

Supporting patients with brain tumours

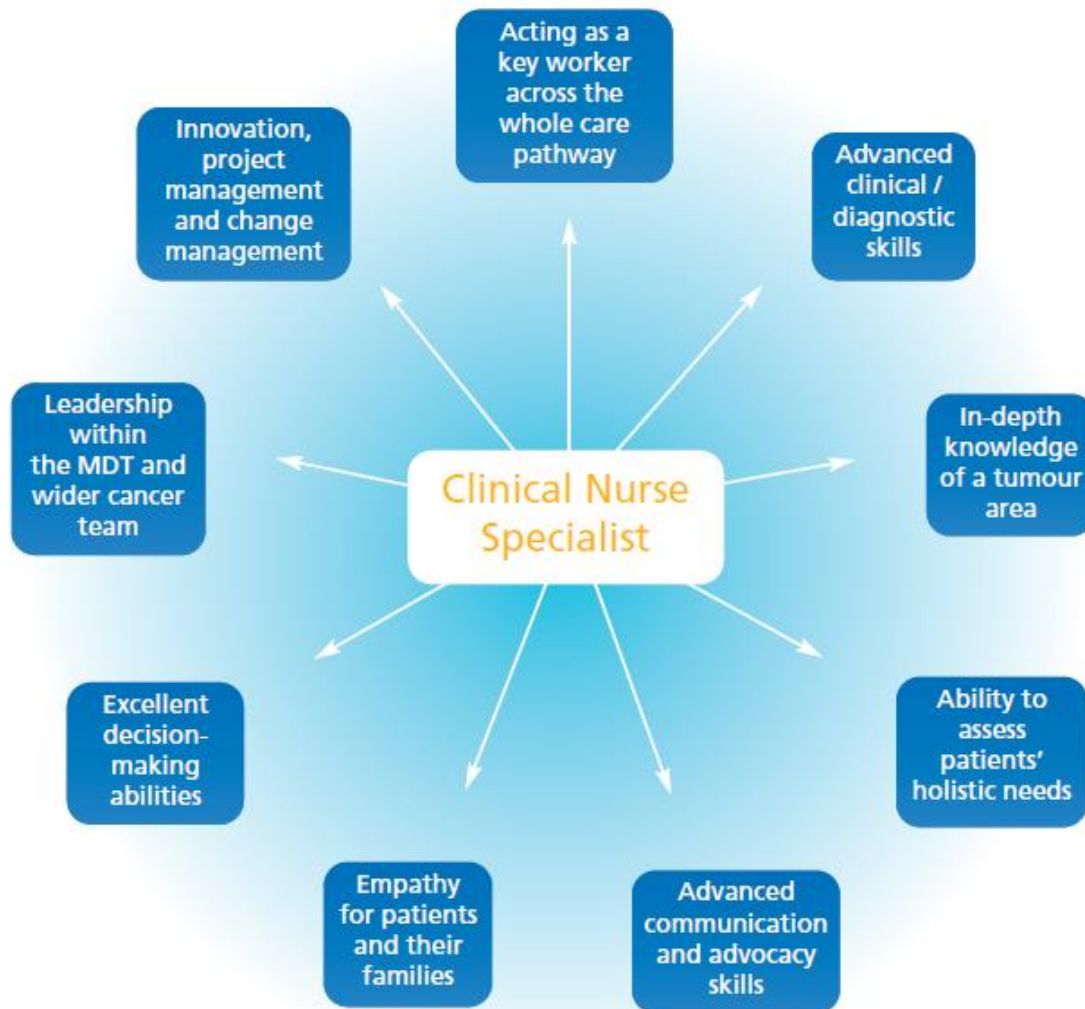
Alison Corbett

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Neuro-Oncology



Key contributions that CNSs make to cancer care



Tumour types & treatment pathways

Low grade tumours

- Low grade astrocytoma
- Low grade oligodendroglioma
- Meningioma
- Ependymoma
- Haemangioblastoma
- Acoustic neuroma
- Pituitary tumours

High Grade Tumours

- High grade astrocytomas
- Medulloblastomas (PNETs)
- Glioblastomas

Treatment

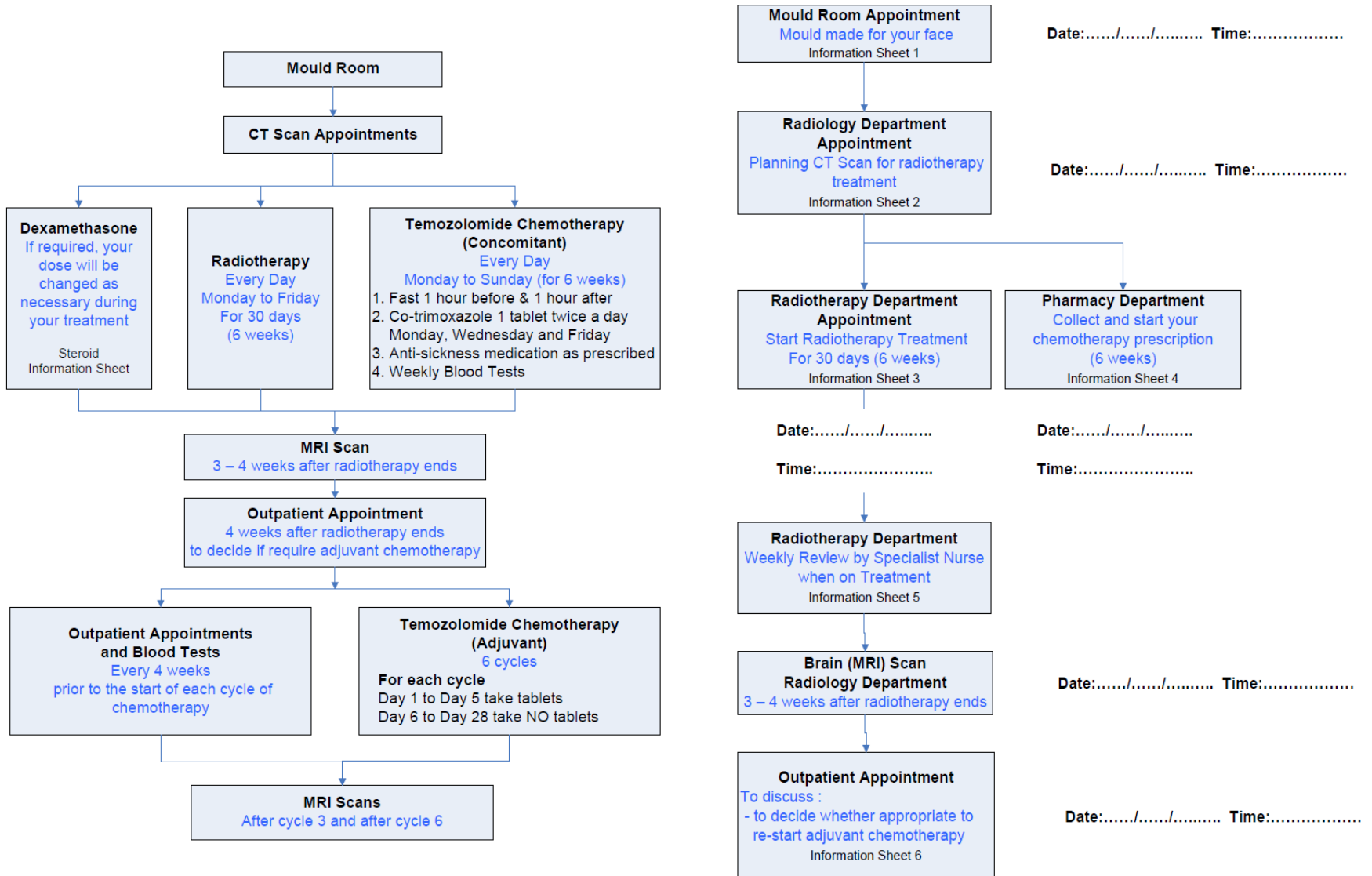
Surgery
Surveillance
Radiotherapy
Radio surgery

Treatment

- Surgery- biopsy/debulk
- Radiotherapy 60Gy in 30#
- with concomitant & adjuvant temozolomide
- 2nd line chemotherapy
- Best supportive care



Pathway 1. Treatment Plan



Specific management requirements

<p>Steroid therapy</p>	<p>Emotional highs & lows, irritability, aggression, loss of libido, diabetes, increased appetite, insomnia, muscle wasting. Managing steroids – slow reductions.</p>
<p>Seizures/Anti epileptic medication management (AEDs)</p>	<p>Fear of seizures in public places, managing medication, side effects of medication, drowsiness, aggression, visits to neurologist & living with epilepsy</p>
<p>Cognitive deficits</p>	<p>Short term memory loss, personality changes, speech problems, lack of concentration, loss of control, changes in role, incontinence, loss of sight/hearing, worsened mobility, loss of independence, safety/vulnerable adult.</p>
<p>Haematology/ biochemistry</p>	<p>Regular blood monitoring, risk of low platelets /neutropenia whilst on treatment. Effect of steroid therapy on blood results ie, blood sugars.</p>
<p>Risk of raised intracranial pressure</p>	<p>Awareness of symptoms and what course of action to take. Nausea, dizziness, am headaches, stiff neck, visual problems – linking symptoms.</p>



Pathway 2. Practical Issues and Referrals

Inability to drive/ change of roles	DVLA , counsellor
Difficulty working & financial issues Loss of job Travel costs	Welfare Officer DLA / AA/DS1500 Prescription exemption Blue badge Macmillan grants
Fertility issues due to treatments Libido/sexual problems	Sperm banking/egg retrieval Couples counselling
Seizures Living with Epilepsy	Epilepsy first aid information Referral to Neurologist
Mobility problems	Referral to Physiotherapist
Co-ordination, balance	Occupational Therapist - Home visit/relaxation
Anxiety	Massage Therapist, counsellor, local centres
Language deficits, short term memory loss	SALT (Speech and Language Therapist)
Difficulties meeting ADLs	Social worker - care package
Hair loss / body image	Hairdresser/make over charities
Nutritional/weight issues/diabetes	Dietician
Holidays	Travel advice and information/ Macmillan



Pathway 3. Psychological Care

1st OPA Week 1

Build trusting relationship
Post Traumatic Stress Debriefing
Montreal Cognitive Assessment (MoCA)
Holistic Needs Assessment (HNA)

2nd OPA Week 2

Expectation Adjustment Interventions
Introduce 'ongoingness'
'Special Consultation' Invitation

On treat Weeks 3-8

Repeat HNA & MoCA as required
Grief & loss therapy
Couples counselling/ relationship changes
Anger management / relaxation techniques
Patient paced increased awareness
Quality of Life assessment

Weeks 7-8 specific

Detachment Counselling
Psychological Needs Assessment-refer
Palliative care referral

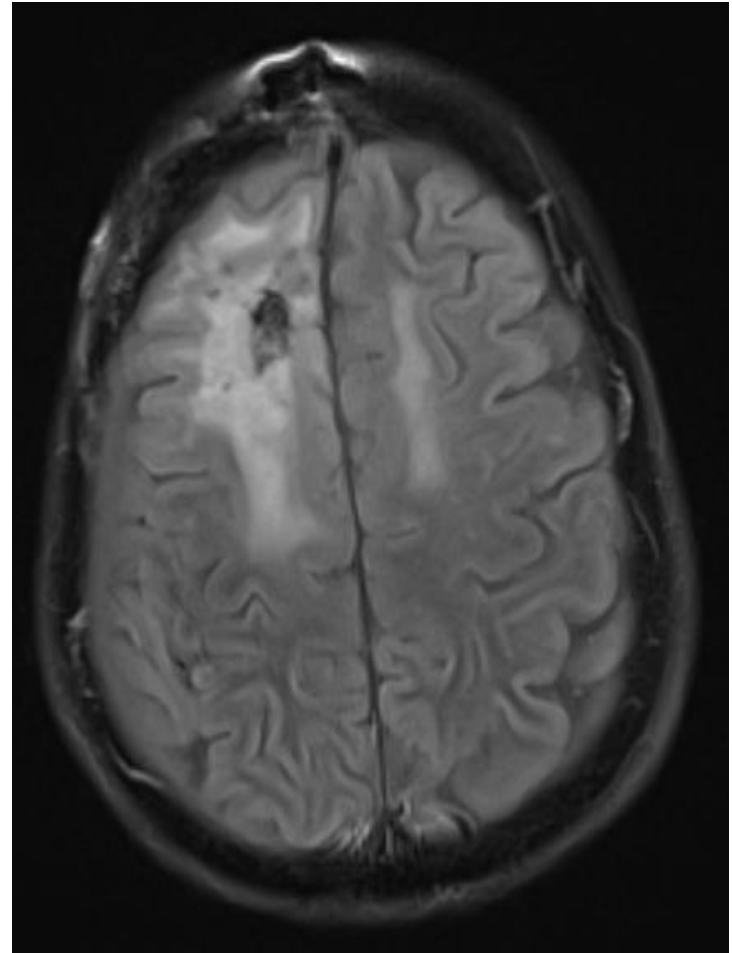
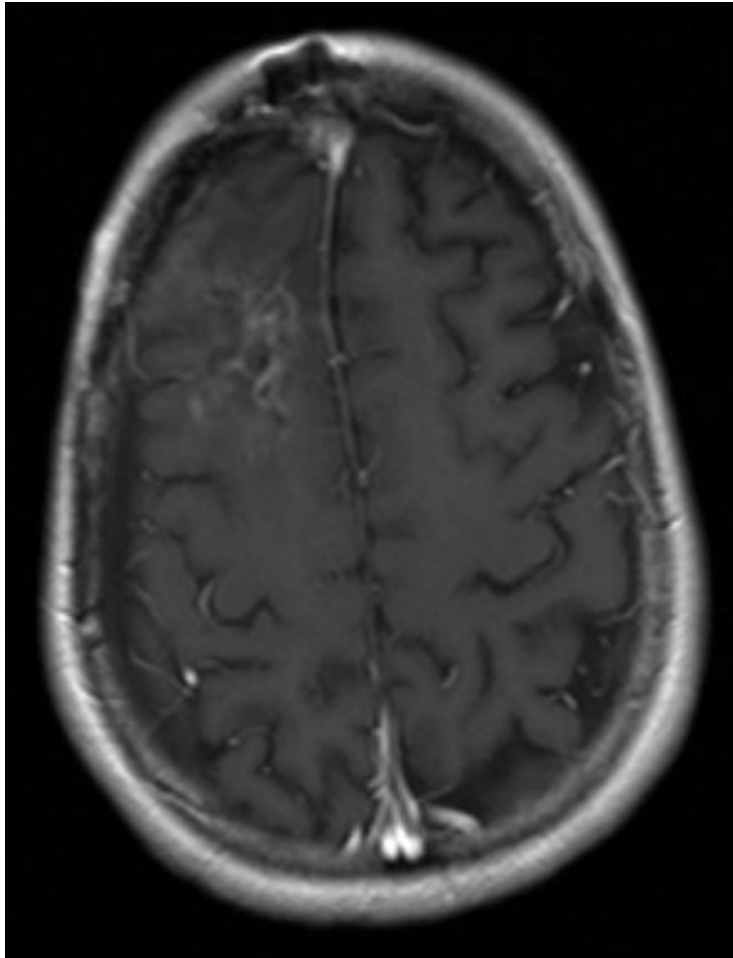


Case study

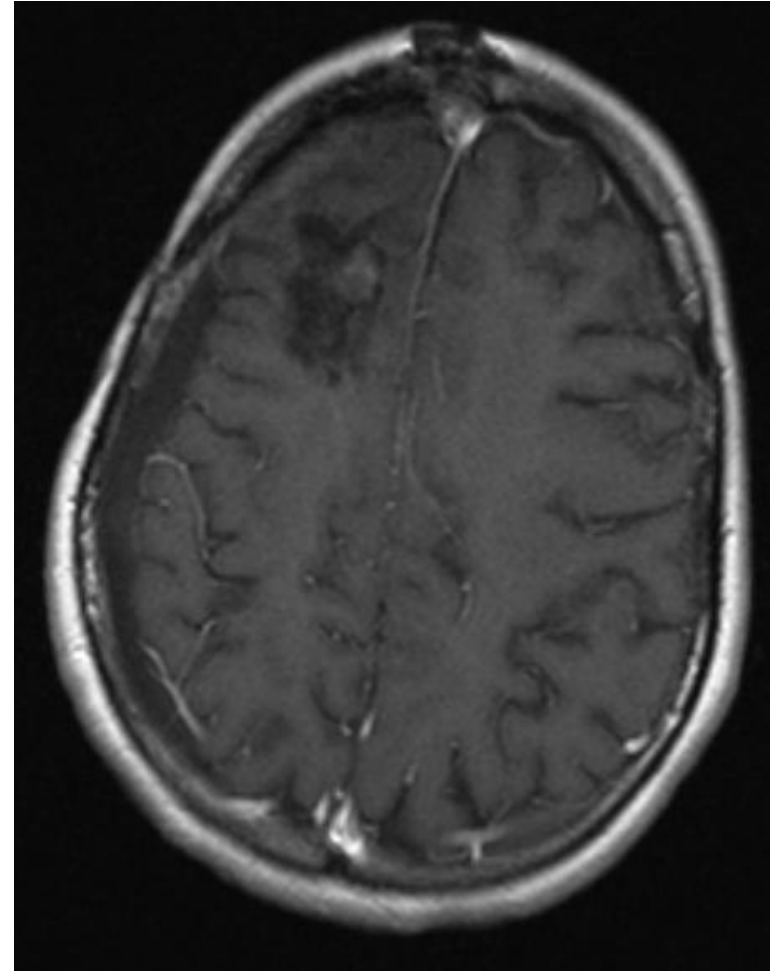
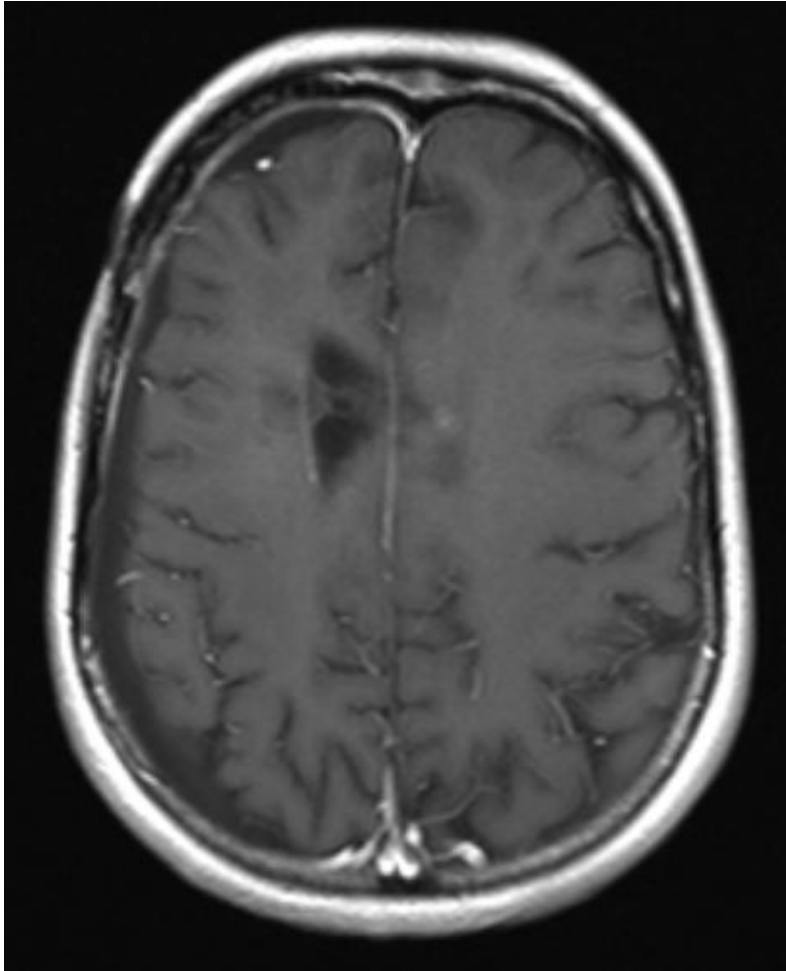
- Female in mid 20s
- Previously fit and well
- PS1
- Presented to GP with symptoms of raised intracranial pressure
- Referred/imaging/referral to Neuro-surgeons.
- Debulking operation November 2011
- WHO Grade III Anaplastic Astrocytoma
- November 2011 fractionated radiotherapy, 60Gy in 30#
- May 2012 new onset seizures - confirmed progressive disease
- Commenced PCV chemotherapy
- Repeated delays due to pancytopenia (over 3 months) stopped October 2012
- Application for Bevacizumab approved - now completed 12 cycles. Remains off steroids.



Imaging - December 2012



Imaging June 2013 and January 2014



Team Work!

- Declined community palliative care and social service input.
- Medical, practical, emotional and psychological needs met by Neuro-oncology team at The Royal Marsden, GP and CLIC Sargent working in collaboration.
- Special needs met included expediting rehousing, grants for wig and clothes to assist with body image difficulties, constant monitoring and communication with regards to bloods, steroid and anti epilepsy management, all of which increased quality of life and reduced social stigma.



Conclusion

I hope that this presentation has;

Highlighted the complex & individual needs of patients with brain tumours

Shown the importance of working in collaboration in order to identify and meet each patient's individual needs in order to achieve maximum quality of life.



Room for improvement?

- We are very appreciative when we can communicate with GPs in a timely fashion and are very much open to suggestions as to how this could be improved.
- If you think that a ‘GP information pack’ would be helpful - to be given to all GPs when we have a new brain tumour patient- then please put this on your feedback form.
- Any other suggestions as to how communication could be improved would also be welcomed.



Thank you for listening

Contact details

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