Salisbury NHS Foundation Trust

Anticipatory Prescribing at End of Life

Patients who are thought to be dying should usually be prescribed medication for the relief of pain, nausea, vomiting, restlessness and respiratory tract secretions, unless there are contraindications. This means that symptoms can be controlled without delay even if they arise overnight.

Examples of appropriate medication for anticipatory prescribing:

Symptom	Medication	Notes
Pain	Diamorphine 2.5-5mg SC PRN	Caution in renal failure* and the frail elderly. For patients already taking opioid analgesia the dose will need to be adjusted. See below for detailed guidance.
Nausea and vomiting	If appropriate, continue with normal antiemetic given via SC route or use Levomepromazine 6.25mg SC PRN	NB Levomepromazine has sedative effect. Please see below for more detailed guidance on nausea management.
Restlessness	Midazolam 2.5-5mg SC PRN	If frank delirium use an antipsychotic rather than midazolam alone. Always consider reversible causes, i.e urinary retention and rectal loading.
Respiratory tract secretions	Glycopyrronium 200 mcg SC PRN (max 1.2 mg in 24 hrs)	Causes less sedation than Hyoscine Hydrobromide. If using Hyoscine Hydrobromide use 400mcg prn SC (max 2.4mg in 24hrs).
Breathlessness	Diamorphine 1.25-2.5mg SC PRN	Low dose of opioid often helpful even if patient on a higher dose of opioid for pain

Consider using a syringe driver for patients who need regular SC medication for the control of pain or other symptoms. Doses should be based on the PRN use in the preceding 24 hours.

PAIN

Diamorphine - For patients already taking oral morphine sulphate give diamorphine via syringe driver, dose = total oral morphine dose in last 24 hours divided by 3. PRN SC dose = 1/6th of syringe driver dose.

Oxycodone - Limited accumulation of metabolites in renal failure compared with morphine, may be useful in patients with renal impairment showing signs of opioid toxicity*. Syringe driver dose = total oral oxycodone dose in last 24 hours divided by 2. PRN SC dose = 1.25-2.5mg if opioid naïve or otherwise 1/6th of syringe driver dose.

Transdermal patches – Leave patch on (dose unchanged) and prescribe PRN opioid. Convert PRN analgesic requirements into syringe driver over 24 hours, to be given concurrently with patch. Would not recommend commencing patch at end of life.

NAUSEA AND VOMITING

Assess most likely cause:

Gastric stasis/intestinal stasis:*(In complete bowel obstruction refer to green book p32)*

- Metoclopramide** Syringe driver - 30 – 60mg over 24 hours, PRN SC dose 10mg

Drugs/Endogenous toxins:

- Haloperidol** Syringe driver – 2.5 – 5mg over 24 hours, PRN SC dose 1.5mg
- Metoclopramide** (dose as above)
- Levomepromazine – Syringe driver – 6.25-25mg (higher dose may cause sedation), PRN SC dose 6.25mg

Raised intracranial pressure:

- Cyclizine – Syringe driver 150mg over 24 hours, PRN SC dose 50mg (max TDS)

Advice and guidance are available from:

- Senior members of the team looking after the patient

- ICID – under Palliative Care. Includes symptom control guidance and opioid conversions.
- The Palliative Care Handbook ("Green Book") – Wessex Palliative Physicians. 8th edition (2014)
- The Hospital Palliative Care Team on bleep 1293
- Palliative Care Service out of hours on Ext: 2113 or via switchboard.

*Please contact Palliative Care for advice on analgesic prescribing in renal / hepatic failure

**Avoid in patients with Parkinson's disease / Lewy Body Dementia

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