Ingreso del Paciente Hematooncológico en UCI.

Estrategia diagnóstica.

Dr. Gastón Burghi.

Prof. Adj. Medicina Intensiva.

La historia hasta mediados de los años ´90.

Study, Year (Reference)	Patients Receiving Mechanical Ventilation	Patients Who Survived to Discharge from Hospital
	n†	n (%)
Bellamy and Oye, 1984 (6)	10	0 (0)
Torrecilla et al., 1987 (8)	16	1 (6.2)
Crawford et al., 1988 (3)	232	16 (6.9)§
Denardo et al., 1989 (10)	41	2 (4.9)
Martin et al., 1990 (9)	24	2 (8.3)
Dees et al., 1990 (11)	8	0 (0)
Afessa et al., 1992 (12)	27	2 (7.4)
Crawford and Petersen, 1992 (7)	348	10 (2.9)§
Paz et al., 1993 (14)	28	1 (3.6)
Faber-Langendoen et al., 1993 (13)	191	6 (3.1)§
Todd et al., 1994 (15)	54	6 (11.1)
Total	979	46 (4.7)
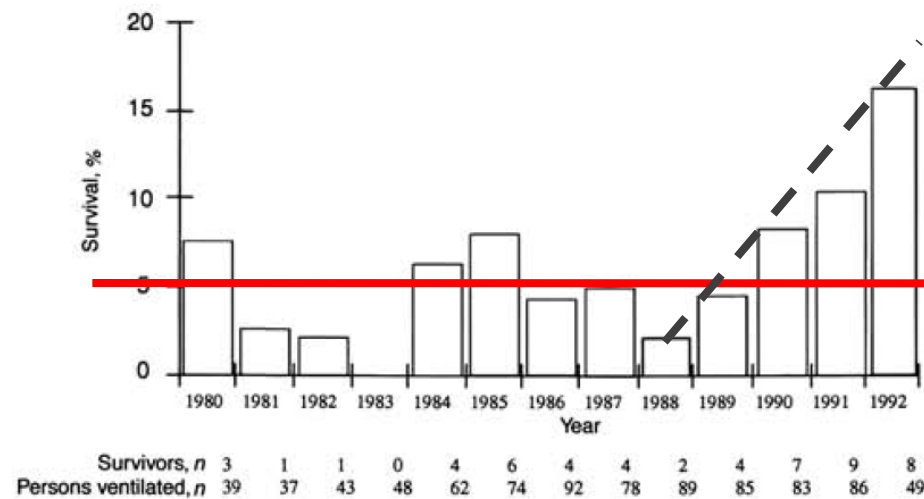
* APACHE II = Acute Physiology and Chronic Health Evaluation II; ICU = intensive care unit; NR =
† Values include postoperative patients only when no other values were available.
‡ Nonpulmonary organ failure before or during mechanical ventilation.
§ Patients who survived for 6 months.

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
Survivors, n	3	1	1	0	4	6	4	4	2	4	7	9	8
Persons ventilated, n	39	37	43	48	62	74	92	78	89	85	83	86	49

Rubenfeld, G. D. et. al. Ann Intern Med 1996;125:625-633

La historia deja sus huellas…

Life-sustaining treatments in patients who died of chronic congestive heart failure compared with metastatic cancer

Tawee Tanvetyanon, MD; John C. Leighton, MD

Pacientes fallecidos en el hospital.
ICC = DCF IV o FEVI< 20%
Cáncer metastásico.
n = 140.

Limitación terapéutica 2,7 vs 6,7 días p=0,006

La historia del nuevo milenio.

The Prognosis of Acute Respiratory Failure in Critically Ill Cancer Patients

Élie Azoulay, MD, PhD, Guillaume Thiéry, MD, Sylvie Chevret, MD, PhD,
Delphine Moreau, MD, Michaël Darmon, MD, Anne Bergeron, MD, PhD, Kun Yang, MD,
Véronique Meignin, MD, Magali Ciroldi, MD, Jean-Roger Le Gall, MD,
Abdellatif Tazi, MD, PhD, and Benoît Schlemmer, MD

	All Patients (%)	Patients who Died (Hospital Mortality Rate)
Total	203 (100)	96 (47.3)

Outcomes of Critically Ill Cancer Patients in a University Hospital Setting

JOHN P. KRESS, JEFFREY CHRISTENSON, ANNE S. POHLMAN, DARREN R. LINKIN, and JESSE B. HALL

Department of Medicine, University of Chicago, Chicago, Illinois

MOST COMMON CANCER TYPES–UNIVARIATE COMPARISON

	Leukemia	Lymphoma	Lung Cancer	p Value
n	80	47	44	
Age, yr, mean $\pm$ SD	50 $\pm$ 16[†§]	57 $\pm$ 15	61 $\pm$ 10	< 0.001
Male/Female	40/40	26/21	21/23	0.75
APACHE II*	22 (16–27)	21 (15–26)	19 (11–22)	0.002
SAPS II*	44 (35–53)	46 (37–57)	41 (27–49)	0.05
MV, %	41	53	46	0.43
Neutropenia, %	58[‡∥]	30[¶]	5	< 0.001
Mortality, %	48	49	48	0.99

- Historia del cáncer en UCI.

- **Mitos entre los intensivistas.**

- Factores pronósticos.

- Dificultades diagnósticas.

- Algoritmo de ingreso / estudio.

Mitos entre los intensivistas.

Neutropenia = mal pronóstico.

original article

Impact of neutropenia on the outcomes of critically ill patients with cancer: a matched case–control study

V. C. Souza-Dantas, J. I. F. Salluh & M. Soares*

ICU and Post-Graduate Program in Oncology, Instituto Nacional de Câncer, Rio de Janeiro, Brazil

Variables	Survivors ($n = 46$, 24%)	Nonsurvivors ($n = 142$, 76%)	Odds ratio (95% CI)	P value
Age (years)	44 (25–65)	50 (34–65)	1.1 (0.99–1.03)	0.126
Neutropenia at ICU admission, n (%)				
No	21 (46)	73 (51)	1.00	0.295
Chemotherapy related	23 (50)	55 (39)	0.69 (0.35–1.37)	
Chemotherapy unrelated	2 (4)	14 (10)	2.01 (0.42–9.55)	
Male gender, n (%)	23 (50)	92 (65)	1.81 (0.94–3.61)	0.106
Type of admission, n (%)				
Medical	38 (83)	133 (94)	1.00	0.048
Emergency surgical	8 (17)	9 (6)	3.11 (1.12–8.61)	
Hospital days before ICU admission $(n)^b$	1 (0–8)	4 (1–12)	1.37 (1.06–1.77)	0.014
SAPS II—first day of ICU (points)	51.6 ± 12.5	64.8 ± 16.4	1.06 (1.03–1.09)	<0.001
SOFA score—first day of ICU (points)	9 (7–11)	12 (9–15)	1.22 (1.11–1.34)	<0.001
Type of cancer, n (%)				
Solid tumor	16 (35)	44 (31)	1.00	0.766
Hematological malignancy	30 (65)	98 (69)	1.19 (0.59–2.40)	
Cancer status, n (%)				
Controlled/remission	13 (28)	22 (16)	1.00	0.133
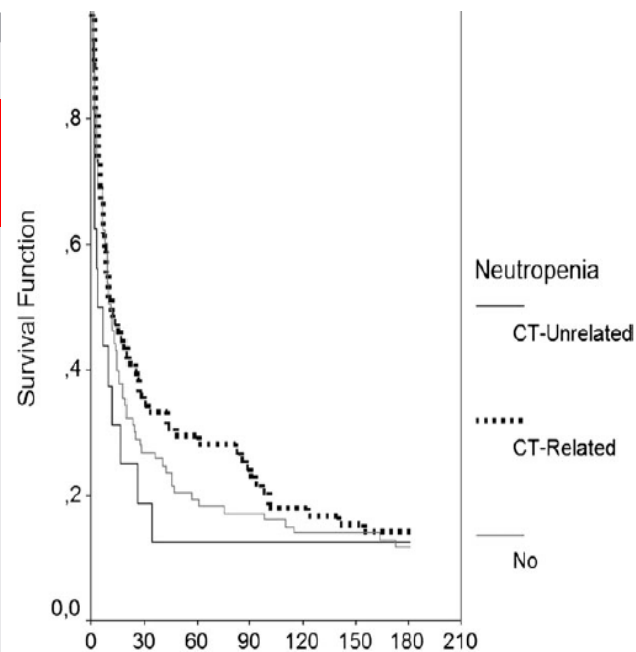
Mitos.

Determinados tipos de cáncer no sobreviven en UCI.

The ICU Trial: A new admission policy for cancer patients requiring mechanical ventilation*

Lucien Lecuyer, MD; Sylvie Chevret, MD, PhD; Guillaume Thiery, MD; Michael Darmon, MD;
Benoît Schlemmer, MD; Élie Azoulay, MD, PhD

Table 1. Characteristics of the malignancy

Patients	Early Decedents (n = 85)	Decedents After Day 4 (n = 62)	Hospital Survivors (n = 41)	p Value
Age, yrs (IQR)	51 (36–67)	56.8 (47.2–66.7)	44.7 (42.1–58.8)	.05
Male gender, n (%)	55 (64)	43 (69.3)	26 (63.4)	.6
Comorbidities, n (%)				
Hypertension	30 (35.3)	19 (30.6)	5 (12.1)	.03
COPD	8 (9.4)	7 (11.3)	6 (14.6)	.7
Chronic heart failure	4 (4.7)	3 (4.8)	2 (4.8)	.9
Long term steroids	1 (1.2)	3 (4.8)	3 (7.3)	.6
One comorbidity	29 (34.1)	35 (56.4)	19 (46.3)	.4
Chronic health status, n (%)				
Normal or slight alteration	74 (87.1)	49 (78.9)	32 (78)	.7
Altered	11 (12.9)	13 (20.9)	9 (21.9)	.9
Bedridden	0	0	0	—
Characteristics of the malignancy, n (%)				
Acute leukemia	25 (29.4)	20 (32.3)	11 (26.8)	.5
Chronic lymphocytic leukemia	5 (6)	3 (4.8)	2 (4.9)	.9
Non-Hodgkin's lymphoma	20 (23.5)	14 (22.6)	11 (26.8)	.6
Multiple myeloma	10 (11.8)	7 (11.3)	4 (9.7)	.8
Lung and breast cancer	12 (14.1)	8 (12.9)	6 (15.3)	.8
Other solid tumor	13 (15.3)	10 (16.1)	7 (17)	.9
Time from diagnosis, days (IQR)	54 (11–179)	37 (6–340)	67 (15–343)	.8
Treatments received for the malignancy				
Courses of chemotherapy, n (IQR)	3 (1–3)	2.5 (0–4)	3.3 (0–5.25)	.7
Autologous stem cell transplantation, n (%)	10 (11.7)	9 (14.5)	5 (12.9)	.8
Status of the malignancy at ICU admission, n (%)				
First 3 months of the treatment	45 (52.9)	36 (58)	23 (56)	.4
Remission or stability	40 (47.1)	21 (34)	16 (39)	.6
Relapse	0	4 (6.5)	2 (5)	.2

Mitos.

Mortalidad en UCI depende de la evolución del tumor.

Prognosis of patients with acute myeloid leukaemia admitted to intensive care

Antoine Rabbat,[1,*] Driss Chaoui,[2,*]
David Montani,[1] Ollivier Legrand,[2]
Aurélie Lefebvre,[1] Bernard Rio,[2] Nicolas
Roche,[1] Christine Lorut,[1] Jean-Pierre
Marie[2] and Gérard Huchon[1]

Summary

This retrospective study assessed the prognostic factors associated with early and long-term outcome in consecutive patients with acute myeloid leukaemia (AML) admitted to the intensive care unit (ICU) over a 9-year period. A total

	All patients ($n = 83$)	Alive at discharge ($n = 55$)	Deaths in ICU ($n = 28$)	P-value
Sex: male/female	40/43	28/27	12/16	NS
Age >60 years, n (%)	22 (27)	13 (24)	9 (32)	NS
Median age (years) ± SD	48 ± 16	47 ± 15	51 ± 16	NS
WBC at diagnosis of AML ($\times 10^9$/l)	50 ± 13	53 ± 11	40 ± 13	NS
Performance status score ≥2 (%)	33 (40)	19 (35)	14 (50)	NS
Secondary AML, n (%)	11 (13)	8 (15)	3 (11)	NS
Cytogenetics abnormalities*, n (%)				
Unfavourable	8/53 (15)	4/38 (11)	4/15 (27)	NS
Intermediate	26/53 (49)	20/38 (52)	6/15 (40)	
Favourable	19/53 (36)	14/38 (37)	5/15 (33)	
AML subtypes (FAB classification), n (%)				
AML0	7 (8)	3 (5)	4 (14)	NS
AML1	14 (17)	10 (18)	4 (14)	
AML2	21 (25)	14 (25)	7 (25)	
AML3	12 (14)	10 (18)	2 (7)	
AML4	15 (18)	9 (17)	6 (21)	
AML5	9 (11)	6 (11)	3 (11)	
AML6	2 (3)	1 (2)	1 (4)	
Undetermined	3 (4)	2 (4)	1 (4)	
Treatment phase at admission to ICU, n (%)				
Before chemotherapy	12 (15)	8 (15)	4 (14)	NS
Induction treatment	44 (53)	29 (53)	15 (53)	
Consolidation treatment	10 (12)	5 (9)	5 (18)	
After transplantation	10 (12)	9 (16)	1 (4)	
Relapse	7 (8)	4 (7)	3 (11)	
PMN <0·5 × 10⁹/l, n (%)	50 (60)	33 (60)	17 (60)	NS
No. achievement of CR, n (%)	25 (30)	19 (34)	6 (21)	NS

Mitos.

Quimioterapia ≠ UCI

Intensive care in patients with newly diagnosed malignancies and a need for cancer chemotherapy*

Michael Darmon, MD; Guillaume Thiery, MD; Magali Ciroldi, MD; Sandra de Miranda, MD;
Lionel Galicier, MD; Emmanuel Raffoux, MD; Jean-Roger Le Gall, MD; Benoît Schlemmer, MD;
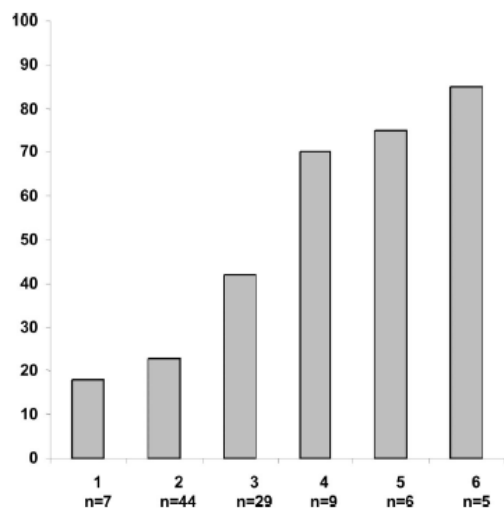Élie Azoulay, MD, PhD

Figure 1. Thirty-day mortality rates (%, y-axis) according to the number of organ failures (columns).

Table 3. Multivariable analysis: Independent predictors of 30-day mortality

	Odds Ratio	95% CI	p Value
Need for vasopressors	6.01	1.86–19.4	.003
Mechanical ventilation	6.36	1.76–22.94	.028
Hepatic failure	7.76	1.25–48.27	.005

- Historia del cáncer en UCI.

- Mitos entre los intensivistas.

- Factores pronósticos.

- Dificultades diagnósticas.

- Algoritmo de ingreso / estudio.

Factores inciden en la mortalidad en UCI.

Mortalidad %

N° de disfunciones.
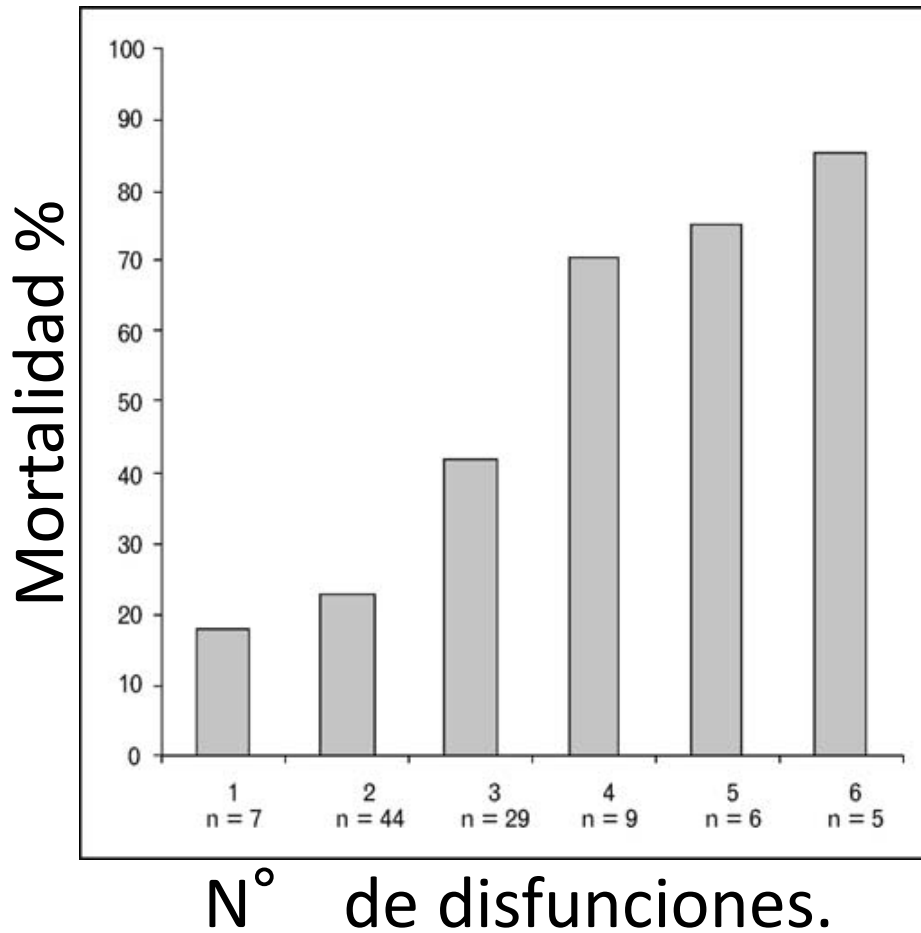
Number of failing organs

Prognostic factors for hospital mortality by multivariate forward stepwise logistic regression analysis in patients with solid cancer (n = 404)

	OR	95% CI	p value
SAPS II*	1.07	1.05 to 1.08	<0.001
Sepsis	2.1	1.2 to 3.7	0.01
ALI/ARDS	2.5	1.2 to 5.3	0.014
Mechanical ventilation	2.4	1.2 to 4.7	0.015

Factores inciden en la mortalidad en UCI.

Survival in neutropenic patients with severe sepsis or septic shock*

Matthieu Legrand, MD; Adeline Max, MD; Vincent Peigne, MD; Eric Mariotte, MD; Emmanuel Canet, MD; Alexandre Debrumetz, MD; Virginie Lemiale, MD; Amélie Seguin, MD; Michael Darmon, MD; Benoît Schlemmer, MD; Élie Azoulay, MD, PhD

1 UCI. 1998-2008

Variable, N (%) or Median (25th–75th)	Alive (n = 215)	Dead (n = 213)	Odds Ratio (95% Confidence Interval)	p
Age, yrs	47 (35–57)	51 (47–55)	1.036 (1.02–1.05)	<.0001
Intensive care unit admission during the second period (between 2004 and 2008)	139 (64.6)	105 (49.3)	0.56 (0.36–0.89)	.01
Shock	123 (57.2)	181 (85.0)	2.69 (1.65–4.38)	<.0001
Acute respiratory failure	61 (28.4)	171 (80.3)	1.98 (1.14–3.44)	.015
Neurologic failure	7 (3.2)	37 (17.4)	4.03 (1.03–15.8)	.04
Hepatic failure	7 (3.2)	20 (9.4)	1.49 (1.16–1.91)	.002
Early acute noninfectious conditions	77 (35.8)	98 (46.0)	1.69 (1.06–2.68)	.02
Initial combination antibiotic therapy	210 (97.7)	181 (85.0)	0.164 (0.05–0.51)	.002
Indwelling catheter removal	68 (31.6)	39 (18.3)	0.50 (0.30–0.85)	.01
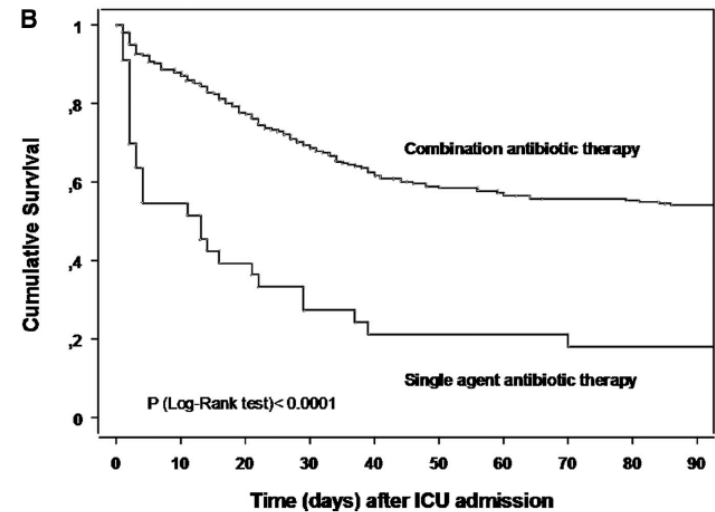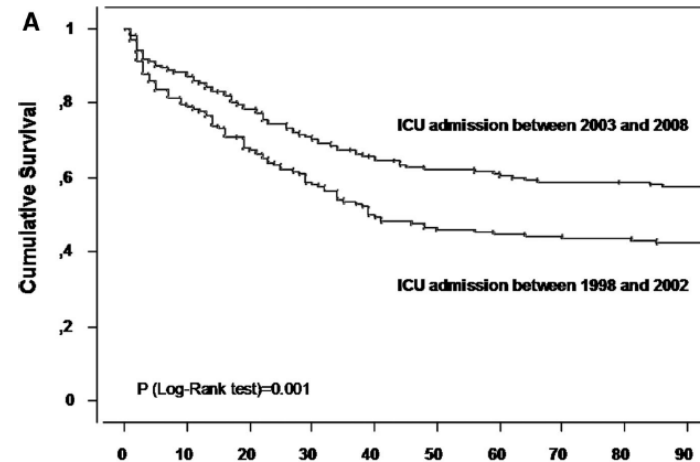
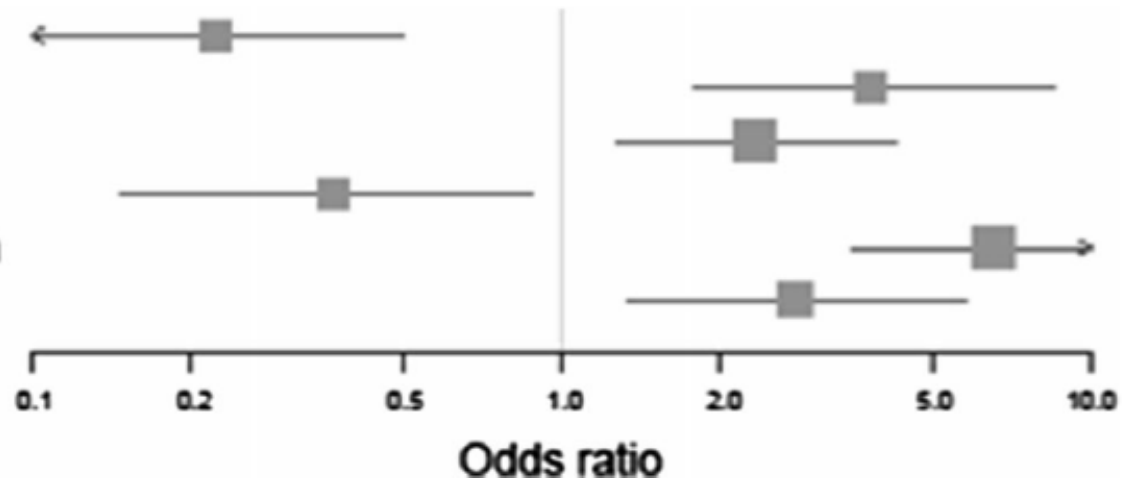# Factores inciden en la mortalidad en UCI.

ORIGINAL

D. Mokart
M. Darmon
M. Resche-Rigon
V. Lemiale

Prognosis of neutropenic patients admitted to the intensive care unit

N=289 años 2010-2012 17 UCIs

Age < 70 years
Allogeneic HSCT
Microbiological documentation
Neutropenic enterocolitis
Invasive mechanical ventilation
Renal replacement therapy

Odds ratio

Factores inciden en la mortalidad en UCI.

The Prognosis of Acute Respiratory Failure
in Critically Ill Cancer Patients

*Élie Azoulay, MD, PhD, Guillaume Thiéry, MD, Sylvie Chevret, MD, PhD,
Delphine Moreau, MD, Michaël Darmon, MD, Anne Bergeron, MD, PhD, Kun Yang, MD,
Véronique Meignin, MD, Magali Ciroldi, MD, Jean-Roger Le Gall, MD,
Abdellatif Tazi, MD, PhD, and Benoît Schlemmer, MD*

n=203. 1 UCI.

TABLE 6. Multivariable Analysis: Independent Predictors of Hospital Death*

	Odds Ratio	95% Confidence Interval	p Value
Cause of ARF			
Congestive heart failure	0.16	0.03–0.72	0.01
Invasive aspergillosis	3.78	1.05–14.24	0.049
No definite diagnosis	3.85	1.26–11.70	0.01
Need for vasopressors	3.19	1.28–7.95	0.01
Need for respiratory support			
NIMV only	1.58	0.37–6.70	0.52
NIMV followed by conventional MV	17.46	5.04–60.52	<0.0001
First-line conventional MV	8.75	2.35–32.54	0.001
Late NIMV failure[†]	10.64	1.05–107.83	0.04

- Historia del cáncer en UCI.

- Mitos entre los intensivistas.

- Factores pronósticos.

- **Dificultades diagnósticas.**

- Algoritmo de ingreso / estudio.

Desconocimiento de la patología neoplásica.

UCI polivalente. Período 1999-2005.

3257 pacientes. 658 fallecidos.

86 autopsias. 43 pacientes oncológicos.

10 errores clase I y II entre los oncológicos (22%).

Necesidad de discusión.

Characteristics	Admitted (n = 105; 51%)	
	No. of Patients	%
Age, years		
Median	52	
Range	39-58	
Female	34	32.4
Poor chronic health status*	35	33.3
Nature of underlying malignancy		
Acute leukemia	29	27.6
Lymphoma	21	20
Solid tumors	22	21
Chronic lymphocytic or myelogenous leukemia	5	4.8
Multiple myeloma	13	12.4
Allogeneic bone marrow or stem-cell transplantation	20	19
Neutropenia	30	28.5
Remission of the malignancy	29	27.6
First-line chemotherapy	35	33.3
Reason for ICU admission request		
Shock	33	31.4
Respiratory failure	25	23.8
Coma	17	16.2
Sepsis	20	19
Acute renal failure	6	5.7
Circumstances of triage decision		
One intensivist	34	32.4
Two intensivists	2	1.9
Intensivist and oncologist	69	65.7
At night	33	35.5
Expected mortality (MPM0 based)		
Median	0.12	
Range	0.05-0.25	
Time from treatment onset, hours		
Median	3	
Range	0-12	
Expected survival > 28 days†	62	59

- Historia del cáncer en UCI.

- Mitos entre los intensivistas.

- Factores pronósticos.

- Dificultades diagnósticas.

- **Algoritmo de ingreso / estudio.**
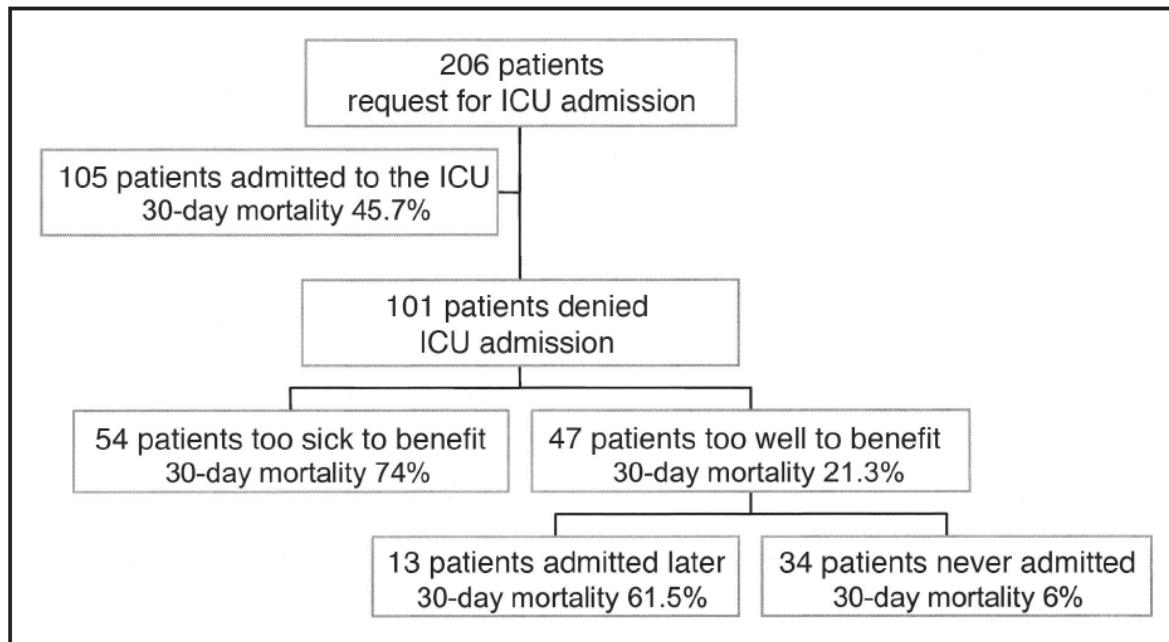
Qué pacientes deben ingresar?

Errores en la selección.

Outcome of Cancer Patients Considered for Intensive Care
Unit Admission: A Hospital-Wide Prospective Study

Guillaume Thiéry, Élie Azoulay, Michael Darmon, Magali Ciroldi, Sandra De Miranda, Vincent Lévy,
Fabienne Fieux, Delphine Moreau, Jean Roger Le Gall, and Benoît Schlemmer

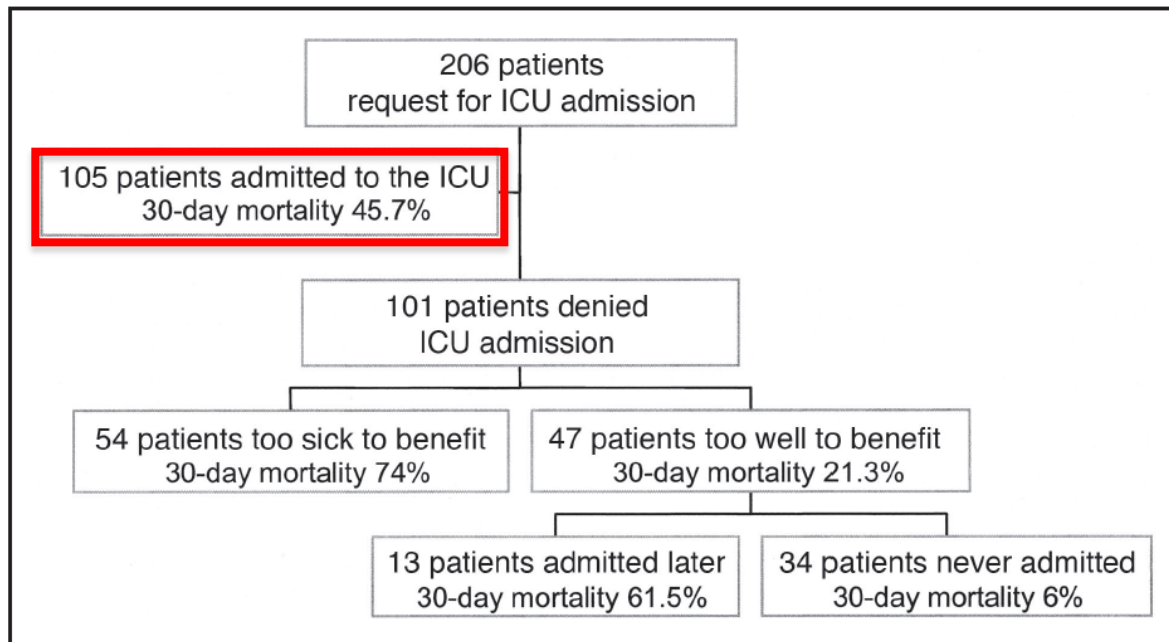# Qué pacientes deben ingresar?

Errores en la selección.

Outcome of Cancer Patients Considered for Intensive Care
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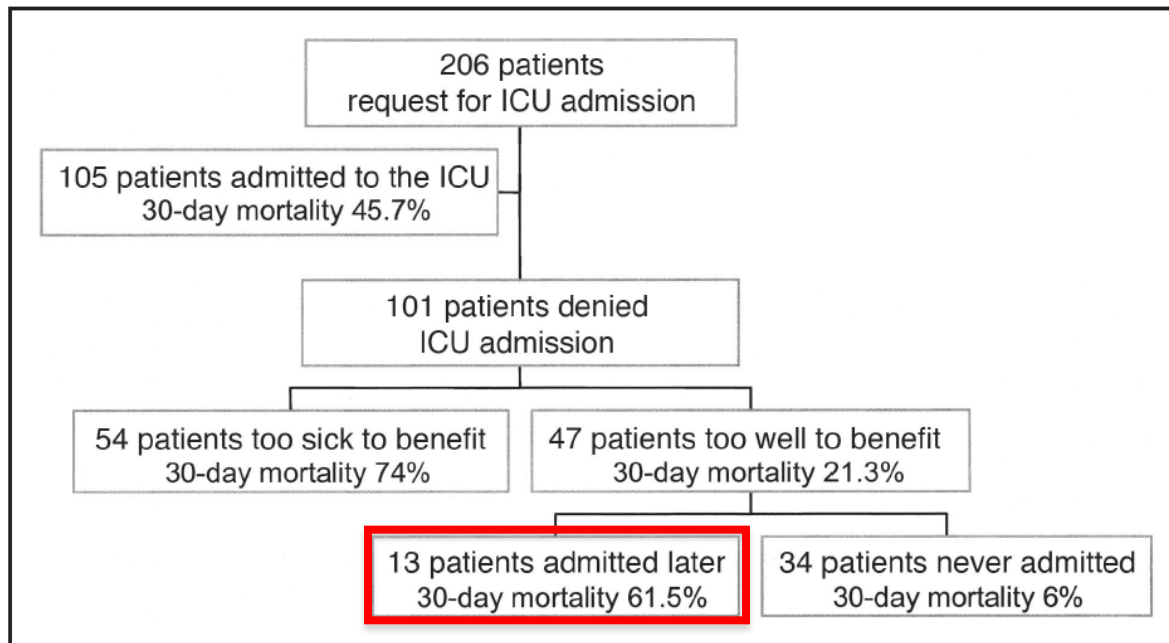# Qué pacientes deben ingresar?

Errores en la selección.

Outcome of Cancer Patients Considered for Intensive Care
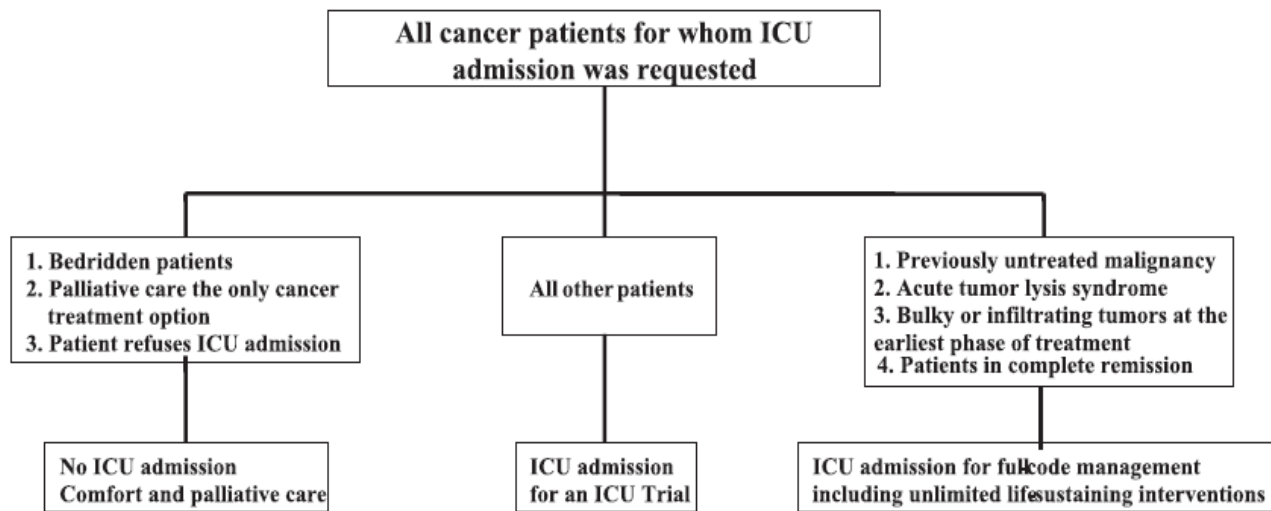Unit Admission: A Hospital-Wide Prospective Study

Guillaume Thiéry, Élie Azoulay, Michael Darmon, Magali Ciroldi, Sandra De Miranda, Vincent Lévy, Fabienne Fieux, Delphine Moreau, Jean Roger Le Gall, and Benoît Schlemmer
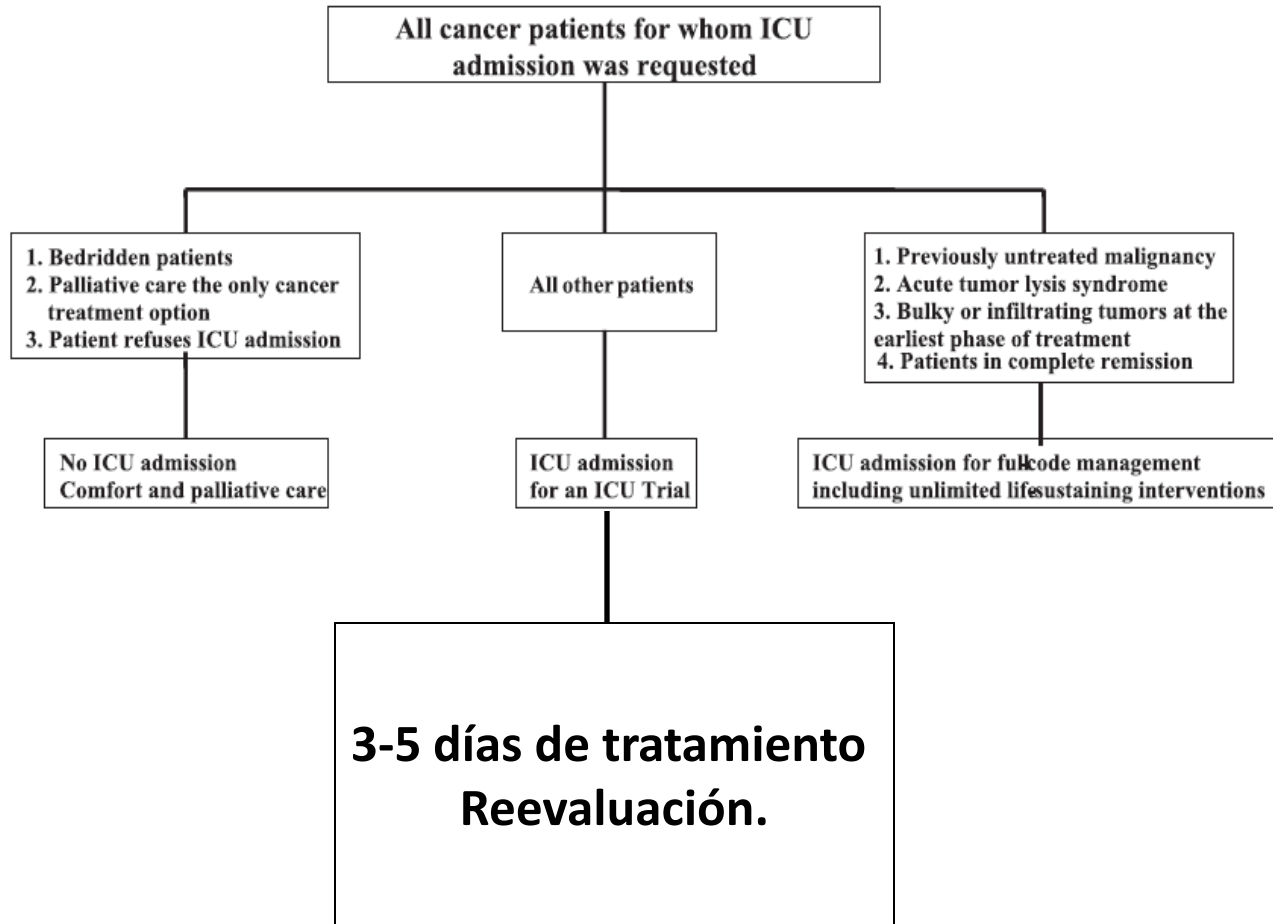
Algoritmo de ingreso.

The ICU Trial: A new admission policy for cancer patients
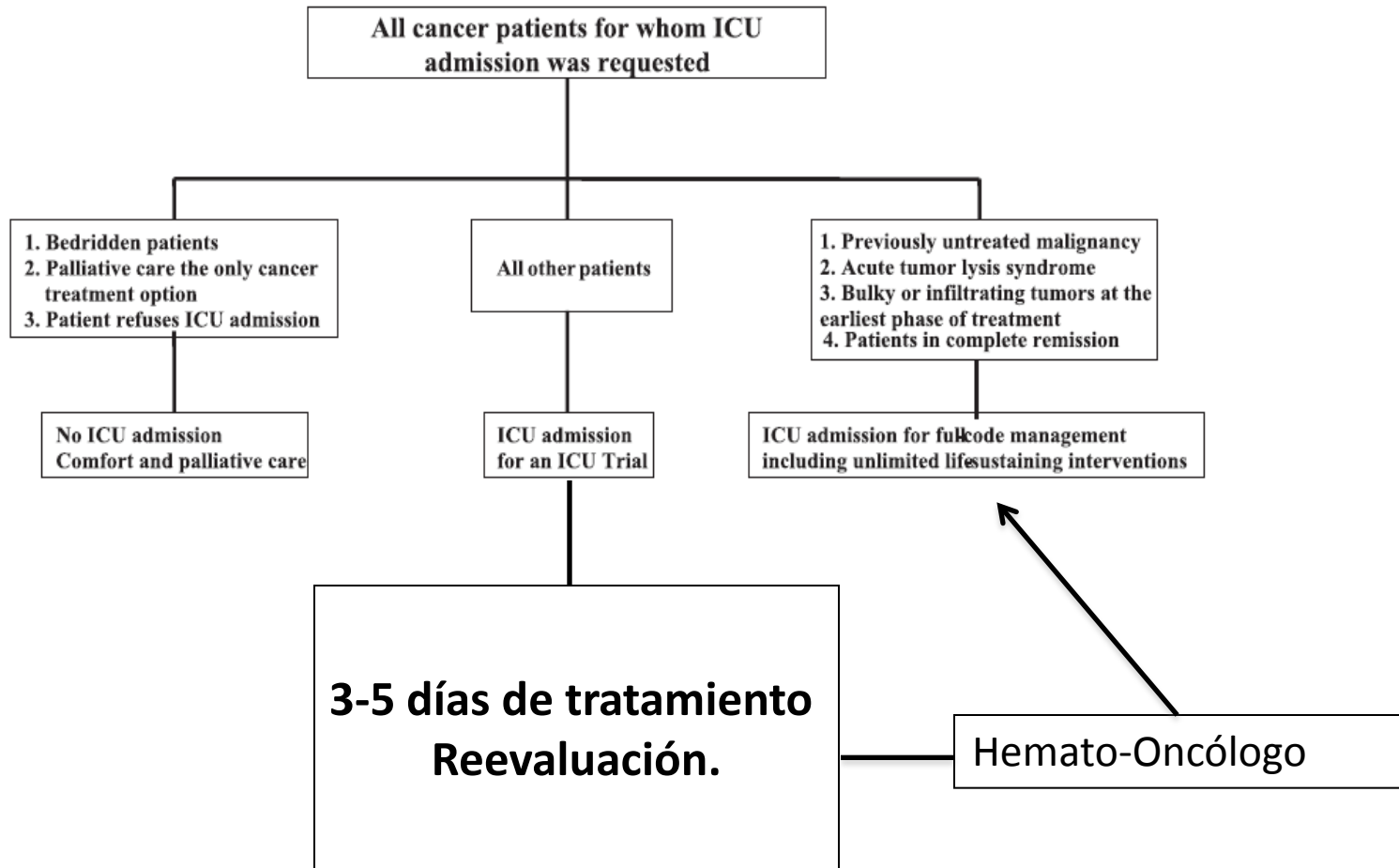requiring mechanical ventilation*

Lucien Lecuyer, MD; Sylvie Chevret, MD, PhD; Guillaume Thiery, MD; Michael Darmon, MD;
Benoît Schlemmer, MD; Élie Azoulay, MD, PhD
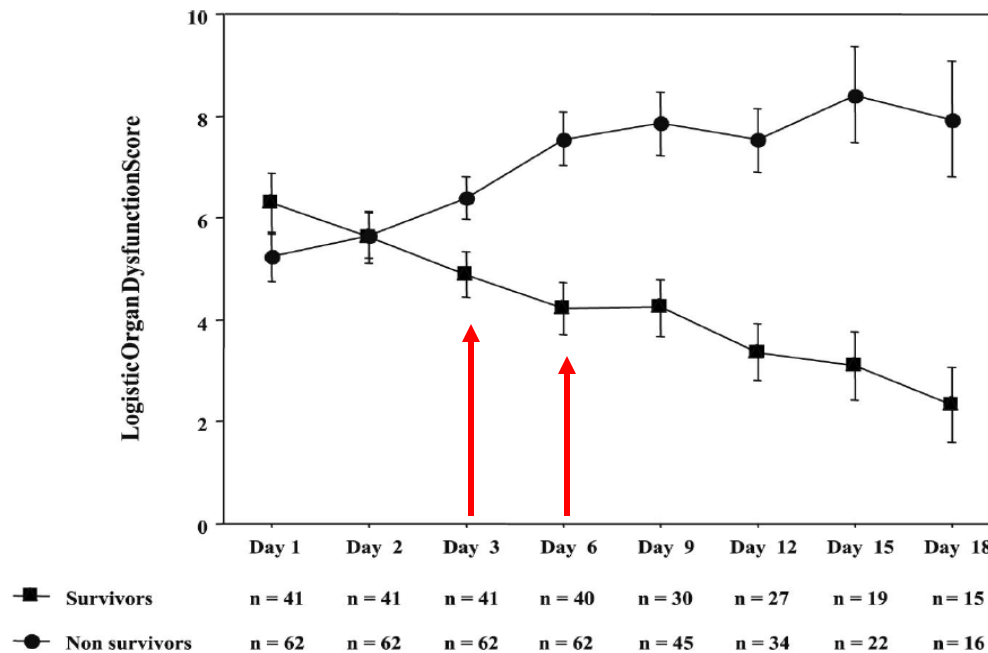
¿Qué pacientes deben ingresar?

All cancer patients for whom ICU admission was requested

1. Bedridden patients
2. Palliative care the only cancer treatment option
3. Patient refuses ICU admission

All other patients

1. Previously untreated malignancy
2. Acute tumor lysis syndrome
3. Bulky or infiltrating tumors at the earliest phase of treatment
4. Patients in complete remission

No ICU admission
Comfort and palliative care

ICU admission for an ICU Trial

ICU admission for full code management including unlimited life sustaining interventions

**3-5 días de tratamiento
Reevaluación.**

¿Qué pacientes deben ingresar?

All cancer patients for whom ICU admission was requested

1. Bedridden patients
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No ICU admission
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ICU admission for an ICU Trial

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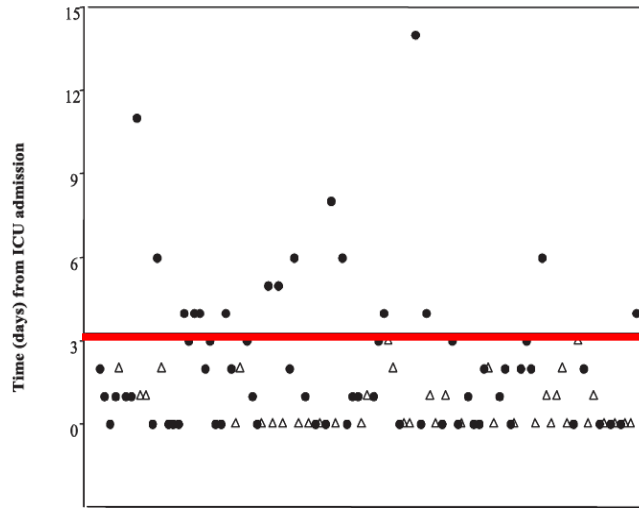**3-5 días de tratamiento Reevaluación.**
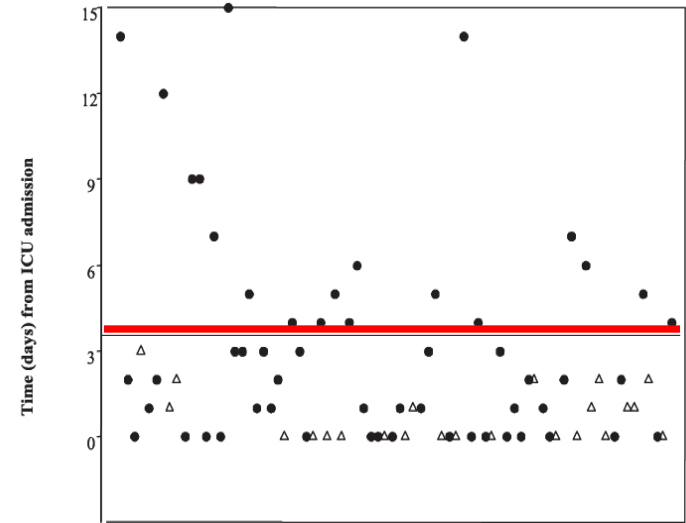
Hemato-Oncólogo

¿Por qué este tiempo?

The ICU Trial: A new admission policy for cancer patients requiring mechanical ventilation*

Lucien Lecuyer, MD; Sylvie Chevret, MD, PhD; Guillaume Thiery, MD; Michael Darmon, MD; Benoît Schlemmer, MD; Élie Azoulay, MD, PhD
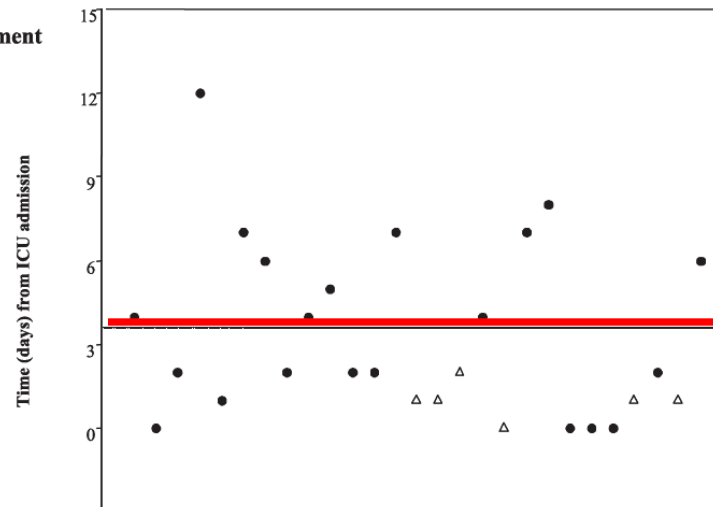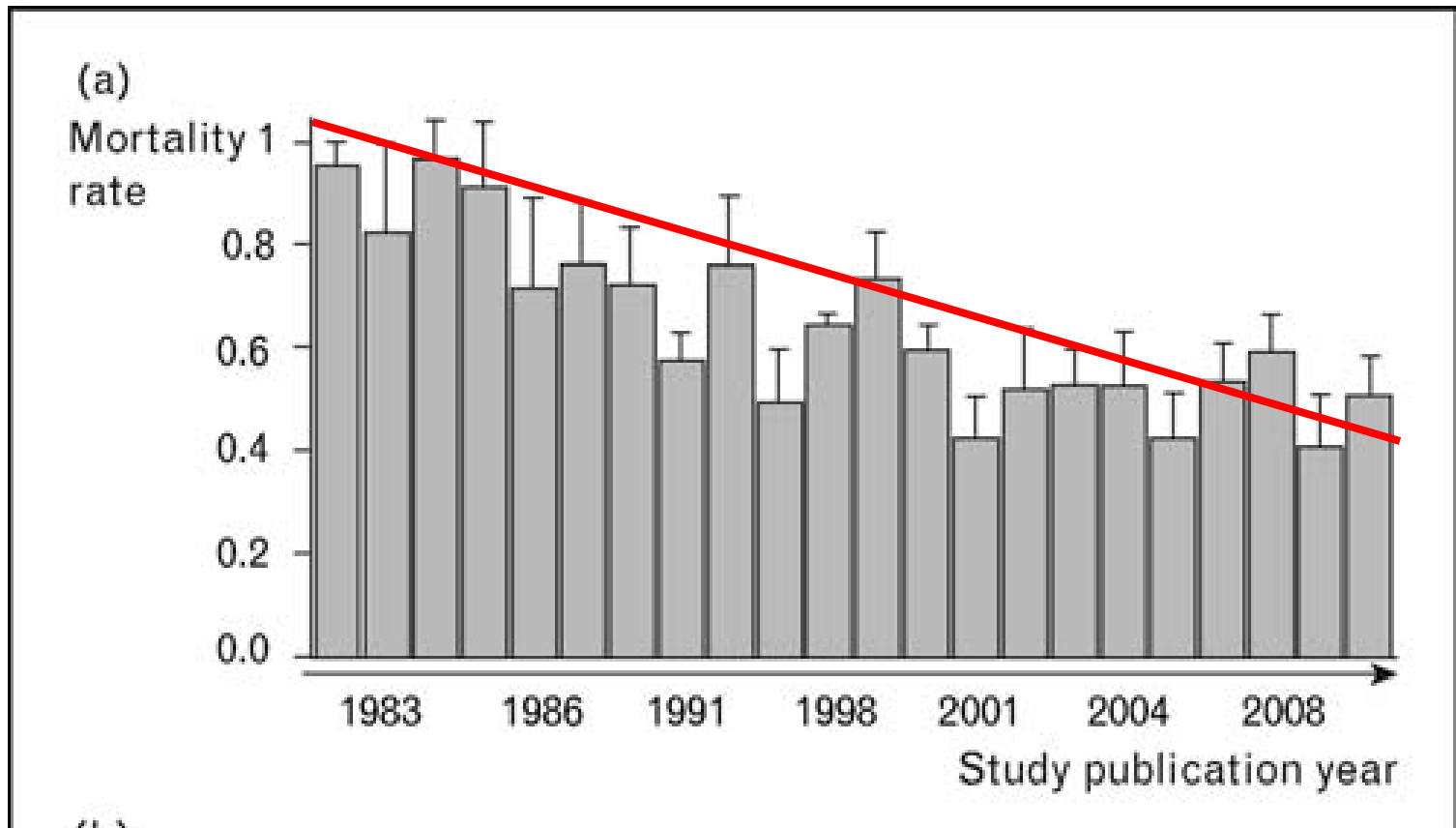
Estrategias

+

Selección de pacientes .

Estrategias + selección.

Critical care management of cancer patients: cause for optimism and need for objectivity
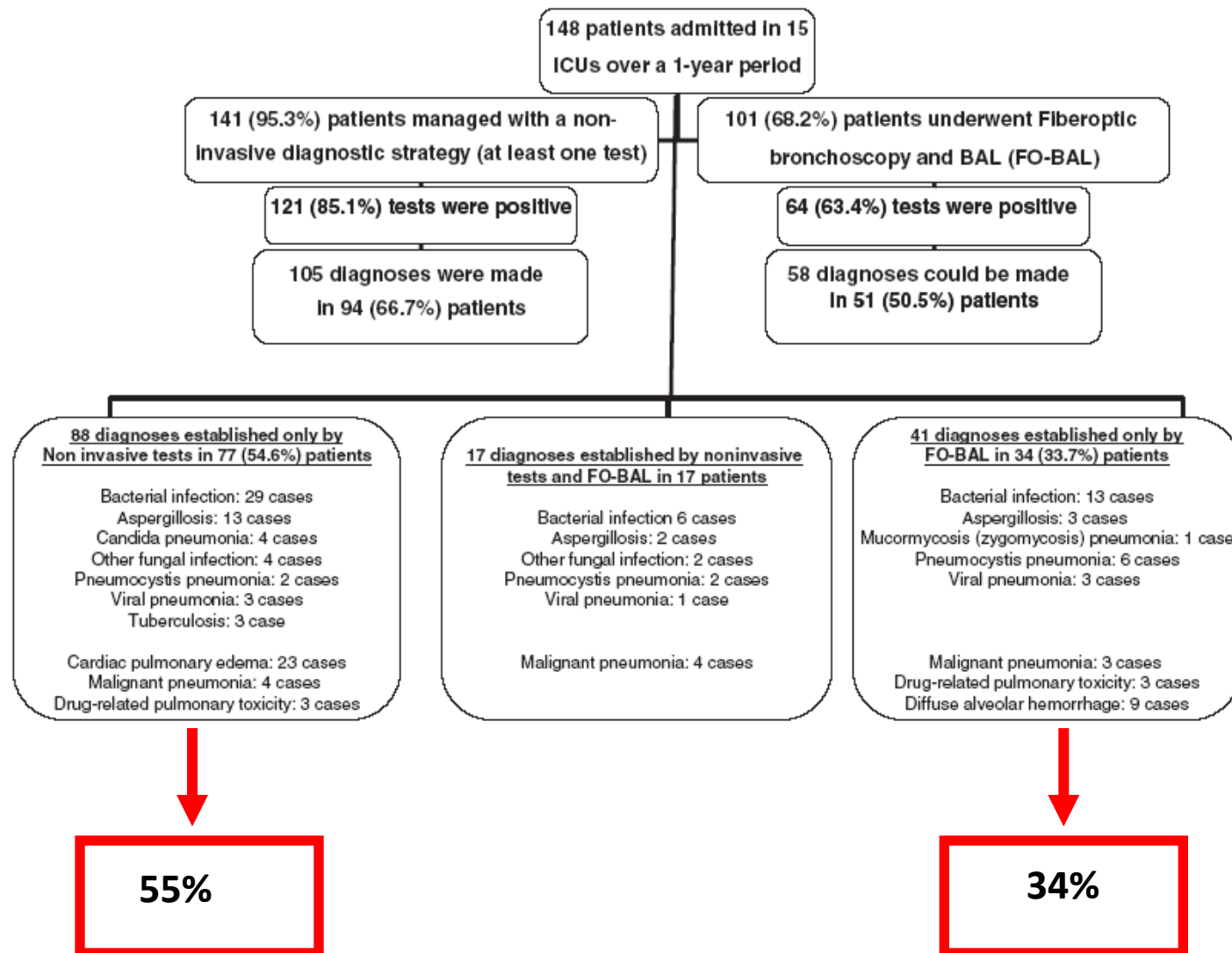Michael Darmon[a] and Elie Azoulay[a,b]

Current Opinion in Oncology 2009, 21:318–326

Estrategias de estudio.

Elie Azoulay, MD, PhD; Djamel Mokart, MD; Antoine Rabbat, MD; Frédéric Pene, MD; Achille Kouatchet, MD; Fabrice Bruneel, MD; François Vincent, MD; Rebecca Hamidfar, MD; Delphine Moreau, MD; Ismaël Mohammedi, MD; Geraldine Epinette, MS; Gaëtan Beduneau, MD; Vincent Castelain, MD; Arnaud de Lassence, MD†; Didier Gruson, MD; Virginie Lemiale, MD; Benoît Renard, MD; Sylvie Chevret, MD, PhD; Benoît Schlemmer, MD

Estrategias de estudio.

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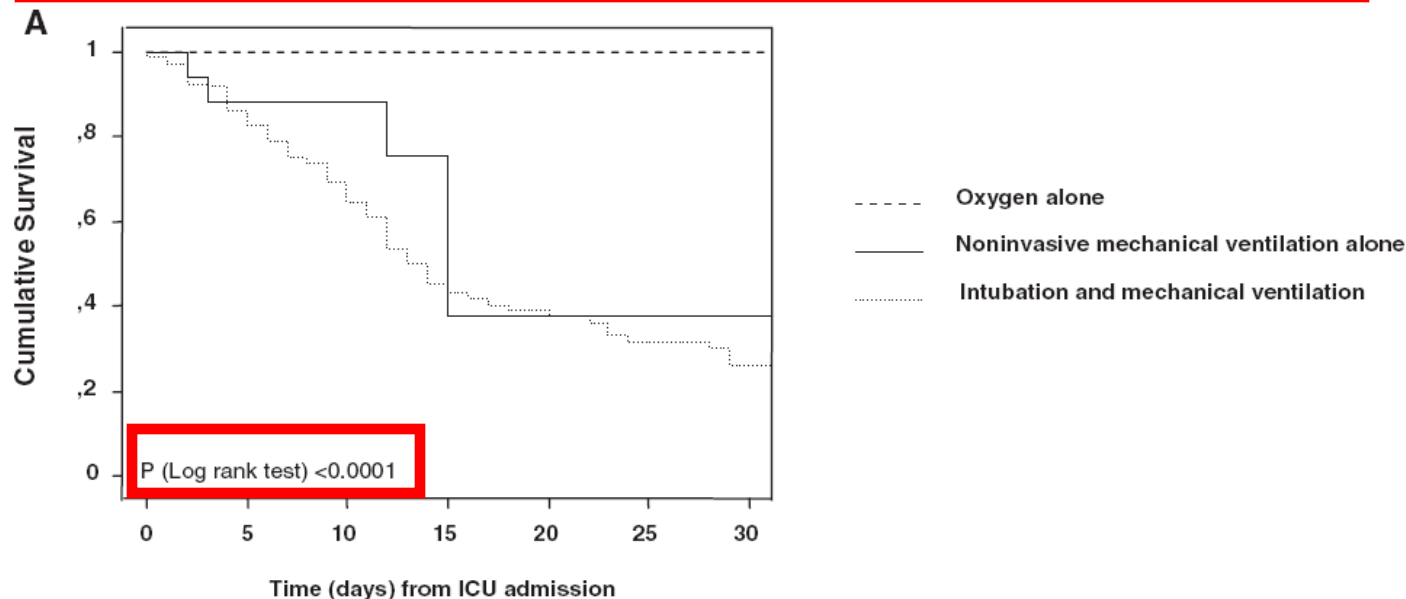
Impact of BAL analysis	
BAL yielded a pathogen	51 (50.5)
BAL was the only conclusive investigation	34 (33.7)
BAL fluid allowed initiation of adequate treatment	36 (35.6)
BAL fluid allowed withdrawal of useless treatments	30 (29.7)
Respiratory complications after FO-BAL in 45 patients not intubated at the time of BAL	
Increased oxygen for >12 hours	6 (13.3)
Initiation of NIMV after FO-BAL	4 (8.9)
Intubation after FO-BAL	12 (26.7)

A

Cumulative Survival vs Time (days) from ICU admission

P (Log rank test) <0.0001

- - - - - Oxygen alone

——— Noninvasive mechanical ventilation alone

············· Intubation and mechanical ventilation

Estrategias de estudio.

Diagnostic Strategy for Hematology and Oncology Patients with Acute Respiratory Failure
Randomized Controlled Trial

Élie Azoulay[1], Djamel Mokart[2], Jérôme Lambert[3], Virginie Lemiale[4], Antoine Rabbat[5], Achille Kouatchet[6], François Vincent[7], Didier Gruson[8], Fabrice Bruneel[9], Géraldine Epinette-Branche[1], Ariane Lafabrie[1], Rebecca Hamidfar-Roy[10], Christophe Cracco[11], Benoît Renard[12], Jean-Marie Tonnelier[13], François Blot[14], Sylvie Chevret[3], and Benoît Schlemmer[1]

314 cancer patients admitted to the ICU with Acute Respiratory Failure (ARF)

49 patients intubated at admission
11 patients refused to participate

34 patients with a known cause of ARF at ICU admission
(9 with cardiac pulmonary edema)

220 patients randomized

1 patient withdrew consent

113 patients in the Invasive Diagnostic Strategy (early FO-BAL)

106 patients in the Noninvasive diagnostic strategy (no early FO-BAL)

No diagnosis: N=23 (20.3%)
101 diagnoses in 90 patients
Established by FOBAL, n=18 (17.8%)
Established by noninvasive tests, n=63 (62.3)
Established by both techniques, n=20 (19.8%)

No diagnosis: N=23 (21.7%)
93 diagnoses in 83 patients
Established by FOBAL, n=2 (2.2%)
Established by noninvasive tests, n=80 (86.1)
Established by both techniques, n=11 (11.8%)

Estrategias de estudio.

Diagnostic Strategy for Hematology and Oncology Patients with Acute Respiratory Failure
Randomized Controlled Trial
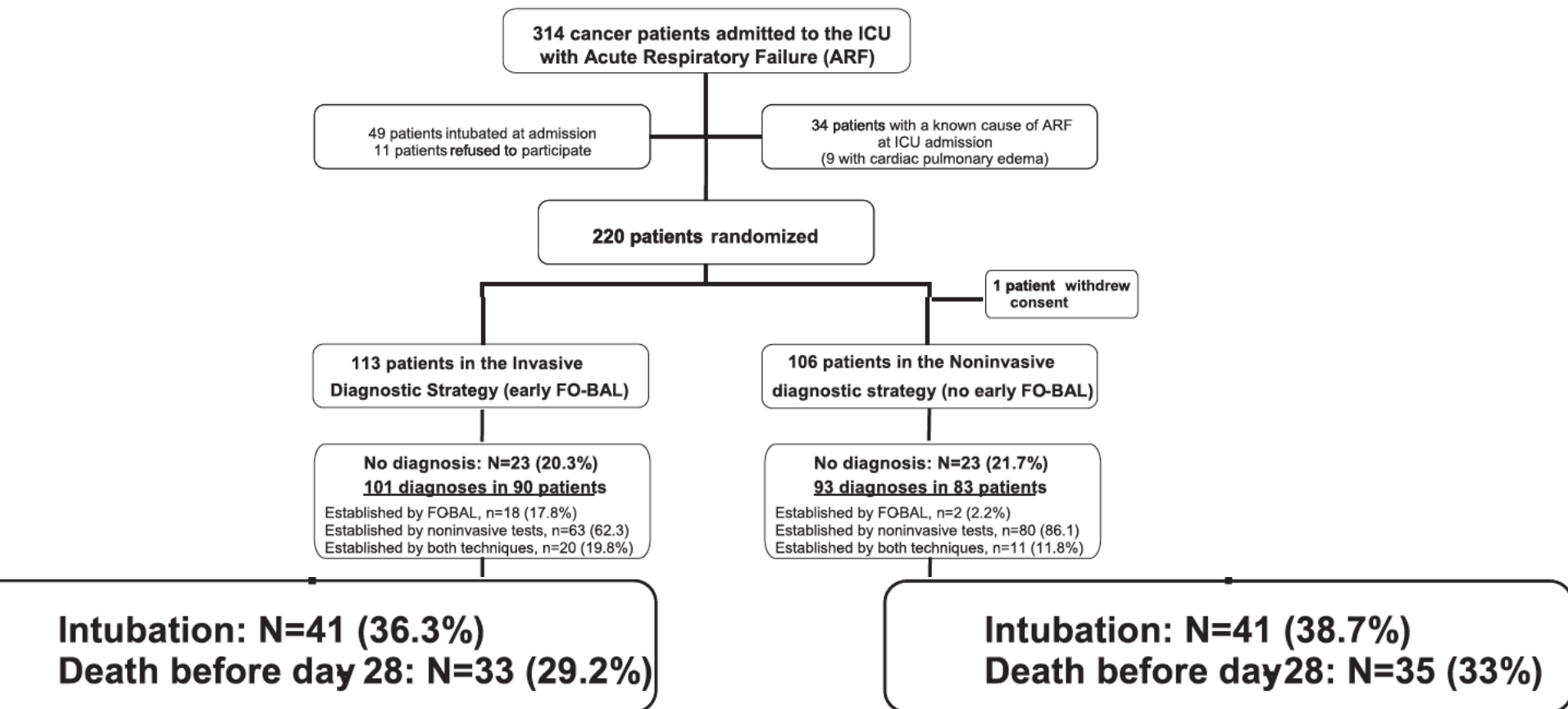
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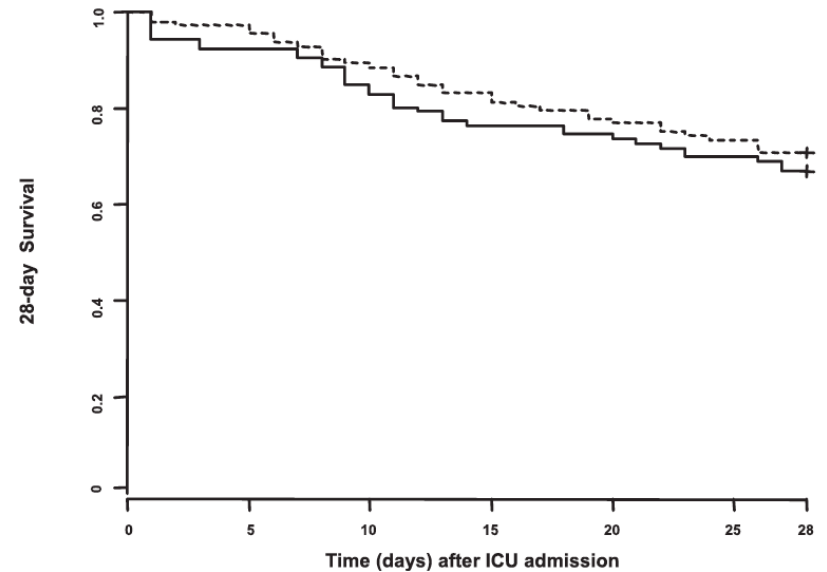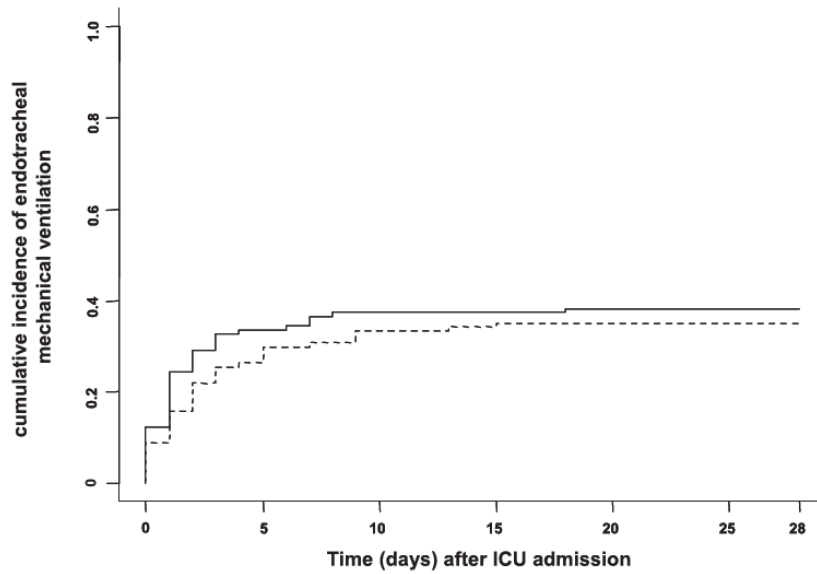
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¿Nuestra realidad?

Factores inciden en la mortalidad en UCI.

n=203. 1 UCI.

TABLE 6. Multivariable Analysis: Independent Predictors of Hospital Death*

	Odds Ratio	95% Confidence Interval	p Value
Cause of ARF			
Congestive heart failure	0.16	0.03–0.72	0.01
Invasive aspergillosis	3.78	1.05–14.24	0.049
No definite diagnosis	3.85	1.26–11.70	0.01
Need for vasopressors	3.19	1.28–7.95	0.01
Need for respiratory support			
NIMV only	1.58	0.37–6.70	0.52
NIMV followed by conventional MV	17.46	5.04–60.52	<0.0001
First-line conventional MV	8.75	2.35–32.54	0.001
Late NIMV failure[†]	10.64	1.05–107.83	0.04

Aspectos a tomar en cuenta a la hora de decidir...

Critical care management of cancer patients: cause for optimism and need for objectivity

Michael Darmon[a] and Elie Azoulay[a,b]