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Managing Dyspnea in Hospice: A Symptom-Directed Approach to Breathlessness

How hospice teams recognize and manage shortness of breath, and why effective relief often depends on more than medication alone.

BetterRX

THE SHORT ANSWER

Dyspnea is the experience of uncomfortable or difficult breathing, often described as shortness of breath or “air hunger.” It is common in advanced illness and can be one of the most distressing symptoms for patients and families.

Dyspnea does not always correspond to oxygen saturation. A patient may experience significant breathlessness with a normal pulse-oximeter reading, while another patient with a low oxygen saturation may appear comfortable. In hospice, the patient's symptoms and observable distress are therefore more important than the oxygen saturation number alone.

Hospice dyspnea management typically begins with simple comfort measures such as positioning, a fan directed toward the face, reduced stimulation, and caregiver reassurance. The team then considers potential contributors and determines whether oxygen, respiratory therapies, or medications are likely to provide meaningful benefit.

For persistent or distressing breathlessness, systemic opioids are an important hospice treatment option for relieving air hunger. Anxiety or panic may further intensify breathlessness and may require additional support.

As illness progresses, the hospice team also reassesses whether inhalers, nebulizers, oxygen, corticosteroids, and other respiratory therapies remain effective, feasible, and consistent with the patient's goals.

The goal is to relieve distress with the least burdensome approach that provides meaningful comfort.

Recognizing and Assessing Dyspnea

Dyspnea is a symptom, not a diagnosis. When a patient can communicate, their description of breathing discomfort is the most useful measure of symptom severity.

Helpful questions include:

- How does your breathing feel right now?
- How severe is it?
- Is it worse at rest, with movement, or when lying down?
- What makes it better or worse?
- Have medications, oxygen, inhalers, positioning, or a fan helped before?
- Are you feeling frightened, anxious, or panicked because of your breathing?

When a patient cannot communicate because of dementia, delirium, neurologic decline, or decreased consciousness, the hospice team can look for signs that may indicate respiratory distress, including:

- Restlessness or agitation
- Rapid or visibly labored breathing
- Accessory-muscle use
- Nasal flaring or grunting
- A fearful facial expression
- Difficulty settling despite repositioning or reassurance

A note about noisy breathing: Near the end of life, respiratory secretions can make breathing sound wet or noisy without necessarily meaning the patient is experiencing dyspnea. The hospice team should assess the patient's comfort rather than assume that noisy breathing itself indicates distress.

A Practical Hospice Dyspnea Approach

When a hospice patient develops or reports worsening shortness of breath, the team can consider:

1. Assess the distress
Determine what the patient is experiencing and look for observable signs when communication is limited.

2. Consider potential contributors
Think about bronchospasm, fluid overload, infection, pleural effusion, airway inflammation, retained secretions, anxiety, or progression of the underlying illness.

3. Start immediate comfort measures
Use positioning, airflow from a fan, a calm environment, reduced stimulation, breathing techniques when

appropriate, and prescribed PRN medications.

4. Consider medications and oxygen based on the clinical situation
For persistent or distressing dyspnea, opioids may provide meaningful relief. Oxygen may be appropriate when symptomatic hypoxemia is present or when the patient experiences clear comfort from it.

5. Reassess as the patient's condition changes
The medication, route, frequency, and overall respiratory regimen may need to change as functional ability declines.

What Can Caregivers Do During an Episode of Breathlessness?

Non-pharmacologic measures should be part of every hospice dyspnea plan. They may provide meaningful relief on their own and can complement medication when symptoms are more severe.

During an episode of shortness of breath, caregivers can:

- Stay with the patient and speak calmly and slowly
- Help the patient sit upright or lean slightly forward if comfortable
- Direct a small fan toward the patient's face
- Reduce unnecessary activity, conversation, noise, and other stimulation
- Loosen restrictive clothing and adjust the room temperature for comfort
- Encourage slow, paced breathing or pursed-lip breathing when the patient can participate
- Give prescribed as-needed medications according to the hospice plan
- Call the hospice team if symptoms are new, worsening, frightening, or not relieved by the established plan

A calm caregiver presence can also help because breathlessness and fear can reinforce one another. A fan directed toward the face is a particularly simple, low-burden intervention that may provide rapid relief for some patients.

Should Potential Contributors Be Evaluated?

Shortness of breath can have several contributors, some of which may be treatable. The hospice team considers the patient's symptoms, overall condition, goals of care, and the potential benefit and burden of addressing those contributors.

Potential contributors include:

- Bronchospasm or wheezing
- Fluid overload
- Infection
- Pleural effusion

- Airway inflammation
- Anemia
- Retained secretions
- Anxiety or panic
- Progression of the underlying illness

When an underlying contributor can be addressed in a way that is likely to improve comfort, the hospice team may incorporate that treatment into the patient's plan of care.

The goal is to identify opportunities to improve comfort while avoiding interventions that add burden without meaningful benefit.

Opioids for Air Hunger

For persistent or distressing dyspnea, systemic opioids are an important hospice treatment option. Their role in this setting is not limited to pain relief. Opioids can help ease the central experience of breathlessness and air hunger, making breathing feel more comfortable.

They may be used alongside non-pharmacologic measures and treatment of appropriate contributors. Treatment should be individualized based on prior opioid exposure, clinical status, organ function, route of administration, symptom severity, and goals of care.

Key principles include:

- Individualize the starting dose rather than using a one-size-fits-all approach
- Titrate according to symptom relief and tolerability
- Use the least burdensome route that remains reliable
- Consider scheduled therapy when dyspnea is frequent or predictable
- Provide appropriate bowel-regimen support when opioids are used regularly
- Reassess both benefit and adverse effects

The goal is relief of respiratory distress, not sedation for its own sake. Importantly, opioids do not need to be reserved only for the final hours of life. When breathlessness remains persistent or distressing despite appropriate comfort measures, they can be an appropriate part of symptom-directed hospice care.

When Anxiety or Panic Makes Dyspnea Worse

Breathlessness can trigger fear, and fear can intensify the experience of not being able to breathe comfortably. This cycle can escalate quickly, particularly when patients feel frightened or unable to catch their breath.

Benzodiazepines such as lorazepam may have a role when anxiety or panic is contributing significantly to respiratory distress. They are generally considered an adjunct rather than the primary treatment for air

hunger itself.

Hospice clinicians should consider the patient's current medications, level of alertness, sedation and delirium risk, history of anxiety, and response to treatment when deciding whether a benzodiazepine is appropriate.

Oxygen for Dyspnea in Hospice

Oxygen may be appropriate when a patient has symptomatic hypoxemia or experiences meaningful comfort from oxygen therapy.

However, oxygen is not automatically the best treatment for shortness of breath. For patients without symptomatic hypoxemia, oxygen may not provide meaningful additional relief, and the equipment itself can create burden.

For patients already using oxygen, the hospice team can reassess whether it continues to provide meaningful comfort and whether the equipment remains practical for the patient and family.

The goal is symptom relief, with oxygen therapy guided by the patient's symptoms, clinical condition, and response to treatment, not by a target oxygen saturation alone.

When the Route Becomes Part of the Treatment Plan

Respiratory medications can remain useful in hospice, but the way they are delivered may need to change as strength, cognition, coordination, swallowing ability, and functional status decline.

A metered-dose inhaler requires coordination between device activation and inhalation. A dry-powder inhaler requires sufficient inspiratory effort to deliver medication effectively. Frailty, tremor, arthritis, weakness, cognitive decline, delirium, and reduced inspiratory flow can make these devices increasingly difficult to use.

Continue or reassess for benefit	Consider changing or discontinuing
■ Patient can use the device effectively ■ Medication provides clear symptom relief ■ Patient prefers the treatment ■ Treatment remains consistent with comfort-focused goals ■ Benefit remains observable	■ Inspiratory flow or coordination is inadequate ■ Weakness, tremor, arthritis, or cognitive decline interferes with administration ■ Caregiver administration becomes difficult or burdensome ■ Treatment burden exceeds likely benefit ■ Benefit is unclear despite appropriate use

A caregiver-administered nebulizer may be easier for some patients, but it is not automatically a better option. Nebulized therapy still requires equipment, medication access, administration time, and caregiver involvement.

The same principle applies to bronchodilators and corticosteroids. These therapies may continue to provide meaningful benefit when bronchospasm, wheezing, airway inflammation, or another responsive condition contributes to dyspnea. As the patient declines, the team may identify opportunities to:

- Simplify complex respiratory regimens
- Remove duplicate or low-benefit therapies
- Transition to a more feasible delivery method
- Reassess maintenance therapies with unclear comfort benefit
- Reduce treatment burden when expected benefit is limited

The right medication is only useful if the patient can receive it reliably, and the right route is the one that provides meaningful comfort without unnecessary burden.

This becomes particularly important in home hospice, where medication access, formulation, administration technique, and caregiver capability can directly affect whether a symptom-management plan works.

How Dyspnea Management Changes as Hospice Patients Decline

The most appropriate respiratory plan may change significantly over the course of hospice care.

Earlier in hospice	As illness progresses
Patient may self-administer medications	Caregiver may need to administer them
Oral and inhaled routes may work well	Alternative routes may become necessary
Complex respiratory regimens may be manageable	Simplification may become more appropriate
PRN treatment may be sufficient	Scheduled therapy may become appropriate

This is why dyspnea management should be viewed as an ongoing process rather than a one-time medication decision.

Common Pitfalls in Hospice Dyspnea Management

Certain approaches can unintentionally add burden or miss an opportunity for better symptom relief.

- **Focusing on oxygen saturation instead of symptoms.** The pulse oximeter provides information but does not tell the whole story of the patient's breathing experience.
- **Assuming oxygen is always the answer.** Oxygen should have a comfort rationale rather than being used automatically for every episode of dyspnea.
- **Continuing an inhaler when effective use has become difficult.** A prescribed inhaler is not necessarily an effective inhaler if the patient can no longer use it properly.
- **Addressing anxiety without also considering air hunger.** Anxiety can amplify dyspnea, but it should not automatically replace treatment directed at the breathing discomfort itself.
- **Adding medication without reassessing the overall regimen.** A medication review may identify duplication or treatment burden before another therapy is added.
- **Waiting until swallowing becomes difficult to consider route changes.** Anticipating changes in administration can help prevent avoidable delays in symptom relief.

How Hospice Pharmacists Support Dyspnea Management

Dyspnea management can change quickly as a patient's condition and ability to administer medications change.

Hospice pharmacists can support the interdisciplinary team by:

- Optimizing opioid selection, dosing, titration, and route
- Reviewing medications for additive sedation and clinically important interactions
- Identifying therapeutic duplication in respiratory regimens
- Recommending practical formulations and delivery methods
- Supporting transitions to alternative routes when swallowing declines
- Reviewing inhaled and nebulized therapies for continued benefit
- Helping simplify medication regimens as goals shift toward comfort
- Supporting timely access to medications needed for symptom management

Effective hospice dyspnea management is therefore not simply about selecting a medication. It requires ongoing assessment, appropriate routes and formulations, regimen simplification, and timely access as the patient's condition changes.

SEE HOW BETTERRX SUPPORTS HOSPICE SYMPTOM MANAGEMENT

Dyspnea care depends on more than choosing a medication. It requires timely access, practical medication delivery, ongoing regimen review, and clinical support as a patient's needs change. **BetterRX helps hospice organizations support symptom management through clinical pharmacy expertise, hospice-specific technology, and pharmacy coordination, helping teams get the right medication and delivery method to the patient when it matters most.**

Frequently Asked Questions

Is dyspnea the same as low oxygen saturation?

No. Dyspnea is the experience of breathing discomfort, while oxygen saturation is an objective measurement. The two do not always correspond. Hospice treatment should be guided by the patient's symptoms, clinical context, and goals of care rather than oxygen saturation alone.

Can dyspnea be managed without opioids?

Yes. Positioning, a fan directed toward the face, reduced stimulation, breathing techniques, reassurance, and treatment of an appropriate contributor may provide meaningful relief. When breathlessness remains persistent or distressing, opioids are an important treatment option in hospice.

Does oxygen help shortness of breath in hospice?

Oxygen can help patients with symptomatic hypoxemia and may provide meaningful comfort for some patients. It should not automatically be started simply because a patient feels short of breath. The hospice team should reassess whether oxygen is providing meaningful benefit.

Should inhalers be stopped in hospice?

Not automatically. Inhalers should be continued when they provide meaningful benefit and the patient can use them effectively. If inhaler use becomes unreliable because of weakness, tremor, cognitive decline, or reduced inspiratory flow, the team may consider a nebulizer, a simpler regimen, or discontinuation of a medication that no longer contributes to comfort.

When should a caregiver call hospice for shortness of breath?

Call hospice when breathlessness is new, worsening, frightening, or not relieved by the established comfort plan. The hospice team should also be contacted for significant agitation, a major change in alertness, new chest discomfort, or any concern that the patient is experiencing uncontrolled distress.

Who decides whether dyspnea medications should be changed?

The hospice interdisciplinary team works with the patient and family to determine the most appropriate approach. Nurses, prescribers, pharmacists, and other members of the team contribute based on the patient's symptoms, response to treatment, abilities, preferences, and goals of care.

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