

## When to Treat Dehydration in the Terminally Ill Patient?

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The need to treat dehydration in terminally ill patients has become a very controversial topic. Numerous reports in the literature have illustrated opposing view points from both a clinical and ethical perspective. Arguments for the maintenance of hydration in terminally ill patients have tended to come from "the traditional medical model". Many health care professionals looking after terminally ill patients have reacted to the generalized use of intravenous fluids in dying patients, and the perceived negative effects of this management. The arguments against rehydration have traditionally been: - Comatose patients do not experience symptom distress; parenteral fluids may prolong dying; less urine results in less need to void or use catheters; less gastrointestinal fluid, nausea and vomiting; less respiratory tract problems such as cough and pulmonary edema; decreased edema and ascites; dehydration may act as a natural anesthetic for the central nervous system; and parenteral hydration is uncomfortable and limits patient mobility. The arguments for rehydration can be summarized as: - Dying patients are more comfortable with parenteral hydration; no evidence fluids prolong life; dehydration can cause confusion, restlessness and neuromuscular irritability; oral hydration is given to dying patients complaining of thirst, therefore parenteral hydration can also be administered; emphasis on poor quality of life detracts from efforts to improve comfort and life quality; parenteral hydration is a minimum standard of care; withholding fluid to dying patients may result in withholding therapies to other compromised patient groups (1, 2).

Our palliative care group has argued that the view point that dehydration in dying patients is never a cause of symptom distress, overlooks the fact that: - 1) dehydration is well recognized in nonterminal patients to cause confusion and restlessness, problems often reported in terminally ill patients; 2) reduced intravascular volume and glomerular filtration rate caused by dehydration is accepted as a cause for prerenal failure, with opioid metabolite accumulation in the presence of renal failure causing confusion, myoclonus and seizures, having been well documented (1, 2, 3). In previous publications we have reviewed the traditional arguments surrounding this topic, the biochemical parameters reported in terminally ill cancer patients, the use of hypodermoclysis and rectal hydration, the findings of recent research on this topic, and presented our perspective on this controversy (2, 3). In common with other reviews (4, 5), we have concluded that the data reported to date is insufficient to reach a final conclusion on the benefit or harm of dehydration in terminally ill patients. Nevertheless, it is worth considering that while some dying patients may not suffer any ill effects from dehydration, there may be others who do manifest symptoms such as confusion or opioid toxicity that may be alleviated or prevented by parenteral hydration. In addition a dehydrated patient with renal failure, should at least have medications such as opioids gradually decreased to avoid accumulation and the development of toxic side effects.

## References

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