Drugs – Concealed Illicit Drugs - Full Clinical Guideline

Reference no.: CG-LEGAL/2017/001

These guidelines are a locally adapted version of The College of Emergency Medicine - Best Practice Guideline - Caring for adult patients suspected of having concealed illicit drugs: June 2014

Summary

- If a patient is brought to the Emergency Department (ED) by police, radiological imaging can only be undertaken with both the patient's consent and a request from the rank of an inspector or equivalent.
- Similarly, intimate examination requires patient consent and a police request from inspector or equivalent. This should only be carried out by a forensic physician.
- ED staff should not handle drug packages at any time as this represents forensic evidence and the chain of evidence must be preserved.
- Do not use urinary toxicology screens to guide management or discharge decisions as there are many false positives and false negatives with this group of patients. (Level 4 evidence)
- Body stuffers should be admitted and observed for 6-8 hours post ingestion, usually this will be to ward 101. (Level 4 evidence)
- Abdominal X-ray (AXR) can be used as a screening test for body packers. If negative or inconclusive, proceed to low dose CT scanning. (Level 3 evidence)
- Treat toxidromes as per toxbase guidelines.
- Opiate toxicity can usually be managed with a naloxone infusion
- Indications for urgent surgical removal of packages are
    - Obstruction or ileus
    - Cocaine or amphetamine toxicity
    - Opiate toxicity not responding to naloxone infusion
- If a proven body packer is asymptomatic they may be discharged to the UK border authority (UKBA) border force who will observe them in designated customs suites.
- Endoscopy should not be used as a method of removing drug packages

Scope

This guideline deals with adult patients presenting to the Emergency Department (ED) having ingested or concealed illicit drugs in body cavities. It covers our legal responsibilities, interactions with the police and provides clinical guidance. This document provides more detailed guidance for the ED regarding the management of patients who are suspected of having concealed illicit drugs. The guidance compliments a previously published template protocol for the management of detainees who are suspected of swallowing or having packed drugs or foreign objects into body orifices or cavities that was published in June 2011.[1]

There were 43 drug related deaths in police custody between 1997 and 2002, 16 of these were due to internal drug concealment[3]. There have been 2 deaths in UKBA custody since 2006.

This Clinical Guideline should also be used in conjunction with "**Drugs Concealed Illicit Drugs - Legal Guideline"** which addresses the legal and ethical issues arising where a patient self-presents and reports having swallowed/ingested a quantity of drugs for concealment. It addresses the balance between involving the police and maintaining patient confidentiality

Key words for search

Body packers, body stuffers, drug concealment, heroin, cocaine

Definitions

- **Body Packers** or "Mules" intentionally conceal well wrapped drug packages by swallowing them, in order to smuggle them across borders or into prisons. The commonest drugs are heroin, cocaine, amphetamines and cannabis. Packers will usually have swallowed large quantities of packets of drugs, which if they leak have a high risk of severe or fatal toxicity. Packages used to be hand made using foil or condoms but are increasingly manufactured using hardened paste coated in various substances.[4] As a consequence, the risk of package rupture has decreased substantially.
- **Body Stuffers** tend to ingest drugs that are more poorly packaged in an unplanned attempt to avoid detection by the police. These tend to be smaller quantities than packers but are less well wrapped. They may also conceal drugs in their rectum or vagina, this is known as pushing. **Pushers** are rare and have few complications.[5]
- **Parachuting** is intentional ingestion of drugs that are wrapped in a covering that is expected to dissolve in order to release the drug for later absorption and delayed symptoms. These patients can be treated as body stuffers.

The Police role

- The Police and Criminal Evidence Act 1984 (PACE) as amended by the Drugs act 2005[6] recommends that an individual is transported to hospital whenever reliable intelligence indicates that the person has packed or stuffed drugs.
- Under section 55 of PACE, police in England and Wales can authorise that a patient have an intimate search for class A drugs However, the person has to consent to a search in writing. The authorisation for such a search has to come from an officer of the rank of inspector or above who has reasonable grounds for believing that the person has concealed class A drugs with the intent to supply. It must be determined that that an intimate search is the only practical way to retrieve the drugs.[7]
- Intimate examination has to be carried out by a Forensic Physician (FP), not a hospital doctor, but has to be carried out at a hospital with resuscitation facilities in case a package should rupture. In this case the Emergency Department may be asked to provide a room for this.
- ED physicians should not handle any drug packets at any point as the chain of evidence cannot be guaranteed. Only the police or Forensic Physician should do this.
- Similarly an Inspector may authorise the use of radiology to detect ingested drugs but the person again has to consent to this in writing. If this has occurred, the ED may be asked to arrange this investigation. Where this happens, the hospital should provide a copy of the images for the police and can arrange to charge the police force for this. Reporting should be carried out by radiologists with appropriate training as the report is likely to become evidence
- The Police are authorised to test for class A drugs (cocaine and heroin only) if a person has been arrested for specified drug offences. They should use their own testing processes carried out in custody. ED drug test results should not be provided to the police.
- The police will usually bring a patient into the ED under arrest, and are likely to stay with the patient until the case is resolved. This will either be when the patient is discharged if they are well (see below) or when the packages have been retrieved. However a patient has the right to speak confidentially to a doctor outside the hearing of police.

United Kingdom Border Force (BF) processes[8]

- BF has the power to request intimate examination and radiological imaging at a hospital. The border force in some areas has a low dose XR scanner to look for internally concealed drug packages with the individual's consent. The sensitivity of the results from such scanners is not known.
- BF has a policy of transferring all individuals suspected of internally concealing drugs to specialist suites near Heathrow, Gatwick and Manchester airports. Specially designed vehicles with onboard captive toilets are used.
- BF do not routinely take detainees to hospital but will request a forensic physician if the person has health problems or request an ambulance if the person becomes unwell.
- Where there is enough evidence to charge an individual with importation of a controlled drug, the detainee may be taken to a police station and then to a magistrates court to be charged. However they will then be transported back to the BF suite if they have not passed all their concealed packages.
- Asymptomatic individuals suspected or charged with concealing drugs are usually observed in BF suites. The chief medical officer's expert group on the medical care of suspected internal drug traffickers [7] has recommended BF use a Custodial Early Warning Score (CEWS) to monitor detainees. This consists of BP, pulse, oxygen saturations, temperature, pupil size, behaviour and AVPU.

General management

- Try to determine in the history what has been concealed, the quantity, when and how it was packed/stuffed. If there is any doubt how much drug was consumed then err on the side of caution and treat as a packer.
- You are not obliged to tell the police these details without the patient's consent. GMC guidance states that information should be disclosed only with patient consent or if it is in the public's best interest or would prevent a violent crime. If you feel that it is, you should weigh the benefits against the potential result of a loss of trust between you and the patient see also **Drugs Concealed Illicit Drugs - Legal Guideline** .[9.10]
- Look for toxidromes (suggestive of package leakage):
    - Cocaine: Tachycardia, hypertension, agitation, diaphoresis, dilated pupils, hyperpyrexia, seizures, chest pain, arrhythmias and paranoia.
    - Heroin: pinpoint pupils, respiratory depression, decreased mental state, decreased bowel sounds and the development of non-cardiogenic pulmonary oedema.
    - Amphetamines: Nausea, vomiting, dilated pupils, tachycardia, hypertension, sweating and convulsions.
- Perform a 12 lead ECG to look for arrhythmias/ST elevation, repeat ECG regularly if the patient is symptomatic. Use benzodiazepines for treatment of cocaine induced chest pain[11]. If there is evidence of ST elevation then refer early to Cardiology for consideration of reperfusion therapy as per toxbase guidance.
- Radiological or toxicological tests cannot be carried out without the patient's consent unless the patient lacks capacity and it is in their best interests.
- Urine toxicology has been shown to be unhelpful in both packers and stuffers as there are many reasons for false positive and false negative results.
- GMC guidance advocates information sharing to ensure safe handover of patients between health and social care providers. On discharge of the patient, you should therefore provide a confidential medical summary detailing all relevant investigations and treatment in a sealed envelope marked for the attention of the forensic medical service
- All patients have a right to refuse investigations and discharge themselves from the hospital even though they are under arrest. Document fully what the patient has been told about their risks. It is recommended that the patient is given a copy of this documentation.

How to manage body stuffers[12]

See appendix 1 for algorithm

- The evidence of the police officers witnessing the swallowing is important. The majority of detainees will deny any drug swallowing as they do not wish to incriminate themselves
- Patients who have swallowed packages may take several hours to develop symptoms and it is very variable depending on the type of wrapping. Patients should be observed for at least 6 -8 hours.[13,14,15] There have been deaths in custody after this time scale, however most of these patients had no clinical observations performed that may have picked up earlier signs of toxicity. If suspicions are high, a patient should be kept longer (usually 12-24 hrs) or until symptoms and signs have resolved.
- Consider the use of activated charcoal 50g[16] to reduce absorption of the drug
- Manage the patient according to toxbase guidelines for the drug ingested[17].
- These patients should be admitted to ward 101 or MAU if need for acute medical input

How to manage body packers

See appendix 2 for algorithm

Imaging

- AXR can be used as a screening test. It has 97% specificity. However if it is negative it does not rule out packing. Newer ways of packaging are more difficult to see on plain AXR. Liquid cocaine does not show on AXR. Gastric packages may be identified on erect CXR.
- Common signs on AXR are repeating uniform geometric patterns e.g. like “tic tacs” or multiple parallel shapes side by side, dilated loops of bowel, the “double condom sign” (rim of air in between two condoms) and the “rosette sign” (air in the tied ends of the condoms.
- Low dose CT without contrast is the most sensitive test. Perform an abdominal CT if the AXR is inconclusive and there is still a clinical suspicion that the patient has ingested packets of illicit drugs.
- CT is the best way to confirm that all packages have been passed, do not rely on a number of clear stools as this is very variable between patients.
- Many radiologist have limited exposure to this scenario and radiology reports may carry the following caveat
- *In my limited experience of reporting imaging in this clinical scenario I cannot see any obvious ingested foreign body. However this cannot be categorically excluded and therefore one should consider a longer period of patient observation.*

If symptomatic and positive imaging

- If the patient is symptomatic for cocaine or amphetamine toxicity, refer urgently to the surgical team for surgical removal. Endoscopic removal risks damaging packages and further leakage. CT will aid surgical intervention. These patients should be admitted under General Surgical Team for urgent laparotomy.
- Follow advice from TOXBASE and the National Poisons Information service for severe cocaine toxicity. Use large doses of bonzodiazepines and nitrates for hypertension. http://www.toxbase.org/Poisons-Index-A-Z/B-Products/Cocaine/
- If a patient is symptomatic with opiate toxicity, then use generous amounts of naloxone, consider a naloxone infusion. http://www.toxbase.org/Poisons-Index-A- Z/B-Products/Body-Packing/
- A patient with opiate intoxication may be able to be maintained on a naloxone infusion.[1,18]. These patients should be admitted to ITU under the General Medical Team, as the risk of death is high
- If a patient with opiate intoxication cannot be maintained on a naloxone infusion the patient should be referred for laparotomy.

If asymptomatic and positive imaging

- Asymptomatic body packers can usually be managed conservatively. This is backed up by several large case series. [19, 1,20,21] These people are usually observed and managed at Border Force centres.
- Laxatives or even whole bowel irrigation can be used under medical supervision: isotonic preparations such as Kleen prep or movicol (macrogliols) are recommended but there is a theoretical risk of rupture with hypertonic solutions such as Fleet, picolax or lactulose. Picolax is reported to damage rubber condoms.
- If discharging an asymptomatic patient to the care of the Border force custody suite or police custody, ED staff should give advice on the clinical signs of toxicity. If it is not possible to discharge these patients and they require admission this should be to ward 101 or MAU

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Documentation Controls

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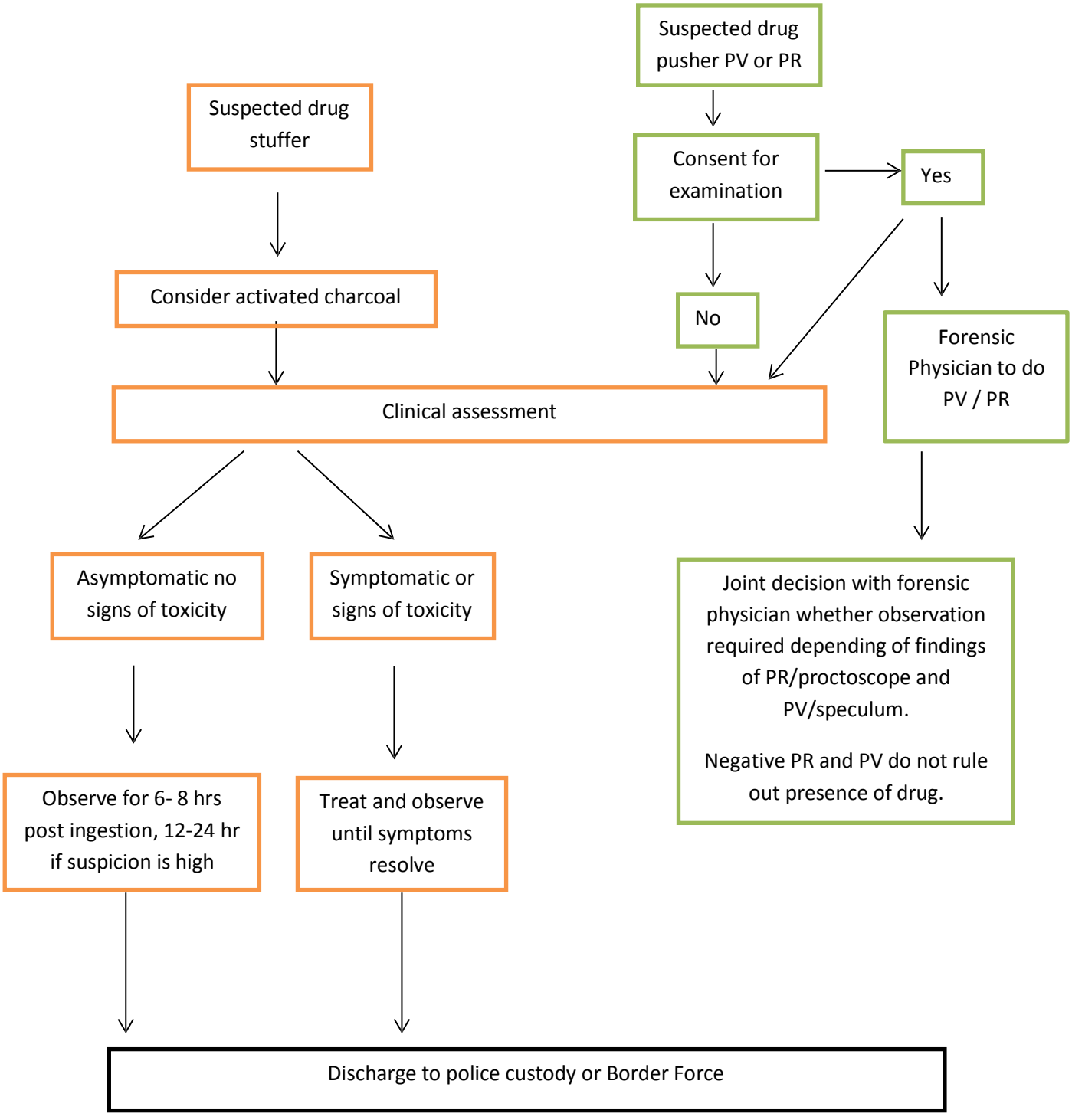
Appendix 1- Algorithm for suspected body stuffers or pushers

If in doubt of quantity, treat as packer.



Appendix 2 - Algorithm for suspected body packer