Palliative nursing interventions for dyspnea

● Decrease anxiety
  --Administer prescribed anxiolytic medications as indicated for anxiety or panic associated with dyspnea.
  --Assist with relaxation techniques, guided imagery.
  --Give patient a way to call for help (call bell/light within reach in a hospital or long-term care facility; hand-held bell or other device in home).

● Treat underlying pathology
  --Administer prescribed bronchodilators and corticosteroids (obstructive pathology)
  --Administer blood products, erythropoietin as prescribed (typically not beneficial in advanced disease)
  --Administer prescribed diuretics and monitor fluid balance

● Alter perception of breathlessness
  --Administer prescribed oxygen therapy via nasal cannula, if tolerated; masks may not be well tolerated.
  --Administer prescribed opioids via oral route (morphine sulfate is used most commonly)
  --Provide air movement in the patient’s environment with a portable fan.

● Reduce respiratory demand
  --Teach patient and family to implement energy conservation measures.
  --Place needed equipment, supplies, and nourishment within reach.
  --For home or hospice care, offer bedside commode, electric bed (with head that elevates)

Prepare for home

Dyspnea may be exacerbated by anxiety, which may trigger episodes of dyspnea, setting off a respiratory crisis in which the patient and his family may panic. For patients getting care at home, patient and family instructions should include anticipation and management of crisis situations. Patients and families should be instructed about medication administration, condition changes that should be reported to the healthcare provider and nurse, and strategies for coping with increased symptoms as the disease progresses. The patient and family need reassurance that the symptom can be effectively managed at home with the need for activation of the emergency medical services or hospitalization and that a nurse will be available at all times via telephone or to conduct a visit.

Dyspnea is an uncomfortable awareness of breathing that’s common in patients approaching the end of life. It’s a highly subjective symptom that often isn’t associated with visible signs of distress, such as tachypnea, diaphoresis, or cyanosis. Patients with primary lung tumors, lung metastases, pleural effusion, and restrictive lung disease may experience significant dyspnea. Although the underlying cause of the dyspnea can be identified and treated in some cases, the burden of additional diagnostic evaluation and treatment aimed at the physiological problem may outweigh the benefits. The treatment of dyspnea varies depending on the patient’s general physical condition and imminence of death.

Source: Brunner & Suddarth’s Textbook of Medical-Surgical Nursing, 10th edition, S. Smeltzer and B. Bare, Lippincott Williams & Wilkins, 2003.
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Assessment
As is true in pain assessment and management, the patient’s report of dyspnea must be believed. Also like the experience of physical pain, the meaning of the dyspnea to the patient may increase his suffering. For example, he may interpret increasing dyspnea as a sign that death is approaching. For some patients, sensation of breathlessness may invoke frightening images of drowning or suffocation, and the resulting cycle of fear and anxiety may create even greater sensation of breathlessness. Physical assessment parameters include:
- symptom intensity, distress, and interference with activities (scale of 0 to 10)
- auscultation of lung sounds
- assessment of fluid balance
- measurement of dependent edema (circumference of lower extremities)
- measurement of abdominal girth
- temperature
- skin color
- sputum quantity and character
- cough

To determine the intensity of the symptom and its interference with daily activities, ask patients to self-report using a scale of 0 to 10, where 0 is not dyspnea and 10 is the worst imaginable dyspnea. Measurement of the patient’s baseline before treatment and subsequent measures during exacerbation of their symptom periodically during treatment and whenever the treatment plan changes will provide ongoing objective evidence for the efficacy of the treatment plan. Physical assessment findings may help you locate the cause of the dyspnea and select nursing interventions to relieve the symptom. Like other symptoms at the end of life, dyspnea can be managed effectively in the absence of assessment and diagnostic data that are standard when the patient’s illness or symptom is reversible.

Nursing management
Nursing management of dyspnea at the end of life is directed toward administering medical treatment for the underlying pathology, monitoring the patient’s response to treatment, helping the patient and family manage anxiety (which exacerbates dyspnea), alternating the perception of the symptom, and conserving energy. Pharmacologic intervention is aimed at modifying lung physiology and improving performance as well as altering the perception of the symptom. Low doses of opioids are very effective in relieving dyspnea, although the mechanism of relief isn’t entirely clear. Although dyspnea in terminal illness is typically not associated with diminished blood oxygen saturation, low-flow oxygen often provides psychological comfort to the patient and his family, particularly in the home setting.