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Información al paciente y su familia

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Herramientas predictiva mortalidad

- Criterios de terminalidad universalmente aceptados.
- Herramientas especificas de órgano o enfermedades prevalentes.
- Herramientas validadas en pacientes oncológicos.

MEDICAL GUIDELINES FOR DETERMINING PROGNOSIS IN SELECTED NON-CANCE

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The SUPPORT Prognostic Model

Objective Estimates of Survival for Seriously Ill Hospitalized Adults

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■ *Objective:* To develop and validate a prognostic model that estimates survival over a 180-day period for seriously ill hospitalized adults (phase I of SUPPORT [Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments]) and to compare this model's predictions with those of an existing prognostic system and with physicians' independent estimates (SUPPORT phase II).

■ *Design:* Prospective cohort study.

■ *Setting:* 5 tertiary care academic centers in the United States.

■ *Participants:* 4301 hospitalized adults were selected for phase I according to diagnosis and severity of illness; 4028 patients were evaluated from phase II.

■ *Measurements:* A survival model was developed using the following predictor variables: diagnosis, age, number of days in the hospital before study entry, presence of cancer, neurologic function, and 11 physiologic measures recorded on day 3 after study entry. Physicians were interviewed on day 3. Patients were followed for survival for 180 days after study entry.

■ *Results:* The area under the receiver-operating characteristics (ROC) curve for prediction of surviving 180 days was 0.79 in phase I, 0.78 in the phase II independent validation, and 0.78 when the acute physiology score from the APACHE (Acute Physiology, Age, Chronic Health Evaluation) III prognostic scoring system was substituted for the SUPPORT physiology score. For phase II patients, the SUPPORT model had equal discrimination and slightly improved calibration compared with physicians' estimates. Combining the SUPPORT model with physicians' estimates improved both predictive accuracy (ROC curve area = 0.82) and the ability to identify patients with high probabilities of survival or death.

■ *Conclusions:* A limited amount of readily available clinical information can provide a foundation for long-term survival estimates that are as accurate as physicians' estimates. The best survival estimates combine an objective prognosis with a physician's clinical estimate.

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The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) was a multicenter study designed to examine outcomes and clinical decision making for seriously ill hospitalized patients (1). A major hypothesis of SUPPORT was that accurate prediction of risk for death might assist physicians in clinical decision making by decreasing uncertainty and by promoting communication among physicians, patients, and patients' families (2, 3). SUPPORT was designed to be completed in two phases. During phase I, we observed and described the natural history of decision making and developed models to predict outcomes. Phase II was a randomized clinical intervention trial in which we evaluated providing objective prognostic information and enhanced communication about prognoses and preferences.

For phase I, we enrolled all patients at five participating sites who had at least one of nine illnesses and who were expected to have an overall 6-month mortality of 50% (Appendix 1). Individual survival probability estimates were developed for these patients using a few readily available variables that described the patient's major disease class, severity of physiologic abnormality, age, and comorbid conditions. We attempted to improve on past prognostic efforts in three ways. First, the SUPPORT population included patients who were not severely physiologically imbalanced, such as patients treated outside of intensive care units; most previous prognostic systems have been confined to intensive care units or emergency rooms (4–7). Second, the SUPPORT model was designed to predict survival to 180 days after study entry rather than to hospital discharge. Third, the independent variables used to predict risk for death were allowed to assume nonlinear relations that more accurately reflected their biological relations with patient survival. We summarize these efforts by describing the development, performance, and validation of the SUPPORT prognostic model, and we compare the model both with previous efforts and with the simultaneous subjective prognostic estimates of the physicians who cared for the study patients.

Methods

Patient Selection

A literature review (8) identified 13 diagnostic groups that had sufficient prognostic information in the medical record to allow identification of a cohort of patients with an aggregate expected 180-day mortality rate of 50%. Pilot testing eliminated 4 of these groups because of inadequate sample size, unreliable estimation of staging from the chart, or relatively low subsequent mortality

National Hospice Organization (NHO)

- Constituye la clasificación universalmente más aceptada para la definición de paciente con enfermedades médicas no oncológicas en fase terminal.

- Se basa en criterios generales de naturaleza mixta clínica, asistencial y de preferencias del paciente y en criterios específicos para cada una de las insuficiencias de órgano terminal.

- Su índice de validez y reproducibilidad no han resultado óptimos, siendo su principal defecto el moderado valor predictivo positivo.