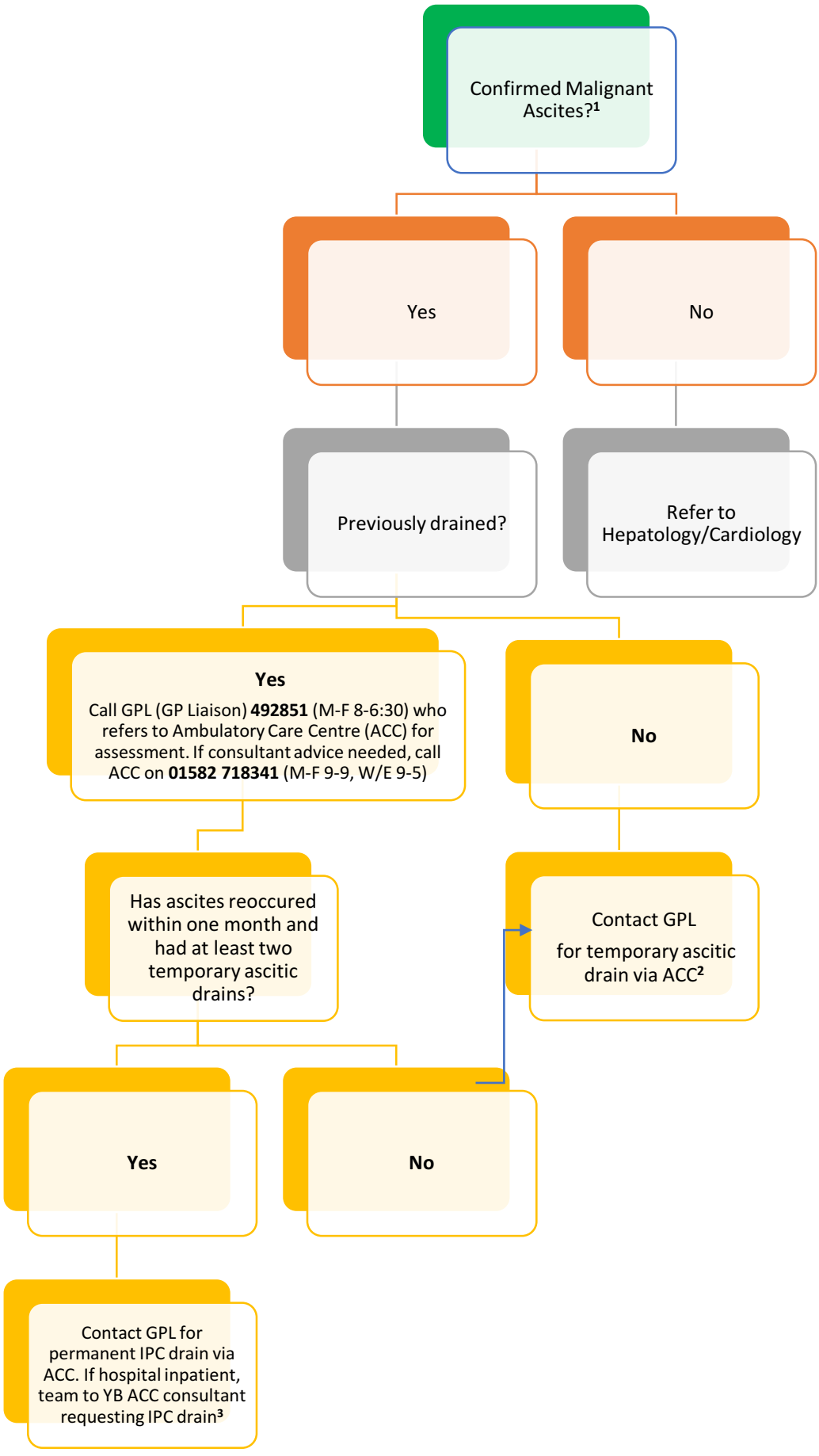
L&D University Hospital Community Malignant ascites drainage pathway



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[1]Confirming Malignant ascites

The 2 main tests for **hospital inpatients** to differentiate ascites due to cirrhosis/portal hypertension vs malignant ascites are:

1. Serum-Ascitic Albumin Gradient SAAG= (serum albumin - ascitic albumin)
   - SAAG ≥ 11 implies transudate (i.e. non-malignant ascites)[4*]
   - SAAG < 11 suggests exudate (e.g. malignant, TB)

2. A positive ascitic cytology may also confirm malignant ascites

To confirm malignant ascites in the community:

a) Confirmed diagnosis of malignancy (oncology letter or Scan reports confirming metastatic disease)
b) absence of known liver or cardiac disease
c) SAAG < 11 (if available)

[2] Temporary Ascitic Drainage (Rocket Medical®) for newly diagnosed Malignant ascites

- GP, hospice or Community team to call GP Liaison (M-F 8-6.30PM) on **492851**, hospital switchboard or Urgent Connect, who then inform Ambulatory Care Centre (ACC), requesting assessment for temporary malignant ascites drainage. If any uncertainty, then call ACC consultant for advice beforehand on **01582 718341** or **x2002** (9-9PM, W/E 9-5)
- Patient invited to attend ACC and ACC doctor will assess patient and take bloods: FBC, UE, Clotting, LFT's. (INR <2, Platelets >50 for ascitic drainage to be performed safely)
- ACC doctor to order urgent USS on ICE and then to **call the Duty Radiologist** requesting USS and mark for drainage within 1-2 hrs (weekdays 9-5 only). USS is only needed for 1st malignant ascites drainage, unless known loculated ascites or organomegaly
- If gynaecology patient, also inform Gynaecology CNS
- Rocket catheter® temporarily inserted in ACC on same day if practical by ACC medical team (or planned for next day)
- Patient remains in ACC for drainage. No monitoring required, no Human Albumin Supplementation (HAS) required, no clamping. Remove drain after 6 hours max or earlier if not draining and cover wound with dressing

- Post-op pain relief. If no contraindication and creatinine ok, give Diclofenac SR, 75mg BD or another NSAID, with Zoton 30mg for 72 hrs and send home from ACC with discharge letter
- Inform GP Liaison of patient's ACC attendance if admitted directly by ACC

[3] Permanent Ascitic Drainage for recurrent malignant ascites (IPC Rocket drain®)

- Only indicated if patient has already had at least two temporary ascitic drains within one month
- Community team or GP to contact GPL requesting IPC drain insertion for recurrent malignant ascites (this being the 3rd episode of ascites needing drainage) via ACC
- ACC consultant will, (if criteria fulfilled) request IPC drain insertion by radiologist on ICE
- Radiology Dept. clerk will liaise with ACC ward clerk to confirm IPC drain date, and for bed made available on the day in ACC
- Information is sent to patient by the Radiology Dept.
- Bloods needed 1 week before IPC drain insertion (FBC, UE, Clotting). If on LWMH, needs to stop on day of procedure
- Patient attends radiology Dept. for planned IPC drain, then transferred to ACC bed for half a day under the responsibility of the ACC consultant
- Inform GP Liaison of patient's ACC attendance
- Rocket IPC Community Training Request Document filled in after procedure by Radiology Department (Faxed to Rocket Medical to ensure reordering of bags and additional training of community nursing team)
- If Gynaecology patient, then notify Gynaecology CNS
- If hospital inpatient, then Yellow Board ACC consultant requesting IPC drain prior to patient being discharged home (patient doesn't need to remain in hospital unless an urgent IPC drain is needed due to gross tense malignant ascites). In this case discuss with Dr Subramanian first (interventional radiologist). If uncertainty, request Palliative Medicine consultant opinion (Dr Herodotou)
- Patient discharged home with letter from ACC (ensure copy goes to GP, oncologist, community Macmillan team, and consultants caring for patient)

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References

1. Malignant ascites: Systematic review and guideline for treatment. Gerhild Becker, Daniel Galandi, Hubert E. Blum. EJC, Volume 42, Issue 5, March 2006, Pages 589-597
2. Management of drainage for malignant ascites in gynaecological cancer, Keen A, Fitzgerald D, Bryant A, Dickinson HO. Cochrane Database of Systematic Reviews, 20 January 2010
3. The PleurX peritoneal catheter drainage system for vacuum-assisted drainage of treatment-resistant, recurrent malignant ascites, NICE, March 2012
4. *Management of Adult Patients with Ascites Due to Cirrhosis: Bruce A. Runyon, Ascites Update 6; 2009, page 2090

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LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY