(SD=1.56, n=15) to 6.0 (SD=3.0, n=15) on a 10-point scale.

Discussion This innovative project exemplifies the theme of constructing, challenging and transforming, as we learnt from neurorehabilitation to address the unique needs of hospice patients with NB. Rehabilitation and palliative care share common principles; rehabilitative palliative care aims to enable people to live as independently and fully as possible within the limitations of advancing illness.[4] This guideline represents the first dedicated to NB specifically in a hospice setting, to the authors' knowledge. While staff awareness and confidence have improved, further research is needed to assess patient symptom improvement. The IPOS subscale 'constipation' may not fully capture NB symptoms, suggesting the need for validation of the NBD score in a hospice setting.

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P-24 GUIDELINE FOR ANTICIPATORY PRESCRIBING FOR TERMINAL HAEMORRHAGE IN CANCER PATIENTS BASED ON CURRENT PRACTICE IN IRELAND

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Background A crisis pack, of one or more medications, is prescribed in anticipation of a terminal haemorrhage with the goal of alleviating patient distress.[1] A challenge in the prescription and administration of crisis packs is the lack of data to allow for evidence-based management. The literature published is largely case reports. Hence there is significant variability in which medications are used, including which dosage and route.

Objectives Establish current practice among senior palliative medicine physicians, regarding anticipatory prescribing to manage a terminal hemorrhage.

Review prescribing and administration of crisis packs in a specialist inpatient hospice unit (IPU) in Galway Hospice Foundation.

Generate a guideline informed by data collected.

Methods Part a) Questionnaire

An electronic questionnaire was sent to palliative medicine consultants and specialist registrars (SpRs) in the Republic of Ireland. Data was analysed using the online survey software and excel.

Part b) Prescribing in one IPU

A chart review of all patients admitted to a single IPU over a 3-month period (June 2023 – August 2023 inclusive) was conducted. Basic demographic data and prescription data was collected. Results were analysed using Stata/SE 18.0.

Results Part a) Questionnaire

The questionnaire was sent to 96 individuals. Response rate was 50%. 100% of participants prescribed crisis packs. The most prescribed medications were morphine (89.6%) and midazolam (100%). Over 95% prescribed medication via the subcutaneous route. Most participants 70.8% vary the dose of crisis medication charted based on if the patient is on a baseline anxiolytic/opioid. The calculations used for dose variation were inconsistent between participants. The most common inclusion criterion for prescribing by malignancy type was head and neck cancer. 65% of participants did not follow a guideline when prescribing.

Part b) Prescribing in one IPU

Study included 75 separate admissions. Three quarters of patients had a malignant diagnosis. No patients died due to an external haemorrhage. Crisis medications were prescribed in 17% of admissions but none were administered. All crisis packs were prescribed as a combination of midazolam and an opioid via subcutaneous route. There was little variation in dosing relative to baseline opioid/anxiolytic, with 76.9% of patients prescribed 10mg of both midazolam and morphine sulfate. In 2 cases the breakthrough (as needed) dose of opioid was greater than the dose of the opioid in the crisis pack.

Disussion Results demonstrate that there is little variation in the medications prescribed or the route. There is significant variation in the doses of medications prescribed and the indications for prescribing. To standardise crisis pack prescribing a guideline should be used. Given the concerns around the use of opioids for an event that is not thought to be painful and the use of subcutaneous route in the setting of a haemorrhage the use of intramuscular midazolam is recommended. Dosage of midazolam recommended is relative to baseline benzodiazepine. Recommendations are described further in the guideline.

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P-25 CHARACTERISING THE EMERGING MODEL OF PALLIATIVE CARE PROVISION TO ADOLESCENTS AND YOUNG ADULTS (AYA) AT A COMPREHENSIVE CANCER CENTRE IN VICTORIA, AUSTRALIA

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Background Early integration of palliative care for adolescents and young adults (AYA) with cancer improves outcomes for patients and families and reduces healthcare utilisation toward the end of life. As AYA oncology evolves, we require innovative models to achieve equitable access to needs-based palliative care for this heterogenous and geographically-dispersed population.

This CCC exists within a multi-hospital precinct and houses the state-wide AYA cancer service and an integrated palliative care service (IPCS) comprising outpatient clinics, inpatient consults, and palliative care units (PCU). Since 2020, there has been a formal collaboration between oncology and the IPCS; internal publication of an AYA palliative care framework;

attendance of palliative care physicians at weekly AYA interdisciplinary meetings; and addition of physicians with paediatric training on IPCS staff. Given these resources, we aimed to understand how they are being used for AYA.

Aim To describe the model of palliative care provision for AYA decedents known to an Australian comprehensive cancer centre (CCC) between 2020 and 2023.

Methods This was an ethics-approved, retrospective examination of medical records of all AYA treated at the CCC who died in the defined time period. Policy changes and staffing models designed to improve palliative care for AYAs are included for context.

Results There were 37 AYA treated at the CCC who died between January 2020 and March 2023 (62% male, median age at death 23 years). Of these, 33 (93%) were known to the IPCS with a median of 4.2 months from referral to death. AYA moved among IPCS care settings with 27 cared for in outpatient clinics, 25 known to the consult service, and 11 spending time in PCU. AYA were also referred to community palliative care services (n=27; 73%).

Outpatient care through the IPCS varied in structure and mode of delivery. AYA had a median of 12 outpatient contacts and met, on average, two different clinicians. The IPCS provided stand-alone appointments (n=22), joint consultation with other medical services (n=17), and joint (n=9) or secondary consultation (n=13) with community palliative care services.

Despite IPCS involvement, AYA had high healthcare utilisation in the last 30 days of life with a total of 254 days spent on acute oncology wards, 20 presentations to emergency, and four admissions to the intensive care unit. In this time, 19 AYA (51%) had input from the IPCS consult service and 11 (30%) were admitted to PCU. Locations of death were acute hospital wards (n=12, 33%), PCU (n=11, 30%), home (n=6, 16%) and ICU (n=2, 5%).

Learnings, practice implications, and future directions

- Integration between our palliative care and AYA cancer teams has improved opportunities to optimise palliative care for AYA.
- Flexibility in the mode and nature of palliative care delivery is important to meet young people 'where they are'.
- We need feedback from AYA and their families about how our model is meeting their needs.

P-26 ANTIDEPRESSANTS FOR THE PALLIATIVE MANAGEMENT OF BREATHLESSNESS IN ADVANCED, LIFE-LIMITING DISEASE – A SYSTEMATIC REVIEW PROTOCOL

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Background Chronic breathlessness is a prevalent and debilitating symptom in people with advanced life-limiting disease and significantly impacts on function and quality of life. Despite this affecting at least half of our patients in the advanced stages of malignant or non-malignant disease, management options remain limited and inadequate. Current medication options, including opioids and benzodiazepines, lack robust evidence of efficacy and can cause significant adverse effects (Holland 2024, Feliciano 2021). Exploration of alternative pharmacotherapies, such as antidepressants, has the potential to improve symptoms and enhance outcomes for patients living with breathlessness due to advanced disease.

Objective To describe the protocol for a systematic review evaluating the efficacy and safety of antidepressants for the management of breathlessness in patients with advanced life-limiting disease.

Methods A comprehensive literature search will be undertaken of electronic databases including Medline, Embase, CINAHL, Cochrane and Emcare. The search strategy will include medical subject headings and text words related to 'antidepressants', 'breathlessness/dyspnoea', 'palliative care' and 'advanced disease', incorporating multiple conditions affecting respiratory function. Reference lists of included studies, grey literature and relevant reviews and guidelines will be hand-searched. Published peer-reviewed studies with no date or language restriction, covering adults with both malignant and non-malignant advanced diseases who receive antidepressants for the management of breathlessness will be included. Studies with mood, depression or anxiety as the primary outcome will be excluded. All retrieved titles and abstracts, as well as full text articles, will be independently dual screened. Disagreements will be resolved through consultation with a third reviewer if necessary. The primary aim of this review is to clarify the efficacy and safety of antidepressants in alleviating breathlessness in patients with advanced disease. Reporting of results will be in accordance with the Preferred Reporting Items of Systematic Reviews and Meta-Analyses (PRISMA) guidelines. If sufficient quantitative data can be analysed together, a meta-analysis approach will be employed. If this is not possible, a narrative synthesis will be used to report findings.

Discussion The results of this review, which are to follow, will evaluate whether antidepressants are beneficial in the symptomatic treatment of breathlessness in patients with advanced disease, thereby informing clinical practice. This review will also identify evidence limitations and gaps in this space that will guide research priorities in evaluating effective pharmacotherapies for managing breathlessness to optimise outcomes in this population.

Ethics and Dissemination As this is a planned review of published literature, ethics approval is not required. The findings of this systematic review will be of broad interest to clinicians and educators in palliative care, and results will be presented at conferences and published in a peer-reviewed journal. The systematic review has been registered on PROSPERO (CRD42024519856).

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