Service Priorities and Programmes

Electronic Presentations

Convention ID: 1009
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Post title: Resident, Queen Mary Hospital,

New Service: SOB program for advanced cancer patients in Queen Mary Hospital

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Keywords:
Breathlessness
Palliative
Malignancy
Non-pharmacological interventions

Introduction
Dyspnea is a common and distressing symptom reported by patients with advanced malignancy. It occurs in up to 70% of patients with advanced cancer, and the symptom is aggravated with disease progression. Because of its complex biopsychosocial etiology and manifestations, pharmacological interventions alone often could not offer adequate relief. Moreover, the use of drugs is sometimes limited by their adverse effects and doses are needed to be titrated carefully. Non-pharmacological interventions should always be combined with pharmacological methods to manage this challenging symptom.

Objectives
1) To describe a “Shortness of Breath”(SOB) program in our institution 2) An audit on the use of non-pharmacological interventions in complement with medical treatment: To evaluate the outcome after the program implementation

Methodology
Description: The SOB program was designed for all advanced cancer patients (both in-patient and out-patient) with dyspnea. It involves palliative care doctors, nurses, home care nurses, occupational therapists and physiotherapists. It aims to improve patients’ symptom by multi-disciplinary approach. Other than medications, non-pharmacological interventions including neuromuscular electrical stimulation, chest wall vibration, walking aids, use of fan, cooler temperature and occupational therapy training e.g. breathing/ relaxation exercises are offered. Patients are categorized according to the modified Medical Research Council (MRC) Scale. Those categorized into 2 or above are referred to occupational therapists and/ or physiotherapists for suitable interventions. The breathing trainings include pursed lip and diaphragmatic breathing, positioning and pacing techniques. All home care patients requiring home oxygen are encouraged to see the occupational therapists for

proper oxygen usage instructions and precautions as well as having the breathing/ relaxation training. The SOB program was implemented in our department since April 2013. Patients with dyspnea (n=56, recruited in November 2012 to January 2013) before program implementation were compared with those (n=58, recruited in April 2013 to June 2013) after implementation.

Result

After implementation of the SOB program, more patients were offered with non-pharmacological interventions (26.8% pre vs. 79.3% post-implementation). More patients received breathing/ relaxation training (7% pre vs. 75.9% post-implementation). Specifically, patients in the home-care group had improvement in symptoms after joining the program (mean: 57.7%, absolute point: 3.25, with visual analog scale). Conclusions: Breathlessness can be managed by multi-disciplinary approach. Similar program can be considered in other palliative centres.