Flinders UNIVERSITY

JOURNAL OF PALLIATIVE MEDICINE
Volume 16, Number 7, 2013

DOI: 10.1089/jpm.2013.0062

Core Medicines for Quality Care of the Dying

Paul A. Tait, BPharm, MClin Pharm, MSHP and Timothy H. M. To, BSc, BMBS, FRACP

Dear Editor:

The proposal by Lindqvist and colleagues[1] of four essential medicines for the control of terminal symptoms is commendable. Having a finite essential medication list facilitates prescribers to prescribe and pharmacies to stock and supply medications to support end-of-life care in the community.[2] With this issue in mind, a recent collaboration of South Australian palliative care clinicians developed a core medicines list for the treatment of symptoms commonly seen at the end of life. As for Lindqvist's model, we also involved widespread consultation with key palliative care stakeholders. We employed a number of criteria, partly informed by Rowett[3] in the development of our list, including

- Evaluation of the medical literature
- Cost (including the availability of government subsidies)
- Medicines that are able to address more than one symptom
- Route(s) of administration

Our core medicines include

- Clonazepam
- Haloperidol
- Hyoscine butylbromide
- Metoclopramide
- Morphine

The differences between the two lists are the choices of benzodiazepine and anticholinergic, and the inclusion of metoclopramide.

Both midazolam and clonazepam are used for symptom control at the end of life. However midazolam's short duration of action means a syringe driver is required for lasting effect, which may be unavailable at short notice. Therefore, with community patients in mind, we proposed clonazepam as our benzodiazepine of choice. In Australia, clonazepam is also eligible for government subsidy, thus cheaper than injectable midazolam for patients. We selected hyoscine butylbromide because of its inability to cross the blood brain barrier to minimize central anticholinergic effects, particularly sedation and delirium, for patients who are still conscious.

Each list was developed to facilitate high-quality symptom control at the end of life for community patients. Regional licensing and subsidy will influence the exact medications on such lists. However with essential medication lists, the imperative is to educate both prescriber and pharmacist to ensure the medications prescribed at the end of life will be available for the patient in his or her time of great need. Without education, the risk is the prescriber, through personal preference, will prescribe medications outside the list and compromise the symptom control of the patient at the end of life simply because the pharmacist is unable to anticipate which medicines to stock.

References

1. Lindqvist O, Lundquist G, Dickman A, Bükki J, Lunder U, Hagelin CL et al.: Four essential drugs needed for quality care of the dying: a Delphi-study based international expert consensus opinion. J Palliat Med 2013;16(1):38–43.
2. Lucey M, McQuillan R, MacCallion A, Corrigan M, Flynn J, Connaire K: Access to medications in the community by patients in a palliative setting: A systems analysis. Palliat Med 2008;22:185–189.
3. Rowett D, Ravenscroft PJ, Hardy J, Currow D: Using national Health Policies to improve access to palliative care medicines in the community. J Pain Symptom Manage 2009;37(3):395–402.

Address correspondence to:
Paul A. Tait, BPharm, MClin Pharm, MSHP
Daw House Hospice
Repatriation General Hospital
700 Goodwood Road
Daw Park, South Australia 5041

E-mail: Paul.Tait@health.sa.gov.au

Southern Adelaide Palliative Services, Repatriation General Hospital, Adelaide, Australia.