

Palliative Care

Aims

- To gain the relevant skills to manage syringe drivers in the community
- To identify best practice in prescribing opioids and other strong medication in the community palliative care setting
- To answer questions you may have regarding care for this group of patients
- To have a look at the hospice and gain an understanding of what we offer

Menu

- The Syringe Driver
- Skills suggested when looking after the dying
- Opioids at the end of life
- Moral and practical considerations
- Alternative opioids their place and problems
- Further learning opportunities
- Practical points about the hospice
- Questions and answers

A Case

- You are contacted by the DN team to say Mr Patient has deteriorated over the past 2 days and can no longer take his medication by mouth.
- He has cancer of the lung with bone and liver mets, there are no further anti-cancer treatments available.
- His pain is well controlled on Zomorph 60mg BD though he has been troubled by nausea, is becoming quite agitated and also chesty.
- You are being requested to prescribe the appropriate medication to manage the last few days of life.

A Case

- Please complete the FP10 for the required medication and the prescription sheets necessary for the district nurses.
- These will be marked for completeness and a prize available for the winner

The Syringe Driver

Prescribing for Syringe Drivers

- Appropriate medication for Mr Patient
 - Diamorphine 40mg or morphine 60mg in syringe driver
 - Midazolam 10mg – 20mg
 - Anti-cholinergic for respiratory secretions
 - Anti-emetic
- Syringe driver and PRN with range
- Water for injections to make up the mixture
- Controlled drugs legally prescribed
 - Words and figures
 - Total amount stated
- Legibility

Opioids and the End of Life

- What are your concerns?

Mr Patient

- You are called to see Mr Patient. You recognise he is dying in the next few hours
- He remains agitated and appears in pain
- The family are asking you to give him something to ease his suffering, suggesting “you wouldn’t let a dog suffer like this”
- You give a dose of diamorphine 7.5mg and midazolam 2.5mg
- What thoughts go through your mind in doing this?

Mr Patient

- Mr Patient dies 1 hour later
- He was very comfortable during that time and the family are pleased you had come and addressed their need
- Mr Patient's son comes to see you a few days after and asks whether the last injection you gave might have hastened his death
- How would you answer this?

Opioids and the End of Life

- What are our concerns?
 - Prescribing in advance
 - Starting opioids at the appropriate dose
 - Misuse of patches
 - Mistakes in dose conversions
 - Considering other drugs that may be required at the same time
 - Prescribing PRN medication alongside the syringe driver

Opioids and the End of Life

- Moral and legal issues
- Practical issues
 - Recognising the dying patient
 - Conversions of strong opioids
 - Prescribing competently
 - Communication skills to support this

The Moral and Legal Issues

- Moral obligation to provide good symptom control for a dying patient
- Potential risk this may shorten the patients life
- High profile cases with doctors in court charged with murder (rightly or wrongly)
- Public perceptions over morphine use and ending life
- Justification comes from the Doctrine of Double Effect (DDE)

Examples

- Annie Lindsell
 - “Terminally ill woman in painless death plea”
 - “Dying woman wins right to end life in dignity”
- Dr Cox
- Dr Moore
- Dr Shipman

The Doctrine of Double Effect

- An action which may shorten life is justified provided the following criteria are met:
 - The intention has to be good
 - The bad effect may be foreseen but not desired
 - The bad effect may not be the means of achieving the good effect
 - The bad effect must in proportion with the good it achieves
- Recognised morally and legally

The Doctrine of Double Effect

- Appears intuitively “right” but this doesn’t mean it is morally (or legally) correct
- Allows intention to be the significant factor (though how to be sure)
- Allows a weighing up of risks between shortening life and controlling symptoms
- Creates a justification to shorten life perhaps starting a slippery slope and potential for abuse

Previous Legal Rulings

- Adams [1957]. Lord Devlin: "The doctor is entitled to relieve pain and suffering even if the measures he takes may incidentally shorten life"
- The drug had not caused the death of the patient, the death was due to the patient's illness
- Cox [1992]. Convicted of attempted murder
- Annie Lindsell [1997]
 - No case to answer
- Dr Moore
 - Not guilty

Previous Legal Rulings

British law therefore will allow the administration of treatments that may hasten death provided three criteria are met:

- The patient must be terminally ill (so that the illness and not the drugs have caused the death)
- The treatment must be right and proper, as accepted by a responsible body of medical opinion
- The motivation for the treatment must be to relieve suffering

What is the Place of the DDE in Practice?

Opioids at the End of Life

- In Specialist Palliative Care:
 - 70-98% receive opioids in last 24 hours
 - Mean doses ranged from 52-659 mg in the last 24 hours
 - ~ 1/3 receive an increase in the last few days of life but it is rare for this to be >100% increase
 - Does **NOT** appear to affect survival
 - DDE rarely, if ever, required to justify increases
 - Indicates a referral to SPC
- Opioid Use in the Last Week of Life and the Implications for End of Life Decision-making. Thorns AR, Sykes NP. *Lancet* 2000; 356: 398-399

Sedatives at the End of Life

- In SPC:
 - “Terminal” sedation: 16 to 52.5%
 - Use of sedatives increases at the end of life
 - Survival does not appear to be affected
 - Good symptom control with sedatives rarely requires the justification of the DDE
- Usual doses / 24 hours:
 - Midazolam 10-30mg
 - Levomepromazine 25 – 50mg
 - Haloperidol 3-5mg

Reason for Sedation

- Delirium / Agitation: 23 – 91%
- Dyspnoea: 9 - 74%
 - o Pain: 6 - 49%
 - o Nausea / vomiting: 2 – 10%
 - o Haemorrhage: 8 – 9%
 - o General deterioration: 2 – 38%
- - Porta Sales J. Sedation and terminal care. EJPC 2001;8(3):97-100.
- Symptoms increase as death approaches

DDE - Summary

- DDE rarely needs to be used in SPC
- Same should apply in general practice
- It does provide a legal defence
- Evidence and experience suggests that if you are using doses within usual guidelines life should not be shortened

Practical Issues: Recognising the Dying Patient

- Which features suggest a patient is dying?

Recognising the Dying Patient

- Shorter prognosis
 - Deteriorating functional ability
 - Increasing fatigue
 - Appropriate stage of disease and excluded treatable causes (or competently refused)
- Last few days or hours
 - Weak / Bed bound
 - Drowsy / Disorientated
 - Disinterest in food / drink
 - Increase in symptoms
 - Agreement amongst the team

Practical Issues: Opioids

- Morphine & diamorphine remain 1st choice
- Parenteral morphine twice as strong as oral
- Parenteral diamorphine 3x as strong as oral morphine
- Always work back from total 24 hour dose
- Breakthrough dose is 1/6 of total 24 hour dose

The Alternative Opioids

- Fentanyl – patch and lollipop
- Oxycodone
- Alfentanil
- Hydromorphone
- Buprenorphine patch

The Perfect Analgesic

- All pains
- No S/Es
- Cheap
- Easy compliance
- Predictable dose
- Available by all routes
- No risk of abuse
- Unaffected by renal or liver failure
- No associated fear
- No drug interactions
- Lasts only as long as the pain

When To Consider Alternatives to Morphine?

- Renal failure
- Intolerance / side effects
- Route of administration
- Duration of action
- ?? Associated fear
- ? Difficult pains
- ? Different receptor activity

Opioid Patches: True / False

- Do fentanyl patches have full effect within 2 hours of application?
- Is 80mg of oral morphine in 24 hours is equivalent to a fentanyl patch 100 micrograms per hour ?
- Do buprenorphine patches (Transtec) have the same side-effects as morphine?
- If a syringe driver is to be started should the patch be removed and the equivalent dose of morphine or diamorphine placed in the driver?

Fentanyl Patch

- Constant release of drug from reservoir in patch
- Develops subcutaneous depot
- Onset 8-12 hours
- Duration of action after removal: 50% activity at 17 hours
- New 12.5 microgram/hour patch

Fentanyl Patches

- Advantages
 - Safe in mild to moderate renal impairment
 - Topical route
 - ? Less S/Es
- Disadvantages
 - Slow titration of patch and reservoir effect
 - Doubts over most accurate conversion and frequent errors
- Keep them going if starting a syringe driver and add extra opioid into the driver

Oral Transmucosal Fentanyl Citrate

- Place in buccal mucosa
- Onset of action 15 minutes for maximum effect; possibly 2-3 minutes for initial effect
- Lasts 3-4 hours
- Titrate to find dose as not predictable
- Risk to teeth and children
- Cost
- ? Role in breakthrough
- ? Role if unable to take orally

Alfentanil

- Uses
 - Syringe driver when patients in renal failure or intolerant of other opioids
 - Easy to use in terms of volume (c.f. with fentanyl) and mixing
 - Available in the hospital but unlikely to be common in the community
- Conversion
 - 10x more potent than diamorphine S/C
 - May crystallise with cyclizine

Oxycodone

- In use elsewhere for 80 years
- Advantages:
 - Similar preparations to morphine including injectable form
 - ? Additional receptor activity
 - ? Less metabolite activity
- Disadvantages:
 - No proven efficacy over other strong opioids
 - Same side-effects and cautions as morphine
- Uses
 - Alternative in morphine intolerance

Oxycodone

- Conversion
 - Orally twice as potent as oral morphine
 - Injectable oxycodone is twice as potent as oral oxycodone
- Oxynorm = immediate release capsules or liquid
- Oxycontin = sustained release tablets
- NB you have to get the tablet / capsule bit right on the prescription

Buprenorphine

- Available in patch (Transtec)
- Heavily pushed by drug company
- ? Comparative evidence available
- Low doses so not much help in palliative care
- More delayed reservoir effect than fentanyl makes titration slower and more complicated
- Theoretical risks of partial antagonist and ceiling effects

Practical Issues: Communication

Opportunities for Further Training

- Reflective practice of colleagues and self
- Encourage feedback in day to day practice
- Advice from palliative care
- Time in the hospice
- Visits with PPATs
- Study days
- Improve your palliative care skills course
- MSc at KIMHS, University of Kent

A Quick Word About Hospice Referral Forms

- The referral form may be the only information we have to make an assessment.
- Please include as much information as possible including results of investigations and detailed medical history
- If there is no evidence that the patient has consented to the referral we will have to return the form
- Please sign them legibly so you can be contacted for further information

And a quick word about money!

Checklist for the Dying Patient.

- Diagnosis of the dying phase
 - Stage of disease
 - Weak / Bed bound
 - Drowsy / Disorientated
 - Disinterest in food / drink
 - Increase in symptoms
- Excluded all treatable causes (or competently refused)
- Agreement amongst the team
- Discussion with partners / relatives / carers
- Place of death decided
- Unnecessary treatment discontinued

Checklist for the Dying Patient.

- DNAR recorded and communicated
- Achieve best symptom control
- Management of the vigil
- Following medication prescribed via parenteral route:
 - Analgesia: e.g. diamorphine S/C at appropriate breakthrough dose
 - Anti-emetic: e.g. haloperidol 1.5-3mg S/C
 - Sedative: midazolam 2.5 – 10mg S/C
 - Anticholinergic: glycopyrronium 0.4mg S/C

Clear notes or handover for out of hours

Conclusion

- Our aim is to work alongside you in providing good care to patients and families
- Advice is available from our medical team 24 hours a day
- Please reflect on the skills that are required from you and how you will develop these

What Skills are Required from You?

- Recognise the key signs and symptoms of the dying patient
- Communicate sensitively on issues related to death and dying
- Prescribe appropriately for the dying to:
 - Discontinue inappropriate drugs
 - Convert oral to subcutaneous drugs
 - Prescribe as required drugs appropriately, including for pain and agitation
 - Prescribe subcutaneous drugs for delivery via a syringe driver
- Use a syringe driver competently

What Skills are Required from You?

- Work as a member of a multi-professional team
- Describe an ethical framework that deals with issues related to the dying patient, including CPR, withholding and withdrawing treatment, foreshortening life, and futility
- Be aware of medico legal issues
- Appreciate cultural and religious traditions related to the dying phase
- Refer appropriately to specialist palliative care teams

What Skills are Required from You?

- Careful documentation of communication and decisions
- To recognise your own limitations and sources of stress, relief and support