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## Poison Control and the EMD

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Since the beginning of the Poison Control Center (PCC) concept in 1953, the role of these expert information and treatment resources has expanded as they became better understood. Regional Picks began forming in the 1970's, staffed with toxicologists (experts in the pharmacology of poisons). A process called "Home Care" for handling childhood poisonings have proven effective by these Regional Poison Centers.

The Medical Priority Dispatch System (MPDS) currently includes one response label that does not fit into any other standard 4-tier response categories. Ingestions (non-intentional poisonings) in children age 1 to 11 are referred by direct electronic telephone transfer to the regional PCC and no mobile response is initially sent. After evaluation by the PCC "interrogator", the patient may be referred to an E.R. Rarely, response by EMD's or paramedics will be initiated by the PCC if necessary. This referral "response" by dispatch is called the Omega Response.

Referral of this category of callers by medical dispatchers to a Regional PCC is very safe and highly effective, both from the economical and medical standpoint. In 1983, the Journal of Pediatrics published a study by Chafee-Bahamon and Lovehoy called "Effectiveness of a Regional Poison Control Center in Reducing Excess Emergency Room Visits for Children's Poisonings."<sup>1</sup> The following are excerpts that will interest the Emergency Medical Dispatcher (also see diagram available in the pdf version of the newsletter):

"Findings of this study indicate that, like reported poisoning incidents, the majority of the pediatric emergency room visits from poisonings are not severe enough to warrant hospital care. Moreover, the overwhelming majority of poisoning visits are from persons who do not contact a poison center. These visits do not represent efficient use of the medical services of hospital staff. Staff rarely do more than confirm the history of the ingestion and either send the patient home without treatment or give milk or ipecac, all of which could be done at home with the assistance of a poison center. It appears, however, that regional poison centers perform patient assessments better than other sources of telephone triage. Local poison centers, which are usually operated by emergency room staff, have been found to be significantly less proficient than regional poison centers in taking a history and making appropriate treatment recommendations. From these studies, it is likely that staff at regional poison centers, who are specially trained in taking histories of poison exposure and who have more time to spend with callers, generally make more accurate assessments than both emergency room staff and practicing pediatricians. The majority of pediatric patients seen in the emergency room for a poisoning incident has made unnecessary visits to the hospital (by using a PCC) physicians would benefit their patients by saving time and expense without jeopardizing their patient's health."

The "Omega" response that refers pediatric ingestions to a PCC has been used in Salt Lake for 13 years and has long been proven medically effective. Each year in the U.S., there are 850,000 acute poison exposures in children under age 5 alone. This study indicates that 23% (195,000) either go directly to the E.R. or call 9-1-1. While many parents wisely call PCC directly, those who call 9-1-1 and report a conscious and breathing child, without priority symptoms, should be immediately electronically transferred to the PCC. A joint written policy with your Regional PCC outlining the mechanical procedures involved should precede this activity and be approved by your Medical Director. Follow-up reports from PCC to the dispatch center on patient outcome can be routinely obtained. In summary, this innovative association of PCC with medical dispatch centers is safe and without question medically appropriate.

1 Chaffe-Bahamon, et. Al., PEDIATRICS Vol. 72, NO. 2, August 1983