

FACTSHEET: CARE OF THE DYING PATIENT WHEN UNABLE TO OBTAIN A SYRINGE DRIVER



At the end of life when the oral route is lost **effective management of symptoms is best achieved using a syringe driver** to deliver a continuous low dose of medication that can be easily titrated. This guidance provides medication options for care of a patient at the end of life **only when a syringe driver is unavailable**. Please see the Kirkwood Toolkit for management of end of life symptoms when a syringe driver is available. Many of the medications we would normally give at end of life are short acting (hence the requirement for a syringe driver) and these can still be given, but we have provided long-acting options in this less than ideal situation.

BREATHLESSNESS WITH RESTLESSNESS

Usual SC would be midazolam - this can still be used PRN at a dose of 2.5-10mg but is short acting.

IF SYRINGE DRIVER UNAVAILABLE:

(1) PHENOBARBITONE (PHENOBARBITAL) 120-200MG IM/IV PRN (available as 200mg/1ml OR 60mg/ml)

- Unlicensed for this indication, but licensed in epilepsy
- Usually reserved for cases of intractable distress at the end of life despite first line measures
- Is sedative, and can cause respiratory depression in high doses
- Cannot be administered SC due to viscosity and dilution requirements
- Long acting when administered PRN – either IM or as a slow IV injection
- Can be given undiluted as IM injection, for IV use - needs dilution to 10 times volume, given over 2 minutes (WFI or 0.9% saline)
- Please see flowchart for dosing intervals. Loading doses are typically required for symptomatic benefit, but can accumulate thereafter with a longer duration of action
- Maximum dose 1200mg/24hrs

(2) IF PHENOBARBITONE UNAVAILABLE – please treat with levomepromazine 25-50mg SC as per agitation guidance overleaf, alongside PRN opioids and/or midazolam for breathlessness if needed. Please note SC opioids and midazolam are short acting, and may result in breakthrough symptoms necessitating frequent use (with multiple contacts with healthcare professionals)

FOR FURTHER ADVICE

Please contact The Kirkwood 24 hour advice line on 01484 557910

TERMINAL AGITATION

This guidance is for management of delirium and agitation in a person who is in the last hours to days of life where the aim is for a comfortable death.

IF SYRINGE DRIVER UNAVAILABLE:

(1) LEVOMEPRMAZINE 25-50mg SC PRN

- Given its long half-life and duration of action, can be administered in OD-BD regular dosing if required
- Maximum dose 300mg/24hrs
- Lower doses recommended in renal failure

(2) PHENOBARBITONE (PHENOBARBITAL) 120-200MG IM/IV PRN - see guidance on page 1

(3) HALOPERIDOL 3-5mg SC PRN

- Given its long half-life and duration of action, can be administered in OD regular dose if required
- Maximum dose 10mg/24hrs
- Lower doses recommended in renal failure (max 5mg/24hrs)

PAIN

At the end of life, opioids are often first line for treatment of pain. Patients whose pain has been well managed on alternatives (e.g. gabapentin) may need opioid alternatives when they are unable to manage these medications. Usual SC opioids are short acting when given PRN. Long acting preparations are available in the form of transdermal patches, but SC opioids will still need to be given until this becomes effective (between 12 and 24hrs).

Please see the Kirkwood Toolkit for guidance with opioid conversions and switching opioids

RESPIRATORY SECRETIONS

Please see the Kirkwood Toolkit for guidance on secretion management at the end of life, which features alternatives to hyoscine butylbromide

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