

SC-B4 + MS-A3

SC-B4-18

CURRENT DIAGNOSTICAL AND THERAPEUTICAL ASPECTS IN MENINGEAL CARCINOMATOSIS

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We report experiences in meningeal carcinomatosis based on 18 patients who were diagnosed and treated in our department between 1984 - 1991. CSF examinations and CAT scans were done in all cases. Immunocytochemical techniques, CSF-tumor markers, MRI and myelography were performed according to individual requirements.

The clinical features in our patients were polyradicular and meningeal syndromes with cranial nerve palsies. Occasionally epileptic seizures or confusion were the leading symptoms.

The hallmark of diagnosis was the detection of malignant CSF cells, which could be disclosed in some cases only by repeated lumbar punctures. The specificity of routine CSF cytology was increased by immunocytochemical techniques, aiming at specific antigens (e.d. Vimentin, Keratin). This method proved to be valuable in differentiating inflammation from malignant CSF cells and gave hints of the primary tumor.

CSF tumor marker assays (e. d. Ca 15-3, CEA) might be a further diagnostic tool for detection of leptomeningeal metastasis. Tumor marker assays require careful standardization for the CSF. Moreover blood-CSF barrier has to be considered of for correct interpretation of results. Cell count, lactate and protein levels, the measurement of locally produced tumor markers and the percentage of positive stained tumor cells were employed to monitor the chemotherapy.

The prognosis of our patients was highly dependent on the biology of the primary tumor and the spread of metastasis at the beginning of therapy. With the use of early intrathecal chemotherapy maximum survivals of up to 18 months were achieved.

MS-A3-01

EMERGENCY MANAGEMENT OF THE UNCONSCIOUS PATIENT

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The management of the unconscious patient is mainly directed by the etiology of the acute disease as well as by the acutely presenting emergency situation.

In many instances taking history is directly leading to appropriate differential diagnostic considerations; the proper clinical, neuroradiological, electrophysiological and laboratory work-up enables the neurologist to direct the first therapeutic management steps appropriately.

The presence of a supratentorial space occupying lesion leads to the clinical picture of transtentorial herniation with the development of midbrain and bulbar brain syndromes, respectively. Infratentorial lesions lead in many instances to typical brainstem dysfunctions often accentuated by occlusive hydrocephalus. Encephalitis and meningoencephalitis are characterized frequently by typical accompanying signs and symptoms. Clinico-neurologically, metabolic disorders and intoxications are the most challenging disease - entities in the neuro-emergency room. Thus, after quick history taking and neurological examination the first step in the management of an unconscious patient has to be to secure vital functions, mainly respiratory oxygenation and circulation. After intubation and inserting a central vein-catheter routine laboratory parameters which have to include red and white blood cell count, glucose, electrolytes, liverfunction tests and kidneyfunction tests as well as coagulation-parameters, bloodgas analysis and sometimes thyroidfunction tests, CT scan, EEG and lumbar puncture are the next diagnostic steps. Screening for toxic substances in urine and blood is warranted in case of according history. Rarely magnetic resonance imaging might lead to a final diagnosis. Since therapeutic measurements, as e.g. thrombolysis, need to be initiated within few hours, the diagnostic management of comatous patients is a highly challenging procedure both to manpower, technical infrastructure and allocated time.

MS-A3-02

TREATMENT STRATEGIES IN GENERALIZED CONVULSIVE STATUS EPILEPTICUS

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When an epileptic seizure is so frequently repeated or so prolonged as to create a fixed and lasting epileptic condition during 30 minutes, the diagnosis of status epilepticus (SE) can be made.

Once the diagnosis is made, a rapid and adequate medical intervention is of an utmost and even vital importance.

After 30 minutes various pathophysiological changes occur mainly in generalized convulsive SE.

The main goal of the treatment is to stop seizures and to prevent or treat medical complications. Treatment plans for convulsive SE differ depending on the centre and the country. A general advice is to use a strict protocol and medication with which the staff is familiar.

The approach to our department will be outlined. The presented protocol can serve as basis for a consensus on treatment strategies.

Benzodiazepines (Clonazepam, Diazepam) and/or Phenytoin are first line drugs. When despite proper treatment SE still continues after 30-60 minutes, we recommend intubation and mechanically assisted ventilation.

When signs of cardio-respiratory insufficiency or aspiration are present earlier intubation is advised.

Hypotension, cardiac arrhythmias, hyperthermic, rhabdomyolysis and renal failure are serious complications with regard to outcome and need vigorous treatment.

MS-A3-03

Stroke - a Challenge for Emergency Neurology
Werner Hacke, Heidelberg, FRG

Although cerebrovascular occlusions are responsible for a considerable percentage of patients admitted to Neurocritical Care Units, there is no consensus concerning a standardized management of such patients. Currently therapy of acute ischemic stroke includes general treatment such as improvement of pulmonary function and early intubation, cardiac care and blood pressure management, fluid and electrolyte balance, ICP-monitoring and treatment of elevated ICP. Specific procedures such as restitution of perfusion and increase of diminished blood flow, as well as prevention of ischemic cellular damage are still under research. In this article, the rationale for different therapeutic strategies is discussed and appropriate approaches to different subgroups life threatening strokes are proposed. In detail, dissection of the carotid and vertebral arteries, basilar occlusion, middle cerebral artery embolism, slowly progressive stroke due to high-grade internal carotid artery stenosis and space-occupying cerebellar infarction will be discussed. Despite the lack of generally accepted and scientifically proven therapies, many approaches seem promising. Individual concepts for defined stroke subgroups need to be verified in controlled prospective multicenter trials.

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