IL CASO DELLE PATOLOGIE CARDIOMETABOLICHE – DAI MODELLI PRESTAZIONALI ALLA PRESA IN CARICO DEL PAZIENTE

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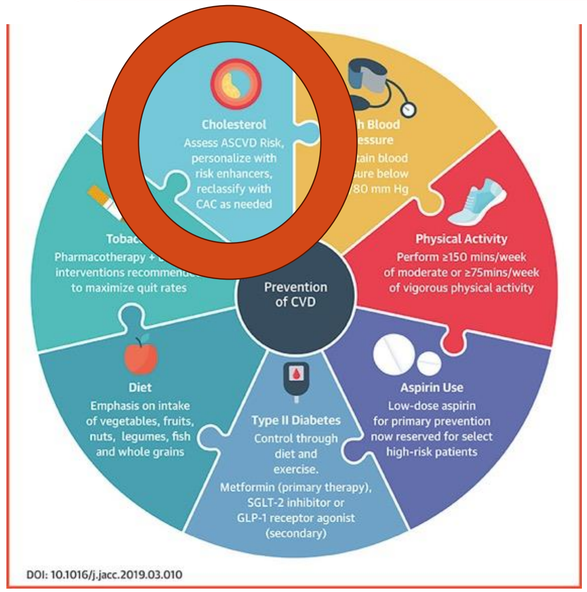
AGENDA

- Terapia dell'ipercolesterolemia: potenzialità e real word
- Nuove indicazioni dalle LG per l'ipertensione arteriosa
- Diabete mellito & co
- Riflessioni e proposte gestionali

Ruolo del colesterolo LDL



Il colesterolo viene, ad oggi, universalmente considerato non un semplice fattore di rischio ma, un **fattore causale di malattia aterosclerotica**

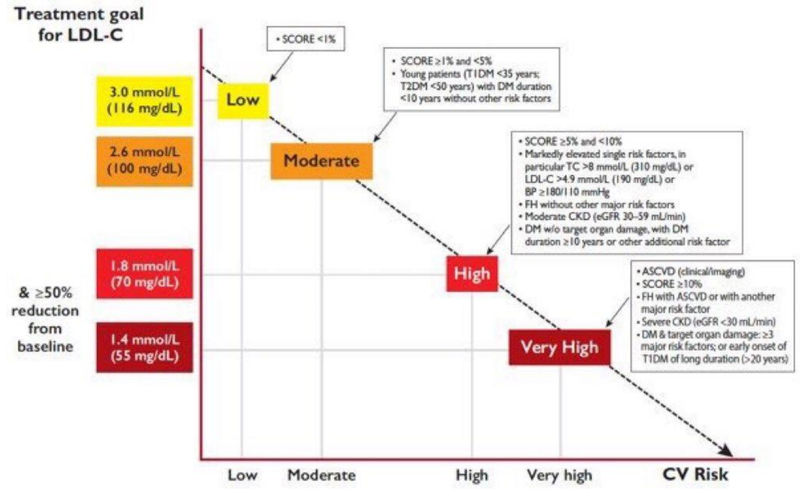
ESC European Society of Cardiology

ESC Congress 2019

LDL-C:The race to the bottom

"LDL-C it's a principal risk factor (cause) of a series cardiovascular disease. We know that there are other extremely important risk factors we know about **blood pressure, cigarette smoking, diabetes, inflamation,** but in the experimental models in the absence of LDL-C is virtually impossible to produce a plaque"

TARGET DIVERSI PER PAZIENTI DIVERSI

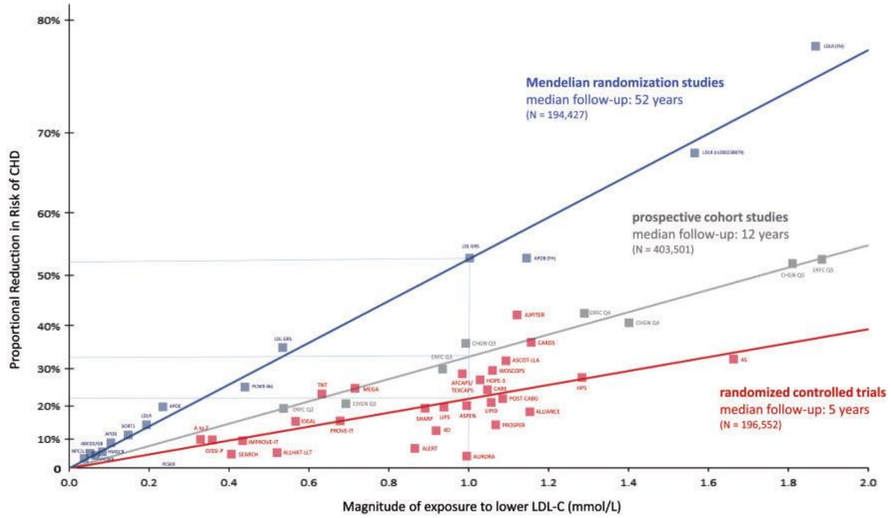


ESC guidelines 2019

ESC European Society of Cardiology
European Heart Journal (2017) 38, 2459–2472
doi:10.1093/eurheartj/ehx144
CURRENT OPINION

Low-density lipoproteins cause atherosclerotic cardiovascular disease. 1. Evidence from genetic, epidemiologic, and clinical studies. A consensus statement from the European Atherosclerosis Society Consensus Panel

Più tempo siamo esposti a bassi valori di colesterolo minore sarà il nostro rischio di presentare un evento aterosclerotico

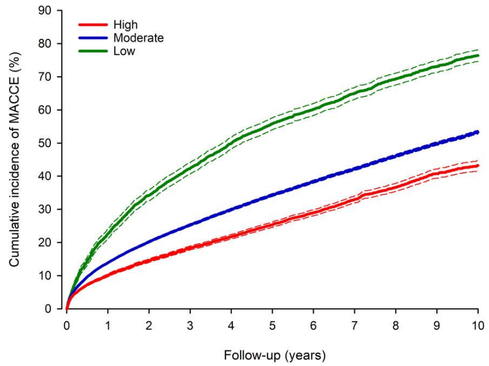


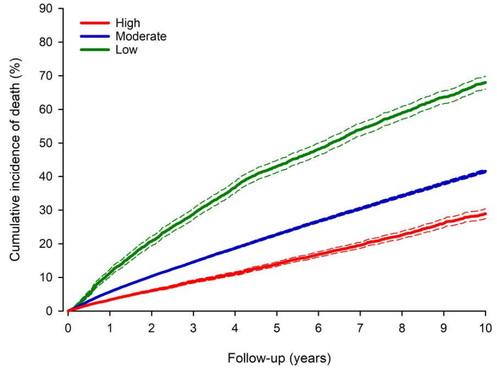
ESC European Society of Cardiology
European Heart Journal - Cardiovascular Pharmacotherapy (2023) 9, 156–164
https://doi.org/10.1093/ehjcvp/pvac064
ORIGINAL ARTICLE
Acute Coronary Syndromes

Initial statin dose after myocardial infarction and long-term cardiovascular outcomes

Ville Kytö[1,2,*], **Päivi Rautava**[2,3] **and Aleksi Tornio**[4,5]

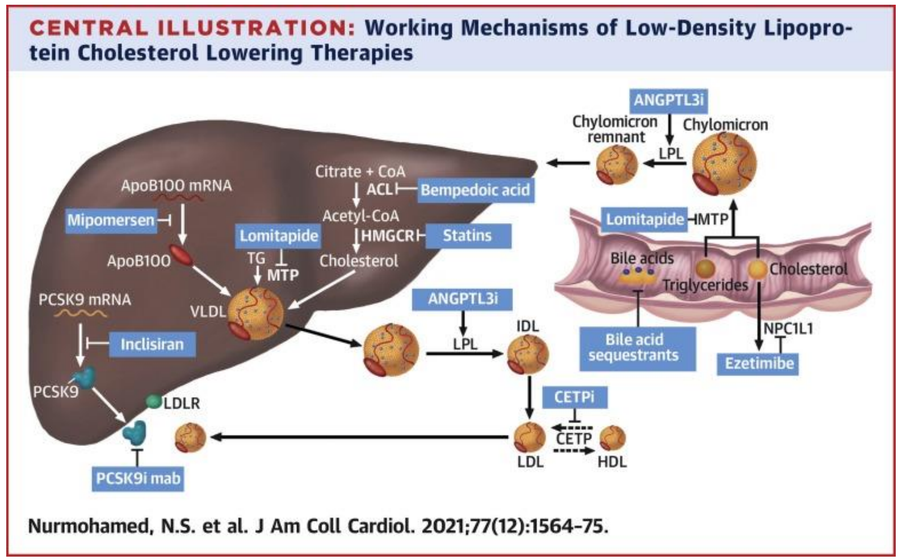
INIZIARE PRESTO





Conclusion Higher initial statin dose after MI is dose-dependently associated with better long-term cardiovascular outcomes. These results underline the importance of using a high statin dose early after MI.

TERAPIE A DISPOSIZIONE



Nurmohamed, N.S. et al. J Am Coll Cardiol. 2021;77(12):1564-75.

LA 'POTENZA' DEI FARMACI A DISPOSIZIONE

Farmaco	Riduzione attesa di C-LDL
Statina a moderata intensità	~30%
Statina ad alta intensità	~50%
Ezetimibe	~18% in monoterapia ~65% in aggiunta a statine ad alta intensità
Anticorpi monoclonali anti- PCSK9 Inclisiran	~60% in monoterapia ~75% in associazione a statine ad alta intensità ~85% in associazione a statine ad alta intensità ed ezetimibe
Acido bempedoico	~18% in aggiunta a statine (intensità moderata o alta) ~24% in monoterapia ipolipemizzante ~25% in pazienti intolleranti alle statine (± ezetimibe) ~30% in aggiunta ad anticorpi monoclonali anti-PCSK9* ~38% in combinazione a dose fissa con ezetimibe (± statine) ~60% in combinazione con ezetimibe e atorvastatina 20 mg

PCSK9, proproteina della convertasi subtilisina/kexina di tipo 9.
*Testato con evolocumab.

G Ital Cardiol 2023;24(6):490-498

CONCLUSIONI

Cholesterol lowering trials in coronary heart disease: frequency of citation and outcome.
U. Ravnskov

***Conclusion*—Lowering serum cholesterol concentrations does not reduce mortality and is unlikely to prevent coronary heart disease. Claims of the opposite are based on preferential citation of supportive trials.**

BMJ. 1992 Jul 4; 305(6844): 15–19

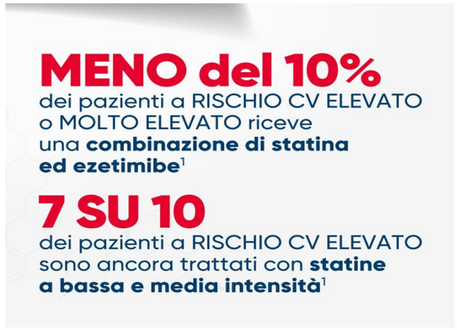
- LOWER
- SOONER
- FOR LONGER
- EFFICACY
- PERSISTENCE
- SAFETY

Atherosclerosis 314 (2020) 74–76
Contents lists available at ScienceDirect
Atherosclerosis
journal homepage: www.elsevier.com/locate/atherosclerosis

EAS Updates

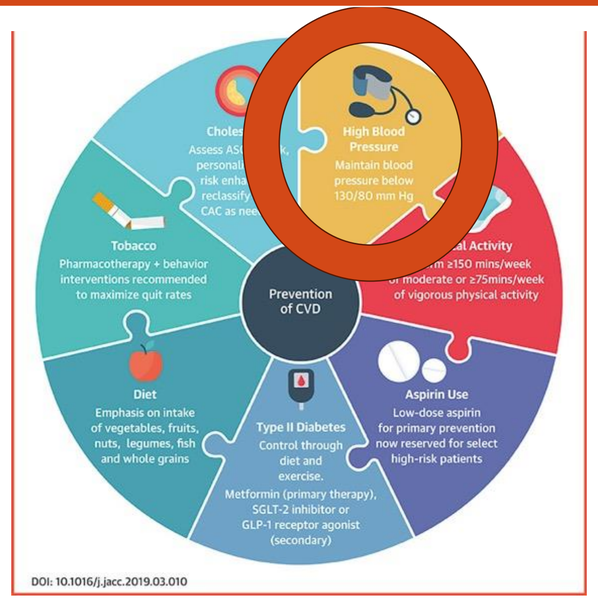
DA VINCI study: Change in approach to cholesterol management will be needed to reduce the implementation gap between guidelines and clinical practice in Europe

Jane K. Stock



Jane K Stock Atherosclerosis 2020

Il paziente con ipertensione arteriosa



ESC European Society of Cardiology
European Heart Journal (2024) 00, 1–107
https://doi.org/10.1093/eurheartj/ehae178
ESC GUIDELINES

2024 ESC Guidelines for the management of elevated blood pressure and hypertension

Developed by the task force on the management of elevated blood pressure and hypertension of the European Society of Cardiology (ESC) and *endorsed by the European Society of Endocrinology (ESE) and the European Stroke Organisation (ESO)*

Cosa c'è di nuovo?

NUOVA CLASSIFICAZIONE

Non-elevated blood pressure	Elevated blood pressure	Hypertension
Office BP	**Office BP**	**Office BP**
SBP <120 mmHg and DBP <70 mmHg	SBP 120–139 mmHg or DBP 70–89 mmHg	SBP ≥140 mmHg or DBP ≥90 mmHg
HBPM	**HBPM**	**HBPM**
SBP <120 mmHg and DBP <70 mmHg	SBP 120–134 mmHg or DBP 70–84 mmHg	SBP ≥135 mmHg or DBP ≥85 mmHg
ABPM	**ABPM**	**ABPM**
Daytime SBP <120 mmHg and Daytime DBP <70 mmHg	Daytime SBP 120–134 mmHg or Daytime DBP 70–84 mmHg	Daytime SBP ≥135 mmHg or Daytime DBP ≥85 mmHg
Insufficient evidence confirming the efficacy and safety of BP pharmacological treatment	Risk stratify to identify individuals with high cardiovascular risk for BP pharmacological treatment	Cardiovascular risk is sufficiently high to merit BP pharmacological treatment initiation

TARGET PIÙ AMBIZIONI

To reduce CVD risk, it is recommended that treated systolic BP values in most adults be targeted to 120–129 mmHg, provided the treatment is well tolerated.	I	A
In cases where on-treatment systolic BP is at or below target (120–129 mmHg) but diastolic BP is not at target (≥80 mmHg), intensifying BP-lowering treatment to achieve an on-treatment diastolic BP of 70–79 mmHg may be considered to reduce CVD risk.	IIb	C
Because the CVD benefit of an on-treatment systolic BP target of 120–129 mmHg may not generalize to the following specific settings, personalized and more lenient systolic BP targets (e.g. <140 mmHg): should be considered among patients meeting the following criteria: • pre-treatment, symptomatic, orthostatic hypotension; • and/or age ≥85 years.	IIa	C
Because the CVD benefit of an on-treatment systolic BP target of 120–129 mmHg may not generalize to the following specific settings, personalized and more lenient BP targets (e.g. <140/90 mmHg) may be considered among patients meeting the following criteria: • clinically significant, moderate to severe frailty at any age; • and/or limited predicted lifespan (<3 years).	IIb	C

PAS 120-129 mmHg

PAD 70-79 mmHg

Epidemiology/Population Science

May Measurement Month 2019

The Global Blood Pressure Screening Campaign of the International Society of Hypertension

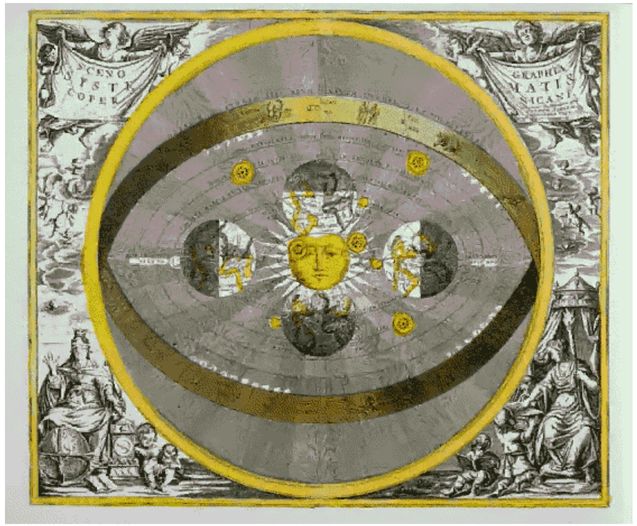
A che punto siamo?

Sottoposti a screening 1 508 130

Region	Number With Hypertension	Proportion With Hypertension	Proportion of Hypertensives Aware	Proportion of Hypertensives on Medication	Proportion of Those on Medication With Controlled BP	Proportion of All Hypertensives Controlled
South Asia	138 236	29.3%	46.2%	43.1%	55.6%	23.9%
East Asia	86 020	30.6%	57.9%	54.7%	63.1%	34.5%
Americas	107 752	41.2%	73.0%	69.7%	61.2%	42.6%
Sub-Saharan Africa	49 616	27.9%	42.7%	34.5%	49.3%	17.0%
South-east Asia and Australasia	58 156	47.8%	65.5%	62.8%	59.6%	37.4%
Europe	46 881	43.6%	71.5%	64.4%	47.9%	30.8%
Northern Africa and Middle East	26 677	30.6%	61.6%	58.1%	58.9%	34.2%
Worldwide	513 337	34.0%	58.7%	54.7%	57.8%	31.7%

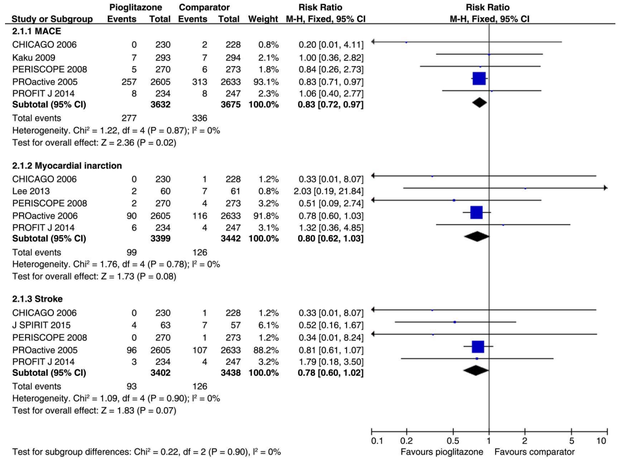
DOI: 10.1161/HYPERTENSIONAHA.120.14874

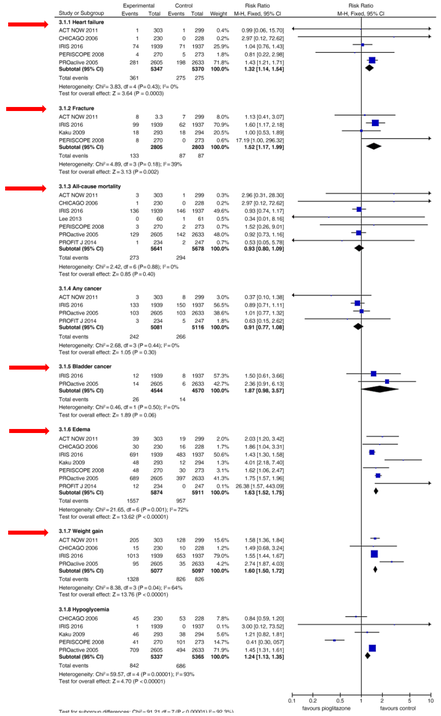
Diabete mellito & co



BMJ Open Pioglitazone and cardiovascular outcomes in patients with insulin resistance, pre-diabetes and type 2 diabetes: a systematic review and meta-analysis

COME TUTTO È INIZIATO





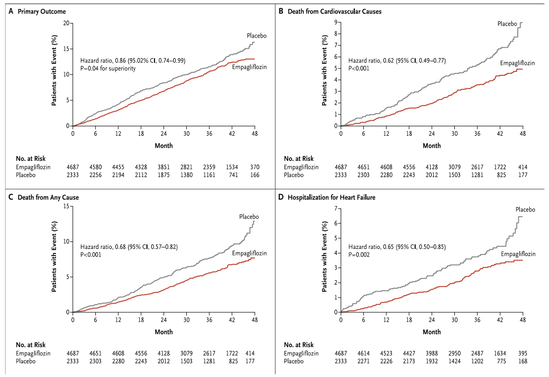
Come tutto è iniziato

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes

Bernard Zinman, M.D., Christoph Wanner, M.D., John M. Lachin, Sc.D., David Fitchett, M.D., Erich Bluhmki, Ph.D., Stefan Hantel, Ph.D., Michaela Mattheus, Dipl. Biomath., Theresa Devins, Dr.P.H., Odd Erik Johansen, M.D., Ph.D., Hans J. Woerle, M.D., Ulf C. Broedl, M.D., and Silvio E. Inzucchi, M.D., for the EMPA-REG OUTCOME Investigators

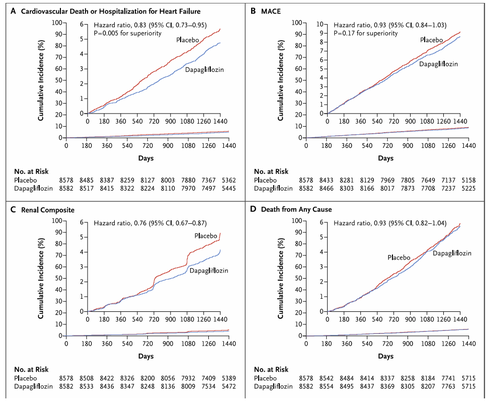


The NEW ENGLAND JOURNAL of MEDICINE

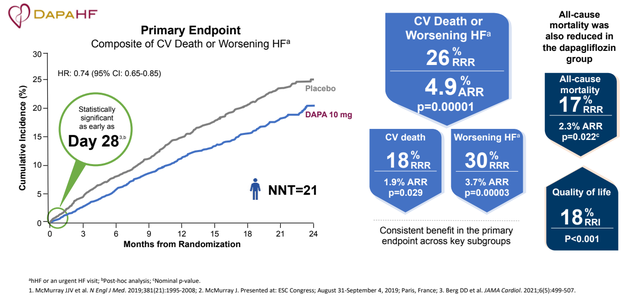
ORIGINAL ARTICLE

Dapagliflozin and Cardiovascular Outcomes in Type 2 Diabetes

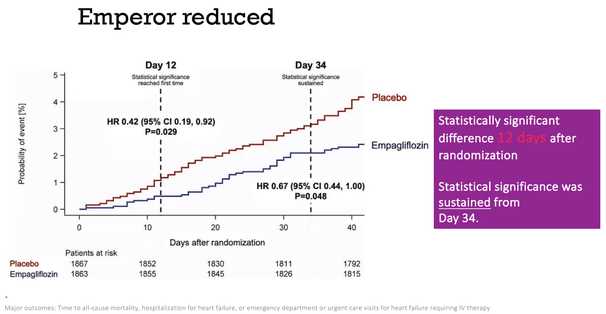
S.D. Wiviott, I. Raz, M.P. Bonaca, O. Mosenzon, E.T. Kato, A. Cahn, M.G. Silverman, T.A. Zelniker, J.F. Kuder, S.A. Murphy, D.L. Bhatt, L.A. Leiter, D.K. McGuire, J.P.H. Wilding, C.T. Ruff, E.A.M. Gause-Nilsson, M. Fredriksson, P.A. Johansson, A.-M. Langkilde, and M.S. Sabatine, for the DECLARE–TIMI 58 Investigators*



SCOMPENSO CARDIACO A FRAZIONE DI EIEZIONE RIDOTTA



[a]HHF or an urgent HF visit; [b]Post-hoc analysis; [c]Nominal p-value.
1. McMurray JJV et al. *N Engl J Med*. 2019;381(21):1995-2008; 2. McMurray J. Presented at: ESC Congress; August 31-September 4, 2019; Paris, France; 3. Berg DD et al. *JAMA Cardiol*. 2021;6(5):499-507.



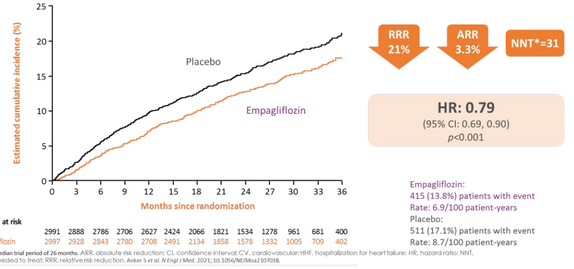
Statistically significant difference 12 days after randomization

Statistical significance was sustained from Day 34.

Major outcomes: Time to all-cause mortality, hospitalization for heart failure, or emergency department or urgent care visits for heart failure requiring IV therapy

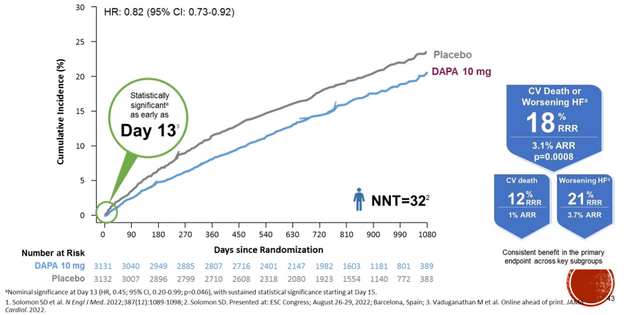
SCOMPENSO CARDIACO A FRAZIONE DI EIEZIONE LIEVEMENTE RIDOTTA O PRESERVATA

Emperor-preserved: Empagliflozin demonstrated a clinically meaningful 21% RRR in the composite primary endpoint of CV death or HHF



*During a median trial period of 26 months. ARR, absolute risk reduction; CI, confidence interval; CV, cardiovascular; HHF, hospitalization for heart failure; HR, hazard ratio; NNT, number needed to treat; RRR, relative risk reduction. Anker S *et al. N Engl J Med.* 2021; 10.1056/NEJMoa2107038.

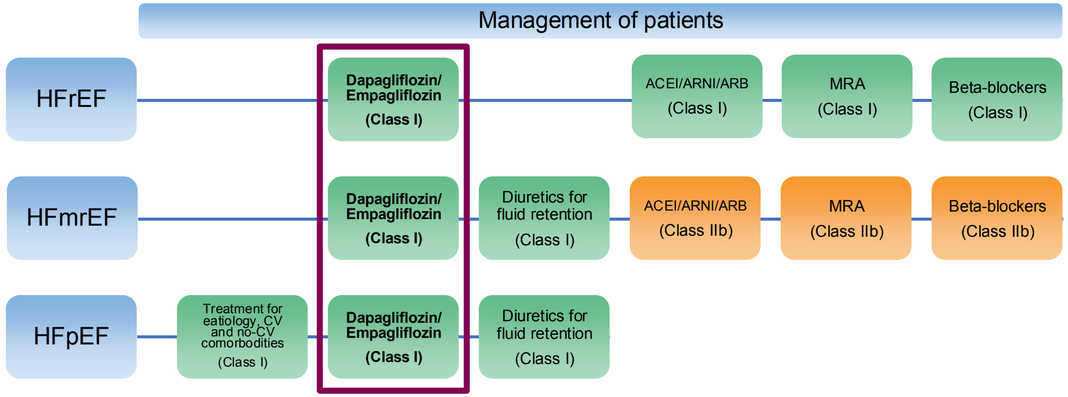
DELIVER- Primary Composite of CV Death, hHF or Urgent HF Visit[1]



*Nominal significance at Day 13 (HR, 0.45; 95% CI, 0.20-0.99; p=0.046), with sustained statistical significance starting at Day 15.
1. Solomon SD et al. *N Engl J Med.* 2022;387(12):1089-1098; 2. Solomon SD. Presented at: ESC Congress; August 26-29, 2022; Barcelona, Spain; 3. Vaduganathan M et al. Online ahead of print. *J Am Coll Cardiol.* 2022.

One for all

ESC Heart Failure Guidelines: Class IA Recommendation for SGLT2-i in Patients With HF



Adapted from: McDonagh TA et al. Eur Heart J. 2021; McDonagh TA et al. Online ahead of print. Eur Heart J. 2023.

EMPA-REG OUTCOME: improvement in kidney outcomes was consistent across kidney-related subgroups

T2D

Reduction in the risk of incident or worsening nephropathy*†[1]

In the overall population

T2D

↓ 39% RRR

HR 0.61
(95% CI 0.53, 0.70)

Albuminuria category (mg/g)

<30 | ≥30

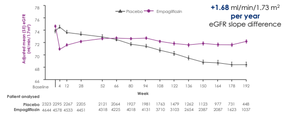
p-interaction=0.87

eGFR category (ml/min/1.73 m²)

≥90
60 to <90
45 to <60
<45

p-interaction=0.74

Rate of kidney function decline was reduced with empagliflozin compared with placebo[2]



+1.68 ml/min/1.73 m² per year eGFR slope difference

The safety profile of empagliflozin was consistent across baseline eGFR subgroups (≥60 and <60 ml/min/1.73 m²)[1]

Events consistent with acute kidney failure, including **AKI and hyperkalaemia** were reported in a **lower percentage of people in the empagliflozin group** than in the placebo group[1]

EMPEROR-Reduced: empagliflozin slowed the rate of kidney function decline in HFrEF, in a population which included people with CKD

Of 3730 people with HFrEF[1,2]:

CKD 47%
Mean eGFR **79** ml/min/1.73 m²
Median UACR **36** mg/g

CKD 53%
Mean eGFR **47** ml/min/1.73 m²
Median UACR **15** mg/g

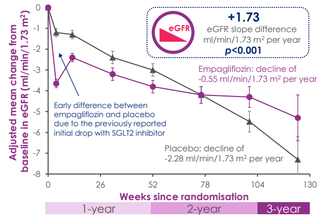
<60 ml/min/1.73 m² in **48%** of people

eGFR

Overall mean **62** ml/min/1.73 m²

50% had diabetes at baseline

Rate of long-term kidney function decline was slower with empagliflozin than placebo[1,2]



eGFR +1.73 eGFR slope difference ml/min/1.73 m² per year p<0.001

Empagliflozin: decline of -0.55 ml/min/1.73 m² per year

Early difference between empagliflozin and placebo due to the previously reported initial drop with SGLT2 inhibitor

Placebo: decline of -2.28 ml/min/1.73 m² per year

EMPEROR-Preserved: empagliflozin slowed the rate of decline in kidney function in people with HFpEF with or without T2D

Of 5988 people with HFpEF[1]:

<60 ml/min/1.73 m² in **50%** of people

eGFR

Overall mean **61** ml/min/1.73 m²

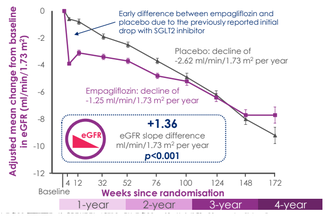
49% had diabetes at baseline

Incidence of the composite kidney outcome in people treated with empagliflozin was similar to placebo*†[1]

HR 0.95
(95% CI 0.73, 1.24)

Incidence of acute kidney failure was similar between treatment arms

Empagliflozin reduced the rate of kidney function decline[1]



Early difference between empagliflozin and placebo due to the previously reported initial drop with SGLT2 inhibitor

Placebo: decline of -2.62 ml/min/1.73 m² per year

Empagliflozin: decline of -1.25 ml/min/1.73 m² per year

eGFR +1.36 eGFR slope difference ml/min/1.73 m² per year p<0.001

EMPRISE: empagliflozin improved kidney-related safety compared with DPP-4i treatment in the US real-world setting

T2D

Of 78,144 people with T2D were included in the 3 Year analysis[1]:

10% had **diabetic nephropathy** at baseline

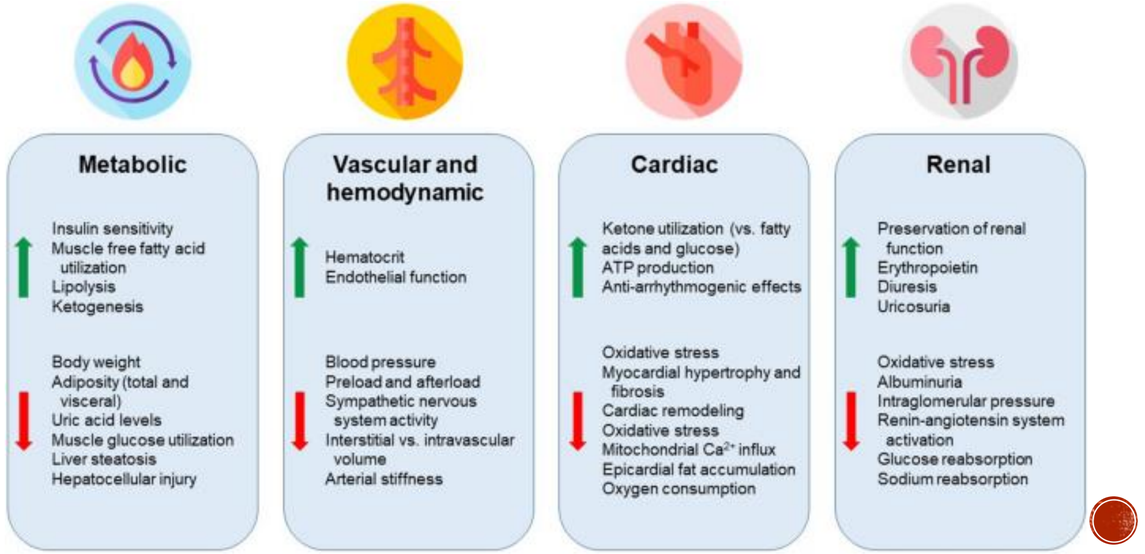
28% had **CV disease***

Empagliflozin reduced the risk of AKI compared with DPP-4i treatment[1]

AKI (primary)‡
↓ 40% RRR
HR 0.60
(95% CI 0.43, 0.85)

AKI (broad)‡
↓ 38% RRR
HR 0.62
(95% CI 0.55, 0.71)

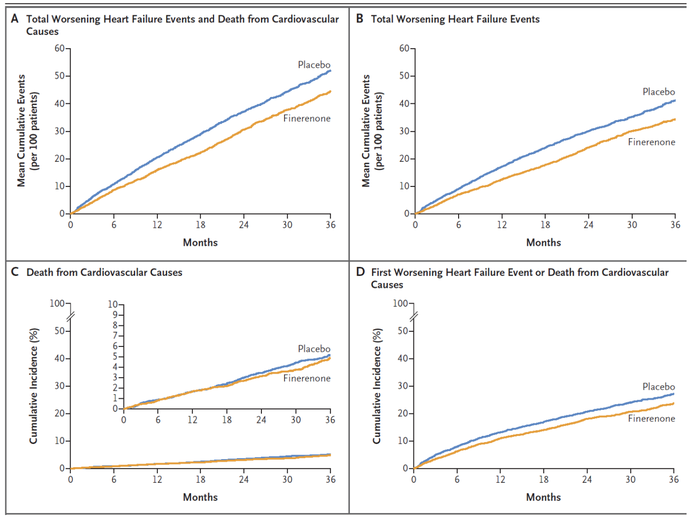
PROTEZIONE CARDIO-NEFRO-METABOLICA



The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812 OCTOBER 24, 2024 VOL. 391 NO. 16

Finerenone in Heart Failure with Mildly Reduced or Preserved Ejection Fraction

S.D. Solomon, J.J.V. McMurray, M. Vaduganathan, B. Claggett, P.S. Jhund, A.S. Desai, A.D. Henderson, C.S.P. Lam, B. Pitt, M. Senni, S.J. Shah, A.A. Voors, F. Zannad, I.Z. Abidin, M.A. Alcocer-Gamba, J.J. Atherton, J. Bauersachs, M. Chang-Sheng, C.-E. Chiang, O. Chioncel, V. Chopra, J. Comin-Colet, G. Filippatos, C. Fonseca, G. Gajos, S. Goland, E. Goncalvesova, S. Kang, T. Katova, M.N. Kosiborod, G. Latkovskis, A.P.-W. Lee, G.C.M. Linssen, G. Llamas-Esperón, V. Mareev, F.A. Martinez, V. Melenovský, B. Merkely, S. Nodari, M.C. Petrie, C.I. Saldarriaga, J.F.K. Saraiva, N. Sato, M. Schou, K. Sharma, R. Troughton, J.A. Udell, H. Ukkonen, O. Vardeny, S. Verma, D. von Lewinski, L. Voronkov, M.B. Yilmaz, S. Zieroth, J. Lay-Flurrie, I. van Gameren, F. Amarante, P. Kolkhof, and P. Viswanathan, for the FINEARTS-HF Committees and Investigators*



CONCLUSIONS

In patients with heart failure and mildly reduced or preserved ejection fraction, finerenone resulted in a significantly lower rate of a composite of total worsening heart failure events and death from cardiovascular causes than placebo

SEMAGLUTIDE (glp-1 ra) MECCANISMI DI CARDIO-NEFROPROTEZIONE

Effetti Metabolici:

1) Riduce la glicemia in modo glucosio-dipendente, stimolando la secrezione di insulina e riducendo la secrezione di glucagone quando la glicemia è elevata
2) Riduce l'appetito per azione sul nucleo arcuato a livello ipotalamico che comparta un ridotto apporto calorico e di conseguenza una riduzione del peso corporeo e della massa grassa
3) Miglioramento dei lipidi plasmatici e una riduzione della pressione arteriosa sistolica e diastolica (azione anti-aterosclerotica)

Effetti Nefroprotettivi:

1) Attenuazione della velocità di declino del filtrato glomerulare stimato (eGFR) e riduzione dell'albuminuria nel tempo

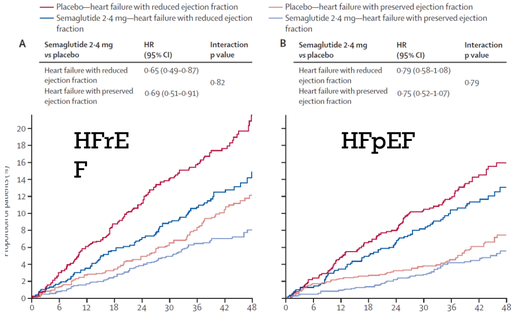
Effetti Anti infiammatori:

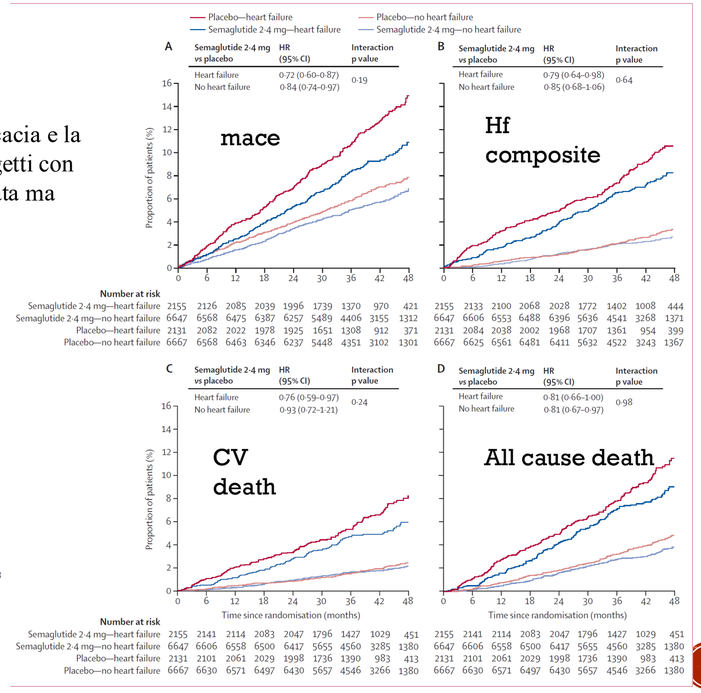
1) riduzione dei livelli di citochine pro-infiammatorie
2) modulazione dell'attività del sistema immunitario

Semaglutide and cardiovascular outcomes in patients with obesity and prevalent heart failure: a prespecified analysis of the SELECT trial

John Deanfield, Subodh Verma, Benjamin M Scirica, Steven E Kahn, Scott S Emerson, Donna Ryan, Ildiko Lingvay, Helen M Colhoun, Jorge Plutzky, Mikhail N Kosiborod, G Kees Hovingh, Søren Hardt-Lindberg, Ofir Frenkel, Peter E Weeke, Søren Rasmussen, Assen Goudev, Chim C Lang, Miguel Urina-Triana, Mikko Pietilä, A Michael Lincoff, for the SELECT Trial Investigators

Lo studio SELECT ha recentemente valutato l'efficacia e la sicurezza di semaglutide 2,4 mg s.c. in 17.604 soggetti con IMC≥27 kg/m2 e una storia di ASCVD documentata ma senza diabete tipo 2 noto





SEMAGLUTIDE

STEP-HFpEF TRIAL

- 529 pazienti con scompenso cardiaco con funzione cardiaca preservata e obesità (BMI >30)
- Semagludite (2.4 mg a settimana) vs placebo per 52 settimane.
- End point primari: Variazione del Kansas City Cardiomyopathy Questionnaire clinical summary score (KCCQ-CSS; valori da 0 a 100, valori più alti indicano meno sintomi e meno limitazione fisica) e cambiamento del peso corporeo .
- End point secondari: 6MWT, composito di morte, scompenso cardiaco, cambiamenti nel KCCQ-CSS e 6MWT, cambiamenti nei valori di PCR.
- **Risultati:** variazione KCCQ-CSS 16.6 points in semaglutide , 8.7 in placebo (differenza stimata 7.8 punti; 95% [CI], 4.8 a 10.9; P<0.001), cambiamento peso corporeo -13.3% in semaglutide e -2.6% in placebo (differenza -10.7 punti percentuali; 95% CI, -11.9 a -9.4; P<0.001).
- Eventi avversi seri : 35 participanti (13.3%) in semaglutide , 71 (26.7%) in placebo.
- **Conclusioni:** Nei pazienti con scompenso cardiaco a funzione sistolica preservata e obesità il trattamento con semaglutide (2.4 mg) porta a riduzione dei sintomi e incremento della capacità di esercizio e perdita di peso rispetto a placebo.

RESEARCH SUMMARY

Semaglutide in Patients with Heart Failure with Preserved Ejection Fraction and Obesity

Kosiborod MN et al. DOI: 10.1056/NEJMoa2306963

CLINICAL PROBLEM

Patients with heart failure with preserved ejection fraction often have obesity, a condition that is associated with a greater burden of heart failure–related symptoms, worse functional capacity, and more impaired quality of life. Whether therapies that target obesity in such patients can alleviate symptoms and physical limitations is unknown.

CLINICAL TRIAL

Design: A multinational, double-blind, randomized, placebo-controlled trial evaluated whether treatment with semaglutide — a glucagon-like peptide 1 receptor agonist approved for long-term weight management — would reduce heart failure–related symptoms and improve physical function, in addition to inducing weight loss, in adults with heart failure with preserved ejection fraction and obesity.

Intervention: 529 patients with a body-mass index of ≥30 were assigned to receive subcutaneous semaglutide (2.4 mg) or placebo once weekly for 52 weeks. The dual primary end points were the change in the Kansas City Cardiomyopathy Questionnaire clinical summary score (KCCQ-CSS), which quantifies heart failure–related symptoms and physical function, and the change in body weight from baseline to week 52.

RESULTS

Efficacy: The mean change in KCCQ-CSS and the mean percentage change in body weight were significantly greater with semaglutide than with placebo.

Safety: Serious adverse events occurred less often with semaglutide than with placebo, primarily because fewer cardiac disorders occurred in the semaglutide group. Adverse events leading to treatment discontinuation were more common with semaglutide.

LIMITATIONS AND REMAINING QUESTIONS

- The number of non-White trial participants was low.
- The trial was not sufficiently powered to evaluate the effects of semaglutide on clinical events, such as hospitalization for heart failure.
- Whether the observed effects of semaglutide would last beyond 1 year is unknown.

Links: Full Article | NEJM Quick Take | Editorial

Heart failure with preserved ejection fraction + BMI ≥30

Semaglutide (N=263)

Placebo (N=266)

Change in KCCQ-CSS at 52 Wk

Change in Body Weight at 52 Wk

Serious Adverse Events

Cardiac Disorders

CONCLUSIONS

In adults with heart failure with preserved ejection fraction and obesity, once-weekly treatment with semaglutide was associated with greater reductions in heart failure–related symptoms and physical limitations and greater weight loss than placebo over 52 weeks.

PROPOSTE DI NUOVI MODELLI GESTIONALI

TARGET SFIDANTI CON FORTI RICADUTE PROGNOSTICHE

VALUTAZIONE CARDIO-METABOLICA «OLISTICA» DEL PZ

FARMACI EFFICACI

~~**VALUTAZIONE MMG**~~
~~**CUP**~~
~~**CONSULENZA CARDIOLOGICA**~~

EQUIPE DI CURA MULTIDISCIPLINARE

MMG:
- ATTREZZATURE DIAGNOSTICHE

INFERMIERE:
- DEVICE PER TELEMONITORAGGIO
- POINT OF CARE
- AMBULATORI VALUTAZIONE RISCHIO CARDIOVASCOLARE

CARDIOLOGO:
- AMBULATORI IN SEDE CON SLOT DEDICATI AI MMG DELLA CASA DI COMUNITA'
- ATTIVITA' DI «HEART TEAM» TERRITORIALE

DIMISSIONE OSPEDALIERA:
- OTTIMIZZAZIONE DELLE CURE
- PIANIFICAZIONE DI FOLLOW-UP

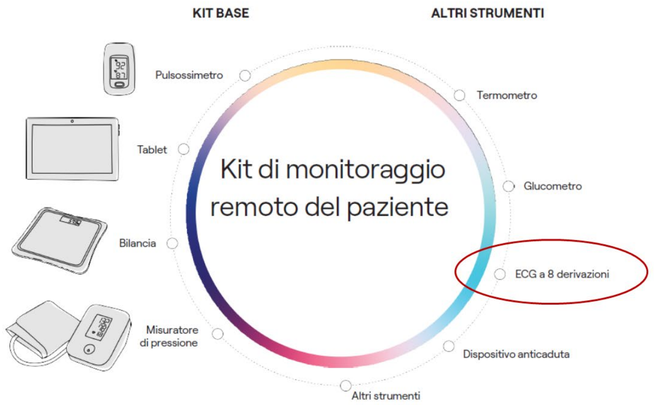
TELEMONITORAGGIO:
- RILEVAZIONE MULTIPARAMETRICA NEL PRIMO MESE CRITICO POST DIMISSIONE

TELEVISITA:
- IMPLEMENTAZIONE RAPIDA DELLA TERAPIA POST DIMISSIONE E VERIFICA DEI TARGET

AMBULATORIO DEDICATO FOLLOW-UP A 1 MESE

PROGRAMMI DI TELERIABILITAZIONE

CONNECT CHF/CKD
Progetto telemonitoraggio post dimissione scompenso cardiaco
AZIENDA USL TOSCANA CENTRO



Durante la fase di telemonitoraggio, tutti i dati sono accessibili anche al MMG ed al Nefrologo in modo da identificare e risolvere eventuali criticità emerse. In particolare, visto che la funzione renale rappresenta un fattore critico potenzialmente limitante la corretta up-tritation della terapia, sono previsti momenti preordinati di confronto con il nefrologo per la discussione dei casi più complessi

Dimissione Ospedaliera dopo SC:
Segnalazione al MMG della dimissione del pz e trasmissione di password per accedere al portale di monitoraggio

Pz ad alto profilo di rischio: consegna di Kit di telemonitoraggio con rilevazione autonoma, giornaliera dei parametri da effettuare nelle prime 3 settimane dalla dimissione → Visita ambulatorio scompenso

Pz a basso profilo di rischio: attivazione dell'infermiere di famiglia (COT) che con kit di monitoraggio mobile effettua un controllo settimanale nelle prime 3 settimane dalla dimissione → Visita ambulatorio scompenso

Contatto in TELEVISITA a 10 gg dalla dimissione per controllo preordinato di: Creatinina (GFR) e albumina/creatinina urinaria Na-K NTproBNP


GRAZIE PER L'ATTENZIONE