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THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

Renal Disease in the Last Days of Life

INTRODUCTION

The guideline is intended to direct care for patients with CKD Stage 4 or 5 (eGFR<30mL/min) with severe renal impairment or end stage renal disease (ESRD). These patients have a high mortality rate, experience significant symptom burden along with psycho-social and spiritual issues. In an appropriate patient, it is necessary to discuss regarding withdrawal of dialysis.

ASSESSMENT

- Assess for nausea, vomiting, itching and other symptoms associated with renal disease, co-morbidities (diabetes mellitus, ischaemic heart disease, peripheral vascular disease), dialysis and other diseases like cancer, old age frailty
- Assessment must determine the underlying aetiology of symptoms, effectiveness of treatment and impact on quality of life for the patient and family (***refer to the Guideline - Symptom Assessment***)
- It is important to rule out presence of potential reversible causes like hypercalcemia, infection, opioid toxicity
- Assessment must include signs and symptoms that indicate terminal phase
    - Profound weakness and social withdrawal
    - Loss of interest in food and drink
    - Dysphagia and difficulty to swallow medications
    - Drowsiness and/or refractory delirium
    - Altered breathing patterns (especially Cheyne-Stokes breathing)
    - Progressive fall of blood pressure and/or temperature
    - Coma

MANAGEMENT

Recommendations

- Use a multi-disciplinary approach
- Review goals of care and initiate advance care planning with the patient and family at the earliest and review on regular basis
- Avoid unnecessary interventions, investigations and monitoring
- Review symptoms, medications and stop medications that do not add to the comfort of the patient
- NSAIDs, morphine and codeine should generally be avoided in patients with ESRD

- Towards the terminal phase, many of the medications can be given as CSCI

Advance care planning

- Determine the goals of care, place of care and preferences of patient and family regarding end of life care
- If appropriate, discuss with patient and family on withdrawal of dialysis, the limited benefits of dialysis at this stage and the timing of withdrawal
- Continue good communication and allow shared decision making with informed consent
- Determine a surrogate decision maker/nominated healthcare spokesperson

Pharmacological measures

- **Pain**
  - Tab. Acetaminophen - 1000mg q6h, maximum of 4000mg; can be used safely without dose adjustments
  - Tab. Tramadol - 50-100mg bd (maximum); use with caution as seizures with higher doses is a concern
  - Methadone - can be used safely in patients with renal failure for moderate to severe pain; initiate at a low dose 200-700 mg/24 hours in opioid naïve patients or switch after determining equivalent dose in patients on opioids
  - Fentanyl patch - can be continued safely and use appropriate rescue dose of morphine or tramadol for breakthrough pain
  - Buprenorphine patch - can be used safely and initiated for moderate to severe pain; use appropriate rescue dose of morphine or tramadol for breakthrough pain
  - Gabapentin - useful in neuropathic pain. For patients receiving haemodialysis, a loading dose of 300mg can be given, followed by 200-300mg after each dialysis session. For patients who are not receiving dialysis, a dose of 200-700mg can be given OD
- **Anxiety and distress**
  - Tab. Lorazepam 0.5-1mg S/L OD and prn (frequency may be increased based on the severity)
  - Tab. Diazepam 2.5-5 mg hsod (up to 2.5mg tid)
  - Inj. Midazolam 2.5-5mg S/C (or a higher dose as CSCI)
- **Breathlessness**
  - Start with immediate release Morphine 2.5 mg PO prn and if >3 doses/24 hours, start Fentanyl patch 6mcg/hour patch and continue the appropriate rescue dose of the immediate release morphine prn
  - Tab. Lorazepam 0.5-1mg S/L hsod and prn (frequency may be increased based on the severity) - consider in presence of panic or anxiety

- Inj. Midazolam 1-3mg S/C q8h and prn - consider in presence of refractory breathlessness and if still breathlessness is uncontrolled, discuss palliative sedation with patient and/or family and two palliative care physicians agree on this

- **Respiratory tract secretions**
  - Inj. Hyoscine butyl bromide 20mg S/C q6h and prn (Maximum 120mg/24 hours)
  - Inj. Glycopyrronium 200mcg S/C q6h - q8h as required
  - Hyoscine Hydrobromide patch 1.5mg/72 hours (if available) can be used once acute secretions are controlled. The patch can be applied behind the ear
- **Nausea and vomiting**
  - Haloperidol 1.5-5mg/24 hours PO, S/C or IV in two to three divided doses
  - Metoclopramide 10mg PO, S/C or IV q6h - q8h - if prokinetic is useful
- **Delirium**
  - **Restless and confused but cooperative**
    - Haloperidol 1.5-5mg PO S/C q4h - q8h
  - **Delirium with paranoia, confusion and/or aggression**
    - Haloperidol 5-10mg S/C or IV q30 - q60 min until relief then maintenance dose is 50% of amount to achieve control (usually between 1.5-20mg/24 hours divided into one to three doses)
    - Add Midazolam 2.5-5mg S/C stat and q6h prn if agitation persists
- **Pruritus (*refer to the Guideline – Pruritus*)**
- **Restless leg syndrome**
  - **Correct the correctable**
    - Iron deficiency anaemia - iron and erythropoietin therapy
    - Improve sleep quality
  - **Non-pharmacological measures**
    - Massage
    - Warm bath
    - Warm/cool compresses
    - Relaxation techniques
    - Good sleep hygiene
    - Foods containing caffeine, nicotine, and alcohol should be reduced as well, especially in the hours before bedtime
    - Exercise
  - **Pharmacological measures**
    - Ropinirole 0.25-2mg/24 hours
    - Pergolide Initially 0.05mg/24 hours, increased gradually with 0.05mg/24 hours, up to 3mg/24 hours
    - Pramipexole 0.125-0.75mg/24 hours

- ❖ Gabapentin 200-300mg 3/7
- ❖ Levodopa 25 - 200mg/24 hours

- **Skin care** ***(refer to the Guideline - Care of the bedridden patient)***
- **Anticipatory prescribing -** To improve care at end of life, it is useful if medications for symptom control are made available at home so that they can be administered without unnecessary delay, if required ***(refer to the Guideline - Anticipatory Prescribing)***

Non-pharmacological Management ***(refer to the Guidelines - Specific symptoms)***

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