Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2021

Les vendredis de réanimation
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Introduction

Intensive Care Med (2021) 47:1181–1247
https://doi.org/10.1007/s00134-021-06506-y

GUIDELINES

Surviving sepsis campaign: international guidelines for management of sepsis and septic shock 2021

-This article is being simultaneously published in *Critical Care Medicine* (DOI: https://doi.org/10.1097/CCM.0000000000005337) and *Intensive Care Medicine* (DOI: https://doi.org/10.1007/s00134-021-06506-y).

Recommendations from these guidelines cannot replace
the clinician's decision-making capability when presented with a unique patient's clinical variables.

Introduction

Classification des recommandations et niveau de preuves

Classe I	Classe IIa	Classe IIb	Classe III
Bénéfice >>> Risque	Bénéfice > Risque des études complémentaires sont nécessaires	Bénéfice ≥ Risque des études complémentaires sont requises; des registres sont requis	Risque ≥ Bénéfice Pas d'études requises

Niveaux de preuve

Niveau d'évidence A : Données issues de plusieurs études randomisées ou de méta analyses avec de larges populations étudiées.

Niveau d'évidence B : Données provenant d'une seule étude randomisée ou d'études non randomisées avec des populations étudiées limitées.

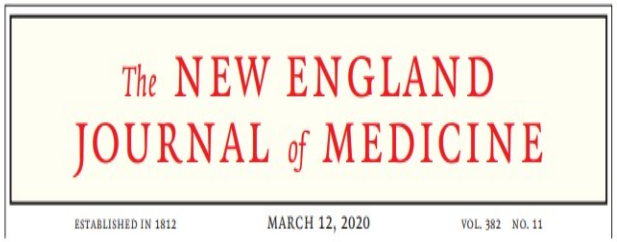
Niveau d'évidence C : Consensus d'experts d'opinion, cas cliniques avec populations étudiées très limitées.

La ventilation

Oxygen targets

Recommendation
46. There is **insufficient evidence to make a recommendation** on the use of conservative oxygen targets in adults with sepsis-induced hypoxemic respiratory failure

Liberal or Conservative Oxygen Therapy for Acute Respiratory Distress Syndrome



Conservative Oxygen Therapy during Mechanical Ventilation in the ICU

The ICU-ROX Investigators and the Australian and New Zealand Intensive Care Society Clinical Trials Group*

THE LANCET

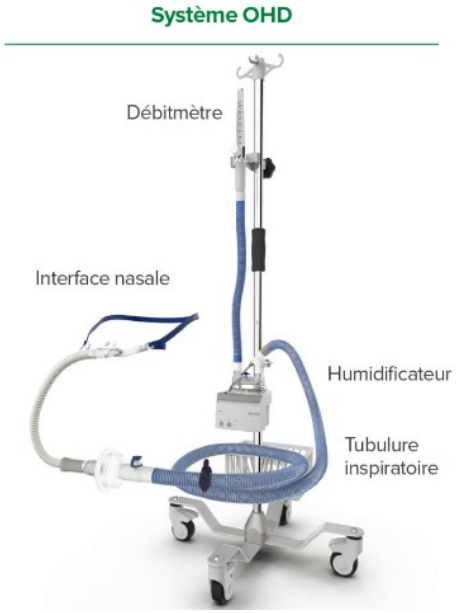
-PaO2 55-70 mmHg ; SpO2 88-92% et de la thérapie chez les patients atteints de sepsis sont limitées, avec trois essais randomisés chez les patients ayant un sepsis en réanimation.
-Dans l'essai ICU-ROX (1 000 participants) , l'oxygénothérapie conservatrice n'a pas eu d'effet significatif sur le résultat principal, à savoir le nombre de jours sans ventilation invasive.
-La mortalité à 90 et 180 jours n'était pas différente.
-L'étude LOCO-2 (stratégie conservatrice) : aucune différence dans la survie à 28 jours.
À l'heure actuelle, les preuves sont insuffisantes pour formuler une recommandation fondée sur des données solides.

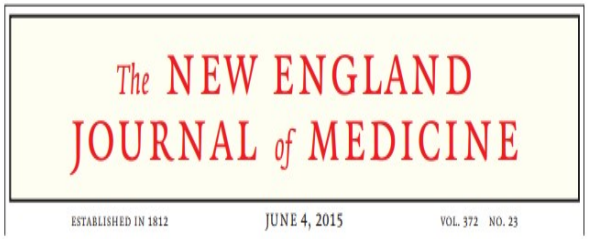
La ventilation

Recommendation

47. For adults with sepsis-induced hypoxemic respiratory failure, we **suggest** the use of high flow nasal oxygen over non-invasive ventilation

Weak recommendation, low quality of evidence





High-Flow Oxygen through Nasal Cannula in Acute Hypoxemic Respiratory Failure

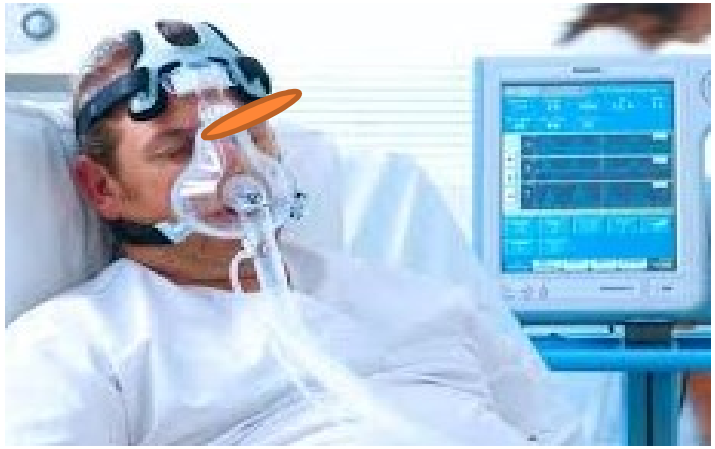
Jean-Pierre Frat, M.D., Arnaud W. Thille, M.D., Ph.D., Alain Mercat, M.D., Ph.D., Christophe Girault, M.D., Ph.D., Stéphanie Ragot, Pharm.D., Ph.D., Sébastien Perbet, M.D., Gwénael Prat, M.D., Thierry Boulain, M.D., Elise Morawiec, M.D., Alice Cottereau, M.D., Jérôme Devaquet, M.D., Saad Nseir, M.D., Ph.D., Keyvan Razazi, M.D., Jean-Paul Mira, M.D., Ph.D., Laurent Argaud, M.D., Ph.D., Jean-Charles Chakarian, M.D., Jean-Damien Ricard, M.D., Ph.D., Xavier Wittebole, M.D., Stéphanie Chevalier, M.D., Alexandre Herbland, M.D., Muriel Fartoukh, M.D., Ph.D., Jean-Michel Constantin, M.D., Ph.D., Jean-Marie Tonnelier, M.D., Marc Pierrot, M.D., Armelle Mathonnet, M.D., Gaëtan Béduneau, M.D., Céline Delétage-Métreau, Ph.D., Jean-Christophe M. Richard, M.D., Ph.D., Laurent Brochard, M.D., and René Robert, M.D., Ph.D., for the FLORALI Study Group and the REVA Network*

- -SDRA : origine pulmonaire ou extra-pulmonaire
- -la ventilation non invasive (VNI) ou l'oxygène à haut débit(HFNC)
- -60 L par minute pour atteindre des fractions d'oxygène inspiré (FiO2) de 95 à 100 %.
- Une revue systématique et une méta-analyse de neuf ont montré que l'HFNC réduit l'intubation par rapport à l'oxygène conventionnel (RR 0,85 ; IC 95 % 0,74-0,99) mais n'affecte pas le risque de décès ou la durée de séjour en USI .
- Bien que la qualité des preuves soit faible, les avantages de HFNC pour le patient en sepsis présentant une hypoxiemie non hypercapnique semblent être justifiés.

La ventilation

Non-invasive ventilation

Recommendation
48. There is **insufficient evidence to make a recommendation** on the use of non-invasive ventilation in comparison to invasive ventilation for adults with sepsis-induced hypoxemic respiratory failure



Intensive Care Med (2016) 42:82–92
DOI 10.1007/s00134-015-4087-4

ORIGINAL

Alexandre Demoule
Sylvie Chevret
Annalisa Carlucci
Achille Kouatchet
Samir Jaber
Ferhat Meziani
Matthieu Schmidt

Changing use of noninvasive ventilation in critically ill patients: trends over 15 years in francophone countries

- Risque : Retarder l'intubation
- Les études publiés sont critiqués en terme de nombre de patients inclus et la methodologie,aucune recommandation claire ne peut être faite. Si la VNI est utilisée chez des patients présentant une insuffisance respiratoire hypoxique associée à un sepsis, nous suggérons de surveiller une réduction précoce du travail respiratoire et de contrôler étroitement les volumes courants .

La ventilation

Protective ventilation in acute respiratory distress syndrome (ARDS)

Recommendation
49. For adults with sepsis-induced ARDS, we **recommend** using a low tidal volume ventilation strategy (6 mL/kg), over a high tidal volume strategy (> 10 mL/kg)
Strong recommendation, high quality of evidence

Recommendation
50. For adults with sepsis-induced severe ARDS, we **recommend** using an upper limit goal for plateau pressures of 30 cm H_2O, over higher plateau pressures
Strong recommendation, moderate quality of evidence

ESICM TRIALS GROUP

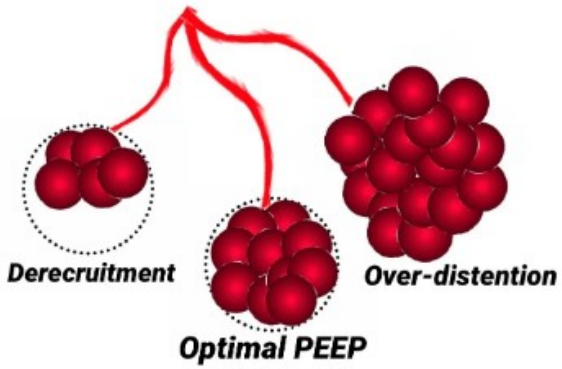
LUNG SAFE: Large observational study to UNderstand the Global impact of Severe Acute respiratory FailurE

LUNG SAFE (Large observational study to UNderstand the Global impact of Severe Acute respiratory FailurE) is a multicentre, prospective, observational, 4-week inception cohort study, which has been carried out by the Acute Respiratory Failure section through the ESICM Trials Group. The study aimed to prospectively assess the burden of, management and therapeutic approaches to, and outcomes from acute hypoxaemic respiratory failure requiring ventilatory support, with a specific focus on ARDS as defined by the Berlin Definition.

La ventilation

Recommendation

51. For adults with moderate to severe sepsis-induced ARDS, we **suggest** using higher PEEP over lower PEEP
Weak recommendation, moderate quality of evidence



- La recommandation est inchangée par rapport à 2016.
- 3 méthodes :

  - en fonction des mesures de la compliance thoracopulmonaire , dans le but d'obtenir la meilleure compliance ou la pression motrice la plus faible, un équilibre entre le recrutement pulmonaire et la surdistension.

  - augmenter la PEP pendant que le patient reçoit un volume courant de 6 mL/kg, jusqu'à ce que la pression des voies aériennes en plateau soit de 28 cm H2O

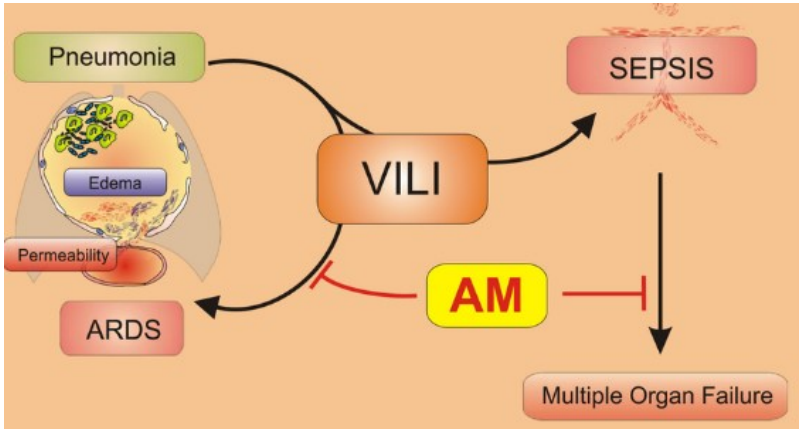
  -Tableau de titration PEEP/FiO2.

- La titration de la PEEP guidée par la pression œsophagienne a été évaluée dans deux essais.

La ventilation

Low tidal volume in non-ARDS respiratory failure

Recommendation
52. For adults with sepsis-induced respiratory failure (without ARDS), we **suggest** using low tidal volume as compared to high tidal volume ventilation
Weak recommendation, low quality of evidence

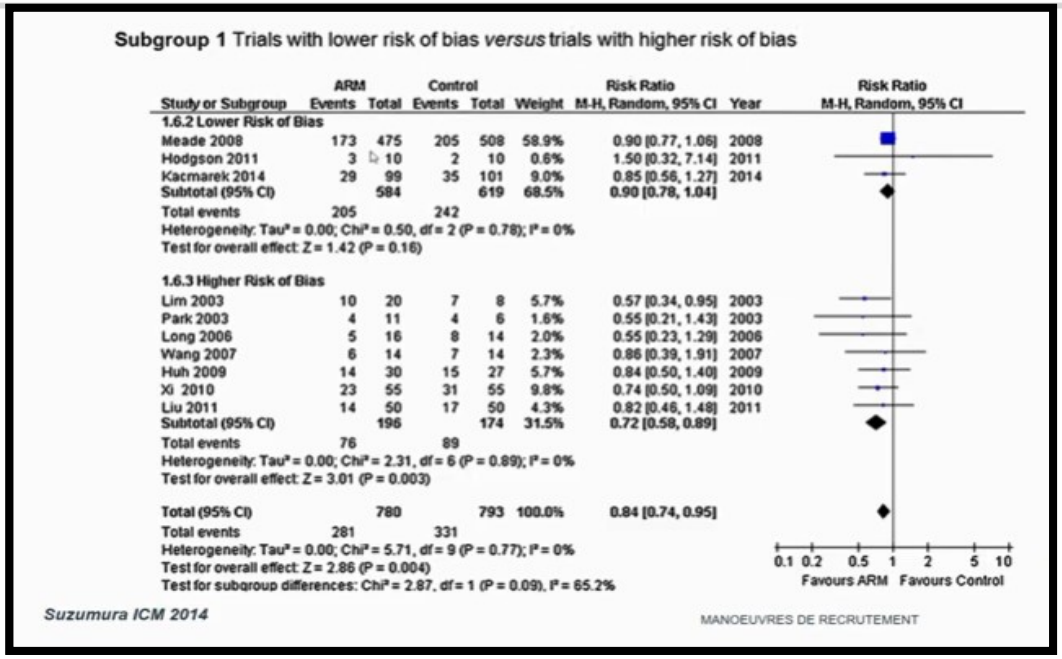


- Nous suggérons donc que la ventilation à faible volume courant soit utilisée chez tous les patients atteints de sepsis .
- L'utilisation de la ventilation à faible volume courant évite le risque de favoriser les lésions pulmonaires induites par la ventilation chez les patients septiques chez qui le diagnostic de SDRA a été manqué.

La ventilation

Recruitment manoeuvres

Recommendations
53. For adults with sepsis-induced moderate-severe ARDS, we **suggest** using traditional recruitment maneuvers *Weak recommendation, moderate quality of evidence*
54. When using recruitment maneuvers, we **recommend against** using incremental PEEP titration/strategy *Strong recommendation, moderate quality of evidence*

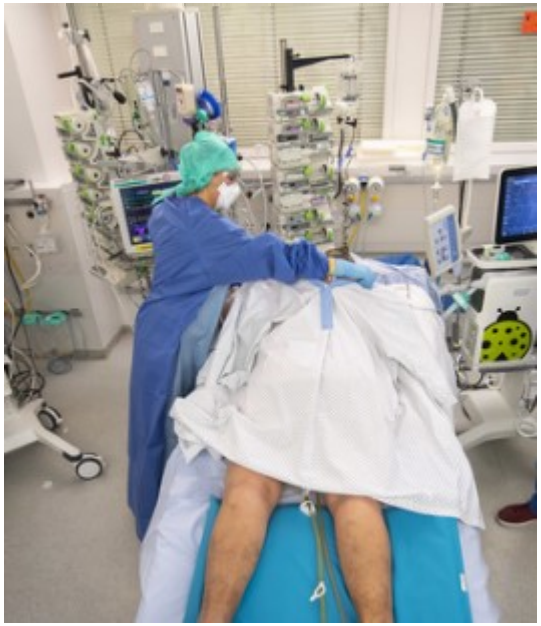


- L'augmentation temporaire de la pression transpulmonaire peut faciliter l'ouverture des alvéoles pour permettre l'échange gazeux ,mais pourrait également entraîner des lésions pulmonaires induites par la ventilation et une hypotension artérielle transitoire.
- Tout patient recevant des manœuvres de recrutement doit être surveillé de près et les manœuvres de recrutement doivent être interrompues si suspicion de complications .

La ventilation

Prone ventilation

Recommendation
55. For adults with sepsis-induced moderate-severe ARDS, we **recommend** using prone ventilation for more than 12 h daily
Strong recommendation, moderate quality of evidence



La ventilation

Neuromuscular blocking agents

Recommendation
56. For adults with sepsis induced moderate-severe ARDS, we **suggest** using intermittent NMBA boluses, over NMBA continuous infusion
Weak recommendation, moderate quality of evidence

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MAY 23, 2019 VOL. 380 NO. 21

Early Neuromuscular Blockade in the Acute Respiratory Distress Syndrome

The National Heart, Lung, and Blood Institute PETAL Clinical Trials Network*

- Compte tenu de l'incertitude des résultats concernants les avantages et les inconvénients des curares, le groupe d'experts a émis une faible recommandation en faveur des bolis intermittents de NMBA par rapport à une perfusion continue.

Extracorporel membrane oxygénation (ECMO)

Recommendation
57. For adults with sepsis-induced severe ARDS, we **suggest** using veno-venous (VV) ECMO when conventional mechanical ventilation fails in experienced centers with the infrastructure in place to support its use
Weak recommendation, low quality of evidence

Efficacy and economic assessment of conventional ventilatory support versus extracorporeal membrane oxygenation for severe adult respiratory failure (CESAR): a multicentre randomised controlled trial

Giles J. Peek, Miranda Mugford, Ravindranath Tiruvoipati, Andrew Wilson, Elizabeth Allen, Mariamma M. Thalanany, Clare L. Hibbert, Ann Truesdale, Felicity Clemens, Nicola Cooper, Richard K. Firmin, Diana Elbourne, for the CESAR trial collaboration

ventilation support. Methods: In this UK-based multicentre trial, we used an independent central randomisation service to randomly assign 180 adults in a 1:1 ratio to receive continued conventional management or referral to consideration for treatment by ECMO. Eligible patients were aged 18-65 years and had severe (Murray score >3·0 or pH <7·20) but potentially reversible respiratory failure. Exclusion criteria were: high pressure (>30 cm H_2O of peak inspiratory pressure) or high FiO_2 (>0·8) ventilation for more than 7 days; intracranial bleeding; any other contraindication to limited heparinisation; or any contraindication to continuation of active treatment. The primary outcome was death or severe disability at 6 months after randomisation or before discharge from hospital. Primary analysis was by intention to treat. Only researchers who did the 6-month follow-up were masked to treatment assignment. Data about resource use and economic outcomes (quality-adjusted

- Une revue systématique récente a trouvé que l'ECMO VV délivrée dans des centres experts réduisait la mortalité des patients atteints de SDRA sévère .
- un coût élevé

La ventilation

2021 VS 2016

Recommendations 2021	Recommendation Strength and Quality of Evidence	Changes From 2016 Recommendations
VENTILATION		
46. There is insufficient evidence to make a recommendation on the use of conservative oxygen targets in adults with sepsis-induced hypoxemic respiratory failure.	***No recommendation***	
47. For adults with sepsis-induced hypoxemic respiratory failure, we suggest the use of high flow nasal oxygen over noninvasive ventilation.	***Weak,*** *low quality of evidence*	***NEW***
48. There is insufficient evidence to make a recommendation on the use of noninvasive ventilation in comparison to invasive ventilation for adults with sepsis-induced hypoxemic respiratory failure.	***No recommendation***	
56. For adults with sepsis induced moderate-severe ARDS, we suggest using intermittent NMBA boluses, over NMBA continuous infusion.	***Weak,*** *moderate-quality evidence*	
57. For adults with sepsis-induced severe ARDS, we suggest using Veno-venous (VV) ECMO when conventional mechanical ventilation fails in experienced centers with the infrastructure in place to support its use.	***Weak,*** *low quality of evidence*	***NEW***

Traitements adjuvants

Corticosteroids

Recommendation
58. For adults with septic shock and an ongoing requirement for vasopressor therapy we **suggest** using IV corticosteroids *Weak recommendation; moderate quality of evidence*
Remark The typical corticosteroid used in adults with septic shock is IV hydrocortisone at a dose of 200 mg/day given as 50 mg intravenously every 6 h or as a continuous infusion. It is suggested that this is commenced at a dose of norepinephrine or epinephrine ≥ 0.25 mcg/kg/min at least 4 h after initiation

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 1, 2018 VOL. 378 NO. 9

Adjunctive Glucocorticoid Therapy in Patients with Septic Shock

B. Venkatesh, S. Finfer, J. Cohen, D. Rajbhandari, Y. Arabi, R. Bellomo, L. Billot, M. Correa, P. Glass, M. Harward, C. Joyce, Q. Li, C. McArthur, A. Perner, A. Rhodes, K. Thompson, S. Webb, and J. Myburgh, for the ADRENAL Trial Investigators and the Australian–New Zealand Intensive Care Society Clinical Trials Group*

- Nous avons défini le besoin continu comme une dose de norépinéphrine ou d'épinéphrine ≥ 0,25 mcg/kg/min pendant au moins 4 heures après l'initiation pour maintenir la PAM cible. La dose d'hydrocortisone est généralement de 200 mg/jour.

Traitements adjuvants

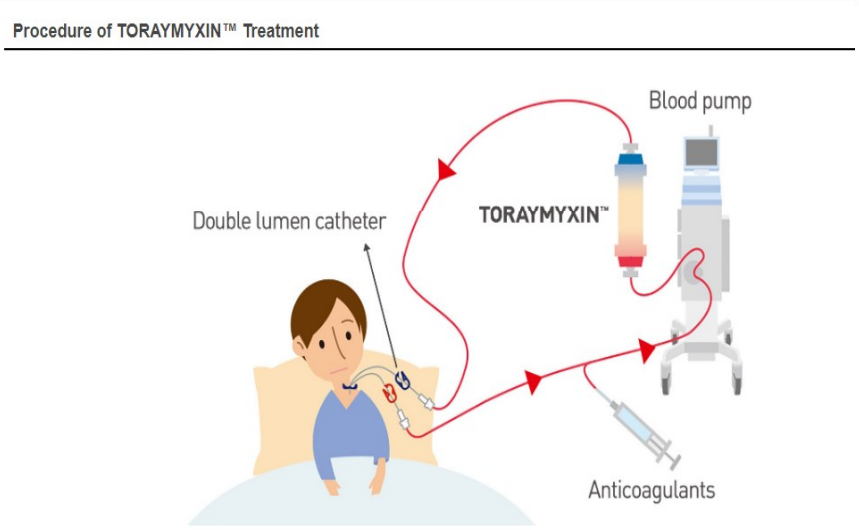
2021 VS 2016

Recommendations 2021	Recommendation Strength and Quality of Evidence	Changes From 2016 Recommendations
ADDITIONAL THERAPIES		
58. For adults with septic shock and an ongoing requirement for vasopressor therapy we suggest using IV corticosteroids.	***Weak,*** *moderate-quality evidence*	**UPGRADE from *Weak recommendation,*** *low quality of evidence* "We suggest against using IV hydrocortisone to treat septic shock patients if adequate fluid resuscitation and vasopressor therapy are able to restore hemodynamic stability (see goals for Initial Resuscitation). If this is not achievable, we suggest IV hydrocortisone at a dose of 200 mg/day."

Traitements adjuvants

Blood Purification

Recommendations
59. For adults with sepsis or septic shock, we **suggest against** using polymyxin B haemoperfusion *Weak recommendation; low quality of evidence*
60. There is **insufficient evidence to make a recommendation** on the use of other blood purification techniques



The JAMA Network

Effect of Targeted Polymyxin B Hemoperfusion on 28-Day Mortality in Patients With Septic Shock and Elevated Endotoxin Level

The EUPHRATES Randomized Clinical Trial

- La polymyxine-B est un antibiotique dont les néphro- et neurotoxicités empêchent l'utilisation par voie systémique.
- La production d'endotoxine par les bactéries Gram négatif est le starter de la réaction inflammatoire du sepsis.
- La possibilité de neutraliser l'ET peut permettre d'améliorer le pronostic du choc septique.
- La polymyxine-B a été intégrée sur des composés polymériques de membranes artificielles pouvant être utilisées en hémoperfusion.
- In vivo ,les membranes recouvertes de polymyxine-B pouvaient permettre de réduire les taux circulants d'ET.
- Plusieurs études cliniques chez l'homme ont été réalisées au cours du sepsis sévère et du choc septique montrant une amélioration de l'état hémodynamique, des conditions d'oxygénation des patients, voire même de la mortalité..

Traitements adjuvants

Red blood cell (RBC) transfusion targets

Recommendation
61. For adults with sepsis or septic shock, we **recommend** using a restrictive (over liberal) transfusion strategy *Strong recommendation; moderate quality of evidence*
Remark A restrictive transfusion strategy typically includes a haemoglobin concentration transfusion trigger of 70 g/L; however, RBC transfusion should not be guided by haemoglobin concentration alone. Assessment of a patient's overall clinical status and consideration of extenuating circumstances such as acute myocardial ischaemia, severe hypoxemia or acute haemorrhage is required

International Journal of *Molecular Sciences*

MDPI

Review

Transfusion of Red Blood Cells to Patients with Sepsis

Yi-Ling Chan [1], Shih-Tsung Han [1], Chih-Huang Li [1], Chin-Chieh Wu [2] and Kuan-Fu Chen [1,2,3,4,*]

1 Department of Emergency Medicine, Chang Gung Memorial Hospital Linkou, Taoyuan 330, Taiwan; ylchan@cgmh.org.tw (Y.-L.C.); adrianhst@gmail.com (S.-T.H.); chhli2002@gmail.com (C.-H.L.)
2 Department of Emergency Medicine, Chang Gung Memorial Hospital Keelung, Keelung 204, Taiwan; wujinja@cgmh.org.tw
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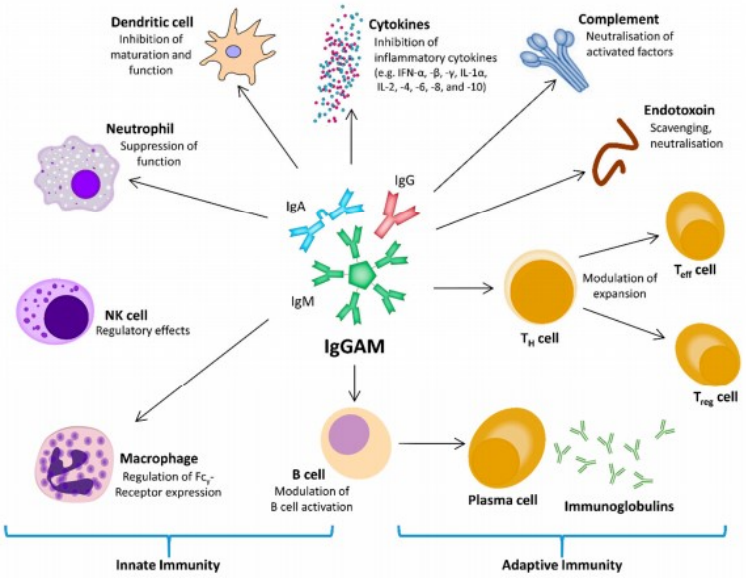
4 Community Medicine Research Center, Chang Gung Memorial Hospital Keelung, Keelung 204, Taiwan
* Correspondence: kfchen@cgmh.org.tw; Tel.: +886-975-360-714

- La recommandation forte de 2016 en faveur d'une stratégie restrictive reste inchangée ; cependant, la qualité globale des preuves est passée de forte à modérée.

Traitements adjuvants

Immunoglobulins

Recommendation
62. For adults with sepsis or septic shock, we **suggest against** using intravenous immunoglobulins
Weak recommendation, low quality of evidence



- Son coût limite également sa faisabilité dans les pays à revenu faible ou intermédiaire.
- Sur la base de ces jugements, les cliniciens peuvent envisager d'éviter l'utilisation systématique des immunoglobulines intraveineuses chez les patients atteints de sepsis et de choc septique.

Traitement adjuvant

Stress ulcer prophylaxis

Recommendation
63. For adults with sepsis or septic shock, and who have risk factors for gastrointestinal (GI) bleeding, we **suggest** using stress ulcer prophylaxis
Weak recommendation, moderate quality of evidence

Venous thromboembolism (VTE) prophylaxis

Recommendations
64. For adults with sepsis or septic shock, we **recommend** using pharmacologic VTE prophylaxis unless a contraindication to such therapy exists *Strong recommendation, moderate quality of evidence*
65. For adults with sepsis or septic shock, we **recommend** using low molecular weight heparin (LMWH) over unfractionated heparin (UFH) for VTE prophylaxis *Strong recommendation, moderate quality of evidence*
66. For adults with sepsis or septic shock, we **suggest against** using mechanical VTE prophylaxis in addition to pharmacological prophylaxis, over pharmacologic prophylaxis alone *Weak recommendation, low quality of evidence*

Traitement adjuvant

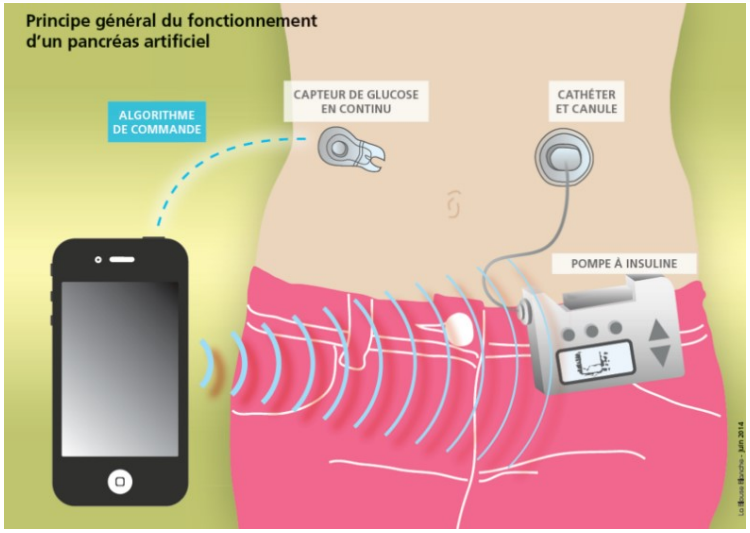
Renal replacement therapy

Recommendations
67. In adults with sepsis or septic shock and AKI who require renal replacement therapy, we **suggest** using either continuous or intermittent renal replacement therapy *Weak recommendation, low quality of evidence*
68. In adults with sepsis or septic shock and AKI, with no definitive indications for renal replacement therapy, we **suggest against** using renal replacement therapy *Weak recommendation, moderate quality of evidence*

Traitement adjuvant

Glucose control

Recommendation
69. For adults with sepsis or septic shock, we **recommend** initiating insulin therapy at a glucose level of ≥ 180 mg/dL (10 mmol/L) *Strong recommendation; moderate quality of evidence*
Remark Following initiation of an insulin therapy, a typical target blood glucose range is 144–180 mg/dL (8–10 mmol/L)



- La gestion électronique du glucose, la surveillance continue du glucose et les systèmes en boucle fermée, peuvent permettre d'obtenir de manière plus sûre un meilleur contrôle glycémique et des taux plus faibles d'hypoglycémie.

Traitement adjuvant

Vitamin C

Recommendation
70. For adults with sepsis or septic shock, we **suggest against** using IV vitamin C
Weak recommendation, low quality of evidence

Bicarbonate therapy

Recommendations
71. For adults with septic shock and hypoperfusion-induced lactic acidemia, we **suggest against** using sodium bicarbonate therapy to improve haemodynamics or to reduce vasopressor requirements *Weak recommendation, low quality of evidence*
72. For adults with septic shock, severe metabolic acidemia (pH ≤ 7.2) and AKI (AKIN score 2 or 3), we **suggest** using sodium bicarbonate therapy *Weak recommendation, low quality of evidence*

Sodium bicarbonate therapy for patients with severe metabolic acidaemia in the intensive care unit (BICAR-ICU): a multicentre, open-label, randomised controlled, phase 3 trial

*Samir Jaber, Catherine Paugam, Emmanuel Futier, Jean-Yves Lefrant, Sigismond Lasocki, Thomas Lescot, Julien Pottecher, Alexandre Demoule, Martine Ferrandière, Karim Asehnoune, Jean Dellamonica, Lionel Velly, Paër-Sélim Abback, Audrey de Jong, Vincent Brunot, Fouad Belafia, Antoine Roquilly, Gérald Chanques, Laurent Muller, Jean-Michel Constantin, Helena Bertet, Kada Klouche, Nicolas Molinari, Boris Jung, for the BICAR-ICU Study Group**

Traitement adjuvant

Nutrition

Recommendation
73. For adult patients with sepsis or septic shock who can be fed enterally, we **suggest** early (within 72 h) initiation of enteral nutrition
Weak recommendation; very low quality of evidence

Editorial

NUTRIREA-2 trial finds that early enteral nutrition and early parenteral nutrition do not differ with regards to major clinical outcomes

Feng Tian[1,2], Gordon S. Doig[1]

[1]Intensive Care Research Unit, Northern Clinical School, Royal North Shore Hospital, University of Sydney, Australia; [2]Research Institute of General Surgery, Jinling Hospital, Medical School of Nanjing University, Nanjing 210093, China

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Provenance: This is an invited Editorial commissioned by Section Editor Dr. Ming Zhong (Department of Critical Care Medicine, Zhongshan Hospital Fudan University, Shanghai, China).

Comment on: Reignier J, Boisramé-Helms J, Brisard L, *et al.* Enteral versus parenteral early nutrition in ventilated adults with shock: a randomised, controlled, multicentre, open-label, parallel-group study (NUTRIREA-2). Lancet 2018;391:133-43.

- -Dans les 72 heures suivant l'admission aux soins intensifs. Le comparateur était la nutrition entérale commencée après 72 heures.
- 44 unités de soins intensifs françaises a randomisé 2 410 patients sous ventilation mécanique invasive en état de choc entre une nutrition entérale précoce et une nutrition parentérale précoce.

Objectifs du traitement

Goals of care

Recommendations
74. For adults with sepsis or septic shock, we **recommend** discussing goals of care and prognosis with patients and families over no such discussion *Best Practice Statement*
75. For adults with sepsis or septic shock, we **suggest** addressing goals of care early (within 72 h) over late [72] *Weak recommendation, low-quality evidence*
76. There is **insufficient evidence to make a recommendation** for any specific standardised criterion to trigger goals of care discussion

Recommendations
77. For adults with sepsis or septic shock, we **recommend** integrating principles of palliative care (which may include palliative care consultation based on clinician judgement) into the treatment plan, when appropriate, to address patient and family symptoms and suffering *Best Practice Statement*
78. For adults with sepsis or septic shock, we **suggest against** routine formal palliative care consultation for all patients over palliative care consultation based on clinician judgement *Weak recommendation, low-quality evidence*

Le post sepsis

Peer support groups

Recommendation
79. For adult survivors of sepsis or septic shock and their families, we **suggest** referral to peer support groups over no such referral
Weak recommendation, very low quality of evidence

Transitions of care

Recommendations
80. For adults with sepsis or septic shock, we **suggest** using a handoff process of critically important information at transitions of care, over no such handoff process *Weak recommendation, very low-quality evidence*
81. There is **insufficient evidence to make a recommendation** for the use of any specific structured handoff tool over usual handoff processes

Le post sepsis

Screening for economic or social support

Recommendation
82. For adults with sepsis or septic shock and their families, we **recommend** screening for economic and social support (including housing, nutritional, financial, and spiritual support), and make referrals where available to meet these needs
Best Practice Statement

Sepsis education for patients and families

Recommendation
83. For adults with sepsis or septic shock and their families, we **suggest** offering written and verbal sepsis education (diagnosis, treatment, and post-ICU/post-sepsis syndrome) prior to hospital discharge and in the follow-up setting
Weak recommendation, very low-quality evidence

Le post sepsis

Shared decision making

Recommendation
84. For adults with sepsis or septic shock and their families, we **recommend** the clinical team provide the opportunity to participate in shared decision making in post-ICU and hospital discharge planning to ensure discharge plans are acceptable and feasible
Best Practice Statement

Post-discharge follow-up

Recommendations
91. For adult survivors of sepsis or septic shock, we **recommend** assessment and follow-up for physical, cognitive, and emotional problems after hospital discharge Best Practice Statement
92. For adult survivors of sepsis or septic shock, we **suggest** referral to a post-critical illness follow-up programme if available *Weak recommendation, very low-quality evidence*
93. For adult survivors of sepsis or septic shock receiving mechanical ventilation for > 48 h or an ICU stay of > 72 h, we **suggest** referral to a post-hospital rehabilitation programme *Weak recommendation, very low-quality evidence*

Le post sepsis

Recommendations
88. For adults with sepsis or septic shock who developed new impairments, we **recommend** hospital discharge plans include follow-up with clinicians able to support and manage new and long-term sequelae *Best Practice Statement*
89. There is **insufficient evidence to make a recommendation** on early post-hospital discharge follow-up compared to routine post-hospital discharge follow-up

What matters most to sepsis survivors: a qualitative analysis to identify specific health-related quality of life domains

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Cognitive therapy

Recommendation
90. There is **insufficient evidence to make a recommendation** on early cognitive therapy for adult survivors of sepsis or septic shock

LES POINTS FORTS

- Questions sélectionnées suite à une évaluation internationale des pratiques et des incertitudes. PICO s'interroge sur les résultats à long terme
- Utilisation du cadre « Evidence to Decision » comme outil transparent et système structuré de formulation de recommandations
- Ventilation : OHD
- PICCO
- Le post spsis

CONCLUSIONS

« Survivre au sepsis » est possible …
à condition d'agir juste et à temps…

Merci