Admission pattern, Clinical outcomes and associated factors among patients admitted in medical intensive care unit at University of Gondar Comprehensive and specialized hospital, Northwest Ethiopia, 2019. A retrospective cross-sectional study.

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Abstract

Background: Intensive care unit (ICU) is a multidisciplinary staffed and specially equipped area of a hospital dedicated to provide care for patient with life-threatening illness. Provision of intensive care services to critically ill patients is a global enterprise. The care is advancing but in resource-limited settings, it is lagging far behind and ICU mortality is still higher due to various reasons. Objective: We aimed to determine the admission patterns, clinical outcomes and associated factors among patients admitted medical intensive care unit (MICU). Results: A total of 738 patients were admitted to MICU during September 2015- April 2019. Two hundred thirty four patients had incomplete data on the registries and their charts could not be located. So that, 504 (68%) of all ICU admissions had complete data and were analyzed. Out of the 504 patients, 268 (53.2%) patients were females. Cardiovascular disease 182(36.1%) was the commonest categorical admission diagnosis. The overall mortality rate of the MICU was 38.7 %. In the multivariate analysis, mortality was associated with need for mechanical ventilation (AOR=5.87, 95% CI: 3.24 - 10.65) and abnormal mental status at admission (AOR = 2.8.8, 95% CI: 1.83- 4.29). Patients who stayed less than four days in MICU are 5 times more likely to dies than who stayed(AOR= 5.58, 95% CI: 3.58- 8.69). Therefore, we recommend improving the acute critical care through the expansion of the care, supply emergency equipment’s and medications and implementation of admission criteria protocols and other local guidelines. Key words: admission, intensive care unit, Length of stay, Mortality, Outcome

Background

Intensive care is a continuum of care from various source of admissions such as trauma unit, emergency department, inpatient wards, and post anesthesia care unit where patients’ requiring a frequent assessment of vital signs, invasive hemodynamic monitoring, intravenous medications and fluid management, ventilatory and nutritional support to assure safe and effective outcomes(1). Access to critical care is a crucial component of healthcare systems hence critically ill patients are admitted to the intensive care units to reduce morbidity and mortality associated with acute illness, trauma or
surgical procedures(2, 3)
Mortality in ICU is a global burden which results in a huge loss of productivity and financial costs. It varies across the world depend on ICU infrastructure, staff availability, and training, pattern, and cause of ICU admission. In developed contents like North America, Oceania, Asia and Europe in ICU mortality relatively low with the rate of 9.3%, 10.3, 13.7% and 18.7% respectively, while in the rest of the world such as South America, and the Middle East the mortality found to be 21.7% and 26.2% (4, 5).

In Ethiopia, the first ICU was introduced more than 30 years ago in Addis Ababa Tikur Anbessa Hospital since then the number of intensive care service is increasing in both public and private hospitals of the country(6). Even though critical care services have been undergoing significant advancements for improvements due to technological progress, new scientific development in treatment outcome of the critically ill patients globally, the progress of critical care service provision in resource-limited settings is lagging far behind and the mortality is still higher (4, 7-9).

In Africa, the ICU mortality rate is high as it compared to the other developed continents. The mortality rate in Nigeria, Uganda, Tanzania, and Kenya were 32.9%, 40.1%, 41.1%, and 53.6% respectively (10-13). Different studies showed that the mortality rate of ICU patients in Ethiopia is relatively similar to other Africa countries. Previous studies done in Jimma, Addis Ababa, and Mekelle showed that the mortality rate was 50.4%, 32% and 27% respectively (14-16).

In developing countries, the burden of critical illness is high. Severe infections such as pneumonia, malaria are endemic, road traffic accident, obstetric complications, and surgical emergencies are common. In addition, underlying malnutrition and HIV infection will make patients to have a poor physiologic function during admission thereby worsen the outcome of critically ill patients. Moreover, the burden is certain to extend with Growing urbanization and rising epidemics, (5, 12, 17).

Provision of ICU care is very challenging in developing countries like Ethiopia. The scarcity of drugs and medical equipment’s, lack of well-trained staffs and poor infrastructures are the main challenges to provide optimal care to critically ill patients (3, 18).

Apart from medical diagnosis of patients, most hospital in low income countries lack formal triage system and emergency department which forces critically ill patients to be seen in either in the ward or outpatient clinics on the bases of “first come first served” which will increases the burden of ICU and compromises patients outcome since triage system decrease waiting time and mortality through identification of critically ill patients with early warning score and care Delivery(1, 19). There is scarcity of information regarding critically ill patients admitted in the ICU in the study area. Therefore, the aim of the current study was to describe the admission patterns, clinical outcomes and associated factors among patients admitted in the medical intensive care unit of UOGCSH.

Methods
Study design, area and period
University of Gondar Comprehensive Specialized Hospital is a specialized teaching hospital located in Amhara National Regional state, North Gondar zone, which is about 738km away from Addis Ababa in Northwest of Ethiopia. It is one of the largest specialized hospitals
providing service to about 5 million people. The critical care service of University of
Gondar Comprehensive Specialized Hospital (UoGCSH) was started in 2011 as a four-bed
MICU capacity with two mechanical ventilators one defibrillator, four non-invasive
hemodynamic monitoring devices, one ultrasound machine, and one ABG-analyzer
machine. The MICU is an open ICU system run under the department of internal medicine.
Currently, the MICU has a team composed of one specialist in pulmonary and critical care
medicine (PCCM), internal medicine residents, senior anesthetists, 2 critical care and 8
clinical nurses, anesthetists, physiotherapists, and other health professionals according to
the demands of the individual cases. The MICU provides critical care service not only for
internal medicine cases but also surgical and obstetrics cases.
A retrospective cross sectional study was conducted based on the ICU registration notes
and charts. Patients who where admitted to the MICU from September 2015 to April, 2019
and whose ICU registry notes and charts were available were included in the study. Missed
Patients chart and incomplete data on the charts were the exclusion criteria (Figure 1).
Study variables
The dependent variable was clinical outcomes (Survivors Vs Non survivors) of patients
admitted to MICU. Independent variables were: Socio-demographic variables (Age, gender,
residency), Clinical diagnosis at admission, presence of comorbid illness, Source ,
frequency and category of admission, vital sign at admission, intervention during MICU
stay, and Length of ICU stay.
Data collection procedures
Data was collected through reviewing chart and ICU registry by using pretested structured
data retrieval form(checklist) which included the chart number, date of admission, age,
gender, source of admission, admission diagnosis, admission category, vital sign during
admission, presence of comorbidity, length of stay, intervention in ICU, and treatment
outcome.
Data processing and analysis procedures
Data was entered, coded and cleaned using the Epi-data software and analyzed using
SPSS version 20. Categorical variables were reported as frequencies and percentages
whereas; median and interquartile range (IQR) were used for continous variables.
Descriptive statistics was carried out and the results were presented using text, tables
and graph. Model fitness was checked using a Hosmer-Lemeshow goodness-of-fit test.
Crude odds ratios with their 95% confidence intervals were estimated in the bivariable
logistic regression analysis to assess the association between each independent variable
and outcome variable. In the bivariable logistic regression, variables with P-value < 0.2
were fitted into the multivariable logistic regression analysis. Adjusted odds ratios with
their 95% confidence intervals were estimated to assess the strength of association, and
variables with P-value < 0.05 were considered statistically significant factors.
Results
Demographic and Admission Characteristics of among patients admitted to MICU
A total of 738 patients were admitted from September 2015 to April 2019. Two hundred
thirty-four patients had incomplete data on the registries and their charts could not be
located. So that, 504 (68%) patients were included in this study.
Patient age ranged from 15 to 98, median (IQR) was 32 (28 – 40) years. Of the total
admitted patients 268 (53.2%) were female with female to male ratio of (F: M) 1.1: 1 and
most of the patients 264(52.4%) were urban residents. From the total 504 case notes reviewed, majority 299(59.3%) patients were admitted from medical ward followed by emergency department 168 (33.3%), surgical ward 29(5.8%) and gynecology and obstetrics ward 8(1.6%) respectively (Table 1).

Table 1: Socio demographic characteristics among patients admitted to MICU of UoGCSH. September 2015 to April 2019, (N=504).

| Characteristics               | Frequency (N) | Percentage (%) |
|-------------------------------|---------------|----------------|
| Sex                           |               |                |
| Male                          | 236           | 46.8           |
| Female                        | 268           | 53.2           |
| Age (years)                   |               |                |
| < 20                          | 58            | 11.5           |
| 20-40                         | 198           | 39.3           |
| 41-60                         | 132           | 26.2           |
| >60                           | 116           | 23             |
| Residency                     |               |                |
| Urban                         | 264           | 52.4           |
| Rural                         | 240           | 47.6           |
| Source of admission           |               |                |
| Medical ward                  | 299           | 59.3           |
| Emergency department          | 168           | 33.3           |
| Surgical ward                 | 29            | 5.8            |
| Gynecology and obstetrics ward| 8             | 1.6            |
| Category of admission         |               |                |
| Emergency medical patients    | 482           | 96             |
| Emergency surgical patients   | 18            | 3.6            |
| Elective surgical patients    | 2             | 0.4            |
| Frequency of admission        |               |                |
| First admission               | 446           | 88.5           |
| Readmission (2 times and above)| 58           | 11.5           |

The commonest categorical diagnosis at admission was all type Cardiovascular, respiratory and infectious diseases with 36.1%, 17.9% and 13.11% of occurrence, respectively (Table 2). Similarly, these disorders are the commonest categorical admission diagnosis in the specific year of the past five years (Figure 2).

Table 2: Distribution of categorical admission diagnosis among patients admitted to MICU of UoGCSH. Gondar. September 2015 to April 2019, (N=504).

| Disease category               | Frequency (N) | Percent (%) |
|-------------------------------|---------------|-------------|
| Cardiovascular disease        | 182           | 36.1        |
| Respiratory disease           | 90            | 17.9        |
| Infectious disease            | 66            | 13.1        |
| Neurologic disease            | 44            | 8.7         |
| Endocrine disease             | 36            | 7.1         |
| Renal disease                 | 18            | 3.6         |
| Hematologic disease           | 22            | 4.4         |
| Poisoning                     | 14            | 2.8         |
| Miscellaneous conditions      | 32            | 6.3         |
| Total                         | 504           | 100         |

Key: Miscellaneous conditions; GI disorder, Rheumatologic, Malignancies, Electrolyte disorder.

All respiratory infections were under respiratory disease.

Infective heart disease and rheumatic heart disease were under cardiovascular disease

Guillen Barrie Syndrome was under the category of Infectious disease
The most common specific diagnosis at ICU admission was all types of myocardial infarction 96 (19%) followed by Heart failure 56 (11.1%), ARDS 46 (8.9%), septic shock 37 (7.3%) and HIV infection 25 (5%) of the all admissions (Table 3).

Table 3: Distribution of common specific admission diagnosis among patients admitted to MICU of UoGCSH. September 2015 to April 2019, (n=376).

| Specific Diagnosis                        | Frequency (n) | Percent (%) |
|------------------------------------------|---------------|-------------|
| Myocardial infarction (MI)               | 96            | 19          |
| Congestive Heart failure (CHF)           | 56            | 11.1        |
| Acute respiratory disease syndrome (ARDS)| 45            | 8.9         |
| Septic shock                             | 37            | 7.3         |
| Diabetic keto Acidosis (DKA)             | 28            | 5.6         |
| Stroke                                   | 25            | 5           |
| Human immuno deficiency virus (HIV)      | 25            | 5           |
| Pneumonia                                | 25            | 5           |
| Cardiogenic shock                        | 20            | 4           |
| Pulmonary thrombo embolism (PTE)         | 19            | 3.7         |

Table 4: Distribution of admission vital signs among patients admitted toMICU of UoGCSH.
Variables | Frequency (n) | Percent (%)
--- | --- | ---
Pulse rate (bpm) | <60 | 4 | 0.8 |
| 60-100 | 166 | 32.9 |
| >100 | 331 | 65.7 |
| No pulse | 3 | 0.6 |
Respiratory rate (bpm) | <12 | 7 | 1.4 |
| 12-20 | 72 | 14.3 |
| >20 | 423 | 83.9 |
| Apnea | 2 | 0.4 |
Mean arterial pressure (mmHg) | 65-106 | 302 | 59.9 |
| <65 | 122 | 24.2 |
| >106 | 65 | 12.9 |
| Unrecordable | 15 | 3 |
Peripheral oxygen saturation (SPO2) | <90% | 227 | 45.0 |
| 90%-100% | 277 | 55.0 |
Temperature (°C) | < 36.5 | 120 | 23.8 |
| 36.5 - 37.5 | 151 | 30.0 |
| >37.5 | 233 | 46.2 |
Mental status | Conscious | 299 | 59.3 |
| Confused | 53 | 10.5 |
| Lethargic | 43 | 8.5 |
| Unconscious | 109 | 21.7 |

Total | 504 |

Intervention done in MICU: Three hundred and eighty-two (75.8%) patients were in mechanical ventilation with facilitation of tracheal intubation, 323(64.1%) were in antibiotics, 311(61.6%) were received anticoagulants, 162(32.1%) patients received inotrope support respectively.

Clinical Outcome of patients admitted to MICU: The overall mortality rate of the MICU was 38.87%. Three hundred and nine (61.3%) patients were survivors, among them 238(77%) of patients were improved and transferred to the wards. 30(9.7%) were cured and got discharged to home, 36(11.6%) were left against medical advice, and 5(1.6%) patients were referred to another setting for further treatment.

The highest mortality rate (46.6%) was observed in 2009; the lowest mortality rate (29.1%) was observed in 2008 (Figure 4). The proportion of death among females (40.6%) was higher than males (36.5%) however, there was no significant sex difference in patients clinical outcome($X^2=1$, $P=0.33$). The proportion of mortality was increased as the age increases. Among the non survivors, 43.9% of patients were beyond 60 years old and 32.7% patients were under 20 years old.

In ICU mortality was not significant among source of admission as the proportion of mortality from emergency department, medical ward, surgical ward and gynecology/obstetrics was found to be 40%, 38%, 34%, and 40% respectively with ($P=0.91$). Among the commonest specific admission diagnosis, cardiogenic shock (57.1%) had the highest case fatality ratio followed by ARDS (54.4%) and ischemic heart disease (53.5%) (Table 5).
Table 5: Case fatality ratio, among patients admitted to MICU of UoGCSH. September 2015 to April 2019, (n=376).

| Specific disease                      | Number of patients admitted | Case fatality ration |
|---------------------------------------|----------------------------|----------------------|
| Cardiogenic shock                     | 14                         | 57.1                 |
| Acute Respiratory Distress Syndrome (ARDS) | 22                         | 54.4                 |
| Ischemic heart disease                | 71                         | 53.5                 |
| Congestive heart failure              | 29                         | 44.8                 |
| Severe pneumonia                      | 15                         | 40                   |
| Septic shock                          | 32                         | 37.5                 |
| Pulmonary Thrombo embolism (PTE)      | 14                         | 34.5                 |
| Stroke                                | 11                         | 19.7                 |
| Human Immunodeficiency Virus (HIV) infection | 17                         | 19.7                 |
| Diabetic Keto Acidosis (DKA)          | 16                         | 29.4                 |

The median length of ICU stay (IQR) was 4.0 (2.0–5.0) days. The most frequent stay (19.8%) was 1 day. The minimum stay in ICU was 30 minutes secondary to poisoning while the maximum stay was 24 days with the diagnosis of myocardial infarction. About 81.7% of patients died or discharged with in the first one week of stay. The median duration of mechanical ventilation was 4.5(1-6) (interquartilerange) days. Patients with Myocardia infarction, Gullies Barrie Syndrome, and ARDS had longer duration of mechanical ventilation.

Patients who stayed in MICU for less than 4 days were 5 times more likely to die than who stayed four and above days. As illustrated in the following figure most of the patients died in the first 24 hours of admission (figure 5).

Bivariate logistic analysis shown that gender, diagnosis at admission, need for mechanical ventilation, duration of mechanical ventilation, length of ICU stay, mean arterial pressure at admission, and mental status at admission were significantly associated with the clinical out of MICU patients. However, in a multivariate analysis, the associated risk factors of death were the need for mechanical ventilation, abnormal mental status at admission and length of ICU stay (Table 6).

Table 6: Multivariable logistic regression showing the factors associated with mortality among patients admitted to MICU of UoGCSH. September 2015 to April 2019, (N=504).

| Variables                  | Crude ratio | odds ratio | Adjusted odds ratio | 95% Confidence Interval | P-value |
|----------------------------|-------------|------------|---------------------|-------------------------|---------|
| Mechanical ventilator      | Yes         | 4.312      | 1.00                | (3.244, 10.65)          | 0.001*  |
|                           | No          | 1.00       | 1.00                |                         |         |
| Mental status at admission | Conscious   | 1.00       | 1.00                |                         |         |
|                           | Abnormal    | 0.237      | 2.808               | (1.843, 4.279)          | 0.001*  |
|                           | mental status |          |                     |                         |         |
| Length of ICU stay         | < 4 days    | 4.37       | 5.58                | (3.58, 8.69)            | 0.001*  |
|                           | ≥ 4 days    | 1.00       | 1.00                |                         |         |

Key: *Significantly associated at P<0.05, 1.00: reference
Discussion

The outcomes of patients admitted to intensive care unit depends on the clinical condition of patients arrival, level of training and experience of staffs, resource, infrastructure and capacity of the unit (18, 20, 21). In this study, the overall in ICU mortality found to be 38.7% (95% CI: 34.5, 43.1). This finding is comparable with the previous studies done in Addis Ababa (39%) and Jimma (37.7%) (14, 15). It also similar to the studies conducted in sub-Saharan African countries of Nigeria, Uganda and Tanzania was 34.6% 40.1%, 41.1% respectively (18, 21, 22). However, the overall ICU mortality of the current study was higher than studies done in Mekelle, Ethiopia (27%) and Scandinavian countries (9.1%)(16, 23). This discrepancy might be due to lack of necessary medical equipments (ABG-analyzer machine, portable dialysis machine and portable x-ray service), infrastructure, and training. In addition, the lack of high dependency unit in the study area might be one of the contributing factors for the higher rate of ICU mortality (18, 22).

In our study, the mortality rate was lower than the previous studies done in other parts of Ethiopia Hosanna (46%), Jimma (50.4%), and Kenya (53.6%). This could be due to the difference in diagnosis of admission. Poly trauma and traumatic brain injury were the main diagnosis of admission in the previous studies. In the current study, the median length of ICU stay found to be 4 days which resembles to the other African countries (13, 22). In our study, Out of 504 patients, 118(23%) where stayed in ICU 24 hours or less. Out of whom 89 (75%) of patients died in the mentioned period of time which accounted for 45% of overall ICU mortality. In addition, patients who stayed in ICU for less than four days were 5 times more likely to die than patients who stayed four or more days with (AOR=5.58, p<0.001) which is comparable with the study done in Uganda (17). However, our result was different from the study conducted in Hosanna, the length of ICU stay was more than 14 days, which was strongly associated with ICU mortality (OR=4.113,P <0.039)(24). The discrepancy on the median length of ICU stay might be explained due to late arrival to ICU and delay in intervention, shortage of crucial emergency drugs including inotropes, anti-arrhythmic drugs, and antibiotics, absence of airway management and cardiopulmonary resuscitation equipment’s in the medical emergency ward. Furthermore, vital signs and overall clinical conditions of the patients on admission to the MICU was found to very be poor, which may shown a gap in the continuity of care from emergency medicine department, medical and surgical wards to MICU. Early death might also be explained by a limited number of ICU bed since the World Federation of Societies of Intensive and Critical Care Medicine recommends the ICU need to have at least 5% of total hospital beds. Furthermore, shortage of functional mechanical ventilator which delays and denied admission of critically ill patients to MICU (18, 25).

This study revealed that need for mechanical ventilation is independent risk factor of ICU mortality with (AOR: 5.578, P<0.001) which was similar with the studies done in Kenya and Brazil were mechanical ventilator was independent risk factors for death (AOR= 10.7, p<0.001) and (AOR: 6.37, p<0.001) respectively (26, 27). The possible explanation for this association could be related that mechanical ventilatoris initiated for the patients with
respiratory failure, unable to protect the airway and hemodynamic instability. Furthermore, patients who need intubation and mechanical ventilator more vulnerable for ventilator associated pneumonia and other nosocomial infection which further compromises the clinical outcome of critically ill patients (28, 29). In addition, these patients who were on mechanical ventilator were presented with unstable vital sign and comorbid conditions which might be increased the odds of in ICU mortality. Our study revealed that patients who presented with abnormal mental status were more likely to die in MICU than conscious patients (AOR: 2.741, P<0.001). This result may linked with the severity of disease condition during admission. Disturbance level of consciousness is related with severe decompensated disease, cerebral hypo-perfusion due to sepsis, blood loss, poisoning, and neurological disorder. Beside to this patients with abnormal mental status might not protect their airways with further increases the probability of respiratory and infectious disease(30).

In the current study, majority of patients were adult with an average age group of 20-40 years and median age of 32 years. Since, most of young the patients were diagnosed with infectious disease and respiratory disorder which might increase the probability of MICU admission. Our result is in accordance with the studies done in other sub-Saharan counties as the median age of patients in Kenya (29 years) and Tanzania (34 years), years of age respectively(13, 22). Contrarily, the patient’s population in this study was younger than the developed nation as the mean age of ICU admission in Scandinavian countries 59.3 years, and Korea 64.7 years. The difference could be in the above-mentioned studies most of patients were admitted secondary to age-related degenerative and comorbid disease (3, 20, 31).

Despite the fact that the young patients took the majority proportion of admission the number of deaths increased with increasing age similar to the Addis Ababa and Mekelle(15, 16). This might be the old patients were presented with Less organ physiologic preserve, unstable vital sign and more comorbid score.

In the present study, females were more likely to admit and die in MICU than males. Which was in contrast to the other African countries were males predominate the admission and mortality proportion of the ICU of Kenya, Uganda, Tanzania, and Nigeria(3, 18, 21, 27). The gender difference could be explained by the majority of females in the current study were admitted with comorbid illness and are aged with 26% of them were above the age of 60 years.

A disease of cardiovascular system accounted for 36% of all ICU admission followed by respiratory (17.9%). This is similar to the previous study done in Jimma and Mekelle(16, 31). However, it is different from a study conducted in Uganda were infectious illness predominant (18) and in Nigeria were post-operative care were the main reason for admission(3).

Among patients of all age group myocardial infarction (56%), ARDS (27%), CHF (24%), and cardiogenic shock constituted more 60% of in ICU mortality. This could be due to the lack of laboratory workup for cardiac enzymes like troponin and creatinine kinase, cardiac monitoring such as central Venus pressure monitoring, intra-arterial line and vaso-active medications such as phenylephrine and Ephedrine.

In the current study, there was higher case fatality ratio of cardiogenic shock (57.1%), ARDS (54.4%) and ischemic heart disease (53.5%) which is different from Mekelle septic shock (58%) and Addis Ababa severe pneumonia (56.4%)(15, 16). This discrepancy might be due to the lack service for cardiac criticals such as cardiac catheterization laboratory and
isolated cardiac intensive care unit for percutaneous intervention and pacing.

Limitation of the study
Although this study has provided information regarding the pattern of admission, clinical outcomes and associated factors among critically ill patients admitted to the MICU, there were some limitations that could be address in another study. Due to the nature of study design, retrospective study based on the ICU registries and charts, only limited data were retrieved. So that necessary variables, which helps to identify indepente risk factors of clinical outcomes of patients admitted to the ICU were not collected. In addition, data related to Physiologic and laboratory variables necessary to calculate severity and prognostic score such as sequential organ failure assessment (SOFA), Simplified Acute Physiology Score (SAPS) and Acute Physiology and Chronic Health Disease Classification System (APACHE) to predict in ICU mortality were not collected due to inability to locate in the available written chart and ICU registry books.

Conclusion
The overall mortality rate in the medical intensive care unit is high. Cardiovascular disorder were the most common cause of admission and death. Need for mechanical ventilator, abnormal mental status on admission and short ICU stay were significantly associated with the clinical outcome of MICU patients. This study also demonstrated that the majority of critically ill patients died with in the first 24 hours of admission. Therefore, we recommend to we recommend improving the acute critical care through the expansion of the care, supply emergency equipment’s and medications and implementation of admission criteria protocols and other local guidelines.

Abbreviations

| Abbreviation | Description                       |
|--------------|-----------------------------------|
| ARDS         | Acute Respiratory Distress Syndrome |
| CHF          | Congested Heart Failure           |
| DKA          | Diabetic Ketoacidosis             |
| HIV          | Human Immunodeficiency Virus      |
| ICU          | Intensive Care Unit               |
| LOS          | Length of Stay                    |
| MICU         | Medical Intensive Care Unit       |
| TBI          | Traumatic Brain Injury            |
| UoGCSH       | University of Gondar Comprehensive Specialized Hospital |

Declarations
Ethics approval and consent to participate: This study was approved by the ethical review bord of School of Medicine, College of Medicine and Health Sciences with reference number of (SOM/140/02/2019). Permission also received from medical director of the hospital before the
commencement of the study. Data was collected from chart and log book clinical

Consent for publication: Not applicable

Availability of data and material: The datasets used/or analyzed during the current study is available from the corresponding author on reasonable request.

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Authors' contributions This work was carried out in collaboration among all authors. HG contributed to the conception and design of the study, acquired, analyzed and interpreted the data drafted and revised the manuscript. GF, NM, DY and NR participate in reviewing the design and methods of data collection, interpretation and preparation of the manuscript. All authors participate in preparation and critical review of the manuscripts. In addition, all authors read and approved the manuscript.

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Diagram illustrating data collection procedure among patients admitted to MICU of UoGCSH September 2015 to April 2019, (N=504).

Figure 1

A total of 738 patients were admitted from September 2015 to April 2019.

504 patients were included in this study.

52 patients' data were incomplete.

386 patients' charts were reviewed.

182 patients' charts were not located.

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Figure 2

Trends of common Categorical Admission Diagnosis among patients admitted to MICU of UoGCSH September 2015 to April 2019, (n=340).
Figure 3

Frequency of common comorbid illness among patients admitted to MICU of UoGCSH. September 2015 to April 2019, (n=256). Key: Miscellaneous Conditions: Gastro intestinal disorders, Post-operative conditions, Trauma, Malignancy, Tetanus, Myasthenia Gravis.
Figure 4
Trend of in ICU mortality among patients admitted to MICU of UoGCSH from 2014-2019 (n=195).

Figure 5
Length of ICU stay between survivor and non-survivor among patients admitted to MICU of UoGCSH September 2015 to April 2019, (N=504).
Supplementary Files

This is a list of supplementary files associated with the primary manuscript. Click to download.

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