social care services but also care about the mode of delivery of services to terminally ill patients so they felt dignified until the last moments of life.

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P-75 NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS) IN CANCER PAIN: TESTING PATIENT ELIGIBILITY FOR RECRUITMENT TO A CLINICAL TRIAL

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Introduction Insufficient quality evidence exists to support or refute the use of non-steroidal anti-inflammatory drugs (NSAIDs) in the management of cancer pain.[1] Palliative physicians support a placebo-controlled trial of NSAIDs as strong opioid adjuncts for cancer-induced bone pain (CIBP) as the most pragmatic design to benefit clinical practice.[2] We aimed to determine the number, demographics and co-morbidities of palliative patients receiving radiotherapy for CIBP, guiding the feasibility of a future trial.

Method Five years of retrospective radiotherapy data from the regional Leeds Cancer Centre was filtered (94% sensitive, 90% specific) to achieve a palliative cohort with CIBP. Demographics and survival were linked to available serology and co-morbidity data. Linear regression and descriptive statistics were used.

Results Over five years, 2411 patients received palliative radiotherapy for CIBP in Leeds (mean 478 patients/year). Median age (IQR) was 70 (62–77); negatively skewed (-0.69). More were male (58%). 61.8% died within 1 year of radiotherapy; 46.6% within 6 months. Age did not correlate with survival duration, r(1878) 0.015,p=0.51. A large minority (30.1%) underwent further radiotherapy on subsequent dates. During the 6 months prior to radiotherapy, serology from 1063 (44.2%) patients were available; eGFR was ≥90 mL/min/1.73m2 in 47.0% and ≥60 mL/min/1.73m2 in 83.0%. Similarly, a minority had markers of impaired synthetic liver function (platelets<150 109/L in 7.9%; bilirubin ≥21 in 3.4%; INR ≥1.2 in 20.5%), excluding hypoalbuminaemia (54.1%). From available data (51.6% of sample), 20.2% had a coded co-morbidity contra-indicating NSAID prescription. Combining serological (eGFR>60 mL/min/1.73m2) and contra-indicated co-morbidity data, 68.5% of this population could be considered for NSAID prescription.

Conclusions Patient numbers at a single regional radiotherapy centre support the feasibility of trial recruitment. Available serology and co-morbidity data suggest two thirds may be suitable for NSAID prescription. This may be an underestimate, considering data limitations. Concerning survival post radiotherapy, NSAIDs could provide sustained benefit for this population if proven efficacious.

REFERENCES

1. Derry S, Wiffen PJ, Moore RA, McNicol ED, Bell RF, Carr DB, McIntyre M, Wee B. 2017. Oral nonsteroidal anti-inflammatory drugs (NSAIDs) for cancer pain in adults. *Cochrane Database of Systematic Reviews* 2017. Issue 7.
2. Page AJ, Mulvey MR, Bennett MI. 2020. Designing a clinical trial of non-steroidal anti-inflammatory drugs for cancer pain: a survey of UK palliative care physicians. *BMJ Support Palliat Care*. Published Online First: 02 December 2020.

P-76 METHADONE PRESCRIBING AND OUTCOMES – A SERVICE EVALUATION TO REVIEW CHANGES IN PRACTICE

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Background Methadone is a synthetic opioid which has actions on both mu and NMDA receptors and can be used in pain management. A service evaluation on the use of methadone was initially conducted in 2013. This service evaluation was repeated. The aim was to review how methadone was being used and if titration methods had changed.

Methods Prospective data was collected from patients who were initiated on methadone in Sheffield (n=21) and Doncaster (n=1). The data collected included diagnosis, indication for methadone, method of titration, pain scores and adverse effects. Methods for initiating methadone included stop-and-go (SAG), addition (ADD) and cross-titration (CT).

Results 22 inpatients were prescribed methadone over a ten-month period. In 2013, initiating methadone using SAG was seen in 72% patients but in 2021, CT was the preferred method (91%). Pain scores on average (out of ten) reduced from 7.2–3.6 which is similar to previous results. The median daily background oral morphine equivalent dose prior to methadone initiation was 165 mg (range 120–800 mg) and had reduced to 90 mg (range 0–400 mg) on day five. 50% patients had an ECG prior to commencing methadone, (92% in the 2013 review) with no documented QTc prolongation on a day six ECG. The median background dose of methadone on death or discharge was 15 mg (range 8 mg-45 mg).

Conclusions The method used most frequently for introducing methadone has changed to CT. This could be due to a change in practice following the previous service evaluation as adverse effects were most seen with SAG (2 patients required naloxone for respiratory depression). Overall, the methadone doses used were small to moderate achieving reductions in overall opioid dosing and a perceived benefit in pain control. The reduction in rate of initial ECG monitoring of QTc interval and its clinical significance will be discussed at our departmental audit meeting.

P-77 HOW DOES AGE, SEX, ETHNICITY AND DIAGNOSIS AFFECT THE PAIN REPORTED BY PALLIATIVE CARE PATIENTS IN A HOSPICE SETTING?

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Introduction Palliative care improves the quality of life, well-being and symptom control in patients with advanced disease. Globally only 14% of those in need are thought to receive palliative care. The most common symptom resulting in admission to a palliative care provider is uncontrolled pain. Regular use of symptom assessment measures such as the integrated palliative care outcome scale (IPOS) improves the