Draft palliativedrugs.com guidelines
Opioids for breathlessness

1 Generally, opioids are more beneficial to patients who are breathless at rest than those breathless only on exertion. Even with maximal exertion, breathlessness generally recovers within a few minutes, much quicker than the time it takes to locate, administer and obtain benefit from an opioid and non-drug measures should be used in this circumstance.

2 Morphine and other opioids reduce the ventilatory response to hypercapnoea, hypoxia and exercise, decreasing respiratory effort and breathlessness. Improvements are seen at doses that *do not* cause respiratory depression.

3 A systematic review supports the use of opioids by the oral and parenteral but *not* the nebulised route, and the latter should not be used outside of a clinical trial.

4 In *opioid-naïve* patients:
- start with small doses of morphine, e.g. 2.5–5mg PO p.r.n.; larger doses can be poorly tolerated
- if ≥2 doses/24h are needed, prescribe morphine regularly and titrate the dose according to response, duration of effect and undesirable effects
- relatively small doses may suffice, e.g. 20–60mg/24h.

5 In patients *already taking morphine for pain* and with:
- *severe* breathlessness (i.e. ≥7/10), a dose that is 100% or more of the q4h analgesic dose may be needed
- *moderate* breathlessness (i.e. 4–6/10), a dose equivalent to 50–100% of the q4h analgesic dose may suffice
- *mild* breathlessness (i.e. ≤3/10), a dose equivalent to 25–50% of the q4h analgesic dose may suffice.
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6 In some patients, morphine by CSCI is better tolerated and provides greater relief, possibly by avoiding the peaks (with undesirable effects) and troughs (with loss of effect) of oral medication.

Severe breathlessness in the last days of life

1 Patients often fear suffocating to death and a positive approach to the patient, their family and colleagues about the relief of terminal breathlessness is important:
- no patient should die with distressing breathlessness
- failure to relieve terminal breathlessness is a failure to utilize drug treatment correctly
- give an opioid with a sedative-anxiolytic parenterally, e.g. (dia)morphine and midazolam by CSCI and p.r.n.
- if the patient becomes agitated or confused (sometimes aggravated by a benzodiazepine), haloperidol or levomepromazine should be added.

2 If using an alternative opioid to morphine, adopt the same approach as above.

3 Because of the distress, inability to sleep and exhaustion, patients and their carers generally accept that drug-related drowsiness may need to be the price paid for greater comfort. However, in the absence of overwhelming distress, sedation is not the primary aim of treatment and some patients become mentally brighter when their breathlessness is reduced. Even so, because increasing drowsiness also generally reflects the deteriorating clinical condition, it is important to stress the gravity of the situation and the aim of treatment to the relatives.