Symptom Management in Comfort-Focused Care Plan During COVID-19 Pandemic

Dyspnea/Labored Breathing:

- Opioids are gold standard for managing air hunger at end of life
  - **See attached flow chart for opioid management of dyspnea**
- For co-existing anxiety associated with dyspnea:
  - Administer benzodiazepine (e.g. **Lorazepam 1-2mg PO q2hrs or 0.5-1mg IV q1h prn**)
    - If possible, avoid benzodiazepines for patients at risk for paradoxical delirium (e.g. existing dementia, age>65, existing encephalopathy/delirium)
    - For such at-risk patients, instead consider a neuroleptic agent as first line (e.g. **Haloperidol 1-2mg IV q2 hr prn** or **Olanzapine 2.5-5mg PO/SL q6h prn**)
      - If anxiety remains uncontrolled after a neuroleptic administered regularly, *then* consider addition of benzodiazepine as above

Terminal Delirium:

- Counsel family on causes of delirium and possibility that delirium may not resolve despite best efforts
- Nonpharmacologic measures should always be implemented: eg. blinds up/lights on during day, removing tethers, familiar faces/providers at bedside, minimizing nighttime disruptions, avoiding anticholinergic medications
- Pharmacologic measures for agitated delirium: **Haloperidol 2-4mg IV q2h prn**
  - Haloperidol dose can be escalated (monitor for extrapyramidal symptoms) or medication can be rotated to **Olanzapine 2.5-5mg q6hrs PO prn** if no response to haloperidol and able to take POs.
  - If patient has Parkinson's or Lewy Body Dementia, avoid haloperidol/olanzapine and instead replace with **Quetiapine 25-50mg PO q8h prn** (if able to take PO)
  - If further advice needed, place palliative care consult for virtual consult assistance.

Terminal Secretions (upper airway):

- Counsel family that patient is not 'drowning' and that sound is air passing through pooled saliva (more uncomfortable to family to hear than patient, as patient is usually not conscious at this stage)
- Avoid deep suctioning as may trigger discomfort and gag reflex. Consider gentle oral suctioning and/or laying patient in decubitus position to allow saliva to drain
- Manage with **Glycopyrrolate 0.2-0.4 mg IV q6h prn** (low threshold to change to scheduled dosing if needed)
- If patient with low risk of delirium or already obtunded, can consider addition of **transdermal scopolamine** (with understanding that patch takes at least 12 hours to be absorbed and take effect)
- Avoid nebulized saline to thin secretions to avoid aerosolizing virus

Constipation (recommend for any patient on opioid therapy):

- If able to take oral agents, start:
  - **Senna 2 tabs PO qhs**, can increase up to 2 tabs PO TID if needed
  - **Polyethylene Glycol 17gm packet PO QD-BID prn**
  - Avoid Docusate given lack of data demonstrating benefit
  - If unable to take oral agents, suggest **Bisacodyl suppository PR daily prn** signs of abdominal discomfort/distention likely due to constipation

Pain:

- Opioid bolus dosing is the quickest way to achieve pain control at end-of-life, can follow flow chart for dyspnea
- In patients who are of having possible COVID-19 or who have confirmed COVID-19, would avoid steroids for pain. There is limited data guiding practice regarding NSAIDs in patients suspected of having or with confirmed COVID.
- However, if no concern for COVID-19, NSAIDs or steroids may be used if indicated (unless viral symptoms develop, in which case stopping steroids agents should be considered, and judgement should be used regarding NSAIDs)

This document was prepared (in March, 2020) by and for MGH medical professionals (a.k.a. clinicians, care givers) and is being made available publicly for informational purposes only, in the context of a public health emergency related to COVID-19 (a.k.a. the coronavirus) and in connection with the state of emergency declared by the Governor of the Commonwealth of Massachusetts and the President of the United States. It is neither an attempt to substitute for the practice of medicine nor as a substitute for the provision of any medical professional services. Furthermore, the content is not meant to be complete, exhaustive, or a substitute for medical professional advice, diagnosis, or treatment. The information herein should be adapted to each specific patient based on the treating medical professional's independent professional judgment and consideration of the patient's needs, the resources available at the location from where the medical professional services are being provided (e.g., healthcare institution, ambulatory clinic, physician's office, etc.), and any other unique circumstances. This information should not be used to replace, substitute for, or overrule a qualified medical professional's judgment.

© Copyright 2020 The General Hospital Corporation. All Rights Reserved.

MASSACHUSETTS GENERAL HOSPITAL
DIVISION OF PALLIATIVE CARE AND GERIATRIC MEDICINE