Non-Opioid Symptom Management

Everything other than pain · match the drug to the mechanism, because the wrong antiemetic simply does not work

Pick by *mechanism*

NAUSEA: MATCH THE RECEPTOR

the commonest reason an antiemetic fails is that it was aimed at the wrong pathway

Cause	First choice	Why
Drugs, metabolic, opioids *chemoreceptor trigger zone*	**Haloperidol**, low dose, or metoclopramide	**The CTZ is dopamine driven**, so a dopamine antagonist is the rational choice. Haloperidol at antiemetic doses is far lower than antipsychotic dosing and is a palliative workhorse
Gastric stasis, early satiety	**Metoclopramide**, a prokinetic	It moves the stomach as well as blocking dopamine. **Contraindicated in complete bowel obstruction**, where a prokinetic increases colic
Bowel obstruction	**Haloperidol plus an antisecretory** (glycopyrrolate or octreotide), with dexamethasone	**Avoid prokinetics.** The aim is to reduce secretions and colic rather than push contents through an obstruction. Consider a venting gastrostomy in the right patient
Vestibular, movement-related	**Antihistamine or anticholinergic**: meclizine, scopolamine	The vestibular pathway is histaminergic and cholinergic, so dopamine blockers underperform here
Raised intracranial pressure	**Dexamethasone**	Treats the cause by reducing peritumoral edema
Chemotherapy	**Ondansetron**, with dexamethasone and an NK1 antagonist per protocol	Serotonin driven. **Note ondansetron constipates and prolongs the QTc**, and is a poor choice for opioid-induced nausea where a dopamine antagonist works better

BREATHLESSNESS

the most frightening symptom, and the most under-treated

OPIOIDS ARE THE TREATMENT

Low-dose opioid is first-line for refractory breathlessness, and it works independently of any effect on oxygenation. **Used properly it does not hasten death**, and fear of that is the main reason patients are left breathless. Start low, titrate, document the indication.

NON-DRUG MEASURES WORK

A fan directed at the face stimulates the trigeminal nerve and genuinely reduces the sensation, with good evidence and no side effects. Also sitting upright, an open window, pacing activity, and a calm presence.

OXYGEN ONLY IF HYPOXIC

Oxygen does not help breathlessness in a non-hypoxic patient, where airflow does just as much. Treat reversible causes when consistent with goals: effusion, anemia, bronchospasm, heart failure, pulmonary embolism. **Benzodiazepines are second-line**, for the anxiety component.

THE OTHER SYMPTOMS

each has a drug worth knowing by name

Symptom	Approach
Delirium	**Look for the reversible cause first**: opioids and other drugs, urinary retention, constipation, infection, hypercalcemia, hypoxia. **Non-drug measures are the mainstay**. Use **haloperidol** for distressing agitation, and note **benzodiazepines usually worsen delirium** except in alcohol withdrawal or terminal agitation
Constipation	**A stimulant laxative with every opioid, from day one**, since tolerance to constipation never develops. Senna with or without a softener; escalate to an osmotic. **Exclude impaction and obstruction before escalating**, and consider a peripherally acting mu antagonist such as methylnaltrexone for genuinely refractory opioid-induced constipation
Respiratory secretions *the "death rattle"*	**Reposition first**, and reduce parenteral fluids. Antimuscarinics such as **glycopyrrolate** (which does not cross the blood-brain barrier, so less sedating) or hyoscine. **They prevent new secretions rather than clearing existing ones, so give early**. **Explain to the family that it does not distress the patient**, since it usually distresses them far more
Anorexia and cachexia	**Dexamethasone** gives a short-lived appetite improvement. **Explain that artificial nutrition does not extend life or improve quality in advanced cancer or advanced dementia**, and can add burden. Focus on **food as comfort and pleasure**, and address the family's distress, which is often greater than the patient's
Fatigue	Treat the reversible: anemia, hypothyroidism, depression, hypercalcemia, drugs. **Energy conservation and graded activity** help. Corticosteroids give a short-term lift; methylphenidate is sometimes used with specialist input
Mouth care	**The single most appreciated intervention at the end of life**, and the most neglected. Regular oral care, saliva substitutes, treating candidiasis. **Dry mouth, not thirst, is what fluids fail to fix**

THE LESS COMMON ONES

each has a specific answer that is easy to forget

Symptom	Approach
Hiccups	Exhausting and demoralizing when persistent. Look for **gastric distension** first, which is the commonest cause and responds to a prokinetic and a simethicone-type agent. Then **baclofen**, or chlorpromazine, gabapentin or metoclopramide. Consider phrenic irritation from tumor or subdiaphragmatic disease
Pruritus	Depends on the cause: **cholestatic** itch responds to cholestyramine, rifampin, naltrexone or sertraline rather than to antihistamines. **Uremic** itch responds to gabapentin. **Opioid-induced** itch is histamine release, so consider rotating the opioid. **Antihistamines mostly just sedate** in the non-histaminergic causes
Anxiety and insomnia	Ask what the fear actually is: uncontrolled pain, dying alone, being a burden, or an unresolved practical matter. **Much of it is not treated by a drug**. Where medication is needed, a short-acting benzodiazepine, and treat any coexisting delirium first rather than deepening it
Seizures at the end of life	Anticipate them in brain tumors, brain metastases and severe metabolic derangement. **Prescribe a PRN by a route that will still work**, usually buccal or subcutaneous midazolam, and ensure the family knows what to do. Continue antiseizure cover when the oral route is lost rather than simply stopping it

PEARLS & PITFALLS

- **Constipation causes nausea, delirium, pain and agitation.** Before adding a fourth drug for any of those, **check when the patient last opened their bowels and do a rectal examination.** This is the highest-yield thing on this sheet.
- **Review the medication list and stop what no longer serves the goals:** statins, bisphosphonates, most antihypertensives, oral hypoglycemics, vitamins. **Deprescribing is an active intervention**, and each stopped drug is one fewer burden.
- **Anticipatory prescribing is what prevents a crisis at 2 a.m.** Write PRN orders in advance for **pain, breathlessness, nausea, agitation and secretions**, with a route that will still work when swallowing fails, usually subcutaneous.
- **Distinguish terminal agitation from reversible delirium and from unrelieved symptoms.** A patient thrashing may be in pain, in urinary retention, or hypoxic. **Examine before sedating**, since sedation for an untreated full bladder is a failure of assessment, not a failure of the drug.

References: Published palliative care symptom management guidance and consensus reviews on nausea by mechanism, refractory breathlessness, delirium and end-of-life secretions · standard palliative prescribing references.

Educational aid; verify against current guidance, local formulary and patient factors.