

Editorial

Critically Ill Cancer Patients: A Current Perspective

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Patients living with cancer have been increasing because progresses in the treatment of malignancies [1]. Many of these patients require admission to intensive care unit (ICU) due to cancer-related complications such as acute respiratory failure and infection [2,3]. The heterogeneity with regard to nature and curability of the disease, as well as the severity of acute underlying conditions was used to support refuse for ICU admission; but mortality rates of critically ill cancer patients have decreased in the latest decades because advances in the management of malignancies and organ failures [4].

The ICU mortality rates in cancer patients range between 30% and 77% [5-9]. Furthermore, ICU mortality rate for critically ill ventilated patients with cancer is greater than 45% [10,11]. Reasons of ICU admission, type of malignancy and therapies before ICU admission may affect outcomes [12]. However, the number and severity of organ failures is the main prognostic factor in critically ill patients with cancer. Thus, Sequential Organ Failure Assessment (SOFA) should be taken into account when evaluating patients for ICU admission [5,13]. Consequently, early ICU admission with the lowest SOFA score is desired.

Time-limited trials of intensive care are commonly used in patients perceived to have a poor prognosis. This approach, named "ICU trial", seems to be adequate in patients who do not fulfill the "full code" criteria, but for whom the option of a potentially life-extending therapy is available. The optimal duration of such trials is unknown. Recent data suggest that trials of ICU care lasting 1 to 4 days may be sufficient in patients with poor-prognosis solid tumors, whereas patients with hematologic malignant neoplasms or less severe illness seem to benefit from longer trials of intensive care [14]. On the other hand, a multidisciplinary treating team of physicians should aid in changing the goals from restorative to palliative care when there appears to be no possible benefit from any treatment. End-of life-decisions and code status should be made by consensus, based on patients' autonomy and dignity.

Organ support methods and sepsis management is the mainstay of treatment for critically ill patients with cancer. However, some malignancy-specific problems including oncological emergencies, organ dysfunction due to expansive or infiltrative cancer,

chemotoxicity, radiotoxicity, tumour lysis syndrome, leukostasis and hemophagocytic lymphohistiocytosis require a specialized therapy [15-18].

Conclusion

In conclusions, the management of critically ill cancer patients is complex, requiring a close collaboration between intensivist and oncologist. Both the real chance of survival and the degree of acute pathophysiological disturbances expressed as organs dysfunction should be considered during assessment of oncological patients; but a general reluctance to admit critically ill cancer patients to the ICU cannot be justified anymore.

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