

# Clinical guidelines for symptom control in patients with Covid-19 (2 pages)

In **acute phase of Covid-19** it is important patients have their symptoms controlled **alongside** active medical treatment.

Most common symptoms in last days of life are pyrexia, rigors, severe breathlessness, cough, delirium and agitation.

**NB** Opioid and benzodiazepine use in palliation should not be withheld because of fear of causing respiratory depression.

**For all Covid-19 patients**, please ensure the following symptoms are considered and **prn/regular** medication prescribed:

**SD** =syringe driver **sc** =subcutaneous **MR** =modified release **IR** =immediate release **SL**=Sublingual **TDD**= total daily dose

Symptom	Clinical indication	Recommendation
<b>Breathlessness (at rest or minimal exertion)</b>	Opioid naïve (no previous opioids) and able to swallow	<b>1st line</b> Morphine sulphate MR (modified release) oral 5 mg (MST)12 hourly and increase as necessary to 15mg 12 hourly ( <b>Max</b> 30mg/24 hours) <b>NB</b> If <b>eGFR &lt;30 mL/min</b> oral oxycodone MR 5mg 12 hourly
		<b>Alternative</b> Morphine sulphate IR (immediate release) oral 2 to 5mg 2 to 4 hourly <b>prn</b> <b>NB</b> If <b>eGFR &lt;30 mL/min</b> Oxycodone IR oral 1 to 2 mg 2 to 4 hourly <b>prn</b>
	Patients on regular opioids for pain relief	Morphine sulphate IR oral 2 to 5mg 2 to 4 hourly <b>prn</b> or one twelfth of the 24 hour dose for pain, whichever is greater. <b>NB</b> If <b>eGFR &lt;30 mL/min</b> Oxycodone IR oral 1 to 2 mg 2 to 4 hourly <b>prn</b>
	Patients who are <b>unable to swallow</b> use subcutaneous(sc) medications	a) <b>opioid naïve</b> Morphine sulphate 2mg sc 2 to 4 hourly <b>prn</b> If > 2 doses required per day, consider a syringe driver ( <b>SD</b> ) Starting dose <b>SD</b> morphine sulphate 10mg/24hour <b>NB</b> If <b>eGFR &lt;30 mL/min</b> Oxycodone 1 to 2 mg sc 2 to 4 hourly <b>prn</b> If > 2 doses use a <b>SD</b> Oxycodone 5mg/24 hour b) <b>already on regular opioids (oral or transdermal)</b> refer to conversion charts on 'Anticipatory Drugs and Syringe Driver Chart' and note the advice above: 'Patients who are on regular opioids for pain relief'
<b>Anxiety</b>	Patients who can swallow	Lorazepam 500micrograms to 1mg <b>SL</b> 2 to 4 hourly <b>prn</b> <b>Max</b> 4mg/24 hours (2mg in elderly patients)
	Patients <b>unable to swallow</b>	Midazolam 2 to 5mg sc 2 to 4 hourly <b>prn</b> If > 2 doses required daily, consider a syringe driver Starting dose <b>SD</b> Midazolam 10mg/24hour <b>Max</b> 30mg/24hours <b>NB</b> If <b>eGFR &lt;30mL/min</b> reduce starting dose <b>SD</b> Midazolam 5mg/24hr
<b>Cough</b>	Opioid naïve	<b>1<sup>st</sup> line</b> Simple linctus 5mL qds <b>2<sup>nd</sup> line</b> Opioids dosing as for breathlessness see above
<b>Fever</b>		Regular Paracetamol ( <b>Fan use &amp; PR route may spread the virus</b> ) <b>In the last days of life consider an NSAID e.g. Parecoxib 40mg sc daily</b>
<b>Delirium</b>	Potentially reversible	<i>Pharmacological measures only indicated in severe delirium with distressing hallucinations or severe agitation.</i> <b>1<sup>st</sup> line</b> Haloperidol 500micrograms to 1mg oral /sc <b>stat</b> . Observe for 30 to 60 minutes. Repeat if necessary and thereafter 8 hourly <b>prn</b> . <b>Max</b> 5mg/24 hours
	NB In Parkinson's patient use Lorazepam as 1 <sup>st</sup> line	<b>2<sup>nd</sup> Line (1<sup>st</sup> line in Parkinson's Disease)</b> Lorazepam 500microgram to 1mg <b>SL</b> 2 to 4 hourly <b>Max</b> 4mg/24 hour (2mg in elderly patients) Be aware that benzodiazepines may increase levels of confusion
	<b>Irreversible terminal delirium/agitation not expected to recover.</b> Patient is dying	<b>1<sup>st</sup> line</b> Midazolam 2 to 5 mg sc 1 to 4 hourly <b>prn</b> If > 2 doses required daily, consider a <b>SD</b> Starting dose <b>SD</b> Midazolam 10mg/24hour <b>Max</b> 60mg/24hours <b>NB</b> If <b>eGFR &lt;30 mL/min</b> <b>SD</b> Midazolam to 5mg/24 hour <b>Max</b> 30mg/24hours
	Seek advice from palliative care if 1 <sup>st</sup> line midazolam not helping as 2 <sup>nd</sup> line drug doses may need to be escalated rapidly	<b>2<sup>nd</sup> line</b> Levomepromazine or Haloperidol and continue midazolam in <b>SD</b> Levomepromazine 12.5mg to 25mg sc 1 to 4 hourly <b>prn</b> <b>SD</b> 25mg/24hour <b>Max</b> 100mg/24hr <b>NB</b> If <b>eGFR &lt;30 mL/min</b> or <b>elderly use lower starting doses</b> Levomepromazine 6.25mg to 12.5mg sc 1 to 4 hourly <b>prn</b> <b>SD</b> 12.5mg/24hour <b>OR</b> Haloperidol 500micrograms to 1mg sc 1 to 4 hourly <b>prn</b> <b>SD</b> 3 mg over 24 hour <b>Max</b> 5mg/24 hour
<b>Pain</b>	Use WHO analgesic ladder	<b>Step 1</b> Paracetamol, <b>Step 2</b> weak opioids <b>Step 3</b> morphine IR 2 to 5mg 2 to 4 hourly and titrate Convert to morphine MR. <b>prn dose</b> is total daily dose(TDD)divided by 6 If <b>eGFR &lt;30 mL/min</b> use oxycodone IR 1 to 2mg 2 to 4 hourly and titrate
	<b>Conversions for a SD sc prn dose =TDD/6</b>	Oral morphine to sc morphine divide by 2 Oral oxycodone to sc oxycodone divide by 2 If on a transdermal patch keep in situ and top up with sc opioid <b>prn</b> and/or <b>SD</b>

**NB** If starting a regular opioid, then consider starting a prn laxative (e.g. Laxido 1 to 2 sachets bd **prn** or picosulphate 5 to 10mL od **prn**) and antiemetic (e.g. haloperidol 500micrograms to 1mg oral/sc 8 hourly **prn**) If a patient **rapidly deteriorates despite active management** then please follow the **last days of life documentation**.

# Non-pharmacological symptom control in patients with Covid-19

Use of non-drug symptom management strategies can help relieve symptoms and reduce reliance on medications  
Generally non-drug approaches to symptom management are preferred, particularly for mild to moderate symptoms

Symptom	Non-pharmacological measures
<b>Breathlessness (at rest or minimal exertion)</b>	<ul style="list-style-type: none"> <li>Positioning (Sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward)</li> <li>Relaxation techniques</li> <li>Reduce room temperature</li> <li>Cooling the face by using a cool flannel or cloth</li> <li>Reassurance</li> <li><b>Avoid portable fans</b> due to infection control risk in COVID-19</li> </ul>
<b>Anxiety</b>	<ul style="list-style-type: none"> <li>Facilitate expression of emotions</li> <li>Explore fears and concerns</li> <li>Address spiritual or religious needs</li> <li>Distraction – e.g. playing music or radio</li> <li>Offer reassurance</li> </ul>
<b>Cough</b>	<ul style="list-style-type: none"> <li>Suck on menthol sweets (e.g. Fisherman's friend)</li> <li>Humidify room air</li> <li>Oral fluids</li> <li>Elevate the head when sleeping</li> </ul>
<b>Fever</b>	<ul style="list-style-type: none"> <li>Reduce room temperature</li> <li>Wear loose clothing</li> <li>Cooling the face by using a cool flannel or cloth</li> <li>Oral fluids</li> <li><b>Avoid portable fans</b> as infection control risk</li> </ul>
<b>Delirium</b>	<p><b>Check for reversible causes</b></p> <ul style="list-style-type: none"> <li>Infection</li> <li>Electrolyte disturbance</li> <li>Dehydration</li> <li>Hypoxia</li> <li>Hyper/hypoglycaemia</li> <li>Urinary retention</li> <li>Constipation</li> <li>Pain</li> <li>Medication related</li> <li>Medication or alcohol withdrawal</li> </ul> <p>• Reorient (explain where they are, who you are etc) and reassure</p> <p>• Ensure lighting levels mimic the time of day</p> <p>• Ensure the patient has access to glasses and hearing aid if applicable</p> <p>• If family members can be present involve them in reassuring patient</p> <p>• Ensure continuity of care by staff known to patient where possible</p> <p>• Avoid moving people within and between wards or rooms unless absolutely necessary</p>
<b>Agitation/ Terminal restlessness</b>	<p><b>Check for reversible causes:</b></p> <ul style="list-style-type: none"> <li>Urinary retention</li> <li>Constipation</li> <li>Pain – remember to check both syringe driver functioning correctly and skin site</li> <li>Repositioning</li> <li>Reassurance</li> <li>Calm surrounding environment</li> </ul>

If you require <b>advice</b> , please contact the <b>Specialist Palliative Care Team</b> directly on the numbers below			
York Specialist Palliative Care team (SPCT)		Scarborough Specialist Palliative Care team (SPCT)	
<b>In hours</b>	<ul style="list-style-type: none"> <li>Community SPCT 01904 777770</li> <li>Hospital SPCT 01904 725835</li> <li>St Leonard's Hospice 01904 708553</li> </ul>	<b>In hours</b>	<ul style="list-style-type: none"> <li>Community SPCT 01723 356043</li> <li>Hospital SPCT 01723 342446</li> <li>St Catherine's Hospice 01723 351421</li> </ul>
<b>Out of hours</b>	<ul style="list-style-type: none"> <li>GP OOH 0300 1231 183</li> <li>St Leonard's Hospice 01904 708553</li> </ul>	<b>Out of hours</b>	<ul style="list-style-type: none"> <li>GP OOH NHS 111</li> <li>Palcall 01723 354506</li> </ul>
<b>Community nursing</b>	•Single point of access (SPA) 01904 721200	<b>Community nursing</b>	•S&R Community Services (CAS) 01653 609609
<b>There is always access to a consultant on call via your local hospice</b>			

Author York Teaching Hospitals Palliative Care team in collaboration with St Leonard's Hospice, St Catherine's Hospice  
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