Attitudes to Using Opioids to Treat Dyspnea in Advanced COPD: A Qualitative Study of Family Physicians and Respiratory Therapists

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Background

750,000 live with COPD.
4th leading cause of death
20,000/year

250,000 deaths/year

Many patients with advanced COPD:
- Suffer from refractory dyspnea
- Live with fear and anxiety of next exacerbation
- Place relief from dyspnea at the top[1] of their priorities for improvements to end of life care[1]

Relieving Dyspnea: Potential benefit of Opioids[2]:

Opioids could influence dyspnea by:
- a reduction in total ventilation
- an increase in ventilatory efficiency with exercise
- reduction in responses to hypoxia/hypercapnia
- reduction in the drive to breathe
- an effect on bronchoconstriction

A Cochrane review confirmed overall benefit of both oral and parenteral opioids. Both were were more effective than placebo (meta regression).[3] Never-the-less barriers to use of opioids exist at many levels.[2]

Barriers to use of opioids[2]:

Professional societies - lack of consensus on the role of opioids in the treatment of dyspnea in COPD.

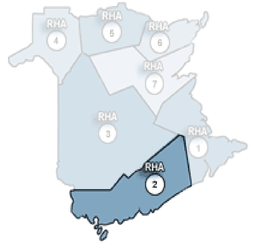
Physicians **-** discomfort and inexperience with potential side effects of sedation and respiratory depression, opioid prescribing, pharmacokinetics, titration and monitoring of clinical response.

Patients and family barriers - Fears/implications of using a narcotic often underpins initial reluctance to consider opioids. When this reluctance is overcome, the reduction of fear that morphine induces comes through consistently and for some, the improvements in quality of life have been profound.

Given the potential benefits,barriers to opioid use and building on results of a survey we presented at CHEST 2008[4], we sought to further understand attitudes to use of opioids for advanced COPD by interviewing clinicians in Eastern Canada.

Study

Design: Community based study in Southern New Brunswick, Canada



We used interpretive description, a qualitative, grounded approach developed to inform clinical practice related to the phenomenon of interest. We conducted one-on-one semi-structured interviews with a purposive sample of 10 Family Physicians and 8 Registered Respiratory Therapists. Interviews covered practice type, years of experience, comfort with dyspnea management in advanced COPD, and professionals' attitudes and barriers to prescriptions of opioids for dyspnea. Interviews were recorded and transcribed verbatim. We are presenting the results of a preliminary analysis.

Results

Family Physicians and Respiratory Therapists identify:

• Control of dyspnea as the number one challenge in treating patients with advanced COPD

• Lack of education and guidelines around use of opioids for dyspnea in advanced COPD as a significant concern

• Addiction and respiratory suppression not an issue if "imminently dying"

•Concerns re: addiction and respiratory depression increase when asked about their comfort level with using opioids to treat dyspnea over the "longer term"

For Family Physicians:

• In rural areas, *access* to education is an issue

• Because of lack of guidelines, concerns that license could be revoked if it was felt that opioids were being used irresponsibly:

> *"It's only for patients that are terminal. If they're not terminal and they're on morphine, I would have some concerns about that"*

• For Family Physicians with palliative care training:

> *"I've been very comfortable {prescribing opioids for dyspnea}. I mean, in my training, I did a full month of palliative care"*

• Some Family Physicians feel nurses (allied health) may be more "in-tune" with patients' distress because of the increased time spent with them when patients become housebound

• In treating dyspnea: *"you run out of tricks"*

• In treating COPD:

> *"like a roller coaster"* (disease trajectory)

> *"gradual downhill process…no matter what you do there's no improvement, it's disheartening"*

For Respiratory Therapists:

• As a profession - limited involvement in palliative care

• Defining "end-stages" of COPD is difficult *(few* months? *few* years?)

• Feel they have limited knowledge of treating dyspnea beyond breathing techniques, positioning, relaxation, and inhaled conventional respiratory medications

• Some suggest clinicians may wait too long to start comfort measures

• In treating dyspnea:

> *"weighs you down emotionally because sometimes you feel helpless" (in treating)*
> *"overwhelming when you don't have physicians on board…so going in to see them {patients} over and over again and not getting anywhere …can be quite discouraging"*

•For some Respiratory Therapists with palliative care exposure:

> *"if this also gets maxed out, there are no other tools in the arsenal"*

> *"I think it's {opioid treatment} crucial…I think it decreases the adrenaline response to discomfort and anxiety so that their CO_2 production starts to decrease a bit so it gives their breathing more of a chance to stabilize"*

> *"difficult providing care you feel is not beneficial; knowing opioids could work better but unable to use…(no prescription)"*

Conclusions

For both patients and clinicians, control of dyspnea in advancing COPD remains the main challenge.

Inequities in symptom control are compounded by a lack of guidelines and reflect physician comfort/ experience in this area.

Many physicians retain an aversion to use of opioids for dyspnea in advanced COPD that is not grounded in current evidence.

Clinical Implications

Further studies should explore patient experiences of opioid therapy as a treatment for the dyspnea of advanced COPD.

While we await outcomes of well designed clinical trials, can we justify denying patients with advanced COPD an approach to palliation of a symptom that is so often and so profoundly difficult to manage effectively within conventional pulmonary medicine practice?[2]

References

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