

LETTERS TO THE EDITOR

Reader Questions Benefit of Nebulized Opioids

We read with interest the continuing education article on the management of refractory dyspnea in lung cancer in the July 2005 issue of the *Oncology Nursing Forum* (Jantarakupt & Porock, 2005). The distressing symptom of dyspnea, with its impact on patients and caregivers, continues to attract rigorous research around the world. The knowledge base has progressed since 2002, and, given the nature of these advances, a need exists for this research to be reflected in clinical practice.

A systematic review on the role of opioids in dyspnea was published in 2002 (Jennings, Davies, Higgins, Gibbs, & Broadley, 2002). A long-awaited finding from this meta-analysis was that oral morphine showed measurable benefit in people with refractory dyspnea. But, contrary to the article by Jantarakupt and Porock (2005), no predictable benefit from nebulized opioids was found. Contemporaneously, the first adequately powered, double-blind, placebo-controlled trial of oral once-daily, sustained-release morphine demonstrated reductions in dyspnea of the same magnitude as the meta-analysis (Abernethy et al., 2003).

The role of oxygen also was studied in a systematic review published well before the current *Oncology Nursing Forum* article (Booth et al., 2004). In this, Booth et al. were unable to demonstrate any specific population that would derive additional symptomatic benefit from oxygen when they did not already qualify for long-term home oxygen therapy. Many of the studies included in Booth et al.'s systematic review focused on functional status and not on relief of the subjective sensation of dyspnea. As such, the conclusions currently articulated by

Jantarakupt and Porock (2005) that "some arguments remain against the use of oxygen therapy for patients with cancer" should be worded more strongly. We have no current evidence of benefit beyond that which could be offered by medical air. In response to this paucity of data, a multisite, double-blind, international study is under way comparing oxygen and medical air for normoxemic patients with refractory dyspnea (Abernethy, Currow, Frith, & Fazekas, 2005).

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Abernethy, A.P., Currow, D.C., Frith, P., Fazekas, B.S., McHugh, A., & Bui, C. (2003). Randomised, double blind, placebo controlled crossover trial of sustained release morphine for the management of refractory dyspnoea. *BMJ*, 327, 523–528.

Abernethy, A.P., Currow, D.C., Frith, P.A., & Fazekas, B.A. (2005). Prescribing palliative oxygen: A clinician survey of expected benefit and patterns of use. *Palliative Medicine*, 19, 165–172.

Booth, S., Anderson, H., Swannick, M., Wade, R., Kite, S., & Johnson, M. (2004). The use of oxygen in the palliation of breathlessness. A report of the expert working group of the Scientific Committee of the Association of Palliative Medicine. *Respiratory Medicine*, 98(1), 66–77.

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Jennings, A.L., Davies, A.N., Higgins, J.P., Gibbs, J.S., & Broadley, K.E. (2002). A systematic review of the use of opioids in the management of dyspnoea. *Thorax*, 57, 939–944.

The Authors Respond

We appreciated the commentators' interest in our article on dyspnea management for patients with cancer. Clearly, the knowledge about using nebulized opioids and oxygen for dyspnea management has progressed since our article was prepared for publication. The article we wrote was prepared from 2002–2003, and several studies were published while the manuscript was in the process of publication. After the editor reviewed the manuscript, it was accepted to publish in late 2004.

Recently, more studies have been conducted on the efficacy of morphine in relieving dyspnea. As our colleagues highlighted, Jennings, Davies, Higgins, Gibbs, and Broadley (2005) have reviewed randomized, controlled trial studies and concluded that no statistically significant improvement of dyspnea occurred after nebulized morphine. We agree that nurses and other healthcare providers have to be aware of new studies. However, Jennings et al. also noted that the data from a meta-analysis, based on included studies, were insufficient to conclude that nebulized morphine was not effective for dyspnea management. They also suggested that more research is needed to determine the most appropriate treatment regimen.

Oral morphine also has been used frequently for dyspnea management with minimal side effects. Abernethy et al. (2003) demonstrated the superiority of oral morphine for relief of dyspnea. The efficacy and safety of morphine are acceptable, and the drug could be applied to patients suffering with dyspnea. However, this was the first adequately powered, double-blind, placebo-controlled trial of oral sustained-release morphine administered daily, and several limitations were noted. Thus, when morphine is administered as suggested, nurses should be aware of the limitations of the study.

Oxygen has long been an accepted intervention to reduce dyspnea. Regardless of whether oxygen physically diminishes the sensation of dyspnea in nonhypoxic patients, we still support the suggestion that patients

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can have psychological benefits from oxygen administration. Because dyspnea causes fear and depression that in turn induce more shortness of breath, oxygen may reduce these symptoms and consequently reduce dyspnea. The reimbursement of long-term oxygen therapy is limited to hypoxic patients as indicated by arterial blood gases; despite this limitation, when patients are in the hospital, psychological benefits gained from oxygen administration are sufficient rationale to provide oxygen to dyspneic patients. Although oxygen should be used for patients who would be likely to benefit most from oxygen therapy, because controversies have appeared, more research on the topic is highly recommended. The results of the international study examining the role of oxygen in dyspnea when patients are experiencing breathlessness conducted by Abernethy, Currow, Frith, and Fazekas (2005) provides us with more information about the use of oxygen in palliative care.

Your comments have been helpful to us and are very beneficial for other healthcare providers and oncology nurse researchers. Dyspnea is a distressing symptom, and original empirical work must continue—as well as synthesis of review articles and meta-analyses—so that we can provide better, consistent care for our patients.

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Abernethy, A.P., Currow, D.C., Frith, P., Fazekas, B.S., McHugh, A., & Bui, C. (2003). Randomised, double blind, placebo controlled crossover trial of sustained release morphine for the management of refractory dyspnoea. *BMJ*, 327, 523–528.

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Reader Comments on *Oncology Nursing Forum* Editorial

I thoroughly appreciated your editorial, “Professional Aging” (Vol. 33, p. 191). I am an avid reader and take seriously that it is my responsibility to remain informed and current, often through reference reading done on my own time. I supervise a small group of novice oncology nurses in an outpatient treatment center and have encouraged them to do the same. As I read from the *Oncology Nursing Forum*, *Clinical Journal of Oncology Nursing*, the Oncology Nursing Society Web site, reference texts, etc., I always find something relevant to our practice and enriching to the knowledge needs of not only myself but to each of the newer nurses, and I will bring that article in and summarize for them what I found so helpful or exciting to learn. Usually their response is, “Where did you get that article? I’d like to read that.” More often now, I’m hearing, “Yes, I saw that article and read most of it too.”

It is all too frequent these days to find bedrock institutions (churches, for instance) accommodating their intended audiences by tweaking their product or watering down their message to the point that very little substance remains. We are left feeling “unfed.” It takes courage and integrity to stay true to one’s expressed values and objectives in the midst of those who do not. I am proud to be a member of such an outstanding professional organization like the Oncology Nursing Society, knowing that products born out of it will always reflect the mission and purpose of the society.

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Reader Inquires About Facilities That Ban Opioid Medications

Thank you for the excellent review of transmucosal fentanyl in the March 2006 *Oncology Nursing Forum* (Vol. 33, pp.

257–264). I am wondering if the author has had success in getting extended-care facilities to allow the use of this medication? One facility I recently worked with will not allow its use. The rationale is that the length of time required for its use makes it an easy target for potential confiscation (intentional or unintentional) by workers, family members, or other patients in the facility. I have requested to meet with the director of nursing and director of the facility and intend to continue to pursue this with them. I would appreciate any advice you can give me. Thank you.

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The Author Responds

As mentioned in the article, transmucosal fentanyl is an expensive product, but I have seen it used with great success in a local nursing home to assist one patient who had spinal cord injury pain. Pain episodes would necessitate trips to the local emergency room so he could receive large doses of IV opioids. Using the transmucosal fentanyl, which works like an IV bolus, kept him in the nursing home and gave everyone better control over the pain.

Diversion of drugs does exist, but I do not think it is an excuse to refuse to supply or use a certain product. Diversion is a concern with any opioid. Oral hydrocodone/acetaminophen products, common stock opioids in most settings, are some of the most abused and diverted opioids in the country. Universal precautions should be applied to all opioids.

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Correction

Caryl D. Fulcher’s, APRN, BC, name was inadvertently omitted as the author of the Clinical Challenges column, “Depression Management During Cancer Treatment,” in the January 2006 issue (Vol. 33, pp. 33–35). We apologize for the error.