New Zealand and Australia, the most commonly prescribed options were similar. Opioid supply issues are impacting the evidence-based practice of experienced clinicians in Australia and New Zealand. Constructing stronger government policy is recommended for the ongoing safety and efficacy of cancer pain management.

P-41 CALCIPHYLAXIS AND PALLIATIVE CARE. COMPLEX SYMPTOMS, TREATMENT SIDE EFFECTS AND CHOOSING THE OPTIMAL MODEL OF SUPPORTIVE CARE. A CASE STUDY AND DISCUSSION

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Calciphylaxis, or calcific uraemic arteriolopathy (CUA), is a clinical syndrome usually associated with advanced renal disease, which is characterized by vascular calcification and the development of painful ischaemic ulcers. It is a rare disease, with an incidence of only 4.5 cases per 1000 patient-years on dialysis (Toussaint et al 2024). Diagnosis generally implies a poor prognosis, with an overall mortality of approximately 50 per cent at six months (McCarthy et al 2016). Calciphylaxis also causes significant symptom burden, with painful skin lesions requiring a specialised approach to analgaesia. Treatments are limited and can result in adverse side effects. Despite its poor prognosis and significant symptom burden, only a minority of patients diagnosed with calciphylaxis are referred for specialist palliative care (Gaster et al 2021).

We present a case of a 53-year-old female with previous renal transplant, admitted to Monash Health, Melbourne with non-uraemic calciphylaxis. She was referred to our specialist palliative care consult service for management of complex disease and treatment-related symptoms. Ischaemic wound pain in calciphylaxis is well described, and our patient required multiple analgaesic agents to achieve adequate pain relief. However, her most burdensome symptom was severe nausea and vomiting, which related to sodium thiosulfate infusions – one of few recognized treatments for the disease.

After failing first and second-line anti-emetics, a levomepromazine infusion enabled adequate tolerance of sodium thiosulphate treatment. She was transitioned from levomepromazine to intermittent doses of oral olanzapine, administered as premedication to therapy. Once she achieved a treatment response, she was discharged home, returning for maintenance therapy with intermittent sodium thiosulfate infusions administered as an outpatient, in a day-clinic infusion setting. At this time, her palliative care was transitioned to our Monash Hospital-in-the-Home Palliative Care (HITH PC) team. At the time of writing, sodium thiosulfate infusions have continued for over 6 months, with an enduring response, well tolerated with the above premedication regime.

Traditional community palliative care models were not well equipped to meet this patient's needs. Her uncertain prognosis, and active goals of care, precluded a solely symptom-based focus. Her medical complexity and the interplay between supportive and active care (with frequent nephrology intervention) also meant that consolidating treatment teams within the one health service offered the best continuity of care. Our HITH PC service provided a transformative model to deliver specialist palliative care interventions as required.

Our case highlights the role of specialist palliative care working in novel ways, alongside nephrologists in providing optimal symptom management to manage the complex symptom burden associated with calciphylaxis and its treatments.

P- 42 HITH PALLIATIVE CARE – BRIDGING GAPS BETWEEN TRADITIONAL COMMUNITY AND INPATIENT PALLIATIVE CARE MODELS

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Community palliative care (CPC) services provide a comprehensive service to many patients with life limiting conditions. Factors which may challenge traditional community models include responding to same-day requests for admissions, admitting clients who wish to pursue active treatment alongside symptom management and managing patients who have complex treatment plans whose care is still overseen by hospital-based specialists. Another recognised challenge is communication between hospital and community providers, particularly during acute admissions. This is important for optimal transition of care both on admission and when patients return home. In response to these challenges, Monash Health developed a Hospital-In-The-Home Palliative Care (HITH PC) service with dedicated palliative medicine specialist EFT and additional consult support from our RAPID palliative care team. This service aims to overcome deficiencies in traditional models, and support patients to receive specialist palliative care acutely in the community setting when desired.

Our HITH PC model provides outreach care to varied patient cohorts. Our largest cohort includes patients with recurrent pleural effusions and ascites, requiring frequent drainage via indwelling Rocket and PleurX drains. These patients receive regular visits from HITH nursing staff for drainage of pleural effusions and ascites, as well as specialist palliative care which is provided via a telehealth model. Many of these patients are jointly managed with CPC, and their care is discussed at a weekly HITH PC MDT. A second HITH PC model is delivering continuous subcutaneous infusions of palliative care medications when required for optimal symptom management or end of life care. This service supports patients to be discharged from hospital earlier, and avoids unnecessary ED and acute hospital presentations. Deteriorating RACF patients with unstable symptoms can be admitted same-day to our service for urgent assessment and initiation of care, whilst awaiting transition to traditional CPC models. HITH PC is also able to oversee complex cancer pain management, involving opioid rotations or titration guided by palliative medicine in a bed-substitution model of care.

A key initiative is our weekly HITH Palliative Care Multidisciplinary Discussion Team Meeting (MDT). This meeting is attended by medical, nursing and allied health staff from Monash Health HITH and Palliative Care teams, as well as clinical representatives from our regional CPC services. It enables direct and regular discussion of joint clients, to optimise handover and ensure seamless transition of care between services. Having evolved during the COVID-19 pandemic, a period of transformation in community care provision, this meeting is now an established part of our usual care.

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