Non-Medical Prescribing in Palliative Care and End of Life Care

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Agenda

- Key facts about Palliative Care
- Care of dying adults in the last days of life – NICE guideline [NG31]
- Assessment of Pain: Four Categories
- Drugs Commonly Used in Palliative and End of Life Care
- Other things to remember…
- Prescribing and treating is not always the right thing to do
- My experience: tips and advice
- Close

Key facts about Palliative Care

- ✓ Improving quality of life of patients with life limiting illnesses and incurable disease.
- ✓ Holistic and person-centered care – Physical, Psychological, Social, Spiritual.
- ✓ Dignified and comfortable End of Life Care.
- ✓ Early input enables good symptom control, reduces (unnecessary hospital admissions, advanced care planning (the person's goals, wishes, what is important to them?)

Care of dying adults in the last days of life – NICE guideline [NG31]

Recommendations:

Recognising dying – last days of life

Communication, shared decision-making

Manage symptoms:

Pain; Breathlessness; Nausea and Vomiting; Anxiety; Delirium; Agitation; Respiratory secretions

Anticipatory prescribing – "just incase medications"

Assessment of Pain: Four Categories

Physical	Psychological
• Cancer related pain • Fractures • Abdominal distention – Bowel obstruction, Ascites, Urinary retention • Constipation • Pressure sores • Chronic conditions	These factors have a profound effect on the perception and experience of pain • Anxiety • Depression • Fear
Social	**Spiritual**
• Explore network of support • How has the pain affected their day to day life.	• Unremitting pain, can cause spiritual distress/pain. • Self image • Hope, Fear and Forgiveness • Does not have to be related to a religious belief system.

Drugs Commonly Used in Palliative and EoLC

Anti-Muscarinic (Anti-cholinergic) – Glycopyrronium, Hyoscine Hydrobromide/Butylbromide – To "dry secretions".

Rarely sedating in comparison to Hyoscine/less central effects

Usually given S/C in EoLC

Poor bio-availability/absorption in PO preparation

Blocks pro-kinetic effect of Metoclopramide and Domperidone (anti-emetics)

NB: Also used in MND for drooling and excessive salivation.

Drugs Commonly Used in Palliative and EoLC continued...

Morphine – Gold standard, if not contra-indicated; Liver is the principle site of metabolism but also other organs, including the kidneys. Therefore, there is risk of accumulation and opioid side effects, if renal function is deranged.

Also used for SOB - Multiple formulations available

Oxycodone – More potent than morphine (Oxycodone to Morphine ratio 1:2)

Mild to moderate hepatic impairment clearance decreases

Renal failure – slower excretion, though generally the drug of choice in renal failure with reduced ranges prescribed.

Multiple formulations

Alfentanil – Used in End Stage Renal Failure; Metabolised by the liver

10-20x more potent than Morphine

Duration of action only 30minutes, so used infrequently as a PRN dose to manage pain, often used in syringe drivers.

Transdermal Patches – Good to use if pain is controlled, and for patients who are unable to take oral medications

Drugs Commonly Used in Palliative and EoLC continued...

- **Pro-kinetics** – Metoclopramide – avoid in bowel obstruction – seek SPCT advice, can cause GI perforation, avoid if colic is present as Metoclopramide can exacerbate this. Can be used in delayed gastric emptying.
- **Anti Muscarinic and Anti Histaminic** – Cyclizine – Can be used in mechanical bowel obstruction (with colic)
- **Anti-psychotics** – Haloperidol, Levomepromazine – Avoid in Lewy Body Dementia, Parkinson's disease (can cause extra pyramidal s/e) and history or risk of seizures/epilepsy.
- Levomepromazine broad spectrum, can be used as second line agent, after Midazolam for severe terminal agitation and psychosis.
- **Benzodiazepine/Anxiolytic** – Midazolam – Terminal agitation, restlessness, replacement for anti-convulsant (Multi-focal Myoclonus, Epilepsy).

Other Things to Remember...

Adjuvants

- Corticosteroids
- Neuropathic agents
- Bisphosphonates – Hypercalcaemia/ Bone metastasis
- NSAIDS ("Coxibs" – less to no effect on platelet function and prolonged bleeding time
- PPI's

Remember!

- Bowel movements – Laxatives
- Passing urine?
- Xerostomia
- Candidiasis

Prescribing and treating is not always the right thing to do…

Uncertainty in diagnosing dying and clinical decision making

- 'Clinical decision making, needs to allow for recovery where the potential exists, but equally there is the need to avoid futile intervention'.

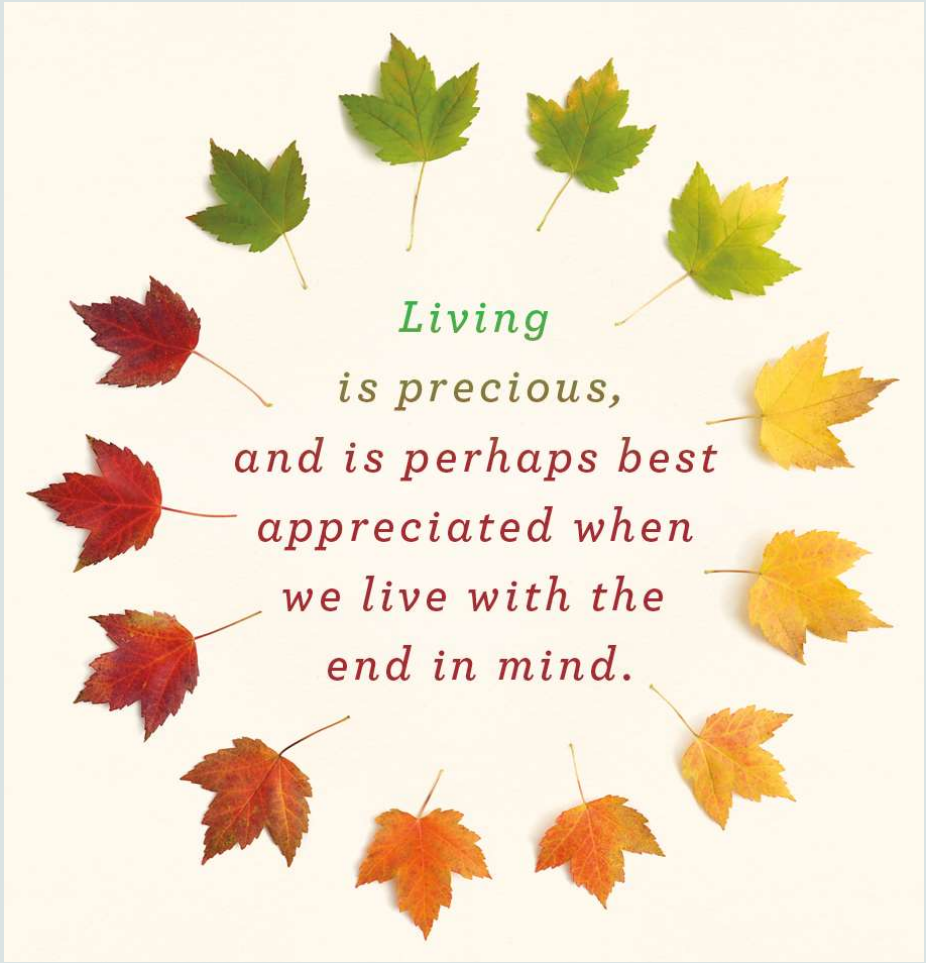
(Kennedy et al, 2013).

De-prescribing in End of Life Care

What to continue? What to replace? What to discontinue?

My Experience: Tips and Advice

- Take into account the patient's co-morbidities.
- Drug interactions, renal/liver impairment
- When completing a drug history, make sure to include details of any anticipatory medicines that the patient already has.
- Ask explicitly about patches – many patients and families forget to mention these.
- Controlled drug prescriptions written correctly.
- Speak to your friendly pharmacists.
- Access resources – BNF, PCF, Microguide, Local formulary, NICE guidance, Electronic Medicines Compendium (EMC).



Dr Kathryn Mannix

With the End in Mind

How To Live And Die Well

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Thank you

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