DYSPNEA - General Principles D-1.0

- Consider possible underlying causes and treat if possible and appropriate. Dyspnea is one fo the most feared aspects of dying.
- Opioids often provide dyspnea relief.
- Dyspnea is more common in the advanced and imminently dying phases.
- Use incremental titration until, when asked, "Is your breathing easy now?" the patient replies, "Yes".

Adapted from: Medical Care of the Dying 3rd Edition
Victoria Hospice Society

- **Treatment:**
  - Explanation / information
  - Modify pathological process
    - drugs
    - radiation/chemotherapy
    - procedures
  - Comfort relief
    - oxygen
      - call for RT assessment if available
      - some patients find O2 helpful even with normal O2 sats – this may be due to "air flow".
    - relaxation techniques (e.g. therapeutic touch, music, massage etc)
    - open window/fan
    - anxiolytics
    - opioids

- **Respiratory congestion**
  - Discussion with family should take place early to prevent anxiety
  - Respiratory congestion can be distressing to the patient &/or family and these cases should be treated.
  - Early detection and treatment results in better outcomes.

- **Suctioning** is generally not appropriate as the secretions are usually below the larynx and therefore inaccessible.

- **Nebulized Opioids**
  - There is currently no clear scientific or clinical basis to justify its use.
  - Other studies have found questionable or no beneficial effect.
  - There has been anecdotal reports of success using nebulized opioids (mainly morphine).
  - The current indications for use are in clinical trials or as a 3rd line test drug in individual situations where other standard measures are not beneficial.

DYSPNEA - Guidelines D-2.0

- **Reassurance and relaxation techniques as applicable. Fresh air / fan as needed.**
- **Hydromorphone can be substituted for morphine at any level in a 1:5 ratio.**

MILD

- lorazepam 1mg PO/SL q6h prn
- bronchodilator

MODERATE

- lorazepam 1-2mg PO/SL q6h and prn
- bronchodilator esp if any bronchospasms heard on ausculation
- **If on an opioid**, increase dose by 50-100% and titrate as needed
- **If not on an opioid**, start morphine 5mg PO q4h and ½ dose q1h prn
- **For upper airway secretions** & PPS 10% (i.e. dying)- Atropine 0.6mg, or Hyosine 0.4 – 0.6 mg, SC q30min until relief then q1h prn
- **If unrelieved**
  - → consider: sedative *doses* of methotrimeprazine (Nozinan), Diazepam, CPZ or midazolam (Versed)
    versed dose – start 1 mg/hr s/c and increase by 1 mg q ½ - 1 hr. If dyspnea requires urgent management give 2 – 4 mg s/c loading dose before starting infusion.

SEVERE

- lorazepam 2-4mg PO/SL/SC q4h and prn
- bronchodilator
- **If on an opioid**, increase dose by 100% and titrate, may require a 200-400% increase
- **If not on an opioid, start morphine 5mg q4h routinely and ½ dose q1h prn**
- **For upper airway secretions,** Atropine 0.6mg or Hyosine 0.4 – 0.6 mg, SC q30min until relief then q1h prn
- **Consider:** dexamethasone for lymphangitic lung disease or furosemide if clinically indicated for heart failure.
- **If unrelieved**
  - → consider: sedative *doses* of methotrimeprazine (Nozinan), Diazepam, CPZ or midazolam (Versed)
    versed dose – start 1 mg/hr s/c and increase by 1 mg q ½ - 1 hr. If dyspnea requires urgent management give 2 – 4 mg s/c loading dose before starting infusion.

DYSPNEA - Guidelines continued D-2.1

EXTREME DYSPNEA

- lorazepam 2-4mg PO/SL/SC/IV q1h and prn
- **If on opioid**
  - → Total 24hr ***dose ÷ 6 – give SC STAT***
  - → **Repeat same dose q20min SC until dyspnea breaks or death occurs.**
  - → Do not D/C **previous regular opioid dose (for pain)**
- **If not on an opioid:**
  - → give **morphine 10-15mg SC STAT**
  - → if no relief after 20 minutes, repeat morphine q20min SC until dyspnea breaks (i.e. significant lessening) or death
- **For upper airway secretions -** Atropine 1mg or hyosine 0.6 mg sc q30 min until relief then q1h prn
- **If unrelieved**
  - → consider: sedative *doses* of methotrimeprazine (Nozinan), Diazepam, CPZ or midazolam (Versed)
    versed dose – start 1 mg/hr s/c and increase by 1 mg q ½ - 1 hr. If dyspnea requires urgent management give 2 – 4 mg s/c loading dose before starting infusion.

ONCE DYSPNEA BREAKS

Stop and observe as serum drug level is still rising

- If dyspnea is now mild, give ½ of last dose
- Establish new regular q4h dose once SOB is fully settled
- take 40% of the total amount required to break the dyspnea
- ***add*** to previous regular dose
- titrate if necessary