

Methods: The records of patients with SAT at a single tertiary care institution from 2015 to 2018 were retrospectively reviewed. Patients without follow-up imaging were excluded.

Results: Records of 11 patients were identified, 6 (55%) of whom were male, with a mean age of 63 years (interquartile range 56–70). Seven (64%) patients reported a positive smoking history. Nine (82%) patients had been treated recently for a variety of solid organ cancers, and 2 (18%) were under care for hematologic malignancies. The majority (82%) of patients had received prior chemotherapy, in 6 (55%) it included platinum-based chemotherapy, while targeted immunotherapy was applied in 4 (36%) patients. There were 5 (45%) patients in the cohort that had received prior radiation therapy. The majority (82%) of patients had recent computed tomography imaging (median of 2.6 months prior), at which time there was no evidence of SAT. All patients were managed initially with therapeutic anticoagulation for a median duration of 2.8 months. SAT was an incidental finding in the majority of patients, with only 4 (36%) patients symptomatic at the time of diagnosis. Two patients who presented with acute limb ischemia were treated with endovascular aortic thrombectomy and open lower extremity thromboembolism, while the other two presented with scattered abdominal and limb microembolization and were therefore treated conservatively with anticoagulation. All four of these patients were noted to have resolution of their symptoms, and there was no recurrence at any time during follow-up. All 7 (64%) asymptomatic patients were treated with therapeutic anticoagulation, and were followed with serial imaging and clinical examinations. Follow-up imaging showed improvement or complete resolution of SAT in 6 (86%) of patients. None of the patients developed symptoms, and in the 4 patients who were noted to have complete resolution of SAT, the time to resolution was 1.5 months.

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Conclusions: SAT is a challenging problem with multifactorial etiology in the oncologic patients. In most cases, prompt medical management can be safe and effective, without need for surgical intervention or long-term anticoagulation. Larger prospective series are needed to better understand the underlying mechanisms and potentially prevent SAT in cancer patients.

□ PATIENT NAVIGATION FOR COMPLEX CARE PATIENTS IN THE EMERGENCY DEPARTMENT: A SURVEY OF ONCOLOGY PATIENT NAVIGATORS



Background: Emergency departments (EDs) care for patients with complex medical problems who require a coordinated care approach. Patient navigation services, which help assist patients with care coordination, have been widely implemented for patients with cancer in a variety of settings, but

this approach has not been described in the ED. We sought to better understand the potential for ED-based patient navigation services from the perspective of individuals currently providing these services in other settings.

Methods: A survey was conducted of participants at a regional conference for patient navigation services of patients with cancer.

Results: Eighty-five completed surveys were returned, representing a response rate of 64%. Ninety-one percent of responses indicated that lay navigation services would be either very helpful or moderately helpful for ED patients with cancer. Coordination of care, the provision of emotional support, and education relevant to their medical conditions during the ED visit were identified as priorities for an ED-based lay navigation program. The lack of navigators with experience in the ED, the physical space constraints of the ED, and the time constraints associated with an ED visit were identified as the primary barriers to establishing a lay navigation program in the ED.

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Conclusions: These results identify the care priorities and barriers to be overcome during the development of an ED-based lay navigation program from the perspective of those currently providing patient navigator services.

□ EDITORIAL ON THE CURRENT STATUS OF THE RESIDENCY EDUCATION ON ONCOLOGIC EMERGENCIES



Cancer is the second leading cause of death in the United States. Furthermore, it contributes to a significant number of emergency department (ED) visits, and patients with cancer are much more likely to bounce back to the ED than the general population. Cancer patients are often immunosuppressed and commonly have altered physiology that predisposes them to a variety of complex pathophysiologic conditions. In a renaissance era of novel cancer therapies (including checkpoint inhibitors and chimeric antigen receptor–modified T-cell [CAR-T] therapy), it is imperative that emergency physicians (EPs) are educated on the common complications from cancer and cancer therapies.

A recent abstract presented at the 2019 MD Anderson Oncologic Emergencies Conference by Rajha et al. demonstrated that there may be some significant gaps in the emergency medicine education of oncologic emergencies (1). Specifically, a questionnaire was sent to several emergency