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Seizure Management at EOL

- The aim is to prevent and control seizures with the minimum of disruption to the patient
- In patients approaching EOL, avoid reliance on IV route +/- acute care where possible
- Steroids can often be discontinued unless they are required for control of raised ICP
- SC Dexamethasone >8mg/24 hours is often best used in a separate CSCI

Acute Seizure Management at EOL

- An acute seizure may settle spontaneously
- Acute management includes maintaining the airway, emergency drug management and a re-assessment of anti-epileptic medication
- Intranasal, buccal or subcutaneous midazolam can be used for the control of recurrent or prolonged seizures
  - 5-10mg repeated every 5-10 mins to a maximum of 30mg
- Lorazapam sublingual has also been used with effect for patients who do not lose consciousness during a seizure

Acute Seizure Management in community setting

- If seizures are prolonged/recurrent despite treatment, hospital admission may need to be considered. Paramedics may be able to administer IV lorazepam to avoid acute admission

- Seizures can be very frightening to witness by a patients family and friends. Important part of ACP

- Choice of management will be individual dependent on patient/family choice and confidence level in managing medications etc

Buccal Midazolam

- Studies on seizure control in children show it is as effective as IV Diazepam. There is a shorter time to starting treatment and to control of seizures

- The dose in adults is determined by weight

  - < 50kg 5mg Midazolam

  - > 50kg 10mg Midazolam

- Midazolam injection is used 10mg/2ml

- If used intra-nasally half of the dose is given in each nostril

- The buccal route is an alternative particularly if there is excessive head movement due to seizures

Midazolam CSCI for Seizure prevention at EOL

- The recommended starting dose is between 10-30mg/24 hours

- Considerations in choosing dose:
  - History of seizures – type, frequency
  - Current anti-epileptics e.g. Monotherapy vs. Combination, Dose – high vs. low

Keppra CSCI

- Can be considered for seizures not controlled with Midazolam CSCI
- May also be considered for patients already established on po Keppra – particularly if prognosis may be longer (non sedating)
- Equivalent PO to SC dose i.e.
  - Keppra 500mg BD po = Keppra 1000mg/24 hours CSCI
  - Due to volume (100mg/ml) Keppra 2000mg is maximum dose in one CSCI
  - Should be used in a separate CSCI, diluted with N Saline – currently trials ongoing to establish compatibilities
- Availability/ cost may be a restricting factor

Complex seizure management at EOL

- If seizures remain poorly controlled despite Midazolam and Keppra via CSCI, the use of Phenobarbitol may be considered
  - 100-200mg IM
  - 600-2400mg / 24 hrs vis CSCI
- This should be used and prescribed only after discussion with a Palliative Care Consultant
- Phenobarbitol should be used in a separate CSCI, diluted as well as possible with N Saline
- In exceptional circumstances, propofol may be required, close liaison with critical care

Questions