

Joann Bennett DO FACOI

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Symptom Management of Dyspnea

56 year old female

- Worsening shortness of breath over 1 week
- Hx of 20 pack yrs tobacco
- Extensive workup and treatment
- Continued complaint of breathlessness despite in depth assessment and treatment

I'M
HAVING
TROUBLE
BREATHING



LYNCH

Dyspnea/breathlessness

- Multiple disease processes lead to symptom
- Dyspnea may occur in the absence of hypoxemia
- Final common pathway of many acute and chronic diseases
 - Heart disease
 - Lung disease
 - Anxiety
 - Thromboembolic disease
 - Acid base disorders
 - Volume overload states
 - Uncontrolled pain

- Symptom management can be delivered concomitantly with treatment of disease
- Symptom management can be delivered as part of comprehensive end of life care

Patient Interview

- Ask patient about symptoms and intensity routinely
- No dyspnea scale has been found to be superior in assessment of breathlessness
 - Borg, Visual Analog Scale, Numerical Rating Scale
- Psychosocial, Cultural and Spiritual issues are integral to the understanding of the patients goals of care

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“He’s complaining of chest pain, shortness of breath, cramps and dizziness. Do you sell earplugs?”

Significance of Dyspnea as a symptom

- Skilbeck et al
 - 95% COPD patients reported breathlessness as most significant symptom
 - 60% of these patients indicated the highest severity level on the scale
- Edmonds et al
 - Surrogate reported high frequency of breathlessness (94%) rating it as “very distressing” (76%)

Significance of Dyspnea as a symptom

- 95% COPD patients report dyspnea as a significant symptom during their last year of life
- Patients fear sensation of “suffocating” at the end of life

Prognosis

- Cancer related diagnosis most predictable trajectory.
- Many studies of survival and prognosis in cancer group
- NonCancer causes of dyspnea more difficult to determine survival and disability. In this group, the duration of symptoms and effect on functionality and quality of life may be the most significant. This increases the imperative to treat dyspnea.



"So should I bother with dinner?"

Treatment of choice

- Opioid medication
- Oral or parenteral
- Morphine most common
- In patients with renal failure or allergy use alternative such as Hydromorphone, Fentanyl
- Start with lower doses in opioid naïve patient
- Once daily use of opioid is defined may convert to long acting agent with breakthrough dosage

Mechanism of Action Opioids

- Bind to opioid receptors
- Reduction of ventilatory frequency allows improved alveolar ventilation
- Decreased oxygen consumption
- Decrease perception of dyspnea
- Decreased anxiety

Opioid Dosing

- Opioid naïve patient Roxanol (liquid Morphine)
- Adjust dosage to manage symptoms and meet patient goals

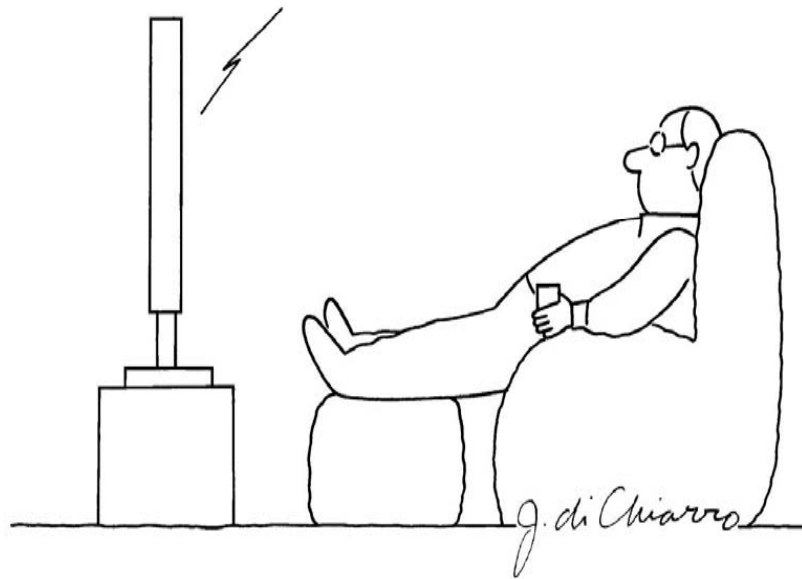
Other treatment options

- Oxygen vs. Room Air
- Bipap
- Relaxation/Meditation
- Pursed Lip Breathing
 - Pulmonary rehab technique
- Nebulized Morphine not recommended
 - RCT show Nebulized Morphine = Saline
- Nebulized Furosemide
 - Anecdotal reports of effectiveness
 - No good RCT

Barriers to the use of opioids

- Ethical
 - Principle of Double Effect
- Addiction vs. tolerance
- Cultural Issues
- Incomplete or ineffective Communication
- Fear of Hastening Death

THE RESULTS OF A STUDY
RELEASED TODAY CONFIRM
THAT LIVING IS THE NUMBER
ONE CAUSE OF DEATH.



Principle of Double Effect

- Intent to treat symptom not to hasten death
- Goal of palliative medicine is to improve quality of life, meet patient care goals
- Physicians should not be afraid to give Opioids to achieve symptom control
 - In fact it is our ethical obligation to the patient to treat symptoms adequately

Coexistent symptoms

- Anxiety
- Depression
- Social isolation

Opioid Side Effects

- Constipation
 - Prescribe Senna bowel program routinely
 - Instruct patient to report if no BM
- Confusion
- Drowsiness
- Hallucinations
- Nausea/vomiting
- Psychosis

References

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