Data were extracted and checked by two authors. Cochrane Collaboration guidelines assessed bias risk in 6-domains. GRADE criteria rated overall evidence.

**Results**

Six papers were identified (including two from previous review), outlining five RCTs and two n-of-1 trials. Five used MPD alone and two MPD as adjunct to mirtazapine or SSRI, for a total of 229 patients. Trials compared MPD to placebo or desipramine. Small sample sizes and poor recruitment meant all trials were at high bias risk. Unfortunately, trials were heterogeneous and meaningful meta-analysis could not be performed. Most trials showed a trend toward effectiveness, however results were frequently not statistically significant. One recent trial found no evidence of effect. Methylphenidate was generally well-tolerated.

**Conclusion**

There remains no conclusive evidence as to whether methylphenidate is an effective antidepressant in PC cohorts.

**REFERENCE**


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**A RAPID EVIDENCE ASSESSMENT OF THE OPTIMAL PHENOBARBITAL DOSAGE REGIMEN FOR MANAGEMENT OF INTRACTABLE AGITATION IN THE LAST DAYS OF LIFE TO PRODUCE A CLINICAL GUIDELINE**

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**Background**

Agitation is a common symptom at the end of life; without prompt assessment and management it can cause significant distress to patients and relatives. Clinical practice in the pharmacological management of intractable terminal agitation varies, particularly if the commonly used agents (benzodiazepines and antipsychotics) have failed to be effective. These difficult clinical scenarios require a robust approach to control symptoms effectively. This review aims to facilitate production of an evidence-based guideline for the use of Phenobarbital for intractable agitation at the end of life, for use within a Specialist Inpatient Palliative Care Unit.

**Method**

A literature search was carried out through EMBASE, Medline, CINAHL and PubMed databases, using synonyms of ‘Phenobarbital’, ‘Palliative’ and ‘Agitation’ as search terms.

Two researchers reviewed the search results. Articles specifying doses of injectable Phenobarbital were included for review. Additionally, in the case of review articles, the original sources stating dosage were reviewed where available.

**Results**

11 of the 25 articles from the initial search met inclusion criteria. Of these, 6 were excluded as they lacked sufficient detail. With the inclusion of one further source referenced in a review article, a total of 6 core sources were used. They described various doses of Phenobarbital used for end-of-life agitation.

**Conclusions**

This review of the current evidence base provided no standard or optimal dosing regime. However, based on the available evidence, a clinical guideline will be produced for use of Phenobarbital in intractable agitation at the end of life in our unit: with an IM loading dose of 200 mg followed by a continuous subcutaneous infusion of 800 mg-1600 mg/24 hrs. Due to the infrequency of this presentation and the use of Phenobarbital; sharing and evaluating the guideline at a regional level would facilitate more rapid efficacy assessment and refinement.