OP-11 A DOUBLE-BLIND RANDOMISED CONTROLLED TRIAL OF DOSE-ESCALATED CBD/THC OIL FOR SYMPTOM MANAGEMENT IN ADVANCED CANCER

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Background Patients with advanced cancer commonly access cannabis in an attempt to improve their symptoms. It has been difficult to show evidence of benefit for individual symptoms in a randomised controlled trial setting however. Rather than focus on specific symptoms, we have chosen to assess the benefit, if any, of medicinal cannabis (MC) on total symptom burden.

Objective To assess the impact of a 1:1 10mg/10mg THC/CBD oil on total symptom burden in patients with advanced cancer receiving palliative care.

Methods Eligible patients had a total symptom distress score (TSDS) as measured by an Edmonton Symptom Assessment Scale (ESAS) of $\geq$10/90 (with a least one symptom score $\geq$3) and a negative baseline THC urine test. They were excluded if they had severe liver, renal or psychiatric dysfunction or were still driving a motor vehicle. Participants were randomised to MC oil, with a dose escalation from 2.5mg to 30mg/day, or matched placebo over 14 days according to tolerance and efficacy. The patient determined dose was then continued for another 14 days. The primary outcome measure was change in TSDS from baseline at 14 days. Secondary outcomes included participant selected dose, individual symptom scores, change in TSDS over time, opioid use, depression, anxiety and stress (DASS), QoL (EORTC), global impression of change (GIC) and adverse events (AEs).

Results One hundred and forty-five patients were randomised over 46 months to reach the planned sample size of 120 at day 14. The median (range) dose for those in the active arm was 15mg (5–30mg) THC/CBD per day. The mean (SD) change in TSDS from baseline was -6.30 (12.30) for MC and -6.98 (12.56) for placebo, with no difference between arms (p=0.76). Response (defined as $\geq$6 point fall in TSDS from baseline) was 25/56 (44.6%) for MC and 32/65 (49.2%) for placebo, p=0.75. 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) in favor of MC, remaining significant when adjusted for baseline values (mean (SE) 0.85 (0.42)) (p=0.04) and supported by a reduction in QoL pain scores (difference in reduction of pain score/day 0.46 (SE 0.2), p=0.02). AEs of special interest revealed an increased incidence of confusion, feeling high, and exaggerated sense of well-being in MC arm. There was no difference between arms for any other secondary outcome. Attrition from toxicity was higher in the MC arm.

Discussion The delivery of palliative care led to an improvement in TSDS over time in patients with advanced cancer. The addition of MC did not add to this benefit but did result in a small improvement in pain scores at the expense of increased toxicity.

OP-12 MANAGING TREATMENT-REFRACTORY DIARRHOEA IN PALLIATIVE CARE

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Building on a case report[1] published earlier this year, we wish to present another two interesting cases where the novel use of clonidine has effectively resolved chronic treatment-refractory diarrhoea. There is currently minimal literature on how to manage chronic diarrhoea in a palliative setting, and in this presentation, we will summarise and outline a treatment algorithm. We will also discuss the beginnings of our prospective case series audit, looking into patient-reported outcome measures post clonidine for opioid-refractory chronic diarrhoea, presently taking place at the Wesley Hospital, Brisbane. Diarrhoea can be a distressing symptom and occurs in about 6% of advanced cancer and 7–10% of hospice patients.[1] Currently, there is a spotlight on clonidine and its use in palliative care for pain and terminal agitation management. Its use, however, for palliative diarrhoea management has only briefly been discussed, more than 30 years ago, and is not part of standard practice. We wish to challenge the current treatment patterns and transform the recommendations for chronic diarrhoea in palliative care. Clonidine has been found to be beneficial in multiple aetiologies of diarrhoea but especially in autonomic enteropathy. We will present cases where clonidine has successfully treated chronic diarrhoea secondary to recurrent coeliac plexus blocks, short gut syndrome and chemotherapy/infection. These cases, also demonstrate clonidine's effectiveness, where octreotide, the current last-line of treatment, has failed. Within one week of commencing clonidine, we saw an improvement in the frequency and consistency of diarrhoea for our patients, ultimately leading to the resolution of the symptom, without significant adverse events.

REFERENCE

1. Kahawita T, Leong LJP, McConaghy JR. The use of clonidine to manage chronic refractory diarrhoea in a palliative patient: a case report. *Progress in Palliative Care.* Published online: 07 Feb 2024.

OP-13 ASSESSING THE COMPLETION RATE OF ADVANCE CARE PLANNING OF NEW PATIENT REFERRALS TO SPECIALIST PALLIATIVE CARE AND QUALITY OF SAME – A RETROSPECTIVE CHART ANALYSIS

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Introduction Enhancing advance care planning has become a policy priority in Australia and internationally. This study compares the prevalence and quality of advance care planning documents in new referrals to a community palliative care service to documents subsequently completed by the community palliative care service, as well as determining the prevalence of patients who died in their preferred place of death.

Method This retrospective chart analysis of 150 patients referred to the Gold Coast Community Palliative Care Service between January and May 2021 reviewed all types of advance