palliative care unit. He also had chronic rhinitis and mild impaired consciousness caused by Parkinsonian syndrome; his performance status was 4. One day, he complained of dyspnea and uncomfortable respiration without respiratory failure. Initially, there were no identifiable causes of dyspnea on clinical examination. We then examined the nasal cavity and detected an enormous volume of dried nasal mucus bilaterally in the nasal cavity (Fig. 1).

After removing the dried nasal mucus with tweezers, the dyspnea immediately disappeared. The same symptom was reported again two weeks later, and the same treatment proved effective. We periodically examined the nasal cavity and applied moisturizing cream to the region. Once this protocol was enacted, the dried nasal mucus no longer accumulated.

Case 2

A 70-year-old man with a three-month history of hepatocellular carcinoma and mild impaired consciousness from hepatic encephalopathy was admitted to the palliative care unit. His performance status was 4. He previously lost swallowing function and, therefore, was fed using a nasogastric tube. One day, he complained of dyspnea and uncomfortable respiration without respiratory failure. On clinical examination, a large amount of dried nasal mucus was detected bilaterally in the nasal cavity. The nasal mucus was removed in a manner similar to that used for Case 1, and his respiratory symptoms were similarly relieved.

Comment

Dried nasal mucus comprises a desiccated piece of nasal mucus and dust from the air. Relatively large accumulations of dried nasal mucus cause discomfort and respiratory symptoms; however, most patients can eject the debris on their own. Therefore, dried nasal mucus does not typically grow to an extremely large size. Patients with advanced cancer often have impaired consciousness and cannot eject dried nasal mucus themselves; thus, the debris can grow to enormous size. Large pieces of dried nasal mucus obstruct the nasal cavity, resulting in dyspnea. In these cases, the patient compensates by breathing through the mouth; this ensures that oxygen saturation does not decrease. If we can assess the cause of dyspnea appropriately, then treatment is simple and easy and does not require medication or oxygen supplementation. In our experience, patients at a high risk of recurrence of dried nasal mucus obstructions may be any patient with an impaired consciousness, low performance status, nasal tumor, nasal catheter or oxygen cannula, and chronic rhinitis.

Although observation of the nasal cavity is sometimes forgotten and easily overlooked, examination is an important component in relieving dyspnea in patients with advanced cancer.

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References


Re: Recommendations for Bowel Obstruction With Peritoneal Carcinomatosis by Laval et al.

To the Editor:

Laval et al. are to be commended for their comprehensive review article on management of malignant bowel obstruction (MBO) in patients with peritoneal carcinomatosis. They address an issue, however, which I would like to comment on from a palliative care perspective. Current evidence does not support their statement that “rehydration is needed for virtually every patient.” An earlier observational study on patients with MBO reported intravenous volume depletion with signs of fluid retention, regardless of artificial hydration (AH) administration. According to a large survey conducted by the same group, health...
care professionals witnessed volume-dependent adverse effects of AH on patients with terminal cancer. The lack of benefit of AH on dry mouth and thirst in MBO, a correlation of large AH volumes with an increase of bowel secretions, but also possible preventive effects of AH on metabolic symptoms, have to be considered. Moreover, focusing on the last week of life in cancer patients, a systematic review found conflicting evidence of AH effects: Although some studies reported improved nausea and dehydration symptoms, others found increases of ascitic fluid and gastrointestinal secretions. Finally, a recent randomized placebo-controlled trial was not able to demonstrate any benefit of AH in terms of symptom control, quality of life, and survival. Being aware that these studies include conditions other than MBO, most of the observed patients share common features, such as dehydration, edema, abdominal symptoms, low serum albumin levels, and a very poor prognosis. Thus, an individual risk-adapted approach that carefully balances harms and benefits of AH seems more appropriate than a global recommendation in favor of this intervention.

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Pain Assessment Using the Critical-Care Pain Observation Tool: Comment on Li et al.

To the Editor:

The recent report on pain assessment using the Critical-Care Pain Observation Tool (CPOT) is very interesting. Li et al. concluded that “The CPOT has good psychometric properties and can be used as a reliable and valid instrument for pain assessment.” In fact, there are some concerns regarding the use of the CPOT.

First, the tool still has limitations in some situations. Gélinas et al. noted that the tool should be further assessed in “critically ill populations (e.g., head injury).” Second, Gélinas et al. also found that the tool “did not allow an effective communication” among critical care team members. Finally, it also was reported that the CPOT assessment has a poor relationship to patient self-report.

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References

Author’s Reply

To the Editor:

We read with great interest the correspondence from Dr. Wiwanitkit about our recent report in the Journal of Pain and Symptom Management. In our report, we concluded that “The CPOT [Critical-Care Pain Observation Tool] has good psychometric