You are Cordially Invited to Our Scientific Symposium at Euroanaesthesia 2016 in London

The Future of Noninvasive Monitoring: Optimizing Fluid, Blood and Oxygen

Interactive Session, please ask any questions to our Faculty now! For more information, please stop by Masimo, Stand G10. Register and ask your questions at www.masimo.com/thefuture

High-Risk Surgical Patients: Oxygen Delivery and Hemodynamic Strategies
Jean-Louis Vincent, MD, PhD
Professor of Intensive Care Medicine (Université Libre de Bruxelles)
Department of Intensive Care, Erasme University Hospital
President, World Federation of Intensive and Critical Care Societies (WFSICCM)

Oxygen Reserve Index (ORI™): Validation and Application of a New Variable
Thomas W.L. Scheeren, MD, PhD
Professor of Anaesthesiology, Head Cardiothoracic Anaesthesia
Department of Anaesthesiology, University Medical Center Groningen
Groningen, The Netherlands

Oxygen Delivery (DO2): An Oversimplified Concept?
Azriel Perel, MD
Professor of Anesthesiology and Intensive Care
Sheba Medical Center, Tel Aviv University
Tel Aviv, Israel

Location:
N Hall 5, ExCel Congress Center, London

Date and Time:
Sunday May 29th • 12:15pm - 1:45pm

Lunch will be provided

Chairperson:
Prof. Jean-Louis Vincent

Please register at www.masimo.com/thefuture
resources to facilitate safe discharge from the ICU and hospital, with only 50% able to be discharged home."

Senior author Professor Rinaldo Bellomo commented that better understanding of PerCI could assist ICU teams in discussing prospects for patients who have been in the ICU a long time. "We need to help the fraction who are inevitably going to die do so with dignity, and at the same time help those who are not fated to die to get better treatment," he said.

A critical care resuscitation unit (CCRU) at the University of Maryland Medical Center (UMMC) has significantly improved transfer times for non-trauma critically ill patients, according to a recent study (Scalea et al. 2016).

In its first full year of operation, for the subset of adult patients admitted for critical care, transfers increased 64.5 percent compared to a previous year (2,228 vs. 1,354), with a 93.6% increase in critically ill surgical patients. Of the 2,228 patients, 1,318 (59.2%) were transferred to the CCRU; the remaining 910 patients were transferred directly to a UMMC ICU. More transfer patients required an operation during their hospital stay (46 percent vs. 31.1%) and a higher percentage were in the operating room within 12 hours of arriving (41% vs. 21.4%). For patients requiring operations, median time to arrival and operating room (118 vs 223 minutes and 1,113 vs 3,424 minutes, respectively) and median hospital length of stay (13 vs 17 days) were reduced significantly. Patients arrived in nearly half the time (129 vs. 234 minutes). The CCRU also significantly decreased the percentage of lost admissions from 25.7% to 14% in this subset.

Co-author Lewis Rubinson, MD, PhD, Associate Professor of Medicine at University of Maryland School of Medicine, said in an email to ICU Management & Practice: "We believe this is a game changer. We have begun to emulate the trauma system for non-trauma time-sensitive critical care and believe this is a logical and powerful way for academic centres to coordinate all of their time-sensitive transfers rather than having them occur haphazardly."

Dr. Rubinson added: "Direct transfer to ICUs makes sense to reduce another round of handoffs. The dilemma is that availability for admissions must be 24/7. Workflow in ICUs works contrary to admissions when there are many patients to round on—either rounding gets short changed or the admission does not receive all hands on deck. When rounds are over, direct transfers could receive more attention but there is not always bed availability. In addition, most ICUs are not set up to take the referring facilities' information and establish a pre-arrival readiness posture to be able to optimise immediate evaluation, resuscitation and intervention for patients. Lastly, if we directly admitted to each specialty ICU than each would require 24/7 open staffed available beds to be able to meet emergent demand. We have 7 adult specialty ICUs and the amount of resources which would be required to make sure each individually is always ready for an emergent admission would be tremendous. Also, the different ICUs would not have optimal capability to take a patient outside of their specialty. The ability to move patients from receipt and resuscitation allows for an ongoing readiness posture to take the next patient."

Reference

Reference

Dedicated Resuscitation Unit Improves Transfer Times

Around Day 10 of an ICU stay, patients enter a state called persistent critical illness, or PerCI, where the reason they entered the hospital becomes less important than who they were before they became ill or injured.

Image credit: University of Michigan and Monash University

Image credit: University of Maryland Medical System

Reference