Managing Symptoms in Hospice

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Disclosures

- I have no actual or potential conflict of interest in relation to this program or presentation

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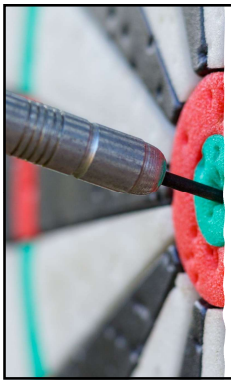

Goals Objectives

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Goals and objectives

1) Review the definition of hospice.

2) Cite the 4 levels of hospice care.

3) Identify and define the major symptoms of patients in hospice. Pain, Nausea, Agitation, Resp

4) Apply pharmacotherapeutics (controlled and noncontrolled) in managing hospice patients at EOL care with symptoms (uncontrolled pain, acute dyspnea, intractable nausea, and terminal agitation). DISCUSS CHEAPO MEDS.

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DEA Fed and SCDHEC

- Schedule I: Substances in this schedule have no currently accepted medical uses in the United States, a lack of accepted safety for use under medical supervision and a high potential for abuse.
- Schedule II: Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.
- Schedule III: Substances in the schedule have a potential for abuse less than substances in Schedules I and II and abuse may lead to moderate or low physical dependence or high psychological dependence.
- Schedule IV: Substances in the schedule have a low potential for abuse relative to substances in Schedule III.
- Schedule V: Substances in this schedule have a low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics

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Definition of hospice

Hospice care focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life.

- At some point, it may not be possible to cure a serious illness, or a patient may choose not to undergo certain treatments. Hospice is designed for this situation.

Palliative care can focus on treatment for cure and to manage chronic illness

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More definitions

- **Opioid tolerant: Those receiving for one week or >, 60 mg/day PO MS, 25 MCG/hour fentanyl patch, 30 mg/day PO oxycodone, 8 mg/day dilaudid, 25 mg/day oxymorphone**
- **Opioid naïve: Those who have not received opioids in the 30 days**

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More definitions

- **Opioid non-tolerant**
- **Unable to tolerate opioids for reasons such as sedation, nausea etc.**

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Four levels of Hospice Care

- **Community based in home (Facility such as ALF or home)**
- **Continuous routine care (Hospice house or LTC setting)**
- **Respite (in a facility such as a hospice house)**
- **GIP in patient**
  - **"General in patient" in hospice house, LTC setting or hospital setting that has designated CMS hospice unit and staff…..manage acute symptoms**

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At home hospice

- **Care provided at home**
- **Provider sees patient in home monthly**

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Continuous routine care

- Managing chronic hospice symptoms in a facility
- Need to be evaluated monthly by a provider

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Respite

- Patient comes into a hospice facility for five days
- For caregiver burnout
- CMS pays for respite care under hospice services.
- Provider sees patient in home usually prior to or shortly after respite stay

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GIP: General inpatient

- Short term management of acute symptoms: Usually 3-5 days
- Provider sees patient daily
- These are symptoms that CANNOT be managed at home or in ALF or LTC

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GIP

- Focuses on acute symptom management
- Imminent death does not meet criteria
- Symptom management includes
  - Analgesic pain needs that CANNOT be managed at home (every hour or IV drip)
  - SQ, Transdermal, IM, IV or Epidural Meds
  - Frequent titration
  - Frequent dressing changes
  - Frequent monitoring by a skilled RN, 2x per shift for example.
  - Agitation or delirium with behavioral symptoms that cannot be managed at home
  - Symptom management for nausea, vomiting, respiratory distress, or terminal complications such as seizures or bleeding that would be uncontrollable at home

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Hospice GIP inpatient other requirements

- 24-hour nursing care services with the ability for an RN to provide direct patient care on all shifts.
- Availability of spiritual and psychosocial care and assistance.
- A home-like atmosphere to preserve patient dignity and privacy; private room
- Ability to receive visitors at all times.
- Provider sees patient and family daily while patient is in GIP status.

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PAIN

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GIP: Acute or Uncontrolled Symptoms: What are we talking about?

- **Acute Pain or intractable pain**
- **Intractable Nausea**
- **Dyspnea, resp distress**
- **Agitation, acute or terminal**
- **Wounds with odor or DC**

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Acute Pain or Intractable Pain management

Pain score	**PPQRST**	**Presenting symptom: Pain**	**Quality: Burning, stabbing**
Region: Where	**Severity: Pain score ?/10**	**Timing: Onset Duration Frequency**	**Palliative measures: Other meds that did or did not work**

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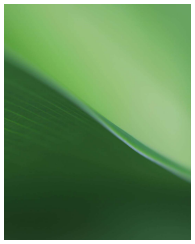
Opioids for Acute Pain Management

MS ER

Fentanyl

Dilaudid

CADD: MS or Dilaudid



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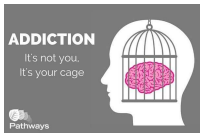
Opioids

- **Opioid drugs work by binding to the body's opioid receptors, which are found in areas of the brain that control pain and emotions.**
- **After taking opioids many times, the brain adapts to the drug, diminishing its sensitivity, making it hard to feel pleasure from anything besides the drug…. Tolerance or Addiction occurs**



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Rule of thumb all opioid RX for acute or chronic pain in hospice

- **Dose is based on**
  - **Current opioid intake**
  - **Use lowest effective dose**
  - **Start dose**
  - **Titrate slowly**
  - **Taper slowly**
  - **Opioid naïve or nontolerant or tolerant**
  - **Conversion dosing when switch meds**

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Morphine in general for acute mod-severe pain in hospice

Range 15 mg to 1600 mg daily

WARNING: addiction, abuse, and misuse; life-threatening respiratory depression; accidental ingestion; neonatal opioid withdrawal syndrome; and risks from concomitant use with benzodiazepines or other CNS depressants

SE: Constipation, blocks catecholamine surg releases necessary for EOL (Catecholamines facilitate death)

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- **Tylenol with Codeine (Tylenol 3 ® or Tylenol 4 ®)**
- **Administration: Codeine is often seen prescribed with acetaminophen (Tylenol) in tablet or solution form Dosages:**
  - **oral solution:120mg/12mg/5ml**
  - **tablets: 300mg/15mg, 300mg/30mg, 300mg/60mg**
- **Max Dosing:**
  - **360 mg per day though >60mg per day rarely more effective or well tolerated in opiate-naive patients**
- **Most common side effects: ● GI (constipation, nausea, vomiting) and clouded mentation**

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MS Immediate Release (IR): Acute mod-severe pain in hospice. Often used with Tylenol

- **Dose PO q4h prn**
- **Start: 10-30 mg IR PO q4h prn**
- **Consider low start dose, titrate slowly in pts 65 YO or older**
- **Taper total daily dose by no more than 10-25% q2-4wk**

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MS ER Cap daily for opioid naïve or nontolerant for acute mod-severe pain in hospice

- **ER dose PO q24h**
- **Max: 1600 mg/day**
- **Start 30 mg ER PO q24h in opioid-naive and opioid-nontolerant pts**
- **May increase dose q3-4 days**
- **May open ER cap, but do not crush/chew/dissolve contents**

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MS ER Cap BID in Opioid naïve or nontolerant for acute mod-severe pain in hospice

- **Individualize ER dose PO q12**
- **Start 15 mg BID**
- **Used as alternative in opioid-naive pts**
- **May increase dose q1-2 days**
- **May open ER cap, but do not crush/chew/dissolve contents**

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MS ER caps daily for opioid tolerant for acute mod-severe pain in hospice

- **Can start 60 mg/dose ER to >120 mg/day ER in opioid-tolerant pts only**

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MS ER TAB BID - TID for Opioid naïve and nontolerant patients for acute mod-severe pain in hospice

- ER dose PO q8-12h
- Start 15 mg ER PO q8-12h in opioid-naive pts
- Start 15 mg ER PO q12h in opioid-nontolerant pts
- May increase dose q1-2 days to 60 mg/dose ER to 120 mg/day ER
- Do not cut/crush/chew/dissolve ER tab

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MS ER Tabs BID or TID in opioid tolerant pts for acute mod-severe pain in hospice	**60 mg to 200 mg ER tab BID**
	Do not cut/crush/chew/dissolve ER tab

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MS Rectal use for acute mod-severe pain in hospice	**10-20 mg PR q4h prn**
	Use lowest start dose in elderly or debilitated pts

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MS CADD Continuous infusion for acute mod-severe pain in opioid naïve or tolerant patients in hospice

- 0.8-10 mg/h IV
- Max 10 mg/h IV start dose in opioid-naive pts
- Consider higher start dose in opioid-tolerant pts, titrate
- Consider low start dose, titrate slowly in pts 65 YO or older
- We titrate 1-10 mg and up if necessary, EVERYONE see your institution protocol

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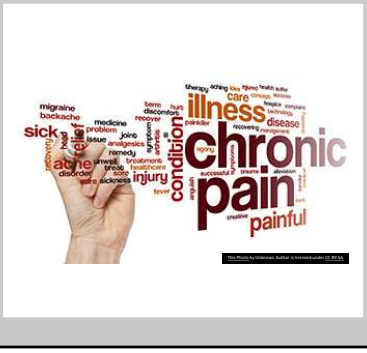
Mod-severe chronic pain in hospice patients Guide

- Use lowest effective dose, shortest effective tx duration
- Consider start dose
- Titrate slowly
- Taper slowly by no more than 10-25% every 2-4 weeks to DC if coming off meds.



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MS IR in Mod-severe chronic pain in hospice, often used with Tylenol

- Start PO 10-30 mg every 4 hours PRN

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MS ER Cap daily q24 hours dose in Mod-severe chronic pain in hospice

- **Max dose 1600 mg per day**
- **Start dose 30 mg every 24 hours**
- **May increase dose every 3-4 days**
- **May open ER cap, but do not crush/chew/dissolve contents**

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MS ER Cap BID dose in Mod-severe chronic pain in hospice

- **Start 30 mg q 12 hours in opioid non-tolerant**
- **For opioid tolerant, can start 60, 100,120 mg**
- **May increase every 1-2 days**
- **May open ER cap, but do not crush/chew/dissolve contents**

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MS ER TABS BID – TID dose in Mod-severe chronic pain in hospice

- **Start 15 mg q 8-12 hours in opioid naïve**
- **Start 15 mg q 12 hours in opioid non-tolerant**
- **For opioid tolerant, can use 60-200 tab BID**
- **May increase every 1-2 days**
- **Do not cut/crush/chew/dissolve contents**

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MS Rectal in Mod to severe chronic pain in hospice

- 10-20 mg every 4 hours rectally if unable to swallow

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Special considerations

- **Renal dosing**
  - **CrCl 10-50, decrease dose by 25%.**
  - **If CrCl < 10, avoid use**
  - **Avoid if on HD (hemodialysis)/PD (peritoneal)**
- **Hepatic dosing**
  - **If have cirrhosis, decrease start dose, titrate slowly**
  - **In my setting, we don't monitor that stuff, focus on EOL and CMS won't pay for labs etc.**

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Fentanyl

- **50-100 times more potent than MS**
- **10 mg MS = 100 MCG of Fentanyl**
- **Frequently added to or substituted for street heroin which makes it more powerful and increases risk of OD.**
  - **In 2017, 59 percent of opioid-related OD deaths involved fentanyl compared to 14.3 percent in 2010.**
- **High risk for addiction and dependence.**
- **Can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol or other illicit drugs such as heroin or cocaine.**

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Fentanyl

- **Street names**
  - **Apace, China Girl, China Town, China White, Dance Fever, Goodfellas, Great Bear, He-Man, Poison and Tango & Cash**
- **Brands:** **Duragesic, Abstral, Subsys, and Ionsys, sublimaze**

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Fentanyl

- **Great for chronic cancer and ESRD pain in hospice care**
- **SE:**
  - **extreme happiness**
  - **drowsiness**
  - **nausea**
  - **confusion**
  - **constipation**
  - **sedation**
  - **problems breathing**
  - **unconsciousness**

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Fentanyl

- Hepatic excretion (not renal)
- Fentanyl transdermal patch delivers a continuous dose of the medication, needs to be changed every 72 hours.
- There are 5 different patch dosages available: **12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, and 100 mcg/hr**.

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Fentanyl

- **As a rule, used for opioid tolerant patients with chronic pain**

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Fentanyl Patch

- **As a rule, do not use fentanyl patches in opioid-naïve patients with non-cancer pain because of the potential for serious adverse effects……however:**
  - **We do use in renal patients with chronic pain due to hepatic clearance.**
- For some opioid-naïve cancer patients the potential harms with the fentanyl patch may be considered acceptable when balanced with expected benefits —
- If so, start with the lowest-dose patch (**12 micrograms per hour = 288 mcg per day, equiv to 28.8 MG MS per day or MS 1.2 mg per hour**) and monitor closely.

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Fentanyl patch: What to tell the patient

- **Do not use a fentanyl patch that is cut, damaged, or changed in any way. If you use cut or damaged patches, you may receive most or all of the medication at once, instead of slowly over 3 days. This may cause serious problems, including overdose and death.**
- **You may bathe, swim, or shower while you are wearing a fentanyl patch. If the patch falls off, dispose of it properly. Then dry your skin completely and apply a new patch. Leave the new patch in place for 72 hours after you apply it.**
- **You can apply a fentanyl patch to your chest, back, upper arms, or the sides of your waist**

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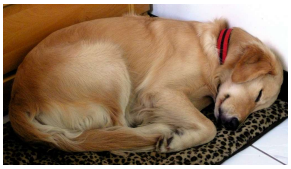
Dog and fentanyl



- I AM NOT STUPID!!!!

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Fentanyl dosing IV

- The usual dose is **25 mcg IV every 3 to 5 minutes as needed**.
- Premedication with a benzodiazepine may potentiate the response to fentanyl; a reduced fentanyl dose may be needed.
- NOTE: Fentanyl should be administered as an inducing agent only by those trained in anesthesia. Monitor ventilation closely. I did not do fentanyl drips.

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Dilaudid: Hydromorphone

- **Conversion**
  - **150 mg Dilaudid = 600 mg MS**
  - **1.3 mg Dilaudid = 10 mg MS**
- **Opioid agonist**
- **MS derivative**
- **Street names**
  - **Dust, Dillies, Smack, D, Footballs**
- **IV, Oral tabs, suppositories**
- **For mod-severe chronic pain**

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Dilaudid Doses and Forms

- Tabs
  - 2mg, 4mg, 8mg
- Tabs ER
  - 8mg, 12mg, 16mg, 32mg
- Suppository
  - 3 mg
- PO liquid
  - 5mg/5CC

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Dilaudid

- Injection
  - 1mg/1CC
  - 2mg/1CC
  - 4mg/1CC
  - 10mg/1CC

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Dilaudid

- For mod-severe pain
- IR
  - Tabs 2-4 mg q 4-6 hours PRN
  - Oral liquid 2.5-10 mg every 3-6 hours

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Dilaudid

- IM is not recommended, body composition interferes with absorption, lag peak time for med

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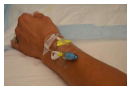
Dilaudid for mod-severe chronic pain

IV

- Opioid naïve:
  - 0.2 to 1 mg IV every 2-3 hours
- If opioid tolerant, may require higher dose

CADD

- 0.5 mg to 3 mg per hour, titrate up if necessary



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Dilaudid ER

- Chronic severe pain
- Long acting (Exalgo ER)
  - For opioid tolerant patients
  - 8-64 mg per day
  - Can increase dose every 3-4 days
  - Titrate up with increases of 25-50%.
  - Do not crush/divide/dissolve. Swallow whole
  - Cost = $80.00 to $270.00

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Dilaudid ER (Exalgo)

- Start Exalgo ER at 50% of calculated daily dosage requirements.
- Convert from Fentanyl to Exalgo
  - Start Exalgo 18 hours after removal of fentanyl patch at 50% of calculated total 24 hour fentanyl dose
  - Ex: If fentanyl patch is 25 MCG, then Exalgo is 12 mg PO q 24 hour

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Dilaudid ER (Exalgo)

- Taper off by decreasing dose 25-50% every 2-3 days to a dose of 8mg every 24 hours before discontinuing.

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Dilaudid

- Rectal
  - 3 mg every 6-8 hours

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Dilaudid

- SE:
  - Euphoria
  - Resp depression
  - Sedation
  - Constipation
  - Cough suppression

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Helper meds

- Steroids. Anti-inflammatory medicines that may help relieve pain by decreasing inflammation. They may be used along with other pain relievers for nerve, bone, or other types of pain. Decadron
- Antidepressants. Treating any existing depression or anxiety can make pain easier to control. These drugs may also be useful in pain caused by nerve damage: Cymbalta for neuropathic and back pain

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Helper meds

- Anticonvulsants. These medicines are usually used to control seizures, but they can also help control nerve-related pain. Tegretol, ~~Gabapentin~~
- Muscle relaxants. Anxiolytics and muscle relaxants may be used along with pain medicine if pain is aggravated by tension or muscle spasms.
- Bisphosphonates. These meds prevent fractures in people whose cancer has spread to the bone. They can play a key role in relieving bone injury and pain: Boniva, Fosamax

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Marijuana: CBD Update and Medical Marijuana Update:

- **SC remains one of the 14 states that does not allow the general medical use of cannabis. As of 2025, SC legislature has not passed The South Carolina Compassionate Care Act. The bill for 2022, 2023, 2024, sponsored by Senator Davis failed in the House. Passed the Senate.**

In 2024, DOJ published a proposed rule to transfer marijuana from Schedule I to Schedule III, which it went through.

In 2025: Trump reclassifies cannabis to class III
Dec 18, 2025 · President Donald Trump signed an executive order Thursday reclassifying marijuana as a Schedule III substance with looser restrictions.

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Intractable Nausea

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What body functions or chemicals are involved in nausea?

Acute nausea or intractable nausea

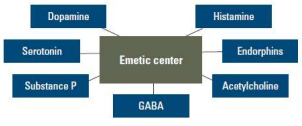

Figure. Neurotransmitters Involved in Emesis.
GABA = gamma-aminobutyric acid.

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Table 2. Non–Treatment-Related Causes of Nausea/Vomiting in Cancer Patients

Etiology	Intervention(s)*
PHYSIOLOGIC:	
Brain metastases	Radiation therapy, dexamethasone
Gastritis/gastroesophageal reflux disease	H_2 blocker, proton pump inhibitor
Dehydration	IV fluids
ELECTROLYTE DISTURBANCES:	
Hyponatremia	IV saline, spironolactone
Hypercalcemia	IV saline, loop diuretics, bisphosphonates
Gastroparesis	Metoclopramide
Concurrent medications	Delete or change medications
Bowel obstruction	Octreotide, antiemetics
Vestibular dysfunction	Meclizine
Excessive secretions (in head & neck patients)	Anticholinergics
Malignant ascites	Paracentesis, spironolactone
Anorexia	Olanzapine, megestrol acetate, cannabinoids
Chronic nausea	Olanzapine, haloperidol, metoclopramide, cannabinoids
BEHAVIORAL:	
Patient expectation of nausea	
Anxiety	Lorazepam, alprazolam
Depression	Antidepressants
Psychogenic nausea/vomiting	Psychiatric interventions

*Recommendations for interventions are based on recent National Comprehensive Cancer Network,[10] Multinational Association of Supportive Care in Cancer/European Society for Medical Oncology,[12] and American Society of Clinical Oncology[11] guidelines.

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Breakthrough nausea

Phenothiazines (Thorazine), metoclopramide (reglan), dexamethasone, or olanzapine (zyprexia) may be effective in the treatment of breakthrough nausea and vomiting

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Reglan: Dopamine antagonist

Dose PO
- **10 mg to 15 mg QID**

- **Short term therapy**
  - **4-12 weeks only**

- **SE:**
  - **Tremors, dystonia, anxiety, EPS SE, confusion, insomnia, TD rare but can happen esp in older women**

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Zofran DOSAGE AND FORMS Dopamine antagonist

- Tablet Q 8-12 hours
  - 4mg
  - 8mg
  - 24mg
- oral solution Q 8-12 hours
  - 4mg/5mL
- oral soluble film, strip of layers of med, sticks to oral membranes
  - 4mg
  - 8mg
- orally disintegrating tablets Q8-12 hours
  - 4mg
  - 8mg

injectable solution, Q 8 hours
- 2mg/ml, not to exceed 16mg per dose

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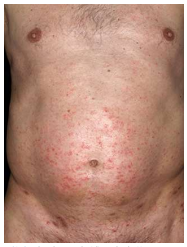
Zofran

- Uremic or cholestatic pruritis, off label
  - 8 mg every 8-12 hours up to five months



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Zofran SE

- Headache
- Lightheadedness
- Dizziness
- Drowsiness
- Tiredness
- Constipation

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Haldol: Antipsychotic, neuroleptic

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Haldol: Dosage and Forms

Can be used for nausea, intractable

Tablet
- 0.5mg
- 1mg
- 2mg
- 5mg
- 10mg
- 20mg

Oral concentrate
- 2mg/mL

injectable solution, lactate
- 5mg/mL

- Max dose per day = 20 mg

- SE: NMS, EPS

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Zyprexia: Antipsychotic but can be used for breakthrough nausea

- **5mg, 10mg, 15mg, 20mg PO**
- **Opioid-related considerations – increases withdrawal**
- **SE: WT GAIN, Increase in LDL but in EOL not concerned**
- **Used for breakthrough nausea**

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Terminal Agitation

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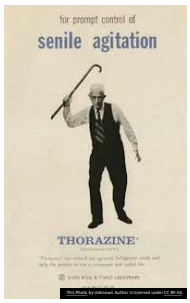

Terminal agitation

- The personality change can be sudden and dramatic, leaving loved ones feeling helpless and overwhelmed.
- Terminal restlessness is also called terminal agitation, excited delirium, terminal delirium or end-stage restlessness.

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Terminal agitation

- Agitation (fidgeting, pacing, twitching, tossing and turning)
- Anxiety, fear or panic
- Angry outbursts, aggression or irrational accusations of wrongdoing
- Difficulty making decisions, such as asking for an item and then rejecting it
- Unsettled behavior, such as pulling at clothes, bedsheets or intravenous (IV) lines
- Depression
- Irritability
- Moaning or crying out
- Disorientation or difficulty paying attention
- Hallucinations or paranoia
- Mental decline, confusion or dementia

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Terminal Agitation: Possible Causes

- Uncontrolled pain
- Certain medications, such as pain-relieving opioids, steroids, anti-seizure medication or chemotherapy medications
- A recent change in medication
- Fever, which may be a sign of an infection or other health issue
- Medical issues such as dehydration or anemia

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Terminal agitation: Causes

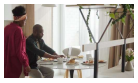
Emotional issues, such as fear, anxiety, depression or guilt, as patients try to cope with terminal illness and end-of-life

Inadequate oxygen to the brain (often caused by heart or lung failure), brain swelling or brain tumors

Chemical imbalance, often caused by organs shutting down at end of life

Excessive calcium

Constipation or urinary retention, arising from changes in muscle movements and ability to detect bodily sensations that control these functions



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Terminal agitation

- It often occurs in the pre-active dying phase, which usually lasts two weeks approx.
- Many people experience other end-of-life symptoms at the same time, such as tiredness and decreased food and water intake.

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Haldol: Agitation or severe delirium

- EPS
- NMS
- Prolonged QT

- May be needed for delirium; use only haloperidol lactate for IV administration; do not use haloperidol decanoate.
- 2-10 mg IV initially, depending on degree of agitation; if response inadequate, may repeat bolus q15-30min, sequentially doubling initial bolus dose; when calm achieved, administer 25% of last bolus dose q6hr; taper dose after patient is controlled
- Prolongs QT interval: May occur with cumulative doses ≥35 mg/day, or single doses ≥ 20 mg torsades de pointes (prolonged QT and ventricular arrhythmia)

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Haldol: Agitation or severe delirium

- 5-10 MG IM start dose
- 1-2 mg every 6 hours
- No more than 20 mg per day
- When stabilized, switch to PO or Oral concentrate

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Ativan: Lorazepam

- Used to treat anxiety and restlessness.
- Class of benzodiazepines
- Enhances the effects of a natural chemical in the body (GABA).

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Ativan Dosing and Forms

- 0.5 mg, 1 mg, and 2 mg tablets are available.
- The usual range is 2 to 6 mg/day given in divided doses, the largest dose being taken before bedtime, but the daily dosage may vary from 1 to 10 mg/day.
- For anxiety, most patients require an initial dose of 2 to 3 mg/day given two times a day or three times a day.

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Ativan: Elderly

- For elderly or debilitated patients, an initial dosage of 1 to 2 mg/day in divided doses is recommended, to be adjusted as needed and tolerated.
- The dosage of Ativan should be increased gradually when needed to help avoid adverse effects. When higher dosage is indicated, the evening dose should be increased before the daytime doses.

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Ativan SE

Drowsiness
Dizziness
Loss of coordination
Headache
Nausea
Blurred vision
Change in sexual interest/ability
Constipation
Heartburn
Change in appetite

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Zyprexia

Klonopin

- Used for Lewy body dementia terminal agitation

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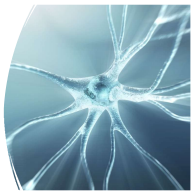
Dyspnea



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Acute or Refractory Dyspnea

- Definition
  - Can't breathe
  - Can't catch my breath
  - Breathing discomfort
- Unlike other symptoms, dyspnea intensifies in severity throughout the duration of the patient's disease trajectory.

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Dyspnea type	Mechanism	Examples
Malignant	Direct tumor effects	•Bronchial compression •Superior vena cava obstruction •Lymphangitic carcinomatosis •Venous thromboembolism
	Malignant effusions	•Pericardial effusion •Pleural effusion •Ascites
	Treatment-related	•Pneumonitis from systemic therapy or radiation •Lobectomy or pneumonectomy
Nonmalignant	Cardiovascular	•Congestive heart failure •Ischemic heart disease
	Pulmonary	•Chronic obstructive pulmonary disease •Interstitial lung disease •Pneumonia

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Acute or Refractory Dyspnea

- **Refractory dyspnea:**
  - **Opioids are a safe and effective treatment.**
  - **Benzodiazepines can be considered, but the evidence for their use is weak.**
  - **Supplemental oxygen is beneficial if patients are hypoxemic, or if they have concurrent chronic obstructive pulmonary disease.**
  - **One important diagnosis to consider in all cancer patients is venous thromboembolism.**

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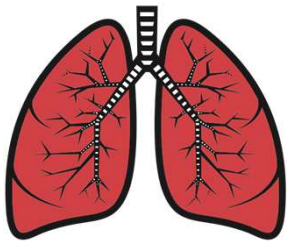
Dyspnea

- **Sudden onset of dyspnea in cancer may suggest VTE (venous thrombotic embolism) or PE**



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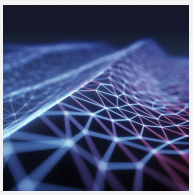
MS

First line of treatment

Slows down the respirations

2.5–5 mg oral morphine or the equivalent, every 4–6 hours, to establish efficacy and tolerability.

Once a stable dose has been achieved, consider switching to a slow-release



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MS

- If they can't swallow, use SL
- 10 mg SL STAT and every hour PRN till stable

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Wounds

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Wounds

AB

BID wound cleaning for GIP level of acute care, BID or daily

Terminal phase, goal is to keep patient clean and dry, and comfortable

Educate family on wounds that the wounds won't heal

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Wound staging

Stage 1	**ulcers have not yet broken through the skin.**
Stage 2	**ulcers have a break in the top two layers of skin.**
Stage 3	**ulcers affect the top two layers of skin, as well as fatty tissue.**
Stage 4	**ulcers are deep wounds that may impact muscle, tendons, ligaments, and bone.**

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Wounds

- Flagyl into the open wound to control odor. Open up the flagyl and sprinkle contents into would and cover with dressing.
- Coffee grounds in the room also help with odor control.

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Questions and Thank you!!!!

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