6 PALLIATIVE CARE FOR PATIENTS WITH COVID-19

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MODULE 6: PALLIATIVE CARE OF PATIENTS WITH COVID-19

KEY RECOMMENDATIONS

- Palliative care of COVID-19 patients includes the alleviation of symptoms causing distress, and the promotion of a dignified death.
- The most common physical symptoms requiring palliation include breathlessness, anxiety, increased secretions, cough and fever. These can be at least partly alleviated via the judicious use of symptomatic treatment.

In terms of the National Policy Framework and Strategy on Palliative Care, palliative care is the holistic multidisciplinary care of a patient and family affected by a life-limiting or life-threatening illness. It is applicable from the time of diagnosis onwards for all adults and children across their lifespan, and includes bereavement care for the family.[1] It is an approach that aims to improve the quality of life of patients, caregivers and families by preventing and alleviating suffering through early identification, assessment and management of pain and other physical, spiritual or psychosocial conditions.[2]

While the palliative care principles of symptom control, and psychosocial and spiritual support are relevant from the time of diagnosis, this particular section is relevant to the care of severely ill patients who are not candidates for more intensive management and are deteriorating despite best supportive care. The goal in these patients is to alleviate the symptoms that cause distress and to promote a dignified death.

- Spiritual and psychological well-being are paramount, since many of these patients may die alone in a room without their loved ones present. To this end:
  - Explain the prognosis to the patient and their family.
  - Encourage them to talk to their family/friends by phone if possible.
  - Guide families on how to communicate with the patient, if this is needed.
  - Refer patients and families to the palliative care team (if available) for further counselling as required. If a palliative team is not available, seek resources such as hospices, non-governmental or faith-based organisations that are willing to assist with counselling services.
  - Ensure privacy for patients and their family.

- The most common physical symptoms requiring palliation include breathlessness, anxiety, increased secretions, cough and fever, as well as constipation from opioid use.
  - Interventions include non-pharmacological and pharmacological strategies.
  - Do not withhold medications for fear of respiratory depression.
  - Doses in this guideline are a starting point and can be increased as necessary.
  - The side effects of the medicines should be explained to the patient. Some may cause increased confusion and should be explained to the family (telephonically).

- Stop vital signs monitoring and routine blood tests during this phase of illness as this is uncomfortable for the patient and causes unnecessary contact.

- If the patient is unable to eat, do not use artificial (NGT/PEG, etc.) nutrition. Offer oral fluids as tolerated.
- Unnecessary medications for control of chronic illnesses may be stopped, unless essential for acute symptom management.
- Regular mouth care (cleaning and keeping moist) and skin care (regular turning) is essential.

A table of palliative symptom management options is provided below.[3]

- If a patient is unable to swallow, morphine-controlled release tablets may be administered rectally.
- Some oral medications (but not slow/prolonged release formulations) may be crushed or capsules emptied into liquid and administered orally.
- If IV access is not available, medications may be administered subcutaneously (SC) through either a primed butterfly needle sited on the upper chest or back above the scapula and secured with a transparent dressing, or with a portable syringe driver (if available).

Table 1: Symptoms and suggested treatment

Symptom	Non-pharmacological	Pharmacological
Fever	Cool cloth	Paracetamol 500mg - 1g PO 6 hourly/prn
Nausea		Metoclopramide 10mg PO/IVI/IM 8 hourly/prn If metoclopramide is ineffective or contra-indicated (i.e. inoperable bowel obstruction): haloperidol 1.5–5mg PO daily
Breathlessness	Open window – fresh air Sit upright	Start with morphine syrup at 2.5 – 5mg PO prn, if > 2 doses needed /24 hours: Morphine-controlled release tablets 10mg 12 hourly OR Morphine syrup 2.5 – 5mg PO 6 hourly/prn If cannot swallow – Morphine sulphate 1mg IVI/SC – can repeat 6 hourly if necessary If severe underlying respiratory disease (e.g. COPD): start with morphine syrup 1mg PO prn/6 hourly) If able to swallow tablets, can convert to morphine-controlled release tablets (24-hour requirement/2 given 12 hourly) Give nausea prophylaxis and add laxatives Increase doses as required for symptom control
Cough		Morphine as above
Anxiety – can contribute to breathlessness	Deep breathing Talking to family may help Counselling	Benzodiazepine – e.g. diazepam 2.5-5mg PO. Repeat if required up to 12 hourly. OR lorazepam 0.5-1mg PO. Repeat as necessary to control symptoms. If patient unable to take oral medication: midazolam SC/IV 1-5mg as needed; titrate to effect.

Symptom	Non-pharmacological	Pharmacological
Respiratory secretions	Position semi-prone for postural drainage or sit upright/semi-recumbent if pulmonary oedema or reflux	Hyoscine butylbromide 20mg SC/IM. Increase dose to effect to maximum of 120 mg.
Delirium	Orientation Treat other symptoms – pain, hypoxia, anxiety	Haloperidol 0.5 mg 8 hourly PO/IVI/SC. Titrate dosage up as required and use the minimum dose that controls the symptoms. In the elderly or where there is no response or resistance to haloperidol: ADD lorazepam 0.5-1 mg 2-4 hourly PO as required. Tablets may be crushed and administered sublingually. OR in patients unable to swallow: midazolam 0.5-5 mg SC/IV immediately. Titrate up slowly. Lower doses are indicated for patients with liver dysfunction.
Constipation (side-effect of opioids)		The combination of a softener and a stimulant laxative is generally recommended, and the choice of laxatives should be made on an individual basis. Sennosides A and B, 13.5mg PO at night. In resistant cases, increase to 2 tablets AND/OR Lactulose 15-30ml 12-24 hourly PO. Severe constipation in patients who are unable to swallow: bisacodyl 10mg suppository PR daily OR glycerine (glycerol), 2.4g suppository PR when necessary.

Remember:

- Continue supplemental oxygen as needed.
- Stop artificial fluids/feeds – continue orally as tolerated.
- Continue regular mouth and skin care as far as contact precautions allow.
- Allow the patient to talk to family using their own phone if possible.

REFERENCES

1. National Policy Framework and Strategy on Palliative Care 2017 – 2022. National Department of Health. http://www.health.gov.za/index.php/2014-03-17-09-09-38/policies-and-guidelines.
2. WHO Definition of Palliative Care. http://www.who.int/cancer/palliative/definition/en/ (accessed 15/08/2016).
3. Twycross R, Wilcock A, eds. PC4 Palliative Care Formulary, 4th Edition. Nottingham. United Kingdom: Palliativedrugs.com LTD, 2011.