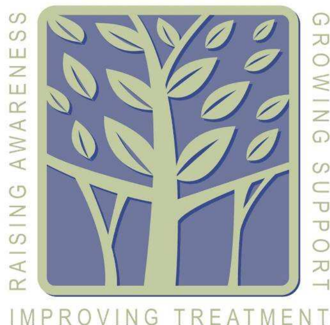

Global Year Against Cancer Pain

OCTOBER 2008 – OCTOBER 2009

Pain and Symptom Management During the Final Days of Life

Pain

It is critical to assess and manage cancer pain. Many patients at the end of life are unable to verbally report pain using standardized scales. In this situation, evaluate behavioral cues such as facial grimacing, guarding, or vocalizing. Rule out other potential causes of distress such as constipation, urinary distension, or emotional and spiritual distress.

Administration of opioids may be complicated by the inability to swallow. Alternate routes of administration include buccal, sublingual, rectal, subcutaneous, or intravenous delivery. Doses may be decreased in some cases, as organ system failure leads to reduced excretion of the drug and or its metabolites, as well as other factors. Myoclonus may occur when higher doses of opioids are administered, particularly in the face of renal dysfunction. Reducing the opioid dose or rotating to another opioid can be effective, and adding benzodiazepines can be helpful.

Other Common Symptoms at the End of Life

Dyspnea

Dyspnea or air hunger can occur due a variety of causes, including bronchospasm, effusions, airway obstruction, thick secretions, or hypoxia. Opioids are the first-line therapy for dyspnea; for opioid-naive patients, very low doses can be effective. Other agents that can be used include bronchodilators to treat bronchospasm, benzodiazepines to address anxiety, and corticosteroids to reduce inflammation and obstruction. Oxygen is sometimes useful in the hypoxic patient, although fans moving air across the face can often be as therapeutic and less costly.

Delirium

Identify and treat reversible causes, including polypharmacy, metabolic abnormalities or dehydration. Agents used to treat delirium include the following (i.v. = intravenously, p.o. = orally (by mouth), p.r. = rectally, p.r.n. = as occasion requires, s.c. = subcutaneously, s.l. = sublingually):

- Haloperidol: 1–4 mg p.o. or i.v./s.c. every 6 hours (may repeat every hour p.r.n. in severe delirium)
- Lorazepam: 0.5–2 mg p.o. or s.l. or i.v. every 4 hours p.r.n.
- Olanzapine: 2.5–20 mg p.o. every bedtime or orally disintegrating tablet 5–20 mg every bedtime
- Risperidone: 0.5 mg p.o. every afternoon, increase by 0.25–0.5 mg every 2–7 days
- Chlorpromazine: 12.5–25 mg p.o. or s.c. every 4–12 hours, or 25 mg p.r. every 4–12 hours (i.v. administration can cause hypotension; avoid unless other agents are ineffective and oral/rectal routes are unavailable)

Terminal Secretions

Terminal secretions (sometimes called the “death rattle”) are an accumulation of oral secretions that would normally be cleared but cannot be as the patient is growing weaker. Change the patient’s positioning, reduce parenteral and enteral fluids, and explain to family members that this is not believed to be uncomfortable for their loved one. Anticholinergic agents can be used to dry secretions, including:

- Atropine: 0.4 mg s.c. every 15 minutes
- Scopolamine: One or two 1.5-mg scopolamine patches, or scopolamine 50 mcg/hour i.v. or s.c.
- Glycopyrrolate: 1–2 mg orally or 0.1–0.2 mg i.v. or s.c. every 4 hours

Existential Distress

Some individuals fear the dying process, abandonment during this time, and the unknown after death. Offer spiritual and emotional support, and be present to the patient and his or her loved ones. Encourage life review as a method to provide meaning to the individual’s life.

Considerations When Caring for the Dying

- The patient and family (as defined by the patient) is the unit of care.
- Education of family members regarding signs of impending death will assist in reducing their anxiety.
- Collaborate with other members of the health care team (e.g., social workers, chaplains, and nurses) to provide emotional support to the dying patient and his or her family members.
- Provide reassurance and role model comforting activities.
- Honor the patient's culture; respect cultural preferences and rituals.
- Consider the developmental stage of any children involved (patients, siblings, children, or grandchildren) when communicating about death.
- Identify those family members at risk for abnormal grief reactions and refer them for counseling and support.

References

1. Bennett M, Lucas V, Brennan M, Hughes A, O'Donnell V, Wee B; Association for Palliative Medicine's Science Committee. Using anti-muscarinic drugs in the management of death rattle: evidence-based guidelines for palliative care. Palliat Med 2002;16:369–74.
2. Fürst CJ, Doyle D. The terminal phase. In Doyle D, Hanks G, Cherny NI, Calman K, editors. Oxford textbook of palliative medicine, 3rd ed. New York: Oxford University Press; 2004. p. 1117–33.
3. Lawlor PG, Gagnon B, Mancini IL, Pereira JL, Hanson J, Suarez-Almazor ME, Bruera ED. Occurrence, causes, and outcome of delirium in patients with advanced cancer: a prospective study. Arch Intern Med 2000;160:786–94.
4. Potter J, Hami F, Bryan T, Quigley C. Symptoms in 400 patients referred to palliative care services: prevalence and patterns. Palliat Med 2003;17:310–4.
5. Sykes N, Thorns A. The use of opioids and sedatives at the end of life. Lancet Oncol 2003;4:312–8.

© 2009 International Association for the Study of Pain®