

# Bolnavul acut/urgenta

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# DEFINITION OF CRITICALLY ILL



- Critical illness is any disease process which causes physiological instability leading to disability or death within minutes or hours.
- A critically ill patient is one at imminent risk of death; the severity of illness must be recognized early and appropriate measures taken promptly to assess, diagnose and manage the illness.

Patient category

# Clinical observations

Not critically ill



Potential critical illness



Critically ill

Appearance	Neurological	Respiratory	Cardiovascular
Normal	Alert Cooperative	Normal RR >8 <20 b/min pattern	HR 60– 100b/min SBP > 90 mmHg UO > 0.5 ml/kg/hr
<b>SWEATY</b>	<b>CONFUSED ACCESSORY MUSCLE USE</b>	<b>RR-30/MIN</b>	<b>HR&gt;120/MIN</b>
Grey Blue Mottled skin	Unresponsive or eyesopen to pain only Fitting	Silent chest RR < 8 > 30 b/min Agonal respirations	HR < 50 b/min HR > 150 b/min SBP < 60 mmHg
Cardiac arrest or death			

# PHILOSOPHY OF MANAGEMENT

- Outcome in ICU is predominantly determined by initial management of patient at risk of life threatening illness.

“TIME IS TISSUE”

So a prompt and protocolized resuscitation regimen helps in salvaging these patients.

ASSESSMENT AND MANAGEMENT SHOULD  
GO HAND IN HAND

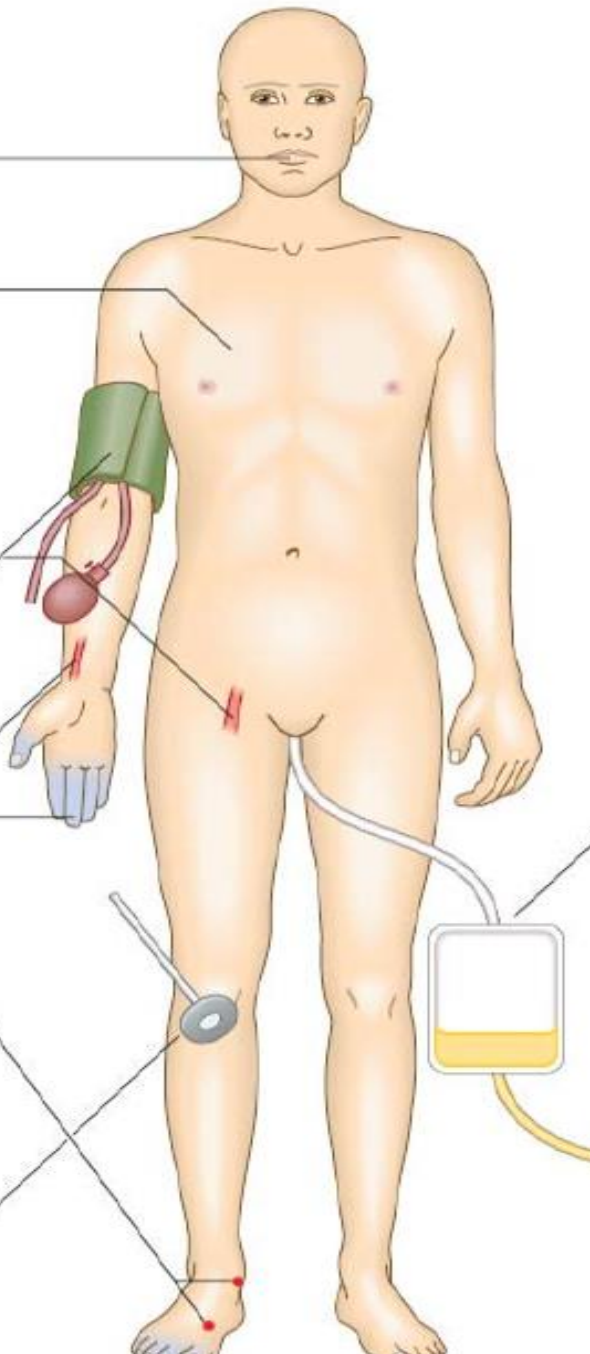
# PRIORITIES

1. Prompt *resuscitation* & adhering to *advanced life support* guidelines
2. Urgent *treatment of life threatening emergencies* (hypotension, hypoxaemia , hyperkalaemia, hypoglycaemia and dysrhythmias)
3. *Analysis of the deranged physiology*
4. Establish a *complete diagnosis* (as history & further diagnostic results are available)
5. Careful *monitoring* of the patient's condition and response to treatment



# 1 Initial assessment

- A**irway  
? Clear
  
- B**reathing  
Distress  
Rate  
Chest movement  
Auscultation
  
- C**irculation  
Pulse:  
Rate  
Rhythm  
Volume  
Blood pressure:  
Direct arterial pressure  
Peripheral perfusion:  
Peripheral pulses  
Temperature  
Colour  
Capillary refill
  
- D**isability  
Conscious level:  
Glasgow Coma Scale  
Pupil responses  
Localising signs



# 2 Immediate management

- Airway:  
Support, ? Intubate
- Breathing:  
Oxygen  
Continuous positive airway pressure (CPAP), non-invasive ventilation (NIV)  
Intubate and ventilate
- Circulation:  
Venous access  
Fluids  
Vasoactive drugs

# 3 Monitoring

- Heart rate; ECG
- Respiratory rate;  $SpO_2$
- BP—arterial line
- Temperature
- GCS; pupil size, reaction
- Urine output
- Central venous pressure

# 4 Initial investigations

- Full blood count
- Urea and electrolytes
- Creatinine
- Glucose
- Arterial blood gas lactate
- Coagulation
- Cultures: blood, urine, sputum
- Chest X-ray
- ECG

- Pacient constient, cooperant
  - Ce s-a intamplat?
  - Ce nu e bine in acest moment?
  - Exista o trauma Doare ceva?

**Daca este posibil: scurt istoric  
(astm/BCV/DZ/Depresie)**

**A**llergies

**M**edication

**P**ast medical history

**L**ast meal

**E**vents preceding the current incident

# Glasgow Coma Scale

**TABLE 38-2**

**Glasgow Coma Scale**

BEHAVIOR	RESPONSE	SCORE
Eye opening response	Spontaneously	4
	To speech	3
	To pain	2
	No response	1
Best verbal response	Oriented to time, place, and person	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No response	1
Best motor response	Obeys commands	6
	Moves to localized pain	5
	Flexion withdrawal from pain	4
	Abnormal flexion (decorticate)	3
	Abnormal extension (decerebrate)	2
	No response	1
Total score:	<i>Best response</i>	15
	<i>Comatose client</i>	8 or less
	<i>Totally unresponsive</i>	3

**Nivelul de constienta**

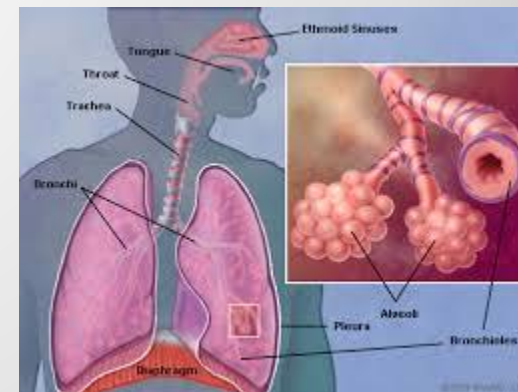
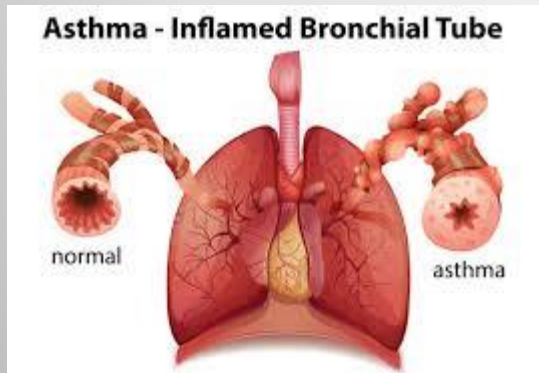


## Evaluare:

- Tensiune Arteriala
- Alura Ventriculara
- Puls
- Temperatura
- Frecventa respiratorie
- Diureza +- sonda urinara
- Timpul de reumplere capilara

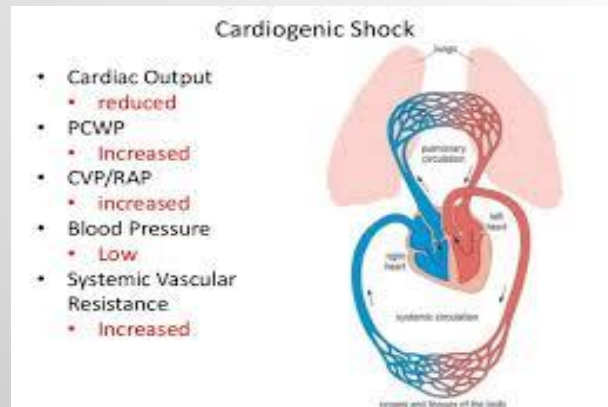
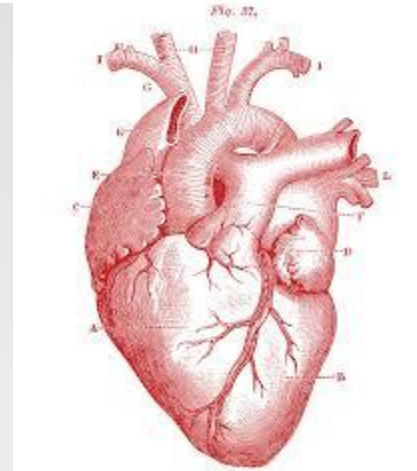
**Examinarea pacientului critic**

- Stridor / tiraj intercostal
- Obstrucție
- Frecvența respiratorie ( $>35/\text{min}$ ,  $<8/\text{min}$ )
- Respirație de tip abdominal
- Detresa respiratorie (nu poate să rostească o frază/ utilizează mm accesorii)
- $\text{SaO}_2 < 90\%$  sub oxigenoterapie
- $\uparrow \text{Pco}_2$  (gazometrie)



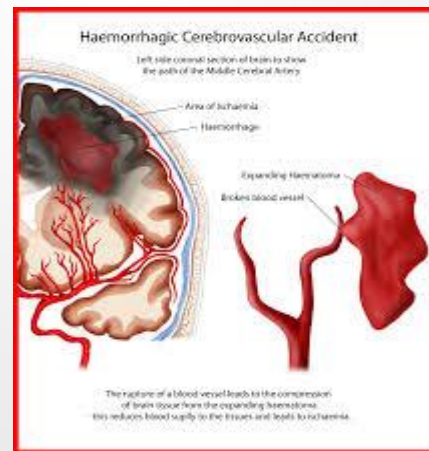
**Semne respiratorii**

- Puls absent
- AV > 180 /min sau av < 40/min
- TA < 100mmHg
- Timp de reumplere capilara ↑↑
- Oligurie/anurie
- ECG: TV/FV/BAV/Asistola



## Semne cardiovasculare

- Nu raspunde la comenzi
- Nu raspunde la stimuli durerosi
- Raspunde la stimuli durerosi doar la nivelul de hemicorp
- Frecventa respiratorie joasa
- Alterarea brusca a starii de constienta
- Mioza/midriaza/reflex fotomotor
- Crize tonico-clonice
- Glasgow <10



**Semne neurologice**

