March 2020 - Breathlessness management guidelines:

For community professionals to use to care for patients with known or suspected COVID-19 in community settings

Key principles:

- This guidance is intended for the management of breathlessness in patients who are known to be in the last weeks / days of life dying with COVID-19 or suspected COVID-19
- This should be read in conjunction with local palliative care symptom control guidelines.
- The goal of care is to manage symptomatic breathlessness and associated anxiety. These symptoms are managed with non-pharmacological interventions, opioids and benzodiazepines. These medications should not be withheld for fear of respiratory depression as they give great comfort and are the mainstays of symptom management. Most people need low doses of medication to achieve symptom relief; some will need higher doses, and the doses may need to be increased as the patient deteriorates. The guidance overleaf suggests sensible safe starting doses for people who may be in the last weeks / days of life.
- Consider alternatives to subcutaneous routes by switching early to patches or buccal preparations to ensure symptom control is not affected by availability of staff to given PRN medication or set up syringe drivers.
- Both opioids and benzodiazepines are likely to be sedative. Adequate symptom control in a deteriorating / dying patient who is significantly hypoxic may result in sedation, such that the patient becomes drowsy / semi-conscious or unconscious. This needs to be carefully communicated in advance to the patient (if appropriate), family and those important to the patient, and professional carers.
- Support informal carers in becoming confident with administration of oral/buccal/transdermal medications and consider supporting them in the administration of subcutaneous medication where appropriate (see separate guidance)
- All doses are starting doses for opioid naïve patients. Please reduce or use alternatives in renal or liver impairment and titrate up/convert as appropriate for patients already on strong opioids. Contact your local palliative care team for further advice.
- Vital observations should be stopped and comfort observations used. Oxygen (if it has been part of treatment) may no longer be useful. If of no benefit it can be stopped; many find an oxygen mask difficult to tolerate at this time.

Symptom	Non-pharmacological approaches	Starting doses in opioid naïve patients			
		Oral route	**Subcutaneous route**	**Syringe driver doses**	**Medications via alternative routes**
Breathlessness	Cool flannel around the face and nose Draught from an open window **NB:** Fan therapy is *not* advised due to infection control risks for others	Morphine sulphate immediate release 1-2mg PO PRN hourly and titrate to response or Morphine sulphate modified release 5mg PO BD and titrate to response In renal failure, consider Oxycodone – seek advice from Palliative Care	Morphine sulphate 1-2mg SC PRN hourly and titrate to response In. renal failure, consider Oxycodone – seek advice from Palliative Care	Morphine sulphate 10mg/24 hours and titrate according to response In renal failure, consider halving dose or oxycodone – seek advice from Palliative Care	Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days Concentrated oral morphine solution (20mg/ml) at dose of 2.5-5mg (0.125-0.25mls) administered buccally (draw up in syringe then inject into side of mouth and rub cheek to enable absorption). Seek advice from palliative care team
Agitation / anxiety – likely to be contributing to breathlessness	See above Consider relaxation CDs, breathing exercises (extend 'out' breath) etc	Lorazepam 500mcg-1mg sublingually QDS	Midazolam 2.5-5mg SC PRN hourly	Midazolam 10mg/24 hours and titrate according to response (reduce to 5mg/24 hours if eGFR <30)	Midazolam 10mg/2mls for buccal or nasal administration 0.5-1ml PRN hourly Prefilled midazolam buccal solution (Buccolam 10mg/2ml or Epistatus 10mg/ml) Rectal diazepam 10mg PR PRN
Respiratory secretions	Positioning Reassurance for carers	N/A	*Glycopyrronium 200-300mcg SC hourly (max 1.2mg/24 hrs) *Hyoscine butylbromide 20mg SC hourly (max 120mg/24 hrs) *Hyoscine hydrobromide 0.4mg SC hourly (max 1.6mg/24 hrs) *Choice depends on local formulary	*Glycopyrronium 0.8-1.2mg/24 hours *Hyoscine butylbromide 60-120mg/24 hours Hyoscine hydrobromide 1.2-1.6mg/24 hours *Choice depends on local formulary	Hyoscine hydrobromide patches (Scopoderm) 1mg 72 hourly (can use 2 patches) Glycopyrronium injection applied buccally 200-300mcg SC hourly (max 1.2mg/24 hrs)
Fever	Cool flannel	Paracetamol 1g PO QDS	N/A	N/A	Paracetamol suppositories 1g QDS PR