Palliative OPAT at SWFT

DR HELEN DILLON

CONSULTANT IN INFECTIOUS DISEASES & ACUTE MEDICINE.

WARWICK HOSPITAL

OPAT at SWFT

- The team
  - Dr Helen Dillon (Consultant ID/Acute Med. Clinical Lead)
  - Julie Wilkinson (Advance Practice Pharmacist. Team Manager)
  - Rachel Kenion (OPAT nurse specialist/Trainee ACP)
    - 4 Band 5 nurses (In post since Jan 2019)
    - 1 Band 3 Clinical/Admin support (In post Feb 2019)
- Running since Sept 2015
  - Partially funded initially
  - Business case went to board July 2017.
  - Funded service since April 2018

OPAT at SWFT

	2017/18	2018/19
No of new pts	195	270
Total no of pts on IVs	179	211
Total no of pts on just orals	16	59
Cum. bed days saved from IVs	5046	
Savings from IVs*	£1,766,100	
Bed equivalents from IVs	13.82	
Additional bed days saved from oral patients	593	
Total no of bed equivalents from IV & PO	15.44	

Palliative OPAT

2016/17 – 3 patients

- 2 PICC line infections
- 1 Liver abscess

Case 1 – Mr JS

- 66 year old man
  - Metastatic rectosigmoid adenocarcinoma (liver & bone mets).
  - Stopped Chemo 4/52 previously due to disease progression. Recent CT had shown liver abscess. Oncology consultant keen to treat as clinically stable.

- Day1: Long discussion with patient & daughter. Agreed on IV Ertapenem OD. Daughter taught to administer.
  - 14/7 IV. Clinical improvement. CRP 161 – 52
  - Admission to hospice for symptom control while on IVs. Hospice nurses gave IVs

- Day 14: Daughter concerned re:loss of appetite on IV Abx. Decided to trial PO Cipro.
  - Some nausea with PO Abx but maintaining weight and keen to continue
  - Repeat USS at 6 weeks showed abscess had reduced from 6.7-3.2cm. CRP 30

Mr JS

- Week 6: Discussions with him & his daughter re:stopping/continuing PO antibiotics. Keen to continue at that point.
  - Continued for a further 14/7 then agreed to trial stopping as negative side effects thought to be out weighing benefit.
  - Remained well.
    - Survived for a further 18/12!
    - Staging CT in Nov of 2017 showed resolution of previously noted abscess.

Palliative OPAT

- 2017/18
  - 11 patients
    - Liver abscess/infected liver mets (x2)
    - Pelvic abscess/Infected pelvic tumour
    - Sepsis of unknown source (?infected mets)
    - Thigh abscess
    - Discitis
    - Breast abscess
    - Line infection (x2)
    - UTI/Urosepsis (x2)

Types of ‘palliative’ patient

- 1.A patient with an end stage disease/disease with no further treatment options who develops an otherwise treatable infection.
  - E.g thigh abscess, urosepsis, PJI
- 2. A patient who develops an infection that is not likely to be curable without surgery and who due to frailty, personal choice or other comorbidities is not a candidate for invasive treatments.
  - E.g intraabdominal abscess, endocarditis, empyema.
- 3. A patient with advanced malignancy who develops an infection directly associated with their malignancy.
  - E.g infected liver mets, pelvic abscess.

Case 2: Dr JT

- July 2017
  - 54 year old lady.
  - Metastatic colorectal cancer (lung, peritoneal mets) with significant local invasion
    - Staging laparotomy in Jan 2017 , planned for palliative pelvic exenteration with subperiosteal excision. In preparation, rcvd 5 cycles of chemo. Unfortunately complicated by bowel perforation, needing emergency op + stoma. Bilateral nephrostomies.
    - Several episodes of sepsis secondary to chronic pelvic collection .
    - CT July 2017: Disease progression despite chemo. No longer candidate for surgery.

Dr JT

- July 2017 – referred to OPAT
  - Very frail. Losing weight.
  - Chronic PV discharge despite PO co-amoxiclav (distressing)
  - CRP 300

  - 11/07: IV Ertapenem. Husband trained to administer.
    - For life-long Abx of some form (suppressive).
    - Significant improvement clinically. CRP 114.
    - 10/08 switched to PO Levofloxacin
    - Regular OPAT review on orals (some via phone)

- 10/08-09/11
  - Remained in regular contact. Doing very well.
  - OPAT facilitated Blood transfusion x2 and dietician input.
- Mid Nov
  - CRP rising
  - Fevers/discharge/general health worsening
  - Agreed to restart IVs 23/11.
  - Once again, improved significantly on Ivs. Returned to a good QoL. Remained well until early Jan 2018.

- Jan 2018
  - Deteriorating despite Abx.
  - Lots of conversations with JT and her husband re:stopping Ivs
  - Decision to stop on 07/01.
  - Admitted to hospice 13/01.
  - Died peacefully 15/01.

Palliative OPAT

2018/19

14 patients (1 active)

- Line infection
- Urosepsis (x2)
- Discitis
- Septic arthritis (x2)
- PJI (x2)
- Infected pacing site
- Empyema
- Intraabdominal abscess
- Endocarditis
- Infected mets (x2)

Our experience

- Complex
- Time consuming
- Affect figures (readmissions)

- Positive outcomes – sometimes surprising!
- Excellent feedback – patients, families, referring consultants

- Different way of working
  - Reducing clinic reviews
  - Close working with family
  - MDT approach – palliative care, GPs, community nurses, family