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Authors

Hakim, Miriam
Kamangar, Nader

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LEPTOMENINGEAL CARCINOMATOSIS IN A PATIENT WITH METASTATIC OVARIAN CANCER

Miriam Hakim¹, Nader Kamangar¹

Introduction/Hypothesis: Leptomeningeal carcinomatosis is most commonly associated with breast cancer, lung cancer, melanoma, gastrointestinal cancers, primary central nervous system cancers, and hematologic malignancies. It is rarely a complication of ovarian cancer.

Methods: A 54-year-old female with a history of metastatic, recurrent, and high-grade serous ovarian carcinoma was admitted to the intensive care unit for acute onset altered mental status, headache, and acute symptomatic hyponatremia.

Results: Cerebrospinal fluid analysis was notable for an elevated opening pressure and protein level, a mildly elevated white blood cell count with lymphocytic pleocytosis, and a low glucose level. However, infectious workup of the fluid including a meningococcal panel and cultures was negative, raising suspicion for a noninfectious etiology in the setting of metastatic cancer. On neuroimaging, she was found to have leptomeningeal carcinomatosis and three small parenchymal metastases. For her severe hyponatremia, she was treated with hypertonic saline and then initiated on salt tablets. Upon improvement in her sodium level and mental status, she was transferred out of the intensive care unit and started therapy with palliative wide beam radiation. Due to a decline in her functional status and overall poor prognosis, the family opted for discharge with home hospice.

Conclusions: This case illustrates the rare metastasis of ovarian carcinoma to the leptomeninges. Although leptomeningeal carcinomatosis is not commonly seen in this type of cancer, it is important to consider the diagnosis in cancer patients who present with signs and symptoms of meningococcal encephalitis but have a negative infectious workup because it portends a poor prognosis and limited treatment options.

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A RESUSCITATION UNIT'S NURSING PROTOCOL FOR MONITORING STROKE PATIENTS UNDERGOING THROMBECTOMY

Nathaniel Woods¹, Suzanne Jacetzold¹, Ashley Aitken¹, Gurshawn Tuteja², Madison McGann³, Priya Patel⁴, Mubariz Hassan³, Karen Yarbrough⁵, Michael Phipps⁵, Gaurav Jindal⁵, Mary Ellen Dietrich¹, Ann Matta⁶, Daniel Haase⁷, Quincy Tran⁸

Introduction/Hypothesis: Control of blood pressure (BP) in ischemic stroke patients is challenging and can significantly impact outcome. Stroke patients transferred to an academic medical center may not have a neurocritical care bed readily available, therefore, are admitted to the Critical Care Resuscitation Unit (CCRU). BP management in these patients was found to vary by provider and nursing staff. CCRU staff collaborated with the Stroke team to develop a protocol to standardize the monitoring of BP and interventions to maintain a pre-specified goal, as well as reducing time intervals to angiogram.

Methods: A pre-post study of stroke patients transferred from other hospitals and undergoing thrombectomy were evaluated for variability in systolic BP (BPSV) during the 8 hours post thrombectomy. Secondary outcomes were time to angiogram; frequency of BP interventions, and 90-day modified Rankin Score (mRS) 0-2. Interventions were defined as any BP infusion adjustments, administration of intravenous medication or fluid. Descriptive analysis was used to compare groups.

Results: Thirty-two patients with 20 BP measurements each were compared with 127 historical controls with 8 BP measurements each. Mean age and National Institute of Health Stroke Score were similar between groups. BPSV was 14 [Standard Deviation (SD) 6] for study group and 15 (8) for controls, $p=0.72$. Study group's median time to angiogram was 22 minutes [Interquartile (IQR) 14-36], compared with 30 minutes [IQR 21-46, $p=0.049$] for control group. Mean post-thrombectomy intravenous crystalloids was 735 milliliters (700) for study group vs 500 (400), $p=0.02$, for controls. Study patients received 4 (4) interventions, compared with 2 (2) for control group, $p<0.01$. Functional independence (mRS 0-2) did not significantly differ between the study group (31%) compared with controls (40%, $p=0.32$).

Conclusions: Time interval from CCRU arrival to angiogram was significantly reduced during the study period with a significantly increased frequency of interventions in an attempt to manage BP. While this did not show a significant improvement in BPSV or outcome due to sample size, we believe that standardization of care improved monitoring of patients.

¹University of Maryland Medical Center, Baltimore, MD, ²Medical College of Georgia, Augusta, GA, ³University of Maryland Department of Emergency Medicine, Baltimore, MD, ⁴University of Maryland College Park, College Park, MD, ⁵University of Maryland School of Medicine, Baltimore, MD, ⁶University of Maryland School of Nursing, Baltimore, MD, ⁷Baltimore, MD, ⁸University of Maryland Medical Center, Ellicott City, MD

¹Olive View-UCLA Medical Center, Sylmar, CA