PALLIATIVE MEDS INFO NEWSLETTER

Volume (1) Issue (1) March 2012.

Welcome to the first edition of the Palliative Meds Info Service newsletter. The newsletter will share summaries of some of our most interesting or frequently asked questions and discuss practical issues relating to medicines use in palliative care. Enjoy!

Palliative Meds Info
Palliative Care Medicines Information Service

Our Lady's Hospice & Care Services
tel: 01 4912578 Harold's Cross
palliativemedsinfo@olh.ie & Blackrock

Palliative Meds Info – the story so far….

The National Palliative Medicines Information Service **Palliative Meds Info** based at Our Lady's Hospice & Care Service was officially launched by the Minister Mary Harney, TD, Minister for Health and Children on 22nd September 2010.

What is Palliative Medicines Info?

It's a telephone and email enquiry answering service on all aspects of medicines use in palliative care. We are currently developing our webpage (available via www.olh.ie) which together with the newsletter will proactively circulate information on medicines in palliative care to health professionals. Palliative Meds Info aims to assist practitioners in providing the very best care to their patients with palliative care needs.

What type of enquiries will be answered?

All types of enquiries that are medicines related and which related to the treatment and symptom control of patients with life-limiting illnesses will be taken.

How can you contact us?

Contact us at Our Lady's Hospice and Care Services on 01 4912578 or at palliativemedsinfo@olh.ie
For more information, visit our webpage by clicking on the logo on Our Lady's Hospice & Care Services homepage: www.olh.ie

Your Views

To ensure the service meets your information needs, we would love to get your suggestions for topics for our newsletter or for any aspect of the service. Email us palliativemedsinfo@olh.ie

Cliona Hayden
Eimear O'Dwyer
Fiona McGrehan

Our Lady's Hospice & Care Services

Opioid Rotation for Opioid-Induced Pruritis

Q: A patient developed opioid-induced pruritus when taking morphine. Is there any evidence to support opioid rotation to relieve the opioid-induced pruritus?

Answer Summary

- Pruritus occurs in about 2-10% of patients treated systemically with opioids.
- The risk is markedly increased when opioids are given intraspinally.
- The prevalence of itching also rises with increasing dosage.
- Evidence to support opioid rotation to treat opioid-induced itch is limited to a very small number of case reports.
- Other treatment strategies include the use of opioid antagonists in low doses.

There is varying incidence of itch associated with different opioids as out lined in the table. Read the full enquiry on our webpage: 'Will opioid rotation resolve an opioid induced itch?'.

OPIOID	REPORTED INCIDENCE OF ITCH
Morphine	IV/SC routes: Up to 80% Oral = Less than 1%
Oxycodone	Controlled-release = 13%; Immediate-release = 3% or greater.
Hydromorphone	Extended-release = 1% to 8%
Fentanyl	*All routes:* 3%-10%
Alfentanil	0.3% - 1%
Methadone	Incidence is not outlined but pruritus is listed as an adverse effect.

Calcitonin in Resistant Hypercalcaemia

Q. Can calcitonin be used to treat severe hypercalcaemia that is resistant to bisphosphonates?

Answer Summary

Calcitonin can be used to treat hypercalcaemia of malignancy. It may be particularly useful in life-threatening hypercalcaemia in addition to rehydration and diuresis because of its rapid effect. However, it is rarely effective where bisphosphonates have failed to reduce serum calcium adequately. Its rapid effect is usually short-lived and it is therefore generally given as adjunct to bisphosphonates or may be useful if bisphosphonates are specifically contraindicated. It is usually given intramuscularly or subcutaneously. In emergency situations it can be given by continuous intravenous infusion. There are two types of calcitonin in clinical use, synthetic calcitonin of salmon origin, referred to as calcitonin (salmon) and synthetic human calcitonin. Calcitonin (salmon) is the most potent. Miacalcic® - calcitonin (salmon) 100 units/ml solution for injection or infusion, licensed in the UK, is available as an unlicensed product in Ireland. The calcium-lowering effect of calcitonin is caused both by a decrease in the efflux of calcium from the bone to the extracellular fluid (ECF) and inhibition of renal tubular reabsorption of calcium. Frequent monitoring of the clinical and laboratory response including the measurement of serum calcium is recommended especially in the early phase of treatment. **Subcutaneous Dose:** 100 units s.c. every 6-8 hours adjusted after one or two days according to response up to a maximum of 400 units every 6-8 hours. For more detailed information contact Palliative Meds Info or see our webpage: Calcitonin in Resistant Hypercalcaemia

Focus on Transdermal Patches:

See Palliative Meds Info Service Webpage for:

- Transdermal Opioid Patches: Information Sheet.
- Fentanyl patch – Q. Can fentanyl transdermal patches be applied 48 hourly?
- Fentanyl patch – Q. How many patches can be applied at once?

Other Information on our Website:

- Methadone – From Hospital to Home – Practical Information

The supply of methadone to palliative care patients in the community has been reported to be challenging. We hope that the accessibility of this information will support GPs and community pharmacists in caring for palliative care patients and help the transition of patients from hospice/hospital setting to their homes.

- Treatment Options for a Painful Mouth

Here we discuss treatment options and strategies for managing oral pain in palliative care patients.

Did you know about the Oxycontin® & Targin® 'Ghost' tablets?

Oxycodone is released over 12 hours from the Oxycontin® matrix tablet. Oxycodone and naloxone are released over 12 hours from the Targin® matrix tablet. This matrix provides the 'sustained release' properties of the tablet. This matrix or 'ghost' does not completely dissolve and may be passed in the stool or through an ileostomy. Patients may report seeing this matrix and think that the drug has not been absorbed or may not be working. If it is passed in the stool, it contains little or no residual active substances and it is of no clinical consequence. However, if it is passed through an ileostomy within 12 hours after taking it the patient may not have received a full dose. In this case, the dose of Oxycontin® or Targin® should be adjusted according to the pain requirements of the patient. It may be appropriate to advise patients with ileostomy tubes in situ of the ghost tablet effect.