Acute Oncology: A Bona Fide Subspecialty or a Distraction from the Day Job?

D. Gilligan

Cambridge University Hospitals NHS Trust, Cambridge, UK

Received 24 October 2013; accepted 4 November 2013

The concept of acute oncology and a clinical service to support it has developed rapidly over the past 5 years. It principally arose out of the publication of two reports. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report in 2008 [1] and the National Chemotherapy Advisory group (NCAG) report in 2009 [2]. The NCEPOD report highlighted the process (or lack of process) of care of patients who died within 30 days of receiving systemic anticancer therapy (SACT). It made a number of wide-ranging recommendations, including better co-ordination of services for patients admitted as emergencies with SACT toxicity. As a result of these findings, the NCAG report went on to recommend the establishment of an acute oncology service (AOS) in relevant hospitals to improve the management of cancer patients admitted as an emergency. In parallel to these reports, there has been increasing awareness of a need to manage cancer-related complications, including better management of metastatic spinal cord compression [3]. Finally, patients who present acutely, usually as in-patients, with a new diagnosis of cancer and, in particular, malignancy of unknown origin, logically form a group who need oncological advice in the acute setting.

These reports culminated in the National Cancer Action Team publishing peer review measures for acute oncology in April 2011 [4] and many acute Trusts will have been or are being peer reviewed against these published standards. The peer review measures are wide ranging and state that every hospital with an emergency department and/or acute medical beds or specialist oncology beds needs to be subject to these measures. This means that in practice there are probably three broad types of AOS; specialist cancer hospitals with no emergency department, larger hospitals with dedicated oncology beds (frequently those with a radiotherapy department) and smaller District General Hospitals (DGH) with an emergency department but no dedicated oncology beds. Not surprisingly, implementation of an AOS has been carried out in many different ways dependent on various factors, especially the type of hospital and manpower available. Some, usually larger, institutions have integrated AOS into their pre-existing on-call arrangements, having a ‘consultant of the day’ or ‘consultant of the week’. To do this properly requires consultants to clear time in their schedules when on-call, which may mean cancelling other clinical duties such as out-patient clinics or radiotherapy planning sessions. This can be a challenge in an already busy schedule with cancer targets to be met. Others have created new posts with a dedicated acute oncology interest and sessions. However, many individuals have had to integrate an AOS into an already busy job plan. If they work or have sessional commitments in a smaller centre or DGH, then it can quickly become very onerous as the peer review measures state that an in-patient assessment service should have a minimum of one programmed activity of direct clinical care for each weekday and there is a requirement for there to be a least two oncologists involved for every institution for clinical cover. There is no stipulation as to whether the role should be carried out by a clinical, medical or haemato-oncologist. To date new posts with dedicated AOS sessions seem to have been fairly evenly split between medical and clinical oncology. The measures state that an AOS should operate on each of the five weekdays, but it is more than possible given the direction of travel of unplanned care within the National Health Service that this will before too long become a 7 days per week service [5].

As many patients who present with malignancy of unknown origin will be acute admissions, advice on their management and especially the nature and extent of investigations required will frequently fall to an AOS. They may also be responsible for the onward care of those identified as cancer of unknown primary.
In November 2012, a Royal College of Physicians and Royal College of Radiologists joint working party produced a report [6]. This report highlighted the sometimes difficult pathway for cancer patients and their carers in the acute setting, with particular emphasis on issues around information, communication, co-ordination of care and decision making. It made seven recommendations directed towards patient safety, reducing risk and improving the quality of care. Cancer patients admitted to hospital acutely unwell will represent a range of scenarios. At one end of the spectrum they may be admitted with a problem unrelated to and unaffected by their cancer prognosis, e.g. myocardial infarction, that needs to be managed by a non-oncological specialist team with advice, if needed, from an AOS. At the other end of the spectrum, an acute admission may have been precipitated by a significant progression of malignancy, raising issues of whether treatment needs to be discontinued and end of life care commenced. It is likely that an AOS team urgently reviewing such a patient may not be the usual team treating that patient and it is essential that good communication skills are used with all involved, patient, carers and other health professionals, so that there is a clear understanding of the situation and its management. This emphasises the need for close working with palliative care teams and good integration with AOS. Palliative care professionals may already be part of an AOS and can play vital roles in assessing patients, possibly avoiding unnecessary investigations and admission to hospital.

An AOS has also led to other developments and these have included closer working with colleagues in emergency and acute medicine, together with the development of training packages to make frontline staff more aware of how to manage common oncological emergencies. In every hospital, an acute oncology team should meet regularly to discuss key operational issues.

Peer review measures have mandated the establishment of specialist nurses in acute oncology. Initially, these roles may have been covered by other oncology clinical nurse specialists, but increasingly they are now dedicated AOS clinical nurse specialists. The implementation and role of such nursing posts vary, but these are increasingly important in making a service work. Nurse roles can be and have been extended to provide triage, assessment and treatment for sick oncology patients and in practice they may provide vital frontline treatments in a more timely manner, such as improving door to needle time for patients with suspected neutropenic sepsis. They have also helped to co-ordinate emergency hotlines where patients can telephone in for urgent help and advice. As an AOS has grown, many Trusts have looked to define a physical space for an AOS to operate in. Cancer emergency assessment units with dedicated chair or bed spaces are being set up to streamline an AOS and many have the backing and support of clinical commissioning groups, as they may be able to proactively manage cases, avoid hospital admissions and, therefore, relieve pressure on hard pressed emergency departments.

What does this mean for the speciality of clinical oncology? Do we recognise acute oncology as a subspeciality interest, such as breast or colorectal cancer, or is it a deviation and division of effort in providing high-quality cancer treatment, such as delivering world class radiotherapy? If the former view is taken, it could be seen as a challenging interest with real gains in patient safety and improvement in the immediate holistic quality of care for our patients. If the latter, it detracts from the time taken to develop optimal treatment plans, both radical and palliative, for patients that hopefully lead to the hard end points of improved survival. Whatever view is taken, acute oncology is here to stay and the debate we need to have is how best to integrate it into our cancer services and improve treatment for acutely ill cancer patients in any given institution.

Other editorials in this series will examine and discuss the further role of specialist nurses and the impact on specialist registrar training.

References