



Original article

Body packers: grading of risk as a guide to management and intervention

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The dual aims of management of the drug smuggler are for low morbidity and mortality combined with a low operation rate. In our experience, presented in this paper, adherence to the principle of identifying the high-risk patient by symptoms and signs combines safety with low rates of intervention.

Key words: Body packers – Drug smuggling – Identification

The first case reports of the smuggling of illicit drugs by internal bodily concealment appeared in the mid-1970s.¹ Packages containing the drug are either swallowed or inserted into the vagina, rectum or even ear² with a view to retrieval once the 'body packer' or 'mule' has reached his or her destination. These body packers differ from 'body stuffers' who quickly swallow packets containing drugs when confronted with the authorities. The most common drugs involved are cocaine and heroin, although there are reports of amphetamines, ecstasy and cannabis also being smuggled by this route.³ Body packers often co-ingest antimotility agents such as loperamide or co-phenotrope to slow transit time of the packages, especially as many smugglers are on long aeroplane flights.⁴ Many plan to take laxatives upon arrival at their destination to aid passage of the packets.

Smugglers present to hospital either after detection by customs, or following the development of symptoms and signs. The only previous serious attempt to rationalise the management of these smugglers was made almost 20 years ago by McCarron and Wood.⁴ They suggested that the high-risk patients could be identified on the basis of package characteristics, of which they claimed there were

three main types. This is now obsolete, as almost all packaging is similar, type II in their classification, and rupture rates in more recent series have been low.⁵

At this hospital, it has been the practice to identify the high-risk patient from the symptoms and clinical signs, not package type. A revised classification for identifying the 'at risk' body packer is listed in Table 1. Between January 1995 and December 1999, a total of 252 people suspected of trafficking drugs underwent abdominal X-ray in this hospital. Of these, 51 (20.2%) were demonstrated to be carrying packages.

Of those identified, 42 (82%) were categorised as grade I and were managed at Heathrow Medical Centre. Stool examination was undertaken and the patient was considered clear after the passage of two packet-free stools. There were no complications in this group.

A further 8 (16%) patients were classified as grade II. They had swallowed between 3–149 packages and two had co-ingested an antidiarrhoeal. All had symptoms; eight complained of abdominal pain and one patient had nausea. On clinical examination, two patients had abdominal tenderness, one patient had a palpable mass, and one patient had both tenderness and packages that

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Table 1 Proposed new grading system for body packers with proposals for management

	Grade I	Grade II	Grade III	Grade IV
Symptoms	None	Abdominal pain, nausea	Bowel obstruction, failure of packages to progress	Severe abdominal pain
Signs	None	None	Imminent package rupture	Signs of acute drug toxicity (including nausea, vomiting, tachycardia, hypo- or hypertension, fitting, confusion, agitation)
Medical intervention	Observation and laxatives/suppositories	Close monitoring (surgical ward) and laxatives/suppositories	Resuscitation and nasogastric tube if vomiting	Resuscitation, benzodiazepines, antihypertensives (not β -blockers).
Surgical intervention	None	None	Semi-urgent surgery	Immediate surgery

could be felt on abdominal and rectal examination. Abdominal X-rays showed packages in the stomach in one case, the large intestine in six cases and both the small and large bowel in one. All were managed successfully with conservative measures including enemas and laxatives. In two of these patients, packets were partially disrupted after passage per rectum. However, neither patient exhibited signs of toxicity and so conservative management was continued. Both passed their remaining packages within 24 h. Average in-patient stay was 5.9 days (range, 1–17 days).

The one remaining patient was classified as grade III. Abdominal X-ray had shown the swallowed packages still to be in the stomach even though this smuggler had swallowed 23 packages of cocaine 5 days before admission to hospital. Thus there was considered to be a gastric outlet

obstruction, and the patient was scheduled for semi-urgent surgery. The packages were removed at laparotomy; recovery was uneventful and the patient was discharged into custody 7 days later.

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