Challenging OPAT referrals-
Just because we CAN….does that mean we SHOULD?

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HSC South Eastern Health and Social Care Trust

Objectives

- Overview of South Eastern Trust
- Outline SET OPAT service
- Referral considerations
- Case presentations

South Eastern Trust

- Approx. 700 inpatient beds
- Population of 355, 000 (440, 000 acute services)
- Main hospital sites:
- Ulster hospital (Dundonald)
- Lagan Valley hospital (Lisburn)
- Downe hospital (Downpatrick)
- Downshire hospital (Downpatrick)
- Ards community hospital (Newtownards)

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South Eastern Trust cont….

- Regional centre for Plastics in NI
- Tertiary referral centre for max fax
- Tertiary referral centre for complex ortho surgery

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OPAT at SET

- Established dedicated OPAT team 2019:

-0.9WTE OPAT Antimicrobial Pharmacist Lead

-0.9WTE Antimicrobial OPAT pharmacist

-0.5WTE Consultant in Infection

- New 0.5 WTE OPAT nurse October 2024
- No admin support

OPAT 24/25

337 referrals received-220 episodes completed

5064 OBDs saved

96 referrals rejected

Around 50% bone and joint-OM, SA

18% Bronchiectasis

10%Abscesses/collections

Referral considerations

- Patients ideally stable and otherwise MFFD BUT…

- Aging population- multiple co-morbidities
- Increasing acuity and frailty
- Constant bed pressures/undesignated beds
- Surgical waiting lists
- MOFD?
- Expansion of H@H-confusion around patient criteria??

Not suitable

- **96** referrals rejected 24/25:
- 3 endocarditis-vancomycin not OPAT-able
  - -not MFFD
  - -not MFFD/Anidulafungin not OPAT-able
- 36 not MFFD
- 1 QDS pip-taz not OPAT-able
- 8 no nursing capacity
- 12 stopped abx
- 24 IV/PO switch indicated
- 12 social considerations

Points to consider:

- Is OPAT appropriate-infection stable and predictable?
- Aim of continued IVs in absence of source control
- Clear lines of responsibility
- Patient suitability/ consent
- Role of palliative antibiotics

Case 1-Endocarditis

- 38 year old female
- Complex history- Addisons, diabetes, gastroparesis, PEJ, LTC, long-term PICC (multiple issues), 2 previous endocarditis episodes, social considerations

- Admitted 31/3/25 via ED to ICU-sepsis ?source, addisonian crisis-Taz, teico,+clari
- Transfer to ward 4/4-Candida albicans in BC 6/4/25
- TTE 7/4-very large multi-lobulated vegetation adherent to tricuspid valve- not for surgery
- Native TV candidal endocarditis, Bilateral thrombotic and septic provoked Pes

- IV Anidulafungin started 7/4 (ongoing maintenance dose IV infusion over 90mins)
- Multiple repeat TTEs- vegetation growing in size despite antibiotics
- Referred to OPAT 6/6 (treated already for 8 weeks)- queried aim of continued IVs
- ?long-term **suppression** options vs **treatment**
- ?Rezafungin
- ?PO posaconazole/ voriconazole –Posaconazole trialled but still not MFFD
- Palliated 24/7, passed away 26/7

Case 2-Endocarditis

- 92 year old female-dementia, AF
- B/C positive 22/6 Strep salivarius
- 27/6 ECHO (TTE) :MV NVE
- IV benpen 4/52
- Cardiology- not for surgical intervention
- IV diuretics commenced-bilateral pleural effusions
- Multiple blood transfusions- low Hb
- ECHO 24/7 (TTE): Large highly mobile mass remains
- IV vancomycin 29/7- for 6 further weeks as per cardiology

- OPAT approached- advised stop but ward team continued
- **Treatment vs palliation?**
- Drowsiness 5/8-CT brain-acute infarcts likely secondary to septic emboli from infective endocarditis
- Palliated 5/8, passed away 5/8

Case 3-Prosthetic hip infection

- 78 year old female- hx AF, alcohol excess
- R #NOF and arthroplasty May 2024
- Admitted under Ortho for elective THR 21/5/25
- Wound breakdown and ooze with collection on CT 27/5
- New PE 27/5- provoked re. surgery
- Further washout 9/7-pus in joint
- Samples: *MSSA, B. fragilis,*
- IV flx, PO metronidazole, PO rifampicin from 9/7
- Referral to OPAT 15/7 but wound ooze +++ ?further surgical intervention

- **Source control-MFFD??**
- Returned to surgery 26/7- new THR
- Discharged with OPAT 11/8/25 to complete ceft 4g OD + PO mtz

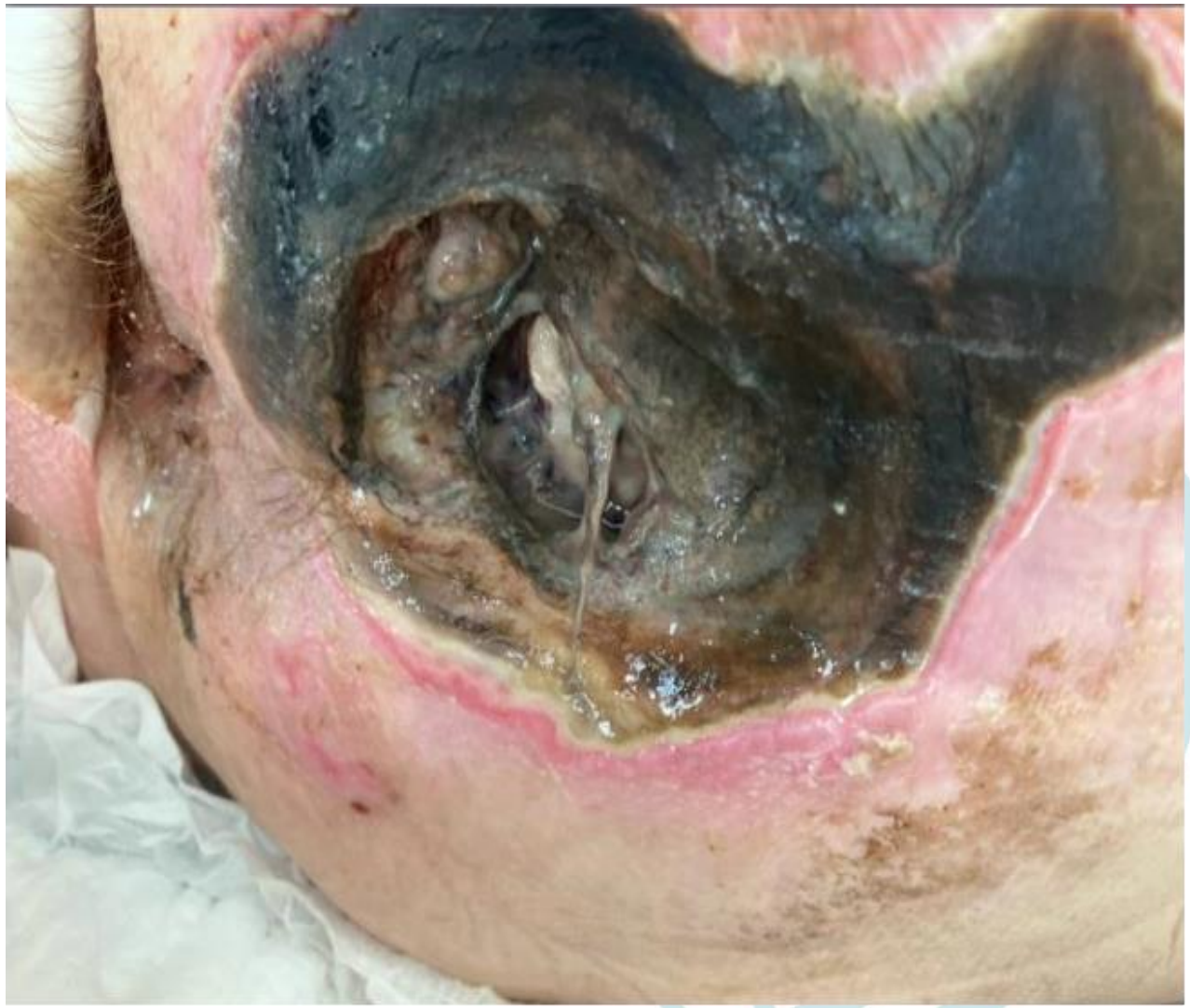
Case 4-Chronic OM of ankle

- 28 year old male- hx CML, chronic OM L ankle, multiple occurrences
- Admitted 21/8/24 –hx acute fall and swollen ankle, pyrexic and generally unwell, AKI
- BC 21/8- MRSA
- Previous washout 2/6/24 and IV teico then PO doxy for OM L ankle (MRSA)
- TTE- no evidence of IE but HF diagnosed
- MRI L ankle 5/9-multi-loculated collection 42x22mm
- Ortho RV-not for drainage-conservative mgt
- Referred for OPAT 11/10/24- refusing PICC line, erythema ongoing, no improvement on repeat MRI, not MFFD, patient refusing OPAT

- **Source control, patient choice**
- Received 17 weeks IV treatment as IP
- Represented 14/7/25-MRI- abscess remains 13x11mm-Ortho RV – not for intervention- IV teicoplanin 15/7-30/7
- Oritavancin dose 31/7 and 7/8

Case 5- Sacral OM

- 71 year old male admitted 25/4 with D&V, chronic sacral wound (2019)
- Infection-? Sacral wound/?GI –IV taz
- Xray sacrum 28/4- OM-Switched to IV ceftriaxone and PO metronidazole, TVN input, not for debridement as per Plastics
- Referred to OPAT 9/5 for 6/52 course
- Overlying wound 11cm x8cm and probing to bone, extensive necrotic tissue
- Debridement indicated-plastics/Ortho mgt?
- **Source control/lines of responsibility**
- 14/5,16/5, 20/5-Plastics team debrided on ward+ VAC
- OPAT to finish 6 weeks-? Future reconstruction



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How do we dispel the myth that IV antibiotics are the ONLY solution?

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What can we do?

- Earlier inpatient consult
- Robust OPAT referral triage
- ?restrict who can refer
- Good relationships with ward teams for open communication
- Attend Audit meetings to remind teams of OPAT service criteria
- ???

Questions? Suggestions?

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