LONG-TERM ABDOMINAL DRAINS (LTADS) FOR PATIENTS WITH DECOMPENSATED END-STAGE LIVER DISEASE: A PALLIATIVE MEDICINE PERSPECTIVE

Kirsty Thorpe, Sarinah Hanna, Hildegard Kolb. NHS Grampian

Introduction Long-term abdominal drains (LTADs) prevent ascites build-up, improve quality of life (QOL) and reduce hospital admissions for patients with refractory ascites. In NHS Grampian patients with decompensated end-stage liver disease (ESLD) not suitable for transplant or TIPSS are offered an informed choice between repeated large-volume paracentesis (LVP) and LTAD. In NHSG, LTADs are inserted by Palliative Medicine physicians.

Methods • Retrospective data collection/analysis for ESLD patients who underwent LTAD insertion in NHSG between 2020–2022.

Results 23 ESLD patients underwent LTAD insertion. 8 further patients were referred for LTAD but died before insertion. In the 3 months prior to LTAD, patients had an average of 3 admissions for LVP (range 1–6). The mean number of days between LTAD insertion and death was 59 (range 7–320). LTAD insertion prevented a mean of 2 further admissions for LVP per patient (range 0–10). 74% had no complications and either had LTAD in until death, or are still alive. 2 patients (9%) had infections; 1 resolved with antibiotics, 1 required drain removal. 4 patients (15%) accidentally had their LTADs pulled out or damaged. Prior to LTAD, 65% of patients had no evidence of advance care planning (ACP). Post-LTAD, 74% of patients had an improvement in documented ACP. Only 17% of patients died in an acute hospital, the majority dying at home or in a palliative care unit or community hospital.

Conclusion The majority of patients had no complications from LTAD and it remained in situ until death, reducing hospital admissions and allowing more time at home. 74% had improvement in ACP documentation after LTAD insertion, and only 17% of patients died in an acute hospital, compared to the national figure of 73%. Having Palliative Medicine physicians running the LTAD service allows early introduction of Palliative Care for decompensated ESLD patients and offers the opportunity for holistic assessment and ACP discussions.

IDENTIFYING THE FINANCIAL COSTS OF ANTICIPATORY MEDICATION PRESCRIPTIONS: A RETROSPECTIVE OBSERVATIONAL STUDY USING GENERAL PRACTITIONER AND COMMUNITY NURSING RECORDS

1Lloyd Morgan, 1Stephen Barclay, 1Kristian Pollock Kristian, 1Efthalia Massou, 1Ben Bowes. 1Primary Care Unit, Department of Public Health and Primary Care, University of Cambridge; 2Nottingham Centre for the Advancement of Research into Supportive, Palliative and End of Life Care, School of Health Sciences, University of Nottingham; 3The Queen’s Nursing Institute, London

Introduction Ascites is the accumulation of fluid in the peritoneal cavity, often associated with a poor quality of life and poor prognosis. There is limited national guidance on management of malignant ascites. This guideline has been produced to enable healthcare professionals to make evidence-based, patient-centred decisions about the management of ascites in patients with life-limiting cancer.

Method A comprehensive literature search was conducted, including a key word search in the Cochrane and NICE databases. Articles were graded using SIGN criteria. Surveys of professionals/clinical notes were performed to assess current practice. These were collated and reviewed by the guideline development group (CDG) and a guideline drafted.

Results Medical management Evidence for diuretics less clear in malignant ascites. Serum-ascites albumin gradient (SAAG) can be calculated from ascitic tap. SAAG >1.1g/dL most likely to benefit. Spironolactone is first line diuretic, starting at 100mg and titrated to 400mg every 3–4 days as required. If insufficient response, furosemide can be added. Large volume paracentesis (LVP): Accepted standard of care for large volume tense ascites if diuretic resistance/intolerance. Limited evidence to support use of human albumin solution in LVP for malignant ascites. There are limited indications for a drain to be clamped. Drain removal after six hours is recommended. Permanent indwelling peritoneal catheters May help with symptom control by avoiding repeated LVP. PleurX peritoneal catheter is recommended by NICE as an option to manage refractory malignant ascites. The CDG recommend considering after two LVP. Estimated cost saving of £1051 for PleurX insertion compared to in-patient LVP.

Conclusion Malignant ascites is a condition that has a significant impact on a patient’s quality of life. We have collated a NICE accredited guideline to help consolidate evidence and standardise the approach to management of these patients.