Metabolic or drug induced: Haloperidol 500micrograms to 5mg oral nocte, ( ), OR: Levomepromazine, oral or sc, from 6.25 mg od.

Intestinal obstruction - contact Specialist Palliative Care Team.

AGITATION:

Treat underlying cause: e.g. drugs/ hypercalcaemia/ infection/ dehydration/ pain/ urinary retention, etc. Midazolam - from 2.5 mg stat, every 2 - 4 hours, or: Haloperidol - 2.5 to 10 mg, oral or subcutaneous.

TERMINAL RESTLESSNESS:

Midazolam – from 10mg to 30 mg subcutaneous over 24hrs via syringe driver. If still restless, seek specialist palliative care advice.

HYPERCALCAEMIA:

Consider when symptoms include dehydration, constipation, confusion, nausea & vomiting and increased thirst. Treat symptomatic patients with an adjusted serum calcium > 2.6 mmol/L with intravenous fluids and iv bisphosphonate – contact Specialist Palliative Care Team.

TERMINAL SECRETIONS:

Hyoscine hydrobromide - 600 mcg subcutaneously stat, 600 micrograms – 2.4mg over 24 hours sc via syringe driver. For specific symptom control advice in the last days of life, see the Liverpool Care Pathway (LCP)
http://www.liv.ac.uk/mcpcil/liverpool-care-pathway/

BREATHLESSNESS:

Intractable breathlessness due to end stage disease may respond to low dose opiates and/ or benzodiazepines. These can be given orally or subcutaneously via syringe driver.

ORAL THRUSH:

Good oral hygiene, and: Miconazole oral gel 24mg/ml qds treatment should be continued for 48hours after lesions have healed. Fluconazole 50mg daily for 7 days.

USEFUL TELEPHONE NUMBERS:

Rotherham Hospice Ward.
01709 308962
Has link to Palliative Medicine Drs & Consultant on duty.

Palliative Medicine Consultants:
424671

Community Hospice Team 24hr Advice line.
01709 308910

RFT Macmillan CNSs:
427180

RFT Medicines Information:
304126.

Specialist Dietician:
304291.

Compiled by NHS Rotherham & The Rotherham NHS Foundation Trust staff.

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ROTHERHAM PALLIATIVE CARE SERVICES

Adult Palliative Care Formulary – January 2012.
Review Date – January 2014.

This core formulary is a basic guide for prescribers in hospital and primary care across the district. It is intended to be used in conjunction with the Palliative Care section of the current British National Formulary (B.N.F.). The listed medications are available from hospital and community pharmacies. The compilers believe that the majority of symptoms can be effectively managed within this formulary and that its acceptance and use will enhance the quality and consistency of palliative care for patients. Note: much of palliative care prescribing is by its nature outside of product licence.

It is recommended that strong opioids are prescribed in small total quantities (maximum one month's treatment) in the community, as large quantities may not be used up when dosages change.

Specialist palliative care advice should be sought early to avoid symptom crisis. Contact telephone numbers are listed on the back page.

PAIN

Analgesia should be prescribed and administered on a REGULAR basis 24 hours a day. If a step by step approach is used there will be fewer side effects.

STEP 1: Paracetamol tablets - 1g qds

STEP 2: Step 1 plus weak opioid, e.g.Codeine Phosphate 15mg to 60mg qds

STEP 3: Replace Step 2 weak opioid, with regular 4 hourly immediate release strong opioid, (e.g. Oramorph liquid 10mg/5ml 2.5 – 10mg Oramorph 4 hourly when required.)

Titrate according to response.
Patients should be pain free for 48 hours before conversion to12 hourly sustained release morphine (e.g. Zomorph).

Conversion: calculate the total daily dose of immediate release morphine and divide by 2.
e.g. 10mg (immediate release morphine) 4 hourly = 60mg in 24 hours = 30mg 12 hourly

Co-prescribe rescue doses of immediate release morphine equivalent to 1/6 (one sixth) of total daily dose of sustained release morphine. e.g. If: 30mg Zomorph 12 hourly then rescue dose = 10mg PRN (up to six doses in 24 hours.)

Continue paracetamol.

For patients who are in renal or liver failure seek specialist palliative care advice.

REMEMBER:

Stimulant laxatives should be considered from Step 2. The dose of the laxative should be titrated as the opiate dose increases.

An anti-emetic, for drug induced nausea and vomiting should be considered. e.g. Haloperidol 500 micrograms to 3mg nocte, or 1.5mg bd.

ALTERNATIVE OPIATES, for when morphine is poorly tolerated - seek Specialist Palliative Care advice.

Oral Oxycodone MR (OxyContin) tablets – dose equals HALF of the oral morphine sulphate dose. NB. Oxycodone prescription must state clearly whether: Immediate release capsules or liquid, or modified release (MR) tablets, or injection.

Transdermal: Fentanyl patch – Fentanyl patch takes over 12 hours to reach its therapeutic effect.
NB. Fentanyl 25mcg/hr patch is equivalent to 90mg morphine sulphate over 24 hours.

Sub-cutaneous injection, via syringe driver over 24hrs, and “rescue” doses of:- Diamorphine or Oxycodone.

Oral morphine ratio to subcutaneous diamorphine:- If in pain, use: 2:1 ratio. If not in pain, use: 3:1 ratio. e.g. 10 mg oral morphine is equivalent to 3 - 5 mg subcutaneous diamorphine.

Oral oxycodone ratio to subcutaneous oxycodone: - 3:2 ratio e.g. 30mg oral oxycodone is equivalent to 20mg subcutaneous oxycodone.

Conversion table available in the Palliative Care section of the B.N.F.

Remember to prescribe rescue doses. Pain control must be titrated using immediate release morphine (or oxycodone) for breakthrough pain.

NB. If patient is on any other opioid, please inform Rotherham Specialist Palliative Care Team.

SPECIFIC PAIN MANAGEMENT:

Consider Gastric Protection: With: NSAIDs, &/or with corticosteroids. e.g. Lansoprazole 15mg od.

Musculo-Skeletal, Soft Tissue & Bone Pain: NSAIDs: Ibuprofen – 400 mg tds, (maximum 2400 mg in 24 hours) or: Diclofenac - 50mg tds. (Avoid in severe renal failure.)

Bone Pain: Consider radiotherapy or bisphosphonates - seek specialist advice.

Nerve Pain: Amitriptyline (check for contra-indications first) 25 - 100mg nocte, increase every 3 days according to response. (Start at 10mg in the elderly.) or: Gabapentin 300 – 1800mg CAPSULES, increasing as stated in BNF Pregabalin 50 – 600mg, increasing as stated in BNF. If partial response to amitriptyline, may add gabapentin or pregabalin; if NO response, replace.

Colic: Consider constipation. If acute spasm: Hyoscine butyl-bromide (Buscopan) 10 - 20mg SIX hourly as required, oral or subcutaneous.

Liver Capsule Pain: Dexamethasone 4 - 8mg mane, and titrate down (do not give after 14.00hrs)

Raised Intracranial Pressure: Dexamethasone 8 - 16mg daily and titrate down (do not give after 14.00hrs)

CONSTIPATION:

Consider the cause: e.g. Opiates.

Stimulants: If drug-induced: Senna 2 - 4 tablets nocte or bd, or: Bisacodyl 5 - 20mg nocte

Softener: Docusate 100 - 300mg nocte or bd.

Combined: Movicol/Laxido sachets, dose as recommended, or: Co-danthramer 1 - 3 capsules nocte, or: Co-danthrusate 5 - 15mls nocte or bd

Impaction: Rectal: Suppositories Bisacodyl 1 – 2 suppositories, or: Glycerin 4g 1 - 2 suppositories. AND: Movicol sachets. Or Enemas: Microlax (sodium citrate), or Phosphate, or Arachis oil enema with overnight retention (NB. Avoid arachis oil in patients with peanut allergy)

NAUSEA AND VOMITING:

Consider the cause: obstruction/ constipation/ hypercalcaemia / opiates, etc.

Raised intra-cranial pressure: - Cyclizine 25 to 50mg tds oral, or subcutaneous (25 to 50 mg stat), (up to 150mg /24 hrs in syringe driver)

Gastric stasis: - Metoclopramide 10 to 20mg qds oral or subcutaneous (10 mg stat) (40 to 80mg/24 hrs.)