GUIDELINES FOR USE OF MEDICATION FOR SYMPTOM CONTROL IN PALLIATIVE CARE
DEPARTMENT OF ELDERLY MEDICINE

After the initial assessment by the clerking doctor regular drugs are prescribed for the presenting symptoms. In addition drugs are prescribed on the prn chart for analgesia, nausea, vomiting, anxiety, agitation and increased secretions to be used if these symptoms occur or get worse. They should be prescribed with an indication for their use and a frequency.

1. Nausea and Vomiting

For non-specific nausea use Haloperidol as a 1-3mg SC or 1.5 mg oral stat dose tds or 5-10mg over 24hrs in a syringe driver for persisting symptoms.
For nausea or vomiting caused by specific reasons such as poor gastric emptying or raised intracranial pressure refer to the flow chart (Encl 1).

2. Shortness of Breath (SOB)

Oramorph 2mg 4hrly is used initially.
If 2mg is not effective or patient has pain as well use 5mg 4hrly.
If patient is unable to swallow give 2.5mg diamorphine SC stat and a syringe driver with 10mg Diamorphine over 24hrs.
Patients with heart failure may only need a dose at night.

3. Increased Secretions

Use Hyoscine Hydrobromide stat dose 400 mcgms SC, maximum dose is 2.4mg over 24 hrs.
For continuing symptoms a syringe driver should be set up with 2.4 mg over 24 hrs .
If sedation of the patient is undesirable use SC Glycopyrronium : stat dose 200mcgms, 24 hr syringe driver dose 1.2mg.

4. Terminal Agitation

See agitation flow chart (Encl 2).

5. Pain

Take a pain history.
For simple headache, bone and joint pain, or non-colicky abdominal pain, use Paracetamol 1gm qds.
For a new undiagnosed pain ask the doctor to review the patient.
Bone, joint pain or liver capsule pain may need NSAIDs, eg Diclofenac MR 75mg bd.
Colicky abdominal pain may need Hyoscine Butylbromide or bowel care.
Nerve pain : consider Amitriptyline, Valproate or Gabapentin (Consultant signature).
Headache from cerebral metastases may respond to Dexamethasone.

For ongoing pain give analgesics regularly by the clock.
If Paracetamol is not effective use combined mild opiate and Paracetamol tablets eg Co-codamol 8/500 ii qds, Co-dydramol or Co-codamol 30/500 ii qds.

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For continual diagnosed pain not responding to non-opiates or mild opiates use 4hrly Oramorph at a dose of 5mg after Paracetamol or 10mg after mild opiates.

Convert to 12hrly MR oral Morphine when the dose is stable by dividing the 24hr total Morphine dose into bd dosage.

If the patient cannot swallow, is vomiting, or is too sleepy to take oral analgesics, use SC Diamorphine. The stat dose is 1/3 of the oral stat Morphine dose. The 24hr syringe driver dose is 1/3 of the total 24hr oral Morphine dose or the total SC Diamorphine dose.

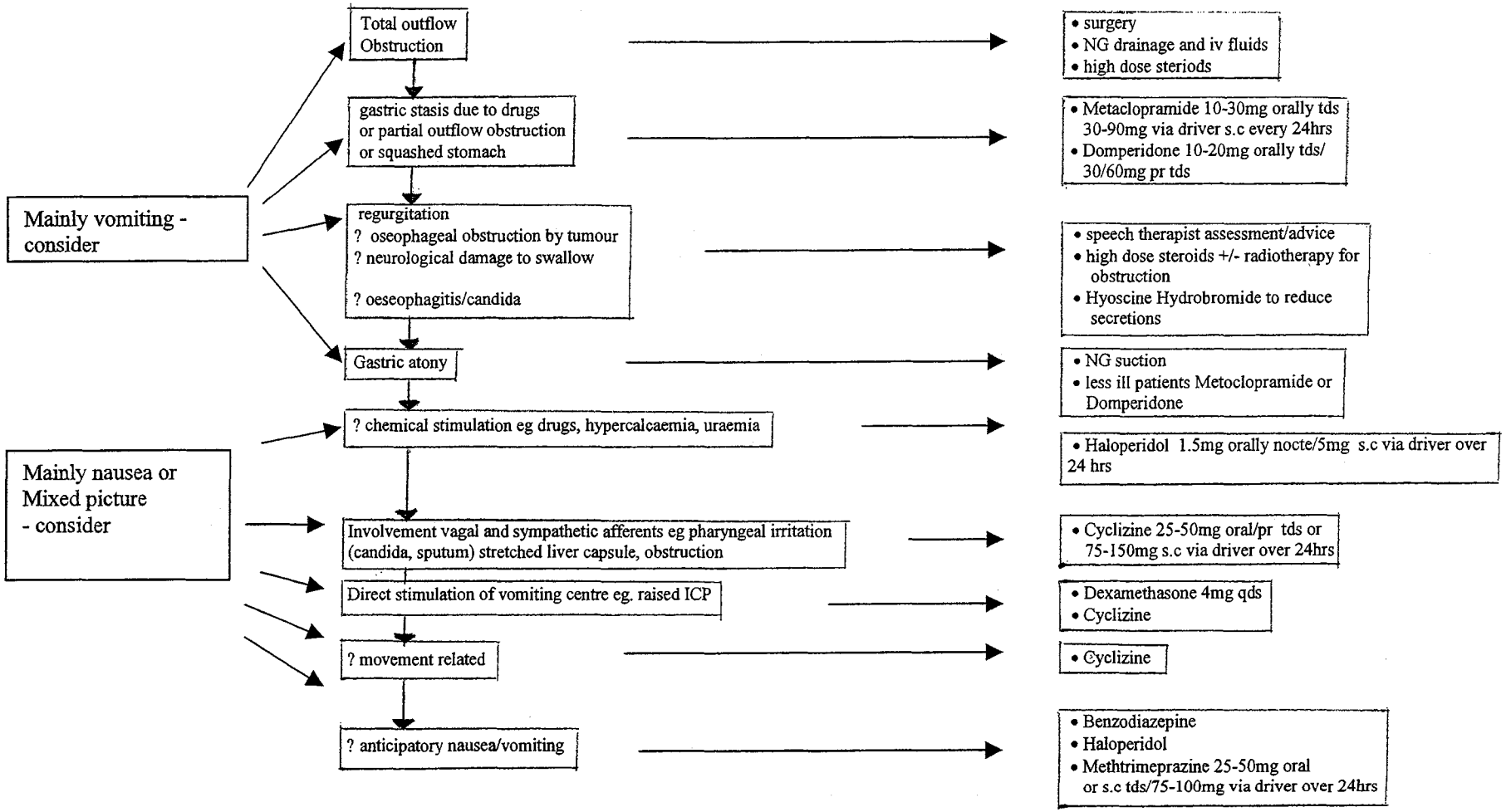
In a patient who has not previously used Morphine start with 10-15mg Diamorphine in a syringe driver over 24hrs depending on patient weight and pain severity.

For breakthrough pain see flow chart (Encl 3).

After 24hrs regular analgesia the Morphine dose will need reviewing by adding all the 24hr Morphine needed and dividing by 6 to give the new regular 4hrly dose.
The prn dose will need to be adjusted by the doctor if the regular dose increase ≤ .

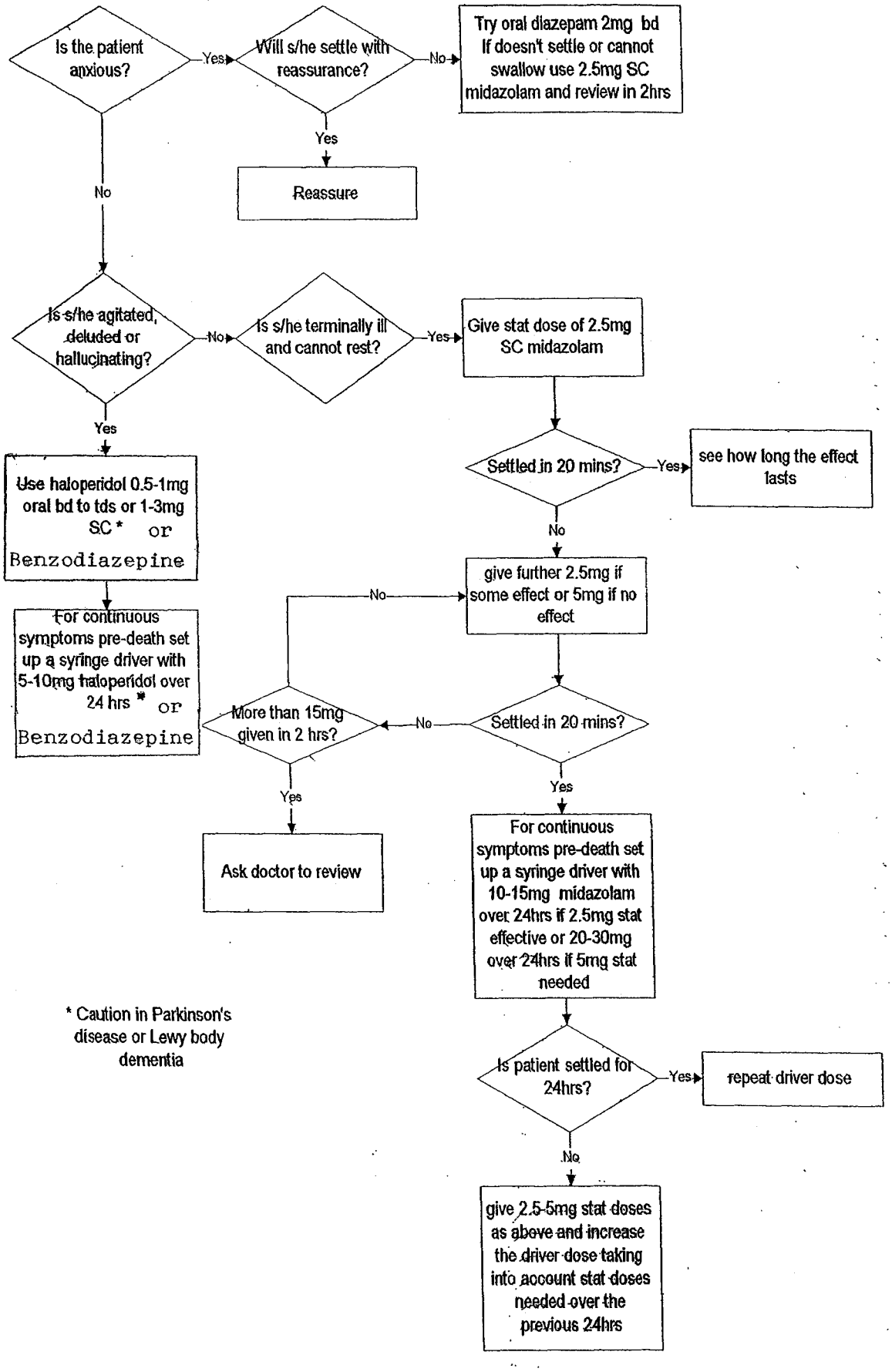
Enclosure 1

MANAGEMENT OF NAUSEA AND VOMITING



Enclosure 2

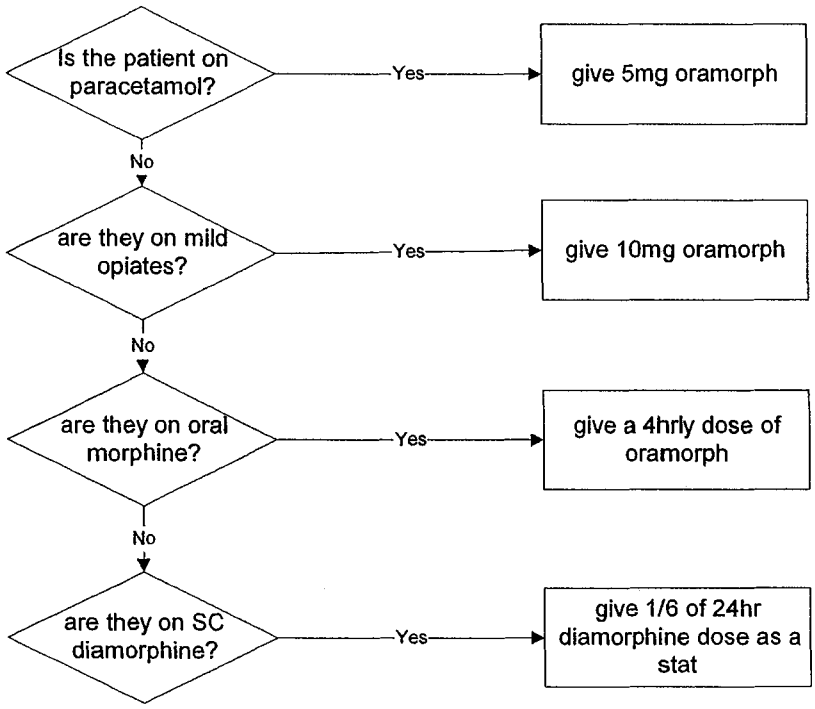
Palliative care agitation flow-chart



* Caution in Parkinson's disease or Lewy body dementia

Enclosure 3

Flow Chart For Breakthrough Pain (before the next regular dose is due)



For all patients: review pain after 1/2 hr.