only 2/10 had 'protected' SPA time (an important factor in maintaining adequate Continuing Personal Development). This small pilot study is to be extended across the region.

REFERENCES

1. http://apmonline.org/wp-content/uploads/2015/04/web-version_2015-Analysis_FINAL_100816.pdf
2. http://apmonline.org/wp-content/uploads/2015/04/APM-Workforce-Report-for-Palliative-Medicine-2012-2016.pdf
3. http://digital.nhs.uk/catalogue/PUB16931/nhs-staf-2014-med-dent-detl-tab.xls
4. http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/Supporting_spec_doctors-guide_good_practice_cd_290408.pdf

P-61 DANGEROUS VARIATIONS IN EQUIANALGESIC DOSING FOR TRANSDERMAL FENTANYL

Anna Bradley, Andrew Davies. *Royal Surrey County Hospital, Guildford, UK*

10.1136/bmjspcare-2017-00133.61

Background Opioid rotation/switching is common in palliative care, and one of the most common switches is between oral morphine and transdermal fentanyl. The purpose of this review was to highlight the wide variation in equianalgesic doses that exists according to different sources.

Method In January 2016, we reviewed national guidelines and Summaries of Product Characteristics for transdermal fentanyl preparations available in the United Kingdom, to determine recommended equianalgesic doses for oral morphine and transdermal fentanyl.

Results

Abstract P-61 Table 1 Examples of oral morphine dose variations from different sources

Source	Fentanyl dose (micrograms/hour)				
	12	25	50	75	100
BNF	30	60	120	180	240
PCF (stable dose for several weeks)		<135	135–224	225–314	315–404
PCF (stable dose for long periods)	<44	45–89	90–149	150–209	210–269
Durogesic Dtrans (stable dose for several weeks)		<135	135–224	225–314	315–404
Durogesic Dtrans (stable dose for long periods)	<44	45–89	90–149	150–209	210–269
Fencino (opioid rotation due to adverse reaction)	<90	90–134	135–224	225–314	315–404
Fencino (stable, well tolerated opioid therapy)	<60	60–89	90–149	150–209	210–269

See Table 1. As can be seen from the Table, there can be up to a threefold difference in dose of oral morphine for a specific dose of transdermal fentanyl ie, 12 micrograms/hour=30 mg or 90 mg.

Conclusions This review highlights clinically significant (and potentially dangerous) differences in equianalgesic doses of transdermal fentanyl. We would suggest that there needs to be a national/international consensus on equianalgesic doses for transdermal fentanyl.

P-62 RESPONSE TO ONCOLOGICAL TREATMENTS: WHAT OUTCOMES DO ONCOLOGISTS AND PALLIATIVE MEDICINE PHYSICIANS CHOOSE?

Anna Bradley, Andrew Davies. *Royal Surrey County Hospital, Guildford, UK*

10.1136/bmjspcare-2017-00133.62

Background There are a variety of ways of describing response to oncological treatments eg, response rate, progression-free survival and overall survival. However, there is limited information about the terminology preferences of oncologists or palliative medicine physicians.

Method All oncologists and palliative medicine physicians (including consultants, specialty trainees and "other" doctors) from four cancer centres in the United Kingdom were contacted in April 2016 to complete an online survey.

The question that was posed was as follows: "A new treatment is developed for carcinoma of the umbilicus which increases the median survival of patients from six months to twelve months. However, 75% of patients have an objective decrease in size of the tumour after six months of treatment. How would you explain the new treatment to a patient with carcinoma of the umbilicus?" Potential responses were: "with treatment you have a 50% chance of surviving twelve months"; "treatment will double your life expectancy"; "the new treatment is a 'game changer'"; "treatment will increase your life expectancy by six months"; and "75% of patients will respond to treatment".

Results There were 111 responses in total (oncologists=97, palliative medicine physicians=14). Table 1 demonstrates the range of responses.

Abstract P-62 Table 1 A table to demonstrate responses between specialties

Possible response	Oncology	Palliative Medicine
With treatment you have a 50% chance of surviving twelve months	18%	14%
Treatment will double your life expectancy	8%	7%
The new treatment is a 'game changer'	2%	7%
Treatment will increase your life expectancy by six months	38%	29%
75% of patients will respond to treatment	34%	43%

Conclusions In both groups, the most popular answers were "treatment will increase your life expectancy by six months" and "75% of patients will respond to treatment", with more oncologists talking about increase in survival and more palliative medicine physicians talking about response rates. These results were somewhat surprising, and so we plan to explore this issue further with a new mixed method research study.

P-63 SUBCUTANEOUS LEVETIRACETAM FOR THE MANAGEMENT OF SEIZURES AT THE END OF LIFE

[1]Anna Sutherland, [2]John Curtin, [2]Victoria Bradley, [3]Maggie Presswood, [4]Olivia Bush, [3]Victoria Hedges, [1]Katrien Naessens. *[1]Sue Ryder Hospice Nettlebed, Chalgrove, UK; [2]Florence Nightingale Hospice, Stoke Mandeville Hospital, Mandeville Road, Aylesbury; [3]Sir Micael Sobell House Hospice, Churchill Hospital, Headington, Oxford; [4]Katharine House Hospice, Aynho Road, Adderbury*

10.1136/bmjspcare-2017-00133.63