Sir,—I agree entirely with this view that paravertebral block would provide reduction in requirement for morphine, greater than that achieved with the intercostal block used in our technique. Several of the chest radiographs, including the one in the article, demonstrated contrast medium in the paravertebral space. The statement “it should not be assumed that an intercostal injection of contrast medium and intercostal infusion of bupivacaine behave similarly”, referred only to our study and was intended as a suggestion as to why we had a paravertebral injection radiographically, but an intercostal injection clinically.

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WHOLE BOWEL IRRIGATION IN ACUTE POISONING

Sir,—We read with interest the review on management of acute poisoning by Collee and Hanson [1]. We suggest an additional intervention which may occasionally be useful in reducing absorption of some poisons from the intestine. There are situations in which induction of vomiting, gastric lavage and administration of activated charcoal may be inadequate. These include: late presentation after ingestion when significant amounts of drug have entered the small intestine; ingestion of very large amounts when the residual drug remaining after gastric emptying may still be present in toxic amounts; ingestion of a drug, such as iron, which is not adsorbed by activated charcoal.

Under these circumstances a useful treatment is the use of whole bowel irrigation. This consists of rapid enteral administration of large amounts of lavage fluid over several hours as in preparation for colonoscopy or large bowel surgery.

We have recently treated six children aged from 18 months to 5 yr who presented after ingestion of the tricyclic antidepressant dothiepin (Prothiaden). There was uncertainty about the amount ingested and the interval between ingestion and presentation, although in no case was this interval less than 1 h. In four of the patients, there were symptoms which suggested that the drug had passed into the small intestine from where it was being absorbed. Four patients were given ipecacuanha to induce vomiting and two underwent gastric lavage. Because of concern that further absorption of the drug would occur from the small intestine, these six children underwent whole bowel irrigation.

This was administered as polyethylene glycol sulphate via a nasogastric tube at 500 ml h⁻¹ and continued for 6 h or until the rectal effluent was clear. Plasma electrolyte concentrations were measured before, during and after treatment and there were no changes. No patient deteriorated during treatment and those with symptoms improved.

Sir,—We would agree that this technique could be a valuable additional intervention under the following circumstances:

(1) that there has been a serious intoxication with potential loss of life;
(2) that the manoeuvre is performed under strict metabolic fluid balance control;
(3) that there is full control of the airway and, where it is compromised, intubation is performed before irrigation. Whole bowel irrigation should be conducted, if at all possible, in an Intensive Care Unit.

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Tenenbein [2] used whole bowel irrigation in eight children after toxic drug ingestion and found it useful in four. There were no changes in electrolyte concentrations or PCV. In a study of healthy volunteers given a large overdose of ampicillin, Tenenbein, Cohen and Sitar [3] found in 67% reduction in drug absorption after whole bowel irrigation. This was more effective than gastric lavage, ipecacuanha-induced emesis and activated charcoal administration which reduced absorption of ampicillin by 32%, 38% and 57%, respectively [4]. The solution we used (polyethylene glycol) is associated with insignificant absorption or secretion of water and electrolytes during lavage [5].

We suggest that this technique may be useful in some cases of acute poisoning.

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