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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10.1136/spcare-2024-ANZSPM.61

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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10.1136/spcare-2024-ANZSPM.62

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

worse adverse effect in relation to the study arm and the concomitant medication classes/medications of interest.

Results The dose of CBD self-selected by participants was not related to opioid use or medications including benzodiazepines and antipsychotics. The likelihood of developing an adverse effect whilst on study or when taking specific medications was not increased by the use of CBD. There was a suggestion that paracetamol could be protective against the side-effects of CBD but this was not supported by all analyses.

Discussion Although there is potential for CBD to interact with multiple medications, the findings of this sub-study suggest that concerns regarding clinically significant drug interactions with CBD may be unfounded.

P-15 CLINICAL STUDIES OF MEDICINAL CANNABIS IN PALLIATIVE CARE – THE DEVELOPMENT OF A RESEARCH PROGRAM

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10.1136/spcare-2024-ANZSPM.63

Background Medicinal Cannabis (MC) was legalised in Australia in 2016 for a range of indications including palliative care, despite a lack of research evidence. Patients with advanced cancer in the community commonly access cannabis aiming to improve their symptoms. Following the award of grants from the NHMRC – Medical Research Future Fund in 2018 and 2020, we have developed a medicinal cannabis research program.

Objectives To define the role (if any) of cannabinoids in patients with symptoms from advanced cancer.

To conduct robust phase three clinical trials to contribute to the evidence base for medicinal cannabis prescribing in Australia.

Methods Develop and complete a pilot study to test the feasibility of a larger RCT with an MC product in an advanced cancer patient population and develop phase 3 MC trials 1, 2 and 3 of different products and concentrations. Explore qualitative studies around patient use and views of MC products in our community and conduct sub studies testing the anti-inflammatory properties of cannabinoids. Investigate the detection of tetrahydrocannabionol (THC) medicinal products in relation to motor vehicle driving and real-world implications. Conduct post trial long term surveillance of marketed products using the authorised prescriber scheme.

Results In the pilot study 86% of recruits completed the primary outcome with 46% meeting the definition of response. The study drug was well tolerated. MedCan 1, a cannabidiol (CBD) versus placebo RCT (n=144), showed all components of the Edmonton Symptom Assessment Scale (ESAS) improved (fell) over time with no difference between arms. There was no detectable effect of CBD on quality of life, depression, or anxiety. Adverse events did not differ significantly between arms apart from dyspnoea that was more common with CBD. Most participants reported feeling better or much better at days 14 and 28. In MedCan 2, a (THC)/CBD 1:1 versus placebo RCT, the results showed no total ESAS difference between arms. There was a significant difference in reduction in ESAS pain scores at day 14 (mean (SD) -1.41 (2.15) MC, -0.46 (2.82) placebo), p = 0.04 in favour of MC. Adverse events of special interest revealed an increased incidence of confusion, feeling high, and exaggerated sense of well-being in the MC arm. In a C-reactive protein sub study, we were unable to demonstrate an anti-inflammatory effect of CBD in cancer patients.

Discussion Medicinal cannabis is commonly used in the community by people with cancer to treat the associated troubling symptoms of their disease and treatment. Our trials have been designed to define the best and safest place for MC in supportive care. Our results have been included in systematic reviews, meta-analyses, and international guidelines. Health consumers have provided valuable input into the design of our trials and ongoing safety monitoring. Currently we have 15 publications with MedCan 3, MedCan Drive, MedCan Inflam, MedCan Post trial, and two qualitative studies still in the recruitment phase. Our results will continue to inform policy and practice around MC prescribing both nationally and internationally.

P-16 BALANCING QUALITY OF LIFE AND MEDICAL FUTILITY: AN ETHICAL DILEMMA IN END STAGE RENAL DISEASE

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10.1136/spcare-2024-ANZSPM.64

Decisions around dialysis withdrawal can be highly complex and challenging for patients, caregivers, and healthcare providers. There are various reasons why dialysis withdrawal may be considered, including access failure, acute medical complications, or chronic deterioration. Shared decision-making is recommended to align this decision with the patient and family's goals, values, and preferences.[1]

However, problems can arise when there is a misalignment or disagreement between what the family/patient desires and what the medical team deems medically appropriate.

In this case, we discuss a 74-year-old woman with end-stage renal failure on intermittent haemodialysis. She lacks decision-making capacity and is bedbound and dependent in her activities of daily living due to her advanced dementia. Her recent medical deterioration and lack of access has made it difficult to continue haemodialysis. Despite the medical team's recommendation to withdraw dialysis, her main spokesperson, a close friend, does not agree and insists on pursuing further treatment. This presents an ethical dilemma - is it appropriate to persist with dialysis in this medically frail patient, at the spokesperson's insistence, when the treatment may not be medically appropriate or beneficial given her current state?

The Jonsen's 4 box ethical framework was used to consider the medical indications, patient preferences, quality of life, and contextual features to plan care in the patient's best interests in the absence of decision-making capacity.

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