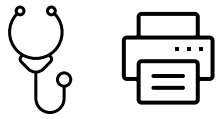
Medical notes



Principles of analgesia at the end of life

1. Pharmacological analgesia should be administered orally if possible. Some residents will still be able to swallow until death.
2. Anticipatory prescribing is an essential element of care.
3. Rectal paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs) may be helpful. NSAIDs are useful when inflammation is a major contributor to pain. Note, however, that some residents will not want rectal medication.
4. Most adjuvant analgesics are unable to be administered when the resident is unable to swallow. Low dose once daily subcutaneous dexamethasone is an option but may cause agitation.
5. Opioids are the mainstay of pain management at the end of life and morphine is the preferred choice due to its familiarity, predictability, accessibility and ease of administration.[13]
6. Although there are valid concerns about risks of respiratory depression and sedation with the use of opioids, older people, especially those with dementia, are more likely to suffer harm from under-recognition and under-treatment of their pain.[10]
7. Uncontrolled pain can hasten death. The safest approach is to start with a low dose short-acting opioid and cautiously increase until pain relief is adequate. Regular dosing achieves better pain relief with less opioid.
8. Once the opioid requirements are known, continuous subcutaneous infusion based on the previous 24-hour requirements can be commenced.
9. The initial subcutaneous dose is one third of the oral dose, to take into account the reduced bioavailability of oral preparations.[11,21]
10. It is not safe or effective to crush slow release opioid capsules or tablets. Speak to a pharmacist if there is any problem administering medication and they will be able to provide advice on alternative methods.
11. Initiating a transdermal opioid patch in the last days of life is not recommended as the onset of action is too slow to achieve timely pain relief and rapid titration of doses.[13]
12. Breakthrough analgesia should be prescribed equivalent to one sixth to one twelfth of the daily opioid dose with a dosing interval of 1 hour.
13. Three consecutive doses taken without adequate pain relief should prompt urgent review. All facilities should have a documented escalation procedure for this event.[13]
14. The background dose can be increased depending on the resident's response to the opioid doses over the prior 24 hours.
15. If two or more breakthrough doses are required, it is reasonable to increase the background daily dose to include these doses, to a maximum increase of 30 per cent. The breakthrough dose may then need to be adjusted in line with the new background dose.
16. To manage delirium, antipsychotic medication (e.g. haloperidol 0.5mg subcutaneously) may be helpful, if other non-pharmacological strategies are ineffective. However, it should be noted that psychotropic medications may be ineffective, or even worsen delirium symptoms, at the end of life.[22]

Essential palliative medications	
Clonazepam drops 2.5mg/ml (1 bottle-10ml)*	Pain, dyspnoea, delirium, anxiety, sedation
Haloperidol injection 5mg/ml	Nausea, delirium
Hydromorphone injection 2mg/ml#	Pain, dyspnoea
Hyoscine butylbromide injection 20mg/ml (5 amps)	Respiratory secretions, gut or renal colic
Midazolam 5mg/ml (10 amps)**	Dyspnoea, delirium, anxiety, sedation
Morphine sulphate injection 10mg/ml (5 amps)	Pain, dyspnoea

*PBS indication: seizures only ** Not PBS listed

5 times more potent than morphine