REFERENCES

1. Charon R. Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA*. 2001;**286**(15):1897–1902.
2. Richmond C. Dame Cicely Saunders. *BMJ*. 2005 Jul 23;**331**(7510):238.
3. Krisberg K. Narrative medicine: every patient has a story. https://www.aamc.org/news/narrative-medicine-every-patient-has-story, Accessed 9/27/2023.
4. Lanocha N, Mahoney D. Fostering Humanism Through Stories: A Plea for Narrative Medicine in Palliative Care Education. *J Pain Symptom Manage*. 2023 Mar;**65**(3):e229-e231.
5. Mezirow, J. 1991. *Transformative dimensions of adult learning*, San Francisco: Jossey-Bass.
6. Jaqua B, Johnson W, Daniels G, Xi AS. Storytelling and Written Reflection: Tools to Foster Meaning and Connection in Graduate Medical Education Settings. *J Grad Med Educ*. 2022 Oct;**14**(5):624–627.

OP-6 COMMUNITY PHARMACY ENGAGEMENT IN PALLIATIVE CARE

[1]Peter Allcroft*, [2]Paul Tait, [3]Michaela DelCampo. *[1]Commission On Excellence In Innovation And Health, Adelaide, Australia; [2]Rural Support Service South Australia, Adelaide, Australia; [3]Central Adelaide Local Health Network, Adelaide, Australia*

10.1136/spcare-2024-ANZSPM.6

Access to injectable medicines in the community is crucial for people wishing to die at home. Previous surveys in South Australia in 2012 demonstrated only 6% of pharmacies were able to facilitate medication provision to support dying at home. Following SA State Government funding in 2023 for 30 community pharmacies across SA to stock vital medications to support terminal phase symptom management in the community, we undertook a follow up survey to assess if there had been an improvement in the number of pharmacies who stock medications for symptom management at end of life.

An electronic survey was sent to all 499 registered pharmacies in South Australia via email with reminder follow up emails on 2 occasions. Data included postcode location which enabled an understanding of Socioeconomic Indexes for Area (SEIFA) quintiles of the respondents. The survey asked about medications held to provide symptom management for commonly encountered end of life symptoms. The 'preparedness score' (Range 0–5) was calculated as 1 point for each medicine held. Ethics approval was provided by SA DHW HREC.

Despite a low response rate of 41/499 pharmacies (8.2%), the respondents represented the distribution across SEIFA quintiles, and metropolitan and rural locations. While 23/41 (56%) held a valuable range of formulations, 12 (29%) stocked no medications to manage end of life medications. The 23 pharmacies with a preparedness score of 5 were in regional SA, higher sociodemographic regions, were linked with a Residential Aged Care facility and were aware of patients with palliative care needs in their area.

Whilst the response rate was poor, it appears that when compared to 2012, there has been an improvement in the number of pharmacies holding critical medications for end-of-life care at home. Strategies to improve the engagement of community pharmacies to stock medications used for end-of-life care is important. A 3-way co-operation between the pharmacist, General Practitioner and Specialist Palliative Care services would seem to be a good starting point by raising the awareness of potential patients to ensure stock is on hand. Strengthening these partnerships will help to care for people at home, and potentially reduce the impact on the acute care hospital sector. Further governmental support is critical to ensure policies and funding are directed to improving the care for people with life limiting illness to remain at home for end-of-life care if that is their preference.

OP-7 THE TIMING OF OPIOID INITIATION AND SWITCHING IN ADVANCED CANCER

[1,2,3]Aaron K Wong*, [1,3]Dorothy Wang, [2]Ian Gordon, [1]Marliese Alexander, [1]Beverly Siew, [1,3]Natasha Yap, [1,2,3]Brian Le, [1,2,3]Jennifer Philip. *[1]Peter MacCallum Cancer Centre, Melbourne, Australia; [2]University of Melbourne, Australia; [3]The Royal Melbourne Hospital, Australia*

10.1136/spcare-2024-ANZSPM.7

Background Cancer pain guidelines call for early opioid initiation. However, the timing of opioid initiation in relation to advanced cancer diagnosis has not been elucidated. The most frequent opioid used differs according to country and region, and the timing and frequency surrounding opioid switching in Australia also not been clearly documented. The role of palliative care teams in initiating opioids for advanced cancer is also unclear.

Aim To determine the timing of opioid initiation and switching by prescriber and cancer type, in relation to key timepoints in the cancer illness course (diagnosis, palliative care referral, and death).

Design Retrospective cohort study.

Setting/Participants Patients at a quaternary cancer centre diagnosed with incurable advanced biliary/liver, colorectal, lung, renal/bladder, and pancreatic cancers between 1 August 2020 – 1 August 2022 were eligible. Demographics, clinical characteristics, health service use, and details of longitudinal slow and immediate release opioid prescriptions are reported.

Results Among 200 patients, median time from advanced cancer diagnosis to first immediate release opioid prescription was 23 days (IQR 1, 82) and to slow release opioid prescription was 47 days (IQR 14, 155). Most patients (95%, (n=190) were referred to palliative care (median time to referral 54 days (IQR 18, 190)). Non-palliative care prescribers initiated slow release opioids for half of participants (49%, n=97) prior to referral. Patients with pancreatic cancer had earliest time to slow/immediate release opioid prescription (median 10 days (IQR 0, 39) and 26 days (IQR 1, 43) respectively) and shortest survival (median 136 days (IQR 82, 214)).

Over half (58%) patients underwent opioid switching at least once. Of these, approximately two-thirds switched due to uncontrolled pain or adverse effects and the remainder switched due to need to use a separate route for clinical reasons. Over a quarter (28%) switched opioids twice and 8% switched three times. The opioid dose threshold for switching appeared to be almost always approximately double of the opioid starting dose.

Discussion/Conclusions Time from diagnosis of advanced cancer to opioid commencement is short (median 3 weeks). Therefore people with advanced cancer require early pain intervention and management within the first month after diagnosis. Median time from opioid commencement to death was 4 months and this may mitigate patient and prescriber concerns around opioid tolerance and dependence which often develop over longer time periods.

Opioid switching is more common in our centre compared to the available data published in Europe. Potential reasons for this will be discussed. Time to opioid initiation varies according to cancer type, suggesting a difference in pain

presentations. Diagnosis of advanced pancreatic cancer is associated earlier opioid commencement. People with pancreatic cancer may benefit from routine early referral to palliative care services to coordinate complex pain management needs due to earlier pain presentations and shorter prognosis.

OP-8 A FEASIBILITY RANDOMIZED CONTROLLED TRIAL COMPARING OPIOID DOSE ESCALATION VS. METHADONE ADDITION FOR REFRACTORY CANCER PAIN

[1]Takako Ikegami*, [2,3]Hiromichi Matsuoka, [4]Kosuke Terada, [5]Shunsuke Oyamada, [6]Keisuke Ariyoshi, [1]Naho Matsubara, [1]Ayaka Ishikawa, [1]Rumi Nishimura, [1]Naruaki Kawasaki, [1]Sayaka Arakawa, [1]Hiroto Ishiki, [4]Makoto Maeda, [4]Hironobu Hashimoto, [7]Tomofumi Miura, [8]Hiroshi Ishiguro, [9]Yoshihisa Matsumoto, [1,3]Eriko Satomi. *[1]Department of Palliative Medicine, National Cancer Center Hospital, Chuoku, Japan; [2]Department of Psycho-oncology, National Cancer Center Hospital, Chuoku, Japan; [3]Department of Palliative and Supportive Care Development, National Cancer Center Hospital, Chuoku, Japan; [4]Department of Pharmacy, National Cancer Center Hospital, Chuoku, Japan; [5]Biostatictics, Japanese Organization for Research and Treatment of Cancer; [6]) Data Center, Japanese Organisation for Research and Treatment of Cancer, Arakawaku, Japan; [6]Data Center, Japanese Organization for Research and Treatment of Cancer, Arakawaku, Japan; [7]Department of Palliative Medicine, National Cancer Center East Hospital , Kashiwa city, Japan; [8]Breast Oncology Service, Saitama Medical University International Medical Center, Hidaka city, Japan; [9]Department of Palliative Medicine, Cancer Institute Hospital of JFCR, Koutoku, Japan*

10.1136/spcare-2024-ANZSPM.8

Background Cancer pain affects 38–85% of cancer patients, with higher incidence in advanced stages.[1] Poorly controlled cancer pain, often with neuropathic elements, presents a significant unmet medical need. Despite various opioid formulations, 47% of physicians report difficulties in managing opioid-refractory pain.[2] Methadone has shown superior efficacy to other opioids, such as morphine, especially for neuropathic pain poorly controlled by other opioids.[3] Currently, opioid escalation is the standard, but is often inadequate, and although the methadone add-on (AO) method has been reported to be safe and effective for refractory cancer pain, no randomized controlled trials (RCTs) have been conducted.

Aims This study aims to explore the feasibility of conducting a double-blind RCT to assess the efficacy and safety of the methadone AO method for opioid escalation in patients with cancer pain.

Methods This study is a single-facility, double-blind, parallel-arm RCT. A total of 22 patients will be enrolled between July 2024 and September 2025. Eligible participants are adults with unresectable advanced cancer experiencing refractory cancer pain on an appropriate dose of opioid analgesia (60–300 mg oral morphine equivalent daily dose, OMEDD) and a Karnofsky Performance Status (KPS) >50. Participants will be randomized (1:1) to the methadone AO arm or the standard treatment arm. Evaluations will be conducted at baseline (randomization), day 1, 8, and 15. In the methadone AO arm, patients will receive over-capsulated methadone 5 mg or 10 mg, and in the 5 mg group, placebo will be used to unify the twice-daily dosing of the study drug. In the standard treatment arm, patients will receive over-capsulated oxycodone 10 mg or 20 mg. The primary endpoint is the completion rate of the two-week study treatment, defined as 70% or more. Secondary endpoints include changes in BPI scores before and after the study treatment and adverse events.

Discussion Several considerations influenced the study design. First, the methadone dosage required careful determination. Previous studies suggest equivalence ratios of OMEDD 30–90 = 4:1, 90–300 = 6:1, and over 300 = 8:1. For this study, we set the morphine-to-methadone ratio at 6:1, which is safer than the 3:1 and 5:1 reported in other studies but less conservative than NCCN recommended 10:1. Second, the primary endpoint was defined as achieving a study completion rate of at least 70%. Although no prospective clinical trials exist, a Canadian cohort study (N=146) reported a continuation rate of 78.1% at Day 15 with a mean methadone dose of 6 mg. This data and discussions within our study group, led us to set a 70% completion rate. Finally, we chose a 2-week study period based on previous research: Mercadante et al. (n=108) found stable methadone doses over 4 weeks, and Bruera et al. (n=103) reported over 20% pain relief by Day 8 with no dose change between Days 14 and 28. Thus, 2 weeks is sufficient for efficacy and safety assessment. Based on the results of our study, we plan to conduct a larger-scale RCT of the methadone to establish a treatment for refractory cancer pain.

REFERENCES

1. Poulain P, Berleur MP, Lefki S, *et al*. Efficacy and safety of two methadone titration methods for the treatment of cancer-related pain: The EQUIMETH2 Trial (Methadone for Cancer-Related Pain). *J Pain Symptom Manage.* 2016 Nov;**52**(5):626–636.e1
2. Mercadante S, Porzio G, Ferrera P, *et al*. Sustained-release oral morphine versus transdermal fentanyl and oral methadone in cancer pain management. *Eur J Pain.* 2008 Nov;**12**(8):1040–6.
3. Bruera E, Palmer JL, Bosnjak S, et al. Methadone versus morphine as a first-line strong opioid for cancer pain: a randomized, double-blind study. *J Clin Oncol.* 2004 Jan 1;**22**(1):185–92.

OP-9 SHOULD WE GIVE UP ON LIDOCAINE TRIALS? IMPLICATIONS OF PRELIMINARY RESULTS OF THE LIDOCAINE FOR NEUROPATHIC CANCER PAIN FEASIBILITY STUDY (LICPAIN)

[1,2,3]Jessica Lee*, [1]Emily Huang, [1]Eugenia Hutton, [4]Angela Rao-Newton, [5]Rajesh Aggarwal, [6]Davinia Seah, [7,8]Melanie Lovell, [9]Chadi Ayoub, [10]Priyanka Vandersman, [11]Belinda Butcher, [12]David Currow, [13]Jane Phillips, [8]Andrew McLachlan, Beverly Noble, [14]Linda Brown, [15]Nikki McCaffrey, [16]Belinda Fazekas, [6]Richard Chye, [17]Christine Sanderson, [18]Caitlin Sheehan, [1,3]Ghauri Aggarwal, [19]Katalin Urban, [1,3]Anthony Linton, [1]Marion Kow, [1]Rachel George, [2]Meera Agar. *[1]Concord Repatriation General Hospital, Sydney, Australia; [2]Improving Palliative, Aged and Chronic Care through Clinical Research and Translation (IMPACCT) University Technology Sydney, Ultimo, Australia; [3]Concord Clinical School, University of Sydney, Concord, Australia; [4]University of Tasmania, Sydney, Australia; [5]Bankstown-Lidcombe Hospital, Bankstown, Australia; [6]St Vincent's Hospital, Darlinghurst, Australia; [7]Hammondcare, Greenwich, Australia; [8]University of Sydney, Camperdown, Australia; [9]Mayo College of Medicine, Phoenix, USA; [10]College of Nursing and Health Sciences, Flinders University, Adelaide, Australia; [11]Writesource Medical, Lane Cove, Australia; [12]Faculty of Science, Medicine and Health, University of Wollongong,Wollongong, Australia; [13]School of Nursing, Queensland University of Technology , Brisbane, Australia; [14]Victorian Department of Health, Melbourne, Australia; [15]Deakin University, Melbourne, Australia; [16]IMPACCT Trials Coordination Centre – ITCC University Technology Sydney, Ultimo, Australia; [17]Territory Palliative Care, Alice Springs, Australia; [18]South Eastern Sydney LHD, Kogarah, Australia; [19]Northern Rivers Supportive and Palliative Care, Lismore, Australia*

10.1136/spcare-2024-ANZSPM.9

Background Lidocaine infusions are used variably around Australia to treat people with neuropathic cancer pain. The LiCPAIN trial aimed to determine the feasibility of conducting a double-blind randomised controlled trial of continuous subcutaneous lidocaine for neuropathic cancer pain. The primary objective was

Methods Palliative care inpatients at 5 metropolitan NSW sites were randomised to a 72-hour continuous infusion of subcutaneous lidocaine or placebo at 1–2mg/kg/hr, capped at 120mg/