Atendimento humanizado e formação dos futuros médicos

José Guilherme Schwam Júnior

Neurologista com Fellowship em Distúrbios do Movimento – USP/RP

Membro do International Parkinson and Movement Disorder Society

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É importante treinar novos médicos?

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VIEWS & REVIEWS

Accuracy of clinical diagnosis of Parkinson disease

A systematic review and meta-analysis

Giovanni Rizzo, MD
Massimiliano Copetti, PhD
Simona Arcuti, PhD
Davide Martino, MD
Andrea Fontana, MSc
Giancarlo Logroscino, MD

Correspondence to Dr. Logroscino: giancarlo.logroscino@uniba.it

ABSTRACT

Objective: To evaluate the diagnostic accuracy of clinical diagnosis of Parkinson disease (PD) reported in the last 25 years by a systematic review and meta-analysis.

Methods: We searched for articles published between 1988 and August 2014. Studies were included if reporting diagnostic parameters regarding clinical diagnosis of PD or crude data. The selected studies were subclassified based on different study setting, type of test diagnosis, and gold standard. Bayesian meta-analyses of available data were performed.

Results: We selected 20 studies, including 11 using pathologic examination as gold standard. Considering only these 11 studies, the pooled diagnostic accuracy was 80.6% (95% credible interval [CrI] 75.2%–85.3%). Accuracy was 73.8% (95% CrI 67.8%–79.6%) for clinical diagnosis performed mainly by nonexperts. Accuracy of clinical diagnosis performed by movement disorders experts rose from 79.6% (95% CrI 46%–95.1%) of initial assessment to 83.9% (95% CrI 69.7%–92.6%) of refined diagnosis after follow-up. Using UK Parkinson's Disease Society Brain Bank Research Center criteria, the pooled diagnostic accuracy was 82.7% (95% CrI 62.6%–93%).

Conclusion: The overall validity of clinical diagnosis of PD is not satisfying. The accuracy did not significantly improve in the last 25 years, particularly in the early stages of disease, where response to dopaminergic treatment is less defined and hallmarks of alternative diagnoses such as atypical parkinsonism may not have emerged. Misclassification rate should be considered to calculate the sample size both in observational studies and randomized controlled trials. Imaging and biomarkers are urgently needed to improve the accuracy of clinical diagnosis in vivo.

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DISCUSSION

In keeping with previous UK studies[4,5] we found significant misdiagnosis of PD in the community. The present study is novel on two counts: first, in applying selection criteria to the case record, which enriched the proportion of patients with an erroneous diagnosis compared with assessing patients at random; and second, in the systematic and successful discontinuation of established antiparkinson therapy when PD was considered an unlikely diagnosis.

It is recommended that patients with suspected PD undergo specialist assessment and ongoing diagnostic review, based on a wrong PD diagnosis in 47% of community cases and 6–25% in specialist cases.[10] The proportion of PD Society survey respondents not attending a hospital specialist attendance for management of their PD was 15.4% (out of 10,128), which is almost identical to the 15.3% of patients in our series who did not have ongoing hospital attendance. Given that patients managed only in primary care were at least five times more likely to be rediagnosed and stop antiparkinson therapy without deterioration than patients attending a hospital specialist, our study has implications for the organization and delivery of care for patients with a diagnosis of possible PD. However, even detailed specialist assessment was imperfect, with two of our cases considered unlikely to have PD through detailed study clinical assessment deteriorating after therapy cessation and then being reconfirmed as having PD by FP-CIT SPECT. The alternative underlying diagnosis in patients completing therapy withdrawal was sometimes obvious, but in the significant majority of

The most common alternative diagnoses were ET and VP, in keeping with previous community studies.[4,5] While the main application of FP-CIT SPECT is earlier in the diagnostic algorithm,[22] our results suggest a role in longer-duration diagnoses when there is clinical diagnostic uncertainty. Given the 6–13% annual decline in dopaminergic activity in PD (versus an age-related decline of 0–2.5% per decade),[23–25] the differentiation of normal from abnormal FP-CIT becomes greater with longer symptom duration. The probability of false-negative FP-CIT SPECT after many years (mean 6.0, SD 4.1 years in the 16 cases with normal FP-CIT SPECT in our study) is extremely low, especially given that dopamine levels decline to half of normal before the first motor signs of PD emerge.[26]

An important diagnostic consideration in the present study is one of VP, as a levodopa therapy trial of up to 1000mg/day has been suggested.[27] In a retrospective series of pathologically confirmed VP, 12 of 17 cases had an excellent response to levodopa documented in the case record (mean daily dose 450 mg, range 100–1000 mg). Although 3 of their 17 patients did not respond to levodopa, the dose did not exceed 400 mg/day. Our study examines the levodopa response in VP indirectly; in the 10 cases rediagnosed as VP in whom antiparkinson therapy was successfully withdrawn there was no clinical deterioration or change in UPDRS score (mean LEU 248 units/day (SD 157), range 50–500). While some patients with VP might improve earlier during their clinical course or at higher levodopa doses, our study has the advantage of blinded assessment, and suggests that the dopaminergic therapy is ineffective, at least within a subset of patients with VP.

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Número de idosos no Brasil cresceu 50% em uma década, segundo IBGE

Nos últimos 10 anos o Brasil ganhou 8,5 milhões de cidadãos acima dos 60 anos. Essa parcela da população deve chegar a 38 milhões em 2027.

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1 COMENTÁRIOS

O IBGE (Instituto Brasileiro de Geografia e Estatística) divulgou recentemente mais uma estimativa populacional do Brasil, que agora conta com 207 milhões de habitantes. Mas entre rankings

É importante treinar novos médicos?

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Treinamento e Humanização!!

OMS: “Saúde é um bem estar físico, mental e social!”

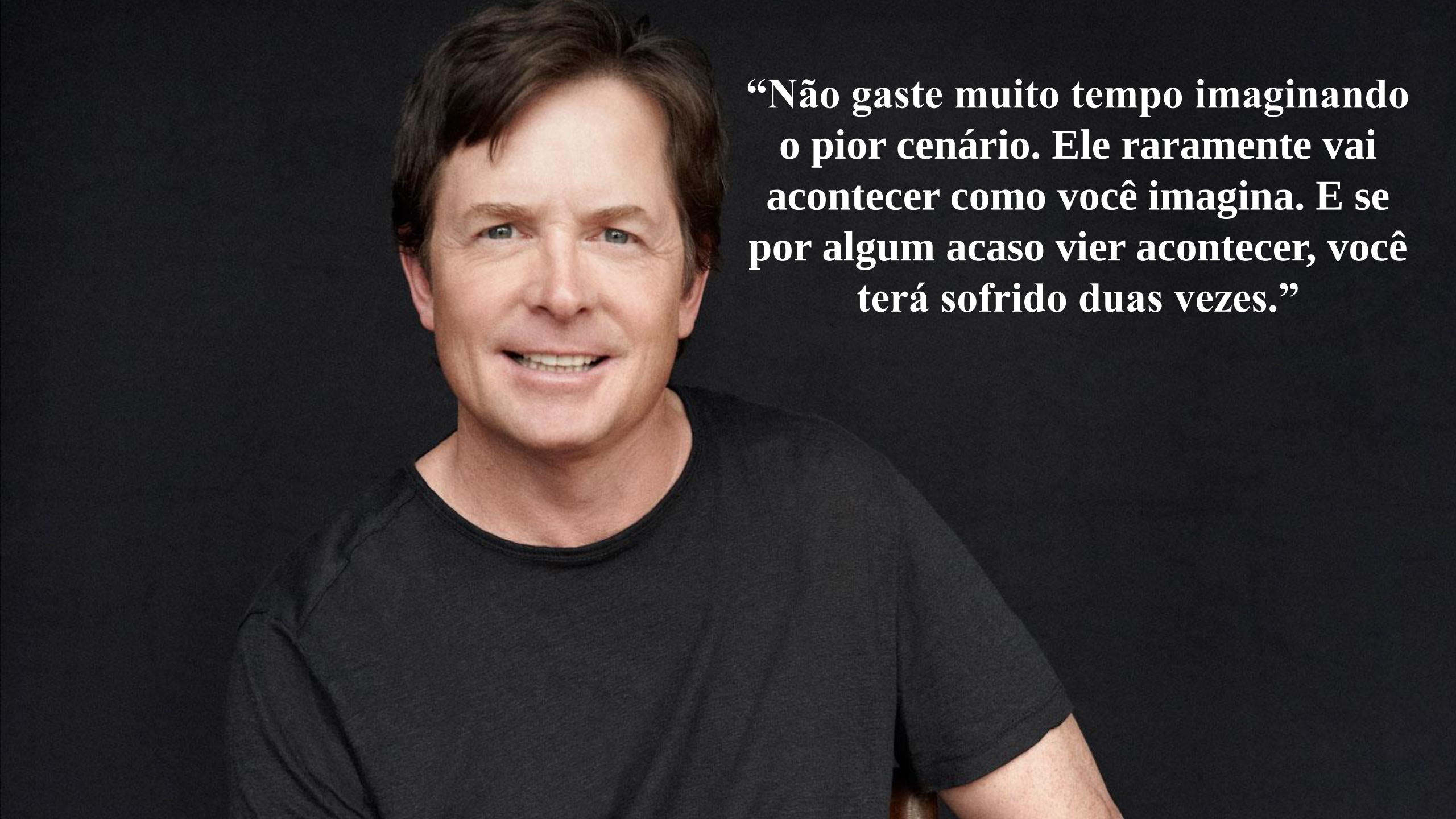
Parkinson: Prejuízo físico, mental e **social**!!

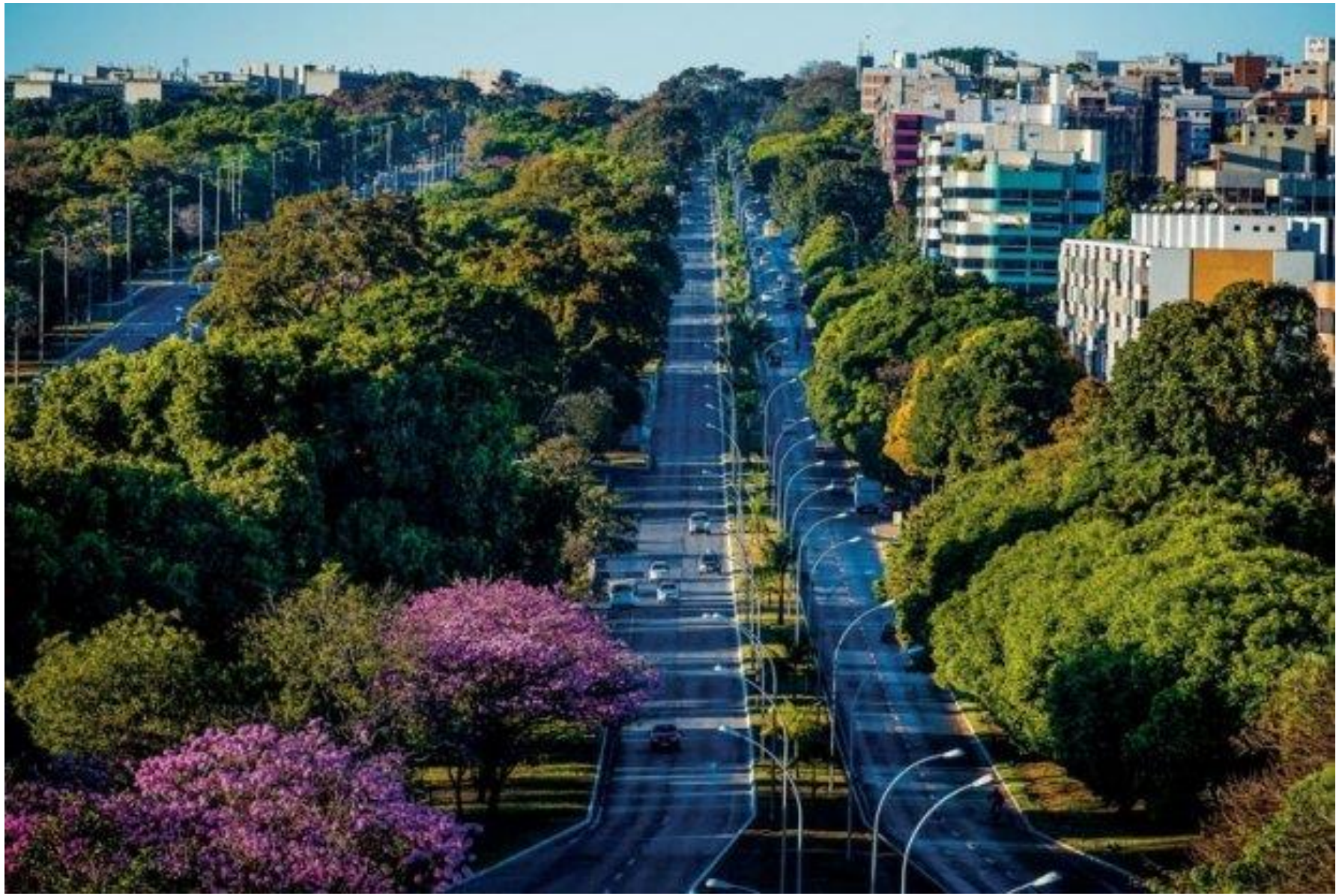
O médico, seu paciente e a doença (Balint):

“Os médicos conhecem com detalhes a farmacologia das drogas que utilizam no tratamento de seus doentes, porém não sabem se usar como medicamento”.

- Médico=> treinamento → Físico
- Profissionais de saúde=> humanizado → Mental
- Políticas públicas=> divulgação,leis,discussões → Social

S A Ú D E


“Não gaste muito tempo imaginando o pior cenário. Ele raramente vai acontecer como você imagina. E se por algum acaso vier acontecer, você terá sofrido duas vezes.”



Que sejamos semeadura de um futuro que é agora!!