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Psychiatric patients are more vulnerable to the Spanish euthanasia law?☆

¿Los pacientes psiquiátricos son más vulnerables ante la ley de la eutanasia española?

Dear Editor,

Active euthanasia and assisted suicide (EAS) are legal in Luxemburg, the Netherlands, Colombia, Germany, New Zealand, Belgium, Canada, Switzerland and several states in the United States and in Australia.[1] Spain has recently become one of the countries where EAS is legal after approval of the law on 17th December 2020 by the Congress of Deputies (BOE-122/000020). The people eligible to benefit from this law would be those of full legal age and full capacity to act and decide, who suffer from a severe, chronic and debilitating condition or a severe and incurable disease causing intolerable levels of physical or mental suffering. This law empowers patients who may be living under intolerable circumstances, providing them with the option to die. However, it also opens the door for psychiatric patients with a mental disorder (many of them considered chronic, disabling and causing mental pain) to be able to request EAS. One recent systematic review confirmed an increase in psychiatric patients requesting EAS in the countries where it has been legalized.[1] The authors found that the clinical characteristics of the patients who requested or who were cases of EAS were similar to those psychiatric patients who commit completed suicide: a history of prior intent; isolation; depressive disorder; personality disorder. Another population vulnerable to the application of this law is the geriatric population. There is growing demand for EAS in patients with geriatric syndromes in the countries which are less restrictive regarding the law.[2] The problem is that these syndromes are usually accompanied by mental and emotional problems, as well as cognitive ones.

This law invites reflection in the 3 previously mentioned points: 1) full capacity to act; 2) severe, chronic and incapacitating/incurable; and 3) causing intolerable mental pain.

Firstly, the law on euthanasia requires that the patient takes the conscious decision to request EAS, is able to understand the consequences of requesting EAS versus the available treatment alternatives. Decision-making ability is linked to the abilities of taking in relevant feedback, understanding the consequences of their decisions and issuing and communicating a verdict based on the analysis of that information.[3] Although suffering from a mental disorder does not incapacitate the patient in taking decisions, it may limit their capacity. In fact, cognitive impairments in taking decisions are a sign of vulnerability in suicide patients.[4] Patients with these impairments take decisions based on short-term rewards (e.g. pain relief) without bearing in mind the long-term consequences (e.g. death), leading to riskier decisions. Previous studies in Holland have shown in over half of EAS cases that the assessing physician made an overall judgment about the patient's decisional capacity, instead of this being based on validated cognitive tests.[5] Furthermore, a large number of psychiatric patients withdraw their request to commit EAS midway.[1] This proves that the desire to die is not stable over time, and is related to state of mind variables that can be treated. The law provides for these possible changes since the patient has to repeat their desire to request EAS, thus impeding impulsive behaviour. However, in order to protect psychiatric patients it would be recommendable to establish a structured and multidisciplinary assessment of their ability to decide and of the risk of suicide with a EAS request, so that the neurocognitive capacities of the patient are assessed, along with their general mental state based on valid and reliable tests, with follow-up and re-assessment after a certain period of time.

Regarding the terms chronic and incurable, the actual definition of psychological distress includes feelings of desperation, impotence and irreversibility of the pain, with a prolonged duration over time.[6] In a recent study, Lengvenyte et al.[7] analysed the clinical records of 66 patients who had requested EAS in the Netherlands using the data abstraction

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method in search of 9 dimensions of psychological distress. This study showed that 100% of patients felt irreversible psychological pain. However, one of the most striking findings was that the patients who had rejected treatment showed a higher number of psychological distress dimensions. Thus, drugs such as bupenorfrin or psychotherapy had demonstrated their effectiveness in reducing psychological distress.[8] As a consequence, if effective treatments exist for reducing psychological distress, the irreversibility of this pain may be in doubt. In addition, concepts such as treatment-resistant depression are currently strongly criticized, since no clear consensus exists among professionals as to when a certain case may be considered untreatable. Therefore, prior to approving the EAS request of a patient, it is logical to consider the combination of psychotherapy and treatments with analgesic properties as a solution for physical and psychological distress, in addition to the treatments recommended for mental disorders.

Lastly, a condition of approval for a EAS request is that the disease or its associated limitations must cause constant or unbearable mental or physical suffering. However, intense psychological pain is a characteristic which is present in almost all psychiatric disorders and has become a trans-diagnostic variable in psychiatry.[6] Likewise, ''classical'' suicide has been considered as a form of escaping from unbearable psychological pain. In fact, high psychological pain may predict future suicide attempts in depressed patients.[9] Also, psychological and physical pain share common biological structures and an increase in one of them may lead to an increase in the other.[10] This vicious circle has been connected to an increase in the prevalence of psychiatric disorders in patients with chronic pain.

It is not a question of psychiatrising patients who request EAS nor leaving the decision in the hands of psychiatrists about who may benefit from this law (indeed we would advocate a multidisciplinary team), but rather one of protecting the psychiatric patients who are at risk of suicide, since they could be given the necessary means to complete it. This is in direct conflict with decades of globally recommended suicide prevention measures. That said, the lack of psychiatrists and psychologists in the Spanish public health system limits access to mental health treatment. The question therefore is not whether psychological pain is irreversible but whether the health system is capable of offering sufficient means to treat this psychological pain and of providing all the possible patient treatment options. Regarding costs and benefits, it is cheaper to prescribe EAS than providing the health system with a larger number of professionals and paying for appropriate consultation and psychotherapy, especially when we are speaking of geriatric and psychiatric patients who ''cost more than they contribute''. This type of thought and a lax law could lead us down a ''slippery slope'' where EAS was systematically prescribed due to the lack of means with the excuse that the patient's pain is irreversible.[2]

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Lithium toxicity: The SILENT threat[☆]

Intoxicación por litio: la amenaza SILENTiosa

Dear Editor,

Lithium as medication is mainly used in psychiatry as treatment for bipolar disorder and to a lesser extent in neurology (preventative of cluster headache and Kleine-Levin syndrome). Treatment with lithium may give rise to both acute and chronic neurotoxicity.[1] The syndrome of Irreversible lithium-effectuated neurotoxicity (SILENT) refers to the persistent neurological sequelae after lithium intoxication. We describe a case of SILENT secondary to heatstroke.

A 42-year old male with a history of type 1 bipolar disorder, chronic oenolism, meningitis as a child, epilepsy and mild intellectual disability was treated with 400-200-400 mg lithium carbonate, 500-500-500 mg valproic acid, 10-10-10 mg olanzapine and 1-1-1 mg. clonazepam. The latest lithaemia (12 days prior to hospital admission) was within therapeutic range (.9 mEq/L). The patient was found on a public highway in the summer of 2018 due to impaired consciousness (Glasgow Coma Scale 6), hyperthermia (40 °c) and low blood pressure (70/40 mmHg), requiring intubation. Analysis highlighted severe hyponatraemia (120 mEq/L) with no rabdomyolysis (CK 317 U/L), with reasonable suspicion of heatstroke and ruling out of malignant neuroleptic syndrome. The other analyses, lumbar puncture and urine toxicants tested normal. Valproate levels were normal but lithaemia was not requested. Computerised axial tomography (CAT) of the brain showed a triventricular hydrocephalus which was already known. After 24 h natraemia was 134 mEq/L. A On the fourth day the patient was extubated, with continuous generalised choreoathetosis movements, scandid dysartheria, broad horizontal-rotatory nystagmus and spastic tetraparesis being observed. Lithium was discontinued and levodopa/carbidopa was started, with slight clinical improvement. Days later, a clear bilateral cerebellar syndrome with appendicular dysmetria and trunk ataxia could be observed. Two nuclear magnetic resonance imaging (NMRI) of the brain were performed, the first nine days after admission and the second at day 24 (Fig. 1A), both without any changes compatible with myelinolysis. After one month of admission the patient had a severe appendicular and axial cerebellar disorder with choreoathetosis movements, mild tetraparesis and pyramidalism. An MRI after eight months (Fig. 1B) showed no alterations other than known hydrocephalus. Given the neurological semiology, the persistence of sequelae more than two months after lithium withdrawal and normal neuroimaging, the patient was finally diagnosed with SILENT.

SILENT involves the neurological sequelae resulting from acute lithium carbonate intoxication and is less frequent from chronic use, when they persist two months after ceasing treatment.[1,2] Despite of the fact that lithium is still widely used today, SILENT is an uncommon entity.[1,3,4] Its physiopathology is as yet unknown, although demyelin-

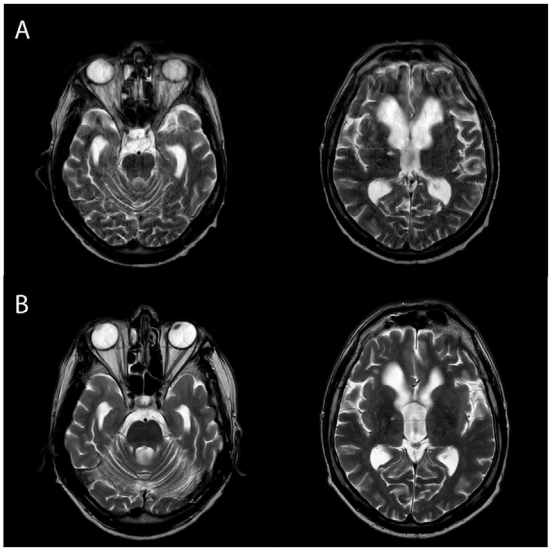

Figure 1 Evolution of brain NMRI.
Bottom of image: Brain NMRI in T2 sequence, cross-sectional slices at protuberance level (A1 and B1) and base lymph nodes (A2 and B2), of our patient. Images A) correspond to the NMRI performed during admission, 24 days after symptom onset and images B) to that performed after 8 months. In both a triventricular hydrocephalus is observed with no evidence of demyelinating lesions characteristic of osmotic myelinolysis either in the protuberance or base lymph nodes.

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