# Palliative care

## *Executive summary*

## Introduction

## Palliative care is given when a patient is known to be dying or when they have a condition which cannot be cured and which will cause them to gradually deteriorate until they die. The priority under these circumstances is to maintain the patient’s comfort and to avoid distressing interventions or, indeed, any intervention that is uncomfortable unless there is a clear benefit.

## Target users

* Nurses
* Doctors

## Target area of use

* Outpatient department
* Ward

## Key areas of focus / New additions / Changes

This guideline briefly discusses the principles of palliative care and the important decisions that need to be made. It outlines the treatment options available to patients receiving palliative care.

## Limitations

None

## Decisions about resuscitation and escalation of treatment

The doctors should make a decision to approach a patient palliatively when they have a diagnosis that is causing significant symptoms and which cannot be reversed. This can be a very difficult call to make and where there is uncertainty, it is appropriate to involve a consultant in the decision-making process.

Once the decision has been made that a patient should be approached palliatively, two other factors should be considered.

* Is this patient likely to die during this admission? Should they be resuscitated if they die?
* Should the nurses continue to check their observations? Even if they continue, should they calculate MEWS and alert the doctors about any changes?

Both of these topics must be discussed with a consultant and any decision not to attempt resuscitation or not to calculate MEWS should be clearly documented in the notes and communicated to all staff looking after the patient.

There must be careful consideration of how this is communicated with the patient and their relatives. International best practice suggests that this communication occurs, but this must be modified in accordance with our cultural context. The senior staff of the department should be consulted about this.

## Approach to the patient receiving palliative care

### Important issues to consider

* Does the patient need to be kept in hospital or can their needs be met at home? If they can go home, do the carers know how to look after the patient? Do they know what to do if they need help or they have any questions or concerns?
* Does the patient need all the medications they are currently taking? Are the medicines likely to improve the outcome or the symptoms that the patient has? Are they causing any side effects?
* Is the patient in pain? If they are taking strong pain killers, are they nauseated and have they been to toilet? Do they have any other side effects?
* Are there any other distressing symptoms – cough, shortness of breath, difficulty sleeping etc?
* Can the patient swallow? What are they eating or drinking?

## Specific treatments

In a palliative care setting, it is sometimes appropriate to use medications in unusual ways. This is because the risk of addiction is not important and because the patient’s comfort is more important than theoretical long term risks. Many of the recommendations below are, therefore, unlicensed and should only be prescribed by a doctor.

### Pain

Pain relief in palliative care is aimed at controlling the pain completely. It is better to give medications regularly and in adequate doses to prevent pain than to give pain relief once the pain has developed. Different medications can be used in combination to effectively treat the patient.

It is best to begin with simple analgesia and gradually increase the strength of medications given until the pain is controlled. However, in our setting, patients often present in severe established pain and, in these circumstances, we must be more aggressive in our treatment.

Note that all patients prescribed codeine or morphine in a palliative care setting must also be prescribed medication for nausea and constipation.

Simple pain relief

Paracetamol should be used in the first instance at a dose of 15 mg/kg up to 1 g PO QDS. This should be spread throughout the 24 hour period.

If this is not adequate, consider introducing ibuprofen 10 mg/kg up to 400 mg PO TDS. This is contraindicated in patients with a history of dyspepsia and must be taken after food. Ibuprofen is an anti-inflammatory agent, so is particularly effective where inflammation is causing the pain and is the first line option in these circumstances.

Mild opiates

If simple analgesia is not effective, then add codeine.

Codeine phosphate is useful for moderate pain. Give 1 mg/kg up to 60 mg PO TDS.

Some doctors like to use tramadol at this point. However, this is a partial agonist with complex pharmacokinetics. This means it cannot be used in combination with strong opiates and that it is impossible to predict what dose will be needed in any particular patient.

Strong opiates

These should be introduced in the place of mild opiates if they have not been effective in controlling the pain or if the patient is in severe pain, they may be used in the first instance.

All patients should be prescribed both a regular dose of morphine (usually as MST) as well as a PRN dose of oral morphine solution to be given if they experience breakthrough pain. The dose of the PRN dose is usually one third of that of the regular BD MST dose.

The initial dose of morphine is 0.1 mg/kg up to 5 mg PO every 4 hours for oral morphine solution or 0.3 mg/kg up to 15 mg PO BD for MST. If the patient is already taking codeine, then divide the total daily dose by 8-10 to get the equivalent total daily dose of morphine. (A patient taking 60 mg TDS of codeine needs at least 18-22 mg a day of morphine for the equivalent effect).

Note that MST must be given strictly every 12 hours and should never be given more frequently than this. The dose must be increased instead of the frequency. The dose should be increased under the supervision of the doctors until the patient’s pain is controlled.

Specific kinds of pain:

* Neuropathic pain – shooting or burning pains which do not respond to simple pain relief or to opiates. Amitriptyline 0.2 mg/kg up to 50 mg PO should be given at night.
* Muscle spasm – give diazepam 0.25 mg/kg up to 5 mg PO TDS (note that this should only ever be given to palliative care patients for this indication).
* Colicky pain – pain due to gastric or intestinal spasm may be improved by Buscopan (hyoscine butylbromide) 0.3 mg/kg up to 10 mg TDS – this is not on our formulary, but is easily obtained from local pharmacies. Loperamide 0.1 mg/kg up to 4 mg PO QDS is an alternative, but will cause constipation.

### Poor appetite

Consider using prednisolone 0.5-1 mg/kg up to 15-30 mg PO OD.

### Dry or sore mouth

Examine the mouth for candida and treat with nystatin oral solution 1,000,000 units QDS if found.

If there is no obvious cause, sucking papaya or pineapple slices can be very effective.

If the mouth is very sore, a loperamide capsule can be opened and the contents suspended in water. The suspension should be swilled around the mouth and spat out. This can be done up to 4 times a day and provides very effective local pain relief.

### Difficulty swallowing

If there is an obstructing tumour, try dexamethasone 0.15 mg/kg up to 8 mg OD to temporarily reduce the obstruction. If this is not available, the equivalent dose of prednisolone is 1-2 mg/kg up to 50 mg OD.

Check that there is no evidence of oesophageal candidiasis. If there is, then treat with fluconazole 3 mg/kg up to 200 mg OD.

### Hiccups

This is often a consequence of gastric distension and can be treated with magnesium trisilicate. If this doesn’t help, try omeprazole 0.5 mg/kg up to 20 mg OD and metoclopramide 0.1 mg/kg up to 10 mg TDS. Other alternatives include chlorpromazine 0.5 mg/kg up to 25 mg up to TDS and nifedipine 0.5 mg/kg up to 20 mg OD.

### Nausea and vomiting

The cause of this must be identified and treated. The commonest cause is related to opiate prescription and all patients receiving opiates should be prescribed anti-emetics prophylactically. Often the nausea settles after 4-5 days of treatment and the anti-emetic can then be stopped. Haloperidol, metoclopramide and promethazine are all effective.

Metoclopramide 0.1 mg/kg up to 10 mg PO TDS is useful for gastric and functional intestinal causes of nausea and vomiting.

Promethazine 0.5 mg/kg up to 25 mg PO TDS can be used when the cause is mechanical obstruction or raised intracranial pressure.

Haloperidol 0.125 mg/kg up to 1.5 mg PO up to BD is particularly useful when the cause is renal failure or suspected electrolyte disturbance.

### Constipation

This is often distressing for patients and is an inevitable consequence of treatment with opiates. Lactulose 2.5-20ml PO BD should be given to prevent this. Once constipation develops, patients often need bisacodyl 5-20 mg PO at night.

### Fitting

This is common in patients with cerebral tumours, but is also seen in patients with uraemia. Phenytoin (starting dose 1.5-2.5 mg/kg up to 150 mg BD) or carbamazepine (starting dose 5 mg/kg up to 200 mg at night) should be prescribed early – even before a fit has occurred if the patient is at risk of this.

### Restlessness and confusion

This may require treatment with an antipsychotic. The dose and frequency needs to be adjusted according to the patient’s response. Begin with promethazine 0.25 mg/kg up to 12.5 mg PO TDS. This can be increased to a maximum dose of 0.5 mg/kg up to 25 mg TDS.

Alternatively, haloperidol may be used at a dose of 0.1-0.25 mg/kg up to 1-3 mg PO up to TDS.

### Raised intracranial pressure

Headache due to raised intracranial pressure should be treated with high dose steroids. Use dexamethasone 0.3 mg/kg up to 16 mg PO in the morning for 4-5 days, then reduce to 0.1 mg/kg up to 5 mg OD.

### Difficulty sleeping

Look for the cause of this – possibilities include discomfort, cramps, night sweats, joint stiffness and fear. The cause should be treated in the first instance. If this is not effective, diazepam 0.25 mg/kg up to 5 mg PO at night can be used.

### Shortness of breath

This can be very distressing for patients. If there is any wheeze or obstruction, try dexamethasone 0.075-0.15 mg/kg up to 4-8 mg PO OD. If the patient is anxious, diazepam up to 5 mg PO TDS may help. Otherwise, this symptom often responds to a regular low dose of oral morphine – prescribe as for pain.

### Intractable cough

Oral morphine is effective if given regularly – usually lower doses are needed compared to those required for pain relief.

### Fungating tumours and painful wounds

Fungating smelly tumours should be dressed and treated with topical metronidazole, which is made up by crushing metronidazole tablets into paraffin ointment. Some patients will require oral metronidazole.

Where wounds are painful, this can be reduced by opening a loperamide capsule and suspending the contents in water. The suspension can be painted over the wound as often as necessary.

### Itch

This is often helped by the use of emulsifying ointment – which can be rubbed on as often is necessary. Anti-histamines are usually ineffective and may cause significant side effects.

## Key Issues for Nursing care

## It is very important that patients know that they can ask for help at any time. Tell them and their relatives to inform the nursing staff if they are in pain, vomiting or having any other symptoms. If a patient informs you about these problems, check the drug chart and dispense any PRN medications prescribed. If the problems are new or nothing is prescribed, call the doctor to review the patient.

Patients and their relatives may be very afraid during this phase of care. Take time to listen to them, to identify their fears and to honestly reassure them. This does not mean telling them not to worry, but reassuring them that we are there to help and will do all we can to ensure they are not in any discomfort or distress.

Ensure you are aware of which patients are for palliative care. Check if MEWS should be calculated and if resuscitation is to be initiated if they deteriorate.

## References

Joint Formulary Committee (2016) British National Formulary. 72nd Ed., London: British Medical Association and  Royal Pharmaceutical Society of Great Britain.

Joint Formulary Committee (2016) British National Formulary for Children. London: British Medical Association and  Royal Pharmaceutical Society of Great Britain.

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| --- | --- | --- |
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