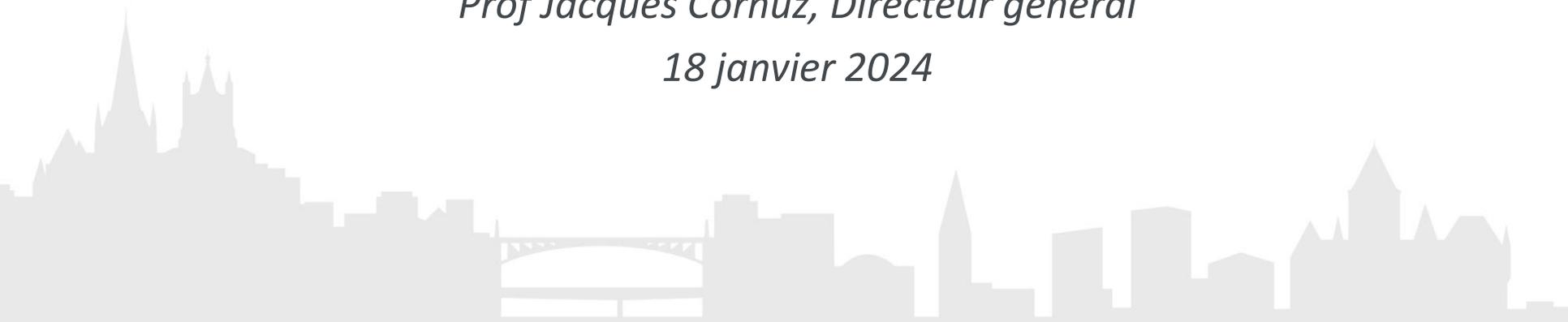


Jeudi d'Unisanté Rétrospective 2023

Prof Jacques Cornuz, Directeur général

18 janvier 2024



Plan

- Introduction
- De l'observation à ...
- ... l'expérimentation
- ... la modélisation
- ... la généralisation
- ... la réflexion
- ... la décision
- ... la conclusion et ... la discussion!

Plan

- Introduction
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Introduction

- Données de la littérature scientifique médicale 2023
- Participation à certains congrès et colloques
- Contact avec de nombreux collègues: S. Monod, V. D'Acremont, D. Nanchen, A. Gouveia, K. Selby, D. Vernez, I. Locatelli, S. Dunet.
- Quelques petits quiz!
- Dias parfois en anglais
- Subjectivité +++: «On ne se refait pas»!
- Pas de conflits d'intérêt et pas d'aide de ...Chat GPT!

Plan

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Major Update: Masks for Prevention of SARS-CoV-2 in Health Care and Community Settings—Final Update of a Living, Rapid Review

Roger Chou, MD; and Tracy Dana, MLS

[Ann Intern Med](#) 2023



Masque et Covid-19 – R. Chou, Annals 2023

Revue sur l'impact-efficacité selon le degré de preuve

Strength of evidence

- Moderate
- ◆ Low
- Insufficient

Direction of effect

	Favors intervention A
	Effects similar or no difference
	No or too little evidence to determine

RCT = randomized controlled trial.

* N95 or equivalent/similar respirators (for example, P2, FFP2, FFP3).

Figure 2. Masks for prevention of SARS-CoV-2 evidence map.

Comparison	Number and Types of Studies	Strength of Evidence, Direction of Effect
Community setting		
Mask (any or unspecified) vs. no mask in household contacts and other community settings	2 RCTs (13, 14) and 7 observational studies (16, 25, 26, 29, 33, 34, 36)	◆/●
N95* vs. surgical mask in household contacts and other community settings	1 observational study (16)	■
N95* vs. no mask in household contacts and other community settings	1 observational study (16)	■
Surgical mask vs. no mask in household contacts and other community settings	2 RCTs (13, 14) and 2 observational studies (16, 25)	◆
Cloth mask vs. no mask in household contacts and other community settings†	1 RCT (13) and 2 observational studies (16, 25)	■
Surgical vs. cloth mask in household contacts and other community settings	1 RCT (13) and 1 observational study (16)	◆
Consistent/always mask use vs. inconsistent mask use	6 observational studies (16, 17, 22, 24, 25, 36)	■
Health care setting		
Mask (any or unspecified type) vs. no mask	4 observational studies (20, 21, 31, 35)	■
N95* vs. no mask	3 observational studies (21, 32, 35)	■
Surgical mask vs. no mask	1 observational study (35)	■
Consistent/always mask use vs. inconsistent mask use	5 observational studies (15, 19, 23, 28, 30)	■
N95 vs. surgical mask	1 RCT (4) and 4 observational studies (18, 19, 27, 31)	◆

Strength of evidence

- Moderate
- ◆ Low
- Insufficient

Direction of effect

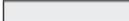
-  Favors intervention A
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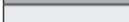
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Masque et Covid-19 – R. Chou, Annals 2023

I

Conclusion: Updated evidence suggests that masks may be associated with a small reduction in risk for SARS-CoV-2 infection in community settings. Surgical masks and N95 respirators may be associated with similar infection risk in routine patient care settings, but a beneficial effect of N95 respirators cannot be ruled out.

Update britannique 2023

[Home](#) > [COVID-19](#) > [Health and wellbeing during COVID-19](#) > [Face coverings and COVID-19: statement from an expert panel](#)



[UK Health](#)
[Security](#)
[Agency](#)



Research and analysis

The role of face coverings in mitigating the transmission of SARS-CoV-2 virus: statement from the Respiratory Evidence Panel (2021)

Updated 30 March 2023

Update britannique 2023

- Transmission par voie aérienne au-delà de **2 mètres** possible (degré de confiance élevé)
- **Facteurs contributifs** à la transmission du SARS-CoV-2
 - environnements mal ventilés
 - exposition prolongée
 - activités susceptibles de générer plus d'aérosols
 - charge virale élevée
 - maladie symptomatique précoce (degré moyen)
- **Ventilation efficace** devrait être utilisée pour réduire l'exposition en suspension dans l'air au-delà de 2 mètres (degré élevé)

Update britannique 2023

- Les données de laboratoire montrent que les masques non médicaux (tels que les masques en tissu) composés de 2 ou 3 couches peuvent avoir une efficacité de filtration similaire à celle des masques chirurgicaux (degré de confiance élevé)

les données probantes suggèrent que tous les types de couvre-visages sont, dans une certaine mesure, efficaces pour réduire la transmission du SRAS-CoV-2 dans les établissements de soins de santé et les milieux publics et communautaires

Masque et Covid-19 – R. Chou, Annals 2023

I

Conclusion: Updated evidence suggests that masks may be associated with a small reduction in risk for SARS-CoV-2 infection in community settings. Surgical masks and N95 respirators may be associated with similar infection risk in routine patient care settings, but a beneficial effect of N95 respirators cannot be ruled out.

Cohortes populationnelles

Cohortes populationnelles

- Framingham (1949), USA 5'200
- Whitehall (1967), UK 19'000
- Nurses Health study (1976), USA 121'000

- Et maintenant?
- NaKo, Allemagne 200'000
- UK Biobank, GB 500'000
- CH: Swiss Health Cohort? 100'000?

- UK Biobank dataset
- 500'000 sujets
- 32'000 participants (origine européenne) avec un examen IRM !
- 65 ans, 44% de femmes



Biological Psychiatry Global Open Science

Volume 4, Issue 1, January 2024, Pages 74-82



Archival Report

Investigating the Relationship Between Smoking Behavior and Global Brain Volume

Yoonhoo Chang^a, Vera Thornton^a, Ariya Chaloemtoem^a, Andrey P. Anokhin^a,

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Yoonhoo Chang[□], Vera Thornton[□], Ariya Chaloemtoem[□], Andrey P. Anokhin[□]

UK Biobank data shows dose-dependent link between smoking and brain shrinkage

UK Biobank 2023

Table 2. Effect Size and p Value for Total Brain Measures With the Smoking Phenotypes

Brain Measures	Effect Size	SE	t_{53}	p Value
History of Daily Smoking, $N = 32,094$				
Volume of brain	-3,360.95	605.39	-5.55	2.85×10^{-8}
Volume of gray matter	-2,964.18	360.42	-8.22	2.04×10^{-16}
Volume of white matter	-801.74	403.24	-1.99	4.68×10^{-2}
Volume of cerebrospinal fluid	4.93	3.03	1.63	.10
Number of Pack Years of Smoking, $n = 8622$				
Volume of brain	-128.75	33.52	-3.84	1.23×10^{-4}
Volume of gray matter	-83.87	20.17	-4.16	3.25×10^{-5}
Volume of white matter	-63.61	22.28	-2.85	4.32×10^{-3}
Volume of cerebrospinal fluid	0.29	0.17	1.68	.09
Time Since Smoking Cessation, $n = 8111$				
Volume of brain	-5.01	57.08	-0.09	.93
Volume of gray matter	9.86	34.39	0.29	.77
Volume of white matter	15.64	38.04	0.41	.68
Volume of cerebrospinal fluid	-0.55	0.29	-1.89	.06

UK Biobank 2023

- Tabagisme: associé (après ajustement) à un volume de cerveau plus ... petit!
 - de 3,4 cm³ en moyenne
 - 3 cm³ de matière grise
 - Rappel: taille moyenne 900-1200 cm³
- Relation dose-réponse entre le nombre de paquets-années et la taille du cerveau : chaque paquet-année est associé à une taille de cerveau de 0.13 cm³ plus petite en moyenne
- Arrêter de fumer ne fait pas retrouver la taille de cerveau perdue (!)

UK Biobank 2023

- Analyse sur un score génétique: l'effet causal se fait dans le sens

Tabagisme \longrightarrow rétrécissement du cerveau

et non pas l'inverse

petite taille de cerveau \longrightarrow tabagisme !

Observation via un *matching*

Cigarette smoking in childhood and risk of all-cause and cause-specific mortality in adulthood

Xue Liu¹, Jiahong Sun¹, Min Zhao², Pascal Bovet³ and Bo Xi^{1*}

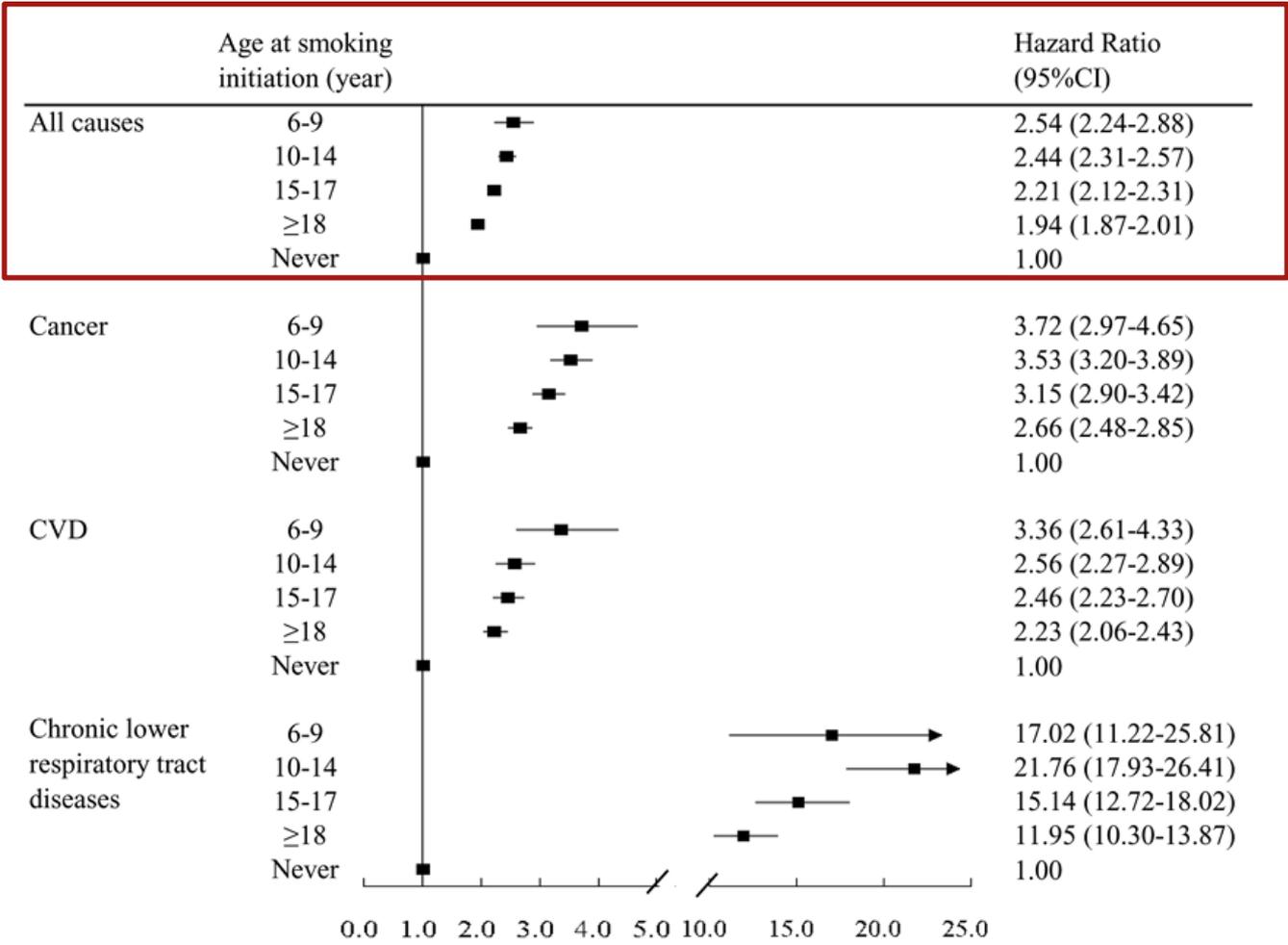
Frontiers in Public Health 2023

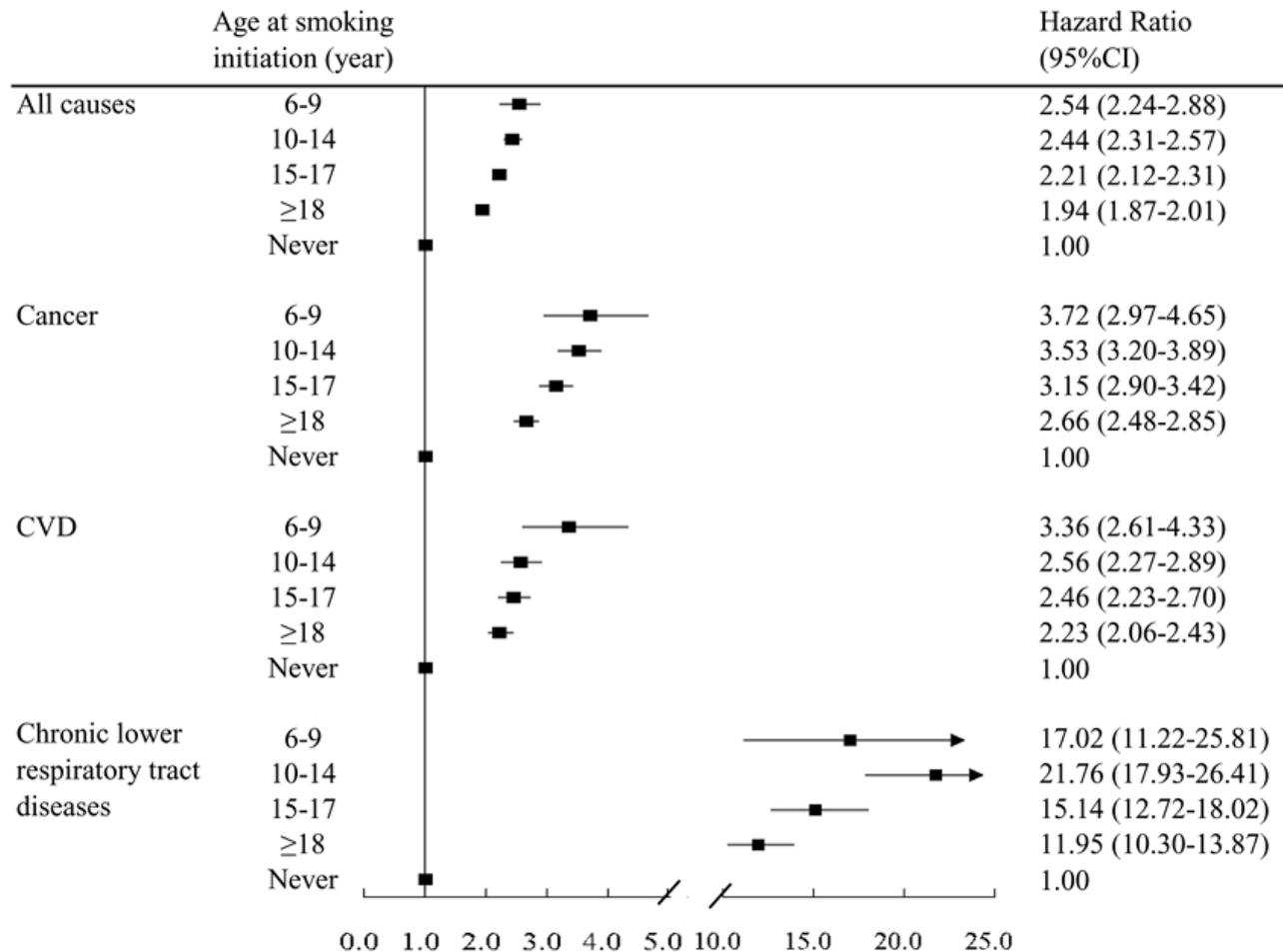
Observation via un *matching*

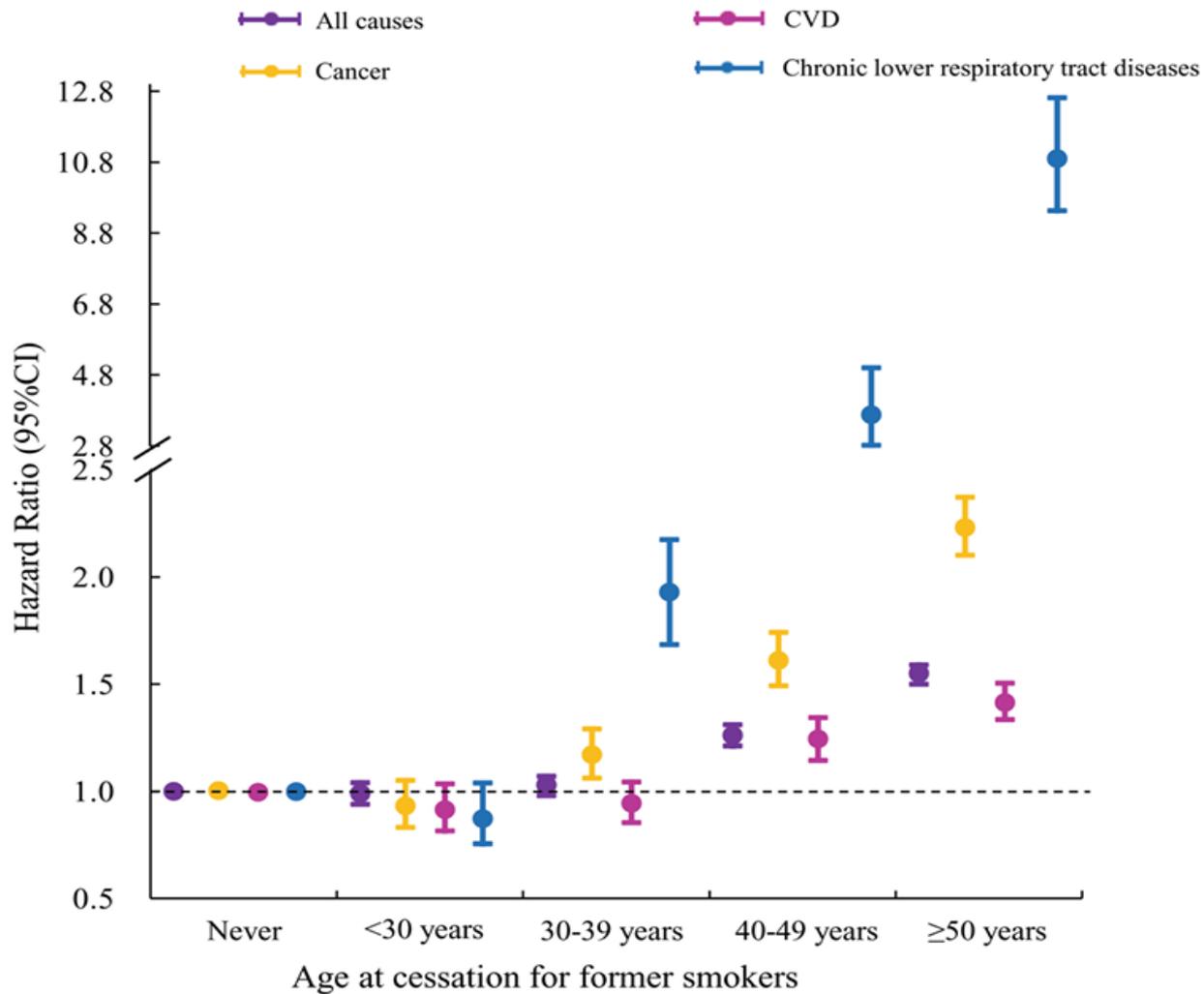
- Matching de deux bases de données: US national Health Interview National Death Index
- 472'000 sujets: 99'000 fumeurs et 101'000 ex-fumeurs
- Age de l'initiation du tabagisme:
 - 6-9 ans!
 - 10-14 ans
 - 15-17 ans
 - ≥ 18 ans

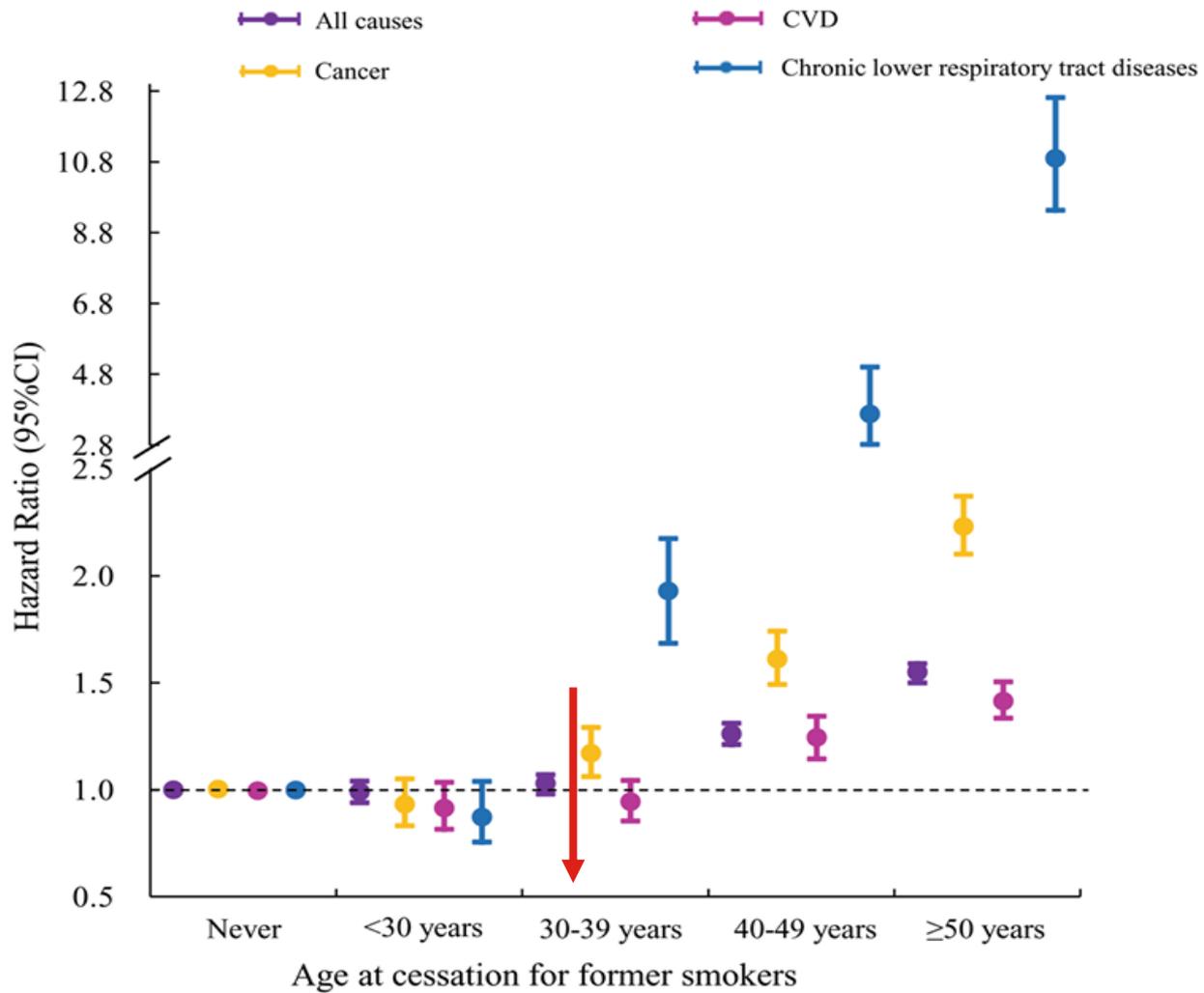
Observation via un *matching*

- Matching de deux bases de données: US national Health Interview National Death Index
- 472'000 sujets: 99'000 fumeurs et 101'000 ex-fumeurs
- Age de l'initiation du tabagisme:
 - 6-9 ans 1460
 - 10-14 ans 15'000
 - 15-17 ans 34'000
 - ≥ 18 ans 49'000









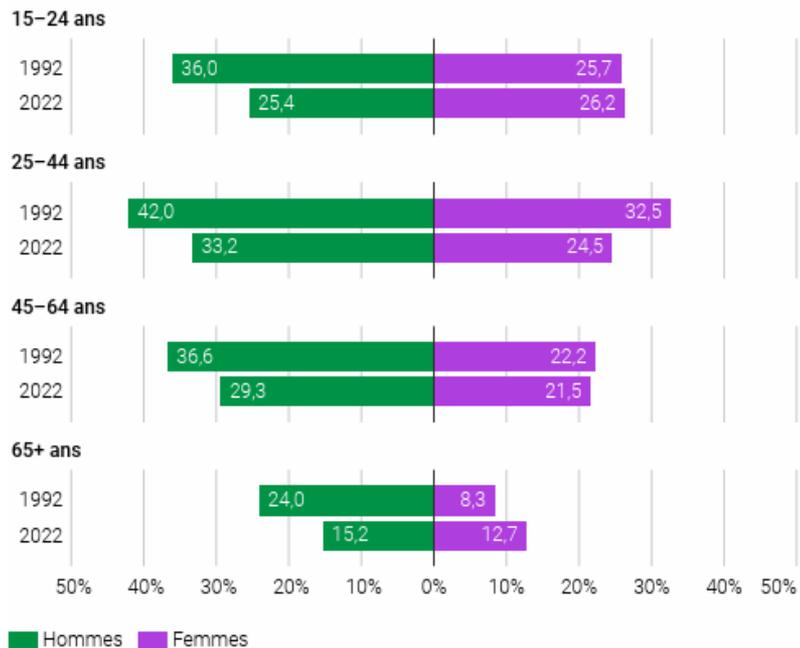
Tabagisme: où en est-on en Suisse en 2023-2024?

Tabagisme en Suisse

Consommation de tabac

Population de 15 ans et plus vivant en ménage privé

G19



OFSP 2023

Pourquoi?

Ranked 79th
in a survey of 80 countries.

Switzerland - a Non-Party to the FCTC, Has No Rules to Halt Tobacco Industry Interference

TOBACCO CONTROL SCALE 2021

How does your country rate on tobacco control?

2021 Rank	Country	2019 Rank	Score
1	Ireland	▲ 3	82
1	UK	— 1	81
3	France	▼ 2	79
4	Netherlands	▲ 14	67
5	Hungary	▲ 8	65
6	Norway	▼ 5	63
7	Finland	▼ 6	60
8	Iceland	▼ 4	59
8	Romania	▲ 12	61
10	Belgium	— 10	59
11	Spain	▼ 10	58
12	Turkey	▲ 17	58
13	Denmark	▲ 29	56
14	Israel	▼ 7	55
14	Greece	▼ 13	55
14	Malta	▲ 17	55
17	Slovenia	▼ 8	54
18	Italy	▼ 15	52
18	Russian Federation	▲ 29	52
18	Lithuania	▲ 29	52
21	Czechia	▲ 23	49
21	Estonia	▲ 23	49
21	Poland	▲ 23	49
21	Sweden	▼ 15	49
21	Croatia	▼ 17	49
26	Latvia	▼ 23	48
26	Austria	▼ 20	48
28	Cyprus	▼ 27	47
28	Luxembourg	▲ 34	47
30	Portugal	▼ 20	46
30	Slovakia	▲ 32	46
30	Ukraine	▼ 20	46
33	Bulgaria	▼ 27	44
34	Germany	▲ 36	42
35	Serbia	▼ 33	39
36	Switzerland	▼ 35	38
37	Bosnia & Herzegovina	(new)	38

Joussens L, Olfelt L, Felix A, Femenand E. The Tobacco Control Scale 2021 in Europe. European Smoke Free Partnership, Catalan Institute of Oncology 2022. Available at: www.tobaccocontrolscale.org/TCS2021

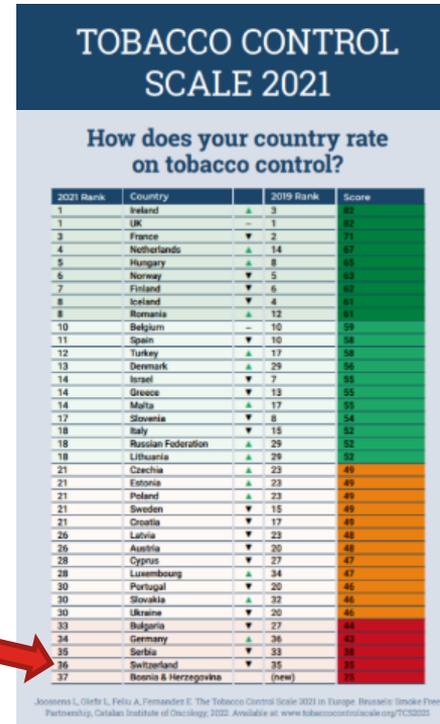
Tobacco Control Scale 2021 in Europe,
www.tobaccocontrolscale.org

Contexte suisse

- *Tobacco Control Scale* : 36^e/37
- Réglementation fédérale faible, publicité abondante
- Ingérence de l'industrie

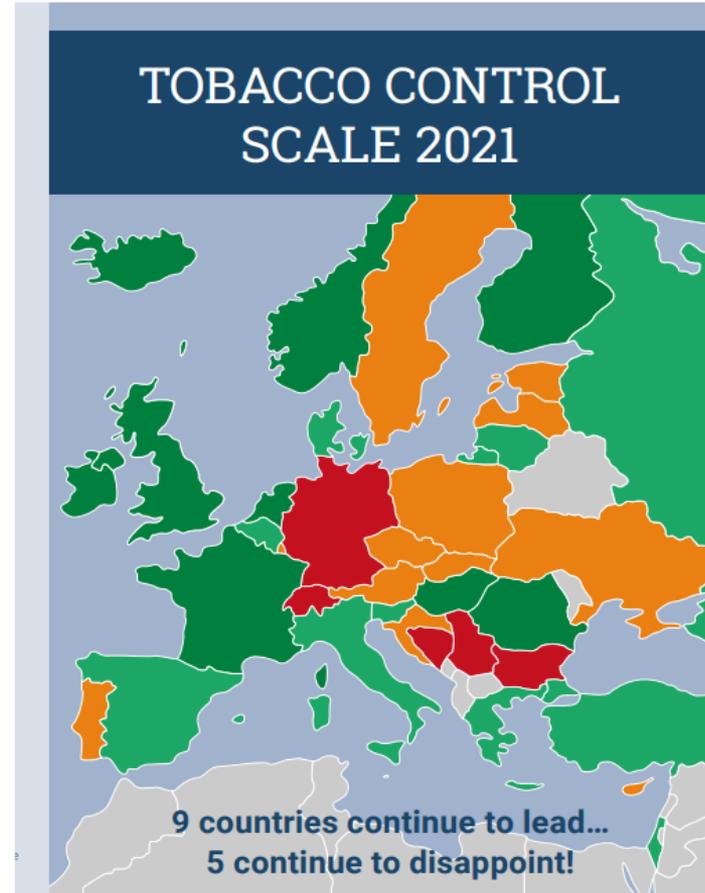
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Tobacco Control Scale 2021 in Europe,
www.tobaccocontrolscale.org

Classement européen



Contexte suisse



Densité très forte des points de vente des produits du tabac :

- Densité 10 fois plus forte qu'en France
- ~ 14'000 points de vente (supermarchés, stations-services, kiosques, shops, etc.)
- ~ 18'000 distributeurs automatiques



Why did Swiss citizens vote to ban tobacco advertising?

Luc Lebon ,¹ Pascal Diethelm,² Valentine Ballmer,¹ Hugo Molineaux,²
Karin Zürcher,¹ Jacques Cornuz¹

Tob Control 2023;**0**:1–6. doi:10.1136/tc-2023-057986



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Tobacco Control 1996;**5**:149–153

14

SPECIAL COMMUNICATION

Why did Swiss citizens refuse to ban tobacco advertising?

Jacques Cornuz, Bernard Burnand, Ichiro Kawachi, Felix Gutzwiller, Fred Paccaud

Initiative « Enfants et jeunes sans tabac »

B



A

**Aujourd'hui
le tabac!**
**Demain
le cervelas?**



NON

à l'initiative extrême
contre la publicité

interdiction-publicite-non.ch

B

**Enfants
sans tabac**

OUI

le 13 février

La publicité pour le tabac
pousse les enfants à fumer.

unisanté

Centre universitaire de médecine générale
et santé publique - Lausanne

Plan

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Conseils

- Un de vos patient, âgé de 73 ans, va être hospitalisé pour une operation élektive
- Que lui recommandez-vous de prendre avec lui avant de quitter son domicile?

Conseils

- Un de vos patient, âgé de 73 ans, va être hospitalisé pour une operation elective
- Que lui recommandez-vous de prendre avec lui avant de quitter son domicile?



L'OFSP	Vivre en bonne santé	Maladies	Médecine & recherche	Assurances	Stratégie & politique	Professions de la santé	Lois & autorisations	Chiffres & statistiques	
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Office fédéral de la santé publique OFSP > L'OFSP > Actualités > Communiqués de presse > En Suisse, 6 % des patients contractent une infection à l'hôpital

< L'OFSP

< [Retour au sommaire](#)



Actualités

Communiqués de presse

A la une

En Suisse, 6 % des patients contractent une infection à l'hôpital

SWISSNOSC

National Center
for Infection Control

Swissnoso Annual Report

Epidemiology of healthcare-associated infections in Switzerland 2022

September 2023

JAMA Internal Medicine | [Original Investigation](#)

Association Between Daily Toothbrushing and Hospital-Acquired Pneumonia

A Systematic Review and Meta-Analysis

Selina Ehrenzeller, MD; Michael Klompas, MD, MPH

- 15 RCT
- 10'742 patients
- Hospitalisés dans les SI et/ou dans les services (à l'étage!)

Figure 2. Risk of Bias Summary

Random sequence generation (selection bias)	+	+	+	+	+	+	?	+	+	+	+	+	+	+	+
Allocation concealment (selection bias)	+	+	+	+	+	+	?	+	?	+	+	+	+	+	+
Blinding of participants and personnel (performance bias)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Blinding of outcome assessment (detection bias)	+	?	+	+	+	+	?	?	?	?	+	+	+	+	+
Incomplete outcome data (attrition bias)	+	?	?	+	-	+	+	?	-	+	+	+	+	+	+
Selective reporting (reporting bias)	+	+	?	+	+	+	+	+	+	+	+	+	+	+	+
Other bias ^a			-							?		-			
	Yao et al, 44 2011	Singh et al, 43 2022	Salarzehi et al, 32 2021	Pobo et al, 46 2009	Nasiriani et al, 40 2016	Lorente et al, 45 2012	Long et al, 50 2012	Khan et al, 49 2017	Gong et al, 31 2018	Giuliano et al, 47 2021	Félix, 51 2016	Falahinia et al, 39 2016	de Lacerda Vidal et al, 41 2017	Chacko et al, 44 2017	Bellissimo-Rodrigues et al, 42 2014

Green plus signs indicate low risk of bias; yellow question marks, unclear risk of bias; and red minus signs, high risk of bias.

Source	Experimental group		Control group		RR (95% CI)	Weight, %
	No. of events	No. of patients	No. of events	No. of patients		
1.1.1 VAP						
Bellissimo-Rodrigues et al, ⁴² 2014	8	98	17	96	0.46 (0.21-1.02)	5.3
Chacko et al, ⁴⁴ 2017	5	104	7	102	0.70 (0.23-2.14)	2.7
de Lacerda Vidal et al, ⁴¹ 2017	17	105	28	108	0.62 (0.36-1.07)	11.5
Falahinia et al, ³⁹ 2016	19	34	21	34	0.90 (0.61-1.35)	21.0
Félix, ⁵¹ 2016	1	30	3	28	0.31 (0.03-2.82)	0.7
Gong et al, ³¹ 2018	9	40	13	40	0.69 (0.33-1.43)	6.3
Khan et al, ⁴⁹ 2017	0	4	1	5	0.40 (0.02-7.82)	0.4
Lorente et al, ⁴⁵ 2012	21	217	24	219	0.88 (0.51-1.54)	10.8
Pobo et al, ⁴⁶ 2009	15	74	18	73	0.82 (0.45-1.50)	9.1
Salarzahi et al, ³² 2021	1	30	5	30	0.20 (0.02-1.61)	0.8
Singh et al, ⁴³ 2022	32	110	52	110	0.62 (0.43-0.88)	26.9
Yao et al, ⁴⁴ 2011	4	28	14	25	0.26 (0.10-0.67)	3.5
Subtotal	132	874	203	870	0.68 (0.57-0.82)	99.0

Heterogeneity: $\tau^2 = 0.00$; $\chi^2_{11} = 10.37$ ($P = .50$); $I^2 = 0\%$
 Test for overall effect: $z = 4.13$ ($P < .001$)

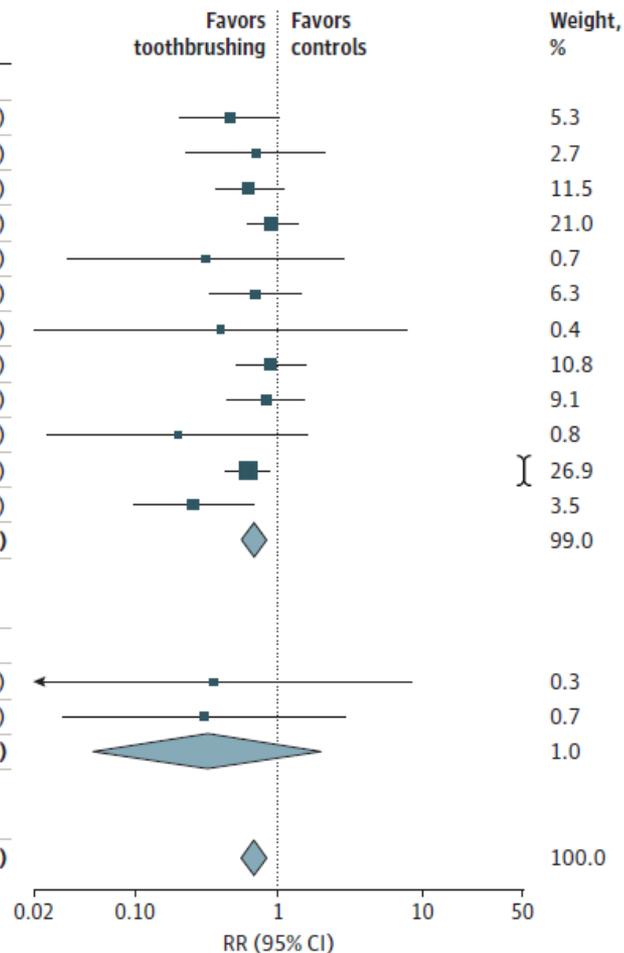
1.1.2 NV-HAP

Bellissimo-Rodrigues et al, ⁴² 2014	0	29	1	31	0.36 (0.02-8.39)	0.3
Giuliano et al, ⁴⁷ 2021	1	393	3	360	0.31 (0.03-2.92)	0.7
Subtotal	1	422	4	391	0.32 (0.05-2.02)	1.0

Heterogeneity: $\tau^2 = 0.00$; $\chi^2_1 = 0.01$ ($P = .94$); $I^2 = 0\%$
 Test for overall effect: $z = 1.21$ ($P = .23$)

Total	133	1296	207	1261	0.67 (0.56-0.81)	100.0
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Heterogeneity: $\tau^2 = 0.00$; $\chi^2_{13} = 11.01$ ($P = .61$); $I^2 = 0\%$
 Test for overall effect: $z = 4.23$ ($P < .001$)
 Test for subgroup differences: $\chi^2_1 = 0.63$ ($P = .43$); $I^2 = 0\%$



Source	Experimental group		Control group		RR (95% CI)	Weight, %
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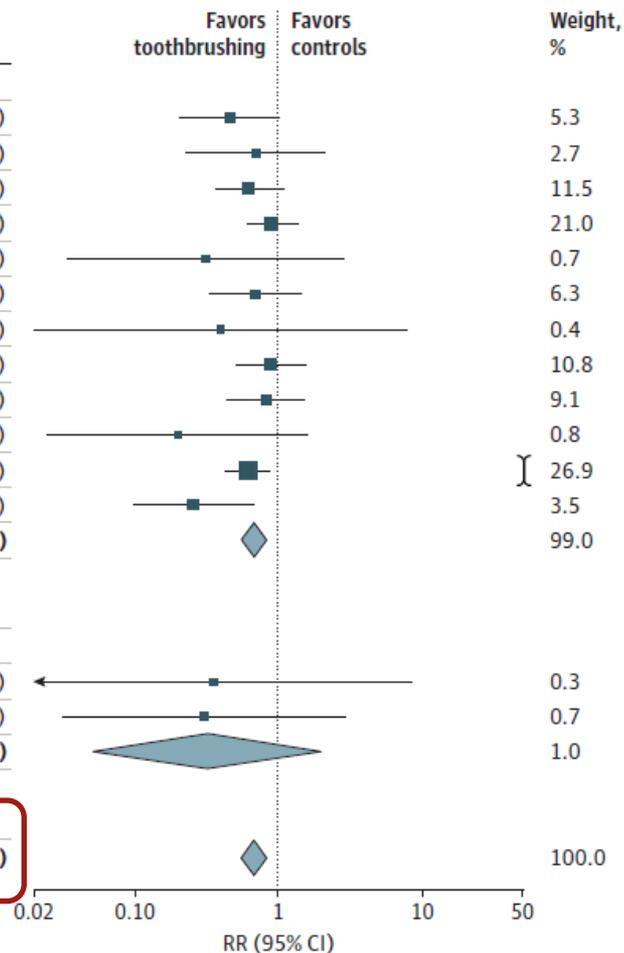
1.1.2 NV-HAP

Bellissimo-Rodrigues et al, ⁴² 2014	0	29	1	31	0.36 (0.02-8.39)	0.3
Giuliano et al, ⁴⁷ 2021	1	393	3	360	0.31 (0.03-2.92)	0.7
Subtotal	1	422	4	391	0.32 (0.05-2.02)	1.0

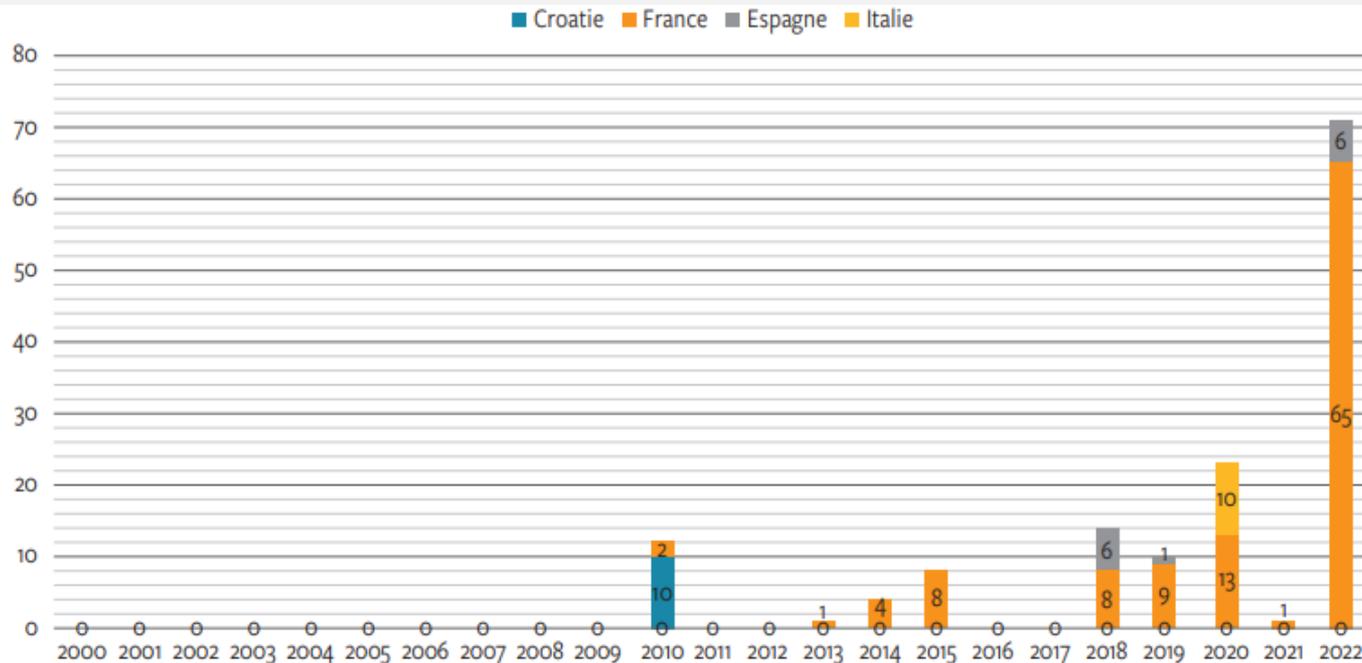
Heterogeneity: $\tau^2 = 0.00$; $\chi^2_1 = 0.01$ ($P = .94$); $I^2 = 0\%$
 Test for overall effect: $z = 1.21$ ($P = .23$)

Total	133	1296	207	1261	0.67 (0.56-0.81)	100.0
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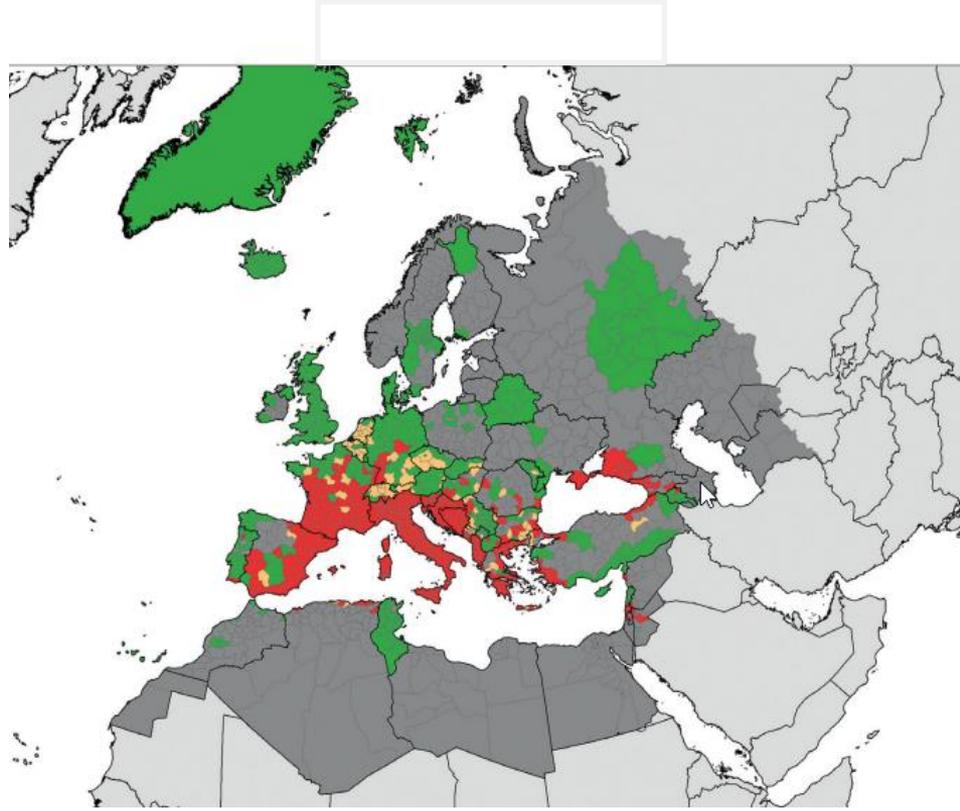
Heterogeneity: $\tau^2 = 0.00$; $\chi^2_{13} = 11.01$ ($P = .61$); $I^2 = 0\%$
 Test for overall effect: $z = 4.23$ ($P < .001$)
 Test for subgroup differences: $\chi^2_1 = 0.63$ ($P = .43$); $I^2 = 0\%$



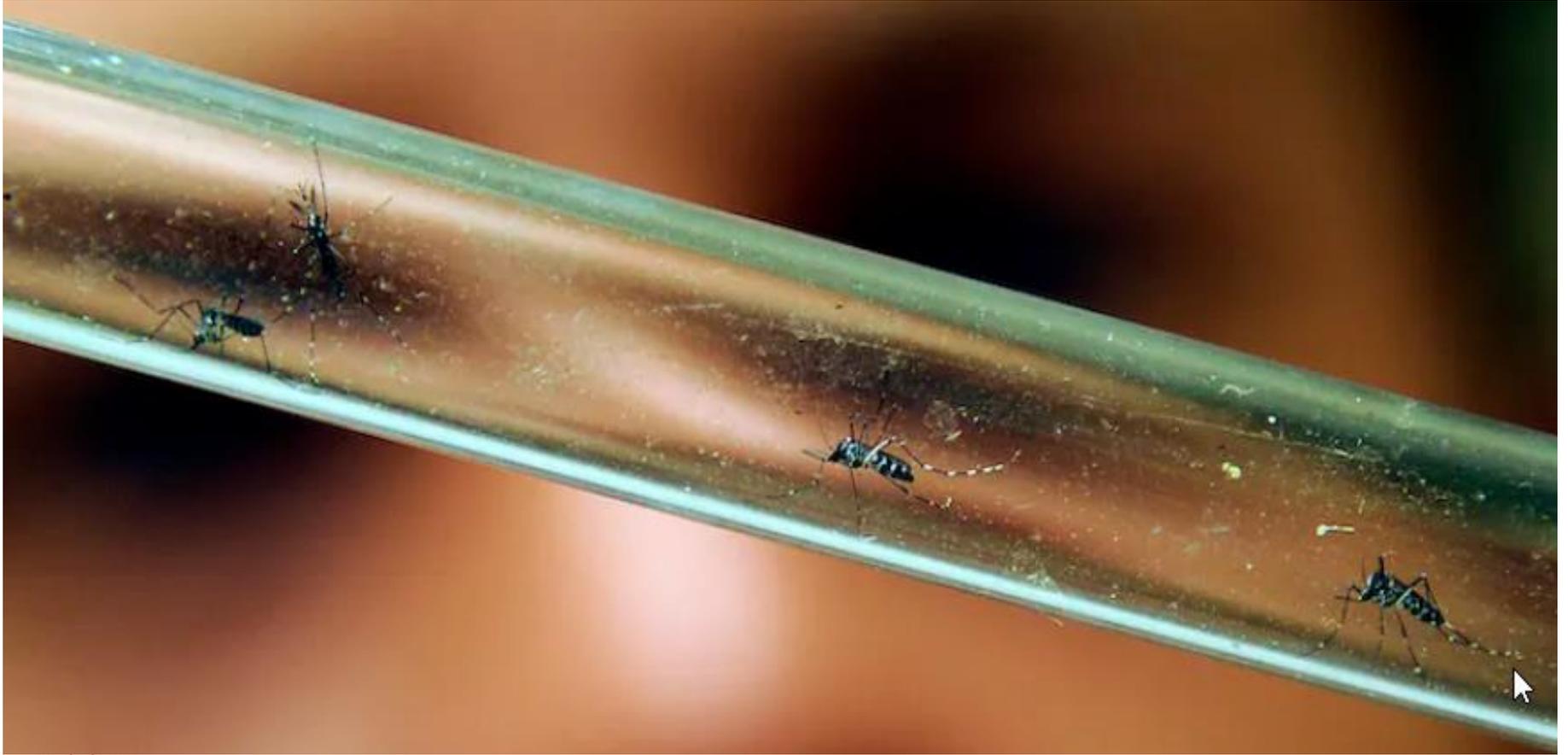
De quelle maladie est-il question?



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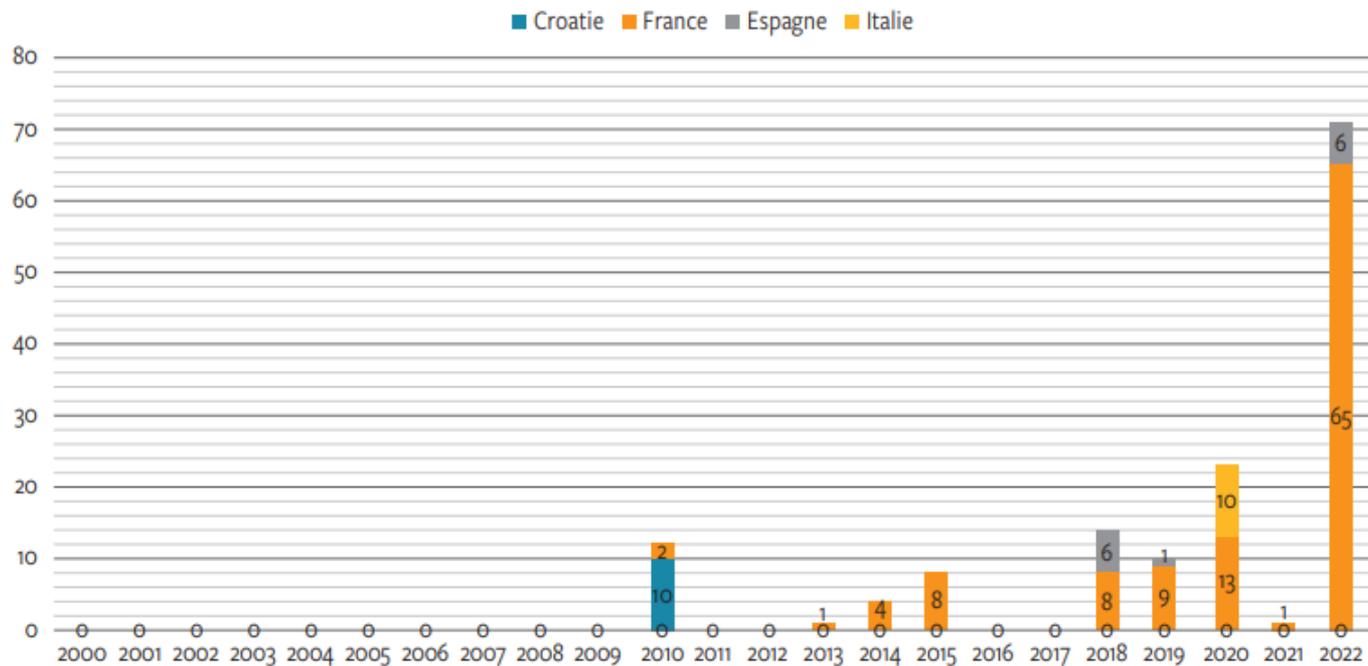
De quelle maladie est-il question?



Dengue en Europe

FIG 5

Nombre de cas confirmés de dengue autochtone en Europe continentale (2000-2022)⁹



THE CONVERSATION

Academic rigour, journalistic flair

Virus de la dengue en France métropolitaine : à quoi faut-il s'attendre cette année ?

Published: July 19, 2023 9.12pm CEST • Updated: July 22, 2023 9.24am CEST

Safety and immunogenicity of a synthetic nanoparticle-based, T cell priming peptide vaccine against dengue in healthy adults in Switzerland: a double-blind, randomized, vehicle-controlled, phase 1 study

Alix Miauton,^{a,} Régine Audran,^b Juliette Besson,^a Hélène Maby-El Hajjami,^c Maxime Karlen,^a Loane Warpelin-Decrausaz,^{c,d} Loredana Sene,^c Sylvain Schaufelberger,^e Vincent Faivre,^e Mohamed Faouzi,^f Mary-Anne Hartley,^a François Spertini,^b and Blaise Genton^a*

Lancet 2023

Vaccin contre la dengue – étude Unisanté

Contexte

- 2 vaccins vivants atténués induisent des anticorps.
- Risque d'augmenter la sévérité de la maladie lors du contact avec le virus: mécanisme de facilitation de l'infection par des anticorps.

Nouvelle approche (Emergex PepGNP– injection sous cutané)

- Principe: Immunité cellulaire, sans stimulation humorale.
- Composé d'un nanodosage de fragments synthétiques du virus, fusionnés à des nanoparticules d'or.
- Cible: lympho T (immunité cellulaire), pour éliminer les cellules infectées par le virus et éviter une réplication

Résultats

Sujets

- 26 participants, 18-45 ans suivis pendant six mois (2021-2022).

Résultats

- Aucun événement indésirable grave lié au vaccin
- Effets secondaires locaux (douleur site d'injection)
- Résultats immunologiques: stimulation d'une réponse cellulaire spécifique contre le virus de la dengue, sans produire d'anticorps.

NB: Un potentiel vaccin pour le COVID-19, basé sur la même technologie, testé par Unisanté sur 26 participants et participantes. Les résultats sont en cours de publication.

Prévention/dépistage cardiovasculaire

- Quelle nouveauté ?
- Quelle piste à suivre ces prochaines années?

Subclinical Coronary Atherosclerosis and Risk for Myocardial Infarction in a Danish Cohort

A Prospective Observational Cohort Study

Andreas Fuchs, MD, PhD; Jørgen Tobias Kühl, MD, PhD, DMSc; Per Ejlstrup Sigvardsen, MD, PhD; Shoaib Afzal, MD, PhD; Andreas Dehlbæk Knudsen, MD, PhD; Mathias Bech Møller, MD, PhD; Martina Chantal de Knecht, MD, PhD; Mathias Holm Sørgaard, MD, PhD; Børge Grønne Nordestgaard, MD, DMSc; Lars Valeur Køber, MD, DMSc; and Klaus Fuglsang Kofoed, MD, PhD, DMSc

Annals 2023

ATS subclinique

Figure 1. Illustration of combined subclinical coronary atherosclerosis groups by coronary computed tomography angiography.

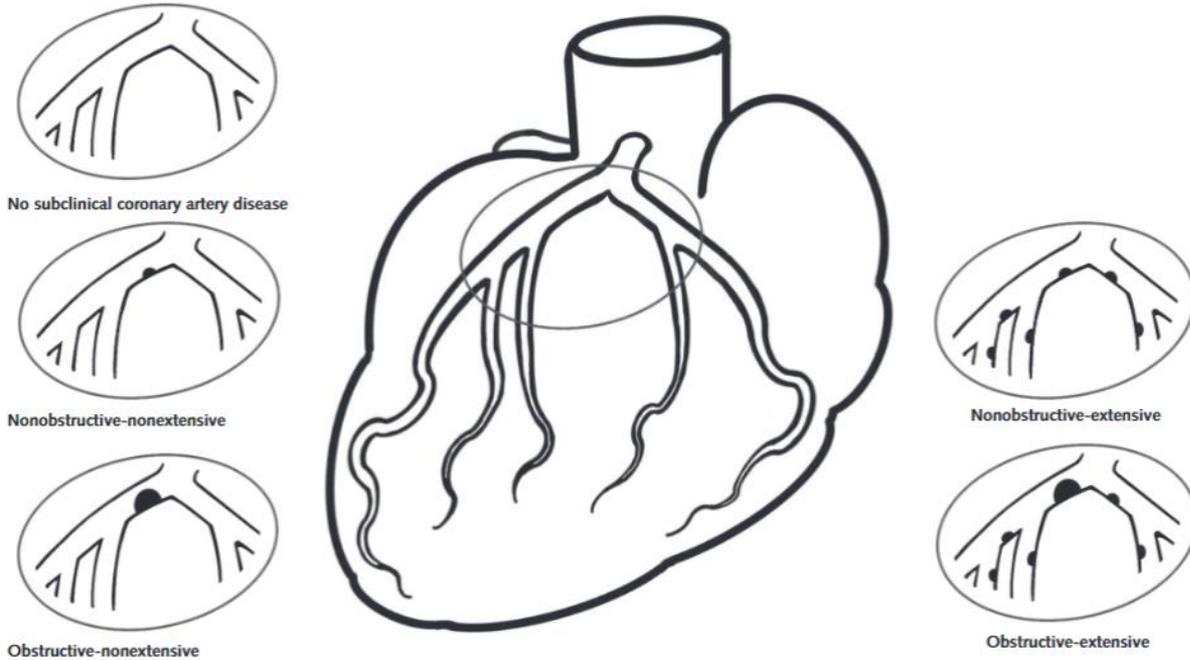


Table. Clinical Characteristics of the Study Cohort

Characteristic	All	Men	Women	Standardized Mean Difference
Participants, n	9533	4089	5444	
Mean age (95% CI), y	60.2 (42.7-79.7)	60.3 (42.7-80.6)	60.1 (42.8-79.1)	0.01
Body metrics				
Mean body surface area (95% CI), m ²	1.9 (1.5-2.3)	2.0 (1.8-2.4)	1.8 (1.5-2.1)	1.76
Mean body mass index (95% CI), kg/m ²	25.7 (19.8-34.4)	26.5 (21.2-33.8)	25.3 (19.3-34.7)	0.24
Cardiovascular risk factors, n (%)				
Overweight or obesity*	5456 (57)	2793 (68)	2663 (49)	0.28
Hypertension†	3967 (42)	1905 (48)	2062 (38)	0.14
Hypercholesterolemia‡	5679 (60)	2494 (61)	3185 (59)	0.03
Diabetes	175 (2)	99 (2)	76 (1)	0.06
Current smoker	1042 (11)	453 (11)	589 (11)	0.00
Medicine, n (%)				
Aspirin	632 (7)	311 (8)	321 (6)	0.06
Statin	1015 (11)	489 (12)	526 (10)	0.05
Educational-economic factors				
Mean education level (95% CI), y§	11.1 (7.7-14.5)	11.1 (7.6-14.6)	11.1 (7.8-14.5)	-0.01
Income class, n (%)				0.16
Low	462 (5)	144 (4)	318 (6)	
Middle	3584 (38)	1334 (33)	2250 (41)	
High	5487 (58)	2611 (64)	2876 (53)	

* Overweight or obesity: body mass index >25 kg/m².

† Hypertension: ≥140/90 mm Hg or prescribed antihypertensive medication.

‡ Hypercholesterolemia: low density lipoprotein ≥3 mmol/L (116 mg/dL) or prescribed statins.

§ Education level: years of school.

|| Income class: low: <\$25 000 per year, middle: \$25 000 to \$80 000 per year, high: >\$80 000 per year.

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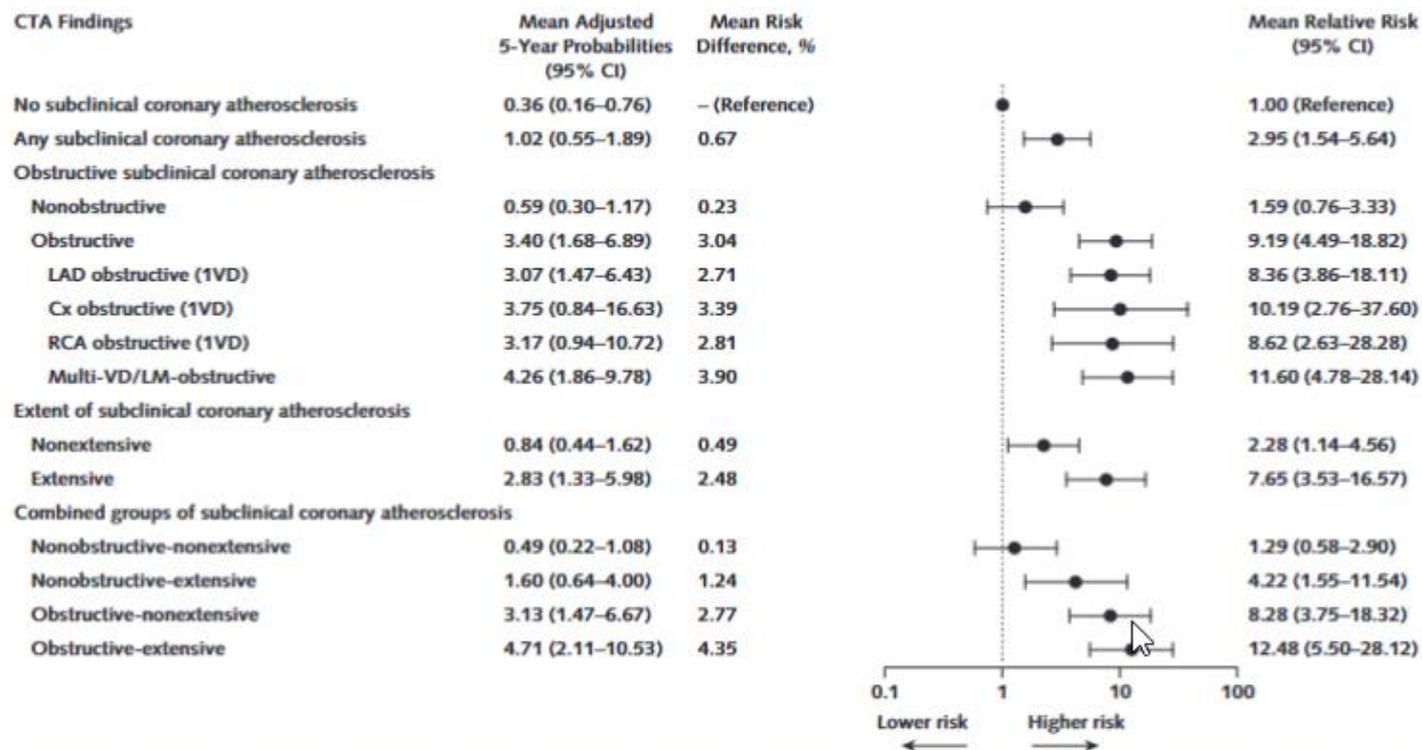
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§ Education level: years of school.

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- Obstruction: 46% (36% chez F et 61% chez H)
- Suivi en Moyenne 3,5 ans (1-9 ans)
- 193 décès et 71 IM

Figure 3. Adjusted 5-year probabilities, risk differences, and relative risks for myocardial infarction according to coronary CTA findings of subclinical atherosclerosis.

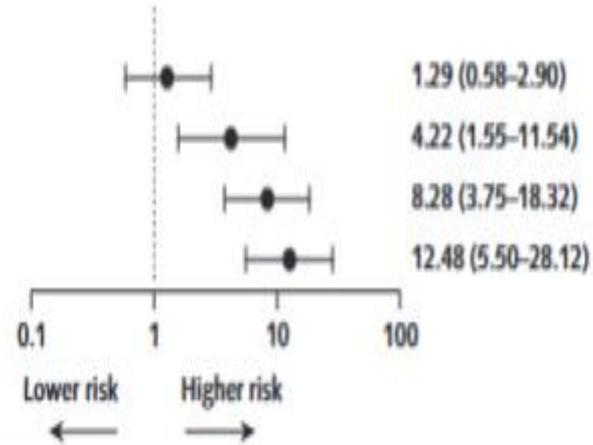


Analyses were adjusted for sex, age, arterial hypertension, hypercholesterolemia, current smoking, overweight or obesity, diabetes, aspirin, statin, education level, and income class. 1VD = single vessel disease; CTA = computed tomography angiography; Cx = circumflex artery; LAD = left anterior descending artery; LM = left main artery; RCA = right coronary artery; VD = vessel disease.

Cohorte danoise

Combined groups of subclinical coronary atherosclerosis

Nonobstructive-nonextensive	0.49 (0.22-1.08)	0.13
Nonobstructive-extensive	1.60 (0.64-4.00)	1.24
Obstructive-nonextensive	3.13 (1.47-6.67)	2.77
Obstructive-extensive	4.71 (2.11-10.53)	4.35



Score calcique coronarien (CAC-score): densité et quantité de calcium du réseau coronarien - indicateur de la charge athéromateuse des coronaires
RR (catégorie 1-4): de 1,8 à 7,0

Cohorte danoise

EDITORIAL

Annals of Internal Medicine

Contemporary Natural History of Coronary Artery Disease

This exceptional and important study now provides a benchmark against which to observe the contemporary natural history of coronary artery disease. It also provides invaluable data about event rates and prevalence of asymptomatic coronary artery disease that will inform public health prevention strategies and ongoing clinical trials of targeting preventative therapies in persons screened for occult coronary artery disease.

Cohorte danoise

- *Stay Tuned!*
- Après l'observation (cohortes), l'expérimentation (essais cliniques)!
- Deux RCT de prévention I en cours dans population à risque
 - Danemark
 - Ecosse

Plan

- Introduction
- De l'observation à ...
- ... l'expérimentation
- ... la modélisation
- ... la généralisation
- ... la réflexion
- ... la décision
- ... la conclusion et ... la discussion!

Indefinite Anticoagulant Therapy for First Unprovoked Venous Thromboembolism

A Cost-Effectiveness Study

Faizan Khan, PhD; Doug Coyle, PhD; Kednapa Thavorn, PhD; Sasha van Katwyk, MSc; Tobias Tritschler, MD; Brian Hutton, PhD; Grégoire Le Gal, MD, PhD; Marc A. Rodger, MD*; and Dean A. Fergusson, PhD*

Annals 2023

Figure 1. Schematic of Markov model structure.

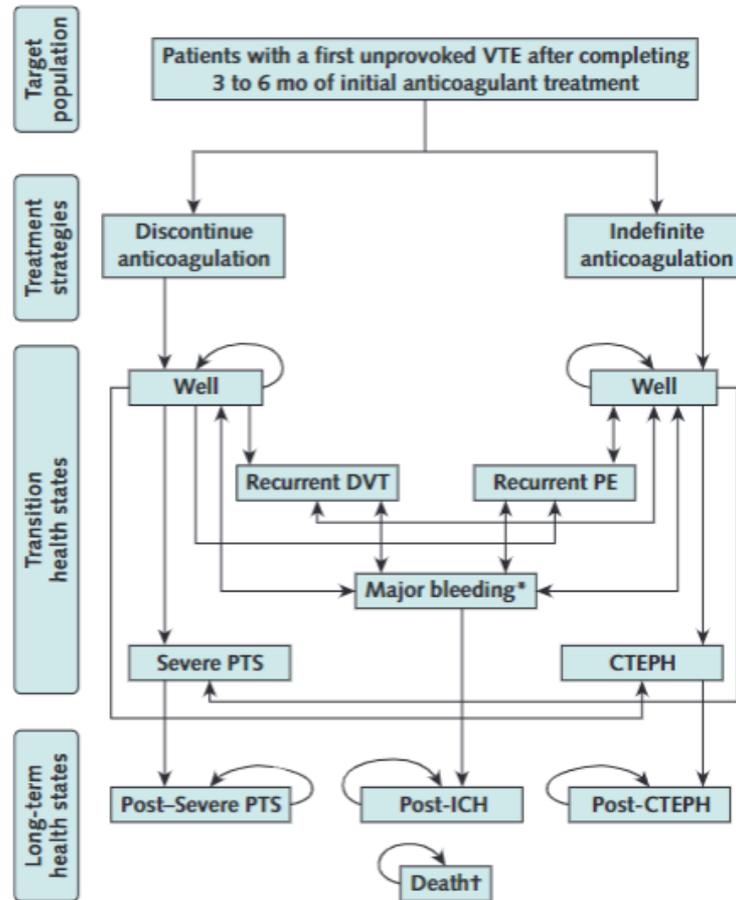


Table 2. Mean Clinical Benefits, Harms, Costs, and Life-Years With Indefinite Anticoagulation Versus Discontinuing Anticoagulation in Patients With a First Unprovoked VTE Aged 55 Years

Outcomes	Discontinuing Anticoagulation* (95% UI)	Indefinite Anticoagulation* (95% UI)	Incremental Difference† (95% UI)	Probability of Incremental Benefit,‡ %
Recurrent VTE§	631 (498 to 769)	263 (205 to 328)	-368 (-232 to -508)	-
Fatal PE§	24 (13 to 38)	10 (5 to 17)	-14 (-3 to -28)	-
Major bleeding§	158 (123 to 198)	272 (205 to 349)	114 (67 to 168)	-
Intracranial hemorrhage§	41 (28 to 58)	71 (41 to 110)	30 (11 to 55)	-
Fatal bleeding§	15 (5 to 31)	26 (9 to 53)	11 (3 to 23)	-
Costs, \$				
Undiscounted	22 649 (16 117 to 30 262)	41 881 (28 196 to 58 681)	19 231 (10 855 to 30 413)	-
Discounted	17 801 (12 803 to 23 654)	33 815 (22 732 to 47 377)	16 014 (9006 to 25 342)	-
Life-years				
Undiscounted	25.83 (25.64 to 25.96)	25.72 (25.40 to 25.93)	-0.109 (-0.288 to 0.030)	7
Discounted	20.88 (20.74 to 20.98)	20.80 (20.57 to 20.96)	-0.076 (-0.209 to 0.028)	9
QALYs				
Undiscounted	22.07 (21.82 to 22.30)	21.96 (21.64 to 22.24)	-0.107 (-0.263 to 0.018)	5
Discounted	17.84 (17.64 to 18.01)	17.76 (17.52 to 17.97)	-0.075 (-0.192 to 0.017)	6
Net monetary benefit, \$	-	-	-19 786 (-30 649 to -10 537)	0
Net health benefit, QALYs	-	-	-0.396 (-0.613 to -0.211)	0

PE = pulmonary embolism; QALY = quality-adjusted life-year; UI = uncertainty interval; VTE = venous thromboembolism.

* Average lifetime duration for which patients were anticoagulated vs. not anticoagulated was 19.7 and 7.2 discounted years, respectively.

† Indefinite anticoagulation with therapeutic-dose direct oral anticoagulants vs. discontinue anticoagulation; negative values are events prevented and positive values are excess events.

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Conclusion: Clinicians should use shared decision making to incorporate individual patient preferences and values when considering treatment duration for unprovoked VTE.



ISDM 2024

12th International Shared Decision Making Conference

Coproduction: Harnessing the power of partnerships

Lausanne, Switzerland

July 7 - 10 2024

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Submission **closed** / Soumission **clôturée**

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La recherche en médecine générale

La recherche est un moteur essentiel de l'amélioration de la qualité de soins.

Ce principe a été à la base de la réforme de 1958 dont l'un des objectifs était de mettre la recherche scientifique au cœur des CHU. Si cette réforme a permis de grandes avancées pour la recherche hospitalo-universitaire, elle a, au contraire, engendré un retard considérable en France dans le domaine de la recherche en soins primaires qui représente pourtant la majeure partie des soins dispensés dans notre système de santé, avec environ 300 millions d'actes par an réalisés par les Médecins Généralistes (MG) [De Pourville, 2006].

Plusieurs travaux ont mis en évidence la nécessaire adéquation entre les besoins de santé des populations et une distribution appropriée des ressources pour la recherche.

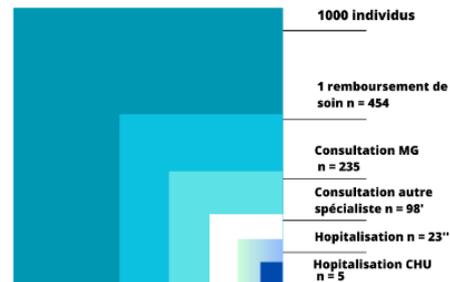
La première fut publiée dans le *New England Journal of Medicine* par Kerr White en 1961 [White et al., 1961]. À l'aide du « Carré de White ». Ils ont estimé que dans une population de 1000 adultes suivis pendant 1 mois, 750 signalaient un trouble de santé, 250 consultaient un médecin, 9 étaient hospitalisés, 5 dirigés vers un autre médecin et 1 hospitalisé dans un centre universitaire. Ce travail a été plusieurs fois réactualisé entre autres en 1976 [White, 1976], en 1996 [White et al., 1996], en 2001 [Green et al., 2001] et en 2003 [De Maeseneer et al., 2003]. Les auteurs ont trouvé à chaque fois un constat commun : la majorité des problèmes de santé les plus fréquents n'est pas vue en soins secondaires ou tertiaires, même si ces niveaux de soins se coordonnent et se complètent. Ce travail a été répliqué récemment en France par l'équipe du Pr Catherine Laporte : les résultats décrivent le même constat (cf figure ci dessous). Les recommandations de bonnes pratiques basées sur des études chez des « patients hospitalisés » ne peuvent ainsi pas coïncider avec les enjeux de la médecine générale.

Dans un rapport de 2008 sur la Santé dans le monde intitulé « *primary care now more than ever* », l'OMS a clairement souligné le besoin de développer la production de connaissances et donc les travaux de recherche en soins primaires [Van Lerberghe, 2008].

En France, les soins primaires font intervenir plusieurs professionnels de santé (médecins, sage-femmes, dentistes, pharmaciens, infirmiers, kinésithérapeutes, ...) avec un rôle de coordonnateur du parcours de soin par les médecins généralistes. Le développement de l'exercice coordonné est à l'œuvre dans les Maisons de Santé Pluriprofessionnelles (MSP) et les centres de santé (CS).

Le développement de la Filière universitaire de médecine générale (FUMG), a permis de développer considérablement la recherche en soins primaires ces vingt dernières années, toutefois notre pays reste, en matière de production scientifique, largement devancé par les Pays-Bas, le Canada, les États-Unis et le Royaume-Uni du fait d'un engagement fort et ancien des systèmes de santé dans le déploiement de la discipline universitaire, de la structuration de réseaux d'investigateurs et de bases de données.

La recherche en soins primaires en France est maintenant dynamique et en pleine croissance. Son développement est essentiel pour la réussite d'essais cliniques ambulatoires d'importance. Le CNGE travaille pleinement sur l'enjeu de poursuivre la structuration de la recherche en soins primaires.



*: Ambulatoire n = 74 / Hospitalier n = 24
*: Privé n = 13 / public non universitaire n = 10

Figure issue de l'article "The French ecology of Medical Care. A nationwide population-based cross sectional study." - Laporte et al. - (Données en cours de publication)

Ecologie des soins de 1e ligne



Débat : Changer les mots pour changer le système de santé ?

Publié : 15 juin 2023, 18:41 CEST

Jun 2023

[Débat : Changer les mots pour changer le système de santé ? theconversation.com](https://theconversation.com)

Carrée de White 1961

- White KL, Williams TF, Greenberg BG - The ecology of medical care, N Engl J Med 1961;265:885-92
- First study aiming to visualize the ecology of care in adult general population
- Monthly prevalence of illness in the community and the respective roles of primary care professionals vs hospitals in provision of care

NEJM 1961

White 1961

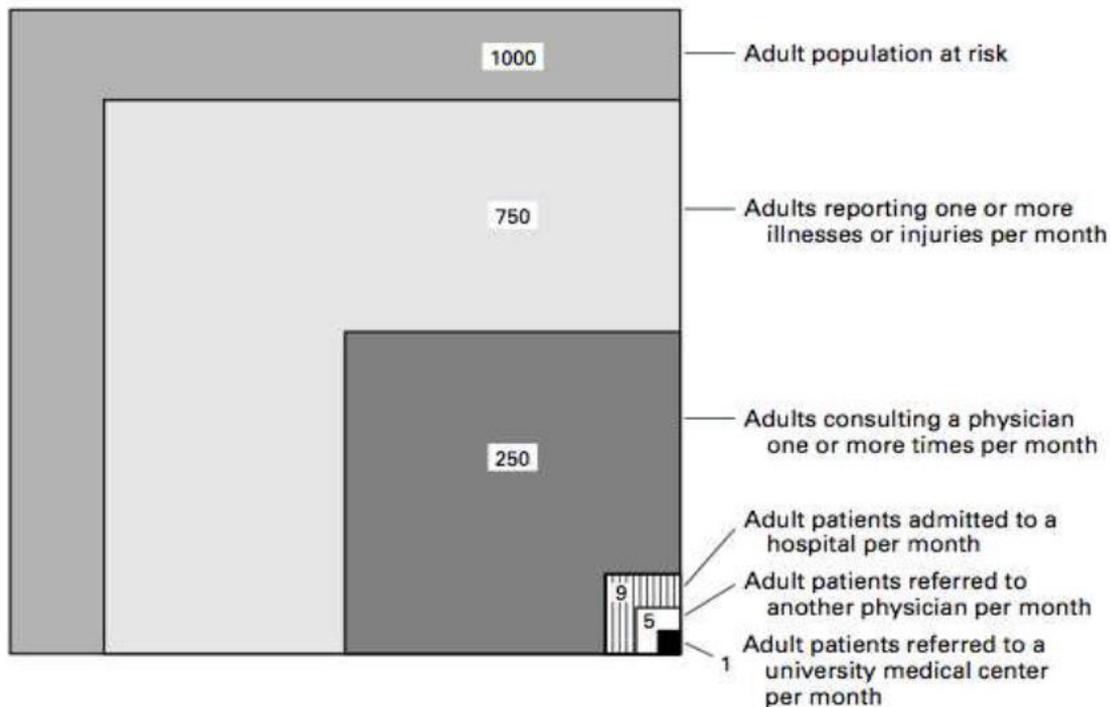


Figure 1. Monthly Prevalence Estimates of Illness in the Community and the Roles of Physicians, Hospitals, and University Medical Centers in the Provision of Medical Care.

Data are for persons 16 years of age and older. Reprinted from the 1961 report by White et al.³

USA - 2001

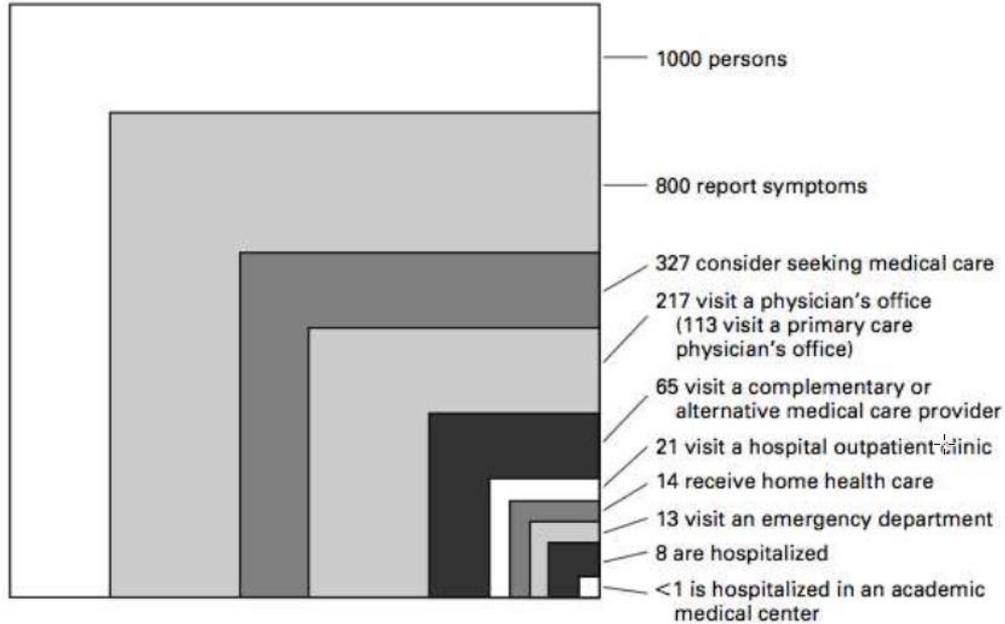


Figure 2. Results of a Reanalysis of the Monthly Prevalence of Illness in the Community and the Roles of Various Sources of Health Care.

Each box represents a subgroup of the largest box, which comprises 1000 persons. Data are for persons of all ages.

Green NEJM 2001

Hong Kong - 2005

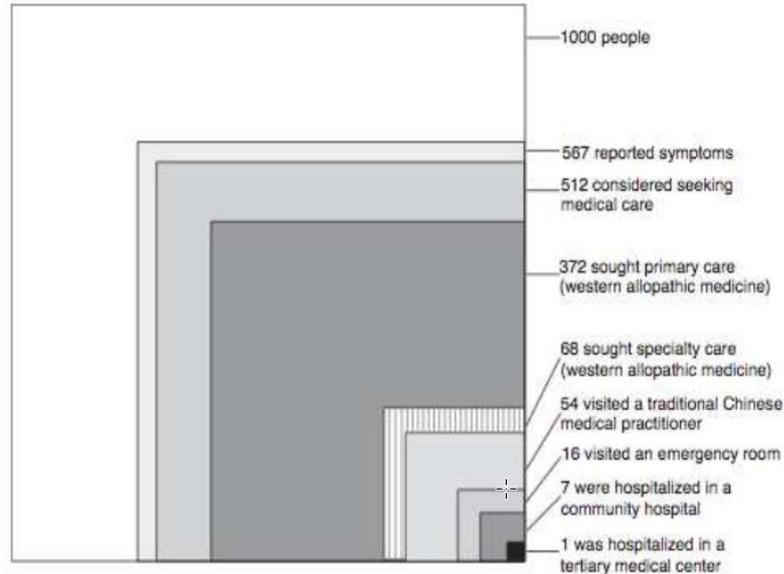


Fig. 3. Monthly prevalence estimates of illness in the community and the roles of various sources of health care. *Note:* Data are for the HK general population in 2002. Each box represents a subgroup of the two largest boxes, which comprises 1000 people from the general population and 567 who report symptoms respectively. Final estimate is the number of people per 1000 in HK population who experience each type of event.

Leung GM
Soc Sci Med 2005

Japan 2005

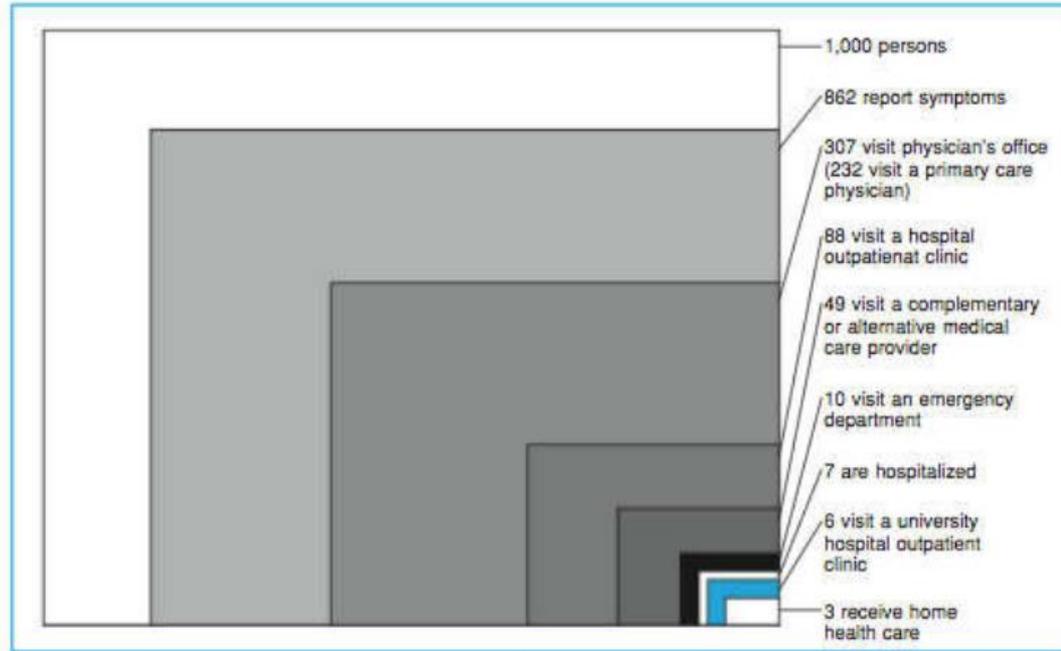


Fig. 1 Monthly prevalence estimates of symptoms and health care utilization in Japanese population
Each box does not necessarily represent a subgroup of the larger box, i.e., some values are overlapping.
The values are based on 1,000 persons.

Fukui
Jap Med Ass J 2005

Taiwan - 2011

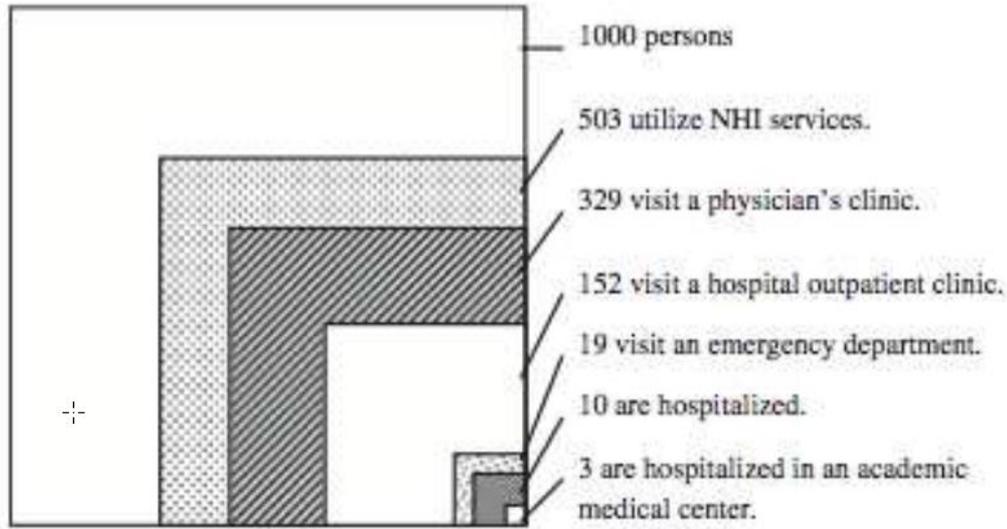


Fig. 1. Monthly prevalence estimates of healthcare utilization in Taiwan in 2005. Each box does not necessarily represent a subgroup of the larger box (i.e. some values overlap). Values are based on 1000 individuals.

Shao CC
J Chin Med Assoc 2011

Sweden - 2011

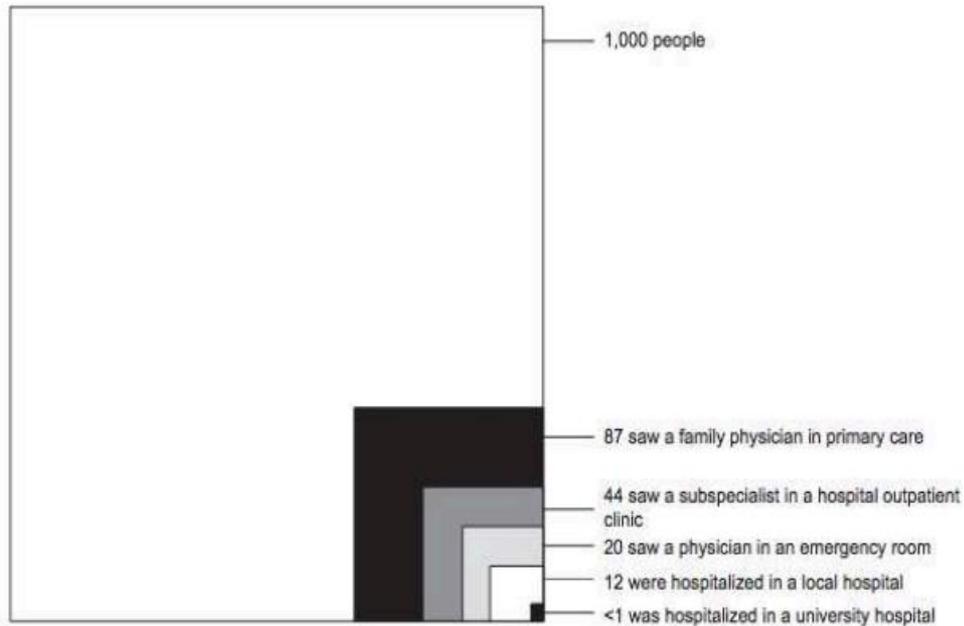


Figure 1. Number of people per 1000 inhabitants who had at least one appointment with a physician in an average month by the different health care settings.

Ferro A
Scand J Prim Health care
2011

Norway 2012

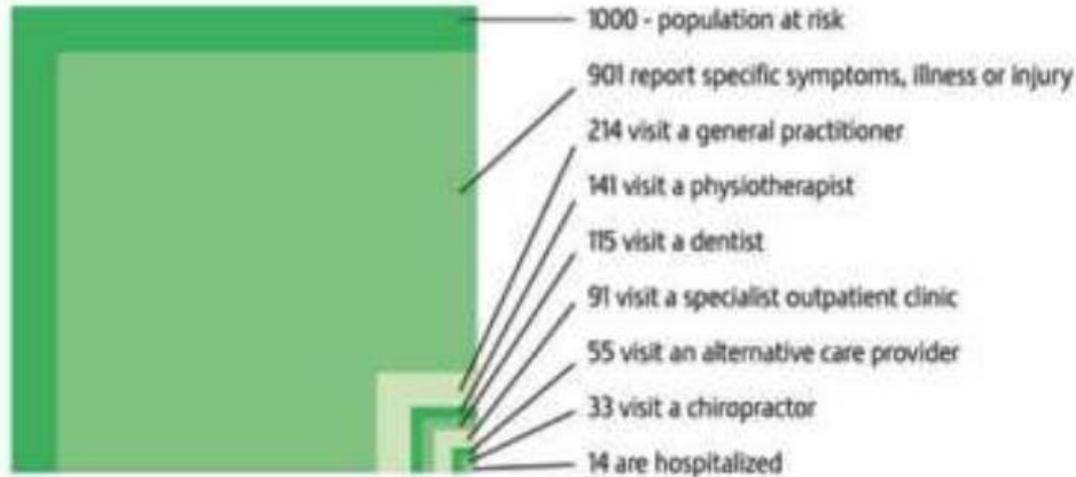
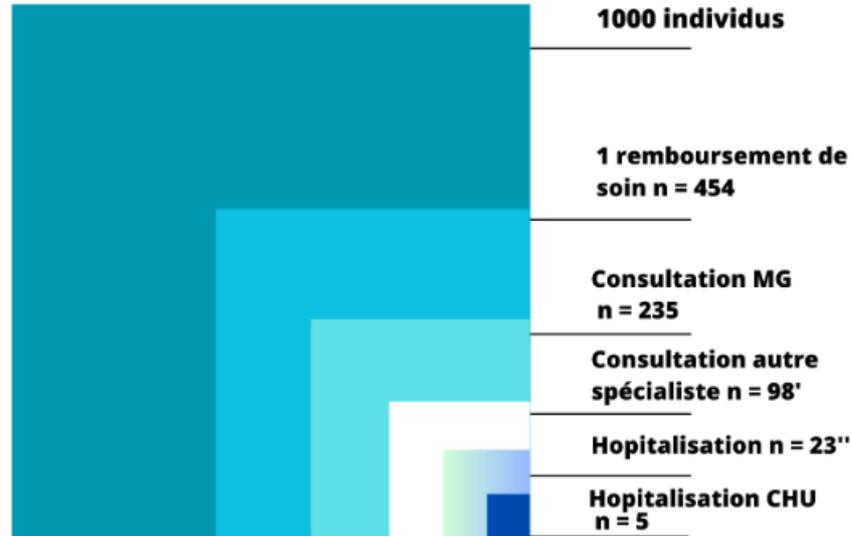


Figure 1. Monthly prevalence estimates of self-reported symptoms and illnesses, and use of different health care services for persons 30 years and over.

Hansen AH
J Pub Health Res 2012

France (en développement)



*: Ambulatoire n = 74 / Hospitalier n = 24
*: Privé n = 13 / public non universitaire n = 10

Figure issue de l'article "The French ecology of Medical Care. A nationwide population-based cross sectional study." - Laporte *et al.* - (Données en cours de publication)

Et en Suisse?

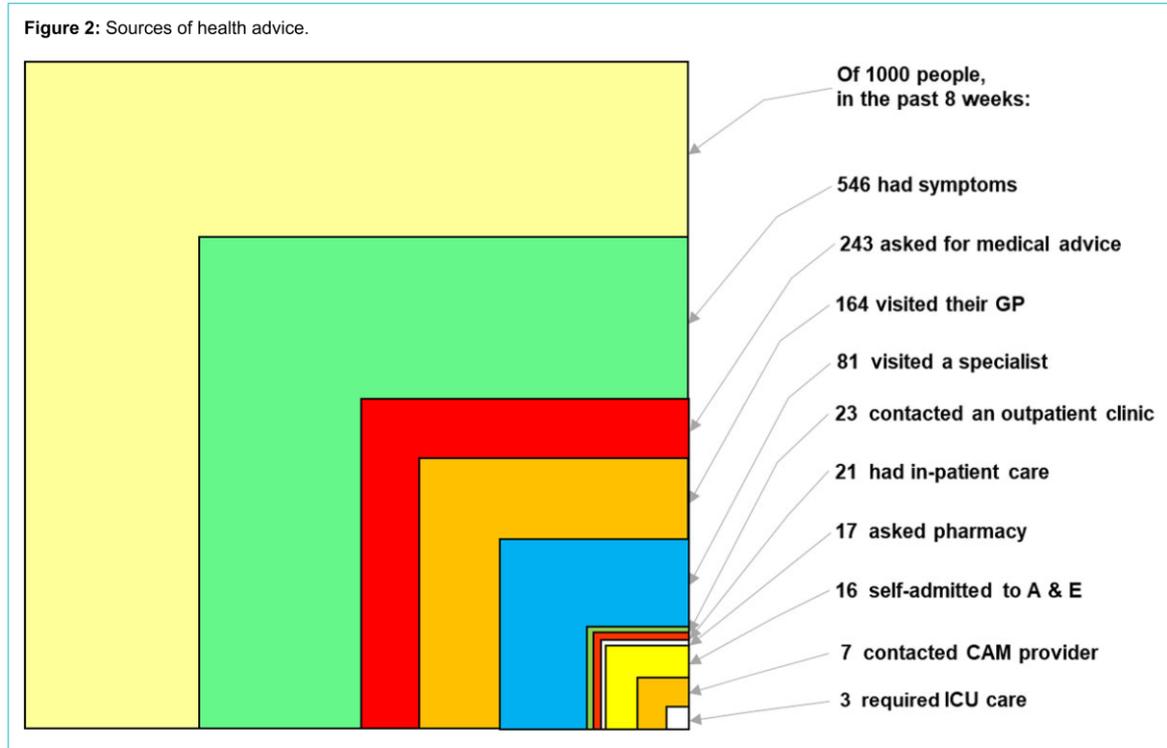
The ecology of medical care in Switzerland: prevalence of illness in the community and healthcare utilisation in Switzerland

Giezendanner Stéphanie, Bretschneider Wiebke, Fischer Roland, Diaz Hernandez Laura, Zeller Andreas

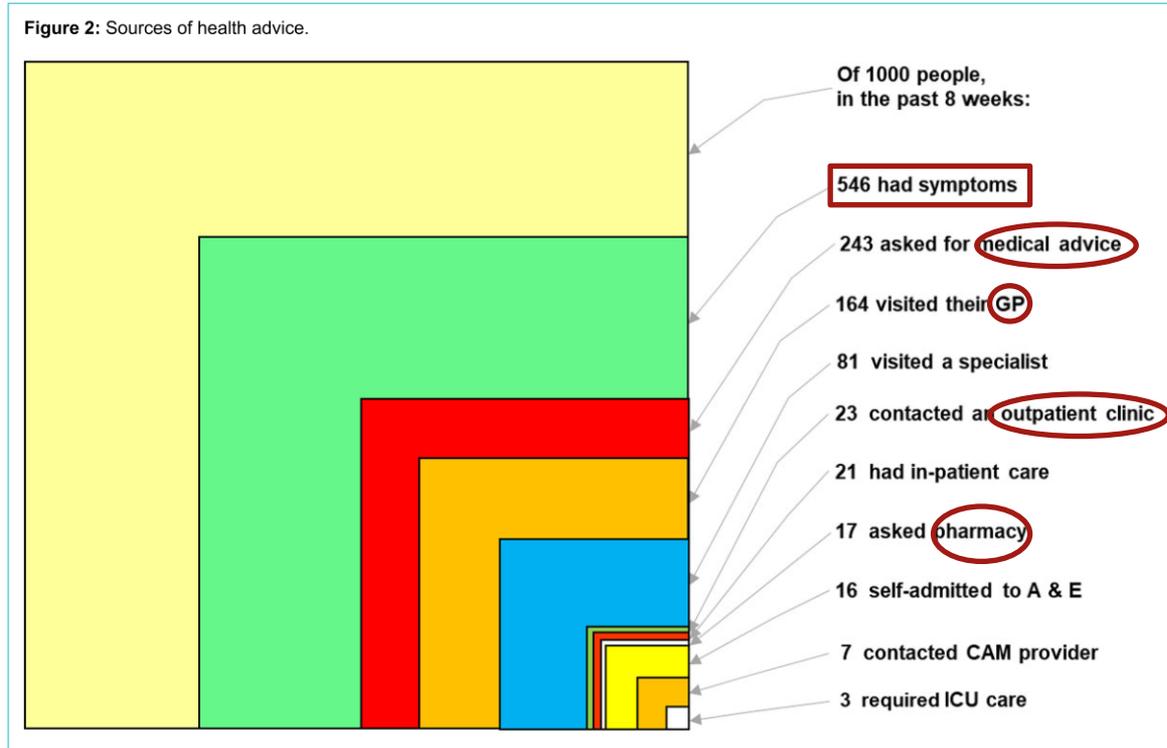
Centre for Primary Health Care, University of Basel, Switzerland

- Population-based, cross sectional survey
- Adult Swiss population
- 2 telephone interviews (May – November)
- Health seeking behavior during the 2 months
- 1025 persons, 51% females, median age 52

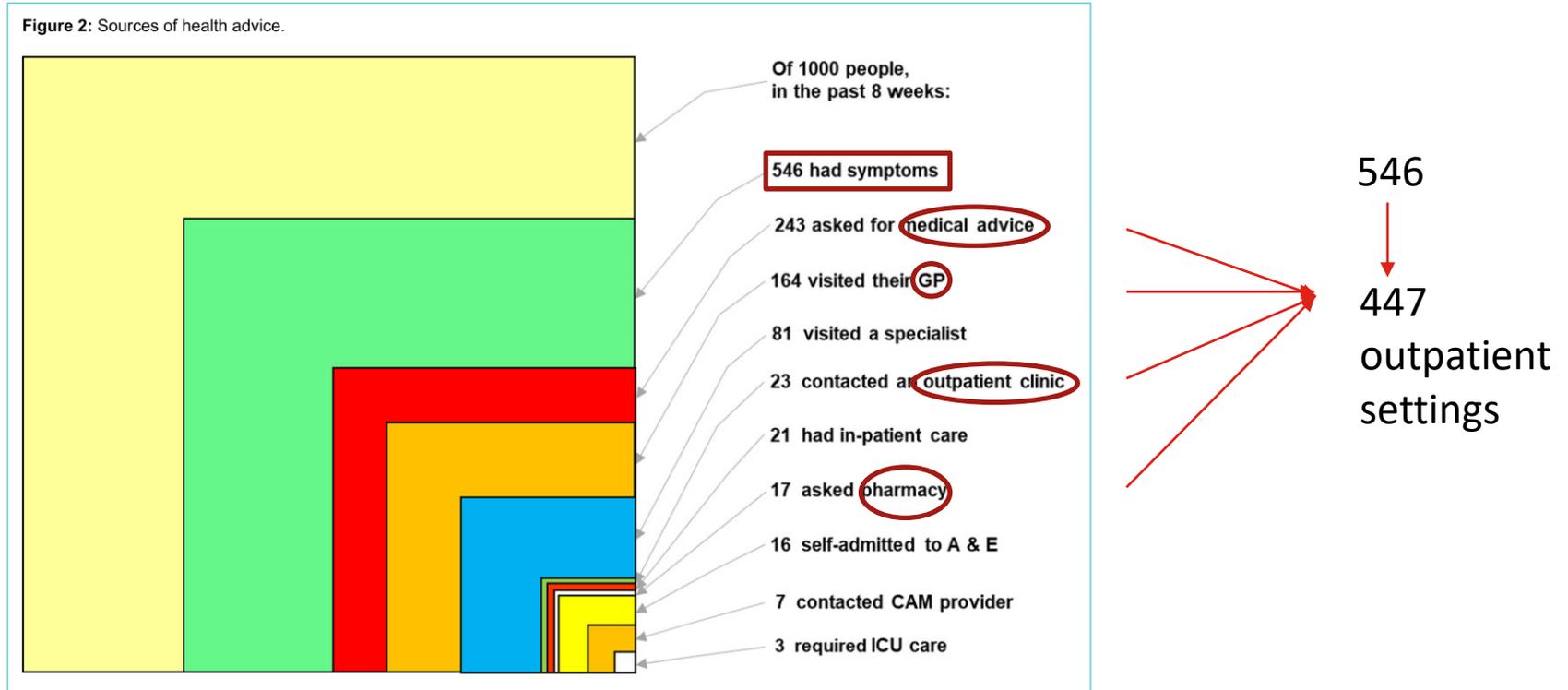
Switzerland -2020



Switzerland - 2020



Switzerland



Ecology of care

- 60 years later, more or less unchanged!
- Similar in many countries
- Remains unacknowledged to its full extent
- Important issues during Covid-19
- Crucial for GPs and their research agenda

Plan

- Introduction
- De l'observation à ...
- ... l'expérimentation
- ... la modélisation
- ... la généralisation
- ... la réflexion
- ... la décision
- ... la conclusion et ... la discussion!

unisanté

Centre universitaire de médecine générale
et santé publique • Lausanne

Workshop Stakeholders Loi fédérale de santé : Une voie pour la réforme du système de santé Suisse?

Stéphanie Monod, MD

Berne, le 30 octobre 2023

 SAMWASSM

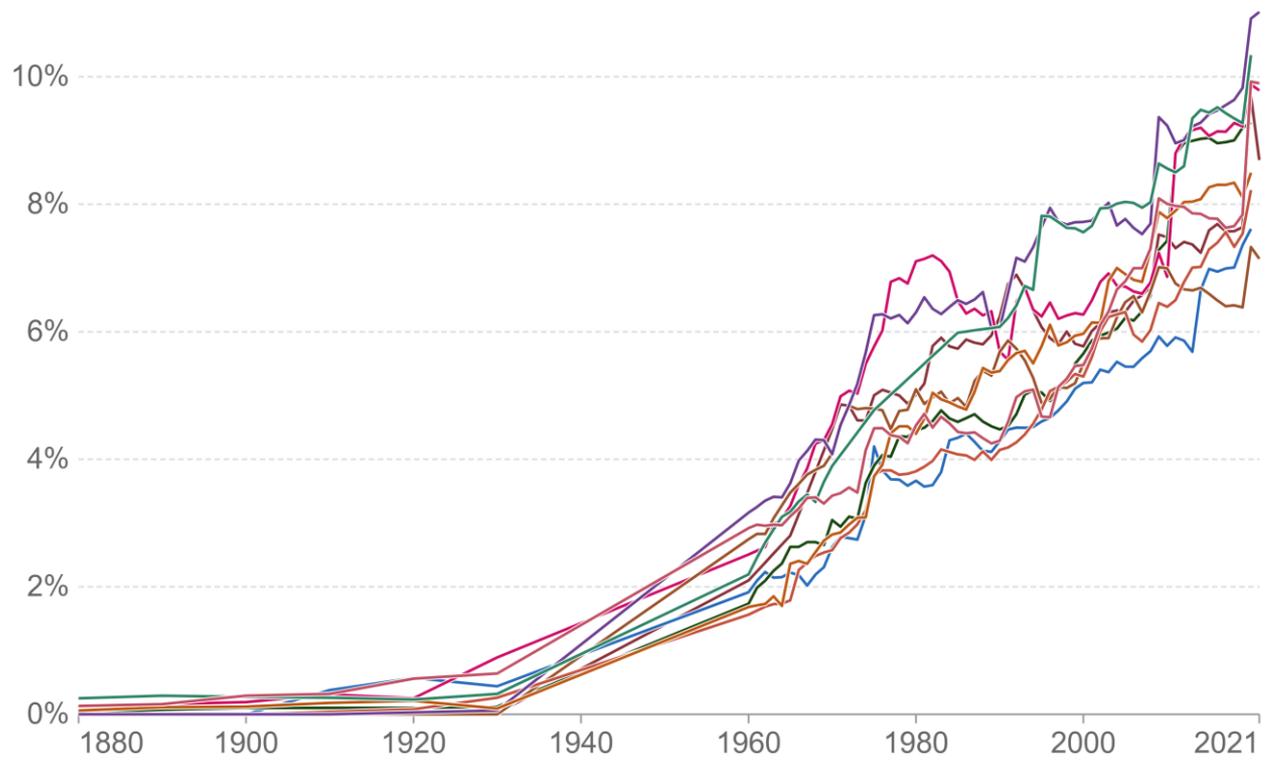
unisanté

Unil

UNIL | Université de Lausanne

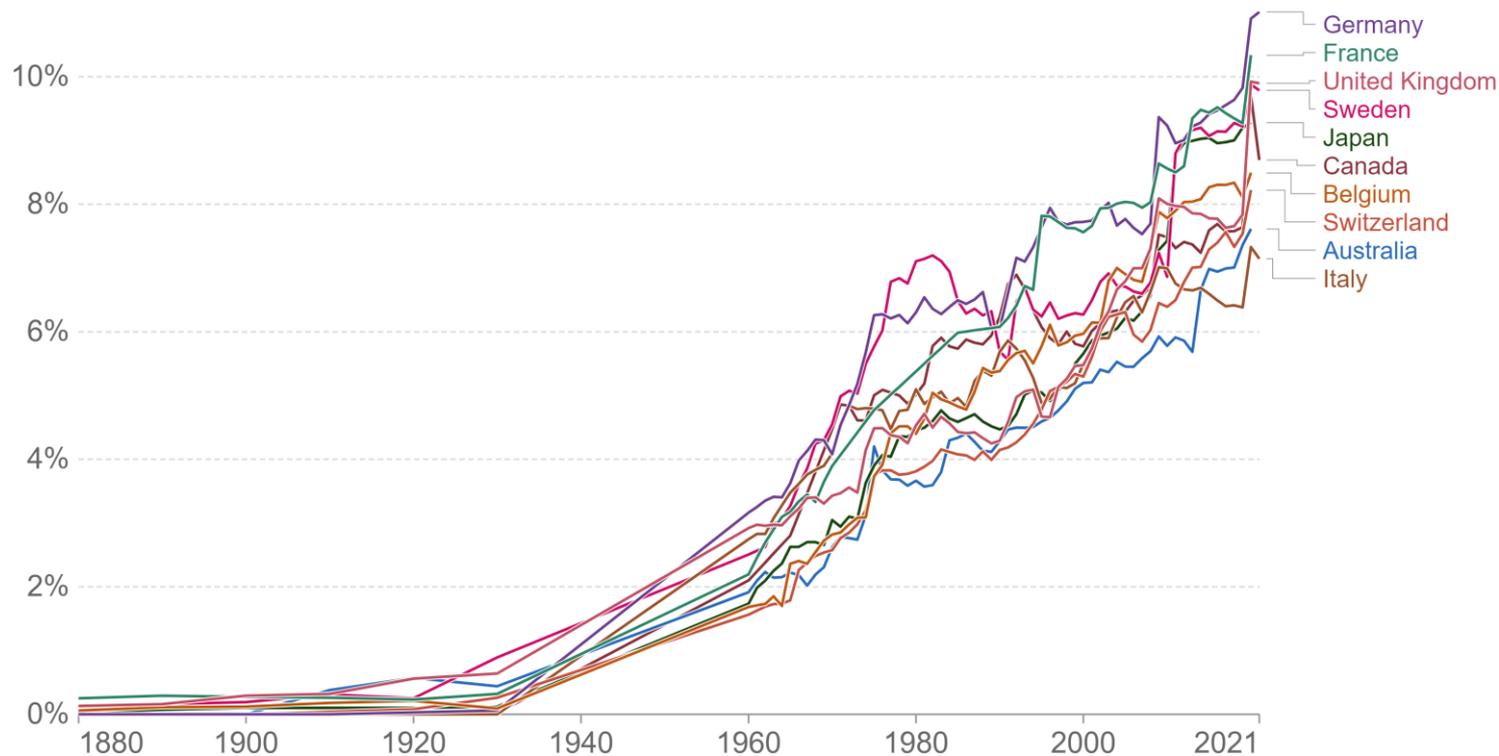


FONDATION
LEENAARDS



Government health expenditure as a share of GDP, 1880 to 2021

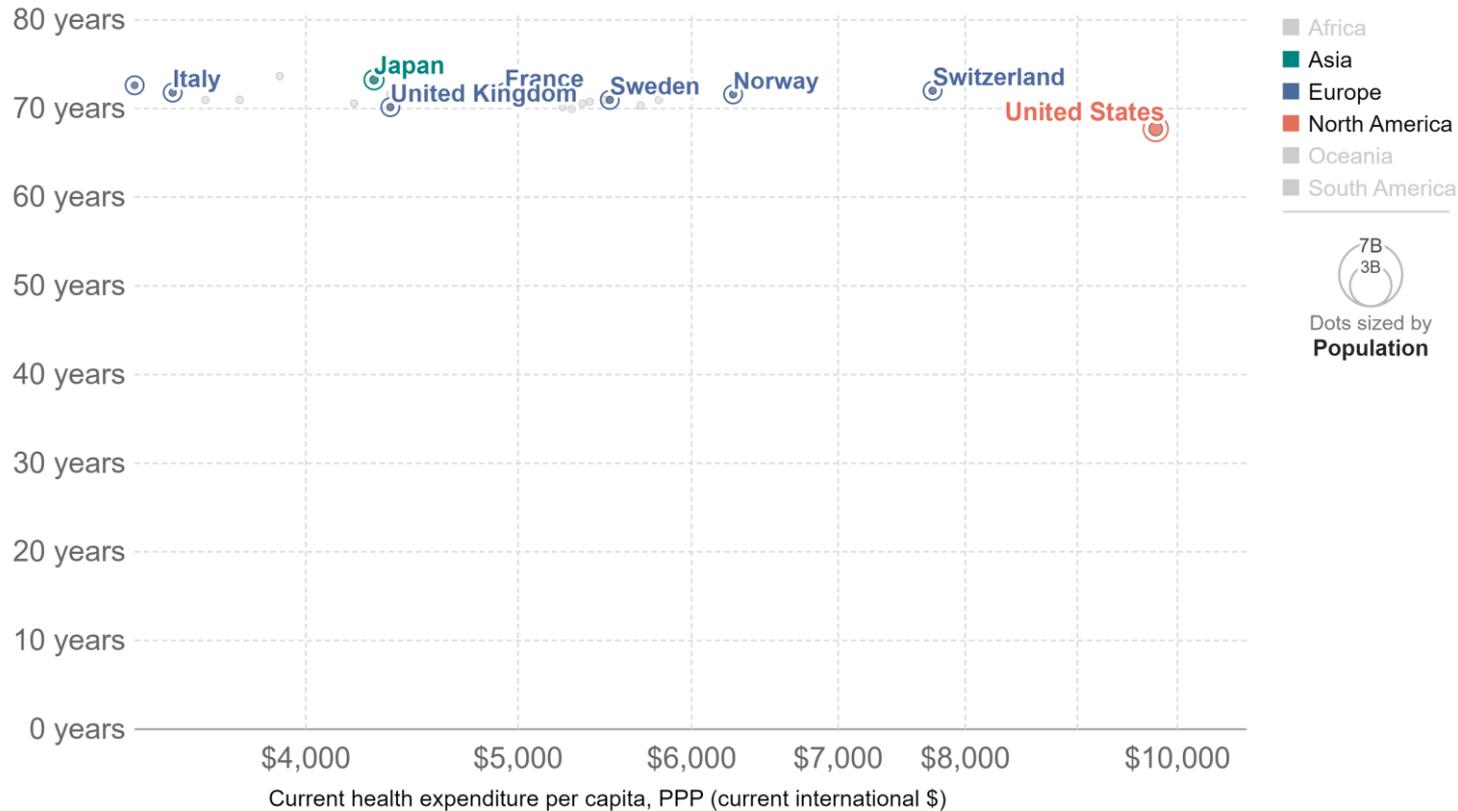
This metric captures spending on government funded health care systems and social health insurance, as well as compulsory health insurance.



Source: Our World In Data based on Lindert (1994), OECD (1993), OECD Stat

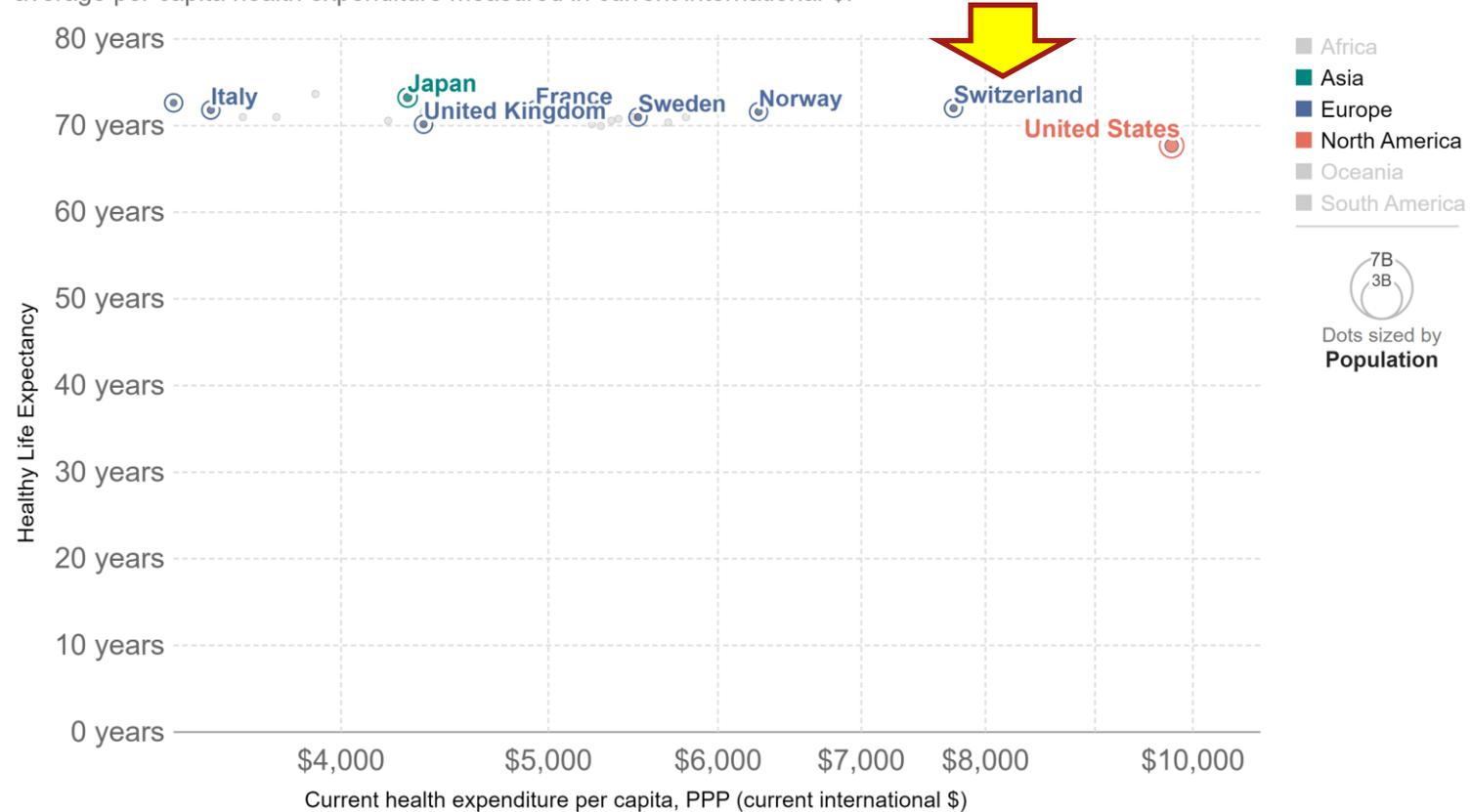
Note: Health spending includes final consumption of health care goods and services (i.e. current health expenditure). This excludes spending on capital investments.

OurWorldInData.org/financing-healthcare • CC BY



Healthy life expectancy vs. health expenditure per capita, 2016

Healthy life expectancy, defined as the average number of years lived free from disability or disease burden, versus average per capita health expenditure measured in current international- $\$$.



Plan

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Crise du système de santé:

Cantons et
Confédération,
il est encore temps!

par Stéphanie
Monod

Professeure
titulaire
à l'Université
de Lausanne -
Univisita



Essai qui retrace la construction sociale de notre système et donne des orientations

Principaux messages

- Système devenu illisible et ingouvernable
- Les réformettes ne serviront à rien d'autre que de noyer encore le débat de fond qui doit advenir.
- La santé est un bien public que toute société civilisée se doit de protéger, y compris contre des intérêts financiers débridés.

Crise du système de santé:

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The Role of the Academies of Medicine in Anticipating the Future of Health and Medicine

Victor J. Dzau, MD

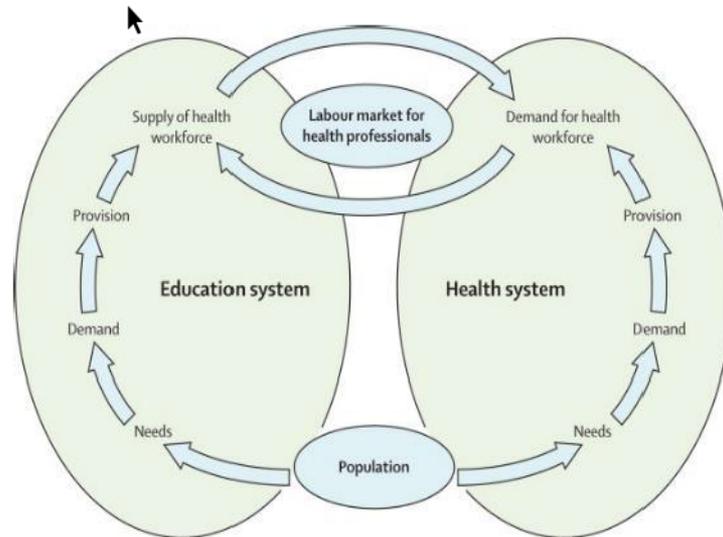
President, US National Academy of Medicine

Swiss Academy of Medical Sciences

November 2, 2023

Workforce for the Future

“To train an effective workforce, the education system must be aligned with health system needs”



Now more than ever, we must also take care to be aligned with community, population, and societal needs

Exercer, revue francophone de MG

- **Éditorial**

LS



Xavier Gocko
Directeur de la rédaction
x.gocko@exercer.fr
exercer 2023;197:387.

L'art de l'EBM

“ Ce qui est affirmé sans preuve peut être nié sans preuve. ”

Euclide

Exercer, revue francophone de MG

- **Éditorial**



Xavier Gocko
Directeur de la rédaction
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exercer 2023;197:387.

L'art de l'EBM

“ Ce qui est affirmé sans preuve peut être nié sans preuve. ”

Euclide

- *L'art de la médecine consiste à distraire le malade pendant que ...la nature le guérit - Voltaire*

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Encore et toujours le PSA!

Current policies on early detection of prostate cancer create overdiagnosis and inequity with minimal benefit

Informed choice approaches lead to high rates of unsystematic PSA testing, especially among those least likely to benefit and most likely to be harmed, argue **Andrew Vickers and colleagues**

Andrew Vickers,¹ Frank O'Brien,² Francesco Montorsi,³ David Galvin,⁴ Ola Bratt,⁵ Sigrid Carlsson,^{1,5,6} James WF Catto,⁷ Agne Krilaviciute,⁸ Michael Philbin,⁹ Peter Albers^{8,10}

Table 1 | National recommendations on prostate specific antigen (PSA) screening compared with empirical data on PSA testing in the population*

Country	Recommendation	Current use of PSA testing
Australia	"The PSA test is not suitable for population screening ... We encourage men to speak to their doctor so they can make an informed choice about prostate cancer testing" ⁵	High rates of PSA screening (around 20% of men screened annually, about 50% in lifetime) with comparable rates in men aged 75-84 and 45-74 ⁶
Canada	No population based screening. Policies vary by province. In some, the nationalised health insurance system does not pay for PSA in asymptomatic men; in others testing is free ⁷	40-60% of men of screening age have annual testing, with a 50% rate in men aged ≥70. ^{8,9} Lower rates of testing in people from minorities and those on low incomes or less well educated ¹⁰
France	No national screening programme, but PSA testing available after shared decision making ¹¹	Around 30% of men ≥40 have had a PSA test in past year. ¹² Highest testing rate in men aged over 70, with about 50% having at least one test and 20% having more than 3 tests over three years ¹¹
Germany	No national screening programme. PSA testing has not been approved by the German statutory health insurance and patients have to pay themselves ¹³	Around 75% of men >55 have been tested. ¹⁴ Around half of PSA tests are in men aged over 69 ¹⁵
Ireland	No national screening programme but PSA testing available after informed consent and shared decision making ¹⁶	Close to 500 000 PSA tests a year ¹⁷ with an eligible population of around 600 000 ¹⁸
Italy	No national screening programme	About 75% of men >50 have ever had a PSA test. Highest prevalence of annual testing (roughly 50%) in men aged ≥70 ^{19 20}
Sweden	"The health system should not offer screening for prostate cancer with PSA." ²¹ Population based PSA testing programmes are being piloted in some regions ²²	About 70% ever had a PSA test with highest rates in men aged 70-89 (30%-50% over 2 years) ^{23 24}
Switzerland	No national screening programme	Around 70% of have been tested, with 40% in the past two years. High rates in older men (around 50% in past 2 years for age ≥70). Testing positively correlated with education, income, and urban location ²⁵
UK	Screening for prostate cancer is currently not recommended. ²⁶ The NHS has an "informed choice programme": "If you're aged 50 or over and decide to have your PSA levels tested after talking to a GP, the NHS will pay for it" ²⁷	Strong regional variation in PSA testing ²⁸ and high inequity, with testing inversely correlated with economic deprivation. ²⁹ Testing rates about twice as high in men aged 70-90 (about 40% in past years) as in men aged 50-59 (about 20%) ^{30 31}
US	"For men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one" ³²	About 30% of men receive PSA test each year. Highest rates for men aged 70-79 and considerable screening (~30%) in men aged ≥80. ^{33 34} Clear evidence of disparities with screening rates associated with education and insurance status ³³ and lower rates among people from minority groups ³⁵

* Note that most studies were unable to distinguish PSA used for screening versus PSA used for clinical reasons, such as follow-up in a patient with prostate cancer. However, the latter will be a small minority of the total and hence are unlikely to influence estimates importantly.

† It is hard to find policy documentation that patients can receive PSA if they request it, but high rates of PSA testing suggest that this is the case.

- Dosage de PSA:
 - chez > 70 ans: surdiagnostic, surtraitement (10'000 en GB!)
 - Surtout dans les classes sociales élevées
 - Suivi de biopsies inutiles
- Appel pour des programmes nationaux
 - 50-70 ans
 - Intervalles entre tests précisés
 - Biopsie uniquement après un 2e intervention (IRM)
 - Qualité - suivi assurés
- Ex. Suède (phase pilote) et Lituanie (diminution de 80% chez > 70) ans
- Alternative: restreindre après une consultation chez l'urologue!

PSA: du nouveau?



American
Urological
Association

Membership

Meetings &
Education

Guidelines & Quality

Leadership &
Business

Advocacy

Research & Data

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Guidelines

Guideline Statement

Early Detection of Prostate Cancer: AUA/SUO Guideline (2023)

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Centre universitaire de médecine générale
et santé publique - Lausanne

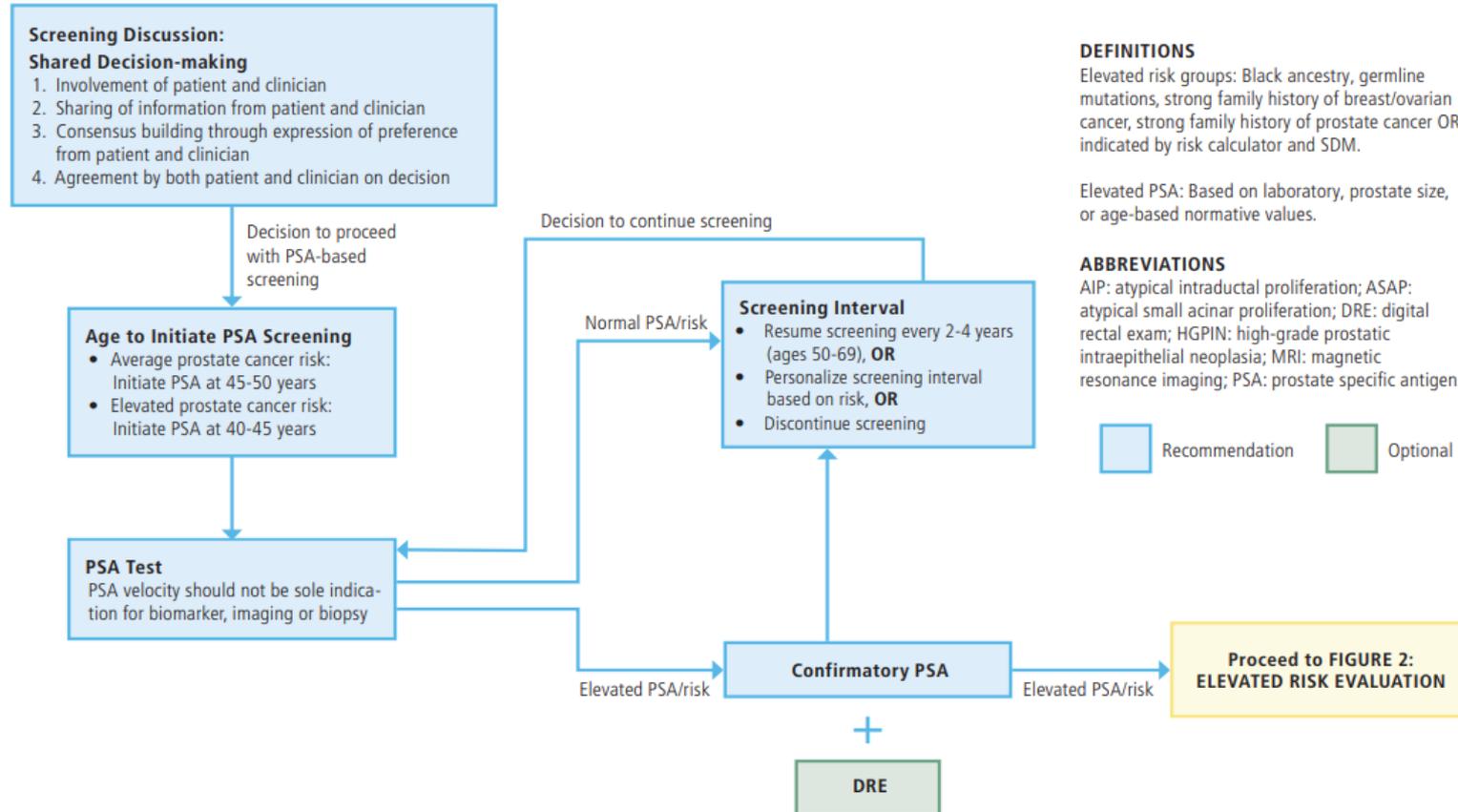
PSA Screening

1. Clinicians should engage in shared decision-making (SDM) with people for whom prostate cancer screening would be appropriate and proceed based on a person's values and preferences. (*Clinical Principle*)
2. When screening for prostate cancer, clinicians should use PSA as the first screening test. (*Strong Recommendation; Evidence Level: Grade A*)
3. For people with a newly elevated PSA, clinicians should repeat the PSA prior to a secondary biomarker, imaging, or biopsy. (*Expert Opinion*)
4. Clinicians may begin prostate cancer screening and offer a baseline PSA test to people between ages 45 to 50 years. (*Conditional Recommendation; Evidence Level: Grade B*)
5. Clinicians should offer prostate cancer screening beginning at age 40 to 45 years for people at increased risk of developing prostate cancer based on the following factors: Black ancestry, germline mutations, strong family history of prostate cancer. (*Strong Recommendation; Evidence Level: Grade B*)

6. Clinicians should offer regular prostate cancer screening every 2 to 4 years to people aged 50 to 69 years. (*Strong Recommendation; Evidence Level: Grade A*)
7. Clinicians may personalize the re-screening interval, or decide to discontinue screening, based on patient preference, age, PSA, prostate cancer risk, life expectancy, and general health following SDM. (*Conditional Recommendation; Evidence Level: Grade B*)
8. Clinicians may use digital rectal exam (DRE) alongside PSA to establish risk of clinically significant prostate cancer. (*Conditional Recommendation; Evidence Level: Grade C*)
9. For people undergoing prostate cancer screening, clinicians should not use PSA velocity as the sole indication for a secondary biomarker, imaging, or biopsy. (*Strong Recommendation; Evidence Level: Grade B*)
10. Clinicians and patients may use validated risk calculators to inform the SDM process regarding prostate biopsy. (*Conditional Recommendation; Evidence Level: Grade B*)
11. When the risk of clinically significant prostate cancer is sufficiently low based on available clinical, laboratory, and imaging data, clinicians and patients may forgo near-term prostate biopsy. (*Clinical Principle*)

Early Detection of Prostate Cancer Algorithm

FIGURE 1: INITIAL SCREENING FOR PROSTATE CANCER



Et à Unisanté?

- Recommandations SSU de 2012:

Tableau 4. Quand doser le PSA et à quelle fréquence? Quels sont les dérivés du PSA les plus utiles?

PSA	Dosage	Remarques
PSA total	Oui	Le PSA total est toujours le meilleur marqueur pour l'évaluation du carcinome prostatique.
PSA libre et quotient PSA libre/total	Non	Le quotient PSA libre/total peut parfois donner des informations complémentaires mais n'est généralement pas très utile.
Dérivés du PSA (Velocity, Density, PSA complexé, etc.)	Non	Les dérivés du PSA ont surtout un intérêt scientifique et peuvent aussi parfois donner des informations complémentaires en clinique. La routine clinique peut s'en passer.
PSA <1 ng/ml	Contrôle à 3 ans	La probabilité d'un futur carcinome prostatique dépend de la hauteur du taux de PSA initial.
PSA ≥1 à <2 ng/ml	Contrôle à 2 ans	
PSA ≥2 à <3 ng/ml	Contrôle à 1 an	

- Résultat >7 ng/ml = biopsie
- Entre 3 et 7 ng/ml = possiblement répéter, surtout si vous suspectez une autre cause (HBP, prostatite, rapports sexuels, toucher rectal)
- Arrêter le dépistage >70 ans

Une decision française cruciale!

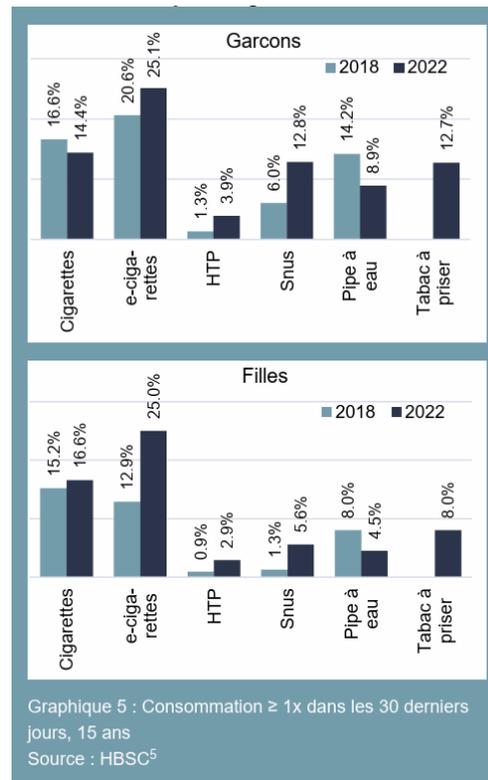
Une decision française cruciale!



CH: Prévalence de consommation chez les jeunes de 15 ans

Usage $\geq 1x$ dans les 30 derniers jours

- Cigarettes électroniques
25%
- Cigarettes conventionnelles
15%

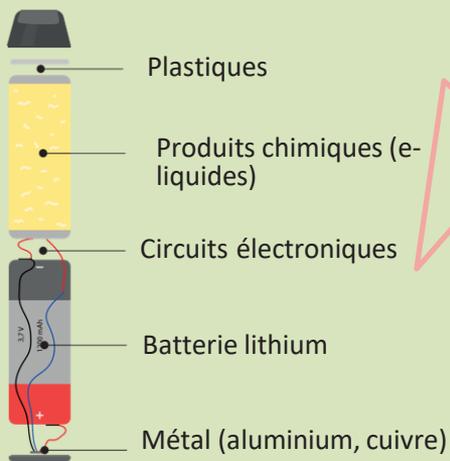




Cigarettes électroniques jetables. Crédits Photo : Edlira Nano

Interdire les puffs, c'est aussi bon pour l'environnement

Présentées comme recyclables, les puffs sont pourtant **très difficiles à recycler**.



Dispositifs jetés après 300-600 bouffées, soit **1 à 2 paquets de cigarettes**



La majorité des puffs sont **jetées dans les poubelles et dans la nature**



Les matières premières et précieuses (lithium, cuivre, etc.) disparaissent alors qu'elles pourraient être réutilisées.



Dans la nature, décomposition en microplastiques et en produits chimiques : pollution des sols et cours d'eau.



Dans les poubelles et les déchèteries : risques d'explosion et d'incendie

« La cigarette électronique jetable “puff”, un fléau environnemental et sanitaire qu’il faut interdire d’urgence »

Un collectif de plus de vingt de personnalités – médecins, tabacologues et défenseurs de l’environnement – appelle, dans une tribune au « Monde », à l’interdiction de la cigarette électronique jetable, comme c’est déjà le cas en Allemagne, en Belgique et en Irlande, et à soutenir la proposition de loi déposée en ce sens par une trentaine de députés.

Publié le 30 avril 2023 à 18h00, modifié le 30 avril 2023 à 18h00 | 🕒 Lecture 3 min.

SANTÉ • TABAC

L'Assemblée nationale vote l'interdiction des puffs

Les députés à l'origine du texte et le gouvernement espèrent conjointement la suppression des cigarettes électroniques jetables d'ici septembre 2024, mais elle devra d'abord être validée par la Commission européenne.

Le Monde avec AFP

Publié le 05 décembre 2023 à 00h56, modifié le 05 décembre 2023 à 09h53 - 🕒 Lecture 2 min.

How the FDA Can Improve Public Health — Helping People Stop Smoking

Neal L. Benowitz, M.D., Kenneth E. Warner, Ph.D., Matthew L. Myers, J.D., Dorothy Hatsukami, Ph.D., Micah L. Berman, J.D., Donna Vallone, Ph.D., and Joanna E. Cohen, Ph.D.

NEJM 2023

Plan

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Conclusion

- Prendre du temps, du recul pour ... l'observation!

NATURE AND NURTURE

EDITORIAL

Prescribing nature

Evidence and funds are needed to ensure green social prescribing supports health and the environment



ROLE MODEL

Tom Miller

The GP partner tells **Kathy Oxtoby** how his love of the natural world helped drive a “nature prescriptions” scheme for patients



The scheme is a way for people to get in touch with nature as a therapeutic intervention

LOUIE CAMPBELL/ISTOCK

Birdwatching and medicine: stories of curiosity and wonder

Parallels in repeated observation of natural phenomena bring connection and meaning for **Maria B Antony**

Quand le médecin rencontre l'oiseau: quelques similitudes entre la pratique clinique et l'ornithologie

Pr JACQUES CORNUZ², Drs CHARLES DVOŘÁK³, GILBERT ABETEL⁴ et FRANÇOIS BURNIER⁴

Rev Med Suisse 2018; 14: 1955-7

	Similitudes entre la médecine et l'ornithologie	
	Médecine	Ornithologie
Sens de l'observation	Indispensable	Indispensable
Piège diagnostique	La tachypnée et la douleur rétrosternale	Le chant imitateur de l'étourneau
Probabilité prétest	Selon l'âge et le contexte socio-démographique	Selon le biotope
Heuristiques	Fréquents	Fréquents
Outil diagnostique	Le stéthoscope	La paire de jumelles
Science participative	Parfois	Toujours
Recensement	Parfois	Fréquent
Rôle de la migration	Nécessité parfois vitale pour (sur)vivre	Nécessité vitale pour se reproduire
Rôle des pairs aînés	Indispensable	Primordiale

Birdwatching and medicine: stories of curiosity and wonder

Parallels in repeated observation of natural phenomena bring connection and meaning for **Maria B Antony**



L'ACTU

Mars 2023



Détail

De futurs médecins s'initient à l'ornithologie

Ce printemps, une trentaine d'étudiantes et étudiants de médecine ont suivi une initiation à l'ornithologie. Des sorties sur le terrain et un échange avec un ornithologue de renom ont permis de tirer des parallèles entre la médecine et l'étude scientifique des oiseaux.



Quand le médecin rencontre l'oiseau: quelques similitudes entre la pratique clinique et l'ornithologie

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Rôle des pairs aînés	Indispensable	Primordiale

Merci de votre attention



Figure 4. Adjusted 5-year probabilities, risk differences, and relative risks for death or myocardial infarction according to coronary CTA findings of subclinical coronary atherosclerosis.

