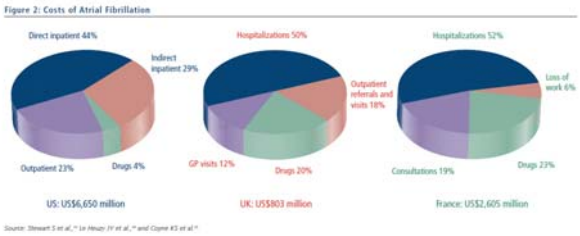
Stewart S, Murphy N, Walker A, et al., Cost of an emerging epidemic; an economic analysis of atrial fibrillation in the UK, *Heart*, 2004;90:286–92.
Le Heuzy JY, Paziaud O, Piot O, et al., Cost of care distribution in atrial fibrillation patients: The COCAF study, *Am Heart J*, 2004;147:121–6.
Coyne KS, Paramore C, Grandy S, et al., Assessing the direct costs of treating nonvalvular atrial fibrillation in the United States, *Value*

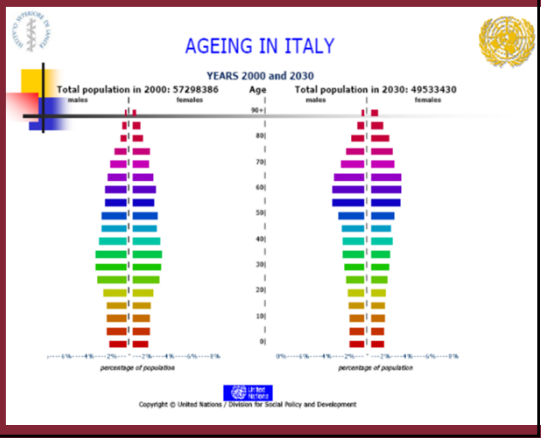


UN PERCORSO POSSIBILE PER IL TRATTAMENTO DELLA FIBRILLAZIONE ATRIALE E DELL'ICTUS CARDIOEMBOLICO

M.L. Sacchetti

Dipartimento di Neurologia e Psichiatria

SAPIENZA
UNIVERSITÀ DI ROMA



European Heart Journal Advance Access published August 24, 2012

European Heart Journal
doi:10.1093/eurheartj/ehs253

ESC GUIDELINES

2012 focused update of the ESC Guidelines for the management of atrial fibrillation

"The current estimate of the prevalence of atrial fibrillation (AF) in the developed world is approximately 1.5–2% of the general population, with a average age of patients in this condition steadily rising, such that it now average between 75 and 85 years"

Le principali consequenze della FA[1,3]

- Infarto cerebrale
- Scompenso cardiaco
- Demenza

Le donne con FA corrono un rischio doppio rispetto agli uomini di avere un ictus cerebrale (3% vs 1,6%)

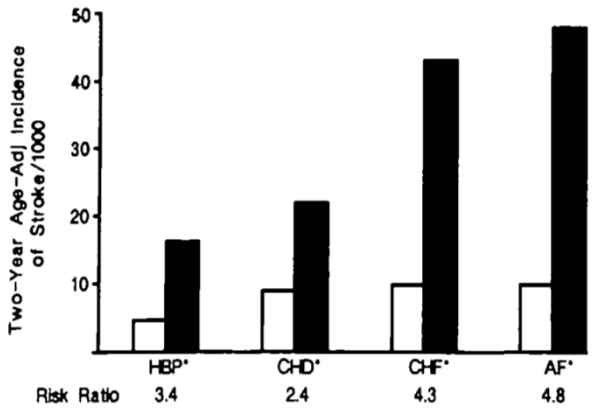


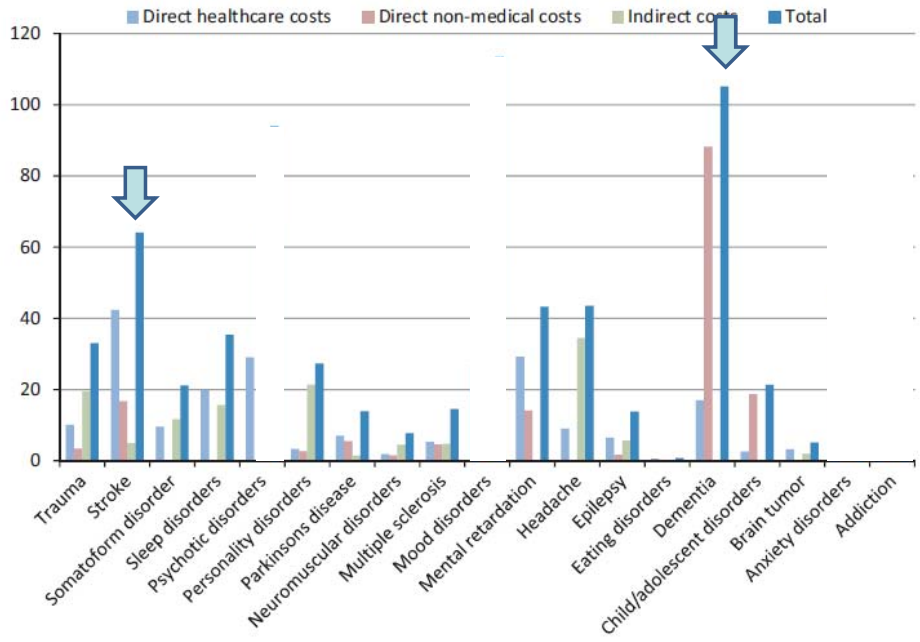
FIGURE 1. *Bar graph of 2-year age-adjusted incidence of stroke according to presence (filled bars) and absence (open bars) of cardiovascular condition. HBP, hypertension; CHD, coronary heart disease; CHF, cardiac failure; AF, atrial fibrillation.* *p<0.001 *different from unity.*

Stroke. 1991;22:983-988

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J Am Coll Cardiol. 2011;57(11):e101-e198.

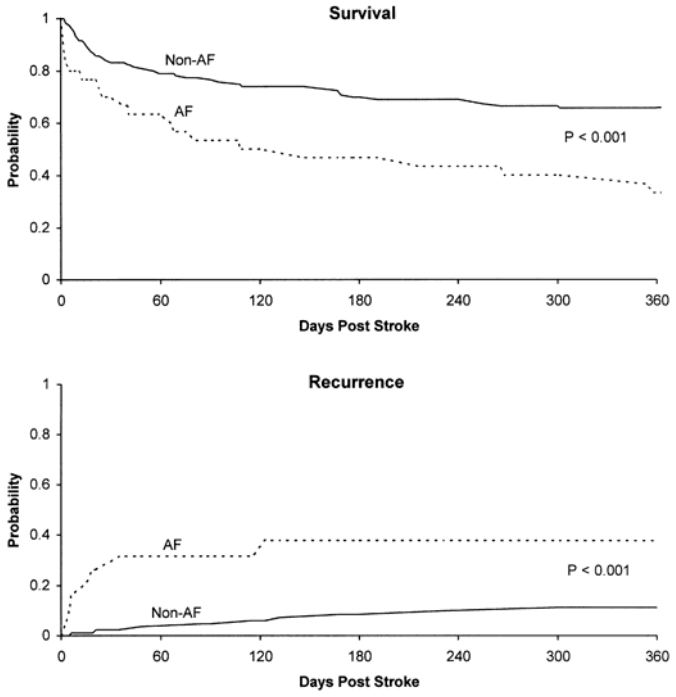
Costi delle malattie Neurologiche in Europa (bilioni €PPP2010)



M.L. Sacchetti

Olesen J. Eurp. J. Neurol. 2012; 19:155-162

One-year Kaplan-Meier survival and stroke recurrence curves for 120 non-AF subjects and 30 AF subjects.



American Heart Association
Learn and Live

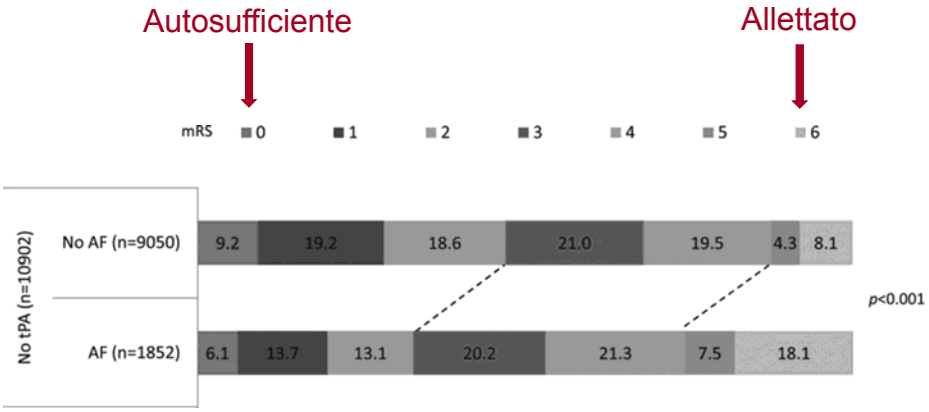
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Lin H et al. Stroke 1996;27:1760-1764

Copyright © American Heart Association

Functional outcomes at discharge in patients receiving and not receiving thrombolysis stratified by atrial fibrillation.

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Saposnik G et al. Stroke 2013;44:99-104

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Stroke Prevention: What works

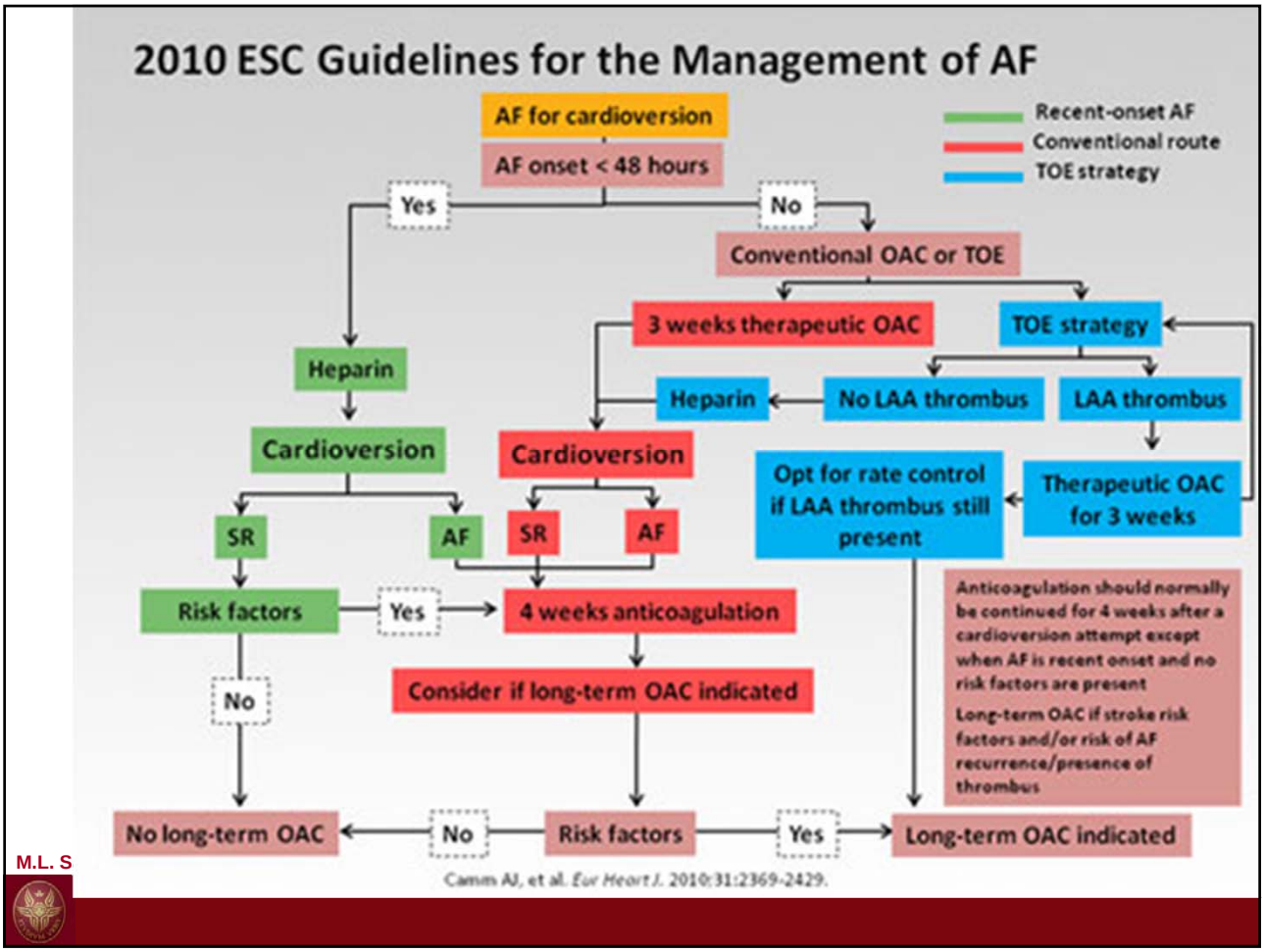
Intervention	Stroke Prevention Effect
Smoking cessation	Prevents stroke by half in six months
Cretan Mediterranean Diet	Prevents stroke by 60% in 4 years
Blood pressure control	Prevents stroke by 40-50% in 2 years
Antiplatelet agents	Prevents stroke by 25-30% in 2 years
Anticoagulation for atrial fibrillation	Prevents stroke by half in a year
Lipid lowering with statins	Prevents stroke by 25-30% in 2 years
Diabetes control	Prevents stroke by 30% in 4 years
Homocysteine treatment with vitamins	Prevents stroke by 24% in 2 years
Endarterectomy for severe symptomatic carotid stenosis	Prevents stroke by 66% in 2 years

Getting it all right can reduce the risk of stroke by 80-90% in secondary prevention[1]

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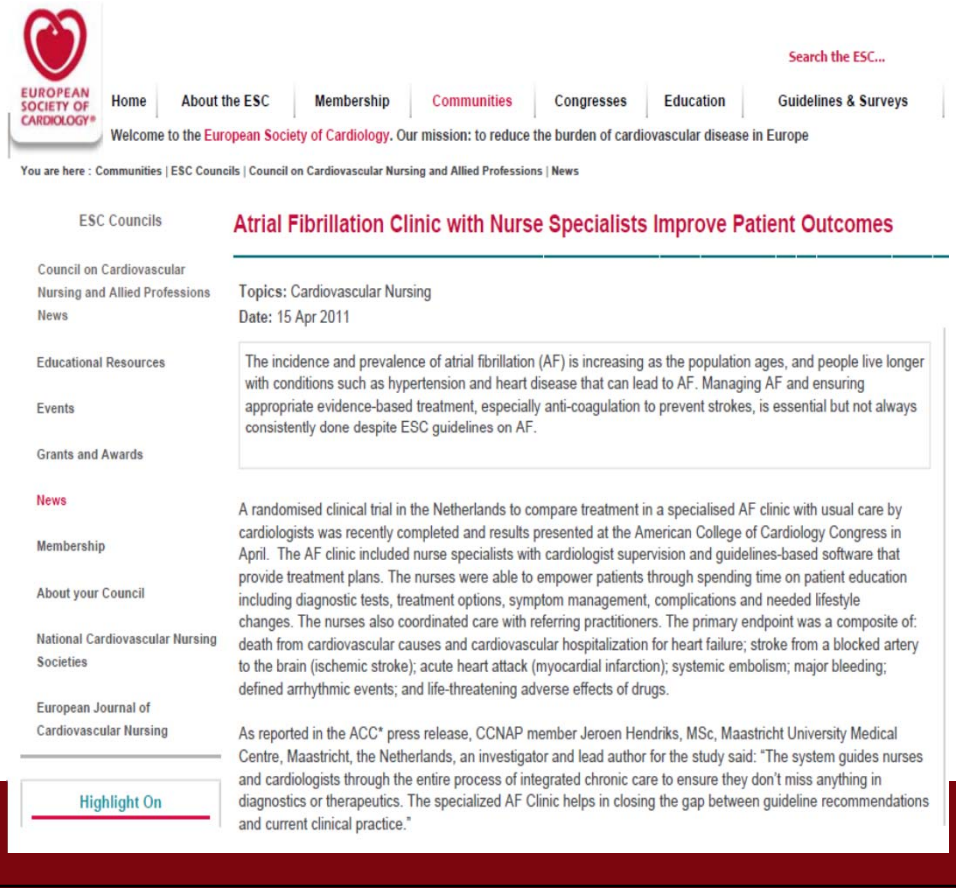


1. Hackam DG, Spence JD. Stroke. 2007;38:1881-5.


2010 ESC Guidelines for the Management of AF
AF for cardioversion
AF onset < 48 hours
Recent-onset AF
Conventional route
TOE strategy
Yes
No
Conventional OAC or TOE
3 weeks therapeutic OAC
TOE strategy
Heparin
Heparin
No LAA thrombus
LAA thrombus
Cardioversion
Cardioversion
Opt for rate control if LAA thrombus still present
Therapeutic OAC for 3 weeks
SR
AF
SR
AF
Risk factors
Yes
4 weeks anticoagulation
Anticoagulation should normally be continued for 4 weeks after a cardioversion attempt except when AF is recent onset and no risk factors are present
Long-term OAC if stroke risk factors and/or risk of AF recurrence/presence of thrombus
No
Consider if long-term OAC indicated
No long-term OAC
No
Risk factors
Yes
Long-term OAC indicated
Camm AJ, et al. Eur Heart J. 2010;31:2369-2429.

M.L. S

Come garantire la gestione appropriata del singolo



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Highlight On

Atrial Fibrillation Clinic with Nurse Specialists Improve Patient Outcomes

Topics: Cardiovascular Nursing
Date: 15 Apr 2011

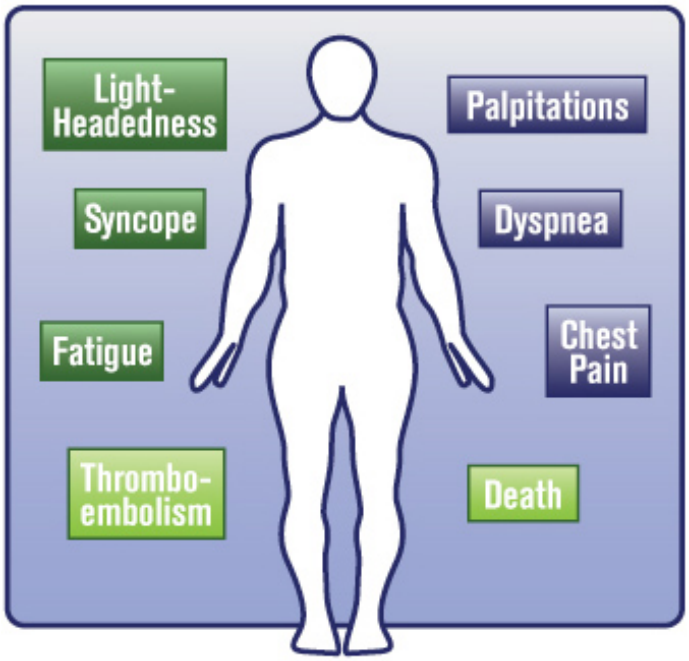
The incidence and prevalence of atrial fibrillation (AF) is increasing as the population ages, and people live longer with conditions such as hypertension and heart disease that can lead to AF. Managing AF and ensuring appropriate evidence-based treatment, especially anti-coagulation to prevent strokes, is essential but not always consistently done despite ESC guidelines on AF.

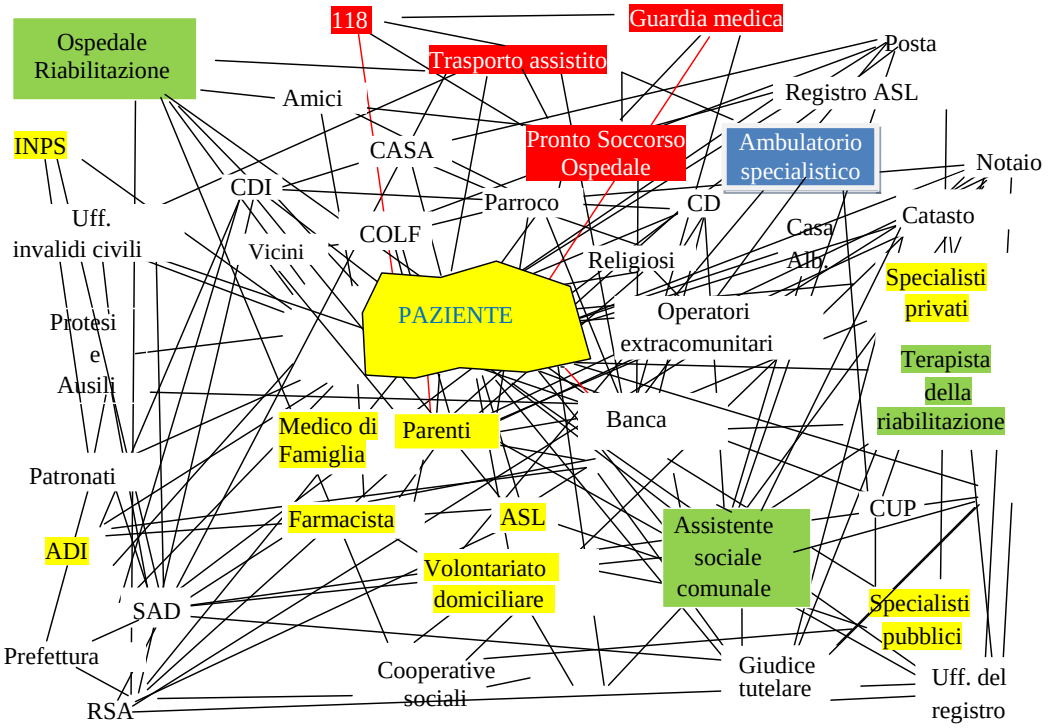
A randomised clinical trial in the Netherlands to compare treatment in a specialised AF clinic with usual care by cardiologists was recently completed and results presented at the American College of Cardiology Congress in April. The AF clinic included nurse specialists with cardiologist supervision and guidelines-based software that provide treatment plans. The nurses were able to empower patients through spending time on patient education including diagnostic tests, treatment options, symptom management, complications and needed lifestyle changes. The nurses also coordinated care with referring practitioners. The primary endpoint was a composite of: death from cardiovascular causes and cardiovascular hospitalization for heart failure; stroke from a blocked artery to the brain (ischemic stroke); acute heart attack (myocardial infarction); systemic embolism; major bleeding; defined arrhythmic events; and life-threatening adverse effects of drugs.

As reported in the ACC* press release, CCNAP member Jeroen Hendriks, MSc, Maastricht University Medical Centre, Maastricht, the Netherlands, an investigator and lead author for the study said: "The system guides nurses and cardiologists through the entire process of integrated chronic care to ensure they don't miss anything in diagnostics or therapeutics. The specialized AF Clinic helps in closing the gap between guideline recommendations and current clinical practice."

M.L. Sacchetti

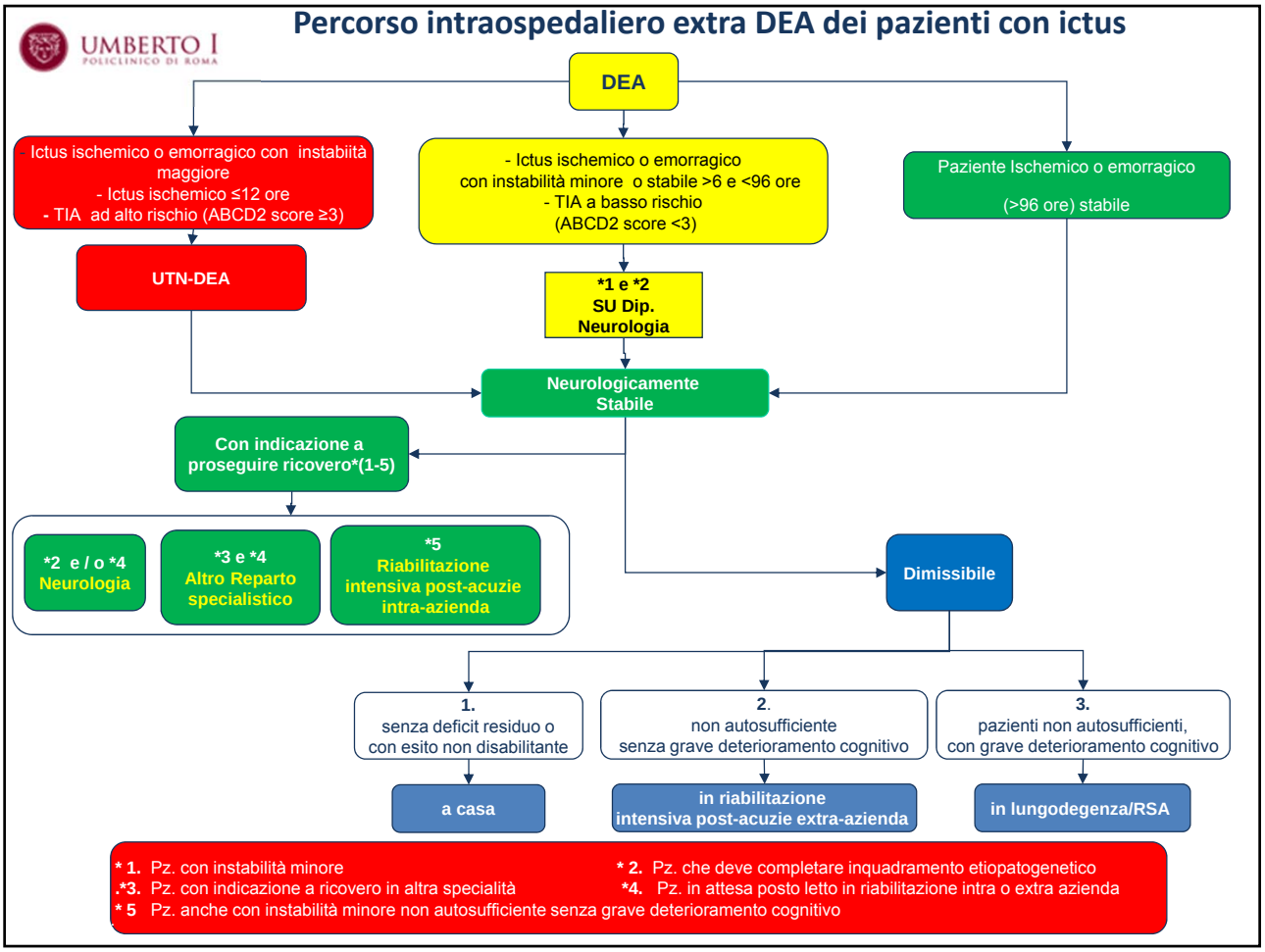
Presentazione clinica della FA





M.L. Sacchetti

Cortesia S. Casazza, 2007 modificato


UMBERTO I
POLICLINICO DI ROMA
Percorso intraospedaliero extra DEA dei pazienti con ictus
DEA
- Ictus ischemico o emorragico con instabilità maggiore
- Ictus ischemico ≤12 ore
- TIA ad alto rischio (ABCD2 score ≥3)
- Ictus ischemico o emorragico con instabilità minore o stabile >6 e <96 ore
- TIA a basso rischio (ABCD2 score <3)
Paziente Ischemico o emorragico (>96 ore) stabile
UTN-DEA
*1 e *2 SU Dip. Neurologia
Neurologicamente Stabile
Con indicazione a proseguire ricovero*(1-5)
*2 e / o *4 Neurologia
*3 e *4 Altro Reparto specialistico
*5 Riabilitazione intensiva post-acuzie intra-azienda
Dimissibile
1. senza deficit residuo o con esito non disabilitante
2. non autosufficiente senza grave deterioramento cognitivo
3. pazienti non autosufficienti, con grave deterioramento cognitivo
a casa
in riabilitazione intensiva post-acuzie extra-azienda
in lungodegenza/RSA
* 1. Pz. con instabilità minore
* 2. Pz. che deve completare inquadramento etiopatogenetico
*3. Pz. con indicazione a ricovero in altra specialità
*4. Pz. in attesa posto letto in riabilitazione intra o extra azienda
* 5 Pz. anche con instabilità minore non autosufficiente senza grave deterioramento cognitivo

Heart, Lung and Circulation

Available online 15 November 2012

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Letter to the Editor

Atrial Fibrillation and the Meaning of Life

Peter French

Calvary Hospital Canberra Medicine, Mary Potter Circuit, Belconnen, Canberra, A.C.T. 2617, Australia

http://dx.doi.org/10.1016/j.hlc.2012.10.007, How to Cite or Link Using DOI

The sun, the Earth, just everything,
Took six days of creation,
But then to torment mankind,
The Devil invented atrial fibrillation.

So AF remains a puzzle,
With no easy answers today,

And if anyone can cure AF,
He really will be clever,
Because the difference between true love and AF,
Is that AF is for ever!

M.L. Sacchetti

Letter to the Editor

Atrial Fibrillation and the Meaning of Life

The sun, the Earth, just everything,
Took six days of creation,
But then to torment mankind,
The Devil invented atrial fibrillation.
In the journey from cradle to grave,
Once only death and taxes were certain,
Now there's AF to entertain,
Before that final curtain.
But, there's no such thing as just AF,
The arrhythmia has many faces.
The good, the bad, the just plain ugly,
The irregular pulse that races.
In Bombay, Beirut and Baghdad,
The management is the same.
Control the rate and thin the blood,
Restoring normal rhythm is also an aim.
Choose an anticoagulant,
Once there were only a few.
Heparin, Antiplatelets and Warfarin
And now there's some that are new!
And the reason we anticoagulate,
Is to prevent embolic strife.
Whilst a bleed may ruin your day,
A stroke will ruin your life!
And in terms of rhythm control,
Just line up and take your turn,
There's a smorgasbord of options,
We can poison, shock and burn.
There are many pills to take,
With side-effects to rue.
Some cause lethargy, others Torsade,
And one even turns you blue.

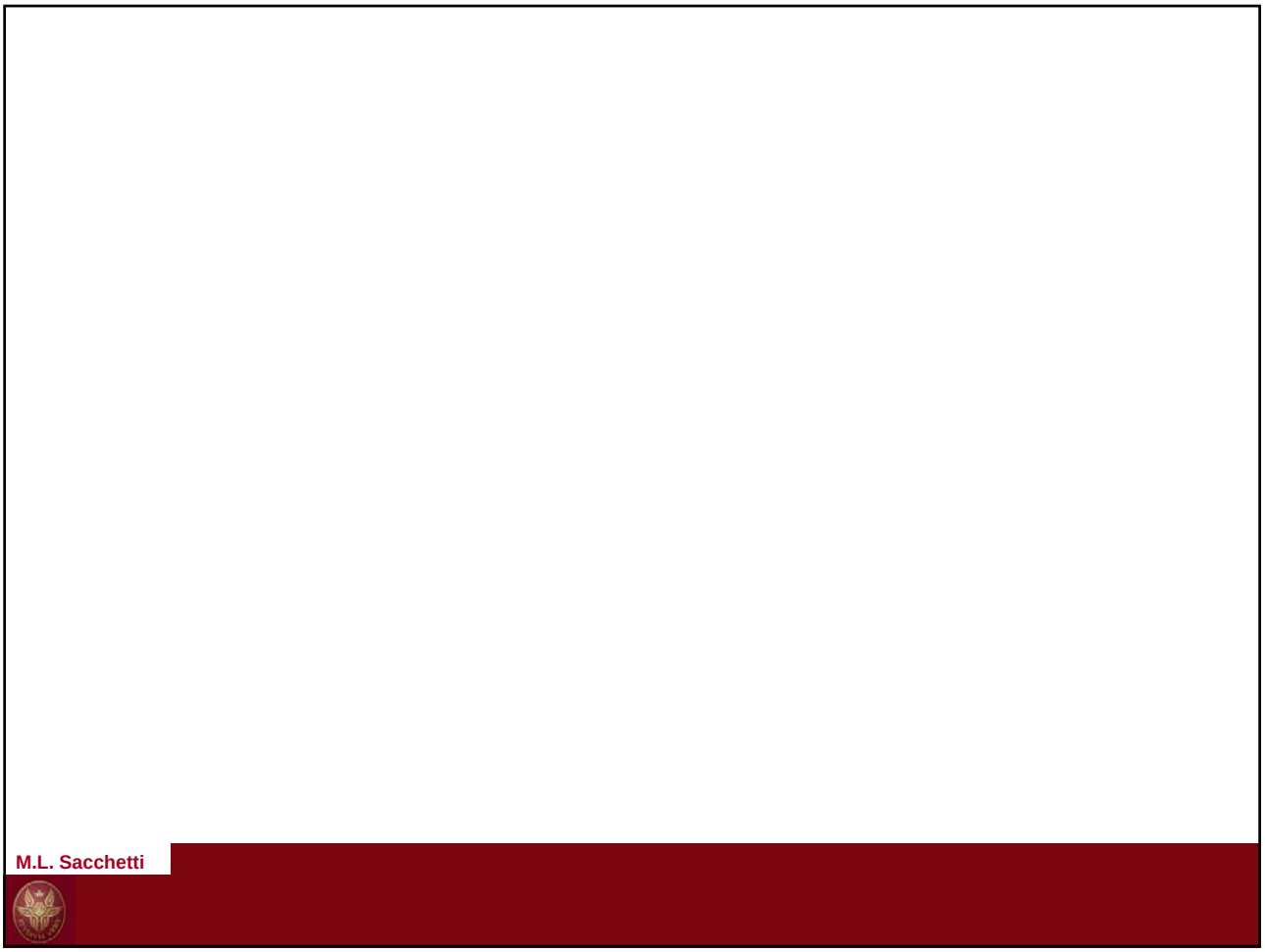
But if the pills begin to fail,
And the rhythm is out of whack,
Just call the electric twiddlers,
They'll give your heart a zap.
But if they zap, then zap again,
And AF won't go away,
The twiddlers change their tactics,
They'll fight a different way.
First, EP checks the circuits,
Then, spot welding with RFA,
It's napalming the heart,
To keep aFib at bay.
And during this you lie there,
With wires up every vein,
They turn you on, they turn you off,
While you're doped out of your brain.
So the management of AF,
Is a multidisciplinary game.
Because when all treatment fails,
There's lots of people to blame.
So AF remains a puzzle,
With no easy answers today,
Some poison, others burn,
Some patients even pray.
And if anyone can cure AF,
He really will be clever,
Because the difference between true love and AF,
Is that AF is for ever!

Peter French *
Calvary Hospital Canberra Medicine,
Mary Potter Circuit, Belconnen,
Canberra, A.C.T. 2617, Australia
Tel.: +61 02 6253 0177; fax: +61 02 6253 0188.
E-mail address: pfre2301@bigpond.net.au

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1443-9506/04/$36.00
http://dx.doi.org/10.1016/j.hlc.2012.10.007

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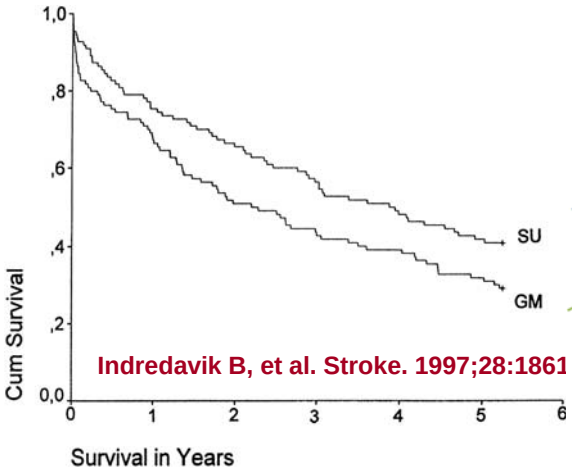

M.L. Sacchetti

Organised inpatient (stroke unit) care for stroke (Review)

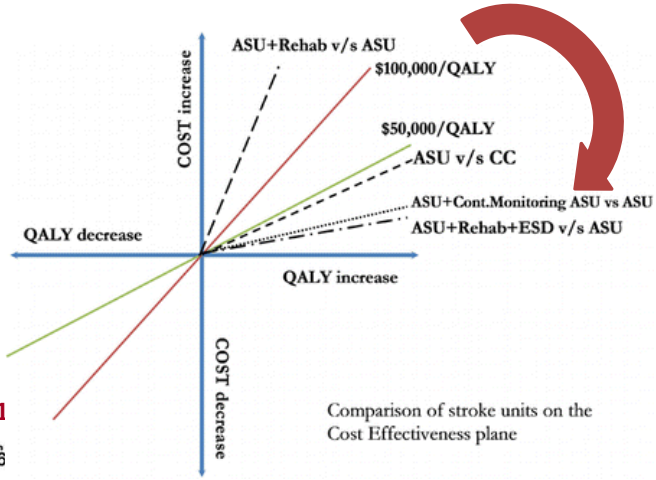
THE COCHRANE COLLABORATION

L'assistenza in Stroke Unit è più efficace e meno costosa di quella disorganizzata o 'spontanea'

A maggiore complessità organizzativa corrisponde maggiore risparmio



Indredavik B, et al. Stroke. 1997;28:1861



Meta-analysis of Cost Effectiveness of Different Stroke Unit Subtypes
International Stroke Conference 2012.

M.L. Sacchetti

Presidenza del Consiglio dei Ministri

CONFERENZA PERMANENTE PER I RAPPORTI TRA LO STATO, LE REGIONI E LE PROVINCIE AUTONOME DI TRENTO E BOLZANO

Accordo, ai sensi dell'art. 4 del decreto legislativo 28 agosto 1997, n. 281, tra il Ministro della salute, le Regioni e le Province autonome di Trento e di Bolzano, concernente "linee di indirizzo per la definizione del percorso assistenziale ai pazienti con ictus cerebrale".

Rep. n. 2195 del 3 Febbraio 2005

2005

DOCUMENTO DI INDIRIZZO PER LA DEFINIZIONE DEL PERCORSO ASSISTENZIALE AI PAZIENTI CON ICTUS CEREBRALE.

Scopo del presente documento è, quindi, quello di presentare in un modo sintetico e ragionato le strategie, per trasferire nella pratica corrente gli elementi di provata efficacia oggi disponibili, allo scopo di identificare gli aspetti essenziali del percorso assistenziale al paziente con ictus, lasciando poi alle singole realtà regionali il compito di definire in modo più preciso i modelli organizzativi più confacenti al contesto locale.

1. **Prevenzione**
2. **Prove di efficacia per la stroke care e la trombolisi**
3. **Percorso assistenziale (pre-ospedaliera, ospedaliera, post-ospedaliera)**
4. **Monitoraggio dell'implementazione delle reti stroke (AUDIT)**

M.L. Sacchetti

Quaderni del Ministero della Salute
2
n. 2, marzo-aprile 2010

Organizzazione dell'assistenza all'ictus: le Stroke Unit

Quaderni del Ministero della Salute
Ministero della Salute

TAKE HOME MESSAGES

Secondo i dati dello studio PROSIT riferiti a un'indagine sui 677 ospedali che ricoverano almeno 50 ictus per anno, meno del 10% degli ospedali è dotato di una Stroke Unit (SU). La maggior parte (il 75%) delle SU è in ambito neurologico. L'attuale offerta assistenziale all'ictus acuto è dunque inadeguata e assolutamente basso è il numero dei pazienti con ictus ischemico che hanno accesso alla terapia trombolitica. È possibile migliorare la qualità dell'assistenza all'ictus con beneficio per i pazienti in termini di ridotta mortalità e disabilità e conseguentemente anche minori costi assistenziali e sociali nel lungo termine. Il miglioramento del processo assistenziale comporta inoltre una riduzione delle giornate di degenza e conseguentemente un risparmio in termini di posti letto. Con una degenza media di 8,4 giorni in SU, rispetto alla degenza media nazionale di 12,2 giorni per 129.200 ictus nel 2005 o di 10,4 giorni per 113.288 ictus nel 2008 (questi ultimi dati sono preliminari), si potrebbero risparmiare tra i 1512 e i 621 letti.

Il fabbisogno, su una popolazione di 57.500.000, corrisponde a circa 50 letti per milione di abitanti, in linea con quanto viene generalmente previsto nelle linee guida. L'obiettivo a lungo termine è quindi di sei SU di otto letti tra II e III livello per milione di abitanti. L'obiettivo a medio termine è la realizzazione almeno del 50% di SU di II e III livello, con la transitoria permanenza di SU di I livello che dovranno gradualmente acquisire il livello superiore. Questo può essere realizzato attraverso la riorganizzazione delle risorse sanitarie già impegnate nell'assistenza all'ictus acuto, a partire dalle UO di Neurologia, e attraverso la realizzazione di percorsi assistenziali e riabilitativi integrati.

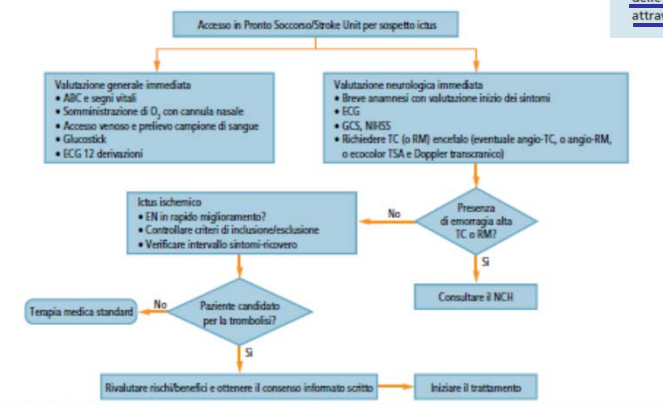


Figura 4.3 Percorso diagnostico-terapeutico: selezione dei pazienti.

ISSN 2038-5293
Quaderni del Ministero della Salute
14
n. 14, marzo-aprile 2012

Criteri di appropriatezza strutturale, tecnologica e clinica nella prevenzione, diagnosi e cura della patologia cerebrovascolare

Italian regions	No. Of SU	No. Of inhabitants	km2	SU/inhabitants	SU/km^2
Valle D'Aosta	1	126,660	3,263	127,000	3,263
Piemonte	17	4,441,946	25,402	261,000	1,494
Lombardia	34	9,826,142	23,863	289,000	702
Trentino Alto Adige	2	1,021,857	13,607	511,000	6,803
Veneto	15	4,912,438	18,339	327,000	1,227
Friuli Venezia Giulia	2	1,234,079	7,858	617,000	3,929
Liguria	5	1, 615,986	5,422	323,000	1,084
Emilia Romagna	12	4,337,435	22,446	361,000	1,870
Toscana	10	3,730,130	22,994	373,000	2,299
Marche	5	1,552,968	9,366	311,000	1,873
Umbria	4	900,790	8,456	225,000	2,114
Abruzzo	4	1,338,898	10,763	335,000	2,691
Lazio	5	5,681,868	17,236	1,136,000	3,447
Campania	2	5,820,795	13,590	2,910,000	6,795
Molise	1	320,229	4,438	320,000	4,438
Basilicata	–	588,879	9,995	–	–
Puglia	4	4,084,035	19,358	1,021,000	4,839
Calabria	2	2,009,252	15,081	1,005,000	7,540
Sicilia	4	5,042,992	25,711	1,260,000	6,428
Sardegna	2	1,672,404	24,090	836,000	12,045
Total	**130**	**60,259,782**	**301,336**	**464,000**	**2,318**

M.L. Sa