

## Palliative management for Patients with Covid-19 infections

**Some patients with this infection may require palliative management of their condition and this guide supplements the Symptom Management Guidelines in the CARE DECISIONS document.**

Experience has shown the main symptoms as a result of this illness experienced by patients are as follows:

- **Breathlessness/Dyspnoea**
- **Agitation**
- **Anxiety**

In addition to above, other pre-existing conditions may need to be considered when assessing patients' needs eg management of pain and nausea. The following gives initial guidance for symptom management of the above:

**Use of Opioids:** There is good evidence that opioids reduce breathlessness in cancer and non-cancer patients. Opioids do not cause CO<sub>2</sub> retention, if used appropriately

- If possible start with **Oral Morphine (Oramorph)** 2.5mg – 5mg prn 2 hourly initially and increase by 30-50% up to max of 30mg/24hours
- If beneficial consider 4 hourly regular dosing
- If NBM start 1.25-2.5mg **Subcutaneous Morphine** injection prn 2 hourly and titrate as above. ,
- The lowest starting dose should be used in the elderly.
- In the presence of **moderate-severe renal impairment**, oxycodone should be used if possible starting oral oxycodone 1-2mg prn 4 hourly or use 1mg subcutaneous oxycodone injection (smaller doses are not safely measured)
- When starting opioids monitor for signs of toxicity ie myoclonic jerks, new drowsiness, visual hallucinations or vivid dreams and at a later stage reduced respiratory rate below 8/min. If concerns re toxicity IV naloxone should be given in line with UHB guidance.

**Use of benzodiazepines:** There is no evidence that benzodiazepines directly relieve breathlessness but they are commonly used for anxiety that can accompany dyspnoea. Patients experiencing panic attacks may also benefit from explanation, including reassurance.

- Lorazepam 0.5mg sublingual prn up to qds. Can be uptitrated
- Diazepam 2mg qds
- Midazolam 5 – 15 mg CSCI/24 hour in terminal phase, may need higher doses

Infusions can be administered in the acute setting with the use of a Fresenius pump used **subcutaneously** to ensure availability of McKinley T34 pumps for community use.

### **Terminal breathlessness**

Breathlessness in imminently dying patients can be distressing for both patients, their loved-ones and healthcare professionals. A calm, positive, logical approach can do much to

alleviate the distress of the patient. Often terminal anxiolytics may be necessary to alleviate the associated distress of breathlessness.

Treatment of dyspnoea:

- Start Morphine Sulphate via continuous subcutaneous infusion (CSCI) .The dose will depend on whether the patient is already receiving an oral opioid.
- **If taking oral morphine** divide the total 24 hour dose by two for the appropriate 24 hour dose of SC morphine.
- If the patient is **opioid naïve**, consider starting morphine 10- 15mg/24hours CSCI with 2.5mg SC prn and titrate as required.
- Alternatively 24hours CSCI with oxycodone 5-10mg/24 hours could be used with significant renal dysfunction.

To relieve the **anxiety/agitation of terminal breathlessness** consider adding:

- Midazolam 5- 10mg/24hours CSCI with 2.5mg SC stat and titrate as required according to prn use. Start lower dose with renal dysfunction

If midazolam is not effective or available consider:

- Levomepromazine 12.5 mg - 25mg/24hours CSCI with 6.25 mg SC stat and titrate as required. Levomepromazine also has antinausea effects.

### **Respiratory Secretions at the End of Life**

There is no consistent evidence to show that noisy upper airway secretions cause breathlessness to the dying patient, but the sound can be difficult for family members and choking must be avoided at all cost.

Consider the following:

- Reposition the person on one side with the upper body elevated to aid postural drainage.
- Consider upper airway suctioning if appropriate
- Consider a trial of anticholinergics and /or diuretics to reduce noisy respiratory secretions if they are causing distress and conservative measures have not been successful.
- The anticholinergic drug of choice is Hyoscine hydrobromide 0.4mg subcut PRN 2-hourly up to 2.4mg over 24 hours.
- Alternatives which are less sedating include: Glycopyrronium bromide - 0.2 mg PRN 2 hourly subcutaneous up to 1.2mg total over 24 hours and Hyoscine butylbromide (Buscopan) - 20 mg subcutaneous PRN, up to 120mg over 24 hours.
- Furosemide injection can be used subcutaneously if no IV access in similar doses if indicated and should be considered if not responsive to anticholinergics or history of cardiovascular disease.
- Ensure the patient receives regular oral care using soft toothbrush and oral balance gel.