

My Father Is on a Ventilator After Cancer Treatment

Families' FAQ: "What should we be pushing for?" | Quick tip for families in intensive care

A daughter's father was admitted to ICU after a fever following cancer treatment. He became confused and combative, was intubated and paralyzed, and is now awake, agitated and not following commands. Cultures show no infection and scans are clear. Here is what families in this situation should ask for.

Q. What is actually happening to him?

Confusion, combativeness and shallow breathing after cancer treatment is a classic picture of **acute encephalopathy**, a sudden decline in brain function. Possible causes include a reaction to chemotherapy or immunotherapy, paraneoplastic encephalopathy (the cancer triggering an immune attack on the brain), septic or metabolic encephalopathy, meningitis/encephalitis even with negative cultures so far, and PRES (posterior reversible encephalopathy syndrome).

Q. Why is he awake but not following commands?

Even 48 hours of paralytic drugs can cause **ICU-acquired weakness**, lingering sedative effects and a "cognitive haze" lasting days. But being awake without following simple commands such as "squeeze my hand" suggests a gap between wakefulness and responsiveness that needs **urgent neurological evaluation**. Clear CTs and MRI are good news (no stroke, bleed or obvious tumor) but do not rule out encephalopathy, seizures or autoimmune encephalitis.

Q. Should we push for a neurologist, even if the hospital has none?

Yes, push for it **today**: transfer to a hospital with on-site neurology, teleneurology (remote video consult), or a formal referral to a larger hospital. The longer encephalopathy goes undiagnosed, the greater the risk of permanent cognitive impairment.

Q. Why does the EEG matter so much?

Non-convulsive status epilepticus is continuous seizure activity without visible convulsions. It can look just like this: awake, agitated, not following commands, fluctuating BP and heart rate. It is treatable only if diagnosed. Ask: "Has it been formally ruled out? When is the EEG, and who is interpreting it?"

Q. What other tests should we ask about?

Metabolic and toxicology workup: ammonia, thiamine (B1), sodium, glucose, calcium, magnesium, phosphate, liver, kidney and thyroid function, drug levels (some chemotherapy agents are neurotoxic) and an autoimmune encephalitis panel (anti-NMDA receptor, LGI1, CASPR2). **Lumbar puncture**: if not done, ask why. CSF analysis can detect infection, cancer spread to the brain's membranes and autoimmune markers. A normal MRI does not make it unnecessary.

Q. Is the sedation plan right?

Propofol and Precedex (dexmedetomidine) are short-acting and appropriate. Ask about **daily sedation holds**, a documented sedation target (e.g. RASS -1 to 0), adequate pain management and a delirium protocol (orientation, lighting, sleep-wake cycle, family involvement). Agitation raising BP and heart rate is often pain, disorientation or delirium, not just "being awake".

Q. How do we get him off the ventilator?

Weaning needs the lungs **and** the brain ready. Ask whether he passes daily spontaneous breathing trials (minimal support for 30-120 minutes), what his respiratory mechanics are (tidal volumes, respiratory rate, negative inspiratory force) and whether the weaning plan and a target date are documented.

Q. Should we consider a transfer?

A small hospital without on-staff neurology may not be the right place. Ask about a **major tertiary hospital** with 24/7 neurology, neurointensive care, autoimmune encephalitis workup and continuous EEG monitoring. You can request and advocate for transfer; an independent clinical advocate can help if the team resists.

Q. Which medical records should we request?

Request **all** records now, in writing, every few days: ICU nursing notes, physician notes, labs, cultures and microbiology, CT/MRI reports, ventilator settings, medication charts and physical therapy notes. Having them allows an independent expert to review and give a second opinion.

Q. What if he can't be weaned?

He may need a tracheostomy and long-term ventilation, but this does **not** mean permanent ICU. **Intensive Care at Home** provides Critical Care nurse-led home care for invasive (tracheostomy) or non-invasive (CPAP/BiPAP) ventilation, plus palliative care. It is Australia's only third-party accredited service, covers all states and territories, and also assists families in the USA, Canada, UK and India.

Need independent expert advocacy? Intensive Care Hotline can help.

Patrik Hutzl brings 25 years of critical care nursing experience. A consulting call can help you review records, form questions for the ICU team, advocate directly with the team and navigate a transfer. [intensivcarehotline.com](https://www.intensivcarehotline.com) | support@intensivcarehotline.com | [intensivcareathome.com](https://www.intensivcareathome.com)

General information for families, not a substitute for advice from your loved one's treating medical team.