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MedEst|2026 | Vol.6: e545 | ISSN: 2789-7567 |RNPS: 2524| LETTER TO THE EDITOR

Ethical redefinitions in tumor lysis syndrome: between clinical guidelines and the ethical protocol

Redefiniciones éticas en el síndrome de lisis tumoral: entre guías clínicas y el protocolo ético

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Dear Director:

With regard to the article "Toward an ethical protocol for tumor lysis syndrome: first steps for its development," by Correa Rodríguez et al., published in MedEst in 2026, we consider it timely not only to broaden the debate it offers, but also to warn that neither current clinical guidelines nor a future rigid ethical protocol will be sufficient to resolve the most controversial dilemmas. (1)

The gap identified by these authors is plausible, and their contribution with the premises for a practical solution constitutes one of the first in this field. However, international clinical guidelines on tumor lysis syndrome (TLS), which are the reference standard for decision-making, do not incorporate ethical aspects. (2-6) Although they focus on diagnostic criteria, risk stratification, and pharmacological prophylaxis, they do not address the broad variability that clinical practice and medical bioethics face daily. (1,7-9)

The failure to include these components in clinical guidelines means that their management is not systematic and that the problems remain only at the institutional level and are resolved with a high degree of bias. Their first classifications, in 2004, by Cairo and Bishop, established the standard reference for all research on the subject. (1,10)

However, since then the ethical component has been excluded, remaining subject only to its implementation in the humanized practice of health personnel and/or institutional establishments.

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Coiffier et al., in 2008, and the international panel of experts consulted by Cairo et al., in 2010, represented the beginning of this systematic exclusion. [2,3] The subsequent appearance of new guidelines and consultation with experts, although influenced by specialists in oncology, oncohematology, pathophysiology, prophylaxis, and treatment of TLS, did not respond to the presence of an ethics committee, expert members in bioethics, or patient advocates. [4-6]

In contrast, Chan et al. updated the guidelines for the diagnosis and treatment of TLS from a patient safety approach. [6] However, said update focused on closing gaps in personnel knowledge about management and the drugs used, their availability and dosing accuracy, in addition to the same clinical sections that have remained constant in the scientific literature year after year.

The most recent evidence from Correa Rodríguez et al. exposes fragilities in perception, communication to the patient, futility in intensive care units, and access to costly treatments. Their integrative ethical framework in solid neoplasms contextualizes the gaps that this syndrome poses. Although their evidence is limited to case reports, it constitutes, to our knowledge, an increasingly accurate approach to the most deeply rooted dilemmas. [9]

This qualitative consistency justifies a systematic analysis and the quantification of adverse outcomes associated with not addressing these aspects. The integration of clinical practice and medical bioethics, balancing both according to the clinical moment, would be the best option to resolve dilemmas that a written, inflexible protocol could not resolve. [1,9] Any ethical protocol must, by design, be modifiable and subject to the intervention of ethics committees in real time.

It is important to note that some ethical dilemmas not documented in clinical cases deserve to be recognized and addressed with a combination of both practices. The inclusion of the perspective of those who survived this complication but with physical and psychological sequelae, as well as of family members with psychological harm, offers a comprehensive view of this complication. [9] This has been cataloged as one of the topics with the greatest ethical conflict in oncological practice. [7-9]

In this letter we elaborate, illustratively, a series of dimensions and aspects that go beyond what is structured in the first steps for the ethical protocol of this syndrome, and we integrate a proposal for decision-making and practical approach. [1]

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Table 1. Unresolved ethical-care tensions in TLS, with a proposal for explicit decision-making

Dimension	Concrete scenario	Central conflict	Unanswered ethical question	Decision proposal
Resource triage	Only ICU bed for: A) TLS + neoplasm with curative potential; B) TLS + cancer without curative options.	Beneficence versus justice.	Should an ethics committee intervene in real time, or is a written protocol enough?	Ethics committee intervention using scales with oncological prognosis + TLS severity + real ICU need. If equal score, prioritize the patient who would benefit most in the ICU.
Medication triage	Last dose of rasburicase: A) hyperuricemia > 10 mg/dL + oliguria; B) mild hyperuricemia with risk of progressive renal damage.	Biological urgency versus distributive efficiency.	Does the cost of the drug justify denying it to the one with less damage but who could progress?	If established renal damage > 48 h and no improvement: give to A. If uricemia 8–10 mg/dL + LDH > 2 UN + rapid tumor progression: give to B.
Omission of screening	G6PD deficiency not screened before rasburicase.	Time versus safety.	Is it mandatory to wait for screening even if TLS is fulminant?	If severe TLS: administer without screening, monitor methemoglobinemia every 4 h. If no severity criteria: defer until screening or use allopurinol.
Generic consent	General consent for chemotherapy in a	Autonomy versus non-maleficenc	Is a consent that does not	Incorporate it into all high-risk chemotherapy consents. Record

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	patient who develops fulminant TLS.	e.	explicitly mention the risk of death from TLS legally valid?	it in writing.
Lack of informed palliative alternative	TLS and disseminated cancer admitted to the ICU, without offering palliative care.	Beneficence versus autonomy.	Does omitting the palliative option in consent constitute malpractice by omission?	At 48–72 h without improvement in renal or neurological function: meeting with palliative care and family to reorient therapeutic effort.

ICU: intensive care unit; TLS: tumor lysis syndrome; LDH: lactate dehydrogenase; UN: upper normal limit; G6PD: glucose-6-phosphate dehydrogenase. **Source:** prepared by the authors.

Table 2. Perspective of patients, family members, and other post-TLS harms

Aspects	Emerging situation	Ethical problem	Practical proposal
Family members of the deceased patient	Possible refusal of treatment after the real probability of death from it.	The therapeutic paradox is not communicated.	Consent must explicitly include death from the treatment.
Family members of the deceased patient	Denial of advanced life support after a poor prognosis.	Therapeutic obstinacy not discussed.	Establish ethical triggers to reassess life support at 48–72 h without improvement.
Family members of the deceased patient	Death of the patient after announcing clinical stability to family members.	False security in risk communication.	Clarity to the family and the patient, without giving false hope.
Psychological sequelae after	Fear of restarting chemotherapy	Therapeutic abandonment due to trauma.	Psychological evaluation before restarting.

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surviving TLS	after surviving TLS.		Consider alternative regimens of lower risk.
Psychological sequelae after surviving TLS	Hypervigilance to any symptom.	Atypical post-traumatic stress disorder.	Include PTSD examination in post-TLS follow-up, not only renal function.
Psychological sequelae after surviving TLS	Grief over the loss of a family member who suffered psychological harm as a caregiver.	Collateral damage in primary caregivers.	Offer psychological support to family members during and after hospitalization.
Physical sequelae after surviving TLS	Dissatisfaction at remaining on constant hemodialysis.	Quality of life not considered in acute decisions.	Ask before oncological treatment: "Would you be willing to live with chronic dialysis if necessary?"

TLS: tumor lysis syndrome; ICU: intensive care unit; PTSD: post-traumatic stress disorder. **Source:** prepared by the authors.

This letter does not offer a systematic analysis nor does it intend to exhaust the problem. It only seeks to point out, from the experience of having attempted to build the first ethical protocol for TLS, that ethical protocols are necessary but not sufficient conditions. We invite the scientific community to work so that TLS clinical guidelines include evidence-based ethical components that are debatable in real time.

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CONFLICT OF INTERESTS

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