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

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