End of life management of breathlessness and cough

This guidance provides first line management alongside alternative medications and routes of administration for patients with palliative care needs in the last days of life. For palliative management of these symptoms earlier in a person’s illness, please see MD164 Early management of intractable breathlessness (in the Kirkwood toolkit). For care of the dying patient with COVID-19, please also see the relevant toolkit documents.

### Breathlessness and cough at end of life

**First line: STRONG OPIOID**

- If opioid naïve with normal renal function: morphine sulphate 2.5-5mg SC PRN. Starting dose via syringe driver 5-10mg/24hrs
- If opioid naïve with eGFR <40: oxycodone 1.25-2.5mg SC PRN. Starting dose via syringe driver 5-10mg/24hrs
- If taking regular oral opioid: convert to appropriate syringe driver and PRN doses (see MD161 Opioid conversion chart in toolkit)

**Second line: MIDAZOLAM SC**

- PRN dose: 2.5-5mg SC
- Initial syringe driver dose 10-15mg/24hrs
- Maximum dose 100mg/24hrs
- Available formulations 10mg/2ml (2ml amps), 1mg/ml (2ml & 5ml amps)

If SC midazolam unavailable: BUCCAL MIDAZOLAM

- PRN dose: 2.5-5mg buccal dose
- Available formulations: oromucosal solution (5mg/ml) pre-filled syringes – 2.5mg, 5mg, 7.5mg and 10mg
- Health professionals should use caution in patients with suspected COVID-19 with all buccal and sublingual medicines due to proximity to oral secretions.

If other options unavailable: RECTAL DIAZEPAM

- Starting dose 2-5mg OD
- Maximum dose 30mg/24hrs in 3 divided doses
- Available as 1.25ml or 2.5ml tubes at strength of 2mg/ml

**PLEASE NOTE:** Lorazepam may be administered subcutaneously but only rarely and with caution via this route. Diazepam should never be administered subcutaneously (Palliative Care Formulary 6). Please contact Kirkwood Hospice for advice.

If viral infection suspected

Avoid corticosteroids unless absolutely necessary to treat underlying condition or to avoid steroid withdrawal

Avoid aerosol generating procedures and use nebulisers and high flow oxygen more carefully (as per PHE advice)