

ENFERMEDAD CEREBROVASCULAR, INMOVILISMO Y COMPLICACIONES

TUTOR: ROBERTO ALVES LOURENCO

Miembros Grupo 5

Giner Vanessa González

Milena Bolaños Sánchez

Ana Patricia Navarrete Reyes

Marcelo Carlos Schapira

Dagoberto Güilamo Hirujo

Francisco Javier López Esqueda



Oficina Regional de la
Organización Mundial de la Salud



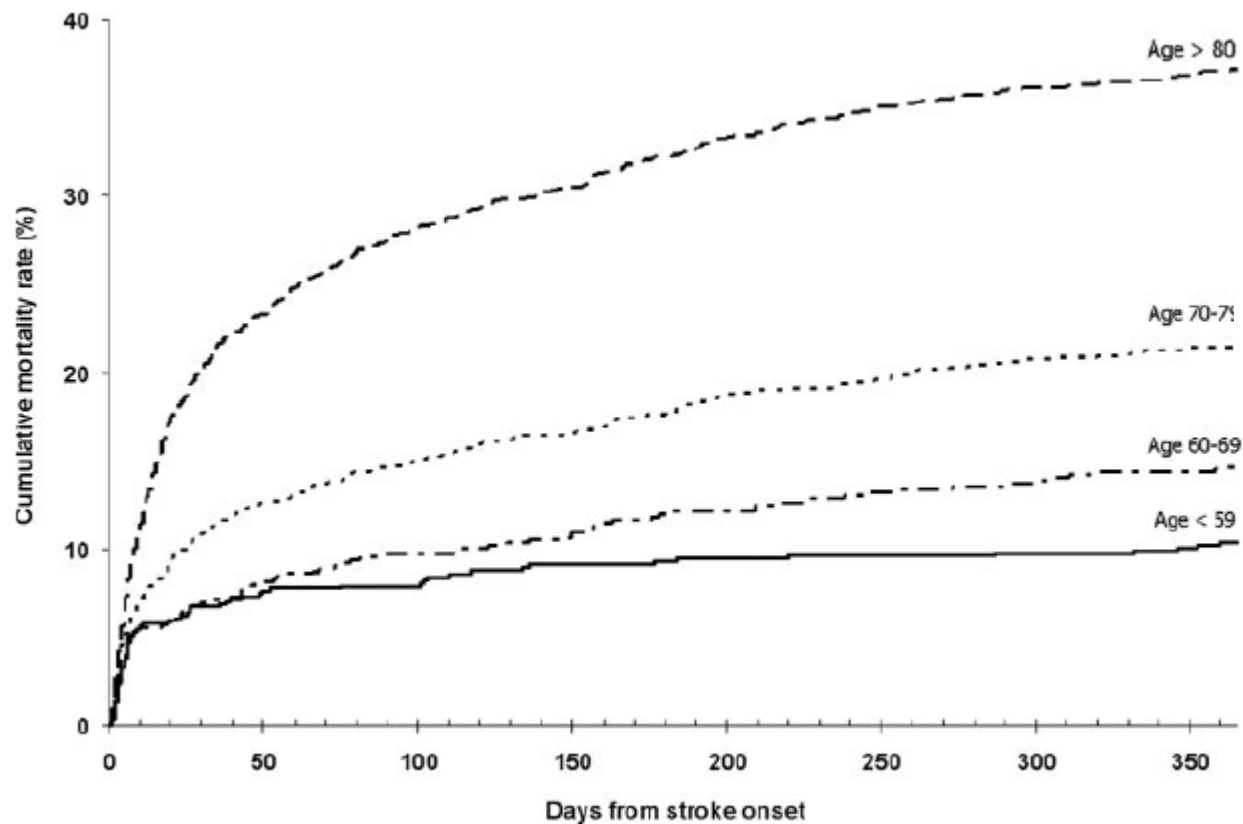
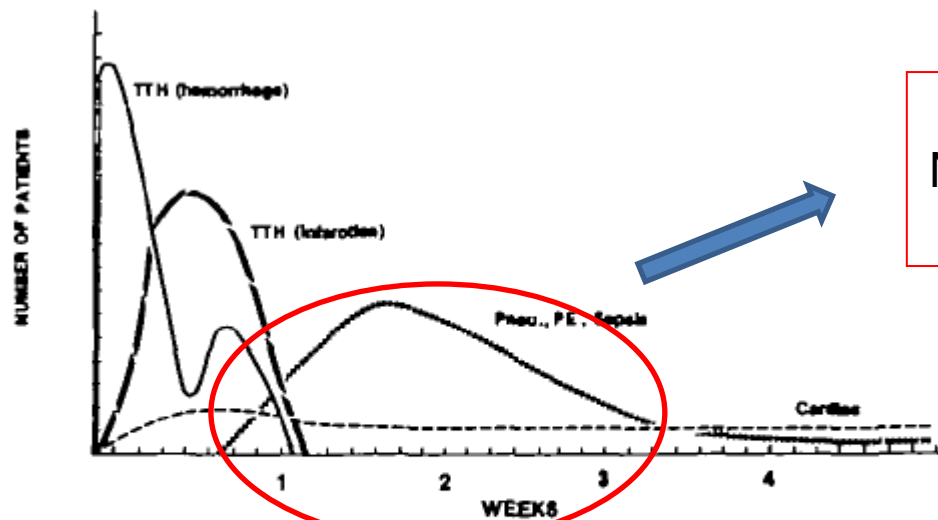


Figure 1. Cumulative mortality by age group. This figure represents the cumulative mortality (Kaplan–Meier failure curves) by age group in the first year. Note a significant difference in mortality for each age group when compared with those 59 years and younger (log-rank $P < 0.001$).

Early Mortality Following Stroke: A Prospective Review

FRANK L. SILVER, M.D.,* JOHN W. NORRIS, M.D., F.R.C.P.,
ANTHONY J. LEWIS, M.B., F.R.C.P. (C), AND
VLADIMIR C. HACHINSKI, M.D., F.R.C.P. (C)†



Mayor mortalidad por
Neumonía y tromboembolismo
de pulmón

Complicaciones
por la inmovilidad

FIGURE 4. *Diagrammatic representation of the causes of death following supratentorial infarction and hemorrhage. (TTH = transtentorial herniation; Pneu = pneumonia; PE = pulmonary thromboembolism).*

The Prevalence of Joint Contractures, Pressure Sores, Painful Shoulder, Other Pain, Falls, and Depression in the Year After a Severely Disabling Stroke

Table 2. Number of Patients With Each Complication at Each Time Point

	Pressure Sore	Shoulder Pain	Contracture	Falls	Pain	Depression
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
3 months (N=122)	21 (17)	44 (36)	53 (43)	56 (46)	47 (39)	43 (35)
6 months (N=89)	12 (13)	37 (42)	50 (56)	53 (60)	39 (44)	36 (40)
12 months (N=73)	13 (18)	34 (47)	49 (67)	42 (58)	38 (52)	31 (42)

Stroke 2008;39:3329-3334

Comments, Opinions, and Reviews

Falls, Fractures, and Osteoporosis After Stroke Time to Think About Protection?

Kenneth E.S. Poole, BM, MRCP; Jonathan Reeve, DM, BSc, FRCP;
Elizabeth A. Warburton, MA, DM, MRCP

(Stroke. 2002;33:1432-1436.)

Does the Prevention of Complications Explain the Survival Benefit of Organized Inpatient (Stroke Unit) Care?

Further Analysis of a Systematic Review

TABLE 1. Comparison of Complications Occurring in Stroke Units Versus Conventional Care

Outcome/Category	No. of Events: Stroke Unit (%)	No. of Events: Control (%)	OR (median)	95% CrI
Neurological				
Anxiety or depression	112 (16.7)	132 (19.7)	0.74	(0.27–1.97)
Seizures	15 (2.7)	17 (3.1)	0.86	(0.37–1.95)
Stroke progression or recurrence*	85 (9.4)	121 (13.5)	0.66	(0.46–0.95)
Cardiovascular				
Cardiovascular†	83 (14.2)	66 (11.0)	1.52	(0.58–4.54)
Complications of immobility				
Chest infection	87 (12.0)	134 (18.6)	0.60	(0.42–0.87)
Other infections‡	122 (13.5)	201 (21.9)	0.56	(0.40–0.84)
Dehydration	21 (5.1)	43 (10.1)	0.81	(0.31–2.53)
Venous thromboembolism§	30 (4.4)	35 (5.0)	0.85	(0.49–1.49)
Falls	28 (18.4)	43 (28.3)	0.57	(0.33–0.97)
Pressure sores	21 (4.7)	43 (9.6)	0.44	(0.22–0.85)
Pain	70 (12.1)	71 (12.3)	0.73	(0.14–2.60)
Other complications				
Other	22 (2.9)	24 (3.1)	0.95	(0.46–2.10)

[Stroke. 2007;38:2536-2540.

Palliative care needs of patients with neurologic or neurosurgical conditions

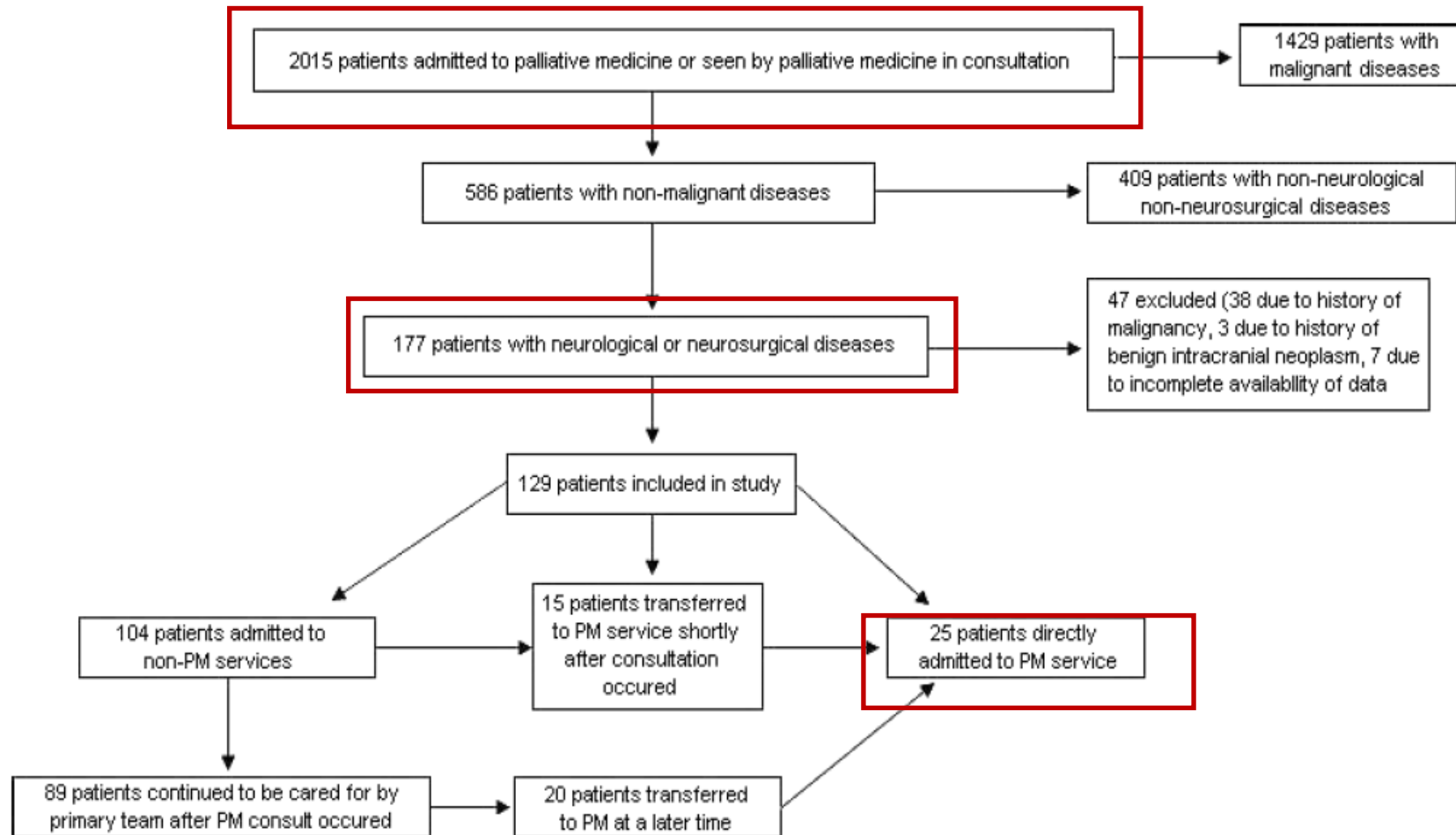


Figure 1 Summary of patients seen by the Palliative Medicine service from January 2004 to January 2007.

The last days of dying stroke patients referred to a palliative care consult team in an acute hospital

Table 2 Symptom prevalence in the 42 patients

Symptoms	<i>n</i> (%)
Dyspnoea or dyspnoea behaviour(s)	34 (81)
Pain or pain behaviour(s)	29 (69)
Mouth dryness	26 (62)
Constipation	16 (38)
Anxiety, sadness	11 (26)
Delirium	6 (14)
Sleep disorders	5 (12)
Other symptoms	5 (12)

n, number of patients

Palliative Care Consultations in Hospitalized Stroke Patients

TABLE 1. COMPARISON OF STROKE PATIENTS AND NONSTROKE PATIENTS WITH A PALLIATIVE CARE CONSULT

	<i>Stroke</i> (n = 101)	<i>Cancer</i> (n = 673)	<i>CHF and COPD</i> (n = 255)	<i>Dementia</i> (n = 56)
Mean age, years (SD)	72.4 (13.4)	63.3 (14.3)	71.5 (14.6)	81.7 (10.0)
Male, n (%)	49 (48.5)	349 (56.8)	99 (61.1)	28 (50.0)
Non-white, n (%)	11 (10.9)	129 (19.3)	19 (11.7)	11 (19.6)
Median LOS, days (IQR)	10.0 (13.0)	10.0 (14.0)	15.0 (20.0)	14.5 (16.0)
Inpatient death, n (%)	80 (79.2)	295 (43.8)	130 (51.0)	29 (51.8)
Reason for consult, ^a n (%)				
Symptom management	10 (9.9)	298 (44.3)	55 (21.6)	11 (19.6)
EOL decision-making	33 (32.7)	106 (15.8)	60 (23.5)	5 (9.1)
Moderate/severe symptoms, ^a n (%)				
Pain	5 (5.0)	326 (48.4)	53 (20.8)	11 (19.6)
Dyspnea	4 (4.0)	167 (24.8)	96 (37.6)	7 (12.7)
Nausea	0 (0.0)	93 (13.8)	11 (4.3)	1 (1.8)
Depression	3 (3.0)	106 (15.8)	34 (13.3)	4 (7.1)
Palliative Performance Scale, mean (SD)	19.8 (17.6)	44.1 (20.1)	37.3 (17.6)	33.8 (16.7)
With capacity, n (%)	5 (5.0)	329 (48.9)	87 (34.1)	2 (3.6)

^aNot mutually exclusive.

CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; SD, standard deviation; LOS, length of stay; IQR, interquartile range; EOL, end of life.

The last days of dying stroke patients referred to a palliative care consult team in an acute hospital

Table 4 Major and contributing causes of death in the 42 patients

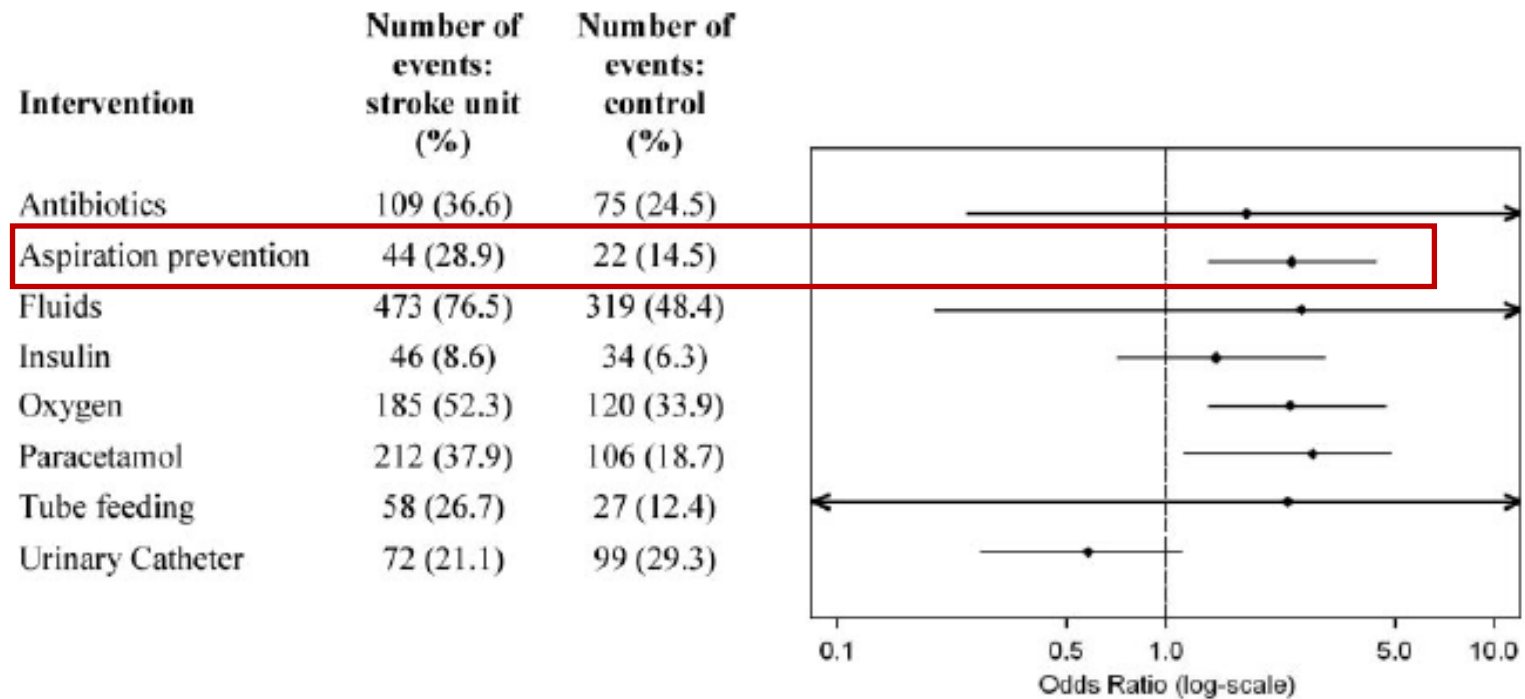
Causes/complications underlying death	As the main cause <i>n</i> (%)	As a contributing factor <i>n</i> (%)
Neurological causes or complications of acute ischaemic or haemorrhagic stroke	16 (38)	1 (2)
Mass effect, herniation, acute hydrocephalus	8	1
Recurrent cerebral infarction, recurrent intracerebral haemorrhage, haemorrhagic transformation	7	–
Status epilepticus	1	–
Specific medical causes	11 (26)	22 (52)
Pneumonitis caused by aspiration, bacterial pneumonia	3	10
Heart failure, ischaemic heart disease	3	8
Pulmonary embolus	2	–
Other	3	4
Multiple medical complications	15 (36)	–

n, number of patients

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2010, 17: 73–77

Does the Prevention of Complications Explain the Survival Benefit of Organized Inpatient (Stroke Unit) Care?

Further Analysis of a Systematic Review



Stroke. 2007;38:2536-2540.

*Brian H C Le Consultant in Palliative Medicine Royal Melbourne
Hospital Parkville Letter to editor* **Palliative care in stroke**

– Todos los paciente fueron referidos por la Unidad de
Stroke , cerca del final de la vida con el objetivo de:

- **Orientación respecto al manejo de los síntomas**
- **Apoyo al paciente y sus familiares**
- **Ayuda respecto a la toma de decisión clínica compleja.**
- **Discusiones acerca de la hidratación artificial y la nutrición.**

T Stevens y Cols, University of Southampton

Palliative care in stroke: a critical review of the literature

- Se desconocen las preferencias tanto de los pacientes con ACV como de sus familiares, con respecto a los cuidados paliativos.
- Hay pocos datos que permitan distinguir entre la provisión de cuidados paliativos a los pacientes que mueren en la fase aguda del ACV y aquellos que fallecen más tardíamente.

Conclusiones

- Los ancianos con ACV tienen más mortalidad
- Muy pocos pacientes con ACV son referidos a las Unidades de Cuidados Paliativos
- Por lo general se refieren a Cuidados Paliativos los ACV en fase terminal.
- Las complicaciones de la inmovilidad aparecen precozmente y aumentan en el primer año.