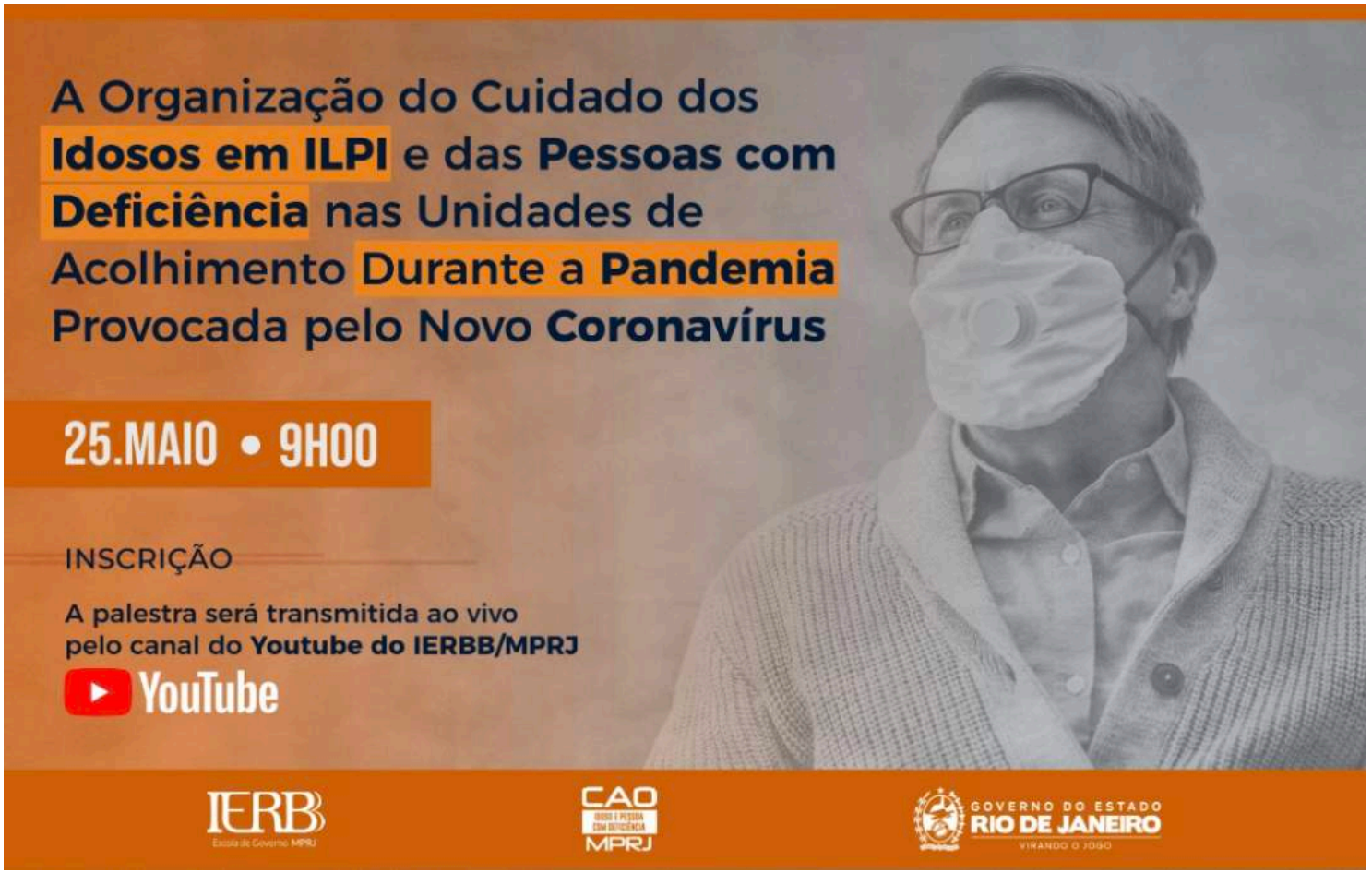

A Organização do Cuidado dos Idosos em ILPI e das Pessoas com Deficiência nas Unidades de Acolhimento Durante a Pandemia Provocada pelo Novo Coronavírus
25.MAIO • 9H00
INSCRIÇÃO
A palestra será transmitida ao vivo pelo canal do Youtube do IERBB/MPRJ
YouTube
IERBB
CAO MPRJ
GOVERNO DO ESTADO RIO DE JANEIRO

Covid-19: Manejo Clínico em Idosos nas ILPIs

Virgílio Garcia Moreira MD MSc PhD

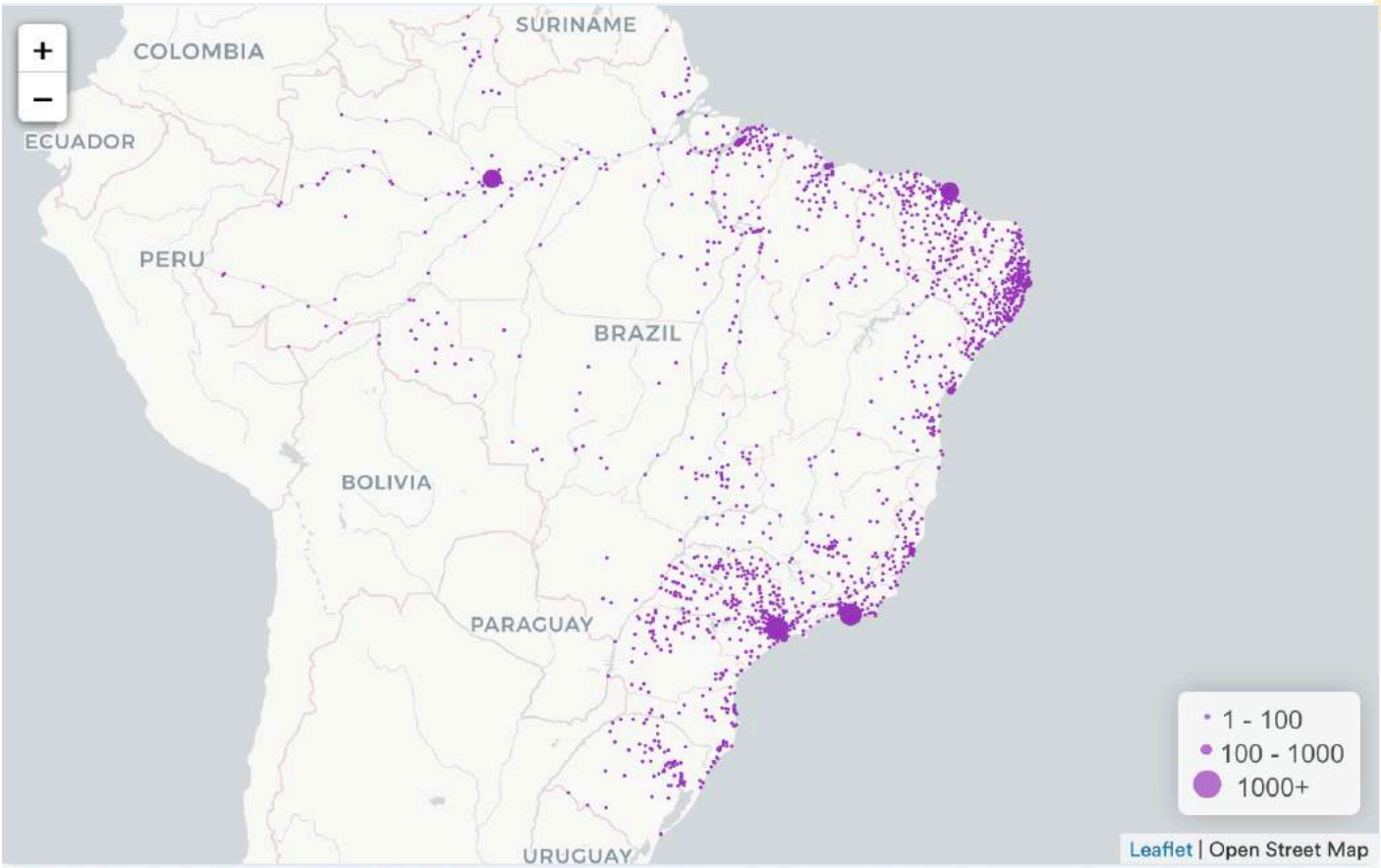
Médico Geriatra

Pesquisador Associado do Laboratório de Pesquisas em Envelhecimento Humano – GeronLab – Universidade do Estado do Rio de Janeiro

Membro da Comissão Científica da Sociedade Brasileira de Geriatria e Gerontologia – Rio de Janeiro

Adhikari SP, Meng S, Wu YJ, et al. Epidemiology, causes, clinical manifestation and diagnosis, prevention and control of coronavirus disease (COVID-19) during the early outbreak period: a scoping review. Infect Dis Poverty 2020; 9: 29

Óbitos de COVID-19 por Município de notificação



Fonte: Secretarias Estaduais de Saúde. Brasil, 2020

https://covid.saude.gov.br (acessado em 24/05/2020)

https://covid.saude.gov.br (acessado em 24/05/2020)

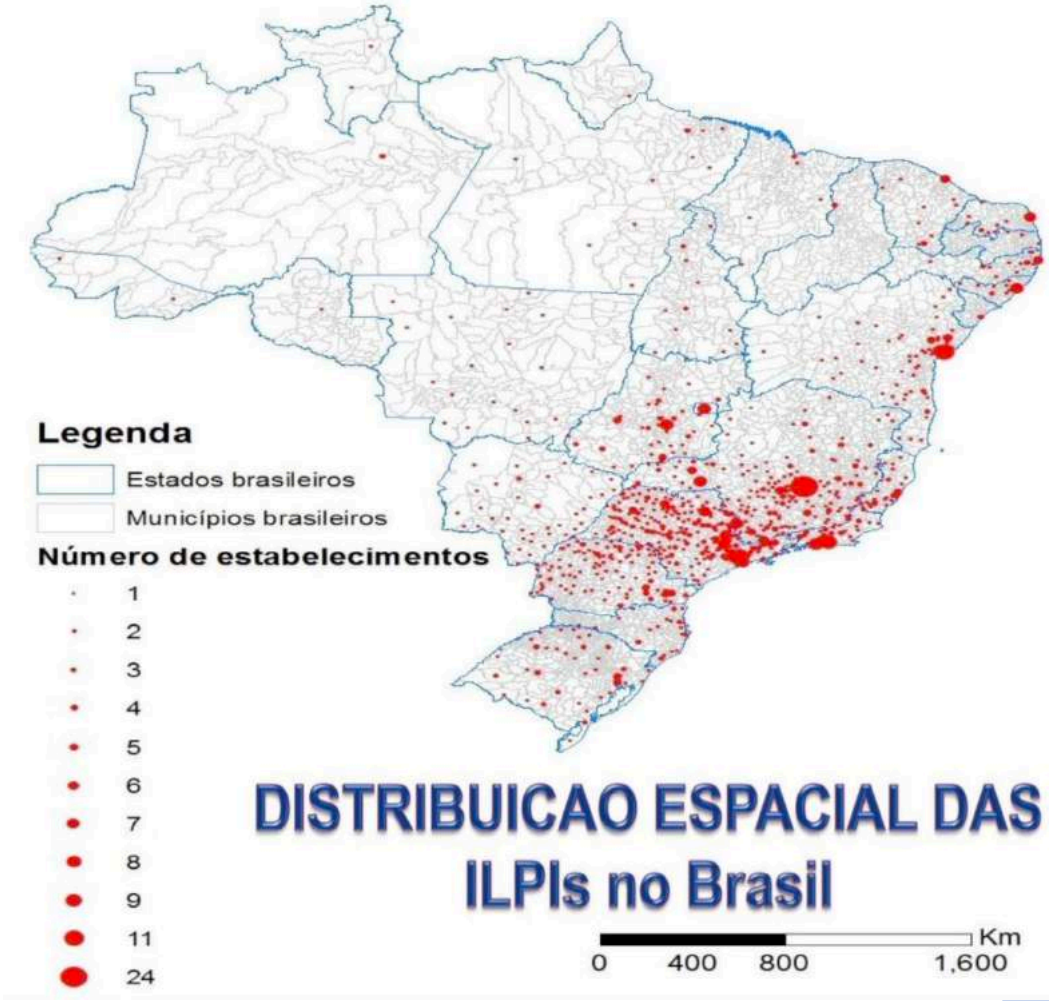
INTERNATIONAL LONG TERM CARE POLICY NETWORK

Mortality associated with COVID-19 outbreaks in care homes: early international evidence

Adelina Comas-Herrera, Joseba Zalakaín, Charles Litwin, Amy T. Hsu, Natasha Lane and Jose-Luis Fernández

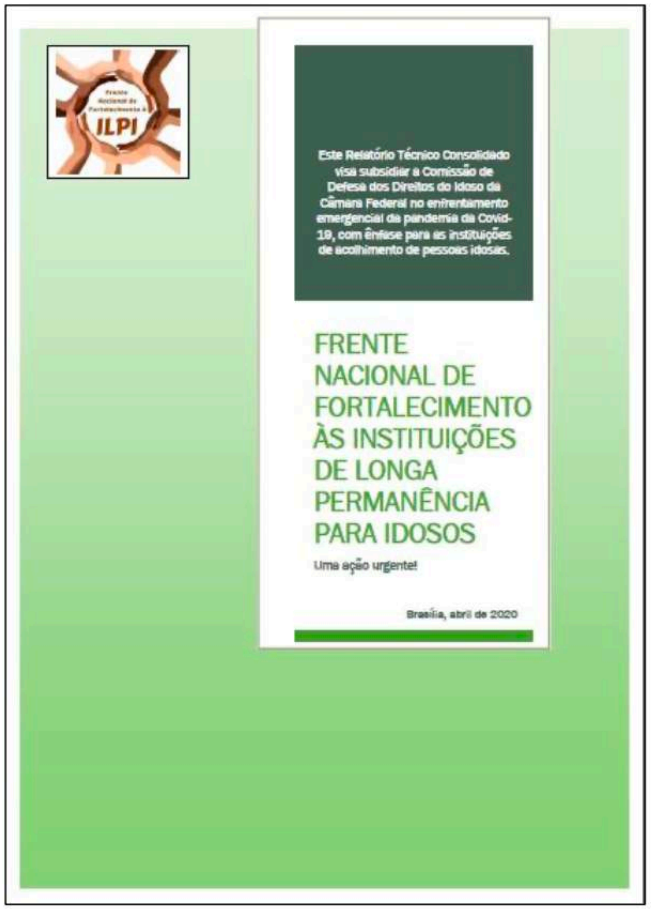
- Israel: 32%
- Dinamarca: 33%
- Alemanha: 36%
- França: 51%
- Ontário, Canadá: 70%

Adelina Comas-Herrera JZ, CharlesLitewin, Amy Hsu, Natashca Lane, Jose-Luis Fernandez. Mortality associated with COVID-19 outbreaks in care homes: early international evidence, (2020, accessed 18/05/2020 2020)



Giacomin, K. et al. Frente Nacional de Fortalecimento ILPIS. SBGG; 2020

Relatório Final



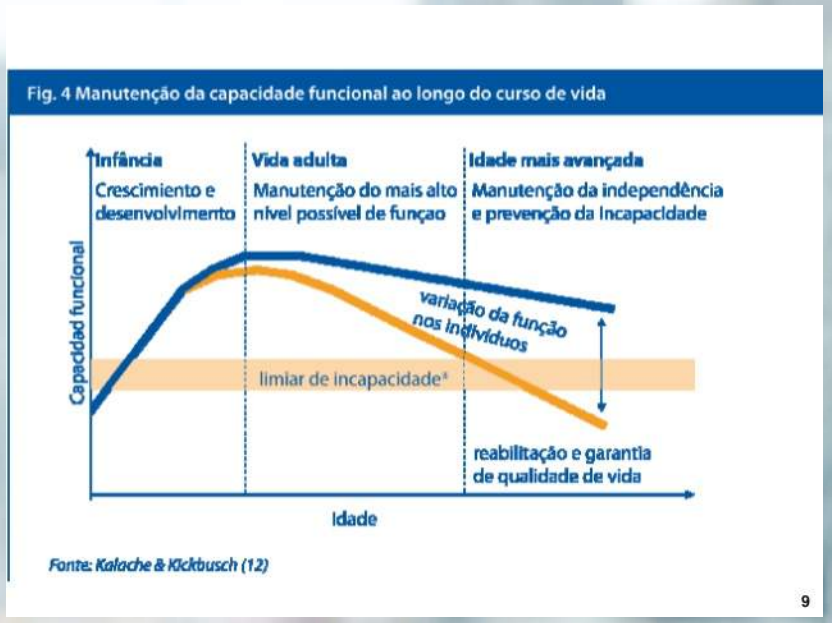
https://sbgg.org.br/relatorio-tecnico-frente-nacional-de-fortalecimento-a-ilpi-2/

Giacomin, K. et al. Frente Nacional de Fortalecimento ILPIS. SBGG; 2020

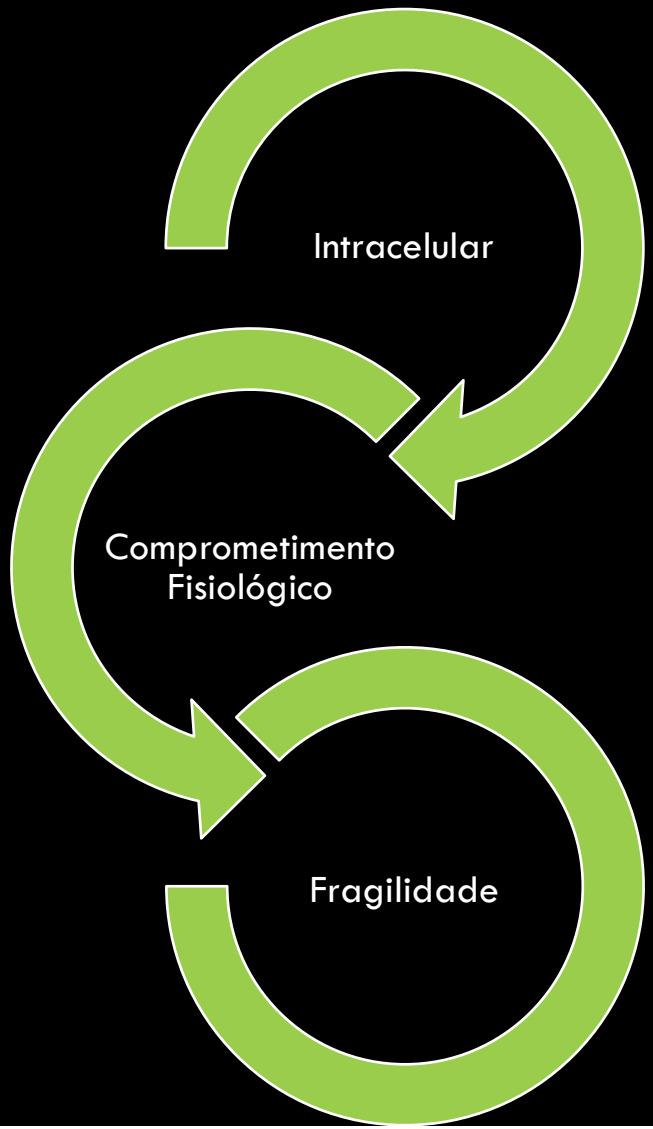

Urgência das ILPIs?

Alterações Fisiológicas no Idoso

1. Sistema Imunológico
2. Sistema Cardiovascular
3. Centro Termo-regulador
4. Perda de Massa Muscular
5. Redução da água intracelular
6. Aumento da gordura corporal



Fragilidade
Modelo hipotético



Estresse Oxidativo
Senescência Celular
Lesão em DNA
Doenças Inflamatórias

Anorexia
Sarcopenia
Comprometimento da imunidade
Declínio Cognitivo
Disfunção Endócrina

Fraqueza muscular
Velocidade reduzida
Perda de Peso
Sensação de Exaustão
Gasto calórico reduzido

Walston, 2006

Fragilidade

Vulnerabilidade

ARTIGO ESPECIAL

CONSENSO BRASILEIRO DE FRAGILIDADE EM IDOSOS: CONCEITOS, EPIDEMIOLOGIA E INSTRUMENTOS DE AVALIAÇÃO

Brazilian consensus on frailty in older people: concepts, epidemiology and evaluation instruments

Roberto Alves Lourenço[a,b], Virgílio Garcia Moreira[a,b], Renato Gorga Bandeira de Mello[a,c], Itamar de Souza Santos[a,d], Sumika Mori Lin[a,d], Ana Lúcia Fiebrantz Pinto[a,e], Lygia Paccini Lustosa[a,f], Yeda Aparecida de Oliveira Duarte[a,d], Juliana Alcântara Ribeiro[a,e], Clarice Câmara Correia[a,g], Henrique Novaes Mansur[a,h], Euler Ribeiro[a,i], Roberta Rigo Dalla Corte[a,c], Eduardo Ferriolli[a,i], Carlos André Uehara[a,k], Ana Maeda[a,k], Tamara Petroni[a,k], Terezinha Silva Lima[a,i], Sergio Falcão Durão[a,i], Ivan Aprahamian[a,m], Carla Maria Avesani[a,b], Wilson Jacob Filho[a,d]

RESUMO

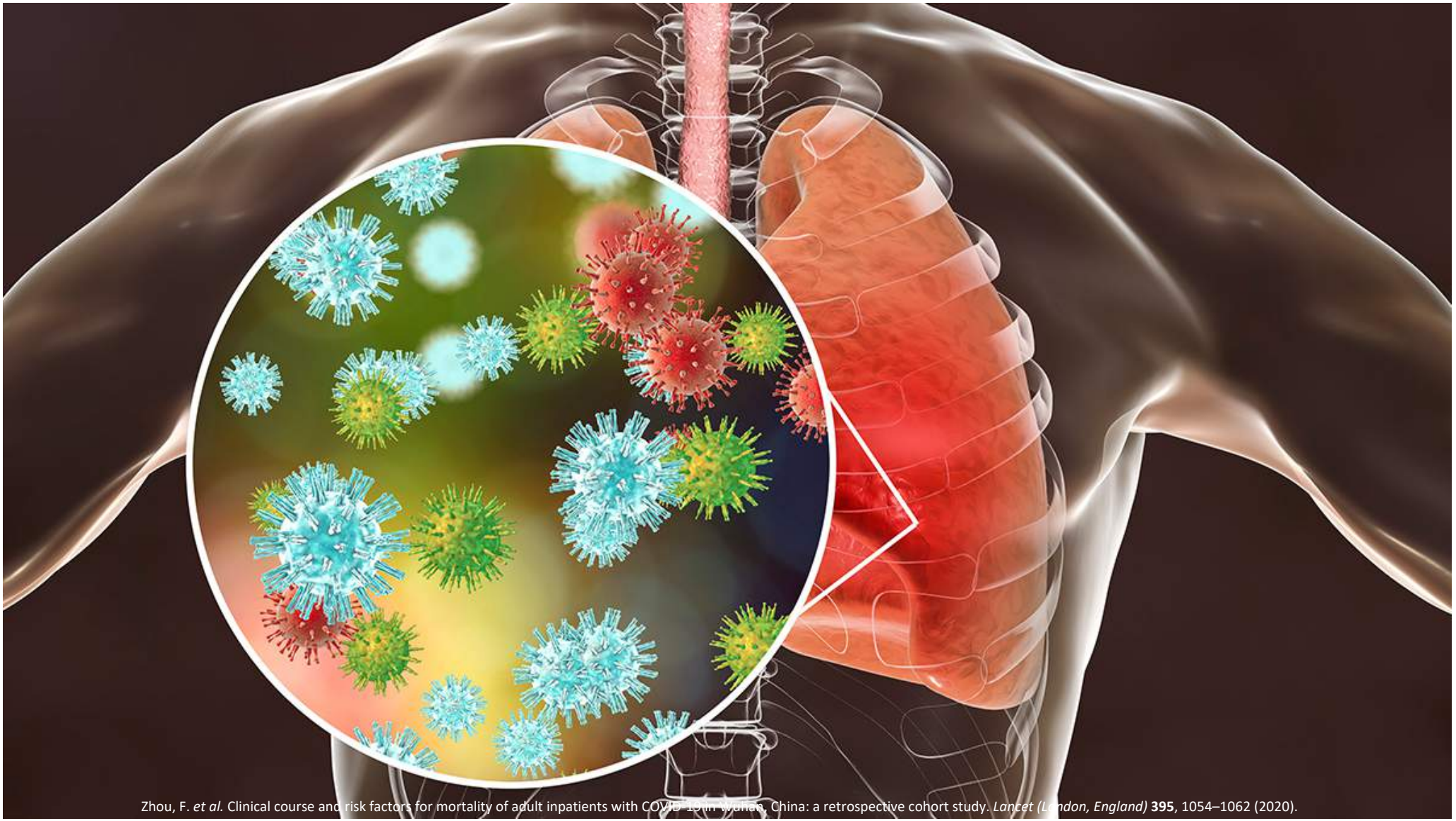
O objetivo do presente trabalho foi descrever as definições conceitual e operacional da síndrome de fragilidade recomendadas pelo Consenso Brasileiro de Fragilidade em Idosos. Em 2015, uma força-tarefa composta de especialistas brasileiros em envelhecimento humano conduziu uma revisão bibliográfica sobre fragilidade em idosos no Brasil e estabeleceu um consenso acerca dos principais achados por meio de reuniões periódicas. No total, 72 artigos foram incluídos para análise, entre os quais, uma revisão sistemática, duas discussões conceituais, duas descrições metodológicas, quatro estudos longitudinais focando mortalidade e piora do perfil de fragilidade, oito estudos de adaptação transcultural e 55 estudos transversais ou de prevalência. Quarenta e cinco estudos (62,5%) utilizaram a escala de fragilidade do Cardiovascular Health Study (EFCHS), dos quais sete (15,2%) usaram pontos de corte não ajustados para a amostra e 17 (36,9%) modificaram pelo menos um dos cinco itens que compõem o instrumento. A prevalência de fragilidade variou entre 6,7 e 74,1%. Quando utilizada a EFCHS, a ampla variação de prevalência — de 8 a 49,3% — dependeu dos pontos de corte empregados para classificar as alterações na velocidade de marcha e na força de preensão palmar, bem como do cenário de investigação. Os estudos foram baseados em quatro grandes modelos conceituais de fragilidade. A fragilidade em idosos representa um estado de vulnerabilidade fisiológica e não deve ser confundida com incapacidades ou multimorbidades. Na população brasileira, a prevalência de fragilidade ainda não está adequadamente estimada, e os pontos de corte dos itens que compõem as escalas de fragilidade devem ser adaptados aos parâmetros dessa população.

PALAVRAS-CHAVE: envelhecimento; idoso; saúde do idoso; vulnerabilidade; fragilidade; idoso fragilizado.

Geriatr Gerontol Aging. 2018;12(2):121-35

- **Paliação → 100%**
- **ILPI → 52%**
- **Enfermaria → 46,5%**
- **Ambulatório Geriátrico → 35%**
- **Comunidade → 8,1%**

Lourenço RA, Moreira VG, Mello RB et al. Consenso brasileiro de fragilidade em idosos: conceitos, epidemiologia e instrumentos de avaliação. *Geriatrics, Gerontology and Aging* 2018; 12: 121-135.



Zhou, F. *et al.* Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. *Lancet (London, England)* **395**, 1054–1062 (2020).

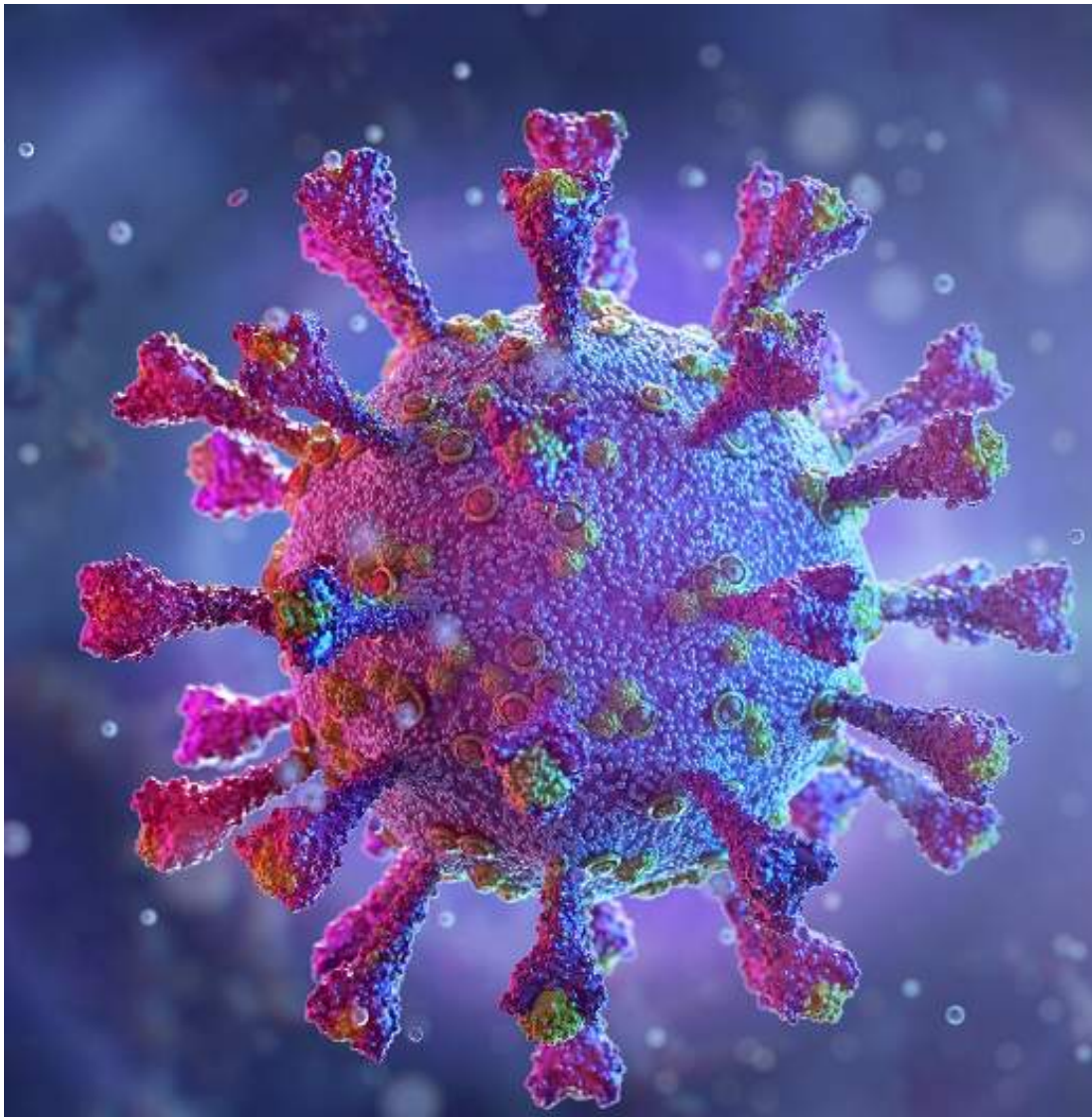
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Clinical Characteristics of Coronavirus Disease 2019 in China

W. Guan, Z. Ni, Yu Hu, W. Liang, C. Ou, J. He, L. Liu, H. Shan, C. Lei, D.S.C. Hui, B. Du, L. Li, G. Zeng, K.-Y. Yuen, R. Chen, C. Tang, T. Wang, P. Chen, J. Xiang, S. Li, Jin-lin Wang, Z. Liang, Y. Peng, L. Wei, Y. Liu, Ya-hua Hu, P. Peng, Jian-ming Wang, J. Liu, Z. Chen, G. Li, Z. Zheng, S. Qiu, J. Luo, C. Ye, S. Zhu, and N. Zhong, for the China Medical Treatment Expert Group for Covid-19*

Guan WJ, Ni ZY, Hu Y, et al. Clinical Characteristics of Coronavirus Disease 2019 in China. *N Engl J Med* 2020; 382: 1708-1720.



Sinais e Sintomas	Percentagem de indivíduos com **doença severa** e seus sintomas
Conjuntivite	2,3%
Congestão Nasal	3,5%
Dor de Cabeça	15%
Tosse	70%
Dor de garganta	13,3%
Fadiga	39.9%
Falta de ar	37,6%
Náusea e vômitos	4,5%
Dor muscular	17,3%
Diarreia	5,8%

Guan WJ, Ni ZY, Hu Y, et al. Clinical Characteristics of Coronavirus Disease 2019 in China. *N Engl J Med* 2020; 382: 1708-1720.

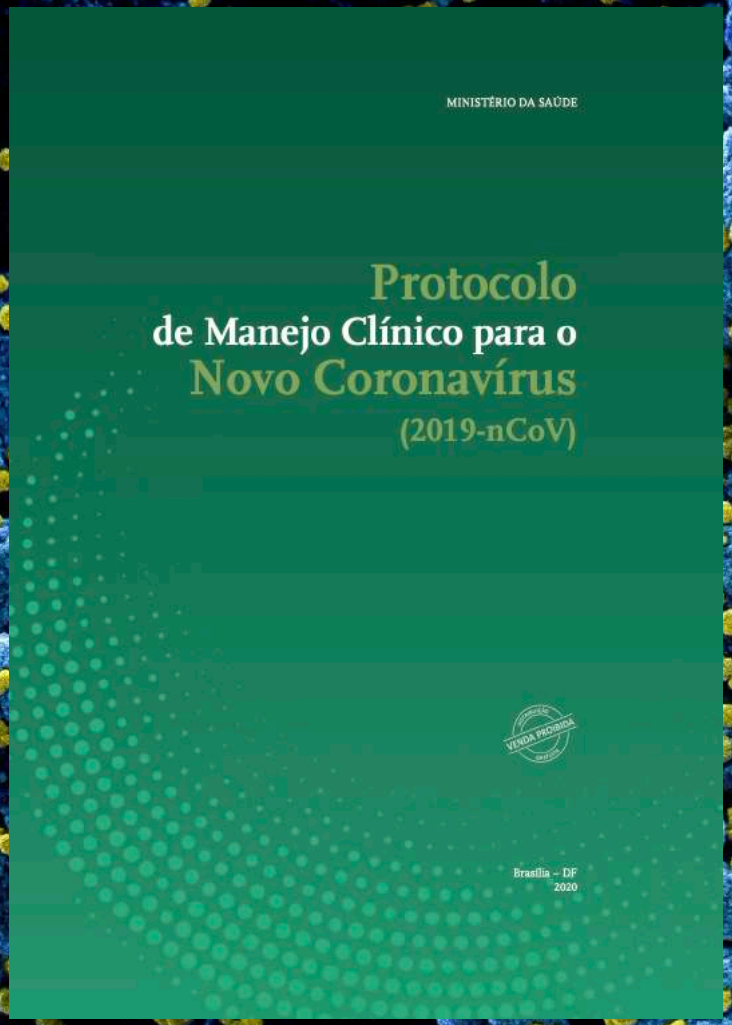


Tabela. Sinais e sintomas de Covid-19 observados na comunidade da província de Wuhan

Sinais e sintomas Covid-19	
Febre	83%
Tosse	82%
Falta de ar	31%
Dor Muscular	11%
Confusão mental	9%
Dor de garganta	5%
Rinorréia	4%
Dor no peito	2%
Diarréia	2%
Náusea e vômito	1%

Ministério da Saúde. Protocolo de manejo clínico para o Novo Coronavírus. Brasília –DF. 2020

GRUPO FORÇA COLABORATIVA COVID-19 BRASIL

Orientações sobre Diagnóstico, Tratamento e Isolamento de Pacientes com COVID-19.

Versão 01 Data:13/04/2020

II. Considerações Sobre o Diagnóstico Clínico

(Dra. Cláudia Fernanda de Lacerda Vidal, Dra. Cláudia Maio Carrilho, Dr. Ricardo Martins, Dr. Rogean Rodrigues Nunes, Dr. Luis Antonio dos Santos Diego, Dr. Clóvis Arns da Cunha)

Resumo executivo sobre diagnóstico clínico

- *O período de incubação é de até 14 dias, com média de 4-5 dias.*
- *Sinais e sintomas incluem febre (83%-99%), tosse (59-82%), astenia (44-70%), anorexia (40%), mialgia (11-35%), dispneia (31-40%), secreção respiratória (27%), perda de paladar e/ou olfato (mais de 80%). A dispneia deve ser um sinal de alerta, devendo-se checar a oximetria digital e, se alterada, colher gasometria arterial.*
- *A média de idade dos casos de pneumonia situa-se entre 47-59 anos.*
- *A apresentação clínica pode variar de doença leve a moderada, que inclui "síndrome gripal" e leve, sem necessidade de oxigenioterapia ou internamento hospitalar; representam aproximadamente 80% dos casos sintomáticos; doença grave em torno de 15 % dos casos, que incluem os pacientes com pneumonia e hipoxemia, e necessitam hospitalização; doença crítica com falência respiratória (necessidade de ventilação mecânica - VM), choque séptico e disfunção múltipla de órgãos em 5%.*


• Fatores de Risco Para Doença Grave
• Idosos
• Doenças Cardiovasculares
• Diabetes Mellitus
• Hipertensão Arterial Sistêmica
• Doença Pulmonar Obstrutiva Crônica
• Neoplasias

Swiss Medical Weekly

Formerly: Schweizerische Medizinische Wochenschrift

An open access, online journal • www.smw.ch

Viewpoint | Published 23 March 2020
Cite this as: Swiss Med Wkly. 2020;150:w20231

Mimics and chameleons of COVID-19

Nickel Christian H., Bingisser R.

Emergency Department, University Hospital Basel, University of Basel, Switzerland


• Critérios de Gravidade
• Frequência Respiratória > 23 irpm
• Saturação de O2 < 93%
Idosos: sinais e sintomas atípicos

Mensuração de sinais vitais e alerta para a Equipe de Saúde

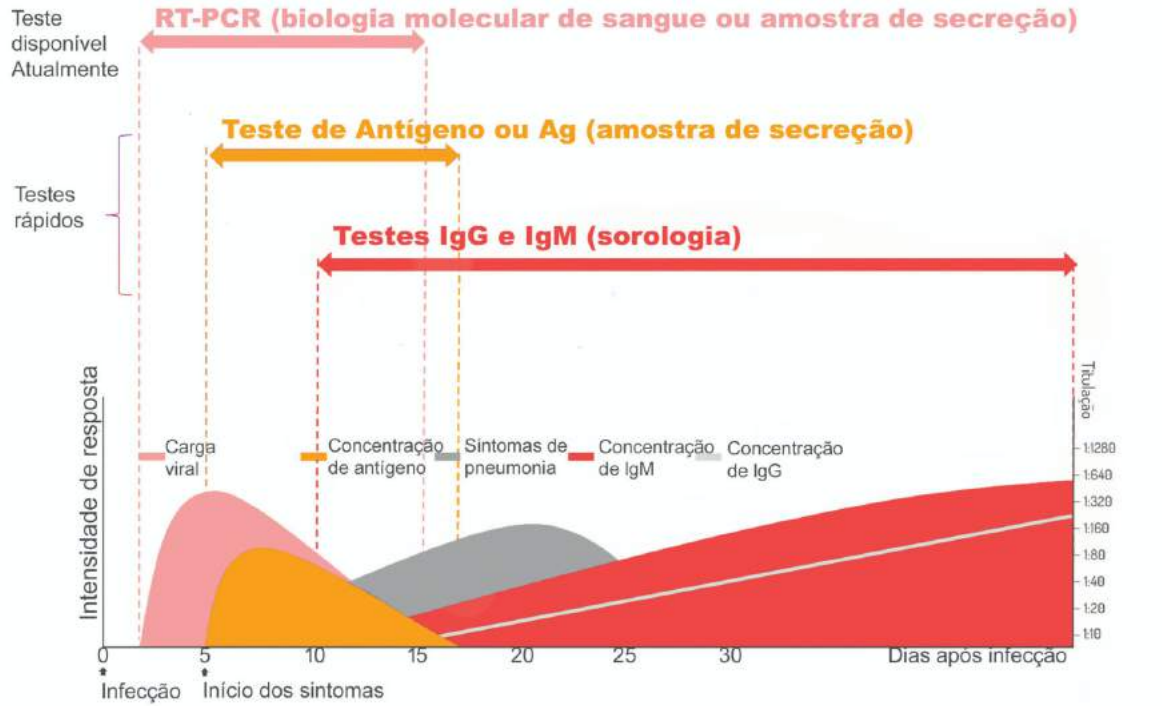
Medição Vital	Horário	19/04/2020	20/04/2020	21/04/2020	22/04/2020	23/04/2020	24/04/2020	25/04/2020
Diurese	09:00	Presente	Presente	Presente	Ausente	Presente	Presente	Presente
	20:00	Ausente	Presente	Ausente	Presente	Presente	Presente	Presente
Evacuações	09:00	Ausente	Ausente	Pastosa	Bem moldadas	Pastosa	Pastosa	Bem moldadas
	20:00	Bem moldadas	Bem moldadas	Bem moldadas	Bem moldadas	Ausente	Ausente	Ausente
Frequência Cardíaca (bpm)	09:00	77 bpm	73 bpm	70 bpm	75 bpm	75 bpm	74 bpm	73 bpm
	20:00	75 bpm	75 bpm	75 bpm	**97 bpm**	77 bpm	**96 bpm**	74 bpm
Frequência Respiratória (irpm)	09:00	21 irpm	22 irpm	21 irpm	**23 irpm**	21 irpm	20 irpm	20 irpm
	20:00	**23 irpm**	21 irpm	**23 irpm**	20 irpm	22 irpm	**23 irpm**	21 irpm
Glicemia (mg/dl)	06:00	**70 mg/dl**	98 mg/dl	98 mg/dl	105 mg/dl	98 mg/dl	98 mg/dl	146 mg/dl
	11:00	105 mg/dl	197 mg/dl	105 mg/dl	149 mg/dl	**236 mg/dl**	170 mg/dl	197 mg/dl
	17:00	105 mg/dl	137 mg/dl	**220 mg/dl**	137 mg/dl	105 mg/dl	**380 mg/dl**	**272 mg/dl**
Pressão Arterial (mmHg)	09:00	**138 / 121**	147 / 73	147 / 81	150 / 80	120 / 60	119 / 69	168 / 80
	20:00	150 / 80	140 / 80	150 / 80	140 / 87	130 / 70	122 / 69	150 / 87
Saturação de Oxigênio (SpO2)	09:00	**91 SpO2%**	98 SpO2%	97 SpO2%	96 SpO2%	94 SpO2%	98 SpO2%	96 SpO2%
	20:00	96 SpO2%	93 SpO2%	96 SpO2%	96 SpO2%	98 SpO2%	97 SpO2%	95 SpO2%
Temperatura (°C)	09:00	36.1 °C	35 °C	36.3 °C	**39 °C**	36.5 °C	**38 °C**	36.3 °C
	20:00	36.5 °C	36 °C	36.5 °C	36 °C	36.2 °C	36.1 °C	36 °C


Sinais Vitais
1. Frequência Cardíaca
2. Frequência Respiratória
3. Temperatura
4. Pressão Arterial
5. Saturação de Oxigênio

Risco

CONTAMINADOS E CONTAMINANTES


Diagnóstico



Fonte: Eco Diagnóstica. Referência: Cellular immune responses to severe acute respiratory syndrome coronavirus infection insenescent BALB/c Mice:CD4+T cells are important in control of SARD-CoV infection. Jun Chen | EL PAÍS

IgA/IgM - Fase Aguda: positivo em até 90% dos casos (até 5 dia)

IgG – "Cura": positividade 68 a 78% (10 a 18 dias)

RT-PCR – Fase Aguda 4 a 6 dia (Padrão Ouro)

*** Testes Imunocromatográficos: Necessitam de validação para o Brasil**

Guo, L. *et al.* Profiling Early Humoral Response to Diagnose Novel Coronavirus Disease (COVID-19). *Clin. Infect. Dis.* (2020).


A ILPI tem condições
de dar suporte
clínico ao idoso?

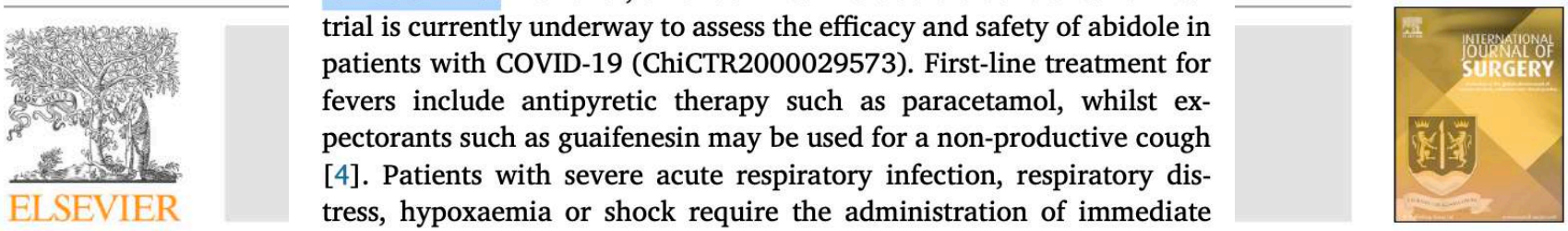
Tratamento

CORONAVÍRUS
COVID-19

ORIENTAÇÕES DO MINISTÉRIO DA SAÚDE PARA TRATAMENTO MEDICAMENTOSO PRECOCE DE PACIENTES COM DIAGNÓSTICO DA COVID-19

1.7. Treatment

At present, no effective antiviral treatment or vaccine is available for COVID-19. However, a randomized multicentre controlled clinical trial is currently underway to assess the efficacy and safety of abidole in patients with COVID-19 (ChiCTR2000029573). First-line treatment for fevers include antipyretic therapy such as paracetamol, whilst expectorants such as guaifenesin may be used for a non-productive cough [4]. Patients with severe acute respiratory infection, respiratory distress, hypoxaemia or shock require the administration of immediate oxygen therapy. This should be at 5 L/min to reach SpO_2 targets of ≥90% in non-pregnant adults and children, and ≥92–95% in pregnant



Review

World Health Organization declares global emergency: A review of the 2019 novel coronavirus (COVID-19)

Catrin Sohrabi[a,1], Zaid Alsafi[b,1], Niamh O'Neill[a,*], Mehdi Khan[b], Ahmed Kerwan[c], Ahmed Al-Jabir[c], Christos Iosifidis[a], Riaz Agha[d]

[a] *Barts and The London School of Medicine and Dentistry, Queen Mary University of London, United Kingdom*
[b] *UCL Medical School, University College London, United Kingdom*
[c] *GKT School of Medical Education, King's College London, United Kingdom*
[d] *Barts Health NHS Trust, London, United Kingdom*

Sohrabi C, Alsafi Z, O'Neill N, et al. World Health Organization declares global emergency: A review of the 2019 novel coronavirus (COVID-19). Int J Surg 2020; 76: 71-76

Special Article | 13 May 2020

Should Clinicians Use Chloroquine or Hydroxychloroquine Alone or in Combination With Azithromycin for the Prophylaxis or Treatment of COVID-19? FREE

Living Practice Points From the American College of Physicians (Version 1)

Amir Qaseem, MD, PhD, MHA, Jennifer Yost, RN, PhD, Itziar Etxeandia-Ikobaltzeta, PharmD, PhD, Matthew C. Miller, MD, George M. Abraham, MD, MPH, Adam Jacob Obley, MD, Mary Ann Forciea, MD, Janet A. Jokela, MD, MPH, Linda L. Humphrey, MD, MPH, for the Scientific Medical Policy Committee of the American College of Physicians View fewer authors

Author, Article and Disclosure Information

https://doi.org/10.7326/M20-1998

Annals of Internal medicine, 2020

Should chloroquine or hydroxychloroquine alone or in combination with azithromycin be used as prophylaxis against COVID-19 in the general population?

Interventions	Use?	Rationale
Chloroquine	NO	No available evidence
Chloroquine + Azithromycin	NO	No available evidence
Hydroxychloroquine	NO	No available evidence
Hydroxychloroquine + Azithromycin	NO	No available evidence

Should chloroquine or hydroxychloroquine in combination with azithromycin be used for treatment of patients with COVID-19?

Interventions	Use?	Rationale
Chloroquine	NO*	No available evidence in COVID-19–positive patients
Chloroquine + Azithromycin	NO*	No available evidence in COVID-19–positive patients
Hydroxychloroquine	NO*	Insufficient evidence about benefits and harms
Hydroxychloroquine + Azithromycin	NO*	Insufficient evidence about benefits and harms

* In light of known harms and very uncertain evidence of benefit in patients with COVID-19, using shared and informed decision-making with patients (and their families), clinicians may treat hospitalized COVID-19–positive patients with chloroquine or hydroxychloroquine alone or in combination with azithromycin in the context of a clinical trial.

Annals of Internal medicine, 2020

Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis

Mandeep R Mehra, Sapan S Desai, Frank Ruschitzka, Amit N Patel

Summary

Background Hydroxychloroquine or chloroquine, often in combination with a second-generation macrolide, are being widely used for treatment of COVID-19, despite no conclusive evidence of their benefit. Although generally safe when used for approved indications such as autoimmune disease or malaria, the safety and benefit of these treatment regimens are poorly evaluated in COVID-19.

Methods We did a multinational registry analysis of the use of hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19. The registry comprised data from 671 hospitals in six continents. We included patients hospitalised between Dec 20, 2019, and April 14, 2020, with a positive laboratory finding for SARS-CoV-2. Patients who received one of the treatments of interest within 48 h of diagnosis were included in one of four treatment groups (chloroquine alone, chloroquine with a macrolide, hydroxychloroquine alone, or hydroxychloroquine with a macrolide), and patients who received none of these treatments formed the control group. Patients for whom one of the treatments of interest was initiated more than 48 h after diagnosis or while they were on mechanical ventilation, as well as patients who received remdesivir, were excluded. The main outcomes of interest were in-hospital mortality and the occurrence of de-novo ventricular arrhythmias (non-sustained or sustained ventricular tachycardia or ventricular fibrillation).

Findings 96 032 patients (mean age 53·8 years, 46·3% women) with COVID-19 were hospitalised during the study period and met the inclusion criteria. Of these, 14 888 patients were in the treatment groups (1868 received chloroquine, 3783 received chloroquine with a macrolide, 3016 received hydroxychloroquine, and 6221 received hydroxychloroquine with a macrolide) and 81 144 patients were in the control group. 10 698 (11·1%) patients died in hospital. After controlling for multiple confounding factors (age, sex, race or ethnicity, body-mass index, underlying cardiovascular disease and its risk factors, diabetes, underlying lung disease, smoking, immunosuppressed condition, and baseline disease severity), when compared with mortality in the control group (9·3%), hydroxychloroquine (18·0%; hazard ratio 1·335, 95% CI 1·223–1·457), hydroxychloroquine with a macrolide (23·8%; 1·447, 1·368–1·531), chloroquine (16·4%; 1·365, 1·218–1·531), and chloroquine with a macrolide (22·2%; 1·368, 1·273–1·469) were each independently associated with an increased risk of in-hospital mortality. Compared with the control group (0·3%), hydroxychloroquine (6·1%; 2·369, 1·935–2·900), hydroxychloroquine with a macrolide (8·1%; 5·106, 4·106–5·983), chloroquine (4·3%; 3·561, 2·760–4·596), and chloroquine with a macrolide (6·5%; 4·011, 3·344–4·812) were independently associated with an increased risk of de-novo ventricular arrhythmia during hospitalisation.

Interpretation We were unable to confirm a benefit of hydroxychloroquine or chloroquine, when used alone or with a macrolide, on in-hospital outcomes for COVID-19. Each of these drug regimens was associated with decreased in-hospital survival and an increased frequency of ventricular arrhythmias when used for treatment of COVID-19.

Funding William Harvey Distinguished Chair in Advanced Cardiovascular Medicine at Brigham and Women's Hospital.

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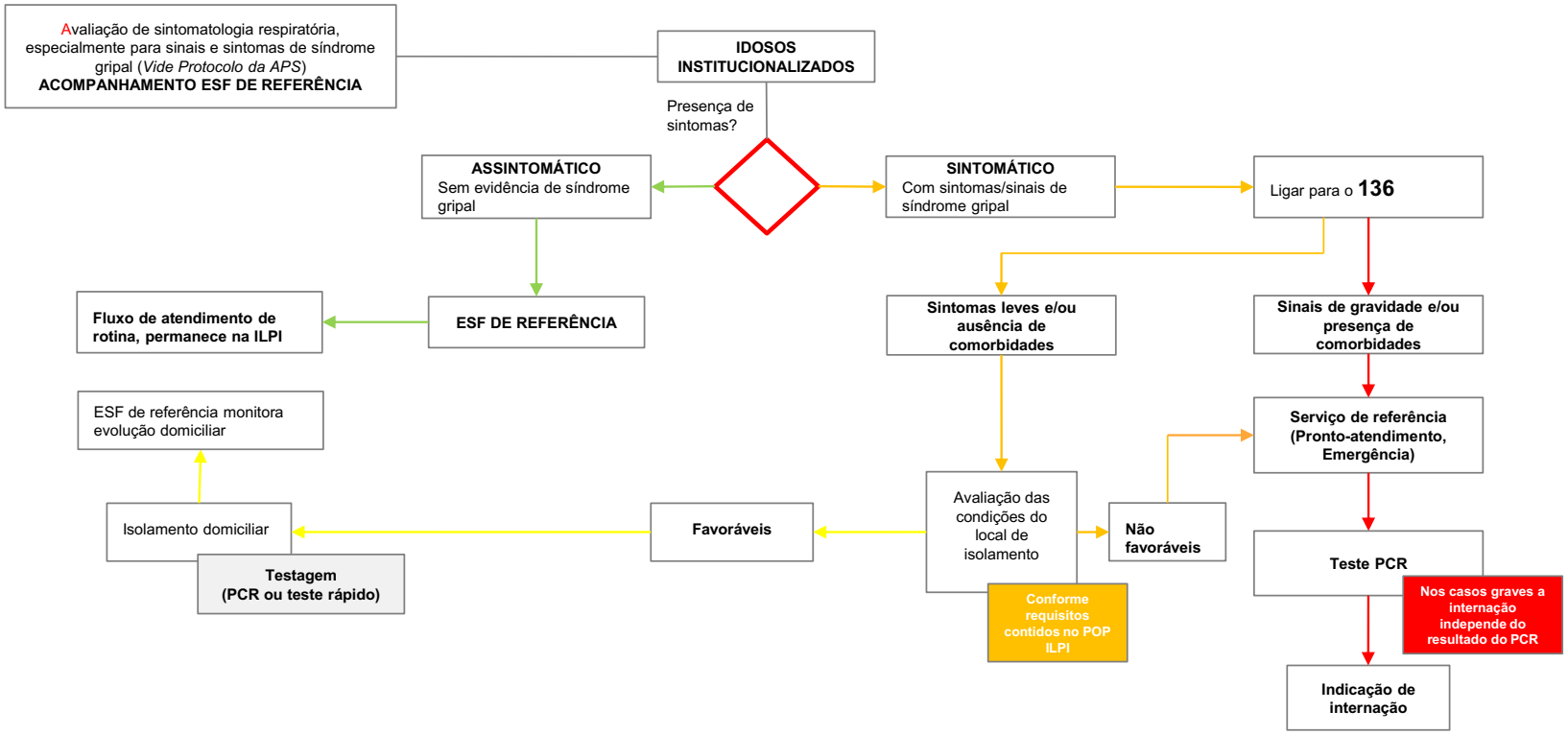
See Online/Comment
https://doi.org/10.1016/
S0140-6736(20)31174-0

Brigham and Women's Hospital Heart and Vascular Center and Harvard Medical School, Boston, MA, USA (Prof M R Mehra MD); **Surgisphere Corporation, Chicago, IL, USA** (S S Desai MD); **University Heart Center, University Hospital Zurich, Zurich, Switzerland** (Prof F Ruschitzka MD); **Department of Biomedical Engineering, University of Utah, Salt Lake City, UT, USA** (A N Patel MD); **and HCA Research Institute, Nashville, TN, USA** (A N Patel)

Correspondence to:
Prof Mandeep R Mehra, Brigham and Women's Hospital Heart and Vascular Center and Harvard Medical School, Boston, MA 02115, USA
mmehra@bwh.harvard.edu

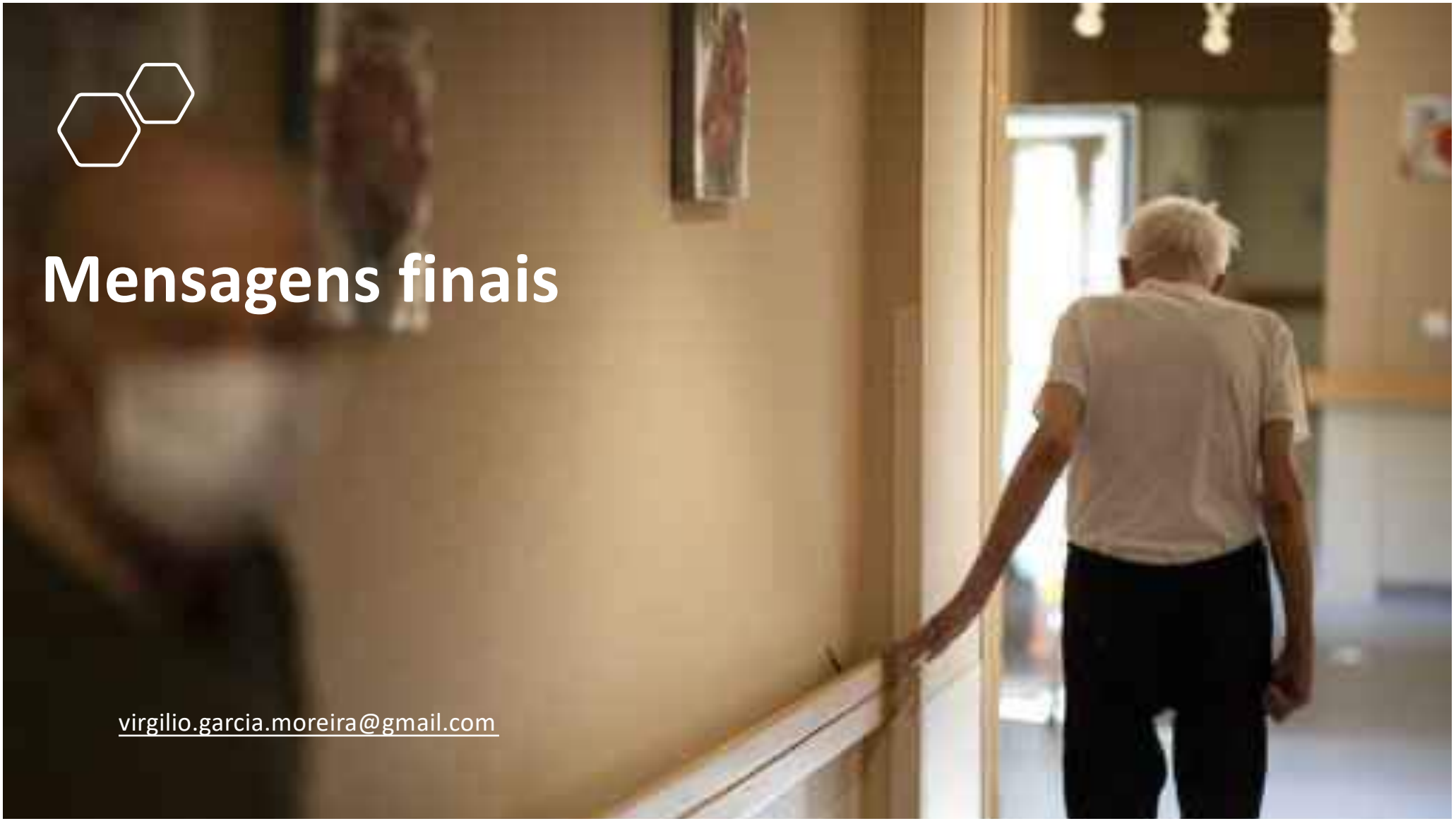
- 96 032 pacientes
- Redução da sobrevida
- Aumento de Arritmias ventriculares

FLUXOGRAMA DE MANEJO DE CASOS SUSPEITOS DE COVID-19 EM INSTITUIÇÕES DE LONGA PERMANÊNCIA DE IDOSOS (ILPI)



Ministério da Saúde. 2020

Mensagens finais



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