Author’s response to reviews

Title: Sedation in palliative care - a critical analysis of 7 years experience

Authors:
Prof H. Christof Muller-Busch (muebu@t-online.de)
Inge Andres (andresi@t-online.de)
Thomas Jehser (tjehser@havelhoehe.de)

Version: 3 Date: 22 Apr 2003

Thank you for the useful comments. Most of them I have considered in the revised manuscript. The changes in detail:

Comments on Morita

Compulsory

1. The major compulsory comments have been considered in the revised manuscript. Agitated delirium, restlessness and agitated anxiety are sometimes difficult to differentiate as well as classification into physical and psychological. Especially in this retrospective analysis classification of delirium was the most difficult.

2. Data collection now is in more detail. The ranking of symptoms is explained

3. Statistical methods and p values were added

4. Definitions were more clarified

5. Whole number of patients in Fig. 1 is completed

6. Primary disease diagnoses were added in Table 2

7. Discussion of sedation for more psychological distress has been clarified

Discretionary

1. The findings of this study are presented in relation to problems on discussion in the literature. Data presentation has made more clear. Figures were reduced and tables completed. Some important ethical aspects of the discussion part I would like to remain included.

2. The discussion on definition goes on. In the revised manuscript I avoided the mostly used term TS Palliative sedation which seems to be more attractive but can be misunderstood too e.g. it is usually used for short procedures with sedation at least in some languages.

3. Hydration in final life situations is a difficult issue which I did not further comment on in this article - we handle it according to clinical signs not on laboratory parameters. Infusions are given, when signs of dehydration e.g. delirium could be attributed to insufficient fluid intake. But this is rare. Oral uptake on thirst to our experience is a could self controlled regulation of fluid demand. This also means that light or intermittent sedation allows reports of thirst and swallowing.
4. Patients backgrounds should be further investigated. It seems younger women with extreme somatic and psychological distress are mostly candidates for sedation - the reason for that should be investigated - also patients with oro- und hypopharyngeal tumors.

Comments on Radbruch

Discretionary

1. Heavy (as used in the EAPC Task Force Paper) is the same as deep
2. Background, methods and results remarks have been considered
3. The mean time of sedation can be longer then 48 hrs as seen in the tables, but consideration of sedation was restricted to situation when death could be expected in the next 48 hours and no other strategies e.g. antidepressants or anticonvulsants with a longer onset of effect were excluded.
4. The tables and figures have been revised completely with 468 patients without and 80 patients with sedation. Sorry for the incorrect number of patients.

Compulsory

1. The compulsory comments of Radbruch were considered in the revised manuscript which includes 548 (not 448!!!) patients. The use of the term terminal sedation was avoided. Certainly this is a retrospective study - but the intention was to reconsider guidelines and concentrate on perhaps better alternatives. This only can be done, when you reflect, what you are or have been doing, make it transparent for discussion and relate it to others. This is the intention of this study. Restlessness, anxiety and delirium are especially in late stages near death sometimes very difficult to classify into somatic or more psychosocial origin. The lowering of consciousness by sedation is the form of treatment to treat refractory symptoms which are insufficiently affected by pain medication, neuroleptics, antiemetic, anxiolytics etc. There is a narrow line and the question of intention certainly is the most important. What is adequate and inadequate? Adequate treatment is also relative...Sedation can be a form of adequate treatment if adequately performed

2. Insomnia for some patients is were burdensome and it can be a acceptable indication for (intermittent) sedation in the last days of life - also cachexia for some is extremely burdensome - certainly not as a primary indication for sedation and certainly not TS in the narrow sense. Cachexia in relation to fatigue, anxiety, depression, in regrouping the patients I excluded cachexia.

3. The reasons for the increasing incidence of sedation in our unit are discussed

4. In relation with the first consideration of TS in 1995 and the ethical problems associated we looked for a schedule in what kind of clinical situations and with which intention intravenous administration of benzodiazepines would be appropriate. The definition with time restriction "expected or possible death in the next 48 hrs" we introduced then as a kind of internal guideline for the future (except the "technical" part, which we considered later)- reconsideration is in progress. Monitoring concentrates on clinical parameters (Puls/RR) and communication as the sedation is not performed as anesthesia (which could?) and the main parameters were signs and reports of comfort. Some patients had pO2 - monitoring - but there is still no "standard"

5. As this was and is originally a study for internal discussion, data collection and systematic analysis was done by one person who also knew about the patients- some missing data especially on prevalent symptoms and duration of sedation had to be collected by discussion with the doctors more involved in the sedation - certainly a disadvantage but in this field "unrelated" data-analysis (by "independent" rating) would have brought even more confusion and inconsistency - Medical charts
are also dependent on documentation abilities of those who are in charge - I wonder if an “independent observer” could distinguish between sedation for symptom relief and slow euthanasia? This is not the point - the point of this study is to demonstrate transparency for an open discussion...

6. The discussion part has been revised.

7. Conclusions were reformulated. The reconsideration of our guidelines with regard to patients needs, intention and the value of personal support has been included in the discussion part.