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.

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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

identification and management of pain. Despite the benefits, the proportion of IPOS completion is around half of what it should be, and these rates are much lower in ethnic minority patients. This study compares the pain scores of patients according to their diagnosis, age, sex and ethnicity.
Methods This study was an audit of pre-collected retrospective data from St Gemma's hospice. The IPOS pain scores of 576 inpatients between 2019–20 were included. Exclusion criteria were patients with less than two recorded IPOS scores.
Results There was a significant increase from initial to final pain in the total sample, non-cancer conditions, females and younger patients. As well as a non-significant greater increase in the pain of ethnic minority patients. Lung cancer patients experienced a non-significant reduction in pain.
Conclusions High-quality UK based studies are required to expand on the current research demonstrating ethnic inequalities in pain assessment, management and care provision. The gender imbalance may be due to females more openly disclosing their needs, evidence also indicates that female pain is under-documented and overlooked by physicians. The lower pain levels reported by older patients has been attributed to their acceptance of pain as part of the end of life and willingness to reduce their activity levels as a result. The provision of care for chronic, terminal non-cancer diseases can be improved through early and sustained palliative intervention, that is offered without bias, based on clinical need.

P-78 CASE REPORT: ROTATION OF HIGH DOSE ALFENTANIL TO OXYCODONE VIA CONTINUOUS SUBCUTANEOUS INFUSION

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Background The evidence base surrounding conversion of high dose alfentanil to oxycodone via continuous subcutaneous infusion (CSCI) is limited. This case report aims to contribute to this. A lady in her 50s with a uterine leiomyosarcoma developed intra-abdominal sepsis secondary to a large mesenteric mass while in an acute hospital. The sepsis precipitated morphine sulphate toxicity and acute kidney injury prompting opioid rotation to alfentanil via CSCI and prn oxycodone. Escalation of abdominal pain during subsequent hospice admission necessitated titration of alfentanil to 28 mg/24 hours. Persistent pain scores of greater than or equal to 6 on the symptom assessment scale (SAS) over 3 consecutive days when alfentanil was titrated from 24 mg to 28 mg, suggested higher doses were not conferring additional analgesic benefit.
Management Rotated to oxycodone via CSCI to manage persistent severe pain. Renal impairment resolved at this time. 28 mg subcutaneous alfentanil estimated as 840 mg oral morphine sulphate equivalent (1 mg injectable alfentanil: 30 mg oral morphine sulphate). Using conversion factor of 1.5:1 estimated as approximately 560 mg oral and 280 mg subcutaneous oxycodone. Considering inter-individual variation, limited evidence and incomplete cross-tolerance; for safety, the dose of oxycodone was reduced by 50%. A CSCI with oxycodone 140 mg was commenced over 24 hours resulting in significant analgesic benefit with a SAS score of 0 (pain) in the succeeding two days. Use of prn analgesia was reduced and no opioid toxicity was observed. No other medicines were adjusted.
Discussion This is consistent with anecdotal evidence that the analgesic efficacy of alfentanil wanes at doses >20 mg/day possibly indicating tolerance. Admittedly, alfentanil was titrated in small increments in the days preceding rotation. Half the estimated equivalent oxycodone dose conferred analgesic benefit supporting significant dose reduction when rotating.
Conclusion This case describes improved analgesic efficacy despite 50% dose reduction when converting high dose alfentanil to oxycodone via CSCI.

P-79 USE OF NALOXONE FOR OPIOID TOXICITY IN ADULT PALLIATIVE CARE PATIENTS: RESULTS FROM A RETROSPECTIVE CASE NOTES AUDIT AT A LARGE TEACHING HOSPITAL IN CENTRAL ENGLAND

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Background Naloxone, an opioid antagonist, is commonly used in acute care settings to reverse the effects of opioid toxicity. It is nevertheless recognised that managing respiratory depression in patients on long-term opiates should be different to managing an acute opioid overdose in adults. It is not clear, however, whether this is observed in our 1200-bed hospital.
Methods A list of all inpatients who received naloxone whilst at our hospital during 2019 was procured. Only records of patients either known to our service or with an underlying life-limiting condition were selected for analysis. Data obtained included age, sex, diagnosis, opioid and CNS depressant history, indication for, and dose(s) of, naloxone, and outcome. Descriptive statistics obtained on Microsoft Excel.
Results Twenty-eight out of 159 patients met our inclusion criteria. Twelve patients had a cancer diagnosis; 23 were on any opioid or CNS depressant prior to admission. Forty-two doses of naloxone were given overall, with reduced consciousness/GCS being the most common recorded reason for its use. Twenty-four patients had a respiratory rate recorded and in only five patients was it ever eight or fewer breaths per minute. Doses of naloxone ranged from 100 to 400 mcg (mode 100 mcg). Fifteen patients received only a single dose.
Discussion In our hospital the use of naloxone to reverse the effects of opioid toxicity is inconsistent, with wide variations in practice. Although local and regional guidelines are readily available on the Trust Intranet, there was little adherence to them, particularly with respect to record keeping. It is concerning that naloxone may have been advised inappropriately in a majority of palliative patients. There is a clear need both for further education of prescribers and for research into the human factors associated with naloxone use.

P-80 METHADONE AS AN ADJUNCT RATHER THAN A REPLACEMENT ANALGESIA (THE 'STOP AND GO' OR 'PROGRESSIVE' METHOD)

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Background At Severn Hospice, oral methadone is used as an adjunct to opioid analgesia to manage complex pain. This