Palliative care resources in Barnsley: what's new?

Or: everything you need to know about palliative care in 30 minutes…

Dr Becky Hirst MA MBChB FRCP MMedEd ATCL

Consultant in Palliative Medicine

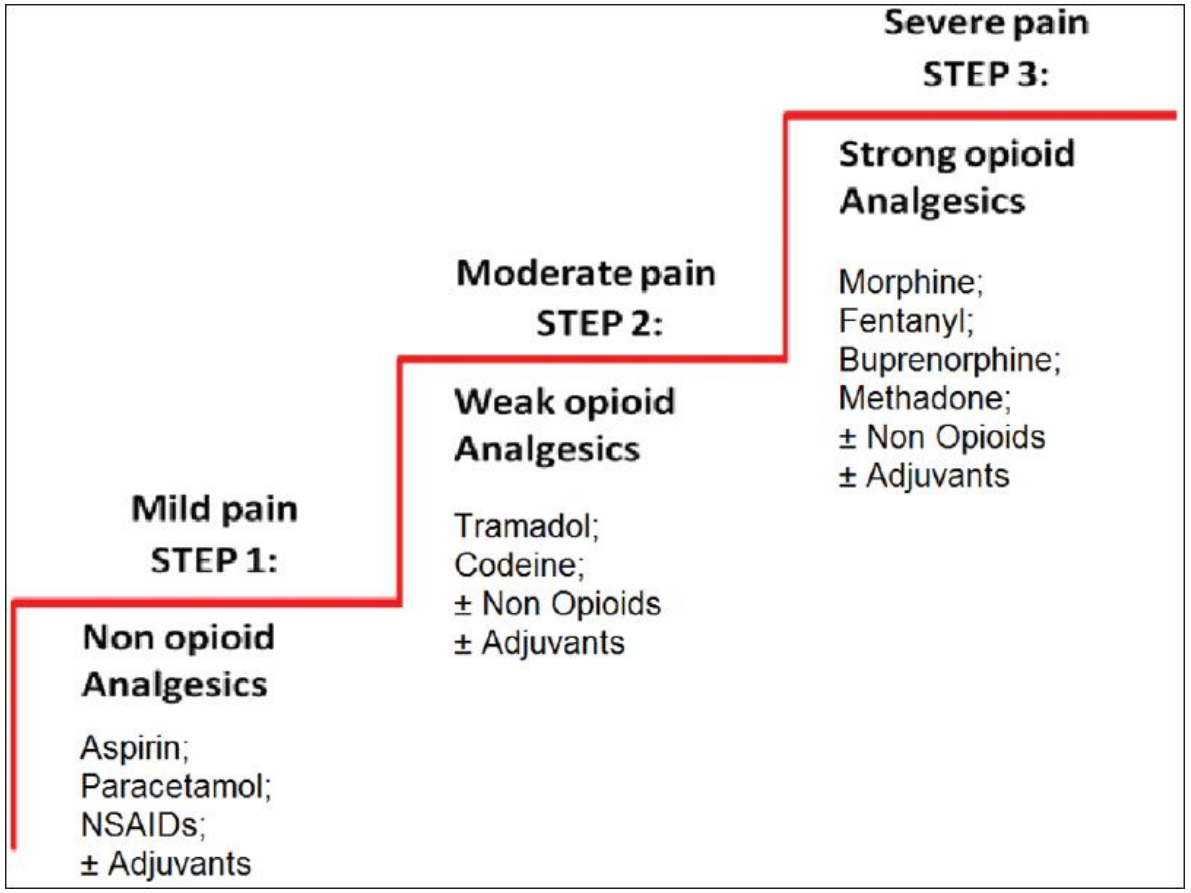
What’s new locally?

- Updated Palliative Care Formulary
- Updated document ‘Last days of life care: symptom management guidance for professionals’
- C19

Palliative Care Formulary

Management of pain

WHO Pain Ladder



- Only applicable to pain in advanced life-limiting disease
- Not applicable to chronic pain
- May need to co-prescribe anti-emetic (e.g. haloperidol) and laxatives at steps 2 and 3
- Step 3 – aim for background controlled release opioid with short-acting opioid for breakthrough
- Once on a step 3 opioid there is no advantage to adding in a step 2 opioid

Which strong opioid?

- Morphine
  - Cheap and cheerful
  - Toxic metabolites accumulate in renal impairment
- Oxycodone
  - Less cheap but likely to be equally cheerful
  - Better tolerated in mild to moderate renal impairment
- Fentanyl
  - Not suitable for acute pain needing rapid dose titration
  - Only to be used in opioid tolerant patients (already established on a strong opioid): 25microgram of fentanyl = approx. 90mg oral morphine Not renally cleared (but is hepatically metabolised)
- Buprenorphine
  - Not suitable for acute pain needing rapid dose titration
  - Not renally cleared (but is hepatically metabolised)

Adjuvant analgesics

- Consider at all steps on WHO ladder
- Probably a lot of cancer pain is a mixture of nociceptive and neuropathic
- Neuropathic pain
  - Choice of tricyclic antidepressants, SNRIs, gabapentinoids, other anticonvulsants
  - Clonazepam
  - Ketamine
- Bone pain
  - NSAIDs, neuromodulatory agents, bisphosphonate
- Hepatic distension syndrome (liver capsule pain)
  - Usually responds well to opioids
  - Risks of steroids may well outweigh benefits

Side effects of opioids

- Everyone will have small pupils and virtually everyone gets constipated
- Nausea/vomiting and sedation common in the first few days – should wear off
- Confusion/delirium – don't rush to attribute this to the opioids
- Respiratory effects
  - Rare to be affected by chronic opioid dosing, particularly oral
  - Reduced conscious level with unremarkable O_2 sats and respiratory rate is unlikely to be opioid induced
- Opioid toxicity
  - Pain poorly responsive to opioids or accumulation
  - Trio of sedation, hallucinations and myoclonus
  - May respond to reduction in dose/frequency or opioid switch (methadone)


SPONGE
BATH
BRAINLESS TALES.com

Pharmacological management of common symptoms

Always consider reversible causes and think about non-drug management

Constipation

- Evidence is that no particular laxative is superior
- Think about volume and palatability
- Macrogols and lactulose often poorly tolerated
- Combine softener e.g. docusate capsules with stimulant e.g. senna or sodium picosulfate
- Naloxegol (peripherally acting opioid antagonist) may be useful

Nausea and vomiting

- Haloperidol
  - Good for metabolic/drug induced N&V
  - Prescribe liquid (capsules no longer available and tablets expensive)
- Cyclizine
  - May be helpful with central causes e.g. brain tumour
  - Antagonises metoclopramide
  - Often causes site irritation and precipitation in syringe driver
- Metoclopramide/domperidone
  - Prokinetic
  - MHRA guidance for short term use, but benefits may outweigh risks in palliative care
- Levomepromazine
  - When narrower spectrum antiemetics aren’t cutting the mustard
- Ondansetron
  - Rarely useful first line in palliative care

Breathlessness

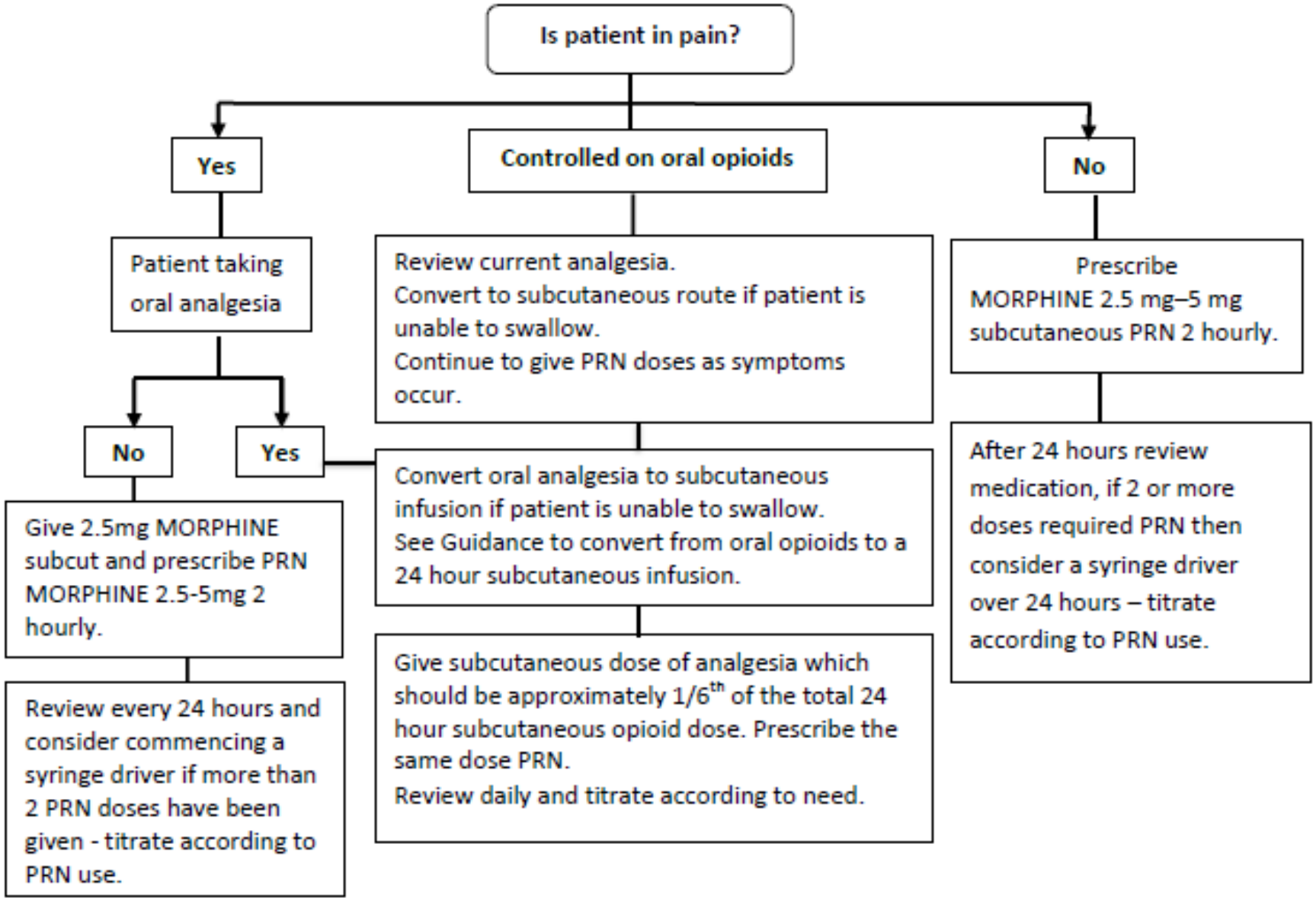
- Avoid prescribing oxygen if not hypoxic (O2 sats > 92%)
- A fan is just as good
- Small doses of opioid effective especially in heart failure
- Lorazepam may be useful if also anxious

Last days of life care: symptom management guidance for professionals

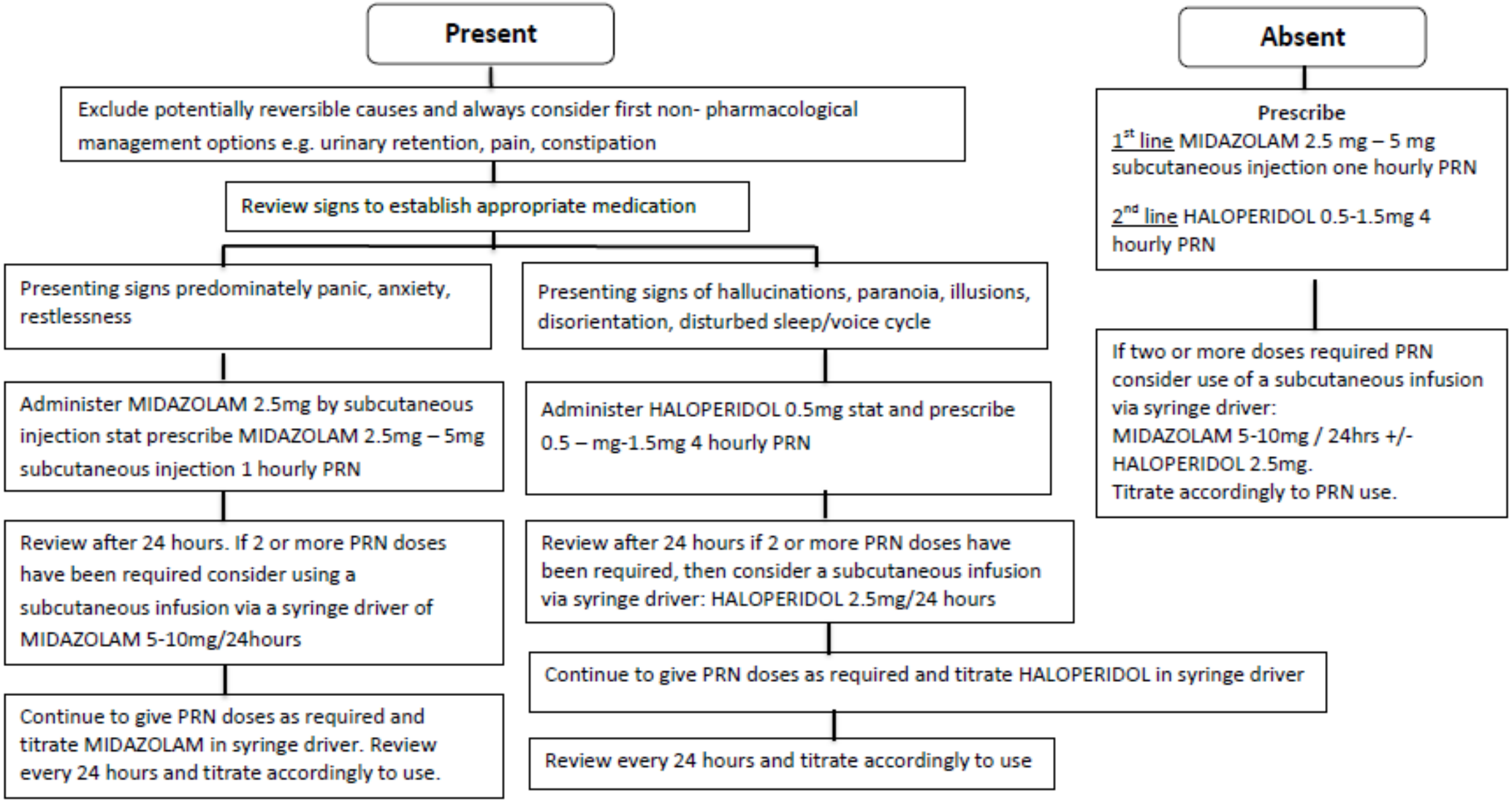
General points

- Have a low threshold for prescribing subcutaneous anticipatory medication
- Prescriptions must take into account patient's existing medication and dose
- Breakthrough analgesic doses are usually between 1/6 and 1/10 of total daily dose
- Two or more breakthrough doses in 24 hours should precipitate a review of background medication
- If a patient has a fentanyl or buprenorphine patch *in situ* continue to change this as prescribed and add further analgesia subcutaneously via syringe driver if necessary

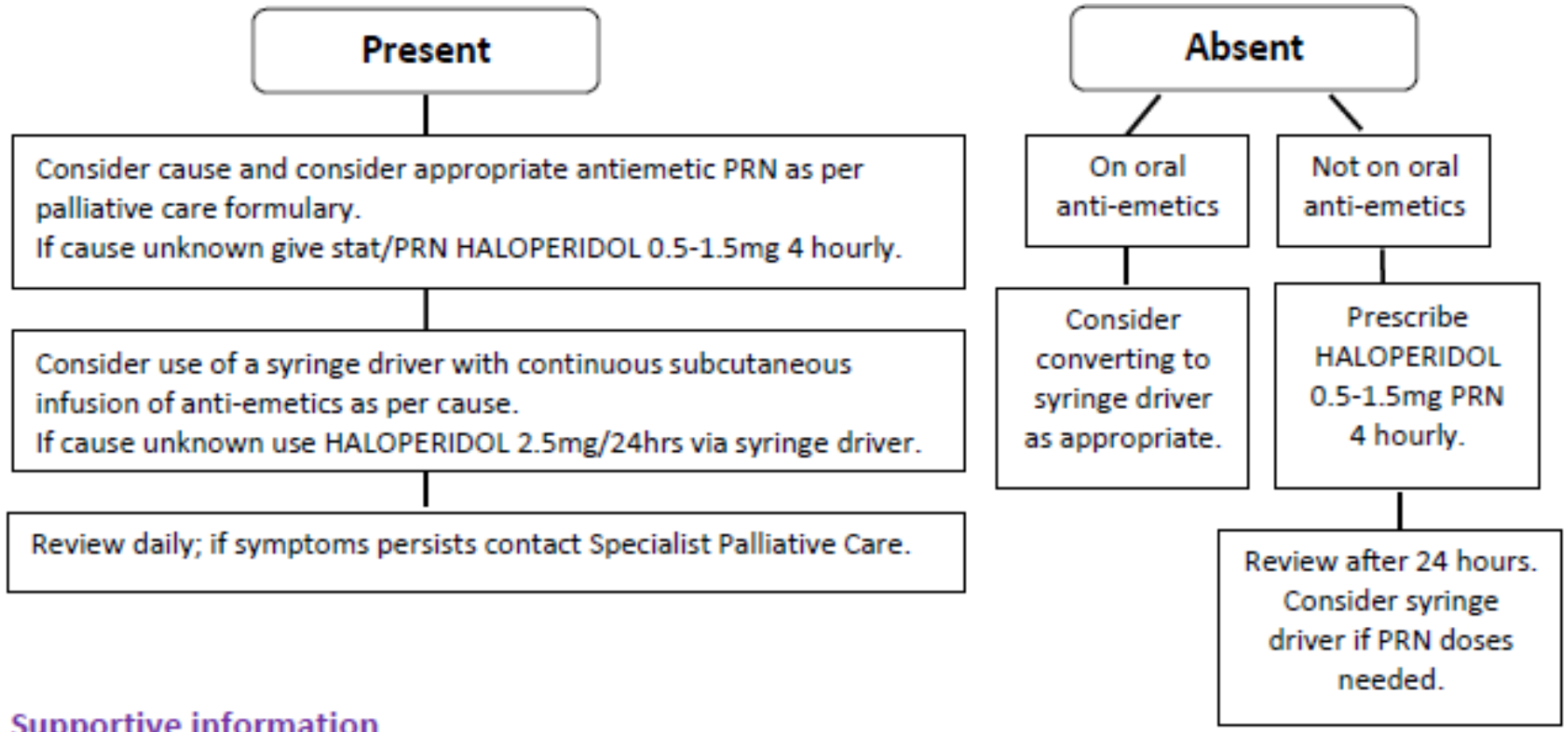
Pain


Is patient in pain?
Yes
Controlled on oral opioids
No
Patient taking oral analgesia
Review current analgesia.
Convert to subcutaneous route if patient is unable to swallow.
Continue to give PRN doses as symptoms occur.
Prescribe MORPHINE 2.5 mg–5 mg subcutaneous PRN 2 hourly.
No
Yes
Convert oral analgesia to subcutaneous infusion if patient is unable to swallow.
See Guidance to convert from oral opioids to a 24 hour subcutaneous infusion.
After 24 hours review medication, if 2 or more doses required PRN then consider a syringe driver over 24 hours – titrate according to PRN use.
Give 2.5mg MORPHINE subcut and prescribe PRN MORPHINE 2.5-5mg 2 hourly.
Review every 24 hours and consider commencing a syringe driver if more than 2 PRN doses have been given - titrate according to PRN use.
Give subcutaneous dose of analgesia which should be approximately 1/6th of the total 24 hour subcutaneous opioid dose. Prescribe the same dose PRN.
Review daily and titrate according to need.

Agitation, delirium and anxiety



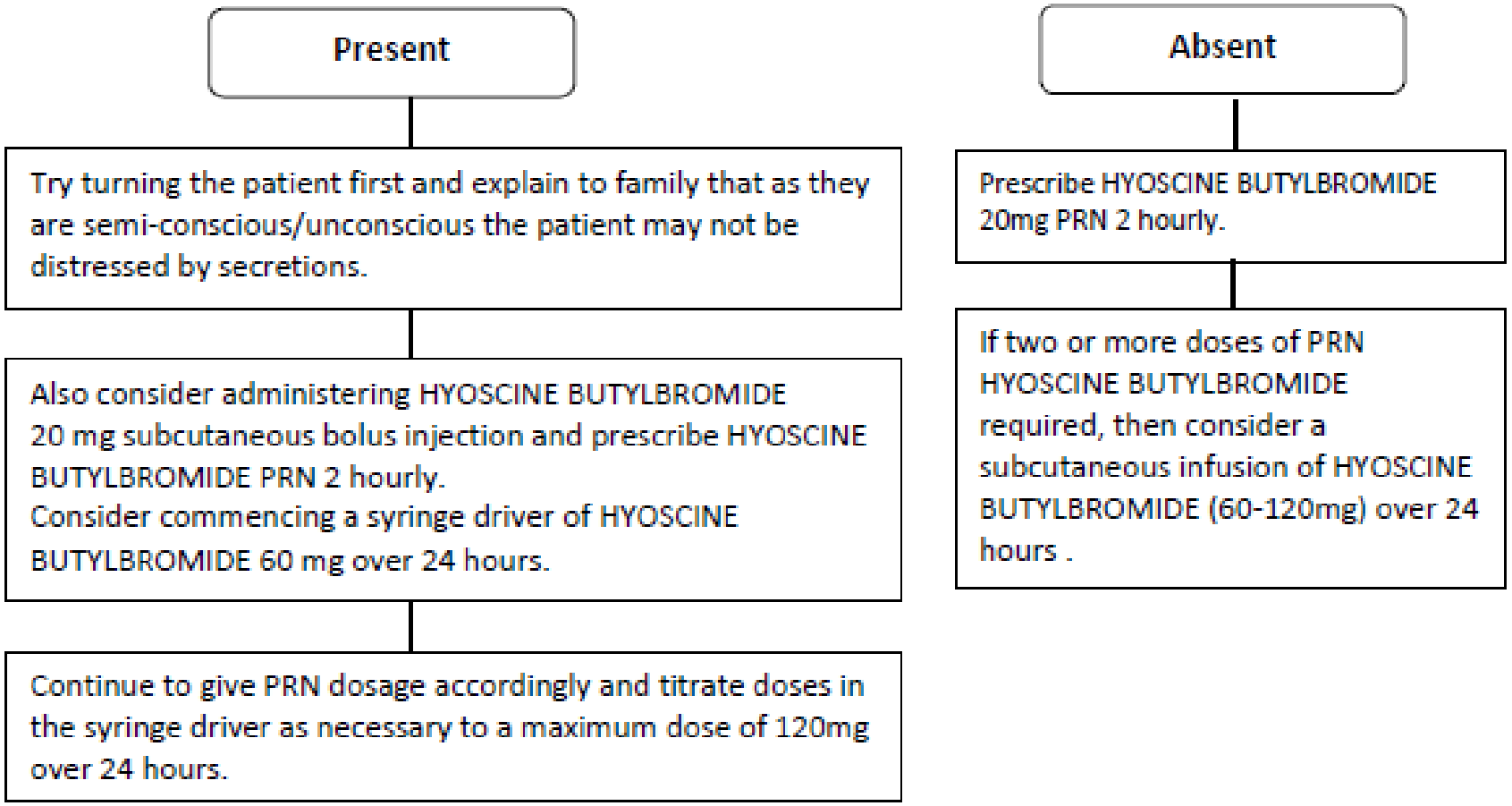
Nausea and vomiting



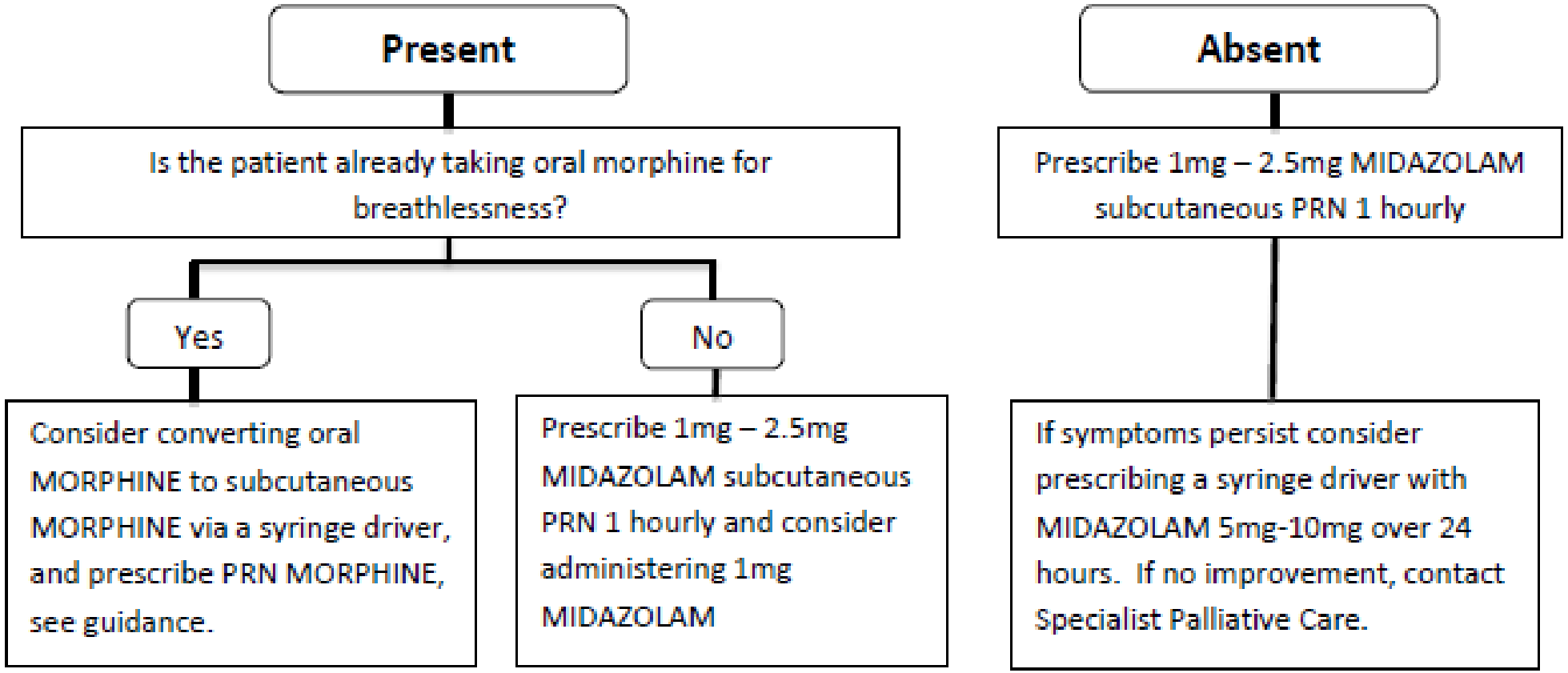
Supportive information

- **If symptoms persist or further advice is needed contact the Specialist Palliative Care Team**
- HALOPERIDOL is not recommended for patients with Parkinson's Disease. For alternative anti-emetics see palliative care formulary or contact the Specialist Palliative Care team.

Respiratory tract secretions



Breathlessness



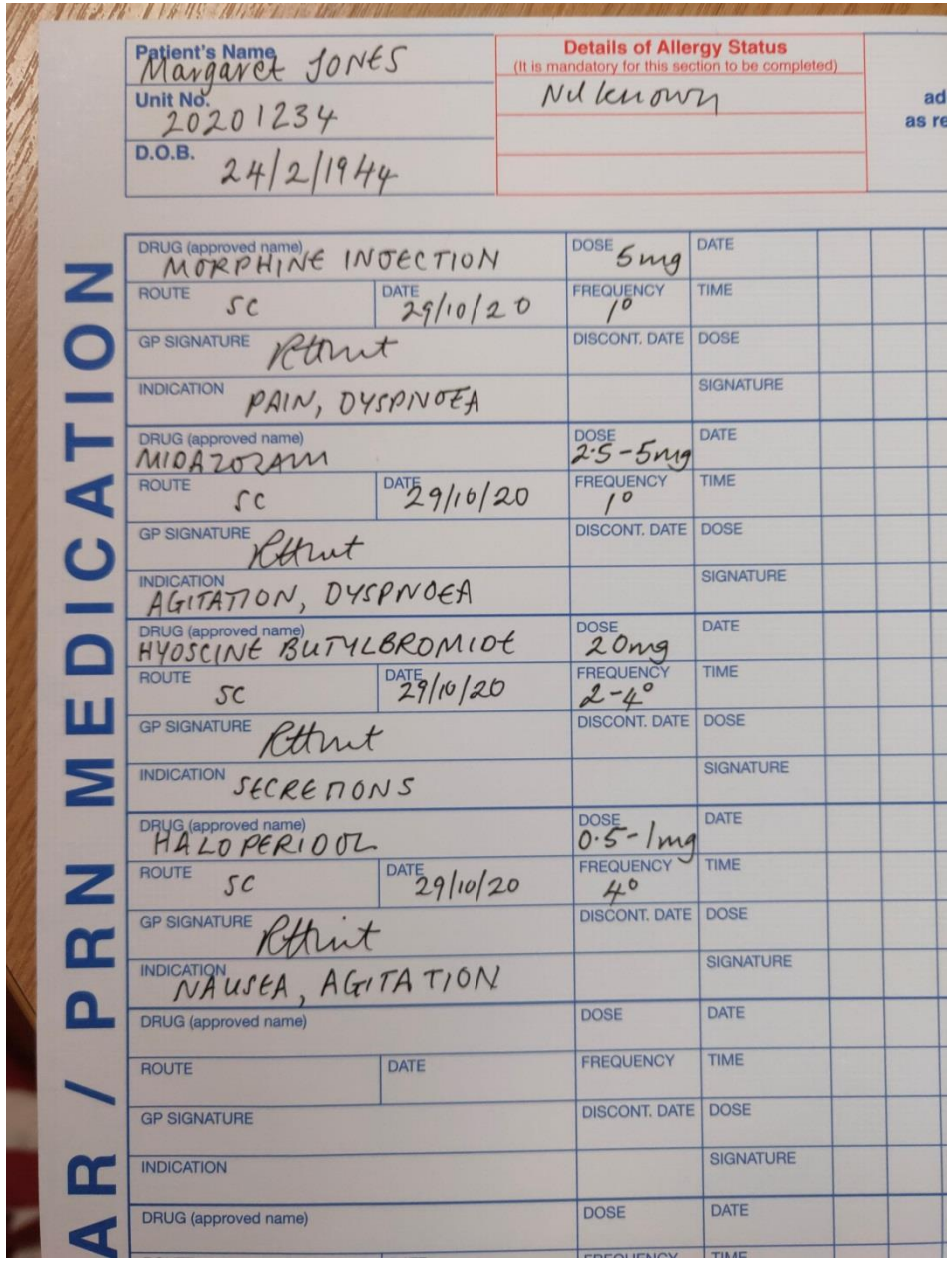
Margaret Jones

- 76 year old lady
- Metastatic breast cancer
- Pain has been well controlled on controlled release morphine (Zomorph®) 30mg twice a day with occasional instant release morphine (Oramorph®) 10mg
- Over last week daughter says has been becoming more sleepy
- Starting to struggle with swallowing medication

Conversion

Guidelines for Converting Oral Analgesia to Subcutaneous

Converting from	To	Factor
Oral Morphine	Subcutaneous Morphine	Divide by 2
Oral Morphine	Subcutaneous Oxycodone	Divide by 4
Oral Oxycodone	Subcutaneous Oxycodone	Divide by 2



Patient's Name: Margaret JONES
Unit No.: 20201234
D.O.B.: 24/2/1944

Details of Allergy Status
(It is mandatory for this section to be completed)
Nil known

AR / PRN MEDICATION

DRUG (approved name) MORPHINE INJECTION			DOSE 5mg	DATE	
ROUTE SC	DATE 29/10/20		FREQUENCY 1°	TIME	
GP SIGNATURE Rthurt			DISCONT. DATE	DOSE	
INDICATION PAIN, DYSPNOEA				SIGNATURE	
DRUG (approved name) MIDAZOLAM			DOSE 2.5-5mg	DATE	
ROUTE SC	DATE 29/10/20		FREQUENCY 1°	TIME	
GP SIGNATURE Rthurt			DISCONT. DATE	DOSE	
INDICATION AGITATION, DYSPNOEA				SIGNATURE	
DRUG (approved name) HYOSCINE BUTYLBROMIDE			DOSE 20mg	DATE	
ROUTE SC	DATE 29/10/20		FREQUENCY 2-4°	TIME	
GP SIGNATURE Rthurt			DISCONT. DATE	DOSE	
INDICATION SECRETIONS				SIGNATURE	
DRUG (approved name) HALOPERIDOL			DOSE 0.5-1mg	DATE	
ROUTE SC	DATE 29/10/20		FREQUENCY 4°	TIME	
GP SIGNATURE Rthurt			DISCONT. DATE	DOSE	
INDICATION NAUSEA, AGITATION				SIGNATURE	
DRUG (approved name)			DOSE	DATE	
ROUTE	DATE		FREQUENCY	TIME	
GP SIGNATURE			DISCONT. DATE	DOSE	
INDICATION				SIGNATURE	
DRUG (approved name)			DOSE	DATE	

Patient's Name	Details of Allergy Status (It is mandatory for this section to be completed)	Subcutaneous Syringe Driver Medication
Margaret JONES	Nil known	Syringe Driver No.
Unit No. 20201234		Infusion Fluid
D.O.B. 24/2/1944		Duration

(Please note ONE chart per syringe driver)

DRUG	DOSE	DURATION	DATE
MORPHINE	30mg	24°	
GP SIGNATURE / DATE / START DATE / DISCONT. DATE		ROUTE	TIME
RCHrint 29/10/20 29/10/20		SC	
TREATMENT CHANGE		INDICATION	RATE SET
Increase by intervals of 10mg/24h to a maximum of 60mg in 24h before review		pain	DOSE
GP SIGNATURE / DATE / START DATE / DISCONT. DATE			SIGNATURE
RCHrint 29/10/20			

DRUG	DOSE	DURATION	DATE
GP SIGNATURE / DATE / START DATE / DISCONT. DATE		ROUTE	TIME
TREATMENT CHANGE		INDICATION	RATE SET
			DOSE
GP SIGNATURE / DATE / START DATE / DISCONT. DATE			SIGNATURE

DRUG	DOSE	DURATION	DATE
DATE / START DATE / DISCONT. DATE		ROUTE	TIME

Covid-19

Dying with/from Covid-19

- Mild respiratory symptoms but approaching end of life from other conditions
- Death from Covid-19 via one or bothe the following mechanisms:
  - Type 1 respiratory failure from Acute Respiratory Distress Syndrome (ARDS)
  - Systemic shock from ‘cytokine storm’ that resembles bacterial septic shock
- Terminal phase can be very rapid
- Common terminal symptoms include pyrexia, rigors, severe dyspnoea, cough, delirium and agitation

Symptom control

- Experience has been that haven’t usually required different doses from other dying patients
- No shortage of syringe drivers
- Duty Nurse on SPC advice line has up to date list of what stocks of palliative care drugs different pharmacies have
- Clark’s at Penistone providing informal 24 hour support for prescriptions

And finally…

What can and can't SPC offer at the moment?

- Can offer same day advice via duty nurse Advice Line – 645280
- Medical advice from hospice doctor 24/7 - 244244
- Still doing face to face assessments BUT
- Cannot guarantee same day visiting either medical or nursing
- Remit is to offer specialist palliative care – management of problems outside the expertise of primary care team
- Other aspects of patient's care may be better met by other professionals
  - District nurses - equipment, social support, general palliative care
- Sometimes CNSs need a GP review for a patient
- If you think a patient might benefit from hospice admission then please phone and discuss it – can't usually offer same day admission but tend not to run much of a waiting list

Thank you

"Well, it's not a good sign, that's for sure ... "