Drugs Commonly Used in Hospice and Palliative Care

This is a general guide to help patients and families discuss with their physicians and caregivers the drugs used to treat pain and other symptoms. These drugs may have side effects not listed here. Also, combinations of drugs may contribute to adverse effects.

When correct doses are utilized, many of these medications very effectively alleviate symptoms commonly experienced near the end of life and are a great blessing. Also, the reported side effects can be confused with true end-stage symptoms. Stopping medications that are mitigating end-stage symptoms may make symptoms worse.

Ethical healthcare providers administer only the doses necessary to alleviate pain and other symptoms, and never intend to shorten life.

Be vigilant. Not all healthcare providers are ethical. Numerous reports from families of hospice and palliative care patients indicate that a one-size-fits-all pattern of administering a combination of opioids and anti-anxiety drugs has emerged. **Whether or not patients have pain and/or agitation, they may begin to receive these drugs upon admission.** Be wary of combinations of drugs such as morphine, Ativan, and Haldol, as well as the administration of opioids when they are not necessary for pain relief or the amount and/or frequency seems excessive. Be suspicious of any medication, especially an opioid or benzodiazepine (primarily used to treat anxiety), given every hour or two.

Pain Management: Opioids

Side effects: nausea, vomiting, slowed and shallow breathing, itchiness, rashes, constipation, confusion, coma, and in rare cases, increased pain. Some side effects are common; others are rare. The likelihood of some increases as the dosage increases; others can occur even in very low doses.

Morphine

- Short-acting (MSIR, Roxanol, suppositories)
- Long-acting (MS Contin, Oramorph SR, Kadain, Avinza)

Oxycodone

- Short-acting (Roxicodone, Oxyfast, Oxydose)
- Long-acting (OxyContin)

Hydromorphone (Dilaudid)

Codeine

Oxymorphone

Fentanyl

- Long-acting (Duragesic patches)
- Short-acting (Actiq Lozenges)
- Nasal sprays and injections

Fentanyl, a very potent opioid, effectively relieves extreme pain. It should be prescribed only when truly appropriate for a patient's condition, at the correct dose and interval between doses, and by the right route. Patients must be carefully monitored. The difference between a therapeutic and a deadly dose is small.

WARNING: Fentanyl, when misused, can cause life-threatening respiratory depression. **Avoid use in patients with impaired consciousness, coma, or head injury.** *See:* **drugs.com/fentanyl.html**

Pain Management: Combination Drugs

Hydrocodone/Tylenol-acetaminophen (Anexsia, Lorcet, Lortab, Norco, Vicodin, Zydone)

Codeine/Aspirin (Empirin with codeine)

Oxycodone/Tylenol-acetaminophen (Percocet, Roxicet)

Oxycodone/aspirin (Percodan)

Codeine/Tylenol-acetaminophen

Hydrocodone/Ibuprofen (Vicoprofen)

WARNING: In 2016, the U.S. Food and Drug Administration (FDA) ordered that its "strongest warnings" be added to labels on opioid pain medications and benzodiazepines after finding that the growing use of opioid medicines combined with benzodiazepines or other drugs that depress the central nervous system has resulted in serious side effects, including slowed or difficult breathing, and deaths.

www.fda.gov/Drugs/DrugSafety/ucm518473.htm

Opioid Agonist

Naloxone (Narcan) – This drug can reverse the effects/side effects of opioids; SAVES LIVES IN CASES OF LETHAL OVERDOSING.

Drugs Used to Treat Anxiety and Delirium: Antipsychotics

These may cause neurological symptoms (e.g., Parkinson's-like movements), flushing, dry skin, altered mental state, tremors, muscle jerking, insomnia, difficulty speaking or swallowing, fast heartbeat, constipation and even death.

Haloperidol *(*Haldol)*

Risperidone *(*Risperdal)**

Olanzapine *(*Zyprexa)

Quetiapine *(*Seroquel)

Aripiprazole *(*Abilify)

Benzodiazepines (Valium, Librium, Klonopin, Ativan) – **should not be used in delirium**

- Short-acting (Opana)
- Long-acting (Opana ER)

***Haldol** is not commonly used to treat nausea and vomiting (N/V). However, it can be tried when several other N/V medications have been used without result. Be cautious if the provider suggests Haldol as a first attempt to alleviate N/V or prescribes it to be given every 1-2 hours.

** **Risperdal,** in particular, is not approved for the treatment of patients with dementia due to increased risk of death.

Pain Management: Non-opioids

These can cause agitation, anxiety, confusion, vision problems, headache, constipation, insomnia and dizziness, as well as other side effects listed.

Tramadol HCL (Ultram) – **similar to opioids**

Tricyclic antidepressants (amitriptyline, a.k.a. Elavil; desipramine, a.k.a. Norpramin; imipramine, a.k.a. Tofranil; nortriptyline, a.k.a. Pamelor) – **tremors, tingling, numbness, hallucinations, urinary retention**

Steroids (such as dexamethasone, a.k.a. Decadron, DexPak) – **tiredness, mood swings, elevated blood sugar, high blood pressure, infection, sweats, digestive upset, edema**

SNRIs (venlafaxine, a.k.a. Effexor; Effexor XR; amitriptyline, a.k.a., Cymbalta)

Anti-inflammatory drugs (Motrin-ibuprofen, Advil)

Anti-epileptic drugs (carbamazepine, a.k.a. Tegretol; gabapentin, a.k.a. Neurontin; pregabalin, a.k.a. Lyrica; phenytoin, a.k.a. Dilantin; valproic acid, a.k.a. Depakene; clonazepam, a.k.a. Klonopin) – **sedation, drunk-like walk**.

INFORMATION ABOUT PAIN CONTROL

Nonpharmacological pain control methods (e.g., ice, heat, elevation, immobilization, rest, relaxation techniques, or meditation) should be utilized as part of any pain management plan.

Treating pain requires current knowledge about drugs and their proper use. The realistic goal should not be zero pain, but rather a tolerable level of pain that allows for optimal physical and emotional functioning. The patient's alertness and ability to interact with others should be preserved as much as possible.

Not all acute pain requires treatment with opioids. Opioids should be prescribed only when necessary, in the lowest effective dose, and for the shortest duration necessary. Due to their slower metabolism, most elderly patients need much less opioid medication for treatment of acute pain. Because of the significant risks of central nervous system depression and other side effects, as well as potential interactions with routine medications, the initial opioid doses prescribed for elderly or frail patients should be reduced.

Opioids should not be prescribed for sleep, to relieve anxiety, or for any purpose other than pain control.

Ongoing discussion between patients and their care providers is crucial for proper symptom management. Providers should never simply (or forcibly) medicate without discussion.

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