Taking a palliative approach to residents of Aged Care Facilities
• Most palliative care units use their own conversion charts

• The clinical situation also will guide the conversion
Remember to increase the size of the Breakthrough Opioid

• How big should the breakthrough dose be?
  • As a general rule should be 10 -20% of the total daily dose

• We often see poorly controlled pain because the breakthrough dose of analgesia is not increased when the background dose of the opioid is increased
MR Smith

• Has done well on the 60 bd of slow release morphine with immediate release morphine as a breakthrough.
• Is now deteriorating and becoming weak - unable to swallow

• How do I replace the Morphine
  • Convert to Subcut and give over 24hrs
• 120 of morphine plus and extra 60 mg in breakthrough
  • 180 mg of oral morphine
• This converts to 60 to 90 mg of morphine subcutaneously over 24 hours
• What about a patch instead?

• What if the patient already has a patch?
These slides are take from a PEPA workshop as below.

Palliative Care in General Practice

Workshop conducted in partnership with Primary Health Care Networks
Presenters Dr Alison Kearney
CN Anne Hales
RBWH Supportive and Palliative Care
Workshop Outline

• Some trends in palliative care delivery
• Recognising those who need palliative care
• Communication Symptom assessment and management
• Case scenarios
• Local service networks and resources for practice
Learning Outcomes

At the end of this workshop, you will have a better understanding of:

• How to identify individuals in the Aged care setting who could benefit from palliative care

• Strategies for communicating with patients and families about prognosis and goals and preferences for care

• The principles of palliative care, including assessment and management of pain and other common symptoms

• Resources to support general practitioners to provide palliative care

• Self care strategies to effectively manage the personal issues related to working in this field.
Some Important Trends in Palliative Care Delivery
Principles of Palliative Care


- Palliative care is an approach that improves the **quality of life** of **patients and their families** facing the problem associated with **life-threatening illness**, through the **prevention and relief of suffering** by means of **early identification** and **impeccable assessment and treatment** of pain and other problems, physical, psychosocial and spiritual.

- Key principles include:
  - Relief from pain and suffering
  - Affirms life / dying is normal
  - Neither hasten or postpone death
  - Holistic – integrates psychological and spiritual
  - Bereavement
  - Team approach
  - Applicable early in course of illness in conjunction with life prolonging therapies (added in 2008)
Important trends in palliative care delivery (1)

• Most people will die of non-malignant disease with uncertain disease course.

• Palliative care should be based on need not prognosis or age, including any chronic or malignant disease, even if the trajectory is ambiguous or unknown.

• RBWH 60:40 ratio

Source: The GSF Prognostic Indicator Guidance The National GSF Centre’s guidance for clinicians to support earlier recognition of patients nearing the end of life http://www.goldstandardsframework.org.uk/
Important trends in palliative care delivery (2)

Growing evidence of the benefit of early integration of palliative care

2017 Cochrane Review - Advanced Cancer Patients

- Small number of studies report benefit of early palliative care in terms of quality of life and symptom intensity
- Effect sizes are small, but clinical significance may be substantial
- Landmark Temel paper in NEJM showing SURVIVAL benefit with early pall care – not yet replicated

2017 Systematic Review – Hospital, Hospice and Community Settings

- Strong support for an approach of “general palliative care for all plus specialist palliative care as needed”.
Important trends in palliative care delivery (3)

- GP role is critical
- Many patients will not have or need specialist palliative care involvement
- Integration between specialist providers and primary care is essential

Palliative Care Australia (2005)
Core Skills for GPs

- Early recognition of approaching end of life
  - Identifying those who can benefit
- Consideration and recording of the patient's wishes
  - Communicating with patients and families and advance care planning
- Planning for inevitable deterioration and crises at the end of life
  - Symptom support
  - Practical, emotional and spiritual support
  - Accessing resources and working with specialist palliative care teams

Primary Palliative Care
- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about
  - Prognosis
  - Goals of treatment
  - Suffering
  - Code status

Specialty Palliative Care
- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment
  - Within families
  - Between staff and families
  - Among treatment teams
- Assistance in addressing cases of near futility

Core Skill: Recognising Dying
Recognising dying

Gold Standards Framework Prognostic Indicator Tool

Three triggers that suggest that patients are nearing the end of life are:

1. The Surprise Question: ‘Would you be surprised if this patient were to die in the next year’? Validated in renal and oncology popns

2. General indicators of decline - deterioration, increasing need or choice for no further active care.

3. Specific clinical indicators related to certain conditions.

Supportive and Palliative Care Indicators Tool (SPICT)
http://www.spict.org.uk/

Discussion Question

These tools are often not used in general practice - how do you judge when a patient requires palliative care?
The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

**Look for any general indicators of poor or deteriorating health.**
- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (e.g., The person stays in bed or in a chair for more than half the day).
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care, chooses to reduce, stop or not have treatment, or wishes to focus on quality of life.

**Look for clinical indicators of one or multiple life-limiting conditions.**

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Heart/ Vascular disease</th>
<th>Kidney disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional ability deteriorating due to progressive cancer.</td>
<td>Heart failure or extensive, unstable coronary artery disease, with breathlessness or chest pain at rest or on minimal effort.</td>
<td>Stage 4 or 5 chronic kidney disease eGFR &lt; 30/ml/min with deteriorating health.</td>
</tr>
<tr>
<td>Too frail for cancer treatment or treatment is for symptom control.</td>
<td>Severe, inoperable peripheral vascular disease.</td>
<td>Kidney failure complicating other life limiting conditions or treatments.</td>
</tr>
<tr>
<td>Dementia/ frailty</td>
<td>Respiratory disease</td>
<td>Liver disease</td>
</tr>
<tr>
<td>Unable to dress, walk or eat without help.</td>
<td>Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.</td>
<td>Cirrhosis with one or more complications in the past year:</td>
</tr>
<tr>
<td>Eating and drinking less; difficulty with swallowing.</td>
<td>Persistent hypoxia needing long term oxygen therapy.</td>
<td>• diuretic resistant ascites</td>
</tr>
<tr>
<td>Unintended weight loss.</td>
<td>Miss needed ventilation or respiratory failure is contraindicated.</td>
<td>• hepatic encephalopathy</td>
</tr>
<tr>
<td>Not able to communicate by speaking, write social interaction.</td>
<td></td>
<td>• hepatorenal syndrome</td>
</tr>
<tr>
<td>Frequent falls; fatigued.</td>
<td></td>
<td>• bacterial peritonitis</td>
</tr>
<tr>
<td>Recurrent febrile episodes or infectious; aspiration pneumonia.</td>
<td></td>
<td>• recurrent varicose bleed</td>
</tr>
<tr>
<td>Neurological disease</td>
<td></td>
<td>Liver transplant is not possible.</td>
</tr>
<tr>
<td>Progressive deterioration in physical and/or cognitive function despite optimal therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent aspiration pneumonia; breathless or respiratory failure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent paralysis after stroke with significant loss of function and ongoing disability.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other conditions**
Deteriorating and at risk of dying with other conditions or complications that are not reversible, any treatment available will have a poor outcome.

**Review current care and care planning.**
- Review current treatment and medication to ensure the person receives optimal care, minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.
Core Skill:
Communicating about end of life issues
Communication: What do patients want from health professionals?

• Clear and honest communication
  • What is happening?
  • What might happen?
  • How they want to be looked after
  • How they want to spend their remaining time
  • Proposed framework to aid end of life communication – Prof J Clayton
  • MJA 18/6/2007 Volume 186 Number 12

Palliative Care – Dying with Dignity: By Robin Love M.D.
https://youtu.be/c_X0klotR3s
Core Skill:
Assessing and Managing Common Symptoms
Principles for Symptom Assessment and Management

• Consider validated tools, including history, treatments already tried?
• Recognise multifactorial nature and cluster presentations
• Assess and treat holistically and pre-emptively
• Consider reversible or irreversible cause
• Consider potential benefits and burdens of treatment, including the patient’s place in the course of their illness and their overall goals of care and their wishes.
• Provide individualised and patient-centred management
• Reassess
• Consider referral to specialist palliative care if complex or cannot be controlled
Pain

Defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in such terms.

Pain is always subjective

(Dr Will Syrmis St Vincent’s Private Hospital Brisbane Presentation from PEPA GP Workshop, Roma, QLD)
What are the different types of pain?

<table>
<thead>
<tr>
<th>Temporal</th>
<th>Pathophysiological</th>
<th>Aetiological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>Nociceptive</td>
<td>Due to cancer</td>
</tr>
<tr>
<td>Chronic</td>
<td>-somatic</td>
<td>Due to cancer treatment</td>
</tr>
<tr>
<td>Incidental</td>
<td>-visceral</td>
<td>Due to general debility</td>
</tr>
<tr>
<td>Neuropathic</td>
<td></td>
<td>Unrelated to cancer/treatment</td>
</tr>
<tr>
<td>- central</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- peripheral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- sympathetic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychogenic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

http://flipper.diff.org/app/items/info/7372
Cancer Pain

• Affects 30-40% of patients at time of diagnosis or during disease-modifying treatment

• Affects 70-90% of those with advanced disease

• Most patients have more than one pain

• In advanced cancer – 80% have more than one pain; One third will have 4 or more

• In cancer:
  • > 80% will achieve good pain control
  • 15% will have fair control
  • < 5% will have poor or no control
Non-Malignant Pain

- End stage cardiac failure (angina)

- End stage vascular disease (neuropathic)

- Motor Neurone disease (cramps, spasticity, immobility)

- End stage renal failure (generalised pain)
Barriers to Pain Management

Medical / Nursing / Patient attitudes to pain management...

- poor knowledge of management strategies
- inappropriate attitudes (cancer pain is inevitable)
- poor clinical assessment skills
- inappropriate beliefs of addiction / tolerance
- a lack of appreciation of the non physical manifestations of pain.

(McCafferty & Ferrell, 1997)

- pain is only severe in cancer
A useful mnemonic for the history is:

O – Origin/location/onset - Where is your pain? When did your pain start?

P – provocative/palliative - What makes it better/worse?

Q - Quality – what is the pain like?

R – Radiation - does it radiate anywhere else?

S – Severity – How would you rate the pain? – Scale of 0-10

T - Timing – how does pain severity vary over time?

U - Understanding – what is the meaning of this pain to you?

Examination looking for tender areas, masses, areas of abnormal sensation etc.
Pain Assessment

Functional

• Are you able to sleep at night?

• Does the pain stop you doing what you like?

• Are you concerned about your pain treatment?

• Do you worry about taking pain killers?

(Kingorn & Gamlin, 2001)
Pain assessment: Tools for special populations

Abbey Pain Scale

• For patients with dementia or who cannot verbalise
• Considers six areas:
  • Vocalisation
  • Facial expressions
  • Change in body language
  • Behavioural change
  • Physiological changes
  • Physical changes

WHO principles of analgesic use:

By the mouth: oral route preferred

By the clock: analgesics should be given regularly/prophylactically for persistent pain

By the ladder: use 3 step analgesic ladder (if after optimising the dose a drug fails to give adequate relief, move up the ladder, not sideways in the same efficacy group)
Low dose strong opioid +/- non-opioid +/- adjuvant

Strong Opioid +/- non-opioid +/- adjuvant

Anticancer treatment where possible and appropriate -radiotherapy, systemic treatment, surgery

Local therapy for regional pains, (e.g. nerve block, physical support, surgery, intrathecal delivery)

Other modalities of therapy, (e.g. physiotherapy, psychotherapy)

Treatment of other aspects of suffering that may cause or aggravate pain -physical, social, cultural, spiritual, psychological
Advanced WHO-ladder

VI  Neurolytic Techniques
    Neuroablative T.
    Neurostimulation

V   Spinal
    Analgesia

IV  Parenteral
    Analgesia

III Strong opioids/oral/transdermal
    + Step I

II  Weak opioids/oral
    + Step I

I   Nonopioids/oral
    + adjuvants
Pain

Principles of Pain Management in Palliative Care

Use regular analgesia
  • Doses individually titrated
  • Try to “prevent” pain

Set realistic goals
  • Pain free, full nights sleep
  • Pain free at rest during day
  • Pain free on movement (may be difficult)

Reassess repeatedly and regularly
  • Use of pain scales (numerical/visual)

Empathy, understanding, diversion, attention to mood are all essential adjuncts to drugs.
Non-Pharmacological Treatment

- Warm baths, heat packs
- Music, distraction
- Massage, relaxation
- Diligent bowel care
- Soft mattress, pressure area management
- Spiritual, pastoral care
- Physiotherapy, occupational therapy
Initiating Opioids

- Reassure patient about safety/efficacy of opioids in cancer pain
- Prescribe a laxative and antiemetic
- In opioid naive patients:
  - Morphine elixir 2.5-5mg po 2nd hrly prn +/- Kapanol 10mg nocte or MS Contin 5mg BD
  - Review regularly during titration phase
  - Calculate breakthrough dose as 1/6 or 1/10 total daily dose of morphine and give as prn

Caution: morphine in renal failure or severe liver impairment as accumulation of M6G metabolite can cause confusion, drowsiness, myoclonic jerks, hyperalgesia
Initiating Opioids

Morphine
- MS contin (+ sachets)
- Kapanol daily or bd (PEG not NG)
- PRN – morphine liquid (eg Ordine, 1mg/mL, 2mg/mL, 5mg/mL, 10mg/mL), morphine tablets (eg Sevredol),

- **Oxycodone (x 1.5 morphine)**
  - Oxycontin bd
  - Targin – (up to 160/80 mg daily)
  - PRN – oxycodone tablets, oxycodone capsules, oxycodone liquid

- **Hydromorphone (x 5 morphine)**
  - Jurnista once daily (low bioavailability)
  - Dilaudid
Initiating Opioids

Fentanyl (25mcg/hr = 60mg morphine)
- Durogesic Patch
- Actiq Lozenge
- Abstral (need to be on 60mg OME)

Buprenorphine patch (5mcg/hr = 10mg morphine)
Tapentadol (mu agonist and NADr reuptake inhib) (x 1/3 morphine)
Tramadol (x 1/5 morphine)
Opioid Prescribing

• Care with conversions either drug to drug or route
• Conversion to s/c reduce dose by at least 50%

• Renal impairment
• Avoid morphine *
• Fentanyl, methadone, buprenorphine safe
• Hydromorphone* Oxycodone* use cautiously
• * = removed by dialysis
Hepatic Impairment

- Cyt p450 enzymes metabolism impacted before glucoronidation
- Morphine, Hydromorphone use cautiously, low dose longer dosing interval
- Fentanyl drug of choice
- Oxycodone avoid cyt p450 metabolism
- Targin ineffective
Pain Adjuncts

- **Corticosteroids**: dexamethasone
- **Anti-depressants**: tricyclic antidepressants (NNT=2.8)
- **Anti-epileptics**: gabapentin (NNT3.7 to 4.3, NNH 3.7), pregabalin (NNT=3.3-5.6)
- **NMDA receptor blockers**: methadone, ketamine
- **Spinal analgesia** (morphine/fentanyl +/- bupivicaine+/ - clonidine)
- **Antispasmodics**: Clonazepam, baclofen, buscopan
- **(NSAIDs)** ketorolac, ibuprofen etc
- **Bisphosphonates**
Opioid switching between administration routes or drugs is a common practice in palliative care
Opioid Conversion

Common reasons for switching between different opioids, (or between routes of administration)

• inadequate analgesia
  • individual variability in response to opioid, hyperalgesia, maximum dose of the opioid is reached, (e.g. tramadol, Buprenorphine patches

• toxicity or intolerable side effects
  • cognitive dysfunction, drowsiness, myoclonus

• changing clinical status
  • dysphagia, malabsorption, bowel obstruction, development of renal / hepatic failure, concern regarding potential drug abuse

• drug interactions

• financial or drug availability issues
Opioid Conversion

Equianalgesia

A number of equianalgesic tables exist to aid conversions but these can vary widely in their recommendations.

Equianalgesic doses are difficult to determine due to variation amongst individuals in kinetics and pharmacodynamics and conversion tables are generally recommended as an initial guide only.

Steps for opioid conversion

1. Determine the total previous opioid dose over the past 24 hours. Remember to consider doses of prn analgesia.

2. Convert the total previous opioid dose to oral morphine equivalent in mg/24hrs.

3. Then convert daily oral morphine equivalent dose to the opioid of choice.

4. Consider further modifications of that dose based on incomplete cross tolerance or other factors as listed above.

5. Monitor patients closely until stable.
### Opioid Conversion

#### A) PREVIOUS DOSE X CONVERSION FACTOR = ORAL MORPHINE DOSE (mg/24hrs)

<table>
<thead>
<tr>
<th>Previous Opioid Dose / 24 hrs</th>
<th>Route</th>
<th>Conversion factor (Dose = oral morphine mg/24 hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine po</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Morphine S/C</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Hydromorphone po</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Hydromorphone S/C</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Oxycodone SR mg</td>
<td></td>
<td>1.5</td>
</tr>
<tr>
<td>Oxycodone mg</td>
<td></td>
<td>1.5</td>
</tr>
<tr>
<td>Tramadol SR mg</td>
<td></td>
<td>0.1</td>
</tr>
<tr>
<td>Tramadol mg po</td>
<td></td>
<td>0.25 – 0.2</td>
</tr>
<tr>
<td>Tramadol mg S/C</td>
<td></td>
<td>0.4 – 0.5 (?)</td>
</tr>
<tr>
<td>Fentanyl patch mcg/hr</td>
<td>topical</td>
<td>3.6</td>
</tr>
<tr>
<td>Fentanyl mcg S/C</td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td>Fentanyl mcg sublingual</td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td>Sufentanil mcg S/C</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Codeine mg po</td>
<td></td>
<td>0.08</td>
</tr>
<tr>
<td>Methadone mg po</td>
<td></td>
<td>complex</td>
</tr>
</tbody>
</table>
## Opioid Conversion

### B) ORAL MORPHINE DOSE X CONVERSION FACTOR – OPIOID OF CHOICE DOSE (units/24hrs)

<table>
<thead>
<tr>
<th>Conversion Factor</th>
<th>Opioid of Choice (Dose / 24 hrs)</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Morphine mg</td>
<td>po</td>
</tr>
<tr>
<td>0.33</td>
<td></td>
<td>S/C</td>
</tr>
<tr>
<td>0.2</td>
<td>Hydromorphone mg</td>
<td>po</td>
</tr>
<tr>
<td>0.067</td>
<td></td>
<td>S/C</td>
</tr>
<tr>
<td>0.66</td>
<td>Oxycodone SR mg</td>
<td>po</td>
</tr>
<tr>
<td>0.66</td>
<td>Oxycodone mg</td>
<td>po</td>
</tr>
<tr>
<td>10</td>
<td>Tramadol SR mg</td>
<td>po</td>
</tr>
<tr>
<td>4-5</td>
<td>Tramadol mg</td>
<td>po</td>
</tr>
<tr>
<td>2.0 – 2.5(?)</td>
<td></td>
<td>S/C</td>
</tr>
<tr>
<td>0.28</td>
<td>Fentanyl patch mcg/hr</td>
<td>topical</td>
</tr>
<tr>
<td>5</td>
<td>Fentanyl mcg</td>
<td>S/C</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>sublingual</td>
</tr>
<tr>
<td>0.5</td>
<td>Sufentanil mcg</td>
<td>S/C</td>
</tr>
<tr>
<td>12.5</td>
<td>Codeine mg</td>
<td>po</td>
</tr>
<tr>
<td>complex</td>
<td>Methadone mg</td>
<td>po</td>
</tr>
</tbody>
</table>
Opioid Rotation

• Add the regular opioid and the breakthrough and convert to an Oral Morphine equivalent

• Convert to the desired new opioid

• Reduce by 25% to account for incomplete cross tolerance
Opioid Calculator

- Australian and New Zealand College of Anaesthetists Faculty of Pain Medicine has published an online calculator
- (Also available as a smartphone APP)

### Opioid Calculator

**ANZCA**

**Details** | **Reviews** | **Related**
--- | --- | ---

**iPhone**

#### Opioids

<table>
<thead>
<tr>
<th>Route</th>
<th>Base</th>
<th>Additional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ORAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>—</td>
<td>+</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>—</td>
<td>+</td>
</tr>
<tr>
<td>mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td>—</td>
<td>+</td>
</tr>
<tr>
<td><strong>SUBLINGUAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mcg/hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>—</td>
<td>+</td>
</tr>
<tr>
<td>Morphine 33</td>
<td>—</td>
<td>+</td>
</tr>
<tr>
<td><strong>TRANSDERMAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mcg/hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>—</td>
<td>+</td>
</tr>
<tr>
<td><strong>PARENTERAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>—</td>
<td>+</td>
</tr>
<tr>
<td>Codeine</td>
<td>—</td>
<td>+</td>
</tr>
</tbody>
</table>

#### Opioid Target

<table>
<thead>
<tr>
<th>Route</th>
<th>Base</th>
<th>Additional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ORAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Morphine oral ~ 107 mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SUBLINGUAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodeone</td>
<td>71 mg/day</td>
<td></td>
</tr>
<tr>
<td>Oxymerone</td>
<td>36 mg/day</td>
<td></td>
</tr>
<tr>
<td>Tapentadol</td>
<td>258 mg/day</td>
<td></td>
</tr>
<tr>
<td><strong>TRANSDERMAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>2075 mcg/day</td>
<td></td>
</tr>
<tr>
<td><strong>PARENTERAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>54 mcg/hr</td>
<td></td>
</tr>
</tbody>
</table>
Case One

• Mr Smith
• 77 years old
• Metastatic lung cancer
• Liver and Bone/Spine
• Pain from bony metastasis
• Using a lot of breakthrough endone
• Background of Modified Release Oxycodone/naloxone 40/20 bd
• Has had 5 mg immediate release oxycodone by eight doses today
• Family asking for something to be done about the pain.
• Consider Adjuvants

• Consider XRT

• Consider a rotation
• 40 bd of oxycodone plus 8 * 5 mg immediate release oxycodone
  • 120 mg oxycodone daily
  • Conversion to morphine is 1:1.5 = 180 mg of morphine
  • This could be converted to 60mg bd of slow release morphine (Using a 25% reduction for incomplete cross tolerance)
Mrs Jones

- End Stage Dementia
- Declining functional State
- Poor oral intake
- Recent Pneumonia treated in hospital
- The GP and the family have completed an advance care plan that states she is “Not for invasive measures”
This is not enough to prevent your patient being sent to hospital

• Very Explicit instructions are needed for the nursing staff and the families

• For example
  • When your mother gets unwell do you want us to send her to the hospital or do you want us to keep her here and make her comfortable?
  • If she gets breathless in the middle of the night is it ok for us to give her morphine to make her comfortable and not call the ambulance?
  • This necessitates Anticipatory Prescribing
Anticipatory Prescribing

• Pain
  • Morphine 2.5mg subcut Q1 hour for pain and breathlessness

• Breathlessness
  • Morphine 2.5mg subcut Q1 hour for pain and breathlessness

• Nausea
  • Haloperidol .5-1 mg Subcutaneously Q2hr as required for Nausea

• Agitation
  • Midazolam 2.5 mg subcut Q1 hr as needed
Terminal Phase

*Recognising dying is the first step in terminal care management*
- Allows patient, family and healthcare team to prepare
- Communication is key – clear, concise and honest; patient centred focusing on wishes, needs and values; family centred; shared decision making
- Need goals of care with documentation if necessary eg ARP
- Rationalise medications
- Anticipatory prescribing (usually 4 drugs)
- Cease burdensome interventions
- Comfort
- Communication!!
- Development of an individualised plan of care – need to leave contact numbers and written plan
# Continuous Subcutaneous Infusion Devices

## Indications

- Unable to take oral medications
  - Nausea and vomiting
  - Dysphagia
  - Malabsorption
  - Decreased level of consciousness

Also useful for stabilisation of acute symptoms and to establish baseline medication needs

## Advantages

- Less invasive than other parenteral routes
- Decreased risk of infection
- Increased comfort
- Portable, lightweight
- Easily used at home
- Daily refilling
- Can administer a combination of drugs

Resource / Guidelines / Drug compatibility @
Case--- Harold

90 year old gentleman who had a bad fall, transferred to hospital from the facility and was cared for by the emergency team. Returned to the Facility

Past medical history: Dementia; AF; renal failure; depression; HT

Presenting Problem: Discharged from hospital following admission after a fall with no injectable forms of pain relief or other palliative care medications. He is no longer able to swallow oral medication. It is clearly documented from hospital (and family aware) that the goal of care is to keep Harold comfortable now. The family understands that he is close to the end of his life. He has also requested that his body be donated for medical research.

Injuries sustained:

Subdural haematoma – left frontal lobe

Left sided rib #’s; minimally displaced fractures : Left anterolateral 5/7/8/9th ribs and Left lateral 3/4/5th ribs; minimally displaced # of L distal clavicle
Current Medications
Immediate Release oxycodone 5mg PO prn q6th hourly
Mirtazapine 30 mg PO nocte
Digoxin 62.5mg PO x 2 mane
Asprin 100mg PO mane
Risperidone 0.5mg PO BD
Irbesartan 150mg PO mane

On Examination
Acute confusional state; febrile; ashen appearance
Bedbound; significant bruising to left side
Laboured breathing and hyperventilation
Bilateral pleural effusions – not sure if they develop from the trauma or if present prior to fall
Questions

1. How do you identify the most appropriate family member / carer to talk to in this situation?

2. How do you manage this difficult conversation to answer their questions and relieve their distress?

3. What do you consider when choosing medications for Harold?

4. What are the issues that you think will arise when Harold dies?
   • Does the coroner need to be involved?
   • How do you manage these situations?
Prescribing

1. Commence a continuous subcutaneous infusion with 2mg hydromorphone (for pain and breathlessness) and 1mg of haloperidol (for delirium) over 24 hours
2. Cease all oral medication
3. Write up breakthrough medications: Haloperidol; Midazolam (for restlessness); Hydromorphone, Busopan

Management Plan Considerations

1. Ensure the nursing team have the skillset
2. Referral to Specialist Palliative Care Team (if indicated)
3. Instructions for insertion of an indwelling catheter if needed
4. Others??
Case - Margaret

86 year old woman living in a residential aged care facility

Presenting problem: You have been called to review Margaret because she is now bedbound and has reduced oral intake for the past few months. She has a five day history of increased confusion and hitting out at staff. She is non-verbal and has rubbed all of her hair off the left front area of her scalp.

Past medical history: End stage vascular dementia: Alcohol use and liver cirrhosis; GORD

Current medications:

- Buprenorphine 15mcg transdermal
- Risperidone 0.5mg PO BD
- Vitamin D capsule 1000iu mane
- Thiamin 100mg PO mane
- Pantoprazole 40mg PO mane
- Paracetamol 500mg x2 QID
- Coloxyl & Senna PO x2 DB
- Two-cal supplement
On Examination
Laboured breathing
Febrile
Productive cough
Distended abdomen with visible vascularity
Hyperperistaltic bowel sounds
Bowels not opened well for eight days
Caput medusa

Family
Margaret’s daughter says that she is being “starved to death” and in the same sentence “why can’t we help her die?” as she has been suffering with end stage dementia for the last two years. She is crying and angry and wonders if we should feed her artificially. This daughter is not the EPOA.
Questions

1. How do you assess Margaret’s symptoms when she is non-verbal?
2. How do you decide whether or not Margaret is dying?
3. What influences your decision making about the goals of care?
4. What do you need to consider when choosing medications?
5. How do you respond to the difficult questions from the daughter?
Medications Prescribed

1. Cease oral meds
2. Continue buprenorphine patch
3. Commence continuous subcutaneous infusion to supplement with Morphine 10mg/24 hours (or Hydromorphone 2mg if available), haloperidol 2mg, midazolam 5mg
4. Prescribe prn breakthrough medication for pain, agitation, nausea and vomiting

Other Management Plan Considerations ??
Local Service Networks

• What resources do we have in our local networks to support palliative care delivery?
Local palliative care teams

- RBWH – in pt consults, OPD phone 3646 6138
- TPCH – PCU, OPD phone 3139 4601
- Redcliffe – PCU, OPD, support Caboolture phone 3883 7638
- St Vincents – PCU, OPD, community team, support to Holy Spirit Northside – option for private pts 3240 1111
- Karuna home palliative care – community team, NPs 3632 8300
- Metro North community team – new service 3049 1210
- RADAR is here to help
  - You can access direct advice from a palliative care specialist (or a Geriatrician)
• National Consensus Statement: Essential elements for safe and high-quality end-of life care  

• Principles for Palliative and End-of-Life Care in Residential Aged Care  

• Dying to Talk Discussion Starter  

• ATSI Discussion Starter  
Welcome to GP Pain Help

The GP Pain Help app and website aims to help GPs manage cancer pain in their patients. The content has been developed by the Centre for Palliative Care Research and Education (CPCRE) and the app and website by the Australian College of Rural and Remote Medicine (ACRRM).

Acknowledgement

CPCRE acknowledges the assistance of Professor Janet Hardy and Dr Phillip Good in development of this pain aid for GPs, as well as the many
End of Life Law in Australia provides accurate, practical and relevant information to assist you in navigating the challenging legal issues that can arise with end of life decision-making.

This website is an initiative of the Australian Centre for Health Law Research. It is designed to be used by patients, families, health and legal practitioners, the media, policymakers and the broader community to access information about Australian laws relating to death, dying and decision-making at the end of life. These laws are very complex, particularly in Australia where the law differs between States and Territories, and where areas of uncertainty about the law exist. This website provides you with a broad introduction to these laws. It can also help you stay up to date with Recent Developments in the end of life area.

How to use this website
You can select a topic to explore a legal issue, and where the law differs between States and Territories, you can select the webpage which explains the law in a particular jurisdiction. On this website there is also:

- A Legal Overview which outlines fundamental concepts relating to the law at end of life in Australia.

Find out more about the law at end of life
For more information about the law at the end of life, select a topic below.

- About
- Recent Developments
- Legal Overview

https://end-of-life.qut.edu.au/