

The Medical Ethics and Legalization of End-of-Life Care in Critically Ill Patients

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Since the Life-Sustaining Treatment Act implemented in February 4th, 2018, was legalized in the means of respecting the will of the patients who are critically ill, ethical and administrative issues surrounding this law remain controversial. Here we report a case of an 86-year old Korean man with bladder cancer who went through futile intensive unit care before withholding life-sustaining treatments. He had documented advance directive beforehand but did not rewrite his wishes after legislation enactment. The patient initially refused chemotherapy or surgery, however received radiotherapy as an alternative treatment. His bladder cancer recurred two years later, and he was admitted to urology department for supportive care already knowing his life expectancy would be less than three months. Two weeks later, acute respiratory distress syndrome developed and he was emergently intubated, transferred to surgical intensive care unit to be mechanically ventilated. Having agreed upon grave prognosis, Physician Orders for Life-Sustaining Treatment was then written, but was not completed due to lack of the document, certificate of family relations. With an incomplete documentation, cardiopulmonary resuscitation was administered on anticipated cardiac arrest. He survived for 20 more hours before the certificate of family relations was ready, and life sustaining therapies including ventilatory, hemodynamic support were removed. While end of life care should be patient centered and based primarily on fundamental ethics including autonomy, beneficence, nonmaleficence, and justice, it is often times disrupted by over-rigid bureaucracy. Distress may arise from contradictory goals among patient, family members, and related physicians which may lead to unnecessary conflict and futile treatments. Shared decision making upon thorough and effective communication is essential in establishing the appropriate goal of care. This communication however, should ideally be made in advance, as many problems arise in the process of documenting and determining the specific point of limiting life-sustaining treatments.



A case of multiple intracerebral hemorrhage confusing with brain tumor

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ICH is the second most common cause of stroke, following ischemic stroke. ICH typically occurs in the putamen (50%) or thalamus (15%), cerebellum, etc. We report a case of multiple hemorrhage lesion can be mistaken for a metastatic brain tumor at first. A 75-year-old woman with a history of angina and hypertension 5 years ago was transferred for sudden onset dysarthria. She had been incomplete brain tumor operation 30 years ago. She has taken aspirin due to angina. Previous hospital brain CT scan was performed, the result was multiple metastatic hemorrhage in Parietal-Occipital area, Lt. We conducted chest, abdomen CT and PET-CT for finding primary origin tumor on April 6. Chest and abdomen CT scan showed no evidence of Primary lesion. PET-CT scan showed multiple hypo-metabolic lesions in brain, hyper-metabolic lesion in right maxillary sinus and right highest mediastinal area (Fig. 1). So we decided to perform excisional biopsy of the brain lesion and Rt. sinus lesion of nasal cavity. Pathological findings of nasal mucosa and brain lesion were chronic inflammation, hemorrhage and organizing fibrin clots, respectively. As a result, we conclude that the brain imaging and sudden onset dysarthria were due to brain hemorrhage. Multiple ICH is an uncommon event. It has been reported 0.7~2% of brain hemorrhagic events. Brain tumor and ICH can cause of acute dysarthria. In this case, we miss diagnosed due to history of brain tumor at first. We should have considered brain hemorrhage first, because the patient had a medication history and acute onset of symptoms

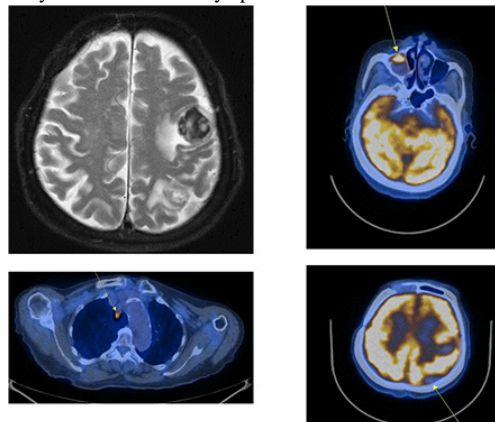


Fig.1