Pallium Canada

Webinar Q&A
Shortage of Palliative Medications during COVID-19: Options – Wednesday April 15, 2020 @ 2 pm ET

Remaining Questions	CPC Exchange
Valerie 02:15 PM **Nozinan both PO and parenteral?**	There were several questions submitted during the webinar that the panellists were unable to answer due to the time restrictions of the webinar. Please continue the discussion by joining the Canadian Palliative Care Exchange and posting your question as a discussion topic. There is no cost to participate. Join now to share and learn alongside your colleagues from across Canada: www.cpcexchange.ca
Anonymous 02:16 PM **Half the Covid deaths have been in long term care. Should this setting not be a priority for needed meds?**	
Elisabeth 02:17 PM **BC here - reported shortages of palliative meds include: hydromorphone, dexamethasone, midazolam, octreotide, salbutamol MDI. Hearing of "half fills" from pharmacists for families.**	
David 02:20 PM **Has anyone in the province spoken with the distributers of meds to pharmacies?**	
Desiree 02:22 PM **If we can use chlorpromazine, can we use prochlorperazine?**	
Valerie 02:27 PM **Are there thoughts on expiry dates of medications? Is it possible to use recently expired supplies of these medications if there were critical shortages?**	

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Lynne 02:28 PM **Could we also address ODB coverage for substitutions ie sq lorazepam?**		
Danica 02:35 PM **Is there any evidence for buccal route for any of these medications similar to how we use methadone?**		
Rebecca 02:35 PM **Are any pharamacies repurposing unused medications from SRKs in any regions? If so how are they doing this while taking infection control into conisderation? (ON)**		
Question	**Answer**	**CPC Exchange**
Anne 02:11 PM **What would be your maximum dilaudid dose sub cut q4h before saying you did a good enough trial with no response and would think about palliative sedation? (of course, would add Ativan before going to sedation for dyspnea)**	Tough to give a precise number. I think it would be less about the amount of the standing dose than perhaps the number of PRNs (and dose of PRNs) you are giving, and whether it is having any apparent effect at all. The literature describes a “dyspnea crisis” which is very distressing and maybe you would want to go to sedation fairly quickly without waiting for opioids to kick in. But otherwise I would not necessarily have a fixed number in mind.	If you’d like to continue this conversation head to the Canadian Palliative Care Exchange and create a discussion topic or contribute to a conversation already taking place. There is no cost to participate. Join now to share and learn alongside your colleagues from across Canada: www.cpcexchange.ca
Anonymous 02:14 pm	Health Canada is suggesting that there may be logical shortages of	

Will injectable Fentanyl be in short supply?	different medications – fentanyl wasn't at the top of the list, but I wouldn't rule it out.	
Michael 02:17 pm **Would you be willing to share the palliative care over set specific to COVID that Dr. Arya mentioned? I work in a small rural hospital and would rather use established practice as opposed to "re-inventing the wheel"**	Do you mean the 1-pager that Dr. Pereira showed at the start? It will be posted by pallium afterwards. For an SMK order set, there is one in our CMAJ publication from 2 weeks ago.	
Valerie 02:17 pm **Is there a website where medication shortages are reported regularly so we can keep up to date on these?**	Sadly no- this is so variable by region and time that I'm not sure we could keep this up, or who would actually know what is what. Even in neighbouring parts of Ontario it seems to be totally different.	
Viv 02:27 pm **What is the dose of loxapine?**	SC- would give 5-10mg as a starting dose for sedation, can repeat dosing q4h. You can go up fairly high- as much as 200mg for ICU patients in France.	
Anonymous 02:40 pm **I have an MD who is extremely concerned regarding the respiratory depression possibility with midazolam. There is less concern with Ativan. What would an Ativan equivalent dose be before**	Personally, I'm not sure there is any data to suggest that midaz or lorazepam are that much different in terms of resp depression (neither are all that risky). So, I would say, if you need to sedate someone who is very symptomatic, I would use 2mg-4mg and go from there.	

respiratory depression were a concern? Thank you.		
Jean 02:40 pm **Thoughts on lidocaine pre-propofol administration to prevent pain on administration?**	It's always written about but in order for it to work, you need to give the lido and then tourniquet the vein to keep it static for 30-60sec. Most people don't do that.	
Natalie 02:46 pm **What about using diazepam for sedation? Is it very available?**	Fantastic option commonly used for EtOH withdrawal. The big issue is that it is available only IV and PO. Can't be given SC due to skin irritation.	
Tracy 02:47 pm **We are experiencing shortages of dexamethasone (PO and injectables) and some concentrations of injectable hydromorphone in NS.**	For dex- you can give hydroxycortisone subcutaneously (albeit you may need multiple injection sites due to volume) and I saw a reference for IM solumedrol	
Pam 02:50 PM **Methadone can be hyperconcentrated to 100mg/mL and given sL, works well, I.e. 50mg = 0.5mL**	A great option that we've used in the ICU before. Just have to be conscious of the volume for patients who require high doses. Can only absorb so much.	
Clarissa 02:54 pm	If pt. can tolerate PO- try prednisone at 5:1 dosing compared with dex.	

Pain - dexamethasone used for pain secondary to boney mets etc. - was told locally PO on back order		