

Faut-il sédater les patients en réanimation?

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Department d'Anesthésie-Réanimation

Médecine Periopératoire





Liens d'intérêt

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FRESENIUS-KABI
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   PHILIPS
  HAMILTON
  MASSIMO
   BBRAUN
BiRD-Corporation
ASTUTE Medical
 Fisher-Paykel
Sedana Medical
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Ministère de la santé PHRC ANR-DGOS

Faut-il sédater les patients en réanimation?

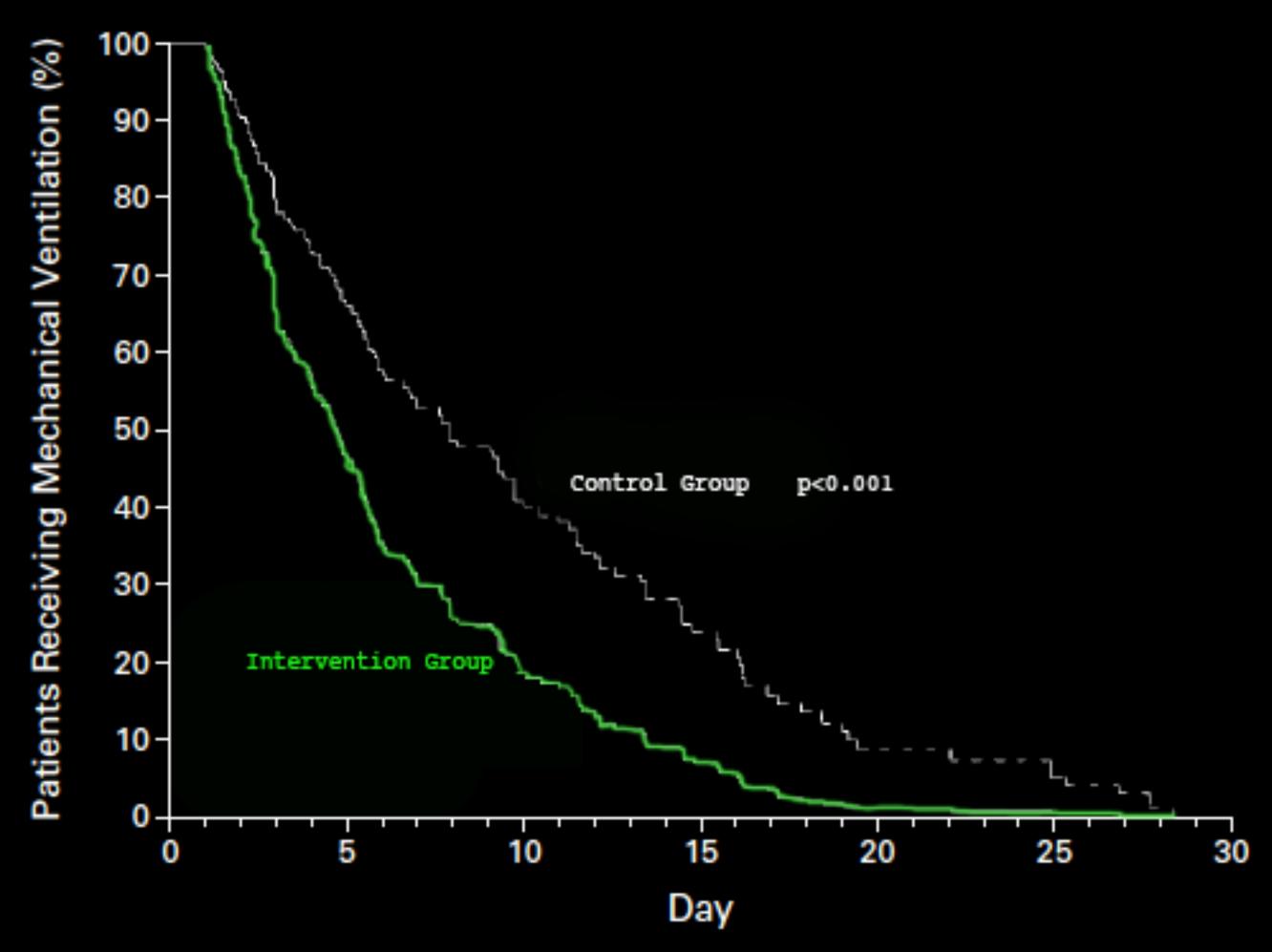






DAILY INTERRUPTION OF SEDATIVE INFUSIONS IN CRITICALLY ILL PATIENTS UNDERGOING MECHANICAL VENTILATION

JOHN P. KRESS, M.D., ANNE S. POHLMAN, R.N., MICHAEL F. O'CONNOR, M.D., AND JESSE B. HALL, M.D.



Staff perceptions on the use of a sedution protocol in the intensive care setting

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-BATTERSON

The Use of Continuous IV Sedation Is Associated With Prolongation of Mechanical Ventilation*

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Using and understanding sedation scoring systems: a systematic review

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Introduction

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Mechanically Ventilated Critically III Patients

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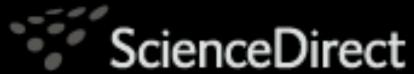
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Disponible en ligne sur www.sciencedirect.com



Annales Françaises d'Anesthésie et de Réanimation 27 (2008) 541-551



http://france.elsevier.com/direct/ANNFAR/

Texte long du jury

Sédation-analgésie en réanimation (nouveau-né exclu)[★]
Sedation and analgesia in intensive care (with the exception of new-born babies)

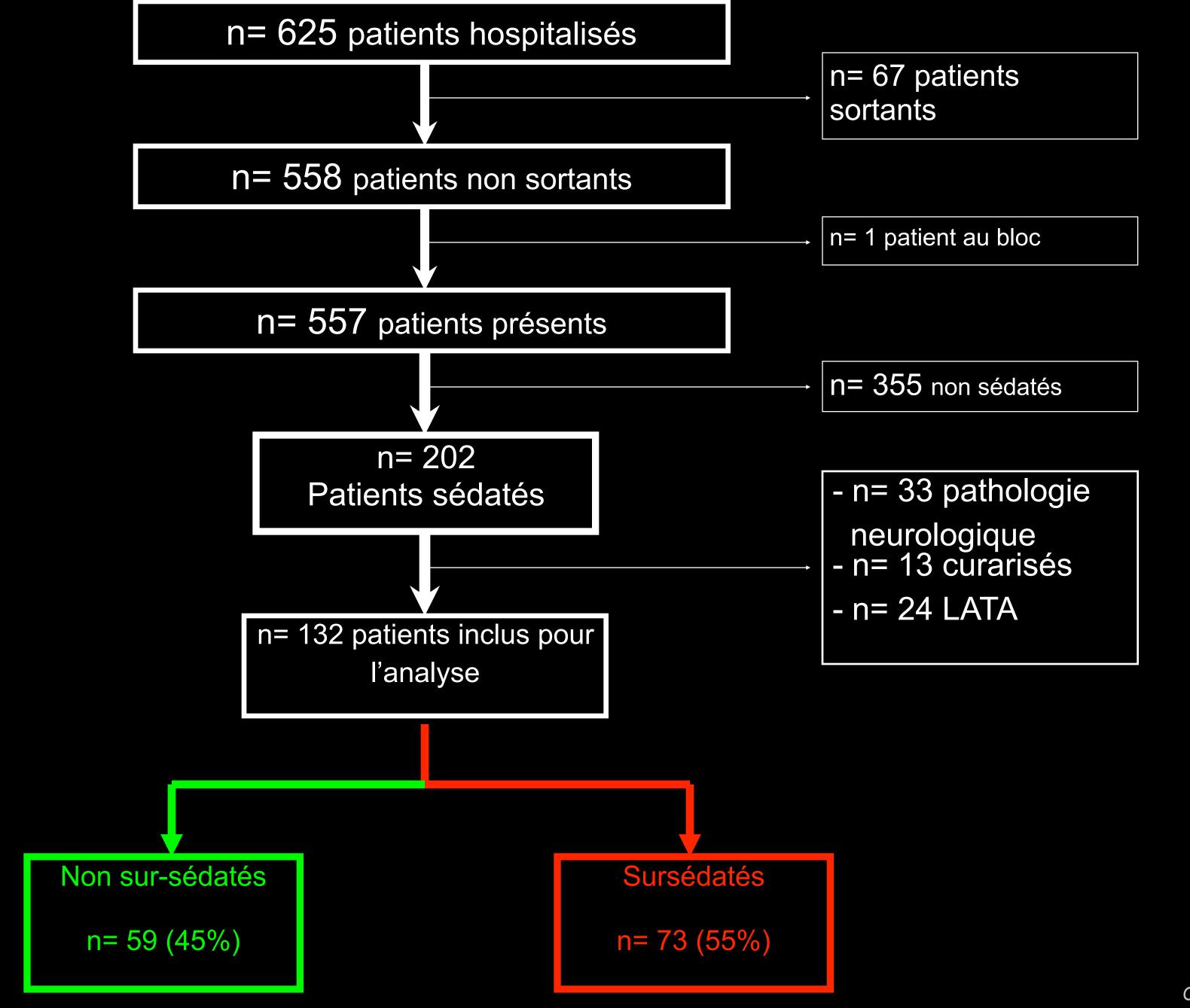


Que retenir de la conférence de consensus ?...

Les indications d'une sédation profonde sont :

SDRA à la phase initiale Cérébro-lésé avec HTIC En dehors ...

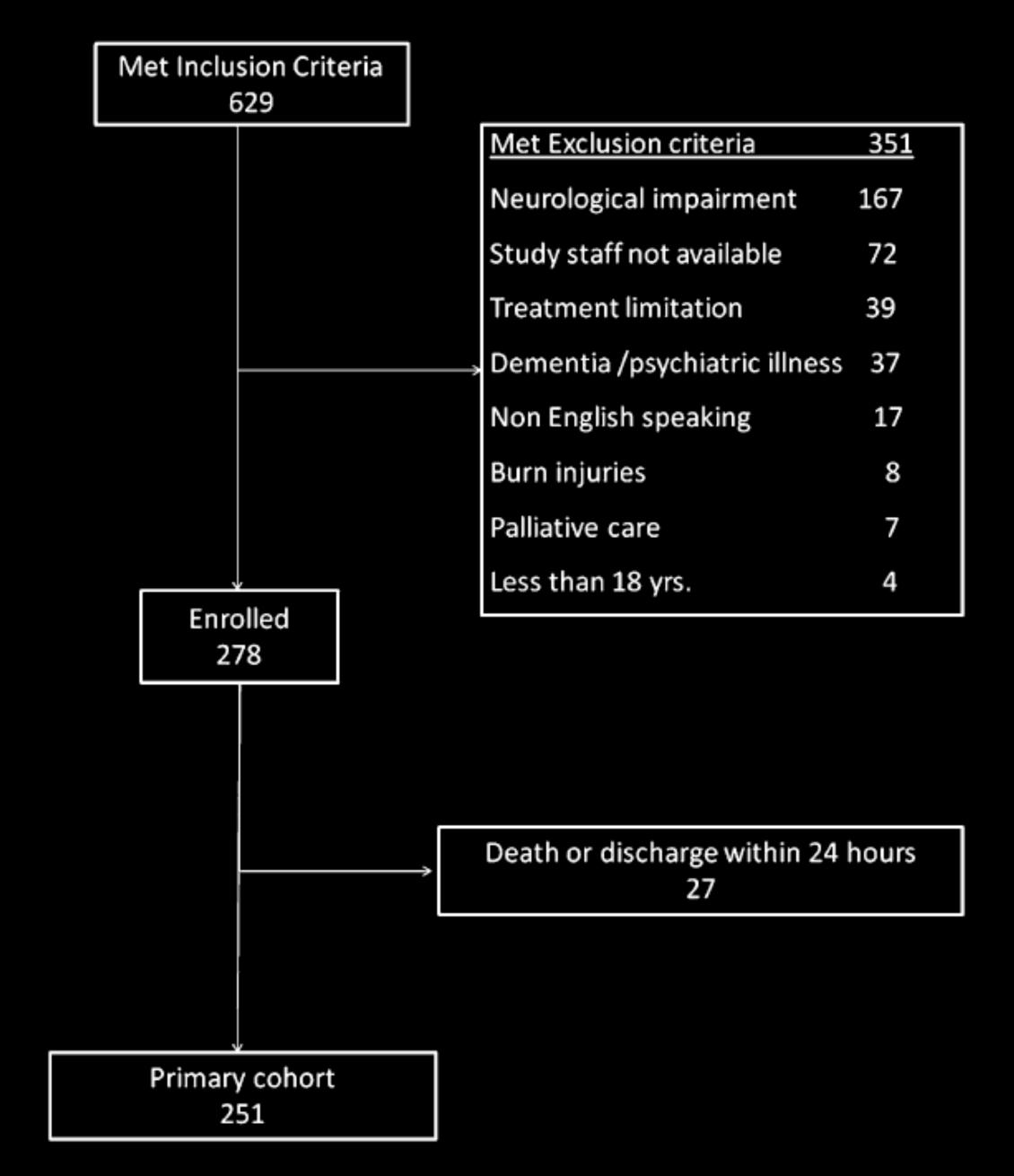
Pas d'indication, à une sédation profonde



Chanques, AFAR 2011

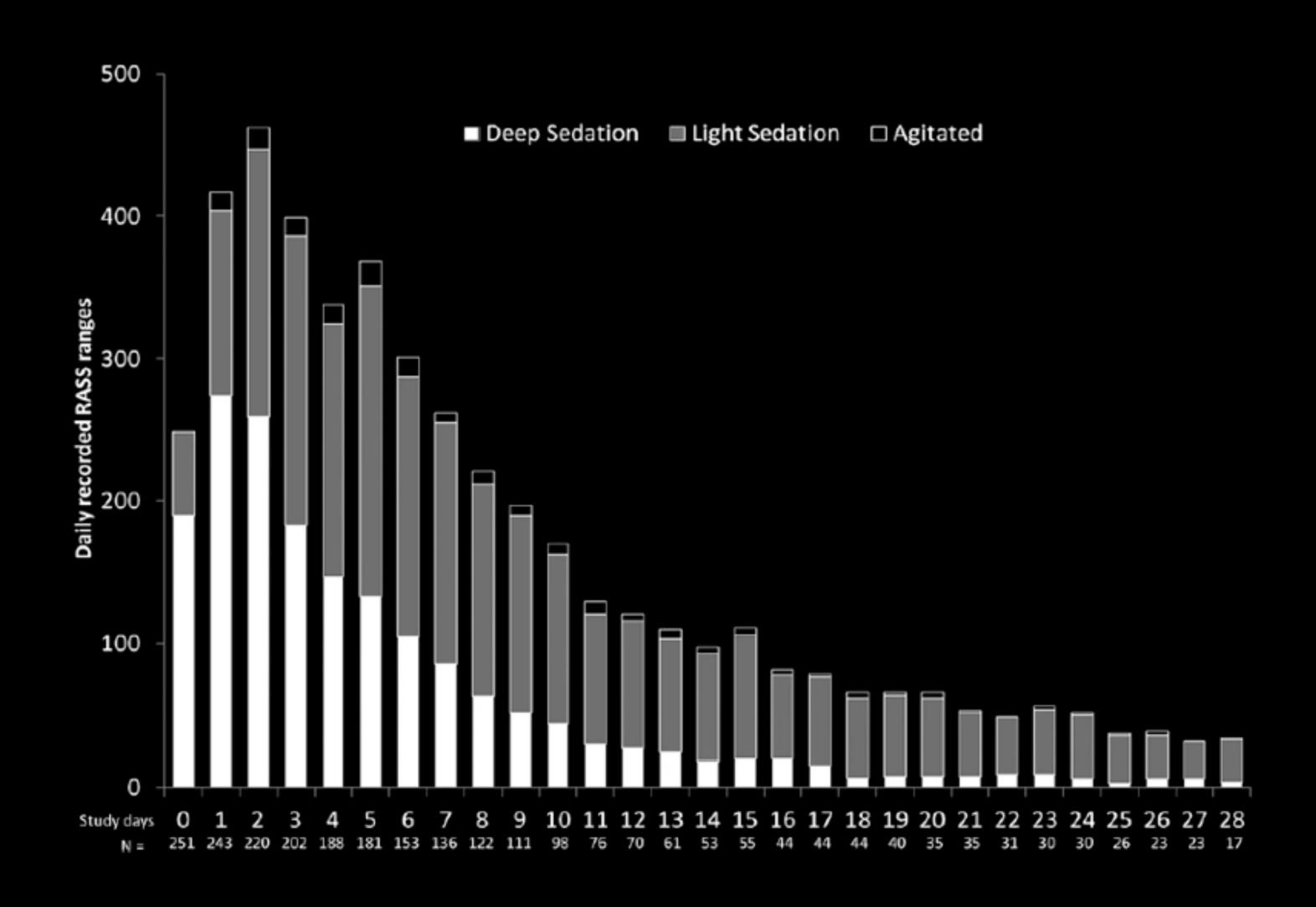
Early Intensive Care Sedation Predicts Long-Terr Mortality in Ventilated Critically III Patients

Yahya Shehabi^{1,2}, Rinaldo Bellomo^{3,4,5,6}, Michael C. Reade^{7,8}, Michael Bailey⁵, Frances Bass², Belinda Howe⁵, Colin McArthur⁹, Ian M. Seppelt¹⁰, Steve Webb^{11,12}, and Leonie Weisbrodt¹³; Sedation Practice in Intensive Care Evaluation (SPICE) Study Investigators and the ANZICS Clinical Tria



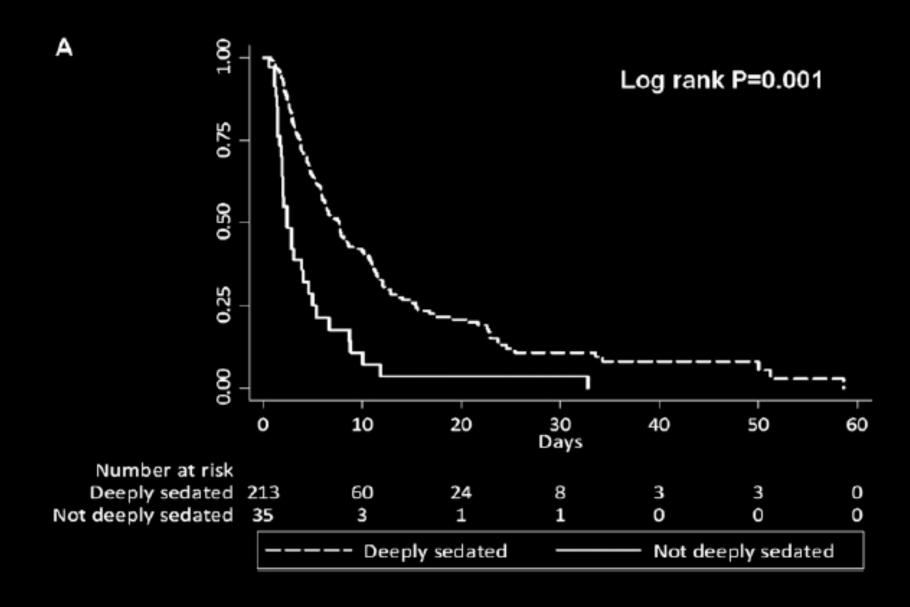
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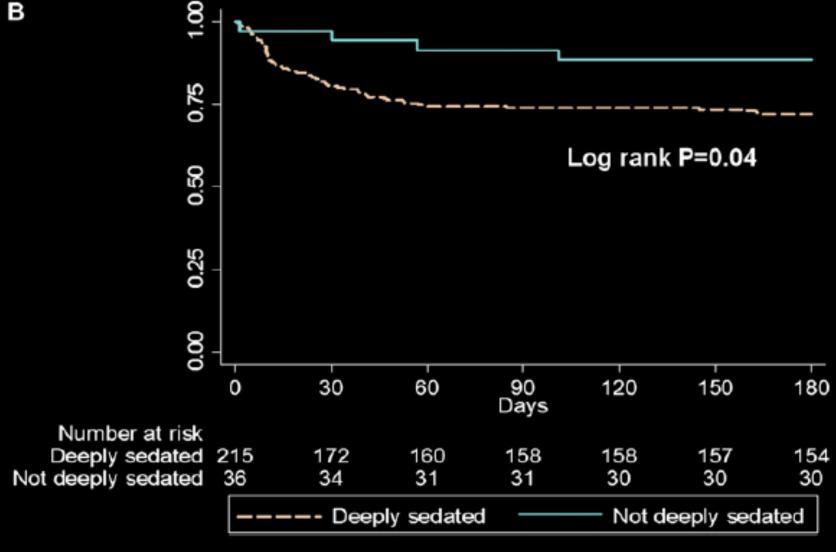
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	Time to Extubation			Delirium after 48 h			180-d Mortality		
	HR	95% CI	P Value	HR	95% CI	P Value	HR	95% CI	P Valu
RASS, -3 to -5*	0.90	0.87- 0.94	< 0.001	1.05	0.99-1.11	0.10	1.08	1.01-1.16	0.027
APACHE II	0.99	0.97-1.02	0.79	1.01	0.99-1.04	0.47	1.02	0.99-1.06	0.21
Age	0.99	0.98-1.00	0.71	1.00	0.99-1.01	0.62	1.03	1.01-1.05	0.009
Male sex	0.63	0.46-0.87	0.02	1.10	0.72-1.70	0.64	1.05	0.78-2.34	0.25
Operative	0.77	0.48-1.24	0.33	0.98	0.48-2.01	0.96	1.20	0.52-2.79	0.67
Elective	1.25	0.74-2.11	0.36	0.41	0.16-1.09	0.07	1.18	0.50 - 2.85	0.71
Cardiac [†]	0.83	0.45-1.56	0.88	0.26	0.01-0.67	0.01	1.77	0.56-5.61	0.33
Respiratory [†]	0.48	0.30-0.77	0.01	0.65	0.34-1.25	0.20	1.43	0.47-4.38	0.53
Sepsis [†]	0.66	0.35-1.24	0.18	0.95	0.26-1.34	0.20	1.82	0.53-6.20	0.34
Gastrointestinal [†]	1.11	0.62-1.98	0.86	0.73	0.33-1.64	0.45	1.43	0.42-4.86	0.57
Vasopressors	0.69	0.49-0.97	0.02	1.33	0.82 - 2.18	0.25	0.68	0.36-1.28	0.23
Dialysis [‡]	0.59	0.36-0.95	0.03	1.70	0.96-3.01	0.07	2.45	1.31-4.56	0.005
Rural hospital	1.53	0.85-2.77	0.14	1.14	0.67-1.95	0.63	0.74	0.23-2.06	0.56
Metro hospital	1.00	0.67–1.49	0.89	1.26	0.60-2.61	0.5	1.05	0.53-2.09	0.88

En dehors de SDRA et HTiC

PAS D'INDICATION À UNE SÉDATION PROFONDE.

Nécessité d'analgésie ...

Sédation basée sur l'Analgésie

Top 10 Myths Regarding Sedation and Delirium in the ICU

September 2013 • Volume 41 • Number 9 (Suppl.)

Gregory J. Peitz, PharmD, BCPS^{1,2}; Michele C. Balas, PhD, RN, APRN-NP, CCRN³; Keith M. Olsen, PharmD, FCCP, FCCM²; Brenda T. Pun, RN, MSN, ACNP⁴; E. Wesley Ely, MD, MPH^{5,6}

Myth 3: Only Surgical ICU Patients Experience Pain

ICU patients routinely receive sedatives and analgesics during their care, and yet 27–77% of all ICU patients still experience significant pain (23), with resulting negative alterations in phys-



Que retenir de la conférence de consensus ?...

Chaque service de Réanimation doit disposer d'un Protocole écrit de sédation.

Impact d'un protocole de sédation

	n=	Type d'étude	Protocole	DDV	DMS
Brook et al. CCM 99	321	RCT	presc. méd. vs. protocole	4.9 VS 2.3 j	7.5 VS 5.7
Kress et al. NEJM 00	128	RCT	Protocol vs DI	7.3 VS 4.9 j	9.9 VS 6.4 j
Brattebo et al. BMJ 02	285	Before-After	presc. méd. vs. protocole	7.4 VS 5.3 j	9.3 VS 8.3 j
De Jonghe CCM 05	102	Before-After	presc. méd. vs. protocole	10.3 VS 4.4 j	15 VS 8 j
Elliott ICM 06	322	Before-Afetr	Presc. Med VS protocole	4.8 vs 5.6 j	7.1 VS 8.2 j
Quenot et al. CCM 07	423	Before-After	Presc. Med VS protocol	8 VS 4.2 j	11 VS 5 j
De Wit CC 08	74	RCT	DI VS protocol	6.7 VS 3.9 j	15 VS 8 j
Arias-Ribeira CCM	356	Before-after	presc. méd. vs. protocole	¥ Sevrage	
Bucknall CCM 08	312	RCT	Protocol vs Press Med	79 VS 58 h	94 VS 88 h

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Arias-Ribeira CCM	356	Before-after	presc. méd. vs. protocole	■ Sevrage	« Ventialtor free Days »
Bucknall CCM 08	312	RCT	Protocol vs Press Med	79 VS 58 h	94 VS 88 h

Etudes Australiennes
Infirmières de réanimation
Ratio 1/1
Pas de preuve du suivi du protocole

Qu'est-ce qu'un protocole de sédation?

Formation

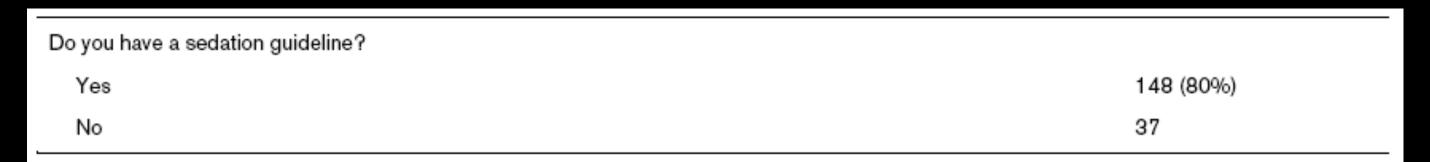
Choisir des molécules

Elaborer un algorithme

Evaluer la vigilance et l'analgésie

Protocoles écrits pour

- 85% protocole de contrôle strict de la glycémie
- 44% protocole de prise en charge du choc septique
- 47% protocole de sevrage de la VM



Reischreiter crit care 2008

30% des services ont un protocole écrit de sédation

84% des personnes interrogées pensent qu'un protocole pourrait améliorer la sédation dans leur service.

30% des services ont un protocole écrit de sédation

34 % des services évaluent la sédation et l'analgésie

52%

36% des services ont un protocole écrit de sédation

34 % des services évaluent la sédation et l'analgésie

80%

52% 60%

36% des services ont un protocole écrit de sédation

34 % des services évaluent la sédation et l'analgésie

80% 90%

Révolution en Réanimation

New Trends in ICU?

Less is more

Moins ventiler

Moins Remplir

Moins Séclater

Effect of Protocolized Sedation on Clinical Outcomes in Mechanically Ventilated Intensive Care Unit Patients. A MetaAnalysis.

	Protocolized sedation			Usual care				Mean difference	Mean difference
Study	Mean	SD	Total	Mean	SD	Total	Weight (%)	IV, random (95% CI)	IV. random (95% CI)
Duration of mechanical ventilation									
Brook et al, ⁷ 1999	3.71	5.56	162	5.16	6.4	159	22.6	-1.45 (-2.76 to -0.14)	
Kress et al,8 2000	4.7	4.52	68	7.3	9.41	60	15.0	-2.60 (-5.21 to 0.01)	
Girard et al, 11 2008	7.1	7	167	9.2	8.4	168	20.5	-2.10 (-3.76 to -0.44)	
Bucknall et al, 12 2008	3.29	3.61	153	2.41	3.45	159	25.4	0.88 (0.10 to 1.66)	<u>■</u>
Anifantaki et al, 10 2009	7.7	13.5	49	8.7	8.35	4 8	8.0	-1.00 (-5.46 to 3.46)	
Weisbrodt et al,9 2011	8	8.08	26	8.4	7.3	24	8.5	-0.40 (-4.66 to 3.86)	
Subtotal (95% CI)			625			618	100.0	-1.04 (-2.54 to 0.47)	<u> </u>
Heterogeneity: τ^2 =2.16; χ^2 =19.20, d f=5 (P =.002); I^2 =74% Test for overall effect: z =1.35 (P =.18)									
ICU LOS									
Brook et al, ⁷ 1999	5.7	5.9	162	7.5	6.5	159	25.6	-1.80 (-3.16 to -0.44)	-
Kress et al, ⁸ 2000	6.4	6.01	68	9.9	9.78	60	15.6	-3.50 (-6.36 to -0.64)	
Bucknall et al, 12 2008	3.92	7.66	153	3.67	6.58	159	23.9	0.25 (-1.34 to 1.84)	
Girard et al, 11 2008	9.1	9.41	167	12.9	13.49	168	17.8	-3.80 (-6.29 to -1.31)	 [
Anifantaki et al, ¹⁰ 2009	14	13.5	49	12	10.17	48	8.3	2.00 (-2.75 to 6.75)	
Weisbrodt et al, ⁹ 2011	8.2	8.08	26	11.3	8.3	24	8.8	-3.10 (-7.65 to 1.45)	
Subtotal (95% CI)	0.2	3.33	625	5	0.5	618	100.0	-1.73 (-3.32 to -0.14)	•
Heterogeneity: τ^2 =2.10; χ^2 =12 Test for overall effect: z =2.13 (P=.03); l²	2=60%						
Hospital LOS									
Brook et al, ⁷ 1999	14	17.3	162	19.9	24.2	159	22.8	-5.90 (-10.51 to -1.29)	
Kress et al,8 2000	13.3	9.41	68	16.9	13.42	60	27.9	-3.60 (-7.67 to 0.47)	
Bucknall et al, 12 2008	13	18.6	153	13	60.6	159	5.8	0.00 (-9.87 to 9.87)	
Girard et al, 11 2008	14.9	13.26	167	19.2	18.3	168	36.1	-4.30 (-7.72 to -0.88)	——
Anifantaki et al, 10 2009	31	47.6	49	21	31.6	48	2.3	10.00 (-6.05 to 26.05)	
Weisbrodt et al, ⁹ 2011	21.1	22.76	26	18.5	14.6	24	5.1	2.60 (-7.92 to 13.12)	
Subtotal (95% CI)			625			618	100.0	-3.55 (-5.98 to -1.12)	
Heterogeneity: $\tau^2 = 1.20$; $\chi^2 = 5.7$	71, df=5 (P:	=.34); <i>l</i> ² =	=12%						20 10 0 10 20
Test for overall effect: $z=2.86$ ($P=.004$)									-20 -10 0 10 20 Favors protocol Favors usual care
									Tavors protocor Tavors usuar care

Que deviennent nos patients?



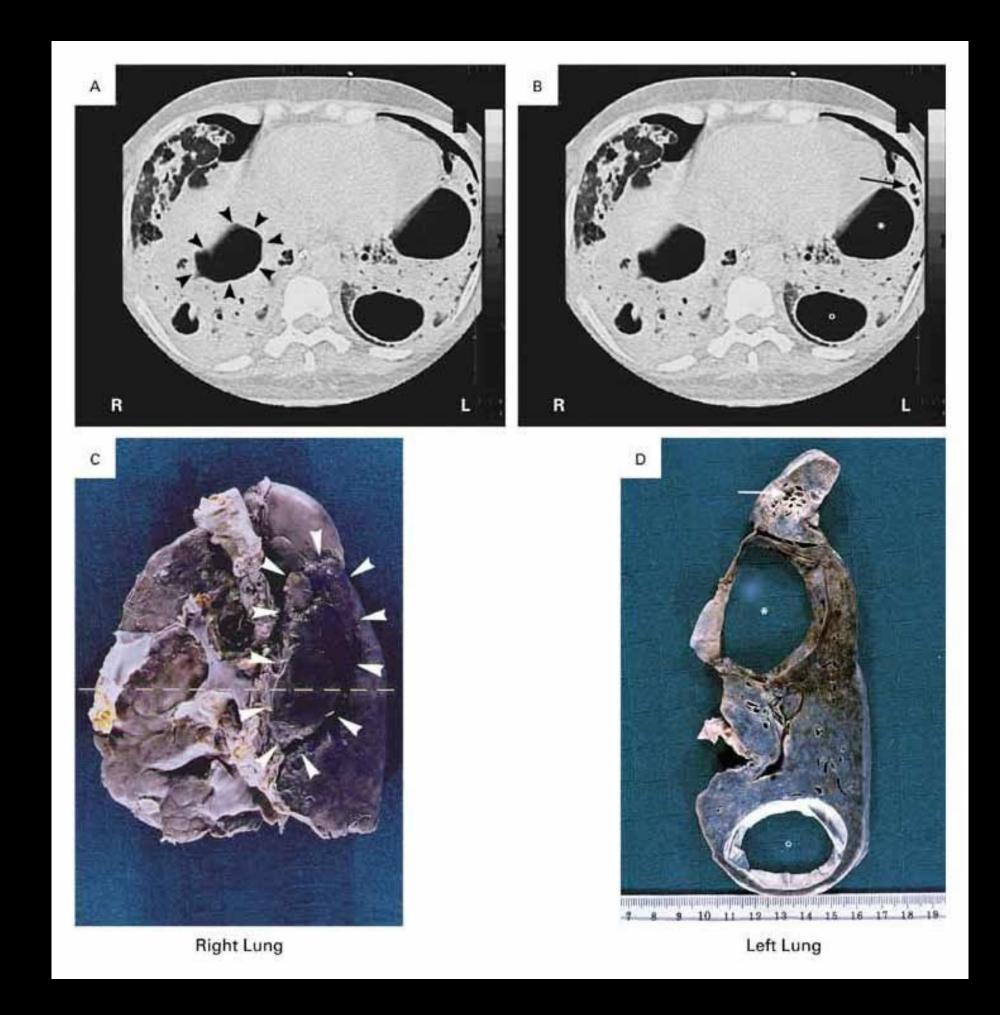
Que deviennent les survivants?

Que deviennent les survivants du SDRA?









ESTABLISHED IN 1812

APRIL 7, 2011

VOL. 364 NO. 14

Functional Disability 5 Years after Acute Respiratory Distress Syndrome

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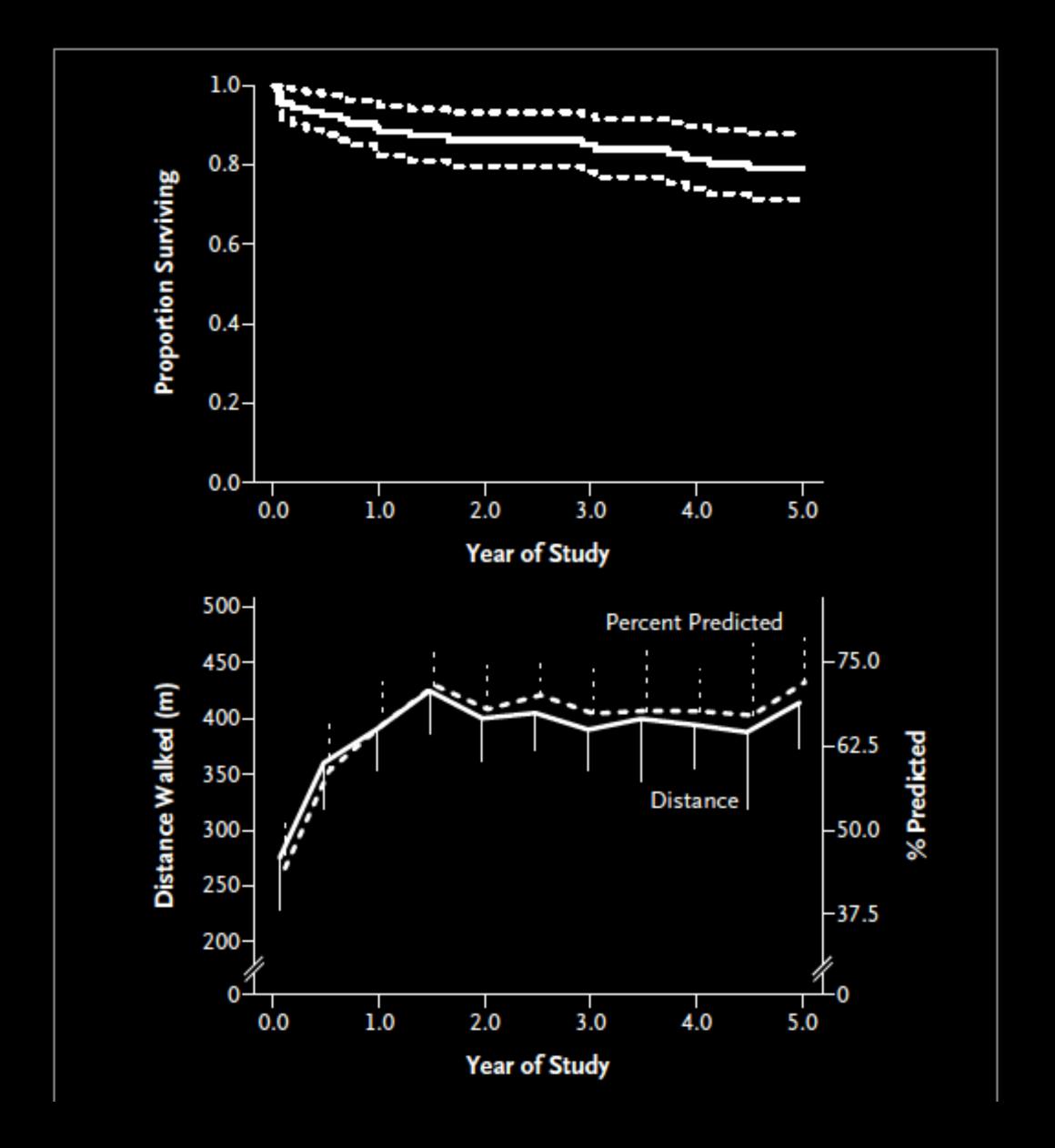
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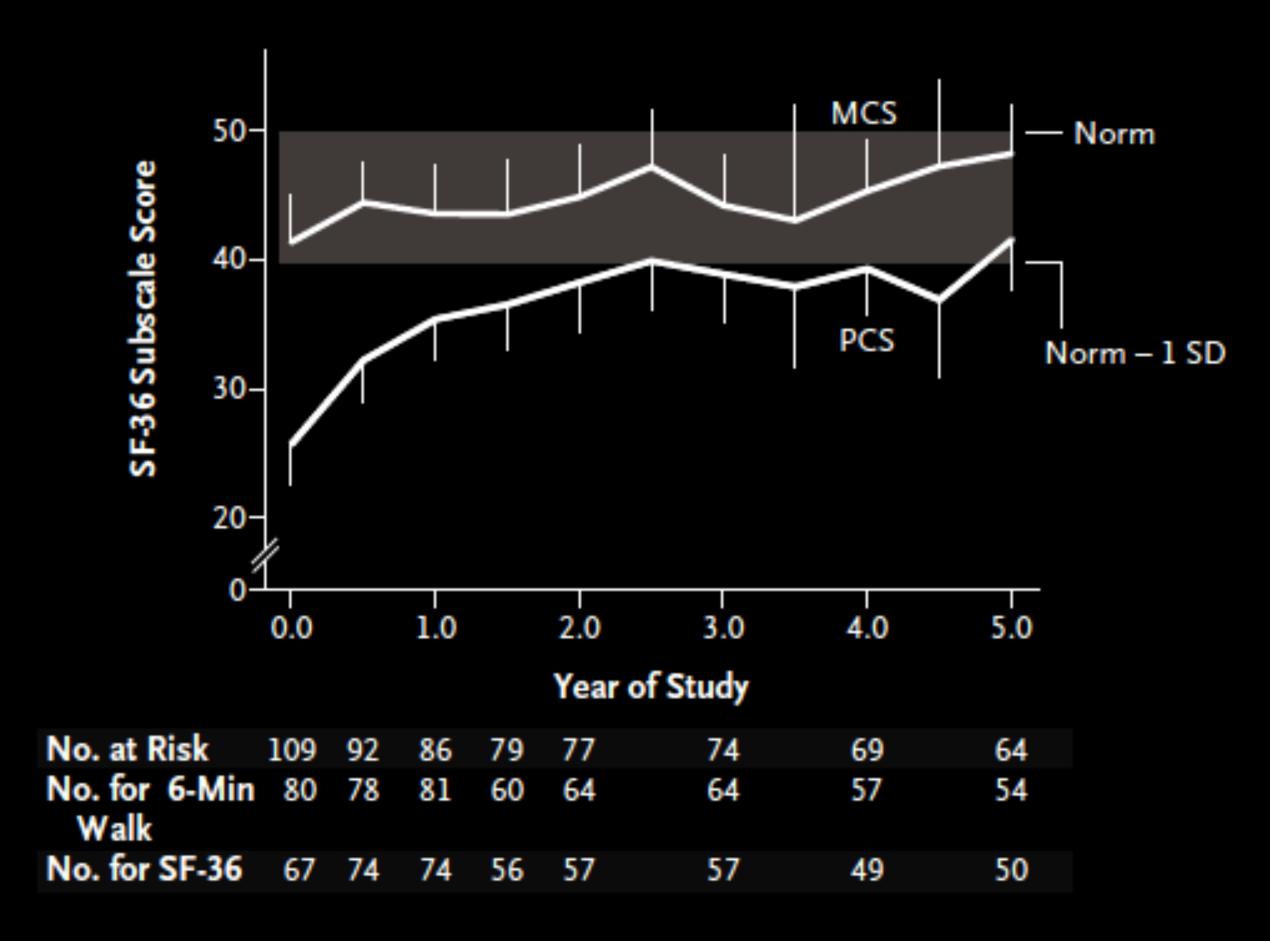
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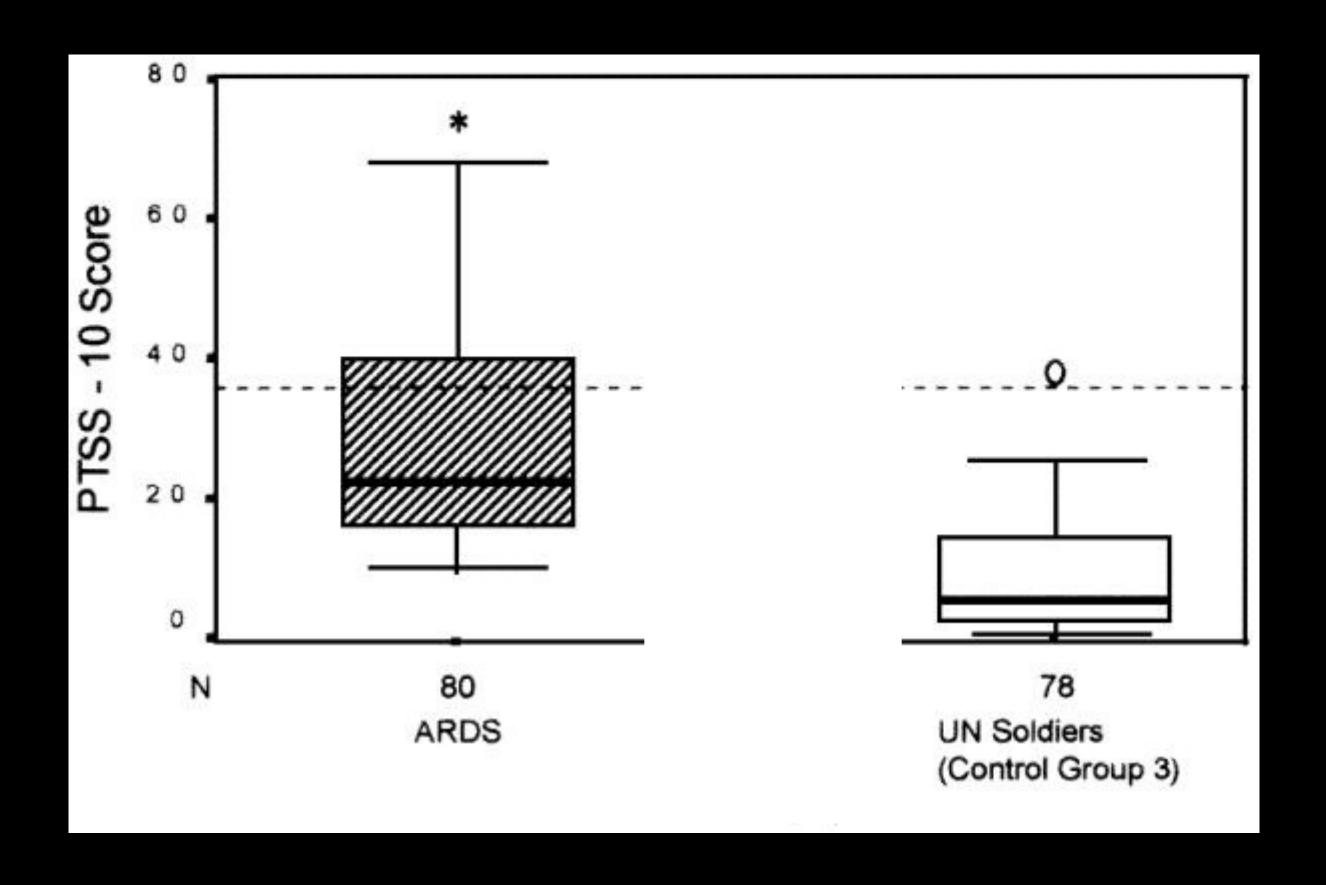
Syndrome de stress post traumatique (PTSD)





SSPT: trouble anxieux sévère qui se manifeste à la suite d'une expérience vécue comme traumatisante (attentats, viol, guerre...).

Health-related quality of life and posttraumatic stress disorder in survivors of the acute respiratory distress syndrome.



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In summary, young, previously working patients with ARDS who have few coexisting illnesses may not recover completely and may have ongoing functional limitations after an episode of critical illness. This may be attributed to persistent ICU-acquired weakness, in addition to a variety of other physical and mental health impairments. Family members may also have psychological dysfunction, which may further compromise outcomes. The health burden of critical illness may be likened to that of chronic disease with similar health care utilization. Research priorities include a better understanding of the pathophysiology of ICU-acquired weakness and an evaluation of the effects of a customized, family-centered, rehabilitation program on longterm outcomes after a critical illness.

Impact d'un protocole de sédation?

Protocolized sedation effect on post-ICU posttraumatic stress disorder prevalence: A systematic review and network meta-analysis

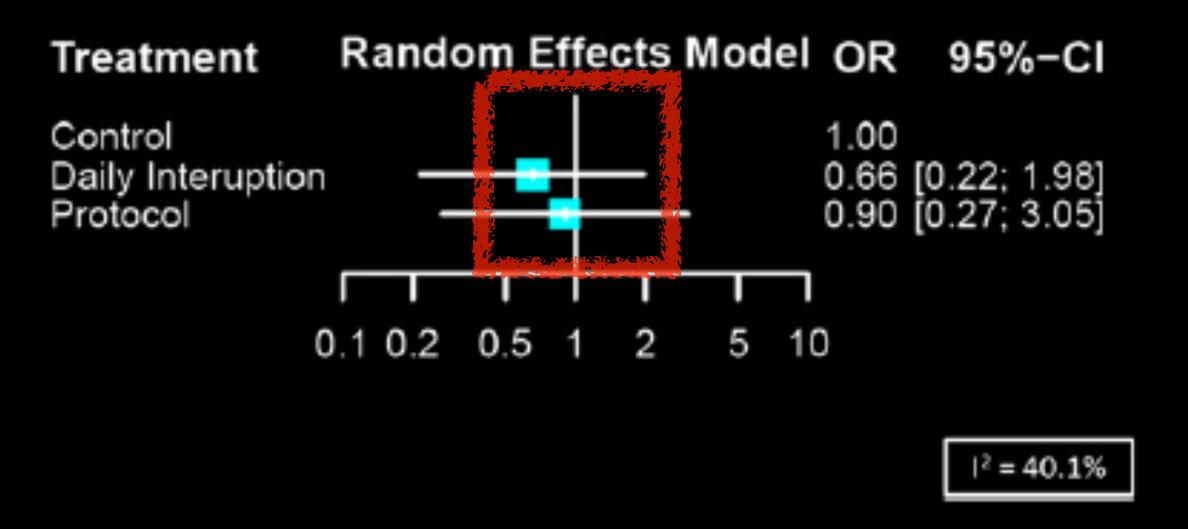
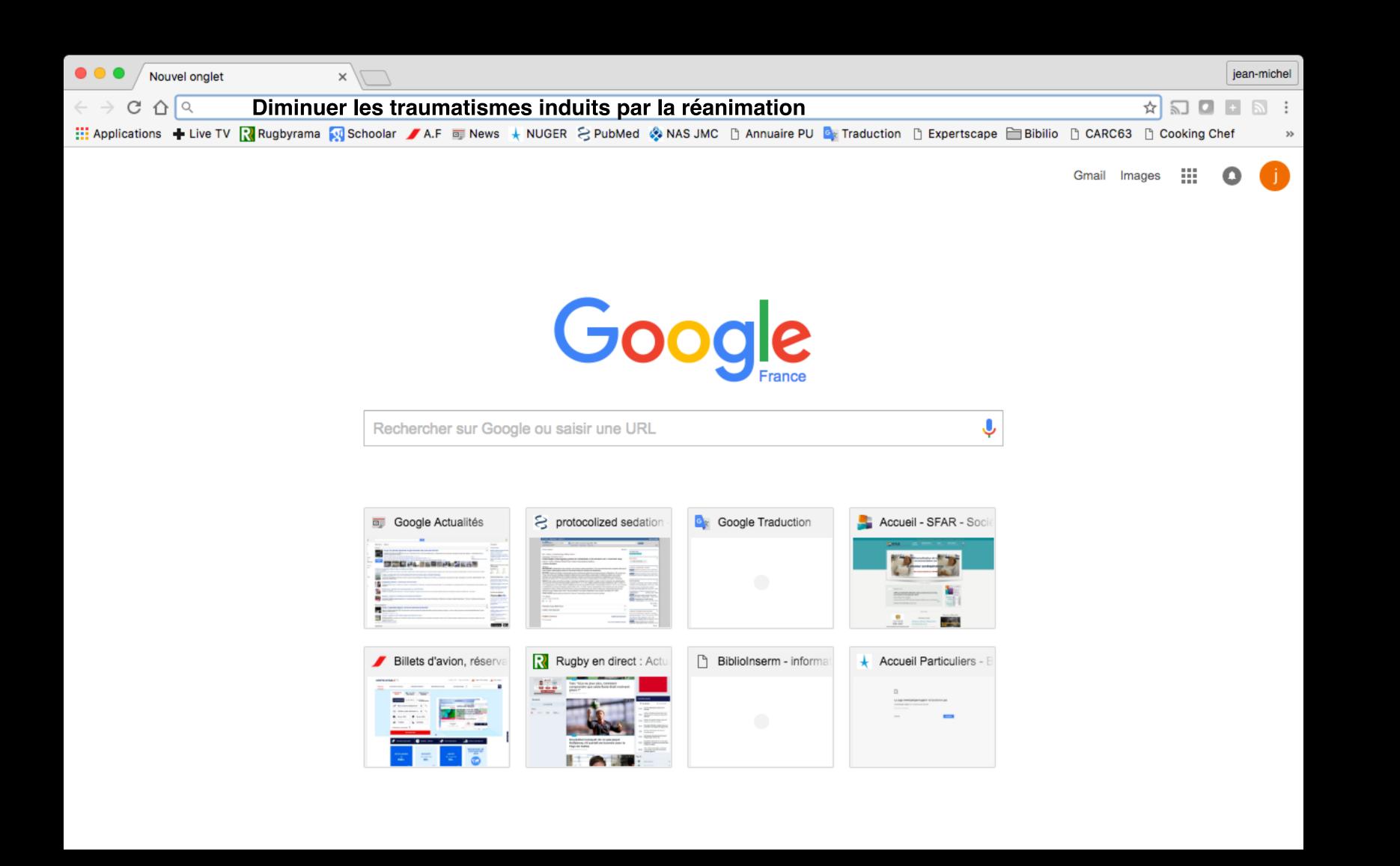


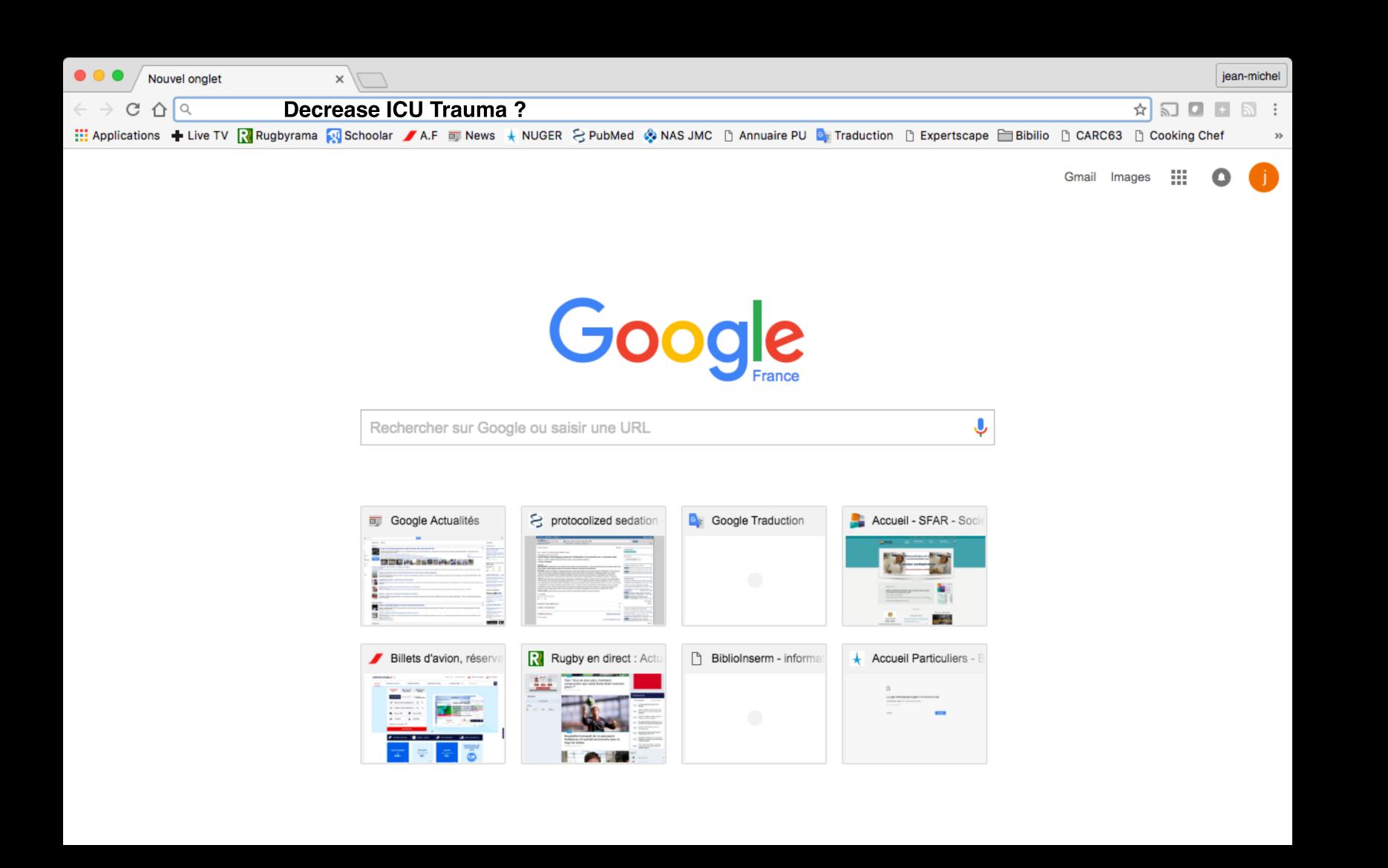
Fig. 3. Forest plot for PTSD prevalence.





Solutions?





"All the News That's Fit to Print"

The New York Times

Washington Edition

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OL. CLVIII No. 54,553

MONDAY, JANUARY 12, 2009

New Idea to Cut I.C.U. Trauma: Get Patients Up, Tubes and All

By GINA KOLATA

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Now, though, researchers say they are alarmed by what they are finding as they track patients for months or years after an I.C.U. stay. Patients, even young ones, can be weak for years. Some have difficulty thinking and concentrating or have post-traumatic stress disorder and terrible memories of nightmares they had while heavily sedated.

While patients may be suffering lingering effects from illnesses that brought them to the I.C.U.,

For years, doctors thought researchers are increasingly contients came out of an intensive or months on life support in the units can elicit unexpected, longlasting effects.

> So now some I.C.U.'s are trying what seems like a radical solution: reducing sedation levels and getting patients up and walking even though they are gravely ill, complete with feeding tubes, intravenous lines and tethers to

Even a few days in an I.C.U. can be physically devastating immediately afterward, said Dr. Naeem Ali of Ohio State Universi-

Continued on Page All

New Approach to Cut Trauma From I.C.U.: Get Patients Walking



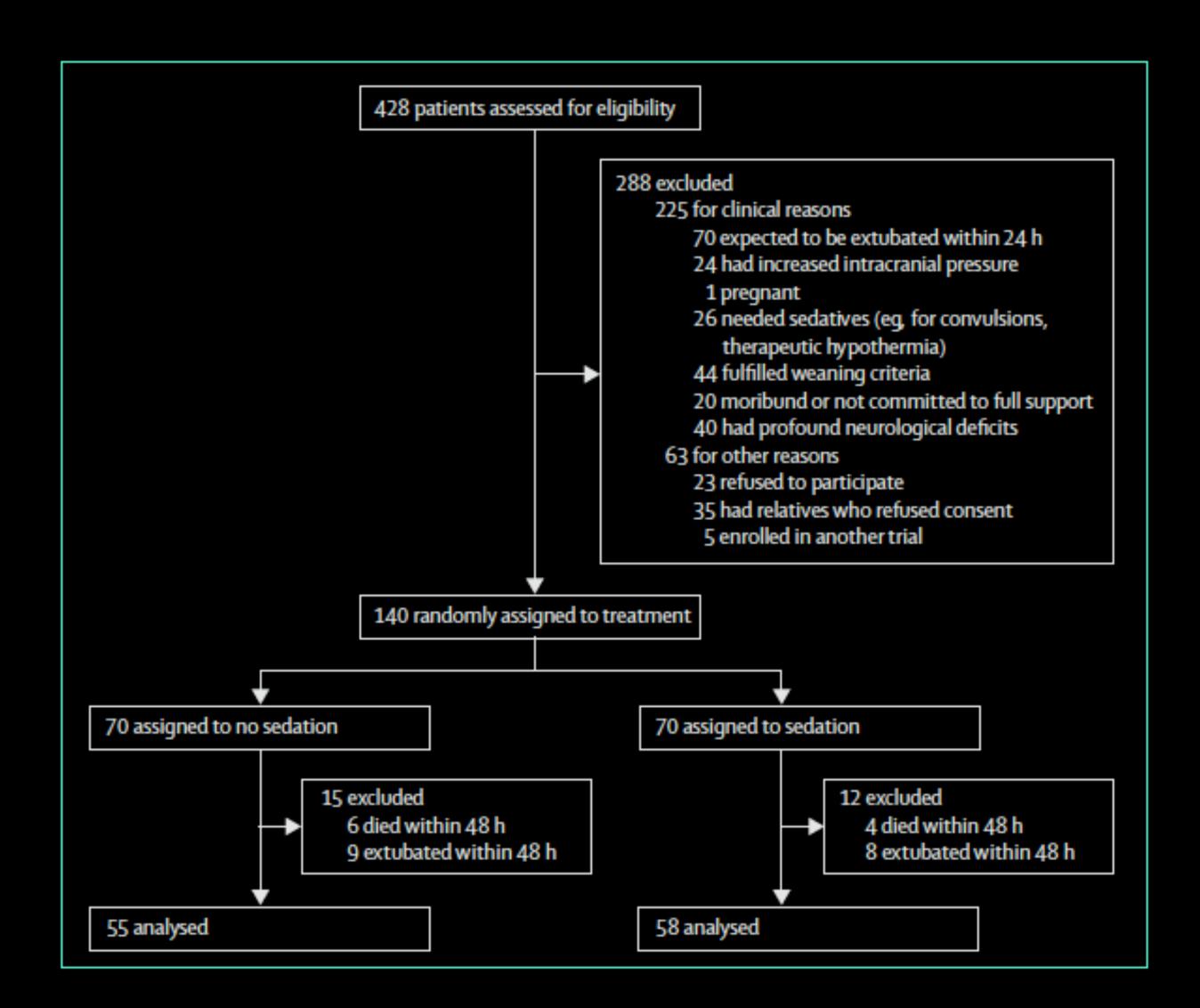


NO Sécation

A protocol of no sedation for critically ill patients receiving mechanical ventilation: a randomised trial



Thomas Strøm, Torben Martinussen, Palle Toft



A protocol of no sedation for critically ill patients receiving mechanical ventilation: a randomised trial



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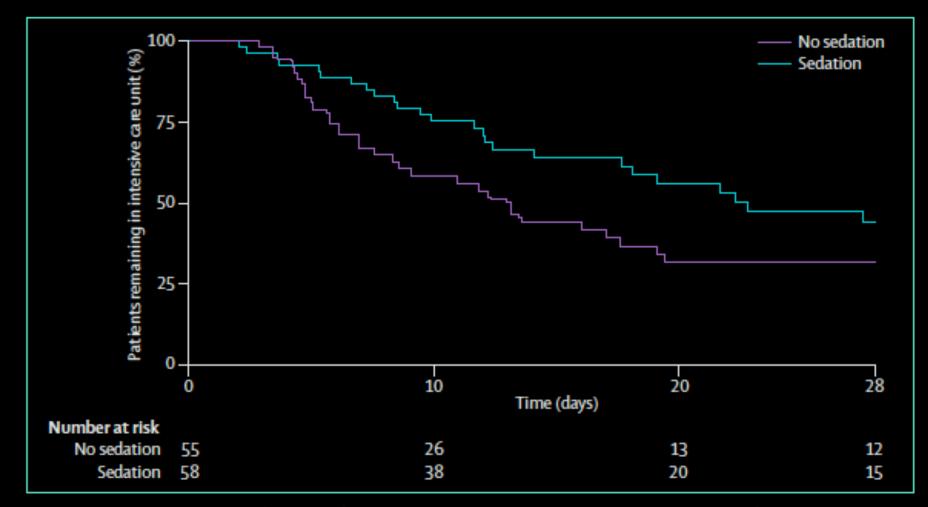


Figure 2: Kaplan-Meier plot of length of stay in the intensive care unit and number at risk from admission to 28 days

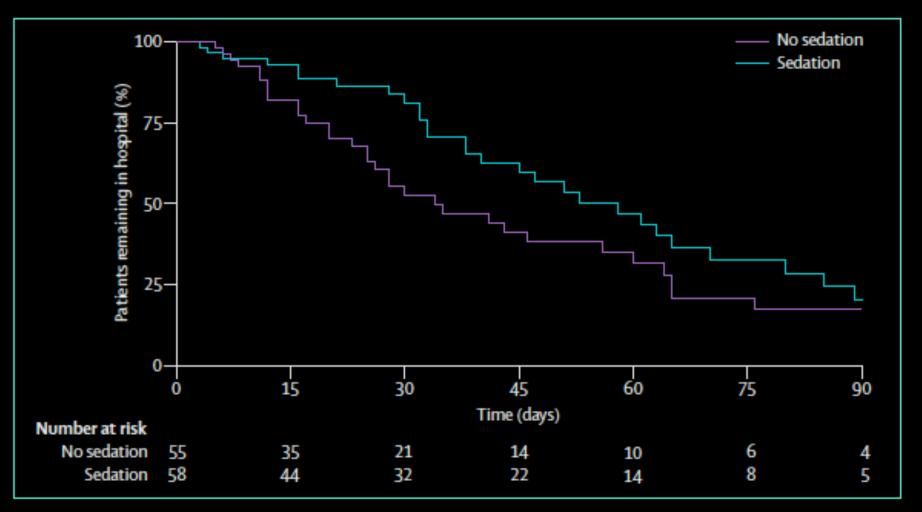


Figure 3: Kaplan-Meier plot of length of stay in hospital and number at risk from admission to 90 days

A protocol of no sedation for critically ill patients receiving mechanical ventilation: a randomised trial



Thomas Strøm, Torben Martinussen, Palle Toft







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Continued on Page All





Il faut sédater les patients

Sédation légère

Sédation Coopérative



Réhabilitation précoce

C'est mieux de ne pas sédater!

Atrophie Diaphragme

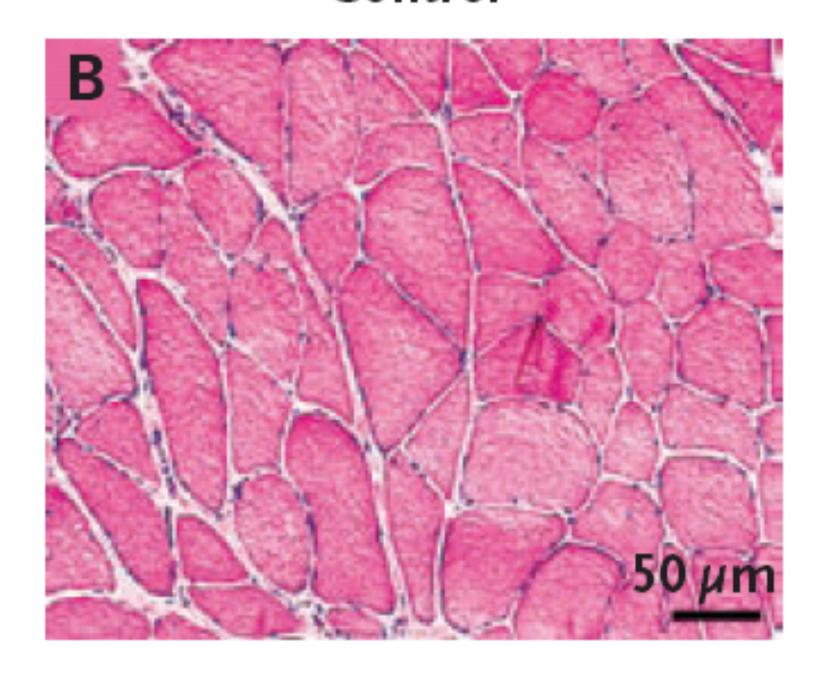
Short-term MV

2 - 3 hours

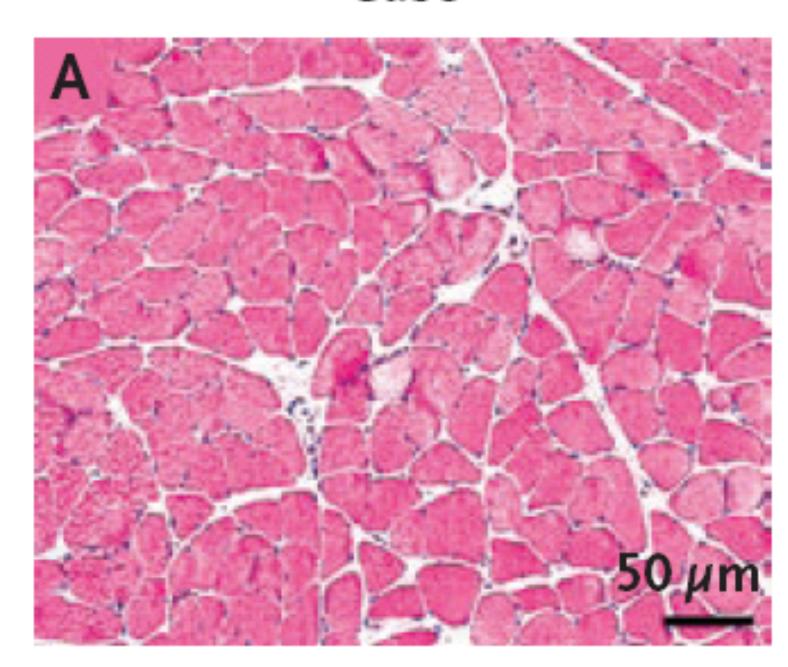
Prolonged MV

18 - 69 hours

Control

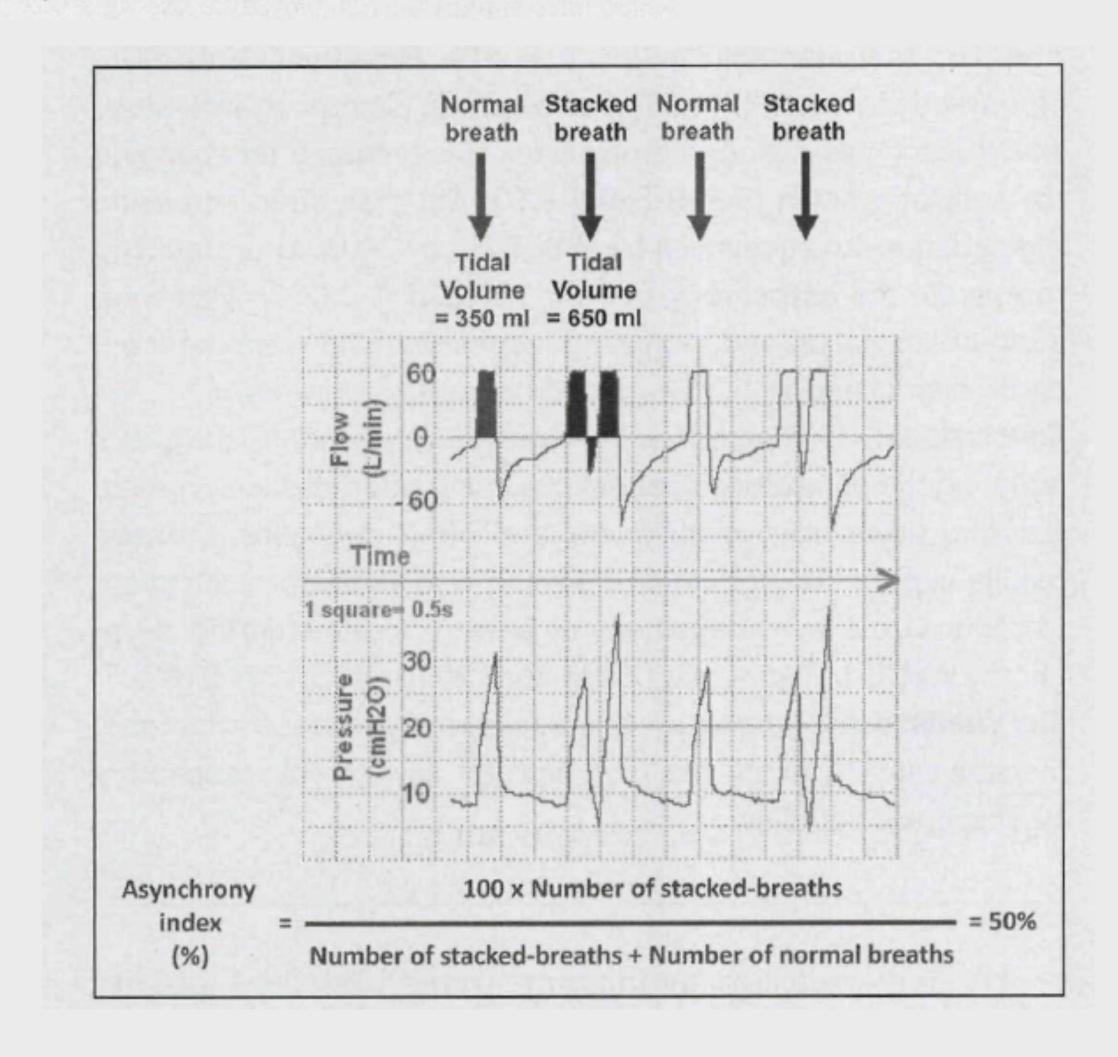


Case



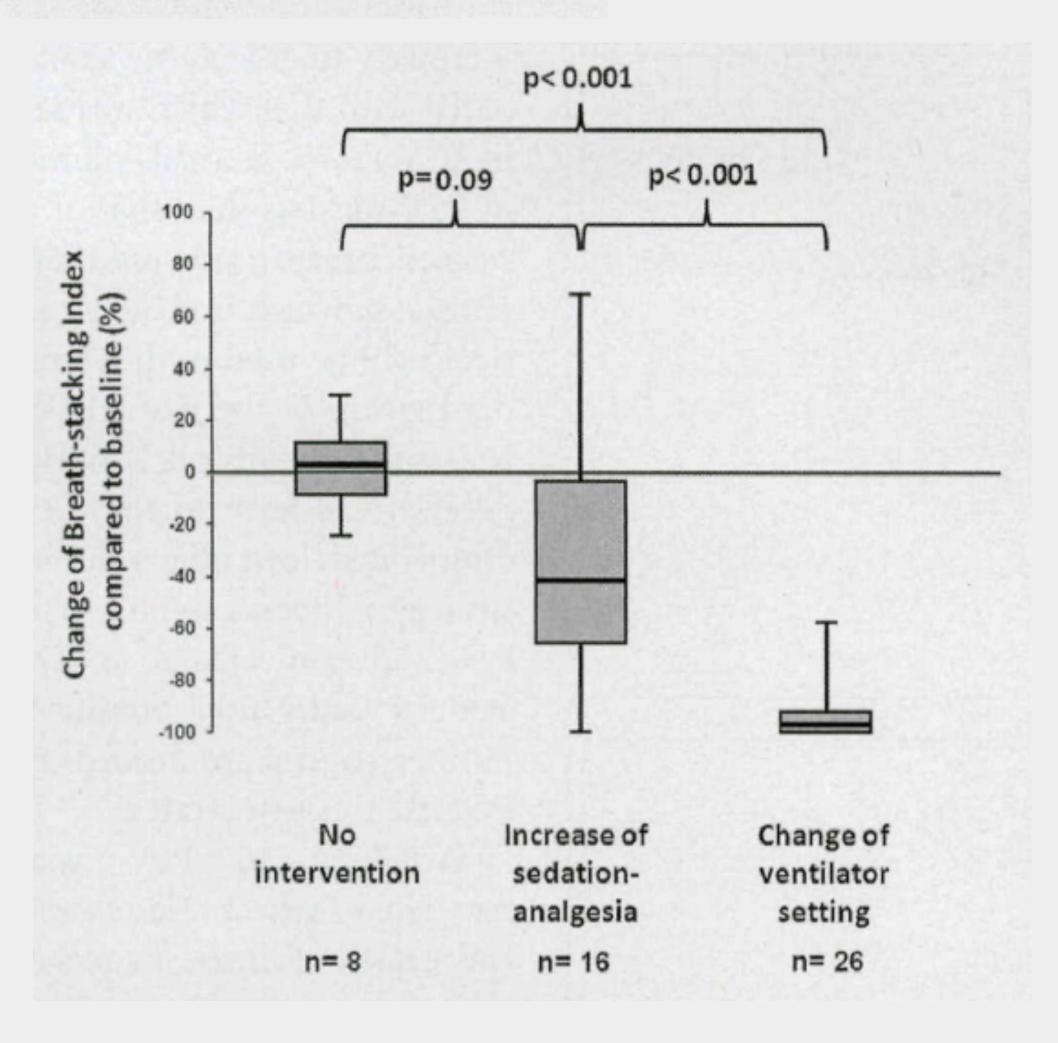
Impact of Ventilator Adjustment and Sedation– Analgesia Practices on Severe Asynchrony in Patients Ventilated in Assist-Control Mode*

Gerald Chanques, MD¹⁻³; John P. Kress, MD¹; Anne Pohlman, MSN¹; Shruti Patel, MD¹; Jason Poston, MD¹; Samir Jaber, MD^{2,3}; Jesse B. Hall, MD¹



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Adapter le patient au ventilateur

Adapter le patient au ventilateur

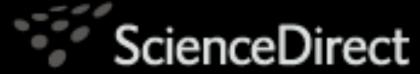
Adapter le ventilateur au patient



Conclusion



Disponible en ligne sur www.sciencedirect.com



Annales Françaises d'Anesthésie et de Réanimation 27 (2008) 541-551



http://france.elsevier.com/direct/ANNFAR/

Texte long du jury

Sédation-analgésie en réanimation (nouveau-né exclu)[№] Sedation and analgesia in intensive care (with the exception

of new-born babies)



Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit

Clinical Practice Guidelines for the Prevention and Management of Pain, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult Patients in the ICU

Question. Should a pharmacologic agent lys no use of this Pharmacologic Prevention and Treatment a benzodi. Cardiac Surgery Surgical Patients Not Undergoling MOBILIZATION)

Survivors of critical including Total accoming muscle including total including INMOBILIZATION)

INMOBILIZATION)

CHARLIZATION Prevention. **Physical** critically ill adults? with PAIN **DELIRIUM Light Sedation**

Daily Sedative Interruption/Nurse-Protocolized Sedation

Question: In critically ill, intubated adults, is there a differce between daily sedative interruption (DSI) protocols and

sessment

Survivors of critical illness frequently experience many long-term sequelae, including ICU-acquired muscle weakness

Objective Sedation Monitoring and siety requently administered to phy, and evoked potentials) useful in managing stion related harr

Opioids remain a mainstay for pain management in most ICU settings. However, their side effects preoccupy clinicians because of

Pharmacologic Adjuvants to Opioid Therapy

AGITATION Sedatives are frequently administered to critically ill patients from morhanically ven. Sedatives are trequently authorized to relieve anxiety, reduce the stress of being mechanically ven-

Question: Should noise and light reduction strategies (vs not using these strategies) be used at night to improve sleep in

Protocol-Based Pain Assessment and Management

AGITATION/SEDATION

Question: Should a protocol-based (analgesia/analgosedation) ain assessment and management program be used in the care

Pain management is complex because pain patterns are highly individual (e.g., acute, chronic, and acute-on-chronic), it arises

Delirium is common in critically ill adults. The delirium encountered in the ICU and other settings are assumed to be equivalent pathophysiologic states. Delirium is a clinical diag-

Pharmacologic Interventions to Reduce Procedural Pain Bedside procedures in the ICU can include regular activities (e.g., turning) and discrete procedures (e.g., arterial catheter ian) Dain chauld be accessed and appropriate

Poor sleep is a common complaint and a source of distress for constants (A2C A27) close dismension in the Poor sleep is a common complaint and a source of disruption in the many critically ill patients (436, 437). Sleep disruption on the control of the control o many crucally in patients (430, 437). Sleep disruption in the critically ill can be severe and is characterized by sleep fragment critically ill can be severe and is characterized links abnormal circadian rhythms increased links abnormal circadian rhythms. SLEEP DISRUPTION Ubjecti critically ill can be severe and is characterized by sleep (stage critically ill can be severe and is characterized by sleep (stage critically ill can be severe and is characterized by sleep (stage critically ill can be severe and is characterized by sleep tragmentally increased light sleep (stage critically ill can be severe and is characterized by sleep tragmentally increased light sleep (stage critically ill can be severe and is characterized by sleep tragmentally ill can be severe and is characterized by

Question: Does light sedation (vs deep sedation), regardless of the sedative agent(s) used, significantly affect outcomes in critically ill, mechanically ventilated adults?

Nonpharmacologic Interventions to Reduce Pain Question: Should a Pharmacologic agent (vs no use of this Pharmacologic Prevention and Treatment

Prevention.

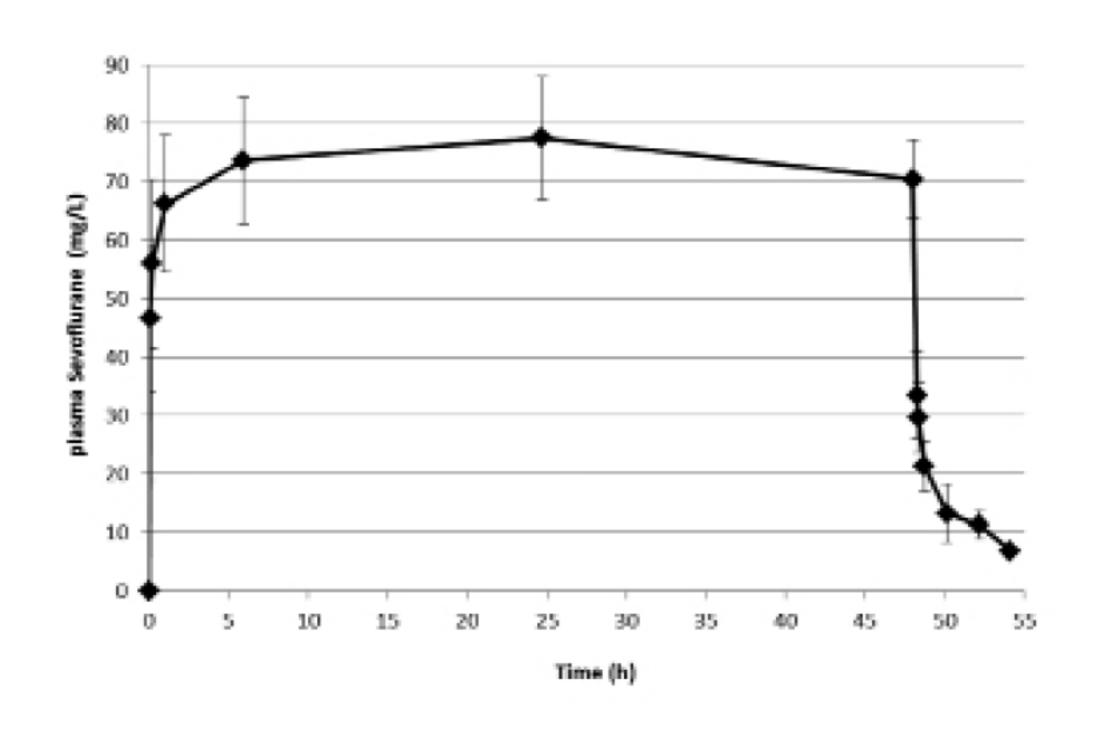
Faut-il sédater les patients en réanimation?

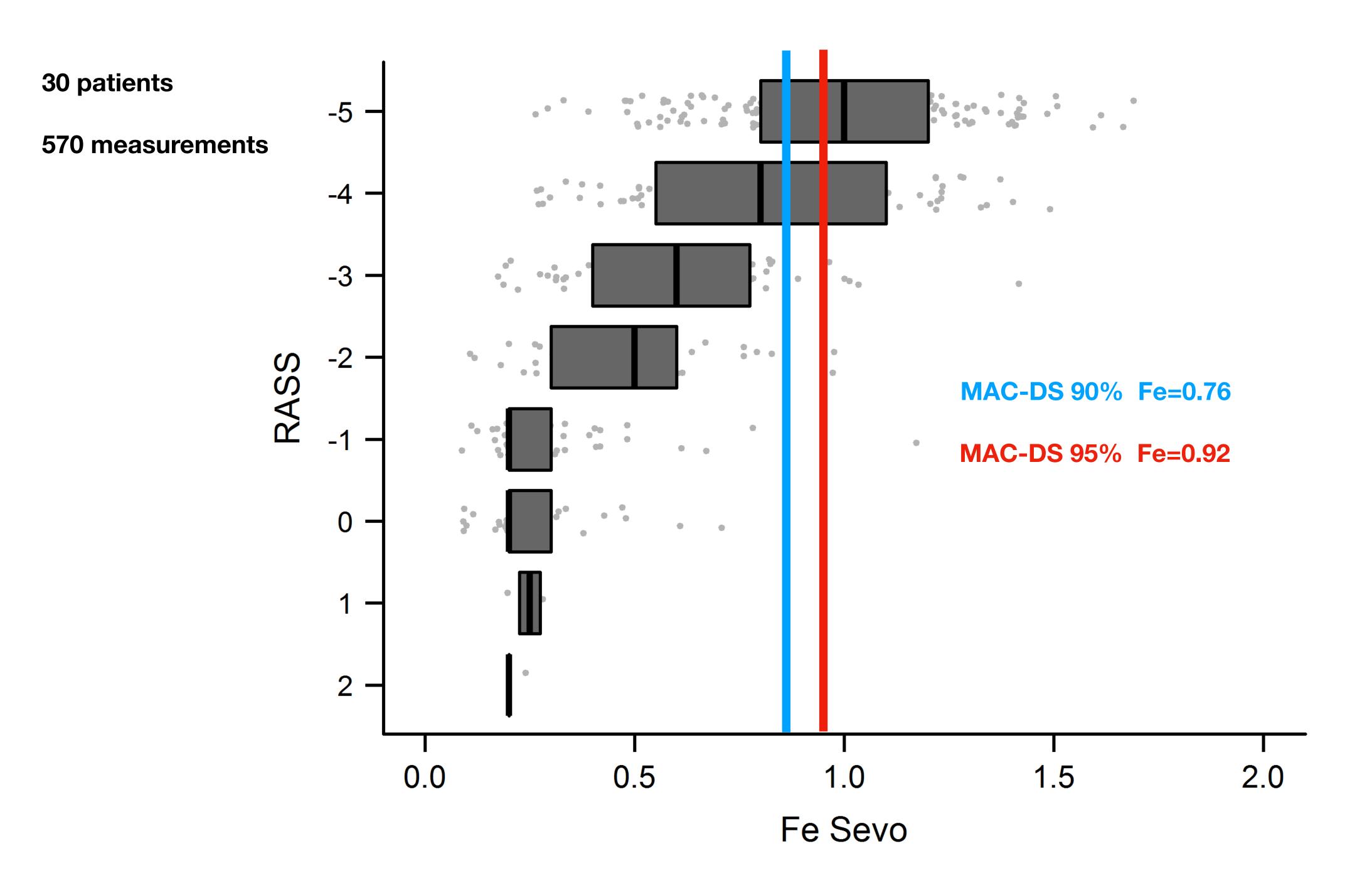
POULE

POULT

la sédation profonde quand on en a besoin

Sevoflurane





POULE

Arrêt des sédations profondes inutiles

Contre

Absence de sedation, contention mécanique, agitation, douleur, stress ...



POULE

Sédation légère et coopérative

centrée sur le patient



Merci de votre attention ...