HERPC

Hull & East Riding Prescribing Committee

Guideline for the prescribing of Glycopyrronium injection in Palliative Care

1. BACKGROUND

Glycopyrronium is a synthetic quaternary ammonium compound with non-selective antimuscarinic activity. It has poor oral bioavailability (less than 5%). In Palliative Care, Glycopyrronium bromide is used as a second line agent for drying secretions usually after Hyoscine Butylbromide has been used, although in some centres, Glycopyrronium is first line before hyoscine.

The injection contains Glycopyrronium bromide 200microgram per ml, available as 1ml and 3ml ampoules.

Note Glycopyrronium is licensed for use as an antimuscarinic agent in pre-operative and intra-operative surgical scenario and as a bronchodilator in respiratory settings. An oral solution is available to treat sialorrhoea in children and an oral tablet is used as add-on therapy for peptic ulcer. Glycopyrronium injection has been approved for use in the National Covid-19 symptom control guidelines

2. INDICATION

Glycopyrronium injection is indicated in Palliative Care for the control of secretions. This is not a licensed indication

3. DOSE / DURATION

Treatment will usually be initiated by a prescriber with experience in Palliative Care.
The usual starting dose is 200microgram to 400microgram, by subcutaneous injection, every 4 hours when required up to three times within 24 hours, up to a maximum of 1200microgram in 24 hours. The decision to replace when required (prn) dosing with 24hr syringe driver administration would normally be taken after review of efficacy on 'when-required' basis.
In bedded units such as hospital or hospice, treatment often starts with doses of 400microgram, and then as above.

4. CONTRAINDICATIONS / CAUTIONS

Contraindications

Hypersensitivity to Glycopyrronium bromide or excipient
Myasthenia gravis

Cautions

QT prolongation – pre-existing, or use of other agents with this predisposition

Glaucoma; bladder outflow obstruction – see www.emc for a full list of cautions

5. INTERACTIONS

Interactions with frequently met drugs include other drugs with antimuscarinic activity, eg phenothiazine, antihistamines, and tricyclic antidepressants, prokinetics such as metoclopramide and domperidone.
Due to delayed gut transit time, digoxin absorption may increase but paracetamol absorption decrease. Sublingual absorption may decrease due to reduced saliva production (NB with GTN or lorazepam)
If a drug interaction is suspected, please contact a Palliative Care Specialist, a Macmillan Pharmacist or Medicines Information at HUTH

6. ADVERSE EFFECTS

Constipation, and dry mouth principally.

Details of contraindications, cautions, drug interactions and adverse effects listed above are not exhaustive. For further information always check with BNF www.bnf.org.uk or SPC (www.medicines.org.uk).

7. MONITORING

There are no specific drug monitoring requirements.
Response to treatment will be response to treatment will be reviewed by the clinicians involved in the patient's care.

8. INFORMATION TO PATIENT

Patients or relatives/carers should be informed of risks and benefits of treatment including which follow up arrangements (eg monitoring) will come from the Specialist team and which (eg supply) arrangements from the GP

APPROVAL PROCESS

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