Assisted dying: the search continues

Sir

My editorial (vol 70(5), 2009, p. 254) proposed assisted dying with safeguards to end the suffering of terminally ill adults for whom good palliative care is not a solution which, at last, palliative care practitioners reluctantly admit does occur (Finlay et al, 2009).

Dr Grogan et al (vol 70(8), 2009, p. 434), in responding to my editorial, largely rely on speculation about what they, without adducing any evidence, think may happen, such as contending that 'Patients would lose confidence in doctors'. In so doing, they simply ignore the evidence that out of seven European countries surveyed, including the UK, the Dutch have the highest regard and trust for their doctors (Kmietovicz, 2002) and that in the UK 83% said that if medically-assisted dying were legal they would trust their doctors the same amount or more (YouGov, 2004).

Likewise Grogan et al ignore the evidence from Oregon where, after over 10 years of legalized assisted dying, there is no evidence whatsoever of a 'slippery slope' (Oregon Department of Human Services, 2009). Any future legislation in the UK will be based on the Oregon legislation but with even more stringent safeguards in place.

I asked health professionals who oppose assisted dying what better solution they propose for terminally ill people whose final wish is to decide for themselves on the time and manner of their deaths. Dr Grogan et al's response that '"we"… do not think it is necessary' does not present an answer. The views of 'they' the patients surely warrant consideration – after all it is 'they' who are suffering.

I would invite readers to look at the evidence that is available from countries where assisted dying has been lawful for some time, and form their own opinion on whether there is a better solution than the one I propose.

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Finlay of Llandaff I, Herodotou N, Clark A (2009) Facing up to death and palliative care. *TimesOnline* July 17 (www.timesonline.co.uk/tol/comment/letters/article6717105.ece accessed 22 September 2009)
Kmietovicz Z (2002) R.E.S.P.E.C.T.—why doctors are still getting enough of it. *BMJ* **324**: 11
Oregon Department of Human Services (2009) *Eleventh Annual Report on Oregon's Death with Dignity Act.* Oregon Department of Human Services, Portland, Oregon
YouGov (2004) YouGov Survey Results. Results for VES. (www.yougov.co.uk/extranets/ygarchives/content/pdf/OMI040101090_1.pdf accessed 16 April 2009)

A diagnostic niche for MRCP

Sir,

The proposal that 'it is preferable to perform [endoscopic retrograde cholangiopancreatography] preoperatively only when the presentation is highly suspicious of common bile duct stones' (vol 70(6), 2009, p. 339) has special relevance for non-urgent cases of suspected choledocholithiasis, as some patients might experience spontaneous passage of common bile duct calculi. These may be associated with spontaneous reduction in elevated levels of serum alkaline phosphatase (of hepatic origin) and serum bilirubin, abnormalities in those two parameters of liver function being the ones traditionally associated with biliary obstruction (Frank et al, 1989).

Magnetic resonance cholangiopancreatography (MRCP) distinguishes more accurately than ultrasound, and more safely than endoscopic retrograde cholangiopancreatography, between patients who experience spontaneous passage of common bile duct calculi despite persisting abnormality in liver function tests, and those who, despite restoration of normal levels of serum alkaline phosphatase and serum bilirubin, have persisting retention of common bile duct calculi.

Accordingly, magnetic resonance cholangiopancreatography could have been the ideal modality to 'minimize unnecessary endoscopic retrograde cholangiopancreatography' in the study by Varadarajulu et al (2006) where the investigators had to rely on endoscopic retrograde cholangiopancreatography to confirm that common bile duct calculi were absent, despite concurrently abnormal liver function tests, in four out of 33 patients with suspected choledocholithiasis. Endoscopic retrograde cholangiopancreatography was likewise the chosen modality for validating that there was persistent retention of common bile duct calculi in three out of 18 (i.e. 16.6%) patients in that study, despite concurrent normality of liver function tests (Varadarajulu et al, 2006).

In another report, among 88 consecutive patients aged 57–99 years in whom the presence of common bile duct calculi was eventually validated (in 87 instances either by endoscopic retrograde cholangiopancreatography or by open choledocholithotomy, and in one other case by magnetic resonance cholangiopancreatography), there were 16 (18%) patients with a mean age of 80 years in whom common bile duct calculi were identified despite preceding restoration of serum alkaline phosphatase and serum bilirubin to normal levels (Jolobe, 2003).

In these 16 patients, before the fall in blood levels of these parameters, the mean value for peak serum alkaline phosphatase was 244.3 iu/litre, with concurrent mean serum bilirubin 39.4 μmol/litre and concurrent mean gamma-glutamyltransferase 470.9 iu/litre. Serum alkaline phosphatase subsequently fell to nadir levels averaging 86.3 iu/litre (reference range 25–125 iu/litre), with concurrent normalization of all serum bilirubin levels (reference range 3–21 μmol/litre). Concurrent nadir levels for serum gamma-glutamyltransferase levels, however, averaged 103.6 iu/litre (reference range 0–50 iu/litre). Prior ultrasonography had detected common bile duct calculi in only three of these 16 patients, and a common bile duct diameter of 6 mm or more in only eight. In one other patient the diagnostic quality of ultrasonography was impaired by pneumobilia (Jolobe, 2003).

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Frank B and members of the Patient Care Committee of the American Gastroenterological Association (1989) Clinical evaluation of jaundice. *JAMA* **262**: 3031–4
Jolobe OMP (2003) Fluctuation in levels of biochemical parameters in choledocholithiasis. (letter). *J R Coll Physicians Edinb* **33**: 295
Varadarajulu S, Eloubeidi MA, Wilcox CM, Hawes RH, Cotton PB (2006) Do all patients with abnormal intraoperative cholangiogram merit endoscopic retrograde cholangiopancreatography? *Surg Endosc* **20**: 801–5