Silibinin

Where Is the Ethical Conundrum?

To the Editor:

We read with great interest the recent article by Gores et al in CHEST (October 2014). While applauding the successful outcome of *Amanita* mushroom poisoning, it mystifies us that the authors perceived any ethical quandary concerning the use of silibinin. We would consider it more ethically questionable to deprive the patient an opportunity to receive silibinin.

Silibinin is the treatment best supported by available canine\(^2-3\) and human evidence.\(^4-6\) It has long been approved in Europe, where it is the drug of choice for amatoxin poisoning. While the market for silibinin in the United States is too small to justify efforts by the manufacturer to pursue US Food and Drug Administration approval, the drug is essentially available for compassionate use under the National Institutes of Health–registered study protocol referenced in the original case report.\(^7\)

We recognize the rationale for IV N-acetylcysteine, IV penicillin G, and multidose-activated charcoal. All three have low risk and a modest role in treatment of amatoxin poisoning, but evidence of their efficacy is weak to nonexistent.

The authors seem concerned about the botanical origins of the drug. We point out that we have no anxiety about using other drugs derived from plants such as the willow and the poppy in our daily practice.

Most patients with amatoxin poisoning survive, and it is impossible to say whether this patient’s outcome would have been different without silibinin. Given the available evidence, we would want silibinin if we were inadvertently poisoned with amatoxin-containing mushrooms.

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References


Response

To the Editor:

We thank the authors for their interest in our ethical dilemma\(^1\) and for giving us another opportunity to emphasize our message. When faced with a patient with hepatic failure following *Amanita* poisoning, we chose to offer treatment with the investigational drug silibinin.\(^1\) In doing so, we sought to balance its risks and benefits, attributes that we found difficult to quantify. The evidence making silibinin the “treatment best supported” relies on animal studies alone. Publications reporting use in patients include only uncontrolled case reports or series in which all subjects were treated with the drug.\(^2-4\) This is thin ice, indeed. On balance, we chose to...
offer the drug but found that we wrestled with our decision.

We have little doubt that many clinicians would, like these authors, see no conundrum. But we were troubled by our inclination to action, knowing that sometimes doing nothing is the best medicine.\textsuperscript{5,6} When faced with uncertainty, physicians often choose action over inaction, for many psychologic, medicolegal, and other reasons. But “clinical inertia” may serve to protect unwitting patients from our own overzealous attempts to help.\textsuperscript{7} In their closing paragraph, the authors justify our concern: They “want silibinin.” That is exactly the problem we hoped to illuminate.

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