Introduction

Since the first intensive care units (ICUs) were established in the United States in the 1960s, there has been a gradual growth in the appreciation of the importance and magnitude of critical illness. In the 1980s, Jacobs and Noseworthy [1] reported that ICU expenditures in the United States accounted for 1% of the gross domestic product, and similar findings were reported more recently [2]. The frequency of critical illness and the provision of critical care services have now reached what can be considered epidemic proportions. Of the 38 million annual U.S. hospital admissions of children and adults [3], nearly 6 million, or 2% of the U.S. population, are admitted to an ICU [4]. The disease burden of the myriad disorders and conditions that constitute critical illness is of sufficient scale that efforts to prevent and treat critical illness have implications for overall public health.

The clinical epidemiology of critical illness is vital to inform clinical care, meaningful patient-oriented research, and health policy in critical care. Describing the natural history of disease informs the development of treatments to improve outcomes and the care delivered at the bedside. Understanding the burden of disease influences the prioritization of research efforts and the allocation of health care resources. Knowledge of risk factors for disease aids in prevention of disease, timely intervention to treat it, and selection of study populations. However, there are a number of challenges in performing clinical epidemiologic research in critical care, not the least of which is related to a core principle of epidemiology. Delineating the epidemiology of a disease or condition starts with the ability to identify it, both reliably (different clinicians classify a patient in the same way as each other and over time) and validly (the classification distinguishes people with the disease from those without it). In critical care, this may be conceptually straightforward but is operationally challenging. In this chapter, we discuss several issues related to clinical epidemiology in critical care and summarize some of the large-scale work that has been done examining the epidemiology of critical illnesses in children.

Challenges of Defining a Population in Critical Care

Critical illness is made up of a heterogeneous group of conditions and disorders that share a risk of organ dysfunction, long-term morbidity, and mortality. However, definitions of the syndromes that most consider quintessential critical care diseases (sepsis, acute respiratory distress syndrome [ARDS] / acute lung injury [ALI], and even organ failure) lack gold standard tests by which to identify them. By necessity, then, definitions have been developed by consensus and expert opinion. Although these definitions represent a substantial improvement over the prior state of phenomnologic disarray, they still suffer from limitations in reliability and validity [5,6]. Even the minimum degree of organ dysfunction, or risk thereof, that suggests that a patient is critically ill is often debated.

Another challenge to identifying patients with critical illness is that critical illness is often defined by where care takes place (i.e., the ICU) and the interventions used to treat it (e.g., mechanical ventilation, infusions of medications to support hemodynamics, continuous renal replacement therapy). Although convenient, these definitions are significantly limited. The definition of an illness cannot rely on the availability of an ICU bed. Care that is provided in an ICU in one country or region may be provided on the ward in another (and even in a given hospital, the availability of ICU beds may change with hospital and ICU census). Critical illness often begins before ICU admission and can last beyond ICU discharge. The use of many interventions varies by provider, even when controlling for patient factors, such as severity of illness, so it is much easier to determine which patients received an intervention than it is to determine which patients actually needed it [7–11]. Nonetheless, with the increasing availability of large-scale databases and increasing numbers of large-scale epidemiologic studies of prospectively collected data, the size and scope of pediatric critical illness are beginning to be characterized.
Epidemiology of Children Receiving Critical Care Services

National estimates of the overall use of ICU services for children are limited. Extrapolating from a survey conducted in 2001 by Randolph and colleagues [12] for which pediatric ICU (PICU) directors were asked to report their annual number of PICU admissions, over 230,000 children are admitted to PICUs annually. In preliminary work, Garber et al. [13] estimated that 480,000 infants and children less than 20 years old received intensive care services in the United States in 2001 (in neonatal ICUs [NICUs], PICUs, and pediatric beds in adult ICUs). These patients represented 6.6% of pediatric hospitalizations. The population-based incidence of ICU care for infants was 10 to 25 times that for older children. Hospital mortality rate was 2.4% (or over 11,000 deaths nationally), was similar across age groups, and was consistent with that reported in Randolph and colleagues’ survey (2.9%) [12]. Mean hospital costs were $19,000 per patient, and total ICU costs were nearly $8 billion nationally (30% of all hospital costs for children) [13].

Angus et al. [14] performed a study of the use of ICU services at the end of life for children and adults and found that one in five Americans overall died while using ICU services in the United States in 1999. Although many more adults than children died, children were more likely than adults to receive ICU services at the end of life. Nearly half of infants and one third of older children who died in 1999 received ICU care. Subsequent preliminary analyses of the pediatric sample from this population found that 29% of children aged 1 to 19 years who died did so after receiving ICU care, and, among hospitalized children who died, ICU care was much more common for those without a history of chronic illness [15].

Despite the limitations of a geographic definition of critical illness, our understanding of the magnitude of critical illness among children is enhanced by information about the provision of pediatric critical care services [16]. Only 9% of counties in the United States have PICUs, and 99% of the PICUs are located in urban counties [17]. The number of hospital beds overall for children has been decreasing since the 1980s in the United States, but ICU beds for children have been increasing. In 1989, Pollack and others identified 276 pediatric-specific ICUs in the United States, with an average of 528 admissions per year [18]. Pediatric intensivists were available to 73% of the units, and reported mortality rate was 5.5%. In 2001, Randolph and colleagues found 349 PICUs, with an average of 672 admissions per year [12]. Pediatric intensivists were available to 94% of the units, and reported mortality rate was 2.9%. The number of available PICU beds between 1995 and 2001 increased by 24% and outpaced population growth of children by 17.5%. The number of beds per child varied substantially by region—from 1 per 15,250 children in Arkansas, Louisiana, and Texas to 1 per 27,440 in New England. Whether this variation reflects different regional pediatric critical care needs is unknown.

The reason for the increasing numbers of PICU beds is also unclear and likely multifactorial. It may reflect changes in referral patterns, with an increasing number of smaller hospitals providing care for patients previously transferred to larger units. Although this would be somewhat surprising in light of increasing evidence that higher volume units have better severity-adjusted outcomes than their smaller counterparts [19–21], health care financing affords incentives to provide intensive care services even at smaller hospitals. On the other hand, patients who remain at smaller hospitals may be less severely ill than those who are transferred to tertiary care and may merely require additional monitoring that is not available on the wards of many hospitals.

Perhaps the most important factor in the increasing demand for PICU services is an increasing number of children in the population living with chronic medical conditions. Success in the treatment of extremely low-birth-weight babies, children with neurodevelopmental abnormalities, cancer, or cystic fibrosis, and organ transplant recipients has lead to longer life expectancies and decreased mortality rates. These successes have also led to an increased number of children living at increased risk of critical illness [22–26]. In a population-based study at a tertiary PICU in New York, almost half (45%) of all unscheduled admissions to the PICU were for patients with chronic health conditions, 32% of whom received technology-assisted care (such as mechanical ventilation, oxygen, tracheostomies, and intravenous therapies) [27]. Children with chronic conditions were 3.3 times more likely than healthy children to have an unscheduled PICU admission, and those receiving technology-assisted care were 373 times more likely. The most common conditions were neurologic, accounting for 15% of all unscheduled admissions. Similarly, 23% of all admissions (both scheduled and unscheduled) to a large, tertiary PICU had preexisting neurodevelopmental disorders [28]. Although hospital mortality rate was only 3%, patients were discharged with significantly greater needs for ventilatory and nutritional technology support than they had on admission. In addition to increasing the number of PICU admissions, children with chronic illness may require lengthy PICU stays. Indeed, former premature babies admitted to the PICU consumed more health care resources than their nonpremature counterparts, including longer lengths of stay and higher rates of mechanical ventilation [29].

Epidemiology of Mechanical Ventilation and Acute Respiratory Distress Syndrome/Acute Lung Injury

The provision of mechanical ventilation (MV) for acute respiratory failure was a major motivating factor in the development of ICUs and is one of the hallmarks of critical care. National estimates of respiratory failure among infants and children have been derived from analyses of administrative records of patients receiving mechanical ventilation. Of course, some patients are ventilated in the ICU for reasons other than respiratory failure (such as extreme hemodynamic instability or after prolonged surgery). Therefore, the incidence of MV is higher than the incidence of respiratory failure. Rates of mechanical ventilation were higher in neonates than in any other age group (80,000 babies per year, or 1.8% of U.S. neonates) [30]. Although very-low-birth weight babies had extremely high rates of MV (52%/year), one third of ventilated neonates were of normal birth weight. Hospital mortality rate was 11.1%, and total U.S. hospital costs were $4.4 billion in 1994. Preliminary work examining older children found that 35,000 children aged 1 to 19 years were ventilated in the United States in 1999 [31]. Duration of MV was 4 or more days for over one third of patients. Most were ventilated for medical (as opposed to surgical) reasons, and the most common associated condition was severe sepsis (in 35%). Hospital mortality rate (13.8%) was higher than that of neonates, and estimated national hospital costs were lower ($1 billion).