



Letter to Editor

When Symptoms become Vital Signs.... Fetch your End-of-Life Care Crash Cart

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Dear Editor,

As Tagore poignantly expressed, 'Death is not extinguishing the light; it is only putting out the lamp because the dawn has come'.^[1] This timeless perspective invites us to reframe our approach to dying – not as a failure of medicine, but as a natural and meaningful part of life's journey.

By gradually moving beyond the traditional biomedical model – which often emphasises cure alone – we have an opportunity to transform hospitals into healing environments where quality of life, dignity and comfort are prioritised in the terminal phase.^[2] Shifting the focus from aggressive physiological monitoring to attentive monitoring for the discomforting symptoms and signs of distress allows us to better meet the physical, emotional and spiritual needs of patients and their families during this profound time.

Yet, this shift in perspective remains elusive within the healthcare community, particularly in acute care settings, where most patients with chronic, life-limiting illnesses spend their final days.^[3,4] Encouragingly, the 2023 Supreme Court of India judgment, which granted legal validity to advance medical directives and simplified the process of withholding or withdrawing life-sustaining treatment, marks a crucial milestone in the country's end-of-life care landscape.^[5] With this legal clarity, hospital-based end-of-life care is likely to increase, necessitating a parallel strengthening of institutional preparedness, healthcare provider education and the availability of essential resources.

Once the dying phase is identified, this must be followed by proactive assessment and management of symptoms by a multidisciplinary team. During this phase, healthcare providers must anticipate distress, rather than wait for patients or families to report symptoms. Literature describes

over 55 symptoms that may manifest at the end of life, many of which are underrecognised and poorly managed, particularly in imminently dying patients.^[6] Common distressing issues include pain, anorexia-cachexia, delirium, nausea, vomiting, dyspnoea, constipation and asthenia, among others.^[6]

The hospital's end-of-life care (EOLC) policy must contain an EOLC symptom monitoring chart. An example that is being used in our hospital is attached, as shown in Figure 1.

We propose the implementation of an 'End-of-Life Care (EOLC) Crash Cart' [Table 1], a structured and easily accessible resource that includes anticipatory prescriptions and essential pharmacological agents tailored to manage the most common and distressing symptoms in the terminal phase of illness.^[7,8] The cart should be easily available for ready use once a patient is on end-of-life care (just like an Emergency Crash cart for Code Blue). The cart may be individualised through team discussions whenever required. Its availability would ensure timely symptom control, minimise unnecessary delays in medication administration and foster a sense of preparedness within the care team.

Such a system can significantly enhance the confidence and clinical autonomy of nurses and other frontline healthcare providers, enabling them to respond swiftly and appropriately to evolving symptom burdens. Empowering the team in this way not only improves patient comfort but also reduces the moral distress associated with witnessing suffering that could otherwise be mitigated. However, this pharmacological readiness must be complemented by non-pharmacological interventions grounded in communication, compassion and collaborative care.

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Received: 26 June 2025 Accepted: 03 November 2025 Published: 10 February 2026 DOI: 10.25259/IJPC_231_2025

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Table 1: “EOLC Crash Cart” suggested drugs for symptom management and recommended doses for adult patients at the end of life (EOL).

Symptom	Drug	Formulation/strength	Recommended dose
Pain/Dyspnoea	Morphine	Oral IR Tablet 10 mg; Injection 15 mg/mL	Oral: 2.5–10 mg q4 h; IV/SC: 1–3 mg q1h PRN or continuous infusion
	Fentanyl	Injection 50 mcg/mL; OTFC 200 mcg	IV/SC: 25–50 mcg q1 h PRN; OTFC: 200 mcg for breakthrough pain (opioid-tolerant only)
	Acetaminophen	Tablet 500 mg, 650 mg; Injection 1 g/100 mL	Oral/IV: 500–1,000 mg q6–8 h (max 4 g/day)
	Dexamethasone	Tablet 0.5 mg, 4 mg; Injection 4 mg/mL	Oral/IV/SC: 4–16 mg/day (divided) for pain, raised ICP, dyspnoea, fatigue
	Hydrocortisone	Injection 100 mg/vial	IV: 25–100 mg q6–8 h (as an adjuvant in dyspnoea)
Delirium/ Nausea	Haloperidol	Tablet 0.5 mg, 5 mg; Injection 5 mg/mL	Oral: 0.5–2 mg q8–12 h; SC/IV: 0.5–2 mg q4–6 h PRN (max 10 mg/day)
	Quetiapine	Tablet 12.5 mg, 25 mg	Oral: 12.5–50 mg q12 h
	Olanzapine	Tablet 2.5 mg, 5 mg	Oral: 2.5–10 mg at night (max 20 mg/day)
	Metoclopramide	Tablet 10 mg; Injection 5 mg/mL	Oral/IV/SC: 10 mg q6–8 h (max 40 mg/day)
Insomnia/ anxiety/seizure	Midazolam	Injection 5 mg/5 mL; Nasal Spray 0.5 mg/puff	SC/IV: 2.5–5 mg q2–4h PRN; CI: 0.5–2 mg/h; Nasal: 2.5–5 mg
	Lorazepam	Tablet 0.5–1 mg; Injection 1 mg/mL	Oral/SL: 0.5–2 mg q6–8h PRN; IV: 2–4 mg for seizure (may repeat)
Respiratory/GI secretions	Glycopyrrolate	Tablet 1–2 mg; Injection 0.2 mg/mL	Oral: 1–2 mg q6–8h; SC/IV: 0.2–0.4 mg q4–6 h PRN (max 1.2 mg/day)
	Hyoscine butylbromide	Tablet 10 mg; Injection 10 mg/mL	Oral/SC/IV: 20 mg q6–8 h (max 120 mg/day)
Constipation	Milk of magnesia/ liquid paraffin	Syrup	Oral: 10–30 mL once daily
	Lactulose	Syrup 10 g/15 mL	Oral: 15–30 mL once or twice daily (titrate to effect)
	Bisacodyl	Tablet 5 mg; Suppository 5 mg	Oral: 5–10 mg HS; Rectal: 10 mg once daily
Cough	Linctus codeine	Syrup 10 mg/5 mL	Oral: 10–20 mg q6h PRN (max 120 mg/day)
Gastritis/GI protection	Pantoprazole	Tablet 40 mg; Injection 40 mg/vial	Oral/IV: 40 mg OD–BD
Cardiac failure/ oedema	Furosemide	Injection 40 mg/4 mL	IV: 20–40 mg once, repeat PRN (may double dose if resistant)
Opioid toxicity/ overdose	Naloxone	Injection 0.4 mg/mL	IV: 0.1–0.2 mg q2–3 min PRN until reversal; infusion may be needed

IR: Immediate relief, PRN: As and when required, OTFC: Oral transmucosal fentanyl citrate, ICP: Intracranial pressure, CI: Continuous infusion, GI: Gastrointestinal. For patients who are not able to swallow and do not have an IV access, subcutaneous/rectal/sublingual (oral tablets crushed and made into a paste with small amounts of water) can be used as an alternate route.

Ethical approval: The Institutional Review Board approval is not required.

Declaration of patient consent: Patient’s consent was not required as there are no patients in this study.

Financial support and sponsorship: Nil.

Conflicts of interest: Dr.Gaurav Chanana is on the Editorial Board of the journal.

Use of artificial intelligence (AI)-assisted technology for manuscript preparation: The authors confirm that they have used artificial intelligence (AI)-assisted technology solely for language refinement and to improve the clarity of writing. No AI assistance was employed in the generation of scientific content, data analysis or interpretation.

Date: _____ UHID: _____ Mobile No: _____		Paste Sticker here:	
Name: _____ Age: _____ Gender: _____			
Sign(at the bottom) during each assessment - a signature indicates the patient was assessed as given below : If any concerns remain unresolved or persist, then an explanation/comment will be recorded on the progress notes			
Symptoms {Present (+) / Absent (-)}	Date: _____ Day: _____		
	Morning	Evening	Night
Pain			
Agitation			
Respiratory tract secretions			
Nausea			
Vomiting			
Breathlessness			
Urinary problems			
Bowel Problems (last passage of stool)			
Other Assessment	Morning	Evening	Night
Oral Intake (present/absent)			
IV fluids (ongoing/none)			
Oral cavity (moist/clean/dry/other)			
Hair care (done/ not done)			
Oral care (done/ not done)			
Sponging (done/ not done)			
Perineal care (done/ not done)			
Skin integrity/Bed sore stage			
The person`s psychological wellbeing is maintained (Yes/No)			
The person`s spiritual wellbeing is maintained (Yes/No)			
The wellbeing of relative/carer attending to dying person is maintained (Yes/No)			
Signature of nurse: (performing assessment)			

Figure 1: End-of-life care monitoring. IV: Intravenous.

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How to cite this article: Pruthi M, Chanana G. When Symptoms become Vital Signs.... Fetch your End-of-Life Care Crash Cart. *Indian J Palliat Care*. 2026;32:111-3. doi: 10.25259/IJPC_231_2025