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The robot physician's (RP-7) management and care in unstable ICU oncology patients

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Background: The timely assessment and treatment of ICU Surgical and Medical Oncology patients is important for Oncology Surgeons and Medical Oncologists and Intensivists. We hypothesized that the use of Robot Physician's (RP-7) ICU management and care in ICU can improve ICU physician rapid response to unstable ICU Oncology patients.

Methods: This is a prospective study using a before-after, cohort-control design to test the effectiveness of RP. We have used RP to make multidisciplinary ICU rounds in the ICU and for Emergency cases. Data concerning several aspects of the RP interaction including the latency of the response, the problem being treated, the intervention that was ordered and the type of information gathered using the RP were documented. The effect of RP on ICU length of stay and cost was assessed.

Results: The use of RP was associated with a reduction in latency of attending physician face-to-face response for routine and urgent pages compared to conventional care (RP: 10.2±3.3 minutes vs. conventional: 220±80 minutes); the response latencies for Oncology Emergency (8.0±2.8 vs. 150±55 minutes) and for Respiratory Failure (12±04 vs. 110±45 minutes) were reduced (P<0.001) as was the LOS for patients with AML (5 days) and ARDS (10 days). There was an increase in ICU occupancy by 20% compared with the pre-robot era and there was an ICU cost savings of KD2.2 million attributable to the use of RP.

Conclusion: The use of RP enabled rapid face-to-face ICU intensivist-physician response to unstable ICU Oncology patients and resulted in decreased ICU cost and LOS.

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Better outcome in primary gastro-intestinal lymphoma operated before chemo/radiotherapy: An observation in children

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Primary tumors of the gastrointestinal (GI) tract are rare in children and represent less than 5% of all pediatric neoplasms. Non-Hodgkin's lymphoma (NHL) remains the most common type of primary extra nodal lymphomas of the GI tract (5 to 10% of all NHL) while abdomen is the most frequent onset site of non-endemic Burkitt's lymphoma. We present our experience with 7 cases of GI lymphoma needed emergency surgery for bowel obstruction/perforation during and before chemo-radiation. We retrospectively reviewed the record from Feb 2011 to March 2014 and all patients needed surgery for bowel obstruction/perforation was included in study. Patients were registered according to criteria developed by Dawson and colleagues. Surgical outcome and quality of life was compared among the patients operated before and during chemo-radiation. Duration of follow-up was 3 month post surgery. Four out of 7 patients were operated during chemo-radiation in which 2 patients were died in post-operative period because of tumor load, immunosupression, malnutrition and sepsis. Rest 2 patients continued chemo-radiation but quality of life was not appropriate because of malnutrition and recurrent neutropenia and one patient was lost in follow-up. Three out of 7 patients were operated before initiation of chemo-radiation. All patients tolerated chemo-radiation better than previous group and their quality of life was better. Quality of life of the patients of GI lymphoma is better in those patients who had resection of the mass prior to chemo-radiotherapy rather than those who are subjected to surgery during chemo-radiotherapy regimen. Probably it occurs because of better oral intake though a detailed study is needed to reach a definitive result.

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