Physical Concerns – “YES” to Breathing

Start With
Asking the patient the below questions

Are you having trouble breathing normally just sitting here in this room?

If YES

A “yes” answer should trigger immediate attention by a nurse, APC or physician in clinic if available, or emergency room who should **obtain:** Objective, clinical data including history, physical examination
- Physician examination should include O2 saturation at rest and with exertion.

Next Step
Primary treating medical team is first-line to address. This team could include a primary care provider or emergency room physician depending on what location or provider the patient seeks.

Refer to Physician/APC
Primary treating team decide whether to send for additional evaluation and testing for cause of dyspnea (CXR, CT scan perhaps pulmonary embolism protocol, echo, cardiac rule-out, hemoglobin, etc.)

**If Yes**

**Options/Recourse**

**MA or higher screener:** communicate this answer of yes to having trouble breathing normally but able to function directly to Physician/APC

**APC or higher screener:**
- Assess for acute reversible conditions and/or co-morbidities
- Co-morbidities should be evaluated (including for example emphysema, CHF, anemia, pleural effusion, thyroid)
- Objective, clinical data including history, physical examination

Refer to Physician/APC
Primary treating team decide whether to send for additional evaluation and testing for cause of dyspnea (CXR, CT scan perhaps pulmonary embolism protocol, echo, cardiac rule-out, hemoglobin, etc.)

**Importantly obtain:**
- Physician examination should include O2 saturation at rest and with exertion.

Include criteria for home oxygen if ordering (Medicare guidelines for O2 level) being certain to include all ordering requirements

Share Patient Links and Handouts as appropriate

See Reference links below for additional information

Notes

**Stages I-III:** Assess for disease recurrence or comorbid condition to manage (for example a new effusion, heart failure, volume overload, pulmonary embolism, anemia). May need palliative care for symptom management (primary palliative care). May be a role for physical medicine, pulmonary rehab, or physical therapy referral at this point if the patient is feeling short of breath and there is no clear cause.

**Stage IV:** Assess for acute reversible conditions, co-morbidities. Typically the oncologist would handle if reversible, causes not related to an underlying co-morbidity which might be treated by a different subspecialist. If symptoms are due to late stage disease progression, for example breathlessness due to progression, please consider:
- Thoracentesis if moderate to large pleural effusion; or placement of indwelling pleurex catheter if repetitive thoracentesis is expected
- Fan for relief of dyspnea - discuss whether NIPPV indicated, wanted, helpful or able to be delivered
- Medications like opioids or decadron for shortness of breath

Consider palliative referral (see NCCN guidelines for Dyspnea) if shortness of breath is not relieved by standard opioids or if the patient has another complex end of life (EOL) need.

**Geriatric:** Similar process of care for all ages

Patient Links and Handouts:

- American Cancer Society, Shortness of breath
- Cancer.Net, Shortness of Breath or Dyspnea
- NIH, Oxygen Safety

CSOC Patient Handout can be accessed at:
http://cancer-help.me/breathing

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