PALLIATIVE CARE & PANCREATIC CANCER

AN INTRODUCTION TO SYMPTOM MANAGEMENT AT END OF LIFE

‘Our vision is to EXCEL at patient care’
OBJECTIVES

- To be able to identify symptoms that may be present at end of life

- To understand the options available to manage problematic symptoms

- To be aware of how to access specialist support and advice
COMMON SYMPTOMS

- Pain
- Nausea / vomiting
- Delirium / agitation
- Breathlessness
- Respiratory secretions
- Dry mouth
GOOD SYMPTOM MANAGEMENT INVOLVES....

Accurate assessment & evaluation

Regular intervention

Regular re-assessment
  - *Is current intervention effective?*
  - *Is the patient experiencing any side effects?*
ANTICIPATORY MEDICATIONS

Medication prescribed in anticipation of symptoms, designed to enable rapid relief at whatever time the patient develops distressing symptoms. Drugs prescribed in anticipation may include previous or current prescriptions, sometimes with a change in the route of administration, and newly prescribed drugs for anticipated new symptoms.

NICE 2017
General Prescribing Guidance for the Dying Person.

To be used in conjunction with the
Coventry and Warwickshire Unified Holistic Assessment and Individual Plan of Care for the Dying Person version 05.12.17

Endorsed by the CASTLE Expert Advisory Group for Coventry and Warwickshire 08.12.17
N.B - In the last few days / hours of life, patients may be unable to take their medication orally

Transdermal patches *can* be continued

Medications are usually given subcutaneously either as a stat / PRN medication or via CSCI

<table>
<thead>
<tr>
<th>Medication</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine / Diamorphine</td>
<td>Pain, Breathlessness</td>
</tr>
<tr>
<td>Midazolam</td>
<td>Restlessness / agitation, Breathlessness</td>
</tr>
<tr>
<td>Glycopyrronium</td>
<td>Respiratory secretions</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Nausea &amp; vomiting, Agitation, Hallucinations / confusion</td>
</tr>
</tbody>
</table>
WHEN TO PRESCRIBE

Patient is being supported by Individual Plan of Care for the Dying Person

Should be considered when patient is being supported by the AMBER bundle

For patients being discharged – Rapid discharge home to die

Gut feeling / surprise question
# PAIN

## NON-DRUG MEASURES

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Bowel intervention</td>
</tr>
<tr>
<td>Pressure sores</td>
<td>Mattress change, intervention</td>
</tr>
<tr>
<td>Muscle spasm</td>
<td>Massage, heat / cold pack</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Distraction, emotional support</td>
</tr>
</tbody>
</table>
DRUG MEASURES

Opiate naïve patients

- Morphine 2.5mg subcutaneously hourly as required

Patients currently on long acting Morphine / Codeine / Tramadol should be converted to appropriate dose of Morphine / Diamorphine in CSCI

*Remember PRN dose should be 1/6 total 24 hour dose*
# Palliative Care

Guidelines for the use of drugs in symptom control

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## Chapter 1: Pain

### Relative Doses of Opioids

<table>
<thead>
<tr>
<th>Analgesic</th>
<th>Approximate equivalence to 10mg oral morphine on repeated dosing</th>
<th>Duration of action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oral dose</td>
<td>IM/SC dose</td>
</tr>
<tr>
<td>Morphine</td>
<td>10mg</td>
<td>5mg</td>
</tr>
<tr>
<td>alfentanil (injectable)</td>
<td>0.3mg = 300 micrograms</td>
<td>30 minutes IM</td>
</tr>
<tr>
<td>Buprenorphine (sublingual)</td>
<td>0.2mg = 200 micrograms</td>
<td>-</td>
</tr>
<tr>
<td>Codeine #</td>
<td>100mg</td>
<td>-</td>
</tr>
<tr>
<td>Diamorphine</td>
<td>-</td>
<td>3mg</td>
</tr>
<tr>
<td>Dilaudid codeine</td>
<td>100mg</td>
<td>-</td>
</tr>
<tr>
<td>Fentanyl (injectable)</td>
<td>-</td>
<td>Seek specialist palliative care advice (see also page 18)</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.3mg</td>
<td>0.6 mg = 600 micrograms</td>
</tr>
<tr>
<td>Methadone</td>
<td>-</td>
<td>Prolonged plasma half-life leads to accumulation on repeated dosing. Requires titration under specialist supervision. Seek specialist palliative care advice.</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>5mg*</td>
<td>2.5</td>
</tr>
<tr>
<td>Tramadol</td>
<td>100mg</td>
<td>-</td>
</tr>
</tbody>
</table>

* Manufactures guidelines of 2:1 ratio of oxycodone : morphine (note other conversions use a 1.5:1 ratio for oxycodone : morphine)

# Determined for parenteral but also appears to apply to oral route

**IM** - intramuscular  
**SC** - subcutaneous

For opioid transdermal patch conversions see page 16
NAUSEA & VOMITING

NON-DRUG MEASURES

- Minimise unpleasant smells
- Positioning to avoid reflux

DRUG MEASURES

- Choice of anti-emetic influenced by cause (s)
- Can current anti-emetic be given via CSCI?
DELIRIUM & AGITATION

NON-DRUG MEASURES

- Look for reversible causes such as position, urinary retention, constipation, unfinished business

DRUG MEASURES

- Midazolam 2.5 - 5mg subcutaneously as required

- Haloperidol 0.5 - 1.5mg subcutaneously hourly (maximum 5mg/24h) if delirium / psychotic features present such as hallucinations & confusion
BREATHLESSNESS

NON-DRUG MEASURES

- Fan
- Positioning e.g. lying at 45° to minimise splinting of diaphragm
- Distraction
- Visualisation
DRUG MEASURES

- Morphine 2.5mg subcutaneously as required
- Benzodiazepines if the patient is known to be anxious and panicky. Midazolam 2.5 – 5mg subcutaneously up to hourly as required
- Lorazepam 0.5mg sublingual 4-6 hourly PRN

Occasionally;
- Bronchodilators if there is wheeze and have previously helped
- Oxygen if the patient is known to be hypoxic but often no better than a fan
RESPIRATORY SECRETIONS

NON-DRUG MEASURES

- Explain cause to the family. Patients are often unaware of the noise, treatment may benefit family more than patient
- Are parenteral fluids causing fluid overload?
- Repositioning may help

DRUG MEASURES

- Glycopyrronium 200mcg subcutaneously PRN (max. 1.8mg/24hours), consider starting a syringe driver with Glycopyrronium 600mcg over 24 hours as soon as noise becomes bothersome
- Suctioning of the oropharynx rarely helps
DRY MOUTH

- Help the patient to take sips of water where wanted
- Regular mouth care
- Saliva-substitute gels
- Lip balm
Figure 1 - Algorithm for the last days of life

Discuss changing the approach to diabetes management with individual and/or family if not already explored. If the person remains on insulin ensure the Diabetes Specialist Nurse (DSN) are involved and agree monitoring strategy.

- **Type 2 diabetes**
  - Diet controlled or Metformin treated
  - Stop monitoring blood glucose

- **Type 2 diabetes on other tablets and/or insulin or GLP1 Agonist**
  - Stop tablets and GLP1 injections
  - Consider stopping insulin if the individual only requires a small dose

- **Type 1 diabetes always on insulin**
  - Continue once daily morning dose of insulin Glargine (Lantus®), Insulin Degludec (Tresiba®) with reduction in dose
  - Check blood glucose once a day at bedtime:
    - If below 8 mmol/l reduce insulin by 10-20%
    - If above 26 increase insulin by 10-20% to reduce risk of symptoms or ketosis

- If insulin stopped:
  - Urea and electrolytes daily
  - If capillary blood glucose: if blood glucose over 20 mmol/l give 6 units rapid acting insulin
  - Re-check capillary blood glucose after 2 hours

- If insulin to continue:
  - Prescribe once daily morning dose of long acting insulin Glargine (Lantus®) or Insulin Degludec (Tresiba®) based on 25% less than total previous daily insulin dose

- If patient requires rapid acting insulin more than twice consider daily glucagon insulin or an analog e.g. Glargine (Lantus®) or Insulin Degludec (Tresiba®)

Key:
- Humanlis/NovoRapid/NovoMix (NovoNordisk)
- Humulin/Protium/leumian Basal (Insulin Degludec/Insulin Glargine)

**Notes**
- Keep tests to a minimum. It may be necessary to perform some tests to ensure unpleasant symptoms do not occur due to low or high blood glucose.
- It is difficult to identify symptoms due to hypoglycaemia in a dying patient.
- Altered mental state could be due to abnormal blood glucose levels.
- Test urine or blood for glucose if the patient is symptomatic.
- Be aware for symptoms in previously insulin treated patient where insulin has been discontinued.
- Frequent glucose monitoring may be useful in these individuals to avoid finger prick testing.
KEY POINTS

- Consider the psychological, social and spiritual causes of symptoms, not just the physical
- Think about non-drug measures
- Prescribe anticipatory drugs in a timely manner
- Seek advice if any concerns
HOSPITAL PALLIATIVE CARE TEAM
Ext. 3773   Mon-Fri 8.30-4.30

OUT OF HOURS SUPPORT
Saturday, Sunday & Bank Holidays (9-5)
Community Integrated Single Point of Access (iSPA)
01926 600818
OOH Clinical Telephone Advice
for palliative and end of life care
led by
Coventry and Warwickshire
Consultants in Palliative Medicine
via
Warwick Myton Hospice
01926 492 518
Welcome to our CASTLE website
Care and Support Towards Life's End -
the Palliative and End of Life Care website of the
CASTLE Expert Advisory Group of
Coventry and Warwickshire.

This website is primarily for Health and Social Care Professionals working in the fields of Palliative and End of Life Care within Coventry and Warwickshire.

The website was originally created as a work stream from the Coventry and Warwickshire End of Life Care Provider Forum. A large number of Health and Social Care Teams have been consulted during the development of this website. The Coventry and Warwickshire End of Life Care Provider Forum was disbanded in September 2013 and the CASTLE website is now owned collectively by the CASTLE Expert Advisory Group of Coventry and Warwickshire.

Please help us to keep this website up-to-date and valuable for all users. Please contact us if you notice any areas which need updating. We hope that you find this website useful and we would value your constructive feedback.

http://www.c-a-s-t-l-e.org.uk/