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Palliative Care

Goals of Care / Future Directions

- clarify if goal is palliation OR prolongation of life OR balance of both
- make sure patient is able to make goal decisions with clear mind (i.e. not depressed, not confused, not being pressured, not in unremitting pain)

PAIN - is pain relief adequate? If NO, re-assess for reversible cause and start or increase analgesia (see below)
- **mild pain** -> acetaminophen and/or NSAIDS (particularly in bone pain)
  - avoid NSAIDS in elderly, renal impaired, GI bleed (consider PPI)
- **moderate pain** -> weak opioid (codeine or tramadol)
- **severe pain** -> strong opioid (morphine, oxycodone, hydromorphone)

Equivalencies	PO	Parenteral	IV:PO	duration
Morphine	30mg	10mg	3	3-4h
Codeine	200mg	130mg	1.5	3-4h
Oxycodone	15-20mg	-	-	3-5h
Hydromorphone	7.5mg	1.5mg	5	3-5h
Fentanyl	-	100mcg	-	1-3h

Typical Starting po doses	
Morphine	5-10mg q4h
Codeine	8-15mg q4h
Oxycodone	2.5-5mg q4h
Hydromorphone	1-2mg q4h
breakthrough dose = 10% of 24hr total q 1h prn	

- opioid adverse effects:
  - constipation (prevent or treat with PEG 3350 *OR* senna)
  - somnolence/sedation (consider switching or add psycho-stimulant)
  - nausea (metoclopramide 10mg PO/SC/IV QID PRN)
  - neurotoxicity (avoid renal impairment – i.e. good hydration)
  - respiratory depression (RARE with careful titration)
- adjuvant therapy:
  - bone pain (1st line: NSAIDS; 2nd line: dexamethasone, bisphosphonates)
  - neuropathic pain (nortriptyline, gabapentin)
- titrating opioid dose upwards (if > 2 doses of breakthrough needed/24h)
  - add up previous 24 hour total, and divide by 6 to get new q4h dose
  - remember: give 10% of this new 24 hr total as the breakthrough dose

NAUSEA&VOMITING:
- opioid-induced: - metoclopramide (see above)
  - haloperidol 1-5mg PO/SC BID/TID/PRN (watch for EPs/e)
- malignant bowel obstruction: haloperidol (as above)
- chemo/radiotherapy induced: ondansetron 4-8mg PO/SC/IV BID/TID

DYSPNEA: awareness of breathing; frequent and often multifactorial
- treat/optimize treatment for reversible causes (eg. PE, COPD, etc.)
- try air directed across face, sit upright and by open window
- systemic opioids: initiate as for **PAIN**
- O2 nasal prongs: in hypoxic patients (SaO2 < 88% or PaO2 < 55 mmHg)

DELIRIUM:
- control symptoms: haloperidol or methotrimeprazine (more sedating)
- treat the underlying cause (if possible and indicated)
- educate family (disease fluctuations, need for antipsychotics > opioids)

PAIN CRISIS:
- rule out delirium, psycho-spiritual crisis, opioid neurotoxicity
- use appropriate breakthrough dose
- consider emergent breakthrough dosing with fentanyl (NOT by patch)

SPINAL CORD COMPRESSION:
- recognize and treat ASAP to reduce morbidity
- dexamethasone 8-10mg PO/SC/IV STAT if any suspicion, then BID/TID
- urgent radiotherapy and/or neurosurgery referral

Key References: Pereira J, *The Pallium Palliative Pocketbook*, Edmonton, The Pallium Project, 2008; Larkin PJ. The management of constipation in palliative care: clinical practice recommendations, *Palliat Med*. 2008 Oct;22(7):796-807. Pereira J, Lawlor P, Vigano A, Dorgan M, Bruera E. Equianalgesic dose ratios for opioids. *J Pain Symptom Management*. 2001; 22(2): 672-87.