Lothian Palliative Care Guidelines

**Breathlessness in Palliative Care**

Is treatment of the underlying illness appropriate? → Check with specialist if in doubt

Are there any reversible causes of breathlessness?
- Cardiac failure
- Infection
- Anaemia
- Pleural effusion
- Pulmonary embolus
- Arrhythmia
- Pneumothorax
- Bronchospasm

Treat if appropriate

Is STRIDOR present?

- a) Give high dose dexamethasone 16mg daily, IV/IM / oral
- [In the community, if able to swallow, give 60mg of oral prednisolone, before admission]
- b) Seek advice – urgent referral to: oncologist / ENT surgeon

Is superior vena cava obstruction present?

- a) Give high dose dexamethasone 16mg daily, IV/IM/ oral
- or give 60mg of prednisolone orally, before admission
- b) Seek advice – urgent referral to:-
- oncologist, ENT surgeon or interventional radiologist
- (Stenting and/or palliative radiotherapy should be considered. Avoid giving steroids after 2pm, reduce to lowest effective dose)

### 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? (particularly if carcinomatous lymphangitis suspected or has COPD that has previously responded to steroids)
- 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
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Breathlessness at rest — drug treatment is more likely to be needed

Management of breathlessness at rest

Well ventilated room (fan and/or open window)
Advice on posture
Trial of opioid: monitor patient response and side effects
- 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
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.

Increasing breathlessness at rest
(may suggest a short prognosis if no reversible cause(s) can be found)

- Plan management of breathlessness in the terminal phase with staff team, patient and family including:
  - use of drugs (eg. opioids, benzodiazepines – see below)
  - the option of sedation in the terminal phase
  - (in the event of uncontrolled distress from breathlessness)

Management of severe breathlessness in the last days or hours

- Regular and as needed opioids to reduce respiratory distress.
- If patient is having difficulty with oral medication, convert oral opioid to the SC route
  (24hr oral morphine dose divided by 3 = 24hr SC diamorphine dose)
- 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

Management of noisy breathing or secretions

- 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

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