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Buddha

Charles Stimler

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A M E R I C A N C O L L E G E O F



P H Y S I C I A N S[®]

Minocycline Sclerosis for Malignant Pericardial Effusions

To the Editor:

Dr. Markiewicz and his group, who have published many outstanding investigations, reported in *CHEST* (June 1996) on successful minocycline sclerosis for malignant pericardial effusions.¹ Half their patients had severe pain (which also occurs with other sclerosants;² two had diffuse ST-T changes suggesting pericardial or subepicardial injury. Both of these raise questions of whether this effective agent is also optimal for sclerotherapy. Indeed, the distinguished authors recognized that "a randomized study is required." One wonders why this was not done, since they included "all patients with compressive malignant pericardial effusions," implying a prospective investigation. They also overlooked another basic concept in prospective randomized controlled trials—the ethical imperative to give all patients a "50-50 chance" not to get the investigational therapy lest it be worse than placebo or established therapy.³ This is accomplished by randomizing the first patient, even while gaining experience in dosing and collateral effects (the discredited "pilot" studies).³ Moreover, in our experience (still under investigation), indwelling pericardial tubes—soft, flat, multihole—stimulate dense adhesions without irritative agents.² Finally, a description of the ST-T changes in their patients may be enlightening to suggest their nature and for comparison with other therapies.

Despite the foregoing considerations, the authors¹ can be complimented for solidly adding minocycline to the large list of pericardial sclerosants² with the hope that they may do the randomized study they mention.

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To the Editor:

We read with interest Dr. Spodick's letter and fully agree with his comments. Randomized studies are needed to evaluate whether agents causing sclerosis of the pericardium are more effective than drainage alone in preventing recurrence of malignant pericardial effusion. Excellent randomized studies address this issue in patients with pleural effusion.^{1,2} Similar studies are sorely lacking for pericardial effusion, possibly owing to the small number of patients with malignant pericardial effusion seen in any given center, and to the assumption that agents effective for the pleura are probably effective for the pericardium. Our study in the dog with a normal pericardium indicates that instillation of minocycline (Minocin) through a pericardial drain is more effective in causing adhesions than instillation of normal saline solution.³ This experimental study does not necessarily demonstrate the effectiveness of the drug in the human with pericardial disease.

ECG changes following intrapericardial injection of minocyc-

cline in two patients consisted of marked upwardly concave elevation of the ST-T segment in leads L₁, L₂, aVL, aVF, V₄-V₆, associated with severe inspiratory chest pain, but no obvious hemodynamic changes. ECG returned to baseline within 6 h, together with resolution of chest pain. No enzymatic or ECG evidence of myocardial infarction was noted. One of the two patients with ECG changes died suddenly of circulatory collapse 24 h later.

This patient had terminal cancer and his death was not unexpected. Postmortem examination was not performed and the possibility that minocycline contributed to death cannot be excluded. We recommend that patients receiving minocycline intrapericardially be followed up closely for possible untoward side effects.

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Buddha

To the Editor:

There is an alternative interpretation to the Buddhist teachings surrounding death and dying, which emphasizes the importance of life as well as maintaining and prolonging a meaningful life. The single purpose of Buddhism is to demonstrate to mankind the path to enlightenment; it essentially has no other purpose. Furthermore, the path to enlightenment cannot be pursued effectively except while enmeshed in the world of karma, that is, during the present lifetime here on earth. Unlike other religions that emphasize the importance of the afterlife, the Buddhist philosophy tends to deemphasize it. Indeed, Buddha often discouraged speculation on the afterlife, existence of God, or other theological topics that are the cornerstones of many other religions. The reason for this is that the urgency to achieve enlightenment in Buddhism is so great that there is no time to waste energy on other less critical objectives. Buddha often used this analogy of a burning building: if one were trapped in a burning building, would one take the time to inquire as to who set the fire, why it happened, what kind of fire it was, etc? Certainly, these questions can wait until after exiting the building. In Buddhism, human life is taught as extraordinarily precious precisely because only it offers the promise of achieving enlightenment and permanently escaping from the "fires" of desire, greed, and ignorance.

Buddha always preached about the importance of maintaining health, since without a healthy body one's path to enlightenment was obstructed; the body is, after all, an important tool to use toward the achievement of enlightenment. This was why prior to his enlightenment, Buddha so carefully nursed himself back to

health after leaving the ascetic colony where he had spent 6 years studying. The irony of the editorial "CPR or DNR: Lessons From Buddha"¹ is that the authors attempt to use an exception to prove the rule. That is, they are using the example of the Buddha (an enlightened being) as a model for how we (mostly unenlightened beings) should behave. According to Buddhist doctrine, from the very moment that Buddha became enlightened, his life was no longer necessary for his development. He could have entered nirvana then and there (which would have meant instant death to his earthly body) and not suffered any karmic repercussions. Buddha *chose* to stay on earth for many more years out of a profound compassion for all of mankind and a desire to liberate as many people as he could. Since he had already achieved enlightenment, it made no difference to him (from a Buddhist perspective) when he died since his remaining life was essentially a gift to all mankind. The sense of urgency regarding achieving his enlightenment no longer existed.

This interpretation of Buddhist teachings leads me to a different conclusion regarding an approach to DNR and CPR. I thoroughly agree with the authors that the fear of the unknown and the fear of death cannot be acceptable reasons for unrealistic and unaffordable treatment. However, such types of decisions must always be tempered with an appreciation of the enormous value of human life. The way I interpret Buddhism's philosophy toward this issue is that "where there is life there is hope." Buddhism teaches that within each one of us there exists a latent Buddha, and at any moment it might be realized. The achievement of enlightenment can even occur in the very instant before death (or perhaps in the interval between CPR and death), and if it does, then that life has reached perfection.

Even in the Buddha's final exhortation ("Decay is inherent in all component things! Work out your salvation with diligence"), the note of urgency regarding salvation (enlightenment) is patently obvious. Rather than reading this as a suggestion to gently extinguish the flame, I read it as saying "Rage, rage, against the dying of the light!" although in the Buddhist version, the light is analogous to a candle that can be (and is) relit many, many times.

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To the Editor:

Universal religious teachings such as Buddhism are treasured for their great wisdom. Such systems of thought appeal to a vast populace, with each individual understanding the points of the doctrine in his own unique way. It is hard to define a religious truth of any tradition that will find complete consensus. This is all the more true for Buddhism, which was orally transmitted for over 500 years before the teachings were written down, and by that late date, no unanimity could be found. Consequently, there never was a codified "bible," rather a compilation of sacred Buddhist scriptures that number in the tens of thousands. (Columbia University has a copy of the thousands of sacred volumes of the Taisho edition of the *Tripitika*.)¹

Certainly no one could argue against the great compassion of the Buddha. This was the central tenet of his teaching. The fact that he did not address the question of an afterlife or of a god is a natural corollary to his doctrines. Indians believe in karma—infinite rebirth. The Buddhist understanding was that life is inherently painful, and that infinite rebirth propels pain infinitely. Since the ancient Vedic gods of India (it was not a monotheistic

society) were also subject to karma, deities were useless in the pursuit of enlightenment. This is why in the scriptural tradition when Mara, god of death and desire, offers the meditating Buddha-To-Be a high place in the ranks of the god, he is rejected.² If one teaching can be firmly associated with the Buddhist doctrine, it is the one encapsulated in the Four Truths—attachment leads to pain.³ This truth can be expressed more concretely as the attachment to life, for it alone leads to rebirth. Extinguishing the desire to live is the means to nirvana.

Dr. Stimler takes exception to "using the example of the Buddha as a model for how we should behave," but it is important to take enlightened people, such as the Buddha, as models, though we ourselves may fall short of that blessed state. It is only by studying the wisdom of those who understand the human condition and what is frankly possible that reasonable goals be set and hopefully achieved. Further, one cannot apply the Buddha's death bed sermon urging healthy people to be aware of their mortality and to try and detach themselves from the karmic conditions of the wheel of suffering as an excuse to prolong the pain-filled life of terminally ill people. As Dr. Stimler himself quotes the Buddha as saying, "A sick body is a hindrance to enlightenment."

Prolonging life at any cost is not a Buddhist value. In fact, the practice of suicide was sometimes considered a symbolic act of enlightenment. One may only think back to the self-immolation of the Buddhist monks in Vietnam, the zen samurai warriors adhering to their creed of *bushido*, or the less well-known Mahayanist sacrifices (ritual suicide is described in the *Lotus Sutra* chapter XXII. Charles Eliot in *Japanese Buddhism*, argues against the practice and the Buddha's condoning of it)⁴ to see how the doctrine was later interpreted thousands of miles from the site and over 2,000 years after the founder's sermons.

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Measurement of Pleural Fluid Cholesterol Levels

To the Editor:

In a letter to the editor in *CHEST* (July 1996), Romero et al¹ report that the criteria of pleural cholesterol level >45 mg/dL and pleural lactate dehydrogenase (LDH) level >200 IU, proposed by us for the identification of pleural exudates,² have been inaccurate when applied to their patients, especially regarding specificity. Searching for an explanation for this discrepancy, we have become aware that we are using different methods for the determination of LDH activity, so that the upper normal limits for serum are not the same. Therefore, the cutoff point of 200 IU does not have the same meaning for both groups. In our article,

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