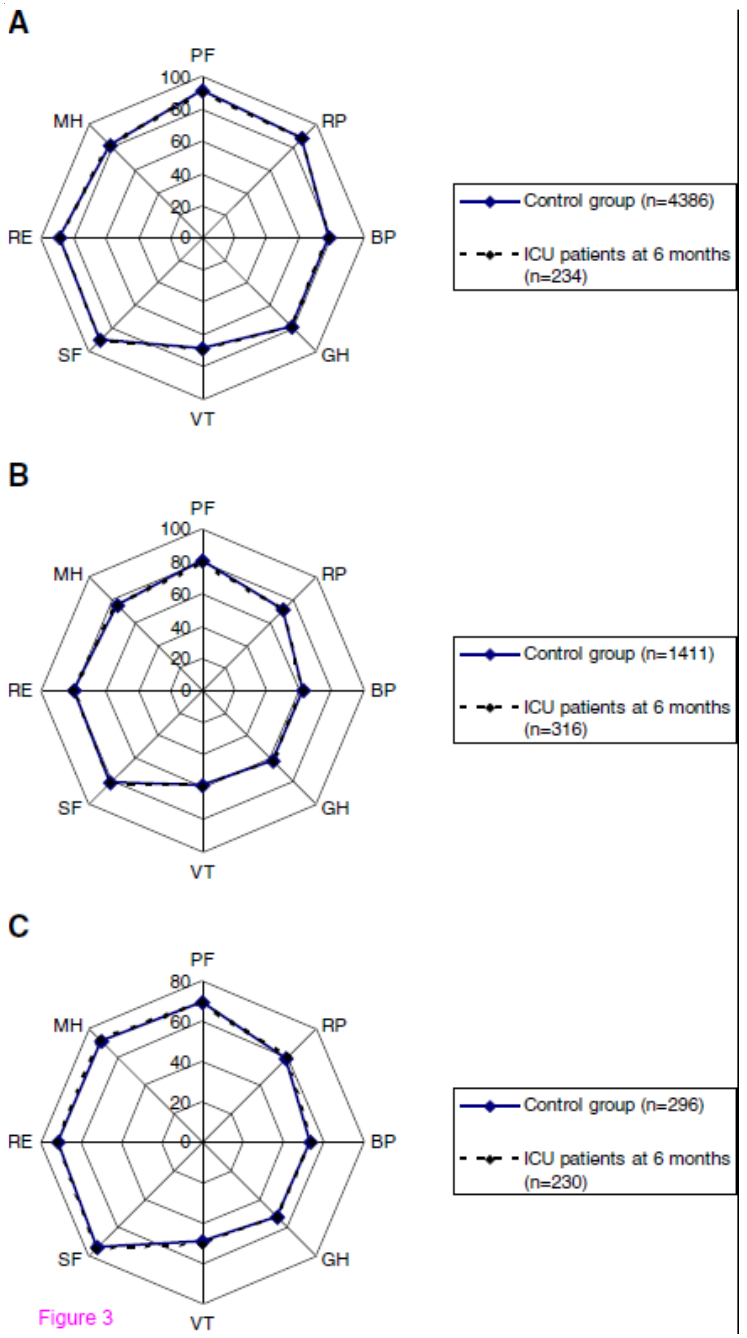


Figure 3

physical functioning (PF)
role limited by physical problems (RP)
bodily pain(BP)
general health (GH)
vitality (VT)
social functioning (SF)
role limited by emotional problems (RE)
mental health (MH

- possiamo modificare l’outcome a distanza modificando il nostro comportamento **durante** il ricovero in TI?

- possiamo modificarlo **dopo** la dimissione dalla TI?

- se sì, fin dove deve estendersi il nostro ambito di cura?

-il diario dei famigliari

In letteratura, i diari dei pazienti possono assolvere la funzione di:

memoria, ossia essere usati come strumento per aiutare i pazienti, una volta usciti dalla TI, a ricordarsi della loro esperienza;

strumento terapeutico per diminuire i casi di Sindrome Post Traumatica da Stress (PTSD);

parte integrante nel processo di **cura** ;

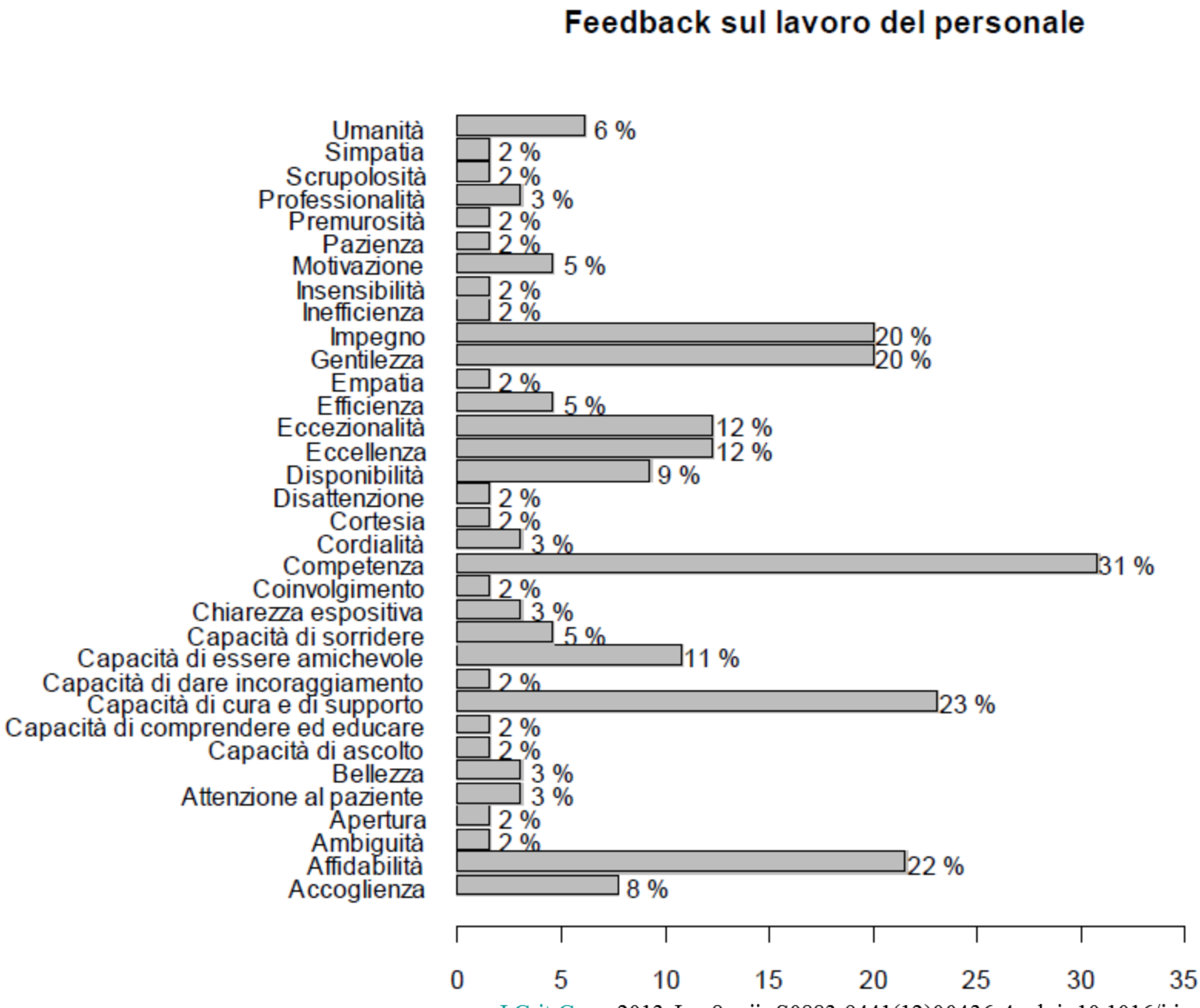
strumento per **coinvolgere** i familiari nel processo di cura;

mezzo di **comunicazione** tra pazienti e familiari.

A narrative-based study on communication by family members in Intensive Care Unit.

DIARI IN TERAPIA INTENSIVA

J Crit Care. 2013 Jan 8. pii: S0883-9441(12)00436-4. doi: 10.1016/j.jcrc.2012.11.001



J Crit Care. 2013 Jan 8. pii: S0883-9441(12)00436-4. doi: 10.1016/j.jcrc.2012.11.001

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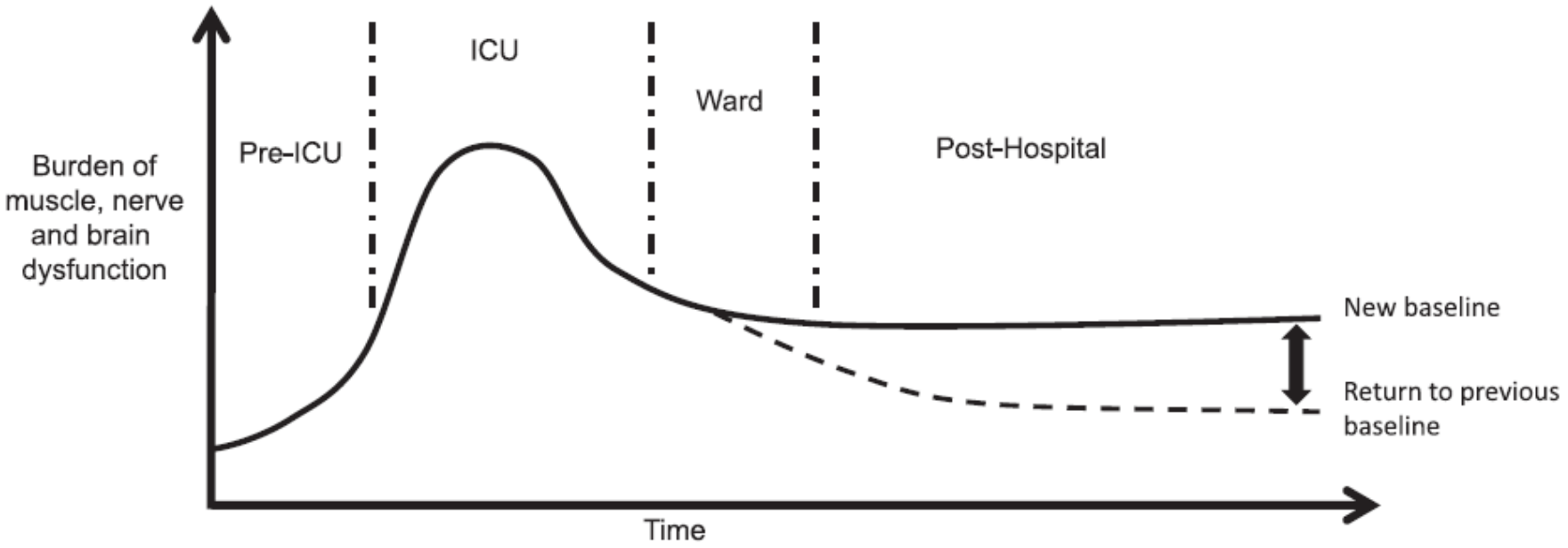
Cognitive Dysfunction in ICU Patients: Risk Factors, Predictors, and Rehabilitation Interventions

M. Elizabeth Wilcox, MD, MPH[1]; Nathan E. Brummel, MD, MSCI[2]; Kristin Archer, DPT, PhD[3]; E. Wesley Ely, MD, MPH[2,4,5]; James C. Jackson, PsyD[2,5,6]; Ramona O. Hopkins, PhD[7,8]



(*Crit Care Med* 2013; 41:S81–S98)


Grazie