

Conclusion There is clearly a need for greater awareness of the pharmacology in symptom control in end-stage liver disease. As a result of this study, peer-reviewed clinical standards and guidelines are being formulated for the management of specific symptoms related to end-stage liver disease to provide standardised care across the network.

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PLANT: 'PALLIATIVE LIFE-STATE & NUTRITION TOOL' © – REVIEW OF THE USE OF PLANT IN A HOSPICE

Eleni Tsiompanou. *Woking and Sam Beare Hospices, Health Being Institute, College of Medicine*

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Background Palliative patients have a number of dietary concerns. The first step to good nutrition care is nutrition assessment. The PLANT tool, developed with the support of a multidisciplinary team, highlights problems that affect the intake, digestion and assimilation of food and overall quality of life. It has been offered to the community and in-patient unit teams of a hospice for use.

Methods a retrospective review of 30 randomly chosen PLANT tools filled in the last 6 months was done. Hospice staff were asked to give feedback about its' use.

Results 13% of patients had special dietary requirements and 13% food allergies and intolerances. 77% had lost weight while 23% had gained weight. 70% of patients were concerned about their weight. In 73% of cases current weight was recorded, while BMI was calculated in only 33%.

Symptoms in order of frequency were: fatigue 100%, dry mouth 87%, sadness or depression 87%, reduced appetite 83%, flatulence 83%, sleep problems 80%, constipation 77%, taste or smell changes 73%, nausea 73%, abdominal bloating 67%, abdominal pain 63%, belching 63%, sore mouth/throat 60%, hiccups 60%, vomiting 53%, loneliness or isolation 53%, diarrhoea 43%, nocturnal defaecation 43%, heartburn/acid reflux 33%.

Hospice healthcare professionals found the tool innovative and useful. However, some thought it was inappropriate to ask palliative care patients about weight and eating related symptoms and voiced their concern that it would cause unnecessary distress to patients. Furthermore, some of the staff thought that it was adding to their workload by having to fill in yet another tool.

Conclusions The PLANT tool can help to identify key symptoms that affect the nutritional state and overall life-state of patients. More work is needed to increase awareness amongst healthcare professionals of the impact of nutrition problems on patients' health, disease and sense of wellbeing.

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AUDIT OF COMPLIANCE WITH NICE GUIDANCE ON PRESCRIBING STRONG OPIOIDS

Tammy Oxley, Lucy Walker, Sophie Thomas, Yasmin Rejaei, Debbie Atkinson. *Mid Yorkshire NHS Hospital Trust*

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The 2012 NICE guidelines on prescribing strong opioids cover prescribing in advanced disease. The aims of our audit were to demonstrate compliance with these guidelines at The Mid Yorkshire Hospitals NHS Trust (MYHT).

A prospective audit was undertaken and data collected from 97 patients who had been started on strong opioids across MYHT. Patients included were those reviewed by the hospital and community Specialist Palliative Care Team (SPCT) and inpatients on both respiratory and oncology wards. Patients reviewed by the SPCT team were identified using the weekly patient MDT list and further information found using SystemOne. Hospital inpatients were identified using the controlled drug books and cross referencing with medical notes.

48% of patients were initiated on a strong opioid without having previously been on a weak opioid. Information giving was poor with only 0%–20% of the audited patients being informed about specific matters documented in the NICE guidelines, including advice regarding drowsiness and driving. Disappointingly, only 42% of patients commenced on a strong opioid were also prescribed a laxative. Prescribing in renal impairment was not fully in line with NICE guidance suggesting consultation with a specialist if moderate to severe impairment present – in 4/6 cases where inpatients (excluding those reviewed by the SPCT) had an eGFR of <30 no specialist input was sought.

Limitations of the audit include that a relatively small data set was collected from each clinical area. In addition, the audit relied on healthcare professionals formally documenting decision making and discussions with patients in the notes.

Recommendations include sharing the results with the audited specialities and specific education regarding the benefits of using a trust-wide opioid leaflet to assist with information giving. A quality improvement project focusing on improving co-prescribing laxatives was subsequently undertaken within the respiratory department.

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HYPONATREMIA IN PALLIATIVE CARE; IS IT ALWAYS SIADH?

Abraham M Varghese, Sunitha M Daniel. *Little Flower Hospital and Research Centre, Angamaly, Kerala, India, Amrita Institute of Medical Sciences, Amrita University, Kochi, India*

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Background Hyponatremia, the most common electrolyte disturbance in clinical practice affecting up to 15%–28% of admitted patients, is defined as a serum sodium concentration ($[Na^+]$) <135 mmol/L. Hyponatremia at admission is known to increase the duration and cost of stay of hospitalized patients. The prevalence of hyponatremia in palliative care is about 28% of at the time of referral. Hyponatremia can be asymptomatic or can cause symptoms like nausea and lethargy to convulsions and coma. It is important to evaluate the cause of hyponatremia to have a targeted management strategy.

Methods A retrospective case note analysis was carried out among patients admitted under a palliative care unit of a tertiary referral hospital in South India, over a period of 6 months. The sodium level on admission and during the inpatient stay, along with symptoms, drug history and cause of hyponatremia was evaluated.

Results Out of 11 patients who presented with hyponatremia, median age was 59;7 patients were male. All the patients had a cancer diagnosis, with 28% had cancer of GI tract,91% had stage IV disease. The median sodium level on admission was 125;82% had hypotonic hyponatraemia. 37% were asymptomatic on presentation,while 18% had generalised weakness.

Median number of drugs for each patient was 4 and a number of drugs were implicated to cause hyponatremia. 55% of patients were found to have a diagnosis of SIADH, the other causes were extrarenal solute loss (18%), Pseudo hyponatremia (18%) and cirrhosis (9%). Only 45% were treated with Tolvaptan, while the rest had sodium replacement, fluid restriction and other supportive care. 27% died during the admission and 36% died within the next 6 months of discharge.

Conclusions SIADH is not always the cause of hyponatremia in palliative care patients, hence there is a need for accurate diagnosis of patients to enable a targeted management strategy.

155 THE ROLE OF PALLIATIVE MEDICINE IN END STAGE DUCHENNE MUSCULAR DYSTROPHY

Brian Mburu, Derek Willis. *Severn Hospice*

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Background Duchenne Muscular Dystrophy (DMD) is a progressive muscle wasting disease. It is the most common type of muscular dystrophy in the UK. Those affected usually die in their late 20s or early 30s due to cardiac or respiratory problems. As the disease progresses they may need management of symptoms arising from complications of late disease, such as pain. This poster looks into the joint services provided by the community palliative team at Shrewsbury and Telford Severn hospice and the Oswestry neuromuscular clinic caring for five patients with advanced Duchenne muscular dystrophy. **Methods** The notes from the clinic consultations of the five patients involved were perused and the consultations noted, along with the proposed management plan. Subsequent clinic follow ups were looked into to review response to the management plan and note any amendments to treatment that were made.

Results The five patients presented with pain as their main symptom. Different choices of analgesia were tried with different responses. All patients reported improvement in their symptoms after starting analgesia with some requiring a combination of analgesics. In addition to this, some of the patients required input from other services regarding other aspects of patient care, such as the respiratory team for sleep studies and assessment for ventilatory support, or access to the hospice for various social events in a safe and welcoming environment.

Conclusion As there are no guidelines for management of DMD, management may involve trials of different analgesia for pain management in addition to involvement of a multi-disciplinary team to address other care issues. As palliative medicine involves symptomatic treatment of patients with advanced and terminal disease and holistic care, there is a role for palliative medicine in management of patients with end stage Duchenne muscular dystrophy.

156 CANNABIS USE IN A RURAL PALLIATIVE CARE COMMUNITY: A SURVEY

Lynn Davies, Alice O'Connor, Caroline Hart. *Severn Hospices, Shropshire*

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Interest in Cannabis as a medicinal product is growing globally; recent scheduling review of Cannabis by the Chief

Medical Officer puts forward a strong case for the therapeutic benefit of cannabis-based medicinal products. We have noticed an increased incidence of questions, from patients and carers relating to Cannabis use. More patients appear to confide in us about their use of Cannabis. The incidence of Cannabis use in a palliative care population is little known.

We undertook a sequential survey of fifty patients referred into and triaged as requiring domiciliary review by the Severn Hospice Nurse Outreach team. Each patient was asked at the end of the usual initial assessment whether they would take part in the anonymised survey.

Results 50 consecutive patients referred to the Shropshire community palliative care team (outreach specialist nurses) 36 patients completed the survey.

Of 36 questionnaires completed 8 patients declined completion. 10 patients (almost a third of those completing the survey) had considered using Cannabis, 18 had not.

The study population (n=36) were mainly aged over 70 (n=21). Gender split was fairly equal. Of those who had considered cannabis (n=10), the main reason was for pain relief (n=6). Other reasons included general wellbeing and treatment/cure. Half of those who had considered cannabis were on chemotherapy. Ages in the 'cannabis curious' group tended to be younger – with 40% aged less than 70. Half of these had researched Cannabis using only Media sources.

Conclusions In a survey of 50 palliative care patients in a rural county of England asked 'Have you considered the use of Cannabis' most had not. Of 10 patients who said they had considered it, the most commonly cited reason was Pain relief.

157 SYMPTOM CONTROL OF DYSPNOEA IN PATIENTS WITH CYSTIC FIBROSIS

Claribel Simmons, Krishna Dani. *Health Education North East, NHS Greater Glasgow and Clyde*

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Background Cystic fibrosis (CF) remains an incurable condition in respiratory medicine. One of the main symptoms is dyspnoea. CF is a multi-system disorder and treatment of pulmonary symptoms tends to focus on medication which can be nebulised therefore minimizing the systemic side effects. Traditionally in palliative medicine opioids are effective at relieving dyspnoea however nebulised opioid is not routinely recommended. In patients with CF who are at risk of gastrointestinal complications such as a distal intestinal obstruction syndrome (DIOS), administration of nebulised opioids has been sporadically reported to improve dyspnoea and minimize the risk of constipation.

The aim of this systematic review was to examine the role of nebulised opioids in improving dyspnoea in patients with CF.

Methods Medline (1946–2018) and Embase (1974–2018) were searched. Eligible studies met the following criteria: patients with CF, patients >13 years of age

Results 70 studies were eligible. Three studies fulfilled the criteria for review. The three studies described different case reports of nebulised opioid in patients with CF. The ages ranged from 13 years to 48 years. All patients had end stage respiratory failure due to CF. Two patients received nebulised morphine and one patient received nebulised fentanyl.