LETTERS TO THE EDITOR

Abandon gastric lavage in the accident and emergency department?

Sir

In answer to Dr Proudfoot (*Archives of Emergency Medicine*, 1984, 1, No. 2, 65–71), I would like to make the following comments (which do not apply to paediatric cases).

The first principle in the treatment of poisoning is to remove the noxious agent. In the case of ingested poison this is often done by Nature herself. When the patient has not vomited, most accident and emergency departments carry out gastric lavage almost as routine. There are certain absolute contra-indications—poisoning by corrosives, known oesophageal disease and refusal by the patient. Other relative contra-indications are the aggressive patient and the very elderly frail patient.

Notwithstanding these exceptions, we are still left with the majority of self-poisoned cases. Although accident and emergency departments probably carry out more gastric lavages than is necessary in this group, the thought of abandoning the procedure does seem an extreme, if not dangerous, move.

The alternative is an effective dose of tinct. Ipecac., which may take 20–30 minutes to act. Anyone who has witnessed a patient who starts to vomit while becoming increasingly drowsy or even comatose knowing the resultant danger will obviously try to prevent such a happening.

Because an accident and emergency department is a busy place where serious accidents and cardiac arrest cases have priority, one must be absolutely certain that other emergencies are left in no danger. Gastric lavage does increase this safety measure, and the sooner it is carried out the better. We all know of patients who decide to take their own discharge while waiting for attention and they are the very ones who may die later from the effects of their overdose.

There is probably no controversy over the cases in which lavage is beneficial even up to 24 hours after the overdose, namely in cases of aspirin and tricyclic overdose. In the latter, delayed gastric emptying is a common phenomenon. Furthermore, if 'Medicoal' proves to be useful in delaying absorption of the drug and is to become a regular therapeutic agent, then it must be given by way of the gastric tube, for no patient will swallow two large tumblerfuls of this black tasteless fluid!

I would ask the question 'How are we to know what the patient has taken?' It is our experience that a considerable number of patients do not tell the truth (if in fact they know it) about what drugs they have taken, how much they have taken or when they have taken it. This accords with the findings of Wright (1980) and Murray *et al.* (1974).

Patients are even less reliable when under the influence of drink, and alcohol is quite commonly taken before or with the overdose. Those with pints of beer and a handful of tablets in the stomach are just the ones most likely to vomit and inhale. This can be prevented by gastric lavage—an empty stomach is a safe stomach.

Dr Proudfoot mentions that in many cases no tablets are recovered and the stomach is perfectly clear. Such information can only be obtained by lavage. This is a good sign,

and in the absence of symptoms and without raised serum salicylate or paracetamol levels, it means the patient can safely be discharged home.

I agree gastric lavage should not be used as a punitive measure, but one cannot help noticing the salutary effect it has on groups of teenagers from school or residential care centres, who think they will take an overdose 'just for a lark'.

Provided that the decision to carry out gastric lavage is always made by a senior house officer (who should have been instructed in toxicology by his seniors) and that the procedure is performed by competent trained nurses, it is not so traumatic as Dr Proudfoot implies and will, I think, continue to be a standard method of treatment.

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REFERENCES

- Murray J. C., Campbell D., Reid J. M. & Telfer A. B. M. (1974) *Scottish Medical Journal* **19**, 279-000.
Wright N. (1980) An assessment of the unreliability of the history given by self-poisoned patients. *Clinical Toxicology* **16**, 381-384.

Sir

Dr Adams and I seem to agree more than we disagree. The title of my contribution on gastric lavage was dictated by the Editor and intended to be provocative, but I accept that my attempt to question the validity of some widely held views on the value and use of this procedure was somewhat blinkered. I therefore welcome Dr Adams' comments, which place gastric lavage firmly and realistically in the context of the unique problems and priorities of the accident and emergency department. However, while these increase the difficulties, in an ideal world they would not be allowed to dictate, even to a minor degree, the most appropriate treatment for the poisoned patient.

I suspect that lavage may not be as beneficial late in the course of salicylate poisoning as Dr Adams thinks, but her view would have the unqualified support of my teacher and predecessor, Dr Henry Matthew. Knowing my scepticism in this matter, he inscribed the copy of his book which he presented to me with the words 'It's never too late to aspirate in salicylate'! Despite my admiration and respect for him, I can only say that I do not know the evidence for the statement. However, I do agree, on theoretical grounds at least, that tricyclic antidepressants should delay gastric emptying but, again, the evidence is lacking and it is not uncommon to hear active bowel sounds in patients who are deeply unconscious after overdoses of these drugs.

As far as knowing what the patients have taken is concerned, I appreciate the difficulties expressed by Dr Adams but take comfort from the fact that clinicians have had to make the best for many years of patients' inability to inform them accurately, and the low mortality from poisoning treated in hospital suggests that they manage remarkably well.

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