

Miscellaneous Symptom 'Round-up'

Laura Edwards

Introduction

- Breathlessness
- Cough
- Itch
- sweating
- Hiccups



Breathlessness

- Common in patients with advanced cancer
- 90-95% patients with COPD, 60-90% heart disease, also renal disease, neuromuscular disease
- an independent predictor of survival second only to performance status



Pathogenesis

- Central pattern generator in brainstem-modulated by higher centres, chemoreceptors, airways (distortion, collapse), respiratory muscles (weakness, fatigue)
- voluntary control allows this to be overridden. During exertion there is an increase in the work of breathing reflecting increased motor command to the respiratory muscles. In health this is matched by an appropriate increase in ventilation.
- Breathing in health thus perceived as comfortable.

Pathogenesis

- Where the mechanical response cannot meet the demands of the motor command there is a mismatch
- e.g. increased ventilatory drive (e.g. exercise, panic), muscle abnormalities, increased resistance, reduced ventilatory efficacy e.g. disease of lung parenchyma/
Vasculature
- Perceived as abnormal or unpleasant

Correctable Causes

- Infection/COPD/Asthma
- PE
- Hypoxia
- Obstruction trachea/bronchus , SVCO
- Lymphangitis carcinomatosa
- Ascites
- Pleural or Pericardial effusion
- Anaemia
- Heart failure
- Respiratory muscle weakness e.g. MND



Non-pharmacological management

- Positioning
- Explore meaning of breathlessness to patient
- Breathing control advice
- Relaxation techniques
- Fans
- Maximise functional ability e.g. OT, PT, SW, DN

Pharmacological management

- Consider trial of bronchodilators
- Opioids-most beneficial when patients are breathless at rest, if only on exertion it is quicker to rest then seek out a dose of oramorph
- Opioids reduce the ventilatory response to hypercapnoea, hypoxia and exercise.
- Improvement is seen at doses that do not cause respiratory depression
- Start with 2.5-5mg PRN and titrate
- Anxiolytics do not have a specific anti-breathlessness effect but there is an association between breathlessness and anxiety- so they help but use limited by sedation
- Oxygen-only better than air in severe hypoxia



Cough

- Mechanical or chemical stimulation of stretch and C-fibre receptors in the airway or other structures innervated by the vagus, trigeminal or phrenic nerves
- Afferent inputs terminate in nucleus tractus solitarius in the brain stem, input allows it to be voluntarily induced or suppressed



Management

- A wet cough usually serves a purpose, a dry cough should be suppressed
- Wet cough-physio, postural drainage, saline nebs, chemical mucolytic e.g. carbocisteine
- Dry cough- simple linctus, codeine then morphine n.b. If already on an opioid there is no point!



Management

- Opioid antitussives act centrally via a serotonergic mechanism to decrease the release of glutamate.
- No practice recommendations on Cochrane but morphine and codeine helpful
- Also sodium cromoglycate
- Gabapentin in idiopathic chronic cough
- Diazepam in intractable cough secondary to lung mets.



Hiccup

- An involuntary reflex characterized by sudden (usually unilateral) repetitive contraction of the diaphragm with abrupt closure of the glottis

Causes

- Gastric distension, reflux, gastritis (most cases)
- Cholecystitis
- Diaphragmatic or phrenic nerve irritation
- Metabolic
- Toxicity-fever, infection
- Drugs-alcohol, benzodiazepines, opioids (?delayed gastric emptying)

Management

- Measures to reduce gastric distension
- Correct biochemical abnormalities
- If irritation of diaphragm-try baclofen
- Peripheral or central nerve lesion-gabapentin
- Pharyngeal stimulation-folk remedies, ice-cold Greek yoghurt, elevation of PaCO₂- breath-holding

Pharmacological Management

- PPI, prokinetics
- peripheral cause-baclofen
- Central cause-metoclopramide (haloperidol, chlorpromazine)
- End of Life Care-midazolam

EXCLUSIVE

JENNIFER MEE

HICCUP GIRL, CONVICTED OF MURDER

abc

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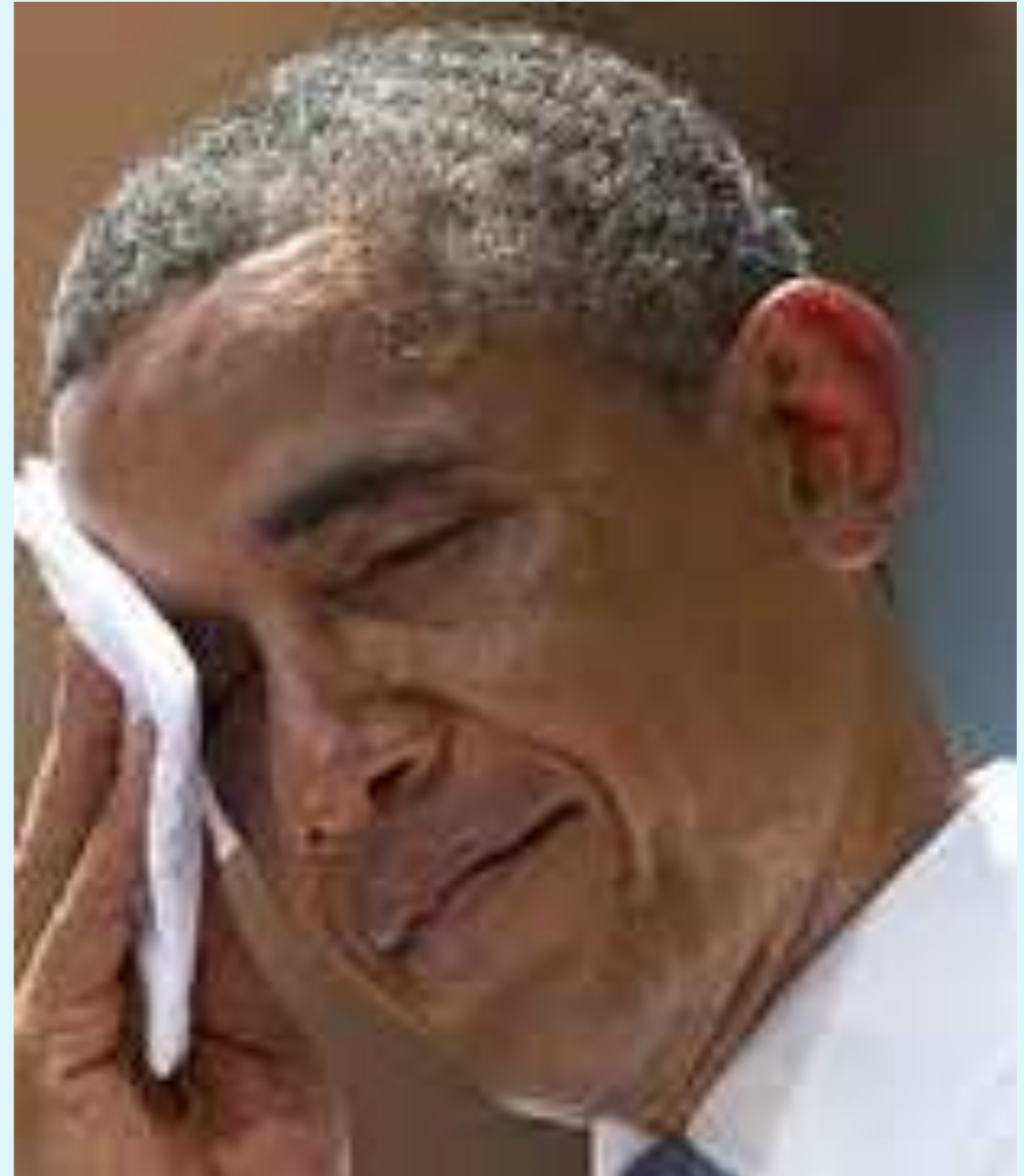
Sweating

- Hyperhidrosis (excessive sweating)
- Nocturnal diaphoresis (night sweats)
- In palliative care mostly hyperhidrosis
- Other causes-endocrine, menopause, infections, cancer, withdrawal of some medication



Evidence?

- Megace, - in hormone-related sweats
- Mirtazapine-some benefit in non-palliative care setting
- NSAIDS- in neoplastic fever
- SSRIs in post-menopausal women
- Thalidomide-in distressing sweating in terminal disease
- Venlafaxine-in hormone-related sweats (but can also cause them)



Try

- Breast cancer-megace, venlafaxine, gabapentin
- Prostate cancer-megace, diethylstilboestrol, cyproterone, venlafaxine
- Endometrial Ca-megace
- Localised-botulinum toxin, aluminium hydroxide
- Generalised-NSAID, SSRI, venlafaxine, thalidomide
- Consider an antimuscarinic eg amitryptilline-but this can also cause sweats
- There is some evidence for acupuncture



Itch

- Pruritus-An unpleasant sensation which provokes a desire to scratch
- Histamine is only a causal factor in itch of cutaneous or mucosal origin and has no place in the management of central itch
- Similar pathway to pain- C-fibres



Causes

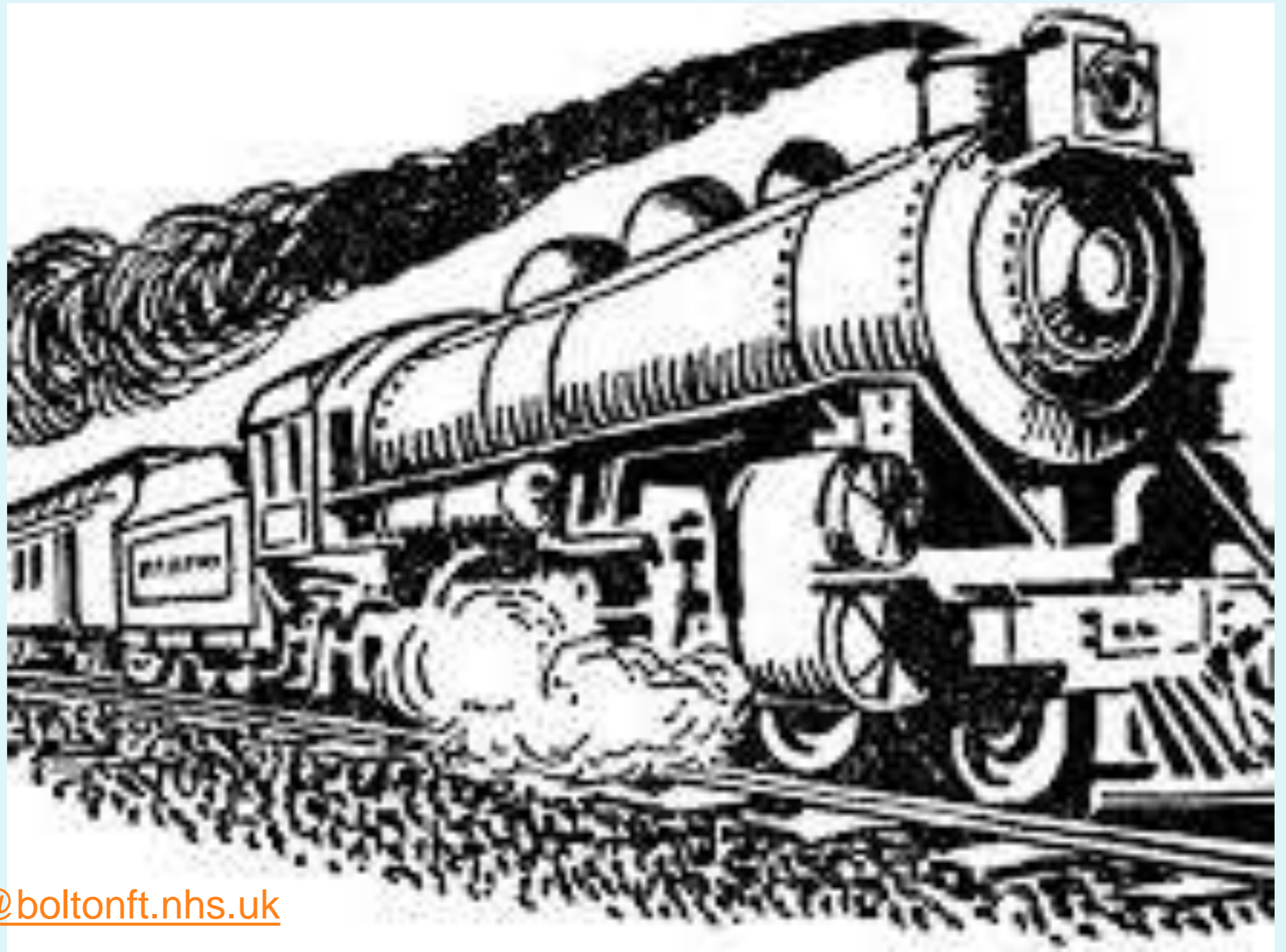
- Primary skin disease
- Drugs n.b opioids
- Systemic disease e.g. chronic renal failure, cholestasis, hepatitis, haematological, hyper and hypothyroidism, cancer, MS, Psychosis

Management

- Rehydrate skin
- Stop causative medication if possible
- Relieve biliary obstruction
- Non-drug measures-gentle rubbing, keep nails short, avoid hot baths, pat skin dry after bathing or use a hair dryer on cool setting

Pharmacological Treatment

- **Topical**-emollients, phenol (anaesthetises cutaneous nerve-endings), menthol (counter irritant)
- **Systemic**-night sedation, steroids for inflamed (not infected skin)
- **Ondansetron**-5-HT involved in itch of renal failure and cholestasis
- **Cholestasis**-rifampicin (inhibits uptake of bile acids by hepatocytes), sertraline
- **Uraemia**-gabapentin
- **Lymphoma**-prednisolone (cimetidine)
- **Paraneoplastic**-paroxetine, mirtazapine



- Thank you

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