Posters

PWE-001 ARE FEMORAL TUNNELLED CENTRAL VENOUS CATHETERS SAFE TO USE FOR HPN?

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Background Patients with Intestinal Failure (IF) require reliable intravenous access for provision of Parenteral Nutrition. Venous access for Home Parenteral Nutrition (HPN) patients with Type 3 IF can be compromised due to thrombosis of deep veins. Preferred choice of veins for central venous catheter are the supra cardiac veins. Femoral tunnelled CVC are avoided due to concerns of catheter related blood stream infection (CRBSI) and are considered as a last resort when all other thoracic CVC access is exhausted. We assess the outcomes of tunnelled femoral catheters in our cohort of HPN patients.

Methods We did a retrospective analysis of a prospectively collected data of all HPN patients and venous access from January 2013 to December 2018 managed at a National HPN Unit. The details of venous access, complications of CVC, sex and details of stoma extracted from database.

Results In a cohort of 9 HPN patients with tunnelled femoral CVC, 6 were females and 3 were males leading to a total of 8418 days. A total 3 episodes of CRBSI were recorded in 1 patient. All of the 3 episodes (methicillin – sensitive *Staphylococcus aureus* (MSSA), *Escherichia Coli* and CNS) were successfully salvaged. The average no of days for femoral CVC was 935 days. The rate of CRBSI was 0.35 per 1000 catheter days. 8 patients had stoma or open abdominal wound. There were no episodes of ipsilateral femoral DVT. The CVC was replaced for 2 patients due to fracture of CVC.

Conclusion Tunnelled femoral CVC CRBSI rate (0.35) is comparable to thoracic veins CVC CRBSI rate(0.31) in our unit. Furthermore femoral access could be considered as a reliable access to provide HPN. It may be considered as an option if more than 2 thoracic deep veins are occluded to prevent complete occlusion of SVC. We feel tunnelled femoral CVC is a safe option to consider for HPN

PWE-002 HOME PARENTERAL NUTRITION IN THE PALLIATIVE PATIENT: A SINGLE CENTRE EXPERIENCE

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Background Few studies have assessed the benefit of nutritional support in advanced cancer patients. We aimed to investigate survival in patients receiving parenteral nutrition (PN) for intestinal failure (IF) in the palliative setting and identify factors associated with improved survival.

Methods Patients were identified from a database in an IF tertiary referral centre. Data were collected retrospectively for all cancer patients who commenced PN for a palliative indication between 01/01/2011 and 31/03/2018. These included; age on commencing PN, time from diagnosis (first MDT) to

commencing PN (lead time), initial hospital admission length, cancer type, mechanism of IF, and date of death. Co-morbidities were recorded using the validated Charlson index. Mechanism of IF was subdivided into 3 groups; obstruction (n=30), short bowel syndrome/high output fistula (n=22), and other (n=4). Cancer diagnoses were grouped into gynae and peritoneal (n=26), gastrointestinal (GI) (n=18), and other (n=12). Categorical variables were compared using fisher's exact and continuous variables using Kruskal-Wallis. Survival rates were compared using Kaplan-Meier curves and cox regression. P<0.05 was used for significance.

Results 56 patients (mean age 57; 71.4% female) were identified during the study period. Patients with gynae/peritoneal primary were older when commencing PN (p0.02) compared to other tumour groups. Patients with gynae/peritoneal cancers also had a longer lead time prior to starting PN compared to the other groups (Kruskal-Wallis p0.01; Kaplan Meier p0.04).

However once PN was started there was no difference in mortality between groups. 90 day mortality was 38.4% for gynae/peritoneal, 27.7% for GI, and 25.0% for others (p0.633). 150 day mortality, the rate was 61.5% for gynae/peritoneal, 44.4% for GI, and 50.0% for others (p value 0.515). Kaplan-Meier curves appeared to diverge between gynae/peritoneal and GI cancers although this wasn't significant (p0.56) and cox regression showed near identical survival between these groups (HR 1.02 p0.97).

There was also no difference in mortality rates for different mechanisms of IF, 90 day mortality was 36.6% for obstruction, 31.8% for short bowel/fistula, and 0.0% for others (p0.372). 150 day mortality was 60.0% for obstruction, 45.5% for short bowel/fistula, and 50.0% for others (p0.647).

Conclusions Patients with slow growing gynae/peritoneal cancers have been diagnosed with cancer for longer than other cancer types prior to commencing palliative PN. However once PN is commenced survival between groups in this cohort was similar. An extended follow up and a larger sample size may yet demonstrate significant differences. A prospective study is required to assess for other factors that may influence survival.

PWE-003 HOW SUCCESSFUL IS BEDSIDE NASO-JEJUNAL PLACEMENT IN A NEURO-CRITICAL CARE UNIT (NCCU)?

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Introduction Enteral nutrition (EN) is the optimal route of feeding in critical care patients and naso-gastric (NG) feeding is the primary route¹. Mechanically ventilated patients are at risk of delayed gastric emptying (DGE). In 2016, in our NCCU, the delay inserting endoscopically-placed naso-jejunal tubes (NJTs) led to the use of unnecessary parenteral nutrition (PN) in 15% of cases². Bedside self-propelling NJT were piloted and a protocol was written for their use and insertion. **Methods** This retrospective audit determined whether self-propelling NJT insertion protocol was being adhered to appropriately and the success rate of insertion.

Patients admitted to NCCU between October 2016-March 2018 were included if they met the following criteria:

1. Failure to absorb gastric feed ($\geq$ two gastric residual volumes –GRVs– >400 ml within 24 hours), despite dual prokinetic therapy (metoclopramide and erythromycin for 2–8 hr).