1.4 Dyspnea

Key Points

1. Dyspnea is the subjective sense of breathlessness or smothering.
   Patients can self-report the severity of their dyspnea using a scale similar to the pain scale. Hypoxia and dyspnea are not always concordant; patients with hypoxia may or may not have dyspnea. Dyspnea is reported by over half of patients at Life's End.

2. Dyspnea may have multiple causes.
   Palliative care does not exclude the search for and treatment of the underlying causes of dyspnea. Palliative care recognizes that the causes of the dyspnea may not be responsive to treatment or that the burden of treatment may outweigh the benefit.

3. Oxygen alone often does not relieve dyspnea.
   Oxygen is a potent symbol of medical care. However, patients routinely can neither tolerate, nor have available in the home, more than 2–5 L of Oxygen by nasal prong. Oxygen alone is usually not adequate treatment to relieve chronic dyspnea.

4. Low-dose opioids can often safely relieve symptoms of dyspnea.
   Low doses of short-acting oral opioids often can reduce dyspnea without sedation or respiratory depression.

5. Dyspnea causes chronic anxiety, which may respond to low-dose benzodiazepines.

6. Dyspnea often responds to non-pharmacological interventions better than to oxygen.
   Many patients find that a fan blowing cool air on the face is more effective for the relief of dyspnea than a 100% non-rebreather mask.

Dyspnea

The Palliative Response

The Experience of Dyspnea

- Shortness of breath
- Breathlessness
- Smothering feeling
- Suffocation
- Present at rest
- Worsened by activity

Diagnosing Dyspnea

- Self-report is the key
  To detecting dyspnea
  To appreciating the severity of dyspnea
- Use analog scale to help people self-report severity of shortness of breath
  Now?
  At the worst?
  At the best?
  After treatment?

Diagnosing Dyspnea

- Prevalence may be greater in patients with life-threatening illness
  COPD
  CHF
  Lung cancer
- Blood gas, oxygen saturation, and respiratory rate do not substitute for patient's self-assessment and report of dyspnea

Fix It versus *Treat It* Paradigm

- Look for reversible causes
- Help patients, families, and colleagues consider the burden of treatment of the underlying cause versus the benefit of treatment

Fix It versus *Treat It* Paradigm

- Treat dyspnea as a symptom while looking for a reversible cause
- The cause of the dyspnea may take some time to improve
- Often dyspnea does not have a reversible cause, yet patients do not have to suffer unrelieved dyspnea for the remainder of life

Potentially Reversible
Causes of Dyspnea

- Pneumonia and bronchitis
- Pulmonary edema
- Tumor and pleural effusions
- Bronchospasm
- Airway obstruction
- COPD
- Asthma
- Thick secretions

Potentially Reversible
Causes of Dyspnea

- Anxiety
- Pulmonary embolism
- Anemia
- Metabolic disturbance
- Hypoxemia
- Family and practical issues
- Environmental problems

Benefit versus Burden of Treatment

- It is always important to consider causes of dyspnea
- However, before deciding the extent of evaluation beyond history and physical, begin to weigh benefit versus burden of disease-modifying treatment.

Symptomatic Management
Oxygen

- Oxygen is a potent symbol of medical care
- Try to avoid mask

  Causes discomfort from sense of smothering

  Involves unpleasant accumulation of mucus and moisture

  Interferes with communication and oral intake

Symptomatic Management
Oxygen

- Use humidifier if using nasal prong
- Most people will not tolerate more than 2 l/m
- Be guided by patient comfort, not by oxygen saturation
- Home oxygen is usually provided by a concentrator, which cannot provide more than 5 l/m
- A fan or air conditioner may provide the same level of comfort

Symptomatic Management
Opioids

- Opioids are the most effective treatment for unrelieved dyspnea
- Central and peripheral effects
- Begin with small doses of short-acting opioids
- MS 5mg or Oxycodone 5mg orally q4 hours *Offer/May Refuse* is often a good starting point
- Use analog scale as in pain management to monitor effect

Symptomatic Management
Opioids

- Physicians are afraid people will stop breathing
- It may reassure wary colleagues of the safety of this approach to order *Give if respiratory rate of greater than 20/m*, since relief of dyspnea may not be related to decrease in rate

Symptomatic Management
Nonpharmacological

- Fan
- Keep environment cool, but avoid chilling patient
- Consider cool foods
- Reposition patient; allow to sit up in bed or chair
- Avoid environmental irritants
- Avoid claustrophobic settings
- Have a plan for the next episode of dyspnea to give patient and family sense of control

Symptomatic Management
Anxiolyics

- Anxiety may be a component for patients suffering with dyspnea
- Lorazepam (Ativan) is safe to combine with opioids for dyspnea

  0.5–1mg prn q2 hours may be helpful

  Some patients may benefit from scheduled doses

Dyspnea Review

- Dyspnea is common in patients referred to palliative care
- Dyspnea is also common in the general patient population
- Dyspnea can be effectively controlled in most patients whether or not referred to palliative care
- Visual analog scale is the best tool for assessing dyspnea and monitoring effectiveness of its treatment

Selected Readings

Overview of Dyspnea Treatment

Shaiova, L. A. "Management of Dyspnea in Patients with Advanced Cancer." In *Principles and Practice of Supportive Oncology* edited by A. M. Berger, R. K. Portenoy, and D. E. Weissman. New York: Lipincott Williams & Wilkins Healthcare 2 (1999): 1–11.

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Oral Morphine as Symptomatic Treatment

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