Treatment of Nausea and Vomiting in Long-Term Survivors of Pancreatic Cancer

To the Editor:

Endoscopic stenting of the common bile duct is a recognized method of palliation for biliary obstruction due to pancreatic carcinoma. Drainage of the distended biliary duct rapidly reduces the symptoms of pain, jaundice, pruritus, nausea, and vomiting. This procedure may prolong a patient’s life and occasionally long-term survivors with patent biliary stents are seen. Some of these patients experience chronic nausea and vomiting, resistant to treatment with standard antiemetics. We report here an illustrative case.

A 78-year-old woman with cancer of the pancreas and liver metastases experienced epigastric pain, distension, nausea, vomiting, weight loss, and tiredness. There was no jaundice or pruritus. A tumor in the pancreatic head causing distension of the common bile duct and a single liver metastasis were seen on ultrasound scan. A teflon stent was placed in the common bile duct endoscopically. Her symptoms decreased and she started to eat better. However, two weeks later, she started to complain of nausea and vomiting. There was no sign of stent obstruction, no pain or increased body temperature. Nausea became severe in time. Domperidone and metoclopramide up to 80 mg/day orally were not successful. Ondansetron tablets 8 mg three times daily helped marginally but caused severe constipation. Ondansetron, a specific 5-HT3-receptor antagonist, was only slightly successful and its use resulted in severe constipation, a known adverse effect of this drug.5 The patient’s nausea responded to very low doses of levomepromazine. This drug exercises its antiemetic effect through interaction with D2, H1, muscarinic and 5-HT2-receptor antagonism.6

Long-term use of ondansetron was not necessary and extremely expensive (US$750 per month × 12 months, fully reimbursed). Levomepromazine (at the cost of US$5 per month) is not reimbursed by the insurance in the Netherlands nor it is licensed as an antiemetic. Although there is ample evidence of its antiemetic activity,6,7 the cost of drug licensing are much higher then the potential financial gain. Levomepromazine is one of the most useful broad-spectrum antiemetics, especially useful in palliative care where there may be multiple factors underlying the nausea and vomiting and involvement of multiple receptor systems.5

In conclusion, nausea and vomiting in patients with pancreatic carcinoma may be at least partially due to malabsorption and abnor-
mal gastrointestinal motility. Use of pancreatic enzymes may relieve symptoms and levomepromazine may be an effective antiemetic in such terminally ill patients.

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References

Topiramate Relieves Idiopathic and Symptomatic Trigeminal Neuralgia

To the Editor:

Topiramate (TPM) is a new antiepileptic drug (AED) recently approved for the treatment of partial seizures. It has a broad spectrum of anticonvulsant actions that may result from actions on voltage-gated Na channels and Ca channels, as well as on GABA and glutamate channels.1 Recently, TPM was found to be effective for several neuralgic symptoms, including intercostal neuralgia,2 cluster headache,3 and infantile spasms.4

Trigeminal neuralgia (TN) is a sudden recurrent pain in the distribution of the fifth cranial nerve. It may be essential or secondary to demonstrable structural lesions, such as aneurysm or multiple sclerosis (MS). In MS patients, TN is likely due to an ephaptic transmission between demyelinated axons at the fifth root entry zone in the pons.

Carbamazepine (CBZ) is the first choice medication for TN. Many patients are resistant to this drug, however, or cannot tolerate it. This is most likely when other neurological symptoms are present, such as in MS. Recently, other AEDs, such as lamotrigine (LMT) and gabapentin (GBP),5 have been shown to be effective for treating TN, both in essential and in secondary cases. We report 4 subjects, 1 with essential TN and 3 with secondary TN, who were resistant or intolerant of other AEDs, but could be successfully treated with TPM. In each case, subjective pain level was rated utilizing a previously described three-point scale: 0 = no pain, 1 = mild, 2 = moderate, 3 = severe.5 Titration began with 25 mg/daily and was increased by 25 mg every three days until pain relief was achieved or dosage reached 300 mg daily. The trial was conducted at the Department of Neurological Sciences and Vision, University of Genoa and S. Camillo Hospital, Rome and written informed consent was obtained from all subjects.

Case 1
A 57-year-old woman had essential TN for more than 15 years. Brain MRI was normal. She was previously treated with CBZ (1600 mg/day), phenytoin (PHT) (300 mg/day), lamotrigine (300 mg/day) and GBP (2400 mg/day), with which she experienced only transient pain relief. The patient was successfully treated with TPM at a dose of 300 mg daily, and was pain-free after six months of treatment.

Case 2
A 35-year-old man underwent a surgical intervention for arteriovenous malformation in