Symptom Management in Palliative Patients at End of Life

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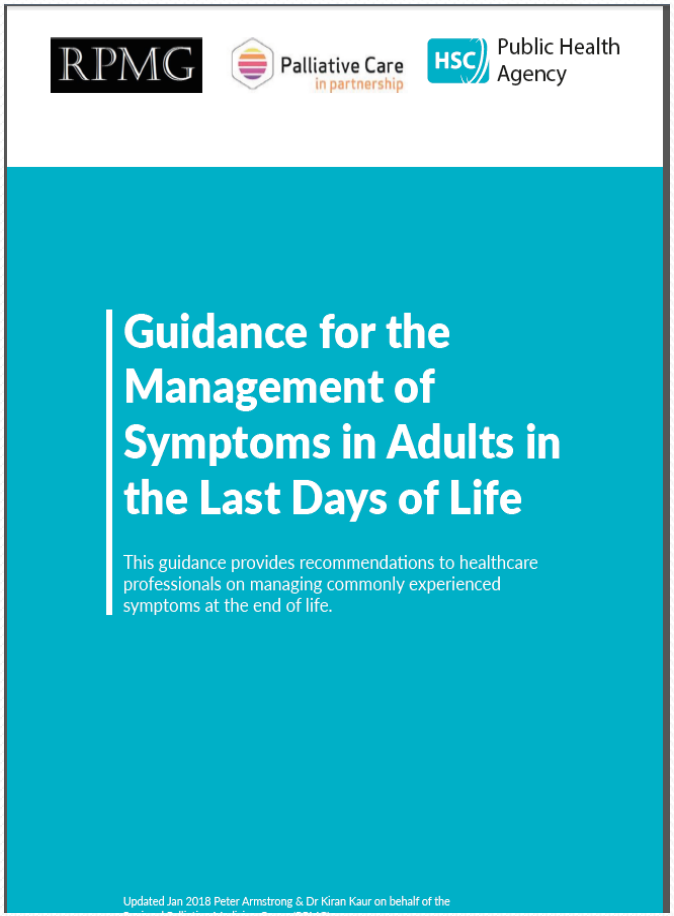
Aims

- Keep you awake

- Discuss the common symptoms:
  - Nausea & Vomiting
  - Breathlessness
  - Anxiety and agitation
  - Midazolam- use other than agitation
  - Secretions



Managing symptoms during end of life care

- The symptoms it addresses are:
  - **Pain**
  - **Breathlessness**
  - **Nausea and vomiting (N&V)**
  - **Anxiety, delirium and agitation**
  - **Respiratory secretions**

- Administration of medication by subcutaneous (SC) injection and continuous SC infusion (CSCI) over 24 hours – recognising the fact that dying people may be unable to take PO medication.

- Encourages and advises on medication and doses for **anticipatory prescribing**

Recognised regionally as the guidance that should be used in hospitals, hospices, care homes & patients own homes for controlling symptoms at the end of life.

http://www.professionalpalliativehub.com/guidelines/northern-ireland-palliative-care-tools-guidance

Nausea and vomiting- causes

Cancer

- Tumour toxins
- Gastric irritation
- Gastric stasis / reflux
- Hepatomegaly
- Gross ascites
- Bowel obstruction – (partial or complete)
- Raised intracranial pressure
- **Hypercalcaemia**

Treatment / drugs

Chemotherapy
Radiotherapy
Drugs
NSAIDs, Opioids, Antibiotics

Concurrent / debility

Constipation
Infection
Renal failure
Biochemical disturbance
Peptic ulcer
Anxiety
Full bladder
Uncontrolled pain

Management of Nausea & Vomiting

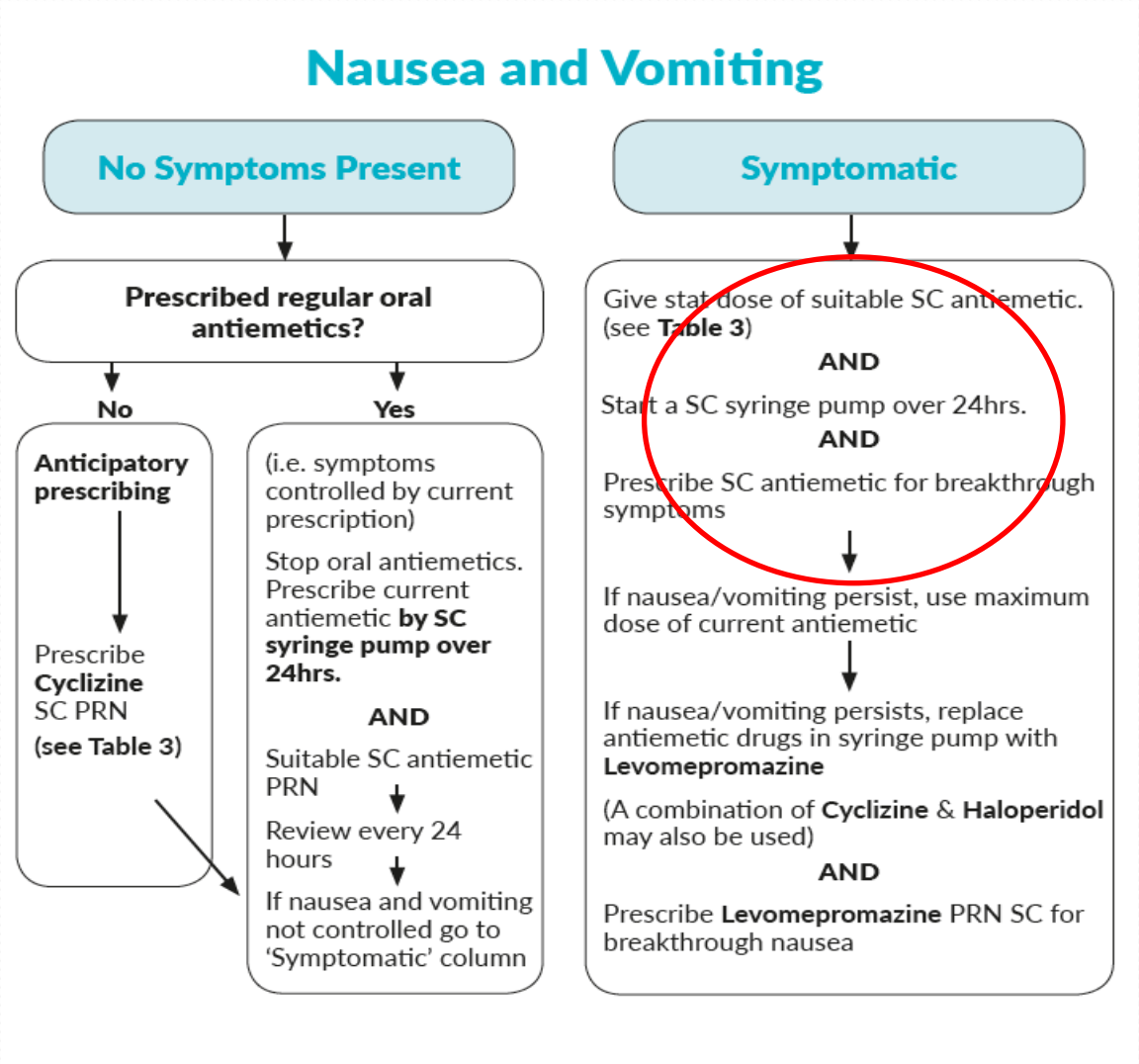


Table 3. Choice of Antiemetic

Lower doses are indicated in severe renal or hepatic impairment

	Drug	Indications for Use	SC stat PRN dose	SC 24 hour dose	Strength and Pack size
1st line	**Cyclizine**	Non-specific nausea & vomiting Mechanical bowel obstruction. Raised intracranial pressure	50mg every 8 hours PRN	100mg – 150mg	50mg injection Pack of 5
	Haloperidol	Chemical/ Metabolic causes.	500 micrograms - 1mg every 6 - 8 hours PRN	1.5mg *	5mg/ml injection Pack of 10
	Metoclopramide	Partial mechanical bowel obstruction Gastric stasis (Prokinetic antiemetic - discontinue if colic develops).	10mg every 6 - 8 hours PRN (max TDS)	30mg *	10mg/2ml injection Pack of 10
2nd line	**Levomepromazine**	Broad spectrum antiemetic Sedation at high doses	5mg every 4 - 6 hours PRN	5mg - 25mg	25mg/ml injection Pack of 10
3rd line	**Ondansetron**	Intractable vomiting due to chemical, abdominal and cerebral causes when above approaches fail	4mg - 8mg every 6 - 8 hours PRN	8mg – 24mg	4mg or 8mg injection Pack of 5

*Higher doses may be used in specialist practice.

Anti-emetics and Receptors

Receptor	Drug	Relative potency
Cholinergic (Ach)	Hyoscine Hydrobromide Levomepromazine Cyclizine	+++ ++ ++
Dopamine (D2)	Haloperidol Metoclopramide Domperidone Levomepromazine	+++ ++ ++ ++
Serotonin type 2 (5HT2)	Levomepromazine	+++
Serotonin type 3 (5HT3)	Ondansetron Granisetron	+++ +++
Histamine (H1)	Cyclizine Levomepromazine	++ +++

Extrapyramidal side effects

Anti-emetics and side effects

- Choose pick combinations with different receptor affinities
- Avoid antagonist activities (Cyclizine and metoclopramide)

Case study

- 59 yr old man with metastatic colon cancer
- Referred from hospital for ongoing management of N&V
- Initial assessment
- Contact by DN due to nausea and vomiting
- Joint review with GP
- Passed away peacefully in own home 3 days following joint review

Breathlessness

- Consider non-pharmacological treatments
- The main treatment is low dose opioid which do not cause CO_2 retention if used appropriately.
- Doses required can be lower than that needed for pain management.
- Consider if symptoms are intermittent or persistent?
- Is the patient already taking a regular opioid for breathlessness?
- For patients who are conscious and can tolerate oral medicines, consider continuing oral opioids and this can be done alongside a CSCI.
- Breathlessness is often accompanied by anxiety

Case study

- 53 yr old with short history of advanced lung cancer referred by GP
- Initial assessment
- Consider reversible causes
- Pain management
- Breathlessness management
- Reviewed regularly
- Patient passed away peacefully

Anxiety, Delirium and Agitation

- Assess the patient for common causes:
  - Unfamiliar surroundings with unfamiliar carers
  - Unresolved pain, urinary retention or severe constipation
  - Medication or nicotine withdrawal
  - Biochemical derangements
  - Infection
  - Brain metastases
- Treat what you can and consider what is suitable for the end stage of their disease

Terminal Agitation

- Anticipatory prescribing is advisable even in the absence of symptoms
- First line medicine is a benzodiazepine midazolam
- Always prescribe 10mg/2ml strength
- Levomepromazine or haloperidol can also be used second line for agitation.

Midazolam- other uses

- Refractory Hiccups
- Seizures at EOL
- Myoclonus
- Movement disorders
- Muscle spams
- PO benzodiazepines
- Itch

Noisy Respiratory Secretions

- Occurs in ~50% of patients at the end of their lives
- Use anti-muscarinic drugs
  - Glycopyrronium
  - Hyoscine Hydrobromide
  - Hyoscine Butylbromide (Buscopan®)
- Hyoscine hydrobromide may cause sedation and paradoxical agitation (but has anti-emetic effect).
- Even if the patient has no symptoms, consider anticipatory prescribing
- Using prophylactically?????