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Relief of Dyspnea

Refractory Dyspnea

Manage underlying causes of dyspnea

Is the patient hypoxic?

Yes → Manage underlying causes of hypoxia → Supplemental O2 → Still dyspneic? → No / Yes

No → Non-pharm Interventions → Is patient comfort care or actively dying? → No / Yes

- Opioid PO q2h PRN dyspnea
- Opioid IV q1h PRN dyspnea
- Titrate to relief
- Avoid benzos

- Opioid IV q15 min PRN dyspnea
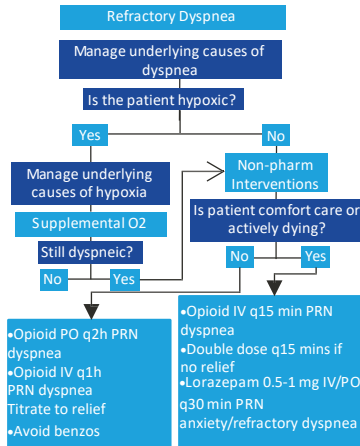- Double dose q15 mins if no relief
- Lorazepam 0.5-1 mg IV/PO q30 min PRN anxiety/refractory dyspnea

Non-Pharmacologic Interventions:
- Bring patient upright or to sitting position
- Consider mindfulness, mindful breathing

Pharmacologic Interventions:
- Opioids are treatment of choice for refractory dyspnea
- For symptomatic patients, using PRN or bolus dosing titrated to relief is more effective and safe compared to starting an opioid infusion

Dosing Tips:
- For opioid naïve patients
  - PO Morphine 5-10 mg
  - PO Oxycodone 2.5-5 mg
  - IV/SC Morphine 2-4 mg
  - IV/SC Hydromorphone 0.4-0.6 mg
- Consider smaller doses for elderly/frail

Opioid Quick Tips

Pharmacodynamics of Opioids:
- **Time to peak effect / Duration of Action**
- **PO Opioids: 30-60 minutes / 3-4 hours**
- **IV Opioids: 5-15 minutes / 3-4 hours**
- Time to peak effect is the same for analgesia, relief of dyspnea, and sedation

Other Opioid Principles:
- **If initial dose of IV opioid is ineffective** after 2 doses at least 15 minutes apart, double the dose
- Typically **need 6-8 hours of controlled symptoms to calculate a continuous opioid infusion**
- **If starting a continuous infusion**, do not change more often than every 6 hours. Adjust infusion dose based on the 24 hour sum of PRNs

Relative Strengths & Conversion

Opioid Agent	Oral Dose	IV Dose
Morphine	30	10
Oxycodone	20	--
Hydromorphone	7.5	1.5

*Avoid fentanyl due to shortage

If Using Opioids, Start a Bowel Regimen:
- Goal is 1 BM QD or QOD, no straining
- Senna 2 tabs q HS, can increase to 4 tabs BID
- Add Miralax 17 gm daily, can increase to BID
- Bisacodyl 10 mg suppository if no BM in 72 hrs

Communication Skills

What They Say	What You Say
How bad is this?	From the information I have now, your loved one's situation is serious enough that your loved one should be in the hospital. **We will know more over the next day,** and we will update you.
Is my mother going to make it?	**I imagine you are scared.** Here's what I can say: because she is 70, and is already dealing with other medical problems **it is quite possible that she will not make it out of the hospital. Honestly, it is too soon to say for certain.**
Shouldn't she be in an intensive care unit?	You/your loved one's situation does not meet criteria for the ICU right now. We are supporting her with treatments (oxygen) to relieve her shortness of breath and we are closely monitoring her condition. **We will provide all the available treatment we have that will help her and we'll keep in touch with you by phone.**
What happens if she gets sicker?	If she gets sicker, we will continue to do our best to support her with oxygen and medicines for her breathing. If she gets worse despite those best treatments, she will be evaluating for her likelihood of benefiting from treatment with a ventilator. I can see that you really care about her.
How can you just take her off a ventilator when her life depends on it?	Unfortunately her condition has gotten worse, even though we are doing everything. She is dying now and the ventilator is not helping her to improve as we had hoped. This means that we need to take her off the ventilator to make sure she has a peaceful death and does not suffer. I wish things were different.

Resuscitation Status COVID-19	Example Language
Approach to when your clinical judgment is that a patient would not benefit from resuscitation	Given your overall condition, **I worry that if your heart or lungs stopped working, a breathing machine or CPR won't be able to help you live longer or improve your quality of life**. My recommendation is that if we get to that point, we use medications to focus on your comfort and allow you to die peacefully. This means we would not have you go to the ICU, be on a breathing machine, or use CPR. I imagine this may be hard to hear.
If in agreement:	These are really hard conversations. **I think this plan makes the most sense for you.**
If not in agreement:	These are really hard conversations. **We may need to talk about this again.**

When/How to Call for Help

[Insert Palliative Care Contact Info Here]

We are here to help. We've got your back.

In addition to typical circumstances and consults, please consult us if:
- Patient in respiratory distress and not getting comfortable with initial efforts

Additional Resources

www.capc.org/toolkits/covid-19-response-resources/

Download these apps (Google Play or App Store) for more palliative care resources:

VitalTalk Tips (Communication)   Fast Facts (Symptom Management)

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