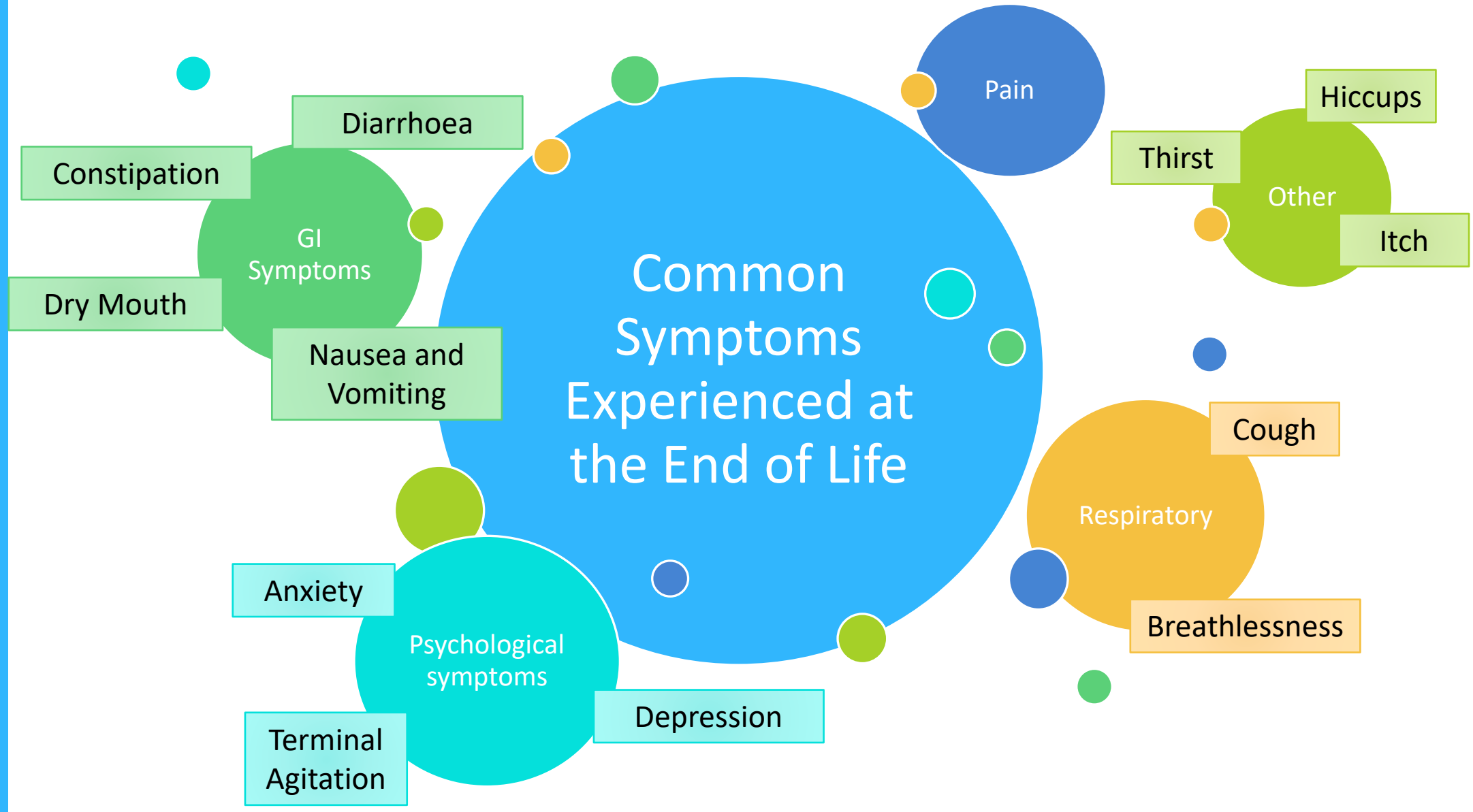
Managing Symptoms in Palliative Patients for Clinical Staff

CENTRAL LANCASHIRE PALLIATIVE & END OF LIFE CARE EDUCATION

Learning Objectives

- To be able and willing to listen to an individual describing their symptoms and know how to direct the them for more help
- To know who to contact if symptoms or pain are not being managed well
- To know how to support an individual to access medicines or other treatment, especially at weekends and holidays
- To understand common symptoms associated with the approach of end of life
- To understand how different factors can alleviate or exacerbate pain and discomfort
- To understand the importance of a holistic understanding and assessment of the individual's perception of their symptoms and the impact this may have on their choices
- To understand the range of therapeutic options available including practical support or psychological therapy, for symptom management available to them and any potential risks and benefits
- To understand that symptoms have many causes and that different causes may require different approaches to treatment, care and support
- To understand that symptom and pain management should be organised around the needs of the individual, and delivered in a coordinated manner
- To be able to support the individual retain dignity during symptom management
- To understand the importance of, and know how to, provide regular symptom relief and measure its effectiveness
- To understand when to refer concerns about an individual's symptoms to specialist colleagues
- To understand local and national policy relating to medicines management

What are the common symptoms someone might experience in the last year of their life?


Common Symptoms Experienced at the End of Life
Pain
GI Symptoms
Diarrhoea
Constipation
Dry Mouth
Nausea and Vomiting
Other
Hiccups
Thirst
Itch
Respiratory
Cough
Breathlessness
Psychological symptoms
Anxiety
Depression
Terminal Agitation

Assessing a Patient's Symptoms

When assessing symptoms it is important to consider:

- What symptoms they have
- What those symptoms are like
- What helps/ worsens the symptoms

This helps when deciding how to manage them.

Also look for non-verbal signs of symptoms- this is particularly important in patients who are too unwell to communicate.

What non-verbal signs would you look for when assessing a patient's symptoms?

Pain: Scenario

You are caring for a patient [insert location]. They have metastatic prostate cancer and are in the last weeks of their life. They are still able to take oral medication. They are on regular codeine and paracetamol, and they have some liquid morphine (oramorph) that they can take if they need to.

They have been getting more pain in their hip and they are finding it more difficult to walk.

What would you want to know?

What might you do next?

Pain Management

WHO Step 1
Non-Opioids

→

WHO Step 2
Non-Opioid + Weak Opioid

→

WHO Step 3
Non-Opioid + Strong Opioid

Starting Opioids

Option 1:

- Regularly: Oral morphine liquid 2.5-5mg 4hr
- PRN: 2.5-5mg 1hr

Option 2:

- Regularly: MR morphine 10mg 12hr
- PRN: 2.5-5mg 1hr

Starting Adjuvents

Neuropathic Agents:

- Gabapentin 100-300mg ON
- Pregabalin 25mg OD-BD
- Amitriptyline 10mg ON

Anti-inflammatories:

- Ibuprofen 400mg TDS
- Naproxen 500mg BD
- Celecoxib 100-200mg BD

Give with food

Total Pain


Co-morbid causes
Caused by treatment
Caused by cancer
Physical
Anxiety
Fear of suffering
Depression
Past experience of illness
Psychological
TOTAL PAIN
Loss of role and social status
Loss of job
Financial concerns
Worries about future of family
Dependency
Social
Anger at fate / anger with God
Loss of faith
Finding meaning
Fear of the unknown
Spiritual

Transdermal Patches

Medication to manage pain can be given via a patch

Patches can be helpful if someone is unable to swallow medication, but they are not appropriate for everyone

Do not start if opioid naïve- titrate with morphine/ oxycodone until pain is controlled

Use prn morphine or oxycodone for breakthrough pain

Stick to dry, hairless skin- clip hair, no not shave

After application it takes:

- 12-24hrs before analgesic effect
- Up to 72hrs to achieve steady state

After removal some drug remains- fold in on itself before disposal

When to stop other regular opioids:

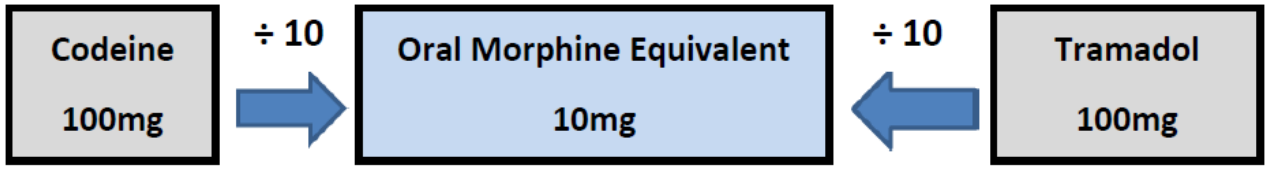
- Give regular doses for the first 12hrs the patch is on
- If taking MR opioid- apply patch and give the final MR dose at the same time

When a patient is dying:

Leave the patch in situ and change as normal.

Can use a syringe driver alongside if >2 prn doses are required in 24hrs

Changing Between Different Opioids



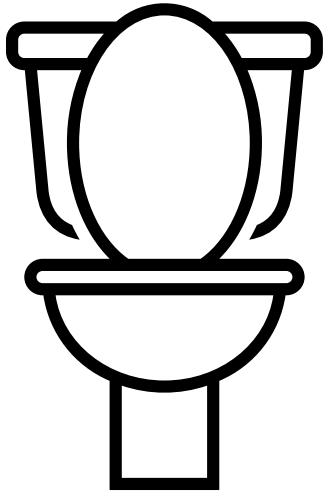
	Morphine (mg)					Oxycodone (mg)					Fentanyl Patch (mcg/hr)	Buprenorphine Patch (mcg/hr)
Route	Oral			SC		Oral			SC			
	24hr total	12hrly MR dose	PRN	CSCI 24h	PRN	24hr total	12hrly MR dose	PRN	CSCI 24h	PRN		
Dose	20	10	3	10	2	10	5	2	5	1	-	-
	30	15	5	15	3	15	*	3	7.5	1	12 micrograms	10 micrograms
	40	20	7	20	3	20	10	3	10	2	-	-
	50	25	8	25	4	25	*	6	13	2	-	20 micrograms
	60	30	10	30	5	30	15	5	15	3	25 micrograms	-
	70	35	12	35	6	35	*	6	18	3	-	30 micrograms
	80	40	13	40	7	40	20	7	20	3	-	-
	100	50	17	50	8	50	25	8	25	4	-	-
	120	60	20	60	10	60	30	10	30	5	50 micrograms	-

Seek specialist advice for higher doses

* When equal divided doses not possible due to tablet strength e.g. Oxycodone 25mg/24hrs . Prescribe equal doses at higher or lower level e.g. 10mg BD or 15mg BD, dependent on clinical judgement *

GI Symptoms

If the patient has established symptoms give regular medication not prn!



Lots of things can cause a patient to have GI symptoms

The most common symptoms in patients with a palliative illness are:

- Nausea and vomiting
- Constipation
- Diarrhoea
- Dry mouth

The best medication to help manage them will depend on the cause.

Like with pain, it is important to find out what the symptom is like, what helps and what makes it worse.

The Clinical Practice Summary gives advice on which one to use depending on the problem

GI Symptoms: Scenario

You go to see a 70 year old lady. She is known to have metastatic ovarian cancer and end stage renal failure (eGFR 6). She tells you that she has been feeling increasingly sick over the past week.

What questions would you want to ask?

What might be causing her nausea?

What would you want to do next?

Patients who become nauseated or start vomiting:

For gastritis, gastric stasis, functional bowel obstruction - Prokinetic anti-emetic:
Metoclopramide 10 mg TDS PO/SC or CSCI 30 mg/24 hours [above 30 mg with specialist advice] (*avoid in complete bowel obstruction—see guidance on bowel obstruction). There is an increased risk of neurological adverse effects at doses higher than 30 mg/24hours and if used for longer than 5 days.*

Domperidone 10mg BD - TDS PO
There is an increased risk of cardiac side effects at dose higher than 30mg/24hour and if used for longer than 7 days — see BNF for more information

For most chemical causes of vomiting (e.g. medication, hypercalcaemia, renal failure)
Centrally acting anti-emetic:
Haloperidol 500 micrograms - 1.5 mg at bedtime PO/SC or CSCI/24 hours (*monitor for undesirable effects when switching route at higher doses as some patients may require a dose reduction when switching from the oral route to SC)*
Metoclopramide also has a central action.

For vestibular symptoms - anti-emetic acting in vestibular system and vomiting centre:
Cyclizine 50 mg BD - TDS PO/SC or CSCI 75 mg - 150 mg / 24 hours

Sometimes it is necessary to convert to a broad spectrum anti-emetic
Broad- spectrum anti-emetic:
Levomepromazine 6.25 mg PO or 2.5 mg SC at bedtime, or 6.25 mg CSCI/24 hours — to maximum 25 mg/24h

Nausea and Vomiting: Which Antiemetic should I pick?

Your patient is thought to be feeling nauseated due to constipation…

Constipation

Established constipation: softener + stimulant most effective

Review PO laxatives every 3-4 days

Rectal interventions must be guided by PR findings

Treatment and Management : Oral laxatives commonly used in palliative care				
Indications (Bristol Stool Chart)	**Type of laxative**	**Drug name**	**Starting dose**	**Additional notes**
Soft, bulky stools - low colonic activity	Stimulant laxatives *Avoid if possibility of bowel obstruction*	Senna tablets	1-2 tabs at night	Takes 8-12 hours to have effect. May cause abdominal colic.
		Senna syrup	5-10 ml at night	See above—Reduce dose if colic develops.
		Bisacodyl tablets	1-2 tabs at night	
Hard dry faeces	Softener (weak stimulant at higher doses)	docusate sodium	Start at 100 mg BD or TDS	Takes 24-48 hours to have an effect. Mainly acts as softener, but doses over 400 mg may have weak stimulant action. Syrup is available but the taste is unpleasant.
Colon full and colic present	Osmotic laxatives	Macrogols	1—3 sachet BD	May be used to treat faecal impaction. Give 8 sachets in 1 litre of water, over 6 hours. Contraindicated in complete bowel obstruction .
		Lactulose	15 ml BD	Can be associated with flatulence/ abdominal colic. Can take 48 hours to have an effect.
Colon full, no colic	Combination laxatives (stimulant + softening agent)	senna + docusate		Use senna alone initially.
		senna + lactulose		
		co-danthramer suspension	5-10 ml at night and increase to BD as needed	Only licensed for use in terminally ill patients of all ages. May cause abdominal colic. May cause skin irritation– avoid in faecal incontinence.
Hard faeces - colon full		Codanthramer Strong Capsules and Codanthramer strong suspension	See BNF for additional guidance	May cause skin irritation– avoid in faecal incontinence. (More expensive and may be hard to source)
Opioid induced constipation resistant to above methods		Naloxegol	25 mg OD (12.5 mg in frailty)	For opioid induced constipation that has failed to respond to standard measures (oral laxatives and rectal intervention) - seek specialist advice.

Breathlessness: Scenario

You go to see a 65 year old gentleman with end stage COPD. He has had 4 admissions to hospital in the last 6 months with his COPD, but they have said there is nothing further that can be done to treat the COPD itself (his inhalers and nebulisers are all optimised and there is no infection to treat at the moment). He is really struggling with breathlessness.

What can be done to help people who are breathless?

Breathlessness

Breathlessness is a subjective experience of breathing discomfort

Research suggests that up to 50% of patients with cancer might feel breathless

This increases to up to 90% of patients in the last weeks of their life

Breathlessness varies in severity- some patients won't need any intervention but for some it will be their main symptom

Management can generally be divided into:

1. Treatment of the underlying condition
2. Non-pharmacological management
3. Pharmacological management of symptoms

Non-Pharmacological Management

These aim to reduce the impact of breathlessness and the distress that often accompanies it.

Practical support:

- Mobility aids
- Care support

Psychological support:

- Support groups
- Consider a referral to clinical psychology

Fans:

- Moving air can reduce the sensation of breathlessness

Pharmacological Management

Opioids:

- Start MR morphine 5mg BD
- Can titrate more slowly with IR morphine QDS
- **Max beneficial dose usually 30mg/24hrs**

The use of O2:

- **May be helpful in hypoxic patients**
- Use with caution esp in patients with T2 respiratory failure

Benzodiazepines can be considered when opioids and non-pharmacological measures have failed to control breathlessness and the patient remains anxious/distressed

- Lorazepam 0.5 - 1mg SL/PO PRN 2-4 hrly (max dose 4mg/24hrs or 2mg/24hrs for frail/elderly).

Steroids

Why might a palliative patient be on steroids?

Steroids are often used to help with symptoms in patients with palliative conditions.

Give before 2pm

Review clinical response within 7 days

Giving S/C or IV

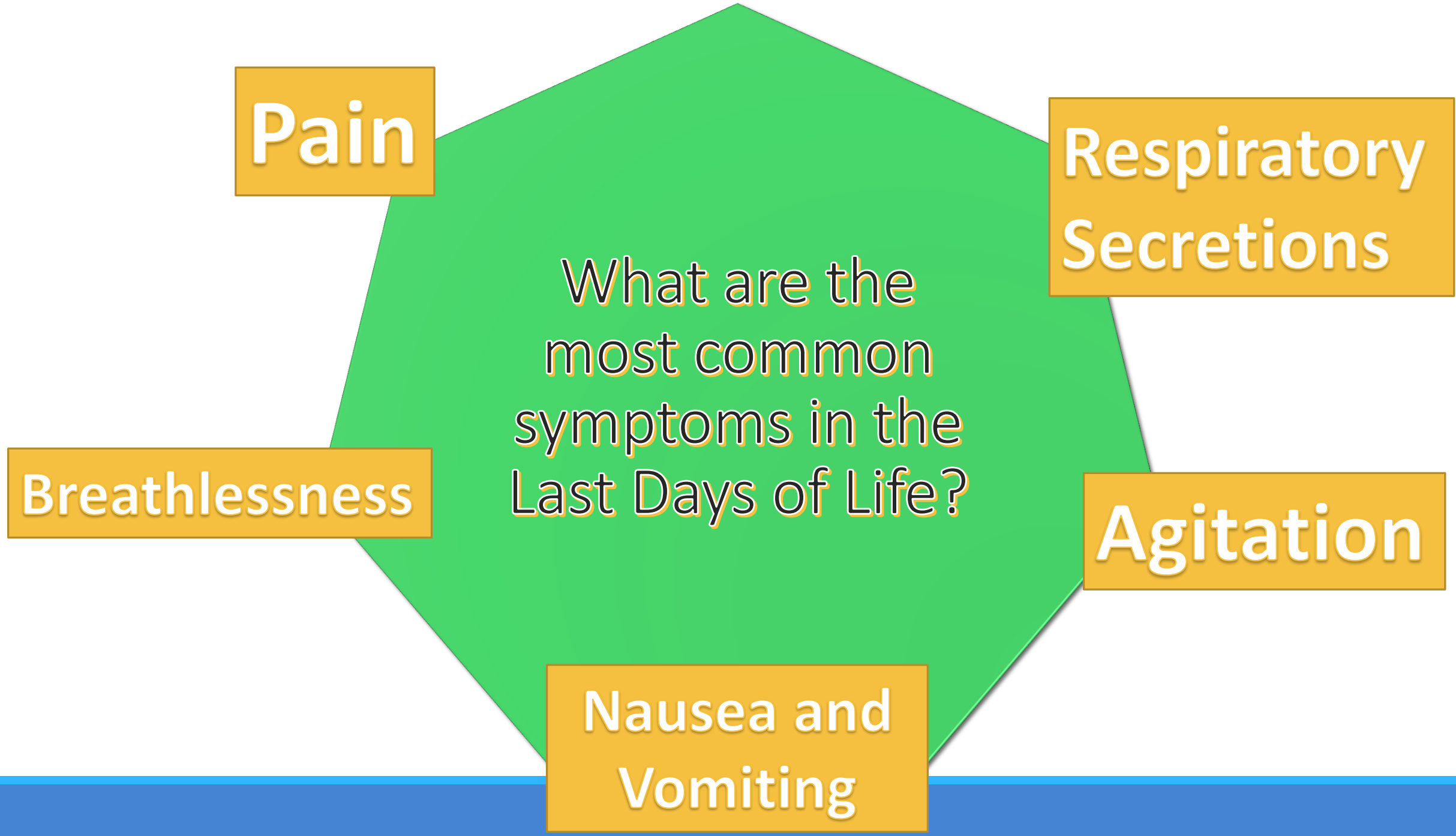
- For practical purposes: 3.3mg/ml injection may be considered equal to 4mg tablet

DO NOT STOP SUDDENLY

Potency: Dexamethasone 1mg ~ Prednisolone 7.5mg

Adverse Effects:

- Glucose metabolism- raised BMs
- Insomnia
- Dyspepsia
- Psychiatric Disturbance
- Change in Appearance
- MSK Problems- proximal myopathy, osteoporosis and AVN
- Increased risk of infection
- Skin changes
- Hypertension
- Oedema
- Pancreatitis


What are the most common symptoms in the Last Days of Life?
Pain
Respiratory Secretions
Breathlessness
Agitation
Nausea and Vomiting

Pain in the Last Days of Life

Causes of pain in the LDOL:

- Pre-existing pain (underlying conditions e.g. cancer, arthritis)
- Increased time in bed- stiffness, pressure sores
- Psychological distress can increase pain

Not all patients will have pain in LDOL

PRN s/c morphine or oxycodone depending on eGFR

- If already on prn opioid do not change type/ dose

If patients are on regular PO analgesia and cannot swallow consider a syringe driver

If they have a patch- **leave it in place**

Prescribe:
PO morphine 5 mg or SC morphine 2.5 mg 1 hourly PRN

PO morphine 2.5 mg or SC morphine 1 - 2 mg 1 hourly PRN if frail or renal impairment

If requires three or more doses within 24 hours seek medical review and increase PRN dose to 10mg PO or 5mg SC 1 hourly

Breathlessness in the Last Days of Life

Non-Pharmacological:

- Fans/ Open window
- Position changes

Oxygen

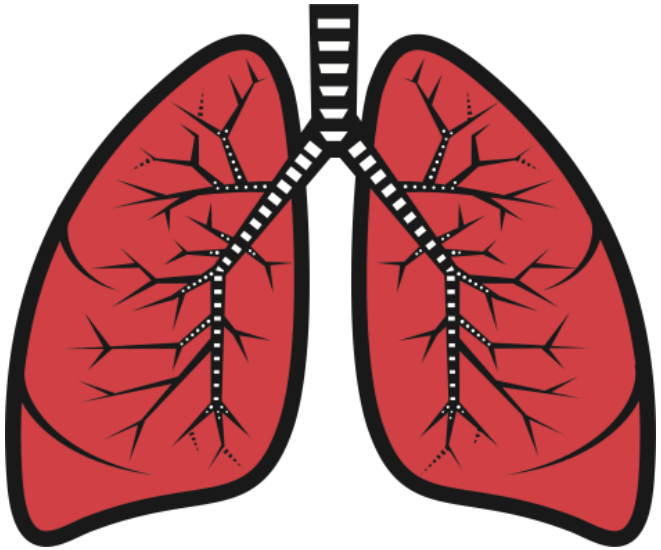
Oxygen can be helpful if patient hypoxic
Titrate to comfort not saturations

Pharmacological:

- Morphine 2.5-5mg s/c 4 hourly (or oxycodone 1-2mg s/c if eGFR <30)

- If SOB due to heart failure then consider a diuretic (e.g furosemide via syringe driver)

Respiratory Tract Secretions in the Last Days of Life



Non-pharmacological options:

- Repositioning
- Cautious suctioning (if available)

Pharmacological:

- Glycopyrronium 200micrograms s/c max 1 hourly
- Alternative is Hyoscine Butylbromide (avoid in renal failure)
- Will reduce production of oral secretions but won't remove what's there
- May cause dry mouth- ensure patient has frequent mouthcare

Nausea and Vomiting in the Last Days of Life

If they are already on an antiemetic and it is working this does not need to be changed

If they are not then we use levomepromazine as it is good for lots of different causes of N+V

This can be sedating- start with the lowest dose

In renal failure haloperidol is often used first line

Terminal Agitation/ Delirium

Look for reversible causes of agitation e.g.

Urinary retention

Constipation

Uncontrolled pain

Unmet spiritual needs

Environment (noise and light)

Medication withdrawal/ nicotine

Pharmacological Options:

INITIALLY:

Midazolam 2.5mg - 5 mgs SC up to 1 hourly PRN
If eGFR < 30 consider giving a reduced dose of midazolam, e.g. 1 mg - 2.5 mg SC PRN 1 hourly

DELIRIOUS:

Consider Haloperidol 0.5—1.5 mg SC 2 hourly PRN or
Levomepromazine 6.25mg SC 2 hourly PRN (monitor for extrapyramidal side effects)

If 2 or more doses of medication required to settle the patient in a 24hour period consider setting up a continuous subcutaneous infusion (CSCI)

ONGOING:

Agitation	**Dose Range via CSCI/24 hours**
Midazolam for agitation	up to 30 mg
Haloperidol for agitation	up to 5 mg
Levomepromazine	up to 25 mg

Seek Specialist Palliative Care advice if doses above 30 mg of midazolam, 5 mg of haloperidol or 25mg of levomepromazine are needed.

Syringe Drivers

What is a syringe driver?

When should a syringe driver be started?

If a patient has required more than 2 doses of the same prn medication in 24hrs consider a syringe driver

Can also be used as a route for established medication

Use and potential side effects must be explained to the patient and relatives before it is started

Not all patients who are dying will require a CSCI (continuous subcutaneous infusion) via a syringe driver.

Not all medication can go in a syringe together

Generally, mix with water for injection (occasionally saline required)

Pre-set to run over 24hrs

Max volume is 17mls (20ml syringe) or 22mls (30ml syringe)

Supplemental Fluids in the Last Days of Life

Sometimes we give additional fluids to patients who are dying

This is to improve their comfort and quality of life- the decision must be made on an individual basis

Potential indications	Potential complications
Symptomatic dehydration	Line discomfort/infection
Thirst (may be unrelated to fluid status)	Oedema/ascites/effusions
Reversible renal impairment	Worsening secretions
Opioid toxicity	Increased symptom burden as a result of above
Excess sedation	Systemic fluid overload

Around 1L/ 24hrs

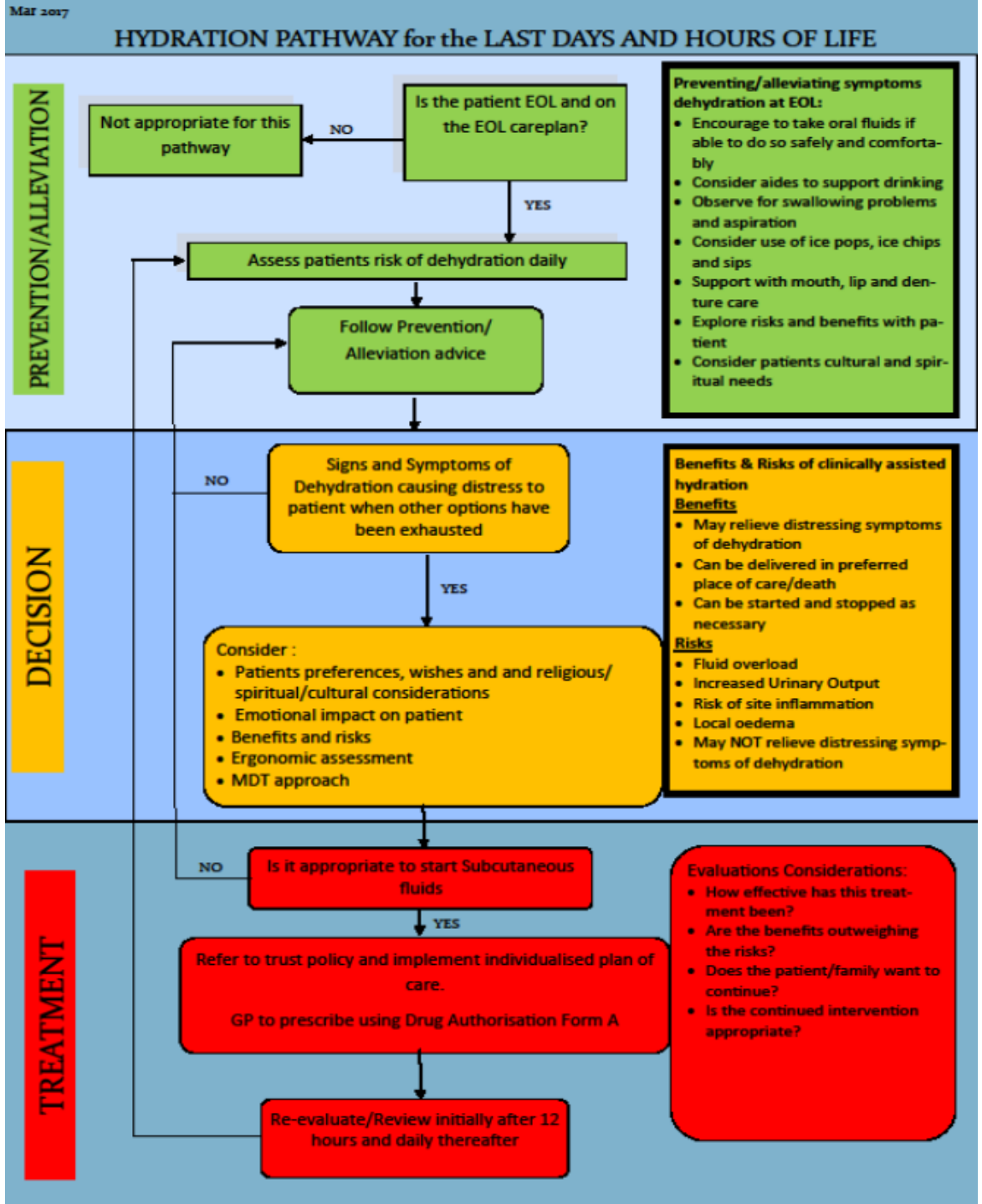
Should always be alongside other quality care e.g. mouth care

There's no clear evidence to show that subcutaneous fluids helps someone live longer or improves their quality of life.

In the community there is a specific pathway for patients who need sub-cut fluids

If you are involved in this process, please review the LSCFT policy

'Procedure for the Administration of Subcutaneous Fluids in Adults at End of Life in the Community Setting'



Managing pre-existing conditions

Plan for managing underlying conditions should be individualised

Focus should be on symptoms- both controlling them and not exacerbating them

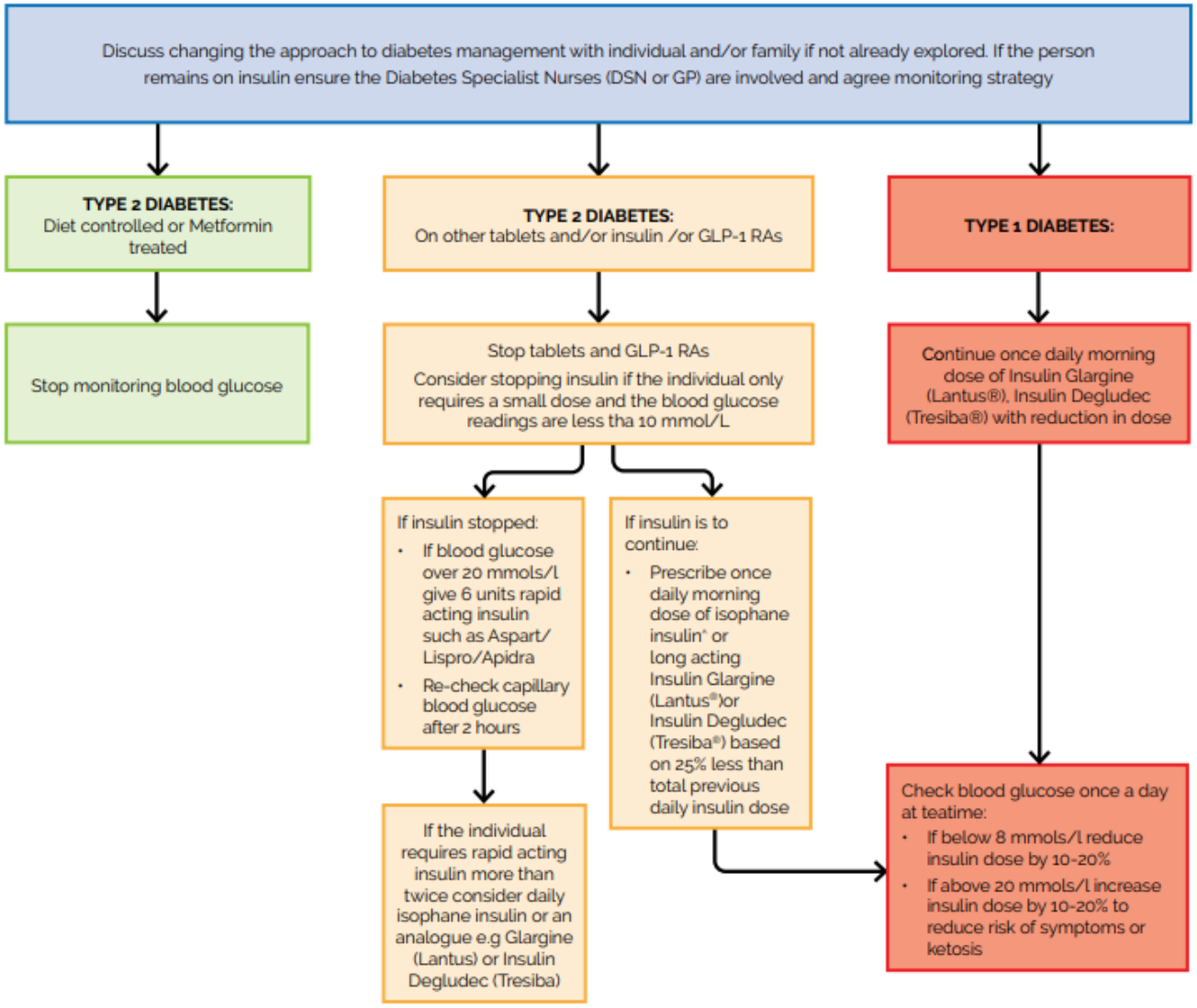
Some medications may be continued as they are helping to control symptoms or because sudden cessation could cause discomfort e.g.

- Dexamethasone/ steroids- can continue to be given s/c
- **Parkinson's Disease**: Consider convertion of levodopa to a Rotigotine patch (Beware that this can cause hallucinations/ agitation)

Diabetes in the last days of life

There is national guidance on managing diabetes in the last days of life

Guidance produced by Diabetes UK



Managing Seizures in LDOL

If the patient is on an established antiepileptic this should be continued where possible

Keppra and sodium valproate can be given via syringe driver

They cannot be mixed with other medication and volume can be a problem (some patients might need more than 1 syringe driver)

For new/ uncontrolled seizures:

If seizure lasting >5mins give midazolam 5-10mg s/c or buccal
Repeat after 5 mins if needed

Consider midazolam 20-30mg in syringe driver if >2 doses required

Guidance: The Clinical Practice Summary

Prescribing guidance first produced 2012

Current update 2021

Guidance based on evidence where available and consensus of expert opinion

Disclaimer:

These practice summaries are a place to begin. They cannot replace advice from experienced clinicians.
Fundamental to the practice of palliative and end of life care is the individualised care of the patient and those important to them. If symptoms fail to respond to usual measures, or you are concerned that the guidance here may not be appropriate to the clinical situation you are in, contact your local specialist palliative care service for advice.
IF IN DOUBT ASK.

NHS North West Coast Clinical Networks

Getting Help

Specialist palliative care advice can be accessed 24hrs a day 7 days a week

Contact 01772629171

(In hours in hospital contact the hospital palliative care team)

Questions?