Causes of breathlessness, secretions and noisy breathing.
Possible interventions

Sally Willis, Clinical Nurse Specialist
What is breathlessness?

- Frightening and debilitating experience
- Affects the individual’s ability to function
- Interaction between physical, psychosocial and emotional factors
- Unique to the individual

Jessica Corner et al 1999
Dyspnoea is defined as a “subjective experience of breathing discomfort that consists of qualitatively distinct sensations that vary in intensity”
OR

• “It is what the patient says it is.”
Prevalence

• Common symptom at end of life for patients with COPD, heart failure and cancer
• Up to 70% of patients with advanced cancer report dyspnoea in last few weeks of life. Often worse as death approaches.
Causes of breathlessness

Lung related
Not lung related
Assessment

- Understanding shortness of breath from the patient’s perspective is the foundation of effective management
- Medical history
- Symptoms
- Social circumstances
- Psychological
- Spiritual
breathlessness

- Distress
- Restricted mobility
- Low mood
- Anxiety
- Inability to perform ADL
- Restricted social functioning
- Inability to work
- Financial hardship
- Sleep disruption
- Fatigue
- Inability to perform ADL
- Fear of suffocation
- Disruption in relationships and sexual functioning
Management of breathlessness

- Reversible causes
- Pharmacological management
- Non-pharmacological management
Drug Management

- Opioids
- Benzodiazepines
- Steroids
- Nebulised medications
- Oxygen
Opioids

• If not on regular opioid, start with Oramorph 2.5mgs qds
• If already on regular opioid then can encourage using for breathlessness
• Can use smaller dose
Benzodiazepines

- Little evidence for the use in breathlessness but consider if panic attacks or high level of anxiety
- SL Lorazepam 0.5-1mg prn
- Diazepam 2-5mgs tds
- Midazolam sc 2.5mgs
Steroids

- Dexamethasone or Prednisolone
- Give before 14.00hrs
- Lowest dose that is effective, stop after a week if no benefit
Nebulised meds

• Normal saline 0.9%, for cough and expectoration
• Salbutamol 2.5-5mgs qds or Ipratropium Bromide 0.25-0.5mgs qds if bronchospasm
Oxygen

• Evidence for use in breathlessness for palliative patients is not very clear. Aim is to improve symptoms and quality of life. Use of oxygen can be restrictive and therefore impact on quality of life

• Caution with COPD patients
Non-pharmacological management

• Physical

• Psychological

• Social

• Spiritual
Physiotherapy
Aim of presentation

• Understand the role of physiotherapy in the breathless patient.
Objective

• Be able to refer a patient for physiotherapy where you feel appropriate.

and/or

• Use some of the techniques you learn today to help a breathless patient.
Treatment options

1. Positioning - is fundamental in achieving a reduction in breathlessness.

2. Breathing control - Initial attention to their breathing. Followed by a slow introduction into elements to enable them to regain control of their breathing.

Positioning

• Supported upright sitting/high side lying
• Relaxed upper chest/shoulders/arms
Breathing Control

• In through the nose out through the mouth.
• Expiration exceed inspiration.
• Abdomen rise on breathing in.
• Abdomen fall on breathing out.
Secretion Management

- ACBT - proven to be effective in the clearance of secretions.
- Suctioning.
Secretions

Excessive respiratory secretions are common at end of life.

Management

• Glycopyrronium 1.2-2.4mgs via syringe driver, 400mcgs stat doses.

• Hyoscine butylbromide 60-120mgs via syringe driver, stats 20mgs
• Hyoscine hydrobromide 1.2-2.4mgs via syringe driver, stats 400mcgs. But risk of confusion, sedation and agitation.
• Repositioning
• Suction
• Support for family
Final thought

You don’t need to be a qualified practitioner to make a difference – we all can, using simple techniques!
References:


Thank you