Respiratory Tract Secretions

Respiratory tract secretions are generally seen only in dying people who are too weak to expectorate and are no longer able to clear their oral and upper airway secretions. The pooled secretions in the oropharynx and bronchi vibrate as air moves over them. It is audible and is described as noisy, rattling, gurgling and unpleasant. It is often called the 'death rattle'.

Definition

Classifications

- **Type I** due to salivary secretions.
- **Type II** due to accumulated bronchial secretions in the presence of pulmonary disease and infections, tumour, fluid retention or aspiration.

Studies suggest that people who develop noisy respirations have the following risk factors:

- Lung cancer
- Chest infections, i.e., pneumonia
- Brain tumours
- Head and neck cancers
- Pulmonary diseases, i.e., asthma, bronchitis, bronchiectasis
- Neuromuscular disorders, i.e., myasthenia gravis, Guillain-Barre syndrome
- Cystic fibrosis
- Cardiac arrest
- Heart failure
- Cessation of steroids in cerebral involvement.

These situations are associated with an increase in oral, bronchial mucous and exudative secretions.

Assessment

1 Consider the person's diagnosis – does the person have the risk factors? Is the breathing noisy and rattily? There are no standardised assessment tools to classify or measure the intensity of secretions, but some research has used subjective noise scores.

2 Consider the distress of the person – are they restless or frowning?

3 Consider the distress of the person's family/whānau and carers – they may be anxious and fear the person is choking to death or drowning. Approximately half of those relatives and friends who witness it, as well as hospital staff, find the noise of respiratory tract secretions distressing.

Respiratory Tract Secretions

Holistic considerations

Reflect on: Te Whare Tapa Wha principles (Durie 1994)

Emotional considerations:	What does this symptom mean for the family/whānau?
Spiritual considerations:	Are there any considerations that need to be taken into account around this time?
Social considerations:	How does this symptom affect family/whānau?
Physical considerations:	

1 Anticipate problems if the person has the risk factors that increase airway secretions.

2 Reposition the person, often on their side in a semi-recumbent position, to facilitate postural drainage. Or raise the head of the bed and prop up the person with pillows.

3 Carefully assess hydration and reduce or cease parenteral fluids if required.

4 Explain the changes being observed in the dying person to the family and whānau. Communicate with compassion and sensitivity. Reassure the family the reason their loved one is not able to cough or clear their throat is due to their unconscious state – the person is not usually distressed.

5 Use distraction therapy, e.g., music, TV, family talking and reminiscing.

6 Use aromatherapy therapy, e.g., any of the following essential oils in an aroma burner or vaporiser: eucalyptus, cypress, ylang ylang, lavender, lemon, lime, cypress, marjoram, cedarwood.

7 Regularly provide mouth and lip care. Wipe away any dribbling with tissues. Use appropriate mouth swabs, e.g., Den Tips® Disposable Oral Swabs, to gently wipe any loose secretions out of the person's mouth if they allow it.

8 If the person has been receiving supplementary oxygen, it may no longer be necessary and can be discontinued. If the person remains on oxygen and thick secretions are a problem, add humidity if the device allows it.

9 Suctioning is not normally used in palliative care. In some hospitals, tracheal aspiration may be performed by skilled personnel, clearing secretions before anticholinergic drugs are started – this remains a complex and difficult procedure.

10 Many studies indicate a need for further research in order to develop 'best practice' standards.

Respiratory Tract Secretions

Early intervention may enable more successful management of this symptom

RESPIRATORY TRACT SECRETIONS

PRESENT

- Explain symptom to family and whānau
- Re-position person
- If persistent and causing distress

1. Give STAT dose
   hyoscine Butylbromide 20 mg
   Q2-4 hourly via subcutaneous line

2. Prescribe PRN dose
   hyoscine Butylbromide 20 mg
   Q2 hourly PRN via subcutaneous line
   (**Maximum 120 mg in 24 hours).**

Review within 6 hours:
If symptoms persist and stat dose **was** helpful, consider:
HYJOSCINE BUTYLBROMIDE
40 – 80mg over 24 hours via CSCI
(**Maximum total daily dose of 120 mg in 24 hours).**

If symptoms persist, consider contacting the Specialist Palliative care team for advice

ABSENT

Review if the person has known risk factors fo excessive secretions (as above).

These situations are associated with an increase I oral, bronchial mucous and exudative secretions.

Prescribe PRN dose
hyoscine Butylbromide 20 mg
Q2 hourly PRN via subcutaneous line
(**Maximum 120 mg in 24 hours).**

If respiratory tract secretions occur change to "PRESENT" guide.

PRN *(as required)*
Q *(not more often than every)*

Anticipatory prescribing in this manner will ensure that in the last hours and days of life ther is no delay responding to a symptom if it occurs.

If you require further advice 24hrs each day 7 days a week please contact the Specialist Palliative Care Service at Mercy Hospice - PH (09) 3615966

Acknowledgement to Ministry of Health for sharing Resources Te Ara Whakapiri
Reviewed: 01.2019
Resource Folder - Section: 4