Parenteral haloperidol shortage December 2015

Prescribing guidance for symptom management in the LAST DAYS OF LIFE

There is a shortage of parenteral haloperidol which is likely to continue to the end of 2016. For management of both nausea/vomiting and delirium/agitation in the last days of life **levomepromazine** can be used instead.

Levomepromazine

Time to peak plasma concentration 30–90min SC. ***Duration of action*** 12–24h.

Cautions

Dementia (short term use only) Parkinsonism, postural hypotension, antihypertensive medication, epilepsy (lowered seizure threshold), hypothyroidism, myasthenia gravis.

Undesirable effects

Drowsiness, postural hypotension, antimuscarinic effects. Prolongation of the QT interval and torsade de pointes.

Dose and use

Levomepromazine is often given by continuous subcutaneous infusion (CSCI). Infusions must be protected from light to prevent degradation of the drug and must be discarded if a yellow/pink/purple colour occurs. To reduce the likelihood of inflammatory reactions at the skin infusion site, dilute to the largest practical volume and consider the use of 0.9% saline as the diluent. However, given its long plasma half life, most patients can be maintained satisfactorily on intermittent injections, 1-3 times/24h.

Levomepromazine in the last days of life:

Indication	Start with:	Initial maintenance with:	If symptoms remain uncontrolled:
Terminal agitation ± delirium	6.25mg SC stat and q2h p.r.n.	12.5mg/24hrs via CSCI or as a once daily dose	Seek advice from specialist palliative care team / Pallcall
Anti-emetic	6.25mg SC stat, at bedtime & q4h p.r.n.	6.25-12.5mg/24hrs via CSCI or as a once daily evening dose	Seek advice from specialist palliative care team / Pallcall

CSCI compatibility with other drugs: There are 2-drug compatibility data for levomepromazine in water for injection with **alfentanil**, **hyoscine *butylbromide***,**midazolam**, **morphine sulfate** and **oxycodone**. Levomepromazine is *incompatible* with **ketorolac**. Concentration-dependent *incompatibility* occurs with **dexamethasone**, and **octreotide**.

Supply ***Injection*** 25mg/mL, 1mL amp=£2.

NB Levomepromazine is listed in the Barnsley Palliative Care Formulary Drug List and therefore should be available at participating community pharmacies.

Dr Rachel Vedder
December 2015
Written with reference to Barnsley PCF 2014-2017, PCF 5 www.palliativedrugs.com

Parenteral haloperidol shortage December 2015

Prescribing guidance for symptom management in PALLIATIVE CARE (but not last days of life) when parenteral medication is required for nausea/vomiting or delirium

There is a shortage of parenteral haloperidol which is likely to continue to the end of 2016.

Nausea/vomiting

There are a number of anti-emetic alternatives to haloperidol used frequently in palliative care that can be given subcutaneously as well as intravenously:

- Metoclopramide
- Cyclizine
- Ondansetron
- Levomepromazine

Guidance for choosing the most appropriate alternative can be found in these places:

Barnsley Palliative Care Formulary 2014-2017 (PCF 2014-2017)
Available online by following the link at:
http://www.barnsleyccg.nhs.uk/members-professionals/palliative-care.htm
It can also be found on the Barnsley hospital intranet.

Barnsley Specialist Palliative Care teams:
Community 9am-5pm Mon-Fri 01226 433580 Sat, Sun, Bank holidays 01226 436095
Hospital 8:30am-4:30pm 01226 434921 or bleep via switchboard
Hospice 01226 244244
Palcall telephone advice line (nights, weekends, bank holidays) 01226 244244

Delirium

For palliative care patients exhibiting delirium or psychosis please consider the following:

- Use non-pharmacological interventions to orientate and calm the patient.
- If drugs are also needed treat with **oral** anti-psychotics where possible - haloperidol or atypical anti-psychotics such as olanzapine or quetiapine may be used

If parenteral drugs are required levomepromazine can be used as a subcutaneous alternative to haloperidol, but please be aware:

- Levomepromazine is more **sedating** than haloperidol and is more likely to cause **postural hypotension**, therefore particular care must be taken in patients who are mobilising, and risk of falls should be accounted for.
- Management advice in these circumstances can be sought from specialist palliative care (as above) and psychiatry, and a small stock of parenteral haloperidol will be available for selected patients.

Dr Rachel Vedder
December 2015
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