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

YOU MUST HAVE A GOALS OF CARE CONVERSATION WITH PATIENT/SDM PRIOR TO INITIATING GUIDELINES

- These recommendations are consistent with: DNR, no ICU transfer, and comfort-focused supportive care
- The most common symptoms of COVID-19 at the end of life are severe dyspnea and agitated delirium
- Please see the COVID-19 Communication Tool and/or the Serious Illness Conversation Guide to assist with conversation
- Opioids are the mainstay of dyspnea management, to treat acute respiratory distress & can be helpful for cough
- Mild symptoms: RR < 25, 5-10 word sentences; moderate: RR 25-30, 5 word sentences; severe: RR > 30, 1-2 word sentences

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

Mild Dyspnea/ Respiratory Distress
- start with PRN dosing, but low threshold to change to scheduled q4h dosing

Moderate to Severe Dyspnea/ Respiratory Distress
- start with scheduled q4h & PRN dosing or may consider continuous infusion if available

Morphine
1-2.5 mg SQ/IV q30min PRN

Hydromorphone
0.25-0.5 mg SQ/IV q30min PRN

Fentanyl
12.5-50 mcg SQ/IV q15min PRN

- begin with lower end of dosing range for frail elderly
- if > 5 PRN in 24h, MD to review & consider scheduled dose or increase in already scheduled dose
- if changing to a scheduled q4h dose, CONTINUE PRN dose

TITRATE UP AS NEEDED

Patient already taking opioids

Mild Dyspnea/ Respiratory Distress
- continue previous opioid, consider increasing by 25%

Moderate to Severe Dyspnea/ Respiratory Distress
- continue previous opioid, consider increasing by 25-50%

To manage breakthrough symptoms: **start opioid PRN at 10% of new 24h opioid dose**

For further assistance including telephone support please page the Palliative Medicine Consult team via the KGH Switchboard at 613-549-6666

Adjuvants

Associated anxiety:
Lorazepam 0.5-1 mg SL/SQ q2h PRN
- if > 3 PRN in 24h, MD to review & consider scheduled q6-12h & q2h PRN dosing

Severe dyspnea/anxiety:
Midazolam 0.5-4 mg SQ/IV q30min PRN (initial dosing)
- if > 3 PRN in 24h, MD to review & consider scheduled & PRN dosing or continuous infusion if available for symptom management (not sedation)
- for difficult or refractory symptoms, please consult Palliative Medicine. Rapid titration of medications may be needed

Agitation/restlessness:
Methotrimeprazine 2.5-12.5 mg SQ/IV q2h PRN
- if > 3 PRN in 24h, MD to review & consider scheduled q4h & q2h PRN dosing
- parenteral formulation can also be given buccally

Respiratory Secretions / Congestion near End-of-Life:
Advise family & bedside staff: noisy breathing not usually uncomfortable for the patient
Consider **glycopyrrolate** or **scopolamine** 0.4 mg SQ q4h PRN (scopolamine is more sedating) or **atropine** 1% (ophthalmic drops) 1-2 drops SL q4h PRN
If fluid overload, consider **furosemide** 20mg SQ q2h PRN & monitor response
Consider inserting foley catheter

Engage with your team to ensure comfort is the priority as patients approach end of life. Ensure written orders reflect this. Unmanaged symptoms at EOL add distress for patients, loved ones, and staff.

* These recommendations are for reference and do not supersede clinical judgment
* Evidence supports that appropriate opioid doses do not hasten death in other conditions like advanced cancer or COPD
* Reassess dosing as patient's condition or level of intervention changes

Adapted with permission from BC Centre for Palliative Care Guidelines by the Division of Palliative Medicine, Queen's University and the South East Regional Palliative Care Network. Version April 1, 2020. Latest version of this document: http://serpcn.ca/80/Clinical_Tools/