



## Emergency Care Sick Palliative and Problems Oncology in Emergency Department during the COVID-19 Pandemic

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### Abstract

Emergency medical care in palliative patients during the COVID-19 pandemic, it is important to provide a consistent treatment for stable patients that should be consistent with the goals and benefits, the perspective of these patients, but avoiding palliative patients with a poor prognosis that is unlikely to survive. Cancer is the second leading cause of death in the world around 8.8 million deaths a year. Worldwide, about 7 million to 10 million patients are diagnosed with cancer each year, recently there has been a significant increase in the number of cases diagnosed with cancer. About 70% of cancer deaths are in low- and middle-income countries. The goals of emergency medical care based on the criteria of BLS and ACLS, that is should be done "Do not do resuscitation, do not intubate but continue medical treatment excluding end tracheal intubation without prospects for the patient, but offering BLS only treatment concentrated symptomatic. ED is often the only place that can provide the necessary medical interventions (e.g., intravenous fluids or pain management medications). Medications as well as immediate access to advanced diagnostic tests when needed such as CT, RM and other diagnostic and treatment procedures.

**Keywords:** Palliative care; Emergency department; Emergency medical support; Training

### Introduction

Emergency medical care for palliative patients during the COVID-19 pandemic, it is important that in ED to provide a consistent treatment for stable patients that should be consistent with the goals and benefits, the patient's perspective and avoid patient's palliative with a poor prognosis that is unlikely to survive [1]. Palliative care includes for people suffering from life-threatening diseases, aiming to improve the quality of life by often attempting to positively progress the disease. Palliative care addresses not only the issue of physical suffering from the disease, but also issues related to in all aspects: Physiological, social, psychological and spiritual. Palliative care is essentially full ongoing active care in patients with life-threatening illnesses. Palliative care should provide relief of signs and symptoms by improving the best possible quality of life. The five types of cancer that cause the highest number of deaths at the system level are carcinomas: Pulmonary 1.69 million deaths, hepatic 788,000 deaths, colorectal 774,000 deaths, gastric 754,000 deaths, and thoracic cortex 571,000 deaths. In most countries there may be changes to a country's health care system, but they can be well-organized units with home medical teams, primary and secondary care, hospital consultants and health care providers in emergency department [2]. ED is often the only place that can provide life expectancy for possible and necessary medical interventions (e.g., intravenous fluids or painkillers. Medications as well as immediate access to advanced diagnostic tests (e.g., computed tomography or magnetic resonance imaging) as well as other diagnostic and treatment procedures and ACLS, how to proceed "Do not resuscitate, do not intubate but continue medical treatment, knowing the meningitis in the population? Excluding benign benefit intratracheal intubation, but offering BLS only concentrated symptomatic treatment. Palliative addresses not only the issue of physical suffering from the disease, but also issues related to in all aspects: physiological, social, psychological of spiritual [3]. EMS must to provide complete, continuous, active emergency medical care to patients with life-threatening illnesses and by providing relief from signs and symptoms by improving the best possible quality of life.

### Purpose of the Work

The purpose is to show the number of malignant patients seeking ED, the reason for coming for emergency medical care and aiming to improve the quality of life and the course of the

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disease occupying pain, monitoring and treatment of side effects of cytostatics, radiotherapy and patients affected by COVID-19 in the Emergency Clinic.

## Material and Methods

The study is of retrospective observational type which included 105 patients with oncological problems, palliative as well as concomitant diseases for the period March to August 2020 during the pandemic COVID-19 [4]. The data were taken from the documentation of patients in the ED archive as anesthetic data (gender, age, and place of residence, status of life parameters, results of objective examination, results of laboratory diagnostic research, radiological data. The data are presented in tables and graphs.

**Working methodology:** These patients were treated by emergency physicians and consulting services with the emergency medical care team for assistance with any need related to palliative care and we reviewed the clinical characteristics and outcomes of patients who received medical interventions that did not match the expected prognosis [5-7]. Palliative care intervention focused on observation, diagnostics, specialist consulting, moderate or advanced treatment, and systematization. Data were collected from the medical register. For the period March - August 2020 during the time of the COVID-19 pandemic, such as age, gender, location, evaluation of vital signs, monitoring, complications and hospitalization.

## Results

The study is of retrospective type realized for the period March to August 2020 treated 1 to 5 patients with oncological and palliative problems, with concomitant diseases and identified with the PR-CPR COVID-19 test at the Emergency Clinic of UCCK in Prishtina. Patients by age <65 years were 8 cases or 7.6%, 65 to 74 years were 16 cases or 15.2%, 75 to 84 years were 45 cases or 42.8%, 85 to 94 years were 29 cases or 27.6% and 95 to 104 years were 7 cases or 6.6% (Tables 1-11) [8,9].

According to the place of residence in the city there were 66 cases or 62.8%, while in the village there were 49 cases or 37.2%. According to the vital signs stable were 28 cases or 26.4%, while unstable 77 cases or 73.6%. According to the support provision BLS there were 79 cases or 75.2%, while with ACLS there were 26 cases or 25.0%. According to the stabilization of the stabilized health condition were 77 or 77.3%, while unsterilized were 53 cases or 22.7%. There were 78 cases or 77.3% admitted to the hospital, while 37 cases or 25.7 were not admitted to the hospital (Table 12).

**Table 1:** Age, median (range), y.

Age	No. (%)
<65	8 (7.6)
65-74	16 (15.2)
75-84	45 (42.8)
85-94	29 (27.6)
95-104	7 (6.6)

**Table 2:** Confirmed with COVID19 PT-CPR.

Positive	66 (62.8)
Not confirmed COVID PT-CPR	
Negative, for COVID-19	29 (27.6)
Unknown, not tested suspected COVID-19	6 (5.5)
Negative, treated for a medical condition other than COVID-19	4 (7.6)

**Table 3:** Sex/Ethnicity/race.

Sex	No. (%)
Male	58 (55.2)
Female	47 (44.7)
Ethnicity	
Albanien	98 (93.3)
Other	17 (16.1)

**Table 4:** Comorbidities.

Comorbidities	No. (%)
Hypertension	32 (30.4)
Cardiovascular disease Comorbidities	19 (18.0)
Diabetes mellitus	8 (7.6)
Chronic kidney disease	8 (7.6)
Documented history of dementia	7 (6.6)
Obesity (BMI $\geq$ 30) <sup>a</sup>	5 (4.7)
Chronic lung condition	4 (3.8)
Neurologic disease and/or history of neurosurgery	10 (9.5)
End-stage renal failure on hemodialysis	6 (5.7)
Immunosuppression	2 (1.9)
Active cancer	2 (1.9)
Liver disease	2 (1.9)

**Table 5:** By Location.

Place	No. (%)
City	66 (62.8)
Village	49 (37.2)

**Table 6:** Signs and symptoms.

Signs and symptoms	No. (%)
Pain	57 (54.2)
Vomitus	9 (8.5)
Anemia	7 (6.6)
Cardiac dysrhythmia	9 (8.5)
Dyspnea	10 (52.7)
Conscious	4 (3.8)
Unconscious	9 (8.5)

**Table 7:** By vital signs.

Vital sign	No. (%)
Stabl	28 (26.4)
No stabl	77 (73.6)

**Table 8:** By CPR.

CPR	No. (%)
BLS	79 (75.2)
ACLS	26 (25.0)

Patients with moderate complications were 48 cases or 47.5% and those with severe complications were 57 cases or 52.5%. Oncology patients after the presentation of signs and symptoms with pain were 57 cases or 54.2%, with vomiting were 9 cases or 8.5, with anemia 7 cases or 6.6%, with cardiac dissection were 9 cases or 8.5%, with dyspnea were 10 cases or 9.52%, conscious 4 cases or 3.8% and unconscious were 9 cases or 8.5%.

**Table 9:** By stabilization ED.

Stabilization ED	No. (%)
Stabilization	77 (77.3)
No stabilization	38 (22.7)

**Table 10:** By admissions.

Admissions	No. (%)
Hospitalization	78 (74.2)
No hospitalization	37 (25.8)

**Table 11:** By complications.

Complications	No. (%)
Moderate	48 (47.5)
Serious	57 (52.5)

**Table 12:** Possible problems.

Possible Problems	No. (%)
Stay for a long time in ED	21 (20.0)
They often come to ED	18 (17.1)
Other clinics do not want to accept them	15 (14.2)
Unbearable family members waiting	13 (12.3)
Unnecessary examinations	10 (9.5)
Pain management is difficult	9 (8.5)
Relatives of the patient with anyone seeking hospitalization	9 (8.5)
They hardly agree with reality	10 (9.5)

It is a necessity of the time that in ED there is a palliative care space, but it is necessary that emergency physicians should receive official training on how to manage palliative patients; this will contribute and help reduce ED overcrowding. Patients with oncological and palliative problems in ED, after receiving, monitoring, observation, laboratory diagnosis, radiology and medical consultations, with decision-making were systematized according to the diagnosis and treatment unit for further treatment according to the pathology of the disease. After the palliative care intervention the criteria of BLS were determined, ACLS "Do not do resuscitation alone" (follow all the principles of palliative care except CPR), do not incubate, continue the symptomatic medical treatment "(follow all the steps of palliative care) excluding intubation and CPR); and taking care directed only at relieving pain and psychological and social problems.

## Discussion

It is very important that the emergency physician should make an early identification of signs and symptoms, based on primary criteria (life-threatening patients, frequent hospitalizations due to worsening vital signs, complex care requirements) and secondary (Indicators). Specific needs, long-term care hospitalization, advanced age, pathological fractures, metastases, necessary oxygen therapy, outpatient cardiac arrest and limited social support (e.g., family stress, chronic mental illness) to be admitted ED.

## Conclusion

Implemented medical interventions of patients with malignant diseases are a small part of the total number of interventions and

treatment. The most common medical care was emergency medical care, pain management, monitoring and treatment of side effects of cytostatics and radiotherapy. Based on the research, it is clear that we have an increase in medical visits with oncological problems, the emergency doctor, very quickly manages to identify the obstacles and showing the optimal care in ED, as well as the use of valuable resources of health care.

But a very important thing for these patients with oncological problems diagnosed with COVID-19 their transport to the respective clinics, was noticed the creation of medical teams for transport by ambulance ACLS with emergency doctor because other clinics which dealt with the treatment of patients with oncological problems verified or suspected of having COVID-19 did not know how to transport them. The establishment of medical teams with emergency transport physicians will enable a correct professional transport and in this way can avoid possible complications during transport. ED special spaces should be created, human resources educated and trained for palliative care treatment. A comprehensive national program should be established for a specific integrated program in emergency palliative care training, guidelines and protocols designed for emergency medical service providers at three levels of health care.

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