

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. Davies⁵ 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.

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THE USE OF ALFENTANIL IN A SPECIALIST PALLIATIVE CARE INPATIENT UNIT

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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.

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

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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.