Review Article

Prevalence, Impact, and Treatment of Death Rattle: A Systematic Review

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Abstract

Context. Death rattle, or respiratory tract secretion in the dying patient, is a common and potentially distressing symptom in dying patients. Health care professionals often struggle with this symptom because of the uncertainty about management.

Objectives. To give an overview of the current evidence on the prevalence of death rattle in dying patients, its impact on patients, relatives, and professional caregivers, and the effectiveness of interventions.

Methods. We systematically searched the databases PubMed, EMBASE, CINAHL, PsychINFO, and Web of Science. English-language articles containing original data on the prevalence or impact of death rattle or on the effects of interventions were included.

Results. We identified 39 articles, of which 29 reported on the prevalence of death rattle, eight on its impact, and 11 on the effectiveness of interventions. There is a wide variation in reported prevalence rates (12%–92%; weighted mean, 35%). Death rattle leads to distress in both relatives and professional caregivers, but its impact on patients is unclear. Different medication regimens have been studied, that is, scopolamine, glycopyrronium, hyoscine butylbromide, atropine, and/or octreotide. Only one study used a placebo group. There is no evidence that the use of any antimuscarinic drug is superior to no treatment.

Conclusion. Death rattle is a rather common symptom in dying patients, but it is doubtful if patients suffer from this symptom. Current literature does not support the standard use of antimuscarinic drugs in the treatment of death rattle. J Pain Symptom Manage 2013;■:■–■. © *2013 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words

Death rattle, end-of-life care, palliative care, symptoms, dying

Introduction

Care for the dying has received growing attention over the past decade, in both health care research and practice. Although several challenges of performing research in end-of-life care have been reported,[1–5] the demand for

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evidence-based guidelines is increasing. Until now, for many symptoms associated with the dying phase, research has been scarce, as is the case for death rattle. Death rattle, or respiratory tract secretion in the dying patient, is a common symptom in dying patients, although reported prevalences vary considerably.[6–10] Death rattle is thought to be caused by an accumulation of secretions in the airways.[11] It is unclear whether or to what extent it represents discomfort for the patient, and whether nursing and medical interventions to reduce its prevalence are needed or effective. Even when the patient does not appear to be disturbed by the symptom, treatment is often initiated because of distress in the attending relatives.[12–14] Treatment modalities include nursing interventions, for example, repositioning of the patient and suction of secretions and pharmacologic interventions. The use of antimuscarinic drugs is recommended in several palliative care textbooks.[11,15–18]

A recent Cochrane review focusing on interventions for death rattle concluded that there is no evidence that any intervention, pharmacologic or nonpharmacologic, was superior to placebo in the treatment of noisy breathing in dying patients.[19] This Cochrane review was based on four articles (two English and two German) and only included Level A evidence studies, that is, randomized controlled trials and high-quality prospective controlled studies. Randomized controlled trials among patients who are in the dying phase are rare, mainly because of ethical and practical considerations related to randomization, informed consent, the use of placebo, and follow-up.[1–5] Studies with a lower level of evidence can also provide useful information on care for dying patients. We performed a systematic search of the scientific literature with the aim of giving a comprehensive overview of empirical studies on the prevalence of death rattle, its impact on patients, relatives, and professional caregivers, and the effectiveness of interventions.

Methods

We conducted a systematic search of the databases PubMed, EMBASE, CINAHL, Web of Science, and PsychINFO. All the databases were searched for articles published up to August 2012 in English on the prevalence, impact, and treatment of death rattle. Fig. 1 presents a detailed overview of the search strategy. The search strategy was not restricted to recent publications to retrieve all the relevant literature. In addition, we hand-searched reference lists of included articles and relevant literature reviews.

Study Selection

Studies were included when they met the following inclusion criteria: the study described original empirical research about death rattle in the dying phase of human adults and the study included data about the prevalence of death rattle, experiences of patients, relatives, or professional caregivers with death rattle, or the effectiveness of interventions. Studies on the prevalence of death rattle had to include at least 50 subjects. Reviews, comments, case studies, letters, and conference abstracts were excluded.

All duplicates were removed. Articles were selected in a stepwise procedure. First, all titles were assessed as possibly relevant or not relevant; titles that were not relevant were excluded. In the second step, the abstracts of the remaining articles were screened on the selection criteria. If the abstracts met these criteria, the full text was assessed in Step 3.

Titles of 10% of the articles were independently assessed by two reviewers (M.E.L. and A.v.d.H.). Cohen's kappa was calculated to determine the level of agreement: $\kappa = 0.78$, indicating a substantial agreement.[20] Differences in scoring were discussed until consensus was reached. The remaining titles were assessed by M.E.L. This procedure was repeated for the assessment of abstracts ($\kappa = 0.77$) and full texts ($\kappa = 0.90$). For all the studies that did not pass the selection process, the reasons for noninclusion were registered.

Data Extraction

We collected information on general characteristics of the studies and results related to our research questions, using a standardized extraction form. Extracted data included the number of patients studied, study setting, study design, source of information, frequency of measurements, measurement method, primary diagnosis (cancer or noncancer), and general patient characteristics. We also extracted data on the

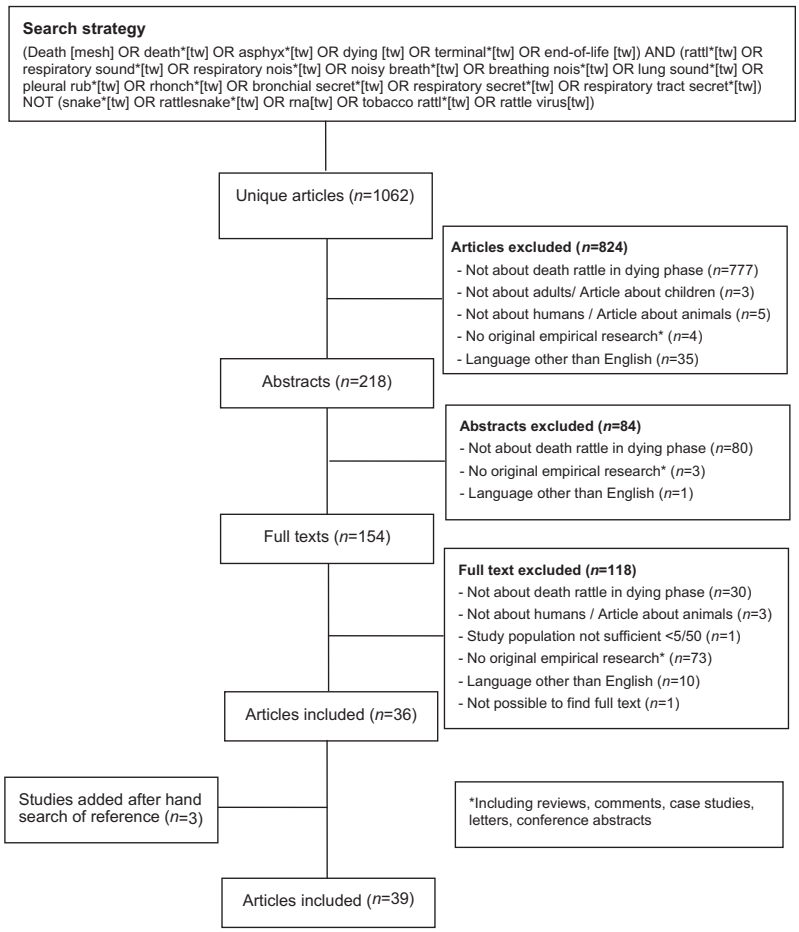

Fig. 1. Search strategy and selection of articles.

prevalence of death rattle, assessments of the impact of death rattle on patients, relatives, and professional caregivers, and effects of medical and nonmedical interventions.

Quality Assessment

The quality of the selected studies was assessed using the multimethod assessment tool devised by Hawker et al.[21] This tool can be used to evaluate studies with quantitative and qualitative designs. All studies were assessed on nine different aspects: abstract and title, introduction and aims, methods and data, sampling, data analysis, ethics and bias, results, transferability or generalizability, and implications and usefulness. For each aspect, a score was given on a four-point scale, from 1, very poor, to 4, good. Summing the different area scores results in a total score, from 9, very poor, to 36, good.

Results

Selection of Articles

Our search yielded 1062 unique articles. In the first step, 824 articles were excluded because the articles' titles were assessed as not relevant. In the second step, 84 articles were excluded because their abstracts did not meet the selection criteria. This resulted in 154 remaining articles, of which 36 articles could be included after assessment of the full texts (Fig. 1). A manual search of references identified three other studies, for a total of 39 studies (Table 1).

The studies were published between 1988 and 2012. Eight studies were performed in Asia, of which seven were done in Japan; two in Australia; one in New Zealand; 24 in Europe, of which 16 were done in the U.K.; and four in North America. The 39 studies included three randomized controlled trails,[22–24] two

Table 1
General Characteristics of the Included Studies ($N = 39$)

First Author, Country	Year of Publication	Setting	Sample Size	Design	Quality Assessment[a]
Asia					
Yamaguchi et al.,[27] Japan	2012	Hospital, PCU, and home care	161	Prospective observational study	28
Morita et al.,[29] Japan	2005	Hospital, PCU, and home care	226	Prospective observational study	29
Seah et al.,[48] Singapore	2005	Hospital	189	Medical records review	27
Morita et al.,[28] Japan	2004	Hospital, PCU, and home care	310	Prospective observational study	29
Morita et al.,[34] Japan	2004	PCU	195	Retrospective survey	20
Morita et al.,[8] Japan	2000	Hospital	245	Prospective observational study	26
Morita et al.,[31] Japan	1999	Hospice	350	Prospective observational study	26
Morita et al.,[30] Japan	1998	Hospice	100	Prospective observational study	23
Australia					
Sheehan et al.,[50] Australia	2011	PCU	199	Medical records review	28
Clark et al.,[22] Australia	2008	Hospital	10	Randomized controlled trail	29
Lichter and Hunt,[10] New Zealand	1990	Hospice	200	Prospective observational study	21
Europe					
Lundquist et al.,[49] Sweden	2011	Hospital, home care, PCU, and residential care	2382	Medical records review	31
Mercadante et al.,[35] Italy	2011	Home care	181	Retrospective survey	29
Bradley et al.,[52] UK	2010	Hospital and hospice	15	Qualitative interviews	29
Pace et al.,[45] Italy	2009	Home care	169	Medical records review	23
Wildiers et al.,[23] Belgium	2009	PCU	333	Randomized controlled trail	32
Jakobsson et al.,[42] Sweden	2008	Residential care and home care	229	Medical records review	30
Wee et al.,[13] UK	2008	Hospice	41	Qualitative focus groups	27
Wee et al.,[12] UK	2006	Hospital, hospice, and home care	12	Qualitative interviews	31
Wee et al.,[14] UK	2006	Hospital, hospice, and home care	17	Qualitative interviews	30
Hugel et al.,[41] UK	2006	PCU	165	Medical records review	25
Grogan et al.,[38] UK	2005	Hospice/PCU	68	Medical records review	21
Kass and Ellershaw,[43] UK	2003	PCU	202	Medical records review	26
Fowell et al.,[37] UK	2002	Hospital, hospice, PCU, and home care	500	Medical records review	28
Wildiers and Menten,[9] Belgium	2002	Hospital	107	Medical records review	20
Back et al.,[25] UK	2001	PCU	504	Prospective comparative study	26
Ellershaw et al.,[36] UK	2001	PCU	168	Medical records review	25
Hughes et al.,[26] UK	2000	Hospice and PCU	111	Prospective comparative study	20
Watts and Jenkins,[32] UK	1999	Not specified	23	Cross-sectional survey	17
Pautex et al.,[46] Switzerland	1997	Hospital	100	Medical records review	20
Watts et al.,[33] UK	1997	PCU	23	Cross-sectional survey	23
Bennett,[6] UK	1996	Hospice	96	Medical records review	22
Ellershaw et al.,[7] UK	1995	Hospice	82	Prospective observational study	28
Power and Kearney,[47] Ireland	1992	Hospice	100	Medical records review	19
Hoskin and Hanks,[40] UK	1988	Hospital	158	Medical records review	20
North America					
Heisler et al.,[24] USA	2012	PCU	137	Randomized controlled trail	31
Protus et al.,[51] USA	2012	Hospice	147	Medical records review	23
Hall et al.,[39] Canada	2002	Long-term care facilities	185	Medical records review	27
Lindley-Davis,[44] USA	1991	Home care	11	Medical records review	24

PCU = palliative care unit.
[a]Quality assessment: 9, very poor; 18, poor; 27, fair; and 36, good.

prospective comparative studies,[25,26] eight prospective observational studies,[7,8,10,27–31] two cross-sectional surveys,[32,33] two retrospective surveys,[34,35] 18 medical record reviews,[6,9,36–51] three qualitative interview studies,[12,14,52] and one qualitative focus group study.[13]

Quality Assessment

The total scores for quality of the included articles are presented in Table 1. One article was rated between "very poor" and "poor," 20 articles were rated between "poor" and "fair," and 18 articles were rated between "fair" and "good."

Labels and Definitions of Death Rattle

Various labels were used to describe death rattle: bronchial secretion (troubling/noisy/terminal), respiratory (tract) secretions, increasing secretions, noisy-retained secretions, terminal secretions, pulmonary rattles, noisy (rattling/moist) breathing (at the end of life), or respiratory symptoms. In addition, definitions of death rattle varied between studies. Twenty-two articles provided a definition of death rattle. Elements included in these definitions were the noise or sound associated with death rattle,[6–9,12–14,22–26,28–31,33,41,43,50–52] the movement of (accumulated) secretions,[7–9,22,23,28–31,41,43,50,51] location in the hypopharynx, bronchial tree,[7,8,25,28–31,41,43,51] or upper airways,[9,23,50] the relation with respiration,[6–9,12–14,22,23,25,28–31,33,41,43,50,52] its occurrence in the terminal phase of an illness,[6,9,12,14,22,23,25,41] its relation with weakness and/or inability to cough or clear the airways,[6,9,22,23,25,51] and the idea that it can be distressing for those involved.[6,8,22,25,41,50,51]

Prevalence of Death Rattle

Data on the prevalence of death rattle were reported in 29 articles (Table 2). Sample sizes ranged between 68 and 2382 patients. Studies were performed in hospitals (34%), palliative care units (45%), home care (28%), hospices (34%), or long-term care facilities (7%); some studies concerned more than one type of setting. Sixteen studies were performed in a population of patients with a diagnosis of primary cancer, eight in a mixed population (cancer and noncancer combined), and in five studies, the diagnoses of patients were not specified.

The prevalence of death rattle varied between studies. The lowest and highest percentages reported were 12%, in a retrospective study of 169 patients with brain tumors,[45] and 92%, in a prospective study of 82 patients with various forms of cancer.[7] The weighted mean for these 29 studies was 35%. The reported median time from the onset of death rattle until death was between 11 and 28 hours.[23–25,30,41,43,51]

Six studies[23–25,27–29] used a scoring scale as proposed by Back et al.[25] to assess the severity of death rattle. This scoring scale records the volume of noise associated with death rattle: 0, inaudible; 1, audible only very close to the patient; 2, clearly audible at the end of the bed, in a quiet room; 3, clearly audible at about 20 ft (9.5 m) (at the door of the room), in a quiet room. Of these six studies, four presented data about the severity of death rattle: 6%–17% of all patients had a death rattle score of 1, 19%–26% had a score of 2, and 5%–11% had a score of 3.[23–25,28]

Patient characteristics that were found to be significantly associated with the presence of death rattle were disoriented cognitive function,[42] male gender,[43] lung cancer,[8,28,43] a tumor located in bone, liver, intestinal tract,[8] or brain,[6,8] pneumonia,[28] and a duration of stay in a hospice for more than nine days[6] (Appendix available at jpsmjournal.com).

Impact of Death Rattle

Data on the impact of death rattle on patients, relatives, and professional caregivers were reported in eight studies: four quantitative[32–34,44] and four qualitative studies[12–14,52] (Table 3). Sample sizes in the four quantitative studies ranged between 11 and 65 respondents. Respondents were nurses[32,33,44] or bereaved relatives.[34] Sample sizes in the four qualitative studies ranged between 12 and 41 respondents. Respondents were professional or informal caregivers (nurses, physicians, and volunteers)[13,52] or bereaved relatives.[12,14]

Impact on Patients. In a study among nurses, 87% indicated that they felt that death rattle does not distress the dying patient.[32] A qualitative study among physicians, nurses, and volunteers suggested that patients may feel distressed because of the sound of death rattle of other patients in the same ward.[13]

Table 2
Studies Reporting on the Prevalence of Death Rattle ($N = 29$)

First Author, Country, Year	Setting	Symptom Label	Measurement Method	Design	Sample Size[a]	Diagnosis	Prevalence (%)
Pace et al.,[45] Italy, 2009	Home care	Death rattle	Death rattle presence as listed in medical record	Retrospective	169	Cancer (brain tumors)	12
Seah et al.,[48] Singapore, 2005	Hospital	Troubling respiratory secretions	Death rattle presence as listed in medical record	Retrospective	189	Mixed (cancer and various noncancer)	15
Mercadante et al.,[35] Italy, 2011	Home care	Death rattle	Death rattle presence during last two hours of patient's life as determined by relatives	Retrospective	181	Cancer (various tumors)	16
Lundquist et al.,[49] Sweden, 2011	Hospital, PCU, home care, and residential care	Respiratory tract secretions	Death rattle presence as listed in medical record	Retrospective	2382	Cancer (various tumors)	17
Wildiers and Menten,[9] Belgium, 2002	Hospital	Death rattle	Death rattle presence as listed in medical record	Retrospective	107	Cancer (various tumors)	23
Protus et al.,[51] USA, 2012	Hospice	Terminal respiratory secretions	Death rattle presence as listed in medical record	Retrospective	147	Mixed (cancer and various noncancer)	27
Jakobsson et al.,[42] Sweden, 2008	Residential care and home care	Pulmonary rattles	Death rattle presence as listed in medical record	Retrospective	229	Diagnosis not specified	30
Morita et al.,[34] Japan, 2004	PCU	Bronchial secretion	Death rattle frequency during last week of patient's life as rated by relatives: "not at all," "sometimes," "often," "very often." Prevalence based on grouping together "often" and "very often"	Retrospective	195	Cancer (not specified)	33
Hoskin and Hanks,[40] UK, 1988	Hospital	Respiratory symptoms	Death rattle presence based on antimuscarinic drugs use as listed in medical record	Retrospective	158	Cancer (various tumors)	34
Morita et al.,[30] Japan, 1998	Hospice	Death rattle	Death rattle presence observed by professional caregivers	Prospective	100	Cancer (various tumors)	35
Pautex et al.,[46] Switzerland, 1997	Hospital	Death rattle	Death rattle presence as listed in medical record	Retrospective	100	Mixed (cancer and various noncancer)	38
Hall et al.,[39] Canada, 2002	Hospice	Noisy breathing	Death rattle presence as listed in medical record	Retrospective	185	Mixed (cancer and various noncancer)	39
Morita et al.,[28] Japan, 2004	Hospital, PCU, and home care	Bronchial secretion	Death rattle scoring scale by Back et al.[25]	Prospective	310	Cancer (lung/ abdominal)	41
Back et al.,[25] UK, 2001	PCU	Death rattle	Death rattle scoring scale by Back et al.[25]	Prospective	504	Cancer (various tumors)	41
Yamaguchi et al.,[27] Japan, 2012	Hospital, PCU, and home care	Bronchial secretion	Death rattle scoring scale by Back et al.[25]	Prospective	151	Cancer (abdominal)	43
Heisler et al.,[24] USA, 2012	PCU	Death rattle	Death rattle scoring scale by Back et al.[25]	Prospective	404	Mixed (cancer and various noncancer)	44
Morita et al.,[8] Japan, 2000	Hospital	Death rattle	Death rattle presence as observed by professional caregivers	Prospective	245	Cancer (various tumors)	44

Morita et al.,[31] Japan, 1999	Hospice	Death rattle	Death rattle presence as observed by professional caregivers	Prospective	350	Cancer (various tumors)	44
Power and Kearney,[47] Ireland, 1992	Hospice	Respiratory secretions	Death rattle presence based on use of antimuscarinic drugs as listed in medical record	Retrospective	100	Diagnosis not specified	44
Morita et al.,[29] Japan, 2005	Hospital, PCU, and home care	Bronchial secretion	Death rattle scoring scale by Back et al.[25]	Prospective	226	Cancer (abdominal)	45
Ellershaw et al.,[36] UK, 2001	PCU	Respiratory tract secretions	Death rattle presence as listed in medical record	Retrospective	168	Diagnosis not specified	45
Bennett,[6] UK, 1996	Hospice	Death rattle	Death rattle presence as listed in medical record	Retrospective	96	Mixed (cancer and various noncancer)	45
Kass and Ellershaw,[43] UK, 2003	PCU	Respiratory tract secretions	Death rattle presence as listed in medical record	Retrospective	202	Cancer (various tumors)	49
Fowell et al.,[37] UK, 2002	Hospital, hospice, PCU, and home care	Respiratory tract secretions	Death rattle presence as listed in medical record	Retrospective	500	Mixed (cancer and various noncancer)	50
Lichter and Hunt,[10] New Zealand, 1990	Hospice	Noisy and moist breathing	Death rattle presence as observed by professional caregivers	Prospective	200	Diagnosis not specified	56
Grogan et al.,[38] UK, 2005	Hospice and PCU	Respiratory secretions	Death rattle presence as listed in medical record	Retrospective	68	Diagnosis not specified	59
Sheehan et al.,[50] Australia, 2011	PCU	Noisy respiratory secretions	Death rattle presence based on antimuscarinic drugs use as listed in medical record	Retrospective	199	Mixed (cancer and various noncancer)	60
Hugel et al.,[41] UK, 2006	PCU	Respiratory tract secretions	Death rattle presence as listed in medical record	Retrospective	165	Cancer (various tumors)	80
Ellershaw et al.,[7] UK, 1995	Hospice	Respiratory tract secretions	Death rattle presence observed by professional caregivers or antimuscarinic drug administered	Prospective	82	Cancer (various tumors)	92

PCU = palliative care unit.
[a]Number of patients in the study on which prevalence was based.

Table 3
Studies Reporting on Impact of Death Rattle ($N = 8$)

First Author, Country	Year of Publication	Setting	Design	Source	Sample Size[a]	Description of Death Rattle Impact
Quantitative studies						
Morita et al.,[34] Japan	2004	PCU	Retrospective survey of relatives	Relatives of patient with death rattle	65	**Impact on relatives** Relatives' reports on the impact of death rattle: "not distressed at all" ($n = 0/0\%$), "not so distressed" ($n = 3/5\%$), "slightly distressed" ($n = 10/15\%$), "distressed" ($n = 17/26\%$), or "very distressed" ($n = 34/52\%$).
Watts and Jenkins,[32] UK	1999	Not specified	Cross-sectional survey of nurses	Nurses	23	**Impact on patients** Death rattle does not distress the dying person ($n = 30/87\%$) **Impact on relatives** Death rattle distresses relatives ($n = 23/100\%$). Relatives mention to nurse that the death rattle in particular had caused them distress ($n = 12/52\%$) **Impact on caregivers** Death rattle distresses nurses ($n = 18/79\%$), some thought that suction is appropriate ($n = 6/26\%$)
Watts et al.,[33] UK	1997	PCU	Cross-sectional survey of nurses	Nurses	23	**Impact on relatives** Death rattle causes distress to all parties but particularly to relatives ($n = 23/100\%$)
Lindley-Davis,[44] USA	1991	Home care	Medical records review	Nurses	11	**Impact on relatives** Relatives' distress with death rattle: Relatives had high levels of anxiety as the patient began "gagging" and "drowning" in secretions. ($n =$ not mentioned in the article)
Qualitative studies						
Bradley et al.,[52] UK	2010	Hospital, hospice	Qualitative interviews with physicians and nurses	Physicians and nurses	15	**Impact on relatives** Death rattle can cause family distress. Some families find a positive side to the presence of death rattle (it gives them reassurance to hear them breathe). Respondents believe that families may benefit from their management choices. **Impact on caregivers** Nurses and other staff are likely to be distressed by death rattle; some respondents suggest that death rattle has little to no impact. The impact is described as feeling uncomfortable, feeling frustrated or unpleasant, or as death rattle being distressing or hard to bear.

						Caregivers may benefit from management decisions because doing something feels more comfortable than doing nothing
Wee et al.,[13] UK	2008	Hospice	Qualitative focus groups with staff and volunteers	Physicians, nurses, and volunteers	41	**Impact on patients** Patients in the same ward may feel distressed because of the sound of death rattle of other patients. **Impact on relatives** Death rattle is believed to distress relatives. **Impact on caregivers** Hospice staff and volunteers have largely negative feelings about death rattle. Doctors and nurses were divided about why they intervened. The way in which they themselves make sense of the sound influences both their response to relatives and the actions they take.
Wee et al.,[12] UK	2006	Hospital, hospice, and home care	Qualitative interviews	Relatives of patient with death rattle	12	**Impact on relatives** Some have explicit negative feelings about the sound of death rattle. This was sometimes associated with their concerns about the patient's suffering. Others are not distressed; some even found it helpful, as a warning sign of impending death.
Wee et al.,[14] UK	2006	Hospital, hospice, and home care	Qualitative interviews	Relatives of patient with death rattle	17	**Impact on relatives** Most are distressed by the sound of death rattle. Others are not particularly bothered, regard it as a useful warning sign that death was imminent or are more distressed by other issues surrounding the dying process. Relatives may take their cue from the patient's appearance, being concerned if the patient looks distressed, but less so if the patient is not obviously disturbed.

PCU = palliative care unit.
[a]People in the study who reported on impact of death rattle.

Impact on Relatives. Eight studies provided information on the impact of death rattle on relatives. According to one study, relatives perceived death rattle as "not so distressing" in 5%, "slightly distressing" in 15%, "distressing" in 26%, and "very distressing" in 52%.[34] In two studies among nurses, 100% of them indicated that death rattle causes distress for all those involved but particularly for relatives.[32,33] Such distress is, according to one study among nurses, related to relatives experiencing that patients were "gagging" and "drowning" in secretions (no percentage mentioned).[44] The qualitative studies suggested that, although death rattle was regarded as distressing for most relatives,[12–14,52] some relatives found it reassuring to hear the patient breathe or regarded death rattle as a helpful warning sign of impending death.[12,14,52]

Impact on Professional Caregivers. One quantitative and two qualitative studies reported on the impact of death rattle on professional caregivers. In a cross-sectional survey, 79% of nurses regarded death rattle as distressing.[32] Focus groups with hospice staff and volunteers and interviews with physicians and nurses showed that for them, death rattle may be distressing.[13,52] Interviewed nurses and physicians mentioned that they themselves possibly benefited from interventions to diminish death rattle. This benefit is related to being able to do something for the patient and family.[52]

Interventions for Death Rattle

Eleven studies reported on the effectiveness of interventions for death rattle (Table 4). Sample sizes ranged between 5 and 167 respondents per study group. Nine studies described medical interventions and two studies described the association between the hydration level and death rattle. No studies were found on the effectiveness of other interventions, for example, repositioning of the patient, explanation of the symptom to relatives, or suctioning of secretions. Eight studies had a comparative design, comparing two or three interventions.[22–27,29,41] Three studies were not controlled.[9,43,51]

Six studies compared two or three medication regimens. Medications studied included scopolamine,[22,23,25,26,41] glycopyrronium,[25,26,41] hyoscine butylbromide,[23,26] atropine,[23,24] and octreotide.[22] Three studies found no differences in the effectiveness of the different medication regimens.[22,23,26] One randomized controlled trial found no differences in the prevalence of death rattle between patients receiving atropine and patients receiving a placebo.[24] One comparative but uncontrolled study found that scopolamine was significantly more effective than glycopyrronium in reducing the severity of death rattle as recorded by nurses 30 minutes after the administration of the medication, but no difference was found one hour after the administration and at the final measurement before death.[25] A retrospective study using medical records found contrasting results: patients who received glycopyrronium were significantly more often reported as having a response to treatment than patients receiving scopolamine.[41] Two studies compared two groups with different hydration regimens (<1 L/day vs. ≥1 L/day).[27,29] A reduced level of hydration was found not to change the prevalence of death rattle.

Discussion

The prevalence of death rattle was found to vary widely. Several characteristics of studies that assessed prevalence may explain this variance. First, there is a wide variety of labels and definitions used to describe death rattle, with the noise or sound as a constant element in all definitions. Whether the various labels all represent the exact same phenomenon is, however, not clear. Second, different study designs were used: 34% were prospective studies and 64% were retrospective studies. The weighted mean for the prevalence of death rattle in the prospective studies was 45% compared with 30% in the retrospective studies. Third, few studies reported the exact point in time during the dying process at which the presence of death rattle was assessed. The natural course of death rattle is not clear. Kass and Ellershaw[43] suggest that the prevalence of death rattle typically increases when death approaches. However, Heisler et al.[24] performed a placebo-controlled trial and found a decrease in death rattle scores over time in the placebo group. Fourth, studies reporting on prevalence were often restricted to patients with cancer, but some studies also included noncancer patients. Whether specific diseases are

Table 4
Studies Reporting on Interventions for Death Rattle and Their Effectiveness ($N = 11$)

First Author, Country, Year, Design	Setting	Diagnosis	Interventions for Death Rattle		
			Description of Intervention[a]	Outcome Measure	Effectiveness of Intervention
Two or more study groups (medication)					
Heisler et al.,[24] USA, 2012, randomized controlled trial	PCU	Mixed (cancer and various noncancer)	1) **Atropine ($n = 74$)** 1 mg sublingually (two drops of 1% solution) 2) **Placebo ($n = 63$)** Two drops of placebo (saline) solution	Reduction of score with ≥1 point *Death rattle score by Back* et al.[25]	**No difference between groups** Effectiveness after two hours; 38%, 41% ($P = 0.73$) Effectiveness after four hours; 40%, 52% ($P = 0.21$)
Wildiers et al.,[23] Belgium, 2009, randomized controlled trial	PCU	Cancer (various tumors)	1) **Atropine ($n = 115$)** 0.5 mg SC bolus, followed by 3 mg/24 hours 2) **Scopolamine ($n = 112$)** 0.25 mg SC bolus, followed by 1.5 mg/24 hours 3) **Hyoscine butylbromide ($n = 106$)** 20 mg SC bolus, followed by 60 mg/24 hours	Lowering of score to 0 or 1 *Death rattle score by Back* et al.[25]	**No difference between groups** Effectiveness after one hour; 42%, 37%, and 42% ($P = 0.72$) Effectiveness after 24 hours; 76%, 68%, and 60% (NS; *P* unknown)
Clark et al.,[22] Australia, 2008, randomized controlled trial	Hospital	Cancer (various tumors)	1) **Octreotide ($n = 5$)** 0.2 mg bolus, if death rattle persisted ≥one hour 0.4 mg Scopolamine was administered 2) **Scopolamine ($n = 5$)** 0.4 mg bolus, if death rattle persisted ≥one hour 0.2 mg Octreotide was administered	A decrease in the level of death rattle *Level categorized into five points: none, mild, moderate, severe, and very severe*	**No difference between groups** Overall effectiveness; 40% and 40%
Back et al.,[25] UK, 2001, prospective comparative study	PCU	Cancer (various tumors)	1) **Scopolamine ($n = 108$)** 0.4 mg SC bolus, if the noise was still unacceptable ≥30 minutes. 0.4 mg SC was repeated. Optionally followed by 1.2–2.4 mg/24 hours SC 2) **Glycopyrronium ($n = 62$)** 0.2 mg SC bolus, if the noise was still unacceptable ≥30 minutes. 0.2 mg SC was repeated. Optionally followed by 0.8 mg/24 hours SC	Death rattle scores at 30 minutes, one hour, and final scores before death were compared with the initial score and categorized as better, the same, or worse. *Death rattle score by Back* et al.[25]	**Scopolamine group responded more often than glycopyrronium group ($P = 0.002$)** at $t = 30$ minutes Effectiveness after 30 minutes; 56% and 27% ($P = 0.002$) Effectiveness after one hour; 57% and 40% ($P = 0.09$) Symptom free at death; 51% and 42% ($P = 0.12$)
Hughes et al.,[26] UK, 2000, prospective comparative study	Hospice and PCU	Diagnosis not specified	1) **Scopolamine ($n = 37$)** 0.4 mg bolus, after 30 minutes with no result 0.6 mg bolus and	Level of relief of death rattle noise and of relatives' distress. Baseline levels	**No difference between groups** Effectiveness after 30 minutes; 35%, 54%, and 46% (*P* unknown)

(*Continued*)

Table 4
Continued

First Author, Country, Year, Design	Setting	Diagnosis	Interventions for Death Rattle		
			Description of Intervention[a]	Outcome Measure	Effectiveness of Intervention
			2.4 mg/24 hours, after 30 minutes with no result 0.6 mg scopolamine[b] 2) **Hyoscine butylbromide (*n* = 37)** 20 mg bolus, after 30 minutes with no result 20 mg bolus and 20 mg/24 hours, after 30 minutes with no result 0.2 mg glycopyrronium[b] 3) **Glycopyrronium (*n* = 37)** 0.2 mg bolus, after 30 minutes with no result 0.4 mg bolus and 0.6 mg/24 hours, after 30 minutes with no result 0.4 mg glycopyrronium[b]	• Intensity of death rattle noise: mild, moderate, or severe • Relatives' distress: not at all, a little, quite a bit, or very much Level of change • Absent, much better, slightly better, same, slightly worse, or much worse	Symptom free at death; 54%, 65%, and 65% (NS; *P* unknown)
Two or more study groups (medication)					
Hugel et al.,[41] UK, 2006, medical records review	PCU	Cancer (various tumors)	1) **Glycopyrronium (*n* = 36)** 0.2 mg SC bolus, followed by 0.6 mg/24 hours (+ prn 0.2 mg). If two or more prn doses/24 hours were required, then the continuous dose increased to 1.2 mg/24 hours 2) **Scopolamine (*n* = 36)** 0.4 mg SC bolus, followed by 1.2 mg/24 hours (+ prn 0.4 mg). If two or more prn doses/24 hours were required, then the continuous dose increased to 2.4 mg/24 hours	Response was determined grouping together immediate, late, and transient response and comparing it with no response *Response categorized*[c]	**Glycopyrronium group responded more often than scopolamine group (*P* = 0.01)** Overall response: 100%, 78% (*P* = 0.01) Symptom free at death: 72%, 58% (*P* unknown)
Two or more study groups (nonmedication)					
Morita et al.,[29] Japan, 2005, prospective observational study	Hospital, PCU, and home care	Cancer (abdominal)	1) **Hydration group (*n* = 59)** ≥1 L/day at one and three weeks before death 2) **Nonhydration group (*n* = 167)** <1 L/day at one and three weeks before death	Symptom severity in the last three weeks of the patients with and without hydration *Death rattle score by Back* et al.[25]	**No difference between groups** Difference in death rattle score ≥1 (*P* = 0.79) Difference in death rattle score ≥2 (*P* = 0.74)
Yamaguchi et al.,[27] Japan, 2012, prospective observational study	Hospital, PCU, and home care	Cancer (abdominal)	1) **Large volume hydration group (*n* = 80)** ≥1 L/day at study inclusion	Symptom severity 48 hours before death *Death rattle score by Back* et al.[25]	**No difference between groups** Difference in death rattle prevalence (*P* = 0.073)

			2) **Small volume hydration group ($n = 56$)** <1 L/day at study inclusion		
One group					
Protus et al.,[51] USA, 2012, medical records review	Hospice	Mixed (cancer and various noncancer)	1) **Atropine ($n = 22$)** Two drops of 1% solution sublingually (0.5 mg per drop) every two hours as needed	The reduction or resolution of death rattle	Overall effectiveness: 86%
Kass and Ellershaw[43] UK, 2003, medical records review	PCU	Cancer (various tumors)	1) **Scopolamine ($n = 59$)** 0.4 mg bolus, followed by 1.2 mg/24 hours if there was no result after 24 hours the continuous dose increased to 2.4 mg/24 hours	The presence or absence of death rattle	Effectiveness within four hours: 31% Overall effectiveness/symptom free before death: 64%
Wildiers and Menten,[9] Belgium, 2002, medical records review	Hospital	Cancer (various tumors)	1) **Scopolamine ($n = 25$)** 0.25 mg/four hours bolus or IV dose between 1 and 2.5 mg/24 hours	Medication was effective when there was no evidence for persisting disturbing rattle (as well for relatives as for the caregivers).	Overall effectiveness: 72%

PCU = palliative care unit; SC = subcutaneous; NS, nonsignificant; prn = pro re nata (as needed medication); IV = intravenous.
[a]n is the number of patients in the intervention group.
[b]Treatment schedule continued: after 30 minutes with no result, 0.4 mg of glycopyrronium, after 30 minutes with no result, 0.4 mg of glycopyrronium.
[c]A response included immediate (within four hours), late (after more than four hours), transient (symptom-free episodes after treatment but not symptom free at death), and no response (no symptom-free episode).

associated with the prevalence of death rattle is unclear. Only patients with cerebral or lung malignancies were found to have a higher risk of death rattle.[6,8,28,43] More studies are needed to give insight into specific relationships between underlying disease and death rattle prevalence rate. Fifth, measurement methods to determine the prevalence of death rattle varied between the different studies. Validated instruments, such as the death rattle scoring scale,[25] were not used by most studies.

The impact of death rattle on patients remains unclear and can only be based on subjective reports of others. It is often assumed by health care professionals that patients are not distressed by this symptom because they are generally unconscious when death rattle develops. Many professional caregivers assume that death rattle is distressing for relatives.[13] Whether relatives experience distress seems to be related to their judgment as to whether a patient is comfortable. For some relatives, the symptom can also be helpful because it either demonstrates that the patient is still alive or is seen as a sign of impending death. Professional caregivers themselves may also be distressed by the noise of death rattle, which often results in a medical intervention. Wee et al.[13] and Heisler et al.[24] suggest that the way in which professional caregivers interpret the symptom can influence their response and actions, which could also affect relatives' perceptions. Professional caregivers should be aware of this effect.

A number of different interventions for the treatment of death rattle are included in guidelines and palliative care textbooks: repositioning of the patient, explanation of the symptom to relatives, suctioning of secretions, reduction of artificial hydration, administration of antimuscarinic drugs, and sedation. Only reducing the level of hydration and treatment with antimuscarinic drugs have been studied for their effectiveness. Two studies among patients with abdominal cancer found no relation between the level of hydration and the prevalence of death rattle. There is no evidence that the use of any antimuscarinic drug is superior to no treatment. This finding is in line with the previous Cochrane review focusing on interventions for death rattle.[19] However, studies on the effect of pharmacologic interventions are limited by their lack of a placebo group. Well-designed studies to assess the relation between hydration and death rattle, and studies on the effects of nonpharmacologic interventions for death rattle, are still lacking. More prospective randomized controlled studies on the effectiveness of medical therapy and other interventions are urgently needed to confirm these findings.

We conclude that death rattle is a common symptom in dying patients. Approximately one-third of dying patients will present with this symptom. Current evidence does not support the standard use of antimuscarinic drugs in the treatment of death rattle. More high-quality studies are needed to give insight into the effects of interventions, both pharmacologic and nonpharmacologic. Until then, care should focus on communication about the symptom with relatives and others involved in the care of these patients. Regarding the symptom as being part of the normal dying process could contribute to the lowering of distress levels of those involved.

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References

1. Casarett DJ, Knebel A, Helmers K. Ethical challenges of palliative care research. J Pain Symptom Manage 2003;25:S3–S5.

2. Cook AM, Finlay IG, Butler-Keating RJ. Recruiting into palliative care trials: lessons learnt from a feasibility study. Palliat Med 2002;16:163–165.

3. Fost N. Can acutely ill patients consent to research? Resolving an ethical dilemma with facts. Acad Emerg Med 1999;6:772–774.

4. Gardiner C, Barnes S, Small N, et al. Reconciling informed consent and 'do no harm': ethical challenges in palliative-care research and practice in chronic obstructive pulmonary disease. Palliat Med 2010;24:469–472.

5. Rees E. The ethics and practicalities of consent in palliative care research: an overview. Int J Palliat Nurs 2001;7:489–492.

6. Bennett MI. Death rattle: an audit of hyoscine (scopolamine) use and review of management. J Pain Symptom Manage 1996;12:229–233.

7. Ellershaw JE, Sutcliffe JM, Saunders CM. Dehydration and the dying patient. J Pain Symptom Manage 1995;10:192–197.

8. Morita T, Tsunoda J, Inoue S, Chihara S. Risk factors for death rattle in terminally ill cancer patients: a prospective exploratory study. Palliat Med 2000;14:19–23.

9. Wildiers H, Menten J. Death rattle: prevalence, prevention and treatment. J Pain Symptom Manage 2002;23:310–317.

10. Lichter I, Hunt E. The last 48 hours of life. J Palliat Care 1990;6:7–15.

11. Twycross R, Lichter I. The terminal phase. In: Doyle D, Hanks G, MacDonald N, eds. Oxford textbook of palliative medicine, 2nd ed. Oxford: Oxford University Press, 1998:977–992.

12. Wee BL, Coleman PG, Hillier R, Holgate SH. The sound of death rattle I: are relatives distressed by hearing this sound? Palliat Med 2006;20: 171–175.

13. Wee B, Coleman P, Hillier R, Holgate S. Death rattle: its impact on staff and volunteers in palliative care. Palliat Med 2008;22:173–176.

14. Wee BL, Coleman PG, Hillier R, Holgate SH. The sound of death rattle II: how do relatives interpret the sound? Palliat Med 2006;20:177–181.

15. Twycross R, Wilcock A. Symptom management in advanced cancer. Oxford: Radcliffe Publishing, 2001.

16. Twycross R. Palliative care formulary. Oxford: Radcliffe Publishing, 2002.

17. Emanuel L, Librach S. Palliative care: Core skills and clinical competencies. Expert consult. St. Louis, MO: Elsevier Saunders, 2011.

18. Watson M, Lucas C, Hoy A, Wells J. Oxford handbook of palliative care. New York: Oxford University Press, 2009.

19. Wee B, Hillier R. Interventions for noisy breathing in patients near to death. Cochrane Database Syst Rev 2008;1:CD005177.

20. Landis JR, Koch GG. The measurement of observer agreement for categorical data. Biometrics 1977;33:159–174.

21. Hawker S, Payne S, Kerr C, Hardey M, Powell J. Appraising the evidence: reviewing disparate data systematically. Qual Health Res 2002;12:1284–1299.

22. Clark K, Currow DC, Agar M, Fazekas BS, Abernethy AP. A pilot phase II randomized, crossover, double-blinded, controlled efficacy study of octreotide versus hyoscine hydrobromide for control of noisy breathing at the end-of-life. J Pain Palliat Care Pharmacother 2008;22:131–138.

23. Wildiers H, Dhaenekint C, Demeulenaere P, et al. Atropine, hyoscine butylbromide, or scopolamine are equally effective for the treatment of death rattle in terminal care. J Pain Symptom Manage 2009;38:124–133.

24. Heisler M, Hamilton G, Abbott A, et al. Randomized double-blind trial of sublingual atropine vs. placebo for the management of death rattle. J Pain Symptom Manage 2013;45:14–22.

25. Back IN, Jenkins K, Blower A, Beckhelling J. A study comparing hyoscine hydrobromide and glycopyrrolate in the treatment of death rattle. Palliat Med 2001;15:329–336.

26. Hughes A, Wilcock A, Corcoran R, Lucas V, King A. Audit of three antimuscarinic drugs for managing retained secretions. Palliat Med 2000;14: 221–222.

27. Yamaguchi T, Morita T, Shinjo T, et al. Effect of parenteral hydration therapy based on the Japanese national clinical guideline on quality of life, discomfort, and symptom intensity in patients with advanced cancer. J Pain Symptom Manage 2012;43: 1001–1012.

28. Morita T, Hyodo I, Yoshimi T, et al. Incidence and underlying etiologies of bronchial secretion in terminally ill cancer patients: a multicenter, prospective, observational study. J Pain Symptom Manage 2004;27:533–539.

29. Morita T, Hyodo I, Yoshimi T, et al. Association between hydration volume and symptoms in terminally ill cancer patients with abdominal malignancies. Ann Oncol 2005;16:640–647.

30. Morita T, Ichiki T, Tsunoda J, Inoue S, Chihara S. A prospective study on the dying process in terminally ill cancer patients. Am J Hosp Palliat Care 1998;15:217–222.

31. Morita T, Tsunoda J, Inoue S, Chihara S. Contributing factors to physical symptoms in terminally-ill cancer patients. J Pain Symptom Manage 1999;18:338–346.

32. Watts T, Jenkins K. Palliative care nurses' feelings about death rattle. J Clin Nurs 1999;8:615–616.

33. Watts T, Jenkins K, Back I. Problem and management of noisy rattling breathing in dying patients. Int J Palliat Nurs 1997;3:245–252.

34. Morita T, Hirai K, Sakaguchi Y, Tsuneto S, Shima Y. Family-peceived distress about appetite loss and bronchial secretion in the terminal phase. J Pain Symptom Manage 2004;27:98–99.

35. Mercadante S, Valle A, Porzio G, et al. How do cancer patients receiving palliative care at home die? A descriptive study. J Pain Symptom Manage 2011;42:702–709.

36. Ellershaw J, Smith C, Overill S, Walker SE, Aldridge J. Care of the dying: setting standards for symptom control in the last 48 hours of life. J Pain Symptom Manage 2001;21:12–17.

37. Fowell A, Finlay I, Johnstone R, Minto L. An integrated care pathway for the last two days of life:

Wales-wide benchmarking in palliative care. Int J Palliat Nurs 2002;8:566–573.

38. Grogan E, Peel LM, Peel ET. Drugs at the end of life: does an integrated care pathway simplify prescribing? J Integr Care Pathways 2005;9:78–80.

39. Hall P, Schroder C, Weaver L. The last 48 hours of life in long-term care: a focused chart audit. J Am Geriatr Soc 2002;50:501–506.

40. Hoskin PJ, Hanks GW. The management of symptoms in advanced cancer: experience in a hospital-based continuing care unit. J R Soc Med 1988; 81:341–344.

41. Hugel H, Ellershaw J, Gambles M. Respiratory tract secretions in the dying patient: a comparison between glycopyrronium and hyoscine hydrobromide. J Palliat Med 2006;9:279–284.

42. Jakobsson E, Gaston-Johansson F, Ohlen J, Bergh I. Clinical problems at the end of life in a Swedish population, including the role of advancing age and physical and cognitive function. Scand J Public Health 2008;36:177–182.

43. Kass RM, Ellershaw J. Respiratory tract secretions in the dying patient: a retrospective study. J Pain Symptom Manage 2003;26:897–902.

44. Lindley-Davis B. Process of dying: defining characteristics. Cancer Nurs 1991;14:328–333.

45. Pace A, Di Lorenzo C, Guariglia L, et al. End of life issues in brain tumor patients. J Neurooncol 2009;91:39–43.

46. Pautex S, Herrmann FR, Le Lous P, et al. Symptom relief in the last week of life: is dementia always a limiting factor? J Am Geriatr Soc 2007;55: 1316–1317.

47. Power D, Kearney M. Management of the final 24 hours. Ir Med J 1992;85:93–95.

48. Seah ST, Low JA, Chan YH. Symptoms and care of dying elderly patients in an acute hospital. Singapore Med J 2005;46:210–214.

49. Lundquist G, Rasmussen BH, Axelsson B. Information of imminent death or not: does it make a difference? J Clin Oncol 2011;29:3927–3931.

50. Sheehan C, Clark K, Lam L, Chye R. A retrospective analysis of primary diagnosis, comorbidities, anticholinergic load, and other factors on treatment for noisy respiratory secretions at the end of life. J Palliat Med 2011;14: 1211–1216.

51. Protus BM, Grauer PA, Kimbrel JM. Evaluation of atropine 1% ophthalmic solution administered sublingually for the management of terminal respiratory secretions. Am J Hosp Palliat Care 2012. [Epub ahead of print].

52. Bradley K, Wee B, Aoun S. Management of death rattle: what influences the decision making of palliative medicine doctors and clinical nurse specialists? Prog Palliat Care 2010;18: 270–274.

Appendix

Prevalence in Subgroups

Author/Country/Year of Publication	Setting	Diagnosis	Sample Size[a]	Prevalence in Subgroups	
Jakobsson et al.[42], Sweden, 2008	Residential care, home care	Diagnosis not specified	229	Physical function	
				• Adl-independent	28%
				• Adl-dependent	32% ($P > 0.05$)
				Cognitive function	
				• Oriented	25%
				• Disoriented	41% ($P = 0.022$)
Morita et al.[29], Japan, 2005	Hospital, PCU, home care	Cancer (abdominal)	226	Hydration status	
				Prevalence ofsecretion score ≥ 1[b]	
				• Hydration +[c]	44%
				• Hydration −[d]	46% ($P > 0.05$)
				Prevalence of secretion score ≥ 2[b]	
				• Hydration +	19%
				• Hydration −	17% ($P > 0.05$)
Morita et al.[28], Japan, 2004	Hospital, PCU, home care	Cancer (lung + abdominal)	310	Primary tumor site	
				• Abdominal	67%
				• Lung	46% ($P = 0.001$)
				Brain metastases	
				• Present	56%
				• Absent	51% ($P > 0.05$)
				Lung metastases	
				• Present	58%
				• Absent	47% ($P > 0.05$)
				Pneumonia	
				• Present	68%
				• Absent	46% ($P = 0.002$)
				Dysphagia	
				• Present	75%
				• Absent	49% ($P > 0.05$)
				No correlation with age and gender	
Kass et al.[43], UK, 2003	PCU	Cancer (various tumors)	202	Tumor locations	
				• Lung cancer	68%
				• GI cancer	42%
				• Hepatobiliary and pancreatic cancer	40%
				• Breast	46%
				• Gynecological cancer—breast	35%

(*Continued*)

Appendix Continued

Author/Country/Year of Publication	Setting	Diagnosis	Sample Size[a]	Prevalence in Subgroups	
				• Urological, renal and prostatic cancer	29%
				• Musculoskeletal and skin cancer	43%
				• Brain cancer	75%
				• Other ca or unknown primary	50%
				• non-cancer	50%
				Risk factors for development	
				• Age	($P > 0.05$)
				• **Male gender**	($P = 0.034$) RR 1,35
				• **Lung cancer**	($P = 0.003$) RR 1.58
Morita et al.[8], Japan, 2000	Hospital	Cancer (various tumors)	245	Tumor in brain	
				• Present	21%
				• Absent	9% ($P < 0.01$)
				Tumor in lung	
				• Present	63%
				• Absent	34% ($P < 0.01$)
				Tumor in bone	
				• Present	46%
				• Absent	29% ($P < 0.01$)
				Tumor in liver	
				• Present	32%
				• Absent	51% ($P < 0.01$)
				Tumor in intestinal tract	
				• Present	27%
				• Absent	40% ($P < 0.05$)
Pautex et al.[46], Switserland, 1997	Hospital	Mixed (cancer and various non-cancer)	100	Dementia	
				• Yes	46%
				• No	30% ($P > 0.05$)
Bennett et al.[61], UK, 1996	Hospice	Mixed (long, liver, brain tumors, COPD, heart failure)	96	**Duration of stay > 9 days Cerebral malignancy**	$P = 0.048$
				No correlation with pulmonary malignancies or pulmonary diseases	$P = 0.048$

PCU = palliative care unit; GI = gastrointestinal; RR = relative risk; COPD = chronic obstructive pulmonary disease; ADL = activities of daily living.
[a]Number of patients in the study on which prevalence was based.
[b]Death rattle score25 : 'inaudible' (score 0), 'audible only very close to the patient' (score 1), 'clearly audible at the end of the bed in a quiet room' (score 2) and 'clearly audible at about 6m or at the door of the room' (score 3).
[c]Artificial hydration ≥ 1 l/day.
[d]Artificial hydration < 1 l/day.