P-27 SAFETY PROFILE OF LIDOCAINE INFUSION IN PEOPLE WITH ADVANCED CANCER; SECONDARY OUTCOME DATA FROM LICPAIN FEASIBILITY TRIAL

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Background Adverse events of continuous subcutaneous infusion of lidocaine in people with neuropathic cancer pain have rarely been collected in a systematic way despite its use in clinical practice. The LiCPAIN trial aimed to determine the feasibility of conducting a double-blind randomized controlled trial of continuous subcutaneous lidocaine for neuropathic pain in people with advanced cancer. This analysis aimed to describe and compare treatment emergent adverse events (TEAEs) in the lidocaine and placebo arms.

Methods Adverse events (AE) were collected twice a day using a structured checklist based on the National Cancer Institute Common Terminology Criteria for Adverse Events (CTCAE) version 4, daily ECG and vital signs were reviewed. Severity, causality and the action taken with respect to study treatment were determined by the investigator. The proportion of people experiencing each TEAE were compared between lidocaine and placebo groups using Chi-squared tests.

Results Of the 17 participants who completed the trial, 11 (65%) were allocated to lidocaine infusion and 6 (35%) to placebo. There were 63 events experienced during the trial, 43 in the lidocaine group and 20 in the placebo group. Overall, 10 (91%) people in the lidocaine group and four (67%) in the placebo group experienced one or more TEAE (p=0.21), all of which included 'possibly, probably or definitely related' AE events.

The most common TEAE for the lidocaine group were tremor (n=5), fatigue (n=3), somnolence (n=3), dizziness (n=3), ataxia (n=3) and neoplasms (n=3). Only one of these events (neoplasm) was reported in the control group. AE that were classified as neoplasms represented disease progression in an advanced cancer population. Grade 3 or worse TEAE occurred in four participants in the lidocaine group: during the intervention (fatigue), during follow-up (depressed level of consciousness, neoplasms, terminal agitation) and post-study (neoplasms). They occurred in two participants in the placebo group: during the intervention (abdominal pain, hypertension) and follow-up (neoplasms, hypertension, biliary sepsis), p=0.90. There were four serious AE of neoplasm leading to death: in the lidocaine arm one occurred during follow up and two were an incidental finding post-study; in the placebo arm one death occurred during follow up (p=0.62). One of these deaths was determined to have a 'possible' causal relation to the lidocaine infusion with the others. No AE were detected on ECG.

Discussion Structured assessment found no significant difference between lidocaine and placebo groups regarding the number of participants experiencing one or more TEAE, related events, grade 3 or worse or serious AE. This study was not powered to compare AE between groups, therefore all p-values are considered nominal and caution is needed when interpreting this data to inform clinical practice. AE were common but mostly graded low severity in both intervention and placebo groups. Clinicians should monitor carefully for neurological symptoms as part of a structured assessment. A number of AE including those graded serious occurred in the follow up or post-study phase, which may be expected in this population. Future studies may further characterise the safety profile of lidocaine infusions in people with advanced cancer.

P-28 OPIOID REQUIREMENTS AND PALLIATIVE PAIN MANAGEMENT IN YOUNG ADULT CANCER PATIENTS AT THE END OF LIFE: A RETROSPECTIVE REVIEW AT AN AUSTRALIAN COMPREHENSIVE CANCER HOSPITAL

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Introduction Young Adult cancer patients, aged 18–39 years, represent a unique demographic. Evidence from a limited body of international research indicates that these patients tend to experience a high symptom burden, particularly pain, during their final month of life1. In Australia, there is limited knowledge regarding their end-of-life symptoms and management strategies.

Objective This study aimed to identify the prevalence, severity, mechanisms and the specialist palliative management of pain in young adult patients who received end-of-life care and died at the Chris O'Brien Lifehouse, an Australian comprehensive cancer hospital.

Methods

A retrospective design analysed the case notes of 72 eligible patients, aged 18–39 years at diagnosis, who died in the hospital between January 2017 and May 2024. Quantitative analysis was performed on the collected data.

Results All patients had solid organ metastatic disease with the most common types being sarcoma (33%), lung (15%), and gynaecological cancer (10%). All patients received specialist palliative care input. The median length of hospitalisation to time of death was 17 days (SD 18.6 range 0–122). All patients experienced pain and received opioids. 87% of patient scored their pain on admission as moderate-severe on the Edmonton Symptom Assessment Scale (ESAS). The mean Oral Morphine Equivalent Dose (oMEDD) was 275 mg (SD 403.7, range 20- 2250) with 30 patients (41%) receiving more than 300 mg of OMEDD. 25 (35%) patients received methadone, 15 (20%) patients received infusion ketamine, 6 (8%) patients received infusion lignocaine and 7 (9%) patients underwent interventional pain procedure. 64 patients (89%) received benzodiazepine for agitation and/or anxiety. 4 patients

(5%) had severe refractory pain requiring palliative sedation with levomepromazine and/or phenobarbitone.

Discussion and Conclusion Our findings showed that complex pain is highly prevalent in young adult cancer patients at the end of life requiring opioids, adjuncts and interventional pain strategies for management. This may be explained by age specific tumour types and predilection for bone and pelvic pain syndromes. Our data offer important information to the limited existing information in this area. In comparison standard palliative care cohort, our data showed that a large proportion of young adult patients require high doses of opioids for analgesia defined as OMEDD of more 300 mg2. Despite this pain remained poorly controlled in some patients requiring benzodiazepine or palliative sedation at the end of life, suggestive of total pain phenomenon, similarly reflected in several case reports1. When required, these patients require high doses of sedatives. Future research is needed to identify tailored treatment regimens for young adults with cancer-related pain, focusing on psychological symptom profile encompassing total pain.

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P-29 THE EVOLUTION OF 'PALLIATIVE CARE: ITS MORE THAN THEY THINK' CAMPAIGN

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Research conducted in The Prince Charles Hospital, Brisbane using conversational analysis of direct observation during initial Palliative Care outpatient consultations highlighted that patients have a very limited understanding of what palliative care is. Often palliative care is thought to involve care that occurs only immediately before death. This occurs despite referrals being made by medical professionals. Therefore, we surmised that either these clinicians also do not understand the scope of palliative care, or they are not effectively communicating this to the patients they are referring.

We set out to try to better understand clinicians' attitudes to palliative care and how we could improve their understanding of the full scope of palliative care enabling them to be able to communicate this better with patients.

The project was focused on the thoracic team at The Prince Charles Hospital, being one of the major referring teams. To assess understanding an anonymised survey was undertaken using the Knowledge and attitudes towards hospital and palliative care (KAHP) scale and several free text questions aimed at barriers and facilitators to palliative care referrals. Both medical practitioners and senior nursing staff were invited to complete the survey electronically.

19 responses from roughly 100 invited clinicians were received. 13 of these were from medical practitioners. Overall, clinicians felt that patients would benefit if palliative care was initiated earlier in the course of the illness, that palliative care improved symptom control and met the needs of the family better than conventional care. However, clinicians felt that discussing palliative care could cause patients and families to lose hope and that telling patients that they are dying is difficult. Despite this more than half of the respondents felt knowledgeable enough to discuss palliative care and well trained to take care of the symptoms in life limiting illnesses. Highlighted barriers to palliative care referral included a lack of time, not discussing palliative care with the patient and patients not being ready for palliative care. Potential facilitators to easier referral included clearer referral processes, increased knowledge about local resources, access to patient brochures and an increased profile of palliative care.

This led to the development of educational materials for clinicians with Palliative Care Australia (PCA) and the 'More than they think campaign'. Resources developed included a brochure, posters, slide show, video and a local services factsheet. These materials have been rolled out in The Prince Charles Hospital as part of an education program to the Thoracic department. They have also been made available via the PCA website for use by other services. We are currently in the process of evaluating the effectiveness of this education campaign.

P-30 IL-16 BLOOD LEVELS AND COMBINED POLYMORPHISM OF CCL11 AND IL-16 ARE THE BIOMARKERS TO SELECT OXYCODONE FOR CANCER PAIN MANAGEMENT

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Background For precision medicine for cancer pain, we identified a SNP in CCL11 (rs17809012) as one of the biomarkers significantly associated with the analgesic effect of morphine by screening 74 pain-related single nucleotide polymorphisms (SNPs).[1] In this study, to explore biomarkers for predicting opioid efficacy, we aimed to evaluate whether plasma concentrations of chemokines/cytokines and their SNPs in combination can accurately predict the most appropriate opioid for pain relief in cancer patients.

Methods In this study, plasma concentrations of several chemokines/cytokines were determined in pretreatment plasma samples obtained from a total of 138 patients enrolled in our previous clinical trial[2] who were randomly assigned to the morphine (N=70) and oxycodone (N=68) groups. The relationship between pre-treatment blood concentrations of various chemokines/cytokines and NRS (opioid analgesic effect) in the oxycodone group was investigated using simple regression analysis. Regarding IL-16, which showed promising results, we performed simple regression analysis using opioid type as independent variable and ΔNRS as dependent variable and multiple regression analysis using opioid type and IL-16 concentration (high or low) and opioid type IL-16 concentration (interaction term) as independent variables and NRS as dependent variable among all patients. Finally, we evaluated the relationship between the combination of both CCL11 and IL-16 SNPs and opioid efficacy using multiple regression analysis.

Results In the oxycodone group, there was a significant difference in NRS between groups (p=0.013) of patients with high (n=34) and low (n=34) blood levels of IL-16, and oxycodone was more effective in patients with lower IL-16 levels (p=0.038), whereas morphine was more effective in patients