



S O C I E D A D
L A T I N O A M E R I C A N A
D E C A R D I O L O G I A
I N T E R V E N C I O N I S T A

XVII Jornadas **SOLACI**

6° Región Cono Sur



Que Tanto Nos Adherimos a las “Guidelines”?

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**XVII Jornadas SOLACI 2012, 6ª Región Cono Sur
Montevideo, Uruguay. Junio de 2012**

Medicina Basada en Evidencia: Inicios

“Si un hombre te dice que él ha encontrado hechos que ha observado y ha confirmado con su propia experiencia..., debes tener precaución en aceptar lo que te dice.

Por el contrario, investiga y sopesa esta opinión o hipótesis de acuerdo a los requerimientos de la lógica pura, sin prestar atención al contenido de lo que él afirma empíricamente.”

Utilidad de MBE y Guidelines

Lograr balance:

“objetivismo” vs. “empirismo”

Herramienta:

**Integrar la experiencia clínica individual,
con la mejor evidencia clínica externa
disponible a partir de una investigación
sistemática**

Guías de Práctica Clínica

¿Qué es una Guía de Práctica Clínica?

Las Guías de Práctica Clínica (GPC) son un conjunto de *“recomendaciones desarrolladas de forma sistemática para ayudar a profesionales y pacientes a tomar decisiones sobre la atención sanitaria más apropiada, y a seleccionar las opciones diagnósticas o terapéuticas más adecuadas a la hora de abordar un problema de salud o una condición clínica específica”*.



HEALTHGRADES®
HealthGrades Hospital Quality
and Clinical Excellence Study
January 2011

**De ≈5.000 hospitales en U.S. evaluados
Solo 268 hospitales (5%) tuvieron un riesgo ajustado de
mortalidad y de complicaciones lo suficientemente bajo
como para ser designados como
Health Grades Hospital Distinguido por
Excelencia Clínica**

**Desde 2007 hasta 2009, si todos los hospitales hubiesen realizado
nivelación Health Grades Hospital Distinguido por Excelencia Clínica:
Podrían haberse evitado:**

- 158,684 muertes Medicare**
- 3,511 complicaciones hospitalarias Medicare**



HEALTHGRADES®
**HealthGrades Hospital Quality
 and Clinical Excellence Study**
 January 2011

**Appendix B: Inhospital Mortality Performance:
 Distinguished Hospitals for Clinical Excellence (DH-CE) Compared to All Other U.S. Hospitals**

(3-Year Aggregate Relative Risk-Adjusted Inhospital Mortality Performance: 2007-2009)

Procedure or Diagnosis	Total Number of U.S. Medicare Hospitalizations	DH-CE Hospitals Average Observed-to-Expected Inhospital Mortality Ratio	All Other U.S. Hospitals Average Observed-to-Expected Inhospital Mortality Ratio	Relative Risk Reduction Associated with DH-CE Hospitals Compared to All Other U.S. Hospitals ¹	Number of Lives That Could Have Been Saved If All Patients were Treated at DH-CE Hospitals (2007-2009) ²	P-Value (DH-CE Hospital Mortality Compared to National Mortality Average)
Bowel Obstruction	489,053	.68	1.07	36.24%	4,628	<.001
Chronic Obstructive Pulmonary						
Coronary Bypass Surgery	254,744	.79	1.07	26.27%	1,317	<.001
Coronary Interventional Procedures (Angioplasty/Stent)	853,195	.83	1.06	22.02%	2,544	<.001
Myocardial Infarction)	751,365	.84	1.04	18.95%	10,875	<.001
Heart Failure	1,756,644	.69	1.07	35.54%	19,547	<.001
Pancreatitis	151,887	.72	1.07	32.41%	1,073	<.001
Pneumonia	1,432,436	.64	1.07	40.17%	24,897	<.001
Pulmonary Embolism	166,485	.71	1.08	34.54%	2,123	<.001
Resection/Repair of Abdominal Aorta	70,298	.84	1.04	18.94%	459	<.001
Respiratory Failure	449,595	.78	1.05	25.55%	19,057	<.001
Sepsis	958,124	.79	1.05	24.66%	40,747	<.001
Stroke	673,527	.73	1.06	31.20%	12,121	<.001
Valve Replacement Surgery	128,243	.83	1.06	21.33%	1,317	<.001
3-Year Performance Average		0.74	1.06	29.82%		
Totals	10,491,302				158,684	

¹ Relative Risk Reduction determines the difference in performance between DH-CE and All Other hospitals. Calculated as follows: (Non-DH-CE O/E - DH-CE O/E) / Non-DH-CE O/E.
² Lives saved were calculated: All Other hospitals' 3-year actual number of mortalities - (All Other hospitals' 3-year expected number of mortalities x DH-CE O/E ratio).

ACCF/SCAI/STS/AATS/AHA/ASNC 2009 Appropriateness Criteria for Coronary Revascularization

Multicenter, prospective study of patients
National Cardiovascular Data Registry undergoing PCI
Between July 2009- September 30, 2010
1.091 U.S. hospitals

n= 500.154 PCIs

355 417 (71.1%) for SCA

98.6% appropriate, 0.3% uncertain, 1.1% inappropriate.

144.737 (28.9%) for nonacute indications

50.4% appropriate, 38.0% uncertain, 11.6% inappropriate.

Appropriateness of Coronary Revascularization for Patients Without Acute Coronary Syndromes

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Rochester, Minnesota; Toledo, Ohio; and Atlanta, Georgia*

Datos de pacientes sometidos a CABG y PCI

NO SCA o CABG previa

En New York: 2009 y 2010

Criterios para considerar:

Apropiados – Inciertos o Inapropiados los criterios de RVC

Table 1**Rating Cases as Appropriate
for Revascularization According to
ACC/AHA Appropriate Use Criteria Patients***

Case Description	Procedure Performed	
	CABG	PCI
Total cases reported	14,519	81,407
Eligible cases—no ACS, no previous CABG (% of all cases reported that are eligible)	10,460 (72.04)	33,970 (41.73)
Eligible cases where rating cannot be determined	2,292	9,425
Cases rated for appropriateness of revascularization	8,168	24,545
Revascularization (CABG or PCI) is		
Appropriate	7,372 90.25%	8,856 36.08%
Inappropriate	91 1.11%	3,508 14.29%
Uncertain	705 8.63%	12,181 49.63%

**SCAI/AATS/ACCF/STS Multisociety Expert Consensus Statement: Operator & Institutional Requirements for Transcatheter Valve Repair and Replacement; Part I
TAVR**

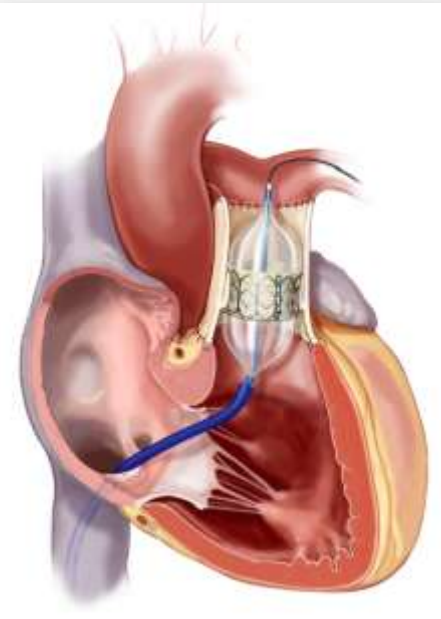
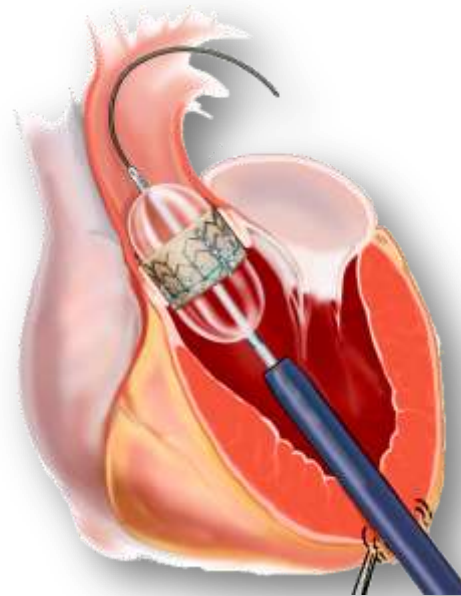
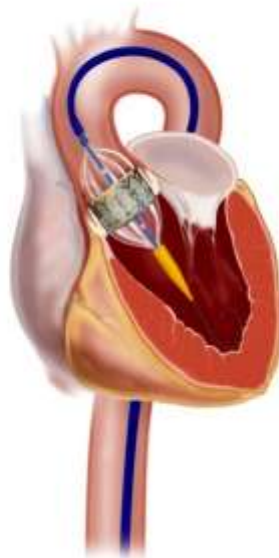
Carl L. Tommaso, R. Morton Bolman, III, Ted Feldman, Joseph Bavaria, Michael A. Acker, Gabriel Aldea, Duke E. Cameron, Larry S. Dean, David Fullerton, Ziyad M. Hijazi, Eric Horlick, D. Craig Miller, Marc R. Moon, Richard Ringel, Carlos E. Ruiz, Alfredo Trento, Bonnie H. Weiner, and Evan M. Zahn

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The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://content.onlinejacc.org>



Reparación de Válvula Aortica Transcatéter

Esfuerzo conjunto: Heart Team

Aptitudes y Destrezas:

- Dispositivos de asistencia ventricular
- Reparación endovascular de aneurismas

Facilidades Institucionales:

- Salas Híbridas
- Laboratorio de Eco (TT-TE-3D)

Reparación de Válvula Aortica Transcatéter

Espacio Físico:

- Área mínima de 74m²
- Ventilación-aire acondicionado-difusores de flujo laminar
- Lámparas cielíticas

Programa Institucional:

- Transplante – Dispositivos asistencia ventricular

Programa de Evaluación Institucional:

- Mínimo de casos por año
- Desenlaces peri procedimiento y a 1 año
- Reporte obligatorio en una base de datos reconocida:
 - **Sobrevida**
 - **Complicaciones**
 - **Reintervenciones**
 - **Calidad de vida del paciente**

Reparación de Válvula Aortica Transcatéter

Programa Institucional Intervención

- 1.000 cateterismos / año
- 400 PCI / año

Cardiólogo Intervencionista

- Board Certified
- 100 procedimientos estructurales
- 30 procedimientos estructurales izquierdos / año: 60% valvuloplastias aórtica
 - EVAR
 - TEVAR
 - Valvuloplastia Áo con balón
 - Cierre fugas paravalvulares
 - Cierre CIV dispositivo
 - No se incluye CIA-FOP

Reparación de Válvula Aortica Transcatéter

Programa Institucional Cirugía

- 50 AVR por año
- (10 AVR de alto riesgo STS \geq 6)
- Mínimo 2 cirujanos experimentados

Cirujano Cardiovascular

- Board Certified
- 100 AVR en su carrera
- Al menos 10 de alto riesgo
- 25 AVR / año o 50 / 2 años
- 20 AVR en el último año antes de iniciar programa TAVI
- Experiencia Bypass
- Experiencia en exposición e intervención retroperitoneal de las arterias iliacas

EXPERT CONSENSUS DOCUMENT

2012 ACCF/AATS/SCAI/STS Expert Consensus Document on Transcatheter Aortic Valve Replacement

Developed in collaboration with the American Heart Association, American Society of Echocardiography, European Association for Cardio-Thoracic Surgery, Heart Failure Society of America, Mended Hearts, Society of Cardiovascular Anesthesiologists, Society of Cardiovascular Computed Tomography, and Society for Cardiovascular Magnetic Resonance

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7.3. Lower-Risk Populations

Data from the STS Registry indicate that approximately 10% of patients undergoing AVR have an STS score ≥ 8 and therefore would be potential candidates for TAVR using current selection criteria. There has been interest in expanding the potential group of candidates for TAVR to include patients with an STS score ≥ 4 . This would broaden to 25% the number of patients who might be treated with TAVR rather than AVR. There has been concern about the potential for "selection creep," with more lower-risk patients treated with TAVR. This should be avoided until more evidence-based data become available on the outcome of TAVR versus AVR in these patients. The planned and ongoing trials evaluating both the Sapien and the CoreValve in lower-risk populations will be of central importance in identifying subsequent utilization of this technology in expanded patient groups.

8. Introduction of TAVR Into Practice: U.S. Versus European Perspective

8.1. U.S. Perspective

The U.S. perspective reflects the fact that TAVR approval required a randomized controlled trial, the full extent of which has just now been published (124). This contrasts with Europe where 3 new waves of iterations of current valves are already in relatively widespread clinical use. Accordingly, from the U.S. perspective, the rollout of this technology is a key issue. This rollout is influenced by the societal beliefs in a free market; convenient and timely access to medical care; patient and physician expectations; as well as return on investment by companies and institutions alike. These latter issues have led to the proliferation of advanced cardiovascular facilities, which could complicate the rollout of new-device strategies such as TAVR. For example, the state of California alone has 125 facilities that perform percutaneous coronary intervention, the county/city of Los Angeles has 33 cardiovascular surgical and primary ST-elevation myocardial infarction centers. The Dallas-Fort Worth Metropolitan region also has 33 full-service cardiovascular surgical centers. To plan for each of these centers in either Los Angeles or the Dallas-Fort Worth region to offer TAVR would result in the dilution of concentrated experience. Thus, for a complicated procedure such as TAVR, which is applied in some of the highest-risk patients treated for cardiovascular disease, such as those enrolled in the PARTNER and CoreValve trials, setting up specialized centers of excellence should be a top consideration for optimizing patient care and outcomes.

The concept of development of these specialized heart centers is likely to be somewhat controversial, given the expectation in the United States that each hospital with experienced personnel should be able to perform any and all indicated procedures. However, results of TAVR are likely to be optimal when performed by a heart team of experi-

enced surgeons, structural interventional cardiologists, and CV imaging specialists working together in high-volume tertiary care centers with ancillary support services capable of dealing with very complex patients with advanced comorbid conditions. For detailed recommendations, please refer to the Multisocietal Position Statement on Operator and Institutional Requirements for TVRR (218). The specific details of the U.S. rollout and reimbursement for this procedure are as yet to be fully determined. The criteria for regulatory approval and reimbursement by appropriate federal agencies should be based upon expertise; high, adjudicated procedure volumes; and documentation of a healthcare team approach. In addition, mandatory enrollment in structural heart disease registries should be required so that short- and longer-term outcomes can be assessed and updated with new evolving data.

8.2. European Perspective

Adoption of TAVR has been rapid, and the changing trends in Europe have escalated; in selected centers in Germany, TAVR accounts for over 30% of all AVRs. For example, 1 single center has an experience of more than 1,300 TAVRs and has trained more than 360 doctors in over 32 centers from more than 30 countries. Germany itself has approximately 87 centers performing TAVR. The success of TAVR is dependent on the design of the applicator device, the experience of the operator, the use of intraoperative imaging and the high costs involved with the procedure. The rollout of TAVR varies in different countries because of insurance providers in Europe and the high costs involved in these operative procedures. The rollout of TAVR is expected to be limited in the future, unless cost-effective strategies for survival are available. The U.S. perspective on the development of active TAVR centers is described and can serve as a model for other countries.

The rollout included 2 specific technologies (i.e., Medtronic CoreValve and Edwards Sapien). The development of this program consisted of didactic session, simulator training, observation of cases at experienced centers, and proctoring at new centers. Core essentials of the program included a multidisciplinary team process for patient selection and for procedural performance. All patients undergoing TAVR were entered into a Central Cardiac Audit Database, which included clinical as well as administrative data using standardized data elements and definitions. This approach has the advantage of including all patients with either of the 2 devices, monitoring the potential of changing patient selection criteria, the ability to document learning curve and the opportunity to evaluate the outcome of patients treated with each of the devices. Particularly relevant findings include the observation that: 1) 30-day and mid-term mortality was equivalent in proctored and nonproctored cases, and 2) the fact that outcomes in the first 20 cases were similar to subsequent cases in each of the 25 centers involved.

Latinoamerican Perspective?

7.3. Lower-Risk Populations

Data from the STS Registry indicate that approximately 10% of patients would therefore would using current selection criteria, expanding the potential for TAVR rather than surgical AVR. Ongoing trials evaluating TAVR versus AVR in lower-risk populations are identifying subsequent expanded patient groups.

8. Introduction U.S. Versus Eu

8.1. U.S. Perspective

The U.S. perspective required a random which has just with Europe when valves are already Accordingly, from technology is a key societal beliefs in access to medical as well as return on alike. These latter advanced cardiovascular the rollout of new example, the state perform percutaneous of Los Angeles has ST-elevation myocardial Fort Worth Metro cardiovascular surgery centers in either I region to offer T concentrated experience such as TAVR, which

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enced surgeons, structural interventional cardiologists, and CV imaging specialists working together in high-volume

4.3.2.5. MEDTRONIC COREVALVE U.S. PIVOTAL TRIAL

The U.S. pivotal trial with the Medtronic CoreValve self-expanding valve is currently enrolling patients at 40 sites (NCT # 01240902). Patients are allocated into either an Extreme Risk cohort, similar to Cohort B inoperable patients in the PARTNER trial or a High Risk cohort analogous to PARTNER Cohort A. There will be 487 patients enrolled in the extreme-risk group with an additional 100 patients with inadequate iliofemoral access placed in a nested registry of alternative access with either subclavian or direct aortic approaches. The High Risk cohort will enroll 790 patients in a 1:1 randomization between TAVR and surgical AVR.

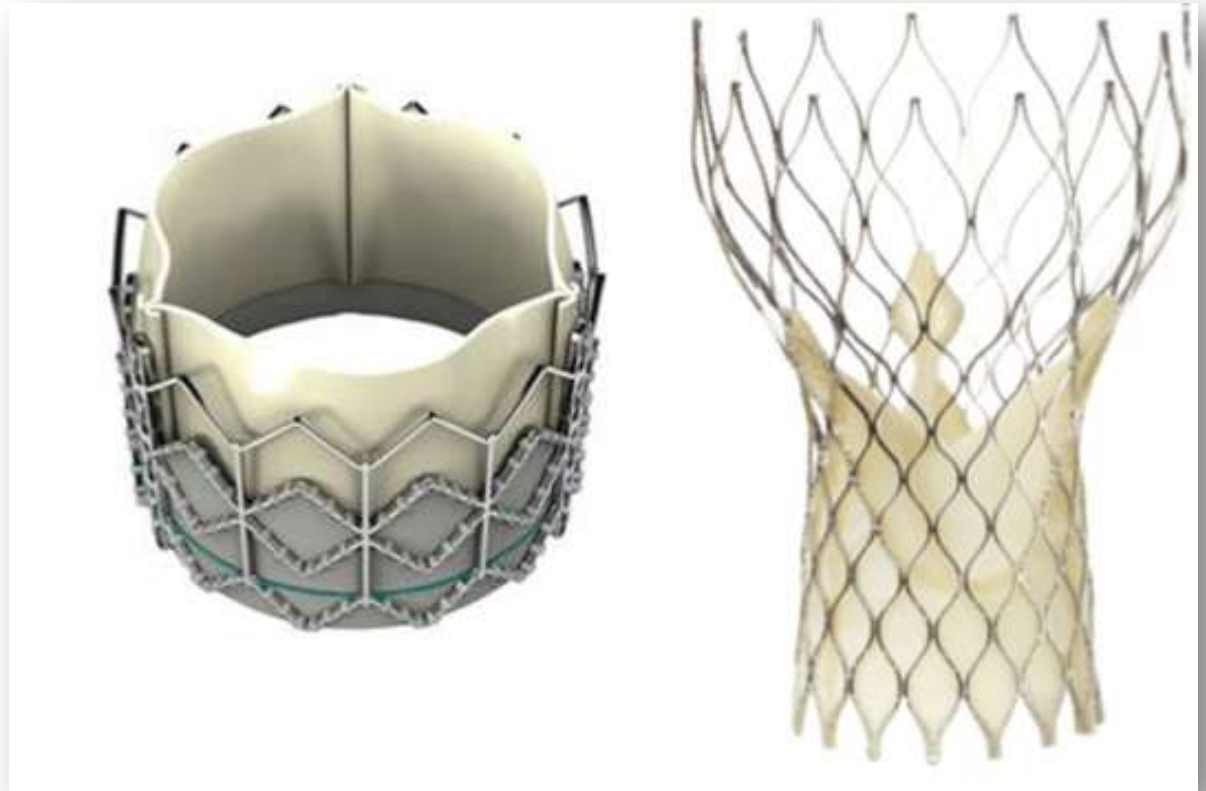
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CoreValve™ en Latinoamérica

Global: Edwards™: > 30.000 - CoreValve™: > 25.000

LA -Total > 1.000

**México
Panamá
Colombia (131)
Venezuela
Perú
Brasil
Uruguay
Chile
Argentina**



ESTADÍSTICAS SANITARIAS MUNDIALES 2012



**Organización
Mundial de la Salud**

Grupos de Países Según los Ingresos

Ingresos bajos: Afganistán, Bangladesh, Benin, Burkina Faso, Burundi, Camboya, Chad, Comoras, Eritrea, Etiopía, Gambia, Guinea, Guinea-Bissau, Haití, Kenya, Kirguistán, Liberia, Madagascar, Malawi, Malí, Mozambique, Myanmar, Nepal, Níger, República Centroafricana, República Democrática del Congo, República Popular Democrática de Corea, República Unida de Tanzania, Rwanda, Sierra Leona, Somalia, Tayikistán, Togo, Uganda, Zimbabwe.

Grupos de Países Según los Ingresos

Ingresos medianos bajos: Angola, Armenia, Belice, Bhután, Bolivia (Estado Plurinacional de), Cabo Verde, Camerún, Congo, Côte d'Ivoire, Djibouti, Egipto, El Salvador, Fiji, Filipinas, Georgia, Ghana, Guatemala, Guyana, Honduras, India, Indonesia, Iraq, Islas Marshall, Islas Salomón, Kiribati, Lesotho, Marruecos, Mauritania, Micronesia (Estados Federados de), Mongolia, Nicaragua, Nigeria, Pakistán, Papua Nueva Guinea, Paraguay, República Árabe Siria, República de Moldova, República Democrática Popular Lao, Samoa, Santo Tomé y Príncipe, Senegal, Sri Lanka, Sudán, Swazilandia, Timor-Leste, Tonga, Turkmenistán, Tuvalu, Ucrania, Uzbekistán, Vanuatu, Viet Nam, Yemen, Zambia.

Grupos de Países Según los Ingresos

Ingresos medianos altos: Albania, Argelia, Antigua y Barbuda, Argentina, Azerbaiyán, Belarús, Bosnia y Herzegovina, Botswana, Brasil, Bulgaria, Chile, China, Colombia, Costa Rica, Cuba, Dominica, Ecuador, Ex República Yugoslava de Macedonia, Federación de Rusia, Gabón, Granada, Irán (República Islámica del), Islas Cook,** Jamaica, Jordania, Kazajstán, Letonia, Líbano, Libia, Lituania, Malasia, Maldivas, Mauricio, México, Montenegro, Namibia, Nauru**, Niue,** Palau, Panamá, Perú, República Dominicana, Rumania, Saint Kitts y Nevis, San Vicente y las Granadinas, Santa Lucía, Serbia, Seychelles, Sudáfrica, Suriname, Tailandia, Túnez, Turquía, Uruguay, Venezuela (República Bolivariana de).

Grupos de Países Según los Ingresos

Ingresos altos: Alemania, Andorra, Arabia Saudita, Australia, Austria, Bahamas, Bahrein, Barbados, Bélgica, Brunei Darussalam, Canadá, Chipre, Croacia, Dinamarca, Emiratos Árabes Unidos, Eslovaquia, Eslovenia, España, Estados Unidos de América, Estonia, Finlandia, Francia, Grecia, Guinea Ecuatorial, Hungría, Irlanda, Islandia, Israel, Italia, Japón, Kuwait, Luxemburgo, Malta, Mónaco, Noruega, Nueva Zelandia, Omán, Países Bajos, Polonia, Portugal, Qatar, Reino Unido de Gran Bretaña e Irlanda del Norte, República Checa, República de Corea, San Marino, Singapur, Suecia, Suiza, Trinidad y Tabago,

Gastos en salud y cobertura universal

Gasto Total en Salud per Capita - 2009 (US\$)

Estados Unidos	7960	Argentina	787
Canadá	4519	Brasil	734
Suiza	7185	Colombia	392
Francia	4840	Chile	802
Alemania	4723	México	525
Italia	3323	Perú	236
España	3032	Honduras	134
		Haití	40
		Uruguay	787
		Venezuela	688

Gastos en salud y cobertura universal

Gasto Total en Salud % PIB (US\$)

Alemania	11.7 %	Argentina	9.5 %
Australia	8.7 %	Bolivia	5.1 %
Bélgica	10.8 %	Brasil	8.8 %
Canadá	11.4 %	Chile	8.4 %
China	5.1 %	Colombia	7.6 %
Dinamarca	11.5 %	Ecuador	8.8 %
España	9.6 %	México	6.5
Francia	11.9 %	Uruguay	8.4 %
Estados Unidos	16.9 %		
Italia	9.7 %		

Gastos en salud y cobertura universal

Tasa Bruta Mortalidad / 1.000 Hbs

Alemania	10.1 %	Argentina	7.9 %
Australia	6.5 %	Brasil	6.3 %
Canadá	7.1 %	Colombia	4.4 %
Dinamarca	9.8 %	Ecuador	4.9 %
España	8.3 %	Guatemala	5.8 %
Estados Unidos	8.1 %	México	5.0 %
Francia	8.4 %	Perú	4.7 %
Italia	9.5 %	Uruguay	9.9 %
Suiza	8.0 %		

Ejercicio Profesional en LA

Hay una gran brecha entre:

Lo que sabemos que hay que hacer, y..

Lo que hacemos en la práctica



**Joint Commission
International**

Hospitales Acreditación y Certificación En Latinoamérica

<i>Brasil</i>	<i>21</i>
<i>Chile</i>	<i>2</i>
<i>Colombia</i>	<i>2</i>
<i>Costa Rica</i>	<i>3</i>
<i>Ecuador</i>	<i>1</i>
<i>México</i>	<i>8</i>
<i>Nicaragua</i>	<i>1</i>

RENASICA II

Mexican Registry of Acute Coronary Syndromes

Armando García-Castillo,* Carlos Jerjes-Sánchez,* Pedro Martínez Bermúdez,* José Ramón Azpiri-López,** Alonso Autrey Caballero,*** Carlos Martínez Sánchez,**** Marco Antonio Ramos Corrales,***** Guillermo Llamas,***** Jesús Martínez Sánchez,***** Alfonso J Treviño*

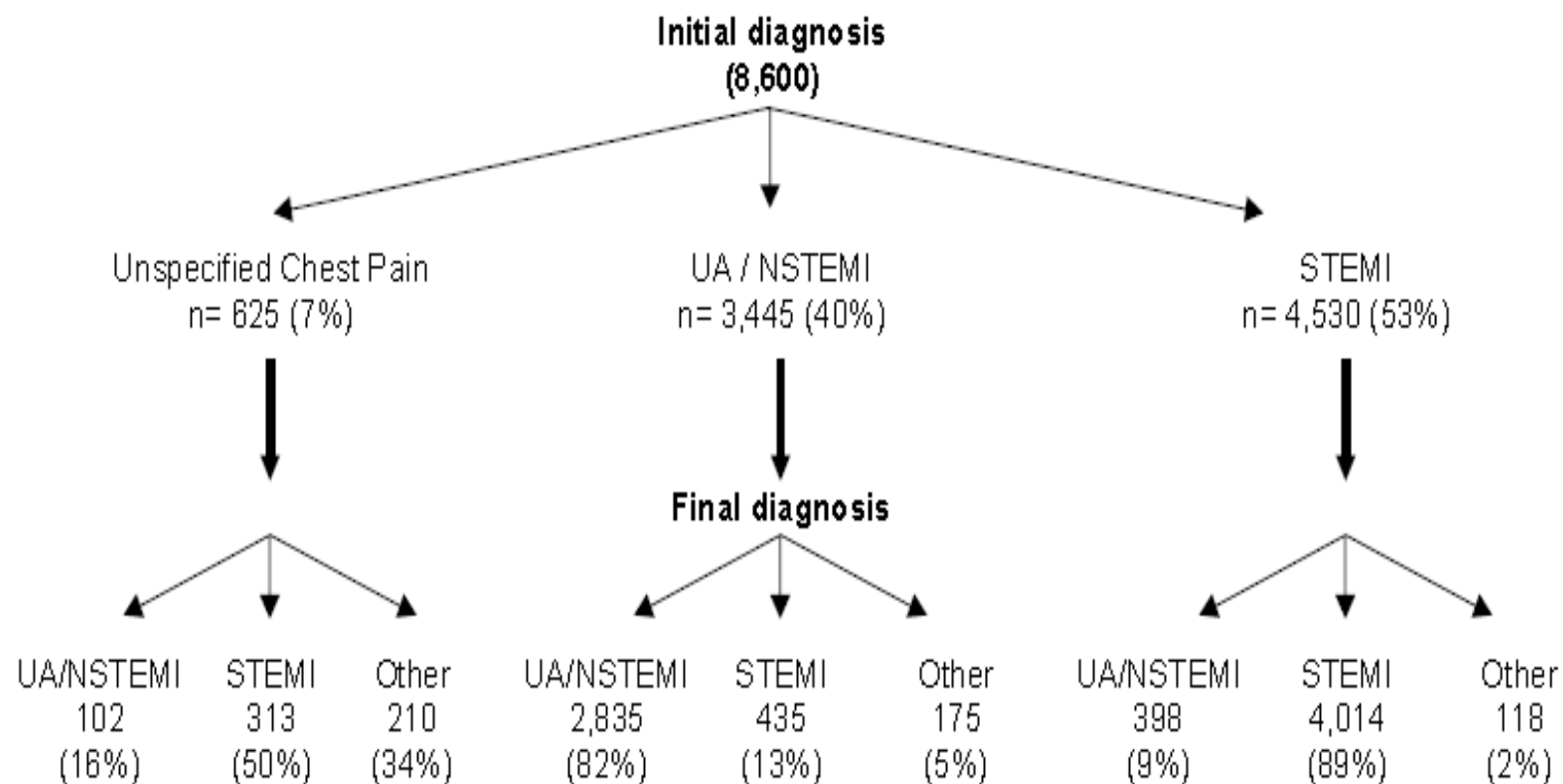
On behalf of RENASICA II investigators[§]

Table I. Demographic characteristics in patients with ACS.

Characteristic	All patients No 8,098 (%)	UA/NSTEMI No 3,543 (%)	STEMI No 4,555 (%)
Age (yr, ± SD)	62 ± 12	64 ± 12	62 ± 12
Male	72	66	77
Weight (kg, ± SD)	73 ± 13	74 ± 13	73 ± 13
Medical history			
Smoking	64	61	66
Diabetes	42	41	43
Hypertension	55	60	50
Hypercholesterolemia	27	28	26
History			
Infarction	26	32	23
Angina	38	46	33
Heart failure	5	7	3
Stroke	2	2	2
PTCA	9	12	6
CABG	3	5	2
Renal failure	3	3	2
PAD	3	4	2
Clinical characteristics			
Chest pain on admission			
Typical	80	78	85
Atypical	11	13	9
SBP (mm Hg, ± SD)	128 ± 27	132 ± 26	125 ± 27

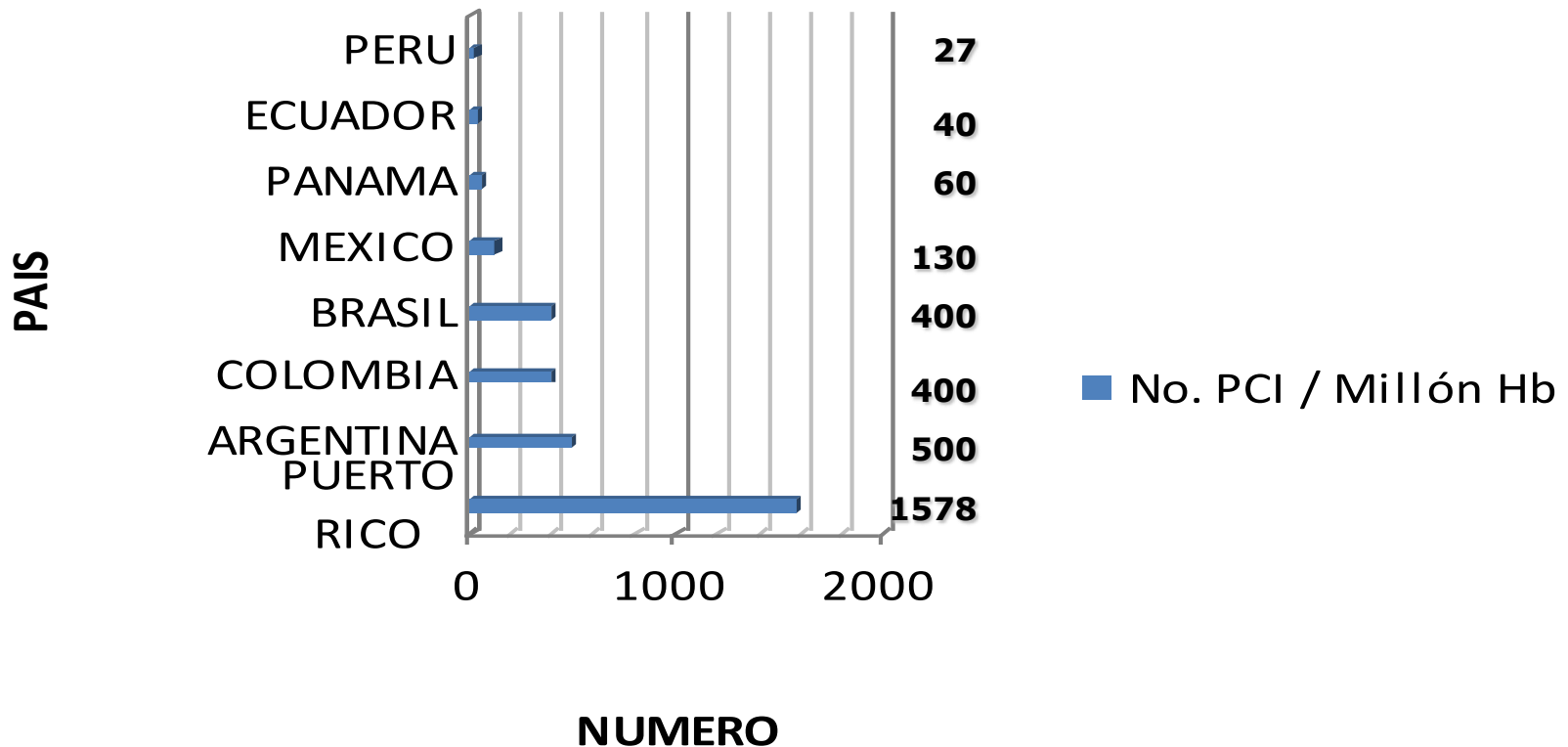
High risk UA/NSTEMI	—	36	—
STEMI			
Anterior	—	—	56
Inferior/posterior	—	—	40
Other			4
In-hospital treatment			
Aspirin	89	90	88
Nitrates	62	58	66
ACE inhibitors	59	54	64
UFH	52	50	54
Oral beta blockers	51	50	51
LMWH	45	45	44
Clopidogrel	44	50	38
CChB	19	25	12
Both heparins	17	16	18
IIb/IIIa inhibitors	16	16	16
Statins	13	11	14
Angiotensin II inhibitors	7	7	7
Ticlopidine	3	2	3
Oral anticoagulation	0.2	0.02	0.4
Fibrinolytic therapy	23	4	37
PCI	28	31	25
CABG	6	8	4

PAD: peripheral artery disease; SBP: systolic blood pressure; DBP: diastolic blood pressure; UFH: unfractionated heparin; LMWH: low molecular weight heparin; CChB: calcium channel blockers; ACE: angiotensin-converting enzyme; PCI: percutaneous coronary intervention.

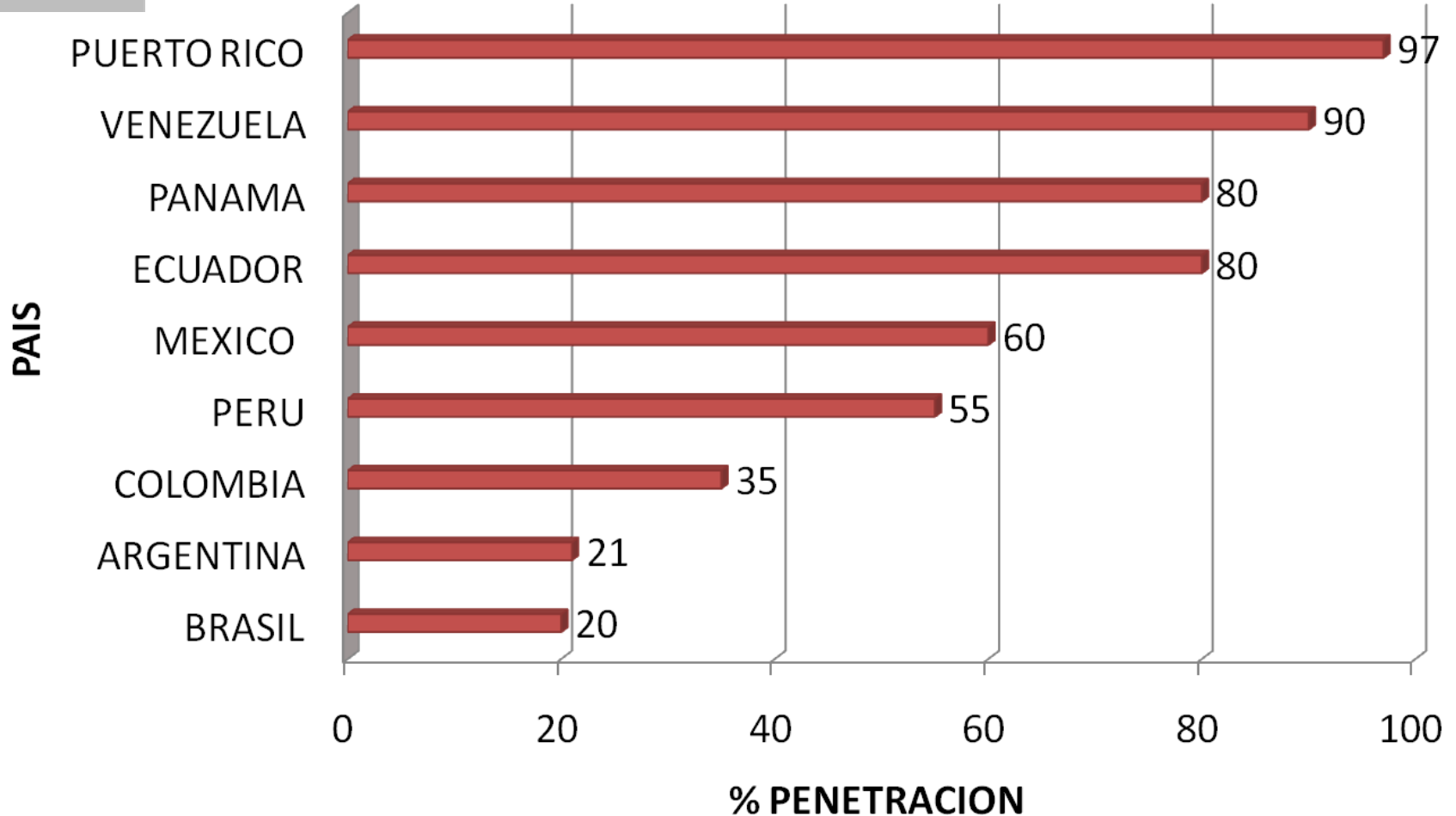


Correlation between initial and final diagnosis of 8,600 patients enrolled in RENASICA II. UA/NSTEMI: unstable angina/non ST elevation myocardial infarction; STEMI: ST elevation myocardial infarction.

PCI / millón Hb - Latinoamérica



Penetración DES - Latinoamérica





SPECIAL ARTICLE

The production of articles on cardiology from Latin America in Medline indexed journals

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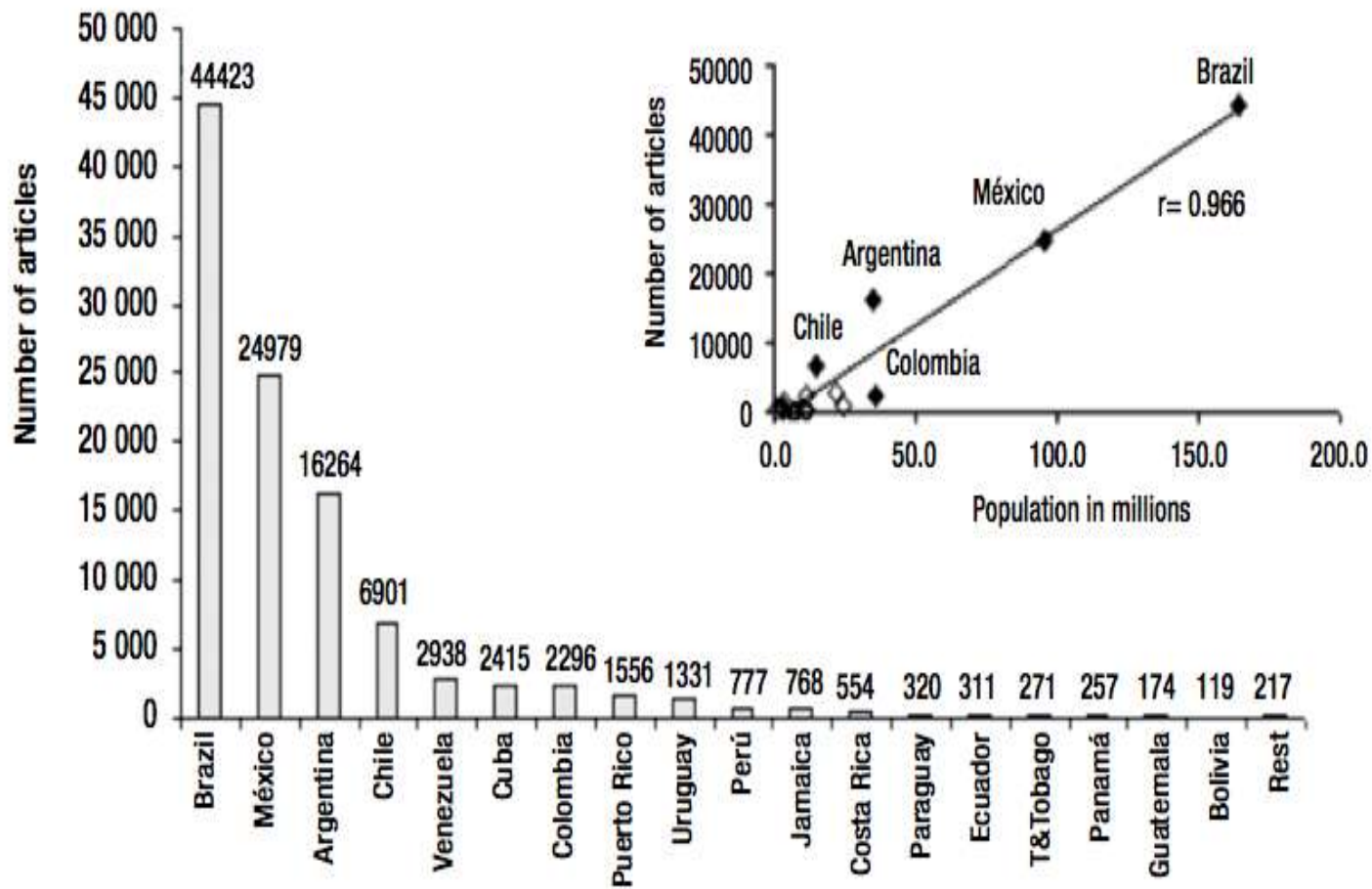
Objetivo: Analizar la producción de artículos de investigación cardiológica publicados por los países latinoamericanos en revistas internacionales.

Métodos: Búsqueda bibliográfica en PubMed de artículos biomédicos y cardiológicos. Correspondientes al periodo de 1987 a 2006.

Resultados: 106 871 artículos biomédicos y 11 416 cardiológicos (10.6%) Brasil, México y Argentina contribuyeron con 80% de las publicaciones.

Factor de impacto de las revistas superior en las publicaciones de Chile y Argentina

Conclusiones: La producción científica cardiológica de América Latina tiene marcadas diferencias entre los países,



Médicos Clínicos

Cirujanos

*Adherencia a
Guías de Práctica Clínica (GPC)
es
Solicitada
Diariamente*

Colegas

**Compañías
De
Seguros**

Instituciones

**Pacientes y
Familias**

Industria

Periodistas...



Dificultades Para Actuar en MBE y Guías de Práctica Clínica

- **Se requiere gran número de pacientes, dinero y tiempo para lograr “evidencia”**
- **Tecnología nos llega más rápido que la evidencia**
- **Disponemos de métodos diagnósticos no invasivos con sensibilidad y especificidad desconocida en nuestro medio**
- **No hay control de calidad – auditoría**
- **El uso de MBE: “*cuando nos conviene*”**

Dificultades Para Actuar en MBE y Guías de Práctica Clínica

- **Presiones administrativas institucionales**
- **Influencia de la industria y casas farmacéuticas**
- **Sistema de Salud: busca más atención rápida que calidad**
- **Variabilidad en la idoneidad médica**
- **Variabilidad en tecnología hospitalaria disponible**
- **La gran mayoría de las decisiones de RVC, no son tomadas en Consenso**
- **TMO: Frecuentemente incompleto**
- **PCI: Frecuentemente es incompleta (ej: DES, DTA)**
- **CABG: Frecuentemente es incompleta (ej: LIMA-DA)**

Fórmula Para La Mejor Práctica en LA

- **Se hace necesario conocer nuestros resultados:**

Bases de datos

Registros

Estudios clínicos

etc



Fórmula Para La Mejor Práctica en LA

- **Conocimiento científico**
- **Conocimiento y aplicación de Guidelines**
- **Experiencia / Responsabilidad / Etica**
- **Sentido común**
- **Trabajo en equipo**
- **Tecnología**
- **Juntas MD-QX**



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- **Trabajo en equipo**
- **Tecnología**
- **Junta de expertos**

Condiciones Difíciles de Cumplir en LA



REGIONAL CONSULTATION

Priorities for cardiovascular health in the Americas



KEY MESSAGES FOR POLICYMAKERS



Aplicar *guías de práctica clínica adaptadas* a las necesidades, recursos y cultura local y definir y armonizar las funciones y responsabilidades de todos los niveles de la red de servicio.

Aplicación adecuada y la observancia de las pautas de práctica clínica adecuadamente diseñadas y fuertemente basada en evidencias, es un prerrequisito para ofrecer una atención de calidad, reducir la variabilidad injustificada y finalmente reducir prevenible morbilidad y mortalidad, así como los costos.

Que Tanto Nos adherimos a las “Guidelines”?

Con Exactitud: No se

Pienso que muy poco e irregular