**www.palliativedrugs.com survey**

## Hyoscine butylbromide injection in palliative care - What is your experience?

**May – August 2017**

Number of responses = 294

1) How long have you been qualified? (one_of)

| *answer* | *votes* | *% of vote* |
|---|---|---|
| <1 year | 7 | 2% |
| 1-5 years | 25 | 9% |
| 6-10 years | 30 | 10% |
| 11-25 years | 127 | 43% |
| >25 years | 107 | 36% |

2) In a palliative care setting, which parenteral route(s) do you use hyoscine *butylbromide*? (many_of)

| *answer* | *votes* | *% of voters* |
|---|---|---|
| SC | 286 | 97% |
| CSCI | 222 | 76% |
| IM | 10 | 3% |
| IV | 27 | 9% |
| Do not use | 6 | 2% |

3) When using hyoscine *butylbromide* by SC bolus injection have your patients experienced cardiovascular toxicity? (one_of)

| *answer* | *votes* | *% of vote* |
|---|---|---|
| Yes | 3 | 1% |
| No | 281 | 96% |
| Do not use SC | 9 | 3% |

4) When using hyoscine *butylbromide* CSCI have your patients experienced cardiovascular toxicity? (one_of)

| *answer* | *votes* | *% of vote* |
|---|---|---|
| Yes | 4 | 1% |
| No | 256 | 87% |
| Do not use CSCI | 29 | 10% |

5) When using hyoscine *butylbromide* IM have your patients experienced cardiovascular toxicity? (one_of)

| *answer* | *votes* | *% of vote* |
|---|---|---|
| Yes | 2 | 1% |
| No | 20 | 7% |
| Do not use IM | 262 | 89% |

6) When using hyoscine *butylbromide* IV have your patients experienced cardiovascular toxicity? (one_of)

| *answer* | *votes* | *% of vote* |
|---|---|---|
| Yes | 7 | 2% |
| No | 39 | 13% |
| Do not use IV | 239 | 81% |

7) Are you considering changing your practice in relation to the use of *hyoscine butylbromide* SC/CSCI in palliative care? (one_of)

| *answer* | *votes* | *% of vote* |
|---|---|---|
| Yes | 43 | 15% |
| No | 240 | 82% |
| Do not use SC/CSCI | 5 | 2% |

7a) If yes, or possibly, please explain how. (freetext)

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| **Global changes in drug, dose, frequency of use or indication:** |
| We were using it first line for secretions due to its cost effectiveness. I am advised by hospital drug and therapeutics committee to change guidance and practice. I have written down guidance for hyoscine *hydrobromide* for routine cases |
| Will consider alternative for people not in last days/hours of life |
| Reducing dose as often as possible, use of subcutaneous application as often as possible |
| May reduce p.r.n. dose. Greater caution when patients not very end of life, e.g. using it for colic |
| I have reduced frequency of use, though not stopped. Consider the recent warnings when prescribing |
| Rarely used on regular basis. I tend to use it SC p.r.n. as an add on / adjunct for abdominal colicky pain |
| Will in future only use for colicky abdomen pain, not for secretions |
| Evidence shows that it is rarely effective for excessive secretions at end of life which is where I use it most. I feel that this is better managed with positioning and good communication |
| |
| **Changes relating to use in patients with pre-existing cardiac disease:** |
| Not prescribed routinely as a just in case medication for patients with heart disease |
| Giving other antisecretory SC, e.g. glycopyrronium and avoid using hyoscine *butylbromide* if patient has history of IHD, arrhythmias |
| Probably question about cardiac issues and then make a benefits /burdens decision |
| Use with caution in patients with tachyarrhythmias, e.g. reduced dose |
| Possibly - if known cardiac disease, would weigh pros and cons more carefully - but tend to only use it near end of life anyway |
| Be cautious in patients with cardiovascular disease and use CSCI when possible rather than SC bolus |
| More aware of the possibilities of cardiovascular toxicity in susceptible patients- consider lower ceiling dose |
| Extra caution in patients who have a cardiac history, depending on level and nature of symptomatology and treatment escalation plan |
| Will be more cautious about using with patients with likely cardiovascular disease |
| Discussed with team and at present continuing same practice. However, might consider alternative if strong history of current cardio-vascular disease |
| In patients with known cardiac history consider using alternative medication |
| Consider very carefully for use in patients with cardiac problems/history of cardiac problems. but continue to balance risks and benefits |
| Likely to consider alternative if known cardiac history in patient who is not imminently dying |
| Would be more cautious in patients with known cardiac disease, particularly if they are not actively dying |
| Will be more cautious if patients have significant cardiovascular disease or tachycardia- perhaps shifts the risk - benefits balance slightly |

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| In some patients, (e.g. with CVD, IHD, end stage heart failure) I may now consider using a reduced dose SC p.r.n. or opting for a CSCI over 24 hours rather than using p.r.n. |
| I will be keeping a close eye to check for a patient's cardiac history (if any) and will be advising an alternative if they do have a cardiac history |
| I will use with increased caution, particularly in patients with cardiac disease. I may be less likely to prescribe for patients with pre-existing cardiac disease, if alternatives are available |
| |
| **Greater awareness and caution:** |
| Have highlighted awareness of CVS risks but no planned change in practice. |
| I have an increased awareness of the cardiac risks to consider now |
| I must read more about the cardiac effects because I have never had a patient showing those but definitely be more careful |
| Being extra cautious when we use in the dying scenario |
| It will make us more cautious when using it |
| It will raise concern with staff to observe closely for cardiovascular toxicity |
| Discuss risk of cardiotoxicity |
| Discussing with family/patient about potential low risk, but this is likely outweighed by hoped for benefit of drug for excess secretions or anti-spasm in GI obstruction |
| Will consider proactively to explain cardiac side effects and why taking balanced approach in an appropriate patient |
| Awareness of cardiac side effect, for use with caution |
| |
| **Other miscellaneous comments:** |
| I have considered making changes, and decided that none were necessary, in view of route of administration I use, i.e. not IM or IV. I am already cautious in patients with cardiovascular disease - weighting up the pros and cons, etc. |
| Use with caution - tend to use it more in gynae-oncology patients, e.g. ovarian cancer, with bowel obstruction for colic. It can be effective, these patients aren't necessarily dying, I would still use but with caution |
| The change I am considering is using it in place of octreotide |
| I'm aware of the cardiac toxicity in patients with cardiac diseases, but I also know that many problems may occur with hyoscine butylbromide in patients with glaucoma |
| Locally hyoscine *butylbromide* is now first-line |
| No evidence of effectiveness for decreasing airway secretions |

8) Have you seen cardiovascular toxicity with any other antimuscarinic drug used in a palliative care setting? (yes_no)

| *answer* | *votes* | *% of vote* |
|---|---|---|
| Yes | 18 | 6% |
| No | 270 | 92% |

8a) If yes, please give details of drug, indication, dose, route, complication, onset in relation to injection, outcome. (freetext)

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| Atropine, tachycardia |
| Atropine subcutaneously, tachycardia |
| Cyclizine 50 mg t.d.s. IV: rebound tachycardia that stopped on cessation of drug (given for nausea) |
| Cyclizine given IV caused a patient to have a VT arrest |
| I am aware of a patient who had a cardiac arrest following IV cyclizine, but it is unclear whether there was a direct correlation (patient receiving curative chemotherapy). This has been reported via the yellow card reporting system |
| Tachycardia with cyclizine CSCI, sufficient to change the drug but didn't cause significant patient harm |

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|---|
| Glycopyrronium |
| Hyoscine *hydrobromide*, tachycardia |
| Hyoscine *hydrobromide* |
| Hyoscine *hydrobromide* (scopolamine); death rattle; 2-3mg/24h; CSCI; tachycardia; <12h; no problems |
| Tachycardia, without angina by many of drugs with antimuscarinic effect |
| Very difficult to say with any certainty- as most patients have multiple complexity |
| Probably - but the benefits in relief of severe abdominal colic far outweigh the risks of non-symptomatic tachycardia, which may arise physiologically from many facets of underlying illness |
| Tachycardia, flushing |

| 9) Further comments. (freetext) |
|---|
| As hyoscine *butylbromide* SC and CSCI is used predominantly at the end of life, it is difficult to ascertain whether they have died from terminal disease or cardiac toxicity |
| I am prescribing hyoscine *butylbromide* in the terminal phase in most cases so am not looking closely for CVS toxicity. In other settings however, I have not encountered it |
| When patients are very close to dying I wouldn't spot or be so concerned about cardiac effects if hyoscine *butylbromide* helping symptoms which is sometimes debatable |
| Not seen clinically, is slightly different from side effects not happening, especially in terminal phase. Also, may be side effects such as ECG changes may not be clinically significant. It's an unknown area as we don't monitor it |
| Difficult to assess as tachycardia is common in preterminal states. We do not see tachycardia as an absolute contraindication |
| No cardiovascular toxicity noted, although I guess we have not looked specifically for that, and our patients are not monitored, so it would be interesting to see if anyone else has had any adverse drug reactions |
| I am not aware of any cardiovascular toxicity when used SC but for many, it is used at the end of life, so I would not necessarily be monitoring for this |
| I don't check for cardiovascular problems as patients are needing SC hyoscine *butylbromide* for bowel obstruction, or bronchial rales, and therefore already extremely sick. This makes cardiovascular problems a minor issue |
| Never knowingly encountered cardiac toxicity in using hyoscine *butylbromide* by SC or CSCI. I guess I might have missed a subtle effect |
| We use hyoscine *butylbromide* only in dying patients |
| My clinical practice is confined to symptom management and end of life care |
| We only have hyoscine *butylbromide* in Costa Rica for controlling secretions at end of life, there is no other antimuscarinic available |
| In some countries hyoscine *butylbromide* is the main antisecretory drug |
| Hyoscine *butylbromide* has been our go-to drug for abdominal cramping pain. It has been very effective in bowel perforation, blocked stomas and obstruction. I would be loathed to lose it from the toolbox |
| Very important drug, especially to dry out secretions in terminal phase and reduce death rattle |
| This will inform my risk benefit calculations and will be useful to inform patients |
| I look forward to further guidance (PCF etc) specifically relevant to palliative care setting |
| I don't use it often but I haven't experienced any problems |
| We all know sometimes no drug works for secretions and there is no good evidence that it is any better than placebo. I feel it is helpful in colicky abdominal pain |
| Tend to use in obstruction or if glycopyrronium not available. Always titrate slowly and not come across cardiovascular issues as far as I am aware. However, do tend to use towards end of life<br>It is used too much in Queensland instead of hyoscine *hydrobromide* for secretions as it is cheaper on external script |
| We use glycopyrronium routinely for chest secretions. I only tend to use hyoscine *butylbromide* for abdominal colic and large volume vomits in bowel obstruction |
| Have used glycopyrronium more than hyoscine *butylbromide* as longer halflife for prn doses. |