# PARENTAL DRUGS FOR END OF LIFE CARE – symptom control with the subcutaneous route
# PANDEMIC CORONAVIRUS

**COVID symptom control for end of life care: parenteral medications ( patients needing subcutaneous route)**

A brief synopsis of advice for symptom control of those patients with significant symptoms from COVID.

- It is aimed for patients in any care setting – home, hospital, nursing home and the hospice
- All patients need an individual assessment and individualised prescribing.
- **Specialist palliative care advice is available 24/7 via the Palliative Care Advice line on 01736 757707** and you should seek advice if unsure about what drugs or dosages to prescribe.
- Key is to consider whether the patients requires parenteral (sub cut) medications or non parenteral (oral, rectal, topical, sublingual routes). This guidance considers the parenteral group. Guidance is available for the non-parenteral group.
- If the patient is currently on regular analgesia, benzodiazepines or antiemetic medications and can no longer take these by mouth please take this into account in prescribing as they may need higher or regular doses subcutaneously.
- This guidance addresses symptoms of pain, agitation, nausea and respiratory secretions. This is not an exhaustive list and individual patients may have other troublesome symptoms which need attention and may need specialist advice. All patients at end of life will need attention given to skin and mouth care, bladder and bowel symptoms and may need appropriate prescribing to address these.

Palliative Care contact for advice details:

- 24/7 advice line (consultant pall med) **01736 757 707**
- Community team Monday to Sunday, 9am-5pm **01208 251300**
- Hospital palliative care nursing team Monday to Sunday (from 30/3/2020) 8am to 4pm via **bleep 3055**

**For patients with <u>distressing breathlessness</u> at rest please consider starting a subcutaneous syringe pump/24hrs of:**

Morphine* 10mg + midazolam 10mg OR

Alfentanil* 500micrograms + midazolam 5mg (if eGFR <15)

Add haloperidol 2.5 – 5mg or levomepromazine 12.5 if delirium or nausea/vomiting

Add hyoscine hydrobromide 1.2 – 2.4mg or hyoscine butylbromide (buscopan) 60mg (if eGFR<15) or glycopyrronium 0.6-1.2mg (if eGFR<15) if chest secretions

**** For those patients already on opioids, please see APG and opioid conversion table below**

**Please ensure prn medication is written up for each symptom pain/breathlessness/cough/nausea & vomiting/agitation & delirium, respiratory secretions – as per APG guidance attached.**

**Cough** – sc opioid as per APG guidance.

**Pyrexia** - Use paracetamol oral or PR 1g up to QDS

| Symptom | Drug | PRN subcutaneous dose for anticipatory symptoms, as needed | Starting dose range over 24 hours in syringe driver (subcutaneous) if needed | Vial Strengths | Maximum dose over 24 hours |
|---|---|---|---|---|---|
| **1. Pain/Breathlessness**<br><br>NB If already on oral opioids, see below for conversion. **If severe renal impairment, seek specialist advice** | **Diamorphine** | 2.5mg 1 hourly if opioid naïve or 1/6th of 24 hr subcutaneous opioid dose | 7.5mg-15mg<br><br>(if not already taking | 5,10,30 or 100mg amps | No upper limit |
| | **Morphine** | 2.5mg-5mg 1 hourly prn if opioid naïve or 1/6th of 24 hr subcutaneous opioid dose | 10mg-20mg<br><br>(if not already taking opioids) | 10mg/ml | No upper limit |
| **2. Nausea/vomiting**<br><br>Opioid or centrally induced | **Haloperidol and/or** | 1.5mg-3mg bd | 3mg-5mg | 5mg/ml | 10mg |
| | **Cyclizine*** | 50mg tds (if not on regular cyclizine) | 150mg | 50mg/ml | 150mg |
| Prokinetic | **Metoclopramide** | 10mg tds | 30mg-60mg | 10mg/2ml | 80mg |
| Second Line | **Levomepromazine** | 6.25mg qds | 6.25mg-12.5mg | 25mg/ml | 25mg |
| **3. Agitation** | **Midazolam** | 2.5mg-5mg initially 1 hourly prn | 10mg-30mg | 10mg/2ml | 60mg |
| +hallucinations or confusion | **Haloperidol** | 1.5mg-3mg bd | 3mg-5mg | 5mg/ml | 10mg |
| | **Levomepromazine** | 6.25-12.5mg (max qds) | 6.25mg-12.5mg | 25mg/ml | 100mg |
| **4. Noisy breathing due to respiratory tract secretions** | **Glycopyrronium Bromide** | 200 microgram 4 hourly | 600microgram – 1200 microgram | 600mcg/3ml | 1200 microgram |
| | **Hyoscine Butylbromide*** | 20mg 4 hourly | 60mg-100mg | 20mg/ml | 120mg |
| | **Hyoscine Hydrobromide** | 400 microgram 4 hourly | 1.2mg-2.4mg | 400mcg/ml | 2.4mg |

Advice is available 24 hours a day, 7 days a week to any healthcare professional from **the ADVICE LINE at Cornwall Hospice Care – 01736 757707**
The guidance above are well accepted drugs and doses used at the end-of-life. Call the advice line if advice is needed at any time.

## Opioid dose conversion

| Oral Morphine | | | Subcutaneous Morphine | | Subcutaneous Diamorphine | | Oral Oxycodone | | | Subcutaneous Oxycodone | | Fentanyl Transdermal | Subcutaneous Alfentanil | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4hr dose (mg) | 12hr SR dose (mg) | 24 hr total dose (mg) | 4hr dose (mg) | 24hr total dose (mg) | 4hr dose (mg) | 24hr total dose (mg) | 4hr dose (mg) | 12hr SR dose (mg) | 24hr total dose (mg) | 4hr dose (mg) | 24hr total dose (mg) | Patch strength (micrograms) | 4hr dose (mg) | 24hr total dose (mg) |
| 5 | 15 | 30 | 2.5 | 15 | 1.25 | 10 | 2.5 | 7.5 | 15 | 1.25 | 7.5 | 12mcg | 0.125 | 1 |
| 10 | 30 | 60 | 5 | 30 | 2.5-5 | 20 | 5 | 15 | 30 | 2.5 | 15 | 25mcg | 0.25 | 2 |
| 15 | 45 | 90 | 7.5 | 45 | 5 | 30 | 7.5 | 25 | 50 | 3.75 | 25 | 25mcg | 0.5 | 3 |
| 20 | 60 | 120 | 10 | 60 | 7.5 | 40 | 10 | 30 | 60 | 5 | 30 | 37mcg | 0.75 | 4 |
| 30 | 90 | 180 | 15 | 90 | 10 | 60 | 15 | 45 | 90 | 7.5 | 45 | 50mcg | 1 | 6 |
| 40 | 120 | 240 | 20 | 120 | 12.5 | 80 | 20 | 60 | 120 | 10 | 60 | 75mcg | 1.25 | 8 |
| 50 | 150 | 300 | 25 | 150 | 15 | 100 | 25 | 75 | 150 | 12.5 | 75 | 75mcg | 1.5 | 10 |
| 60 | 180 | 360 | 30 | 180 | 20 | 120 | 30 | 90 | 180 | 15 | 90 | 100mcg | 2 | 12 |
| 70 | 210 | 420 | 35 | 210 | 25 | 140 | 35 | 105 | 210 | 17.5 | 100 | 125mcg | 2.5 | 14 |
| 80 | 240 | 480 | 40 | 240 | 27.5 | 160 | 40 | 120 | 240 | 20 | 120 | 125mcg | 2.5 | 16 |
| 90 | 270 | 540 | 45 | 270 | 30 | 180 | 45 | 135 | 270 | 22.5 | 135 | 150mcg | 3 | 18 |
| 100 | 300 | 600 | 50 | 300 | 35 | 200 | 50 | 150 | 300 | 25 | 150 | 150mcg | 3.5 | 20 |
| 110 | 330 | 660 | 55 | 330 | 37.5 | 220 | 55 | 165 | 330 | 27.5 | 165 | 175mcg | 3.75 | 22 |
| 120 | 360 | 720 | 60 | 360 | 40 | 240 | 60 | 180 | 360 | 30 | 180 | 200mcg | 4 | 24 |

This is to be used as a guide rather than a set of definitive equivalences. Most data on doses is based on single dose studies so it is not necessarily applicable in chronic use, also individual patients metabolise different drugs at varying rates. The advice is always to calculate doses using Morphine as standard and to adjust them to suit the patient and the situation. Some of these doses have by necessity been rounded up or down to fit in with the preparations available.(Reproduced with kind permission of Margaret Gibbs, St Christopher's Hospice 2nd edition 2006)

| DRUG | DRUG DOSE | APPROXIMATE CODEINE EQUIVALENCE | APPROXIMATE ORAL MORPHINE EQUIVALENCE |
|---|---|---|---|
| BuTrans 5 | 5 micrograms/**hour** | 60mg/**24 hours** | 10mg/ **24 hours** |
| BuTrans 10 | 10 micrograms/**hour** | 120mg/**24 hours** | 20mg/ **24 hours** |
| BuTrans 20 | 20 micrograms/**hour** | 240mg/ **24 hours** | 40mg/ **24 hours** |

*or anticipatory prescribing guidance. Authors: B Medlock (GP partner), J Gibbins, C Campbell, R Newman, K Scott, M Huddart, D Stevens (Consultants in Palliative Medicine, Cornwall Hospice Care).**V7**. Due for*
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