Dyspnea: Recognizing and Managing an Invisible Problem

Rita Wickham, PhD, RN, AOCN®, CHPN
2002 Oncology Nursing Society/Schering Oncology/Biotech Clinical Lectureship

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 epigastric 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 epigastric mass).

Case Study 2

After experiencing progressive dysphagia, R.A., a 45-year-old man, was diagnosed with esophageal carcinoma. His initial treatment was an esophagectomy, and he began chemotherapy three weeks later. The chemotherapy was interrupted after two cycles for radiation therapy to the tumor bed. Chemotherapy and radiation therapy were complicated by nausea and vomiting, and his jejunostomy tube, which had been placed for enteral feedings, fell out. After the fourth radiation treatment, he suddenly developed severe shortness of breath and pleuritic chest pain. He became extremely anxious and felt as if he were going to die. Oxygen was started at 2 liters per nasal cannula, and a portable chest radiograph was done. He had no redness, tenderness, or swelling, and he had a negative Homan’s sign in both of his calves.

Case Study 3

A.T., a 72-year-old man, was diagnosed with prostate cancer seven years ago. He suffered a massive cerebral vascular accident six months ago that resulted in left-sided paralysis and expressive aphasia. His cancer is stable, but he has developed pneumonia several times in the past few months. He again has pneumonia, which now is antibiotic-resistant. A.T. is minimally responsive, his respiratory rate is 36 breaths per minute, he has coarse crackles throughout both lung fields, and he has easily audible rattling respirations. He continues on enteral feedings through a jejunostomy tube and is receiving IV fluids (1,000 cc every 12 hours).

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

Rita Wickham, PhD, RN, AOCN®, CHPN, is a clinical nurse specialist with the Palliative Care Service at Rush-Presbyterian-St. Luke’s Medical Center and an associate professor in Rush College of Nursing, both in Chicago, IL. As the recipient of the 2002 Oncology Nursing Society (ONS)/Schering Oncology/Biotech Clinical Lectureship, Wickham presented this paper at the 2002 ONS Congress in Washington, DC. (Mention of specific products and opinions related to those products do not imply endorsement by the Oncology Nursing Forum or ONS.)

Digital Object Identifier: 10.1188/02.ONF.925-933

925