

Prescribing Guidance for Dying Patients

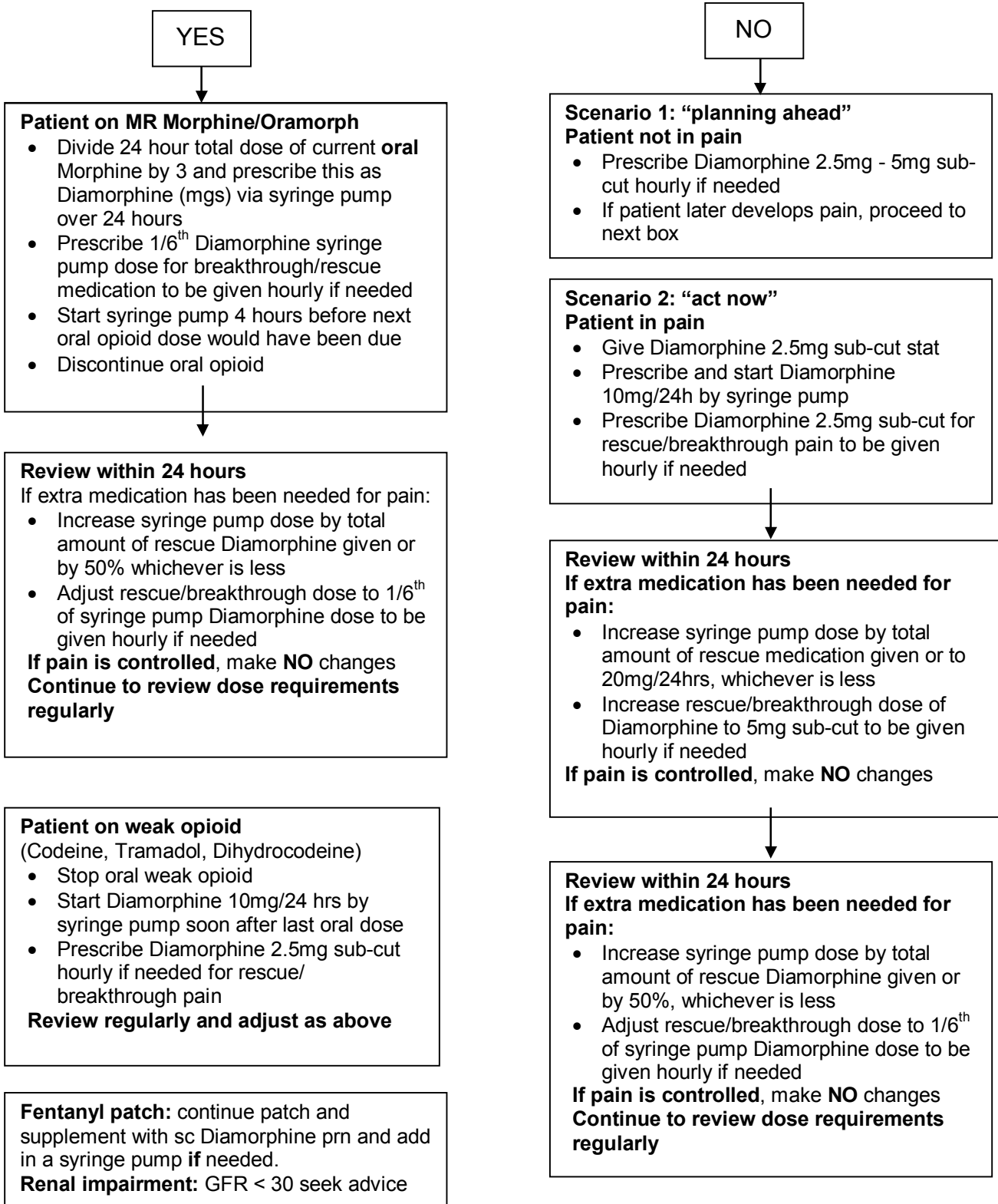


Most patients are comforted by the knowledge that medication is helpful and available if required at the end of their life.

The following flow charts are to be used as a guide for patients in their last hours of life. Further information is available from the West Midlands Palliative Care Physicians “Guidelines for the use of drugs in symptom control” www.wmpcg.co.uk and the Palliative Care Formulary.

PAIN AT THE END OF LIFE

Is patient already on opioid drugs and unable to tolerate or absorb oral medication?



If symptoms persist or you need advice please contact the Medical or CNS Team at Severn Hospice.

NAUSEA AND/OR VOMITING AT THE END OF LIFE

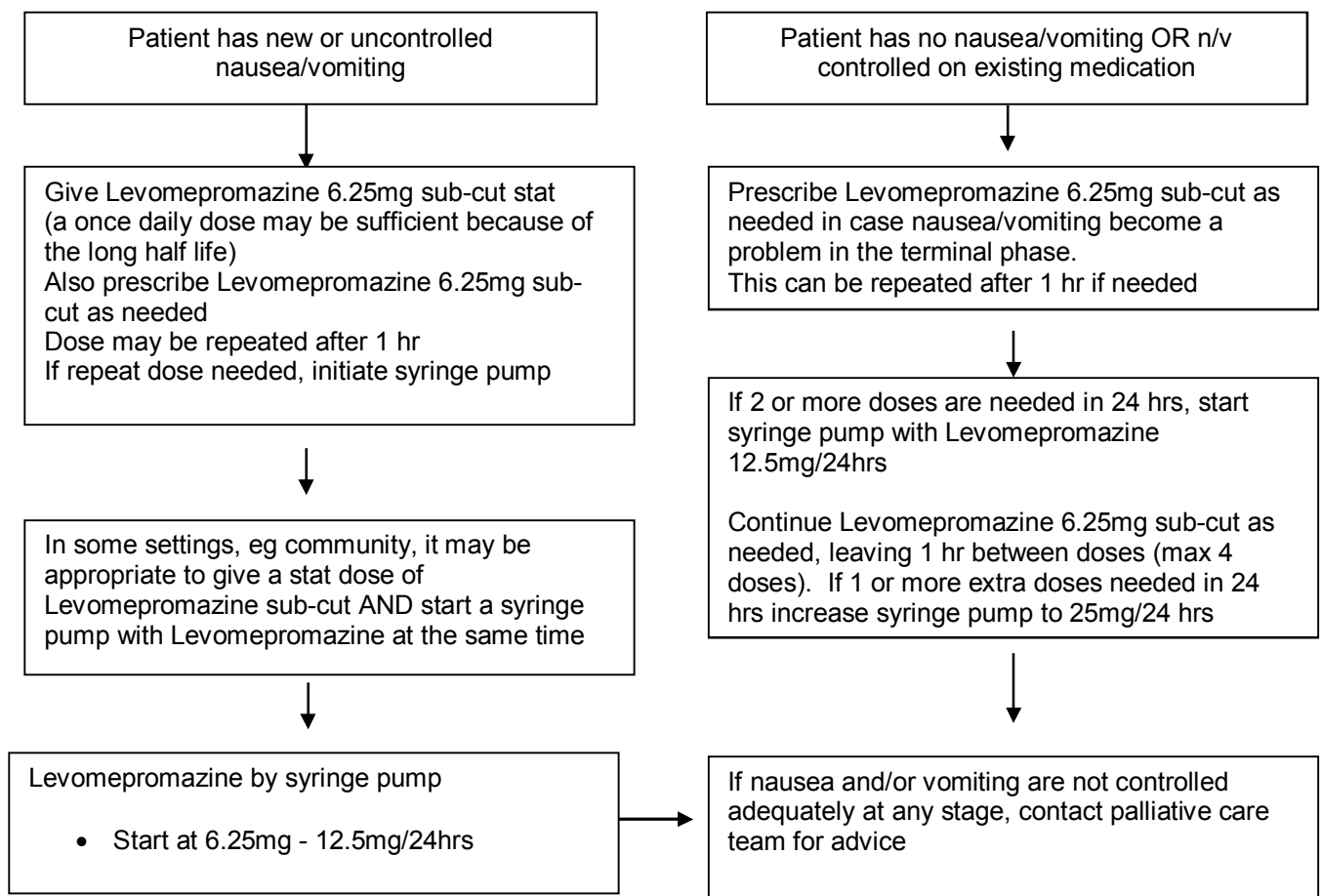
Important note: this guidance applies to the end of life ONLY

Effective palliation of nausea and vomiting earlier in the illness requires a cause-specific approach

Patients entering the terminal phase with **good symptom control** from an oral anti-emetic should **continue the same drug** given via a syringe pump when they are unable to take oral medication.

Domperidone should be replaced by Metoclopramide and Prochlorperazine (stemetil) by Cyclizine.

For new symptoms of nausea/vomiting that are difficult to control Levomepromazine (Nozinan) is recommended because of its broad spectrum of action.



Levomepromazine doses above 25mg/24 hr has a sedative effect.

If symptoms persist or you need advice please contact the Medical or CNS Team at Severn Hospice.

RESTLESSNESS/AGITATION AT END OF LIFE

Consider and manage common causes of restlessness, eg. Urinary retention, faecal impaction, hypoxia and pain.

PATIENT IS RESTLESS/AGITATED

PATIENT IS NOT RESTLESS/AGITATED

Non-drug intervention is essential: reassurance, calm environment, use of sound and aromatherapy. Have you taken into account their spiritual needs?

Immediate management

Give medication sub-cut stat:

Midazolam 2.5 - 5mg

OR

Haloperidol 2.5mg

Start syringe pump:

Midazolam 10 - 20mg/24h

OR

Haloperidol 5mg/24h

Prescribe rescue doses sub-cut hourly:

Midazolam 2.5 - 5mg

AND/OR

Haloperidol 2.5mg

Planning ahead

Prescribe sub-cut hourly as needed

Either Midazolam 2.5mg

OR

Haloperidol 2.5mg

Review within 24 hrs

If 2 or more doses needed **and are effective**, start syringe pump of same drug (see left)

If 2 or more doses tried **but are not effective**, switch to the other drug or consider Levomepromazine (see below)

Review within 24 hours

Midazolam:

1-2 extra doses, increase driver dose by 50%,
3 or more extra doses, double driver dose
Continue rescue doses of 5mg sub-cut prn
If Midazolam driver dose >40mg/24hrs, consider Levomepromazine and seek advice.

Haloperidol:

Any extra doses, increase driver dose to 10mg/24h and continue rescue doses
Max haloperidol dose 20mg/24hrs

Midazolam and Haloperidol are very effective when used in combination

Persistent symptoms

Levomepromazine:

- Is an effective **sedative**
- It may be added to Midazolam (if Midazolam partly effective) or used to replace haloperidol.
- Start syringe pump at 25mg/24h
- Use rescue dose 12.5mg sub-cut hourly as needed

Higher doses are sometimes needed please discuss with the Drs or CNS at Severn Hospice if doses over 50mg/24hrs are used.

If symptoms persist or you need advice please contact the Medical or CNS Team at Severn Hospice.

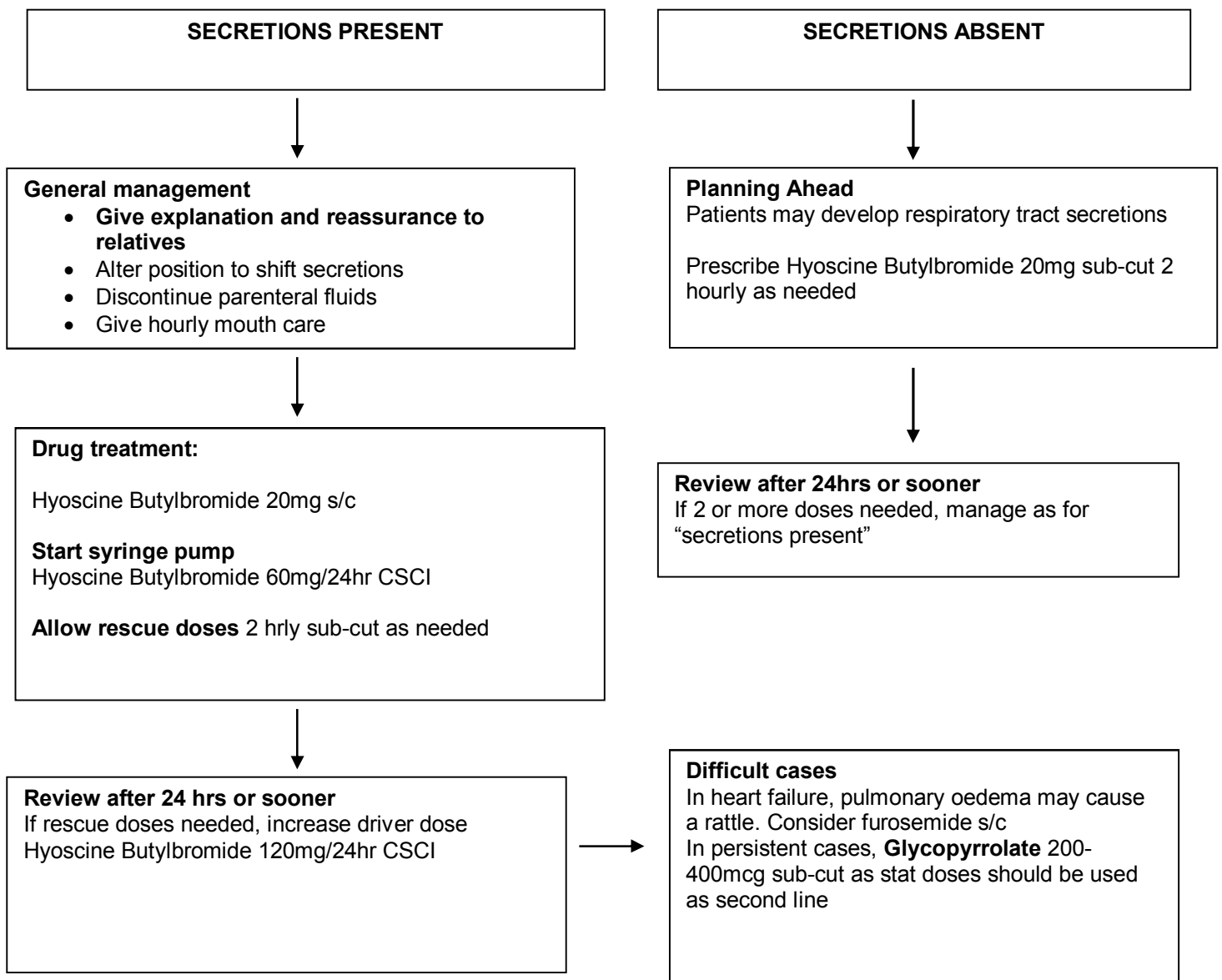
RESPIRATORY TRACT SECRETIONS IN A DYING PATIENT

Dying patients may be unable to cough effectively or swallow, which can lead to retained secretions in the upper respiratory tract. There is little evidence to support the effectiveness of drug treatment for this symptom. If the patient appears comfortable and not distressed reassure relatives and staff.

Hyoscine Butylbromide is our drug of choice to use for respiratory tract secretions at end of life

Hyoscine Butylbromide is non-sedating; Note it does not mix well with Cyclizine in a syringe and blocks the prokinetic antiemetic action of Metoclopramide

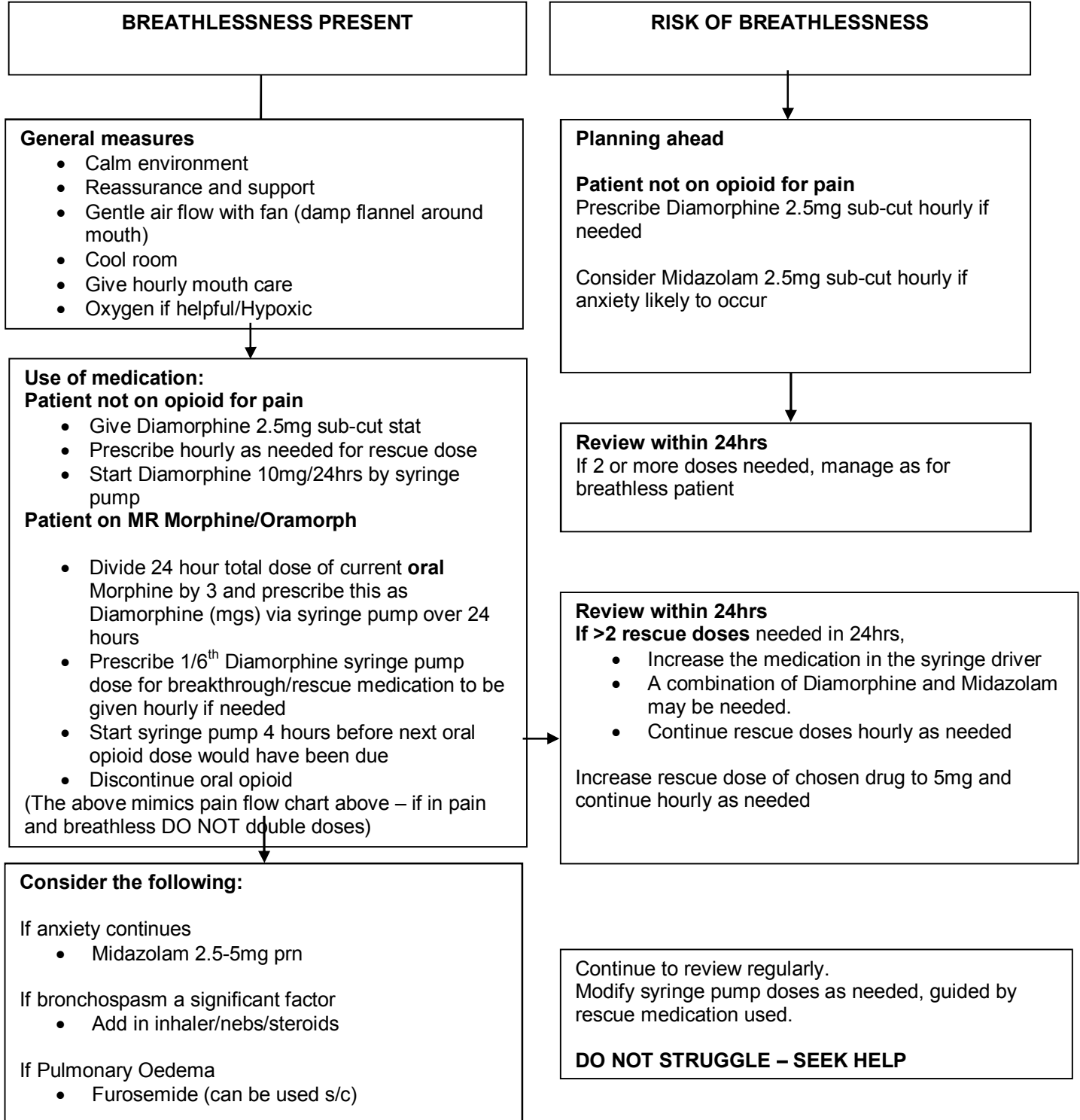
If rattling breathing is associated with breathlessness in a semiconscious patient add in an opioid +/- an anxiolytic sedative (midazolam)



If symptoms persist or you need advice please contact the team at Severn Hospice.

BREATHLESSNESS AT END OF LIFE

Terminal breathlessness is very frightening and must be treated as a serious symptom, untreated it can lead to escalation of symptoms, distress and terminal agitation.



If symptoms persist or you need advice please contact the team at Severn Hospice.