

used it covertly or admitted to using it for reasons other than pain.

- 4/18 had risk factors for addiction. 3 of these 4 patients showed 'concerning use'.
- 9/18 patients were discharged on buccal fentanyl; there was scope for improvement in the quality of discharge instructions as to how the patient should use buccal fentanyl.

**Conclusions** 5/18 patients (28%) were felt to have 'concerning use' of buccal fentanyl. 3 of these had clear risk factors for addiction this that were identified on admission. Since the time of data collection, the manufacturers have produced a guide for healthcare professionals that includes standardised screening tests for assessing the risk for potential opioid abuse in patients with breakthrough pain. Routine use of these should be considered, with clear explanation of risks shared with all patients, but particularly those with pre-existing risk factors. Patients discharged on buccal fentanyl should be discussed with the GP and have a clear plan on the discharge letter as to the dose, frequency, and type of pain that this is to be used for, along with the rationale.

#### 104 SODIUM VALPROATE SUBCUTANEOUS INFUSION; A VALUABLE ADJUNCT IN THE MANAGEMENT OF NEUROPATHIC PAIN IN PALLIATIVE PATIENTS

C Davis, HK Crispin, C Marshall, S Haig, S Pennell, A Jenks. *University Hospital Southampton NHS Foundation Trust*

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**Introduction** Sodium valproate continuous subcutaneous infusion (CSCI) may be underutilised in the multi-modal management of neuropathic pain especially for patients requiring parenteral pain management due to phase of illness or symptom severity. We present a case series of adult patients treated with a sodium valproate CSCI.

**Method** Prospective data collection; six consecutive clinical cases managed by the Hospital Specialist Palliative Care Team (HSPCT) during final quarter of 2017.

Sodium valproate was commenced at a dose of 200–600 mg/24 hour, in conjunction with a separate opioid or midazolam CSCI. Doses were up-titrated individually to between 400 mg/24 hour and 1500 mg/24 hour (maximal increments of 300 mg/24 hour).

**Results** 4/6 patients had metastatic cancer, one cervical myelopathy and one osteoradionecrosis of the base of his skull; all had clinical reasons to require parenteral treatment. 5 experienced clinically significant improved pain control within 48 hours; allodynia resolved in the two patients who experienced this, one of whom had residual severe nociceptive pain due to rapidly progressive disease. There was no initial benefit attained in the patient whose starting dose was 200 mg/24 hour, but a dose of 400 mg/24 hour was beneficial. There were no complications attributable to this treatment. Only 2/6 patients required an increase in opioid dose.

**Conclusion** Unlike most neuropathic pain agents, sodium valproate is available in a parenteral preparation. Other benefits include that it is non-sedating and relatively safe in patients with renal impairment although dose modification is recommended. Six patients with a neuropathic component to their pain treated with sodium valproate CSCI as part of a multi-modal analgesic strategy achieved rapid, efficacious control of their neuropathic pain. Titration was achieved over the course

of days, the treatment was well-tolerated. We have found a starting dose of 400 mg/24 hour to offer clinically relevant improvement in pain control. This case series supports our impression that it is an opioid sparing intervention.

## Service development | Posters 105–151

#### 105 PALLIATIVE CARE NEEDS OF ADULTS WITH NEUROMUSCULAR DISORDERS: A PILOT CLINIC

Mike Macfarlane, Tracey Willis, Derek Willis. *West Midlands Deanery, The Robert Jones and Agnes Hunt Orthopaedic Hospital, Severn Hospice*

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**Background** Neuromuscular disorders (NMD) have traditionally been managed by paediatric services. As more patients with these conditions are now living into adulthood, however, it is unclear a) what the palliative care needs are for this new adult population and b) how palliative care services can meet these needs.

**Methods** A 12 month pilot clinic was run jointly by a palliative medicine consultant and members of the neuromuscular multidisciplinary team (MDT) from a regional NMD centre. The aim of the clinic was to assess a) the number of patients, b) diagnoses and c) symptom burden that required palliative care input.

Patients were recruited if the NMD MDT assessed that they had significant symptom burden or that their disease trajectory had changed.

**Results** 9 patients were recruited to the joint clinic which was conducted 4 times in the year. These patients had a range of neuromuscular conditions and a variety of symptoms. Pain was the most commonly encountered symptom and ranged from very mild to severe with a mean pain score at initial assessment of 3 out of 5 (moderate).

**Conclusions** Adult patients with a variety of neuromuscular disorders were identified as having an unmet palliative care need. A range of symptoms were identified, with moderate pain being the most common. Despite these patients' symptom burden they are seldom referred to palliative care services.

#### 106 ARE REFERRALS FOR NON-INVASIVE VENTILATIONS (NIV) IN PATIENTS WITH MOTOR NEURONE DISEASE (MND) PROCESSED IN A SHORT TIME?

Thurkaa Shanmugalingam, Harriet Roebuck. *Colchester Hospital University Foundation Trust (CHUFT)*

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**Background** Patients with MND are at risk of respiratory compromise due to chest wall weakness and require NIV. As prognosis is short this should be a rapid referral to respiratory services. We advise that time between referral and assessment should be aimed at <6 weeks.

**Methods** Neurorehabilitation team lead supplied the details of eight MND patients referred for NIV assessments to Colchester Hospital (CHUFT) within the last twelve months. The usual referral pathway is via Papworth Hospital Cambridge but these patients were either too unwell or had chosen not to travel to Cambridge for assessment. A review of the patient's paper notes, Order comms system, Electronic