

with an RFBM within 4 hours after each dose for ≥ 2 of the first 4 doses versus placebo (5.3% cancer; 11.3% non-cancer). Median time to laxation was significantly ($P \leq 0.0002$) shorter in cancer (0.96 hours) and non-cancer (1.25 hours) patients 24 hours after the first dose versus placebo (≥ 23 hours). Rescue laxatives were used by 39.7% of cancer and 30.6% of non-cancer MNTX patients versus 51.8% and 39.4% of placebo patients. Of 108 open-label extension double-blind MNTX patients, 79 (73.1%) achieved ≥ 3 RFBMs/week with ≥ 1 RFBM/week increase in ≥ 3 of 4 weeks versus 48 (46.6%) of 103 double-blind placebo patients (data from double-blind and 2 weeks of open-label).

Conclusion. MNTX improved laxation with a faster onset and reduced rescue laxative use.

Implications for Research, Policy, or Practice. These data support the efficacy of MNTX in cancer/non-cancer patients.

Treatment with Methylnaltrexone in Patients with Opioid-Induced Constipation with or Without Active Cancer (S812)



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Objectives

1. Describe that methylnaltrexone is equally effective in treating opioid-induced constipation in patients with advanced illness with and without active cancer.
2. Articulate that treatment with methylnaltrexone does not increase pain scores in patients treated with opioids for pain due to advanced illnesses independent of cause.

Original Research Background. Subcutaneous (SC) methylnaltrexone is approved for opioid-induced constipation (OIC) in adults with chronic non-cancer pain and OIC in adults with advanced illness or with active cancer who require opioid dosage escalation for palliative care.

Research Objectives. Post hoc analysis of pooled data from 3 randomized studies of patients with advanced illness and OIC.

Methods. Patients received single doses of SC MNTX 0.15 or 0.30 mg/kg or placebo (study 301); SC MNTX 0.15 mg/kg or placebo every other day for 2 weeks (study 302); and SC MNTX 8 or 12 mg in patients 38– <62 or ≥ 62 kg, respectively, or placebo every

other day for 2 weeks (study 4000). Data were stratified by those with/without cancer. Efficacy endpoints included laxation ≤ 4 hours and rescue-free laxation (RFL) ≤ 24 hours after the first dose; time to RFL; and pain scores.

Results. Median baseline opioid use was higher in cancer (MNTX: 190 mg/d, n=198; placebo: 200 mg/d, n=157) versus non-cancer patients (MNTX: 120.0 mg/d, n=82; placebo: 80.0 mg/d, n=80). MNTX significantly increased the percentage of patients with a laxation response ≤ 4 hours and RFL ≤ 24 hours after the first dose in cancer (MNTX: 61.1% and 71.2% vs placebo: 15.3% and 41.4%, respectively; $P < 0.0001$) and non-cancer patients (MNTX: 62.2% and 74.4% vs placebo 17.5% and 37.5%, respectively; $P < 0.0001$). MNTX significantly reduced the median time to RFL at 4 hours in cancer (MNTX: 1.1 h, placebo: >4 h; $P \leq 0.0001$) and non-cancer patients (MNTX: 1.1 h, placebo: >4 h; $P \leq 0.0001$). Mean changes in pain scores were similar (cancer patients, MNTX: -0.4 vs placebo: -0.2 ; non-cancer patients, MNTX: -0.4 vs placebo: -0.4).

Conclusion. MNTX increased laxation responses and improved clinical signs of constipation in OIC patients with/without cancer.

Implications for Research, Policy, or Practice. MNTX patients continued opioid treatment with a reduction in constipation symptoms.

Physician Use of Empathy During Clinical Practice (S813)



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Objectives

1. Discuss mixed methods research outcomes of how and when physicians use empathy when interacting with their patients during clinical practice.
2. Demonstrate the importance of empathy and its use during clinical practice.

Original Research Background. The use of empathy during clinical practice is paramount to delivering quality patient care and is important for understanding patient concerns at both the cognitive and affective levels. Physician use of empathy is associated with better patient and family experiences, higher patient satisfaction, increased patient compliance, and trust. Conversely a lack of empathy may adversely impact

a patient's treatment course or impede communication about prognosis.

Research Objectives. To determine how and when physicians use empathy when interacting with their patients.

Methods. A cross-sectional survey of 76 physicians working in a large urban hospital was conducted in August of 2017. Physicians were asked a series of questions with Likert scale responses as well as asked to respond to open-ended questions.

Results. All physicians self-report that they always (42.1%) or usually (57.9%) use empathic statements when engaging with patients. 98.6% of physicians believe that their colleagues always (19.2%) or usually (79.5%) use empathic statements when communicating with patients. Almost half of physicians indicated that using the words "I understand" denotes an empathic statement. 68% of physicians report that they would not like to receive more training or assistance about how and when to use empathy in the health care setting.

Conclusion. Although almost all physicians report that they and their colleagues use empathic statements while engaging with patients, almost half of physicians surveyed identified that telling a patient "I understand" is an expression of empathy; however, using the words "I understand" is traditionally not considered to be an expression of empathy. Although almost half of all physicians could not correctly iterate words of empathy, the majority of physicians report that they are not interested in receiving more training about how and when to use empathy.

Implications for Research, Policy, or Practice. This study emphasizes the need for physician education on both the importance and application of empathy during clinical practice.

"No Really, Dr. Surgeon, I Am NOT Here to Kill Your Patient; Let's Collaborate!": The Development of Surgical Oncology Education Resources for Palliative Care Providers in the Perioperative Setting (S814)



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Objectives

1. Describe the process used to develop surgeon and palliative care clinician approved learning materials focusing on diagnosis and surgical intervention to be used in the perioperative setting by palliative care clinicians in a multi-center study of perioperative palliative care.

2. Present the obstacles to consensus and how the materials were finalized, approved, and operationalized for use in a multi-center study by all stakeholders.

Original Research Background. Evidence supports significant cultural barriers to palliative care in surgical settings. Development of palliative care interventions targeting surgical patients and family members may benefit from close partnership between surgical and palliative care clinicians.

Research Objectives. To facilitate close engagement between surgical, oncologic, and palliative care clinicians to agree on key, and sometimes controversial, information concerning surgical oncologic diagnoses and operations for the use of palliative care clinicians providing palliative care in the perioperative setting for patients with upper GI cancers preparing for surgery.

Methods. Perioperative palliative care goals, barriers, and approaches were discussed among patient, family member, surgeon, oncologist, anesthesiologist, and palliative care clinician team members at a stakeholder summit. Based on these discussions, surgeon, palliative care physician and anesthesiologist team members developed one-page information sheets that were iteratively revised through a detailed feedback process involving front-line palliative care clinicians, oncologists, anesthesiologists, and surgeons.

Results. Sheets were developed for the seven diagnoses of pancreatic adenocarcinoma, pancreatic neuroendocrine tumors, hepatocellular carcinoma, gastric carcinoma, cholangiocarcinoma, and esophageal adenocarcinoma and the five surgeries of pancreatoduodenectomy, distal pancreatectomy, hepatectomy, gastrectomy, and esophagectomy. Sheet content involving prognostic information was controversial with regards to framing and content discussed, requiring multiple iterations. After five iterative drafts, the final content was approved by all stakeholders, including surgeons, and was operationalized for use in a multi-center randomized controlled trial of perioperative palliative care.

Conclusion. Close engagement between stakeholders can facilitate acceptance and utilization of palliative care, even in settings where significant cultural barriers exist and when content includes potentially contentious issues.

Implications for Research, Policy, or Practice. Barriers to palliative care can be addressed and overcome through close, open and iterative feedback between key stakeholders.