

Gastrointestinal decontamination for poisoning patients in primary hospitals – do we see the real picture?

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Introduction:

Appropriate early treatments following deliberate self poisoning may prevent later complications and mortality. In primary care hospitals where the majority of patients receive their treatments, gastric decontamination is considered as an important part of the treatment protocols but gastric lavage, forced emesis and activated charcoal are the most common practices. This study aims to measure whether the actual decontamination practice in peripheral hospitals was the same as the recorded/ordered decontamination.

Methodology:

This study was conducted as a part of a cluster randomised controlled trial conducted in 34 rural peripheral hospitals in Sri Lanka. Exposure history, clinical assessment, treatments and outcome details were collected from peripheral hospital records. In secondary referral hospitals prospective data were collected from patients transferred from primary hospitals. Details of peripheral hospital treatments, including the decontamination method and activated charcoal administration were collected directly from interviews of patients and relatives. The agreement between the information from the informants versus peripheral and secondary hospital medical records was compared.

Results:

There were 1458 admissions to 34 hospitals during the 10 month study period, of which 933 were transferred. We selected a group of 362 consecutively transferred patients from the secondary care hospitals and according to the hospital records 277 of them (76.5%) were given either gastric lavage (46% - 128/277) or forced emesis (54% - 149/277) before transfer. But the data from the patients showed that 252/277 – 90.9% - had received forced emesis, and only 16/277 - 5.8% - received gastric lavage.

Discussion

Forced emesis is “not recommended” in the national treatment guidelines for the treatment of poisoning, despite this it is still used as the first line treatment in primary care hospitals in Sri

Lanka. However it is recorded as gastric lavage in patient records possibly due to misinterpretation of the terms used to describe treatments. In peripheral hospitals, the non medical attending staff initiate forced emesis before the arrival of doctor, and even after prescribing gastric lavage, due to lack of supervision. These factors may be the main reasons for the observed gap between medical records and actual practice. Hence any training programs to improve peripheral hospital care should focus on the above factors.

Conclusion:

Forced emesis seems to be the most common decontamination method in peripheral hospitals in Sri Lanka despite the recommendations from the national guidelines. The lack of credible details on peripheral treatments due to the discrepancies of using the term forced emesis and gastric lavage seems to be a barrier to understand the actual practise of the low resource peripheral hospital settings and to improve the clinical management by promoting correct procedures.