

# Clinical Resource Guide: Palliative Sedation

## INTRODUCTION TO PALLIATIVE SEDATION

Palliative sedation is the practice of relieving refractory and distressing symptoms in a terminally ill person, primarily through pharmacologically reducing consciousness. It is typically administered by intravenous, subcutaneous, or rectal route. Palliative sedation is considered a last resort in extreme situations for patients whose symptoms cannot be controlled by any other methods. These symptoms are typically overwhelming pain, dyspnea, nausea, convulsions, hemorrhage, or agitated delirium. For some patients, relief of symptoms may outweigh the desire to be fully conscious.

### Pharmacist Corner Objectives

- 1.) Describe criteria and ethical considerations of palliative sedation
- 2.) Understand the pharmacological management of palliative sedation
- 3.) Identify clinical pearls and palliative sedation tips

## CRITERIA FOR PALLIATIVE SEDATION

- All means of alleviating suffering have been ineffective or have produced intolerable side effects
- The goal is to palliate symptoms, not hasten death
- Advisory council or ethics committee consultation and review
- The decision is in line with the care goals of the patient or appointed decision maker

## ETHICAL CONCERNS: SEDATION VS EUTHANASIA

There are fundamental differences between sedation and euthanasia. The intended goal of palliative sedation is to relieve severe distress and suffering from symptoms

perceived to be unbearable. It is not intended to hasten death, but rather, to better control refractory symptoms. In contrast, euthanasia is performed with the intent to end the patient’s life. A careful interdisciplinary review and consideration by an ethical committee is advised.

**Table 1. Pharmacological Management of Palliative Sedation**

Anesthetics			
Medication	Usual Adult Dose	Common Formulations	Notes
<b>Propofol</b>	0.3-1mg/kg/hr continuous	10mg/ml injection	<ul style="list-style-type: none"> <li>• Reduce dose when used with opioids</li> <li>• Reserve use for instances where other sedatives are ineffective</li> </ul>
Antipsychotics			
Medication	Usual Adult Dose	Common Formulations	Notes
<b>Haloperidol</b>	0.5-2mg Q4-12hr	Tablets: 0.5, 2, 2, 5, 10mg Oral solution: 2mg/ml Injection: 5mg/ml	<ul style="list-style-type: none"> <li>• First-line for patients with terminal restlessness/delirium</li> <li>• Monitor for extrapyramidal side effects</li> </ul>
<b>Chlorpromazine</b>	25-100mg Q4-12hr intermittent or 3-5mg/hr continuous	Tablets: 10, 25, 50, 100, 200mg Injection: 25mg/ml	<ul style="list-style-type: none"> <li>• More sedating than haloperidol</li> <li>• Effective sedative and anxiolytic with rapid onset</li> <li>• Tissue damage may occur with SC use</li> <li>• Associated with QT prolongation</li> </ul>

Barbiturates			
Medication	Usual Adult Dose	Common Formulations	Notes
<b>Pentobarbital</b>	1-5mg/kg/hr continuous	Injection: 50mg/ml	<ul style="list-style-type: none"> <li>Consider a loading dose of 50-100mg with initiation of continuous infusion</li> <li>Increases drug metabolism and can decrease serum concentration of other drugs</li> </ul>
<b>Phenobarbital</b>	60-120mg Q4-12hr intermittent or 0.5mg/kg/hr continuous	Tablets: 15, 16.2, 30, 32.4, 60, 64.8, 97.2, 100mg Injection: 65mg/ml, 120mg/ml	<ul style="list-style-type: none"> <li>Increases drug metabolism and can decrease serum concentration of other drugs</li> <li>Useful in patients with high tolerance to benzodiazepines and antipsychotics</li> </ul>
Benzodiazepines			
Medication	Usual Adult Dose	Common Formulations	Notes
<b>Lorazepam</b>	0.5-2mg Q2-8hr intermittent or 0.01-0.1mg/kg/hr continuous	Tablets: 0.5, 1, 2mg Oral solution: 2mg/ml Injection: 2mg/ml, 4mg/ml	<ul style="list-style-type: none"> <li>Refrigeration recommended for oral solution and injection</li> <li>Often given with an antipsychotic to relieve agitated delirium</li> <li>Relatively slow onset</li> </ul>
<b>Midazolam</b>	0.5-1mg/hr continuous	Injection: 1mg/ml, 5mg/ml	<ul style="list-style-type: none"> <li>May give 5mg IM injection STAT followed by continuous infusion</li> <li>Drug of choice for respite sedation due to short half-life</li> <li>Often given with an antipsychotic to relieve agitated delirium</li> <li>Assess and evaluate dose every 24 hours</li> </ul>

## PHARMACOLOGICAL MANAGEMENT: CLINICAL PEARLS

1. Treatment of other symptoms such as pain or nausea should be continued along with palliative sedation.
2. Level of sedation may range from light to complete unconsciousness. The lowest amount of sedation that has the desired effect should be used.
3. It may be appropriate to reduce sedation periodically to assess efficacy and continued need.
4. Artificial hydration and nutrition are not typically expected to benefit patients receiving palliative sedation, as patients are typically imminently dying (e.g., 24-72 hours).
5. When possible, palliative sedation should be discussed as part of comprehensive goals of care planning when death is not imminent but the patient is at risk of intolerable suffering.

## SUMMARY

Palliative sedation utilizes specific sedative non-opioid medications to reduce consciousness. The goal is to relieve suffering in terminally ill patients when all other options have been exhausted. Decisions should be made via an interdisciplinary approach with consideration for treatment method, ethical concerns, and patient's wishes.

## References:

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2. Palliative Care Network of Wisconsin. (2022, October 13). Palliative sedation in the home setting - Palliative Care Network of Wisconsin. <https://www.mypcnow.org/fast-fact/palliative-sedation-in-the-home-setting/>
3. American Academy of Hospice and Palliative Medicine. (n.d.). Palliative sedation | AAHPM. 2024. <https://aahpm.org/positions/palliative-sedation>
4. Cherny, N., MD. (2022). Palliative sedation. UpToDate.