



Journal Club
14 Gennaio 2011
La complessità in geriatria

La medicina della complessità: appunti per una teoria

Marco Trabucchi

The art of medicine

Medicine and the human story

Athar Yawar

Lancet 375:546-7, 2010



Questa è la galassia Sombrero altrimenti detta M104 nel catalogo di Messier a una distanza di 28 milioni di anni luce. Questa è considerata una delle foto più belle fatte da Hubble.

La complessità dei sistemi di cura aumenta con il progredire della scienza, della coscienza dei diritti e dei doveri, con l'abbassamento dei livelli di tolleranza, con la burocratizzazione della medicina, con l'entrata di altri "giocatori" (scienza dell'organizzazione, economia, tecnologie). E' necessario prenderne coscienza, evitando nostalgie e comportamenti consoni all'"era" precedente.

**Costruire una prassi senza pessimismo e
semplificazioni**

La crisi del modello medico “semplice” di fronte alle malattie di origine incerta, di lunga durata, dall’evoluzione imprevedibile, come sono quelle dell’anziano.

Complessità e...

- **Il contenuto di una rivista scientifica**
- **Le linee guida nell'anziano**
- **Il trattamento con oppiacei dell'anziano**
- **La sindrome di Tako-Tsubo**
- **La cura**

**Il primo numero 2011 di una rivista prestigiosissima
(Arch Int Med) come modello di complessità.
Una medicina plurima, complessa o confusa?**



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The Implications of Therapeutic Complexity on Adherence to Cardiovascular Medications

Online

Nitesh K. Choudhry, MD, PhD; Michael A. Fischer, MD, MS; Jerry Avorn, MD; Joshua N. Liberman, PhD; Sebastian Schneeweiss, MD, ScD; Juliana Pakes, MEd; Troyen A. Brennan, MD, JD, MPH; William H. Shrank, MD, MSHS

**INVITED COMMENTARY
Prescription Refill Management and Its Effect on Adherence**

Amanda H. Salanitro, MD, MSPH; Sunil Kripalani, MD, MSc

Online

ONLINE FIRST | HEALTH CARE REFORM

Medicare Expenditures Among Nursing Home Residents With Advanced Dementia

Online

Keith S. Goldfeld, MPA, MS; David G. Stevenson, PhD; Mary Beth Hamel, MD, MPH; Susan L. Mitchell, MD, MPH

ONLINE FIRST | HEALTH CARE REFORM

Geographic Concentration and Correlates of Nursing Home Closures: 1999-2008

Online

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GET CHECKED ABSTRACTS CLEAR

January 10, 2011

The Implications of Therapeutic Complexity on Adherence to Cardiovascular Medications

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Arch Intern Med. Published online January 10, 2011.
doi:10.1001/archinternmed.2010.495
[ABSTRACT](#) | [FULL TEXT](#) | [PDF](#)

There's No Place Like Home

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Arch Intern Med. Published online January 10, 2011.
doi:10.1001/archinternmed.2010.493a
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Amanda H. Salanitro; Sunil Kripalani
Arch Intern Med. Published online January 10, 2011.
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**Classi di argomenti trattati in un solo numero di una rivista di medicina interna:
tecnologia (cuore, linee guida), interazione somato-psiche (HIV), aspetti politico-amministrativi-organizzativi (privatizzazione, rapporti tra medici, costi delle case di riposo), resistenze batteriche, aspetti etici (rapporti con le case farmaceutiche, errori prevenibili, scelta delle terapie, fino a quando curare), tabacco, geriatria (case di riposo, effetti collaterali dei farmaci), ecc.**

Alcune considerazioni sul rapporto tra contenuti, modalità di presentazione, reali esigenze del lettore nella logica di una oggettiva complessità.

Occorre segmentare le informazioni da apprendere o tutto è necessario per un'adeguata formazione del medico?

Le riviste scientifiche -e ancor peggio sarà con la pubblicistica on line- hanno rinunciato a scegliere una linea culturale?

Il riconoscimento della complessità non è esso stesso una scelta culturale?

**Vi è una complessità da superare per agire clinicamente (la compliance per le cure farmacologiche di un paziente anziano e le opportunità prescrittive), mentre vi è una complessità da "vivere" per poter capire il paziente e definire un iter di cura.
Come apprendere comportamenti adeguati?**

Le linee guida come strumento per affrontare la complessità che caratterizza la clinica dell'anziano: servono?

Il dibattito sulle linee guida è un modello di complessità:

- a) richiede una tecnologia sofisticata, ma ancora non definita, per la messa a punto dei contenuti
- b) non sempre è dimostrato il collegamento con l'outcome
- c) impossibilità di gestione nelle multimorbilità
- d) manca il "governo dell'applicazione"
- e) aspetti psicologici, organizzativi, economici che coinvolgono i medici, l'equipe, i gestori e i programmatori
- f) incertezza della scelte politiche
- g) ruolo della soggettività del paziente e dei familiari nell'adozione delle linee guida.

Le linee guida: l'assenza di certezze non può essere una scusa per la mediocrità.

"Science is the father of knowledge, but opinion breeds ignorance" (Ippocrate)

"Opinion has caused more trouble on this little earth than plagues or earthquakes" (Voltaire)

...ma allora che ruolo dare al giudizio individuale che nel mondo reale governa i sistemi?

Forse Ippocrate e Voltaire sono premoderni...

La realtà è molto diversa dalla teoria e molto variegata.

Ma la teoria è adeguata alla realtà?

BACKGROUND

Current methods of risk adjustment rely on diagnoses recorded in clinical and administrative records. Differences among providers in diagnostic practices could lead to bias.

METHODS

We used Medicare claims data from 1999 through 2006 to measure trends in diagnostic practices for Medicare beneficiaries. Regions were grouped into five quintiles according to the intensity of hospital and physician services that beneficiaries in the region received. We compared trends with respect to diagnoses, laboratory testing, imaging, and the assignment of Hierarchical Condition Categories (HCCs) among beneficiaries who moved to regions with a higher or lower intensity of practice.

RESULTS

Beneficiaries within each quintile who moved during the study period to regions with a higher or lower intensity of practice had similar numbers of diagnoses and similar HCC risk scores (as derived from HCC coding algorithms) before their move. The number of diagnoses and the HCC measures increased as the cohort aged, but they increased to a greater extent among beneficiaries who moved to regions with a higher intensity of practice than among those who moved to regions with the same or lower intensity of practice. For example, among beneficiaries who lived initially in regions in the lowest quintile, there was a greater increase in the average number of diagnoses among those who moved to regions in a higher quintile than among those who moved to regions within the lowest quintile (increase of 100.8%; 95% confidence interval [CI], 89.6 to 112.1; vs. increase of 61.7%; 95% CI, 55.8 to 67.4). Moving to each higher quintile of intensity was associated with an additional 5.9% increase (95% CI, 5.2 to 6.7) in HCC scores, and results were similar with respect to laboratory testing and imaging.

CONCLUSIONS

Substantial differences in diagnostic practices that are unlikely to be related to patient characteristics are observed across U.S. regions. The use of clinical or claims-based diagnoses in risk adjustment may introduce important biases in comparative-effectiveness studies, public reporting, and payment reforms.

Regional Variations in Diagnostic Practices

Yunjie Song, Ph.D., Jonathan Skinner, Ph.D., Julie Bynum, M.D., M.P.H.,
Jason Sutherland, Ph.D., John E. Wennberg, M.D., M.P.H.,
and Elliott S. Fisher, M.D., M.P.H.

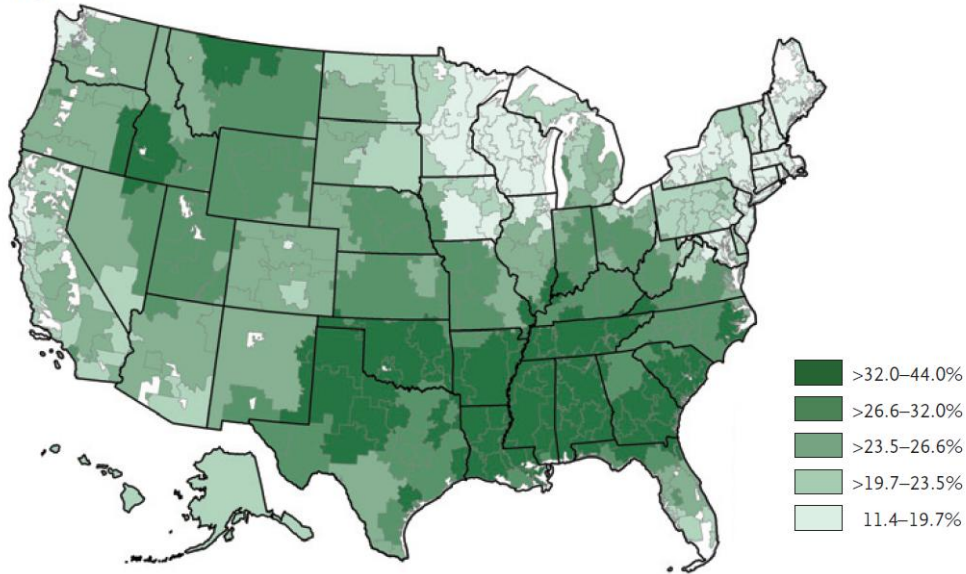
N Engl J Med 2010;363:45-53.

Geographic Variation in the Quality of Prescribing

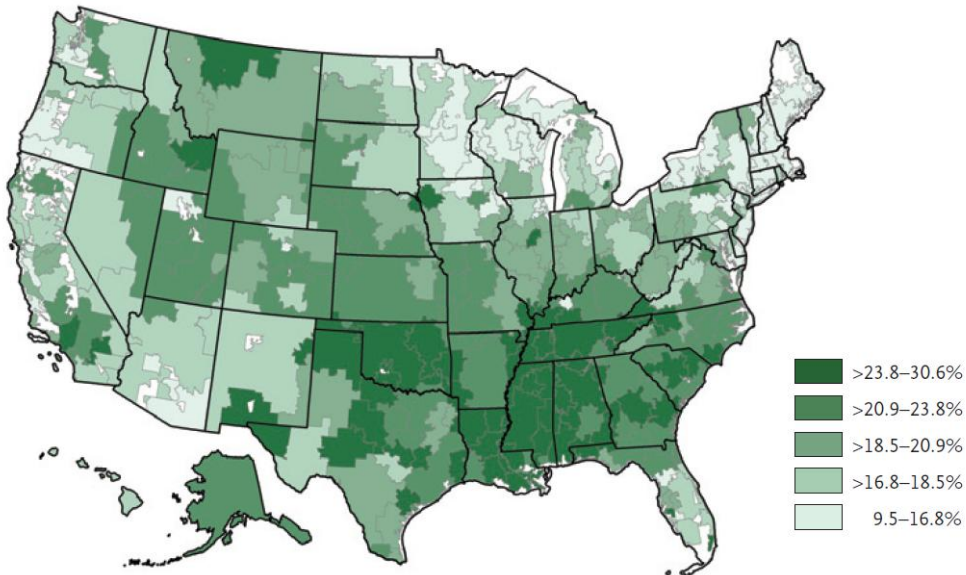
Yuting Zhang, Ph.D., Katherine Baicker, Ph.D., and Joseph P. Newhouse, Ph.D.

N ENGL J MED 363;21:1985-1988, 2010

A High-Risk Drugs



B Potentially Harmful Drug–Disease Interactions



**N ENGL J MED
363;21:1985-1988,
2010**

Quintiles of Performance on HEDIS Measures of the Quality of Drug Prescribing, According to Hospital-Referral Region, in 2007. Measures on HEDIS (Healthcare Effectiveness Data and Information Set) range from 11.4 to 44.0% for use of high-risk drugs (Panel A) and from 9.5 to 30.6% for potentially harmful drug–disease interactions (Panel B). Lower scores indicate better quality.

Variation in Annual Pharmacy Spending and HEDIS Quality Measures Related to Medication Use among Elderly Beneficiaries in Different Hospital-Referral Regions.*

Variable	Lowest Value	25th Percentile	Median	75th Percentile	Highest Value	Mean \pm SD	Ratio of Highest Value to Lowest Value	Ratio of 75th to 25th Percentile	Coefficient of Variation
<i>2007 dollars</i>									
Drug spending									
Annual gross spending per beneficiary	1,851	2,274	2,413	2,537	3,026	2,410 \pm 204	1.63	1.12	0.08
<i>percent</i>									
HEDIS quality measure									
Use of high-risk medication	11.4	20.6	24.9	30.6	44.0	25.8 \pm 6.9	3.85	1.49	0.27
Potentially harmful drug–disease interactions									
Dementia	11.2	21.0	24.3	29.0	45.7	25.1 \pm 6.0	4.09	1.38	0.24
Hip or pelvic fracture	4.5	15.4	19.0	22.6	38.4	19.1 \pm 5.5	8.62	1.47	0.29
Chronic renal disease	3.2	11.2	13.4	16.0	24.9	13.8 \pm 3.8	7.80	1.43	0.27
\geq 1 Condition	9.5	17.3	19.7	22.8	30.6	20.2 \pm 4.2	3.22	1.31	0.21

* The lowest-value column shows data for the hospital-referral region that was lowest within each category among hospital-referral regions in which the measure applied to at least 25 beneficiaries. Drug spending, which is reported in 2007 dollars, includes out-of-pocket spending by beneficiaries, subsidy amounts paid by the government, and spending by Medicare Part D plans before rebates. Values for adjusted annual gross drug spending per beneficiary differ slightly from those in our previous study¹ because we used an improved measure of the number of people receiving the low-income subsidy; this change does not affect the conclusions of the previous study. Lower scores on each of the quality measures in the Healthcare Effectiveness Data and Information Set (HEDIS) represent better quality. A total of 256 hospital-referral regions were included in the analysis of the proportion of elderly beneficiaries with hip or pelvic fracture who were receiving potentially harmful drugs. All other analyses included 306 hospital-referral regions.

Vi sono alcuni elementi in gioco nella prassi della medicina:

- **La teoria scientifica**
- **L'opinione individuale**
- **La realtà della sofferenza**
- **L'organizzazione sanitaria**
- **La cultura diffusa**

Come interagiscono?

Un caso di autonomia prescrittiva rispetto alle indicazioni regolatorie: gli ACEIs nel MCI e la memantina nella demenza lieve.

Treatment With Cholinesterase Inhibitors and Memantine of Patients in the Alzheimer's Disease Neuroimaging Initiative

Lon S. Schneider, MD, MS; Philip S. Insel, MS; Michael W. Weiner, MD;
for the Alzheimer's Disease Neuroimaging Initiative

Objectives: To assess the clinical characteristics and course of patients with mild cognitive impairment (MCI) and mild Alzheimer disease (AD) treated with cholinesterase inhibitors (ChEIs) and memantine hydrochloride.

Design: Cohort study.

Setting: The 59 recruiting sites for the Alzheimer's Disease Neuroimaging Initiative (ADNI).

Participants: Outpatients with MCI and AD in ADNI.

Main Outcome Measures: The AD Assessment Scale–cognitive subscale (ADAS-cog), Mini-Mental State Examination (MMSE), Clinical Dementia Rating (CDR) scale, and Functional Activities Questionnaire (FAQ).

Results: A total of 177 (44.0%) of 402 MCI patients and 159 (84.6%) of 188 mild-AD patients were treated with ChEIs and 11.4% of MCI patients and 45.7% of AD patients with memantine at entry. Mild-cognitive-impair-

ment patients who received ChEIs with or without memantine were more impaired, showed greater decline in scores, and progressed to dementia sooner than patients who did not receive ChEIs. Alzheimer-disease patients who received ChEIs and memantine took them longer, were more functionally impaired, and showed greater decline on the MMSE and CDR (but not on the ADAS-cog or FAQ) than those who received ChEIs only.

Conclusions: Academic physicians frequently prescribe ChEIs and memantine earlier than indicated in the US Food and Drug Administration–approved labeling to patients who are relatively more severely impaired or who are rapidly progressing toward cognitive impairment. The use of these medications in ADNI is associated with clinical decline and may affect the interpretation of clinical trial outcomes.

Study Registration: clinicalTrials.gov Identifier: NCT00106899

Arch Neurol. 2011;68(1):58-66

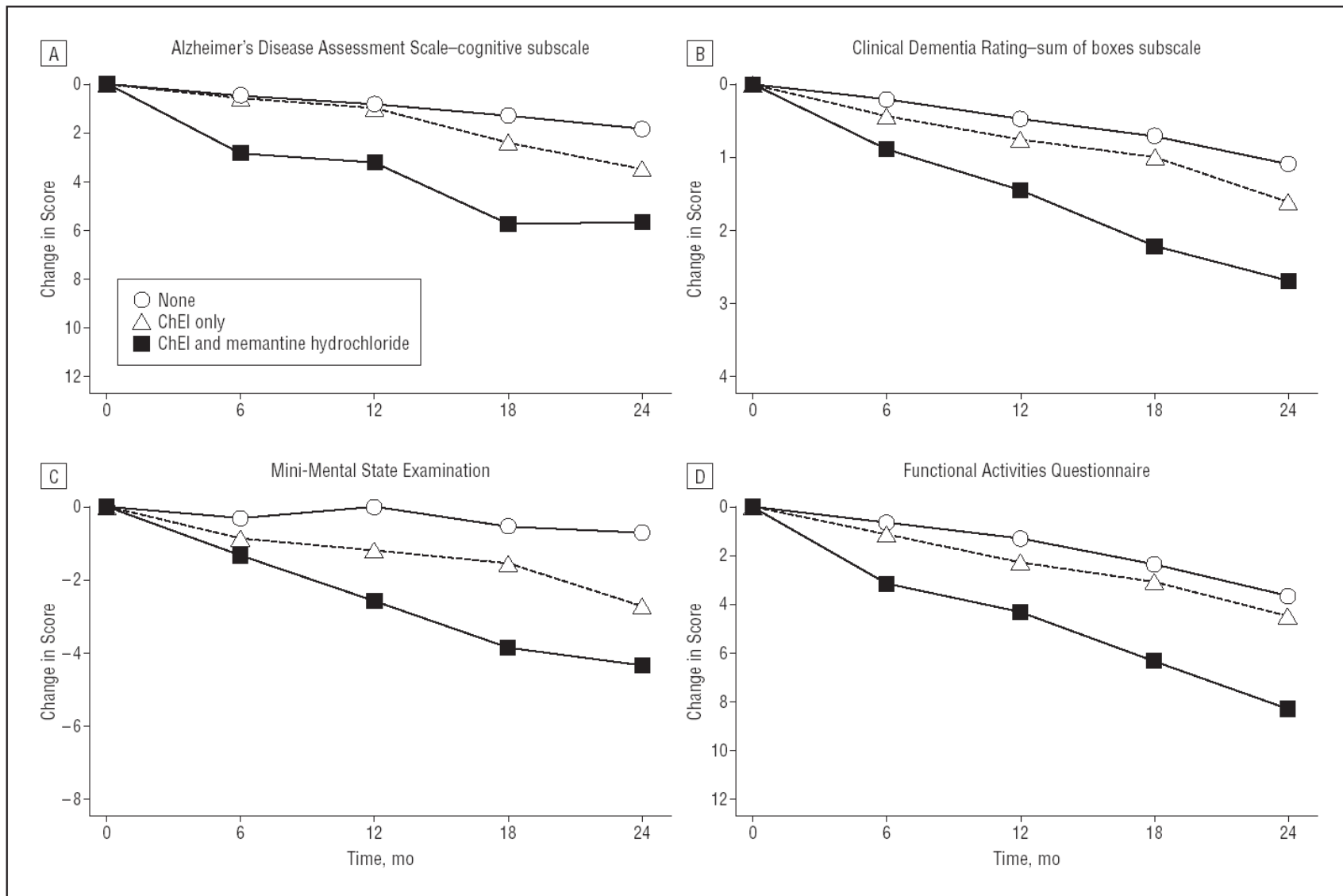


Figure 1. Observed change on clinical outcomes by treatment for patients with mild cognitive impairment. See Table 3 for values. ChEI indicates cholinesterase inhibitor.

**Una dimostrazione che l'autonomia
prescrittiva crea fallimenti?**

**Un esempio attuale di complessità:
la prescrizione degli oppiacei.**

“When I see a patient with arthritis coming in the front door, I leave by the back door”.

William Osler

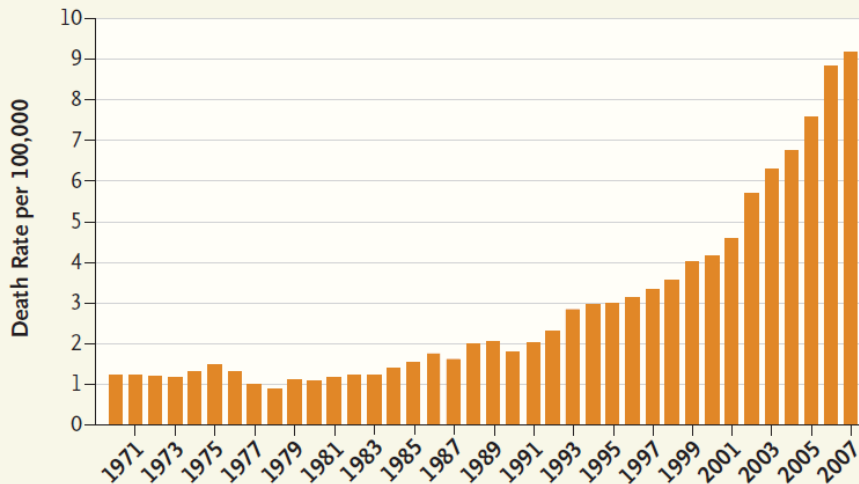
**Non è una difficoltà di oggi; anzi si è aggravata per tutte le illusioni di progresso imposte all’umanità.
...i farmaci per il dolore sono gli stessi da almeno 50 anni.**

A Flood of Opioids, a Rising Tide of Deaths

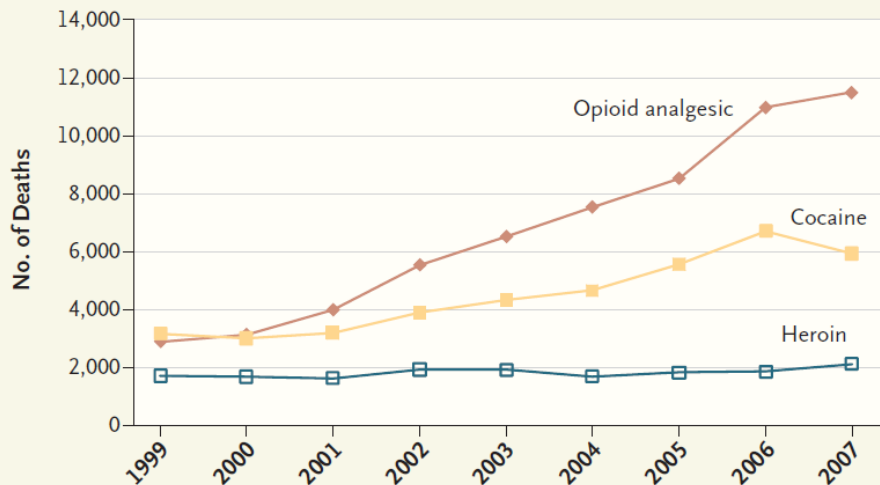
Susan Okie, M.D.

N ENGL J MED 363;21:1981-1983, 2010

A Deaths from Unintentional Drug Overdoses in the United States, 1970–2007



B Deaths from Unintentional Drug Overdoses in the United States According to Major Type of Drug, 1999–2007



U.S. Rates of Death from Unintentional Drug Overdoses and Numbers of Deaths, According to Major Type of Drug.

Shown are nationwide rates of death from unintentional drug overdoses from 1970 through 2007 (Panel A) and the numbers of such deaths from opioid analgesics, cocaine, and heroin from 1999 through 2007 (Panel B). Data are from the National Vital Statistics System, Centers for Disease Control and Prevention.

**N ENGL J MED
363;21:1981-1983,
2010**

The Comparative Safety of Analgesics in Older Adults With Arthritis

Daniel H. Solomon, MD, MPH; Jeremy A. Rassen, ScD; Robert J. Glynn, PhD;
Joy Lee, BA; Raisa Levin, MS; Sebastian Schneeweiss, MD, ScD

Background: The safety of alternative analgesics is unclear. We examined the comparative safety of nonselective NSAIDs (nsNSAIDs), selective cyclooxygenase 2 inhibitors (coxibs), and opioids.

Methods: Medicare beneficiaries from Pennsylvania and New Jersey who initiated therapy with an nsNSAID, a coxib, or an opioid from January 1, 1999, through December 31, 2005, were matched on propensity scores. We studied the risk of adverse events related to analgesics using incidence rates and adjusted hazard ratios (HRs) from Cox proportional hazards regression.

Results: The mean age of participants was 80.0 years, and almost 85% were female. After propensity score matching, the 3 analgesic cohorts were well balanced on baseline covariates. Compared with nsNSAIDs, coxibs (HR, 1.28; 95% confidence interval [CI], 1.01-1.62) and opioids (1.77; 1.39-2.24) exhibited elevated relative risk for

cardiovascular events. Gastrointestinal tract bleeding risk was reduced for coxib users (HR, 0.60; 95% CI, 0.35-1.00) but was similar for opioid users. Use of coxibs and nsNSAIDs resulted in a similar risk for fracture; however, fracture risk was elevated with opioid use (HR, 4.47; 95% CI, 3.12-6.41). Use of opioids (HR, 1.68; 95% CI, 1.37-2.07) but not coxibs was associated with an increased risk for safety events requiring hospitalization compared with use of nsNSAIDs. In addition, use of opioids (HR, 1.87; 95% CI, 1.39-2.53) but not coxibs raised the risk of all-cause mortality compared with use of nsNSAIDs.

Conclusions: The comparative safety of analgesics varies depending on the safety event studied. Opioid use exhibits an increased relative risk of many safety events compared with nsNSAIDs.

Arch Intern Med. 2010;170(22):1968-1978

La prescrizione di oppiacei

**Dopo la spinta in avanti vi è oggi uno stop vigoroso:
una questione culturale, scientifica, di interessi
particolari?**

In the end, however, it is the clinician who will remain responsible for balancing the risks and benefits for each patient when choosing the dose and class of analgesic, and further comparative safety studies should help shape those decisions more effectively.

J. Graf, Arch Intern Med 170(22):1976-1978, 2010.

La complessità dell'attuale dibattito sulla prescrizione di oppiacei è data dalla scarsità di conoscenze cliniche, dalle pressioni mediatiche e pseudoscientifiche, dal senso di colpa dei medici di fronte ai fallimenti...

**Un esempio di medicina complessa
(e strana!)**

"Tako-tsubo" is the japanese name for octopus traps that fishermen still use to catch octopus. In this syndrome, the heart (left ventricle) takes the shape of an octopus trap (tako-tsubo).

Tako-tsubo Cardiomyopathy or Syndrome is also known as:

- **neurogenic myocardial stunning,**
- **stress cardiomyopathy**
- **stress-induced cardiomyopathy,**
- **transient left ventricular apical ballooning,**
- **"ampulla" cardiomyopathy**
- **"broken heart syndrome"**

About 70-80% of cases of Tako-tsubo Syndrome occur in post-menopausal women under some form of extreme, exceptional and prolonged mental stress,...

La sindrome di Tako-Tsubo e il dolore dell'orfano anziano.

Dal crepacuore “nostrano” alla sindrome con il nome giapponese, passando per le modificazioni demografiche, il cambiamento del costume, il progresso scientifico e culturale, una medicina che è allo stesso tempo parcellizzata e attenta all’insieme.

Un vero progresso?

**Cosa unisce gli esempi soprariportati?
Il desiderio di orientarsi nella complessità, non
per guidarla, ma per imparare a nuotare (per i
medici: curare).**

**Oggi l'economia tende a distruggere la complessità.
Come dobbiamo collocarci? Essere difensori della
clinica e della sua struttura logica.**

**Crisi economica delle regioni ➡ commissariamento ➡
addizionale Irpef ➡ dimissione DG dalle aziende
sanitarie ➡ rinomina su contenuti esclusivamente
economici.**

Queste scelte sono in controtendenza rispetto a quelle di chi riconosce il ruolo centrale della complessità nella vita collettiva. Non ci possono trovare consenzienti.

...per noi la complessità è un'occasione per il miglioramento della clinica.

Si è iniziato a considerare la sempre più evidente perdita del controllo, cioè l'impossibilità di esercitare previsioni puntuali sul decorso futuro delle organizzazioni e di sospingerle verso un'unica traiettoria auspicata, non più come una calamità, ma come un'opportunità di notevole interesse: l'opportunità di elaborare una nuova arte del governo delle organizzazioni, attenta al farsi e al disfarsi in tempo reale delle tendenze gravide di futuro e capace di assumersi il rischio di operare per il consolidamento e l'amplificazione di talune di queste, senza alcuna garanzia circa la necessità del loro successo.

Bocchi e Ceruti, 2008

Il medico non è chiamato ad essere un esperto delle teorie della complessità, ma ad essere attento alle realtà che si muovono attorno al suo rapporto con il paziente, compiendo sintesi operative che mai ne siano impoverimenti. L'universo -sia quello grandissimo che sta sopra di noi, sia quello altrettanto grande che sta nel nostro cuore e nella nostra mente- non è regolato come un orologio, né si rompe con le modalità di un orologio. Per superare questa logica, e vivere in quella della complessità, è necessario abbandonare i modelli lineari, accettare l'impredicibilità, rispettare e utilizzare l'autonomia e la creatività e rispondere in maniera flessibile all'emergere di situazioni ed opportunità.