

normal saline is recommended, tap water is acceptable. The patient should be placed in Trendelenburg and left lateral decubitus positions to prevent aspiration (even if an endotracheal tube is in place). Lavage decreases ingested absorption by an average of 52% if performed within 5 min of ingestion administration, 26% if performed at 30 min, and 16% if performed at 60 min. Significant amounts of ingested drug are recovered from <10% of patients. Aspiration is a common complication (occurring in up to 10% of patients), especially when lavage is performed improperly. Serious complications (esophageal and gastric perforation, tube misplacement in the trachea) occur in ~1% of patients. For this reason, the physician should personally insert the lavage tube and confirm its placement, and the patient must be cooperative during the procedure. Gastric lavage is contraindicated in corrosive or petroleum distillate ingestions because of the respective risks of gastroesophageal perforation and aspiration pneumonitis. It is also contraindicated in patients with a compromised unprotected airway and those at risk for hemorrhage or perforation due to esophageal or gastric pathology or recent surgery. Finally, gastric lavage is absolutely contraindicated in combative patients or those who refuse, as most published complications involve patient resistance to the procedure.

*Syrup of ipecac*, an emetogenic agent that was once the substance most commonly used for decontamination, no longer has a role in poisoning management. Even the American Academy of Pediatrics—traditionally the strongest proponent of ipecac—issued a policy statement in 2003 recommending that ipecac should no longer be used in poisoning treatment. Chronic ipecac use (by patients with anorexia nervosa or bulimia) has been reported to cause electrolyte and fluid abnormalities, cardiac toxicity, and myopathy.

*Whole-bowel irrigation* is performed by administering a bowel-cleansing solution containing electrolytes and polyethylene glycol (Golytely, Colyte) orally or by gastric tube at a rate of 2 L/h (0.5 L/h in children) until rectal effluent is clear. The patient must be in a sitting position. Although data are limited, whole-bowel irrigation appears to be as effective as other decontamination procedures in