The management of hiccups in terminally ill patients

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Abstract
There is a reasonable amount of literature on the subject of hiccups. However, the evidence shows that existing practice relies heavily on anecdotal case reports and clinical experience. Hiccups affect talking, eating and sleeping, and can lead to weight loss, exhaustion, anxiety and depression, all factors affecting quality of life.

According to Wilcock and Twycross (1996) hiccups are ‘caused by a sudden involuntary contraction of one or both sides of the diaphragm associated with closure of the glottis’. Persistent hiccups are those that last more than 48 hours, whereas intractable hiccups are those that last more than one month (Lewis, 1985).

Common causes of hiccups in terminal disease include gastric distension, gastro-oesophageal reflux, diaphragmatic irritation, phrenic nerve irritation, toxicity and central nervous system tumour (Twycross and Wilcock, 2001).

Intractable hiccups are occasionally seen in patients with a terminal disease, and can be a distressing symptom for some. It is important to elicit from the patient how a symptom affects them as an individual, in order to be able to plan care that effectively improves their quality of life.

Nursing management
A review of the literature shows that the effective management of hiccups depends on the patient and how they respond to a particular pharmacological approach.

Learning objectives
Each week Nursing Times publishes a guided learning article with reflection points to help you with your CPD. After reading the article you should be able to:

- Explain the physiological causes of hiccups;
- Understand the effect of hiccups on a patient’s quality of life;
- Know the pharmacological interventions for hiccups;
- Describe the non-pharmacological interventions for hiccups.

Reference

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Box 1. Case study
A 55-year-old man with metastatic cancer of the colon with subacute bowel obstruction was admitted to a hospice. He was distressed by his inability to drink as this caused heartburn and more hiccups. He was not sleeping well due to abdominal distension and felt low in mood.

Metoclopramide did not alleviate the hiccups. Haloperidol resolved the hiccups for approximately two days, and when they did return they were less severe. Haloperidol was added to his syringe driver and the hiccups were resolved. He was able to drink more and his mood lifted.

The case study in Box 1 describes a patient who had hiccups caused by gastric distension, the most common cause of hiccups in terminal illness (Wilcock and Twycross, 1996). Metoclopramide did not relieve the condition. However, other case reports have found metoclopramide to be effective (Slipman et al, 2001).

Wilcock and Twycross (1996) discuss the case of two terminally ill patients suffering with hiccups where chlorpromazine, metoclopramide, dexamethasone, haloperidol and baclofen were used, all of which had been ineffective. Midazolam was given to relieve the patient’s distress and the hiccups stopped.

In a study by Ramirez and Graham (1992) baclofen was evaluated in a double-blind randomised controlled trial and found to successfully terminate intractable hiccups. In this study, four men with intractable hiccups received baclofen and their hiccup-free periods increased by 69 per cent.

The use of pharmacological approaches has been questioned because of the potential for adverse reactions in patients who are terminally ill. De Ruyscher et al (1996) found that for one patient domperidone, chlorpromazine, haloperidol and nifedipine had been ineffective. However, the regular use of nebulised saline during the day and as required overnight was found to be effective.

Metoclopramide and baclofen aim to relieve gastric distension by improving gastric emptying and relaxing the diaphragm. They are also important to assess the patient’s bowel functioning and to treat constipation, if indicated, as this may...
be contributing to the gastric distension. If the hiccups are not resolved by this, haloperidol and chlorpromazine could be used with the aim of suppressing the hiccup reflex.

Non-pharmacological approaches (Box 2) are worth consideration but may not be appropriate for patients in the terminal stage of their disease. Alternative therapies such as acupuncture and hypnotherapy have been reported as effective treatments (Department of Health, 2002).

**Impact on quality of life**

An understanding of the palliative care needs of patients is based on the central concept of quality of life.

A broad understanding of a patient’s quality of life is achievable by asking them how they view their life. A more focused understanding can be obtained by asking how they view their symptoms and functioning.

Quality of life is subjective not only between individuals, but also for individual patients as they travel through their illness trajectory. This is a concept known as the response shift, where patients are able to change their perception of their quality of life accordingly as their illness progresses (Rees et al, 2004).

In palliative care, tools that can be used to measure a patient’s quality of life include the Quality-of-Life Index and the Hospice Quality-of-Life Index (McMillan, 1996). Such tools can be used to measure outcomes in health care but could be further developed to accurately measure quality of life in respect of the response shift (Rees et al, 2004).

Quality of life is multifaceted and can challenge an individual’s view of the world. In illness, the patient may be challenged by the symptoms they experience and question their psychosocial, spiritual and physical sense of self and the meaning this places on relationships with those close to them. These challenges may influence a patient’s decision-making with regard to treatment options as the side-effects of therapies may affect their quality of life (Mystakidou et al, 2002).

Hiccups can often cause severe distress and they can consequently affect the quality of life for some terminally ill patients. Indeed, persistent hiccups can effect the way patients talk, sleep, eat and drink, and in some can lead to weight loss, exhaustion, anxiety and depression (Wilcock and Twycross, 1996).

For example, the patient discussed in the case study (Box 1) was low in mood and despondent because of his persistent hiccups.

The levels of anxiety and emotional distress suffered by a patient may contribute to hiccups. In palliative care, understanding the patient’s perception of the impact of the symptom on his/her quality of life is essential in order to alleviate distress and promote comfort.

**Conclusion**

Self-awareness of communication skills is vital in order to achieve effective symptom management for patients. The NICE guidance Improving Supportive and Palliative Care for Adults with Cancer (NICE, 2004) highlights the importance of professionals being able to communicate with patients. Skills that encourage the patient to explore the impact the symptom has had on their quality of life from a physical, psychosocial and spiritual perspective is fundamental in palliative care.

Reflective practice may help professionals to question and challenge assumptions about quality of life and what may be considered to be ‘normal’. Implementing a tool into clinical practice to measure quality of life for patients may improve the outcome of patients’ care.

The effective management of symptoms (hiccups being an example) is dependent not only on a number of clinical approaches but also on the support offered by the multidisciplinary team. Listening to the patient’s feelings and fears may help them to put the symptom into context and help them to view their quality of life with new hope and meaning.

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**REFERENCES**


NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer. London: NICE.


