Palliative Care Masterclass

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End of Life

- Palliative diagnosis (cancer or organ failure) or frailty
- Completed active treatment (or chosen to stop)
- Ruled our reversible causes of deterioration eg infection, hypercalcaemia, renal failure, opioid toxicity
- If dying discuss DNAR and consider appropriate place of care
- If symptomatic – hospice nurse referral or advice from palliative consultant

General indicators of decline

- Co-morbidities
- General physical decline, decreased function, increased need for support
- Progressive disease disease and complex symptom burden
- Decreasing response to treatments
- Progressive weight loss
- Repeated unplanned/crisis admissions
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
- Serum albumin <25g/l
- Considered eligible for DS1500 payment

If reversible cause identified or procedure needed

SETrust

- Infection and oral AB not appropriate. If IV needed - ECAH
- Hypercalcaemia - iv bisphosphonate – Marie Curie, Medical Day Case
- Blood transfusion – Marie Curie, Medical Day Case, ECAH
- Paracentesis – Medical Day case via GI reg/cons. GI hub soon to open to direct GP referrals (paracentesis difficult if ambulance needed)
- Medical Day Case Contacts,UHD - Karyn Dowie, Amanda McWhirter

Belfast – Marie Curie as above, ACAH, Acute oncology

Identifying Terminal Phase

- Increasingly drowsy
- Decrease in po intake
- Unable to swallow
- Bed bound
- Irregular or shallow breathing
- Respiratory secretions

Common Symptoms

- Pain
- Nausea
- Anxiety / agitation
- SOB
- Respiratory secretions

Anticipatory prescribing

NG31: Care of dying adults in the last days of life, 2015

Prescribing ‘as required’ medicines for symptom control at the end of life in advance of their need. It ensures they are available to relieve symptoms as soon as they occur, and can reduce prescribing delays or difficulties accessing medication, especially out of hours.

Guidance for the Management of Symptoms in Adults in the Last Days of Life

This guidance provides recommendations to healthcare professionals on managing commonly experienced symptoms at the end of life.
They focus on administration by subcutaneous (SC) injection and SC syringe pump over 24 hours, recognising that the dying person may be unable to take or tolerate oral medicines. Click on the links below to the management of the following symptoms:

Pain
Breathlessness
Nausea and vomiting
Anxiety, delirium and agitation
Noisy respiratory secretions

When it is recognised that a person may be entering the last days of life:

- Review their current medicines.
- Stop any prescribed medicines not providing symptomatic benefit or that may cause harm.
- Discuss and agree any medication changes with the dying person and those important to them (as appropriate).

Anticipatory prescribing by the subcutaneous route to cover the five symptoms above ensures a supply of medicines are available to relieve symptoms as soon as they occur.

- These recommendations are a GUIDE, and should be used as such. They may differ from other recommendations but have been chosen to reflect expert opinion, best evidence and safety.

SC PRN drugs at EOL

RPMG Guidance for symptom management in the last days of life

- **Pain** – Morphine Sulphate 2 - 5mg 2-4 hourly (or oxycodone 1-2mg)
- **SOB** – Morphine Sulphate 1 - 2mg sc 4 hourly (or oxycodone 0.5-1mg)
- **Anxiety / Agitation** – Midazolam 2 - 5mg sc 2-4 hourly
  If ineffective Levomepromazine 2.5 - 5mg OR
  Haloperidol 0.5-1mg sc
- **Secretions** - Glycopyrronium 200mcg sc 4 hourly

(Lorazepam 0.5mg 4 hourly prn Subligual is alternative for anxiety)

COVID – PRN drugs at EOL

Covid-19:Symptom Management in Last Days of Life

SOB

- Morphine Sulphate 2-5mg 2 hourly sc (oxycodone 1-2mg if eGFR<30)

Anxiety

- Midazolam 2-5mg 2 hourly sc
- Lorazepam 0.5-1mg 4 hourly Sublingual

Agitation

- Haloperidol 0.5-1mg sc 2 hourly
- Levomepromazine 5-10mg sc 4 hourly

Secretions

- Glycopyrronium 200mcg sc 4 hourly
- Hyoscine Butylbromide 20mg sc 4 hourly
- Hyoscine Hydrobromide 400mcg sc 4 hourly

- Prescribe ALL options for each symptom

Difference??

- Higher prn morphine dose for SOB
- Higher Levomepromazine for agitation

Main differences

- Ensure drugs can be administered frequently
- Multiple drugs available for each symptom
- Regular review
- Early consideration of CSCI

CSCI

- **Pain** – Dose dependant on previous opioids and number of prn
- **SOB** - Morphine 2-5 (may need increased to 10mg)
  (or oxycodone 1-5mg). Increase if on opioids
- **Anxiety** – add Midazolam 2-10mg
- **Agitation** – add Haloperidol 1-3mg
  or Levomepromazine 10mg (may need increased to 15 or 20mg)
- **Secretions** – Glycopyrronium 600-1200mcg
  or Hyoscine Butylbromide (Buscopan) 60-120mg
  or Hyoscine Hydrobromide 1200-2400mcg

If patient has Covid

Covid-19:Symptom Management in Last Days of Life

- **SOB** – May need 10mg Morphine (but often appropriate to start at 5mg or lower)
- **Anxiety** – May need 10mg Midazolam
- **Agitation** - May need to start Haloperidol 3mg and increase to 4/5mg

- Case eg – SOB – Morphine 4mg / Midazolam 2mg
- Agitation – Levomepromazine 10mg, Morphine 3mg, Midazolam 7mg

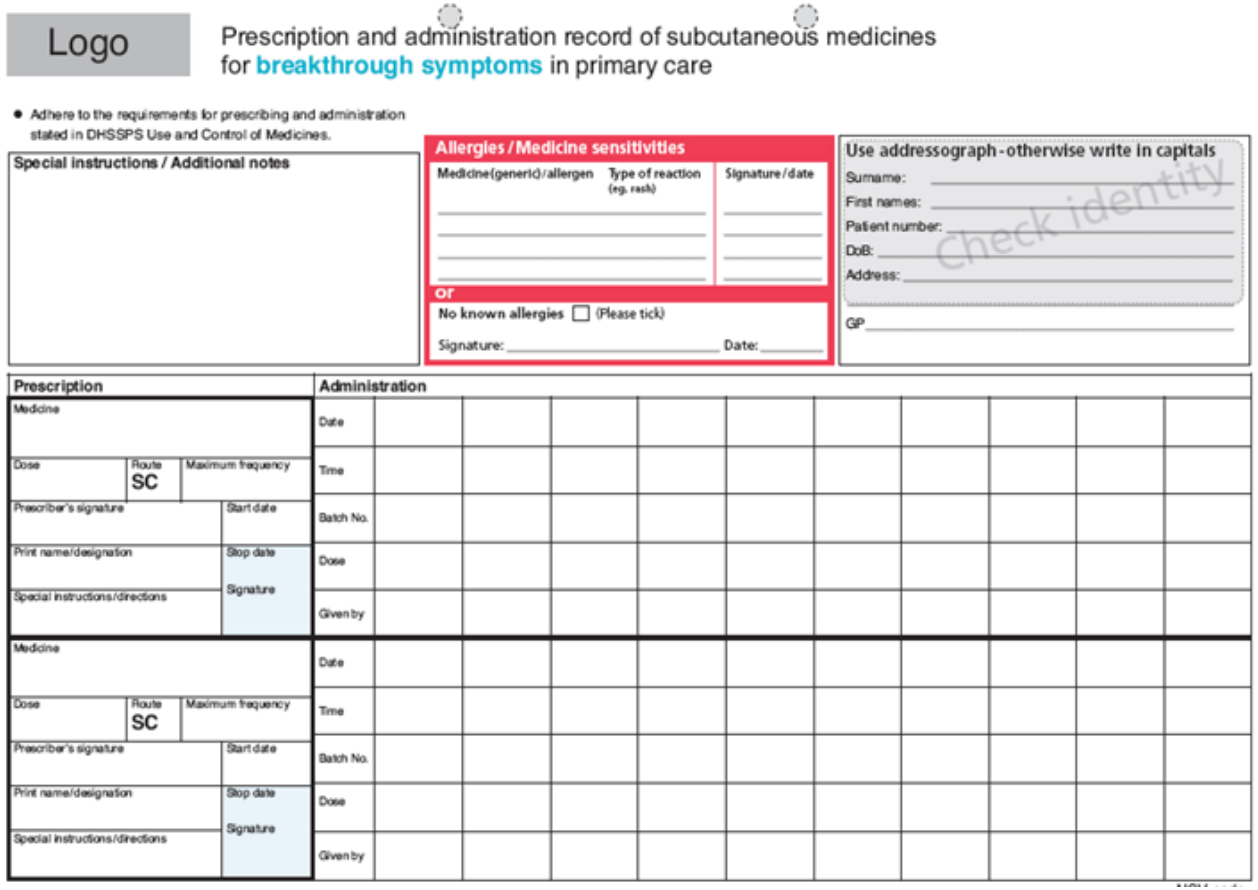
Syringe Driver Compatibilities

- www.book.pallcare.info
- I am a Doctor
- Northern Ireland
- Index on left
- SD drug compatibility

Just in case boxes

- Individualised based on DN/GP assessment and patient symptoms
- Can contain Morphine, Cyclizine, Midazolam, Glycopyrronium and diluent
- GP must prescribe drugs on a standard HS21 prescription form
- Issue a ‘Prescription and administration record of subcutaneous medicines for breakthrough symptoms in primary care’
- Nurse will leave copy of RPMG guidelines, needles, syringes and sharps box
- Only to be administered by nurse / Dr

Prescription and administration record



Logo

Prescription and administration record of subcutaneous medicines for **breakthrough symptoms** in primary care

- Adhere to the requirements for prescribing and administration stated in DHSSPS Use and Control of Medicines.

Special instructions / Additional notes

Allergies / Medicine sensitivities

Medicine (generic) / allergen	Type of reaction (eg. rash)	Signature / date

or

No known allergies ☐ (Please tick)

Signature: _____ Date: _____

Use addressograph - otherwise write in capitals

Surname: _____

First names: _____

Patient number: _____

DoB: _____

Address: _____

Check identity

GP _____

Prescription			Administration										
Medicine			Date										
Dose	Route SC	Maximum frequency	Time										
Prescriber's signature		Start date	Batch No.										
Print name/designation		Stop date	Dose										
Special instructions/directions		Signature	Given by										
Medicine			Date										
Dose	Route SC	Maximum frequency	Time										
Prescriber's signature		Start date	Batch No.										
Print name/designation		Stop date	Dose										
Special instructions/directions		Signature	Given by										

Just in Case boxes for End of Life Care (2020) Information for professionals

Effective symptom control is essential for palliative care patients approaching the end of life.
Anticipatory prescribing involves prescribing 'as required' medicines for symptom control at the end of life in advance of their need. It ensures they are available to relieve symptoms as soon as they occur, and can reduce prescribing delays or difficulties accessing medication, especially out of hours. It is recommended by NICE Guidance (NG31: Care of dying adults in the last days of life, 2015).
'Just in Case' boxes containing anticipatory medicines can contribute to safe and effective anticipatory care for patients in the community. The medicines in the 'Just in Case' box may include those to treat:

•• Nausea and vomiting , Pain, Anxiety, delirium and agitation, Noisy respiratory secretions, Breathlessness

1.Use an individualised approach, assessing which medicines might be required for symptom control.
2.If frequent PRN doses are required, consider starting a subcutaneous syringe pump over 24 hours.
Refer to RPMG Management of Symptoms in the Last Days of Life Guidance (2018).
http://niformulary.hscni.net/Formulary/Adult/PalliativeCare

Anticipatory Prescribing Guidance from Regional Palliative Medicines Group (RPMG) Guidelines 2018

~~INDICATION DRUG AND STRENGTH TO DOSE AND F~~REQUENCY COMMENT PRESCRIBE
Diluting Solution Water for injections or 0.9% Sodium Chloride

Pain	Morphine Sulfate injection 10mg/ml x 10amps	2mg-5mg SC 2-4Hourly PRN	If on an existing opioid, refer to Guidance on Symptom Management in Last Days of Life (2018)
Nausea and Vomiting	Cyclizine injection 50mg/ml x 10amps	50mg SC 8Hourly PRN	May also consider levomepromazine 5mg SC 4- 6Hourly PRN 10mg/ml x 10amps.
Anxiety, delirium and agitation	Midazolam injection 10mg/2ml x 10amps	2mg-5mg SC 4Hourly PRN - may need more frequently	Consider levomepromazine 5-15mg 6Hourly SC PRN if poor response to Midazolam
Noisy respiratory secretions	Glycopyrronium Bromide injection 200micrograms/ml x 10 amps	200micrograms SC 4-6Hourly PRN	Hyoscine hydrobromide 400micrograms SC 4- 6Hourly PRN is also an option.
Breathlessness	Morphine Sulfate injection 10mg/ml x 10amps	1mg-2mg SC 4Hourly PRN	May also consider Midazolam 2mg SC 4Hourly PRN 10mg/2ml x 10amps.

Rapid Discharge for EOL – Case 1

79 year old man

- Laryngeal tumour, aspiration pneumonia
- SOB/Stridor/Anxiety/fear
- Requesting home for EOLC
- CSCI commenced on day of d/c – midazolam 3mg/oxycodone 1mg (eGFR 35) with plan to increase to 5mg/2mg following day
- AB and fluids stopped
- PRN meds prescribed and supplied
- Plan communicated to GP by phone
- Hospice nurse follow up 3 days later
- Pall Med Consultant contact details given to GP for interim period

Case 2

- 58 year old man
- Lung ca
- Large pericardial effusion – not for drain
- MST 20mg bd
- Distressed with SOB
- Keen for d/c ASAP
- CSCI with morphine 20mg and midazolam 5mg prescribed
- DN to commence
- PRN PO oramorph, diazepam , SL lorazepam, SC morphine, midazolam , Levomepromazine and Glycopyrronium prescribed and supplied

- Review next day – morphine increased to 25mg, metoclopramide added
- GP r/v – morphine increased to 30mg, midaz 7.5mg, Levomepromazine added
- Pall med r/v following week – dying. SOB, Secretions++. Mult stats needed
- Morphine increased to 35mg, midazolam 10mg, Levomepromazone 10mg, metoclopramide stopped and max dose Glycopyrronium (1200mcg) added with hyoscine as breakthrough
- Died a few hours later at home

Rarer Drugs on discharge

- Shared Care

Octreotide

- Bowel obstruction, intractable diarrhoea
- May not mix with all combinations. Dilute with N.saline
- Starting dose 300-500mcg for bowel obstruction
- Increase in 100-200mcg increments up to 1500mcg
- 7 day supply from hospital
- Guidelines contain info re S/E and I/A

Octreotide

Palliative care Shared Care Guideline

Specialist Details

Name:
Location:
Tel:

Date:

Patient Identifier

Introduction

Octreotide is an analogue of natural hypothalamic release-inhibiting hormone somatostatin. Its use in palliative medicine is frequently beyond licence and indications include:

- Malignant bowel obstruction/high volume vomiting
- Severe discharge from rectal carcinoma
- Intractable non-infective diarrhoea
- High output GI fistula
- Malignant ascites

Ketamine

- Neuropathic pain

Oral – 50mg/5ml solution

- Start 5-10mg qid (write mg and ml on prescription)
- Increase in 5-10mg increments

CSCI

- Start 25-50mg over 24h
- Doesn’t mix with all drugs
- Dilute N.Saline

Monitor BP, LFT and urine if appropriate

Caution with seizures

Health and Social Care Board

Interface Pharmacist Network
Specialist Medicines

Ketamine

Palliative Care Shared Care Guideline

Specialist Details
Patient Identifier

Introduction
Ketamine is a short acting anaesthetic with analgesic properties at low doses. It is used particularly for neuropathic pain, ischaemic limb pain and refractory cancer pain and as an adjunct to opioid therapy. The dose of opioid may need to be reduced when ketamine is initiated. Ketamine may be given orally or by continuous subcutaneous infusion via syringe pump either as a sole agent or in combination with other agents. Ketamine for these indications is unlicensed and should only be initiated by a Palliative Medicine Specialist. **Ketamine is a schedule 2 (part 1) controlled drug.**

Adult Dosage and Administration

Patients unable to swallow

Abstral

- PRN SUBLINGUAL short acting opioid (fentanyl)
- Starting dose 100mcg, increase in 100mcg increments to 400mcg if needed
- 4 hourly
- Patient must be on equivalent of 60mg po morphine

Buccal Midazolam (Buccolam)

- Same dose as SC
- Prefilled syringes 2.5mg, 5mg, 7.5mg and 10mg
- Family can administer

Dynastat

- SC NSAID. PRN 10-20mg. CSCI up to 40-80mg. GI S/E and renal failure

Keppra

- Antiepileptic
- Same dose as po over 24h
- Dilute in water for injection. Separate syringe driver

Clonazepam

- Acts on neuropathic pain as well as Benzodiazepine
- PO 0.25mg or 0.5mg nocte. Can add SC to CSCI (same dose)

Opioid Switch

- 1ST Line – Morphine
- 2nd Line – Oxycodone (1st line in renal impairment)
- Alfentanil via CSCI if severe renal impairment (30 times stronger than po morphine). Consider when eGFR<30
- Hydromorphone only if other opioids not tolerated or liver and renal impairment. Can use po or SC (7.5 times stronger than morphine)

  Risk of error – 2 strengths SC 2mg/ml and 10mg /ml.

  4mg of 10mg/ml solution is 0.4ml
- Fentanyl SC - 150 times stronger than po morphine

1.Table 1. Opioid Conversions Table

PO (Oral) to SC (Subcutaneous)
Oral Morphine to SC Morphine – Divide by 2 E.g. 30 mg Oral Morphine = 15 mg SC Morphine
Oral Morphine to SC Diamorphine – Divide by 3 E.g. 30 mg Oral Morphine = 10 mg SC Diamorphine
Oral Oxycodone to SC Oxycodone – Divide by 2 E.g. 10 mg Oral Oxycodone = 5 mg SC Oxycodone
Oral Morphine to SC Alfentanil – Divide by 30 E.g. 30 mg Oral Morphine = 1 mg SC Alfentanil Alfentanil may be used in patients with severe renal impairment; seek specialist advice when necessary
SC (Subcutaneous) to SC
SC Morphine to SC Diamorphine – Divide by 1.5 E.g. 15 mg SC Morphine = 10 mg SC Diamorphine
SC Morphine to SC Oxycodone – Divide by 2 E.g. 20 mg SC Morphine = 10 mg SC Oxycodone Note this may differ from other available conversions
PO (Oral) to PO
Oral Morphine to Oral Oxycodone – Divide by 2 E.g. 30mg Oral Morphine = 15mg Oral Oxycodone
Oral Codeine / Dihydrocodeine / Tramadol to Oral Morphine – Divide by 10 E.g. 240 mg Oral Codeine = 24 mg Oral Morphine

Opioid Toxicity

- Drowsiness, myoclonic jerking, confusion, hallucinations, respiratory depression

Reversal of opioids - caution

- If used when not needed or in larger doses than needed can cause rapid reversal leading to intense pain and distress and an increase in sympathetic nervous stimulation and cytokine release precipitating acute withdrawl. This may result in hypertension, cardiac arrhythmias, pulmonary oedema and cardiac arrest

If Opioid reversal is needed

- If RR < 8 breaths/min with patient very drowsy/comatose/unconscious/ hypoxic and/or cyanosed) refer to “Naloxone for Reversal of Severe Opioid Toxicity in Adult Patients on Long Term Opioid treatment for Pain Control” Guidelines
- * If patient is in the dying phase, it is not appropriate to reverse opioids. Haloperidol can be used to treat symptoms of toxicity

- Aim is to reverse respiratory depression without compromising pain control

Naloxone dose

- Stop opioids
- Dilute Naloxone amp (400microgram/ml) **to 10ml** with N.saline in 10ml syringe
- Diluted Naloxone 40mcg/ml
- Administer 40-80mcg (1-2ml) as a slow bolus and repeat every 2 mins until RR>8
- Flush cannula between boluses
- Onset of action 1-2mins
- Duration of action 15-90mins.

Case 1

NM

- 67 year old man
- For transfer home for EOLC
- Pain and agitation on minimal movement. Prone to toxicity. Haloperidol 1mg in CSCI
- Tolerating prn SC oxycodone 4mg prn (30mg in CSCI)
- Had this with midazolam 2mg pre transfer
- Drowsy and jerking
- Family complained that opioid reversal not given

Case 2

- 45 year old lady
- Stable opioid dose
- Renal function deteriorating
- Progressive drowsiness
- No other reversible causes identified eg infection or hypercalcaemia
- 40mcg Naloxone given
- Sudden extreme agitation. Needing midazolam

Nausea

1st line – Metoclopramide 10mg tid (if poor GI motility) OR
Cyclizine 50mg tid (avoid in Liver and Heart failure)

2nd line – if on Cyclizine, add Haloperidol 0.5mg prn then 1.5mg nocte

3rd line – switch to Levomepromazine 3-6mg nocte and prn (sedating)

4th line – add Ondansetron 4mg prn then tid (constipating

Use the same doses SC via CSCI if needed

Constipation

- Softener – Docusate 100mg bd up to 500mg daily
- Stimulant – Senna 7.5-15mg nocte
  Bisacodyl 5-10mg nocte
  Sodium Picosulphate 5-10mg nocte
- Osmotic – Lactulose 10-20ml od-bd
  Laxido 1 sachet bd or tid
- PR intervention – Micralax enema, Bisacodyl suppositories
  Phosphate enema

Itch

- Emollient
- Eurax cream
- Antihistamine
- Paroxetine
- Ondansetron if opioid induced or renal failure
- Cholestyramine in cholestasis (poorly tolerated)

Sweats

- Treat infection
- Fan
- Paracetamol
- NSAID’s
- Steroids
- Amitriptyline
- Scopoderm patch
- Cimetidine

Ascites

- Limited benefit from Diuretics – Spirnolactone or Furosemide
- If used monitor U&E. Stop if not helping or causing drop in eGFR, high potassium or low BP
- Paracentesis if very symptomatic
- If recurrent consider pigtail drain or pleurx catheter

Liver Failure

Pain

- Paracetamol 1g tid po if long term use
- Avoid NSAID’s
- Morphine is best choice of opioid
- Hydromorphone is alternative if renal failure also and not tolerating morphine
- Avoid Amitriptyline

- Nausea
- 1st line – Metoclopramide 5mg tid (reduced dose). OR
  Haloperidol 0.5-1mg bd

2nd Line – Ondansetron 4mg bd (reduced dose)

3rd line – Levomepromazine 3mg nocte (up to 12mg bd, but sedating)

Avoid Cyclizine

Emergencies

Terminal Haemorrhage

- Inform family of possibility
- Dark towels
- SC and Buccal Midazolam

MSCC

- Suspicion if known bone mets and increased back pain – may be neuropathic
- Decrease in mobility or loss of power
- Altered sensation
- Incontinence
- If patient previously mobile and aim is to maintain this – urgent MRI needed – transfer to ED.
- If recent imaging speak with oncology
- Dexamethasone 8mg bd with PPI

Case 1

- 80 year old man
- Met prostate. Spine. Prev XRT to Lspine twice. No further
- Pain in neck (occ rad to left arm) and lower back to right leg. Leg worst. Neck improving.
- C spine non tender. PNS exam normal
- Pregabalin 50mg bd commenced. MST 25mg bd continued
- No urgent investigations planned

- Following week – increased leg weakness and sensory disturbance
- Admitted UHD
- MRI – progressive disease in spine with pathological fractures. No SCC but developing lesion C7 – XRT
- No further XRT possible to rest of spine
- Mobility maintained – d/c home mob with rolater and catheter in situ

Case 2

- 82 year old man
- Met prostate. Recent XRT to Lspine / sacrum
- Increased sacral pain and faecal incontinence (has catheter)
- Gen condition and mobility deteriorating
- ?SCC but may not get further XRT. May not benefit. Huge effort for MRI or treatment
- After discussion with patient and wife no investigations planned. Remained home and died 2 months later

Palliative Care Advice

- SE trust – direct line 028 90413854
- Belfast Trust – 028 96151900 (24/7 during Covid)
- Either Trust – Marie Curie Day Therapy - option for urgent medical OP (face to face or virtual)