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PATIENT AND SURVIVOR CARE

The role of intensive care in the changing paradigm of modern cancer care.

[Louise Catherine Connell](#) , [Fauzi Othman](#) , [John McCaffrey](#) , [Desmond Carney](#) , [Brian Marsh](#) , [Catherine Margaret Kelly](#)

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Abstract

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Background: Many metastatic cancers are now treated like a chronic disease. Expanding treatment options, increasing age; varying co-morbid illness; and improving cancer-specific survival mean that decisions regarding the timeliness and appropriateness of transfer to the Intensive Care Unit (ICU) are complex. We sought to examine the clinical, demographic and outcome characteristics of oncology/haematology patients transferred to ICU at a large academic teaching hospital. **Methods:** Data was extracted from a prospectively maintained database for all patients with documented malignancy admitted to ICU between September 2009 & December 2011. Clinicopathological variables examined included; cancer type; tumour stage; time from diagnosis; age; co-morbidities; and treatment history. The Sequential Organ Failure Assessment (SOFA), an ICU-specific scoring system, was reviewed for each patient. We report 30 day and 6-month mortality. **Results:** A total of 52 patients have been analysed to date. The common cancer types were well represented; breast (11.5%), colorectal (11.5%), lung (11.5%) and acute leukaemia (19.2%). Mean age at time of ICU admission was 60 years (range 29-82). The maximum number of prior lines of chemotherapy (CT) was 5 (range 0-5). Approximately 50% of patients had metastatic disease at time of ICU admission. The most frequent reasons for admission were sepsis (n=16, 31%) and respiratory distress (n=15, 29%). Use of mechanical ventilation, vasopressors and renal dialysis was 51.9%, 61.5% & 21.1% respectively.

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 By Matthew Stenger, The ASCO Post, 2013

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 Marcio Soares et al., J Clin Oncol, 2016

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Four patients (7.7 %) received CT in the ICU setting. ICU-specific mortality was 28.8% (n=15). Thirty-day and 6-month mortality rates were 38.5% & 61.5% respectively.

Conclusions: A significant proportion of patients admitted to ICU had advanced disease and had received multiple lines of CT previously. The ICU-specific mortality rate was lower than expected at 28.8% and may reflect stringent selection criteria. Patients transferred tended to have had long periods of disease remission/stabilisation or had a new diagnosis of malignancy with unknown CT sensitivity status. Analysis of patient selection at ward level is on-going and will identify other factors influencing ICU transfer decisions.

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