letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: Clinicalmedicine@rcplondon.ac.uk.

Poisons: initial assessment and management

Editor – We very much enjoyed the paper by Bradberry and Vale (*Clin Med* March/April 2003, pp 107–10) but would like to point out that whilst intravenous flumazenil is considered relatively safe when used with iatrogenic benzodiazepine overdose, it is dangerous when given to patients in A&E whom you suspect or know to have taken benzodiazepines. This is because it may result in seizures which do not respond to conventional first-line therapy.

JOHN TRENFIELD

Specialist Registrar in Emergency Medicine

FHEY PROBST

Consultant in Emergency Medicine

Charing Cross Hospital, London

Editor – Bradberry and Vale (*Clin Med* March/April 2003, pp 107–10) are correct to advise a 'systematic approach to the poisoned patient'. However, it would be remiss not to raise related issues that, if overlooked, would be detrimental to patient care. They state that initial assessment of the patient's state is based on 'the established clinical method of *history, examination and investigation*.' We do not dispute the importance of this but suggest that initial assessment should begin with 'A (airway), B (breathing), C (circulation) and D (Disability)'.

Our argument is based on the premiss that a low or falling score on the Glasgow Coma Scale (GCS) is associated with air-

way obstruction (partial or complete), diminished upper airway reflexes and subsequent risk of aspiration.¹ Failure to recognise signs of respiratory compromise and of clouded consciousness have been implicated in poor outcome.^{2,3} Without early protection of the airway (endotracheal intubation), respiratory morbidity increased in severe acute poisoning patients.⁴ This resulted in an increased incidence of aspiration, prolonging intubation times and length of stay on intensive care. Guidelines on the management of the acutely poisoned were subsequently amended.

In our NHS Trust, 10–15% of acute poisoning patients have impaired conscious levels on initial assessment by ambulance personnel (Newcastle Hospitals NHS Trust Audit Department, personal communication). We therefore recommend that clinicians have a high index of suspicion in relation to airway and ventilatory compromise in such patient groups. Guidelines for intubation and ventilation in the unconscious patient may be helpful (see Table 1).

Bradberry and Vale offer an in-depth review of the investigative management of acutely poisoned patients. However, their description of the initial assessment of such patients is sketchy and should include ventilatory, circulatory and GCS assessment to facilitate early recognition of problems.

References

- 1 Rello J, Diaz E, Roque M, Valles J. Risk factors for developing pneumonia within 48 hours of intubation. *Am J Resp Crit Care Med* 1999;159(6):1742–6.

- 2 Sax FL, Charlson ME. Medical patients at high risk of catastrophic deterioration. *Crit Care Med* 1987;15:510–15.
- 3 McQuillan P, Pilkington S, Allan A, Taylor B *et al*. Confidential enquiry into quality of care before admission to intensive care. *BMJ* 1998;316:1853–8.
- 4 Cosgrove JF, Gascoigne AD. Inadequate assessment of the airway and ventilation in acute poisoning. A need for improved education. *Resuscitation* 1999;40:161–4.
- 5 Gentelman *et al*. *BMJ* 1993;307:547–52.

JOSEPH F COSGROVE

Consultant in Anaesthesia and Critical Care
Freeman Hospital, Newcastle upon Tyne

ALISTAIR D GASCOIGNE

Consultant in Respiratory Medicine and
Critical Care

Royal Victoria Infirmary, Newcastle upon Tyne

Consent with understanding: a movement towards informed decisions – how far do we go?

Editor – Mayberry and Mayberry's contribution to understanding and obtaining consent has always been illuminating, in particular the concept of moving away from passive informed consent towards active informed decisions by patients (*Clin Med* November/December 2002, pp 523–6). The quality of information provided and the way it is understood is vital. Alternatives should be discussed, together with associated risks and complications. Mayberry and Mayberry have also shown, in a study of information leaflets used in endoscopy units, that clinical negligence solicitors felt consent should be obtained at least two weeks before the procedure and patients told about the test

Table 1. Indications for intubation and ventilation of coma patients (from Ref 5).

Immediate indications

- Coma: not obeying commands, not speaking, not eye opening, ie: GCS <8
- Loss of protective laryngeal reflexes
- Ventilatory insufficiency as judged by arterial blood gases:
 - hypoxaemia (Pa O₂ <9 kPa on air or <13 kPa on oxygen)
 - hypercarbia (Pa CO₂ >6 kPa)
- Spontaneous hyperventilation causing Pa CO₂ <3.5 kPa
- Respiratory arrhythmia

Indications before transferring a patient (including within a hospital)

- Significantly deteriorating conscious level, even if not coma
- Bilateral fractured mandible
- Copious bleeding into mouth
- Seizures