

PALLIATIVE CARE TIPS

Issue # 21 Palliative Sedation

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Definition: A process of inducing and maintaining deep sleep in order to relieve **refractory symptoms** in the palliative care setting when the patient is actively dying (days to a week of life expectancy). **Refractory symptom** is a condition where all other possible treatments have failed and no methods are available for alleviation of the symptom within the timeframe and risk-benefit ratio that the patient can tolerate, based on repeated and careful assessments by skilled experts as well as the team's consensus. Although "terminal sedation" has long been used to describe this practice, **Palliative Sedation** is thought to be a more appropriate term due to the possibility of misinterpreting the intention of sedation as being "termination of life".

Significance: Ethical validity: recent evidence does not demonstrate any shortening of survival in appropriately selected patients who received **Palliative Sedation**. It should be emphasized that the intention of this practice is exclusively to relieve **refractory symptoms** for those who are actively dying.

Approach:

Prior to considering **Palliative Sedation**:

1. Is the estimated survival prognosis longer than a week? If yes, then consider **temporary sedation** while awaiting the outcome of interventions aimed at reversal of factors contributing to symptoms (such as response to treatment for hypercalcemia, treatable infection, etc.).

Prior to initiating Palliative Sedation, the following questions should be answered:

1. Are the estimated survival prognosis days to a week?
2. Have the goals of care been established amongst the patient, or his or her proxy, and the health care team? (The goals of care in this circumstance should be to achieve maximum comfort for patient and allow the patient to die as part of the course of illness, rather than to use medical therapy to extend life.)
3. Has a thorough assessment been conducted to identify and treat reversible problems contributing to symptoms?
4. Have appropriate consultations been made with palliative care and other specialists to alleviate suffering?
5. Have non-pharmacological approaches been maximized, e.g. distraction or relaxation techniques in the case of anxiety/dyspnea?
6. Have other pharmacological treatments been maximized, e.g. appropriate titration of opioids in the case of dyspnea or of neuroleptics in the case of delirium?

When proceeding with Palliative Sedation:

1. Administer a loading dose of midazolam 2.5–5 mg subcutaneously, followed by midazolam 1 mg/hour by continuous subcutaneous infusion, then titrate until the patient becomes deeply sedated and appears to be comfortable.
2. The midazolam infusion can be titrated up or down every 5 to 10 minutes as needed.
3. The goal is to ensure comfort. No regular vital sign check is recommended, including respiratory rate; however, ensure that no sign of respiratory distress is observed.
4. Keep the room quiet.
5. A Foley catheter may be inserted at the appropriate timing.
6. Consider Tips # (how to diagnose the dying) # (how to care dying patient) # (noisy respiration)
7. Various levels and durations of sedation have been described in the literature; however considering the presence of refractory symptoms and proximity of death, it is best to limit **Palliative Sedation** to deep and continuous sedation. This reflects our current clinical practice.

When considering **Palliative Sedation**, it is strongly recommended to consult the Edmonton Zone Palliative Care Program. PLEASE SEE: Evidence-based care management tool

<http://www.palliative.org/NewPC/pdfs/management/3A6%20Palliative%20Sedation%20and%20Addendum.pdf>

REMEMBER: For referrals, questions, or telephone consultations call 496-1300 weekdays and weekends.

Palliative Care Tips are now available on our Website: www.palliative.org