StChristopher's
More than just a hospice

Anticipatory prescribing for symptom control for frail elderly patients in the last days of life ('Just in case' injectables)

Scope: This guidance should be used alongside NICE guidance for care of patients in the last days of life (https://www.nice.org.uk/guidance/ng31) and Palliative care for adults: strong opioids for pain relief https://www.nice.org.uk/Guidance/CG140. This guidance is intended for both generalist and palliative care prescribers across hospice and community settings.

Paperwork: Every patient needs a copy of:

- Authorisation to administer charts: 'Continuous Subcutaneous Infusion…', 'As required…' and 'Regular and Single Dose…' administration charts you write for this patient
- Controlled Drug Stock Balance Chart
- 'Guidelines When Using Syringe Pump Community Charts' and
- Subcutaneous T34 Syringe Pump Infusion Administration Record and Checklist.

Paperwork available at: https://rmpartners.nhs.uk/our-work/palliative-and-end-of-life-care/.

General Principles:

- Offer oral drugs where the patient can swallow; consider liquid preparations to aid administration.
- Consider transdermal preparations where likely prognosis > 1 week, but ensure breakthrough (oral or subcutaneous) available.
- Prescribe current and/or anticipatory meds for the 4 key symptoms:
  a. Pain
  b. Nausea / Vomiting
  c. Agitation
  d. Respiratory secretions.
- Individualise your prescribing plan considering:
  a. likely causes of any symptoms
  b. other medical conditions (including renal failure, heart failure, parkinsons) and other medications concurrently prescribed
  c. previous response to medications
  d. patient preferences.
- Review and rationalise other regular medications and consider the risk/benefit of continuing with these (for example anticoagulants, antibiotics, antiepileptic or diabetic medications) and whether or not medications require a gradual dose reduction (eg steroids). Consider discussion with senior clinicians when reducing/stopping disease modifying medications (eg cardiac meds).
- Start new drugs at the lowest effective dose and regularly review and titrate as required for symptom control. Lower doses may be needed in the frail elderly because of altered organ function and increased sensitivity.
- Dosing frequency of prns of 1 hourly is to ensure adequate initial dosing to achieve symptom control: if more than 3 prn doses are required in 24 hours telephone for advice.
- **Telephone the hospice for advice (020 87678 4500) in any case where the patients' symptoms are not responding or further specialist assessment/support with decision making is required.**

PAIN

- Doses below are for patients who are opioid naïve i.e. not on regular codeine / tramadol / buprenorphine / morphine or other opioid. Where patients are already on regular opioids, starting doses will be higher to incorporate previous 24 hour dose of opioid.

1. Transdermal

Buprenorphine 5 micrograms to 20 micrograms every 7 days

- ensure prn oral or injectable breakthrough available (see below)

2. Injectables: subcutaneous

Renal Function	PRN	24 hour syringe driver
eGFR known / likely > 50 mls / minute or stable at > 30 mls / minute	MORPHINE SULPHATE 1 mg to 2 mg to 5 mg 1 hrly	MORPHINE SULPHATE 5 mg to 10 mg to 20 mg
eGFR 30 - 50 mls /minute and likely to deteriorate	OXYCODONE 1 mg to 2 mg 1 hrly	OXYCODONE 5 mg to 10 mg
For all patients with eGFR < 30mls / minute please discuss with specialist palliative care team		
eGFR < 30 mls / minute	ALFENTANIL 50 to 100 to 200 microgram 1 hrly	ALFENTANIL 500 microgram to 1 mg to 2 mg

Breathlessness: Opioids are also helpful to relieve breathlessness and may be commenced at similar doses – please state indication as 'breathlessness' on chart.

NAUSEA / VOMITING

1. Injectables: subcutaneous

- Choice of antiemetic may be influenced by the likely aetiology of nausea: consider reversible causes (eg hypercalcaemia).
- Choice of antiemetic **must** take into account comorbidities
  a. Avoid cyclizine in severe heart failure
  b. Avoid dopamine antagonists (Haloperidol/Metoclopramide/Levomepromazine) in patients with Parkinsons and Lewy body dementia
  c. Avoid prokinetics (Metoclopramide/Domperidone) in patients with bowel obstruction
  d. Avoid Levomepromazine in patients with high risk of seizures
  e. Use lowest possible doses in renal failure

Drug	PRN	24 hour syringe driver
Haloperidol	500 microgram to 1 mg 8 hrly	1 mg to 2 mg to 3 mg
Cyclizine	25 mg to 50 mg 8 hrly	100 mg to 150 mg
Metoclopramide	10 mg 8 hrly	30 mg
Levomepromazine	2.5 mg to 5 mg 4 hrly	5 mg to 15 mg

AGITATION

1. Injectables: subcutaneous

	PRN	24 hour syringe driver
No relevant comorbidities	MIDAZOLAM 1 mg to 2 mg 1 hrly	MIDAZOLAM 5 mg to 20 mg
Renal failure (eGFR < 30 mls/min)	MIDAZOLAM 1 mg to 2 mg 1 hrly	MIDAZOLAM 5 mg to 10 mg

RESPIRATORY SECRETIONS

1. Transdermal

Hyoscine hydrobromide 1.5 mg patches = 1 mg per 24 hours: every 72 hours.

- ensure prn oral or injectable breakthrough available (see below)

2. Injectables: subcutaneous

PRN	24 hour syringe driver
GLYCOPYRRONIUM 200 microgram to 400 microgram 1 hrly	GLYCOPYRRONIUM 600 microgram to 1.2 mg to 2.4 mg