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Grampians Regional PALLIATIVE CARE TEAM

DUROGESIC, AND NOW DENPAX

Durogesic, a transdermal fentanyl patch, has been available on the NHS for some time for the treatment of chronic severe pain of both malignant and non-malignant cause.

A new brand of transdermal fentanyl is now available on the National Health Service (NHS). It is called Denpax, and is available in the same range of strengths as Durogesic, namely 12, 25, 50, 75 and 100 micrograms per hour. RADAR, a magazine funded by the Federal Department of Health and Ageing, reports that Denpax is bioequivalent to Durogesic, and that equivalent strengths of each will deliver equivalent amounts of fentanyl over the 72 hour (three day) life of the patch. The PBAC has listed Denpax on the basis that it is equivalent in effectiveness and cost to Durogesic. There is no difference in the price to the patient.

Although Durogesic and Denpax are presumed to be equivalent and that changing from one to the other should be trouble-free, it is reasonable to be watchful. It is also wise to be sure that patients understand that they are the same drug. I wonder if we might see people who apply both patches at the same time if this is not clearly explained.

Some general word of caution in relation to fentanyl may be worth repeating. Firstly, there is an apparent sense in the community that fentanyl patches are somehow safer than oral medication. This is not the case. Fentanyl is a potent opioid with the same general class side effects as others, and the same risks. When commencing an opioid for cancer pain, it is safer to commence a shorter acting drug and stabilise the patient before transferring to the transdermal patch, as the slow action of fentanyl patches, while an advantage in convenience, is a disadvantage when titrating to pain relief. I have seen several patients who have been become drowsy and nauseated on 25 microgram patches. For the same reasons, fentanyl patches are not likely to be useful in patients whose pain levels are changing rapidly. Two potential advantages of fentanyl patches are that they provide for reliable absorption in the case of bowel problems, and fentanyl, not relying on the kidney for excretion, does not accumulate in the body in renal failure, and may therefore be a safer drug in that situation.

All patients with cancer pain on long acting forms of opioid such as patches or oral long-acting formulations such as MS Contin, OxyContin or Jurnista need to have a short acting form of opioid available for breakthrough pain. It is generally appropriate to use a short acting form of the same opioid, but in some cases such as transdermal fentanyl it is easier and cheaper to use another. There is generally no problem in doing this.

When switching from one brand of transdermal fentanyl to another, it is worth telling patients to:

- stop using one brand when starting the other, and return any unused patches to the pharmacy.
- never wear more than one brand at the same time.
- don't expose the patch to heat, such as hot packs, as this will increase the speed of absorption.
- don't cut or divide the patches.
- keep a record of application dates.
- apply the next patch to a different site, to reduce the incidence of skin irritation.
- used patches still contain some fentanyl, and can represent a danger - for example to children, fold them in half and dispose of them safely.
- read the information provided with the patch.

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FAMILY AND COMMUNITY UNDERSTANDING OF PALLIATIVE SEDATION

Palliative sedation is an accepted part of clinical practice which attempts to manage distressing refractory symptoms at the end of life. However the family and community understanding about the aim of sedation is sometimes incomplete. The confusion in our society most likely stems from the debate and variation in the medical community about what palliative sedation actually entails.

Classens et al (1) defines palliative sedation as “the intentional administration of sedative drugs in doses and combinations required to reduce consciousness of a terminal patient as much as necessary to adequately relieve one or more refractory symptoms”. The principle of proportionality is engrained in this statement and when combined with a clear intent it has been suggested that this provides the best “moral compass” to help a palliative care practitioner manage patients on a daily basis (2). From this

simple definition the concept of sedation fragments almost infinitely when it comes to the clinical application.

Although the medical community feels that the ethical standpoint is distinct and obvious, the occasional confusion in the general population demonstrates that more public discussion regarding sedation is needed. Extensive and open information giving is vital with each new clinical situation to explore the fears about sedation being equated to euthanasia and physician assisted suicide (PAS).
Morita et al (3) identified through multidimensional analysis of survey data that the general population's responses placed "deep sedation" much closer to PAS or euthanasia than physicians, who identified deep sedation as closer to intermittent sedation. From a practical standpoint it is clear that in our community there are families and groups that at least partially equate palliative sedation with euthanasia which indicates that open discussion and societal education about the aim of sedation remains essential.

Cherny (4) encapsulates the crux of the family stress response by stating that "they suffer with the patient and will survive with the memories, pain and the potential guilt for not having been effective advocates for their loved ones". Identifying the balance point between unrelieved symptoms and possibly initiating sedation prematurely is challenging for all medical professionals, so it is not difficult to understand that families will experience this wrenching dilemma more keenly.

The role of palliative sedation, initiated appropriately and with proportionality, is invaluable in the management of intractable terminal symptoms and distress. The level of palliative sedation will be indicated by the level of symptoms. This means that the timing and amount of sedation will vary as much as the clinical presentation. Discussing the proportional nature of sedation with the family allows for a more nuanced and patient-centered approach.

There exists a difference in medical understanding and community perception of the use of medications to lower a patient's conscious state to reduce symptomology. However this problem is not insurmountable. It needs to be approached in a considered, family-orientated manner with ongoing and open discussions with the relatives about the ongoing unequivocal aim of patient comfort.

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