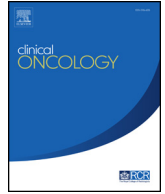




ELSEVIER

Contents lists available at ScienceDirect

Clinical Oncology

journal homepage: www.clinicaloncologyonline.net

Original Article

A Study of the Incidence and Management of Admissions for Cancer-related Symptoms in a District General Hospital: the Potential Role of an Acute Oncology Service

C.M. Bruce^{*†}, J. Smith[‡], A. Price^{*†}^{*}The University of Edinburgh, Edinburgh, UK[†]Edinburgh Cancer Centre, Western General Hospital, Edinburgh, UK[‡]Borders General Hospital, Melrose, UK

Received 3 October 2016; received in revised form 27 February 2017; accepted 20 March 2017

Abstract

Aims: The non-specialist management of cancer patients is becoming increasingly complex. Acute oncology services (AOS), aiming to provide rapid access to specialist advice, have been shown to improve patient experience and reduce length of inpatient stay. The present study aimed to inform service provision in a district general hospital (DGH) by investigating cancer patients, not on active anti-cancer treatment, where the disease itself precipitated admission. This is a vulnerable group who are potentially disenfranchised of focused oncological input due to having less robust care pathways established to date.

Materials and methods: A record was available of all cancer patients, not on active anti-cancer treatment, admitted to a Scottish DGH over a 3 month period. All but five of these patient records were retrospectively reviewed.

Results: The study group ($n = 63$) comprised 31 males and 32 females; median age was 70 years (range 30–90). The most common reasons for admission were pain (33%), breathlessness (29%) and nausea/vomiting (27%). Symptoms/signs were experienced a median of 4.0 days (range 0.1–35.0) before admission. The median length of stay was 6 days (range 0–39). Ten, 27 and 46% of patients were referred to a cancer nurse specialist, oncologist and palliative care team, respectively. Seventy-six per cent died within 6 months of admission.

Conclusions: About one patient/day was admitted with cancer complications, many of whom will have contacted primary care in the week preceding admission. An AOS, integrating primary and secondary care, would benefit cancer patients by (i) optimising community care, potentially reducing hospital admissions and (ii) increasing inpatient specialist input to reduce length of inpatient stay. Implementation of an AOS would probably have a significant impact on both cancer patients at an individual level and service provision at a regional and national level.

© 2017 The Royal College of Radiologists. Published by Elsevier Ltd. All rights reserved.

Key words: Acute oncology service; cancer; oncology; palliative care

Introduction

An ever-increasing number of cancer patients are attending acute medical units for unscheduled care [1–3]. As cancer therapies advance and become more specialised and cancer patient survival improves, the ability of general physicians to provide optimal care in the absence of specialist oncology input is becoming increasingly difficult [1,4,5].

Acute oncology comprises the management of cancer patients presenting with previously undiagnosed cancer, complications of their cancer treatment or complications of their cancer itself [1,4,6]. The 2009 National Chemotherapy Advisory Group published a report suggesting that all hospitals with an emergency department should establish an acute oncology service (AOS) comprising input from emergency medicine, general medicine and oncology teams [4,6–8]. According to the acute oncology *Manual for cancer services* peer review standards [8] an AOS is aimed at providing rapid access to specialist advice (including consultant review within 24 h or on Monday if admitted over the weekend) trying to prevent cancer patients being

Author for correspondence: C.M. Bruce, Edinburgh Cancer Centre, Western General Hospital, Crewe Road South, Edinburgh EH4 2XU, UK.

E-mail address: carolinembrace@gmail.com (C.M. Bruce).

<http://dx.doi.org/10.1016/j.clon.2017.03.012>

0936-6555/© 2017 The Royal College of Radiologists. Published by Elsevier Ltd. All rights reserved.

admitted to hospital where possible and helping to streamline a safe and rapid discharge where admission is unavoidable [1,4]. The acute oncology peer review standards guidance refers to the management of chemotherapy complications, malignant spinal cord compression and non-acute presentations of cancer of unknown primary but is less clear about 'patients potentially suffering from certain emergencies caused by the disease process itself, whether the primary site is known, unknown or presumed'. This study focused on patients with a pre-existing diagnosis of cancer who were not on anti-cancer treatment but were admitted due to the disease itself; this is a vulnerable group who are potentially disenfranchised of focused oncological input due to having less robust care pathways established to date. This study attempted to quantify and assess the needs of this under-invested group, for which there is a sizable unmet need at the interface of community and several hospital services. There are several different models of AOS, including specialist oncology consultant and nurse-led patient review and advice services, training for physicians working in acute medical units and emergency departments and dedicated oncology triage units for cancer patients (allowing removal of oncology patients from acute medical admission units) where facilities allow [1,4–6]. Evidence in recent years supports the concept of AOS, highlighting benefits in terms of improved communication between services, reduced length of hospital stay and improved cancer patient experience [4–6].

The present study collected data as part of a pilot project for a nurse-led AOS in a Scottish district general hospital (DGH) located over an hour away from the nearest cancer centre (Edinburgh Cancer Centre) with two oncologists whose job plans allowed time for inpatient reviews. We focused on the experience of existing cancer patients with regards to non-treatment related complications as a significant need at the interface between acute medicine, oncology, medicine of the elderly (MOE), primary and palliative care, which had hitherto received less attention than the other two aspects of acute oncology (i.e. new presentations of patients with cancer and the management of treatment-related complications). We show that these patients represent a substantial inpatient clinical workload which might be averted, to the benefit of patients and service, with earlier interventions and improved coordination of services.

This study aimed to inform service provision in a DGH by investigating the circumstances, management and outcomes of cancer patients where the disease itself precipitated admission.

Materials and Methods

Service Provision during the Study Period

The Borders General Hospital is a DGH comprising 238 beds, located 46 miles from the 'local' Edinburgh Cancer Centre. At present, there is no AOS in place. At the time of this study the haemato-oncology team consisted of two

consultant haematologists (on-site cover, including inpatient review, for 5 days, and on-call cover from a different hospital at the weekends), one nurse consultant, four nurse specialists (one for each of colorectal, lung, breast and urology, who were present 5 days a week), a lung and a breast oncologist (who each visited on 1 day a week and had 1–2 h per week of inpatient ward time) and chemotherapy nurses based in the nurse-led outpatient chemotherapy unit. A colorectal oncologist also visited for half a day per week but did not have dedicated time for inpatient review included in his job plan. Patients were admitted under the acute physicians, surgeons and palliative care physicians and reviewed by the oncologists or oncology nurses in the acute admission unit and downstream medical and surgical wards. Emergency patient admission reviews took place on an *ad hoc* basis, either when direct referrals were made or admissions serendipitously discovered with no formal pathways for referral or review. There was also a palliative care team comprising one consultant, one specialty grade doctor and four clinical nurse specialists (one based in the hospital and three in the community). There were dedicated palliative care beds within an inpatient ward.

Data Collection and Analysis

A record was available of all oncology patients, who were not on active anti-cancer treatment, admitted as an emergency to the Borders General Hospital between March and May 2012 for disease-related complications. All but five of these patients' case records could be obtained and were retrospectively reviewed. Data were obtained on patient demographics, tumour site, types and duration of symptoms and signs experienced before admission, length of stay, time to initiating management of the presenting symptom or sign, community symptom management input before admission, referrals to and time to review by specialist services, and death during and within 6 months of the admission. Fisher's exact test was used to compare categorical data. The Mann–Whitney U test was used to compare continuous variables. Data were analysed using Microsoft Excel, Graphpad Prism v6 and Statsdirect v2.8.0.

Results

Demographic Details

In total, 63 patient case notes were available and analysed in the study, comprising 31 (49%) men and 32 (51%) women. The median age was 70 years (range 30–90). The spread of patients across each cancer site is shown in [Table 1](#).

Thirty-five (56%) patients were admitted via general practitioner or out of hours services, 13 (21%) self-presented to the emergency department and six (10%) were referred from another specialist. There were no data for the mode of admission for nine patients (14%).

Download English Version:

<https://daneshyari.com/en/article/5698051>

Download Persian Version:

<https://daneshyari.com/article/5698051>

[Daneshyari.com](https://daneshyari.com)