Palliative Care Symptom Control Guidelines

The aim of this guidance is to provide an information resource for health care professionals caring for adult palliative care patients in the last days of life. It is intended that they be used by qualified health care professionals in the context of each individual patient's needs. The guidance refers to patients across the following settings: Mid Yorkshire Hospitals NHS Trust, Wakefield Hospice and The Prince of Wales Hospice, Pontefract.

The choice of some drugs and the use of the subcutaneous route of delivery recommended within these guidelines is outside some of the drugs' licenses. In palliative care and pain management this practice is both necessary and common and all the suggested guidance is standard practice. Further information regarding prescribing unauthorized medicine or authorized medicines for off-label indications can be found in the current version of the Palliative Care Formulary.

For further advice, please contact your local Specialist Palliative Care Service.

Updated: February 2020 Next review date: February 2022

Pain management for patients unable to take oral medication

In patients with moderate renal impairment (eGFR< 40ml/min) consider oxycodone first line, if eGFR <10ml/min, seek specialist advice.

Is the patient already taking oral morphine?

YES

To convert a patient from oral morphine to a 24 hour syringe driver of morphine, **divide the TOTAL dose of oral morphine used in the previous 24 hours by 2**

e.g. Zomorph® 30mg twice daily = 60mg ÷ by 2 = 30mg morphine to be given s/c via a syringe driver over 24 hours.

(Remember to consider adding in breakthrough doses of morphine taken within the last 24 hours)

PRN Analgesia

Always prescribe SC prn morphine dose which equals **1/6** of the dose used in the syringe driver over 24 hours.

NO

ANTICIPATORY PRESCRIBING

Ensure morphine 1 - 2.5mg SC prn is prescribed and available

Please review the medication after 24 hours. If two or more doses are required prn then consider a syringe driver over 24 hours. 5-10mg SC morphine over 24 hours is a safe starting dose

KEY PRACTICE POINTS

Please remember:

- To reassess patient following any change in analgesia, for both pain and side effects of medications at least every 24 hours.
- If the patient is in pain at the time of commencing syringe driver please give a prn dose.
- If the patient's pain remains uncontrolled, first check that syringe driver is working. Then consider increasing the total dose of analgesia in the syringe driver by 30% over 24 hours.
- If the patient is requiring more than 120mg oral morphine equivalent in 24 hours, please seek advice from the Specialist Palliative Care team
- If symptoms persist, if there is rapidly escalating pain or if you are concerned about side effects, please seek advice.
- If you are unsure how to convert a patient from other strong opioids to morphine, please consult the Trust's Opioid Conversion Chart and/or contact the Specialist Palliative Care Team or Pharmacy for advice.

Pain management for patients on a transdermal patch

*In patients with moderate renal impairment (eGFR< 40ml/min) consider prn SC oxycodone first line

Patient on a fentanyl or buprenorphine patch

Patch present but pain not controlled

Continue with the patch and change as per manufacturer's instructions
…AND

- Give prn SC injection of morphine *
- If two or more prn doses required, consider starting morphine syringe driver *in addition* to patch (use the total of breakthrough analgesia used in the last 24

Please do not increase the strength of the patch.

If symptoms persist, and you are not sure what to do next or are concerned about side effects, please contact the Specialist Palliative Care Team.

Patch present and pain controlled

ANTICIPATORY PRESCRIBING

Continue with the patch.

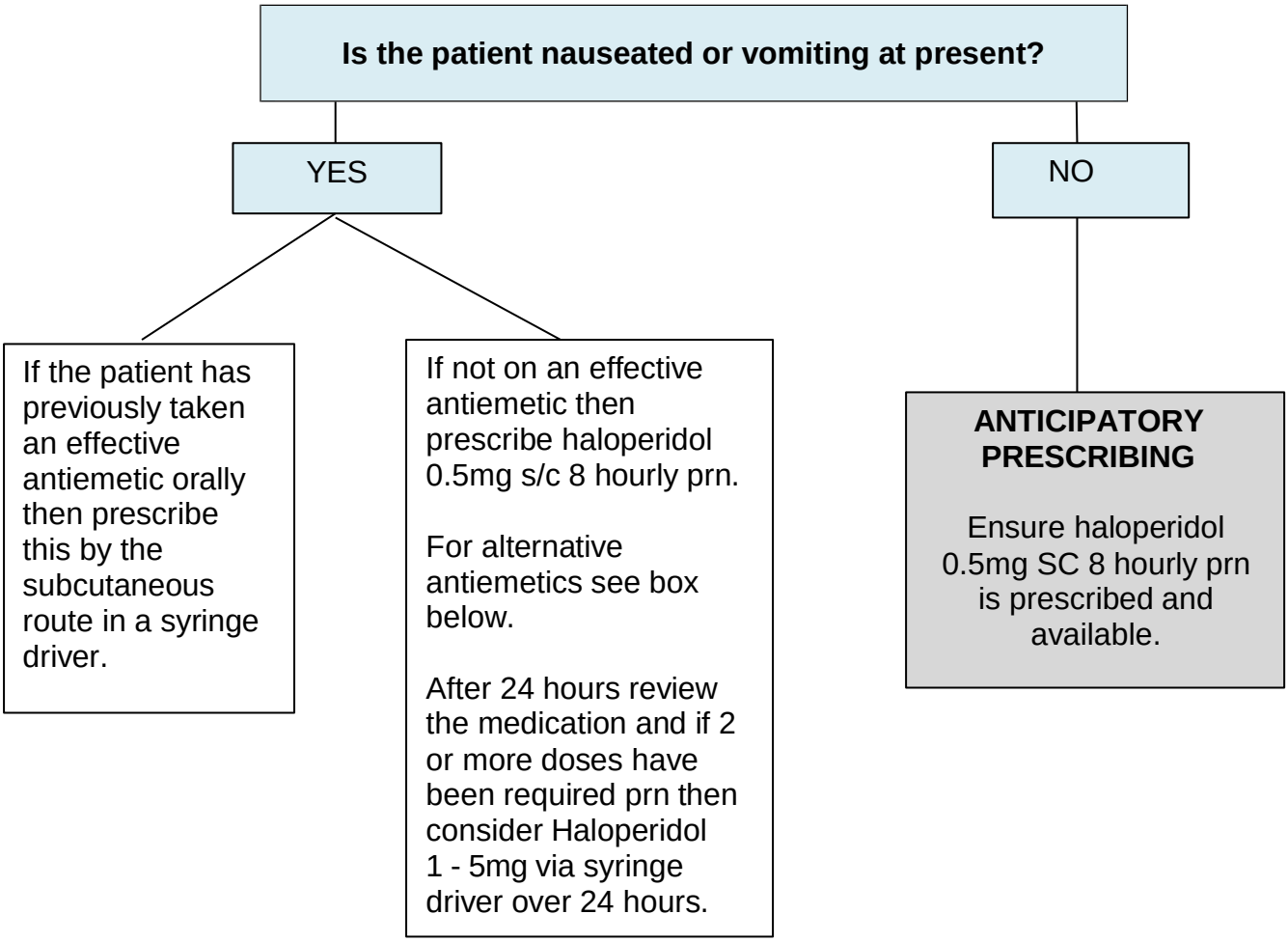
Ensure morphine * SC prn is prescribed and available for pain (dose varies according to patch strength: see BNF or seek advice

KEY PRACTICE POINTS

Please remember to consider alternative opioids in patients with renal or liver impairment. Or if the patients usual PRN opioid is Oxycodone.

Nausea and vomiting

Consider the cause of nausea and vomiting.
For advice please contact the Specialist Palliative Care Team



KEY PRACTICE POINTS

- Alternative antiemetics may be prescribed e.g.
  - Cyclizine 50mg SC 8 hourly prn (150mg via syringe driver over 24 hrs if required)
  - Levomepromazine 3 – 6.25mg SC prn (6.25 - 25mg via syringe driver over 24 hrs if required)
- Cyclizine is NOT recommended in patients with heart failure.
- Caution: cyclizine may crystallize with hyoscine butylbromide and/or morphine. Please monitor and seek advice if necessary.
- Be aware of extra pyramidal side effects with haloperidol – use with caution, for example, in Parkinson's disease (seek advice if needed)

Terminal restlessness/agitation

Is the patient restless or agitated at present?

YES

Consider and treat appropriately:

- Physical discomfort – pain, urinary retention, faecal impaction, malfunctioning syringe driver
- Respiratory distress – dyspnoea, cough
- Neurological problems – fits, hallucinations. (Remember these may be drug induced e.g. opioids)
- Psychological distress

If there are no reversible precipitating factors or delirium, midazolam is the drug of choice.

Prescribe midazolam 2.5 – 5mg s/c prn.

If 3 or more doses are required then consider the use of a syringe driver with midazolam 10 – 20 mg over 24 hrs.

NO

ANTICIPATORY PRESCRIBING

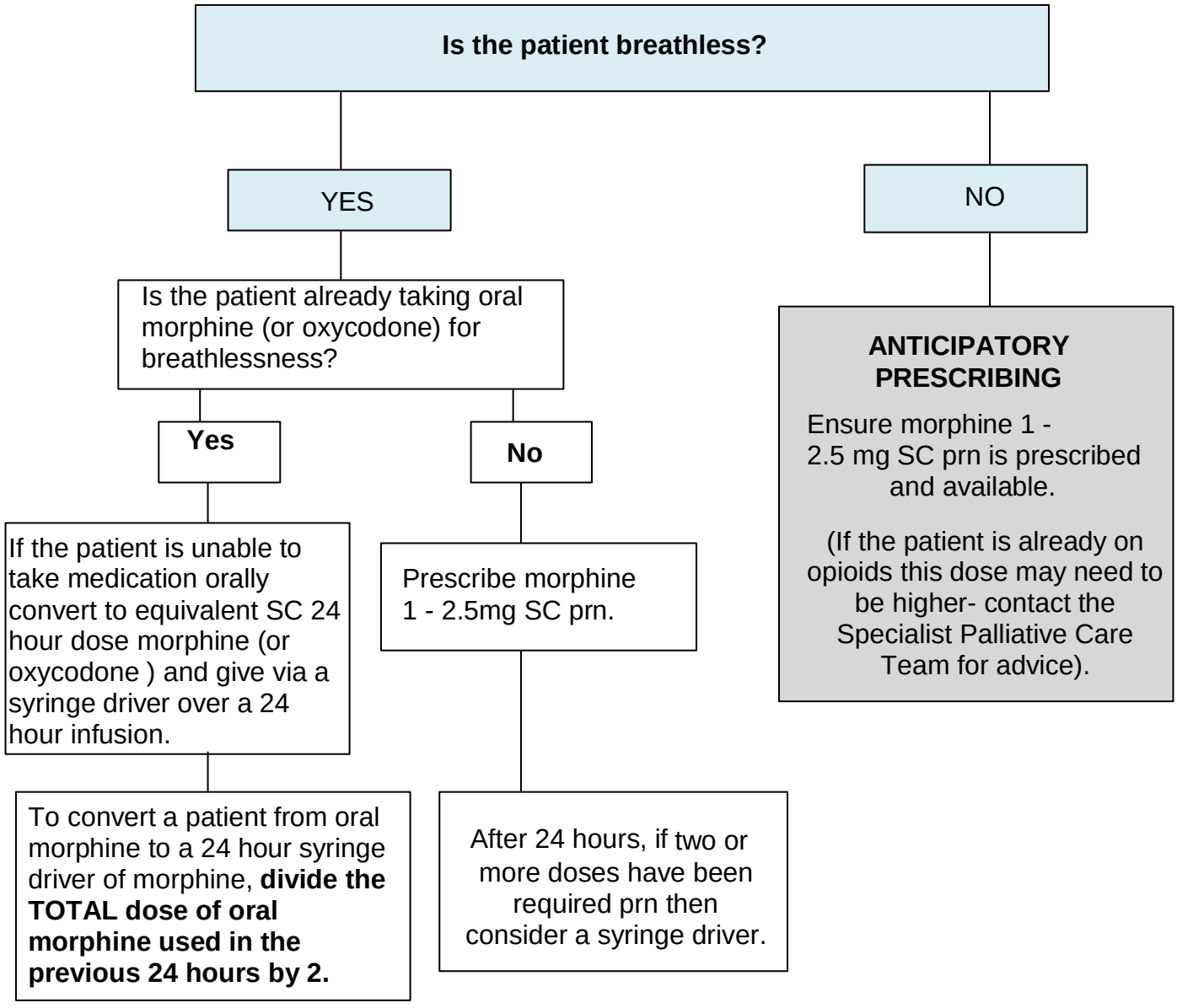
Ensure that midazolam 2.5 – 5 mg SC prn is prescribed and available.

KEY PRACTICE POINTS

- The management of agitation and restlessness does not usually require the use of an opioid unless the agitation is thought to be caused by pain.
- If the patient has features suggestive of delirium always consider non-pharmacological measures first. If symptoms persist despite this, consider haloperidol 0.5mg – 1mg s/c prn
- If there is ongoing restlessness and agitation despite these measures and you are not sure what to do next please contact the Specialist Palliative Care Team.

Breathlessness

*In patients with moderate renal impairment (eGFR< 40ml/min) consider prn SC oxycodone first line



KEY PRACTICE POINTS

- **If the patient is breathless and anxious prescribe midazolam 2.5 – 5mg SC prn.**
- **If symptoms persist or you have any concerns, please contact the Specialist Palliative Care Team.**

Respiratory tract secretions

Does the patient have noisy or troublesome respiratory tract secretions?

YES

Consider non-pharmacological measures:

- Reposition the patient
- Explain the cause of the problem to the relatives/carers and emphasise that this is unlikely to be causing distress to the patient .

Give a stat dose of hyoscine butylbromide 20mg SC.

If effective, commence a syringe driver of hyoscine butylbromide 60mg - 120mg over 24 hours.

If symptoms persist and you are not sure what to do next or are concerned about side effects, please contact the Specialist Palliative Care Team.

NO

ANTICIPATORY PRESCRIBING

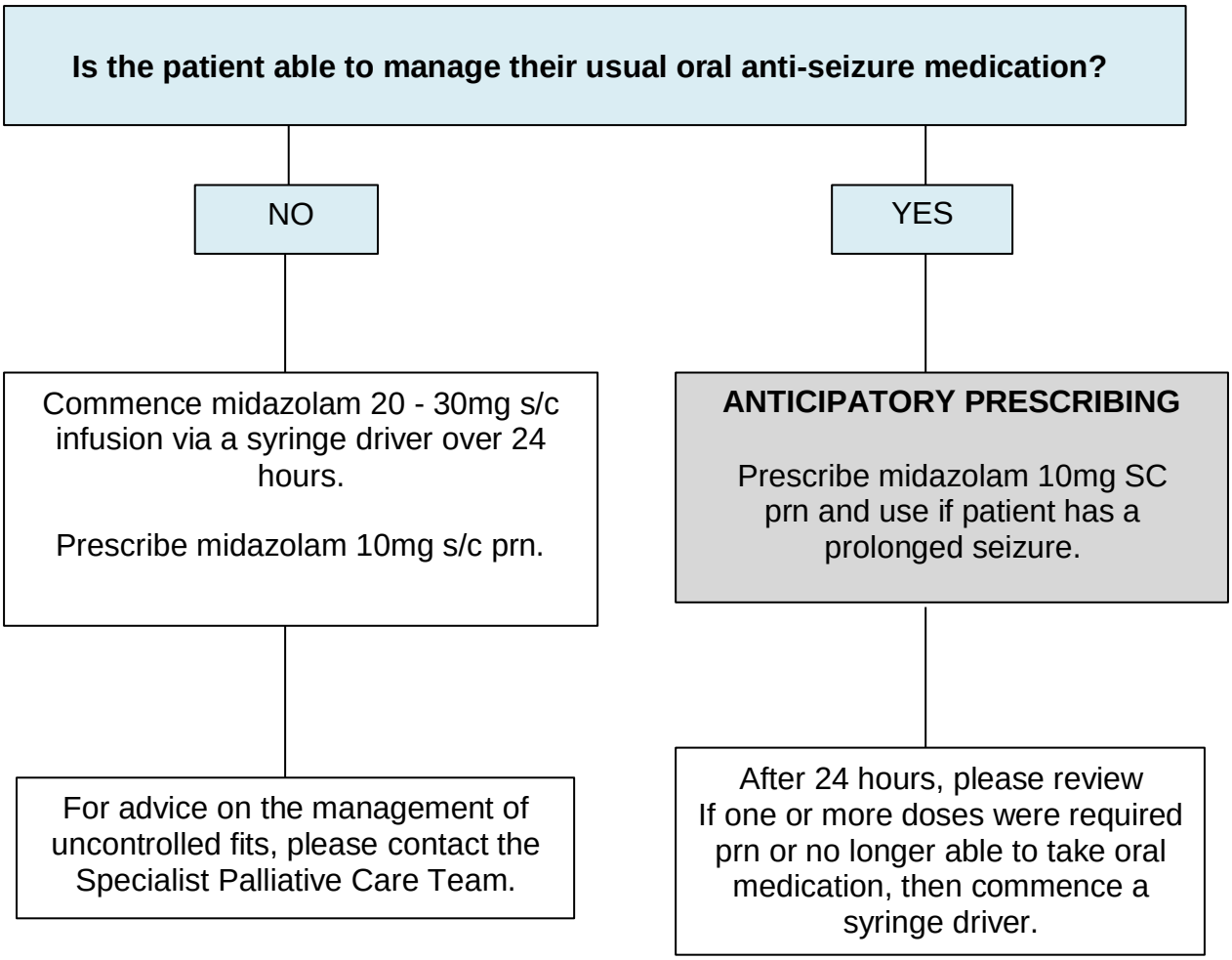
Ensure hyoscine butylbromide 20mg SC prn is prescribed and available.

If more than 2 doses of SC hyoscine butylbromide is needed, consider commencing a syringe driver of 60mg – 120 mg over 24 hours.

KEY PRACTICE POINTS

- **Caution – ensure correct product and dose are selected.**
- **Hyoscine butylbromide is non-sedating but short acting and should be used first line.**
- **Glycopyrronium 200micrograms SC prn (600-1200 micrograms over 24h) may be used as an alternative.**

Management of seizures



KEY PRACTICE POINTS

- Seizures in advanced cancer can either be provoked (e.g. primary or secondary brain tumour, biochemical disturbance) or relate to long standing epilepsy.
- Steroids are sometimes used to control oedema around brain tumours and should be continued orally where used for this indication until the patient is unable to swallow medication.
  Contact the Specialist Palliative Care Team for further advice.