Intensive Hospice & Palliative Care

- All treatments are palliative!
- No patients are cured of LM!
- All will die! Some of progressive systemic disease but
- Most with progressive neurologic dysfunction with many if not most of the symptoms noted earlier!
- Patients appropriate for aggressive treatment also need aggressive Sx Rx and comprehensive, holistic PC
- All others should get intensive H & PC
- What does that mean?
  - There is no literature to tell us what to expect and what to do RE SxRx and best supportive care
  - H/O and PC texts
  - H/O or PC journals
- Let's write that article!

Symptoms in Patients Dying of (Breast) Meningeal Carcinomatosis

Services MS et al. *J Impt Stuff 2010*

(from Gauthier et al)

Headache	**34%**	**100%**
Cranial nerve symptoms	**25**	**100**
Cerebellar signs	**24**	**100**
Nausea and vomiting	**23**	**100**
Visual disturbance	**22**	**100**
Radicular pain	**21**	**100**
Glascow coma scale < 15	**21**	**100**
Paresthesia	**19**	**100**
Meningismis	**12**	**100**
Motor deficit	**11**	**100**
Dysarthria	**2**	**100**

Challenges in Intensive Symptom Management of Leptomeningeal Metastases Services MS et al. *J Impt Stuff 2010*

- Reporting on our recent series of patients (n=2)
  - We can find more patients (PHO/FMC record review?)
- Severe Headache
  - Steroids, opioids, and complementary therapies
- Radicular pain
  - Steroids, opioids (methadone), gabapentin (or other anticonvulsants (keppra?), ketamine, muscle relaxants (benzos and baclofen)
  - Complementary therapies (PT, massage, guided imagery)
- Nausea & Vomiting
  - Steroids, anticholinergics (cochlear involvement), target every receptor if refractory (haloperidol, ondansetron, antihistamines, anticholinergics, cannabinoids)

Refractory Pain

- Opioid dosing
- Opioid rotation
  - Fentanyl and methadone
- Maximal adjuvant therapy (neuropathic)
  - Anticonvulsants, antidepresents
  - Ketorolac (Toradol)
  - Ketamine
- Psychosocial and spiritual therapies
- Total sedation

Use That Ommaya?

- **Intraventricular Administration of Morphine for Control of Intractable Cancer Pain in 90 Patients.** Karavelis et al
- Neurosurgery. 39(1):57-62, July 1996.
- No recent literature
- “We haven’t done that in years.” R Rauck

Once Daily Administration of Morphine

	Mean	Median	Minimum	Maximum
Age (yr)	57	58	23	80
Pain duration (mo)	10	6	0.5	120
Duration of reservoir use (d)	95	46	1	1362
Morphine dose (mg)	1	1	0.25	4
Quality of analgesia (%)	78	90	0[a]	100
Duration of analgesia (h)	22	24	0[a]	72

[a] **Complications.**

Theoretically – does it make sense to consider intraventricular administration of other medications using Ommaya reservoir already in place? Need a consultant!

- Seizures –
  - Keppra, phenytoin, steroids, benzos, midazolam
- Constipation – paresis + opioids
  - Broad spectrum oral agents, MNTX, disimpaction
- Psychosis – hallucinations, delusions, paranoia
  - Haldol, Thorazine, minimize steroids
- Paresis, paresthesia, paralysis – I
  - Intensive personal care
  - Bed, mattress
- Senses - visual (to blind), auditory (to deaf)
  - CH could no longer read; JJ could no longer see
- Anxiety
  - Long-acting benzos, companionship
- Physical space
  - Bed, Mattress
  - Quiet, dark/light, room for PCG(s)

- Depression
  - Ritalin, Remeron, Effexor
  - Complementary, counseling, pastoral care
- Social
  - Institutionalized for Sx Rx and personal care needs
  - Loss of roles
  - Counseling, pastoral care, social support
- Spiritual
  - Fatal + suffering
  - Losses
  - Profound existential suffering
- JJ - “Why am I still here?!!”
- “I thought I’d wake up dead and in heaven!”
- “Let me go! Don’t be selfish, let me go!”
- Incremental, palliative sedation

Great Teachers

- CH and JJ
- Medical students
- WE ALL learned so much
- Paybacks…
- A devastating complication with an ominous prognosis and high likelihood of intensive symptom management
- We can do a better job