Critically Ill Cancer Patients: Issues in Management of Acute Respiratory Failure

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Objectives

Cancer incidence has increased over the last few decades [1]. On the other hand there is improvement in survival of patients with several types of solid tumors due to new advances in cancer therapy. As consequence there is increase in number of cancer patients who develop respiratory complications either due to the aggressive manifestations of their disease or the side effects of the treatment (e.g. neutropenic infections, antineoplastic drugs related pneumonitis). Acute respiratory failure one of the main reasons for admitting cancer patients to intensive care units [2]. It is a dilemma weather that every critically sick cancer patient has to be admitted to ICU. Although the problem is worldwide; this issue looks more complicated in health facilities that have limited resources.

Methods

To review the current standards of diagnosis and management of acute respiratory failure in cancer patients, a methodological literature pub med search was conducted. Used key words were: cancer patients, oncology patients, acute respiratory failure, intensive care units and critical illness.

Results

There are available recommendations outlines for management of respiratory failure in critically cancer patients [3-5]. Special consideration should be given to cancer patients while applying assessment tools for ICU admission. APACHE II, SAPS II and SOFA are the most relevant scores for assessing critically ill cancer patients [6]. The mortality of cancer patients admitted to ICU with acute respiratory failure remains high (around 50%-60%) [2,7], so that early detection and proper management of respiratory complications by the primary physicians (oncologists/ internists) is of paramount. The decision of DNR (do not resuscitate) should be taken earlier for appropriate patients with advanced cancer by the primary treating oncologists to avoid unnecessary ICU admissions. In case of any unexpected or sudden deterioration in full code patients, the prognostic associated with the etiology of the acute respiratory failure, in the context of life expectancy from the underlying malignancy should be discussed before or soon after admission to the ICU [8,9].

Conclusion

Multidisciplinary team approach is essential in treating critically ill cancer patients with acute respiratory failure. Although the discussion of the prognosis of cancer is very important, however malignancy/metastatic cancer itself should not be seen alone as an exclusion criterion for ICU admissions. Planned ceiling of care and addressing DNR status at appropriate time may help avoiding prolongation of suffering in patients with advanced cancer presenting with acute respiratory failure.

References
