Terminal restlessness (delirium in the last days of life) is often associated with progressive multiple organ failure and is generally not reversible. It may be exacerbated by unresolved psychological or spiritual distress.

An antipsychotic is the drug of first choice but combining it with a benzodiazepine is often necessary to control agitation as benzodiazepines alone can cause paradoxical agitation. In situations where seizures are a definite risk, a benzodiazepine should always be prescribed as well as an antipsychotic drug.

Causes / exacerbating factors
- Physical discomfort – unrelieved pain, retention of urine or distended rectum, inability to move, uncomfortable bed, breathlessness.
- Infection.
- Raised intracranial pressure.
- Biochemical abnormalities – hypercalcaemia, uraemia, hypoxia.
- Drugs – opioid toxicity (especially in conjunction with uraemia), hyoscine, phenothiazines.
- Psychological / spiritual distress – anger, fear, guilt.

Management
1. Accurately assess the patient.
2. Ameliorate all physical elements if possible e.g. analgesia, catheterisation.
3. Listen to the patient and discuss fears, anger and guilt.
   Communicate with family. Terminal restlessness is very distressing to the family and they may need support.

DRUG THERAPY

Haloperidol Antipsychotic and anti-emetic.
   Dose 2.5-5mg PO / SC stat (repeat after 30 minutes if patient has not settled), followed by CSCI 5-10mg /24hrs.
   Less sedating than Levomepromazine.
   Risk of extrapyramidal side effects at higher doses.

Levomepromazine Antipsychotic, sedative and antiemetic.
   Dose 12.5mg SC stat followed by 12.5-200mg / 24 hrs CSCI.

Midazolam Sedative, anxiolytic and anticonvulsant.
   Dose 2.5-5mg SC stat followed by 10-120mg / 24hrs CSCI.
   It is short acting (1-4hrs) when used SC therefore CSCI is recommended to maintain symptom control. Occasionally higher doses are necessary, particularly if the patient has had longstanding anxiety and prior treatment with oral benzodiazepines.

Diazepam Anxiolytic, sedative and anticonvulsant.
   Dose 20-60mg / 24 hrs PR. Alternative route of administration if CSCI is not possible.
Phenobarbitone  Potent sedative and anticonvulsant.  
Dose 100-200mg SC stat followed by 600-1200mg / 24hrs CSCI.  
This is oily and cannot mix with most drugs in the syringe driver. Can be used for sedation in terminal delirium not responding to Midazolam 60mg/24h and either Haloperidol 30mg/24h or Levomepromazine 200mg/24h.

Clonazepam 500 microgram stat SC. 2-8mg/24hrs CSCI. Used in some centres as alternative to Midazolam.

References
1. Adam J. ABC of Palliative Care. The last 48 hours. BMJ 1997; 315 :1600 -03