Palliative Care and Dyspnea

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Dyspnea is a frequent focus of palliative care, which nurses can better address using the skills of comprehensive assessment and an updated knowledge base about appropriate medical, pharmaceutical, and nonpharmaceutical interventions. A solid clinical foundation about dyspnea allows clinicians to establish an effective plan of care. This column features two clinical case studies, which review clinical assessment in palliative care and appropriate targeted treatment strategies and interventions.

**Assessment**

With multiple risk factors associated with dyspnea, a thorough assessment identifying its causes leads to appropriate and effective treatment options. Figure 1 lists objective and subjective areas of assessment.

Dyspnea occurrence should begin by asking the patient if he or she is short of breath. At the end of life, patients’ cognitive function often declines, leaving them unable to respond to yes or no questions. One assessment tool to use with unresponsive or cognitively impaired patients is the Respiratory Distress Observation Scale (RDOS). The RDOS is an ordinal scale that uses eight parameters, allowing the clinician to rate dyspnea based on its own observations of the patient (Campbell323325Templin, Walch, 2010).

Assessments can suggest the cause of the dyspnea. For example, if the patient has a long-standing COPD history, he or she may show signs of clubbing on finger tips. If a pleural effusion is present, lung sounds may be absent or diminished (Joyce, 2010).

**Treatment**

Guidelines for palliative care recommend that initial treatment for dyspnea should target the underlying cause—cancer or noncancer related (National Comprehensive Cancer Network [NCCN], 2013). Then, relief of symptoms can proceed. With a confirmed effusion, the treatment of choice usually is fluid removal. If accumulated fluid is a pleural effusion, thoracentesis is ordered (see Figure 2).

During thoracentesis, a needle is inserted into the effusion area and fluid is drawn out. Pathology review of the fluid determines the cause of the fluid collection. If the evaluated fluid is related to malignancy, the effusion will likely return. If a patient is having multiple procedures to drain the effusion, the physician may order placement of an indwelling catheter to manage the malignant effusion.

A hypoxic patient is treated with oxygen therapy. When patients are anxious, benzodiazepines are a treatment option (NCCN, 2013). If inflammation is present, corticosteroids may be ordered (Klein et al., 2011). The inflammation could be related to a malignancy, allergies, or noncancerous pulmonary conditions.

At the end of life, excess secretions can be present, often referred to as the “death rattle.” Scopolamine, atropine 1% sublingual drops, and glycopyrrolate all have been shown to be effective treatments (NCCN, 2013). With known or unknown etiology for dyspnea, opioids can decrease symptoms. For cases of confirmed effusion when the patient is waiting for thoracentesis, opioid treatment can help...