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Evening Medical Update: Updates in Oncology
November 2021

Assessment & management of common oncology emergencies at the front door – Dr Joanne Evans, Consultant of Medical Oncology

Why is it so difficult to get acute oncology to accept patients to the specialist oncology ward when they present acutely and how can we ensure to have these difficult escalation conversations in the context acute pneumonitis with immunotherapy?
Acute oncology and specialist oncology are two totally different things, and this has been lost in translation over the last 12 years. The role of Acute Oncology is to ensure patients don't stay in hospital longer than they need to from a cancer point of view, and also to ensure complications of cancer or cancer treatment complications are managed correctly. The presentation of cancer and cancer and treatment emergencies are covered in all the main training syllabuses, both for general medicine and ED, and these patients are everyone's responsibility.

For every cancer patient to be taken over by specialist oncology would mean we would need far, far, far more in-patient beds, and much bigger teams.

Acute oncology patients often have medical needs as well as oncological, and it is important to recognise that neither Medical nor Clinical Oncologists have any GIM training. For the majority of us, the last time we did any medicine formally was as an SHO, a long time back. This is why Acute Oncology exists - it's an interface. If a patient has a problem best managed by Specialist Oncology, the majority of them will be transferred without argument. In many places Acute Oncology is an advice and guidance service, and patients selected for transfer are identified by high risk features for adverse outcome, or where the treatment needed to bring them out of their cancer complication might be radiotherapy or chemotherapy.

Acute pneumonitis is survivable. These patients might well need escalation to survive what is an iatrogenic event. These patients often need to be managed under a medical team in enhanced care or HDU/ITU. Usually the best person to get advice from is the patient's own oncologist, as there is no 'one size fits all' escalation policy for oncology. In the case of iatrogenic complications, most Acute Oncology services will advocate for a patent to be for reasonable escalation, unless an opinion to the contrary is already documented from clinic.

To what extent can giving steroids affect histology of the malignancy especially the lymphomas?
It can delay a definitive diagnosis until disease has sufficiently progressed, and high dose steroids are a part of many haemato-oncology treatment regimens. The caveat to not being so weary of delivering steroids are some of the obstructive or compressive presentations (especially Metastatic Spinal Cord Compression, Brain Metastasis and rapidly progressing Superior Vena Caval Obstruction). Most patients would be more grateful of not being paraplegic, or dead from coning than to run the risk or definitive treatment delay awaiting tissue. A spectacular radiological response to steroids also gives good clues to aetiology! That said, at my centre, we try hard to get an emergency biopsy, using the surgical NECOPD list if necessary, before starting steroids, but I have started steroids without tissue where the risk of delaying is permanent disability or death.

How often do you get mixed histology for a given malignancy (referring to the patient with adeno and small cell) and how do we address this in tissue sampling?
Not frequently, but it is why full histological examination of a surgical specimen post operatively is vital. A biopsy is a representation of a whole sample. It diagnoses the issue, but sometimes doesn't confirm the full nature or natural history of a tumour. Advances in liquid biopsy will likely see this change over time, with a sample hopefully more representative of the whole, although we do know already that some types of cancer cell are not so readily shed in

to the peripheral circulation and using the example above, it might be that a small area of small cell would not easily be detected amongst the rest of the tumour

Would you do a rectal examination in a neutropenic patient presenting with supposed malaena?
No. A PR is not going to confirm melaena or alter how you treat this patient. The presence of any PR bleeding would heighten my concern for neutropenic colitis. Depending on where suspected bleeding site was, CT angiography can be useful if it is not safe to scope a patient, but usually the mainstay of treatment would be conservative management until a definitive test could be safely conducted. True story - the last neutropenic patients with a ?UGIB (malaenia) I was asked to review had eaten 3 beetroot the evening before...