

# 7.3 Symptoms other than pain 634

# 7.3 Symptoms other than pain 634

ESSENTIALS Common symptoms in life-limiting illness include pain, fatigue, anorexia, nausea, constipation, and dyspnoea. These may be due to disease or disease progression, treatment side effects, an inter-current acute problem, or comorbidity. Effective treatment always depends on making as precise a diagnosis as possible (e.g. pharmacological management of nausea and vomiting is guided by the presumed mechanism). Symptoms can also herald an emergency (e.g. sepsis, delirium, spinal cord compression), when the patient's frailty, likely prognosis, and own values and wishes need to be taken into account in planning management. Individualized assessment and decision-making are vital. Introduction A symptom is a patient's complaint or problem. The principles of symptom management are:

1. Identify the cause of the symptom by history, relevant examination and investigation
2. Clarify the meaning of the symptom with the patient
3. Treat the cause, if possible
4. Treat the symptom, while the cause is being treated, and especially if the cause cannot be treated
5. Provide explanation and education
6. Pharmacological and nonpharmacological treatments should be considered
7. Frequent or continuous symptoms need regular treatment, not as-required treatment
8. Oral treatment is simple and usually as effective as parenteral treatment Common symptoms in life-limiting illness include pain, fatigue, anorexia, nausea, constipation, and dyspnoea (Table 7.3.1). Patients with life-limiting illnesses often have multiple comorbidities and might be on many medications. The management of symptoms needs to take account of the cause of the symptom, the patient's goals and wishes, the existence of comorbidities, the patient's prognosis, and the effect of polypharmacy. When there are multiple symptoms, discussion with the patient and clinical assessment are needed to prioritize how symptoms are dealt with. Symptoms may be due to:
9. Disease or disease progression
10. Treatment side effects

11. Intercurrent acute problem

12. A comorbidity An important part of symptom management is the realization that although a patient has a life-limiting illness, active medical intervention to treat symptoms, avoid harm, and improve quality of life are important. A fatalistic approach should be avoided simply because a patient has been identified as having palliative care needs or a life-limiting illness. Symptoms might indicate an emergency, a serious medical problem requiring treatment to prevent significant harm, or a negative impact on the patient's life (Box 7.3.1). Nausea and vomiting Nausea and vomiting may arise from a variety of causes. Assessment follows the usual format of history, examination and investigation to establish the likely diagnosis.

7.3 Symptoms other than pain Regina McQuillan Table 7.3.1

| Common symptoms in life-limiting illness | Symptom | Cancer | Heart disease | COPD      | Pain   |
|--|---------|--------|---------------|-----------|--------|
| Depression                               | 3-77%   | 9-36%  | 37-71%        | Anxiety   | 13-79% |
| Confusion                                | 6-93%   | 18-32% | 18-33%        | Fatigue   | 32-90% |
| Insomnia                                 | 6-96%   | 36-48% | 55-65%        | Nausea    | 6-68%  |
| Constipation                             | 23-65%  | 38-42% | 27-44%        | Diarrhoea | 3-29%  |
|  |         |        |               | Anorexia  | 30-92% |

7.3 Symptoms other than pain 635 History • Onset, precipitating, and relieving factors • Volume, content (including haematemesis) of vomitus • Symptoms such as anorexia, early satiety, and belching, which may be associated with squashed stomach or delayed gastric emptying due to obstruction or gastroparesis • Symptoms suggestive of contributing causes (e.g. constipation, renal failure, brain metastases, thirst and/or confusion) that may suggest hypercalcaemia or infection • Medication changes Examination guided by history to check for: • Dehydration • Hepatomegaly • Constipation • Bowel obstruction Investigations • Electrolytes, (including corrected calcium in cancer) • Renal function, as renal impairment may cause nausea • Liver blood tests for evidence of liver metastases • Full blood count, for evidence of infection • Radiology, depending on likely cause Reverse the reversible If a cause can be found for the nausea, that should be treated (e.g. treatment of infection or hypercalcaemia). Other causes of nausea may be more difficult to treat (e.g. renal failure), and the benefits and burdens of treatment need to be considered in light of the patient's performance status, likely prognosis, and treatment preferences. Nonpharmacological management of nausea and vomiting include modifying the diet (small meals), avoiding precipitants (e.g. smells), and providing education to the patient and family. Treatment Pharmacological management of nausea and vomiting is usually guided by the presumed mechanism (Table 7.3.2). Motility disorders, for example, gastroparesis, may respond to prokinetic such as domperidone 10 mg tds. Domperidone does not cross the blood-brain barrier. Higher doses of domperidone can be tried, up to 90 mg daily, but there is a risk of QT prolongation. Metoclopramide can be used; the dose is 10 mg tds. Metoclopramide crosses the blood-brain barrier and there are risks of extrapyramidal side effects. The European Medicines Agency has recommended that metoclopramide be used for no more than five days at a time. Chemotherapy-related nausea and vomiting, use 5-HT<sub>3</sub> antagonists, metoclopramide or steroids (e.g. dexamethasone 4 mg daily). Intracranial disorders, including brain metastases, use anticholinergics (e.g. cyclizine or levomepromazine). Nausea can be multifactorial, and a combination of antiemetics might be needed. Antiemetics should be tried at appropriate doses and given regularly if the nausea and vomiting are frequent or continuous. If a patient has severe nausea or vomiting, the antiemetic might not be absorbed and might not be effective. Parenteral antiemetics might be needed, as bolus injections (subcutaneous, intramuscular, or intravenous),

or as a subcutaneous infusion or an intravenous infusion. Constipation Constipation is common in patients with life-limiting illness. Prevention is important, by education, regular assessment, and nonpharmacological measures, including dietary modification (which can be difficult in the context of advanced illness and anorexia), attention to hydration and exercise, where possible. Laxatives should be chosen depending on tolerability to patient. Laxatives are in two main groups: one group are stool softeners, the others are stimulant; most have a mixed action. Start with a stimulant laxative and titrate to maximum dose tolerated before adding a second drug. Treatment See Table 7.3.3. Breathlessness If there is a sudden onset of severe dyspnoea, consider whether this is an emergency, such as stridor, pulmonary embolus, or mucus plugging, and what should be the urgent management of the patient. Dyspnoea is often multifactorial, and difficult to manage pharmacologically. Look for a reversible cause, which might be Box 7.3.1 Case vignette Mrs KL is a 68-year-old lady who attended her GP with right upper quadrant (RUQ) discomfort and weight loss. She is a heavy smoker, had GOLD stage 11 chronic obstructive pulmonary disease (COPD), and hypertension. She was evaluated by her GP, who found new hepatomegaly, and arranged blood tests and a liver ultrasound which showed liver metastases. Her GP was concerned that she may have lung cancer and she was referred for urgent assessment. An ultrasound-guided liver biopsy showed adenocarcinoma, consistent with an upper gastrointestinal (GI) cancer. A gastroscopy (OGD) and biopsy confirmed gastric cancer. Mrs KL was referred to an oncologist. Mrs KL was told that surgery and radiotherapy were not possible. She was offered palliative chemotherapy to reduce symptoms and prolong life but she refused this. She was started on regular paracetamol 1gm tds for her RUQ pain. Two weeks later she attended her GP with anorexia. She felt very full after eating a small amount of food. Mrs KL missed not being able to eat meals with her family and feared wasting away before she died. Her GP advised small meals and snacks, discussed the natural history of cancer, and prescribed domperidone 10 mg tds. Her anorexia persisted. Her GP prescribed steroids as dexamethasone 4 mg daily. Mrs KL declined as she had had side effects with steroids in the past. Mrs KL decided to continue with a modified diet of small meals and snacks. Three weeks later Mrs KL complained that every evening she has a large vomit including food she ate earlier that day. Her GP was concerned that she might have gastric outlet obstruction. She was referred for an urgent OGD, and was found to have an obstruction which was successfully stented and Mrs KL was able to eat small meals again. Two weeks later, Mrs KL presented with increased abdominal pain in her RUQ, despite regular paracetamol. She felt she had too many tablets to take. Her GP decided to start on her on low-dose morphine slow release, 5 mg twice a day, and stopped the paracetamol. She also prescribed a laxative, senna two tablets at night, to prevent constipation. As a result of her comments about medication, her GP reviewed her drugs and stopped medication for secondary prevention of cardiovascular disease, including aspirin, statins, and angiotensin-converting-enzyme (ACE) inhibitors.

636 Section 7 Pain and palliative care disease related or due to comorbidity, such as pleural effusion, lower respiratory tract infection, acute exacerbation of congestive cardiac failure, or chronic obstructive pulmonary disease (COPD) (Box 7.3.2). Nonpharmacological management includes respiratory rehabilitation techniques such as positioning, breathing techniques, anxiety management, and managed exercise. Cold air, from a fan blowing across the face, may also be helpful. There is good evidence for the use of opioids. Morphine 2 mg orally every 4–6 hours can be tried and titrated to effectiveness, or side effects, or lack of benefit. If a dose is reached that is beneficial, a modified release preparation can be used. Benzodiazepines such as lorazepam 500 micrograms every 4–6 hours, diazepam 2–5 mg at night (long half-life) or subcutaneous (SC)

midazolam 2 mg at 4–6 hourly intervals are sometimes used, but there is less evidence to support this.

**Table 7.3.2 Pharmacological management of nausea and vomiting guided by the presumed mechanism**

| Cause  | Associated symptoms and signs   | Treat cause   | Drug and dose  |
|--|---|---|--|
| Mouth problems, including dry mouth, candida                           | Dry mouth, coated tongue, mouth soreness  | Treat candida   | Oral hygiene   |
| Treat dry mouth  | with artificial saliva, saliva stimulant (e.g. pilocarpine, use of chewing gum to increase saliva production) | Squashed stomach  | Early satiety, belching, hiccups   |
| Small meals  | Metoclopramide 10 mg tds (up to 90 mg daily) <sup>a</sup>   | Domperidone 10 mg tds (up to 90 mg daily) <sup>b</sup>  | Gastroparesis  |
| Early satiety, belching, hiccups                                       | Small meals   | Metoclopramide 10 mg tds (up to 90 mg daily) <sup>a</sup>   | Domperidone 10 mg tds (up to 90 mg daily) <sup>b</sup>                                 |
| Gastric outlet obstruction   | Early satiety, belching, hiccups, vomiting of recent meals  | Refer for possible stenting   | Hypercalcaemia   |
| Associated symptoms of hypercalcaemia, thirst, constipation, confusion | Treat raised calcium  | Renal failure   | Nausea, associated renal failure symptoms, confusion, urinary symptoms                 |
| Weigh benefits and burdens of active management of renal failure       | Cyclizine 50 mg tds   | Haloperidol 0.5–2 mg daily  | Levomepromazine 6–12 mg daily  |
| Chemotherapy-related   | Related temporally to chemotherapy; different types of treatment cause nausea and vomiting at different times | Discuss with oncologists  | Raised intracranial pressure   |
| Worse in morning, associated headache; Vomiting with little nausea     | Weigh benefits and burdens of palliative radiotherapy and/or chemotherapy                                     | Trial of steroids to reduce associated oedema.  | Cyclizine 50 mg tds  |
| Levomepromazine 6–12 mg daily  | Bowel obstruction   | Vomiting, absolute constipation; in subacute obstruction, alternating constipation, and diarrhoea | If likely to be a single site of obstruction- consider if surgery or stenting possible |
| Trial of steroids. Trial prokinetics in subacute bowel obstruction.    | Cyclizine 150 mg daily as SC infusion +/- haloperidol 1–2.5 mg daily  | <sup>a</sup> Recent guidance related to extrapyramidal side effects                               | <sup>b</sup> Risk of prolonged QT syndrome   |
| <sup>c</sup> Unlicensed use  | <b>Table 7.3.3 Constipation treatment</b>   | Example   | Start dose   |
| Speed of action  | Oral softener   | Macrogols   | Polyethylene glycol 1–3 sachets daily  |
| 1–3 days   | Osmotic laxatives   | Lactulose 15 ml twice daily   | 1–2 days   |
| Surfactants  | Docosate 500 mg daily in divided doses  | 1–3 days  | Oral stimulants  |
| Anthracenes  | Senna 1–2 tablets; 10 ml daily  | 8–12 hours  | Polyphenolics  |
| Bisacodyl 1–2 tablets daily  | 6–12 hours  | Rectal softener   | Focal lubricants   |
| Arachis oil  | One 1 hour  | Docosate enema  | One 5–20 mins  |
| Osmotic laxatives  | Glycerol  | One 5–15 mins   | Saline laxatives   |
| Phosphate enema  | One 15 mins   | Rectal Stimulant  | Bisacodyl 1–2 15–60 mins   |

**7.3 Symptoms other than pain**

**637 Oxygen** should be tried for hypoxic patients, and discontinued if there is no benefit to avoid psychological dependence. There is no benefit in using oxygen for patients who are not hypoxic.

**Cough** New onset cough should be evaluated to see if there is a reversible cause, for example, a respiratory tract infection. Treatment directed at the cause should be tried in the first instance. In cancer patients palliative chemotherapy might, by reducing tumour bulk in the lung, improve cough. If there are one or two localized areas of cancer in the lung, palliative radiotherapy might help. Simple linctus should be tried. Sodium cromoglycate might be beneficial if patients can use an inhaler. If that is ineffective, consider using an opioid such as dextromethorphan, codeine, or low-dose morphine.

**Death rattle** Noisy breathing is common in the last hours and days of life. Although the cause is not clear, it is thought that saliva and bronchial secretions which are normally swallowed or expectorated remain in the mouth or airways and the movement of air causes the rattly or chesty sound. Patients usually have a reduced level of consciousness at this time and usually do not seem to be distressed. However, the sounds can cause distress to family and staff. Education of family, giving explanation and reassurance is important. Nonpharmacological management includes positioning and a trial of suctioning; suctioning might, however, cause irritation and an increase in secretions. The main pharmacological man-

agement involves anticholinergics, such as hyoscine butylbromide or glycopyrronium, which can be given parenterally as SC bolus doses or SC infusion. Hyoscine hydrobromide crosses the blood-brain barrier, and can cause delirium; however, as it can be given transdermally, it might be worth trying if the SC route is not possible. These drugs can cause quite a severe dry mouth. Cachexia Cachexia is common in advanced illness, but most research is in cancer cachexia. Patients with cancer cachexia have anorexia, early satiety, and nausea. They might have altered taste or smell. Reversible causes for anorexia and nausea should be considered including for example, dry mouth, candida, hypercalcaemia, medication and renal failure. Early cachexia might be reversed or eased by interventions such as nutritional supplements. Refractory cachexia cannot be reversed, but management might reduce symptoms and anxiety associated with this. The non-pharmacological management of cachexia includes patient and family support and education. In earlier stages, education about nutritional intake and strategies to manage a poor appetite are helpful. As illness progresses, education about the nature of cachexia, and an understanding of why appetite is poor can help both patients and families. Nutritional support is rarely beneficial in advanced cancer, but might be helpful in selected patients. Potential benefits need to be weighed with burdens of stress caused by patients being encouraged to increase intake when they cannot. Parenteral nutrition is rarely indicated. Pharmacological management is limited. A trial of steroids might improve appetite and quality of life, but ideally should not be used for more than two weeks as side effects, especially muscle weakness, can outweigh benefit. Megesterol and progestins can increase appetite and body weight, but not muscle mass, and do not improve survival. Prokinetics might improve symptoms in patients with early satiety, nausea or dyspepsia. Regular metoclopramide or domperidone can be used. Fatigue The management of fatigue should be approached in the same way as management of all other symptoms: evaluate the cause, treat any reversible cause, provide education, and plan treatment. There is little evidence to support any pharmacological treatment. Steroids, such as dexamethasone 4 mg daily, should be tried for three days, and if no benefit, stopped. Methylphenidate has also been used, starting at a dose of 5 mg daily to 15 mg. This is an unlicensed use, and caution is required in patients with anxiety, cardiac disease, or epilepsy. Nonpharmacological management includes patient and family education about pacing and conserving energy. Graded exercise can also be tried. Referral to occupational therapy and physiotherapy services might be beneficial. Emergencies in palliative care Symptoms can herald an emergency, and palliative care patients, despite living with life-limiting illness, might develop a problem which can rapidly affect the duration or quality of their life. Emergencies include sepsis, delirium and, in cancer patients, hypercalcaemia, spinal cord compression, massive haemorrhage, and superior vena caval obstruction. The management of these problems, for example, sepsis or delirium, is the same as the management of these problems in the general population, but the patient's frailty, likely prognosis, and own values and wishes need to be taken into account when planning treatment. For example, a patient with severe sepsis who is receiving palliative chemotherapy might be neutropenic, and might benefit from active management of the sepsis; a patient with multiple severe lower respiratory tract infections secondary to end-stage COPD or dementia might not benefit in the same way. Individualized assessment and decision-making is vital. Spinal cord compression Spinal cord compression is a risk in patients who have vertebral or epidural metastases. Symptoms include cervical or thoracic spinal pain, severe lower spinal pain, spinal pain worse on straining (e.g. coughing), or spinal pain worse when lying flat. Neurological symptoms are radicular pain, limb weakness, difficulty in walking, sensory changes, and bladder or bowel dysfunction. Signs include spinal tenderness, and reduced power, sensory changes, and

Box 7.3.2 Case vignette Mrs KL developed a cough with increased breathlessness and

attended her GP. Her GP assessed her and was concerned when she said she had coughed up small amounts of blood. On examination, she had signs of COPD, but also had evidence of a pleural effusion with absent air entry at the right lung base. An urgent chest X-ray confirmed a pleural effusion. Mrs KL had a chest drain inserted and a total of four litres of blood stained fluid drained with considerable relief.

638 Section 7 Pain and palliative care urinary retention. If spinal cord compression is suspected, an MRI should be arranged within 24 hours, and dexamethasone 16 mg daily commenced, while definitive treatment, for example, surgery or radiotherapy, is being planned. Bowel obstruction Bowel obstruction occurs in 3–15% of cancer patients. Patients present with nausea, vomiting, constipation, abdominal pain, and colic. The management of bowel obstruction in the first instance is consideration if stenting or surgery is possible. In end-stage disease, where neither surgery nor stenting is possible, and the prognosis is short, the focus is on symptom management. Medication usually has to be given parenterally. Pain can be treated with analgesia, such as opioids. Colic is treated with anticholinergics, such as hyoscine butylbromide, which can also reduce gastrointestinal secretions, and thus reduce vomiting and abdominal distension. Ranitidine, 200 mg daily, also decreases gastrointestinal secretions. Dexamethasone, 8 mg daily, might help resolve the obstruction. There is clinical experience of using octreotide, a somatostatin analogue, although a recent well-designed randomized controlled trial does not support its use. Delirium Delirium is very common in the medically frail, affecting approximately 20% of all hospital inpatients. Delirium affects up to 80% of people towards the end of their life. The management of delirium in a patient with palliative care needs is the same as the management in all patients, including reversing possible causes and support and re-orientation. If patients are distressed, treatment with haloperidol or olanzapine might be necessary. Although many patients with palliative care needs are on opioids, if a patient on stable opioids become delirious, alternate causes need to be sought including sepsis, renal failure, and dehydration. However, as delirium can be a terminal event, the benefit of attempting to reverse the cause of the delirium needs to be considered in the context of patient's likely survival. Patients in the last days of life who are delirious might need treatment with benzodiazepines to reduce anxiety, and to provide sedation if the patient is very distressed. If a patient has sedation, it is essential that all other interventions required to maintain comfort, including other medication, artificial nutrition, and hydration and nursing care are considered and provided where necessary. Conclusion Patients with life-limiting illness often have multiple symptoms, both physical and mental. Although a patient might have a life-limiting illness, active management of symptoms will help improve a patient's quality of life. The clinician's role is assessment and diagnosis of the cause of the symptoms, using medical knowledge to plan treatment, including referral to other members of the multidisciplinary team, in the context of the patient's diagnosis, prognosis, and multimorbidity; and providing education and explanation to the patient and their family. FURTHER READING Currow D, et al. (2015). Double-blind, randomized trial of octreotide in malignant bowel obstruction. *J Pain Symptom Manage*, 49, 814–21. European Palliative Care Research Centre (PRC) (2015). Cachexia in Palliative Care. <https://www.ntnu.edu/prc/results/epcrc-guidelines> European Palliative Care Research Centre (PRC) (2015). Depression in Advanced Disease. <https://www.ntnu.edu/prc/results/epcrc-guidelines> Larkin PJ, et al. (2008). The management of constipation in palliative care: clinical practice recommendations. *Palliat Med*, 22, 786–807. National Clinical Effectiveness Committee (2015). Management of Constipation in Adult Patients Receiving Palliative Care. National Clinical Guideline No. 10. <http://health.gov.ie/wp-content/uploads/2015/11/Mgmt-of-Constipation-Guideline.pdf> National Institute for Health and Care

Excellence (NICE) (2008). Metastatic Spinal Cord Compression in Adults: Risk Assessment, Diagnosis and Management. Clinical guideline [CG75]. <https://www.nice.org.uk/guidance/cg75>

National Institute for Health and Care Excellence (NICE) (2014). Delirium in Adults. Quality standard [QS63]. <https://www.nice.org.uk/guidance/qs63>

NHS Scotland (2014). Scottish Palliative Care Guidelines: Breathlessness. <http://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/breathlessness.aspx>

NHS Scotland (2014). Scottish Palliative Care Guidelines: Nausea and Vomiting. <http://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/nausea-and-vomiting.aspx>

Solano JP, Gomes B, Higginson IJ (2006). A comparison of symptom prevalence in far advanced cancer, AIDS, heart disease, chronic obstructive pulmonary disease and renal disease. *J Pain Symptom Manage*, 31, 58–69.

Wee B, Hillier R (2008). Interventions for noisy breathing in patients near to death. *Cochrane Database Syst Rev*, 1, CD005177.

Wee B, et al. (2011). Management of chronic cough in patients receiving palliative care: review of evidence and recommendations by a task group of the Association for Palliative Medicine of Great Britain and Ireland. *Palliat Med*, 26, 780–7.

---

Revision #1

Created 2026-01-22 16:44:42 UTC by Omar Ayman

Updated 2026-01-22 16:44:42 UTC by Omar Ayman