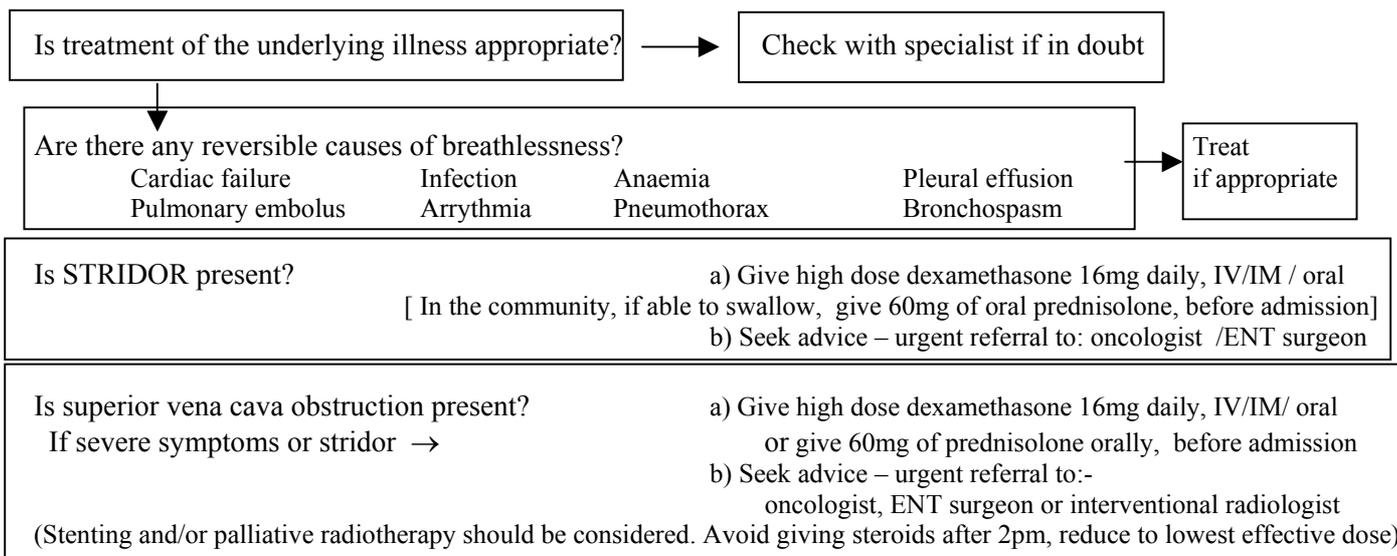


Breathlessness in Palliative Care



Palliative Care

- Multidisciplinary assessment of patient / family is essential
eg. physiotherapist, OT, specialist nurses, social services etc. may be needed as well as ward staff / primary care team
- Palliative measures described below are as important in managing breathlessness in advanced, non-malignant disease as in cancer patients

- Anxiety and panic attacks Anxiety and hyperventilation are common in breathlessness →
 Simple breathing exercises
 Relaxation training
 Ask about anxieties/ fears (eg. suffocation) and allay when possible
 Offer written information about living with breathlessness
 Discuss possible drug management with patient / family eg.
 - Lorazepam 0.5mg SL, for panic attacks
 - Diazepam 2mg, oral, at night, if more chronic anxiety (increase dose gradually as necessary)
- Consider lifestyle adaptations Discuss limitations and listen to patient / family concerns
 Maximise abilities including using breathing retraining, energy conservation
 Review benefit entitlement (may be eligible under special rules scheme)
 Consider need for equipment / aids and a package of community care

If the patient has more severe/ persistent problems with anxiety and/or lifestyle adjustment and has a longer prognosis, consider referral to a specialist breathlessness service and/or clinical psychologist (if available).

Is a trial of steroids appropriate? <i>(particularly if carcinomatous lymphangitis suspected or has COPD that has previously responded to steroids)</i>	Dexamethasone 4– 8mg bd, oral (last dose no later than 2pm) Stop if no effect within 1 week If effective, reduce gradually to lowest effective dose
--	---

Consider a trial of nebulised bronchodilators	Salbutamol 2.5– 5mg qds +/- ipratropium Nebulised sodium chloride 0.9% may help loosen retained secretions
---	---

Breathlessness at rest – drug treatment is more likely to be needed

Management of breathlessness at rest	<p>Well ventilated room (fan and/or open window) Advice on posture Trial of opioid: monitor patient response and side effects</p> <ul style="list-style-type: none"> • Oral normal release morphine, 4-6 hourly or as needed. → if pain is controlled on a regular opioid, 25% of the 4 hourly equivalent dose of oral morphine, as needed, may be adequate for breathlessness. → if patient frail, opioid naive or has non-malignant disease; start with oral normal release morphine 2.5mg, 6-8 hourly or at night. • Increase oral morphine dose slowly in steps of about 30%, if needed • If unable to take oral medication, use SC route (see below) diamorphine 1.25-2.5mg, SC, as needed – if opioid naive +/- diamorphine 5-10 mg / 24hrs SC in a driver <p>If hypoxic, consider a trial of oxygen via nasal cannula or mask at 24% or higher. Important to avoid patient becoming oxygen dependent for psychological reasons. If patient is to be discharged home on oxygen, plan well in advance</p>
---	---

<p>Increasing breathlessness at rest <i>(may suggest a short prognosis if no reversible cause(s) can be found)</i></p>	<p>- Plan management of breathlessness in the terminal phase with staff team, patient and family including:</p> <ul style="list-style-type: none"> • use of drugs (eg. opioids, benzodiazepines – see below) • the option of sedation in the terminal phase (in the event of uncontrolled distress from breathlessness)
--	---

<p>Management of severe breathlessness in the last days or hours</p>	<ul style="list-style-type: none"> • Regular and as needed opioids to reduce respiratory distress. • If patient is having difficulty with oral medication, → convert oral opioid to the SC route <u>(24hr oral morphine dose divided by 3 = 24hr SC diamorphine dose)</u> • Give midazolam 2.5-5mg SC, as needed for anxiety/ fear • Add midazolam 5-10mg/ 24 hour to SC infusion via syringe driver Increase midazolam in SC infusion according to the amount of extra prn doses required or according to the level of distress. Some patients may need 30-80mg of SC midazolam /24hours • Discuss the above with family and explain that the intent is to reduce the distress, associated with severe breathlessness
---	---

<p>Management of noisy breathing or secretions</p>	<ul style="list-style-type: none"> • Changing position may help • Give hyoscine butylbromide 20mg SC stat. If it helps → use stat doses of 20mg SC, 4-6 hourly or hyoscine butylbromide 40mg/24hrs SC in a driver • Suction may be required if patient has copious oropharyngeal secretions and is unconscious.
---	--

NB; Buscopan (hyoscine butylbromide) causes less sedation and confusion than hyoscine hydrobromide. However, if more sedation is required, consider using hyoscine hydrobromide 400micrograms, SC, 4hourly or 0.8-1.2mg /24hrs, SC in a driver

SIGN. Management of Lung Cancer (publication 23). Edinburgh: Scottish Intercollegiate Guidelines Network in collaboration with the Scottish Cancer Therapy Network, 1998.

Corner J, Plant H, A'Hern R, Bailey C. Non-pharmacological intervention for breathlessness in lung cancer. Palliative Medicine 1996;10:299-305.

Crowcher K, Hanks G. Long term management of respiratory symptoms in advanced cancer. Journal of Pain and Symptom Management 1990;5:320 - 330.

Allard P, Lamontagne C, Bernard P et al. How effective are supplementary doses of opioids for dyspnoea in terminally ill cancer patients? A randomised, clinical trial. Journal Pain & Symptom Management 1999;17(4):256-265

Conference report: 4th Oxford Seminar in Palliative Care Therapeutics. Breathlessness. CLIP Update Service March 1998. St Oswald's Hospice, Newcastle. Hochland & Hochland Ltd.

Bruera E, MacMillan K, Pither J, MacDonald N. Effects of morphine on the dyspnoea of terminal cancer patients. Journal of Pain and Symptom Management 1990;5:341 - 344.

Bruera E, deStoutz N, Velasco-Leiva A, Schoeller T, Hanson J. Effects of oxygen on dyspnoea in hypoxaemic terminal cancer patients. Lancet 1993;1993(342):13-14.

Booth S, Kelly M, Cox N, Adams L, Guz A. Does oxygen help dyspnoea in patients with cancer? American Journal of Critical Care Medicine 1996;153:1515-1518.

O'Donnell V. The pharmacological management of respiratory tract secretions. International J Palliative Nursing 1998;4(4)199-203

Issue date: January 2002 (revised June 2002) **Review date: December 2003**