

SROVNÁNÍ DIAGNOSTICKÝCH KRITÉRIÍ SIRS A qSOFA V PODMÍNKÁCH URGENTNÍ MEDICÍNY



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PROČ SE ZAJÍMAT O SEPSI V URGENTNÍ MEDICÍNĚ?

V intenzivní medicíně již dlouho v centru pozornosti...

Surviving sepsis campaign, aktualizace doporučení, Sepsis-3

System	0 bodů	1 bod	2 body	3 body	4 body
Respirační					
PaO ₂ /FiO ₂ mmHg (kPa)	≥ 400 (53,3)	<400 (53,3)	<300 (40)	<200 26,7) s podporou dýchání	<100 (13,3) s podporou dýchání
Koagulace					
Trombocyty x 10 ³ /μL	≥150	<150	<100	<50	<20
Játra					
Bilirubin mg/dL (μmol/l)	<1,2 (20)	1,2 – 1,9 (20 – 32)	2,0 – 5,9 (33 – 101)	6,0 – 11,9 102 – 204)	>12,0 (204)
Kardiovaskulární	MAP ≥ 70 mmHg	MAP < 70 mmHg	Dopamin < 5 nebo jakákoliv dávka dobutaminu ¹	Dopamin 5,1-15 nebo adrenalin ≤ 0,1 nebo noradrenalin ≤ 0,1 ¹	Dopamin > 15 nebo adrenalin > 0,1 nebo noradrenalin > 0,1 ¹
Centrální nervový systém					
Glasgow Coma Score	15	13 – 14	10 – 12	6 - 9	<6
Renální funkce					
Kreatinin mg/dL (μmol/L)	<1,2 (110)	1,2 – 1,9 (110 – 170)	2,0 – 3,4 (171 – 299)	3,5 – 4,9 (300 – 440)	>5,0 (440)
Diuréza (mL/d)				<500	<200

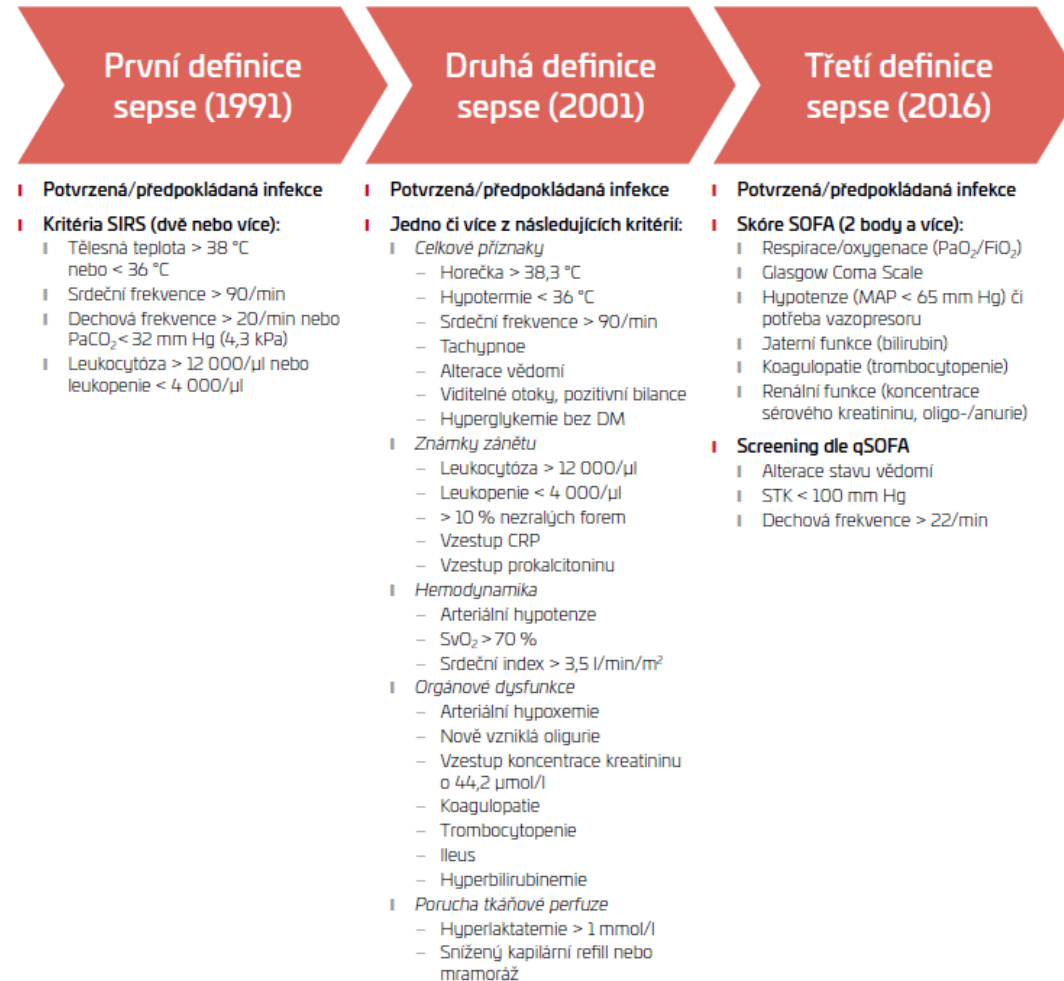
Zkratky: FiO₂ - frakce vdechovaného kyslíku, MAP – (mean arterial pressure) = střední arteriální tlak, PaO₂ - parciální tlak kyslíku

¹ Dávky katecholaminů jsou uvedeny jako μg/kg/min po dobu nejméně jedné hodiny



VÝVOJ DEFINIC SEPSE

(Zdroj: Matějovič M.: Sepse a její nová definice, Postgraduální nefrologie, XV, 2017 (1): 4-7.

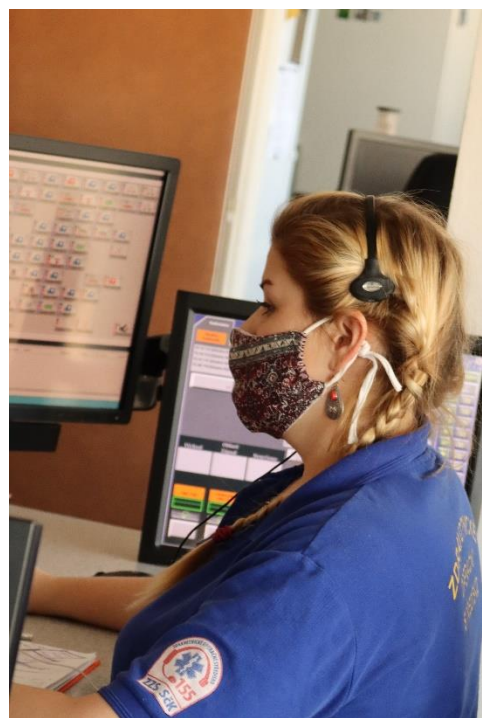


OBR. 1 Srovnání původních definic a nové definice sepse

CRP – C-reaktivní protein; DM – diabetes mellitus; FIO₂ – inspirační koncentrace kyslíku; MAP – střední arteriální tlak; PaCO₂ – parciální tlak oxidu uhličitého v arteriální krvi; PaO₂ – parciální tlak kyslíku v arteriální krvi; SIRS – kritéria systémové zánětlivé odpovědi (systemic inflammatory response syndrome); SvO₂ – saturace smíšené žilní krve; STK – systolický krevní tlak

ROZDÍLY OPROTI INTENZIVNÍ MEDICÍNĚ

Neselektovaná populace v PNP a na UP, mitigované příznaky nebo zcela matoucí příznaky, prodlevy v diagnostice i v léčbě při přijímání na standardní oddělení...



SKÓROVACÍ SYSTÉMY PRO DETEKCI SEPSE

qSOFA pro primární péči včetně přednemocniční a pro urgentní příjmy?

SIRS = 2 a více faktorů:

- ▣ teplota nad 38° C nebo pod 36° C
- ▣ Tepová frekvence nad 90/min.
- ▣ Dechová frekvence nad 20 dechů/min nebo PaO₂ pod 32 mmHg (4,3 kPa)
- ▣ Leukocyty nad 12 000 nebo pod 4000 nebo více než 10 % nezralých forem



SOFA / qSOFA = 2 a více bodů

- alterace stavu vědomí – GCS < 15
- dechová frekvence > 22
- systolický tlak ≤ 100

NĚKTERÉ DALŠÍ SKÓROVACÍ SYSTÉMY

CIS (Clinical Impression Score), PIRO, NEWS/MEWS, SPEED

Sepsis patients in the emergency department: stratification using the Clinical Impression Score, Predisposition, Infection, Response and Organ dysfunction score or quick Sequential Organ Failure Assessment score?

Vincent M. Quinten^a, Matijs van Meurs^{b,c}, Anna E. Wolffensperger^a, Jan C. ter Maaten^a and Jack J.M. Ligtenberg^a

Objective The aim of this study was to compare the stratification of sepsis patients in the emergency department (ED) for ICU admission and mortality using the Predisposition, Infection, Response and Organ dysfunction (PIRO) and quick Sequential Organ Failure Assessment (qSOFA) scores with clinical judgement assessed by the ED staff.

Patients and methods This was a prospective observational study in the ED of a tertiary care teaching hospital. Adult nontrauma patients with suspected infection and at least two Systemic Inflammatory Response Syndrome criteria were included. The primary outcome was direct ED to ICU admission. The secondary outcomes were

predicted in-hospital (AUC = 0.764), 28-day (AUC = 0.784) and 6-month mortality (AUC = 0.695). The qSOFA score also predicted in-hospital (AUC = 0.823), 28-day (AUC = 0.848) and 6-month mortality (AUC = 0.620).

Conclusion Clinical judgement is a fast and reliable method to stratify between ICU and general ward admission in ED patients with sepsis. The PIRO and qSOFA scores do not add value to this stratification, but perform better on the prediction of mortality. In sepsis patients, therefore, the principle of 'treat first what kills first' can be supplemented with 'judge first and calculate later'. *European Journal of Emergency Medicine* 25:328–334 Copyright © 2018 The Author(s). Published by Wolters Kluwer Health, Inc.

Superior performance of National Early Warning Score compared with quick Sepsis-related Organ Failure Assessment Score in predicting adverse outcomes: a retrospective observational study of patients in the prehospital setting

Daniel J. Silcock^a, Alasdair R. Corfield^{b,c}, Kevin D. Rooney^{a,d} and Harry Staines^d

Background Early intervention and response to deranged physiological parameters in the critically ill patient improve outcomes. A National Early Warning Score (NEWS) based on physiological observations has been developed for use throughout the National Health Service in the UK. The quick Sepsis-related Organ Failure Assessment Score (qSOFA) was developed as a simple bedside criterion to identify adult patients outwith the ICU with suspected infection who are likely to have a prolonged ICU stay or die in hospital. We aim to compare the ability of NEWS and qSOFA to predict adverse outcomes in a prehospital population.

Patients and methods All clinical observations taken by emergency ambulance crews transporting patients to a single hospital were collated along with information relating to mortality over a 2-month period. The performance of the

curve for the primary outcome for qSOFA was 0.679 (95% CI: 0.624–0.733), for NEWS category was 0.707 (95% CI: 0.654–0.761) and for NEWS total score was 0.740 (95% CI: 0.685–0.795). Comparison of the receiver operating characteristic curves between NEWS total score and qSOFA using DeLong's test showed NEWS total score to be superior to qSOFA at predicting combined ICU admission within 48 h of presentation or 30-day mortality ($P = 0.011$).

Conclusion Our study shows qSOFA can identify patients at risk of adverse outcomes in the prehospital setting. However, NEWS is superior to qSOFA in a prehospital environment at identifying patients at risk of adverse outcomes. *European Journal of Emergency Medicine* 00:000–000 Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

The SPEED (sepsis patient evaluation in the emergency department) score: a risk stratification and outcome prediction tool

Jan Philipp Bewersdorf^a, Oliver Hautmann^a, Daniel Kofink^c, Alizan Abdul Khalil^a, Imran Zainal Abidin^b and Alexander Loch^b

Objectives The aim of the study was to identify covariates associated with 28-day mortality in septic patients admitted to the emergency department and derive and validate a score that stratifies mortality risk utilizing parameters that are readily available.

Methods Patients with an admission diagnosis of suspected or confirmed infection and fulfilling at least two criteria for severe inflammatory response syndrome were included in this study. Patients' characteristics, vital signs, and laboratory values were used to identify prognostic factors for mortality. A scoring system was derived and validated. The primary outcome was the 28-day mortality rate.

derivation and 0.81 (0.73–0.90) in the validation set. The SPEED (sepsis patient evaluation in the emergency department) score performed better ($P = 0.02$) than the Mortality in Emergency Department Sepsis score when applied to the complete study population with an area under the curve of 0.81 (0.76–0.85) as compared with 0.74 (0.70–0.79).

Conclusion The SPEED score predicts 28-day mortality in septic patients. It is simple and its predictive value is comparable to that of other scoring systems. *European Journal of Emergency Medicine* 24:170–175 Copyright © 2017 The Author(s). Published by Wolters Kluwer Health, Inc.

Srovnání diagnostických kritérií SIRS a qSOFA pro časnou diagnostiku sepse – 4S - Prospektivní observační studie

Cíl: 200 pacientů, 1. 2. 2018 – 29. 2. 2020, celkem 203 pacientů

1. 3. 2020 – první tři potvrzené případy infekce SARS-CoV-2

• HLAVNÍ CÍL:

- porovnání diagnostických kritérií (SIRS versus qSOFA) sepse v urgentní medicíně: porovnat výše uvedené hodnoty vitálních funkcí u zařazených pacientů (SIRS versus SOFA) podle výsledných skupin: bez dg infekce, infekce, sepse;

• VEDLEJŠÍ CÍLE:

- zjistit dosaženou **diagnostickou přesnost v přednemocniční fázi** na základě výsledné diagnózy v nemocnici (infekční versus neinfekční diagnóza)
- porovnat **hospitalizační letalitu („case-fatality ratio“)** v jednotlivých skupinách



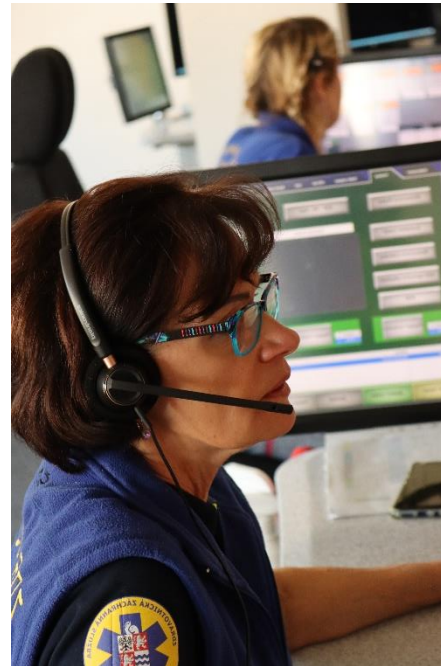
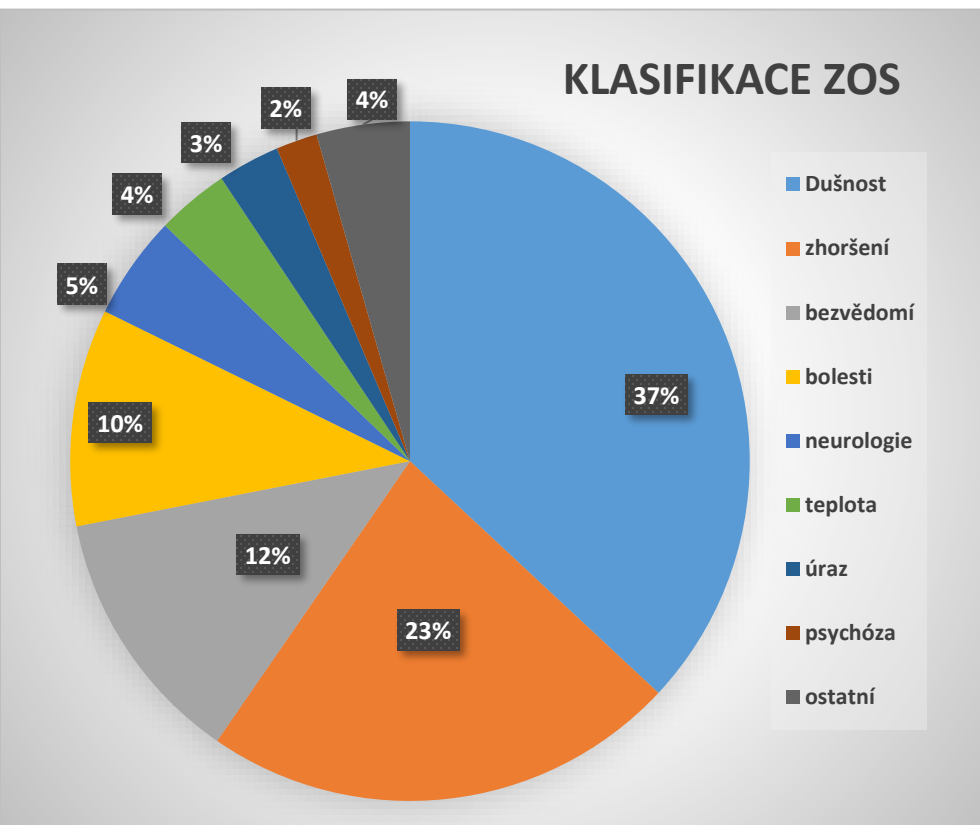
ZAŘAZOVACÍ KRITÉRIA

- febrilní stav nebo hypotermie
- **a současně předpokládaná diagnóza infekčního onemocnění**
 - respirační: dušnost, kašel
 - močové infekce – příznaky infekce močových cest, zavedený permanentní močový katetr
 - GIT – průjmy, zvracení
 - dekubity se sekrecí
 - jakýkoliv suspektní zdroj infekce



DIAGNOSTICKÁ PŘESNOST V PNP

KLASIFIKACE OPERAČNÍHO STŘEDISKA



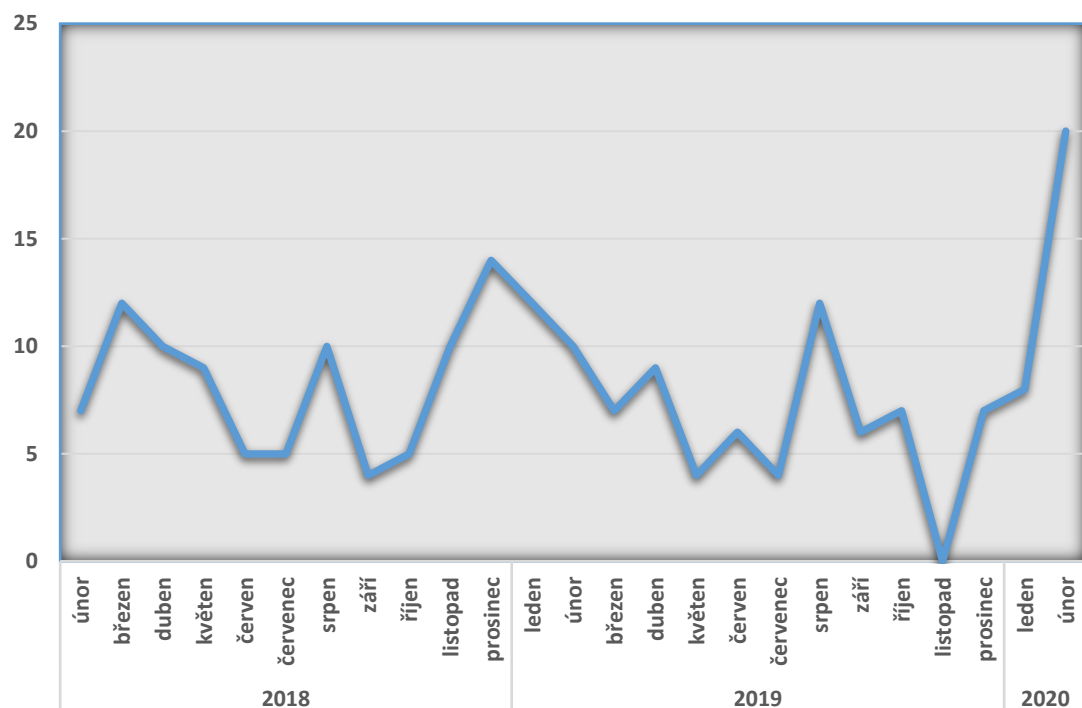
- Dušnost 75
- Zhoršení stavu 46
- Bezvědomí / poruchy vědomí / kolaps 25
- Bolest /na hrudi / břicha / stenokardie / lumbago 21
- CMP / nespecifikované neurologické obtíže 10
- Teplota 7
- Úraz / pád 6
- Psychóza 4
- Dehydratace, hypertenze, alergie, hypoglykémie, intoxikace, křeče, ležící osoba, otevírání bytu, **NEVÍME**

DIAGNOSTICKÁ PŘESNOST V PNP – záchranáři a lékaři

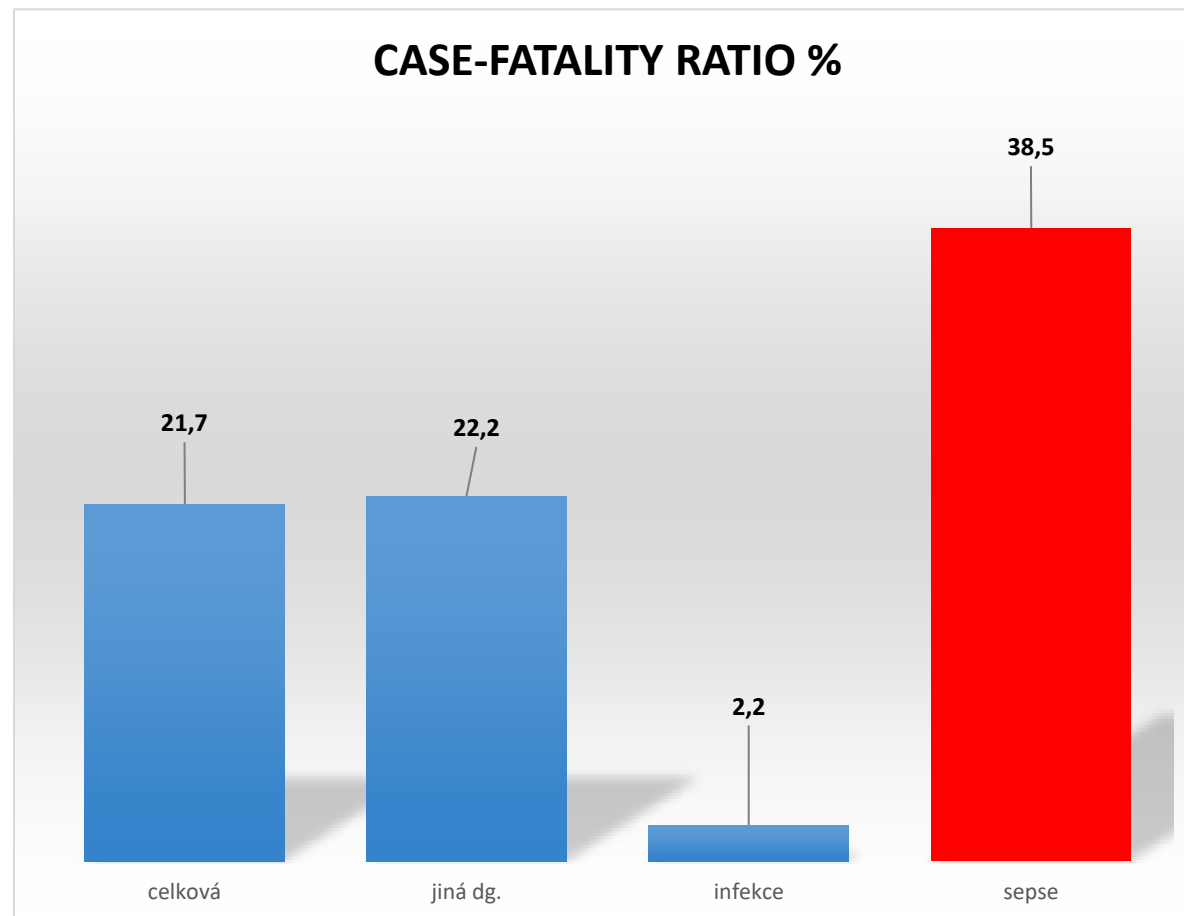
Zařazování pacientů: 204 celkem, 104 sepse, 90 infekce, 9 neinfekční diagnóza

96 % infekční dg, 51 % sepse

ROZLOŽENÍ V ČASE



CASE-FATALITY RATIO %



SIRS NEBO qSOFA V DIAGNOSTICE?

	SENZITIVITA	SPECIFICITA
SIRS - ZZS	71.2% (95%CI: 61.5-79.6)	30.3% (95%CI: 21.5-40.4)
SIRS - UP	87.5% (95%CI: 79.6-93.3)	34.3% (95%CI: 25.1-44.6)
qSOFA - ZZS	39.4% (95%CI: 30.3-49.5)	84.9% (95%CI: 76.2-91.3)
qSOFA - UP	43.3% (95%CI: 33.6-53.4)	83.8% (95%CI: 75.1-90.5)

KLINICKÝ VÝZNAM qSOFA

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January 2018 Volume 71, Issue 1, Pages 1–9.e2 [Next Article >](#)

Low Accuracy of Positive qSOFA Criteria for Predicting 28-Day Mortality in Critically Ill Septic Patients During the Early Period After Emergency Department Presentation

Sung Yoon Hwang, MD, Ik Joon Jo, MD, Se Uk Lee, MD, Tae Rim Lee, MD, Hee Yoon, MD, Won Chul Cha, MD, Min Seob Sim, MD, Tae Gun Shin, MD

PlumX Metrics

DOI: <https://doi.org/10.1016/j.annemergmed.2017.05.022> | [Check for updates](#)

Article Info

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graph TD; A[Assessed for eligibility (n=1,728)] --> B[Total study population (n=1,395)]; A --> C[Exclusion (n=333)  
1. Terminal malignancy (n=160)  
2. DNR orders or refusal of invasive procedures (n=173)]; B --> D[Positive qSOFA within 3 hours (n=717)]; B --> E[Negative qSOFA within 3 hours (n=678)];
```

Figure 1. Patients included in the analysis. DNR, Do not resuscitate.

qSOFA found to have a low sensitivity and poor ability to work as a screening test for ED admitted patients who appeared very sick which questions its implementation against the model of early recognition and timely management.

Prognostic value of prehospital quick sequential organ failure assessment score among patients with suspected infection

Prabakar Vaittinada Ayar^{a,b}, Mathieu Delay^b, Aurélie Avondo^d, François-Xavier Duchateau^e, Pierre Nadiras^f, Frédéric Lapostolle^g, Tahar Chouihed^h and Yonathan Freund^{b,c}

Objective After the third international consensus on sepsis released its new definitions, the prognostic value of quick sequential organ failure assessment (qSOFA) score has been confirmed in the emergency department. However, its validity in the prehospital setting remains unknown. The objective of the study was to assess its accuracy for prehospital patients cared by emergency physician-staffed ambulances (services mobiles d'urgence et de réanimation SMUR).

Patients and methods This was a prospective observational multicenter cohort study (N = 6). All consecutive patients with prehospital clinical suspicion of

qSOFA less than 2 (absolute difference 23%; 95% confidence interval: 13–33%, P < 0.001). The overall discrimination for qSOFA was poor, with an area under the receiver operating characteristic curve of 0.69 (95% confidence interval: 0.62–0.74).

Conclusion In this large multicenter study, prehospital qSOFA presents a strong association with mortality in infected patient, though with poor prognostic performances in our severely ill sample. *European Journal of Emergency Medicine* 00:000–000 Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

European Journal of Emergency Medicine 2018, 00:000–000

Early variation of quick sequential organ failure assessment score to predict in-hospital mortality in emergency department patients with suspected infection

Najla Lemachatti^{a,b}, Mar Ortega^m, Andrea Penaloza^o, Pierrick Le Borgne^h, Pierre-Géraud Claretⁱ, Céline Occelli^j, Jennifer Truchot^c, Florence Dumas^d, Anne-Laure Feral-Pierssens^e, Héry Andrianjafy^k, Sebastien Beaune^f, Youri Yordanov^{a,g}, Pierre Hausfater^{a,b}, Bruno Riou^{a,b}, Ben Bloomⁿ, Evguenia Krastinova^l and Yonathan Freund^{a,b}; for the French Society of Emergency Medicine Collaborators Group and the INFURGSEMES Group

Background The quick sequential organ failure assessment (qSOFA) score showed good prognostic performance in patients with suspicion of infection in the emergency department (ED). However, previous studies only assessed the performance of individual values of qSOFA during the ED stay. As this score may vary over short timeframes, the optimal time of measurement, and the prognostic value of its variation are unclear. The objective of the present study was to prospectively assess the prognostic value of the change in qSOFA over the first 3 h (Δ qSOFA = qSOFA at 3 h – qSOFA at inclusion).

between patients who died and those who survived (0.15, 95% confidence interval: 0.09–0.22, P < 0.001).

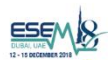
Conclusion In patients with suspected infection presenting to the ED with a qSOFA of 2 or higher, the early change in qSOFA is a strong independent predictor of mortality. *European Journal of Emergency Medicine* 00:000–000 Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

European Journal of Emergency Medicine 2018, 00:000–000

Keywords: emergency department,

KLINICKÝ VÝZNAM qSOFA

umí identifikovat kritického, ale nikoliv nutně septického pacienta
studie se shodují na predikci mortality, na nízké senzitivitě a vysoké specifitě



12-13 NOVEMBER 2019



Is (q)SOFA Criteria accurate for Predicting Mortality in sepsis?

NO

Dr. Nidal Shawish. MD, MB.ChB., JBEM

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CHEST
Organ Dysfunction
and Organ Dysfunction
A Prospective Cohort Study of ED Patients With Sepsis
Williams et al. Chest 2017; 151: 1001-1008

Background: A proposed revision of sepsis definitions has identified the window to implement sepsis-3 criteria (SIRS, defined organ dysfunction as an increase in end organ dysfunction) as a key challenge. We evaluated the diagnostic accuracy of SIRS and qSOFA for organ dysfunction and mortality in ED patients with sepsis.

Methods: We enrolled 8,871 patients with SIRS present in the ED. We evaluated the diagnostic accuracy of SIRS and qSOFA for organ dysfunction and mortality in ED patients with sepsis. We compared the diagnostic accuracy of SIRS and qSOFA for organ dysfunction and mortality in ED patients with sepsis.

Results: We enrolled 8,871 patients with SIRS present in the ED. SIRS was associated with increased risk of organ dysfunction (OR 3.5) and mortality in patients with sepsis. qSOFA was specific but poorly sensitive for organ dysfunction (96.1% and 29.7%, respectively). Mortality for patients with organ dysfunction was similar for Sepsis-2 and Sepsis-3 (12.5% and 11.4%, respectively), although 29% of patients with Sepsis-3 organ dysfunction did not meet Sepsis-2 criteria. Increasing numbers of Sepsis-2 organ system dysfunctions were associated with greater mortality.

Conclusions: SIRS was associated with organ dysfunction and mortality, and abandoning the concept appears premature. A qSOFA score >2 showed high specificity, but poor sensitivity may limit utility as a bedside screening method. Although mortality for organ dysfunction was comparable between Sepsis-2 and Sepsis-3, more prognostic and clinical information is conveyed using Sepsis-2 regarding number and type of organ dysfunctions. The SOFA score may require recalibration with patient's data.

který chcete změnit, a nahradit ho něčím jiným.

(Williams et al., 2017) published in CHEST found that it was not the right time to abandon SIRS criteria.

They enrolled 8,871 patients, with SIRS present in 4,176 (47.1%). SIRS was associated with increased risk of organ dysfunction (relative risk [RR] 3.5) and mortality in patients without organ dysfunction (OR 3.2). SIRS and qSOFA showed similar discrimination for organ dysfunction (area under the receiver operating characteristic curve, 0.72 vs 0.73).

qSOFA was specific but poorly sensitive for organ dysfunction (96.1% and 29.7%, respectively). Mortality for patients with organ dysfunction was similar for Sepsis-2 and Sepsis-3 (12.5% and 11.4%, respectively), although 29% of patients with Sepsis-3 organ dysfunction did not meet Sepsis-2 criteria. Increasing numbers of Sepsis-2 organ system dysfunctions were associated with greater mortality.

CONCLUSIONS:

SIRS was associated with organ dysfunction and mortality, and abandoning the concept appears premature.

A qSOFA score >2 showed high specificity, but poor sensitivity may limit utility as a bedside screening method. Although mortality for organ dysfunction was comparable between Sepsis-2 and Sepsis-3, more prognostic and clinical information is conveyed using Sepsis-2 regarding number and type of organ dysfunctions. The SOFA score may require recalibration with patient's data.

CO DALŠÍHO NÁM DATA UKÁZALA?

	Pocet (%)	Prumerny vek	Prumerne CRP	Prumerne Leukocyty	Prumer Poctu selhavajicich organu
Cely vzorek	203 (100%)	74.1 (12.7)	122.1 (11.8)	12.5 (6.0)	1.4 (1.2)
Muzi	106 (52.2%)	72.4 (14.5)	128.3 (126.2)	12.4 (5.7)	1.5 (1.3)
Zeny	97 (47.8%)	75.9 (14.7)	115.4 (93.9)	12.7 (6.3)	1.3 (1.1)
Bez sepse	99 (48.8%)	73.4 (13.9)	62.6 (64.4)	11.4 (4.8)	0.7 (0.9)
Se sepsi	104 (51.2%)	74.8 (15.4)	178.7 (118.1)	13.6 (6.7)	2.1 (1.1)
Propusten/a	159 (78.3%)	72.5 (14.2)	109.1 (100.8)	12.1 (5.5)	1.2 (1.1)
Zemrel/a	44 (21.7%)	79.9 (15.2)	169.0 (136.0)	14.1 (7.4)	2.2 (1.1)
Sepse+Propusten/a	64 (61.5%)	71.9 (14.6)	177.4 (106.9)	13.2 (6.2)	2.0 (1.2)
Sepse + Zemrel/a	40 (38.5%)	79.3 (15.7)	180.8 (135.4)	14.4 (7.4)	2.3 (1.1)

JEDNOTLIVÉ POLOŽKY qSOFA V PNP

	Pocet (%)	Prumerny Systolicky tlak	Prumerny diastolicky tlak	Prumerna Dechova Frekvence	Prumerna teplota	Prumerne GCS
Cely vzorek	203 (100%)	131.2 (34.3)	73.3(20.0)	24.5 (9.0)	38.2 (1.2)	13.8 (2.4)
Muzi	106 (52.2%)	132.4 (34.8)	74.3 (19.6)	24.4 (9.9)	38.3 (1.1)	13.7 (2.4)
Zeny	97 (47.8%)	130.0 (33.8)	72.3 (20.5)	23.6 (9.4)	38.0 (1.3)	13.8 (2.6)
Bez sepse	99 (48.8%)	142.2 (30.1)	79.6 (15.9)	22.7 (8.5)	38.3 (1.1)	14.4 (1.6)
Se sepsi	104 (51.2%)	120.8 (34.9)	67.5 (21.8)	25.2 (10.6)	38.1 (1.3)	13.1 (2.9)
Propusten/a	159 (78.3%)	135.1 (33.5)	75.7 (17.9)	23.4 (9.1)	38.2 (1.1)	14.2 (1.9)
Zemrel/a	44 (21.7%)	117.3 (33.8)	64.9 (24.9)	26.2 (11.2)	37.8 (1.4)	12.2 (3.5)
Sepse+Propusten/a	64 (61.5%)	124.4 (35.1)	69.3 (19.1)	24.5 (9.9)	38.2 (1.4)	13.6 (2.7)
Sepse + Zemrel/a	40 (38.5%)	114.8 (135.4)	64.3 (25.4)	26.3 (11.6)	37.9 (1.1)	12.5 (3.2)

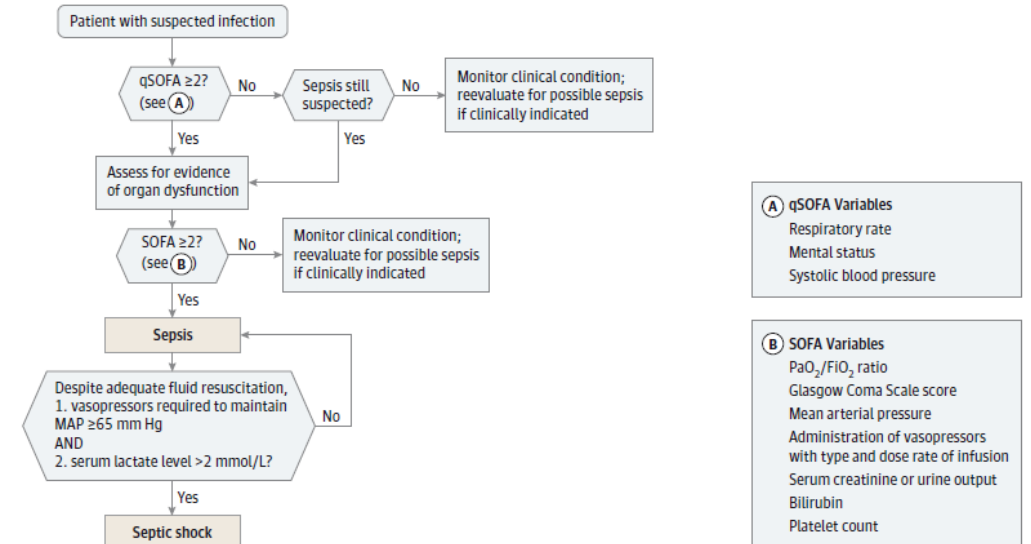
JEDNOTLIVÉ POLOŽKY qSOFA NA UP

	Pocet (%)	<u>Prumerny Systolicky tlak</u>	<u>Prumerny diastolicky tlak</u>	Prumerna Dechova Frekvence	Prumerna teplota	Prumerne GCS
Cely vzorek	203 (100%)	134.3 (32.0)	78.6 (18.8)	24.6 (9.0)	37.8 (1.1)	13.7 (2.4)
Muzi	106 (52.2%)	135.0 (33.4)	80.9 (18.7)	24.5 (9.3)	37.9 (1.0)	13.7 (2.3)
Zeny	97 (47.8%)	133.5 (30.7)	76.1 (19.7)	24.7 (8.6)	37.6 (1.1)	13.8 (2.6)
Bez sepse	99 (48.8%)	143.6 (27.2)	83.5 (16.7)	22.9 (7.3)	37.9 (0.9)	14.5 (1.5)
Se sepsi	104 (51.2%)	125.4 (33.8)	73.9 (19.4)	26.1 (10.1)	37.3 (1.2)	10.0 (2.9)
Propusten/a	159 (78.3%)	137.8 (31.6)	79.8 (18.6)	23.4 (9.1)	37.9 (1.1)	14.2 (1.8)
Zemrel/a	44 (21.7%)	121.5 (30.8)	74.2 (19.2)	25.8 (8.6)	37.4 (1.1)	12.1 (3.5)
Sepse+Propusten/a	64 (61.5%)	128.8 (35.3)	73.7 (19.4)	26.2 (10.8)	37.9 (1.2)	13.5 (2.6)
Sepse + <u>Zemrel/a</u>	40 (38.5%)	119.9 (31.1)	74.2 (19.9)	26.2 (8.9)	37.4 (1.1)	12.3 (3.3)

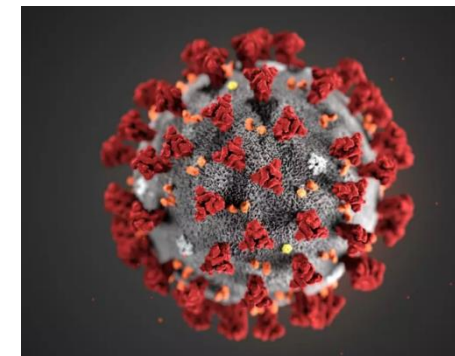
CO DÁL V URGENTNÍ MEDICÍNĚ A JAK SNÍŽIT LETALITU?

- Pro diagnostiku je potřeba zejména na sepsi myslet
 - a pak lze užít jakékoliv skórovací schéma
- Nejvyšší čas vypracovat doporučené postupy pro urgentní medicínu
 - s ohledem na pacienty, co velmi pravděpodobně budou přijati na standardní oddělení
- Každý UP by měl mít organizační a terapeutický standard
 - Včetně vypracované ATB léčby ve spolupráci s místním ATB střediskem

Figure. Operationalization of Clinical Criteria Identifying Patients With Sepsis and Septic Shock



The baseline Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score should be assumed to be zero unless the patient is known to have preexisting (acute or chronic) organ dysfunction before the onset of infection. qSOFA indicates quick SOFA; MAP, mean arterial pressure.





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