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A phase IV real world study on the use of low dose methoxyflurane (PENTHROX™) for the treatment of moderate to severe trauma pain in the Canadian emergency department (ADVANCE-ED): an interim report on secondary outcomes

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Introduction: Inhaled low dose methoxyflurane (MEOF) was recently approved in Canada for the short-term relief of moderate to severe acute pain associated with trauma or interventional medical procedures in conscious adult patients. ADVANCE-ED is an ongoing phase IV, prospective open label study undertaken to generate real-world evidence to complement the global clinical development program through evaluation of the effectiveness of low dose MEOF in Canadian emergency departments (EDs). **Methods:** This multicentre study is enrolling adult (≥18 yrs) patients with moderate to severe acute pain (NRS0-10 ≥ 4) associated with minor trauma. To address limitations from the pivotal study, this study allows patients who were excluded in the pivotal trials: namely, those with severe (≥7) pain, and those using OTC or stably dosed analgesics for other conditions, including chronic pain. Eligible patients receive a single treatment of up to 2 x 3 mL MEOF (2nd 3 mL to be provided only upon request), self-administered by the patient under medical supervision. Rescue medication is permitted at any time, if required. **Results:** Here we describe the patient demographics and treatment satisfaction (Global Medication Performance, GMP) at 50% enrolment (n = 49). Mean (SD) patient age is 48.0 (17.1) yrs and 55.1% are female. Mean pain (SD) reported at enrolment is 8.3 (1.5), with 73.4% of patients with NRS0-10 ≥ 8. Injuries are overwhelmingly limb trauma (87.8%). The most common type is sprain/strain (40.8%), followed by fracture (32.7%). At 5 minutes post-start of administration (STA) of MEOF, 80.4% of patients reported pain relief; this increased to 91.3% at 15 minutes, and 100% of patients reported pain relief by 30 minutes post-STA. GMP was assessed as "good", "very good" or "excellent" by ≥80% of patients both 20 minutes post-start of administration (STA) of MEOF (83.3%) and at discharge (85.8%). When asked to what extent their expectation of pain relief had been met, 32.7% responded good, 26.5% responded "very good" and 22.4% responded "excellent". Three quarters of enrolled patients (75.5%) did not require rescue medication. The most common (≥5%) treatment-related adverse events were dizziness (n = 14, 28.6%) and euphoric mood (n = 4, 8.2%). No serious adverse events have been reported. **Conclusion:** Based on 50% of the patients enrolled in this prospective, open label study, responses to inhaled low-dose MEOF are within expectation for both effectiveness and tolerability.

Keywords: low-dose methoxyflurane, real-world evidence, trauma

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Feasibility of self-assessing functional status in older emergency department patients

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Introduction: Geriatric Emergency Department (ED) guidelines recommend systematic screening of older patients for geriatric syndromes. However, compliance issues to this recommendation have already been observed. Self-assessment tools could be an interesting solution as self-assessed general, mental and physical health was shown to be predictive of functional decline and mortality. The Older Americans Resources and Services scale (OARS), is a simple geriatric functional assessment scale that is widely used by professionals to quantify patients' ability to perform activities of daily living (ADL) and instrumental activities of daily living (IADL). However, its use as a self-assessment tool has never been tested. Objective: to evaluate the feasibility of the self-assessed OARS compared to its standard administration by a research assistant (RA) in older ED patients. **Methods:** A planned sub-analysis of a single center randomized cross-over pilot study in 2018 was realized. Patients aged ≥65 who consulted to the ED for any medical reason were included. Patients were excluded if they: 1) required resuscitation (CTAS 1); 2) were unable to consent/to speak French; 3) had a physical condition preventing the use of an electronic tablet. Patients were randomized 1:1 to either 1) tablet-based functional status self-assessment or 2) the RAs questionnaire administration at first, after which they crossed-over to the other assessment method. Paired t-tests were used to assess the score differences. **Results:** 60 patients were included. Mean age was 74.4 ± 7.6 and 34 (56.7%) participants were women. Mean OARS score according to RA was 25.1 ± 3.3 and mean self-assessed OARS score was 26.4 ± 2.5 ($p < 0.0001$). There was also differences when looking at the AVQ and AIVQ separately. Mean AVQ scores were 12.5 ± 1.8 and 13.5 ± 0.9 ($p < 0.0001$) and mean AIVQ scores were 12.6 ± 1.8 and 12.9 ± 1.8 ($p = 0.04$) for RA assessment and self-assessment, respectively. **Conclusion:** Our results show a statistically significant difference between RA assessment and patient self-assessment of functional status, and this difference seems to be more pronounced regarding AVQ than AIVQ. The study confirms that self-assessment of functional status by older ED patients is feasible, but further testing is required in order to confirm the validity and psychometric values of this self-administered version of the OARS.

Keywords: emergency department, functional status, self-assessment

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Practice patterns of emergency department physicians administering naloxone for patients with suspected opioid overdose

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Introduction: Naloxone is recommended for reversing opioid-associated respiratory depression. There is wide variability in emergency department (ED) practice patterns regarding naloxone use, dosing, and observation time post-administration. This study describes the naloxone practice patterns of ED physicians managing suspected opioid overdose patients. **Methods:** A retrospective chart review was conducted of adult patients (≥ 18 years) presenting to an academic tertiary care centre (consisting of two EDs with an annual census 150,000 visits) in 2017 with suspected opioid overdose who were administered naloxone in the ED. Patients were identified electronically and the following information was abstracted from patient charts: demographics, naloxone dosage and infusion initiation, disposition data, indications for naloxone administration, response to therapy, and adverse effects. Variability in initial and total dose was examined. Initial dose was also compared in those with cardiorespiratory compromise (CPR given, respiratory rate < 8, or desaturation below 89%) using independent samples median tests. Data was

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