Palliative care and crisis medications

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Crisis medications in palliative care

Dr Jessica Borbasi chats to James Edwards about palliative medicine. You will learn more about the role of palliative care and crisis medications for end of life care. We will discuss the Clinical Excellence Commission's guidelines on the prescribing of anticipatory medicines for symptoms experienced in the last days of life. Are you aware of any contraindications? Is there a role for subcutaneous fluids? We will also go through an example case to put this all into perspective.

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About Dr Jessica Borbasi

Dr Jessica Borbasi is an Advance Trainee in Palliative Medicine. After completing her basic physicians training she took a year off to work at a think tank, the Centre for Independent Studies. She is the author of "Life Before Death: improving palliative care for older Australians" and is passionate about educating doctors and the public about the true nature of palliative medicine, particularly its ability to improve living not just dying.

Palliative care & crisis medications

With Dr Jessica Borbasi, Advanced Trainee in Palliative Care Medicine at Greenwich Hospital, New South Wales, Australia

Introduction

Palliative care is about end of life care. Its focus is on enabling people to live better with chronic or terminal illnesses in the period before they die. A landmark trial in palliative care medicine demonstrated that those patients with metastatic lung cancer who received early referral to palliative care had a better quality of life and lived longer.

Case

An 89-year-old man has come to the wards from ED diagnosed with sepsis and metastatic lung disease. He has a fever, tachypnoea and back pain and has been started on IV antibiotics, but no NFR form completed. His recent CT shows metastatic spread to the spine and liver. Upon review, he is refusing any tests and is agitated, removing his nasal prongs. He is competent, understands his

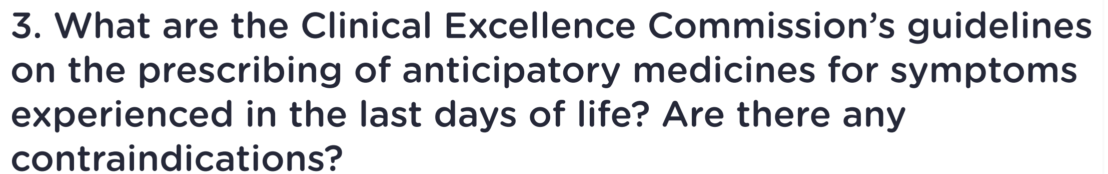
diagnosis and requests to be kept comfortable. His family members and the admitting team are in consensus.

1. What is the role of the palliative care service in this instance?

- Ideally, this man would already be known to the palliative care team, in which case he would have an Advanced Care Directive (ACD) in place
- Symptomatic relief should be provided before the palliative care team arrives
- Establishing and acknowledging the patient's goals (for example being kept comfortable, rather than prolonging life)is important
    - A frank discussion to clarify what components of care a patient does and does not want can be therapeutic for the patient
    - NB: Avoid the phrase 'ceiling of care'. The phrase is a misnomer and gives the impression that beyond a certain point, we no longer care
- Reassure the patient that you do everything to ensure they are pain-free and dignified in the end of life

2. What is the role of medication?

- Treating symptoms is imperative and medications have a role in this but are not always necessary
- Medications must be individualised and have very clear indications
- A butterfly should be inserted for subcutaneous medications
    - Oral and IV medications are not needed so IVCs can be removed
- Communicate with the patient's family – the objective of medications is to relieve suffering, not hasten demise
- Anticipatory prescribing (ordering medications ahead of time) is done to avoid unnecessary suffering
    - Prescribe fixed doses (not ranges) with clear indications
    - Prescribe the whole list (below) of medications together – patients who have the whole list charted are more likely to receive medications and have their suffering relieved
- Anticipatory medications are prescribed for patients who are dying and in the terminal phase (unresponsive, with hours or days to live) and patients deteriorating and expected to soon be in the terminal phase
- Crisis medications are different – there is no consensus on which medications and doses to prescribe in certain crises which occur in palliative care (e.g. massive haemorrhage)
    - In these instances, be with the patient to reassure them; they may die imminently and having someone present to reassure them is preferable to dying alone



3. What are the Clinical Excellence Commission's guidelines on the prescribing of anticipatory medicines for symptoms experienced in the last days of life? Are there any contraindications?

- Morphine 2.5mg subcut q1hrly, max: 6 PRN doses = 15mg / 24hr (in an opioid naïve patient with normal renal function)
    - Indication: pain and/or breathlessness
        - There is no evidence that prescribing opioids appropriately in end of life hastens death
        - Consider age – more conservative doses with increasing age
        - Seek help before changing oral opioids to regular subcut doses to ensure adequate analgesia
        - The metabolites of morphine are renally excreted so using morphine in renal impairment can lead to accumulation of metabolites and opioid toxicity
        - Instead, use (cautiously) hydromorphone – it is 5x more potent than morphine and often associated with medication errors
- Midazolam 2.5mg subcut q2hrly, max: 6 PRN doses = 15mg / 24hr
    - Indication: agitation, terminal restlessness and anxiety (which leads to breathlessness)
    - If a patient has anxiety, rather than needing sedation, consider lorazepam instead
- Metoclopramide 10mg subcut q8hrly, max: 3 PRN doses = 30mg / 24hr
    - Indication: nausea and vomiting (1st line)
    - Contraindications: suspected bowel obstruction, Parkinson's Disease, Lewy Body Dementia
    - Observe for extrapyramidal side effects (e.g. parkinsonism – tremor, rigidity, bradykinesia)
- Haloperidol 1mg q4hrly, max: 3 PRN doses = 3mg / 24hr
    - Indication: nausea and vomiting (2nd line), preferred in renal impairment
    - Contraindications: Parkinson's Disease, Lewy Body Dementia
    - Observe for extrapyramidal side effects (e.g. parkinsonism – tremor, rigidity, bradykinesia)
    - Alternatives to metoclopramide and haloperidol include ondansetron and cyclizine
- Glycopyrrolate is no longer used for terminal (respiratory tract) secretions
    - Limited evidence to support use of anticholinergics in drying terminal secretions

    - The 'death rattle' does not cause distress to the patient but may cause the family to be anxious
    - Educate nursing staff and families
    - Talk to nursing staff about position changes every 4 hours, which can relieve the noise
    - Consider playing music in the background
- Have a good working relationship with nursing staff – they administer PRN medications and spend the most time with patients
    - Frequently assess the adequacy of the medication doses by asking nursing staff for feedback (e.g. Did it make a difference to their grimacing?) and have a low threshold for increasing them

4. Is there a role for subcutaneous fluids?

- Reduced oral intake may prompt concerns about dehydration
- However, when a patient's terminal illness is so advanced that they have stopped eating and drinking, it is usually because they are now unable to process oral intake
- At this level of metabolism, their bodies do not have the same fluid and nutritional requirements we do
- A randomised controlled trial (RCT) of hospice patients in 2013 showed that patients who received 1L of fluid a day compared to placebo did not have better symptomatic control, quality of life or survival than placebo
- Unnecessary fluids can be harmful – consider risks of cerebral oedema, gastric distension and APO
- It is, however, common for patients to develop a dry mouth and mouth care is imperative for relieving this
    - Use aqua spray as much as necessary and paw paw ointment on the lips

Take home messages

- Good palliative care adopts a team approach
    - Communicate well with nurses – they are in the best position to assess the adequacy of medications used to relieve suffering in end of life care
    - Communicate well with families – towards the end of life, patients may not be able to tell you how they're feeling and families often know the patients best
- Talk to patients about advanced care planning and end of life care

    - Evidence shows patients find these conversations useful and that, if done in a compassionate manner, they do not cause distress
- Treating physical symptoms is imperative
- Sit down with patients – it gives the perception of spending longer time with them
- Attempt to address a patient's existential distress; be kind and patient and ask what you need to know about them in order to take the best care of them

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