I have blood cancer of course I am precious!

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CASE SCENARIO

- 50-year-old Jacob presents to the ED after being seen earlier that the day by his GP with acute chest pain since that morning.
- On questioning further, he mentions that he was having complaints of breathlessness for the past few days.
- He also has a background of Diffuse B-cell Lymphoma for which he was treated 8 months back and he is in remission now.
- He has been managed with iron tablets for his shortness of breath in the view of iron deficiency anaemia.

CASE SCENARIO CONTD

Investigations

- Blood counts reveal WBC – 3.5, Hb – 95, Platelets – 55, CRP - <5, Electrolytes unremarkable.
- Creat and urea – normal range.
- ECG - RBBB with abnormal QRS. No ST elevation/depression.
- Troponins and BNP are being sent off in the ED.

Case scenario continued

- The medical team in the ED initiate management for acute chest pain and organise a cardiology referral along with a CXR.
- Patient is noted to have pulmonary oedema which was picked up following thorough investigations and was managed with diuretics.
- Following a detailed assessment of the patient, the cardiology registrar in the local hospital contacted the cancer hospital where the patient was treated for lymphoma.
- That is where the actual cause was picked up which is RCHOP!

Mystery unveiled !

- Apparently, the patient was treated with cumulative doses of anthracyclines (Doxorubicin) to manage his lymphoma which is at a greater risk to cause Cardiomyopathy.
- This has not been mentioned in the discharge summary by the haematology team and follow-up ECHO or appointments with cardiology was not arranged.
- Adversely, worsening of unnoticed cardiomyopathy ultimately presented as HF resulting in pulmonary oedema.

How could this be prevented ?

- A robust protocol system from the parent team and adequate awareness on the patient's medical records creating an awareness amongst medical team of the local hospital would have prevented complications in this patient.
- This was an actual example of a patient who was treated in our hospital 5 years back who suffered these complications.
- Although his treatment had taken place months back, the impact that it had on his health was long standing.

What are some similar issues missed in primary and secondary care ? PART 1

- Patients with a risk of Tumor Lysis Syndrome
- If not charted properly in the patient's medical history, this could be something that can be easily missed and the treatment can change completely which significantly affects the clinical outcome.

How is TLS missed?

How is this missed?

- Newly undiagnosed leukaemia
- Patients undergoing treatment in day care, presenting to GP/local hospital with a different illness.
- Non-specific parameters - Sometimes K and P can be in the high normal range and Calcium can be low masking the complete picture of TLS.

What are some similar issues missed in primary and secondary care ? PART 2

- Symptoms of GvHD could often mimic infection.
- They commonly set in within the first 100 days of transplant.
- However, the emphasis on patients having the risk of GvHD is not as pronounced since most of the patients present with pronounced clinical features and sometimes complications like UGI bleed, transverse colitis corresponding to gut GvHD and deranged liver function due to liver GvHD.

How can this be avoided?

- These complications can be avoided by organising regular follow-ups with blood tests for patients, post-transplant in the view of altering the immunosuppressants as per their clinical presentation.
- It is also important to consider invasive procedures like colonoscopy and UGI scopy in the view of gut GvHD when in doubt as the immunity status makes these patients more prone to complications quickly.

What are some similar issues missed in primary and secondary care ? PART 3

Haemophagocytic lymphohistiocytosis

- This is a rare yet dreaded complication in patients with lymphoma.
- A hyper-inflammatory response that could occur to particular triggers like infection or cancer.
- Can present with signs mimicking an infection. Usually picked up by increased ferritins and triglycerides which is often not sent as part of septic screening.
- Although, it starts off like a moderate reaction it can escalate very quickly and cause significant rate of morbidity and mortality.
- Immediate consideration for steroids like prednisolone is key.

Few other challenges faced in managing patients with haematological malignancies

- Compliance with medications especially for patients on steroids as part of their immunosuppression.
- Chemotherapy/biospecifics/CAR-T/transplant related complications.
- Wide range of susceptibility to infections - this expands the requirement of investigating for microbial organisms and in-depth MDT discussions for management of infections.

Few other challenges faced in managing patients with haematological malignancies

- Complications related to nutritional deficiencies and poor weight gain post treatment.
- More risk of cord compression and renal failure in patients especially with myeloma and lymphoma.
- Maintenance of PICC line and dealing with associated complications.

THANK YOU FOR THE OPPORTUNITY !!