Palliative care in general medicine

Editor – May I expand the brief report of my contribution to the debate on hydration in terminal care (November/December 1997, pp698–9). Speaking about the dangers of withholding hydration I discussed the problem of thirst, drawing attention to the fact that thirst or a dry mouth is a major symptom in 66% of terminally ill patients. I pointed out that traditional methods of suppressing thirst by moistening the mouth may give only transient relief. Physiologists report that thirst quenching involves three phases: 1) an initial oro-pharyngeal phase involving neural reflexes that are provoked by the act of swallowing liquid, not simply having the mouth moistened; 2) a gastrointestinal phase due to gastric distension by fluid; and 3) a post-absorptive phase as fluid restores the plasma osmolality to normal, and thirst is finally quenched. Sustained thirst relief is best achieved with fluid replacement. To try to relieve thirst without giving fluids makes little physiological sense.

Other points that need careful and constructive debate by the medical profession were also omitted from the report:

- The practice of sedation without hydration in palliative care is open to misuse.
- When sedation without hydration is considered for any reason a second consultant opinion should be obligatory, for 'doctors are as likely as anyone else to make mistakes or err in judgement'.
- There should be a confidential inquiry into the use of parenteral sedation in palliative care, and some effective monitoring system.
- There is a need to address the issue of how best to resolve clinical ethical disputes during life. Some forum in which relatives can participate is needed.
- There is a need for research to determine whether thirst really is reduced in patients dying of cancer, and if so what is the mechanism. If thirst is reduced, such patients, like the healthy elderly, will be at increased risk of dehydration.

New guidelines on the ethical use of artificial hydration in terminal care are to be welcomed as a step in the right direction, but there is further to go. In my view attention to hydration is not merely optional, it should be a basic part of good medicine and good palliative care.

References
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Cardiological examinations

Editor – In his letter, Dr Obel criticises a technique that many physicians use to auscultate changes in the heart sounds 'during inspiration' and 'during expiration' (November/December pp 704–5). The technique he criticises is one which I was taught and continue to use, but with one very important additional proviso omitted from his description: the patient must be instructed to stop breathing at end expiration (or end inspiration), while keeping his glottis open. Provided that the airway remains open, the intra-thoracic pressure is primarily determined by the elastic recoil of the lungs, and is lowest (most negative) at end inspiration, and highest (least negative, or even slightly positive) at end expiration, which is what is intended. If the patient actively closes his glottis and 'holds his breath', on the other hand, the consequences will tend to be as Dr Obel describes – raised intra-thoracic pressure with the breath held at end inspiration, and (less consistently) lowered intra-thoracic pressure if it is held at end expiration. I find that the average patient can understand the distinction between stopping breathing with the glottis open, and 'breath-holding', and can comply with instructions to do the former rather than the latter. In the absence of specific instructions to the contrary, a patient will often 'breath-hold' if told to stop breathing at some point during the respiratory cycle. This natural tendency, combined with poor patient communication, may be what has led to Dr Obel's observations.

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