SYMPTOM CONTROL , PALLIATIVE CARE & REFERRAL GUIDELINES FOR PATIENTS WITH ADVANCED CHRONIC RESPIRATORY DISEASE
Quick Reference Guide

Patients with advanced respiratory disease experience health-related quality of life similar to, or worse than that of patients with advanced lung cancer.

Symptoms commonly experienced include pain, nausea, constipation, depression and low mood as well as breathlessness and anxiety.

Holistic assessment of patients' needs is vital, addressing social and spiritual needs as well as screening for and treating physical and psychological symptoms.

Prognosis is difficult to predict, so ***advance care planning should commence early***. The following factors indicate a patient with COPD may be in the last year of life (consider suitability for listing on the GP palliative care register):

- FEV1 <30% predicted
- Recurrent hospital admissions (at least 3 in last 12 months due to COPD)
- Long-term oxygen therapy
- MRC grade 4/5 (dyspnoea after 100 metres on the level, or housebound)
- Signs of right heart failure
- Other factors e.g. anorexia, previous ITU/NIV, resistant organisms
- More than 6 weeks of systemic steroids for COPD in preceding 6 months.

For patients with interstitial lung disease, idiopathic pulmonary fibrosis (IPF) confers a worse prognosis than other subtypes (median survival three years).

Palliative Management of Breathlessness

Rule out reversible causes and optimise standard therapy.
Consider non-drug techniques (e.g. handheld fan, breathing techniques, relaxation techniques)

Opioid naïve patient

- Commence immediate release oral morphine 2.5mg q.d.s. and 2.5mg prn (max q.d.s.)
- Titrate regular opioid dose weekly according to response, initially to 5mg oral morphine q.d.s, and then 7.5mg oral morphine q.d.s if beneficial and tolerated.
- The maximum dose of oral morphine that is likely to be helpful for dyspnoea is 30mg/24 hour period (in divided doses).
- Once established a stable dose of immediate release oral morphine, conversion to long-acting morphine could be considered for ease of administration.
- For patients with significant renal impairment (eGFR < 30ml/min), an alternative opioid e.g. oxycodone should be used – seek specialist advice.

When used in this way, opioids have been shown to be safe and effective, including in patients with type 2 respiratory failure [*Ekstrom MP et al, BMJ 2014*].

Consider p.r.n. benzodiazepines (e.g. lorazepam 0.5 – 1mg sublingually 4 hourly p.r.n. (max 4mg/24h) for episodes of panic associated with breathlessness despite the measures listed above.

Specialist palliative care referral should be considered for patients with uncontrolled physical, psychological, social or spiritual care needs despite initial measures.

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