



PROVA SCRITTA N. 1

IL DELIRIUM





PROVA SCRITTA N. 2

LA FRAGILITA'

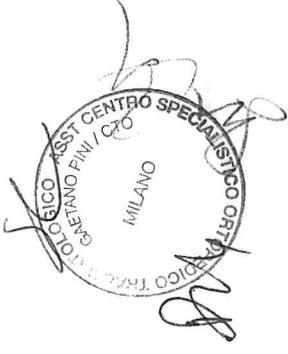




PROVA SCRITTA N. 3

LA SARCOPENIA

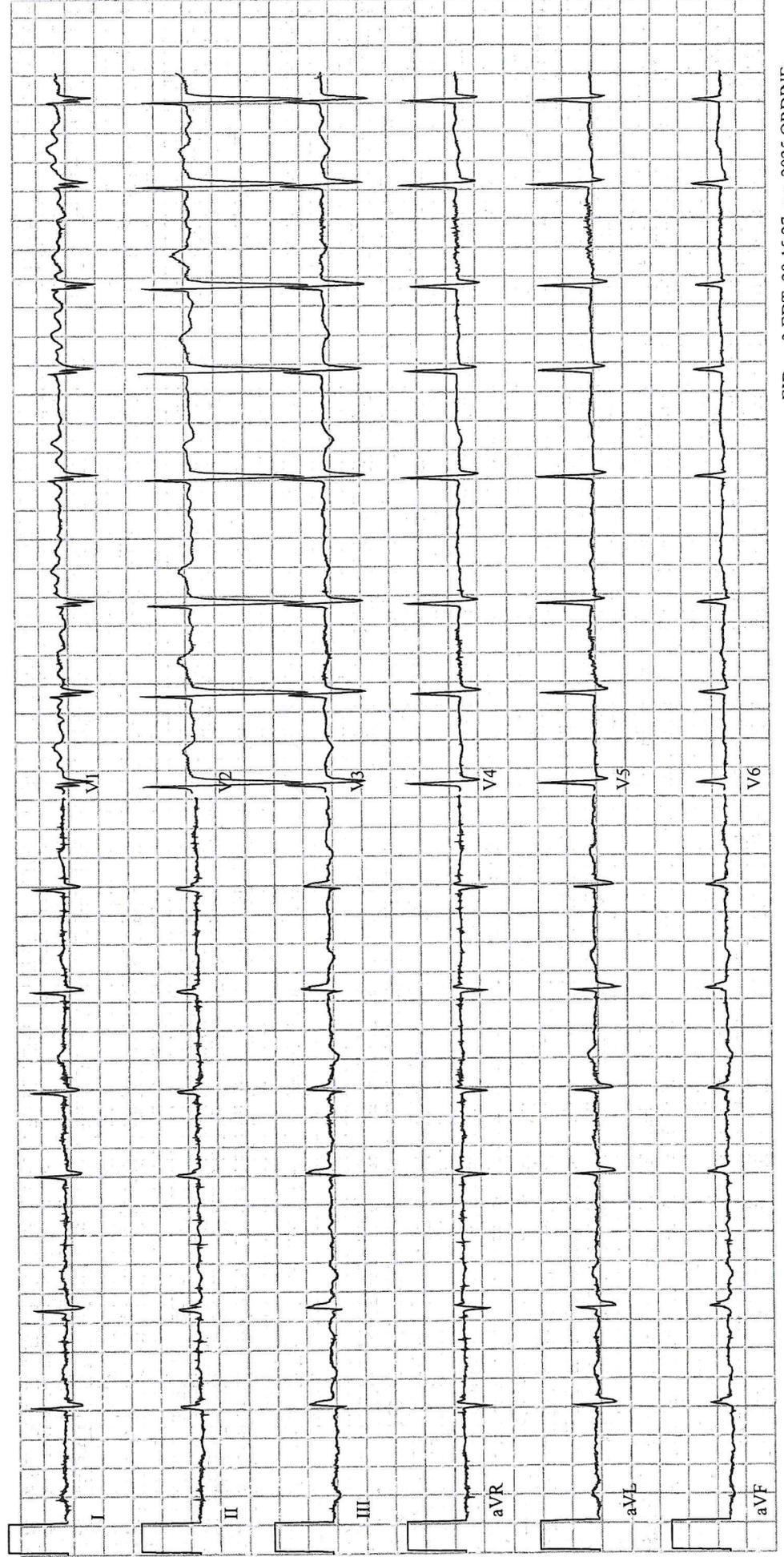




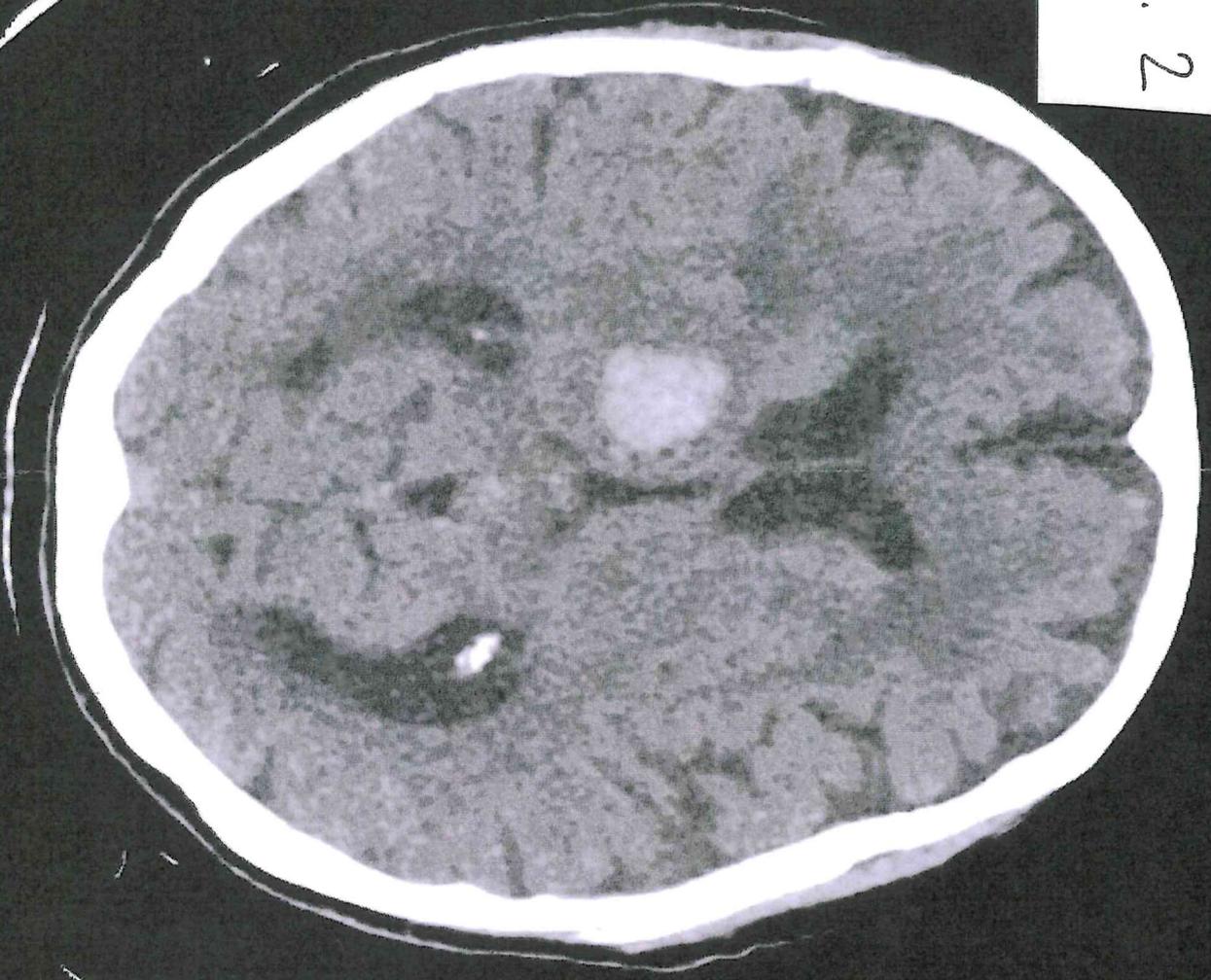
TECNICO:
Indicazioni: **PROVA PRATICA N. 1**

Med.:

Confermato da: Debora Di Maggio



Prova Pratica N. 2



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PROVA PRATICA N. 3



Sistema Socio Sanitario



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ASST Nord Milano

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Sesso:	Sig.ra / Mrs.
Data di Nascita:	
CF:	Richiesta Num.
Indirizzo:	Accettazione: 03-03-2025
3	Provenienza: CN Pronto Soccorso
MILANO	Destinazione:
20100	
Pag. n° 3 di 4	

Esame	Risultato	Unità di Misura	Valori di Riferimento	Metodo
S-Creatina Chinasi	* 196	U/L	[24 - 170]	IFCC
S-Amilasi	48	U/L	[28 - 100]	IFCC
S-Proteina C Reattiva	* 40,1	mg/L	[0,0 - 5,0]	Immunoturbidimetrico
Sg-Emogasanalisi Arteriosa				
pH gas A	* 7,260		[7,350 - 7,450]	
pCO2 A	* 60,0	mmHg	[35 - 45]	
pO2 A	* 40,0	mmHg	[80 - 100]	
HCO3 Act	26,9	mmol/L		
Eccesso di Basi A	-1,4	mmol/L	[-2,0 - 2,0]	
B(ecf)	-0,2			
ctCO2 A	28,7			
Sg-Emogas -Hct	41,0	%		
tHb	13,6	g/dL		
Saturazione O2 A	* 66,5	%	[95,0 - 100,0]	
FO2Hb A	* 64,9	%	[95 - 99]	
Carbossiemoglobina	2,2	%	[0,5 - 2,5] Fumatori fino a 6	
Metaemoglobina	* 0,3	%	[0,4 - 1,5]	
FHHb A	* 32,7	%	[1 - 5]	
pO2(a)/FO2(I) A	Non calcolabile			
pH (T)	7,2			
pCO2(T)	60,0			
pO2(T)	40,0			
pO2(a/A)(T)	Non calcolabile			
Sg-Emogas -Na+	135,0	mmol/L	[135,0 - 148,0]	



PROVA ORALE N. 1

LA MALNUTRIZIONE

DOMANDA INFORMATICA

DIFFERENZA TRA HARDWARE E SOFTWARE





PROVA ORALE N. 2

LA VALUTAZIONE MULTIDIMENSIONALE GERIATRICA

DOMANDA INFORMATICA

COS'E' UN MOTORE DI RICERCA





PROVA ORALE N. 3

LA POLIFARMACOTERAPIA NELL' ANZIANO

DOMANDA INFORMATICA

COS'E' UNA PEC



CLINICAL PRACTICE

Caren G. Solomon, M.D., M.P.H., *Editor*

Delirium in Hospitalized Older Adults

Edward R. Marcantonio, M.D.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

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A 75-year-old man is admitted for scheduled major abdominal surgery. He is functionally independent, with mild forgetfulness. His intraoperative course is uneventful, but on postoperative day 2, severe confusion and agitation develop. What is going on? How would you manage this patient's care? Could his condition have been prevented?

THE CLINICAL PROBLEM

ALTHOUGH DELIRIUM HAS BEEN DESCRIBED IN THE MEDICAL LITERATURE for more than two millennia, the condition is still frequently not recognized, evaluated, or managed appropriately.^{1,2} Delirium is also known as acute confusional state, altered mental status, and toxic metabolic encephalopathy, among more than 30 descriptive terms.³ Delirium can be thought of as acute brain failure⁴ and is the final common pathway of multiple mechanisms, similar to acute heart failure. The official definition of delirium in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5),⁵ requires a disturbance in attention and awareness that develops acutely and tends to fluctuate (Table 1). The pathophysiological mechanisms of delirium remain poorly understood; leading models include neurotransmitter imbalance and neuroinflammation.^{1,2,7,8}

Delirium is extremely common in hospitalized older adults. One third of general medical patients who are 70 years of age or older have delirium; the condition is present in half of these patients on admission and develops during hospitalization in the other half.⁷ Delirium is the most common surgical complication among older adults, with an incidence of 15 to 25% after major elective surgery and 50% after high-risk procedures such as hip-fracture repair and cardiac surgery.⁸ Among patients undergoing mechanical ventilation in the intensive care unit (ICU), the cumulative incidence of delirium, when combined with stupor and coma, exceeds 75%.⁹ Delirium is present in 10 to 15% of older adults in the emergency department.¹⁰ The prevalence of delirium at the end of life approaches 85% in palliative care settings.¹

Although many clinicians think of patients with delirium as being agitated, hyperactive delirium represents only 25% of cases, with the others having hypoactive ("quiet") delirium.^{1,7,8} Hypoactive delirium is associated with a poorer prognosis, potentially because it is less frequently recognized.^{11,12} The features of delirium range from mild to extremely severe, with greater severity associated with worse outcomes.^{1,2,7,8}



An audio version of this article is available at NEJM.org

