15es JOURNÉES FRANCOPHONES Alvéole

Réadaptation respiratoire :

une personne, un accompagnement

Exacerbation aiguë de BPCO : le moment pour optimiser la prise en charge globale.

JM Grosbois

Lyon 21/03/2024

NX-FR-FVU-PPTX-240002

alvéole
OSEZ UN SOUFFLE NOUVEAU
Groupe de travail de la SPLF pour Exercice et Réhabilitation Respiratoire

SPLF
Société de Pneumologie de Langue Française

Déclaration des liens d'intérêts

J'ai actuellement, ou j'ai eu au cours des trois dernières années, une affiliation ou des intérêts financiers ou intérêts de tout ordre avec les sociétés commerciales suivantes en lien avec la santé.

° Liens d'intérêt :

Astra Zeneca, Boehringer Ingelheim, Chiesi, CSL Behring, GSK

° Liens d'intérêt en relation avec la présentation :

Adair, Aeris Santé, Elivie, France Oxygène, Homeperf, LVL, Médopale, NorOx, Santélys, Santéo, SOS Oxygène, Sysmed, VentilHome, VitalAire

ARS Hauts de France et

Dr Jean Marie Grosbois

WHERE? WHO? WHAT? WHEN? WHO?
HOW? WHAT? WHEN? WHERE? HOW?
WHY? WHO? WHERE? WHAT? WHEN?
WHEN? WHY? WHAT? HOW? WHO?
WHERE? WHO? WHY? WHEN? WHAT?
WHAT? WHEN? WHO? WHERE? HOW?
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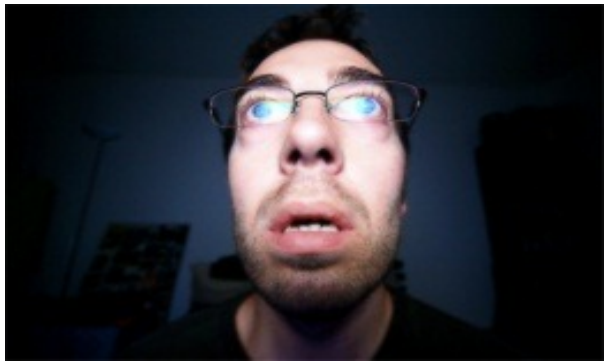
HOW? WHAT? WHEN? WHY? WHO?
WHERE? WHO? HOW? WHAT? WHY?

Un patient



Pouvoir et Liberté du Médecin et des PS

Compliance

Observance

Adhésion

Alliance thérapeutique Négociation

Observance personnelle

Autogestion

SOIN

Pouvoir et Liberté de la Personne

CURE + CARE = CURARE

« patient paralysé »

« perte de pouvoir »

La Réadaptation Respiratoire : en centre, à domicile, en hybride
une personne, un accompagnement

Pouvoir et Liberté du Médecin et des PS

Compliance

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« patient paralysé »

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CARE + CURE = CARURE

« personne plus forte »

« reprise du pouvoir »

« re-mise en mouvement »

SOIN

PRENDRE SOIN

Pouvoir et Liberté de la Personne

An Official American Thoracic Society/European Respiratory Society Policy Statement: Enhancing Implementation, Use, and Delivery of Pulmonary Rehabilitation

Carolyn L. Rochester, Ioannis Vogiatzis, Anne E. Holland, Suzanne C. Lareau, Darcy D. Marciniuk, Milo A. Puhan, Martijn A. Spruit, Sarah Masefield, Richard Casaburi, Enrico M. Clini, Rebecca Crouch, Judith Garcia-Aymerich, Chris Garvey, Roger S. Goldstein, Kylie Hill, Michael Morgan, Linda Nici, Fabio Pitta, Andrew L. Ries, Sally J. Singh, Thierry Troosters, Peter J. Wijkstra, Barbara P. Yawn, and Richard L. ZuWallack; on behalf of the ATS/ERS Task Force on Policy in Pulmonary Rehabilitation

Am J Respir Crit Care Med Vol 192, Iss 11, pp 1373–1386, Dec 1, 2015

Box 5: Increasing Patient Access to PR

Recommendations:

- Patient access to PR should be improved by augmenting program commissioning through increased sustainable payer funding.
- New PR programs should be created in geographic areas where demand exceeds capacity.
- Novel PR program models should be developed and studied that will make evidence-based PR more accessible and acceptable to patients and payers; this may include new approaches within hospital-based programs, community-based programs, comprehensive and well-resourced home-based or telehealth-supported programs, or other novel models of program delivery.
- Selection criteria for PR should reflect current published evidence. The evidence indicates that patients who benefit from PR include not only persons with moderate to severe airflow limitation but also those with mild to moderate airflow limitation with symptom-limited exercise tolerance, those after hospitalization for COPD exacerbation, and those with symptomatic non-COPD respiratory conditions. Increasing patient access for these patient groups will depend on increased referrals, increased payer funding, and patient demand for services.

Effectiveness of home-based pulmonary rehabilitation: systematic review and meta-analysis

Uzzaman MN, Agarwal D, Chan SC, *et al.*
Eur Respir Rev 2022; 31: 220076

Effects of Home-Based Pulmonary Rehabilitation on Dyspnea, Exercise Capacity, Quality of Life and Impact of the Disease in COPD Patients: A Systematic Review

Diêgo Mendes Xavier, Endi Lanza Galvão, Alenice Aliane Fonseca, Glaciele Maria de Souza & Vanessa Pereira Lima

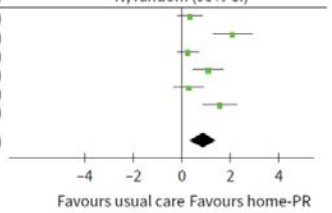
COPD: JOURNAL OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE
2022, VOL. 19, NO. 1, 18–46

Comparison: Home-PR *versus* usual care

a) Functional exercise capacity

Study or subgroup	Home-PR Mean±SD	Total	Usual care Mean±SD	Total	Weight	SMD IV, random (95% CI)
Boxall, 2005 (6MWT)	39±91.85	30	4.2±114.36	30	17.9%	0.33 (−0.18–0.84)
Ghanem, 2010 (6MWT)	52.71±30.01	25	−15.44±35.83	14	14.5%	2.07 (1.26–2.89)
Johnson-Warrington, 2016 (ISWT)	45±51.85	39	30±70.37	39	18.6%	0.24 (−0.21–0.69)
Pradella, 2015 (6MWT)	65.7±65.7	32	5.6±24.2	18	16.7%	1.08 (0.46–1.70)
Singh, 2003 (6MWT)	54±62.19	20	6.3±222.74	20	16.7%	0.29 (−0.34–0.91)
Varas, 2018 (ESWT)	6.1±5.7	21	−0.9±2.1	19	15.6%	1.57 (0.85–2.28)
Total (95% CI)		167		140	100.0%	0.08 (0.32–1.44)

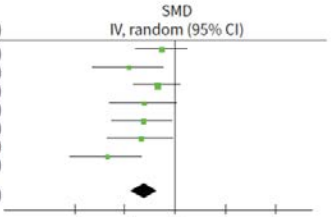
Heterogeneity: Tau²=0.38; Chi²=25.78, df=5 (p<0.0001); I²= 81%
Test for overall effect: Z=3.09 (p=0.002)



b) Health-related quality of life

Study or subgroup	Home-PR Mean±SD	Total	Usual care Mean±SD	Total	Weight	SMD IV, random (95% CI)
Boxall, 2005 (SGRQ)	−5.8±16.13	30	−1.4±17.07	30	17.5%	−0.26 (−0.77–0.25)
Ghanem, 2010 (SF-36)	−30±40.0494	25	2.18±21.459	14	11.2%	−0.91(−1.60–−0.22)
Johnson-Warrington, 2016 (CRQ)	−1.41±1.48	39	−0.89±1.51	39	20.7%	−0.34 (−0.79–0.10)
Mohammadi, 2013 (SF-12)	−6.8±7.8309	20	−2.56±5.6748	20	12.7%	−0.61 (−1.24–0.03)
Pradella, 2015 (SGRQ)	−6.4±16.1	32	3.1±12.2	18	14.1%	−0.63 (−1.22–−0.04)
Singh, 2003 (CRQ)	−0.89±1.3103	20	−0.05±1.1315	20	12.6%	−0.67 (−1.31–−0.03)
Varas, 2018 (SGRQ)	−4.4±3.6	21	1±4.3	19	11.1%	−1.34 (−2.03–−0.65)
Total (95% CI)		187		160	100.0%	−0.62 (−0.88–−0.36)

Heterogeneity: Tau²=0.03; Chi²=8.18, df=6 (p=0.23); I²= 27%
Test for overall effect: Z=4.68 (p<0.00001)

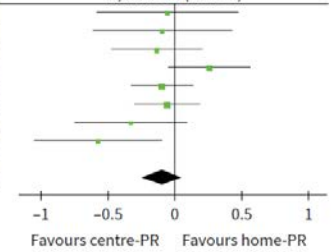


Comparison: home-PR versus centre-PR

c) Functional exercise capacity

Study or subgroup	Home-PR Mean±SD	Total	Centre-PR Mean±SD	Total	Weight	SMD IV, random (95% CI)
Chen, 2018 (6MWT)	38.29±78.66	29	43.01±86.62	26	6.8%	−0.06 (−0.59–0.47)
Güell, 2008 (6MWT)	54±103.13	28	65±126.67	29	7.0%	−0.09 (−0.61–0.43)
Hansen, 2020 (6MWT)	17.2±46.74	67	23.5±46.74	67	13.3%	−0.13 (−0.47–0.21)
Holland, 2017 (6MWT)	29.39±70.15	80	10.82±71.55	86	15.2%	0.26 (−0.04–0.57)
Horton, 2018 (ISWT)	21±209.307	145	41±216.4133	142	20.7%	−0.09 (−0.33–0.14)
Maltais, 2008 (6MWT)	8±51.0452	126	11±51.0452	126	19.4%	−0.06 (−0.31–0.19)
Mendes de Oliveira, 2010 (6MWT)	73.2±50.2	42	93.6±70.6	46	9.7%	−0.33 (−0.75–0.09)
Pehlivan, 2020 (6MWT)	18±61.18	39	66±102.75	32	8.0%	−0.58 (−1.05–−0.10)
Total (95% CI)		556		554	100.0%	−0.10 (−0.25–0.05)

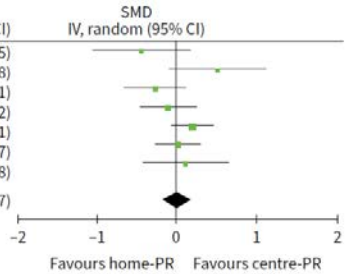
Heterogeneity: Tau²=0.01; Chi²=10.38, df=7 (p=0.17); I²= 33%
Test for overall effect: Z=1.26 (p=0.21)



d) Health-related quality of life

Study or subgroup	Home-PR Mean±SD	Total	Centre-PR Mean±SD	Total	Weight	SMD IV, random (95% CI)
Chen, 2018 (CAT)	−3.2±5.06	29	−1.27±4.95	26	7.5%	−0.38 (−0.91–0.15)
Güell, 2008 (CRQ)	−0.1±1.09	28	−0.65±1.27	29	7.7%	0.46 (−0.07–0.98)
Hansen, 2020 (CAT)	−1.7±6.1496	67	−0.3±6.1495	67	14.7%	−0.23 (−0.57–0.11)
Holland, 2017 (CRQ)	−2.43±4.6733	80	−2.02±4.6175	86	16.9%	−0.09 (−0.39–0.22)
Horton, 2018 (CRQ)	−0.28±1.9146	145	−0.61±1.7755	142	22.6%	0.18 (−0.05–0.41)
Maltais, 2008 (CRQ)	−0.49±0.9642	126	−0.51±0.9075	126	21.3%	0.02 (−0.23–0.27)
Pehlivan, 2020 (CAT)	−5±8.76	39	−6±9.34	32	9.3%	0.11 (−0.36–0.58)
Total (95% CI)		514		508	100.0%	0.01 (−0.15–0.17)

Heterogeneity: Tau²=0.02; Chi²=9.23, df=6 (p=0.16); I²= 35%
Test for overall effect: Z=0.17 (p=0.87)



Our systematic review identified 16 studies involving a total of 1800 COPD patients from 11 different countries. The effects of home-PR on exercise capacity and/or HRQoL in people with COPD were compared to either centre-PR (n=7) or usual care (n=8). One study had both comparators [52]. Overall, statistically significant improvement was found in functional exercise capacity and HRQoL in home-PR groups when compared with usual care, but no statistically significant differences were found in exercise capacity and HRQoL between home-PR and centre-PR groups.

EVALUATION DU PROJET ARTICLE 51 OCCITAN'AIR

03/10/2023

AXE 1 – FAISABILITE / OPERATIONNALITE

Faible	Moyen	Fort

AXE 2 – EFFICACITE / EFFICIENCE

Faible	Moyen	Fort

AXE 3 – REPLICABILITE

Faible	Moyen	Fort

https://www.occitanie.ars.sante.fr/experimenter-des-organisations-innovantes-art51-loi-de-financement-de-la-securite-sociale-2018

La Réadaptation Respiratoire à Domicile : une personne, un accompagnement

FormAction Santé
Osez un souffle nouveau

PROJET D'EXPERIMENTATION D'INNOVATION EN SANTE

Diagnostic éducatif
BEP
Entretien de compréhension

Evaluation T0

Réentrainement effort AVQ

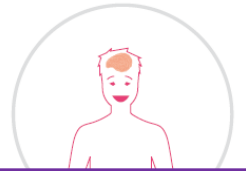
ETP

Accompagnement psycho social et motivationnel

Evaluation T2 T8 T14

Self Management

RÉHABILITATION RESPIRATOIRE



RR Dom : 8 séances en présentiel

n = 3 700

RR TéléDom : 4 séances en présentiel et 4 séances en distanciel

n = 320

1 séance 6 et 12 mois après le stage

Capacité physique (TS6, TUG, 10LC)
Humeur (HAD)
Qualité de vie (VSRQ, CCQ, CAT…)

Capacité physique (TS6, TUG, 10LC)
Humeur (HAD)
Qualité de vie (VSRQ, CCQ, CAT…)

Courriers prescripteur & médecin référent

Courriers prescripteur & médecin référent

Courriers prescripteur & médecin référent

La Réadaptation Respiratoire à Domicile : une personne, un accompagnement

FormAction Santé
Osez un souffle nouveau

Equipe : Care Manager

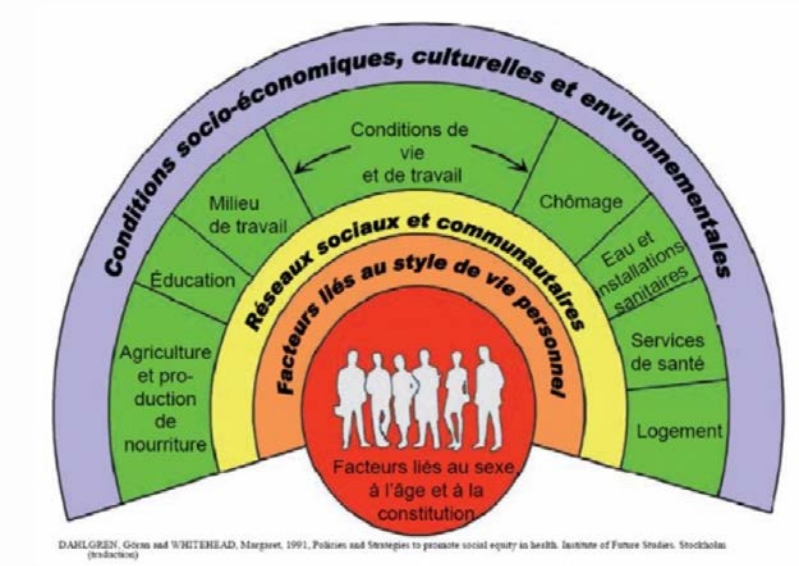
1 assistante
3 IDE
2 Kiné
4 prof APA
1 diététicienne
1 esthéticienne socio médicale
1 arthérapeute
1 psychologue
1 pneumologue

La Réadaptation Respiratoire à Domicile : une personne, un accompagnement

« aller vers…. »

Les déterminants de la Santé

5 niveaux



1 Facteurs liés au **genre, âge** et constitution

2 **Facteurs liés au style de vie personnel : tabagisme, alcool, alimentation, activités physiques….**

3 Réseaux sociaux et communautaires : influences sociales et collectives (présence ou non d'un soutien mutuel **(aidant et/ou conjoint)** dans certaines situations…).

4 **Conditions de vie et de travail** : **accès au** travail, conditions de travail, **service de santé**, nourriture, **éducation.**

5 **Conditions socio économiques, culturelles et environnementales**

Dahlgren G, Whitehead M, 1991
Policies and strategies to promote social equity in health
Stockholm, Institute for Future Studies.

Physical and affective components of dyspnoea are improved by pulmonary rehabilitation in COPD

Jean-Marie Grosbois,[1] Sarah Gephine,[2,3] Maeva Kyheng,[4] Julie Henguelle,[5] Olivier Le Rouzic,[5] Didier Saey,[3] François Maltais,[3] Cecile Chenivesse[5,6]

BMJ Open Resp Res 2022;**9**:e001160. doi:10.1136/bmjresp-2021-001160

Characteristics	Total group (n=225)
Age, years	65±11
Female, nb (%)	82 (36.4)
BMI, kg/m^2	28±8
LTOT, nb (%)	162 (72.0)
NIV, nb (%)	92 (40.9)
CPAP, nb (%)	17 (7.6)
No equipment, nb (%)	38 (16.9)
FEV_1, % of predicted	35±15

Table 2 Assessments at baseline (M0) and changes in the outcomes at short term (M2), medium term (M8) and long term (M14) after PR

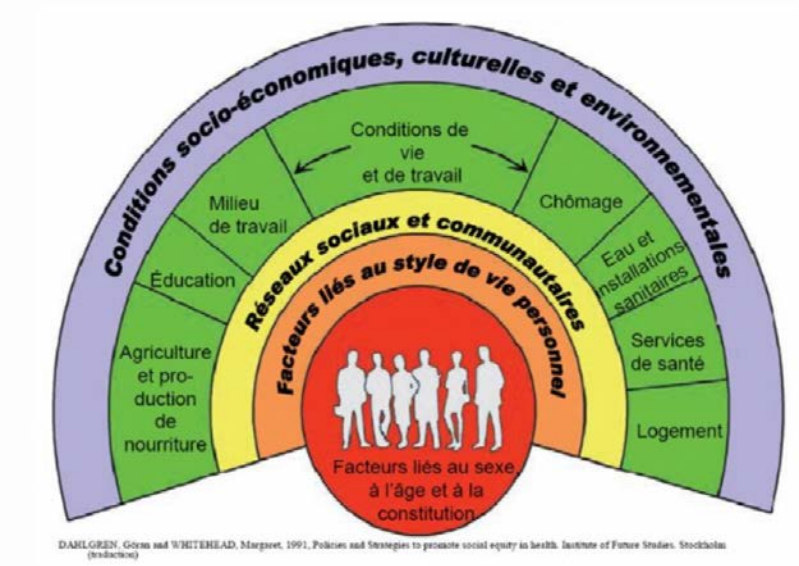
	M0	M2		M8		M14	
			ΔM2 - baseline		ΔM8 - baseline		ΔM14 - baseline
Assessments	Score	Score	Estimates (95% CI)	Score	Estimates (95% CI)	Score	Estimates (95% CI)
D-12 questionnaire							
Physical (0–21)	13.7±0.4	10.5±0.4	−3.1 (−4.0 to −2.3)	9.8±0.4	−3.9 (−4.9 to −3.0)	9.8±0.5	−3.8 (−4.8 to −2.9)
Affective (0–15)	8.2±0.3	6.1±0.3	−2.2 (−2.8 to −1.6)	6.0±0.4	−2.3 (−2.9 to −1.6)	5.6±0.4	−2.7 (−3.4 to −2.0)
Total score (0–36)	21.9±0.7	16.6±0.7	−5.3 (−6.7 to 4.0)	15.7±0.8	−6.2 (−7.7 to −4.7)	15.2±0.8	−6.7 (−8.3 to −5.1)
mMRC (0–4)	3.2±0.1	3.0±0.1	−0.2 (−0.4 to −0.1)	3.0±0.1	−0.3 (−0.4 to −0.1)	2.9±0.1	−0.3 (−0.5 to −0.2)
VSRQ, score (0–80)	28.9±1.4	39.0±1.4	10.1 (7.7 to 12.5)	38.2±1.5	9.3 (6.7 to 11.9)	36.4±1.5	7.5 (4.7 to 10.2)
Anxiety symptom (0–21)	9.9±0.3	8.2±0.3	−1.7 (−2.2 to −1.1)	8.0±0.3	−1.9 (−2.4 to −1.3)	7.7±0.3	−2.1 (−2.7 to −1.5)
Depressive symptom (0–21)	8.3±0.3	6.7±0.3	−1.6 (−2.1 to −1.1)	6.1±0.3	−2.3 (−2.8 to −1.7)	6.2±0.3	−2.1 (−2.7 to −1.6)
FAS, score (10–50)	28 (23 to 25)	28 (23 to 35)	−0.2 (−0.3 to −0.1)*	24 (19 to 29)	−0.2 (−0.3 to −0.1)*	24 (18 to 30)	−0.1 (−0.2 to −0.0)*
6MST, strokes	299±14	370±13	73.1 (53.7 to 92.5)	337±14	40.1 (18.1 to 62.0)	343±15	46.0 (21.7 to 70.3)

La Réadaptation Respiratoire à Domicile : une personne, un accompagnement

« aller vers…. »

Les déterminants de la Santé

5 niveaux



DAHLGREN, Göran and WHITEHEAD, Margaret, 1991, Policies and Strategies to promote social equity in health. Institute of Future Studies. Stockholm (traduction)

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Stockholm, Institute for Future Studies.

Expérimentation RR TéléDom :

4 séances en présentiel

4 séances en distanciel

(16 janvier 2022 au 31 décembre 2023)

306 patients hospitalisés pour EABPCO

32 (10.4%) refusaient d'emblée la RR

16 (5.2%) refusaient la RR après le bilan éducatif

82 (26.8%) ont refusé RR TéléDom

mais accepté RR Dom

176 (57.5%) patients ont réalisé RR TéléDom

RR TéléDom	Délai en jours
Réception courrier vs BEP	12.0 ± 6.4
BEP vs première séance	8.6 ± 3.3
Réception courrier vs dernière séance	82.9 ± 13.3

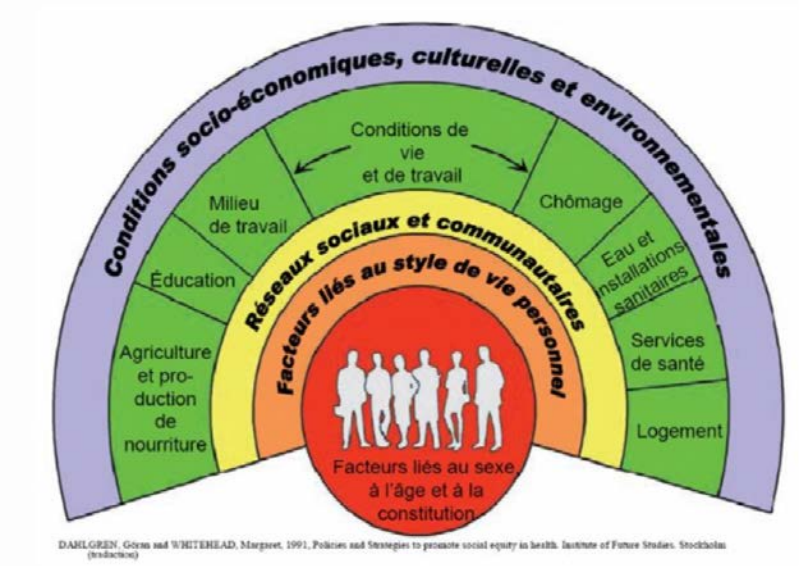
	RR TéléDom			
Caractéristiques	**n**	**T2**	ΔT2 – T0	p
CAT	141	19.2 ± 8.3	-3.3 ± 6.2	<0.001
EQ-5D-3L	142	63 ± 18	+9 ± 18	<0.001
FAS	142	23.7 ± 8.7	-3.4 ± 6.3	<0.001
Dyspnea12	140	14.8 ± 9.4	-4.3 ± 7.3	<0.01
mMRC	143	2.47 ± 1.07	-0.45 ± 0.81	<0.05
HAD				
Anxiété	141	8.2 ± 3.9	-1.5 ± 3.0	<0.01
Dépression	141	5.7 ± 4.4	-2.2 ± 3.3	<0.01
TS6 coups	106	400 ± 168	+64 ± 88	<0.005
TUG, sec	135	6.9 ± 1.9	-2.3 ± 3.6	<0.001
5 LC, sec	134	10.0 ± 3.1	-1.6 ± 3.0	<0.001

La Réadaptation Respiratoire à Domicile : une personne, un accompagnement

« aller vers…. »

Les déterminants de la Santé

5 niveaux



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Policies and strategies to promote social equity in health
Stockholm, Institute for Future Studies.

Women and COPD: do we need more evidence?

Christophe Gut-Gobert[1], Arnaud Cavaillès[2], Adrien Dixmier[3], Stéphanie Guillot[4], Stéphane Jouneau[5,6], Christophe Leroyer[1], Sylvain Marchand-Adam[7], David Marquette[8], Jean-Claude Meurice[9], Nicolas Desvigne[10], Hugues Morel[3], Christine Person-Tacnet[11] and Chantal Raherison[12]

Eur Respir Rev 2019; 28: 180055

Clinical characteristics and quality of life in women with COPD: an observational study

Chantal Raherison[1*], Isabelle Tillie-Leblond[2], Anne Prudhomme[3], Camille Taillé[4,5], Elisabeth Biron[6], Cecilia Nocent-Ejnaini[7], Benigne Mathieu[8] and Juliette Ostinelli[8]

BMC Women's Health 2014, **14**:31

Impact of gender on COPD expression in a real-life cohort

Nicolas Roche[1*], Gaetan Deslée[2], Denis Caillaud[3], Graziella Brinchault[4], Isabelle Court-Fortune[5], Pascale Nesme-Meyer[6], Pascale Surpas[7], Roger Escamilla[8], Thierry Perez[9], Pascal Chanez[10], Christophe Pinet[11], Gilles Jebrak[12], Jean-Louis Paillasseur[13], Pierre-Régis Burgel[1] for the INITIATIVES BPCO Scientific Committee

Roche *et al. Respiratory Research* 2014, **15**:20

Existe-t-il des spécificités chez les femmes atteintes de BPCO ?

Are there specific characteristics of COPD in women?

C. Raherison[a,*], E. Biron[b], C. Nocent-Ejnaini[c], C. Taillé[d], I. Tillie-Leblond[e], A. Prudhomme[f]

Revue des Maladies Respiratoires (2010) 27, 611–624

Conclusion

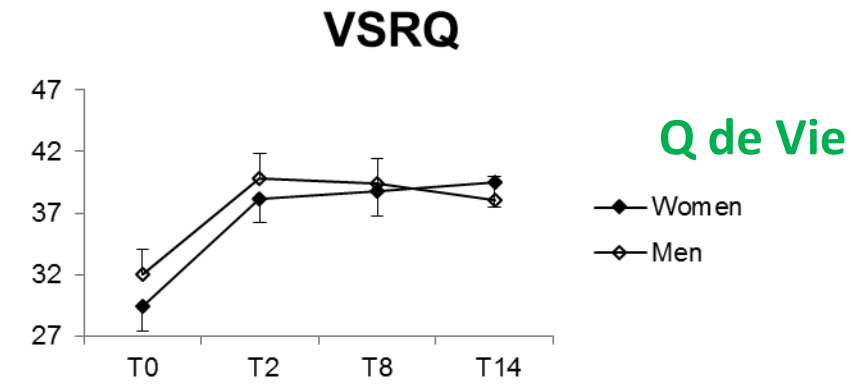
The present study shows that, for a given age and level of airflow obstruction, women with COPD experience different intensity of dyspnea than men. In addition, women have lower BMI, which also contributes to their higher BOD scores. Finally, anxiety appears more frequent in women. Mechanisms underlying these differences remain to be fully understood, but this suggests that COPD assessment and treatment might benefit from a more gender-specific approach.

Gender does not impact the short- or long-term outcomes of home-based pulmonary rehabilitation in patients with COPD

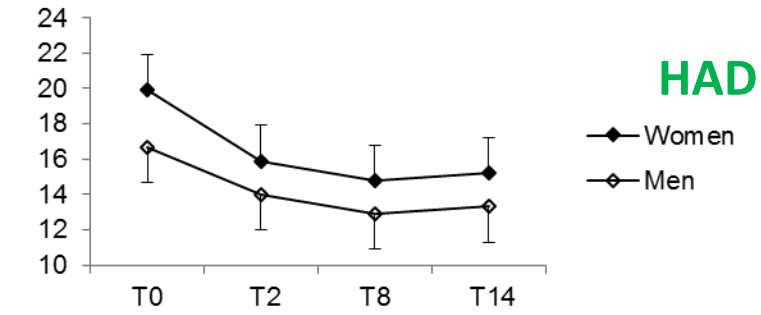
Jean-Marie Grosbois[1,2], Sarah Gephine[3,4], Anne Sophie Diot[5], Maeva Kyheng[6,7], François Machuron[6,7], Gaelle Terce[2], Benoit Wallaert[5,8,9], Cécile Chenivesse[5,8,9] and Olivier Le Rouzic[5,8,9]

ERJ Open Res 2020; 6: 00032-2020

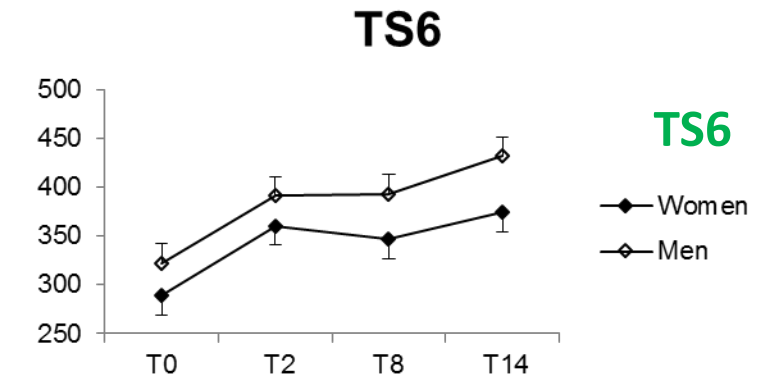
Parameter	All patients N=480	Women N=170 (35.4)	Men N=310 (64.6)	p value
Age (years)	64.2 ± 11.3	62.1 ± 12.3	65.3 ± 10.6	0.004
BMI (kg/m2)	27.0 ± 7.7	28.0 ± 9.1	26.4 ± 6.8	0.045
Living arrangement				
Alone (%)	162 (33.7)	86 (50.6)	76 (24.5)	<0.001
EPICES	38.5 ± 18.8	41.6 ± 20.3	36.7 ± 17.7	0.011
Socio economic deprivation (%)	288 (60)	113 (66.5)	175 (56.4)	0.031
Coronary artery disease or arteritis	127 (26.5)	27 (15.9)	100 (32.3)	<0 .001
HADS (score)				
Anxiety	9.9 ± 4.6	11.5 ± 4.6	8.9 ± 4.3	<0.001
Depression	8.0 ± 4.2	8.4 ± 4.6	7.8 ± 4.0	0.1370
Total	17.8 ± 7.7	19.9 ± 8.1	16.7 ± 7.2	<0.001
VSRQ (score)	31.2 ± 15.3	29.4 ± 14.6	32.1 ± 14.6	0.0894
6MST (strokes)	310.1 ± 154.0	288.5 ± 148.4	322.5 ± 157.8	0.0350



Q de Vie



HAD



TS6

Rape, asthma and dysfunctional breathing

Hancox RJ, Morgan J, Dickson N, *et al.*
Eur Respir J 2020; 55: 1902455

Suivi longitudinal de 1037 personnes nées en 1972-1973
Evaluation à 26 et 38 ans : e-questionnaire

Viol	Avant 16 ans	Avant 38 ans	Prévalence totale
Femmes	10%	14.9%	18.9%
Hommes	2.3%	2.1%	3.9%

Nijmegen	Viol	Non Viol	p
Femmes	15	11	<0.001
Hommes	19.5	8	<0.001

TABLE 1 Unadjusted and adjusted associations between rape and asthma and dysfunctional breathing at age 38 years

	Unadjusted				Adjusted#			
	n	OR	95% CI	p-value	n	OR	95% CI	p-value
Women								
Asthma	466	3.10	1.83–5.25	<0.001	389	4.47	2.22–8.99	<0.001
Wheeze	466	2.83	1.74–4.59	<0.001	389	2.19	1.23–3.90	0.008
Dysfunctional breathing	457	2.68	1.59–4.52	<0.001	383	2.71	1.47–5.01	0.001
Men								
Asthma	472	1.04	0.29–3.70	0.947	417	1.77	0.32–9.93	0.514
Wheeze	472	0.82	0.27–2.55	0.736	417	0.59	0.16–2.17	0.430
Dysfunctional breathing	462	10.1	3.80–26.7	0.001	408	8.05	2.53–25.7	<0.001

#: adjusted for smoking history (pack-years) up to age 38 years, childhood and adult socio-economic status, and childhood asthma.

Clinicians should recognise the possibility of prior traumatic experiences triggering either dysfunctional breathing or late-onset asthma, and consider whether psychological counselling or other forms of therapy would help their patients.

Home-based pulmonary rehabilitation for adults with severe asthma exposed to psychosocial chronic stressors

Sarah Gephine [a,b,*], Stéphanie Fry [c], Emilie Margoline [c], Alice Gicquello [d], Cécile Chenivesse [e], Jean-Marie Grosbois [a]

Respiratory Medicine 217 (2023) 107349

Chronic stressors : 43.2%

16.7% : traumatic experience related to an intensive care unit stay

26.5% : Physical, sexual and psychological violence

Baseline characteristics	Chronic Stressors (n=48) 43.2%	NO chronic stressors (n=63)	p
Age, years	49.7 ± 16.2	58.3 ± 14.5	0.004
Female, n (%)	43 (89.6)	45 (71.4)	0.014
Anxiety treated with drug, n (%)	27 (56.2)	23 (36.5)	0.027
Depression treated with drug, n (%)	19 (39.5)	4 (6.3)	0.001

Baseline assessments	Chronic Stressors (n=48) 43.2%	NO chronic stressors (n=63)	p
Nijmegen, score (0-64)	28.0 (18.8 to 36.0)	22.7 (14.0 to 30.0)	0.028
Anxiety symptoms (0-21)	12.3 (8.5 to 16.0)	9.6 (6.0 to 13.0)	0.003
Depression symptoms (0-21)	8.3 (4.0 to 13.3)	7.4 (4.0 to 10.5)	0.369
FAS, score (10-50)	30.8 (23.0 to 39.0)	27.4 (22.0 to 33.7)	0.041
EQ5D3L-VAS (0-100)	46.9 (30.0 to 65.0)	50.3 (40.0 to 60.0)	0.241
CAT (0-40)	25.1 (19.5 to 36.0)	22.5 (16.5 to 27.0)	0.035
6MST, strokes	300 (67 to 508)	336 (200 to 509)	0.294
TUG, seconds	7.8 (5.4 to 8.4)	8.4 (5.9 to 9.3)	0.443

Home-based pulmonary rehabilitation for adults with severe asthma exposed to psychosocial chronic stressors

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Respiratory Medicine 217 (2023) 107349

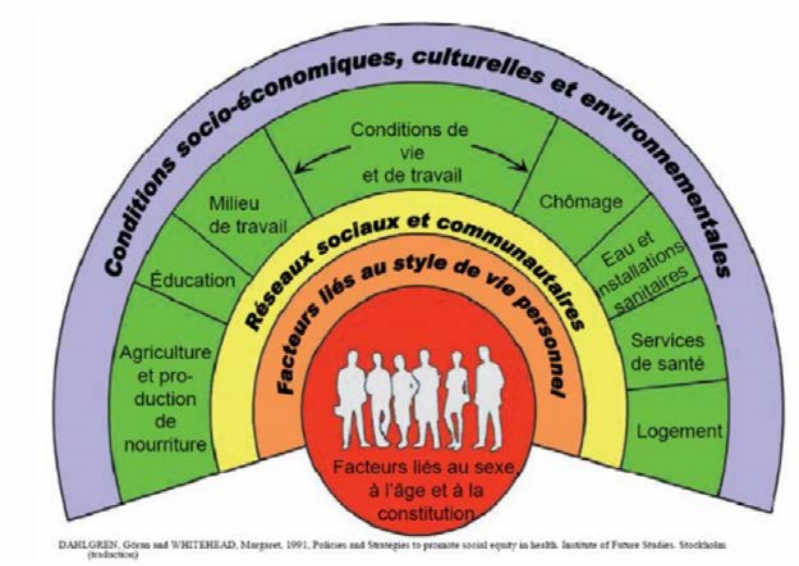
		Chronic stressors		No chronic stressors	
	MCID	End of PR (M2)	ΔM2-baseline	End of PR (M2)	ΔM2-baseline
Nijmegen		21.5 ± 10.7	-6.0 (-8.0 to -4.0)	18.2 ± 8.7	-4.6 (-6.2 to -3.0)
Anxiety symptoms	(1.5)	9.5 ± 4.1	-2.8 (-4.0 to -1.6)	8.1 ± 3.5	-1.5 (-2.2 to -0.8)
Depression symptoms	(1.5)	5.6 ± 3.3	-2.7 (-3.6 to -1.7)	5.2 ± 3.4	-2.2 (-2.9 to -1.6)
FAS	(4)	24.7 ± 6.6	-6.1 (-8.6 to -3.6)	23.2 ± 5.9	-4.0 (-5.2 to -2.7)
EQ5D3L-VAS		61.5 ± 13.2	14.7 (9.7 to 19.7)	62.9 ± 15.1	11.8 (7.9 to 15.7)
CAT (0-40)	(2)	19.3 ± 6.6	-5.3 (-7.6 to -3.1)	18.4 ± 6.3	-4.2 (-5.5 to -2.8)
6MST	(40)	341 ± 216	41 (3 to 80)	366 ± 206	24 (-10 to 58)
TUG	(1.5)	6.5 ± 2.5	-1.2 (-1.9 to -0.5)	7.8 ± 3.2	-0.8 (-1.4 to -0.1)

La Réadaptation Respiratoire à Domicile : une personne, un accompagnement

« aller vers…. »

Les déterminants de la Santé

5 niveaux



DAHLGREN, Göran and WHITEHEAD, Margaret, 1991, Policies and Strategies to promote social equity in health. Institute of Future Studies. Stockholm (traduction)

1 Facteurs liés au **genre,** âge et constitution

2 **Facteurs liés au style de vie personnel** : **tabagisme, alcool, alimentation, activités physiques**….

3 Réseaux sociaux et communautaires : influences sociales et collectives (présence ou non d'un soutien mutuel **(aidant et/ou conjoint)** dans certaines situations…).

4 **Conditions de vie et de travail** : **accès au** travail, conditions de travail, **service de santé**, nourriture, **éducation.**

5 **Conditions socio économiques, culturelles et environnementales**

Dahlgren G, Whitehead M, 1991
Policies and strategies to promote social equity in health
Stockholm, Institute for Future Studies.

Socioeconomic deprivation and the outcome of pulmonary rehabilitation in England and Wales

Michael C Steiner,[1] Derek Lowe,[2] Katy Beckford,[3] John Blakey,[4] Charlotte E Bolton,[5] Sarah Elkin,[6] William D -C Man,[7,8] C Michael Roberts,[9] Louise Sewell,[10] Paul Walker,[11] Sally J Singh[1]

Thorax 2017:**0**:1–8.

210 programmes de RR

7413 patients

What is the bottom line?

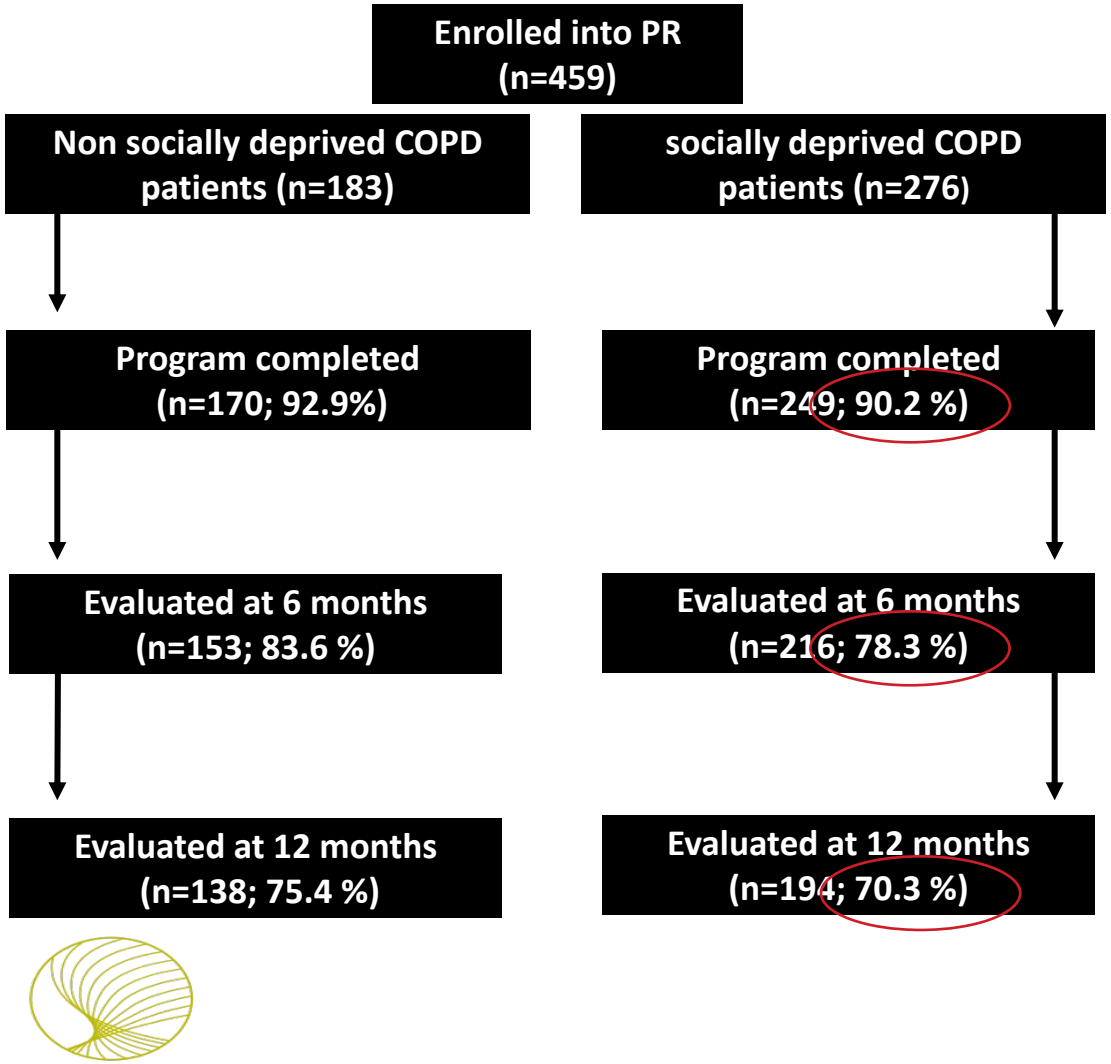
- Using data from the national audit of PR clinical outcomes in England and Wales, we demonstrate that patients living in more socially deprived areas are less likely to complete a programme of PR, but clinical outcomes in those who do finish treatment are similar to those referred from less deprived areas.

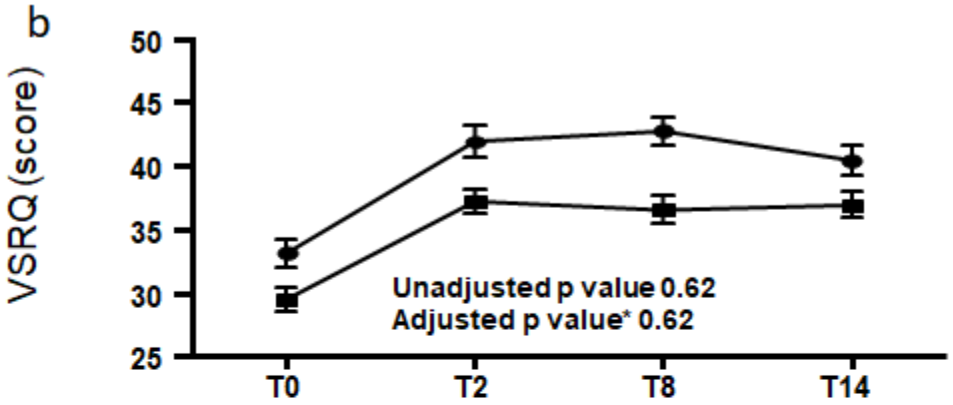
Influence Of Socioeconomic Deprivation On Short- And Long-Term Outcomes Of Home-Based Pulmonary Rehabilitation In Patients With Chronic Obstructive Pulmonary Disease

JMGrosbois, J Heluain Robiquet, F Machuron,

G Terce, C Chenivesse, B Wallaert, O Le Rouzic

IJCOPD 2019;14:2441-2449





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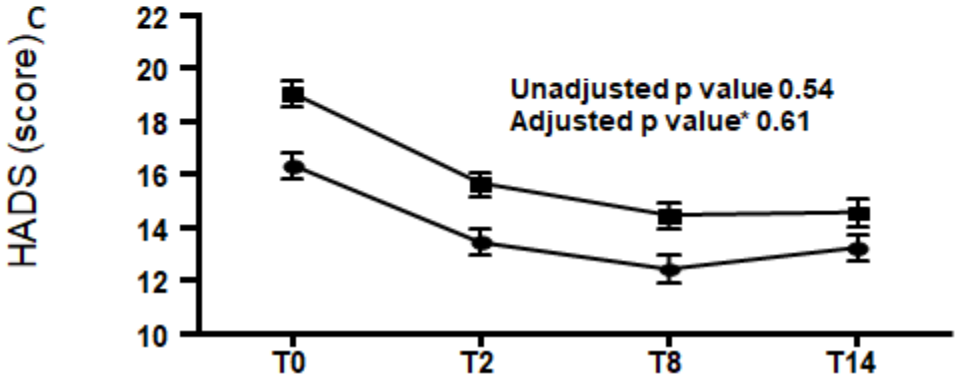

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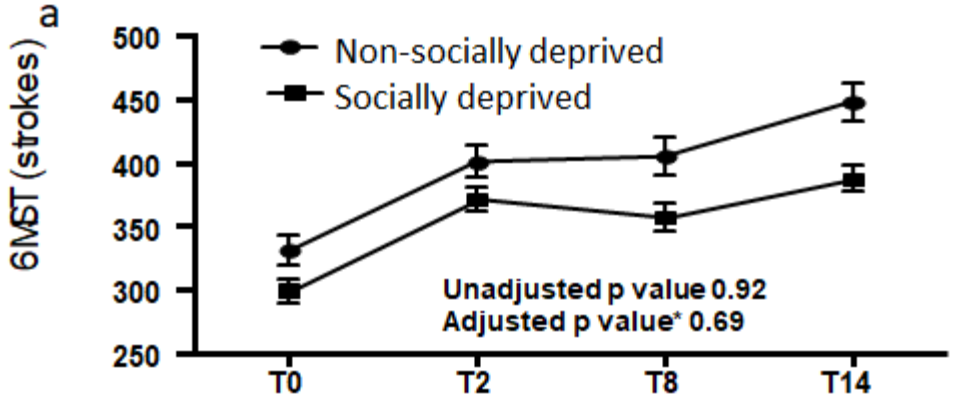

TS6

La Réadaptation Respiratoire à Domicile : une personne, un accompagnement

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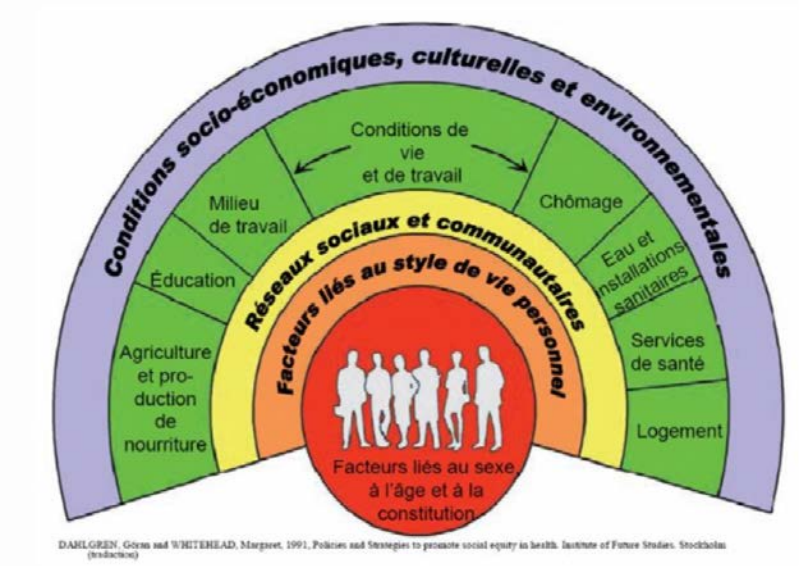

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Experiences of Living and Dying With COPD: A Systematic Review and Synthesis of the Qualitative Empirical Literature

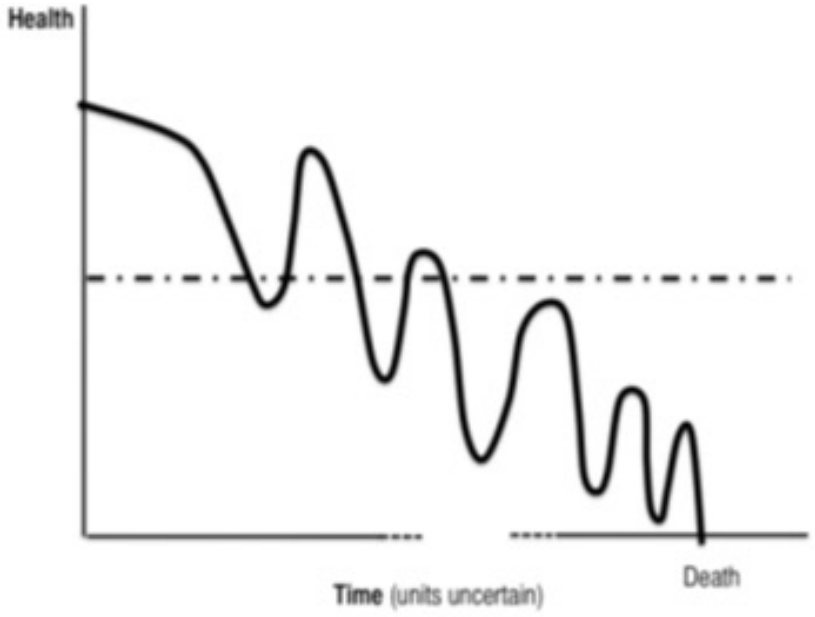
M Giacomini, D DeJean, D Simeonov, A Smith

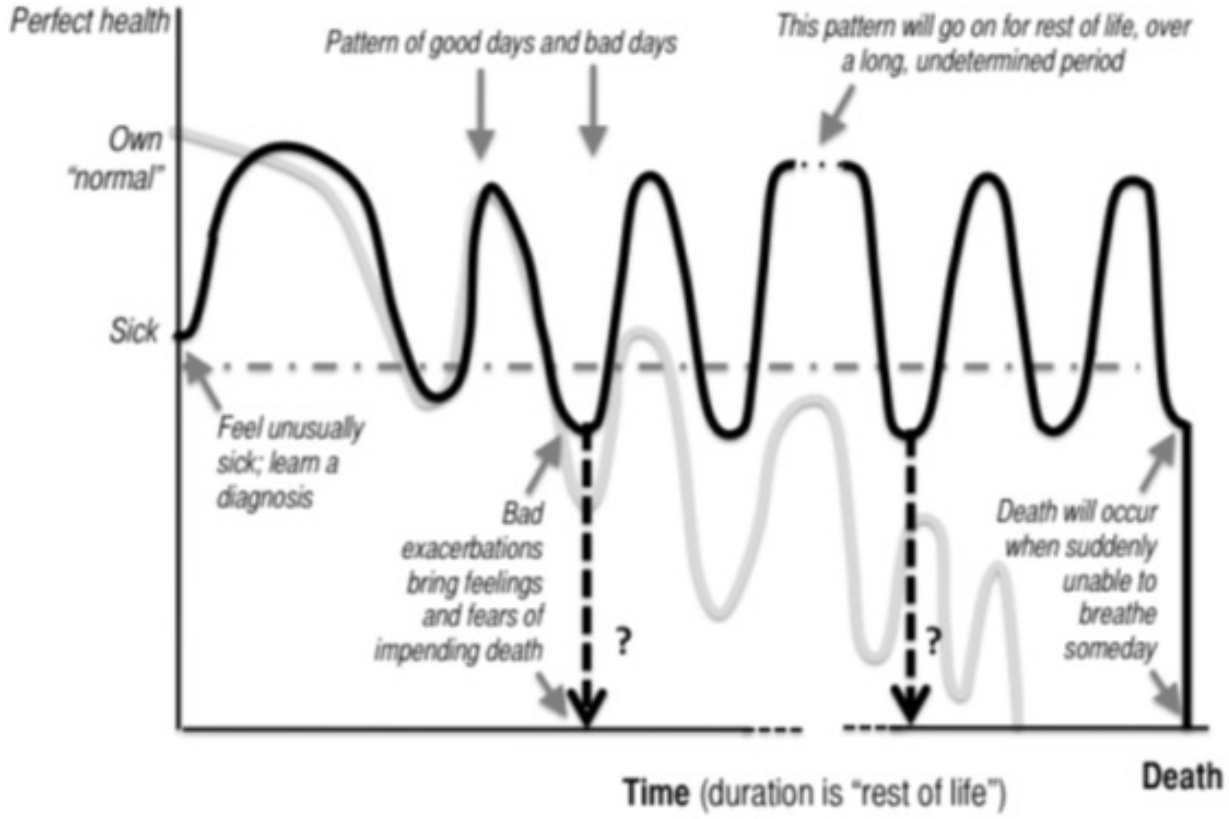
Ontario Health Technology Assessment Series; Vol. 12: No. 13, pp. 1–47, March 2012

Experiences of Carers

Vision de l'aidant

- Carers' challenges often echo patients' challenges, and include anxiety, uncertainty about the future, helplessness, powerlessness, depression, difficulties maintaining employment, loss of mobility and freedoms, strained relationships, and growing social isolation.





Vision du soignant

Vision du patient

Improving the wellbeing of caregivers of patients with COPD using a home-based pulmonary rehabilitation programme

Jean-Marie Grosbois[1], Sarah Gephine[2], Maeva Kyheng[3], Olivier Le Rouzic[4,5] and Cécile Chenivesse[4,5]

ERJ Open Res 2022; 8: 00255-2022

Aidants

° HAD (Hospital Anxiety Depression)

anxiety (score ≥ 11) = 46%

depression (score ≥ 11) = 11.6%

° FAS (Fatigue Assessment Score)

Fatigue (score ≥ 22) = 44.2%

° Zarit (Fardeau)

Fardeau (score > 24) = 34.8%

Assessments	Baseline M0	End of PR M2	ΔM2 – M0	p-value
Informal caregivers N=138				
Anxiety symptoms	9.5 (4.7)	8.5 (4.9)	-0.9 (3.5)	0.006
Depressive symptoms	5.2 (4.1)	4.3 (3.5)	-0.6 (3.1)	0.047
FAS, score	21.9 (7.7)	20.1 (7.2)	-1.4 (6.6)	0.026
ZBI, score	21.6 (15.1)	18.9 (15)	-2.5 (11.4)	0.024
Patients N=241				
Anxiety symptoms	9.5 (4.7)	8.0 (4.2)	-1.5 (3.6)	<0.001
Depressive symptoms	8.0 (3.9)	5.8 (4.0)	-2.0 (3.4)	<0.001
FAS, score	27.7 (8.2)	22.7 (7.4)	-4.6 (7.0)	<0.001
mMRC, score	3.0 (1.1)	2.4 (1.2)	-0.5 (0.8)	<0.001
CCQ, total score	3.1 (1.1)	2.3 (1.1)	-0.7 (0.8)	<0.001
6MST, strokes	302 (157)	398 (172)	83 (61)	<0.001

BPCO avec un aidant :
amélioration plus importante de l'Anxiété et Fatigue

15es JOURNÉES FRANCOPHONES Alvéole

Réadaptation respiratoire : en centre, à Domicile, en Hybride

une personne, un accompagnement

Exacerbation aiguë de BPCO : le moment pour changer.

Mais aussi

GOLD 3 et 4, GOLD 2 avec comorbidités

Appareillage (OLD, VNI)

Dyspnée invalidante (mMRC 2)

Péri opératoire

…….

Et les autres MRC…