End-of-life care in the ED for patients imminently dying of a highly transmissible acute respiratory infection (eg COVID-19)

Airway secretions:

- Glycopyrrolate 0.4 mg subcut/IV q4h prn OR
- Scopolamine 0.4 mg subcut/IV q4h prn (scopolamine crosses the blood-brain barrier and will cause more sedation, which may be helpful if the patient is agitated)

Agitation/ Delirium:

- Haloperidol 0.5 mg- 1 mg subcut/IV q2h prn
- If severe add Midazolam 0.5- 1mg subcut/IV q30min prn
- If severe add Methotrimeprazine 12.5- 25 mg subcut q4h prn

Pain:

If opioid naive (subcut route preferred as has longer half-life compared to IV)

- Morphine 2.5- 5 mg subcut/IV q30min prn OR
- Hydromorphone 0.5-1mg subcut/IV q30min prn

If opioid tolerant, refer to opioid equianalgesia and conversion tables for equivalent subcut/IV dosing

Dyspnea:

If opioid-naïve, low-dose morphine (50-75% of dose used for pain relief) is the medication of choice

- Morphine 1-2.5 mg subcut/IV q30min prn OR
- Hydromorphone 0.25-0.5 mg subcut/IV q30min PRN OR
- Fentanyl 12.5-50 micrograms subcut/IV q15min prn

If opioid tolerant, give breakthrough doses to effect (breakthrough dose is calculated as 10% of the total daily dose of subcut/IV opioid in 24 hrs)

- If severe, add Midazolam 0.5-1mg subcut/IV q30min prn
- For severe respiratory distress, consideration can be given to ketamine in dissociative dosing (1-2 mg/kg IV or 4 mg/kg IM) as a temporizing measure until the above medications can be titrated to effect.

Nausea/Vomiting:

- Haloperidol 0.5 mg- 1mg subcut/IV q4h prn OR
- Ondansetron 4 mg subcut/IV q6h PRN

Fever:

- Acetaminophen 650 mg po/pr q4h prn

Approach to withdrawal of mechanical ventilation