Pain Management in Advanced Illness and towards the End of Life

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Speaker Disclosure
I have NO actual or potential conflict of interest to disclose in relation to this program or presentation.

Goals
1. Appreciate the concept of “total pain”
2. Describe the importance of pain assessment
3. Develop a systematic approach to assess pain and related symptoms in seriously ill patients
Concept of Total Pain...

The suffering that encompasses all of a person's physical, psychological, social, spiritual, and practical struggles.

Dame Cicely Saunders

Prevalence of Pain in Seriously Ill (Palliative) Patients

- Cancer: 35% to 96%
- Heart Disease: 63% to 80%
- COPD: 34% to 77%
- Renal Disease: 47% to 50%
- AIDS: 63% to 80%
Where do Patients Die vs. Where do they Want to Die?

- Hospital 50% 1st choice Home
- Nursing Home 30% 2nd choice Hospital
- Home 20% NEVER Nursing Home

End-of-Life/Palliative Education Resource Center (EPERC), The Medical College of Wisconsin, 2008 http://www.mcw.edu/palliativecare/EPERC.htm

Who is sick?

Patients are sick when because of impairments of function they cannot pursue their purposes and goals.

Erik Cassel, M.D.

Achieving Quality of Life at the End of Life

- Maintaining and/or maximizing physical function
- Control of physical symptoms
- Management of psychological, social and spiritual issues
Symptom Management

- Pain
- Nausea/Vomiting
- Dyspnea
- Constipation
- Anxiety
- Delirium
- Depression
- Anorexia
- Fatigue

Assessment of Pain

- Where is the pain?
- When did the pain start?
- Describe the pain
- Are there any alleviating or precipitating factors

Symptoms are under-reported by patients unless standardized questionnaire used

White C, et al. “Now that You Mention It, Doctor, ...” Symptom Reporting and the Need for Systematic Questioning in a Specialist Palliative Care Unit, J Pain Palliat Care Pharmacother 2009; 23(5):447-450
Assessment of Pain

- Assessed regularly
- Direct communication with patient
- Cognitively impaired or patient cannot communicate:
  - Grimacing, moaning, tachycardia, tachypnea, agitation, tenderness to palpation
  - Discuss with family members/caregivers
Assessment of Pain:

Alzheimer’s (Major Neurocognitive Disorder)

Score: 1-3=Mild, 4-6=Moderate, 7-10= Severe

Warden et al 2003)

Barriers to Assessment:

Patient and Family

▶ Stoicism (individual/culture)
▶ Denial: linking pain to deterioration
▶ Cognition/Affect
▶ Fear
▶ that increasing pain is a herald of disease progression
▶ of addiction and abuse

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Barriers to Assessment:

Health Care Providers

▶ Inadequate assessment
▶ Fear: doing harm, diversion, legal issues
▶ Excluding non-pharmacological modalities
▶ Poor recognition of “global” pain
▶ Psychological
▶ Social
▶ Cultural
▶ Spiritual

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Barriers to Assessment: HealthCare System

- Restrictive formularies
- Cost/Access
- Limited insurance coverage for pharmacological and nonpharmacological modalities (PT, Mental health counseling)
- Lack of pain and palliative care specialists
- Lack of support for education

Mayhara et al 2015.

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Pain Management: General Guidelines

- Identify and treat the underlying cause when possible
  - Visceral/Somatic, Neuropathic Pain
  - Pain associated with depression, anxiety, or existential stress

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Pain Management: General Guidelines

- Visceral Pain: organs, obstruction, perforation (deep, squeezing, colicky)
- Somatic Pain: skin, muscle, bone (aching, gnawing,) well localized
- Neuropathic Pain: (burning, shooting, shock-like)
- Pain associated with depression, existential pain: difficult to categorize, altered affect

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Pain Management: General Guidelines

- **Visceral Pain**: Tx with IV route, NSAIDS, opioids, ketamine
- **Somatic Pain**: Tx with acetaminophen, NSAIDS, steroids
- **Neuropathic Pain**: Tx with gabapentin, pregabalin, SNRI, nerve blocks
- **Other Pain**: Pain associated with depression, existential pain
  - SSRI, SNRI,
  - multidisciplinary team including social workers, chaplains

Someone can have one, two, three, or more sources of pain. Multiple etiologies of pain often exist.

Bone Pain: Metastases, compression or pathologic fxs
- Constant, worse with movement
- Prostaglandins from metastases/inflammation
- Rule out cord compression

Tx with:
- Opioids, NSAID’s, corticosteroids, bisphosphonates
- Radiation therapy, orthopedic intervention
- External bracing
- Consultation
# Pain Management: General Guideline

- Start with NSAIDs or Acetaminophen
- If not controlled augment: consider opioid for mild to moderate pain (e.g., Tramadol)
- Consider stronger opioid for moderate to severe pain (Morphine, Oxycodone, Hydromorphone)
- Pain can have more than one underlying cause!

# Pain at End of Life (days)

- Opioids are often utilized
- Liquid Concentrates very helpful, easy to administer sublingual (Morphine 20 mg/1 ml)
- Schedule around the clock dosing
- Add breakthrough dosing (perhaps with a different Rx)
- Don’t forget about constipation (Quality measure)

# Opioid: Morphine

- Mechanism of action:
  Binds to opioid receptors (mu, kappa, delta and others) in the CNS, causing inhibition of ascending pain pathways, altering the perception of and response to pain
  Decreases the sensation of “breathlessness” through a mechanism that is not well defined
UNDERSTANDING PAIN

Physiologic Stimulus
- Nociceptive
- Neuropathic

Biopsychosocial
- Spiritual Context
  - Sympathetic arousal
  - Inflammatory status
  - Resilience

Physical
- Work status
- Relationships
- Financial status

Psychological
- Coping

Social
- Secondary gain

Spiritual
- Religious faith
- Existential issues
- Purpose

Experience of Pain

THE IMPACT OF PAIN

SLEEP DISTURBANCE
SUBSTANCE MISUSE
SECONdARY PHYSICAL PROBLEMS
FUNCTIONAL DISABILITIES
ANXIETY DEPRESSION
COGNITIVE DISTORTIONS
INCREASED STRESSES

Pain Management

Moderate Pain: Immediate Release (IR) Opioids
- Tramadol (PO)
- Morphine (PO/SL, SQ, IV)
- Oxycodeone (PO)
- Hydromorphone (PO/SL, SQ, IV)
- Fentanyl (Transdermal Patch, IV)
e.g.: Morphine 5 mg SQ q 4 h ATC and q1h as needed for pain and/or dyspnea

Severe Pain: Long-acting (LA) Opioids with SL doses for prn or incident pain
e.g.: Morphine Sulfate LA (MS Contin) 15 mg q 12 hours with morphine IR (Roxanol) 5 mg q 1 h prn
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Opioids: Dosage and Administration

▶ Morphine (“Opioid Naïve”):

- PO/SL: 5 mg PO q 4 hrs. PRN
- SQ/IV: 2 mg SQ q 4 hrs. PRN

▶ Patients on stable ATC opioids may experience breakthrough pain.
- Disease progression vs new or unrelated pain
- Identify cause or precipitating factors

Scheduled doses for breakthrough - based on amount of PRN medications required in a 24hr period

▶ Dose for breakthrough: using an IR is 5%-15% of total daily opioid dose, administered at an appropriate interval and never use ER/LA for breakthrough

Know the Risk Factors for Respiratory Depression

Generally preceded by sedation and decreased respiratory rate

Risk factors for respiratory depression include:

- Sleep apnea or a sleep disorder diagnosis
- Morbid obesity with a high risk of sleep apnea
- Snoring
- Risk increases with age (>60)
- No recent opioid use
- Post-surgery (particularly upper abdominal or thoracic)
- Use of other sedating agents (CNS depressants), such as benzodiazepines and alcohol
- Preexisting pulmonary or cardiac disease or dysfunction or major organ failure
- Smoking

Opioid Side Effects

- Most Common
  - **Constipation** (Tolerance does not develop)
    - Drowsiness
    - Nausea
    - Vomiting
  - Risk is increased in elderly patients

Opioid Formulations

Immediate Release (Short Acting):
- For opioid naive
- For pain crisis

Long Acting formulations:
- Reserve for stable situation.
- Add short acting opioids for breakthrough pain

Opioid Neurotoxicity

Clinical:
- Myoclonus, hallucinations, cognitive impairment, delirium, severe somnolence, dysesthesia, allodynia

Mechanism unclear

Management strategies:
- Switching opioids (rotation)
- Decreasing opioid dose (if pain is well controlled)
- Hydration
Adjuvants for Neuropathic Pain

First Line:
- gabapentin, pregabalin, TCA
- Start low and go slow, do not titrate before 5 days

Second Line:
- pregabalin
- corticosteroids

Third line:
- ketamine, lidocaine

Adjuvants for Bone Pain

NSAIDS
- Limited use for severe pain
- Awareness of risks: renal function/GI bleed

Steroids
- Can be beneficial quickly
- Awareness of "roid rage"

Radiation Therapy
- 85% response rate within 1-2 weeks
- Analgesia can last months
- Consider life expectancy, can patient tolerate transport mechanics

Constipation
- Patients with advanced illness are often on opioids which can contribute to constipation
- Always start bowel regimen at the time opioids are initiated:
  - NOT colace
  - Stimulant (i.e. senna) recommended initial medication
- Consider making changes to bowel regimen if patient does not have a bowel movement after three days
Constipation: OMM
- Cross-fiber kneading and inhibition (sustained pressure) to the paraspinal musculature
- Passive joint mobilization of the thoracolumbar spine @ T10-L2
  - Influence the sympathetic nervous supply to colon
- Indirect osteopathic techniques to the abdominal viscera
  - To treat abdominal bloating
- Strain-counterstrain over the ileocaecal valve and gastroduodenal junction in the epigastric region
  - Influencing smooth muscle contracture
- Manipulation of the colon using direct visceral techniques
  - Re-dooming the diaphragm
  - “Mesenteric Lift”
  - “Colonic Stim”
  - “Sacral Rocking”

**Constipation: Oral Treatment**

- Bulk forming laxatives
  - Avoid psyllium unless hydrating with at least 500mL water
- Surfactants (stool softeners)
  - Docusate Sodium (Colace) - not great
- Osmotic Agents
  - Polyethylene (Miralax), Lactulose, Sorbitol
  - Glycerin (suppository), Magnesium Citrate
- Stimulant Laxatives
  - Senna, Bisacodyl especially if on opioids!

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**Opioid Induced Constipation**

**Currently Approved Therapies**

<table>
<thead>
<tr>
<th>Agent</th>
<th>Lubiprostone</th>
<th>Methylnaltrexone</th>
<th>Naloxegol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism of Action</td>
<td>Chloride channel activator</td>
<td>Reciprocal opium receptor antagonistic (NORAA)</td>
<td>Reciprocal opium receptor antagonist (NORAA)</td>
</tr>
<tr>
<td>Route of Administration</td>
<td>Oral</td>
<td>Subcutaneous</td>
<td>Oral</td>
</tr>
<tr>
<td>Recommended Dose</td>
<td>24 mcg</td>
<td>12 mg/4 mL</td>
<td>25 mg/13 mg</td>
</tr>
<tr>
<td>Dosing Frequency</td>
<td>Twice daily</td>
<td>Once daily</td>
<td>Once daily</td>
</tr>
<tr>
<td>Clinical Considerations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Take with food and water
- Do not exceed or use for length of opioid treatment
- Take an extra dose if constipation persists
- Do not substitute for another opioid

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**Diarrhea - Causes**

- Infections
- GI bleeding
- Malabsorption
- Medications
- Obstruction
- Overflow incontinence
- Stress
Management Approach to Dyspnea

- Screen
- Assess

- Identify and treat underlying causes if possible and if appropriate
- Treatment of symptom
- Communicate: Explain situation to patient and family and reassure

Dyspnea: “Breathlessness”

- Assessing dyspnea is subjective
  - Respiratory rate, O2 saturation, lab studies, ABGs, PFTs may not be accurate in predicting presence or severity of dyspnea
- Look at the patient for signs of distress (i.e. use of accessory muscles, tachypnea, tachycardia)
- Ask patient about severity of dyspnea if patient can communicate

Breathlessness - Causes

- Anxiety
- Airway obstruction
- Bronchospasm
- Hypoxemia
- Pleural effusion
- Pneumonia
- Pulmonary edema
- Pulmonary embolism
- Thick secretions
- Anemia
- Metabolic
- Family / financial / legal / spiritual / practical issues
Prevalence of Dyspnea in Serious Illness

<table>
<thead>
<tr>
<th>Population</th>
<th>Prevalence of dyspnea (percent)</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (mixed)</td>
<td>10 to 70</td>
<td>Solano 2006(1)</td>
</tr>
<tr>
<td>AIDS</td>
<td>11 to 62</td>
<td>Solano 2006(1)</td>
</tr>
<tr>
<td>Lung cancer (primary or metastatic)</td>
<td>82 to 85</td>
<td>Solano 2006(1)</td>
</tr>
<tr>
<td>Heart disease</td>
<td>60 to 88</td>
<td>Solano 2006(1)</td>
</tr>
<tr>
<td>COPD</td>
<td>90 to 95</td>
<td>Solano 2006(1)</td>
</tr>
<tr>
<td>Renal disease</td>
<td>11 to 62</td>
<td>Solano 2006(1)</td>
</tr>
<tr>
<td>Stroke</td>
<td>37</td>
<td>Addington-Hall 1992(1)</td>
</tr>
<tr>
<td>ALS</td>
<td>47 to 50</td>
<td>O'Brien 1992(11), Hela 1992(12)</td>
</tr>
<tr>
<td>Dementia</td>
<td>70</td>
<td>Lloyd-Williams 1996(13)</td>
</tr>
</tbody>
</table>
| No cardiopulmonary disease (e.g., no primary or secondary lung pathology, cardiac failure, or respiratory disease) | 45 to 81 | Curren 2010(14)  

Dyspnea: Specific causes and treatments
- CHF
  - Diuretics
- COPD
  - Bronchodilators
  - Corticosteroids
- Ascites
  - Furosemide
  - Spironolactone
  - Drainage
- Anemia
  - Blood Transfusion
- Infection
  - Antibiotics
  - Antivirals
  - Antifungals
- Depression
  - SSRI, SNRI
  - Therapy
- Anxiety
  - Benzodiazepine
- Pain

Dyspnea Treatment
- **Opioids**: First Line Agents?
- Oxygen
- Bronchodilators
- Steroids
- Anticholinergics

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Oxygen
- Benefit of supplemental oxygen is uncertain in patients with advanced terminal illness
- ACP recommends supplemental oxygen if patient is hypoxic
- Supplemental oxygen is routinely given in clinical practice as a comfort measure
- Placebo effect may play a role in relief of dyspnea

Non-Pharmacological
- Provide a calm environment
- Keep the room at as cool a temperature as tolerated
- Provide a fan at bedside
- Upright sitting position
- Play comforting music or read to the patient
- Encourage family members to visit

Respiratory Secretions
- Anticholinergics
  - Glycopyrrolate - 0.2 mg SQ q 4 to 6 hrs
  - Scopolamine Patch - 1 - 2 patch(es) q 72 hrs
  - Atropine - 1 to 2 drops sublingual every 4 to 6 hrs
  (Suction: should be avoided as it causes discomfort and anxiety)
Nausea and Vomiting

Nausea is reported more commonly than vomiting

- Common causes:
  - Opioids
  - Chemotherapy
  - Radiation
  - Gastroparesis
  - Organ failure
  - Bowel obstruction
  - Constipation
  - Ascites
  - Pain
  - Anxiety
  - Malignancy
  - Gastritis
  - Metabolic abnormalities
  - Constipation

Non-Pharmacological Interventions:

- Avoid sights or smells associated with nausea
- Maintain a quiet and relaxing environment
- Provide small, frequent meals chosen by patient
- Provide frequent liquids
- Music therapy
- Relaxation techniques
- Companionship

Vomiting Center (Central Pattern Generator)
Nausea and Vomiting

- **Dopamine receptor antagonists**
  - Haloperidol (Haldol): Often used in Hospice
    - Initial dose: 0.5 to 1 mg PO/SL/SQ q 2 h PRN
  - Metoclopramide (Reglan)
    - Also acts as a prokinetic agent
      - First line agent for gastroparesis
  - Prochlorperazine (Compazine)
    - Rectal suppositories are a last resort, least comfortable option

  Monitor for EPS, dystonia if using dopamine antagonists

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Nausea and Vomiting

- **Antihistamine (H1 receptor, Vestibular system)**
  - Meclizine (Antivert): Vertigo
    - Dimenhydrinate (Dramamine): Motion sickness
    - Diphenhydramine (Benadryl)
    - Promethazine (Phenergan)

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Nausea and Vomiting

- **Anticholinergics**: Motion sickness
  - (Muscarinic antagonists)
    - Scopolamine Transdermal - also good for management of secretions (time to onset)

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Nausea and Vomiting

- 5-HT3 receptor antagonists
  - Ondansetron (Zofran)
  - Granisetron
  - Dolasetron
  - Palonosetron
  - Tropisetron

Clinical indications: Chemotherapy, Radiation, Post-op

Management of Diarrhea

- Establish normal bowel pattern
- Avoid gas-forming foods
- Increase bulk
- Transient, mild diarrhea
  - attapulgite (Kaypectate)
  - bismuth salts (PeptoBismol)
- Persistent Diarrhea
  - Loperamide (Imodium)
  - Diphenoxylate/atropine (Lomotil)

“Man lives in three dimensions: the somatic, the mental, and the spiritual. The spiritual dimension cannot be ignored, for it is what makes us human.”

Victor Frankl

*Man's Search for Meaning*
Anxiety

Often described as a feeling of “helplessness” or “fear”

Anxiety can be related to many factors
  • Psychological
  • Physical
  • Social
  • Spiritual

Anxiety: Clinical Manifestations

▶ Emotional Symptoms
  ▶ Irritability, feelings of impending doom
  ▶ Changes in behavior
  ▶ Avoidance, psychomotor agitation, compulsions

▶ Autonomic Symptoms
  ▶ Tachycardia, tachypnea, dizziness, diaphoresis, nausea

▶ Expressions of fear about death, concerns about religious beliefs

Anxiety: Treatment

▶ Acute exacerbation - benzodiazepines
  PO/SI/SQ
  ▶ Alprazolam (Xanax)
  ▶ Diazepam (Valium)
  ▶ Lorazepam (Ativan) 0.25 mg to 2 mg e.g., Lorazepam 1 mg PO/SI q 4 h ATC and 1 mg q 2 h PRN for anxiety

▶ Psychotherapy, OMM, Cognitive Behavioral Therapy

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Depression

- Underdiagnosed and undertreated
- Reduced quality of life, greater difficulty in managing illness, decreased adherence.
- Impaired capacity for pleasure, meaning, connection,
- Amplifies pain and other symptoms, and causes anguish and worry in family members and friends
- Interferes with the emotional work - of separating and saying goodbye

Screening for Depression

- Depressed mood, sadness, grief, and feelings of loss: all appropriate responses to advanced disease and dying
- Feelings of hopelessness, helplessness, worthlessness, guilt, and suicidal ideation (even mild or passive) are among the best indicators of depressive syndromes in patients with advanced disease
- PHQ-9, Geriatric Depression Scale, Edmonton Symptom Assessment Scale

Depression: Treatment

- Psychostimulants - for patients with short life expectancy (days to weeks)
  - Dextroamphetamine
  - Methylphenidate
  - Modafinil
  - Onset of action in 24 to 48 hrs
- SSRIs, SNRIs
  - the latter especially if pt also has neuropathic pain
- TCAs
  - Efficacious
  - may take several weeks
Depression

▶ Grief and Bereavement are natural attendants to the Dying Process
▶ Pastoral Care
▶ Spiritual nursing
▶ Cognitive Behavioral Counseling
▶ Aromatherapy
▶ Music therapy

Screening for Depression

▶ Screening for depression should be carried out in all palliative care patients given the high prevalence of symptoms
▶ American Society of Clinical Oncology recommendations
  “Every patient with cancer should be screened for depression when the initial diagnosis of cancer is made and periodically thereafter as clinically indicated, especially with changes in cancer or treatment status (e.g., post-treatment, recurrence, or progression) as well as transition to palliative care.”

Delirium

▶ Definition: a disturbance of consciousness and cognition of sudden onset and can be accompanied by psychomotor agitation
▶ Estimated to occur in 25% to 85% of terminally ill patients (often hypOactive)
▶ The most common neuropsychiatric complication seen in cancer patients nearing end of life
▶ Hyperactive delirium can cause significant distress for patients and family members
Delirium often multifactorial

Contributing Factors
- Metabolic abnormalities
  - Hypercalcemia, Uremia
- Organ failure
  - Kidney, Liver
- Infection
- Brain tumor
- Metastases
- Opioid induced neurotoxicity
- Benzodiazepines
- Anticholinergics
- Glucocorticoids
- Dehydration

Delirium: Treatment
- Haloperidol (Haldol)
  - Dose: 0.5 to 1 mg PO/SQ q 2 h PRN
  - If symptoms of delirium persist after 24 to 48 hrs of administering full doses of Haloperidol, then consider more sedating neuroleptics such as Chlorpromazine (Thorazine)
- Always consider reversible causes
Anorexia

▶ Reduced caloric intake, loss of appetite
▶ In patients with chronic serious and/or life threatening illness, weight loss associated with poorer outcomes
▶ Contributing factors include chronic nausea, constipation, taste alterations, xerostomia, dyspnea, and depression

Anorexia

Pharmacological Interventions:
- Glucocorticoids
- Megestrol acetate
  - Risk of DVT, thromboembolism
- Dronabinol
  - FDA approved for anorexia associated with AIDS
- Mirtazapine (?)

Fatigue

Pain
Psychological factors
Endocrine abnormalities
Paraneoplastic neurological syndromes
Autoimmune failure
Metabolic abnormalities
Cancer therapy
Deconditioning
Dehydration
Anemia
Infection
Anemia
Infection
Fatigue
Pre-existing comorbidities
Cachexia/malnutrition
Cachexia/malnutrition
After Addressing the Underlying Cause(s) and Potential Contributors to Fatigue, Consider:

- Psychostimulants
  - Methylphenidate, modanafil, pamoline
- Cholinesterase inhibitors
  - Donepezil
- Corticosteroids
- Progestational agents
  - Megestrol acetate
- IN ALL PATIENTS, CONSIDER NONPHARMACOLOGIC MEASURES
  - Education, counseling
  - Exercise program, energy conservation
  - Reassessment at regular intervals

Normal Dying Process

- Loss of appetite
- Decreased oral fluid intake
- Decreased urine output
- Less frequent bowel movements
- Less alert, sleeps more
- Possibly mild confusion

Normal dying process

- Gradual dehydration causes endorphin release
- Artificial food / fluids may make situation worse by causing
  - Nausea / vomiting
  - Difficulty breathing
  - Edema, ascites
Nutrition and Hydration

- The majority of patients with advanced illness will experience decreased oral intake as they approach end of life
- Decreased oral intake is a source of significant distress for family members
- Artificial nutrition and hydration is not indicated

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MEDICATIONS - when the end of life is near

- Reassess; limit to essential medications
- Choose less invasive route of administration
  - Buccal mucosal or oral first, then consider rectal
  - Subcutaneous, intravenous only if necessary
  - Intramuscular almost never

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Medications: Routes of Administration

- PO/SL
- SQ/IV
- Transdermal
- CADD Pump
- Rectal
The Comfort Kit aka Emergency Medication Kit

- "It was there for when the pain became too intolerable and that the oral medication wasn’t going to be sufficient, and to give her better pain relief and to make her more comfortable."
- "I wasn’t going to administer anything but... the nurses were... available to us and that was great."
- "I was particularly grateful that he was able to be kept comfortable ongoing without us having to wait for someone to come."
- "My only concern was that if anybody found out it was there, I didn’t really have a safe secure place to keep it..."


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Typical Composition of a Comfort Kit

- Pain/Dyspnea
  - Morphine/opioid (Roxanol 20mg/mL)
  - Lorazepam
- Anxiolytic
  - Lorazepam
- Delirium
  - Haloperidol
  - Lorazepam
- Seizures
  - Lorazepam
- Anxiety/Insomnia
  - Lorazepam
- Oral secretions
  - Atropine drops
- Antiemetic: haloperidol, prochlorperazine, promethazine
- Constipation
  - Sennosides
  - Bisacodyl suppositories
  - Fleets enema
- Antidiarrheals
  - Bisacodyl suppositories
  - Fleet’s enema

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Connection:

- And the Power of Compassionate Presence
Summary

- Patients with advanced illness commonly present with pain and other distressing symptoms.
- Assessing and managing symptoms appropriately provides comfort to patients as they approach the end of life.
- Understanding pain as a component of “total pain” can help clinicians identify areas of concern.

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