

4ª REUNIÃO
INTERNACIONAL
**GRUPO PORTUGUÊS
DE TRIAGEM**

.....
10 OUT. 2018
INFARMED \ LISBOA



Triagem Pediátrica após MTS III



4ª REUNIÃO INTERNACIONAL
GRUPO PORTUGUÊS DE TRIAGEM



MTS III as novidades num minuto



Novos fluxogramas

Criança com suspeita de maus tratos

Criança que não se sente bem



Indisposição no RN

$\leq 28d$

Indisposição no bebé

$\leq 12m$

Indisposição na criança

$> 12m$



4ª REUNIÃO INTERNACIONAL
GRUPO PORTUGUÊS DE TRIAGEM

Temperatura RN ($\leq 28d$)		
RN quente	$\geq 38,5^{\circ}\text{C}$	Laranja
RN subfebril /Febrícula	$37,5^{\circ}\text{C}-38,4^{\circ}\text{C}$	Amarelo
Temperatura Lactentes ($\leq 12m$)		
Bebé quente	$\geq 38,5^{\circ}\text{C}$	Laranja
Bebé subfebril /Febrícula	$37,5^{\circ}\text{C}-38,4^{\circ}\text{C}$	Verde
Temperatura Crianças $>12m$, adolescentes e adultos		
Muito quente	$\geq 41^{\circ}\text{C}$	Laranja
Quente	$38,5^{\circ}\text{C} - 40,9^{\circ}\text{C}$	Amarelo
Febrícula/ Subfebril	$37,5^{\circ}\text{C}-38,4^{\circ}\text{C}$	Verde

Temperatura timpânica



4ª REUNIÃO INTERNACIONAL
GRUPO PORTUGUÊS DE TRIAGEM

Temperatura RN ($\leq 28d$)		
RN quente	$\geq 39^{\circ}\text{C}$	Laranja
RN subfebril /Febrícula	$38^{\circ}\text{C}-38,9^{\circ}\text{C}$	Amarelo
Temperatura Lactentes ($\leq 12m$)		
Bebé quente	$\geq 39^{\circ}\text{C}$	Laranja
Bebé subfebril /Febrícula	$38^{\circ}\text{C}-38,9^{\circ}\text{C}$	Verde
Temperatura Crianças $>12m$, adolescentes e adultos		
Muito quente	$\geq 41,5^{\circ}\text{C}$	Laranja
Quente	$39^{\circ}\text{C} - 41,4^{\circ}\text{C}$	Amarelo
Febrícula/ Subfebril	$38^{\circ}\text{C}-38,9^{\circ}\text{C}$	Verde

Temperatura retal



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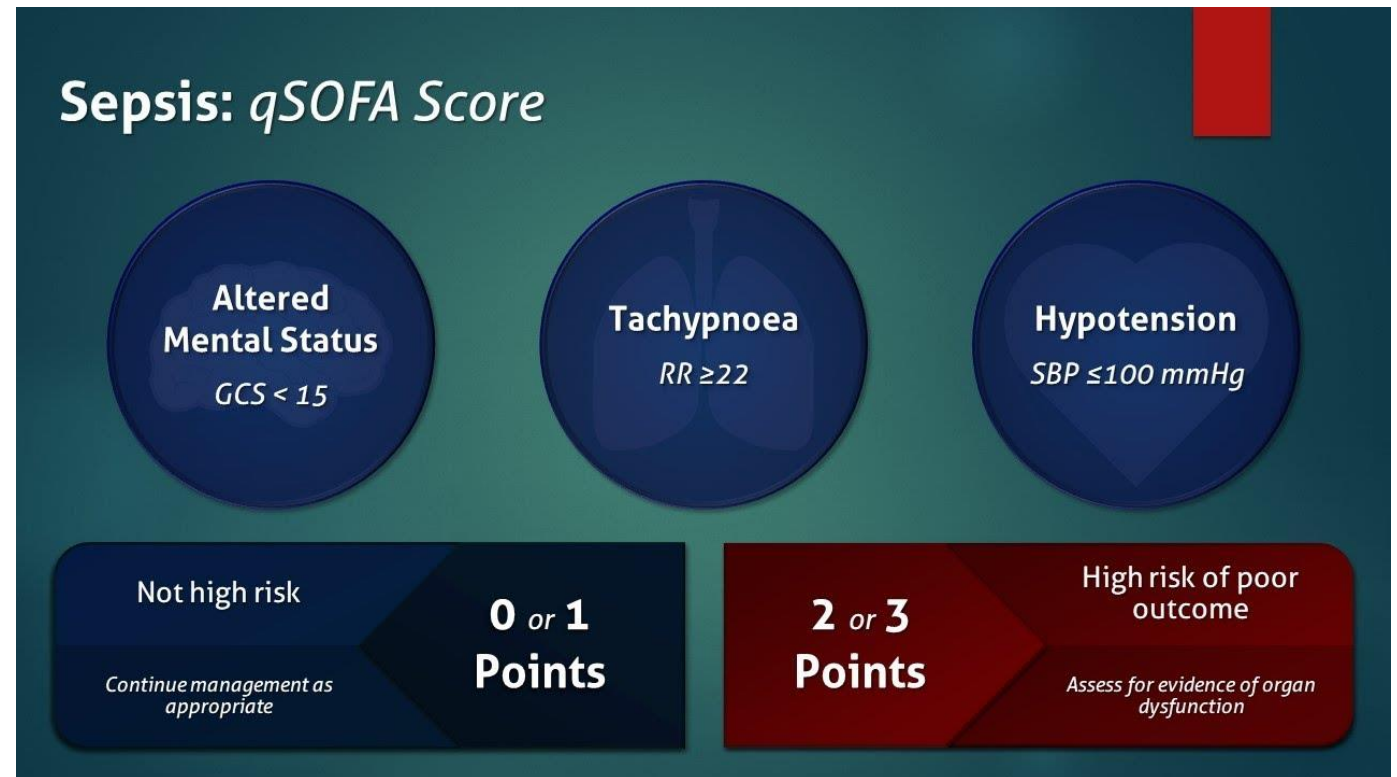
Idade	Peso (kg) P50		Frequência Respiratória	Frequência Cardíaca	TA Sistólica	
			Ciclos/min P6 - P95	Batimentos/min P6 - P95	P50 / Altura*	
					P6	P90
RN	3.3	3.2	25 - 50	120 - 170	65 - 75	80 - 90
1 m	4.5	4.2				
3 m	6.4	5.8	25 - 45	115 - 160		
6 m	7.9	7.3	20 - 40	110 - 160	70 - 75	85 - 95
12 m	9.6	8.9				
18 m	10.9	10.2	20 - 35	100 - 155	70 - 80	85 - 100
2 A	12.2	11.5	20 - 30	100 - 150		
3 A	14.3	13.9		90 - 140		
4 A	16.3	16.1		80 - 135		
5 A	18.3	18.2				

Parâmetros vitais



Novo discriminador

Possível Sepsis





FOLHA de CATÁSTROFE

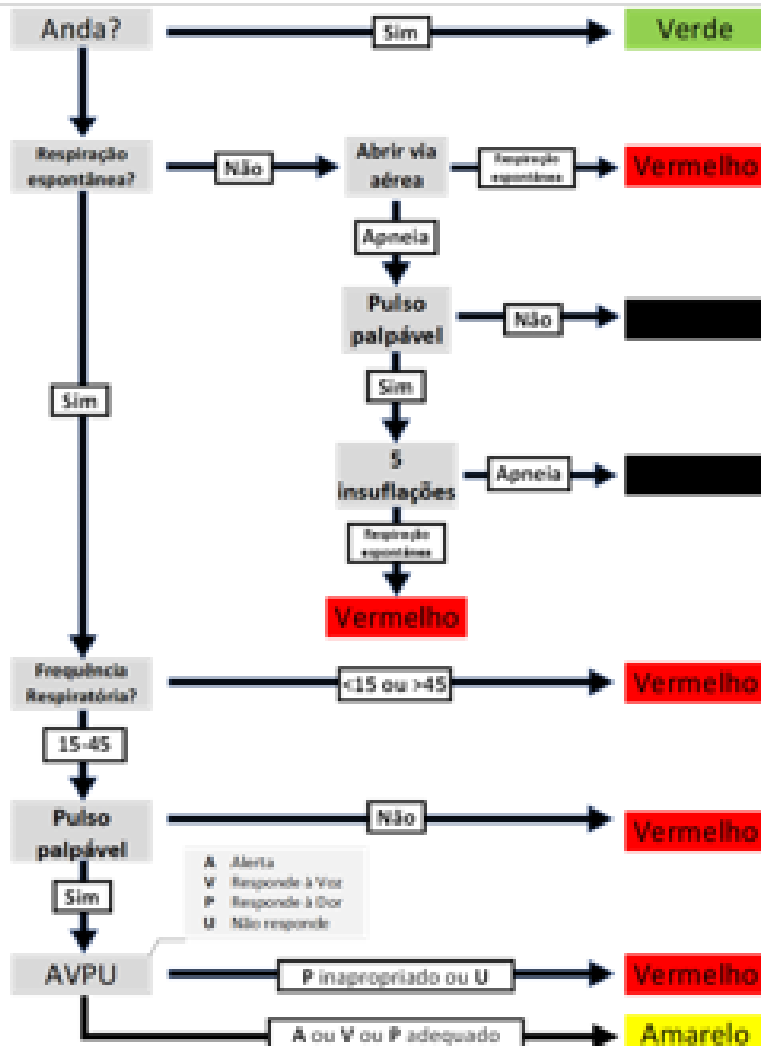
Caso nº _____

Data __/__/__ Hora ____:____

Hospital: _____

TRIAGEM PRIMÁRIA

≤ 7 anos
Aparenta ser criança



> 7 anos
Aparenta ser adolescente ou adulto



Observações:



FOLHA de CATÁSTROFE

Hospital:

Caso nº _____

Data __/__/__ Hora ____:____

TRIAGEM SECUNDÁRIA

Prioridades

TRTS	COR
10	Vermelho
11	Amarelo
12	Verde
0	Preto

Hora							
	TRTS	TRTS	TRTS	TRTS	TRTS	TRTS	TRTS
Freq. Resp.							
P.A. Sist.							
Glasgow							
	T	T	T	T	T	T	T
Cor							
Prioridade							
Nº Mec.							

	Escala Coma Glasgow modificada <2A	Escala Coma Glasgow	
Abertura dos olhos	Espontâneo	Espontâneo	4
	Voz	Voz	3
	Dor	Dor	2
	Sem resposta	Sem resposta	1
Resposta verbal	Balbucia, Sorri, Interação	Orientada	5
	Inadequada, Choro consolável	Confusa	4
	Choro/gritos, Pouco consolável	Inapropriada	3
	Gemido/agitação, Inconsolável	Imperceptível	2
	Sem resposta	Sem resposta	1
Resposta motora	Espontâneo	Ordem	6
	Localiza, Fuga ao toque	Localiza	5
	Fuga à dor	Fuga	4
	Flexão	Flexão	3
	Extensão	Extensão	2
	Sem resposta	Sem resposta	1

IDADE	<6m	6m-23m	2-7 A	8-11 A	≥12A	TRTS
Frequência Respiratória	25-45	20-40	17-34	13-30	10-20	4
	>45	>40	>34	>30	>20	3
	13-24	11-19	7-16	7-12	6-9	2
	1-12	1-10	1-7	1-6	1-5	1
	0	0	0	0	0	0
Pressão Arterial Sistólica	>65	>70	>70	>80	>90	4
	53-64	60-69	60-69	70-79	76-89	3
	40-52	50-59	50-59	50-60	50-75	2
	1-39	1-40	1-49	1-49	1-40	1
	0	0	0	0	0	0
Escala Coma de Glasgow			13-15			4
			9-12			3
			6-8			2
			4-5			1
			3			0



MTS III

E agora???

22anos

19 anos em PT

Validity of triage systems for paediatric emergency care: a systematic review

Maria Clara de Magalhães-Barbosa,¹ Jaqueline Rodrigues Robaina,¹
Arnaldo Prata-Barbosa,^{1,2} Claudia de Souza Lopes³

de Magalhães-Barbosa MC, et al. *Emerg Med J* 2017;0:1–9. doi:10.1136/emmermed-2016-206058

Recent reviews suggest that there are many gaps regarding the validity of triage systems, particularly in the paediatric population.^{15 17–20} The aim of this study was to perform a systematic review on the validity of triage systems for paediatric emergency



Validity of triage systems for paediatric emergency care: a systematic review

Results We found 25 studies on seven triage systems: Manchester Triage System (MTS); paediatric version of Canadian Triage and Acuity Scale (PedCTAS) and its adaptation for Taiwan (paediatric version of the

Bostwana (Princess Marina Triage Scale). Only studies on the MTS used a reference standard for urgency, while all systems were evaluated using a proxy outcome for urgency such as admission. Over half of

Validity of triage systems for paediatric emergency care: a systematic review

all studies were low quality. The MTS, PedCTAS and ESI v.4 presented the largest number of moderate and high quality studies. The three tools performed better in their countries or near them, showing a consistent association with hospitalisation and resource utilisation. Studies of all three tools found that patients at the lowest urgency levels were hospitalised, reflecting undertriage.

Table 1 Characteristics of validity studies of triage systems for paediatric emergency care

Triage system	Author, year	Country	Number of centres	Sample size	Study population	Study design
						Validity assessment
1—PedCTAS	Gravel J <i>et al</i> ²⁵	Canada	Multicentre (12)	n=550 940	<18 years	Retrospective
2—PedCTAS	Gravel J <i>et al</i> ²⁶	Canada	Multicentre (9)	n=1464	<18 years	Prospective
3—PedCTAS	Gravel J <i>et al</i> ²⁷	Canada	One centre	n=58 529	<18 years	Retrospective
4—PedCTAS	Gravel J <i>et al</i> ⁴⁷	Canada	One centre	n=28 349	<18 years	Retrospective
5—PedCTAS	Ma W <i>et al</i> ²⁸	Canada	One centre	n=1618	0–19 years	Retrospective
6—PedCTAS	Gouin S <i>et al</i> ²⁹	Canada	One centre	n=1281	0–19 years	Prospective
7—PedCTAS	Fernandez <i>et al</i> ³⁰	Spain	One centre	n=57 617	0–14 years	Retrospective
8—PedCTAS	Al-Hindi AA <i>et al</i> ³¹	Saudi Arabia	One centre	n=3337	0–12 years	Prospective
9—TTAS	Chang YC <i>et al</i> ³²	Thailand	One centre	n=84 874	<18 years	Retrospective
10—ESI v.4	Green NA <i>et al</i> ³³	USA	One centre	n=780	<18 years	Retrospective
11—ESI v.4	Travers DA <i>et al</i> ³⁴	USA	One centre	n=1000	<18 years	Prospective
12—ESI v.4	Baumann MR <i>et al</i> ³⁵	USA	One centre	n=510	<14 years	Retrospective
13—ESI v.4	Jafari-Rouhi AH <i>et al</i> ³⁶	Iran	One centre	n=1104	<18 years	Prospective
14—MTS	Roukema J <i>et al</i> ¹⁶	Netherlands	One centre	n=1065	<16 years	Retrospective
15—MTS	Van Veen M <i>et al</i> ³⁷	Netherlands	Multicentre (2)	n=13 554	<16 years	Prospective
16—MTS	Seiger N <i>et al</i> ³⁸	Netherlands	Multicentre (2)	n=13 408	<16 years	Retrospective
17—MTS	Van Veen M <i>et al</i> ³⁹	Netherlands	Multicentre (2)	n=11 260	<16 years	Prospective
18—MTS	Nijman RG <i>et al</i> ⁴⁰	Netherlands	One centre	n=1255	1 month to 16 years	Prospective
19—MTS	Van Veen M <i>et al</i> ⁴¹	Netherlands	Multicentre (2)	n=3975	<16 years	Prospective
20—MTS	Seiger N <i>et al</i> ⁴²	Netherlands	One centre	n=8592	<16 years	Prospective
21—MTS	Seiger N <i>et al</i> ⁴³	Netherlands, Portugal and England	Multicentre (3)	n=60 375	<16 years	Retrospective
22—MTS	Madramany AA <i>et al</i> ⁴⁴	Spain	One centre	n=23 173	<14 years	Retrospective
23—SRTS	Maningas PA <i>et al</i> ⁴⁵	USA	One centre	n=7077	<13 years	Retrospective
24—SATS	Twomey M <i>et al</i> ¹²	South Africa	Multicentre (6)	n=2014	<13 years	Prospective
25—PATS	Mullan PC <i>et al</i> ⁴⁶	Botswana	One centre	n=35 948	<13 years	Retrospective

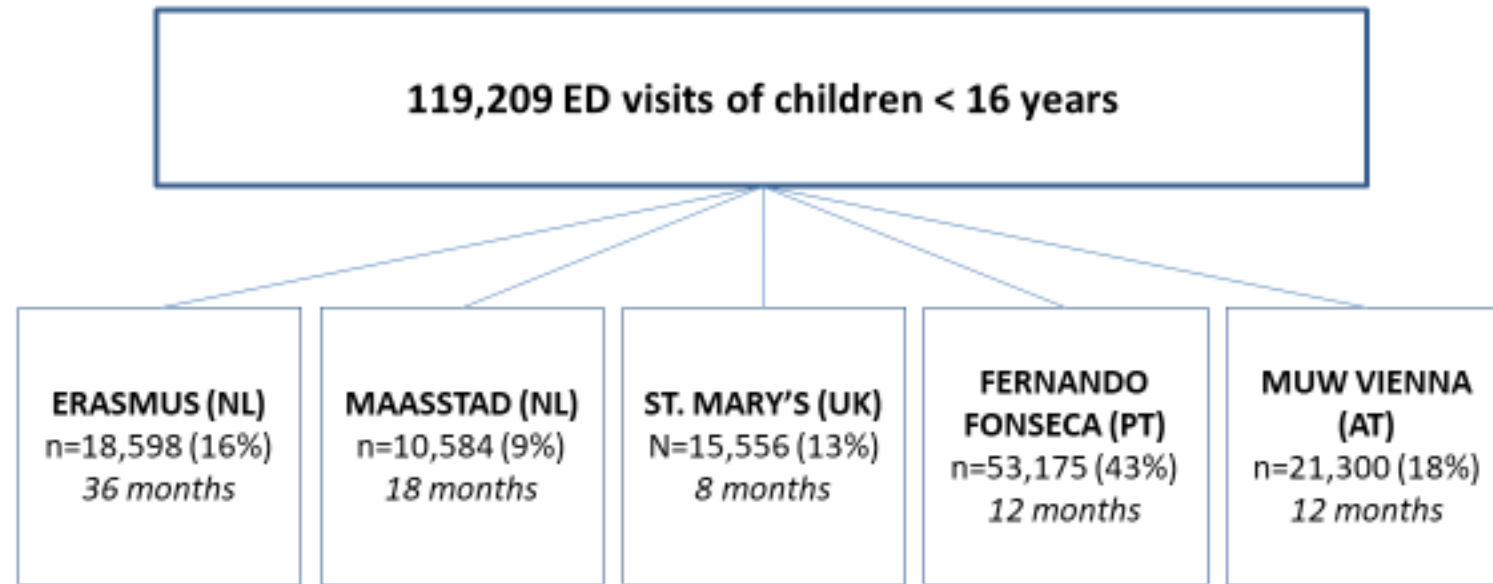
Table 2 Risk of bias in validity studies of paediatric triage systems

Triage system	Author/year/country	Bias type/kappa					Quality of discussion	Methodological quality
		Participants	Attrition/losses	Measurement	Outcome measures	Statistical analysis		
		kw ² 0.70 (0.58–0.78)	kw ² 0.66 (0.54–0.80)	kw ² 0.77 (0.56–0.89)	kw ² 0.57 (0.24–0.67)	kw ² 0.85 (0.72–0.97)		
PedCTAS	Gravel <i>et al</i> ²⁵ , 2013, Canada ²⁵	Low risk	Low risk	Low risk	Uncertain	Uncertain	Good	Moderate
PedCTAS	Gravel <i>et al</i> , 2012, Canada ²⁶	Uncertain	Low risk	Low risk	Uncertain	Low risk	Good	Moderate
PedCTAS	Gravel <i>et al</i> , 2009, Canada ²⁷	Low risk	Uncertain	Low risk	Uncertain	Uncertain	Good	Moderate
PedCTAS	Gravel <i>et al</i> , 2008, Canada ⁴⁷	Low risk	Low risk	Low risk	Low risk	Low risk	Good	High
PedCTAS	Ma <i>et al</i> , 2009, Canada ²⁸	Uncertain	Low risk	Low risk	Uncertain	High risk	Good	Low
PedCTAS	Gouin <i>et al</i> , 2005, Canada ²⁹	Uncertain	High risk	Low risk	Uncertain	Uncertain	Good	Low
PedCTAS	Fernandez <i>et al</i> , 2010, Spain ³⁰	Low risk	Low risk	Uncertain	Uncertain	High risk	Fair	Low
PedCTAS	Al-Hindi <i>et al</i> , 2014, Saudi Arabia ³¹	High risk	Uncertain	Uncertain	Uncertain	Uncertain	Fair	Low
TTAS	Yu-Che Chang <i>et al</i> , 2013, Thailand ³²	Low risk	Low risk	High risk	Uncertain	Uncertain	Fair	Low
ESI v.4	Green <i>et al</i> , 2012, USA ³³	Low risk	Low risk	Low risk	High risk	Uncertain	Good	Moderate
ESI v.4	Travers <i>et al</i> , 2009, USA ³⁴	Low risk	Low risk	Low risk	Uncertain	Uncertain	Good	Moderate
ESI v.4	Baumann <i>et al</i> , 2005, USA ³⁵	High risk	Low risk	Low risk	High risk	Uncertain	Good	Low
ESI v.4	Jafari-Rouhi <i>et al</i> , 2013, Iran ³⁶	Uncertain	Uncertain	Low risk	High risk	High risk	Poor	Low
MTS	Roukema <i>et al</i> , 2006 Netherlands ³⁶	Low risk	Low risk	Low risk	Uncertain	Uncertain	Good	Moderate
MTS	Van Veen <i>et al</i> , 2008, Netherlands ³⁷	Low risk	Uncertain	Low risk	Uncertain	Low risk	Good	Moderate
MTS	Seiger <i>et al</i> , 2011, Netherlands ³⁸	Uncertain	Low risk	Low risk	Uncertain	Low risk	Good	Moderate
MTS	Van Veen <i>et al</i> , 2012, Netherlands ³⁹	Low risk	Low risk	Low risk	Uncertain	Low risk	Good	High
MTS	Nijman <i>et al</i> , 2011, Netherlands ⁴⁰	Uncertain	Low risk	Low risk	High risk	Low risk	Good	Moderate
MTS	Van Veen <i>et al</i> , 2011, Netherlands ⁴¹	Low risk	Uncertain	Uncertain	Uncertain	Uncertain	Good	Low
MTS	Seiger <i>et al</i> , 2013, Netherlands ⁴²	Uncertain	Low risk	Uncertain	Uncertain	Low risk	Good	Moderate
MTS	Seiger <i>et al</i> , 2014, Netherlands/Portugal/England ⁴³	Low risk	Uncertain	Uncertain	Uncertain	Low risk	Good	Moderate
MTS	Madramany <i>et al</i> , 2013, Spain ⁴⁴	Uncertain	High risk	High risk	Uncertain	Uncertain	Fair	Low
SATS	Twomey <i>et al</i> , 2013 ¹²	Uncertain	Low risk	Low risk	Uncertain	High risk	Fair	Low
PATS	Mullan <i>et al</i> , 2014 ⁴⁶	Uncertain	Uncertain	Low risk	Uncertain	Uncertain	Good	Low
SRTS	Maningas <i>et al</i> , 2006, USA ⁴⁵	Uncertain	Uncertain	Low risk	Uncertain	Uncertain	Good	Low

Validity of triage systems for paediatric emergency care: a systematic review

Conclusions There is some evidence to corroborate the validity of the MTS, PedCTAS and ESI v.4 for paediatric emergency care in their own countries or near them. Efforts to improve the sensitivity and to minimise the undertriage rates should continue. Cross-cultural adaptation is necessary when adopting these triage systems in other countries.

Triage database



RESEARCH ARTICLE

Validity of the Manchester Triage System in emergency care: A prospective observational study

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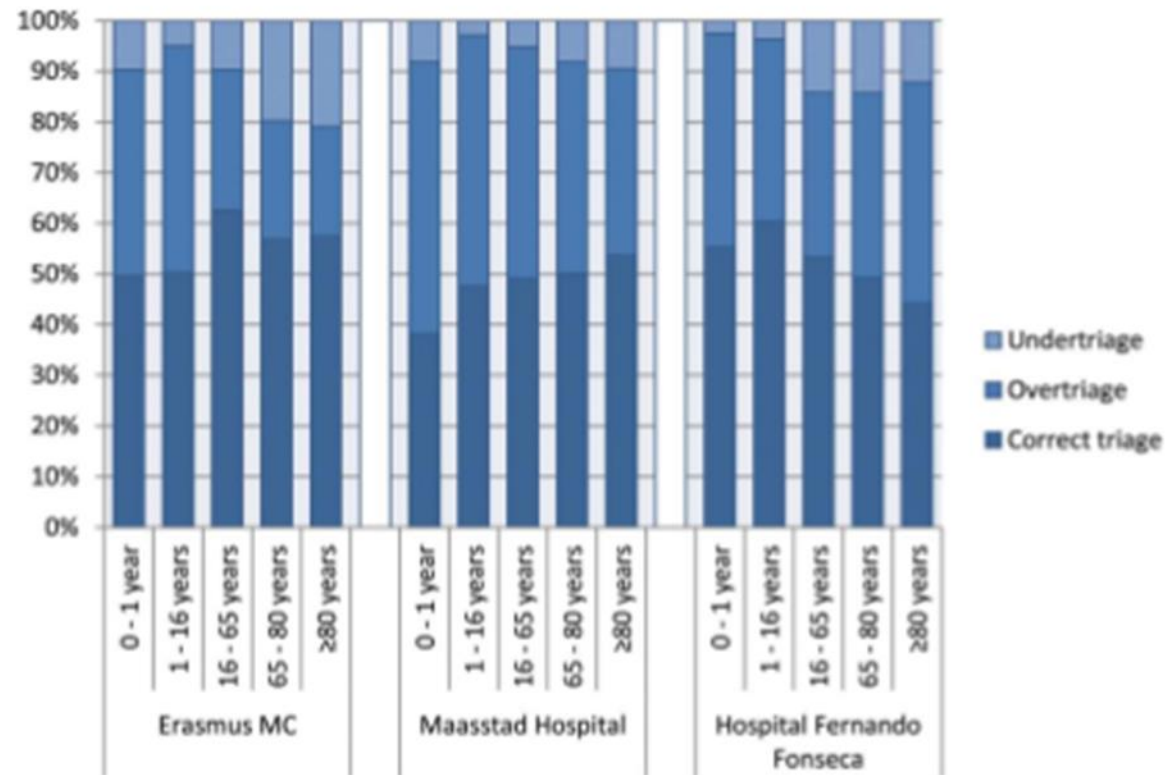
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Table 4. Diagnostic performance of the MTS, as determined by the 3-category reference standard.

	Erasmus MC		Maasstad		Fernando Fonseca	
	<16 years n = 6185	≥16 years n = 19,398	<16 years n = 7032	≥16 years n = 25,500	<16 years n = 52,843	≥16 years n = 177,705
<i>Absolute classification (%)</i>						
Correct triage	3104 (50.2)	11,940 (61.6)	3232 (46.0)	12,685 (49.7)	31,506 (59.6)	91,796 (51.7)
Overtriage	2722 (44.0)	5221 (26.9)	3534 (50.3)	11,228 (44.0)	19,487 (36.9)	60,928 (34.3)
Undertriage	359 (5.8)	2237 (11.5)	266 (3.8)	1587 (6.2)	1850 (3.5)	24,981 (14.1)
<i>Diagnostic accuracy (95% confidence interval)</i>						
Sensitivity	0.65 (0.61 to 0.70)	0.47 (0.44 to 0.49)	0.66 (0.57 to 0.74)	0.72 (0.70 to 0.75)	0.83 (0.79 to 0.87)	0.87 (0.85 to 0.90)
Specificity	0.89 (0.88 to 0.90)	0.94 (0.94 to 0.94)	0.83 (0.83 to 0.84)	0.87 (0.87 to 0.87)	0.83 (0.82 to 0.83)	0.84 (0.84 to 0.84)
Positive likelihood ratio	6.12 (5.54 to 6.78)	7.66 (7.11 to 8.26)	3.99 (3.47 to 4.59)	5.59 (5.33 to 5.86)	4.79 (4.55 to 5.05)	5.36 (5.20 to 5.52)
Negative likelihood ratio	0.39 (0.34 to 0.44)	0.57 (0.55 to 0.59)	0.41 (0.32 to 0.52)	0.32 (0.29 to 0.35)	0.20 (0.16 to 0.26)	0.15 (0.13 to 0.18)
Diagnostic Odds Ratio	15.8 (12.8 to 19.6)	13.5 (12.1 to 15.0)	9.8 (6.7 to 14.5)	17.7 (15.5 to 20.1)	23.8 (17.7 to 32.0)	35.3 (28.4 to 43.9)



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RESEARCH ARTICLE

Validity of the Manchester Triage System in emergency care: A prospective observational study

Conclusions

Validity of the MTS in emergency care is moderate to good, with lowest performance in the young and elderly patients. Future studies on the validity of triage systems should be restricted to large, multicenter studies to define modifications and improve generalizability of the findings.



MTS III

E agora???

22anos

19 anos em PT

Sepsis: *qSOFA* Score

**Altered
Mental Status**

GCS < 15

Tachypnoea

RR ≥ 22

Hypotension

SBP ≤ 100 mmHg

Not high risk

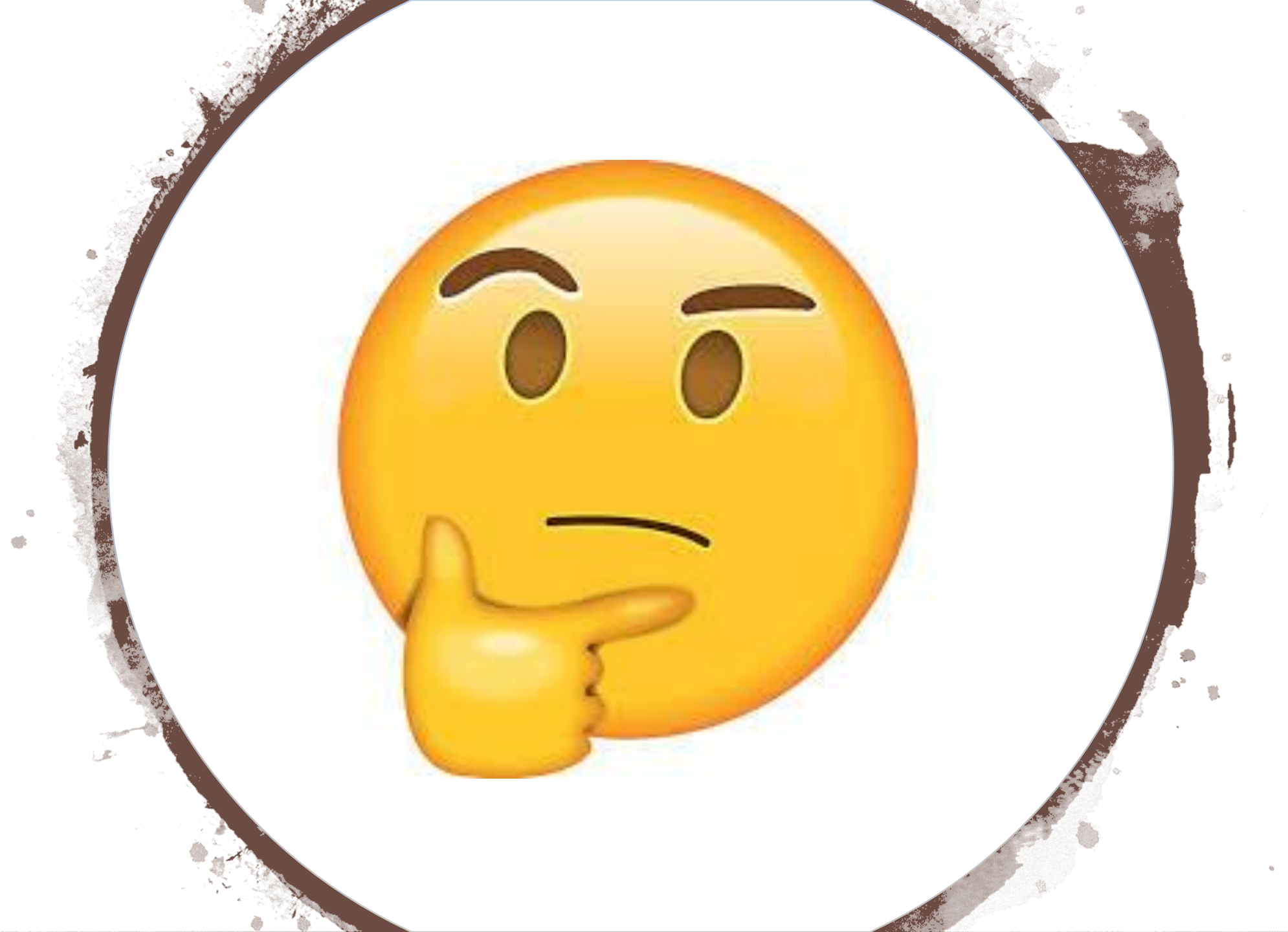
*Continue management as
appropriate*

**0 or 1
Points**

**2 or 3
Points**

High risk of poor
outcome

*Assess for evidence of organ
dysfunction*



A Comparison of the Quick-SOFA and Systemic Inflammatory Response Syndrome Criteria for the Diagnosis of Sepsis and Prediction of Mortality

A Systematic Review and Meta-Analysis

[Chest.](#) 2018 Mar;153(3):646-655. doi: 10.1016/j.chest.2017.12.015. Epub 2017 Dec 28.



A Comparison of the Quick-SOFA and Systemic Inflammatory Response Syndrome Criteria for the Diagnosis of Sepsis and Prediction of Mortality

A Systematic Review and Meta-Analysis

Conclusions

The SIRS was significantly superior to the qSOFA for sepsis diagnosis, and the qSOFA was slightly better than the SIRS in predicting hospital mortality. The association of both criteria could provide a better model to initiate or escalate therapy in patients with sepsis.

qSOFA, SIRS and NEWS for predicting inhospital mortality and ICU admission in emergency admissions treated as sepsis

Robert Goulden,¹ Marie-Claire Hoyle,¹ Jessie Monis,¹ Darran Railton,¹ Victoria Riley,¹ Paul Martin,¹ Reynaldo Martina,² Emmanuel Nsutebu¹

Goulden R, et al. *Emerg Med J* 2018;**35**:345–349. doi:10.1136/emmermed-2017-207120



qSOFA, SIRS and NEWS for predicting inhospital mortality and ICU admission in emergency admissions treated as sepsis

Robert Goulden,¹ Marie-Claire Hoyle,¹ Jessie Monis,¹ Darran Railton,¹ Victoria Riley,¹ Paul Martin,¹ Reynaldo Martina,² Emmanuel Nsutebu¹

Conclusion NEWS has equivalent or superior value for most test characteristics relative to SIRS and qSOFA, calling into question the rationale of adopting qSOFA in institutions where NEWS is already in use.

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Chart 1: The NEWS scoring system

Physiological parameter	3	2	1	Score 0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO ₂ Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO ₂ Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

National Early Warning Score



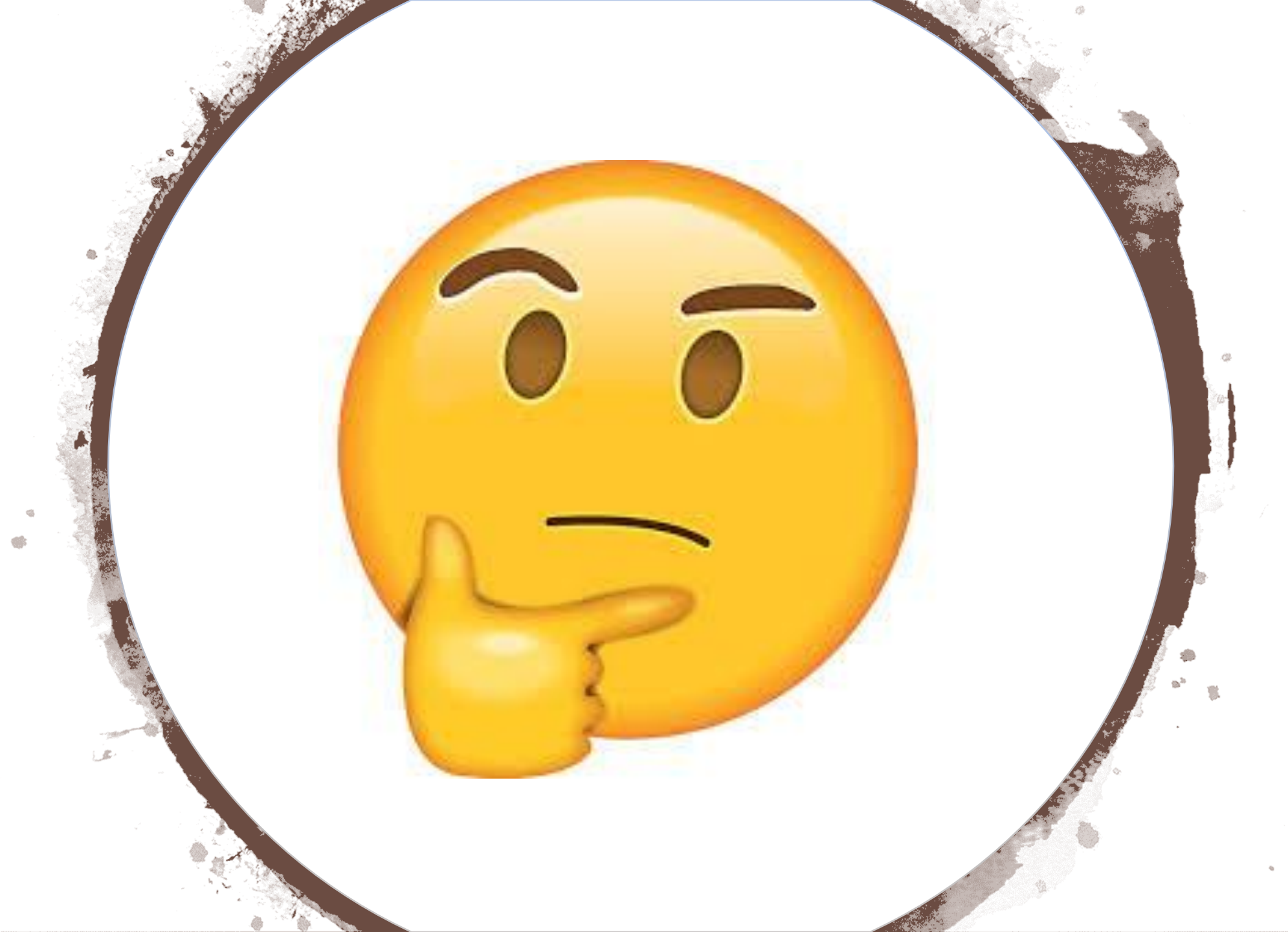
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Pediatric systemic inflammatory response syndrome vital signs and laboratory values by age

Age group	Heart rate (beats/minute)		Respiratory rate (breaths/minute)	Leukocyte count (leukocytes x $10^3/\text{mm}^3$)	Systolic blood pressure (mmHg)
	Tachycardia	Bradycardia			
Newborn (0 days to 1 week)	>180	<100	>50	>34	<59
Neonate (1 week to 1 month)	>180	<100	>40	>19.5 or <5	<79
Infant (1 month to 1 year)	>180	<90	>34	>17.5 or <5	<75
Toddler and preschool (>1 to 5 years)	>140	NA	>22	>15.5 or <6	<74
School age (>5 to 12 years)	>130	NA	>18	>13.5 or <4.5	<83
Adolescent (>12 to <18 years)	>110	NA	>14	>11 or <4.5	<90

SIRS





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Translating Sepsis-3 Criteria in Children: Prognostic Accuracy of Age-Adjusted Quick SOFA Score in Children Visiting the Emergency Department With Suspected Bacterial Infection

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OPEN ACCESS



to current attempts to translate sepsis-3 criteria to children. qSOFA shows moderate prognostic accuracy for PICU transfer and/or mortality. The prognostic accuracy of qSOFA tends to be higher than SIRS and is significantly higher than qPELOD-2. Prognostic accuracy of qSOFA did not improve after inclusion of lactate. Prospective multicenter studies in larger ED populations of febrile children should be performed to further determine the utility of the qSOFA score in the pediatric ED. Pediatric sepsis researchers should assure that pediatric Sepsis-3 criteria are applicable to ED patients as well.

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“O trabalho enobrece o homem”

Max weber





Comparison of paediatric major incident primary triage tools

L A Wallis, S Carley



Emerg Med J 2006;23:475-478. doi: 10.1136/emj.2005.032672

Comparing the Accuracy of Three Pediatric Disaster Triage Strategies: A Simulation-Based Investigation

Mark X. Cicero, MD; Frank Overly, MD; Linda Brown, MD; Jorge Yarzebski, NREMT-P; Barbara Walsh, MD; Veronika Shabanova, MPH; Marc Auerbach, MD, MSc; Antonio Riera, MD; Kathleen Adelgais, MD, MPH; Garth Meckler, MD; David C. Cone, MD; Carl R. Baum, MD

Performance characteristics of five triage tools for major incidents involving traumatic injuries to children

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