

American  
Academy  
of Clinical  
Toxicology,  
Inc.



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## President's Corner

G. Randall Bond, MD



### “May you live in interesting times”

*Old Chinese proverb/curse*

Little did I know... what a daily experience the AACT presidency would be. So much happens behind the scenes. In the last few months, major issues continue to be those I spoke of in my last President's Corner: financially closing out the last two meetings

while transitioning the financial “system” from Greg Gaar to Marty Caravati, forming a legal partnership with the AAPCC to host the NACCT, reviewing ongoing NACCT 2007 plans and plans for AACT specific events at NACCT, negotiating along side the EAPCCT to renew the AACT's association with Clinical Toxicology, selecting candidates for president-elect, and arranging a special election.

The last of the bills have been paid for NACCT 2006 and the accounting is almost complete. It turns out transitioning treasurers has been more complicated than we imagined, particularly with new tax rules for non-profits in New Jersey (the state in which we are incorporated) and consequent discussions formalizing our partnership with the AAPCC for hosting the NACCT. These new auditing rules may raise the level of accounting we must do and were the impetus for registering the NACCT partnership. Formal separation of the NACCT has added another layer of accounting for our Treasurer.

In this process of financial transition, our association manager, the office of the Pennsylvania Medical Society, has worked very hard. Over the summer, several of our projects and support needs were delayed and many of you communicated your frustration to the executive. When we approached the Pennsylvania Medical Society, they promised to redouble their efforts and we have seen a difference. We have been assigned a new liaison who will attend our mid-year board meeting. The web site has been updated and become more useful. I particularly recommend that you use the link to *Clinical Toxicology*

from the Members Only site. As noted, they were great advocates in the financial transition. If you are experiencing any problems with the office or web site please let us know immediately.

NAACT 2007 is coming together. The hotel, the city, and its famous restaurants await us. This week I saw a “top 10” list with New Orleans the fifth most exciting US city to visit (after NYC, SF, Chicago and Santa Fe). It should be great! Contemporary Forums, our meeting manager, is doing their usual superb job. Symposia topics have been chosen and speakers have been contacted. Please give your thanks to those symposia organizers and organizing committee members who are working very hard to be sure there is great quality and great coordination. It is no small task. Abstracts are due April 1 by 11:59 pm EST, and will be reviewed in April. That is the next major task.

I am pleased with the progress the AACT and the EAPCCT have made with Informa, publisher of *Clinical Toxicology*. If you are an author, you know that the delay from acceptance to publication has been more than a year. That has been very discouraging to authors and threatens the quality and reputation of the journal. To get the science out, we now anticipate going to an electronic first publication system, starting with the backlog. To clear this backlog on paper and prevent it from recurring, the number of pages will increase significantly in 2007 and 2008, to a long term plan of 10 issues and two supplements per year. Ultimately, this will allow the journal to devote more pages to reviews as well.

You should have heard by now, the special election for president-elect is underway. You face a tough choice. Two highly qualified candidates are running—Michael Greenberg and Elizabeth Scharman. The election will be completed by the mid-year Board of Trustees meeting.

Your Board of Trustees will be meeting March 27-28 in Philadelphia. In addition to my report, we will receive reports from Marty Caravati, each of the committees, and the interest groups. We will consider the next steps the Academy should take to serve you and advance our discipline. Please, if you have ideas, contact me or speak to a board member before the meeting. We look forward to hearing from you.

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## In The Literature

David Juurlink MD, PhD

### A Clinical Tool for Assessing Risk After Self-harm

Cooper J, Kapur N, Dunning J, Guthrie E., et al. *Ann Emerg Med* 2006;48:459-466.

#### Background

Each year in the United States, approximately 400,000 patients present to Emergency Departments (EDs) for deliberate self harm. While some are admitted, the majority are not. The major concern for those who are discharged is the risk of repetition. Unfortunately, even in hospitals with the resources to perform a mental health assessment before discharge, predicting repeat self harm is difficult because of the low specificity of identified risk factors. In this study, the investigators' aim was to develop a simple risk-stratification decision rule for use in the assessment of ED patients with self-harm.

#### Methods

The investigators prospectively studied 9,086 patients who presented after self-harm to five EDs in England over period of about 3.5 years. They collected social, demographic, and clinical information for each patient at each attendance, including details about the act (e.g., premeditation, suicide note, etc.), the method of self-harm (substance ingested, etc.), and an extensive array of life stressors and other contributing factors.

The authors derived a decision rule using recursive partitioning (RP), a technique used to "mine" large data sets. RP is a means of uncovering hidden patterns in the data using a set of rules to split data into a hierarchy of smaller and more homogeneous subgroups, eventually determining the best combinations of predictor variables for the question at hand. In this study, the main objective was to discriminate between patients at higher and lower short-term risk (within six months) of repetition or suicide. Data from three EDs comprised the derivation set, and the model was validated using data from the remaining two EDs. Most assessments were done by senior house officers.

#### Results

Of 11,819 episodes of self-harm, 22 percent were not included in the analysis because the patients either refused treatment or left before assessment. Among the remaining 9,086 patients, the predominant method of self-harm was poisoning (85 percent). Overall, 1,538 (17 percent) repeated within 6 months, including 22 deaths by suicide. The investigators generated a four-question rule with a sensitivity of 94 percent and specificity of 25 percent to identify patients at higher risk of repetition or suicide:

- Is there any previous history of self-harm?
- Is there any previous psychiatric care?
- Were benzodiazepines used in the present attempt?
- Is the patient currently under psychiatric care?

In total, 25 percent of patients met all four of these low-risk criteria. In addition to the rule's high sensitivity (a "no" response to all four questions ruled out most repeat episodes), the rule successfully identified all 22 patients who committed suicide within the following six months. In sensitivity analysis, the role performed slightly better in women and patients older than 35 years.

#### Implications for Practice

The Manchester Self-Harm Rule provides a simple and clinically intuitive means of identifying ED patients at lower risk of repeated self-harm in the near term. The generalizability of the prediction rule is somewhat threatened by the exclusion of a large number of patients, and there will obviously be patients in whom its application is not possible or unnecessary. While most patients will not meet all four criteria, the rule will be of some help to clinicians, particularly in facilities with limited resources to conduct mental health assessments. Like all clinical prediction rules, the Manchester Self-Harm Rule is not perfect, and its use should be tempered by clinical judgment.