

PRINCIPLES OF MANAGEMENT

The principles are applicable to the care of patients dying from cancer and non-malignant disease.

RECOGNISE THAT DEATH IS APPROACHING

Studies have found that dying patients will manifest some or all of the following:

- Profound weakness - usually bedbound
- Drowsy or reduced cognition - semi-comatose
- Diminished intake of food and fluids - only able to take sips of fluid
- Difficulty in swallowing medication - no longer able to take tablets

TREATMENT OF SYMPTOMS

The prime aim of all treatment at this stage is the control of symptoms current and potential.

- **Discontinue any medication which is not essential**
e.g. anti-hypertensives long term antibiotics steroids
replacement hormones anti-arrhythmics anti-coagulants
vitamins and iron diuretics hypoglycaemics
iron preparations
- **Prescribe medication necessary to control current distressing symptoms**
- **All patients who are dying would benefit from having subcutaneous medication prescribed IN CASE distressing symptoms develop**
- **All medication needs should be reviewed every 24hrs**
- **If two or more doses of prn medication have been required, then consider the use of a syringe driver for continuous subcutaneous infusion (CSI)**

The most frequently reported symptoms are:-

- Pain
- Nausea / Vomiting
- Agitation / Restlessness
- Excessive secretions / Noisy breathing

The algorithms attached will support you in your management of these symptoms.

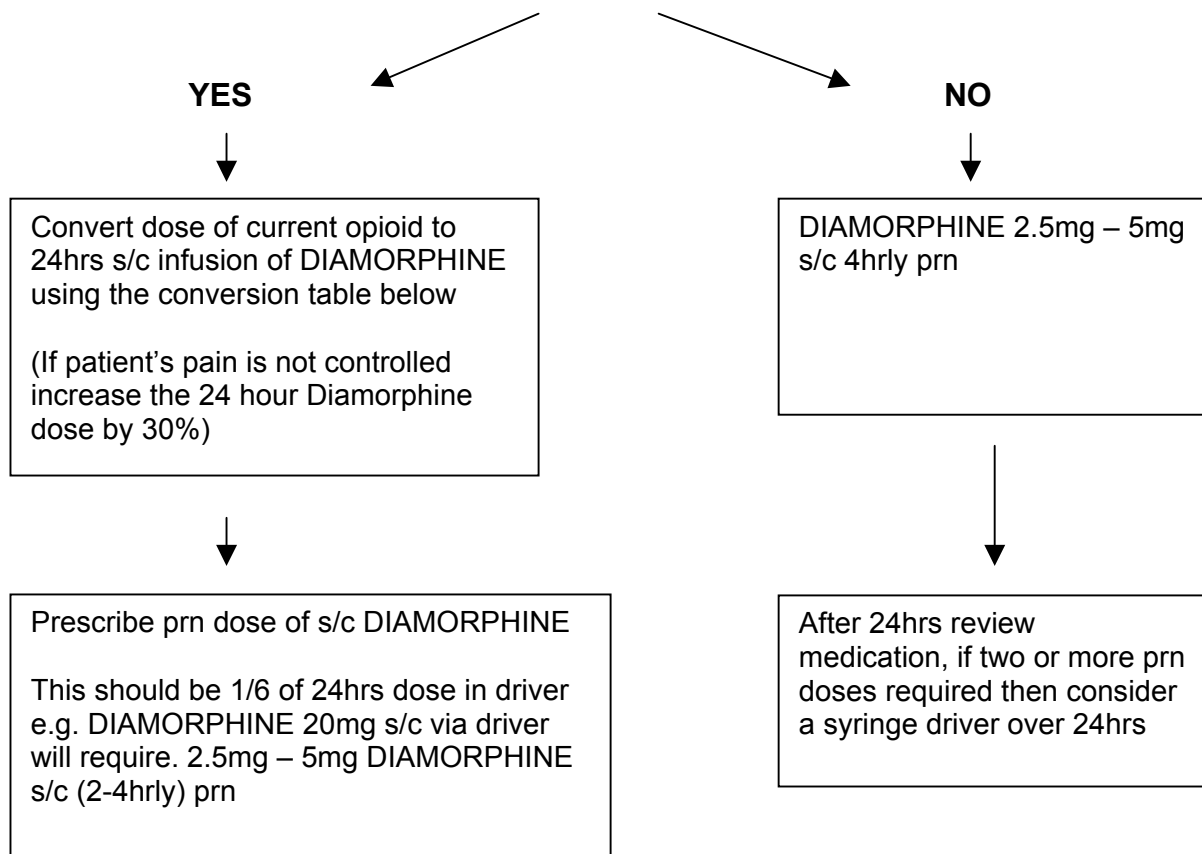
ADVICE AND SUPPORT

For pathway advice – Contact: Care Pathway Facilitator, ext 6025
Palliative Care Team, ext 5835
Drug Information, YDH Pharmacy, ext 5960

For out of hour's symptom control advice – Contact: St. Leonard's Hospice
Tel: 01904 708553

PAIN

Is patient already taking oral morphine or another opioid?



Strong opioid	Conversion to s/c diamorphine over 24 hours	Example
Morphine/ MST/ Oramorph/ Zomorph	Divide total Morphine dose by 3	Zomorph 30mg bd = 20mg Diamorphine s/c over 24 hrs
Fentanyl patch	Leave patch on and top up with diamorphine in syringe driver (usually 1/5 strength of patch) Diamorphine dose (mg) in 24 hours is approximately equivalent to the patch strength (mcg)	Fentanyl patch 75 mcg 72 hrs = 75mg Diamorphine s/c 24 hrs Top up dose in syringe driver is 1/5 patch strength = 15mg diamorphine Breakthrough dose is initially 15mg. Will need increasing as diamorphine requirements increase
Remember to include prn doses in your calculations		

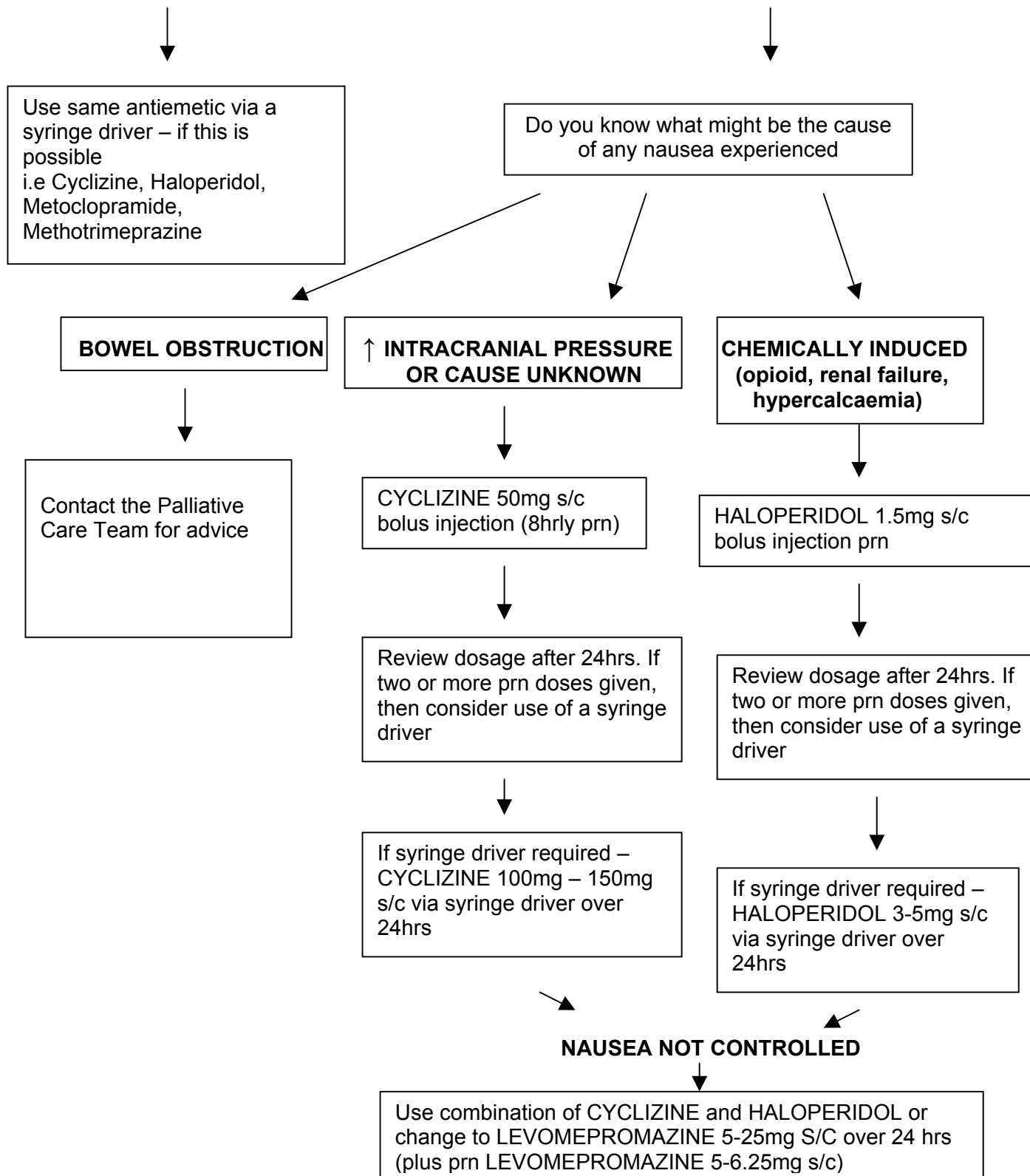
For pathway problems – seek advice from the Palliative Care Team: ext 5835

For out of hour's symptom control – seek advice from St. Leonard's Hospice: Tel 708553

NAUSEA AND VOMITING

**ALREADY TAKING ANTIEMETIC
AND NAUSEA CONTROLLED**

**NOT TAKING ORAL ANTI-EMETIC or
NAUSEA NOT PRESENT or NOT CONTROLLED**

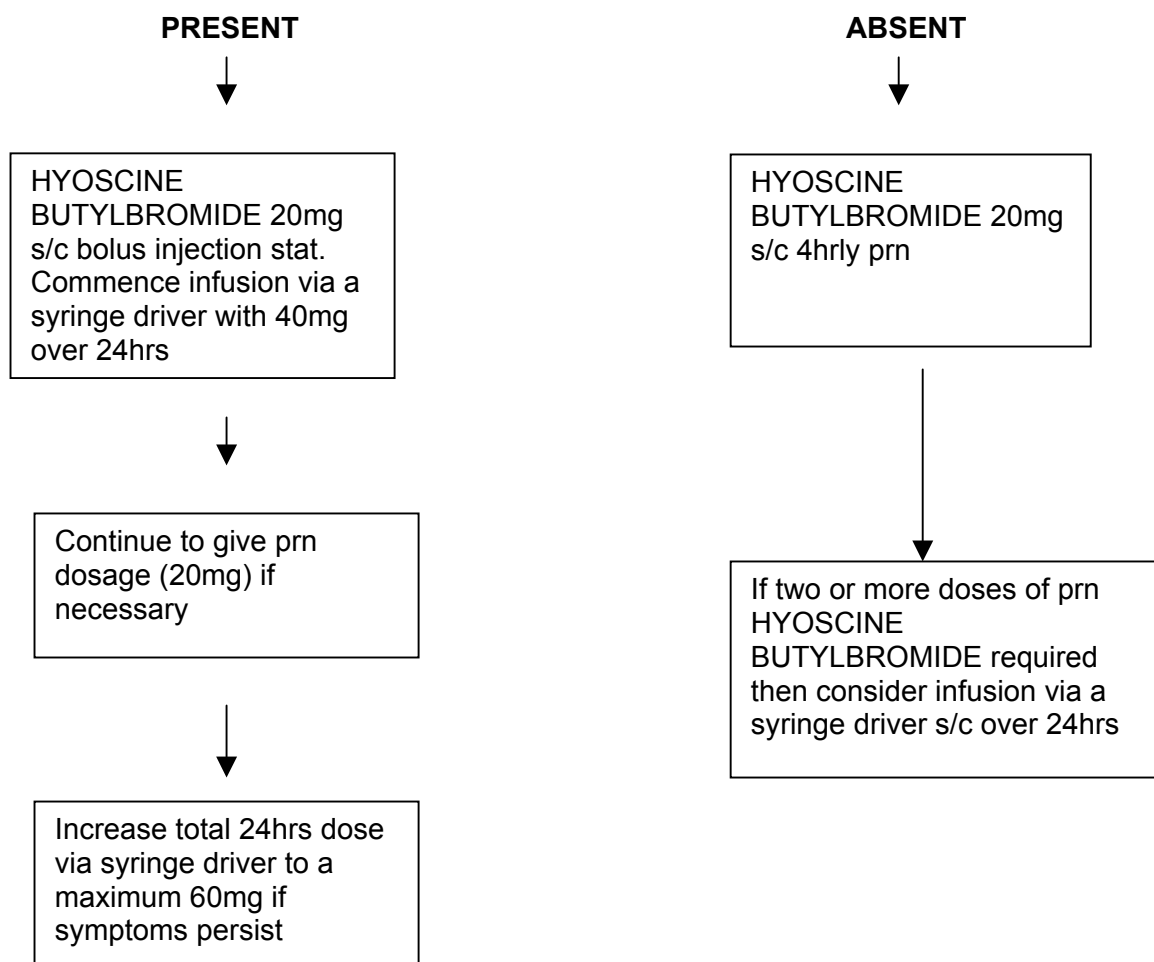


For pathway problems – seek advice from the Palliative Care Team: ext 5835

For out of hour's symptom control – seek advice from St. Leonard's Hospice: Tel 708553

RESPIRATORY TRACT SECRETIONS

(Remember you cannot clear existing secretions, but you can help stop further production)



NOTE

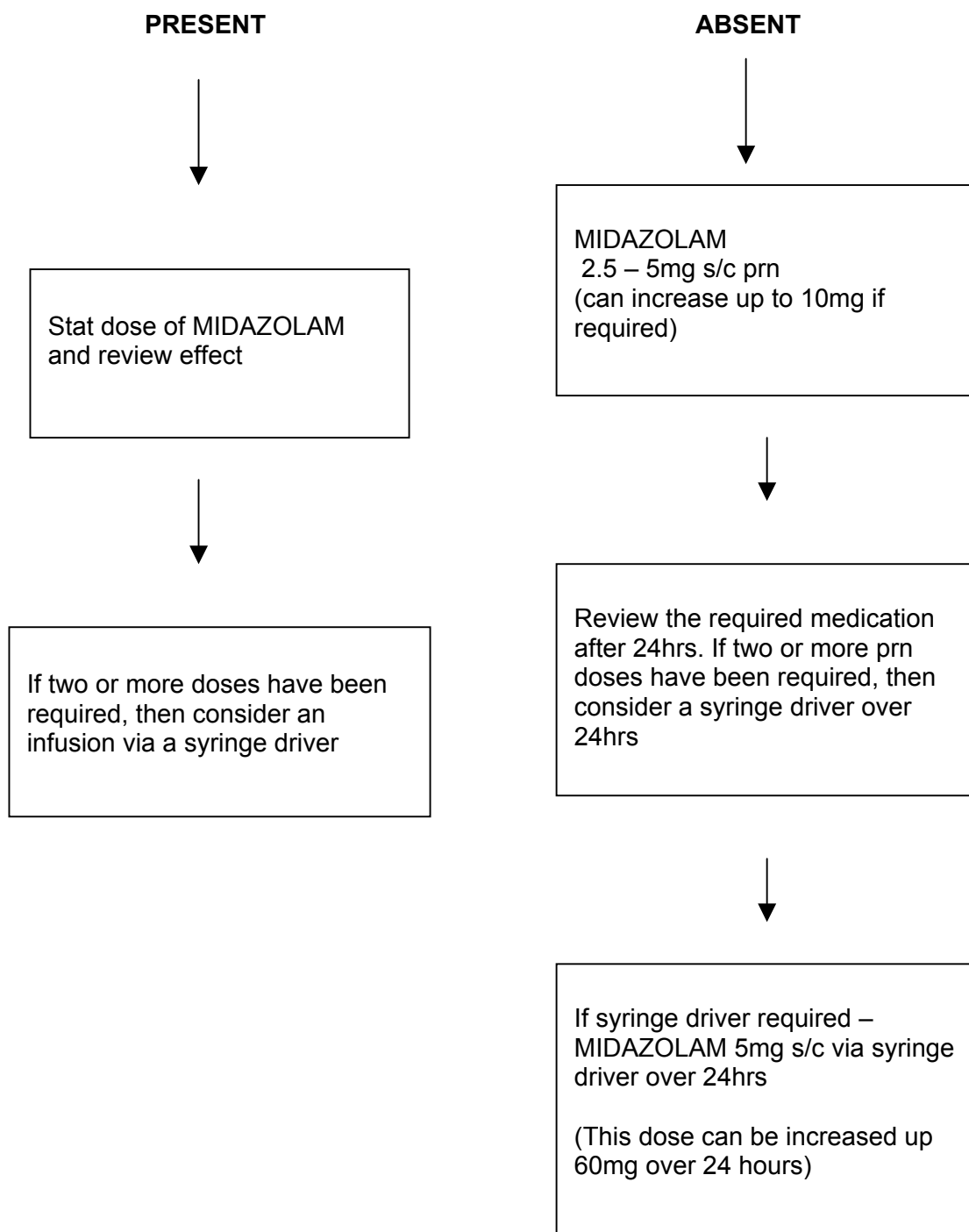
HYOSCINE BUTYL BROMIDE is less sedating than HYOSCINE HYDROBROMIDE and less expensive. It occasionally can precipitate when mixed with CYCLIZINE. If problems discuss with pharmacy

GLYCOPYRRONIUM may be used for patients who do not tolerate Hyoscine or where Hyoscine fails, 200mcg s/c prn dose and 400mcg-2400mcg s/c via syringe driver over 24 hours.

For pathway problems – seek advice from the Palliative Care Team: ext 5835

For out of hour's symptom control – seek advice from St. Leonard's Hospice: Tel 708553

AGITATION / TERMINAL RESTLESSNESS



For pathway problems – seek advice from the Palliative Care Team: ext 5835

For out of hour's symptom control – seek advice from St. Leonard's Hospice: Tel 708553

CHOICE OF DRUGS FOR USE IN SYRINGE DRIVERS

(USUAL DOSE RANGES QUOTED)

DIAMORPHINE N.B. Parenteral Diamorphine is 3 x stronger than oral morphine. If pain not controlled, increase dose by 30% to 50%

DRUG	USE	STAT DOSE	S/C DOSE OVER 24 HRS IN SD
CYCLIZINE (Antihistamine) 50mg/ml injection	Antiemetic, centrally acting on vomiting centre. Good for nausea associated with bowel obstruction or increased intracranial pressure Dilute with water	50mg	100-150mg
HALOPERIDOL (Neuroleptic) 5mg/ml injection	Antiemetic – good for chemically induced nausea	1.5mg	3-5mg
	Control of hallucinations	1.5-3mg	3-10mg
	Caution in terminal restlessness with twitching – lowers seizure threshold		
METOCLOPRAMIDE 10mg in 2ml injection	Antiemetic (1) prokinetic (accelerates GI transit) (2) centrally acting on chemo-receptor trigger zone (CTZ), blocking transmission to vomiting centre	10mg	40-60mg
METHOTRIMEPRAZINE/ LEVOMEPRMAZINE (NOZINAN) (Phenothiazine) 25mg/ml injection	Broad spectrum antiemetic, works on CTZ and vomiting centre (at lower doses)	5 - 6.25mg	5-25mg
	Terminal agitation	12.5-25mg	12.5-100mg
	Dilute with saline when used alone		
MIDAZOLAM (HYPNOVEL) (Benzodiazepine) 10mg in 2ml	Sedative/anxiolytic (terminal agitation), anticonvulsant, muscle relaxant, controls myoclonus	2.5-10mg	5-60mg
HYOSCINE BUTYLBROMIDE (BUSCOPAN) (Antimuscarinic)	Antisecretory and antispasmodic properties Useful in reducing respiratory tract secretions May precipitate when mixed with CYCLIZINE or HALOPERIDOL Less sedating than HYOSCINE HYDROBROMIDE	20mg	40-60mg
HYOSCINE HYDROBROMIDE (Antimuscarinic)	Antisecretory and antispasmodic properties Useful in reducing respiratory tract secretions	400mcg	400mcg-2.4g

For pathway problems – seek advice from the Palliative Care Team: ext 5835

For out of hour's symptom control – seek advice from St. Leonard's Hospice: Tel 708553

