receiving antibiotics was conducted. The pre and post antibiotic IPOS scores for pain, breathlessness, confusion and 'other' symptoms were analysed using a paired T test facilitated by SPSS V11.

Results The most common use of antibiotics was documented to control 'other' symptoms (n=16) not covered by IPOS. The most common 'other' symptom recorded were fever (n=7), but also included cough, incontinence and drowsiness.

Antibiotics caused an average reduction in the IPOS scores for pain of 0.45, CI 1.49 to -1.28 (p 0.11). Breathlessness reduced by 0.16 (CI 1.44 to -0.60, p 0.42). Confusion reduced by 0.26 (CI 1.13 to -0.78, p 0.17). Other symptoms improved by 0.65 (CI -0.11 to -1.18 p 0.02).

Conclusion Although some patients did report improvements, the findings of this audit suggest that antibiotics may not affect patients' IPOS reported symptoms. This prompts reflection on both the use of antibiotics and the implementation of IPOS in the hospices. The potential clinical and research implications of utilising IPOS to evaluate the effectiveness of specific palliative care interventions warrants further research.

REFERENCES

1. Murtagh FE, Ramsenthaler C, Firth A, Groeneveld EI, Lovell N, Simon ST, Denzel J, Guo P, Bernhardt F, Schildmann, E., van Oorschot B, Hodiamont F, Streitwieser S, Higginson IJ and Bausewein C. 'A brief, patient- and proxy-reported outcome measure in advanced illness: Validity, reliability and responsiveness of the Integrated Palliative care Outcome Scale (IPOS)'. *Palliative Medicine* 2019;**33**(8):pp. 1045–1057.
2. Reinbolt RE, Shenk AM, White PH and Navari RM. 'symptomatic treatment of infections in patients with advanced cancer receiving hospice care'. *Journal of Pain and Symptom Management* 2005;**30**(2):pp. 175–182.
3. Helde-Frankling M, Bergqvist J, Bergman P and Bjorkhem-Bergman L. 'Antibiotic treatment in end-of-life cancer patients. 'A retrospective observational study at a palliative care center in Sweden'. *Cancers* 2016;**8**(9).
4. Nakagawa S, Toya Y, Okamoto Y, Tsuneto S, Goya S, Tanimukai H, Matsuda Y, Ohno Y, Eto H, Tsugane M, Takagi T and Uejima E. 'Can anti-infective drugs improve the infection-related symptoms of patients with cancer during the terminal stages of their lives?'. *Journal of Palliative Medicine* 2010; **13**(5): pp. 535–540.
5. Rosenberg JH, Albrecht JS, Fromme EK, Noble BN, McGregor JC, Comer AC and Furuno JP. 'Antimicrobial use for symptom management in patients receiving hospice and palliative care: a systematic review'. *Journal of palliative medicine* 2013; **16**(12): pp. 1568–1574.

133

DRAMATIC RESPONSES TO DABRAFENIB – CHALLENGES FOR PALLIATIVE CARE PROVIDERS IN THE NEW ERA OF TARGETED THERAPY AND IMMUNOTHERAPY

Mairéad Doherty, Sarah McLean. *Our Lady's Hospice and Care Services, St Vincent's Private Hospital, Dublin*

10.1136/spcare-2021-PCC.151

Background Immunotherapy has improved the survival associated with many cancers, changing the landscape of oncological management. This paradigm shift confronts palliative care providers with novel clinical dilemmas. We describe two cases in which a dramatic response to immunotherapy led to a rapid improvement in symptoms, requiring prompt clinical management.

Case 1 A 32 year-old woman with extensively metastatic malignant melanoma presented with worsening headache and abdominal pain. Imaging demonstrated progression of disease on pembrolizumab.

Management - BRAF mutation analysis confirmed V600 mutations. Upon commencement of dabrafenib 150 mg

twice daily analgesia included hydromorphone 12 mg/24 hours subcutaneously, pregabalin 50 mg three times daily, dexamethasone 8 mgs twice daily, regular diclofenac and paracetamol.

Outcome - Within 48 hours, the patient developed opioid toxicity with respiratory depression. Hydromorphone was held, and restarted at 6mg/24hours. Within 7 days the dose was reduced to 3mg/24hours due to adequate pain control. Imaging confirmed disease response. After a period of rehabilitation the patient was discharged on palladone SR 2 mg twice daily.

Case 2 A 56 year-old woman with a 5-year history of non-small cell lung cancer (confirmed BRAF-mutated) presented in acute liver failure, with almost complete tumour replacement of the liver parenchyma.

Management - At presentation, she was on a treatment break from dabrafenib, due to intolerable nausea. On re-challenge, nausea recurred. However, with aggressive anti-emetic management, including ondansetron 24mgs/24 hours subcutaneously, she tolerated an initial dose of dabrafenib 50 mgs daily, and subsequently 150 mgs.

Outcome - Her liver function began to improve within 24 hours of commencing dabrafenib. Within 8 days, she demonstrated signs of opioid toxicity, and became severely constipated, requiring discontinuation of subcutaneous fentanyl and ondansetron. She was discharged home 2 weeks later with essentially normal liver function.

Conclusion Immunotherapy continues to revolutionise oncological management, and as this treatment modality evolves, is likely to present further challenges for palliative care providers.

134

CASE REPORT: INDWELLING PERITONEAL CATHETER INSERTION FOR MANAGEMENT OF MASSIVE ASCITES IN A YOUNG PATIENT WITH CONGESTIVE CARDIAC FAILURE

Mary Holloway, Fiona Wiseman. *Northamptonshire Healthcare NHS Foundation Trust*

10.1136/spcare-2021-PCC.152

Background Indwelling peritoneal catheters are widely available for patients with malignant ascites, but are not usually used in patients with non-malignant disease. Most patients with non-malignant ascites have liver failure and are managed with regular temporary drains. A small proportion have cardiac ascites which is usually managed with diuretics and fluid restriction

Case Ms X was a 28 year old lady with massive ascites due to cardiac failure from ischaemic cardiomyopathy. She was no longer a candidate for cardiac transplantation and had frequent hospital admissions due to decompensation with pulmonary oedema despite oral diuretics. Her reported quality of life and functional ability was poor. She was admitted to the hospice for consideration of continuous subcutaneous infusion (CSCI) of furosemide due to worsening symptoms. Pulmonary oedema at the time of admission was managed with IV furosemide given in divided doses as short infusions. Her abdomen was distended and ward ultrasound scan revealed large volume ascites. Following literature review and discussion of the risks and potential benefits, a tunnelled ascitic drain was sited by an Interventional