Kevorkian plays important role in advancing physician-assisted suicide

To the Editor:

In an editorial in the February issue of the JAOA, Frederick Goldstein, PhD, took issue with Jack Kevorkian, MD, for assisting dying patients in ending their lives at a time of their choosing. Dr Goldstein believes that Dr Kevorkian instead should conduct research on the management of end-of-life health issues and, presumably, encourage his patients to participate in his research, rather than end their lives.

Dr Goldstein queried, "why doesn't [Dr Kevorkian] join those of us conducting clinical research? Why doesn't he try to improve the problems terminally ill patients experience instead of providing only one final solution?" Dr Goldstein and others have devoted their careers to medical research, and I am appreciative. However, I also am grateful to Dr Kevorkian for making himself available to patients in need at the end of life and for advancing public debate on physician-assisted suicide and euthanasia. He may be playing a vastly more important role in this realm than he could in any other.

Dr Goldstein observed, "I work with several physicians who have many patients who volunteer to participate in my clinical research projects." "Volunteer" is the operative word; if Dr Goldstein has access to patients who wish to participate in his research, I am pleased both for him and for research medicine. However, for the foreseeable future, medical circumstances sometimes will lead patients to opt for an assisted death instead. I think the fact that organized medicine does not support that option for all terminally ill patients represents a terrible indictment of the profession.

Dr Goldstein pointed out, "When we are successful in reducing [difficulty breathing and swallowing, pain, and depression] we also decrease the desire of patients to

commit suicide"; probably true and irrelevant for Dr Kevorkian's patients. As was the case for the gentleman many of us watched die on television some months ago, these patients have exhausted their medical options at the end of life. They are in need of compassionate assistance in dying with dignity, not best-case platitudes about how end-of-life traumas sometimes can be managed for other patients under other circumstances.

Dr Goldstein closed with "Jack Kevorkian's method decreases the opportunity for clinical researchers to work with terminally ill patients. It reduces the development of procedures that will provide more comfort at life's end. It is Kevorkian's policy that should be terminated—not the lives of patients." Implicit is the assumption that the needs of research medicine should supersede those of individual, dying patients. Better would be to let patients decide for themselves. Best would be to sanction euthanasia for terminally ill patients who desire it so that friends and family can be present when their loved ones leave on their final journey. An end-of-life treatment plan that includes the option for a humane, physician-assisted departure, as opposed to being focused narrowly on fighting disease and forestalling death at all cost, would very much be in keeping with the osteopathic perspective.

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Response

To the Editor:

Dr Hartman not only misunderstood several points of my editorial, but also fails to understand that Dr Kevorkian does not provide a "humane physician-assisted departure." My reply therefore is twofold.

■ **The Kevorkian aspect**—Dr Kevorkian does not confer with physicians who care for a dying patient to determine if, in fact, the patient actually has a terminal disease. Public disclosure of certain autopsy results indicates that many of the patients killed by Dr Kevorkian had no identifiable pathologic process.

Dr Kevorkian kills patients in motel rooms, places devoid of any comfort at the end of life compared with that which is provided in the patient's home surrounded by family.

Dr Kevorkian has no interest in trying any form of treatment—other than termination of life—to help ease the patient's problems.

These actions are not in keeping with "the osteopathic perspective"; in fact, they are the antithesis.

■ **My clinical research**—Dr Hartman misunderstands the research process. Having been involved in research for the past 36 years, I have clearly observed the exponential growth of scientific literature. Data are pouring out of medical journals and the Internet faster than anyone predicted. Therefore, any clinical scientist who wishes to have a significant impact must have a narrow focus on the target disorder. This approach does not mean that a broad perspective is absent in planning clinical trials; it just indicates that specificity is necessary for success.

Dr Hartman also misunderstands the fact that we healthcare professionals who are devoted to proper and adequate terminal care are *not* "forestalling death at any cost." We are making patients as comfortable as possible while they die—with whatever means we have at present—while simultaneously pursuing advancements in treatment of the dying patient.

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Cold-induced urticaria associated with hypothyroidism

To the editor:

Cold urticaria is a form of physical urticaria that is precipitated by exposure to cold. Several diseases have been associated with cold urticaria, including hypothyroidism.¹ Association of cold-induced urticaria with hypothyroidism is exceptionally rare. We have a patient in whom Raynaud's phenomenon was initially diagnosed when she was referred to our clinic, but in fact she has cold-induced urticaria as well as hypothyroidism. A review of MEDLINE resulted in two reports of such an association.^{1,2} The following case, to our knowledge, is the first reported in North America.

The patient, a 74-year-old white woman, was referred to our clinic for reevaluation of what was initially diagnosed as Raynaud's phenomenon with an elevated antinuclear antibody (ANA). The patient reported that in the fall of the past year, pruritus of her extremities began to develop with cold exposure. She has continued the symptoms to the present time. She does not note any tri-color changes of Raynaud's phenomenon associated with the pruritus. She had noted some erythema but not hivelike lesions with the pruritus. The patient has not had any constitutional symptoms. She has not had any significant ocular symptoms, oral ulcerations, or lymphadenopathy. She denies a history of anemia or blood clots, rash, hair loss, or photosensitivity. She denies any significant cardiopulmonary, gastrointestinal, or genitourinary tract syndromes.

Her past medical history is notable for hypertension for which she takes atenolol. She has an approximately 8-year history of hypothyroidism for which she is on replacement therapy. The patient had two operations on the right knee. She takes naproxen for the pain.

Physical examination revealed the following values: blood pressure, 150/90 mm Hg; pulse rate, 60 beats per minute and regular. She weighed 60 kg. Findings at examination of the head, eyes, ears, neck, throat, chest, cardiovascular system, abdomen, and extremities were within normal limits. Musculoskeletal examination revealed asymptomatic Heberden's and Bouchard's nodes. There was a deformity of the right knee

with well-healed scars. Nail fold capillary microscopy revealed no significant capillary dilation or loss. An ice cube test was performed on the left forearm; after 5 minutes, the patient had central blanching with surrounding erythema and significant pruritus. The patient appeared to have a minimal wheal in the blanched area.

Results of laboratory tests included a normal sedimentation rate, a positive ANA at 1:160 titer in nucleolar pattern, a negative rheumatoid factor, normal IgG, IgM, IgE, IgA, C3, C4, and total hemolytic complement levels. The results of the complete blood cell count with differential and chemistry testing were normal as well. At this time, additional tests were performed which included serum protein electrophoresis and measurement of serum cryoglobulin, cryofibrinogen, and sensitive thyroid-stimulating hormone (TSH) levels. All levels were within normal limits except the TSH, 16.08 IU/mL (normal, 0.35 to 5.5 IU/mL). Further testing also detected antithyroid antibody.

Initial assessment of our patient did not indicate Raynaud's phenomenon. The patient's symptoms and the laboratory findings did not support a diagnosis of a rheumatic disease. Her symptoms of significant pruritus and positive ice cube test indicated a form fruste of cold urticaria. The significant elevation of TSH and presence of antithyroid antibody indicated hypothyroidism with insufficient replacement therapy as well as an autoimmune phenomenon. The association of cold urticaria and hypothyroidism is an extremely rare phenomenon. The unlimited search of MEDLINE review resulted in two reports.^{1,2} Neittaanmaki¹ evaluated 220 patients with cold urticaria in Finland. He reported on three patients with asymptomatic autoimmune thyroiditis in the beginning of the cold urticaria symptoms and one case of hypothyroidism (post autoimmune thyroiditis) which appeared 1 year before cold urticaria symptoms.¹ The second report is by Anton and associates,² who reported a cold urticaria associated with hypothyroidism in a 34-year-old woman.

The cause-effect relationship of cold-induced urticaria to hypothyroidism is unclear. The question whether treating the underlying disease such as hypothyroidism or others would suppress cold urticarial symptoms needs to be investigated.

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Questions on 'Hairy cell leukemia' case report

To the editor:

The case report by Kirkpatrick and colleagues, "Hairy cell leukemia with an associated lupus-type anticoagulant" (*JAOA*, 1999;99:109-112, 116), inspires a few questions and comments. Although hairy cell leukemia is a rare disorder, the antiphospholipid antibody syndrome is not. Antiphospholipid antibodies are most commonly IgG. It is interesting that this patient's were an IgM subclass. Although in vitro these appear as anticoagulants, probably because of their binding to phospholipid substrate, in the patient they may have procoagulant activity causing clotting. Several mechanisms may account for this activity, including: increased thrombin generation, lowered levels of protein S, and acquired activated protein C complex resistance. Antiphospholipid antibody has been observed to bind with β_2 glycoprotein-1 and to be associated with vascular endothelial apoptosis; the promotion of monocyte adherence to antiphospholipid antibody has been shown to displace annexin V from the endothelial surface, thus promoting exposed endothelium-contact factor activation.

Is the finding of the IgM anticardiolipin antibody in this patient with hairy cell leukemia an association or a coincidental finding? What happened to the antibody after the patient was treated with cladribine (2CdA)? Could the antibody titer have been

used as a marker of this patient's disease activity?

An additional point I wish to consider is the remission status of this patient's disease as described. I am not sure I agree with the conclusion that further chemotherapy for this patient was not warranted. The patient had minimal or no response to the first course of 2CdA. Delayed responses of hairy cell leukemia to 2CdA are well documented, but by response criteria, this patient had at best a partial response, and a second course of therapy might have been indicated.

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Response

To the Editor:

I am responding to a letter from Dr Marino concerning the article, "Hairy cell leukemia with an associated lupus-type anticoagulant," by Jon Kirkpatrick, DO, Roy R. Danks, DO, and myself (*JAOA*, 1999;99:109-112, 116). I would first like to thank him for his comments on associated lupus anticoagulants. This letter provides reasons for not rechallenging my patient with cladribine (2CdA) because of certain data avail-

able to me and unpublished at the time of subsequent clinical follow-up of the patient.

Variables that were considered before initiating treatment were:

- ☐ her hemoglobin and platelet counts,
- ☐ high triglyceride level,
- ☐ bone marrow infiltration, and
- ☐ increasing abdominal discomfort and enlarged spleen.

The results of laboratory studies and physical findings in the accompanying *Table* show that she has had slow but gradual improvement in all parameters.

Because of improving parameters, improving clinical status, the patient's age, and her overall health, it was decided not to proceed with the second course of 2CdA. Under the circumstances, it was thought that she had received adequate treatment.

She is being followed up in my clinic every 3 months, with her last visit being in April 1999. ♦

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Table
Gradual Improvement in Laboratory and Physical Parameters of
Patient With Hairy Cell Leukemia (HCL)

Parameter	Prechemotherapy	Postchemotherapy		
		6 Weeks	3 Months	30 Months
☐ WBC, million/mm ³	4.0	3.9	3.3	3.3
— Neutrophils, %	40	76	85	80
☐ Hemoglobin, g/dL	9.4	10.7	11.6	11.6
☐ Platelets, thousands/mm ³	127	173	153	144
☐ Prothrombin time/INR*	35.7/11.2	...	...	34.0/7.7†
☐ Triglyceride/ cholesterol, mg/dL	539/104	...	88/142	...
☐ Spleen size	Abdominal discomfort Palpable to pelvis	...	Palpable 4 cm below left midclavical	No change
☐ Bone marrow	...	Improved	...	...
☐ Peripheral blood smear	Positive for HCL	...	Negative	Negative

* INR = international normalized ratio.

† One year postchemotherapy.