COMMON PALLIATIVE CARE (PC) BILLING CODES, OHIP, FEB. 2012

CODE	DESCRIPTION
K023 *	PC support (≥ 20-min. visit, may bill more than 1)
B966	Home visit (special visit)
B998	Home visit (first patient seen)
A902	Home visit for pronouncement (includes death certificate)
A771	Home visit – completion of death certificate (without pronouncement)
C882, E083	PC hospital visit (MRP)
C777	Pronouncement of death in hospital
C771	Certification of death in hospital
C945	Palliative consultation in hospital (minimum 50 min.)
A945	Palliative consultation outside of hospital (minimum 50 min.)
K015*	Counseling relatives—scheduled visit (≥ 20 minutes)
K070	Home Care Application
K071	Acute home care supervision phone communication with RN/RPN (Maximum every week for the first 8 weeks following admission to CCAC)
K072	Chronic home care supervision (maximum 2 per month commencing in the 9th week following admission to the home care program)
G511	Telephone management regarding patient receiving pc at home (2 per pt/ week) - need to document, cannot claim with K071 or K072
G512	Providing supervision of palliative care to a patient for a period of 1 week (commencing at midnight Sunday) (should be billed by the MRP who is actively managing the care; billing by 1 MD only)

* Must record time spent with patient on patient chart.
Note: G511, K071 or K072 are not eligible for payment to any physician when rendered during a week that G512 is rendered.

Serving Erie St. Clair and the South West LHINs

PALLIATIVE PAIN AND SYMPTOM MANAGEMENT POCKET REFERENCE GUIDE

Symbols:

*** Indicates not covered by ODB**

√ Indicates see website for reference &/ or additional information:

www.palliativecareswo.ca
www.thehealthline.ca

DEVELOPED BY: Palliative Care Experts in the Erie St. Clair and South West LHINs

NOVEMBER 2009

DISCLAIMER

The "Palliative Pain and Symptom Management Pocket Reference Guide" provides pain and symptom management information; this information is not medical advice. This guide was developed as general information for physicians and registered nurses with palliative care expertise only; physicians and nurses should exercise their own independent clinical judgment. To the best of our ability, we have provided references for the information contained within this reference guide. Where references are not available, the information reflects local practice by Palliative Care Expert Physicians in the Erie St. Clair and South West Local Health Integration Networks (LHINs). Health care providers must be fully informed before prescribing any products and while we endeavour to keep the information up to date and correct, we make no representation or warranties of any kind, express or implied about the completeness, accuracy, reliability or suitability with respect to the information or products.

In no event will we be liable for any loss or damages including without limitation, indirect or consequential loss or damage or any loss or damage whatsoever arising from or out of the use of this reference guide.

Note: many references for the **PALLIATIVE PAIN & SYMPTOM MANAGEMENT POCKET REFERENCE GUIDE** originate with The Pallium Palliative Pocket Book 2008. To purchase this manual visit http://www.market-marche.chpca.net/

www.palliativecareswo.ca
www.thehealthline.ca

Palliative Pain and Symptom
Management Consultation
Program, Southwestern Ontario.
St. Joseph's Health Care,
London, Ontario, Canada.
November 2009

COMMITTEE MEMBERS

Dr. Glen Maddison, Chair November 2009 to Present
Dr. Ingrid Harle, Chair 2007- October 2009

WINDSOR AND ESSEX COUNTY

Sharon Allen, NP, M.SC.N., CHPCN(C)
Angie Deneweth, NP
Janet Elder, Reg.N, CHPCN(c)
Jim Gall, MD
Carole Gill, Reg.N., CHPCN(C)
Karen Riley, BSCPhm, Pharm D, BCPS, RPh

KENT AND LAMBTON COUNTIES

Ann Brignell, Reg.N., CHPCN(C)
Glen Maddison, MD

ELGIN AND OXFORD COUNTIES

Brian Fathers, BSC Pharm, R Pharmacist
Ida Tigchelaar, Reg.N., CHPCN(C)

LONDON AND MIDDLESEX COUNTY

Sharon Baker, MD
Ingrid Harle, MD, FRCSC, CCFP, FCFP, ABHPM
Nancy Keat, Reg.N., B.SC.N., M.SC., CHPCN(C)

HURON AND PERTH COUNTIES

Judy White, Reg.N., CHPCN(C)

GREY AND BRUCE COUNTIES

Hilli Huff, MD, CCFP
Liz Laird, Reg.N., BSCN, CHPCN(C)
Marie Palmer, Reg.N., B.A., CHPCN(C)

NOTES

INDEX

PAIN MANAGEMENT

Pain Management Steps 1
Opioid Dosage 1
Titration of Opioids 1
Opioid Toxicity 2
Opioid Rotation 3
Equianalgesic Dose 3
Fentanyl Patch 4
Analgesics to Avoid 4
Opioid Overdose 5
Common Opioid Side Effects 5
Must Know 5
Pseudoaddiction/Tolerance/Dependence 5
Wounds 6
Incident Pain/Procedural Pain 6
Etiology of Pain 6
Adjuvant Interventions 6

SYMPTOM MANAGEMENT

G.I Protection 8
Nausea 8
Mouth Care 9
Bowel Routine 9
Malignant Non-operable Bowel Obstruction 10
Malignant Ascites 10
Hiccups 11
Dyspnea 11
Respiratory Secretions 12
Hypercalcemia 12
Excessive Sedation 12
Delirium 13
Depression 13
Acute Seizure Control 13
Myoclonic Jerking 14
Terminal Restlessness 14
Intractable Symptoms at End of Life 14

PPS 15
ESAS 16
Equianalgesic Dosing Chart 17
Common PC Billing Codes, OHIP, April 2008 .....back cover

PAIN MANAGEMENT

PAIN MANAGEMENT STEPS

- screen for pain: ask regularly (i.e., the 5th vital sign, use ESAS √) and observe for behaviours indicative of pain
- assess to determine the etiology of the pain √
- initiate interventions considering the patient's goals, age, PPS √, pain type, kidney/liver function
- monitor and document the efficacy of each intervention using a pain intensity scale of 0 – 10
- assess efficacy of breakthrough doses one hour post oral dose, half hour post SC dose, 5 – 10 minutes post IV dose
- reassess & revise the plan as necessary until goals are met
- consult with a palliative care expert when comfort goals are not being met √

OPIOID DOSAGE

- the appropriate dose of opioid is the amount that manages the pain with the fewest side effects
- there is no ceiling dose unless using a mixed analgesic such as Tylenol with codeine or oxycocet, which contain acetaminophen as well as an opioid; acetaminophen has a total daily intake limit of 2.6 gm (in the elderly or those with organ impairment) to 4.0 gm (healthy patient) √

TITRATION OF OPIOIDS

- start with q4h around the clock (ATC) dosing with immediate release (IR) opioid and titrate to effect or until side effects become unmanageable
- when titrating, allow the opioid to reach steady state before increasing the regular around the clock (ATC) dose
  - steady state occurs at 4 – 5 times the drug half-life. Half-life depends on the particular opioid and whether it is immediate release or long acting
- generally, immediate release opioids can be titrated every 24 hrs and long acting opioids can be titrated every 48 – 60 hrs

NOTES

Equianalgesic Dosing Chart

All equivalencies are approximate; use this chart as a guideline only.

Oral Routes:	**Ratio**
Morphine 10 mg = Percocet 1 tab (5/325) = Oxycodone 5 mg	2:1
Morphine 10 mg = Codeine 100 mg = 3 Tylenol #3 tabs (90/900)	1:10
Morphine 10 mg = Hydromorphone 2 mg	5:1

Oral to Subcutaneous Routes: Ratio 2 (po): 1 (sc)

Morphine10 mg po = Morphine 5 mg sc
Hydromorphone 10 mg po = Hydromorphone 5 mg sc

Subcutaneous Equianalgesia:

Morphine 10 mg sc = Hydromorphone 2 mg sc

Conversion to Transdermal Fentanyl. There are various accepted methods.

1. Morphine 60-134 mg po in 24 hrs = Fentanyl 25 mcg patch q72h (CPS, page 783, table 3, 2007) **Note: this range of morphine is very broad which may result in significant under dosing.**
2. Morphine 2 mg po in 24 h = 1 mcg/hour of fentanyl transdermal, rounded to the nearest patch size, e.g. 216 mg of oral morphine per 24 hours is approximately equianalgesic to a 100 mcg/hour fentanyl transdermal patch. (*Breitbart W. An alternative algorithm for dosing transdermal fentanyl for cancer-related pain.* Oncology *2000; 14:695-702)* **Note: This dose may be excessive when used in a medically compromised patient and/or the frail elderly; use clinical judgment.**

Guidelines for Calculating Breakthrough Doses (BTD)

Calculate approximately 10 % of the total daily dose of the scheduled opioid and administer it as needed for uncontrolled pain.

The breakthrough dose is calculated in the same way no matter what route of administration is being used *(Managing Cancer Pain The Canadian Healthcare Professional's Reference 2005, Chapter 5 page 35)*

For opioids taken by mouth:

e.g. Morphine 15 mg q12h po = 30mg po total in 24 hours
10 % of 30 mg = 3 mg (max. dose) po **q1h prn** for breakthrough pain

For opioids taken sc:

e.g. Morphine 10 mg q4h sc = 60 mg sc in 24 h
10% of 60 mg = 6 mg (max. dose) sc **q1h prn**

For CSCI:

e.g. Morphine 2.5mg q1h sc continuous infusion = 60mg in 24 hours
10% of 60mg = 6 mg (max. dose) sc **q1h prn* or 3mg q1/2h prn**

**Clinical judgment may indicate the need to lower the calculated dose.*

Pain Management

Titration of Opioids (continued)

- once the steady state has been reached, a new order for the ATC dose of opioid is calculated based on the TOTAL opioid dose administered in the previous 24 hours [TOTAL = break through (BT) doses used plus regular ATC doses in 24 hours]. Use clinical judgment in determining the new ATC order
- always order a BT, immediate release dose:
  - whenever possible use the same opioid as is being administered on a regular basis
  - calculate approximately 10 % of the TOTAL daily dose of the scheduled ATC opioid and order it prn for uncontrolled pain (see page 17)
  - the breakthrough dose is calculated in the same way no matter which route of administration is being used
- consider opioid rotation for unmanageable side effects and adjuvant interventions for difficult to manage pain
- the fentanyl patch (**LU 201**) is a slow release form of a quick acting medication (fentanyl). **Do not titrate to a stronger patch more rapidly than every 6 days**
  - if pain is not managed, increase BT doses, using IR opioids (e.g., morphine, hydromorphone) until it is safe to titrate the patch √

Opioid Toxicity

- metabolites of morphine and to a lesser extent, hydromorphone must be cleared renally; anyone with renal compromise (including the elderly) is at increased risk for toxicity
- suspect opioid toxicity if increased agitation occurs
- myoclonus may be an early warning sign of opioid toxicity
- dehydration may increase risk of toxicity

PAIN MANAGEMENT

CONSIDER OPIOID ROTATION IF ONE OF THE FOLLOWING OCCURS

- decreased renal function (neurotoxic metabolite build up associated with morphine and hydromorphone)
- intractable nausea and/or vomiting
- delirium (hyperactive or hypoactive)
- myoclonus
- dysphoria
- persistent intolerable sedation

OPIOID ROTATION (SWITCHING TO ANOTHER OPIOID)

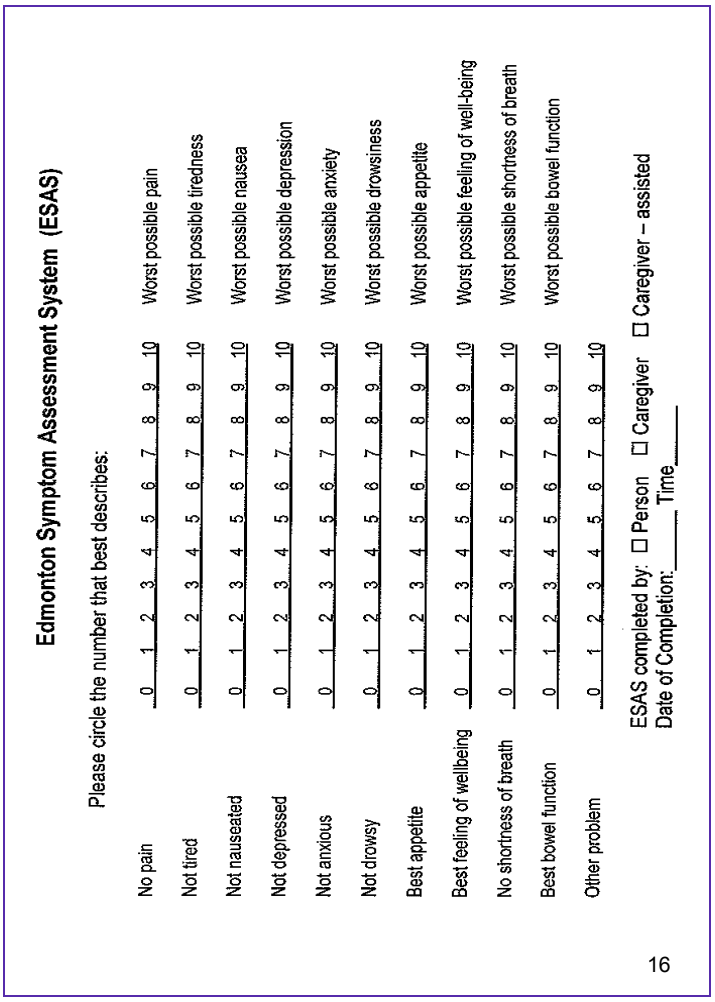
When rotating opioids:

- determine the equianalgesic dose
- consider **decreasing the dose of new drug by 30%** to account for incomplete cross-tolerance √
- Use breakthrough (BT) doses and titrate to effect

EQUIANALGESIC DOSE (APPROXIMATE ONLY)

DRUG	PO	SC OR IV
Morphine	20 mg	10 mg
Hydromorphone	5 mg	2 mg
Oxycodone	10 mg	NA
Codeine	200 mg	120 mg

- three Tylenol # 3s are approximately equal to morphine 10 mg PO plus acetaminophen 900 mg PO
- two Percocet are approximately equal to morphine 20 mg PO plus acetaminophen 650 mg PO
- remember incomplete cross-tolerance √
- methadone is used for analgesia. It has unusual pharmacodynamics and pharmacokinetics and multiple interactions with other drugs √. Physicians require an exemption license to prescribe methadone for pain



Edmonton Symptom Assessment System (ESAS)

Please circle the number that best describes:

No pain	0 1 2 3 4 5 6 7 8 9 10	Worst possible pain
Not tired	0 1 2 3 4 5 6 7 8 9 10	Worst possible tiredness
Not nauseated	0 1 2 3 4 5 6 7 8 9 10	Worst possible nausea
Not depressed	0 1 2 3 4 5 6 7 8 9 10	Worst possible depression
Not anxious	0 1 2 3 4 5 6 7 8 9 10	Worst possible anxiety
Not drowsy	0 1 2 3 4 5 6 7 8 9 10	Worst possible drowsiness
Best appetite	0 1 2 3 4 5 6 7 8 9 10	Worst possible appetite
Best feeling of wellbeing	0 1 2 3 4 5 6 7 8 9 10	Worst possible feeling of well-being
No shortness of breath	0 1 2 3 4 5 6 7 8 9 10	Worst possible shortness of breath
Best bowel function	0 1 2 3 4 5 6 7 8 9 10	Worst possible bowel function
Other problem	0 1 2 3 4 5 6 7 8 9 10	

ESAS completed by: ☐ Person ☐ Caregiver ☐ Caregiver – assisted
Date of Completion:_____ Time_____

Palliative Performance Scale (PPSv2) version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100 %	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90 %	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80 %	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70 %	Reduced	Unable Normal Job/work Significant disease	Full	Normal or reduced	Full
60 %	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50 %	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40 %	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30 %	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20 %	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10 %	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0 %	Death	-	-	-	-

Reprinted with permission from: Victoria Hospice Society 2005.

PAIN MANAGEMENT

FENTANYL PATCH

- do **not** use for rapidly escalating pain
- do **not** use in an opioid naïve person √
- do **not** cut reservoir patch
- patches are changed q72h (occasionally q48h); fentanyl does not have a short acting oral equivalent for BT pain √

Starting Fentanyl:

- starting dose: 60 - 134 mg oral morphine per day is approximately equal to fentanyl 25 mcg patch q 72h √
- an appropriate BT dose for fentanyl 25 mcg patch would be morphine 10 mg PO q1h prn or hydromorphone 2 mg PO q1h prn
- regular dosing of the q4h (IR) oral opioid is continued for 12 hours **after** applying a fentanyl patch
- the patch can be applied simultaneously with the administration of the last dose of a long acting (q12h) oral opioid or 12 hours after administration of a q24h opioid

Stopping Fentanyl:

- fentanyl patch has 12-18 hour half-life
- commence regular ATC opioid dosing 12 hours **after** removing the patch; give BT doses as required

ANALGESICS TO AVOID

- Fiorinal® not for use in palliative care
- meperidine (Demerol®)- neurotoxic metabolite accumulation √
- pentazocine (Talwin®) - agonist-antagonist with severe psychotomimetic effects
- propoxyphene - increased risk of side effects profile in the elderly

Pain Management

Opioid Overdose

- use sedation scale to determine level of sedation √
- consider the PPS
- step 1: stimulate the person if sedation is increasing
- step 2: if sedation is **unexpected** and the sedation score is 3 and respiratory rate is ≤ 6/min and this is **unexpected**, consider judicious use of naloxone. If too much naloxone is given, it will precipitate a pain crisis. Starting IV dose: dilute naloxone 0.4 mg/ml with N/S 9 ml and give 1ml IV q 5-10 minutes until respirations > 6 and sedation level < 3 √
- physician consultation required

Common Opioid Side Effects

- constipation: is universal and tolerance does not occur
- consider osmotic & stimulant laxatives daily, titrate to effect
- nausea / vomiting: consider CTZ, D-2 antagonist as a prophylactic measure; tolerance may develop
- sedation √: usually temporary. If sedation is persistent, consider opioid rotation or use of methylphenidate. Consider the PPS

Must Know

- if treatment (e.g., radiation) results in decreased pain, then gradually decrease opioids. Too much opioid may lead to sedation as the pain level decreases

Pseudoaddiction / Tolerance / Dependence

- pseudoaddiction describes behaviours that may be perceived as drug-seeking but actually only occur when pain is under treated; the behaviours resolve when pain is effectively managed
- most patients over time do become physiologically dependent on opioids and will have withdrawal symptoms with abrupt discontinuation or major dose reduction√
- opioid tolerance and physical dependence are physiological and do NOT equate with addiction √

Symptom Management

Myoclonic Jerking (can be due to opioid toxicity √)

- consider hydration
- consider side effects of medications
- check calcium and creatinine blood levels
- reduce or rotate opioid
- lorazepam 1 – 2 mg PO/SL/SC q6h
- clonazepam 0.5 – 2 mg PO qhs (or 0.5 mg PO q6h prn)

Terminal Restlessness

- eliminate all possible causes (e.g., urinary retention, fecal impaction)
- consult with person and family regarding intent of interventions
- haloperidol 1.0 mg – 5.0 mg SC q 6h
- haloperidol 1.0 mg – 5.0 mg SC q6h plus lorazepam 1 - 4 mg SC/SL q6h (or midazolam* 2.5- 5mg SC q 6h)
- methotrimeprazine 5 - 50 mg PO/SC od and q4h prn
- midazolam,* lorazepam (same as dosage for seizures)

Intractable Symptoms at End of Life

Criteria for sedation for intractable symptoms √:

- verify that symptoms are intractable; palliative medicine consultation highly recommended
- patient/family conference with PC team to inform and obtain consent for sedation as sedation precludes communication with patient; and suggest d/c IV/parenteral feeding
- possible medications that can be used for intractable symptoms at EOL include midazolam, methotrimeprazine, propofol, phenobarbital

5

14

SYMPTOM MANAGEMENT

DELIRIUM (CONSIDER ETIOLOGY AND TREAT APPROPRIATELY)
Hyperactive, hypoactive (may masquerade as depression) and mixed √

- look for disordered thinking, fluctuating course, altered cognition
- consider opioid rotation
- haloperidol 0.5 – 5.0 mg PO/SC q4-6h prn as interim (first line)
- methotrimeprazine 5 - 50 mg PO/SC q4h prn

DEPRESSION

- consult PC team for emotional, psychosocial support
- antidepressants (SSRI & SNRI) (consider PPS before initiating)
- consider concurrent use of SSRI/SNRI with methylphenidate 10 – 20 mg PO bid 0800h & noon; suggested maximum 1 mg/kg/day; d/c when SSRI/SNRI effective

ACUTE SEIZURE CONTROL (IF PATIENT IS ACTIVELY SEIZURING √)

- lorazepam 2 mg Buccally or SC stat and 2 mg Buccally or SC q30 min prn until controlled
- **Or** midazolam * 5 – 10 mg SC stat and q30 min until controlled

Ongoing maintenance if / when patient no longer able to swallow:

- phenobarbital 30 – 240 mg SC q 8-12h (not available in community above 30 mg/ml)
- midazolam 20 – 60 mg /24h per CSCI
- carbamazepine supp * 25% increase from oral dose; or 8 – 20 mg/kg/day, bid or qid
- valproic acid liquid 15 – 60 mg kg/day PR bid or qid
- diazepam 10-20 mg PR q 15 min prn

PAIN MANAGEMENT

WOUNDS: morphine in intrasite gel for local analgesia √

INCIDENT PAIN / PROCEDURAL PAIN

- pre-empt predictably occurring pain by using a prn dose in advance
- use a short acting opioid and administer prior to the procedure or event. Allow 1 hour following PO administration and ½ hour following SC for the opioid to reach peak effect
- first choice is sufentanil 12.5 -50 mcg SL 15 minutes prior to procedure; if sufentanil not available may use fentanyl injectable * can be used sublingually for incident or procedural pain √ 25-50 mcg SL 30 minutes prior to procedure
- consider EMLA ® topical cream for painful IV starts

ADJUVANT / CO- ANALGESIC PAIN MANAGEMENT

CONSIDERATION OF THE ETIOLOGY OF PAIN IS ESSENTIAL IN SELECTECTING THE MOST EFFECTIVE ADJUVANT MEDICATION

- opioids are first line, then consider appropriate co-analgesic/ adjuvant for each pain syndrome (e.g., bone, nerve, inflammatory, intracranial pressure, ischemia, muscle spasms)

ADJUVANT INTERVENTIONS
Bone Pain:

- NSAIDs
- bisphosphonates
- corticosteroids
- radiation
- consider orthopedic stabilization

13

6

PAIN MANAGEMENT

ADJUVANT INTERVENTIONS (CONTINUED)

Neuropathic Pain:

- radiation of tumour to relieve tumour pressure
- TCA and/or anti-convulsant meds; common drugs used are:
  - nortriptyline, amitriptyline
  - carbamazepine, valproic acid
  - gabapentin * √: for starting dose and titration guidelines
  - Pregabalin * √: indicated for diabetic peripheral neuropathy and postherpetic neuralgia
- consult anesthesia or interventional radiology for nerve block
- methadone √ is an excellent drug but requires a methadone exemption license for pain management; consult with a palliative care physician

Liver Capsule Pain:

- corticosteroids

Tumour expanding in a small space:

- corticosteroids
- radiation

Inflammatory Pain:

- NSAIDs
- corticosteroids

Raised Intracranial Pressure: (from intracranial tumours)

- corticosteroid
- radiation, neurosurgery

Muscle Spasms:

- benzodiazepine
- baclofen

SYMPTOM MANAGEMENT

SEVERE PROGRESSIVE DYSPNEA √

- consult with a Palliative Medicine Expert
- protocol for sedation for intractable symptoms at the end of life may be required √

RESPIRATORY SECRETIONS

- atropine 1% ophthalmic 3 gtts SL/Buccal Space q1-2h prn
- glycopyrrolate * 0.2 – 0.4 mg SC (each ml = 0.2 mg) q4h (non-sedating as does not cross blood-brain barrier)
- hyoscine hydrobromide * 0.4 mg SC q3h
  (also available as Transderm V patch * q 3 days – paranoia and confusion may develop in elderly patients)
- consider repositioning
- suctioning is not usually indicated

HYPERCALCEMIA (CORRECTED VALUE OVER 2.65 MMOL √)

To calculate corrected calcium level =
total serum calcium level + [(40 minus serum albumin level) x .02]

OR to correct, add 0.02 mmol for every gm albumin below normal

- hydrate with normal saline
- pamidronate 60 – 90 mg IV in 500 ml normal saline over 4 hours, q3-4 weeks – wait 72 hours post infusion to recheck levels
- zoledronic acid * 4 mg in 50 cc normal saline IV over 15 minutes q 3- 4 weeks

EXCESSIVE SEDATION

- assess analgesic and reduce if possible
- consider opioid rotation
- methylphenidate 2.5 - 15 mg PO 0800 h & 12 noon (start low & titrate to maximum effect 30-60 mg od); may also improve cognitive function, activity (consider PPS, prior to initiation)

7

12

SYMPTOM MANAGEMENT

HICCUPS (NOTE–CHLORPROMAZINE CAUSES ORTHOSTATIC HYPOTENSION √)

- haloperidol 1 – 2.5 PO/ SC q4h prn
- metoclopramide 10 – 20 mg SC */PO qid
- baclofen 10 – 20 mg PO q4h prn
- methotrimeprazine 12.5 – 25 mg PO/SC q6h prn
- chlorpromazine 12.5 – 50 mg PO/IV q4h prn

DYSPNEA

First Line:

- fan (air movement)
- oxygen √ for ODB criteria
- positioning of patient for ease of breathing & comfort
- emotional support and safety
- physiotherapy

Second Line:

- recent studies have indicated that the use of systemic opioid is more effective than nebulized opioid √
- if opioid naïve, start with low dose, short acting opioid q4h for dyspnea control (e.g., morphine 2.5 - 5 mg PO q4h)
- if on long acting opioid for pain, increase the baseline by 30% for dyspnea control and adjust breakthrough dose
- use the adjusted breakthrough opioid dose for pain or dyspnea
- titrate opioid using pain management principles √

Other measures to consider based on etiology of dyspnea:

- nebulized normal saline q4 - 6h
- nebulized salbutamol and ipratropium (LU #258) q4 - 6h
- lorazepam 1 – 2 mg SL q1h prn for accompanying anxiety
- dexamethasone 4 – 8 mg PO/SC od and adjust according to response

SYMPTOM MANAGEMENT

G.I. PROTECTION √

- H2 antagonist (e.g., ranitidine 150 mg PO bid)
- cytoprotector (e.g., misoprostol 200 mg PO tid – qid)
- proton pump inhibitor (PPI), (e.g., rabeprazole 20 mg PO od)

NAUSEA (CONSIDER ETIOLOGY)

Prokinetics (may be contraindicated in complete bowel obstruction):

- metoclopramide (10 – 20 mg PO/ SC */ IV * q 4h – 6h)
- domperidone 10 – 20 mg PO qid

CTZ, D2 Receptor or Antagonist:

- haloperidol 0.5 – 2.5 mg PO/ SC bid – tid

Steroid:

- dexamethasone 2 – 8 mg PO/ SC/ IV od

5HT3 Antagonist:

- ondansetron * √ 4 – 8 mg PO/SC/ IV bid – tid (main indication for use in early radiation/chemo induced nausea & vomiting)

Antihistamine:

- diphenhydramine 25 – 50 mg PO/SC/IV q4h prn

Cannabinoids:

- nabilone 0.25 mg – 2 mg PO bid

Vestibular Etiology:

- scopolamine 0.3mg SC q3-4h prn
- meclizine 25-50 mg PO tid prn
- Transderm-V Patch* change q 72h

Broad Spectrum:

- methotrimeprazine 2.5 – 12.5 mg PO/SC q6h prn
- prochlorperazine 5 -10 mg PO/PR/IV q4h prn (do not give SC)

NOTE: prochlorperazine and dimenhydrinate generally not very effective in patients receiving palliative care

11

8

SYMPTOM MANAGEMENT

MOUTH CARE √

- local institutions may have preferred formulations √
- saline or soda bicarbonate rinse and spit q1h prn
- chlorhexidine 0.2% rinse and spit q8h
- artificial saliva

Thrush (candidiasis):

- nystatin suspension 500,000 units qid (topical or swish and swallow); clean and soak dentures
- fluconazole 100 mg PO od x 10-14 days (LU #202); for maintenance dose 100 mg PO weekly

Painful Mouth:

- lidocaine viscous, swish and spit (caution: assess swallowing)
- morphine 5- 10 mg rinse and spit; morphine is not lipophilic and binds to raw wounds in mouth

BOWEL ROUTINE (DAILY DOSING AND PRN)

CONSIDER ETIOLOGY OF CONSTIPATION √

Start concurrently with opioids & titrate individually or in combination:

- sennosides (1-8 tablets) PO bid - tid (mild stimulant)
- lactulose 15 – 60 ml PO od to qid (osmotic laxative)
- bisacodyl 5 mg (1 – 4 tablets) PO od – bid (stronger stimulant)
- bisacodyl suppository 10 mg PR prn
- milk of magnesia 15 – 60 ml PO od to qid (osmotic laxative caution in renal failure)
- Fleet Enema prn (caution in renal failure)
- methylnaltrexone *√: consider etiology; use only in opioid induced constipation; if weight is: 38- 62 kg give 8 mg SC for 62-114 kg give 12 mg SC; if weight falls outside these ranges dose is 0.15 mg/kg SC. Give SC q 2days for 2 weeks. If inadequate laxation response after 4 doses then discontinue. Can be given on a prn basis SC; may only be needed q 3-4 days

SYMPTOM MANAGEMENT

MALIGNANT NON-OPERABLE BOWEL OBSTRUCTION

- rule out obstipation versus other causes of mechanical obstruction
- assess current medications for administration by non-oral route

First choice is pharmacological management:

- consider NG tube decompression for short periods (i.e., 24-48h) to enhance efficacy of medication

Partial Bowel Obstruction:

- prokinetic: metoclopramide 10 – 20 mg SC */IV * q4-6h
- steroid: dexamethasone 2 – 4 mg SC/IV od - bid
- antiemetic: haloperidol 0.5 – 1.0 mg SC/PO q 8-12h
- antispasmodic: hyoscine butylbromide * 10 – 20 mg SC/IV q 4-6h

Complete Bowel Obstruction:

- consider stopping prokinetic medications if there is increased abdominal cramping/pain with their use
- continue anti-inflammatory (dexamethasone), antiemetic
- consider IV fluids
- octreotide * 100 – 300 mcg SC bid or tid (reduces gastro-intestinal secretions)
- consider venting gastrostomy tube√

MALIGNANT ASCITES

Before paracentesis, maximize diuretics usage to decrease albumin loss:

- furosemide 40- 80 mg PO/IV* bid (0800h and 1400h) plus spironolactone 50 – 200 mg PO bid (0800 h and 1400 h)
- paracentesis is only for symptom relief