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## Canadian Family Medicine Clinical Card

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# Palliative Care

### Goals of Care / Future Directions

- clarify if goal is palliation OR prolongation of life OR balance of both
- make sure patient is able to make goal decisions with clear mind (i.e. not depressed, not confused, not being pressured, not in unremitting pain)

**PAIN** - is pain relief adequate? If NO, re-assess for reversible cause and start or increase analgesia (see below)

- mild pain -> acetaminophen and/or NSAIDS (particularly in bone pain)
  - avoid NSAIDS in elderly, renal impaired, GI bleed (consider PPI)
- moderate -> weak opioid (codeine or tramadol)
- severe -> strong opioid (morphine, oxycodone, hydromorphone)

Equivalencies	PO	Parenteral	IV : PO	Duration
Morphine	30mg	10mg	3	3-4h
Codeine	200mg	130mg	1.5	3-4h
Oxycodone	15-20 mg	-	-	3-5h
Hydromorphone	7.5mg	1.5mg	5	3-5h
Fentanyl	-	100mcg	-	1-3h

### Typical Starting PO doses

Morphine	5-10mg q4h
Codeine	8-15mg q4h
Oxycodone	2.5-5mg q4h
Hydromorphone	1-2mg q4h
breakthrough dose = 10% of 24hr total q 1h prn	

### OPIOID ADVERSE EFFECTS:

- constipation (prevent or treat with PEG 3350 OR senna)
- somnolence/sedation (consider switching or add psycho-stimulant)
- nausea (metoclopramide 10mg PO/SC/IV QID PRN)
- neurotoxicity (avoid renal impairment - i.e. good hydration)
- respiratory depression (RARE with careful titration)

### ADJUVANT THERAPY:

- bone pain (1<sup>st</sup> line: NSAIDS; 2<sup>nd</sup> line: dexamethasone, bisphosphonates)
- neuropathic pain (nortriptyline, gabapentin)

### TITRATING OPIOID DOSE UPWARDS (if > 2 doses of breakthrough needed/24h):

- add up previous 24 hour total, and divide by 6 to get new q4h dose
- remember: give 10% of this new 24 hr total as the breakthrough dose

### NAUSEA/VOMITING:

- opioid-induced: - metoclopramide (see above)
  - haloperidol 1-5mg PO/SC BID/TID/PRN (watch for EPSE)
- malignant bowel obstruction: haloperidol (as above)
- chemo/radiotherapy induced: ondansetron 4-8mg PO/SC/IV BID/TID

### DYSYPNEA (awareness of breathing; frequent and often multifactorial):

- treat/optimize treatment for reversible causes (eg. PE, COPD, etc.)
- try air directed across face, sit upright and by open window
- systemic opioids: initiate as for **PAIN**
- O<sub>2</sub> nasal prongs: in hypoxic patients (SaO<sub>2</sub> < 88% or PaO<sub>2</sub> < 55 mmHg)

### DELIRIUM:

- control symptoms: haloperidol or methotrimeprazine (more sedating)
- treat the underlying cause (if possible and indicated)
- educate family (disease fluctuations, need for antipsychotics > opioids)

### PAIN CRISIS:

- rule out delirium, psycho-spiritual crisis, opioid neurotoxicity
- use appropriate breakthrough dose
- consider emergent breakthrough dosing with fentanyl (NOT by patch)

### SPINAL CORD COMPRESSION:

- recognize and treat ASAP to reduce morbidity
- dexamethasone 8-10mg PO/SC/IV STAT if any suspicion, then BID/TID
- urgent radiotherapy and/or neurosurgery referral