141 **WHAT MAKES PATIENTS PREFER HOSPITAL BASED BREATHLESSNESS SUPPORT SERVICES COMPARED TO GP BASED SERVICES? QUALITATIVE ANALYSIS OF FREE TEXT QUESTIONS WITHIN A DISCRETE CHOICE EXPERIMENT**

U Raja, D Yi, N Lovell, IJ Higginson. *King's College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation*

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Introduction Chronic breathlessness is common, and is frightening for patients and carers with associated distress and higher care use. The OPTBREATHE study (a discrete choice experience (DCE)) looked at patient and carer preference with regards to breathlessness support services, and found that patients and carers preferred hospital based services when compared to GP based services.

Aim Using free text questions within the DCE, explore possible reasons why patients and carers might express a preference for hospital-based breathlessness support services.

Methods Textual analysis of the free text questions (completed by participants) alongside the DCE as part of the OPT-BREATHE study. Free text answers were analysed thematically and grouped into categories.

Results 190 patients and 68 carers participated in the DCE. There were 69 free-text answers provided. Data was organised using the following categories: waiting times, additional support by professionals, presumed quality of care, perceived risks, location of care and patient or carer preferences. There were 5 occurrences of the belief that GPs couldn't provide specialist care. 1 patient did not want to see the GP due to perceived risk of infection. 6 patients didn't want to have any additional support provided by professionals such as social workers and physiotherapists. There were 11 occurrences of patients wanting to have all the treatment at home.

Conclusion Analysis of the free text questions provides some understanding about why patients and carers might express a preference for hospital based breathlessness support services. Educating patients and carers may help change attitudes and increase access to GP-based services in the future. Multiple patients and carers wanted the majority of services to be provided at home. This would need to be thought of including providing care with a healthcare professional they prefer.

142 **ENHANCING CANCER SURVIVORSHIP – OVERCOMING THE CHALLENGES OF INTRODUCING THE 'RECOVERY PACKAGE' IN A CANCER CENTRE**

Julie Bliss, Alison Franks, Bill Kelly, Carole Bailey, Andrzej Malaczoski, Dan Acquah. *University Hospitals Coventry and Warwickshire NHS Trust*

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Background With the explosion of effective treatments for cancers, approximately 500,000 UK citizens are living with the physical and psychological consequences. In 2013 the National Cancer Survivorship Initiative, including Macmillan Cancer Support 'Recovery Package'(RP), was launched, focused on improving quality of life for these people. We report our approach and progress at UHCW.

Method We initiated a multi-professional steering group, including hospital staff, commissioners, a GP, rehabilitation and exercise specialists and a patient representative. The Health Needs Assessment (HNA) was in elementary use, but

needed encouragement. Cancer care reviews(CCR) are the province of General Practice – our GP member is driving it. For the End of treatment summaries, EoTS, (for professionals) and Health and well-being events, HWbE, (providing information, support and signposting for patients empowering them to self-manage, with support, the emphasis being on living well beyond cancer), we initiated two 'task and finish'groups. **Results** HNA – initially one nurse incorporating it, now eight.

CCRs – unfunded, but education and incorporation ongoing.

EoTS – through collaboration with oncology IT team automatically generated letters developed in oncology electronic medical record and prescribing system, informing on potential medium – long-term treatment side effects, using a structured and consistent format. Piloted for curative radiotherapy in prostate cancer – telephone audit conducted after a month with recipient GPs – letters modified accordingly. Summaries currently active for four cancer sites, three launching imminently. Systemic treatment summaries in development.

HWbE – new concept, no prescribed format, nor any budget so initial ambitions refined. All patients starting treatment invited to monthly events. Six attended the first. Most recently (the fourth), there were 38. Evaluation enthusiastic and positive from patients and relatives.

Conclusion Implementing RP is challenging, requiring effective co-operative multi-professional/multi-agency collaboration. Automated summaries, audit, feedback, imagination and flexibility are crucial.

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143 **OLANZAPINE FOR THE PREVENTION AND TREATMENT OF CANCER-RELATED NAUSEA AND VOMITING IN ADULTS: A NEW COCHRANE SYSTEMATIC REVIEW**

A Sutherland, K Naessens, E Plugge, L Ware, K Head, MJ Burton, B Wee. *Katharine House Hospice, Cochrane UK, Oxford Radcliffe Trust/Health Education Thames Valley, Cochrane ENT, University of Oxford, Sir Michael Sobell House, Churchill Hospital Oxford*

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Background The use of olanzapine as an anti-emetic represents a new use of an old second generation atypical anti-psychotic drug.

Objectives To assess the efficacy and safety of olanzapine when used as an anti-emetic in the prevention and treatment of nausea and vomiting related to cancer in adults.

Results We included 14 RCTs (1917 participants). Eight studies await classification and 13 are ongoing. Olanzapine probably doubles the likelihood of freedom from nausea and vomiting during chemotherapy from 25% to 50% (RR 1.98, 95% CI 1.59 to 2.47; 561 participants; solid tumours; HEC or MEC therapy; moderate quality evidence) when added to standard therapy. Number Needed to Treat for additional benefit (NNTB) was 5 (95% CI 3.3 to 6.6). It is uncertain if olanzapine increases the risk of serious adverse events (absolute risk difference 0.7% more, 95% CI 0.2 fewer to 5.2 more, RR 2.46, 95% CI 0.48 to 12.55; low quality evidence). Olanzapine may increase other adverse events (RR 1.71, 95% CI 0.99 to 2.96; low quality evidence) and probably increases somnolence and fatigue compared to no treatment or placebo (anticipated absolute risk 8.2% more, 95% CI 1.9 to 18.8; participants=464; studies=5; moderate

quality evidence). Olanzapine probably reduces delayed and vomiting. It is unclear if efficacy differs between 5 mg and 10 mg doses. We cannot exclude the possibility that 5 mg may be associated with a lower risk of somnolence and fatigue than 10 mg.

Conclusions There is moderate quality evidence that oral olanzapine increases freedom from nausea and vomiting in adults undergoing chemotherapy for solid tumours. There is uncertainty whether it increases serious adverse events. It may increase the likelihood of other adverse events and probably increases somnolence and fatigue. There is uncertainty about the relative benefits and harms of lower (5 mg) and higher (10 mg) doses.

144 EVALUATION OF EXISTING PRACTICE: DENOSUMAB FOR HYPERCALCAEMIA OF MALIGNANCY

Emily Kavanagh, Elizabeth Woods, Jolene Brown, Felicity Dewhurst, Kerry Waterfield, Grace Rowley, Jonathan Pickard, Donna Wakefield. *Palliative Medicine Registrars at Health Education North East*

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Background Hypercalcaemia of malignancy (HoM) is a burdensome problem affecting up to 44% of patients with advanced cancer. The standard of care is treatment with an intravenous bisphosphonate. Bisphosphonates are contraindicated in renal failure.

Denosumab is a monoclonal antibody that inhibits osteoclast differentiation and activity. Licensed for the prevention of skeletal related events in patients with bone metastases, Denosumab has been noted to cause hypocalcaemia in previously normocalcaemic patients. Denosumab is administered by subcutaneous injection and is safe in renal failure.

Ad hoc use of Denosumab for HoM has been observed in the palliative care setting.

We aimed to evaluate existing practice around the use of Denosumab for HoM by palliative medicine consultants in the North East of England.

Methods We constructed an online survey informed by a targeted literature review. The survey was disseminated electronically to all consultants in the North East regional palliative care physicians' group. An email reminder was sent after 7 weeks. The survey was closed after 8 weeks.

Results There were 28 respondents out of a possible 34. Eleven (39.3%) had used Denosumab for HoM. Of these, all used Denosumab for bisphosphonate refractory hypercalcaemia. There was some experience where bisphosphonates were contraindicated due to renal impairment. One patient was administered Denosumab at home. Four respondents used Denosumab in repeated doses for the same patient. Eight respondents reported that Denosumab successfully reduced serum calcium; three reported 'sometimes'. Doses varied between 60 mg and 120 mg.

All consulted with another specialty (oncology 90.9%) prior to using Denosumab.

There was high variability in the duration to re-test serum calcium. Two respondents encountered hypocalcaemia. There were no other adverse effects reported.

Conclusions Our results describe regional experience in the use of Denosumab. There was a wide variation in dosing and monitoring practices. The development of evidence-based guidance is strongly recommended.

145 WHAT OUTCOMES ARE IMPORTANT IN A DRUG TRIAL FOR CHRONIC BREATHLESSNESS AND ARE WE CAPTURING CHANGE?

N Lovell, SN Etkind, S Bajwah, M Maddocks, IJ Higginson. *Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, King's College London*

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Background Chronic breathlessness is common, distressing and remains a challenging to assess and treat. New treatments are emerging, but must be evaluated using appropriate outcomes that reflect the concerns of people experiencing the symptom.

Aim To determine which outcomes are important to patients with chronic breathlessness, and the ability of outcome measurement tools to capture change during a drug treatment trial.

Methods Mixed-methods analysis of a multi-centre randomised double-blind feasibility trial of mirtazapine (ISRCTN registration 33236160). Quantitative outcome measures: numerical rating scale (NRS) for worst breathlessness in the last 24 hours, and chronic respiratory questionnaire (CRQ) were paired to in-depth qualitative data from interviews exploring outcomes of importance within the trial. Qualitative data was analysed thematically and quantitative data analysed according to the standard guidance for each questionnaire. The combined analyses were then triangulated, drawing upon a model of total breathlessness.

Results Paired data were available for 22 of 64 participants in the trial (data collected August 2016-December 2017). 16/22 (73%) were male; median (range) age 72 (57-85) years. Primary diagnoses were chronic obstructive pulmonary disease 10/22 (45%), interstitial lung disease 9/22 (41%), chronic heart failure 2/22 (9%) and lung cancer 1/22 (4%). Participants described outcomes of importance encompassing physical, social, emotional and spiritual domains. For many, perceived changes described during qualitative interview were consistent with changes in both NRS and CRQ scores. This was despite some participants expressing difficulties aligning an experience of breathlessness when completing scale for scale-based questionnaires.

Conclusions The main concerns described by participants in a drug trial for chronic breathlessness cross multiple health domains supporting a model of total breathlessness and the inclusion of multi-domain measures within trials. The agreement between paired qualitative and quantitative data indicates that both the NRS and CRQ outcome measures capture changes described by participants appropriately, and are suitable to use in definitive trials.

146 A CLUSTER RANDOMISED FEASIBILITY TRIAL (CRCT) TO TEST THE ROUTINE USE OF THE NEEDS ASSESSMENT TOOL: CANCER (NAT:C) IN PRIMARY CARE TO REDUCE UNMET PATIENT AND CARER NEEDS AND DETERMINE THE FEASIBILITY OF A DEFINITIVE TRIAL

Miriam Johnson, Elvis Amoakwa, Victoria Allgar, John Blenkinsopp, David Currow, Amanda Farrin, Robbie Foy, Una MacLeod, David Meads, Alexandra Wright-Hughes, Joseph Clark. *Wolfson Palliative Care Centre, University of Hull, University of York, University of Northumbria, University of Leeds*

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Background People with cancer commonly have distressing symptoms and unidentified palliative care needs. The Needs