Renal failure - prescribing at the end of life

For patients with eGFR below 50 mL/min/1.73m^2 or with rapidly deteriorating renal function

Assessment

- Nausea and itch are common symptoms

General

- Caution with NSAIDs – be aware of increased bleeding tendency.
- Check most recent creatinine clearance (eGFR). For extremes of weight eGFR may not be accurate – seek specialist advice.
- Leave buprenorphine and fentanyl patches in place and continue to change as usual.

Pain management

- Paracetamol is safe to use. Use a maximum of 3g/day if eGFR <10 mL/min/1.73m^2
- Avoid codeine. Low dose tramadol (IR) is better tolerated, starting at 50 mg b.d. regularly. In case this is insufficient, prescribe an extra 50 mg p.r.n (b.d. maximum, 4 – 6 hourly).
- If eGFR >10 but < 50 mL/min/1.73m^2 use oxycodone instead of morphine (unless patient also has synthetic liver disease - refer to "Liver disease – prescribing at the end of life" guideline)
  - If converting from oral oxycodone to 24 hour SC infusion of oxycodone divide the 24 hour oral oxycodone dose by 2.
    Prescribe p.r.n SC oxycodone at 1/6th of the background daily s/c dose.
  - For patients on morphine see palliative care opioid wheel for advice on dose conversion or seek specialist advice.
  - If not currently taking opioids start with oxycodone 2mg SC repeat after 30 mins p.r.n (LTHT 1 hour). Maximum 4 doses in 24 hours then prescriber review required.
- If eGFR <10 mL/min/1.73m^2 oxycodone may still be used as p.r.n. If a regular opioid is needed a 24 hour SC infusion of alfentanil via syringe driver is suggested. Please seek specialist palliative care advice.
- Monitor patient as decreased dose and increased dosing intervals may be required.

Agitation (Consider reversible causes)

- Beware of increased sensitivity to sedatives. Start with low dose eg midazolam e.g. 1.25mg SC p.r.n. (titrated to 5mg if needed). If required, start haloperidol at 1mg SC p.r.n. Dose interval may need to be increased.

Nausea and vomiting

- Haloperidol, ondansetron and levomepromazine are used for uraemic nausea.
- Use haloperidol first line if trying to avoid sedative side effects. Start with a low dose e.g. 1 mg SC p.r.n. A dose can be repeated after one hour. Maximum 3 doses in 24 hours then seek review.
- Otherwise use low dose levomepromazine 2.5mg to 6.25mg SC p.r.n. Max 12.5 mg in 24 hours then medical review required.
- Avoid cyclizine.

Noisy respiratory secretions

- No drug modifications needed, but avoid hyoscine hydrobromide because of its central effects

Please contact your local Specialist Palliative Care Team for further advice or information

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