Managing Common End of Life Symptoms in Community Patients with COVID-19

This guidance is intended for those patients who have distressing symptoms due to COVID-19 infection and are dying.
This is a "live" document that will be revised in line with the changing clinical situation and updated national guidance.
The specialist palliative care teams will be able to provide additional advice and guidance to healthcare professionals but it will not be possible for them to provide direct care to everybody who needs it, especially as the pandemic progresses
This guidance is based on APM Guidance and clinical experience

Common symptoms are:
1. Delirium/Terminal Agitation
2. Cough
3. Fever
4. Breathlessness

These guidelines assume that correctable causes of the above symptoms have been managed appropriately. Examples include:

- Antibiotic treatment for superadded bacterial infection may improve fever, cough, breathlessness and delirium
- Optimising treatment of comorbidities (e.g. COPD, heart failure) may improve cough and breathlessness.

Pharmacological Management of Symptoms

Delirium/Terminal Agitation

Use parenteral Levomepromazine and Midazolam to ease distress

Give a stat dose of Levomepromazine s/c 25mg (12.5mg in frail/elderly) and Midazolam s/c 5mg (2.5mg in frail/elderly)

Then:
If syringe driver available

- Start a s/c syringe driver with Levomepromazine 50mg/24hours (25mg/24hours in frail/elderly) and Midazolam 10mg/24hours
- Prescribe a s/c syringe driver range on Community MAR chart to allow titration of dose:
  Levomepromazine 50mg – 200mg (25mg-100mg in frail/elderly)over 24 hours
  Midazolam 10mg – 30mg over 24hours.
- If symptoms not settled with Levomepromazine syringe driver 50mg/24hour and Midazolam syringe driver 10mg/24hour contact specialist palliative care team for advice on dose titration.
- Prescribe p.r.n. Levomepromazine s/c 25mg (12.5mg in frail/elderly) and p.r.n. Midazolam s/c 5mg (2.5mg in frail/elderly). Leave at least an hour between doses. Maximum 6 doses in 24 hours.
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Or:
If syringe driver unavailable

- Levomepromazine can be give b.d. by s/c injection 25mg (12.5mg in frail/elderly) and titrated according to response
- Lorazepam 1mg Tablet can be administered by buccal or sublingual route–duration of action approx. 8-10 hrs.
  - Initial dose 0.5mg (half a 1mg tablet).
  - Either place tablet under the tongue and allow to dissolve, or dissolve in a few drops of warm water and draw up in a 1ml oral syringe and put between patients cheek and gum.
  - Dose can be increased to 1mg, 1 hour between doses, maximum of 4 doses in 24 hours.
  - Specify Genus or PVL or TEVA Brand of Lorazepam on prescription as these dissolve more easily
- Prescribe p.r.n. Levomepromazine s/c 25mg (12.5mg in frail/elderly) and p.r.n. Midazolam s/c 5mg (2.5mg in frail/elderly) for healthcare professionals to administer if needed/if available

Cough

A strong opioid is the most effective cough suppressant. Initial dose is the same as for breathlessness:
Morphine Sulphate s/c prn 5mg (2.5mg in frail/elderly) and 10mg/24hours by s/c syringe driver; titrate as necessary

Fever

Paracetamol 1g q.d.s. oral plus non-pharmacological interventions

If persistent distressing fever: consider: Ketorolac 15mg-30mg s/c 6hrly Maximum 90mg/24hours
(This is on the Palliative Care Drugs List held by designated community pharmacies across the city, all pharmacies will be able to order it in.)

Breathlessness

Opioids and Benzodiazepines may reduce the perception of breathlessness. Measures are likely to be different to those usually taken for chronic breathlessness and doses may need rapidly titrating to effect.

- **Give a stat dose of Morphine Sulfate s/c 5mg (2.5mg in frail/elderly) and Midazolam s/c 5mg (2.5mg in frail/elderly)**

Then:
If syringe driver available use subcutaneous opioid and subcutaneous midazolam.

- **If opioid naïve:**
    - Start a s/c syringe driver with Morphine Sulfate 10mg/24hours and Midazolam 10mg/24hours
    - Prescribe p.r.n. Morphine Sulfate s/c 5mg (2.5mg in frail/elderly) and p.r.n. Midazolam s/c 5mg (2.5mg in frail/elderly) Leave at least an hour between doses. Maximum 6 doses in 24 hours.
    - Prescribe a s/c syringe driver range on Community MAR chart to allow titration of dose:
      Morphine Sulfate 10mg - 30mg over 24 hours
      Midazolam 10mg - 30mg over 24 hours

- **If already taking oral morphine or another oral opioid**
    - Convert 24 hr oral opioid dose to the equivalent 24hr s/c dose using Leeds Opioid Conversion Guide for Adult Palliative Care Patients
    - Convert the oral p.r.n. dose to equivalent s/c p.r.n. dose using Leeds Opioid Conversion Guide for Adult Palliative Care Patients. Leave at least an hour between doses. Maximum 6 doses in 24 hours
    - Prescribe Midazolam p.r.n.as above
    - Prescribe a s/c syringe driver range on Community MAR chart to allow titration of dose:
      For opioids as per guidance on EPACCS
      Midazolam as above

- **If already on a fentanyl or buprenorphine patch**
    - Leave the patch on
    - Convert the oral p.r.n. dose to equivalent s/c p.r.n. dose using Leeds Opioid Conversion Guide for Adult Palliative Care Patients
    - Use Midazolam as above
    - Seek specialist palliative care advice regarding opioid dose to prescribe in syringe driver

Or:
If syringe driver unavailable – Seek specialist palliative guidance for opioid patch titration

- **If opioid naïve:**
    - Apply Fentanyl 12mcg/hr matrix patch
    - **Lorazepam Tablets can be administered by buccal or sublingual route**–duration of action 8-10 hrs.
        - Initial dose 0.5mg (half a 1mg tablet).
        - Either place tablet under the tongue and allow to dissolve, or dissolve in a few drops of warm water and draw up in a 1ml oral syringe and put between patients cheek and gum.
        - Dose can be increased to 1mg, 1 hour between doses, maximum of 4 doses in 24 hours.
        - Specify Genus or PVL or TEVA Brand of Lorazepam on prescription as these dissolve easily
    - Prescribe p.r.n. Morphine Sulfate s/c 5mg (2.5mg in frail/elderly) and p.r.n. Midazolam s/c 5mg (2.5mg in frail/elderly). Leave at least an hour between doses. Maximum 6 doses in 24 hours.

- **If already taking oral morphine or another oral opioid**
    - Convert 24 hour oral opioid dose to the equivalent fentanyl patch dose using Leeds Opioid Conversion Guide for Adult Palliative Care Patients. Apply patch at the same time as taking last dose of MR oral opioid or as soon as possible after this time.
    - Convert the oral p.r.n. dose to equivalent s/c p.r.n. dose using Leeds Opioid Conversion Guide for Adult Palliative Care Patients. Leave at least an hour between doses. Maximum 6 doses in 24 hours
    - Use sublingual or buccal lorazepam as above
    - Prescribe Midazolam s/c p.r.n. as above

- **If already on a fentanyl or buprenorphine patch**
    - Leave the patch on
    - Convert the oral p.r.n. dose to equivalent s/c p.r.n. dose using Leeds Opioid Conversion Guide for Adult Palliative Care Patients. Leave at least an hour between doses. Maximum 6 doses in 24 hours
    - Use sublingual or buccal lorazepam as above
    - Prescribe Midazolam s/c p.r.n. as above