NECESIDAD DEL CÓDIGO ANEURISMA

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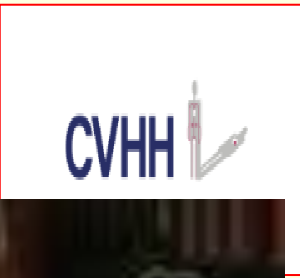
INTRODUCCIÓN



EMERGENCIA!!!!

INTRODUCCIÓN
MORTALIDAD EN EL AAA-r

- Mortalidad elevada en distintas series: 40-60% (1)
- Desde el EVAR se consigue ↓ la mortalidad: 17-24% (2-3)

1.- Dillon M, et als. Endovascular treatment for r-AAA. Cochrane Database Syst Rev. 2007 Jan 24
2.- Rödel SG, et als. Endovascular treatment of r-AAA: is there a long-term benefit at follow-up? J Cardiovasc Surg (Torino). 2012 Feb;53
3.- Mehta M, et als. Establishing a protocol for endovascular treatment of r-AAA: outcomes of a prospective analysis. J Vasc Surg. 2006 Jul;44

INTRODUCCIÓN

- Número de cirugías en el sector aórtico en el Servicio de A. y Cirugía Vascular del HUSC en 2018 ⟷ 2024
  - Total: 78 ⟷ 92 (Programadas+Urgentes)
  - Urgentes: 33 ⟷ 19
  - Técnica Endovascular: 75.78% ⟷ 81.30%

REQUERIMIENTOS PARA EVAR AAAr

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CÓDIGO ANEURISMA I

No perder tiempo

- >50 años
- Dolor lumbar
- Síncope

- Masa pulsatil periumbil.
- AAA conocido
- Ant. familiar

Hipotensión Hemostática

⇓

AAAr mientras no se demuestre lo contrario

⇓

Eco abd/TAC

⇓

Cita prefert. ⇑ AAA no roto ⇐ AAAr ⇒ Otro diagnóstico

⇓

CÓDIGO ANEURISMA

⇐

-**C. Vascular** -Urgencias
-Anestesista -Rx
-Quirófano - UCI

⇒

- Vía venosa periférica
- Analitica y EKG
- Hipotensión hemostática

⇓

Traslado al Hospital Útil

CÓDIGO ANEURISMA II

SOSPECHA

Inestable: UCI en URG. lo lleva al TAC

Estable: Médico de URG. lo lleva al TAC

Llegada al Hospital ÚTIL

Diag. Cierto

AngioTAC: 1mm

Cirugía abierta

EVAR

Anestesia General

Anestesia loco-regional

Traslado a Qx Radiológico 3Q12

No perder tiempo

Hipotensión Hemostática

HIPOTENSIÓN HEMOSTÁTICA

- O2
- Vía venosa periférica
- Control T/A cada 15´
- Respuesta a órdenes verbales

OBJETIVO

Diagnóstico de AAAr

T/A

<80 mmHg

80-90mmHg

>140 mmHg

No respuesta Verbal

Respuesta Verbal

- Fenilefrina:
  50µg en bolos hasta respuesta

- Suero: Bolos 100 cc/30´

No líquidos

- Hipotensores:
  Nitroglicerina:
  0.1 µg/Kg/minuto

evida NET

- Recepción de notificación cuando la planificación esté resuelta, vía e-mail y app móvil.
- Descarga del informe de planificación en formato PDF.

Date of CT Study:	08/08/2017 8:52
Patient I.D.:	
Patient D.O.B.:	21/05/1942 — Patient Sex: (•) Male ( ) Female
CT Slice Thickness:	1.0
Implanting Physician:	HERRERA, JOSE DAMIA
Hospital Name:	
Evaluation Date:	
Procedure Date:	

QTY	Product Code	Remarks
1	ETBF2820C166EE	DERECHA
1	ETBF2816C166EE	IZQUIERDA
1	ETLW1620C124EE	
1	ETLW1616C124EE	

Suprarenal angulation

Infrarenal angulation

DIAM

D1a 25

D1b 27

D2 60

D3 29

D4R 16

D5R 17

D6R 17

D7R 10

L1 24

L2 121

Total Length (mm)

L2 + L3 r = 169 mm

L2 + L3 l = 164 mm

Please consider additional length according to the vessel turtuosity

L3R 48

L3L 42

DIAM

13 D4L

15 D5L

14 D6L

8 D7L

SMA patent ☐ Yes ☐ No	Proximal neck angulation	Proximal neck calcification ☐ Yes ☐ No	IMA patent ☐ Yes ☐ No	Left iliac calcification ☐ Yes ☐ No	Proposed bifur side ☐ Right ☐ Left
Lowest renal artery ☐ Right ☐ Left	Proximal neck thrombus ☐ Yes ☐ No	Lumbar patent ☐ Yes ☐ No	Right iliac calcification ☐ Yes ☐ No	Coil hypo ☐ Right ☐ Left ☐ No	

☐ Not an endovascular candidate

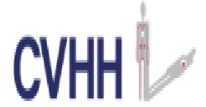
Case Planning Notes: ENDOPROTESIS ABDOMINAL BIFURCADA A ILIACAS COMUNES.

Tiempo Medio 17´

CÓDIGO ANEURISMA CONCLUSIONES

- Elaboración de un **PROTOCOLO**
- Implicar a todo el equipo
  - •Cirujanos
  - •Anestesista → Local/ Loco-Rg.
  - •Intensivistas
  - •Radiólogos
  - •Enfermería
  - •Médicos: Atn.P./Urgen.
- Consenso con los Hospitales que derivan al Hosp. Útil
- Equipos de Urgencias: 061 y Críticos
- Autoridades sanitarias y Sociedades Científicas
  - •Implicación
  - •Coste cero
  - •Logro "político"

CÓDIGO ANEURISMA



RESEARCH — Open Access

A protocol-based treatment for ruptured abdominal aortic aneurysm contributed to improving aorta-related mortality: a retrospective cohort study

Yusuke Takei[1*], Masahiro Tezuka[1], Shunsuke Saito[1], Takeshi Ogasawara[2], Masahiro Seki[1], Takashi Kato[1], Yasuyuki Kanno[1], Shotaro Hirota[1], Ikuko Shibasaki[1] and Hirotsugu Fukuda[1]

Abstract

Background Recent guidelines state that improving the survival rate of patients with ruptured abdominal aortic aneurysm (rAAA) requires a protocol or algorithm for the emergency management of these patients. We aimed to investigate whether introducing a protocol treatment for rAAA improves clinical outcomes compared with the pre-protocol strategy.

Methods At our institution, 92 patients treated for rAAA between June 2008 and August 2022 were retrospectively analyzed. In 2014, the protocol-based treatment was introduced comprising a transfer algorithm to shorten the time to proximal control, use of an endovascular occlusion balloon, strict indications for endovascular aortic aneurysm repair (EVAR) or open surgical repair, and perioperative care, including for abdominal compartment syndrome (ACS). Clinical outcomes were compared between the protocol and pre-protocol group, including operative status, all-cause mortality, and rAAA-related death at 30-day, in-hospital, and 1-year postoperative follow-ups.

Results Overall, 52 and 40 patients received the protocol-based and pre-protocol treatments, respectively. EVAR was more frequently performed in the protocol group. The rate of achieving time to proximal control was significantly faster, and the transfusion volume was lower in the protocol group. ACS occurred more frequently in the protocol group with a higher EVAR. No difference was found in all-cause mortality between the two groups. The protocol group exhibited fewer rAAA-related deaths than the pre-protocol group during the following time points: 30 days (9.6% vs. 22.5%), during the hospital stay (11.5% vs. 30.0%), and 1 year (14.5% vs. 31.5%).

Conclusions The protocol-based treatment improved the survival rate of patients with rAAA.

- Mortl. 30 días: 9.6 Vs.22.5%
- Estancia M: 11.5 Vs. 30.0

Yusuke T. el al. BMC Cardiovasc Disord. 2023 Sep 1;23(1):436.