LE CONSULENZE NEUROLOGICHE URGENTI … IN MEDICINA

FRANCESO COREA - NEUROLOGIA, FOLIGNO

Disclosures: none

2007—> 2020 MEDICINA GENERALE

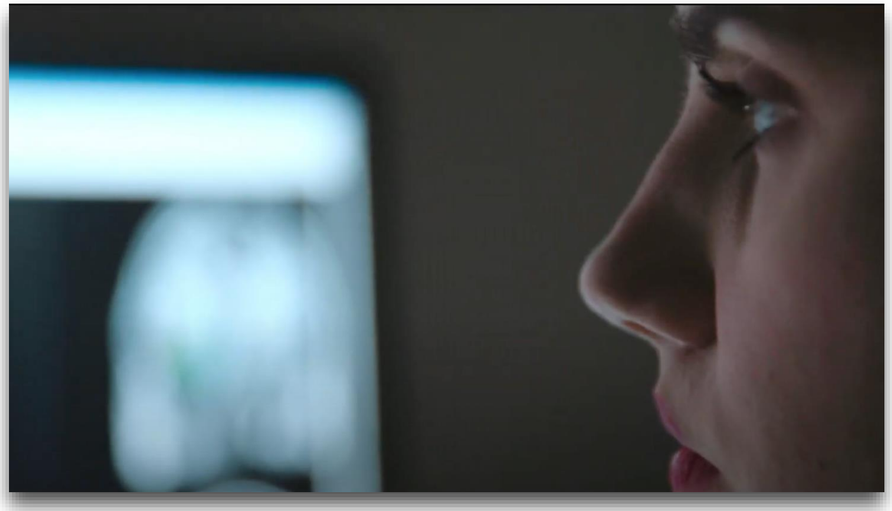
Posti letto 30.590
Ricoveri 1.109.921
Giornate di degenza 10milioni
Degenza media 9,1
Utilizzo posti letto 91,8

-20% nel 2020 posti letto (24mila)
Ricoveri 700mila
Giornate 7 milioni
Degenza media 10
Utilizzo posti letto 87%

Conosci il neurologo, proteggi il tuo cervello.

FONDAZIONE SOCIETÀ ITALIANA DI NEUROLOGIA
Sin

Sin
SOCIETÀ ITALIANA DI NEUROLOGIA



aanbrain · Segui già

aanbrain Yes, Dr. Glaucomflecken, we will cover neuro-ophthalmology at #AANAM, but we didn't forget about ALL the OTHER subspecialties of neurology!

March 17 is the last day to save with advance registration discounts. Visit the link in our bio to learn more and to complete your registration.

#Neurology #Neurologist #NeurologyResident #Neuro #Neuroscience #Neurological #AANscience #NeurologyRF #AANadvocacy #NeurologyProud

22 sett. Visualizza traduzione

neurodrcorrea 👀... probably

Piace a **aconp_vcomcc** e **altri**

MARZO 15

Aggiungi un commento... Pubblica

Will Flanary, MD

NEUROLOGICAL PATIENT CARE IN EMERGENCY DEPARTMENTS. A REVIEW OF THE CURRENT SITUATION IN SPAIN

Neuologia. 2011 May;26(4):233-8. doi: 10.1016/j.nrl.2010.07.033. Epub 2010 Nov 30.

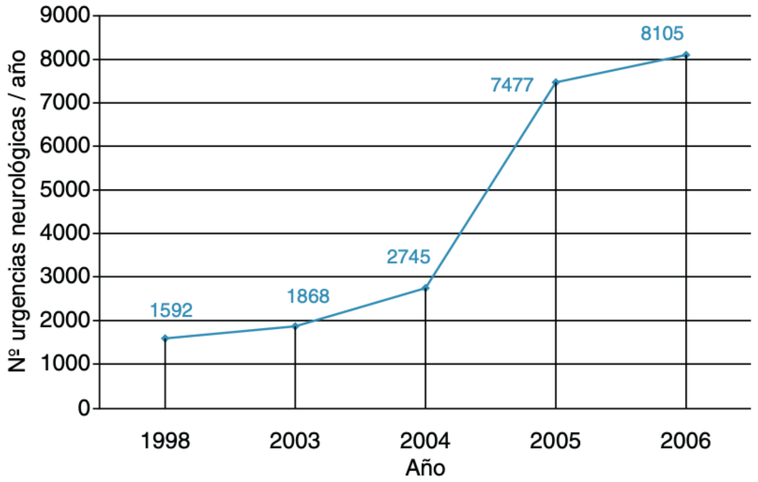


Figura 1 Cifras publicadas de urgencias neurológicas atendidas, anualmente, en diferentes hospitales españoles (los años 2005 y 2006 corresponden al mismo centro hospitalario[6]) a lo largo de los últimos años[5–13].

MOTIVI - IPOTESI

	Motivo consulenza neurologo	N	%
	Deficit neurologici focali	210	20.98
	Cefalea	127	12.69
2	Perdita transitoria di coscienza	127	12.69
	Deficit di forza/o disturbi sensitivi	114	11.39
	Vertigini	91	9.09
1	Manifestazione epilettica	88	8.79
	Delirium/stato confusionale acuto	74	7.39
	Trauma cranico	51	5.09
	Disturbi acuti della visione	45	4.50
	Dolori muscolari	18	1.80
	Coma	15	1.50
3	Febbre e segni neurologici	13	1.30
	Para/tetraplegia	11	1.10
	Disturbi del movimento (iper o ipociniesie)	10	1.00
	Disturbi funzionali/psichiatrici	7	0.70

EMERGENCY DEPARTMENT CONSULTATIONS FOR PATIENTS WITH NEUROLOGICAL EMERGENCIES

Table 1 Chief complaints of consulted patients[a]

	Number (%)	95% CI	
Focal weakness	110 (22.0)	18.3	25.7
Headache	91 (18.2)	14.7	21.7
Dizziness/vertigo	80 (16.0)	12.7	19.3
Seizure	71 (14.2)	11.1	17.3
Focal sensory changes	69 (13.8)	10.7	16.9
AMS/coma/lethargy	63 (12.6)	9.6	15.6
Speech difficulties	53 (10.6)	7.8	13.4
Visual changes	39 (7.8)	5.4	10.2
Back pain	27 (5.4)	3.4	7.4
Other[b]	73 (14.6)	5.7	10.7

European Journal of Neurology 2011, 18: 1317–1322 doi:10.1111/j.1468-1331.2011.03390.x

MOTIVI - IPOTESI

Ipotesi diagnostica	N	%
Ictus ischemico	163	16.28
Attacco ischemico transitorio	95	9.49
Cefalea primaria	84	8.39
Crisi epilettica in epilessia nota	58	5.79
Sincope cardiogena	57	5.69
Vertigine periferica	57	5.69
Prima crisi epilettica	54	5.39
Trauma cranico	45	4.50
Mono-radiculo-plessopatia	43	4.30
Cefalea sintomatica	36	3.60
Disturbo psichiatrico	36	3.60
Delirium in demenza	32	3.20
Vertigine centrale	30	3.00
Sincope neurogena	29	2.90
Encefalopatia metabolica	21	2.10

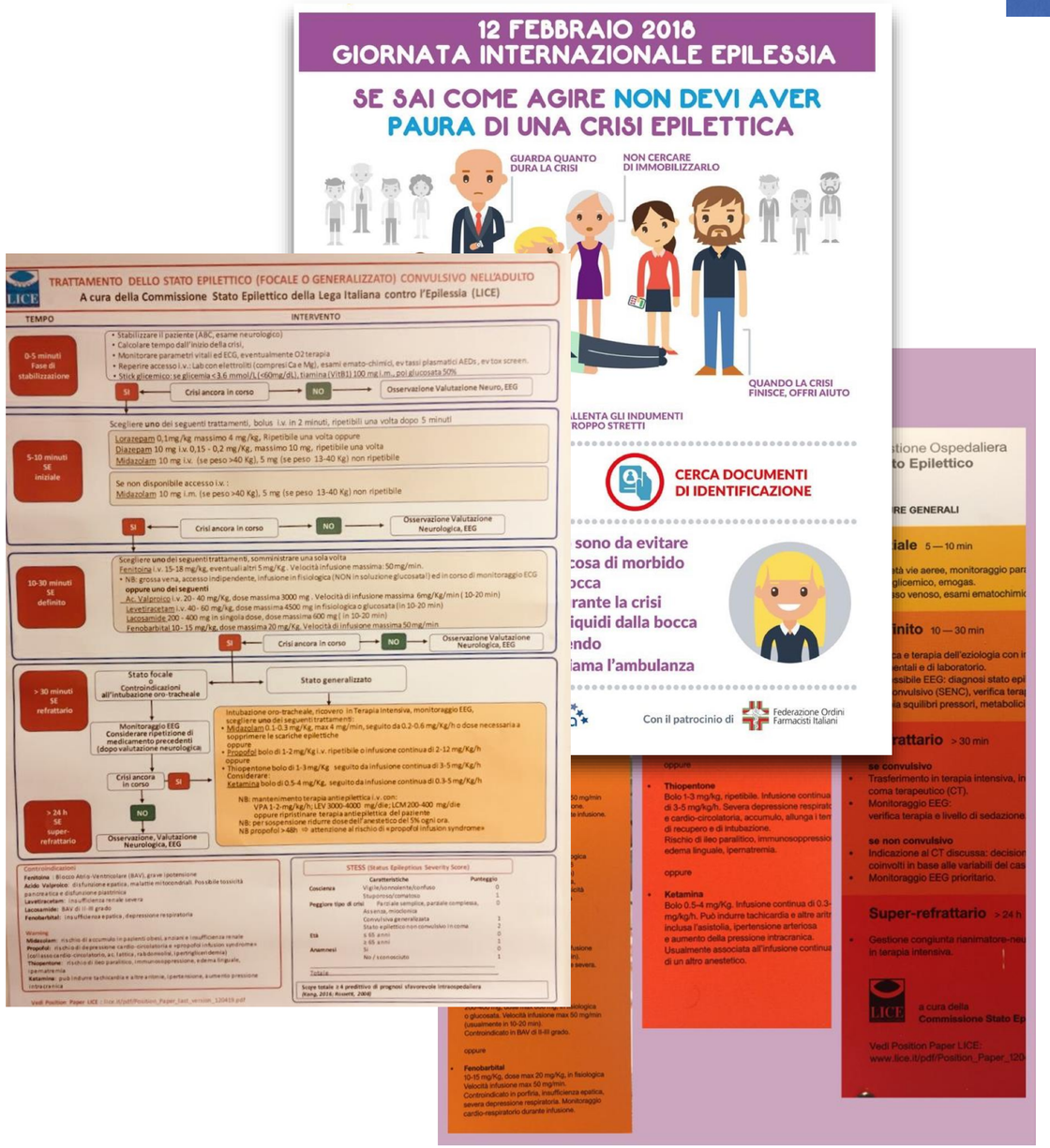
EPIDEMIOLOGY AND OUTCOMES OF STATUS EPILEPTICUS

Table 1

Worldwide Incidence of Status Epilepticus

Incidence of Status Epilepticus in Various Studies and Countries				
Authors	**Nation**	**Study Design**	**Incidence**	**Population**
DeLorenzo et al 1996[11]	U.S.A.	Prospective	41/100.000	Any age
Hesdorffer et al 1998[12]	U.S.A.	Retrospective	18.3/100.000	Any age
Jallon et al 1999[10]	Switzerland	Prospective	16.3/100.000	Any age
Coeytaux et al 2000[3]	Switzerland	Prospective	9.9/100.000	Any age
Knake et al 2001[8]	Germany	Prospective	15/100.000	Any age
Vignatelli et al 2003[5]	Italy	Prospective	13.1/100.000	Adults
Vignatelli et al 2005[6]	Italy	Prospective	15/100.000	Adults
Govoni et al 2008[7]	Italy	Retrospective	27.2/100.000	Any age
Sadarangani et al 2008[16]	Kenya	Prospective	35/100.000	Children
Bhalla et al 2014[9]	France	Prospective	8.52/100.000	Any age
Ong et al 2015[14]	Taiwan	Retrospective	4.6/100.000	Any age
Tiamkao et al 2015[13]	Thailand	Retrospective	5.2/100.000	Any age
Bergin et al 2019[17]	Auckland	Retrospective	29.3/100.000	Any age
Leitinger et al 2019[18]	Austria	Retrospective	36.1/100.000	Adults
Rodin et al 2021[4]	Denmark	Prospective	10.7/100.000	Adults
Vijiala et al 2021[72]	Switzerland	Prospective	8.6/100.000	Adults

Michele Ascoli,1,2 Edoardo Ferlazzo,1,2 Sara Gasparini,1,2 Giovanni Mastroianni,2 Rita Citraro,3 Roberta Roberti,3 and Emilio Russo3 Int J Gen Med. 2021; 14: 2965–2973.


12 FEBBRAIO 2018
GIORNATA INTERNAZIONALE EPILESSIA
SE SAI COME AGIRE NON DEVI AVER
PAURA DI UNA CRISI EPILETTICA
GUARDA QUANTO DURA LA CRISI
NON CERCARE DI IMMOBILIZZARLO
QUANDO LA CRISI FINISCE, OFFRI AIUTO
CERCA DOCUMENTI DI IDENTIFICAZIONE
Con il patrocinio di
Federazione Ordini Farmacisti Italiani
TRATTAMENTO DELLO STATO EPILETTICO (FOCALE O GENERALIZZATO) CONVULSIVO NELL'ADULTO
A cura della Commissione Stato Epilettico della Lega Italiana contro l'Epilessia (LICE)
TEMPO
INTERVENTO
0-5 minuti Fase di stabilizzazione
5-10 minuti SE iniziale
10-30 minuti SE definito
> 30 minuti SE refrattario
> 24 h SE super-refrattario
Lorazepam 0,1mg/kg massimo 4 mg/kg, Ripetibile una volta oppure
Diazepam 10 mg i.v. 0,15 - 0,2 mg/Kg, massimo 10 mg, ripetibile una volta
Midazolam 10 mg i.v. (se peso >40 Kg), 5 mg (se peso 13-40 Kg) non ripetibile
Se non disponibile accesso i.v. :
Midazolam 10 mg i.m. (se peso >40 Kg), 5 mg (se peso 13-40 Kg) non ripetibile
Fenitoina 15-18 mg/kg, eventuali altri 5 mg/Kg. Velocità infusione massima: 50 mg/min.
oppure uno dei seguenti
Ac. Valproico 20 - 40 mg/Kg, dose massima 3000 mg. Velocità di infusione massima 6mg/Kg/min (10-20 min)
Levetiracetam 40 - 60 mg/kg, dose massima 4500 mg in fisiologica o glucosata (in 10-20 min)
Lacosamide 200 - 400 mg in singola dose, dose massima 600 mg (in 10-20 min)
Fenobarbital 10 - 15 mg/kg, dose massima 20 mg/Kg. Velocità di infusione massima 50 mg/min
Crisi ancora in corso
Osservazione Valutazione Neurologica, EEG
Stato focale o Controindicazioni all'intubazione oro-tracheale
Stato generalizzato
Monitoraggio EEG
Considerare ripetizione di medicamento precedenti (dopo valutazione neurologica)
Intubazione oro-tracheale, ricovero in Terapia intensiva, monitoraggio EEG,
Midazolam 0.1-0.3 mg/Kg, max 4 mg/min, seguito da 0.2-0.6 mg/Kg/h o dose necessaria a sopprimere le scariche epilettiche
Propofol bolo di 1-2 mg/Kg i.v. ripetibile o infusione continua di 2-12 mg/Kg/h
Thiopentone bolo di 1-3 mg/Kg seguito da infusione continua di 3-5 mg/Kg/h
Considerare:
Ketamina bolo di 0.5-4 mg/Kg, seguito da infusione continua di 0.3-5 mg/Kg/h
NB: mantenimento terapia antiepilettica i.v. con:
VPA 1-2 mg/kg/h; LEV 3000-4000 mg/die; LCM 200-400 mg/die
oppure ripristinare terapia antiepilettica del paziente
NB: per sospensione ridurre dose dell'anestetico del 5% ogni ora.
NB propofol >48h -> attenzione al rischio di «propofol infusion syndrome»
Osservazione, Valutazione Neurologica, EEG
STESS (Status Epilepticus Severity Score)
Caratteristiche
Punteggio
Coscienza
Vigile/sonnolente/confuso
Stuporoso/comatoso
Peggiore tipo di crisi
Parziale semplice, parziale complessa, Assenza, mioclonia
Convulsiva generalizzata
Stato epilettico non convulsivo in coma
Età
≤ 65 anni
≥ 65 anni
Anamnesi
Sì
No / sconosciuto
Totale
Scipe totale ≥ 4 predittivo di prognosi sfavorevole intraospedaliera (Rang, 2016; Rossetti, 2006)
Vedi Position Paper LICE
Gestione Ospedaliera
to Epilettico
RE GENERALI
iale 5 — 10 min
inito 10 — 30 min
rattario > 30 min
se convulsivo
Trasferimento in terapia intensiva, in coma terapeutico (CT).
Monitoraggio EEG: verifica terapia e livello di sedazione
se non convulsivo
Indicazione al CT discussa: decision coinvolti in base alle variabili del cas
Monitoraggio EEG prioritario.
Super-refrattario > 24 h
Gestione congiunta rianimatore-neu in terapia intensiva.
a cura della Commissione Stato Ep
Vedi Position Paper LICE:
www.lice.it/pdf/Position_Paper_120
Thiopentone
Bolo 1-3 mg/kg, ripetibile. Infusione continua di 3-5 mg/kg/h. Severa depressione respirat e cardio-circolatoria, accumulo, allunga i te di recupero e di intubazione.
Rischio di ileo paralitico, immunosoppressio edema linguale, ipernatremia.
oppure
Ketamina
Bolo 0.5-4 mg/Kg. Infusione continua di 0.3- mg/kg/h. Può indurre tachicardia e altre arit inclusa l'asistolia, ipertensione arteriosa e aumento della pressione intracranica. Usualmente associata all'infusione continua di un altro anestetico.
oppure
Fenobarbital
10-15 mg/Kg, dose max 20 mg/Kg, in fisiologica
Velocità infusione max 50 mg/min.
Controindicato in porfiria, insufficienza epatica, severa depressione respiratoria. Monitoraggio cardio-respiratorio durante infusione.

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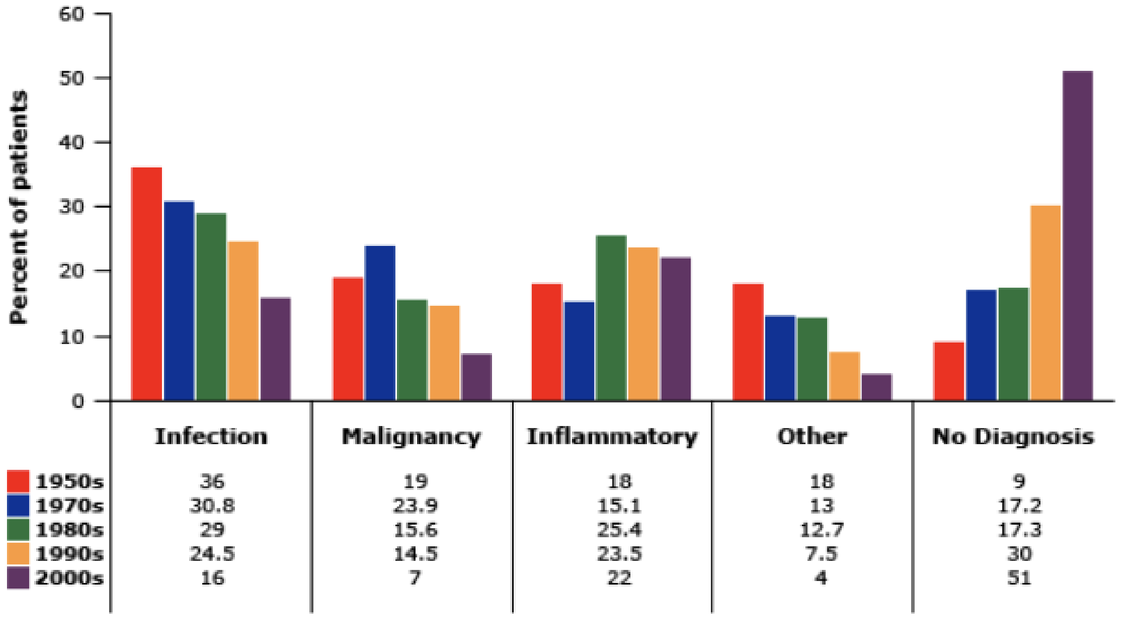
	Disturbi funzionali/psichiatrici	7	0.70

FUO …

The percentage of patients with fever of unknown origin by cause during four decades



	Infection	Malignancy	Inflammatory	Other	No Diagnosis
1950s	36	19	18	18	9
1970s	30.8	23.9	15.1	13	17.2
1980s	29	15.6	25.4	12.7	17.3
1990s	24.5	14.5	23.5	7.5	30
2000s	16	7	22	4	51

Adapted from: Mourad O, Palda V, Detsky AS. Arch Intern Med 2003; 163:545.

Articles

Biofire FilmArray Meningitis/Encephalitis panel for the aetiological diagnosis of central nervous system infections: A systematic review and diagnostic test accuracy meta-analysis

Juliana Trujillo-Gómez,[a,b,c] Sofia Tsokani,[d] Catalina Arango-Ferreira,[a,b] Santiago Atehortúa-Muñoz,[e,f] Maria José Jimenez-Villegas,[a,b] Carolina Serrano-Tabares,[a,e] Areti-Angeliki Veroniki,[g] and Ivan D. Florez[a,h,i,]*

Interpretation FA/ME may have acceptable-to-high sensitivities and high specificities for identifying bacteria, especially for *S.pneumoniae*, and viruses, especially for HSV-2, and enteroviruses. Sensitivities for L.*monocytogenes*, *H. influenzae*, *E.coli*, and HSV-1 were suboptimal.

FUO...

Table I. Causes of fever of unknown origin in adults [modified from Cunha *et al*. 2015 (54)].

Main causes of classic FUO in adults			
Infections	NIID	Malignancy	Miscellaneous
Bacterial 1. Subacute endocarditis 2. Abdominal, pelvic and renal abscess 3. Spondylodiscitis 4. Chronic prostatitis 5. Periapical dental abscess 6. Vascular graft infection 7. Extrapulmonary and miliary tuberculosis 8. Typhoid fever 9. Bartonellosis 10. Borreliosis 11. Brucellosis 12. Non-tuberculous mycobacteria 13. Q fever 14. Whipple disease 15. Actinomycosis 16. Syphilis 17. Listeriosis *Viral* 1. CMV 2. EBV 3. Multicentric Castleman's disease *Fungal* 1. Histoplasmosis (disseminated) *Parasitic* 1. Visceral leishmaniosis 2. Malaria 3. Toxoplasmosis 4. Amoebic abscess	1. AOSD 2. Polymyalgia rheumatica/giant vessels arteritis 3. Sarcoidosis 4. Polyarteritis nodosa 5. Systemic lupus erythematous 6. Rheumatoid arthritis 7. Small vessels vasculitis 8. Takayasu's arteritis 9. Kikuchis' disease 10. Polyarticular gout 11. Behçet's disease 12. Late-onset rheumatoid arthritis	1. Lymphoma (HL, NHL) 2. Solid tumours (renal cell carcinoma, hepatocellular carcinoma, tumour metastatic to the liver) 3. Myelodysplastic syndrome 4. Leukaemia 5. Atrial myxoma 6. CNS tumours	1. De Quervain thyroiditis 2. Drug fever 3. Factitious fever 4. Inflammatory bowel diseases 5. Sweet syndrome 6. Deep vein thrombosis/pulmonary embolism 7. Hypersensitivity pneumonia 8. Schnitzler syndrome 9. Hemophagocytic syndrome *Hereditary AutoInflammatory Diseases (AIDs)* 1. Familial Mediterranean fever (FMF) 2. Tumour necrosis factor receptor-associated periodic syndrome (TRAPS) 3. Cryopyrin-associated periodic syndromes (CAPS) 4. Mevalonate kinase deficiency (MKD)

AOSD: Adult onset Still's disease; CMV: cytomegalovirus; EBV: Epstein-Barr virus; FUO: fever of unknown origin; HL: Hodgkin's lymphoma; NHL: non-Hodgkin's lymphoma; NIID: non-infectious inflammatory diseases.

SINCOPE

Europace Advance Access published June 24, 2015

Europace
doi:10.1093/europace/euv115

EHRA POSITION PAPER

Syncope Unit: rationale and requirement – the European Heart Rhythm Association position statement endorsed by the Heart Rhythm Society

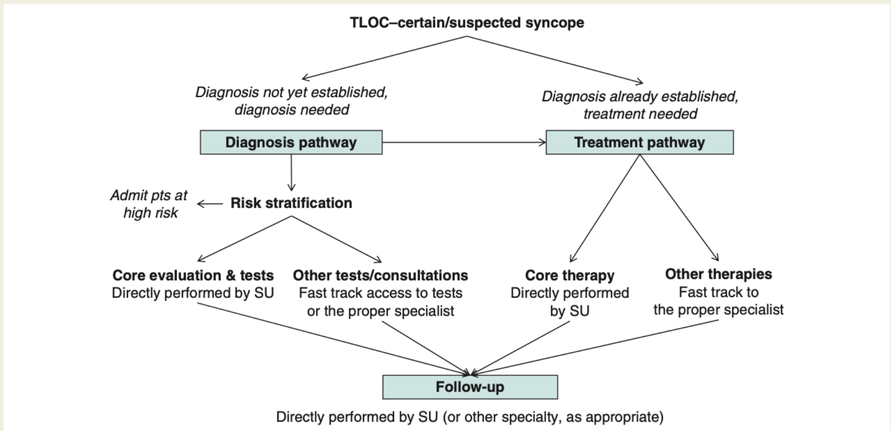


Figure 1 Framework for a comprehensive management of patients with T-LOC of certain/suspected syncopal nature referred to the SU. Core evaluation and therapy depend on each model of care delivery, with a minimum acceptable set described in *Consensus Statement 1*.

Circulation
Volume 136, Issue 5, 1 August 2017; Pages e60-e122
https://doi.org/10.1161/CIR.0000000000000499

American Heart Association.

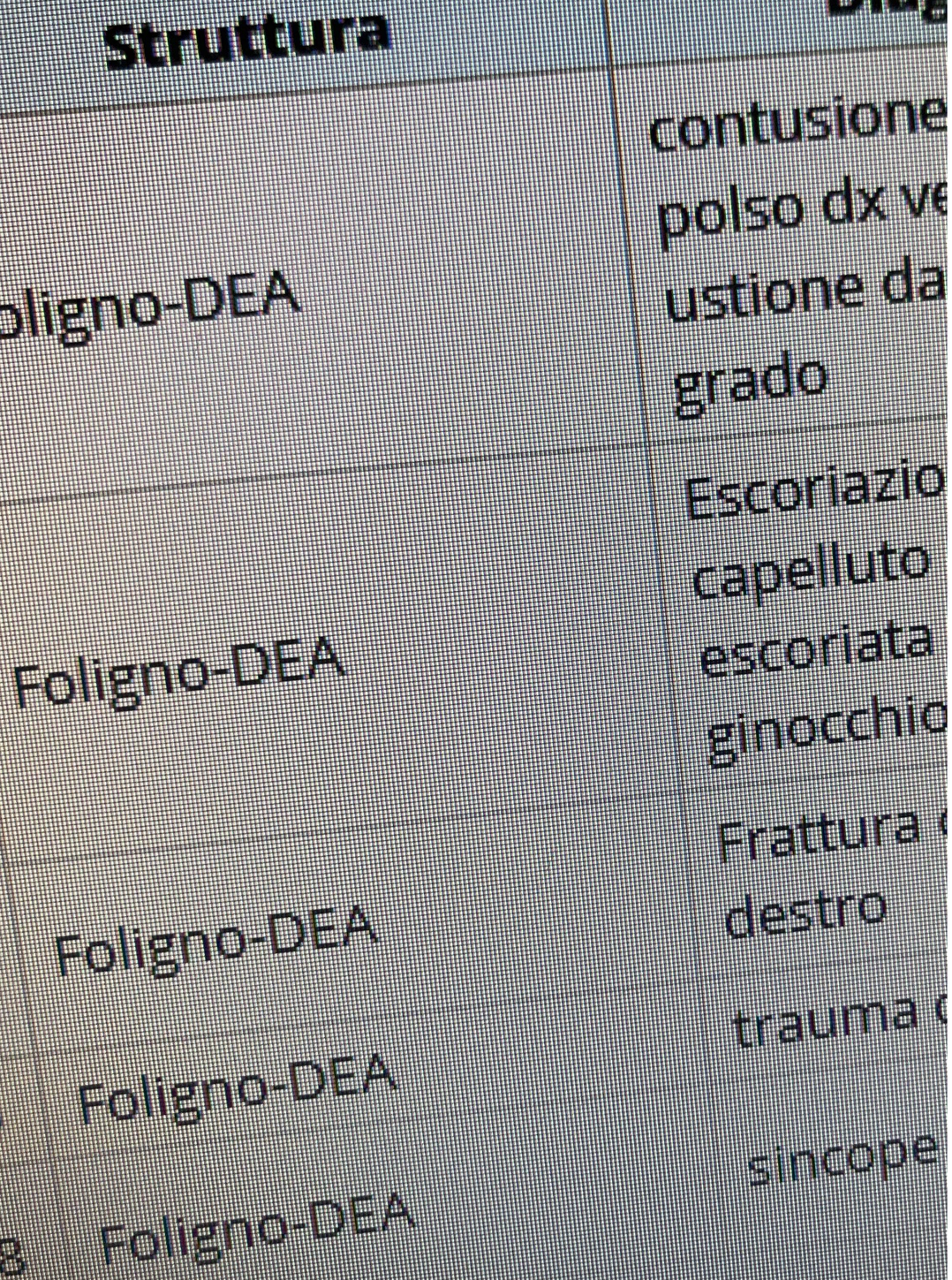
CLINICAL STATEMENTS AND GUIDELINES

2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients With Syncope: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society

A systematic review found that EEG, CT, MRI, and carotid ultrasound were ordered in 11% to 58% of patients with a presentation of syncope.[78] The evidence suggests that routine neurological testing is of very limited value in the context of syncope evaluation and management; the diagnostic yield is low, with very high cost per diagnosis.

Recommendations for Neurological Diagnostics (Table view)

COR	LOE	Recommendations
IIa	C-LD	**Simultaneous monitoring of an EEG and hemodynamic parameters during tilt-table testing can be useful to distinguish among syncope, pseudosyncope, and epilepsy.[229,261–263]**
See Online Data Supplement 16.		Although a thoughtful and detailed history usually suffices to distinguish among convulsive syncope, epileptic convulsions, and pseudosyncope, an EEG is particularly important when a diagnosis cannot be established after a thorough initial evaluation. EEG findings are characteristic if an episode can be induced during the tilt-table testing.[261–263] Epileptiform discharges are recorded during epileptic convulsions whereas, during syncope, an EEG generally shows diffuse brainwave slowing with delta waves and a flat line pattern.[263] Pseudosyncope and psychogenic nonepileptic seizures are associated with a normal EEG.[229]
III: No Benefit	B-NR	**MRI and CT of the head are not recommended in the routine evaluation of patients with syncope in the absence of focal neurological findings or head injury that support further evaluation.[78,260]**
See Online Data Supplement 16.		Syncope is due to global cerebral hypoperfusion, and brain structural abnormalities are rare. Nonetheless, MRI and CT are frequently used and infrequently helpful. In 5 studies investigating patients with syncope, MRI was used in 11% of 397 patients and established a diagnosis in only 0.24%. Similarly, in 10 studies of investigation of syncope, CT was used in 57% of 2728 patients and established a diagnosis in only 1%.[77,78,256,257,260] Given the cost and impact on health service facilities, MRI and CT should not be routinely used in the assessment of syncope. Neurological imaging may be indicated if significant head injury as a result of syncope is suspected. Although there is general concern about potential radiation-mediated harm from CT, there are very limited data on the actual harm from CT for syncope evaluation.
III: No Benefit	B-NR	**Carotid artery imaging is not recommended in the routine evaluation of patients with syncope in the absence of focal neurological findings that support further evaluation.[77,78,256,257,260]**
See Online Data Supplement 16.		Syncope is due to global cerebral hypoperfusion and therefore not to unilateral ischemia. A review of 5 studies of carotid artery ultrasound and Doppler use in patients with syncope found that these modalities were used in 58% of 551 patients and established a diagnosis in 0.5%.[77,78,256,257,260] Carotid artery ultrasound should not be routinely used in the assessment of syncope.
III: No Benefit	B-NR	**Routine recording of an EEG is not recommended in the evaluation of patients with syncope in the absence of specific neurological features suggestive of a seizure.[36,77,254–258]**
See Online Data Supplement 16.		EEGs are ordered frequently for the evaluation of syncope. A review of 7 studies of use of an EEG in patients with syncope found that it was used in 52% of 2084 patients and established a diagnosis in 0.7%.[36,77,254–258] EEGs should not be routinely used in the assessment of syncope.



INDICATORI

Diabete mellito tipo1, tiroidite di hashimoto

-cadute improvvise senza pdc.

-dolori lombari con rigidità arti inferiori.

-GAD +++

MEDICINA

1. Partecipazione (meglio se informale)
2. Integrazione (PDTA, sincope)
3. Comunicazione (poster, pieghevoli)
4. Risorse (filmarray, slot EEG)
5. Aggiornamento (ECM, seminari)

NEUROLOGY: WHERE PASSION FUELS PROMISE