

PALLIATIVE CARE

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A. Ethical Questions

1. When there are limitations to ICU/ventilator access and all other interventions to treat severe COVID-19 have been exhausted, is it appropriate to say, “There is nothing more that we can do?”
2. Is using morphine and sedative medication in the last days/hours of the life of severe COVID-19 patients appropriate?
3. What is the obligation of the healthcare system to patients with severe COVID-19 who are actively dying?

B. Scenarios

1. A 73-year-old lady with CKD stage 5 presents with worsening dyspnea and is found to be PCR+ve for COVID-19. Her serum creatinine is 980 umol/l and she has metabolic acidosis. She told her family clearly that she does not want any form of renal replacement therapy.
2. A 58-year-old gentleman was admitted with a large Middle Cerebral Artery infarct and poor GCS with a background of diabetes mellitus and hypertension. He developed fever and worsening oxygen saturation with tachypnoea during admission and was PCR+ve for COVID-19. There are no more ventilators available, and his O₂ saturation is 80% on a 12L/min facemask.
3. A 67-year-old man with diabetes mellitus, hypertension, and coronary artery disease is admitted with COVID-19. His O₂ saturation on the facemask at 10 L/min is 85%, and he is very restless and pulls the mask and IV lines off.
4. A 43-year-old lady with a history of breast cancer metastatic to the bones and liver presents with severe cancer pain. She is exposed to a COVID-19 positive patient while in the emergency department and is now isolated as a PUI. During isolation, she is in severe pain but has no respiratory symptoms.
5. A 54-year-old gentleman with no prior medical illness developed severe COVID-19 and has been ventilated for the past 35 days in ICU. He has had all possible treatments for COVID-19 and was treated with multiple antibiotics for subsequent bouts of sepsis. His GCS is very poor, and he has not responded despite sedation being ceased for several days. The intensivist cannot wean down the ventilator settings, and a CT scan shows a badly damaged lung. His family wonder if they can take him home.

C. Background

1. Palliative care is an approach that improves the quality of life for patients and families facing problems associated with life-threatening illnesses. While many COVID-19

patients survive the disease, those who are elderly and with multiple comorbidities have the highest risks of death and should be afforded palliative care in the event of severe deterioration.

2. In patients who do not have COVID-19 but suffer from chronic, incurable illnesses, palliative care is by definition a necessity for all these patients; however, during the pandemic, these patients endure additional suffering as their access to supportive care has become compromised due to lockdown and movement control orders. Patients in these groups may become fearful of accessing care in view of the risk of exposure to the virus from others, especially in emergency departments.
3. Apart from that, many patients who present with deterioration from organ failure or metastatic cancer often have dyspnoea as a common symptom. This may require them to be isolated in a SARI ward for swabbing to rule out covid infection. During this isolation period, these patients suffer significantly as they are weak and disabled, while some even pass on in isolation wards alone where families are unable to be with them.
4. For COVID-19 patients who are severely ill, palliative care should be provided to address symptoms of dyspnoea and pain due to severe inflammatory pathology whilst still receiving acute interventions to prevent mortality. In patients who were not offered life support interventions due to their poor prognosis, palliative care must be provided as the failure to do so would be considered unethical.

D. Guiding Principles

1. Palliative care is not merely providing care in the last days of life but is also applicable to all patients who have severe distress from any life-limiting illness regardless of interventions.
2. Palliative care considers care for the whole patient not merely for physical symptoms but also psychological, social, and spiritual problems.
3. Palliative care can be provided by any healthcare professional at a basic level and does not necessarily require a specialist in palliative medicine.
4. Essential medications, primarily opioids and sedative medications, are the cornerstone to appropriate physical symptom management in both non-COVID-19 and COVID-19 patients.

E. Recommendations

1. All healthcare services must be aware of basic guidelines for providing palliative care in both non-COVID-19 and COVID-19 patients.
2. In all isolation wards (SARI/PUI/COVID), essential medications to relieve common symptoms should be made readily available. Common symptoms include dyspnoea, restlessness, pain, and delirium. The use of oral and parenteral medications is essential, and the administration (route) of these medications could be individualised to provide the most effective and convenient care. (ie. 24-hour subcutaneous infusions may be most comfortable for patients in the terminal phase).
3. All patients suffering from incurable chronic illnesses who regularly require palliative care could be tested with RTK Ag test to reduce the time needed for isolation and allow care to be provided in a general ward and the easing of restrictions/limitations that are commonly imposed in a SARI setting.
4. Where possible, non-COVID-19 palliative care patients should be managed in the community under homecare teams to prevent the need for patients to access overcrowded hospitals where the risk of infection is much higher. The healthcare system should support community services (both government and NGO run) to provide safe and effective homecare by ensuring there is adequate provision of PPE, essential medications and access to travel into areas where movement control orders are imposed.
5. As a best practice, homecare teams should have partnerships/linkages with hospital services to access support in the event of exposure to COVID-19 positive individuals during the course of duty. Such support should include access to testing of staff as well as advice by occupational safety and health teams. Vaccinations of all staff should be provided with a priority for those actively involved in patient care.
6. If COVID-19 patients have been decided by the team to be managed expectantly, supportive measures and symptom management must be adequately provided. This includes using opioid infusions and sedative medication for the management of dyspnoea and restlessness. Adequate communication must be provided to both the patient and family in a compassionate and empathetic manner by experienced personnel. The family should be given options to visit if this is possible under PPE cover.

7. All healthcare professionals should be trained with essential communication skills to provide compassionate and empathetic conversations with patients and families dealing with life-threatening conditions under the current COVID-19 restrictions.

F. Clinical Management of Common Symptoms in Palliative Care

1. Common symptoms that may be encountered in severely ill COVID-19 patients requiring palliative care include:
 - a. Dyspnoea
 - b. Pain
 - c. Restlessness and delirium
 - d. Respiratory secretions
2. Before commencing pharmacological measures, consider the following appropriate concurrent measures:
 - a. Optimise management of underlying conditions (e.g. COPD, heart failure, asthma)
 - b. Treat reversible conditions (e.g. anemia, pleural effusion, gross ascites)
 - c. Employ non-pharmacological interventions (e.g. cooling face, relaxation techniques, positioning of body)
3. The figure ([Figure 1](#)) below describes the STARTING doses for pharmacological management of common symptoms. Gradual titration of dose should be according to symptoms and response. A reasonable increase in dose is about 30-50% of the prior baseline dose. If possible, consider referral to palliative care team if severe renal failure or pain/dyspnoea unresponsive to opioids.

Figure 1: Intensive Symptom Management

PAIN	DYSPNOEA
<p>Aq morphine 3-5mg 4 hrly and PRN</p> <p><u>If mild-moderate renal impairment:</u></p> <p>Aq morphine 2-3mg 6-8 hrly and PRN</p> <p><u>If severe renal impairment:</u></p> <p>SC fentanyl infusion 4-12mcg/h + Aq morphine 2-3mg PRN</p> <p>Increase background dose if >2 PRN doses /day</p> <p>If the patient is already on opioids, increase the dose by 30%</p> <p>Consider changing to SC route if not tolerating orally (Aq morphine 2mg=SCmorphine 1mg)</p> <p>Pain should be monitored using standard pain scores in patients who are able to speak.</p> <p>If poorly responsive, assess pain using the FLACC scale.</p> <p>Use concurrent laxatives to prevent constipation</p>	<p>SC Morphine 1-2mg 4-8 hrly and PRN (upper limit of usual dose: 15mg/24h)</p> <p><u>If severe renal impairment:</u></p> <p>SC Fentanyl infusion 4mcg/h + SC morphine 1mg PRN</p> <p>Increase by 2-4mcg/h every 6-8 hours as needed (upper limit of usual dose: 12mcg/h)</p> <p>Manage associated anxiety/ agitation:</p> <p>SC Midazolam 2.5mg PRN SL Lorazepam 0.5mg PRN</p> <p>May combine both in an infusion:</p> <p>SC Morphine 10-15mg + Midazolam 5-10mg over 24H</p> <p>Dyspnoea can be assessed by the following:</p> <ul style="list-style-type: none"> - Dyspnoea score 1-10 if patient able to speak (similar to pain score). - Respiratory rate (to aim for <25/min) - Use of accessory muscles of respiration. - Anxiety and restlessness
<p>DELIRIUM & RESTLESSNESS</p> <p>SC Haloperidol 0.5-1mg ON and PRN (every 0.5-1 hour) till calmer</p> <p>If intractable or terminal delirium/restlessness:</p> <p>SC Midazolam 2.5mg PRN</p> <p>Consider infusion SC Midazolam 15-20mg over 24h if persistent restlessness.</p> <p>Manage all reversible precipitants, carry out non-pharmacological measures.</p>	<p>TERMINAL RESPIRATORY SECRETIONS</p> <p>SC Buscopan 20mg QID/PRN</p> <p>Consider infusion SC Buscopan 60-180mg over 24 h if persistent secretions.</p> <p>Re-position patient.</p> <p>Only offer suctioning if oral secretions visible</p> <p>Alternatively, SC Glycopyrolate 200-400mcg prn/tds may be used.</p>

4. Essential medications to stock in isolation wards:
 - a. Aq Morphine 10mg/5ml
 - b. T./ Inj. Metoclopramide 10mg
 - c. T. Lorazepam 1mg
 - d. Inj. Fentanyl 50mcg/ml
 - e. Inj. Haloperidol 5mg/ml
 - f. Inj midazolam 5mg/ml
 - g. Inj. Buscopan 20mg/ml
 - h. Laxatives to manage constipation
5. Safety of using opioids and sedative medications in COVID-19 patients with respiratory distress
 - a. Clinicians are occasionally fearful of using opioids and sedative medications in patients with respiratory distress for fear of causing respiratory depression and hastening death.
 - b. Current evidence studying the role of opioids and benzodiazepines in patients with dyspnoea from numerous causes including cancer, chronic obstructive pulmonary disease (COPD), interstitial lung disease (ILD) and bronchiectasis have shown that these medications are effective in reducing dyspnoea and do not lead to excess mortality or acute hospitalisation of such patients and oxygen saturations are not affected.
 - c. Patients with dyspnoea are tachypnoeic and when the dose of opioids is carefully titrated against the patient's respiratory rate, respiratory depression does not occur.
 - d. In severely ill COVID-19 patients who are unable to be mechanically ventilated, clinicians should not withhold treatment of severe dyspnoea with opioids and benzodiazepines due to the fears as stated above.

G. References

1. National Palliative Care Policy and Strategy 2019-2030. Putrajaya: Ministry of Health, Malaysia; 2019.

2. Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises: a WHO guide. Geneva: World Health Organization; 2018.
3. Alleviating suffering and upholding dignity in the midst of CoViD-19 response:A place for palliative care. Humanitarian Health Ethics Research Group, March 31st , 2020
4. NHS (UK).Publications approval reference: 001559. Clinical guide for the management of palliative care in hospital during the coronavirus pandemic. Keeping the care in healthcare . 27 March 2020, Version 1
5. E-Book on palliative care guidelines for COVID-19 Pandemic. Kerala: PalliCovidKerala; April 2020
6. Covid ready communication playbook: Vital talk (retrieved on 1st May 2020 at <https://www.vitaltalk.org/covid-resources/>)
7. Palliative Care Guidelines for patients diagnosed as SARI/PUI-COVID admitted to isolation wards. Palliative Unit, Hospital Selayang. May 2020.
8. Lovell N, Maddocks M, Etkind SN, Taylor K, Carey I, Vora V, Marsh L, Higginson IJ, Prentice W, Edmonds P, Sleeman KE. Characteristics, Symptom Management, and Outcomes of 101 Patients With COVID-19 Referred for Hospital Palliative Care. *J Pain Symptom Manage*. 2020 Jul;60(1):e77-e81. doi: 10.1016/j.jpainsymman.2020.04.015. Epub 2020 Apr 20. PMID: 32325167; PMCID: PMC7169932.
9. Finney LJ. Is it safe to prescribe benzodiazepines or opioids for dyspnoea in interstitial lung disease?. *Breathe (Sheff)*. 2019;15(2):137-139. doi:10.1183/20734735.0015-2019
10. Sabrina Bajwah, Joanna M. Davies, Hanan Tanash, David C. Currow, Adejoke O. Oluyase, Magnus Ekström. Safety of benzodiazepines and opioids in interstitial lung disease: a national prospective study. *European Respiratory Journal* Dec 2018, 52 (6) 1801278; DOI: 10.1183/13993003.01278-2018
11. Verberkt CA, van den Beuken-van Everdingen MHJ, Schols JMGA, Datla S, Dirksen CD, Johnson MJ, van Kuijk SMJ, Wouters EFM, Janssen DJA. Respiratory adverse effects of opioids for breathlessness: a systematic review and meta-analysis. *Eur Respir J*. 2017 Nov 22;50(5):1701153. doi: 10.1183/13993003.01153-2017. PMID: 29167300.
12. Ekström MP, Bornefalk-Hermansson A, Abernethy AP, Currow DC. Safety of benzodiazepines and opioids in very severe respiratory disease: national prospective study. *BMJ*. 2014 Jan 30;348:g445. doi: 10.1136/bmj.g445. PMID: 24482539; PMCID: PMC3906915.