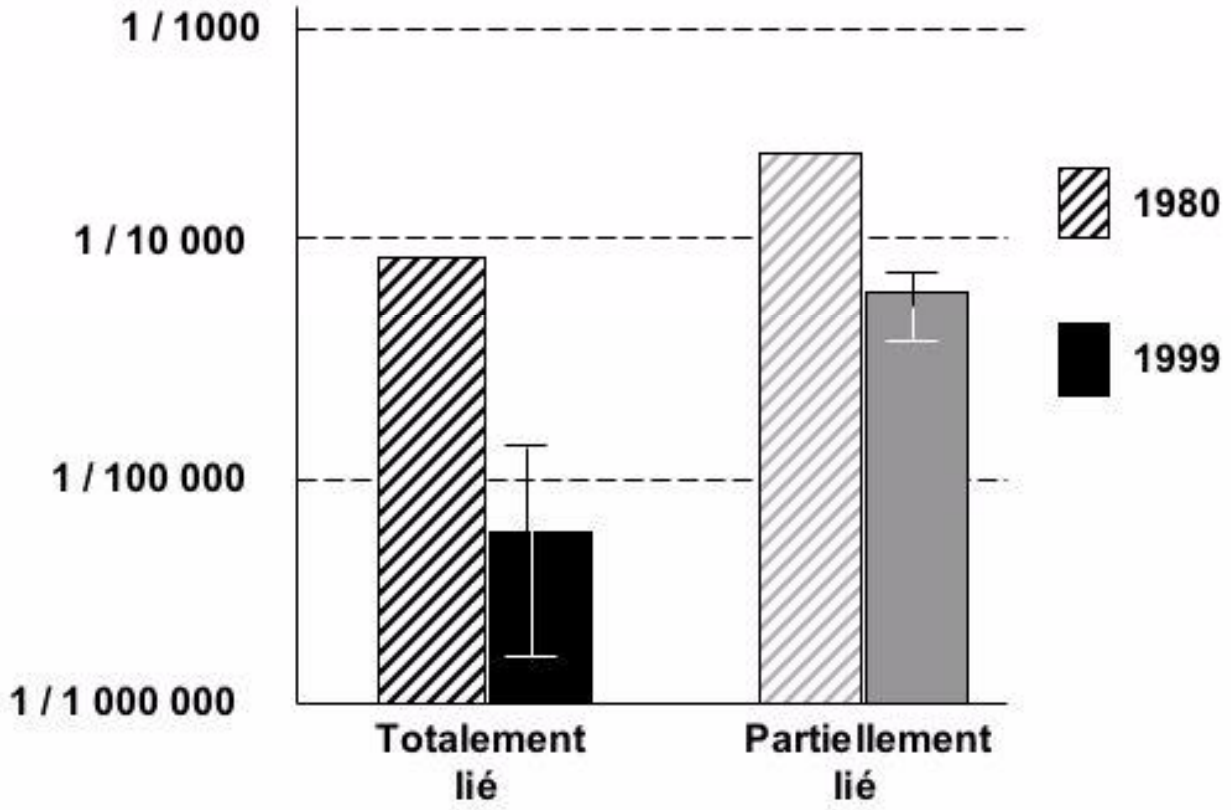
« Qui fait quoi » en péri-opératoire dans mon établissement ?

Kamran SAMII
CH Rodez

Pourquoi prendre en charge le postopératoire?

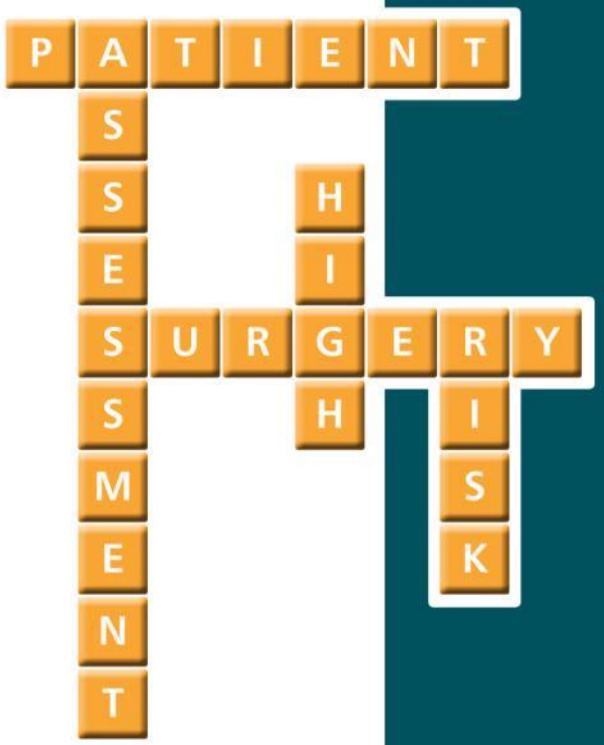
Utilité médicale?

Evolution de la mortalité



Lienhart A. SFAR 2003

Et plus tard que se passe-t-il?



Knowing the Risk

A review of the peri-operative care of surgical patients

NCEPOD

Study population

- All patients aged 16 or over undergoing inpatient surgery between 1st and 7th March 2010 inclusive
- Exclusions
  - Day cases
  - Obstetric
  - Cardiac
  - Transplant
  - Neurosurgery cases

30 day outcome

Table 3.27 Outcome at 30 days post operation by risk

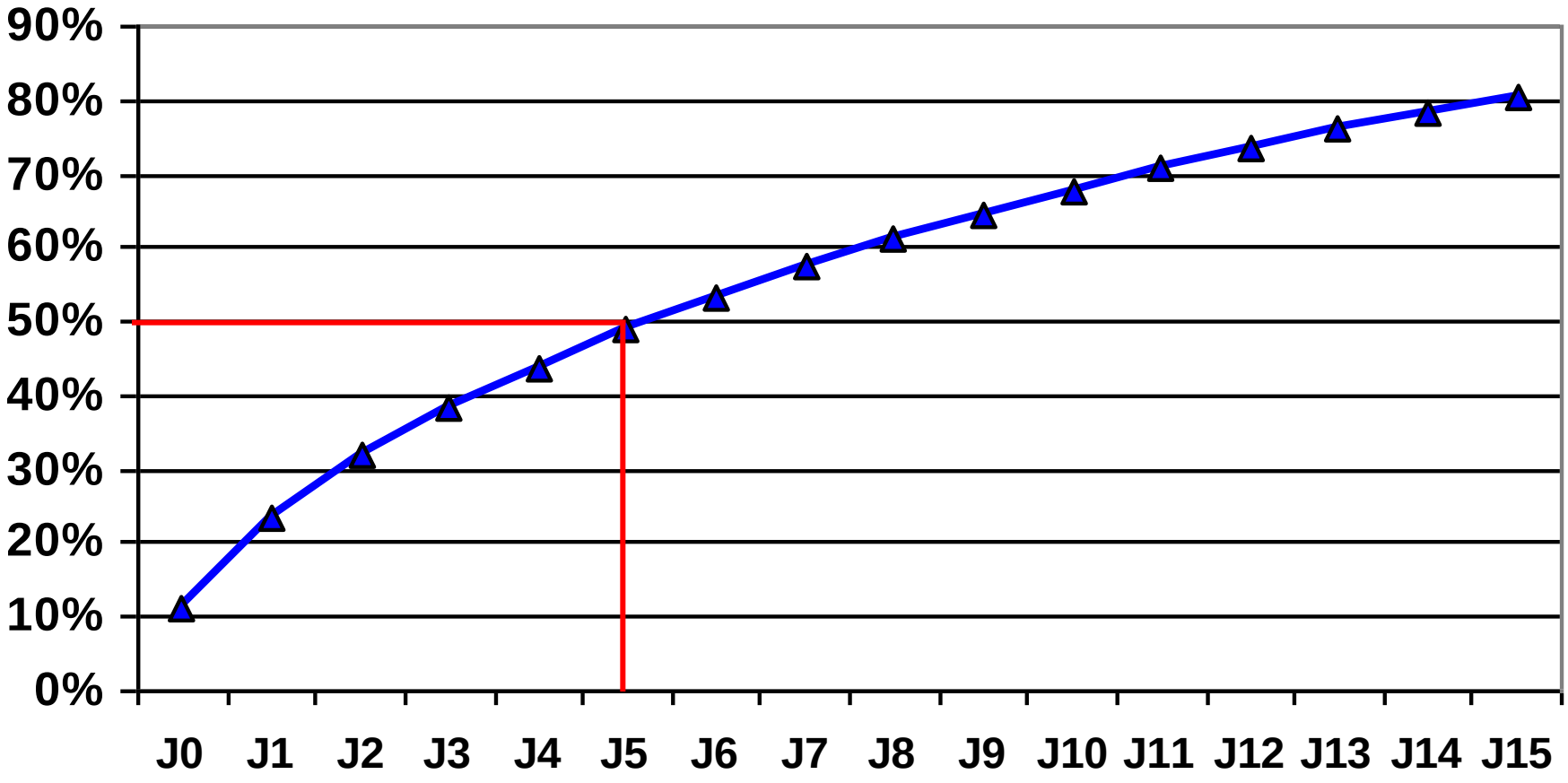
	Risk	
30 day outcome	**Low (%)**	**High (%)**
Alive	10468	2503
Deceased	43 (0.4)	165 (6.2)
Total	**10511**	**2668**

Quand surviennent les décès ?

NCEPOD 1992-93

Données sur 19'816 décès en chirurgie (6-70 ans)

Courbe cumulative des décès per et postopératoires



Mortalité per-opératoire 1:140 000

mortalité postopératoire: 1:250

Rapport 1/500

Problème universel?

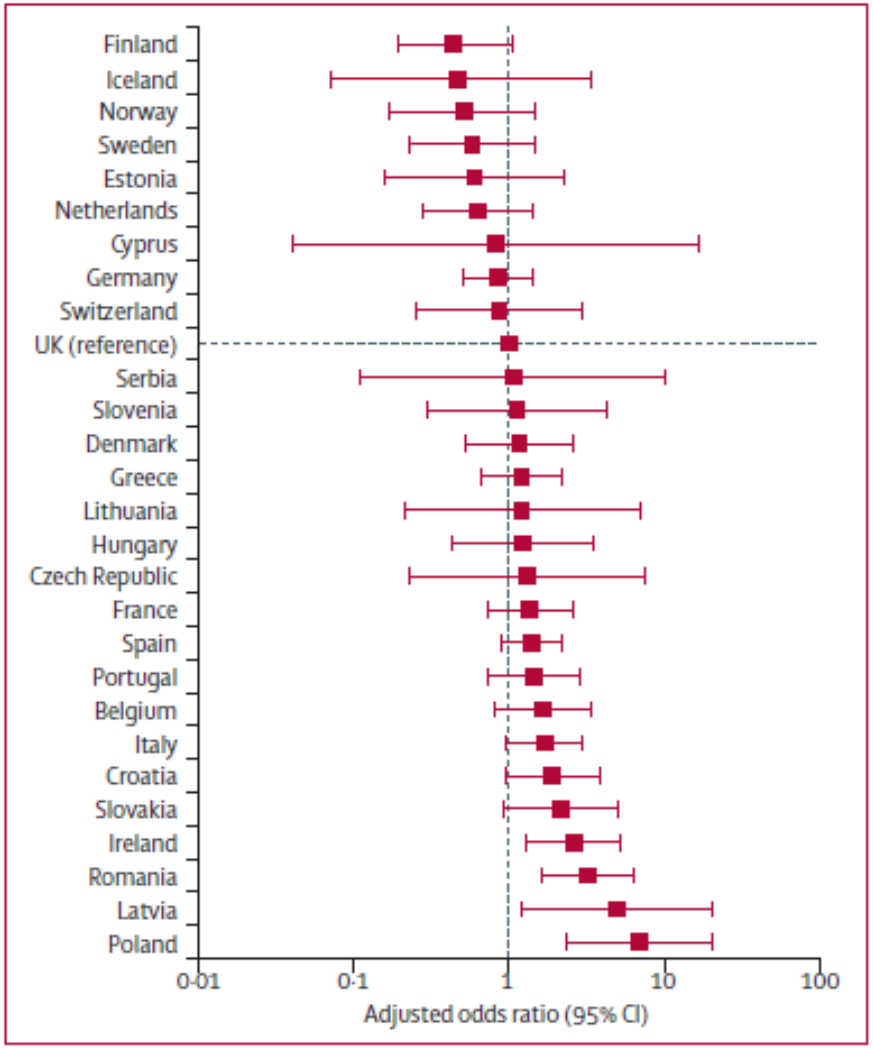
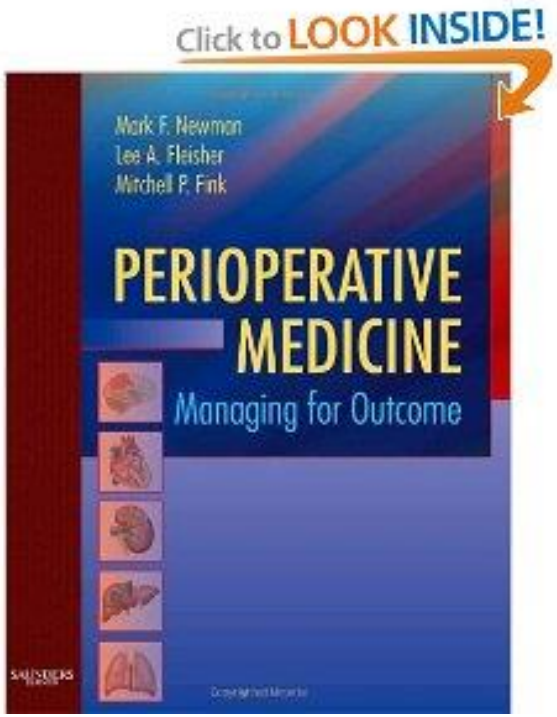


Figure 3: **Adjusted odds ratio for death in hospital after surgery for each country**

Lancet 2012; 380: 1059–65

Utilité médicale?

Postopératoire est un problème médical majeur


Click to LOOK INSIDE!
Mark F. Newman
Lee A. Fleisher
Mitchell P. Fink
PERIOPERATIVE MEDICINE
Managing for Outcome


Perioperative Medicine

Notre responsabilité?

Notre responsabilité?

- Conseil de l'Ordre:

  « La responsabilité de l'anesthésiste-réanimateur débute avec la consultation d'anesthésie et ne cesse qu'à la fin des soins postopératoires du domaine de sa compétence ».

Notre responsabilité?

- Conseil de l'Ordre:

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- Cour de Cassation:

  « Cette mission qui délimite la responsabilité de l'anesthésiste pendant et après l'opération, s'étend à tous les actes médicaux accomplis par lui et au suivi qu'ils nécessitent le cas échéant au-delà du réveil… ».

La prise en charge médicale postopératoire est notre responsabilité

Peut on la déléguer?

Réanimation?

Mortality after surgery in Europe: a 7 day cohort study

*Rupert M Pearse, Rui P Moreno, Peter Bauer, Paulo Pelosi, Philipp Metnitz, Claudia Spies, Benoit Vallet, Jean-Louis Vincent, Andreas Hoeft, Andrew Rhodes, for the European Surgical Outcomes Study (EuSOS) group for the Trials groups of the European Society of Intensive Care Medicine and the European Society of Anaesthesiology**

Summary

Background Clinical outcomes after major surgery are poorly described at the national level. Evidence of heterogeneity between hospitals and health-care systems suggests potential to improve care for patients but this potential remains unconfirmed. The European Surgical Outcomes Study was an international study designed to assess outcomes after non-cardiac surgery in Europe.

Methods We did this 7 day cohort study between April 4 and April 11, 2011. We collected data describing consecutive patients aged 16 years and older undergoing inpatient non-cardiac surgery in 498 hospitals across 28 European nations. Patients were followed up for a maximum of 60 days. The primary endpoint was in-hospital mortality. Secondary outcome measures were duration of hospital stay and admission to critical care. We used χ^2 and Fisher's exact tests to compare categorical variables and the *t* test or the Mann-Whitney *U* test to compare continuous variables. Significance was set at $p<0.05$. We constructed multilevel logistic regression models to adjust for the differences in mortality rates between countries.

Findings We included 46 539 patients, of whom 1855 (4%) died before hospital discharge. 3599 (8%) patients were admitted to critical care after surgery with a median length of stay of 1·2 days (IQR 0·9–3·6). 1358 (73%) patients who died were not admitted to critical care at any stage after surgery. Crude mortality rates varied widely between countries (from 1·2% [95% CI 0·0–3·0] for Iceland to 21·5% [16·9–26·2] for Latvia). After adjustment for confounding variables, important differences remained between countries when compared with the UK, the country with the largest dataset (OR range from 0·44 [95% CI 0·19–1·05; p=0·06] for Finland to 6·92 [2·37–20·27; p=0·0004] for Poland).

Lancet 2012; 380: 1059–65

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ROUTINE POSTOPERATIVE INTENSIVE CARE MONITORING IS NOT NECESSARY AFTER RADICAL CYSTECTOMY

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From the Departments of Urologic Surgery and Patient Care Services, Vanderbilt University Medical Center, Nashville, Tennessee

ABSTRACT

Purpose: Patients undergoing radical cystectomy have historically required intensive care monitoring in the perioperative period. We examined the postoperative care of these patients since the institution of a clinical care pathway with special attention to the need for intensive care unit admission.

Materials and Methods: We reviewed the records of 304 consecutive patients who underwent radical cystectomy from December 1995 to July 2000. Variables examined were the location and nature of postoperative care, American Society of Anesthesiologists score, estimated blood loss, transfusion requirement, hospital stay, perioperative minor complications, major complications, the mortality rate and urinary diversion type.

Results: Of the 304 patients 20 (6.5%) required intensive care unit monitoring during postoperative recovery and 18 were admitted directly to the intensive care unit postoperatively. Compared with the total population those admitted to the intensive care unit had increased hospital stay ($p = 0.002$), higher American Society of Anesthesiologists score ($p < 0.001$), higher transfusion requirement ($p = 0.001$) and shorter operative time ($p = 0.02$). Patients who received blood transfusion and those with major complications were more likely to need intensive care unit care ($p = 0.019$ and < 0.001, respectively). A single patient died who did not receive intensive care unit care.

Conclusions: Our clinical care pathway outlines postoperative care on the regular urology floor for patients who undergo radical cystectomy. This policy has been safe and efficacious. We believe that admission to the intensive care unit should only be done in select cases.

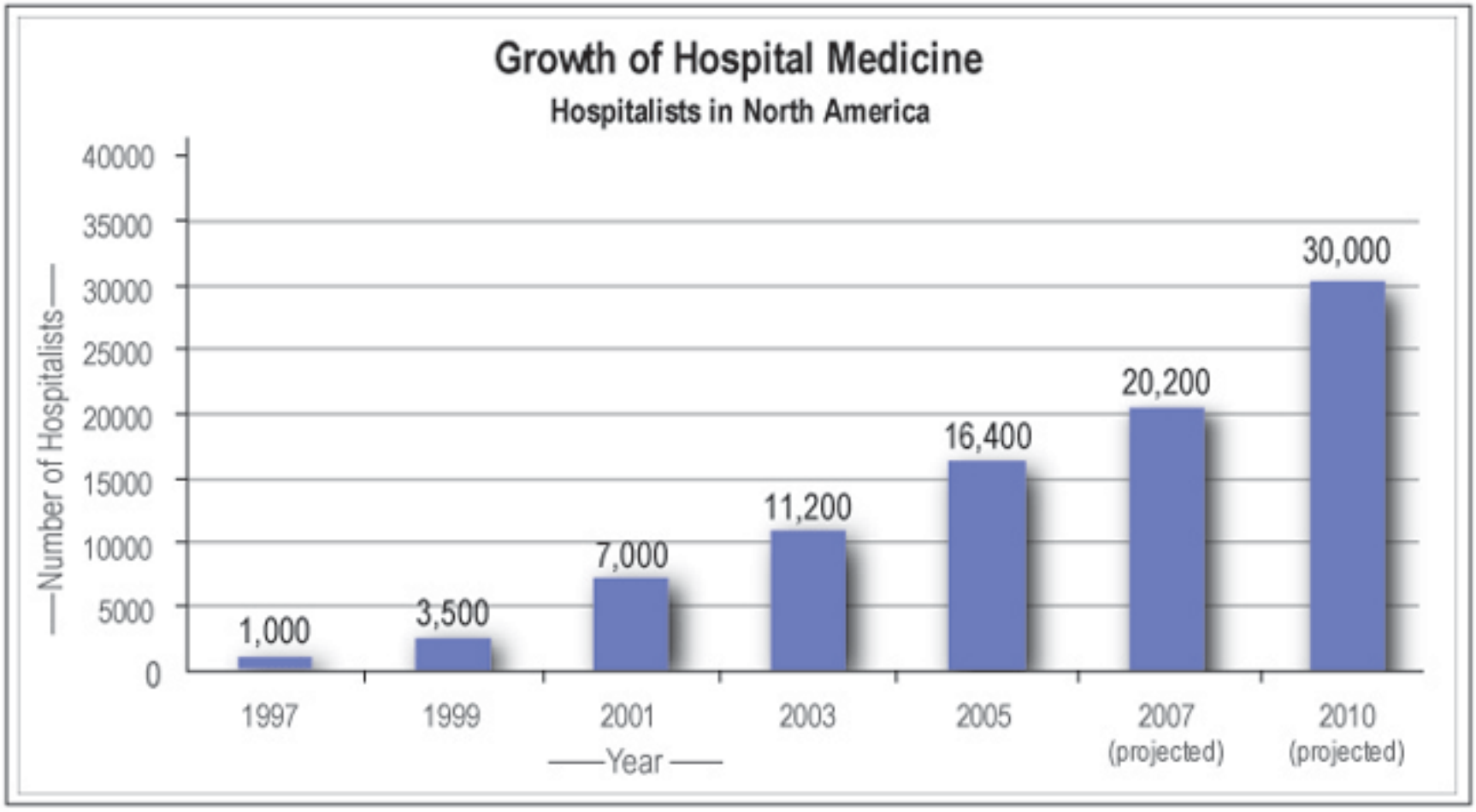
Réanimation ne résout pas tous les problèmes

Prise en charge par autre médecin?

Hospitalists and anesthesiologists as perioperative physicians: Are their roles complementary?

Proc (Bayl Univ Med Cent) 2007;20:140–142

Adebola O. Adesanya, MD, and Girish P. Joshi, MD


Growth of Hospital Medicine
Hospitalists in North America
Number of Hospitalists
40000
35000
30000
25000
20000
15000
10000
5000
0
1,000
3,500
7,000
11,200
16,400
20,200
30,000
1997
1999
2001
2003
2005
2007 (projected)
2010 (projected)
Year

Possible par un autre médecin

Chirurgien: non en France

Généraliste ou « hospitaliste »

Utile pour nous?

Anesthesiology
1996; 84:712–5

Anesthesia and Perioperative Medicine

A Department of Anesthesiology Changes Its Name

Calvert C. Alpert, M.D., Joanne M. Conroy, M.D.,† Raymond C. Roy, Ph.D., M.D.‡*

ON August 11, 1995, the board of trustees of the Medical University of South Carolina approved changing the name of the Department of Anesthesiology to the Department of Anesthesia and Perioperative Medicine. The impetus to include perioperative medicine in our name came from five fronts. First, there were the proposals of Greene and Saidman in their respective 31st and 33rd Rovenstine lectures at the 1992 and 1994 annual meetings of the American Society of Anesthesiologists (ASA) that a name change for the specialty was in order. Greene believed that anesthesia had moved from a defining term for the profession to a confining one. To make the point that many of us were involved in much more than anesthetic administration, he took the intellectual if not esoteric tack of creating a new word, metesthesia, which he defined as everything we do.[1] Saidman, although recognizing the merit in Greene's observation, suggested dropping all derivatives of the term "anaesthesia." He proposed perioperative medicine and pain management as a term that unambiguously described the full extent of our activities.[2]

Second, there was the fear that external economic pressure would soon be exerted on us to "right-size" our department. By assuming greater responsibility for more aspects of the system that cares for the surgical patient, we become the right people to keep around to manage the delivery of perioperative care. In the current fee-for-service system, there is a financial disincentive to spend nonrevenue-generating time performing tasks outside the operating room that are essential to the delivery of quality anesthesia care and for which we are legally and ethically held accountable. When global or capitated fee systems become the norm, we no longer want our share to be based solely on anesthesia time and the performance of specific psychomotor tasks. We want to be reimbursed for our decisions on what should be done and for our management of the consequences of these decisions. Surgeons and internists will be more than willing to accept our activities in this area when they realize (1) we are reducing their "at risk" costs, (2) they must see more patients in the operating room and clinic, and (3) they are no longer being reimbursed fee-for-service for reading electrocardiograms, providing consults, and managing patient-controlled analgesia. As Rosenthal stated, "With the many changes in health care delivery, the future survival of anesthesiology as a specialty may well depend on the acceptance that perioperative involvement, rather than sole intraoperative anesthesia practice, is the purview of the anesthesiologists."[3]

Third, there was the appreciation of the more subtle contributions of anesthesia to perioperative mortality and morbidity.[4] When Yeager *et al.* compared epidural-general with epidural analgesia and general with par-

Intérêt à court terme discutable

Intérêt à moyen terme sure et certain

Médecine péri-opératoire

- Vrai problème médical
- Notre responsabilité
- Notre intérêt

Pièges?

- **Absence de règles du jeu**
- **Petite main du chirurgien**
- **Discontinuité de l'équipe d'anesthésie**
- **Gestion désorganisée des spécialistes consultés**

Nécessité d’une charte

PROPOSITION DE PRISE EN CHARGE MÉDICO-CHIRURGICALE DANS LES SERVICES DE CHIRURGIE

A compter du 1° avril 2012, un anesthésiste sera affecté chaque semaine au pôle III et IV,

L’anesthésiste prend en charge:

• L'analgésie postopératoire.
• La transfusion sanguine et l’hémovigilance
• Les soins médicaux liés au terrain et les traitements spécifiques (ex : AVK, antiagrégants plaquettaires, diabétologie, cardiologie…)
• La prévention de la maladie thromboembolique (mise en place et suivi du traitement)
• L'antibiothérapie en collaboration avec l'équipe chirurgicale et/ou le médecin interniste.
• Tout problème relevant de sa compétence d'anesthésiste réanimateur
• Les consultations d’anesthésie pour reprise chirurgicale: le chirurgien informant directement l’anesthésiste et le cadre du bloc opératoire du type de chirurgie et de la date de l’intervention
• Les effets secondaires ou indésirables en relation avec l'anesthésie réanimation.

L’équipe chirurgicale prend en charge:

• Le diagnostic et le traitement de toute pathologie liée au traumatisme ou à l’accident : osseuse, digestive, urologique, vasculaire, cranio- rachidienne, maxillo-facial, ophtalmo, orl …
• Elle apporte son concours à la prise en charge des problèmes chirurgicaux intercurrents non liés au motif d’hospitalisation mais susceptibles de survenir au décours de l’hospitalisation (ex : syndrome abdominal aigu, ischémie aiguë…)
• Le dépistage et le diagnostic de la maladie thromboembolique. La mise en place du traitement curatif de la maladie thromboembolique confirmée, pourra être prescrit par le chirurgien ou par l’anesthésiste à la demande du chirurgien.
• Le dépistage d’éventuels problèmes médicaux intercurrents pendant l’hospitalisation du patient. Il peut les prendre en charge s’il le souhaite

Les Prescriptions médicales :

Lors de la visite préopératoire, l’anesthésiste reporte et valide l’ensemble des traitements en cours du patient sur le dossier informatique.
Au cours de l’hospitalisation le renouvellement des prescriptions et/ou sa modification est assuré par l’équipe chirurgicale.
Lors de la sortie du patient, l’ordonnance de sortie est assurés par l’équipe chirurgicale.

- Absence de règles du jeu
- Petite main du chirurgien
- Discontinuité de l’équipe d’anesthésie
- Gestion désorganisée des spécialistes consultés
- **Financement**

Surveillance continue

- 1 IDE/ 6 patients
- IGS 2 > 15 (sans âge)
- 260 €/jour privé
- 326 €/jour public

Tableau I. a. Score IGS II, d'après [13]

Variable	26	13	12	11	9	7	6	5	4	3	2	0	1	2	3	4	6	7	8	9	10	12	15	16	17	18
Age (an)												40						40-59				6069	7074	7579		> 80
FC (b · min-1)				40												120-159		> 160								
PAS (mmHg)		> 70						7099				100120		> 200												
T (°C)												< 39			> 39											
PaO2/FIO2 Si VA/CPAP				< 100	100-99		> 200																			
Diurèse L · j-1			< 0,5						0,5-0,99			1														
Urée mmol · L-1g · L-1												< 10 0,6					10-29,90,6-1,79				> 30> 1,8					
Globules blancs /1 000			< 1,0									1,0-19,9			> 20											
Kaliémie mmol · -1										< 3		,0-4,9			> 5											
Natrémie mmol · L-1								< 125				125-144	145													
HCO3 mmol · L-1							< 15			15-19		20														
Bilirubine mmol · L-1mg · L-1												< 68,4< 40				68,4102				> 102> 60						
Glasgow (points)	< 6	6 à 8				9 à 10						14-15														
Maladie chroniques																				Métastases	Hématologie				sida	
Type d'admission												Chirurgie programmée					Médical		Chirurgie urgente							
Total																										

Ne pas nous endormir sur nos lauriers

- Baisse mortalité per-opératoire
- Paiement à l'acte
- Pénurie d'anesthésiste: surcote

Les règles du jeu peuvent changer

- Baisse mortalité per-opératoire: et le postop?
- Paiement à l'acte: paiement par pathologie
- Pénurie d'anesthésiste: surcote: évolution à 5 ans

Médecine péri-opératoire

- Vrai problème médical
- Notre responsabilité
- Notre intérêt
- Faire charte
- Mettre en place des unités de surveillance continue