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

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**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.

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### A NICE ACCREDITED GUIDELINE FOR THE MANAGEMENT OF MALIGNANT ASCITES

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**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.

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

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**Background** The prescribing of injectable end-of-life anticipatory medications ahead of possible need is recommended practice. The financial costs of anticipatory medication remain unknown.

**Aims** To identify the prescription, usage and wastage costs of anticipatory medications dispensed to patients living at home and in residential care.

**Design** Retrospective observational study using general practitioner and community nursing records.

**Data Collection** Data were collected from eleven general practitioner practices using the records of the last 30 most recent deaths per practice. Patients were aged 18+ and died between 2017–2019 from any cause except trauma, sudden death or suicide.

**Analysis** Anticipatory medications were prescribed to 167/329 patients, of which 164 were included in the analysis. Costs were analysed at both patient-level and drug-level using univariate and multivariate quantitative analysis.

**Results** Median anticipatory prescription cost was £43.17 (IQR: £38.98–£60.47, range £8.76 to £229.82). Median administration prescription cost was £2.16 (IQR: £0.00–£12.09, range £0.00 to £83.14). Median wastage was £41.47 (IQR: £29.15–£54.33, range £0.00 to £195.36). Prescription, usage and wastage costs were significantly higher for patients prescribed an anticipatory syringe driver. There were wide