Simposio SIGG-GIMSI

IL GRUPPO ITALIANO MULTIDISCIPLINARE SINCOPE (GIMSI): OLTRE UN DECENNIO DI COLLABORAZIONE

La Syncope Unit Geriatrica

Chiara Mussi

Centro di Valutazione e Ricerca Gerontologica

Università di Modena e Reggio Emilia

Definizione di Syncope Unit

- Obiettivo diagnostico e terapeutico: Servizio che si basa sull'approccio standardizzato alla diagnosi e gestione delle perdite di coscienza transitorie, con staff dedicato ed accesso preferenziale a test diagnostici e terapie appropriate.
- Obiettivo educativo: formare medici che si vogliono specializzare sul tema della 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

Rose Anne Kenny (Chairperson, Ireland), Michele Brignole (Co-chairperson, Italy), Gheorghe-Andrei Dan (Romania), Jean Claude Deharo (France), J. Gert van Dijk (The Netherlands), Colin Doherty (Ireland), Mohamed Hamdan (USA), Angel Moya (Spain), Steve W. Parry (UK), Richard Sutton (UK), Andrea Ungar (Italy), and Wouter Wieling (The Netherlands)

tion. The authors emphasize that there is, at present, insufficient available evidence whether an SU (examples of a number of models are detailed later in the document) is superior in efficiency or outcomes to a syncope specialist[4] or newer technologically driven models of syncope management.[5] We anticipate that the Position Paper will stimulate structured research to determine best practice models for T-LOC evaluation in different settings and cultures.

Vantaggi della SU

Table I Expected benefits of Syncope Unit

Expected benefits
Specialist opinion for patients
Early accurate and efficient diagnosis
Timely treatment
Better application of recommended guidelines
Less duplication and fragmentation of services
Single source of communication for all stakeholders
Shorter length of stay for hospital inpatients
Reduction of total care costs
Better systems for monitoring and evaluation of practice at local, national, and international level
Better quality control at local, national and international level
Access to harmonized data across different hospitals
High quality, evidence-based data for research
Evidence-based innovation in diagnosis, treatments and healthcare model

Early: l'anziano cade, prima capisco perché, prima prevengo

Duplication: l'anziano ha tante patologie, fa una valanga di esami, evitarne qualcuno è fondamentale

Single source: quanti medici vede un anziano? Di quanti si fida? Chi diventa punto di riferimento?

Durata della degenza (!!!)

Parte scientifica: l'anziano è difficile da studiare. Avere database real-life è fondamentale.

Resistenze

Table 2 Barriers to establishing the Syncope Unit

Barriers to establishing an SU
Lack of awareness of the benefits of an SU due to inadequate research trials comparing SUs to normal practice
Underestimation of consequences of syncope
Lack of awareness of benefit of an SU on quality-of-life
Low numbers of syncope specialists
Lack of formal syncope training programmes
Wide age range from paediatric to oldest patients
Skill sets required in a number of domains such as cardiology, geriatrics, paediatrics, physiology, neurology, and psychiatry
Syncope not a recognized subspecialty
Reluctance to introduce innovative proposals
Necessity to engage multiple stakeholders
Inadequate reimbursement of syncope core management
New economic cost models required to evaluate an SU
Fear of increasing costs by the development of a new structure instead of reducing them

Il geriatra è adatto a portare avanti una SU perché è lo specialista più conscio delle conseguenze della caduta

Problema della Quality of Life: outcome mai valutato nei grandi trial clinici, dove prevale la mortalità. Ma sempre presente nella mente del Geriatra

Troppa gente: il Geriatra è il mago del Team, è abituato a gestire in modalità multiple task (tante patologie, tanti farmaci, tanti specialisti)

GIMSI

Gruppo Italiano Multidisciplinare per lo Studio della Sincope

Pescara Ospedale Spirito Santo
Avellino Az. Ospedaliera SG Moscati
Modena Ospedale S. Agostino Estense
Firenze Ospedale Careggi
Trento Ospedale S. Chiara

Gruppo Italiano Sincope (GIS)

GIMSI

Syncope Unit

SYD

Syncope and Dementia

- **O. diagnostico e terapeutico** secondo linee guida condivise a livello europeo
- **O. educativo:** formare geriatri che si vogliono specializzare sul tema della sincope
- **O. scientifico**: raccolta di dati e produzione di studi real life

Il GIS ha dimostrato che:

- La forma più frequente di sincope nell'anziano è la **vasovagale (66,6%)**
- Negli anziani "giovani" prevale la forma neuroriflessa
- Negli anziani "vecchi" è più frequente la forma disautonomica

Diagnosis and Characteristics of Syncope in Older Patients Referred to Geriatric Departments

Andrea Ungar, MD, PhD,[*†] *Chiara Mussi, MD, PhD,*[‡] *Attilio Del Rosso, MD,*[§] *Gabriele Noro, MD,*[‖] *Pasquale Abete, MD, PhD,*[¶] *Loredana Ghirelli, MD,*[#] *Tommaso Cellai, MD,*[*†] *Annalisa Landi, MD,*[*†] *Gianfranco Salvioli, MD,*[‡] *Franco Rengo, MD,*[¶] *Niccolò Marchionni, MD,*[*†] *and Giulio Masotti, MD,*[*†] *for the Italian Group for the Study of Syncope in the Elderly*

Il GIS ha dimostrato che:

Age and Ageing 2011; **0:** 1–6
doi: 10.1093/ageing/afr109

- I pazienti con sincope muoiono di più se sono più anziani e malati
- E' più probabile che un anziano abbia recidive se è più vecchio e disabile
- All'analisi univariata la mortalità è maggiore nei pazienti con sincope cardiogena, ma nelle curve Kaplan-Meyer (multivariata) rimangono significative solo **l'età** e la **comorbilità elevata**

Two-year morbidity and mortality in elderly patients with syncope

Andrea Ungar[1,2], Gianluigi Galizia[3], Alessandro Morrione[1,2], Chiara Mussi[4], Gabriele Noro[5], Loredana Ghirelli[6], Giulio Masotti[1,2], Franco Rengo[3], Niccolò Marchionni[1,2], Pasquale Abete[3]

Il GIS ha dimostrato che:

- Non è vero che gli anziani hanno pochi sintomi prodromici e che l'anamnesi non serve a niente perché tanto gli anziani non si ricordano nulla …

Role of Early Symptoms in Assessment of Syncope in Elderly People: Results from the Italian Group for the Study of Syncope in the Elderly

Gianluigi Galizia, MD,[*] Pasquale Abete, MD, PhD,[*] Chiara Mussi, MD,[†] Gabriele Noro, MD,[‡] Alessandro Morrione, MD,[§] Assunta Langellotto, MD,[*] Annalisa Landi, MD,[§] Francesco Cacciatore, MD, PhD,[‖] Giulio Masotti, MD,[§] Franco Rengo, MD,[‖] Niccolò Marchionni, MD,[§] and Andrea Ungar, MD[§]*

CONCLUSION: The data show that symptoms such as nausea, blurred vision, and sweating are predictive of non-cardiac syncope, whereas only dyspnea is predictive of cardiac syncope in elderly people. **J Am Geriatr Soc 57:18–23, 2009.**

Il GIS è entrato in Ortopedia …

- In un terzo dei pazienti anziani con frattura di femore la caduta è di tipo non spiegato

Research Article

Unexplained Falls Are Frequent in Patients with Fall-Related Injury Admitted to Orthopaedic Wards: The UFO Study (Unexplained Falls in Older Patients)

Mussi Chiara,[1] Galizia Gianluigi,[2] Abete Pasquale,[2]
Morrione Alessandro,[3] Maraviglia Alice,[3] Noro Gabriele,[4] Cavagnaro Paolo,[5]
Ghirelli Loredana,[6] Tava Giovanni,[4] Rengo Franco,[2] Masotti Giulio,[3] Salvioli Gianfranco,[1]
Marchionni Niccolò,[3] and Ungar Andrea[3]

Hindawi Publishing Corporation
Current Gerontology and Geriatrics Research
Volume 2013, Article ID 928603, 6 pages
http://dx.doi.org/10.1155/2013/928603

Il GIS ha dimostrato che:

- Non è giustificato NON studiare la sincope nell'anziano, perché è possibile applicare il protocollo diagnostico proposto dall'ESC anche negli ultra90enni, ottenendo una diagnosi eziologica nel 90% dei pazienti studiati

Diagnosis and Characteristics of Syncope in Older Patients Referred to Geriatric Departments

Andrea Ungar, MD, PhD,[*†] *Chiara Mussi, MD, PhD,*[‡] *Attilio Del Rosso, MD,*[§] *Gabriele Noro, MD,*[‖] *Pasquale Abete, MD, PhD,*[¶] *Loredana Ghirelli, MD,*[#] *Tommaso Cellai, MD,*[*†] *Annalisa Landi, MD,*[*†] *Gianfranco Salvioli, MD,*[‡] *Franco Rengo, MD,*[¶] *Niccolò Marchionni, MD,*[*†] *and Giulio Masotti, MD,*[*†] *for the Italian Group for the Study of Syncope in the Elderly*

CONCLUSION: The protocol is applicable even beyond the age of 90 in geriatric departments. The standardized protocol is associated with a reduction in the frequency of unexplained syncope to about 10%. **J Am Geriatr Soc 54: 1531–1536, 2006.**

Il GIS ha dimostrato che …

- Possiamo fare il Tilt negli anziani perché serve a far diagnosi eziologica di sincope, senza timore di effetti collaterali gravi

CLINICAL INVESTIGATIONS

Usefulness and Safety of Shortened Head-Up Tilt Testing Potentiated with Sublingual Glyceryl Trinitrate in Older Patients with Recurrent Unexplained Syncope

Attilio Del Rosso, MD, Andrea Ungar, MD,† Paolo Bartoli, MD,* Tommaso Cellai, MD,† Chiara Mussi, MD,‡ Niccolò Marchionni, MD,† Giulio Masotti, MD† and The Gruppo Italiano di Studio della sincope dell'anziano*

CONCLUSION: The shortened GTN-HUT provides satisfactory positivity rate and specificity in older patients. This test may be considered as a diagnostic tool in assessing recurrent unexplained syncope in older patients. J Am Geriatr Soc 50:1324–1328, 2002.

Aging Clin Exp Res. 2015 Dec;27(6):877-82. doi: 10.1007/s40520-015-0354-z. Epub 2015 Mar 29.

The "syncope and dementia" study: a prospective, observational, multicenter study of elderly patients with dementia and episodes of "suspected" transient loss of consciousness.

Ungar A[1], Mussi C[2], Nicosia F[3], Ceccofiglio A[4], Bellelli G[5,6], Bo M[7], Riccio D[8], Landi F[9], Martone AM[9], Langellotto A[10], Ghidoni G[2], Noro G[11], Abete P[12].

Author information

Abstract

BACKGROUND AND AIM: Syncope and related falls are one of the main causes and the predominant cause of hospitalization in elderly patients with dementia. However, the diagnostic protocol for syncope is difficult to apply to patients with dementia. Thus, we developed a "simplified" protocol to be used in a prospective, observational, and multicenter study in elderly patients with dementia and transient loss of consciousness suspected for syncope or unexplained falls. Here, we describe the protocol, its feasibility and the characteristics of the patients enrolled in the study.

METHODS: Patients aged ≥65 years with a diagnosis of dementia and one or more episodes of transient loss of consciousness during the previous 3 months, subsequently referred to a Geriatric Department in different regions of Italy, from February 2012 to May 2014, were enrolled. A simplified protocol was applied in all patients. Selected patients underwent a second-level evaluation.

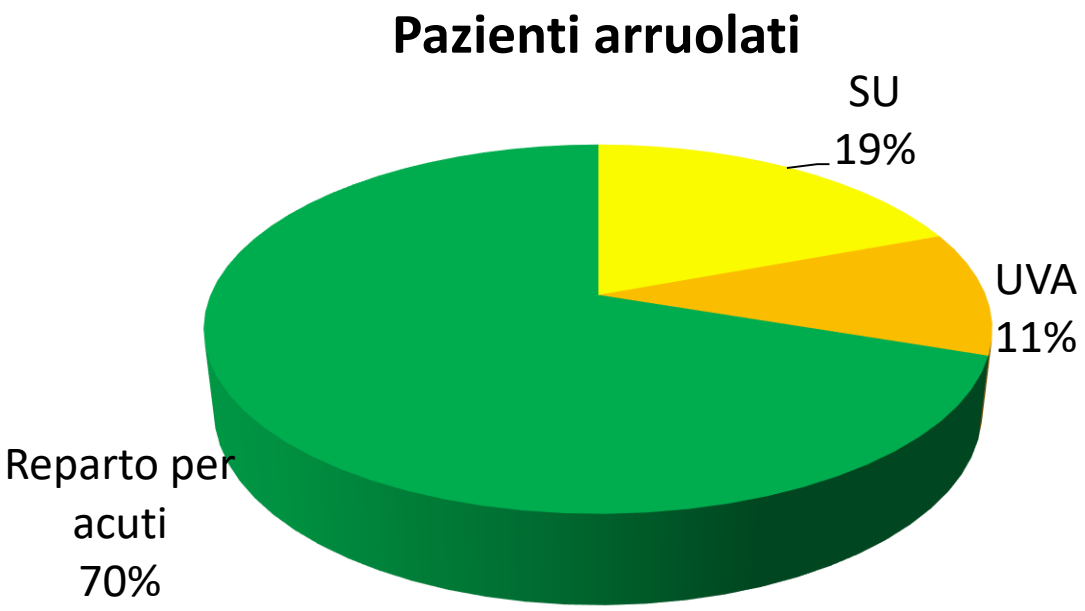
RESULTS: Three hundred and three patients were enrolled; 52.6 % presented with episodes suspected to be syncope, 44.5 % for unexplained fall and 2.9 % both. Vascular dementia had been previously diagnosed in 53.6 % of participants, Alzheimer's disease in 23.5 % and mixed forms in 12.6 %. Patients presented with high comorbidity (CIRS score = 3.6 ± 2), severe functional impairment, (BADL lost = 3 ± 2), and polypharmacy (6 ± 3 drugs).

CONCLUSION: Elderly patients with dementia enrolled for suspected syncope and unexplained falls have high comorbidity and disability. The clinical presentation is often atypical and the presence of unexplained falls is particularly frequent.

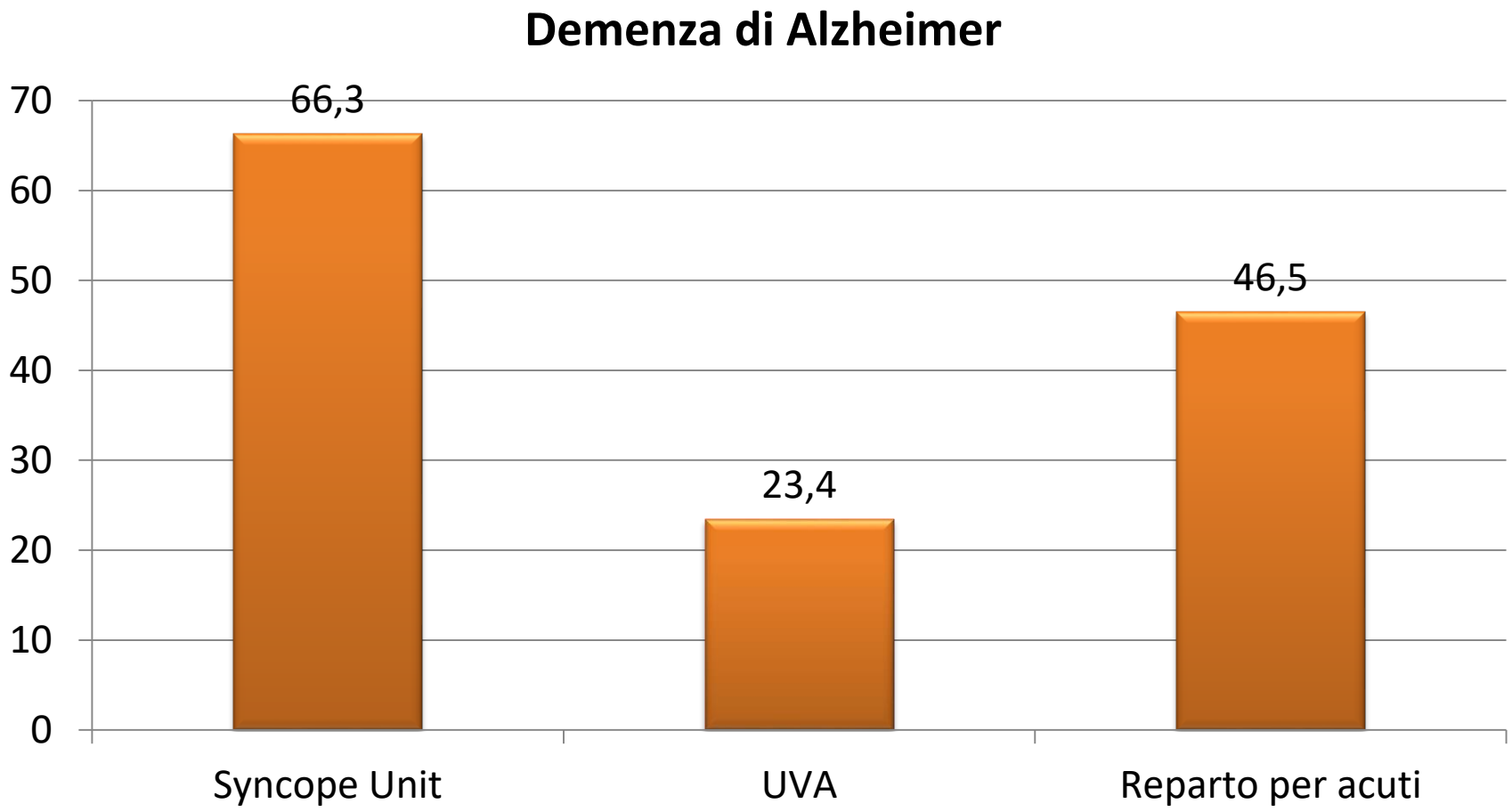
KEYWORDS: Dementia; Falls; Orthostatic hypotension; Syncope

Le Syncope Unit dello Studio SYD

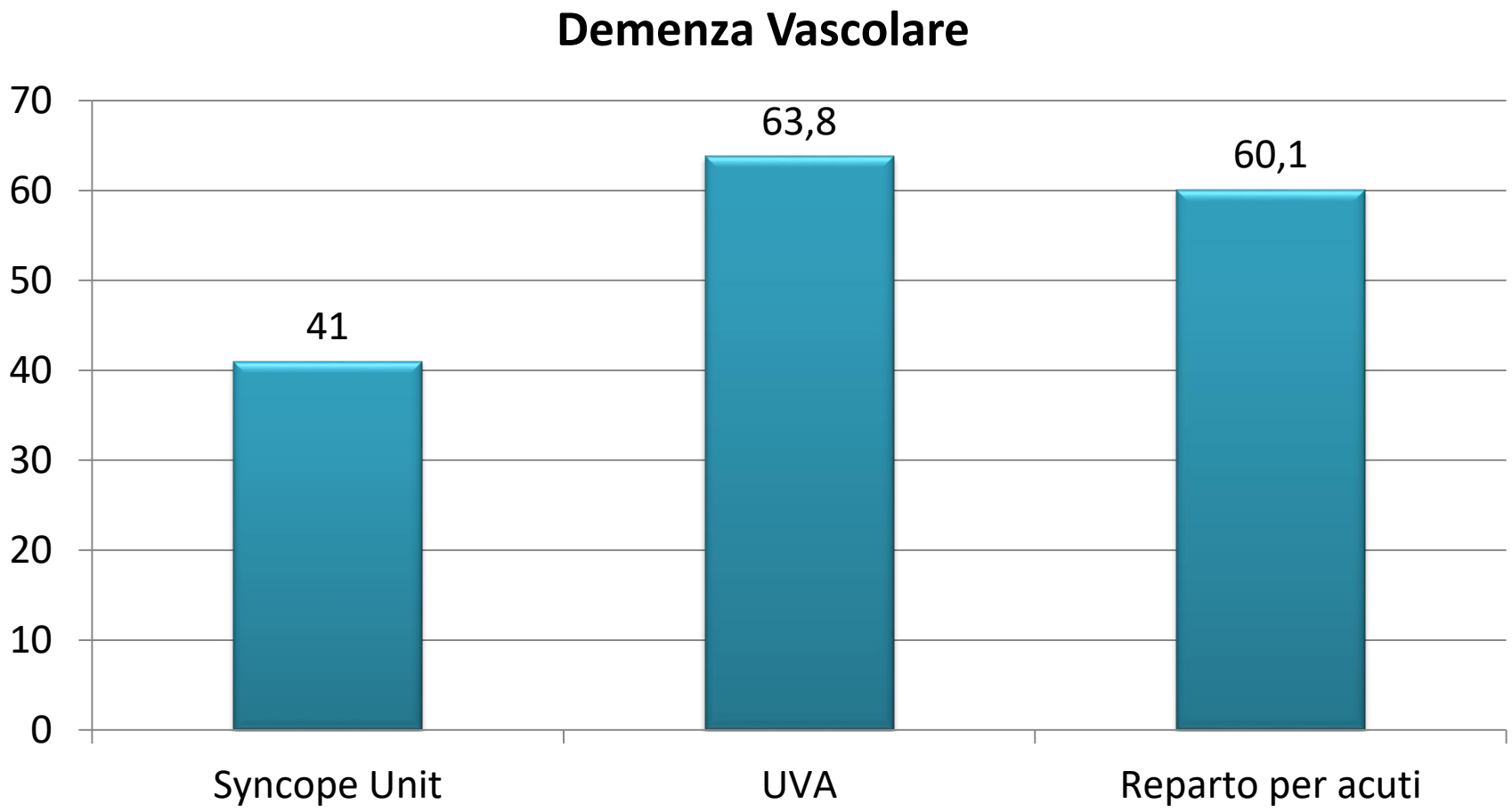
- Su 431 soggetti, il 19,3% è stato arruolato da SU, che sono poche rispetto ai reparti per acuti e alle UVA



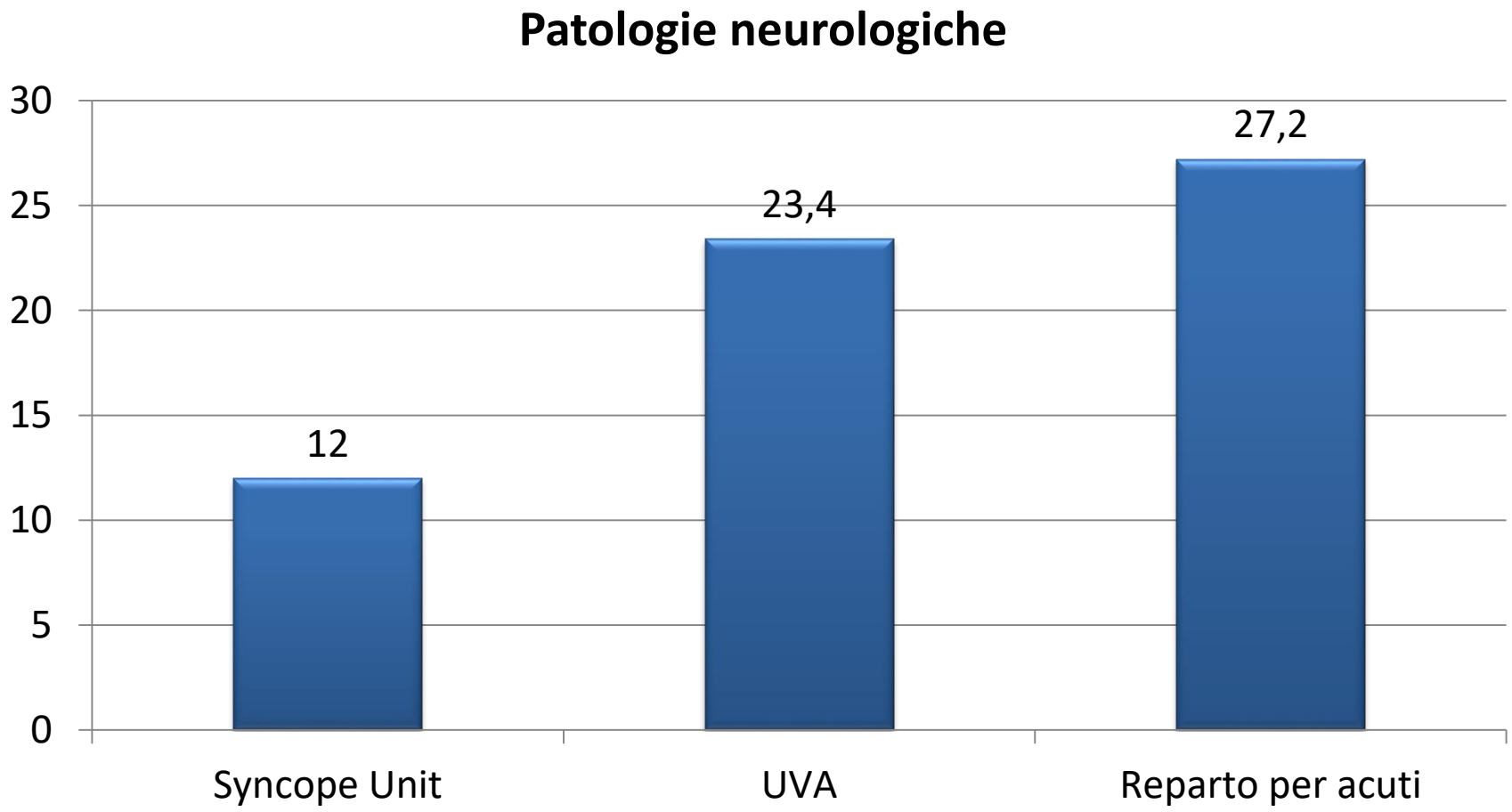
Tipi di demenza



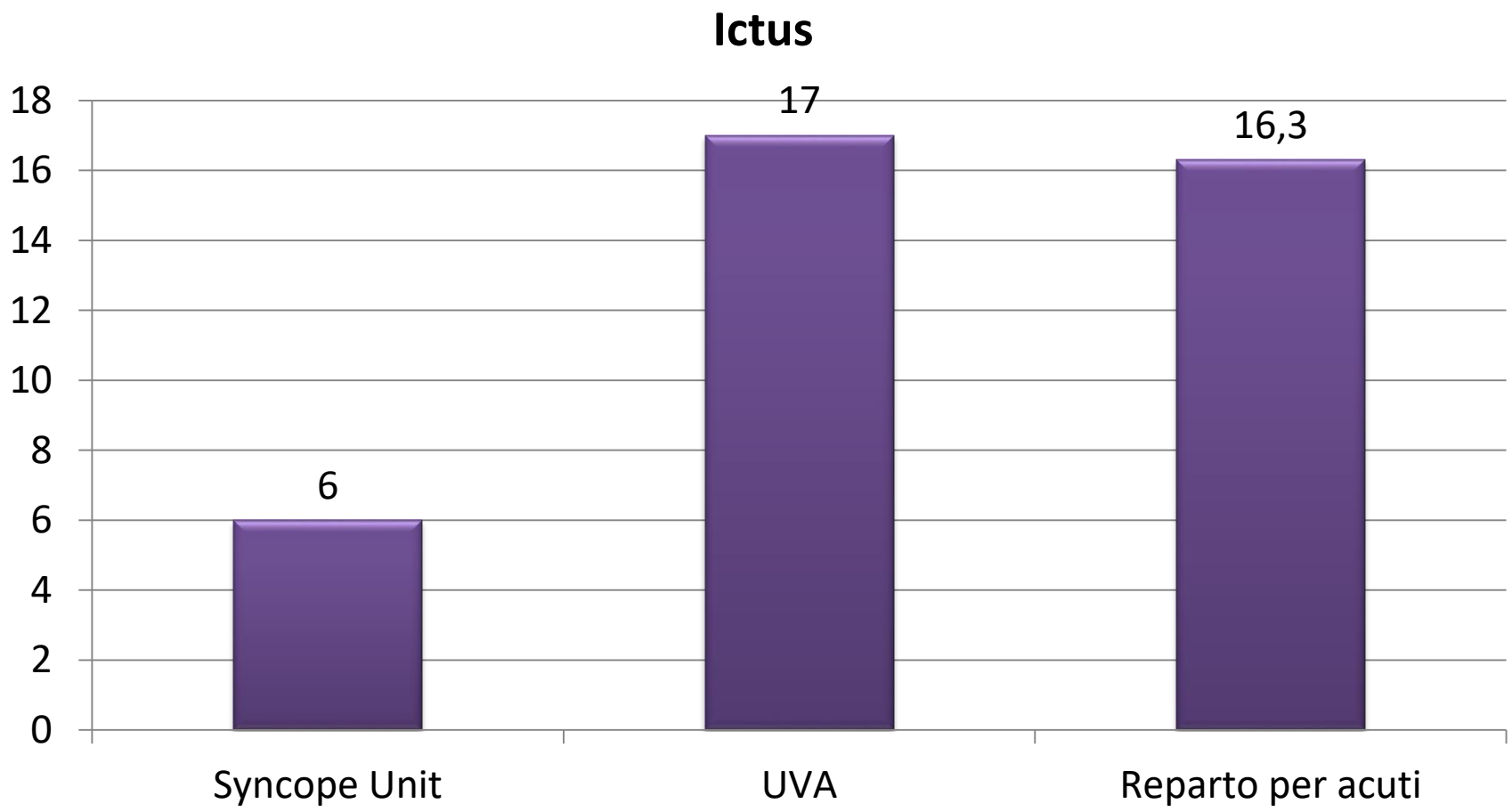
Tipi di demenza

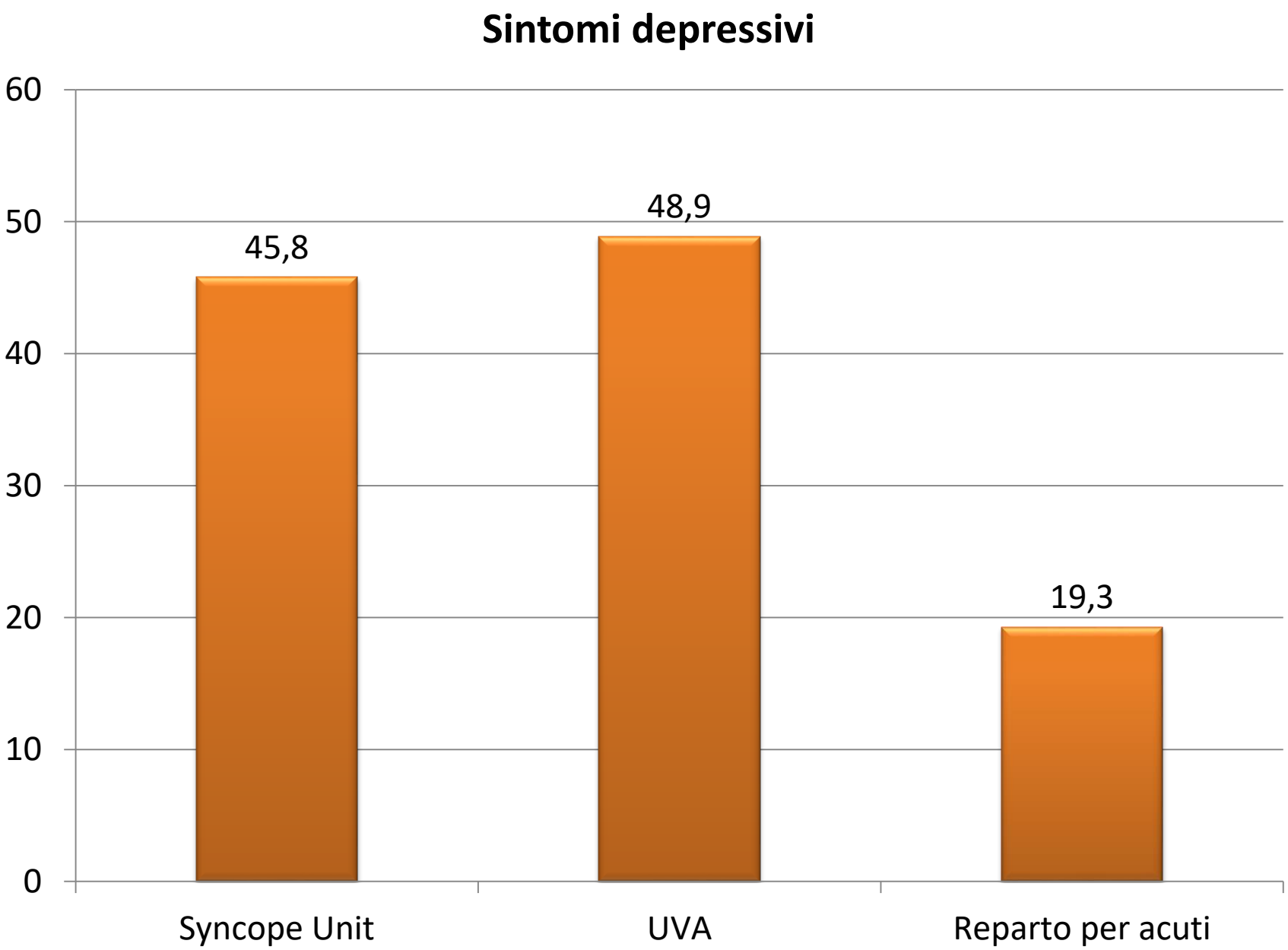


Altre comorbilità

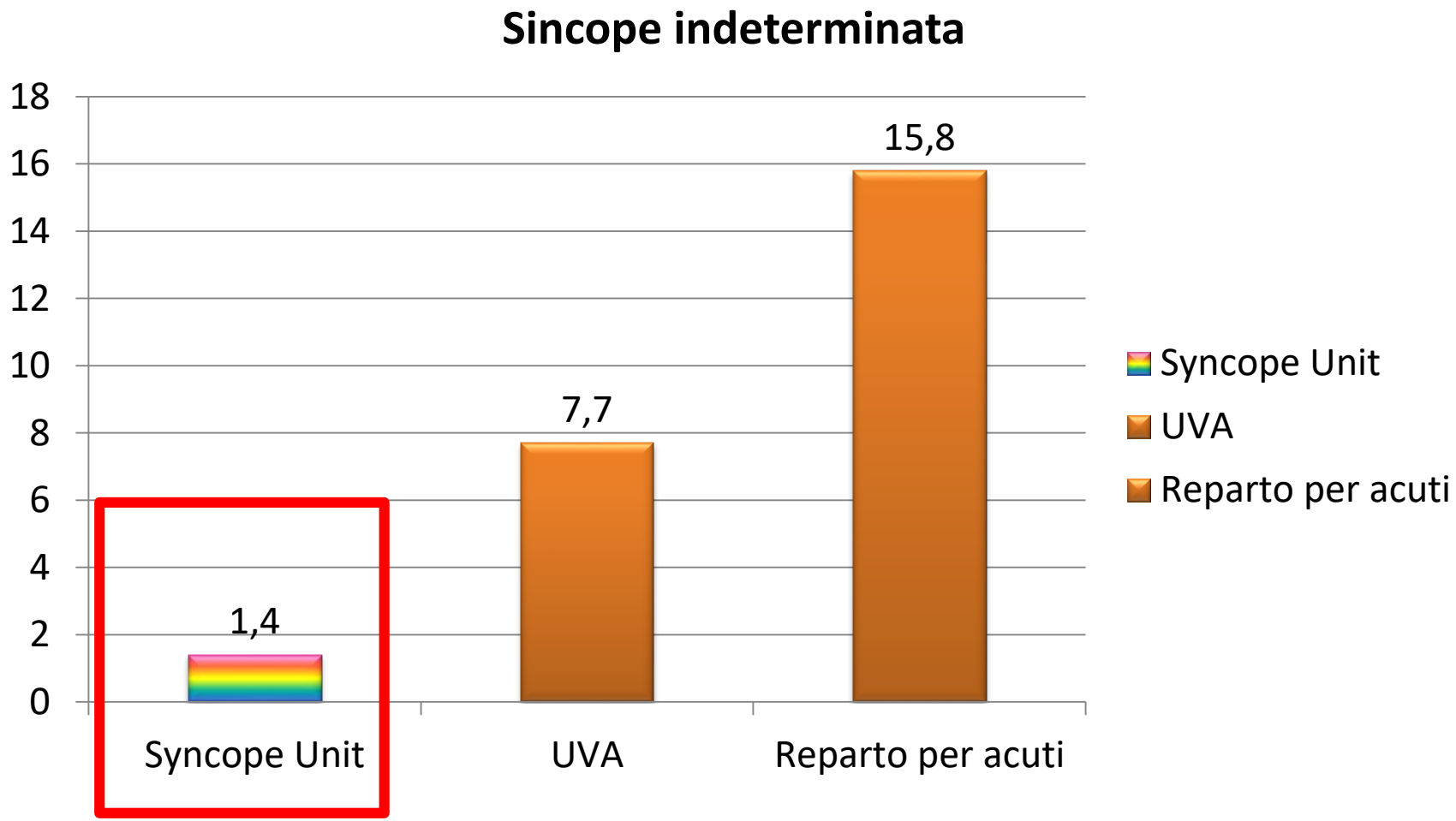


Altre comorbilità



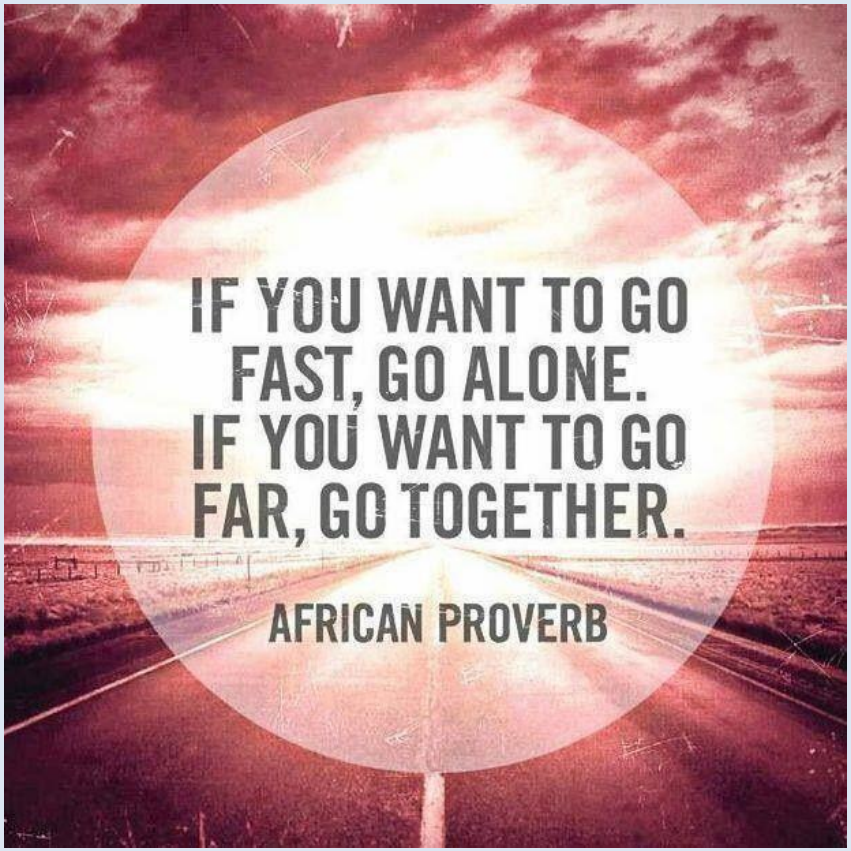

Sintomi depressivi
60
50
40
30
20
10
0
45,8
48,9
19,3
Syncope Unit
UVA
Reparto per acuti

Diagnosi finale



KEEP
CALM
AND
JOIN OUR
TEAM

GRAZIE!


IF YOU WANT TO GO
FAST, GO ALONE.
IF YOU WANT TO GO
FAR, GO TOGETHER.
AFRICAN PROVERB