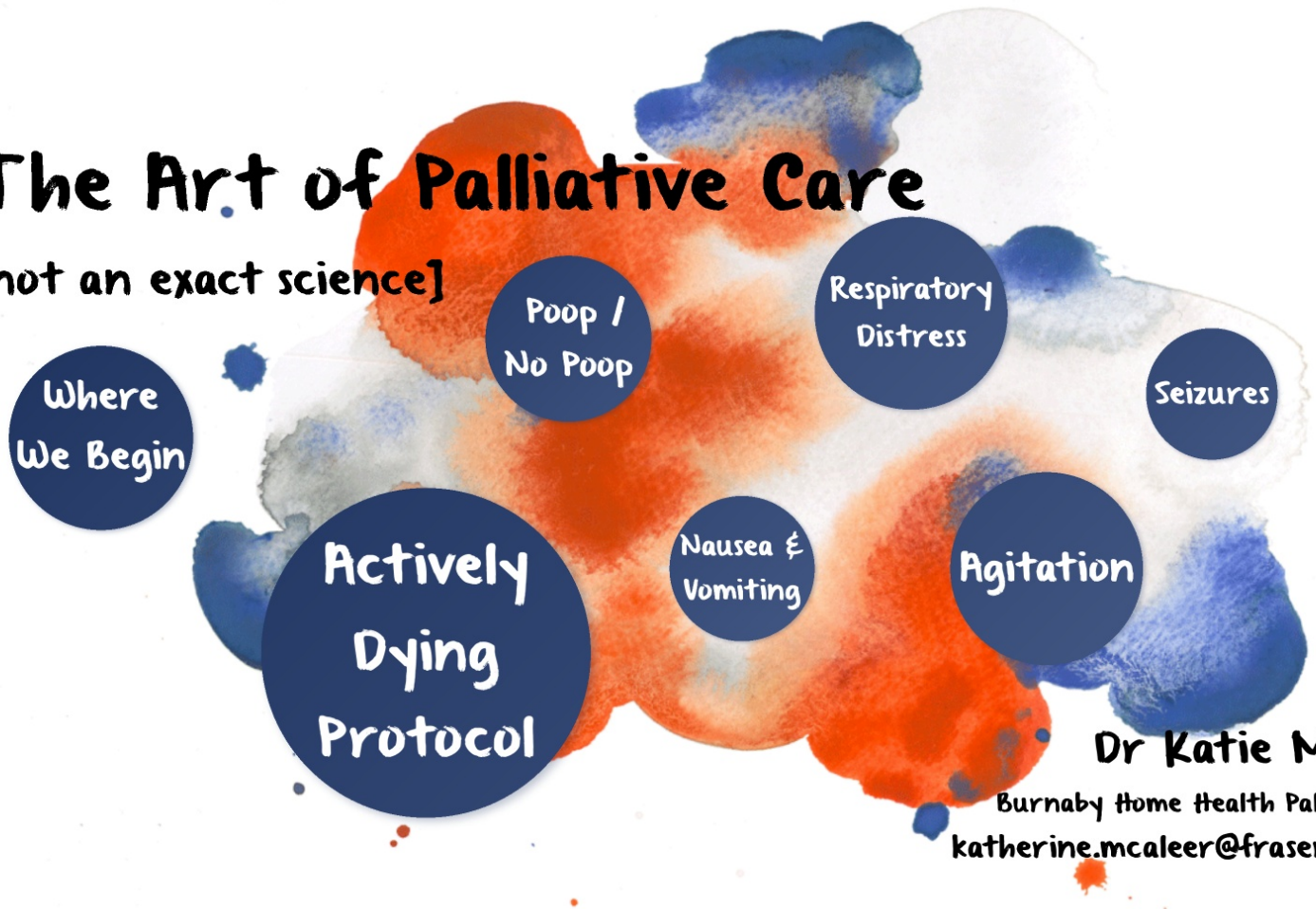
The Art of Palliative Care

[not an exact science]



Dr Katie McAleer

Burnaby Home Health Palliative Care

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No Disclosures

I DO NOT have an affiliation (financial or otherwise) with any for-profit or not-for-profit organizations



Learning Objectives

What We'll Cover Today

Actively Dying Protocol aka Going Down the PPO Rabbit Hole**:**

- Update
- Potential Pitfalls & Gaps in Symptom Management:
  STOPP & START & End-of-Life-Care & PPOs &
  The Vicious Cycle of Well-intentioned Iatrogenic (anticholinergic / antipsychotic) s/e!

Managing Uncontrolled Symptoms:

- Constipation
- Nausea & Vomiting
- Respiratory Distress
- Severe Agitation
- Seizures

Audience-Guided Discussion

The Art of Palliative Care

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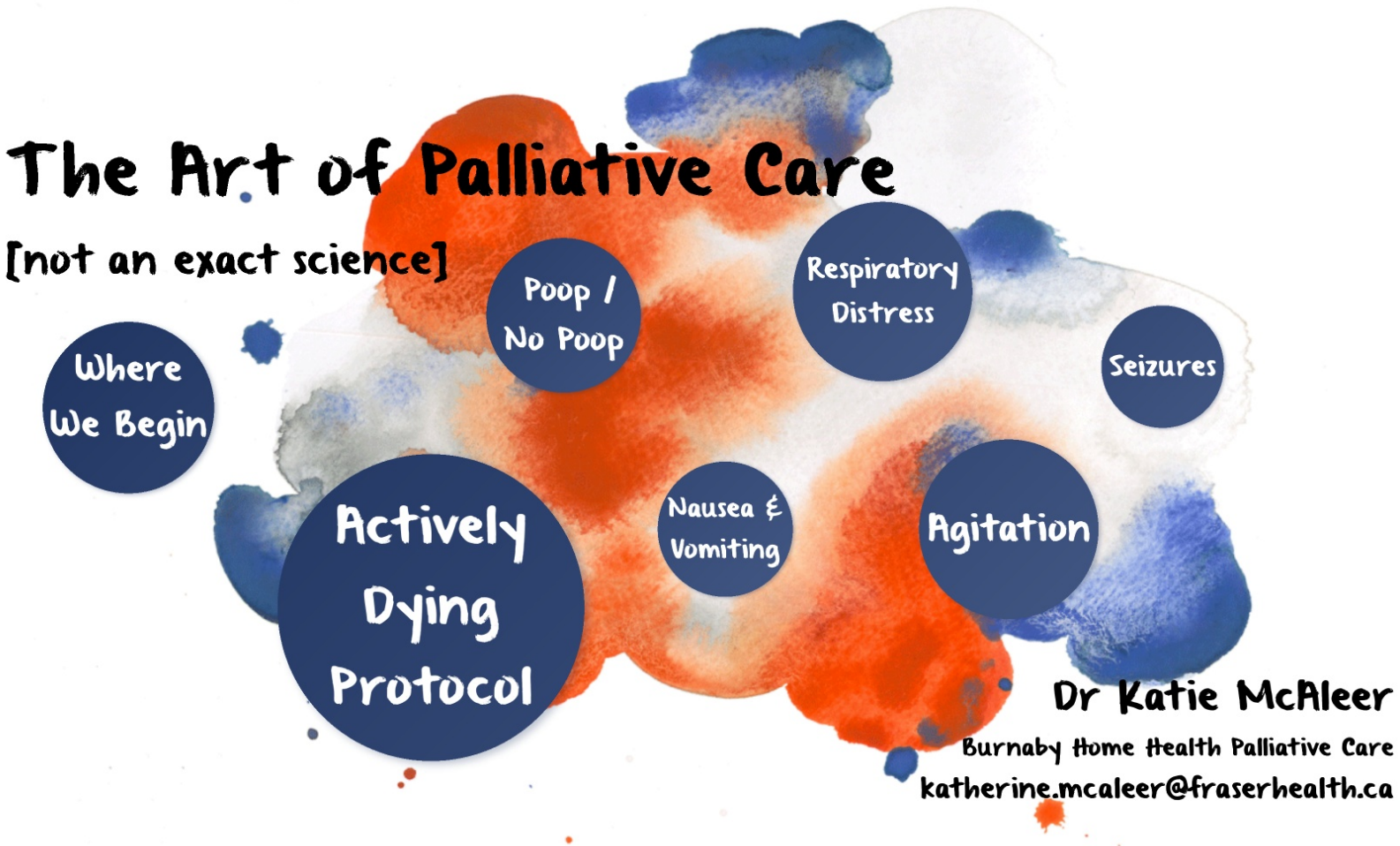

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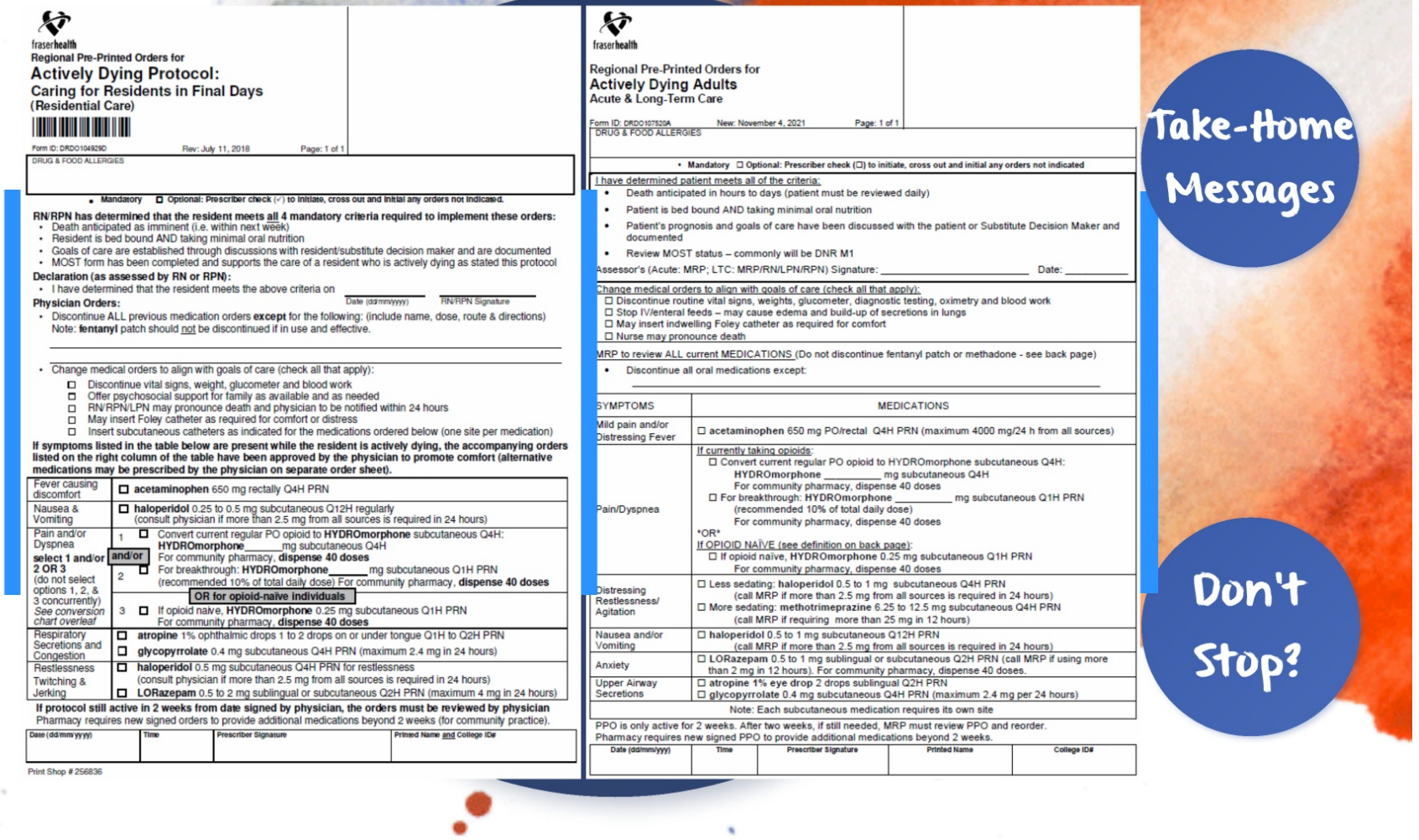

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Regional Pre-Printed Orders for

Actively Dying Protocol:

Caring for Residents in Final Days

(Residential Care)

Form ID: DRDO104929D Rev: July 11, 2018 Page: 1 of 1

DRUG & FOOD ALLERGIES

• Mandatory ☐ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

RN/RPN has determined that the resident meets all 4 mandatory criteria required to implement these orders:

- Death anticipated as imminent (i.e. within next week)
- Resident is bed bound AND taking minimal oral nutrition
- Goals of care are established through discussions with resident/substitute decision maker and are documented
- MOST form has been completed and supports the care of a resident who is actively dying as stated this protocol

Declaration (as assessed by RN or RPN):

- I have determined that the resident meets the above criteria on _____ (Date (dd/mm/yyyy)) _____ (RN/RPN Signature)

Physician Orders:

- Discontinue ALL previous medication orders **except** for the following: (include name, dose, route & directions)
  Note: **fentanyl** patch should not be discontinued if in use and effective.

_____

_____

- Change medical orders to align with goals of care (check all that apply):
  - ☐ Discontinue vital signs, weight, glucometer and blood work
  - ☐ Offer psychosocial support for family as available and as needed
  - ☐ RN/RPN/LPN may pronounce death and physician to be notified within 24 hours
  - ☐ May insert Foley catheter as required for comfort or distress
  - ☐ Insert subcutaneous catheters as indicated for the medications ordered below (one site per medication)

If symptoms listed in the table below are present while the resident is actively dying, the accompanying orders listed on the right column of the table have been approved by the physician to promote comfort (alternative medications may be prescribed by the physician on separate order sheet).

Fever causing discomfort		☐ **acetaminophen** 650 mg rectally Q4H PRN
Nausea & Vomiting		☐ **haloperidol** 0.25 to 0.5 mg subcutaneous Q12H regularly (consult physician if more than 2.5 mg from all sources is required in 24 hours)
Pain and/or Dyspnea **select 1 and/or 2 OR 3** (do not select options 1, 2, & 3 concurrently) *See conversion chart overleaf*	1	☐ Convert current regular PO opioid to **HYDROmorphone** subcutaneous Q4H: **HYDROmorphone**_____mg subcutaneous Q4H For community pharmacy, **dispense 40 doses**
	and/or	
	2	☐ For breakthrough: **HYDROmorphone**_____ mg subcutaneous Q1H PRN (recommended 10% of total daily dose) For community pharmacy, **dispense 40 doses**
		OR for opioid-naïve individuals
	3	☐ If opioid naïve, **HYDROmorphone** 0.25 mg subcutaneous Q1H PRN For community pharmacy, **dispense 40 doses**
Respiratory Secretions and Congestion		☐ **atropine** 1% ophthalmic drops 1 to 2 drops on or under tongue Q1H to Q2H PRN ☐ **glycopyrrolate** 0.4 mg subcutaneous Q4H PRN (maximum 2.4 mg in 24 hours)
Restlessness Twitching & Jerking		☐ **haloperidol** 0.5 mg subcutaneous Q4H PRN for restlessness (consult physician if more than 2.5 mg from all sources is required in 24 hours) ☐ **LORazepam** 0.5 to 2 mg sublingual or subcutaneous Q2H PRN (maximum 4 mg in 24 hours)

If protocol still active in 2 weeks from date signed by physician, the orders must be reviewed by physician
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Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#

Print Shop # 256836

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Regional Pre-Printed Orders for

Actively Dying Adults

Acute & Long-Term Care

Form ID: DRDO107529A New: November 4, 2021 Page: 1 of 1

DRUG & FOOD ALLERGIES

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- Patient is bed bound AND taking minimal oral nutrition
- Patient's prognosis and goals of care have been discussed with the patient or Substitute Decision Maker and documented
- Review MOST status – commonly will be DNR M1

Assessor's (Acute: MRP; LTC: MRP/RN/LPN/RPN) Signature: _____ Date: _____

Change medical orders to align with goals of care (check all that apply):

- ☐ Discontinue routine vital signs, weights, glucometer, diagnostic testing, oximetry and blood work
- ☐ Stop IV/enteral feeds – may cause edema and build-up of secretions in lungs
- ☐ May insert indwelling Foley catheter as required for comfort
- ☐ Nurse may pronounce death

MRP to review ALL current MEDICATIONS (Do not discontinue fentanyl patch or methadone - see back page)

- Discontinue all oral medications except:

_____

SYMPTOMS	MEDICATIONS
Mild pain and/or Distressing Fever	☐ **acetaminophen** 650 mg PO/rectal Q4H PRN (maximum 4000 mg/24 h from all sources)
Pain/Dyspnea	If currently taking opioids: ☐ Convert current regular PO opioid to HYDROmorphone subcutaneous Q4H: **HYDROmorphone** _____ mg subcutaneous Q4H For community pharmacy, dispense 40 doses ☐ For breakthrough: **HYDROmorphone** _____ mg subcutaneous Q1H PRN (recommended 10% of total daily dose) For community pharmacy, dispense 40 doses *OR* If OPIOID NAÏVE (see definition on back page): ☐ If opioid naïve, **HYDROmorphone** 0.25 mg subcutaneous Q1H PRN For community pharmacy, dispense 40 doses
Distressing Restlessness/ Agitation	☐ Less sedating: **haloperidol** 0.5 to 1 mg subcutaneous Q4H PRN (call MRP if more than 2.5 mg from all sources is required in 24 hours) ☐ More sedating: **methotrimeprazine** 6.25 to 12.5 mg subcutaneous Q4H PRN (call MRP if requiring more than 25 mg in 12 hours)
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Anxiety	☐ **LORazepam** 0.5 to 1 mg sublingual or subcutaneous Q2H PRN (call MRP if using more than 2 mg in 12 hours). For community pharmacy, dispense 40 doses.
Upper Airway Secretions	☐ **atropine 1% eye drop** 2 drops sublingual Q2H PRN ☐ **glycopyrrolate** 0.4 mg subcutaneous Q4H PRN (maximum 2.4 mg per 24 hours)
Note: Each subcutaneous medication requires its own site	

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  Date (dd/mm/yyyy) RN/RPN Signature

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  Note: **fentanyl** patch should not be discontinued if in use and effective.

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If symptoms listed in the table below are present while the resident is actively dying, the accompanying orders listed on the right column of the table have been approved by the physician to promote comfort (alternative medications may be prescribed by the physician on separate order sheet)

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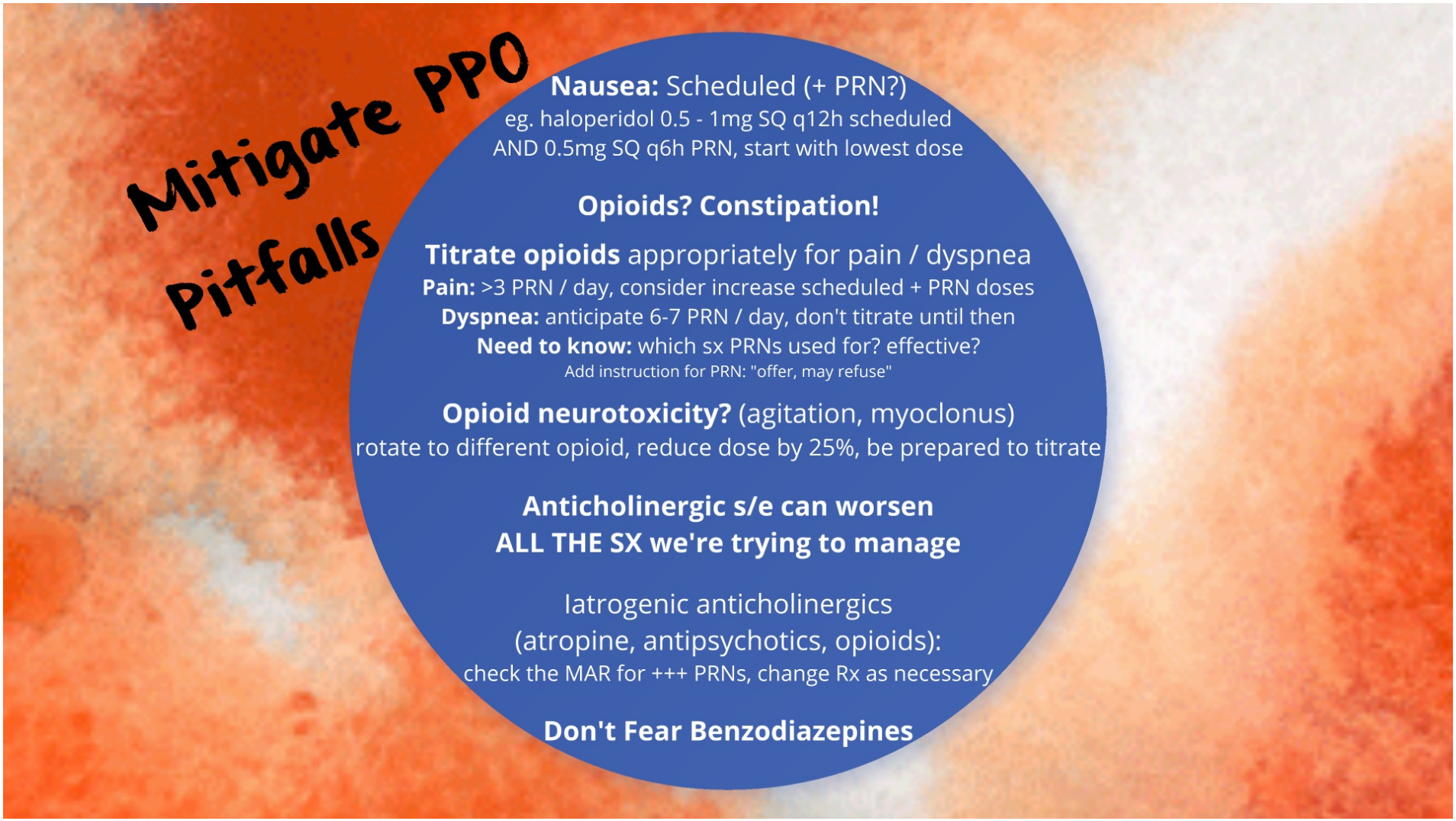
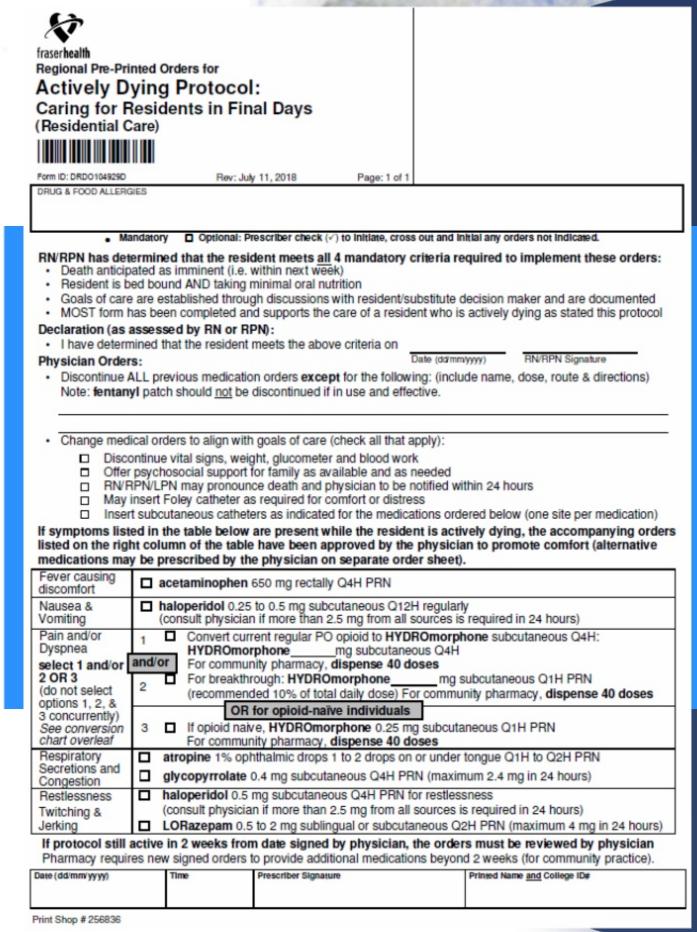

Mitigate PPO Pitfalls
Nausea: Scheduled (+ PRN?)
eg. haloperidol 0.5 - 1mg SQ q12h scheduled
AND 0.5mg SQ q6h PRN, start with lowest dose
Opioids? Constipation!
Titrate opioids appropriately for pain / dyspnea
Pain: >3 PRN / day, consider increase scheduled + PRN doses
Dyspnea: anticipate 6-7 PRN / day, don't titrate until then
Need to know: which sx PRNs used for? effective?
Add instruction for PRN: "offer, may refuse"
Opioid neurotoxicity? (agitation, myoclonus)
rotate to different opioid, reduce dose by 25%, be prepared to titrate
Anticholinergic s/e can worsen
ALL THE SX we're trying to manage
Iatrogenic anticholinergics
(atropine, antipsychotics, opioids):
check the MAR for +++ PRNs, change Rx as necessary
Don't Fear Benzodiazepines



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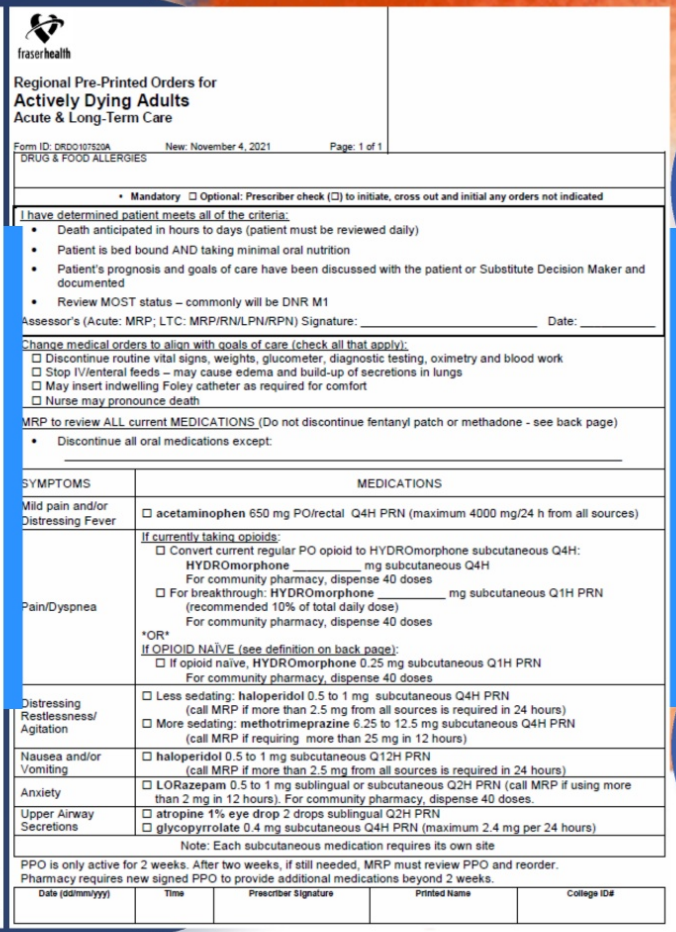

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Regional Pre-Printed Orders for

Actively Dying Adults

Acute & Long-Term Care

Form ID: DRDO107529A New: November 4, 2021 Page: 1 of 1

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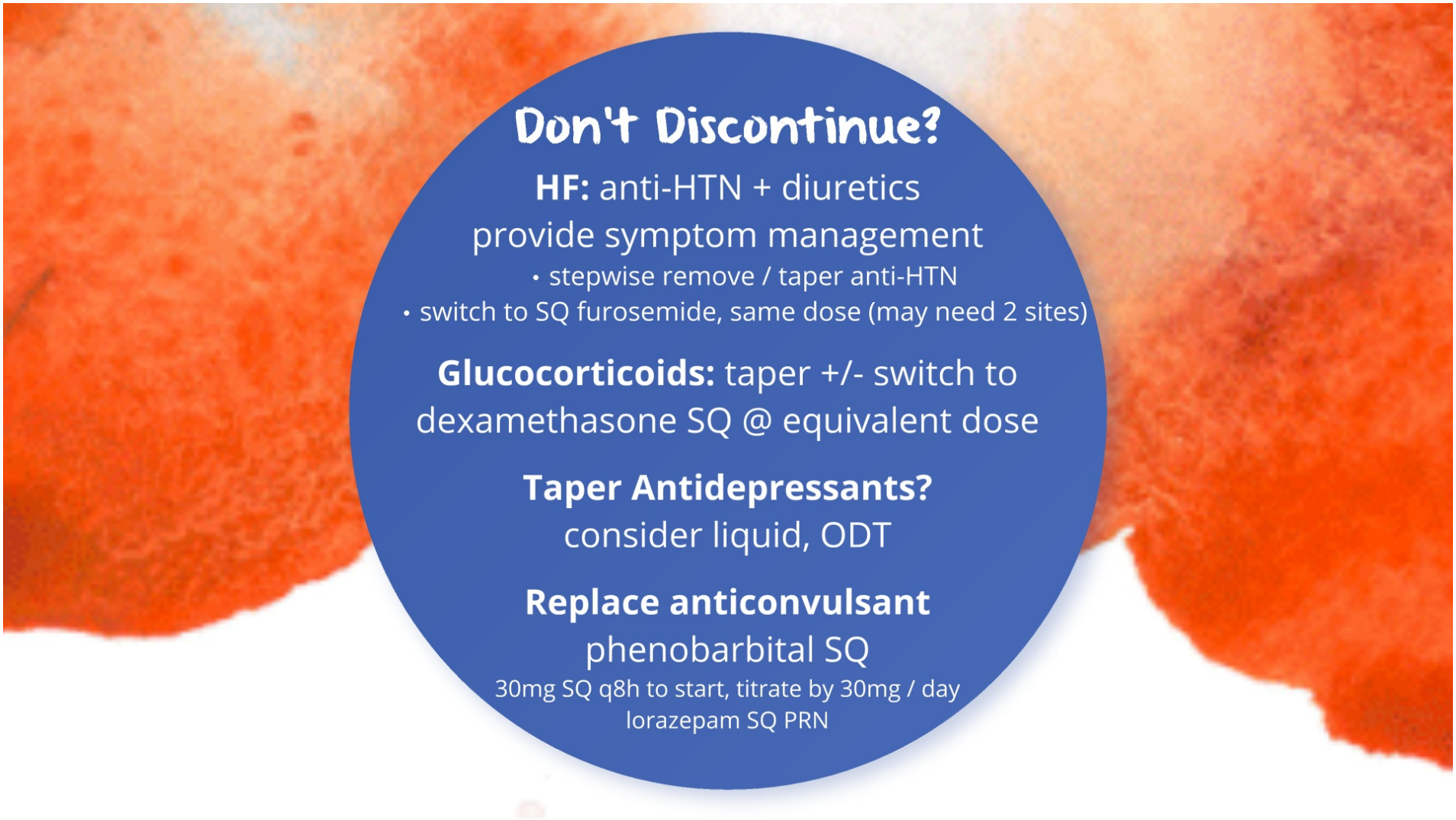
Take-Home Messages

Don't Stop?


Don't Discontinue?
HF: anti-HTN + diuretics
provide symptom management
• stepwise remove / taper anti-HTN
• switch to SQ furosemide, same dose (may need 2 sites)
Glucocorticoids: taper +/- switch to
dexamethasone SQ @ equivalent dose
Taper Antidepressants?
consider liquid, ODT
Replace anticonvulsant
phenobarbital SQ
30mg SQ q8h to start, titrate by 30mg / day
lorazepam SQ PRN

The Art of Palliative Care

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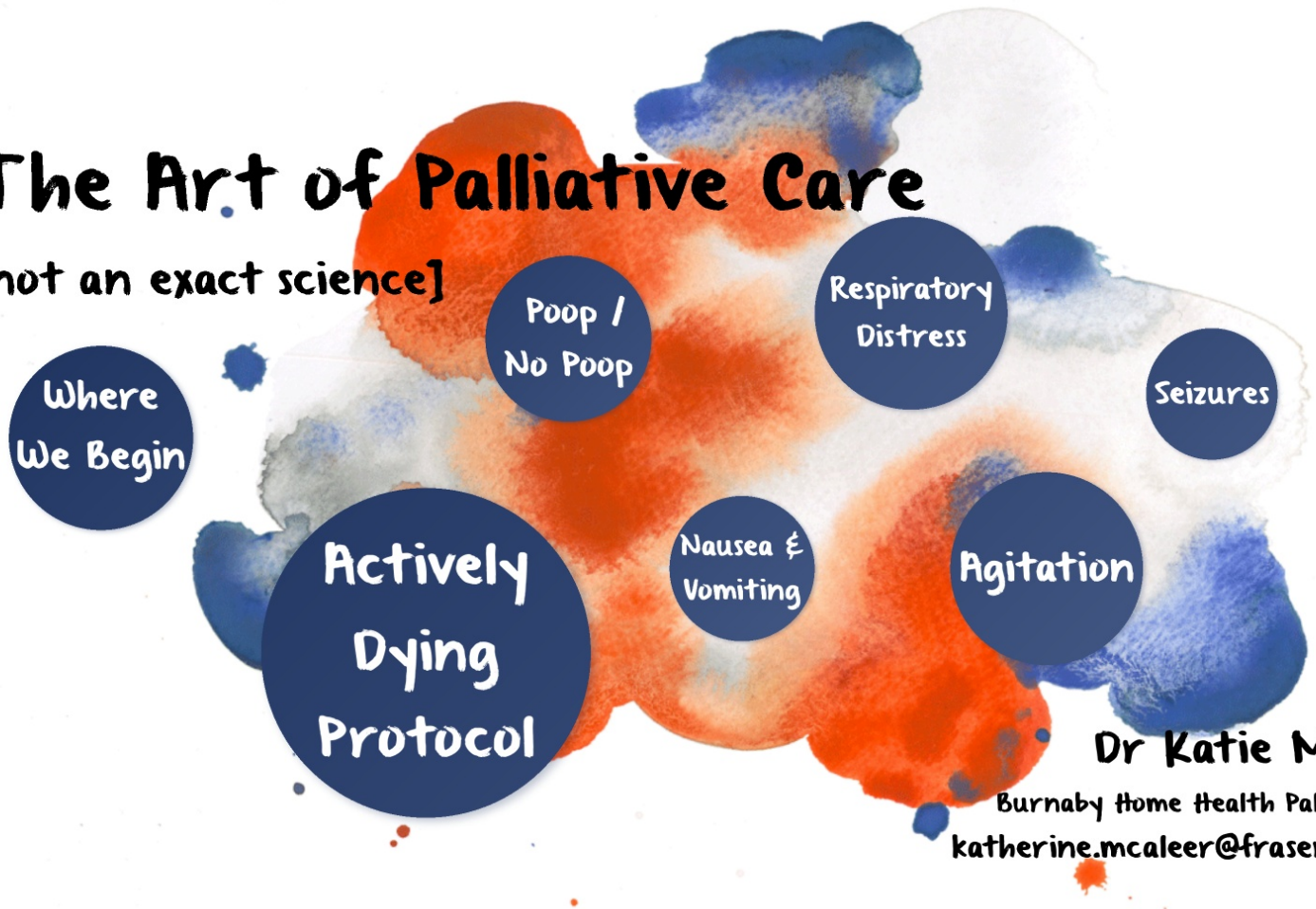

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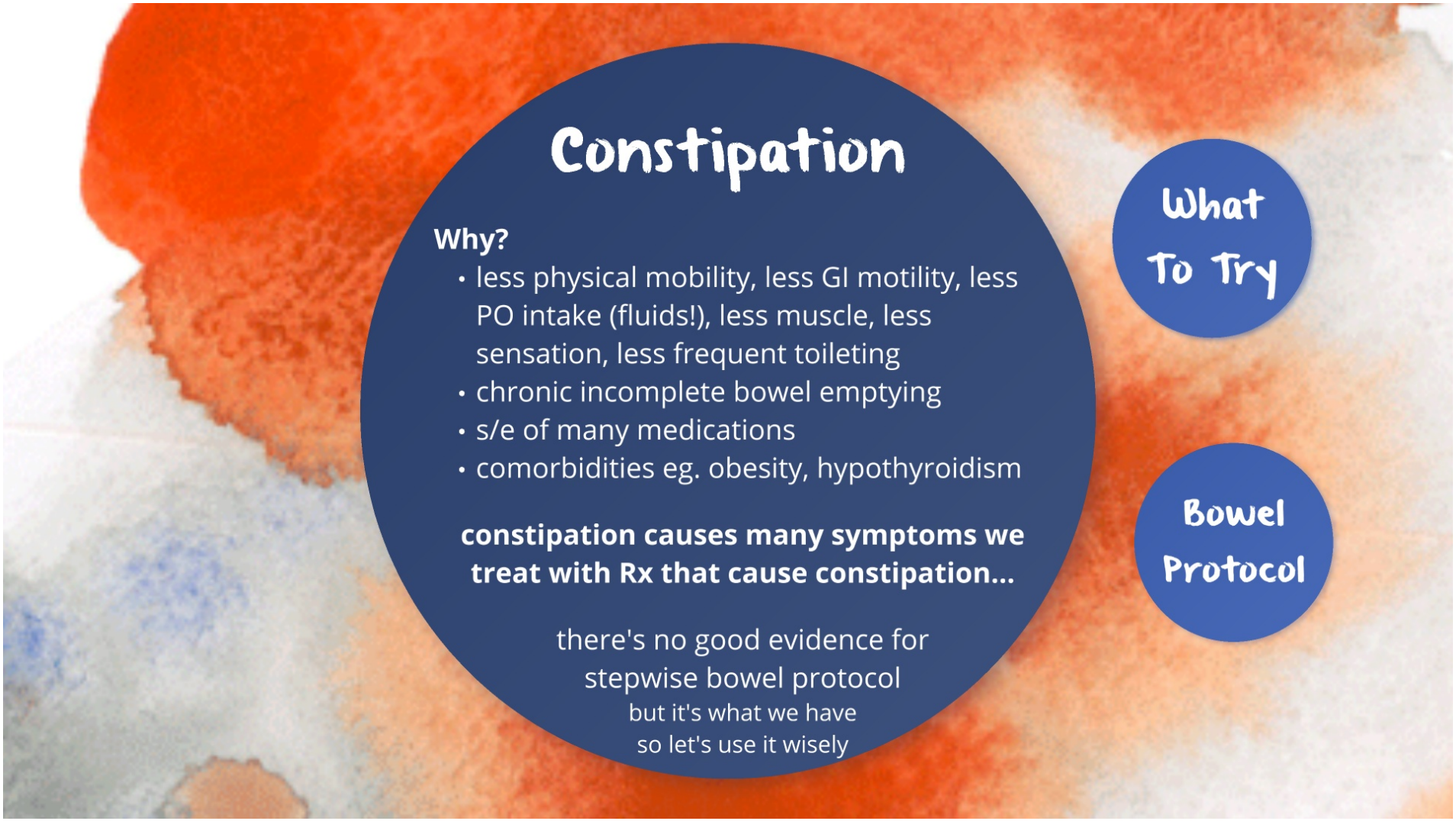
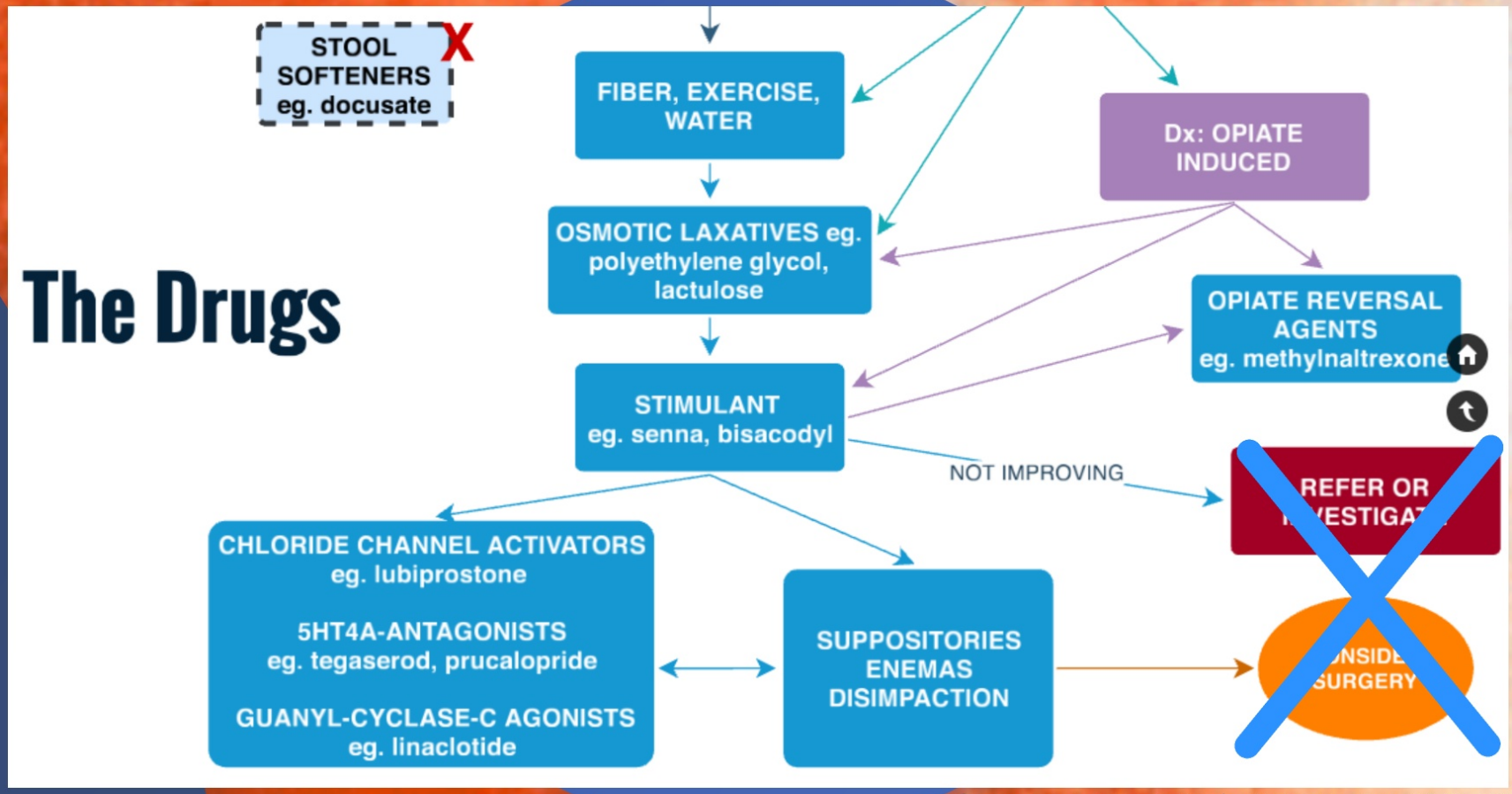
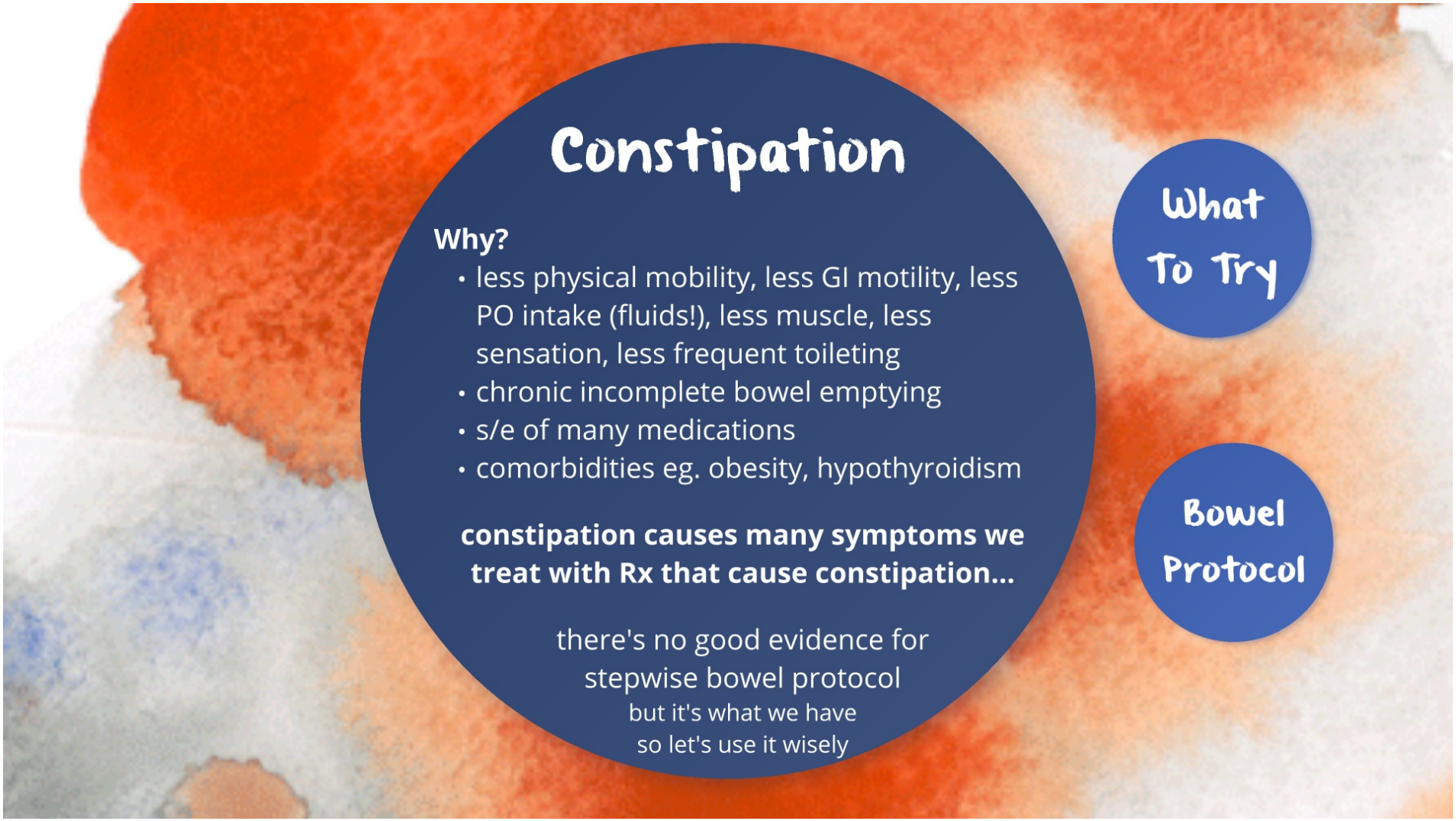
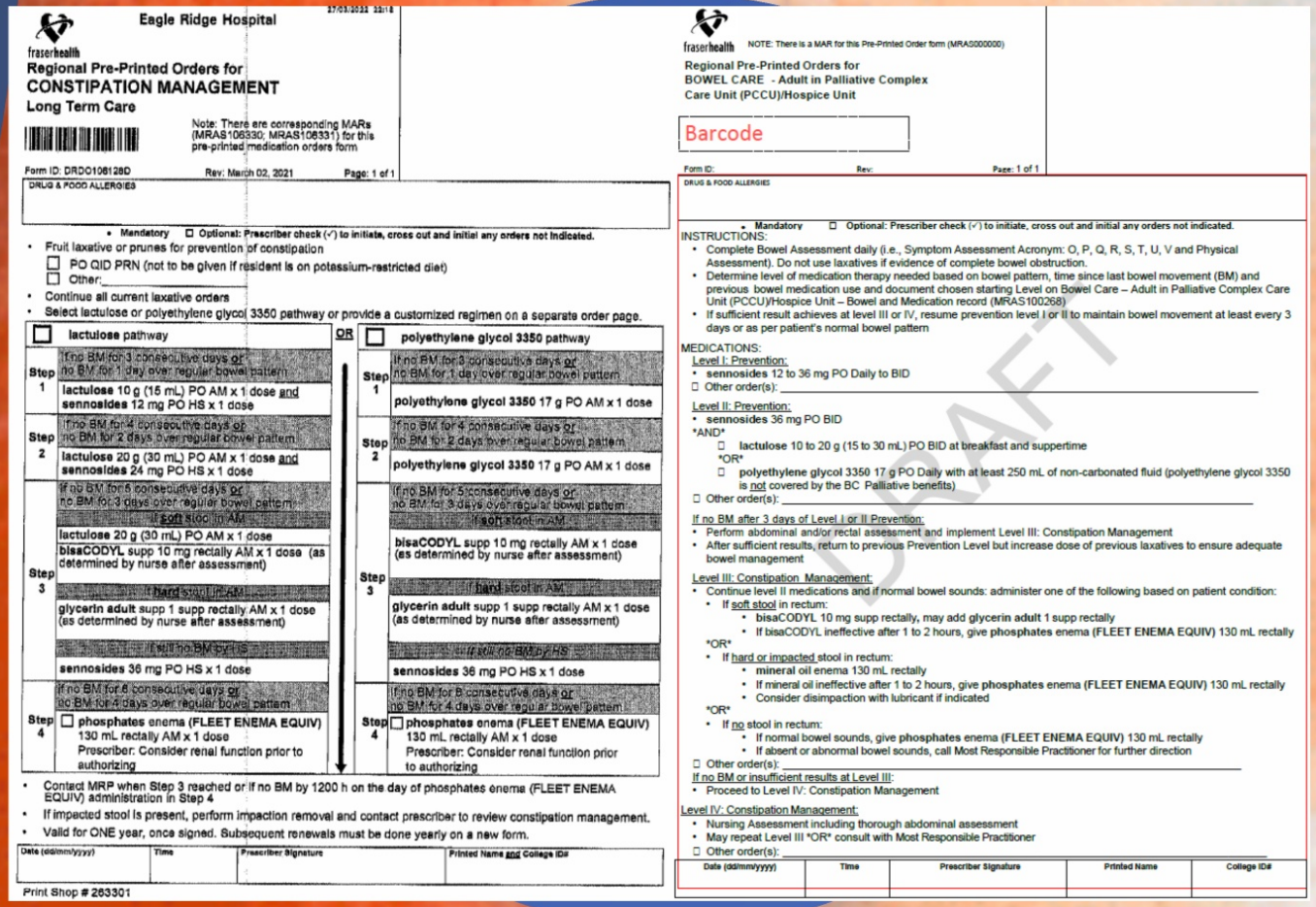

Constipation
Why?
• less physical mobility, less GI motility, less PO intake (fluids!), less muscle, less sensation, less frequent toileting
• chronic incomplete bowel emptying
• s/e of many medications
• comorbidities eg. obesity, hypothyroidism
constipation causes many symptoms we treat with Rx that cause constipation...
there's no good evidence for stepwise bowel protocol
but it's what we have
so let's use it wisely
What To Try
Bowel Protocol

The Drugs



from a great presentation by Dr. Jessica Otte, 10.Mar.2020
available online at Therapeutics Initiative


Constipation
Why?
• less physical mobility, less GI motility, less PO intake (fluids!), less muscle, less sensation, less frequent toileting
• chronic incomplete bowel emptying
• s/e of many medications
• comorbidities eg. obesity, hypothyroidism
constipation causes many symptoms we treat with Rx that cause constipation...
there's no good evidence for stepwise bowel protocol
but it's what we have
so let's use it wisely
What To Try
Bowel Protocol



Eagle Ridge Hospital

fraserhealth

Regional Pre-Printed Orders for
CONSTIPATION MANAGEMENT
Long Term Care

Note: There are corresponding MARs (MRAS106330; MRAS106331) for this pre-printed medication orders form

Form ID: DRDO106128D Rev: March 02, 2021 Page: 1 of 1

DRUG & FOOD ALLERGIES

• Mandatory ☐ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

- Fruit laxative or prunes for prevention of constipation
  - ☐ PO QID PRN (not to be given if resident is on potassium-restricted diet)
  - ☐ Other:_____
- Continue all current laxative orders
- Select lactulose or polyethylene glycol 3350 pathway or provide a customized regimen on a separate order page.

	☐ **lactulose** pathway	OR	☐ **polyethylene glycol 3350** pathway
Step 1	If no BM for 3 consecutive days or no BM for 1 day over regular bowel pattern **lactulose** 10 g (15 mL) PO AM x 1 dose and **sennosides** 12 mg PO HS x 1 dose		If no BM for 3 consecutive days or no BM for 1 day over regular bowel pattern **polyethylene glycol 3350** 17 g PO AM x 1 dose
Step 2	If no BM for 4 consecutive days or no BM for 2 days over regular bowel pattern **lactulose** 20 g (30 mL) PO AM x 1 dose and **sennosides** 24 mg PO HS x 1 dose		If no BM for 4 consecutive days or no BM for 2 days over regular bowel pattern **polyethylene glycol 3350** 17 g PO AM x 1 dose
Step 3	If no BM for 5 consecutive days or no BM for 3 days over regular bowel pattern If soft stool in AM: **lactulose** 20 g (30 mL) PO AM x 1 dose **bisaCODYL** supp 10 mg rectally AM x 1 dose (as determined by nurse after assessment) If hard stool in AM: **glycerin adult** supp 1 supp rectally AM x 1 dose (as determined by nurse after assessment) If still no BM by HS: **sennosides** 36 mg PO HS x 1 dose		If no BM for 5 consecutive days or no BM for 3 days over regular bowel pattern If soft stool in AM: **bisaCODYL** supp 10 mg rectally AM x 1 dose (as determined by nurse after assessment) If hard stool in AM: **glycerin adult** supp 1 supp rectally AM x 1 dose (as determined by nurse after assessment) If still no BM by HS: **sennosides** 36 mg PO HS x 1 dose
Step 4	If no BM for 6 consecutive days or no BM for 4 days over regular bowel pattern ☐ **phosphates** enema **(FLEET ENEMA EQUIV)** 130 mL rectally AM x 1 dose Prescriber: Consider renal function prior to authorizing		If no BM for 6 consecutive days or no BM for 4 days over regular bowel pattern ☐ **phosphates** enema **(FLEET ENEMA EQUIV)** 130 mL rectally AM x 1 dose Prescriber: Consider renal function prior to authorizing

- Contact MRP when Step 3 reached or if no BM by 1200 h on the day of phosphates enema (FLEET ENEMA EQUIV) administration in Step 4
- If impacted stool is present, perform impaction removal and contact prescriber to review constipation management.
- Valid for ONE year, once signed. Subsequent renewals must be done yearly on a new form.

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#

Print Shop # 263301

fraserhealth NOTE: There is a MAR for this Pre-Printed Order form (MRAS000000)

Regional Pre-Printed Orders for
BOWEL CARE - Adult in Palliative Complex Care Unit (PCCU)/Hospice Unit

Barcode

Form ID: Rev: Page: 1 of 1

DRUG & FOOD ALLERGIES

• Mandatory ☐ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

INSTRUCTIONS:
- Complete Bowel Assessment daily (i.e., Symptom Assessment Acronym: O, P, Q, R, S, T, U, V and Physical Assessment). Do not use laxatives if evidence of complete bowel obstruction.
- Determine level of medication therapy needed based on bowel pattern, time since last bowel movement (BM) and previous bowel medication use and document chosen starting Level on Bowel Care – Adult in Palliative Complex Care Unit (PCCU)/Hospice Unit – Bowel and Medication record (MRAS100268)
- If sufficient result achieves at level III or IV, resume prevention level I or II to maintain bowel movement at least every 3 days or as per patient's normal bowel pattern

MEDICATIONS:

Level I: Prevention:
- **sennosides** 12 to 36 mg PO Daily to BID
- ☐ Other order(s): _____

Level II: Prevention:
- **sennosides** 36 mg PO BID

AND
- ☐ **lactulose** 10 to 20 g (15 to 30 mL) PO BID at breakfast and suppertime

OR
- ☐ **polyethylene glycol** 3350 17 g PO Daily with at least 250 mL of non-carbonated fluid (polyethylene glycol 3350 is not covered by the BC Palliative benefits)

☐ Other order(s): _____

If no BM after 3 days of Level I or II Prevention:
- Perform abdominal and/or rectal assessment and implement Level III: Constipation Management
- After sufficient results, return to previous Prevention Level but increase dose of previous laxatives to ensure adequate bowel management

Level III: Constipation Management:
- Continue level II medications and if normal bowel sounds: administer one of the following based on patient condition:
  - If soft stool in rectum:
    - **bisa**CODYL 10 mg supp rectally, may add **glycerin adult** 1 supp rectally
    - If bisaCODYL ineffective after 1 to 2 hours, give **phosphates** enema **(FLEET ENEMA EQUIV)** 130 mL rectally

  OR
  - If hard or impacted stool in rectum:
    - **mineral** oil enema 130 mL rectally
    - If mineral oil ineffective after 1 to 2 hours, give **phosphates** enema **(FLEET ENEMA EQUIV)** 130 mL rectally
    - Consider disimpaction with lubricant if indicated

  OR
  - If no stool in rectum:
    - If normal bowel sounds, give **phosphates** enema **(FLEET ENEMA EQUIV)** 130 mL rectally
    - If absent or abnormal bowel sounds, call Most Responsible Practitioner for further direction

☐ Other order(s): _____

If no BM or insufficient results at Level III:
- Proceed to Level IV: Constipation Management

Level IV: Constipation Management:
- Nursing Assessment including thorough abdominal assessment
- May repeat Level III *OR* consult with Most Responsible Practitioner

☐ Other order(s): _____

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name	College ID#

DRAFT

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

INSTRUCTIONS:

- Complete Bowel Assessment daily (i.e., Symptom Assessment Acronym: O, P, Q, R, S, T, U, V and Physical Assessment). Do not use laxatives if evidence of complete bowel obstruction.
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AND

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OR

☐ **polyethylene glycol 3350** 17 g PO Daily with at least 250 mL of non-carbonated fluid (polyethylene glycol 3350 is not covered by the BC Palliative benefits)

☐ Other order(s): _____

If no BM after 3 days of Level I or II Prevention:

- Perform abdominal and/or rectal assessment and implement Level III: Constipation Management
- After sufficient results, return to previous Prevention Level but increase dose of previous laxatives to ensure adequate bowel management

Level III: Constipation Management:

DRAFT

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

- Fruit laxative or prunes for prevention of constipation
  - ☐ PO QID PRN (not to be given if resident is on potassium-restricted diet)
  - ☐ Other:_____
- Continue all current laxative orders
- Select lactulose or polyethylene glycol 3350 pathway or provide a customized regimen on a separate order page.

☐ **lactulose** pathway	
Step 1	If no BM for 3 consecutive days **or** no BM for 1 day over regular bowel pattern
	lactulose 10 g (15 mL) PO AM x 1 dose **and** **sennosides** 12 mg PO HS x 1 dose
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	lactulose 20 g (30 mL) PO AM x 1 dose **and** **sennosides** 24 mg PO HS x 1 dose
Step	If no BM for 5 consecutive days **or** no BM for 3 days over regular bowel pattern
	If **soft** stool in AM
	lactulose 20 g (30 mL) PO AM x 1 dose
	bisaCODYL supp 10 mg rectally AM x 1 dose (as determined by nurse after assessment)

OR

☐ **polyethylene glycol 3350** pathway	
Step 1	If no BM for 3 consecutive days **or** no BM for 1 day over regular bowel pattern
	polyethylene glycol 3350 17 g PO AM x 1 dose
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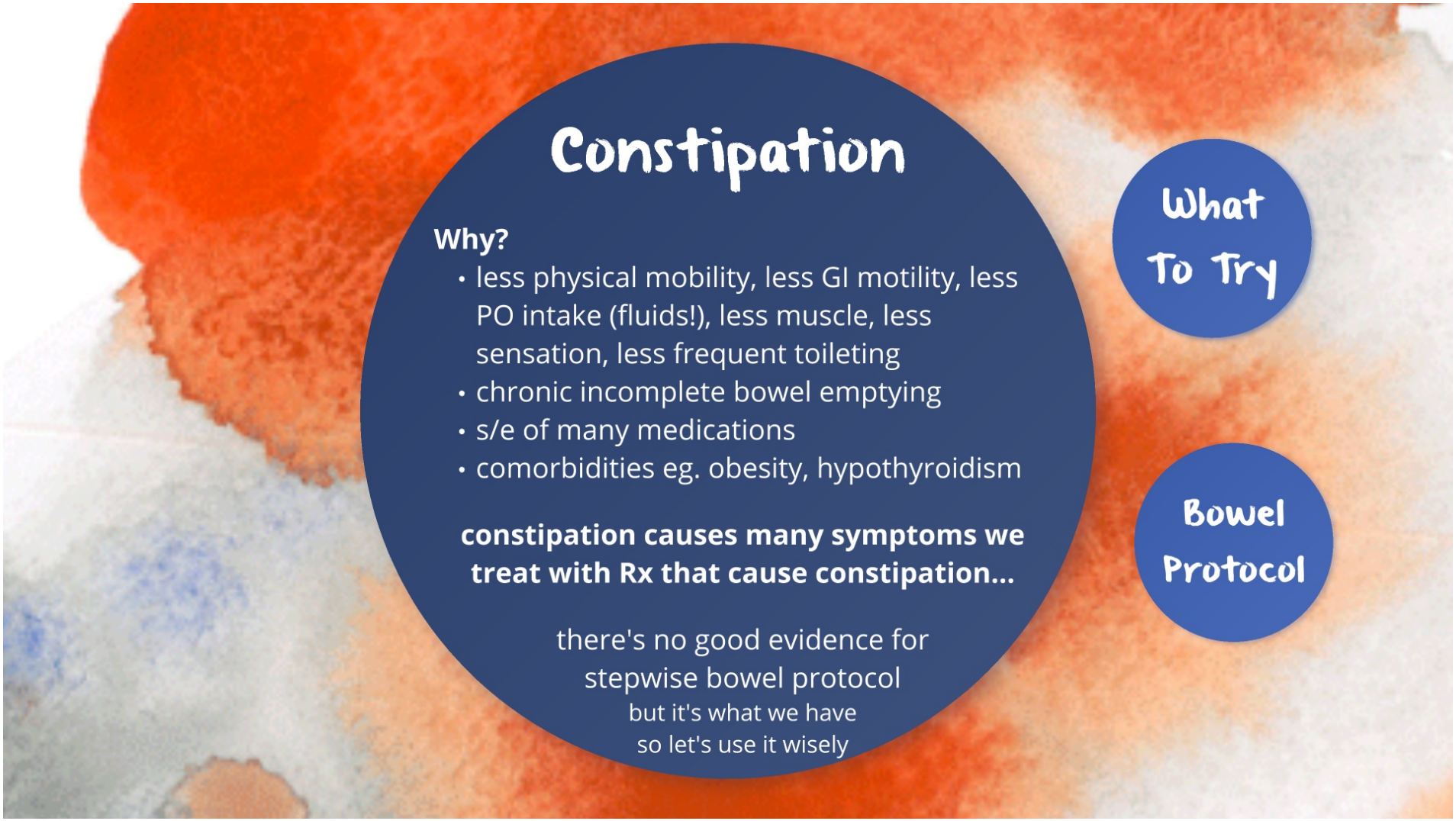
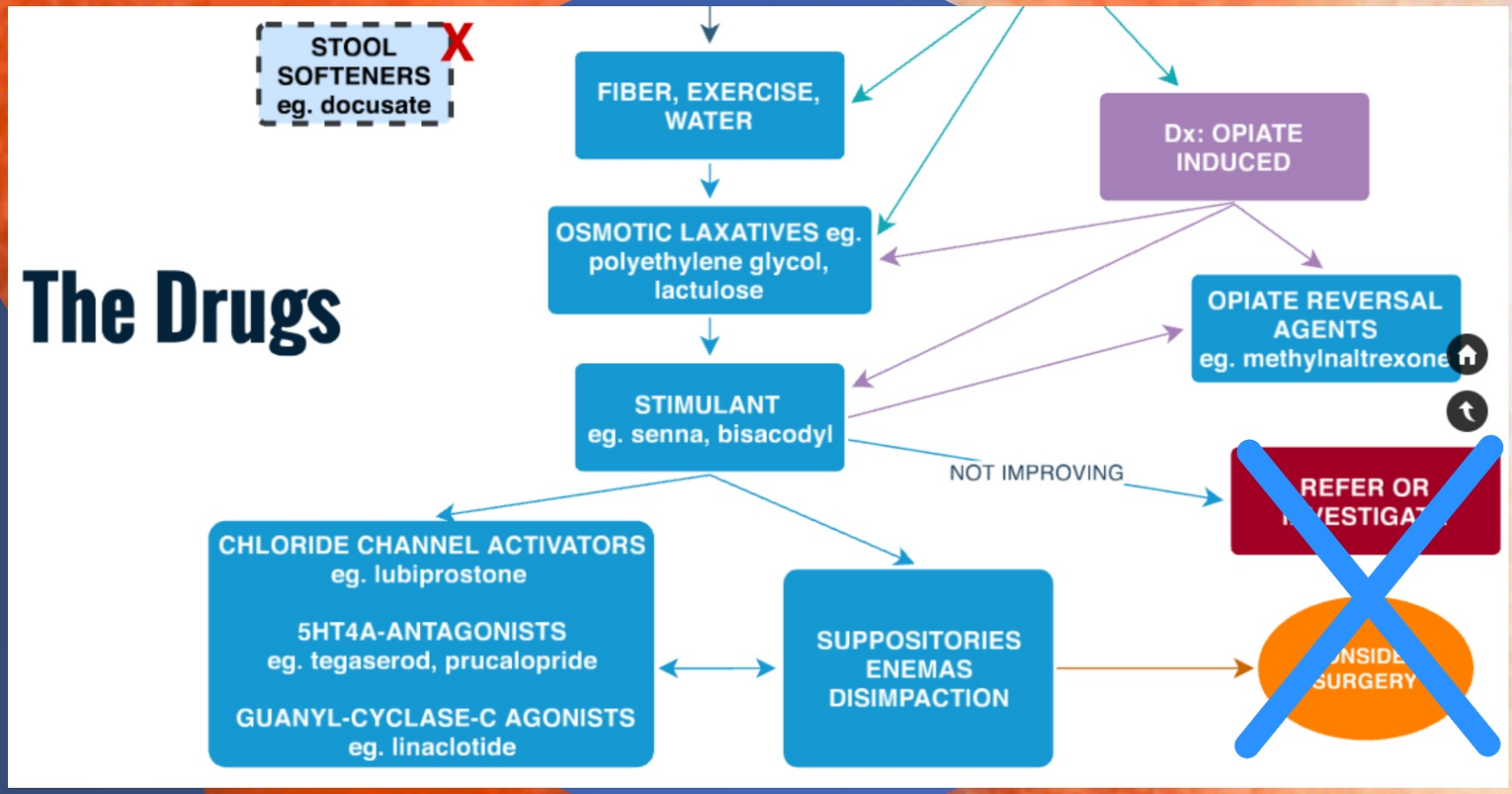
	bisaCODYL supp 10 mg rectally AM x 1 dose (as determined by nurse after assessment)


Constipation
Why?
• less physical mobility, less GI motility, less PO intake (fluids!), less muscle, less sensation, less frequent toileting
• chronic incomplete bowel emptying
• s/e of many medications
• comorbidities eg. obesity, hypothyroidism
constipation causes many symptoms we treat with Rx that cause constipation...
there's no good evidence for stepwise bowel protocol
but it's what we have
so let's use it wisely
What To Try
Bowel Protocol

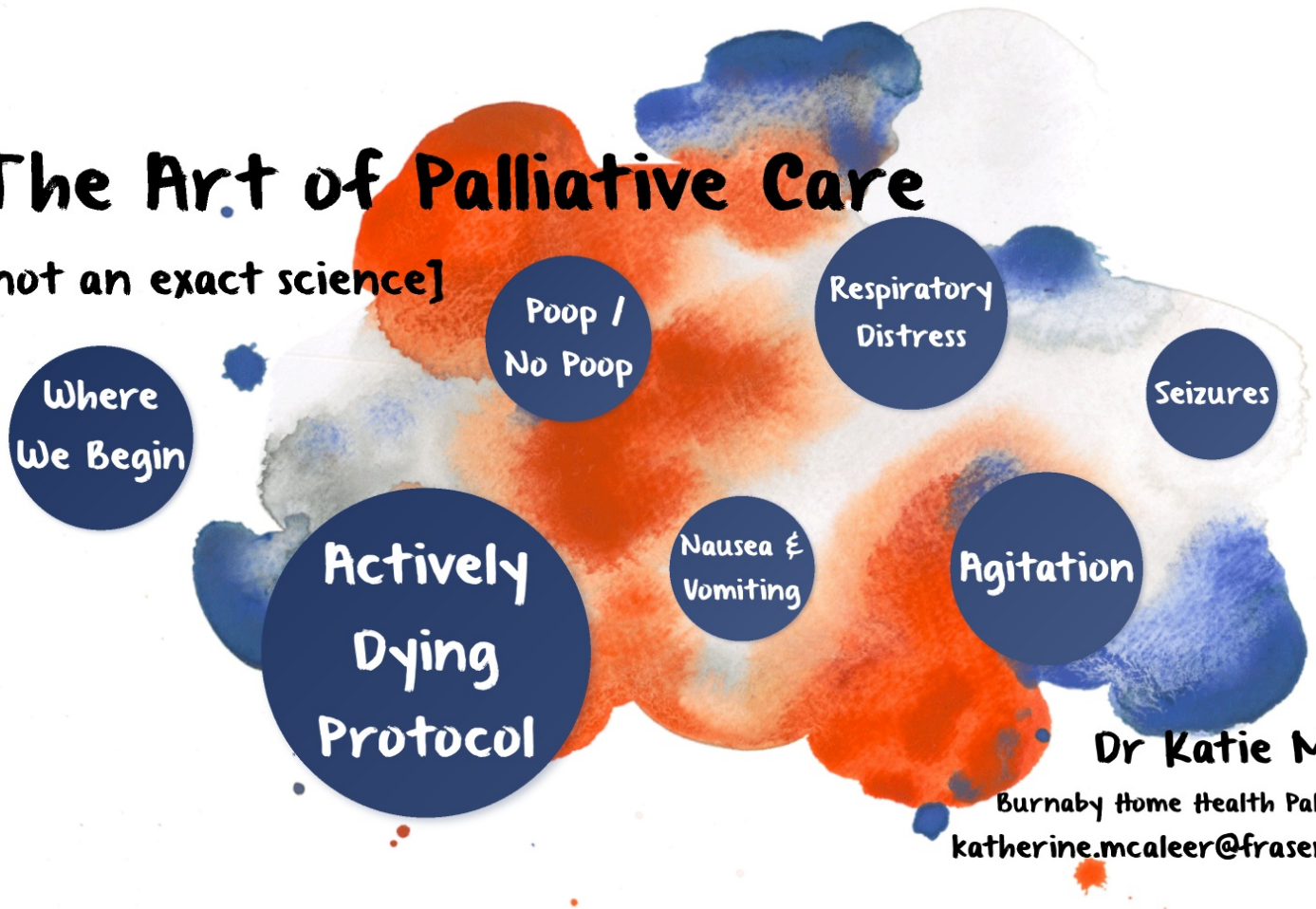
The Drugs



from a great presentation by Dr. Jessica Otte, 10.Mar.2020
available online at Therapeutics Initiative

The Art of Palliative Care

[not an exact science]



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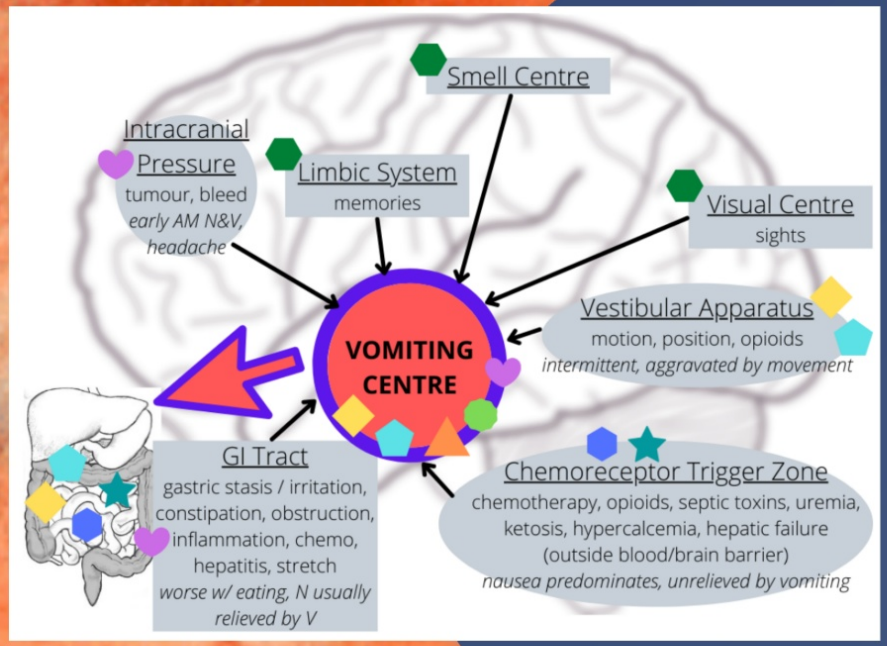
Why?



antimuscarinics
dry, dilated pupils
scopolamine (C)
hydroxyzine (P)

antihistamines
sedating
dimenhydrinate(C)
hydroxyzine (C)
methotrimeprazine
promethazine (C,P)

antiserotonin (5HT2)
methotrimeprazine

antiserotonin (5HT3)
prokinetic:
metoclopramide
constipating:
ondansetron *($$$)*

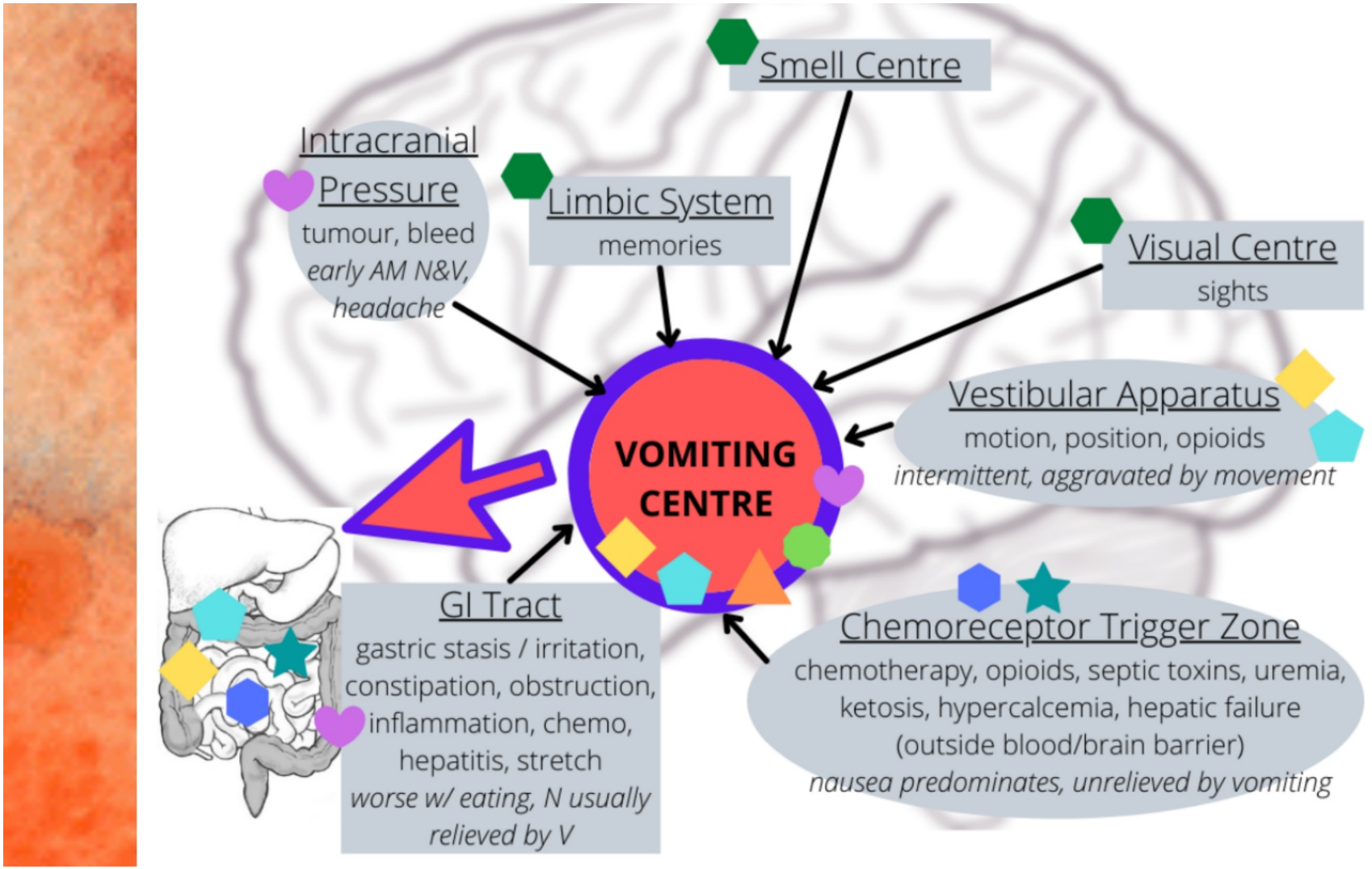
steroids
insomnia, mania
other long-term
dexamethasone

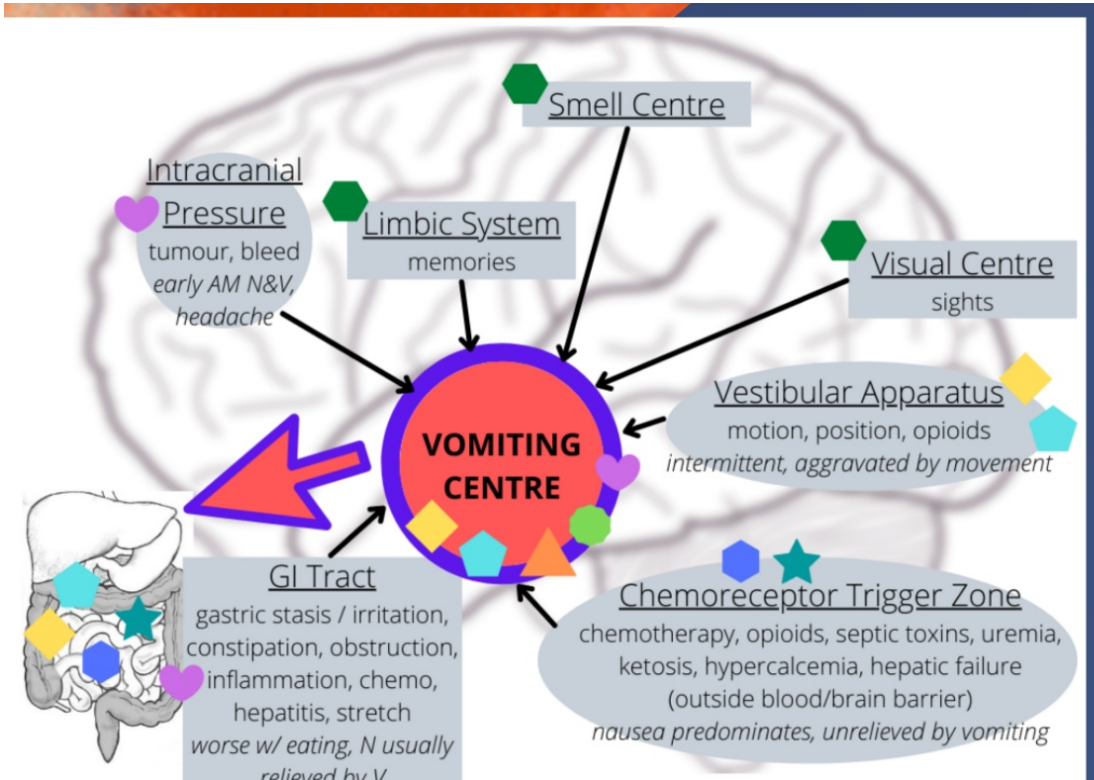
antidopamine
sedation, akathisia
avoid in Parkinson Dsx
metoclopramide (C,P)
methotrimeprazine (C)
haloperidol (C)
domperidone (P)
olanzapine (C)

cannabinoids
variable
nabilone
sativex
other products

benzodiazepines
sedating
lorazepam
diazepam
midazolam

What To Try


Smell Centre
Intracranial Pressure
tumour, bleed
early AM N&V, headache
Limbic System
memories
Visual Centre
sights
VOMITING CENTRE
Vestibular Apparatus
motion, position, opioids
intermittent, aggravated by movement
GI Tract
gastric stasis / irritation, constipation, obstruction, inflammation, chemo, hepatitis, stretch
worse w/ eating, N usually relieved by V
Chemoreceptor Trigger Zone
chemotherapy, opioids, septic toxins, uremia, ketosis, hypercalcemia, hepatic failure (outside blood/brain barrier)
nausea predominates, unrelieved by vomiting



antimuscarinics
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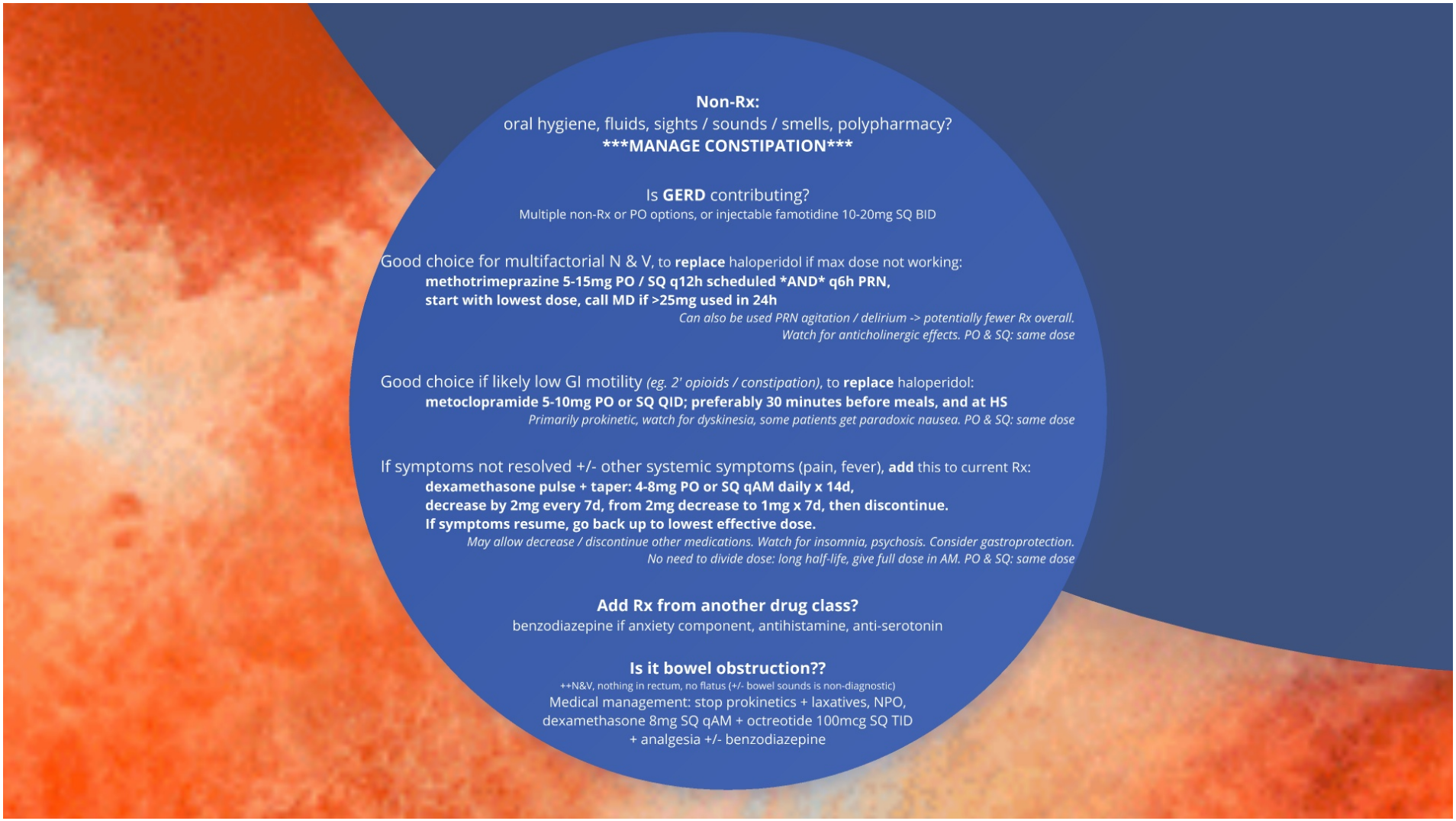
olanzapine (C)

cannabinoids
variable
nabilone
sativex
other products

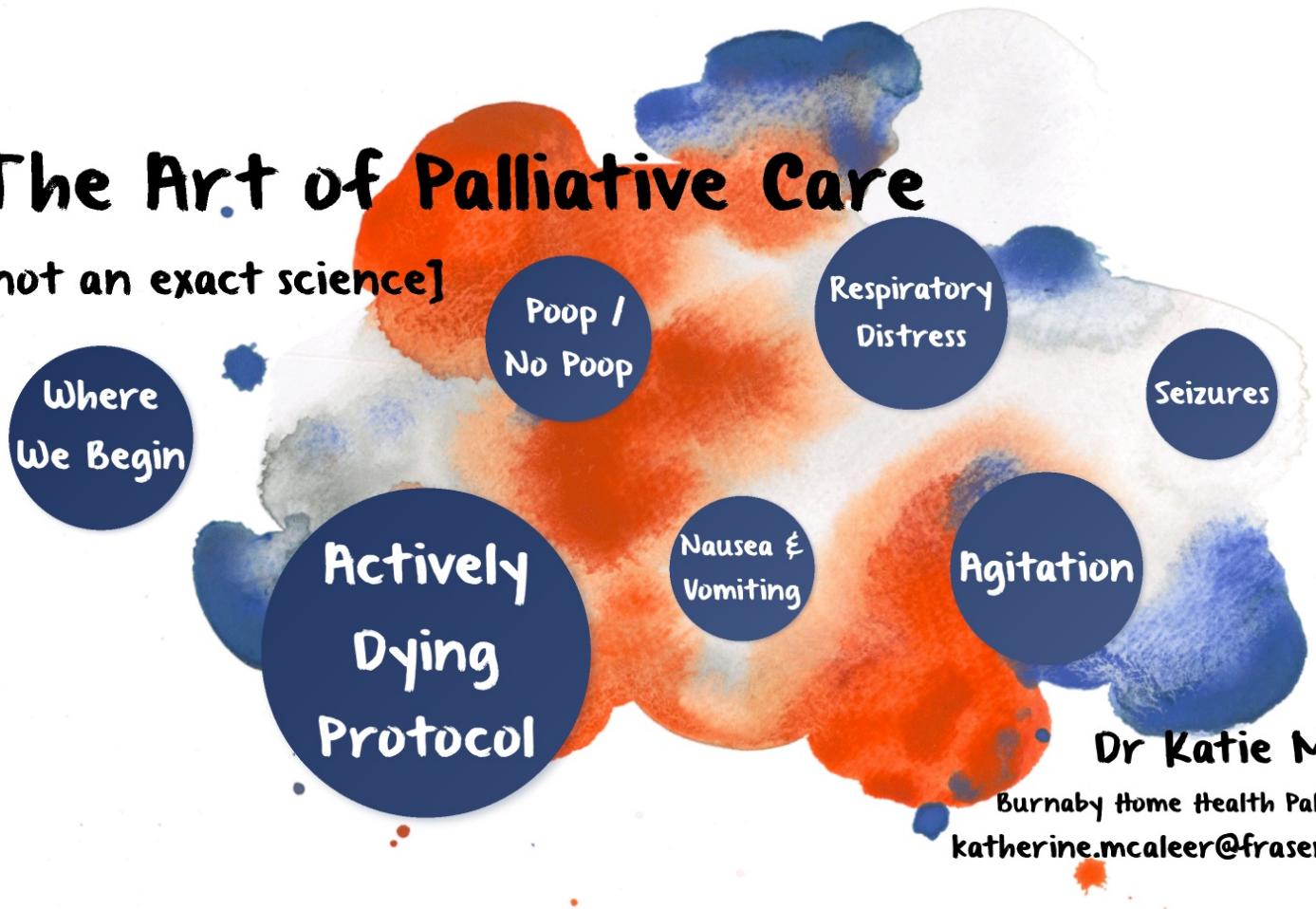
benzodiazepines
sedating
lorazepam
diazepam
midazolam

What To Try


Non-Rx:
oral hygiene, fluids, sights / sounds / smells, polypharmacy?
*****MANAGE CONSTIPATION*****
Is **GERD** contributing?
Multiple non-Rx or PO options, or injectable famotidine 10-20mg SQ BID
Good choice for multifactorial N & V, to **replace** haloperidol if max dose not working:
methotrimeprazine 5-15mg PO / SQ q12h scheduled *AND* q6h PRN,
start with lowest dose, call MD if >25mg used in 24h
Can also be used PRN agitation / delirium -> potentially fewer Rx overall.
Watch for anticholinergic effects. PO & SQ: same dose
Good choice if likely low GI motility *(eg. 2' opioids / constipation)*, to **replace** haloperidol:
metoclopramide 5-10mg PO or SQ QID; preferably 30 minutes before meals, and at HS
Primarily prokinetic, watch for dyskinesia, some patients get paradoxic nausea. PO & SQ: same dose
If symptoms not resolved +/- other systemic symptoms (pain, fever), **add** this to current Rx:
dexamethasone pulse + taper: 4-8mg PO or SQ qAM daily x 14d,
decrease by 2mg every 7d, from 2mg decrease to 1mg x 7d, then discontinue.
If symptoms resume, go back up to lowest effective dose.
May allow decrease / discontinue other medications. Watch for insomnia, psychosis. Consider gastroprotection.
No need to divide dose: long half-life, give full dose in AM. PO & SQ: same dose
Add Rx from another drug class?
benzodiazepine if anxiety component, antihistamine, anti-serotonin
Is it bowel obstruction??
++N&V, nothing in rectum, no flatus (+/- bowel sounds is non-diagnostic)
Medical management: stop prokinetics + laxatives, NPO,
dexamethasone 8mg SQ qAM + octreotide 100mcg SQ TID
+ analgesia +/- benzodiazepine

The Art of Palliative Care

[not an exact science]



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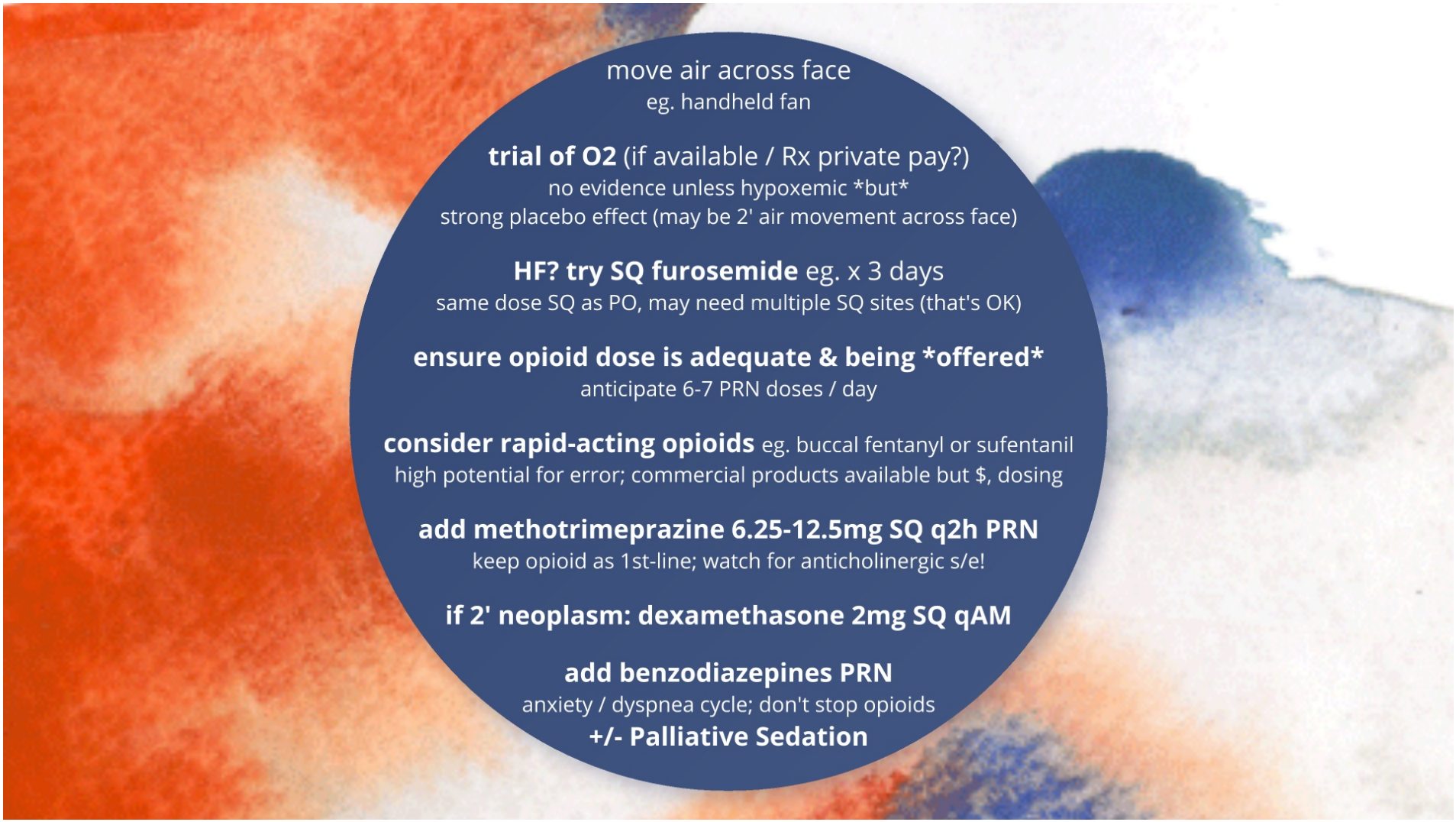
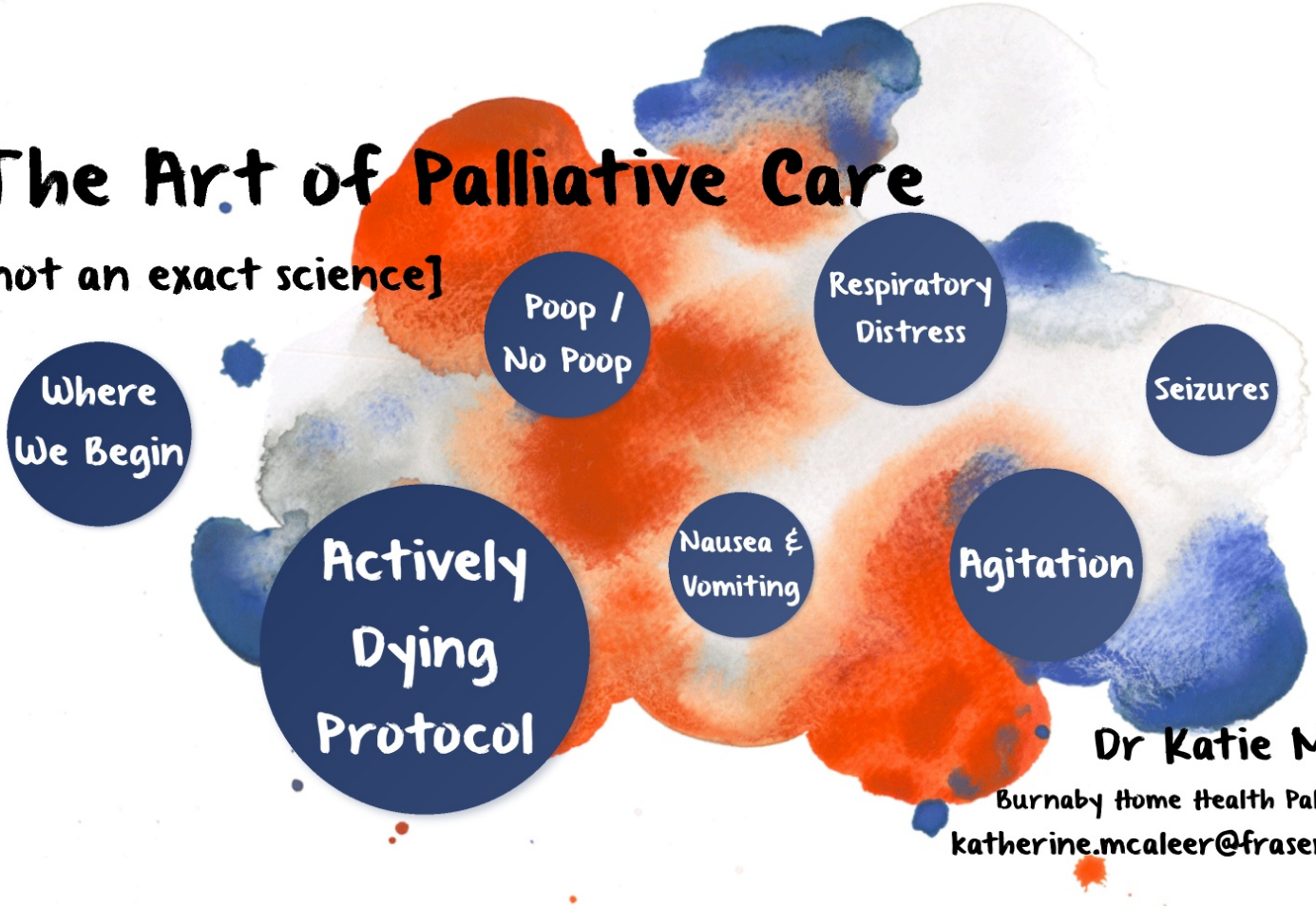

move air across face
eg. handheld fan
trial of O2 (if available / Rx private pay?)
no evidence unless hypoxemic *but*
strong placebo effect (may be 2' air movement across face)
HF? try SQ furosemide eg. x 3 days
same dose SQ as PO, may need multiple SQ sites (that's OK)
ensure opioid dose is adequate & being *offered*
anticipate 6-7 PRN doses / day
consider rapid-acting opioids eg. buccal fentanyl or sufentanil
high potential for error; commercial products available but $, dosing
add methotrimeprazine 6.25-12.5mg SQ q2h PRN
keep opioid as 1st-line; watch for anticholinergic s/e!
if 2' neoplasm: dexamethasone 2mg SQ qAM
add benzodiazepines PRN
anxiety / dyspnea cycle; don't stop opioids
+/- Palliative Sedation

The Art of Palliative Care

[not an exact science]



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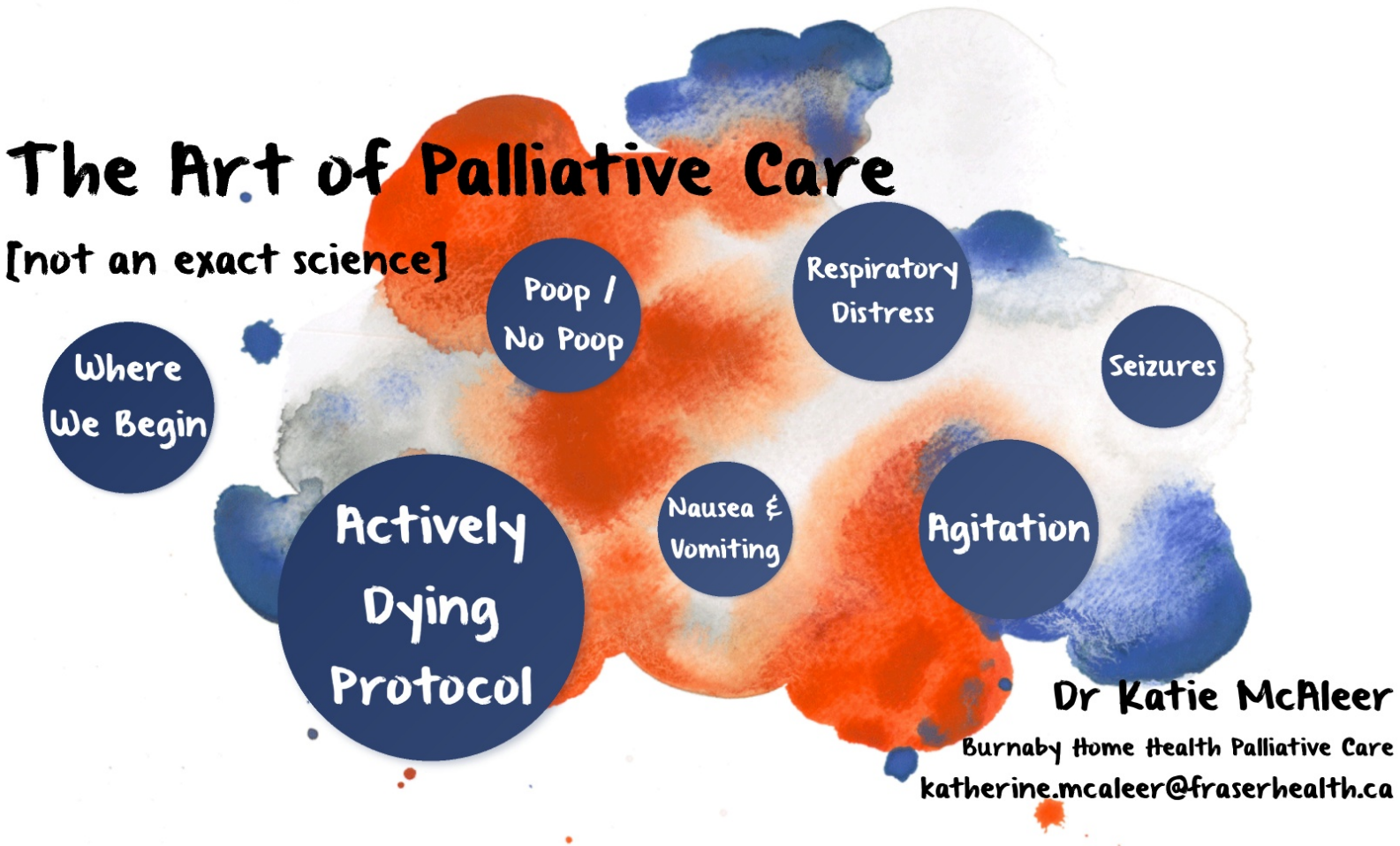
Why?
etiology often multifactorial, may be irreversible / terminal,
but good to consider potentially reversible & treat accordingly
Medication s/e? (review anticholinergics / PRNs / opioid neurotoxicity?)
Constipation? Urinary retention? Unmanaged pain / sx?
Central neuro signs? (not likely able to tx but can help explain)
Glucose +/-? (2' dexamethasone? consider insulin / dextrose PRN hypoglyc)
HyperCa++? (disease-congruent? consider Xgeva x i, calcitonin)
Hypoxemia? Anemia? Sepsis? (don't necessarily treat)
What to Try if irreversible / not meaningfully reversible
1st line: antipsychotic
haloperidol / methotrimeprazine as per Actively Dying PPO
start low, go slow, maximize; goal is "treat / reverse", sedation is s/e
2nd line, low threshold to add: benzodiazepine*
lorazepam 0.5-4mg SL q2h PRN, titrate dose to achieve ~q8-12h dosing
OR
midazolam 0.5-10mg SQ q30min PRN, titrate dose to achieve ~q4-8h dosing
goal is mild / moderate sedation, can then decrease / discontinue antipsychotic
*This dosing strategy can also be used to initiate Palliative Sedation, which should
be considered for unmanaged symptoms despite maximal medical therapy
**while using sedation: continue all
previous symptom management**

The Art of Palliative Care

[not an exact science]



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Why?
etiology often multifactorial, may be irreversible / terminal, but good to consider potentially reversible & **treat accordingly**
Medication s/e?
(antipsychotic Rx can lower seizure threshold / check for ++ PRNs / opioid neurotoxicity?)
Prior diagnosis? (currently undertreated?)
Central neuro signs? (not likely treatable but can help explain)
Hypoxemia? Anemia? Sepsis? (don't not necessarily treat)
What to Try
STAT if distressing & while awaiting tx of any reversible
consider writing "crisis" seizure orders when start Actively Dying PPO
1st line: benzodiazepine
lorazepam *OR* **midazolam 0.5-2mg SQ q15min PRN until seizure stops**
can continue intermittent tx if seizures infrequent / non-distressing
2nd line, if multiple distressing seizures: scheduled benzodiazepine or sedative
lorazepam 0.5-4mg SL q2h PRN, titrate dose to achieve ~q8-12h dosing
OR
midazolam 0.5-10mg SQ q30min PRN, titrate dose to achieve ~q4-8h dosing
OR
phenobarbital 30mg SQ q8h, titrate by 30mg / day to achieve no seizures
goal is no seizures, may require mild / moderate sedation
****while using sedation: continue all previous symptom management****

The Art of Palliative Care

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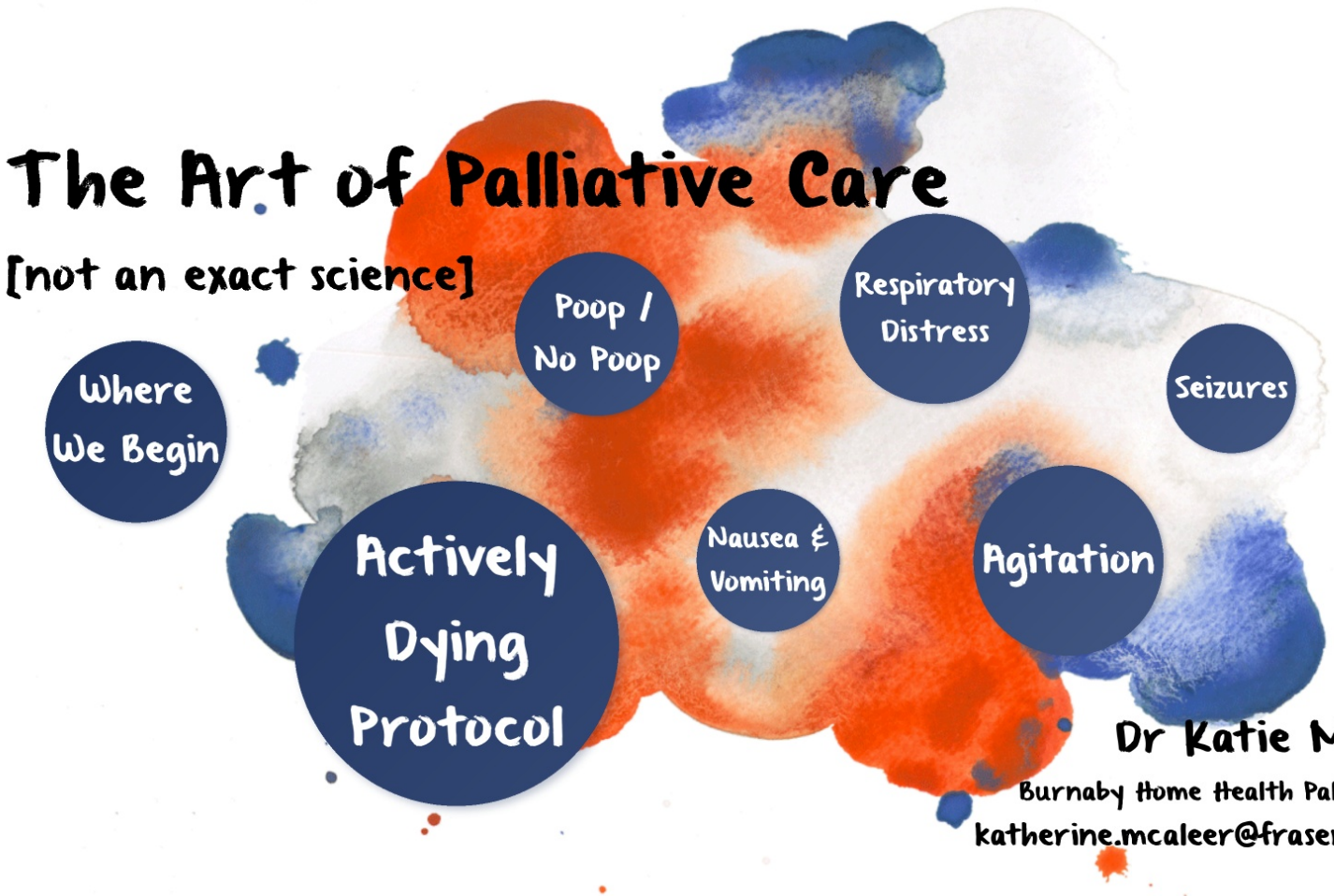

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