St Margaret's Hospice Care

Managing key symptoms in patients who are unwell with COVID-19

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March 2020

What symptoms might patients commonly experience?

- Breathlessness
- Cough
- Fever
- Delirium/Agitation

Breathlessness

- The subjective sensation of discomfort with breathing. Breathlessness can cause significant distress, especially when associated with anxiety.
- Consider whether there are other reversible causes:
  - Other underlying conditions eg Lung carcinoma, COPD
  - Other pathologies eg Pulmonary embolism, pneumonia, pleural effusion
  - Is there another reversible problem?

Management-Non-pharmacological

- Assist the person into a comfortable position. Leaning forward can help. Perhaps rest forward onto a few stacked pillows, if able. Let the shoulders droop, keep the head up and the legs uncrossed.
- Relaxation techniques – simple breathing exercises can be helpful
  - Blow as you go- For example, when standing up, breathe in **before** you stand up, and then blow out **as** you stand up (when making the effort)
  - Paced breathing- breathe in for one step then out for two steps Breathing a rectangle.
- Reduce room temperature-Where possible ensure an open window with a flow of air. The sensation of airflow on the face can be hugely helpful in relieving a sensation of breathlessness
- Cool the face by using a cool flannel or cloth the sternal area is also helpful
- Oxygen may be helpful **if** oxygen sats are low and if available

Pharmacological Measures

- Opioids may reduce the perception of breathlessness
  - Oramorph solution 2.5 – 5mg PO prn. Morphine 1-2mg SC prn if unable to swallow
  - Morphine modified release 5mg bd (titrate up as needed for breathlessness)
  - **NB** if the patient is already taking an opioid then the dosing will vary depending on their existing dose and which opioid this is.
- Anxiolytics for anxiety
  - lorazepam 0.5-1mg SL prn
- In the last days of life
  - Morphine 2.5-5mg SC prn (if not already taking an opioid)
  - Midazolam 2.5-5mg SC prn for associated agitation or distress.
  - Levomepromazine 12.5-25mg PO can be used as an alternative if s/c meds are not available or unable to be given.
  - Consider morphine 10mg and or midazolam 10mg over 24 hours via syringe driver, increasing stepwise as required.

Cough- Non pharmacological measures

- Cover the mouth and nose with a tissue when sneezing, coughing, blowing or wiping the nose. Wash hands after disposing of tissue
- Encourage oral fluids as able.
- Try honey and lemon in warm water or cough sweets
- Advise elevating the head when sleeping
- Avoid smoking

Cough-pharmacological measures

- simple linctus 5-10mg PO QDS, or if ineffective
- codeine linctus 30-60mg PO QDS or
- morphine sulphate immediate release solution 2.5mg PO 4 hourly
- If severe and the patient is distressed by their symptoms or if they are approaching end of life:
  - morphine sulphate injection 10mg CSCI over 24 hours and 2.5-5mg SC 4 hourly prn
- If all these measures fail, seek specialist advice

Management of fever- (Tympanic temp>37.8)

- **Associated symptoms and signs**
  - shivering
  - shaking
  - chills
  - aching muscles and joints
- **Non pharmacological measures**
  - Reduce room temperature
  - Wear loose clothing
  - Cool the face by using a cool flannel or cloth
  - Encourage oral fluids as able
- **Pharmacological**
- Paracetamol 1g PO/PR QDS
- If a patient is close to the end of life, it may be appropriate to consider use of NSAIDs eg Diclofenac 100mg PR daily

Delirium

- Delirium is an acute confusional state that can happen when someone is ill. It is a SUDDEN change over a few hours or days and tends to vary at different times of day. People may be confused at times and then seem their normal selves at other times. People who become delirious may start behaving in ways that are unusual for them - they may become more agitated than normal or feel more sleepy and withdrawn. People with dementia are more prone to becoming delirious.

Delirium-
Non pharmacological measures

- Identify and manage the possible underlying cause or combination of causes (for example a full bladder, constipation or pain.)
- Ensure effective communication and reorientation (for example, explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- Consider involving family, friends and carers to help with this
- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk (if possible)
- Avoid moving people into a different room unless absolutely necessary.
- Ensure adequate lighting

Delirium- pharmacological measures

- Haloperidol is often the first line choice for managing delirium when medication is needed to relieve acute confusion and distress:
- Start with 500 mcg PO/SC at bedtime and q2h prn
- if necessary, increase in 0.5−1mg increments
- median effective dose 2.5mg/24h (range 250 microgram - 10mg / 24h
- consider a higher starting dose (1.5-3mg PO/SC) when a patient's distress is severe and/or immediate danger to self or others
- An alternative to haloperidol is levomepromazine 12.5-25mg PO/SC 4 hourly

- If the patient remains agitated, it may become necessary to add a benzodiazepine, e.g.
- lorazepam 500 mcg-1mg SL bd and prn

Delirium/Terminal Agitation Management at the end of life.

- Often a combination of of levomepromazine and midazolam may be needed to treat confusion and agitation in the last hours to days of life.
- Levomepromazine (helpful for delirium)
  - Start 12.5-25mg SC stat and q4 hrly
  - if necessary, titrate dose according to response
  - Dose range can be from 25-200mg / 24h CSCI (Advise if needing>100mg seek specialist advice)
  - alternatively, smaller doses given as an SC bolus at bedtime, bd and prn
- Midazolam (helpful for anxiety)
  - start with 2.5-5mg SC stat and q2-4h prn
  - if necessary, increase progressively to 10mg SC/q2-4h prn
  - Dose range from 10-60mg / 24h CSCI
- If the above is ineffective, seek specialist palliative care advice

In conclusion:

- It is important to emphasise that medication advice may be influenced by availability of drugs and may need to be individualised.
- If a patients symptoms are not responding to the measures advised, please contact further specialist advice.
- Further advice around management of patients at the end of life can be found in the presentation “Care of the Dying person”

If you have questions or concerns

- Please do not hesitate to call our 24hr advice line on

  01823 333822 or 01935 709480

- For further information see:
- Caring for the dying person
- Treatment Escalation Planning conversations

available on St Margarets Hospice and SGPET websites