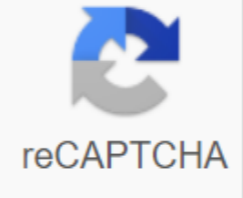




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Cateterismo cardiaco pdf 2017

The Sana Mi Corazon Association, in partnership with the Diagnostic Hospital, is holding the 14th Day of Catheterization, which began yesterday and will end on February 17, 2017 at the Hospital de Diagnosko Colonia Mediza. This time, complex heart catheterization procedures are performed for 22 children with severe congenital heart defects, who are from low-income families. It is important to note that, as in previous days, these events are free. Procedures are performed by a team from The Heart Care International with the participation of physicians, nurses, anesthesiologists and respiratory therapy technicians supported by Salvadoran interventional paediatric cardiologists, including Dr. Mauricio Velado and Dr. Theodore de Jesus Alvarengo. All this equipment is assisted by nurse and technicians of the diagnostic hospital staff. As part of its Social Responsibility Programme, the Diagnostic Hospital donates the use of the latest digital angiographic apparatus angiographer (ARTIS See), and donates to all patients hospitalization, nursing and postoperative medicines. The estimated amount the diagnostic hospital will donate on that day is more than \$35,000. The Diagnostic Hospital and Sana Mi Corazon worked together for 12 years, performing catheterization days for Salvadoran children from low-income families. With 22 children participating that day, there will be 322 hearts that we helped save through this project. Since 2004, our heart catheterization laboratory has been available to children at Bloom Hospital suffering from congenital heart defects for free interventions, in collaboration with generous private non-profit institutions such as Sana Mi Corazon at Latidos de Esperance (Gift of Life), who organize these kinds of days and provide the expensive materials and devices needed to perform the procedure and invite volunteers and nurses from other countries to contribute. With the two programmes mentioned above, the Diagnostic Hospital has participated in the healing of more than 400 hearts of Salvadoran children. The value of our donation still exceeds \$450,000. Support for the most needy Our most needy care was started in 1995 with patients from Rosales Hospital who were offered free of charge, our angiography team to accommodate pacemakers and other cardiovascular procedures. 1995 to 2015 1,650 patients at Rosales Hospital with an interventional value of \$800, resulting in a donation totaling \$1,320,000. Return Target Summary. Determine whether the heart catheterization procedure for patients with suspected coronary heart disease at the Surgical Medical Hospital of the Salvadoran Social Security Institute from January to December 2016 is adequately shown. Methodology. Retrospective descriptive study. A review of 290 clinical records was conducted, the sample was calculated using clean quests, resulting in 209 patients undergoing cardiac catheterization. The indication of catheterization is classified as appropriate, uncertain or inappropriate. The pre-tested risk of coronary homeopathy was calculated with the help of the Global Registry of Acute Coronary Events and Thrombolyte in myocardial infarction. With the help of Chi-square, categorical variables were compared. Results. Most of the patients undergoing cardiac catheterization were men over the age of 50, with a high risk of pretest for coronary heart disease, as the Global Register of Acute Coronary Events Score and Thrombolysis in myocardial infarction score. There was a correlation between the degree of pre-progic risk of coronary homeopathy and the detection of angiographic trauma. In the category assigned on the basis of the Criteria for The Proper Use of Diagnostic Heart Catheterization, 68 per cent of catheterizations were listed as appropriate indications, of which 99 per cent were able to detect coronary heart disease. Conclusions. Cardiac catheterization is duly shown in a surgical medical hospital. There is a link between the pretest risk for coronary homeopathy and the category assigned to indicate catheterization, in accordance with the relevant use criteria for diagnostic catheterization in the detection of coronary heart disease. Goal. To determine whether heart catheterization is correctly shown to patients with suspected coronary heart disease at the Medical Chiergico Hospital (a third-level institution belonging to Instituto Salvadoreo del Seguro Social), from January to December 2016. Methodology. A descriptive retrospective study. Clinical patient records were reviewed, classifying the procedure's readings as: appropriate, uncertain or inadequate. The preliminary risk score was calculated using the Global Registry of Acute Coronary Events and Thrombolysis in myocardial infarction. A square chi test was used to compare categorical variables. Results. Most of the patients who underwent cardiac katerinas were men aged 50 years or more, with a high pre-bite risk of coronary disease, calculated by the Global Register of Acute Coronary Events and Thrombolysis in myocardial infarction. There was a correlation between the risk and the presence of angiographic trauma. As for the category assigned, in accordance with the relevant criteria of use for the diagnosis of catheterization, 68% of catheterizations were classified as appropriate, detecting coronary heart disease in 99% of them. Conclusions. The cardiac boating is being properly indicated in the surgical medical hospital. There is a relationship between the preliminary risk assessment procedure and the category categorized as catering, in accordance with the relevant criteria for use for diagnostic catheterization in the diagnosis of coronary heart disease. The introduction of coronary heart disease or coronary heart disease is a common name for a group of closely related syndromes that produce myocardial ischemia. Among them is coronary atherosclerosis, which affects the walls of the coronary arteries with a tendency to clog them, disabling the oxygen needed for a certain area of the heart muscle. This makes it difficult to function and can cause acute myocardial infarction1. Diagnosis of myocardial infarction is primarily based on medical history, electrocardiographic findings and heart enzymes, mainly serum troponins and mb fractions (from skeletal muscles and brain) creatininesis and imaging such as echocardiography and coronary artery 2-3. According to the World Health Organization (WHO), 17 million people 4, 5, 6 people die from heart disease and stroke every year. These diseases are expected to be the leading cause of death and disability by 2020, and the death toll is expected to rise to 20 million and 24 million by 20307-9. The WHO Health Report estimates that 12.6% (7.2 million) of all deaths worldwide were due to coronary heart disease.10 At the Salvadoran Institute of Social Welfare (ISSS), coronary heart disease was the sixth cause of death in 2010 (deaths of 67.6 per 100,000 inhabitants). It was the second leading cause of death in 2015. In women, it was the leading cause of death, and in men - the fourth11-12. Today, cardiac catheterization is the gold standard for studying coronary artery permeability. It not only provides information about the light of the glass, but also allows a therapeutic approach13, 14. This method is based on the intra-jurisdictional administration of the contrast radio package (this is an invasive method). An X-ray test is then performed to identify the morphology of the arterial tree as well as its various accidents pistons, thrombosis, aneurysm, stenosis15. This method is recommended for use where it is necessary to determine the presence or severity of a suspected heart injury that cannot be adequately assessed by non-invasive methods.16 Angiography is a diagnostic test that has been researched since the 1980s. The proportion of relevant angiography in the literature ranged from 49% to 84%, depending on the location of the study, the population and the method of determining18-19. Patients are selected to perform this procedure on the basis of pre-delivery risk, defined as the likelihood of coronary heart disease before cardiac catheterization20-21. Cardiac catheterization has been practiced in the CCC since 1991. In the last four years (2014-2018), 3,566 interventions have been performed with an average annual rate of 891,522. Other studies report that an average of 135 patients with myocardial infarction are consulted annually. At SSS Surgical Medical Hospital, on average, 15 to 20 cardiac catheterization procedures are performed each month22. This study is designed to determine whether the heart catheterization procedure was adequately shown to patients with suspected coronary heart disease at the Surgical Medical Hospital during 2016. Methodology This is a retrospective descriptive study consisting of a review of clinical records of patients who were treated with heart catheterization, between January and December 2016. Of the 455 records of patients undergoing cardiac catheterization, both diagnostic (338) and therapeutic (117) who were visited at the SURGICAL Medical Hospital of the CCC during 2016, only diagnostic catheterization records were taken. A total of 338 files were selected. Incomplete records were not taken into account. Forty-eight incomplete files were deleted. Of the selected dossier (290) the sample was calculated through Pure quest23, with a 98% confidence interval. Finally, the sample consisted of 209 records of patients undergoing cardiac catheterization. The information was collected on the basis of a sheet approved by the ISSA Ethics Committee. The data collected was digitized and organized through Microsoft Office Excel 2003 software. The analysis of the information was carried out using the Statistical Analytics Software (SAS), resulting in a significant p 0.05. Frequency calculations and square chi testing were carried out. The indication of diagnostic catheterization was classified into three categories based on the relevant use criteria for diagnostic catheterization (AUC)21, a guidance proposed in 2012 that 166 readings, developed and catalogued by an independent technical team and divided on a scale of scores from 1 to 9, to refer to the use of cardiac catheterization as: appropriate, uncertain and inappropriate. The results of this guide were confirmed in an observational multicenter cohort study conducted at the Heart Network in Ontario, Canada24. In addition, the preliminary risk test was based on the GRACE (Global Registry of Acute Coronary Events) and TIMI (Thrombolysis in Myocardial Infarction). Both assess the risk of death after cardiovascular events based on patient characteristics as demographic, clinical, electrocardiographic and laboratory. These scales are used by adding one point for each variable, which is present according to the patient's information and according to their outcome patients are classified into three risk groups depending on the risk of fatal outcome: very low risk, low risk with a probability of 4.7% - 8.3%, risk from 13.2% to 19.9%, high, indicating a risk between 26.2% and 40.9%25-27. The MediCalc28 calculator was used to calculate both scales. The data is presented through double-entry contingency tables and larger-data bar charts in which data is classified and correlated, based on demographic factors of the subjects studied and categories of cardiac catheterization. The results of general procedures performed in cardiac catheterization, 44% correspond to cardiac catheterization; and of these 74% are the first. Of the 209 files examined, 66.5% belong to male patients. 81.8% are over 50 years old. It is noted that the number of cardiac catheterizations increases with age through trend lines (graph 1). 79% are active SSS quotes and 84% come from urban areas. Based on the preliminary risk calculation test through the TIMI score, 59.8% of patients have a very high risk, 92% of patients have coronary heart disease (Figure 2). According to the AUC criteria, 67.4% of diagnostic cardiac catheterizations were correctly indicated. Ischemic heart disease was detected in 99.2% of them (Figure 3). Figure 4 shows crossovers of sexual and age-variable patients with a degree of likelihood of coronary heart disease, pretest risk and category assigned by the AUC criteria for the likelihood of documenting significant angiographic injuries. Patients over the age of 50 are found to be at a higher risk of pre-evaluation, and it is in these patients that angiographic trauma is effectively documented. The chi squared test shows that coronary heart disease, although mostly documented in men, is sex-independent (0.7475, p 0.05). Although it tends to increase in relation to the age of the patient, there is no statistical significance between these variables (2.63, p 0.62). There is a link between pre-risk (73.56, p 0.05) and the AUC category of diagnostic cardiac catheterization with the probability of documenting coronary homeopathy (159.7, p 0.05). The discussion of 66.5% of the patients studied corresponds to the male sex, which coincides with the international literature, where this age group suffers most from cardiovascular diseases. In women, the peak of cases is in the age range of 60-69 years. This can be explained by the completion of estrogen protection, which coincides with menopause and leads to an increased cardiovascular risk in this population14. Of the patients undergoing cardiac catheterization, 82% are over 50 years old, with more frequent use of cardiac catheterization in the patient's age. The preliminary risk used to select patients depends on age, so the use of this resource is also justified6-25. When calculating the pretest risk of patients, through the TIMI and GRACE score, the majority (59.8%) is a risk classified as high. That is, most subjects undergoing cardiac catheterization have a high risk of coronary heart disease. This is also due to the age distribution of the subjects. Significant angiographic damage can be demonstrated in 92% of these catheterizations. In the case of those listed as very low risk, only 22% detected coronary apathy, so the previous two models are commonly used in emergency services to identify a subgroup of patients with the highest-risk myocardial infarction who should have invasive intervention. Of the total amount of cardiac catheterization performed in the ISSS hemodynamics laboratory, at the Surgical Medical Hospital as a national reference center, two-thirds are first-time cardiac catheterization. This makes clear the usual use of this resource to diagnose patients with suspected coronary heart disease9-22. Figure 1. Distribution of catheterization by gender and age Chart 2. The presence of coronary heart disease in the pre-tested risk of a category assigned for catheterization in accordance with the criteria of AUC21 and the presence of coronary heart disease through catheterization, it was documented that 67.5% were classified as appropriate indication, 14.3% insufficient and 18.2% as uncertain. Acceptable choice of patients in hospital should be recognized Surgical, because compared to the data of the study of verification24, conducted in 2015 in Canadian centers, reporting 58.2% respective, 10.8% inadequate and 31% uncertain. 99% of catheterization listed as appropriate is actually coronary heart disease. Thus, the probability of documenting an angiographic injury through catheterization falls into the category assigned to it. In the group within the indefinite category, 28% of these patients reflect cardiac catheterization of coronary homeopathy, so the analysis of these patients should be optimized. In the analysis of the patient's age and sexual variables and the probability of documenting coronary heart disease, statistical significance was not found. The value was found between coronary heart disease, documented cardiac catheterization, and pretest risk, as other variables, such as medical history, electrocardiographic findings and emity height, were required to assign a patient's risk, as well as to the category assigned by the AUC criteria, as they assess the clinical context of the indication for cardiac catheterization based on the patient's pre-test risk. Figure 3. The presence of coronary heart disease by category (AUC) indicating catheterization Figure 4. Cardiac catheterization is positive for coronary heart disease depending on age, gender and pre-sale risk Limitations of this study lie in the lack of electronic patient records in the cardiac catheterization room. There is only one handwritten record of scant patient data, which makes it difficult to collect reports that need to be evaluated. In addition, the study excluded these incomplete files (only 48) and did not classify the population according to their category as insured (quote, beneficiary or retiree), which may have changed the demographic results of the study. It is important to train medical staff to meet the criteria for the use of diagnostic cardiac catheterization (AUC) to optimize the timely use of this resource. Thus, the patient can be provided with the best diagnostic and therapeutic option. Introduction in various areas of patient care with suspected coronary heart disease is calculating the risk of a preliminary test using the GRACE and TIMI assessment as a tool to determine which patient will benefit more from diagnostic cardiac catheterization. Expand knowledge among medical staff about coronary heart disease and globally established diagnostic guidelines to provide the patient with quality care and proper management. Conclusions Most performed in a surgical medical hospital on suspicion of coronary heart disease is adequately indicated. The preliminary risk of coronary heart disease in most patients with heart catheterization is classified as high. Ischemic heart disease has been documented by cardiac catheterization to a greater extent in male patients over 50 years of age. The higher the risk of pre-testing, the higher the likelihood of documenting angiographic trauma from cardiac catheterization. The best category assigned to the aUC criteria is more likely to document angiographic trauma from cardiac catheterization. Selwyn AP, Brownwald E. Ischemic Heart Disease. In: Casper DL, Brownwald E, Fauci AS, Hauser SL, Longo DL, Jameson JL, Harrison's Internal Medicine Principles. 16 Red. 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