Re: Thoughts on the Current Management of Acute Aluminum Phosphide Toxicity and Proposals for Therapy: An Evidence-based Review

Sir,

We read with interest the latest review by Farahani et al.[1] As we have currently proposed a flowchart for treating aluminum phosphide (ALP) poisoning,[2] we think there are some concerns about this article that deserve mention.

- **Clinical manifestations:** Although producing methemoglobinemia is theoretically possible in ALP poisoning none of the cited references confirmed it as a significant byproduct. They used a co-oximeter to confirm methemoglobinemia, while as shown before, this could be a dyshemoglobin falsely positive for methemoglobin by the co-oximeter[3,4]

- **Gastric decontamination:** We think gastric ventilation – by evacuation of phosphine from gastrointestinal (GI) tract – is another possible hypothesis but needs investigation.[5] In addition, although water-soluble compounds such as potassium permanganate can theoretically induce pH_{3} released within seconds postingestion, they may change metal phosphide to less toxic phosphate components. On the other hand, since they have not used this modality of treatment in their routine practice, one would have expected a lower mortality, which was not the case. The authors chose not to use bicarbonate for gastric decontamination with a similar hypothesis. We all know that phosphine release is facilitated by moisture and stomach acidity.[2] In reality, we cannot dry the GI secretions, but we can reduce the stomach acidity by sodium bicarbonate. Bearing in mind that phosphine starts to be released seconds after GI contact, we may retard its complete release. The authors advised bicarbonate in treating ALP poisoning with pH <7,[1] another practice that has not decreased their mortality rates. These recommendations are against other reports and are based on unproven hypotheses.[5] While the authors are against using water-soluble material, they simultaneously used bicarbonate and potassium permanganate for gastric decontamination in a recent case report.[1] Activated charcoal can absorb gases including intestinal gas and is traditionally used for treating diarrhea and inflammatory bowel syndrome. It may, therefore, absorb phosphine although combining with water may facilitate phosphine release. This is actually a remedy when phosphine is released in contact with gastric secretions.[2] Maitai showed that all three above-mentioned water-soluble materials reduced the mortality rate of rats exposed to metal phosphide with most effective to be bicarbonate and less efficacy with potassium permanganate.[1] More investigations are needed before excluding these remedies from the routine treatment strategy.

- **Management of severe hypotension/cardiac dysfunction:** We recently reported an interventional study to demonstrate the efficacy of glucose/insulin/potassium in treating ALP poisoning and reducing the mortality from 72.7% to 50%.[6] Nowadays, this protocol is routinely used in many Iranian centers[2]

- **Management of severe metabolic acidosis:** We agree that metabolic acidosis is a reflection of hypoperfusion, and excessive bicarbonate use may worsen the outcome by reducing tissue O_{2} delivery. However, there is a direct link between cardiac failure and arrhythmia in ALP poisoning with severe metabolic acidosis. In the study of Jaiswal et al., all 12 patients with electrocardiogram abnormalities survived after full correction of metabolic acidosis and survival rate improved to 55% among 40 patients.[7]
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Conflicts of interest
There are no conflicts of interest.

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Letters to the Editor
Sir,
The incidence of brought dead (BD) is high in tertiary care centers, but there is a lack of proper audit and relevant data of these cases. Although there are few studies regarding mortality pattern of children, none of them takes BD into account. We did a retrospective analysis of BD cases at the emergency room of tertiary care teaching hospital, over a year from January 2014 to December 2014. A patient was declared dead if there was neither pulse nor a response to stimulation and cardiopulmonary resuscitation was tried for a period of 20 min. A total of 186 cases were recruited for the study. Neonatal mortality constitutes 40% of under-5 mortality and approximately 57% of infant mortality [Table 1].

Most neonatal deaths (99%) arise in low- and middle-income countries and approximately half occur at home. [2] In our study also, newborn constitutes nearly 35% of cases of BD. Unfortunately, the cause of death could not be revealed due to overlapping signs and symptoms in the lack of investigations and postmortem. Most cases are in the early age group, and infectious etiology including acute encephalitis syndrome (AES) and sepsis accounts for most of them [Table 2].

Road traffic accidents (RTAs) are common causes of BD in adults; however, we did not find it responsible for any of the case, it could be because of either less number of cases

Table 1: Age-wise distribution of brought dead cases

| Age group       | Number of cases | Percentage of cases |
|-----------------|-----------------|---------------------|
| <28 days        | 65              | 34.9                |
| 1 month to 1 year | 49              | 26.3                |
| 1-5 years       | 26              | 13.9                |
| 5-10 years      | 27              | 14.5                |
| 10-19 years     | 19              | 10.2                |

Table 2: Cause of death

- AES constitutes the maximum number of BD although it is a vague term including all etiologies of fever and altered sensorium such as bacterial meningitis, tubercular meningitis, cerebral malaria, and acute disseminated encephalomyelitis.

- Road traffic accidents (RTAs) are common causes of BD in adults; however, we did not find it responsible for any of the case, it could be because of either less number of cases.