Palliative Vasoactive Therapy in Patients With Septic Shock

To the Editor:

We read with interest the article by Quill et al\(^1\) in this issue of CHEST (see page 573) showing that the risk-adjusted propensity to withdraw life support in an ICU is directly associated with the standardized mortality ratio of the ICU. We believe that the reasons the end-of-life decision-making process is so variable deserve discussion. There may be two additional reasons to explain why so many discrepancies can be reported across centers and, in the same center, across apparently similar cases. First, most of the variables collected in databases are not able to capture each specific context (eg, the number of patients with do not resuscitate orders in the ICU, clinicians’ beliefs and burnout, as well as patients’ and relatives’ preferences and values). Second, in some groups of patients, the goals of care may be changing over time. Indeed, the literature is currently focused on guiding clinicians to provide patients with a full code management based on the best current evidence. However, an increasing number of patients are admitted to the ICU with treatment-limitation decisions but with curative intent.\(^2,3\) These patients are receiving the least invasive management, with the hope that this will actually prolong their life. For instance, patients with acute respiratory failure who declined tracheal intubation may benefit from noninvasive mechanical ventilation, with good survival and preserved quality of life, without an increase of post-ICU burden.\(^4\)

In patients with sepsis, we would like to draw attention to a new clinical vignette of patients with septic shock and treatment-limitation decisions. We report a case series of 57 patients with intractable cancer who presented with septic shock (9% of all patients with cancer with septic shock admitted over a 7-year study period). All the patients were admitted to the ICU with a code status that precluded surgery, intubation, and dialysis. Recent chemotherapy was administered to one-half of the patients over the last 4 weeks. ICU management for all of them consisted of noninvasive management including early antibiotics, source control when needed (catheter withdrawal, urine drainage), echocardiography-guided fluid expansion, and norepinephrine. Patients and relatives were aware of the situation and of the possible shift to comfort, according to response to therapy. At ICU admission, 21 patients (37%) presented with neutropenia, and 33 (58%) of them had two or more organ dysfunctions. The source of sepsis was urinary tract infections in 37%, catheter-related infection in 23%, and pneumonia in 21%, and 9% of the patients had sepsis from unknown origin. Norepinephrine was administered at a dose of 1.3 (1-2 interquartile range) mg/h for a median duration of 24 (24-39 interquartile range) h. Survival was 86% at ICU discharge and 58% at 6 months. Only 30% of the patients were finally discharged home.

Assessment of performance status in survivors 3 months after ICU discharge showed a decline as compared with this reported prior to ICU admission (median [interquartile range]: 2 [1-3] vs 1 [1-2]; \(P < .01\)).

Patients, relatives, and clinicians must be aware of this clinical vignette and preliminary results. Our goal is to offer seriously ill patients treatments that fulfill their preferences and values, while providing them with honest and loyal information.\(^5\) Studies assessing quantitative and qualitative outcomes in patients with treatment-limitation decisions admitted to the ICU with septic shock are warranted. The challenge clearly stands in addressing the following question: Do we actually prolong their life or do we only prolong the dying process?

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1 Quill et al. See page 573 in this issue of CHEST.
References


