



OPTIONS FOR CLIENTS WHO CANNOT SWALLOW

Gastric/Jejunal Tubes and Rectal Administration of Aid-In Dying Medications

Suggestions from EOLWA

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Death with Dignity is legal even if a person cannot swallow or can no longer eat. The Washington Death with Dignity Act was written and passed with the expectation that those who qualify for and decide to take life-ending medicines would simply swallow (ingest) the medicine, then fall asleep and die. Some of our clients are unable to swallow¹.

If the medicine is administered into the food 'tract' (medically known as the 'gastrointestinal or GI' tract – which starts at the mouth and ends at the rectum), patients can take life-ending medications at either end, or through a tube somewhere in-between.

Gastric Tubes or Jejunal tubes:

Using medicines to end life does require a segment of the GI tract long enough for medicines to be administered and well absorbed. Patients unable to swallow can be provided tubes inserted into the GI tract to administer fluids, nutrition, and medications. A 'nasogastric' (through the nose into the stomach) tube might be used for this purpose. A PEG (Percutaneous Endoscopic Gastrostomy) tube can be placed through the abdomen into the stomach. Or, a 'J' tube can be placed through the abdomen into the jejunum (the small intestine). Any of these tubes can be used by clients to self-administer life-ending medications. The person needs to be able to 'ingest' by self-administering the life-ending medications. Examples of modes of self-administration include: pushing on a syringe into a tube; opening a stopcock or removing a clamp on a gravity fed bag; or turning on a switch for a device set to administer the medicine.

Rectal Administration:

End-of-life medications may be self-administered using the rectal part of the GI tract when the patient can no longer swallow fluids or food, or can no longer utilize upper GI tubes for whatever reason (obstruction, severe nausea, poor stomach motility, etc.)

¹ Swallowing can be lost if some process, such as cancer, obstructs the mouth, throat, esophagus, stomach, or intestine, or if some neurologic disease interferes with swallowing. Persons who cannot keep food, liquids, and medications 'down' (in the stomach) may be candidates for life-ending medication by tube into the gastrointestinal tract.

RECTAL ADMINISTRATION OF AID-IN DYING MEDICATIONS

End-of-life medications may be self-administered using the rectal part of the GI tract when the patient can no longer swallow fluids or food, or can no longer utilize upper GI tubes for whatever reason.

CHOICE OF CATHETER

- Foley Catheter or urinary catheter can be used for administration of liquids into the rectum.
 - Sizes 18-22fr² are optimal for self-administration of medications.
 - EOLWA recommends using a FOLEY CATHETER for rectal administration of medications.
- A Macy Catheter is specifically made to administer medications to the rectum.
 - (<https://www.macycatheter.com>) It is only made in one size.
 - It has a small opening, 14fr², about 4.5mm external size, and requires additional dilution/thinning of medications. The volume of liquid can create an urge to defecate.
 - Cost \$125 - \$150 (internet search 1/27/21) though may be provided by hospice.

CHOICE OF SYRINGE

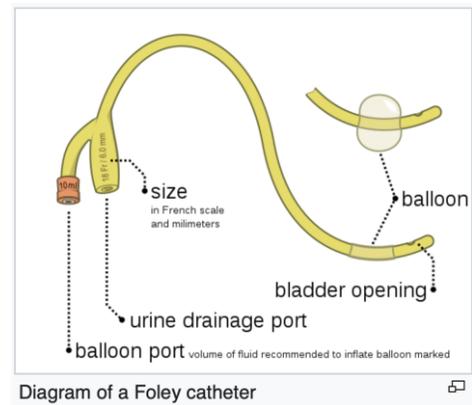
- A single 100cc syringe can hold the entire volume of the lethal medications – but is harder to push than 60cc syringes. If client/dying person has significant arm weakness, it may be best to have two 60cc syringes (with the dose split between the two).

SUPPLIES

- Foley catheter **18-22fr²** with a **20 – 30cc** inflatable balloon to keep the catheter from coming out.
- **Catheter-compatible three-way stopcock or simple clamp** for closing the catheter after drug self-administration, sometimes also called a Lopez Enteral Valve.
- Two 60mL or one 100mL **catheter tipped syringes**.
- **20 - 30mL Luer lock syringe** to inflate the balloon.

*These supplies can be found through compounding pharmacies, hospice care teams, or on the internet.
If you have questions about where to find these supplies,
please contact End of Life Washington at 206-256-1636*

² fr = French, which is a measure of lumen diameter; 3fr is about 1mm



PRE-CARE

A Fleet Enema, self-administered the day before or the morning of medications, is usually sufficient to provide an empty rectum. A small amount of firm stool in the rectum is OK. The enema is recommended but is not required.

CATHETER INSERTION

Placing a rectal catheter is similar to using an enema. Although catheter placement does not require a clinician, it is probably better to have someone who has experience with catheters do this. This may mean hiring a clinician such as a private duty nurse. End of Life Washington volunteers can NOT place rectal catheters.

1. An enema is suggested the evening before the day of death to provide an empty rectum.
2. Test the catheter balloon with 20 - 30mL of air or water prior to inserting the catheter into the rectum, then totally deflate the balloon.
3. Place a chux (underpad) under the dying person (or a shower curtain liner under the sheet) if the client is in a non-hospice bed.
4. Have the client position themselves lying on their back, head up about 45 degrees and legs in frog-leg position. An alternative is to have them roll onto their left side with their 'bottom' toward you.
5. Reassure client that you will tell them of each step of the process.
6. Perform a rectal exam, to make certain there is access for meds, nothing blocking passage, and no obstructing stool in the rectal vault. If needed, use enema or remove stool.
7. Lubricate foley tip with K-Y gel and insert about 6 inches. A 6-inch mark can be placed on the catheter using a sharpie type marker. Tell client they may feel some fullness. Inflate balloon on the foley to 20 – 30mL (depending on balloon size) with water using Luer lock syringe. Remove syringe and pull the catheter gently against the rectal sphincter to provide a seal, so medication stays in the rectum.
8. If client/dying person is on their side, help client change position to lying on their back with knees raised and feet on bed. The chux pad or shower curtain liner should still be underneath.
9. Thread the other end of the catheter up between the legs, along the perineum, up through to the waist (not along the outside of the thigh as this makes occlusion of the catheter more likely). Pants or undergarments can be pulled up over this, and the injection end of the catheter can be accessed by the client at their waistline.

MIXING THE MEDICATIONS

- Antiemetic pre-meds are not essential with rectally administered medications; but they are often used. They can be dissolved in 2oz warm water and administered via catheter about 45 minutes before lethal medications.
- **Mix the powdered life-ending drugs (e.g., DDMAPH or DDMA) with 90mL (3 ounces) of water or clear juice.** Add the liquid to the bottle of powder and agitate well for thirty seconds ('Happy Birthday' 3 times). Do not try to fill the syringes from the med bottle. Instead, pour out the mixed contents of the pharmacy bottle into a glass container: *a measuring cup, or a heavy drinking glass with a wide top, works well.* Any granular or unmixed sediment on the bottom of the pharmacy bottle can be rinsed with a tiny amount of liquid and poured out into the measuring cup or glass.

MED ADMINISTRATION

1. Draw up liquid medication into syringes – this will be about 90mL in a 100cc syringe or 45mL in each 60cc syringe. Most patients can tolerate a total of about 100mL in the rectum without stimulating any contractions which might expel the meds.
*If the mixed drugs sit in the syringes for a while before the patient is ready to push the medication into the rectal catheter, there may be some settling of the mixture. Agitate the mixture in the syringe (with its tip plugged) by rocking it back and forth **before attaching to the rectal catheter.*** A second syringe also needs to be rocked back and forth before attaching to the rectal catheter. This is most easily done by someone other than the person helping the client handle the rectal catheter and initial syringe.
2. Make sure the client is comfortable and able to use the plunger to administer the medications. Assist with attaching the catheter tipped syringe into the stopcock outlet, opening the valve properly by turning the stopcock. An assistant/family member may hold this connection securely **BUT** the client **must** push the plunger themselves to introduce the meds.
3. Instruct the client to **slowly** depress the plunger to self-administer. The medication in each syringe should be administered over the course of 2 minutes (4 minutes or so total), which enables the patient to tolerate the installation of the medication without the urge to defecate. The stopcock outlet should be closed between syringes to prevent leakage.
4. Reassure client that they may feel a fullness in the rectum but that it's totally okay and the medicine will stay in place.
If intestinal contractions begin and the client feels a need to have a bowel movement, *advise the client to 'hold it in', either using sphincter control or by holding the butt-cheeks closed.*
5. Close the valve on the stopcock or clamp the catheter before removing the syringe, so meds don't leak out. (NOTE: it is not necessary to flush the catheter, as less than 3mL total remains inside it after clamping.)
6. Help client lower his/her legs for comfort. Pull up underwear for modesty, if desired.
7. Reassure that all is going according to plan. Sit with client or gather family, as client wishes.

AFTER MED ADMINISTRATION

1. Time to sleep and time to death has not varied much from oral administration; time to deep sleep can be between 3-15 minutes, and time to death will generally be 2-6 hours.
2. Families may benefit from support through the normal signs and symptoms of dying.

POSTMORTEM CARE Do not remove catheter postmortem so that no leakage occurs.

NOTE: Rectal administration is **NOT RECOMMENDED** for anyone who has had a totally nonfunctioning rectum for many months. When the rectum has been surgically isolated from the upper bowel, which occurs in patients who have been living with a colostomy or ileostomy, the mucosa changes and loses its absorptive capacity. These patients may be unable to absorb medications. Significant rectal surgery/radiation treatment or any current condition that may hinder absorption of medications from rectal mucosa may make it difficult to successfully use the rectal route for life-ending medication administration.

For questions, concerns, and/or information, email Wayne T Dodge, MD: dodgeateolwa@gmail.com
We are continually working on quality improvement of this process, and we would love to hear from you.