End of Life Symptom Control

In End Stage Kidney Disease

These guidelines are partly based on and used with permission from the United Kingdom Expert Consensus Group which produced the guidelines according to best practice and evidence base


Fever

Present

Paracetamol 1g qid po / prn
Fan; tepid sponge.

Absent

Monitor
Pruritus

If able to swallow

If on dialysis – Gabapentin 100mg after each dialysis and titrate to effect.
If not on dialysis and eGFR < 15 - Gabapentin 100mg every 2\textsuperscript{nd} night and titrate to effect.
If not on dialysis and eGFR > 15 - Gabapentin 100mg nocte and titrate to effect.
As an alternate to Gabapentin could use Pregabalin commencing at 25mg.

Unable to swallow

Midazolam 2.5mg – 5mg sci q 4 hours

For pruritus please ensure the patient is not washing in hot water or using soap, consider using Sorbolene cream.
Painful oral mucosa

Present

- Xylocaine viscus gargle, Orabase gel topically
- Treat oral thrush with Nystatin drops 2ml q4h
- Clean mouth with Sodium Bicarbonate Mouthwash QID

Absent

- Maintain oral care Q4H
Hiccups

Present

Metoclopramide 10mg tds s/c
Alternative treatments – Haloperidol 0.5 -1 mg bd po/sci
Baclofen 5mg bd-tds (if patient can swallow)

If it does not work, get the Palliative Care team to review

Absent

Note: UK expert group expressed caution about the use of Metoclopramide. Caution based on risk of accumulation in severe renal impairment and extrapyramidal side effects.
Pain

Patient is in pain

Patient’s pain is controlled

Patient is already taking oral opioids

Yes

If the patient is already taking strong opioids, contact the Palliative Care Team

No

Hydromorphone 0.25 – 0.5 mg Q4H s/c and 0.25-0.5mg sci prn q 2-4 hours.

Supportive Information:
To convert from other strong opioids contact the Palliative Care Team / Pharmacy for further advice & support as needed.
Morphine and its metabolites are most likely to cause toxicity (myoclonic jerks, profound narcosis and respiratory depression) and is not recommended. In a patient who is unable to swallow, Hydromorphone or Fentanyl in regular subcutaneous doses or in a continuous infusion is recommended. Transdermal fentanyl may also be prescribed.

If symptoms persist contact the Palliative Care Team
Anticipatory prescribing in this manner will ensure that in the last hours /days of life there is no delay responding to a symptom if it occurs.
Dyspnoea

Present

1. Small dose opioid – Hydromorphone 0.25-0.5mg sci qid and prn q 2-4 hours and
   2. Lorazepam 0.5mg bd-tds sublingually and prn q4-6 hours.
   Increase both to effect. If dyspnea persists contact the Palliative Care Team for advice

Absent

Supportive Information:
If symptoms persist contact the Palliative Care Team for further advice and support.

Placing a fan near the patient’s face has been shown to be efficacious in several randomised controlled trials.

If the patient is very breathless and anxious and the above is not settling dyspnea consider Midazolam 2.5mg sci prn q 4hours and, if necessary, regular Midazolam 2.5mg q 4hours. With deterioration consider commencing a combination of Hydromorphone and Midazolom by continuous infusion.

Please note – Morphine is not recommended due to accumulation of metabolites and toxicity.
Anticipatory prescribing in this manner will ensure that in the last hours /days of life there is no delay responding to a symptom if it occurs.
Terminal restlessness and agitation

**Present**

- If conscious – Haloperidol 1mg bd po/sc and prn (1-2 mg prn q 12 hrs)

- If unconscious – Midazolam 2.5mg qid sci and prn (2.5-5 mg sci q 2-4 hours)

- Review the required medication after 24 hrs, if three or more prn doses have been required consider giving Midazolam via a syringe driver over 24 hours

- Continue to give prn dosage accordingly

- If agitation persists with Haloperidol consider Levomepromazine 25 – 50 mg bd – tds (200 mg max 24 hr)

**Absent**

- Chart on prn order as for ‘Present’ to cover the potential presentation of the symptom

* Restlessness and agitation related to delirium should never be managed with benzodiazepines alone.

* Ensure there are no reversible causes of delirium / agitation such as medication toxicity, sepsis, constipation, pain & urinary retention.

**Supportive Information**

**If symptoms persist contact the Palliative Care Team**

Anticipatory prescribing in this manner will ensure that in the last hours /days of life there is no delay responding to a symptom if it occurs.
Respiratory Tract /Terminal Secretions

Present

Treatments include:
1. Glycopyrrolate 200 mcg (0.2 mg) s/c prn q 1-2 hours.
2. Atropine 1% eye drops sublingually 2 drops tds and prn 2-4 drops q 4 – 6 hours.
3. Hyoscine butylbromide (Buscopan) 20mg sci q4 hours and prn q 2- 4 hours.

If three or more doses of prn Glycopyrrolate or Buscopan are required then consider commencing a continuous infusion via syringe driver.

For Glycopyrrolate approx doses of 2.4-3.2 mg over 24 hours; for Buscopan 80-240mg over 24 hours.

Absent

Chart on prn order as per ‘Present’ to cover the potential presentation of the symptom

Supportive Information
If symptoms persist contact the Palliative Care Team

Anticipatory prescribing in this manner will ensure that in the last hours /days of life there is no delay responding to a symptom if it occurs.

NOTE: Hyoscine Hydrobromide is not recommended due to permeability of the blood / brain barrier in uraemia and a consequent risk of paradoxical agitation.
Nausea and Vomiting

Present

Metoclopramide 10mg tds po/sci
Haloperidol bd and prn (0.5 – 1mg sci q 12 hours)

Absent

Chart Haloperidol as per ‘Present’ on prn order to cover the potential presentation of the symptom

Review the required medication after 24 hrs, if three or more prn doses have been required then consider Haloperidol 1.5 – 3 mg in a Syringe Driver over 24 hrs

Supportive Information:

If symptoms persist contact the Palliative Care Team

Suitable alternative second line medication : Levomepromazine 6.25 mg s/c prn bd. (if Syringe Driver is required then consider 12 mg s/c in a Syringe Driver over 24 hrs and titrating to effect).

Anticipatory prescribing in this manner will ensure that in the last hours /days of life there is no delay responding to a symptom if it occurs.

NOTE: Exercise caution with Cyclizine. There is an increased cerebral sensitivity to cyclizine in patients with CKD and cyclizine may induce hypotension, tacharrytmias.
Constipation

- Present
  - Swallow present?
    - Yes: Coloxyl & Senna 1 – 3 tabs bd or tds
    - No: Glycerine & Bisacodyl suppositories
  - Absent: Monitor for comfort

Supportive Information:
If able to swallow consider prophylactic coloxyl & senna 1 – 3 tabs bd or tds to prevent constipation or Movicol 1 sachet bd in ½ glass of water

NOTE: It may not be appropriate to intervene in the terminal phase
Diarrhoea

Present

Has faecal impaction with overflow been excluded?

Yes

- Imodium 2 tabs q4h prn / regularly

No

- Digital rectal exam
  - Treatment as per constipation

Absent

* Please ensure diarrhoea is not impaction / overflow