Novel Referral Pathway for Patients with New Solid Tumors Discharged from the Emergency Department: A Pilot Study

"New Cancer Pathway"

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Comparative Study > Am J Emerg Med. 1992 Jul;10(4):290-3.

doi: 10.1016/0735-6757(92)90004-h.

Cancer presentation in the emergency department: a failure of primary care

S W Hargarten ¹, M J Richards, A J Anderson

Affiliations + expand

PMID: 1616514 DOI: 10.1016/0735-6757(92)90004-h



Departme



Mortality due to cancer treatment delay Quantification to support prioritisation and modelling

Summary		ninimising system ly improve surviva	-	-	ent could
🗹 Study design 🖉	Systematic and meta-a		of all ages with ajor cancer type	es	
Data sources		17 cancer treatme icipants treated	ent indications		
4 Comparison	Exposure and outcome				
		al according to w gery, systemic tre			
II Outcomes		Surgery	A	ljuvant treatm	ent*
Mortality for each four week increase in delay	0.9	——————————————————————————————————————	azard ratio 95% 1.2 0.9	CI	1.:
Bladder				•	-
Breast				-+-	8
Colon					
Head and neck		-+-		-•-	
Non-small cell lung carcin	noma —	•		_• _	
Mortality increases as delay increases Breast cancer surgery delay for 1000 women (baseline 12% mortality)	4 weeks 8 weeks	dditional deaths 10 ####### 20 ###########################		Evidence que Only high va studies acco for major pro factors were	lidity ounting ognostic
		nic treatment, apart fi		020 BMJ Publishin	ng group

* Adjuvant systemic treatment, apart from head and neck cancer, which was adjuvant radiotherapy

 Review
 > Nat Rev Clin Oncol. 2017 Jan;14(1):45-56. doi: 10.1038/nrclinonc.2016.155.

 Epub 2016 Oct 11.

Diagnosis of cancer as an emergency: a critical review of current evidence

Yin Zhou ¹, Gary A Abel ¹ ², Willie Hamilton ², Kathy Pritchard-Jones ³ ⁴, Cary P Gross ⁵, Fiona M Walter ¹, Cristina Renzi ⁶, Sam Johnson ⁷, Sean McPhail ⁷, Lucy Elliss-Brookes ⁷, Georgios Lyratzopoulos ¹ ⁶ ⁷

Affiliations + expand PMID: 27725680 DOI: 10.1038/nrclinonc.2016.155



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How do you manage this CT scan in the ED?



- 1. Admit the patient
- 2. Discharge
 - 1. Pcp
 - 2. Pulmonary
 - 3. Thoracic
 - 4. IR
 - 5. Give them
 - paperwork to call a doctor
- 3. What factors influence
 - 1. Race/ethnicity/SES

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ΠJ

Feasibility of an E-oncology consult service

Ambulatory E-Co	onsult to Hematology / Oncology	✓ <u>A</u> ccept	X Cancel
Status:	Normal Standing Future		^
Class:	Normal 🔎		
Process Inst.:	You can request an Interprofessional consultation (IPC) if you as the primary care or attending provider requests the opin treatment advice of a patient's problem from a specialty consulting provider (Physician/APP), without a face-to-face visit, be a lab interpretation/result, a urgent question, clinical question planning for next steps. The idea behind the IPC is that care or attending provider will own and manage the patient's care in lieu of a referral.	Examples co	ould ^
	Interprofessional consult questions raised by the treating provider should meet the following criteria:		
	 * Focused questions that a specialist can reasonably answer, with associated and relevant medical history also provided/ available. * Be answerable using only the information available in the EHR. 		1
	If you have a question about a process (such as getting someone into clinic) please send an In Basket message to the dep (Ex: "P Pulm" for Pulmonary or "P Onc" for Oncology) and do not create an e-Consult.	oartment po	•
• Comments:			
	Reason for Visit: ***		
	Patient consented to Interprofessional Consult.		~
\rm Next Required		✓ <u>A</u> ccept	X Cancel

	N = 28 (unless otherwise	
	specified)	95% CI
Age (IQR)	55.0 (11)	
Gender (female)	12 (42.9%)	0.25-0.63
Race		
White	18 (64.3%)	0.44-0.81
Black	10 (35.7%)	0.19-0.56
Ethicity (latino)	8 (28.6%)	0.13-0.49
Self-pay insurance	11 (39.3%)	0.22-0.59
Alcohol Use	16 (57.1%)	0.37-0.76
Tobacco Use	20 (71.4%)	0.51-0.87

Days to consult (IQR)?	1 (1)	
Minutes spent managing E-referral		
(IQR)	8 (2.5)	
What did e-referral do?		
Refer to subspecialist	9 (32.1%)	0.16-0.52
Order IR guided biopsy	8 (28.6%)	0.13-0.49
Order imaging	7 (25%)	0.11-0.45
Refer to pcp	5 (17.9%)	0.06-0.37
Arrange oncology clinic		
appointment	4 (14.3%)	0.04-0.33
Order labs	2 (7.1%)	0.008-0.24
Present at tumor board	1 (3.6%)	0.001-0.18
Did patient get a biopsy? -yes	18 (72%)	0.51-0.88
Days to biopsy (IQR)?	14 (14.5)	
Appropriate Consult? -No	3 (10.7%)	0.04-0.27

Stage (n =15)		
I	2 (13.3%)	0.04-0.38
II	2 (13.3%)	0.04-0.38
III	2 (13.3%)	0.04-0.38
IV	9 (60.0%)	0.36-0.80
Definitely not cancer	4 (14.3%)	0.06-0.32
Mortality - deceased	2 (7.1%)	0.02-0.23
Lost to follow up	4 (14.3%)	0.06-0.31

Type of confirmed	d cancer	
Lung cancer	4 (14.3%)	0.06-0.32
Renal cell		
carcinoma	3 (10.7%)	0.04-0.27
Breast cancer	2 (7.1%)	0.02-0.23
Oral cancer	1 (3.6%)	0.006-0.18
Neck squamous		
cell carcinoma	1 (3.6%)	0.006-0.18
Pancreatic		
cancer	1 (3.6%)	0.006-0.18
Germ cell tumor	1 (3.6%)	0.006-0.18
Lymphoma	1 (3.6%)	0.006-0.18
Testicular cancer	1 (3.6%)	0.006-0.18

Conclusions

- Referring patients from the ED for cancer work up is safe and feasible
- Most advanced stage
- Can measure time to biopsy from referral
- Next steps:
 - Improve outcomes?
 - Target specific cancers (lung)

