

PALLIATIVE CARE/HOSPICE MEDICATIONS AND DEPRESCRIBING

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RESOURCES

The information I am presenting today came from CAPC.org (Center to Advance Palliative Care), UpToDate, 2023 and several books from the American Academy of Hospice and Palliative Medicine, including their Essential Practices books and The Primer of Palliative Care.

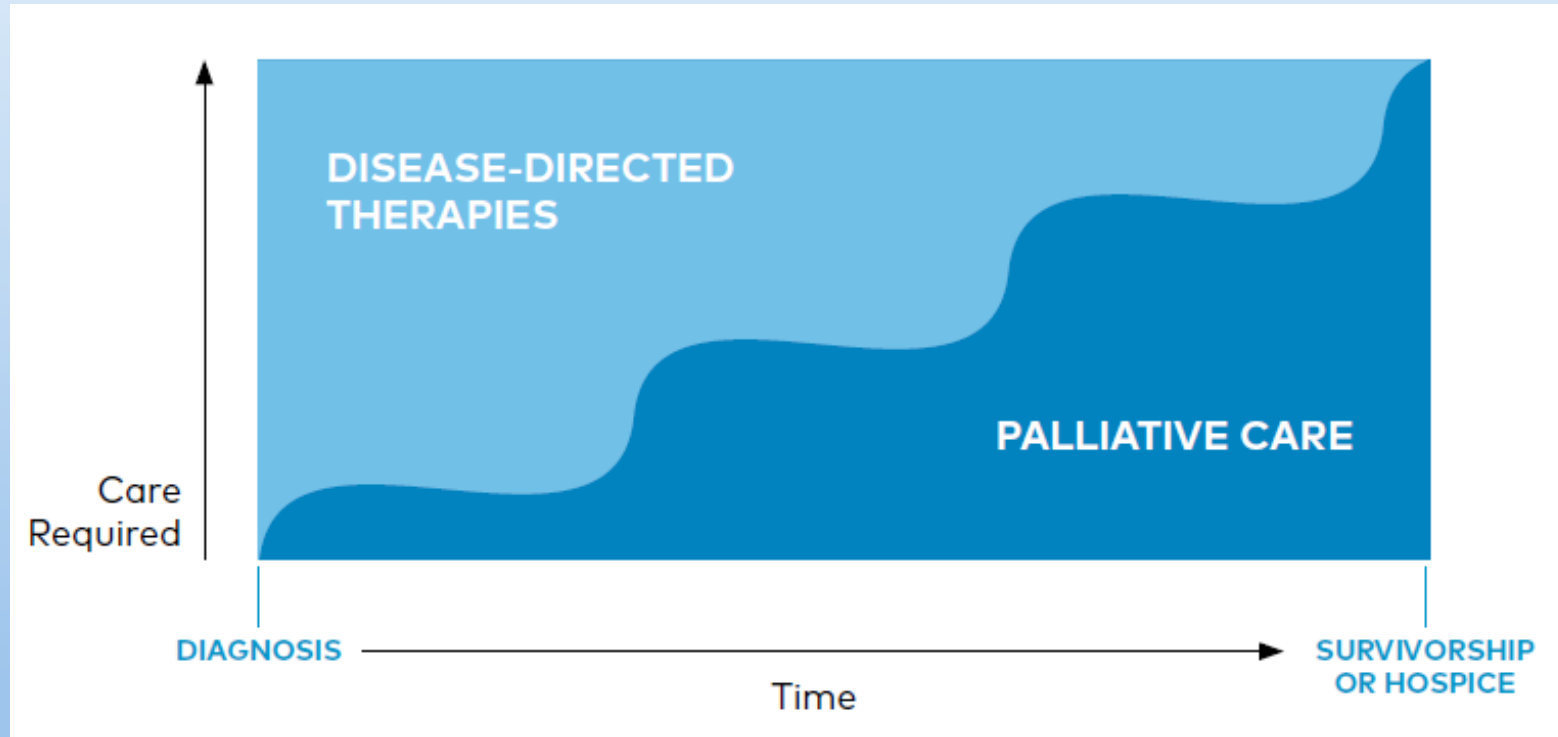
WHAT IS PALLIATIVE CARE?

- Palliative care is specialized medical care for people with **serious illness**.
- It focuses on providing patients with **relief** from the symptoms, pain, and stress of a serious illness
- The goal is to **improve quality of life** for both the patient and the family.
- It is appropriate at any age and at any stage in a serious illness and **is provided along with regular disease treatment**.

WHY DO ORGANIZATIONS NEED PALLIATIVE CARE?

1. A small subset of patients hold the largest concentration of risk for poor quality and spending
2. Strong evidence that palliative care improves quality, satisfaction, and cost appropriateness
3. There are very few strategies that simultaneously improve quality and reduce spending

PALLIATIVE CARE IS DELIVERED CONCURRENT WITH DISEASE TREATMENT



Core competencies in palliative care — — — ➔

Specialty palliative care — — — ➔

INTRODUCING PALLIATIVE CARE

Come up with your own scripting.

“What have you heard about palliative care?”

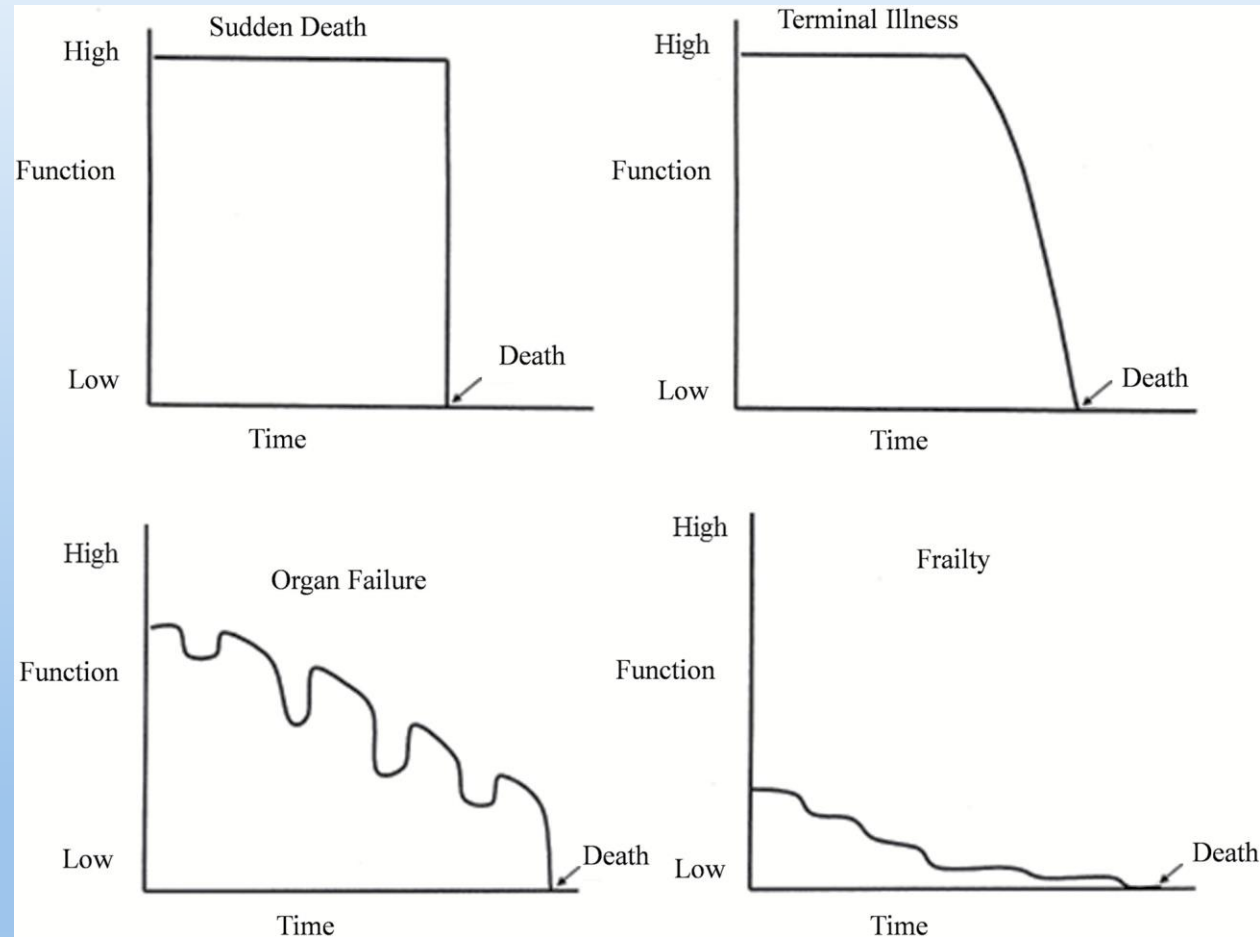
“I want to better understand what matters most to you so you can make some important health decisions?”

“In thinking about your future, what are you most afraid of in regards to your health?”

Palliative care can provide another access point to your providers.

Hope for the best and prepare for the worst.

FIGURE 1. THEORETICAL TRAJECTORIES OF DYING.
REPRODUCED WITH PERMISSION FROM LUNNEY ET AL. (2002).



PROGNOSIS

Most people want to know, “How long, Doc?” (They crave and dread this info, although some may not want to know)

Overly optimistic predictions can lead to overuse of ineffective or unwanted disease directed treatments, delay in hospice referrals and unrealistic expectations, unnecessary tests and procedures, poor symptoms control

Overly pessimistic predictions can lead to underuse of treatments that can really help

Would you be surprised if this patient died in the next 12 months?

- Clinical judgement/experience
- Some data anchor points
 - PPS, Karnofsky score, ECOG (functional based scales)
 - Responses to treatments
- Be aware of your own emotions/biases

Caveat:

“It is impossible to predict for any individual with certainty, but..”

Ballpark:

“On average, a person with your illness will live (hours to days, days to weeks, weeks to months, several months) and..”

“Disease-directed treatment, if it works, might extend that time by (a month or two)..”

Exceptions:

“It may be longer, and we will do our best to try to make that happen for you, but it also could be shorter, so we might want to do some preparation in case things don’t go as we hope. In any event, we will do everything in our power to give you the best care possible no matter what happens.”

“I also hope that you’ll be here for (your son’s graduation, granddaughter’s wedding, anniversary) but I worry that your time may be shorter than that, even with our best efforts.”

81 YEAR OLD MALE W/ CHF, CKD, COPD

Before OPC

Between 2015-16 he had 5 ER visits/hospital stays for CHF, COPD exacerbations averaging 6 days per admission

OPC referral made

After OPC

One night hospital stay 2020 for TIA

One ER visit 2022 for pneumonia

21 OPC home visits since admitted to OPC, continued to see PCP 10 times in this period.

Pt was DNR, but refused hospice for personal reasons

Frequency of OPC contact increased, patient recently passed away in the home

CHF

Still have about 50% mortality in 5 years after diagnosis of heart failure

Symptoms experienced in last year of life include severe dyspnea (61%), pain (78%), low mood (59%), anxiety (30%). Many also report confusion, insomnia, anorexia, n/v

Frequent hospitalizations/re-hospitalizations, up to 40% readmission rate for those with hospice eligibility but not on hospice or palliative care (reduced to 5% if on hospice/palliative care)

Functional decline in HF leads to poor QOL, often functional decline occurs earlier than those patients dying of cancer

Often have multiple co-morbidities contributing to decrease function

COPD

3rd leading cause of death, significant number of hospitalizations

Pt with COPD spend increasing amounts of time in hospital as disease progresses

Progressive functional decline, poor quality of life, increased dependence, incapacitating breathlessness

Often get technological interventions without their preferences being known and die in ICU due to highly variable disease trajectory. Exacerbations can come on suddenly.

Prognosis difficult to predict: combination of lung function (GOLD class) exacerbation frequency, dyspnea

Cor pulmonale, hypercapnia, low FEV1 are associated with increased 6 month mortality

DEMENTIA

- Patients diagnosed with dementia (Vascular, Alzheimer's) have a shortened life expectancy. Any downturn can become terminal event
 - Those with advanced dementia hospitalized with pneumonia or hip fracture have a 6 month mortality rate of 50%
 - Common illnesses like pneumonia, UTI, febrile illness can become terminal or leave patient with a new lower level of functioning upon recovery
- Need good advanced care planning
 - Caregiver needs, up to 24 hour care at some point
 - Decisions regarding G tube
 - Code status

CANCER — 69 YEAR OLD FEMALE WITH STAGE 4 PANCREATIC CANCER.

Diagnosed early 2021

Started palliative chemo. Multiple adverse effects including n/v, recurrent c diff, chronic diarrhea, significant pain leading to several hospital stays

Early 2022 met with oncology, still wanted to try palliative chemo, pt was not ready for hospice. Referred to OPC at this time.

Has had several admissions this year for side effects. OPC has been involved, seeing her regularly to manage symptoms. Developed relationship which helped with her transition to hospice Nov 2022. Her OPC NP continues to follow her in hospice because of this relationship.

Recent GIP admission for pain control with IV medications. Currently well-palliated.

CHRONIC RENAL FAILURE

Large symptom burden of pt with ESRD leading to poor QOL

- Fatigue
- Pain (up to 50%) neuropathy, renal disease, osteodystrophy, vascular disease, calciphylaxis
- Dyspnea
- Anorexia
- Pruritus
- Mood disturbance
- Sleep disturbance
- Delirium/agitation
- Restless legs
- N/V

Pt who never start dialysis can live for months to years (6-24 months) w/conservative management

Not starting dialysis does not equal stopping dialysis

May not be outcome advantage in early vs late initiation of dialysis so delaying initiation is an acceptable option.

5 year survival on dialysis approx. 40-50% (hemodialysis vs peritoneal) but if >75 year old, drops to 17%

Dialysis pt who requires cpr, only 8% survive to hospital discharge and only 3% alive in 6 months. This is important because up to 87% of patients on dialysis want full code.

92 YEAR OLD WITH STAGE 5 CKD, CAD, CHF S/P TAVR, ANXIETY

GFR 13 (between 13-16 for last 5 years)

Does not want dialysis after discussing risks/benefits

Goes to PCP once a year for last several. Nephrology referred to OPC.

Symptoms of anxiety, fatigue now being managed

Goal of transitioning to hospice when time is appropriate

TIME TO RE-EVALUATE

Palliative Care provides that “pause” in a patient’s disease trajectory

- A re-focus back to the patient (person) rather than the disease and what must be done next
- Provide education/answer questions about disease
- Discuss what things may look like going forward
- Help identify goals

Often patients will see many providers for same condition and it can be hard to find time for these discussions in a busy clinic setting.

WE ALL DO PALLIATIVE CARE, SO WHEN SHOULD YOU CALL US?

Homebound or has difficulty getting to appointments

Chronic conditions and high risk for frequent hospitalizations/re-admission

Goals of symptom management vs cure of disease

Pt expresses desire to not go to hospital or is refusing to go to ER when you recommend this

There is a disconnect between patient's goals and their conditions, request for futile care

Limited social support/lack of resources

Psychological/spiritual distress

Decreasing functional status, increased dependence for adls

"Pre-hospice," dwindling frail elderly

OPC - ROCKFORD

2 NP/1 SW, in past we have had RN and chaplain

Couple patient types:

- True palliative – clear DNR, clear goals of care, no hospitalizations, will transition to hospice when appropriate. Sometimes still full code, but relationship building and time are key.
- Medically complex – multiple hospitalizations, full code
 - See for a few visits, work on education, goals of care, social issues
 - Ask them to call us for concerns so we can address timely
 - May be discharged from OPC if no utilization or clearly want aggressive treatment

Co-manage with PCP, limited labs/tests ordered (keeping a palliative, symptom management approach)

We typically don't see patients who only need

- Pain management
- Psych management
- Social support (better served by care management)

OSF HOSPICE - ROCKFORD

Begins after active treatment of the disease is stopped and it is clear the patient is not going to survive the illness

Pt must have anticipated lifespan of 6 months or less

Provided in patient's home/nursing home

Focus on symptoms, quality of life according to patient's wishes

Team of providers (nurse, chaplain, social work, bereavement, CNA, MD/NP)

NEW – more patient-facing

FUTURE OF OSF OPC AND HOSPICE - ROCKFORD

Current census is around 100 each

Practice and team growth

Would like to see more patients come to hospice through OPC, then we know we are getting better at identifying patients with serious illness and giving them the most benefit from these comprehensive services

If patients “graduate” from hospice, will place in OPC and continue to manage as if in hospice so the transition back to hospice can be done smoothly when time is right

DESPRESCRIBING IN PALLIATIVE CARE/HOSPICE

Refers to a process of medication withdrawal, supervised by a healthcare professional and team with the goal of managing polypharmacy and improving outcomes

Common goals include reducing overall medication burden, reducing the risk of specific geriatric syndromes such as falls and cognitive impairment, and improving global health outcomes such as hospitalizations and death.

Occurs mostly with geriatric, palliative care and hospice patients, but can be applicable to any patient.

DEPRESCRIBING

Commonly overused and high-risk medications are good targets for deprescribing. These include sedative-hypnotics, anticholinergic medications, long acting sulfonylureas such as glyburide, PPI and NSAIDS in the absence of compelling indications.

Use a stepwise approach which includes engaging the patient, gathering information, identifying and deciding on medications to deprescribe, and implementing a plan with monitoring and follow up.

Tapering is always a good strategy to discontinue or to the lowest dose.

Shared decision making is vital with goals of care.

Common barriers especially in palliative care include: care shared between multiple providers, challenges in identifying appropriate medications, and the clinical inertia can be addressed through communication, education, and other strategies.

PATIENTS TARGETED FOR DEPRESCRIBING

Polypharmacy – 5 or more medications is a useful benchmark for identifying older adults at higher risk

Multimorbidity

Renal Impairment

Multiple prescribers and transitions of care

Pill burden

Medication nonadherence – this requires shared decision-making and discussion of goals

Older age

Frailty and dementia – caregivers many times feel guilt and pressure about deprescribing

MEDICATIONS THAT ARE HIGH RISK

Use of potentially inappropriate medications for older adults – usually refers to the consensus list of medications such as the American Geriatrics Society Beers Criteria.

Examples: benzodiazepines and benzodiazepine receptor agonists, strongly anticholinergic medications, long acting sulfonylureas such as glyburide, and chronic use of PPI's and nonsteroidal anti-inflammatory drugs (NSAIDS) in the absence of compelling indications.

Other examples are insulins and aspirin (anticoagulants)

Insulin – although treatment is often necessary, many adults with advanced age, multimorbidity, or functional decline receive overaggressive glucose lowering treatments that yields few benefits and substantially greater harms compared with more permissive approaches.

ASA – beneficial for people with known CV or cerebrovascular disease, yet the risk of bleeding increases substantially with age related to falls, decreased hepatic or renal function. ect.

APPROACH TO DEPRESCRIBING

Multistage process, rather than simply the concrete action of stopping a medication. Multiple steps are necessary to ensure that the process is patient-centered and achieves the best possible outcomes. For example, inadequate documentation and/or communication at the end of the process can result in inappropriate medications being restarted.

***** COMMUNICATION and DOCUMENTATION*****

STEPS TO DEPRESCRIBING

Step ONE:

Engage patient, gather relevant information

Compile list of medications prescribed and OTC and complementary medications

Review patient's goals of care, preferences, and values

Consider the patient's overall susceptibility to drug-induced harm, for example frailty, cognitive impairment, other geriatric syndromes such as falls.

Engage patient (caregivers) in a discussion of the process and connect with other healthcare professionals who may need to be consulted or could assist with process.

DEPRESCRIBING

Step two

Identify and decide on drugs to be deprescribed. Each medication should be evaluated for its potential to be reduced in dose or discontinued, considering the balance of current and potential future benefits and harms.

Look for meds that do not have a clear current indication such as PPI for uncomplicated GERD.

Are ineffective

Are used for preventative indications for example bisphosphonates in people nearing the end of life

Cause unacceptable tx burden, insulin in a person with dementia who is fearful of needles.

Beers Criteria Medications

DEPRESCRIBING

Step 3 – Planning, implementation, monitoring, and follow-up

Prioritize drugs for discontinuation and order of withdrawing or tapering, those with the greatest concern for patient should be stopped first.

Stopping drugs one at a time is usually recommended.

Should be a trial for each medication to determine if medication is still providing a benefit.

Tapering is always recommended if the patient's condition may worsen. General rule is 50% reduction every 2-4 weeks with monitoring.

Patients need to be aware of what to self monitor and have good follow-up

DEPRESCRIBING

Practical strategies:

Set aside separate visit to focus on medication review and deprescribing. Reimbursement/billing codes can include the diagnosis that the medication is intended to treat.

Use the expertise and services of pharmacists, nurses, and other healthcare professionals

Start the process: deprescribing does not need to be conducted all in one visit.

Use patient education materials when possible.

DEPRESCRIBING PPI'S

Commonly overused with risks of hip fractures, impaired vitamin B12 absorption, and c diff risk.

Make sure patient does not have a compelling reason for ongoing treatment- such as Barretts esophagus, chronic NSAID use with bleeding risk, severe esophagitis, GI bleed or patients of older age with chronic anticoagulant or corticosteroid use

Again, taper 50% every 2-4 weeks and monitor for symptom reoccurrence (heartburn, dyspepsia, regurgitation)

Occasional symptoms may be managed with on demand antacids, H2 receptor agonist or PPI

If symptoms continue, place back on medication at the lowest dose possible.

DEPRESCRIBING GLUCOSE LOWERING MEDICATIONS

Careful communication and shared decision making is essential since patients have been told for decades about the importance of tight glucose control.

Risk of causing hypoglycemia when patient is unable to verbalize or sense the symptoms of hypoglycemia which can cause ED visits.

Communicate with specialists

Switching to simpler insulin regimens (American Diabetes Association Guidelines offer an algorithm.

Encourage to continue to monitor symptoms and blood sugars daily until stable. Goal if monitoring would be <200 for PC patients.

DEPRESCRIBING ANTIHYPERTENSIVES

Consider when BP is below targets.

Some meds such as short acting beta blockers such as propranolol or alpha-2 agonists such as clonidine should be tapered not just stopped due to the potential withdrawal syndromes.

Other hypertensives such as ACE, thiazide diuretics, and calcium channel blockers do not carry this risk.

Need close monitoring.

DEPRESCRIBING OR CHANGING ANTIDEPRESSANTS

Withdrawal symptoms include insomnia, increased anxiety and flu like symptoms that last few weeks to months. This can be reduced by tapering over weeks.

If nearing hospice, may need to change to a formulary medication.

DEPRESCRIBING CHOLINESTERASE INHIBITORS AND MEMANTINE

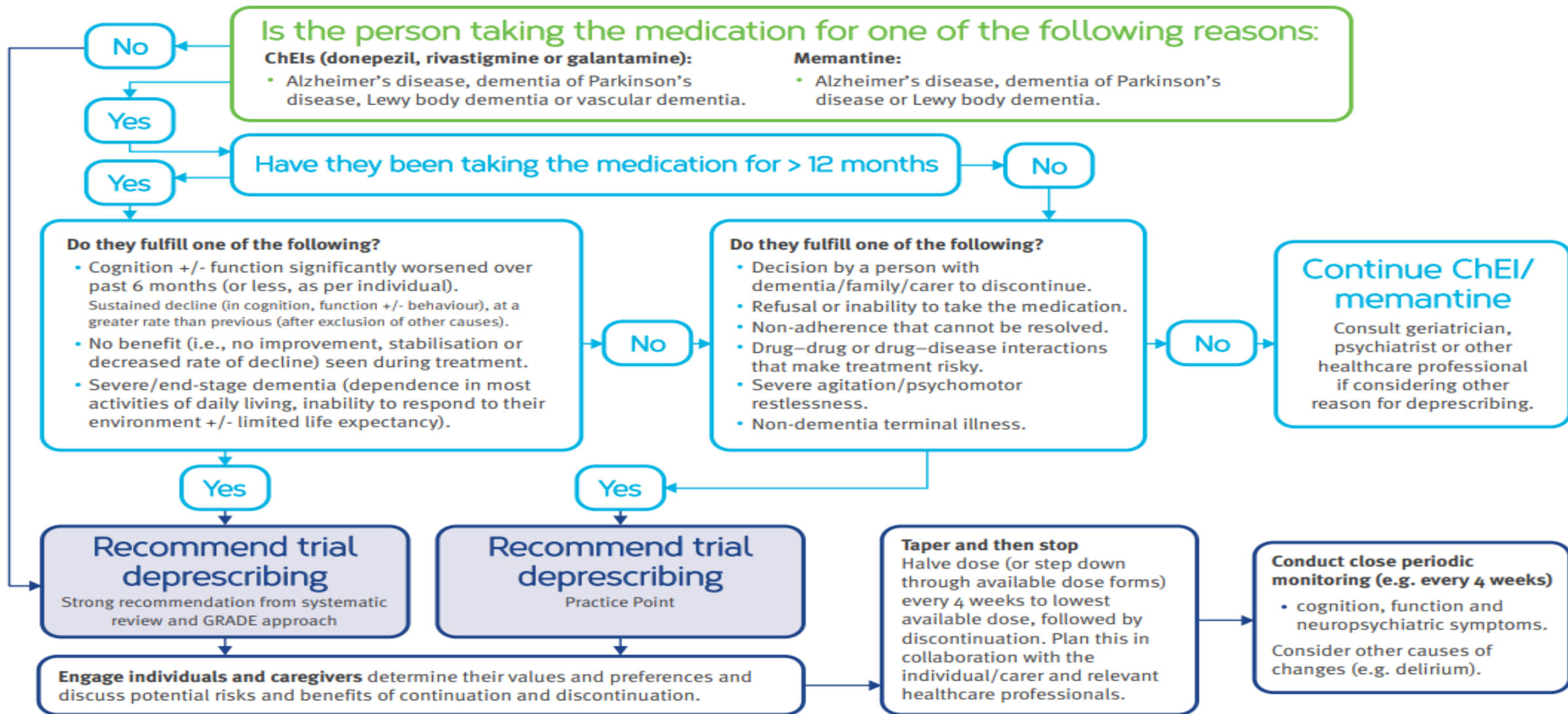
These medications can be challenging due to uncertainty about whether these medication are providing benefit to any given patient.

Reasons to deprescribe; syncope, GI distress, weight loss with cholinesterase inhibitors, FAST >7A (ability to speak less than 6 words), institutionalized or comfort focus with hospice.

Taper of dose and close monitoring for cognitive, functional and neuropsychiatric symptoms are strongly advisable. Half the dose every four weeks to the lowest available dose then stop. This may occur more quickly if nearing end of life.

If significant symptoms occur such as aggression, hallucination or reduced consciousness, previous dose should be restarted, it is reasonable to try a more gradual taper.

If cognitive, behavioral, or psychological symptoms emerge in roughly 2-6 weeks, this may indicate the drug was providing benefit. Need to investigate other causes as well such as UTI





Monitoring during tapering and after discontinuation

Timing of symptoms after dose reduction/ discontinuation	Types of symptoms	Action to be taken by family/nurses/ care staff	Possible cause*
Less than 1 week	Severe symptoms, including agitation, aggression, hallucinations or reduced consciousness	Restart previous dose immediately and contact responsible healthcare professional as soon as possible	Adverse drug withdrawal reaction
2 to 6 weeks	Worsening of cognition, behavioural or psychological symptoms or function	Contact responsible healthcare professional and consider restarting previous dose and/or make an appointment to see responsible healthcare professional at the next available time	Re-emergence of symptoms that were being treated by ChEI/ memantine
6 weeks to 3 months	Worsening of cognition, behavioural or psychological symptoms or function	Contact responsible healthcare professional at the next available time to make an appointment	Likely progression of condition or possible re-emergence of symptoms that were being treated by ChEI/memantine
> 3 months	Any	As per usual care	Progression of condition

- *Exclude other causes of change in condition (e.g. infection or dehydration) first.
- Discuss monitoring plan with the individual/family/carer and write it down for them (e.g. frequency and type of follow-up). Ensure they have a way to contact a clinician if needed.

Engaging individuals and family/carers

Determining suitability for deprescribing

- Discuss treatment goals – what do they value the most (cognition, quality of life, remaining independent)?
- Ask about experience with dementia symptoms when treatment started and over last 6 months.
- Ask about side effects.

Helping the individual and family/carers to make an informed decision

- Deprescribing is a trial – medication can be restarted if appropriate.
- There are uncertain benefits and harms to both continuing and discontinuing the medication.
- Tailor discussion about benefits and harms to the individual.
- Explore fears and concerns about deprescribing.
- Consider medication costs and local reimbursement/subsidisation criteria.
- If the recommendation to deprescribe is being made due to progression of dementia, remind family/carers that the person with dementia may continue to decline after deprescribing, and explain why.

Non-pharmacological management and ongoing care after deprescribing

See (<http://sydney.edu.au/medicine/cdpc/resources/dementia-guidelines.php>) for Australian guidelines on care of people with dementia, including behavioural and psychological symptoms.

ChEI and memantine availability (Australia)

Drug	Strength
Donepezil (Aricept®, Aridon®, Arazil®)	Tablet – 5mg, 10mg
Galantamine (Galantyl®, Gamine XR®, Reminyl®)	Controlled release capsule – 8mg, 16mg, 24mg
Rivastigmine (Exelon®)	Capsule – 1.5mg, 3mg, 4.5mg, 6mg Patch – 4.6mg/24 hours, 9.5mg/24 hours, 13.3mg/24 hours
Memantine (Ebixa®, Memanxa®)	Tablet – 10mg, 20mg

ChEI and memantine side effects

- Common: include gastrointestinal effects, dizziness, confusion, headache, insomnia, agitation, weight loss and falls.
- Rare (ChEI): may include urinary, cardiovascular (e.g. bradycardia), pulmonary and dermatological (e.g. Stevens-Johnson syndrome) complications, Pisa syndrome, seizures, gastrointestinal haemorrhage and rhabdomyolysis.
- Lack of evidence of potential harms in complex older adults.



DEPRESCRIBING PEARLS

Communication with patient and families

Goals of care, preferences, why and how to stop medications, risk of side effects, use the term trial with reassurance the medication can be re-started, if necessary, do frame deprescribing as “not giving up in you or taking something away of value, but optimizing care”.

Patient/family need support.

If patient/family is against medication discontinuation, this should be explored and revisited at intervals. Common in hospice.

Be aware if nearing end of life, expensive medications may not be covered with hospice care. Look at all options.

DEPRESCRIBING

Communication with other providers

This will prevent uncertainties, conflicting instructions to patients and ensure alignment of the therapeutic plan.

Barriers:

Patient/family reluctance

Lack of evidence

Limited time (in office or with hospice)

Care shared among multiple providers

Challenges in recognizing problematic medications

Medical culture – maintaining the “status quo”

94 YEAR OLD MALE WITH VASCULAR DEMENTIA, WIFE DIED 6 MONTHS AGO, PATIENT IS "READY TO DIE" WANTS TO FOCUS ON COMFORT CARE, NO HOSPITALIZATIONS AND TRANSITION TO HOSPICE WHEN APPROPRIATE. PATIENT DOES NOT MEET HOSPICE CRITERIA CURRENTLY. FOLLOWS WITH PCP AND NEUROLOGY.

DAUGHTER IS ASKING IF THERE IS ANY WAY MORALLY TO FOLLOW HIS WISHES.

Medications

1. **Acetaminophen** 650 mg tabs – Take 1 tablet by mouth every 6 hours as needed

Pain Control – **CONTINUE**

2. **Amlodipine(Norvasc)** 5 mg tablet – Take 1 tablet daily

BP Control, would not want BP to rise or risk of CVA? - BP trends 140-150/80 - **CONTINUE**

3. **Aspirin EC** 81 mg tablet – Take 81 mg by mouth daily

ASA can be stopped - **DISCONTINUE**

4. **Cholecalciferol** 50 mcg tablet – Take 50 mcg by mouth daily

Vitamin D can be stopped - **DISCONTINUE**

5. **Cilostazol** (Pletal) 100 mg tablet – Take 1 tablet by mouth 2 times daily

Helps with claudication pain if having, can consider keeping, reducing or stopping - **CONTINUE**

6. **Escitalopram** (Lexapro) 10 mg tablet – Take 1 tablet daily

Antidepressant, lost wife few months back, signs of depression – **CONTINUE increase to 20 mg daily**

7. **Lisinopril** (Prinivil) 2.5 mg tablet – Take 1 tablet by mouth daily

BP control – **CONTINUE**

8. **Memantine** (Namenda) 10 mg tablet – Take 1 tablet twice daily

For memory, not sure if anything really can be preserved, can stop, may discuss with neurology
DISCONTINUE

9. **Metformin** (Glucophage) 1000 mg tablet – Take 1 tablet twice daily

Glucose Control – not eating well – Could reduce or change to MetforminXR 2 tabs daily - **CONTINUE**

10. **Rivastigmine** (Exelon) 13.3 mg/24 hr patch – 1 patch transdermal daily

Has it helped? If not, reduce the same way we titrated up. Neurology recommended to keep for

Now. **CONTINUE**

11. **Tamsulosin** (Flomax) 0.4 capsule – Take 1 capsule by mouth every morning

Helps BPH, would not want urinary discomfort or pain. **CONTINUE**

12. **Trazodone** (Desyrel) 50 mg tablet – Take one tablet by mouth nightly

Would stop if we increase Lexapro - **DISCONTINUE**

PALLIATIVE CARE AND HOSPICE MEDICATIONS

Most important is a throughout history and physical
Discussion about goals and plan of care i.e. comfort
versus treatment, full code versus DNR comfort
What is available in a home environment?
Education to patient and family.

ACUTE AND SEVERE AGITATION

Always consider non-pharmacological ways to control as priority

Lorazepam 0.5-2 mg (2mg/2ml concentration or tablet) repeat in 15-30 minutes if needed.

Haloperidol 0.5-5 mg (2 mg/ml concentration or tablet) repeat in 15-30 minutes if needed.

Both drugs will be titrated up in dose until desired effect is achieved.

Olanzapine (Zyprexa ODT) 5 mg start and titrate up as needed.

Avoid antipsychotic agents Haloperidol/Olanzapine) patients with Parkinson's Disease

ANOREXIA/APPETITE LOSS

Mirtazapine (Remeron) 15-30 mg nightly

Dexamethasone 2-16 mg daily are most effective doses. Best to give in am as this may cause insomnia if given at night.

Megace 40-800 mg PO per day (suspension 40/125 mg/ml) – contraindicated for hormone dependent tumors, have risk of fluid retention, DVT and sexual dysfunction

Cannabis – I do not prescribe cannabis, but I do have a fair amount of patients that use this for appetite. Caution: make sure they notify their prescribers if taking.

ANXIETY

Lorazepam 0.5 mg to 2 mg every 8-12 hours prn (PO/SL/PR)

Alprazolam 0.25-0.5 mg every 6-8 hours prn

Sertraline 50-100 PO mg nightly

Buspar 10 mg PO TID

Wellbutrin 50 mg TID

CONSTIPATION

Miralax 17 gm daily to BID

Docusate/Senna - 50/8.6mg tablets (PO) – Start with one tablet daily and may increase up to 2-3 tablets BID

Dulcolax 10-15 mg PO q day (PO)

Milk of Magnesia 30-60 ml PO Q day or BID

Lactulose 15-30 ml PO qD, may increase to 60 ml daily if needed.

IF no BM in 72 hours, perform rectal exam to r/o impaction and try:

Dulcolax 10 mg suppository

Mineral Oil 30-60 ml PO

Sodium biphosphate Fleet enema or saline enema

If impacted, manually disimpact.

Magnesium Citrate

SHORTNESS OF BREATH

O₂ Therapy

Opioid Therapy – GOLD star treatment is Morphine usually 5-20 mg per hour as needed – (most used is 20mg/ml concentrate)

Anxiety Treatment – Lorazepam 0.25-2mg every 3 hours as needed/Sertraline/Alprazolam

Treatment of bronchospasm – Albuterol/Atrovent inhaler/nebs

Treatment of Illness – CHF/fluid overload, COPD/steroids/antibiotic

PAIN

In PC, pain is managed same as treatment mode, unless patient is DNR comfort, no want to return to hospital and is not wanting hospice. Goals of care conversations are vital.

Hospice –

Look at cause of pain and try to treat cause if within patient's goals.

Is patient opioid naïve? Start low and go slow.

Continue current regimen as long as hospice formulary.

If hospice, we need to look at hospice formulary for cost effectiveness.

Morphine 20mg/ml concentrate 5-20 mg SL every 1 hour as needed

FATIGUE

Treat the cause – anemia, pain, nutritional deficiencies, sleep issues, SOB, infection, medication, deconditioning

Some medications that have been used are modafinil and methylphenidate

Most complained about symptom and most difficult to treat

INSOMNIA

Mirtazapine (Remeron) 15-30 PO mg nightly

Trazodone 25-100 mg PO nightly

Lorazepam 0.25-1 mg PO/SL nightly

Amitriptyline 10-25 mg PO, increase by 25 mg every 3 days as needed

Hydroxyzine (Vistaril) 25-50 mg PO nightly

Benadryl 25-50 mg PO nightly

Watch out for anticholinergic effects in elderly

Non-benzodiazepine hypnotic agents, I rarely use, minimal coverage in hospice

HOSPICE MEDICATIONS FREQUENTLY USED

Morphine (Roxanol) 5-20 mg SL every 1 hour prn for SOB/Pain

Lorazepam (Ativan) 0.5-2 mg SL every 3 hours prn for anxiety

Hyoscyamine (Levsin) 0.125- 0.25 mg PO/SL every 4 hours for secretions

Atropine (10mg/ml) 2 drops SL every 2-3 hours for secretions

Prochlorperazine (Compazine) 10 mg PO every 6-8 hours for nausea

Ondansetron (Zofran) 4-8 mg every 8 hours for nausea

HOSPICE MEDICATIONS FREQUENTLY USED

Haloperidol or Risperidol 0.5-1 mg SL/PO every 4 hours as needed

Acetaminophen (Tylenol) 650 mg every 4 hours for fever

When deprescribing for a hospice patient, goal is comfort. Some medications will need to be changed to an equal formulary per hospice.

For example, Eliquis may be changed out for an ASA or Coumadin depending on situation, Nexium may be changed out to Omeprazole, Fentanyl patch may be changed out to Morphine related to minimal SQ fat in a cancer patient.

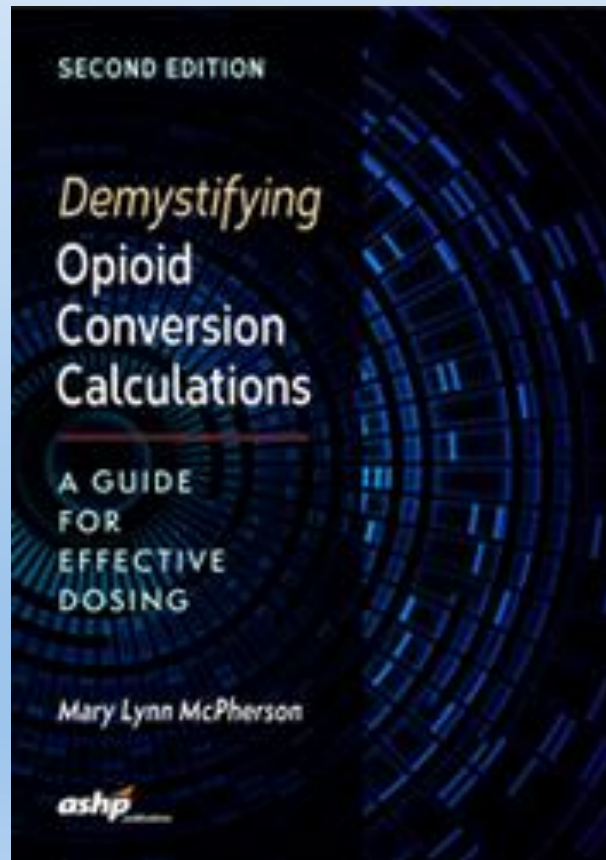
EQUALANALGESIC DOSING

Remember Hydrocodone (Norco) 5 /325 is the same as Morphine 5 mg PO

The use of Morphine always requires education.

Concentrate works very well and is easily titrated.

CLINICAL RESOURCES



App Store Preview

Open the Mac App Store to buy and download apps.

Opioids Dosage Conversion 17+
Chris Marcellino MD LLC
Designed for iPad
★★★★★ 4.2 • 15 Ratings
Free

Screenshots **iPad** iPhone