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 (January 2012)

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 2.1 (June 2012)

Review due June 2014

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	
Doccusate, Arachis Oil (beware peanut allergy), Phosphate	

TERMINAL RESTLESSNESS

Consider reversible causes and treat if possible

- **pain; urinary retention; constipation; nicotine withdrawl; gastric stasis; fear**

Sedative Drugs	
Midazolam (first line)	2.5-5mg subcut PRN 4hrly; max 10mg 10-20mg CSCI /24hr; max 60mg/24hr if anxiety prominent symptom also useful if at risk of fitting
Levomepromazine (second line)	12.5-25mg subcut PRN 8hrly 12.5-50mg CSCI/24hr; max 150mg/24hr if psychotic symptoms are predominant
Haloperidol (second line)	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
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	
Salbutamol nebs	For reversible airways obstruction
Saline nebs	For thick secretions
Oxygen	For hypoxia – d/w Respiratory Team For 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**

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 confusion and sedation

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

End of Life Care Injectable Drugs	
Diamorphine (for pain)	
Stat if naïve: 2.5-5mg PRN 1hrly subcut	Supply 10 x 10mg amps
CSCI dose if naïve: 10-20mg/24hr	
*If already on opioids: convert current opioid to diamorphine * (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 10 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 10 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 Driver (CSCI)

Drug	Dose	Indication
Morphine	If opioid naïve: 10-20mg/24hr	pain
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 Syringe Drivers		
Chlorpromazine	Diazepam	Prochlorperazine

Conversion from ORAL to SUBCUT Opioids				
3mg		1.5mg		1mg
PO Morphine	=	SC Morphine	=	SC Diamorphine
3mg		1.5mg		0.75mg
PO Morphine	=	PO Oxycodone	=	SC Oxycodone

USEFUL ONLINE RESOURCES

Trinity Hospice Information for Healthcare Professionals - http://www.trinityhospice.co.uk/infoforprofessionals.html

Lancs & South Cumbria Palliative Care Prescribing Guidelines
Can be downloaded from Trinity Hospice website - http://www.trinityhospice.co.uk/infoforprofessionals.html