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.

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 practice. These were collated and reviewed by the guideline development group (CDG) and a guideline drafted.

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.
variations in the wastage costs of individual drugs; Haloperidol and Cyclizine contributed 49% of the total wastage costs. **Conclusion** The prescription and wastage costs of anticipatory medications are higher than previously estimated but remain modest. Usage of prescriptions is lower than previously expected. There may be scope to reduce the quantity of drug vials that are routinely prescribed without adversely affecting care; prospective clinical trials are needed to explore this possibility.

**167 CLINICIANS’ PERSPECTIVES ON MORPHINE USE IN CHRONIC BREATHLESSNESS: FINDINGS FROM AN IMPLEMENTATION SURVEY**

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**Background** Morphine may help people with chronic breathlessness. This sub-study investigates clinicians’ perspectives on morphine use as part of the Morphine And BrEathLessness (MABEL) trial to assess the effectiveness and cost-effectiveness of morphine in chronic breathlessness.

**Method** Mixed-methods study using Normalisation Process Theory to organise data collection and analysis of clinicians’ perspectives on morphine use for chronic breathlessness. Clinicians completed two surveys: 1. Learning Needs Assessment (LNA) survey; 2. Modified Normalisation Measurement instrument (NoMAD) at two time-points (immediately and four months post-training) to identify implementation barriers and facilitators.

**Results** 59 clinicians were recruited from 12 sites, (28 doctors; 22 non-prescriber nurses; 6 prescriber nurses; 3 other healthcare professionals; 90% hospital-based; 74% female; years of experience 1 to >15 years). 1. LNA survey. More than two-thirds of clinicians strongly agreed, agreed, or somewhat agreed they had learning needs about using morphine for chronic breathlessness. 2. NoMAD 1. 93% saw the potential value of morphine for breathlessness and drive appropriate use of it. However, only one third agreed that sufficient staff training and resources were available to support use of morphine for breathlessness in practice. NoMAD 2 showed a small increase in the proportion agreeing that the intervention was familiar and felt ‘normal’ compared to NoMAD 1 (70% to 85%).

**Conclusion** Clinicians recognise learning needs about the safe prescription and management of morphine for chronic breathlessness in practice. The potential value of morphine is recognised, but lack of training and resources are barriers to implementation.

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**168 CASE REPORT – HUNGRY FOR THE OPTIMAL REGIME: A PATIENT-DESIGNED METHOD TO WITHDRAW ARTIFICIAL FEEDING AT THE END OF LIFE**

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**Background** There is currently no defined approach for altering feedvolume to withdraw artificial feeding when a patient with neurological disease requests it, at the end of their life.

**Aims** We present a patient-designed regime used to withdraw artificial feeding in the community, without the patient experiencing distressing symptoms of hunger, enabling peaceful death at home.

**Case Study Description:** A 58 year old man with Motor Neurone Disease chose to stop artificial feeding when his communication and movement were severely limited. The patient decided they no longer had quality of life and wanted to withdraw feed to allow natural death. At this stage they were receiving 1000mls of feed via PEG tube within 24 hours. The patient’s main concern was to avoid developing hunger and related pains. They chose to reduce their feed in 250ml per week stages, over a 4-week period. Their reasoning was due to a previous positive experience of reduction of feed by 250mls for symptom management of secretions. The patient felt this would be the least symptomatic approach to withdrawal.

**Results** No hunger was experienced during staged withdrawal. At the point when feed and fluids were stopped completely, the patient experienced some mild, intermittent hunger but was not distressed by it. Nausea and secretions occurred and were addressed with standard palliative approaches.

**Conclusion** This approach was effective for this patient, who only experienced mild symptoms of hunger; however, we cannot be certain it would be effective in all situations. There is currently no recognised guidance for withdrawal of artificial feeding in these circumstances. Given the relative infrequency of these cases, research on a large scale would allow collation of data to devise and develop the optimal regime. We feel it is important this can be facilitated in a patient’s home as well as in healthcare settings.

**169 BREATHLESSNESS EXPERIENCES OF INDIVIDUALS WITH HEART FAILURE IN TURKIYE: A DESCRIPTIVE QUALITATIVE STUDY**

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**Background** Breathlessness is one of the most prevalent symptoms of heart failure in hospital and community-dwelling cohorts. Since breathlessness affects their daily life experiences, individuals try to manage their own breathlessness first rather than seek help sooner. Management varies regardless of individual assessment, but there is no data on the breathlessness experiences and support needs of individuals in Turkish culture.

**Aim** To explore (1) individuals’ self-reported symptoms associated with heart failure: (2) their breathlessness descriptions related to affected factors and impacts on their life: (3) their breathlessness management strategies: and (4) their needs for a comprehensive breathlessness management strategy based on their previous breathlessness relief motivations.

**Methods** A descriptive qualitative study. Twenty individuals with heart failure in Turkey were recruited for one-to-one interviews. Everyone took part in a semi-structured (face-to-face/telephone/email) interview exploring their breathlessness...