completely gone in 16% of patients. In 77%, pain had partially improved. 64% of patients had been suffering with intolerable opiate-related side effects prior to ITDD insertion. Post-insertion, 54% of this group showed a clear improvement in side effects.

73% were affected by complications within 72 hours of insertion, and 60% of patients experienced ongoing complications of some kind. The majority of these were minor complications.

In 89% of patients' records, the notes indicated that there was overall benefit in ITDD insertion. 11% of patients lived longer than predicted by Palliative Care. 34% lived as long as predicted, and 55% lived shorter than predicted at the time of ITDD referral.

Conclusions The vast majority of patients and clinicians felt that ITDD insertion was worthwhile, with significant numbers of patients obtaining an improvement in pain. Whilst the complication rate is high, the vast majority of these were minor without patient harm. It is not possible to draw conclusions regarding extension of prognosis in this retrospective study.

80 INTEROSSEOUS NERVE WRIST BLOCK OF PHENOL FOR METASTATIC UROTHELIAL CANCER: A NOVEL FEAT

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10.1136/spcare-2023-PCC.100

75 year old female with diagnosis of urothelial cancer with presented with history of severe right wrist pain. Pain described as a throbbing toothache affecting her sleep and ability to carry out domestic chores.

On examination, she had reduced range of movement and flexion/extension of right wrist, and visible solid swelling to right wrist. Passive movements of wrist resulted in significant pain.

MRI showed large metastatic deposit within the distal radial metadiaphysis with a pathological fracture and significant soft tissue component. Lesion extended into the flexor and extensor compartments and crossed the intraosseous membrane.

Orthopaedics decided not to excise the tumour as morbidity risk too high. Had 5 fractions of radiotherapy with no improvement in pain. Longtec uptitrated to 20 mg BD, average Shortec 5 mg x 3 a day. Pregabalin added as adjuvant however developed increased somnolence so self ceased. Patient placed in elbow cast which provided some relief. Opioid rotated to Hydromorphone 8mg bd and prn 1.3- 2.6mg. Due to severity of pain consultation was had with Orthopaedics about amputation. Case discussed at Complex Pain MDT, decision made to trial a novel anterior and posterior interosseous nerve block to block nerve supply to wrist.

Patient underwent u/s guided 2 separate injections of phenol into the anterior and posterior interosseous nerve. Hydromorphone was reduced to 4mg PO BD post block.

Outcome Excellent results post block, patient weaned off hydromorphone, reported to be pain free and utilising PRN hydromorphone 1.3 mg infrequently, reporting much better quality of life and ability to carry out domestic chores.

81 COMPARISON OF A NOVEL METHADONE ROTATION METHOD WITH OTHER COMMONLY USED METHADONE ROTATION METHODS

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10.1136/spcare-2023-PCC.101

Background Methadone can be used to treat complex or neuropathic pain. Due to its unique pharmacological properties, switching from another opioid is complex. Ratios and equianalgesic doses are a consequent challenge for physicians, with no standardised ratios in use.

Aims/Objectives To compare a novel method of methadone rotation with other commonly used methadone conversion methods including Perth rapid titration, Brisbane protocol and 3-day switch.

Methods

Ethical approval was obtained A retrospective chart review of all inpatients prescribed methadone during 2018/2019 was conducted. Data collected included demographics, opioid requirement prior to rotation and oral morphine equivalent (OME), presence of opioid toxicity, opioid-sparing interventions, final stable methadone dose prescribed, time to achieve stable dose. Stable methadone dose was defined as a dose that was stable for 5 days or until death/discharge. Using the OME, the expected methadone dose was calculated via rapid titration with both the Perth protocol and 'Brisbane' Protocol, as well as 3-day switch. This data was compared with the results of our study.

Results 86 charts were identified, 9 were not located, 49 were excluded including methadone use as an adjunct and discontinuation of rotation. 28 rotations were analysed. The mean methadone dose was 12.6 mg using this novel method. Calculated methadone doses with Perth protocol were significantly higher than doses achieved using this novel method of rotation, with a mean difference of 13.9mg (p value <0.0001). Calculated doses were also higher when comparing the Brisbane method and this novel method, mean difference noted to be 4.6mg (p value 0.0035). No statistically significant difference was found when comparing with the 3-day switch.

Conclusion Patients rotated to methadone using this novel method received a stable methadone dose lower than they may have received if Perth or Brisbane ratio conversions were used. Methadone rotation remains challenging and further study is needed.

82 MANAGEMENT OF BREAKTHROUGH CANCER PAIN: A MULTI-CENTRE REGIONAL SURVEY OF PRACTICE

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10.1136/spcare-2023-PCC.102

Background Transmucosal Fentanyl products improve sleep, emotional, physical and psychological health.[1] The EAPC state Fentanyl preparations are sometimes preferable to immediate release oral opioids because of rapid onset of action and shorter duration of effect.[2] Recent trials initiating transmucosal Fentanyl at proportional dose to around-the-clock opioid

concluded this is safe and effective.[3,4] For patients using high doses of around-the-clock opioid it is hypothesised that proportional dosing may prevent dropout of participants during titration, due to lack of confidence of efficacy before maximal dose has been achieved.[3]

Methods We performed a systematic review of the literature for pharmacological and non-pharmacological management of breakthrough cancer pain. A survey of healthcare professionals working in specialist palliative care and multi-centre case-note review were performed analysing current management of breakthrough cancer pain.

Results 94 Healthcare professionals (HCP's) responded covering community, hospice and hospital settings. 57% prescribe transmucosal Fentanyl, with most initiating transmucosal Fentanyl every 2–3months. The main benefits are its' short duration of action and rapid onset of action. 73% found the greatest barrier is the titration schedule. 90% found heat and cold packs helpful. Davies[5] also concluded heat, rest and positional change were most beneficial non-pharmacological options. 179 patient case notes were analysed. 56% of those prescribed transmucosal Fentanyl were using equivalent to 60mg morphine as background opioid, 34% were using less than equivalent 60mg morphine. 65% of cases had pain assessed using a tool, 74% of these used the Numeric rating scale. In 84% of patients the titration schedule was used. 83% of patients initiated on transmucosal Fentanyl continued to use it, discontinuation was most commonly due to entering the dying phase.

Conclusion Regional standards and guidelines have been updated following this review. There was consensus that under specialist palliative care guidance where patients are using the equivalent or higher than 60mg Morphine per 24hours it might be appropriate to consider starting transmucosal Fentanyl at higher doses than manufacturer recommendation.

REFERENCES

1. Cuomo A, Cascella M, Forte CA, *et al*. Careful breakthrough cancer pain treatment through rapid-onset transmucosal fentanyl improves the quality of life in cancer patients: results from the BEST Multicentre Study. *Journal of Clinical Medicine* 2020;**9**:1003.
2. Caraceni A, Hanks G, Kaasa S, *et al*. Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC. *Lancet Oncology* 2012; **13**:58–68
3. Mercadante S, Prestia G. The use of sublingual fentanyl for breakthrough pain by using doses proportional to opioid basal regimen. *Current Medical Research & Opinion*. 2013;1–6.
4. Yen T, Chiou J, Chiang W, *et al*. Proportional dose of rapid-onset opioid in breakthrough cancer pain management. An open-label multi-centre study. *Medicine* 2018;**97**:30(e11593).
5. Davies A, Buchanan A, Zeppetella G, *et al*. Breakthrough Cancer Pain: An Observational Study of 1000 European Oncology Patients. *Journal of Pain and Symptom Management* 2013; **46**(5):619–627.

83 THE USE OF ALFENTANIL IN A SPECIALIST PALLIATIVE CARE INPATIENT UNIT

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10.1136/spcare-2023-PCC.103

Background Alfentanil is a strong short acting synthetic opioid which is increasingly used in specialist palliative medicine. There is uncertainty and pragmatism in determining a conversion ratio from other strong opioids to alfentanil. Subcutaneous diamorphine: subcutaneous alfentanil 10:1 was initially used.[1] Recent retrospective chart reviews suggest that this conversion ratio is conservative, although there are conflicting findings in the literature.[2,3,4] These reviews have focused on converting to alfentanil from diamorphine rather than from opioids more commonly used in clinical practice. This retrospective chart review focuses on switching from oxycodone to alfentanil.

Method A retrospective chart review of consecutive hospice inpatients prescribed alfentanil via continuous subcutaneous infusion was undertaken. Patients were identified using controlled drug books. Data pertaining to demographics, primary diagnosis, renal function, indication for alfentanil rotation, opioid use in the 24 hours prior to rotation, initial alfentanil dose, subsequent dose escalation and reason for stopping alfentanil were collected. Ethical approval was obtained prior to commencement.

Results Data were collected for 20 consecutive inpatients. 90% (18/20) had a primary cancer diagnosis. 50% (10/20) had an eGFR <30mL/minute. As per available data, 83% (15/18) patients were prescribed a regular strong opioid prior to alfentanil switch. Of the 10 patients switched from oxycodone to alfentanil, a conversion ratio of oxycodone (subcutaneous): alfentanil (subcutaneous) of 10:1 was used for 6 patients to determine the initial alfentanil dose (Day 0). 5 of these patients required a dose increase on Day 2, as did the 1 patient with Day 2 data available for whom a conversion ratio of >10:1 was used. A ratio of <10mg:1mg was used for 2 patients, who also required increased doses on Day 2.

Conclusion These findings suggest that a conversion ratio of 10mg oxycodone (subcutaneous):1mg alfentanil may be conservative. This needs further evaluation.

REFERENCES

1. Kirkham SR, Pugh R. Opioid analgesia in uraemic patients. *Lancet*. 1995;**345**:1185.
2. Urch CE, Carr S, Minton O. A retrospective review of alfentanil use for pain in the palliative care setting. *Pall Med* 2014;28.
3. Virani F, Miller M. Alfentanil in inpatient palliative medicine: practice survey. *BMJ Supportive and Palliative Care* 2021;0:1–2.
4. Cran A, Dorman S, Kirkham S. Opioid rotation to alfentanil: comparative evaluation of conversion ratios. *BMJ Support Palliat Care* 2017;**7**:bmjspcare-2017–001349-266.

84 DRIVING COMMUNICATION FORWARD: IMPROVING COMMUNICATION FOR PALLIATIVE CARE PATIENTS AROUND DRIVING AND OPIOIDS – A QUALITY IMPROVEMENT REPORT

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10.1136/spcare-2023-PCC.104

Introduction The number of people requiring palliative care is increasing with an aging, co-morbid population. Pain is a prevalent symptom for palliative care patients and is often managed with opioids. Opioids reduce reaction time and can cause drowsiness and visual disturbance. Evidence recommends that driving should be avoided until a stable dose of opioids has been reached. It is vital for patient and public safety that these facts are communicated to patients who are prescribed opioids, as well as the legal consequences if guidance isn't followed. These discussions facilitate joint decisions, optimising patient freedom and quality of life. Surprisingly though these important discussions around driving and opioids don't always occur, and so this project sought to develop a systematic approach to integrating them into practice.