



**Nuovo anno accademico
2006-2007
del Gruppo di Ricerca Geriatrica**

“Casi clinici in geriatria”

Journal Club – 1 settembre 2006

Una revisione metodologica per l'interpretazione dei casi clinici

Marco Trabucchi

La concretezza della realtà in un mondo dominato dall'incertezza: come curare in questo tempo?

Spunti di esperienza, letture, discussioni...

Uno scenario di riferimento per l'interpretazione del singolo caso clinico.

- **chi decide**
- **la cultura clinica**
- **chi assiste**
- **chi paga**

Chi decide?

The problem with the shift from respect for persons to respect for autonomy is that the latter principle fails to acknowledge that some individuals primarily need to be protected.

(Hastings Center Report 36:17-19, 2006)

I nostri pazienti hanno bisogno di essere protetti. Una visione individuale del bisogno di protezione attraverso la raccolta della storia clinica. Non hanno bisogno di un'autonomia teorica, ma della ricerca condivisa di spazi di salute.

International Patient Decision Aids Standards versus un “paternalismo compassionevole”.

Refusal of Care: Patients' Well-being and Physicians' Ethical Obligations “But Doctor, I Want to Go Home”

Joseph A. Carrese, MD, MPH

(JAMA 2006;296:691-695)

The AMA Principles of Medical Ethics in 1980 (and most recently in 2001) stated that “A physician shall respect the rights of patients...”

Among other rights, patients were acknowledged to have the right of self-determination. But does the right of the patient to decide for themselves extend to the right to make a bad decision?

**Il problema del rapporto con i
caregiver, il loro disorientamento,
la loro angoscia, le loro attese...
Quando concedere fiducia?
Quando decidere assieme?**

La cultura clinica

Meta-analysis of frusemide to prevent or treat acute renal failure

Kwok M Ho, David J Sheridan

(BMJ 333:420-3, 2006)

Abstract

Objective To investigate the potential beneficial and adverse effects of frusemide to prevent or treat acute renal failure in adults.

Design Meta-analysis of randomised controlled trials.

Data sources Cochrane controlled trials register (2005 issue 4), Embase, and Medline (1966 to 1 February 2006), without language restrictions.

Review methods Two reviewers checked the quality of the studies and independently extracted data.

Results Nine randomised controlled trials totalling 849 patients with or at risk of acute renal failure were included. Outcome measures not significantly different after frusemide treatment were in-hospital mortality (relative risk 1.11, 95% confidence interval 0.92 to 1.33), risk for requiring renal replacement therapy or dialysis (0.99, 0.80 to 1.22), number of dialysis sessions required (weight mean difference -0.48 sessions, -1.45 to 0.50), and proportion of patients with persistent oliguria (urine output < 500 ml/day: 0.54, 0.18 to 1.61).

Stratifying studies that used frusemide to prevent or treat acute renal failure did not change the results on mortality (relative risk ratio 2.10, 95% confidence interval 0.67 to 6.63) and the risk for requiring dialysis (4.12, 0.46 to 37.2). Evidence suggested an increased risk of temporary deafness and tinnitus in patients treated with high doses of frusemide (relative risk 3.97, 95% confidence interval 1.00 to 15.78).

Conclusions Frusemide is not associated with any significant clinical benefits in the prevention and treatment of acute renal failure in adults. High doses may be associated with an increased risk of ototoxicity.

Acute renal failure occurs in a variety of different circumstances and can complicate pre-existing chronic renal failure. The traditional split into prerenal, renal, and postrenal causes of acute failure is useful, if only to remind doctors of the need for a systematic approach to diagnosis and management of the underlying cause. It is appropriate that prerenal causes come first, because the treatment of hypovolaemia to maintain renal perfusion is the only reliable means of renal protection,³ and intravenous fluids will probably need to be tried for most patients. This includes elderly patients, in whom comorbidity may complicate the picture, and patients with oedema, who may none the less have depletion of intravascular fluids.

(BMJ 333:406-7, 2006)

In normal practice many clinicians, including nephrologists, think that furosemide may help increase urine output in acute renal failure, ease the management of fluid balance, and reduce the degree of hyperkalaemia. The evidence from Ho and Sheridan's paper—that furosemide does not improve mortality, does not reduce the need for renal replacement therapy or the number of dialysis sessions required, and may increase the risk of ototoxicity—must temper this opinion. The priorities in treating acute renal failure are to optimise fluid balance, treat underlying causes, and initiate renal replacement therapy at the appropriate time.

(David N Bennet-Jones, BMJ 333:407-8, 2006)

Ancora una volta il “peccato di astensione” (non idratare) è ritenuto meno grave di quello eventualmente derivante da un atto di cura (EPA da idratazione).

Il ruolo dell'EBM: nonostante le critiche, resta fondamentale.

**La nostra ricerca e la nostra
cultura clinica.**

Characteristics of 2645 hospitalized elderly patients according to LOS.

	Total (N=2646)	≤7 (N=1570)	>7 (N=1063)	
	N (%) / M ± sd	N (%) / M ± sd	N (%) / M ± sd	p
Age	79.2 ± 7.8	79.1 ± 8.1	79.5 ± 7.4	.167
Gender (female)	1756 (66.7)	1058 (67.4)	698 (65.7)	.190
Living alone	768 (29.6)	417 (27.0)	351 (33.4)	.000
Geriatric Depression Scale-GDS*	5.0 ± 3.6	4.9 ± 3.6	5.2 ± 3.6	.031
Depressed (GDS 5+)	1064 (40.3)	595 (48.6)	469 (52.9)	.028
Mini Mental State Examination-MMSE	23.4 ± 8.5	23.0 ± 9.6	23.1 ± 6.7	.797
Severe Dementia	428 (16.6)	267 (17.0)	161 (15.1)	.112
Cumulative Delirium	275 (10.6)	116 (7.4)	159 (15.1)	.000
IADL functions lost (2 wks pre adm.)	3.1 ± 2.9	2.9 ± 2.9	3.3 ± 2.7	.004
IADL functions lost (2+)	1851 (80.4)	1044 (66.7)	807 (76.1)	.000
Barthel Index (2 wks before adm.)	82.4 ± 25.6	82.1 ± 26.1	82.9 ± 23.8	.400
Barthel Index (on admission)	72.1 ± 32.5	73.9 ± 32.5	39.5 ± 32.2	.001
Funct. status change (before and on adm.)				
Loss of 5+ points in Barthel index score	842 (32.0)	430 (27.5)	412 (38.8)	.000
Barthel Index (on discharge)	75.4 ± 31.1	76.9 ± 31.1	73.3 ± 30.8	.004

*On 2216 patients without severe dementia

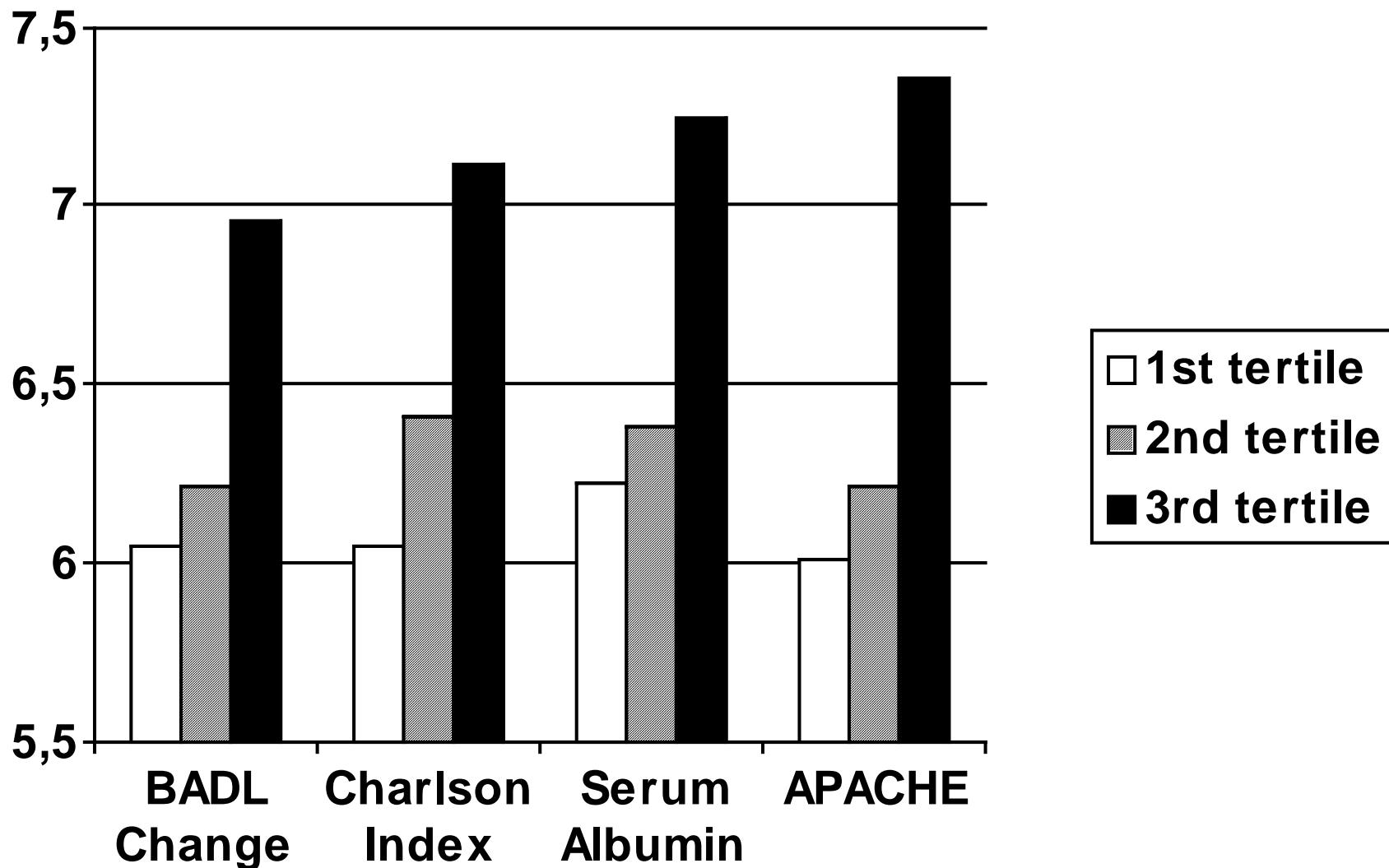
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	Total (N=2646)	≤7 (N=1570)	>7 (N=1063)	
	N (%) / M ± sd	N (%) / M ± sd	N (%) / M ± sd	p
Chronic diseases (n)	5.4 ± 2.0	5.1 ± 1.8	5.8 ± 1.9	.000
Charlson score	3.1 ± 2.4	2.9 ± 2.4	3.5 ± 2.5	.000
Charlson score (4+)	916 (34.8)	488 (31.1)	428 (40.3)	.000
APACHE II score	8.8 ± 4.8	8.2 ± 4.5	9.5 ± 5.2	.000
APACHE II (8+)	1096 (41.6)	582 (37.1)	514 (48.4)	.000
Acute Physiology Score-APS	2.2 ± 2.9	2.0 ± 2.8	2.5 ± 3.2	.000
Serum albumin	3.9 ± 0.7	3.9 ± 0.6	3.8 ± 0.8	.004
Serum albumin (< 3.5g/dl)	580 (22.0)	302 (19.7)	278 (26.2)	.000
Drugs (n)	4.3 ± 1.9	4.1 ± 1.8	4.5 ± 1.9	.002
Drugs (5+)	(44.0)	(41.1)	(46.8)	.022
Respiratory (pneumonia, COPD)	1052 (40.0)	567 (36.1)	485 (45.6)	
Heart failure (NYHA III-IV)	940 (35.7)	508 (32.4)	432 (40.6)	
Complicated Diabetes Mellitus	121 (4.6)	56 (3.6)	65 (6.1)	.002
Major Stroke	355 (13.5)	227 (14.5)	128 (12.0)	.042
Cancer (with metastasis)	230 (8.7)	116 (7.4)	114 (10.7)	
Cancer (without metastasis)	131 (5.0)	63 (4.0)	68 (6.4)	
Liver Cirrhosis	167 (6.3)	87 (5.5)	80 (7.5)	
Major procedures	3.2 ± 3.0	3.2 ± 2.8	3.2 ± 3.6	.875
Length of stay (days)	6.5 ± 3.5	4.5 ± 1.3	9.6 ± 3.6	.000
In hospital mortality	87 (3.3)	50 (3.2)	37 (3.5)	.372

Factors associated to LOS>7 of 2646 hospitalized elderly patients.

	N/events	<i>Adjusted</i> RR (95% C.I.)
Living alone	270	1.2 (0.9-1.5)
Depression	1064	1.3 (1.0-1.6)
Charlson Index score (3+)	920	1.3 (1.0-1.7)
Serum albumin (<3.5g/dl)	582	2.2 (1.4-3.9)
Barthel Index change	846	1.4 (1.1-1.9)
APACHE II (8+)	1100	1.4 (1.1-1.8)
Delirium	279	1.8 (1.2-3.1)
Heart failure (NYHA III-IV)	943	1.6 (1.2-2.1)
Cancer without metastasis	132	1.5 (1.1-2.2)
Age 80+	1209	1.2 (0.9-1.6)
Gender (female)	1756	0.9 (0.7-1.3)
Drugs number (5+)	1164	1.0 (0.8-1.3)
Dementia (IADL&MMSE)	430	0.9 (0.5-1.4)
Cancer with metastasis	231	1.1 (0.8-1.5)
Liver cirrhosis	168	1.0 (0.8-1.2)
Respiratory (COPD/pneumonia)	1057	1.2 (0.9-1.6)
Diabetes Mellitus	467	1.1 (0.8-1.5)
Major Stroke	357	1.0 (0.7-1.6)

Means LOS according predictors tertiles



**L'epidemiologia clinica come
strumento di cultura clinica: LOS
come modello interpretativo
dell'operato clinico.**

Il delirium come modello interpretativo per la comprensione delle interazioni tra fattori di stato (la biologia) e fattori rimuovibili.

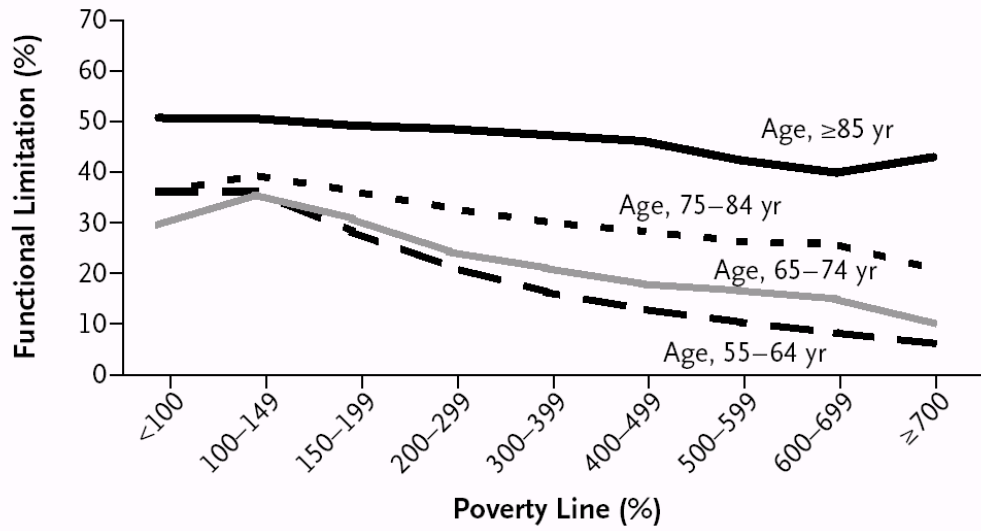
**From a Viagra for each
human problem to a medicine
for the deep needs of human
beings.**

Gradient of Disability across the Socioeconomic Spectrum in the United States

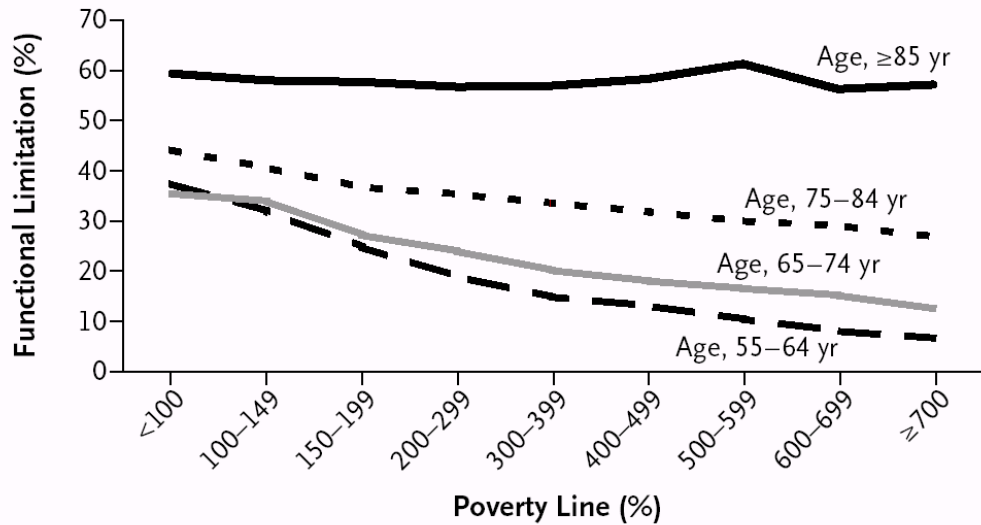
Meredith Minkler, Dr.P.H., Esme Fuller-Thomson, Ph.D., M.S.W.,
and Jack M. Guralnik, M.D., Ph.D.

N Engl J Med 2006;355:695-703.

A Men

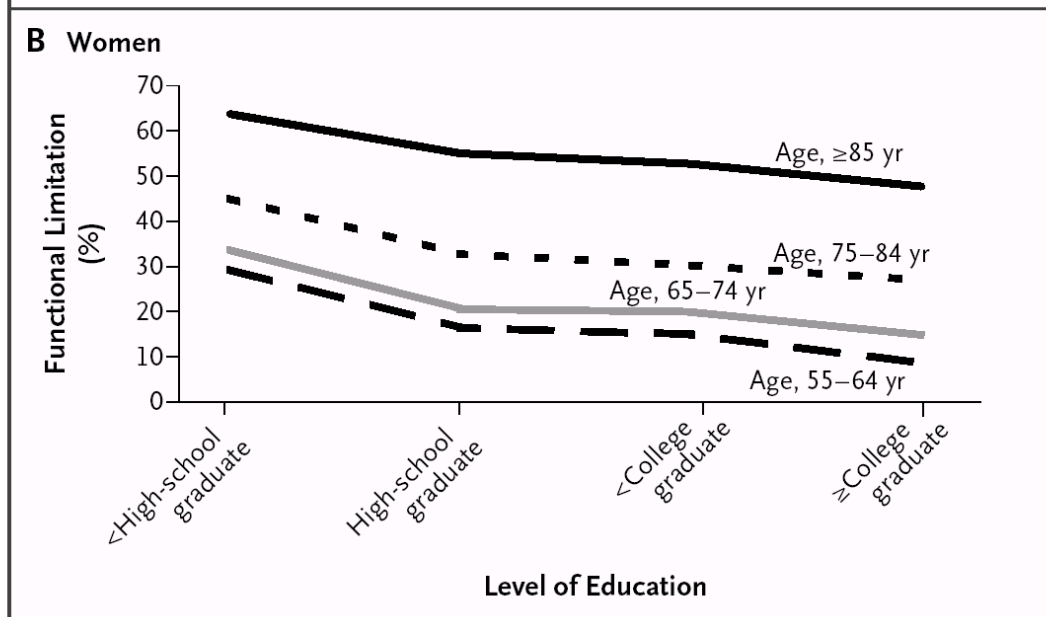
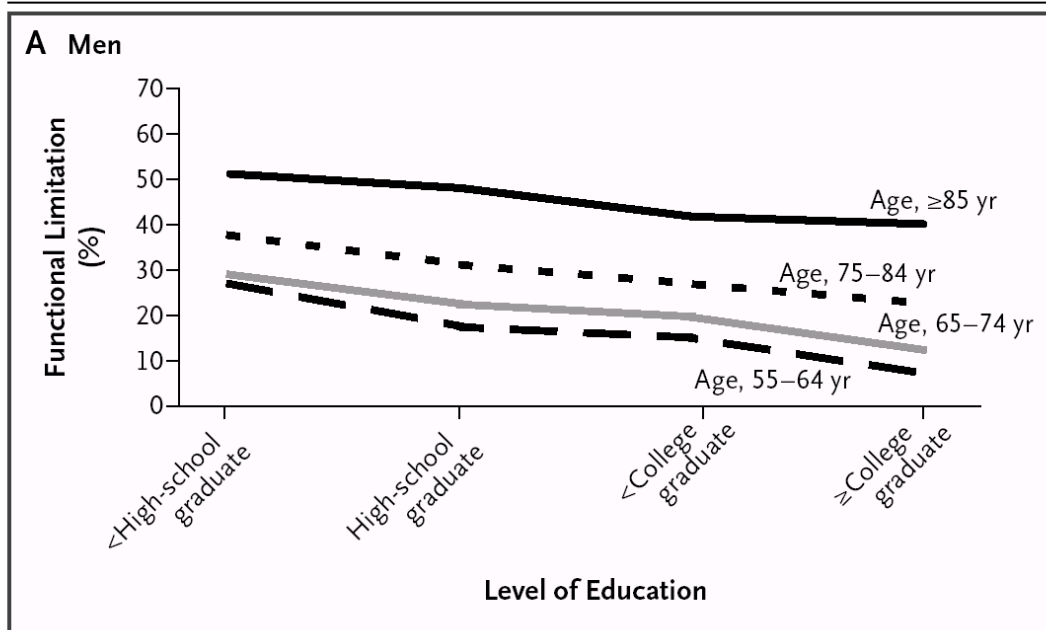


B Women



Percentage of Men (Panel A) and Women (Panel B) with Functional Limitation, According to Poverty Status.

N Engl J Med 2006;355:695-703.



Percentage of Men (Panel A) and Women (Panel B) with Functional Limitation, According to Level of Education.

N Engl J Med 2006;355:695-703.

Il farmaco e i suoi limiti

Data from Stanley's paper in *Endocrinology* showing the results of testicular tissue grafts to inmates and staff of San Quentin Prison. In all, about 650 individuals received transplants, including 7 women.

ANALYSIS OF CASES			
	TOTAL CASES	BENEFITED	NOT BENEFITED
General asthenia.....	330	305	31
Rheumatism.....	58	49	9
Acne vulgaris.....	66	54	12
Neurasthenia.....	56	33	23
Poor vision.....	41	32	9
Asthma.....	21	18	3
Tuberculosis.....	17	10	7
Senility.....	34	27	7
Sex lassitude.....	95	81	14
Impotence.....	19	12	7
Psychopathic inferiority.....	8	..	8
Epilepsy.....	5	3	2
Dementia praecox.....	8	1	7
Paranoia.....	3	2	1
Diabetes.....	4	3	1
Locomotor-ataxia.....	3	3	..
Drug addicts.....	32
Dead.....	11
Unclassified.....	28
No report.....	30		

Journal of Gerontology: BIOLOGICAL SCIENCES
2005, Vol. 60A, No. 2, 142-147

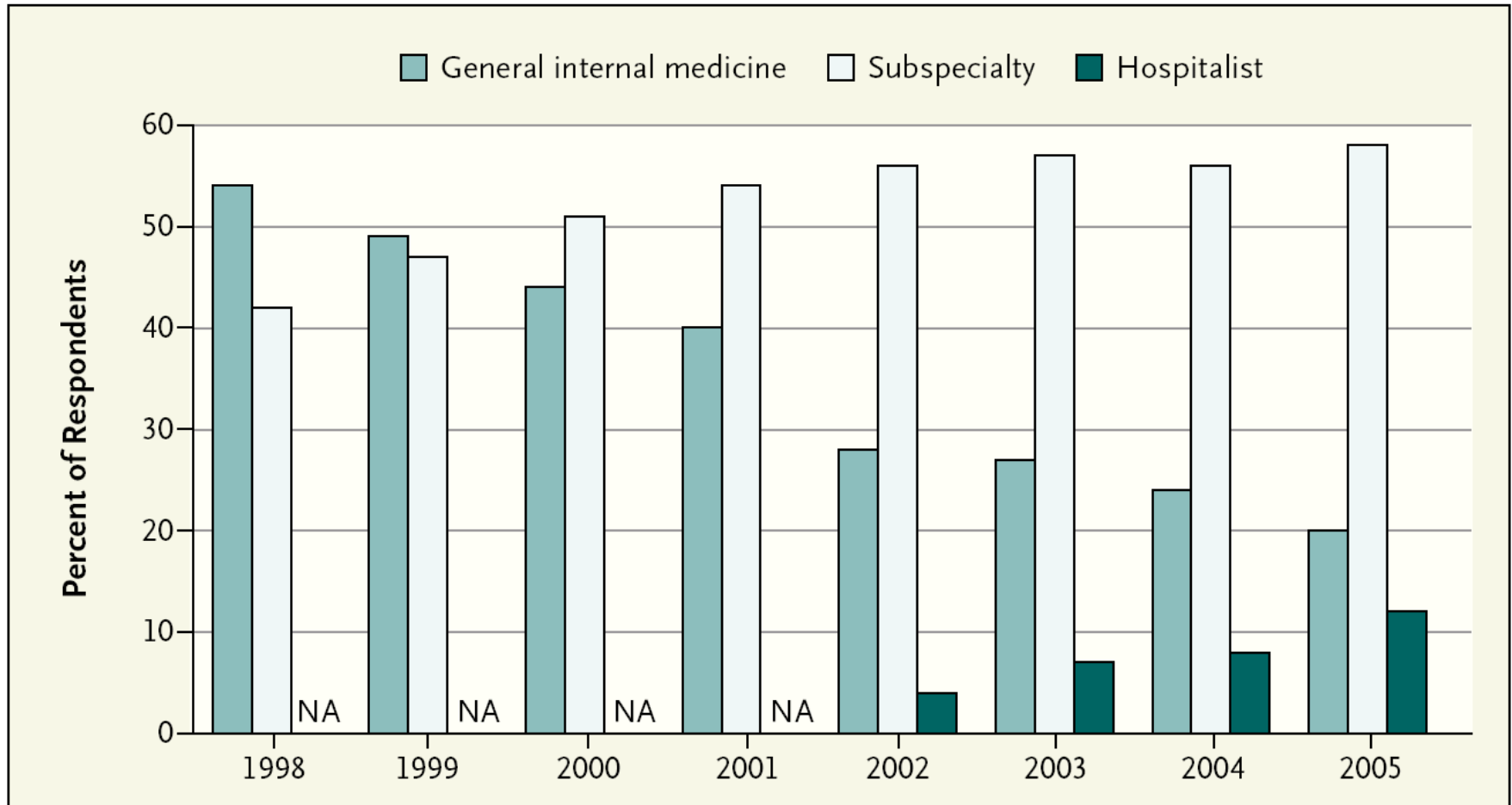
**Chi assisterà i vecchi: le soluzioni
tamponi dell'immigrazione.**

Rather than adjusting the institutions of society to a new trajectory of life, politicians are tempted by the plausibly easier option of demographic engineering. Gillick suggests that increasing the permeability of the Mexican border might alleviate a looming shortage of care workers in the United States. This may seem like a quick fix, but it would be damaging to Mexico and have little effect on longer-term demographic prospects for the United States. Immigrants grow old too, and their children will not be content to be cheap labour. Immigrant labour is even less of a good idea for areas where population density has outgrown both its water supply and its social tolerance, such as southeast England. Ageing populations in the West should create their own destiny, not prey on the underdeveloped world.

(J. Grimley Evans, Nature 442:869, 2006)

Le “famigliari” (nuovo nome al posto dell’orrido badanti) e la compliance (alimentazione, idratazione, farmaci, igiene). Il problema dell’interpretazione dei sintomi da parte di chi gestisce quotidianamente l’anziano.

Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists.



N ENGL J MED 355;9 WWW.NEJM.ORG AUGUST 31, 2006

Chi pagherà per i vecchi?

**Un approccio “low cost”
all’assistenza compromette
anche il tempo dedicato alla
raccolta della storia personale
e di malattia?**

**Risparmiamo punendo gli
anziani che non obbediscono
alle leggi salutistiche dello
Stato?**

(New Engl J Med 355:756-758, 2006)

Oncologists can endorse expensive cancer drugs because they think only about cancer. The broader healthy public has to struggle with whether to impose five dysfunctional years on arthritis sufferers in order to provide two more months of life to someone with lung cancer.

(Hastings Center Report, May-June 2006)

Parochial altruism in humans

Helen Bernhard, Urs Fischbacher & Ernst Fehr

(Nature 442:912-915, 2006)

Siamo altruisti solo con chi appartiene alla nostra “parrocchia” di persone pulite, bianche, cattoliche... Più i vecchi aumentano (soprattutto quelli molto ammalati e dementi) più verrà meno l'altruismo naturale e più dovrà trovare spazio un “dovere colto” di assistenza.

**Le scienze del comportamento
e l'atteggiamento del medico.
Nulla è "asettico" nel processo
decisionale.**

**Dai neuroni specchio alla
compassione, all'"altruismo
limitato": le difficoltà di
un'interpretazione.**

**L'autonomia e la serenità
nell'approccio al paziente e nelle
decisioni può essere rivendicata
solo se disponiamo di un
metodo.**

The proportion of doctors and other health professionals showing above threshold levels of stress has stayed remarkably constant at around 28%, whether the studies are cross sectional or longitudinal, compared with around 18% in the general working population.

(BMJ 2003;326:670-671)

“The only thing that protects elderly people from their medicines is their inability to take them as directed”.

“The main thing that puts elderly people at risk from their medicines is their doctors’ inability to prescribe properly”.

(Age Ageing 2003;32:121-122)

Le proposte per migliorare l'atto terapeutico sono ancora banali.

Reliable, regularly updated decision support systems and information technology are necessary to help avert dangerous drug combinations. Computers are present in every modern dispensary and can reduce the likelihood of some drug-drug interactions. However, computers sometimes fail at this important task because of a lack of regular updates, or because frequent warnings of a trivial nature fatigue the operators and lead them to override more significant ones.

(JAMA 2003;289:1657)

Il ragionamento

- **Rapporto causa-effetto diretto**
- **La colinearità**
- **La casualità**
- **L'incertezza**
- **I fattori interferenti**

Il ruolo delle linee guida e della loro contestualizzazione nel singolo caso (biologia, storia, ambiente).