

Use of Antimicrobial Agents in Actively Dying Inpatients after Suspension of Life-Sustaining Treatments

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Short Communication

Introduction

Antimicrobial treatment's function in end-of-life care has been debated, with experts debating whether antibiotics have long-term helpful benefits on comfort and survival or long-term deleterious impacts on antimicrobial resistance [1]. Antimicrobial usage and variables related with de-escalation were investigated in inpatients who died after suspending life-sustaining therapies (SLST).

Physicians are currently faced with the issue of treating and managing multidrug- or pandrug-resistant bacteria, as well as fungi or viruses with resistance to primary medicines, given the absence of new antimicrobial treatments and an aged or immunocompromised population [2]. They are frequently torn between empiric and anticipatory broad-spectrum antibiotic therapy to avoid the onset and progression of serious infectious illnesses and the preservation of human life.

Description

The role of antimicrobial treatment in near-end-of-life (EOL) or hospice care of terminally ill patients has been debatable, particularly in terms of whether antibiotics in suspected infections can prolong survival and whether patient comfort or excessive use can increase AMR in community and hospital settings, posing long-term public health risks. The majority of these investigations, which included patients with advanced cancer or dementia, did not demonstrate any apparent advantages of antibiotic therapy that may outweigh the risk of AMR. Before and after SLST implantation until death, we gathered the subclass, dosage, and duration of all antibacterial, antifungal, and antiviral medicines for systemic administration [3-5]. Prophylactic or preventive therapy, as well as therapies for suspected or confirmed infections, was among the antimicrobial drugs used. The causes of death listed above were divided into nine categories: Infectious disorders with no chronic co-morbidities, and cardiovascular diseases (CVD) (sudden cardiac arrest from unknown origin, ischemic heart diseases, congestive heart failure, cardiomyopathy, and aortic dissection) solid cancers, central nervous system diseases other than brain tumours (intracranial hemorrhage, stroke, advanced dementia, Alzheimer's disease, and

Parkinson's disease), hematologic malignancies with or without hematopoietic stem cell transplantation hematologic malignancies with or without hematopoietic stem cell transplantation hematologic malignancies with or without hematopoietic stem cell transplant Solid organ transplant status, acute or chronic liver disorders chronic renal diseases requiring dialysis.

The major treatments that are maintained in terminally sick patients post SLST or around the EOL are hydration, artificial feeding, and pharmaceutical control of discomfort and pain.

41, 42, and 43 are the three numbers. Legal factors may impact whether antibiotic medication should be administered in some circumstances, raising ethical difficulties among practitioners. Our data revealed that most patients who were actively dying received maximal antimicrobial treatment using combined antibacterial agents with broad-spectrum antibiotics after SLST was implemented according to their own and families' wishes and the legal framework, in addition to ethical inquiry or moral responsibility.

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Conflict of Interest

The authors declare that they are no conflict of interest.

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