



LETTER TO THE EDITOR

Multidisciplinary rounds in oncology and hematology: Are they superior to rapid response teams?[☆]



Rondas multidisciplinarias en oncología y hematología: ¿son superiores a los equipos de respuesta rápida?

Dear Editor:

Over the last few years, the therapeutic armamentarium for the management of neoplasms has experienced a tremendous growth. Actually, it is associated with an exponentially increasing number of patients who require advanced therapies including life support due to infections-sepsis, respiratory failure, neurological disorders and/or complications associated with chemotherapy. As a matter of fact, we should accept the fact that this is a process on the rise.¹

Fifteen per cent of hematological patients require admission to the intensive care unit (ICU) due to their clinical condition. Also, these admissions are associated with iso-severity criteria being the number of patients with solid tumors admitted for medical reasons relatively low compared to those admitted to recovery rooms.² Azoulay et al.³ confirm an increasing number of oncological and hematological patients admitted to the ICU—representative of an up to 15% occupation rate—and a higher survival rate both for the ICU (mortality rate < 30%) and the hospital (mortality rate < 40%). Regarding hematological patients, more patients admitted to the ICU are in remission and have a better quality of life compared to patients who were never admitted in the first place.

Our former (2000–11) and later data (2012–16) on the implementation of daily multidisciplinary rounds in the onco-hematological unit show higher rates of admission (8%) to the ICU and lower mortality rates at the ICU setting both at the 90-day follow-up and after 90 days (44%, 54%, and 62%) compared to the pre-implementation period of these rounds (53%, 61%, and 66%).⁴ We believe that these

multidisciplinary rounds may outperform the rapid response teams including daily assessments at the hospital floor, monitoring and administration of advanced therapies (high flow, fluids, antibiotics, vasopressors...), decisions on the patient's admission and how early it should occur, and the therapeutic targets that should be reached (non-invasive and invasive ventilation, ECMO, CVHH). However, stable and uncompromised patients who are going to receive some kind of life-threatening therapy (CAR T cell therapy: ARDS, shock...) can also be admitted to the ICU.

Finally, the key points that should be observed in the partnerships achieved among different units are⁵:

- Specific clinical practice guidelines for ICU admission and therapeutic protocols before and after admission should become available (actually they are already available in 79% of monographic ICUs compared to only 27% of polyvalent ICUs).
- Daily meetings between intensivists and oncology and hematology specialists (documented in 90% of monographic centers compared to only 53% of general hospitals).
- Accept that the traditional predictors of mortality have been losing momentum.
- Document the safety profile of the intensive therapies administered at the hospitalization floor.
- Accept that chemotherapy at the ICU setting is safe and its administration is not associated with a worse prognosis.
- Optimize transition from the ICU to the palliative care setting.
- Acquire in-depth knowledge on how to manage toxicity associated with targeted therapies, immunotherapies, and biotherapies.
- Implement the QALY (quality-adjusted life years) score.
- Take into account the family's specific needs.
- Encourage multidisciplinary cooperation.
- Cost assessment.
- Consider the added value of an ICU-oncological setting.

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