Crisis Symptom Control Guidelines

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These guidelines are intended for "quick reference" use in crisis situations. They are designed to complement the more extensive sections on the use of opioid analgesia and use of the syringe driver.

Is the patient unable to swallow?
Is the patient vomiting?
Is the patient semi/unconscious?
If yes, use subcutaneous injection

PAIN

Breakthrough of pre-existing, opioid responsive pain

The following are **not** suitable for breakthrough pain:
Fentanyl patches
Morphine modified release tablets
Boost button on a syringe driver
Use oral morphine liquid or diamorphine/morphine injection

1. Dose for breakthrough pain = 1/6th total opioid dose in the last 24 hours

To convert 24h doses:

Oral Morphine 90mg	= SC Diamorphine 30mg (3:1)
Oral Morphine 90mg	= SC Morphine 45mg (2:1)
Fentanyl patch 25 microgram/h	= SC Diamorphine 30mg

2. Dose should be effective within 30 minutes
3. If ineffective, consider repeating
4. If repeat dose ineffective, consider advice from specialist palliative care team

NEW PAIN – assess as normal clinical practice

Bone pain or stiffness	NSAID - Diclofenac, oral, or PR
Bowel colic/distension	Hyoscine butylbromide 20mg SC Opioid analgesia
Liver pain	Opioid analgesia Steroids - dexamethasone 4-8mg o.d. NSAID - diclofenac, oral, SC or PR

BREATHLESSNESS

Subjective difficulty in breathing
associated with high levels of anxiety and fear
(different from tachypnoea or hyperventilation)

Consider Reversible Causes:

Bronchopneumonia
Anaemia
Pleural effusion
COPD
Heart failure
Pulmonary embolus
SVCO

Treat reversible causes as appropriate to general condition

Palliative Measures:

Opioids

Opioid naïve	- Morphine 2.5-5mg p.r.n.
On regular opioid	- Increase opioid dose by 30-50% - Consider diamorphine/morphine CSCI

Nebulised opioids are no more effective than systemic

Benzodiazepines

Diazepam	1-2mg b.d. p.o.
Lorazepam	0.5 – 1mg p.r.n. SL or p.o.
Midazolam	2.5 - 5mg SC stat 5 – 10mg per 24h CSCI

Other Measures:

Facial cooling/fan

Explanation, reassurance

Involving family and carers in simple relaxation techniques

Oxygen of doubtful benefit unless hypoxic

NAUSEA & VOMITING

Parenteral drugs likely to be needed

Consider reversible cause:

Urinary tract infection
Constipation
Superimposed anxiety (use benzodiazepine)

Assess likeliest cause:

Drugs (opioids, chemotherapy) / **Metabolic** (urea, calcium)	1st line Haloperidol 2nd line Levomepromazine
Gastric stasis	1st line Metoclopramide 2nd line Cyclizine
Intestinal obstruction	
No colic	Metoclopramide + Dexamethasone
With colic pain	1st line Hyoscine butylbromide + haloperidol 2nd line Add Levomepromazine
Raised ICP	1st line Dexamethasone + Cyclizine 2nd line Levomepromazine

(Beware that levomepromazine can reduce the fit threshold)

Uncertain cause	Levomepromazine

Please note that 33% of patients may require two drugs

DRUG DOSES

Metoclopramide	10-20mg q.d.s. p.r.n. SC (p.o. for nausea alone)
Cyclizine	50mg t.d.s. p.r.n. SC (p.o. for nausea alone)
Levomepromazine	6 –12.5mg b.d. p.r.n. SC (p.o. for nausea alone) 5 –12.5mg/24h SC infusion
Haloperidol	1.5mg b.d. p.r.n. SC (p.o. for nausea alone)

AGITATION & RESTLESSNESS

May occur as a pre-terminal event (in final hours or days of life)
10% of agitated patients may need to be sedated

Consider underlying causes – may be treatable

Physical discomfort:

Co-ordinated movements, some voluntary control, eg tossing, turning, fumbling, fidgeting

Uncontrolled pain	-	See Pain section
Full bladder	-	Catheter
Faecal impaction	-	Laxatives
Nausea	-	See Nausea & Vomiting section
Pruritus from opioid	-	Consider antihistamine

Confusion with restlessness -

Co-ordinated movements or uncontrolled twitching

Causes include:

Metabolic failure	-Liver or renal failure -Hypercalcaemia -Hypoxia
Opioid toxicity	-Look for signs Reduce opioids by 30-50%
Infection	-Treat as appropriate to general condition

Cerebral metastases-Consider Dexamethasone 8-16mg p.o.

Recommend sedation:

Midazolam 5mg SC stat
10 – 100mg per 24h CSCI
and / or Levomepromazine 25mg SC stat
25 – 200mg per 24h CSCI

Noisy Breathing & Secretions

Reposition patient with head slightly down if possible

Glycopyrronium, 200 micrograms SC stat or 0.6-1.2 mg/24h CSCI
or
Hyoscine hydrobromide,400 micrograms SC stat or 0.8-1.2 mg/24h CSCI
or
Hyoscine Butylbromide, 20mg SC stat or 60-90mg/24h CSCI

MANAGEMENT OF IATROGENIC OPIOID OVERDOSE

(adapted from www.palliativedrugs.com)

Assessment

If respiratory rate ≥ 8/minute and the patient is easily rousable and not cyanosed, adopt a policy of "wait and see"; consider reducing or omitting the next regular dose of opioid.

If respiratory rate < 8/minute, and the patient is barely rousable/unconscious and/or cyanosed, emergency management is necessary.

Emergency Management

1. Dilute a standard ampoule containing Naloxone 400micrograms to 10ml with sodium chloride 0.9%

2. Administer 0.5ml (20microgram) i/v every two minutes until the patient's respiratory status is satisfactory

3. Further boluses may be necessary because Naloxone is shorter acting than morphine (and other opioids)