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## Letters to the Editor

**ADB-FUBINACA BODY  
PACKER**



**To the Editor:**

We applaud Dr. Nacca et al. for publishing their case of ADB-FUBINACA body packing associated with measured serum concentrations (1). The case is very interesting, and we seek a few clarifications regarding the patient's presentation and care.

First, is it correct to define the patient as a “body packer?” Interestingly, the patient had been a detainee for 5 years in a jail setting. Was he trying to smuggle the drug into jail, deliver the drug to another location, or was he due to be transported to prison? If not, and because the product was poorly wrapped, would he more appropriately be defined as a “body stuffer?”

Secondly, the application of whole bowel irrigation at 100 mL/h seems to be a cautiously conservative regimen. Although most agree to begin at 1–2 L/h in adults (as was done on hospital day 8 in this case), the rate may be altered when the volume is not tolerated secondary to vomiting or ileus (2). Our group has found whole bowel irrigation challenging to effectively perform over the last decade, resulting largely in abandonment of this procedure. Was there a reason for such a gentle trickle of polyethylene glycol rather than a more aggressive flushing of the gut?

Finally, the patient is described more than once as “hypoglycemic” and had transient responses to dextrose boluses. What was the degree of hypoglycemia? One reference chosen regarding this clinical finding included one patient (out of a series of 44) who was hypoglycemic, but does not include the actual blood glucose concentration (3). The second reference states there was no correlation between the cannabinoid concentration and glucose concentration, and for those who did become hypoglycemic, 75% were within the range “indicative of fasting” (4).

We look forward to further discussion of these aspects of the patient's course from Dr. Nacca and colleagues, and again thank them for sharing this interesting case.

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**NACCA ET AL. IN REPLY TO  
MCCANN ET AL.**



**To the Editor:**

We would like to thank Dr. McCann and Dr. Bryant for their interest in our report. We are happy to provide additional information that was lacking from our original publication due to space constraints and unconfirmed details.

Although we understand the confusion regarding our labeling of this case, we maintain that the patient was, in fact, a body packer. During his hospitalization, the prison guards present with the patient reported that he had visitors at the prison that brought potato chips for him. Their suspicion was that the visitors had hidden the packets of drugs in the bag of potato chips; while the patient appeared to be eating potato chips, he was ingesting packets of drug that were later recovered during his hospitalization. We were unable to confirm this report with the patient. Therefore, although the packets were poorly wrapped, we maintain that he was a body packer, as the drugs were

intentionally ingested with the intent of smuggling them into prison from the visiting area.

We agree with Dr. McCann and Dr. Bryant regarding the implementation of whole bowel irrigation (WBI). Our involvement in this case began as consultants through our regional poison center to the treating physicians in a rural intensive care unit; the patient was not transferred to our facility until hospital day 7. It was the decision of the physicians at the outside facility to start at a rate slower than our recommendation, for unclear reasons. Our second attempt at WBI did start with 1 L/h of polyethylene glycol-electrolyte solution. The discussion could be extended to raise concern that initiation of WBI at this rate might not only be ineffective, but possibly detrimental. The administration of subtherapeutic doses of a solute like polyethylene glycol-electrolyte solution might theoretically increase the rate of absorption of previously nonsolubilized drug in the gastrointestinal tract. This theory has been investigated with mixed results (1,2).

As previously mentioned, the patient was transferred to our facility on hospital day 7. While under our care, the patient did not develop hypoglycemia. Laboratory results obtained from the previous facility demonstrated a serum blood glucose of 100–110 mg/dL; however, emergency department notes documented multiple episodes of severe hypoglycemia refractory to boluses of D50, requiring continuous infusion of supplemental dextrose. Unfortunately, the notes do not report exact readings from the point-of-care glucometer.

We again thank Drs. McCann and Bryant for their interest in our case and hope this response provides further clarification.

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