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EDITORIAL

A Second Chance

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All neurologists should read the poignant first person account by Dr David Larach and his family members chronicling his impressive recovery from a dominant hemispheric "malignant" middle cerebral artery infarction following decompressive hemicraniectomy, ICU treatment for raised intracranial pressure, and prolonged neuro-rehabilitation. The outcomes of decompressive hemicraniectomy in this setting have been the subject of much study and debate [1]. It is now clear that younger patients fare better than older ones, that dominant hemispheric infarction no longer should be considered a contraindication to decompressive hemicraniectomy, that meticulous ICU care improves outcomes, and that some neurologists's paternalistic practices of allowing these patients to die is being replaced by an individualized decision-making process based on outcome evidence and informed consent [2].

Dr Larach et al. wisely point out that patients' functional outcomes are influenced not only by neurosurgical and neuro-intensivist skills, but also by the quality and quantity of neuro-rehabilitation services that patients receive following hospital discharge. They rightly decry the limited availability of this important treatment in the United States because of insurance coverage restrictions. Because of the impact on patients' quality of life, the extent of neuro-rehabilitation should be included as a metric in outcome studies.

In a thoughtful commentary on the publication of three European hemicraniectomy trials in 2007 [3], Stephan Mayer highlighted the fact that some operated patients survived with a reasonably good functional recovery [4]. Because unoperated, many of these patients would have died, he called this phenomenon "a second chance on life" in much the same spirit that Dr Larach described his own outcome as "a life worth living."

Dr Larach's account illustrates that neurological disability is not worse than death. Healthy physicians should exercise caution and humility when making medical decisions for patients based on quality of life estimations. There is evidence that young, healthy physicians routinely underestimate the quality of life of their patients who are disabled by spinal cord injury, ALS, cognitive impairment, and other disorders [5]. We all are in Dr Larach's debt to be instructed so movingly about his satisfactory outcome. It is a gift to be reminded, as we are when formerly critically ill patients visit the ICU a year or two later, that, despite their disability, many patients are happy to be alive after receiving what commentators not long ago considered overly aggressive neurocritical care.

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