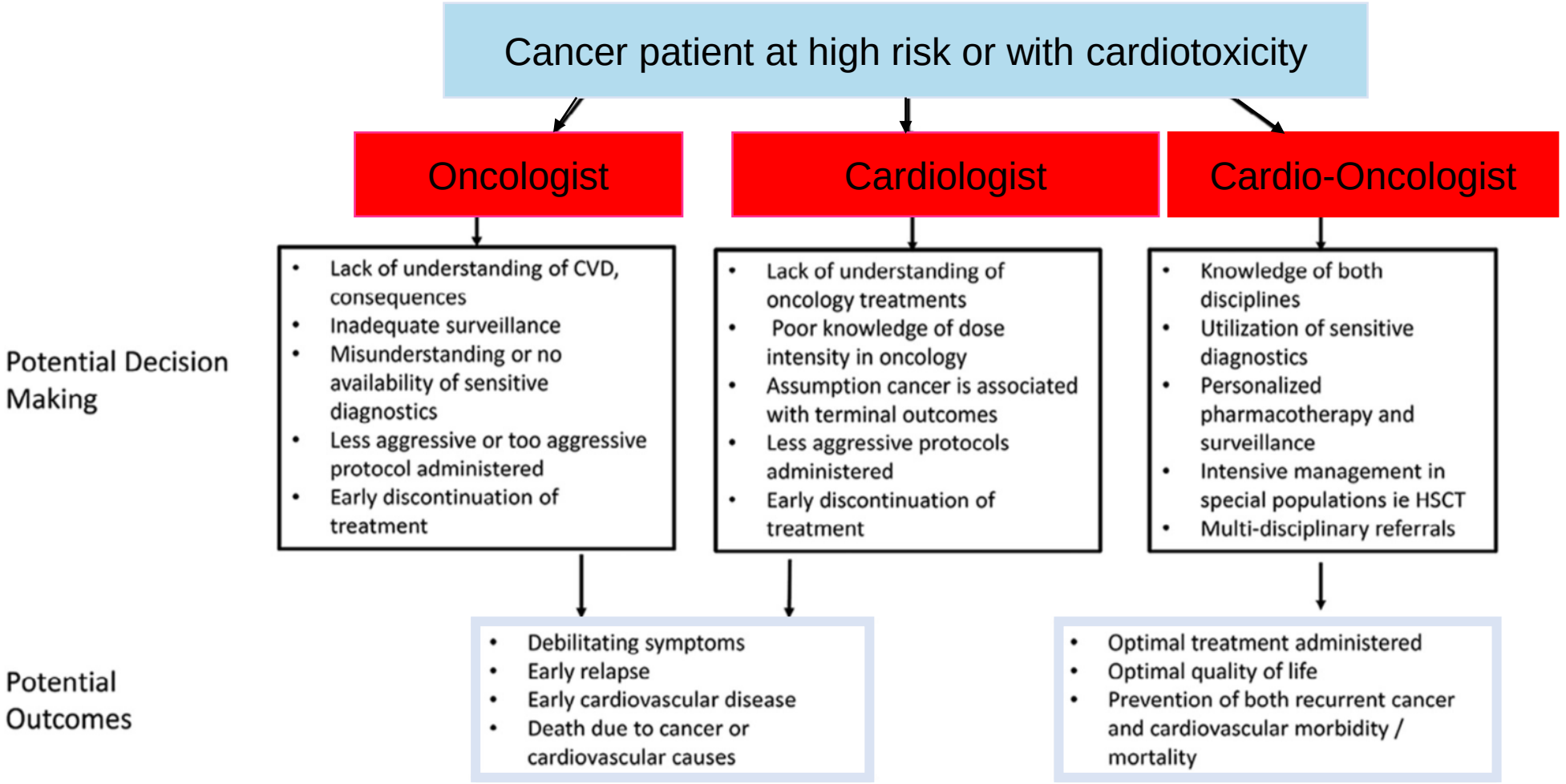
CORSO WEBINAR
10 giugno 2022

# I PERCORSI APPROPRIATI ASSISTENZIALI E TERAPEUTICI IN CARDIONCOLOGIA

## Approccio al paziente ad alto rischio cardiovascolare

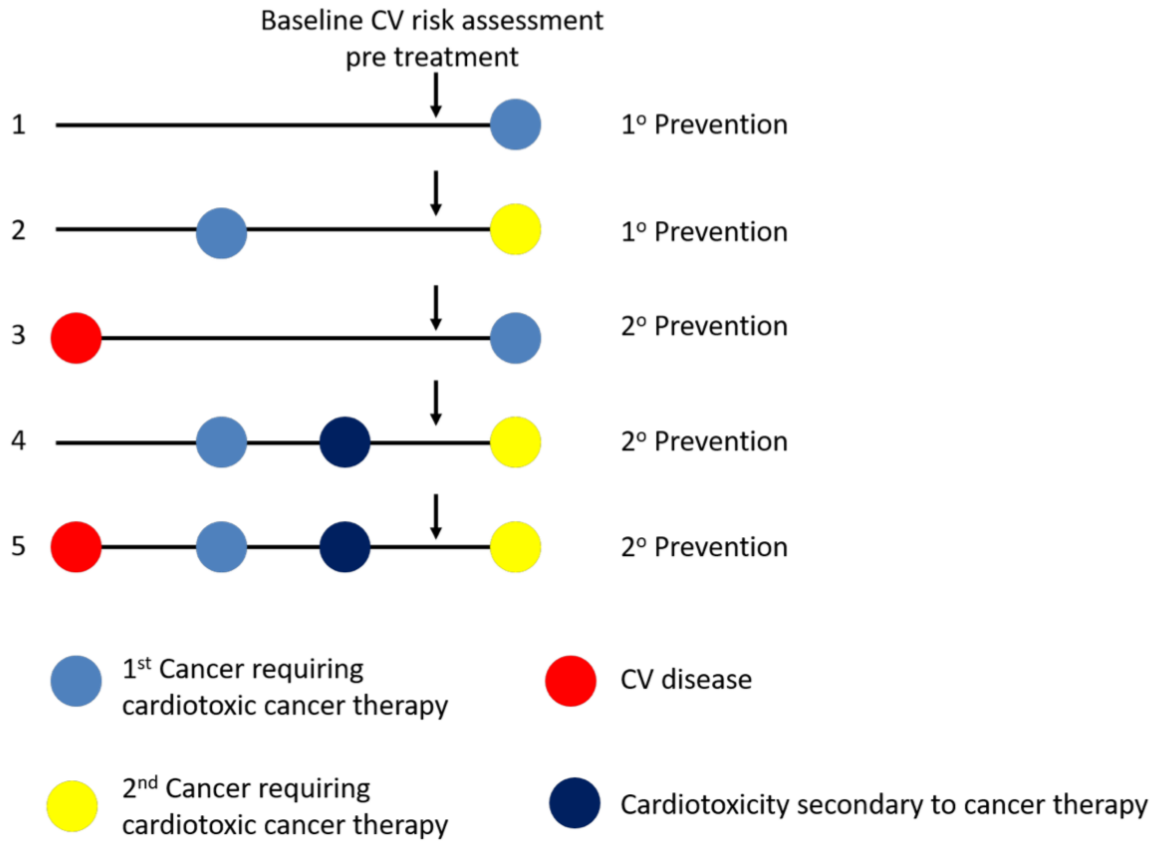
Irma Bisceglia
A.O.S.Camillo-Forlanini
Area Cardioncologia ANMCO

# The Role of Cardio- Oncology in the Interprofessional Care of Adult Patients Receiving Cancer Therapy



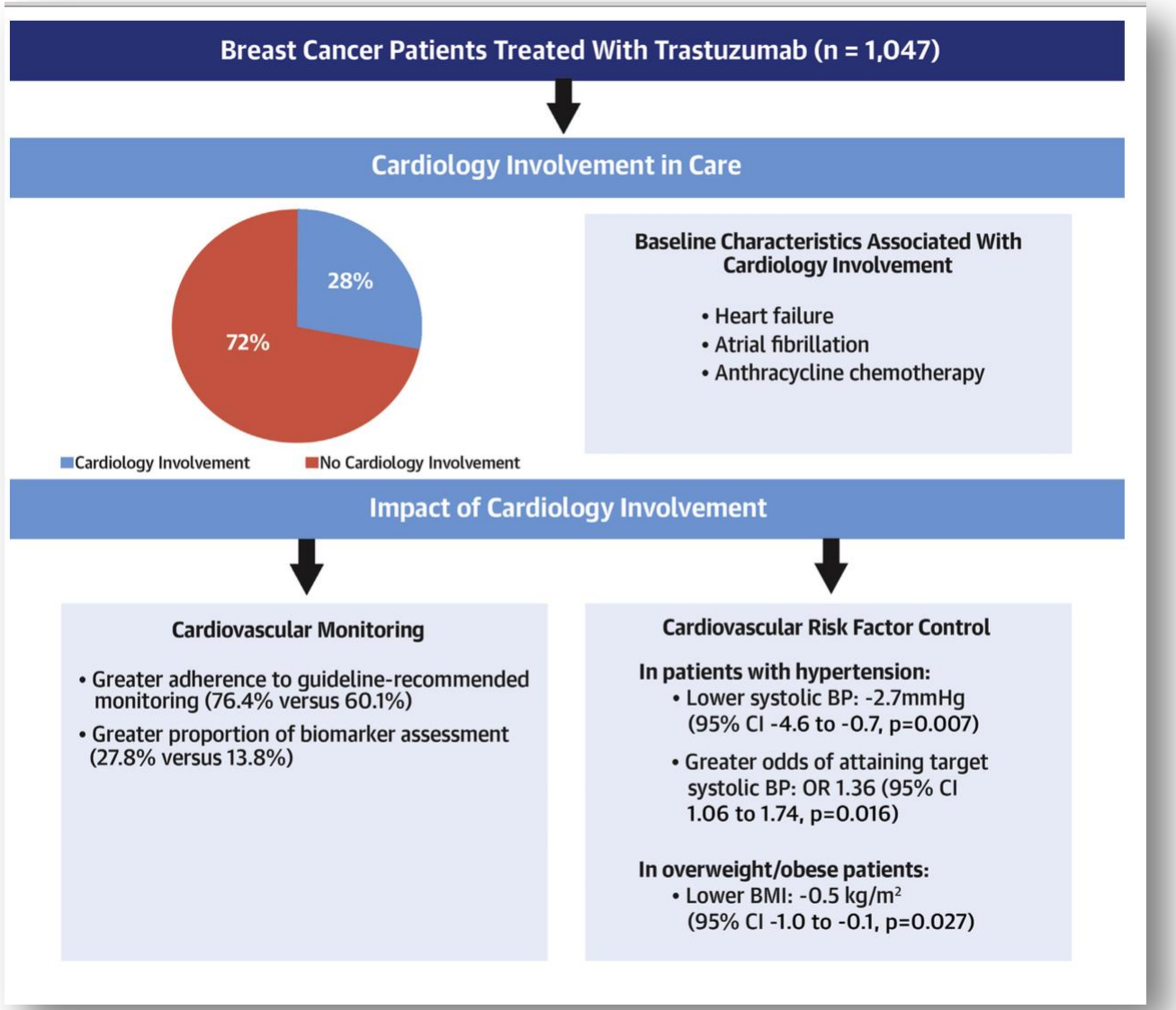

mod from Pituskin Semin Oncol Nurs 2017

# WHY A CARDIO-ONCOLOGY PARTERNSHIP ?




Lyon Eur J Heart Fail 2020

# Cardiology Involvement in Patients With Breast Cancer Treated With Trastuzumab



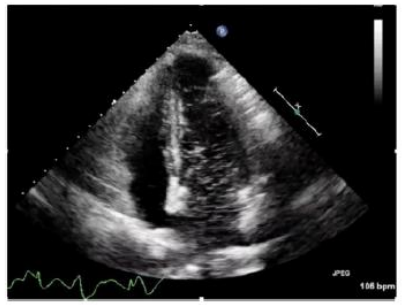

Demissei J Am Coll Cardiol CardioOnc. 2020

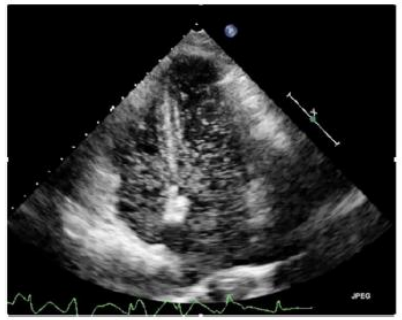
# CARDIO-ONCOLOGY PARTNERSHIP SUCCESS

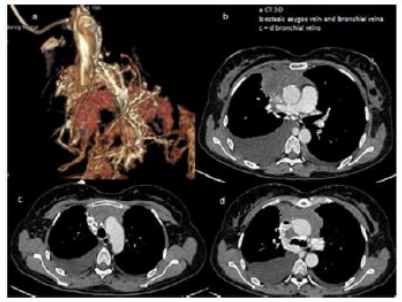

**C50 CARDIO-ONCO-HAEMATOLOGY IN CLINICAL PRACTICE. A "CHANGELING" CASE: MORE THAN PARADOXICAL BUBBLES**

I. Bisceglia, R. Mistrulli, D. Cartoni, V. Buffa, R. Battistini, A. Proia, L. Rigacci, S. Petrolati
OSPEDALE SAN CAMILLO, ROMA; OSPEDALE SANT'ANDREA ROMA; HEMATOLOGY, AZIENDA OSPEDALIERA SAN CAMILLO-FORLANINI, ROMA

39-year-old female, without cardiovascular risk factors. At the end of pregnancy she complained of progressive dyspnoea and so she was admitted to the emergency room. Blood tests showed elevated D-dimer and LDH values. A chest CT scan was performed showing a mediastinal mass of about 15 cm encompassing the ascending aorta, the left brachiocephalic trunk and the superior vena cava, both of which appeared thrombosed. Therapy with low molecular weight heparin was started. The patient underwent a mediastinal biopsy, which documented a primary mediastinal non-Hodgkin's lymphoma. The baseline cardiological evaluation showed a preserved ejection fraction (60%) at echocardiogram (ECHO). The first cycle of chemotherapy with R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine) was started. After an episode of hypoesthesia of the left upper limb, that regressed spontaneously within a few hours, she performed MRI that showed multiple areolas compatible with ischemic disease. Following these results the patient was submitted to an ECHO with saline solution injected through the right brachial vein that documented evidence of early opacification of the left atrium and subsequent opacification of the right sections (after 3 cardiac cycles) (Fig. 1-2). This finding suggested a right-to-left shunting, via the bronchial lower district to the left atrium (pulmonary veins). This suspicion was confirmed by CT angiography, which showed occlusion of the superior vena cava with passage of contrast into azygos and early opacification of peribronchial venous circles (Fig. 3). A patency of foramen ovale was ruled out by injection of saline solution through the femoral vein. After the second cycle of chemotherapy, ECHO showed diffuse hypokinesia and reduced EF to 50%. It was then decided to proceed with the third cycle according to the intensified R-DAEPOCH scheme, except for doxorubicin, because of the cardiotoxicity developed by the patient. A cardioprotective therapy was also started with bisoprolol and ramipril with rapid titration. At subsequent radiological controls, a progressive reduction of the mediastinal mass was found and after just one month, the echocardiogram showed a complete recovery of the EF. Contrast injection confirmed presence of a veno-venous shunt. Cardio-oncology is an intriguing and complex discipline that requires the development of local multidisciplinary teams for challenging situations that patients with cancer may ask us to address.



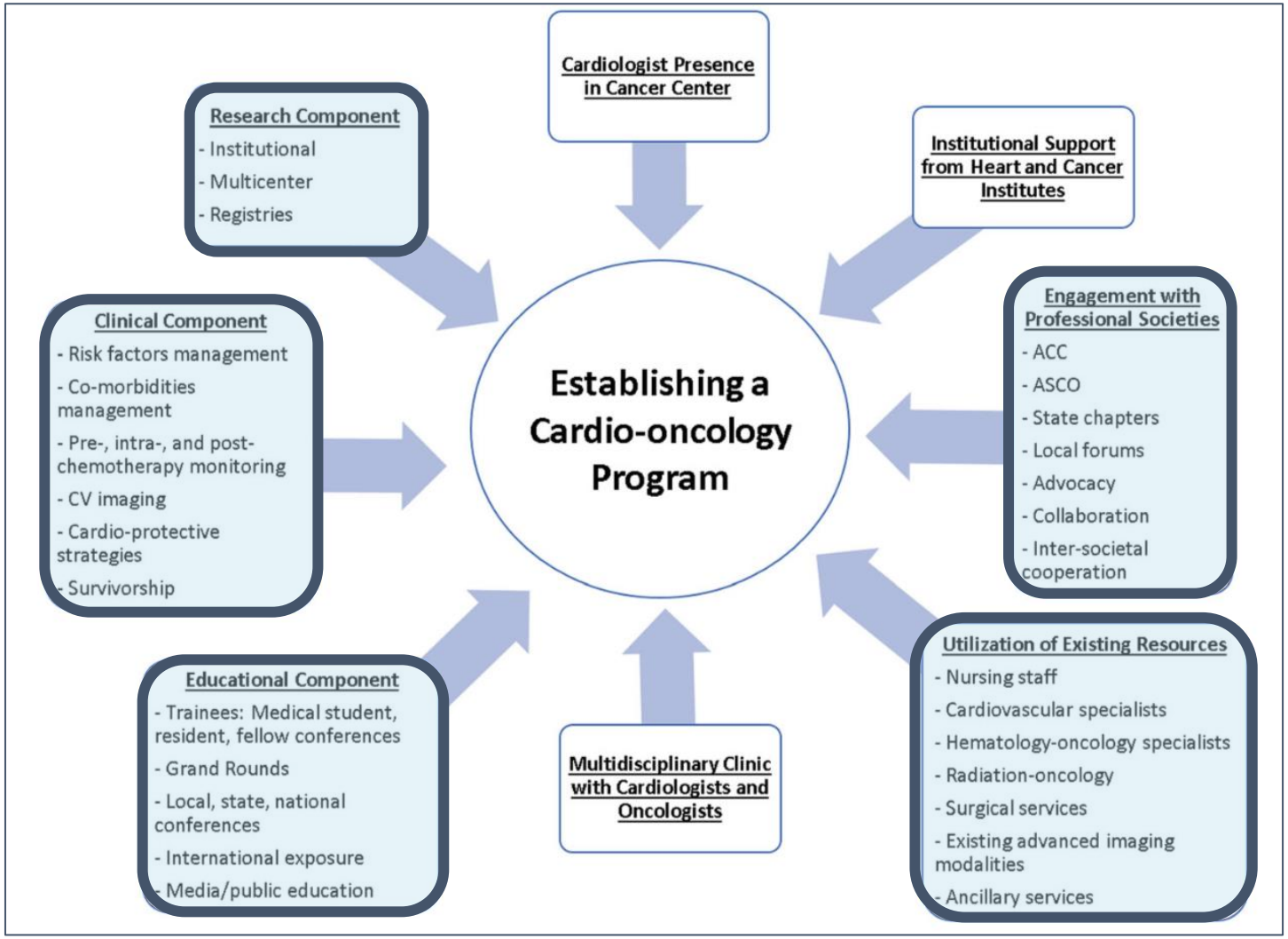
**P140 EFFICACY AND SAFETY OF CHEMOTHERAPY CONTAINING NON-PEGYLATED LIPOSOMAL DOXORUBICIN IN PATIENTS AT HIGH CARDIOVASCULAR RISK: A SINGLE-CENTER EXPERIENCE**

I. Bisceglia, M. Camilli, R. Mistrulli, D. Cartoni, S. Matera, M. Canale, R. Battistini, L. Rigacci, S. Petrolati
OSPEDALE SAN CAMILLO, ROMA; FONDAZIONE POLICLINICO UNIV. A. GEMELLI, ROMA; OSPEDALE SANT'ANDREA DI ROMA, ROMA; OSPEDALE S. MARIA GORETTI, LATINA; NUOVO OSPEDALE VERSILIA, LIDO DI CAMAIORE; HEMATOLOGY, AZIENDA OSPEDALIERA SAN CAMILLO- FORLANINI, ROMA

Anthracyclines represent the most effective chemotherapeutic agent in the treatment of non-Hodgkin's lymphoma (NHL), although their use is limited due to the risk of cardiac toxicity. This occurs mainly in elderly patients, those with a history of cardiovascular (CV) disease and/or multiple concomitant risk factors. Liposomal doxorubicin has been shown to reduce this toxicity. The aim of this retrospective study is to investigate the use of non-pegylated liposomal doxorubicin in high-risk patients in terms of haematological response rate and CV events. In a single centre, 15 patients undergoing R-COMP regimen (Rituximab, Prednisone, Cyclophosphamide, Vincristine, Myocet liposomal doxorubicin) were consecutively collected from January 2020 to December 2021. The mean age of patients was 73.9 years and 60% were male. The baseline mean left ventricular ejection fraction (LVEF) was 55.9%; four patients had a baseline FE of $< 50\%$, two of them had a severe reduction in LVEF. Among all patients, 86.7% had systemic hypertension, 40% diabetes mellitus, 46.7% dyslipidaemia and 20% a family history of CV disease. Moreover, 46.7% of patients had at least two concomitant risk factors and 20% at least three. 20% had a history of ischemic heart disease, 13.3% had previous exposure to anthracyclines and 20% with mediastinal radiotherapy; 26.7% had moderate to severe aortic valvulopathy. According to the joint Cardio-Oncology evaluation, 100% of patients had been considered unsuitable for conventional doxorubicin.. More than 85% of the cases were already on cardioactive therapy at baseline evaluation and 66.7% required titration or modification during chemotherapy. With R-COMP, the whole population was able to finish treatment achieved complete haematological remission. The mean LVEF at the end of treatment was 55.8% ($p = 0.814$).

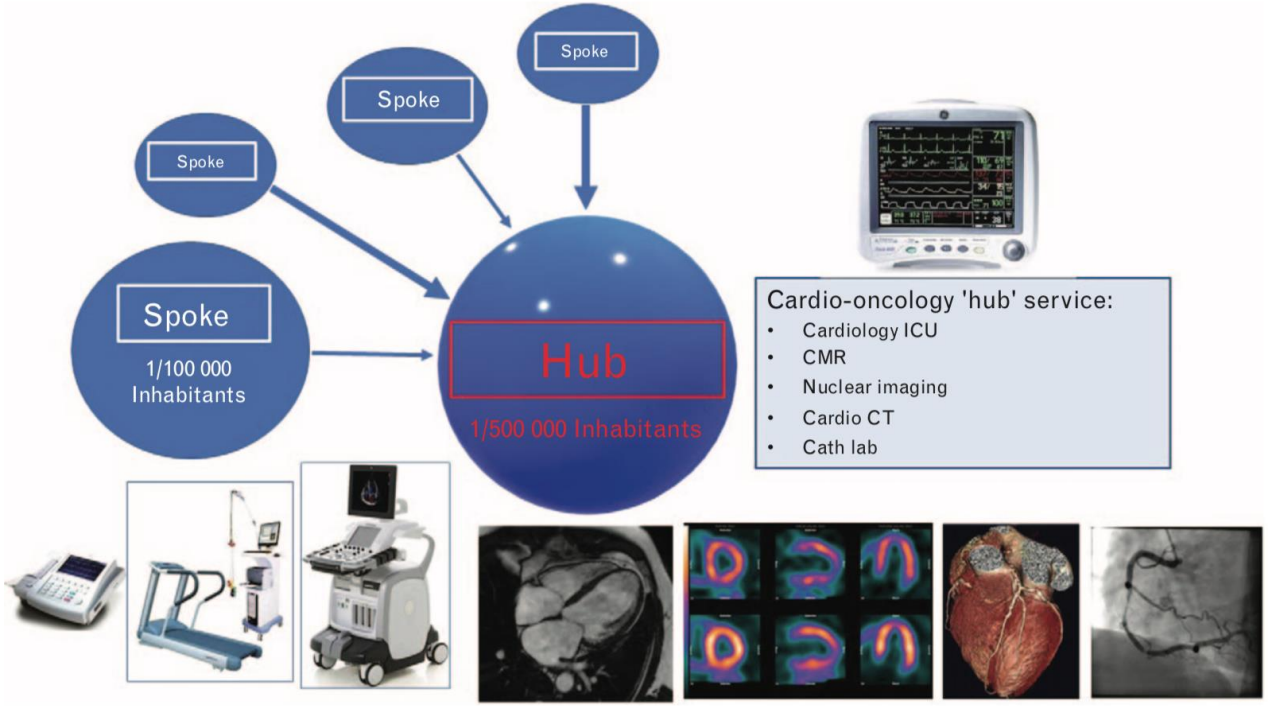
**Conclusions:** Our results support the efficacy and safety of R-COMP in a population at high risk for cardiac events, otherwise excluded from anthracycline-containing therapy. Liposomal formulatio reduces doxorubicin cardiomyocyte accumulation and thus toxicity, providing the best possible treatment for the majority of the onco-haematological population.

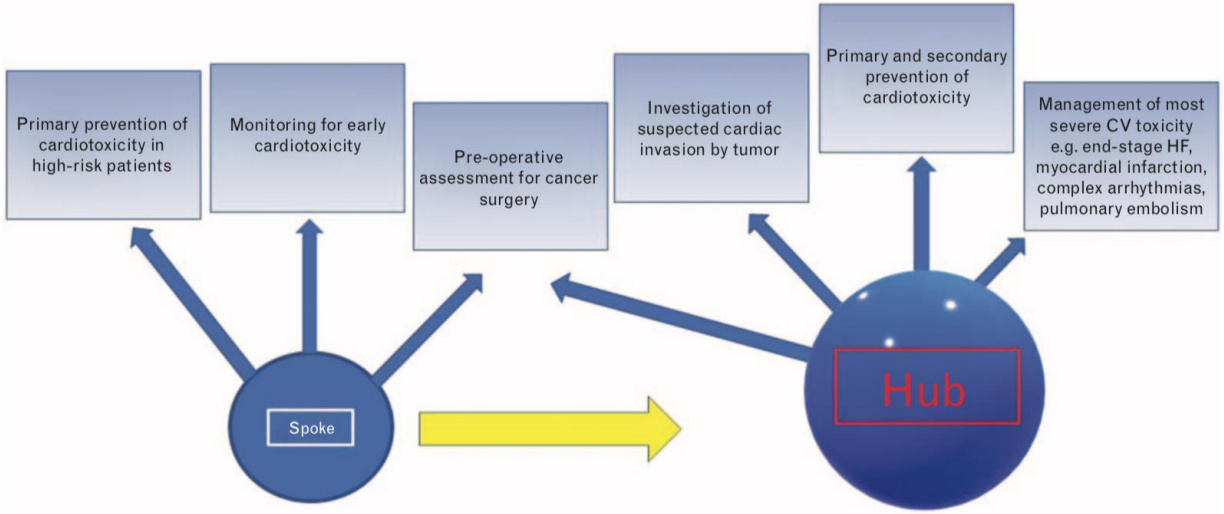
# Practical and cost-effective model to build and sustain a cardio-oncology program




Sadler Cardio Oncology 2020

# Rationale and proposal for cardio-oncology services in Italy




Hub centers should be placed in oncologic centers of tertiary hospitals, able to perform a large number of screening tests before, during and after anticancer therapy but also all the oncologic patients referred from the spoke centers

Galderisi J Cardiovasc Med 2022

# Cardio-oncology organization patterns in Italy: one size does not fit all

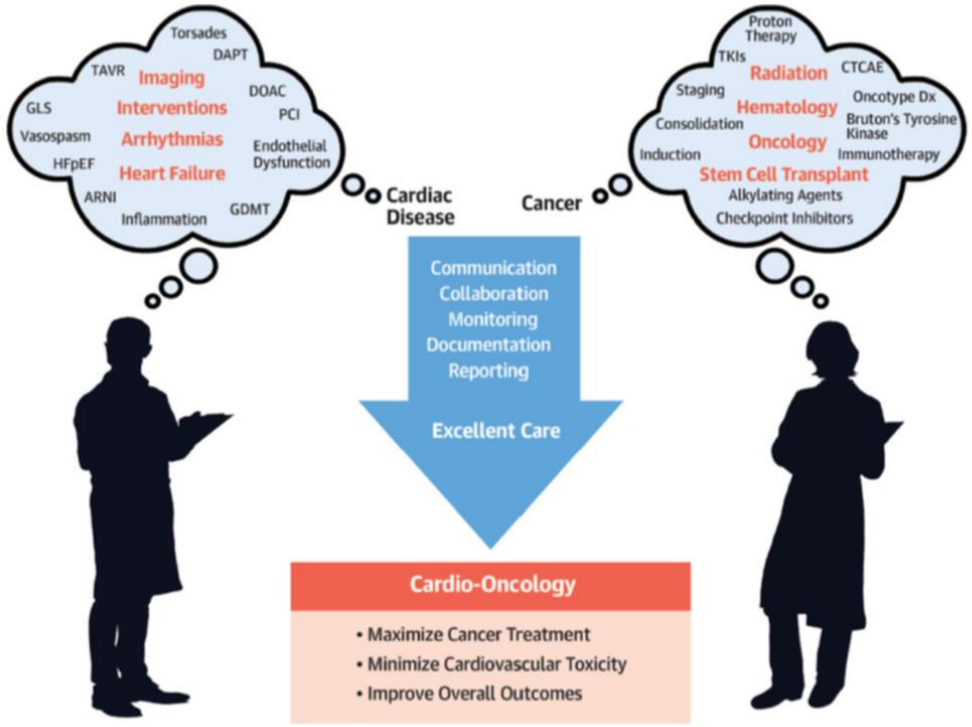
Maria Laura Canale[a], Chiara Lestuzzi[b], Irma Bisceglia[c], Paola Vallerio[d] and Iris Parrini[e], on behalf of Associazione Nazionale Medici Cardiologi Ospedalieri (ANMCO) Cardio-Oncology Task Force

| Size | Strengths | Weaknesses |
|---|---|---|
| XL | High-volume cancer center<br>Routine cardio-oncology evaluation<br>Formalized path with exclusively committed cardiologists<br>Ability to handle innovative drugs<br>Experience with unusual toxicities | Trouble in managing emergency<br>Lack of dedicated ward<br>Lower patient compliance because of distance (patients usually moving from distant places)<br>Troubles in follow-up |
| L | Cardiology and oncology/hematology wards<br>Specialists (usually) sharing the same building<br>Formalized path with committed cardiologists<br>Reference center for neighborhoods<br>Ability to handle emergency | Short time for consultations<br>Not exclusively dedicated cardiologists<br>Lower patient compliance because of distance (patients usually moving from distant places)<br>Troubles in follow-up |
| M | Cardiology and oncology/hematology units co-presence<br>Specialists sharing the same building<br>Formalized path with committed cardiologists (although not exclusive)<br>Face-to-face daily consultations<br>Ability to handle emergency | Trouble in managing experimental or innovative drug toxicity<br>Trouble in physician update<br>Lower number of treated patients than L or XL hospitals |
| S | Cardiology and oncology/hematology services co-presence<br>Close relationship with general practitioners<br>Direct patient access to services (open access model)<br>High-patient compliance | Not able to manage emergency<br>Trouble in managing experimental or innovative drug toxicity<br>Trouble in physician update<br>Low number of treated patient<br>Distance from larger centers (in some cases) |

J Cardiovasc Med 2018

# Clinical practice principles essential to develop a *vibrant* C-O program

- Establish a strong clinical connection with oncologists and hematologists
- Build relationships with primary care and internal medicine providers who are likely to treat cancer survivors
- Identify key administrators and clinicians in each area and ensure that they realize the purpose and benefits of C-O services
- Emphasize to all that optimal CV care has a major positive clinical impact
- Ascertain the best methods for communication among providers
- Participate in multidisciplinary meetings
- Evaluate a patient's eligibility to enroll in C-O clinical trials




Adusumalli J. of Cardiovasc. Trans. Res. 2020

# KEY POINTS

## Which Patients Should Be Referred to CO

| High baseline CV risk profile prior to potenal cardiotoxic therapy or stem cell transplantaon | Planned treatment with cancer therapies known to have higher likelihood of subsequent CV events | Patients who are to assist in monitoring and treatment of CV complications Cancer survivors (lifelong) |
|---|---|---|
| ▪ Established cardiovascular disease<br>▪ Uncontrolled diabetes<br>▪ Hypertension<br>▪ Hyperlipidemia<br>▪ Preexisting chronic inflammatory condition<br>▪ Tobacco use<br>▪ Prior anthracycline use<br>▪ Prior chest radiation<br>▪ Any prior CV toxicity related to cancer therapy | ▪ Anthracyclines, especially with regimens intending to use more than 250 mg/m2 lifetime dosing<br>▪ Radiaton with exposure to heart/vascular structures<br>▪ Anti HER2 therapy in patient with CV risk factors<br>▪ Tyrosine kinase inhibitors targeting VEGFR, BCR-ABL, EGFR,PDGFR<br>▪ Proteasome inhibitors, especially in combination with other therapy<br>▪ Immune checkpoint inhibitors,<br>▪ CAR-T<br>▪ Ibrutinib<br>▪ Androgen deprivation therapy (ADT) | ▪ Prior history of CV complications from cardiotoxic/vascular toxic therapy<br>▪ High-dose anthracyclines (eg, doxorubicin ≥ 250 mg/m$^2$)<br>▪ RT to heart, neck, vascular structures (≥ 30 Gy)<br>▪ Lower-dose anthracycline + lower doses of RT to heart, neck, or vascular structures<br>▪ Lower-dose anthracycline + trastuzumab<br>▪ Young or old age at diagnosis/treatment<br>▪ Prior history of ADT<br>▪ Prior history of immunotherapy with a checkpoint inhibitor or CAR-T<br>▪ Any suspected pericardial disease |

mod Adusumalli J. of Cardiovasc. Trans. Res. 2020

# Baseline cardiovascular risk assessment in cancer patients scheduled to receive cardiotoxic cancer therapies: a position statement and new risk assessment tools from the Cardio-Oncology Study Group of the Heart Failure Association of the European Society of Cardiology in collaboration with the International Cardio-Oncology Society

anthracycline

0 risk factors are 'low risk' or 1 medium[1] risk factor
"low risk"

1 medium[2] risk factor or > 1 medium[1] risk factor with a total of points 2 - 4
"medium risk"

≥ 1 high risk factor or ≥ 5 medium risk factors
"high risk"

≥ 5 medium risk factors
"high risk"

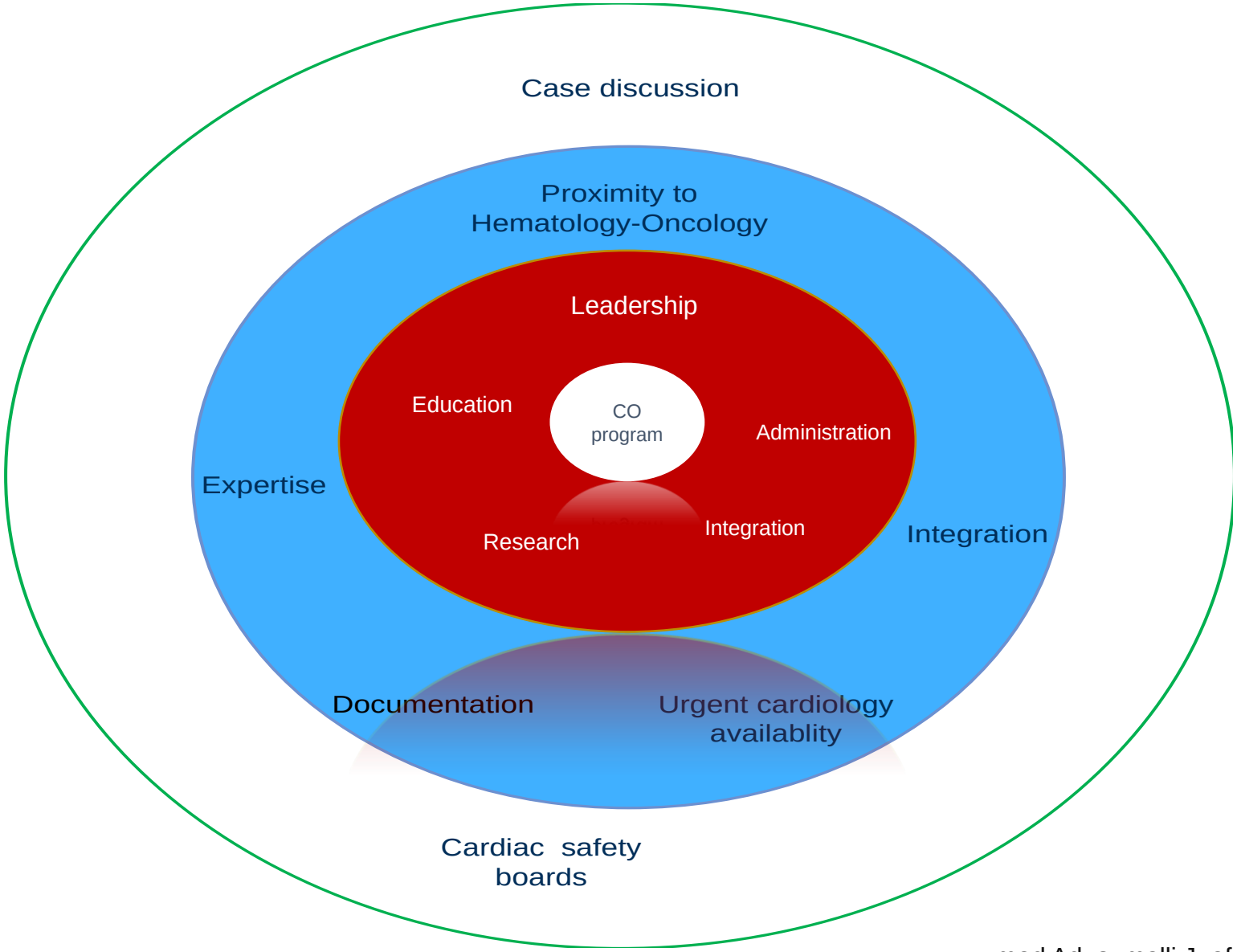
≥ very high risk factors
"very high risk"

HER2-targeted cancer therapies (trastuzumab,pertuzumab, T-DM1, lapatinib, neratinib)

| Risk factor | | Level of evidence |
|---|---|---|
| Previous cardiovascular disease | | |
| Heart failure or cardiomyopathy | Very high | C |
| Severe valvular heart disease | High | B |
| Myocardial infarction or previous coronary revascularisation (PCI or CABG) | High | B |
| Stable angina | High | C |
| Baseline LVEF <50% | High | C |
| Borderline LVEF 50–54% | Medium[2] | B |
| Cardiac biomarkers (where available) | Medium[2] | C |
| Elevated baseline troponin[a] | Medium[2] | B |
| Elevated baseline BNP or NT-proBNP[a] | Medium[2] | C |
| Demographic and cardiovascular risk factors | | |
| Age ≥80 years | High | B |
| Age 65–79 years | Medium[2] | B |
| Hypertension[b] | Medium[1] | B |
| Diabetes mellitus[c] | Medium[1] | C |
| Chronic kidney disease[d] | Medium[1] | C |
| Previous cardiotoxic cancer treatment | | |
| Previous anthracycline exposure | Medium[1f] | B |
| Prior radiotherapy to left chest or mediastinum | | |
| Previous non-anthracycline-based chemotherapy | Very high | C |
| Lifestyle risk factors | Medium[2] | B |
| Current smoker or significant smoking history | Medium[2] | C |
| Obesity (BMI >30 kg/m$^2$) | Medium[1] | C |
| Risk level | Medium[1] | C |

Lyon et al. Eur J Heart Fail 2020

# MAJOR COMPONENTS NECESSARY AND SUGGESTED TOOLS FOR DELIVERING EXCELLENT CARE IN CO

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# Establishing the value of a C-O program

| | |
|---|---|
| **SAFE** | ▪ Incidence of cancer treatment-related cardiotoxicity in patients seen by C-O service (outcome metric) |
| **EFFECTIVE** | ▪ Incidence of cancer treatment-related cardiotoxicity in patients seen by C-O service (outcome metric)<br>▪ Number of cardiotoxicity related cancer treatment interruptions in patients seen by C-O service (outcome metric)<br>▪ Control of CV risk factors including blood pressure, cholesterol, and blood glucose levels (outcome metric)<br>▪ Implementation of appropriate guideline-directed therapies at evidence-based doses (lipid-lowering agents, antihypertensive agents, antiplatelet agents, heart failure medications) |
| **PATIENT-CENTERED** | ▪ Patient-reported outcome metrics (outcome metric)<br>▪ Physical activity (self-reported using validated instrument or via implantable cardiac device/wearable device) (outcome metric) |
| **TIMELY** | ▪ Time from request to completion of a C-O consult in the inpatient and outpatient settings (process metric)<br>▪ Number of trained Cardio-Oncologists per health system (structure metric) |
| **EFFICIENT** | ▪ Appropriateness of C-O service consults as determined by risk stratification protocols (process metric)<br>▪ C-O service capacity utilization (process metric) |
| **EQUITABLE** | ▪ Stratification of quality metrics mentioned above by gender, race, ethnicity, geographic location, and socioeconomic status to ensure there is no variation based on those personal characteristics |

# Regardless of size and make up

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# PDTA AZIENDA OSPEDALIERA S. CAMILLO-FORLANINI

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**2. SCOPO**

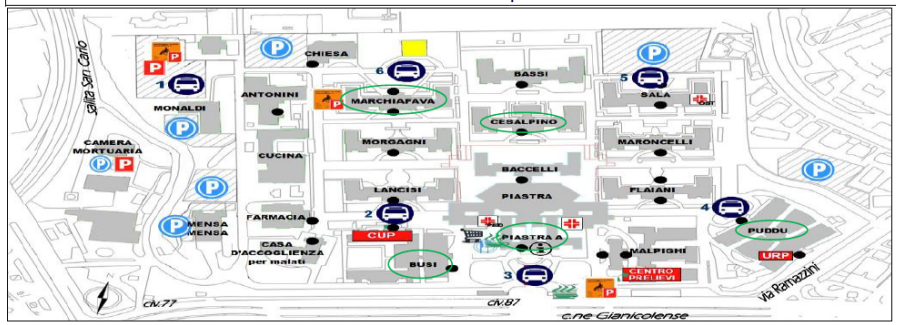
Scopo del presente PDTA è :

1. una chiara esplicitazione degli obiettivi e degli elementi chiave dell'assistenza basata su evidenze scientifiche, best practice, aspettative dei pazienti e loro caratteristiche;
2. la facilitazione delle comunicazioni tra i membri del team e i pazienti e le loro famiglie;
3. il coordinamento del processo di assistenza tramite il coordinamento dei ruoli e l'attuazione consequenziale delle attività dei team multidisciplinari di assistenza, dei pazienti e delle loro famiglie;
4. la documentazione, il monitoraggio e la valutazione delle varianze e degli outcome;
5. l'identificazione delle risorse appropriate.

**3. CAMPO DI APPLICAZIONE**

**Strutture coinvolte e luoghi d'applicazione**

| **UU.OO.** | **SEDE** | **UU.OO.** | **SEDE** |
|---|---|---|---|
| DI.PRO. | PIASTRA<br>SECONDO PIANO | DIREZIONE SANITARIA | PIASTRA<br>SECONDO PIANO |
| AMBULATORIO CARDIO-ONCOLOGIA | PADIGLIONE PUDDU<br>PIANO TERRA | ONCOLOGIA | MARCHIAFAVA<br>TERZO PIANO |
| EMATOLOGIA | CESALPINO<br>PRIMO PIANO | RADIOTERAPIA | BUSI<br>-1 PIANO |
| CARDIOCHIRURGIA | PIASTRA<br>PIANO TERRA | EMODINAMICA | PUDDU<br>PIANO TERRA |
| ANGIOLOGIA | PADIGLIONE PUDDU<br>SECONDO PIANO | | |
| Tutte le UU.OO. ove sia ricoverato un paziente che rientri nel PDTA | | | |




**4. CRITERI DI ACCESSO**

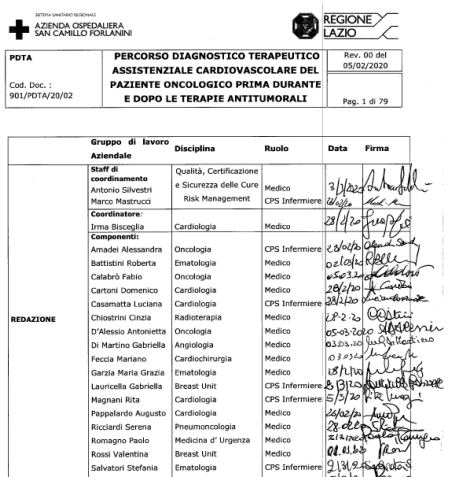
L'ambulatorio di cardioncologia accoglie pazienti provenienti dai day hospital di oncologia, senologia, pneumoncologia, ematologia e dalla radioterapia; molti pazienti sono ambulatoriali e alcuni casi complessi provengono da altri ospedali.

L'accesso viene effettuato mediante richieste inviate via fax per i day hospital , con ricetta regionale firmata dagli oncologi per i pazienti ambulatoriali e per i pazienti di altri ospedali.

I moduli che vengono inviati via fax sono stati redatti tenendo conto della diverse strategie terapeutiche e della complicanze più frequenti.

| **Codici ICD CM** | **Descrizione** |
|---|---|
| 88.72.1 | ECOGRAFIA CARDIACA |
| 88.72.2 | ECODOPPLERGRAFIA CARDIACA |
| 88.72.3 | ECOCOLORDOPPLER |
| 89.01 | ANAMNESI E VALUTAZIONE, DEFINITE BREVI |
| 89.41 | TEST CARDIOVASCOLARE DA SFORZO CON PEDANA MOBILE |
| 89.43 | TEST CARDIOVASCOLARE DA SFORZO CON CICLOERGOMETRO |
| 89.44.1 | PROVA DA SFORZO CARDIORESPIRATORIO |
| 89.50 | ELETTROCARDIOGRAMMA DINAMICO (HOLTER) |
| 89.52 | ELETTROCARDIOGRAMMA |
| 89.61.1 | MONITORAGGIO CONTINUO DELLA PRESSIONE ARTERIOSA |
| 89.7 | VISITA SPECIALISTICA |
| 91.49.2 | PRELIEVO DI SANGUE VENOSO |
| 92.05.2 | SCINTIGRAFIA MIOCARDICA CON INDICATORI DI LESIONE |
| 92.05.3 | ANGIOCARDIOSCINTIGRAFIA DI PRIMO PASSAGGIO (FIRST PASS) |
| 92.09.2 | TOMOSCINTIGRAFIA MIOCARDICA (SPET) DI PERFUSIONE A RIPOSO O DOPO STIMOLO |
| 92.09.9 | TOMOSCINT. MIOCARDICA DI PERFUSIONE A RIPOSO ( SOLO PER PAC ) |
| 92.10.1 | TOMOSCINT.MIOCARDICA PERFUSIONE DOPO STIMOLO ( SOLO PER PAC ) |

# PDTA AZIENDA OSPEDALIERA S. CAMILLO-FORLANINI

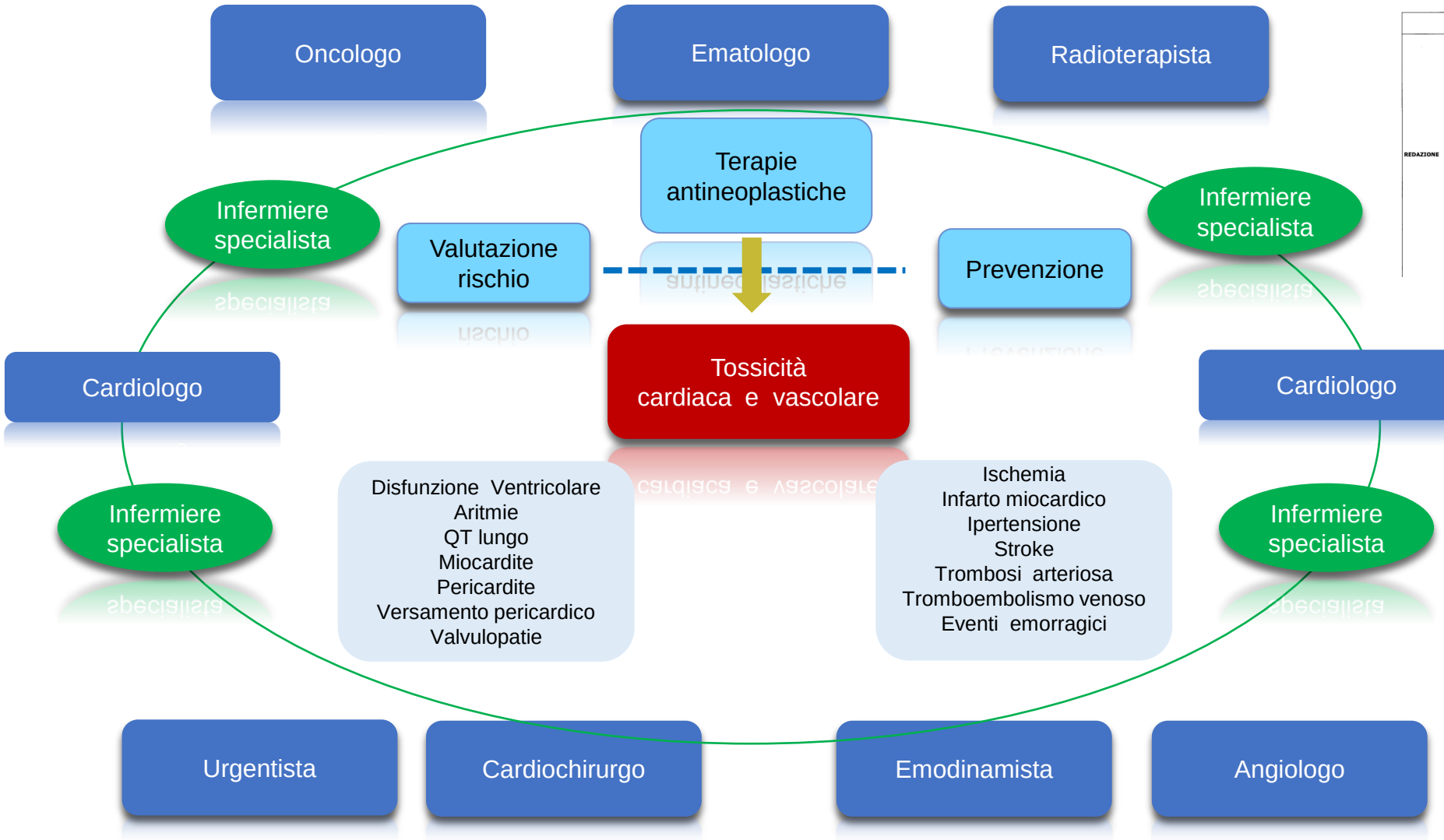


AZIENDA OSPEDALIERA SAN CAMILLO FORLANINI

REGIONE LAZIO

| PDTA | PERCORSO DIAGNOSTICO TERAPEUTICO ASSISTENZIALE CARDIOVASCOLARE DEL PAZIENTE ONCOLOGICO PRIMA DURANTE E DOPO LE TERAPIE ANTITUMORALI | Rev. 00 del 05/02/2020 |
|---|---|---|
| Cod. Doc. : 901/PDTA/20/02 | | Pag. 1 di 79 |

| | Gruppo di lavoro Aziendale | Disciplina | Ruolo | Data | Firma |
|---|---|---|---|---|---|
| REDAZIONE | Staff di coordinamento<br>Antonio Silvestri<br>Marco Mastrucci | Qualità, Certificazione e Sicurezza delle Cure Risk Management | Medico<br>CPS Infermiere | 3/12/20<br>10/12/20 | |
| | Coordinatore:<br>Irma Bisceglia | Cardiologia | Medico | 23/12/20 | |
| | Componenti:<br>Amadei Alessandra | Oncologia | CPS Infermiere | 28/02/20 | |
| | Battistini Roberta | Ematologia | Medico | 02/03/21 | |
| | Calabrò Fabio | Oncologia | Medico | 05/03/21 | |
| | Cartoni Domenico | Cardiologia | Medico | 26/2/20 | |
| | Casamatta Luciana | Cardiologia | CPS Infermiere | 28/4/20 | |
| | Chiostrini Cinzia | Radioterapia | Medico | 28-2-20 | |
| | D'Alessio Antonietta | Oncologia | Medico | 05-03-2020 | |
| | Di Martino Gabriella | Angiologia | Medico | 03.03.20 | |
| | Feccia Mariano | Cardiochirurgia | Medico | 03/03/20 | |
| | Garzia Maria Grazia | Ematologia | Medico | 18/12/20 | |
| | Lauricella Gabriella | Breast Unit | CPS Infermiere | 3/3/20 | |
| | Magnani Rita | Cardiologia | CPS Infermiere | 5/3/20 | |
| | Pappalardo Augusto | Cardiologia | Medico | 26/02/20 | |
| | Ricciardi Serena | Pneumoncologia | Medico | 28.02.20 | |
| | Romagno Paolo | Medicina d' Urgenza | Medico | 27/02/2020 | |
| | Rossi Valentina | Breast Unit | Medico | 02.03.20 | |
| | Salvatori Stefania | Ematologia | CPS Infermiere | 9/3/20 | |



R= RESPONSABILE C= COINVOLTO I= IN

# PDTA AZIENDA OSPEDALIERA S. CAMILLO-FORLANINI

Azienda Ospedaliera San Camillo-Forlanini
SERVIZI CARDIOLOGICI INTEGRATI
Ambulatorio di Cardio-Oncologia
Piano terra Padiglione Puddu
065870 -4489 - 3724-4482 (FAX)

**UNITA OPERATIVA**

Ambulatorio / DH Oncologia  Ambulatorio /DH Breast Unit  Ambulatorio / DH Ematologia  Ambulatorio / DH Pneumo Oncologia

Radioterapia  Altro ospedale

NOME E COGNOME ..... DATA DI NASCITA ..... TEL. .....

**MOTIVO DELLA RICHIESTA**

Pre-chemioterapia  Controllo programmato  Controllo per complicanze  Controllo per tossicità  Pre trapianto  Follow up

**FARMACI**

**Antracicline  Trastuzumab  Fluoropirimidine  Anti VEGF  Inibitori delle tirosinchinasi**

**Carfilzomib/Bortezomib  Immunoterapia  Altro** .....

Data inizio antracicline .....  Data fine antracicline .....

**SEDE NEOPLASIA**

.....

**ESAMI RICHIESTI**

**ECG + VISITA CARDIOLOGICA  ECOCARDIOGRAMMA (*)  ECG per calcolo QT**

DATA E ORA APPUNTAMENTI

ECG + visita cardiologica .....

ECO .....

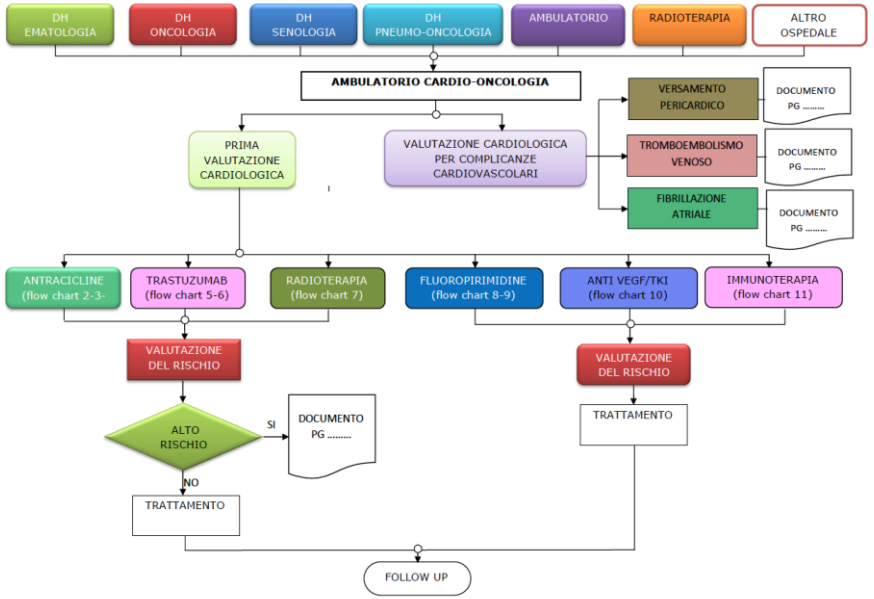
Holter .....

Test da sforzo .....

**(*)** solo per pz sottoposti a trattamento con antracicline e/o trastuzumab

**I PAZIENTI CARDIOPATICI DEVONO ESSERE INVIATI CON RACCOMANDAZIONE**

**DI PORTARE DOCUMENTAZIONE CARDIOLOGICA**




| INDICATORE | VALORE STANDARD | RESPONSABILE |
|---|---|---|
| Documentazione correttamente distribuita | 100% | Responsabili UU.OO |
| Disponibilità della documentazione nei luoghi ove la documentazione stessa deve essere applicata. | 100% | Coordinatore UU.OO |
| Tempi di esecuzione della prima visita cardiologica < 1 settimana | 80% delle richieste | Cardiologo |
| Tempi di esecuzione di ecocardiogramma basale <1 settimana | 80% delle richieste | Cardiologo |
| Esecuzione combinata di visita cardiologica ed ecocardiogramma | 80% delle richieste | Cardiologo |
| Esecuzione di visita cardiologica per sospetta tossicità e/o complicanze entro 24 -48 ore | 80% delle richieste | Cardiologo |
| Esecuzione di ecocardiogramma a fine CT con antracicline ad alte dosi, a 6 mesi, 1 anno | 90% dei pazienti | Cardiologo |

| Attività / Operatore | Medico cardiologia | Medico oncologia | Infermiere cardiologia | Infermiere oncologia | Medico cardiologia interventista |
|---|---|---|---|---|---|
| Compilazione modulistica per ambulatorio di cardiologia | I | **R** | I | C | |
| Invio modulistica per ambulatorio di cardiologia | I | I | C | **R** | |
| Comunicazione data appuntamenti | I | I | **R** | C | |
| Valutazione pazienti a rischio | **R** | C | I | I | I |
| Valutazione collegiale pazienti ad alto rischio | **R *** | **R *** | I | I | **R *** |
| Valutazione tempistica appuntamenti di ritorno | **R** | C | I | I | |
| Valutazione tempistica appuntamenti di richieste urgenti | C | I | **R** | I | |
| Esame clinico | **R** | I | C | I | |
| Prescrizione terapia cardiologica | **R** | C | I | I | |
| Esecuzione test da sforzo | **R** | I | C | I | I |
| Lettura test da sforzo | **R** | I | C | I | I |
| Esecuzione ECG | C | I | **R** | | |
| Lettura ECG | **R** | I | I | I | |
| Coronarografia | C | I | I | I | **R** |
| Ecocardiografia | **R** | I | C | I | |
| Esecuzione Holter | C | I | **R** | I | |
| Lettura Holter | **R** | I | C | I | |

# RETE ITALIANA DEGLI AMBULATORI DI CARDIONCOLOGIA

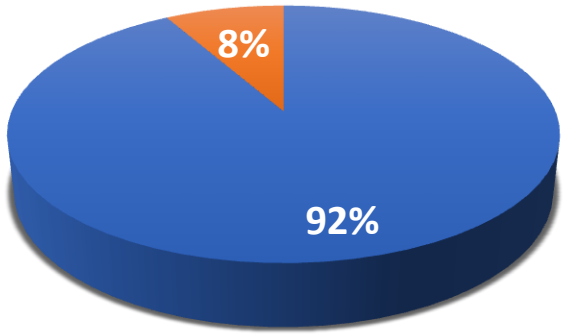
Questionario informativo
somministrato durante la raccolta
dati indirizzata a 612 Unità Operative di Cardiologia

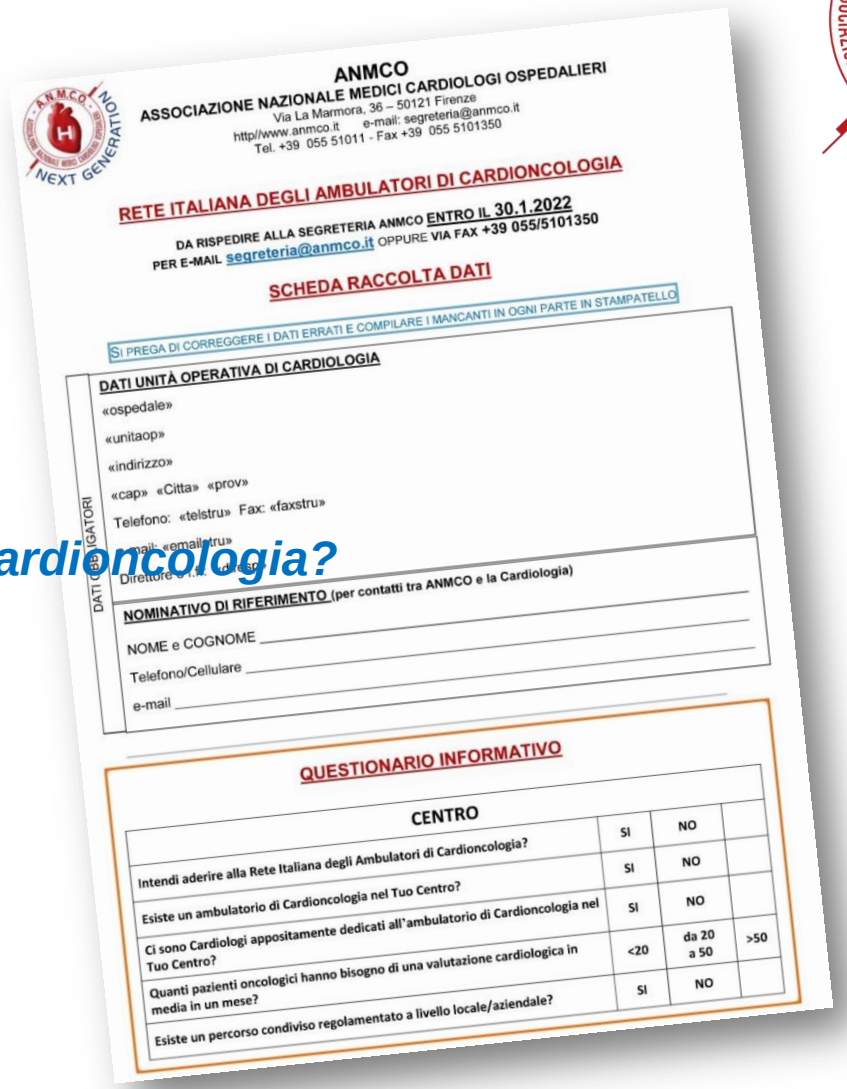
Al questionario informativo in merito
all'attività degli Ambulatori di Cardioncologia hanno risposto
145 centri

***Intendi aderire alla Rete Italiana degli Ambulatori di Cardioncologia?***

→ **Sì = 133**

→ **No = 12**



ANMCO
ASSOCIAZIONE NAZIONALE MEDICI CARDIOLOGI OSPEDALIERI
Via La Marmora, 36 – 50121 Firenze
http//www.anmco.it e-mail: segreteria@anmco.it
Tel. +39 055 51011 - Fax +39 055 5101350

RETE ITALIANA DEGLI AMBULATORI DI CARDIONCOLOGIA

DA RISPEDIRE ALLA SEGRETERIA ANMCO ENTRO IL 30.1.2022
PER E-MAIL segreteria@anmco.it OPPURE VIA FAX +39 055/5101350

SCHEDA RACCOLTA DATI

SI PREGA DI CORREGGERE I DATI ERRATI E COMPILARE I MANCANTI IN OGNI PARTE IN STAMPATELLO

DATI UNITÀ OPERATIVA DI CARDIOLOGIA

«ospedale»
«unitaop»
«indirizzo»
«cap» «Citta» «prov»
Telefono: «telstru» Fax: «faxstru»
e-mail: «emailstru»
Direttore U.O.: «nome»

DATI OBBLIGATORI

NOMINATIVO DI RIFERIMENTO (per contatti tra ANMCO e la Cardiologia)

NOME e COGNOME _____
Telefono/Cellulare _____
e-mail _____

QUESTIONARIO INFORMATIVO

| CENTRO | | | |
|---|---|---|---|
| Intendi aderire alla Rete Italiana degli Ambulatori di Cardioncologia? | SI | NO | |
| Esiste un ambulatorio di Cardioncologia nel Tuo Centro? | SI | NO | |
| Ci sono Cardiologi appositamente dedicati all'ambulatorio di Cardioncologia nel Tuo Centro? | SI | NO | |
| Quanti pazienti oncologici hanno bisogno di una valutazione cardiologica in media in un mese? | <20 | da 20 a 50 | >50 |
| Esiste un percorso condiviso regolamentato a livello locale/aziendale? | SI | NO | |

# Questionario informativo per gli ambulatori di Cardioncologia

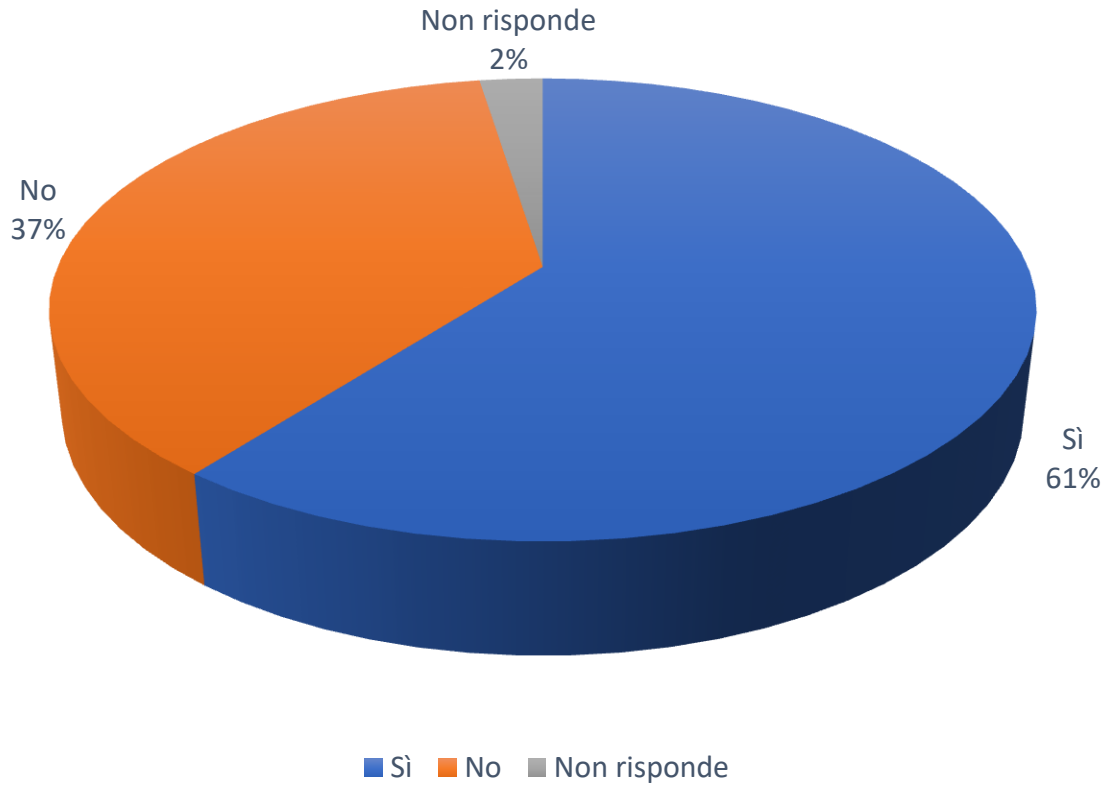
## Esiste un percorso condiviso regolamentato a livello locale/aziendale?

Risultato in base agli 81 centri che hanno un ambulatorio di Cardioncologia:

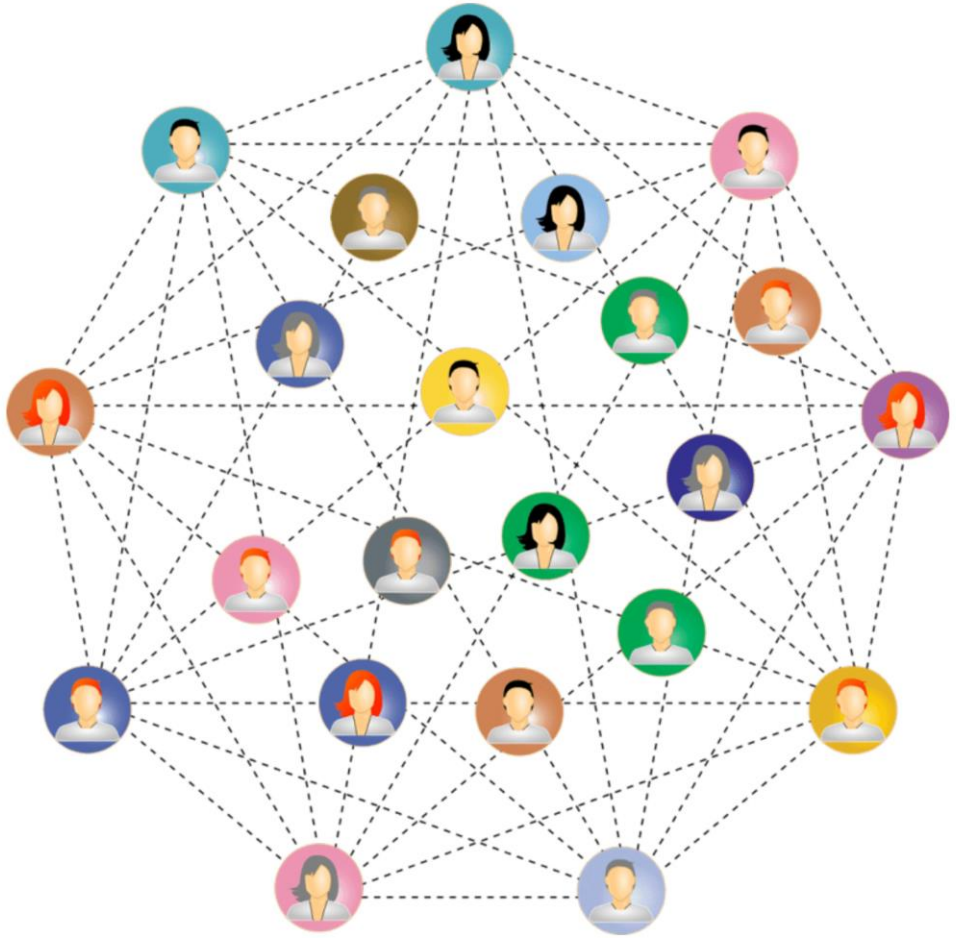
→ Sì 49

→ No 30

→ Non risponde 2



# La CardiOncologia va in RETE


***La creatività è mettere in connessione le cose***

***Steve Jobs***