10 věcí, na které myslet ..

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- VFN – hematoonkologie, ÚHKT
  - 50-70 pacientů/rok
- Solidní nádory
- Neonkologičtí pacienti

- Nine-I investigators group

Osnova

1. Průběh
2. zajištění DC
3. biologická léčba
4. nečekané NÚ
5. diagnostická strategie
6. iniciální strategie ventilace
7. neobjasněná příčina ARF
8. Triage
9. goals of care
10. indikace IP

1. Průběh je rychlý

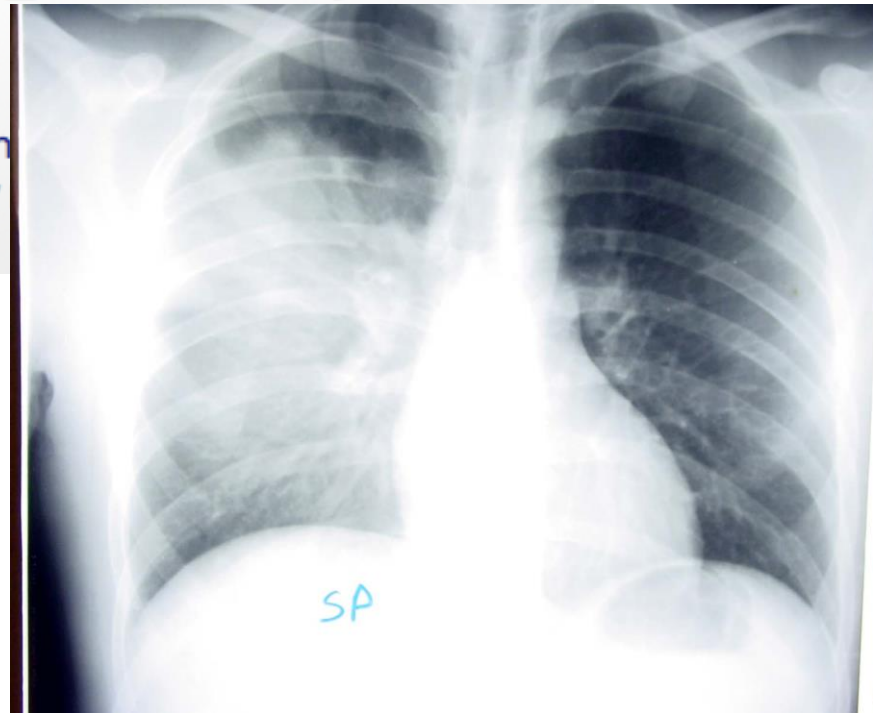
Research Article

Delayed intensive care unit admission is associated with increased mortality in patients with cancer with acute respiratory failure

Djamel Mokart ✉, Jérôme Lambert, David Schnell, Louis Fouché, Antoine Rabbat, Ach

Pages 1724-1729 | Received 20 Aug 2012, Accepted 21 Nov 2012, Accepted author version posted online: 27 Dec 2012

20% → 40%



2. Zajištění DC

Anesthesiology 2004; 100:826–34

Perioperative Cardiorespiratory Complications in Adults with Mediastinal Mass

Incidence and Risk Factors

Philippe Béchard, M.D., M.Sc., F.R.C.P.C., Louis Létourneau, M.D., F.R.C.P.C.,† Yves Lacasse, M.D., M.Sc., F.R.C.P.C.,‡ Dany Côté, M.D., F.R.C.P.C.,§ Jean S. Bussières, M.D., F.R.C.P.C.‖*

3. Biologická léčba

Tip 5. Immunotherapy adverse events and symptoms related to cancer can resemble each other; timing and severity may give a clue

Top Ten Tips for Palliative Care Clinicians Caring for Cancer Patients Receiving Immunotherapies

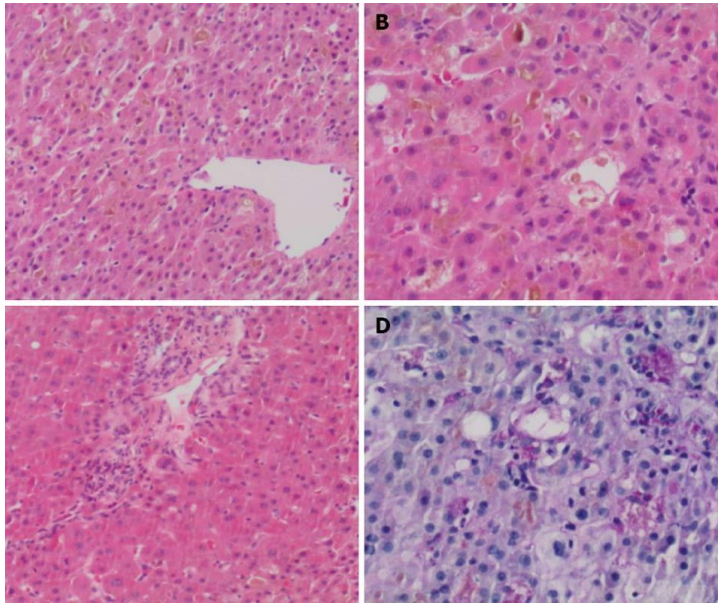
Alison C. Wiesenthal, MD, FACP,[1] Sandip P. Patel, MD,[2] Thomas W. LeBlanc, MD, MA, MHS,[3] Eric J. Roeland, MD,[4] and Arif H. Kamal, MD, MBA, MHS[3,5]

TABLE 2. IMMUNOTHERAPY SIDE EFFECT FREQUENCY AND TREATMENTS FOR GRADE 3+ TOXICITIES

Side effect	*Frequency*	*Treatment*
Fatigue	10–40%	Exercise, stimulants, and/or supportive care
Rash/pruritis	30–50%	Topical +/– systemic glucocorticoids
Diarrhea/colitis	14–30%	Glucocorticoids, consider anti-TNF if refractory or worsening symptoms
Pyrexia	~10%	Acetaminophen, NSAIDs
Pneumonitis	<5%	Systemic glucocorticoids
Transaminitis	10–20%	Monitoring, dose modification and/or delay
Endocrinopathies:	10%	
Hypothyroidism		Thyroid hormone replacement
Hyperthyroidism		Monitoring, dose modification and/or delay
Hypophysitis		High-dose glucocorticoids, hormone supplementation
Adrenal insufficiency		Hospitalization, endocrine consult
Diabetes mellitus type 1		Insulin

Journal of Palliative care, 2018

4. Nečekaná rizika



Case Report

Drug-Induced Liver Injury Caused by Adalimumab: A Case Report and Review of the Bibliography

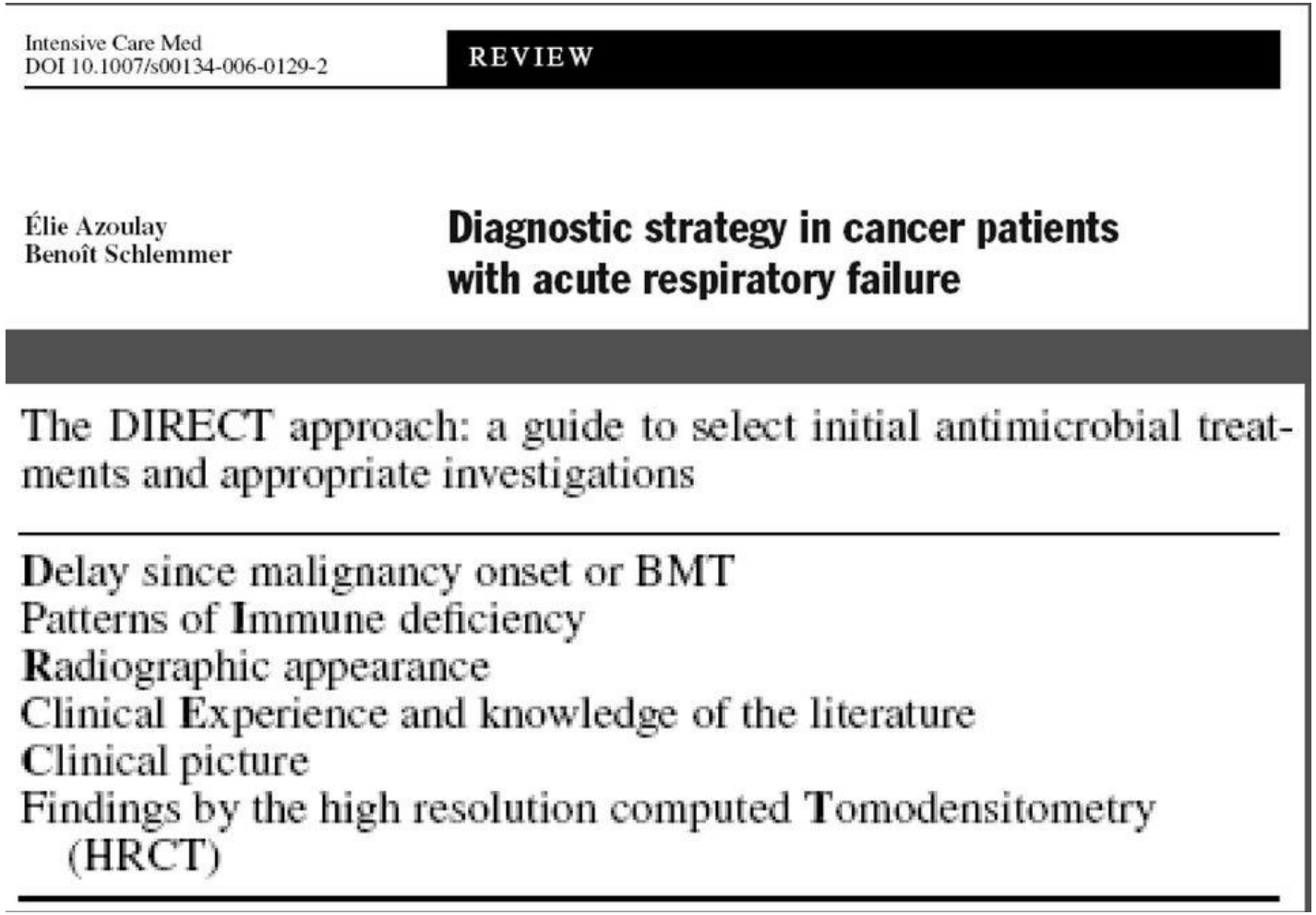
Bernardo Frider,[1] Andres Bruno,[1] Marcelo Ponte,[2] and Marcelo Amante[3]

Expert Review of Clinical Immunology

The Risk of Tuberculosis in Patients Treated with TNF Antagonists

5. Diagnostická strategie

- HK
- RTG, CT, HRCT
- ECHO
- sputum
- BAL
- Sérologie
- PCR krve CMV, Herpes..



Intensive Care Med
DOI 10.1007/s00134-006-0129-2

REVIEW

Élie Azoulay
Benoît Schlemmer

Diagnostic strategy in cancer patients with acute respiratory failure

The DIRECT approach: a guide to select initial antimicrobial treatments and appropriate investigations

Delay since malignancy onset or BMT
Patterns of **I**mmune deficiency
Radiographic appearance
Clinical **E**xperience and knowledge of the literature
Clinical picture
Findings by the high resolution computed **T**omodensitometry (HRCT)

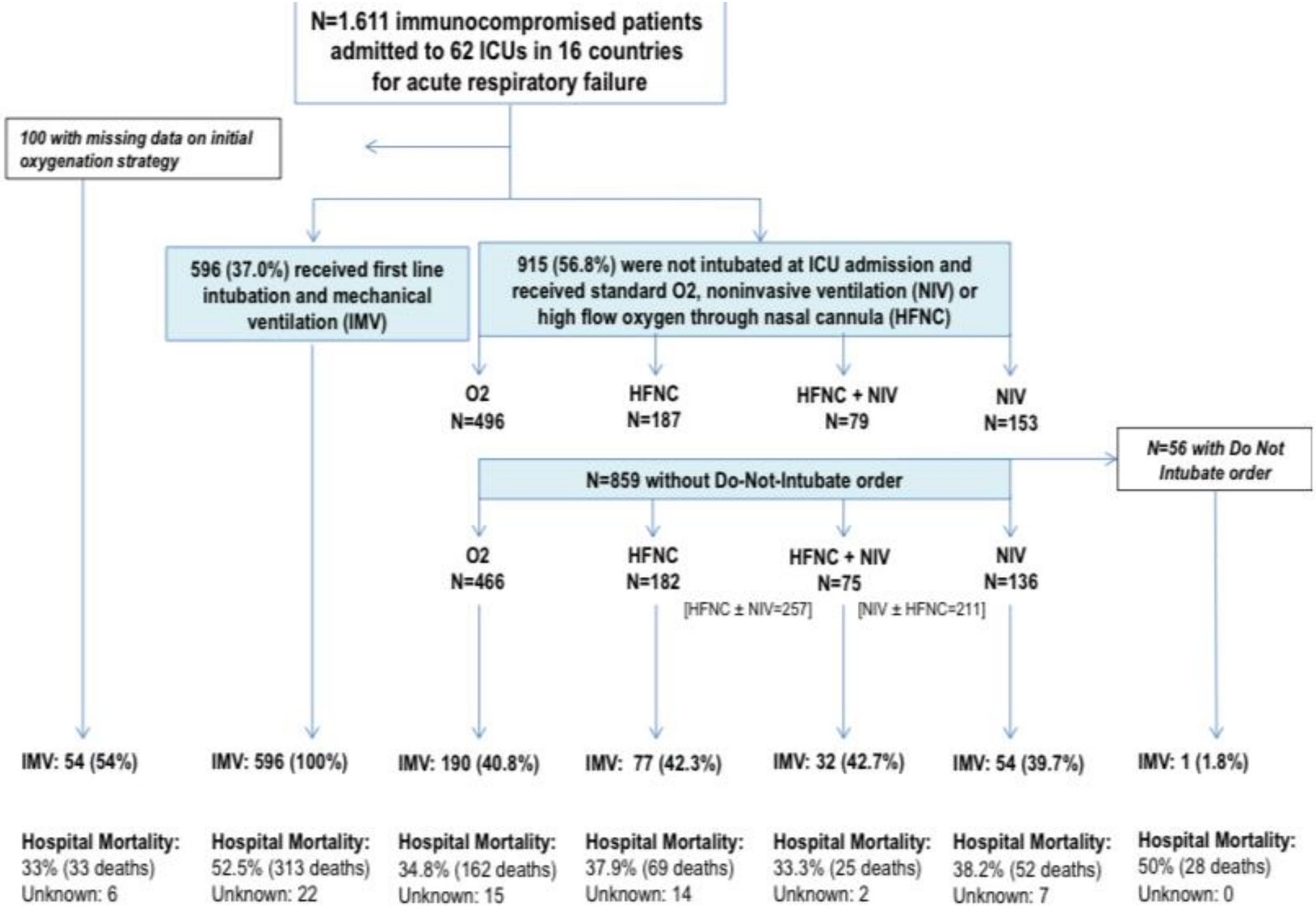
6.Iniciální ventilační strategie

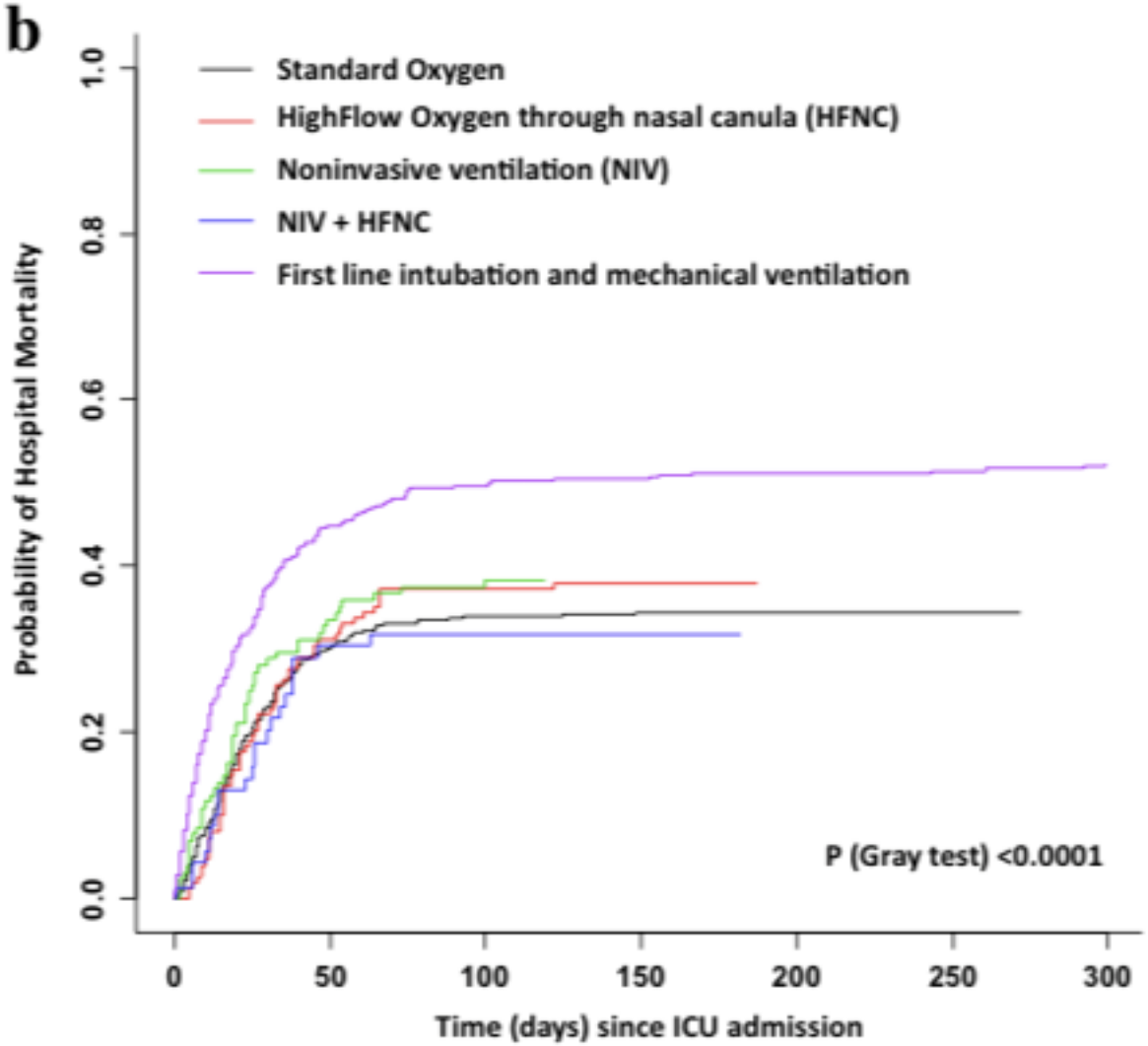
SEVEN-DAY PROFILE PUBLICATION

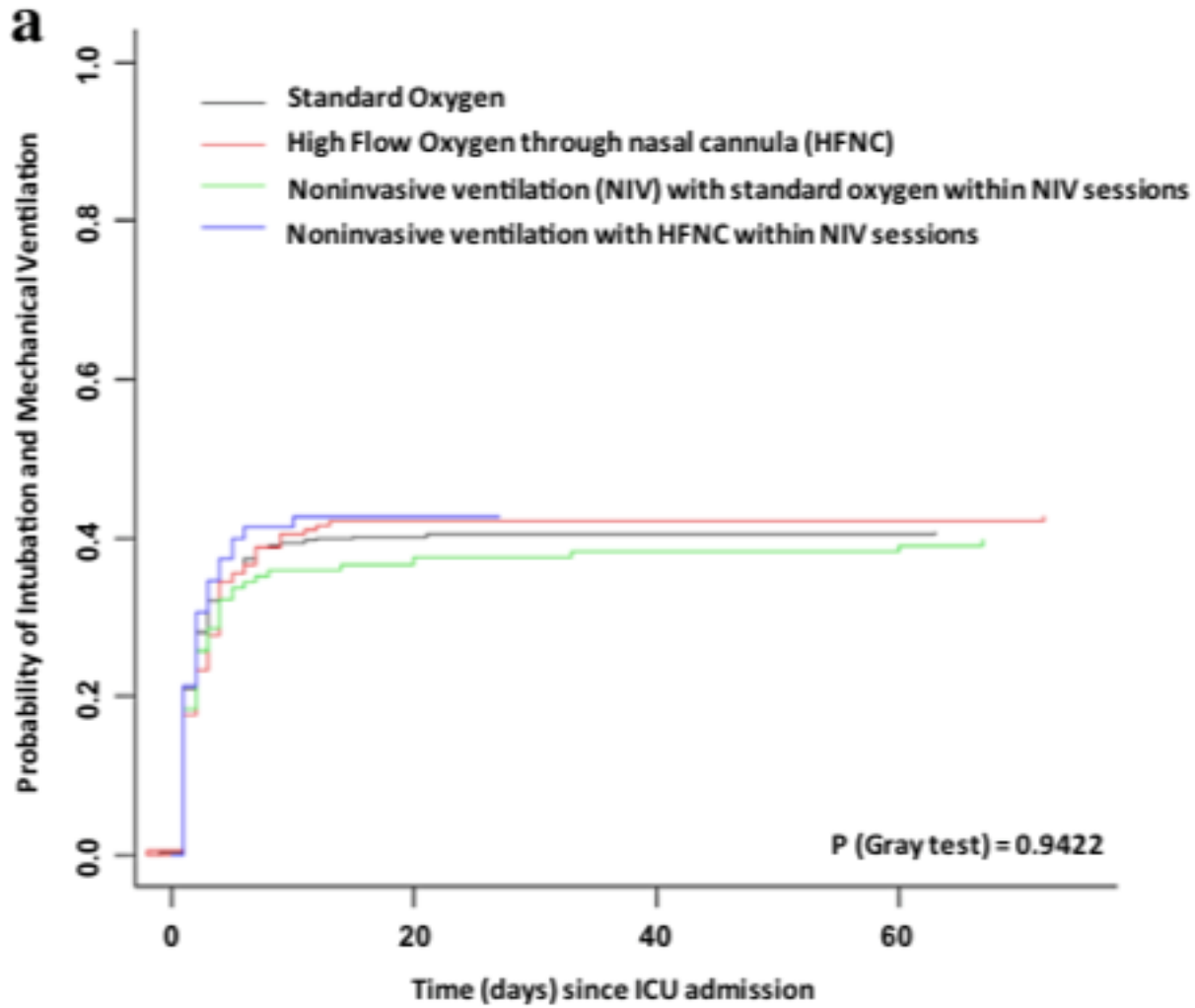
Acute hypoxemic respiratory failure in immunocompromised patients: the Efraim multinational prospective cohort study

1611 pacientů,
51% HO, 35% solidní nádory, 17% systémová onemocnění, 9% Tx
56% nebylo intubováno iniciálně

Intensive Care Med (2017) 43:1808–1819
DOI 10.1007/s00134-017-4947-1


N=1.611 immunocompromised patients admitted to 62 ICUs in 16 countries for acute respiratory failure
100 with missing data on initial oxygenation strategy
596 (37.0%) received first line intubation and mechanical ventilation (IMV)
915 (56.8%) were not intubated at ICU admission and received standard O2, noninvasive ventilation (NIV) or high flow oxygen through nasal cannula (HFNC)
O2 N=496
HFNC N=187
HFNC + NIV N=79
NIV N=153
N=56 with Do Not Intubate order
N=859 without Do-Not-Intubate order
O2 N=466
HFNC N=182
HFNC + NIV N=75
NIV N=136
[HFNC ± NIV=257]
[NIV ± HFNC=211]
IMV: 54 (54%)
IMV: 596 (100%)
IMV: 190 (40.8%)
IMV: 77 (42.3%)
IMV: 32 (42.7%)
IMV: 54 (39.7%)
IMV: 1 (1.8%)
Hospital Mortality: 33% (33 deaths) Unknown: 6
Hospital Mortality: 52.5% (313 deaths) Unknown: 22
Hospital Mortality: 34.8% (162 deaths) Unknown: 15
Hospital Mortality: 37.9% (69 deaths) Unknown: 14
Hospital Mortality: 33.3% (25 deaths) Unknown: 2
Hospital Mortality: 38.2% (52 deaths) Unknown: 7
Hospital Mortality: 50% (28 deaths) Unknown: 0


b
Standard Oxygen
HighFlow Oxygen through nasal canula (HFNC)
Noninvasive ventilation (NIV)
NIV + HFNC
First line intubation and mechanical ventilation
Probability of Hospital Mortality
0.0
0.2
0.4
0.6
0.8
1.0
0
50
100
150
200
250
300
Time (days) since ICU admission
P (Gray test) <0.0001


a
Standard Oxygen
High Flow Oxygen through nasal cannula (HFNC)
Noninvasive ventilation (NIV) with standard oxygen within NIV sessions
Noninvasive ventilation with HFNC within NIV sessions
Probability of Intubation and Mechanical Ventilation
0.0
0.2
0.4
0.6
0.8
1.0
0
20
40
60
Time (days) since ICU admission
P (Gray test) = 0.9422

7. Nejasná příčina ARF

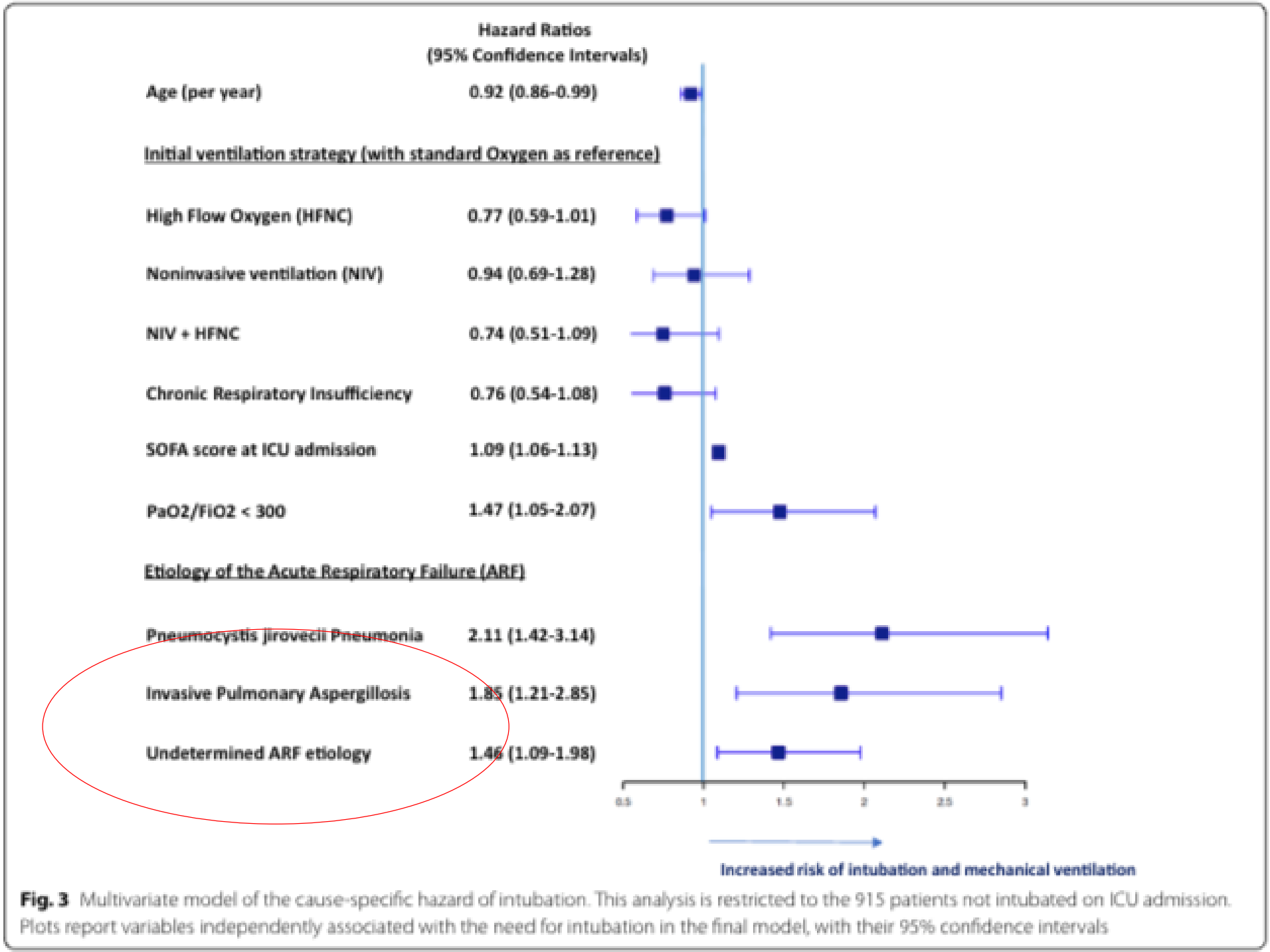


Fig. 3 Multivariate model of the cause-specific hazard of intubation. This analysis is restricted to the 915 patients not intubated on ICU admission. Plots report variables independently associated with the need for intubation in the final model, with their 95% confidence intervals

8. Triage pacientů

- 14% of patients proposed are refused
  - (ratio too well/too sick suggests an early proposition)
- Reasons for refusal are consistent
  - over the past 10 years (performance status, prior QOL)
- Circumstances:
  - consensus decision making
  - clinicians comfortable with the decision
- Outcome
  - too sick to benefit: 3 months survival = 0%
  - too well to benefit: hospital mortality 25%

	refused	admitted
acute respiratory failure	95 (48%)	513 (61,2%)
acute kidney injury	28 (14,1%)	258 (30,8%)
chemotherapy in high risk patient, high risk for tumor lysis, bleeding etc.	21 (10,6%)	379 (45,2%)
shock	67 (33,8%)	349 (41,7%)
coma	17 (8,6%)	194 23,1%)
acute liver failure	5 (2,5%)	66 (7,9%)

9. Cíl léčby a smysl pro pacienta

- Onkologický plán
- Cíl a smysl pro pacienta
- Benefit nejen bezprostřední, ale v trajektorii stonání

10. Přijmout do intenzivní péče nebo nikoliv?

multidisciplinarita

- komplexní pohled na pacienta
  - progrese tumoru
  - psychosociální
  - nutrice
  - komorbidity
- snížit rizika léčby
- lépe komunikovat

  onkolog - paliatr - psycholog - rodina

trajektorie

- časná detekce komplikací
- shoda na cíli léčby

anticipace zhoršení

- reevaluace cíle/limitace léčby

Osnova

1. průběh – rychlý – neodkládat přijetí na ICU
2. zajištění DC ... pozor na hrudní masy
3. biologická léčba – nové molekuly
4. nečekané NÚ – toxicity, TBC
5. diagnostická strategie - DIRECT
6. iniciální strategie ventilace nemá vliv na outcome
7. neobjasněná příčina ARF – vyšší mortalita
8. triage „too well to benefit“
9. goals of care .. nejsou dokumentovány
10. indikace IP – mezioborová spolupráce