Northeastern Ontario
Palliative Pain & Symptom Consultation Service

This program is designed to assist service providers in Northeastern Ontario serving LHIN 13

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Program administered by VON Algoma in cooperation with its community partners.

Keeping Up

Newsletter

Northeastern Ontario
Palliative Pain & Symptom Management Consultation Services
Member of the Palliative Care Consultation Network

End of Life Dyspnea: Best Practices

The NEPPSMC newsletter has addressed a variety of issues in newsletters to date. Topics covered include:

Dealing with Grief over the holidays
Wound care
Skin care
Managing secretions
Delirium
Mouth care
Symptom Relief Kits –a refresher

If you or your agency did not receive these and wish a copy, please contact the consultant for your region. We are also hoping to upload these to a regional website in the future. Please contact us with any issue you would like to see addressed in the quarterly newsletter.

In this issue will be discuss DYSPNEA.

Many of us have done an exercise wherein dyspnea was simulated by the instructor. Commonly palliative care foundations teachers ask their students to try breathing through a straw for an extended period of time… climb stairs using that straw… get dressed, participate in ADLs… Most of us find it quite distressing!! Participants describe the experience as frightening, anxiety producing, distracting, upsetting…

This is DYSPNEA.

According to a resource by Dr. Mike Harlos at Virtualhospice.ca, dyspnea is one of the most common severe symptoms in the last days of life. Surveys indicate that 70% of all palliative patients have dyspnea in their last days and yet only half are treated!!!

Defined as an uncomfortable awareness of breathing, dyspnea at End of Life can have many causes. Causes may be disease specific, such as shortness of breath in congestive heart failure (CHF), infection or due to ascites. It is important to determine cause when possible as this may determine the treatment approach. For example, dyspnea related to CHF may be improved with use of a diuretic such as Furosemide. Infections may cause dyspnea and may improve with use of antibiotics. Airway obstructions can be relieved with use of corticosteroids and bronchodilators.

Dyspnea related to emboli may require anticoagulant therapy to improve. Ascites impinging on breathing can be drained.

Causes may also be nonspecific.

Using a best practice tool like the Edmonton Symptom Assessment Scale (ESAS), dyspnea should be regularly assessed at every patient visit. Numerical Rating Scales (0-10) and Visual Analog Scales (0-10) are recommended. Regular consistent assessment allows for more effective interventions.

ALL HANDS ON DECK!

Dyspnea is better managed if the family is part of the team. The following are suggestions courtesy of Fraser Health Hospice Palliative Care Program, available online at Virtualhospice.ca

- Develop a clear plan for the patient and family to address the pattern of shortness of breath and the patient's way of coping.
- Teach the purpose of each medication, particularly opioids, as families often do not understand the role of these medications. Ensure an understanding of using regular and

breakthrough medications. This is key to effective management.

- It is important to have family track and document mediations and other strategies used for dyspnea – to gauge level of effectiveness.
- Create and provide a Shortness of Breath teaching pamphlet to patient and family.

Non-pharmacological Approaches:

There are many non-pharmacological interventions that are helpful in alleviating or reducing dyspnea. Family should be encouraged to utilize these approaches.

1. Calm reassurance – always stay with the dyspneic patient.
2. Sit the patient up into a semi-reclined/semi-fowlers position.
3. Open a window to allow for fresh air to circulate.
4. Use of a fan –triggers the trigeminal nerve.
5. Alternative therapies for relaxation include: massage, therapeutic touch, visualization, music therapies.

Pharmacological Approaches:

*******Morphine is the mainstay of treatment for dyspnea**

in terminally ill patients*****

The management of nonspecific End of Life (EOL) dyspnea generally includes use of some or all of the following:

- Opioids
- Oxygen (depending on hypoxia)
- And use of Sedative/Benzodiazepines and/or Antipsychotics (Phenothiazines)

More specifically, here are some approached to dyspnea being used locally;

The Symptom Relief Kit (SRK) in Nipissing District recommends the following for managing EOL Dyspnea:

If the patient is on opioids, give regular breakthrough doses.

If the patient is not on opioids give: Morphine 2-5mg s/c Q 1H prn

Or

Midazolam (Versed) 1-5mg s/c Q 1H prn

The SRK in Sudbury District recommends the following for managing EOL Dyspnea:

Hydromorphone (Dilaudid) 1-2mg s/c Q 1H prn

The SRK in Algoma District recommends the following for managing EOL Dyspnea:

Midazolam (Versed) 2.5mg s/c Q 15min prn

Or

Morphine ***OR*** Dilaudid are listed, with no specific doses (left blank for physician) Q 1H prn

Other options for managing EOL Dyspnea include:

Methotrimeprazine (Nozinan) 6.25mg s/c or 5mg po Q 4H prn (as a starting dose)

Open window; Fan blowing air; Quiet calm atmosphere.

May consider Oxygen therapy at low flow rate.

A few other important points....

- Dyspnea management is not the same as secretion control at EOL. Secretions / Congestion should be managed using best practices including use of Atropine and /or Glycopyrrolate. Scopolamine can also be used.

Remember that dyspnea can be managed.

It is important to reassure the family that this symptom is

a high priority for the palliative care team.