

**LE CAUSE DI INSUCCESSO IN ORTOPEDIA
E IN MEDICINA RIABILITATIVA:
DAL PLANNING AL CONTENZIOSO**

PROBLEMATICHE GIURIDICHE E MEDICO LEGALI
LA DIFFICOLTA' APPLICATIVA DELLA LEGGE GELLI-BIANCO



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Dipartimento di Ortopedia, Traumatologia e Riabilitazione, AOU Città della Salute e della Scienza di Torino

- A.O.U. Città della Salute e della Scienza di Torino



Molinette	general rehabilitation, neurorehabilitation
CTO	musculoskeletal rehabilitation
Unità Spinale Unipolare	brain injuries, spinal cord injuries, pelvic rehabilitation
Regina Margherita	cerebral palsy, general pediatric rehabilitation
Sant'Anna	cancer rehabilitation



- agenda

Le cause di insuccesso in ortopedia e in medicina riabilitativa: decorso post operatorio dell'arto inferiore



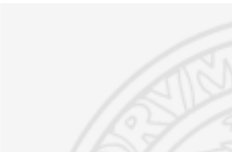
DODICESIMO CONVEGNO DI TRAUMATOLOGIA CLINICA E FORENSE

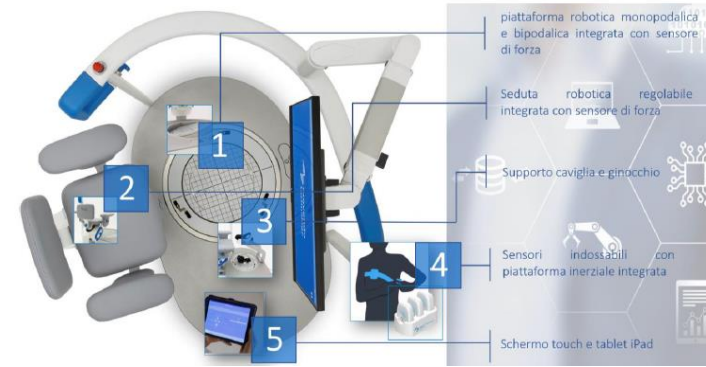
19° Corso di Ortopedia, Traumatologia e Medicina Legale

LE CAUSE DI INSUCCESSO IN ORTOPEDIA E IN MEDICINA RIABILITATIVA: DAL PLANNING AL CONTENZIOSO

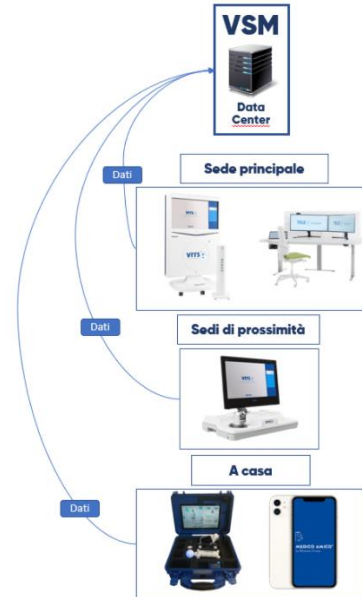


- Esiste un 'nuovo' Paziente ortopedico da riabilitare dopo un intervento agli arti inferiori?
- In modello riabilitativo Bio-Psico-Sociale è applicabile al paziente ortopedico dopo un intervento agli arti inferiori?
- Cause di insuccesso in riabilitazione ortopedica post operatoria dell'arto inferiore





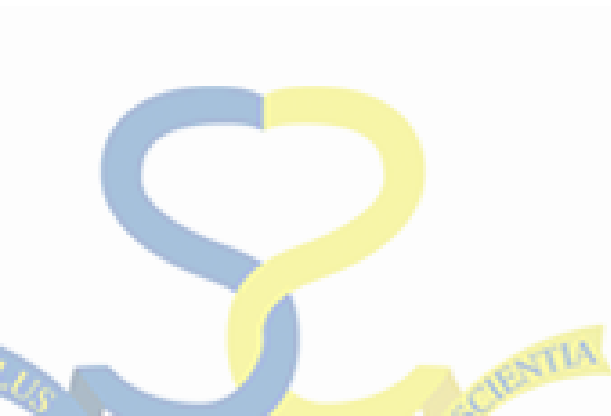
flusso operativo dati.

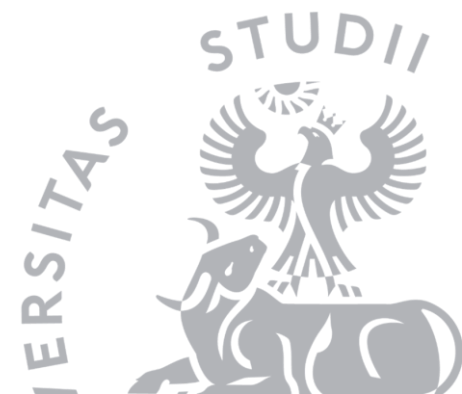
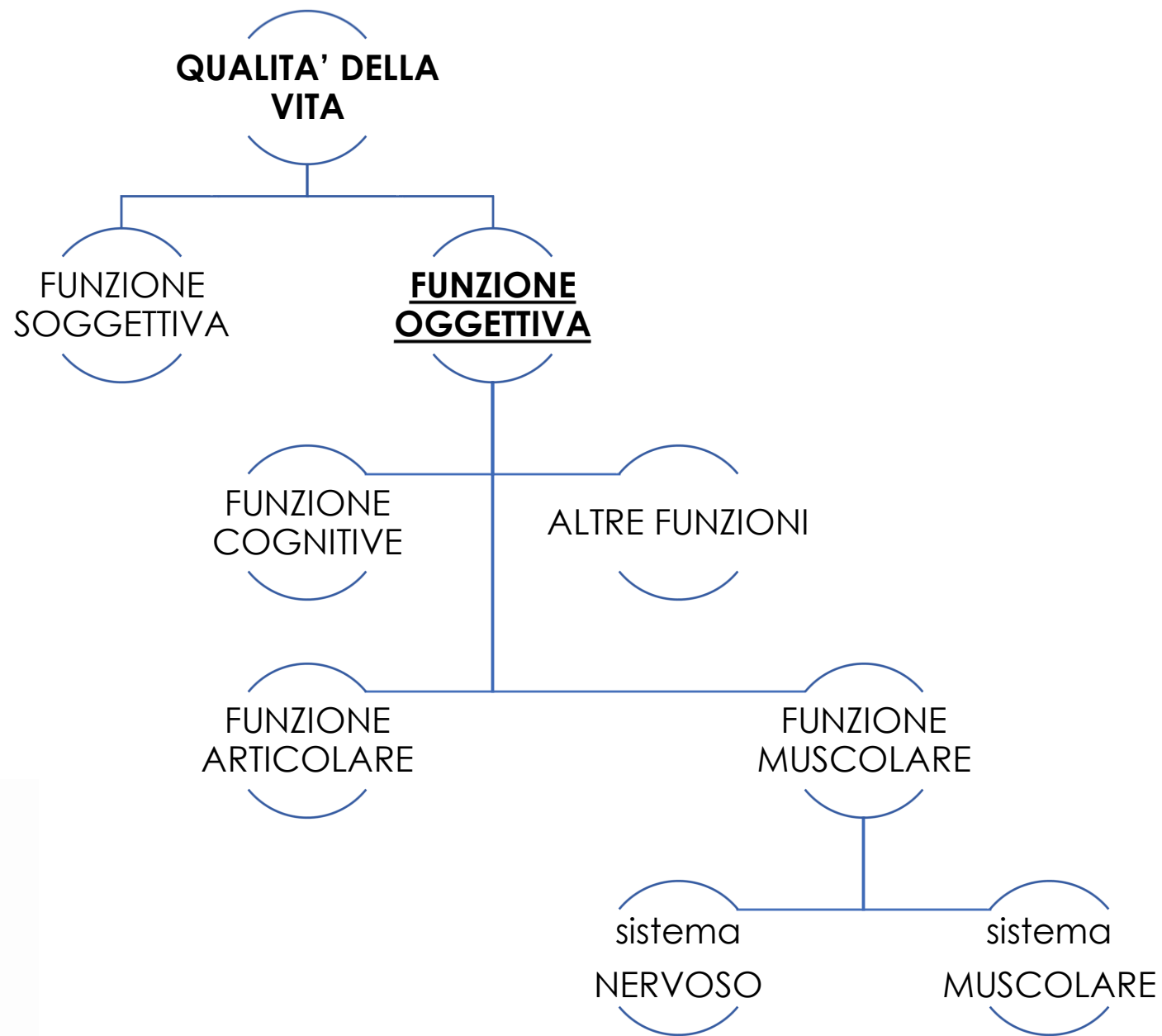


RIABILITA

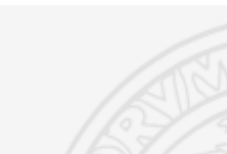
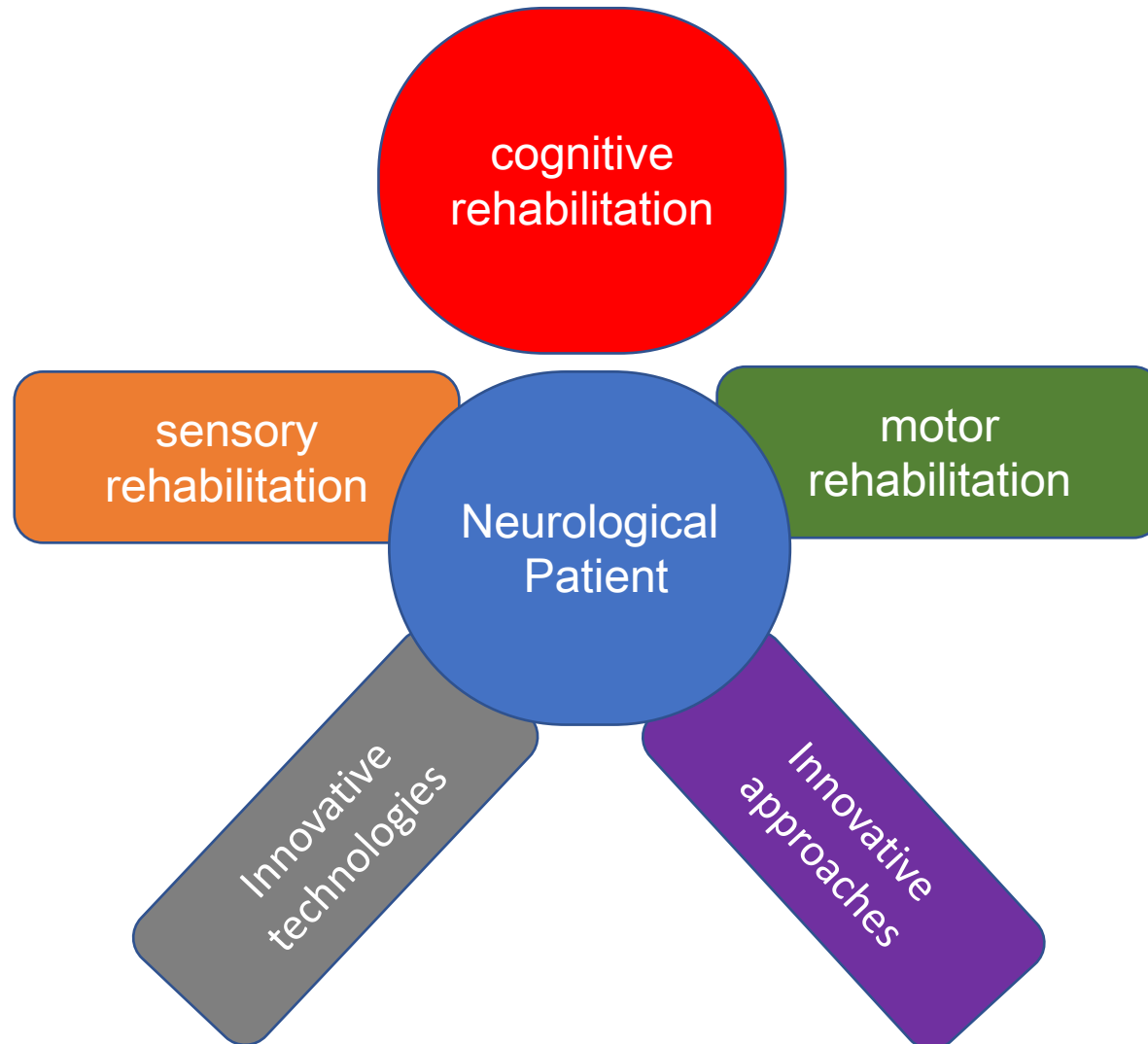


Esiste un **'nuovo'** Paziente ortopedico da riabilitare dopo un intervento agli arti inferiori





Sensory – Cognitive - Motor Rehabilitation



Fast-track

Ir J Med Sci
DOI 10.1007/s11845-017-1641-9



REVIEW ARTICLE

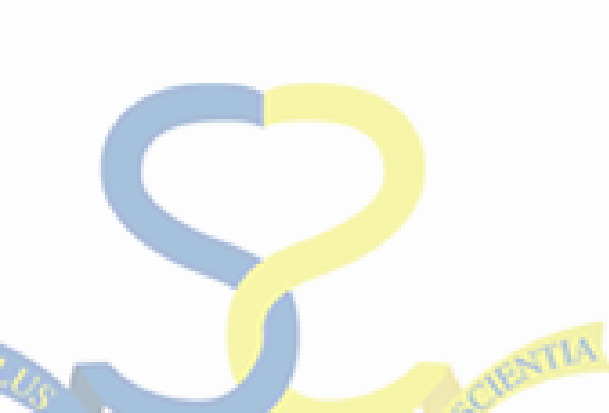
Enhanced recovery protocols in total joint arthroplasty: a review of the literature and their implementation

A. S. Galbraith¹ · E. McGloughlin² · J. Cashman¹

Received: 18 January 2017 / Accepted: 26 May 2017
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Table 1 Sample enhanced recovery programme

Sample enhanced recovery programme	
Pre-operative	Education, e.g. joint academy, arthroplasty school Outpatient consultation, e.g. expectations, consent Discharge planning, e.g. social support structures, social worker, occupational therapist involvement Physiotherapy Pre-assessment outpatient clinic, e.g. anaesthetic assessment, optimisation of co-morbidities, appropriate haematological sampling
Peri-operative	Day of surgery admission Pre-medication, e.g. paracetamol, cyclo-oxygenase 2 selective inhibitors, gabapentinoids Optimal hydration
Intra-operative	Neuraxial versus regional anaesthesia Multimodal blood loss reduction protocol, e.g. use of antifibrinolytics, electrocautery +/- peri-articular injection Avoid surgical drains
Post-operative	Multi-modal analgesia regimen Day-of-surgery mobilisation Venous thromboembolic prophylaxis Rehabilitation programme Early discharge home



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Post-operative



Multi-modal analgesia regimen

Day-of-surgery mobilisation

Venous thromboembolic prophylaxis

Rehabilitation programme

Early discharge home



Fast-track

Mobilizzazione precoce

The Journal of Arthroplasty xxx (2016) 1–4



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journal homepage: www.arthroplastyjournal.org



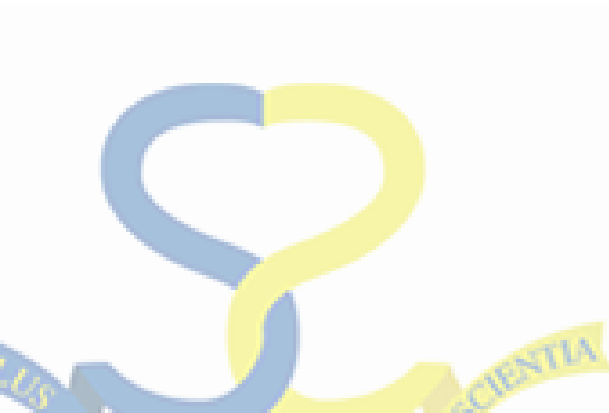
Original Article

Day-of-Surgery Mobilization Reduces the Length of Stay After Elective Hip Arthroplasty

Taro Okamoto, MBBS^{a,*}, Ryan J. Ridley, BSc, MPhysio^b,
Stephen J. Edmondston, DipPhysio, AdvDipPhysio, PhD^a, Mariet Visser, BSc^b,
Julie Headford, GDip, PGDip^a, Piers J. Yates, BSc (Hons), FRCS (Tr & Orth), FRACS (Ortho)^a

^a Department of Orthopaedic Surgery, Fremantle Hospital, Fremantle, WA, Australia

^b Physiotherapy Department, Osborne Park Hospital, Stirling, WA, Australia



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Post-operative

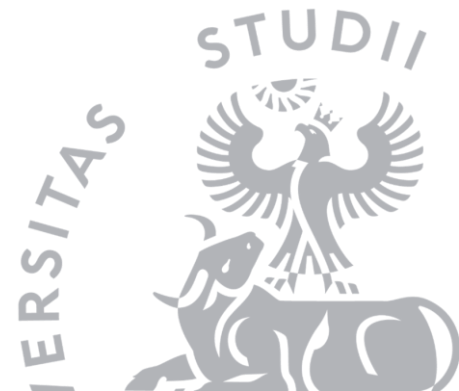
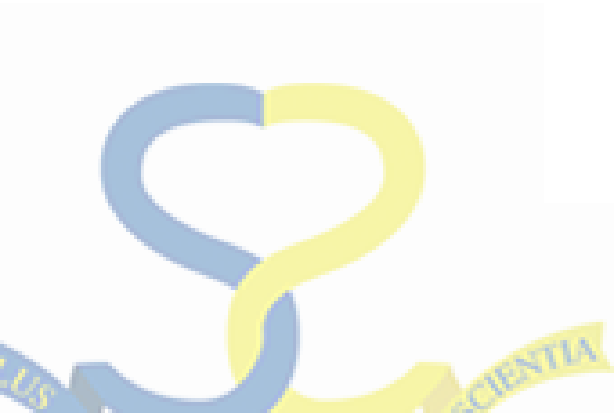
Multi-modal analgesia regimen

Day-of-surgery mobilisation

Venous thromboembolic prophylaxis

Rehabilitation programme

Early discharge home



Fast-track

Review

Fast-track knee arthroplasty – status and future challenges

Henrik Kehlet ^{a,*}, Emmanuel Thienpont ^b

^a Section for Surgical Pathophysiology, Rigshospitalet Copenhagen University, Denmark and The Lundbeck Centre for fast-track hip and knee replacement

^b Department of Orthopaedic Surgery, Cliniques universitaires Saint Luc, Av. Hippocrate 10, 1200 Brussels, Belgium

Table 1

Outcomes to be considered in fast-track TKA

- Preoperative information and optimisation of organ functions
 - Anaesthetic technique
 - Surgical technique
 - Pain/ opioid-sparing multimodal analgesia
 - Early mobilisation/ orthostatic intolerance
 - Muscle function/ rehabilitation
 - Postoperative length of stay (LOS)
 - Post-discharge pain management
 - Cognitive function
 - Perioperative blood management
 - Thromboembolic prophylaxis
 - Postoperative morbidity
 - Organisational issues (drains, tourniquet, etc.)
 - Cost issues
-



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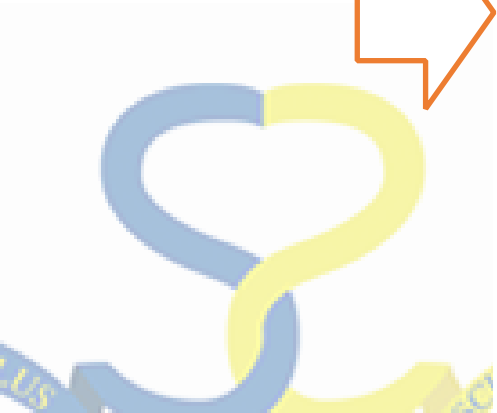
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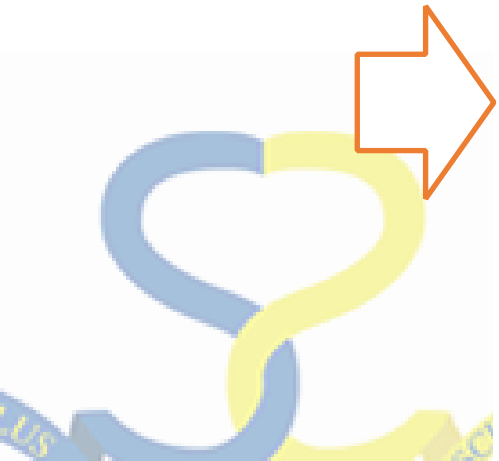
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Fast-track

Arch Orthop Trauma Surg (2009) 129:1585–1591
DOI 10.1007/s00402-009-0825-9

ORTHOPAEDIC SURGERY

Predictive factors influencing fast track rehabilitation following primary total hip and knee arthroplasty

Michael Schneider · Ikuo Kawahara · Gail Ballantyne · Christine McAuley ·
Karen MacGregor · Ruth Garvie · Alistair McKenzie · Deborah MacDonald ·
Steffen J. Breusch



- Domande chiave

STORIA PAZIENTE

ANAMNESI

ESAME OBIETTIVO

DIAGNOSTICA

QUADRO CLINICO

DIAGNOSI

INDICAZIONE
TERAPEUTICA

PROGETTO
RIABILITATIVO
INDIVIDUALE

PROGRAMMA
RIABILITATIVO
INDIVIDUALE

PROGNOSI

ALERT

GOAL

CHI?
COME?
QUANDO?
QUANTO?
DOVE?
PERCHE'?



SNODO

1

2

3

4

5

6

7

8

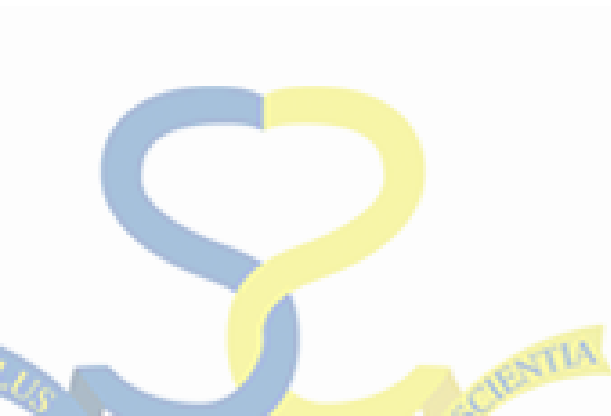
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RIABILITA



In modello riabilitativo Bio-Psico-Sociale è applicabile al paziente ortopedico dopo un intervento agli arti inferiori'



Proposta di Percorso Riabilitativo Individuale

Anagrafica

COGNOME E NOME INDIRIZZO E TELEFONO	DATA E LUOGO DI NASCITA CF:
CARE GIVER E TELEFONO	

ATTUALE COLLOCAZIONE PAZIENTE

SEDE CTO REPARTO

ANAMNESI

VISITA

In trattamento
riabilitativo
 si no

Reparto per acuti
 Lungodegenza
 Cod 75
 Cod 28
 Cod 56 II livello
 Cod 56 I livello
 DH Riabilitativo
 Ambul. RRF
 Residen. socio-sanit.
 Domicilio

Analisi dei bisogni intermedii-assistenziali

Cute: (decubiti) No Si (specificare)
 Respirazione: Spont Cannula O2 v.mec
 Alimentazione p.os Sondino PEG CVC
 Catetere vesc. No Si (specificare)
 Gessi, valve, FEA No Si (specificare)
 Carico No Parz Totale
 Dialisi Disfagia
 Altro (compresi i farmaci):

Descrizione del grado di autonomia

	SI	Parz.	NO
Cura di se	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Controllo sfinterico	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Controllo del tronco	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mobilità a letto	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mobilità nei trasferimenti	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cammino	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Comunicazione	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collabor./partecipaz.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toll. Tratt. Riab	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BARTHEL INDEX ATTUALE	/100		

AUSILI (in uso): No Si (specificare)
 PROBLEMATICHE SOCIALI: No Si (specificare)

DIAGNOSI PRINCIPALE:
E SECONDARIE

(influenzano la disabilità ed obbligatorie solo in ricovero cod 56, 75, 28)

Bisogni clinico-internistici: Elevati Medi Bassi Assenti
 Bisogni assistenziali: Elevati Medi Bassi Assenti
 Bisogni riabilitativi: Elevati Medi Bassi Assenti

F.I.M. attuale = /126 Obbligatoria in deg. cod 56
 LCF attuale = Obbligatoria per ricovero in cod 75
 GCS all'esordio = Obbligatoria per ricovero in cod 75
 ASIA attuale = Obbligatoria per ricovero in cod 28

ICD9CM
 ICD9CM
 ICD9CM
 Cod Dis 1 - 6 : 1

SINTESI DEL PROGETTO RIABILITATIVO

Recupero funzione motoria
(compreso recupero della tolleranza allo sforzo)
 Recupero funzione cardio/
 respiratoria
 Recupero funzione cognitiva
 Recupero funzione comunicativa
 Recupero funzione sensoriale
 Recupero funzione alimentazione
 Ausili
 Altro

Setting appropriato
 Reparto per acuti
 Lungodegenza
 Cod 75
 Cod 28
 Cod 56 II livello
 Cod 56 I livello
 DH Riab.
 Ambulatorio RRF
 Resid. socio-sanit.
 Cure domiciliari

Gradiente di modificabilità della disabilità (Prognosi funzionale): Elevato Medio Basso Da rivalutare

Tempi previsti per la realizzazione: s. c.

Data /2012

Medico proponente

DATA PREVISTA PER IL
CAMBIO DI SETTING

 Non indicazione al
trattamento riabilitativo





Ospedale-Territorio-Domicilio al tempo del PNRR:

*Medicina Riabilitativa di percorso ad
alto contenuto tecnologico
nella casa della comunità*



bisogni complessi → servizi integrati (sanitari e sociosanitari)



RIABILITA



Cause di insuccesso in riabilitazione ortopedica post operatoria dell'arto inferiore



Crederne che il successo in ortopedia dipenda dal gestire 'bene' SOLO la riabilitazione post operatoria!



Take home message

Le cause di insuccesso in ortopedia e in medicina riabilitativa: **decorso post operatorio dell'arto inferiore**

- Assenza di una riabilitazione
- Assenza di un modello riabilitativo integrato con le necessità del Paziente ortopedico
- Non consapevolezza riabilitativa dei nuovi traguardi della chirurgia ortopedica
- Non consapevolezza ortopedica dei nuovi traguardi della medicina fisica riabilitativa
- Tardiva presa in carico riabilitativa del Paz. Ortopedico
- Assenza di percorsi Ospedale, territorio, domicilio
- Frammentato utilizzo di nuove tecnologie riabilitative
- Confusione di ruoli e mansioni del Team riabilitativo: Fisiatra / Fisioterapista



Morale

Dall'Ortopedico al Fisiatra passando dal Fisioterapista
concludendo con il Medico Legale

Attenzione

Prima di dire al paz. 'La gamba è più corta, mettiamo un bel plantare' o il ginocchio non recupera
Perché non ha fatto 'abbastanza' fisioterapia

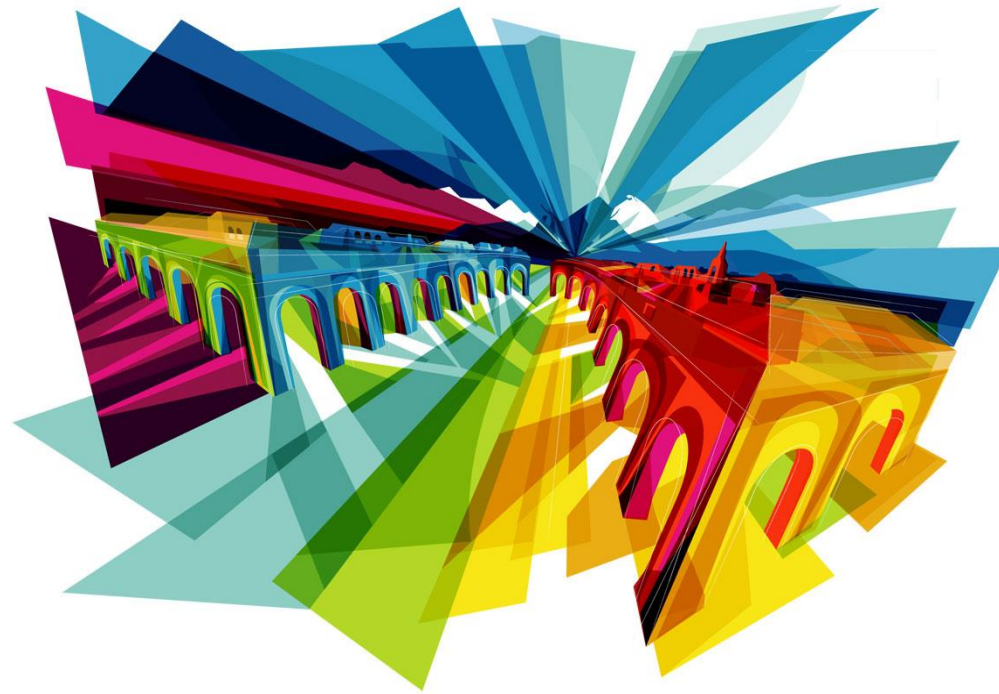
STUDIA!

CONFRONTATI!

e PENSA che potresti aprire un contenzioso Medico Legale basato sulla tua 'ignoranza'



GRAZIE



*“Per scrivere il futuro dobbiamo partire dal presente,
conoscendo il passato”*

