End of life management of delirium and agitation

This guidance is for management of delirium and agitation in those people who are in the last days of life, for whom treatment of reversible causes has either failed to control symptoms or is inappropriate. It may be for severe agitation that these drugs are used in combination.

Please see MD170 Early management of delirium and agitation in palliative care (in the Kirkwood Toolkit) for management of environmental and physical factors that may be contributing to agitation.

**Step 1: BENZODIAZEPINE**

First choice: MIDAZOLAM SC

- If benzodiazepine naïve – use 2.5mg SC initial PRN dose and assess response
- If background midazolam dose ≥ 30mg/24hrs – use 5mg initial SC PRN dose
- If background midazolam dose ≥ 60mg/24hrs – use 10mg initial SC PRN dose
- Start a syringe driver based on PRN requirements and response. Max dose 100mg/24hrs

If midazolam unavailable: Consider use of second line antipsychotic if solely treating agitation. If benzodiazepine required for multiple symptoms, see below options

**IF SYRINGE DRIVER UNAVAILABLE** (or midazolam unavailable but use of a benzodiazepine is required) options include:

- BUCCAL MIDAZOLAM 2.5-10mg buccal dose PRN. Dosing as per SC midazolam. Maximum 100mg/24hrs
- SUBLINGUAL LORAZEPAM 0.5-1MG PRN. Maximum 4mg/24hrs in divided doses. Please note not all brands are for sublingual use
- RECTAL DIAZEPAM 2-5mg PRN, maximum 30mg/24hrs in 3 divided doses

Please speak to Kirkwood Hospice for further advice at any time or if symptoms persist

**Step 2: Add in ANTIPSYCHOTIC**

First choice: LEVOMEPROMAZINE OR HALOPERIDOL in addition to first line drug

If hallucinations predominate: Haloperidol SC

- For terminal agitation, dose 3-5mg SC
- Can be administered as OD dose or via a syringe driver given its long half-life and duration of action
- Maximum dose 10mg/24hrs
- Will accumulate in renal failure and doses should be reduced

If agitation is severe or sedation is required: Levomepromazine SC

- For terminal agitation, dose 25-50mg SC (lower doses in renal failure)
- Can be administered via a syringe driver or as OD-BD daily dosing if syringe driver unavailable, given its long half-life and duration of action
- Maximum dose 300mg/24hrs

If injectable antipsychotics unavailable – see Kirkwood Toolkit document “COVID-19: Care of the dying patient when unable to obtain a syringe driver – non-injectable alternatives”

**Step 3**

Phenobarbitone 120-200mg IM can be administered in some cases of intractable distress at the end of life. If use of this medication is considered, please speak to Kirkwood Hospice.