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# **Characteristics, management and outcomes of active cancer patients with cardiogenic shock**

## **Brief title: Cardiogenic shock and active cancer**

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## **Abstract**

### **Aims**

Characteristics, management, and outcomes of patients with active cancer admitted for cardiogenic shock remain largely unknown. This study aimed to address this issue and identify the determinants of 30-day and 1-year mortality in a large cardiogenic shock cohort of all etiologies.

### **Methods and results**

FRENDSHOCK is a prospective multicenter observational registry conducted in French critical care units between April and October 2016. "Active cancer" was defined as a malignancy diagnosed within the previous weeks with planned or ongoing anticancer therapy. Among the 772 enrolled patients (mean age  $65.7 \pm 14.9$  years; 71.5% male), 51 (6.6%) had active cancer. Among them, the main cancer types were solid cancers (60.8%), and hematological malignancies (27.5%). Solid cancers were mainly urogenital (21.6%), gastrointestinal (15.7%), and lung cancer (9.8%). Medical history, clinical presentation, and baseline echocardiography were almost the same between groups. In-hospital management significantly differed: patients with cancers received more catecholamines or inotropes (norepinephrine 72 vs 52%,  $p=0.005$  and norepinephrine-dobutamine combination 64.7 vs 44.5%,  $p=0.005$ ), but had less mechanical circulatory support (5.9 vs 19.5%,  $p=0.016$ ). They presented similar 30-day mortality rate (29 vs 26%) but a significantly higher mortality at one-year (70.6 vs 45.2%,  $p<0.001$ ). In multivariable analysis, active cancer was not associated with 30-day mortality but was significantly associated with 1-year mortality in 30-day survivors (HR 3.61 [1.29 - 10.11],  $p=0.015$ ).

### **Conclusion**

Active cancer patients accounted for almost 7% of all cases of cardiogenic shock. Early mortality was the same regardless active cancer or not, whereas long-term mortality was significantly increased in patients with active cancer.

**Keywords:** heart failure; cardiogenic shock; cancer; cardio-oncology; prognosis

## **Abbreviation list**

CPs: cancer patient

CRP: C-reactive protein

CS: cardiogenic shock

IABP: intra-aortic balloon pump

ICCU: intensive cardiac care unit

ICU: intensive care unit

MI: myocardial infarction

MCS: mechanical circulatory support

PCI: percutaneous coronary intervention

VA-ECMO: venoarterial-extracorporeal membrane oxygenation

# 1 **Introduction**

2

3 Cardiovascular diseases and cancers are the most prevalent diseases and the leading causes of  
4 death worldwide <sup>1</sup>. Through medical progress, the mortality rate among cancer patients (CPs)  
5 has decreased dramatically over the last three decades <sup>2</sup>. Consequently, an increased number of  
6 CPs, who also share many cardiovascular risk factors, such as age <sup>3</sup>, may develop acute heart  
7 disease such as cardiogenic shock (CS) <sup>4</sup>.

8 CS caused by severe impairment of myocardial performance is a life-threatening condition  
9 defined as persistent low cardiac output, without hypovolemia, resulting in organ  
10 hypoperfusion and multi-organ failure <sup>5</sup>. Although recent progress has been made in the field  
11 of CS, notably regarding diagnosis but also organ support, mortality remains >40% which  
12 makes this condition a major challenge in intensive cardiac care units (ICCU) and intensive  
13 care units (ICU) <sup>6</sup>.

14 The interconnection between cancer and cardiovascular diseases has led to the development of  
15 the field of cardio-oncology <sup>7</sup>, which distinguishes two main types of cardio-oncology  
16 syndromes in CPs <sup>8</sup>. CS belongs to the type 1 cardio-oncological syndrome when the etiology  
17 comes from cancer itself, directly or indirectly through an increase in coronary risk,  
18 thromboembolic events, tamponade, or paraneoplastic syndrome. And CS belongs to type 2  
19 cardio-oncological syndrome when it results from side effects of cancer treatments such as  
20 chemotherapy, radiotherapy, targeted therapy, or immunotherapy.

21 There is currently a critical lack of data regarding cardio-oncology, indeed due to the lack of  
22 large-scale, randomized trials, only 3% of the recommendations are level of evidence A and  
23 21% are level of evidence B in the very first cardio-oncology guidelines published in 2022 <sup>9</sup>.  
24 This lack of data is even more critical regarding CS in CPs. Indeed, most scientific evidence  
25 comes from case reports or large retrospective cohorts with very limited clinical data <sup>10</sup>. This



26 paucity of data makes it difficult for clinicians to know whether CS foreshadows the end of life  
27 of CPs who might benefit from palliative care or whether these CPs might benefit from  
28 intensive management strategies, including mechanical circulatory support (MCS).  
29 The main objective of this study based on the largest European prospective cohort of CS to  
30 date, was to assess characteristics and outcomes of CS according to the presence of active  
31 cancer. The secondary objective was to determine prognostic factors of CS in CPs.

32 **Methods**

33

34 Patient population

35 FRENSHOCK is a prospective multicenter observational registry conducted in metropolitan  
36 France during six months between April and October 2016 in ICU and ICCU (NCT02703038).

37 The methods used for this registry have been previously described <sup>11</sup>. Briefly, the primary  
38 objective was to evaluate the characteristics, management, and outcomes of CS patients, with  
39 a new modified definition of CS as seen in routine clinical practice, on a nationwide scale.

40 All adult patients ( $\geq 18$  years old) with CS were prospectively included in this registry if they  
41 met at least one criterion of (i) hemodynamic criteria, (ii) left and/or right heart overload; and  
42 (iii) signs of organ malperfusion. Patients could be included regardless of CS etiology, and  
43 whether CS was primary or secondary.

44 "Active cancer" was defined as a malignancy diagnosed within the previous weeks with planned  
45 treatment or patients with ongoing cancer treatment such as chemotherapy, radiation therapy,  
46 surgery, targeted therapy, or immunotherapy. The distinction between solid cancers and  
47 hematological malignancies has been individually verified by an oncologist.

48 All institutions were invited to participate in the study, including university teaching hospitals,  
49 general and regional hospitals, and public and private hospitals that manage CS patients  
50 (ICCU, surgical ICUs, medical ICUs, and general ICUs).

51 The study was conducted in accordance with the guidelines for good clinical practice and  
52 French law. Written consent was obtained for all the patients. The data recorded and their  
53 handling and storage were reviewed and approved by the CCTIRS (French Health Research  
54 Data Processing Advisory Committee) (n° 15.897) and the CNIL (French Data Protection  
55 Agency) (n° DR-2016-109).

56

57 Data collection

58 Data on baseline characteristics, including demographics (age, gender, body mass index  
59 (BMI)), risk factors (hypertension, diabetes, current smoking, hypercholesterolemia), and  
60 medical history [cardiomyopathy, myocardial infarction (MI), stroke, peripheral artery disease,  
61 chronic kidney disease, active cancer, chronic obstructive lung disease], were collected as  
62 previously mentioned. Clinical, biological, and echocardiographic data were collected within  
63 the first 24 h after admission. Up to three CS triggers were determined for each patient by the  
64 local investigator, that is, ischemic (Type 1 or Type 2 acute MI according to European  
65 guidelines); ventricular and supraventricular arrhythmia; conduction disorder; infectious  
66 disease; non-compliance (poor compliance with medical treatment or hygiene and diet rules);  
67 or iatrogenesis. Iatrogenesis is defined as unintended consequences, complications, or adverse  
68 effects associated with medical procedures, medications, or interventions performed during the  
69 management of a patient. Investigators could also note other existing factors or etiologies which  
70 were indicated as 'other'. Information regarding the use of cardiac procedures, that is, coronary  
71 angiography and/or percutaneous coronary intervention (PCI); right heart catheterization; the  
72 need for medications (inotropes, vasopressors, diuretics, and fibrinolysis) and organ  
73 replacement therapies such as mechanical ventilation (invasive or non-invasive); temporary  
74 MCS [intra-aortic balloon pump (IABP); extracorporeal membrane oxygenation or Impella®  
75 (Abiomed, Danvers, MA, USA)]; and renal replacement therapy (continuous or intermittent)  
76 were collected. In-hospital complications were noted, such as stroke, bleeding and transfusions,  
77 hemolysis, thrombocytopenia, nosocomial infections, vascular complications, and death.  
78 Information on mortality was obtained directly by the local investigators (cause and date).

79

80 Statistical analysis

81 Continuous variables were reported as means (SD) or medians and interquartile ranges when  
82 appropriate. Discrete variables were described in numbers and percentages. Groups (30-day  
83 survivors and non-survivors) were compared by analysis of variance for continuous variables  
84 and  $\chi^2$  or Fisher's exact test for discrete variables. Odds ratios (ORs) were presented with their  
85 95% confidence intervals (CIs). To determine independent predictors of in-hospital all-cause  
86 mortality, binary logistic regression analyses were used, with a threshold  $<0.10$  for variable  
87 elimination. Variables included in the final models were selected ad hoc based on their  
88 physiological relevance and potential to be associated with outcomes. Two multivariable  
89 analyses were conducted. The first included only variables available on admission: age, gender,  
90 type of institution, risk factors, comorbidities, and causes of CS. A sensitivity analysis was  
91 performed, and lactate peak was added to the covariates in the main analysis. The second model  
92 added in-hospital management variables (first place of admission; respiratory, circulatory, or  
93 renal support; use of inotropes, vasopressors, diuretics, and fibrinolysis in the first 24 h; and  
94 myocardial revascularization). This analysis was repeated on the subset of patients with  
95 ischemic CS. Analyses were repeated using forward stepwise analysis to assess the consistency  
96 of results. Collinearity was assessed by calculating variance inflation factors. Statistical  
97 analyses were performed using IBM SPSS 23.0 (IBM SPSS Inc.). For all analyses, two-sided  
98 P values  $<0.05$  were considered significant.

99 **Results**

100

101 Study population

102 A total of 772 CS patients were included in 49 centers. Among these patients, 51 had active  
103 cancer (6.6%). Clinical characteristics between non-CPs and CPs are presented in Table 1. The  
104 mean age of the CPs population was 68.6 ( $\pm 12.3$ ) years with a predominance of men (76.5%),  
105 not significantly different compared to non-CPs. Employment status was similar between the  
106 two groups. The rate of main cardiovascular risk factors was the same in both groups. In CPs,  
107 a medical history of cardiac disease was reported in 51% (31.4% coronary artery disease),  
108 previous PCI in 29.4%, previous ischemic stroke in 9.8%, peripheral artery disease in 13.7%.  
109 Although, there was also no difference in terms of medical history, except for a higher rate of  
110 cardiac toxicity among CPs ( $p=0.02$ ). There was no difference in previous cardiac treatments.  
111 Besides cardiovascular diseases, 5.9% of CPs had chronic obstructive pulmonary disease and  
112 25.5% had chronic kidney disease.

113 Among CPs, main cancer types were solid cancers (60.8%) and hematological malignancies  
114 accounted for 27.5% (Table 2). Solid cancers were mainly urogenital (21.6%), gastrointestinal  
115 (15.7%), and lung cancer (9.8%).

116 At admission, in CPs, the mean heart rate was 102 ( $\pm 27$ ) bpm (60.8% with sinus rhythm), and  
117 SBP was 102 ( $\pm 25$ ) mmHg (Table 3). Clinical signs of left and right heart failure were  
118 significantly more frequent in CPs compared to non-CPs with 84% (versus 71%,  $p=0.042$ ) and  
119 69% (versus 48%,  $p=0.004$ ) respectively and mottling was reported in 48.8% of the cases.

120 The main triggers of CS (not mutually exclusive) in CPs were ischemic (31.4%), infectious  
121 disease (25.5%), and iatrogenic (19.6%) (Table 1). Infectious disease and iatrogenic triggers  
122 were significantly more frequent compared to non-CPs. Cardiac arrest was the trigger of CS for  
123 3 CPs (5,9%) patients. Most patients in both groups had multiple organ failure as evidenced by

124 kidney dysfunction, hepatic cytolysis and cholestasis, and lactate elevation (Table 3). Lactate  
125 level and C-reactive protein (CRP) at admission were significantly increased in CPs compared  
126 to non-CPs. Hemoglobin level was significantly lower in CPs with more anemia in CPs (78.4  
127 vs 48.7%,  $p < 0.001$ ).

128 Baseline echocardiography at admission showed a mean left ventricular ejection fraction  
129 (LVEF) of 28.2% ( $\pm 13.5$ ) which was not different between groups.

130

131 In-hospital management

132 In-hospital management is reported in **Table 4**. Most CPs were directly admitted in ICCU  
133 (60%); 40% were admitted in ICU, and before admission, the first medical contact occurred  
134 most often within the hospital, as CPs were more often already hospitalized ( $p = 0.035$ ).

135 Medical management was relatively similar between the two groups, except for the  
136 administration of norepinephrine and norepinephrine plus dobutamine combination, which was  
137 significantly higher in CPs (respectively 72 vs. 52%,  $p=0.005$  and 64.7 vs 44.5%,  $p=0.005$ ).

138 Another major difference was the use of MCS, which was much less frequent in CPs (5.9 vs  
139 19.5%,  $p=0.016$ ). There was slightly less coronary angiography performed in CPs, although not  
140 significant. However, the number of diseased vessels and the rate of PCI were similar in both  
141 groups. There was no difference between groups regarding the need for respiratory support or  
142 renal replacement therapy. The median length of stay in ICU and/or ICCU was significantly  
143 higher in CPs compared to non-CPs, with 16 vs. 11 days ( $p=0.041$ ). There was no difference  
144 between groups regarding discharge mode after hospitalization.

145

146 Thirty-day and one-year outcomes and correlates

147 The mortality rate at 30 days was similar in CPs compared to the overall CS population (26%  
148 vs. 29.4%). In-hospital mortality was also similar between the two groups, although it was

149 numerically higher in cancer patients (42.9 vs. 32.8%), but not statistically significantly. The  
150 mortality rate at one-year was significantly increased in CPs, with 45.2% mortality in the  
151 overall population and 70.6% in CPs (Crude HR=1.85 [1.31 – 2.62],  $p<0.001$ ) (**Structured**  
152 **graphical abstract**).

153 In CPs, the multivariable analysis identified three independent factors at admission (a low BMI  
154 (HR: 0.79;  $p=0.009$ ), admission in ICU (HR: 7.05;  $p=0.007$ ), and ASAT  $\geq 180$  IU/L (HR: 4.43;  
155  $p=0.004$ )) associated with higher mortality at 30 days, and two with 1 year mortality (diastolic  
156 blood pressure (HR: 0.97;  $p=0.012$ ) and lactate  $\geq 4$  mmol/L at admission (HR: 3.17;  $p=0.003$ ))  
157 (**Supplementary table 1 and 2**).

158 **Figure 1** shows the Kaplan-Meier Landmark analysis of 30-day CS survivors. Using a  
159 multivariable cox regression among CS patients who were still alive at 30 days, age, active  
160 cancer, low hemoglobin, hyponatremia, low estimated glomerular filtration rate at admission,  
161 volume expansion during the first 24h, furosemide, levosimendan and amiodarone use,  
162 transfusion and renal replacement therapy requirement during in-hospital management were  
163 negatively associated with 1 year mortality although any PCI realization during hospitalization  
164 was protective (**Supplementary table 3**).

165 **Discussion**

166

167 To date, this post hoc analysis of a large prospective, observational multicenter registry of  
168 unselected CS, is the first study aiming at describing characteristics, management, and  
169 outcomes of CS among CPs.

170 The first results show that CPs represent almost 7% of patients in CS. CPs' medical history, but  
171 also clinical presentation, and baseline echocardiography were comparable whether the patient  
172 with CS had active cancer or not. However, in-hospital management significantly differed since  
173 catecholamines, or inotropes were more often used for CPs while on the contrary, CPs had less  
174 MCS. The main result remains that CPs presented similar 30-day mortality rate (about 30%),  
175 but a significantly higher mortality at one-year (70% versus 43%, hence Crude HR=1.85 [1.31  
176 – 2.62],  $p<0.001$ )

177

178 During the last decade, a continuous increase in cancer incidence, accompanied by a stable  
179 decrease in cancer mortality has been observed <sup>2</sup>. Early diagnosis and more efficient treatments  
180 are the most likely explanations for this epidemiological and clinical shift, which has led to an  
181 increase in the life expectancy of CPs. Thus, although still relatively uncommon, the rate of CS  
182 among CPs is likely to increase steadily over time. Moreover, patients with cancer were often  
183 excluded from most of the large cardiology studies and registries <sup>12</sup>.

184 Some shreds of evidence are slowly emerging and in 2021 and 2022, the first consensus  
185 document for “Evaluation and management of cancer patients presenting with acute  
186 cardiovascular disease” was published by a Task Force including the Association of Acute  
187 CardioVascular Care and the Council of Cardio-Oncology of the European Society of  
188 Cardiology <sup>13,14</sup>. Besides, the very first cardio-oncology guidelines were published only very  
189 recently, in 2022, but CS issue is not specifically addressed <sup>9</sup>.



190 The prevalence of active cancers among patients with CS is about 7% in our study. Puymirat et  
191 al. also reported a prevalence between 7 and 8% of CPs among CS in the CUB-Réa database, a  
192 retrospective registry collecting data during 15 years (between 1997 and 2012) in 32 ICUs in  
193 France <sup>15</sup>. In the international ESC-HF-LT Registry, the prevalence of cancer in the subgroup  
194 of patients admitted with CS (n=195) in more than 200 centers between 2011 and 2015 was  
195 around 5% <sup>16</sup>.

196 As expected, anemia was significantly more frequent in CPs than in non-CPs. Cancer-related  
197 anemia is a common comorbidity in CPs that is partly a consequence of concomitant  
198 antineoplastic therapy and a result of chronic inflammation associated with cancer <sup>17</sup>. Indeed,  
199 in the present study, inflammation appeared to be more important in the CPs, as suggested by  
200 the significantly higher CRP level. However, this higher inflammation in CPs may also be  
201 explained by more associated infectious CS triggers.

202 Although difficult to confirm, differences in terms of patient management (more vasopressors  
203 used in CPs), might likely be attributed to multiple factors, including different triggers (with  
204 infections being more frequent in CPs), distinct hemodynamic profiles (with CPs displaying a  
205 higher prevalence of vasoplegic syndrome due to underlying inflammation), and potential  
206 paraneoplasia syndromes in CPs.

207

208 In the present study, 30-day mortality was 29.4% in CPs and cancer was not an independent  
209 variable associated with 30-day mortality. Among, the independent factors at admissions  
210 associated with higher 30-day mortality, a low BMI might be the most pragmatic and helpful  
211 for clinician to help him/her choose the intensity of care in the best interest of the patient. As  
212 expected, admission to ICU rather than ICCU was also an independent factor of 30-mortality  
213 due to the difference in severity between patients.

214 In contrast, at 1 year, CPs have an almost twice excess of mortality (70 vs 43%). Independent  
215 factors identified in multivariable analysis seem too imprecise to use them as parameters to  
216 guide further support. These results are in line with those of the few previous studies. In the  
217 administrative Nationwide Inpatient Sample Database which includes around 500,000 patients  
218 hospitalized for CS between 2004 and 2011, cancer was independently associated with poor  
219 outcomes. Having a solid tumor represented an extremely unfavorable prognostic factor with  
220 an odds ratio (OR) of 1.50 for CPs without metastases and an OR of 2.05 for CPs with  
221 metastases <sup>18</sup>.

222 These results suggest that cancer has a limited influence on the early mortality of CS. While 1-  
223 year mortality is probably more related to cancer, although the lack of data in this study makes  
224 it impossible to confirm this issue. Another hypothesis may be that CS and its consequences  
225 had impeded the continuation or implementation of cancer treatment for CPs.

226 According to a recent experts review on critically ill oncology and hematology patients, no  
227 predefined criteria or prognostic scores of ICU or ICCU triage for admission should be used <sup>19</sup>.

228 Indeed, our data thereby support these recent expert positions on critically ill CPs and cancer  
229 should not be seen as a limiting factor in the short-term period. Each situation being different  
230 and challenging, the benefit-risk assessment must be discussed in an urgent multidisciplinary  
231 manner based on multiple criteria such as performance status and Clinical Frailty Scale <sup>20</sup>.

232 Experts also suggest that time-limited trials should be used for CPs, meaning unlimited ICU  
233 management with a full-code status for a limited period before a re-evaluation of the clinical  
234 situation <sup>19</sup>. The appropriate length of time for full-code status (doing everything that can be  
235 done, including cancer chemotherapy and acute MCS) appears to be around 5 to 7 days for solid  
236 tumors but possibly for up to 14 days for hematologic malignancies <sup>21</sup>. To be noted, in case of  
237 multiple organ failure, full-code management for four to five days leads to similar outcomes as  
238 unlimited aggressive care <sup>22</sup>. Although cancer is not mentioned in this expert consensus, our

239 results suggest that acute MCS for refractory CS should be implemented before the onset of  
240 multi-organ failure in selected patients as a strategy to buy time for cardiac recovery (bridge-  
241 to-recovery strategy) or bridge-to-other therapies (bridge-to-decision strategy) <sup>23</sup>.

242 The 2016 International Society for Heart and Lung Transplantation listing criteria for heart  
243 transplantation advises that the use of MCS support should be considered for patients with  
244 potentially reversible or treatable comorbidities, such as cancer, with subsequent reevaluation  
245 to establish candidacy (Class IIb, Level of Evidence: C) <sup>24</sup>. These guidelines also state that in  
246 patients with preexisting cancers, the risk of tumor recurrence should be stratified with a cardio-  
247 oncology collaboration. And that cardiac transplantation should be considered when risk of  
248 tumor recurrence is low based on tumor type, response to therapy, and negative metastatic  
249 workup. The specific amount of time to wait to transplant after neoplasm remission will depend  
250 on the aforementioned factors, and no arbitrary time period for observation should be used  
251 (Class of Recommendation I, Level of Evidence: C) <sup>24</sup>. Thus, even though in our current study  
252 the use of MCS was lower in CPs, by showing no difference between CPs and non-CPs in terms  
253 of 30-day survival, the criteria for MCS implementation should be based on other parameters  
254 than cancer alone. In the very special case of CS due to immune checkpoint inhibitors-  
255 associated fulminant myocarditis, the latest ESC Guidelines on cardio-oncology recommend an  
256 optimal cardiovascular treatment including mechanical support (Class I, level C) <sup>9</sup>.

257 In contrast, if intensive therapy seems unreasonable given the patient's medical history and  
258 characteristics, then palliative care, often underused in CS <sup>25</sup>, should be considered. Indeed, the  
259 most recent American Heart Association guidelines recommend the involvement of a  
260 multidisciplinary team, including palliative care, for all complex cardiovascular patients <sup>26</sup>.

261

262

263 Limitations

264 As in any observational study, there are limitations to our analysis, such as missing data. The  
265 number of CPs represents a small sample size, even if it appears still enough to highlight  
266 significant, and original data. Data for patients who died before informed consent was obtained  
267 were not collected and recorded in the database because of administrative regulations. So, it  
268 cannot be excluded that the most severe patients i.e., with several comorbidities, frailty or  
269 multiple end-stage organ failure, could not have been admitted in ICU/ICCU for futility or have  
270 been deceased before inclusion. This could be a source of bias resulting in an underestimation  
271 of mortality. This addressing bias may possibly be greater for CPs with an associated risk of  
272 underestimating cancer prevalence among the CS population, but this further reinforces the  
273 message in our view. Indication bias for aggressive therapies among CPs such as MCS is  
274 possible. The existence of metastasis was not recorded. Another limitation to mention is that  
275 SCAI SHOCK Stage Classification was not used for the CS severity classification, nor the  
276 classification of cardio-oncological syndrome for the CPs, given that these scores were not still  
277 available at the time of the study <sup>27</sup>. Then, the factors associated with 30-day mortality should  
278 be interpreted with caution as an exploratory analysis since it is based on a low number of 30-  
279 day deaths (n = 15) in CPs. Finally, while general and more particularly cardiovascular data are  
280 important, cancer-specific data are relatively limited or even missing for some patients.  
281 Although, in the present study, the high proportion of iatrogenic triggers of CS among CPs  
282 suggests that there were numerous type 2 cardio-oncological syndromes but even more type 1  
283 cardio-oncological syndromes.

284

#### 285 Strengths

286 Our study highlights the absolute lack of difference in early mortality between CPs and non-  
287 CPs. Thus, providing evidence that the management of patients with active cancer and CS is  
288 not futile. Our study could partly help clinicians in triage decisions of CPs with CS and limit

289 delay ICU admission which may increase mortality <sup>28</sup>. Further studies are needed to collect  
290 more cancer-related data and better identify patients who might benefit from long-term  
291 intensive management.

292

### 293 **Conclusion**

294

295 In this first, prospective, observational multicenter study describing characteristics,  
296 management, and outcomes of CS among CPs, CPs represent nearly 7% of patients in CS.  
297 Besides cancer status, no difference was found in medical history and initial presentation  
298 between groups. In-hospital management however significantly differs with higher  
299 catecholamine and less MCS use in CPs. The main finding was that early mortality was not  
300 significantly different between CPs and non-CPs, whereas a marked excess of mortality was  
301 noted at 1-year in CPs, which means that therapeutic nihilism should be avoided for well-  
302 selected CPs with CS for whom a more aggressive management might be beneficial.

## **CLINICAL PERSPECTIVES**

**COMPETENCY IN MEDICAL KNOWLEDGE:** Active cancer patients with cardiogenic shock had no difference in 30-day mortality compared to patients without cancer. Whereas a marked excess of mortality was noted at 1-year in active cancer patients.

**COMPETENCY IN PATIENT CARE:** Cardiologists, intensivists, and oncologists should be aware that therapeutic nihilism should be avoided for well-selected active cancer patients with cardiogenic shock for whom a more aggressive management might be beneficial.

**TRANSLATIONAL OUTLOOK:** Further studies are needed to develop algorithms to better predict patients who have the best survival rates among active cancer patients with cardiogenic shock and also determine the optimal therapeutics intensity and regimen in this population.

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## **Conflict of interest**

The authors declare no competing interests.

## **Declarations**

- Ethics approval and consent to participate: The data recorded and their handling and storage were reviewed and approved by the CCTIRS (French Health Research Data Processing Advisory Committee) (n° 15.897) and the CNIL (French Data Protection Agency) (n° DR-2016-109).
- Consent for publication: All authors hereby consent to the publication.
- Availability of data and material: All summarized data are available upon request.
- Authors' contributions :
  - Coordination and supervision of the FRENSHOCK registry: CD
  - Funding acquisition: FR, ME, and EB
  - Project administration: FR, ME, EB and CD
  - Data acquisition: all authors
  - Investigations: all authors

- Conceptualization, HM, JG, and CD
- Statistical analysis: VB
- Writing-original draft: HM and CD
- Writing-review and editing: JG, LB, VB and NA
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## Reference

1. Dagenais GR, Leong DP, Rangarajan S, *et al.* Variations in common diseases, hospital admissions, and deaths in middle-aged adults in 21 countries from five continents (PURE): a prospective cohort study. *Lancet* 2020;**395**:785-794. doi: 10.1016/S0140-6736(19)32007-0
2. Santucci C, Carioli G, Bertuccio P, *et al.* Progress in cancer mortality, incidence, and survival: a global overview. *Eur J Cancer Prev* 2020;**29**:367-381. doi: 10.1097/CEJ.0000000000000594
3. Koene RJ, Prizment AE, Blaes A, Konety SH. Shared Risk Factors in Cardiovascular Disease and Cancer. *Circulation* 2016;**133**:1104-1114. doi: 10.1161/CIRCULATIONAHA.115.020406
4. Curtiaud A, Delmas C, Gantzer J, *et al.* Cardiogenic shock among cancer patients. *Front Cardiovasc Med* 2022;**9**:932400. doi: 10.3389/fcvm.2022.932400
5. Tehrani BN, Truesdell AG, Psozka MA, *et al.* A Standardized and Comprehensive Approach to the Management of Cardiogenic Shock. *JACC Heart Fail* 2020;**8**:879-891. doi: 10.1016/j.jchf.2020.09.005
6. Arrigo M, Jessup M, Mullens W, *et al.* Acute heart failure. *Nat Rev Dis Primers* 2020;**6**:16. doi: 10.1038/s41572-020-0151-7
7. Cardinale D, Colombo A, Lamantia G, *et al.* Cardio-oncology: a new medical issue. *Ecancermedicalscience* 2008;**2**:126. doi: 10.3332/ecancer.2008.126
8. de Boer RA, Aboumsallem JP, Bracun V, *et al.* A new classification of cardio-oncology syndromes. *Cardiooncology* 2021;**7**:24. doi: 10.1186/s40959-021-00110-1
9. Lyon AR, Lopez-Fernandez T, Couch LS, *et al.* 2022 ESC Guidelines on cardio-oncology developed in collaboration with the European Hematology Association (EHA), the European Society for Therapeutic Radiology and Oncology (ESTRO) and the International Cardio-Oncology Society (IC-OS). *Eur Heart J* 2022. doi: 10.1093/eurheartj/ehac244
10. Keramida K, Parissis JT, Chioncel O, Farmakis D. Cardiogenic shock in cancer. *Heart Fail Rev* 2019;**24**:997-1004. doi: 10.1007/s10741-019-09819-9
11. Delmas C, Puymirat E, Leurent G, *et al.* Design and preliminary results of FRENSHOCK 2016: A prospective nationwide multicentre registry on cardiogenic shock. *Arch Cardiovasc Dis* 2019;**112**:343-353. doi: 10.1016/j.acvd.2019.02.001
12. Bonsu J, Charles L, Guha A, *et al.* Representation of Patients With Cardiovascular Disease in Pivotal Cancer Clinical Trials. *Circulation* 2019;**139**:2594-2596. doi: 10.1161/CIRCULATIONAHA.118.039180
13. Gevaert SA, Halvorsen S, Sinnaeve PR, *et al.* Evaluation and management of cancer patients presenting with acute cardiovascular disease: a Consensus Document of the Acute CardioVascular Care (ACVC) association and the ESC council of Cardio-Oncology-Part 1: acute coronary syndromes and acute pericardial diseases. *Eur Heart J Acute Cardiovasc Care* 2021;**10**:947-959. doi: 10.1093/ehjacc/zuab056
14. Gevaert SA, Halvorsen S, Sinnaeve PR, *et al.* Evaluation and management of cancer patients presenting with acute cardiovascular disease: a Clinical Consensus Statement of the Acute CardioVascular Care Association (ACVC) and the ESC council of Cardio-Oncology-part 2: acute heart failure, acute myocardial diseases, acute venous thromboembolic diseases, and acute arrhythmias. *Eur Heart J Acute Cardiovasc Care* 2022;**11**:865-874. doi: 10.1093/ehjacc/zuac107
15. Puymirat E, Fagon JY, Aegerter P, *et al.* Cardiogenic shock in intensive care units: evolution of prevalence, patient profile, management and outcomes, 1997-2012. *Eur J Heart Fail* 2017;**19**:192-200. doi: 10.1002/ejhf.646

16. Chioncel O, Mebazaa A, Harjola VP, *et al.* Clinical phenotypes and outcome of patients hospitalized for acute heart failure: the ESC Heart Failure Long-Term Registry. *Eur J Heart Fail* 2017;**19**:1242-1254. doi: 10.1002/ejhf.890
17. Maccio A, Madeddu C, Gramignano G, *et al.* The role of inflammation, iron, and nutritional status in cancer-related anemia: results of a large, prospective, observational study. *Haematologica* 2015;**100**:124-132. doi: 10.3324/haematol.2014.112813
18. Shaefi S, O'Gara B, Kociol RD, *et al.* Effect of cardiogenic shock hospital volume on mortality in patients with cardiogenic shock. *J Am Heart Assoc* 2015;**4**:e001462. doi: 10.1161/JAHA.114.001462
19. Azoulay E, Schellongowski P, Darmon M, *et al.* The Intensive Care Medicine research agenda on critically ill oncology and hematology patients. *Intensive Care Med* 2017;**43**:1366-1382. doi: 10.1007/s00134-017-4884-z
20. Jung C, Guidet B, Flaatten H, group VIPs. Frailty in intensive care medicine must be measured, interpreted and taken into account! *Intensive Care Med* 2022. doi: 10.1007/s00134-022-06887-8
21. Dumas G, Pastores SM, Munshi L. Five new realities in critical care for patients with cancer. *Intensive Care Med* 2023;**49**:345-348. doi: 10.1007/s00134-023-06988-y
22. Shrimme MG, Ferket BS, Scott DJ, *et al.* Time-Limited Trials of Intensive Care for Critically Ill Patients With Cancer: How Long Is Long Enough? *JAMA Oncol* 2016;**2**:76-83. doi: 10.1001/jamaoncol.2015.3336
23. Chieffo A, Dudek D, Hassager C, *et al.* Joint EAPCI/ACVC expert consensus document on percutaneous ventricular assist devices. *Eur Heart J Acute Cardiovasc Care* 2021;**10**:570-583. doi: 10.1093/ehjacc/zuab015
24. Mehra MR, Canter CE, Hannan MM, *et al.* The 2016 International Society for Heart Lung Transplantation listing criteria for heart transplantation: A 10-year update. *J Heart Lung Transplant* 2016;**35**:1-23. doi: 10.1016/j.healun.2015.10.023
25. Vallabhajosyula S, Prasad A, Dunlay SM, *et al.* Utilization of Palliative Care for Cardiogenic Shock Complicating Acute Myocardial Infarction: A 15-Year National Perspective on Trends, Disparities, Predictors, and Outcomes. *J Am Heart Assoc* 2019;**8**:e011954. doi: 10.1161/JAHA.119.011954
26. Braun LT, Grady KL, Kutner JS, *et al.* Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association. *Circulation* 2016;**134**:e198-225. doi: 10.1161/CIR.0000000000000438
27. Baran DA, Grines CL, Bailey S, *et al.* SCAI clinical expert consensus statement on the classification of cardiogenic shock: This document was endorsed by the American College of Cardiology (ACC), the American Heart Association (AHA), the Society of Critical Care Medicine (SCCM), and the Society of Thoracic Surgeons (STS) in April 2019. *Catheter Cardiovasc Interv* 2019;**94**:29-37. doi: 10.1002/ccd.28329
28. van der Zee EN, Benoit DD, Hazenbroek M, *et al.* Outcome of cancer patients considered for intensive care unit admission in two university hospitals in the Netherlands: the danger of delayed ICU admissions and off-hour triage decisions. *Ann Intensive Care* 2021;**11**:125. doi: 10.1186/s13613-021-00898-2

## **Figure legends**

**Figure 1. Early (30-day) and long-term (1-year) all-cause mortality by Kaplan-Meier landmark analysis according to the cancer status of the patients.**

**Graphical abstract. Characteristics, management, and outcomes of cancer patients with cardiogenic shock: An analysis of the FRENHOCK prospective multicenter registry.**

Kaplan-Meier Landmark analysis of failure rate (all-cause death) of 30-day survivors

aMCS. Acute mechanical circulatory support, CRP. C reactive protein, CS. Cardiogenic shock,

CCU. Critical care unit, LOS. Length of stay in hospital.

## Tables

**Table 1 - Clinical characteristics at admission according to the cancer status of the patients.**

	Overall (n=772)		No cancer (n=721)		Active Cancer (n=51)		P value
Male gender. n/total n (%)	552/772	(71.5)	513/721	(71.2)	39/51	(76.5)	0.416
		+/-		+/-		+/-	
Age (years). mean +/- SD	65.7	14.9	65.5	15.1	68.6	12.3	0.146
BMI (kg/m <sup>2</sup> ). mean +/- SD	25.8	+/- 5.5	25.9	+/- 5.4	24.8	+/- 6.8	0.182
<i>n</i>	744		695		49		
Risk factors. n/total n (%)							
Current smoker	206/740	(27.8)	196/693	(28.3)	10/47	(21.3)	0.300
Diabetes mellitus	217/770	(28.2)	204/719	(28.4)	13/51	(25.5)	0.658
Arterial hypertension	364/771	(47.2)	340/720	(47.2)	24/51	(47.1)	0.982
Dyslipidaemia	277/771	(35.9)	258/720	(35.8)	19/51	(37.3)	0.838
Medical history. n/total n (%)							
History of cardiac disease	433/771	(56.2)	407/720	(56.5)	26/51	(51.0)	0.440
Ischaemic	230/771	(29.8)	214/720	(29.7)	16/51	(31.4)	0.803
Hypertrophic	11/771	(1.4)	10/720	(1.4)	1/51	(2.0)	0.531
Idiopathic	78/771	(10.1)	75/720	(10.4)	3/51	(5.9)	0.468
Toxic	34/771	(4.4)	28/720	(3.9)	6/51	(11.8)	0.020
Multisite pacing	63/771	(8.2)	60/720	(8.3)	3/51	(5.9)	0.791
Defibrillator	127/771	(16.5)	123/720	(17.1)	4/51	(7.8)	0.086
CABG	62/771	(8.0)	59/720	(8.2)	3/51	(5.9)	0.790
PCI	166/771	(21.5)	151/720	(21.0)	15/51	(29.4)	0.156
Peripheral artery disease	91/771	(11.8)	84/720	(11.7)	7/51	(13.7)	0.660
Ischemic stroke	62/771	(8.0)	57/720	(7.9)	5/51	(9.8)	0.594
Chronic renal failure	164/771	(21.3)	151/720	(21.0)	13/51	(25.5)	0.446
Dialysis	11/771	(1.4)	11/720	(1.5)	0/51	(0.0)	1.000
COPD	50/771	(6.5)	47/720	(6.5)	3/51	(5.9)	1.000
Previous medications							
Aspirin	288/772	(37.4)	268/721	(37.3)	20/51	(39.2)	0.782
P2Y12 inhibitor	126/772	(16.4)	118/721	(16.4)	20/51	(39.2)	0.892
Statins	286/772	(37.1)	269/721	(37.4)	17/51	(33.3)	0.560
Betablockers	316/772	(41.0)	297/721	(41.3)	19/51	(37.3)	0.570
Vitamin K antagonist	165/772	(21.4)	155/721	(21.6)	10/51	(19.6)	0.743
Direct oral anticoagulant	56/772	(7.3)	54/721	(7.5)	2/51	(3.9)	0.573
ACE inhibitor or ARB	292/772	(37.9)	272/721	(37.8)	20/51	(39.2)	0.844
Sacubitril / Valsartan	18/772	(2.5)	18/721	(2.7)	0/51	(0.0)	0.630
Furosemide	376/772	(48.8)	345/721	(48.0)	31/51	(60.8)	0.077
Aldosterone antagonist	108/772	(14.0)	100/721	(13.9)	8/51	(15.7)	0.724
Amiodarone	132/772	(17.6)	121/721	(17.3)	11/51	(21.6)	0.435
Proton pump inhibitor	276/772	(36.4)	253/721	(35.7)	23/51	(45.1)	0.179
Triggers. n/total n (%)							
Ischaemic	291/772	(37.7)	275/721	(38.1)	16/51	(31.4)	0.335

Mechanical	24/772	(3.1)	23/721	(3.2)	1/51	(2.0)	1.000
Ventricular							
arrhythmia	98/772	(12.7)	93/721	(12.9)	5/51	(9.8)	0.521
Atrial arrhythmia	108/772	(14.0)	103/721	(14.3)	5/51	(9.8)	0.373
Conductive disorders	18/772	(2.3)	17/721	(2.4)	1/51	(2.0)	1.000
Infectious	96/772	(12.4)	83/721	(11.5)	13/51	(25.5)	0.003
Non compliance	30/772	(3.9)	28/721	(3.9)	2/51	(3.9)	1.000
Iatrogenic	61/772	(7.9)	51/721	(7.1)	10/51	(19.6)	0.004
Other	102/772	(13.2)	91/721	(12.6)	11/51	(21.6)	0.068
None / undefined	111/772	(14.4)	103/721	(14.3)	8/51	(15.7)	0.783

ACE : Angiotensin-Converting Enzyme. ARB : Angiotensin-Receptor Blocker. BMI : Body Mass Index. CABG : Coronary Artery Bypass Graft. COPD : Chronic Obstructive Pulmonary Disease. PCI : Percutaneous Coronary Intervention. SD : Standard Deviation.

**Table 2 – Cancer type and localization in the CPs population (n=51)**

n = 51	n	%
Type of cancer		
Solid	31	60.8
Hematological malignancies	14	27.5
Unknown	6	11.8
Cancer's localization		
Hematological malignancies	14	27.5
Urogenital (incl. Prostate)	11	21.6
Gastrointestinal	8	15.7
Unknown	7	13.7
Lung	5	9.8
Otorhinolaryngeal	3	5.9
Sarcoma	1	2.0

**Table 3 - Clinical, echographic, and biological presentation according to the cancer status of the patients.**

	Overall (n=772)		No cancer (n=721)		Active Cancer (n=51)		P value
First medical contact. n/total n (%)							0.035
Emergency department	257/769	(33.4)	242/718	(33.7)	15/51	(29.4)	
Mobile emergency unit	229/769	(29.8)	215/718	(29.9)	14/51	(27.5)	
Hospital (already hospitalized)	147/769	(19.1)	129/718	(18.0)	18/51	(35.3)	
General practitioner	68/769	(8.8)	67/718	(9.3)	1/51	(2.0)	
Cardiologist	68/769	(8.8)	65/718	(9.1)	3/51	(5.9)	
Admission unit. n/total n (%)							0.145
ICCU	414/590	(70.2)	390/550	(70.9)	24/40	(60.0)	
ICU	176/590	(29.8)	160/550	(29.1)	16/40	(40.0)	
Clinical presentation at admission							
						+/-	
Heart rate (bpm). mean +/- SD	95.6	+/- 29.6	95.2	+/- 29.7	102.3	26.6	0.097
n	769		718		51		
SBP (mmHg). mean +/- SD	101	+/- 25	101	+/- 25	102	+/- 25	0.812
n	770		719		51		
DBP (mmHg). mean +/- SD	63	+/- 17	63	+/- 17	62	+/- 19	0.694
n	769		718		51		
Sinus rhythm. n/total n (%)	399/768	(52.0)	368/717	(51.3)	31/51	(60.8)	0.191
Cardiac arrest. n/total n (%)	79/771	(10.3)	76/720	(10.6)	3/51	(5.9)	0.288
Mottling. n/total n (%)	256/660	(38.8)	235/617	(38.1)	21/43	(48.8)	0.162
Blood tests at admission							
Sodium (mmol/l). mean +/- SD	135	+/- 6	135	+/- 6	136	+/- 6	0.057
n	760		709		51		
eGFR (mL/min/1.73 m <sup>2</sup> ). mean +/- SD	49.6	+/- 26.6	50.0	+/- 26.9	43.5	21.9	0.096
n	751		701		50		
Bilirubin (mg/L). median (IQR)	16 (9 - 29)		16 (10 - 29)		13 (8 - 23)		0.211
n	544		502		42		

Hemoglobin (g/dL). mean +/- SD <i>n</i>	12.5 +/- 2.3 754	12.6 +/- 2.3 703	11.2 +/- 2.4 51	< 0.001
Anemia*. n/total n (%)	361/754 (47.9)	321/703 (45.7)	40/51 (78.4)	< 0.001
Arterial blood lactates (mmol/l). median (IQR) <i>n</i>	3.0 (2.0- 4.7) 684	3.0 (2.0 - 4.6) 639	3.0 (2.0 - 5.3) 45	0.040
ASAT (IU/L). median (IQR) <i>n</i>	90 (39 - 301) 547	91 (39 - 293) 502	80 (33 - 482) 45	0.817
ALAT (IU/L). median (IQR) <i>n</i>	59 (27 - 183) 559	60 (28 - 181) 514	59 (21 - 208) 45	0.674
Nt proBNP (pg/mL). median (IQR) <i>n</i>	9277 (4052 - 23256) 224	9277 (3900 - 22149) 210	33000.0 14	0.139
BNP (pg/mL). median (IQR) <i>n</i>	1150 (477 - 2768) 264	1153 (468 - 2788) 245	1025 (484 - 2595) 19	0.927
Troponin I (µi/L) <i>n</i>	0.76 (0.15 – 14.2) 164	0.68 (0.15 – 14.0) 151	2.20 (0.35 – 43.0) 13	0.236
Troponin I-hs (ng/mL) <i>n</i>	2.79 (0.11 – 60.0) 207	3.0 (0.11 – 62.5) 195	0.52 (0.20 – 10.9) 12	0.770
Troponin T-hs (ng/mL) <i>n</i>	145 (31 – 2174) 260	156 (33 – 2607) 238	90 (7 – 300) 22	0.132
CRP (mg/L). median (IQR) <i>n</i>	28 (9 - 69) 406	27 (9 - 65) 377	57 (25 - 166) 29	0.006
Baseline echography				
LVEF (%). mean +/- SD <i>n</i>	26.3 +/- 13.4 763	26.1 +/- 13.3 712	28.2 +/- 13.5 51	0.300



TAPSE (mm). mean +/- SD	13.4 +/- 5.0	13.4 +/- 5.1	13.6 +/- 4.6	0.851
<i>n</i>	259	237	22	
PSVtdi (cm/s). median (IQR)	8 (6 - 11)	8 (6 - 11)	10 (7 - 14)	0.228
<i>n</i>	206	194	12	
Severe mitral regurgitation. n/total n (%)	107/733 (14.6)	100/683 (14.6)	7/50 (14.0)	0.901
Severe aortic stenosis. n/total n (%)	36/759 (4.7)	34/708 (4.8)	2/51 (3.9)	1.000
Severe aortic regurgitation. n/total n (%)	10/755 (1.3)	9/704 (1.3)	1/51 (2.0)	0.505

\* Men : haemoglobin < 13 g/dL. Women : haemoglobin < 12 g/dL.

ALAT : ALanine AminoTransferase. ASAT : ASpartate AminoTransferase. ICCU : intensive cardiac care unit. ICU : intensive care unit. CRP : C-Reactive Protein. DBP : Diastolic Blood Pressure. eGFR : estimated glomerular filtration rate. IQR : InterQuartile Range. LVEF : Left Ventricular Ejection Fraction. PSVtdi : Peak Systolic Velocity Tissue Doppler Imaging. SBP : Systolic Blood Pressure. SD : Standard Deviation. TAPSE : Tricuspid Annular Plane Systolic Excursion.

**Table 4 - In-hospital management / discharge according to the cancer status of the patients.**

	Overall (n=772)		No cancer (n=721)		Active Cancer (n=51)		P value
Medications used, n (%)							
Diuretics	633/768	(82.4)	590/717	(82.3)	43/51	(84.3)	0.713
Volume expander	321/767	(41.9)	298/716	(41.6)	23/51	(45.1)	0.627
Dobutamine	632/768	(82.3)	586/717	(81.7)	46/51	(90.2)	0.126
If yes, Maximum dose (mg/kg/min):							0.905
5-10	405/632	(63.7)	377/586	(63.9)	28/46	(60.9)	
10-15	136/632	(21.4)	126/586	(21.4)	10/46	(21.7)	
>15	47/632	(7.4)	43/586	(7.3)	4/46	(8.7)	
Unknown	44/632	(7.5)	40/586	(7.5)	4/46	(8.7)	
Norepinephrine	410/768	(53.4)	373/717	(52.0)	37/51	(72.6)	0.005
If yes, Maximum dose (mg/h):							0.272
< 1	86/410	(21.0)	81/373	(21.7)	5/37	(13.5)	
1-5	215/410	(52.4)	197/373	(52.8)	18/37	(48.6)	
>5	75/410	(18.3)	64/373	(17.2)	11/37	(29.7)	
Unknown	34/410	(8.3)	31/373	(8.3)	3/37	(8.1)	
Epinephrine	95/768	(12.4)	90/717	(12.6)	5/51	(9.8)	0.565
If yes, Maximum dose (mg/h):							0.089
< 1	34/95	(35.8)	31/90	(34.4)	3/5	(60.0)	
1-5	40/95	(42.1)	40/90	(44.4)	0/5	(0.0)	
>5	14/95	(14.7)	12/90	(13.3)	2/5	(40.0)	
Unknown	7/95	(7.4)	7/90	(7.8)	0/5	(0.0)	
Norepinephrine + dobutamine combination	352/768	(45.8)	319/717	(44.5)	33/51	(64.7)	0.005
Levosimendan	57/768	(7.4)	55/717	(7.7)	2/51	(3.9)	0.576
Dopamine	2/717	(0.3)	1/717	(0.1)	1/51	(2.0)	0.128
Isoprenaline	32/768	(4.2)	32/717	(4.5)	0/51	(0.0)	0.262
Antiarrhythmic	298/768	(38.8)	277/717	(38.6)	21/51	(41.2)	0.719
Transfusion	128/767	(16.7)	116/716	(16.2)	12/51	(23.5)	0.175
Fibrinolysis	13/767	(1.7)	13/716	(1.8)	0/51	(0.0)	1.000

Organ replacement therapies, n (%)							
Respiratory support							
Invasive	291/768	(37.9)	268/717	(37.4)	23/51	(45.1)	0.272
Non invasive	199/768	(25.9)	187/717	(26.1)	12/51	(23.5)	0.688
Mechanical circulatory support							
IABP	48/141	(34.0)	48/138	(34.8)	0/3	(0.0)	0.551
Impella	26/141	(18.4)	26/138	(18.8)	0/3	(0.0)	1.000
VA-ECMO	85/141	(59.9)	82/138	(59.0)	3/3	(100.0)	0.274
Renal replacement therapy	122/771	(15.8)	113/720	(15.7)	9/51	(17.7)	0.712
Invasive cardiology, n (%)							
CAG	399/772	(51.7)	379/721	(52.6)	20/51	(39.2)	0.065
CAG result							0.158
Normal	74/772	(18.5)	71/721	(18.7)	3/51	(15.0)	
1 - Mono	80/772	(20.1)	79/721	(20.8)	1/51	(5.0)	
2 - Bi	91/772	(22.8)	85/721	(22.4)	6/51	(30.0)	
3 - Tri	87/772	(21.8)	79/721	(20.8)	8/51	(40.0)	
Unknown	67/772	(16.8)	65/721	(17.2)	2/51	(10.0)	
Culprit lesion	256/318	(80.5)	241/301	(80.1)	15/17	(88.2)	0.408
Any PCI	217/772	(28.1)	204/721	(28.3)	13/51	(25.5)	0.667
Any PCI (even in a second time)	226/772	(29.3)	212/721	(29.4)	14/51	(27.5)	0.767
Right heart catheterisation	121/768	(15.8)	111/717	(15.5)	10/51	(19.6)	0.434
Pace-maker implantation	35/733	(4.8)	31/685	(4.5)	4/48	(8.3)	0.232
Automatic Defibrillator implantation	37/733	(5.1)	36/685	(5.3)	1/48	(2.1)	0.504
Radiofrequency ablation	17/733	(2.3)	17/685	(2.5)	0/48	(0.0)	0.619
<b>Discharge</b>							
LVEF (%), mean +/- SD	35.0	+/- 14.5	34.9	+/- 14.5	35.6	+/- 13.5	0.828
<i>n</i>	439		415		24		
LVEF variation *, mean +/- SD	+ 8.5	+/- 14.2	+ 8.4	+/- 14.2	+ 8.5	+/- 14.4	0.986
<i>n</i>	436		412		24		
Length of stay in ICCU or ICU (days), median (IQR)	11 (7 - 21)		11 (7 - 20)		16 (10 - 28)		0.041
<i>n</i>	440		412		28		

Length of stay in hospital (days), median (IQR)	17 (11 - 28)		17 (11 - 27)		18 (13 - 40)		0.156
<i>n</i>	436		412		24		
Discharge							0.165
Home	171/649	(26.3)	164/607	(27.0)	7/42	16.7	
Rehabilitation	44/649	(6.8)	42/607	(6.9)	2/42	4.8	
Transferred (other center/other department)	214/649	(33.0)	200/607	(32.9)	14/42	(33.3)	
Death	217/649	(33.4)	199/607	(32.8)	18/42	(42.9)	
Other	3/649	(0.5)	2/607	(0.3)	1/42	(2.4)	
Registration on transplant waiting list	40/622	(6.4)	39/585	(6.7)	1/37	(2.7)	0.502

\* at discharge compared with admission.

IABP: intra-aortic balloon pump. VA-ECMO: venoarterial-extracorporeal membrane oxygenation. CAG: coronary angiogram. PCI: PCI, percutaneous coronary intervention; LVEF: left ventricular ejection fraction. ICCU: intensive cardiac care unit. ICU: Intensive care unit.

**Figure 1. Early (30-day) and long-term (1-year) all-cause mortality by Kaplan-Meier landmark analysis according to the cancer status of the patients**

