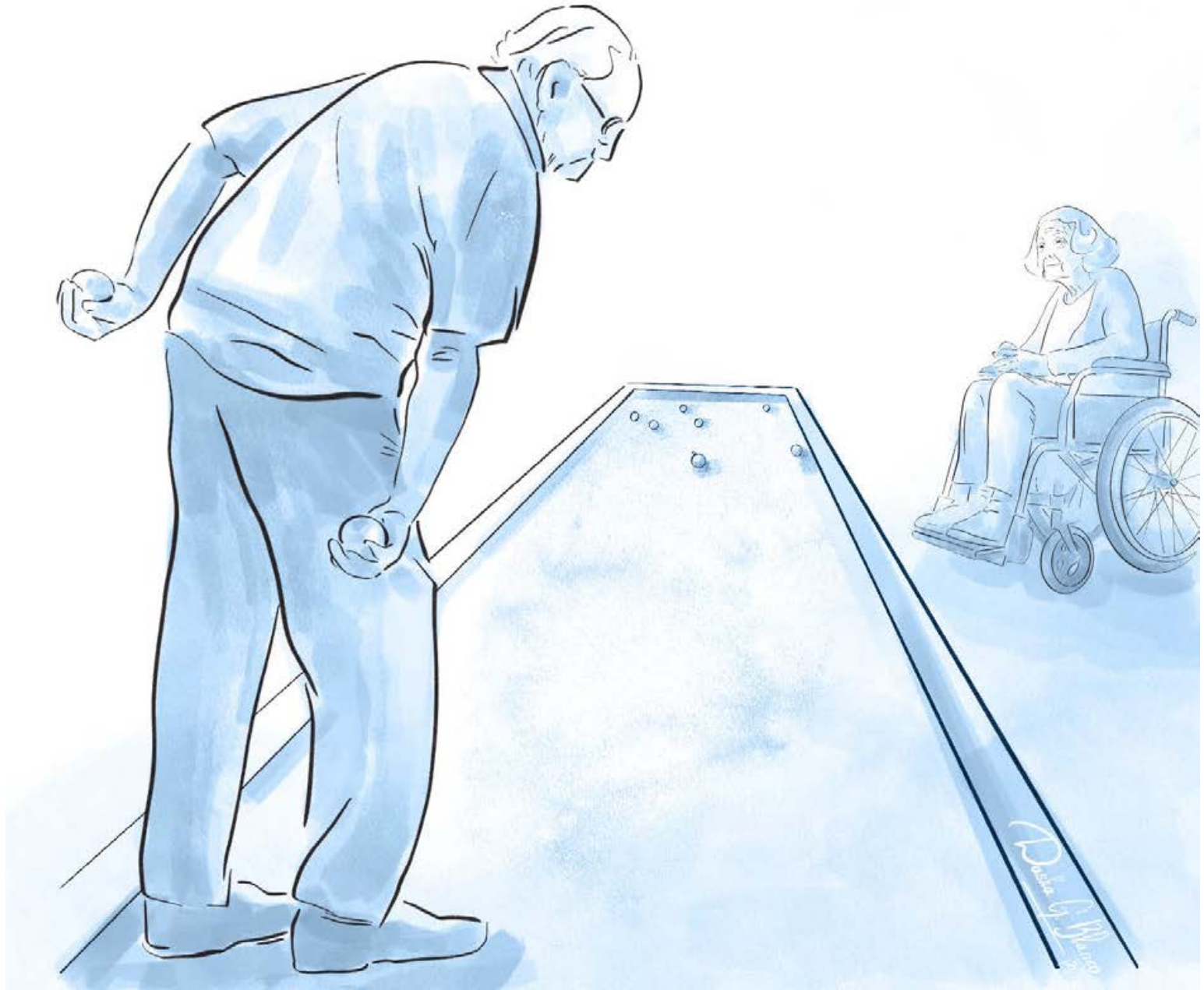
PACIENTE CON FOC
ANTIAGREGADO o ANTICOAGULADO

PROTOCOLOS
DE RECUPERACION FUNCIONAL Y
MEJORA DE RESULTADOS EN MORBIMORTALIDAD

Dra. Concha Cassinello

SaludMadrid Hospital Universitario Infanta Sofía



ANCIANO FRÁGIL

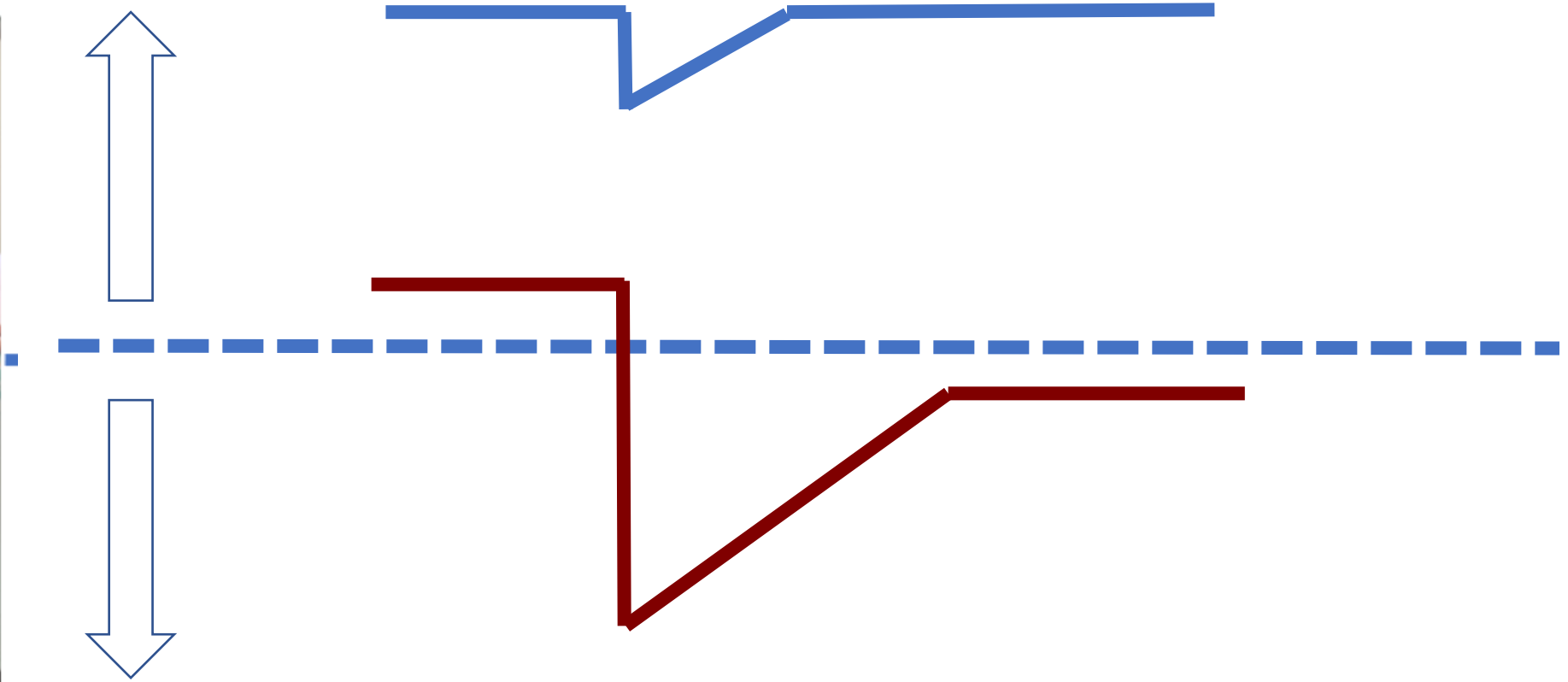
PEOR PRONÓSTICO

ESCALA DE RIESGO

Alta comorbilidad

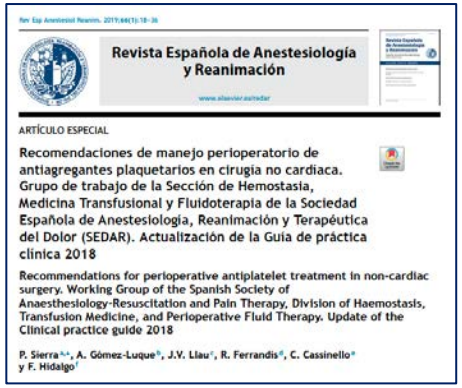
FRAGILIDAD

INDEPENDIENTE



DEPENDIENTE

Clegg et al., Lancet 2013

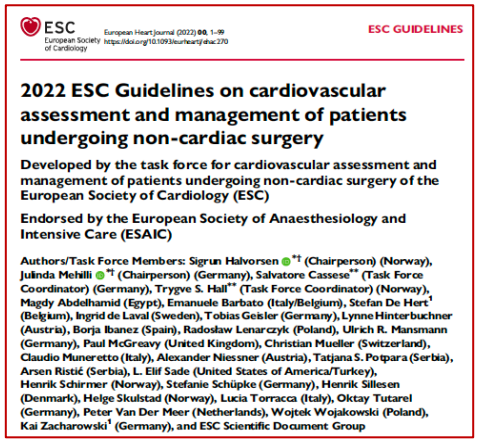

Revista Española de Anestesiología y Reanimación

ARTÍCULO ESPECIAL

Recomendaciones de manejo perioperatorio de antiagregantes plaquetarios en cirugía no cardiaca. Grupo de trabajo de la Sección de Hemostasia, Medicina Transfusional y Fluidoterapia de la Sociedad Española de Anestesiología, Reanimación y Terapéutica del Dolor (SEDAR). Actualización de la Guía de práctica clínica 2018

Recommendations for perioperative antiplatelet treatment in non-cardiac surgery. Working Group of the Spanish Society of Anaesthesiology-Resuscitation and Pain Therapy, Division of Haemostasis, Transfusion Medicine, and Perioperative Fluid Therapy. Update of the Clinical practice guide 2018

P. Sierra, A. Gómez-Luque, J.V. Llau, R. Ferrandis, C. Cassinello y F. Hidalgo


ESC European Society of Cardiology

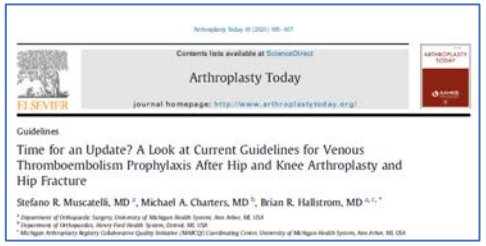
ESC GUIDELINES

2022 ESC Guidelines on cardiovascular assessment and management of patients undergoing non-cardiac surgery

Developed by the task force for cardiovascular assessment and management of patients undergoing non-cardiac surgery of the European Society of Cardiology (ESC)

Endorsed by the European Society of Anaesthesiology and Intensive Care (ESAIC)

Authors/Task Force Members: Sigrun Halvorsen (Chairperson) (Norway), Julinda Mehilli (Chairperson) (Germany), Salvatore Cassese (Task Force Coordinator) (Germany), Trygve S. Hall (Task Force Coordinator) (Norway), Magdy Abdelhamid (Egypt), Emanuele Barbato (Italy/Belgium), Stefan De Hert (Belgium), Ingrid de Laval (Sweden), Tobias Geisler (Germany), Lynne Hinterbuchner (Austria), Borja Ibanez (Spain), Radosław Lenarczyk (Poland), Ulrich R. Mansmann (Germany), Paul McGreavy (United Kingdom), Christian Mueller (Switzerland), Claudio Muneretto (Italy), Alexander Niessner (Austria), Tatjana S. Potpara (Serbia), Arsen Ristić (Serbia), L. Elif Sade (United States of America/Turkey), Henrik Schirmer (Norway), Stefanie Schüpke (Germany), Henrik Sillesen (Denmark), Helge Skulstad (Norway), Lucia Torracca (Italy), Oktay Tutarel (Germany), Peter Van Der Meer (Netherlands), Wojtek Wojakowski (Poland), Kai Zacharowski (Germany), and ESC Scientific Document Group


Arthroplasty Today

Guidelines

Time for an Update? A Look at Current Guidelines for Venous Thromboembolism Prophylaxis After Hip and Knee Arthroplasty and Hip Fracture

Stefano R. Muscatelli, MD, Michael A. Charters, MD, Brian R. Hallstrom, MD

QxAApp

Identificación estudios en PUBMED

IDENTIFICACIÓN

N = 396

REVISIÓN

Texto completo
N = 302

INCLUIDOS

N = 85: AVK: 26;
ACOD: 35; AAP: 57


EJA

Eur J Anaesthesiol 2022; 39:100–132

PODCAST

GUIDELINES

Regional anaesthesia in patients on antithrombotic drugs

Joint ESAIC/ESRA guidelines

Sibylle Kietaibl, Raquel Ferrandis, Anne Godier, Juan Llau, Clara Lobo, Alan JR Macfarlane, Christoph J. Schlimp, Erik Vandermeulen, Thomas Volk, Christian von Heymann, Morné Wolmarans and Arash Afshari


Perioperative Management of Antithrombotic Therapy

An American College of Chest Physicians Clinical Practice Guideline

Check for updates

James D. Douketis, MD, FCCP; Alex C. Spyropoulos, MD, FCCP; M. Hassan Murad, MD, MPH; Juan I. Arcelus, MD; William E. Dager, PharmD; Andrew S. Dunn, MD, MPH; Ramiz A. Fargo, MD, FCCP; Jerrold H. Levy, MD; C. Marc Samama, MD; Sahrish H. Shah, MBBS; Matthew W. Sherwood, MD; Alfonso J. Tafur, MD; Liang V. Tang, MD; and Lisa K. Moores, MD, FCCP

CHEST 2022; 162(5):e207-e243


SECOT

Revista Española de Cirugía Ortopédica y Traumatología

REVIEW ARTICLE

[Translated article] International Consensus Meeting on Venous Thromboembolism (ICM-VTE) after orthopedic procedures, any change in our clinical practice?

O. Marín-Peña, J. Parvizi, C. Restrepo, A. Castel-Oñate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Recommendations from the ICM-VTE: Trauma

The ICM-VTE Trauma Delegates*

Consenso Internacional sobre Tromboembolismo Venoso (ICM-VTE) en COT, ¿cambiará en algo nuestra práctica clínica?

D emora

A nalgesia-Anestesia

T romboprofilaxis

A nemia

F ísico y cognitivo (ejercicio)

O steomalacia

N utrición

O steoporosis

En independientes antes de la FOC
La Independencia puede ↑ desde el 50% al 82%

G Model
REGG-1299; No. of Pages7
ARTICLE IN PRESS
Revista Española de Geriatría y Gerontología xxx (xxxx) xxx–xxx
Revista Española de Geriatría y Gerontología
www.elsevier.es/regg

ORIGINAL ARTICLE

Profile and 3-month evolution of geriatric patients after a hip fracture followed-up at a Fracture Liaison Service (FLS)

Debora Moral-Cuesta[a,b,*], Alicia Gutiérrez-Misis[c,d], Bernardo Abel Cedeño Veloz[a,b,e],

20%

50%

7%

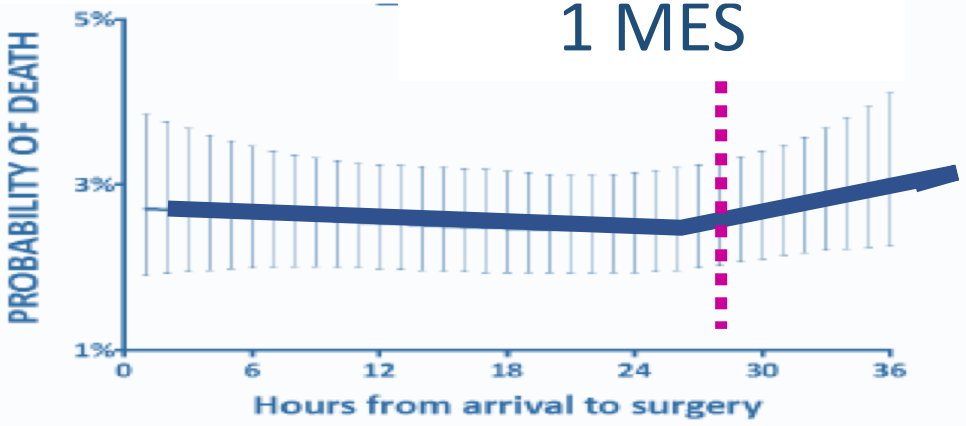
23%

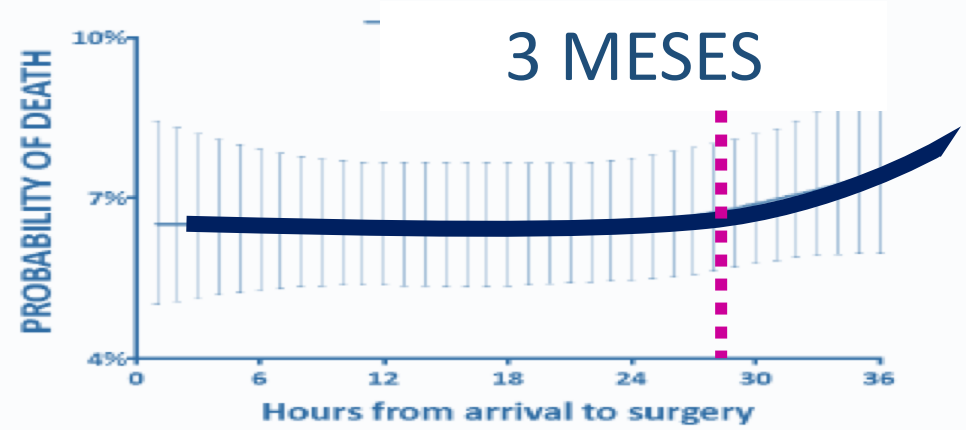
ELSEVIER
Perioperative Care and Operating Room Management
Volume 10, March 2018, Pages 1-9

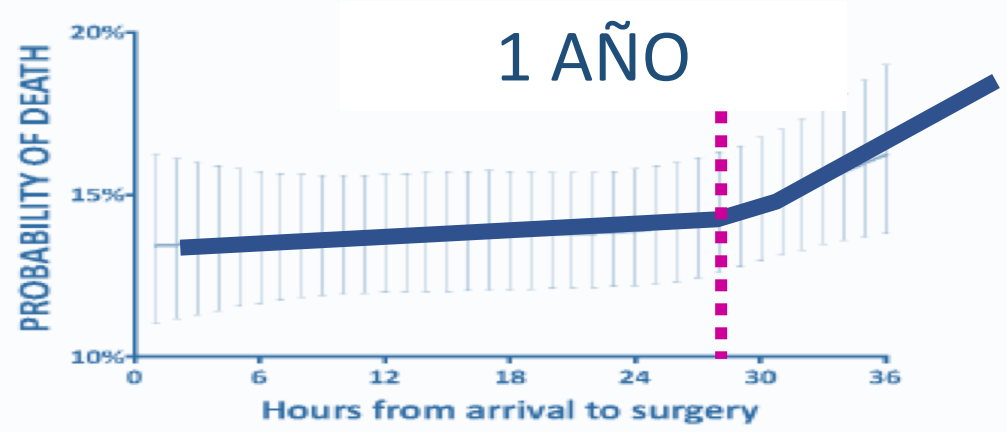
Recommendations for preoperative management of frailty from the Society for Perioperative Assessment and Quality Improvement (SPAQI)

DEMORA ÓPTIMA

AVK / ACOD / AAP





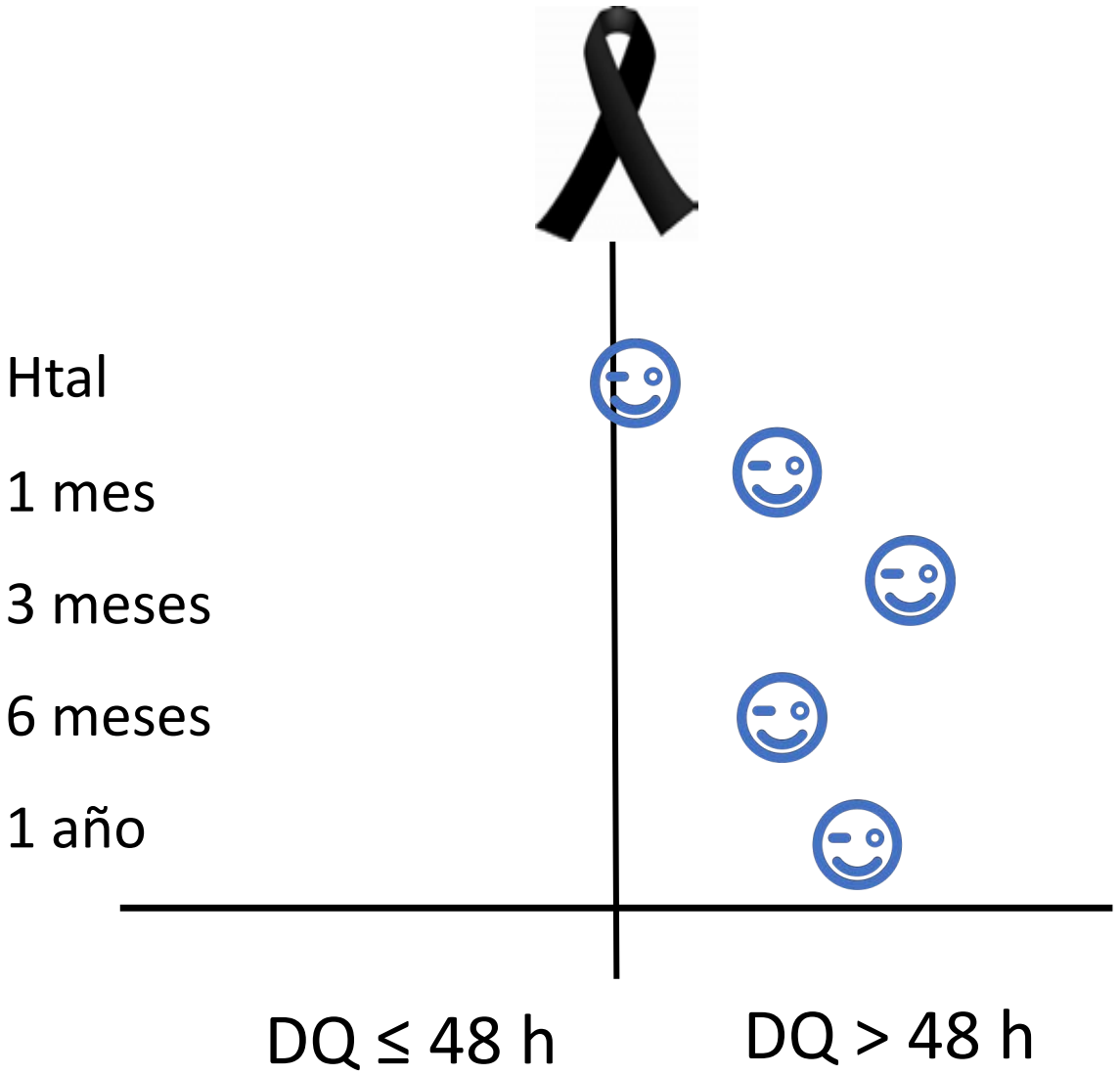


N = 24.000
AAP O ACO

Pincus D, et al. Association Between Wait Time and 30-Day Mortality in Adults Undergoing Hip Fracture Surgery. *JAMA*. 2017;318(20):1994-2003.

Neumonía +TVP + TEP + Muerte	OR ➢ 24 h/ ≤ 24 h
1 m	2,08
3 m	2,2
1 año	2,67

2.330 FOC con AVK, ACOD o AAP



Lu W, Safety of Early Surgery in Hip Fracture Patients Taking Clopidogrel and/or Aspirin: A Systematic Review and Meta-Analysis. J Arthroplasty. 2023 Nov 14:S0883-5403(23)01135-X.

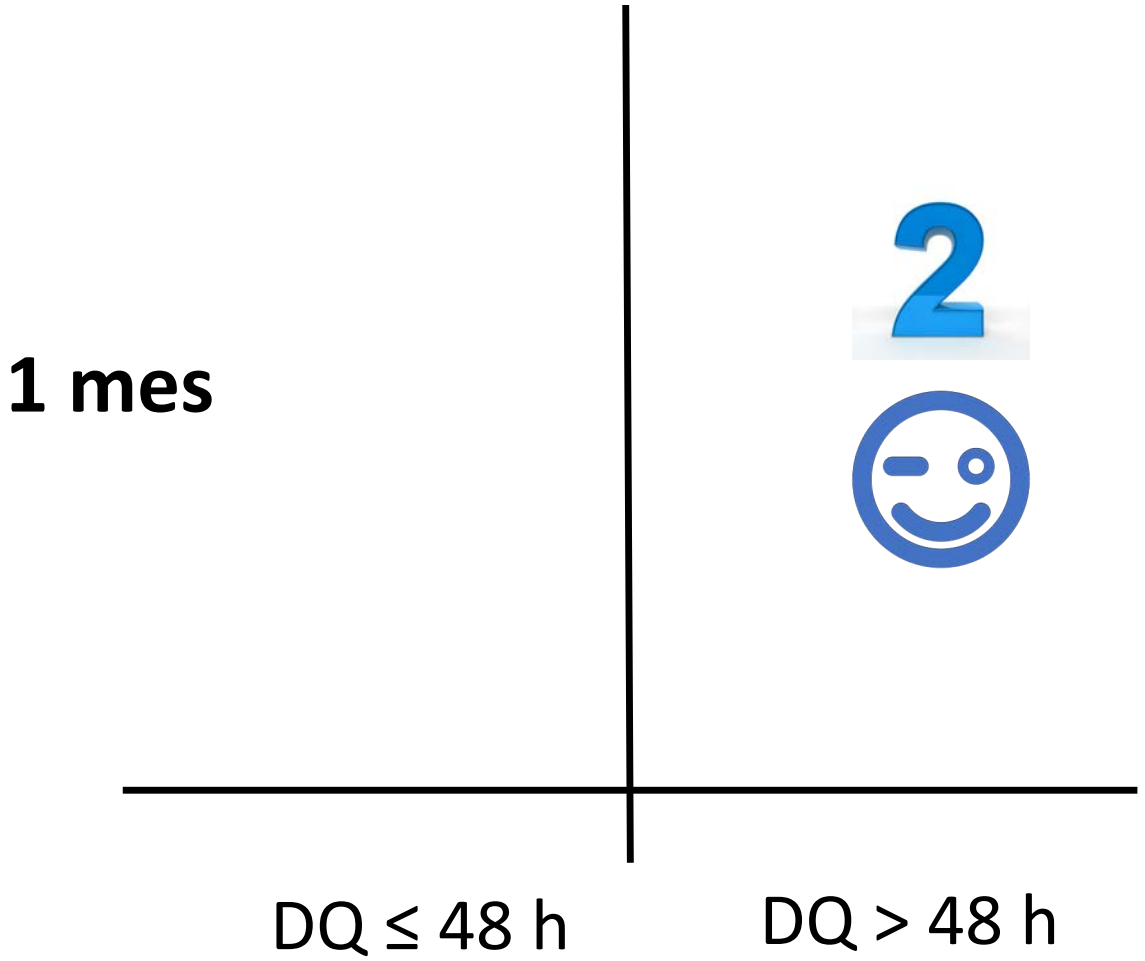
Yang Z, Is hip fracture surgery safe for patients on antiplatelet drugs and is it necessary to delay surgery? A systematic review and meta-analysis. J Orthop Surg Res. 2020 Mar 12;15(1):105.

Mas-Atance J, Randomised comparative study of early versus delayed surgery in hip-fracture patients on concomitant treatment with antiplatelet drugs. Determination of platelet aggregation, perioperative bleeding and a review of annual mortality]. Rev Esp Cir Ortop Traumatol. 2013 Jul-Aug;57(4):240-53.

Anaya R, Early Surgery with Neuraxial Anaesthesia in Patients on Chronic Antiplatelet Therapy with a Proximal Femur Fracture: Multicentric Randomised Clinical Trial. J Clin Med. 2021 Nov 18;10(22):5371.

9.000 FOC con AVK, ACOD o AAP

∑-COMPLICACIONES



Lu W, Safety of Early Surgery in Hip Fracture Patients Taking Clopidogrel and/or Aspirin: A Systematic Review and Meta-Analysis. J Arthroplasty. 2023 Nov 14:S0883-5403(23)01135-X.

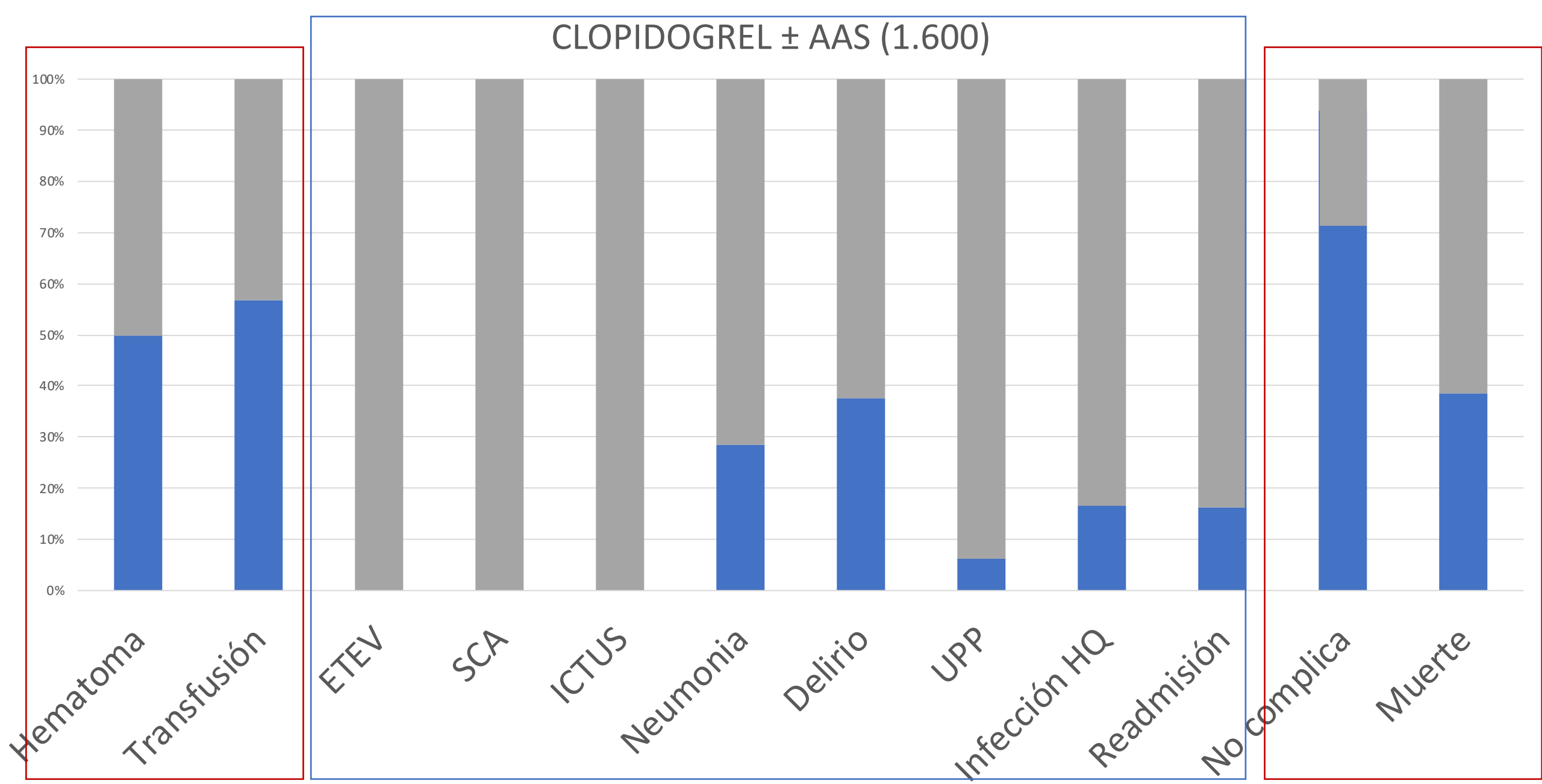
Yang Z, Is hip fracture surgery safe for patients on antiplatelet drugs and is it necessary to delay surgery? A systematic review and meta-analysis. J Orthop Surg Res. 2020 Mar 12;15(1):105.

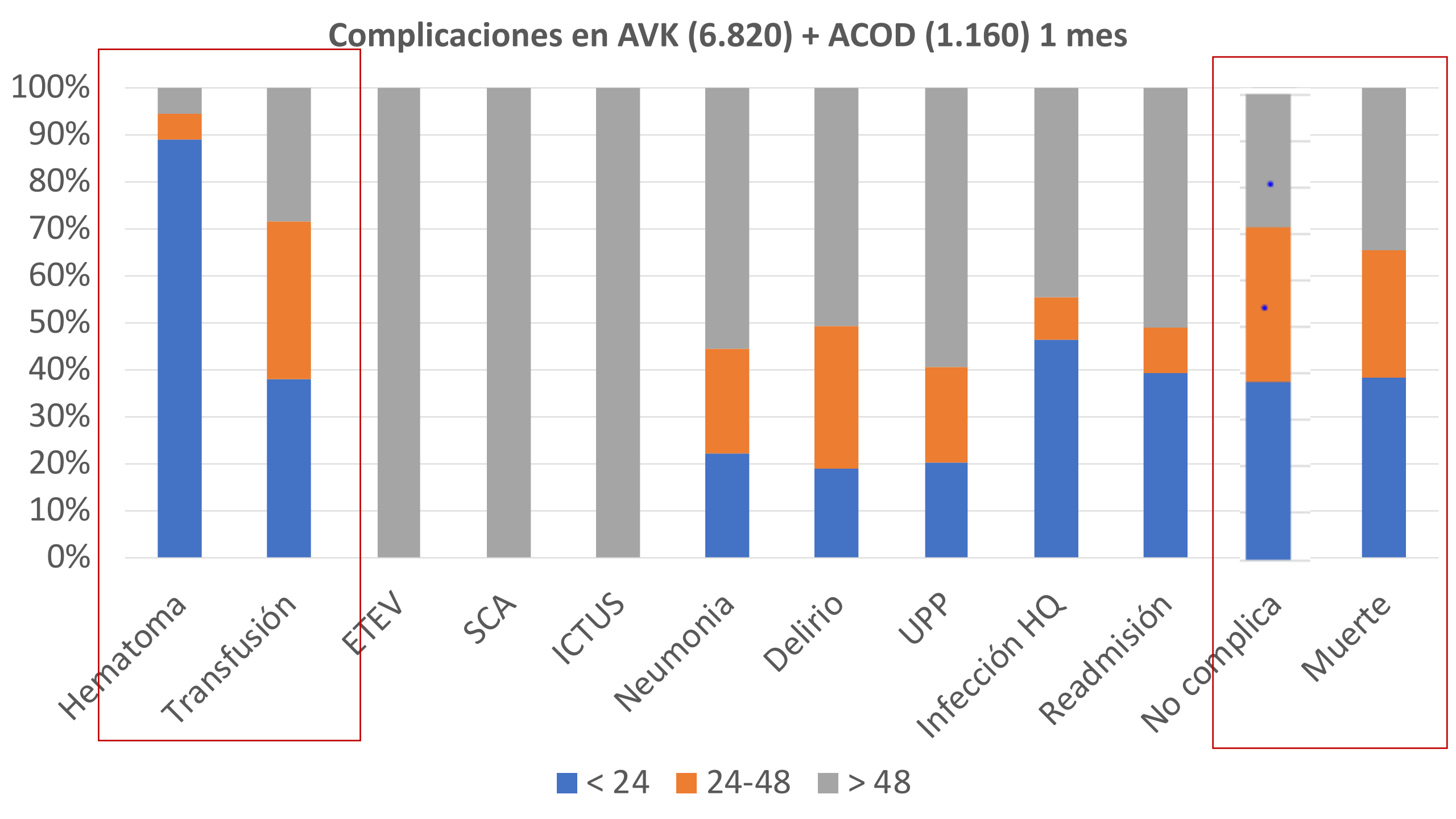
Elete AR, Assessing operative delay and complications in hip fracture patients on anticoagulants and antiplatelets. SAGE Open Med. 2023 Mar 23; 11: 20503121231162410.

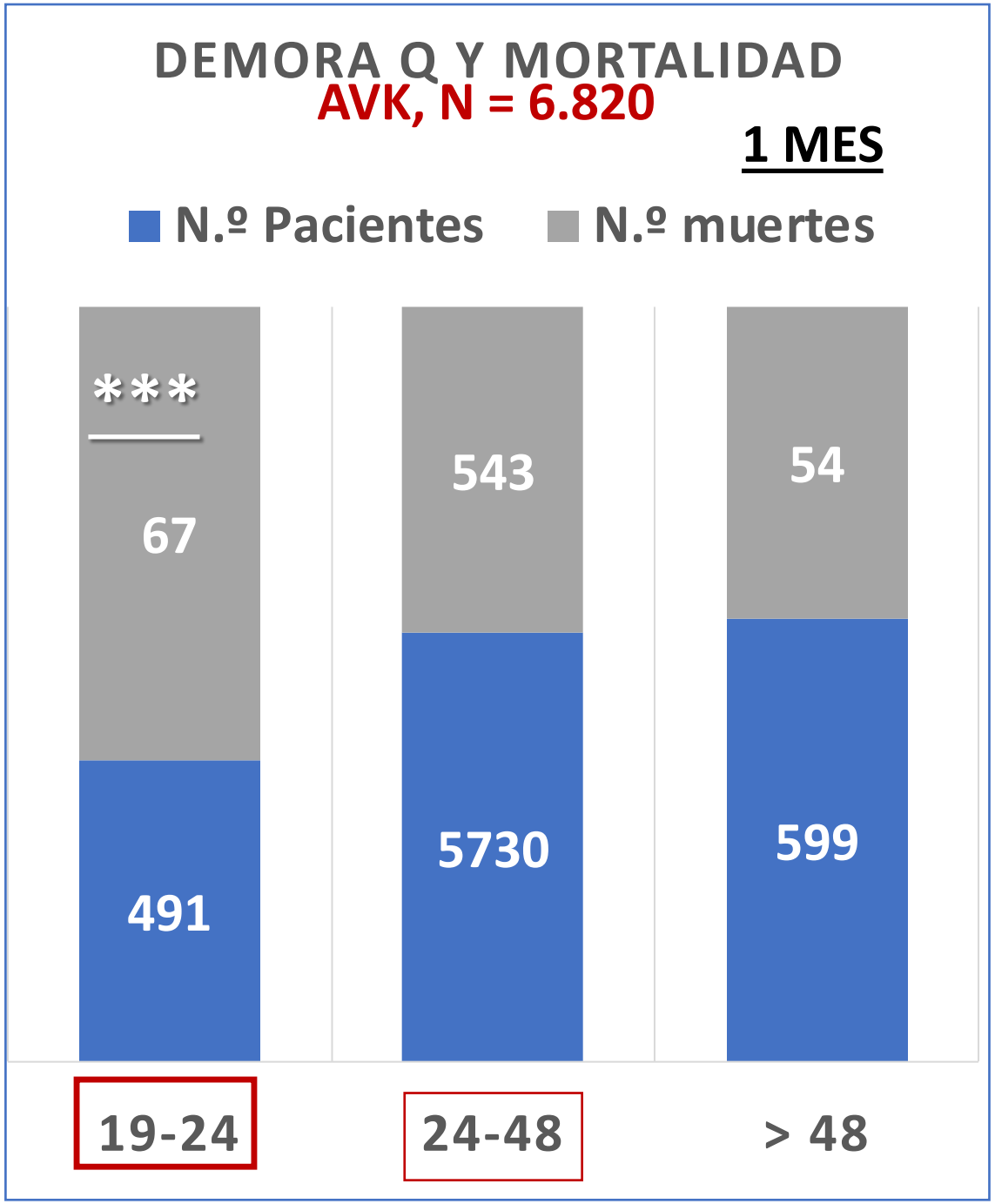
Tarrant SM, Direct Oral Anticoagulants and Timing of Hip Fracture Surgery. J Clin Med. 2020 Jul 12;9(7):2200. doi: 10.3390/jcm9072200

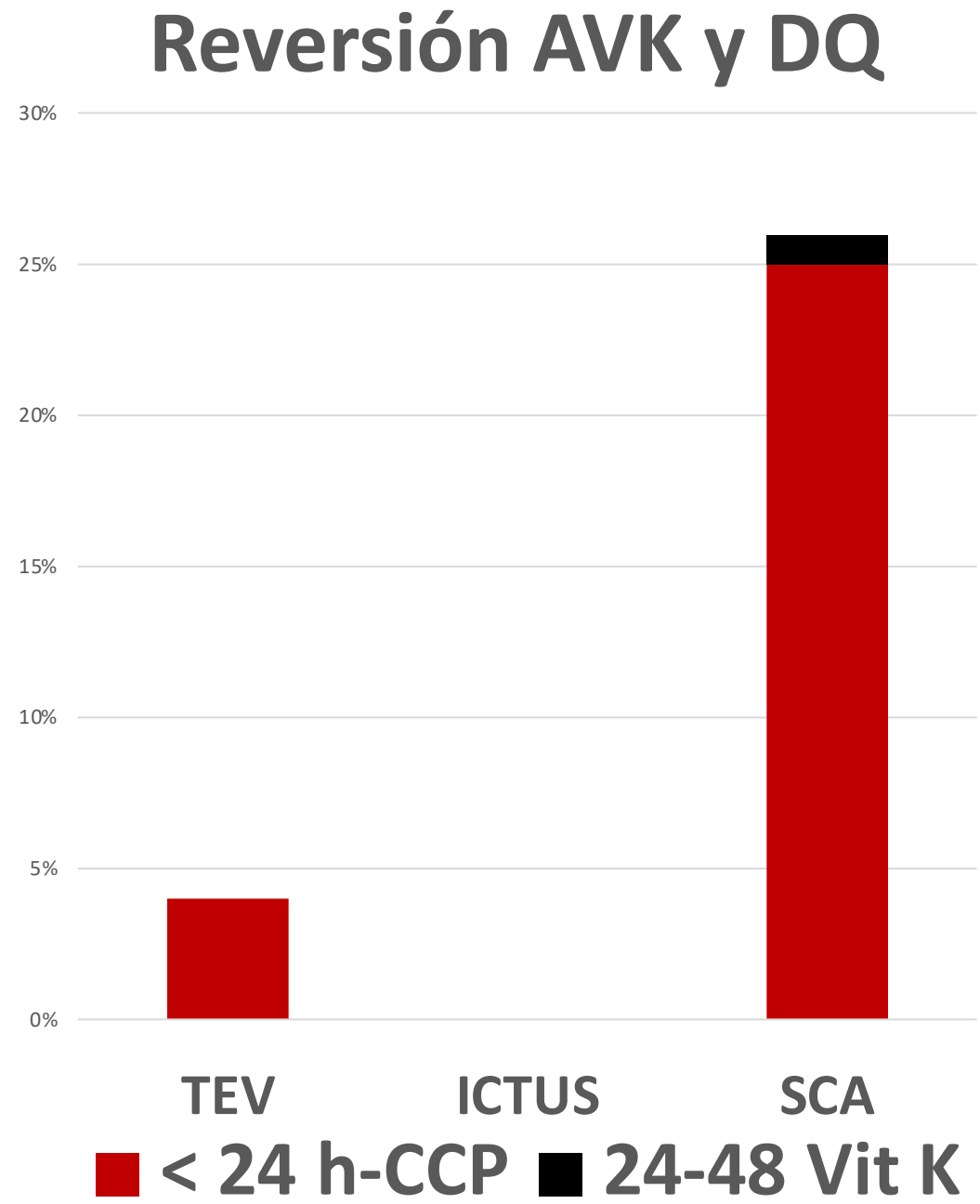
Tarrant SM, Dual Antiplatelet Therapy and Surgical Timing in Geriatric Hip Fracture. J Orthop Trauma. 2020 Oct;34(10):559-565.

Anaya R, Early Surgery with Neuraxial Anaesthesia in Patients on Chronic Antiplatelet Therapy with a Proximal Femur Fracture: Multicentric Randomised Clinical Trial. J Clin Med. 2021 Nov 18;10(22):5371.


CLOPIDOGREL ± AAS (1.600)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Hematoma
Transfusión
ETEV
SCA
ICTUS
Neumonia
Delirio
UPP
Infección HQ
Readmisión
No complica
Muerte
24-48
> 48


Complicaciones en AVK (6.820) + ACOD (1.160) 1 mes
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Hematoma
Transfusión
ETEV
SCA
ICTUS
Neumonia
Delirio
UPP
Infección HQ
Readmisión
No complica
Muerte
< 24
24-48
> 48


DEMORA Q Y MORTALIDAD
AVK, N = 6.820
1 MES
N.º Pacientes
N.º muertes
***
67
491
543
5730
54
599
19-24
24-48
> 48


Reversión AVK y DQ
30%
25%
20%
15%
10%
5%
0%
TEV
ICTUS
SCA
< 24 h-CCP
24-48 Vit K

Complicaciones y mortalidad en FOC

↓ ½ con demora de 24-48 h

- HEMORRAGIA/ TROMBOSIS
- **INSUF. RENAL**
- NEUMONÍA/SEPSIS
- INSUF. CARDIACA
- **DELIRIO**
- **DOLOR**

En las **24-48 h tras el ingreso**

≤ **48 h** → RNFC

Idealmente en **24 h** y sin que pase de **48 h** → AAOS

Al día siguiente del ingreso y no después de **36 h** → UK

DEMORA QUIRÚRGICA

≤ 48 h

55%


SUECIA


FINLANDIA


UK


DINAMARCA


IRLANDA

> 90% en 48 h


NORUEGA


CANADÁ


ALEMANIA


EE. UU


PAÍSES BAJOS

Werner M et al. Differences in hip fracture care in Europe: a systematic review of recent annual reports of hip fracture registries. Eur J Trauma Emerg Surg. 2022 RNFC

96 %

SUECIA
6,6%

FINLANDIA
5,5%

UK 7%

IRLANDA

DINAMARCA

6% / 50% / 80%

NORUEGA
6,5%

CANADÁ
6,5%-7,5%

ALEMANIA
6%

PAÍSES BAJOS

EE. UU
7,7%

Werner M et al. Differences in hip fracture care in Europe: a systematic review of recent annual reports of hip fracture registries. Eur J Trauma Emerg Surg. 2022
RNFC

ANALGESIA Y ANESTESIA

BNP

AI vs AG

SYSTEMATIC REVIEW

Efficacy of Fascia Iliaca Compartment Blocks in Proximal Femoral Fractures in the Prehospital Setting: A Systematic Review and Meta-Analysis

Sabrina Slade, HBsc, MD;[1] Evan Hanna, CCP;[2] Josh Pohlkamp-Hartt, PhD;[3] David W. Savage, MD,

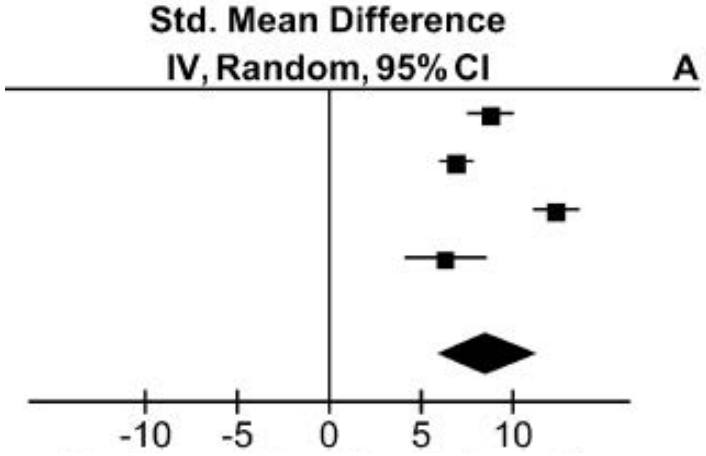
Cochrane Library

Cochrane Database of Systematic Reviews

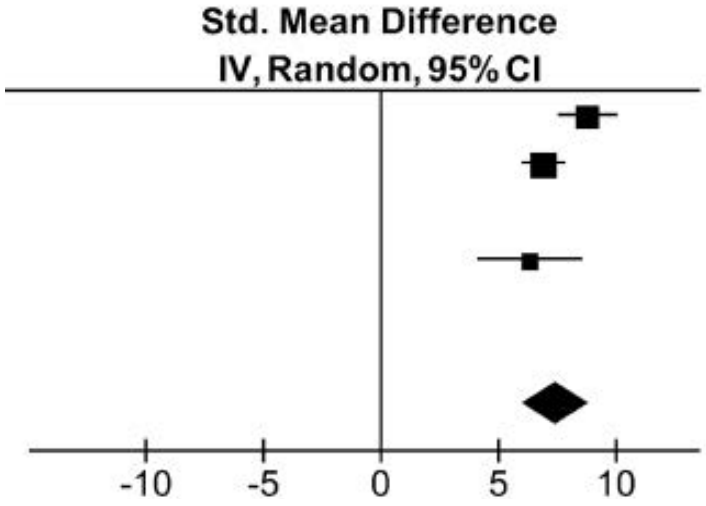
Peripheral nerve blocks for hip fractures in adults (Review)

Guay J, Kopp S

DOLOR PRE-OP EN MOVIMIENTO
A LOS 30 min DEL BNP vs A iv.

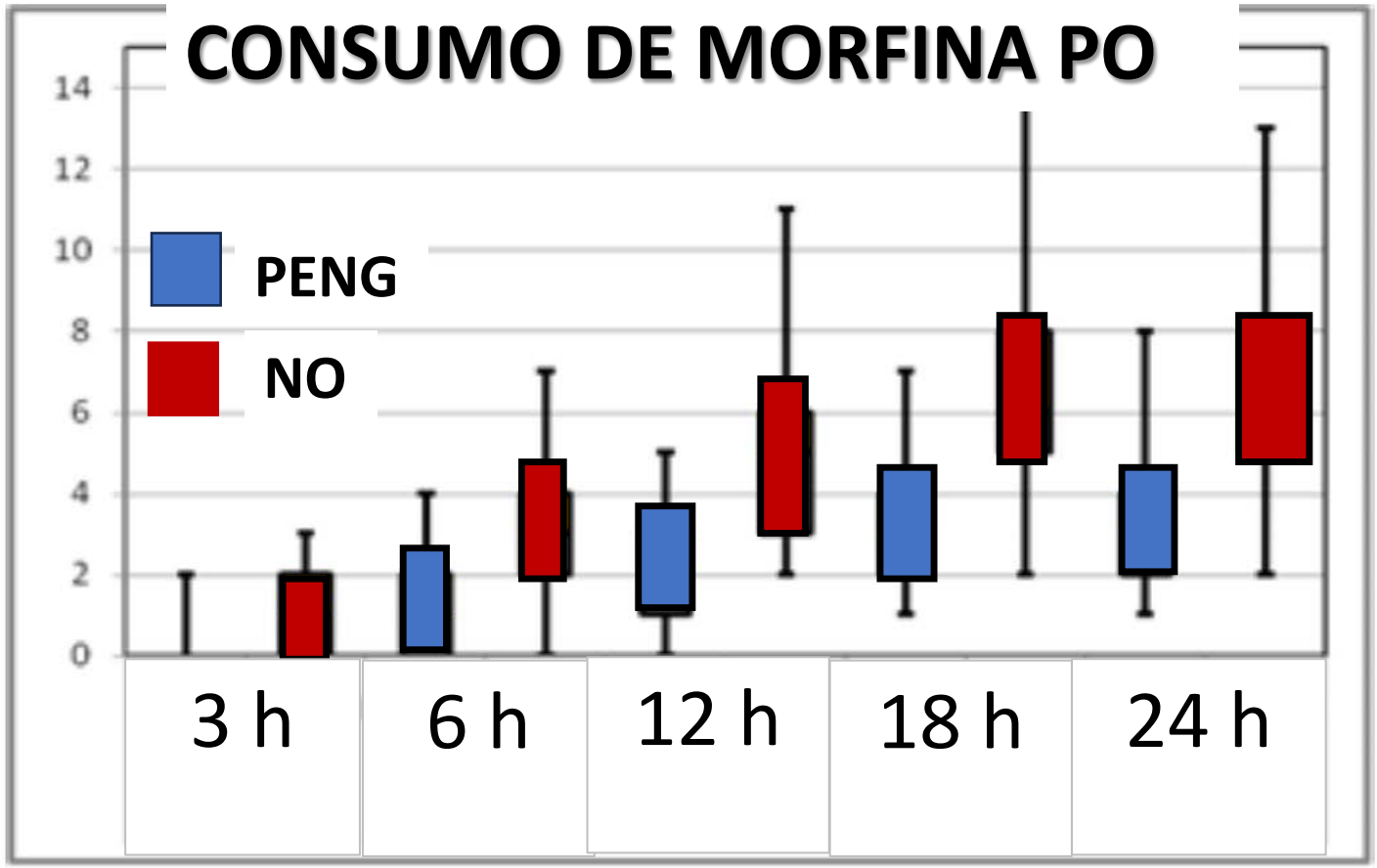


PRE-BNP POST-BNP

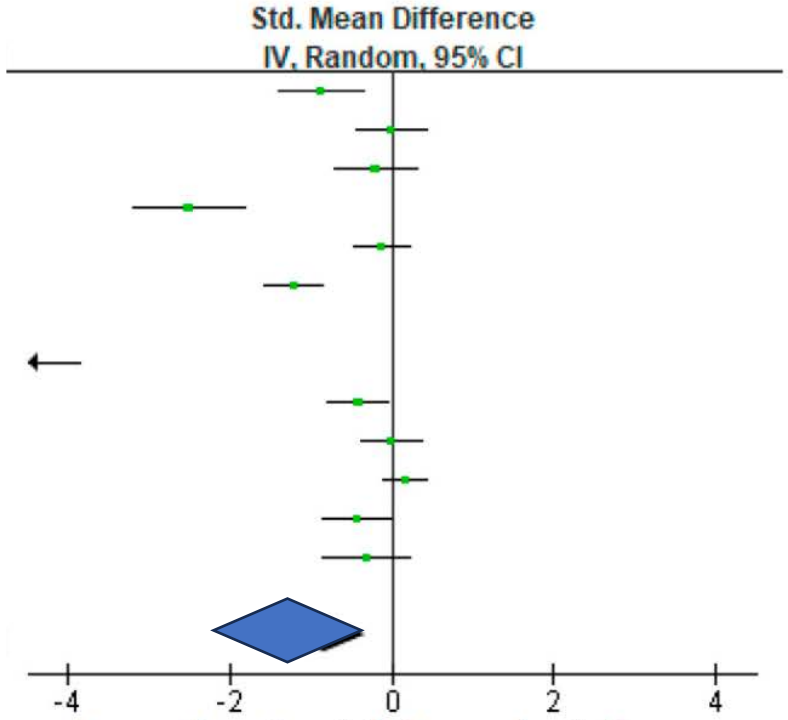


MEJOR ANALGESIA iv Mejor BNP

CONSUMO DE MORFINA PO



BNP Y DOLOR PO



Mejor BNP

Mejor A. iv

Aygun et al. BMC Anesthesiology (2023) 23:316
https://doi.org/10.1186/s12871-023-02245-3

BMC Anesthesiology

RESEARCH Open Access

Effect of ultrasound-guided pericapsular nerve group (PENG) block on pain during patient positioning for central nervous blockade in hip surgery: a randomized controlled trial

Hakan Aygun[1], Serkan Tulgar[2], Yavuz Yigit[3,4*], Ayşe Tasdemir[1], Cengizhan Kurt[5], Caner Genc[2], Sezgin Bilgin[6],

The Effect of Peripheral Nerve Block on Postoperative Delirium in Older Adults Undergoing Hip Surgery: A Systematic Review and Meta-Analysis of Randomized Controlled Trials

Su Yeon Kim, Ha Young Jo, Hyo-Seok Na, Sung-Hee Han, Sang-Hwan Do and Hyun-Jung Shin *

COMPLICACIONES Y FUNCIONALIDAD

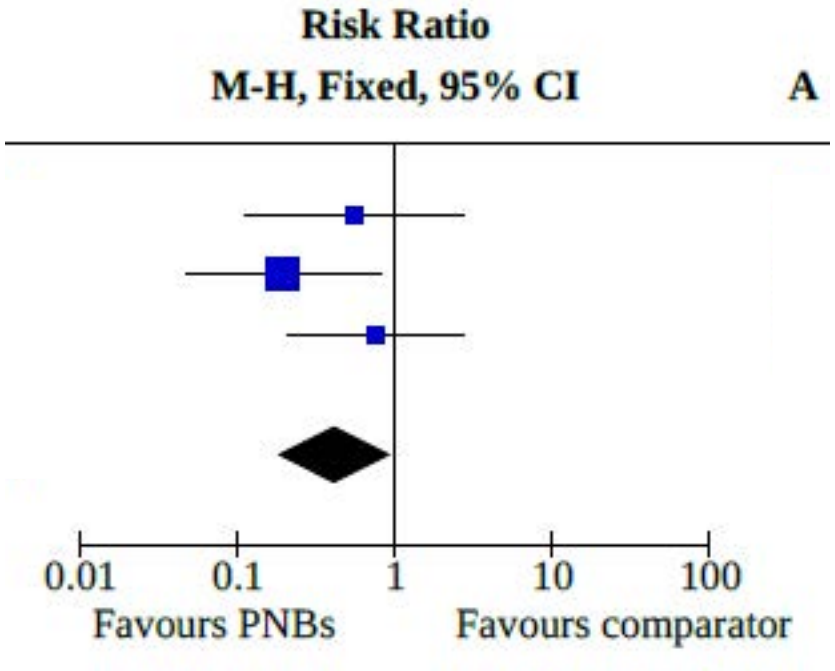
Cochrane Library

Cochrane Database of Systematic Reviews

Peripheral nerve blocks for hip fractures in adults (Review)

Guay J, Kopp S

NEUMONÍA*



TIEMPO A 1ª PASEO PO*

↓ 10,8 h (8,7 a 12,8)

CALIDAD DE RECUPERACIÓN EN 24 h*

QoR SCORE 15:

Mejor BNP 11,5 (10-15)

Aygun et al. BMC Anesthesiology (2023) 23:316
https://doi.org/10.1186/s12871-023-02245-3

BMC Anesthesiology

RESEARCH Open Access

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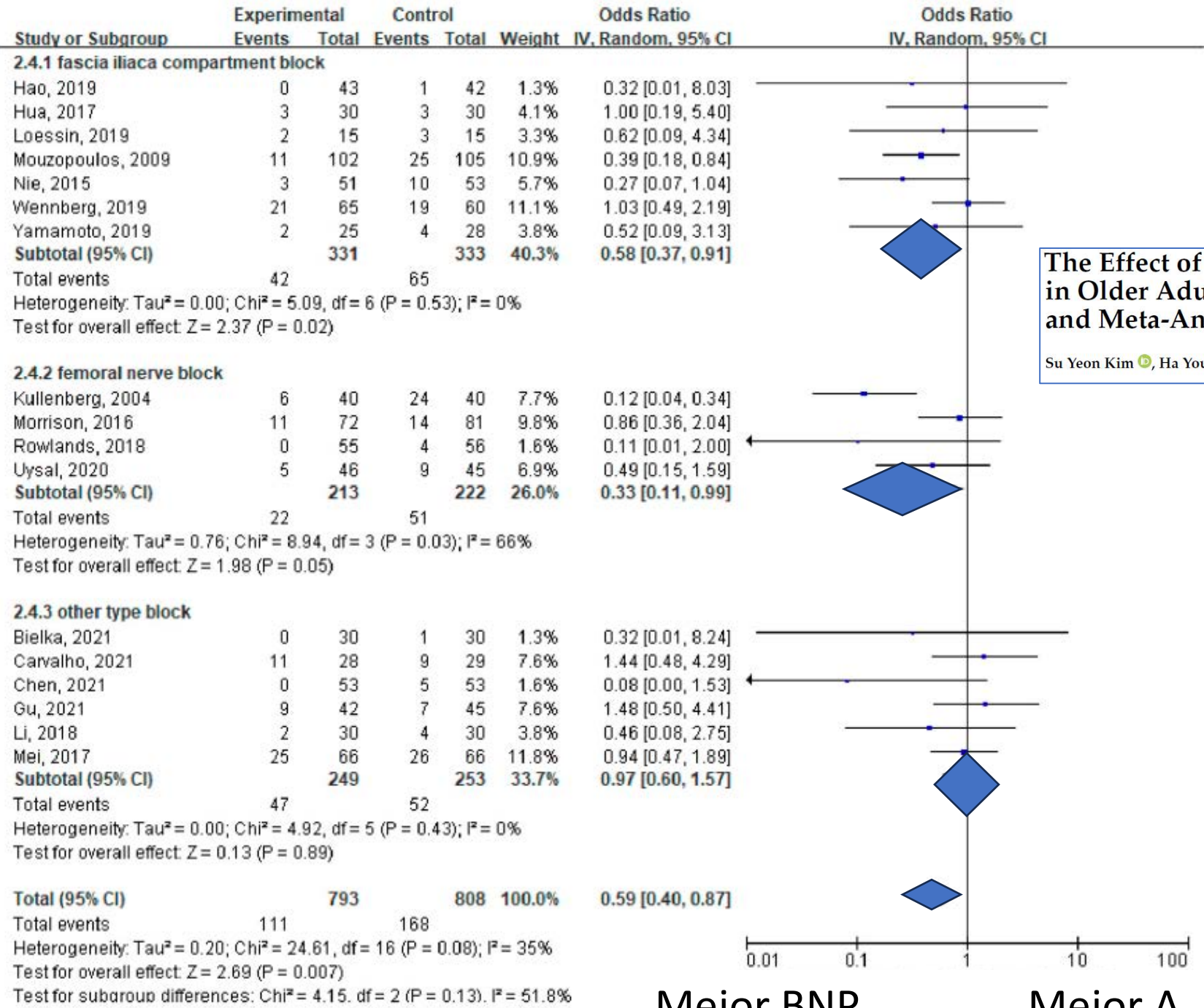
BNP Y DELIRIO



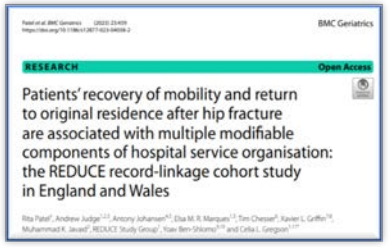
Mejor BNP

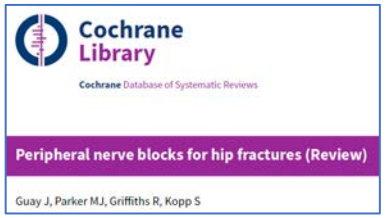
Mejor A. iv

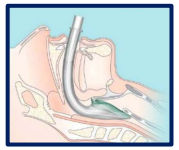
The Effect of Peripheral Nerve Block on Postoperative Delirium in Older Adults Undergoing Hip Surgery: A Systematic Review and Meta-Analysis of Randomized Controlled Trials

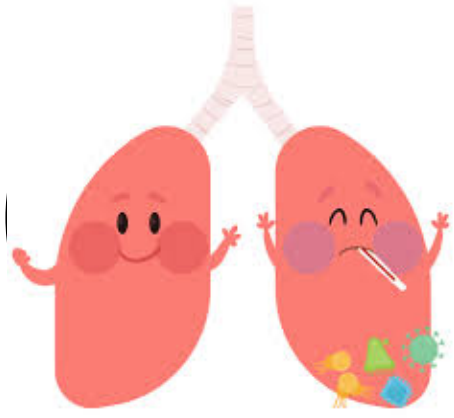
Su Yeon Kim, Ha Young Jo, Hyo-Seok Na, Sung-Hee Han, Sang-Hwan Do and Hyun-Jung Shin *

BNP









PRE

INTRA

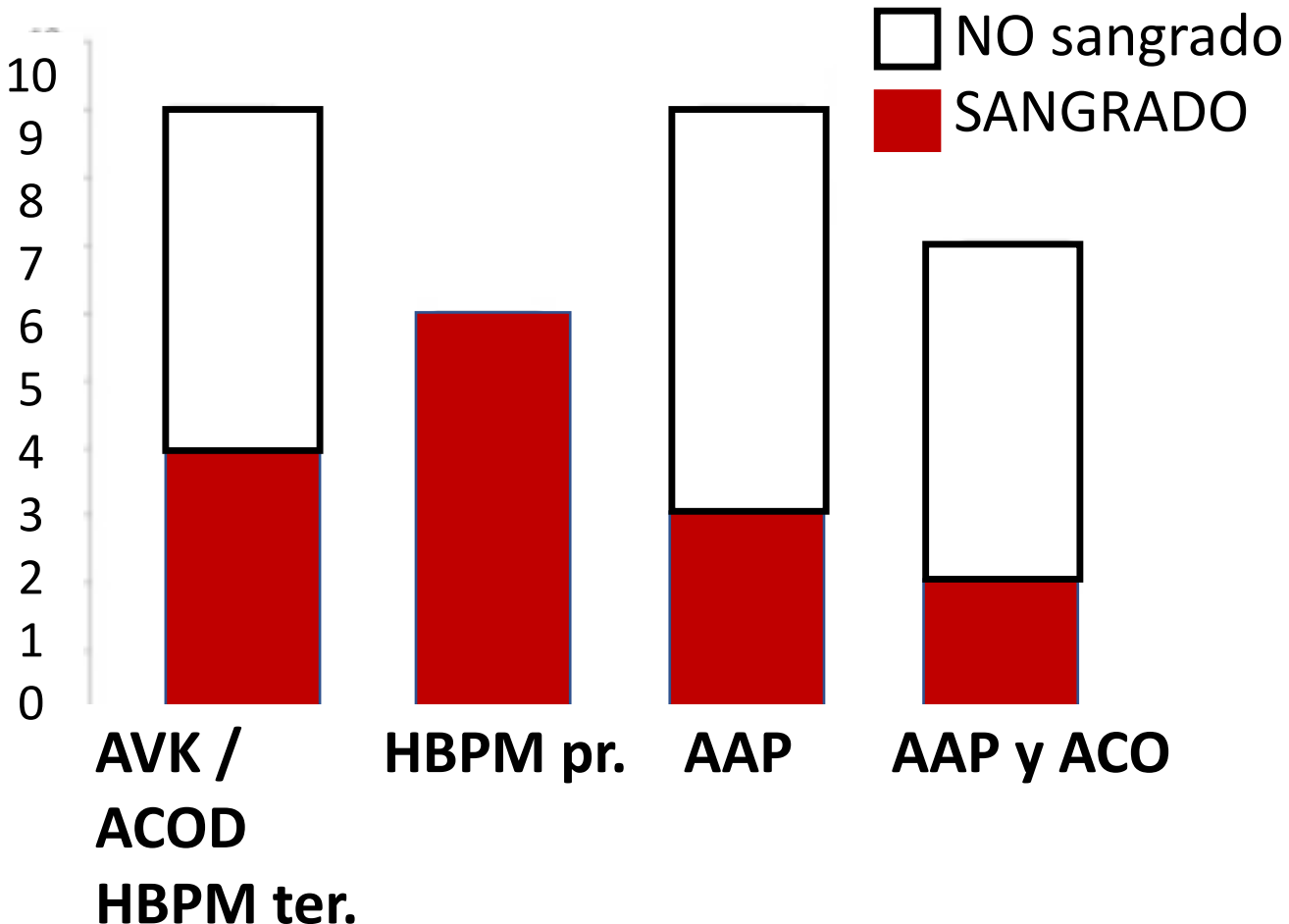
POST

Joubert F. Bleeding complications following peripheral regional anaesthesia in patients treated with anticoagulants or antiplatelet agents: A systematic review. Anaesth Crit Care Pain Med. 2019;38(5):507-516.

9.738 BNP 80 SANGRADOS

50 CASOS-15 SANGRADOS

1978-2018



~~Plexo lumbar posterior~~

c. hemorrágicas leves (1/100)

c. graves (4/10.000)

ESAIC: Se pueden realizar BNP superficiales con ATT

Los BNP superficiales no requieren interrumpir los ATT

Los BNP profundos requieren = interrupción que la A intradural

EJA

Eur J Anaesthesiol 2022; **39**:100–132

PODCAST

GUIDELINES

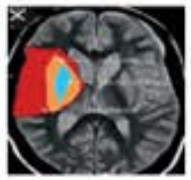
Regional anaesthesia in patients on antithrombotic drugs

Joint ESAIC/ESRA guidelines

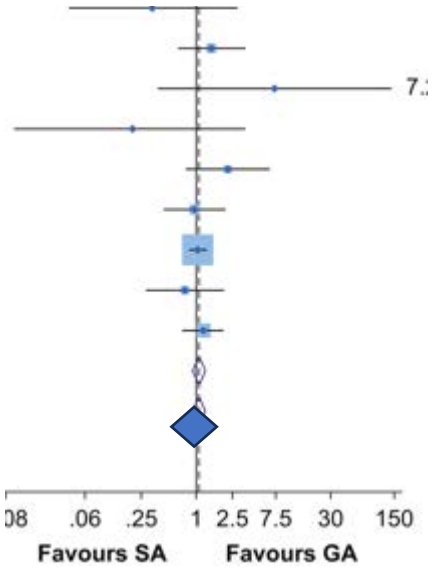
Sibylle Kietaibl, Raquel Ferrandis, Anne Godier, Juan Llau, Clara Lobo, Alan JR Macfarlane,

Joubert F. Bleeding complications following peripheral regional anaesthesia in patients treated with anticoagulants or antiplatelet agents: A systematic review. Anaesth Crit Care Pain Med. 2019;38(5):507-516.

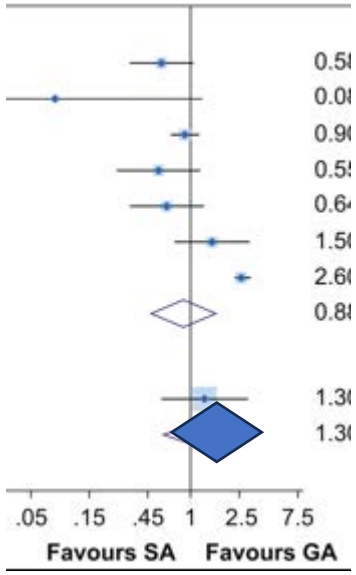
BNP Superficiales	BNP Profundos
Fascia Ilíaca	PENG
3 en 1	Plexo lumbar
Femorocutáneo	Paravertebral lumbar
Erector de la espina	Cuadrado lumbar
Obturador superf.	Sacro



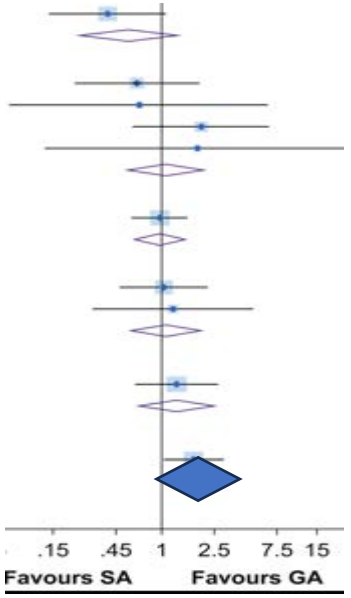
DELIRIUM



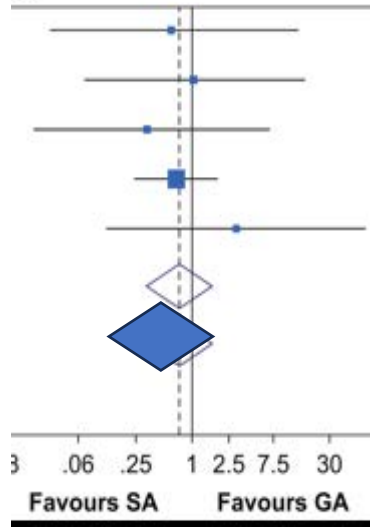
HIPOTENSIÓN

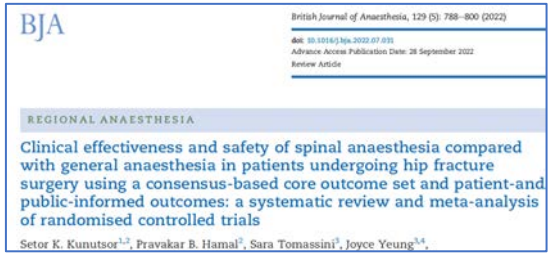


MORTALIDAD



SCA





BJA

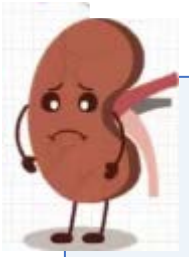
British Journal of Anaesthesia, 129 (5): 788–800 (2022)

doi: 10.1016/j.bja.2022.07.031
Advance Access Publication Date: 28 September 2022
Review Article

REGIONAL ANAESTHESIA

Clinical effectiveness and safety of spinal anaesthesia compared with general anaesthesia in patients undergoing hip fracture surgery using a consensus-based core outcome set and patient-and public-informed outcomes: a systematic review and meta-analysis of randomised controlled trials

Setor K. Kunutsor[1,2], Pravakar B. Hamal[2], Sara Tomassini[3], Joyce Yeung[3,4],



INSUF. RENAL AGUDA: 4 ECR

OR: 0.58; IC 95%: 0.39–0.88; < 0.01

Review

INTERNATIONAL JOURNAL OF SURGERY

OPEN

Comparison of risk of complication between neuraxial anaesthesia and general anaesthesia for hip fracture surgery: a systematic review and meta-analysis

Xi Chen, MD[a], Hairui Li, MD[b], Songlin Li, MD[c], Yiou Wang, MD[c], Ruichen Ma, MD[d], Wenwei Qian, MD[c,*],

Journal of
Clinical Medicine

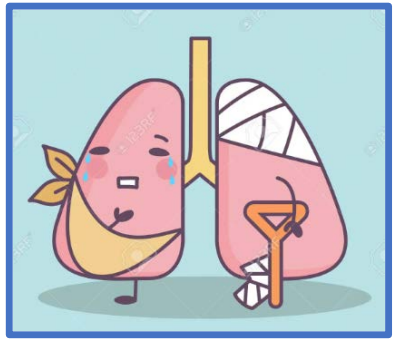
MDPI

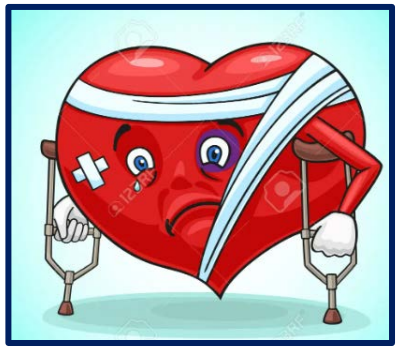
Article

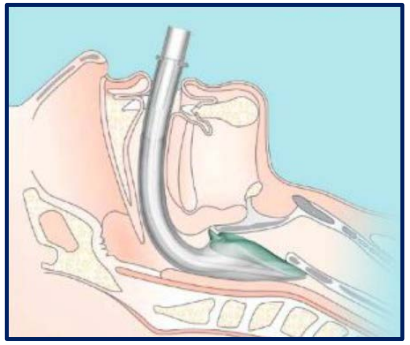
Effect of General vs. Regional Anesthesia on Mortality, Complications, and Prognosis in Older Adults Undergoing Hip Fracture Surgery: A Propensity-Score-Matched Cohort Analysis

Guolei Zhang [1,2,†], Huihui Chen [3,†], Junpu Zha [1,2], Jingtao Zhang [1,2], Jun Di [1,2], Xiaoqing Wang [1], Xin Hu [1,2], Xin Xu [4,5,6,*] and Junfei Guo [1,2,*]

COMPLICACIONES FOC	AG N = 808	AI N = 808	P
CARDIACAS	**<u>18%</u>**	23%	0,01
RESPIRATORIAS	12%	**<u>8,4%</u>**	0,02







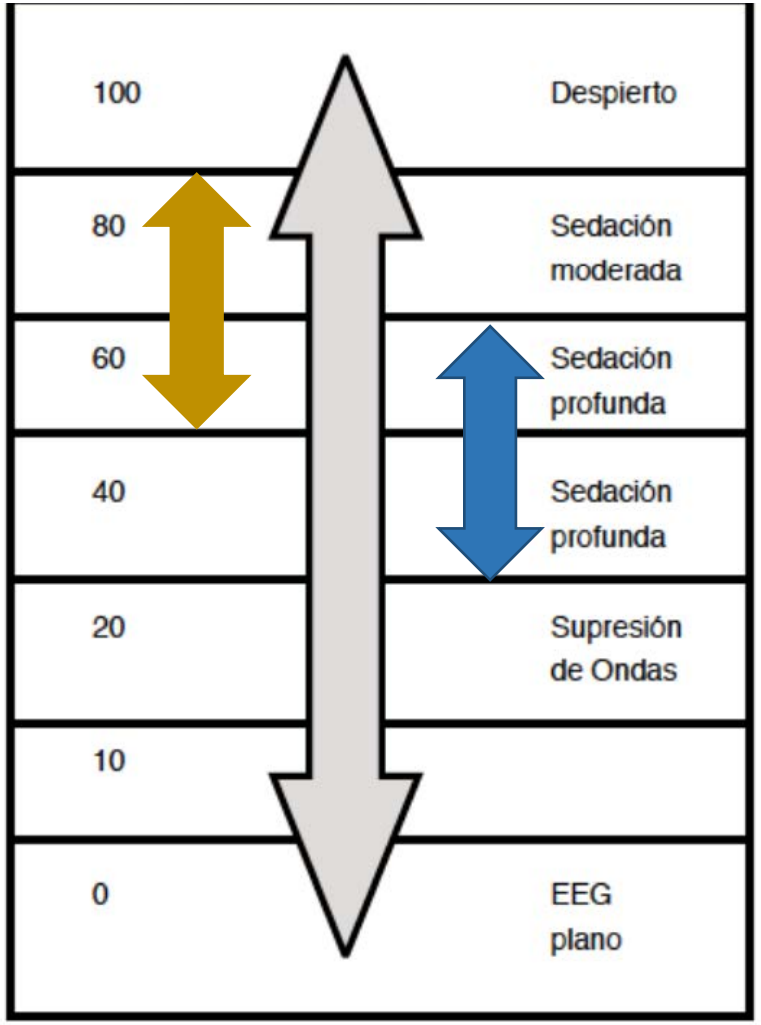
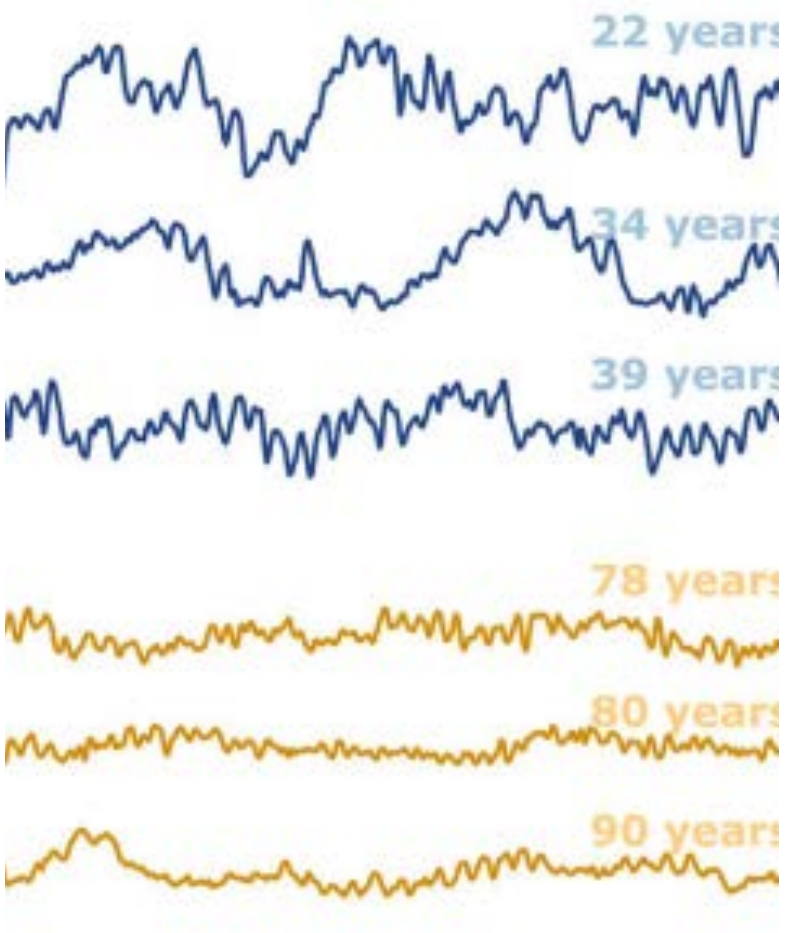


Figura 1. *Rangos del índice BIS.*



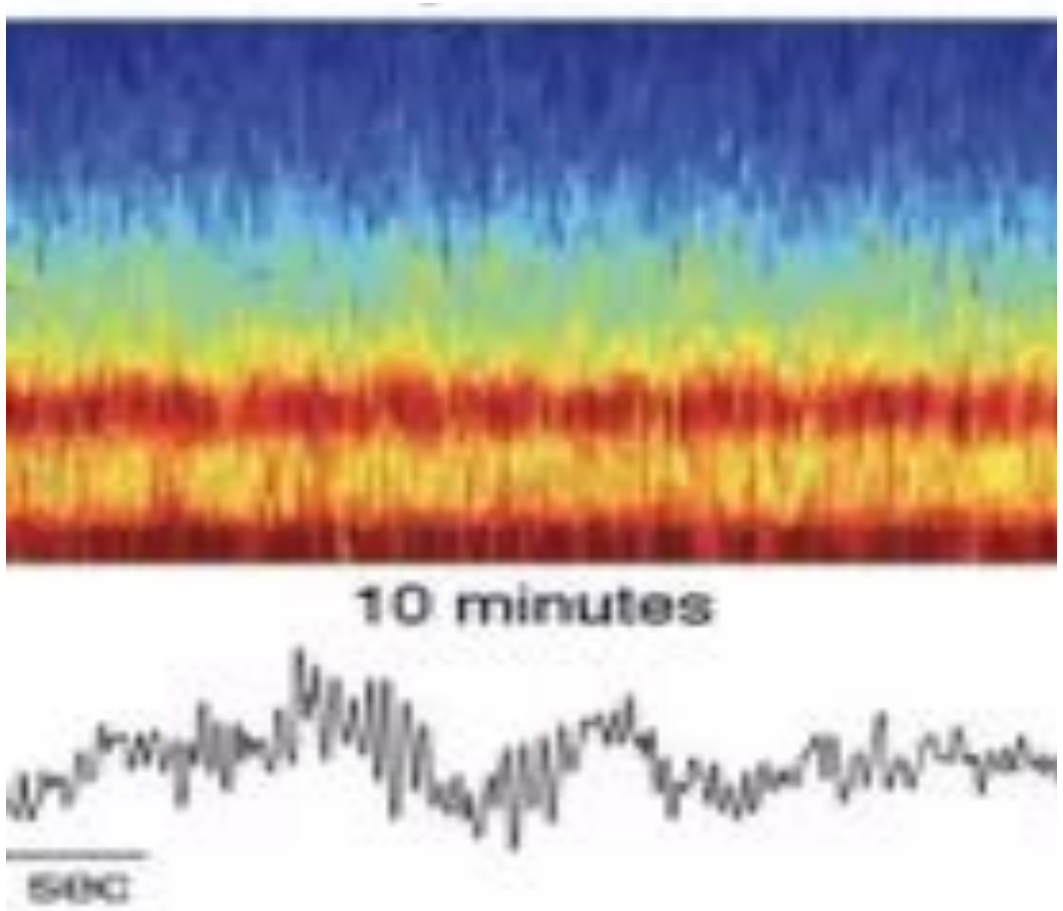
OBJETIVO:
60-80

1ºS ESTUDIOS BIS EXCLUYERON ANCIANOS

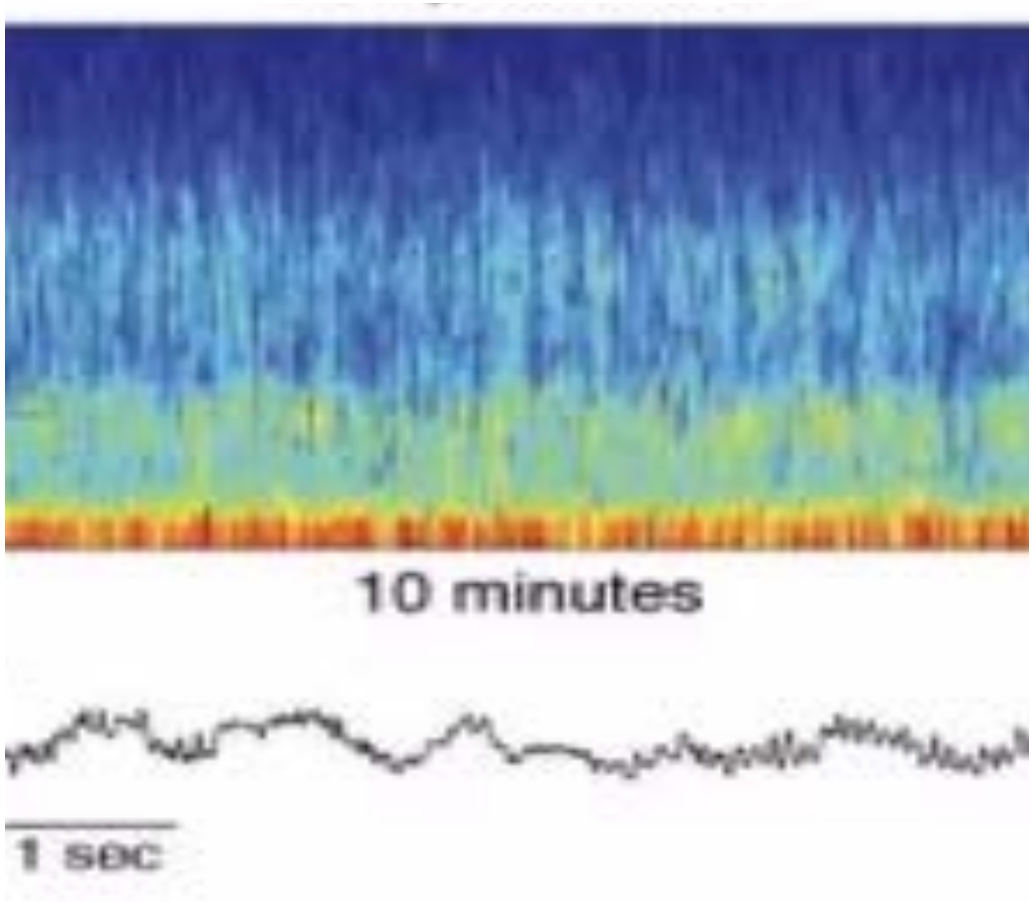
PROPOFOL

BIS Objetivo: 60-80

26 años



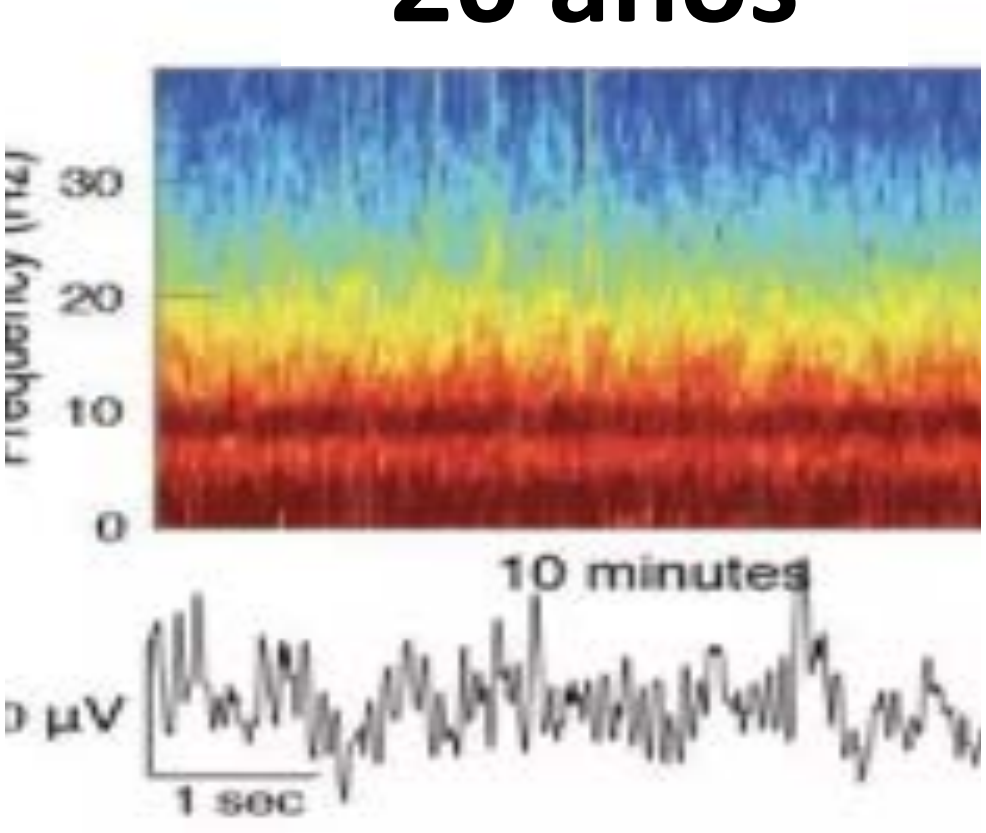
86 años



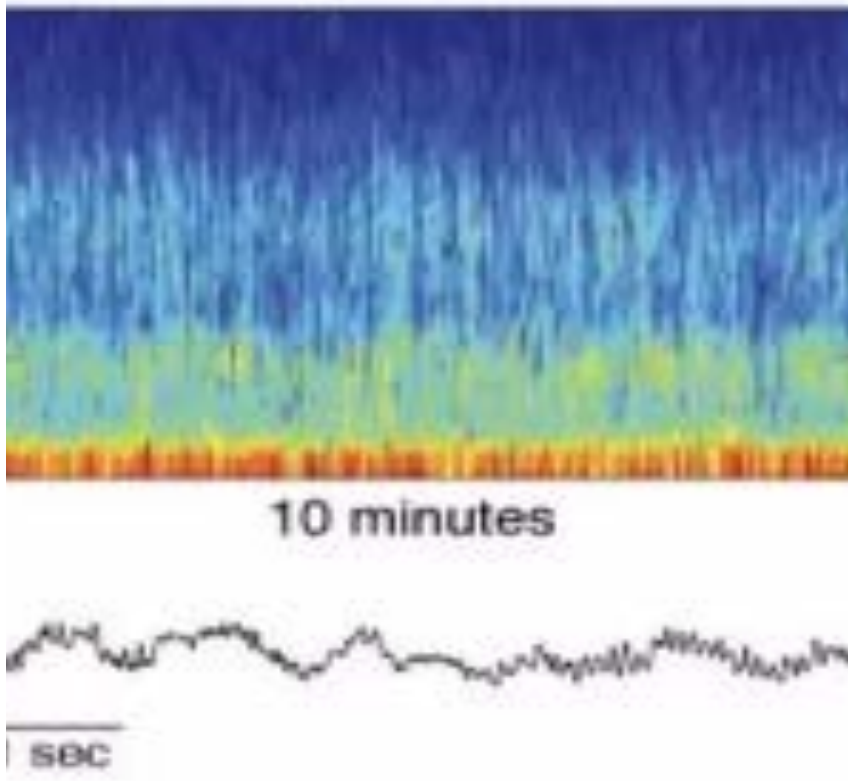
SEVOFLURANO

BIS Objetivo: 60-80

26 años



86 años



BJA Education, 20(5): 142–149 (2020)
doi: 10.1016/j.bjae.2020.02.003
Advance Access Publication Date: 23 March 2020

Anaesthesia for hip fracture repair

C. Shelton[1,2,*] and S. White[3]

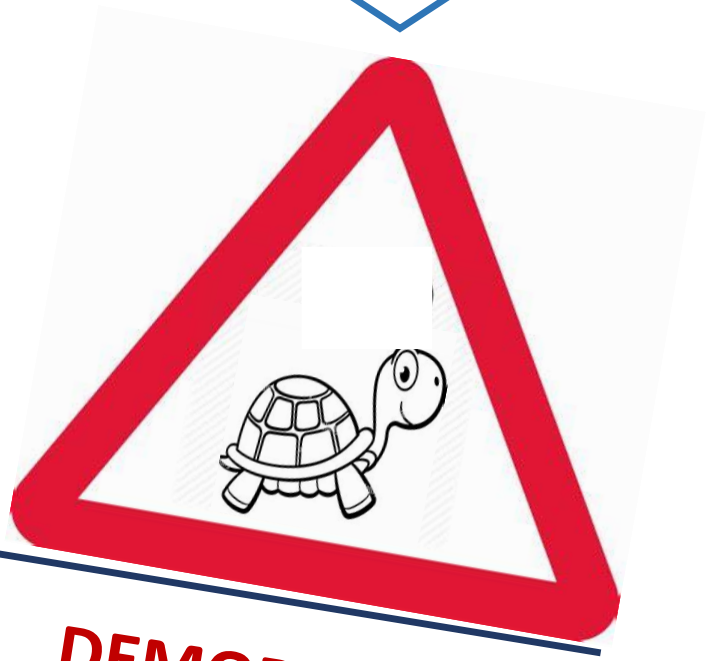
[1]Wythenshawe Hospital, Manchester University NHS Foundation Trust, Manchester, UK, [2]Lancaster Medical School, Lancaster University, Lancaster, UK and [3]Brighton and Sussex University Hospitals NHS Trust, Brighton, UK

*Corresponding author: cliff.shelton@nhs.net

DUPLICA
Σ
Complicación
+

AI ↓70% la IRA

Demora AI vs AG



DEMORA > 48 h

ANESTESIA INTRADURAL
48 H Y 72 H

INR ≤ 1,25
INR ≤ 1,5*

946

Dabigatran + FGe > 80
Xabanes + FGe > 30

597

Pruebas de función plaquetaria Normal*

172

> 150.000 PLQ***

517

AVK

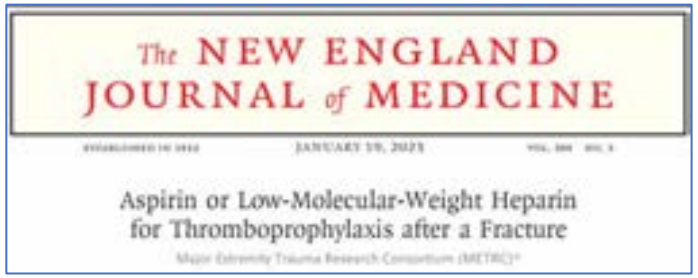
ACOD

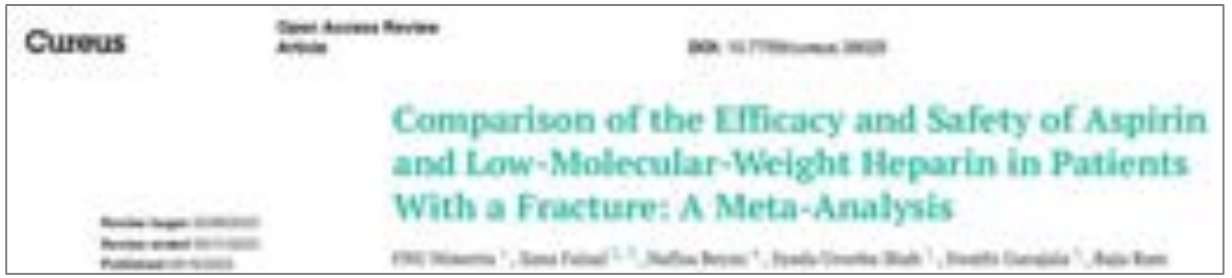
CLOPI

48 h 72 h

TROMBOPROFILAXIS

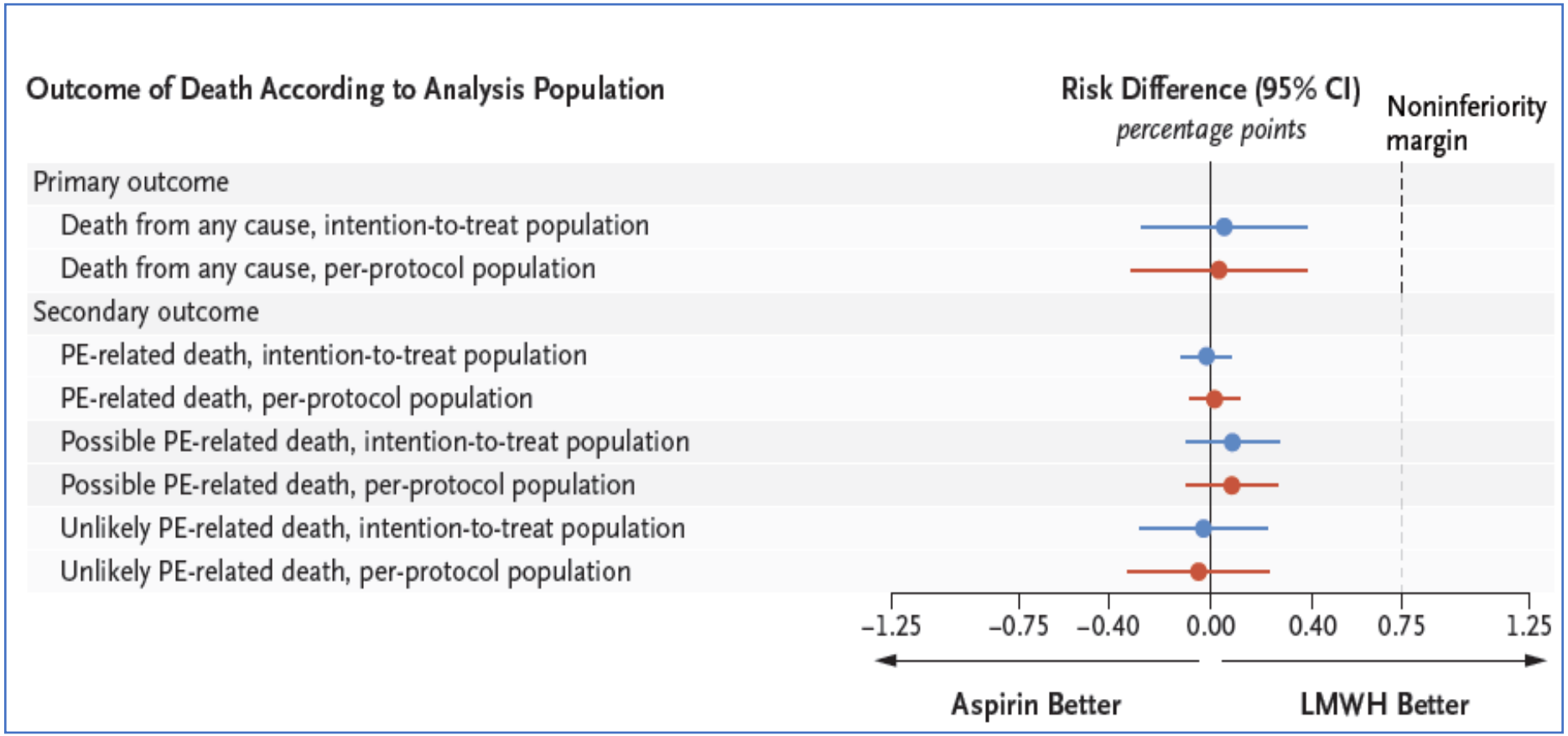
HBPM / AAS / ACOD

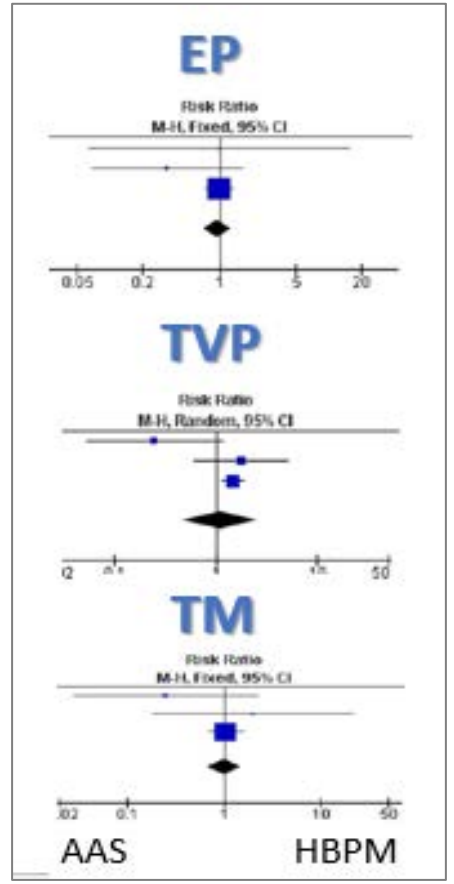




ERC, multicéntrico
Fx: 6.100 AAS / 6.100 Enoxaparina 30mg/12 h

Metaanálisis 2 ERC + 1 EO
Fx: 6.450 AAS / 6.450 Enoxa





Injury 53 (2022) 1169–1176

Contents lists available at ScienceDirect

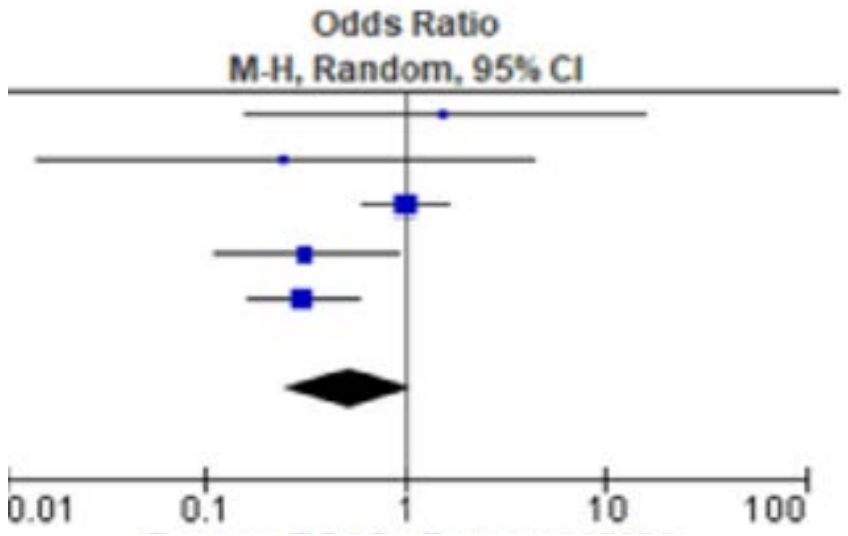
Injury

journal homepage: www.elsevier.com/locate/injury

Equivalence of DOACS and LMWH for thromboprophylaxis after hip fracture surgery: Systematic review and meta-analysis☆

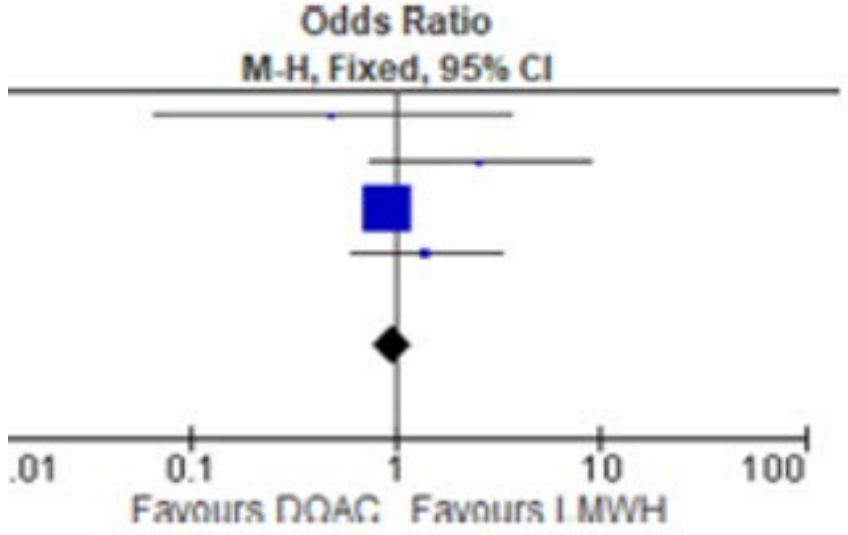
Charlie J. Nederpelt[a,b,*], Quinten Bijman[a], Pieta Krijnen[a], Inger B. Schipper[a]

TVP



Mejor ACOD Mejor HBPM

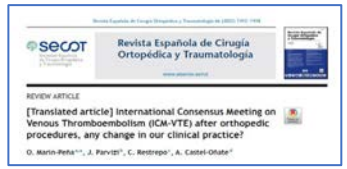
SANGRADO

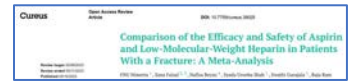


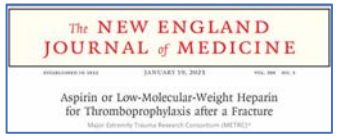
Tromboprofilaxis óptima en ATT y FOC

Se recomiendan

- Profilaxis mecánica y farmacológico.
- **La AAS es eficaz y segura**
- Preoperatoria:
  - sí **DEMORA > 48 h**
  - **AVK**: Cirugía en 24-36 h con INR ≤ 1,7
  - **ACOD y AAP**: Cirugía en 24-48 h
- Postoperatoria: > 12 horas después del cierre
- LMWH, UFH, AVK, **AAS , ACOD**







ANEMIA: HEMORRAGIA Y TRANSFUSIÓN

PBM

¿CÓMO GESTIONAMOS LA HEMORRAGIA, ANEMIA Y TRANSFUSIÓN?

1.5 g/dL

3,5 g/dL

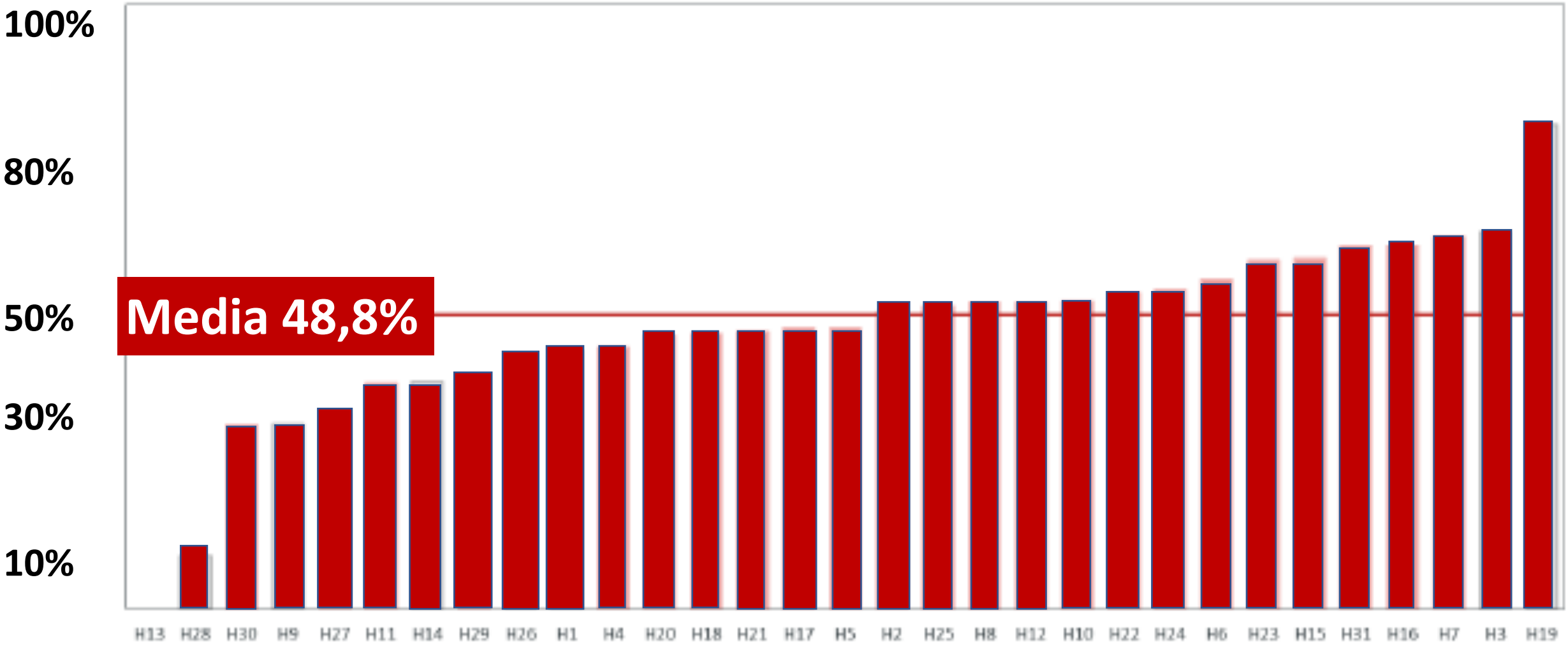
Potter LJ, Doleman B, Moppett IK. A systematic review of pre-operative anaemia and blood transfusion in patients with fractured hips. Anaesthesia 2015;70(4):483-500.

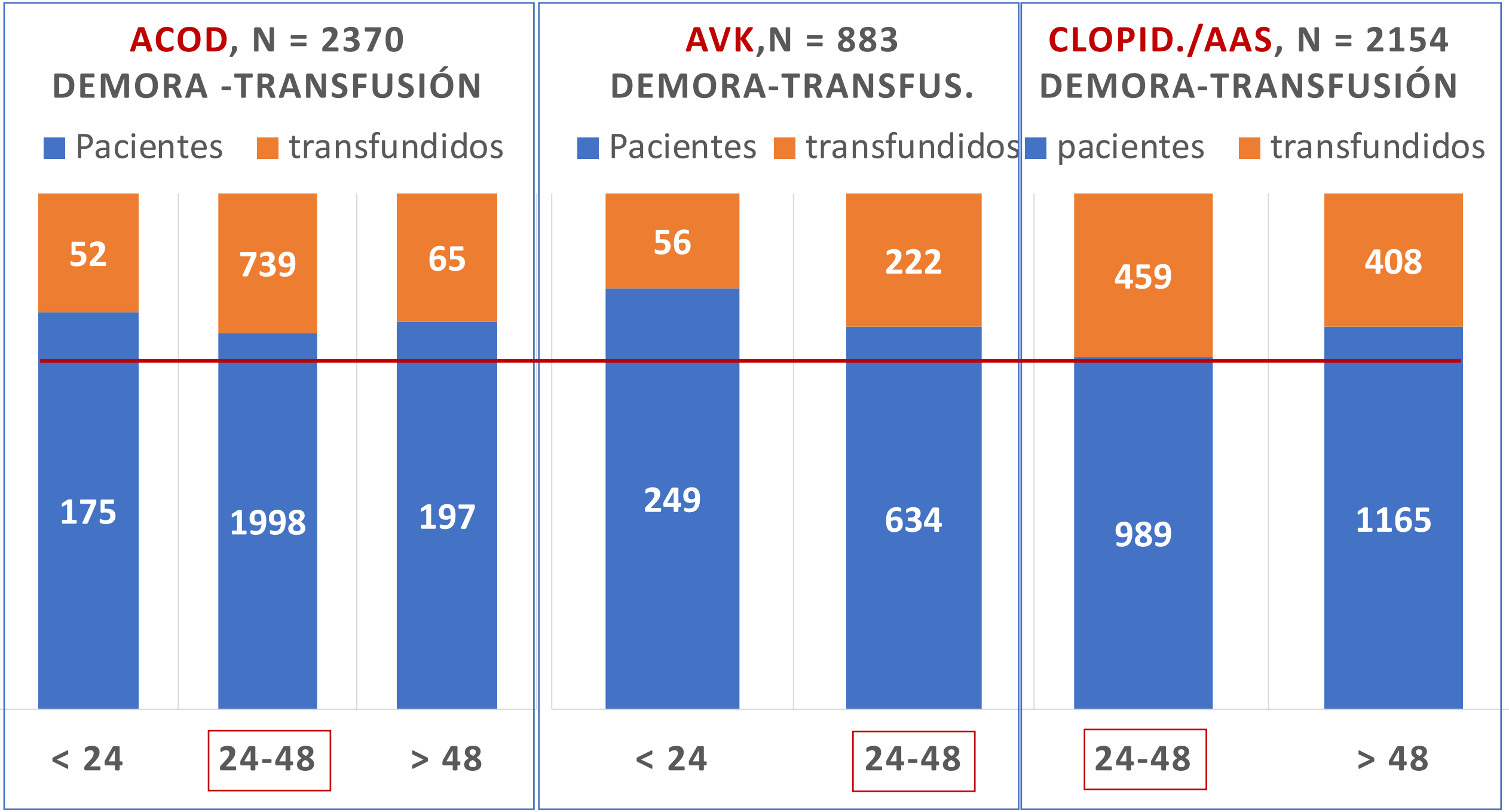
3.5 g/dL

Quijada JL. Factores que incrementan el riesgo de transfusion en los pacientes con fractura de cadera. Rev Ortp Traumatol 2011; 55: 35-38

6-9 g/dL

Transfusión en pacientes con fractura de cadera en España




ACOD, N = 2370
DEMORA -TRANSFUSIÓN
Pacientes
transfundidos
52
739
65
175
1998
197
< 24
24-48
> 48
AVK,N = 883
DEMORA-TRANSFUS.
Pacientes
transfundidos
56
222
249
634
< 24
24-48
CLOPID./AAS, N = 2154
DEMORA-TRANSFUSIÓN
pacientes
transfundidos
459
408
989
1165
24-48
> 48

NINGÚN AAP NI ACO JUSTIFICA UN RETRASO > 48 H DE LA CIRUGÍA DE FOC

COMO LA TRANSFUSIÓN SE ASOCIA CON COMPLICACIONES Y MORTALIDAD

PARA AUMENTAR LA SEGURIDAD DEL PACIENTE

SE DEBEN IMPLANTAR TODAS LAS MEDIDAS DE PBM

Hemorragia intra y PO

ATX: ↓ 200 ml

Hemorragia intraOP

ATX: ↓ 30 ml

Tasa transfusional

ATX: ↓ 40-60%

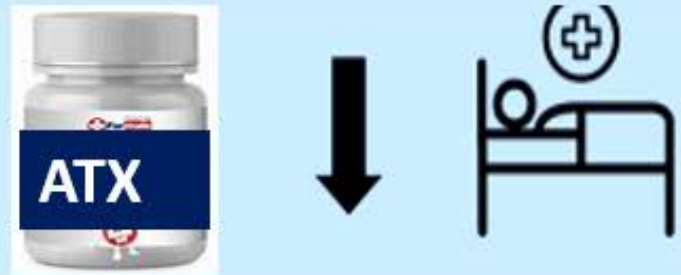
HB +1día PO

ATX: ↑ 0,6 g/dL

HB + 3 días PO

ATX: ↑ 0,7 g/dL

Estancia Hospitalaria



ATX: ↓ 1,4 días

Clinical Pharmacokinetics
https://doi.org/10.1007/s40262-021-01043-9

ORIGINAL RESEARCH ARTICLE

2021

Population Pharmacokinetics of Intra-articular and Intravenous Administration of Tranexamic Acid in Patients Undergoing Total Knee Replacement

Aránzazu González Osuna[1] · Luisa Fernanda Rojas[2] · Claudia Lamas[1,6] · Xavier Aguilera Roig[1,6] · Francesc Pla-Junca[2] · Sebastián Videla[3,4] · Mª José Martínez-Zapata[5] · Marta Valle[2] · FARMATX study group

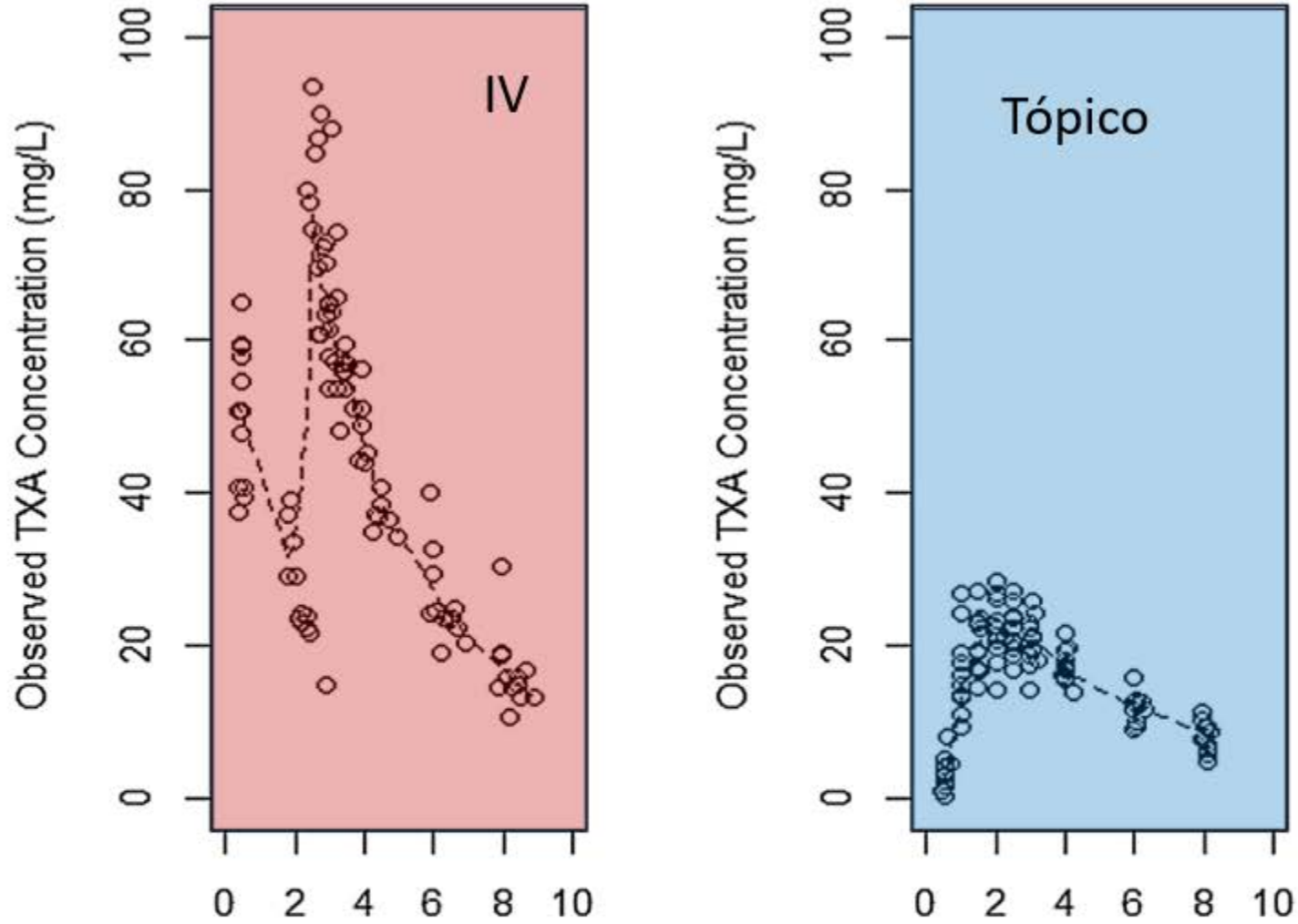
Accepted: 28 May 2021

Tranexamic Acid for Acute Hemorrhage: When Is Enough Evidence Enough?

2019

David Faraoni, MD, PhD, FAHA,* and Jerrold H. Levy, MD, FAHA, FCCI

ESTUDIO FARMATX



Las dosis iv y tópicas se basan en que una concentración de 20 a 50 mg/L podría inhibir completamente la fibrinolísis, y podría asociar eventos trombóticos, pero no se ha demostrado

Tan pronto como posible

Fe++/P: 20 mg/kg iv

ATX iv: 1g + 1g en 8 h o Cir y PO

30% AAP/ACO

P-ATX P-Fe++

ATX P-Fe++

206 P-Fe++

103

P-ATX Fe++

ATX

Fe++

207 Fe++

206 P-ATX

207 ATX

413 p

Open access Protocol

BMJ Open **Study protocol for a multicentre, 2×2 factorial, randomised, controlled trial evaluating the interest of intravenous iron and tranexamic acid to reduce blood transfusion in hip fracture patients (the HiFIT study)**

Sigismond Lasocki ,[1] Thibault Loupec,[2] Elsa Parot-Schinkel,[3] Bruno Vielle,[3]

Ferric derisomaltose and tranexamic acid, combined or alone, for reducing blood transfusion in patients with hip fracture (the HiFIT trial): a multicentre, 2×2 factorial, randomised, double-blind, controlled tria'

Lancet Haematol 2023; 10: e747–55

Sigismond Lasocki, Xavier Capdevila, Bruno Vielle, Benjamin Bijok, Maria Lahlou-Casulli, Vincent Colli

P-ATX-P-Fe: **30%**; HB < 8 >> frecuente

Fe++: 26%

ATX: 27%

ATX + Fe: 15% OR:0,51;IC 98%: 0,27-0,97

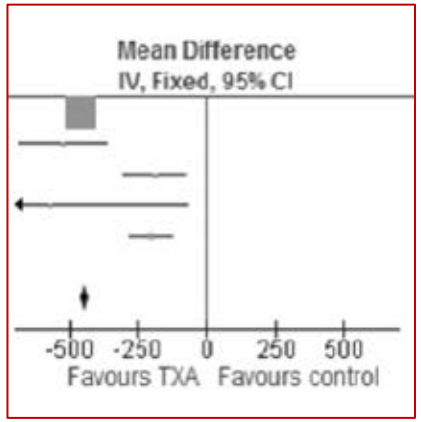
HIP
ISSN 1120-7000
REVIEW ARTICLE

HIP International
2018, Vol. 28(1) 3–10

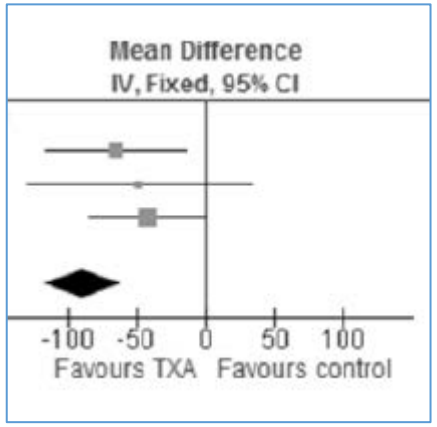
DOI: 10.5301/hipint.5000556
journals.sagepub.com/home/hpi
SAGE

Effect of tranexamic acid use on blood loss and thromboembolic risk in hip fracture surgery: systematic review and meta-analysis

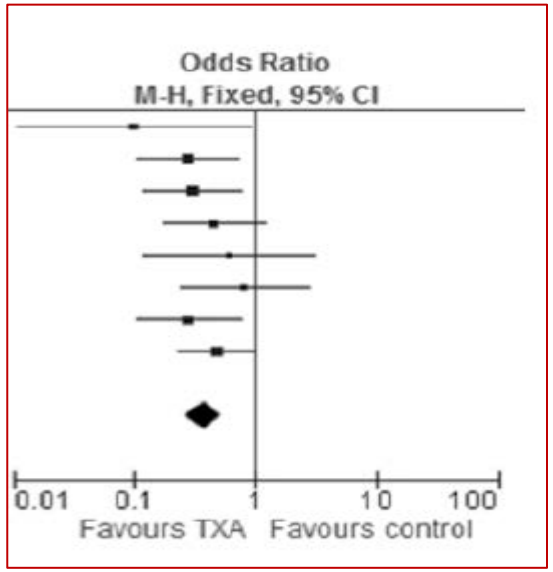
Dinnish Baskaran[1], Syed Rahman[2], Yousuf Salmasi[3], Saied Froghi[4], Onur Berber[5], Marc George[5]



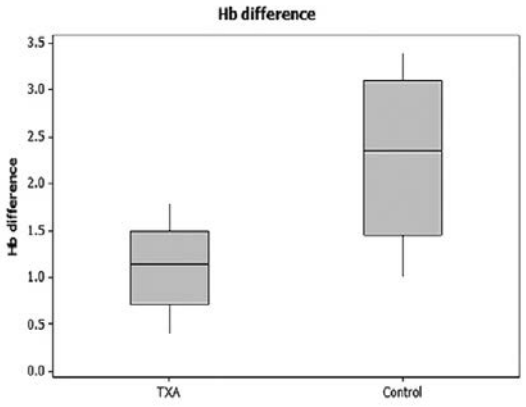
Hemorragia total



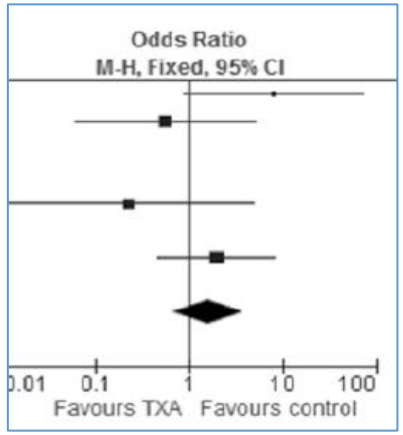
Hemorragia quirúrgica



N.º Transfusiones



↓ **HB***
1,2 vs 2,5



TVP / TEP


Dasha G. Blanco

ANTIAGREGANTES

C. ≤ 48 h

AAP: Sustituir x AAS 100, Suspender otros AAP

NO HBPM preoperatoria en AAP ni ACO

C. > 48 h

AAP:

AAS 100/12 h

ACO:

HBPM Prof.

Si Válvula card. Mec.
Stent F < 6 m
FR Trombotico ↑
CIR < 48 H

ANTICOAGULANTES

Tiempo desde última dosis de AAP a cirugía

REINICIO Y TROMBOPROFI.

INGRESO | **24 H** | **48 H** | **72 H***

BNPS + AG

AAS / Disgren

Cilostazol ± AAS
DIPIRIDAMOL ± AAS

CLOPIDOGREL ± TICAGRELOR ± PRASUGREL ± ± AAS

~~12 H~~

12 h PO
AAS 100/12 h

24 h PO
± clopi 24 h

24-72 h
Prasu/Ticagr

Tiempo desde última dosis a cirugía

INGRESO | 24 H | 48 H | 72 H*

BNPS + AG

DABIGATRAN
FGe > 80

DABIGATRAN
FGe > 50

XABANES
FGe > 30

XABANES FGe<30
Dabigatran F < 50

~~8-12 H~~

12-24 H
ACOD Prof.

24 -48 H
ACOD previo

REINICIO Y TROMBOPROFI.

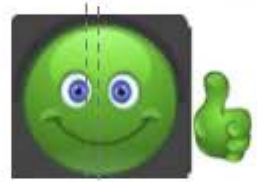
Tiempo desde última dosis a cirugía

REINICIO Y TROMBOPROFI.

INGRESO | 24 H | 48 H | 72 H*

BNPS + AG

INR ≤ 1,5

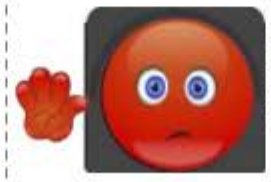


12 H

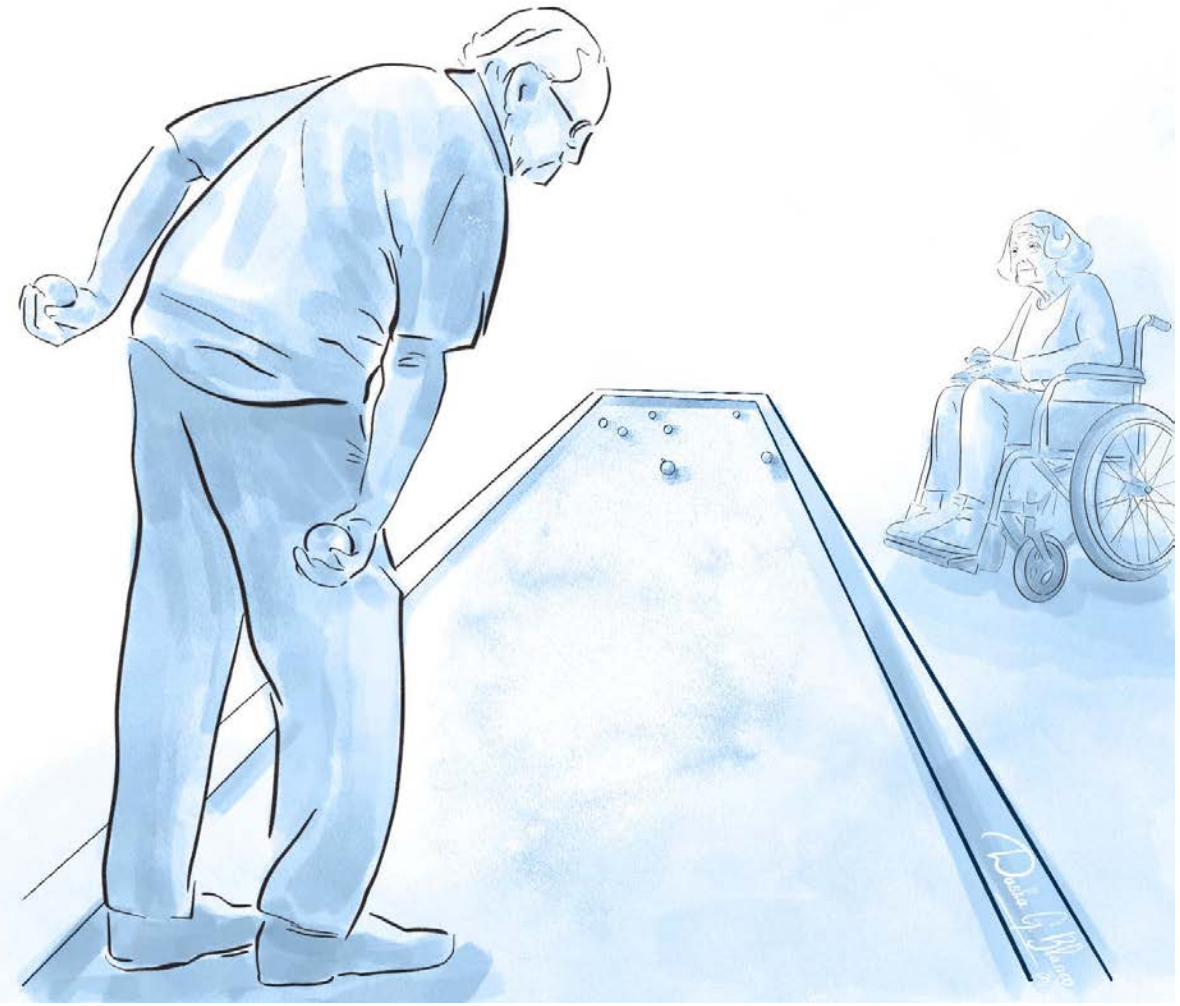
INR ≤ 1,7

24-48 H
AVK +

INR > 1,7



INR ≥ 2
AVK



D emora **≤ 48 h**

A BNP (pre + AG vs AI /PO)

T romboprof: **AAS / AVK / ACOD**

A nemia: Fe ++ /ATX / T de 1 en 1

F isico y cognitivo:**BNP/BIS 60-80**

O steomalacia: Vitamina D

N utrición: Hiperproteicos

O steoporosis: Tto

Dra. Concha Cassinello

Hospital Universitario Infanta Sofía

MUCHAS GRACIAS Y FELIZ NAVIDAD

Dra. Concha Cassinello
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