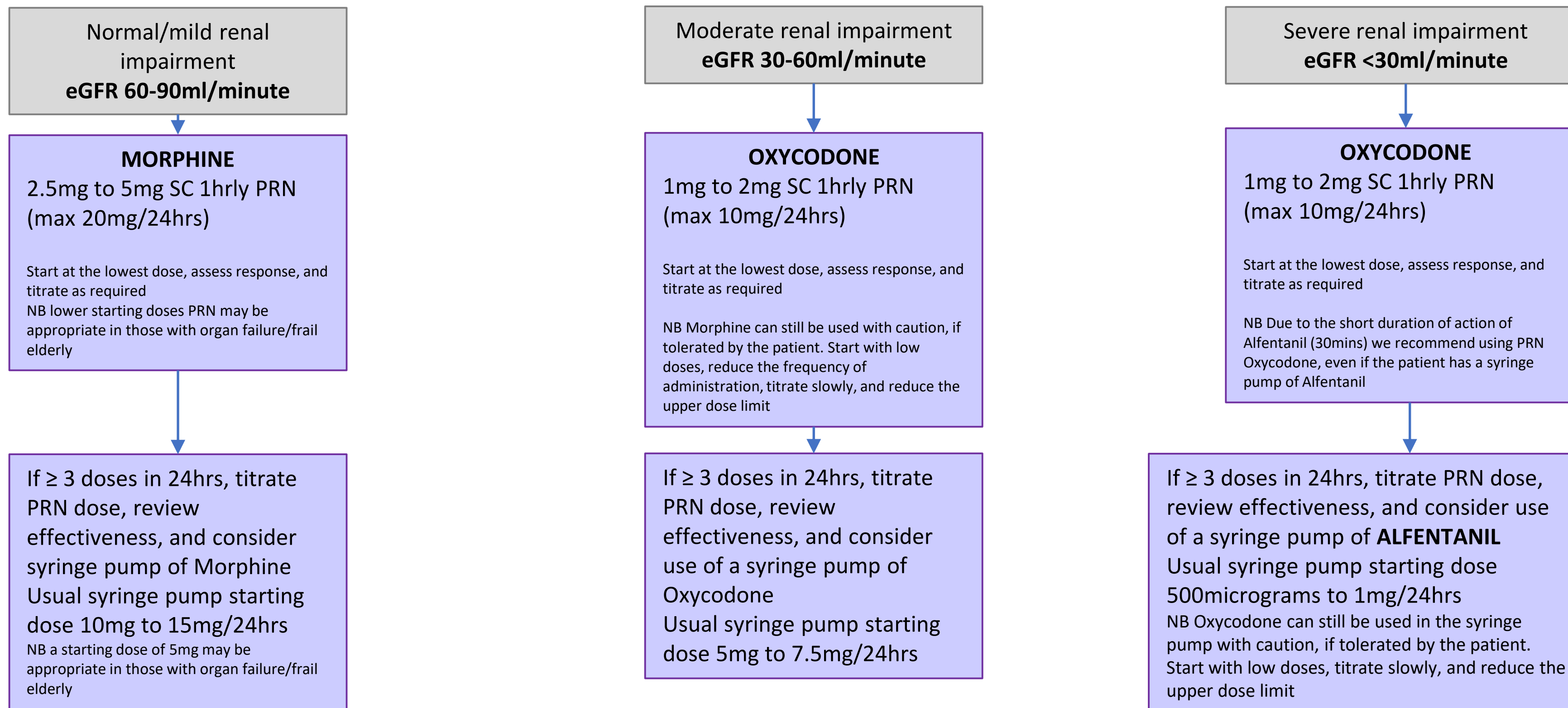
PAIN +/- BREATHLESSNESS

These are recommended starting doses for opioid naïve patients. If higher doses are required, please contact the Specialist Palliative Care team for advice



General considerations;

PRN opioid dose is ~ 1/10th to 1/6th of the total 24hrs background dose.

Check to see if the patient has an opioid patch in situ e.g Fentanyl, Buprenorphine. If the patient is dying it is generally recommended to continue the patch, the PRN dose should reflect the combined 24 hour opioid dose.

Opioid conversions:
- PO Morphine to SC Morphine: ratio 2:1 (divide dose by 2)
- PO Morphine to PO Oxycodone: ratio 2:1 (divide dose by 2)
- PO Oxycodone to SC Oxycodone : ratio 2:1 (divide dose by 2)
- PO Morphine to SC Alfentanil: ratio 30:1 (divide dose by 30)

All opioids should be used with caution in hepatic failure – low doses of Immediate Release Morphine eg. Oramorph recommended as 1st line in community setting.

If ineffective, seek advice from Specialist Palliative Care Team

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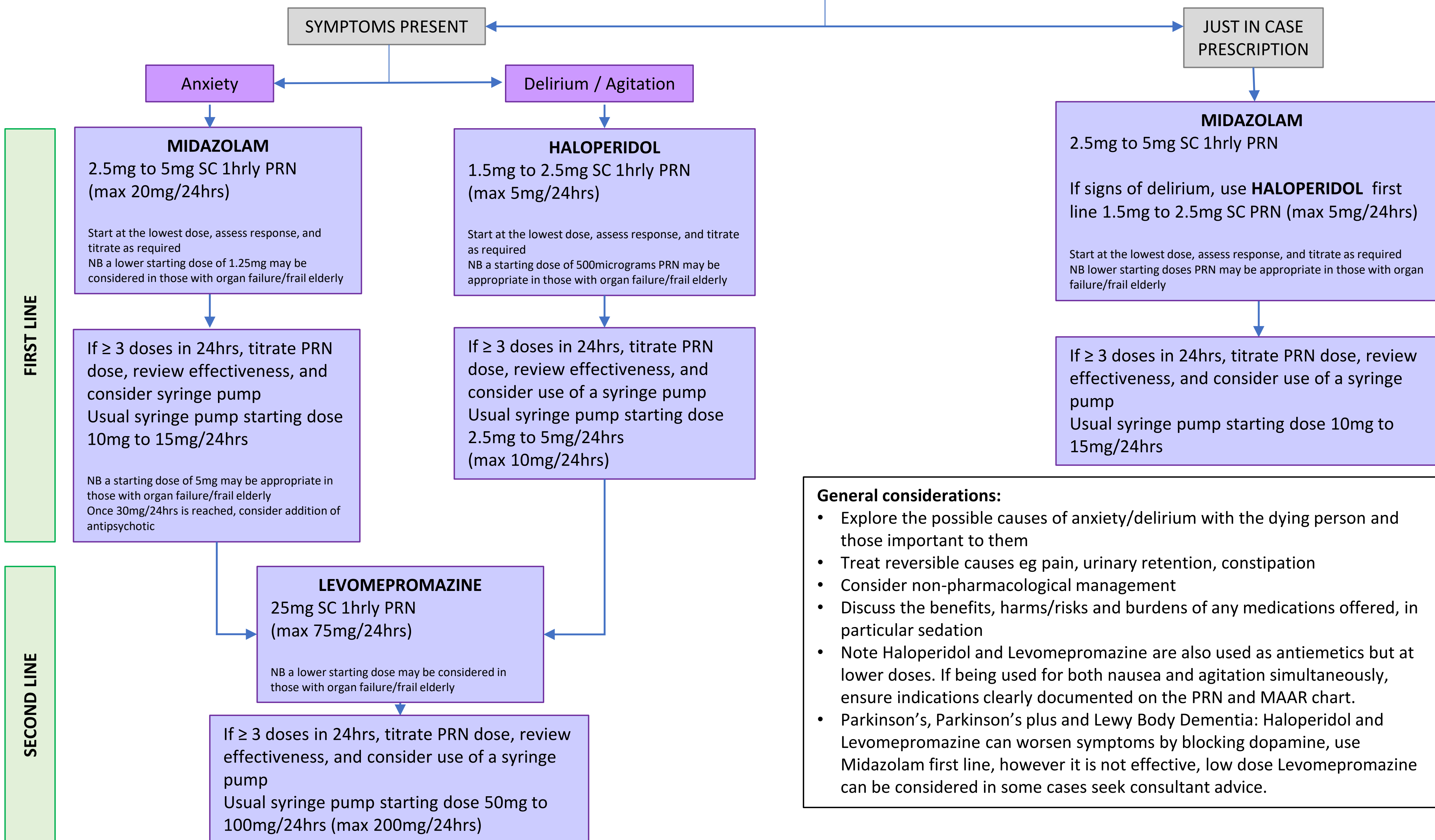

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NAUSEA / VOMITING

SYMPTOMS PRESENT

Cause	Medication: 1st line recommendation
Gastric stasis	*METOCLOPRAMIDE 10mg 2hrly PRN SC (max 30mg/24hrs) Usual syringe pump starting dose 30mg NB avoid in mechanical bowel obstruction, or history of colic
Drugs, endogenous toxins	*HALOPERIDOL 500micrograms to 1mg 2hrly SC PRN (max 5mg/24hrs) Usual syringe pump starting dose 1.5mg to 3mg Consider using lower doses in elderly/frail, renal/hepatic failure
Renal failure	*HALOPERIDOL 500micrograms to 1mg 2hrly SC PRN (max 3mg/24hrs) Usual syringe pump starting dose 1.5mg to 3mg
Intestinal obstruction	*HALOPERIDOL 500micrograms to 1mg 2hrly SC PRN (max 5mg/24hrs) Usual syringe pump starting dose 1.5mg to 3mg Consider using lower doses in elderly/frail, renal/hepatic failure For high volume vomiting consider role of anti-secretory medication e.g Hyoscine Butylbromide
Raised intracranial pressure	**CYCLIZINE** 25mg to 50mg SC 2hrly PRN (max 150mg/24hrs) Usual syringe pump starting dose 75mg to 150mg mixed with water for injection Consider the role of steroids such as **DEXAMETHASONE** (avoid doses after 2pm, monitor blood sugar) Use Levomepromazine with caution as might lower seizure threshold
Unclear, or 1st line choice ineffective	*HALOPERIDOL 500micrograms to 1mg/1.5mg 2hrly SC PRN (max 5mg/24hrs) Usual syringe pump starting dose 1.5mg to 3mg **Broad spectrum anti-emetic:** *LEVOMEPROMAZINE 3.125mg to 6.25mg 2hrly SC (max 25mg/24hrs) Usual syringe pump starting dose 6.25mg to 12.5mg NB may lower seizure threshold, use cautiously in patients with a history of seizures

***Avoid use in Parkinson's Disease, Lewy Body Dementia and Parkinson's Plus Syndromes, use Cyclizine as first line anti-emetic**

JUST IN CASE PRESCRIPTION

*HALOPERIDOL
500micrograms to 1mg SC 2hrly PRN
(max 5mg/24hrs)
Consider using lower maximum doses in elderly/frail, renal/hepatic failure

If ≥ 3 doses in 24hrs, titrate PRN dose, review effectiveness, and consider use of a syringe pump
Usual syringe pump starting dose 1.5 to 3mg/24hrs

General considerations;

- Treat reversible causes where appropriate, consider constipation
- Check bloods if appropriate, rule out hypercalcemia
- Parkinson's, Parkinson's plus and Lewy Body Dementia: Haloperidol, Metoclopramide & Levomepromazine can worsen symptoms by blocking dopamine. Cyclizine is recommended first line or low dose Levomepromazine can be considered in some cases, seek consultant advice
- Haloperidol and Levomepromazine can cause QT prolongation, however the benefit gained may outweigh the risks in the context of end of life care
- All antipsychotics may lower the seizure threshold, however Haloperidol confers the lowest risk
- Consider non-pharmacological management e.g. management of distress and anxiety, dietary advice, eg. Small, low fat meals

If ineffective, seek advice from Specialist Palliative Care Team

RESPIRATORY SECRETIONS

General considerations;

- Audible secretions do not necessarily cause dyspnoea or distress to the patient
- If the usual measures eg repositioning fail, antimuscarinic drugs can be used to reduce the new formation of secretions
- If medication is to be given, start ASAP as it will not improve existing secretions, it will only help reduce the development of further secretions
- Stop mucolytic agents eg Carbocisteine +/- saline nebulizers if antimuscarinic drugs are to be utilised
- In the dying phase the use of suctioning is usually inappropriate
- Antimuscarinics can cause urinary retention, if patient becomes uncomfortable/agitated check for this

FIRST LINE

GLYCOPYRRONIUM
200 to 400micrograms SC 1hrly PRN
(max dose 1.2mg/24hrs)
Usual syringe pump starting dose
600micrograms to 1.2mg

SECOND LINE

HYOSCINE BUTYLBROMIDE (BUSCOPAN)
20mg SC 1hrly PRN
(max dose 120mg/24hrs)
Usual syringe pump starting dose 40 to
80mg

If ineffective, seek advice from Specialist Palliative Care Team

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GENERAL CONSIDERATIONS WHEN PRESCRIBING FOR A DYING PERSON

- These guidelines have been produced for guidance only and do not replace clinical judgement.
- Individualised approach – regular communication with patient and those important to them regarding the indication and purpose of medications prescribed.
- Rationalising medications.
- Prescribing medications for symptom control.
- Choosing the route of administration.
- A syringe pump takes ~3-4hours to establish a steady state drug level in plasma – if the patient is in pain, vomiting or very agitated, give a stat SC injection of appropriate medication while setting up the syringe pump.
- Water for injection or Normal Saline can be used as diluents as per your CCG policy (NB Cyclizine must be mixed with water for injection).
- Re-assessment and titration.
- Start at the lowest prescribed dose and titrate appropriately and proportionately. If an incremental dose range is prescribed, you must use the prescribed dose (eg. 10mg-15mg) NOT choose a mid dose of 12.5mg.
- When prescribing dose ranges, use of the word “to” rather than a dash (which may be mistaken for a decimal point) e.g. morphine 5 mg to 10 mg. This is especially important where charts are handwritten.
- Doses less than 1mg should be written in micrograms eg . 600micrograms to 1.2mg Glycopyrronium.
- Where two medicines are written for the same indication, clearly state which medicine is to be used first line and which is to be used second line and under what circumstances this switch is to be considered.

If in doubt please contact St Raphael’s Hospice on 02080997777 for specialist advice and guidance on prescribing

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