



GeriCare Dyspnoea: Assessment and Management

What is dyspnoea?

Dyspnoea, also known as breathlessness, is a subjective sensation of an uncomfortable awareness of breathing. It is a frequent symptom, occurring in 50-70% of dying patients.

What can cause dyspnoea? Dyspnoea can result from physical illnesses e.g. pneumonia, chronic obstructive pulmonary disease (COPD), and organ failures. It can also be caused by psychological issues e.g. anxiety, fear, and depression.

It is important to know how dyspnoea can affect the patient's physical, psychological and social wellbeing. Dyspnoea can affect the patient's mobility and ability to perform their activities of daily living, also known as ADL. For e.g. patients may need to take more breaks in between while walking. Dyspnoea can also cause anxiety and depression and can result in social isolation.

You may ask, how can we assess dyspnoea then? Well, getting patients to self-report is the best way to assess dyspnoea as it is a subjective symptom. There are several scales available to rate the severity of dyspnoea. Don't worry! For today, we will only talk about one of the easiest scales which is the numerical rating scale. Remember not too long ago in symptoms and problems assessment tool, where we had to climb Bukit Timah hill...Patient rates dyspnoea from a scale of 0 (no breathlessness) to 10 (worst breathlessness).

However, if patient is unable to communicate the severity of his/her dyspnoea, we can use the Respiratory Distress Observation Scale (RDOS).

RDOS comprises of the following components:

- Heart rate per minute (HR/min)
- Respiratory rate per minute (RR/min)
- Restlessness, where patient moves around non-purposefully.
- Abnormal breathing patterns such as the patient's abdomen moves in when breathing in
- Use of accessory muscles
- Grunting when patient breathes out
- Nasal flaring where patient's nostrils are widened during breathing
- Look of fear such as eyes wide open, facial muscles tense, etc.

Now, let's look at how we can manage patients with dyspnoea. There are non-pharmacological and pharmacological measures to manage dyspnoea.

Some of the non-pharmacological measures are:

- Modifying activity to help patients conserve energy such as sitting on a commode while showering instead of standing up.
- Modifying environment for patients such as sitting them upright and supported by nice fluffy pillows or providing fan to relieve their breathlessness. Put patient's belongings close to them so that it is within reach, just like how you want your TV remote to be beside you while you are channel surfing right? Providing oxygen when necessary.
- Providing touch and comfort.



Moving on to the pharmacological measures, there are 2 main treatment goals:

- 1) To look for reversible causes and **treat** the underlying conditions, for example providing antibiotics for lung infections.
- 2) To **relieve** the dyspnoea by using opioids such as morphine and fentanyl and/or benzodiazepines.

In conclusion, dyspnoea is a common symptom in palliative care. Timely assessment and appropriate management of dyspnoea helps our patients achieve the best possible quality of life.

References

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