ESSEX PALLIATIVE, SUPPORTIVE AND END OF LIFE CARE GROUP

FORMULARY AND GUIDELINES FOR MANAGEMENT: Abridged Version for SW Essex

INTRODUCTION

"Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual". WHO (2002)

Generic palliative care (the palliative care approach) is provided by all health care professionals and is an integral part of clinical practice.

The specialist palliative care team becomes involved with patients with an extraordinary level of need. This often reflects an intensity or complexity of problems across the physical, psychological or spiritual domains.

Fast and effective palliation of symptoms is of utmost importance in ensuring best possible quality of life in individuals for whom cure is not possible. Symptom control and other issues should be approached in a holistic way, taking into account not only physical signs but also social, spiritual and emotional dimensions.

Prescribers are reminded that it is good practice to document the reason for choice of drug, particularly if it is not considered a usual first line drug.

For further guidance refer to:
BNF

For further specialist advice please contact:

Palliative Care Consultant on call (contact for specialist palliative care advice 24 hours a day via Southend Hospital switchboard):
01702 435555

Community Support for Palliative Care:
SAAS OneResponse 01268 526259

Hospice contacts

Saint Francis Hospice, Romford	01708 753319
St Luke's Hospice, Basildon	01268 524973

Cost coding applied to this formulary*:

£	<£5
££	£5-£25.00
£££	>£25.00

*Based on 14 day prescription.

Useful information:
CSCI – continuous subcutaneous infusion or syringe drivers/pumps are small battery operated pumps that allow continuous, subcutaneous drug infusions. This permits parenteral drug administration with minimal patient burden and has the advantage of steady plasma levels for a wide range of drugs available for symptom control. They are not just for use in the terminal phase but in any situation where the oral route is inappropriate or unreliable.

KEY

od	-	once daily
bd	-	twice daily
tds	-	three times daily
qds	-	four times daily
nocte	-	at night
PRN	-	as required
stat	-	immediately
hrly	-	hourly
IV	-	intravenous
SC	-	subcutaneous
PR	-	per rectum

PRINCIPLES OF PRESCRIBING IN PALLIATIVE CARE

1. Assess the symptom(s) adequately
2. Establish a realistic management plan with the patient and family
3. Choose drugs based on underlying pathology and physiology
4. Choose an appropriate route of drug administration
5. Avoid polypharmacy where possible
6. Review medication regularly
7. Ensure appropriate quantities of medication are available

SYMPTOM MANAGEMENT: Managing the symptoms following assessment

PAIN:

Assess pain using a pain assessment tool for example:

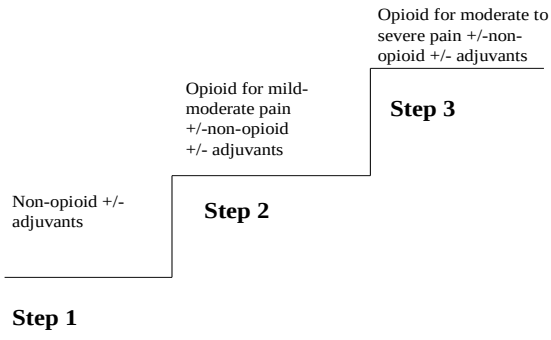
- Visual analogue scale (VAS)
- Verbal rating scale (VRS)
- Abbey Pain Scale for those with dementia and who can't verbalise pain (appendix 1)

Principles of analgesic use:

- *By mouth* where possible: avoid intramuscular/intravenous routes where possible in palliative care patients – subcutaneous absorption is generally as good
- *By the clock* (i.e. regularly)
- *By the WHO ladder*

Remember to prescribe appropriate analgesia for breakthrough pain at 1/6th total 24 hour dose. Monitor response to treatment and modify accordingly.

WHO Analgesic Ladder



Step 1. Non-opioid: paracetamol
Adjuvants: tricyclic antidepressants, anticonvulsants, corticosteroids.

Step 2. Opioids for mild-moderate pain: codeine (co-codamol 8/500, co-codamol 30/500), dihydrocodeine (codydramol 10/500), tramadol

Step 3. Opioids for moderate-severe pain: morphine, oxycodone, fentanyl, diamorphine, methadone, buprenorphine, alfentanil

WHO STEP ONE

Step 1	Usual maximum oral dose for prescribing	Prescribed as	Comment	Costing
Paracetamol	4 gram daily	1gram four times a day to max oral dose	First option	£
Non-steroidal anti-inflammatory drugs (NSAIDs) Consider concurrent use of a gastroprotective agent for at risk patients Avoid in moderate to severe renal failure-estimated GFR less than 30ml/min				
Ibuprofen	2.4 gram daily	400mg to 600mg three to four times a day	Second option	£
Naproxen	1 gram daily	250mg to 500mg twice a day	Second option	£

WHO STEP TWO

Step 2 opioid	Usual maximum oral dose for prescribing	Prescribed as	Approximate 24 hour oral morphine equivalent	Costing
Codeine Phosphate	240mg daily	30mg to 60mg every 4 hours to max oral dose	24mg	£-ff
Dihydrocodeine	240mg daily	30mg every 4 hours to max oral dose	24mg	£

WHO STEP THREE

Morphine sulphate: The opioid of first choice for moderate to severe cancer pain

Initiating morphine analgesia
Talk to the patient: allay any fears or concerns

Remember:

- oral codeine 240mg/day is equivalent to oral morphine 24mg/day
- prescribe breakthrough analgesia (1/6th of the total 24 hour dose, available up to hourly if needed)-see Oramorph oral solution (morphine sulphate oral solution) or Sevredol tablets (morphine sulphate immediate release tablets)
- consider co-prescribing a laxative
- ensure an anti-emetic is available-see section below

Step 3 opioid	Usual maximum oral dose for prescribing	Prescribed as	Costing
Morphine-first choice			
Morphine sulphate oral solution (Oramorph 10mg/5ml)-can also be prescribed for breakthrough pain-see notes above Morphine sulphate (Sevredol) immediate release tablets	Dose adjusted according to response	2.5mg to 5mg up to 1 hourly when required in opioid naïve patients, and for patients already established on regular morphine use 1/6th of the total daily dose up to 1 hourly when required. Sevredol is available	ff

Morphine Injections		as 10 mg, 20 mg, and 50 mg tablets. Opioid naïve patients stating dose should be 1.25mgs – 2.5mgs every 4 hours	
Once established on regular dose that is managing pain calculate the total dose given over the previous 24 hours and divide into 2 doses to allow conversion to modified release morphine. **Please note that there is also an Oramorph concentrated oral solution (morphine sulphate oral solution 100mg/5ml) which may be appropriate in patients on large regular morphine doses. Do not prescribe unless on the advice and recommendation of the Palliative Care Team.**			
Morphine sulphate modified release (prescribe as 1st choice brand Zomorph capsules, other brands include MST Continus tablets)	Dose adjusted according to daily morphine requirements	Zomorph is available as 10mg, 30mg, 60mg, 100mg and 200mg capsules, given every 12 hours in various combinations to achieve the required dose to manage the pain. MST Continus is also available as 5mg and 15mg tablets given every 12 hours, which may be useful when doses of 5mg and 15mg modified release are required.	£-££-£££ dose dependent
NOTE:	For patients who cannot swallow the capsules, Zomorph capsules can be opened and the contents sprinkled on food (e.g. jam or yogurt) and MST Continus is available as a suspension (sachet of granules to mix with water). Zomorph capsules can be opened and the contents flushed down enteral feeding tubes with a diameter of 16Fr or larger or consider the use of the MST Continus suspension/sachets. The manufacturer of Zomorph recommends rinsing the tube following each dose with 30 to 50ml of water (information taken from the NEWT guidelines, 2nd Edition 2010).		
Diamorphine Can be given as single subcutaneous injections or as continuous subcutaneous infusion via syringe driver. It is approximately 3 times more potent than oral morphine, therefore to convert oral morphine to subcutaneous diamorphine give 1/3rd of the total daily oral dose.			
SECOND CHOICE OPIOIDS-rationale for choice should be recorded by prescribing clinician in medical notes or patient record			
Oxycodone : • consider prescribing in patients with moderate renal failure • oral oxycodone is twice as potent milligram for milligram as oral morphine **Indications** Patients with opioid sensitive pain experiencing side effects (particularly psychogenic) with morphine. Patients with moderate renal failure (estimated GFR less than 30ml/min) or for breakthrough dosing in patients with severe renal failure. **Injectable oxycodone:** Approximately twice as potent as oral oxycodone therefore to convert oral oxycodone to subcutaneous oxycodone give ½ of the oral dose			

Step 3 opioid	Usual maximum oral dose for prescribing	Prescribed as	Costing
Oxycodone hydrochloride liquid 5mg/5ml	Dose adjusted according to response	2.5mg up to 1 hourly when required in opioid naïve patients, adjusted according to response	£
Oxycodone hydrochloride immediate release capsules (prescribe as 1st choice brand Shortec capsules)	Dose adjusted according to response	5mg, 10mg, and 20mg capsules, adjusted according to response	££-£££ dose dependent
Oxycodone hydrochloride modified release tablets (prescribe as 1st choice brand Longtec tablets)	Dose adjusted according to daily oxycodone requirements	Lontec is available as 5mg, 10mg, 20mg, 40mg and 80mg tablets, given every 12 hours to achieve the required dose to manage the pain.	££-£££ dose dependent
ALTERNATIVE SECOND CHOICE OPIOIDS-rationale for choice should be recorded by prescribing clinician in medical notes or patients record			
Fentanyl: **Indications** Patients with opioid sensitive pain experiencing side effects with morphine. Patients unable to take oral opioids. Patients with intractable morphine-induced constipation despite regular use of appropriate laxatives. Patients in renal failure. **Guidelines for use** Patch changed every 72 hours. Takes 36-48 hours to reach steady state plasma concentrations. Elimination plasma half-life is 15-17 hours. Inappropriate for patients who need rapid titration of severe uncontrolled pain. 25micrograms fentanyl patch is equivalent to 60mg to 90mg total daily dose of oral morphine. Please refer to the conversion table.			
Step 3 opioid	**Usual maximum oral dose for prescribing**	**Prescribed as**	**Costing**
Fentanyl patches (prescribe as 1st choice brands Matrifen patches or Fencino patches)	Dose adjusted according to response	**Fentanyl patches to be changed every 72 hours.** Matrifen patches and Fencino patches are available as: -12 micrograms/hour for 72 hours -25 micrograms/hour for 72 hours -50 micrograms/hour for 72 hours -75 micrograms/hour for 72 hours -100	££-£££ dose dependent

		micrograms/hour for 72 hours The brand Durogesic DTrans is also available.	
Buprenorphine: Self-adhesive patch delivers drug transdermally and changed every 4 days (TransTec) or 7 days (BuTrans)			

Adjuvant analgesics-recommended for all 3 steps of the analgesia WHO ladder			
Neuropathic pain			
When using anticonvulsants for their analgesic properties: • Start at low dose and increase as tolerated. • May take up to one week before analgesic effect apparent. • If unsure then seek specialist palliative care advice			
Adjuvant Analgesics	**Usual maximum oral dose for prescribing**	**Prescribed as**	**Costing**
Amitriptyline First line in neuropathic pain	75mg daily	Consider 10mg daily at night. Increase dose by 10mg to 25mg weekly until effective dose reached or patient reports unacceptable side effects.	£
Gabapentin Second line	Dose increased according to response, up to maximum of 3.6g daily	100mg to 300mg daily, with dose increased every 4 to 5 days to a three times daily dosing. Use lower dose in renal impairment.	£
Pregabalin (only when gabapentin is effective but patients have unacceptable side effects). Prescribe and dispense as brand name Lyrica for neuropathic pain (NHS England).	Dose increased according to response, up to maximum of 600mg daily (given as a twice daily dose)	75mg twice daily, dose increased after 3 to 7 days to 150mg twice daily, increased further if needed after 7 days. Use lower dose in renal impairment.	£££
The choice of agent for neuropathic pain may also be determined by patient factors, comorbidities, contra-indications and side effects.			

SYMPTOM MANAGEMENT: NAUSEA AND VOMITING

Identify and treat reversible causes:

- Candidiasis-antifungals.
- Constipation-laxatives.
- Cough-anti-tussives.
- Gastric irritation-H2 antagonist or proton pump inhibitor, stop NSAIDS.
- Hypercalcaemia-hydration and bisphosphonates.
- Infection-antibiotics

Use appropriate anti-emetic according to cause:

Cause	Drug	
	First line	**Second line**
Chemical/drug e.g. opioids, hypercalcaemia	Cyclizine oral ££ 50mg three times a day Cyclizine SC ££ 100mg to 150mg/24 hours via CSCI Haloperidol oral £-££ 500micrograms to 1.5mg stat and at bedtime. Typical maintenance dose of 1.5mg to 3mg at bedtime or 500micrograms to 1.5mg twice daily. Dose can be increased if necessary to 5mg to 10 mg daily in divided doses. Haloperidol SC £ 3mg to 5mg/24 hours via CSCI Domperidone oral £ 10mg three times daily, maximum 30mg daily	Metoclopramide oral £ 10mg three times daily (higher doses can be used up to 20mg three times daily, as recommended by palliative care team) Metoclopramide SC £ 30mg to 100mg/24 hours via CSCI Levomepromazine oral ££ 6.25mg to 25mg daily at night. Levomepromazine is available as 25mg tablets-¼ of a tablet to provide dose of 6.25mg. Please note 6mg tablets are unlicensed special and not recommended. Levomepromazine SC ££ 6.25mg to 25mg/24hours via CSCI (higher doses may be recommended by palliative care team).
Gastric stasis	Metoclopramide oral £ 10mg three times daily (higher doses can be used up to 20mg three times daily, as recommended by palliative care team) Metoclopramide SC £ 30mg to 100mg/24 hours via CSCI Domperidone oral £ 10mg three times daily, maximum 30mg daily	
Raised intracranial pressure	Cyclizine oral ££ 50mg three times a day Cyclizine SC ££ 100mg to 150mg/24 hours via CSCI	Levomepromazine oral ££ 6.25mg to 25mg daily at night. Levomepromazine is available as 25mg tablets-¼ of a tablet to provide dose of 6.25mg. Please note 6mg

	Dexamethasone 4mg to 16mg/day oral/SC/via CSCI	tablets are unlicensed special and not recommended. Levomepromazine SC ££ 6.25mg to 25mg/24hours via CSCI (higher doses may be recommended by palliative care team).
Bowel obstruction	Cyclizine oral ££ 50mg three times a day Cyclizine SC ££ 100mg to 150mg/24 hours via CSCI	Haloperidol SC £-££ 3 to 5mg/24 hours via CSCI Hyoscine butylbromide SC ££-£££ 60mg to 120mg/24 hours via CSCI Octreotide-should only be prescribed on Specialist Palliative Care advice and they will provide prescribing guidance. £££

SYMPTOM MANAGEMENT: AGITATION/RESTLESSNES IN THE TERMINAL PHASE
Aim is to reduce agitation sufficiently for comfort and to find a treatable cause if possible.

Consider reversible causes:

- Drug induced
- Full bladder
- Full rectum
- Hypoxia
- Pain/discomfort
- Fear/anxiety
- Alcohol or nicotine withdrawal

Drug	Usual maximum oral/CSCI dose for prescribing	Prescribed as	Costing
Lorazepam-first line	4mg	0.5mg to 1mg sublingually or orally to maximum oral dose	£
Midazolam **NOTE:** Higher SC doses can be given but should be initiated following Specialist Palliative Care advice	Up to 30mg/24 hours via CSCI. In cases of resistant agitation dose can be increased to 80mg, but only under palliative specialist advice.	2.5mg to 10mg stat subcutaneous injection 10mg to 20mg/24 hours via CSCI	£££
Agitation, psychosis and hallucinations			
Haloperidol		Oral dose of 0.5mg to 1mg as required to maximum oral dose of 10mg. Stat dose of 2.5mg to 5 mg SC or 5mg to 10mg/24 hours via CSCI.	£ £
Levomepromazine – for guidance when prescribing please contact specialist palliative care advice	Doses greater than 100mg/24 hours via CSCI should be given under specialist supervision	Stat dose of 12.5mg to 25 mg SC and 12.5mg to 50 mg over 24 hours via CSCI. Titrate dose according to response in increments of 12.5mg to maximum dose of 300mg/24 hours.	£££

SYMPTOM MANAGEMENT: RETAINED SECRETIONS IN THE TERMINAL PHASE

- Often occurs because patient is too weak to clear secretions
- Usually more distressing for carers than for patient.
- May respond to appropriate positioning (semi-recumbant)

Drug	Usual maximum dose for prescribing	Prescribed as	Costing
Glycopyrronium **First line**	1200micrograms/24 hours via CSCI	200micrograms SC up to three times daily, and 600micrograms to 1200micrograms over 24 hours via CSCI	££
Hyoscine hydrobromide **Second line**	2400micrograms/24 hours via CSCI	Stat dose of 600micrograms SC and 1200micrograms to 2400micrograms/24 hours via CSCI	£££
Hyoscine butylbromide **Third line**	120mg/24 hours via CSCI	Stat dose of 20mg and 60mg to 120mg/24 hours via CSCI	£
If possibility of heart failure consider furosemide 40mg stat			
Furosemide		20mg given as IM stat	£-££

ANTICIPATORY PRESCRIBING
Always prescribe one medication for each symptom 1 to 4 below, and if required prescribe for symptom 5

Anticpiatory medication is medication for palliative patients, prescribed and available for an in case of need or for when required i.e. in anticipation of expected symptoms to ensure timely management.

Readily available anticipatory medication can prevent inappropriate re-admissions at end of life/for palliative patients to secondary care. **It is especially important to ensure that these are available out of hours, weekends and public holidays. Authorisation or signature with the prescription should always be given enabling communtiy practitioners to administer the medication, and not delay care and impact on patient experience.**

Symptom	Drug	Subcutaneous PRN dose	Anticipatory/starting dose in syringe driver (via continuous subcutaneous infusion)
1. Pain For patients in renal failure seek specialist advice	Morphine sulphate **First line** Diamorphine **Second line**	2.5mg to 5mg 1 hourly 1/6th of total 24 hour subcutaneous opioid dose given 1 hourly 2.5mg to 5mg 1 hourly 1/6th of total 24 hour subcutaneous opioid dose given 1 hourly	For opioid naïve patients: 10mg to 20mg For patients already on oral opioids use conversion below For opioid naïve patients: 5mg to 10mg For patients already on oral opioids use conversion below
2. Nausea/ vomiting If effective anti-emetic already being used orally then this should be continued via CSCI	Cyclizine Haloperidol Levomepromazine	50mg TDS 1.5mg OD or BD, increased to maximum of 10mg per day 6.25mg to 25mg per day	150mg 3mg to 5mg 5mg to 25mg
3. Agitation	Midazolam Levomepromazine	2.5 to 5mg up to 1 hourly 12.5mg to 25mg TDS	10mg to 20mg 12.5mg to 25mg
4. Excessive secretions/noisy breathing	Hyoscine hydrobromide Glycopyrronium	Stat dose of 400micrograms 200micrograms stat	1.2mg to 2.4mg 0.6mg to 1.2mg
5. Fits/ convulsions For patients on oral anticonvulsants who become unable to swallow/ absorb them	Midazolam	5 to 10mg 1 hourly	20 to 40mg
Please ensure that water for injection 10mls x 10 ampules is prescribed when injectables are needed.			

For conversion of oral opioids to continuous subcutaneous opioids delivered via a syringe driver over 24 hours:
Oral morphine to subcutaneous morphine sulphate: divide total oral 24 hour dose by 2
Oral morphine to subcutaneous diamorphine: divide total oral 24 hour dose by 3
Oral oxycodone to subcutaneous oxycodone: divide total oral 24 hour dose by 2
For patients on fentanyl patches leave patch in situ and prescribe appropriate subcutaneous prn dose of opioid (for choice and dose of opioid see Palliative Care Formulary or seek specialist advice)

Equivalent Doses of Morphine and Related Opioids

Oral treatment					Parenteral treatment				Transdermal
Morphine			Oxycodone		Morphine		Diamorphine		Fentanyl
4 Hour immediate release tabs/liq e.g. Sevredol, Oramorph	12 Hour controlled release caps e.g. Zomorph	24 Hour controlled release caps e.g. MXL	4 to 6 Hour immediate release caps/liq e.g. Shortec caps, OxyNorm liquid 5mg/5ml	12 Hour modified release tabs e.g. Longtec tabs	4 Hour injection S/C, IM	Continuous infusion S/C	4 Hour injection S/C, IM	Continuous infusion S/C	72 Hour controlled release patch e.g. Matrifen or Fencino
Every 4 hours	**Every 12 hours**	**Every 24 hours**	**Every 4 to 6 hours**	**Every 12 hours**	**Every 4 hours**	**Over 24 hours**	**Every 4 hours**	**Over 24 hours**	**Every 72 hours**
5 mg	15 mg	30 mg	2.5 mg	5 mg - 10 mg	2.5 mg	15 mg	2 mg	10 mg	12 micrograms/h
10 mg	30 mg	60 mg	5 mg	10 mg – 15 mg	5 mg	30 mg	3 mg	20 mg	25 micrograms/h
15 mg	45 mg	90 mg	7.5 mg	20 mg	7.5 mg	45 mg	5 mg	30 mg	37 micrograms/h
20 mg	60 mg	120 mg	10 mg	30 mg	10 mg	60 mg	7 mg	40 mg	37 micrograms/h
30 mg	90 mg	180 mg	15 mg	40 mg	15 mg	90 mg	10 mg	60 mg	50 micrograms/h
40 mg	120 mg	240 mg	20 mg	60 mg	20 mg	120 mg	13 mg	80 mg	62 micrograms/h
50 mg	150 mg	300 mg	25 mg	70 mg	25 mg	150 mg	17 mg	100 mg	75 micrograms/h
60 mg	180 mg	360 mg	30 mg	90 mg	30 mg	180 mg	20 mg	120 mg	100 micrograms/h
80 mg	240 mg	480 mg	40 mg	120 mg	40 mg	240 mg	27 mg	160 mg	125 micrograms/h
100 mg	300 mg	600 mg	50 mg	150 mg	50 mg	300 mg	33 mg	200 mg	175 micrograms/h

Note 1: When opioids are prescribed prophylactic laxatives should be prescribed concurrently to treat constipation, eg: Senna, Docusate.
Note 2: When long acting preparations are used, always prescribe a short acting immediate release preparation equivalent to the four hourly dose for breakthrough pain.
Note 3: When starting opioid-based analgesia, nausea can occur for the first 7 – 10 days and an antiemetic may be required.
Note 4: Oxycodone and Diamorphine may be considered equivalent, on a mg for mg basis, when given as a continuous infusion in a syringe driver.
This chart is a guide only. For full details see individual data sheets.

Equivalent Doses of Morphine and Related Opioids

Oral treatment			Parenteral treatment			Additional information
Morphine			Morphine		Alfentanyl	
4 Hour immediate release tabs/liq e.g. Sevredol, Oramorph	12 Hour controlled release tabs e.g. MST, Zomorph	24 Hour controlled release caps e.g. MXL, Morcap SR	4 Hour injection S/C, IM	Continuous infusion S/C	Continuous infusion S/C	
Every 4 hours	**Every 12 hours**	**Every 24 hours**	**Every 4 hours**	**Over 24 hours**	**Over 24 hours**	
5 mg	15 mg	30 mg	2.5 mg	15 mg	1 mg	
10 mg	30 mg	60 mg	5 mg	30 mg	2 mg	
15 mg	45 mg	90 mg	7.5 mg	45 mg	3 mg	
20 mg	60 mg	120 mg	10 mg	60 mg	4 mg	
30 mg	90 mg	180 mg	15 mg	90 mg	6 mg	
40 mg	120 mg	240 mg	20 mg	120 mg	8 mg	
50 mg	150 mg	300 mg	25 mg	150 mg	10 mg	
60 mg	180 mg	360 mg	30 mg	180 mg	12 mg	
80 mg	240 mg	480 mg	40 mg	240 mg	16 mg	
100 mg	300 mg	600 mg	50 mg	300 mg	20 mg	

Oral Codeine and Oral Morphine

Oral Codeine may be considered to be 1/10 the potency of Oral Morphine e.g. 10mg oral codeine = 1mg oral Morphine (ratios of 1/8 & 1/6 have been quoted so further adjustments may need to be made within the 1st 24hours)

Tramadol

Equivalence varies:
Injection: 100mg Tramadol = 10mg Morphine
Oral: 50mg Tramadol = 5-10mg Morphine

Oral Transmucosal Fentanyl Preparations

e.g. sublingual tablets, buccal tablets
There are currently no defined conversion ratios and for this reason morphine/oxycodone are recommended for breakthrough pain when Fentanyl patches are being used.

Each of the oral transmucosal Fentanyl preparations need to be individually titrated according to manufacturers' recommendations.

Buprenorphine Patches

There may be difficulties in escalating doses and converting to other agents.
Transtec is a 96hr patch licensed for cancer pain
Butrans is a 7day patch licensed for non-malignant pain.

Alfentanyl

Alfentanil may be used if a patient has significant renal impairment. If this is the case, the as required opioid would be oxycodone rather than morphine.

Note 1: When opioids are prescribed prophylactic laxatives should be prescribed concurrently to treat constipation, eg: Senna, Docusate.
Note 2: When long acting preparations are used, always prescribe a short acting immediate release preparation equivalent to the plain release dose for breakthrough pain.
Note 3: When starting opioid-based analgesia, nausea can occur for the first 7 – 10 days and an antiemetic may be required.
Note 4: Oxycodone and Diamorphine may be considered equivalent, on a mg for mg basis, when given as a continuous infusion in a syringe driver.
This chart is a guide only. For full details see individual data sheets.

SYPMTOM MANAGEMENT: CONSTIPATION

- Use a combination of stimulant laxative with a softener/osmotic laxative.
- Titrate laxatives individually according to stool consistency (ease of defecation) rather than frequency – reference Bristol Stool Chart-Appendix 2
- Avoid lactulose. It can cause bloating and wind.
- If diarrhoea occurs as a result of laxative therapy, stop for 24 hours then recommence on dose level down.
- If co-danthramer rash develops in peri anal area, stop and replace with a faecal softener and a stimulant laxative.
- Bulk forming agents eg Fybogel are not effective in preventing opioid-induced constipation.

Type of constipation	Oral management tablets/capsules	Oral management syrups/ liquids	Rectal management	Comments
Rectum full, faeces soft	Senna 7.5mg 2 to 4 nocte £ Bisacodyl 5mg to 20mg nocte £ Co-Danthramer 25/200 1 to 3 nocte ££ Co-Danthramer strong 37.5/500 1 to 3 nocte ££	Senna 7.5mg/5ml syrup 10ml to 20ml nocte £ Co-danthramer 25/200 in 5ml suspension 5ml to 10ml nocte £££ Co-danthramer 75/1000 in 5ml strong suspension 5ml nocte £££	Bisacodyl 10mg suppository 1 OM ££	Danthron stains urine red and can cause perianal irritation. Do not use in patients with faecal or urinary incontinence
Rectum full, faeces hard	Docusate Sodium up to 500 mg daily in divided doses £-££	Docusate Sodium 50mg/5ml up to 500mg daily Laxido (macrogol oral powder) 1-6 sachets/day £-££	Glycerol suppositories Phosphate enema	
Colon full, with colic	Docusate Sodium up to 500 mg daily in divided doses £-££	Docusate Sodium 50mg/5ml up to 600mg daily ££ Laxido (macrogol oral powder) 1-6 sachets/day £-££		
Colon full, with no colic	Co-Danthramer 25/200 1 to 3 nocte ££ Co-Danthramer strong 37.5/500 1 to 3 nocte ££	Co-danthramer 25/200 in 5ml suspension 5ml to 10ml nocte £££ Co-danthramer 75/1000 in 5ml strong suspension 5ml nocte £££ Laxido (macrogol oral powder) 1-6 sachets/day £-££	Bisacodyl 10mg suppository 1 OM ££	

DIARRHOEA

1. Loperamide 2 mg after each stool can increase from 2 mg QDS to 4mg QDS.
2. Consider codeine 30mg to 60 mg QDS if ineffective.
3. Use combination of Loperamide and Codeine.
4. Consider octreotide to reduce high output diarrhoea 300micrograms to 1000 micrograms/24 hours by continuous subcutaneous infusion or 100micrograms to 300micrograms TDS by SC injection. A depot preparation of octreotide or lanreotide may be considered following specialist initiation/recommendation for patients requiring medium to long term octreotide.
5. Steatorrhea/fat malabsorption requires pancreatic enzymes plus proton pump inhibitor.

CARE OF THE DYING: Terminal phase patient management
Recognition of the terminal phase

- Increasing weakness and immobility
- Loss of interest in food and fluid
- Difficulty in swallowing
- Often develops over days to weeks
- Potentially reversible causes have been excluded or deemed untreatable

Review of hydration and nutrition

- offer oral fluid as tolerated
- consider if there is any need for clinically assisted hydration
- offer oral nutrition as tolerated; risk/ comfort feeding is acceptable
- consider any need for clinically assisted nutrition

Principles of symptom control in the terminal phase

- rationalise regular medication-can/should anything be stopped?
- anticipate the route of drug administration-does parenteral medication need to be used/available?
- ensure that drugs currently maintaining good symptom control by the oral route are available via the subcutaneous/transdermal route so that they can be used if the patient becomes unable to swallow
- ensure the availability of drugs for new symptoms that may arise - including drugs that can be used even if the patient is unable to swallow review regularly

SYMPTOM MANAGEMENT OTHER:
There are a number of other common symptoms that can occur and require management. This guidance is intended to provide guidance and advice for the management of more usual symptoms.

For guidance in managing other signs and symptoms the specialist palliative care team can be contacted for advice or you can contact OneResponse (SAAS – 01268 526259)

Hypercalcaemia signs and symptoms:		
Mild (calcium <3.0)	**Moderate(calcium 3.0-4.0)**	**Severe (calcium .4.0)**
Lethargy	Fatigue	Dehydration
Weakness	Nausea and vomiting	Confusion
	Lethargy	Ileus
	Polyuria and polydipsia	Drowsiness
	Anorexia	Coma
	Weakness	Neurological deficits
	Constipation	Cardiac arrhythmias

Spinal cord compression:	
Symptoms	**Signs**
Back pain (early) >80 Local bone pain Root compression pain Radicular pain, worse on Coughing	Bony tenderness

Altered sensation >50% • Numbness • Pins and needles	Brisk reflexes
Weakness 75%	Upgoing plantars
Sphincter disturbance (late) 40 • Urinary retention • Constipation	Urinary retention
	Sensory level
	Loss of saddle sensation (late)

Superior Vena Cava Obstruction (SVCO)	
Symptoms	Signs
Dyspnoea	**Tachypnoea**
Headache	**Suffused injected conjunctivae**
Dizziness	**Cyanosis**
Syncope	**Distended non pulsatile neck veins**
Visual changes	Dilated collateral superficial veins of upper chest
Swelling * Facial (esp.peri-orbital * Neck * Arms and hands	**Oedema** Facial and peri-orbital * Neck * Arms and hands

Cause of cough
Infection
Lung Tumour
Lymphangitis
LVF / Pulmonary oedema
Asthma / Bronchospasm
Oesophageal reflux
Aspiration
Pleural effusion
Radiotherapy induced pulmonary fibrosis pneumonitis

Bowel obstruction
Ascertain the likely site of obstruction based on clinical history and examination i.e. gastroduodenal junction, small bowel or large bowel. Are there likely to be multiple sites of obstruction? e.g. in history of previous abdominal irradiation or surgery. Is the patient fit for surgery? Remember that bowel obstruction may not be related to the patients known cancer and that a surgical opinion should be considered.

Hiccups
Hiccup is characterised by diaphragmatic spasm. Persistent hiccups can be a source of significant distress for patients and has the potential to interfere with normal daily activities of talking, dietary intake and sleeping.

Haemorrhage and management
In a patient already close to death, occurrence of a severe haemorrhage is often a terminal event and resuscitation measures are not appropriate. Such a haemorrhage is perhaps one of

the most dreaded of all terminal events and, if witnessed, can be extremely distressing to all involved. The goal of management of the event must be to minimise anxiety and ensure death with dignity, providing a calm reassuring atmosphere

Guidelines for the event at home

It is important that the following equipment is available in the event of a severe haemorrhage at home. They should be stored discreetly but be readily available and accessible

- Gloves and apron
- Green/blue or old dark towels
- Suction as appropriate
- Yellow waste bags

Breathlessness

Palliative Oxygen Therapy-POT (GPs can initiate oxygen (usually LTOT) in palliative care)

The recommendations BTS make are as follows:

- Patients with cancer or end stage respiratory or cardiac disease with intractable breathlessness **should not** receive oxygen therapy if their SpO2 levels are >92%
- These patients should be reviewed and receive an assessment for a trial of medication (guidance can also be sought from the specialist palliative care team)

The following can be useful where there is an element of anxiety or panic in a patient who is breathless.

- Lorazepam 0.5mg- 2mg sublingual prn
- Diazepam 2-5mg PO bd-tds +/- prn
- Midazolam 2.5-10mg SC prn

For specialist palliative care advice the following can be contacted:

Hospital Specialist Palliative Care Teams

Basildon Hospital	extension 4740 (hospital switchboard 01268 524900)
Monday-Sunday	9am –5pm

Community Support for Palliative Care:

SAAS OneResponse	01268 526259

Hospice contacts

Saint Francis Hospice, Romford	01708 753319
St Luke's Hospice, Basildon	01268 524973

Appendix 1:

Name:

Date of Birth:

MNM Number:

NHS Number:

(or affix hospital label here)

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the patient / service user, score questions 1 to 6.

Name of person completing the scale

Signature:..... **Print Name:** .....

Date: .....**Time:** .....

Latest pain relief given was ..... **at** .....**hrs**

Q1 Vocalisation **Q1** ☐
eg Whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3

Q2 Facial expression **Q2** ☐
eg looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3

Q3 Change in body language **Q3** ☐
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3

Q4 Behavioural Change **Q4** ☐
eg increased confusion, refusing to eat, alteration in usual pattern
Absent 0 Mild 1 Moderate 2 Severe 3

Q5 Physiological change **Q5** ☐
eg temperature, pulse or blood pressure outside normal limits
Absent 0 Mild 1 Moderate 2 Severe 3

Q6 Physical changes **Q6** ☐
eg skin tears, pressure areas, arthritis contractures, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 – 6 and record here ⇨ **Total Pain Score** ☐

Now tick the box that matches the Total Pain Score ⇨

0 – 2 No Pain	3 – 7 Mild	8 – 13 Moderate	14 + Severe

Finally, tick the box which matches the type of pain ⇨

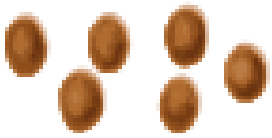
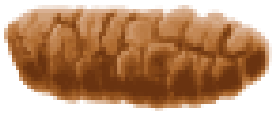
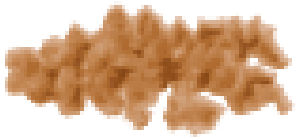
Chronic	Acute	Acute on Chronic

File in the nursing records section of the patients health record Order Code: IE887	Time ▶					
Q1 Vocalisation						

Absent	0					
Mild	1					
Moderate	2					
Severe	3					
Q2 Facial expression						
Absent	0					
Mild	1					
Moderate	2					
Severe	3					
Q3 Change in body language						
Absent	0					
Mild	1					
Moderate	2					
Severe	3					
Q4 Behavioural Change						
Absent	0					
Mild	1					
Moderate	2					
Severe	3					
Q5 Physiological change						
Absent	0					
Mild	1					
Moderate	2					
Severe	3					
Q6 Physical changes						
Absent	0					
Mild	1					
Moderate	2					
Severe	3					
Add scores for 1 – 6. This is the Total Pain Score - record here						
Now Tick the box that matches the Total Pain Score						
No Pain	0 - 2					
Mild	3 - 7					
Moderate	8 - 13					
Severe	14 +					
Finally, tick the box which matches the type of pain						
Chronic						
Acute						
Acute on Chronic						
	SIGNATURE					

Appendix 2:

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid