Interdisciplinaridade na atenção ao adulto com comprometimento neurológico

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Rehabilitation 2030

World Health Organization

REHABILITATION IN HEALTH SYSTEMS: GUIDE FOR ACTION

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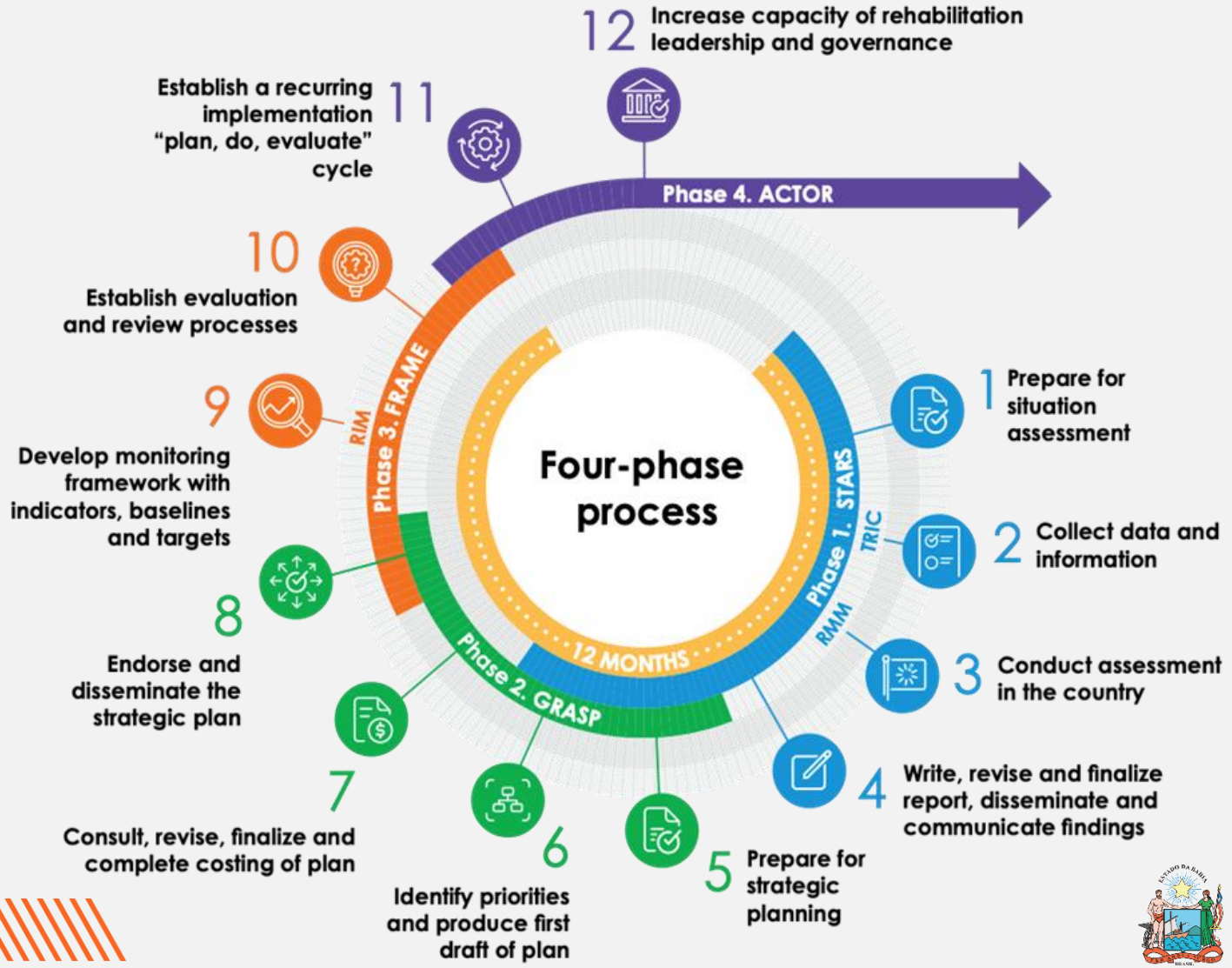
Rehabilitation is an essential part of health care, and is integral to achieving universal health coverage. Rehabilitation needs are increasing globally, along with rising prevalence of noncommunicable diseases and ageing populations. National efforts must strengthen health systems to provide rehabilitation, making it available to everyone at all levels of health care, whenever needed.

The World Health Organization's Rehabilitation 2030 Call for action sets out 10 key activities:

1. Creating strong leadership and political support for rehabilitation at subnational, national and global levels.
2. Strengthening rehabilitation planning and implementation at national and subnational levels, including within emergency preparedness and response.
3. Improving integration of rehabilitation into the health sector and strengthening intersectoral links to effectively and efficiently meet population needs.
4. Incorporating rehabilitation into universal health coverage.
5. Building comprehensive rehabilitation service delivery models to progressively achieve equitable access to quality services, including assistive products, for all the population, including those in rural and remote areas.
6. Developing a strong, multidisciplinary rehabilitation workforce that is suitable for each country context and ensuring rehabilitation as a topic is included in all health workforce education efforts.
7. Expanding financing for rehabilitation through appropriate mechanisms.
8. Collecting information relevant to rehabilitation to enhance health information systems, including system-level rehabilitation data and information on functioning using the International Classification of Functioning, Disability and Health (ICF).
9. Building research capacity and expanding the availability of quality evidence for rehabilitation.
10. Establishing and strengthening networks and partnerships in rehabilitation, particularly between low-, middle- and high-income countries.



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Neurorreabilitação em adultos

Principais condições atendidas

Acidente vascular encefálico (AVE)

Traumatismo cranio-encefálico (TCE)

Traumatismo raqui-medular (TRM)

Paralisia cerebral em adultos (PC)

AVE

Segunda causa de morte e incapacidade em todo o mundo

Condição neurológica que leva a maior demanda para reabilitação

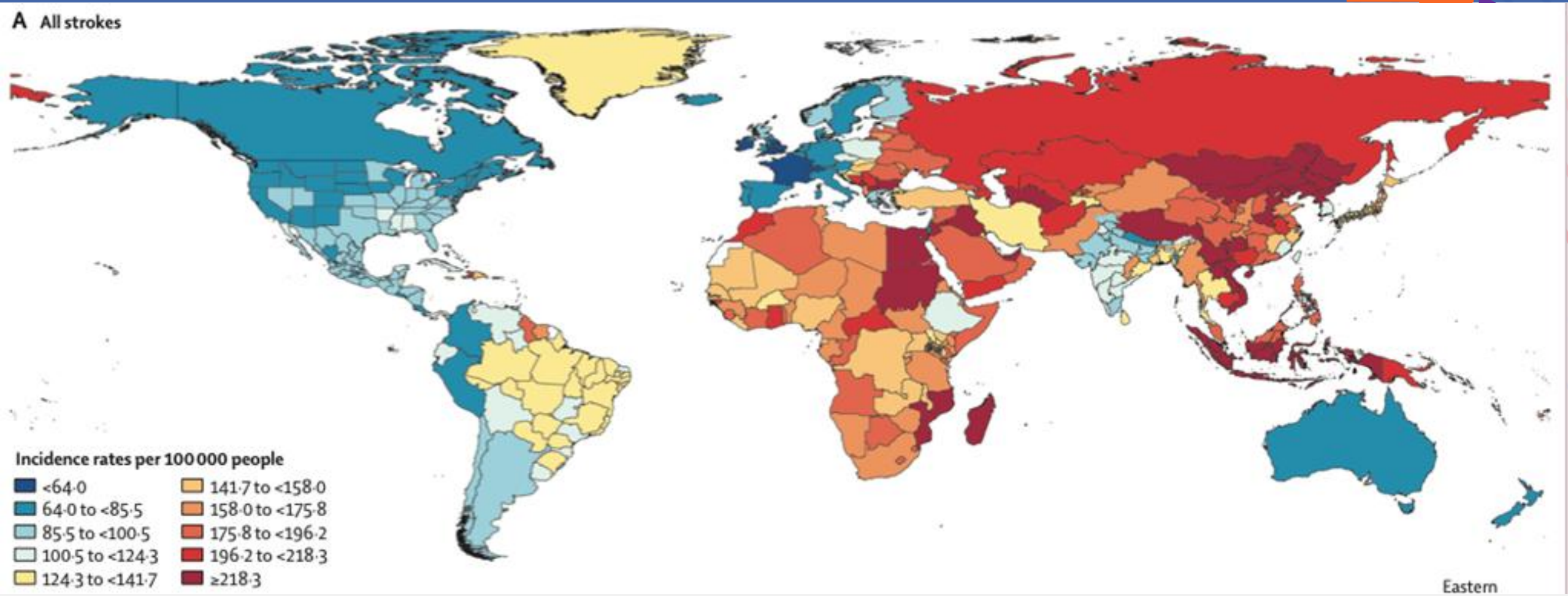
Mais de ⅔ dos pacientes irão necessitar de reabilitação após a fase aguda

No mundo: 86 milhões de pessoas com incapacidade pós AVE

Johnson CO et al. Lancet Neurol, 2019

Global, regional, and national burden of stroke and its risk factors, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019

*GBD 2019 Stroke Collaborators**


A All strokes
Incidence rates per 100 000 people
<64·0
64·0 to <85·5
85·5 to <100·5
100·5 to <124·3
124·3 to <141·7
141·7 to <158·0
158·0 to <175·8
175·8 to <196·2
196·2 to <218·3
≥218·3
Eastern

Interpretation The annual number of strokes and deaths due to stroke increased substantially from 1990 to 2019, despite substantial reductions in age-standardised rates, particularly among people older than 70 years. The highest age-standardised stroke-related mortality and DALY rates were in the World Bank low-income group. The fastest-growing risk factor for stroke between 1990 and 2019 was high body-mass index. Without urgent implementation of effective primary prevention strategies, the stroke burden will probably continue to grow across the world, particularly in low-income countries.

AVE Brasil

Redução da letalidade

2005: 55,7%

2015: 30,5%

*desigualdades sociais, > nas áreas mais ricas

Lotufo PA et al. Rev Bras Epidemiol, 2017

Principais fatores de risco modificáveis

- Hipertensão arterial sistêmica
- Diabetes mellitus tipo II
- Obesidade
- Doenças cardíacas
  - Fibrilação atrial
  - Cardiopatia chagásica
- Dislipidemia
- Tabagismo

Incapacidade pós AVE

Multifatorial

- Déficit neurológico
- Complicações clínicas pós AVE
- Controle inadequado dos fatores de risco
- Condições psico-sociais

Check list pós AVE

2013 - Post-stroke Checklist

11 itens

Philp I et al. J Stroke Cardiovasc Dis, 2013

2019 - versão revisada

14 itens

Turner GM et al. BMC Fam Pract, 2019

Check list pós AVE

1- Prevenção secundária

Modificações de hábitos de vida, acompanhamento médico e uso de medicamentos

2- Participação em atividades de vida diária

3- Alimentação e condições nutricionais

4- Mobilidade

5- Espasticidade

Check list pós AVE

6- Dor

7- Controle esfincteriano

8- Comunicação

Alterações de linguagem, comunicação alternativa

9- Humor

Depressão e ansiedade

10- Habilidades cognitivas

Check list pós AVE

11- Fadiga

12- Vida pós AVE

Capacidade para trabalhar, hobbies, lazer, direção de veículos…

13- Relacionamento social e familiar

14- Outros desafios pós AVE

Stroke at baseline of the Brazilian Longitudinal Study of Adult Health (ELSA-Brasil): a cross-sectional analysis

Fernanda Gabriela de Abreu[I], Alessandra Carvalho Goulart[II], Marina Gabriela Birck[III], Isabela Martins Benseñor[IV]

Centro de Pesquisa Clínica e Epidemiológica (CPCE), Hospital Universitário (HU), Universidade de São Paulo (USP), São Paulo (SP), Brazil

Sao Paulo Med J. 2018;136(5):398-406

ABSTRACT

BACKGROUND: Secondary prevention of stroke is a very important goal for achieving continuous reduction in stroke mortality rates over the next decades.

DESIGN AND SETTING: Cross-sectional analysis on the Brazilian Longitudinal Study of Adult Health (ELSA-Brasil), with data from Salvador, Vitória, Belo Horizonte, Rio de Janeiro, São Paulo and Porto Alegre.

METHODS: This descriptive analysis focused on secondary prevention of stroke among participants who self-reported a medical diagnosis of stroke at the baseline of ELSA-Brasil, and its association with sociodemographic characteristics.

RESULTS: Overall, 197 participants (1.3%) reported a prior medical history of stroke. Participants with stroke were older and less educated and had lower mean monthly family income, compared with non-stroke participants. Among all stroke cases, 23.7% did not use any medication for secondary prevention of stroke. Use of secondary prevention was higher among men than among women (respectively, 59.6% versus 40.4%; P = 0.02 for aspirin; and 71.4% versus 28.6%; P = 0.04 for other antiplatelet drugs). Having private health insurance was associated with greater use of less cost-effective and more expensive medications (like angiotensinogen receptor blockers) and a tendency to use antiplatelet drugs other than aspirin, among participants reporting stroke, compared with others. Use of medication decreased as time passed after suffering a stroke.

CONCLUSIONS: In this sample of individuals with better access to healthcare services, use of secondary prevention for stroke was low, which may suggest that the situation in the general population is worse. Sex was the most important sociodemographic variable associated with low use of secondary prevention.

Projeto Terapêutico Singular (PTS)

Processo que envolve usuários, famílias, equipe multiprofissional e redes sociais de apoio

Foco na ampliação da autonomia e participação efetiva dos usuários na construção do projeto

Momentos principais

- Avaliação
- Definição de ações prioritárias
- Divisão de reponsabilidade
- Reavaliação

_ Domínio do check-list pós AVE para elaboração do PTS

web PALESTRA

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