Palliative and End of Life management of COVID-19 patients – emergency guidance

Please use in conjunction with local palliative care guidance +/- contact

Farleigh Hospice: 01245 455478; Broomfield Hospital: 01245 362000 and ask for consultant on call for palliative medicine

One Response: 01268 526259 St Lukes-01268 526259

Havens- 01702 220350 Southend Hospital: 01702 435555 and ask for consultant on call for palliative medicine

Mid and South Essex Health and Care Partnership

SYMPTOM	USUAL MANAGEMENT	OTHER MANAGEMENT	ADDITIONAL MANAGEMENT
COUGH	Minimise the risk of cross-transmission. • Trial of simple linctus 5-10ml PO QDS • If ineffective, trial of codeine linctus 30-60mg QDS	• Humidify room air • Positioning – elevate head of the bed • Avoid smoking	• Step up to morphine sulphate oral solution 2.5- 5mg if initial management has failed • If severe or end of life, consider addition of CSCI: • Morphine CSCI (10mg) over 24 hours plus 2.5mg SC 4 hourly PRN
DYSPNOEA/ BREATHLESSNESS	Humidified oxygen (if evidence of hypoxaemia) • Trial of low dose modified release morphine e.g. Morphine SR 5mg BD up to 15mg BD i.e.30mg daily • Lorazepam 0.5mg SL PRN for anxiety	• Positioning • Relaxation techniques • Handheld fans (not in-patient setting) • Guided breathing techniques	Consider prescribing anticipatory SC medications: • Morphine inj 1.25-2.5mg SC PRN • Midazolam 2.5-5mg SC PRN If severe or end of life, consider addition of CSCI: • Morphine +/- midazolam CSCI (morphine dose 10-30mg/24 hours and midazolam dose 10- 60mg/24 hours)
PAIN	Follow WHO analgesic ladder: • Mild pain – paracetamol 1g QDS • Moderate pain – add in codeine 30-60mg QDS • Severe pain – stop codeine and commence regular strong opioid (e.g. morphine) and prescribe PRN doses See equivalence chart attached *** caution advised in opioid naïve patients, the elderly and those with renal impairment***	Positioning	Avoid NSAIDs in Covid-19 patient Up titrate oral analgesia in the usual manner Continue with transdermal preparations if patient already using-N.B. caution in fever due to possible increase in transdermal absorption Consider prescribing anticipatory SC medications: • Morphine inj 2.5-5mg SC PRN (although review dose if already on regular opioids) If severe or end of life, consider addition of CSCI: • Morphine CSCI (10-30mg/24 hours ***remember to take into account existing opioid medications and calculate dose accordingly***
RESPIRATORY SECRETIONS	• Hyoscine Butylbromide (Buscopan®) inj 20mg SC PRN (CSCI 60-120mg/24 hours) • Glycopyrronium 200-400micrograms SC PRN (CSCI 600micrograms-1.2mg/24 hours) • Hyoscine Hydrobromide 400micrograms SC PRN (CSCI 1.2mg/24 hours)	• Re-position patient on side or semi-prone to promote postural drainage • Avoid suctioning if possible	Seek specialist advice before considering use of hyoscine hydrobromide transdermal patch (1mg/72 hours)

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DELIRIUM	• Haloperidol 0.5 mg-2.5 mg PRN 2 hourly • Lorazepam 0.5mg PO/SL PRN	• Identify and treat underlying cause if possible (urinary retention, constipation etc) • Communicate and re-orientate patient • Adequate lighting	Consider prescribing anticipatory SC medications: First line: • Midazolam 2.5-5mg SC PRN • Haloperidol inj 1.5-2.5mg SC PRN Second line: • Levomepromazine inj 12.5mg SC PRN If severe or end of life, consider addition of CSCI First line: • Haloperidol CSCI (2.5-10mg/24 hours) • +/- midazolam (10-60mg/24 hours) Second line: • If above fails, change haloperidol to levomepromazine CSCI (25-100mg/24 hours) +/- midazolam as above
NAUSEA & VOMITING	First line: • Haloperidol 0.5-1.5mg PO PRN 2 hourly or • Cyclizine 50mg PO TDS Second line: • Levomepromazine 6.25mg PO nocte	• Consider and treat underlying cause if possible • Remove avoidable triggers	Consider prescribing anticipatory SC medications: First line: • Haloperidol inj 0.5-1.5mg SC PRN (up to 2 hourly) • Cyclizine inj 50mg SC up to TDS Second line: • Levomepromazine 6.25-12.5mg SC PRN up to TDS If severe or end of life, consider addition of CSCI: First line: • Haloperidol CSCI (2.5-10mg/24 hours) • Cyclizine CSCI (100-150mg/24 hours) Second line: • Levomepromazine CSCI (6.25-25mg/24 hours)
FEVER (Temp > 37.8°C)	Paracetamol 1g PO/PR QDS (Max 4g/24hrs, 2-3g/24hrs in elderly/<50kg)	Cooling measures	Avoid NSAIDs in Covid-19 patient

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Guide to Equivalent doses of Morphine and Opioids

This is intended to be used as a guide rather than for definitive equivalences. Individuals metabolise drugs at varying rates. The advice is always to calculate doses using oral morphine as a standard and then adjust them to the patient and situation. Some of the doses have been rounded up or down to fit with the preparations available.

- Doses documented relate to the total 24 hour dose. If using a BD preparation, this should be divided into two twelve hourly doses. Prescribe by brand for safety reasons
- When prescribing a long-acting opioid preparation or if administering opioid as a continuous subcutaneous infusion, always prescribe a short-acting immediate release preparation for breakthrough pain. The breakthrough dose required should be calculated by taking the total 24 hourly dose and diving by 6
- All oral transmucosal fentanyl need individual titration

**This is a specialist only drug so can only be prescribed by the specialist palliative care team

Codeine/ Dihydrocodeine	Tramadol*	Morphine		Oxycodone		Alfentanil**	Diamorphine	Fentanyl transdermal patch	Buprenorphine transdermal patch
Oral (mg) 24hr total dose	Oral (mg) 24hr total dose	Oral (mg) 24hr total dose	Sub-cutaneous (mg) 24hr total dose	Oral (mg) 24hr total dose	Sub-cutaneous (mg) 24hr total dose	Sub-cutaneous (mg) 24hr total dose	Sub-cutaneous (mg) 24 hour total dose	Dose in mcg/hr Change 72 hourly	Dose in mcg/hr BuTrans/Butec patch change every 7 days Transtec change every 96 hours
120mg	100mg	10mg	5mg	-	-	0.25mg	2.5mg	-	Butec 5
240mg	200mg	20mg	10mg	10mg	5mg	0.5mg	5mg	-	Butec 10
-	300mg	30mg	15mg	15mg	7.5mg	1mg	10mg	12	BuTrans 15
-	400mg	40mg	20mg	20mg	10mg	1.5mg	15mg	-	Butec 20
-	-	60mg	30mg	30mg	15mg	2mg	20mg	25	Transtec 35
		90mg	45mg	45mg	20mg	3mg	30mg	37	Transtec 52.5
-	-	120mg	60mg	60mg	30mg	4mg	40mg	37	Transtec 70
-	-	180mg	90mg	90mg	45mg	6mg	60mg	50	Transtec 105
-	-	240mg	120mg	120mg	60mg	8mg	80mg	62	Transtec 140
-	-	300mg	150mg	150mg	75mg	10mg	100mg	75	-
-	-	360mg	180mg	180mg	90mg	12mg	120mg	100	-
-	-	480mg	240mg	240mg	120mg	16mg	160mg	125	-
-	-	600mg	300mg	300mg	150mg	20mg	200mg	150	-

- Prescribe **prophylactic laxatives** concurrently to avoid constipation e.g. Senna Docusate.
- When prescribing Long Acting preps always prescribe an Immediate Release preps equivalent to the four hourly dose for **breakthrough pain**.
- When starting opioid-based analgesia, nausea can occur for the first 7 – 10 days and an **antiemetic** may be required.
- Oxycodone and Diamorphine may be considered equivalent, on a mg for mg basis, when given as a **continuous subcutaneous infusion via syringe pump**.
- **Caution:** When converting oral to s/c Oxycodone use half the oral dose
- There may be difficulties in escalating doses and converting to other agents with buprenorphine patches

* **NOTE** * 'however extensive clinical experience has led many physicians to regard the potency ratio for PO tramadol and PO morphine to be 1:10

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