PALLIATION OF BREATHLESSNESS IN NON-CANCER CONDITIONS

GUIDELINES TO ACCOMPANY THE FLOWCHART

Introduction and Background

From work and discussion through the Joint Palliative Care Group and the Respiratory LIT Group it was evident that clinicians felt there was a gap in guidance in how to help non-cancer patients with breathlessness symptoms. The Breathlessness Pathway has been developed by members from Primary and Secondary Care to assist clinicians in their management of these patients.

The Breathlessness task group decided the pathway should be limited to Non-Cancer patients because:

- Acute high dose intervention is not usually needed for patients with non-malignant breathlessness since they tend to be opiate naïve.
- There is a risk that a cancer patient would not be treated quickly and aggressively enough if we try to keep them on the same pathway
- Opioid titration for malignant use is more complex therefore separating them allows for a simple titration process.

The following guidelines provide explanations/clarification where necessary:

Identification Triggers

The Identification triggers are self-evident. For MRC and NYHA Classification Tables see Appendix 1.

The Pathway should be implemented when the optimum treatment is failing - refer to the GSF Prognostic Indicator Guidance: http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf

Reversible Causes

As the flow chart indicates please assess the patient for reversible causes and treat as appropriate:

- Pulmonary oedema,
- Bronchospasm,
- Anaemia,
- Pleural effusion,
- Venous thromboembolism,
- Arrhythmia,
- Pneumothorax,
- Infection,
- Pulmonary embolism,
- Cardiac failure,
- Treatable cancer

First Line

Optimise medical treatment including reviewing patient's inhaler technique; Consider use of bronchodilators via Metered Dose Inhaler and a spacer and using tidal breathing technique. When choosing a delivery system for inhaled medications, consider:

- The ability of the person to develop and maintain an effective technique with the specific device
- When used alone, a standard pressurized metered-dose inhaler is rarely appropriate for elderly people, as many have poor inhaler technique. The addition of a large-volume spacer improves both acquisition and retention of drug and allows carers to assist those people with cognitive impairment or physical disabilities affecting hand function.
- The suitability of the device to the person's (and carer's) lifestyle, considering such factors as portability and convenience.
- The person's preference for, and willingness to use, a particular device.
- The medication (and dose) being prescribed.
- A spacer should be used by people on high-dose inhaled corticosteroids.
- A mouthpiece, rather than a mask, should be used with a nebulizer if possible.
- Cost — choose the device with the lowest overall cost (taking into account the daily required dose and product price per dose).

Good technique is essential in ensuring optimum use of inhaler devices. Only prescribe the inhaler after the person (or their carer) has received training in its use and has demonstrated an acceptable technique.

Repeated checks are essential, as poor technique, even after training, is common.

Some frail people cannot consistently achieve the minimum inspiratory flow rate required for use of dry-powder devices or breath-actuated metered-dose inhalers.

The impact of exacerbations should be minimised by starting appropriate treatment with oral steroids and/or antibiotics. Antibiotics should be reserved until signs of infection are present.

Diuretics should be considered where appropriate in patients with Heart failure.

Resources:
http://cks.nice.org.uk/chronic-obstructive-pulmonary-disease#!prescribinginfo
NICE COPD CG101 http://guidance.nice.org.uk/CG101/Guidance/pdf/English
NICE Heart Failure CG 108 http://www.nice.org.uk/guidance/CG108

Factors guiding the choice of a delivery system are based on published expert opinion [MeReC, 2002; Dolovich et al, 2005] and a guideline produced by the Scottish Intercollegiate Guidelines Network and British Thoracic Society [SIGN and BTS, 2008].
BTS/SIGN 2008

Oxygen:
Consider oxygen for patients who are hypoxic. Otherwise there is little evidence supporting use of oxygen for breathlessness and a fan may be equally effective.

Resources:
Cambridge BIS Manual, Section 1 Chapter 5 "Pharmacological Treatment – Oxygen" pg 34

Non-Pharmacological Management

Non-pharmacological management and education are essential to assist patients to develop coping strategies in managing this symptom. Education for patients and relatives about their condition and why it causes breathlessness is essential. Clinicians need to be mindful of assessing for anxiety/depressive symptoms to which there is a high prevalence in this group of patients. Practical measures including fan therapy, breathing control exercises and

relaxation techniques can be of benefit. There is an accompanying leaflet developed by the Breathlessness task group that clinicians can give to patients to explain these strategies.

Some patients may benefit from psychological interventions including IAPT/psychologist referral.

Non-pharmacological interventions should be robustly explored before looking at medicine management.

Resources:
http://www.cuh.org.uk/cms/addenbrookes-hospital/services/breathlessness-intervention-service-bis/resources/patient-information-leaflets

http://www.macmillan.org.uk/Cancerinformation/Endoflife/Thelastfewweeks.aspx

Pharmacological Management

MDT Approach
Using a multi-disciplinary approach is essential to ensure that all parties are aware of changes/titration of medication, if appropriate. The patient should be given a 'patient held titration chart' to provide information about the patient's medication/titration regime. The aim of this is to assist the clinicians that may be involved in their care. The patient should be encouraged to take this document to any consultation related to their breathing.

Medicine Review
The aim of the Medicine Review is to instigate a conversation between the GP and patient about which medicines are no longer relevant at this palliative stage. Nurses involved with deteriorating patients (<12 m life expectancy) need to trigger a request for a GP Medicine Review. Currently patients continue on unnecessary medication and often in expensive liquid form.

Advance Care Planning
Advance Care Planning is a voluntary process, which is reversible and NOT legally binding, empowering a person to make decisions and highlight their wishes about their future health care in consultation with their health care providers, family members and other important people in their lives. It can provide patients, together with their family and carers (if the patient chooses), with an opportunity to consider and articulate their **wishes, preferences** and **priorities** for care should they lose the capacity to do so in the future.

An advance care plan can help plan for the future, it is a dynamic process not a one off event. It can help ensure that an individual's choices are respected for future medical treatment. Whilst preferences can be expressed, it **cannot demand** treatments / interventions.

The process promotes open discussion between health and social care staff, patients and their families or carers about whether patients' wishes are achievable. It enables proactive planning to ensure patients' goals are realistic, taking into consideration the resources available. An advance care plan has been found to reduce the level of stress, anxiety and depression that family members experience during bereavement

It is the patient's document, ideally written down and shared with HCPs

Opioids

When prescribing opiates for breathlessness please follow the suggested guide: the Opioid Titration Chart (taken from the Cambridge BIS Manual).
Please see the Cambridge BIS Manual Section 1 Chapter 5 “Pharmacological Treatment” for full rationale. This titration chart is also available on patient held chart.

Prescribing opiates for breathlessness is an off license use of the drug.

When prescribing opiates, it is best practice to warn patients of potential side effects and to also prescribe a regular laxative and prn anti emetic (***NICE guideline: Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults***- **CG 140**). The choice of laxative and anti emetic should be tailored to the patient.

It should be noted that morphine accumulates in patients with renal impairment. Patients displaying signs of opiate toxicity (hallucinations, agitation, drowsiness, twitching) or an **eGFR < 15** should be discussed with Specialist Palliative Care.

Resources:
Nice Guidance CG140
http://publications.nice.org.uk/opioids-in-palliative-care-safe-and-effective-prescribing-of-strong-opioids-for-pain-in-palliative-cg140

www.palliativedrugs.com
Palliative Care Formulary useful for drug conversions (subscription charge)

Benzodiazepines

There is less evidence for the use of benzodiazepines in breathlessness and clinicians need to be aware that in patients with breathlessness symptoms in non-cancer diagnoses often live for months and years and therefore the risk of dependency is high. Non-pharmacological approaches of reducing or minimising the impact of anxiety are preferred. Low dose Lorazepam may be an appropriate choice if opiates have not been effective.

Patients with long term chronic conditions should be assessed for depression; treatment options including IAPT, non-pharmacological approaches and antidepressants may be considered.

Glossary of terms

Abbreviation	
MRC	Medical Research Council
NYHA	New York Heart Association
NICE	National Institute of Clinical Excellence
LIT	Local implementation team
Cambridge BIS	Cambridge Breathlessness Intervention Service

APPENDIX 1

MRC (Medical Research Council) dyspnoea scale

Grade	Degree of breathlessness related to activities
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying or walking up a slight hill
3	Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4	Stops for breath after walking about 100m or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing or undressing

NYHA (New York Heart Association) Classification

Class	Patient Symptoms
Class **I** (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnoea (shortness of breath).
Class **II** (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnoea.
Class **III** (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnoea.
Class **IV** (Severe)	Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased