

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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Calciophylaxis, or calcific uraemic arteriopathy (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). Calciophylaxis also causes significant symptom burden, with painful skin lesions requiring a specialised approach to analgesia. 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 calciophylaxis 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 calciophylaxis. She was referred to our specialist palliative care consult service for management of complex disease and treatment-related symptoms. Ischaemic wound pain in calciophylaxis is well described, and our patient required multiple analgesic 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 thiosulfate treatment. She was transitioned from levomepromazine to intermittent doses of oral olanzapine, administered as pre-medication 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 calciophylaxis 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 Multi-disciplinary 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.

To date, our HITH palliative care model has serviced over 320 clients. Interventions such as our MDT have transformed our relationships with CPC partners and improved our transitions in care. We have provided HITH PC to over 200 patients with Rocket/PleurX drains. Our specialised care cohorts have enabled many patients with complex care needs to receive complex interventions and to remain in the community for longer. Our HITH PC service challenges and augments traditional models, to improve care for our community.

P-43

### EVERYBODY'S TALKING: IS PAT THE NEW VAD? A NARRATIVE REVIEW OF PSYCHEDELIC ASSISTED THERAPIES FOR PEOPLE FACING LIFE THREATENING ILLNESS

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**Background** Psychedelic therapies for treatment of treatment-resistant depression (TRD), and PTSD garner high interest (e.g. New England Journal, Cochrane, Nature Medicine). Research and use is current people living with the existential challenges of a terminal illness. We explore what is known about the use of Psychedelic Assisted Therapy (PAT), indications for use and outcomes of importance in this group. **Aim:** To review the evidence for PAT for people facing life threatening illness. **Method:** We use narrative review to identify themes regarding the evidence, clinical considerations, of PAT in people facing life threatening illness.

**Results** We found several important studies, licencing approvals, and themes

- In July 2023, Mitchell, J.M. et al. MDMA-assisted therapy for moderate to severe PTSD: a randomized, placebo-controlled phase 3 trial. This article ranked in the 99th percentile (ranked 60th) and the 98th percentile (ranked 2nd) of articles of a similar age in Nature Medicine.

- 2024 the US Food and drug administration is reviewing the application for MDMA supported therapy for this indication with a decision expected this year.
  - o Schipper S et al have recently had a systematic review and meta analysis accepted by Cochrane (2024), their findings suggest more investigation of a role for PAT of anxiety, depression and existential distress, for patients with life-threatening disease.
- The Australian Therapeutic Goods acceptance of the indications permit prescribing MDMA for the treatment of post-traumatic stress disorder (PTSD) and psilocybin for treatment-resistant depression (TRD) by psychiatrists who are specifically authorised under the TGA's Authorised Prescriber scheme, is effective from 1 July 2023.
- Seven reviews for indications in palliative care settings are currently underway, with a total recruitment target of 720 participants.
- These emerging treatments require engagement from clinicians, consumer and advocacy groups, to understand the evidence the particular issues associated (e.g. in PAT, informed consent poses challenges) Other issues to be

discussed are costs, a potential role for Palliative Care Physicians in diagnosis, referral, and palliative care multidisciplinary team members as potentially skilled co-therapists PAT.

- Critically, training for this emergent modality is pertinent.

**Discussion** These studies and decisions including the US FDA MDMA in PTSD and results of current studies in PAT for patients with prognoses up to 2yrs will shape our practice. Although mentioned in the successful TGA application, PAT for existential distress (unless for TRD or PTSD) in people receiving palliative care is not approved. At this stage we can say the following themes are present in the literature, efficacy and ethics in palliative care settings, ethics of consent, training accreditation and governance. **Conclusion:** Strategies to better understand safe integration of PAT in to care for people with life limiting illness are needed.

P-44

### A SYSTEMATIC REVIEW OF OPIOID ANALGESIC USE IN PATIENTS WITH KIDNEY DISEASE

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Opioid analgesics are useful in the management of moderate to severe pain. A number of patients taking opioids have compromised kidney function, guidelines and recommendations exist, however at the time of review the evidence backing recommendations for analgesic choice in kidney disease was unclear. In this systematic review we examine the available evidence on the safety and analgesic effect of opioid use in adults with kidney disease. Eight electronic databases were searched from inception to January 2023. Articles in English, reporting on opioid use and pharmacokinetic data among adults with kidney dysfunction were included. Article screening, data extraction, and quality assessment were conducted by at least two investigators independently. This review was registered prospectively on PROSPERO (ID: CRD42020159091). 32 observational studies included, 14 of these reported on morphine, 3 related to fentanyl, two hydromorphone use and 13 articles reported on other opioids including codeine, dihydrocodeine, and buprenorphine.

We found there is limited and low-quality evidence to inform the safety and analgesic effect of opioid use in kidney disease. Morphine remains the opioid for which there is the most evidence available on safety and analgesic effect in this context. Caution and consideration of potential risks and benefits should be applied when using all opioids, beyond that we suggest the context of dose, half-life and pain or non-pain indication (eg breathlessness) must be considered for each individual. Further at opioids at low to moderate doses, morphine may be a safer option than non-morphine especially if increased dosing interval or short duration of treatment is appropriate. Further high-quality studies examining clinical