XXIX Congresso Nazionale ANCE

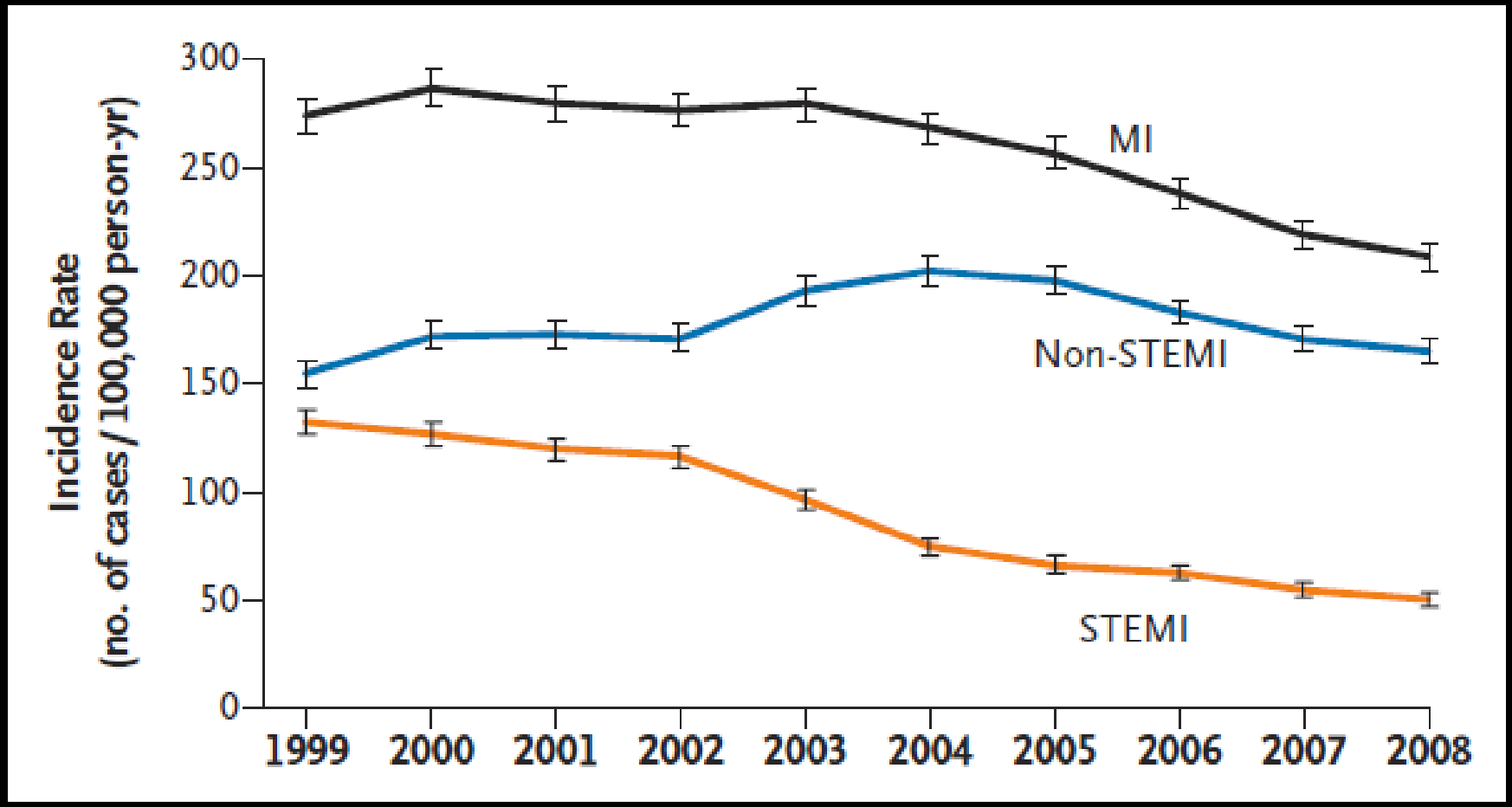
Presa in carico del paziente post SCA sul territorio: quali pazienti e quando?

Guglielmo Bernardi

ARC (Associazione per la Ricerca in Cardiologia) Pordenone

Sorrento (NA) 10 - 13 ottobre 2019

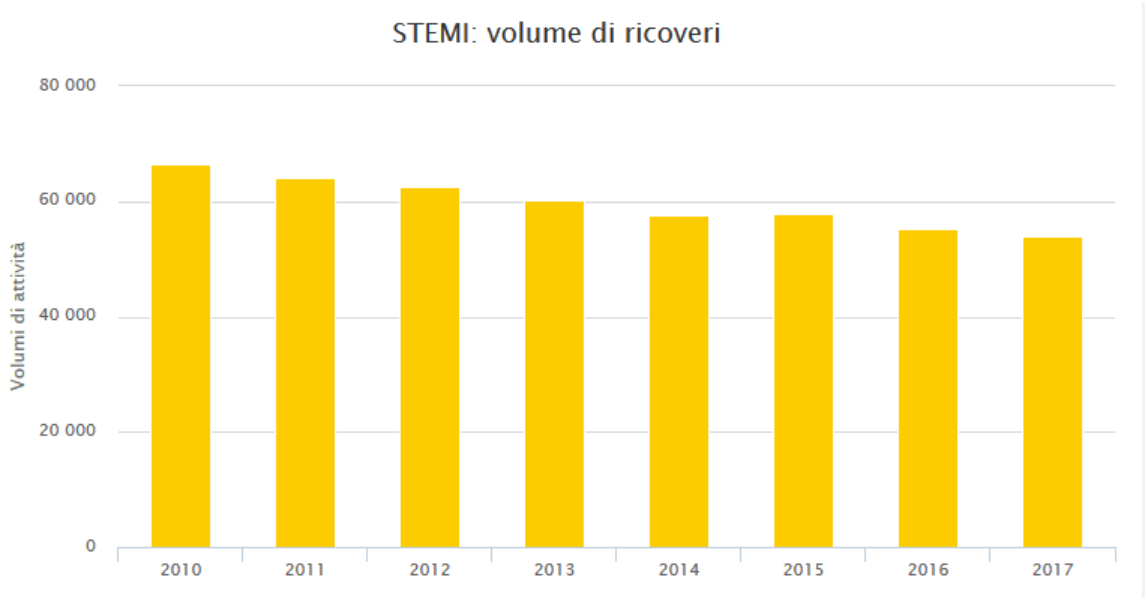
Epidemiologia STEMI - NSTEMI

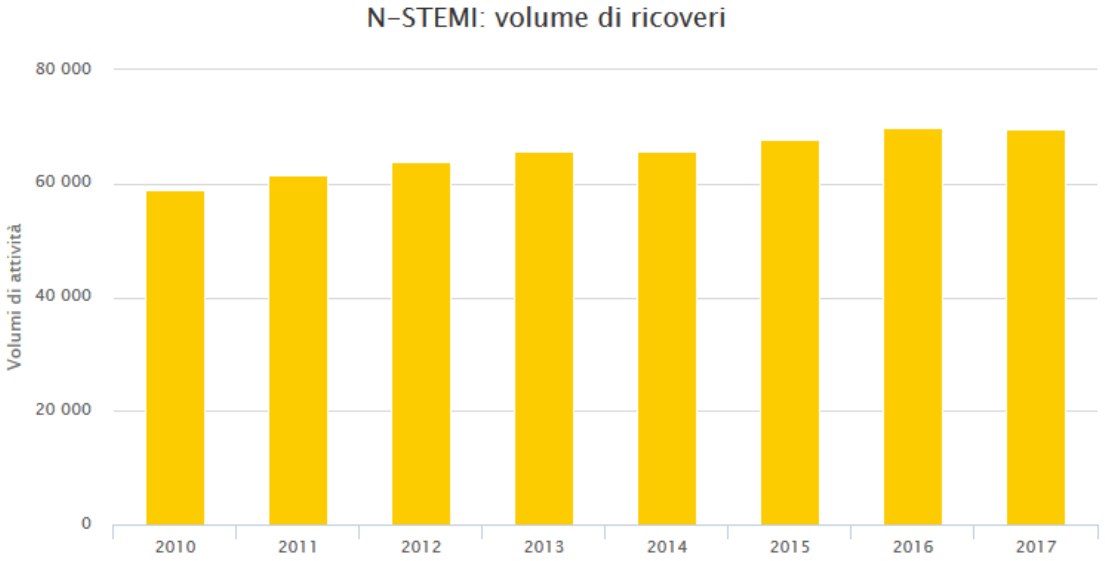


Yeh RW, NEJM 2010;362:2155

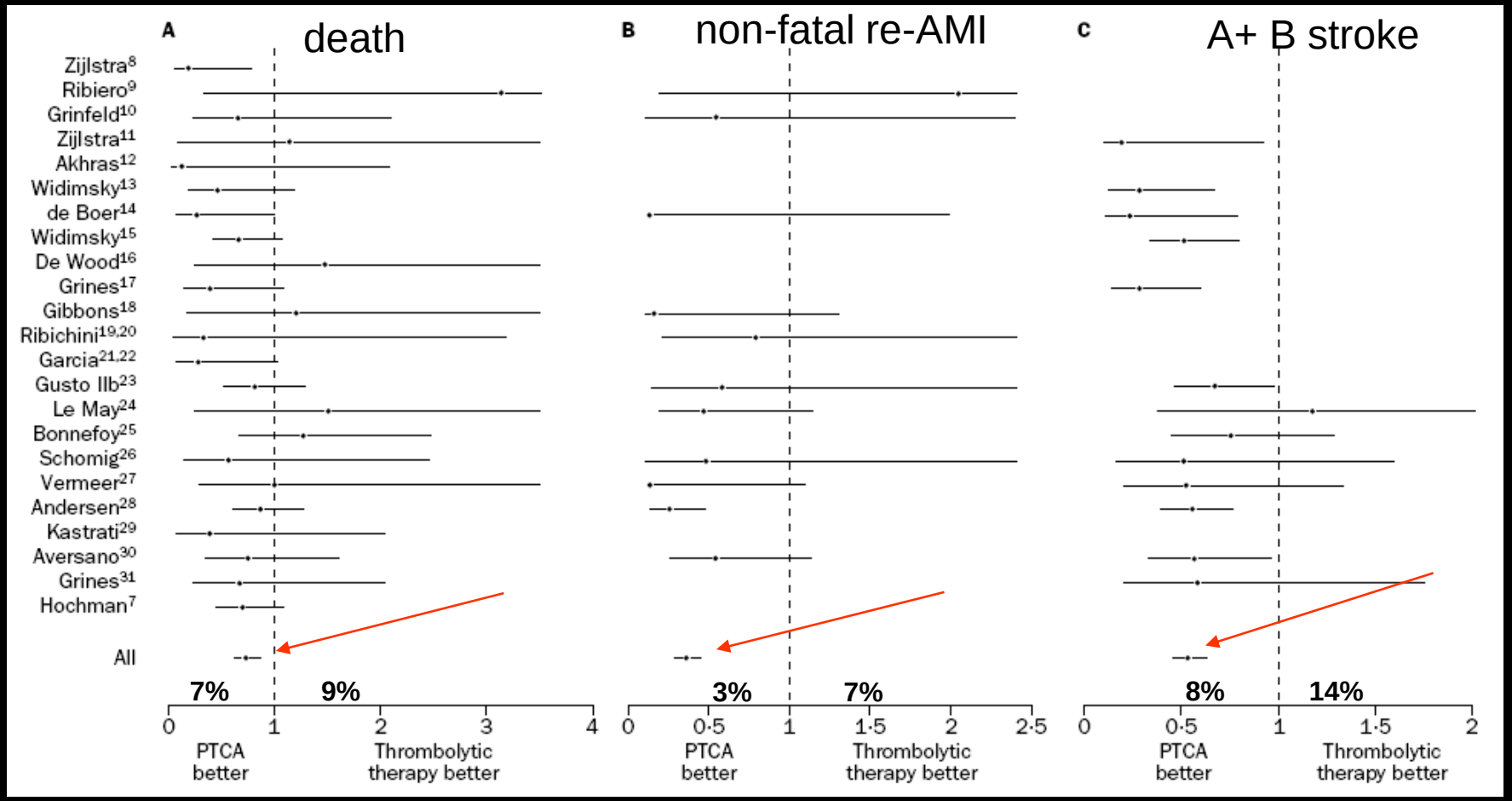
Programma Nazionale Esiti – PNE

Volume di ricoveri in Italia, anni 2010-2017





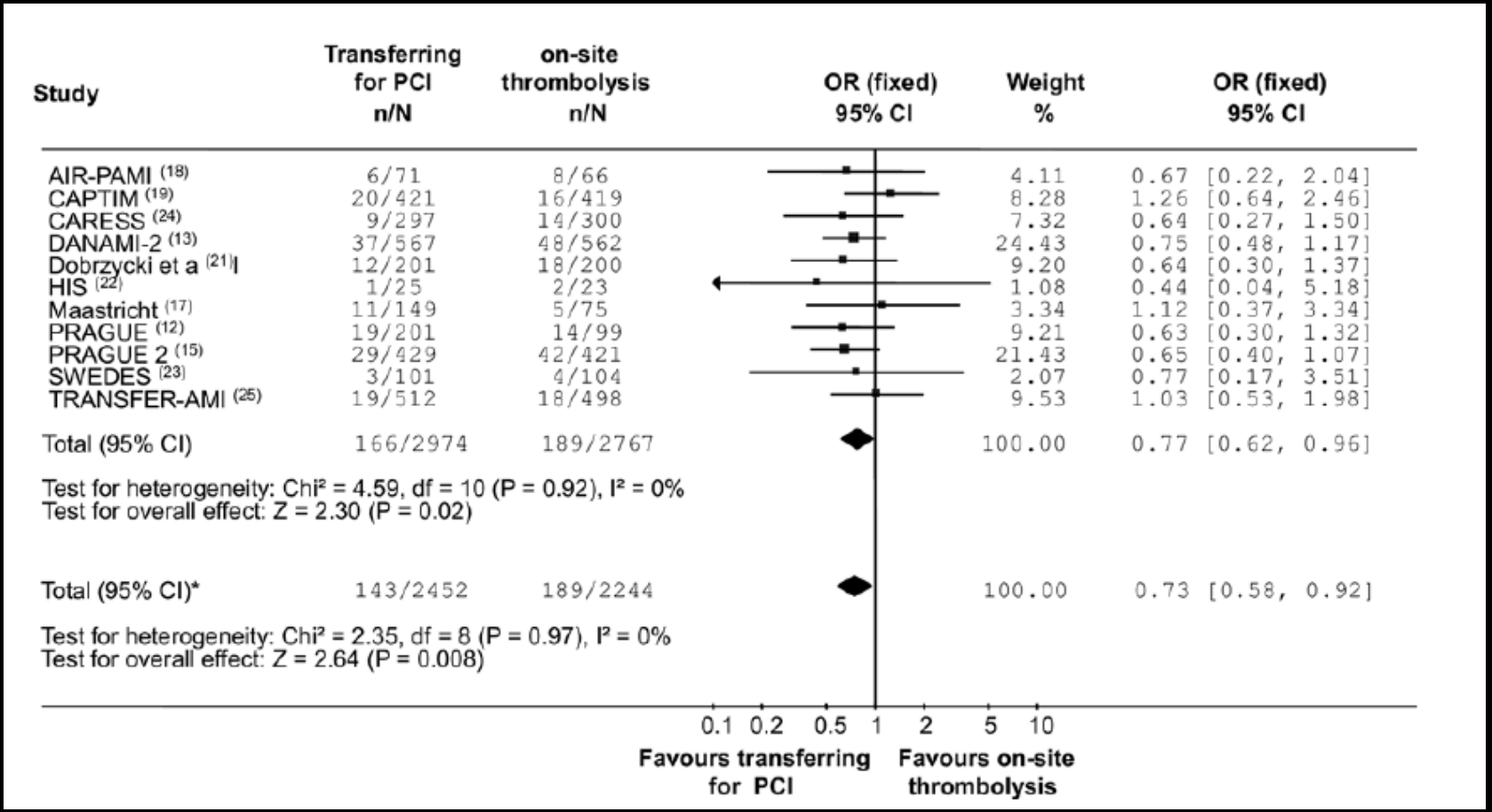
PTCA primaria vs terapia trombolitica ev nello STEMI *23 trial randomizzati (7.739 pz)*



Odds ratios (95% CI)

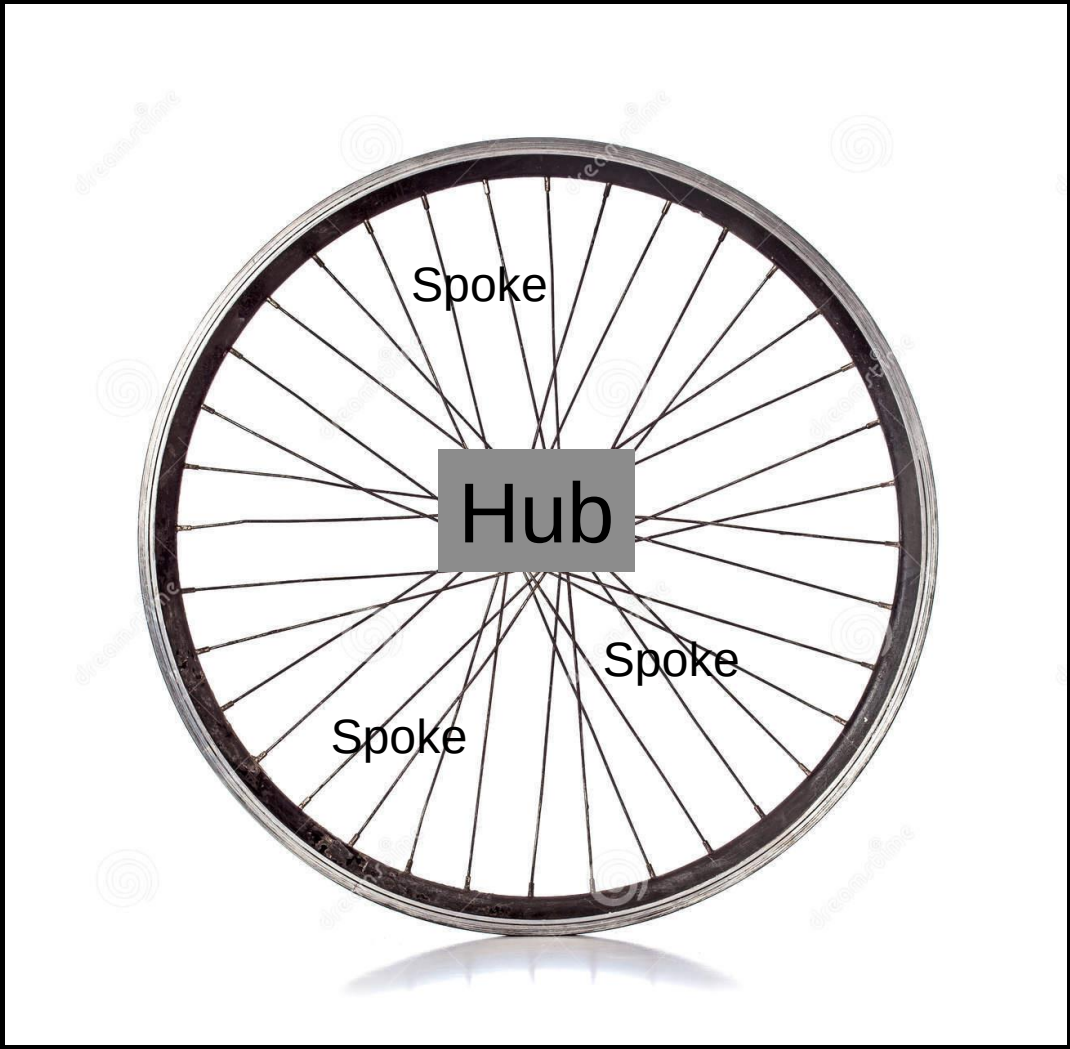
Keeley EC, Lancet 2003

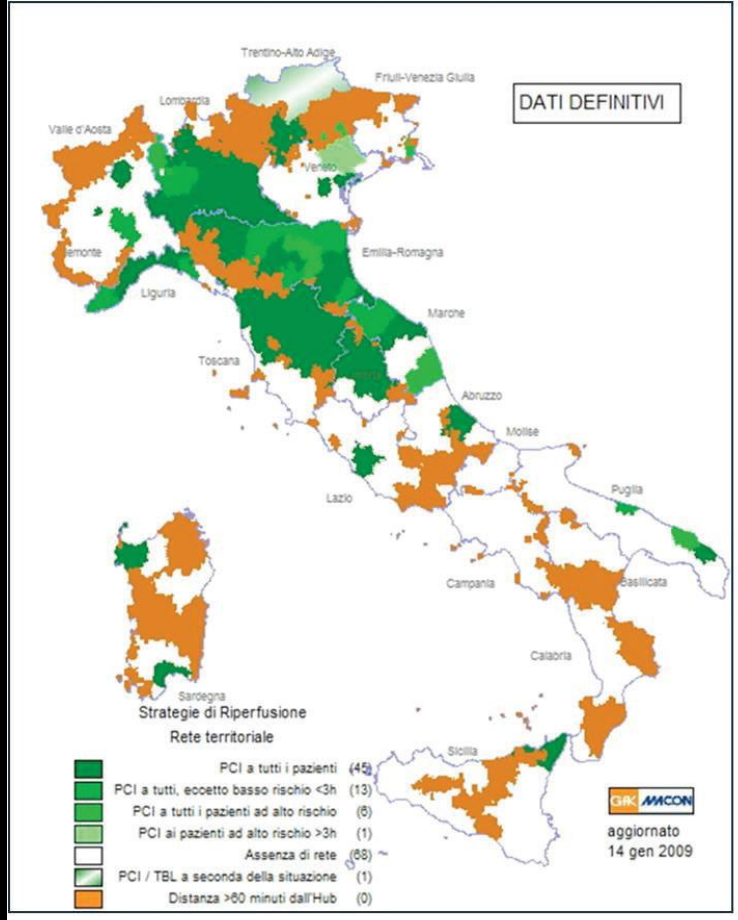
Transfer for P-PCI versus immediate TL and mortality *5.741 pts, 30-day follow-up*



De Luca, Ann Emerg Med. 2008;52:665

Modello Hub & Spoke

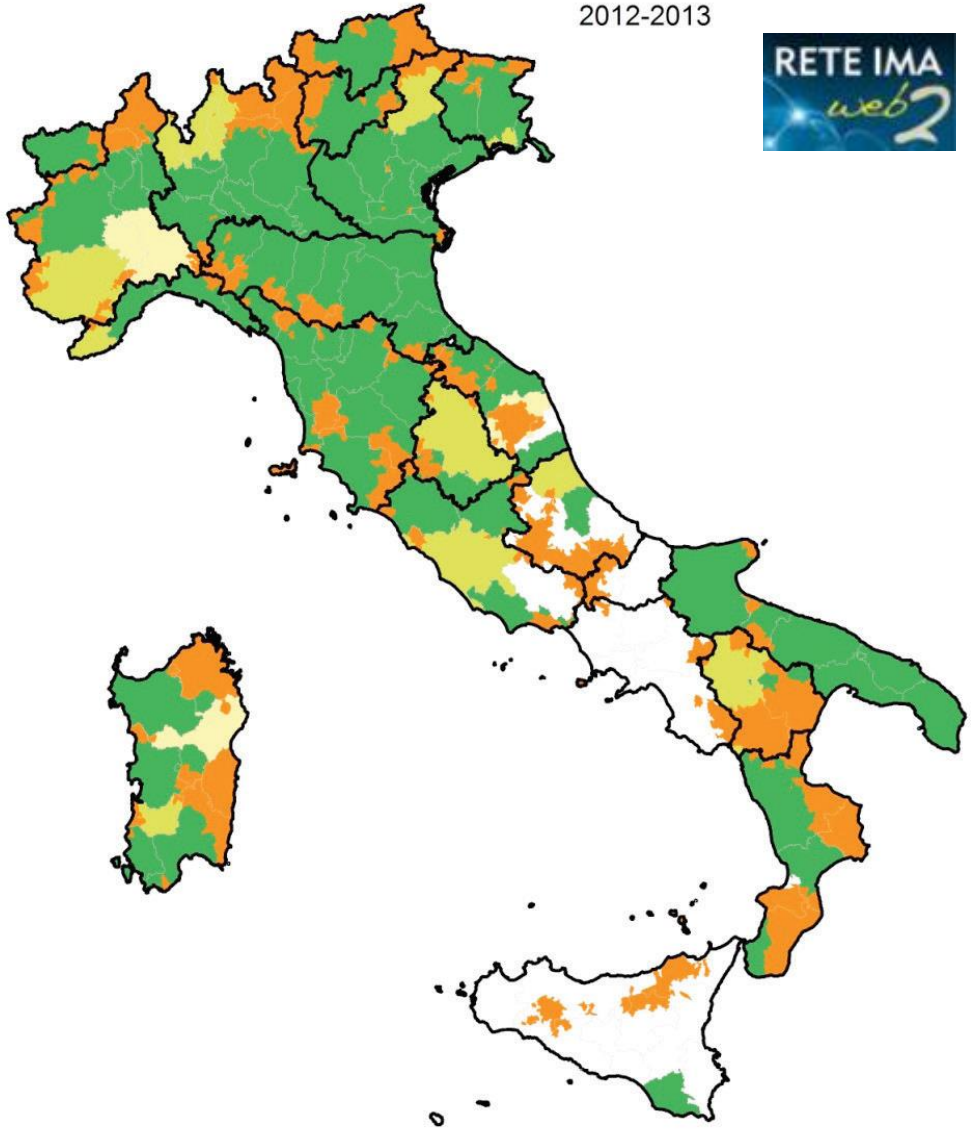




Strategia di Riperfusione

Rilevazione Rete IMA Web
2012-2013

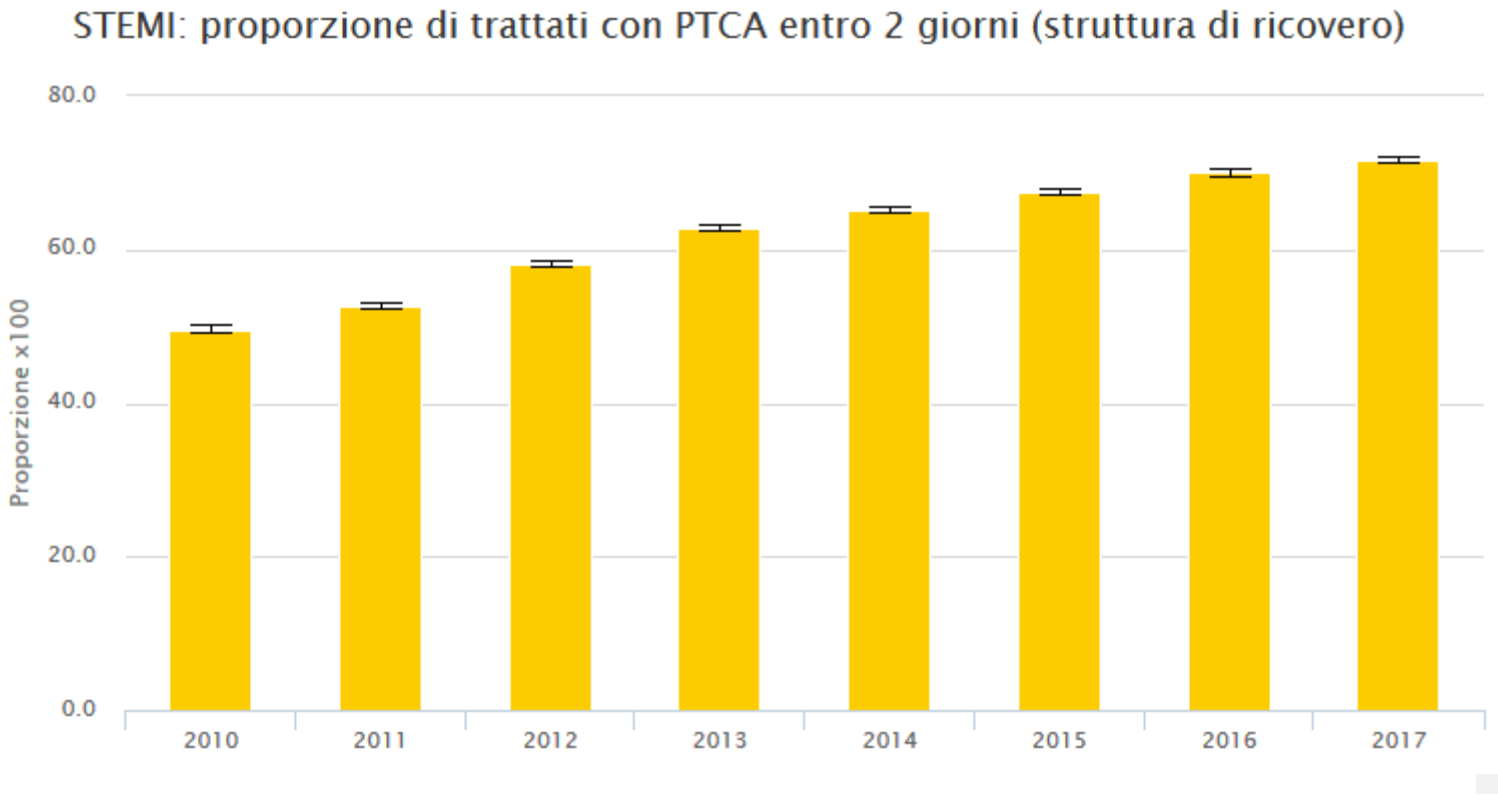
RETE IMA web 2



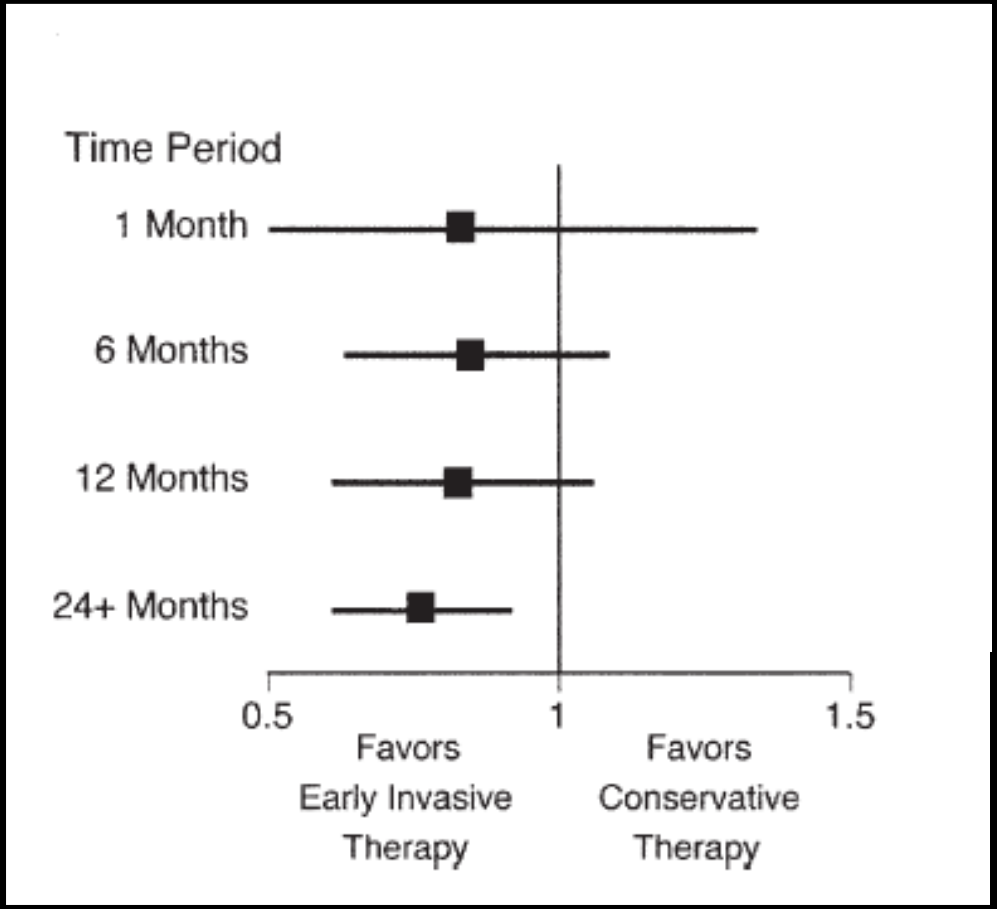
(verde scuro) Strategia A: Rete con stategia PPCI sempre
(verde chiaro) Strategia B: Rete con mix di strategie (PPCI e TBL)
(colore giallo): Strategia C: Rete con stategia TBL sempre
(colore bianco): No Rete
(colore ariancione): Comuni > 60 min dall'Hub

Programma Nazionale Esiti – PNE

STEMI trattati con PTCA entro 2 gg, anni 2010-2017



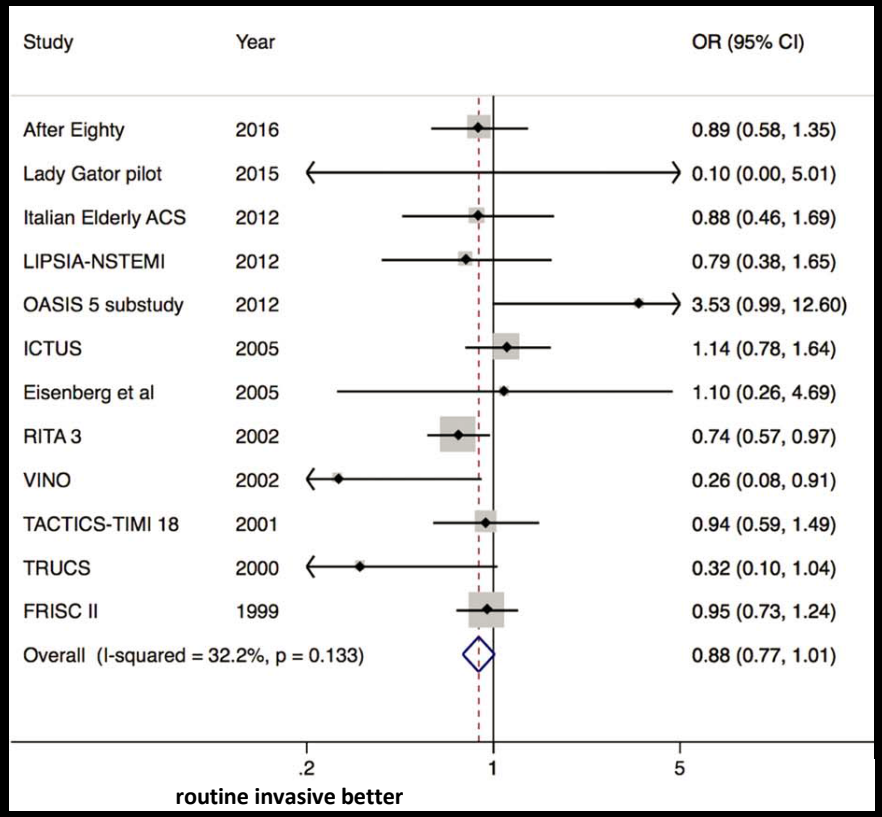
Relative risk of all-cause mortality for early invasive therapy vs conservative therapy as a function of time in NSTEMI *Meta-Analysis of CRT - 2 years follow-up*



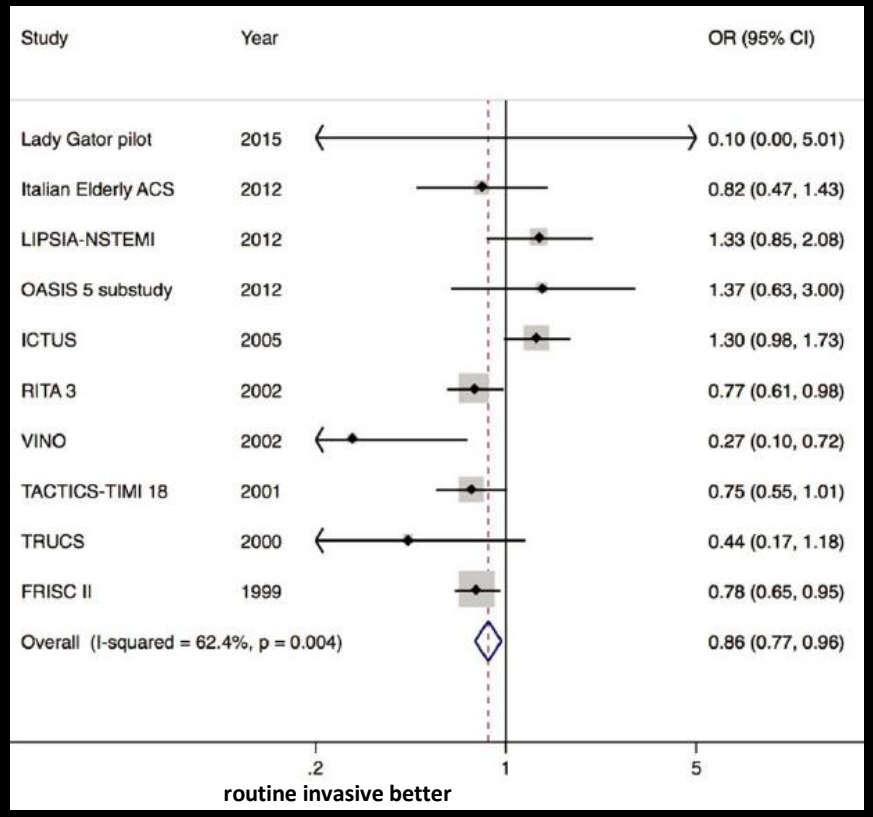
Bavry AA, JACC 2006;48:1319

Routine invasive versus selective invasive strategies for NSTE-ACS *Updated Meta-Analysis of 12 RCTs, (9.650 pts)*

all cause mortality



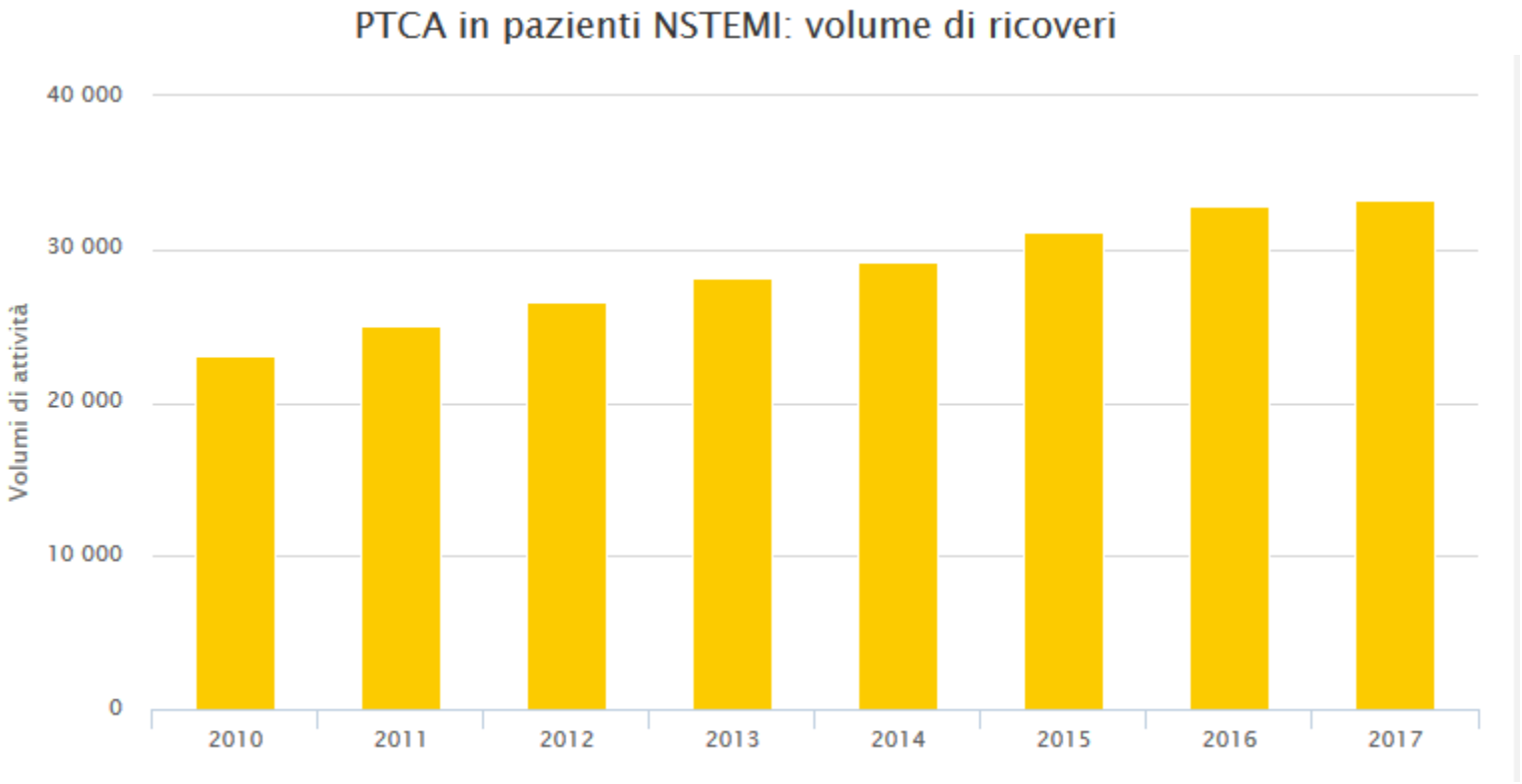
composite EP: all-cause mortality or non-fatal MI



Elgendy IY, CCI 2016;88:765

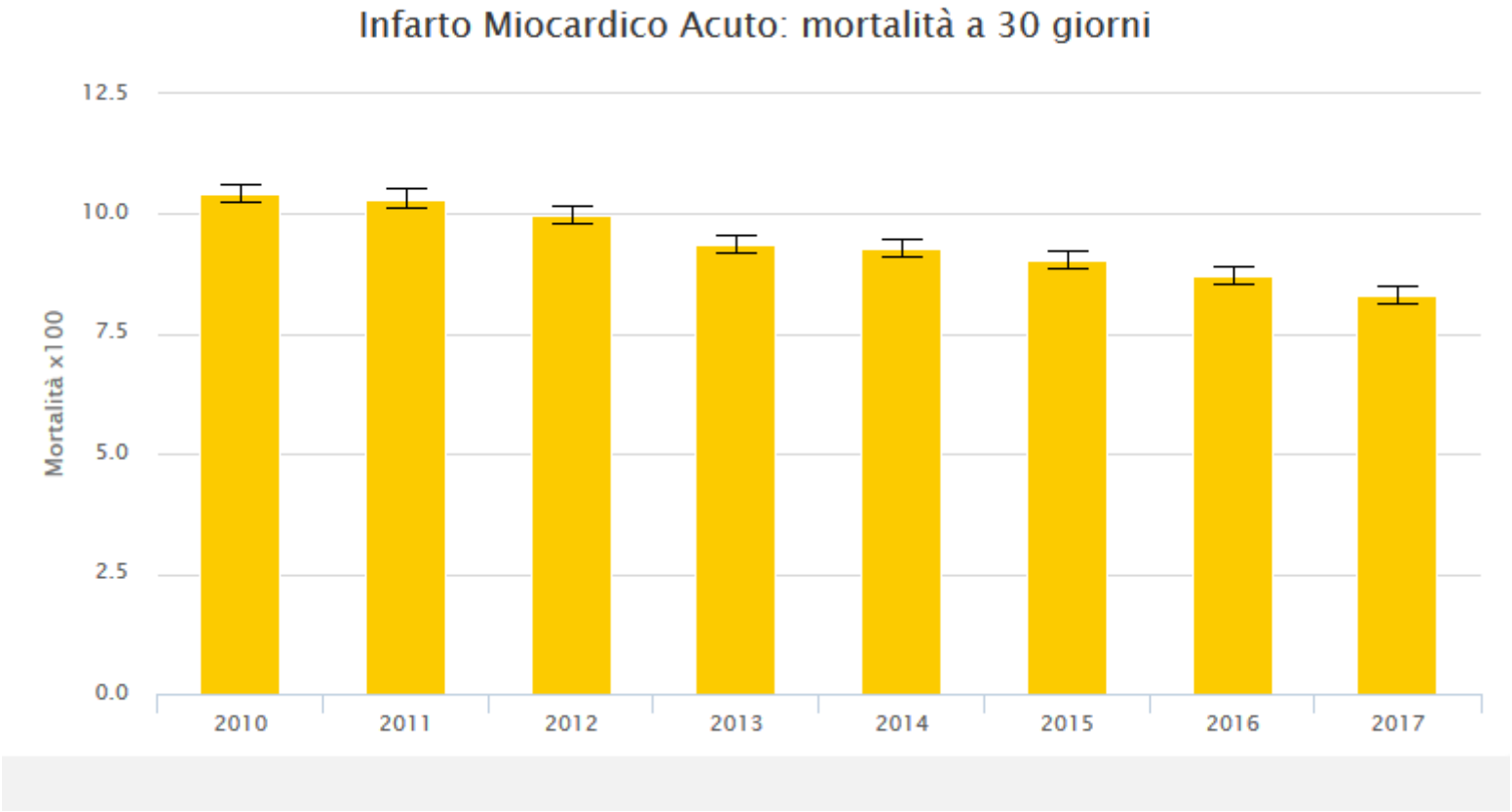
Programma Nazionale Esiti – PNE

NSTEMI trattati con PTCA, anni 2010-2017



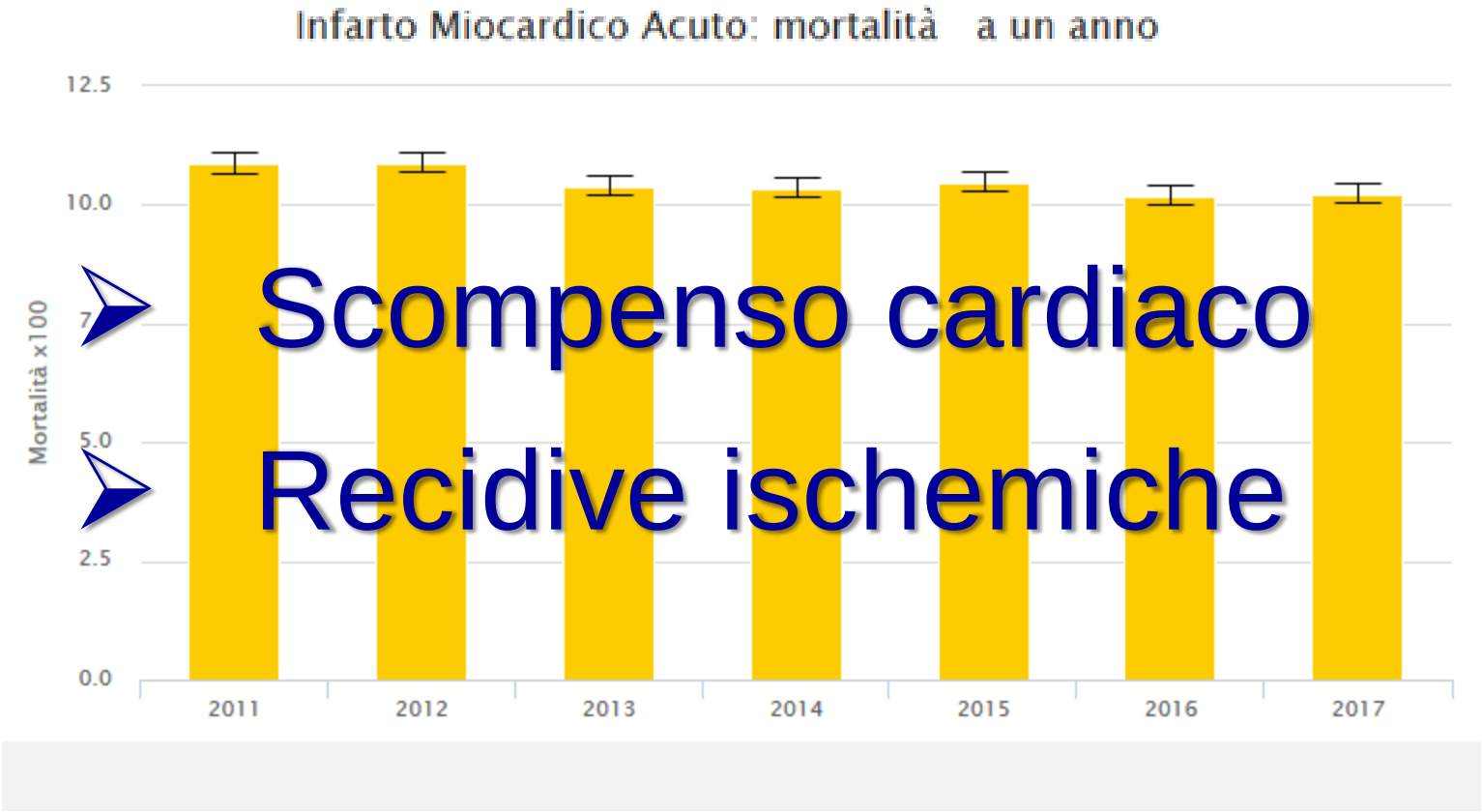
Programma Nazionale Esiti – PNE

STEMI + NSTEMI in Italia, anni 2010-2017

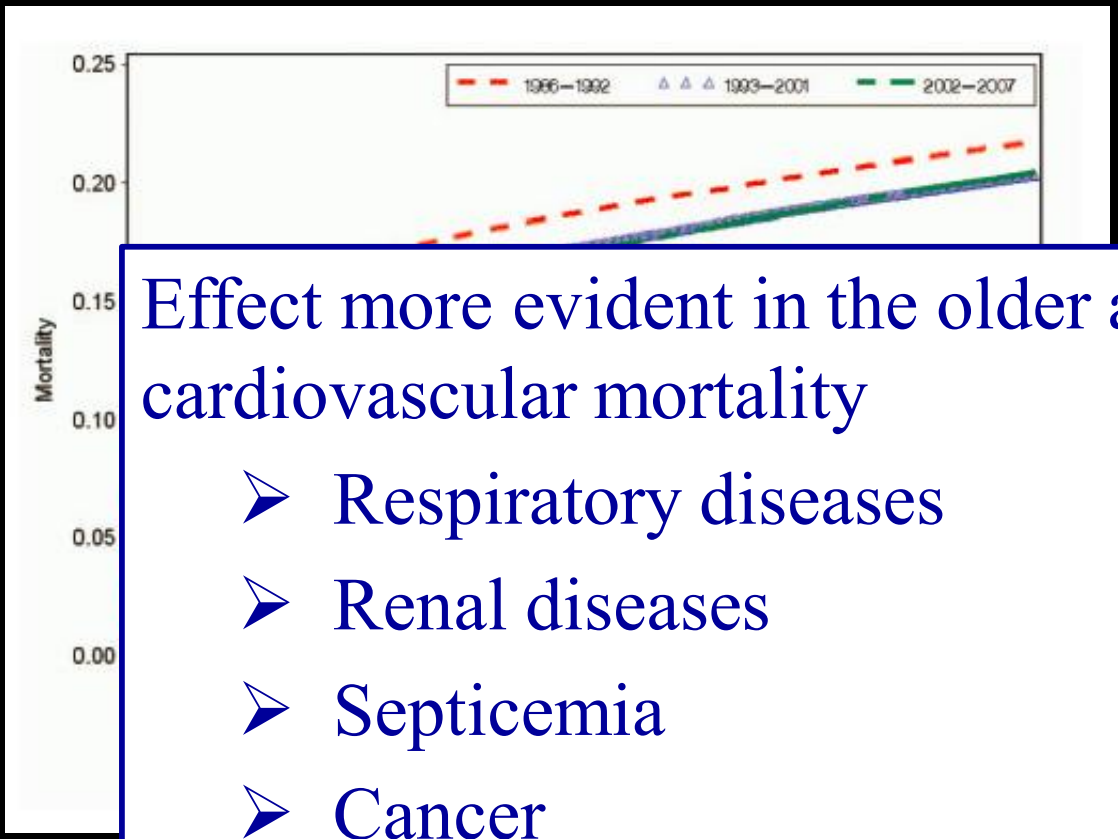


Programma Nazionale Esiti – PNE

STEMI + NSTEMI in Italia, anni 2011-2017

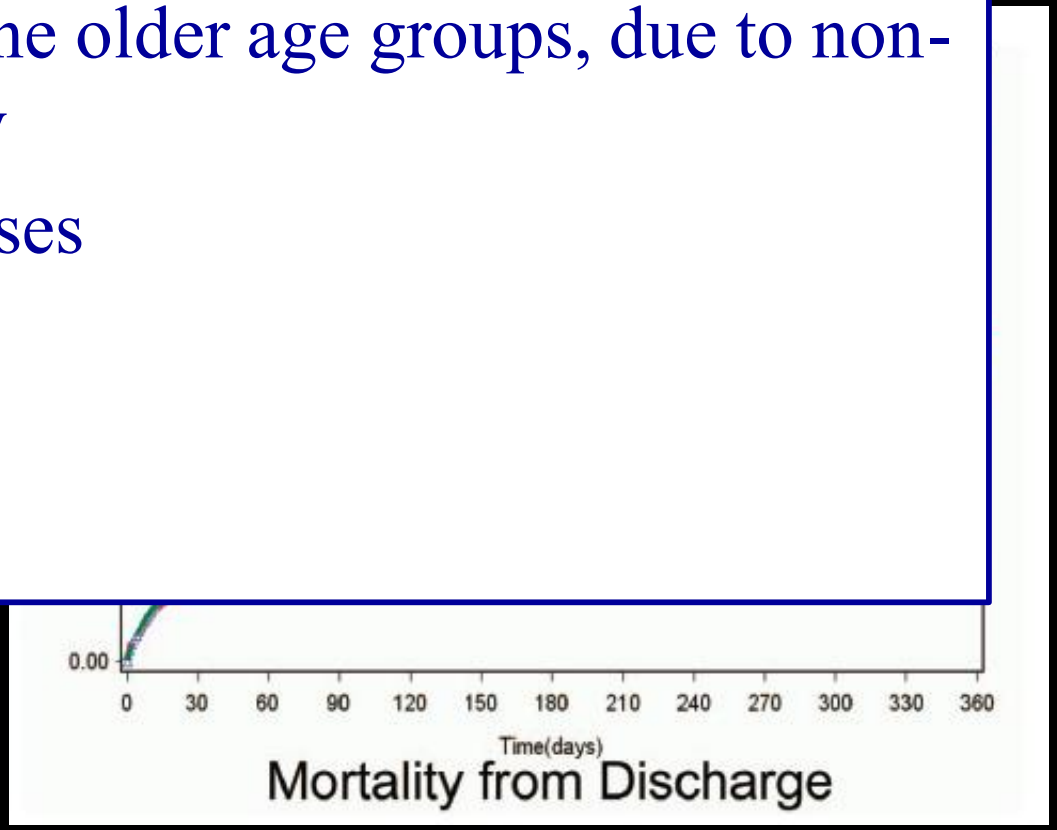


Mortality of patients admitted with a first AMI in New Jersey *years 1986 – 2007*



Effect more evident in the older age groups, due to non-cardiovascular mortality

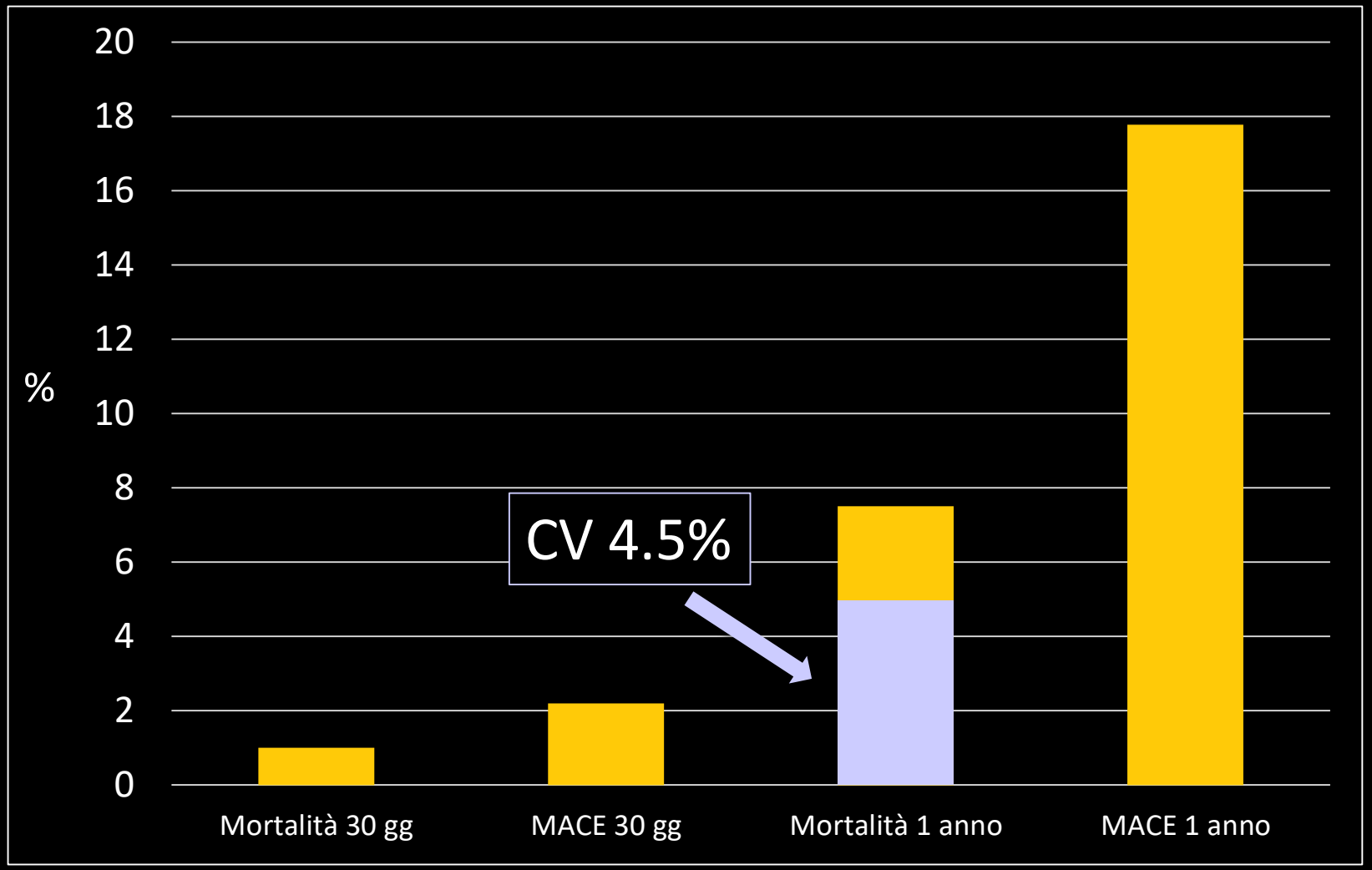
- Respiratory diseases
- Renal diseases
- Septicemia
- Cancer



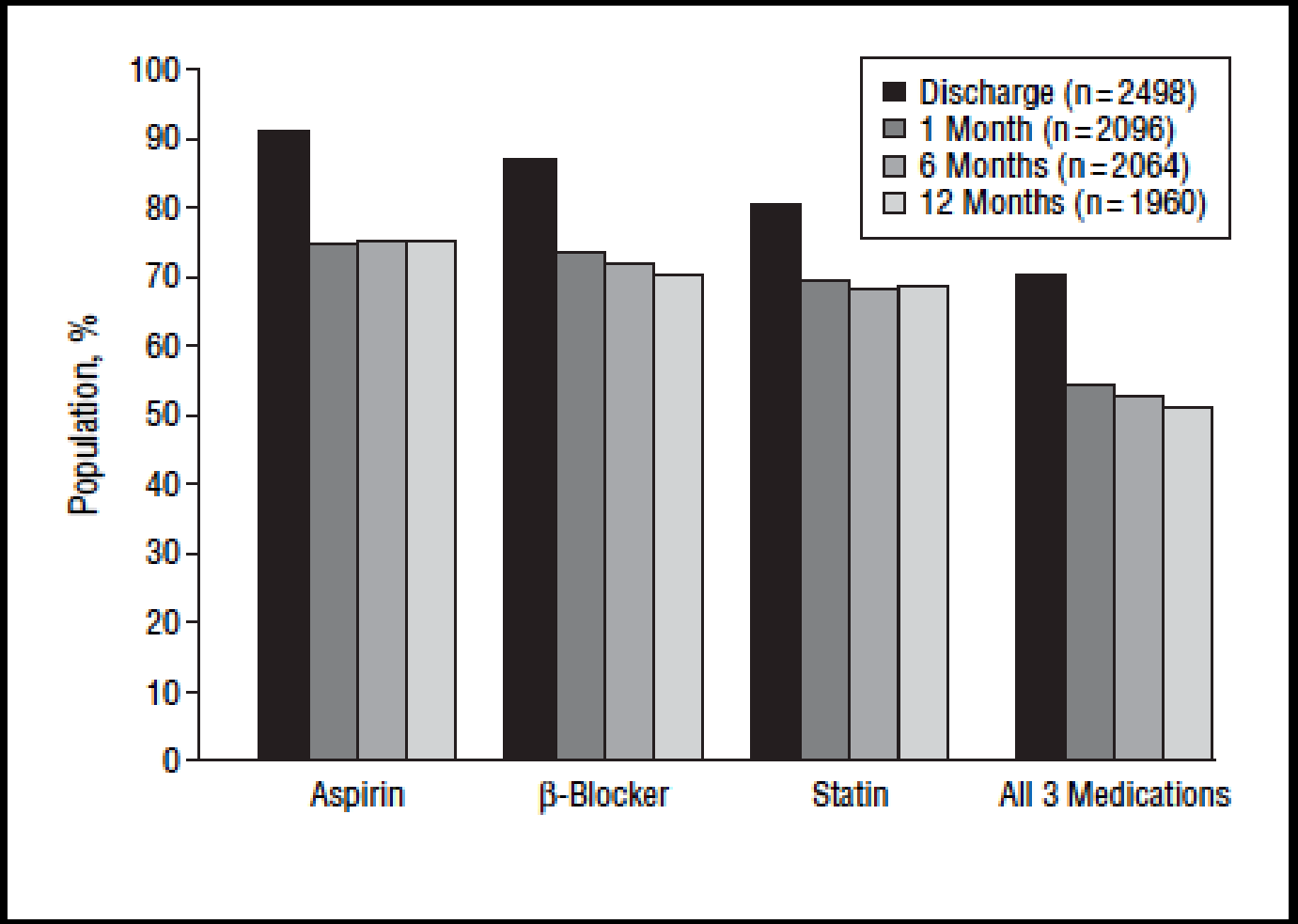
Kostis WJ, Circ Cardiovasc Qual Outcomes 2010;3:581

NSTEMI: eventi clinici a 30 gg e a 1 anno

403 pz consecutivi, 24.12.2014 – 20.04.2016



Medication therapy discontinuation after AMI *PREMIER Registry*



Ho PM, Arch Intern Med. 2006;166:1842

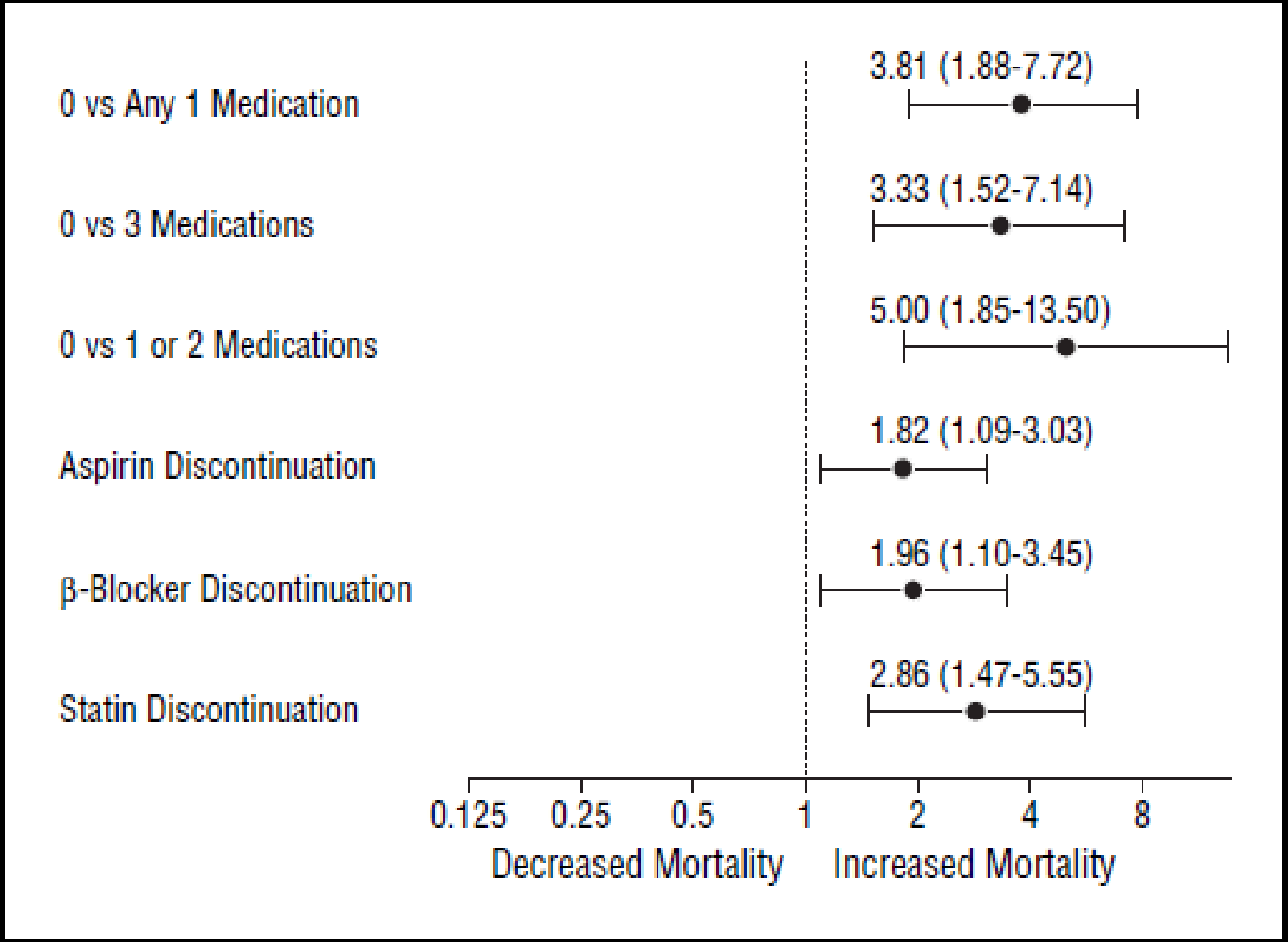
EUROASPIRE IV cross-sectional survey in 14 European regions

The medical risk factor control was very poor…

- 42.8% of HPT pts on treatment <140/90 mm Hg
- 32.7% if pts LDL-cholesterol <2.5 mmol/l (96 mg/dl)
- 58.5% of pts type 2 diabetes HbA1c <7.0%

Eur J Prev Cardiol 2016;23:2007

Evidence-based medical therapies interruption and prognosis after AMI *PREMIER Registry*

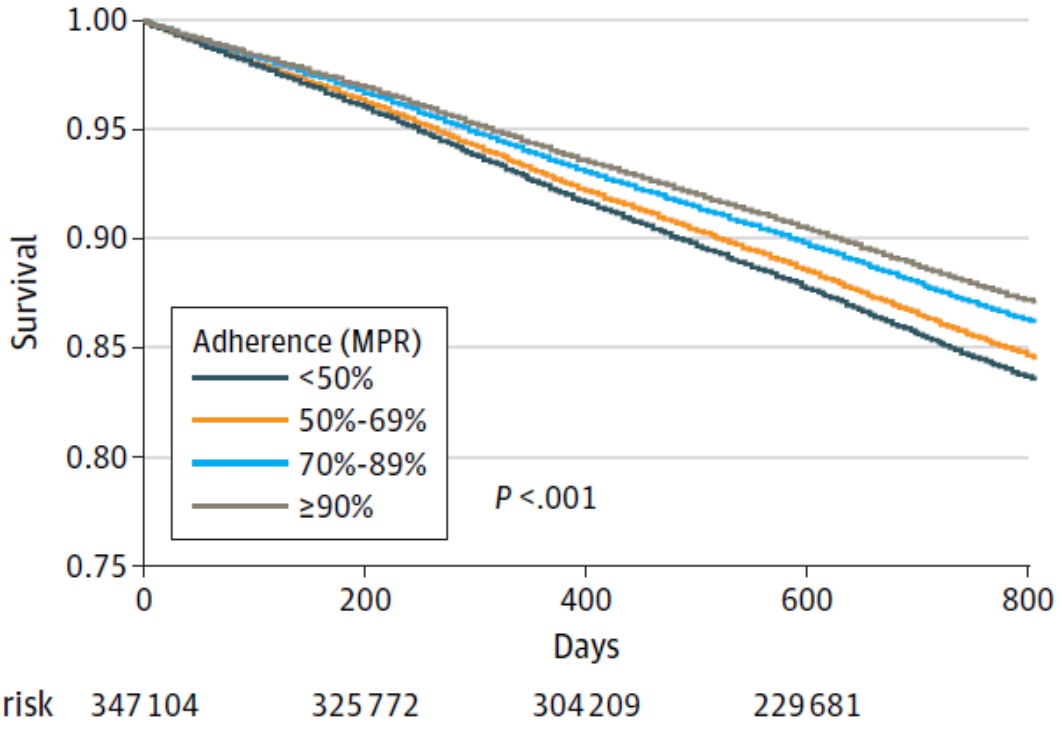


Ho PM, Arch Intern Med. 2006;166:1842

Statin adherence & mortality in pts with ACD

Retrospective cohort analysis,VA Health System (Jan 2013 – Apr 2014)

Survival curves by statin adherence level

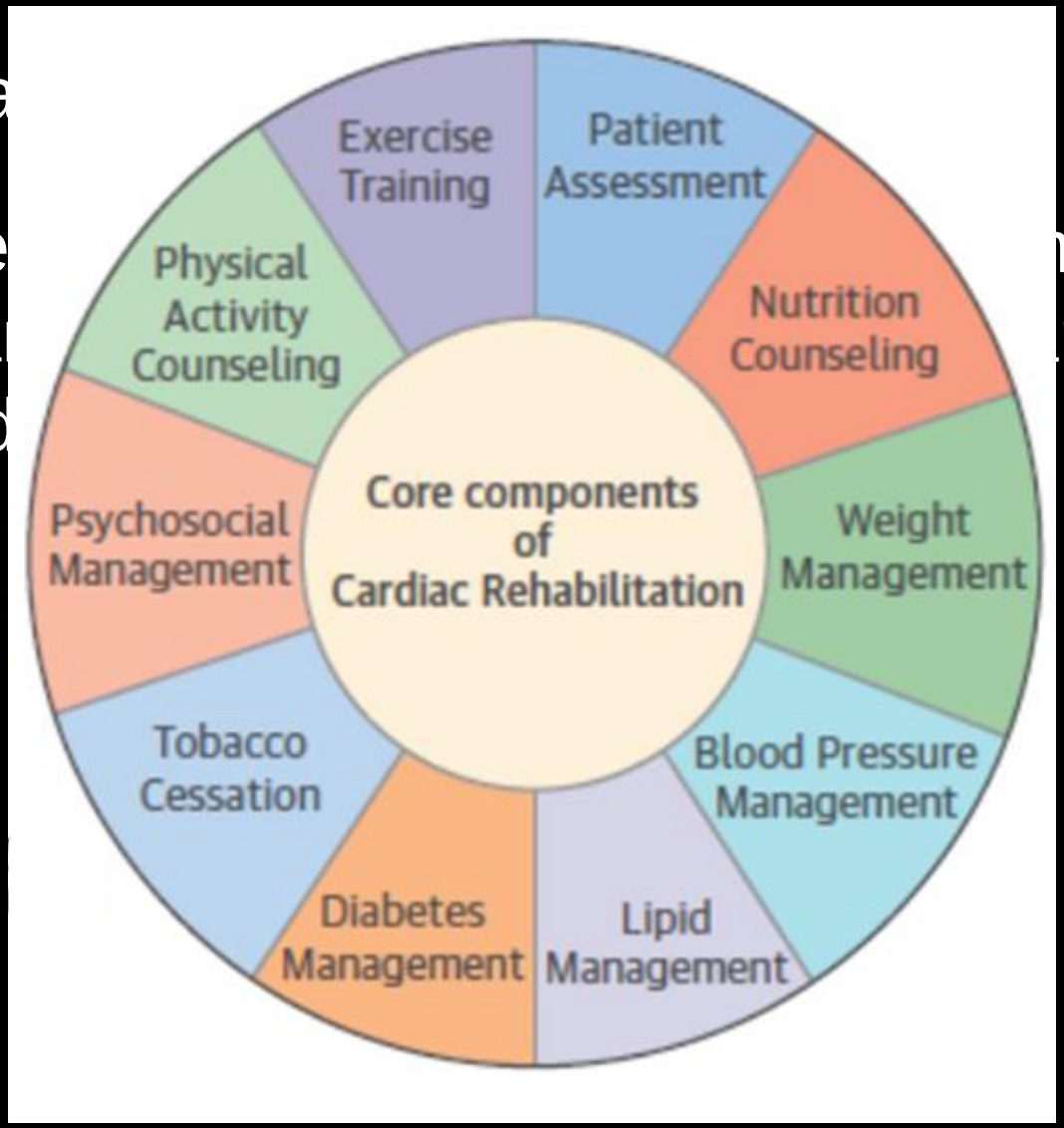


Plotted values include point estimates and 95% confidence intervals. There is a dose-response association between adherence and survival, with the greatest survival among the most adherent patients.

Rodriguez F, JAMA Cardiol 2019;4:206

Cardiologia Preventiva e Riabilitativa

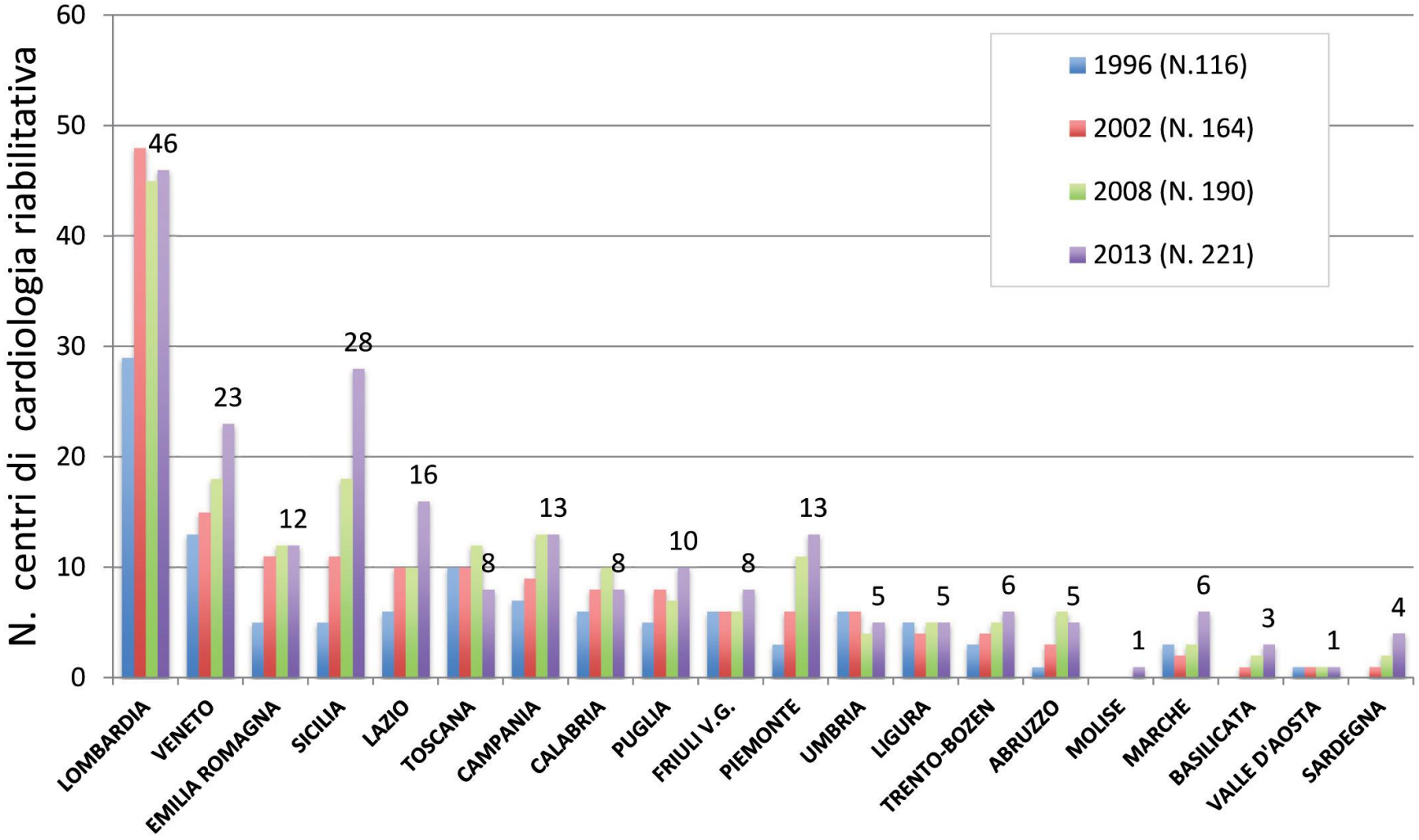
- Raccoma
- Il riferime misure di
  performa ria
  stabilite d



Sandesara PB, JACC 2015;65:389

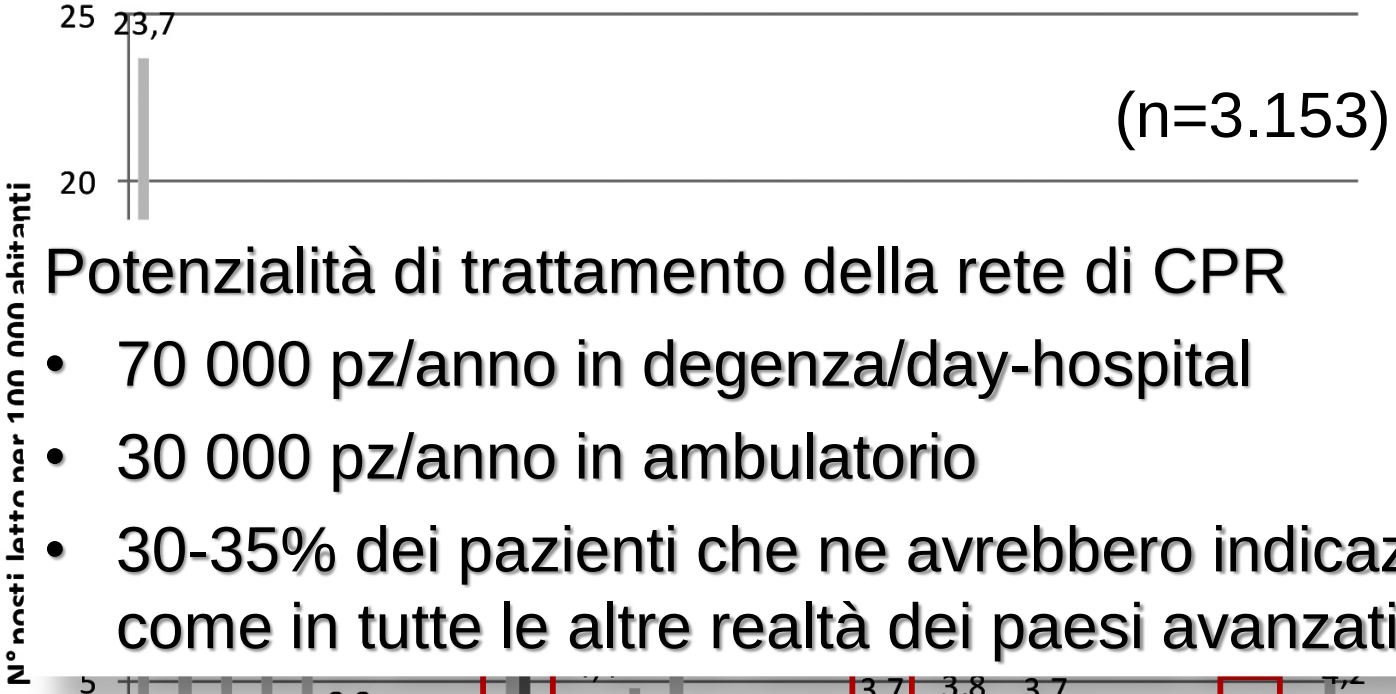
Italian Survey on Cardiac Rehabilitation (ISYDE.13)

Distribuzione regionale dei centri di CR in Italia ed evoluzione 1996 – 2013



Griffo R, G Ital Cardiol 2016;17:217

ISYDE.13 – Numero medio di posti letto di degenza ordinaria di CR per 100.000 ab per regione e macro-area



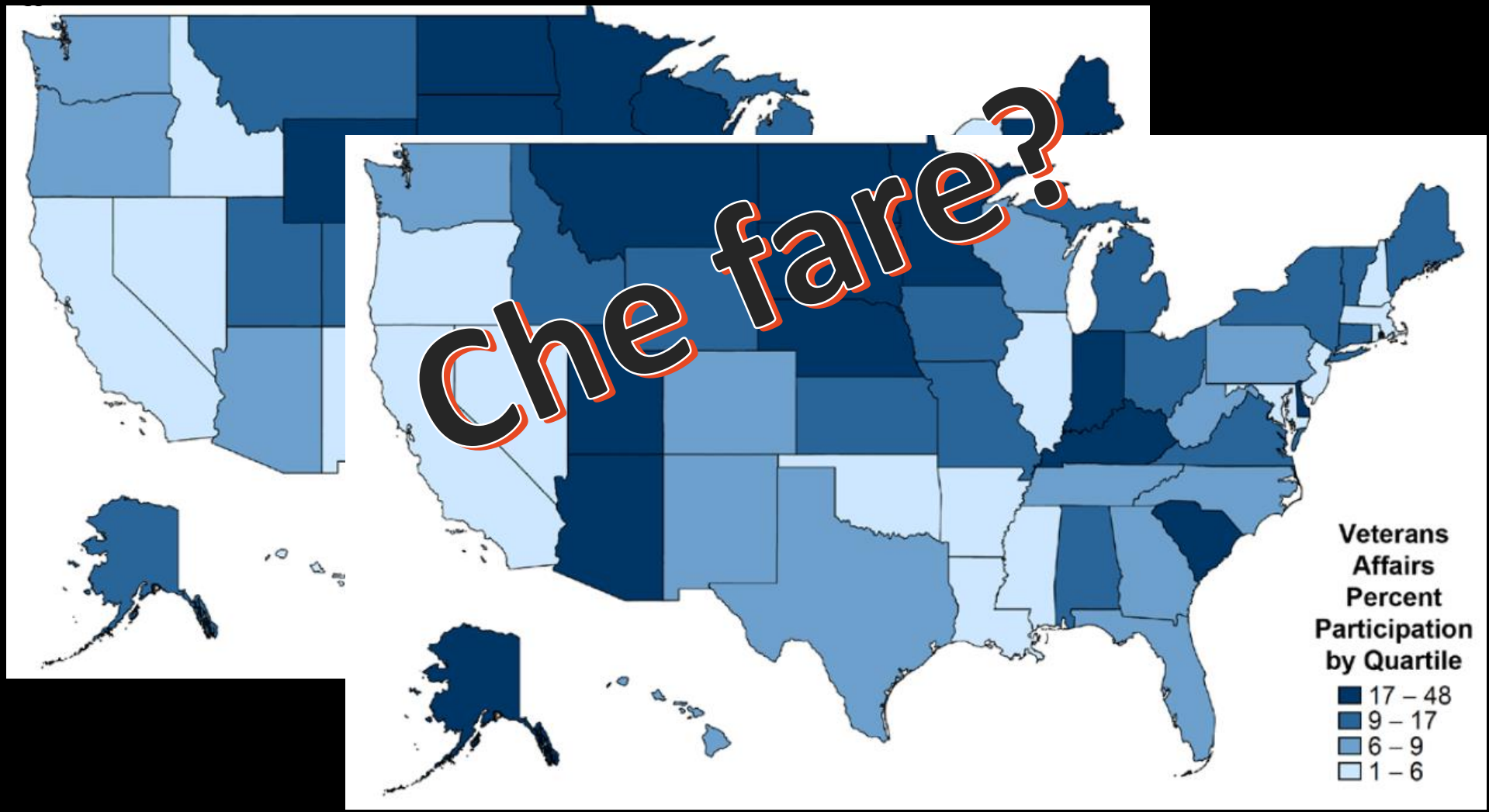
Potenzialità di trattamento della rete di CPR

- 70 000 pz/anno in degenza/day-hospital
- 30 000 pz/anno in ambulatorio
- 30-35% dei pazienti che ne avrebbero indicazione come in tutte le altre realtà dei paesi avanzati

Griffo R, G Ital Cardiol 2016;17:217

Standardized rates of participation in cardiac rehabilitation post AMI, PCI, or CABG in USA

(years 2007 – 2011)



Beatty AL, Circulation 2018;137:1899

Reti per la presa in carico delle malattie cardiache (Regione FVG)

- EMERGENZE CARDIOLOGICHE
- GRAVI INSUFFICIENZE D'ORGANO E TRAPIANTI: FILIERA CUORE
- INSUFFICIENZA CARDIACA CRONICA

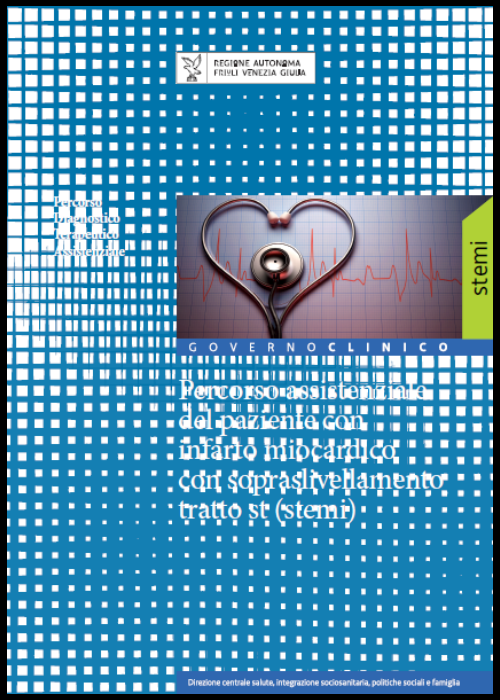
REGIONE AUTONOMA FRIULI VENEZIA GIULIA

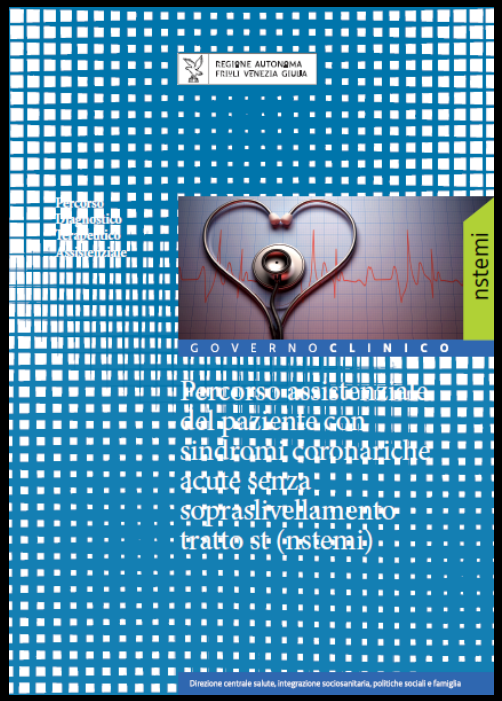
EMERGENZE CARDIOLOGICHE

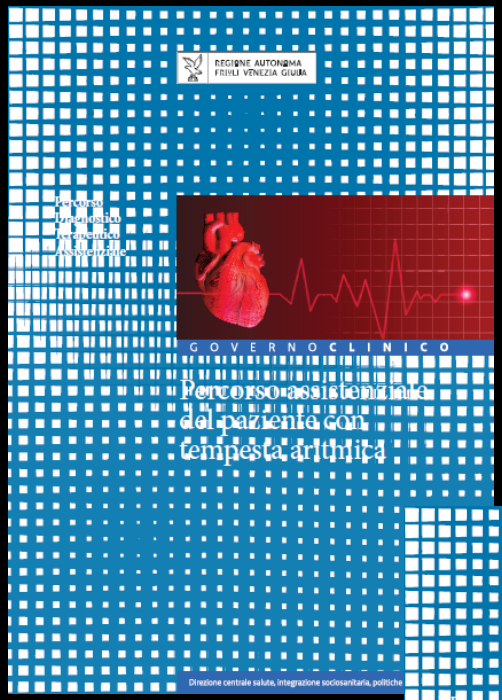
- Sindrome coronarica acuta
  - STEMI
  - NSTEMI
- Arresto cardiaco
- Sindrome aortica acuta
- Tempesta aritmica
- Insufficienza cardiaca acuta

REGIONE AUTONOMA
FRIULI VENEZIA GIULIA

REGIONE AUTONOMA
FRIULI VENEZIA GIULIA







REGIONE AUTONOMA FRIULI VENEZIA GIULIA

Per gentilezza di M. Werren, modificato

L'obiettivo primario alla dimissione dopo una sindrome coronarica acuta è favorire la presa in carico del paziente e la continuità assistenziale da parte delle strutture territoriali (MMG, personale delle Riabilitazioni, cardiologi ambulatoriali).

STRATIFICAZIONE DEL RISCHIO ALLA DIMISSIONE (DA PARTE DEL CARDIOLOGO)

Lettera di dimissione

DEFINIZIONE DEL PERCORSO CARDIOLOGICO CON **APPUNTAMENTO**

FOLLOW-UP

- **Agende dedicate** (aperte solo allo specialista)
- Possibilità di presa in carico precoce del paziente in caso di riacutizzazione
  - canale di comunicazione diretta con il MMG
  - spazi dedicati in agenda

REVIEW

CME CREDIT

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CLEVELAND CLINIC JOURNAL OF MEDICINE VOLUME 85 • NUMBER 7 JULY 2018

Cardiac rehabilitation:
A class 1 recommendation

SCA a elevato rischio trombotico

- Elevato rischio cardiovascolare residuo (GRACE)
- Diabete mellito
- Insufficienza renale
- Arteriopatia periferica
- Una storia di angina o di pregresso IMA
- Malattia multivasale
- Rivascolarizzazione incompleta
- Mancata rivascolarizzazione/riperfusione
- Età avanzata

G Ital Cardiol 2014;15 (Suppl 1 al 1)

SCA ad alto rischio clinico: scompenso cardiaco e/o disfunzione ventricolare sinistra

- FE <40%
- FE 40% - 45% con associato un predittore di rimodellamento
  - insufficienza mitralica >1
  - riempimento diastolico restrittivo
  - alto score di asinergia e ventricolo non dilatato

G Ital Cardiol 2014;15 (Suppl 1 al 1)

Early discharge

- Early presentation after symptom onset
- No or mild-moderate biomarker elevation
- Normal LV function
- Single-vessel CAD
- Successful PCI
- Discharge the next day

Check-list pre-dimissione da inserire nella cartella clinica

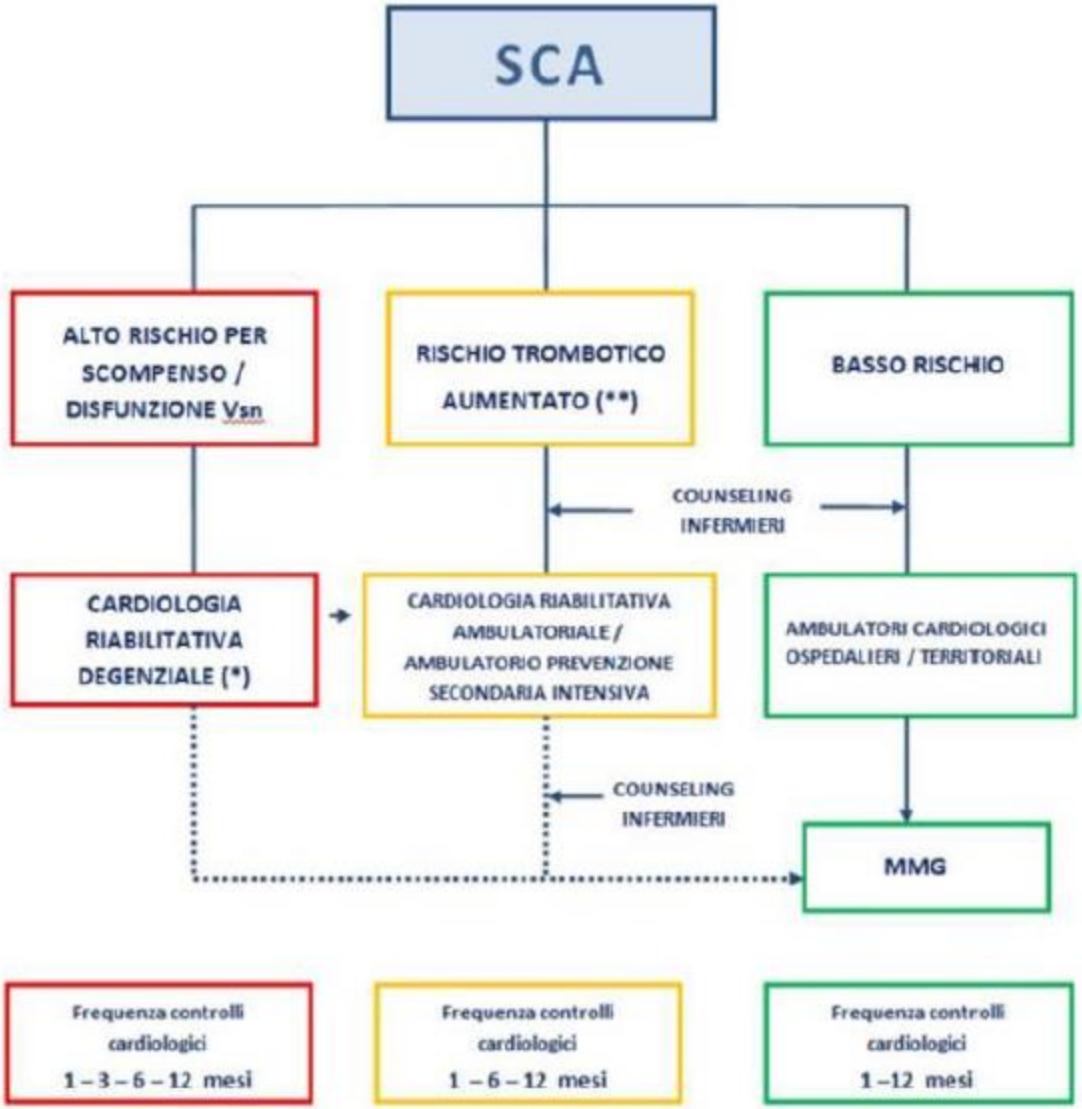
1. Classe Killip max	☐
2. Frazione di eiezione <40%	☐
3. Frazione di eiezione ≥40%-<45% con:	
a) pattern di riempimento diastolico restrittivo	☐
b) insufficienza mitralica >1	☐
c) WMSI elevato e ventricolo non dilatato	☐
4. Importante variazione del BNP	☐
5. Uso di diuretici dell'ansa	☐
6. Arteriopatia periferica	☐
7. Storia di angina o pregresso infarto miocardico	☐
8. Malattia coronarica multivasale	☐
9. Rivascolarizzazione incompleta	☐
10. Pazienti non rivascolarizzati	☐

BNP, peptide natriuretico cerebrale; WMSI, indice di cinesi parietale.

G Ital Cardiol 2014;15 (Suppl 1 al 1)

Per gentilezza di M. Werren, modificato

Riabilitazione e follow up - ACS



(*) In sua assenza programma di controlli ambulatoriali con ECO a 1-3-6-12 mesi

(**) Il livello di rischio trombotico richiesto per l'inserimento in questo percorso va valutato in rapporto alle potenzialità organizzative del centro

Home-Based Cardiac Rehabilitation

Definition

Systematic, comprehensive, and personalized services that involve:

- Medical evaluation
- Prescribed exercise
- Cardiovascular risk factor modification
- Patient education
- Behavioral activation/counseling

Delivered mostly or entirely outside of the traditional Central Based Cardiac Rehabilitation setting

Imperial College
National Heart and Lung Institute

A COMPARISON OF A MULTI-DISCIPLINARY HOME BASED CARDIAC REHABILITATION PROGRAMME WITH COMPREHENSIVE CONVENTIONAL REHABILITATION IN POST-MYOCARDIAL INFARCTION PATIENTS.

JENNIFER M. BELL, B.A., MPhil.

Thesis submitted to the University of London
for the degree of Doctor of Philosophy

1998

UK Heart Manual

THE HEART MANUAL

Facilitator Login

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Latest News

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- "....the UK Heart Manual (NHS Lothian) is perhaps the most extensively studied self-management book....."
- June literature update now available
- Heart Failure Manual training places now available!
- Is it time to refresh your Heart Manual facilitation and knowledge skills?

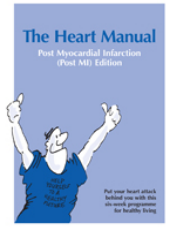
The Heart Manual is a well established NHS service providing evidence-based programmes for individuals recovering from myocardial infarction, revascularisation, stroke and cancer. Our programmes are facilitated by specially trained clinicians worldwide to individually tailor the programme and support patients' understanding and management of their condition.

http://www.theheartmanual.com

The Heart Manual

Post Myocardial Infarction

Home
About
How to use
Part 1
Part 2
Week 1
Week 2
Week 3
Week 4
Week 5
Week 6
Part 3



This programme/website is called the Heart Manual: Post MI Edition because it can help you to understand why you had a heart attack.

It will also tell you the things that you can do to recover in the quickest and safest way.

It can tell you about the medicines you are taking.

If you live with someone it can help them to understand your condition.

The main part of the programme/website is divided into six weekly sections. There are some simple exercises to do, and each week there is a small section to read.

The bad news

The first reaction after a heart attack is often relief that you have survived. But once you get home, this may turn into worry about:

- how it will affect your life
- having another heart attack
- what you can or can't do
- going back to work.

Upset emotions are common. Most people in the same position occasionally feel:

- sad
- afraid
- bad-tempered
- moody.

The good news

These worries are often caused by:

- out-of-date ideas
- wrong ideas
- not knowing the true facts.

Reading this Manual will help you to find out the truth about heart attacks. The upset feelings are normal and will pass as you get stronger.

LOGIN
Walking Record
Exercise Record
Daily Activity Record
Home Exercise Plan
Relaxation
Emergency Info
Patient Questionnaire

Go back to last page

Before you can login you must accept our Terms & Conditions

The Heart Manual

Put your h
behind yo
six-week
for he

How to use the Manual

Part 1: Your Heart Attack: the Facts

(pages 9–16)

This section is for you to read while you are recovering.

It is labelled like this:

Starting your recovery

It tells you the plain facts about your heart attack. You should read this section first, and you might want to come back to it a few times during your recovery.

If you live with someone, get them to read this section, too. It can help them just as much as it helps you.

You should also listen to the 'Questions and Answers' CD.

Part 2: The Weekly Programme

(pages 17–132)

This part consists of six weekly sections.

The weeks are clearly labelled like this:

Week 1

Each weekly section has important information to help you to recover, and an exercise programme to help you back to fitness in easy stages.

Every day:

- follow your plan morning and evening as advised by your facilitator
- Each time mark your activities in the charts provided
- practise relaxation by listening to tracks 1 and 2 on the relaxation CD.

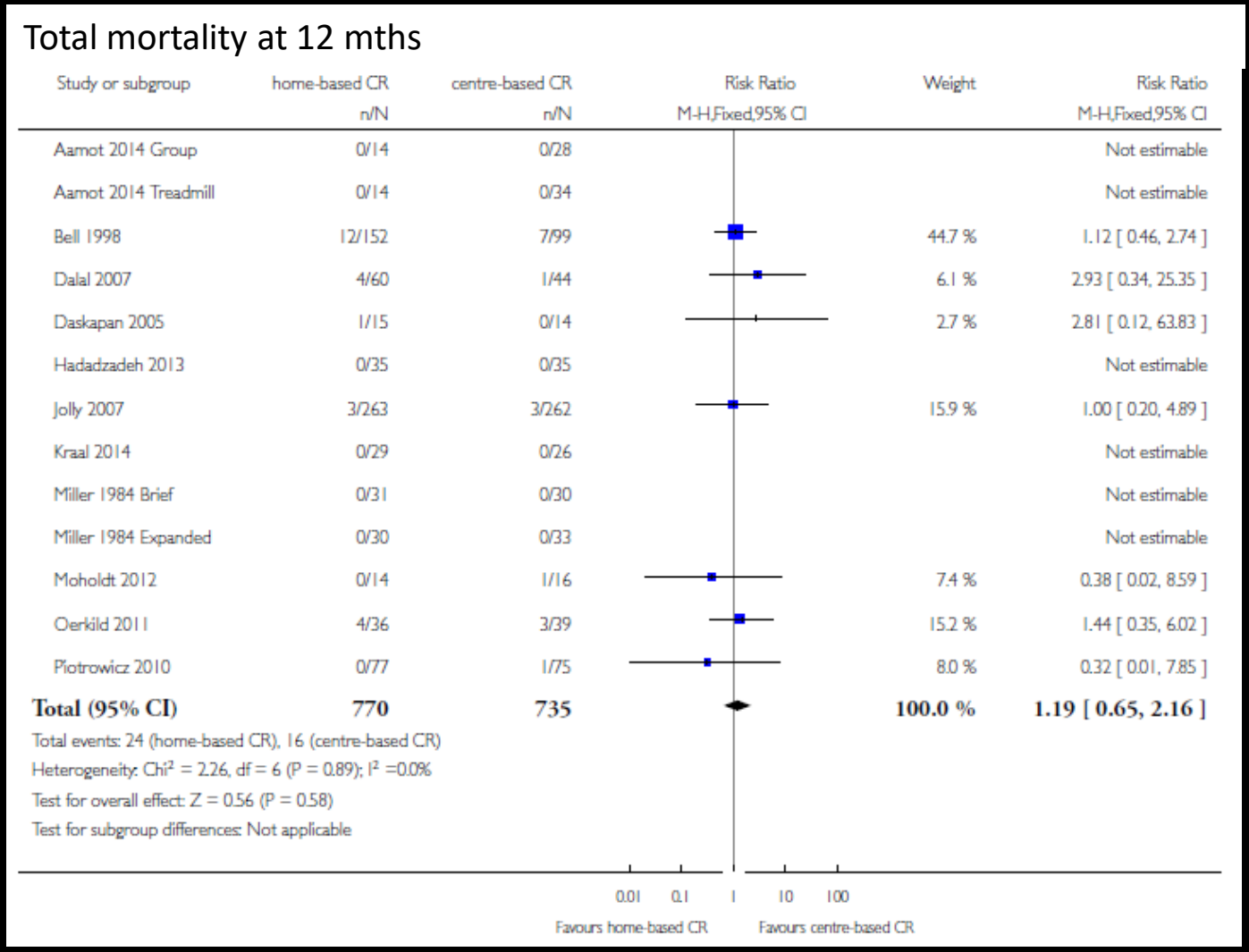
Part 3: Facts and Advice to Help Your Recovery

(pages 133–171)

This part provides extra information about your recovery, medicines and other things you might want to know. You can read it right through or dip into it to answer your questions.

Home-base vs centre-based rehabiltaiton

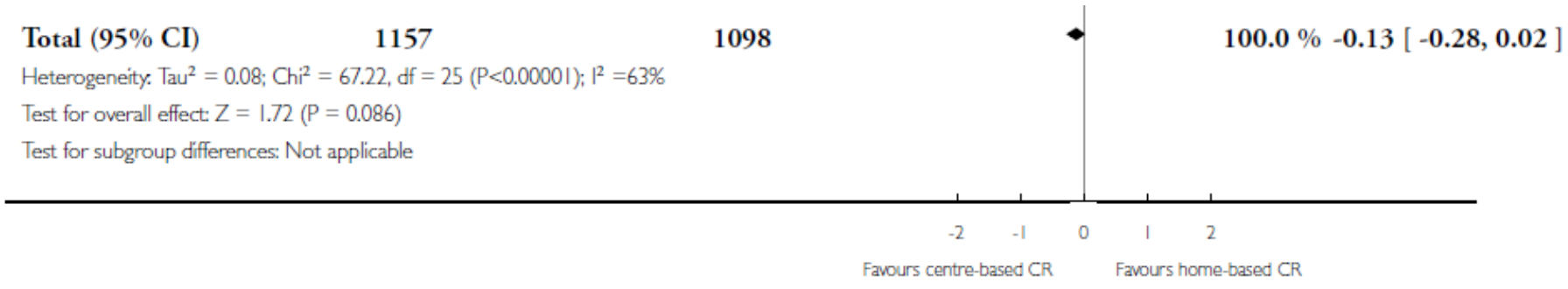
23 randomized trials, 2.890 pts



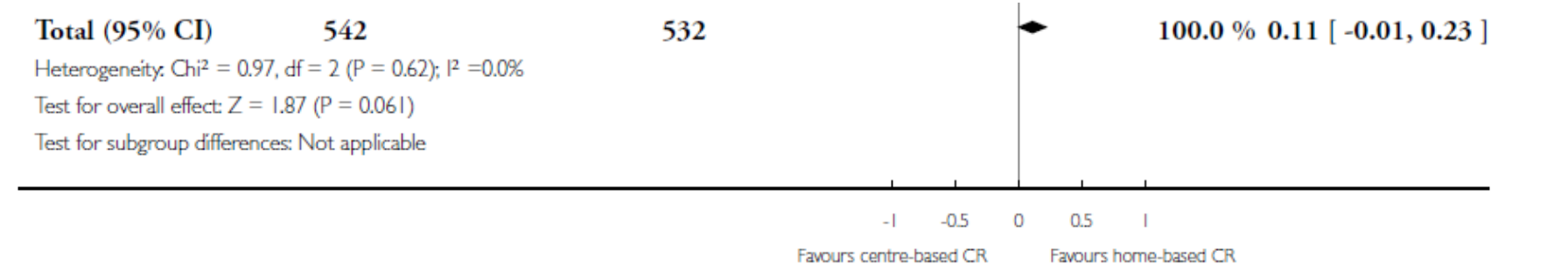
Anderson L, Cochrane Database Syst Rev 2017;6:CD007130

Home-base vs centre-based rehabiltaiton

Exercise capacity ≤ 12 months



Exercise capacity 12 to 24 months



Anderson L, Cochrane Database Syst Rev 2017;6:CD007130

JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
VOL. ■, NO. ■, 2019

PUBLISHED BY ELSEVIER

AACVPR/AHA/ACC SCIENTIFIC STATEMENT

Home-Based Cardiac Rehabilitation

A Scientific Statement From the American Association of Cardiovascular and Pulmonary Rehabilitation, the American Heart Association, and the American College of Cardiology

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…HBCR may be a reasonable option for selected clinically stable low- to moderate-risk patients who are eligible for CR but cannot attend a traditional center-based CR program.

Centri di Assistenza Primaria*

Aggregazione di

- Medici di medicina generale (MMG)
- Personale dipendente dei MMG
- Pediatri di libera scelta
- Medici di continuità assistenziale
- Specialisti
- Altro personale (da distretto, ospedale)

*saranno sostituiti progressivamente dalle Medicine di Gruppo Integrate

REGIONE AUTONOMA FRIULI VENEZIA GIULIA

Legge regionale 2014/17

Centri di assistenza primaria (CAP)

Funzioni (sintesi)

- Assicura prestazioni di assistenza primaria (di medicina generale, infermieristiche, ambulatoriali, domiciliari e specialistiche)
- Garantisce la continuità dell'assistenza
- Ha un bacino di utenza di norma compreso tra 20.000 e 30.000 abitanti
- Ospita ambulatori medici, punti prelievo, diagnostica strumentale di primo livello, ambulatori specialistici, servizi di salute mentale, servizi amministrativi
- Garantisce l'attività assistenziale nell'arco delle ventiquattro ore per tutti giorni della settimana, tramite il coordinamento delle varie figure professionali che lo compongono
- È centro di riferimento dell'assistenza domiciliare

REGIONE AUTONOMA FRIULI VENEZIA GIULIA

Legge regionale 2014/17

Conclusioni

- La mortalità precoce delle SCA in Italia è in diminuzione grazie al progressivo utilizzo di una strategia invasiva basata sul modello Hub & Spoke
- La mortalità ad un anno è rimasta tuttavia sostanzialmente invariata a causa di un incremento nella complessità dei pazienti e di un'offerta di trattamento riabilitativo ancora troppo limitata
- La cardiologia e la medicina del territorio possono contribuire notevolmente a migliorare questa situazione mediante l'utilizzo di nuovi modelli organizzativi integrati
- Il supporto degli organismi regionali appare indispensabile per impostare e sostenere tali modelli

Costruire …

…un modello sostenibile