# SPAGG

**Coversheet for Specialist Palliative Audit and Guideline Group Agreed Documentation**

This sheet is to accompany all documentation agreed by SPAGG. This will assist maintenance of the guidelines as well as demonstrating the governance process undertaken prior to members seeking local approval in their areas of work.

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| **Document Title** | Anticipatory Medication Guidelines |
| **Document Date** | August 2021 |
| **Document Purpose and Intended Audience** | The aim of these guidelines is to ensure staff are informed and able to manage patients symptoms at the end of life<br><br>These guidelines are suitable for use in both primary community care and in the in-patient setting |
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| **References** | N/A |
| **Consultation Process** | Reviewed by SPAGG and ratified |
| **Monitoring** | This will be audited and reviewed every 3 years |
| **Review Date** (must be within three years) | August 2024 |
| **Approval Signatures:**<br>SPAGG chair<br>SPAGG secretary | <br>J. Tomas<br>A. Gray |
| **Date Approved by SPAGG: August 2021** | |
| **Date submitted to Area Prescribing Committee: N/A** | |

**Version History**

| Version | Date | Summary of change/ process |
|---|---|---|
| | | |

# Anticipatory Medication Guidelines

Symptoms commonly experienced by patients entering the terminal phase include pain, agitation, nausea, vomiting, breathlessness and excessive chest secretions.

To provide prompt and effective symptom control and to reduce distress and anxiety for patients and their carers, it is advocated that medications used to manage these symptoms are prescribed in anticipation of need. These medications are prescribed in anticipation of patient being unable to swallow their regular symptom control medications, and given by the subcutaneous (SC) route if needed when unable to take by oral route.

The following table and algorithms outline common doses of drugs used to treat the above symptoms and is for use in all settings. They have been designed to be used in conjunction with any local prescribing guidance and authorisation forms.

For further information or if symptoms not managed please consult your local palliative care team or your pharmacist.

For the purposes of this document the dying phase is considered to be a prognosis of less than six weeks, or if 'phase of illness' ranking is used then when patient considered to be 'deteriorating' or 'dying' (further guidance on recognising the dying phase). For community medicines administration please complete the local authorisation form.

| Symptom | Drug | Dose | Route | Notes |
|---|---|---|---|---|
| Pain (eGFR >30) | Morphine Sulfate<br><br>If eGFR <30 consider either opioid switch below, or dose reduction | 2.5 - 5mg | Subcutaneous injection | If patient already taking regular morphine the PRN dose is usually 1/6$^{th}$ of the 24 hour opioid dose. For patients receiving alternative opioids please contact the palliative care team or pharmacist for advice. |
| Pain (eGFR<30) | See specialist algorithm for either Fentanyl or Alfentanil | | | |
| Agitation | Midazolam | 2.5mg - 5mg<br>*(If eGFR <30 dose reduction to 1.25mg – 2.5mg) | Subcutaneous injection | To be given hourly as required.<br>Maximum 60mg in 24hrs.<br><br>N.B. if eGFR <30<br>Maximum 30mg in 24hrs |
| Nausea and vomiting | Levomepromazine | 2.5mg - 5mg | Subcutaneous injection | Four hourly as required.<br>Maximum dose 25mg in 24 hours |
| Chest Secretions | Hyoscine butylbromide | 20mg | Subcutaneous injection | Two hourly as required.<br>Maximum dose 120mg in 24 hours |
| Breathlessness | Morphine Sulphate | 2.5-5mg -2.5mg<br>*(If eGFR <30 dose reduction to 1.25mg – 2.5mg) | Subcutaneous injection | Hourly as required |

# OPIOID CONVERSION: Anticipatory medication

There is no exact equivalent between opioids, starting low and titrating upwards is recommended safe practice.

Approximately equivalent opioid doses for PRN use:

| Oral morphine | Morphine subcutaneous injection |
|---|---|
| 5 mg | 2.5 mg |
| 10 mg | 5 mg |

Approximately equivalent opioid doses for starting doses in subcutaneous infusions:

| Oral morphine in 24 hours | Morphine injection via CSCI |
|---|---|
| 30 mg | 15 mg |
| 60 mg | 30 mg |

**Opioid choice in pre–existing renal impairment**: Morphine is NOT routinely use as continuous infusion in patient with known renal impairment <30) because of the high risk of accumulation and adverse effects.

However it is **not** necessary to routinely check the renal function of all dying patients who are comfortable on their regular opioid - even if they develop undetected renal impairment, it may not be necessary to convert to an alternative unless they develop side effects or signs of opioid toxicity such as myoclonic jerks; please note drowsiness and reduced consciousness can be part of the dying process and doesn't necessarily mean the person is opioid toxic. If eGFR <30 see our specialist algorithm for either Fentanyl or Alfentanil, the choice of drug will be locality specific.

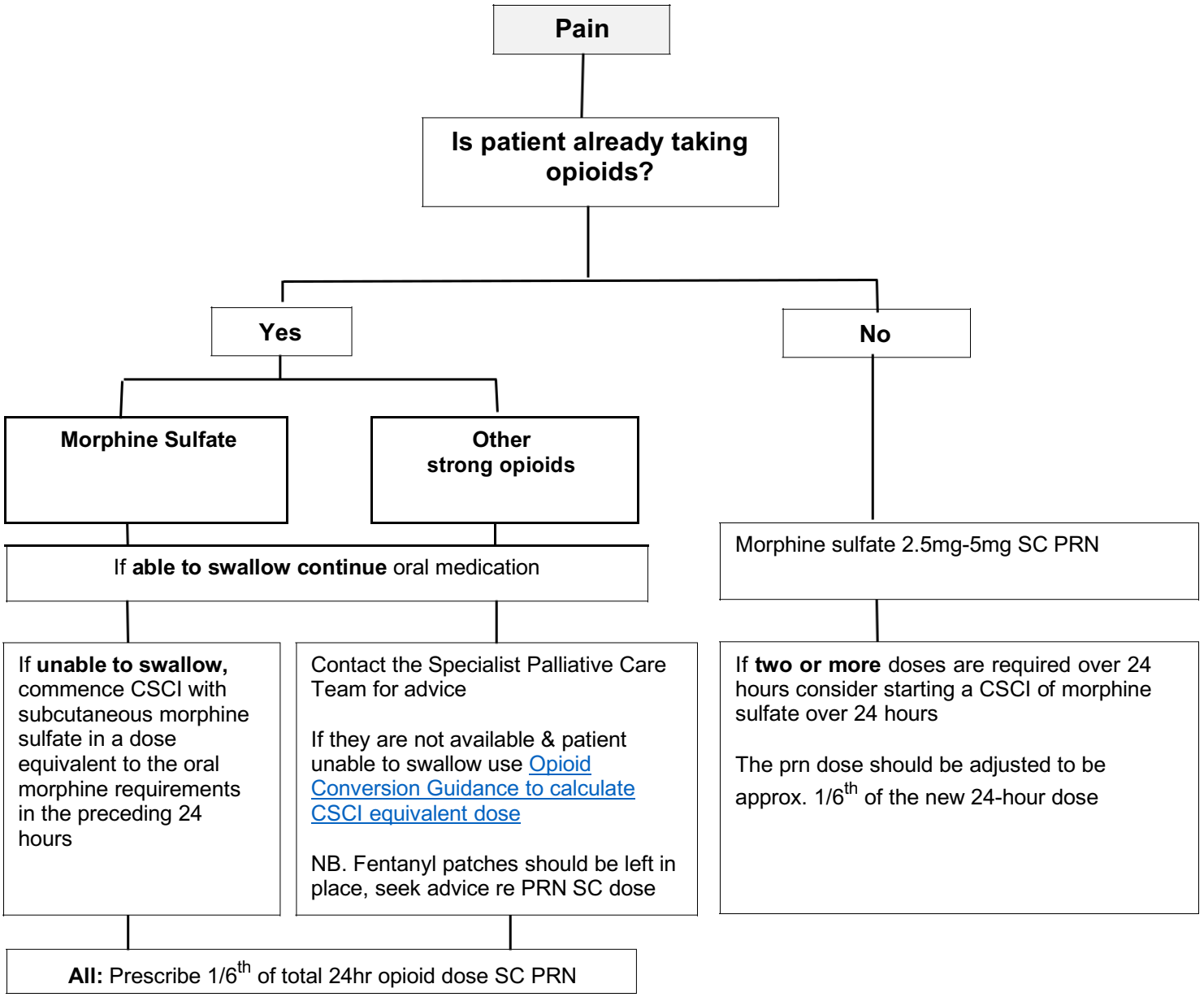
**Seek Specialist Palliative Care Advice**: If converting from alternative strong opioids, if analgesia requirements are escalating, distressing opioid side effects, if clinician is unclear about appropriate choice of opioid or an alternative opioid is prescribed.

## Further information:

West Midlands Palliative Care Physicians Symptom Control Guidelines

# Algorithm for Pain in patients using Morphine Sulfate SUBCUTANEOUSLY (eGFR >30mls/min)

| Explanation & psychological support for patient/carers /family | Exclude treatable causes for pain e.g. constipation | Consider positioning for comfort |
|---|---|---|



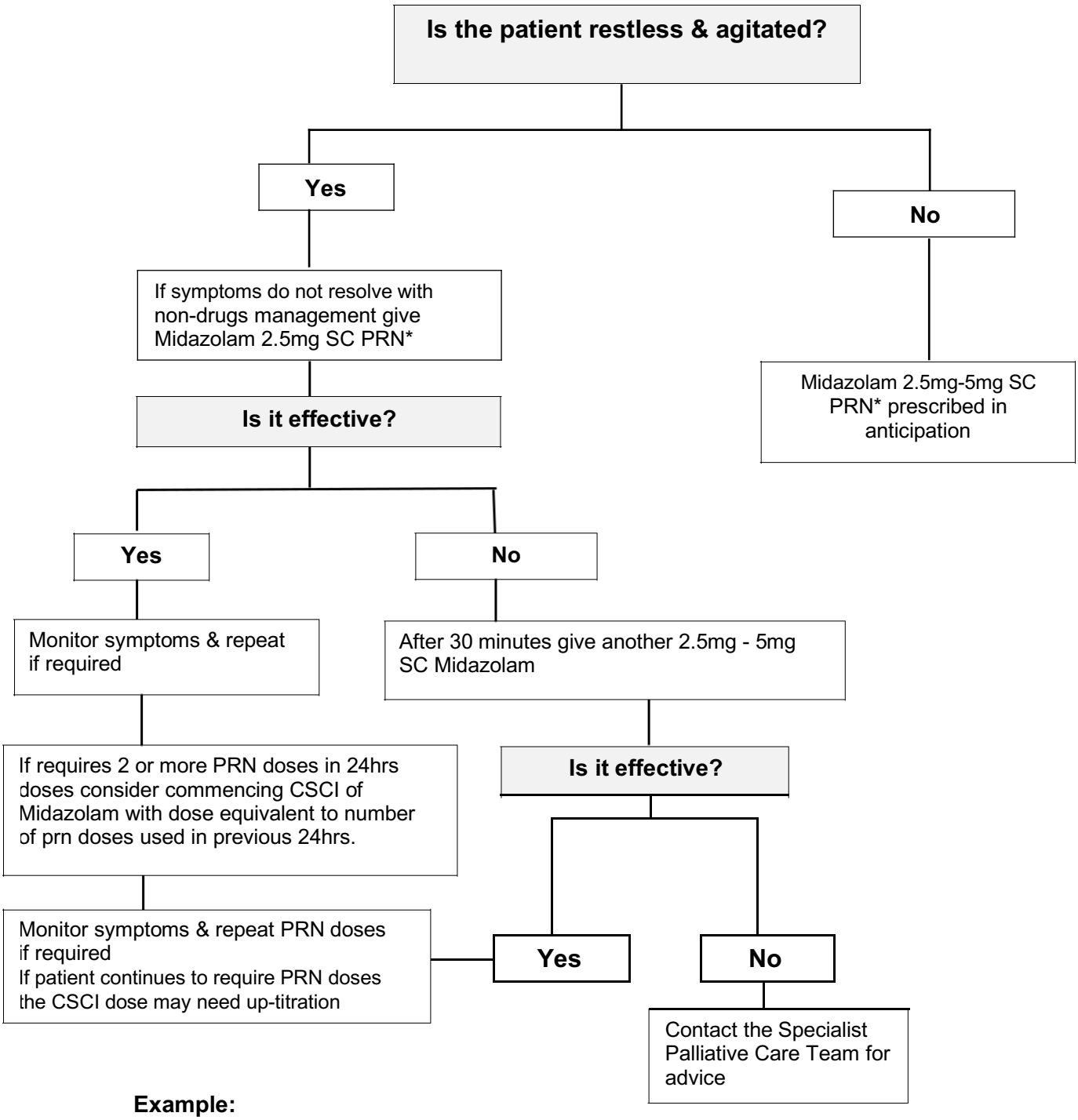

**Example conversions:**

1. To calculate the equivalent total 24 hourly dose of SC morphine, divide total 24 hourly dose of regular oral morphine plus sum total of Oramorph PRNs used by 2 (e.g. 20mg oral morphine = 10mg SC morphine)
2. To calculate the breakthrough dose of morphine sulphate divide total 24-hourly dose of SC morphine by 6 and prescribe this dose, 2 hourly SC PRN (e.g. 15mg SC morphine over 24 hours = 15mg/6 = 2.5mg SC PRN)

**Review pain at each assessment - if more than 2 PRN doses used in 24hrs, consider if 24hr CSCI needs to be increased or seek specialist advice.**

# Algorithm for Agitation

| Explanation & psychological support for patient/carers /family | Exclude causes of delirium e.g. constipation, urinary retention, hypercalcemia, nicotine withdrawal | Consider environmental modifications & non-drug management |
|---|---|---|

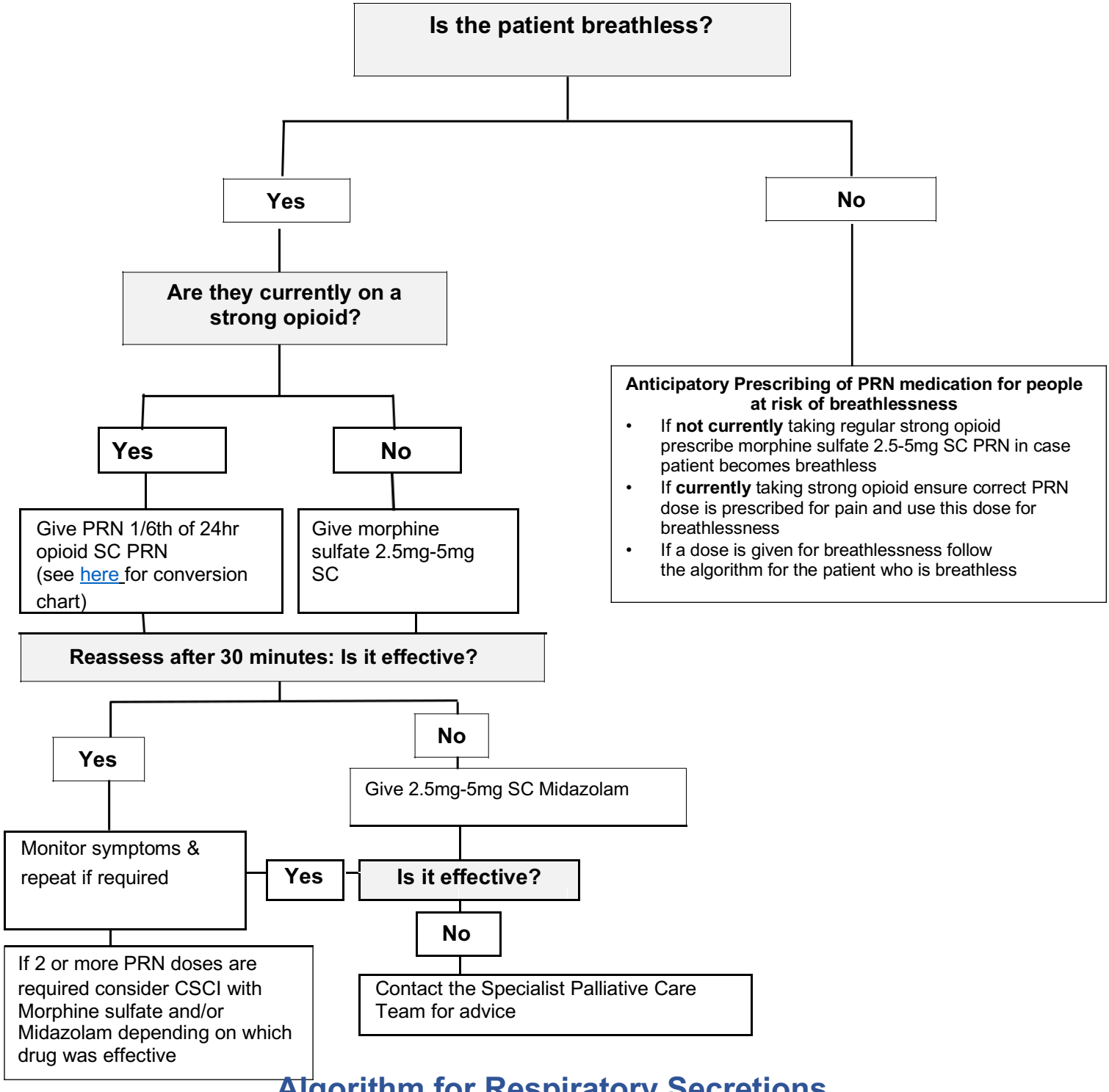



**Example:**
If patient has required 4 doses of 2.5mg Midazolam to manage restlessness in previous 24 hours then a suitable dose would be 10mg midazolam in CSCI over 24hours.

*If eGFR <30 dose give reduced dose of Midazolam 1.25mg – 2.5mg

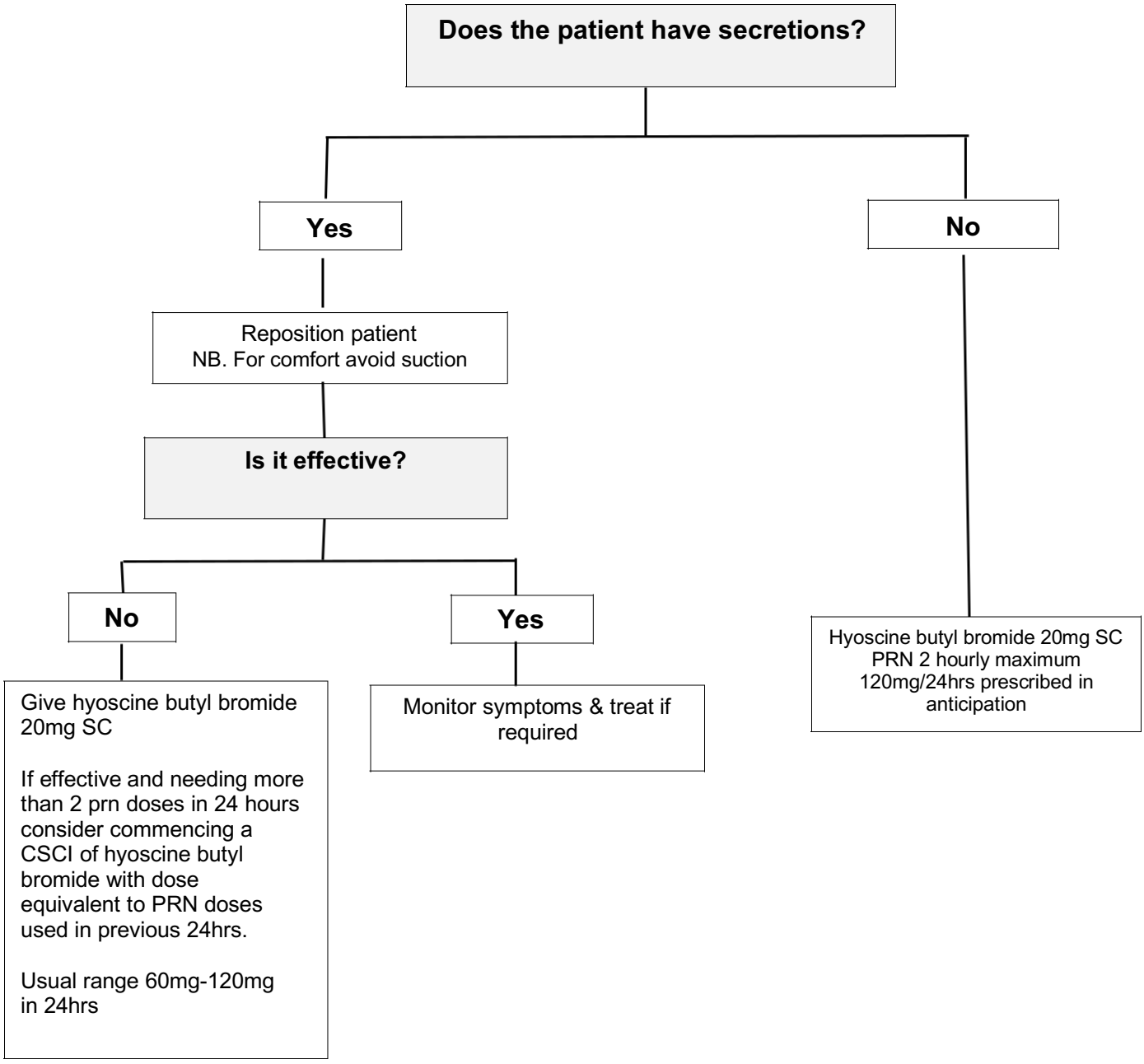
# Algorithm for Breathlessness

| | | |
|---|---|---|
| **Explanation & psychological support for patient/carers /family** | **Consider causes<br>pleural effusion, heart failure<br>pneumonia & treat if appropriate<br>Check blood oxygen levels consider if oxygen appropriate** | **Non pharmacological approaches e.g. positioning, reduce room temperature ,cooling the face by using a cool flannel or cloth** |




# Algorithm for Respiratory Secretions

| Explanation & psychological support for patient/carers/family | Exclude causes of fluid overload e.g. ongoing parenteral fluids, chest infection, nasogastric feed, humidified oxygen | Consider repositioning |
|---|---|---|



# Algorithm for nausea and vomiting

| | | |
|---|---|---|
| **Explanation & psychological support for patient/carers /family** | **Exclude treatable causes e.g. constipation, hypercalcemia, bowel obstruction** | **Consider strategies to keep away triggers e.g. strong smells** |