Management of PAIN in the last days of life – ADULT

IF OPIOID PRESCRIBED FOR PAIN, SAME OPIOID ORDER MAY ALSO BE USED FOR BREATHLESSNESS

Assess patient in the last days of life at least every 4 hours: to allow existing and emerging symptoms to be detected, assessed and treated effectively

Assess pain and if present: instigate non-pharmacological measures (e.g. repositioning, alternative mattress, etc.), give analgesia as below and assess effectiveness

Patient has NOT been on a regular opioid
(not on regular opioid in the last 7 days)

Patient is NOT in pain

For the majority of patients in the last days of life,
MORPHINE should be used as the first line subcutaneous opioid

Discuss with Specialist Palliative care team regarding alternate subcut opioids

Pre-emptively prescribe
PRN subcut morphine
MORPHINE
2.5mg subcut 1 (one) hourly PRN
max PRN dose in 24 hrs = 15mg
(6 PRN doses)
Assess response and initiate further intervention if symptoms remain uncontrolled

Patient is in pain

For the majority of patients in the last days of life,
MORPHINE should be used as the first line subcutaneous opioid

Discuss with Specialist Palliative care team regarding alternate subcut opioids

Prescribe regular subcut morphine
MORPHINE
2.5mg subcut 1 (one) hourly PRN
max PRN dose in 24 hrs = 15mg
(6 PRN doses)
Assess response and initiate further intervention if symptoms remain uncontrolled

Review symptom control at least daily
If 3 or more effective PRN doses required in previous 24 hours,
prescribe regular subcut MORPHINE

Prescribe regular subcut morphine
(to calculate, add together all PRN doses of subcut morphine used in previous 24 hrs)
EITHER
MORPHINE
Dose = 1/6 total PRN dose used in last 24 hours subcut regularly 4 hourly
(max: 2.5mg subcut regularly 4 hourly)
OR
MORPHINE
Dose = total PRN dose used in last 24 hours subcut in 24 hr syringe driver
(max: 15mg subcut in 24 hr syringe driver)

Also prescribe PRN subcut morphine
MORPHINE
PRN dose = 1/6 daily subcut dose (see table overleaf) subcut 1 (one) hourly PRN
max PRN dose in 24 hrs = equivalent to 6 PRN doses
Assess response and initiate further intervention if symptoms remain uncontrolled

Patient HAS been taking a regular ORAL opioid
(regular opioid use during the last 7 days)

Convert regular dose of oral opioid to subcutaneous morphine
See guidelines for switching from oral to subcutaneous opioids overleaf
Use table of common opioid conversions to determine dose of subcut morphine

Discontinue regular oral opioid AND Prescribe regular subcut morphine
EITHER
MORPHINE
Dose = see opioid conversion table overleaf subcut regularly 4 hourly
OR
MORPHINE
Dose = see opioid conversion table overleaf subcut in 24 hr syringe driver

Also prescribe PRN subcut morphine
MORPHINE
PRN dose = 1/6 daily subcut dose (see tablet overleaf)
subcut 1 (one) hourly PRN
max PRN dose in 24 hrs = equivalent to 6 PRN doses
Assess response and initiate further intervention if symptoms remain uncontrolled

Review symptom control at least daily, or more often if symptoms uncontrolled
If 3 or more effective PRN doses required in previous 24 hours, increase regular and PRN doses of subcut MORPHINE by 1/3
Seek advice from local Specialist Palliative Care Team if pain remains poorly controlled

If patient demonstrates clinical features of opioid side effects
Do NOT give an opioid antagonist (eg naloxone), as this will precipitate uncontrolled pain and/or opioid withdrawal symptoms, but do seek URGENT advice from local Specialist Palliative Care Team

Patient IS on a regular TRANSDERMAL opioid
(Buprenorphine or Fentanyl)

LEAVE THE PATCH IN SITU
Prescribe patch at same dose and change as usual

Also prescribe PRN subcut opioid
MORPHINE
subcut 1 (one) hourly PRN
max PRN dose in 24hrs = equivalent to 6 PRN doses
PRN dose = see tables below

Buprenorphine patch	PRN subcut morphine
≤10 microg/hr	2.5mg
20 microg/hr	5mg

Fentanyl patch	PRN subcut morphine
12.5 microg/hr	2.5mg
25 microg/hr	5mg
50 microg/hr	10mg

Discuss with local Specialist Palliative Care Team if on fentanyl patch > 50mcg/hr
Assess response and initiate further intervention if symptoms remain uncontrolled

Review symptom control at least daily
If 3 or more effective PRN doses required in previous 24 hrs, continue patch dose unaltered and add regular subcut opioid analgesia
Seek advice from local Specialist Palliative Care Team

GUIDELINES FOR SWITCHING FROM ORAL TO SUBCUTANEOUS OPIOIDS IN THE LAST DAYS OF LIFE

- All patients on regular opioids should have their oral medications converted to the subcutaneous route when they are unable to swallow or tolerate oral medication
- For the majority of patients in the last days of life, MORPHINE should be used as first line subcutaneous opioid

For patients on ORAL MORPHINE; switch to SUBCUTANEOUS MORPHINE: Use table below to determine dose of regular and PRN subcutaneous morphine to prescribe

Regular Oral MORPHINE Dose			Recommended Regular Subcutaneous MOPRHINE Dose if patient's pain/breathlessness is controlled and has required < 3 PRN doses in previous 24 hours			Recommended Regular Subcutaneous MORPHINE Dose if patient is in pain/breathless and/or has required ≥ 3 PRN doses in previous 24 hours		
Immediate Release (Ordine)	Controlled Release (MS Contin, Kapanol)	Total Daily Oral Dose	Regular 4 hrly Subcut Dose OR	Regular Subcut 24hr Dose in Syringe Driver	PRN Subcut Dose	Regular 4 hrly Subcut Dose OR	Regular 24hr Subcut Dose in Syringe Driver	PRN Subcut Dose
Opioid naive			(only prescribe PRN subcut dose)		2.5mg 1 hrly PRN	2.5mg 4 hrly	15mg in 24hr syringe driver	2.5mg 1 hrly PRN
≤ 7.5mg 4hrly	≤ 25mg BD	≤ 45mg	2.5mg 4hrly	15mg in 24hr syringe driver	2.5mg 1hrly PRN	2.5mg* 4hrly	20mg in 24hr syringe driver	2.5mg* 1hrly PRN
10mg 4hrly	30mg BD	60mg	2.5mg* 4hrly	20mg in 24hr syringe driver	2.5mg* 1hrly PRN	5mg** 4hrly	25mg* in 24hr syringe driver	5mg** 1hrly PRN
15mg 4hrly	45mg BD	90mg	5mg 4hrly	30mg in 24hr syringe driver	5mg 1hrly PRN	7.5mg** 4hrly	40mg in 24hr syringe driver	7.5mg** 1hrly PRN
20mg 4hrly	60mg BD	120mg	7.5mg** 4hrly	40mg in 24hr syringe driver	7.5mg** 1hrly PRN	10mg** 4hrly	50mg* in 24hr syringe driver	10mg** 1hrly PRN
30mg 4hrly	90mg BD	180mg	10mg 4hrly	60mg in 24hr syringe driver	10mg 1hrly PRN	15mg** 4hrly	80mg in 24hr syringe driver	15mg** 1hrly PRN
> 30mg 4hrly	> 90mg BD	> 180mg	Seek advice from local Specialist Palliative Care Team regarding conversion to subcutaneous opioid					
Notes	1. Calculations based on conversion ratio of oral morphine: parenteral morphine = 3:1 (in line with Palliative Care Therapeutic Guidelines - http://www.tg.org.au) 2. For patients whose symptoms are not controlled: calculation incorporates a 1/3 dose increase in background analgesia to address uncontrolled symptoms 3. */** Dose rounded down* or up** to nearest 2.5mg increment for accuracy of administration							

For patients on ORAL OXYCODONE; switch to SUBCUTANEOUS MORPHINE: Use table below to determine dose of regular and PRN subcutaneous morphine to prescribe

Regular Oral OXYCODONE Dose			Recommended Regular Subcutaneous MOPRHINE Dose if patient's pain/breathlessness is controlled and has required < 3 PRN doses in previous 24 hours			Recommended Regular Subcutaneous MORPHINE Dose if patient is in pain / breathless and/or has required ≥ 3 PRN doses in previous 24 hours		
Immediate Release (Endone, OxyNorm)	Controlled Release (OxyContin and/or Targin***)	Total Daily Oral Dose	Regular 4 hrly Subcut Dose OR	Regular 24hr Subcut Dose in Syringe Driver	PRN Subcut Dose	Regular 4 hrly Subcut Dose OR	Regular 24hr Subcut Dose in Syringe Driver	PRN Subcut Dose
≤ 10mg 4hrly	≤ 30mg BD	≤ 60mg	2.5mg* 4hrly	20mg in 24hr syringe driver	2.5mg* 1hrly PRN	5mg 4hrly	30mg in 24 hr syringe driver	5mg 1hrly PRN
–	40mg BD***	80mg	5mg** 4hrly	25mg* in 24hr syringe driver	5mg** 1hrly PRN	7.5mg** 4hrly	40mg in 24 hr syringe driver	7.5mg** 1hrly PRN
15mg 4hrly	45mg BD	90mg	5mg 4hrly	30mg in 24hr syringe driver	5mg 1hrly PRN	7.5mg 4hrly	45mg in 24 hr syringe driver	7.5mg 1hrly PRN
20mg 4hrly	60mg BD	120mg	7.5mg** 4hrly	40mg in 24hr syringe driver	7.5mg** 1hrly PRN	10mg 4hrly	60mg in 24 hrs syringe driver	10mg 1hrly PRN
25mg 4hrly	80mg BD	160mg	10mg** 4hrly	50mg* in 24hr syringe driver	10mg** 1hrly PRN	15mg** 4hrly	80mg in 24 hrs syringe driver	15mg** 1hrly PRN
> 30mg 4hrly	> 90mg BD	> 180mg	Seek advice from local Specialist Palliative Care Team regarding conversion to subcutaneous opioid					
Notes	1. Calculations based on conversion ratio of oral oxycodone : oral morphine = 1:1.5 AND oral morphine : parenteral morphine = 3:1 (in line with Palliative Care Therapeutic Guidelines - http://www.tg.org.au) 2. For patients whose symptoms are controlled: calculation incorporates a 1/3 dose reduction when switching from oxycodone to morphine to allow for incomplete opioid cross tolerance 3. For patients whose symptoms are not controlled: calculation incorporates BOTH a 1/3 dose reduction for incomplete opioid cross tolerance AND a 1/3 dose increase to address uncontrolled pain symptoms 4. */** Dose rounded down* or up** to nearest 2.5mg increment for accuracy of administration *** Maximum Targin dose (combination oxycodone+naloxone) is 40/20 mg BD; patients may be on both OxyContin (single drug controlled-release oxycodone) and Targin if higher analgesic doses required							

For patients on ORAL HYDROMORPHONE

Seek advice from local Specialist Palliative Care Team regarding switching to subcutaneous HYDROmorphone or alternative subcutaneous opioid

For patients on TRANSDERMAL BUPRENORPHINE or FENTANYL PATCHES

- LEAVE THE PATCH IN SITU, prescribe at same dose and change as usual
- If the patient is pain controlled – see flowchart overleaf for guidance on PRN dose of subcutaneous morphine to prescribe for each patch dose
- If the patient is in pain – seek advice from local Specialist Palliative Care Team as regular subcutaneous opioids may be required in addition to the patch

For further symptom management and prescribing advice, see Palliative Care Therapeutic Guidelines (http://www.tg.org.au)

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Last Days of Life

CLINICAL EXCELLENCE COMMISSION