# Sesión bibliográfica

# ¿Qué ha pasado en Navidades?

**Enero 2020**

**Álvaro García Campos**
R3 Medicina Interna

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THE LANCET

Revista Clínica Española

Journal of Clinical Lipidology (2019) ■, ■–■

Journal of Clinical Lipidology

Original Article

# Blood lipid profiles and risk of atrial fibrillation: A systematic review and meta-analysis of cohort studies

Bo Guan, MD[1], Xintao Li, MD[1], Wenqiang Xue, MD, Gary Tse, MD, PhD, Khalid Bin Waleed, MD, PhD, Yichen Liu, MD, Mengyi Zheng, MD, Shouling Wu, MD, PhD, Yunlong Xia, MD, PhD**, Yi Ding, MD, PhD*

PROOF

- **E:** Revisión sistemática + Metaanálisis.
- **O:** Evaluar la relación entre colesterol total, LDL, TG y HDL y aparición de fibrilación auricular.
- **R:** 11 estudios incluidos (9 prospectivos- 2 retrospectivos):
  - 9 Colesterol total.
  - 5 LDL.
  - 8 HDL.
  - 8 TG.

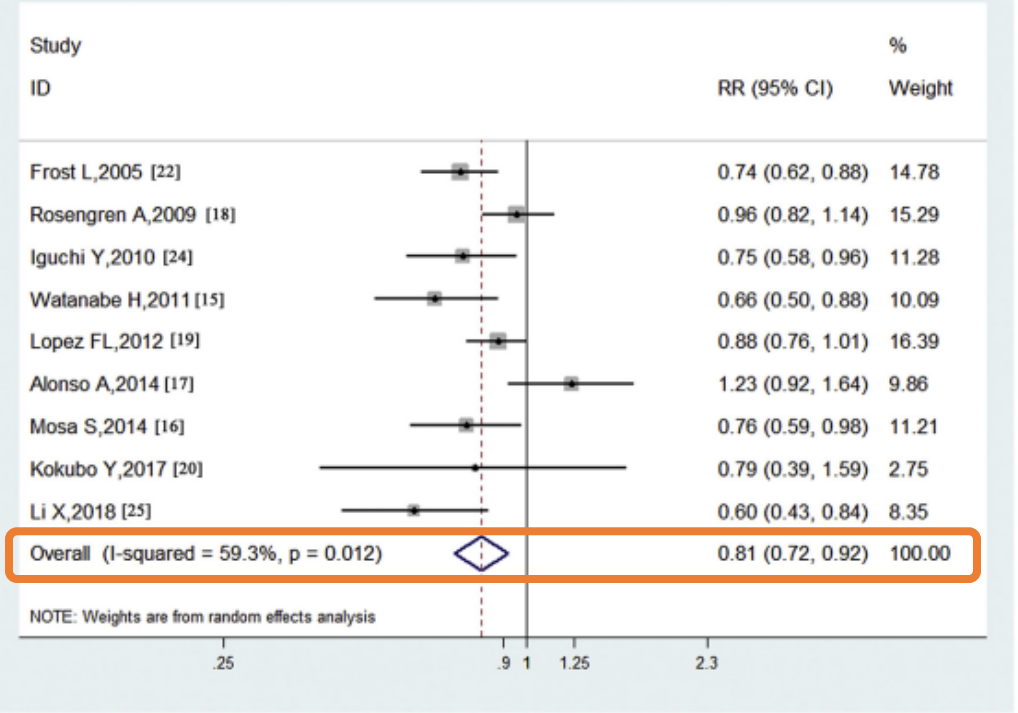



**Figure 2** Total cholesterol and risk of atrial fibrillation. Squares represent relative risk estimates, horizontal lines represent 95% confidence intervals (CIs), and diamond represents the overall relative risk with its 95% CI.

**CT:** RR 0.81 (0.72–0.92)

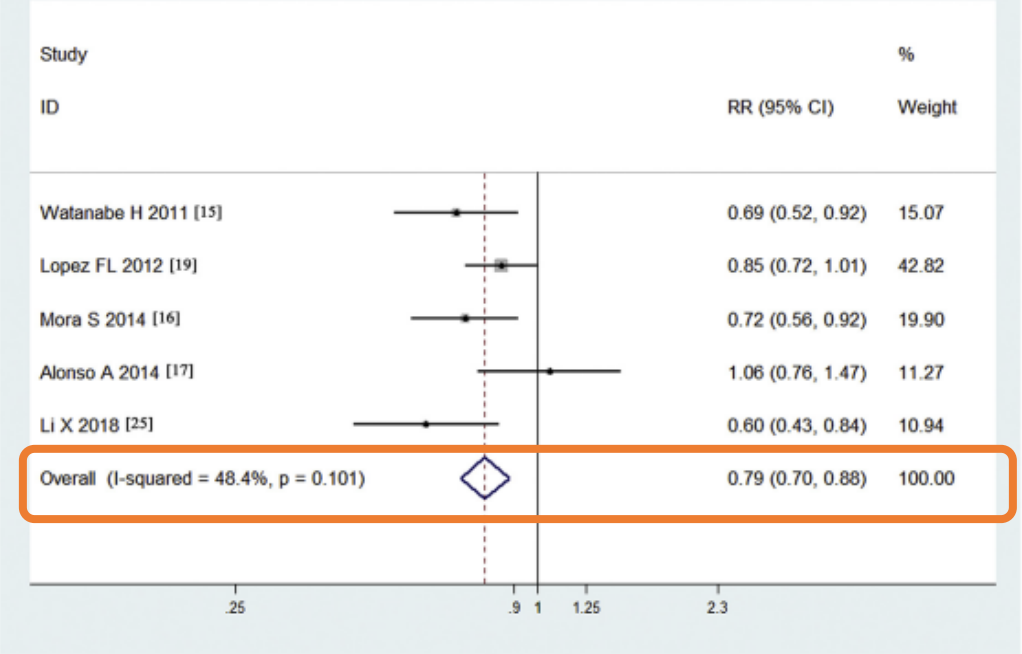



**Figure 3** Low-density lipoprotein cholesterol and risk of atrial fibrillation. Squares represent relative risk estimates, horizontal lines represent 95% confidence intervals (CIs), and diamond represents the overall relative risk with its 95% CI.

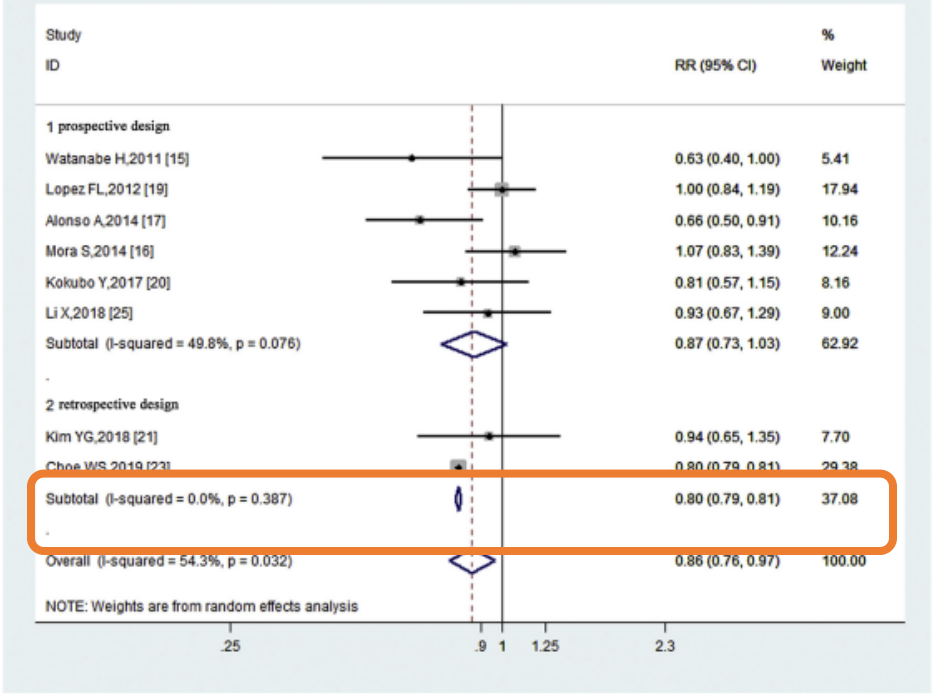



**Figure 4** High-density lipoprotein cholesterol and risk of atrial fibrillation. Squares represent relative risk estimates, horizontal lines represent 95% confidence intervals (CIs), and diamond represents the overall relative risk with its 95% CI.

**LDL:** RR 0.79 (0.70–0.88)

**HDL:** RR 0.86 (0.76–0.96)

## Conclusiones

- Relación inversa entre el CT, LDL-C y HDL-C y riesgo de aparición de Fibrilación auricular.
- Dudas sobre los mecanismos que influyen en el efecto observado.

ELSEVIER

American Heart Journal

Available online 27 December 2019

In Press, Journal Pre-proof

Clinical investigation

# Potassium infusion increases the likelihood of conversion of recent-onset atrial fibrillation – A single-blinded, randomized clinical trial ☆

Kiarash Tazmini MD [a, b, c, 1], Mai S. Aa. Fraz MD [a], Ståle H. Nymo MD, PhD [a], Mathis K. Stokke MD, PhDa [c, d], William E. Louch PhD [b, c], Erik Øie MD, PhD [a, c]

- El manejo antiarrítmico óptimo de la **FA de reciente comienzo y del flutter** es controvertido y existen múltiples estrategias para su manejo.
- **La infusión de potasio** tiene el potencial de pasar a ritmo sinusal.

- **E:** Ensayo clínico doble ciego controlado con placebo. (2013-2017)
- **O:** Investigar si los pacientes con FA o Flutter de reciente comienzo **+** K ≤4.0 mmol/L tienen un incremento de posibilidad de revertir a ritmo sinusal al incrementar el potasio (4.1-5.0 mmol/L).

**Cloruro potásico**

**N=60**

- 9.4 mmol/h (n=11).
- 12 mmol/h (n=19).
- 15 mmol/h (n=30).

**Placebo**

**N= 53**

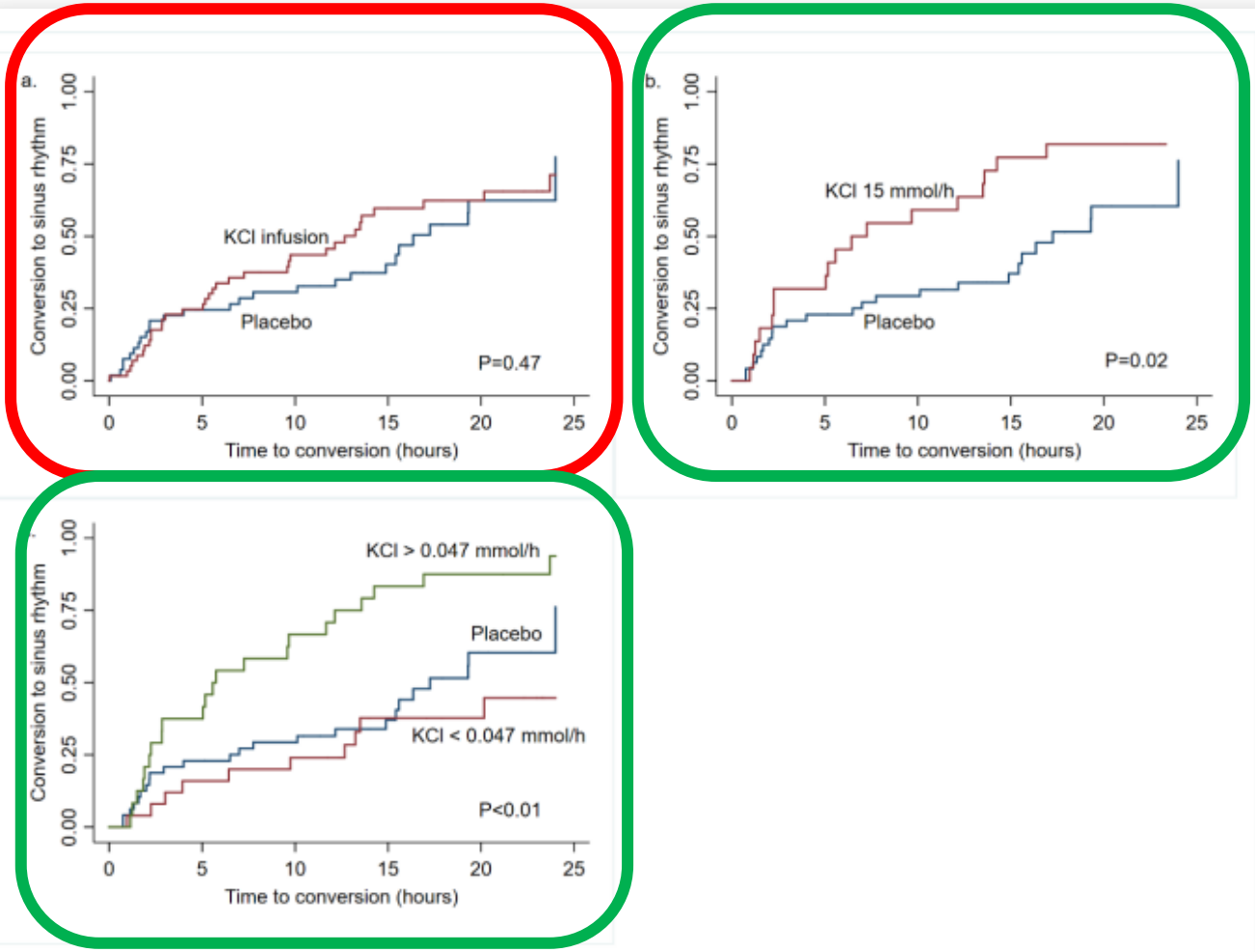



**Figure 2.** Kaplan – Meier curve for time to conversion and conversion to sinus rhythm (per protocol analysis). All patients who received KCl infusion (n=49) versus placebo (n=48) **(a)**. Patients in the 15 mmol/h group (n=22) versus placebo (n=48) **(b)**. All patients who received KCl with a median plasma potassium change per hour above (n=24) and below (n=25) median (0.047 mmol/h) versus placebo (n=48) **(c)**.

- **C:** Aunque el incremento de potasio en plasma **no aumenta de forma significativa la reversión a ritmo sinusa**l, sí parece (análisis post-hoc) que **un incremento rápido de la concentración pueden ser efectivos.**

ORIGINAL ARTICLE FREE PREVIEW

# Alcohol Abstinence in Drinkers with Atrial Fibrillation

Aleksandr Voskoboinik, M.B., B.S., Ph.D., Jonathan M. Kalman, M.B., B.S., Ph.D., Anurika De Silva, Ph.D., Thomas Nicholls, M.B., B.S., Benedict Costello, M.B., B.S., Shane Nanayakkara, M.B., B.S., Sandeep Prabhu, M.B., B.S., Ph.D., Dion Stub, M.B., B.S., Ph.D., Sonia Azzopardi, R.N., Donna Vizi, R.N., Geoffrey Wong, M.B., B.S., Chrishan Nalliah, M.B., B.S., et al.

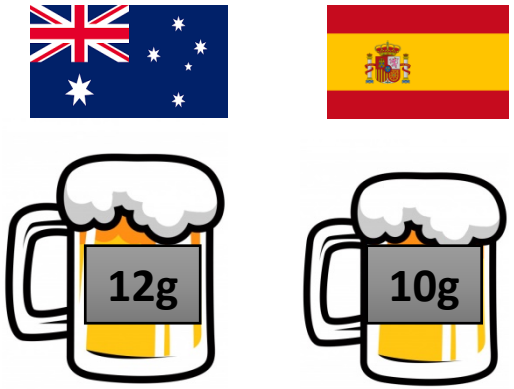
Ensayo clínico aleatorizado multicéntrico (Australia)

**140 pacientes** con consumo de alcohol

**Table 2.** Alcohol Intake at Baseline.

| Variable | Abstinence Group (N=70) | Control Group (N=70) |
|---|---|---|
| Alcohol intake — no. of standard drinks/wk | 16.8±7.7 | 16.4±6.9 |
| Beverages consumed — no. (%) | | |
| Wine | 48 (69) | 47 (67) |
| Beer | 34 (49) | 34 (49) |
| Spirits | 13 (19) | 9 (13) |
| Binge drinking — no. (%)* | 20 (29) | 16 (23) |

* Binge drinking was defined as consumption of 5 or more drinks on a single occasion at least once a month.



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**140 pacientes** con consumo de alcohol

*Objetivos*:
**Recurrencia** de FA
**Tiempo acumulado** en FA

| Abstinence (no alcohol for 6 mo) | Control |
|---|---|
| | |
| (N=70) | (N=70) |
| 53% | 73% |
| HR, 0.55; 95% CI, 0.36–0.84; P=0.005 | |
| 0.5% | 1.2% |

ORIGINAL ARTICLE FREE PREVIEW

# Alcohol Abstinence in Drinkers with Atrial Fibrillation

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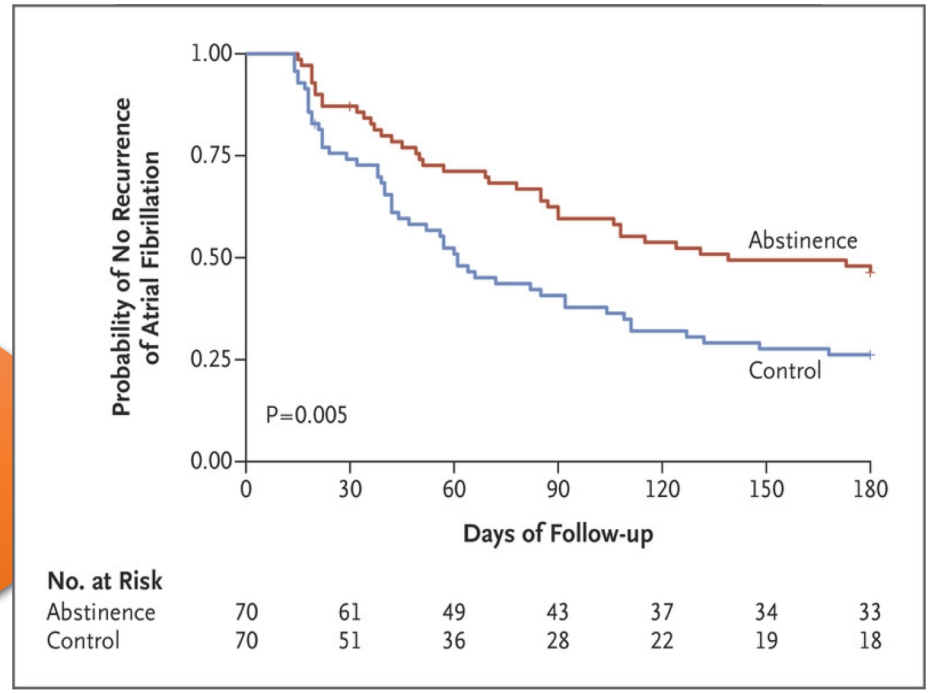
**140 pacientes** con consumo de alcohol

*Objetivos*:
**Recurrencia** de FA
**Tiempo acumulado** en FA



JAMA | Original Investigation

# Effect of a Strategy of Comprehensive Vasodilation vs Usual Care on Mortality and Heart Failure Rehospitalization Among Patients With Acute Heart Failure

## The GALACTIC Randomized Clinical Trial

Ensayo clínico aleatorizado, abierto, multicéntrico

**ICC aguda**
**N = 785**

**Estrategia agresiva y temprana**

**Nitratos a dosis máxima tolerada (sublingual y subcutánea)**
**+**
**Hidralacina**
**+**
**Titular lo antes posible IECA/ARA2/ARNI**

**Estrategia habitual**

**Manejo habitual basado en las guías actuales, con titulaciones más lentas**

JAMA | Original Investigation

# Effect of a Strategy of Comprehensive Vasodilation vs Usual Care on Mortality and Heart Failure Rehospitalization Among Patients With Acute Heart Failure

## The GALACTIC Randomized Clinical Trial

Ensayo clínico aleatorizado, abierto, multicéntrico

Estrategia agresiva

gia habitual

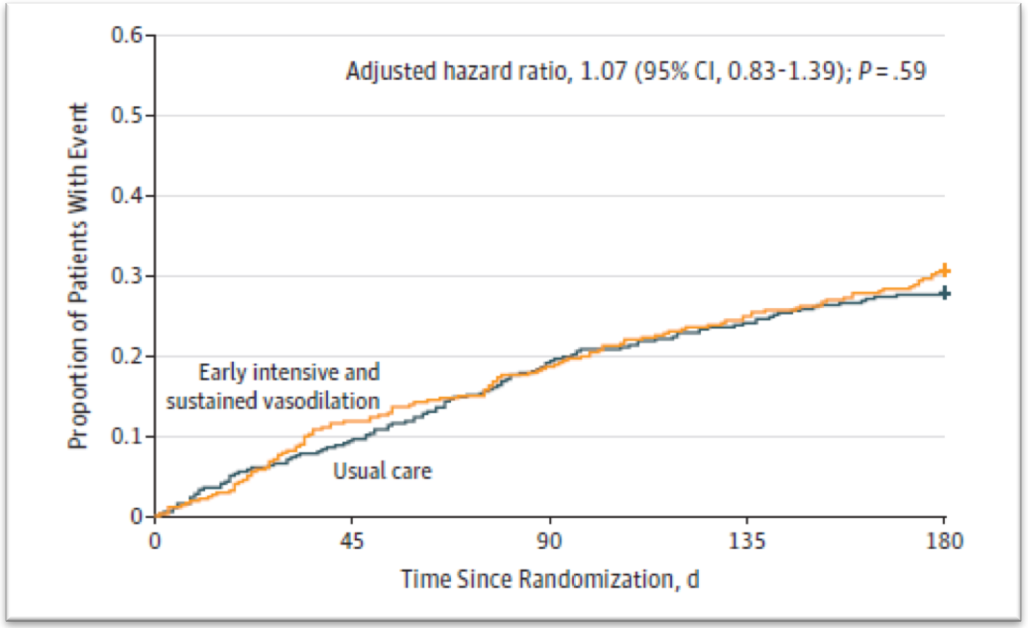
| Characteristics | Intervention (n = 382) | Usual Care (n = 399) |
|---|---|---|
| Age, median (IQR), y | 78.0 (70.0-85.0) | 77.0 (69.0-84.0) |
| Sex | | |
| Female | 140 (37) | 148 (37) |
| Male | 242 (63) | 251 (63) |
| BMI, median (IQR) | 26.5 (23.4-30.3) | 26.6 (23.5-29.7) |
| BNP, median (IQR), ng/L | 1249 (849-2254) [n = 167] | 1272 (845-2146) [n = 220] |
| NT-proBNP, median (IQR), ng/L | 6135 (3359-9899) [n = 167] | 5336 (3021-9517) [n = 179] |
| LVEF, median (IQR), %[b] | 36 (26-50) [n = 334] | 37 (26-51) [n = 352] |
| <40 | 175 (52) | 191 (54) |
| 40-49 | 63 (19) | 59 (17) |
| ≥50 | 96 (29) | 102 (29) |
| Blood pressure, mm Hg | | |
| Diastolic | 75.0 (65.0-86.0) [n = 382] | 75.0 (65.0-86.0) [n = 398] |
| Systolic | 130.0 (117.2-145.0) | 131.0 (118.0-150.0) |

JAMA | Original Investigation

# Effect of a Strategy of Comprehensive Vasodilation vs Usual Care on Mortality and Heart Failure Rehospitalization Among Patients With Acute Heart Failure

## The GALACTIC Randomized Clinical Trial

*Objetivo 1ario*:
**Compuesto de muerte por cualquier causa y rehospitalización por ICC aguda en 180 días**



Annals of Internal Medicine®

# Preoperative *N*-Terminal Pro–B-Type Natriuretic Peptide and Cardiovascular Events After Noncardiac Surgery: A Cohort Study

*Emmanuelle Duceppe, MD; Ameen Patel, MD; Matthew T.V. Chan, MBBS, PhD; Otavio Berwanger, MD, PhD; Gareth Ackland, PhD; Peter A. Kavsak, PhD; Reitze Rodseth, PhD; Bruce Biccard, PhD; Clara K. Chow, PhD; Flavia K. Borges, MD, PhD; Gordon Guyatt, MD, MSc; Rupert*

Ensayo cohortes multicéntrico

**N = 10402**

*Objetivo*:
**Valor predictivo del NT-ProBNP para muerte CV + daño miocárdico a los 30 días**

Annals of Internal Medicine®

# Preoperative *N*-Terminal Pro–B-Type Natriuretic Peptide and Cardiovascular Events After Noncardiac Surgery: A Cohort Study

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Ensayo cohortes multicéntrico

**N = 10402**

| NT-ProBNP | Hazard ratio |
|---|---|
| < 100 pg/ml | *Grupo referencia* |
| 100-200 pg/ml | 2.27 (95% CI, 1.90 to 2.70) |
| 200-1500 pg/ml | 3.63 (CI, 3.13 to 4.21) |
| > 1500 pg/ml | 5.82 (CI, 4.81 to 7.05) |

ESC HEART FAILURE
*ESC Heart Failure* (2019)
Published online in Wiley Online Library (wileyonlinelibrary.com) **DOI:** 10.1002/ehf2.12542

ORIGINAL RESEARCH ARTICLE

# Cognitive impairment in patients with heart failure: an international study

Ercole Vellone[1], Oronzo Chialà[1], Josiane Boyne[2], Leonie Klompstra[3], Lorraine S. Evangelista[4], Maria Back[5], Tuvia Ben Gal[6,7], Jan Mårtensson[8], Anna Strömberg[5] and Tiny Jaarsma[3]*

[1]*Department of Biomedicine and Prevention, University of Rome Tor Vergata, Rome, Italy;* [2]*Department of Cardiology, Maastricht University Medical Centre, Maastricht, The Netherlands;* [3]*Department of Social and Welfare Studies, Faculty of Health Science, Linköping University, Linköping, Sweden;* [4]*Sue & Bill Gross School of Nursing, University of California Irvine, Irvine, CA, USA;* [5]*Division of Physiotherapy, Department of Medical and Health Sciences, Linköping University, Linköping, Sweden;* [6]*Department of Cardiology, Rabin Medical Center (Beilinson Campus), Petah Tikva, Israel;* [7]*Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel;* [8]*Department of Nursing, School of Health and Welfare, Jönköping University, Jönköping, Sweden*

- **E:** Análisis secundario del ensayo clínico Wii-HF.
- **O:** Medir el deterioro cognitivo en los pacientes con IC y evaluar los factores asociados.
- **MyM:** N = 605 pacientes (6 países diferentes).
  - Escala de evaluación cognitiva de Montreal (MOCA) y test de 6 minutos marcha.
- **R:** 67 años promedio (DS 12).
  - 86% clase funcional NYHA II-III.
  - MOCA medio 24 (DS 4) 67% deterioro cognitivo moderado.

**Table 6** Regression analysis predicting MoCA total score and MoCA dimension scores

| Variable | Total MoCA score | Visuospatial/ executive | Naming | Attention | Language | Abstraction | Delayed recall | Orientation |
|---|---|---|---|---|---|---|---|---|
| Gender (Male = 1; Female = 2) | 0.053 | −0.006 | −0.093 | −0.003 | 0.091 | −0.095 | 0.095 | 0.061 |
| Age | -0.210*** | −0.166** | −0.053 | −0.099 | 0.032 | −0.076 | −0.186** | −0.108# |
| Education | 0.152** | 0.168** | 0.033 | 0.133* | 0.213*** | 0.091 | −0.070 | −0.012 |
| Time after HF diagnosis (in months) | 0.023 | 0.042 | −0.133* | 0.011 | −0.026 | −0.079 | 0.033 | 0.081 |
| NYHA class | 0.010 | −0.048 | 0.059 | −0.063 | 0.018 | −0.020 | −0.029 | 0.022 |
| Ejection fraction | 0.070 | 0.082 | 0.017 | 0.000 | 0.093 | 0.109¥ | 0.043 | 0.050 |
| Charlson comorbidity index score | -0.082 | −0.026 | 0.010 | −0.045 | −0.072 | −0.065 | −0.007 | −0.026 |
| Six minute walk test score | 0.311*** | 0.217*** | 0.135* | 0.130* | 0.249*** | 0.013 | 0.106 | 0.258*** |
| $R^2$ | 0.266 | 0.183 | 0.050 | 0.098 | 0.143 | 0.049 | 0.059 | 0.097 |

Lower MoCA scores mean worse cognitive impairment. Numbers in columns are standardized betas. ¥*P* 0.052; #*P* 0.055
HF, heart failure; NYHA, New York Heart Association; MoCA, Montreal cognitive assessment.
*$P < 0.05$,
**$P < 0.01$,
***$P < 0.001$.

Rev Esp Geriatr Gerontol. 2020;55(1):29–33

Revista Española de Geriatría y Gerontología

www.elsevier.es/regg

PROYECTOS DE INVESTIGACIÓN

# Impacto de la FRAgilidad y otros síndromes Geriátricos en el manejo clínico y pronóstico del paciente anciano ambulatorio con Insuficiencia Cardiaca (FRAGIC). Estudio prospectivo y multicéntrico

Pablo Díez-Villanueva[a,*], Jorge Salamanca[a], Albert Ariza-Solé[b], Francesc Formiga[c], Francisco Javier Martín-Sánchez[d], Clara Bonanad Lozano[e], María Teresa Vidán[f], Manuel Martínez-Sellés[g], Beatriz Terres[a], César Jiménez Méndez[a], Héctor Bueno[h] y Fernando Alfonso[a]

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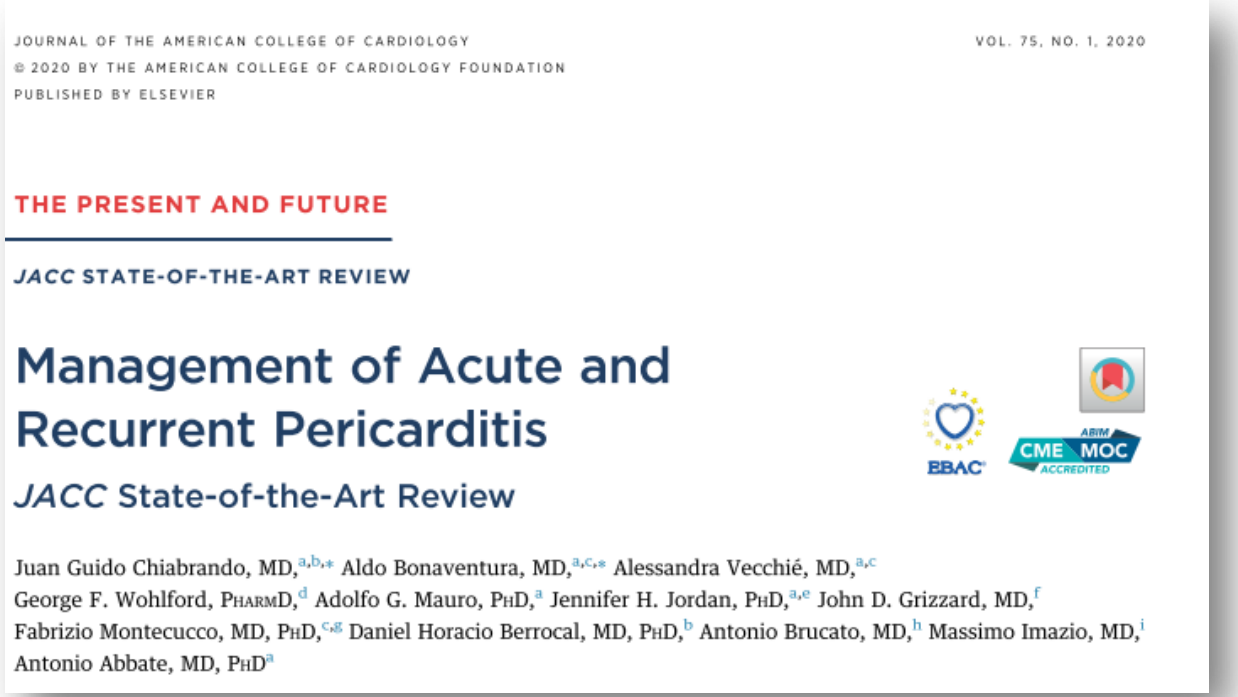
[d] Servicio de Urgencias, Hospital Clínico San Carlos, Instituto de Investigación Sanitaria Hospital Clínico San Carlos (IdISSC), Universidad Complutense de Madrid, Madrid, España
[e] Servicio de Cardiología, Hospital Clínico Universitario de Valencia, Valencia, España
[f] Servicio de Geriatría, Hospital General Universitario Gregorio Marañón (IiSGM), Universidad Complutense de Madrid, Centro de Investigación Biomédica en Red de Fragilidad y Envejecimiento Saludable (CIBERFES), Madrid, España
[g] Servicio de Cardiología, Hospital Universitario Gregorio Marañón, Centro de Investigación Biomédica en Red de Enfermedades Cardiovasculares (CIBERCV), Universidad Complutense de Madrid, Universidad Europea de Madrid, Madrid, España
[h] Servicio de Cardiología, Hospital Universitario 12 de Octubre, CNIC, Madrid, España

- **E:** Observacional prospectivo multicéntrico **(en reclutamiento).** Registro nacional
- **O:** **Características clínicas y epidemiológicas** de pacientes mayores con **IC ambulatoria** en seguimiento por Cardiología.
  - Fragilidad y síndromes geriátricos. Impacto pronóstico.
  - Modelos predictivos de riesgo.
- **MyM:** Muestra 400 pacientes. Mayores de 75 años con IC en seguimiento en Hospital de día y Consultas externas.
  - Valoración geriátrica
  - Predicción de eventos (MAGGIC y BCN-Bio HF calculator).
- **Variable resultado: Mortalidad de cualquier causa y de origen cardiovascular a 1 y 3 años.**



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THE PRESENT AND FUTURE

*JACC* STATE-OF-THE-ART REVIEW

# Management of Acute and Recurrent Pericarditis

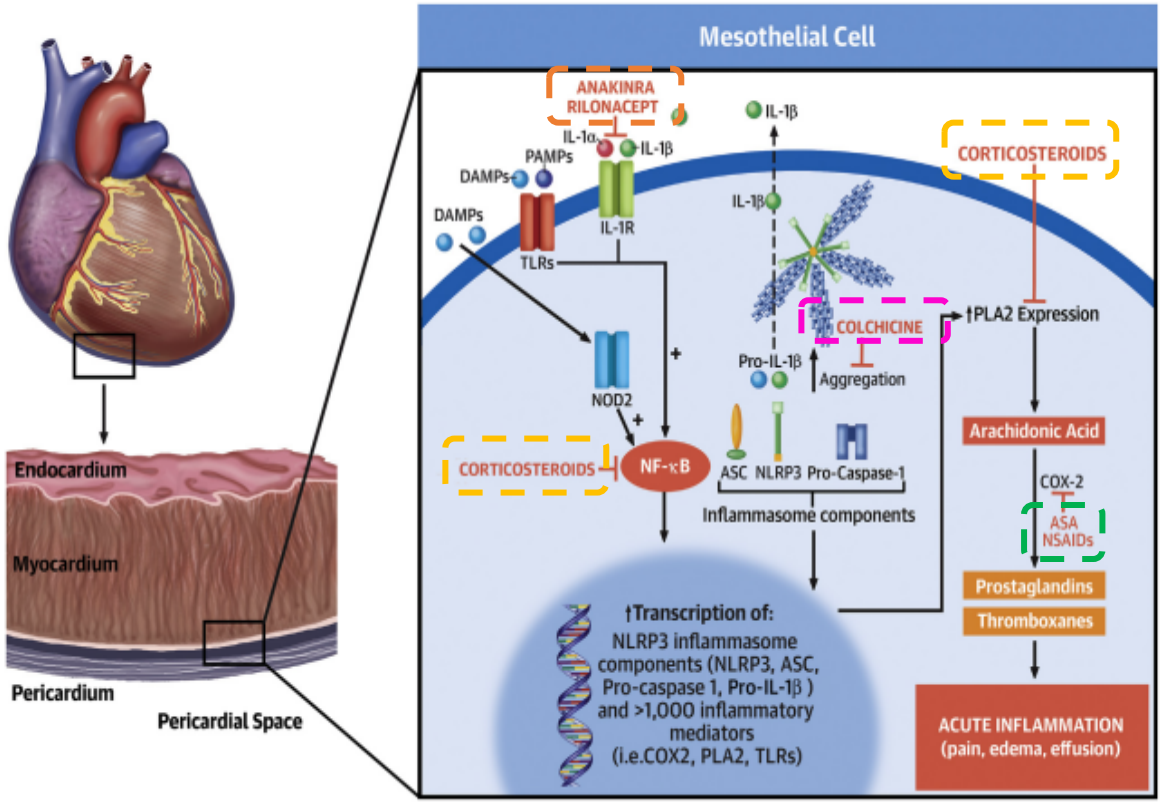
## *JACC* State-of-the-Art Review

Juan Guido Chiabrando, MD,[a,b,*] Aldo Bonaventura, MD,[a,c,*] Alessandra Vecchié, MD,[a,c]
George F. Wohlford, PharmD,[d] Adolfo G. Mauro, PhD,[a] Jennifer H. Jordan, PhD,[a,e] John D. Grizzard, MD,[f]
Fabrizio Montecucco, MD, PhD,[c,g] Daniel Horacio Berrocal, MD, PhD,[b] Antonio Brucato, MD,[h] Massimo Imazio, MD,[i]
Antonio Abbate, MD, PhD[a]

**Resumir las actualizaciones sobre el manejo de la pericarditis aguda y recurrente.**

- Es **la causa más común de enfermedad del pericardio**, generalmente autolimitada pero asociada a un riesgo importante de complicaciones agudas y recurrencias
- El diagnóstico temprano y la instauración del tratamiento **REDUCEN** el riesgo de complicaciones y recurrencias.
- Existen **nuevas terapias** para su tratamiento con resultados prometedores.

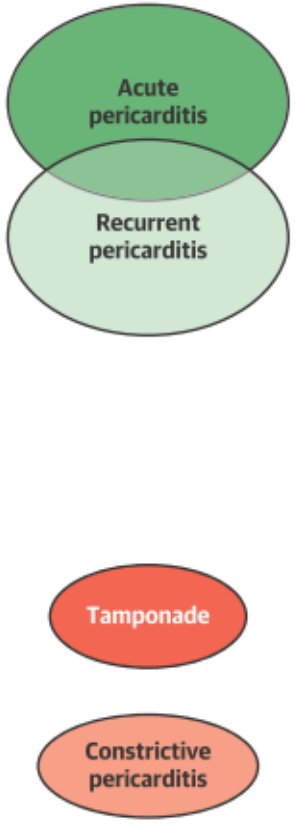
**CENTRAL ILLUSTRATION** Pathophysiology of Acute Pericarditis




Chiabrando, J.G. et al. J Am Coll Cardiol. 2020;75(1):76–92.

Injury to the pericardium leads to the release of DAMPs and PAMPs and induces NF-κB synthesis, which increases the transcription of precursors of inflammatory molecules and associated cytokines (NLRP3, ASC, pro-caspase-1) required for the polymerization of the NLRP3 inflammasome, ultimately releasing IL-1β and IL-18. NF-κB stimulates the synthesis of phospholipase-A2 required for promoting the arachidonic acid pathway and the subsequent synthesis of prostaglandins and thromboxanes. The IL-1 receptor (IL-1R) occupies a central role as IL-1α functions as an alarmin or DAMP being released during tissue injury, and IL-1β is processed and released by the inflammasome leading to amplification of the process. ASA = acetylsalicylic acid; ASC = apoptosis-associated speck-like protein containing a carboxy-terminal caspase-recruiting domain; DAMP = damage-associated molecular pattern; IL = interleukin; IL-1R = interleukin-1 receptor; NF-κB = nuclear factor kappa-light-chain enhancer of activated B cells; NLRP3 = NACHT, leucine-rich repeat, and pyrin domain-containing protein 3; NOD = nucleotide-binding oligomerization domain. NSAID = nonsteroidal anti-inflammatory drug; PAMP = pathogen-associated molecular pattern; PLA2 = phospholipase A2; TLR= toll-like receptor.

**FIGURE 3** Treatment for Acute and Recurrent Pericarditis and Their Complications




| DRUG | DOSE | DURATION |
|---|---|---|
| Aspirin | 750-1,000 mg every 8 h | 1-2 weeks |
| Ibuprofen | 600-800 mg every 8 h | 1-2 weeks |
| Colchicine | 0.5-1.2 mg in one or divided doses | 3 months |
| Aspirin | 750-1,000 mg every 8 h | Weeks-months |
| Ibuprofen | 600-800 mg every 8 h | Weeks-months |
| Indomethacin | 25-50 mg every 8 h | Weeks-months |
| Colchicine | 0.5-1.2 mg in one or divided doses | At least 6 months |
| Prednisone | 0.2-0.5 mg/kg/daily | Months |
| Anakinra | 1-2 mg/kg/daily up to 100 mg/daily | Months |
| Rilonacept | 320 mg once, then 160 mg weekly | Months |
| Azathioprine | 1 mg/kg/daily up to 2-3 mg/kg/daily | Months |
| Methotrexate | 10-15 mg weekly | Months |
| MMF | 2,000 mg daily | Months |
| IVIGs | 400-500 mg/kg/day | 5 days |
| Pericardiocentesis | | |
| Pericardial window | | |
| Active inflammation | Yes → Anti-inflammatory therapy as first line, pericardiectomy for refractory cases | |
| | No → Pericardiectomy | |

Different treatments, their dosing, and duration according to clinical presentation are summarized. IVIGs = intravenous immunoglobulins; MMF = mycophenolate mofetil.

# Irbesartan in Marfan syndrome (AIMS): a double-blind, placebo-controlled randomised trial

Michael Mullen*, Xu Yu Jin*, Anne Child, A Graham Stuart, Matthew Dodd, José Antonio Aragon-Martin, David Gaze, Anatoli Kiotsekoglou, Li Yuan, Jiangting Hu, Claire Foley, Laura Van Dyck, Rosemary Knight, Tim Clayton, Lorna Swan, John D R Thomson, Guliz Erdem, David Crossman, Marcus Flather, on behalf of the AIMS Investigators†

- **E:** Ensayo clínico doble ciego comparado con placebo.
- **O:** Determinar los efectos del ibersartán en la dilatación aórtica en niños y adultos con síndrome de Marfan.
- **MyM:** 22 centros en Reino Unido. Pacientes entre 6 y 40 años con síndrome de Marfan confirmado. Ecocardiograma diámetro aórtico.

**Ecocardiografía basal**

**Irbesartán 75 mg 1 vez al día.**

**Irbesartán 150 mg 1 vez al día** (incremento hasta 300 mg si bien tolerado y > 50 kg)

**N= 104**

**Placebo**

**N= 88**

**Ecocardiografía anual**

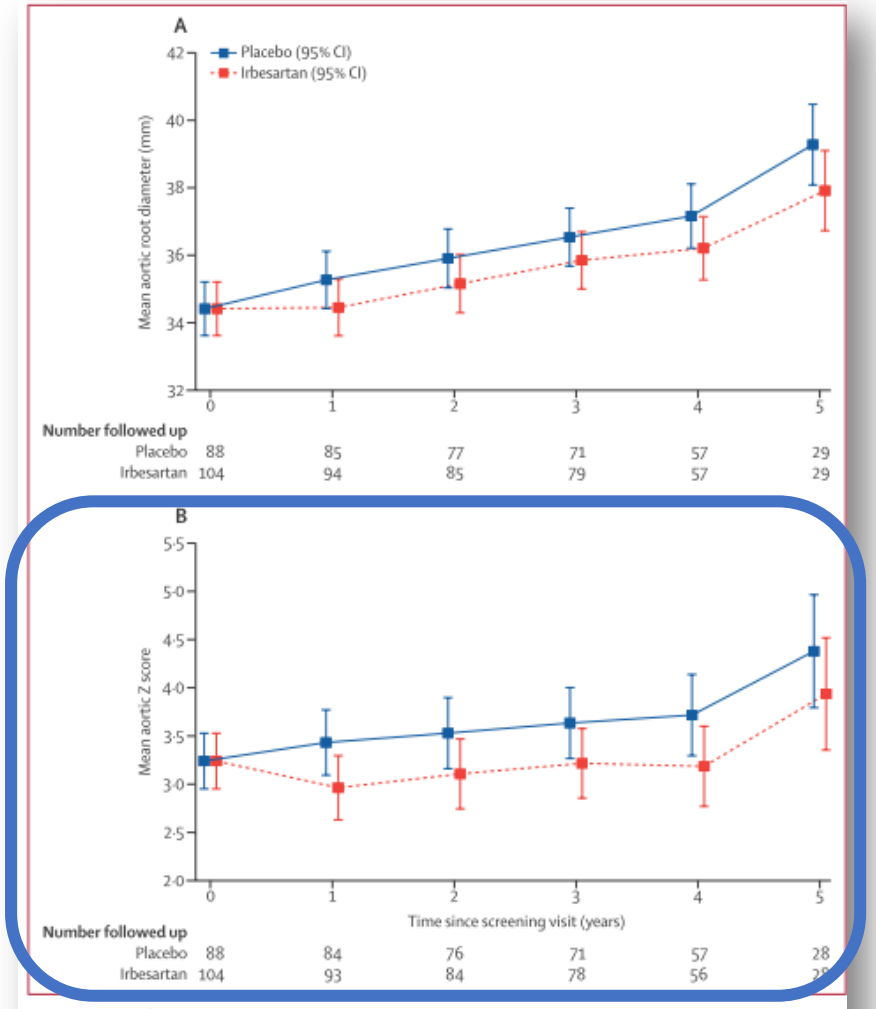



*Figure 2:* **Aortic diameter measurements over time**
(A) Mean aortic root diameter over time. (B) Mean aortic Z score over time. Means were estimated by use of a linear mixed effects model for repeated measures. At the final follow up visit the majority of patients had not reached 5 years of study participation, which accounts for the sharp decrease in numbers available for follow-up between year 4 and 5.

| | Placebo | Irbesartan | Difference (95% CI) | p value |
|---|---|---|---|---|
| Change in aortic Z score (per year), mean (95% CI) | 0·15 (0·08 to 0·22) | 0·05 (–0·02 to 0·11) | –0·10 (–0·19 to –0·01) | 0·035 |
| Aortic Z score | | | | |
| Baseline, mean (SD); n | 3·28 (2·10); 88 | 3·21 (2·00); 104 | .. | .. |
| 1 year, mean (95% CI), n | 3·44 (3·10 to 3·77), 84 | 2·96 (2·63 to 3·30), 93 | –0·47 (–0·74 to –0·20) | 0·0006 |
| 2 years, mean (95% CI), n | 3·53 (3·16 to 3·90), 76 | 3·11 (2·75 to 3·47), 84 | –0·42 (–0·74 to –0·10) | 0·010 |
| 3 years, mean (95% CI), n | 3·63 (3·26 to 4·00), 71 | 3·22 (2·86 to 3·59), 78 | –0·41 (–0·73 to –0·08) | 0·013 |
| 4 years, mean (95% CI), n | 3·72 (3·30 to 4·14), 57 | 3·18 (2·76 to 3·60), 56 | –0·54 (–0·98 to –0·10) | 0·016 |
| 5 years, mean (95% CI), n | 4·38 (3·80 to 4·97), 28 | 3·94 (3·35 to 4·52), 28 | –0·45 (–1·14 to 0·25) | 0·21 |

Comparisons are made between groups at each timepoint. At the final follow-up visit the majority of patients had not reached 5 years of study participation, which accounts for the sharp decrease in numbers available for follow-up between year 4 and 5.

*Table 3:* **Aortic Z score**

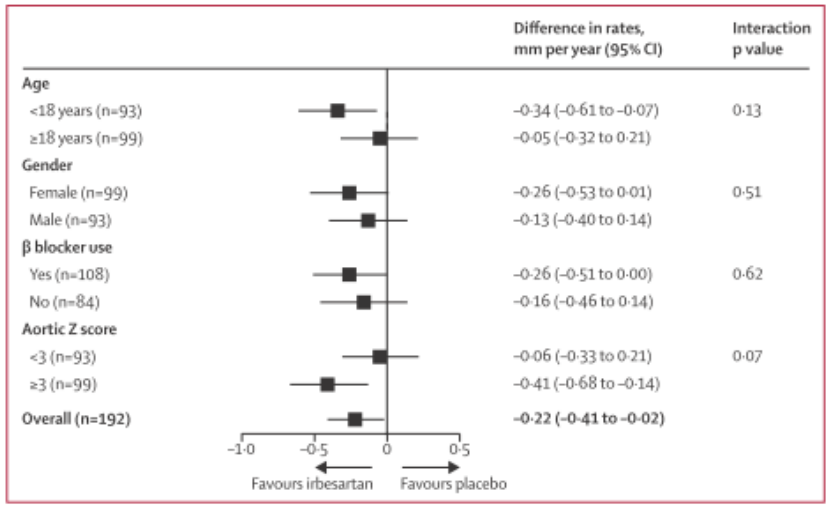



*Figure 3:* **Differences in rate of aortic root diameter change**

Rev Esp Geriatr Gerontol. 2020;55(1):34–41

Revista Española de Geriatría y Gerontología

www.elsevier.es/regg

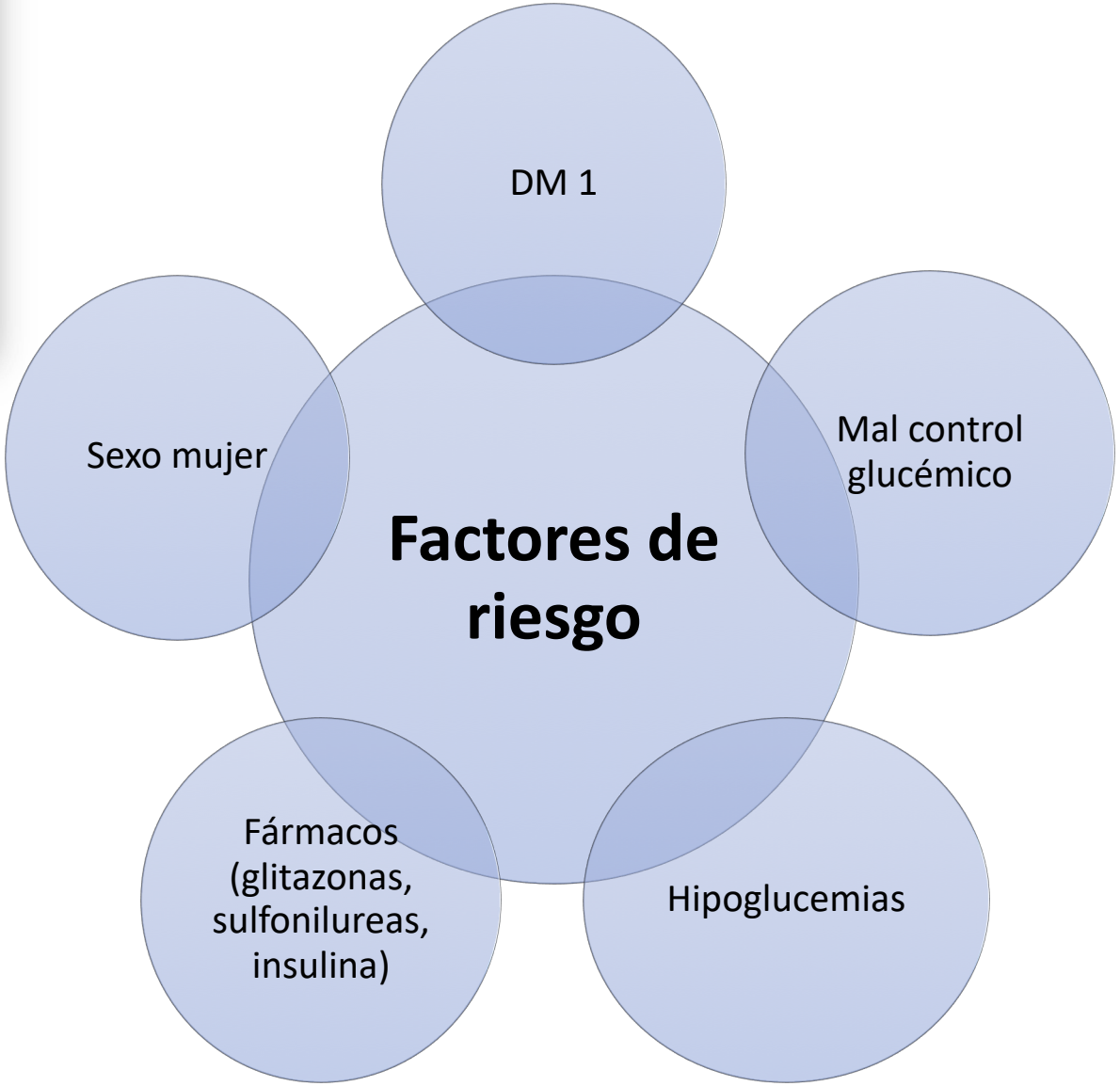
REVISIÓN

Diabetes mellitus y riesgo de fractura de cadera. Revisión sistemática

Francesc Formiga*, María Daniela Freitez Ferreira y Abelardo Montero

*Servicio de Medicina Interna, Hospital Universitario Bellvitge, IDIBELL, L'Hospitalet de Llobregat, Barcelona, España*

- **E:** Revisión sistemática de la literatura.
- **O:** investigar la posible asociación entre DM y fractura de cadera, así como los factores asociados.
- **MyM:** revisión sistemática desde enero de 2001 hasta agosto de 2018 (PubMed y SCOPUS).
- **R:** 27 artículos. (Cohortes prospectivo 11, Cohortes retrospectivo 14).
  - Asociación entre DM y fractura de cadera en mujeres y hombres diabéticos con respecto a los no diabéticos.
  - Muy alta heterogeneidad.



Articles

# Oseltamivir plus usual care versus usual care for influenza-like illness in primary care: an open-label, pragmatic, randomised controlled trial

Christopher C Butler, Alike W van der Velden, Emily Bongard, Benjamin R Saville, Jane Holmes, Samuel Coenen, Johanna Cook, Nick A Francis, Roger J Lewis, Maciek Godycki-Cwirko, Carl Llor, Sławomir Chlabicz, Christos Lionis, Bohumil Seifert, Pär-Daniel Sundvall, Annelies Colliers, Rune Aabenhus, Lars Bjerrum, Nicolay Jonassen Harbin, Morten Lindbæk, Dominik Glinz, Heiner C Bucher, Bernadett Kovács, Ruta Radzeviciene Jurgute, Pia Touboul Lundgren, Paul Little, Andrew W Murphy, An De Sutter, Peter Openshaw, Menno D de Jong, Jason T Connor, Veerle Matheeussen, Margareta Ieven, Herman Goossens, Theo J Verheij

**Clínica de gripe: fiebre** + al menos un **síntoma respiratorio** (tos, dolor de garganta, rinorrea o congestión nasal) + al menos un **síntoma sistémico** (cefalea, mialgias, sudores, escalofríos, astenia)

- **E:** Ensayo clínico abierto, pragmático y adaptativo.
- **O:** Determinar si la adición de tratamiento antiviral en pacientes con clínica de gripe en atención primaria reduce el tiempo de recuperación total.
- **MyM:** Oseltamivir. Pacientes 1 año en adelante que presentasen síntomas de gripe en atención primaria. 36 grupos preespecificados (edad, comorbilidad, duración y severidad de síntomas). 15 enero 2016 y 12 abril 2018.
- **Endpoint primario:** Tiempo de recuperación (regreso a vida basal sin fiebre, cefalea ni dolor muscular).

Tratamiento sintomático
+ **Oseltamivir**

**N= 1629**

Tratamiento sintomático

N= 1637

- En pacientes **menores de 12 años sin comorbilidad y con síntomas leves**: <u>beneficio de oseltamivir 0.70 días.</u>

- En pacientes **mayores de 65 años con comorbilidades y síntomas moderados y graves:** beneficio de oseltamivir 2.30-3.20 días.

| | Usual care (control), n=1529* | Usual care plus oseltamivir (intervention), n=1535* | Difference (95% CI) |
|---|---|---|---|
| Week 1–2 | | | |
| Hospital attendance | 52/1462 (4%) | 43/1469 (3%) | 0·6% (–0·7 to 2·0) |
| Hospital overnight stay | 14/51 (27%) | 8/42 (19%) | 8·4% (–10·8 to 27·6) |
| X-ray confirmed pneumonia | 12/21 (57%) | 7/15 (47%) | 10·5% (–28·2 to 49·1) |
| Week 3–4 | | | |
| Hospital attendance | 22/1393 (2%) | 19/1426 (1%) | 0·2% (–0·7 to 1·2) |
| Hospital overnight stay | 4/22 (18%) | 4/17 (24%) | –5·3% (–36·4 to 25·7) |
| X-ray confirmed pneumonia | 3/5 (60%) | 0/0 (0%) | -- |
| Repeat attendances with health-care services (except hospital)† | 805/1529 (53%) | 796/1535 (52%) | 0·8% (–2·8 to 4·4) |
| Took over-the-counter or other medication† | 1258/1529 (82%) | 1254/1535 (82%) | 0·6% (–2·2 to 3·4) |
| Use of antibiotics† | 202/1529 (13%) | 142/1535 (9%) | 4·0% (1·7 to 6·3) |
| Median days on antibiotics (IQR) | 7 (5–8) | 5 (3–7) | -- |
| Use of acetaminophen containing medicine† | 974/1529 (64%) | 924/1535 (60%) | 3·5% (0·0 to 7·0) |
| Use of ibuprofen containing medicine† | 621/1529 (41%) | 594/1535 (38%) | 1·9% (–1·6 to 5·4) |
| Reports of new infections within the household | 553/1222 (45%) | 485/1237 (39%) | 6·0% (2·1 to 10·0) |

Data are n/N (%) unless otherwise specified. *For the calculation of secondary outcomes, denominator and percentages are those with information from patients' diaries; for hospital admission or overnight stay and pneumonia, data is from phone data too. Overnight hospital stay was calculated for those who attended the hospital and x-ray confirmed pneumonia for those who had an x-ray in the hospital. †If patients did not give an answer to the questions for repeat attendances, over-the-counter or other medication, and antibiotic use it was assumed the answer to the question was no. From over-the-counter medication, acetaminophen and ibuprofen (containing medication) use is shown separately.

*Table 2:* Secondary outcomes

ORIGINAL ARTICLE FREE PREVIEW

# Randomized Trial of Three Anticonvulsant Medications for Status Epilepticus

Jaideep Kapur, M.B., B.S., Ph.D., Jordan Elm, Ph.D., James M. Chamberlain, M.D., William Barsan, M.D., James Cloyd, Pharm.D., Daniel Lowenstein, M.D., Shlomo Shinnar, M.D., Ph.D., Robin Conwit, M.D., Caitlyn Meinzer, Ph.D., Hannah Cock, M.D., Nathan Fountain, M.D., Jason T. Connor, Ph.D., et al., for the NETT and PECARN Investigators*

Ensayo clínico aleatorizado, doble ciego, multicéntrico

1ª línea con **BZD** pero ¿qué pasa después?

*European Journal of Neurology* 2010, **17:** 348–355 doi:10.1111/j.1468-1331.2009.02917.x

EFNS GUIDELINES/CME ARTICLE

# EFNS guideline on the management of status epilepticus in adults

H. Meierkord[a], P. Boon[b], B. Engelsen[c,d], K. Göcke[e], S. Shorvon[f], P. Tinuper[g] and M. Holtkamp[h]

ORIGINAL ARTICLE FREE PREVIEW

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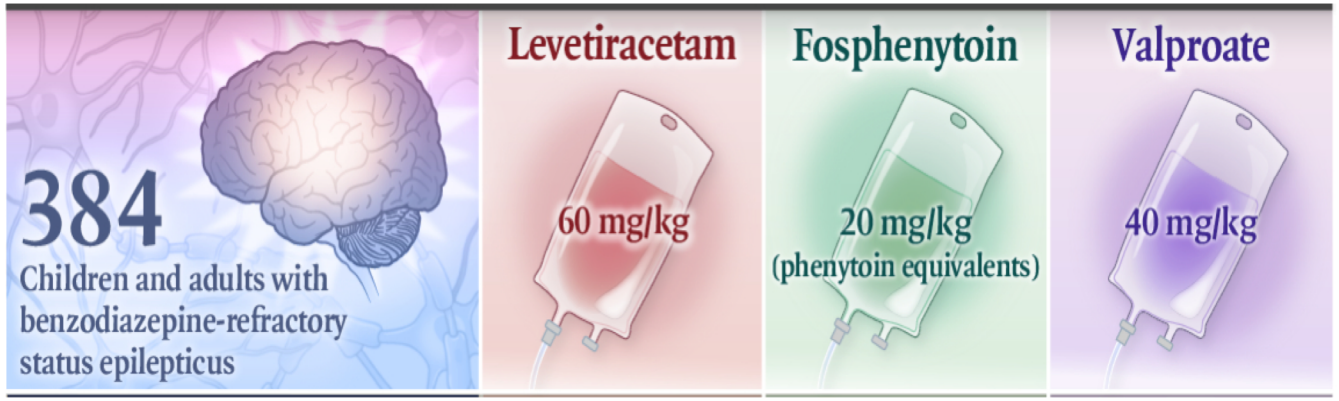
Ensayo clínico aleatorizado, doble ciego, multicéntrico




**Crisis generalizadas** con más de 5 minutos de duración y que persisten tras una dosis adecuada de benzodiacepinas (10 mg de diazepam o midazolam), excluyendo causas secundarias de crisis (hipoglucemias, traumatismos…)

ORIGINAL ARTICLE FREE PREVIEW

# Randomized Trial of Three Anticonvulsant Medications for Status Epilepticus

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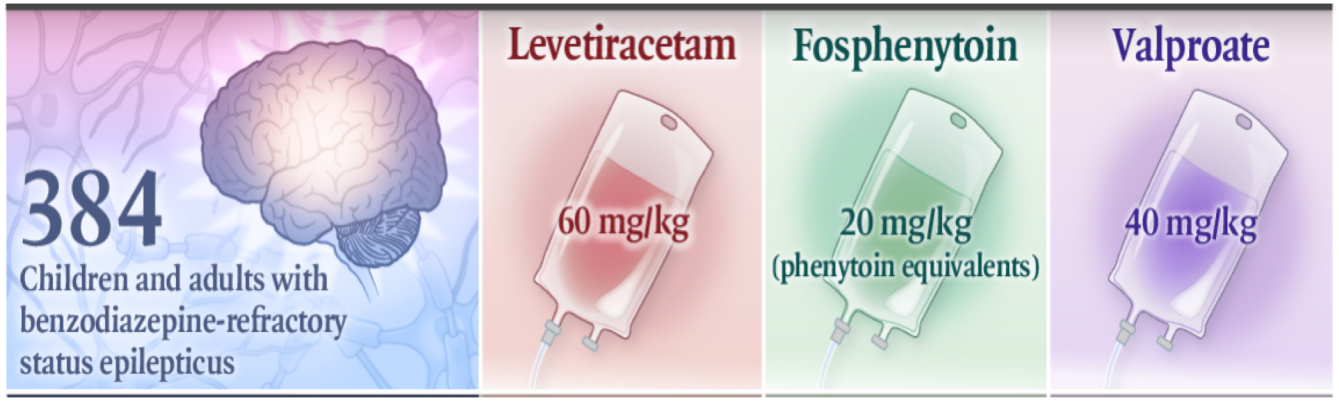
Ensayo clínico aleatorizado, doble ciego, multicéntrico




*Objetivo*:
**Ausencia de crisis y mejoría a los 60 minutos**

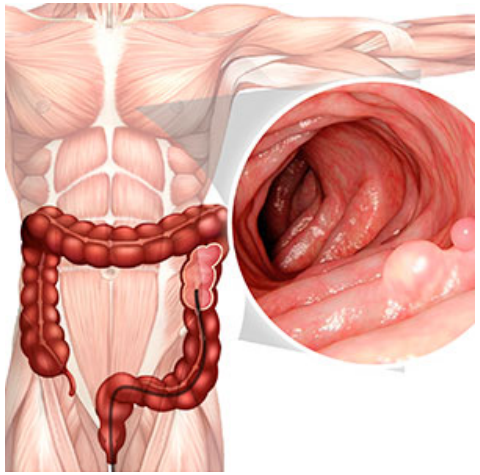
| Levetiracetam | Fosphenytoin | Valproate |
|---|---|---|
| 47% (68/145) | 45% (53/118) | 46% (56/121) |

Gastroenterology 2020;158:168–175

Gastroenterology

# Efficacy and Safety of Early vs Elective Colonoscopy for Acute Lower Gastrointestinal Bleeding

**Ryota Niikura**,[1,*] **Naoyoshi Nagata**,[2,3,*] **Atsuo Yamada**,[1,*] Tetsuro Honda,[4] Kenkei Hasatani,[5] Naoki Ishii,[6] Yasutoshi Shiratori,[6] Hisashi Doyama,[7] Tsutomu Nishida,[8] Tetsuya Sumiyoshi,[9] Tomoki Fujita,[10,11] Shu Kiyotoki,[12] Tomoyuki Yada,[13] Katsumi Yamamoto,[14] Tomohiro Shinozaki,[15,16] Munenori Takata,[17] Tatsuya Mikami,[18] Katsuhiro Mabe,[19] Kazuo Hara,[20] Mitsuhiro Fujishiro,[1,21] and Kazuhiko Koike[1]



Colonoscopia en **menos de 24 horas** en los casos de HDB

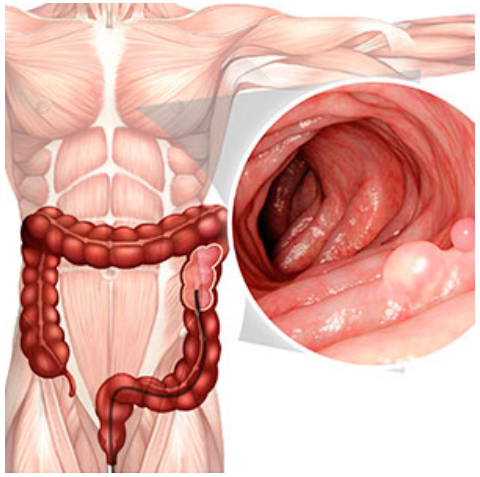
Gastroenterology 2020;158:168–175

Gastroenterology

# Efficacy and Safety of Early vs Elective Colonoscopy for Acute Lower Gastrointestinal Bleeding

**Ryota Niikura,**[1,*] **Naoyoshi Nagata,**[2,3,*] **Atsuo Yamada,**[1,*] Tetsuro Honda,[4] Kenkei Hasatani,[5] Naoki Ishii,[6] Yasutoshi Shiratori,[6] Hisashi Doyama,[7] Tsutomu Nishida,[8] Tetsuya Sumiyoshi,[9] Tomoki Fujita,[10,11] Shu Kiyotoki,[12] Tomoyuki Yada,[13] Katsumi Yamamoto,[14] Tomohiro Shinozaki,[15,16] Munenori Takata,[17] Tatsuya Mikami,[18] Katsuhiro Mabe,[19] Kazuo Hara,[20] Mitsuhiro Fujishiro,[1,21] and Kazuhiko Koike[1]

Ensayo clínico aleatorizado multicéntrico (Japón)



**N = 532**

Colonoscopia **precoz (<24 h)**

Colonoscopia **electiva (24-72h)**

*Objetivo*:
**Localización de estigmas de sangrado recientes**

# Efficacy and Safety of Early vs Elective Colonoscopy for Acute Lower Gastrointestinal Bleeding

**Table 3.** Primary and Secondary Outcomes

| Outcome | Early colonoscopy (n = 79), n (%) | Elective colonoscopy (n = 80), n (%) | Difference | *P* value |
|---|---|---|---|---|
| Primary outcome | | | | |
| SRH identification | 17 (21.5) | 17 (21.3) | 0.3 (–12.5 to 13.0) | .967 |
| SRH identification by central review | 20 (25.3) | 21 (26.3) | –0.9 (–14.5 to 12.7) | .893 |
| Secondary outcome | | | | |
| 30-day rebleeding[a,b] | 11 (15.3) | 5 (6.7) | 8.6 (–1.4 to 18.7) | .094 |
| Success rate of endoscopic treatment[c] | 14/15 (93.3) | 15/15 (100.0) | –6.7 (–19.3 to 6.0) | .309 |
| Success rate of endoscopic treatment for active bleeding[d] | 8/10 (80.0) | 6/8 (75.0) | 5.0 (–0.3 to 0.4) | .800 |
| Need for additional endoscopic examinations | 31 (39.2) | 23 (28.8) | 10.5 (–4.1 to 25.1) | .163 |
| Need for interventional radiology | 1 (1.3) | 0 | 1.3 (–1.2 to 3.7) | .313 |
| Need for surgery | 0 | 0 | 0 | N/A |
| Need for transfusion during hospitalization | 30 (38.0) | 26 (32.5) | 5.5 (–9.4 to 20.3) | .470 |
| Length of stay | 7.1 ± 5.7 | 7.6 ± 6.0 | –0.5 (–2.3 to 1.3) | .112 |
| 30-day thrombotic events[b,e] | 1 (1.4) | 0 | 1.4 (–1.3 to 4.1) | .306 |
| 30-day mortality[b] | 0 | 0 | 0 | N/A |

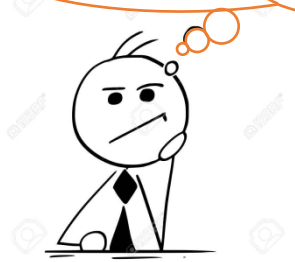
This multicenter RCT showed that early colonoscopy, performed within 24 hours of arrival, did not increase SRH identification rate or reduce 30-day rebleeding when compared with elective colonoscopy in patients with ALGIB.

ORIGINAL ARTICLE FREE PREVIEW

# Metoprolol for the Prevention of Acute Exacerbations of COPD

Mark T. Dransfield, M.D., Helen Voelker, B.A., Surya P. Bhatt, M.D., Keith Brenner, M.D., Richard Casaburi, M.D., Carolyn E. Come, M.D., J. Allen D. Cooper, M.D., Gerard J. Criner, M.D., Jeffrey L. Curtis, M.D., MeiLan K. Han, M.D., Umur Hatipoğlu, M.D., Erika S. Helgeson, Ph.D., et al., for the BLOCK COPD Trial Group*

Estudios observacionales: posible beneficio de BB en EPOC



Efecto del **metoprolol** sobre las exacerbaciones de EPOC en pacientes

ORIGINAL ARTICLE FREE PREVIEW

# Metoprolol for the Prevention of Acute Exacerbations of COPD

Mark T. Dransfield, M.D., Helen Voelker, B.A., Surya P. Bhatt, M.D., Keith Brenner, M.D., Richard Casaburi, M.D., Carolyn E. Come, M.D., J. Allen D. Cooper, M.D., Gerard J. Criner, M.D., Jeffrey L. Curtis, M.D., MeiLan K. Han, M.D., Umur Hatipoğlu, M.D., Erika S. Helgeson, Ph.D., et al., for the BLOCK COPD Trial Group*

Ensayo clínico aleatorizado, doble ciego, multicéntrico (EEUU)

**N = 532**

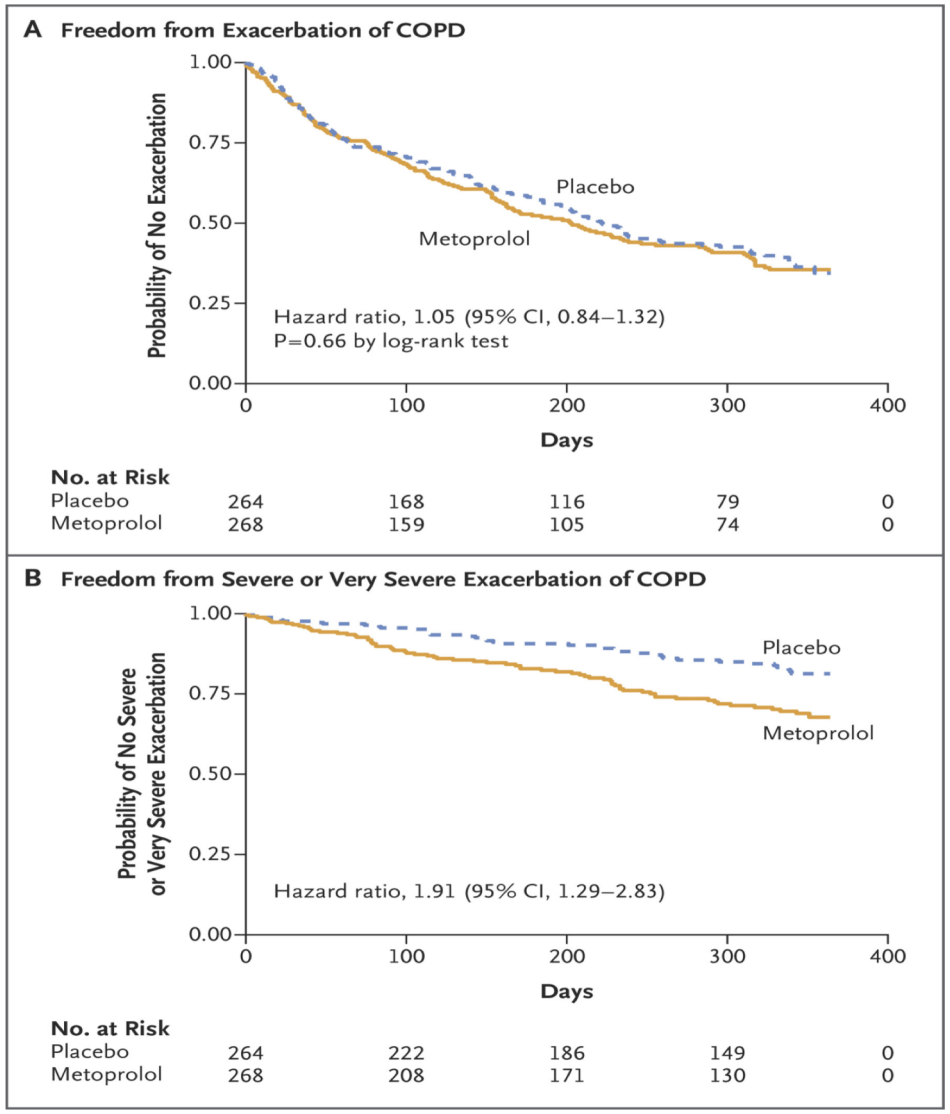
**FEV1 < 80 %**
**FEV1/CVF < 0,7**

**Riesgo de exacerbación** (en el último año).

Atención en Urgencias por exacerbación, prescripción de O2 o corticoterapia por motivo respiratorio.

Indicaciones de betabloqueante por causa **cardiovascular**: ICC, CI

*Objetivo*:
**Tiempo hasta una nueva exacerbación**




Study stopped early for futility and safety concerns

Metoprolol use was associated with a higher risk of severe exacerbation

# GRACIAS POR VUESTRA ATENCIÓN