

INQUADRAMENTO E GESTIONE DELLA BPCO RIACUTIZZATA NEL CARDIOPATICO “CRITICO”



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BPCO.....i numeri

Global Initiative for Chronic
Obstructive
Lung
Disease



GLOBAL STRATEGY FOR THE DIAGNOSIS,
MANAGEMENT, AND PREVENTION OF
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
2017 REPORT

COPD is currently the fourth leading cause of death in the world.

COPD is projected to be the 3rd leading cause of death by 2020.

More than 3 million people died of COPD in 2012 accounting for 6% of all deaths globally.

Globally, the COPD burden is projected to increase in coming decades because of continued exposure to COPD risk factors and aging of the population.

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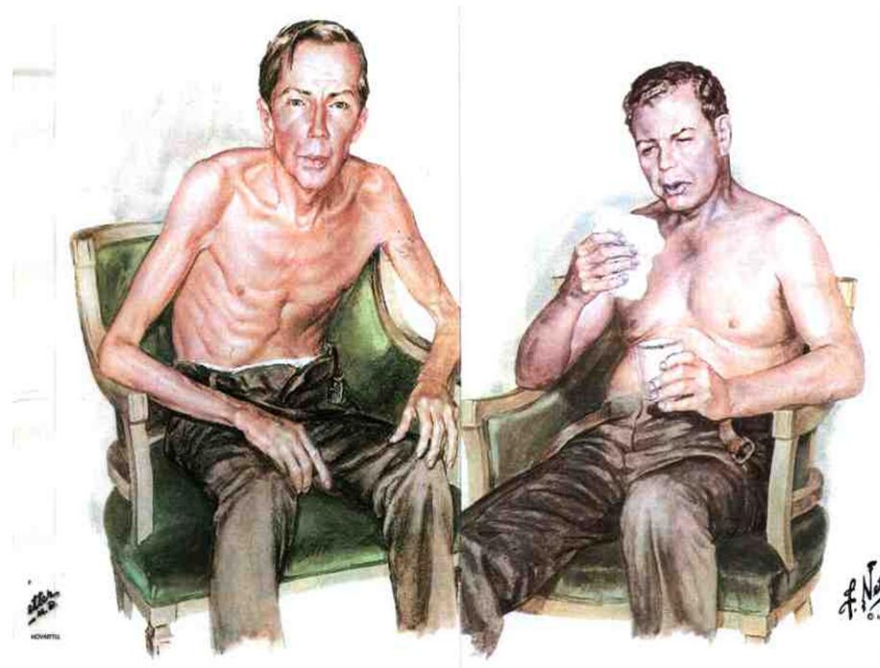
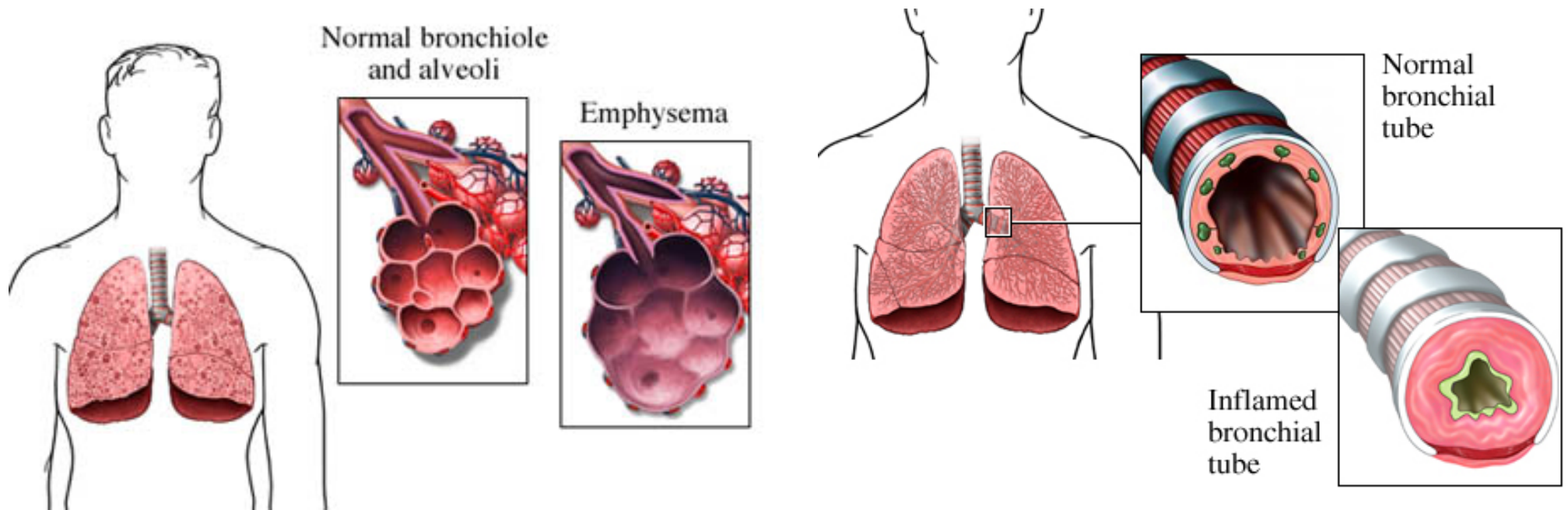
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Estimated 384 million COPD cases in 2010.

Estimated global prevalence of 11.7%.

Higher ≥ 40 year group compared to those < 40

Higher in men than women.



Dyspnea that is:

Progressive over time.
Characteristically worse with exercise.
Persistent.

Chronic cough:

May be intermittent and may be unproductive.
Recurrent wheeze.

Chronic sputum production:

Any pattern of chronic sputum production may indicate COPD.

Recurrent lower respiratory tract infections

History of risk factors:

Host factors (such as genetic factors, congenital/developmental abnormalities etc.).
Tobacco smoke (including popular local preparations).
Smoke from home cooking and heating fuels.
Occupational dusts, vapors, fumes, gases and other chemicals.

Family history of COPD and/or childhood factors:

For example low birthweight. childhood respiratory infections etc.

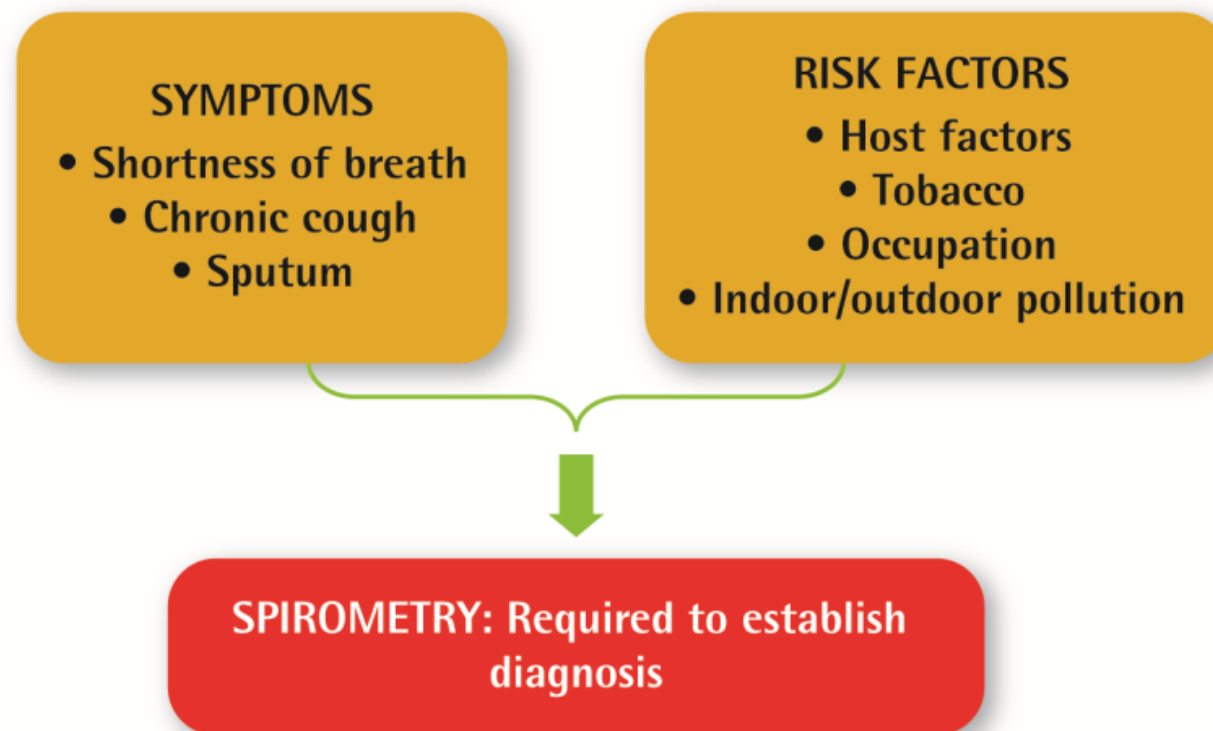


Figure 2.2A. Spirometry – Normal Trace

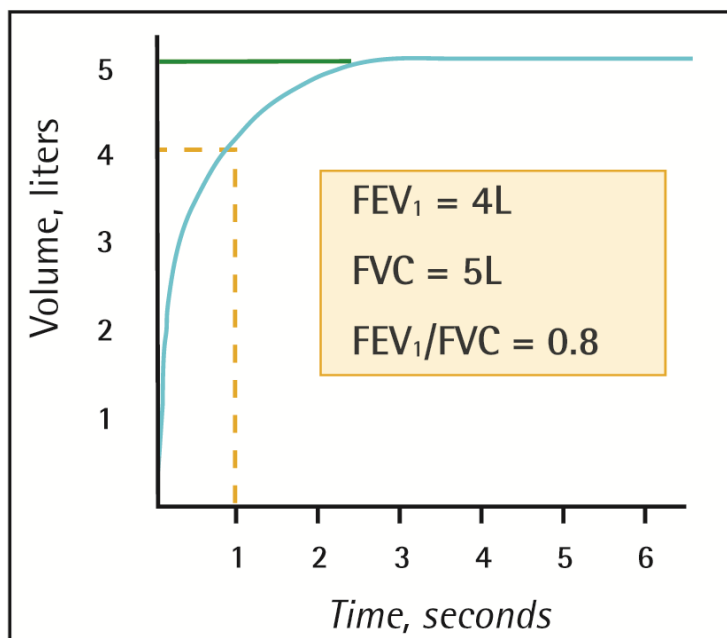
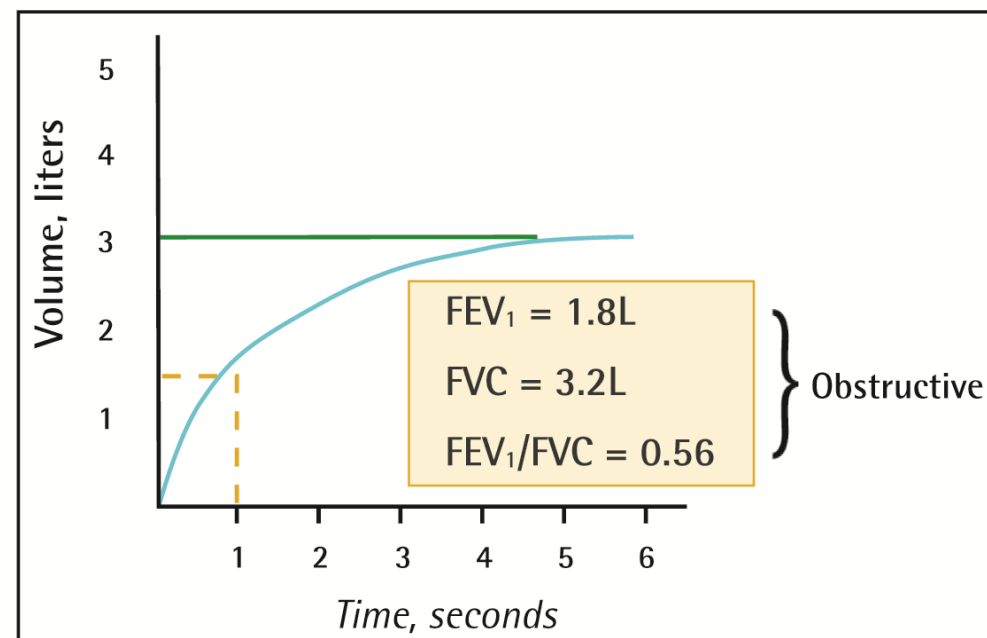


Figure 2.2B. Spirometry – Obstructive Disease



FVC = ———

FEV₁ = - - - - -

Table 2.4. Classification of airflow limitation severity in COPD (Based on post-bronchodilator FEV₁)

In patients with FEV₁/FVC < 0.70:

GOLD 1:	Mild	FEV ₁ ≥ 80% predicted
GOLD 2:	Moderate	50% ≤ FEV ₁ < 80% predicted
GOLD 3:	Severe	30% ≤ FEV ₁ < 50% predicted
GOLD 4:	Very Severe	FEV ₁ < 30% predicted





The war against heart failure: the *Lancet* lecture

Eugene Braunwald

Lancet 2015; 385: 812–24

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Presented at the “At the Limits:

Cardiology, Diabetes,

Nephrology” conference,

London, April 24, 2014

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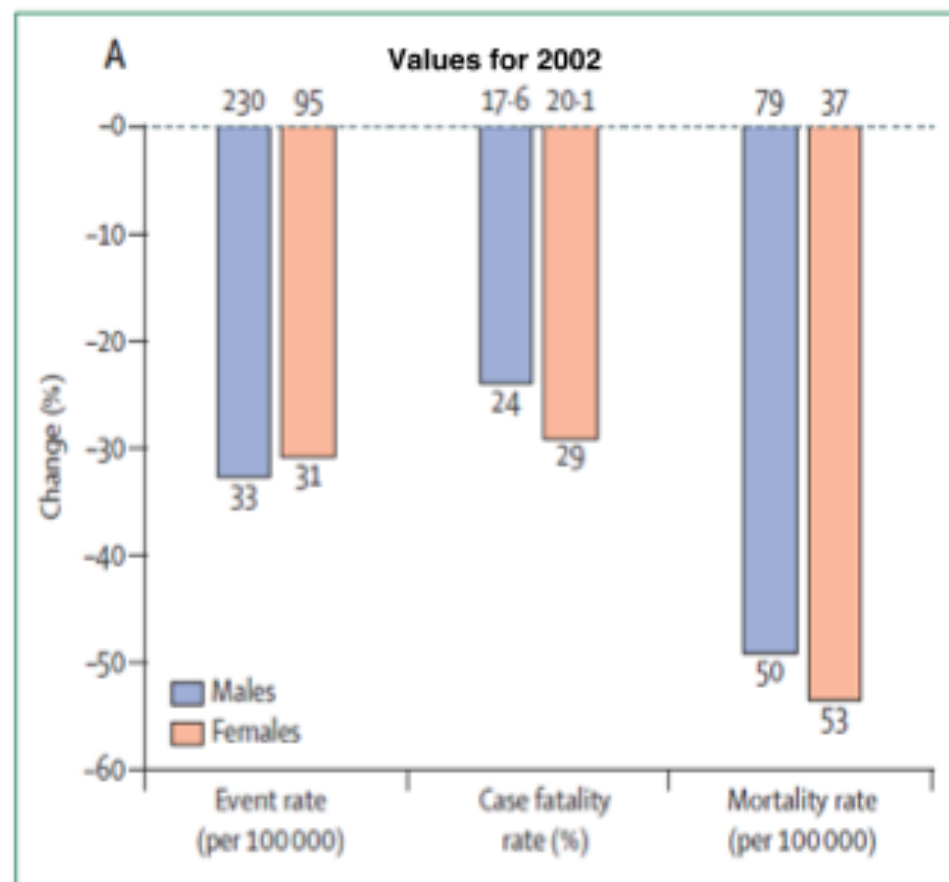
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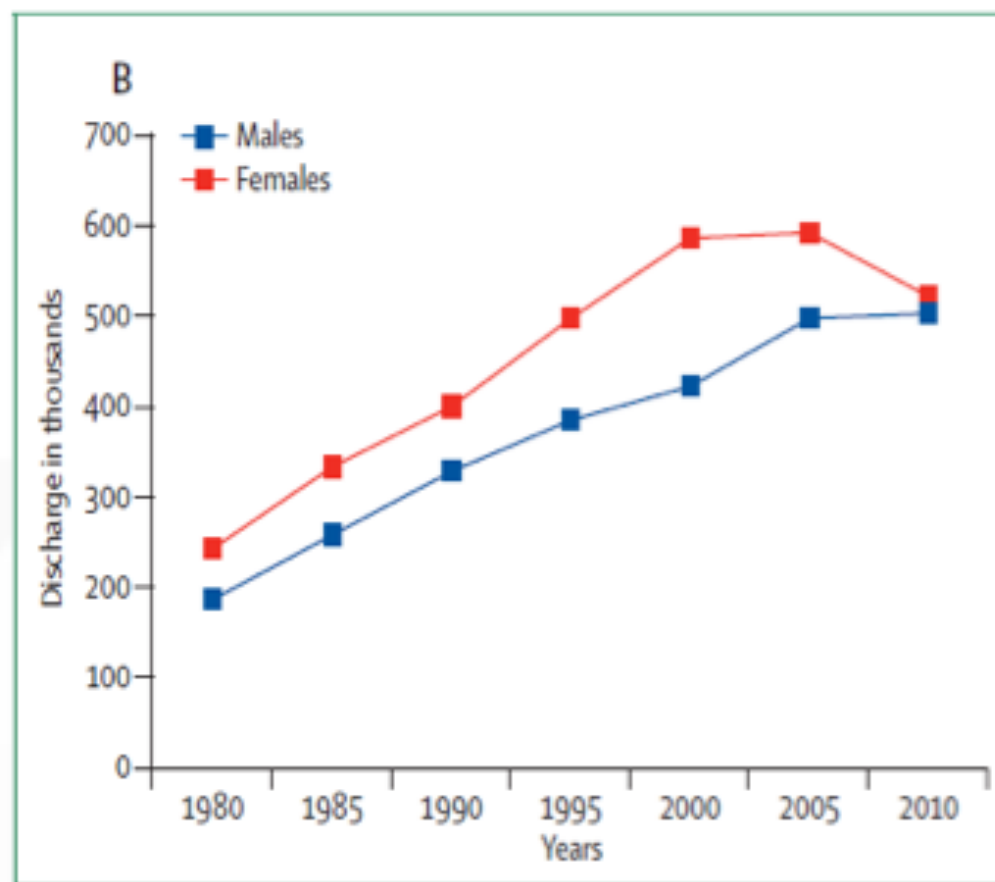
Heart failure is a global problem with an estimated prevalence of 38 million patients worldwide, a number that is increasing with the ageing of the population. It is the most common diagnosis in patients aged 65 years or older admitted to hospital and in high-income nations. Despite some progress, the prognosis of heart failure is worse than that of most cancers. Because of the seriousness of the condition, a declaration of war on five fronts has been proposed for heart failure. Efforts are underway to treat heart failure by enhancing myofilament sensitivity to Ca^{2+} ; transfer of the gene for SERCA2a, the protein that pumps calcium into the sarcoplasmic reticulum of the cardiomyocyte, seems promising in a phase 2 trial. Several other abnormal calcium-handling proteins in the failing heart are candidates for gene therapy; many short, non-coding RNAs—ie, microRNAs (miRNAs)—block gene expression and protein translation. These molecules are crucial to calcium cycling and ventricular hypertrophy. The actions of miRNAs can be blocked by a new class of drugs, antagomirs, some of which have been shown to improve cardiac function in animal models of heart failure; cell therapy, with autologous bone marrow derived mononuclear cells, or autogenous mesenchymal cells, which can be administered as cryopreserved off the shelf products, seem to be promising in both preclinical and early clinical heart failure trials; and long-term ventricular assistance devices are now used increasingly as a destination therapy in patients with advanced heart failure. In selected patients, left ventricular assistance can lead to myocardial recovery and explantation of the device. The approaches to the treatment of heart failure described, when used alone or in combination, could become important weapons in the war against heart failure.

Reduction in Myocardial Infarction in UK from 2002 to 2010



Smolina K et al, *BMJ* 2012; 344: d8059

Hospital discharges for HF In USA from 1980 to 2010



Moran AE et al, *Circulation* 2014; 129: 1493–501.

Ministero della Salute: Rapporto Annuale sui Ricoveri Ospedalieri (anno 2013, pubblicato luglio 2014)

Tavola 2.2.9 - Primi 50 Aggregati clinici di codici (ACC) diagnostici (ICD9CM 2007) per numerosità di dimissioni - Attività per Acuti in Regime ordinario - Anno 2013

RANGO	ACC - AGGREGATI CLINICI DI CODICI DI DIAGNOSI	DIMISSIONI	% SUL TOTALE	% CUMULATA	GIORNATE DI DEGENZA	DEGENZA MEDIA (giorni)
1	0108 Insufficienza cardiaca congestizia, non da ipertensione	192.336	2,9	2,9	1.795.702	9,3
2	0196 Gravidanza e/o parto normale	191.860	2,9	5,8	673.008	3,5
3	0149 Malattie delle vie biliari	161.294	2,4	8,2	1.020.095	6,3
4	0131 Insufficienza respiratoria, arresto respiratorio (adulti)	158.475	2,4	10,6	1.762.802	11,1
10	0144 Azia addominale	113.006	1,7	22,2	357.814	3,1
11	0106 Aritmie cardiache	107.096	1,6	23,8	524.241	4,9
12	0226 Frattura del collo del femore					
13	0045 Chemioterapia e radioterapia					
14	0229 Fratture degli arti superiori					
15	0230 Fratture degli arti inferiori					
16	0211 Altre malattie del tessuto connettivo					
17	0047 Altri e non specificati tumori benigni					
18	0195 Altre complicanze del parto e del puerperio					
19	0205 Spondilosi, patologie dei dischi intervertebrali					
20	0032 Tumori maligni della vescica					
21	0042 Tumori maligni secondari					
22	0225 Disturbi articolari e lussazioni da trauma					
23	0024 Tumori maligni della mammella					
24	0189 Pregresso parto cesareo					
25	0218 Nati vivi sani	58.187	0,9	38,9	301.376	5,2
26	0160 Calcolosi delle vie urinarie	58.186	0,9	39,8	230.851	4,0
27	0134 Altre malattie delle vie respiratorie superiori	55.023	0,8	40,7	156.204	2,8

Consensus Conference Il percorso assistenziale del paziente con scompenso cardiaco

