Management of Terminal Agitation

Bradford, Airedale, Wharfdale and Craven Palliative Care Managed Clinical Network

These practice guidelines have been agreed for use by Specialist Palliative Care Teams in the Bradford, Airedale, Wharfedale & Craven Palliative Care Managed Clinical Network

Terminal Agitation in the last days of life is often due to progressive organ failure but can be exacerbated by psychological and spiritual distress. It is not normally reversible.

Exacerbating factors:

- Physical discomfort: unrelieved pain , urinary retention, distended rectum, inability to move, uncomfortable bed, breathlessness
- Infection
- Biochemical abnormalities: uraemia, hypercalcaemia, hypoxia
- Drugs
- Psychological/Spiritual distress

Overall Management

1. Assess patient
2. Treat underlying causes if possible: oxygen, analgesia, catheter, pressure mattress, review medication
3. Discuss and communicate with patient and family (terminal agitation can be very distressing for the patient and family)
4. Drug management

Drug management: 1st Line

Midazolam (sedative, anxiolytic, anticonvulsant): Particularly if anxiety is prominent

- PRN starting dose 2.5-5mg 30mins-1 hrly SC
- 24hr starting dose 10-20mg SC via Syringe Driver (SD)
- Higher starting doses are sometimes needed if previously on oral benzodiazepines (midazolam 1.5-2mg is equivalent to lorazepam 500mcg or diazepam 5mg[5])
- Titrate SD dose as required
- Assess efficacy of PRN doses once on SD. If symptoms not relieved for longer than 2hrs consider using PRN levomepromazine 12.5mg SC.
- Normally maximum effective dose in SD 60mg/24hrs

Haloperidol (antipsychotic): particularly if delirium present or likely

- Start with 1.5 – 5mg SC stat and 4 hrly PRN (0.5 – 2.5mg SC 4hrly PRN in the elderly)

- Maintain with 3 – 5mg / 24hrs via SD

Drug management 2nd Line *(use if not responding to a minimum of midazolam 30mg over 24hrs SC via SD)*

Levomepromazine (sedative, antipsychotic, antiemetic)

- PRN starting dose 12.5mg 1 hrly SC
- 24hr starting dose 12.5-25mg SC via SD
- It is a long acting drug so give a loading dose of 12.5mg when starting SD
- Titrate SD dose as required
- Normally maximum effective dose in SD 200mg/24hrs
- Normally used in addition to midazolam.

Drug management 3rd Line *(consider if not responding to a minimum combination of midazolam 60mg and levomepromazine 100mg)*

Phenobarbitone (sedative and anticonvulsant)

Only under the guidance of the specialist palliative care Consultant (the Consultant can be contacted out of hours through Marie Curie Hospice on 01274 337000 or Manorlands 01535 642308)

- PRN dose can be given either IM or through IV titration
- PRN dose IV/IM is 200mg
- Continue midazolam and levomepromazine unless there is concern for paradoxical agitation
- If IV route available phenobarbitone should be given as an IV bolus of 200mg/1ml diluted to 10ml with WFI over 2 minutes.
- If no IV route give 200mg undiluted as an IM injection
- If patient remains unsettled after 30mins repeat 200mg IM/IV
- If patient remains unsettled after a further 30mins repeat 200mg IM/IV
- If patient remains unsettled give 200mg IM/IV every hour

Once patient is settled:

- Start 24hr SD containing either 800mg or more if initial settling dose >600mg (do not mix in a SD with other medication)
- ensure PRN phenobarbitone 200mg can be given 1 hrly
- Review SD dose after 24hrs and increase as necessary
- Normal maximum effective dose in SD 2400mg/24hrs

References

1. Adam J. ABC of Palliative Care. The last 48 hours. BMJ 1997; 315 :1600 -03
2. Chater S et al. Sedation for intractable distress in the dying. Palliative Medicine 1998;12:255-69
3. Twycross R, Wilcock A. Symptom management in advanced cancer. Third edition.

4. Changing Gear. Guidelines for managing the last days of life in adults. 1997; The National Council for Hospices and Specialist Palliative Care services.
5. Twycross R, Wilcock A, Howard, P. PCF 6.
6. Dickman A, Schneider J, Varga J. The syringe driver.2nd edition. Oxford University Press
7. Cherny NI, Fallon MT, Kaasa S, Portenoy R, Currow DC. Oxford Textbook of Palliative Medicine. Fifth ed.