Usability testing of EirV3—a computer-based tool for patient and doctor use in palliative care


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Background: The decision to transfer patients (pts) with solid cancer tumours to an intensive care unit (ICU) is still controversial and difficult. Few studies have assessed the outcome for these patients. The aim of this study was to identify 30-day prognostic factors/mortality for pts with solid cancer tumours admitted to an ICU.

Methods: We conducted a retrospective cohort study of all consecutive pts with solid cancer tumours admitted to ICUs at Bordeaux University Hospital, between January 2010 and December 2015. The study end point was 30-day mortality. Secondary end points were to describe the characteristics and outcomes for pts, and ethical practices.

Results: We included 235 patients with solid tumours. Most of them were in a metastatic setting (60%). The most common causes for ICU admission were sepsis (56%) and/or respiratory failure (52%). ICU, 30-day, 90-day mortality rates were 24%, 36% and 50% respectively. After ICU stay, 44% of pts had restarted an anti-tumoral treatment. In multivariate analysis and after excluding SAPS 2 score, two or more organ failures (p = .005) and being under non-curative care (p = .028) were independent prognostic factors of 30-day mortality. A support person was designated in 81% of cases, advance directives expressed in 2% and collective decision reported in 21%. Limitation of life-sustaining therapy was decided for 23% and 43% of pts before admission and during the ICU stay, respectively.
Background: Prostate cancer is a leading cause of cancer-related burden of disease in Australia. Despite careful patient selection and advances in therapy, men may experience a negative impact on quality of life long after diagnosis.

Methods:
From 1.1.2017–31.7.2017 data from all patient contacts were collected. The medical history of patients was collected through the pharmacy system and the records of ED contacts were reviewed. Data regarding the medical history of patients was not available for ED contacts. The International Classification of Diseases (ICD) codes were used to identify patient contacts made to the ED due to reasons relating to prostate cancer complications. All data was collected and stored in a database and was managed using Excel. Data were analyzed using software for statistical analysis (Statistical Package for Social Sciences, SPSS Version 23).

Results:
From a total of 1029 patient contacts 743 met the inclusion criteria. 425 male contacts (60%) and 318 female contacts (43%) were recorded. The median age was 67 years. Of the 743 patient contacts, 239 (32.1%) were due to prostate cancer complications and were referred at least once to the ED. The majority of patient contacts (492, 66.0%) were designated to outpatient palliative care. Reasons for withdrawal were health concern (n = 155, 20.7%), patient death (n = 138, 18.5%), and unspecified (n = 110, 14.8%). Disease progression (n = 74, 9.9%) and death (n = 71, 9.5%) were the leading reasons for withdrawal. The primary reason for admission to the ED was pain (n = 149, 20.0%) followed by deterioration of general condition (n = 144, 19.5%), dyspnea (n = 106, 14.3%), and unspecified (n = 111, 15.0%). Disease progression (n = 141, 19.0%) and pain (n = 130, 18.0%) were the leading reasons for withdrawal.

Conclusions:
The number of organ failures is a rapidly assessable variable that can help oncologists and intensive care specialists in their decision. A support person is often designated but advance directives are still unusual.

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