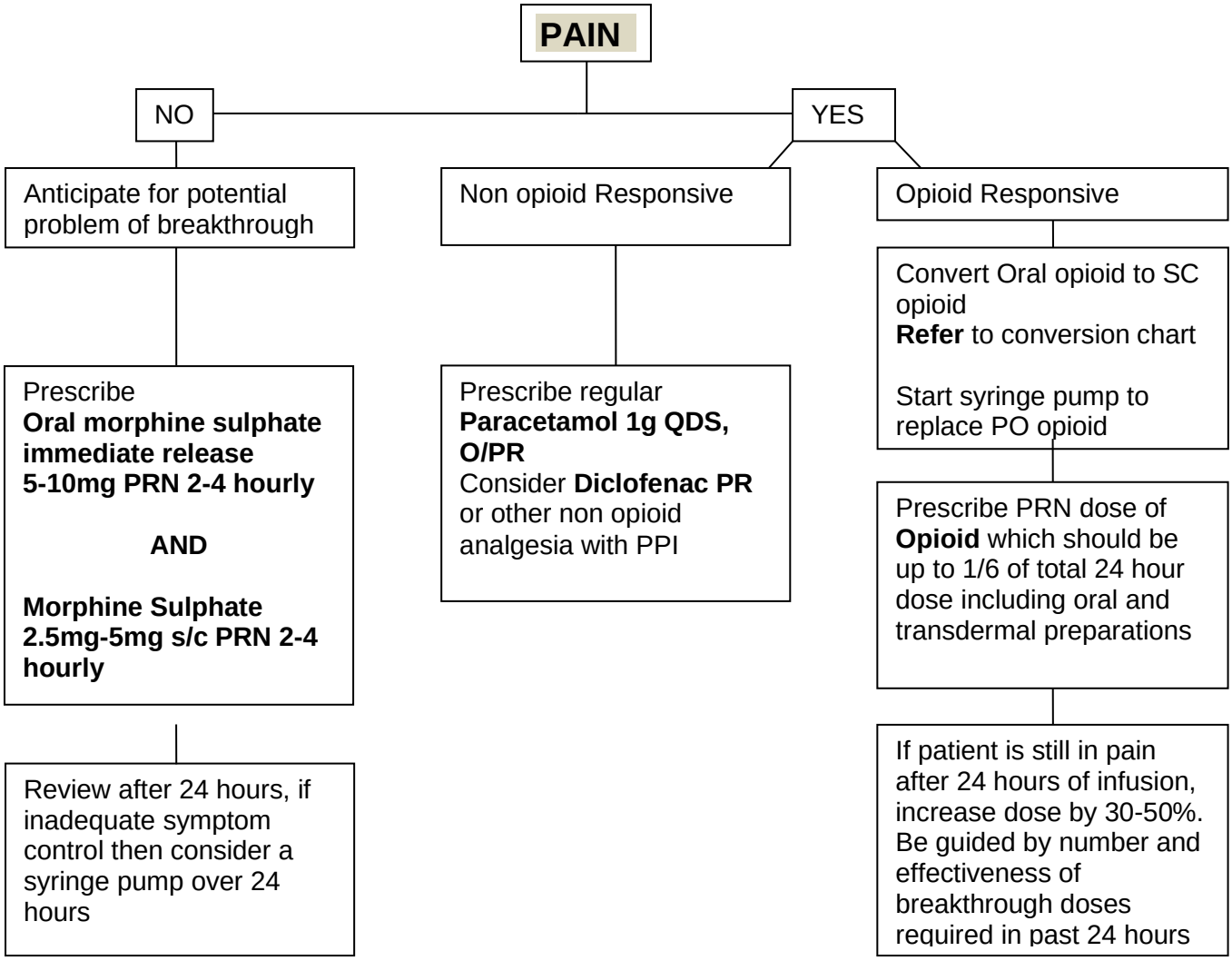
SOMERSET HEALTH COMMUNITY NHS

END OF LIFE SYMPTOM CONTROL GUIDELINES

APPROVED FOR USE BY DOROTHY HOUSE HOSPICE, SOMERSET CCG, SOMERSET NHS FOUNDATION TRUST, ST MARGARET'S HOSPICE AND WESTON HOSPICE



Fentanyl and buprenorphine patches

If patient is using an analgesic patch but requires additional pain relief, continue with patch at usual dose and consider the use of an opioid in a syringe pump in addition. If needed, consult with the Palliative Care Team for further advice/ information

NB: Patients already taking regular opioid analgesia will not routinely require the addition of an anti-emetic in a syringe pump unless nausea/ vomiting are also a problem.
Renal impairment: Caution is required when prescribing opioids; consider taking specialist advice.

IF SYMPTOMS PERSIST PLEASE CONTACT:

Specialist Palliative Care Team 24 hour Helplines
St Margaret's Hospice – 01823 333822 (Somerset Palliative Care advice line)
Weston Hospice - 01934 423900
Dorothy House Hospice - 0345 0130 555

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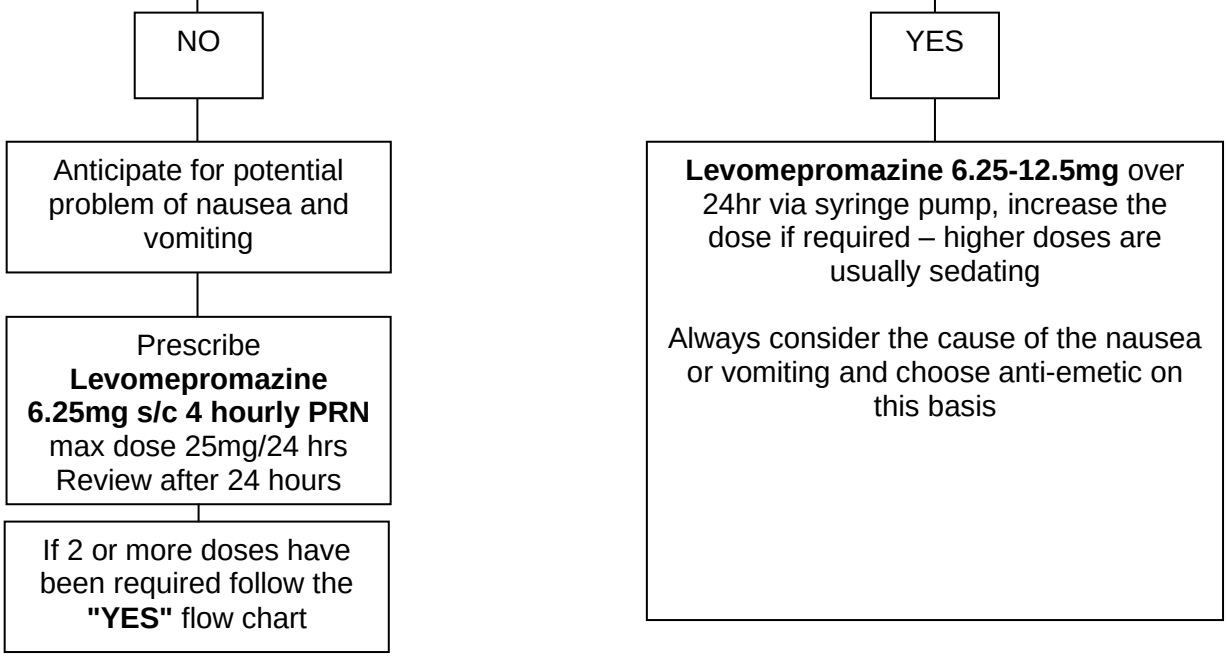
NAUSEA AND VOMITING



SUPPORTIVE INFORMATION

If a patient has been taking an oral anti-emetic effectively but can no longer swallow, use the equivalent dose of this anti-emetic in syringe pump (Total oral 24hr dose = S/C 24hr dose)

Generally levomepromazine may be used first line for nausea and vomiting, however in some circumstances an alternative anti-emetic may be more appropriate, e.g.:

- **Metoclopramide s/c 10mg tds (30mg-60mg via syringe pump over 24hrs)** if gastric stasis suspected. (Do not use if intestinal colic or complete obstruction present)
- **Haloperidol 0.5mg-2.5mg s/c prn, (2.5mg-5mg via syringe pump over 24 hrs)** can be helpful if toxins suspected – e.g. opioids, cytotoxics, radiotherapy, liver or renal failure etc.

Seek specialist advice for antiemetics for patients with Parkinsonism

BOWEL OBSTRUCTION:

Aim to stop nausea and pain and to reduce the frequency of vomits to once a day. Total cessation of vomiting may be impossible in complete obstruction. Give **Hyoscine Butylbromide** (Buscopan ®) **20mg s/c 2 - 4 hourly** for antispasmodic and antisecretory effects. If 2 or more doses required use **60 -80mg** via syringe pump over 24 hours. (Can increase to **120mg/ 24 hours** but seek Specialist Palliative care advice). Octreotide may be helpful but seek specialist advice.

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TROUBLESOME RESPIRATORY TRACT SECRETIONS

Explain the cause of the problem to the family and emphasise that the patient is unlikely to be distressed by the problem. Repositioning the patient may be more effective than medication.

Does repositioning the patient help the respiratory tract secretions?

YES

Anticipate potential problem of respiratory tract secretions distressing patient

Prescribe **Hyoscine Butylbromide (Buscopan ®) s/c 20mg** 2-4 hourly PRN

Review after 24 hours, if two or more doses have been required, follow **"YES"** flow chart

NO

Prescribe **Hyoscine Butylbromide (Buscopan ®) s/c 20 mg** 2 -4 hourly PRN and give stat dose.
Commence continuous s/c infusion of **Hyoscine Butyl bromide 60mg** over 24 hours

Review after 24 hours, if patient continues to be distressed by symptoms increase to **Hyoscine Butylbromide 80mg** – 100mg over 24 hours

Hyoscine Butylbromide (Buscopan®) is incompatible with **Cyclizine** in a syringe pump. If an anti-emetic is required in addition to **Hyoscine Butylbromide,** use **Levomepromazine 6.25-12.5mg** or **Haloperidol 2.5-5mg** / 24 hours instead of **Cyclizine**

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TERMINAL RESTLESSNESS AND AGITATION

NO

Anticipate for potential problem of terminal restlessness and agitation

Prescribe
Midazolam 2.5-5mg s/c 2-4 hourly PRN

Alternatively consider
Diazepam oral 2-10 mg
or **PR (rectally) 5-10mg**

Review after 24 hours.
If two or more doses have been required
follow **"YES"** flow chart

YES

Try to identify cause of agitation if possible and exclude treatable causes, such as pain, constipation, urinary retention

Give **Midazolam 2.5-5mg s/c stat**
Add **Midazolam 10-20mg** s/c
via syringe pump over 24 hours with
Midazolam 2.5mg-5mg s/c 2-4 hourly PRN
OR
Consider using
Levomepromazine 25-50mg s/c
via syringe pump over 24 hours
with
Levomepromazine 6.25-12.5mg s/c 2-4 hourly PRN
(This is especially useful if an antiemetic is also required)

If restlessness or agitation continues titrate up **Midazolam (20-60mg)**
OR **Levomepromazine (50-150mg)**
via syringe pump over 24 hours and seek advice from palliative care team

ANTICONVULSANTS:

If patient usually takes regular anticonvulsants but is no longer able to swallow, consider **Midazolam 20-30mg** s/c via syringe pump over 24 hours (increasing if necessary to maximum of **60mg/ 24 hours**, seek specialist advice)
If patient is taking **Levetiracetam (Keppra)** this may continue to be given via syringe pump sc over 24 hours, oral:sc is 1:1. Discussion with palliative care team is advised.
If patient fitting, then seek urgent specialist advice, consider **Diazepam PR** (rectally) **10-20mg** OR **Midazolam 10mg** buccally or IM

STEROIDS:

Continue with steroids if considered essential for symptom control, otherwise reduce and discontinue. Steroids may be given via a second syringe pump, or as a single daily s/c dose, maximum of 6.6mg as single s/c dose. (4mg PO dexamethasone is pragmatically equivalent to 3.3mg SC).

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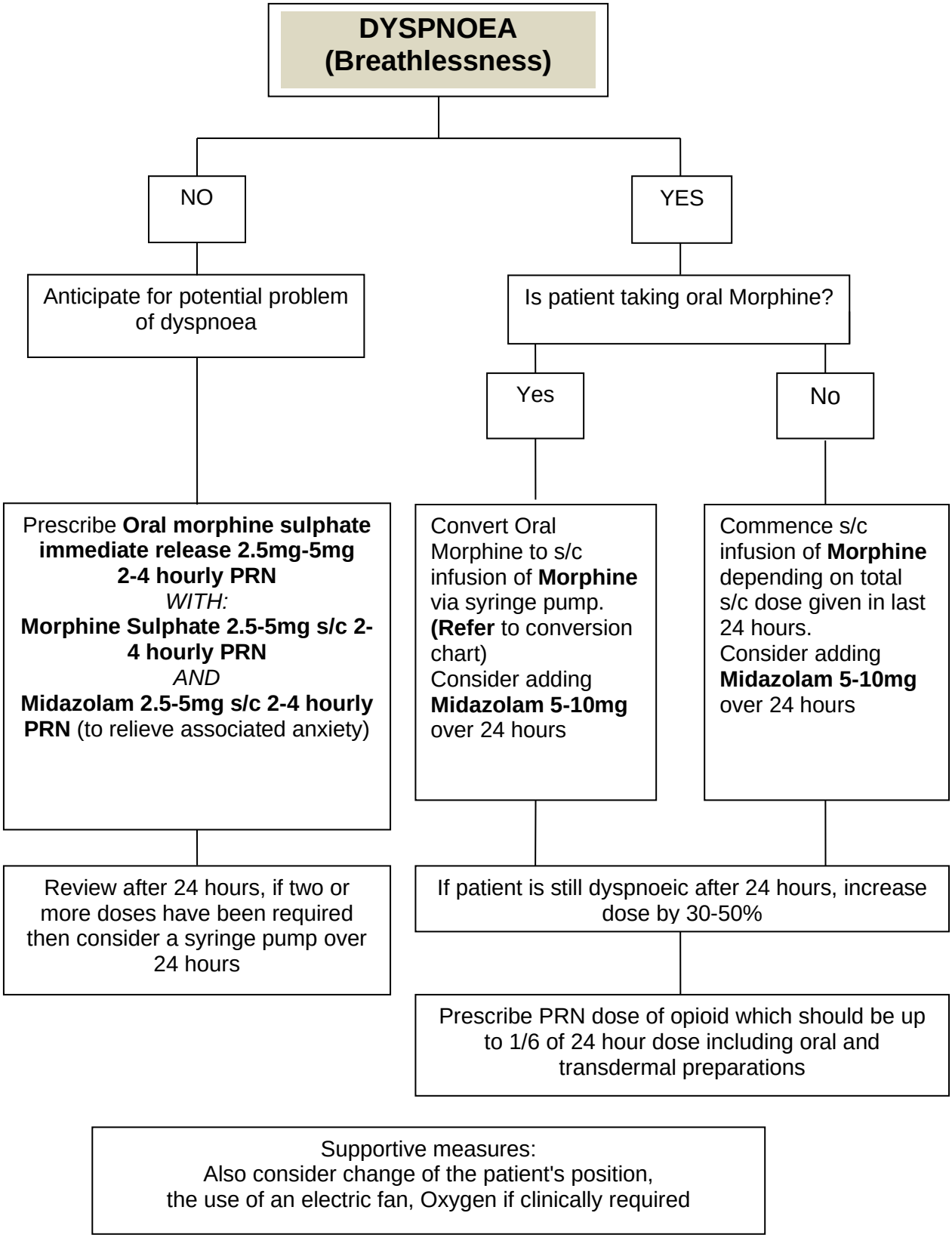

Supportive measures:
Also consider change of the patient's position,
the use of an electric fan, Oxygen if clinically required

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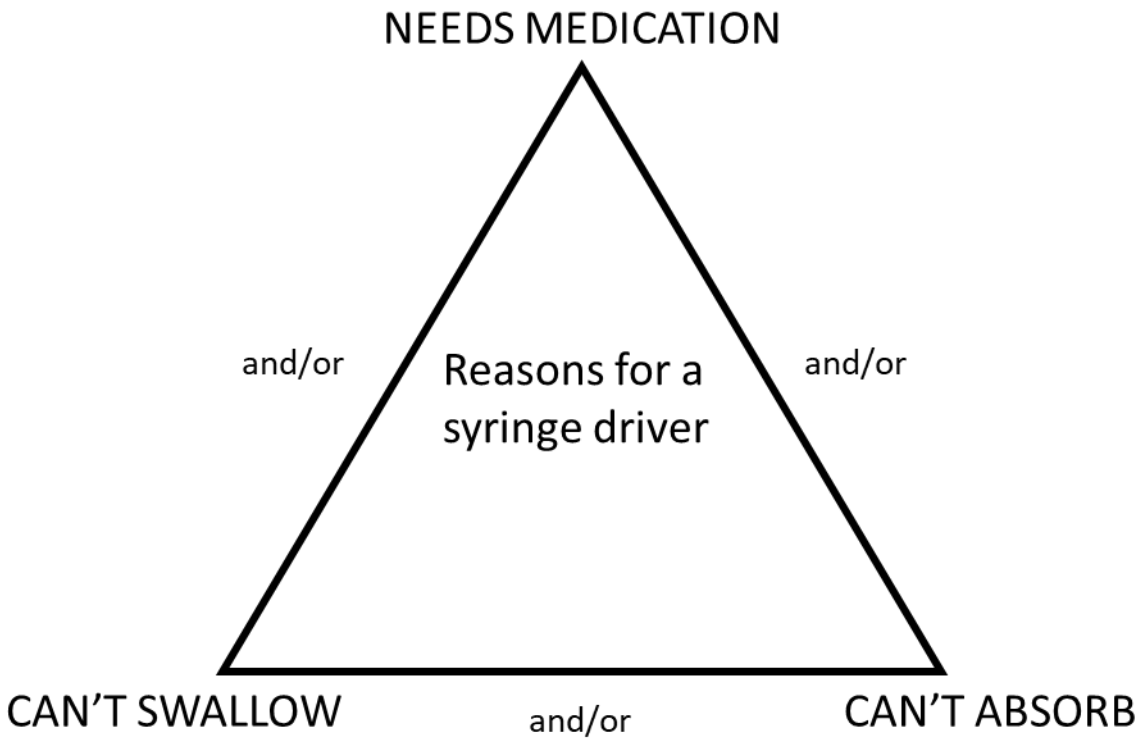
There are 3 broad reasons to start a syringe pump for a palliative patient:



CAN'T SWALLOW:
Eg A patient taking regular pain relief becomes unable to swallow; the pump should start when the patient cannot take oral medication. Any delay will risk opioid withdrawal and uncontrolled pain.

CAN'T ABSORB:
Eg A patient develops vomiting, there are no reversible causes and admission to hospital is not clinically required; the pump should be started to deliver antiemetic and replace oral analgesia. Any delay will risk ongoing poor symptom control and pain.

NEEDS MEDICATION:
Eg A patient is not taking any regular medication. They are dying and have been given PRN medication. A syringe pump is started to control symptoms; the doses in this are clinically guided by the response to any PRN medication they have had.
Please note a patient who is taking regular oral opioid and cannot take it (unable to swallow or vomiting) will require a pump to replace these, irrespective of requiring PRN mediation.

Please review all medication and deprescribe medication that is no longer required

OPIOID DOSE CONVERSION

Fentanyl patches – change every 3 days

Morphine 30mg daily = fentanyl '12' patch

Morphine 60mg daily = fentanyl '25' patch

Morphine 120mg daily = fentanyl '50' patch

Morphine 180mg daily = fentanyl '75'patch

Morphine 240mg daily = fentanyl '100'patch

Buprenorphine: **7 day patch (eg Butec, Reletrans, Butrans)**

Morphine 12mg daily = 5microgram per hour patch

Morphine 24mg daily = 10 microgram per hour patch

Morphine 36 mg daily = 15 microgram per hour patch

Morphine 48mg daily = 20 microgram per hour patch

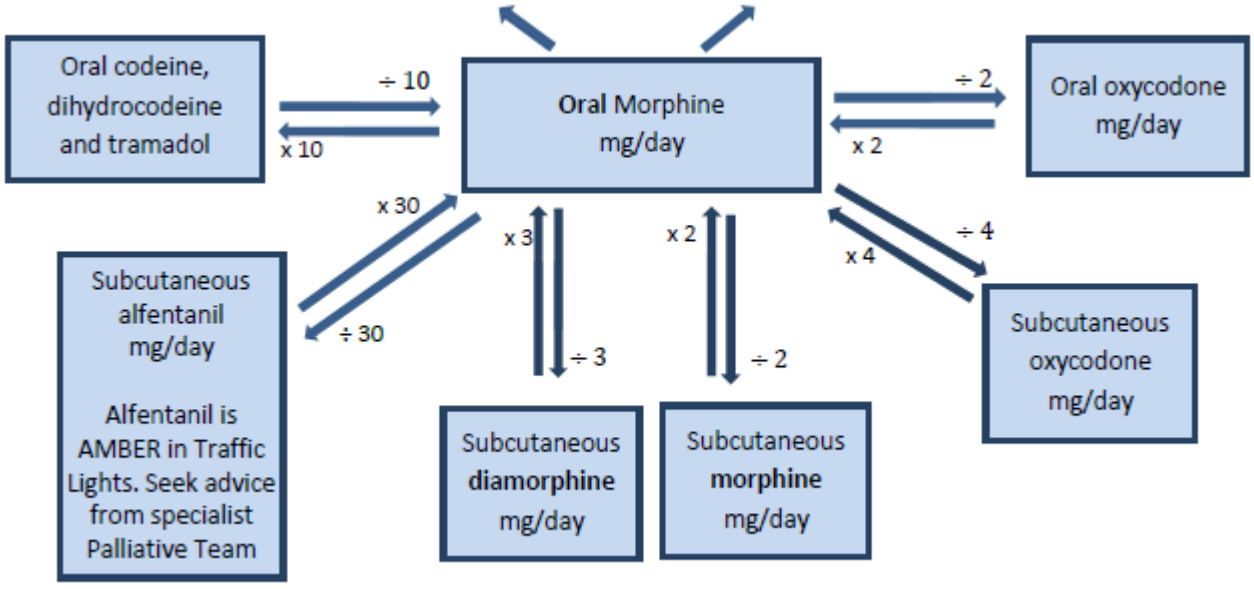
Buprenorphine: **4 day patch (eg Transtec®, Relevtac) and 3 day patch (eg Hapoctasin)**

Morphine 84 mg daily = 35 microgram per hour patch

Morphine 126 mg daily = 52.5 microgram per hour patch

Morphine 168 mg daily = 70 microgram per hour patch

We are aware BNF dose conversions from morphine to oxycodone now differ slightly from those printed below.
If this causes any concern please seek advice from a more experienced practitioner and always consider a dose reduction



Note:

- These conversions are a guide only
- Morphine equivalences for traditional preparations are approximated to allow comparison with available preparations of oral morphine
- The PRN dose of opioid is 1/6 of the 24 hour total opioid dose. PRN doses are usually given every 4 hours.
- If a patient already has a patch, and needs a syringe pump, the patch should be continued and changed as normal. Any additional opioids should be administered and titrated in a syringe pump.

Somerset End of Life Care Palliative Care Handbook (Wessex Guidelines)
Palliative Care Handbook 9th Edition | Resources | End Of Life (eolcare.uk)

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