## Hiccups

### Introduction

Hiccups lasting more than 48 hours are not uncommon in patients with advanced disease and can be very distressing and exhausting. They can affect a patient’s daily living and social functioning.

Most studies were uncontrolled, underpowered and lacked comprehensive data and therefore recommendations for any treatments are made cautiously. Treatment of intractable and persistent hiccups is based on patients’ and clinicians’ preferences until more evidence from randomised controlled trials is available.

Pharmacological treatment should take into account the potential side effects and risks of medication.

### Assessment

- Careful assessment is required to identify the cause.
- Consider severity, duration and impact on a patient’s quality of life.
- Causes include:
  - gastric stasis and distension (the most common cause)
  - gastro-oesophageal reflux
  - metabolic disturbances (for example uraemia, hypercalcaemia, magnesium deficiency)
  - infection
  - irritation of diaphragm or phrenic nerve
  - hepatic disease/hepatomegaly
  - cerebral causes (for example tumour, metastases).
- Damage to phrenic nerve over its course from skull to diaphragm, for example shingles, pressure from mediastinal tumour.

### Management

- Treat reversible causes.
- Hiccups often stop spontaneously. Treatment is only required if hiccups are persistent.
- Try simple physical manoeuvres initially and those that have worked previously.

**Non-pharmacological management**

- Simple measures or ‘home remedies’ can be effective. These include:
  - sipping iced water or swallowing crushed ice
  - breathing into a paper bag, particularly if the patient is hyperventilating
- interrupting normal breathing, for example holding breath
- drinking from wrong/opposite side of a cup
- rubbing the soft palate with a swab to stimulate the nasopharynx.

Acupuncture may be effective.

**Medication**

- **Antiflatulent**: peppermint water 10ml twice daily (refer to practice points and caution in gastro-oesophageal reflux disease).

- **Antacid medication containing simeticone**: for example in Altacite Plus® 10ml between meals and at bedtime when required or Malax Plus® 5ml to 10ml four times daily.

- **Prokinetic**: QT domperidone or QT metoclopramide (refer to practice points) oral 10mg, 8 hourly.

- Treat any gastro-oesophageal reflux with a proton pump inhibitor.

- QT Dexamethasone oral 4mg to 8mg in the morning may reduce compression/irritation if the patient has a hepatic, mediastinal or cerebral disease/tumour. Stop if no benefit after a week.

- **Other options below may be recommended by a specialist:**
  - QT haloperidol oral 500 micrograms to 1mg as required 8 hourly, maintenance dose 1mg to 3mg at bedtime
  - QT baclofen oral 5mg to 20mg, as required 8 hourly (avoid abrupt withdrawal)
  - QT levomepromazine oral 3mg to 6mg at bedtime (now used as an alternative to chlorpromazine; avoid if hypotensive)
  - QT nifedipine oral 5mg to 20mg, as required 8 hourly (avoid if hypotensive).

**Practice points**

- Peppermint water and prokinetics, for example metoclopramide, should not be used concurrently because of their opposing actions on the gastro-oesophageal sphincter.

- Patients and carers should be advised that initial treatment for persistent hiccups should be reviewed after 3 days and changed if there is little or no improvement. This may mean a dose increase or a change of medication. If hiccups are difficult to control, advice will be sought from specialist palliative care colleagues.

- Patients and carers should be advised that if hiccups are preventing the patient from sleeping, they should contact their healthcare professional.

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1 † Indicates this use is off licence  QT Indicates this medication is associated with QT prolongation
Resources


References
