

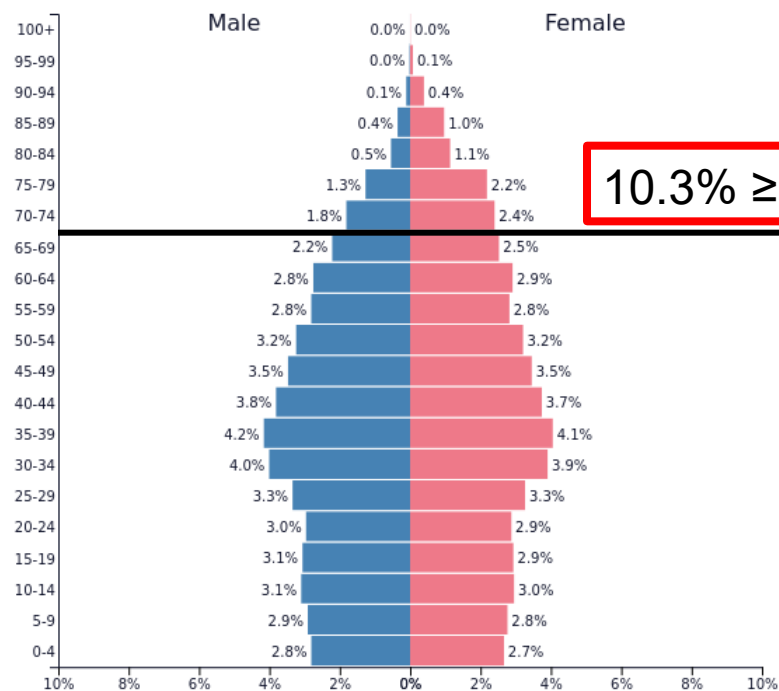
Patients âgés et réanimation

SRLF - 2025

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B Guidet
MIR, Hôpital Saint Antoine, Paris
Sorbonne Université

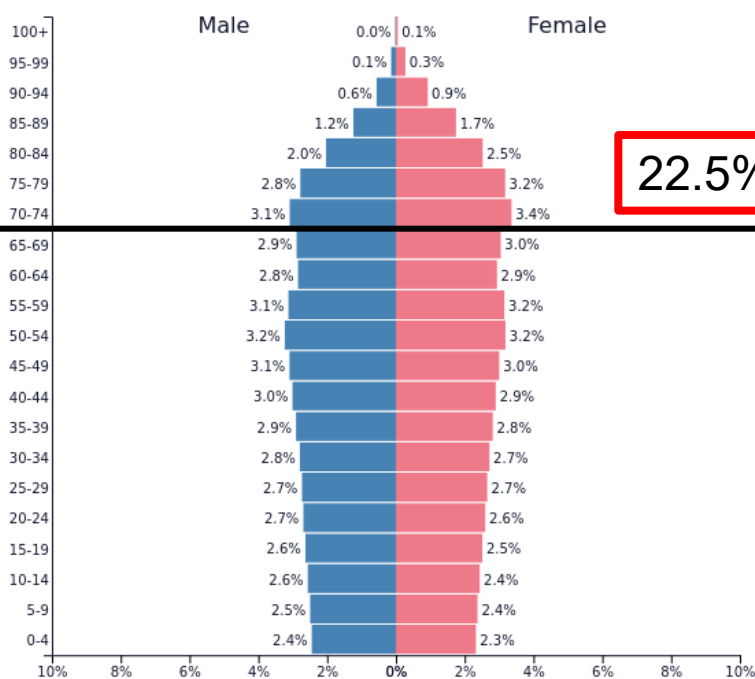
Pyramide des âges – Europe de l'Ouest



10.3% ≥ 70

PopulationPyramid.net

Western Europe - 2000
Population: 182,338,687



22.5% ≥ 70

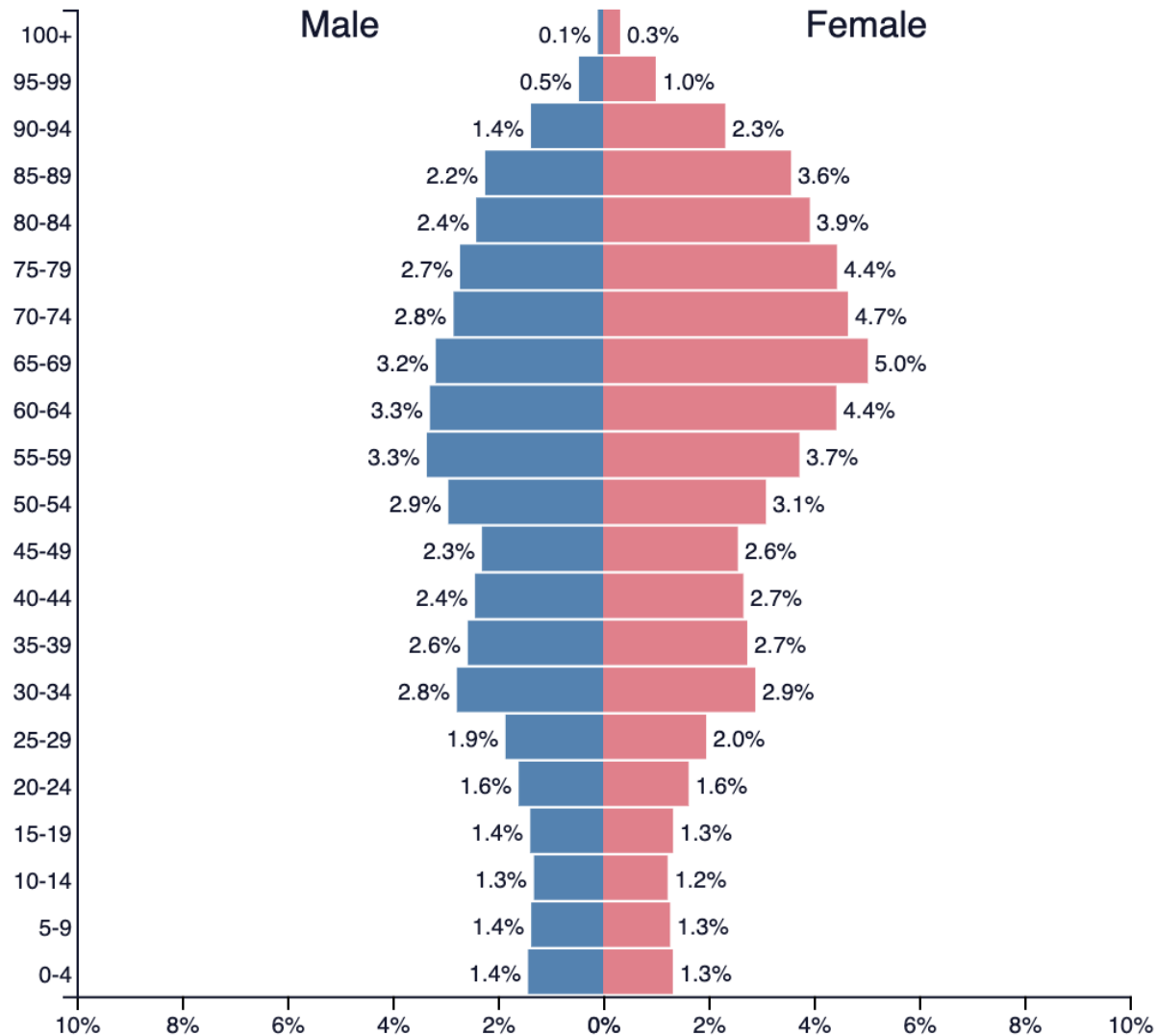
PopulationPyramid.net

Western Europe - 2040
Population: 198,747,904

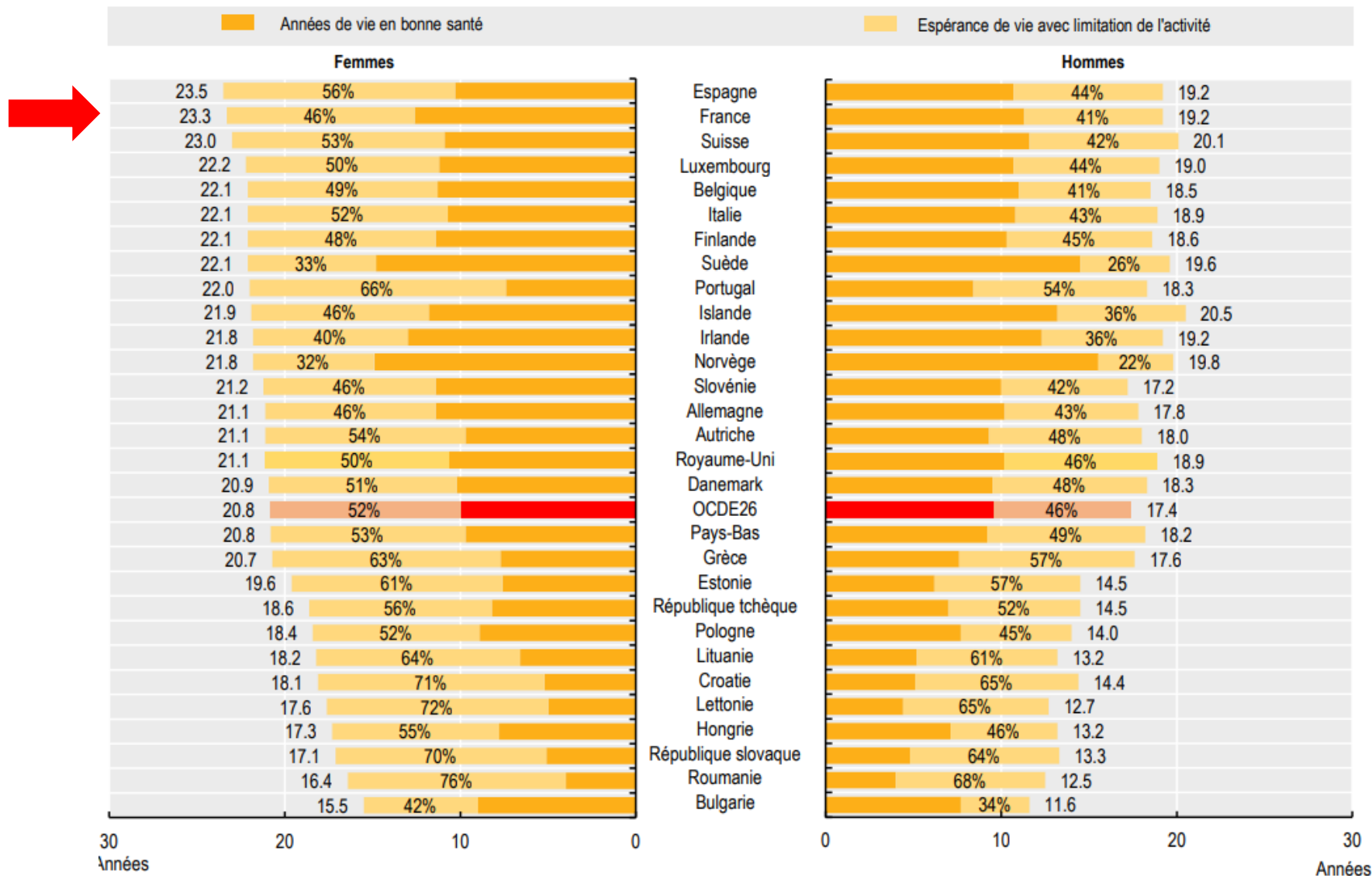
China, Hong Kong SAR ▼

2050

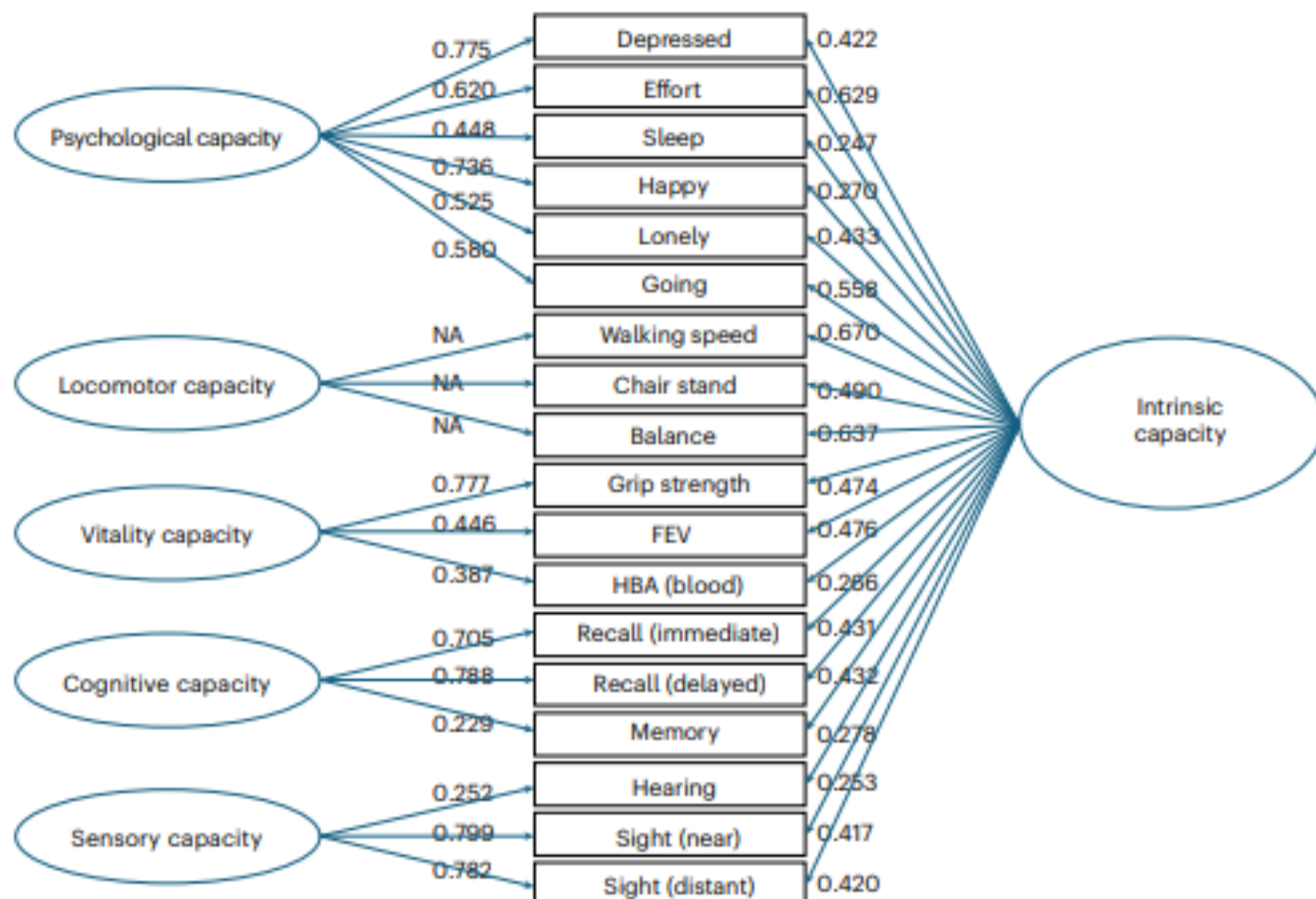
Population: 6,975,390



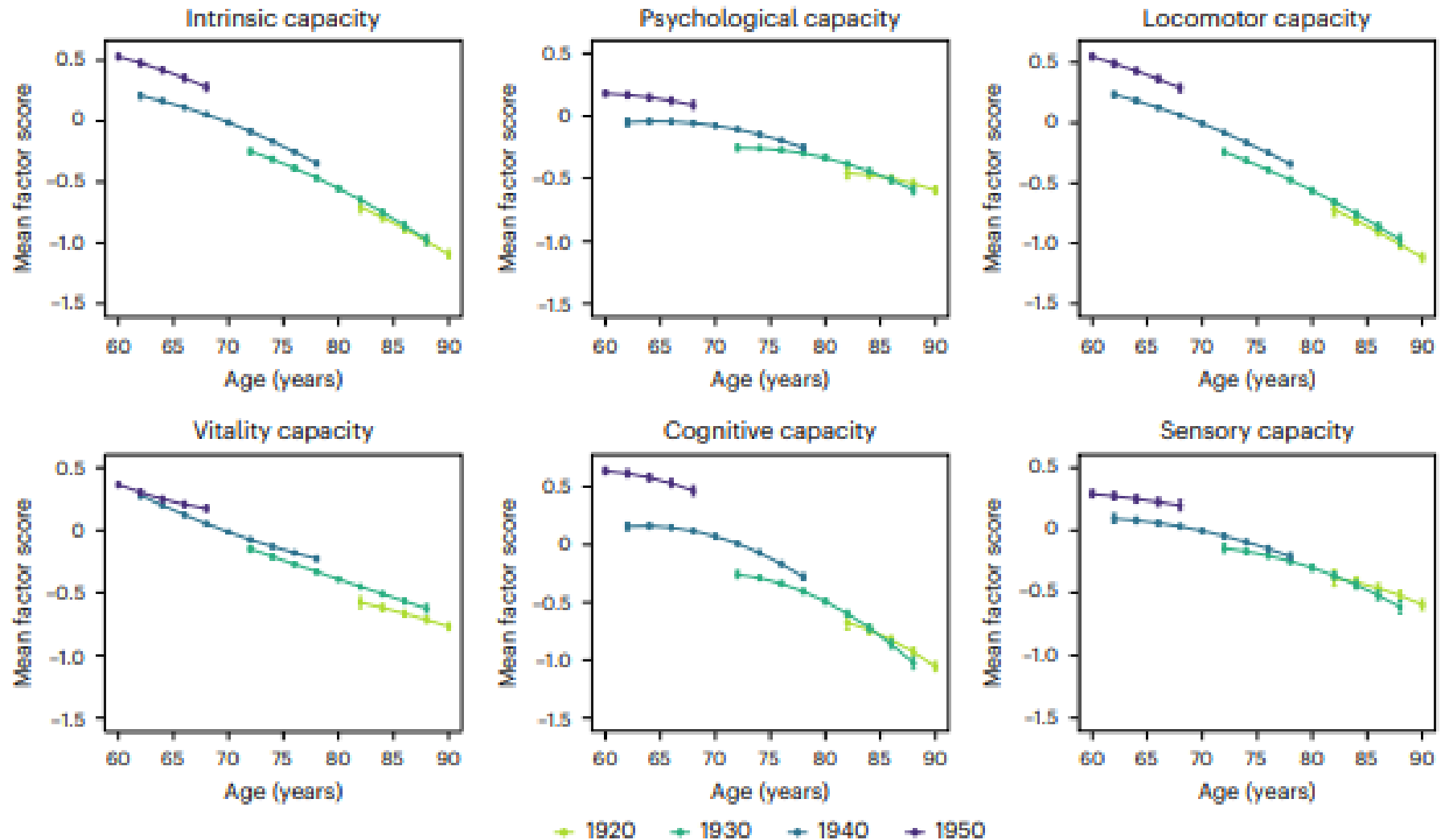
Espérance de vie à 65 ans (Données OCDE) avec et sans limitation de l'activité



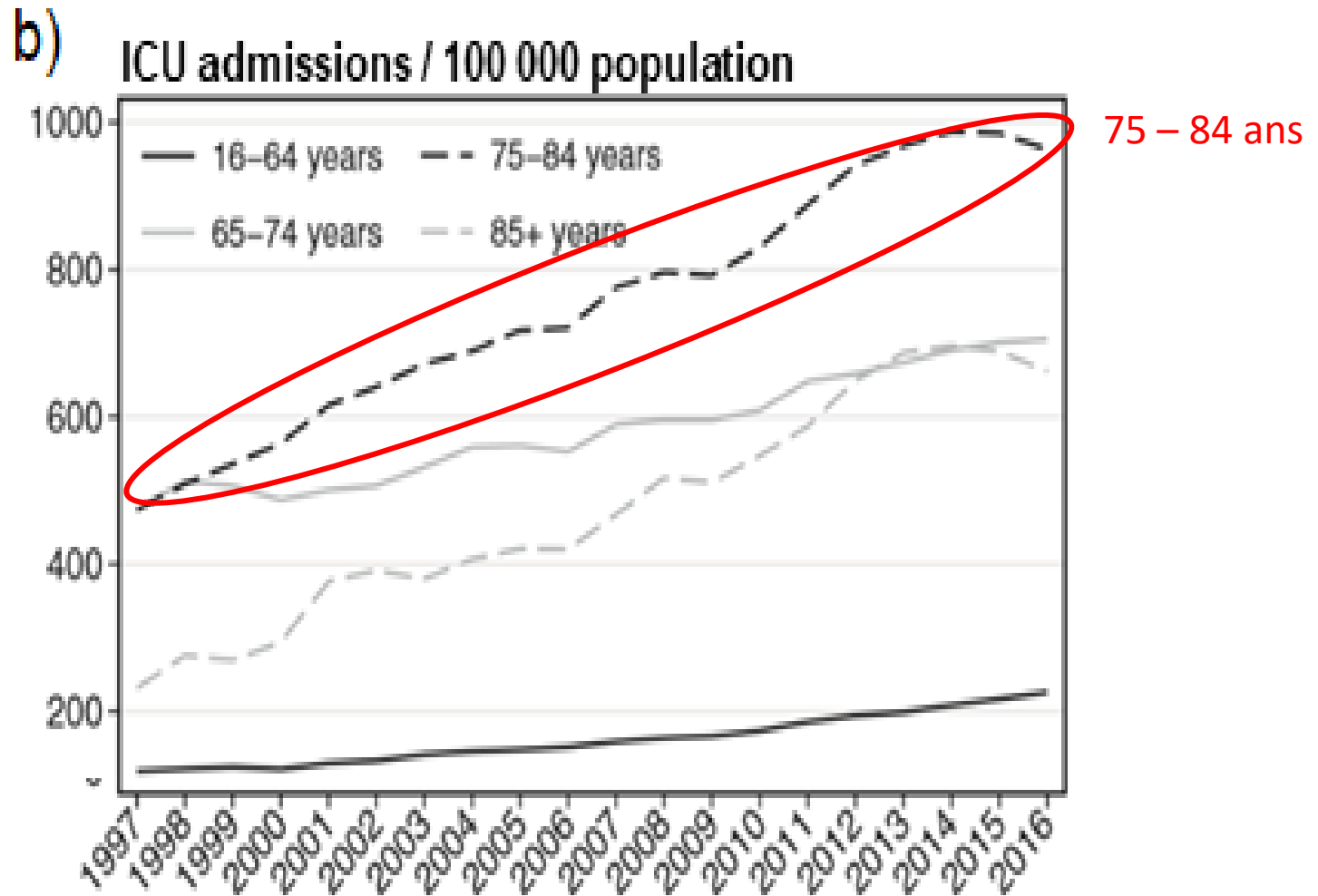
Cohort trends in intrinsic capacity in England and China



Amélioration avec le temps



Patients âgés en réanimation



Attentes qualitatives plus que quantitatives

- Etat fonctionnel et indépendance
- Engagement social
- Prévention de la dégradation physique et mentale

Adaptation de l'offre à la demande:

Sondage ESICM 2019

Pourrez-vous augmenter les admissions?

- Non: 30%
- Un peu : 37%

Si le nombre de lits de réanimation n'augmente pas

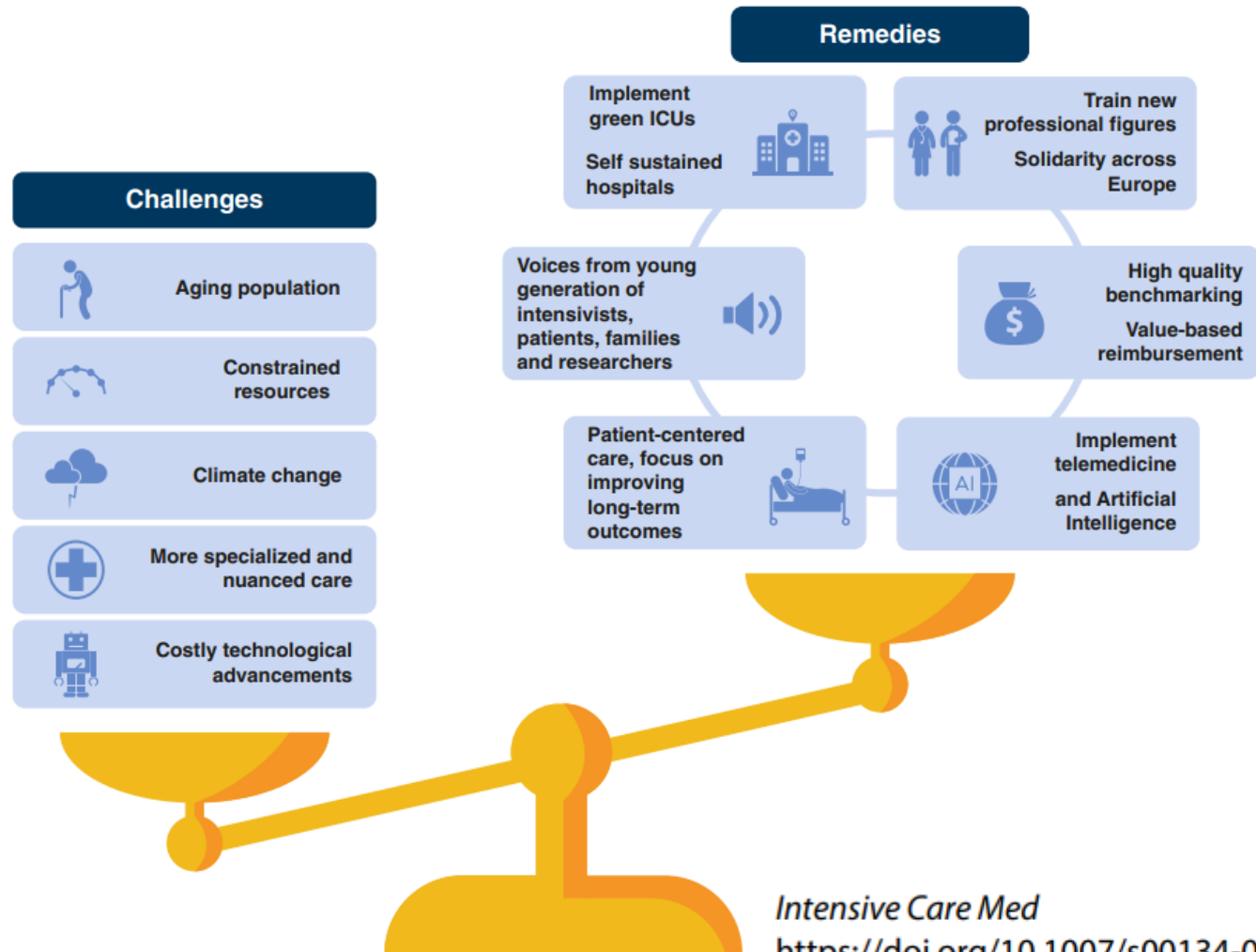
- Il faut améliorer la priorisation d'accès : 66%
- Il faut développer les unités intermédiaires : 33%

Quels outils pour aider à la décision d'orientation?

- Intégrer le souhait du patient : 37%
- Evaluer la fragilité : 36%

Economic sustainability of intensive care in Europe

Maurizio Cecconi^{1,2*} , Claudia D. Spies³ and Rui Moreno^{4,5}



Intensive Care Med

<https://doi.org/10.1007/s00134-023-07268-5>

Questions

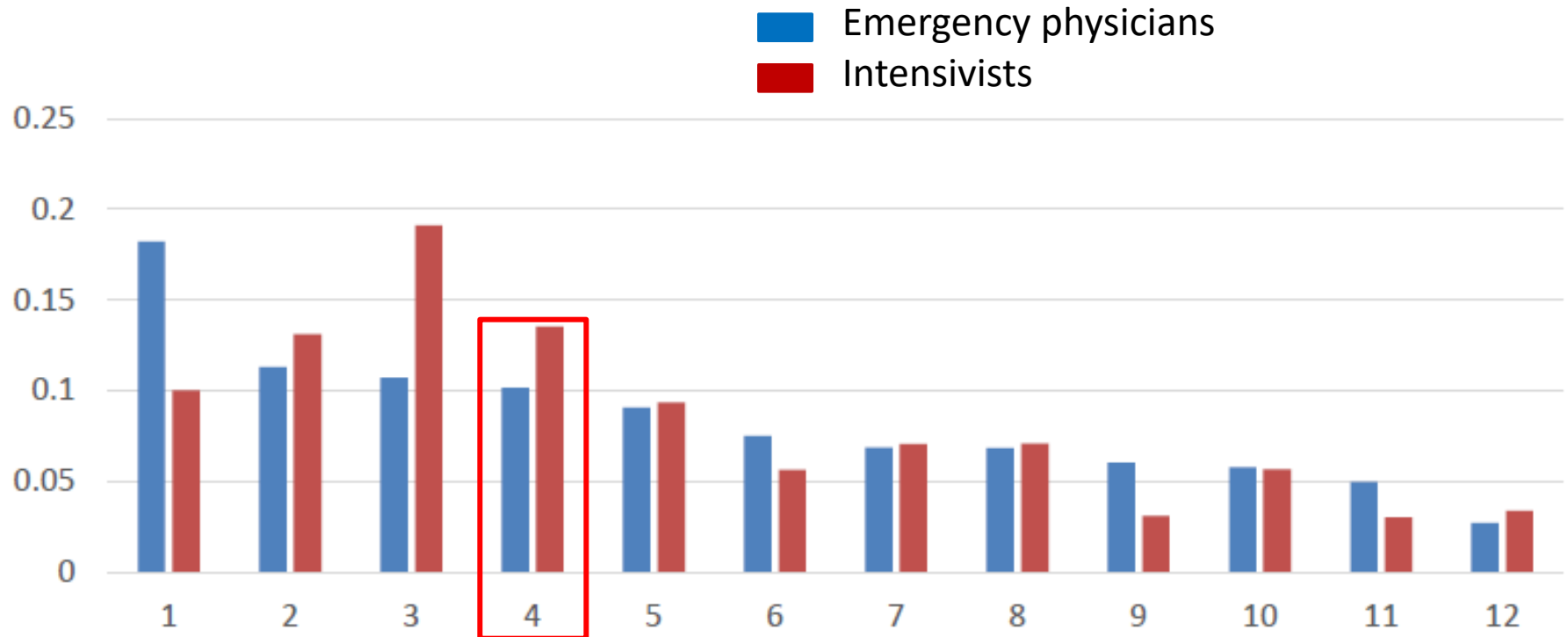
- 1- Faut-il admettre le patient en réanimation?
- 2- Que faire en situation d'incertitude?
- 3- Alternatives à la réanimation
- 4- Prise en soins pendant le séjour y compris décision de LAT
- 5- Trajectoire post réanimation
- 6- Impact sur les aidants
- 7- Futur

1 – Faut-il admettre le patient en réanimation?

- Avis du patient et des proches
- Estimation de la mortalité
- Estimation de l'état fonctionnel et qualité de vie

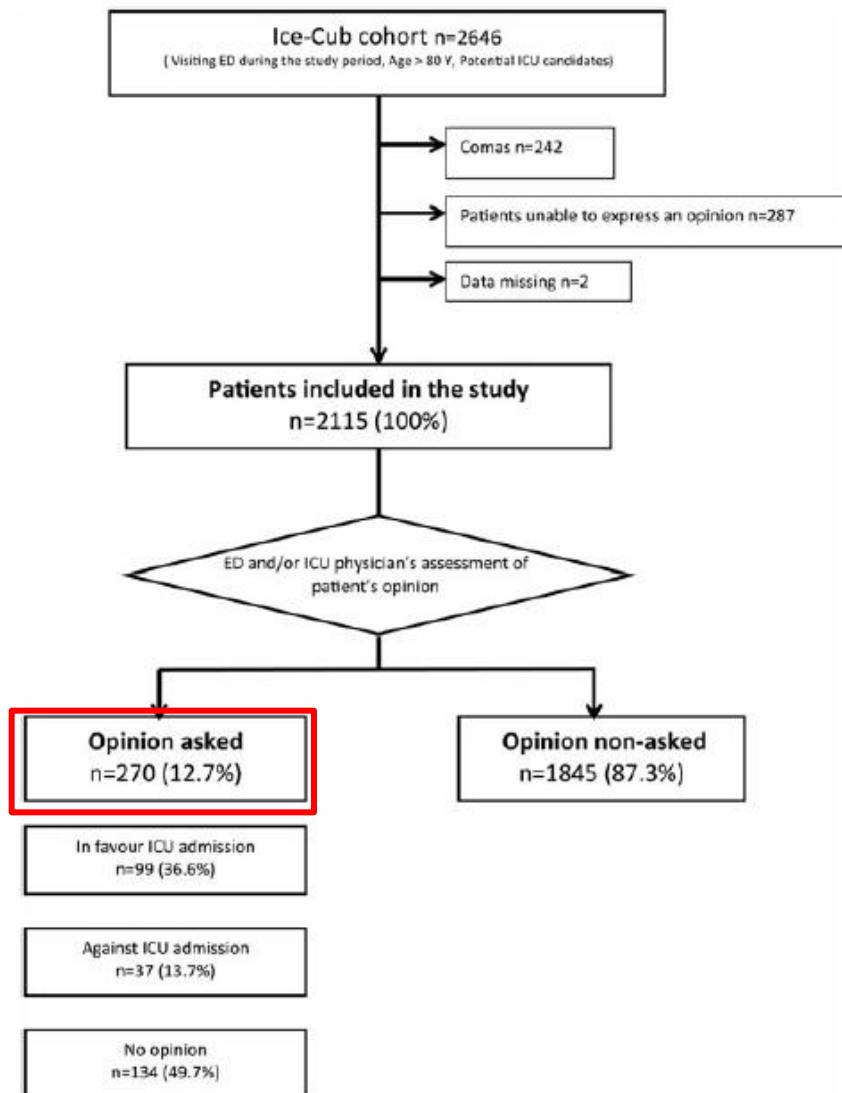
1.1. Avis du patient et des proches

Opinions de médecins urgentistes et réanimateurs sur les critères d'admission en réanimation



An analytic hierarchy process (AHP) was used to determine the relative importance of the 12 criteria (1- severity; 2- functional status; 3-dementia; 4-patient's wishes; 5- chronic illness; 6- nutritional status; 7- decubitus ulcer; 8- position; 9- recent hospitalization; 10- family's wishes; 11- medication; 12- social context) in the opinions of ED and ICU physicians.

Are elderly patients' opinions sought before admission to an intensive care unit? Results of the ICE-CUB study



	Odds ratio	CI 95%	P
Age (per 1 year increase)	0.97	0.94–1.00	0.07
Living place			
Home versus nursing home/hospital	0.65	0.39–1.04	0.08
Chronic conditions			
Dementia	0.47	0.25–0.83	0.01
Chronic neurological disease	0.65	0.35–1.11	0.13
Autonomy			
Full autonomy versus severe FI	2.10	1.39–3.21	<0.01
Moderate FI versus severe FI	1.53	0.95–2.46	0.08
ED physician			
Senior versus junior	0.48	0.35–0.66	<0.01
Relative			
Asked versus not asked	5.46	3.80–7.88	<0.01

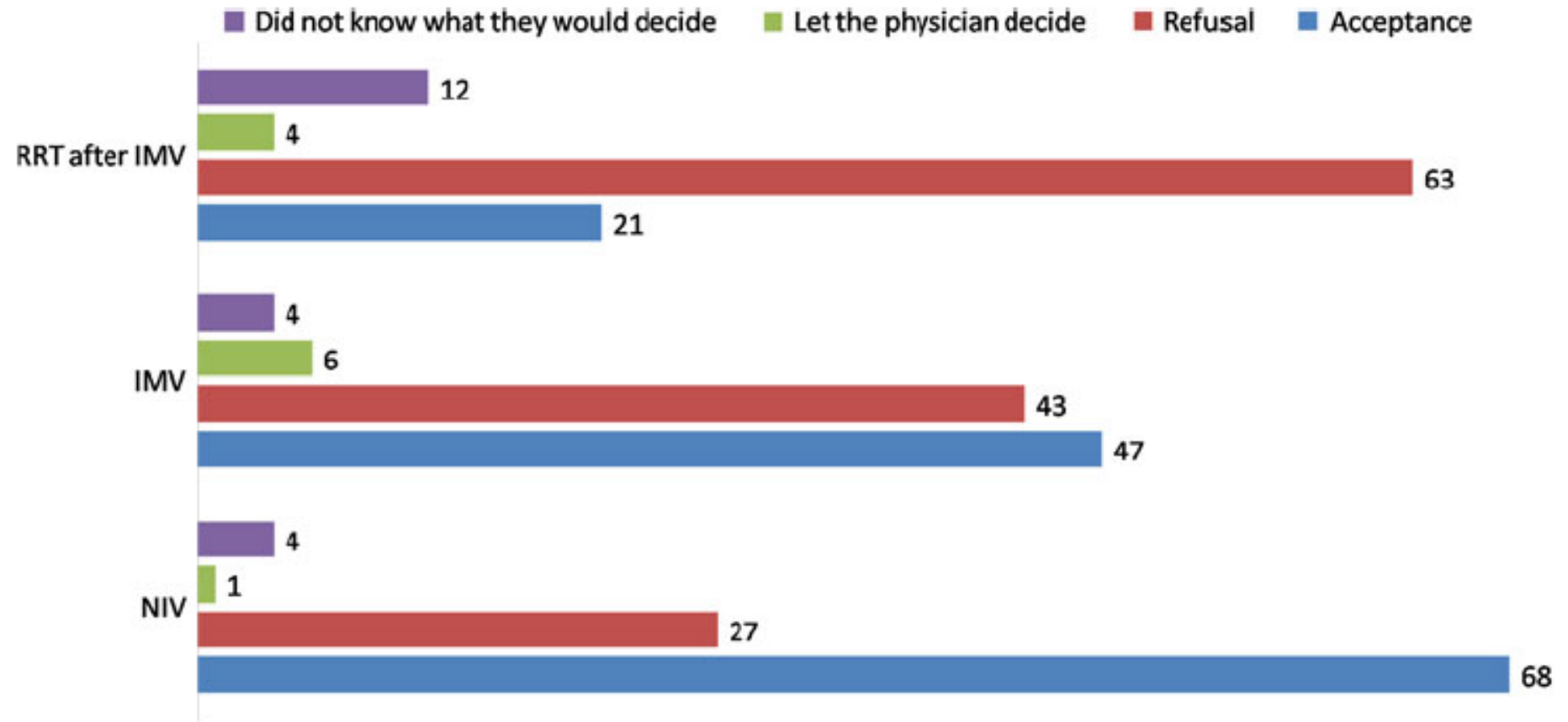
F. Philippart
A. Vesin
C. Bruel
A. Kpodji
B. Durand-Gasselin
P. Garçon
M. Levy-Soussan
J. L. Jagot
N. Calvo-Verjat
J. F. Timsit
B. Misset
M. Garrouste-Orgeas

The ETHICA study (part I): elderly's thoughts about intensive care unit admission for life-sustaining treatments

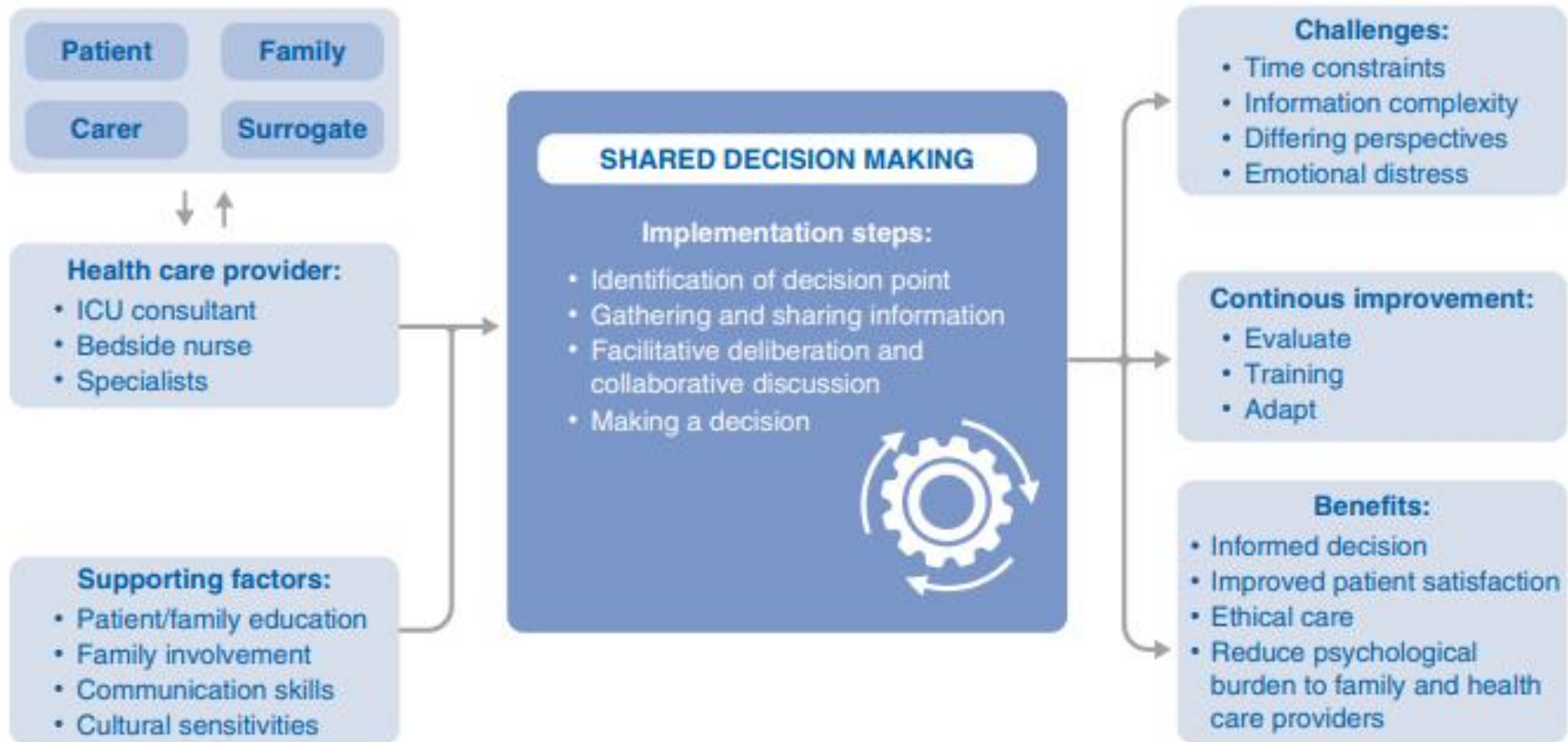
100 participants

Variables	Data
Age (years)	
Mean $\pm$ SD	84.8 $\pm$ 3.5
Females (<i>n</i>)	68
Site of residence (<i>n</i>)	
At home	65
Nursing facility	10
Assisted-living facility	25

Préférences

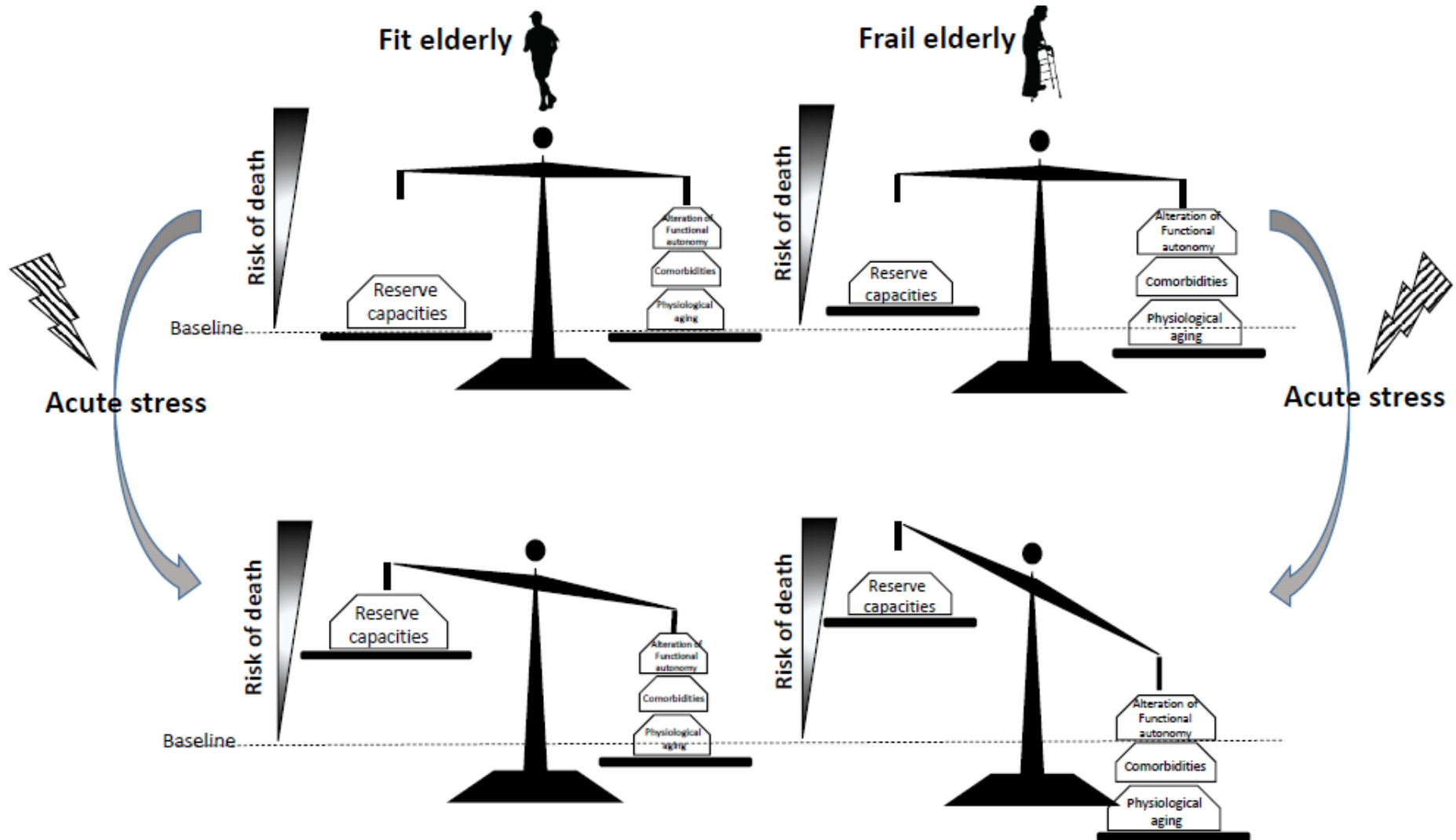


Décisions partagées



1.2. Estimation du pronostic

Impact de la fragilité après une agression

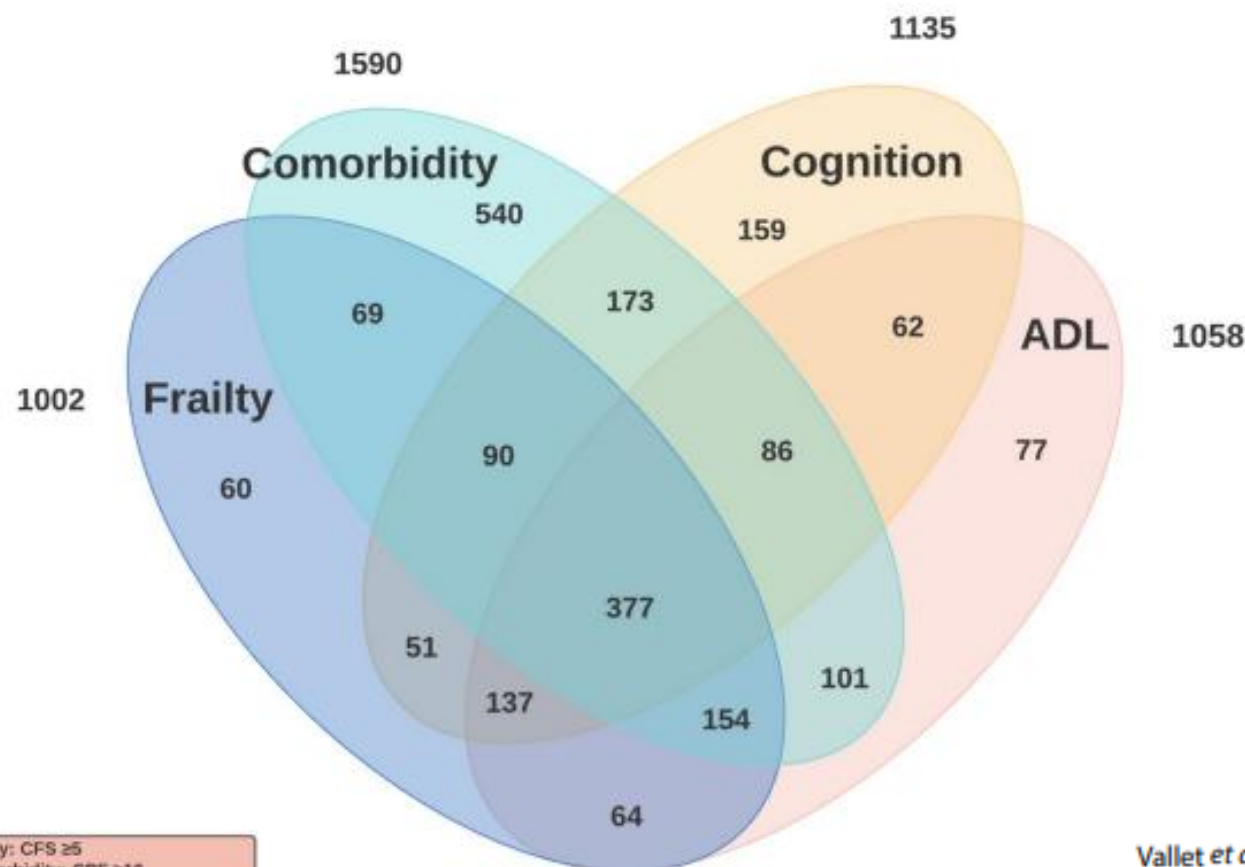




The impact of age-related syndromes on ICU process and outcomes in very old patients

Hélène Vallet¹, Bertrand Guidet^{2*}, Ariane Boumendil³, Dylan W. De Lange⁴, Susannah Leaver⁵, Wojciech Szczeklik⁶, Christian Jung⁷, Sigal Sviri⁸, Michael Beil⁸ and Hans Flaatten⁹

GERIATRIC SYNDROMES (from VIP2) n=2787



Frailty: CFS ≥ 5
Comorbidity: CPF ≥ 10
Cognitive decline: IQCODE $\geq 3,3$
Activity: Katz ADL < 6

Outils d'évaluation gériatrique

- Faciles à utiliser
 - Faisables en condition urgente
 - Pas de données manquantes
 - Reproductibles
- Impact sur la prise en charge et le pronostique
 - Court terme
 - Long terme

Les outils d'évaluation de la fragilité

Frailty scale	Components	Frailty classification	Advantages / drawbacks	Relation to outcomes
Frailty Phenotype (25)	Five items: weight loss, low physical activity, exhaustion, slowness, weakness	Robust: 0 items Pre-frailty: 1–2 items; Frailty: ≥ 3 items	. A comprehensive model, part of a CGA . Useful to evaluate patient trajectories, loss of function and disability in non-life-threatening situations. . Information may be hard to obtain in an emergency situation	Evaluating outcomes in over 75 year-olds after critical illness would require further study
Frailty Index (26)	30 to 92 accumulated health deficits Scores range from 0 (no deficits) to 1 (all deficits are present, though the maximum found is 0.7)	Continuous score Suggested cut-off score for frailty > 0.25	. Comprehensive model which gives an estimation of biological age vs chronological age . Can be applied to most health data sets . Time-consuming, so inconvenient for emergency use	Predicts mortality, disability, and cognitive decline better than chronological age Is associated with long-term mortality, place of residence and physical recovery after critical illness
Clinical Frailty Scale (20, 27, 28, 48, 52, 53, 54, 56)	Visual chart with a description of each picture 9 stages, ranging from 1 (very fit) to 9 (terminally ill)	CFS ≥ 5 defines frail	. Visual tool which easily conveys information . Good interrater reliability . May entail an evaluation based solely on the visual scale . At risk of use for inappropriately conducted triage	Outcomes after critical illness have been frequently studied CFS is a strong predictor of mortality, loss of functional ability, and not being discharged home
Scales based on administrative (computerized) records : The Hospital Frailty Risk Scale (34, 36)	109 summed items from ICD-10 frailty-relevant codes from administrative hospital data.	HFRS : Low risk: score < 5 intermediate risk: score 5–15; high risk: score > 15	. Can be calculated automatically upon patient admission and discharge . Frailty assessment subjected to lack of data and measurement bias . may not reflect disease severity	Inadequate predictors of long-term survival after critical illness

Echelle de fragilité clinique (CFS)

K. Rockwood et al. CMAJ 2005

1 à 3
Fit



1 Très en forme - Personnes qui sont robustes, actives, énergiques et motivées. Ces personnes font de l'exercice régulièrement. Ils sont parmi les plus en forme de leur âge.



2 Bien - Personnes qui ne présentent **aucun symptôme de maladie active** mais sont moins en forme que la catégorie 1. Font souvent, des exercices ou sont très **actives par période**. (par exemple des variations saisonnières).



3 Assez bien - Personnes dont les **problèmes médicaux sont bien contrôlés**, mais ne sont pas **régulièrement actives** au-delà de la marche quotidienne.

4
Pré
fragile



4 Vulnérable - Sans être dépendantes des autres pour l'aide quotidienne, souvent leurs **symptômes limitent leurs activités**. Une plainte fréquente est d'être ralentie et/ou d'être fatiguée pendant la journée.

≥ 5
fragile



5 Légèrement fragile - Personnes qui ont souvent un **ralentissement plus évident**, et ont besoin d'aide dans les **activités d'ordre élevé de la vie quotidienne** (finances, transport, grosses tâches ménagères, médicaments). Généralement, la fragilité légère empêche progressivement de faire les courses, de marcher seul dehors, de préparer les repas et de faire le ménage.



6 Modérément fragile - Personnes qui ont besoin d'aide pour **toutes les activités à l'extérieur** et pour l'**entretien de la maison**. A l'intérieur, elles ont souvent des problèmes pour monter/descendre les escaliers, ont besoin d'aide pour **prendre un bain** et pourraient avoir besoin d'une aide minimale (être à côté) pour s'habiller.



7 Sévèrement fragile - **Totalement dépendantes pour les soins personnels**, quelle que soit la cause (physique ou cognitive). Malgré tout, elles semblent stables et n'ont pas un risque élevé de décéder (dans les prochains 6 mois).



8 Très sévèrement fragile - Totalement dépendantes, la fin de vie approche. Typiquement, elles ne pourraient pas récupérer même d'une maladie mineure/ maladie légère.



9 En phase terminale - Approchant la fin de vie. Cette catégorie concerne les personnes ayant une **espérance de vie < 6 mois**, qui **sinon ne sont pas fragiles de façon évidente**.

Classification de la fragilité des personnes atteintes de démence.

Le degré de fragilité correspond au degré de démence.

Les **symptômes courants de démence légère** inclus : l'oubli des détails d'un événement récent mais le souvenir que l'événement a eu lieu, la répétition de la même question / histoire et le retrait social.

Dans la **démence modérée**, la mémoire récente est très altérée, même si les personnes peuvent bien se rappeler des événements de leur vie passée. Ils peuvent faire des soins personnels avec incitation.

Dans la **démence grave**, elles ne peuvent pas faire les soins personnels sans aide.

ORIGINAL



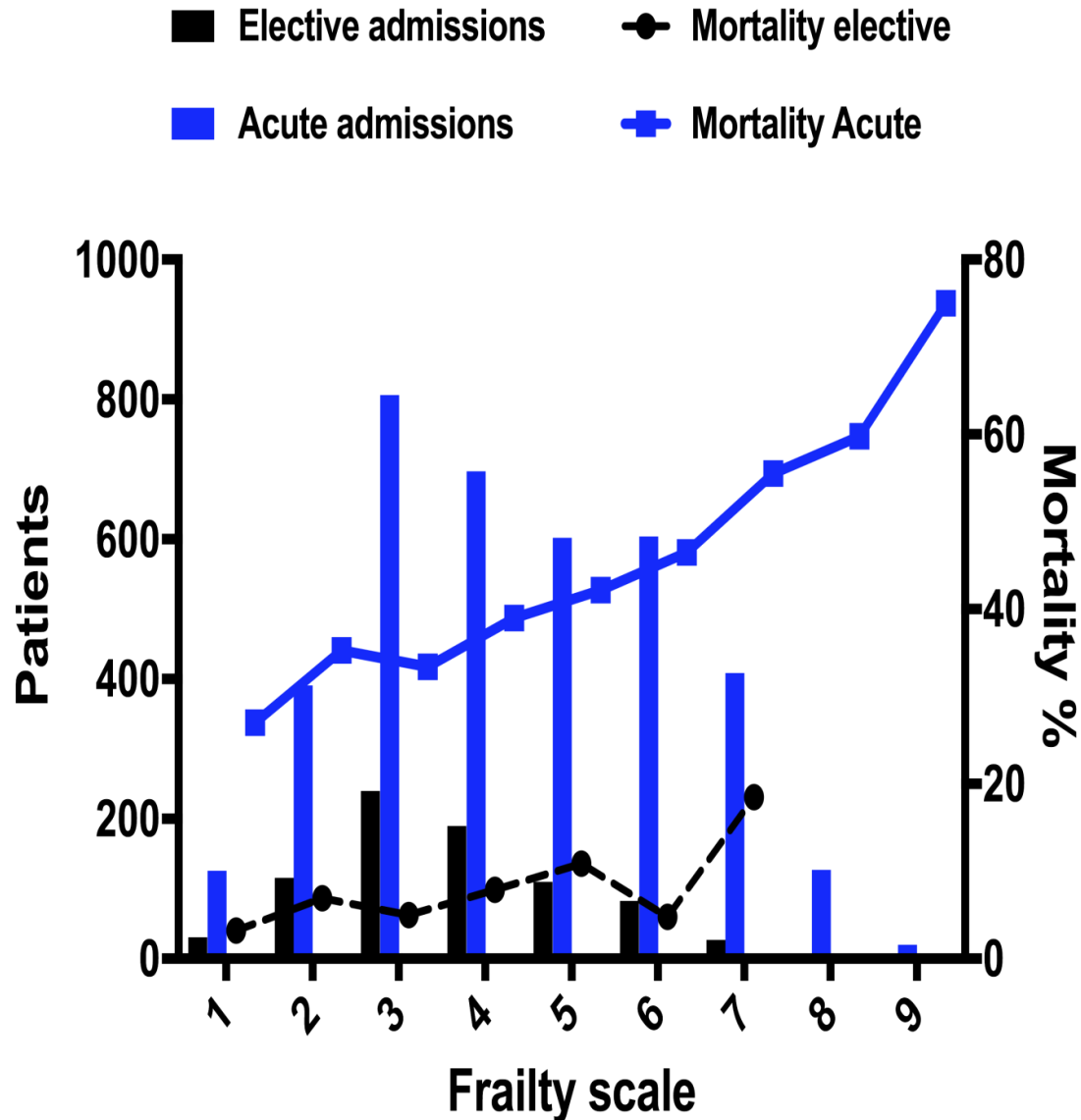
The impact of frailty on ICU and 30-day mortality and the level of care in very elderly patients (≥ 80 years)

Hans Flaatten^{1,2*} , Dylan W. De Lange³, Alessandro Morandi^{4,5}, Finn H. Andersen^{6,7}, Antonio Artigas⁸, Guido Bertolini¹⁰, Ariane Boumendil¹¹, Maurizio Cecconi¹², Steffen Christensen⁹, Loredana Faraldi¹³, Jesper Fjølner⁹, Christian Jung¹⁴, Brian Marsh¹⁵, Rui Moreno¹⁶, Sandra Oeyen¹⁷, Christina Agwald Öhman¹⁸, Bernardo Bollen Pinto¹⁹, Ivo W. Soliman²⁰, Wojciech Szczeklik²¹, Andreas Valentin²², Ximena Watson¹², Tilemachos Zaferidis²³, Bertrand Guidet^{24,25,26} on behalf of the VIP1 study group

21 Pays; 311 réanimations
5132 patients $\geq$ 80 ans
Suivi à 1 mois



Fragilité et mortalité



Analyse multivariée : mortalité à un mois

		HR (95%CI)	p
CFS	Pre vs fit	1.19 (1.03-1.38)	0.021
	Frail vs fit	1.54 (1.38-1.73)	<0.001
Age	Per 5 years	1.2 (1.12-1.28)	<0.001
Gender	male vs female	1.17 (1.06-1.29)	<0.001
SOFA	Per point	1.13 (1.12-1.14)	<0.001
Admission	Urgent vs planned	4.72 (3.65-6.10)	<0.001

ORIGINAL



The contribution of frailty, cognition, activity of daily life and comorbidities on outcome in acutely admitted patients over 80 years in European ICUs: the VIP2 study

Bertrand Guidet^{1*} , Dylan W. de Lange², Ariane Boumendil³, Susannah Leaver⁴, Ximena Watson⁵, Carol Boulanger⁶, Wojciech Szczeklik⁷, Antonio Artigas⁸, Alessandro Morandi⁹, Finn Andersen¹⁰, Tilemachos Zafeiridis¹¹, Christian Jung¹², Rui Moreno¹³, Sten Walther¹⁴, Sandra Oeyen¹⁵, Joerg C. Schefold¹⁶, Maurizio Cecconi^{17,18}, Brian Marsh¹⁹, Michael Joannidis²⁰, Yuriy Nalapko²¹, Muhammed Elhadi²², Jesper Fjølner²³, Hans Flaatten^{24,25} for the VIP2 study group

3920 patients; 242 Réanimations; 22 Pays

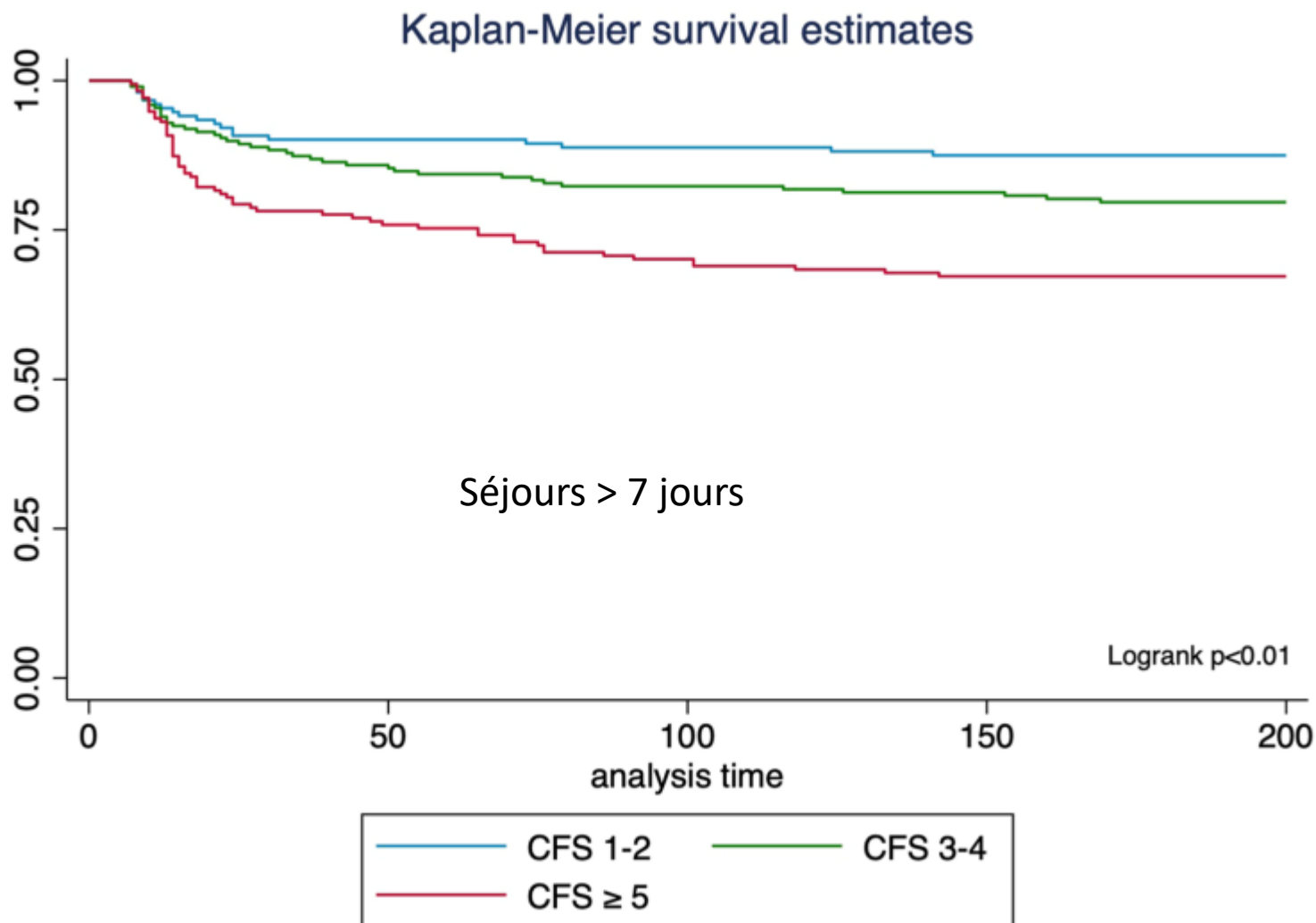
Analyse multivariée: mortalité à un mois

Variables	Categories	HR (95%CI)	p-value
Age	One-point increase	1 (0.99–1.02)	0.79
Habitat (ref = not home)	Own home	0.96 (0.85–1.08)	0.47
Gender (ref = male)	Female	0.94 (0.84–1.04)	0.24
Reason for admission (ref = circulatory failure)	Combined respiratory/circulatory failure	1.13 (0.94–1.36)	0.19
	Emergency surgery	0.68 (0.56–0.84)	0.0003
	Multitrauma w/wo head injury	1.21 (0.85–1.73)	0.28
	Multitrauma without head injury	0.91 (0.61–1.36)	0.64
	Other	0.88 (0.73–1.06)	0.18
	Respiratory failure	0.82 (0.69–0.97)	0.021
	Sepsis (according to Sepsis3)	0.67 (0.55–0.81)	0.0003
SOFA	One-point increase	1.16 (1.14–1.17)	<0.0001
CPS	One-point increase	0.99 (0.98–1)	0.05
CFS	One-point increase	1.08 (1.05–1.12)	<0.0001
Withholding or withdrawal	Yes vs no	4.25 (3.8–4.74)	<0.0001

Long-stay ICU patients with frailty: mortality and recovery outcomes at 6 months

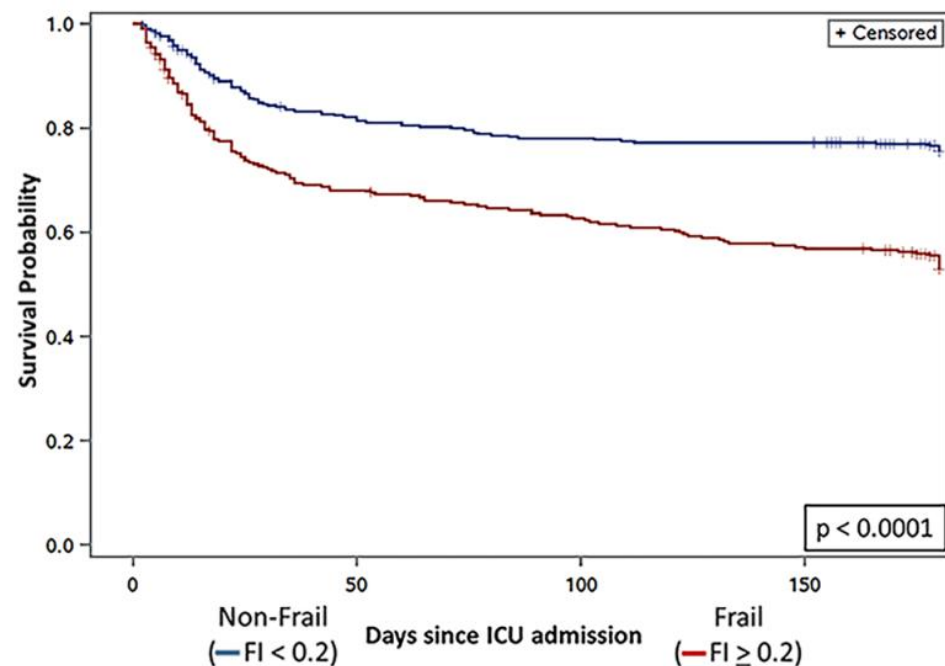
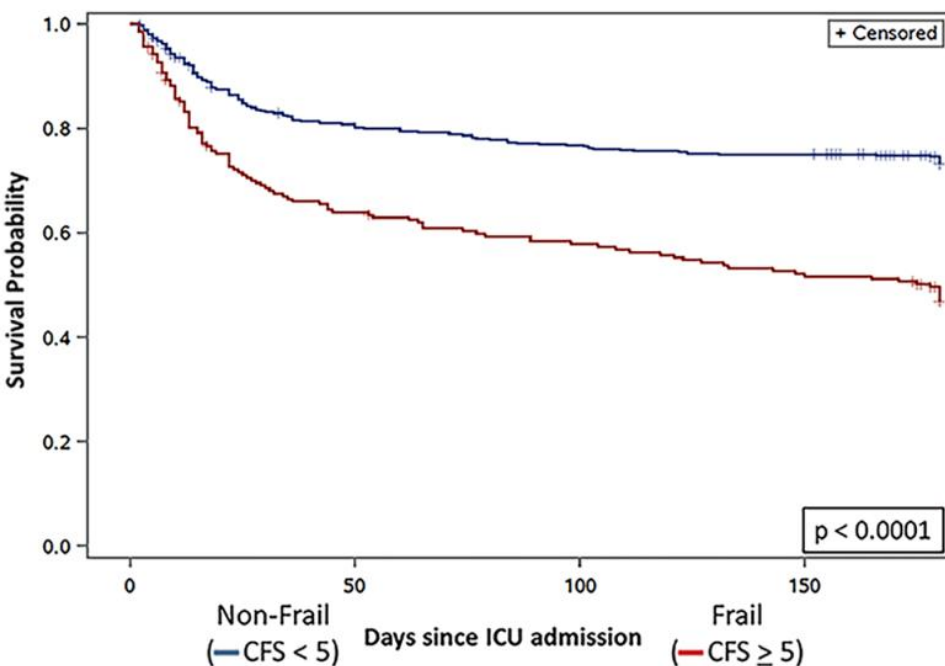
Hannah Wozniak^{1,2*} , Tal Sarah Beckmann³, Andre Dos Santos Rocha³, Jérôme Pugin¹,
Claudia-Paula Heidegger¹ and Sara Cereghetti¹

Annals of Intensive Care (2024) 14:31



Frailty, Outcomes, Recovery and Care Steps of Critically Ill Patients (FORECAST): a prospective, multi-centre, cohort study

John Muscedere^{1*} , Sean M. Bagshaw², Michelle Kho³, Sangeeta Mehta⁴, Deborah J. Cook⁵, J. Gordon Boyd⁶,



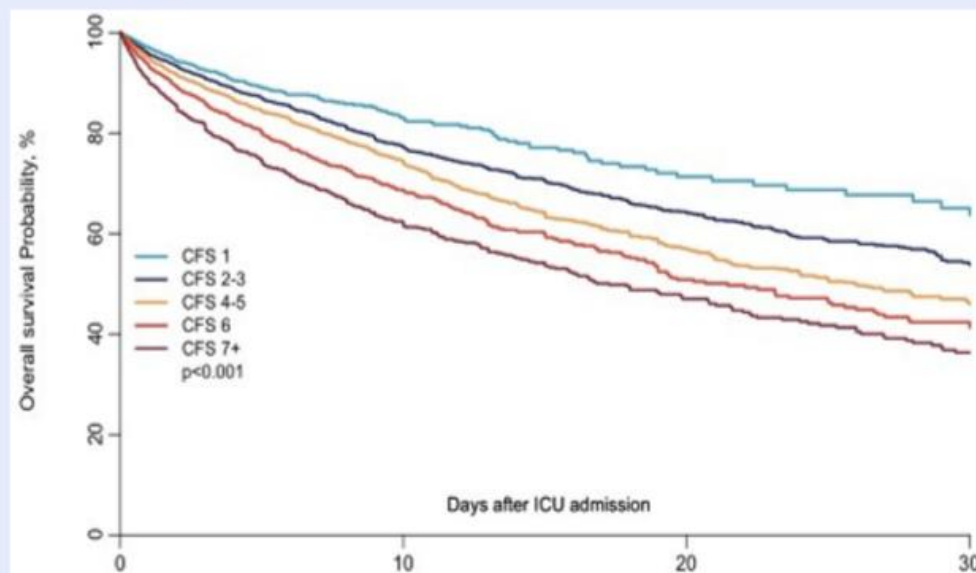
Intensive Care Med

<https://doi.org/10.1007/s00134-024-07404-9>



Statistics: Primary outcome **ICU mortality**. Cox models adjusted for age, sex, and disease severity.

- CFS is an **independent** predictor for the outcome of ICU patients (65 years or more), **across all** the included patient **populations and studies**.
- Being **vulnerable** (CFS 4) alone does **not differ** significantly from being frail (CFS ≥ 5).
- **Frailty** is seldom "all or nothing" but rather a **continuum**.
- CFS requires **more** than the **classical three** categories to better reflect ICU mortality (see Figure on the right).



Reproductibilité inter-observateur

N = 1923 patients; âge médian 84 ans; CSF 4; SOFA 6

Weighted Kappa (linear) 0.86 (0.84-0.87)

Profession	Personnel 1		
Personnel 2 ¹	IDE	Médecin	TEC
IDE	57	309	126
Médecin	162	785	120
TEC	46	96	138

EDITORIAL

Frailty is crucial in FORECASTing outcomes in critical care

Lauren E. Ferrante^{1*} and Wojciech Szczeklik²

Augmented processes of care for fit and frail older ICU patients *in addition to usual care*

1



ICU admission assessments

Clinical Frailty Scale (ordinal scale)

Pre-ICU functional status and trajectory

Baseline cognitive status

Goals of care, values, preferences

2



In ICU care processes

Avoidance of benzodiazepines and antipsychotics

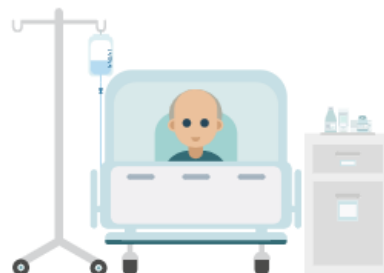
Deprescribe other potentially inappropriate medications using the Beers criteria

Hearing aids or portable amplifiers

Vision aids

Mobilization

3



Hospital ward care processes

Transfer to a geriatrics ward for all older ICU survivors; if not available, then:
 Geriatrics consult and comprehensive geriatric assessment (CGA) for those who are frail or pre-frail

Continue a focus on preventing functional decline and preventing delirium

Augmented rehabilitation efforts in those with functional decline or with a concerning CGA

4



Post-ICU care processes

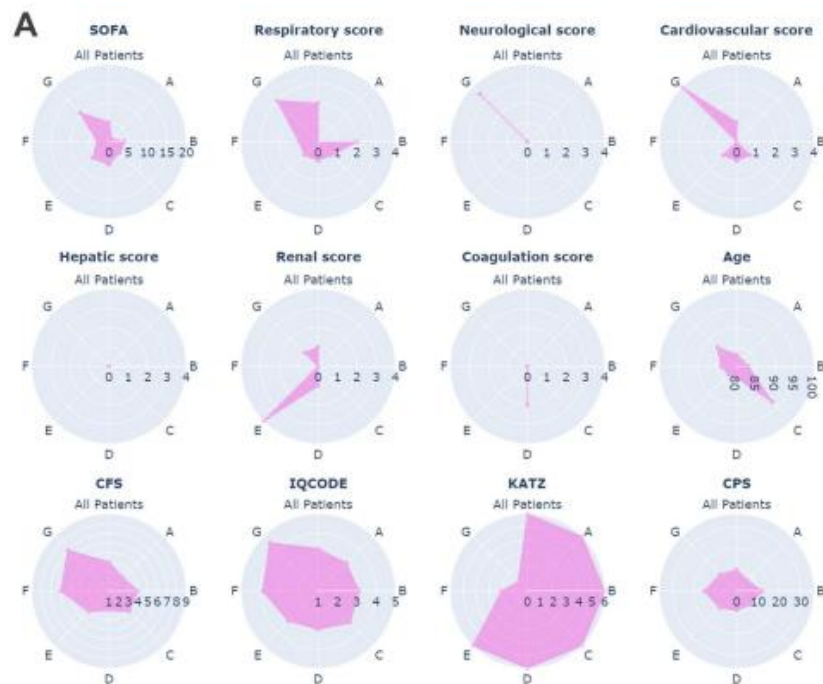
Arrangement of home services and rehabilitation at discharge

Consider Post-ICU follow-up visit and/or transitional care programs

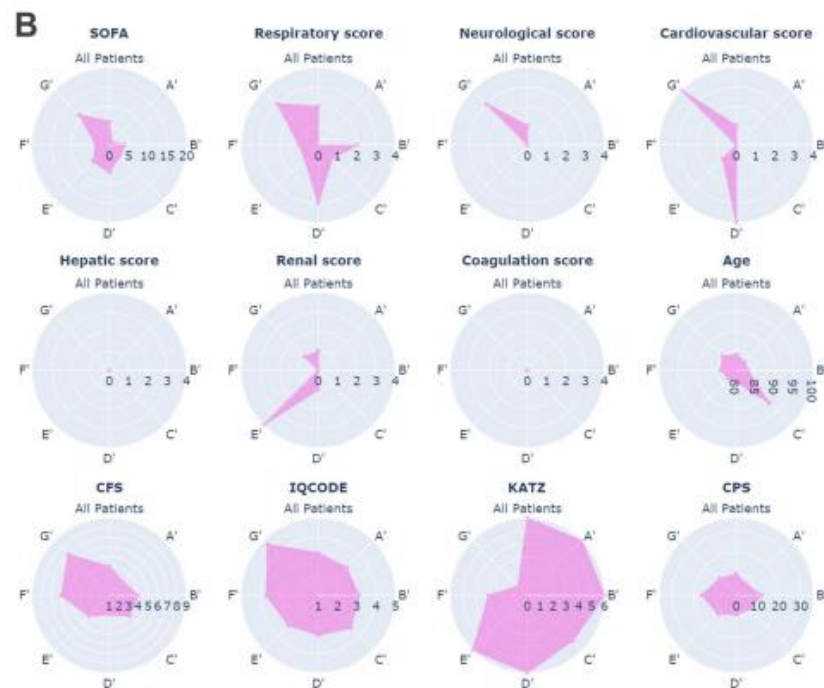
Clustering analysis of geriatric and acute characteristics in a cohort of very old patients on admission to ICU

Oded Mousai¹, Lola Tafoureau¹, Tamar Yovell¹, Hans Flaatten², Bertrand Guidet³, Christian Jung⁴, Dylan de Lange⁵, Susannah Leaver⁶, Wojciech Szczeklik⁷, Jesper Fjølner⁸, Peter Vernon van Heerden⁹, Leo Joskowicz¹, Michael Beil¹⁰, Gal Hyams¹ and Sigal Sviri^{10*} 

Non COVID

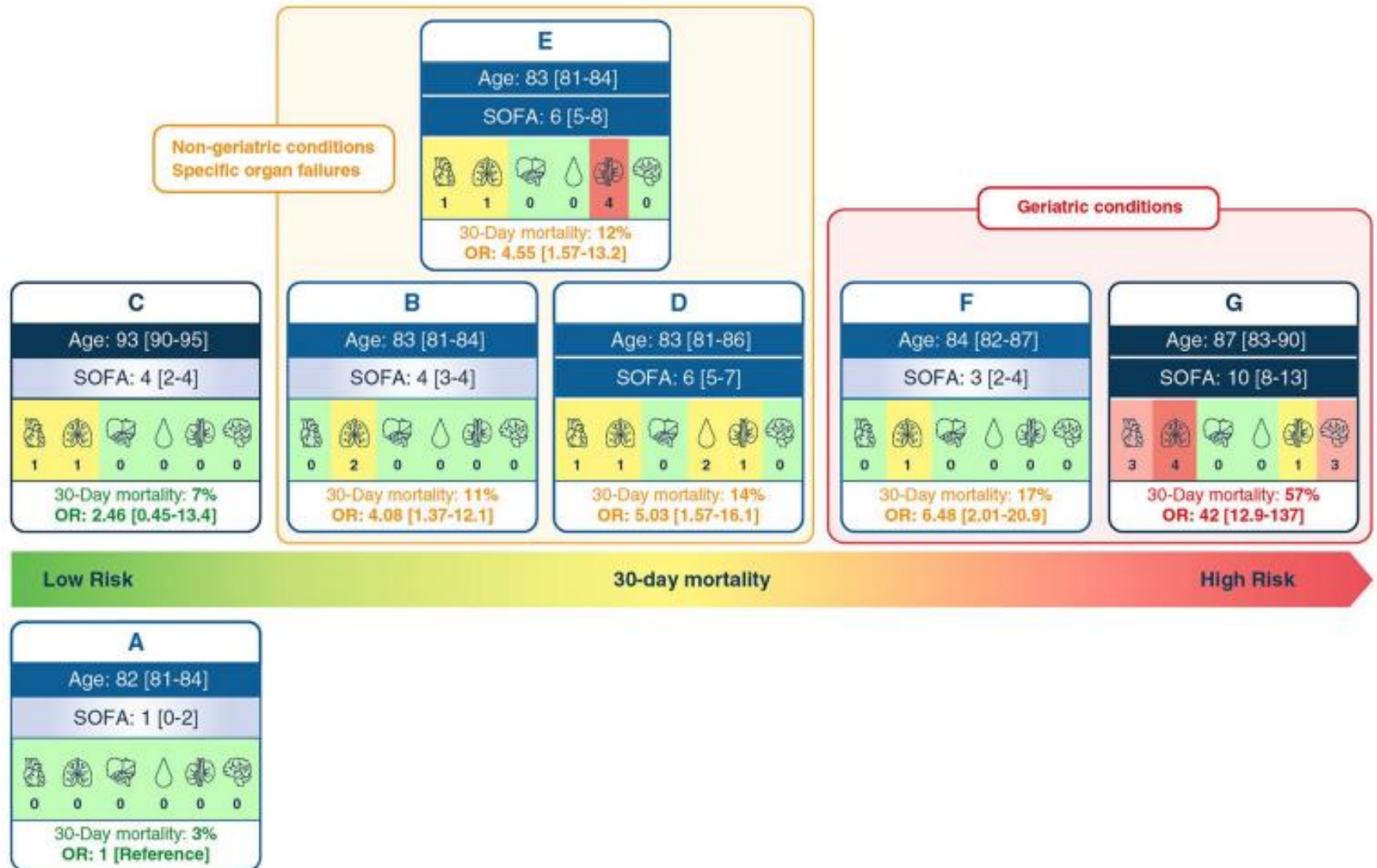


COVID



Tailoring treatments to older people in intensive care. A way forward

Márlon Juliano Romero Aliberti^{1,2*} , Sébastien Bailly³  and Matthew Anstey^{4,5,6} 

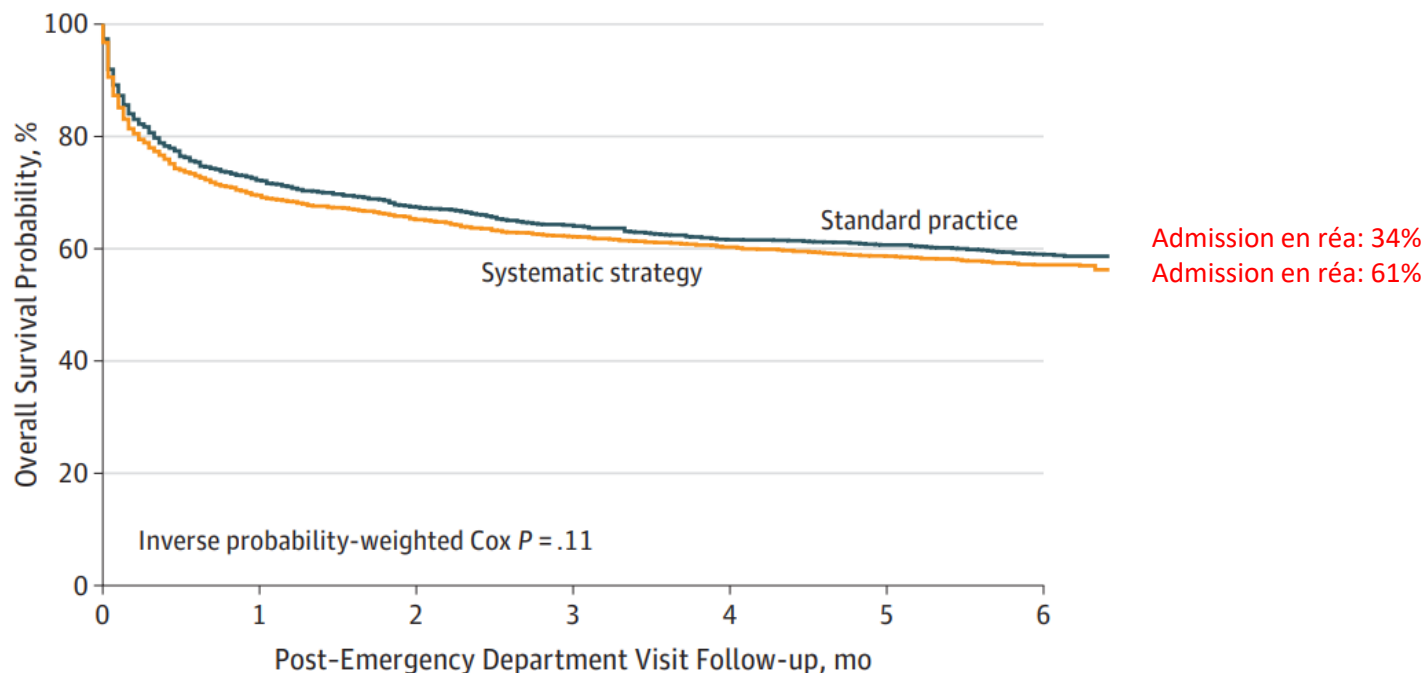


Revue systématique: Mortalité hospitalière

Study	Events	Total		Proportion	95%-CI
Study design:multicenter prospective					
Ball, 2017	24	220	—+	0.11	[0.07; 0.15]
Khouli, 2011	117	484	—+	0.24	[0.20; 0.28]
Guidet, 2017	409	1448	+	0.28	[0.26; 0.31]
Heyland, 2015	153	535	—+	0.29	[0.25; 0.32]
Chin-Yee, 2017	485	1671	+	0.29	[0.27; 0.31]
Ball, 2017	132	418	—+	0.32	[0.27; 0.36]
Boumendil, 2012	108	327	—+	0.33	[0.28; 0.38]
Le Maguet, 2014	65	196	—+	0.33	[0.27; 0.40]
Heyland, 2015	585	1671	+	0.35	[0.33; 0.37]
Ball, 2016	429	1033	+	0.42	[0.39; 0.45]

Effect of Systematic Intensive Care Unit Triage on Long-term Mortality Among Critically Ill Elderly Patients in France A Randomized Clinical Trial

Bertrand Guidet, MD; Guillaume Leblanc, MD; Tabassome Simon, MD, PhD; Maguy Woimant, MD; Jean-Pierre Quenot, MD; Olivier Ganansia, MD; Maxime Maignan, MD; Youri Yordanov, MD; Samuel Delerme, MD; Benoit Doumenc, MD; Muriel Fartoukh, MD; Pierre Charestan, MD; Pauline Trognon, MD; Bertrand Galichon, MD; Nicolas Javaud, MD; Anabela Patzak, MD; Maïté Garrouste-Orgeas, MD; Caroline Thomas, MD; Sylvie Azerad, PharmD; Dominique Pateron, MD; Ariane Boumendil, PhD; for the ICE-CUB 2 Study Network



No. at risk

Standard practice	1518	1126	1042	992	961	941	912
Systematic strategy	1518	1029	966	919	887	860	826

Résultats fonctionnels à 6 mois

Outcomes	Systematic Strategy (n = 1518)	Standard Practice (n = 1518)	Difference in Mean or Rate (95% CI)
Decrease in score in ≥ 1 domain of Index of Independence in ADLs, No./total No. (%) ^d	463/680 (68)	394/657 (60)	8 (3 to 13)
Adjusted analysis ^c			
SF-12 physical component score at 6 mo, mean (95% CI) ^e	36.7 (35.9-37.5)	36.2 (35.5-37.0)	0.5 (-0.6 to 1.5)
Adjusted analysis ^c			
SF-12 mental component score at 6 mo, mean (95% CI) ^e	44.6 (44.1-45.1)	43.7 (43.2-44.2)	0.9 (0.1 to 1.6)
Adjusted analysis ^c			

2 – Que faire en situation d'incertitude?

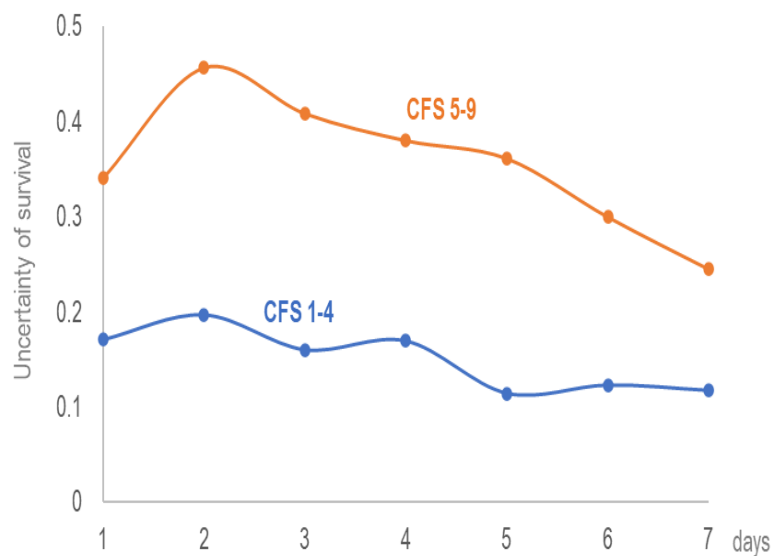
- Place de la réanimation d'attente?
- Le doute doit bénéficier au malade

Il faut du temps

- Construire une relation de confiance avec la famille
- Réduire l'incertitude pronostique
 - Réunir des informations complémentaires
 - Récupérer des directives anticipées
 - Evaluer la réponse au traitement
- La démarche favorise les décisions partagées
 - Au sein de l'équipe
 - Avec les proches
- Formalisation de la conférence de famille (VIP3)

Quelle durée?

Très dépendant du motif d'admission et de l'état de base du patient



3- Alternatives à la réanimation

Place des USI

Place des USI dans l'offre de soins

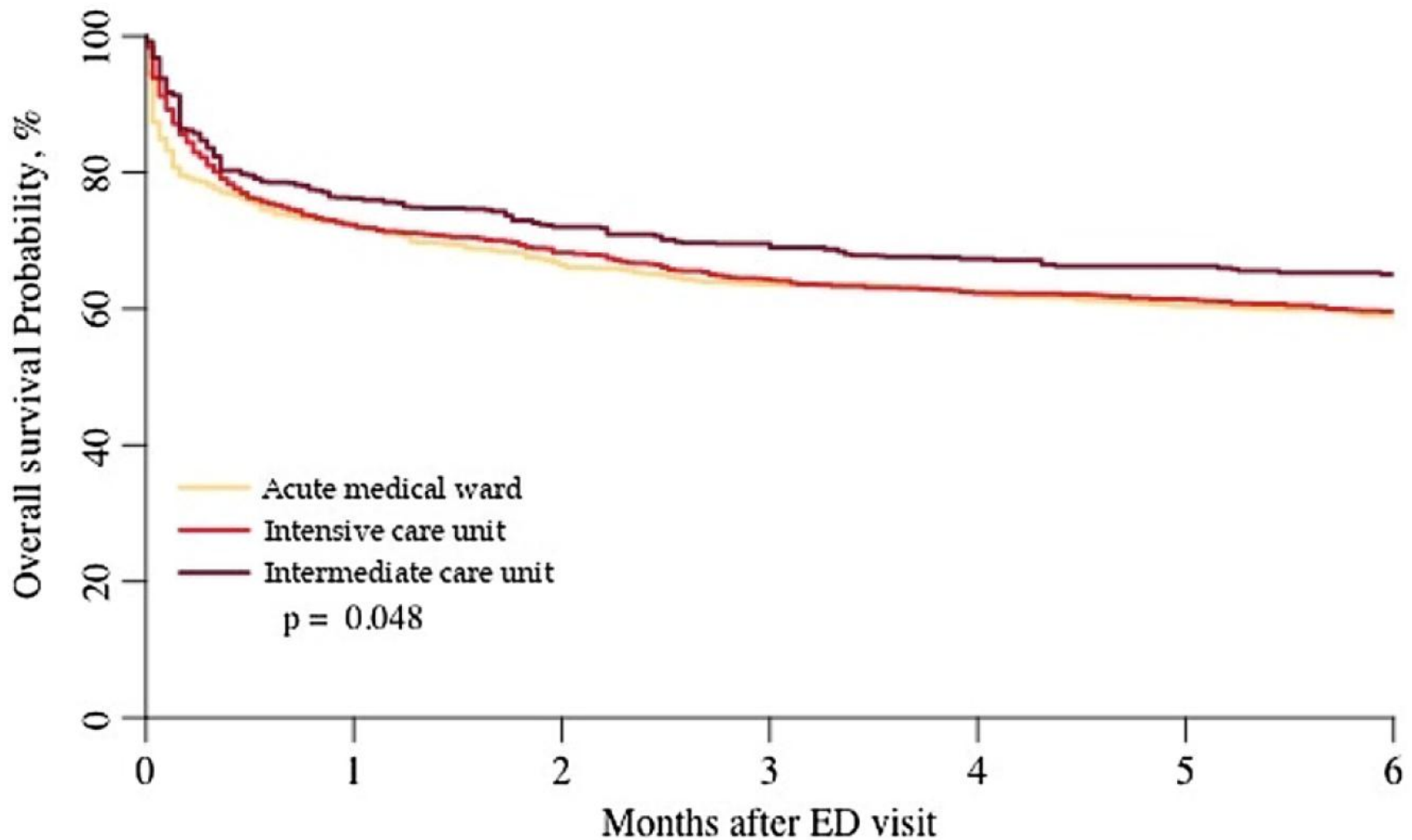
Impact on 6-month outcomes of hospital trajectory in critically ill older patients: analysis of the ICE-CUB2 clinical trial



Sara Thietart^{1*} , Ariane Boumendil², Dominique Pateron³, Bertrand Guidet^{1,4} and H  l  ne Vallet^{5,6} on behalf of the ICE-CUB2 Study Network

	Intensive care unit	Intermediate care unit	Acute medical ward
<i>N</i>	1448	504	1084
Age (years)	84 [80–88]	85 [81–89]	87 [83–92]
Female sex	764 (53)	259 (51)	652 (60)

Courbes de survie ajustées



4- Pendant le séjour en réanimation

- Recommandations de prise en charge à revisiter
- Limitation et arrêt des traitements

Treatment Intensity and Outcome of Patients Aged 80 and Older in Intensive Care Units: A Multicenter Matched-Cohort Study

Ariane Boumendil, MSc,* Philippe Aegerter, PhD, MD,*† Bertrand Guidet, MD,*‡
and the CUB-Rea Network

Table 3. Age-Related Differences in Hospital Care with and Without Adjustment for Matching Criteria

Support and Outcome	Risk Ratio (Miettinen 95% CI)	P-value*	Adjusted Odds Ratio (95% CI)	P-value†
Circulatory support	1.04 (0.98–1.1)	.19	1.08 (0.96–1.21)	.19
Mechanical ventilation	0.85 (0.81–0.90)	<.001	0.69 (0.61–0.78)	<.001
Renal support	0.57 (0.47–0.7)	<.001	0.52 (0.41–0.66)	<.001
Tracheostomy	0.41 (0.31–0.53)	<.001	0.37 (0.28–0.50)	<.001
ICU mortality	1.19 (1.08–1.31)	<.001	1.32 (1.13–1.54)	<.001
Hospital mortality	1.27 (1.17–1.38)	<.001	1.52 (1.31–1.76)	<.001

JAGS 53:88–93, 2005

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Withholding or withdrawing of life-sustaining therapy in older adults (≥ 80 years) admitted to the intensive care unit

Bertrand Guidet^{1,2*} , Hans Flaatten^{3,4}, Ariane Boumendil^{1*}, Alessandro Morandi^{5,6}, Finn H. Andersen^{7,8}, Antonio Artigas⁹, Guido Bertolini¹⁰, Maurizio Cecconi¹¹, Steffen Christensen¹², Loredana Faraldi¹³, Jesper Fjølner¹², Christian Jung¹⁴, Brian Marsh¹⁵, Rui Moreno¹⁶, Sandra Oeyen¹⁷, Christina Agwald Öhman¹⁸, Bernardo Bollen Pinto¹⁹, Ivo W. Soliman²⁰, Wojciech Szczeklik²¹, Andreas Valentin²², Ximena Watson¹¹, Tilemachos Zafeiridis²³ and Dylan W. De Lange²⁰ on behalf of The VIP1 study group.

VIP1 study

- 21 pays
- 309 Réanimations
- 5021 patients de plus d 80 ans

Mortalité

En réanimation

Pas de LAT : 11%

Limitation: 29%

Arrêt : 82%

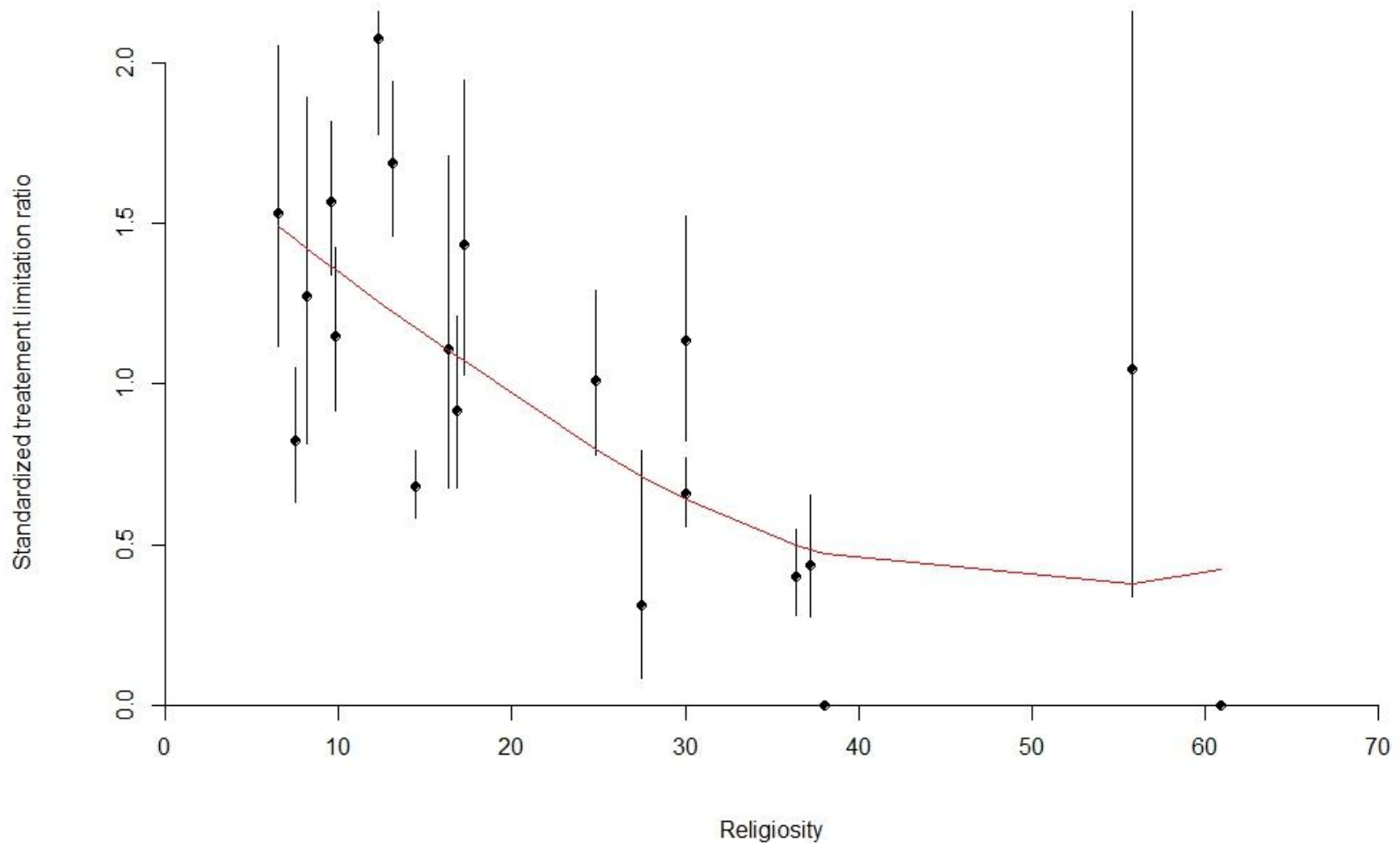
A 30 jours

Pas de LAT : 18 %

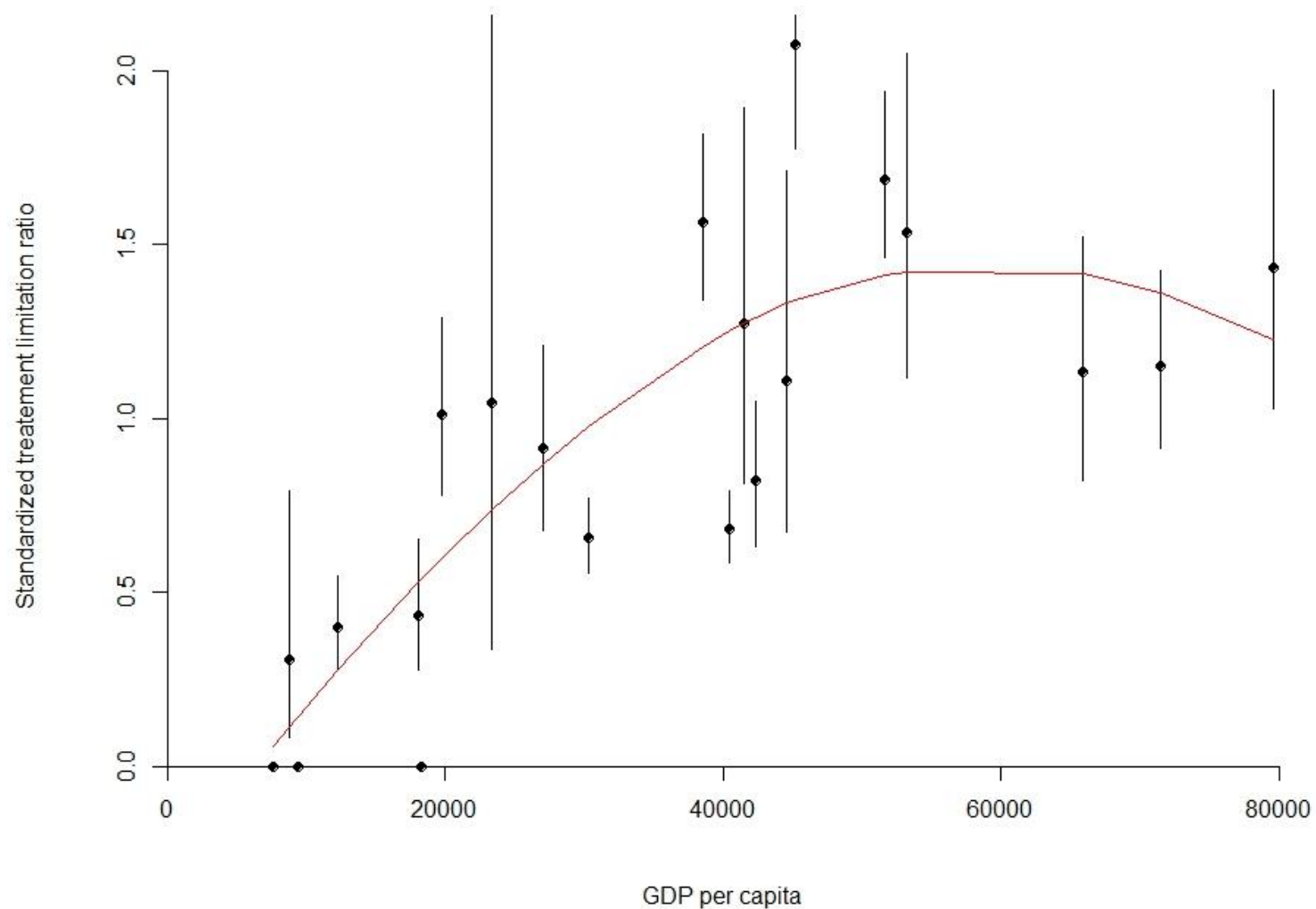
Limitation: 53%

Arrêt : 93 %

Impact de la religion

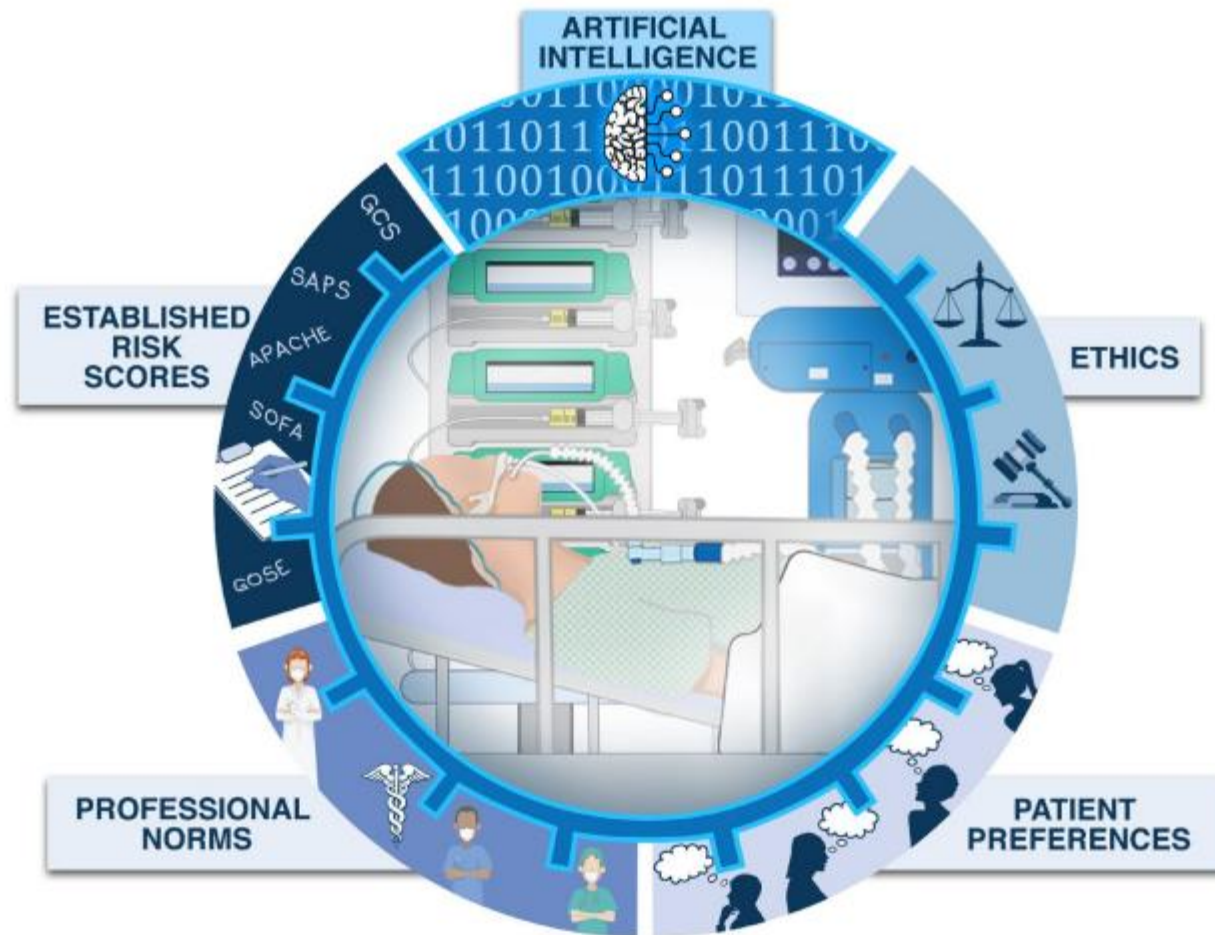


Impact de la richesse du pays



The role of artificial intelligence in life-sustaining treatment decisions: current state and future considerations

Bernhard Wernly^{1,2,3,4*} , Bertrand Guidet⁵ and Michael Beil⁶



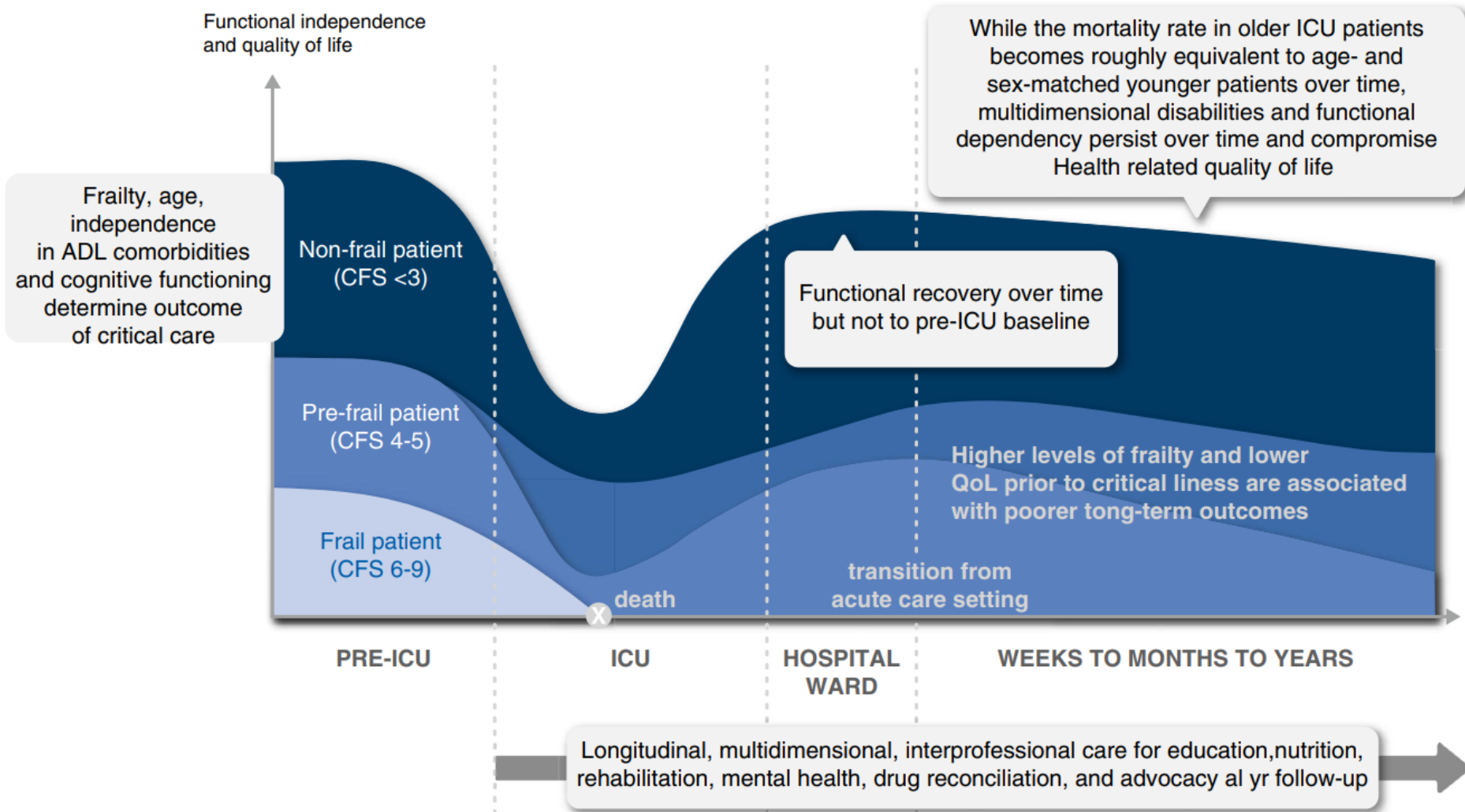
5 – Trajectoire post-réanimation

Mortalité hospitalière après la sortie de réanimation

Bertrand Guidet, MD ^{a,b,c,*}, Eric Hodgson, FCA ^d, Charles Feldman, MB BCh, DSc, PhD, FRCP, FCP ^e,
Fathima Paruk, MBChB, FCOG, PhD ^f, Jeffrey Lipman, MBBCh, MD ^g, Younsuck Koh, MD, PhD ^h,
Jean Louis Vincent, MD, PhD ⁱ, Elie Azoulay, MD, PhD ^j, Charles L. Sprung, MD, M CCP ^k

	Countries	n ICUs	<80 y	>80 y
Δ between in-hospital and in-ICU mortality (%)				
Euricus I (1994-1996)	12 European countries	89	5	11
Euricus II (1997-1999)	9 European countries	39	5.9	12
Bashaw (2000-2005) * vs (65 to 80 y)	Australia and New Zealand	57	6.8*	12
Ihra (1998-2008)	Austria	41	4.5	10.8
CUB-REA (2011)	Ile-de-France	32	4.3	8.3
Reinikainen (1998-2004)	Finland	26	6.9	15.9

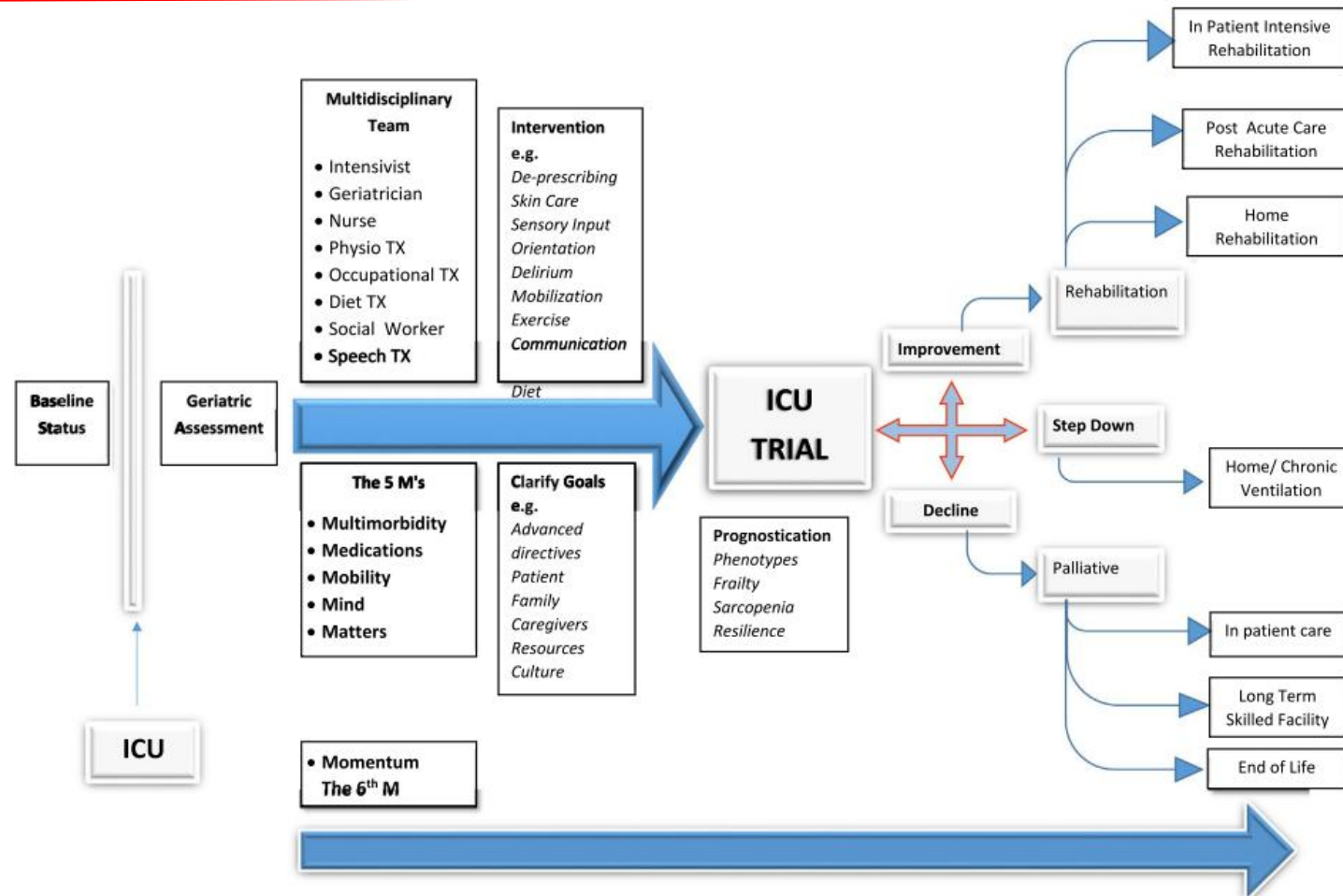
Trajectoire du patient âgé





Critical care beyond organ support: the importance of geriatric rehabilitation

Jeremy M. Jacobs¹, Ana Rahamim², Michael Beil³, Bertrand Guidet^{4,5}, Helene Vallet⁶, Hans Flaatten^{7,8}, Susannah K. Leaver⁹, Dylan de Lange¹⁰, Wojciech Szczeklik¹¹, Christian Jung^{12*}  and Sigal Sviri³



Difficultés dans la mise en œuvre

Patients Centered

- Fatigue
- Weakness
- Pain
- Polypharmacy
- Anxiety/depression
- Confusion
- Agitation
- Ongoing delirium
- Pressure sores
- Lack of Motivation
- Poor compliance
- Need for restraints

Family and Caregiver centered

- Inadequate social support
- Inadequate family support
- Caregiver burden and burnout
- Lack of consensus concerning goals
- Financial constraints

Environmental

- Inadequate availability of rehabilitation therapists
- Inadequate availability of rehabilitation equipment
- Negative perception of rehabilitation by staff members
- Inequalities in provision of rehabilitation for very old

Organizational

- Poor evidence base for this patient population
- Financial constraints
- Attitudes of Stakeholders and Policy makers
- Local and national health care policy
- Ethical and cultural norms
- Ageism

Unité Post-Réanimation Gériatrique (UPREG)

#AP-HP. SORBONNE >>>

Une nouvelle Unité Post Réanimation Gériatrique à l'hôpital Saint-Antoine



La création de cette unité vise à améliorer le pronostic des patients âgés sortants de réanimation et à fluidifier la filière gériatrique. Elle s'inscrit dans la continuité de filières gériatriques telles que l'orthogériatrie ou les urgences gériatriques...

[Lire la suite](#)

Janvier 2023

Projet pilote

Ouverture de 4 lits : fonctionnement USC

Profil des patients:

- 75 ans et plus
- Directement en sortie de réanimation (médicale ou chirurgicale)

Les moyens

Humain

Ratio IDE/patient = 1/4

Ratio AS/patient : 1/4

Matériel

Possibilité de surveillance scopée

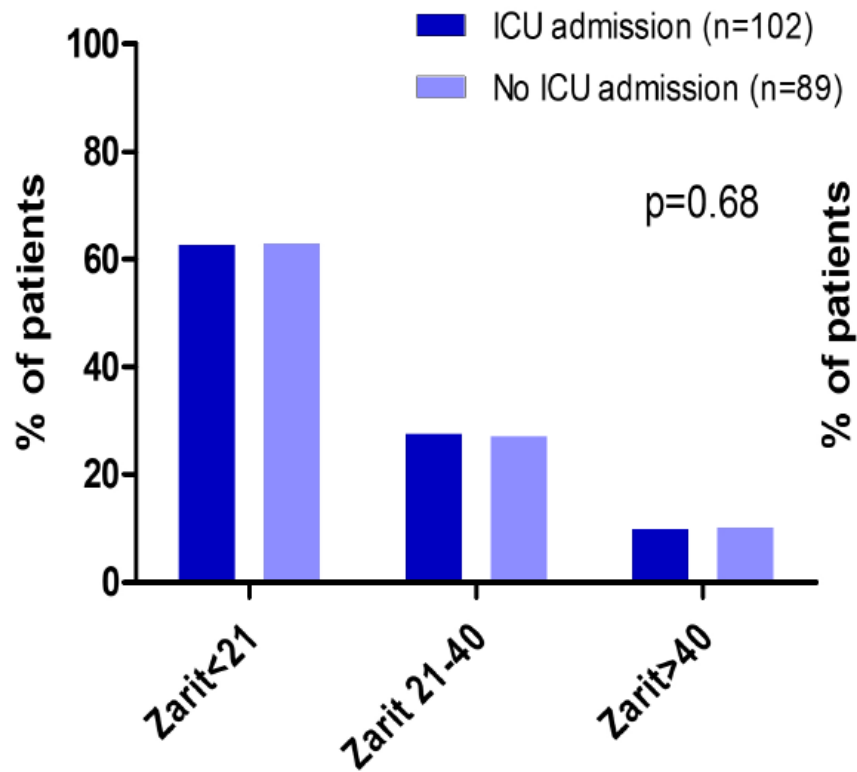
Optiflow sous condition

Cathéter centraux



6 – Charge pour les aidants

Charge perçue par les aidants?



	Multivariate	
Variable	Odds ratio (95%CI)	p-value
Change in ADL (one-point decrease)	1.3 (1-1.68)	0.049
Male vs Female	2.03 (0.99-4.19)	0.054
Physical SF12 (one-point decrease)	0.97 (0.93-1.01)	0.14
Mental SF12 (one-point decrease)	0.94 (0.89-0.98)	0.009

Flaatten · Guidet · Vallet Eds.

Lessons from the ICU

Under the Auspices of the European Society of Intensive Care Medicine

Series Editors: Maurizio Cecconi · Daniel De Backer

Hans Flaatten
Bertrand Guidet
Helene Vallet *Editors*



The Very Old Critically Ill Patients

The Very Old Critically Ill Patients

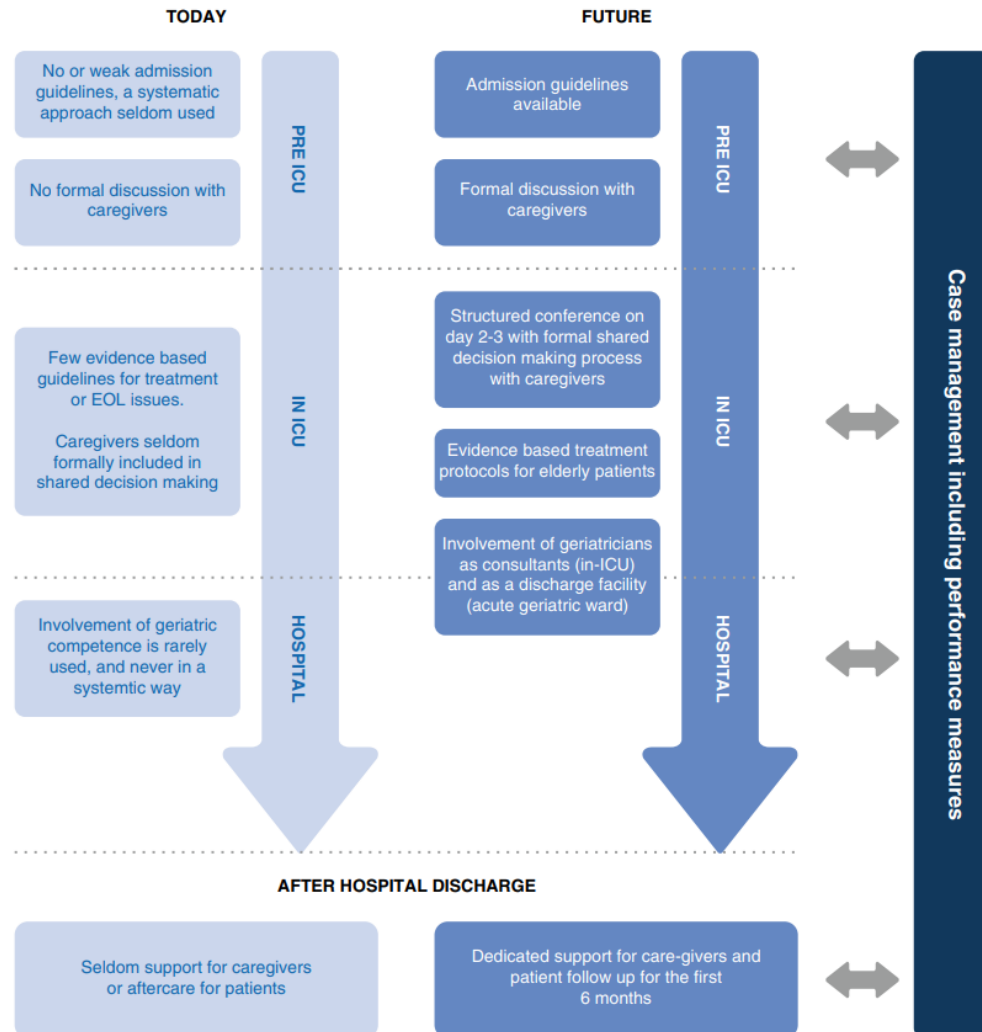


 Springer



The trajectory of very old critically ill patients

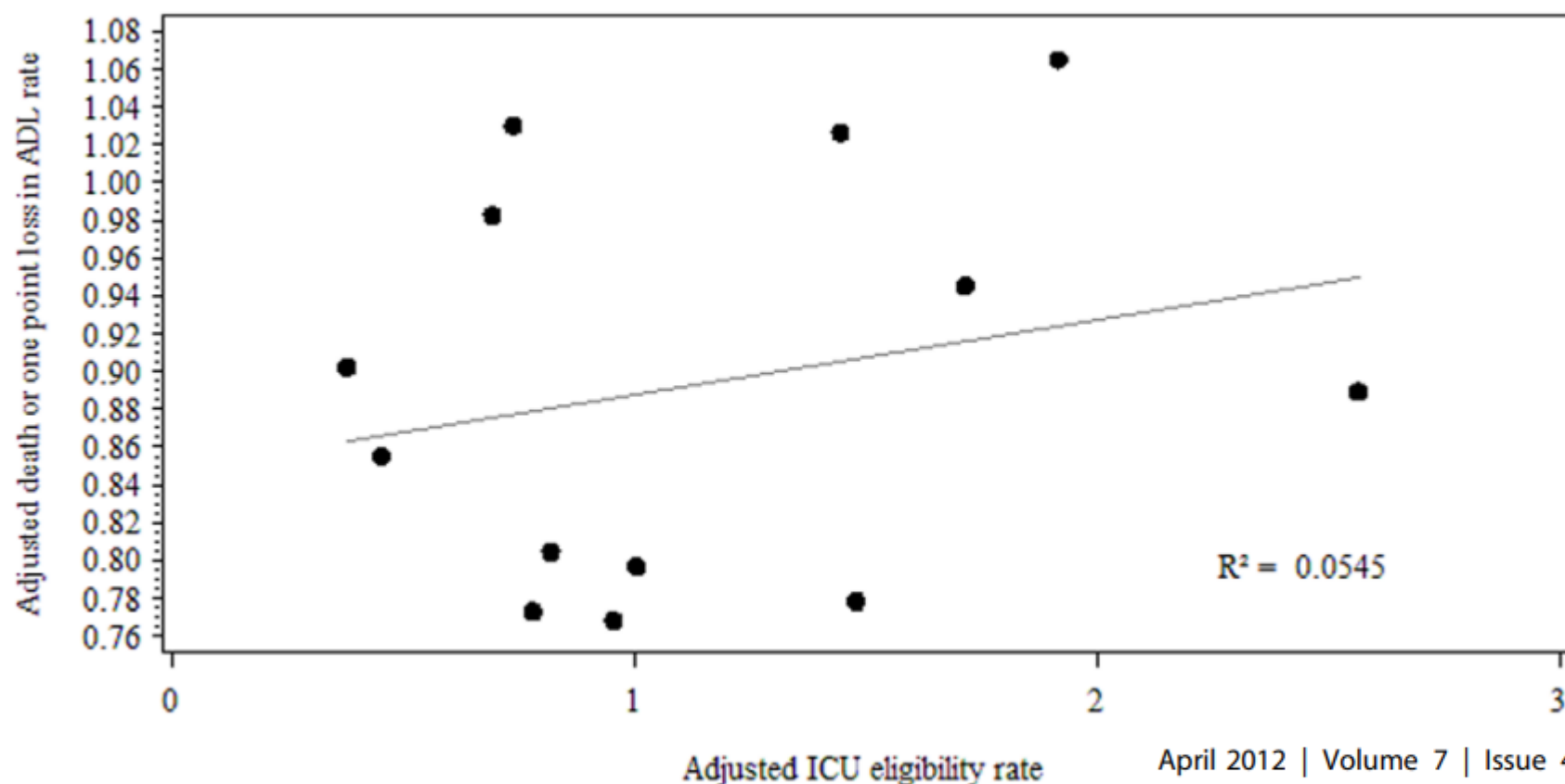
Bertrand Guidet^{1*} , Helene Vallet², Hans Flaatten³, Gavin Joynt⁴, Sean M. Bagshaw⁵, Susannah K. Leaver⁶, Michael Beil⁷, Bin Du⁸, Daniel N. Forte⁹, Derek C. Angus¹⁰, Sigal Sviri¹¹, Dylan de Lange¹², Margaret S. Herridge¹³ and Christian Jung¹⁴



Variability of Intensive Care Admission Decisions for the Very Elderly

% d'admission de 8% à 39%

Ariane Boumendil^{1,2,3*}, Derek C. Angus⁴, Anne-Laure Guitonneau⁵, Anne-Marie Menn⁶, Christine Ginsburg⁷, Khalil Takun⁷, Alain Davido⁸, Rafik Masmoudi⁸, Benoît Doumenc⁹, Dominique Pateron¹⁰, Maité Garrouste-Orgeas¹¹, Dominique Somme¹², Tabassome Simon^{13,14}, Philippe Aegerter^{3,15}, Bertrand Guidet^{1,2,16} on behalf of the ICE-CUB study group[¶]





ESICM consensus-based recommendations for the management of very old patients in intensive care

DECISION-MAKING IN PATIENTS PRESENTING WITH CRITICAL CONDITIONS



Decisions to limit life-sustaining therapy should not be based on chronological age alone.

Patients should be asked about preferences for treatment escalation (if possible).

The evaluation of the expected quality of life after the critical illness has to consider the patient's perspective, (if available).

For patients with substantial prognostic uncertainty due to the acute condition, a time-limited-trial could be considered after agreement with patients / caregivers.

MANAGEMENT IN THE ICU



There should be a guideline for the prevention of pressure ulcers and other skin problems.

Early mobilisation should be initiated in the ICU.

Treatment escalation or de-escalation plans and goals of care should be reviewed at regular intervals in the ICU.

AFTER THE ICU



A statement about future goals of care should be documented in the patient record (e.g., as treatment escalation plan).

Le futur

Formation interdisciplinaire

Adaptation de l'offre de soins

Diffusion – appropriation des recommandations

Remerciements

Etudes multicentriques

Services cliniques

ICE-CUB 1 & 2

VIP 1 & 2

COVIP

Sociétés savantes

SRLF

ESICM: Health Services Research Outcome section

Aide à la recherche

PHRC - DRCI - URC-Est (T Simon)

Expertises

Statistique : A Boumendil

Gériatrie : H Vallet

Médecine d'urgence : D Pateron

Revue systématique : A Dechartres

Base de données CUB-REA : Ph Aegerter

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THE RISE OF OCTOGENARIANS

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