

P-170 THE DEVELOPMENT OF A REGIONAL COMMUNITY PATHWAY FOR THE MANAGEMENT OF PATIENTS WITH SUSPECTED METASTATIC SPINAL CORD COMPRESSION (MSCC)

Becky Harris. *Sue Ryder Leckhampton Court Hospice, Cheltenham, UK*

10.1136/spcare-2022-HUNC.186

Background Metastatic Spinal Cord Compression (MSCC) is a progressive, painful and disabling condition experienced by between 2.5 and 5% of cancer patients (Loblaw, Laperriere & Mackillop, 2003. *Clinical Oncology (R Coll Radiol)*. 15: 211). Compression of the spinal cord from metastases can cause pain, a reduced ability to walk and continence problems, all of which will progress without early recognition and treatment (Nakata, Sugihara, Sugawara, et al., 2020. *Oncol Lett*. 19: 3137).

It is well documented that this patient group continues to present late with devastating results (Levack, Graham, Collie, et al., 2002. *Clin Oncol (R Coll Radiol)*. 14: 472). MSCC is most prevalent in patients with widespread disseminated disease (Nakata, Sugihara, Sugawara, Nakahara, et al., 2020), and as a result the hospice and palliative care community teams encounter these patients on a regular basis. It was noted that there was no clear communication route or guidance for community staff who were concerned that a patient may be displaying signs of MSCC. There was also no single point of contact within acute oncology to address these concerns at an appropriate level of urgency and in a uniform way.

Aim To gain consensus on when investigations were deemed appropriate and on subsequent management.

Methods A working party was established to address these issues, with hospice staff working in partnership with oncology staff. The group collaborated with a number of specialists and stakeholders within both the acute and community trusts.

Results Using NICE guidance (Metastatic spinal cord compression in adults: risk assessment, diagnosis and management. Clinical guideline [CG75]), the working party agreed on and created a pathway and guidelines for the identification and management of all suspected MSCC patients in Gloucestershire.

Conclusions The pathway has been a great success within the palliative care community with physios, doctors and CNS teams using it regularly to identify suspected MSCC patients and make an action plan with the Acute Oncology Service. The pathway aids in establishing clarity when discussing patients with acute oncology teams and consultants, empowering referrers and decreasing delays in accessing investigations.

In the future, a more formal audit of the pathway's impact would be useful, alongside exploring methods of disseminating the pathway to the wider clinical community.

P-171 PARENTERAL DIURETICS TO IMPROVE DYSPNOEA AND OEDEMA IN ADVANCED HEART FAILURE: A SYSTEMATIC REVIEW

¹Alex Hughes, ²Natalie Below, ¹Sabrina Bajwah. ¹*Cicely Saunders Institute, King's College London, London, UK*; ²*University of Glasgow, Glasgow, UK*

10.1136/spcare-2022-HUNC.187

Background Advanced heart failure patients suffer with dyspnoea and peripheral oedema (Sobanski, Alt-Epping, Currow, et

al., 2020. *Cardiovasc Res*. 116: 12) which are frequently treated with parenteral diuretics (Crespo-Leiro, Metra, Lund, et al., 2018. *Eur J Heart Fail*. 20: 1505) despite a limited evidence base in this patient population (McDonagh, Metra, Adamo, et al., 2021. *Eur Heart J*. 42: 3599).

Aim To systematically review and analyse the effectiveness of parenteral diuretics to improve dyspnoea and peripheral oedema in advanced heart failure patients with a significant symptom burden approaching the end of life.

Methods Five databases were searched, as well as hand searching, citation searching and performing a grey literature search. Two independent researchers screened and assessed the studies against set criteria. The RoB2 tool was used to determine study quality and data extraction was undertaken using a standardised pro forma (Higgins, Savović, Page, et al., 2022). Primary outcomes were improvement in dyspnoea and peripheral oedema, reduction in weight and increase in urine output. Secondary outcomes included other measures of heart failure symptomology and adverse effects of diuretic therapy.

Results 4646 records were screened and six studies met the inclusion criteria. Of these six studies, all were RCTs and compared the effectiveness of a continuous vs bolus intravenous diuretic infusion in advanced heart failure patients. Study quality was variable, with two studies having a low overall risk of bias, two with some concerns and two having a high risk. Outcomes with the strongest level of evidence were dyspnoea and peripheral oedema, reduction in weight and urine output, which all favour the continuous intravenous furosemide infusion. Bolus intravenous furosemide infusions also showed outcome improvement, particularly in outcomes corresponding to diuresis.

Conclusions There is strong evidence to suggest that intravenous diuretics improve congestion status in advanced heart failure patients in the short term, with more limited evidence of an associated improvement in dyspnoea and oedema. This review highlights a lack of specific evidence for the administration of diuretics via the subcutaneous route as well as a limited use of relevant palliative care outcome measures. Prospective RCTs are recommended.

P-172 DEVELOPMENT OF A PROCESS FOR MANAGING DEACTIVATION OF ICDs (IMPLANTABLE CARDIAC DEFIBRILLATORS) AND CRT-Ds (CARDIAC RESYNCHRONISATION THERAPY DEFIBRILLATORS)

Amy Majsai Gwyther, Rebecca Bhatia. *Dorothy House Hospice Care, Winsley, UK*

10.1136/spcare-2022-HUNC.188

Background A growing number of patients have ICDs and CRT-Ds in situ (Bradshaw, Stobie, Briffa et al, 2013. *Am Heart J*. 165: 816). Although all device follow up centres (including those which only follow up pacemakers) should have provision for deactivation of ICD function including the facility for domiciliary visits (Beattie. ICD deactivation at the end life: principles and practice. 2009), in our experience, this is rarely available the same day or out of hours.

Unfortunately, ICDs are not always deactivated in a timely way before patients enter the terminal phase (Hill, McIlpatrick, Taylor, et al., 2015. *Eur J Cardiovasc Nurs*. 15: 20), with the risk of delivering unpleasant and unnecessary shocks during the dying process estimated at occurring in up to 33%