P-35 PALLIATIVE FOREQUARTER AMPUTATION FOR INTRACTABLE PAIN IN METASTATIC CANCER – A CASE REPORT

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Background Forequarter amputation (FQA), involving the removal of the upper extremity, scapula and clavicle, is a safe and reliable procedure for palliation of intractable pain, lymphoedema and limb dysfunction in patients with metastatic disease of the shoulder girdle.[1] Although first reported in 1836, use of FQA remains controversial due to the radical nature of the procedure. However, some authors argue it is a justified last resort to provide substantial relief and improve quality of life.[2]

In this report, we discuss the use of FQA for intractable pain in metastatic carcinoma and considerations involved in ensuring patient-centred care.

Methodology A 70 year old right-hand dominant male farmer presented with intractable pain from shoulder girdle metastases of laryngeal squamous cell carcinoma. The management of the primary tumour involved laryngectomy, right hemi-thyroidectomy and neck dissection but the patient declined radiotherapy. He later developed a right shoulder mass over 6 months, progressively increasing in size, causing intractable pain, lymphoedema and limb dysfunction, leading to hospital admission. His metastases was too extensive for radiotherapy, thus referred to a quartenary hospital for FQA.

His medical history include congenital albinism with partial blindness, Takusubo cardiomyopathy and large incisional hernia from previous laparotomy for perforated diverticulum. He communicated via the laryngectomy stoma, had a nasogastric tube for dysphagia, and Australia-modified Karnofsky Peformance Scale (AKPS) 40. Furthermore, he had low health literacy and relied on his wife to oversee his health issues.

Staging PET and MRI confirmed large metastases, 21cm, eroding the right humerus with extensive muscle and brachial plexus involvement. He had pulmonary metastases and synchronous colorectal tumour. Prognosis was thought to be less than 3 months.

There were clinical and ethical concerns regarding the potential morbidity and mortality of performing major amputation on a debilitated patient with metastatic disease, low AKPS and short life expectancy. However, pain control and quality of life were imperative, compounded by the fact that he found the heavy non-functioning arm burdensome even if it became pain-free.

The risks and benefits of amputation was discussed with the patient and his family to provide realistic expectations. The patient was keen to undergo FQA, burdened physically and psychologically by the arm, aware of complications and prognosis.

Results Multiple agents (lignocaine, hydromorphone, methadone, clonidine, dexamethasone, mirtazapine and ketamine) were used concurrently with limited effect and increasing side effects. Interventional strategies met with varying levels of success. Although brachial plexus block provided good relief, it was not sustained beyond 24 hours as interscalene catheter was repeatedly dislodged.

Patient underwent FQA with significant pain relief and opioid reduction. There was also psychological relief with removal of the burdensome arm. The complications of pulmonary embolism and mild phantom limb pain had minimal effect on the patient. Patient was transferred to his local hospital where he died less than one month later from complications of his malignancy.

Conclusion FQA for metastatic carcinoma can significantly improve pain and quality of life. This case highlights the importance of thorough informed discussion to ensure patient-centred care whilst navigating complexities in shared decision making.

REFERENCES

1. Wittig JC, Bickels J, Kollender Y, *et al*. Palliative forequarter amputation for surgical technique, and results. *J Surg Oncol*. 2001;**77**(2):105–113.
2. Merimsky O, Kollender Y, Inbar M, *et al*. Is forequarter amputation justified for palliation of intractable cancer symptoms?. *Oncology* 2001;**60**(1):55–59.

P-36 IMPROVING PALLIATIVE CARE SERVICE PROVISION THROUGH THE APPLICATION OF A QUALITY AND SAFETY AUDIT TOOL

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Background In 2018, Palliative Care Australia issued a report outlining nine standards which intended to guide and support the delivery of high-quality palliative care in Australia. Standard 8 encouraged services to structurally integrate quality improvement into their care provision.[1] The changing patient demographic marked by increasingly older patients affected by chronic disease and the growing variety of interventions available contribute to increasing complexity in palliative care.[2] Quality improvement seeks to address these emerging complexities and the knowledge gaps that exist. Its aim is to improve and develop service provision by identifying best practice in the care of individuals affected by life-limiting illness.[2 3]

Objectives The quality and safety audit tool was introduced to improve palliative care service provision at Austin Health, a tertiary metropolitan public hospital in Victoria.

Methods The tool is utilised in fortnightly meetings attended by clinicians across the palliative care service. Contributing teams include the palliative care ward, consults, clinic, and outreach service. Aligned with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care, fifteen 'Quality Alerts' form the framework used to systematically identify patient cases that warrant discussion.[4] These 'Quality Alerts' reflect the multidimensionality of palliative care and cover areas such as quality of death, challenging symptom management, family distress, voluntary assisted dying requests, care dissatisfaction, complex case management, service partnership issues and referrals for interventional procedures and outcomes. These cases and issues are then reviewed during these meetings, where actionable outcomes are documented and taken forwards by allocated clinicians. This process allows for internal 'peer review' to occur, demonstrating both successes in care and areas for improvement.[2] Providing a safe and approachable environment in which to explore these cases is essential to its efficacy.

Results This framework prompts regular dialogue about patient care and service provision, providing a space for clinicians to reflect and debrief. It has translated into service-wide benefits including the strengthening of interdepartmental relationships,