Results The average age of the AYAH patients was 25.2 years and PCU patients was 78.2 years. Four out of seven patients at AYAH had sarcoma, compared to a range of cancer types in the PCU patients.

Each unit had 2/7 patients with moderately deranged LFTs, and 2/7 with mildly deranged LFTs. A single patient at PCU had moderately deranged renal function.

There were significantly higher average doses of opioids in the AYAH population (2.5x higher), as compared to the PCU population. Data pertaining to average benzodiazepine doses showed they were 1.96x higher in AYAH patients.

The average doses of levomepromazine were 8x higher in AYAH patients compared to PCU. 5/7 AYAH patients required levomepromazine compared to 2/7 PCU patients.

2/7 patients at AYAH required phenobarbitone averaging 2100mg in 48 hours. 0/7 patients at PCU required phenobarbitone. A single patient at AYAH required systemic lidocaine infusion, none at PCU. No patients at either site received ketamine.

Discussion This pilot study suggests that the adolescent and young adult cancer patient population require significantly higher doses of all the end-of-life drugs reviewed. This is likely due to high symptom prevalence as reported in previous studies, as well as better renal and liver function than PCU patients.

This data may impact on medication budgets, and time allocation for staffing. Further investigation is ongoing, including data collection on PRN use which significantly impacts nursing time.

P-11 INDICATION, DOSING AND OUTCOMES OF PHENOBARBITAL USE FOR PALLIATIVE SEDATION THERAPY IN THE INPATIENT SETTING: A RETROSPECTIVE CLINICAL AUDIT

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Background Palliative sedation therapy (PST) is used to treat refractory symptoms at the end of life. Guidelines surrounding commonly used medications for PST are available, but variability exists for subsequent agents including phenobarbital. Doses of phenobarbital loading doses and continuous subcutaneous infusion (CSCI) doses are varied, as is the recommended route of administration and use of concurrent PST.

Objectives Identify the indication, dosing range and time to death from phenobarbital CSCI commencement

Identify the use of preceding, and concurrent PST medication choices

Methods This retrospective clinical audit investigated inpatient phenobarbital CSCI use in the palliative care setting from 1 January 2021 to 22 April 2024. Data was extracted from the electronic medical records system, and collected in a spreadsheet detailing patient characteristics, diagnoses, dosing, timing, and indication for midazolam, levomepromazine, phenobarbital and propofol.

Results 86 patients were identified initially. Five were excluded as phenobarbital was a pre-existing prescription for seizure prevention, thirty-nine were prescribed but not administered phenobarbital, fourteen prescribed and administered phenobarbital on an as-needed basis only, and five were administered in a CSCI for seizure control not PST. 23 patients were included following exclusion.

The most common indication listed for phenobarbital use was 'agitation' (n=21, 75%), followed by 'seizures' (n=5, 18%) and 'sedation for NIV withdrawal' (n=2, 7%). More patients had a malignant diagnosis listed as their cause of death (n=14, 58%) than a non-malignant diagnosis. All patients had the phenobarbital CSCI running at time of death, and were described as comfortable at death. No adverse reactions were documented.

The initiation dose of phenobarbital ranged from 0–200mg subcutaneously (SC), with the most common dose being 200 mg (n=17, 74%). The commencement CSCI dose ranged from 400–1200mg per 24 hours, with the most common starting dose being 800mg (n=8, 35%). The maximum dose used was 1800mg per 24 hours. The average time to death from phenobarbital CSCI commencement was 45 hours. Higher established doses of phenobarbital did not appear to result in a shorter time to death.

Prior to phenobarbital CSCI commencement, all patients had a midazolam CSCI running (mean dose 50mg, range 10–80mg), which was continued in fourteen (60%) patients. Seventeen (74%) patients had a levomepromazine CSCI running (average dose 137mg, range 25–250mg), which was continued in twelve (76%) patients. After phenobarbital commencement, eight (35%) patients had both a midazolam and levomepromazine CSCI running.

Conclusion Within our centre, phenobarbital was infrequently used and most commonly prescribed for agitation. It appears to be an effective medication for refractory symptoms at the end of life. There was a wide range of phenobarbital dosing, and inconsistent prescription of concurrent PST agents. Future studies could expand on appropriate phenobarbital prescribing by considering multi-centre analysis and mixed method studies on the role of other PST agents in conjunction with phenobarbital.

P-12 TOWARDS COMPASSIONATE PALLIATIVE CARE PATHWAYS FOR LONGSTANDING EATING DISORDERS

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Background People with longstanding eating disorders (also referred to as severe and enduring eating disorders) and their families, carers and communities, face challenging and often traumatic realities. Current care pathways for eating disorders often fall short in meeting their multifaceted and complex needs, highlighting the need for alternative approaches. Developing and implementing new care pathways to address these needs requires interdisciplinary collaboration involving stakeholders from both the eating disorder and palliative care sectors, encompassing lived experience, clinical and research expertise. To address this issue, the National Eating Disorders Collaboration (NEDC) commissioned a co-produced, lived experience-led discussion paper, 'Holding Hope—Exploring Compassionate & Holistic Care Pathways for Longstanding Eating Disorders' (Calvert et al., 2023).

Aims The aim of this discussion paper is to explore and address the complex challenges of palliative care for longstanding eating disorders. The discussion paper acknowledges and describes the complex landscape of longstanding eating disorders and palliative care, advocating for alternative care

pathways that are distinct from end-of-life care or voluntary assisted dying. Ultimately, the discussion paper aims to support efforts to develop and implement guidance on the use of palliative care for eating disorders, emphasising compassion, person-centredness, quality of life, autonomy and dignity throughout the illness journey.

Methods The development of the discussion paper involved a literature review and consultations with people with lived experience, their families and supports and professionals across national and international eating disorder and palliative care sectors. The literature review explored key lived experience, clinical and research perspectives and priorities and identified gaps, challenges and facilitators to implementing palliative care for longstanding eating disorders. The consultations, which spanned from 2017 to the present, explored the applicability and need for palliative care for those affected by longstanding eating disorders.

Results The discussion paper advocates for the development of guidelines for the provision of palliative care for longstanding eating disorders. Drawing on the findings from the literature review and consultations, the paper outlines a list of fundamental principles to inform these guidelines: leading with lived experience, person-centred care planning, interdisciplinary collaboration, workforce competence, ethical practice, supportive care networks, robust research and evaluation and public awareness.

Conclusion A transformative shift in care pathways for longstanding eating disorders is needed, including the integration of palliative care, to address the multifaceted and complex needs of this group. The discussion paper calls for guidelines addressing the recommended principles to be developed through critical and courageous dialogue and action across the eating disorder and palliative care sectors and with people with lived experience. People with longstanding eating disorders, their families, supports and communities deserve access to compassionate and holistic care pathways that reshape care experiences and address a long-neglected aspect of palliative care.

P-13 GENOMIC VARIATION IN SYMPTOM EXPRESSION IN MEN WITH CASTRATE RESISTANT PROSTATE CANCER

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Background Men with castrate resistant prostate cancer (CRPC) suffer from symptoms related to both their disease and its treatment with marked variation between individuals with respect to symptom expression despite similar tumour burdens. This may be related to genetic variation.

Objective This study aimed to determine whether genetic variation in cytokine expression can predict severity of symptoms in men with CRPC and investigate whether symptom severity was related to tumour burden.

Methods A prospective, longitudinal consecutive patient cohort study across two Queensland sites. Patient characteristics including tumour burden and current treatment were collected at baseline. Symptom severity was assessed using the Edmonton Symptom Assessment Scale (ESAS-R) 3–4 weekly for up to 6 assessments, with blood taken for genetic analysis once during the study. Cytokine gene variants of each participant were assessed using a panel of SNPs most reported to be associated with symptom variation in the literature. Analysis was performed using R software and the package SNPassoc (R Core team, 2021; Gonzalez JR. et al, 2007).

Results Twenty-eight of 67 (42%) of participants had a low, and 39/67 (58%) a high tumour burden. Tumour burden remained constant throughout the study period for all participants. Twenty-six of 67 (39%) participants were classified as having low ESAS-R severity and 67 (61%) as high ESAS-R severity. Symptom severity was not related to tumour burden or patient characteristics. One hundred and forty-four SNPs from 63 participants were analysed, of which results were available for 142 SNPs. Fifteen SNPs were significantly associated with symptom severity. In multivariable analysis, SNP rs2069772 in IL2 ($p = 0.001$), rs1554606 in IL6 ($p=0.003$), rs2227306 in IL8 ($p=0.008$) and rs2069718 in IFNG ($p=0.001$) were highly predictive of symptom severity.

Discussion Although multiple factors can influence symptom severity, genetic variation may well play a part. The early identification of men likely to develop severe symptoms during the course of their prostate cancer could theoretically enable symptoms to be managed more aggressively from an early stage. Our findings also add to the expanding data bases that document the associations of genetic polymorphism with both disease and symptom expression.

P-14 DRUG INTERACTIONS IN PEOPLE ON CANNABIDIOL – IS THERE CAUSE FOR CONCERN?

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Background There is potential for a wide array of cannabidiol (CBD) drug-drug interactions (DDIs) through modulation of hepatic cytochrome P450 enzymes and various other membrane proteins. Potential DDIs with CBD have been described, but few clinical interaction data exist outside of medications prescribed for epilepsy. Polypharmacy in cancer and palliative care patients increases the likelihood of DDIs. It is therefore important to consider possible drug interactions when prescribing medicinal cannabis.

Objective To look for evidence of drug-drug interactions between concomitant medications and CBD oil in participants with advanced cancer recruited to a placebo-controlled trial of medicinal cannabis for symptom control.

Methods Participants were those recruited to a randomised controlled trial of synthetic CBD versus placebo (MedCan-1, ACTRN 12618001220257, J Clin Oncol 2023;41(7);1444–1452). All participants provided a list of concomitant medications taken in conjunction with trial medications and were advised to continue them throughout the study. Adverse events were recorded throughout the trial. Surrogate measures were used to identify possible drug interactions: 1) the maximum mL of oil self-selected by patients in CBD or placebo groups in relation to specific drug groups or individual agents (on the basis that co-administration of other drugs might limit the dose of CBD tolerated), 2) the occurrence of any new or