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Far West NSW
Palliative and End of Life Model of Care

PALLIATIVE CARE POCKET PRESCRIBING GUIDE
SYMPTOM MANAGAMENT GUIDANCE FOR PRIMARY CARE

These principles are intended for guidance only.
They do not cover all aspects of an individual patient's care.
If uncertain, please contact your local Specialist Palliative Care Team for advice.

In accordance with Palliative Care Therapeutic Guidelines (2016)
Available at http://www.tg.org.au

PRINCIPLES OF SYMPTOM MANAGENT IN PALLIATIVE CARE

- Palliative care patients commonly experience multiple symptoms at any one time; they can occur due to a combination of the life-limiting illness itself, disease-modifying treatment and/or intercurrent illness
- Symptoms may be anticipated; early identification, thorough assessment and impeccable management of each is essential
- A comprehensive clinical assessment (including history, examination, and appropriate investigations) should be undertaken to ascertain the likely cause of the symptom(s) and the impact it is having on the patient physically, psychologically, emotionally, socially and spiritually
- Management of the symptom(s) should occur in partnership with the patient, in line with negotiated realistic and achievable goals of care
- A systematic and individualised approach should be taken to symptom management, including both non-pharmacological and pharmacological interventions
- Consider whether a single medication can be prescribed to manage more than one symptom to lighten the burden of treatment
- Consider deprescribing of non-essential medications to reduce side effects and relieve medication burden
- Ensure regular review, with adjustment of the symptom management plan in response to patient's changing needs and priorities
- Consider referral to Specialist Palliative Care for advice regarding management of refractory symptoms and/or complex needs

Reference: Palliative Care Therapeutic Guidelines (2016)

Adapted from Trinity Hospital Palliative Care Guidance for Primary Care, Fylde Coast End of Life Care Steering Group, Lancashire, UK

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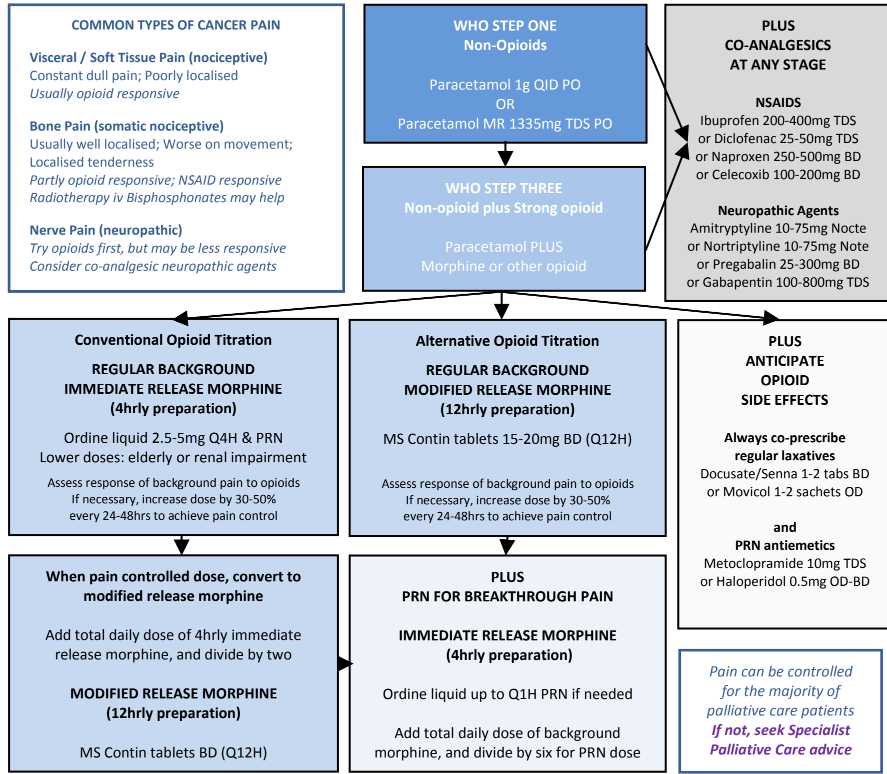
PAIN MANGEMENT in PALLIATIVE CARE PATIENTS



USE OF BUPRENORPHINE/FENTANYL PATCHES

Consider if:

- **Pain is stable, and NOT rapidly changing**
- **Oral route is not appropriate**
- **Oral opioids are not being absorbed**
- **Opioids of choice in renal failure (eGFR<30)**
  (seek Specialist Palliative Care advice in renal failure)
- **Unacceptable side effects from other opioids**

Commencing Buprenorphine / Fentanyl Patches

- Titrate with 4hrly immediate release oral morphine, until pain is controlled
- Calculate patch size using table below
- Remember:
  Buprenorphine 10mcg/hr patch Ξ 20mg oral morphine per day
  Fentanyl 25mcg/hr patch Ξ 60-90mg oral morphine per day
- Stick patch to hairless skin; clip (do not shave) hair
- Initial analgesic effect will take 12-24 hrs, and a steady state may not be achieved for 72 hrs
- Ensure immediate release morphine (or alternative) is available for breakthrough pain; calculate correct dose from table below
- Change patch every 7 days (buprenorphine) or 72 hrs (fentanyl); use a new area of skin each time
- A 12-24hr depot of drug remains in patch when removed; fold patch in itself discard safely
- Symptoms of opioid withdrawal may occur when switching from morphine to fentanyl; manage with PRN morphine

Patches in the Last Days of Life (the Terminal Phase)

- When a patient is dying, **LEAVE PATCH IN SITU**, containing at same dose and change as usual
- Use subcut opioid PRN for breakthrough pain; calculate correct dose from table below
- If additional analgesia needed regularly, start continuous subcut infusion (CSCI) in addition to patch; see overleaf for guidance
- Ensure PRN dose adequate for both patch & CSCI
- **If unsure, seek Specialist Palliative Care advice**

A GUIDE TO EQUIVALENT DOSES FOR OPIOID DRUGS

This table is to be used as a guide rather than a set of definitive equivalences. If unsure at any time, seek Specialist Palliative Care advice.
Use the table to identify an appropriate starting point for your prescribing decision. ALL prescribing decisions must be based on a full clinical assessment.
Ensure that the pain is responding to breakthrough doses of opioid. Think about the role of adjuvant medication before rotating opioids, changing the dose or route.
Never increase an opioid dose by more than 50% of the previous 24 hour regular dose without seeking Specialist Palliative Care advice.
Consider reducing opioid dose by 30-50% if converting from one route to another, or there are signs of opioid toxicity (confusion, drowsiness, myoclonic jerks, slowed respiration, pin-point pupils).
Be aware of drug interactions and remember individual patients may metabolise and absorb different drugs at varying rates.

ORAL MORPHINE			SUBCUTANEOUS MORPHINE		ORAL OXYCODONE		TRANSDERMAL BUPRENORPHINE	TRANSDERMAL FENTANYL *	SUBCUTANEOUS FENTANYL	
4-hr IR dose	12-hr SR dose (twice daily dose)	24-hr SR dose (once daily dose)	4-hr dose	24-hr total dose	4-hr IR dose	12-hr SR dose (twice daily dose)	Patch strength *every 7 days*	Patch strength *every 3 days*	4-hr dose	24-hr total dose
Ordine Sevredol, Apomorph	MS Contin	Kapanol	Morphine Hydrochloride, Sulphate & Tartrate		Endone OxyNorm	OxyContin Targin	Norspan	Denpax, Durogesic, Dutrans, Fenpatch	Fentanyl Citrate	
1 - 2 mg	5 mg	10 mg	-	-	-	-	5 mcg/hr	-	25mcg	100 mcg
2.5 mg	10 mg	20 mg	1.25 mg	5 mg	2.5 mg	5 mg	10 mcg/hr	-	25 - 50 mcg	200 mcg
5 mg	15 mg	30 mg	2.5 mg	10 mg	2.5 - 5 mg	10 mg	20 mcg/hr	12* mcg/hr	50 mcg	300 mcg
10 mg	30 mg	60 mg	5 mg	20 mg	5 - 7.5 mg	20 mg	-	25 mcg/hr	100 mcg	600 mcg
15 mg	45 mg	90 mg	5 mg	30 mg	10 mg	30 mg	-	37 mcg/hr	150 mcg	800 mcg
20 mg	60 mg	120 mg	7.5 – 10 mg	40 mg	12.5 mg	40 mg	-	50 mcg/hr	200 mcg	1200 mcg
SEEK SPECIALIST PALLIATIVE CARE ADVICE REGARDING OPIOID DOSE CONVERSIONS GREATER THAN 100 mg ORAL MORPHINE (OR EQUIVALENT) IN 24 HOURS										
Conversion ratio from oral morphine:			3 : 1		1.5 : 1		1 : 75 - 100	1 : 100 - 150	-	
Conversion ratio from oral morphine:									100 : 1	
Conversion from transdermal fentanyl:									1 : 1	

* Fentanyl: A 12mcg/hr strength is available; but is licensed as a titrating dose NOT as a starting dose. If a patient has not been on an equivalent of 60-90mg of oral morphine per 24 hours, seek specialist palliative care advice before commencing Fentanyl patch.

NAUSEA & VOMITING

- **Correct underlying causes if possible:** (may not be appropriate in last days of life) drugs; uraemia; hypercalcaemia; constipation; bowel obstruction; ascites; severe pain; cough; infection; raised intracranial pressure; anxiety
- **For any cause, prescribe first line antiemetics REGULARLY, and second line PRN**
- **Review efficacy of antiemetic medication daily until symptom control is achieved**
- **1/3 of patients require more than one antiemetic**
- **If symptoms refractory, consider conversation to alternative non-oral route**

PROKINETIC ANTIEMETICS for gastrointestinal causes	
• Early satiety, nausea worse with eating, relief with vomiting	
Treat underlying cause:	
• gastric stasis (widespread cancer, drugs); gastritis; infection; constipation	
Medications	Consider deprescribing
Hyperacidity	PPI, Histamine H2 antagonist
Candida	Nystatin, Fluconazole 50mg OD PO for 7 days
Constipation	Oral and rectal laxatives
FIRST LINE	**Regular prokinetic:** Metoclopramide, Domperidone
SECOND LINE	**PRN dopamine (D2) antagonist:** Haloperidol

CENTRALLY-ACTING ANTIEMETICS for chemoreceptor trigger zone causes	
• constant nausea worse with sight or smell of food, occasional dry retching	
Treat underlying cause:	
• drugs (opioids, antibiotics, chemo); metabolic (hypercalacaemia, uraemia)	
Medications	Consider deprescribing
Hypercalcaemia	IV rehydration, IV bisphosphonates
FIRST LINE	**Regular dopamine (D2) antagonist:** Haloperidol
SECOND LINE	**PRN dopamine (D2) antagonist:** Metoclopramide

CENTRALLY-ACTING ANTIEMETICS for intracranial causes	
• nausea and vomiting worse in morning, with or without headache	
Treat underlying cause:	
• intracranial tumour (primary, metastases); raised intracranial pressure	
Intracranial tumour	Dexamethasone, Cranial radiotherapy
FIRST LINE	**Regular dopamine (D2) antagonist:** Haloperidol
SECOND LINE	**PRN histamine (H1) antagonist:** Cyclizine

OTHER CAUSES of nausea and vomiting	
Vestibular	Prochlorperazine, Haloperidol
Psychological	Psychological support, Anxiolytics, benzodiazepines
Chemo/Radio	5-HT3 antagonist (Ondansetron, Dexamethasone
Refractory	Dexamethasone, seek Specialist Palliative Care advice

ANTIEMETICS	Oral Dose	Subcut dose
METOCLOPRAMIDE (prokinetic, D2 antagonist)	**Regular:** 10mg TDS **PRN:** 10mg PRN (Q8H)	**Regular:** 30mg /24hrs in CSCI **PRN:** 10mg PRN (Q8H)
DOMPERIDONE (prokinetic)	**Regular:** 10mg TDS **PRN:** 10mg PRN (Q8H)	(not available subcut)
HALOPERIDOL (dopamine D2 antagonist)	**Regular:** 0.5-1mg OD-BD **PRN:** 0.5-1mg PRN (Q4H)	**Regular:** 1-2.5mg /24hrs in CSCI **PRN:** 0.5-1mg PRN (Q4H)
CYCLIZINE (histamine H1 antagonist)	**Regular:** 25-50mg TDS **PRN:** 25-50mg PRN (Q8H)	**Regular:** 50-150mg /24hrs in CSCI **PRN:** 25-50mg PRN (Q8H)
LEVOMEPROMAZINE (THIRD LINE, broad spectrum)	SAS medication: seek Specialist Palliative Care advice	
DEXAMETHASONE (steroid)	**Regular:** 4-8mg OD	**Regular:** 4-8mg OD sucbut

SPECIALIST PALLIATIVE CARE ADVICE

FAR WEST LHD	**Broken Hill 08 8080 1333**		**Dareton 03 5021 7200**
WESTERN NSW LHD	**Dubbo** **02 6809 6809**	**Orange** **02 6369 3000**	**Bathurst** **02 6300 5000**

CONSTIPATION

- **Assessment should include abdominal & PR examination**
- **Treatment includes non-pharmacological measures, oral & rectal laxatives**

Initial management if constipation with ORAL LAXATIVES	
First Line	
Combined softener & stimulant oral laxative	Docusate (Coloxyl)/Senna 50/8 mg 1 - 2 tabs, once to twice daily, PO
Second Line	
Hard stool, despite first line oral laxatives	
Increase dose of softener oral laxatives	Docusate (Coloxyl) 240mg, nocte, PO **PLUS** Senna 8-16mg, once to twice daily, PO
OR Switch to iso-osmotic oral laxative	Movicol 1-2 sachets once-twice daily, PO must be dissolved in recommended volume of water
Difficulty expelling soft stool, despite first line oral laxatives	
Increase dose of stimulant oral laxative	Docusate/Senna 1 - 2 tabs, once to twice daily, PO **PLUS** Bisacodyl 5-10mg, once to twice daily, PO

Management of established constipation with RECTAL INTERVENTIONS in additional to ORAL LAXATIVES	
Hard faeces in rectum	
Softener & stimulant suppository	Glycerol 2.8g suppository, PR, PRN (max OD) **PLUS** Bisacodyl 10mg suppository, PR, PRN (max OD)
Soft faeces in rectum	
Stimulant suppository	Bisacodyl 10mg suppository, PR, PRN (max OD)
Empty rectum, with a history of constipation	
Stimulant enema	Microlax enema, PR, PRN (max OD)
Faecal impaction	
Initial management to soften stool	
Softener suppository	Glycerol 2.8g suppository, PR, PRN (max OD)
OR Lubricant enema	Olive oil 20-50mL retention enema, PR, PRN (single)
Second line management, once stool has softened	
Stimulant enema	Microlax enema, PR, PRN (max OD)
Oral management, if rectal intervention is contraindicated	
Iso-osmotic oral laxative	Movicol 8 sachets in 1000mL water, over 2 - 4hrs, PO

ANTICIPATORY PRESCRIBING FOR LAST DAYS OF LIFE

For more detailed guidance: See 'Far West LHD Prescribing Recommendations' and 'Clinical Excellent Commission Last Days of Life Symptom Management Flowcharts'

MORPHINE 10mg/mL injection for pain and/or dyspnoea [PBS / Authority PBS >5 amps]	
PRN dose	Opioid naïve: 2.5-5mg subcut PRN (Q1H), max 6 doses/24hrs
CSCI dose	Opioid naïve: 10-20mg in CSCI over 24hrs
FENTANYL 100mcg/2mL injection for pain/dyspnoea in ESKD (eGFR <30) [non-PBS]	
PRN dose	Opioid naïve: 25-50mcg subcut PRN (Q1H), max 6 doses/24hrs
CSCI dose	Opioid naïve: 100-200mcg in CSCI over 24hrs
MIDAZOLAM 5mg/mL injection for dyspnoea/restlessness/agitation [non-PBS]	
PRN dose	2.5-5mg subcut PRN (Q2H), max 6 doses/24hrs
CSCI dose	10-20mg in CSCI over 24hrs
HALOPERIDOL 5mg/mL injection for restlessness/agitation/nausea/vomiting [PBS]	
PRN dose	1mg subcut PRN (Q4H), max 5mg/24hr
CSCI dose	2-5mg in CSCI over 24hrs
METOCLOPRAMINDE 10mg/2mL injection for nausea/vomiting [PBS]	
PRN dose	10mg subcut PRN (Q8H), max 30mg/24hr
CSCI dose	30mg in CSCI over 24hrs
GLYCOPYRROLATE 0.2mg/mL injection for respiratory tract secretions [non-PBS]	
PRN dose	0.2-0.4mg subcut PRN (Q4H), max 1.2mg/24hr
CSCI dose	0.6-1.2mg in CSCI over 24hrs

Seek Specialist Palliative Care advice for access to non-PBS medications

BREATHLESSNESS (DYSPNOEA)

- **Breathlessness causes considerable anxiety: acknowledge and empathise**
- **Management is the same, regardless of underlying diagnosis**
- **Consider treating underlying cause:** infection; anaemia; CCF; effusion; PE
- **Opioids and benzodiazepines are safe in end-stage respiratory disease**

NON-PHARMACOLOGICAL MANAGEMENT	
Moving cool air	Well ventilated room, open window, fan
Physiotherapy	Breathing management, mobility, aids
Occupational Therapy	Lifestyle modification, aids, adaptations
Psychological	Treat anxiety, psychological support

PHARMACOLOGICAL MANAGEMENT	
Intermittent dyspnoea	
Opioid (titrate up as needed)	Morphine IR (Ordine), 1 - 2mg, PO, PRN (Q1H) **OR** Morphine injection, 0.5 - 1mg, subcut, PRN (Q1H)
PLUS Benzodiazepine if dyspnoea exacerbated by anxiety	Oxazepam, 7.5 - 15mg, PO, PRN (Q1H) **OR** Lorazepam, 0.5 - 1mg, PO / subling, PRN (Q1H) **OR** Midazolam injection, 2.5mg, subcut. PRN (Q1H)
Continuous dyspnoea	
Opioid (titrate up as needed)	Morphine IR (Ordine), 1 - 2mg, PO, Q4H & PRN (Q1H) **OR** Morphine MR (MS Contin), 5-10mg, PO, BD & Morphine IR (Ordine), 1 - 2mg, PO, PRN (Q1H) **OR** Morphine injection, 5-10mg over 24hrs via CSCI
PLUS Benzodiazepine if dyspnoea exacerbated by anxiety	Diazepam, 2mg, PO, BD-TDS **OR** Clonzepam, 0.5-1mg, PO / subling, OD-BD **OR** Midazolam injection, 5-10mg over 24hrs via CSCI
Inhaled Drugs	
Salbutamol nebs	For reversible airways obstruction
Saline nebs	For thick secretions
Oxygen	For hypoxia: consider Enable referral and assessment For symptom control: discuss with palliative care
Other Drugs	
Antibiotics	For infection
Prednisolone	For non-infective exacerbation of airways disease
Dexamethasone	For airway obstruction, SVCO & lymphangitis Start at 12-16mg PO, OD, and titrate down
Diuretics	For pulmonary congestion

ADVANCE CARE PLANNING in NSW

A PERSON WITH CAPACITY always makes healthcare decisions for themselves

ADVANCE CARE PLANNING is the process by which a person with capacity can make their healthcare wishes known, should they be in a position where they are unable to make decisions for themselves in the future. Advance Care Planning includes:

- **ADVANCE CARE PLANNING** – talking to family & health professionals about wishes
- **Appointing an ENDURING GUARDIAN** – appointing a surrogate decision maker
- **Writing an ADVANCE CARE DIRECTIVE** – a legally binding document (see below)

See NSW Planning Ahead (www.planningaheadtools.com.au) for further information

For a PERSON WHO DOES NOT HAVE CAPACITY to make healthcare decisions for themselves, their PERSON RESPONSIBLE becomes their surrogate decision maker:

The PERSON RESPONSIBLE is not necessarily the next of kin. The NSW Guardianship Act (1997) establishes who the Personal Responsible is in order of priority:

1) Advance Care Directive	a valid ACD, made when the person had capacity, must be followed when the person loses capacity
2) Enduring Guardian	if has been given right to make healthcare decisions
3) Spouse / Partner	with whom there is a close continuing relationship
4) Unpaid Carer	who provides or arranges domestic support regularly
5) Relative / Friend	who has a close relationship, frequent contact and a personal interest in the person's welfare