

A Case of Mistaken Poison

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42 years old male patient presented in emergency at DR.RPGMCH Tanda in unconscious state after alleged history of consumption of some poison at around 6.00 pm and was taken to nearby civil hospital where on examination he was found to have vomiting and pain abdomen along with miosis and was treated with gastric lavage and atropine infusion. As patient did not improve he was referred. On reviewing history patient had accidentally consumed 60 ml of some liquid used to kill small insects that live as ectoparasites.

On complaining of pain abdomen and nausea he was taken to nearby hospital where after above treatment no improvement was seen and after three hours of consuming poison the patient became unconscious. On examination at Tanda patient was lying listless. There were some fibrillations noted in his legs and thigh. His GCS was E1M1V1. He was having mydriasis and no reflex to light. On physical examination he was cold to touch with moistness over his palms. He had shallow respiration.

His vitals were as follows- pulse-68/min, RR-12/min, BP-138/92mmhg, temperature-36.5c, his ABG showed Ph- 7.32, pO₂- 86, pCO₂-46, HCO₃-25. Patient was kept on oxygen and monitored regularly for need of intubation. His base line other laboratory tests were- Hb-13, TLC- 11200, Urea-38, Creatinine-0.9, SGOT-68, PT-46, Bil-0.9 RBS-113. CXR was normal. ECG showed ST up sloping in chest leads. Trop was negative. Nothing explained loss of consciousness, so NCCT of head was ordered which was normal. Patient was continued on atropine infusion. In spite of drying of secretions due to atropine infusion patient didn't achieved tachycardia.

Dose of atropine was increased and intensive monitoring was continued. The condition of the patient remained same till 5.00 am in the morning almost twelve hours after consumption of poison when he spontaneously regained consciousness. Atropine was tapered and patient was discharged on the next day. CNS depression was the prominent finding in our

case. The respiratory depression along with CNS depression suggests a direct inhibitory effect on respiratory centre. ^[4] Our patient regained consciousness in 12 hrs which supports findings from other studies (4-48hrs). ^[1, 2] Bradycardia was due to alpha1 and alpha 2 action of amitraz. ^[1]

The combination of bradycardia, miosis and respiratory depression lead to confusion of poisoning with organophosphates in our case. ^[1, 3] The miosis in early phase of amitraz poisoning could be explained on the basis of presynaptic effect of the poison. Atropine was used thinking of organophosphorous poisoning in this case. But earlier reported cases conclude that atropine should be used in those cases of amitraz poisoning where the presentation is with bradycardia^{1, 3}. The analysis of ABG in our case showed respiratory acidosis due to retention of CO₂ as opposite to previous reported cases which showed alkalosis ⁴.

Non specific ECG changes were observed in our case which regressed over next 24 hrs. As there is no specific antidote for amitraz a high level of suspicion and good supportive care along with knowledge of pharmacology of this compound helps in early diagnosis treatment of its effects. With good supportive care prognosis of these patients is good and they can be discharged without organ dysfunction.

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