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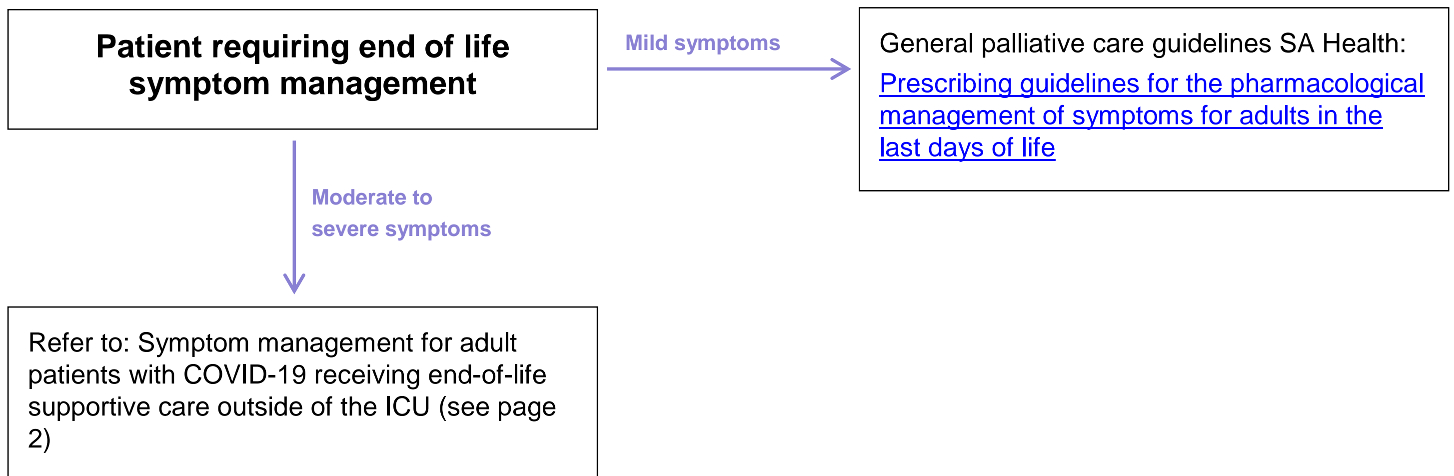
Let's put imagination to work

Symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside of the ICU



General Advice

- Generally, non-drug approaches should be used, particularly in mild to moderate disease. Drug approaches become necessary for severe distressing symptoms, particularly in severe disease. (see *** for non-pharmacological treatments)
- This guideline assumes the patient is receiving all appropriate supportive treatments and correctable causes have been considered and managed. Examples include:
    - antibiotic treatment for a superadded bacterial infection may improve fever, cough, breathlessness and delirium
    - optimising treatment of comorbidities (e.g. chronic obstructive airways disease, heart failure) may improve cough and breathlessness
- Urgent clinical review is required if there is:
    - Inadequate relief of a symptom despite three maximum doses administered in succession at the shortest specified time interval

      OR
    - ANY CONCERN
- Useful resources:
    - palliAGED for GPs App: palliaged.com.au
    - Opioid calculator App: Faculty of Pain Medicine ANZCA
    - Opioid conversion table: ANZCA: https://fpm.anzca.edu.au
- Alternatives to midazolam must be considered in the case of supply problems (anticipated with higher strength)
    - Call for Palliative Care Medicine Consultant for decision support
    - Levomepromazine and Phenobarbitone are useful for sedating patients when midazolam is ineffective or unavailable

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Before enacting these recommendations please identify patient's **Goals of Care**

These recommendations are consistent with: not for resuscitation, not for ICU transfer, comfort-focused supportive care. Refer to the patient's 7 Step Pathway and Advanced Care Directive.

All below are **starting** doses. COVID-19 symptoms may advance quickly, be prepared to escalate dosing.

Moderate/severe symptoms will require regular medication dosing in addition to breakthrough 'prn' doses as needed–it is HIGHLY likely a CSCI (continuous subcutaneous infusion) will be required to ensure good symptom control. If no pump is available, initiate regular intermittent dosing.

Patient NOT already taking opioids ("opioid-naïve")

Breathlessness and cough

OPIOIDS help relieve acute respiratory distress, contribute to energy conservation

MORPHINE

PRN: 5-10mg PO or 2.5-5mg subcut/IV every 1hour

and if needed

Regular dosing: 2.5-5mg subcut/IV every 4 hours

or

CSCI: 10-20mg/24hrs

HYDROMORPHONE (if CrCl <30ml/min)

PRN: 1-2mg PO or 0.5-1.0mg subcut/IV every 1hour

and if needed

Regular dosing: 0.5-1.0mg subcut/IV every 4 hours

or

CSCI: 2-4mg/24hours

Fentanyl (if CrCl<30ml/min)

PRN: 50-75microg subcut/IV every 1hour

and if needed

Regular dosing 50-75microg subcut/IV every 4hours

or

CSCI: 150-300microg/24hours

TITRATE UP AS NEEDED

Severe or poorly controlled symptoms may need rapid titration

If using >3 PRN in 24hrs consider increase CSCI by 25-30% and continue PRN doses

Patient already taking opioids

Continue previous opioid, **consider increasing by 25%**

To manage breakthrough symptoms: **Start opioid PRN at 10% of total daily (24h) opioid dose**

Give PRN: give PO or Subcut doses every 1hour

See guideline for conversion between opioids

Dedicated Palliative Medicine Consultant Phone advice for Doctors, Nurse Practitioners and Palliative Care Nurses: through Specialised Palliative Care Services 24/7 (QEH, Modbury, Flinders Switchboard) or ring 1300 673 122 if unsure of service.

Respiratory secretions/congestion

Advise family & staff: not usually uncomfortable for patient, just noisy, due to patient weakness/ inability to clear secretions

HYOSCINE BUTYLBROMIDE

PRN:20mg every 2-4 hours subcut

and if needed

Regular dosing: 20mg QID subcut

or

CSCI: 80mg/24hrs

If Fluid overload, consider stat Furosemide 20-40mg subcut and monitor response

For Fever:

PRN: Paracetamol 1g QID PO/PR/IV

For nausea:

HALOPERIDOL as for agitation but use 50% doses

Anxiety, SOB and agitation

For associated anxiety:

CLONAZEPAM^

PRN:3-5drops every 4-8hr subling (1drop= 0.1mg)

and if needed

Regular:0.5-1mg every 12 hr subling/subcut

For severe SOB/anxiety:

MIDAZOLAM*

PRN: 2.5-5mg subcut every 1hr

and if needed

Regular: 5mg subcut every 4hr

or

CSCI: 20-60mg/24hours

OR if midazolam unavailable

CLONAZEPAM^

Regular: 0.5-1mg subcut every 6hours

For agitation/delirium:

MIDAZOLAM*

PRN: 2.5-5mg subcut every 1hr

and if needed

Regular: 5mg subcut every 4hr

or

CSCI: 20-60mg/24hours

OR if midazolam unavailable

CLONAZEPAM^

Regular: 0.5-1mg subcut every 6hours

and/or

HALOPERIDOL

PRN: 0.5-1mg PO/subcut every 2hr

and if needed

Regular: 1 -2.5mg PO/subcut every 4hr

or

CSCI: 2.5-10mg/24hours

*Younger patients or those tolerant to benzodiazepines MAY REQUIRE HIGHER DOSES

^Clonazepam adheres to plastic (reducing the drug available through an infusion) so is best administered via intermittent

This document is provided 'as is' to allow immediate use—it is continuing to evolve as we receive feedback. Thank you for your input ad understanding. Feedback to -sally.williams@sa.gov.au

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