

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.

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

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**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 mutation. 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.

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

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**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

Radiologist. Over the course of 16 days, 21 litres was drained with reduction in abdominal distension and leg oedema; her mobility and quality of life improved. To support management at home, Ms X's mother learned to perform the drainage independently. Bloods were monitored weekly and she was readmitted for IV albumin when blood albumin fell to 22 g/l.

The volume of ascites drained gradually reduced to nothing and the drain was removed due to concerns about infection after sepsis developed. The ascites did not recur and Ms X had no further admissions for decompensation of CCF. She died at home 10 weeks after the drain removal

**Conclusion** Permanent ascitic drain insertion can reduce diuretic use and frequency of decompensations in patients with large volume cardiac ascites.

### 135 THE USE OF OPIOIDS IN SYRINGE DRIVERS: AN AUDIT ACROSS 2 SPECIALIST PALLIATIVE CARE SERVICES IN THE EAST MIDLANDS REGION

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**Background** There has been a recent increase in concern regarding the use of opioid medications in syringe drivers following the publicised report of the Gosport Inquiry, 2018. In our own clinical practice we have seen an increased anxiety and caution regarding syringe drivers, particularly in the community.

**Aim** To identify the average starting dose of opioids in syringe drivers for patients known to the Specialist Palliative Care Teams (SPC) across three settings; hospice, hospital and community. John Eastwood Hospice, Mansfield was the initial site in 2018 and a similar audit was conducted at Royal Derby Hospital in 2019.

**Standards** Our standards were taken from a number of sources, including the Palliative Care Formulary. For patients already on opioids, total daily dose should be appropriately converted to the opioid being used in the driver; for an opioid naïve patient, 10–20 mg morphine is suggested. Clinical judgement based on the patient's individual needs is vital.

**Method** Patients commenced on a syringe driver with an opioid across a 2-month period were identified; retrospectively in Mansfield, prospectively in Derby. Retrospective case note review was carried out using electronic and/or paper records.

**Results** The average (mean) starting dose of opioid in a syringe driver (morphine subcutaneous equivalent) prescribed or advised by SPC was 27 mg (range 2.5 mg–160 mg) in Mansfield, 21 mg (range 3.75 mg–80 mg) in Derby. All patients had a documented indication for both the use of an opioid and use of a syringe driver. Doses used were comparable to opioid use in the preceding 24 hours.

**Conclusions** The results from these audits are reassuring; demonstrating that when opioids in syringe drivers are used, the indication is considered, doses used are small compared to standards, and in the majority it is beneficial. The results between sites were similar, suggesting that practice is consistent across different areas of the region.

### 136 A REVIEW OF THE USE OF MUCOLYTIC AGENTS IN MOTOR NEURONE DISEASE (MND). IS THERE BENEFIT TO USING MULTIPLE AGENTS OVER MONO-THERAPY?

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**Background/Aims** In MND, progressive bulbar and diaphragmatic weakness cause weak cough and difficulty expectorating. This can cause difficulty in managing the amount of saliva produced, which can lead to sore skin, wet clothes, embarrassment and precipitation of choking episodes. Thicker sputum can compound this issue. Mucolytics can be useful here, however guidelines for their use tend to be based around anecdotal experience rather than using higher level evidence. This particularly applies to the use of multiple mucolytics. We aimed to learn more about the benefits and harms of multiple mucolytic therapy versus single mucolytic therapy in MND. We hoped to develop a guideline outlining when each, or multiple, agents are appropriate in MND.

**Methods** We reviewed the notes of all patients with MND under the care of a Shropshire Palliative Care Team over a one year period and identified those on multiple mucolytic therapy. We noted outcomes of symptom improvement and side effects reported following initiation of multiple mucolytic therapy.

**Results** Of 64 patients identified, 32 patients required mucolytic therapy, with 31/32 being started on Carbocisteine initially. Of these, 12/32(37.5%) went on to receive multiple mucolytics. Symptom improvement was reported in 2/12 (16.67%) with multiple mucolytic therapy - in both cases the benefit followed the addition of Erdosteine. Worsening of symptoms was reported in 1/12(8.33%) patients. In 9/12(75%) patients, there was either no symptom improvement or no data describing outcomes.

**Conclusions** In most patients receiving multiple mucolytic there was either no symptom improvement or no recorded evidence of outcome. Where multiple mucolytic therapy is used, Erdosteine may be the most effective second line agent, however larger numbers are needed to determine this. Prospective research to collect outcome data to assess the effect of mucolytic therapy in a wider cohort of patients with MND would be useful in ascertaining more definitive conclusions.

### 137 IMPROVING SAFETY OF OPIOID PRESCRIBING AND ADMINISTRATION ON A HOSPICE INPATIENT UNIT (IPU)

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**Introduction** Opioids are commonly used drugs in palliative care, in both healthcare and community settings. The risk for harm from these drugs means that they are subject to additional regulations and good prescribing practice should be followed. NICE guidance on safe prescribing practice recommends that decimal points should be avoided. There should be consideration that palliative care patients often have a significant tablet burden and there is increased risk for error