 FOR LAST DAYS OF LIFE—SEE PAGE 18

Assessment / Description

Causes of breathlessness can be multi-factorial: physical, psychological, social and spiritual factors can all contribute to a person feeling breathless. **Assessment is vital,** particularly in a new presentation. Undertake a history and clinical examination, including oxygen saturations. Investigations such as chest x-ray may be necessary and management will depend on clinical diagnosis. Treat what may be caused by an acute event where appropriate.

Treat reversible causes of breathlessness where appropriate and monitor response
PLUS
Start appropriate non-pharmacological interventions ***(blue box)***

↓

If breathlessness persists and causes distress consider appropriate pharmacological options ***(purple boxes)***

↓

If condition improves, reduce monitoring and evaluate treatment and stop interventions that are no longer needed

Non-Pharmacological options for managing breathlessness

- Calm Environment
- Acknowledgment and explanation
- Adequate positioning of the patient to aid breathing
- Use of fan or cool air across face
- Breathing exercises and relaxation training
- Acupuncture, aromatherapy and other holistic remedies may help

Pharmacological Options

Opioids: start modified release morphine, e.g. MST or Zomorph at 5mg BD, consider using 2.5mg Immediate Release morphine PRN if needed. Slower titration can be considered with regular IR morphine e.g. 1 - 2.5mg QDS (particularly if concerns about undesirable effects). If opioids help breathlessness, usually only a low dose is needed; usual maximum dose 30mg/24 hours.

If patient is unable to tolerate oral medication sub cutaneous morphine via CSCI is an option.
If eGFR <30 ml/min an alternative opioid should be considered and used with caution in this setting; seek specialist palliative care advice if necessary**.**

Oxygen: In a small number of patients oxygen can be helpful, specifically if people have demonstrable hypoxia and are symptomatic; benefits should be assessed over time

Considerable care should be taken in patients with known COPD/Type 2 respiratory failure—watching for CO_2 retention headache, flushed skin, fast pulse, hand flap, drowsiness, etc.

Corticosteroids: may help in patients with tumour compression or lymphangitis carcinomatosis.
No evidence of benefit in non specific dyspnoea.

Lymphangitis or Superior Vena Caval Obstruction (SVCO): treatment dose of dexamethasone in this setting is 16mg orally or parenterally in one or two divided doses. Please seek specialist advice.

Steroids should ideally be given before 2pm. See page 13 for further advice.

Nebulised medication: Sodium Chloride 0.9% may help as a mucolytic, 2.5 - 5 ml 4 hourly PRN
Consider a bronchodilator for bronchospasm e.g. salbutamol 2.5 mg 6 hourly PRN (may be used more frequently in some cases)

Benzodiazepine can be considered when opioids and non-pharmacological measures have failed to control breathlessness and the patient remains anxious/distressed:
Lorazepam 0.5 - 1mg SL/PO PRN 2-4 hrly (max dose 4mg/24hrs or 2mg/24hrs for frail/elderly). If patient unable to tolerate oral medication, consider subcutaneous midazolam 2.5 mg - 5 mg 4hrly prn.

If effective this can be incorporated into a continuous subcutaneous infusion (CSCI) over 24 hours.