Dyspnea: Recognizing and Managing an Invisible Problem

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Case Study 1

B.H. is a 67-year-old woman who was diagnosed 15 years ago with breast cancer that was treated with a modified right mastectomy. About a year ago, she was diagnosed with non-small cell lung cancer. Despite chemotherapy, she had a progressive tumor in her right lung, bilateral pleural effusions, two darkened areas in her right axilla that appeared to be tumors, a large protruding epigastic mass, and moderate hepatomegaly. She was admitted because of uncontrolled pain. Upon admission, she was sitting up in her chair and receiving oxygen, 3 liters per nasal cannula. Three months ago, she noticed shortness of breath that began with activities not previously associated with this sensation. She eventually needed supplemental oxygen but could drive as long as she took her portable oxygen with her; she hated it but was willing to “pay the price of looking sick” to go out with her friends. As her dyspnea and pain worsened, B.H. became more depressed and isolated. She no longer called her three good friends and would not take their phone calls. Now B.H. can walk only from her chair to the bathroom because of shortness of breath. When asked about her hopes, B.H. said she would like to be “in a more comfortable place.” Her fear was that she would die gasping and in pain. She had not responded to third-line chemotherapy, and no further regimens were expected to be beneficial in terms of extending her life or palliating her symptoms. She was not ready to talk about hospice care, but her palliative treatment plan included radiation to her painful tumor masses (i.e., right axilla, liver, and epigastic mass).

Dyspnea, from the Greek words for hard and breathing, is a frequent symptom among seriously ill patients that increases symptom burden and alters quality of life (Desbiens, Mueller-Rizner, Connors, Wenger, & Lynn, 1999). Despite its frequent occurrence, little research exists to support evidence-based care for dyspneic patients with cancer who frequently are underdiagnosed and inadequately managed (Farncombe, 1997). Patients with lung cancer are at greatest risk to develop breathlessness, followed by those with breast, colorectal, or prostate cancer (Desbiens et al.; Escalante et al., 1996; Reuben & Mor, 1986). However, virtually any patient who has a solid or hematologic malignancy