Dying within dying: Ethical dilemmas of treating terminally ill patients with acute life-threatening illnesses

Sir,

With the advent of palliative care, severely ill patients with terminal illnesses are often treated in accordance with their autonomy and with dignity, compassion, and comfort.[1] However, this most often happens if the patient is dying from the said terminal illness such as renal or heart failure or cancer.[2] Such patients may choose to die at home or even in palliative care wards. It is a comforting feeling for physicians and families that nonbeneficial life-sustaining and often agonizing care is not being delivered against a patient’s wishes. There are pathways, protocols, and advance care plans for identifying and allowing such patients to complete their journey at the end of life.[3]

However, an alarming number of patients with terminal illnesses fall through the cracks of this optimal situation.[4] Patients may receive care that is not in keeping with their natural trajectory of illness or wishes if they are admitted with an acute potentially “reversible” pathology while having a background terminal illness such as developing pneumonia, suffering myocardial infarctions, or be involved in trauma.[5] The rising costs of admitting and treating terminally ill patients with acute illness with modern day technology is unsustainable. The aim of this letter is to provide a brief review of the literature on the ethical difficulties that physicians and families face when decision-making in a terminally ill patient (at times with an advance care plan in place) is thrown off balance by a sudden acute illness. The question here is “should physicians feel morally obliged to treat an acute illness when the patient is already far along his or her end of life journey?”

The thematic analysis of these papers revealed the following subtopics: Family communication, reiteration of diagnosis, burden of critical treatment, and goal setting. There was general agreement that terminally ill patients should have continuity of care and preferably be referred to the same center familiar with their terminal diagnosis and end of life goals.

In an aging world with limited critical care resources, there are many demands on acute care settings such as Intensive Care Units. Patients who may not benefit from aggressive life-sustaining care perhaps should not be offered such treatment options such as life-saving surgery, if in fact it is merely prolonging their ultimate fate, unless it can add to alleviating suffering. Instead, effort and resources should be used in trying to match their goals and values, including palliation and providing mindful dignity and comfort. Often symptom control to provide relief is the driving force behind acute admissions in terminally ill patients; however, it seems that frank and consistent communication with patients and families may allay the ethical conflicts that usually arise when a patient presents in extremis while already dying from a separate illness including old age.

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Conflicts of interest
There are no conflicts of interest.

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References
Scorpion bite, a sting to the heart!

Sir,

We read the article “Scorpion bite, a sting to heart” by Agrawal et al. [1] with great interest. The author reported a case of 14-year-old male patient with scorpion bite on the right toe. We want to highlight certain issues regarding diagnosis and management of this patient.

Cardiotoxic effects due to scorpion bite are not rare complications as demonstrated by Kumar et al. [2] that almost more than one-third of these patients have one or more cardiovascular effects.

Prazosin and anti-scorpion venom (SAV) should be the primary line of treatment, as alpha receptors stimulation by the toxin results in hypertension, tachycardia, myocardial dysfunction, pulmonary edema, and cool extremities. [3] However, it has been seen that the late administration of SAV may be effective as the antivenom creates a concentration gradient between plasma and target tissue. The venom bound to antivenom gets excreted, and the toxin in the tissues moves down the concentration gradient into the blood and gets bound by the antivenom. Therefore, even if the venom is not immediately neutralized by antibodies, its removal from the tissue may cause relief in symptoms. [3]

Electrocardiography (ECG) is the most important and easily available tool. No victim with systemic involvement shows normal ECG. RST segment and T waves are most frequently affected. Early myocardial infarction-like pattern, atrial arrhythmias, nonsustained ventricular tachycardia and varied conduction defect due to injury to the conducting system are seen. Conduction defect restore to normal within 1 week, T wave inversion persist for a few weeks. At times, despite good clinical status of the victim, ECG showed mark abnormalities. [4]

Echocardiography is a useful tool for evaluating the various parameters of cardiac function. Echo shows poor global myocardial contractility within 12–15 h of sting, with low ejection fraction, decreased left ventricular performance, and abnormal diastolic filling for 5 days to 4 weeks. Diminished or hypokinetic left ventricular global movement with decrease systolic function was seen in the scintigraphic study. There is a good correlation between clinical improvement and return to normal left ventricular function. [5]

Karnad from India studied haemodynamic pattern in eight scorpion sting cases of Mesobuthus tamulus sting. He recorded severe vasoconstriction and hypertension in mild envenoming while predominant left ventricular dysfunction with normal systemic vascular resistance causing pulmonary edema or severe hypotension in severe envenomation. [6]

These patients are benefitted by the early use of inotropes and vasodilators, which reduce the afterload on the heart. These physiologic principles make dobutamine and milrinone as vasoactive drugs of choice instead of Noradrenaline as used by authors in the index case.

Amiodarone a neuromodulator improves the survival by reduction of serum nor-epinephrine level in four children with scorpion sting who had severe left ventricular dysfunction with raised troponin and serum norepinephrine. [7]

Early hospitalization after sting, and administration of SAV are the key factors in reducing the myocardial dysfunction, and hence related morbidity and mortality.

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