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SA Palliative Care

Community Pharmacy Update

A joint initiative of SA Palliative Care Services and Ambulatory & Primary Health

With some understanding of available strategies, pharmacists may contribute to supporting patients struggling with shortness of breath.

Dyspnoea

Dyspnoea is the unpleasant feeling where a person is aware of their breathing or their need to breathe. Commonly referred to as breathlessness or shortness of breath, it is a subjective symptom which does not correlate with objective markers such as hypoxia or respiratory rate.

Causes may be multi-factorial and include factors that are physical, psychological, social or spiritual in nature. Anxiety may play a significant role. It may begin abruptly or be associated with progressive disease such as Motor Neurone Disease.

Dyspnoea can be frightening and worrying for patients to experience and for carers to watch. People may link it with approaching death.

Symptomatic relief options

Reversible causes of dyspnoea, such as pneumonia, should be considered initially and treated if appropriate.

Assessment of the patient will distinguish if dyspnoea is precipitated or worsened by activity and if so, non-pharmacological strategies can be put into practice to control symptoms. These may include:

- Practising controlled breathing techniques;
- Employing relaxation therapies; and
- Using a small battery operated fan or sitting near an open window

Evidence for the use of oxygen is limited. There may be a benefit for trialling this on a case by case basis.

A pharmacological approach is often first line treatment for dyspnoea that seriously limits a person's activity or presents close to the end of life.

There is evidence for the use of low doses of either oral or parenteral opioids to relieve dyspnoea. Opioids reduce the sensation of dyspnoea without causing respiratory depression with morphine being the most commonly used.

For opioid-naïve patients, with acute intermittent dyspnoea, oral immediate release morphine solution is used at 1mg to 2.5mg per dose. It may be repeated as required every 30 minutes and reviewed after 3 doses.

Modified release opioids also have a place for people with longstanding dyspnoea.

Where dyspnoea presents in patients currently taking opioids for analgesia, the maintenance dose should be increased,

Benzodiazepines are frequently prescribed for management of panic attacks and anxiety associated with dyspnoea, but evidence of their ability to relieve dyspnoea is limited.

Useful resources

- Therapeutic Guidelines for Palliative Care V3 2010
- Seidel R, Sanderson C, Mitchell G, Currow DC. Until the Chemist Opens. Palliation from the Doctor's Bag. Aust Fam Phys 35;4: 225-231

For more information

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