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Título: MANUAL VS. TARGET-CONTROLLED INFUSION INDUCTION WITH PROPOFOL: AN OBSERVATIONAL STUDY
Scientific and Technological Research

Manual vs. target-controlled infusion induction with propofol: An observational study

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ABSTRACT

Background: Target-controlled infusion (TCI) systems allow the administration of drug to achieve a target blood or site-effect concentration. We determine induction and recovery times and the amount of drug used with TCI systems vs. manual induction.

Objective: To determine whether the induction of propofol TCI and manual infusion are two comparable techniques.

Methods: A retrospective observational study was conducted in which sixty-two ASA I-II patients scheduled for elective surgery received induction using TCI or manually. Anesthetic induction was achieved with remifentanil (0.25 μg/kg/min) and propofol (manual bolus injection: 2 mg/kg, or target blood concentration: 5 μg/ml with the TCI system (Marsh model)] with maintenance doses of remifentanil (0.15 μg/kg/min) and propofol (manually 0.10 mg/kg/min or 2.5–4 μg/ml using the TCI system). In both groups, rocuronium bromide was used (induction and maintenance doses: 0.6 and 0.3 mg/kg, respectively) as was morphine (0.1 mg/kg) 45 min before the end of the surgery.

We measured: induction, operative and recovery mean times; bispectral index, heart rate, blood pressure, costs, haemodynamic instability, and intraoperative awareness. A telephone questionnaire was administered 1 month later.

Results: The mean induction time was longer in the TCI than the manual group (1.76 ± 0.94 vs. 0.9 ± 0.4 min, p < 0.001), but the total dose of propofol (TCl: 112.4 ± 60.9 vs. manual: 133.8 ± 80.3 ml, p = 0.241) tended to be smaller and the recovery time was significantly shorter (TCl: 7.48 ± 3.1 vs. manual: 10.3 ± 4.9 min) (p = 0.008).

Conclusions: Induction with propofol using TCI is similar to manually delivered propofol.

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SEGUNDO CLASIFICADO, dotado con 300 € y Diploma

Autora: Dra. Sonsoles María Velilla Zancada

Revista: Wolters Kluwer Health

Título: IMPACT OF VARIATIONS IN BLOOD PRESSURE WITH ORTHOSTATISM ON MORTALITY: THE HOMO STUDY
Impact of variations in blood pressure with orthostatism on mortality: the HOMO study
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Objective The aim of this study was to determine the impact of orthostatic hypotension (OH) and orthostatic hypertension (OHT) on all-cause mortality.

Patients and methods A total of, 1176 adults from the community over 18 years of age were included in this ambispective study. The mean follow-up was 9.4 years. OH and OHT were defined as a decrease or an increase, respectively, in systolic blood pressure (SBP) of at least 20 mmHg and/or diastolic BP of at least 10 mmHg from sitting to standing position at 1 and/or 3 min after standing. The impact of systolic or diastolic OH and systolic or diastolic OHT at 1 and 3 min after standing was also analyzed separately.

Results In total, 135 individuals died during the follow-up. Neither OH (hazard ratio (HR) 1.23; 95% confidence interval (CI): 0.72–2.10) nor OHT (HR 0.90; 95% CI: 0.59–1.38) was associated with all-cause mortality in the adjusted models. In contrast, systolic OHT at 3 min (HR 2.31; 95% CI: 1.14–4.68) was independently associated with global mortality.

Introduction Blood volume is redistributed after standing, leading to the activation of different compensatory mechanisms to maintain blood pressure (BP). Thus, in the upright position, baroreceptors are activated, resulting in an inhibition of the parasympathetic nervous system and an activation of the sympathetic nervous system. This activation increases plasma noradrenaline and adrenaline levels, as well as plasma renin activity, leading to an increase in peripheral artery resistance and cardiac output that reduce BP variations [1,2]. In those patients in whom these mechanisms are altered, such as those with autonomic damage or with arterial stiffness, an excessive fall in BP after postural change can be observed [1,3]. Moreover, some drugs may cause or contribute to excessive BP decline with orthostasis, such as α-blockers, diuretics, angiotensin-II antagonists, angiotensin-converting enzyme inhibitors, calcium antagonist, or tricyclic antidepressants [4]. It must be taken into account that a combination of different mechanisms is the most frequent cause. However, in some patients the accumulation of blood in legs after standing may result in an exaggerated response, with marked increases in noradrenaline that rise BP values after standing [5–7].

Orthostatic hypotension (OH) has been defined by consensus as a decrease in systolic blood pressure (SBP) of at least 20 mmHg and/or diastolic blood pressure (DBP) of at least 10 mmHg within 3 min after standing [8]. As the reproducibility of the measurement of OH is poor [9], the prevalence of OH differs between different studies [10,11]. OH has been associated with age and other cardiovascular risk factors [12–14]. In the European guidelines for the management of hypertension, the evaluation of OH is recommended [15].

To assess OH, it is necessary to take into account those variables that can influence the value of BP, such as the rest time that precedes orthostatic change, the moment in which BP is determined, the measurement time after standing, the posture of the patient, and the posture of the arm. BP value may also depend on population variables, such as the type of population included.

Conclusion Systolic OHT at 3 min is associated with all-cause mortality. The determination of this parameter could add valuable prognostic information during the routine examination of patients.
PRIMER CLASIFICADO, dotado con 500 € y Diploma

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Revista: European Journal of Heart Failure

Título: ASSESSMENT OF BENDOPNEA IMPACT ON DECOMPENSATED HEART FAILURE
Assessment of bendopnea impact on decompensated heart failure

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Aims
We have often found that patients with heart failure had shortness of breath when bending forward. The frequency of bendopnea in patients with decompensated heart failure (DHF), its repercussions on quality of life (QoL), and its prognosis have not yet been studied. This study was carried out to evaluate the characteristics, degree of limitation, and short-term prognosis of patients with bendopnea and DHF.

Methods and results
We conducted a study of 250 patients admitted with DHF. Bendopnea was considered when shortness of breath occurred within 30 s of bending forward. It was present in 122 patients (48.8%). The mean time of onset was 13.4 ± 6.9 s. Patients with bendopnea presented a higher frequency of orthopnoea, paroxysmal nocturnal dyspnoea, oliguria, oedema, elevated jugular venous pressure, abdominal fullness, and worse functional class (NYHA) compared to those without it (P < 0.001). An enlargement of both atria was more frequent in these patients (P < 0.001). Pulmonary artery systolic pressure (PASP) was higher in the bendopnea group (P = 0.001). Body mass index and LVEF were not associated with presence of bendopnea. Subjective QoL limitation was present in 80.3% (95%CI: 74.6–85.7%) of patients with bendopnea (P = 0.01). Patients with bendopnea had a higher mortality rate (P = 0.025) and more advanced NYHA class (P = 0.001). Patients who died had a lower LVEF (P = 0.001), increased PASP (P = 0.08), and lower mean duration of shortness of breath than those who survived (P = 0.01).

Conclusion
Bendopnea is related to advanced HF symptoms and it is associated with mortality in the short term and advanced NYHA functional class. This symptom produces moderate to severe limitation of QoL.

Keywords
Bendopnea • Decompensated heart failure • Quality of life • Mortality

Introduction
Since the first description of heart failure (HF) made in the Eber’s Papyrus, several respiratory symptoms classified by body position [dyspnoea on exertion, orthopnoea, and paroxysmal nocturnal dyspnoea (PND)] have been specified. They have been used to establish HF diagnosis and the functional class (NYHA). We often find patients with HF who have shortness of breath. A new respiratory symptom has been reported, experienced while bending forward when putting on shoes or tying them up, secondary to HF, called bendopnea or flexodyspnoea.1–2 This symptom has been related to an increase in cardiac filling pressures.1 Its frequency, repercussions on quality of life (QoL), and prognosis (mortality and readmission) are uncertain. We conducted the present study to evaluate the characteristics, degree of limitation, and short-term prognosis of patients with bendopnea and HF.

Methods
We evaluated patients with decompensated heart failure (DHF) admitted to our Internal Medicine Department from February 2014 to July 2014 after 6-month follow-up. Demographic information [age, sex, body mass index (BMI), and NYHA class1], HF symptoms in the previous week (dyspnoea, orthopnoea, PND, oedema, ascites, oliguria, abdominal fullness, and palpitations), HF signs (jugular venous pressure increase, hepatomegaly, pleural effusion, and cardiomegaly), and echocardiographic data in the last 3 months [dilatation of cardiac cavities, LVEF and pulmonary artery systolic pressure (PASP)] were

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Correction added on 10 August 2016, after first online publication. “bendopnea” corrected to “bendopnea” throughout the article. Author’s name corrected to Laila El Bikri.
CONCURSO DE POSTERS
TERCER CLASIFICADO, dotado con 100 € y Diploma

Autora: Dra. Cristina Arina Cordeu

Título: PRECISIÓN EN LA UBICACIÓN DE LOS ELECTRODOS PRECORDIALES DEL ECG ENTRE TÉCNICOS SANITARIOS, DUES, MÉDICOS RESIDENTES Y ADJUNTOS.
Comunicación oral

PRECISIÓN EN LA UBICACIÓN DE LOS ELECTRODOS PRECORDIALES DEL ECG ENTRE MÉDICOS ADJUNTOS, RESIDENTES, ENFERMEROS y TÉCNICOS

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Raquel Sáenz Ortega, Alexandra Ibáñez Leza, Jaione González Aguilera.
SEGUNDO CLASIFICADO, dotado con 200 € y Diploma

Autora: Dra. Patricia Santos Holgueras

Título: IMÁGENES TARDÍAS DE GAMMAGRAFÍA CON LEUCOCITOS MARCADOS (GLM) ¿PUEDEN SUSTITUIR A LA GAMMAGRAFÍA DE MÉDULA ÓSEA (GMO)?
IMÁGENES TARDÍAS DE GAMMAGRAFÍA CON LEUCOCITOS MARCADOS (GLM) ¿PUEDEN SUSTITUIR A LA GAMMAGRAFÍA DE MÉDULA ÓSEA (GMO)?

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PRIMER CLASIFICADO, dotado con 300 € y Diploma

Autora: Dra. Valentina Fernández Ladrón

Título: SOSPECHA DE CORIOAMNIONITIS Y FIEBRE INTRAPARTO EN LAS GESTANTES DEL HOSPITAL SAN PEDRO DE LOGROÑO: UN ESTUDIO OBSERVACIONAL PROSPECTIVO
SOSPECHA DE CORIOAMNIONITIS Y FIEBRE INTRAPARTO EN LAS GESTANTES DEL HOSPITAL SAN PEDRO DE LOGROÑO: UN ESTUDIO OBSERVACIONAL PROSPECTIVO.


HOSPITAL SAN PEDRO LOGROÑO. LA RIOJA
TERCER CLASIFICADO, dotado con 100€ y Diploma

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Título: Nuche Rebelde (Miasis)
NUCHE REBELDE
SEGUNDO CLASIFICADO, dotado con 200€ y Diploma

Autor: Dr. Francisco Miguel Martín González

Título: Presión Asistencial
PRIMER CLASIFICADO, dotado con 300€ y Diploma

Autor: Dr. Jesús María Gutiérrez de Bobadilla

Título: Iridodiálisis y Sinequias