

Dyspnea and Delirium at the End of Life

Barton Bobb, MSN, FNP-BC, ACHPN

Dyspnea and delirium are potentially distressing symptoms for patients with cancer at the end of life. They require aggressive management and sometimes even palliative sedation for refractory cases in actively dying patients. This article provides oncology nurses with evidence-based advice on the management of these symptoms.

At a Glance

- Dyspnea and delirium are two common symptoms in patients with cancer at the end of life.
- Systemic opioids are the primary pharmacologic treatment for the symptomatic treatment of dyspnea.
- Haloperidol (Haldol®) and chlorpromazine (Thorazine®) are the most commonly used pharmacologic treatments for delirium. Benzodiazepines are used as palliative sedation for refractory delirium in dying patients.

Barton Bobb, MSN, FNP-BC, ACHPN, is a palliative care nurse practitioner in the Thomas Palliative Care Unit at the Virginia Commonwealth University Massey Cancer Center in Richmond. The author takes full responsibility for the content of the article. The author did not receive honoraria for this work. No financial relationships relevant to the content of this article have been disclosed by the author or editorial staff. Mention of specific products and opinions related to those products do not indicate or imply endorsement by the *Clinical Journal of Oncology Nursing* or the Oncology Nursing Society. Bobb can be reached at barton.bobb@vcuhealth.org, with copy to editor at CJONEditor@ons.org.

Key words: dyspnea; delirium; end-of-life care

Digital Object Identifier: 10.1188/16.CJON.244-246

This article focuses on the symptoms of dyspnea and delirium, which can be extremely distressing to patients with cancer at the end of life. Oncology nurses are well suited to detect and treat these symptoms.

Dyspnea

Dyspnea, which is shortness of breath or the sensation of breathlessness, is one of the most difficult symptoms to treat for patients at the end of life. Earlier in the disease course, efforts usually focus on trying to treat or eliminate the underlying cause of the patient's dyspnea (e.g., drainage of a pleural effusion,

chemotherapy or radiation therapy to try to shrink lung cancer or metastases). However, at the end of life, the focus is usually on symptomatic treatment because the potential burdens outweigh the benefits of pursuing additional diagnosis and aggressive treatments for any underlying etiology causing the patient's dyspnea.

Systemic opioids are one of the long-time, primary options for symptomatic pharmacologic management of dyspnea, but few research studies corroborate their efficacy in patients with cancer. In 2008, several systematic reviews substantiated that opioids help control dyspnea in patients with cancer

(Ben-Aharon, Gaftor-Gvili, Leibovici, & Stemmer, 2008; Booth, Moosavi, & Higginson, 2008; Viola et al., 2008). A more recent systematic review and meta-analysis by Ben-Aharon, Gaftor-Gvili, Leibovici, and Stemmer (2012) concluded that opioids are the only evidence-based pharmacologic symptomatic treatment option for cancer-related dyspnea. A study by Gomutbutra, O'Riordan, and Pantilat (2013), which mostly included patients with cancer, indicated that a combination of benzodiazepines and opioids may be beneficial for the treatment of dyspnea, but benzodiazepines have not been found to have clear and convincing evidence of their efficacy in treating dyspnea in patients with cancer.

However, benzodiazepines can be used to treat intractable dyspnea refractory to all other treatments at the end of life in the form of palliative sedation (Mercadante et al., 2011). Other agents, such as chlorpromazine (Thorazine®) or haloperidol (Haldol®), have also been used to initiate palliative sedation in patients with cancer experiencing dyspnea (Caraceni et al., 2012). Palliative sedation should not be initiated unless dyspnea is truly refractory to other treatments and only with the patient's and family's consent prior to initiation at the end of life.

A fan blowing air across the face is a nonpharmacologic intervention that has been shown to have some efficacy in a randomized, controlled, crossover trial (Galbraith, Fagan, Perkins, Lynch, & Booth, 2010). Oxygen therapy does not appear to have good evidence for its use at the end of life (Abernethy et al., 2010; Campbell, Yarandi, & Dove-Medows, 2013; Choosing Wisely®, 2015).