La variabile TEMPO in Chirurgia Protesica

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Fondazione San Raffaele Giglio

Cefalù

TEMPO

letteratura

The Royal College of Surgeons of England

Ann R Coll Surg Engl 2003; **85**: 40–43

Original article

Surgical time and motion: the intermediate equivalent revisited

PSP Senapati[1], JD Barry[1], P Edwards[1], I Hodzovic[2], K Shute[1], WG Lewis[1]

Departments of [1]Surgery and [2]Anaesthetics, Royal Gwent Hospital, Newport, UK

The relationship between operative time, the intermediate equivalent value (IEV) and the complexity of common general surgical operations was examined. Correlation was found between

Quanto tempo dura l’intervento?

Risultato clinico

Nuovi approcci

Slower Recovery After Two-Incision Than Mini-Posterior-Incision Total Hip Arthroplasty

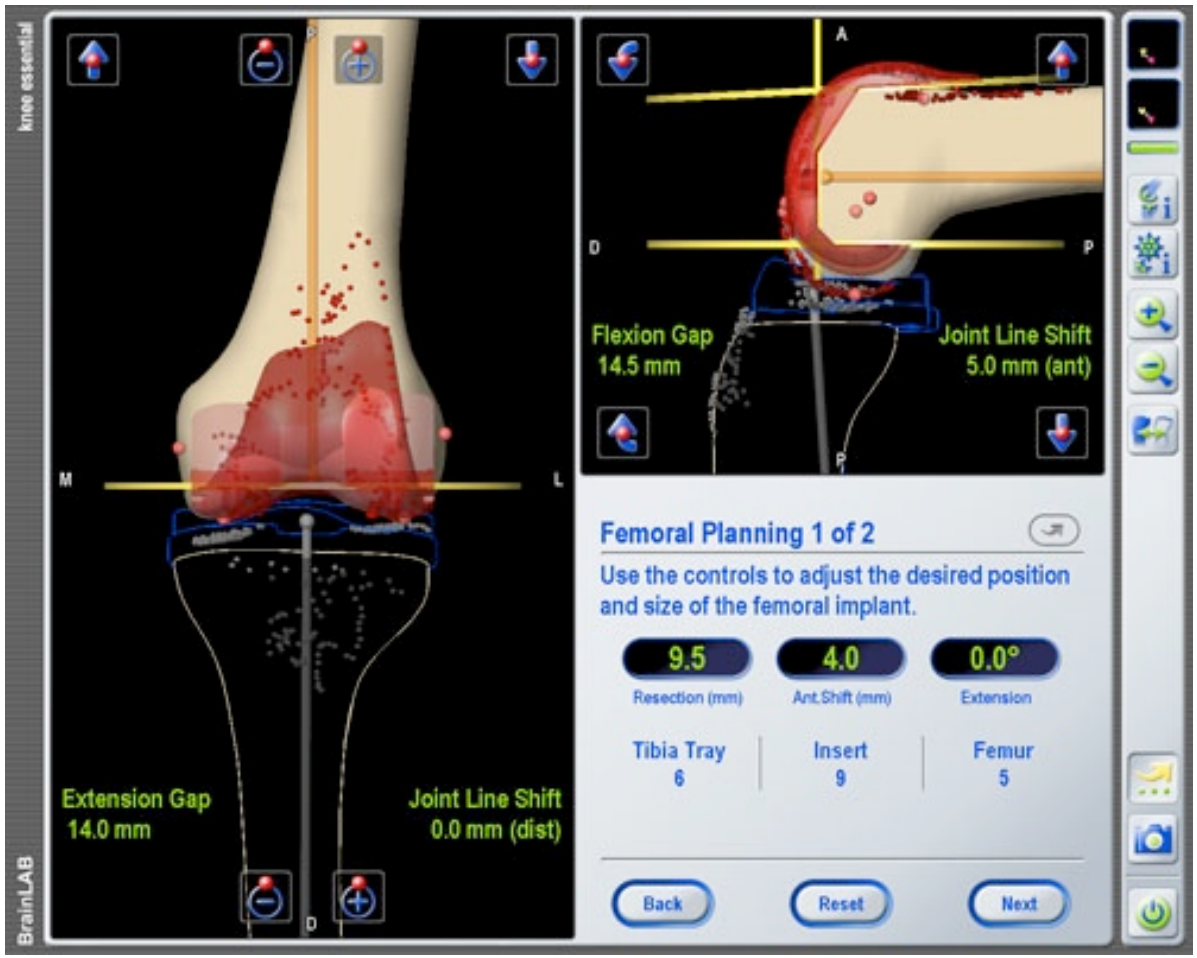
A Randomized Clinical Trial

By Mark W. Pagnano, MD, Robert T. Trousdale, MD, R. Michael Meneghini, MD, and Arlen D. Hanssen, MD

Investigation performed at Mayo Clinic, Rochester, Minnesota

Background: It has been claimed that the two-incision total hip arthroplasty technique provides quicker recovery than other methods do. To date, however, there have been no studies that have directly compared the two-incision technique with another method in similar groups of patients managed with the same advanced anesthetic and rehabilitation protocol. We posed the hypothesis that patients managed with two-incision total hip arthroplasty would recover faster than those managed with mini-posterior-incision total hip arthroplasty and designed a randomized controlled trial specifically (1) to determine if patients recovered faster after two-incision total hip arthroplasty than after mini-posterior-incision total hip arthroplasty as measured on the basis of the attainment of functional milestones that reflect activities of daily living, (2) to determine if the general health outcome after two-incision total hip arthroplasty was better than that after mini-posterior-incision total hip arthroplasty as measured with Short Form-12 (SF-12) scores, and (3) to evaluate the surgical complexity of the two procedures on the basis of the operative time and the prevalence of early complications.

Nuovi strumenti



Velocità del chirurgo

Chirurgia protesica

In Italia (SIOT 2007)

120.000 protesi/anno

¾ anca

intervento tra i più diffusi

nel mondo occidentale

Tempo chirurgico

Brevissimo

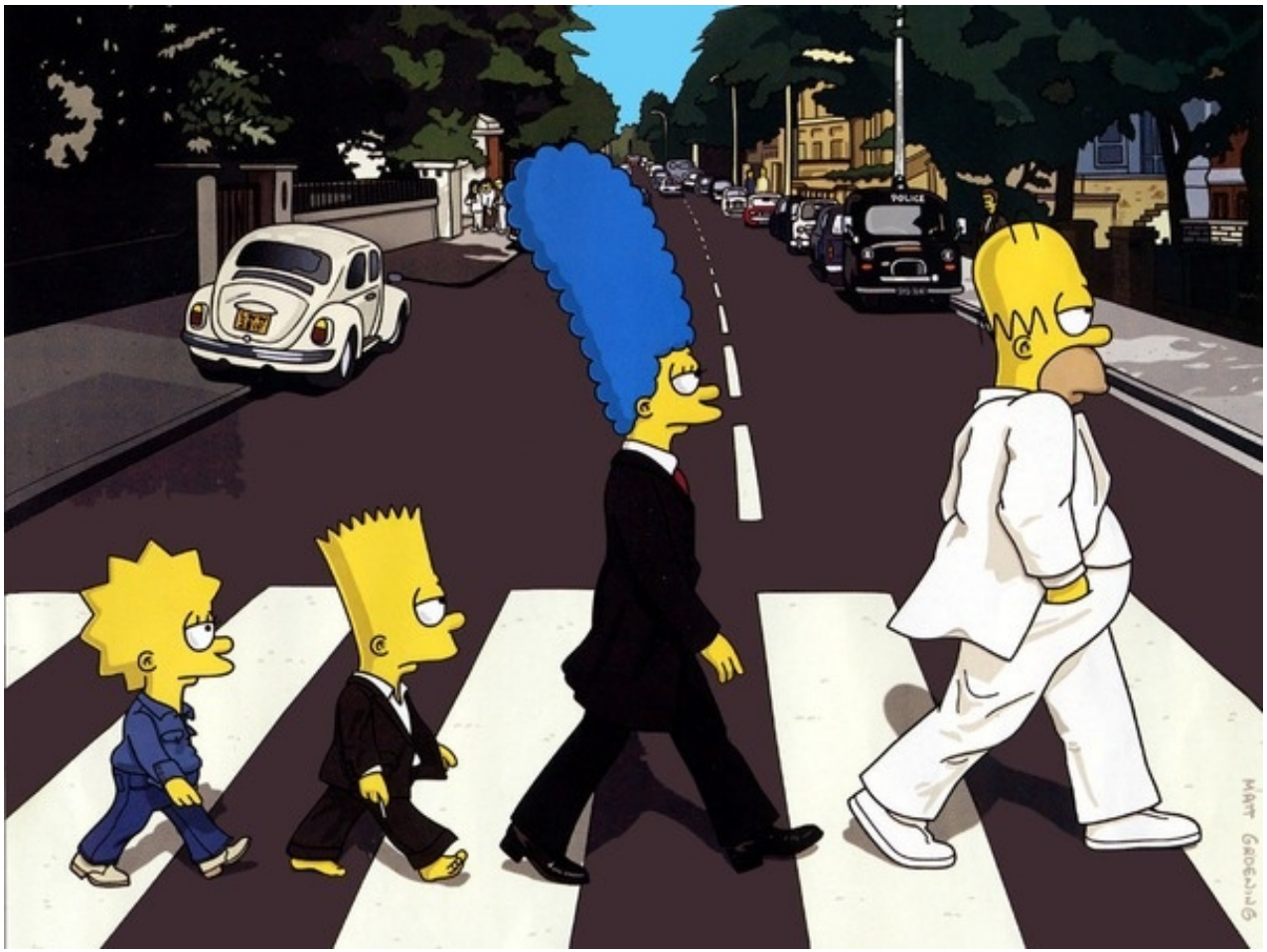
Concentrato di eventi

Efficiente

Fallimento

Organizzazione di sala operatoria

TEAM



ferrista

Ferri per singolo intervento

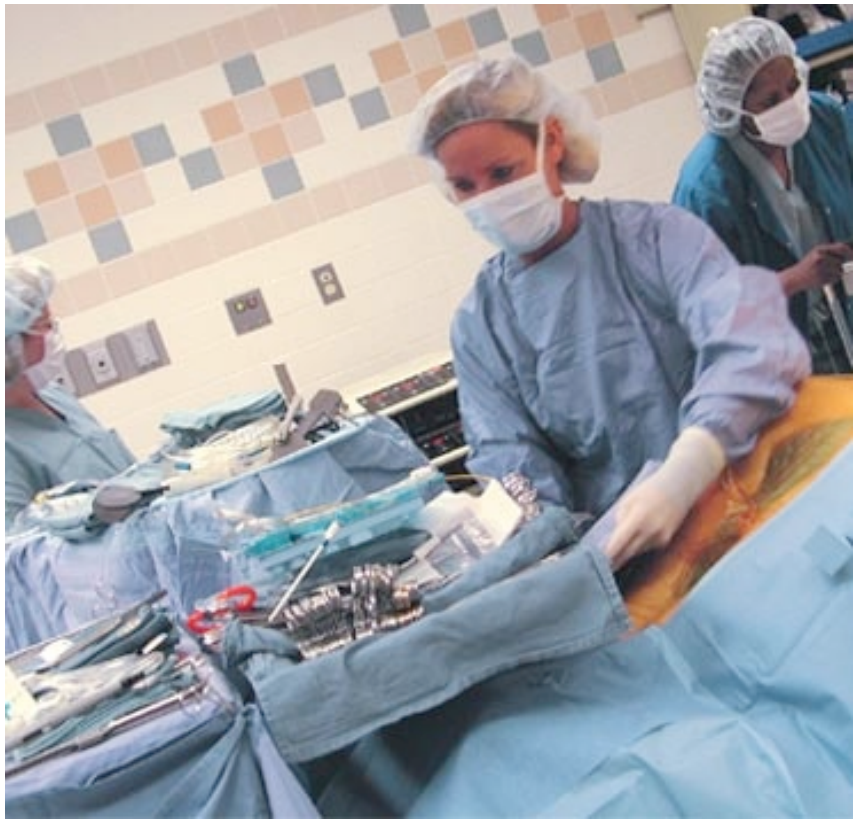
Teleria monouso

Personale di sala

4 sterili

3 runner

7 persone



Time-Dependent Contamination of Opened Sterile Operating-Room Trays

By David J. Dalstrom, MD, Indresh Venkatarayappa, MD, Alison L. Manternach, RN, MSA, Marilyn S. Palcic, PA-C, Beth A. Heyse, RN, and Michael J. Prayson, MD

Investigation performed at Miami Valley Hospital, Dayton, Ohio

Background: There are no clear guidelines for how long a sterile operating-room tray can be exposed to the open environment before the contamination risk becomes unacceptable. The purpose of this study was to determine the time until first contamination and the rate of time-dependent contamination of sterile trays that had been opened in a controlled operating-room environment. We also examined the effect of operating-room traffic on the contamination rate.

Methods: Forty-five sterile trays were opened in a positive-air-flow operating room. The trays were randomly assigned to three groups. All trays were opened with use of sterile technique and were exposed for four hours. Culture specimens were obtained immediately after opening and every thirty minutes thereafter during the study period. Group 1 consisted of fifteen trays that were opened and left uncovered in a locked operating room (i.e., one with no traffic). Group 2 was

anestesia

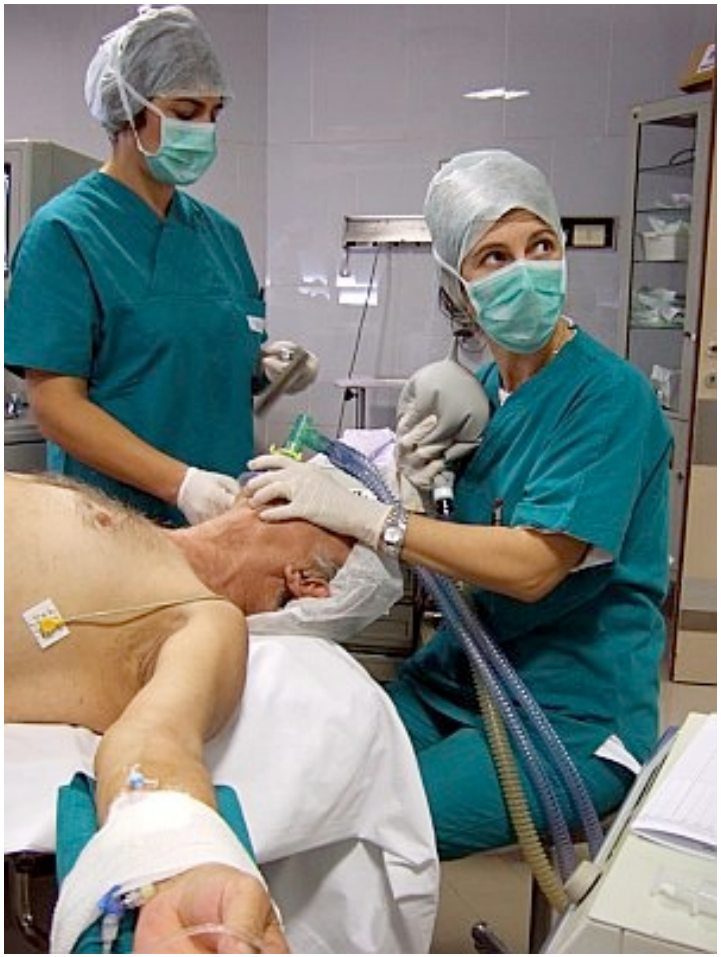
Loco regionale

- Spinale
- Peridurale

Tempo di preparazione

Binomio

CHIRURGO - ANESTESISTA



Infection of the surgical site after arthroplasty of the hip

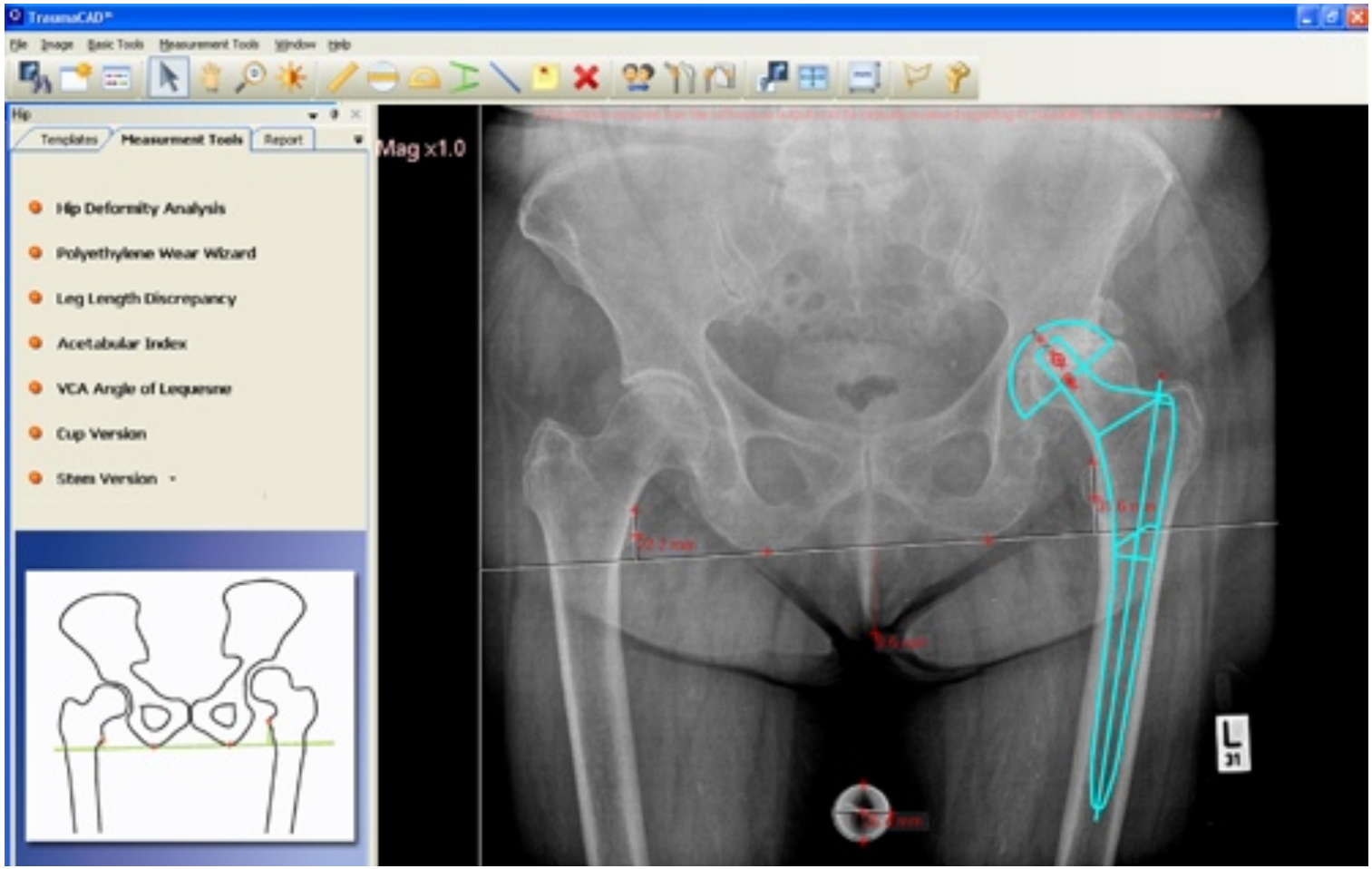
S. Ridgeway,
J. Wilson,
A. Charlet,
G. Kafatos,
A. Pearson,
R. Coello

From the Health Protection Agency, London, England

We wished to estimate the incidence of surgical-site infection (SSI) after total hip replacement (THR) and hemiarthroplasty and its strength of association with major risk factors. The SSI surveillance service prospectively gathered clinical, operative and infection data on inpatients from 102 hospitals in England during a four-year period.

The overall incidence of SSI was 2.23% for 16 291 THRs, 4.97% for 5769 hemiarthroplasty procedures, 3.68% for 2550 revision THRs and 7.6% for 198 revision hemiarthroplasties. *Staphylococcus aureus* was identified in 50% of SSIs; 59% of these isolates were methicillin-resistant (MRSA). In the single variable analysis of THRs, age, female gender, American Society of Anesthesiologists (ASA) score, body mass index, trauma, duration of operation and pre-operative stay were significantly associated with the risk of SSI ($p < 0.05$). For hemiarthroplasty, the ASA score and age were significant factors. In revision THRs male gender, ASA score, trauma, wound class, duration of operation and pre-operative stay were significant risk factors. The median time to detection of SSI was eight

Procedure


TraumaCAD
Hip
Templates
Measurement Tools
Report
Hip Deformity Analysis
Polyethylene Wear Wizard
Leg Length Discrepancy
Acetabular Index
VCA Angle of Lequesne
Cup Version
Stem Version
Mag x1.0
L

Logistica

■ EDITORIAL

Quality of elective surgery in treatment centres

S. R. Cannon

Immediate Past-President, British Orthopaedic Association

In April 2002 the government announced unprecedented investment in the NHS in England, aimed primarily at the reduction of waiting times for elective surgery.[1] One of the methods by which these objectives would be met would be through the development of Treatment Centres, some run by the NHS and some by the independent sector. In October 2002 the Department of Health conducted an extensive formal planning exercise in which all first registered on the Specialist Register of the General Medical Council before they could perform surgery, and that post-operative radiographs of arthroplasty patients would be double reported, thereby introducing a greater level of peer review and integration between the Treatment Centres and the NHS.

Unfortunately, there was little initial discussion with the orthopaedic profession in the procurement exercise, but in late 2003 a number of

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SYMPOSIUM: CLINICAL RISK AND JUDICIAL REASONING

Apologies and Medical Error

Jennifer K. Robbennolt PhD, JD

Published online: 30 October 2008

Abstract One way in which physicians can respond to a medical error is to apologize. Apologies—statements that acknowledge an error and its consequences, take responsibility, and communicate regret for having caused harm—can decrease blame, decrease anger, increase trust, and improve relationships. Importantly, apologies also have the potential to decrease the risk of a medical malpractice lawsuit and can help settle claims by patients. Patients indicate they want and expect explanations and apologies after medical errors and physicians indicate they want to apologize. However, in practice, physicians tend to provide

Introduction

Medical errors happen [24]. When they do, they can have lasting consequences for both the patient and the physician. There is growing awareness of the ways in which disclosing such errors and other adverse events to patients can be a central part of patient care and have relevance to issues of patient safety [12]. Indeed, ethical standards articulated by the American College of Physicians and the American Medical Association oblige the disclosure of errors, the Joint Commission on the Accreditation of


STRATEGY-
HUNT EMERSON

Obiettivo

Tempo chirurgico

VS Risultato clinico

in PTG

materiali e metodi

Fondazione Ospedale San Raffaele Giglio

Analisi retrospettiva

90 artroprotesi di ginocchio

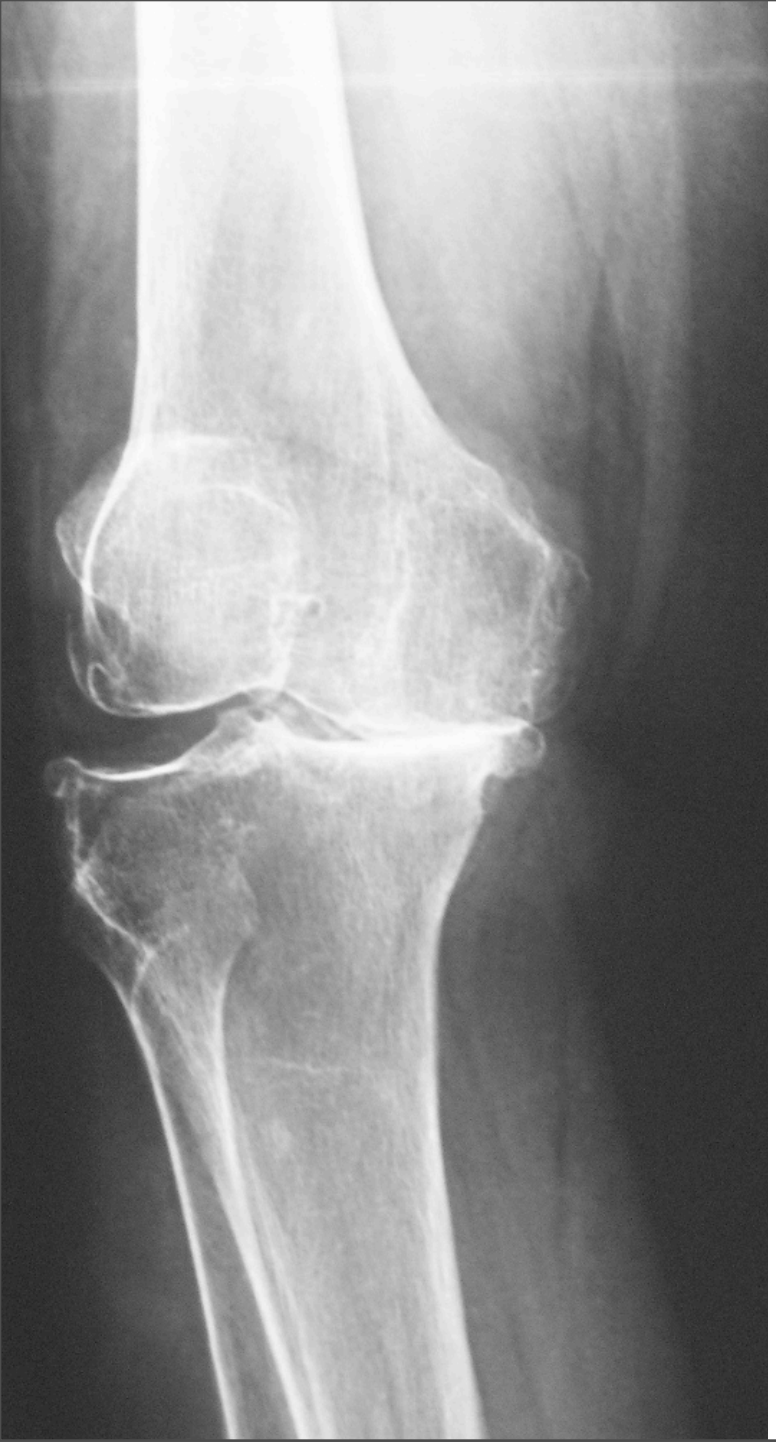
dal nov ‘06 al nov ’07

materiali e metodi

Gonartrosi primaria

Donne 56/78

51-76 anni



materiali e metodi

Varo >10: 65

FFD>5: 52

materiali e metodi

No laccio emostatico

Mini- invasivo

NexGen PS MIS - zimmer

TEMPO

- BMI
- Tipo di anestesia
- Perdite ematiche Intra
- Perdite ematiche Post
- Hb 3° giorno post
- Complicanze post chir
- Ripresa funzionale
- Durata del ricovero

Risultati

Tempo chirurgico:

73 minuti (52-110)

BMI 29,3

p=0,07

Risultati

Tempo chirurgico:

73 minuti (52-110)

Anestesia spinale

65/90

NS

Risultati

Tempo chirurgico:

73 minuti (52-110)

Perdite ematiche intra op

176 ml (110-320)

p=0,018

Risultati

Tempo chirurgico:

73 minuti (52-110)

Perdite ematiche post op

474ml (120-860)

$p<0,0001$

Risultati

Tempo chirurgico:

73 minuti (52-110)

Hb in terza giornata

9.5±1.2 g%

p=0,03

Risultati

2 aritmie post chirgiche

NS tempo

Incarcerato drenaggio

105 min

Risultati

Ripresa funzionale e test sollevamento arto

NS

TEMPO Ch

Risultati

Durata del ricovero

8 giorni (6-16)

NS

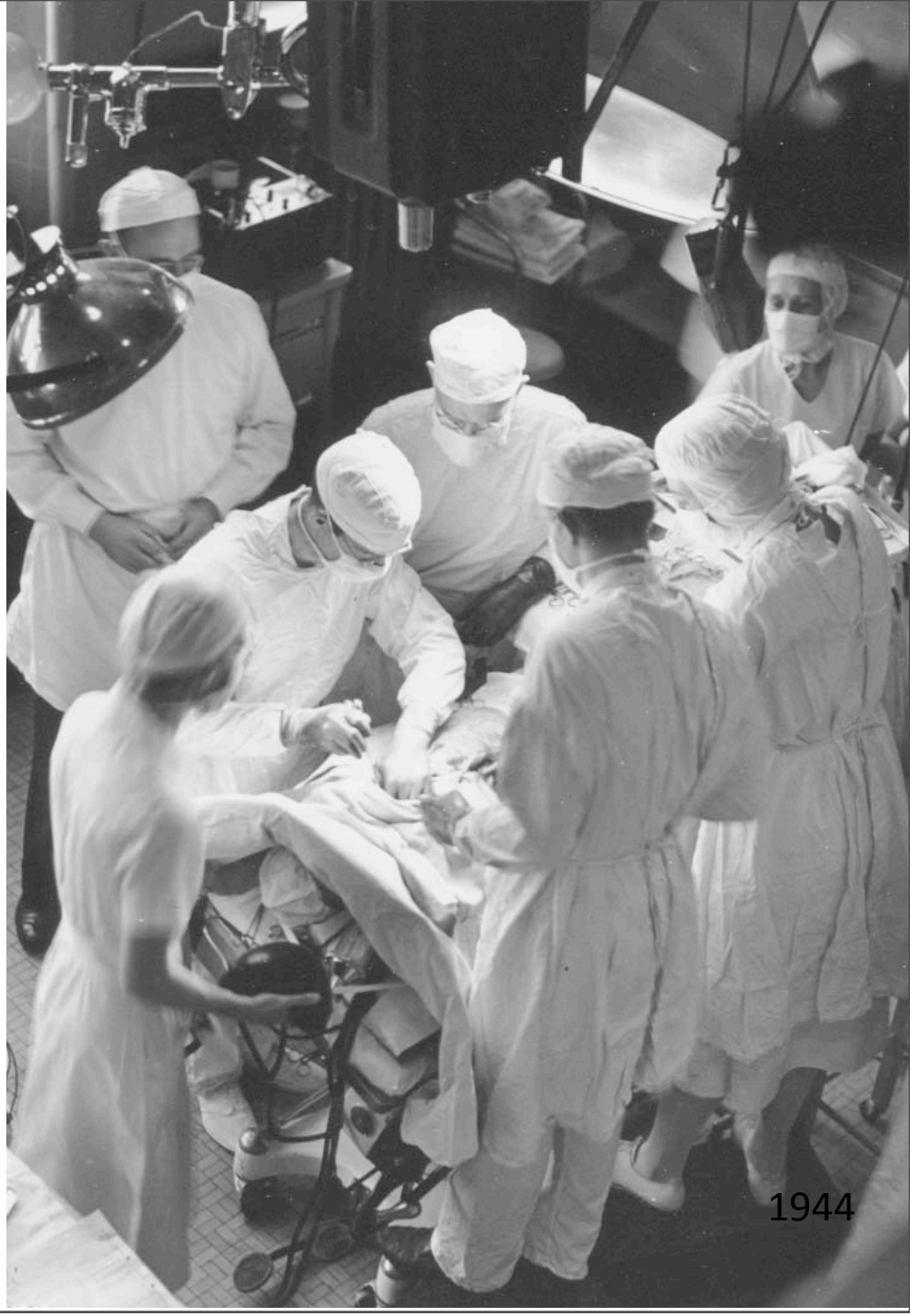
TEMPO Ch

conclusioni

La durata dell'intervento

è correlata alle perdite ematiche

non è correlata alla tecnica mini invasiva ed al recupero funzionale



conclusioni


Fondazione Istituto San Raffaele
Ospedale G. Giglio di Cefalù
Grazie