# Recognizing Imminent Death

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# Goals

- To increase your knowledge and skills in identifying common symptoms of imminent death.
- To increase your knowledge regarding treatment of common imminent death symptoms.
- Learn and use the PPS.

# Objectives

- Understand the three stages of the syndrome of imminent death.
- Understand EBM treatment approaches utilized in caring for patients who are imminently dying.
- Improve your ability to integrate the patient's choices in their EOL care.

# Early Symptoms

- Clinician Recognition
  - Primarily bed bound
  - Loss of interest/ability to eat or drink
  - Altered mental status
- Family Issues
  - Confusing language of physician - - “doing poorly” vs. “patient is dying”
  - Addressing patient goals for treatments at the end of life.
  - Basic care issues: hygiene, eating, incontinence

# Mid Stage of Imminent Death

- Further decline in mental status
  - Less responsive
  - Obtunded
- Low grade fevers
- Oral secretions
- Loss of swallowing reflex
- “Death rattle”

# Late Stage of Imminent Death

- Altered respiratory pattern
- Cool extremities
- Fever
- Coma
- Death
- Time course through various stages is variable

# PPS: Palliative Performance Scale

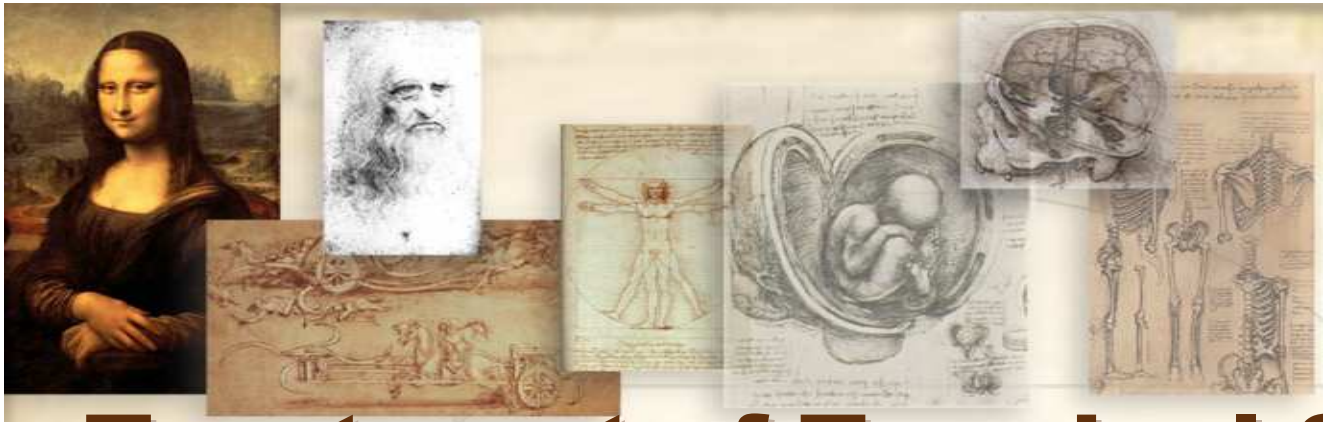
- 100 to 0% scale
- 100%: Perfect Health
- 0%: Death
- 100-80%: NL activities
- 60-70%: Reduced activity, self care and eating
- 50%: Significant disease, markedly ↓ ADL, eating, sleeping more during day.

# Palliative Performance Scale

- 40%: Mainly in bed, ↓ adl's, less eating, ↓ LOC.
- 30%-10%: Bedbound, Full care, sleeps most of day, ↓↓ LOC.
- 0%: Death
- Guide for docs, nurses and family members.

# Treatment of E/S Symptoms

- Shortness of breath (mild):
  - Roxanol, 5 mg po/sl q 4h, titrate
    - Breakthrough dose: 5 mg q 2h
  - Roxanol 10 mg po/sl q 4h, and titrate
    - Breakthrough dose: 10 mg q 2h
  - For children/frail elderly: Roxanol 2.5 to 5 mg po/sl q 4h
    - Breakthrough dose: 2.5-5 mg q 2h



# Treatment of Terminal Symptoms

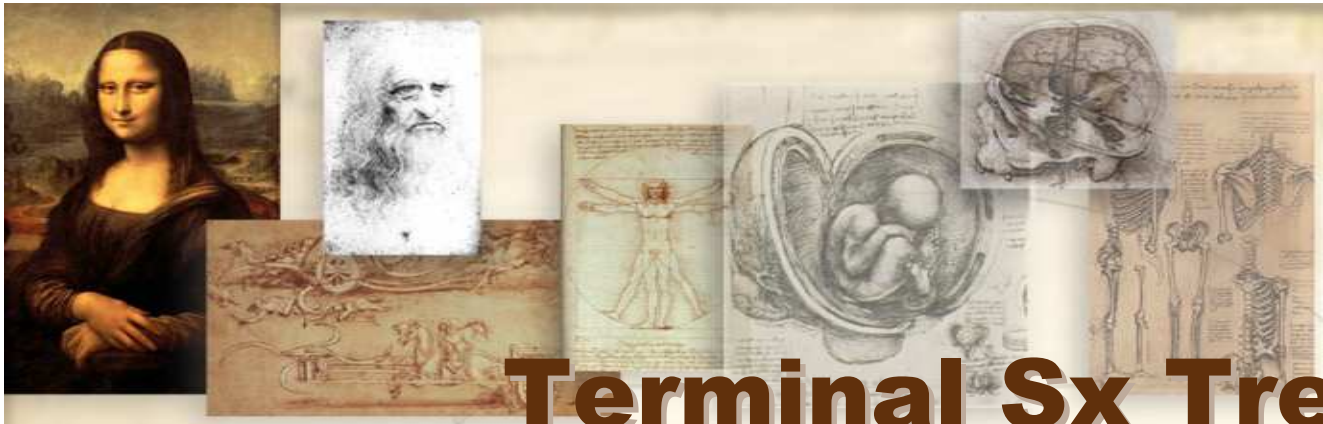
- Severe Dyspnea
  - Morphine sulphate:
    - 10-20 mg SL every 30-60 minutes
    - 2 mg/hr continuous drip
- Use breakthrough doses of 50% of baseline q 1-2h as needed:
  - Titrate aggressively –
    - 1mg/hr every 30 minutes until relief of sx

# Symptom Treatment

- Nausea and Vomiting
- Antihistamines:
  - Meclizine 25-50 mg po q 6h
  - Benadryl 25-50 mg po q 6h (not elderly)
- Acetylcholine antagonists
  - Scopolamine transdermal patches 1 q 72h
- Serotonin antagonists
  - Ondansetron 8 mg IV q 8h

# Nausea Treatments

- Prokinetic Agents
  - Metaclopramide 10-20 mg po q 6h
- Dopamine Antagonists
  - Promethazine 12.5-25 mg po/pr q 4-6h
- Benzodiazepines
  - Lorazepam 0.5-2.0 mg po/sl q 1h until settled, then q4-6h



# Terminal Sx Treatment

- Anxiety
  - Lorazepam 0.5-2.0 mg po/sl or IV q 1h until settled, then dose q 4-6h to keep comfortable
  - Diazepam 5-10 mg po/iv q 1h until settled, then dose q 6-8h until comfortable
  - Clonazepam 0.25-2.0 mg po q 12h
- Personal hygiene
  - Incontinence
  - Pressure sores
  - AVOID hydrogen peroxide, hypochlorites, povidone-iodine

# Terminal Sx Treatment

- Delirium
  - If possible treat underlying cause
  - Use anxiolytics or antipsychotics as needed
  - Non-pharmacologic approaches:
    - Re-orient patient
    - Familiar persons
    - Familiar sounds, smells, pictures
    - Use of lavender extract

# Terminal Sx Treatment

- Death Rattle
  - Scopolamine patch q 72 h
  - Better positioning, proper mouth care
- Altered respirations
  - Better positioning
  - Proper mouth care
  - Use of morphine
- Restlessness
  - Massage, music, soothing talking
  - Use of anxiolytics
  - CARE Channel

# EOL Care

- Coolness/mottling
  - Keep patient warm
- Sleeping
  - Sit with person
  - Pray with person (if desires)
  - When requested, speak quietly and directly
- Disoriented
  - Clear, truthful communication
  - Reorientation, clear explanations
- Eating less
  - Offer small amounts of fluid/food
  - Glycerine swabs, ice chips

# Terminal Restlessness

- Severe agitation
  - Not well controlled with usual tx.
- Treatment options
  - Increase dose of Ativan –2 mg every 6h
  - Consider use of Ativan drip-O.5-1 mg/h
  - Consider use of Midazolam drip 1 mg/h
  - Consider use of Propofol 5-10 mg/hr

# Pain Management

- Morphine Drips
  - MS 2 mg/hr
  - Titrate by 1mg/hr every 15-20 minutes until pain is relieved per patient
  - Adjust basal rate by 50% of total boluses in prior 24 hours

# Pain Management

- Morphine SC Infusions
  - SC can tolerate up to 3 cc/hr
  - Use 25 or 27 gauge needle
  - Can use morphine, dilaudid, or fentanyl
  - Morphine IV:SC is 1:1
  - Others, would check with pharmacist

# Other EOL Issues

- Feeding and Nutrition Issues
  - Cachexia and anorexia at EOL
  - Normal part of dying process
  - NOT starving the patient
  - Give control of nutrition style to patient
  - Help refocus caring needs of family to other areas of concern for the patient

# Other EOL Issues

- CPR discussed as a treatment option
  - Discuss beneficial vs. nonbeneficial
  - Known data on CPR for terminal conditions
- Compassionate Wean Protocol
  - Prepare family and patient
  - Provide appropriate ativan and morphine doses prior to wean
  - Start appropriate drip of morphine
  - Withdraw ventilator, ETT

# Summary

- Discussed common sx of Imminent Death
- Discussed treatment of common sx of Imminent Death
- Learned the PPS
- Discussed other key sx and their management at the EOL
- Website: https://hch.palliativecare.webexone.com

- THANK YOU !