Particular considerations to take into account as part of geriatric palliative care

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This text is an addendum to the recommendations issued by the SFAP (French Counselling and Palliative Care Society - http://www.sfap.org/actualite/outils-et-ressources-soins-palliatifs-et-covid-19) and the French College of Palliative Care. We feel it necessary to insist on the following points concerning Palliative Care for the geriatric population:

ETHICAL CONSIDERATIONS

- The commitment level for care and whether the patient is to be resuscitated should be included in each patient's file. This should guide procedures following the patient's admission, with reassessments made on the patient's clinical conditions. Decisions not to resuscitate are subject to an order from the College, which should be included in the patient's case file.
- The patient and their loved ones should be interviewed for advance instructions, which should be included in the case file (cf. the Covid-19 resuscitation ethics RPMO document, COVIPAL document, etc.)
- It is also crucial to keep family members up-to-date on the patient's clinical condition and palliative care given.

PRACTICAL THERAPEUTIC MEASURES

- **Make sure teams have access to drugs within each care unit!**
- **Recommended doses for young adults should be reduced as a general rule,** per those protocols put forward by the SFAP.
- **Recommendations for combining drugs within a single drum**, as issued by the SFAP, **are valid for Geriatric use.**
- **Dose regimes for the most common conditions**
  - The therapeutic treatments set out below **should be given priority based on those recommendations in place and drug availability within services.**

BREATHLESSNESS	ANXIETY
- MORPHINE: Bolus: 2 mg intravenously (IV) or 3 mg subcutaneously SC Baseline dose: 15 mg IV every 24 hours 20 mg SC every 24 hours Orally: 5 mg bolus then 30 mg daily (15 mg treatments every 12 hours) - **OXYCODONE:** IV or SC: 2 mg bolus then 0.4 mg per hour Orally: 5 mg bolus then 20 mg daily (10 mg treatments every 12 hours) - **SUFENTANIL:** IV or SC: 4 µg bolus then 30 µg IVSE or ESSC - **TRAMADOL** subcutaneously This should only be given in the absence of all of the other drugs listed above! 50 mg bolus then 300 mg every 24 hours Can be increased up to 600 mg every 24 hours	- **MIDAZOLAM:** Bolus: 1 mg IV or SC then 10 mg IVSE or ESSC every 24 hours - **CLONAZEPAM:** 0.5 mg SC or IV bolus twice every 24 hours - **DIAZEPAM** (do not mix with other products) 5 mg IV bolus or 10 mg SC bolus (never to be given on continuous drip or ESIV), max 10 mg every 24 hours - **CHLORPROMAZINE**: 25 mg SC or IV bolus then 100 mg every 24 hours up to 300 mg every 24 hours (on continuous ESIV or ESSC) - **CLORAZEPATE:** 40 mg IV or SC bolus then 80 mg ESIV every 24 hours or 40 mg SC twice every 24 hours (no ESSC!) - Intra-rectal **DIAZEPAM:** (Note no recommendations exist for adults, with even less available for elderly patients) 5 mg bolus (in a syringe for rectal injection), maximum four times daily

RESPIRATORY DISTRESS

Recommended SFAP doses are valid for this emergency situation.

They have been summarised in the tables below: **table 1 is for initial care and table 2 contains dose amounts in the event initial care does not work.**

Table 1: initial care for respiratory distress

	IV then ES	SC then ES	IV then drip	SC then drip	Discontinue SC
Morphine bolus	3 mg	7 mg	3 mg	7 mg	7 mg
Midazolam bolus	2 mg	3 mg	2 mg	3 mg	3 mg
Clonazepam bolus	0.5 mg	0.5 mg	0.5 mg	0.5 mg	0.5 mg
Clorazepate bolus:	40 mg	40 mg	40 mg	40 mg	40 mg
Morphine relays	1.5 mg/h	3 mg/h	30 mg/24h	70 mg/24h	Two or three times daily, where needed
Midazolam relays	2 mg/h	3 mg/h	50 mg/24h	80 mg/24h	
Clonazepam relays	2 mg/24h	2 mg/24h	2 mg/24h	2 mg/24h	
Clorazepate relays	80 mg/24h	40 mg 2x/day	80 mg/24h	40 mg 2x/day	

IV = intravenously; SC = subcutaneously; ES = electrical syringe
Drip = basic drip with 250 or 500 cc fluids for 24 hours.
Boluses are given as initial treatment and then whenever needed.

* Clorazepate (Tranxene) does not do well in SC drips, so give 40 mg as SC bolus every 12 hours.

Table 2: Care procedures for respiratory distress if Table 1 doses prove ineffective

	IV then ES	SC then ES	IV then drip	SC then drip	Discontinue SC
Morphine bolus	7 mg	15 mg	7 mg	15 mg	10 mg
Midazolam bolus	3 mg	7 mg	3 mg	7 mg	10 mg
Bolus clonazepam	1.5 mg	1.5 mg	1.5 mg	1.5 mg	1.5 mg
Clorazepate bolus:	80 mg	80 mg	80 mg	80 mg	80 mg
Morphine relays	3 mg/h	6 mg/h	70 mg/24h	140 mg/24h	Two or three times daily, where needed
Midazolam relays	4 mg/h	7 mg/h	100 mg/24h	200 mg/24h	
Clonazepam relays	4 mg/24h	4 mg/24h	4 mg/24h	4 mg/24h	
Clorazepate relays	160 mg/24h	80 mg twice daily	160 mg/24h	80 mg twice daily	

IV = intravenously; SC = subcutaneously; ES = electrical syringe
Drip = basic drip with 250 or 500 cc fluids for 24 hours.
Boluses are given as initial treatment and then whenever needed.

* Clorazepate (Tranxene) does not do well in SC drips, so give 80 mg as SC bolus every 12 hours.

If treatment still fails, add the following to the SC 24-hour drip/TVKO to keep veins open:
50 mg cyamemazine or 50 mg levomepromazine or 25 mg chlorpromazine

FOR VOMITING

HALOPERIDOL:

- 0.5 to 1 mg SC three times daily up to 5 mg SC three times daily or 1 mg IV (or 10 drops)

ONDANSETRON:

- Apply 8 mg orally dispersible film up to three times daily if patient's liver function preserved
- Intravenously or subcutaneously: One 8 mg ampoule over 15 minutes

every eight hours maximum. For patients with liver disorders reduce to 8 mg every hour orally or IV.

CONFUSION

MIDAZOLAM 0.05 mg/kg SC bolus prior to care: the most satisfying option, with half an ampoule of HALDOL SC if patient's weight is over 40 kg.

GASTRO-INTESTINAL OBSTRUCTION

SCOBUREN (1 mg per kg daily) and **SCOPOLAMINE** (0.05 mg per kg daily) doses identical to those prescribed for adults (give priority to Scoburen over scopolamine so as to limit major atropinine side effects!).

ADDITIONAL MEASURES

Keep good geriatric practice in mind:

- take note of globus and faecaloma, whether the patient is uncomfortable and likely to be easily confused
- Non-medical anti-anxiety measures: having a light in the room, fit hearing prosthetics and glasses as soon as possible, telephone contact with loved ones where possible, etc.
- Mouthwash (use eye guards and an FFP2 mask as there is risk of sputum or cough), oxygen therapy adapted to patient's needs (careful as over 6 l/mn creates risk of virus nebulisation, so caregivers should wear an FFP2 mask)

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