



B.C. INTER-PROFESSIONAL PALLIATIVE SYMPTOM MANAGEMENT GUIDELINES

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DYSPNEA

DEFINITION

Dyspnea is the uncomfortable feeling of being short of breath. It may or may not be associated with hypoxia.

PREVALENCE

Prevalence is high in palliative patients, e.g., in cancer (10-70%), COPD (90-95%), and CHF (60-88%).¹ Intensity tends to worsen towards end of life.²

IMPACT

Results in multidimensional distress to patients and caregivers.³ Quality of life and daily functions can be profoundly negatively impacted. Psychological effects include: anxiety, panic, hopelessness, loss of enjoyment of life, and social isolation.^{1,4} Survival may be shortened in dyspnea patients, averaging as little as 30 days.⁵

STANDARD OF CARE

Step 1 | Goals of care conversation

Determine goals of care in conversation with the patient, family and inter-disciplinary team. Refer to additional resources ([Additional resources for management of dyspnea](#)) for tools to guide conversations and required documentation. Goals of care may change over time and need to be reconsidered at times of transition, e.g., disease progression or transfer to another care setting.

Step 2 | Assessment

Dyspnea Assessment: Using Mnemonic O, P, Q, R, S, T, U and V⁴⁷

Mnemonic Letter	Assessment Questions <i>Whenever possible, ask the patient directly. Involve family as appropriate and desired by the patient.</i>
O nset	When did it begin? How long does it last? How often does it occur?
P rovoking /Palliating	What brings it on? What makes it better? What makes it worse?
Q uality	What does it feel like? Can you describe it? Is it worse lying down or sitting?
R egion/Radiation	Not applicable.
S everity	How severe is this symptom? What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)? Right now? At worst? On average? When you are walking? Or climbing stairs? Or doing activities of daily living? ¹ How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom (e.g., pain in your chest, anxiety, fatigue)?
T reatment	What medications and treatments are you currently using? Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? How effective are these? Do you have any side effects from the medications and treatments? What have you tried in the past? Do you have concerns about side effects or cost of treatments?
U nderstanding	What do you believe is causing this symptom? How is it affecting you and/or your family? What is most concerning to you?
V alues	What overall goals do we need to keep in mind as we manage this symptom? What is your acceptable level for this symptom (0-10)? Are there any beliefs, views or feelings about this symptom that are important to you and your family? What are you having trouble doing because of this symptom that you would like to do?

Symptom Assessment: Physical assessment as appropriate for symptom

Diagnostics: consider goals of care before ordering diagnostic testing

- If indicated, complete: blood count, electrolytes, renal function, oxygen saturation by oximetry, and chest x-ray.
- The choice of appropriate diagnostic tests should be guided by the stage of disease, the prognosis, the balance of the benefits and burdens, treatment goals, and patient preferences. Tests are exhausting for people in a palliative care setting and may be of limited usefulness.^{1, 2, 6, 7} Specialized investigations may be less readily available depending on setting, the choice of which should also be made in light of these same factors.^{6, 8}

Step 3 | Determine possible causes and reverse as possible if in keeping with goals of care

Pulmonary: Airway obstruction, COPD/asthma, damage from chemotherapy, radiation or surgery, emboli, fibrosis, effusion, primary or metastatic tumour.

Cardiac: CHF, CAD, arrhythmias, pericardial effusion.

Neuromuscular: ALS, CVA, poliomyelitis, myasthenia gravis.

Other: Anxiety, fatigue/deconditioning, weakness, pain, severe anemia, infection, carcinomatosis, hepatomegaly, phrenic nerve lesion, peritoneal effusion.

Superior Vena Cava (SVC) obstruction (This is an emergency and requires prompt intervention.)

PRINCIPLES OF MANAGEMENT







When considering a management approach, always balance burden of a possible intervention against the likely benefit (e.g., does the intervention require transfer to another care setting?)

- Dyspnea may not be due to hypoxia. Use other methods to provide fresh air when O₂ levels are satisfactory
- Utilize anticipatory planning to promote self-care for respiratory distress
- Focus on relaxation and other non-pharmacological techniques
- Opioids are first line of pharmacological treatment

Step 4 | Interventions

LEGEND FOR USE OF BULLETS

Bullets are used to identify the type or strength of recommendation that is being made, based on a review of available evidence, using a modified GRADE process.

	Use with confidence: recommendations are supported by moderate to high levels of empirical evidence.
	Use if benefits outweigh potential harm: recommendations are supported by clinical practice experience, anecdotal, observational or case study evidence providing low level empirical evidence.
	Use with caution: Evidence for recommendations is conflicting or insufficient, requiring further study
	Not recommended: high level empirical evidence of no benefit or potential harm

Non-pharmacological interventions

Interventions available in the home and residential care facilities

- 🏠 Develop **activity pacing** with techniques to provide energy conservation.^{14, 15}
- 🏠 **Learn breath control** methods, e.g., pursed lip and diaphragmatic breathing.^{1, 6, 19}
- 🏠 **Small, frequent meals** will reduce abdominal pressure on the diaphragm.¹⁶

Positioning

- ✅ Sit upright, supported by pillow, or forward leaning with arms on table when standing.⁶ When lying on side, position poor lung side down.¹⁶
- 🏠 Stabilization of ribcage may help accessory muscles to engage and improve breathing.²⁹
- 🏠 Avoid compression of chest and abdomen; position for optimal lung expansion.³⁰
- 🏠 Elevate head of bed to a comfortable 15 to 45 degrees, and elevate arms with pillows.^{30, 31}

Support

- ✅ Provide a comprehensive multi-disciplinary care approach when resources are available.^{15, 24, 32, 33}
- ✅ COPD patients, use exercise and pulmonary rehabilitation.²⁴ Tai Chi²⁰ and inspiratory muscle training,²¹ if appropriate and available.
- 🏠 Provide supportive presence when dyspnea distressing; do not leave alone.^{6, 16}
- 🏠 Phone-based coaching may be beneficial to patients and their care-givers.³⁴
- 🏠 Ask YES and NO questions, rather than open-ended, if talking increases dyspnea.¹⁶

Non-pharmacological interventions continued on [next page](#)

Non-pharmacological interventions *continued*

- ☰ Relaxation techniques of guided imagery and therapeutic touch.⁶
- ☰ Anxiety management and relaxation. Problem solve to avoid panic.^{6, 14, 15}

Environment

- ☰ Maintain a calm environment.¹⁶
- ☰ Strive for an air source that is fresh, cool, humidified and free of irritants.¹⁷
- ☰ Identify and avoid provoking exertion triggers.¹³

Interventions requiring additional equipment or admission to acute care

- ☰ **Airflow** with room air is sometimes as effective as oxygen¹⁷ such as medical air via mask or nasal prongs.^{22, 23}
- ☰ **Oxygen** is generally only helpful for hypoxic patients.³⁶
- ✔ Fans to provide airflow,^{1, 6, 15, 16, 24-27} either a hand-held or electric fan for a minimum of five minutes. (This equipment could very likely be obtained in community for minimal cost.)
- ✔ Walking aids.²⁸ Forward leaning on wheeled walkers may help ventilation.^{1, 28}
- ✔ Neuromuscular electric stimulation whenever no practical barriers and if trained provider available.^{1, 15, 28}
- ✔ COPD and motor neuron disease patients, use chest wall vibration only if tolerated and if trained provider available.^{1, 28}

Pharmacological interventions

- ☰ Oral or parenteral opioids are first line pharmacological treatment.³⁵
- ☰ For home oxygen, see program criteria for required oxygen saturation. Consider practical concerns if oxygen is used in the community.

Pharmacological interventions continued on [next page](#)

Pharmacological interventions *continued*

- For non-hypoxic patients, limit trial of oxygen, e.g., 72 hours.³⁹

Mild level of distress (patient rating of 1 to 3/10 -- mild dyspnea)

- Bronchodilators** such as salbutamol, ipratropium for asthma, COPD.^{43, 45}
- Provide PRN oral or parenteral opioids if dyspnea is only episodic, and provide for breakthrough dyspnea when already on regular opioids.
- The size of opioid dose should reflect the patient's severity of dyspnea and opioid tolerance. If no prior opioids and mild dyspnea; use **morphine** 2.5 mg immediate release orally every 4 hours PRN or **HYDROmorphine** 0.5 mg immediate release orally every 4 hours PRN.







Moderate level of distress

(patient rating of 4 to 6/10 -- moderate dyspnea)

- Bronchodilators** such as salbutamol, ipratropium for asthma, COPD.^{43, 45}
- For ongoing dyspnea, begin a regular opioid dose with concurrent PRN:
 - Morphine** orally: 2.5 mg immediate release every 4 hours.
Morphine parenterally: 1 to 1.5 mg SC or IV every 4 hours.
 - Alternatively: **HYDROmorphine** 0.5 mg orally every 4 hours, OR **HYDROmorphine** 0.25 mg SC or IV every 4 hours.
 - Titrate opioid dose incrementally by about 25% according to effectiveness and PRN usage in prior 24 hours. Goal is patient comfort, determined by subjective, objective effect and tolerance.
- Provide preventative anti-emetic and bowel management to prevent, and to immediately manage, opioid adverse effects of nausea, vomiting and constipation. Incidence may triple with opioid use.³⁷
- Monitor for excessive opioid-induced drowsiness; use **Pasero Opioid-Induced Sedation Scale (POSS)** assessment tool ([Underlying causes of dyspnea in palliative care](#)).





Pharmacological interventions continued on [next page](#)

Pharmacological interventions *continued*

-  **Corticosteroid** trial in major airway obstruction, lymphangitis carcinomatosa, radiation or drug-induced pneumonitis,¹ or for endotracheal and bronchial tumors.⁴¹ A limited course duration will likely reduce risk of adverse effects. Assess benefit, as current use evidence limited to COPD patients.³⁵
 -  Use short course **corticosteroids** for COPD dyspnea exacerbations.⁴⁰
-  **Benzodiazepines** may assist anxiety or panic,^{1, 35} e.g., with the combination of midazolam and morphine in terminal stage cancer patients with anxiety.^{1, 35}
 -  A systematic review has found no efficacy evidence of benzodiazepines for the relief of breathlessness in patients with advanced cancer or COPD regardless of type of benzodiazepine, dose or route, nor for prevention of breakthrough dyspnea.⁴²
 -  Use benzodiazepines only as a second or third line agent when opioids and non-pharmacological measures have failed to control breathlessness.
-  **Methotrimeprazine's** role limited to use only as a second line agent or in combination with an opioid when further opioid dose titration is contraindicated.⁴³ Initiate at low doses, monitor for benefit, excessive sedation, and anti-cholinergic side effects such as extrapyramidal effects as reviews have concluded limited to no effectiveness.^{1, 44}


Severe distress

(patient rating of 7 to 10/10 -- severe dyspnea = crisis management)


-  Use opioids and adjunctive anxiolytics/sedatives until comfort is achieved.^{1, 35}
-  Opioid naïve: use morphine 5 mg SC or IV bolus every 5 to 10 minutes. Double dose if no effect every three doses; hold and reassess once dyspnea is reduced, especially if very sedated.¹⁷
-  Opioid tolerant: give full regular opioid dose SC or IV every 5 to 10 minutes. If ineffective, double dose as above.
-  If patient anxious, use one of the following with opioid: either **midazolam 2.5 to 5 mg** SC or IV, OR **lorazepam 5 mg** SC or IV every 5 to 15 minutes PRN.

Pharmacological interventions continued on [next page](#)

Pharmacological interventions *continued*








-  Use incremental opioid titration first line until patient comfortable. Monitor for effectiveness and excessive sedation using POSS.

Not recommended

-  Administration of nebulized opioids.^{37, 46}

Patient and family education

Refer to non-pharmacological interventions section for more information.

-  Ensure inhalers are being used correctly.
-  Inform patient and family that dyspnea is not always caused by low oxygen levels and may not improve with oxygen. Fresh air via a fan, positioning and opioids may be more helpful than oxygen.
-  Build a documented plan, both for ongoing dyspnea and for acute dyspnea episodes.^{1, 9-13}
-  A symptom and medication diary can be useful.
-  Ask about cultural practices involving smoke and respect decisions to continue these practices.
-  Encourage smoking cessation. Dyspnea can be lessened even after early lung cancer diagnosis.¹⁸
-  Teach safe and appropriate use of medications including purpose, adverse effects and how to manage.¹⁵ Include correct use of inhalers.⁶

ADDITIONAL RESOURCES FOR MANAGEMENT OF DYSPNEA

Resources specific to dyspnea

- First Nations Health Authority: “Keep tobacco sacred”
 - <http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/wellness-streams/respecting-tobacco#keep-tobacco-sacred>
- BC Guidelines: Dyspnea (medication table as well)
 - http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative2_dyspnea.pdf
- BC Cancer Agency: Symptom management guidelines: Dyspnea
 - <http://www.bccancer.bc.ca/nursing-site/Documents/5.%20Dyspnea.pdf>
- BC’s Heart Failure Network: Clinical practice guidelines for heart failure symptom management: Dyspnea
 - <http://www.bcheartfailure.ca/wp-content/uploads/downloads/2015/01/Dyspnea-Jan-20151.pdf>
- Managing dyspnea in patients with advanced chronic obstructive pulmonary disease: a Canadian Thoracic Society clinical practice guideline.²⁹
 - <http://www.respiratoryguidelines.ca/>

General Resources

- **Provincial Palliative Care Line** – for **physician** advice or support, call **1 877 711-5757** In ongoing partnership with the Doctors of BC, the toll-free Provincial Palliative Care Consultation Phone Line is staffed by Vancouver Home Hospice Palliative Care physicians 24 hours per day, 7 days per week to assist physicians in B.C. with advice about symptom management, psychosocial issues, or difficult end-of-life decision making.
- BC Centre for Palliative Care: Serious Illness Conversation Guide
 - <http://www.bc-cpc.ca/cpc/>

Additional resources for management of dyspnea continued on [next page](#)

ADDITIONAL RESOURCES FOR MANAGEMENT OF DYSPNEA *CONTINUED*

- BC Guidelines: Palliative Care for the Patient with Incurable Cancer or Advanced Disease
 - <http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/palliative-care>
- BC Palliative Care Benefits: Information for prescribers
 - <http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/prescribers/plan-p-bc-palliative-care-benefits-program>
- National Centre for Complementary and Alternative Medicine (NCCAM) for additional information on the use of non-pharmacological interventions
 - <https://nccih.nih.gov/>
- Canadian Association of Psychosocial Oncology: Pan-Canadian Practice Guideline: Screening, Assessment and Management of Psychosocial Distress, Depression and Anxiety in Adults with Cancer
 - http://www.capo.ca/wp-content/uploads/2015/11/FINAL_Distress_Guideline1.pdf
- Fraser Health psychosocial care guideline
 - <https://www.fraserhealth.ca/media/psychosocial%20care.pdf>

Resources specific to health organization/region

- Fraser Health
 - <http://www.fraserhealth.ca/health-professionals/professional-resources/hospice-palliative-care/>
- First Nations Health Authority
 - <http://www.fnha.ca/>
- Interior Health
 - <https://www.interiorhealth.ca/YourCare/PalliativeCare/Pages/default.aspx>
- Island Health
 - http://www.viha.ca/pal_eol/
- Northern Health
 - *Additional resources for management of dyspnea continued on [next page](#)*

ADDITIONAL RESOURCES FOR MANAGEMENT OF DYSPNEA *CONTINUED*

- <https://www.northernhealth.ca/Professionals/PalliativeCareEndofLifeCare.aspx>
- Providence Health
 - <http://hpc.providencehealthcare.org/>
- Vancouver Coastal Health
 - <http://www.vch.ca/your-care/home-community-care/care-options/hospice-palliative-care>

Resources specific to patient population

- ALS Society of Canada: A Guide to ALS patient care for primary care physicians
 - <https://als.ca/wp-content/uploads/2017/02/A-Guide-to-ALS-Patient-Care-For-Primary-Care-Physicians-English.pdf>
- ALS Society of British Columbia 1-800-708-3228
 - www.alsbc.ca
- BC Cancer Agency: Symptom management guidelines
 - <http://www.bccancer.bc.ca/health-professionals/clinical-resources/nursing/symptom-management>
- BC Renal Agency: Conservative care pathway and symptom management
 - <http://www.bcrenalagency.ca/health-professionals/clinical-resources/palliative-care>
- BC's Heart Failure Network: Clinical practice guidelines for heart failure symptom management
 - <http://www.bcheartfailure.ca/for-bc-healthcare-providers/end-of-life-tools/>
- Canuck Place Children's Hospice
 - <https://www.canuckplace.org/resources/for-health-professionals/>
 - 24 hr line – 1.877.882.2288
 - Page a Pediatric Palliative care physician – 1-604-875-2161 (request palliative physician on call)
- Together for short lives: Basic symptom control in pediatric palliative care
 - http://www.togetherforshortlives.org.uk/professionals/resources/2434/basic_symptom_control_in_paediatric_palliative_care_free_download

UNDERLYING CAUSES OF DYSPNEA IN PALLIATIVE CARE

All information regarding causes of dyspnea is contained within the body of the document.

MEDICATIONS FOR MANAGEMENT OF DYSPNEA

No medication table included in this document

Prices for prescription drugs may be obtained from BC PharmaCare. The British Columbia Palliative Care Benefits Plan <http://www2.gov.bc.ca/assets/gov/health/health-drug-coverage/pharmacare/palliative-formulary.pdf> provides province wide drug coverage for many of the recommended medications– check website to confirm coverage. **Consider price when choosing similarly beneficial medications, especially when the patient / family is covering the cost.**

DYSPNEA MANAGEMENT ALGORITHM

No management algorithm included in this document.

DYSPNEA EXTRA RESOURCES OR ASSESSMENT TOOLS

Pasero Opioid-Induced Sedation Scale (POSS)⁷⁸

5	sleep, easy to arouse
1	awake and alert
2	slightly drowsy, easily aroused
3	frequently drowsy, arousable, drifts off to sleep during conversation
4	somnolent, minimal or no response to physical stimulation

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FHA Home Oxygen Program (HOP) Subsidy:⁽³⁹⁾

<http://www.fraserhealth.ca/Services/HomeandCommunityCare/HomeOxygenProgram/Pages/default.aspx>

The clinical eligibility criteria for the Home Oxygen Program (HOP) apply to the palliative patients:

- Arterial blood gas on room air showing a PaO₂ ≤ 55 mmHg in a steady state reflecting a chronic condition (Chronic Obstructive Pulmonary Disease or Interstitial Lung Disease),
OR
- Steady state daytime hypoxemia with oxygen saturation sustained continuously for 6 minutes,
OR
- PaO₂ = 56 to 60 mmHg with evidence of cor pulmonale, pulmonary hypertension, or congestive heart failure (with ejection fraction less than 20%)
- Exercise limited by hypoxemia and documented to improve with supplemental oxygen (exercise in this instance may mean activities of daily living)
- Nocturnal hypoxemia

In the case of palliative patients in their last few months of life when an arterial blood gas is an inappropriately invasive procedure, application for the HOP subsidy without an ABG, requires a resting room air oxygen saturation below 88% for 6 minutes. This can be documented in the home by homecare nursing staff.

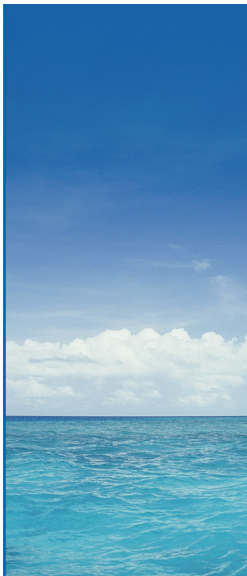
- The **home oxygen program** is very willing to accept referrals for dyspnea assessment and recommendations

Shortness of Breath

Shortness of breath, breathlessness, or dyspnea are terms used to describe awareness of difficulty in breathing.

Like pain, it is a sensation that can be felt only by the person experiencing it and its causes are many and varied.

You may be short of breath only with activity, and be comfortable at rest. Or you may be aware of the effort of breathing even at rest. When this is the case, demands you may not think of as work can make your breathing worse: eating and digesting food after eating; dealing with discomfort such as constipation, pain, or a fever; even laughing. Simply anticipating some event can increase the work of breathing.



What can you do to keep your breathing at a comfortable level?

- Move slowly and pace your activities within your breathing tolerance. Slight shortness of breath is easier to recover from than extreme shortness of breath from rushing or overexertion.
- Rest before and after an activity (including eating).
- Use relaxation techniques in your daily routine such as visualization, self-hypnosis, and deep slow breathing.
- Be aware of the role anxiety may play in your shortness of breath. Getting ready for an activity that will require effort can make you more short of breath in anticipation. To avoid this, think about your breathing and slow it down to a comfortable level before beginning an activity.
- Take medications prescribed for your shortness of breath before activities that are particularly difficult, e.g., dressing or bathing.
- Plan ahead about what you can do if you become short of breath.
- Use fans to move air in your environment.
- Avoid holding your breath during an activity. When getting out of a chair or bending over to put on your shoes, breathe out as you bend and continue to breathe at your normal pace. Do not hold your breath while climbing the stairs.
- Be aware of your breathing pattern. When first feeling short of breath, slow down your activity, concentrate on your breathing and slow it down. Slow your breath by breathing in through your nose, and out very gently through lips loosely pursed as if you are going to whistle.
- Tell family or friends what helps you manage your breathing. For example, turning a fan on; staying with you but staying quiet; putting their hand gently on your shoulder; reminding you to breathe more slowly.

Dyspnea

Are there medications to help?

- Medications such as morphine and hydromorphone are often very effective in decreasing the feeling of shortness of breath. These medications are used in the same way as when treating pain. A regular dose is given for constant relief, with “breakthrough” or “rescue” doses for times of when shortness of breath feels worse.
- People who are short of breath often don’t want to use morphine or hydromorphone medications because of worries about addiction or overdosing. These concerns are common, but these medications are very safe. Addiction is rare and side effects can be easily managed.
- If you feel a great deal of anxiety due to shortness of breath, anti-anxiety drugs can be used on a regular or as needed basis. Methotrimeprazine may be useful as a regular anti-anxiety drug. For acute, sudden episodes of shortness of breath, lorazepam may be helpful.

Do you need oxygen?

- Not usually. Oxygen can help decrease shortness of breath for those people whose lungs cannot move enough oxygen into their bloodstream. But, for many people who are short of breath, the lungs do take in enough oxygen. In this case, oxygen may not help. Other strategies such as air blown on the face by fans, medications and other techniques will often be more helpful.

What can you do when your shortness of breath gets worse?

1. Stop your activity.
2. Get supported in a relaxed position.
3. Concentrate on your breathing, gradually slowing the rate and deepening your breaths. In your mind say “slower breath in, longer breath out” until you feel your breathing responding to your message.
4. If your shortness of breath does not ease to a tolerable level with these strategies, call your physician and discuss adjusting your medication.



- Shortness of breath can be a lonely, frightening and overwhelming experience.
- To cope with it, you will likely need to use several of the approaches described above.
- Shortness of breath is a symptom that can be managed.
- By working with your doctor, nurse, pharmacist and therapists, your shortness of breath can be eased and you can feel more comfortable.

Patient Teaching Handout
Fraser Health

Approved by: HPC, Clinical Practice Committee • July 17, 2006

Pamphlet adapted from Vancouver Coastal Authority with permission.

ਸਾਹ ਚੜਨਾ

Shortness of Breath

ਸਾਹ ਚੜਨਾ, ਸਾਹੋ-ਸਾਹੀ ਹੋਣਾ, ਜਾਂ ਸੁਆਸ ਕਿਰਿਆ ਦੀਆਂ ਔਕੜਾਂ ਨੂੰ ਸਾਹ ਲੈਣ ਵਿਚ ਮੁਸ਼ਕਿਲ ਦੀਆਂ ਹਾਲਤਾਂ ਦਾ ਵਰਨਣ ਕਰਨ ਲਈ ਵਰਤਿਆ ਜਾਂਦਾ ਹੈ।

ਦਰਦ ਦੀ ਤਰਾਂ, ਇਹ ਇਕ ਸੰਵੇਦਨਾ ਹੈ ਜਿਸ ਨੂੰ ਸਿਰਫ ਅਨੁਭਵ ਕਰਨ ਵਾਲਾ ਵਿਅਕਤੀ ਹੀ ਮਹਿਸੂਸ ਕਰ ਸਕਦਾ ਹੈ ਅਤੇ ਇਸ ਦੇ ਅਨੇਕਾਂ ਅਤੇ ਭਿੰਨ-ਭਿੰਨ ਕਾਰਣ ਹੁੰਦੇ ਹਨ।

ਹੋ ਸਕਦਾ ਹੈ ਕਿ ਤੁਹਾਨੂੰ ਕੁਝ ਕਰਨ ਦੇ ਨਾਲ ਹੀ ਸਾਹ ਚੜ੍ਹੇ ਅਤੇ ਆਰਾਮ ਕਰਨ ਨਾਲ ਸੁਖਾਲੇ ਹੋ ਜਾਵੇ। ਜਾਂ ਤੁਹਾਨੂੰ ਆਰਾਮ ਕਰਦੇ ਹੋਏ ਵੀ ਸਾਹ ਲੈਣ ਵਿਚ ਔਖਿਆਈ ਮਹਿਸੂਸ ਹੋਵੇ। ਜਿਥੇ ਤੱਕ ਵੀ ਹੋਵੇ, ਅਜਿਹੇ ਕੰਮ ਜਿੰਨਾਂ ਨੂੰ ਤੁਸੀਂ ਕੰਮ ਨਹੀਂ ਸਮਝਦੇ ਉਹ ਵੀ ਤੁਹਾਡੇ ਸਾਹ ਲੈਣ ਨੂੰ ਔਖਾ ਕਰ ਸਕਦੇ ਹਨ: ਭੋਜਨ ਖਾਣਾ ਅਤੇ ਖਾਣ ਦੇ ਬਾਅਦ ਭੋਜਨ ਹਜ਼ਮ ਹੋਣਾ: ਬੇਆਰਾਮੀ ਨੂੰ ਨਜਿੱਠਣਾ ਜਿਵੇਂ ਕਿ ਕਬਜ਼, ਦਰਦ ਜਾਂ ਬੁਖਾਰ: ਭਾਵੇਂ ਹੱਸਣਾ ਵੀ ਹੋਵੇ। ਕੁਝ ਵੀ ਆਮ ਜਿਹਾ ਕੰਮ ਕਰਨਾ ਸਾਹ ਲੈਣ ਦੇ ਕੰਮ ਨੂੰ ਵਧਾ ਸਕਦੇ ਹਨ।

ਆਪਣੇ ਸਾਹ ਨੂੰ ਠੀਕ ਰੱਖਣ ਲਈ ਤੁਸੀਂ ਕੀ ਕਰ ਸਕਦੇ ਹੋ

What can you do to keep your breathing at a comfortable level?

- ਆਪਣਾ ਸਾਹ ਲੈਣਾ ਬਰਦਾਸ਼ਤ ਕਰ ਸਕਣ ਅਨੁਸਾਰ ਆਪਣੀਆਂ ਕਾਰਜਵਿਧੀਆਂ ਨੂੰ ਹੌਲੀ ਕਰੋ ਅਤੇ ਵਕਤ ਦਿਉ। ਤੇਜ਼ੀ ਜਾਂ ਹਦੋਂ ਵੱਧ ਕੰਮ ਕਰਨ ਨਾਲ ਜ਼ਿਆਦਾ ਸਾਹ ਚੜਨ ਨਾਲੋਂ ਥੋੜ੍ਹਾ ਸਾਹ ਚੜਨ ਤੋਂ ਰਾਜ਼ੀ ਹੋਣਾ ਆਸਾਨ ਹੁੰਦਾ ਹੈ।
- ਕਾਰਜਵਿਧੀ ਤੋਂ ਪਹਿਲਾਂ ਅਤੇ ਬਾਅਦ ਵਿਚ ਆਰਾਮ ਕਰੋ (ਭੋਜਨ ਖਾਣ ਸਮੇਤ)।
- ਆਪਣੀ ਨਿਤ ਦੇ ਕੰਮਾਂ ਜਿਵੇਂ ਕਿ ਸੁਰਤੀ ਵਿਚ ਵੇਖਣਾ, ਆਪਣੇ ਅੰਤਰ-ਧਿਆਨ ਅਤੇ ਹੌਲੀ-ਹੌਲੀ ਡੂੰਘੇ ਸਾਹ ਲੈਣ ਵਿਚ ਨਿੱਸਲ (relax) ਹੋਣ ਦੀਆਂ ਤਕਨੀਕਾਂ ਵਰਤੋ।
- ਤੁਹਾਡੇ ਸਾਹ ਚੜਨ ਵਿਚ ਬੇਚੈਨੀ ਦੇ ਦਖਲ ਤੋਂ ਵੀ ਸੁਚੇਤ ਰਹੋ। ਕਾਰਜਵਿਧੀ ਕਰਨ ਲਈ ਤਿਆਰ ਹੋਣ ਲਈ ਕੋਸ਼ਿਸ਼ ਦੀ ਲੋੜ ਹੋਵੇਗੀ ਜਿਸ ਦੀ ਅਗੇਤਰੀ ਤਿਆਰੀ ਲਈ ਤੁਹਾਨੂੰ ਸਾਹ ਚੜ ਸਕਦਾ ਹੈ। ਇਸ ਤੋਂ ਬਚਣ ਲਈ, ਆਪਣੇ ਸਾਹ ਲੈਣ ਬਾਰੇ ਸੋਚੋ ਅਤੇ ਕੋਈ ਵੀ ਕਾਰਜਵਿਧੀ ਸ਼ੁਰੂ ਕਰਨ ਤੋਂ ਪਹਿਲਾਂ ਆਪਣੇ ਸਾਹ ਨੂੰ ਹੌਲੀ ਹੌਲੀ ਆਰਾਮਦਾਇਕ ਹਾਲਤ ਤੱਕ ਲਿਆਉ।
- ਖਾਸ ਮੁਸ਼ਕਿਲਾਂ ਵਾਲੀਆਂ ਕਾਰਜਵਿਧੀਆਂ ਜਿਵੇਂ ਕਿ ਕਪੜੇ ਪਾਉਣਾ ਜਾਂ ਨਹਾਉਣਾ ਸ਼ੁਰੂ ਕਰਨ ਤੋਂ ਪਹਿਲਾਂ ਆਪਣੇ ਸਾਹ ਚੜਨ ਲਈ ਦੱਸੀਆਂ ਗਈਆਂ ਦਵਾਈਆਂ ਲਉ।
- ਆਪਣੇ ਸਾਹ ਚੜਨ ਦੀ ਹਾਲਤ ਵਿਚ ਤੁਸੀਂ ਕੀ ਕਰ ਸਕਦੇ ਹੋ, ਬਾਰੇ ਸਮੇਂ ਤੋਂ ਪਹਿਲਾਂ ਯੋਜਨਾ ਬਣਾਉ।
- ਆਪਣੇ ਵਾਤਾਵਰਣ ਵਿਚ ਹਵਾ ਦੇ ਆਉਣ-ਜਾਣ ਲਈ ਪੱਖੇ ਦੀ ਵਰਤੋਂ ਕਰੋ।
- ਕਾਰਜਵਿਧੀ ਕਰਨ ਦੌਰਾਨ ਆਪਣੇ ਸਾਹ ਨੂੰ ਰੋਕਣ ਤੋਂ ਸੰਕੋਚ ਕਰੋ। ਕੁਰਸੀ ਤੋਂ ਉਠਣ ਵੇਲੇ ਜਾਂ ਆਪਣੀਆਂ ਜੁੱਤੀਆਂ ਪਾਉਣ ਲਈ ਅੱਗੇ ਨੂੰ ਝੁਕਦੇ ਵੇਲੇ ਸਾਹ ਬਾਹਰ ਕੱਢੋ ਅਤੇ ਆਪਣੇ ਸਾਧਾਰਨ ਤਰੀਕੇ ਨਾਲ ਸਾਹ ਲੈਣਾ ਜਾਰੀ ਰੱਖੋ। ਪੌੜੀਆਂ ਚੜਦੇ ਸਮੇਂ ਆਪਣੇ ਸਾਹ ਨੂੰ ਨਾ ਰੋਕੋ।
- ਸਾਹ ਲੈਣ ਦੀ ਤਰਤੀਬ ਤੋਂ ਸੁਚੇਤ ਰਹੋ। ਜਦੋਂ ਪਹਿਲੀ ਵਾਰ ਸਾਹ ਚੜਦਾ ਮਹਿਸੂਸ ਹੋਵੇ ਤਾਂ ਆਪਣੀ ਕਾਰਜਵਿਧੀ ਨੂੰ ਹੌਲੀ ਕਰੋ, ਆਪਣੇ ਸਾਹ ਲੈਣ ਤੇ ਧਿਆਨ ਦਿਉ ਅਤੇ ਹੌਲੀ ਹੌਲੀ ਸਾਹ ਲਵੋ। ਆਪਣੇ ਨੱਕ ਰਾਹੀਂ ਸਾਹ ਅੰਦਰ ਲੈ ਕੇ, ਅਤੇ ਸੀਟੀ ਮਾਰਨ ਵਾਗ ਬੁਲਾਂ ਰਾਹੀਂ ਸਾਹ ਬਾਹਰ ਕੱਢ ਕੇ ਆਪਣੇ ਸਾਹ ਲੈਣ ਨੂੰ ਹੌਲੀ ਕਰੋ।
- ਸਾਹ ਲੈਣ ਤੇ ਕਾਬੂ ਪਾਉਣ ਵਿਚ ਤੁਹਾਨੂੰ ਕਿਹੜੀ ਗੱਲ ਮਦਦ ਕਰਦੀ ਹੈ, ਦੇ ਬਾਰੇ ਆਪਣੇ ਪਰਿਵਾਰ ਅਤੇ ਮਿਤਰਾਂ ਨੂੰ ਦੱਸੋ। ਉਦਾਹਰਣ ਦੇ ਤੌਰ ਤੇ, ਪੱਖਾ ਚਲਾਉਣ ਤੇ; ਤੁਹਾਡੇ ਕੋਲ ਪਰ ਚੁਪ-ਚਾਪ ਰਹਿਣ ਤੇ; ਤੁਹਾਡੇ ਮੋਢਿਆਂ ਤੇ ਨਰਮੀ ਨਾਲ ਹੱਥ ਰੱਖਣ ਤੇ; ਤੁਹਾਨੂੰ ਹੌਲੀ ਸਾਹ ਲੈਣ ਲਈ ਯਾਦ ਕਰਵਾਉਣਾ ਆਦਿ।

Dyspnea

Hospice Palliative Care Program • Symptom Guidelines

ਕੀ ਮਦਦ ਲਈ ਕੋਈ ਦਵਾਈਆਂ ਹਨ?

Are there medications to help?

- ਸਾਹ ਚੜਨ ਨੂੰ ਘੱਟ ਕਰਨ ਲਈ ਦਵਾਈਆਂ ਜਿਵੇਂ ਕਿ ਮੋਰਫਿਨ ਅਤੇ ਹਾਈਡਰੋਮੋਰਫੋਨ ਅਕਸਰ ਬਹੁਤ ਅਸਰਦਾਰ ਹੁੰਦੀਆਂ ਹਨ। ਇਹ ਦਵਾਈਆਂ ਉਸੇ ਤਰੀਕੇ ਨਾਲ ਵਰਤੀਆਂ ਜਾਂਦੀਆਂ ਹਨ ਜਿਵੇਂ ਕਿ ਦਰਦ ਦਾ ਇਲਾਜ ਕੀਤਾ ਜਾਂਦਾ ਹੈ। ਲਗਾਤਾਰ ਆਰਾਮ ਦਵਾਉਣ ਲਈ ਜਦੋਂ ਕਿ ਸਾਹ ਲੈਣਾ ਬਹੁਤ ਮੁਸ਼ਕਿਲ ਲਗੇ ਤਾਂ “ਬਚਾਉਣ” ਲਈ ਨਿਯਮਕ (regular) ਡੋਜ਼ ਲਗਾਤਾਰ ਦਿੱਤੀ ਜਾਂਦੀ ਹੈ।
- ਜਿੰਨਾਂ ਲੋਕਾਂ ਨੂੰ ਸਾਹ ਚੜਦਾ ਹੋਵੇ ਉਹ ਅਕਸਰ ਮੋਰਫਿਨ ਅਤੇ ਹਾਈਡਰੋਮੋਰਫੋਨ ਦਵਾਈਆਂ ਨਹੀਂ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹਨ ਕਿਉਂਕਿ ਉਹਨਾਂ ਨੂੰ ਅਮਲ ਹੋ ਜਾਣ ਜਾਂ ਜ਼ਿਆਦਾ ਮਿਕਦਾਰ (ਡੋਜ਼) ਲੈ ਲੈਣ ਬਾਰੇ ਚਿੰਤਾ ਹੁੰਦੀ ਹੈ। ਅਜਿਹੇ ਫਿਕਰ ਆਮ ਹਨ, ਪਰ ਇਹ ਦਵਾਈਆਂ ਕਾਫੀ ਸੁਰੱਖਿਅਤ ਹੁੰਦੀਆਂ ਹਨ। ਅਮਲ ਲਗਣਾ ਬਹੁਤ ਘੱਟ ਹੁੰਦਾ ਹੈ ਅਤੇ ਗੌਣ ਅਸਰਾਂ ਤੇ ਆਸਾਨੀ ਨਾਲ ਕਾਬੂ ਪਾਇਆ ਜਾ ਸਕਦਾ ਹੈ।
- ਜੇਕਰ ਤੁਹਾਨੂੰ ਸਾਹ ਚੜਨ ਨਾਲ ਬਹੁਤ ਜ਼ਿਆਦਾ ਬੇਚੈਨੀ ਹੁੰਦੀ ਹੈ ਤਾਂ ਬੇਚੈਨੀ ਨੂੰ ਹਟਾਉਣ ਵਾਲੀਆਂ ਦਵਾਈਆਂ ਦੀ ਨਿਯਮਕ (regular) ਜਾਂ ਲੋੜ ਪੈਣ ਦੇ ਆਧਾਰ ਤੇ ਵਰਤੋਂ ਕੀਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਬੇਚੈਨੀ ਨੂੰ ਹਟਾਉਣ ਵਾਲੀ ਨਿਯਮਕ ਦਵਾਈ ਲਈ ਮੈਥੋਟਾਈਮੈਪਰਾਜ਼ਿਨ ਲਾਭਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ। ਗੰਭੀਰ, ਅਚਾਨਕ ਸਾਹ ਚੜਨ ਦੀਆਂ ਹਾਲਤਾਂ ਲਈ ਲੋਰਾਜ਼ੀਪੈਮ ਮਦਦਗਾਰ ਹੋ ਸਕਦੀ ਹੈ।

ਕੀ ਤੁਹਾਨੂੰ ਆਕਸੀਜਨ ਦੀ ਲੋੜ ਹੈ?

Do you need oxygen?

- ਆਮ ਕਰਕੇ ਨਹੀਂ। ਜਿੰਨਾਂ ਵਿਅਕਤੀਆਂ ਦੇ ਫੇਫੜੇ ਉਹਨਾਂ ਦੇ ਖੂਨ ਵਿਚ ਲੋੜ ਮੁਤਾਬਕ ਆਕਸੀਜਨ ਨਹੀਂ ਭੇਜ ਸਕਦੇ, ਉਹਨਾਂ ਨੂੰ ਸਾਹ ਚੜਨਾ ਘੱਟ ਕਰਨ ਵਿਚ ਆਕਸੀਜਨ ਮਦਦ ਕਰ ਸਕਦੀ ਹੈ। ਪਰ, ਬਹੁਤ ਸਾਰੇ ਲੋਕ ਜਿੰਨਾਂ ਨੂੰ ਸਾਹ ਚੜਦਾ ਹੈ, ਉਹਨਾਂ ਦੇ ਫੇਫੜੇ ਲੋੜ ਅਨੁਸਾਰ ਆਕਸੀਜਨ ਲੈ ਲੈਂਦੇ ਹਨ। ਅਜਿਹੀ ਹਾਲਤ ਵਿਚ, ਆਕਸੀਜਨ ਮਦਦ ਨਹੀਂ ਕਰ ਸਕਦੀਕ ਹੋਰ ਢੰਗ ਜਿਵੇਂ ਕਿ ਪੱਖੇ ਨਾਲ ਮੂੰਹ ਤੇ ਹਵਾ ਪਾਉਣਾ, ਦਵਾਈਆਂ ਅਤੇ ਹੋਰ ਤਕਨੀਕਾਂ ਅਕਸਰ ਜ਼ਿਆਦਾ ਮਦਦਗਾਰ ਹੋ ਸਕਦੀਆਂ ਹਨ।

ਜਦੋਂ ਤੁਹਾਡਾ ਸਾਹ ਚੜਨਾ ਮਾੜੀ ਹਾਲਤ ਵਿਚ ਹੋ ਜਾਵੇ ਤਾਂ ਤੁਸੀਂ ਕੀ ਕਰ ਸਕਦੇ ਹੋ?

What can you do when your shortness of breath gets worse?

1. ਆਪਣੀ ਕਾਰਜਵਿਧੀ ਨੂੰ ਬੰਦ ਕਰ ਦਿਉ।
2. ਨਿਸਲ (ਆਰਾਮਦਾਇਕ) ਹਾਲਤ ਵਿਚ ਸਹਾਰਾ ਲਉ।
3. ਆਪਣੇ ਸਾਹ ਲੈਣ ਤੇ ਧਿਆਨ ਕੇਂਦਰਿਤ ਕਰੋ, ਹੌਲੇ-ਹੌਲੇ ਰਫਤਾਰ ਨੂੰ ਹੌਲੀ ਕਰੋ ਅਤੇ ਆਪਣੇ ਸਾਹਾਂ ਨੂੰ ਡੂੰਘਾ ਕਰੋ। ਜਦੋਂ ਤੱਕ ਤੁਸੀਂ ਆਪਣੇ ਮਨ ਦੇ ਸੁਨੇਹੇ ਅਨੁਸਾਰ ਆਪਣਾ ਸਾਹ ਮਹਿਸੂਸ ਨਹੀਂ ਕਰਦੇ, ਉਦੋਂ ਤੱਕ ਆਪਣੇ ਮੰਨ ਵਿਚ ਇਹ ਕਰੋ “ਹੌਲੀ ਸਾਹ ਅੰਦਰ ਲੈਣਾ ਲੰਬਾ ਕਰਕੇ ਬਾਹਰ ਕੱਢਣਾ”।
4. ਜੇਕਰ ਇਹਨਾਂ ਢੰਗਾਂ ਨਾਲ ਤੁਹਾਡਾ ਸਾਹ ਲੈਣਾ ਆਰਾਮਦਾਇਕ ਹਾਲਤਾਂ ਤੱਕ ਆਸਾਨ ਨਹੀਂ ਹੁੰਦਾ, ਆਪਣੇ ਡਾਕਟਰ ਨੂੰ ਫੋਨ ਕਰੋ ਅਤੇ ਆਪਣੀਆਂ ਦਵਾਈਆਂ ਅਨੁਕੂਲ ਕਰਨ ਲਈ ਵਿਚਾਰ-ਵਟਾਂਦਰਾ ਕਰੋ।



- ਸਾਹ ਚੜਨਾ ਇੱਕਲਾ, ਡਰਾਉਣਾ ਅਤੇ ਜ਼ੋਰਦਾਰ ਤਜਰਬਾ ਹੋ ਸਕਦਾ ਹੈ। ਇਸ ਨਾਲ ਨਜਿੱਠਣ ਲਈ, ਉਪਰ ਦੱਸੀਆਂ ਕਈ ਕੋਸ਼ਿਸ਼ਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ।
- ਸਾਹ ਚੜਨਾ ਇੱਕ ਲੱਛਣ ਹੈ ਜਿਸ ਤੇ ਕਾਬੂ ਪਾਇਆ ਜਾ ਸਕਦਾ ਹੈ। ਆਪਣੇ ਡਾਕਟਰ, ਨਰਸ, ਫਾਰਮਾਸਿਸਟ ਅਤੇ ਥੈਰੈਪਿਸਟ ਨਾਲ ਮਿਲ ਕੇ ਸਾਹ ਚੜਨ ਨੂੰ ਆਸਾਨ ਕੀਤਾ ਜਾ ਸਕਦਾ ਹੈ ਅਤੇ ਤੁਸੀਂ ਜ਼ਿਆਦਾ ਆਰਾਮਦਾਇਕ ਮਹਿਸੂਸ ਕਰ ਸਕਦੇ ਹੋ।

ਮਰੀਜ਼ਾਂ ਨੂੰ ਸਿਖਲਾਈ ਦਾ ਹੈਂਡਆਊਟ
ਫਰੇਜ਼ਰ ਹੈਲਥ

ਮਨਜ਼ੂਰ ਕੀਤਾ ਗਿਆ: ਐਚ ਪੀ ਸੀ, ਕਲੀਨਿਕਲ ਪਰੈਕਟਿਸ ਕਮੇਟੀ • ਜੁਲਾਈ, 2006
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ਇਹ ਪੈਮਫਲਿਟ ਵੈਨਕੂਵਰ ਕੋਸਟਲ ਆਥਾਰਟੀ ਤੋਂ ਆਗਿਆ ਪ੍ਰਾਪਤ ਕਰਕੇ ਬਣਾਇਆ ਗਿਆ ਹੈ