

Tips on Managing Dyspnea

- Dyspnea is the subjective experience of difficult or uncomfortable breathing.
- Frequency of dyspnea is high in patients with end stage COPD, CHF or cancer.
- Causes are often multi-factorial, involving complex interplay between the lungs and brain.
- ❖ Benzodiazepines ALONE are not recommended to treat dyspnea.
- 1. <u>Screen for dyspnea</u> regularly by asking patients with advanced disease, "How is your breathing?" and have them rate their dyspnea on a scale from 0-10 or complete an ESAS. Document your assessment for team communication and to establish a patient specific baseline/history. Self-reporting is the only reliable measure.
- 2. Confirm diagnosis by completing a full history using the symptom assessment acronym O-V and a physical assessment. Consider the patient's goals of care, PPS and disease burden. If congruent with patient goals-of-care, consider imaging, bronchoscopy, ultrasound, spirometry, bloodwork/ABG's, etc.
- 3. <u>Manage</u> by taking into account the **patient's goals of care** and **PPS** (Palliative Performance Status). Managemtn should involve doing **A, B and C simultaneously.**



A. Identify & treat underlying causes:

Anemia, CHF, tumour, emboli, effusions, infection, obstruction, COPD, hypoxia, etc.

B. Manage Symptoms

Non-pharmacological:

Breathing techniques, positioning, airflow/fan(s)

Pharmacological:

Opioids are recommended as a first line pharmacological treatment for dyspnea. Opioids should be ordered PO/SC around the clock with a break through dose. Titrate opioids to effect. *In frail, opioid naïve or patients with COPD, start with small doses and **TITRATE** slowly*. Consider **adding** an adjuvant if dyspnea severe / pre-existing anxiety disorder (Eg. nozinan, lorazepam, steroids etc).

C. <u>Educate and discuss</u> treatment benefits/burdens with the patient, family and caregivers. Clarify and discuss fears and misconceptions.

References:



