EDITORIAL

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POISONING

Over the past few years there has been an increase in the number of patients presenting to medical casualties with history of poisoning. In most of the cases the agent is not known and the history is vague. At times the patient may not even admit to having taken anything. The patients are usually accompanied by hordes of relatives who by their impatient attitude compel the attending doctor to initiate acute medical treatment on the basis of scarce information given .in such cases, it is a test of the doctor's clinical acumen to give the patient emergency care that will prove life- saving in a situation where immediate investigations may not be readily available at hand. A methodical approach by the doctor, counseling of the attendants, and explanation of the ongoing process can alleviate many problems.

Clinical examination of the patient can reveal much valuable information about the agent used for poisoning. Blood pressure, temperature, pulse, respiratory pattern, skin, cardiovascular status, odour of breath and neurologic function should all be assessed. A fast or irregular pulse points towards ingestion of anti muscarinics, tricyclic's or quinine, respiratory depression goes in favour of opiate or barbiturate intoxication, constricted pupils are a hallmark of opiates and organophosphorus poisoning, with dilated pupils favour amphetamine and cocaine poisoning.

In the acute setting, the patient should be exposed to skin decontamination (which is important in case of poisons that are rapidly absorbed from the skin e.g organophosphates), and gastrointestinal decontamination that can be accomplished by emesis as well as gastric lavage with activated charcoal. Even before the exact poison is determined ,50ml of 50% dextrose intravenous I.V, and thiamine 100mg iv should be administered to patients with a diminished level of consciousness or alteration of mental status .Naloxone may be repeated in 1 to 2mg bolus every 2 to 3 minutes up to 8 to 10mg, before narcotic intoxication is excluded .All these should be readily available in the secondary care units and the attending doctors must be well-versed in their usage so that the patients should have received emergency treatment before presenting to tertiary care hospitals. This will reduce their chance of developing difficult to treat complications.

Once a clinical diagnosis of a particular poisoning is made, the patient needs to be administered with an antidote specific for the suspected poison. Most of antidotes are readily available in the market at reasonable prices and can prove to be life –saving in cases where the battle for life seems to have been lost. Flumazenil for benzodiazepines, naloxone for narcotic analgesics, atropine and pralidoxime for organo-phosphates, and anti-snake venom for snake bite poisoning can be easily accessed over-counter.

Recently aluminum phosphide (wheat pill) and zinc phosphide (rat pill) poisoning have become very common among villge-dwellers who have easy access to the pills. Currently no

antidote is known for these poisons and they carry a high mortality which reaches up to 98% in some cases. Vigorous symptomatic management is the only key to saving the lives of these patients.

It is very important for the medicine department and administration and health institution that emergency department doctors should specifically be trained in the diseases and management of different poisoning along with other emergencies.

All the drugs and antidotes required should be available in accident and emergency departments and a reliable and equally responding toxicology laboratory is the need of this hour, keeping in mind easy access of population to poisonous materials and over the counter availability of almost every thing in this country.

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