SYMPTOM CONTROL

GUIDELINES

PRINCIPLES OF MANAGEMENT

These guidelines have been developed for the use of health care professionals in the Hospital setting.

The principles are applicable to the care of patients dying from cancer and non malignant disease.

RECOGNISE THAT DEATH IS APPROACHING

Studies have found that dying patients will manifest some or all of the following:

- Profound weakness - usually bedbound
- Drowsy or reduced cognition - semi-comatose
- Diminished intake of food and fluids - only able to take sips of fluid
- Difficulty in swallowing medications - no longer able to take tablets

TREATMENT OF SYMPTOMS

The prime aim of all treatment at this stage is the control of symptoms current and potential.

Many medications which until now have been regarded as essential, can and should be discontinued, e.g.

anti-hypertensives
replacement hormones
vitamin supplements
iron preparations
hypoglycaemics
long term antibiotics
anti-arrhythmics
diuretics
steroids

ONLY MEDICATIONS WHICH WILL CONTROL OR PREVENT DISTRESSING SYMPTOMS SHOULD BE USED AT THIS TIME

The most common reported symptoms are:-

- Pain
- Nausea / Vomiting
- Agitation / Restlessness
- Excessive secretions / Noisy breathing

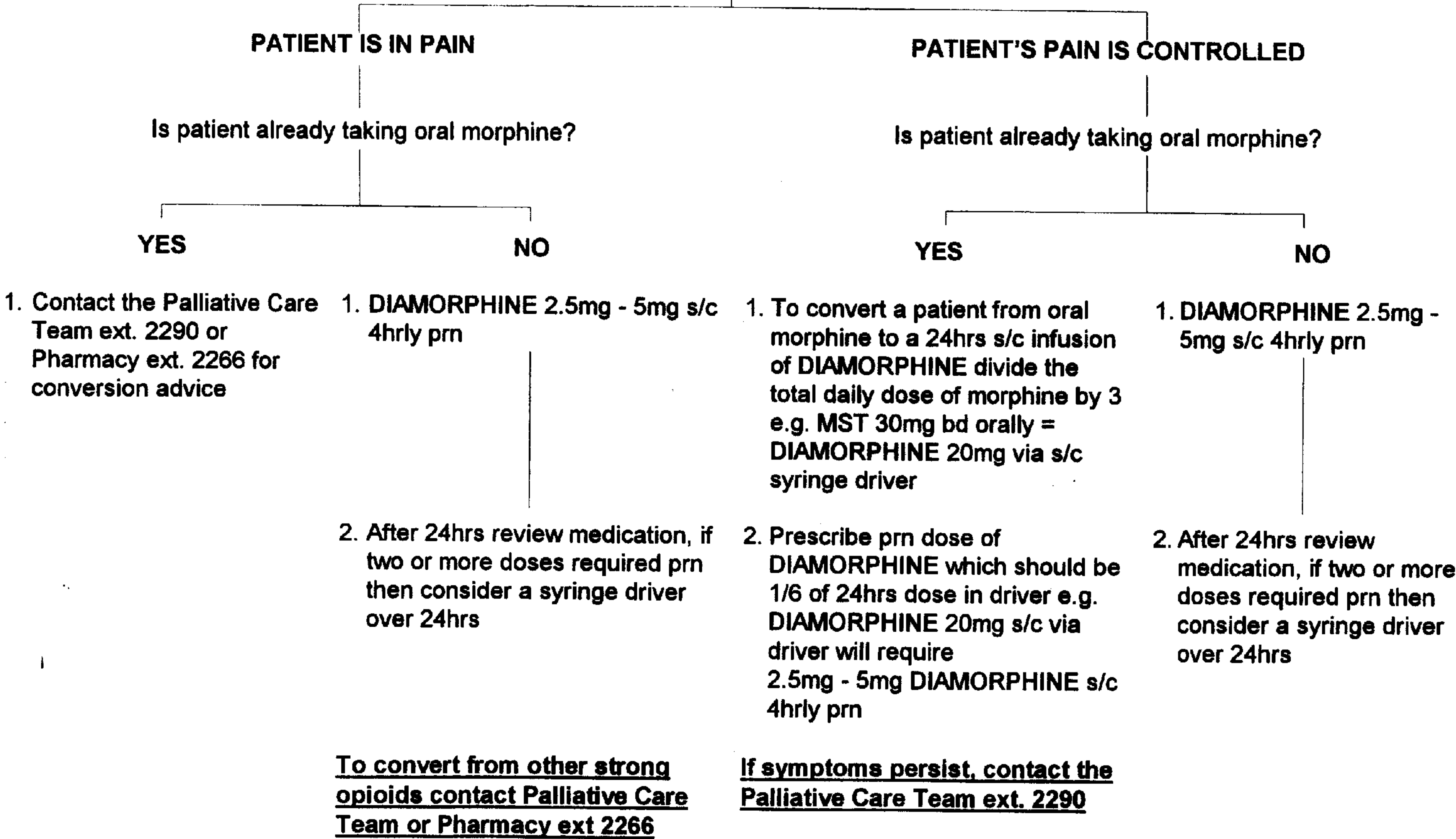
The algorithms attached will support you in your management of these symptoms.

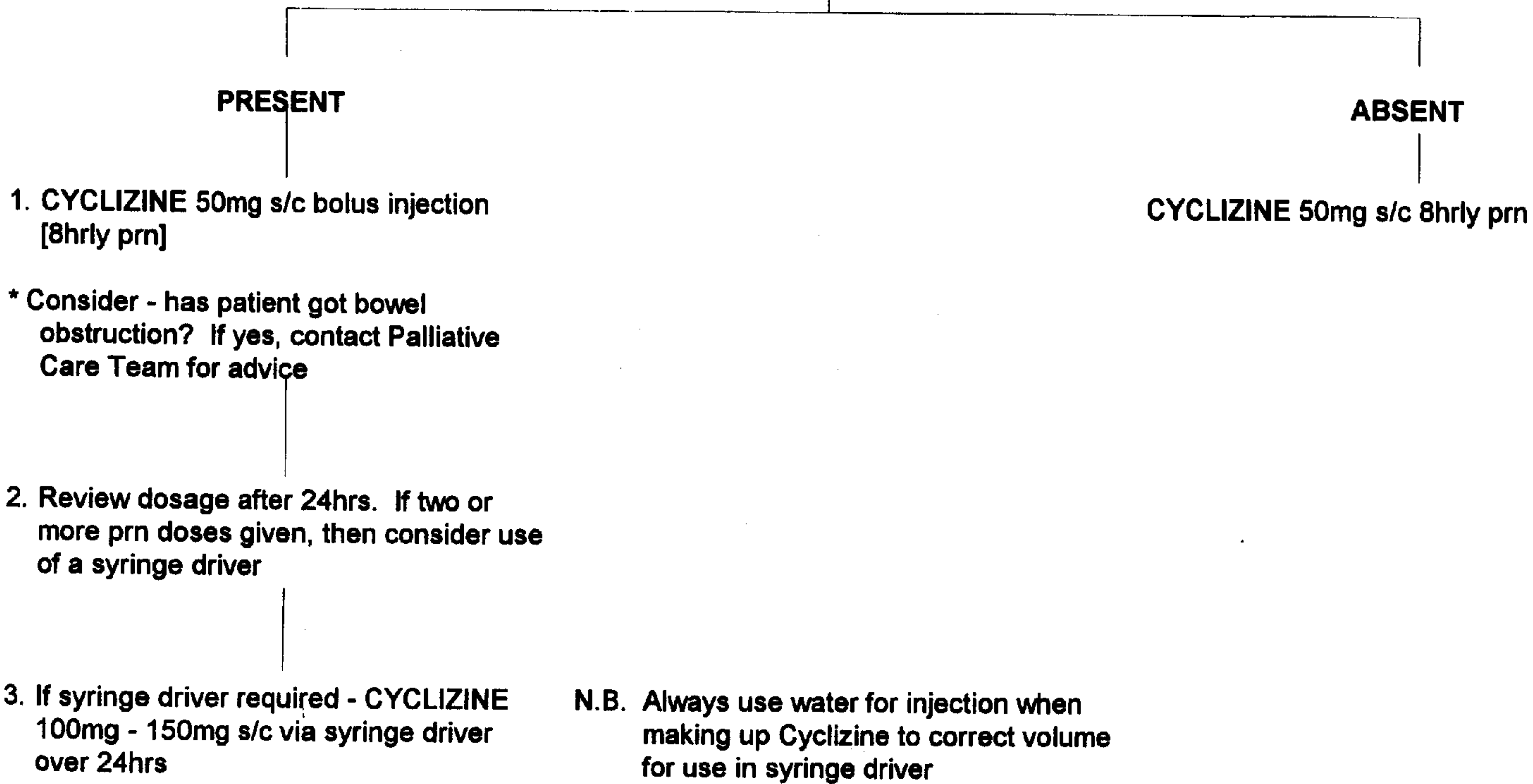
All patients who are dying will have subcutaneous medication prescribed should any of these listed symptoms develop.

All medication needs must be reviewed after 24hrs. If two or more doses of prn medication have been required, then consider the use of a syringe driver (see Syringe Driver Guideline Booklet).

If a syringe driver is required, please obtain one via equipment library (ext. 2603) Not every patient who is dying will require a continuous subcutaneous infusion.

FOR ADVICE AND SUPPORT PLEASE CONTACT THE PALLIATIVE CARE TEAM (ext. 2290) OR PHARMACY (ext. 2266).


PAIN
PATIENT IS IN PAIN
Is patient already taking oral morphine?
YES
NO
1. Contact the Palliative Care Team ext. 2290 or Pharmacy ext. 2266 for conversion advice
1. DIAMORPHINE 2.5mg - 5mg s/c 4hrly prn
2. After 24hrs review medication, if two or more doses required prn then consider a syringe driver over 24hrs
To convert from other strong opioids contact Palliative Care Team or Pharmacy ext 2266
PATIENT'S PAIN IS CONTROLLED
Is patient already taking oral morphine?
YES
NO
1. To convert a patient from oral morphine to a 24hrs s/c infusion of DIAMORPHINE divide the total daily dose of morphine by 3 e.g. MST 30mg bd orally = DIAMORPHINE 20mg via s/c syringe driver
2. Prescribe prn dose of DIAMORPHINE which should be 1/6 of 24hrs dose in driver e.g. DIAMORPHINE 20mg s/c via driver will require 2.5mg - 5mg DIAMORPHINE s/c 4hrly prn
1. DIAMORPHINE 2.5mg - 5mg s/c 4hrly prn
2. After 24hrs review medication, if two or more doses required prn then consider a syringe driver over 24hrs
If symptoms persist, contact the Palliative Care Team ext. 2290



If symptoms persist contact the Palliative Care Team, ext. 2290

RESPIRATORY TRACT SECRETIONS

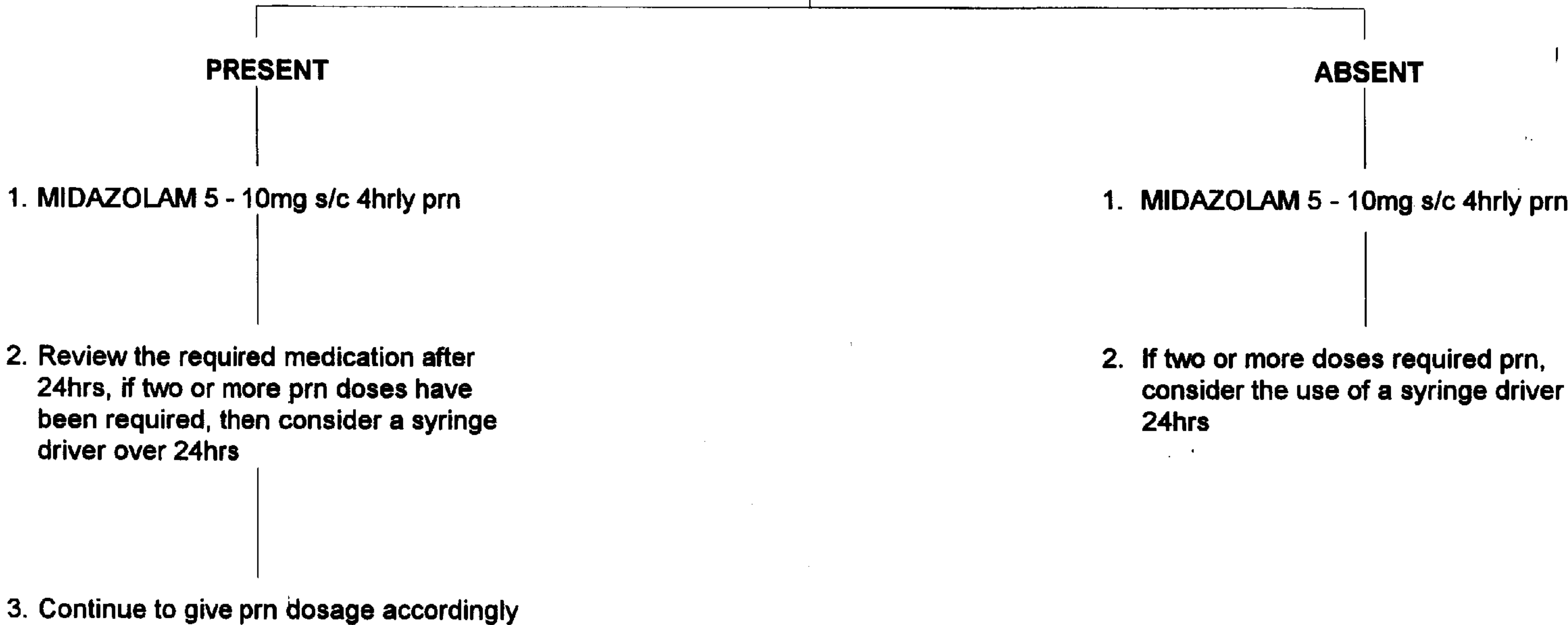
PRESENT

1. **HYOSCINE HYDROBROMIDE 0.4mg s/c bolus injection stat. Commence a syringe driver 1.2mg over 24hrs**
2. **Continue to give prn dosage (0.4mg) accordingly**
3. **Increase total 24hrs dose to 2.4mg after 24hrs if symptoms persist**

ABSENT

1. **HYOSCINE HYDROBROMIDE 0.4mg s/c 4hrly prn**
2. **If two or more doses of prn HYOSCINE HYDROBROMIDE required, then consider a syringe driver s/c over 24hrs**

If symptoms persist contact the Palliative Care Team ext. 2290



TERMINAL RESTLESSNESS AND AGITATION

PRESENT

1. MIDAZOLAM 5 - 10mg s/c 4hrly prn
2. Review the required medication after 24hrs, if two or more prn doses have been required, then consider a syringe driver over 24hrs
3. Continue to give prn dosage accordingly

ABSENT

1. MIDAZOLAM 5 - 10mg s/c 4hrly prn
2. If two or more doses required prn, consider the use of a syringe driver over 24hrs

If symptoms persist contact the Palliative Care Team ext. 2290

CHOICE OF DRUGS FOR USE IN SYRINGE DRIVERS (USUAL DOSE RANGES QUOTED)

DIAMORPHINE N.B. Parenteral Diamorphine is 3 x stronger than oral morphine. If pain not controlled, increase dose by 30% to 50%

DRUG	USE	DOSE
CYCLIZINE (Antihistamine) 50 mg/ml injection	Broad spectrum antiemetic, centrally acting on vomiting centre Mix only with water	50 to 150 mg per 24hrs
HALOPERIDOL (Neuroleptic) 5 mg/ ml injection	Antiemetic - dose 2.5-10 mg over 24hrs Anxiolytic Control of hallucinations - 5-30 mg over 24hrs Caution in terminal restlessness with twitching - lowers seizure threshold	Usually 5mg per 24hrs
METOCLOPRAMIDE 10 mg in 2ml injection	Antiemetic (1) prokinetic (accelerates GI transit) (2) centrally acting on chemo-receptor trigger zone (CTZ), blocking transmission to vomiting centre (crystallisation may occur with Cyclizine, discard if injection discolours)	20 to 40mg per 24hrs
METHOTRIMEPRAZINE/ LEVOMEPROMAZINE (NOZINAN) (Phenothiazine) 25 mg/ml injection	Broad spectrum antiemetic, works on CTZ and vomiting centre (at lower doses) sedative (terminal agitation) ? analgesic effects	25 to 100mg per 24hrs
MIDAZOLAM (HYPNOVEL) (Benzodiazepine) 10 mg in 2ml	Sedative/anxiolytic (terminal agitation), anticonvulsant, muscle relaxant, controls myclonus	10 to 60mg per 24hrs
HYOSCINE HYDROBROMIDE (SCOPOLAMINE) (Antimuscarinic)	Antisecretory properties antiemetic, acts centrally on vomiting centre, anti spasmodic	0.4 to 1.8mg per 24hrs

CAUTION Mixing drugs in Syringe Drivers (Drug Information - ext 2394 for further info)

All of the above drugs are compatible with each other. It is advisable not to mix more than two drugs in one syringe. Please note certain other drugs may not be compatible and should not be mixed together in one syringe. Drugs not recommended for subcutaneous use are Diazepam, Chlorpromazine and Prochlorperazine because they cause skin irritation. Haloperidol may precipitate if concentration is > 2 mg 1ml in presence of Diamorphine. Cyclizine and Diamorphine may precipitate if Cyclizine concentration > 10 mg 1ml or if the concentration of either drug > 25 mg 1ml.

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