PTHC and Guildford and Waverley CCG Palliative Care GP Update

Dr Nick Dando, Consultant in Palliative Medicine
Debbie Hindson, Nurse Consultant
Dr Jacqui Phillips, Consultant in Palliative Medicine

Phyllis Tuckwell Hospice Care

Aims

- Update on service development at PTHC with a particular emphasis on new community-focussed models of care

- Link in with developing models of care for patients with non-malignant life-limiting illness in G+W

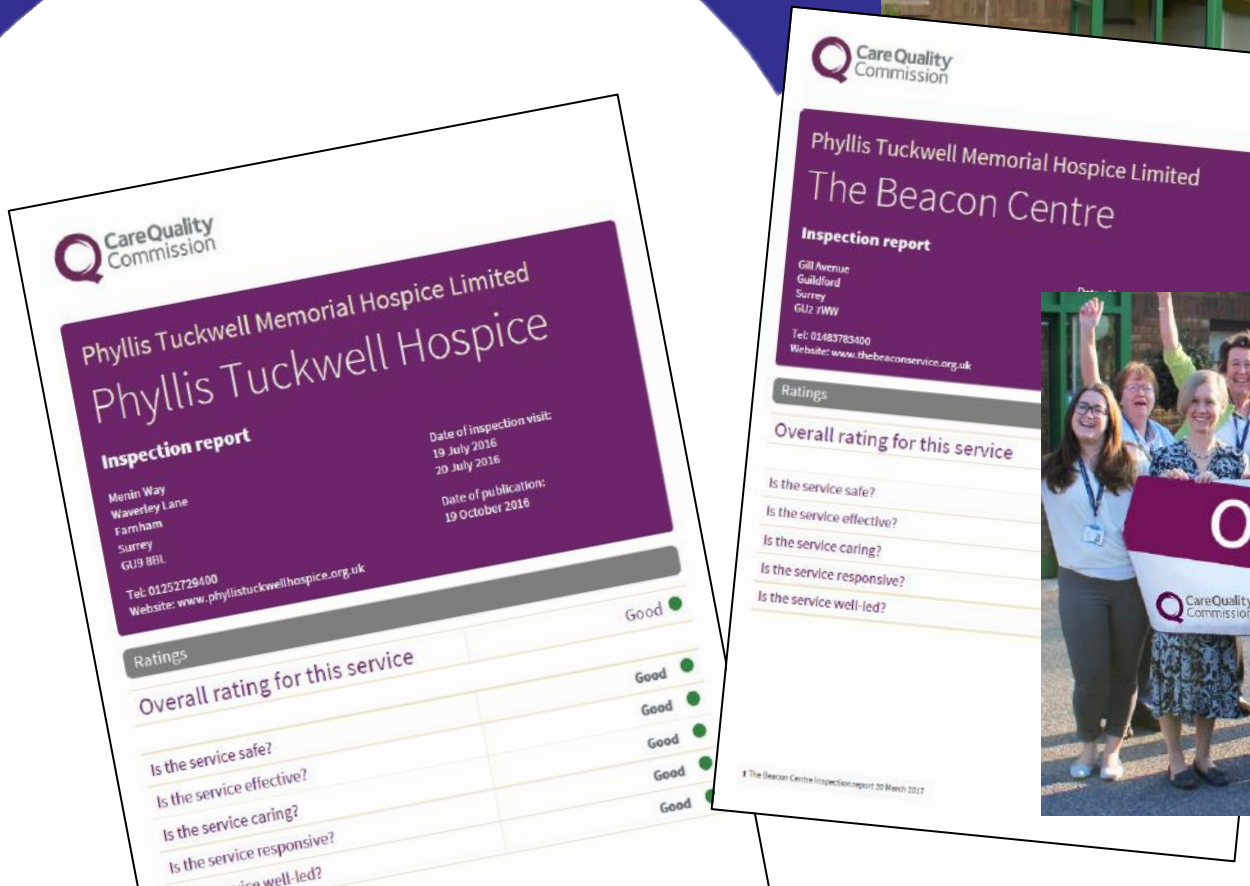
- Symptom control update including cancer pain management and symptom control at the end of life

Non malignant service development 2012 - 2017

- Chronic respiratory disease
- Neurodegenerative disease
- Individualised 3 month blocks of care under the Day Hospice
- Appointment of Debbie Hindson (Nurse Consultant) and Dr Jacqui Phillips (Non-malignant medical lead)

The Beacon Centre

April 2015



Services

Phyllis Tuckwell® Hospice Care
...because every day is precious

Phyllis Tuckwell® **In-Patient Unit**

Phyllis Tuckwell® **Care at Home**

Phyllis Tuckwell® **Living Well Services**

Carers & Relatives Services
Phyllis Tuckwell®

Bereavement Services
Phyllis Tuckwell®

Education & Training
Phyllis Tuckwell®

Living Well

Focusing on the 'Rest of Life'
we are here to help patients, and those closest to them, to:

- maximise their physical health
- help to cope with changes
- improve wellbeing
- be as independent as possible

to get more out of life.

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Emotional Wellbeing

Complementary Therapy

Counselling

Exercise

Physical Health

Tai Chi

Living Well

Focusing on the 'Rest of Life' we are here to help patients, and those closest to them, to:


Creative Writing


Brush with Art


Therapy through Nature

Creative Therapies


Cooke ry

Emotional Wellbeing


Complem entary Therapy

Exerci se


Physical Health


Tai Chi


Counsell ing

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Cookery

Emotional Wellbeing

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Counselling


Physical Health


Tai Chi

Information and Support


"It's been a brilliant experience. Nothing has matched the services here at Phyllis Tuckwell. I can't speak highly enough of it, really."

Symptom control update

Dr Nick Dando

Phyllis Tuckwell
Hospice Care

Aims

- Opioid update
  - Transdermal opioids
  - General prescribing at the end of life
  - Prescribing in renal impairment
- Management of terminal agitation
- Management of secretions

Oral to transdermal Fentanyl conversion

PANG/PCF/BNF

PO Morphine 100mg (50mg BD)

Divide 100

Transdermal fentanyl 1mg in 24 hours

Multiple 1000

Transdermal fentanyl 1000micrograms in 24 hours

Divide 24

= 41.6 micrograms per hour

Fentanyl patch 37microgram/hr
with PRN morphine IR 15mg PO

- This conversion is for patients with stable pain and careful monitoring of pain and side effects should be undertaken when switching to a patch.

Transdermal Fentanyl	PO Morphine	
Micrograms/hr	**mg/24 hours**	**PRN (mg)**
12	30 - 59	5
25	60 – 89	10
37	90 - 119	15
50	120 - 149	20
75	180 - 239	30
100	240 - 299	40

Adapted from: Quick prescribing guide: Use of transdermal fentanyl patches (PCF 5) and Opioid Equivalence for Transdermal Patches Conversion Guide (PANG 2016).
Guidelines for Strong Opioids at Phyllis Tuckwell Hospice. 2017

Buprenorphine

- Buprenorphine is a partial mu agonist which only becomes significant at high doses of Buprenorphine (3-5mg/24hrs).
- It is also a kappa receptor antagonist, which as a consequence can increase mu receptor expression on membrane surfaces, and an agonist for the opioid receptor like 1 (ORL-1) receptor.
- The drug is effective in cancer pain, neuropathic pain and other pain presentations and is associated with less analgesic tolerance.
- These clinical benefits have resulted in increased prescription of buprenorphine in some cancer centres, with more patients being discharged into the community with the medication

Oral to transdermal buprenorphine conversion

Buprenorphine conversion (morphine:buprenorphine 100:1)
Morphine sulfate 25 mg PO BD = 50mg PO in 24 hours
Divide by 100
Buprenorphine 0.5mg in 24 hours
Multiple 1000
Buprenorphine 500 micrograms in 24 hours
Divide by 24
Buprenorphine 20.8 micrograms/hour = BuTrans Patch 20 micrograms/hour
Breakthrough dose = 50 divided by 6 = 8.3mg PO morphine PRN

Buprenorphine Equivalents

Transdermal Buprenorphine	PO Morphine	
	mg/24 hours	PRN (mg)
5microgram/hr	12	2
10microgram/hr	24	5
20microgram/hr	48	10
35 microgram/hr	84	15
52.5 microgram/hr	126	20
70 microgram/hr	168	30

Adapted from Quick Practice Guide: Use of transdermal buprenorphine. PCF 5. Guidelines for Strong Opioids at Phyllis Tuckwell Hospice. 2017

General Prescribing Guidelines in EOLC

Pain	Morphine sulfate	2.5-5mg	SC	PRN
Anxiety	Midazolam	2.5-5mg	SC	PRN
Nausea	Haloperidol	0.5-1.5mg	SC	PRN TDS
Chest secretions	Hyoscine butylbromide	20mg	SC	PRN

If three or more PRN doses needed in 24 hours, start a syringe driver with equivalent drug doses

Example

Water for Injection	Morphine sulfate 15mg Haloperidol 3mg Hyoscine butylbromide 60mg	via sub cut syringe driver over 24 hours

Alfentanil

- Synthetic lipophillic opioid
- Alfentanil may be considered for patients with renal impairment or intolerance to Diamorphine/ Morphine/Oxycodone
- Morphine 30mg PO = Alfentanil 1mg
- Please note Alfentanil has a short duration of action (30min). It may therefore require more frequent PRN dosing, with careful monitoring for side effects.

Sande et al (2017). The use of Opioids in cancer patients with renal impairment– a systematic review. Support Care Cancer. 25: 661-675.

Prescribing in renal impairment

Pain	Oxycodone	1.25mg	SC	4 hourly PRN
Anxiety	Midazolam	2.5mg	SC	PRN
Nausea	Haloperidol	0.5-1.5mg	SC	PRN TDS
Chest secretions	Hyoscine butylbromide	20mg	SC	PRN

If a background syringe driver is needed for pain then use alfentanil

Example

Water for Injection	Alfentanil 500 micrograms	sub cut over 24 hours

Terminal Agitation

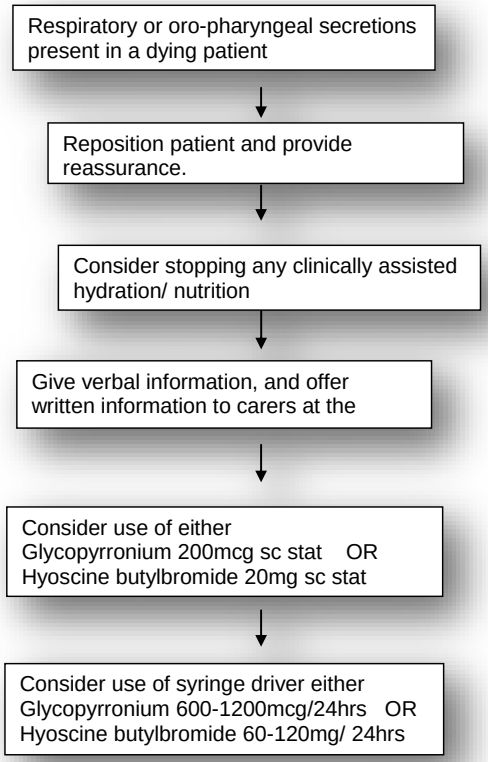
- Patients may develop delirium and confusion at the end of life
- Spectrum of behaviour
- If acutely delirious, consider higher doses of haloperidol rather than midazolam as benzodiazepines may exacerbate confusion

Example

- Haloperidol 1.5 - 2.5mg SC PRN for delirium (max 12mg in 24 hours)

Chest secretions

- Consider the causes
- Assess the impact on the patient
- Reassure and support family
- Consider use of anti-secretory medication



Think:
Consider alternative causes of secretions if no response to above.
Eg. pulmonary oedema, infection or gastric

Think:
Is there distress or breathlessness? Is an opioid or benzodiazepine necessary?

Think:
Is there a role for suction?

Guidelines for the management of noisy respiratory secretions at the end-of-life. PTHC 2017.

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