H. Medical management of suspected persons with body packs[1]

General principles

Separation of the roles of expert and therapist

In connection with suspected persons with body packs, physicians may serve in the role of a therapist or in that of an expert (in a law enforcement procedure or under the Customs Act). Physicians who conduct a radiological investigation in a case of suspected body packing serve as a medical expert vis-à-vis security personnel and the judicial authorities. Physicians and other health professionals who monitor the patient until the packages are eliminated have a therapeutic role. Except in emergency situations, a physician cannot simultaneously serve as expert and therapist. This means that the physician who carries out the radiological investigation in a case of suspected body packing cannot subsequently be responsible for medical surveillance of the patient.

Equivalence of care

A person in whom body packing is suspected and/or confirmed is entitled to receive medical care and treatment equivalent to that provided for the general population.

No coercive measures

The person concerned is to be informed of, and must consent to, any medical interventions. If the person refuses to undergo radiological screening, continuous surveillance for the elimination of possible body packages must take place in a medical setting.

Investigation of suspected body packing (expert role)

The physician may only carry out measures requested by the competent customs or law enforcement authorities if they are proportionate. The implementation of coercive measures is not part of the physician's expert role. If a physical examination has been specifically ordered by the competent customs or law enforcement authorities, an executive physician will decide whether or not the expert role can be assumed. In the event of a positive decision, the following principles are applicable.

1 This appendix is an integral part of the SAMS medical-ethical guidelines «Medical practice in respect of detained persons» from 2002, updated 2013. Appendix lit. H was amended in November 2018.

Diagnostic assessment

- To investigate suspected body packing, a diagnostic assessment is performed. The radiological expert communicates the results to the security personnel and/or judicial authorities.
- As an alternative to imaging procedures, medical surveillance is possible. The use of special body pack toilets is recommended (e.g. the "WC trieurs" available at the university hospitals in Geneva and Bern, or at the provisional police detention centre in Zurich).
- If the person with suspected body packs refuses to undergo radiological screening, it is disproportionate to use compulsion. The performance of a radiological investigation under anaesthesia without the consent of the person concerned is also disproportionate and is therefore not permissible.
- The method of choice is low-dose computed tomography (CT) without a contrast agent. CT provides information on the number and location of body packages.
- In women, a pregnancy test must be carried out prior to imaging.
- Abdominal ultrasound represents an alternative for women who are pregnant. However, this procedure is less reliable.
- Urinary drug testing is of little value because its reliability is variable (sensitivity and specificity 37–50%) and it yields false-positive results in drug users. In addition, it is not suitable for detecting rupture of a package.

If suspected body packing is confirmed, the person concerned must receive medical care.

Medical surveillance and care in the presence of body packages (therapeutic role)

Rupture of a body package is associated with a high risk of death. To ensure timely detection of rupture, medical surveillance must take place in a hospital. It must be carried out in accordance with the following principles:

- Continuous surveillance must be assured round the clock. Vital signs must be checked every 2–4 hours. This also includes neurological assessment (pupils, Glasgow Coma Scale).
- When the first body package is eliminated, its contents should be analysed and the results reported immediately to the attending physician. Possible complications can thus be treated rapidly and specifically.
- In patients with capacity, the physician and other health professionals must not carry out any coercive measures; this also applies if the person concerned is in police custody.

Case history

It is essential that the following information should be obtained:

- *Details of body packing:* number of packages, type of packaging (industrial or home made), substance transported, time since ingestion, use of antispasmodics or constipating agents.
- *Risk factors:* gastrointestinal symptoms, fragments of packaging in stool, previous abdominal surgery.
- *Mental state, especially suicidality:* context of detention, risk of autoaggressive behaviour, evaluation of specific vulnerability (drug dependence with risk of re-ingestion of package contents, psychosis, fragile mental health).

A thorough clinical examination is to be performed in order to identify risk factors:

- *Signs of acute poisoning:* miosis/mydriasis, agitation, somnolence, tachypnoea, bradypnoea.
- *Signs of gastrointestinal complications:* ileus, pain, peritoneal irritation.
- *Signs of gynaecological complications (with intravaginal packages):* bacterial infection (vaginitis/salpingitis).
  → CAUTION: Examination of the body cavity (vagina or rectum) is to be avoided, as it involves a risk of damage to drug packages.

Management of asymptomatic patients

- Medical surveillance must be assured until the last package has been eliminated spontaneously.
- Laxatives should be used with caution, as there is a risk of packages bursting. With the requisite care, they may be administered for medical reasons, but not in order to expedite the expulsion of packages.
  The following may be used: osmotic laxatives (macrogol, Klean-Prep, etc.), 1.5–2 L by mouth/nasogastric tube; or contact laxatives (sodium picosulfate) in the usual dosage.
  → CAUTION: There is an absolute contraindication to the use of oil-based laxatives, as these can increase the porosity of packages.
- After three bowel movements without packages and/or after elimination of the number of packages reported to have been swallowed, a confirmatory radiological investigation (low-dose CT) should be performed.
- If packages are not, or not completely, eliminated spontaneously, a surgical intervention is indicated at the latest after 5–7 days.

Management of symptomatic patients (body packer syndrome)

In cases of acute intoxication, if the patient is sufficiently stable, emergency surgery (laparotomy) is indicated; the patient should subsequently be transferred to intensive care.

Intoxication should be treated as follows[2], in consultation with the head of the emergency/intensive care unit responsible:

- *Opioid toxicity:* airway protection, administration of naloxone to maintain adequate spontaneous respiration:
  - with spontaneous respiration: 0.04–0.05 mg IV with subsequent dose titration;
  - with apnoea: 0.2–1 mg IV with subsequent dose titration.
- *Sympathomimetic toxicity (cocaine):*
  - with agitation: lorazepam 1 mg IV or midazolam 5–10 mg IV every 3–5 minutes;
  - with hypertension: lorazepam 1 mg IV or midazolam 5–10 mg IV every 3–5 minutes or phentolamine 1–5 mg IV every 5–15 minutes; → CAUTION: Beta-blockers are contraindicated;
  - with myocardial ischaemia: lorazepam or midazolam (as above), acetylsalicylic acid 100 mg per os, nitroglycerin 0.4 mg sublingually;
  - with prolonged QT interval: sodium bicarbonate 1–2 mEq/kg IV.

Literature

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2 As of October 2018.