

The following are medications for consideration in treating pain and symptoms of patients on PCAD:

PAIN MANAGEMENT

For Opioid-Naïve Patient:

Morphine Sulfate 15 mg po or 5 mg SQ/IV.
Repeat q 1 hr until pain relief is adequate. Begin Morphine Sulfate 30 mg po or 10 mg SQ/IV q 4 hr ATC or begin IV Morphine Sulfate basal infusion at 2 mg per hour and 2 mg SQ/IV q 1 hr prn.

For Opioid-Treated Patient:

If pain uncontrolled, increase fixed schedule dose by 50%.

Many non-opioid analgesics are available and should be considered after opioid therapy has been optimized. If pain remains uncontrolled, consider consult to Department of Pain Medicine and Palliative Care (Beeper #6702).

ANXIETY & INSOMNIA

Lorazepam 0.5mg po/SQ/IV BID-TID q HS for anxiety.
Temazepam 15 – 30 mg po q HS for anxiety/ insomnia.
Clonazepam 0.5 – 2 mg po BID-TID for anxiety/myoclonus.

CONFUSION/AGITATION

Haloperidol 0.5 mg po/SQ/IV. Repeat q 30 minutes until symptom intensity declines.
Haloperidol 0.5 – 5 mg po/SQ/IV q 4 hr prn.

CONSTIPATION

Lactulose 30 ml po q 2 hr prn until constipation relieved. When symptom improves, begin Lactulose 30 ml po q 12 hr.
Warm Fleets Enema TIW prn

To prevent constipation:

Senokot 1 – 2 tabs po BID and
Colace 1 – 2 tabs po BID.

SYMPTOMS OF DEPRESSION

If anticipated survival is in weeks:

Begin SSRI, e.g., Paroxetine 20 mg po daily, and titrate to effect.

If anticipated survival is in days:

Methylphenidate 2.5 mg po q morning and at noon and escalate daily to 5 – 10 mg po q morning and at noon or
Pemoline 18.75 mg po q morning and at noon and escalate daily to 37.5 mg po q morning and at noon.
Higher doses may be needed.

Consider Liaison Psychiatry consultation

DIARRHEA

Loperamide 4 mg po q 4 hr prn

DYSPNEA

For Opioid-Naïve Patient:

Morphine Sulfate 5 – 15 mg po or 2 – 5 mg SQ/IV. Repeat q 1 hr, if needed. When symptom is improved, begin Morphine Sulfate 30 mg po or 10 mg SQ/IV q 4 hr ATC; or begin Morphine Sulfate basal infusion at 2 mg per hour and 2 mg SQ/IV q 1 hr prn.

For Opioid-Treated Patient:

If dyspnea uncontrolled, increase fixed schedule dose by 50%. *If breathlessness continues*, add Lorazepam 0.5mg po or SQ/IV prn. Repeat q 60 minutes if needed until symptom intensity declines, then begin 1 mg po/SQ/IV q 3 hr.

Additional therapies may include:

Dexamethasone 16 mg po/IV, followed by 4 mg po/IV q 6 hr
Albuterol 2.5 mg via nebulization q 4 hr prn if wheezing present

FEVER

Acetaminophen 650 mg po/PR q 4 hr prn, and/or
Dexamethasone 1.0 mg po/SQ/IV q 12 hr prn

HICCUPS

Chlorpromazine 10 – 25 mg po/IM TID prn
Haloperidol 0.5 – 2 mg po/SQ/IV TID – QID

INTRACTABLE SYMPTOMS, MANAGEMENT OF

Consider referral to Department of Pain Medicine & Palliative Care (Beeper # 6702).

IV HYDRATION

Consider decreasing IV rate to 0.5 – 1 liter/24 hr

NAUSEA/VOMITING

Metoclopramide 10 mg po/IV q 4 hr prn, or
Prochlorperazine 10 mg po/IV q 4 hr or 25 mg PR q 8 hr prn with or without Dexamethasone 4 mg po/IVPB q 6 hr

PRURITIS

Diphenhydramine 25 – 50 mg po/IV q 12 hr
Hydrocortisone 1 % cream to affected areas q 6 hr
Dexamethasone 1.0 mg po daily alone or in combination with above

STOMATITIS

Viscous lidocaine 2 % to painful areas prn
Clotrimazole 10 mg troche 5 times daily
Nystatin S & S q 6 hr prn
Magic Mouthwash prn

TERMINAL SECRETIONS (NOISY RESPIRATIONS)

Scopolamine patches 1.5 – 3 mg 72 hr, or
Scopolamine 0.4 mg SQ q 4 – 6 hr