PALCARE
There's no place like home

THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

SEVERE UNCONTROLLED DISTRESS/ SYMPTOMS

INTRODUCTION

Good symptom control remains the central goal of palliative care in patients with incurable illness. In some patients as they approach the end of life, physical, psycho-social and existential/spiritual problems may not be adequately controlled despite adequate titration of medications in combination with non-pharmacological measures. In such situations sedation may need to be considered as a therapeutic intervention to relieve distress and suffering.

Therapeutic palliative sedation is defined as monitored continued or intermittent administration of medications intended to induce a state of decreased or absent awareness (unconsciousness) to relieve the burden of otherwise intractable suffering refractory to other therapies or interventions.

The common situations requiring therapeutic palliative sedation are:

- Refractory physical symptoms
  - Pain
  - Breathlessness
  - Vomiting
  - Bleeding
  - Fatigue
- Psychological
  - Depression
  - Anxiety
  - Delirium
- Existential distress
  - Feeling of hopelessness/helplessness/worthlessness/meaninglessness/dependency and isolation
  - Fear or panic of impending death
  - Spiritual issues

ASSESSMENT

- Assess the physical symptoms psycho-social and existential/spiritual issues and the adequacy of the therapeutic interventions to manage the same
- Assess the mental capacity of the patient to make his/her own decisions
- Assess for alcohol, benzodiazepine and nicotine withdrawal

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RECOMMENDATION

- Therapeutic palliative sedation should be considered at the end of life, only after all other available treatment options have been exhausted
- Therapeutic palliative sedation should be used with the intent of relieving distress and suffering
- Continue to administer medications such as opioids, psychotropic, anti-secretory and anti-emetics for adequate control of symptoms
- At least one other palliative care physician should be consulted by the treating physician to agree before considering therapeutic palliative sedation
- Patient, family and health care providers should agree before initiating therapeutic palliative sedation
- Minimum quantity of medications should be used to achieve adequate relief of suffering
- Midazolam is the most commonly used medication for therapeutic palliative sedation
- Use Richmond Agitation-Sedation Scale (RASS) as a guide for increasing or decreasing sedation - https://www.mdcalc.com/richmond-agitation-sedation-scale-rass

MANAGEMENT

- **Correct the correctable**
  - Treat the underlying cause
  - If urinary retention, consider catheterization
  - If any biochemical imbalance, consider correction
  - If nicotine withdrawal, use TD nicotine patches
  - If alcohol or benzodiazepine withdrawal, then consider benzodiazepine

- **Non-pharmacological measures**
  - Use a multi-disciplinary approach
  - Assess and record the wishes of patient and family
  - Adequate communication between the doctor, patient, and family on physical, psychological, social and existential/ spiritual issues and the pros and cons of therapeutic palliative sedation should be done in advance, if palliative sedation is considered a possible intervention necessary in the future
  - Clearly document in detail the communication with patient/family

- **Pharmacological measures**

Start with Midazolam

- **Intermittent sedation**
  - Inj. Midazolam 2.5-5mg (max 10mg) S/C stat and q1h prn
- **Continuous sedation**
  - Inj. Midazolam 10-60mg/24 hours CSCI
  - Reported upper dose for agitation is 60mg/24 hours

If Midazolam alone is not effective at doses above 60mg/24 hours (terminal agitation), then add

- Haloperidol 5mg S/C stat, and 10-30mg/24 hours CSCI

If above is not effective, then consider phenobarbital

- Start with loading dose of 200mg (1mL ampoule) as:
  - undiluted intramuscular injection or
  - diluted intravenous bolus given over 2min (1mL ampoule diluted to 10mL with water for injection)
- If agitation persists, give 1 or 2 further doses of 200mg IM/IV prn 30 minutes apart
- If agitation persists or recurs, give further doses of 200mg IM/IV q1h prn
- Maintain with 800mg/24 hours CSCI; or more if total initial dose necessary to control was ≥600mg
- If necessary, increase the dose progressively to 1,600mg/24 hours, i.e. 800mg→1,200mg→1,600mg
- A typical dose is 800–1,200mg/24 hours but can range 200–1,600mg/24 hours

Alternatively

- Consider Chlorpromazine 25mg q4h escalating to 200mg/24 hours PR or S/L

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