THE BREATHLESS ONCOLOGY PATIENT

Introduction

Most commonly this will relate to the disease itself, a super-imposed infection or a co-morbidity (COPD).

There are a number of other important life threatening conditions that need to be considered, however:

Important considerations

These include the following:

Pulmonary embolism:

- This should always be considered unless there is another clear explanation for the dyspnoea on CXR.
- Pulmonary embolism should be considered even if the patient lacks the other "typical" signs and symptoms, as malignant disease is a significant risk factor.

Cardiac tamponade:

- This usually occurs in the setting of a known pulmonary or mediastinal tumor.
- Cardiac tamponade associated with malignancy is usually a subacute/chronic process and on CXR the heart will appear enlarged, (often considerably so)
- If pericardial effusion is suspected the patient must never be sent home until definitive investigation (echocardiography) has been done.
- The best treatment for this is pericardial window, done by a Thoracic surgeon.

SCV obstruction:

- Here again, patients usually have known pulmonary or mediastinal tumor.
- This condition requires high dose steroids and consideration for radiotherapy, chemotherapy or an SVC stent.

Pleural effusion:

- This is not usually immediately life threatening.
- If very large drainage in the Emergency Department will provide symptomatic relief.
- Smaller effusions or patients with previous scarring due to surgery (or if there is diagnostic uncertainty) are best referred to radiology for this procedure, where it can be done under ultrasound guidance.
- It is best managed at second presentations with a VATS pleurodesis rather than recurrent attempts at drainage.

Atypical infections/PCP:

- This should be considered, especially in cases of bilateral infiltrates on CXR.
- This is more likely with patients on immunosupressives or high dose steroids. Many patients will be receiving intermittent high dose steroids for anti-emesis with chemotherapy.

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