

CORRESPONDENCE

Shortness of Breath and Cough in Patients in Palliative Care

by Prof. Dr. med. Claudia Bausewein PhD MSc, Dr. med. Steffen T. Simon MSc
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Connections Are Clearly More Complex

CME articles on palliative medicine are to be welcomed, since they are very important. In the article of Bausewein and Simon (1), the sections regarding drug treatment of palliative symptoms are appropriate and reflect the current state of knowledge.

Unfortunately, the authors did not stringently adhere to their stated objective of restricting the recommendations to patients with refractory dyspnea (for example, in the title, in the defined learning objectives on page 564, and in the algorithm on page 567). It is not stated clearly enough that the cited evidence is from studies that explicitly included only patients in whom tumor specific treatments (chemotherapy, radiotherapy, or surgery) was no longer indicated or not sufficiently effective.

From an oncological perspective, this limitation likely leads to considerable deficits, particularly regarding the care for patients in a palliative setting. The systematic evaluation of possible causes of dyspnea and cough is a crucial step towards the best possible treatment in the palliative setting. This is, for example, stated in the current US guidelines on palliative medicine published by the National Comprehensive Cancer Network (2). A plain chest x-ray (as suggested by Bausewein and Simon) will, for example, not be sufficient to detect pulmonary embolism, which is quite common in cancer patients, or malignant pericardial effusion.

Another important issue not covered by this article is the administration of local treatments such as radiotherapy. Radiotherapy is well recognized as a very effective local treatment generally associated with only minor adverse effects in the treatment of tumor or metastasis related dyspnea, cough, or hemoptysis. Furthermore, the aspect of communication with the patients was not appropriately mentioned. As described in the Canadian guidelines on the relief of dyspnea, preventive treatment of dyspnea should be initiated before a patient displays symptoms. This can be achieved by using structured education programs for patients and by discussing effective, symptom oriented treatment measures that can be applied when the malignant disease is progressing (3).

The process of multidisciplinary treatment decision making is mandatory in order to provide the most appropriate treatment approach for each individual cancer patient being in a palliative situation. Such a process requires a great expertise (4), which has been emphasized by the authors of this CME article. However, the authors have not mentioned important disciplines that can contribute very effectively to the relief of dyspnea in palliative cancer patients. The S3 guideline on palliative medicine that is currently under development will likely provide a more comprehensive perspective.

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REFERENCES

1. Bausewein C, Simon ST: Shortness of breath and cough in patients in palliative care. *Dtsch Arztebl Int* 2013; 110(33–34): 563–72.
2. National Comprehensive Cancer Network: NCCN Guidelines Version 2.2013 Palliative Care. PAL-11, https://subscriptions.nccn.org/gl_login.aspx?ReturnURL=http://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf. Last accessed on 30 September 2013.
3. Cancer Care Ontario: Symptom Management Tools, Pocket Guide Dyspnoe. www.cancercare.on.ca/toolbox/symptools/, S. 2. Last accessed on 30 September 2013.
4. Smith TJ, Temin S, Alesi ER, et al.: American society of clinical oncology provisional clinical opinion: the integration of palliative care into standard oncology care. *J Clin Oncol* 2012; 30: 880–7.

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Conflict of interest statement

The authors declare that no conflict of interest exists.

In Reply:

We thank our correspondents for emphasizing that the therapeutic recommendations in our article are related to refractory dyspnea and cough, as mentioned in our subheadings and the introduction.

Our corresponding colleagues support our opinion that potentially reversible causes of shortness of breath and cough need to be identified in order to be able to use all causal therapeutic options. A number of diagnostic measures are available to this end. We think that a comprehensive differential diagnostic evaluation is the remit of the leading medical specialty (for example, oncology, pneumology) and therefore

restricted ourselves to selected examples of diagnostics from the perspective of palliative medicine. Close collaboration among the different specialties is important while recognizing one another's technical competence, and, in our experience, this has become a good tradition in palliative medicine—entirely in the sense of an “interdisciplinary treatment approach.”

Specific local therapeutic options, such as the mentioned radiotherapy or bronchoscopy are among the disease-specific options that should already have been exhausted or should not be indicated in refractory dyspnea.

As we explained in detail in our sections on history taking and evaluation and general measures, the different aspects of communication with patients and their families are a crucial component in caring for patients with refractory dyspnea. This ranges from careful listening, to the question of whether a patient or family member is experiencing any psychological distress, to showing options for tackling dyspnea and creating and explaining an emergency plan. The suggestion of “preventive” communication is helpful if it is foreseeable that a patient will develop dyspnea.

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REFERENCES

1. Bausewein C, Simon ST: Shortness of breath and cough in patients in palliative care. *Dtsch Arztebl Int* 2013; 110(33–34): 563–72.

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