Giovedì 24 settembre 2015

Aula Blu 2 – 10.00-12.30

Patologia mammaria: l'Anatomia Patologica e le Breast Unit

MODERATORI: S. Bianchi (Firenze), A. Sapino (Torino)

Il documento ministeriale

L. Catalliotti

Paper not received

La formazione del Patologo "Esperto" in patologia mammaria:revisione delle normative europee

F. Pulcini

Paper not received

La discussione multidisciplinare: il ruolo del patologo

I. Castellano

Paper not received

Implicazioni medico legali alla condivisione del documento diindirizzo terapeutico nella discussione medico legale

G. Divella

Sezione di Medicina Legale, DSSPP, Università degli Studi di Torino

Medical liability has become increasingly important in the Italian legal system during the last four decades. This appears to be related to the growth of the National Health Care System (NHCS) and is characterized by a new generation of hospitals staffed by personnel with varied levels of competencies. The transition from the individual medical providers to the collective partnerships has complicated care delivery. The medical field has been impacted by the rapid expansion of jurisprudence in the realm of medical malpractice and increasing complexity of the justice system, and health care consumers are better informed about their legal rights. The relationship between the physician and the citizen has changed and patients have become more proactive, contacting the physician, the hospital, insurance providers or a lawyer when they believe that something went wrong during their treatment. Definitive statistical data are not available about the incidence of medical-legal cases, and little relevant data can be derived from informatics sources. Nevertheless the large number of pronounced judgments that are available about medical malpractice cases illustrates the transformation of the evidence-based medicine into the sentence-based medicine or jurisprudence-based medicine. This phenomenon has produced a negative effect on the budgets of the NHCS and the Regional Health Services, and has caused many insurance companies to withdraw from the medical liability market due to this climate of so-called defensive medicine. In the Italian legal system, physicians must demonstrate responsibility for the consequences resulting from unlawful conduct that may include care omissions or the violation of a specific standard. In order to satisfy the Penal responsibility, leaving aside the intentional offense, article 43 of the Penal Code disciplines the culpable crime that is distinguished as generic fault, (negligence by omission of the minimum qualified diligence required by practice of medicine; imprudence by absence of prevision of possible harmful consequences of interventions; inexperience by ignorance in the managing what another physician of the same professional level would properly do in the same case) and a specific fault due to the violation or non-application of specific rules ("regulations, orders and disciplines"). Moreover, the Italian Court of Cassation have defined (as "obiter dicta"), other rules that specify duties and behavior for all the health care providers. Among these, it is important to point out the so-called warranty obligation by which all professionals, involved in the treatment process (diagnostic and therapeutic), have to cooperate in safeguarding the patient's health at different levels of respective work. It means that the common goal is the protection of the patient from damages derived from a violation of leges artis, guidelines or official protocols that are concerning specific discipline or from mistakes that may be done inside of the synergy of different competencies (Cass. Pen. Sez. VI n. 9638, 2.3.2000). So, every professional must assure standards of diligence, prudence and experience with regard to their personal duty. At the same time, when the common scientific knowledge or one's own specific competency allow the professional to perceive a mistake arising from the actions of a colleague, especially when the mistake is predictable and avoidable (risk of mistake), he/she must do anything to correct the mistake or to remove the risk by which the patient may suffer a damage. This duty becomes particularly relevant in the sharing of the diagnostic and therapeutic decision-making processes. This also appears in similar wording within the Civil contest (Cass. Civ – Sez III - n.8826, 13.4.07). By Civil law, the physician and patient are united by a contractual relationship originating from a social contact and the assumption of liability is the existence of a compensable damage (L. 98/2013); the damage is a consequence of the failure and the damages recoverable are those expected at the time when the debt was incurred. In defining an error and mistake, it may include cognitive versus operational error, clinically significant versus academic error (differences in classification, grading, etc.), and prospective versus retrospective review. It is often related to the degree of the knowledge of the reviewer or of the consultant for the specific case. The error may occur in the diagnostic, prognostic or therapeutic phases. The diagnostic error means that the physician fails to reach a correct diagnosis of the disease that afflicts the patient (wrong collection of anamnestic data, misidentification or underestimation of a symptom, an objective examination performed in a wrong way, or an error in the execution or interpretation of imaging and/or laboratory studies). A diagnostic delay results in a delay of treatment. If the physician reaches a conclusion that is then proved to be unfounded and this affects further therapeutic interventions causing harm, the mistake is detectable

in the prognostic phase. A mistake in the therapeutic phase is when the physician makes a mistake either during the choice of the therapy or at the time of its execution. These mistakes frequently depend upon previous diagnostic mistakes and they can be distinguished either as a medical mistake or as a surgical therapy mistake. Many corrective factors and various methods may be cited in preventing medical mistakes or in the reducing the risk of its incidence. Improving communication with the patient and recording information in the medical records, along with assistance by risk managers may be of benefit to medical staff. The use of medical guidelines that conform to the best evidence-based medicine, or the use of clinical protocols or hospital checklists may improve quality and safety in the health care system (Zarbo RJ et al, 2005; Meier et al., 2008). However, these do not save the health professional from the risk of criminal or civil proceedings if the consequences of their application do not meet the best interests of the patient (Cass. Sez. IV pen., 23/11/10, dep. 2/3/11; L. 189/2012). A decision- making process with the patient, a so-called therapeutic alliance, plays the most important role in the prevention or reduction of failures in the relationships between the health care system and its consumers.

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Giovedì 24 settembre 2015

Aula Gialla 1 – 10.00-12.00

Dermatopatologia

MODERATORI: C. Clemente (Milano), M. Santucci (Firenze)

Stato dell'arte delle patologie bollose dermatologiche

R. Gianotti

Paper not received

Linfomi cutanei: cosa c'è di nuovo?

M. Santucci

Paper not received

I sarcomi della cute

A. Parafioriti, E. Armiraglio, A. Di Bernardo

Anatomia Patologica, Azienda Ospedaliera Istituto Ortopedico Gaetano Pini, Milano

Mesenchymal tumors of the skin represent a wide and heterogeneous group of lesions, including newly described entities, that poses a diagnostic challenge given their rarity, in comparison to epithelial and melanocytic tumors, and the dermatopathololologist reluctance to deal with them. Primary cutaneous sarcomas are relatively rare in comparison to carcinomas and superficial benign mesenchymal tumors of soft tissue such as lipoma, fibrous hystiocytoma, vascular and smooth muscle neoplasms, including angioleiomyoma, and peripheral nerve sheath tumors. The aetiology of sarcomas is still widely unknown with the exception of the small number of tumors occurring in the context of hereditary cancer syndromes associated with well-known genetic mutations and specific molecular pathways alterations. There are also cutaneous virus-driven sarcomas such as Kaposi's Sarcoma associated with Human Herpes Virus 8 (HHV8) infection and multiple leiomyosarcomas associated with Epstein-Barr Virus (EBV) wich usually develop in immunosuppressed patient and in predisposing conditions like chronic lymphoedema, radiation therapy etc.. Cutaneous sarcomas usually present as a palpable mass with or without ulceration. When a patient presents with a superficial/sovrafascial tumor of at least 5 cm of diameter or a deep/subfascial tumor of any size, that should give rise to the suspicion of malignancy, a proper multidisciplinary work-up in a soft-tissue tumor centre is recommended. Punch, shave and fine needle biopsy of superficial skin tumors must be avoided if the diameter is less than 5 cm. and, under those circumstancies, surgical excision would be the most advisable approach. Complete removal of the lesion and negative margins on histological examination are factors of primary importance in the prevention of local reccurrence. Late development of recurrence and metastasis, even several years after the excision of the primary tumor, are associated with some specific histotypes, e.g. classic epithelioid sarcoma. Every histotype of sarcoma, either of superficial or deep soft tissue, may be found in the skin as well in accordance with the concept that mesenchymal and neuroectodermal progenitor cells may give rise in the cutis to a wide range of tumors with different biological behaviour including locally aggressive le-