TRINITY Hospice & Palliative Care Services

PALLIATIVE CARE GUIDANCE FOR PRIMARY CARE

Adapted for the Fylde Coast Health Economy

In accordance with Lancashire & South Cumbria Specialist Palliative Care Services Palliative Care Prescribing Guidance (September 2016)

These principles are intended for guidance only. They do not cover all aspects of an individual patient's care. If uncertain, please contact the Specialist Palliative Care Team for advice.

Trinity Hospice Advice Line 01253 359359 (24 hours)

Adapted by the Fylde Coast End of Life Care Steering Group

Version 4.2 (Sept 2016)

Review due Sept 2018

CONSTIPATION

Assessment should include abdominal & PR examination

Oral Laxatives	
Stimulants	
Senna	15mg nocte, increase to 30mg bd tablets, granules, syrup
Bisacodyl	5-10mg nocte, increase to 10mg bd tablets
Softeners	
Docusate	200mg nocte, increase to 200mg tds capsules, oral solution
Movicol	1-2 sachets nocte, maximum 8/day sachet for reconstitution
Combined Stimulant & Softeners	
Co-danthrusate* (50/60) Co-danthramer* (25/200) Co-danthramer* strong (75/1000)	2 caps/10mLs nocte, increase to bd use strong formulation if insufficient capsules, suspension

* contains danthron: turns urine red; can cause perianal irritation; only licensed in patients with a terminal illness.

Rectal Interventions
First line - Suppositories
Glycerine, Bisacodyl
Second line - Enemas
Sodium citrate (micralax)
Docusate, Phosphate, Arachis Oil (beware peanut allergy)

Naloxegol – use in opioid induced constipation in adult patients who have had an inadequate response to laxatives (trial of 4 days or more). Stop all currently used maintenance laxative therapy and give 25mg once daily in the morning 30minutes before breakfast. Once bowels opening return to maintenance laxatives if possible.

TERMINAL RESTLESSNESS

Consider reversible causes and treat if possible

- **pain; urinary retention; constipation;**
- **nicotine or alcohol withdrawal;**
- **gastric stasis;**
- **fear, anxiety and existential distress**

Sedative Drugs	
Midazolam (first line)	2.5-5mg subcut PRN 2-4hrly; 10-20mg CSCI /24hr; max 60mg/24hr if anxiety prominent symptom also useful if at risk of fitting
Levomepromazine (second line)	6.25-12.5mg subcut PRN 8hrly 12.5-50mg CSCI/24hr; max 150mg/24hr if psychotic symptoms are predominant
Haloperidol (second line)	3-5mg subcut PRN 8hrly 5-30mg CSCI/24hr

BREATHLESSNESS

- **Management at end of life is the same regardless of underlying diagnosis: opioids and benzodiazepines are safe in end stage respiratory disease**
- **Very frightening: reassurance & empathy**
- **Consider treatment of underlying cause: e.g. infection; anaemia; CCF; pleural effusion; PE**

Non-pharmacological Management	
Moving cool air	Well ventilated room, open window, fan Sit up, use bed table for support
Physiotherapy	Breathing management, mobility, aids
OT	Lifestyle modification, aids, adaptations
Psychological	Treat anxiety, psychological support

Pharmacological Management	
Benzodiazepines	
Lorazepam	0.5-1mg po/subling PRN, max 2mg/day
Diazepam	2mg po PRN, max 15mg/day
Midazolam	2.5mg subcut PRN 4hrly, titrate as needed if unable to take oral medication
Opioids	
Morphine solution	2.5mg po PRN 4hrly, titrate as needed
Morphine injection	1.25mg subcut PRN 4hrly if unable to take oral medication
Inhaled Drugs	
Beta agonist nebs (salbutamol / terbutaline)	For reversible airways obstruction
Saline nebs	For thick secretions
Oxygen	ONLY if hypoxic and symptomatic symptom control – d/w SPC Team
Other Drugs	
Dexamethasone	For airway obstruction, SVCO & carcinomatosis lymphangitis
Antibiotics	For infection
Diuretics	For pulmonary congestion

RESPIRATORY TRACT SECRETIONS

General Measures: repositioning to lateral position; suction; avoid over hydration; address family distress

SUCTION RARELY HELPS – if started MUST be continued

Anti-secretory Drugs	
Glycopyrronium (first line)	0.2mg (=200mcg) subcut PRN 4hrly 0.6-1.2mg (=600-1200mcg) CSCI /24hr
Hyoscine hydrobromide (second line)	0.4mg (=400mcg) subcut PRN 4hrly 1.2-2.4mg (=1200-2400mcg) CSCI/24hr may cause sedation and confusion

'JUST IN CASE 4 CORE DRUGS' FOR ANTICIPATORY PRESCRIBING *

End of Life Care Injectable Drugs	
Morphine (for pain)	
Stat if naïve: 2.5mg PRN 1hrly subcut	Supply 5 x 10mg amps
CSCI dose if naïve: 5-10mg/24hr	
*If already on opioids: convert current opioid to morphine * (seek specialist advice if unsure of dose)*	*5 days supply*
Levomepromazine (for nausea & vomiting)	
Stat dose: 6.25mg PRN 8hrly subcut	Supply 5 x 25mg/1mL amps
CSCI dose: 6.25-25mg/24hr	
Midazolam (for restlessness & terminal agitation)	
Stat dose: 2.5-5mg PRN 4hrly subcut	Supply 5 x 10mg/2mL amps
CSCI dose: 10-20mg/24hr (max 60mg)	
Glycopyrronium (for respiratory tract secretions)	
Stat dose: 0.2mg PRN 4 hrly subcut	Supply 5 x 200mcg/1mL amps
CSCI dose: 0.6-1.2mg/24hr	
Water	
Diluent	Supply 10 x 10mL amps

* See 'Just in Case 4 Core Drugs for End of Life Care - Indication for Use' and 'Just in Case 4 Core Drugs Prescribing Guidelines' for more detailed guidance

OTHER DRUGS USED IN CSCIs

Continuous Subcutaneous Syringe Infusion (CSCI)

Drug	Dose	Indication
Oxycodone	If opioid naïve: 5-10mg/24hr	pain
Hyoscine Butylbromide	40-160mg/24hr	abdominal colic
Metoclopramide (pro-kinetic)	30-90mg/24hr	nausea & vomiting
Haloperidol	2.5-5mg/24hr max 10mg/24hr	nausea & vomiting
Cyclizine	100-150mg/24hr max 150mg/24hr	nausea & vomiting
Octreotide ***(specialist use)***	300-900mcg/24h	obstructive vomiting
Hyoscine Hydrobromide	1.2-2.4mg/24hr max 2.4mg/24hr	respiratory secretions
Normal Saline	*not with cyclizine*	diluent

Drugs NOT to be used in SyringePumps		
Chlorpromazine	Diazepam	Prochlorperazine

Conversion from ORAL to SUBCUT Opioids
10mg PO Morphine IR = 5mg SC Morphine
10mg PO Morphine IR = 5mg SC Oxycodone

USEFUL ONLINE RESOURCES

Trinity Hospice Information for Healthcare Professionals

Go to Trinity Hospice website www.healthcare.trinityhospice.co.uk and follow the links...