Re: NHPCO Position Statement on Palliative Sedation

To the Editor:

I thank Timothy Kirk, PhD, and Margaret Mahon, PhD, RN, FAAN, writing for the Palliative Sedation Task Force of the National Hospice and Palliative Care Organization (NHPCO) Ethics Committee, for their article providing clarity on the practice of palliative sedation.¹ As a practitioner, I recognize the importance of eliminating confusion about this practice in the minds of the public and even among medical providers.

The NHPCO is right to clearly distinguish palliative sedation from physician-assisted death (PAD). The commentary distinguishing palliative sedation from PAD in terms of effect, instrument of relief, and legality is important in the optimal utilization of the practice. The NHPCO position statement would be still stronger without the frequent use of a confusing term that leads to fear and misunderstanding.

Unfortunately, throughout their position statement and commentary, the authors use the term “physician-assisted suicide.” This is politicized language that implies a value judgment and carries with it a social stigma. The policy statement of the American Academy of Hospice and Palliative Medicine states “The term PAD is utilized in this document with the belief that it captures the essence of the process in a more accurately descriptive fashion than the more emotionally charged designation “physician-assisted suicide.” The American Medical Student Association, the American Medical Women’s Association, the Washington State Psychological Association, the American College of Legal Medicine, and the American Public Health Association have all rejected the term “physician-assisted suicide” as inaccurate and inappropriate.

As well, assisted suicide has a distinctly different legal status from PAD. The article misstates the law by asserting that “physician-assisted suicide is currently a legal option for patients in Oregon, Washington and Montana.” In fact, the Oregon and Washington laws clearly state “Actions taken in accordance with (the Death with Dignity Act) shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law.” “Assisting another to commit suicide,” clearly distinguished from PAD, remains a crime in those states.

The Montana Supreme Court, “finding no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy,” relies on that state’s Terminally Ill Act. In protecting the end-of-life decisions of a patient, and shielding physicians from criminal, civil, or professional liability who act in accordance with the patient’s wishes, the Terminally Ill Act explicitly “prohibits, for any purpose, treating the death as either ‘suicide or homicide.’”

We encourage the authors in the future to use the value-neutral terms “physician aid in dying” or “physician-assisted death,” and call on the

References

NHPCO Ethics Committee to revise their policy statement to substitute these terms as well.

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Reference

Spontaneous Cervical (C1–C2) Cerebrospinal Fluid Leakage Repaired with Computed Tomography-Guided Cervical Epidural Blood Patch

To the Editor:

Intracranial hypotension syndrome (IHS) is often caused by persistent cerebrospinal fluid (CSF) leakage. IHS usually presents with orthostatic headache, exacerbated by an increase in intracranial pressure, but other symptoms can be present such as nausea, vomiting, dizziness, neck pain, and paresis of the VIth cranial nerve. It can be spontaneous or related to a trauma, such as dural puncture or surgery, or medical causes such as dehydration. Thanks to improvements in neuroradiological imaging quality, magnetic resonance imaging (MRI) diagnosis of IHS is now more common and easier.

IHS is a benign condition, often treated conservatively. If it does not resolve by itself, it usually can be treated with epidural blood patch (EBP), even if a Cochrane meta-analysis showed a lack of randomized controlled trials that confirm the efficacy of this approach. Rarely, IHS is caused by a high cervical problem and, to our knowledge, in the literature there are only three cases of C2 leakage treated with EBP with a large volume of blood (the authors repeated the procedure twice, with 10 mL each time).

Case

A 32-year-old previously healthy woman presented to our hospital with a monthly history of progressively worsening frontal headache, nausea, dizziness, and photophobia. Symptoms partially regressed when lying down and worsened when sitting up or standing. She did not present with any fever.

The patient’s symptoms had started subacutely after heavy physical activity. She also reported a nonconcuissional craniofacial trauma some days before the start of the headache. She was brought to the neurological department of her local hospital. Computed tomography (CT) scan did not show any evident abnormality, but an MRI showed typical signs of IHS (pachymeningeal enhancement, subdural fluid collection at multilevels of the central nervous system, and venous engorge ment); no clear image of the level of fistula was found. She was treated for a month with nonsteroidal anti-inflammatory drugs, intravenous caffeine, fluids and rest, without symptom relief. The patient was referred to our hospital, where we repeated an MRI that revealed collection of fluid in the suboccipital space (Fig. 1a) at the upper cervical muscle level, along with subdural fluid collections (Fig. 1b) and enhancement of the pachymeninges (Fig. 1c). The CSF accumulation at the posterior atlantoepistropheus level suggested the level of the fistula (C1–C2).

With the patient in a prone position and under CT guidance, an 18G needle was inserted in the epidural space at the C5–C6 level, using the air loss-of-resistance technique. Then, a radiopaque 18G epidural catheter was advanced to the C3 level, and we confirmed the level of the tip of the catheter through dye injection. As 1 mL was spread to C2, we decided to inject slowly, into the epidural space, only 2.5 mL of sterile autologous peripheral unclotted venous blood. As CT confirmed spreading of blood to C1 (anterior and posterior), we stopped the injection. At the end of the procedure, the catheter was removed. The patient was awake during the entire procedure and cooperated with a complete neurological examination. She did not complain of any neurological symptoms except neck pain for few hours. All her symptoms regressed within 24 hours after the procedure, and she was discharged after three days.