From: Robinson, Dr T.G. Code A
Sent: 30 April 2003 12:00
To: Baker, Prof R.
Subject: RE: review in a community hospital

Richard

Sorry for the delay in replying.

Regarding stroke patients:
- A role for palliative care in the management of terminal severe stroke patients is increasingly recognised clinically, though the current RCP guidelines for stroke do not offer any specific (or evidence-based guidance). Please note that I have not attempted to define severe stroke here, but this is very important and obviously relates to identification of recognised poor prognostic features, life expectancy, rehabilitation potential, stated premorbid wishes, quality of life, co-morbidities, and full and frank discussion between members of the MDT and family/ carers. I am sure that an important question to ask will be 'what was meant by severe stroke?'.
- However, we have very little use for opiates in such patients. This is usually because of the reduction of sc/ iv fluids (in consultation with the MDT and family/ carers) which as you know increases endogenous opiate and ketone production with associated analgesic and anaesthetic effects. (See Ethics of Artificial Hydration, National Council for Hospice and Specialist Palliative Care Services, 1999). Removal of iv/ sc fluids is rarely used, and as you know the legal basis is not firmly established for stroke patients. In consultation with the palliative care team, we may occassionally use a sc low-dose haloperidol regime to avoid agitation, which is often very distressing.

Regarding other (non-cancer) patients:
- I am really no authority on this but again my own clinical experience is that I have rarely used opiates in such situations. I would like to think that distress and pain has been relieved by other measures (appropriate use/ disuse of fluids as above, nursing care, communication, haloperidol, etc), and that such patients under my care have not died in pain.
- Again the Palliative Care Services are increasingly helpful recognising they have a role for non-cancer patients as well.
- I am unsure if there is any specific guidelines that the palliative care services work to, but it may be worth asking Caroline Cooke (the LOROS consultant covering the LGH who is very helpful).
- Again regarding dementia, it may be sensible to seek James Lindesay's opinion, as you know he is also very active in Alzheimer Disease Society and they may have some guidance.

I am not sure how helpful these comments are. I suspect, as is often the case when issues are sensitive and national guidelines are lacking, that you may receive different answers from different people. You may also find that others have a more 'liberal' use of opiate for the relief of perceived pain in the management of the pre-terminal patient - I am not sure if this is right or wrong but it would not represent the practise of my colleagues or myself on the Stroke Unit here.

Best wishes

Tom

-----Original Message-----
From: Baker, Prof R. [mailto: Code A
Sent: 29 April 2003 16:35
To: Tom Robinson (E-mail)
Subject: review in a community hospital

Tom

I am continuing this investigation, and have just completed a review of 81 records. Can you advise me? In elderly patients who have severe strokes or other advanced disease in old age, is it generally accepted that opiates might be administered in the last few days of life? It would be really helpful to have reference to either research or guidelines on this issue. I need evidence on usual policy on use of opiates in older people with advanced conditions with comorbidities, although not necessarily painful conditions such as cancer. Some of these patients will have dementia.

Richard Baker

Code A