Supporting Last Days of Life
Symptom Control Medication Guidance: Algorithm

Agitation & Anxiety

Present
(Exclude or treat **REVERSIBLE causes***)

Patient is **anxious / frightened**, but **lucid**

Prescribe MIDAZOLAM 2.5-5mg s/c 1 hourly prn (Max total 24 hour dose of 60mg)

If patient requires 3 doses at hourly intervals seek prompt medical review

Review after 24 hours. If 3 or more doses are required then consider use of a CSCI (Continuous Subcutaneous Infusion)

Continue to give prn doses as needed (Max total 24 hour dose of 60mg)

Patient is **confused, agitated** and / or **hallucinating**

Prescribe **HALOPERIDOL 1-2.5mg s/c 4 hourly prn** (Max total 24 hour dose of 10mg)

Review after 24 hours

If 3 or more doses are required then consider value of giving 2.5-10mg over 24 hours via a CSCI

The dose can be titrated to max of 10mg over 24 hours

If patient is still agitated and distressed, consider adding in Midazolam to the CSCI

Absent

Prescribe **MIDAZOLAM 2.5-5mg s/c 1 hourly prn** (Max total 24 hour dose of 60mg)

If patient requires 3 doses at hourly intervals seek prompt medical review

Review after 24 hours. If 3 or more doses are required then consider use of a CSCI

SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

Exclude or treat **REVERSIBLE causes***, e.g. alcohol withdrawal, hypercalcaemia, infection, opioid toxicity, urinary retention or constipation.

If a dose range is prescribed always commence at the lower dose.

The treatment of agitation and anxiety does not usually require the use of opioids unless it is thought to be caused by pain.

LEVOMEPROMAZINE 12.5-25mg s/c 6 hourly prn (Max total 24 hour dose of 100mg) can be used as an alternative to Haloperidol.

If using either Levomepromazine or Haloperidol for the management of nausea and vomiting this should be taken into account when titrating doses for agitation and restlessness.

Consider dose reduction for the elderly, frail or patients with dementia.

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

Twycross R., Wilcock A., & Howard P. (2017) *PCF6: Palliative Care Formulary (6th Ed.).* Oxford: Radcliffe Medical Press.
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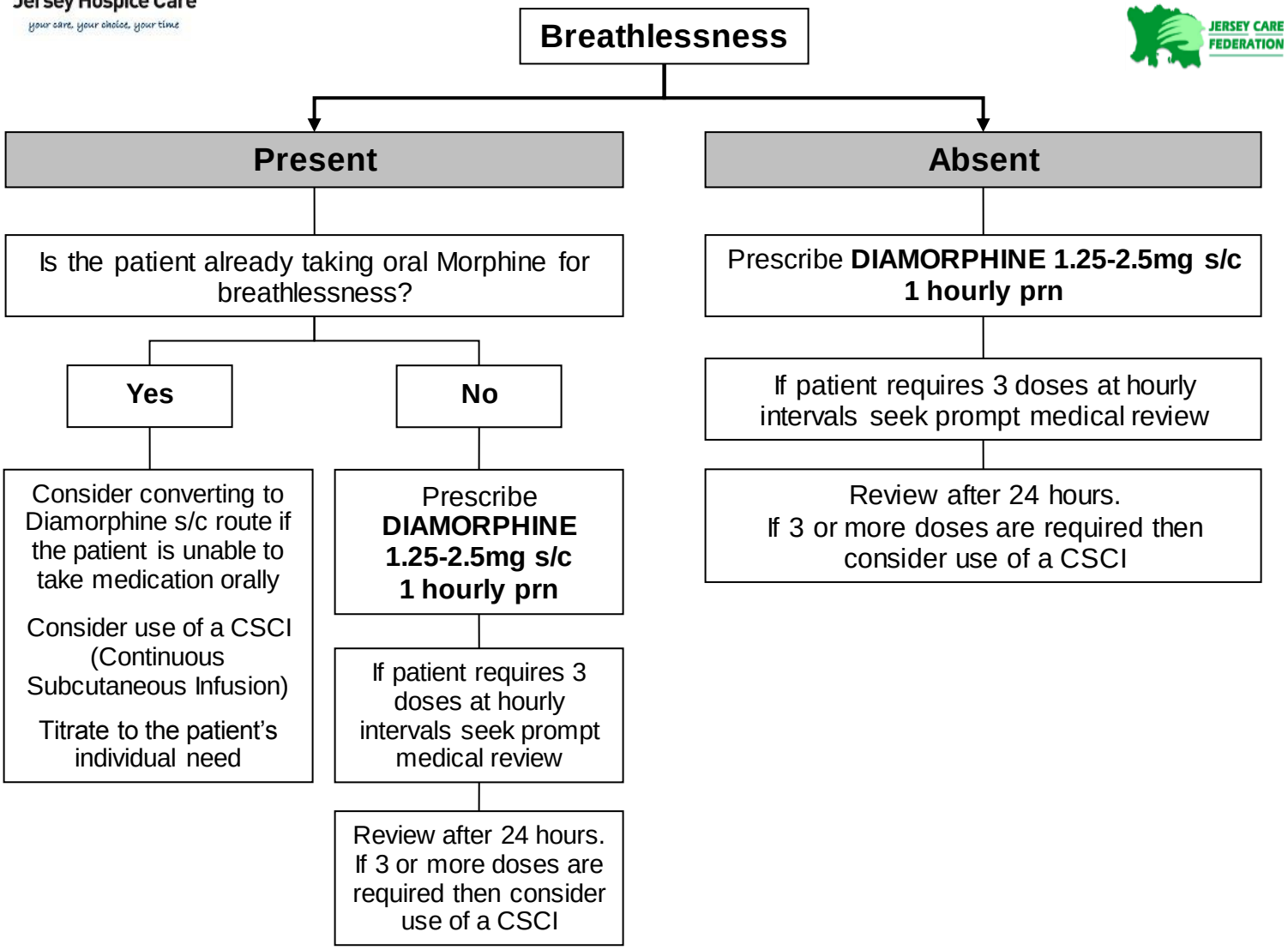

SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team (SPCT) for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

If the patient is breathless and anxious, consider MIDAZOLAM 2.5mg s/c 1 hourly prn.

If a dose range is prescribed always commence at the lower dose.

To convert oral Morphine to a 24 hour CSCI of Diamorphine divide the total (24 hour) dose of Morphine by 3 (e.g. 30mg bd orally = 60mg morphine in 24hrs ÷ 3 = Diamorphine 20mg via a CSCI).

For breakthrough breathlessness prescribe a prn dose of Diamorphine which is 1/6th of total 24 hour dose (i.e. the equivalent of Diamorphine 30mg subcutaneously over 24 hours = 5mg s/c 1 hourly prn).

If using opiates for the management of pain this should be taken into account when titrating opiates for breathlessness.

Consider dose reduction for the elderly, frail or patients with dementia and mild / moderate renal impairment (avoid Diamorphine and Morphine in renal failure – seek advice from SPCT).

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

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Nausea & Vomiting

Present

If the patient is already being given anti-emetics, review the benefit of continued use

Prescribe **LEVOMEPROMAZINE 6.25mg s/c 6 hourly prn**
(Max total 24 hour dose of 25mg)

Use alternative* if Levomepromazine has already been given and is ineffective

Review after 24 hours (earlier review may be required if patient does not respond to Levomepromazine after 2 doses)

If 2 or more doses are required over a 24 hour period then consider use of giving 12.5mg over 24 hours via a CSCI (Continuous Subcutaneous Infusion)

The dose can be titrated to a max of 25mg over 24 hours

Absent

Is the patient already being given anti-emetics?

Yes

Continue treating with current anti-emetics

Review if nausea and vomiting develop

No

Prescribe **LEVOMEPROMAZINE 6.25mg s/c 6 hourly prn**

(Max total 24 hour dose of 25mg)

SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

***Alternative anti-emetics may be prescribed:**

- **CYCLIZINE 50mg s/c TDS prn (max 150mg via a CSCI over 24 hours) – NOT recommended in patients with heart failure**
- **HALOPERIDOL 0.5-1.5mg s/c 6 hourly prn (1.5-5mg via a CSCI over 24 hours)**

If using either Levomepromazine or Haloperidol for the management of agitation and restlessness this should be taken into account when titrating doses for nausea and vomiting.

Consider dose reduction for the elderly, frail or patients with dementia.

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

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Pain

Patient is in pain

Is the patient already taking oral Morphine or another strong opioid* (Fentanyl patches should **not** be removed unless clinically indicated)?

Yes

Review current analgesia, consider opioid dose increase

Consider converting to Diamorphine s/c route if the patient is unable to take medication orally

Consider use of a CSCI (Continuous Subcutaneous Infusion)

Continue to give prn doses as needed (at 1/6th of 24 hour background opiate dose)

No

Review current analgesia

Prescribe **DIAMORPHINE 2.5-5mg s/c 1 hourly prn**

If patient requires 3 doses at hourly intervals seek prompt medical review

Review after 24 hours. If 3 or more doses are required then consider use of a CSCI

Patient's pain is controlled

Is the patient already taking oral Morphine or another strong opioid* (Fentanyl patches should **not** be removed unless clinically indicated)?

Yes

Consider converting to Diamorphine s/c route if the patient is unable to take medication orally

Consider use of a CSCI

Continue to give prn doses as needed (at 1/6th of 24 hour background opiate dose)

No

Prescribe **DIAMORPHINE 2.5-5mg s/c 1 hourly prn**

If patient requires 3 doses at hourly intervals seek prompt medical review

Review after 24 hours. If 3 or more doses are required then consider use of a CSCI

SUPPORTING INFORMATION:

***For conversion of all other strong opioids (e.g. Oxycodone, Fentanyl) into a CSCI / prn doses, or if symptoms persist please contact the Specialist Palliative Care Team (SPCT) for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.**

If a dose range is prescribed always commence at the lower dose.

To convert oral Morphine to a 24 hour CSCI of Diamorphine divide the total (24 hour) dose of Morphine by 3 (e.g. 30mg bd orally = 60mg morphine in 24hrs ÷ 3 = Diamorphine 20mg via a CSCI).

For breakthrough pain prescribe a prn dose of Diamorphine which is 1/6th of total 24 hour dose (i.e. the equivalent of Diamorphine 30mg subcutaneously over 24 hours = 5mg s/c 1 hourly prn).

If using opiates for the management of breathlessness this should be taken into account when titrating opiates for pain.

Consider dose reduction for the elderly, frail or patients with dementia and mild / moderate renal impairment (avoid Diamorphine and Morphine in renal failure – seek advice from SPCT).

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

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Respiratory Tract Secretions

Present

Prescribe **GLYCOPYRRONIUM 200microgram s/c 4 hourly prn** (Max total 24 hour dose of 1.2mg)

If at least 1 dose is required over a 24 hour period then consider use of a CSCI (Continuous Subcutaneous Infusion) 0.6-1.2mg over 24 hours

Continue to give prn doses accordingly (Max total 24 hour dose of 1.2mg)

If symptoms persist after 24 hours consider increasing the total dose to 1.2mg via a CSCI over 24 hours

Absent

Prescribe **GLYCOPYRRONIUM 200micrograms s/c 4 hourly prn** (Max total 24 hour dose of 1.2mg)

SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team (SPCT) for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

HYOSCINE HYDROBROMIDE 400micrograms s/c 4 hourly prn (Max total 24 hour dose of 2.4mg) can be used as an alternative.

If Glycopyrronium OR Hyoscine Hydrobromide have been used and found to be ineffective, do NOT switch to the alternative option - instead please contact the SPCT for advice.

Early treatment of respiratory tract secretions is essential. If treatment with the above medications is withheld until the patient already has excessive secretions they are unlikely to be effective.

Please note that treatment will only reduce secretions for about 50-66% of patients[1].

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

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