

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

<sup>1,2,3</sup>Phillip Good\*, <sup>4</sup>Ristan Greer, <sup>5</sup>Anita Pelecanos, <sup>6</sup>Alison Kearney, <sup>1,2</sup>Georgie Huggett, <sup>1,2</sup>Taylan Gurgenci, <sup>2</sup>Janet Hardy. <sup>1</sup>Mater Health, Brisbane, Australia; <sup>2</sup>Mater Research Institute-University of Queensland, Brisbane, Australia; <sup>3</sup>St Vincent's Private Hospital, Brisbane, Australia; <sup>4</sup>Torus Research, Brisbane, Australia; <sup>5</sup>Queensland Institute of Medical Research, Brisbane, Australia; <sup>6</sup>Royal Brisbane and Women's Hospital, Brisbane, Australia

10.1136/spcare-2024-ANZSPM.11

**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**

Trish Kahawita\*, Laurence Leong. Wesley Hospital, Brisbane, Australia

10.1136/spcare-2024-ANZSPM.12

Building on a case report<sup>1</sup> 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.<sup>1</sup> 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**

Charlotte Reed\*. Gold Coast Hospital and Health Service, Robina

10.1136/spcare-2024-ANZSPM.13

**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

care planning documents with the focus on advance health directives, the Advance Care Directive in Queensland. Accessibility, validity, and appropriateness of advance health directives was assessed. Preferred place of death was compared to actual place of death. The analysis used proportions, binomial confidence intervals and univariate logistic regression.

**Results** 52% of patients were male and the median age was 74 years. Most patients had a cancer diagnosis (85%). The prevalence of advance health directive completion at the time of referral was much higher than other Australian studies (27%). Referrers completed more advance health directives (27%, CI 19.8, 34.5) than community palliative care service (9%, CI 4.5, 16.1); however, had lower upload rates to the electronic medical record (42.5% vs 80%) and 29% were invalid. The strongest predictor of advance health directive completion was preparation of other advance care planning documents. Community palliative care completed more acute resuscitation plans than referrers (44% vs 25%). Completion of an acute resuscitation plan reduced advance health directive completion ( $p = 0.49$ ). Home was the preferred place of death for 47% of patients. 64% of patients died at their preferred place of death.

**Conclusion** This study has a higher prevalence of all types of advance care planning compared to other Australian studies including advance health directives. The community palliative care service had a lower prevalence of advance health directives when compared to referrers. Accessibility remains low with less than half uploaded to the electronic medical record. Almost a third of advance health directive completed prior to referral uploaded to the electronic medical record were invalid highlighting the need to review these documents. The higher prevalence of acute resuscitation plan than advance health directive may be because of a lack of designated time, resources, and funding for opportune completion. A home death remains the goal for most patients.

#### OP-14 PERSONAL VALUES AND ITS IMPACT ON DECISION MAKING IN CANCER PATIENTS AND CAREGIVERS

<sup>1,2</sup>Natasha Michael\*, <sup>3</sup>Xavier Symons, <sup>1</sup>George Mendz, <sup>1,2</sup>David Kissane. <sup>1</sup>University of Notre Dame, Australia, Melbourne, Australia; <sup>2</sup>Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne Australia; <sup>3</sup>Australian Catholic University, Sydney, Australia

10.1136/spcare-2024-ANZSPM.14

**Background** For many, a cancer diagnosis signals death's inevitability and elicits existential concern. In the quest for life prolongation, patients seek futile life-sustaining treatments, fail to appreciate a declining trajectory and lack the opportunity to seek information or plan meaningfully for their future. Advance care planning (ACP) is a process that supports adults at any age or stage of health to plan for future care through an understanding and sharing of personal values, life goals and preferences. An increased emphasis is now placed on exploring personal values to ensure alignment with the choices made relating to treatment and end-of-life desirables. Interventions that incorporate a values-based paradigm remain underdeveloped.

**Method** Using a multi-method research design, we developed a novel intervention using the video vignette technique and incorporated the dyadic approach to examine participants' perceptions, beliefs and attitudes. A randomised controlled trial formed the analytical core of this study, with a secondary

qualitative component. Cancer patient-caregiver dyads were randomised to a values-based video vignette intervention or usual care. We hypothesised that those exposed to the video intervention would be more likely to complete an ACP.

**Results** One hundred and thirteen cancer patient-caregiver dyads were recruited and randomised. Our findings described older participants as more likely to identify with values. Furthermore, we highlight that the mutuality of dyadic relationships in care planning may be conceptualised at three levels: communication, reciprocal influence and patient-caregiver congruence. In eliciting personal values, cancer patients concurrently postured stances of vulnerability and resilience, in keeping with conflicting emotions and experiences. Equanimity in the cancer patient was apparent with acceptance of frailty and finitude of life, sustained benevolence to others and the use of ritual at the end-of-life.

**Conclusion** We highlight that ACP requires contextualisation of individual situations and values and should focus on achieving meaningful outcomes beyond completing documents.

#### OP-15 PREVALENCE OF ENDURING POWER OF ATTORNEY AND ADVANCE HEALTH DIRECTIVE DOCUMENTS AMONG CULTURALLY AND LINGUISTICALLY DIVERSE PATIENTS RECEIVING COMMUNITY PALLIATIVE CARE: A STUDY IN QUEENSLAND'S MOST POPULATED HEALTH SERVICE

<sup>1</sup>Tito Prasetyo\*, <sup>2</sup>Catherine Joyce, <sup>3</sup>Justin Scott, <sup>1,2,4</sup>Greg Parker. <sup>1</sup>Metro South Palliative Care Service, Metro South Health, Brisbane, Australia; <sup>2</sup>Brisbane South Palliative Care Collaborative, Metro South Health, Brisbane, Australia; <sup>3</sup>QCIF Biostatistics, Institute for Molecular Bioscience, The University of Queensland, Brisbane, Australia; <sup>4</sup>Statewide Office of Advance Care Planning, Advance Care Planning Australia, Brisbane, Australia

10.1136/spcare-2024-ANZSPM.15

**Background** Advance Care Planning (ACP) is vital to ensure patients' wishes are respected in healthcare decisions, particularly in the context of palliative care.<sup>1</sup> ACP improves outcomes for patients and their families.<sup>2-3</sup> However, there is limited knowledge of ACP prevalence among Culturally and Linguistically Diverse (CALD) populations, especially in community palliative care settings.<sup>4-5</sup>

**Aims** The primary aim was to determine the prevalence of Enduring Power of Attorney (EPOA) and Advance Health Directive (AHD) within CALD populations versus general population receiving community specialist palliative care services (CSPCS). The secondary aims were to evaluate the prevalence of the above documents 6 months post referrals to a community specialist palliative care service and identify factors influencing completion.

Abstract OP-15 Table 1 Sample characteristics†(n=576)

Characteristic	No. (%)
Age (Years)	
<65	102 (18)
≥65	474 (82)
Median (IQR)	78 (69, 85)
Sex	
Female	265 (46)
Male	311 (54)
Mortality rate (6 months post-referral)	
Deceased	242 (42)
Alive	334 (58)