69 CONGRESO NACIONAL
SOCIEDAD ESPAÑOLA DE FARMACIA HOSPITALARIA

A CORUÑA
17-19 OCT 24

ATENCIÓN FARMACÉUTICA INTEGRAL AL PACIENTE PALIATIVO Y AL FINAL DE LA VIDA

Principios básicos en la atención farmacéutica al paciente paliativo y en curas paliativas

ALEX FERRO URIGUEN

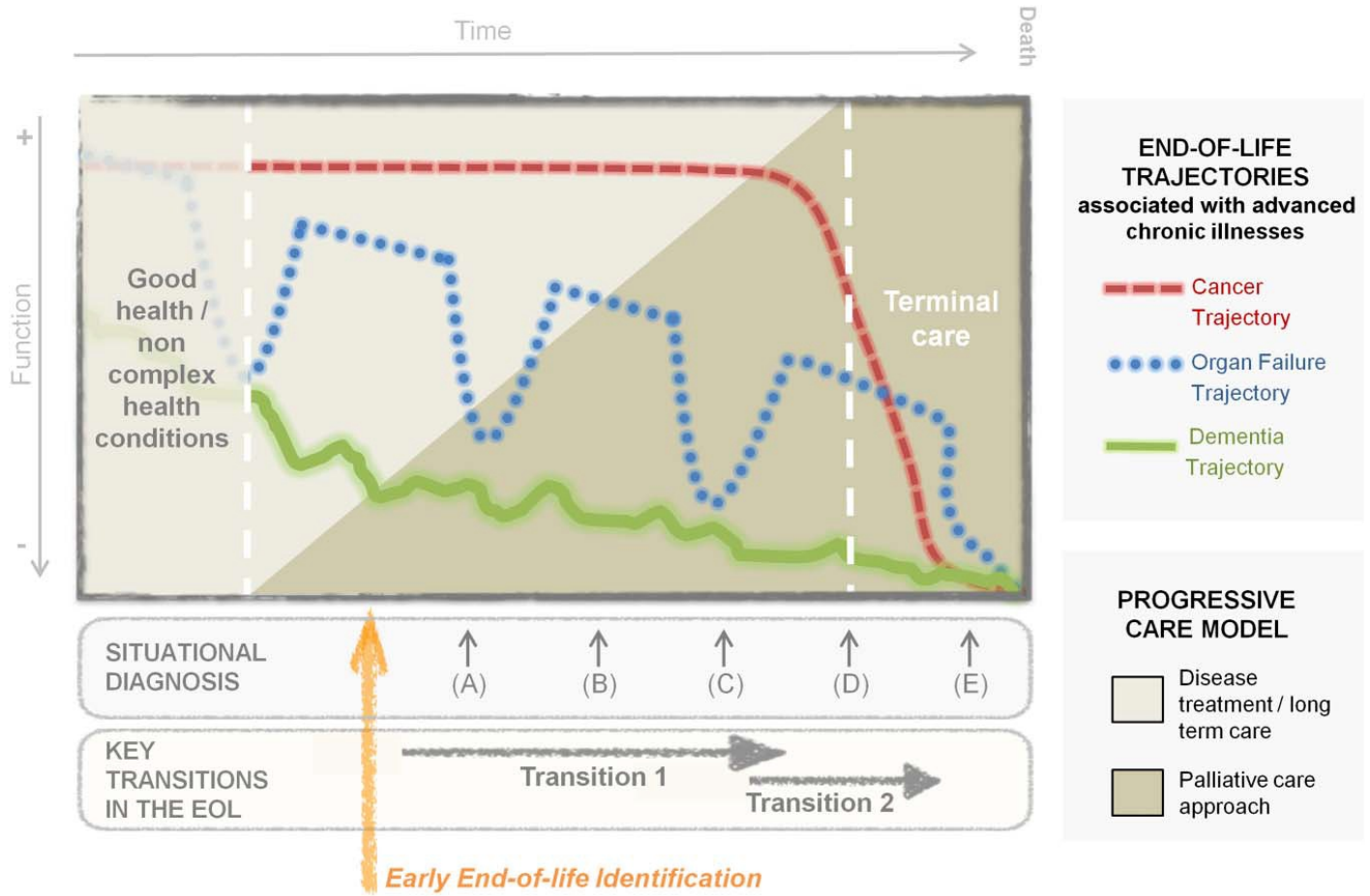
sefh
Sociedad Española de Farmacia Hospitalaria

ATENCIÓN PALIATIVA: Transición Conceptual del Siglo XXI

Enfermedades Crónicas Avanzadas	Identificación	Dimensión de los Cuidados	Cuidados
Cáncer		Físico	Unidades Específicas

ATENCIÓN PALIATIVA: Transición Conceptual del Siglo XXI

Enfermedades Crónicas Avanzadas	Identificación	Dimensión de los Cuidados	Cuidados
Cáncer	Identificación precoz	Físico	Unidades Específicas
Insuficiencia de Órgano	Pronóstico de Vida Limitado	Psicológico	Atención Primaria
Demencia		Social	Atención Hospitalaria
		Espiritual	Centros Residenciales



Amblàs-Novellas J et al. Identifying patients with advanced chronic conditions for a progressive palliative care approach: a cross-sectional study of prognostic indicators related to end-of-life trajectories. BMJ Open. 2016 Sep 19;6(9):e012340. doi: 10.1136/bmjopen-2016-012340

¿Cuántos de los presentes hoy aquí realizáis atención farmacéutica en pacientes con enfermedades crónicas avanzadas y en fase final de vida?

Identificación de enfermedades crónicas evolutivas con pronostico de vida limitado.

ESTUDIO DE PREVALENCIA

1,5 % población

25-40 % en Hospital

60-70 % en centros residenciales

Gómez-Batiste X et al. Prevalence and characteristics of patients with advanced chronic conditions in need of palliative care in the general population: A cross-sectional study. Pall Med 2014; 28: 302-11.

Open access Original research

BMJ Open

How many people will need palliative care in Scotland by 2040? A mixed-method study of projected palliative care need and recommendations for service delivery

Anne M Finucane ,[1,2] Anna E Bone,[3] Simon Etkind,[3] David Carr,[4] Richard Meade,[5] Rosalia Munoz-Arroyo,[4] Sébastien Moine,[2,6] Aghimien Iyayi-Igbinovia,[4] Catherine J Evans,[3] Irene J Higginson,[3] Scott A Murray [2]

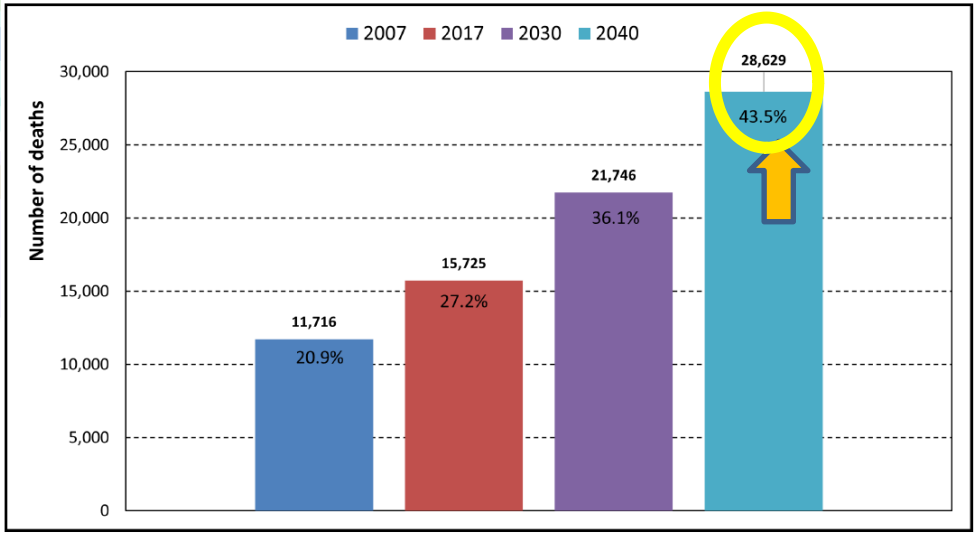


Figure 3 Projected number and percentage of people in Scotland dying from multimorbidity associated with palliative care need, 2017 to 2040. *Note: Data for 2007 and 2017 is actual deaths; data for 2030 and 2040 is projected deaths.*

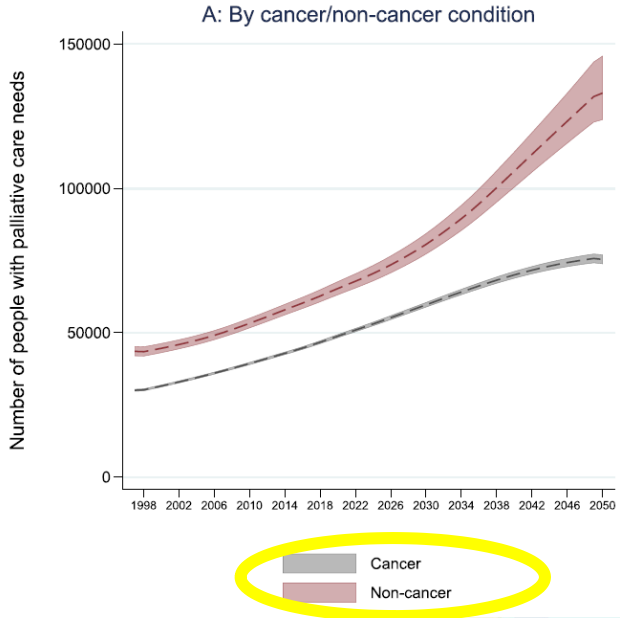
Leniz et al. BMC Medicine (2024) 22:350
https://doi.org/10.1186/s12916-024-03570-1

BMC Medicine

RESEARCH ARTICLE Open Access

Past trends and future projections of palliative care needs in Chile: analysis of routinely available death registry and population data

Javiera Leniz[1,2*], Angélica Domínguez[1], Anna E. Bone[2], Simon Etkind[3,4], Pedro E. Perez-Cruz[5] and Katherine E. Sleeman[2]



Open access Original research

BMJ Open

How many people will need palliative care in Scotland by 2040? A mixed-method study of projected palliative care need and recommendations for service delivery

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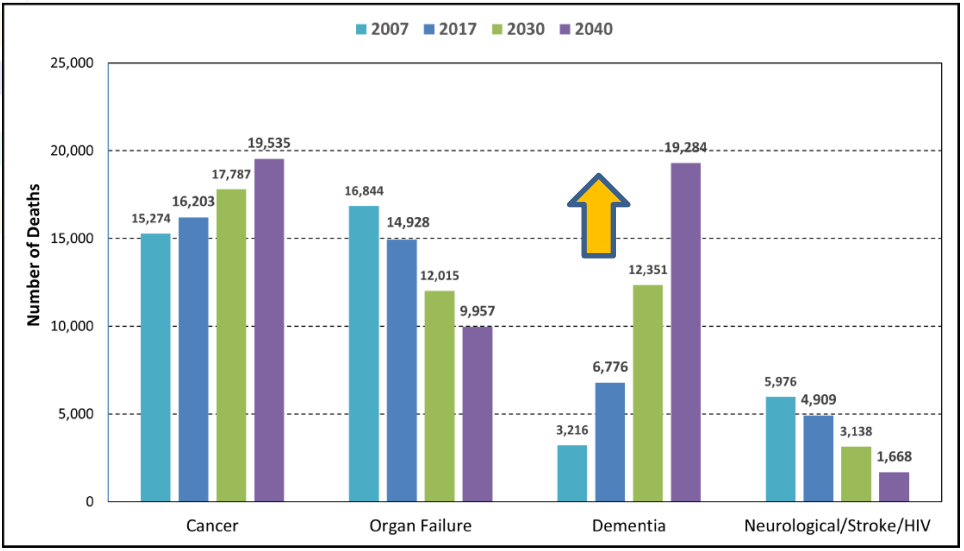

Figure 2 Projected main underlying cause of death associated with palliative care need by disease group up to 2040 using method 2B. *Note: Data for 2007 and 2017 is actual deaths; data for 2030 and 2040 is projected deaths based on method 2B.*

Leniz et al. BMC Medicine (2024) 22:350
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RESEARCH ARTICLE Open Access

Past trends and future projections of palliative care needs in Chile: analysis of routinely available death registry and population data

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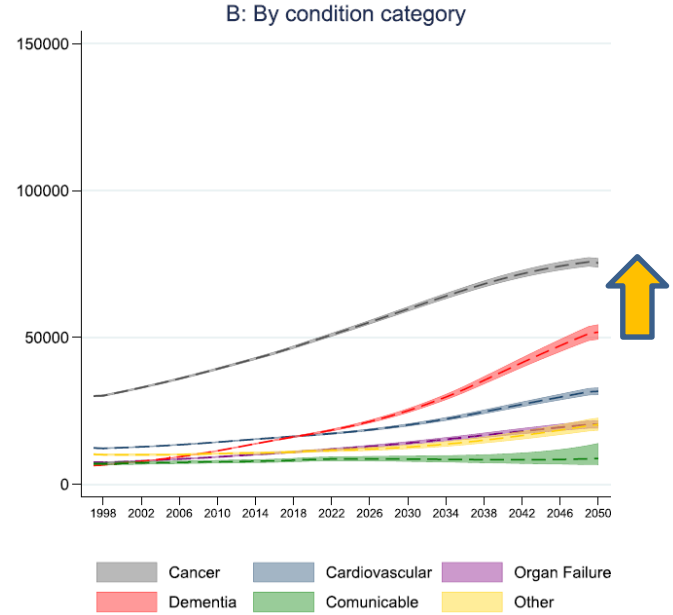


Economic Evaluation Study

Medicine

OPEN

End-of life medical spending and care pathways in the last 12 months of life

A comprehensive analysis of the national claims database in France

2015: 501.121 fallecidos; 59% Hospital

Atención EOL 9 % Gasto Sanitario Total

14 billones de €

28085€/persona

44% del Gasto Últimos 3 meses de vida

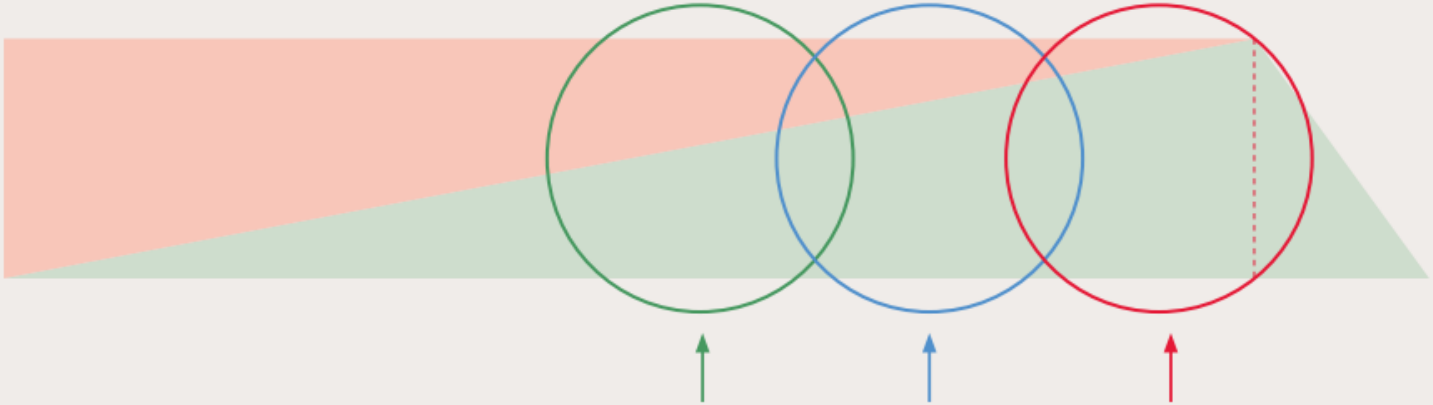
Hospitalizaciones; 70% del Gasto Total

Nze Ossima A, Szfetel D, Denoyel B, Beloucif O, Texereau J, Champion L, Vié JF, Durand-Zaleski I. End-of life medical spending and care pathways in the last 12 months of life: A comprehensive analysis of the national claims database in France. **Medicine. 2023** Aug 4;102(31):e34555.

INSTRUMENTO NECPAL VERSIÓN 4.0 2021

https://www.catedrapaliativos.com/NECPAL

Estadio evolutivo: en función del número de parámetros pronósticos afectados, se pueden identificar 3 grandes grupos pronósticos o estadios evolutivos:



PS
Pregunta sorpresa

Parámetros afectados
- Necesidades identificadas
- Declive funcional
- Declive nutricional
- Multimorbilidad
- Aumento uso recursos
- Indicadores específicos

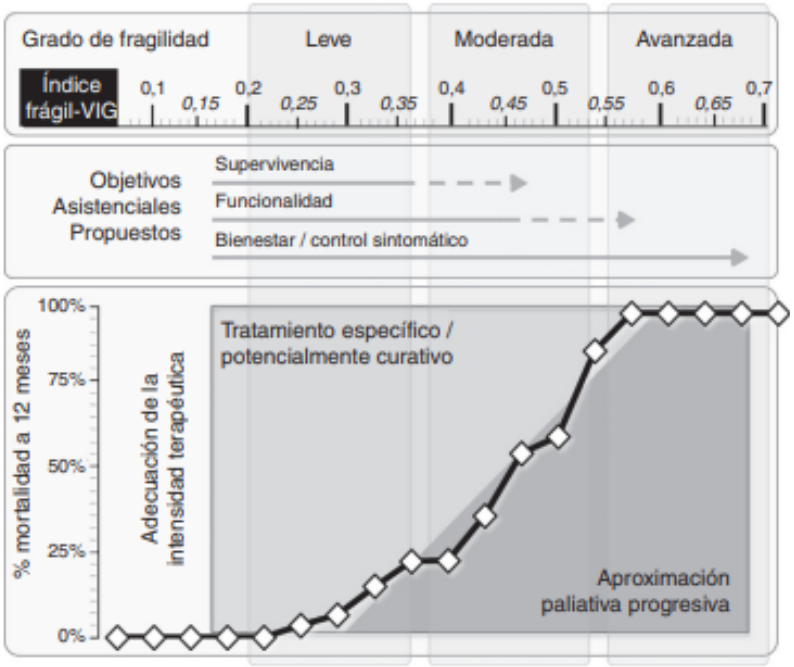
Estadio I
- PS + 1-2 parámetros
- Mediana: 38 meses

Estadio II
- PS + 3-4 parámetros
- Mediana: 17.2 meses

Estadio III
- PS + 5-6 parámetros
- Mediana: 3.6 meses

https://www.catedrapaliativos.com/NECPAL

Índice de fragilidad efecto acumulativo de los déficits individuales donde evalúan la **funcionalidad**, la **situación cognitiva**, la **multimorbilidad**, los **síndromes geriátricos**, la **polifarmacia** y los **elementos sociales**, de tal manera que a mayor número de déficits se corresponde con un mayor grado de fragilidad



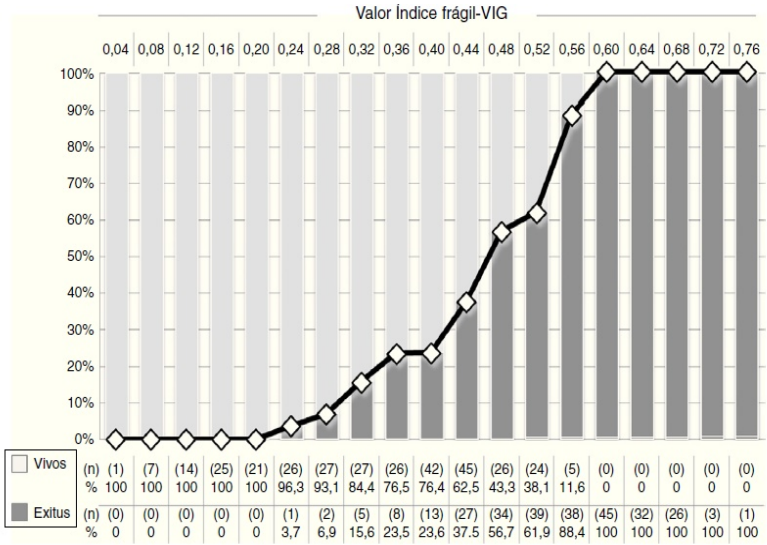
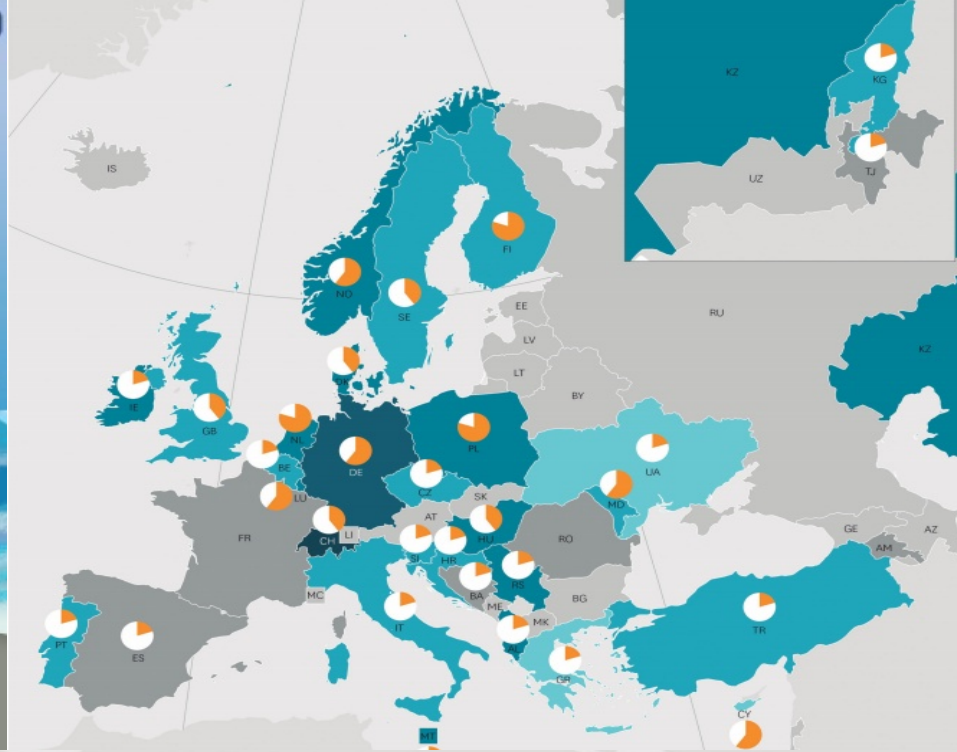


Figura 1. Distribución en número (n) y porcentaje (%) de pacientes *exitus* y vivos a los 12 meses por valor de índice frágil-VIG.

NACIONAL SOCIEDAD ESPAÑOLA DE FARMACIA HOSPITALARIA
A CORUÑA 17-19 OCT 24

Amblàs-Novellas J, Martori JC, Molist Brunet N, Oller R, Gómez-Batiste X, Espaulella Panicot J. Índice frágil-VIG: diseño y evaluación de un índice de fragilidad basado en la Valoración Integral Geriátrica. Rev Esp Geriatr Gerontol. 2016;52(3):119–27.



TIME BEFORE DEATH RECEIVING PALLIATIVE CARE AT PRIMARY LEVEL

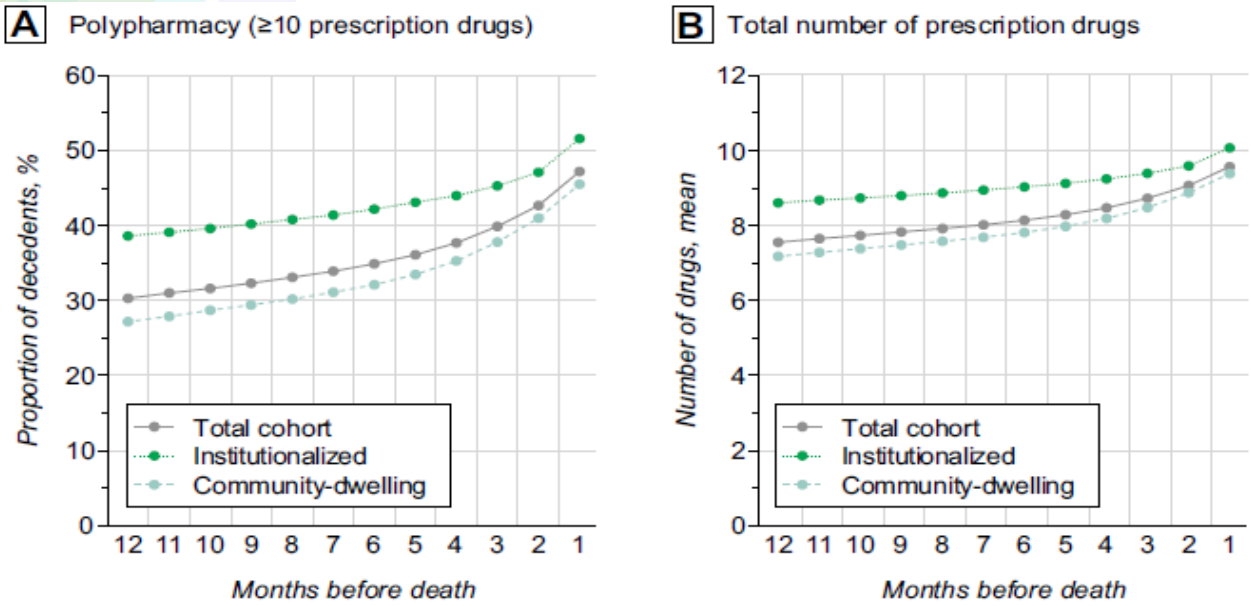
- More than 1 year
- Between 6 months and 1 year
- Between 1 month and 6 months
- Between 1 week and 1 month
- Less than 1 week
- NA

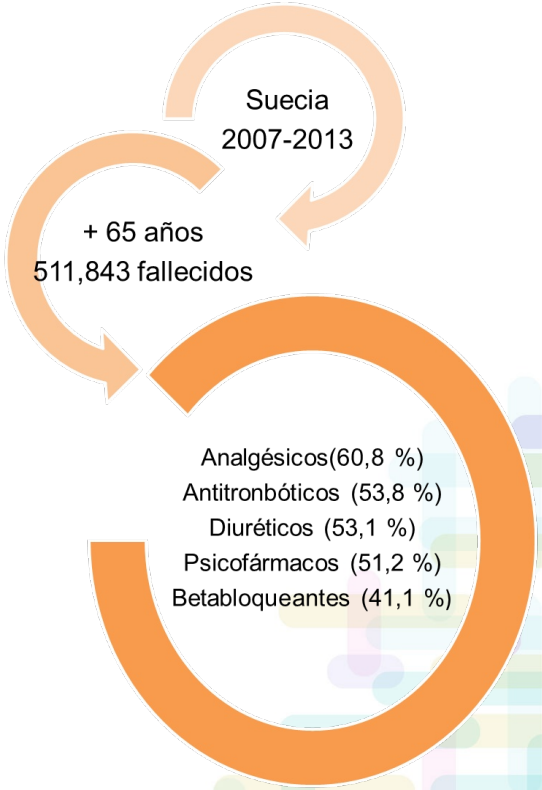
PERCENTAGE OF PALLIATIVE CARE PATIENTS IDENTIFIED AT PRIMARY LEVEL

- 61 - 80%
- 41 - 60%
- 21 - 40%
- 1 - 20%

Choosing Wisely? Measuring the Burden of Medications in Older Adults near the End of Life: Nationwide, Longitudinal Cohort Study

Lucas Morin, MS,[a] Davide L. Vetrano, MD,[a,b] Debora Rizzuto, PhD,[a] Amaia Calderón-Larrañaga, PhD,[a,c] Johan Fastbom, MD, PhD,[a] Kristina Johnell, PhD[a]





69 CONGRESO NACIONAL
SOCIEDAD ESPAÑOLA DE FARMACIA HOSPITALARIA
A CORUÑA 17-19 OCT 24

Morin, Lucas et al. Choosing Wisely? Measuring the Burden of Medications in Older Adults near the End of Life: Nationwide, Longitudinal Cohort Study The American Journal of Medicine. 2017 Aug;130(8):927-936

Original Article

PALLIATIVE MEDICINE

Palliative Medicine
1–11

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DOI: 10.1177/0269216319854013
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SAGE

How many older adults receive drugs of questionable clinical benefit near the end of life? A cohort study

Lucas Morin[1,2], Jonas W Wastesson[1,2], Marie-Laure Laroche[3,4], Johan Fastbom[1] and Kristina Johnell[2]

Estudio Retrospetivo (≥75 años, Suecia) que fallecieron en 2015 con Enf. Crónicas Avanzadas

Descripción de mcos de beneficio clínico cuestionable en los Últ. 3 meses de vida

58415 fallecidos
87 años media
8,9 mcos. crónicos

32% continuaron
14% iniciarion
Estatinas, Ca, VitD, Bifosfonatos, Antidemencia

- **La proporción de pacientes con medicamentos de beneficio clínico cuestionable fue mayor en personas más jóvenes (75-84años, con trayectoria de insuficiencia de órgano y aquellos con mayor número de condiciones crónicas).**

Morin et al. How many older adults receive drugs of questionable clinical benefit near the end of life? A cohort study. Palliat Med 2019 Sep;33(8):1080-1090.

Morbilidad ↑

Fragilidad ↑

Esperanza vida ↓

Complejidad prescripción ↑

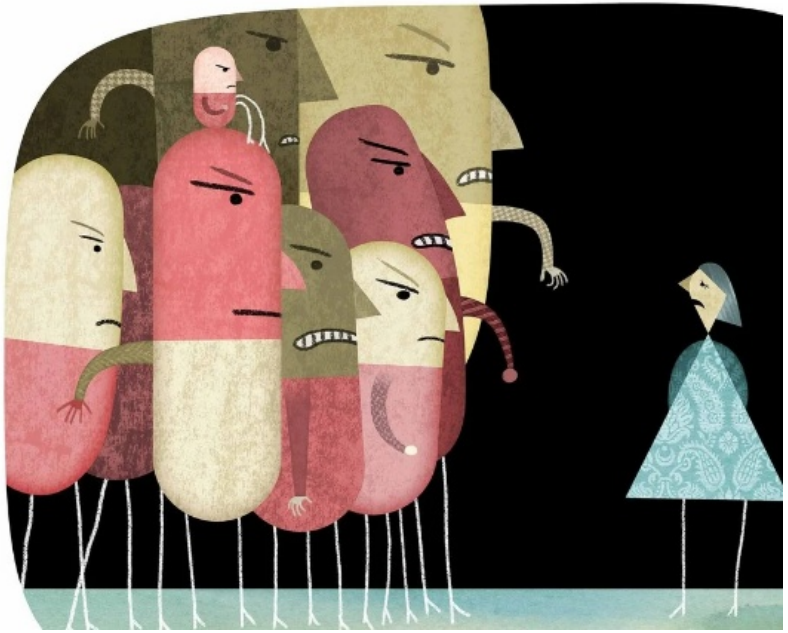
Riesgo de EA ↑

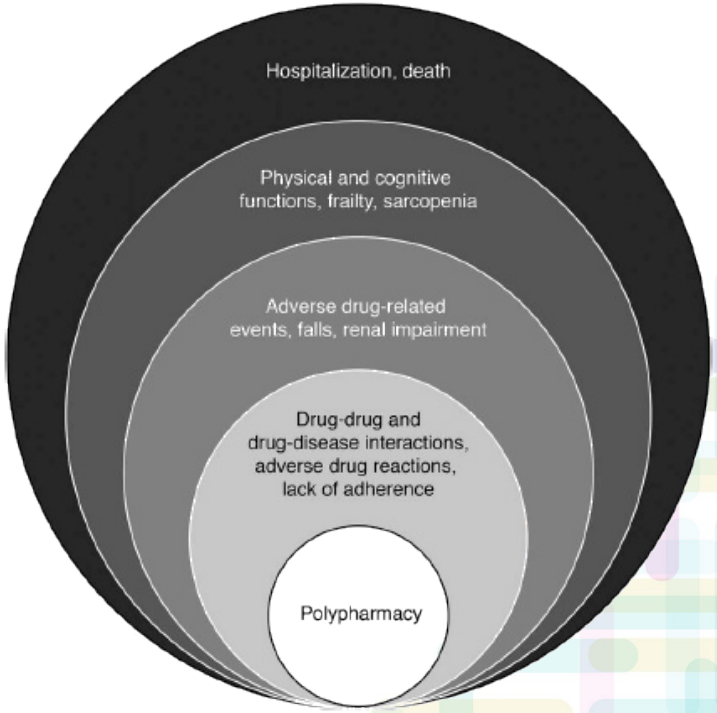
- ~~Enalapril~~
- ~~Atorvastatina~~

- Enalapril
- Bisoprolol
- AAS
- Lorazepam
- Atorvastatina
- Omeprazol
- Ácido Alendrónico
- VitD+Ca

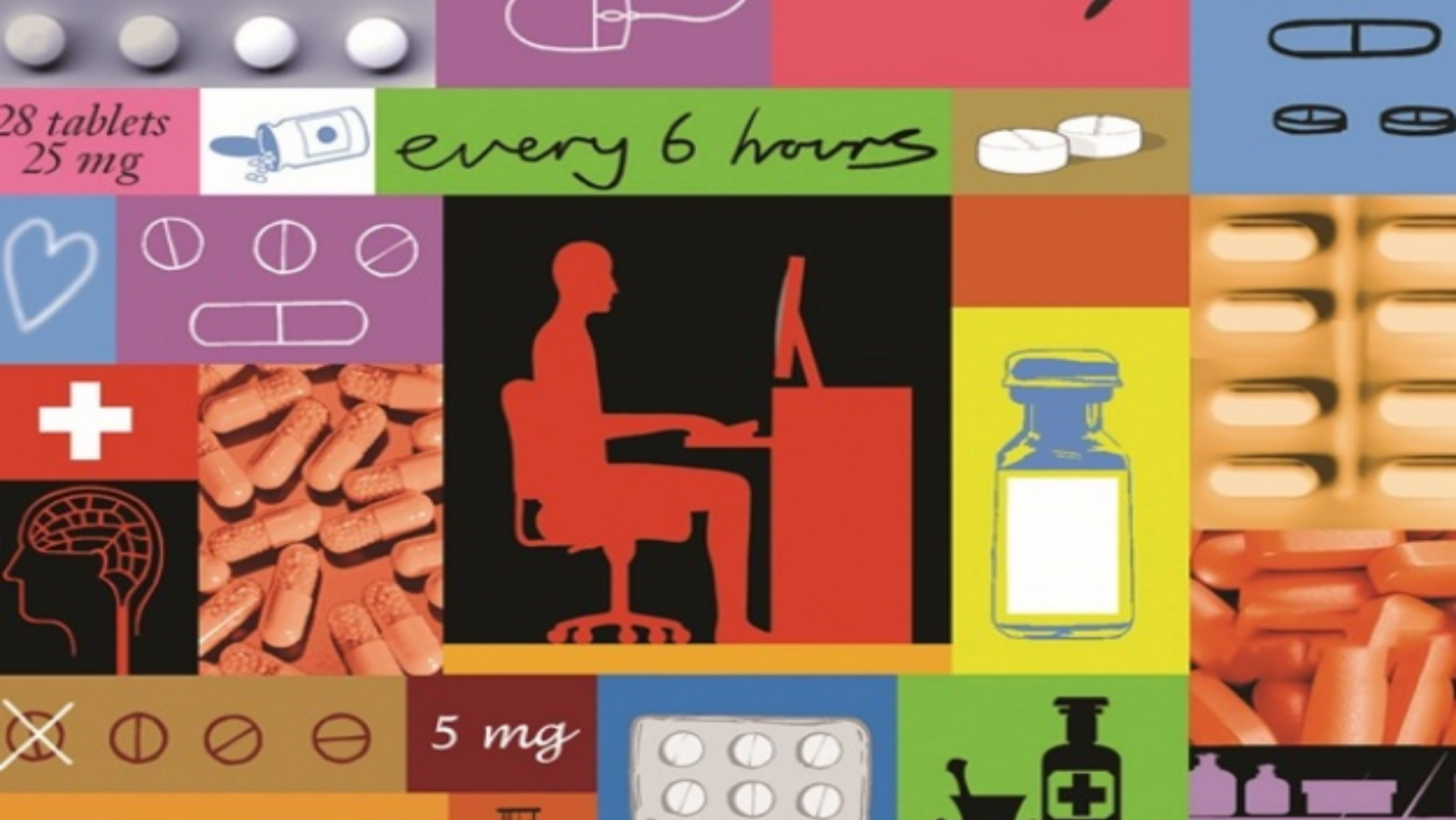
- Omeprazol
- Alopurinol
- Ácido Alendrónico
- Calcio + Vitamina D
- Simvastatina
- Insulina Glargina
- Sitagliptina
- Acenocumarol
- Enalapril
- Bisoprolol
- Tiotropio
- Quetiapina
- Lorazepam
- Escitalopram
- Pregabalina

Polimedicación y Resultados Clínicos Adversos





Wastesson et al. An update on the clinical consequences of polypharmacy in older adults: a narrative review, Expert Opin Drug Saf. 2018 Dec;17(12):1185-1196,


28 tablets
25 mg
every 6 hours
5 mg

Estrategias para la adecuación (“simplificación”) farmacoterapéutica al final de la vida

	Criterios Explícitos “Tala”	Criterios Implícitos “Poda”
Herramientas	Beers STOPP/START Less-Chron	Medication Appropriateness Index (MAI) 7 steps
Herramientas (específicas)	STOPPFrail (Final de Vida) versión 2. European Expert Consensus	Prescripción Centrado en la Persona • Multimorbilidad • End of life DE-TOPPLE

Deprescribing.org , Primary Health Tasmania, http://medstopper.com/

Age and Ageing 2020; 1–7
doi: 10.1093/ageing/afaa159

Table 2. STOPPFRAIL version 2

STOPPFrail is a list of potentially inappropriate prescribing indicators designed to assist physicians with deprescribing decisions. It is intended for older people with limited life expectancy for whom the goal of care is to optimise quality of life and minimise the risk of drug-related morbidity. Goals of care should be clearly defined, and, where possible, medication changes should be discussed and agreed with patient and/or family.

Appropriate candidates for STOPPFrail-guided deprescribing typically meet ALL of the following criteria:

1. Activities of daily living dependency (i.e. assistance with dressing, washing, transferring, walking) and/or severe chronic disease and/or terminal illness.
2. Severe irreversible frailty, i.e. high risk of acute medical complications and clinical deterioration.
3. Physician overseeing care of patient would not be surprised if the patient died in the next 12 months.

Section A: General	• Any drug that the patient persistently fails to take or tolerate despite adequate education and consideration of all appropriate formulations. • Any drug without a clear clinical indication. • Any drug for symptoms which have now resolved (e.g. pain, nausea, vertigo, pruritus)
Section B: Cardiology system	• Lipid-lowering therapies (statins, ezetimibe, bile acid sequestrants, fibrates, nicotinic acid, lomitapide and acipimox). • Antihypertensive therapies: Carefully reduce or discontinue these drugs in patients with systolic blood pressure (SBP) persistently <130 mmHg. An appropriate SBP target in frail older people is 130–160 mmHg. Before stopping, consider whether the drug is treating additional conditions (e.g. beta-blocker for rate control in atrial fibrillation, diuretics for symptomatic heart failure). • Anti-anginal therapy (specifically nitrates, nicorandil, ranolazine): None of these anti-anginal drugs have been proven to reduce cardiovascular mortality or the rate of myocardial infarction. Aim to carefully reduce and discontinue these drugs in patients who have had no reported anginal symptoms in the previous 12 months AND who have no proven or objective evidence of coronary artery disease.
Section C: Coagulation system	• Anti-platelets: No evidence of benefit for primary (as distinct from secondary) cardiovascular prevention. • Aspirin for stroke prevention in atrial fibrillation: Aspirin has little or no role for stroke prevention in frail older people who are not candidates for anticoagulation therapy and may significantly increase bleeding risk.

Table 2. STOPPFRAIL version 2

Section D: Central nervous system	• Neuroleptic antipsychotics in patients with dementia: Aim to reduce dose and discontinue these drugs in patients taking them for longer than 12 weeks if there are no current clinical features of behavioural and psychiatric symptoms of dementia (BPSD). • Memantine: Discontinue and monitor in patients with moderate to severe dementia, unless memantine has clearly improved BPSD.

PAUTAS PARA EL INICIO, EVALUACIÓN Y RETIRADA DEL TRATAMIENTO PSICO-FARMACOLÓGICO

CHROME®

- Depresivo
- Ansioso
- Psicótico
- Impulsivo
- Maniforme
- Alteración del Sueño
- Apático

http://mariawolff.org/wp-content/uploads/documentos/Criterios-CHROME-Maria-Wolff-RevPsicoGer2016.pdf

European Journal of Clinical Pharmacology
https://doi.org/10.1007/s00228-018-2507-4

PHARMACOEPIDEMIOLOGY AND PRESCRIPTION

Adequate, questionable, and inadequate drug prescribing for older adults at the end of life: a European expert consensus

Lucas Morin[1] · Marie-Laure Laroche[2,3] · Davide L. Vetrano[1,4] · Johan Fastbom[1] · Kristina Johnell[1]

Received: 2 May 2018 / Accepted: 14 June 2018

Abstract

Background Clinical guidance is needed to initiate, continue, and discontinue drug treatments near the end of life.

Aim To identify drugs and drug classes most often adequate, questionable, or inadequate for older people at the end of life.

Design Delphi consensus survey.

Setting/participants Forty European experts in geriatrics, clinical pharmacology, and palliative medicine from 10 different countries. Panelists were asked to characterize drug classes as "often adequate," "questionable," or "often inadequate" for use in older adults aged 75 years or older with an estimated life expectancy of ≤ 3 months. We distinguished the continuation of a drug class that was previously prescribed from the initiation of a new drug. Consensus was considered achieved for a given drug or drug class if the level of agreement was ≥ 75%.

Results The expert panel reached consensus on a set of 14 drug classes deemed as "often adequate," 28 drug classes deemed "questionable," and 10 drug classes deemed "often inadequate" for continuation during the last 3 months of life. Regarding the initiation of new drug treatments, the panel reached consensus on a set of 10 drug classes deemed "often adequate," 23 drug classes deemed "questionable," and 23 drug classes deemed "often inadequate". Consensus remained unachieved for some very commonly prescribed drug treatments (e.g., proton-pump inhibitors, furosemide, haloperidol, olanzapine, zopiclone, and selective serotonin reuptake inhibitors).

Conclusion In the absence of high-quality evidence from randomized clinical trials, these consensus-based criteria provide guidance to rationalize drug prescribing for older adults near the end of life.

Table 2 Consensus criteria regarding the *continuation* of drug therapy for older adults (≥ 75 years) with an estimated life expectancy of 3 months or less

Table 3 Consensus criteria regarding the *initiation* of drug therapy for older adults (≥ 75 years) with an estimated life expectancy of 3 months or less

Often adequate
Questionable
Often inadequate

Revista Española de Geriatría y Gerontología

www.elsevier.es/regg

ARTÍCULO ESPECIAL

Modelo de prescripción centrado en la persona para mejorar la adecuación y adherencia terapéutica en los pacientes con multimorbilidad

Joan Espaulella-Panicot[a,b,*], Núria Molist-Brunet[a,b], Daniel Sevilla-Sánchez[a,b], Javier González-Bueno[b], Jordi Amblàs-Novellas[a,b], Núria Solà-Bonada[b] y Carles Codina-Jané[b,c]

[a] Hospital Universitari de la Santa Creu, Vic, Barcelona, España
[b] Hospital Universitari de Vic, Vic, Barcelona, España
[c] Hospital Clínic de Barcelona, Barcelona, España

frontiers | Frontiers in Public Health

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Ferro-Uriguen A, Beobide-Telleria I, Gil-Goikouria J, Peña-Labour PT, Díaz-Vila A, Herasme-Grullón AT,

Application of a person-centered prescription model improves pharmacotherapeutic indicators and reduces costs associated with pharmacological treatment in hospitalized older patients at the end of life

Alexander Ferro-Uriguen[1]*, Idoia Beobide-Telleria[1], Javier Gil-Goikouria[2,3], Petra Teresa Peña-Labour[4], Andrea Díaz-Vila[4], Arlovia Teresa Herasme-Grullón[4], Enrique Echevarría-Orella[2,3] and Jesús Seco-Calvo[5,6]

Step 1

Identify patients with advanced chronic condition and limited life expectancy (G)

Early Identification and Proactive Palliative Care

- NECPAL-CCOMS-OMS

Situational Diagnosis

- Frail-VIG Index

Screening social vulnerability

- Gijon's socio-family evaluation scale

Step 2

Interview with patient or closest caregiver (CP)

Analysis Regular Medication History

- Identification Health Clinical Conditions
- Adherence Analysis by indirect method (community pharmacy dispensed record).

Semi-structured interview

- Allergies and intolerances
- Ask of the Adherence of Regular Prescription
- Over the Counter Medication
- Herbal medicines
- Autonomy to take medicines
- Knowledge drug treatment
- Edmonton symptom assessment system

Step 3

Medication Review (CP)

Medication Appropriateness per drug prescription:

Indication/Effectiveness

- STOPP Frail/ Beers Criteria

Dose Adjustment/Duplication/ Duration

- Product Information
- Lexi-Comps- Geriatric Dosage Handbook

Correct and Practical Directions

- Medication Regimen Complexity Index

Drug-Drug Interactions

- BotPlusWeb/Beers Criteria
- Drug Burden Index

Drug-Disease Interactions

- Beers Criteria

Cost-Effectiveness

- Compared costs to other agents of

Step 4

Treatment Plan (G)

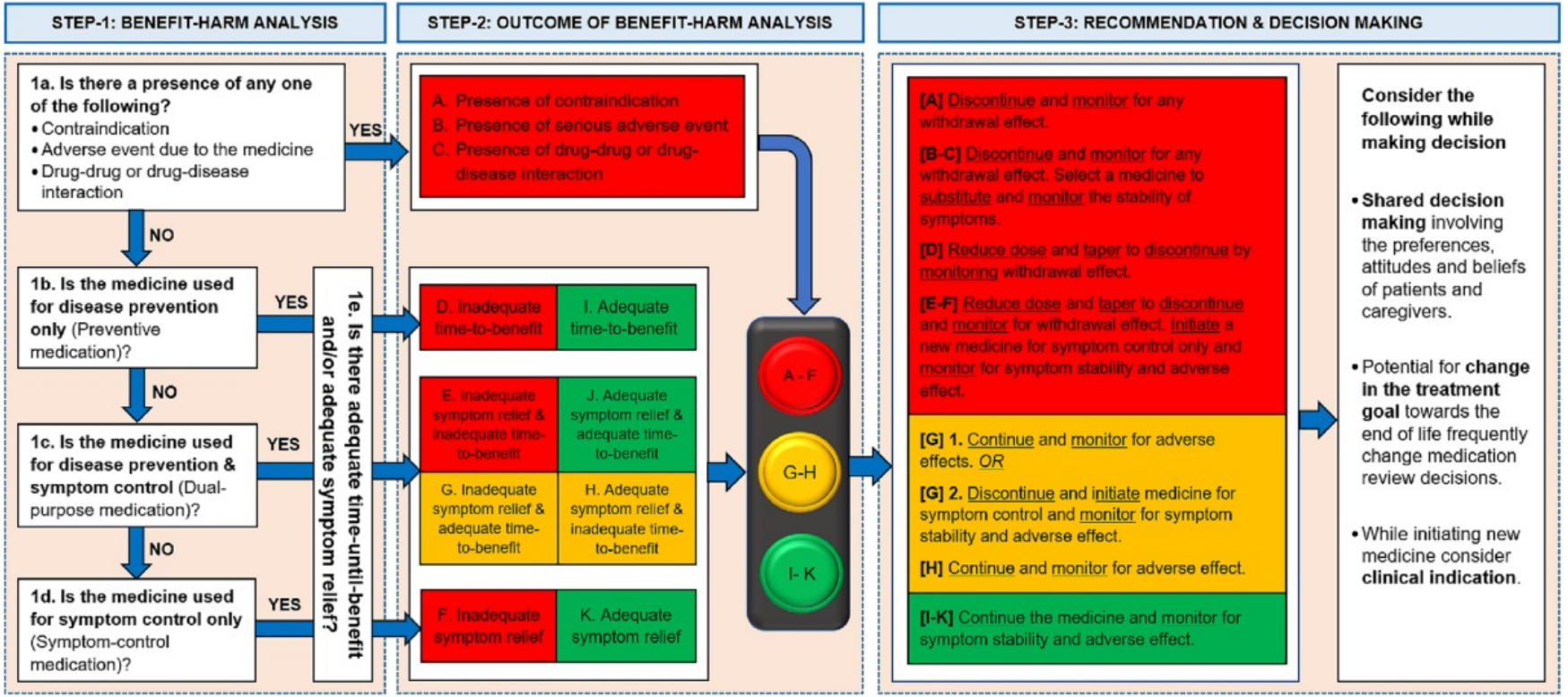
Consensus with patient or closest caregiver

Document the reasons, proccess and results of the medication review in the computerized medical history:

- deprescribing or dose reductions
- deprescribing failure
- new prescription

Update Regular Drug Prescription

DE-TOPPLE



- **Deprescribing:** Deprescribing in this tool is referred to recommendation for substitution with a safer & effective alternative medication, tapering or dose reduction or discontinuation of the medication due to its potential for harm outweighing its benefit.
- **Time-to-benefit:** 'Adequate time-to-benefit' implies when estimated life expectancy is equal or greater than time-to-benefit else 'inadequate time-to-benefit'.
- **Life expectancy:** Less than a year.
- **Symptom relief:** Assessment of adequacy in symptom relief can involve both implicit and explicit judgment to restore quality of life.
- **Medications in acute conditions:** This tool does not imply to medications used for the treatment of acute conditions.

Deprescribing in Older People Approaching End of Life: A Randomized Controlled Trial Using STOPPFrail Criteria

Denis Curtin, MB,†* *Emma Jennings, MB,*†* *Ruth Daunt, MB,*† *Sara Curtin, MSc,*‡ *Mary Randles, MB,*† *Paul Gallagher, PhD,*†* *and Denis O'Mahony, MD*†*

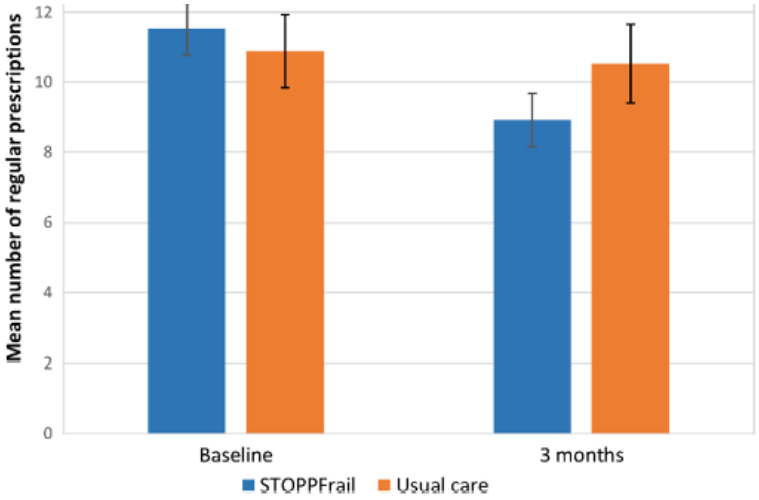


Figure 2. Change in number of regular prescriptions from baseline to 3-month follow-up. Mean (standard deviation) change in the number of regular prescriptions (for final analytic sample, n = 99) at 3 months was −2.61 (±2.73) in the intervention arm and −.36 (±2.60) in the control arm (mean difference = 2.25 ± .54; 95% confidence interval (CI) = 1.18-3.32; $P < .001$). Error bars are 95% CIs.

Table 3. Effect of STOPPFrail-guided deprescribing on secondary outcomes

	Intervention (n=65)		Control (n=65)			
Outcome	Proportion (95% CI)	Number of participants (number of events)	Proportion (95% CI)	Number of participants (number of events)	Relative risk (95% CI)	*P*
ED presentation (not admitted)	0.05 (0.01, 0.13)	3 (5)	0.08 (0.03, 0.17)	5 (8)	0.60 (0.15, 2.41)	0.72
Unplanned hospital admission	0.14 (0.07, 0.24)	9 (10)	0.08 (0.03, 0.17)	5 (6)	1.80 (0.64, 5.08)	0.27
Deaths	0.18 (0.11, 0.3)	12	0.28 (0.18, 0.4)	18	0.67 (0.35, 1.27)	0.22
Unscheduled medical reviews by GP*	0.61 (0.47, 0.73)	31 (68)	0.57 (0.43, 0.70)	27 (52)	1.04 (0.74, 1.45)	0.82
Falls*	0.27 (0.17, 0.40)	14 (24)	0.30 (0.19, 0.44)	14 (32)	0.90 (0.48, 1.69)	0.75
Non-vertebral fractures*	0.02 (0, 0.11)	1 (1)	0.09 (0.03, 0.20)	4 (5)	0.23 (0.03, 1.95)	0.18

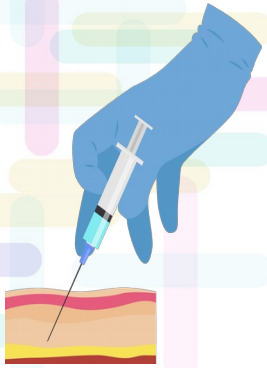
CI = confidence interval; ED = emergency department; GP = general practitioner.
*measured in final analytical sample (intervention [n = 52]; control [n = 47]).

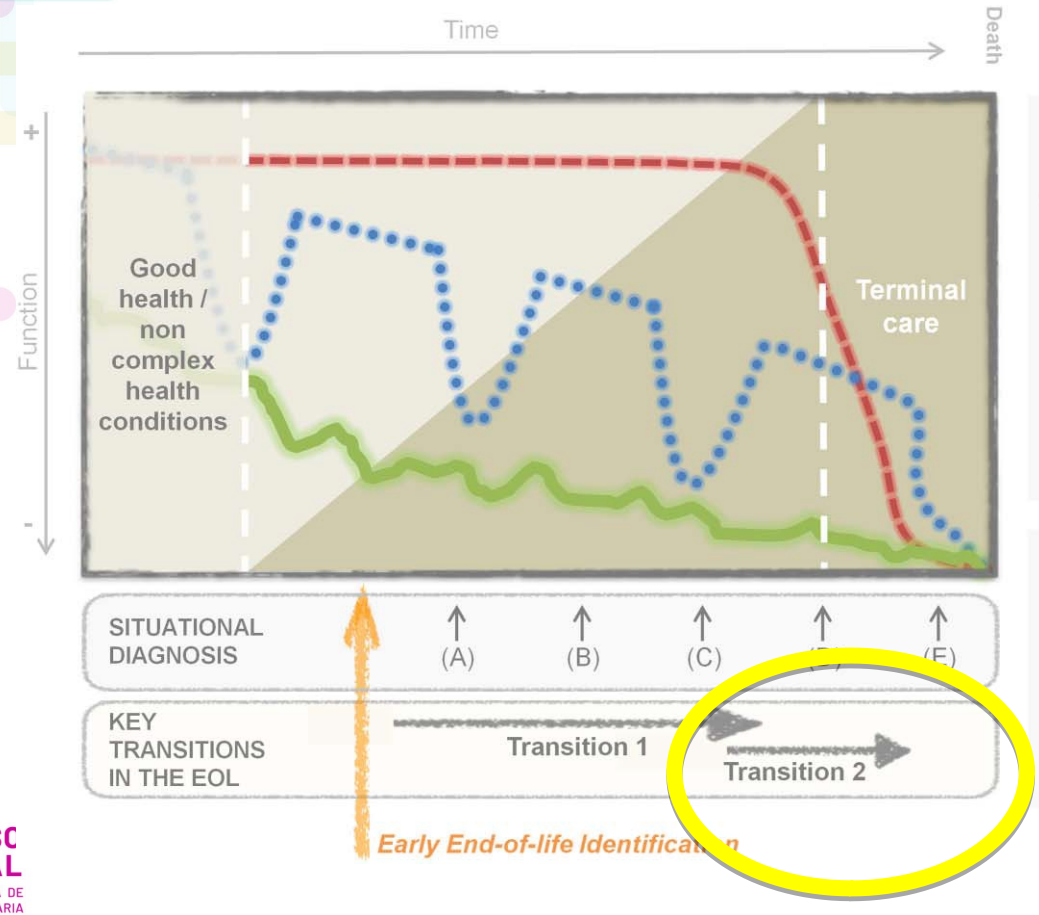
BMJ Open Medication-related experiences of patients with polypharmacy: a systematic review of qualitative studies

- Es complicado entender el tratamiento farmacológico
- Las rutinas son críticas, pero difíciles de mantener
- No todos los medicamentos son importantes para ellos
- **Mantener la función física es el principal objetivo por encima de otros, como aumentar la esperanza de vida**
- Los pacientes quieren tomar menos medicamentos
- Se les dedica poco tiempo en las consultas
- Las RAM tienen un gran impacto en las vidas de los pacientes y les da la impresión de que los profesionales minimizan su importancia

BMJ Open. 2020 Sep 6;10(9):e036158. doi: 10.1136/bmjopen-2019-036158.

ATENCIÓN PALIATIVA Y
Administración de fármacos por VÍA SUBCUTÁNEA





END-OF-LIFE TRAJECTORIES
associated with advanced chronic illnesses

- Cancer Trajectory
- Organ Failure Trajectory
- Dementia Trajectory

PROGRESSIVE CARE MODEL

- Disease treatment / long term care
- Palliative care approach

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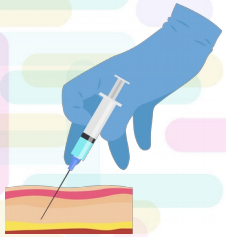
VÍA SUBCUTÁNEA: Indicaciones de uso

- **Alteraciones del aparato digestivo:** náuseas y vómitos, diarrea, disfagia, odinofagia, obstrucción intestinal, malabsorción, fístulas esófagotraqueales o enterocutáneas.
- **Opiáceos**: Intolerancia a opiáceos orales o necesidad de dosis mayores.
- **Alteraciones neurológicas**: convulsiones, delirium, bajo nivel de consciencia, agitación.
- **Accesos periférico endovenoso dificultoso:** edemas, fragilidad venosa, traumatismos en extremidades superiores.
- **Deshidratación** leve a moderada.
- **Control de Síntomas sin posibilidad vía oral**: Exceso de secreciones, disnea, dolor y otros síntomas.
- **Sedación paliativa o Situación de agonía**.

VÍA SUBCUTÁNEA: Bolus vs Perfusión Continua



Bolus

- Picos tras su administración (↑ Efectos secundarios)
- Más posibilidad de reaparición de síntomas.
- Palomilla: máx 2-3ml. Lavar con SF para asegurar que alcanza tejido subcutáneo.

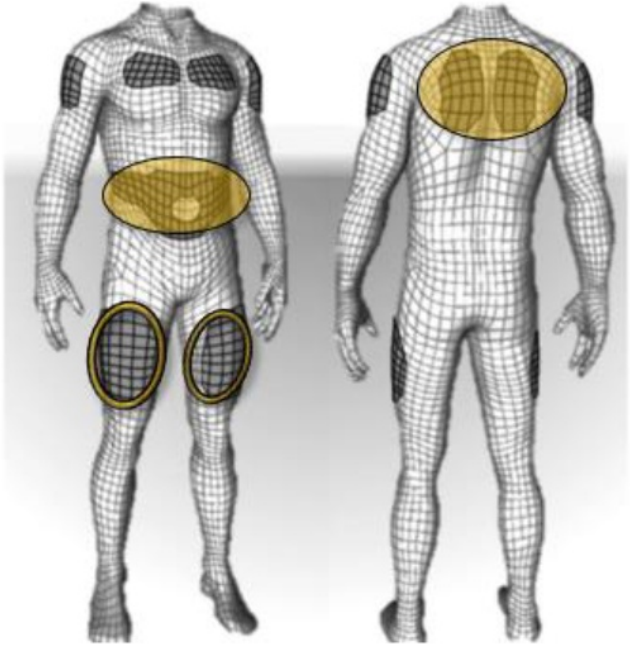
Perfusión continua

- Niveles plasmáticos constantes.
- Por gravedad (micro gotero), Bombas elastoméricas, Bombas electrónicas.
- Permite la administración de mezcla de fármacos
- Sueroterapia.

VÍA SC: Perfusión Continua. Bombas elastoméricas.

1. Uso de Suero Fisiológico
2. Mantener el reductor de flujo a temperatura ambiente
3. Proteger el infusor de luz directa
4. Respetar el volumen de llenado
5. Disponer de un acceso adecuado
6. Mantener el acceso y el infusor a la misma altura

VÍA SUBCUTÁNEA: Hidratación - Hipodermoclisis



Soluciones a infundir:

- **Suero Salino 0,45% y 0,9%**
- **Suero Glucosado 2,5% y 5%**
- **Suero Glucosalino (33% SF)**
- **Ringer Lactato**

+ 20-40 meq ClK por cada 1000ml

Velocidad: 30-80 ml/h (1,2 litros/día)

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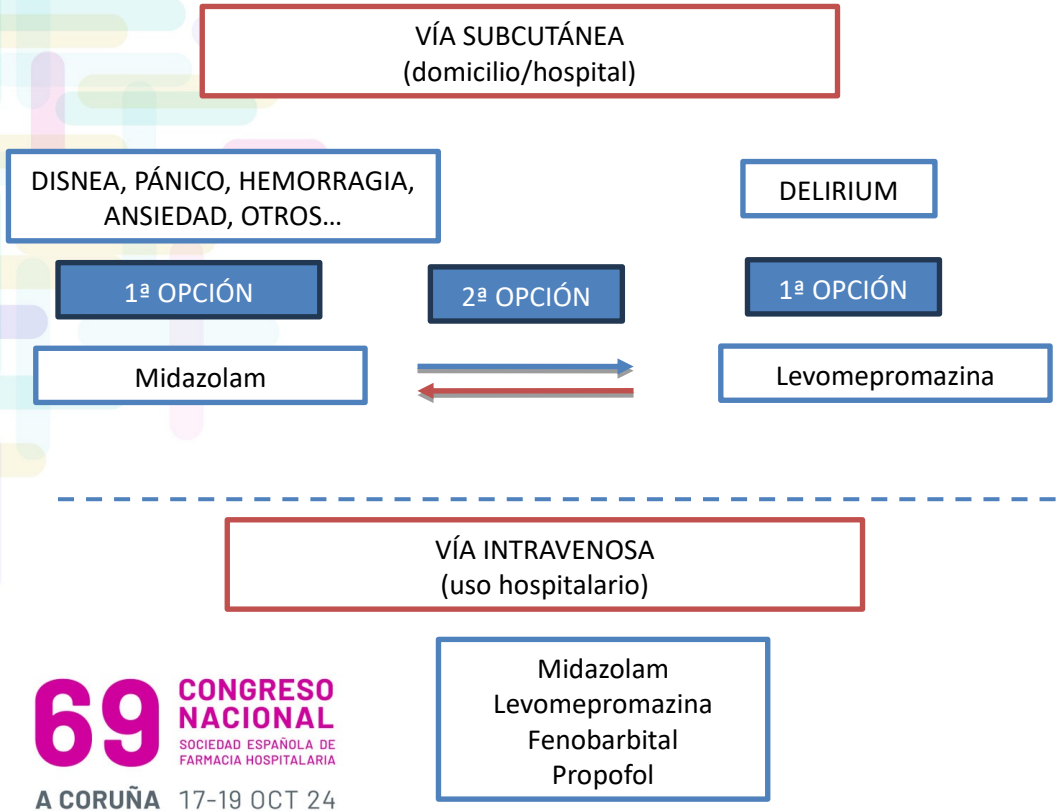
VÍA SUBCUTÁNEA: Sedación paliativa en la agonía



Dosis Techo:

Midazolam
Dosis Máxima Diaria: 160-200mg
Levomepromazina
Dosis Máxima Diaria: 300mg

Efecto paradójico.
Agitación
Ansiedad aumentada
Confusión
Excitación

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Fármaco	Indicaciones
Morfina	Dolor, disnea
Butilescopolamina	Estertores premortem, sialorrea, secreciones respiratorias, obstrucción intestinal
Midazolam	Convulsiones, sedación paliativa
Metoclopramida	Náuseas y vómitos
Haloperidol	Náuseas y vómitos por opioides, vómitos en la obstrucción intestinal, delirium
Levomepromazina	Delirium
Dexametasona	Obstrucción intestinal, convulsiones, hipertensión endocraneal
Diclofenaco*/ dexketoprofeno**	Dolor, fiebre
Ondansetrón	Náuseas y vómitos

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ROTACIÓN DE OPIOIDES

1) Falta de eficacia o control inadecuado del dolor.
2) Efectos secundarios intolerables.
3) Hiperalgesia inducida por opioides.
4) Cambio en la vía de administración (imposibilidad vía oral).

Calcular Dosis Equianalgésica (tablas)

Reducción Dosis Equianalgésica 25-50%
(salvo paso a Fentanilo TD*)

Rescates 5-15% de la Dosis Total Diaria
(Fentanilo dosis mínima*)

*Metadona

Guidelines for opioid rotation. https://www.uptodate.com/

Tabla 9. Tabla de rotación de opioides (ROP-ICO): equivalencias entre diferentes dosis de opioides y ratios de conversión*

Opioide	Posología/vía	Dosis										Ratio de conversión morfina vo: opioide
Morfina (mg)	c/4 h vo	5	10	15	20	30	45	60	90	120	160	
	c/24 h vo	30	60	90	120	180	270	360	540	740	960	
	DE vo	5	10	15	20	30	45	60	90	120	160	
	c/24 h sc	15	30	45	60	90	135	180	270	370	480	2:1 (÷2)
	DE sc	3	5	8	10	15	23	30	45	62	80	
	c/24 h iv	10	20	30	40	60	90	120	180	247	320	3:1 (÷3)
	DE iv	2	3	5	7	10	15	20	30	41	53	
Oxicodona (mg)	c/24 h vo	20	40	60	80	120	180	240	360	490	640	1,5:1 (÷1,5)
	DE vo	3	6	10	13	20	30	40	60	80	100	
Hidromorfona ** (mg)	c/24 h vo	6	12	18	24	36	54	72	108	148	192	5:1 (÷5)
	DE morfina vo	5	10	15	20	30	45	60	90	120	160	
Tapentadol **≠ (mg)	c/24 h vo	100	200	300	400	600	900	1.200	1.800	2.400	3.150	1:3,3 (x3,3)
	DE morfina vo	5	10	15	20	30	45	60	90	120	160	
Metadona (mg)	c/8 h vo	3	5	7	5	7	12	10	15	20	26	< 90 mg →4:1 90-300 mg →8:1 >300 mg →12:1
	DE vo	1,5	3	4	3	4	6	5	8	10	13	
	c/24 h iciv/icsc	7	12	17	12	17	28	24	36	48	60	Metadona oral: metadona sc/iv 1:0,8 → x 0,8
	DE iv/sc	1	2	3	2	3	5	4	6	8	10	
Fentanilo (µg/h)***	Dosis/h c/72 h TTS	12,5	25	37.5	50	75	112,5	150	225	308	400	1 mg morfina: 10 µg fentanilo (x10) (x 10/24 h si parche)
	Dosis del parche	1 de 12	1 de 25	1 de 25 + 1 de 12	1 de 50	1 de 75	1 de 100 + 1 de 12	2 de 75	3 de 75	3 de 100	4 de 100	
Fentanilo (µg)***	c/24 h iv o sc	300	600	900	1.200	1.800	2.700	3.600	5.400	7.400	9.600	
Buprenorfina (µg/h)	c/72 h TTS	17,5	35	52	70	105	157	No administrar dosis superiores de buprenorfina				1 mg morfina: 14 µg buprenorfina (x 14/24 h → Fc = 0,583)
	Dosis del parche	½ de 35	1 de 35	1 de 52,5	1 de 70	1 de 70 + 1 de 35	2 de 70					

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VÍA SUBCUTÁNEA: Combinaciones de fármacos

Combinaciones de fármacos
Morfina + midazolam
Morfina + levomepromazina
Morfina + metoclopramida
Morfina + haloperidol
Morfina + haloperidol + midazolam
Morfina + levomepromazina + midazolam
Morfina + haloperidol + butilescopolamina
Morfina + dexametasona + ranitidina
Oxicodona + butilescopolamina + octreótido
Oxicodona + levomepromazina+ ketamina
Fentanilo + butilescopolamina + octreótido
Morfina + haloperidol + midazolam + butilescopolamina

Dexametasona: cristaliza

Levomepromazina: muy irritante, palomilla separada

Diclofenaco y dexketoprofeno: muy irritantes

Desechar mezclas con precipitados/turbidez

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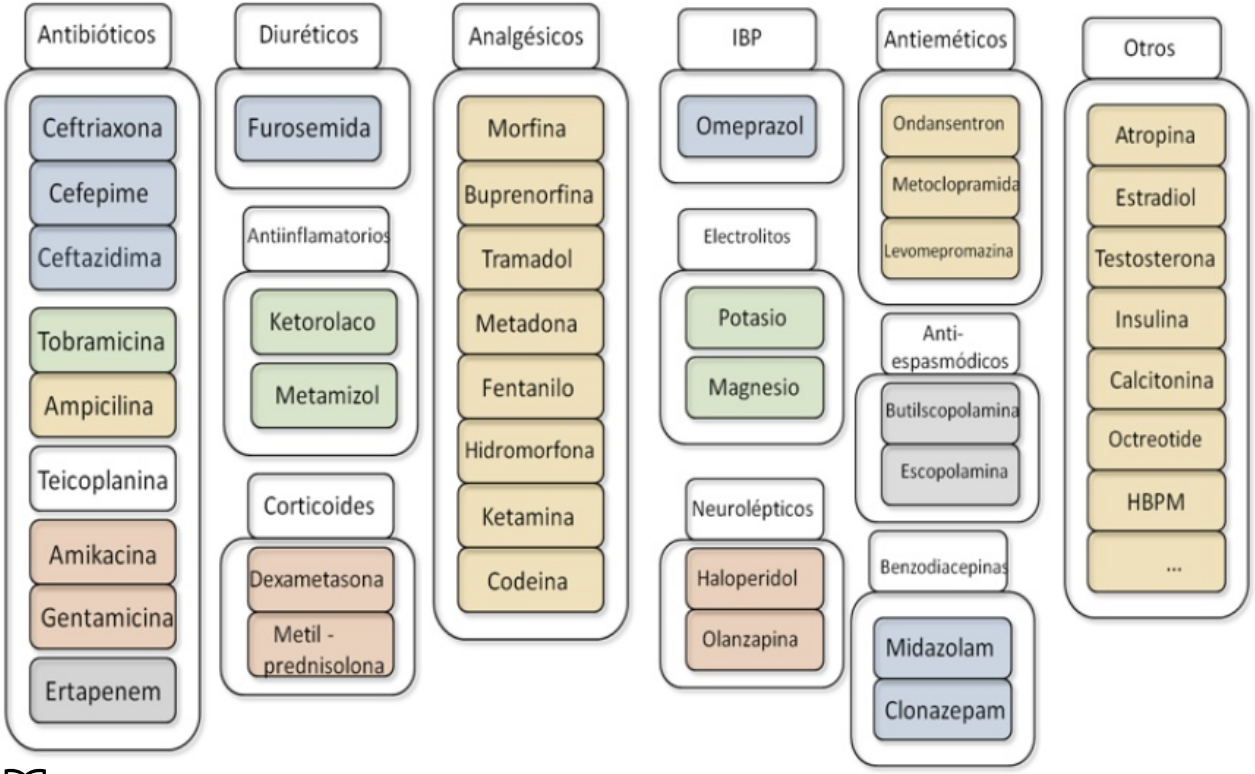
VÍA SUBCUTÁNEA: Listado de fármacos a administrar



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VÍA SC: Bibliografía Uso de fármacos

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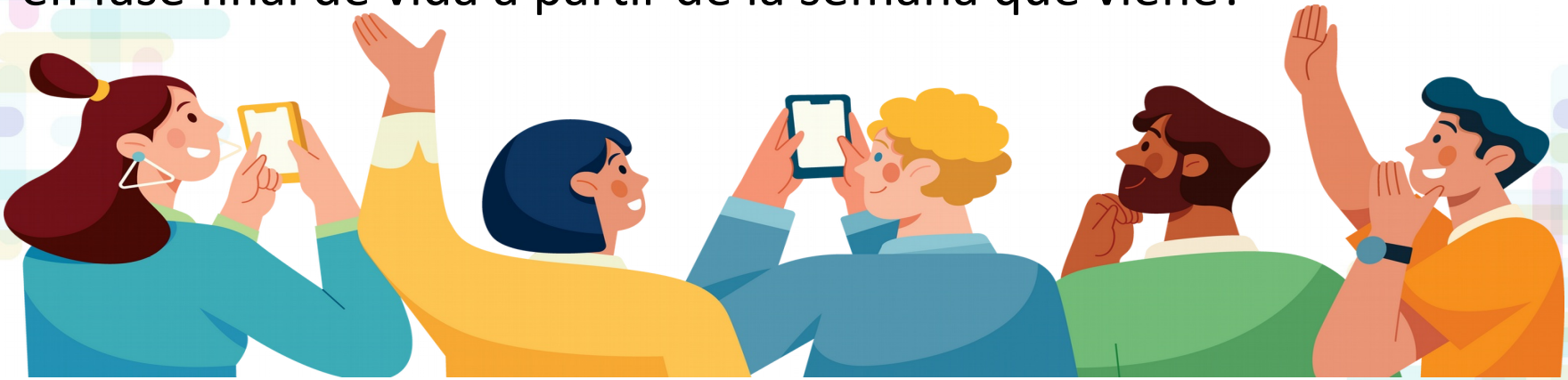
¿Cuántos de los presentes hoy aquí vais a realizar atención farmacéutica en pacientes con enfermedades crónicas avanzadas y en fase final de vida a partir de la semana que viene?



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Moitas grazas

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