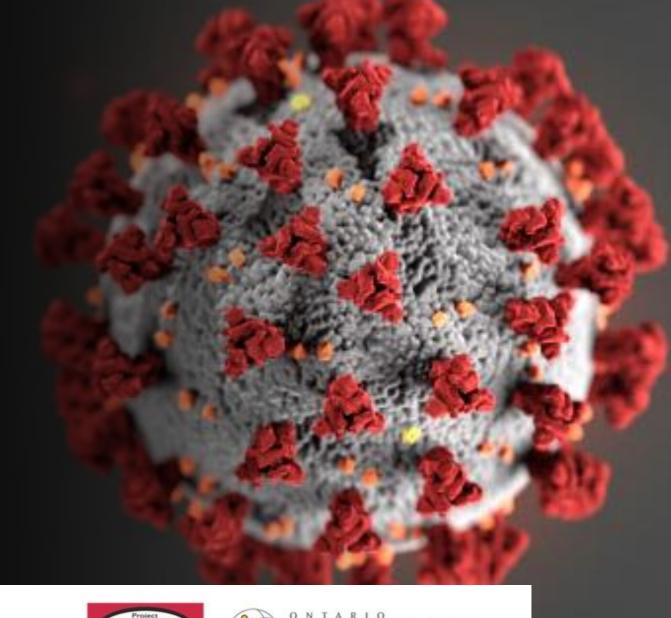
Symptom
Management and
End-of-Life Care in
the COIVD-19
Positive Patient

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Objectives

- 1. Review COVID-19 clinical features.
- 2. Discuss a general symptom management framework, then get into specific symptom control strategies.
- 3. Know who to contact when help is needed.











Spectrum of illness severity

Mild to

Moderate:

80%

No pneumonia, or Mild pneumonia Severe:

15%

Dyspnea,
Hypoxia,
>50% lung
involvement
on imaging

Critical:

5%

Respiratory failure, Shock or, Multiorgan dysfunction

Fatality rate:

- Overall case fatality ranges between2-4%
- Most fatal cases: in advanced age and underlying comorbidities

Fatality rate:

- In patients aged 70 to 79: 8%
- In patients > 80 years old: 15%

Co-morbidities associated with severe illness and mortality

- Cardiovascular
- Diabetes mellitus
- Hypertension
- Chronic Lung Disease
- Chronic Kidney Disease
- Cancer
- Dementia

When do symptoms develop?

- Incubation period within 14 days following exposure
- Symptoms develop in 98% percent of infected individuals within 11 days

Initial Clinical manifestations

Wang D et. al, JAMA 2020

- Fever in 99%
- Fatigue in 70%
- Dry cough in 59%
- Anorexia in 40%
- Myalgias in 35%
- Dyspnea in 31%
- Sputum production in 27%
- Gl symptoms: nausea and diarrhea have been reported; may be the presenting complaint



Context:

1.GOC,

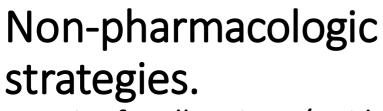
2.Prognosis

3.Symptoms

(burden and severity)

Non-pharmacologic

Pharmacologic

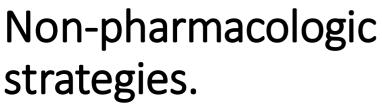


Top Five for all patients/residents.

 Review all medications and discontinue those not contributing to patient comfort.

 Discontinue devices/lines/interventions not necessary for comfort or medication administration.

*ICD magnet management.



Top Five for all patients/residents.

3. Discontinue or minimize intravenous fluids and enteral feeding as this does not contribute to patient comfort nearing EOL.

 All medications delivered through subcutaneous route or IV if already in place.

5. Insert indwelling catheter.

Avoid the use of the following as they may generate aerosolized SARS-CoV2 virus particles:

- Oxygen flow greater than 6L/min
- High-flow nasal cannula oxygen
- Continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP)
- All nebulized treatments (bronchodilators, epinephrine, saline solutions ...)
- Suctioning
- Fan*



☐ Position resident as upright as tolerated.

□Oxygen:

Supplemental oxygen for hypoxic patients/residents to help reduce the work of breathing (titrate to symptoms, not oxygen saturation).

Pharmacologic strategies: General Principles.

COVID-19 symptoms may advance quickly. <u>Be prepared</u> to escalate dosing or start with higher dose in the range given.

Pharmacologic strategies: General Principles.

You're likely going to start with a prn order:

- If greater than 3 prns in 24 hrs, MD to reassess.
- If using > 3 prns in 24 hrs, consider using standing dose with continued access to prn doses. Threshold is low to advance to q4h standing dose.
- Titrate dose as needed according to prns <u>and</u> symptoms.

Dyspnea: Opioid Naïve Morphine 1-2 mg subcut <u>q30</u> mins prn **OR**

 Hydromorphone 0.2-0.5 mg subcut <u>q30 mins prn</u>

Dyspnea: For the Patient/Resident on Opioids

- Continue previous opioid but consider increasing dose by 25%.
- To switch from PO to subcut route of administration, use ratio of 2:1 PO: subcut
- To manage breakthrough symptoms: start opioid prn at 10% of total daily (24h) opioids dose. Give prn q 30 min via subcut route.



- Lorazepam* 0.5 mg subcut q1 hr prn.
- * also useful for managing anxiety

Severe Respiratory Distress

Expect to use an opioid and benzodiazepine **simultaneously** and in higher doses.

For intolerable and refractory dyspnea consider palliative sedation.

Severe Respiratory Distress

• Midazola 1 mg - 5 mg subc STAT and q 5-30 mm continuous in Available? nump) currently anable CU. Gold Standard

 Lorazepam 2 mg subcut STAT and q20 mins prn until symptoms controlled. Maintenance dose: 1-2mg q4-8h standing. Agitation/Restlessness

Non-Sedating Alternative: Risperidone m-tab

- Non-sedating: haloperidol0.5 subcut q1h prn
- Sedating: methotrimeprazine
 2.5 mg 12.5 mg subcut q4h
 prn

Sedating

Alternative: Olanzapine Dissolvable Tab

Agitation/Restlessness Other Sedating Options:

- Phenobarbital: 30-60 mg SC STAT and then 30-60 mg subcut q30 min prn until target sedation achieved. Maintenance: phenobarbital 90-120 mg subcut q8h ATC (max. 400mg/d)*
- Much higher doses of phenobarbital for sedation have been reported (max. 2500mg/24h)

• If phenobarbital is unavailable: First-generation antipsychotic, loxapine.

Respiratory Secretions

- Glycopyrrolate 0.4mg subcut q4h prnOR
- Scopolamine 0.4mg subcut q4h prn (more sedating & anticholinergic)
- If volume overload, furosemide20 mg subcut and monitor response

Nausea/Vomiting

Haloperidol 0.5 mg subcut q 4h prn.

In cases when haloperidol is contraindicated, or when sedation is not desired: use **ondansetron** 4-8 mg subcut q8h prn.

Acetaminophen supp. 650 mg pr q 4h Fever prn

Pain

- Morphine 1 − 2 mg subcut q 30 min prn OR
- Hydromorphone 0.2 0.5 mg subcut q 30 min prn

Laxatives

 Consider the need for laxatives including suppositories and fleet q 3 days prn.

Supportive care and bereavement

 Involve supportive care colleagues (eg. SW, Spiritual Care)

You're not alone. We're in this together.

Info@ontariopalliativecarenetwork.ca

Thoughts, comments, questions?

Thank you.