End of life management of breathlessness and cough

Kirkwood
The Hospice for Kirklees

This guidance provides first-line management alongside alternative medications and routes of administration for patients with palliative care needs **in the last days of life**. For palliative management of these symptoms earlier in a person's illness, please see MD164 Early management of intractable breathlessness in the Kirkwood toolkit.

Pharmacological management

First line: STRONG OPIOID

- If opioid naïve with normal renal function: morphine sulphate 2.5-5mg SC PRN. Starting dose via syringe driver 5-10mg/24hrs
- If opioid naïve with eGFR <40: oxycodone 1.25-2.5mg SC PRN. Starting dose via syringe driver 5-10mg/24hrs
- If taking regular oral opioid: convert to appropriate syringe driver and PRN doses (see MD161 Opioid conversion chart in toolkit)

Second line: MIDAZOLAM SC

- PRN dose: 2.5-5mg SC
- Initial syringe driver dose 10-15mg/24hrs
- Maximum dose 100mg/24hrs
- Available formulations 10mg/2ml (2ml amps), 1mg/ml (2ml & 5ml amps)

If SC midazolam unavailable: BUCCAL MIDAZOLAM

- PRN dose: 2.5-5mg buccal dose
- Available formulations: oromucosal solution (5mg/ml) pre-filled syringes – 2.5mg, 5mg, 7.5mg and 10mg
- Health professionals should use caution in patients with suspected COVID-19 with all buccal and sublingual medicines due to proximity to oral secretions.

If other options unavailable: RECTAL DIAZEPAM

- Starting dose 2-5mg OD
- Maximum dose 30mg/24hrs **in 3 divided doses**
- Available as 1.25ml or 2.5ml tubes at strength of 2mg/ml

PLEASE NOTE: Lorazepam may be administered subcutaneously but only rarely and with caution via this route. Diazepam should never be administered subcutaneously (Palliative Care Formulary 6). Please contact Kirkwood Hospice for advice.

Other measures:

- Reducing room temperature.
- Cooling the face with a cold flannel

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If COVID-19 infection suspected

Steroids:

There is evidence that dexamethasone reduces mortality **in hospitalised patients with confirmed COVID-19 infection who require oxygen or support with ventilation.** There is no evidence of a survival benefit in those who do not require these interventions. If steroids are prescribed for symptom management, an assessment of the potential risks and benefits should be made.

For patients already on long term steroids or those otherwise at risk of withdrawal from recent prolonged courses, please consider SC replacement when the patient is no longer able to manage oral medication. For advice regarding conversion of steroids, please contact Kirkwood Hospice.

Aerosol-generating procedures:

Public Health England (PHE) has issued advice regarding the use of aerosol-generating procedures and increased respiratory transmission during the COVID-19 pandemic. This guidance includes the use of saline nebulisers, non-invasive ventilation and high flow oxygen. We would advise cautious use of such interventions, with appropriate risk assessments and FFP3 protection where necessary.

The full guidance is available via the following link:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-infection-prevention-and-control-guidance-aerosol-generating-procedures

Fans:

When aimed at the lower 2/3 of the face, fans can reduce the sensation of breathlessness.

Concerns have previously been raised about the use of fans for management of fever symptoms and breathlessness during the COVID-19 pandemic.

The Health and Safety Executive (HSE) has produced guidance on ventilation and the use of air conditioning and fans during the pandemic. This guidance advised that fans may improve air circulation and the risk of transmission is extremely low **provided that there is good ventilation** (with outside air) in the area it is being used.

The full guidance is accessible via the links on the following webpage:

https://www.hse.gov.uk/coronavirus/equipment-and-machinery/air-conditioning-and-ventilation.htm

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