FONDAZIONE POLIAMBULANZA
Istituto Ospedaliero

Le cure nell'anziano.
L'intensività.

Giuseppe Natalini

Dipartimento di Emergenza di Alta Specialità
Unità di Terapia Intensiva Polifunzionale

L'anziano in Terapia Intensiva: "problema" reale o falso "problema"?

Unità di Terapia Intensiva Polifunzionale

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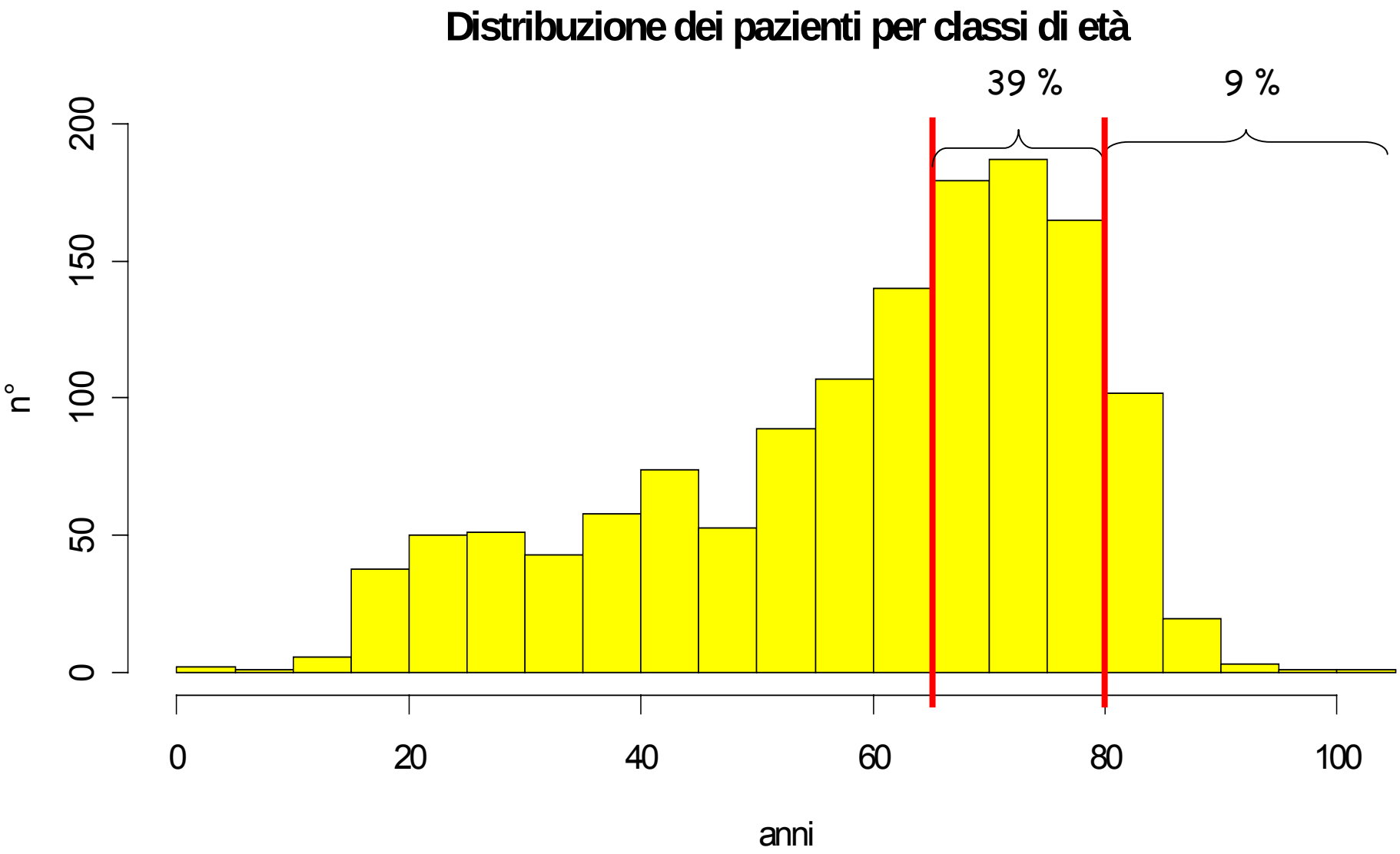
Periodo 2002-2005: media (sd): 59.7 (18.6); mediana (1°Q-3°Q): 64.6 (47-74)



Progetto MARGHERITA Anno 2006

GiViTI

Gruppo italiano per la Valutazione degli interventi in Terapia Intensiva

Rapporto personalizzato

CENTRO 515

POLIAMBULANZA
BRESCIA

50.6 %

	N	%
< 15 anni	1	0.2
15 - 45 anni	88	20.4
46 - 65 anni	124	28.8
66 - 75 anni	122	28.3
> 75 anni	96	22.3
Dati non disponibili	0	
Media (DS)	61.1 (17.3)	
Mediana (Q1-Q3)	66 (50-75)	
Minimo-massimo	14-90	

Rapporto generale

TI POLIVALENTI

58.7 %

	N	%
<15 anni	537	1.2
15 - 45 anni	7114	15.3
46 - 65 anni	11514	24.8
66 - 75 anni	12618	27.2
> 75 anni	14612	31.5
Dati non disponibili	6	
Media (DS)	64.2 (18.3)	
Mediana (Q1-Q3)	69 (55-78)	
Minimo-massimo	0-104	

Derek C. Angus, MB, ChB, MPH
Mark A. Kelley, MD
Robert J. Schmitz, PhD
Alan White, PhD
John Popovich, Jr, MD
for the Committee on Manpower for Pulmonary and Critical Care Societies (COMPACCS)

Current and Projected Workforce Requirements for Care of the Critically Ill and Patients With Pulmonary Disease

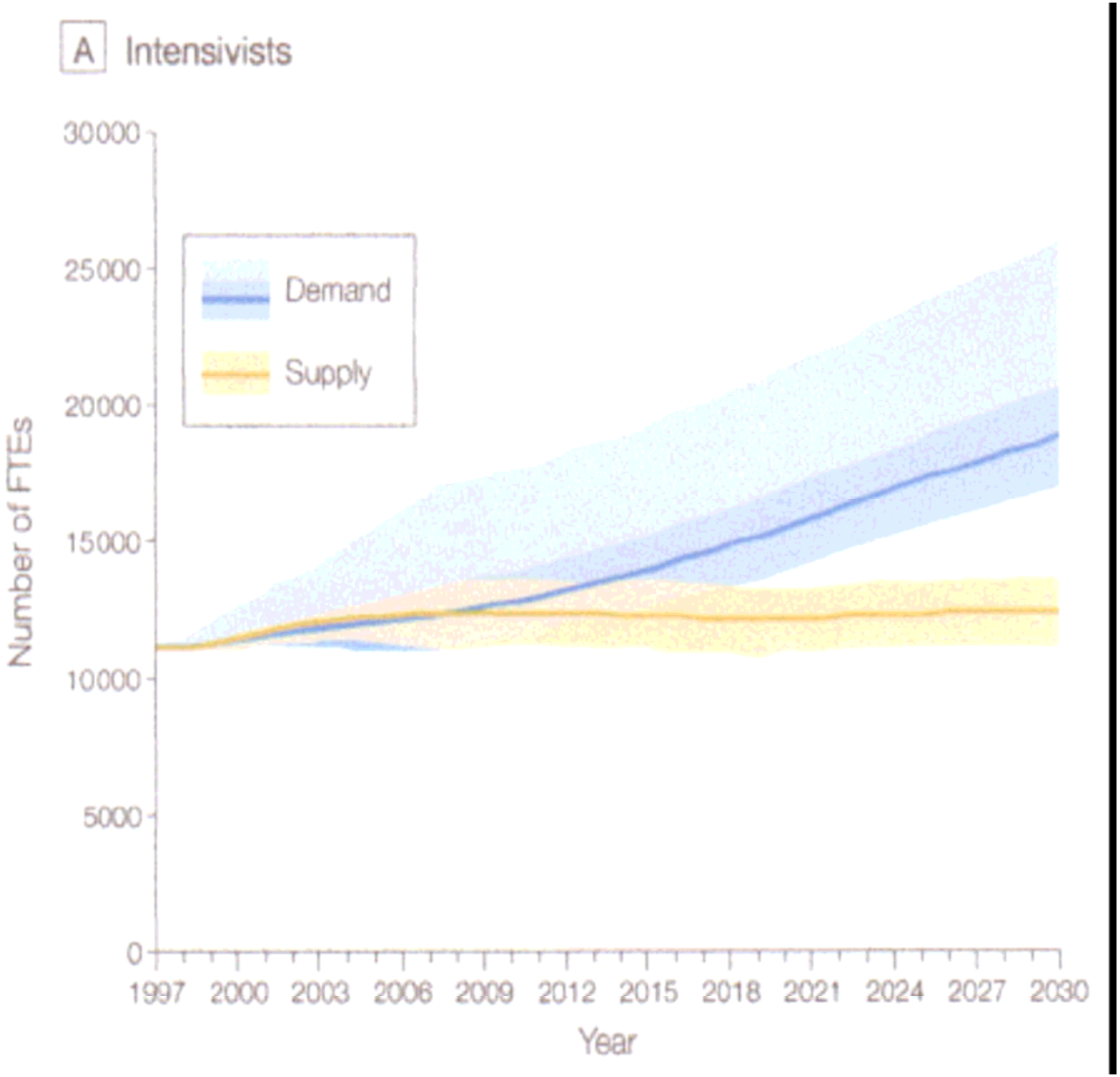
Can We Meet the Requirements of an Aging Population?

JAMA. 2000;284:2762-2770

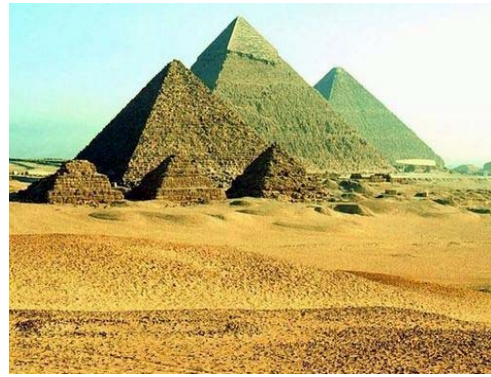
RESULTS

Current Demand for Adult Critical Care Services

More than half of all ICU days (55.8%) were incurred by patients older than 65 years with the number of days per year per 1000 person-years varying from 37.3 for adults younger than 65 years to 178.4, 244.9, and 230.9 for those aged 65 to 74, 75 to 84, and older than 85 years, respectively. Half of the patients


A Intensivists
30000
25000
20000
15000
10000
5000
0
Number of FTEs
Demand
Supply
1997
2000
2003
2006
2009
2012
2015
2018
2021
2024
2027
2030
Year

Take-home



In Terapia Intensiva la maggior parte dei pazienti è anziana.

L'anziano in Terapia Intensiva è un "problema" molto rilevante.

Indicazioni al ricovero in TI

Criteri per l'ammissione nella Unità di Terapia Intensiva Polifunzionale della Fondazione Poliambulanza

Funzione cardiocircolatoria

- frequenza cardiaca <40 battiti/min o >150 battiti/min
- pressione arteriosa sistolica < 90 mmHg
- dopamina > 5 mcg.kg^{-1}.min^{-1}

Funzione respiratoria

- PaO_2 < 60 mmHg con ossigenoterapia
- pH < 7,35 con $PaCO_2$ > 45 mmHg
- frequenza respiratoria >35 atti al minuto
- dispnea con utilizzo dei muscoli respiratori accessori

Funzione renale

- diuresi < 500 ml/die (20 ml/h) nonostante terapia diuretica
- diuresi < 1000 ml/die associata a edema e congestione polmonare
- creatinina > 3,5 mg/dl
- potassiemia > 7 mEq/l

Funzione neurologica

- Glasgow Coma Scale $\leq$ 8 (contemporaneamente non apre gli occhi, non parla, non esegue ordini semplici)
- assenza di protezione delle vie aeree (tosse e deglutizione inadeguate in pazienti non tracheotomizzati)

Altro

- la contemporanea presenza di disfunzione acuta di due o più organi, anche se di gravità inferiore rispetto ai precedenti parametri. Ad esempio alterazioni del sensorio associate ad ipotensione o ipossiemia.
- monitoraggio in pazienti a rischio di compromissione delle funzioni vitali

1.Task Force of the American College of Critical Care Medicine, Society of Critical Care Medicine. Guidelines for intensive care unit admission, discharge and triage. **Crit Care Med 1999; 27: 633-638.**

2.Vincent JL, Moreno R, Takala J, Willatts S, De Mendonca A, Bruining H, Reinhart CK, Suter PM, Thijs LG. The SOFA (Sepsis-related organ failure assessment) score to describe the organ dysfunction/failure. **Intensive Care Med 1996; 22: 707-710.**

La prognosi del paziente anziano in Terapia Intensiva

Mortalità ospedaliera
(periodo 2002-2005)

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	< 65 aa	> 65 aa	P
Mortalità ospedaliera	80/712 (11 %)	151/658 (23 %)	< 0.001

> 75 anni	39 %	(JAMA 1993; 269:3119-23)
	27 %	(Crit Care Med 2001; 29:891-95)
	29 %	(J Trauma 1995; 39:254-59)
	42 %	(J Trauma 2000; 48:229-34)
	31 %	(Crit Care Med 1997; 25:1643-48)
> 80 anni	69 %	(Arch Intern Med 1993; 153:1657-62)
	62 %	(JAMA 1993; 269:1025-29)
> 85 anni	25 %	(Crit Care Med 2001; 29:1853-59)

Mortalità a 1 anno (periodo 2002-2005)

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	< 65 aa	> 65 aa	P
Mortalità	14/60 (23 %)	15/31 (52 %)	0.019
Disabilità (Barthel index)	100 (59-100)	100 (65-100)	0.263
Attività strumentali (IADL)	16 (8-16)	16 (3-16)	0.021

Dati presentati come mediana (10°-90° percentile)

++ mortalità , = disabilità

Mortalità a 1 anna:

- 59 % (Crit Care Med 2000; 28:3389-95)
- 63 % (JAMA 1993; 269:3119-23)
- 81 % (Arch Intern Med 1993; 153:1657-62)
- 64 % (Int Care Med 1991; 17:7-10)

Tipo di ricovero (periodo 2002-2005)

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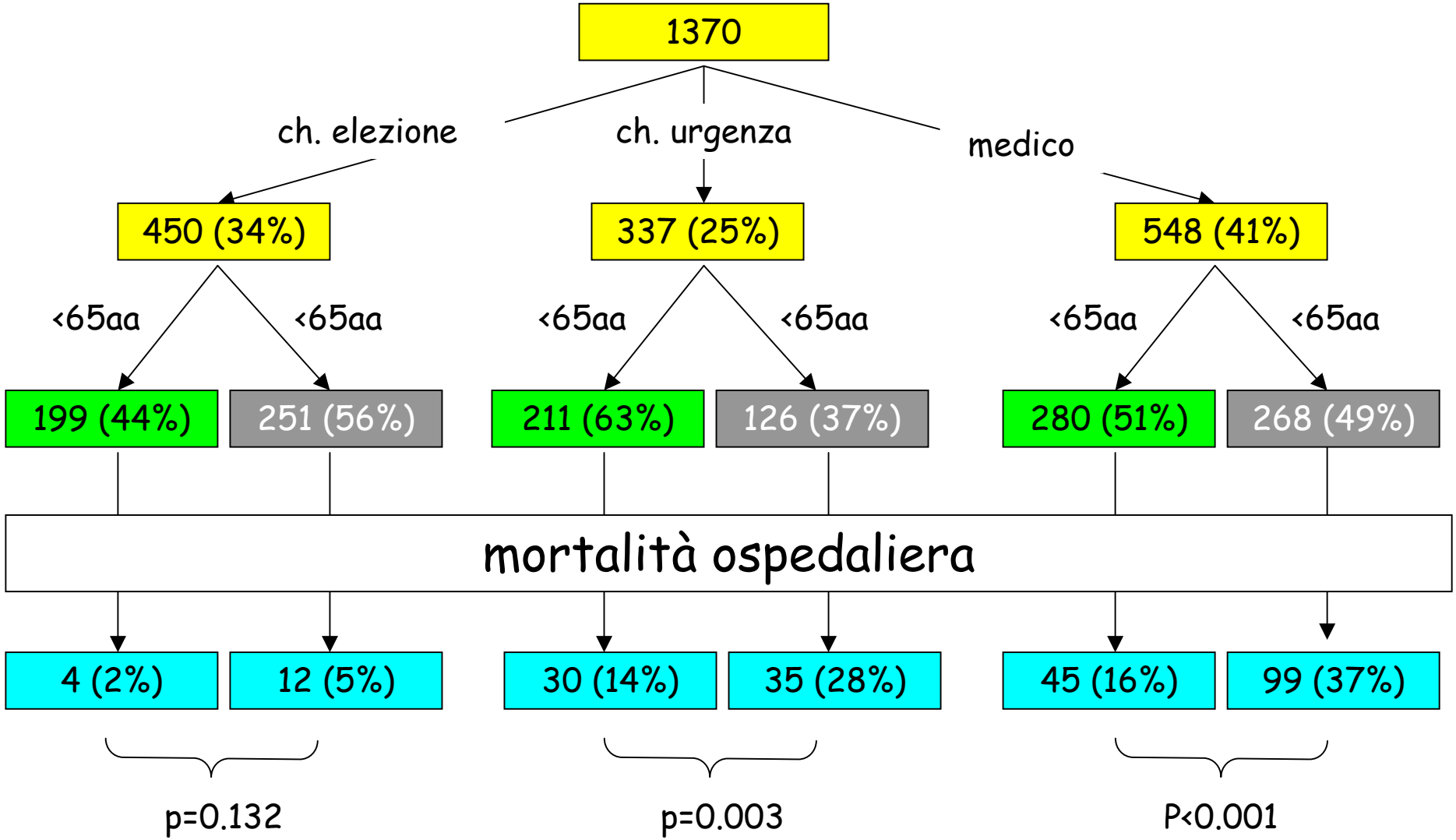
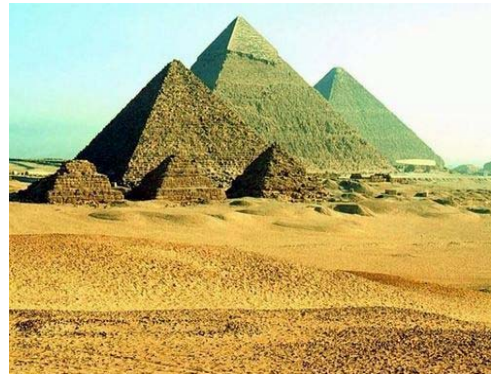


Take-home



- Mortalità: "over 65" > "under 65" (!!!):
  - 20-40 % ospedaliera
  - 50-60 % a 1 anno
- Disabilità dopo ricovero in Terapia Intensiva: "over 65" ~ "under 65"

Fattori associati alla mortalità

Fattori associati alla mortalità

- Età
- Ventilazione meccanica
- Insufficienze d'organo
- Neoplasia
- Arresto cardiaco
- Infarto acuto miocardio
- Malattie autoimmuni
- Malnutrizione
- Livello funzionale pre-ricovero

(*Int Care Med* 1991; 17:7-10)
(Arch Intern Med 1993; 153:1657-62)
(*JAMA* 1993; 269:1025-29)
(*J Trauma* 1995; 39:254-59)
(*Crit Care Med* 1999; 27:2351-57)
(Crit Care Med 2001; 29:891-95)
(Crit Care Med 2001; 29:1853-59)

L'età non è un predittore indipendente di mortalità dopo ricovero in Terapia Intensiva

Chelluri L, Pinsky MR, Grenvik AN: **Outcome of intensive care of the "oldest-old"; critically ill patients.** *Crit Care Med* 1992, **20**:757-761.

Bo M, Massaia M, Raspo S, Bosco F, Cena P, Molaschi M, Fabris F: **Predictive factors of in-hospital mortality in older patients admitted to a medical intensive care unit.** *J Am Geriatr Soc* 2003, **51**:529-533.

Nierman DM, Schechter CB, Cannon LM, Meier DE: **Outcome prediction model for very elderly critically ill patients.** *Crit Care Med* 2001, **29**:1853-1859.

Somme D, Maillet JM, Gisselbrecht M, Novara A, Ract C, Fagon JY: **Critically ill old and the oldest-old patients in intensive care: short- and long-term outcomes.** *Intensive Care Med* 2003, **29**:2137-2143.

Rockwood K, Noseworthy TW, Gibney RT, Konopad E, Shustack A, Stollery D, Johnston R, Grace M: **One-year outcome of elderly and young patients admitted to intensive care units.** *Crit Care Med* 1993, **21**:687-691.

Delirium as a Predictor of Mortality in Mechanically Ventilated Patients in the Intensive Care Unit

JAMA. 2004;291:1753-1762

E. Wesley Ely, MD, MPH
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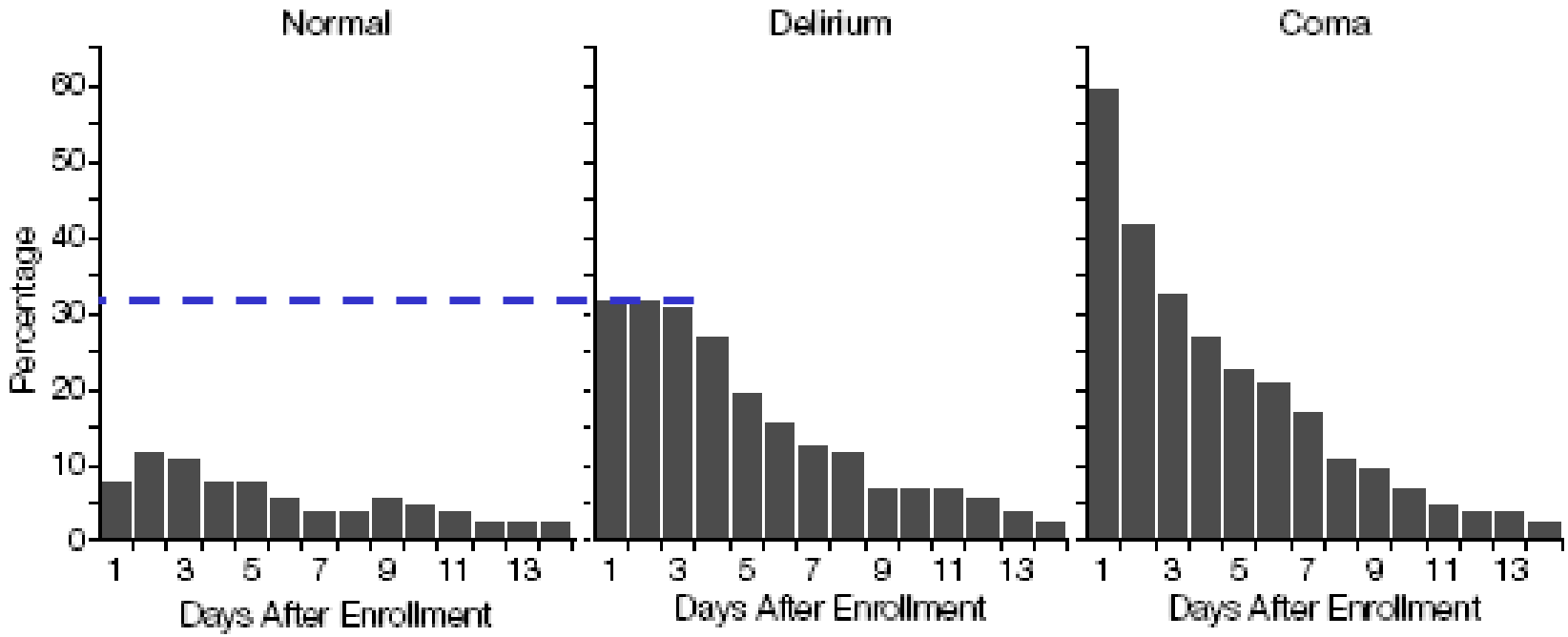
Figure 2. Daily Neurologic Status of 275 Patients in the ICU



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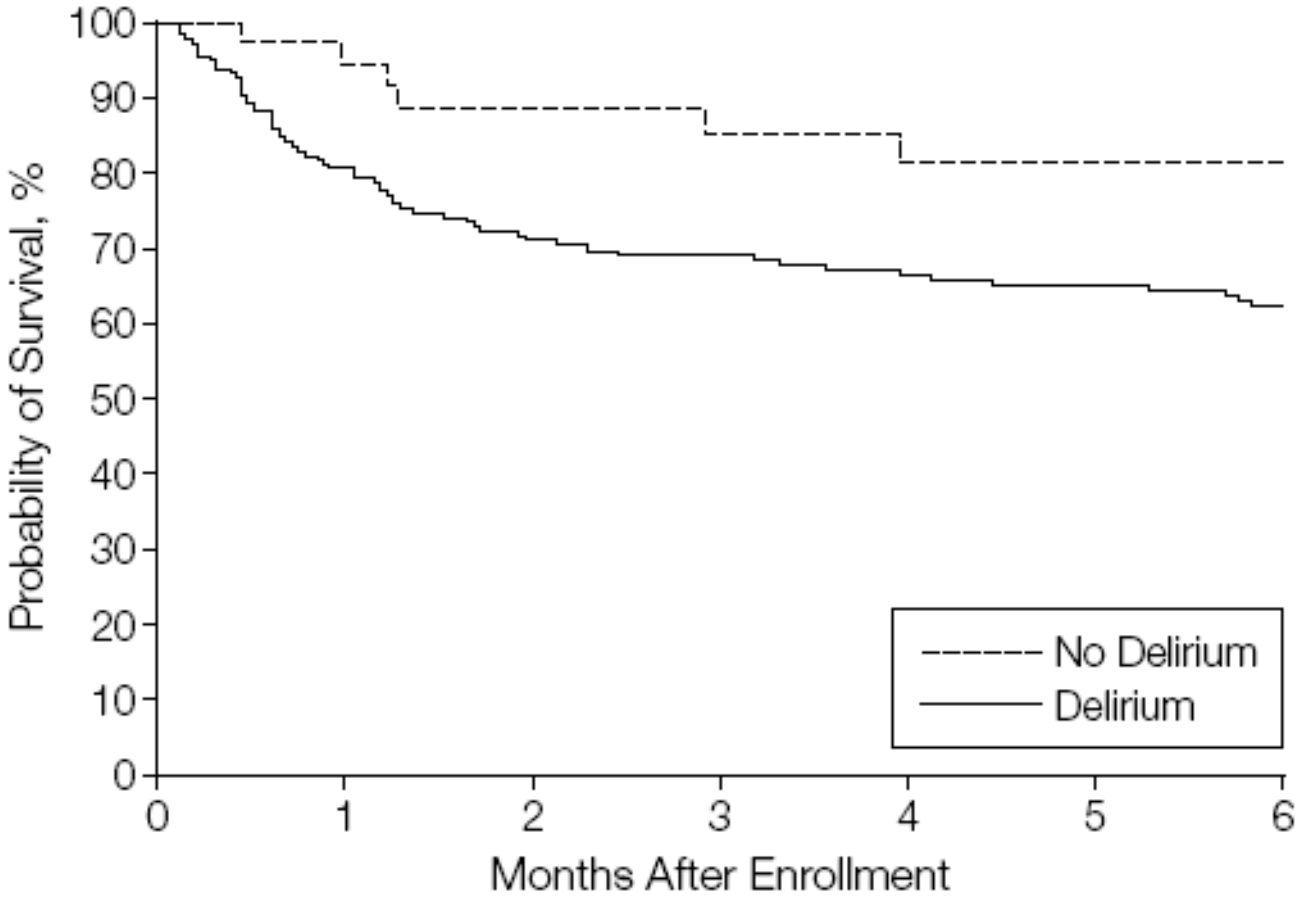

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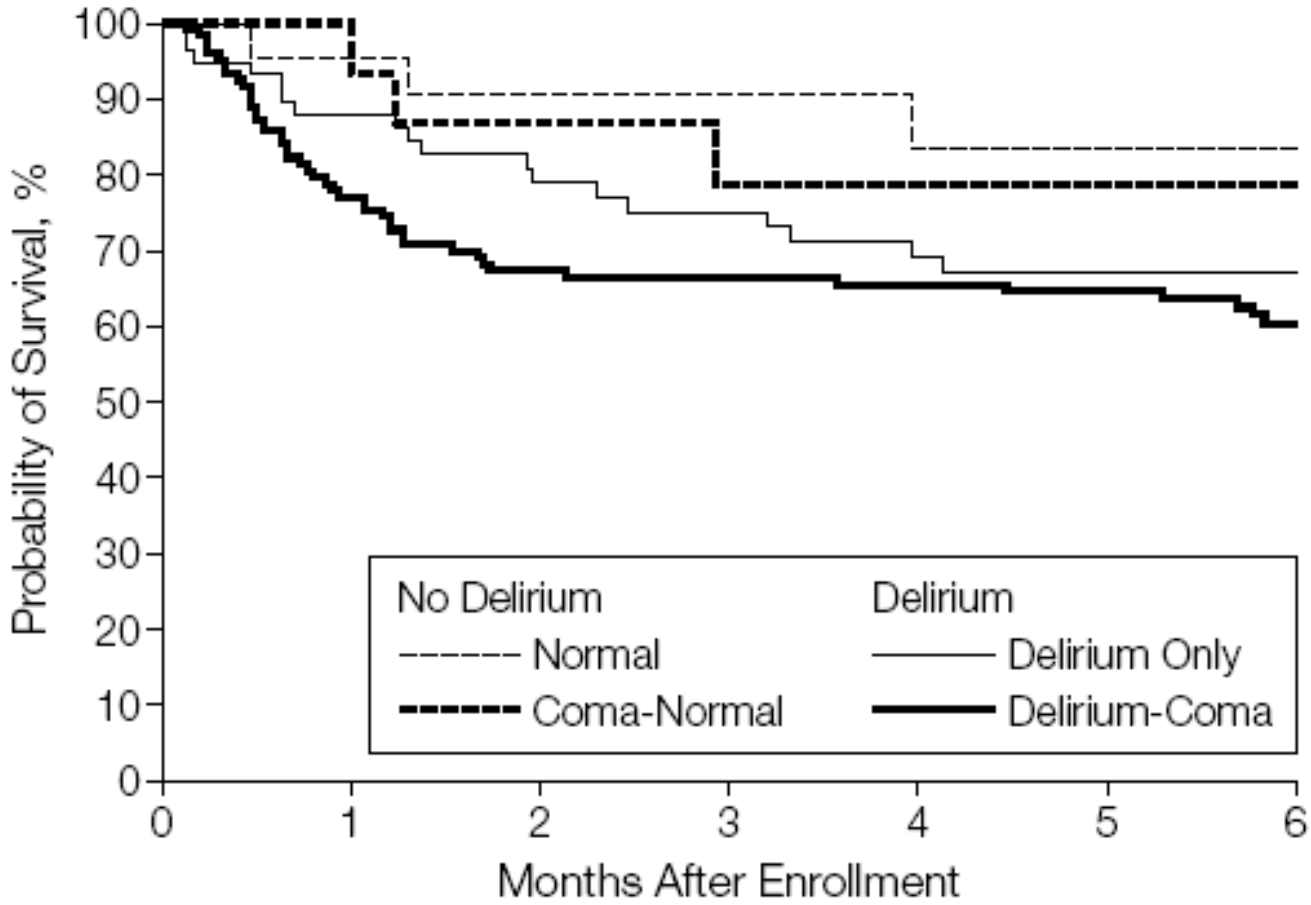

Underrecognition of Preexisting Cognitive Impairment by Physicians in Older ICU Patients*

(CHEST 2003; 124:2267–2274)

Margaret A. Pisani, MD, MPH, FCCP; Carrie Redlich, MD, MPH, FCCP; Lynn McNicoll, MD; E. Wesley Ely, MD, MPH, FCCP; and Sharon K. Inouye, MD, MPH

Table 5—*Patient Characteristics Associated With Recognition of Preexisting Cognitive Impairment by ICU Physicians by Number of Risk Factors

Risk Factors, No.	n/N (%)	Relative Risk
None	3/76 (4)	1.0 (reference value)
One	26/89 (29)	7.3
Two	13/25 (52)	13.0

*n/N = No. of patients in whom cognitive impairment was recognized by physicians/total No. of patients with risk factor. There was a general trend in comparisons of $p < 0.001$ (by Mantel-Haenszel χ^2).

Table 2—*Reporting of Preexisting Cognitive Impairment

Variables	Values
Prevalence of CI by proxy measures (reference standard)	63 (38%)
Attending physician	
Report of CI when present (true positive)	29 (46%)
Report of CI when not present (false positive)	7 (7%)
Sensitivity	46%
Specificity	93%
Intern physician	
Report of CI when present (true positive)	26 (41%)
Report of CI when not present (false positive)	15 (15%)
Sensitivity	41%
Specificity	85%

*n = 165; CI = cognitive impairment.

Table 4—*ICU Physicians' Reporting of Cognitive Impairment Based on Patient Characteristics

Variables	CI Reported (n = 36)	CI Not Reported (n = 129)	Unadjusted Values	Adjusted Values†
Admitted to ICU from a nursing home	17 (47)	15 (12)	1.7 (1.2–2.3)‡	4.7 (2.4–8.9)
Any ADL impairment-no. (%)	31 (86)	51 (40)	4.3 (2.0–10)‡	7.7 (3.4–17.0)

Short-term outcomes in older intensive care unit patients with dementia*

(Crit Care Med 2005; 33:1371–1376)

Margaret A. Pisani, MD, MPH; Carrie A. Redlich, MD, MPH; Lynn McNicoll, MD; E. Wesley Ely, MD, MPH; Rebecca J. Friedkin, PhD; Sharon K. Inouye, MD, MPH

Table 3. Intensive care unit (ICU) and hospital outcomes[a]

	Overall n = 395	Dementia Present n = 66	Dementia Absent n = 329	*p* Value
Days on mechanical ventilation, median (range)[b]	4 (1–145)	2 (1–13)	4 (1–145)	.06
Length of ICU stay in days, median (range)	3 (1–64)	3 (1–18)	3 (1–64)	.07
Length of ICU stay in days for subjects who died, median (range), n = 97		4 (1–18)	6 (1–36)	.25
Length of hospital stay in days, median (range)	11 (1–237)	11 (1–86)	11 (1–237)	.16
Change in code status to less aggressive	61 (15)	16 (24)	45 (14)	.04
Readmission to the ICU[c]	39 (12)	5 (9)	34 (12)	.51
New discharge to a nursing home[d]	76 (23)	8/35 (23)	68/293 (23)	1.0
ICU mortality rate	65 (16)	8 (12)	57 (17)	.37
Hospital mortality rate	97 (25)	14 (21)	83 (25)	.53

[a]Data are presented as number (percentage) unless otherwise indicated: *p* value compares dementia-present to dementia-absent groups; [b]n = 183 number of patients on mechanical ventilation; [c]excludes people who died in their first ICU admission, n = 334; [d]excludes people who were admitted from a nursing home, n = 328.

Unità di Terapia Intensiva Polifunzionale

(periodo 2002-2005, 1370 pazienti)

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Variabili predittive di mortalità ospedaliera

	OR	CI 95 %	P
Disabilità	0.98	0.96-1.00	0.06
Paziente medico	16.2	2.5-323	0.014
Paziente ch. d'urgenza	17.9	2-410	0.021
Disfunzione neurologica (SOFA)	1.9	1.3-3.2	0.003
Disfunzione renale (SOFA)	2.1	1.4-3.3	0.001

$$p=1/(1-e^{-(-4.53-0.02*Barthel+ch.urg*2.88+med*2.78+SOFAneuro*0.66+SOFArene*0.72)})$$

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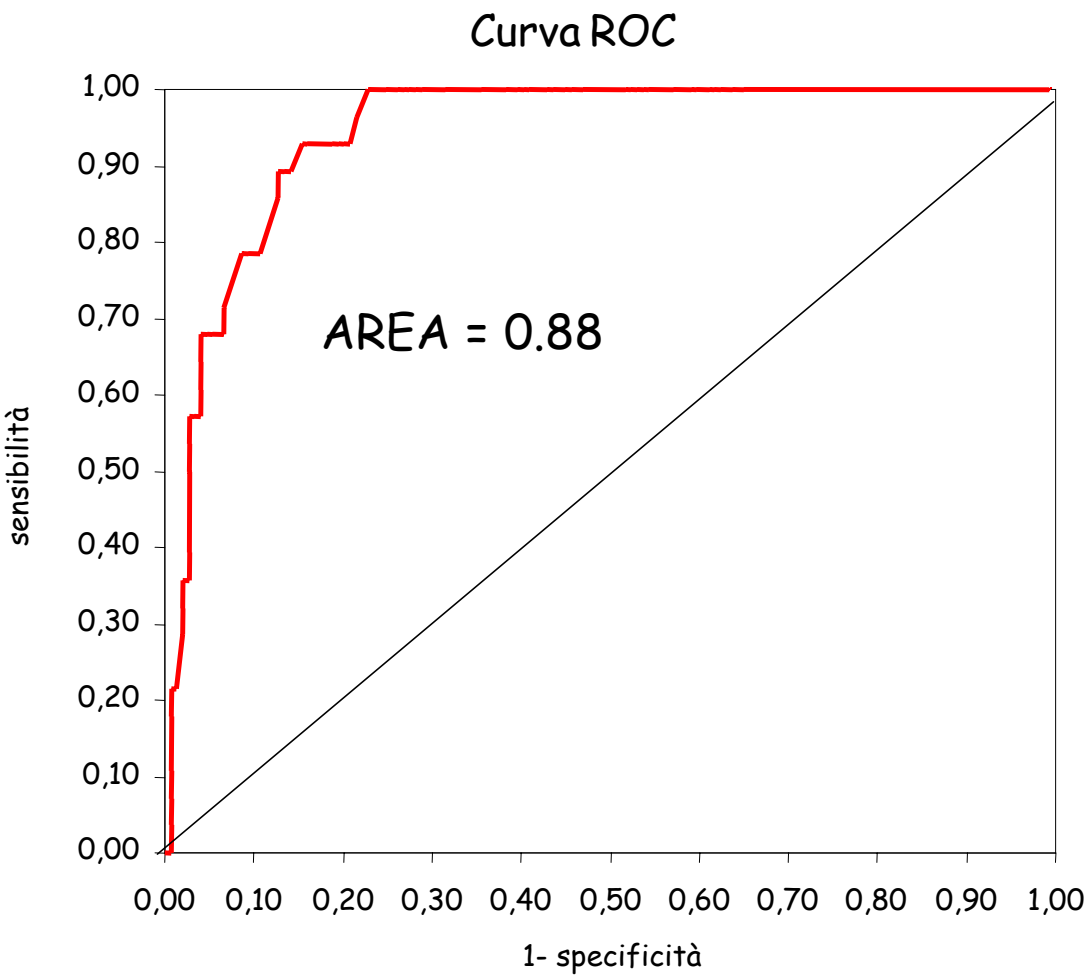
Modello predittivo



Valore soglia: 0.18
Sensibilità: 93 %
Specificità= 84 %
Valore predittivo positivo= 52 %
Valore predittivo negativo=98 %

Valore soglia: 0.55
Sensibilità: 57 %
Specificità= 97 %
Valore predittivo positivo= 80 %
Valore predittivo negativo=92 %

Barthel index

	Con aiuto	Da solo
Mangiare	5	10
Vestirsi	5	10
Pulizia personale	0	5
Fare il bagno	0	5
Controllo defecazione	5	10
Controllo minzione	5	10
Spostarsi dalla sedia al letto e ritornare	10	15
Uso del WC	5	10
Camminare in piano	10	15
Salire e scendere le scale	5	10

SOFA:

Disfunzione neurologica

GCS	SOFA
15	0
13 - 14	1
10 - 12	2
6 - 9	3
3 - 5	4

SOFA: disfunzione renale

Creatinina/diuresi	SOFA
Cr < 1.2 mg/dL	0
Cr 1.2-1.9 mg/dL	1
Cr 2.0-3.4 mg/dL	2
Cr 3.5-4.9 mg/dL o diuresi 200-499 mL/die	3
Cr> 5 o diuresi < 200 mL/die	4

Prima del ricovero in ospedale:

- Barthel index 20 (dipendente negli spostamenti, aiutato nelle altre attività, occasionale perdita controllo degli sfinteri)
- creatinina: 2 mg/dL

Ricoverata in Terapia Intensiva per: sepsi grave secondaria a polmonite, confusione mentale (delirio), anuria

Probabilità di morte: 90 %

Outcome prediction model for very elderly critically ill patients

David M. Nierman, MD, FCCM, FCCP; Clyde B. Schechter, MA, MD, FACPM; Lisa M. Cannon, MD; Diane E. Meier, MD, FACP

(Crit Care Med 2001; 29:1853–1859)

Table 5. Results of fitted ordinal logistic regression analysis

Independent Variable	Coefficient	95% CI
Age (yrs)	+0.035	−0.056 to +0.126
Male gender	+0.037	−0.581 to +0.655
Independent ADL (1 if yes; 0 if no)	+1.324[a]	0.581 to 2.067
Assistance with ADL (1 if required; 0 otherwise)	+1.021[a]	0.277 to 1.765
Noncardiac ICU (0 for CCU or CSICU; 1 for MICU, SICU, or NSICU)	−0.821[b]	−1.499 to −0.142
Heart rate at admission (min^{-1})	−0.021[a]	−0.033 to −0.009
Count of organ system failures (1 each for respiratory, hematologic, neurologic failure, or sepsis)	−0.696[a]	−1.080 to −0.311
Count of ICU procedures (1 each for pressors and mechanical ventilation, −1 for pulmonary artery catheter)	−0.596	−1.109 to −0.083
Cut points for predictive index:		
Death vs. SNF or home	−0.872	
Death or SNF vs. home	+0.805	
No.	242	

ADL, activities of daily living; ICU, intensive care unit; CCU, coronary care unit; CSICU, cardiothoracic surgery ICU; MICU, medical ICU; SICU, surgical ICU; NSICU, neurosurgical ICU; SNF, skilled nursing facility.

[a]Significant at 5% level; [b]Significant at 1% level.

Futility of Resuscitation Criteria for the "Young" Old and the "Old" Old Trauma Patient: A National Trauma Data Bank Analysis

Ram Nirula, MD, MPH, and Lawrence M. Gentilello, MD

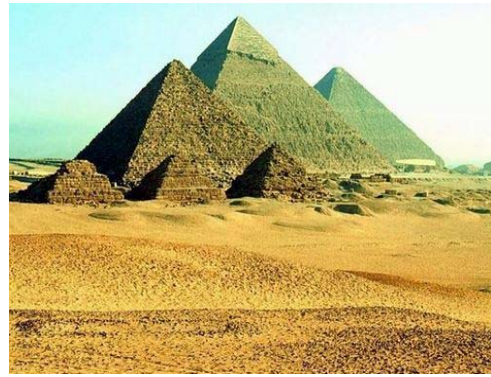
J Trauma. 2004;57:37–41.

the data indicate that for hypotensive 65- to 74-year-olds admitted with a severe chest and/or abdominal injury, only those with severe head injuries (head AIS score ≥ 4) or profound shock (base deficit ≤ −12) have a less than 5% chance of survival. For the same cohort but aged 75 to 84, even moderate head injury (head AIS score of 3) and moderate shock (base deficit ≤ −6) were associated with a greater than 95% probability of death. Finally, for the same cohort but 85 years of age or older, the probability of surviving is less than 5% for those with profound shock or those with moderate shock and moderate head injury (Figs. 1–3).

sopravvivenza < 5 %

Conclusion: Geriatric trauma patients with severe chest and/or abdominal trauma with moderate shock and mild to moderate head injury have an exceedingly low probability of survival. These data support early withdrawal of care in these individuals.

Take-home



- Variabili associate alla mortalità nell'anziano:
  - ✓Disabilità premorbosa
  - ✓Politrauma con trauma cranico e shock
  - ✓Delirio durante la degenza
  - ✓Disfunzione neurologica e renale
- La demenza non sembra una variabile associata alla mortalità

Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients

Antithrombotic Trialists' Collaboration

BMJ 2002;324:71–86

NNT = 26

Benefit per 1000 patients (SE):	36 (5)	38 (5)	36 (6)	9 (3)	22 (3)
Mean months of treatment:	27	1	29	0.7	22
P value:	<0.0001	<0.0001	<0.0001	0.0009	<0.0001

E' efficace l'aspirina nell'infarto miocardico acuto?

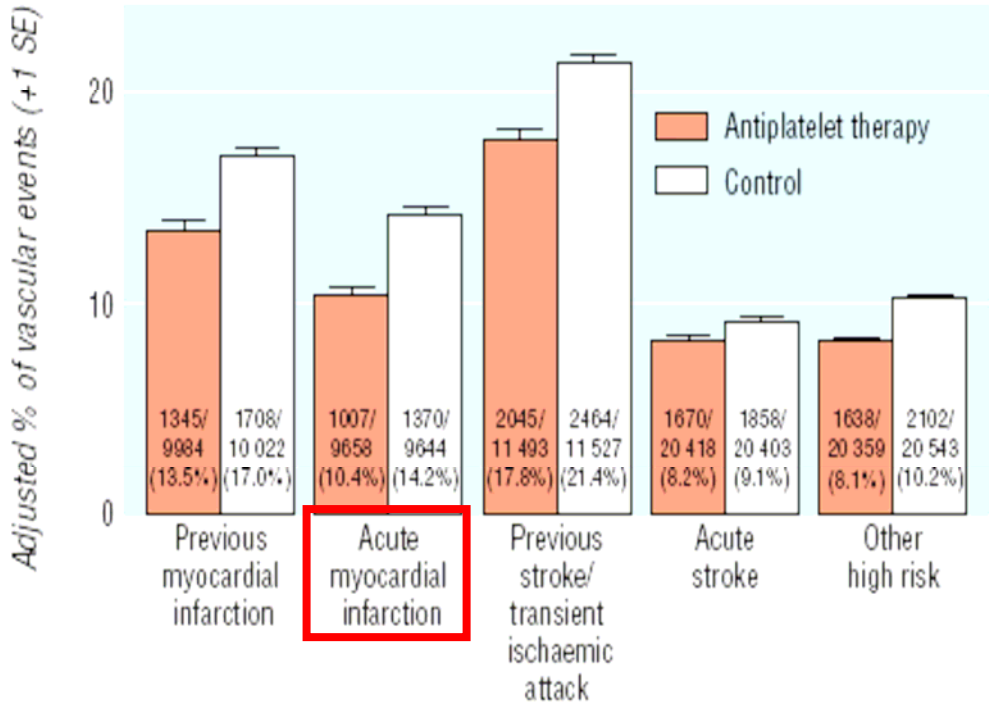


Fig 2 Absolute effects of antiplatelet therapy on vascular events (myocardial infarction, stroke, or vascular death) in five main high risk categories. Adjusted control totals have been calculated after converting any unevenly randomised trials to even ones by counting control groups more than once

85 anni, demente, cade dal balcone ed arriva in ospedale in coma con trauma cranico (ampia lacerazione cerebrale con edema cerebrale) e trauma toracico con shock

E' efficace il ricovero in Terapia Intensiva?

Probabilità di sopravvivenza

con TI: 5 %

senza TI: 0.5 % (?)

NNT: 22

(Aspirina nel IMA: NNT = 26)

Commentary

Debate: What constitutes 'terminality' and how does it relate to a Living Will?

David Crippen*, Mitchell Levy†, Robert Truog‡, Leslie Whetstine§ and John Luce¶

Crit Care 2000, **4**:333–338

The Case

An 88 year-old woman from a nursing home is admitted by ambulance to the emergency department (ED) with respiratory failure, and an elevated temperature. She has shallow ventilations 50 times a minute and her SaO_2 on a 100% rebreather mask is 80%. Old records are being faxed from the nursing home. The emergency physician intubates the patient and her ventilation parameters improve . Subsequently, a chest X-ray (CXR) shows left lower pneumonia and an elevated white blood cell count (WBC). A large amount of secretions are suctioned out. After some sedation, the patient is resting and ventilating quietly. And her vital signs are stable. The patient carries a convincing diagnosis of dementia. Her family says she was competent when she signed a living will five years previously but has since progressed to the point where she is bedridden, fed by staff, unable to discern place and time but seems to brighten around her family. She has not offered any meaningful verbal dialog for one year. When she is questioned, she offers dysconjugate answers, or looks out the window wistfully.

In the ED she is sedated for intubation and is non-verbal. She grimaces to painful stimuli, does not open her eyes spontaneously and does not follow simple commands. At

'Living Will' declaration, signed and notarized in 1995 by the patient, in which she states the following:

"I xxxx being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances below. I direct my physician to withhold or withdraw life support that serves only to prolong the process of me dying if I should be in a terminal condition or a state of permanent unconsciousness. I direct that treatment be limited to measures to keep me comfortable and relieve pain, including pain that might occur by withholding or withdrawing life sustaining treatment. In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment: I do **not** want cardiac resuscitation, blood or blood products, tube feeding or any other form of hydration or nutrition, intubation and/or mechanical respiration, dialysis, antibiotics, any form of surgery or invasive diagnostic test. In addition, I do **not** want to designate another person as my surrogate to make medical treatment decisions for me if I should become incompetent."

Two blood relatives (daughters) arrive shortly after, and both issue orders

First relative

"The living will is very clear. I want her extubated immediately and made comfortable with morphine until she dies."

Second relative

"Wait a minute now. On admission to the ED, she did meet the criteria for the living will and her wishes should have been followed. Following intubation and mechanical ventilation however, my mother is very stable and no longer 'terminally ill'. There is no overriding reason why she cannot be extubated in a day or two and go back to square one. She now has the strong potential to improve (on antibiotic and supportive care) that she did not have before the living will was ignored. Intubation changed all that. Mechanical ventilation is not prolonging death, it is bridging an unstable process so that she may anticipate life. Therefore I say that the living will is no longer relevant. The act of placing my mother on life support supersedes the terms of the living will and we are now in a mode to support her if the odds are such that she has a better chance of life than death."

Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act

Robert L. Fine, MD, and Thomas Wm. Mayo, JD

Ann Intern Med. 2003;138:743-746.

S.H. was a 91-year-old female intensive care unit patient with post–cardiopulmonary resuscitation anoxic encephalopathy superimposed on preexisting quadriplegia, seizure disorder, multiple decubitus ulcers, severe ischemic peripheral vascular disease, and congestive heart failure. Her medical treatment included mechanical ventilator support, artificial nutrition and hydration by percutaneous endoscopic gastrostomy, intravenous antibiotics, various cardiac medications, antiseizure medications, and wound care. She was unresponsive except for showing signs of pain and distress. The treatment team believed that S.H. could be kept alive for many months or more in the ICU but would not survive outside it. The team's opinion was that treatment was "futile," and they wished to switch S.H. to palliative care and withdraw life-sustaining treatment.

Several meetings with the patient's eldest daughter, who held medical power of attorney, failed to change her request that the doctors "do everything" to keep her mother alive. Two other adult children of the patient privately told the attending physicians that they agreed with the recommendation to withdraw life-sustaining treatment, but were unwilling to publicly disagree with their older sibling.

Must the treatment team maintain treatments they judge to be medically futile?

CODICE DI DEONTOLOGIA MEDICA

16 DICEMBRE 2006

Art. 16

- Accanimento diagnostico-terapeutico –

Il medico, anche tenendo conto delle volontà del paziente laddove espresse, deve astenersi dall'ostinazione in trattamenti diagnostici e terapeutici da cui non si possa fondatamente attendere un beneficio per la salute del malato e/o un miglioramento della qualità della vita.

Commissioni di Bioetica SIAARTI

Raccomandazioni SIAARTI per l'ammissione e dimissione dalla terapia intensiva e per la limitazione dei trattamenti in terapia intensiva (Minerva Anestesiol 2003; 69:101-18)

- I pazienti di età molto avanzata, affetti da patologie croniche ingravescenti e altamente invalidanti, raramente possono essere presi in considerazione per l'accesso ai trattamenti intensivi.
- La demenza avanzata va considerata come una grave e invalidante patologia concomitante che ha un'influenza sfavorevole sulla prognosi.

LIMITAZIONE TERAPEUTICA

- **In particolare, non devono essere praticate quelle terapie sproporzionate per eccesso che procrastinano inutilmente la morte.**
- **Pertanto i sanitari non sono moralmente obbligati a iniziare o proseguire trattamenti che mantengono una mera vita biologica e prolungano il processo del morire.**

Gruppo di studio ad hoc della commissione di bioetica della SIAARTI. Raccomandazioni SIAARTI per l'ammissione e la dimissione dalla terapia intensiva e per la limitazione dei trattamenti in terapia intensiva. *Minerva Anestesiol 2003; 69: 101-18.*

CODICE DI DEONTOLOGIA MEDICA

16 DICEMBRE 2006

Art. 35

- Acquisizione del consenso –

Il medico non deve intraprendere attività diagnostica e/o terapeutica senza l'acquisizione del consenso esplicito e informato del paziente.

Il consenso, espresso in forma scritta nei casi previsti dalla legge e nei casi in cui per la particolarità delle prestazioni diagnostiche e/o terapeutiche o per le possibili conseguenze delle stesse sulla integrità fisica si renda opportuna una manifestazione documentata della volontà della persona, è integrativo e non sostitutivo del processo informativo di cui all'art. 33.

Il procedimento diagnostico e/o il trattamento terapeutico che possano comportare grave rischio per l'incolumità della persona, devono essere intrapresi solo in caso di estrema necessità e previa informazione sulle possibili conseguenze, cui deve far seguito una opportuna documentazione del consenso.

In ogni caso, in presenza di documentato rifiuto di persona capace, il medico deve desistere dai conseguenti atti diagnostici e/o curativi, non essendo consentito alcun trattamento medico contro la volontà della persona.

Il medico deve intervenire, in scienza e coscienza, nei confronti del paziente incapace, nel rispetto della dignità della persona e della qualità della vita, evitando ogni accanimento terapeutico, tenendo conto delle precedenti volontà del paziente.

FONDAZIONE POLIAMBULANZA Istituto Ospedaliero

Dipartimento di Emergenza di Alta Specialità

TERAPIA INTENSIVA POLIFUNZIONALE

CONSENSO INFORMATO AL RICOVERO IN TERAPIA INTENSIVA

Brescia, _____

Io sottoscritto _____ sono stato informato dal dott. _____che la mia malattia potrebbe richiedere un ricovero in Terapia Intensiva. Mi è stato spiegato che la Terapia Intensiva è il reparto dove è possibile praticare le terapie più efficaci per consentire di sopravvivere alla maggior parte dei pazienti più gravi.

Sono stato informato che in Terapia Intensiva potrebbe rendersi necessario l'inserimento di un tubo nella trachea per effettuare la ventilazione artificiale (intubazione), la puntura di vasi sanguigni con inserimento di cateteri al loro interno, il posizionamento di tubi di drenaggio e l'esecuzione di trattamenti simili alla dialisi (emofiltrazione) qualora il rene smettesse di funzionare. Se fosse necessaria un'intubazione prolungata, è pratica corrente inserire un tubo nella trachea passando direttamente dal collo (tracheotomia). In caso di guarigione tutti i tubi (anche la tracheotomia) ed i cateteri sono rimossi definitivamente e l'emofiltrazione è sospesa.

Sono stato messo a conoscenza che l'uso di farmaci sedativi può alleviare efficacemente i disagi eventualmente provocati dai trattamenti invasivi.

Mi è stato spiegato che in Terapia Intensiva non verranno praticati trattamenti che non mi possano portare alcun giovamento o che abbiano il solo scopo di prolungare in modo precario e penoso la Vita.

Ho avuto inoltre le seguenti spiegazioni in relazione a domande da me poste:

_____

_____

_____

_____

_____

_____

Dopo le informazioni da me ricevute

☐ accetto ☐ non accetto

di essere ricoverato in Terapia Intensiva e di essere sottoposto ai trattamenti necessari per la cura delle mie malattie.

CODICE DI DEONTOLOGIA MEDICA

16 DICEMBRE 2006

Art. 38

- Autonomia del cittadino e direttive anticipate -

Il medico deve attenersi, nell'ambito della autonomia e indipendenza che caratterizza la professione, alla volontà liberamente espressa della persona di curarsi e deve agire nel rispetto della dignità, della libertà e autonomia della stessa.

Il medico, compatibilmente con l'età, con la capacità di comprensione e con la maturità del soggetto, ha l'obbligo di dare adeguate informazioni al minore e di tenere conto della sua volontà. In caso di divergenze insanabili rispetto alle richieste del legale rappresentante deve segnalare il caso all'autorità giudiziaria; analogamente deve comportarsi di fronte a un maggiorenne infermo di mente.

Il medico, se il paziente non è in grado di esprimere la propria volontà, deve tenere conto nelle proprie scelte di quanto precedentemente manifestato dallo stesso in modo certo e documentato.

Commentary

Debate: What constitutes 'terminality' and how does it relate to a Living Will?

David Crippen*, Mitchell Levy†, Robert Truog‡, Leslie Whetstine§ and John Luce¶

Crit Care 2000, **4**:333–338

Parere etico: continuare le cure

The Case

An 88 year-old woman from a nursing home is admitted by ambulance to the emergency department (ED) with respiratory failure, and an elevated temperature. She has shallow ventilations 50 times a minute and her SaO_2 on a 100% rebreather mask is 80%. Old records are being faxed from the nursing home. The emergency physician intubates the patient and her ventilation parameters improve . Subsequently, a chest X-ray (CXR) shows left lower pneumonia and an elevated white blood cell count (WBC). A large amount of secretions are suctioned out. After some sedation, the patient is resting and ventilating quietly. And her vital signs are stable. The patient carries a convincing diagnosis of dementia. Her family says she was competent when she signed a living will five years previously but has since progressed to the point where she is bedridden, fed by staff, unable to discern place and time but seems to brighten around her family. She has not offered any meaningful verbal dialog for one year. When she is questioned, she offers dysconjugate answers, or looks out the window wistfully.

Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act

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Ann Intern Med. 2003;138:743-746.

Parere comitato etico:

sospendere le cure

S.H. was a 91-year-old female intensive care unit patient with post–cardiopulmonary resuscitation anoxic encephalopathy superimposed on preexisting quadriplegia, seizure disorder, multiple decubitus ulcers, severe ischemic peripheral vascular disease, and congestive heart failure. Her medical treatment included mechanical ventilator support, artificial nutrition and hydration by percutaneous endoscopic gastrostomy, intravenous antibiotics, various cardiac medications, antiseizure medications, and wound care. She was unresponsive except for showing signs of pain and distress. The treatment team believed that S.H. could be kept alive for many months or more in the ICU but would not survive outside it. The team's opinion was that treatment was "futile," and they wished to switch S.H. to palliative care and withdraw life-sustaining treatment.

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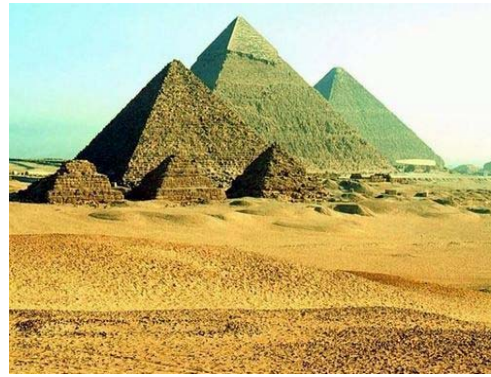
Take-home



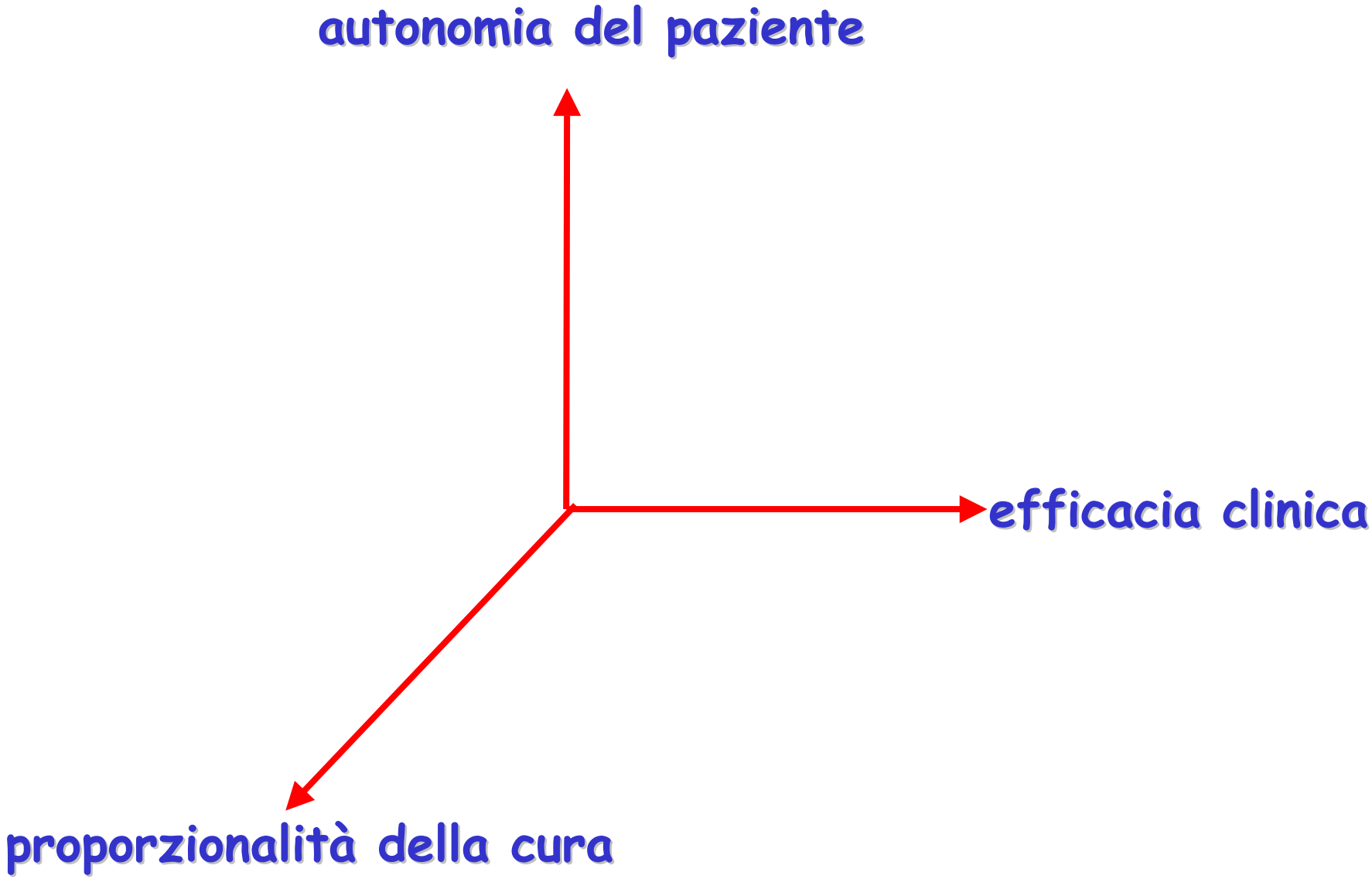
La cura deve considerare:

✓Accanimento terapeutico (mancato beneficio per la salute o qualità di vita – mantenimento di una mera vita biologica – prolungamento del processo del morire)

✓Principio di autonomia – Consenso al ricovero in Terapia Intensiva

Conclusioni

- ✓ La Terapia Intensiva è di norma efficace nella riduzione della mortalità (con costi umani ed economici spesso rilevanti)
- ✓ Associare alla valutazione clinica quella etica e deontologica


autonomia del paziente
efficacia clinica
proporzionalità della cura