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## Letter to the Editor

**TERMINATION OF  
PERSISTENT HICCUPS BY  
DIGITAL RECTAL MASSAGE**



**To the Editor:**

Singultus, or more commonly hiccups, are a well-known phenomenon experienced by most people at some stage in their life. Hiccuping is caused by quick spasmodic contraction of the diaphragm and intercostal muscles, resulting in sharp inspiration and closure of the glottis. A presenting complaint of troublesome hiccuping to the emergency department will typically spark debate and interest amongst physicians. Currently, there is insufficient evidence to guide the treatment of persistent or intractable hiccups with either pharmacologic or nonpharmacologic interventions (1).

Persistent singultus is defined as hiccuping for >48 h; a more sustained bout, known as intractable hiccuping, is defined by lasting for >1 month. In practice, respiratory, palliative, and emergency physicians are the most likely to encounter clinically significant hiccuping.

We present the case of a 31-year-old man who presented to our emergency department in a distressed state complaining of hiccuping for >72 h. During his >3 days of hiccuping, our patient was unable to eat, drink, or sleep. He had no medical history outside of a similar but less severe bout that lasted 24 h roughly 3 years earlier. This first episode self-terminated before he sought medical attention.

Initial investigations in our department revealed normal chest radiograph, electrocardiogram, and baseline laboratory blood results. We considered our options and performed a brief in-department literature review. After failure of simple vagal maneuvers, we outlined available treatment options to our patient. We explained the various pharmacologic interventions, their side effects, and, with certain medications, the need for posttreatment observation. As an alternative, we explained that there were a small number of case reports suggesting the success of digital rectal massage (DRM) for the termination of

hiccuping (2,3). Our patient consented to DRM and favored it over any pharmacologic intervention; most important to him was the relative lack of side effects in comparison with pharmacologic options. Given the lack of evidence-based guidance for treatment of singultus, our patient's involvement in decision-making was particularly important.

Before undergoing DRM, we observed our patient hiccuping 40 times in 1 minute. Our patient was placed in a lateral recumbent position with his hips flexed. A gloved lubricated index finger was passed into his rectum. Rectal massage was carried out in a slow, clockwise fashion with moderate steady pressure being applied. On initiation of DRM, hiccuping ceased immediately. The DRM was continued for 30 seconds. Our patient was held for 1 h of observation, during which he tolerated a light meal and fluids. He was discharged home at 1 h post-DRM. Our patient was followed with telephone contact 24 and 48 hours later, during which he confirmed he was comfortable and without recurrence of hiccuping.

DRM as a treatment option for troublesome singultus can be considered a simple and safe procedure. We demonstrated its effectiveness and feel it should be considered by physicians faced with similar cases.

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