

(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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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 fact-sheet. 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.

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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 trial² 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 Δ NRS 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

with higher IL-16 levels, although insignificant ($p=0.241$; p for interaction= 0.020). Morphine tended to provide a better analgesic effect than oxycodone in patients with the rs4778889 TT genotype and the rs17809012 AG/GG genotype ($n=45$), while a trend toward a better analgesic effect of oxycodone was observed in patients with other genotype combinations of the SNPs ($n=93$) ($p=0.001$ for interaction).

Discussion Our study suggests that IL-16 blood levels and polymorphism (rs4778889) may be useful as a possible biomarker for oxycodone selection. Only patients with IL-16 (rs4778889) TT and CCL11(rs17809012) AG/GG SNPs responded well to morphine, but only about 30% clinically (Japanese), suggesting that oxycodone may be superior for about 70% of patients. Combining these with IL-16 concentrations would further increase accuracy. It is hoped that a larger sample size will lead to the realization of personalized medicine for pain relief in the future through the revalidation of biomarker such as IL-16 identified in this study.

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HARNESSING THE NEW NATIONAL PALLIATIVE CARE STANDARDS FOR ACCREDITATION EVIDENCE!

SHOWCASING THE UPDATED NATIONAL PALLIATIVE CARE STANDARDS FOR SPECIALIST PALLIATIVE CARE PROVIDERS 5.1 ED. (2024) AND THE SIMPLIFIED PALLIATIVE CARE SELF ASSESSMENT (PACSA) CHECKLISTS TO SUPPORT CONTINUOUS QUALITY IMPROVEMENT. HEAR HOW OTHERS ARE USING THE STANDARDS IN PRACTICE

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Palliative Care Australia has been developing standards for more than 15 years to support the specialist palliative care sector to deliver high quality palliative care. A limited scope review conducted in 2023, led to two updates of the Quality Improvement Suite:

1. the introduction of the National Palliative Care Standards for Specialist Palliative Care Providers 5.1 ed. (2024) and
2. a series of downloadable checklist packs that support self-assessment against the revised Standards for clinical and service leadership teams.

The presenter aims to share with the audience the updates to the National Palliative Care Standards and how these were determined.

Utilising the newly launched PaCSA Checklist Packs (for self-assessment), the poster presenter will speak about the evidence collection that can be harnessed through this process to contribute to mandatory accreditation processes with the National Safety and Quality Health Service (NSQHS) Standards, the National Safety and Quality Primary and Community Healthcare Standards, and a range of other relevant Standards and Frameworks as they become available, such as the new Aged Care Standards.

Participants will be able to engage with the new National Palliative Care Standards for Specialist Palliative Care Providers 5.1 Ed. in new and more meaningful ways. The self assessment tools have been simplified to enable practical, timely responses to continuous quality improvement efforts, within the clinical setting and for professional development and service improvement innovations.

Continuous Quality Improvement, while a must within the health system, is often required to be addressed in clinical hours. PCA has listened to the needs of the sector and has established a program that fits within a variety of team or sole clinician settings, and has all the congruencies between other Standards and Frameworks mapped for you, to assist services to meet their QI requirements both within and outside the palliative care specialisation.

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DOES VOLUNTARY ASSISTED DYING IMPACT QUALITY PALLIATIVE CARE? A RETROSPECTIVE MIXED-METHOD STUDY

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Objectives We aimed to explore the relationship between the pursuit of Voluntary Assisted Dying (VAD) and the delivery of quality palliative care in an Australian state where VAD was newly available

Methods We adopted a retrospective convergent mixed-methods design to gather and interpret data from records of 141 patients who expressed an interest in and did or did not pursue VAD over two years. Findings were correlated against quality domains.

Results The mean patient age was 72.4 years, with the majority male, married/partnered, with a cancer diagnosis and identifying with no religion. A third had depression, anxiety or such symptoms, half were in the deteriorating phase, two thirds required help with self-care and 83.7% reported moderate/severe symptoms. Patients sought VAD because of a desire for autonomy (68.1%), actual suffering (57.4%) [existential more than physical], fear of future suffering (51.1%) and social concerns (22.0%). VAD enquiries impacted multiple quality domains, both enhancing or impeding whole person care, family caregiving and the palliative care team. Open communication promoted adherence to therapeutic options and whole person care and allowed for timely access to palliative care. Patients sought VAD over palliative care as a solution to suffering, with the withholding of information impacting therapeutic relationships. Our analysis ascertained that patients could fall into one of three categories: those open to exploring palliative care, those who were ambivalent about palliative care and VAD and those who were committed to pursuing VAD, regardless of palliative care involvement. Exploration of the fears, uncertainties, suffering and needs of these patients and families are critical clinical tasks. Palliative care practitioners are challenged to be companions to patients on each path, regardless of outcome.

Conclusions As legislation is expanded across jurisdictions, palliative care is challenged to accompany patients on their chosen path. Studies are necessary to explore how to ensure the quality of palliative care remains enhanced in those who