Trinity Hospice
Compassion and care

PALLIATIVE CARE GUIDANCE FOR PRIMARY CARE

Adapted for the Fylde Coast Health Economy

In accordance with Lancashire & South Cumbria Clinical Practice Summary Guidelines (May 2017)

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

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CONSTIPATION

Assessment should include abdominal & PR examination. Think about using both oral laxatives and suppositories as needed

Oral Laxatives	
Stimulants	
Senna	7.5mg -15mg nocte, increase to 30mg bd tablets, granules, syrup
Bisacodyl	5-10mg nocte, increase to 10mg bd tablets
Docusate	100mg bd, increase to 200mg tds capsules, oral solution
Osmotic Laxatives	
Macrogols	1-2 sachets nocte, maximum 8/day sachet for reconstitution
Combined Stimulant & Softeners	
Co-danthramer* (25/200) Co-danthramer* strong (75/1000)	2 caps/10mLs nocte, increase to bd use strong formulation if insufficient capsules, suspension
Opioid Constipation	
Naloxegol	25mg daily (12.5mg in frailty)

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

Rectal Interventions
First line - Suppositories
Glycerine, Bisacodyl 10mg suppository
Second line - Enemas
Phosphate, Docusate, Arachis Oil (beware peanut allergy)

TERMINAL RESTLESSNESS

Consider reversible causes and treat if possible
In particular consider:
pain; urinary retention; constipation; fear;
nicotine withdrawal ; gastric stasis; spiritual distress

Seek specialist advice if 24 hour doses above Midazolam 30mg, Haloperidol 5mg or Levomepromazine 25mg are needed

Sedative Drugs	
Midazolam (first line)	2.5-5mg subcut PRN 2hrly; 10-30mg CSCI /24hr if anxiety prominent symptom also useful if at risk of epileptic fit
Levomepromazine (second line)	6.25mg subcut PRN 6 hrly 6.25-12.5mg CSCI/24hr; max 25mg/24hr if psychotic symptoms are predominant
Haloperidol (second line)	0.5mg subcut PRN 2hrly 5mg 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
Causes considerable anxiety: acknowledge & 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	
Opioids	
Morphine solution	2.5mg po PRN 4hrly, titrate as needed
Morphine injection	1.25mg subcut PRN 4hrly if unable to take oral medication
Benzodiazepines	
Lorazepam	0.5-1mg po/subling PRN, max 2mg/day
Midazolam	2.5mg subcut PRN 4hrly, titrate as needed 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. Start at 12-16mg orally and titrate down
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 4 hrly 0.6-1.2mg CSCI /24hr
Hyoscine hydrobromide (second line)	0.4mg (=400mcg) subcut PRN 2hrly 1.2-2.4mg CSCI/24hr may cause confusion and / or sedation

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

End of Life Care Injectable Drugs	
Morphine (for pain)	
If naïve: 2.5mg PRN 1 hrly subcut stat CSCI dose depends on the number of prn morphine doses needed	Supply 5 x 10mg amps
*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: 2.5 – 6.25mg PRN 6hrly subcut CSCI dose: 6.25-12.5mg/24hr	Supply 5 x 25mg/1mL amps
Midazolam (for restlessness & terminal agitation)	
Stat dose: 2.5-5mg PRN 4hrly subcut CSCI dose: 5-10mg/24hr (max 30mg)	Supply 5 x 10mg/2mL amps
Glycopyrronium (for respiratory tract secretions)	
Stat dose: 0.2mg PRN 4hrly subcut CSCI dose: 0.6-1.2mg/24hr	Supply 5 x 200mcg/1mL amps
Water for injection	
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 CSCI

Continuous Subcutaneous Syringe Infusion

Drug	Dose	Indication
Morphine	If opioid naïve: 10-20mg/24hr	pain
Oxycodone	If opioid naïve: 5-10mg/24hr	pain
Hyoscine Butylbromide	60-240mg/24hr	abdominal colic
Metoclopramide (pro-kinetic)	30mg/24hr	nausea & vomiting
Haloperidol	2.5-5mg/24hr	nausea & vomiting
Cyclizine	150mg/24hr	nausea & vomiting
Octreotide ***(specialist use)***	300-900mcg/24h	obstructive vomiting
Hyoscine Hydrobromide	1.2-2.4mg/24	respiratory secretions
Normal Saline	*not with cyclizine*	diluent

Drugs NOT to be used in Syringe Pumps		
Chlorpromazine	Diazepam	Prochlorperazine

Approximate Conversion from ORAL to SUBCUT Opioids

3mg PO Morphine = 1.5mg SC Morphine = 1mg SC Diamorphine

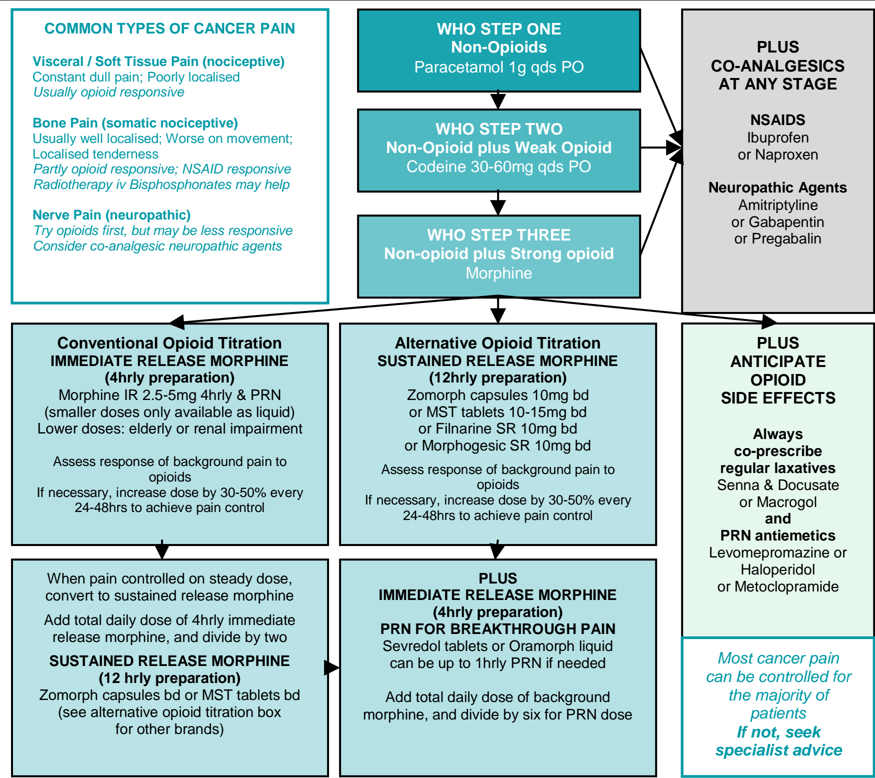
3mg PO Morphine = 1.5mg PO Oxycodone = 0.75mg SC Oxycodone

USEFUL ONLINE RESOURCES

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

Lancashire & South Cumbria Palliative Clinical Practice Summary
https://www.nwcscnsenate.nhs.uk/files/4615/0661/0362/Clinical_Practice_Summary_-_Lancashire__South_Cumbria_Consensus_Guidance.pdf

TREATMENT GUIDANCE FOR CANCER PAIN



USE OF FENTANYL PATCHES

Consider if:

- **Pain is stable, and NOT rapidly changing**
- **Oral route not appropriate**
- **Oral opioids not being absorbed**
- **Unacceptable side effects from other opioids**

Commencing Fentanyl Patches

- Titrate with 4hrly immediate release oral morphine, until pain is controlled
- Calculate patch size using table below
- Remember a fentanyl 25mcg/hr patch is equivalent to a 60-90mg total daily dose of oral morphine
- Stick patch to hairless skin; clip (not shave) hair
- Initial analgesic effect will take 12-24 hrs, and a steady state may not be achieved for 72 hrs
- Ensure immediate release morphine (or alternative) is available for breakthrough pain; calculate correct PRN dose from table below
- Change patch every 72 hrs; use a new area of skin
- A 12-24hr depot of drug remaining when patch removed; fold in on themselves and discard safely
- Opioid withdrawal may occur when switching from morphine to fentanyl; manage with PRN morphine

Buprenorphine & Fentanyl Patches at End of Life

- When a patient is dying, **LEAVE PATCH IN SITU**, and change as before (see frequency in table below)
- Use subcut opioid PRN for breakthrough pain; if PRN needed regularly, start CSCI in addition to patch
- Ensure PRN dose adequate for both patch & CSCI
- **Seek Specialist Palliative Care advice if unsure**

NAUSEA & VOMITING

General Measures

- **Correct reversible causes if possible**
  drugs; uraemia; hypercalcaemia; constipation; bowel obstruction; ascites; severe pain; cough; infection; raised intracranial pressure; anxiety
  (*may not be appropriate if patient is imminently dying*)
- **Review regular oral antiemetic medication: consider conversion to alternative route**
- **For any given cause, prescribe the first line antiemetic REGULARLY, and second line PRN**
- **Review efficacy of antiemetic medication every 24 hrs until control of symptoms is achieved**
- **1/3 of patients need more than one antiemetic**

Prokinetic antiemetics for gastric causes

- gastritis, gastric stasis
- other considerations: antacid, PPI, antifungal, laxatives

First line	
Metoclopramide	pro-kinetic antiemetic 10mg tds PO 10mg sc 4hourly or 30mg CSCI/24hr
Second line	
Levomepromazine	6mg or 6.25mg (¼ 25mg tablet) nocte PO 2.5 – 6.25mg sc 6hourly or 6.2 5-1 2.5mg CSCI/24hr

Centrally acting antiemetics

First line – for chemical causes morphine, drugs, chemo, hypercalcaemia, uraemia	
Levomepromazine	6.25-12.5mg =¼ or ½ 25mg tablet nocte PO (or 6mg tablet nocte PO) or 6.25-12.5mg CSCI/24hr
First line – for central cerebral causes brain primary or metastases, raised ICP, cranial radiotherapy	
Cyclizine	50mg tds PO or 75-150mg CSCI/24hr
Second line – for chemical and central cerebral causes	
Haloperidol	0.5mg nocte PO or 1.5-3mg CSCI/24hr

Review

Switch to oral antiemetic after 72hrs of symptom control

If little or no improvement after 24-48 hrs despite optimising antiemetic dose and route, review cause:
if changed, substitute first line antiemetic

A GUIDE TO EQUIVALENT DOSES FOR OPIOID DRUGS

This table of doses is a **guide,** not a set of definitive equivalences. Use the table to identify an appropriate *starting* point for your prescribing decision. If you are not sure **ASK**.
ALL prescribing decisions must be based on a **full clinical assessment**. Ask if the pain is responsive to rescue doses of opioid. Think about the role of adjuvant medication **before** rotating opioids, changing the dose or route. Consider **reducing prescribed opioid dose by 30-50%** if converting from one route to another or there is concern about **opioid toxicity** (confusion, drowsiness, myoclonic jerks, slowed respiration, pin-point pupils.)
Be aware of drug interactions and remember individual patients may metabolise and absorb different drugs at varying rates.
Never increase an opioid dose by more than 50% of the previous 24 hour regular dose without SPECIALIST ADVICE

Oral Morphine		Oral Oxycodone		Transdermal Buprenorphine		Transdermal Fentanyl	Subcutaneous Morphine		Subcutaneous Oxycodone	
4-hr dose (mg)	12-hr SR dose (mg)	4-hr dose (mg)	12-hr SR dose (mg)	**BuTrans** (mcg/hr) *change every* ***seven*** *days*	**Transtec** (mcg/hr) *change every* ***four*** *days*	Patch strength (mcg/hr) *change every* ***three*** *days*	4-hr dose (mg)	**24-hr** CSCI dose (mg)	4-hr dose (mg)	**24-hr** CSCI dose (mg)
1.25	5	-	-	5	-	-	0.5	-		
2.5	10	-	-	10	-	-	1.25	5		
5	15	2.5	10	15	-	12*	2.5	15	1.25	10
10	30	5	15	25	-	25	5	30	2.5	15
15	45	10	30	35	35	37	7.5	45	5	30
20	60	15	45	-	52.5	50	10	60	7.5	45
SEEK SPECIALIST ADVICE				**SEEK SPECIALIST ADVICE**			**SEEK SPECIALIST ADVICE**			
30	90	20	60		70	75	15	90	10	60
40	120	25	75		105	100	20	120	12.5	75
50	150	30	90		122.5	125	25	150	15	90
60	180	40	120		140	150	30	180	20	120

*Fentanyl- a 12mcg/hr strength is available; but is licenced as a titrating dose, NOT as a starting dose. If a patient has not been on an equivalent of 60-90mg of oral morphine per 24 hours, seek specialist help before commencing Fentanyl patch.

SPECIALIST PALLIATIVE CARE ADVICE

Trinity Hospice Advice Line (24 hours) 01253 359359
Monday to Friday 9am - 5pm
Trinity Community Palliative Care Team 01253 359379
Trinity Hospital Palliative Care Team 01252 953670