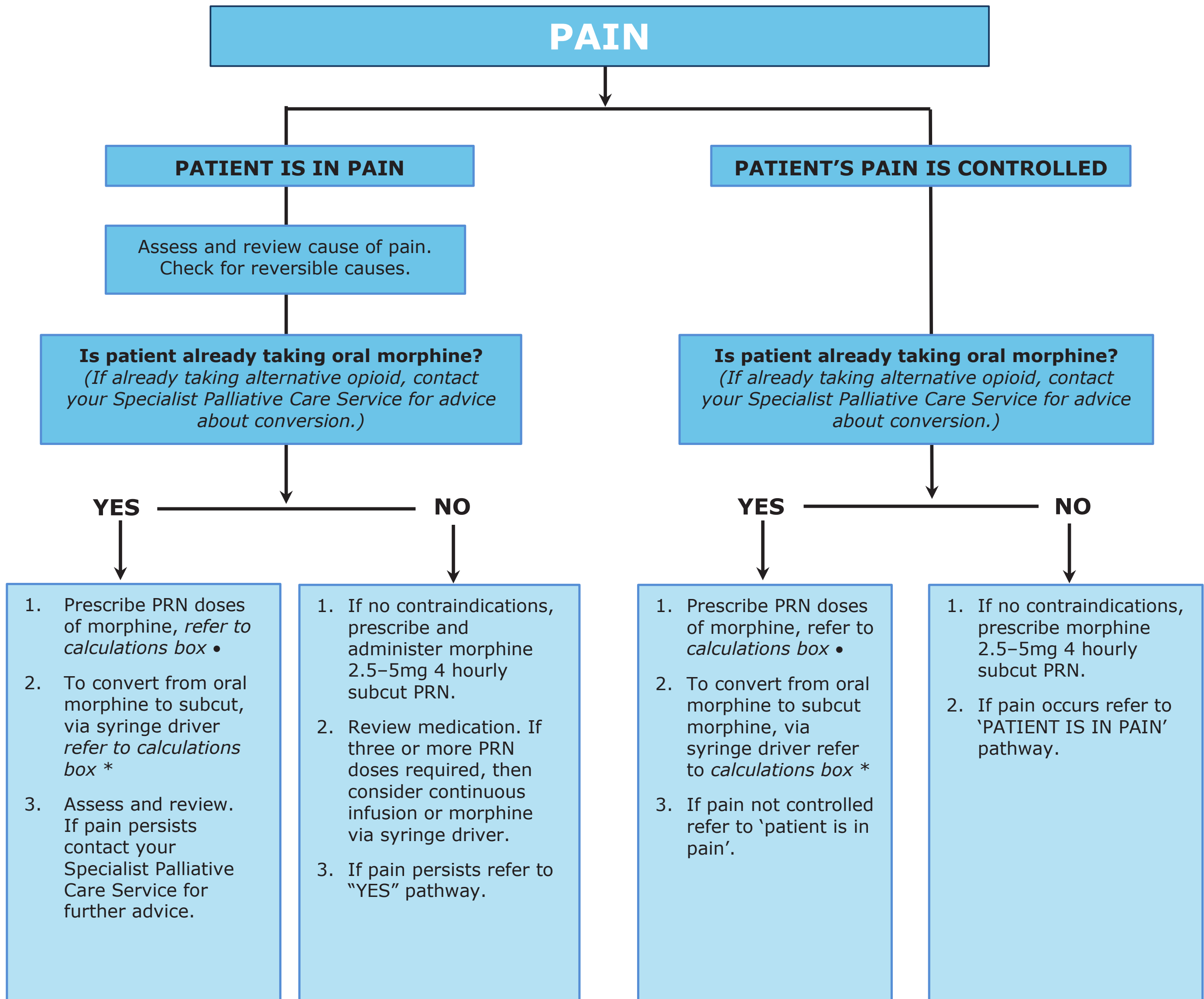
MINISTRY OF HEALTH
MANATŪ HAUORA

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

BINDING MARGIN – NO WRITING



Supporting Information:

- To convert from alternative opioid contact Specialist Palliative Care services for advice.
- Review drug, dose and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.
- If pain is INCIDENT pain only (e.g. on turning) continue with long acting doses and utilise PRN pre-emptive doses.

NB:
subcut (subcutaneous)
PRN (as required)

Calculations

Morphine/Oxycodone:

To CONVERT from oral morphine to subcutaneous morphine: subcutaneous dose = 1/2 oral dose.
To CONVERT from oral oxycodone to subcutaneous oxycodone: subcutaneous dose = 2/3 oral dose.
To CONVERT to 24 hr *continuous subcutaneous infusion (CSCI): Contact your specialist palliative care service for advice.
TO CALCULATE PRN subcutaneous or oral doses (morphine or oxycodone): PRN dose = 1/6 total 24 hour dose 3-4 hourly.

NB: If you require further advice at any time, 24 hours a day, please contact Arohanui Hospice (06) 356 6606.
For Palmerston North Hospital inpatients contact the Hospital Palliative Care Service, Mon to Fri, 8.30am – 5pm.

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For those with Renal Impairment (eGFR≤30) or (eGFR≤15)
PAIN (see Practice Point below)

Is patient already taking oral opioids?
Is the patient already taking opioids?
(If eGFR <30 but >15 consider oxycodone).

YES

See Practice Point below:

1. If patient is already taking strong opioids, keep dosing orally for as long as possible.
2. Prescribe PRN doses of opioid
   - 2.1 For those established on oxycodone consider 1–3mg 4 hourly subcut PRN
   - 2.2 For severe renal failure and those established on Fentanyl consider 12.5–25 micrograms subcut 1–2 hourly PRN.
3. To convert to subcut via syringe driver refer to “CALCULATIONS” box on previous page.
4. Contact your Specialist Palliative Care Service for advice for converting methadone to subcut dosing.

NO

1. eGFR 15-30: oxycodone 1–3mg 4 hourly subcut PRN.
2. eGFR ≤15: fentanyl 25 micrograms subcut 1–2 hourly PRN.

NB:
subcut (subcutaneous)
PRN (as required)

If three or more doses are required over 24 hours consider starting a syringe driver of oxycodone or fentanyl.

Example for oxycodone:

10mg oxycodone in a syringe driver over 24 hours, PRN dose should be 1/6th of the 24 hour dose.
PRN dosing; 10mg oxycodone give 1–3mg 3–4 hourly.

Example for Fentanyl:

Fentanyl 100–250 micrograms in a syringe driver over 24 hours, PRN dose should be 1/8th of the 24 hour dose.
PRN dosing; 100 micrograms/24 hours give 12.5 micrograms 1–2 hourly PRN.
PRN dosing; 200 micrograms/24 hours give 25 micrograms 1–2 hourly PRN.

BINDING MARGIN – NO WRITING

Supporting Information:

- To convert from an alternative opioid contact Specialist Palliative Care services for advice.
- Many of the opioid analgesics and their metabolites may accumulate in Renal Failure causing toxicity with myoclonic jerks, profound narcosis and respiratory depression. Morphine and its metabolites are most likely to cause toxicity. Fentanyl is less likely to cause these problems, as the metabolites are not active.
- The duration of effect from morphine and oxycodone may last longer than in a patient with normal renal function.
- **When discharging to community from hospital and the person is using fentanyl ensure this is available in community setting.**

Calculations

Fentanyl:
For patient established on transdermal fentanyl the subcutaneous PRN dose is roughly equivalent to the hourly transdermal dose, to a maximum of 100 micrograms (2mls) e.g. 25 micrograms subcutaneously PRN 1 hourly. If hourly PRN dosing is not practical in the community then alternatively oxycodone can be used 4 hourly. For dosing advice call specialist palliative care services.

Practice Point: “Because of the risk associated with using an unfamiliar opioid, a pragmatic approach is important. Thus, the cautious use of a familiar opioid (including morphine) may be preferable to switching to an unfamiliar (albeit safer) one. The ease of obtaining and, administering and titrating the opioid are also important considerations, particularly in the community setting”.
Palliative Care Formulary, 7th Edition p727.

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PATIENT ID LABEL

Differentiate between dyspnoea and respiratory tract secretions

DYSPNOEA

PRESENT

Is patient already taking oral morphine or oxycodone for breathlessness?

YES

1. Convert to subcut morphine or oxycodone, prescribe and administer PRN 4 hourly.

NO

1. Prescribe and administer Morphine 2.5mg–5mg subcut PRN 4 hourly, for dyspnoea.

Then:

2. Assess, if still dyspnoeic, consider adjusting morphine or oxycodone dose and/or administering via syringe driver.

   If dyspnoeic **and anxious**:
   - Consider adding midazolam 2.5–5mg subcut PRN 4 hourly
   - Consider continuous infusion of midazolam 5–15mg via syringe driver (lower dose for age and frailty).

3. If dyspnoea persists contact your Specialist Palliative Care Service for further advice.

ABSENT

Is patient already taking oral morphine?

YES

Prescribe appropriate PRN morphine dose for pain or dyspnoea.

NO

Prescribe morphine 2.5–5mg subcut PRN 4 hourly for dyspnoea.

NB:
subcut (subcutaneous)
PRN (as required)

BINDING MARGIN – NO WRITING

Supporting Information:

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- Many of the opioid analgesics and their metabolites may accumulate in Renal Failure causing toxicity with myoclonic jerks, profound narcosis and respiratory depression. Morphine and its metabolites are most likely to cause toxicity. Fentanyl is less likely to cause these problems, as the metabolites are not active.
- The duration of effect from morphine and oxycodone may last longer than in a patient with normal renal function.

Calculations

Morphine/Oxycodone:

To CONVERT from oral morphine to subcutaneous morphine: subcutaneous dose = 1/2 oral dose.
To CONVERT from oral oxycodone to subcutaneous oxycodone: subcutaneous dose = 2/3 oral dose.
To CONVERT to 24 hr *continuous subcutaneous infusion (CSCI): Contact your specialist palliative care service for advice.
TO CALCULATE PRN subcutaneous or oral doses (morphine or oxycodone): prn dose = 1/6 total 24 hour dose 3–4 hourly.

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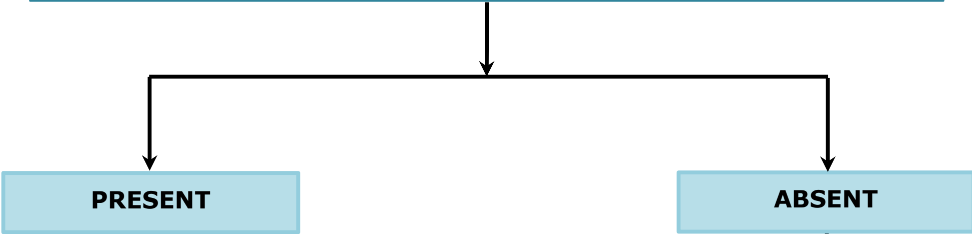
PATIENT ID LABEL

TERMINAL RESTLESSNESS & AGITATION



PRESENT

- Exclude pain
- Exclude urinary retention
- Consider spiritual distress

1. Prescribe and administer midazolam 2.5–5mg subcut PRN 4 hourly (lower dose for age and frailty).
2. Continue to give PRN doses; if 3 or more doses are required in 24 hours, go to Step 3.
3. Review and assess, consider initiating a syringe driver using the total required dose over the previous 24 hours as a guide to dosage. Continue to review daily and titrate – see "Supporting Information".
4. If restlessness and agitation persist, contact your Specialist Palliative Care Service for further advice.

ABSENT

1. Prescribe midazolam 2.5–5mg subcut PRN 4 hourly.

If restlessness and agitation occur change to symptom ***"PRESENT"*** guide.

Pre-existing conditions

- In conditions such as dementia with BPSD (Behavioural and Psychological Symptoms of Dementia), many of the routinely used medications cannot be given subcutaneously so alternatives need to be prescribed.
- For patients on large doses of background anxiolytics, higher doses of benzodiazepines may be required at the end of life.

NB:
subcut (subcutaneous)
PRN (as required)

BINDING MARGIN – NO WRITING

Supporting Information:

- The management of agitation and restlessness does not usually require the use of opioids unless the agitation and restlessness is thought to be caused by pain.
- Review drug, dose and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.

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BINDING MARGIN – NO WRITING

RESPIRATORY TRACT SECRETIONS

PRESENT

- Explain symptom to family and whanau.
- Re-position patient.
- If the symptoms persist and is distressing for the patient, family or whānau, move to next step.

1. PRN hyoscine-n-butylbromide 20mg subcut 4 hourly.

2a. Assess – if symptoms persist and stat dose of hyoscine-n-butylbromide **was** helpful.

Consider syringe driver, with hyoscine-n-butylbromide 60–80mg over 24 hours.

2b. Assess – if symptoms persist and stat dose of hyoscine-n-butylbromide **was not** helpful.

Consider prescribing/applying scopolamine TTS x 1 over 72 hours (3 days).

If symptoms persist contact your Specialist Palliative Care Service for further advice.

ABSENT

1. Prescribe hyoscine-n-butylbromide 20mg subcut PRN 4 hourly.

   If respiratory tract secretions occur change to symptom "***PRESENT***" guide.

NB:
subcut (subcutaneous)
PRN (as required)
hyoscine-n-butylbromide = Buscopan
scopolamine TTS = Scopaderm

Supporting Information:

- Early use of medication may enable more successful management of this symptom.
- Review drug, dose and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.
- Anti-cholinergic medication may not alleviate this symptom.

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BINDING MARGIN – NO WRITING

NAUSEA & VOMITING

PRESENT

1. Prescribe and administer levomepromazine 2.5–5mg subcut PRN 8 hourly.
2. Consider regular administration via syringe driver if symptom persists. i.e. levomepromazine 5mg over 24 hours. Ensure a subcut PRN dose is also available.
3. Review dosage after 24 hours.
4. If symptoms persist, consider increasing dose i.e. levomepromazine 8–10mg over 24 hours via syringe driver.
5. If symptoms persist contact your Specialist Palliative Care Service for further advice.

ABSENT

1. Prescribe levomepromazine 2.5–5mg subcut 8 hourly PRN.

If symptoms occur change to symptom ***'PRESENT'*** guideline.

NB:
subcut (subcutaneous)
PRN (as required)

Supporting Information:

- Levomepromazine can be sedating.
- Review drug, dose and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.

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