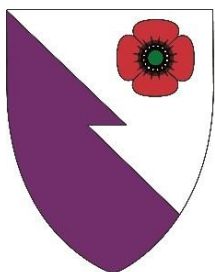


The Royal College of Emergency Medicine

Best Practice Guideline

**Management of
Suspected Internal Drug
Traffickers (SIDT)**



May 2020

Summary of recommendations

Clinical management

1. Toxicology screens (urinary/blood) should not be used to guide management or discharge decisions.
2. A Low Dose CT Scan (LDCT) of the abdomen and pelvis is the investigation of choice in suspected internal drug traffickers (SIDT).
3. Those presenting with an acute abdomen should be offered a CT with contrast and referred for urgent surgical review.
4. Indications for urgent surgical removal of packages include: abdominal pain (possible obstruction or ileus); radiological evidence of remaining package(s) which are too large to pass through the gastric sphincter and evidence of significant/worsening toxicity such as acute psychosis or adrenergic symptoms.
5. Body stuffers should be observed for 8 hours post ingestion if asymptomatic or longer if symptomatic (*Level 4 evidence*).
6. Asymptomatic body packers and pushers can be safely discharged to the police/Border Force (BF) ¹.
7. All patients who are Suspected Internal Drug Traffickers should be provided with a discharge letter.

Legal and ethical issues

1. Current best practice is to perform LDCT to look for internal packages. When consenting the patient, informing them that the findings might not change clinical management and may be used in a subsequent criminal prosecution is essential.
2. In patients aged under 18 years of age there are specific guidelines to follow regarding consenting for examination and imaging (Appendix 3).²
3. Although the police would initiate safeguarding processes, EDs should also implement their own local safeguarding systems.
4. Medical information should be provided to the police in a sealed envelope for attention of the custody healthcare professional in line with Good Medical Practice and Caldecott Principles ^{3 4}.

Forensic issues

1. Any packages or items obtained from the patient should be given as soon as possible to the police as part of their criminal investigation and to preserve the chain of evidence.

Scope

This guideline deals with patients presenting to the Emergency Department (ED) Suspected of Internal Drug Trafficking (SIDT). There are several means of drug concealment described below. Increased awareness amongst police have increased the number of referrals to EDs. Persons under arrest are known as detainees. The document has been reviewed to encompass clinical, radiological, ethical and legal responsibilities for the management of SIDT for ED, and clarifies interactions with the Police and Border Force (BF)⁵. The legal framework upon which this document comments is specific to England, Wales and Northern Ireland.

Reason for development

There were 43 drug related deaths in police custody between 1997 and 2002 with 16 due to internal drug concealment⁶. These deaths in police custody are typically young patients and are preventable in nature. They have a significant impact on the families of the deceased as well as the police officers who are involved. These incidents automatically lead to a Coronial Inquest⁷. There is often concern and apprehension amongst police officers when detaining a person suspected of internal drug trafficking due to risk of death. Clinical staff may also be anxious when dealing with the police and detainees around consent, police powers, clinical investigations and management of patients suspected of drug trafficking.

Definitions

Illicit drugs are imported into the UK by air, sea and land routes and then distributed throughout the country. Individuals may conceal drugs by swallowing drug packages or placing them in their anus or vagina. Patients are unlikely to admit to clinicians that they are concealing drugs.

The following terminology from the Chief Medical Officer's Report on the Medical Care of SIDTs should be adopted by the NHS, Police Forces and BF agencies⁷.

1. Body Packers or "Mules"

Body packers swallow well wrapped drug packages, most commonly cocaine. The packages are subsequently passed and sold on the street.

Packages can number from a dozen to a few hundred and are of varying quality (30-80% purity) and size. Leakage, rupture or unravelling of the packages will expose packers to severe or fatal toxicity. In the past, packages were handmade using various materials, e.g. condoms, but they are now usually machine manufactured, reducing the risk of unravelling or rupturing⁸. They are usually arrested at air, sea and land ports by Border Force officers and referred to local EDs.

2. Body Stuffers

Drug dealers and street users may conceal drugs wrapped in cling film in their mouth. The packages are swallowed or spat out to avoid detection by the police. The packages are smaller in quantity (and dosage) than packers but are poorly protected in the digestive system and so more likely to lead to toxic symptoms. There is a delayed effect of release of the drugs which is why a period of observation in ED of 8 hours is required from time of suspected ingestion.

It is police policy to bring detainees who have been seen to swallow (stuff) drug packages to ED.

3. Pushers

Pushers conceal drugs, usually in containers such as "Kinder eggs" or objects such as mobile phones or sim cards, in their rectum or vagina, to avoid detection. They are at a lower risk due to the packaging method but pushers should be observed carefully as they may also re-swallow to avoid detection⁹.

"County lines" describes tactics by drug dealers who use juveniles and vulnerable adult to transport drugs to suburban areas in this manner. Consider the possibility the patient trafficking drugs may themselves be a victim.

Parachuting is a technique of recreational drug use in which medications or illicit drugs are ingested by wrapping them in a covering that is expected to dissolve or unravel in the gastrointestinal tract and release the drug for later absorption. Such patients should be managed as body-stuffers.

The Police Aspect

The Police and Criminal Evidence Act 1984 (PACE), as amended by the Drugs Act 2005¹⁰ and the Authorised Professional Practice (APP) from the College of Policing, recommend that an individual is transported straight to hospital as a medical emergency whenever an officer suspects a detainee has concealed drugs ¹¹.

The detainee will remain under arrest with officers maintaining a close watch to prevent re-swallowing or disposal of the evidence. However, a patient has the right to speak confidentially to a doctor and suitable arrangements, i.e. hospital security, should be available to enable this if the police are asked to leave.

The police would usually refer juveniles for safeguarding under local MASH or MAPPA procedures^{12 13}. The police may also consider charging the drug dealers with trafficking of children under the Modern Slavery Act 2015¹⁴. EDs should ensure that they complete a safeguarding referral in line with their local policies.

If an untoward incident occurs, e.g. a death, the police or the Independent Office of Police Conduct may seize relevant evidence for investigation¹⁵. Full contemporaneous documentation should take place of any interaction with the police.

Intimate Search

The police and BF have the legislative powers in England and Wales, Northern Ireland and Scotland to authorise and request an intimate search if they have reasonable grounds for believing that the person has concealed class A drugs (PACE section 55b) or anything to cause physical harm (PACE s55a)¹⁶. An emergency physician cannot be compelled to undertake an intimate search whether the patient consents or not.

Intimate searches are **NOT** recommended, even with the aid of a speculum or proctoscope as it may result in injury to patient or examiner, risk breaking the packages, and may not reveal deeply located packages. Instead a LDCT with consent, should be performed to confirm the presence or absence of packages/foreign bodies, their location and number.

Radiology

Under PACE (section 55A) the police and BF have the authority to transfer detainees to a hospital for an X-ray and/or Ultrasound as a criminal investigation tool to detect ingested drugs. This requires consent from the detainee. However clinicians are not required to request an X-ray or USS when presented with the police authority even with consent from the patient (section 55A PACE).

Multiple studies in the last 10 years have shown that the sensitivity and specificity of abdominal X-rays to be poor (especially for liquid containing packages) with CT now the gold standard investigation. Studies have shown that CT has much higher sensitivity and specificity for packages and has the benefit of typically being able to count the number of packages involved. It is therefore the investigation of choice. A lower dose protocol (LDCT), as seen in CT KUBs, should be used in this setting. LDCT techniques vary between different CT manufacturers and it is advisable to use local expertise to achieve a lower dose whilst maintaining diagnostic quality. This can include the use of lower Kv acquisitions and Iterative Reconstruction. It should be possible in a LDCT of the abdomen to achieve a radiation dose of less than 3 mSv; this equates to approximately 1 years background natural radiation exposure in the UK.

Plain film x-rays should NO longer be performed due to their low specificity and sensitivity irrespective of any requests from the Police or Border Force (BF).²² The Border Force has low dose scanners in some ports to help detect potential SIDTs; these positive or suspicious scans should be supplemented by a formal LDCT.

In all cases, the ED clinician must assess for themselves the necessity for imaging and obtain consent from the detainee /patient. The patient has the right to refuse the investigation, see appendix 3 regarding consent and juveniles.

Detainees/patients should be informed that a LDCT may not be therapeutic in nature and may be used as evidence in a criminal investigation. On the other hand a negative LDCT may expedite their release from police custody.

Patients should be advised that if they do have internal drug packages there is a significant risk to their health should they burst or leak.

Pregnancy is a contra-indication for LDCT. In the case of pregnant suspected drug traffickers, passage of drug free stools with the knowledge of the number of packages concealed may be used as an indicator for clearance.

If the patient is so unwell that they lack the ability to provide consent then the emergency physician should act in the patient's best interest with regards performing a scan, if it is safe to do so.

Reporting the LDCT

The Radiology department should create a report of the LDCT which includes the location and estimated number of packages/objects. This information can be added to the ED discharge summary when the patient is subsequently discharged. It can be provided to the police and their custody healthcare personnel only with the consent of the detainee.

This will enable the police or BF to confirm when all packages/objects have been passed/retrieved (Appendix 2). The report may be used as evidence to remand a detainee under s152 of the Criminal Justice Act 1998 (up to 192 hours) to retrieve the remaining drug packages¹⁷.

Certain adulterants, e.g. lignocaine, may cause similar appearance to faecal content. LDCT should be reviewed using both standard abdominal soft tissue and lung window settings by an experienced Radiologist.

In the event of unexpected medical findings being identified by LDCT, the detainee should be referred for further clinical assessment as any other patient would be.

Clinical Management – General

Try to determine from Police or BF officers the nature/suspicion of the arrest, the suspected drug, quantity, when and how it was packed or stuffed.

Perform basic observations (temperature, heart rate, respiratory rate, blood pressure, pupil size and GCS) on all patients with SIDT.

Look for toxidromes (suggestive of package leakage/rupture), see box 1.

Consult TOXBASE for the most up-to-date guidance on the management of specific drug toxicity if abnormal findings noted.

Risk factors for complications associated with concealed drugs are shown below (box 2).

In the event of cardiac arrest, cardiopulmonary resuscitation should be continued for at least an hour and only stopped after discussion with a senior clinician. Prolonged resuscitation, even for several hours, may be appropriate following poisoning as recovery with good neurological outcome may occur.

Any drugs/objects retrieved/passed should be given directly to Police/BF officers. The clinician should complete the MG11 transfer of packages statement, which is likely to reduce the need to attend court (Appendix 2).

Any drug screening by the Police or ED (Cozart test for cocaine and opiate¹⁸) or toxicology should not be used to guide management or discharge decisions due to potential false negatives and positives. Some patients may be users and there may be leakage or none due to the packaging.

Routine blood tests and toxicology screens are not helpful.

Box 1. Common Toxidromes encountered in SIDT

Sympathomimetics e.g. Cocaine	Opiates e.g. Heroin
Tachycardia, hypertension, hyperpyrexia, dilated pupils, convulsions, agitation, chest pain and arrhythmias, nausea, vomiting abdominal pain	Bradycardia, hypotension, hypothermia, miosis, respiratory compromise, CNS depression, pulmonary oedema

Box 2. Risk factors for complications associated with concealed drugs [18]

Abdominal pain

Vomiting

Abnormal vital signs

Poisoning

Improvised/home-made packaging

Large total quantity of drug (especially for body stuffers)

High number of packets (>50)

Large size of packets

Delayed passage of drug packets (>48 h)

Passage of fragments of packaging in stool

Poisoning in a co-transporter

Previous abdominal surgery (greater risk of obstructing secondary to adhesions)

Concomitant drug usage, especially constipating agents

Clinical Management – Body Stuffers ¹⁹ / Parachuting

See appendix 1 for algorithm

- Patients with any clinical signs or symptoms of toxicity should be kept for longer than 8hrs or until signs and symptoms have resolved. Manage the patient according to TOXBASE guidelines for the suspected drug ingested¹⁸
- A LDCT may confirm or refute the presence of packages in the stomach and allow earlier discharge from the ED if negative.
- Patients who have swallowed / stuffed packages may take several hours to develop symptoms depending on the type of wrapping and stomach content. Patients should be observed for at least 8 hours from the point of ingestion even if they refuse treatment / investigations ^{20,21,22}. See discharge advice below.

Clinical Management – Body Pushers

See appendix 1 for algorithm

- No intimate search should be undertaken unless the patient is unwell, however this has to be balanced against the potential risk of accidentally damaging further packets and causing further toxicity. Manage the patient according to TOXBASE guidelines for the suspected drug ingested.¹⁸
- Consider a LDCT which can confirm the presence or absence, the location and number of any packages/foreign bodies.
- If the patient consents to removal of the packages in hospital, the numbers removed should correspond with the numbers seen on LDCT, if this has been performed.
- Patients with packages in the rectum or vagina, may be discharged to the police/BF if clinically well. Having the result of a LDCT scan which positively identifies packages allows the police to implement a constant watch whilst the patient is in custody. See discharge advice below.

Clinical Management – Body Packers

See appendix 1 for algorithm

A LDCT should be considered as the first line imaging investigation of choice in the asymptomatic patient.

Body Packers – symptomatic and positive imaging

- If the patient is symptomatic for cocaine toxicity, refer urgently to the surgical team for surgical removal. Use appropriate doses of benzodiazepines and nitrates for hypertension due to severe cocaine toxicity and sodium bicarbonate for QRS prolongation (TOXBASE). Anaesthetic support is often required for early sedation to manage the hyper-adrenergic symptoms. Endoscopic removal risks damaging packages and further leakage. CT with contrast may aid surgical intervention but should not delay surgery in an unwell patient.

- If a patient is symptomatic with opiate toxicity, then use generous amounts of naloxone and consider a naloxone infusion, may reduce the need for surgery¹⁸ (TOXBASE). CT (with contrast) prior to surgery is helpful but only if the patient can be safely maintained on naloxone. The patient should be monitored closely as there is a high risk of death.

Body Packers – asymptomatic and positive imaging

- Asymptomatic body packers can be managed conservatively, with surgery only being indicated on clinical grounds or when packages become stuck^{5,23,24,25}. Patients/detainees can be observed and managed at police or BF custodies as long as they are passing the packages. See discharge advice below.
- Laxatives or whole bowel irrigation can be used under medical supervision to encourage movement of packages. Isotonic preparations such as Klean-Prep or Movicol (macrogols) are recommended as there is a theoretical risk of rupture with hypertonic solutions such as Fleet, Picolax or lactulose. Picolax is also reported to damage rubber condoms.

Body Packers – mild symptoms and positive imaging

Those with confirmed imaging and mild symptoms, e.g. abdominal pain, can be treated conservatively with close monitoring in hospital.

Body Packers – asymptomatic and refusal of imaging

- Those patients who refuse to consent to LDCT and who are asymptomatic may be discharged to the care of the Police / BF. See discharge advice below.

Body Packers – confirmation of complete clearance of packages

- The police/BF may request confirmation that the patient does not have any packages remaining internally. There is no evidence to base the complete clearance of drug packages on the number of clear stools passed. Packages may get stuck in rugal folds, or ileo-caecal valve. In general, if packages have not been passed within 48 hours they are unlikely to be passed through normal bowel motions.
- If an initial LDCT has been performed with an estimate of packages this may be correlated with the number of packages passed. In some circumstances, e.g. where no initial LDCT has been performed or it is unclear as to number of packages packed an exit LDCT may assist in confirming that no packages remain.

Discharge Advice

- GMC guidance and Caldecott Principles advocate information sharing to ensure the safe handover of patients between health and social care providers and those taking over care of patients ²⁶. On discharge of patients, a confidential medical summary detailing all relevant investigations and treatment should be provided in a sealed envelope marked for the attention of the custody healthcare professional. The patient should be informed of the medical handover.
- All patients with capacity have a right to refuse investigations and discharge themselves from the hospital even though they are under arrest. Document fully what the patient has been told about their risks.
- A discharge summary detailing type, numbers of packages or items removed or remaining will assist the custody healthcare professional in managing the detainee safely.
- Provide the Police / BF with advice on the clinical signs of toxicity when discharging asymptomatic patients who still have retained packages, to the care of the Police or BF.

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Endorsements

National Police Chiefs' Council

Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

Dr Meng Aw-Yong is also Medical Director of the Metropolitan Police Service

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

More research is required on the validity of the low dose scanner used by BF, the safe observation time for drugs stuffers. The Royal College of Radiologists is recommended to consider ensuring training is available for reporting of LDCT for medico-legal purposes.

Audit standards

None

Key words for search

Body packers, body pushers, body stuffers, low dose CT, drug concealment, heroin, cocaine.

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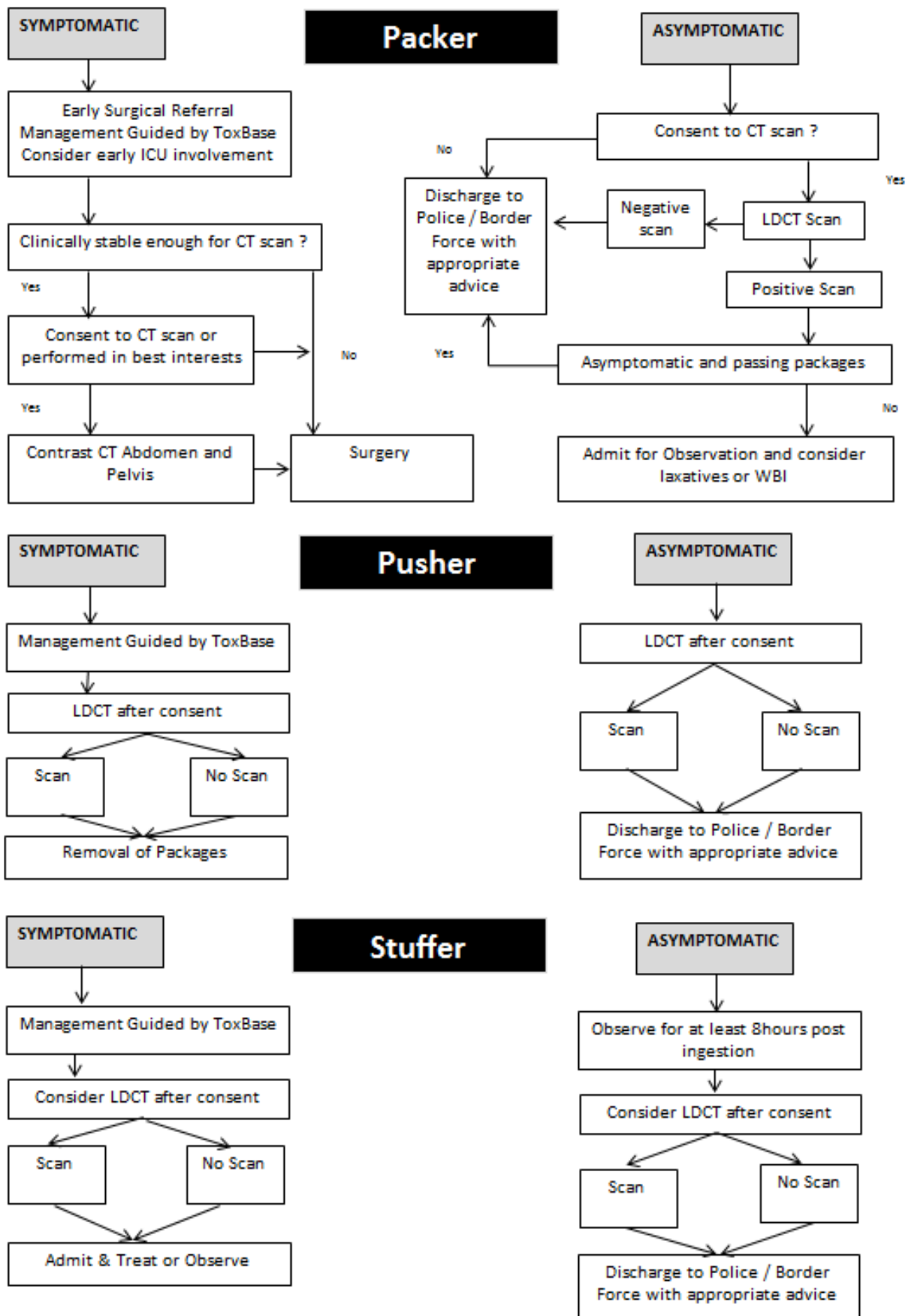
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Appendix 1: Algorithm for suspected internal drug traffickers (SIDT)



Appendix 2: Statement template for handover of retrieved packages

Witness Statement

Form MG11

(CJ Act 1967, s.9 MC Act 1980, s.5A (3) (a) and 5(B); MC Rules 1981, r.70)

Statement of XXXXXX

Age: over 21 years old

Occupation: Medical Practitioner

This statement (consisting of one page each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything, which I know to be false or do not believe to be true.

Dated the XXXXXXXX

Signature

I am currently working as a doctor in XXXX hospital

1. This statement confirms that I was the surgeon operating on Mr/Mrs XXXXX on the xxx day, xxx month, xxx year. I have retrieved XXXX number of packages and have passed them to Border Force officer XXXX at time XXX date XXXX.

Signature

Signature witnessed by.....

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Appendix 3: Consenting a person suspected of drug trafficking for LDCT.

Patient is symptomatic (hence a therapeutic examination)

Patient Age	Needs Patient consent (if has capacity)	Needs parental/guardian	Treat/ investigate if lacks capacity?
≥ 18 years old	Yes	No	Yes in best interest
16 or 17 years old	Yes	Yes if possible but not to delay if life at risk	Yes in best interest
<16 years old	Yes	Yes if possible but not to delay if life at risk	Yes in best interest

Patient is asymptomatic (hence a forensic examination)

Patient Age	Needs patient consent (if has capacity)	Needs parental/guardian
≥18 years old	Yes	No
16 or 17 years old	Yes	Yes
<16 years old	Yes	Yes

If the LDCT is therapeutic in nature i.e. abdominal pain, suspected burst package etc. then a Gillick competent child can consent to a LDCT or treatment without parental consent. It would be good practice to inform the person with parental responsibility and advise the child accordingly.

A juvenile is classified by the police as anyone under the age of 18. Where a person under 18 years, who is judged to have capacity, refuses treatment, such a refusal can be over-ruled either by a person with parental responsibility for the child or by the court. This must be on the basis of the best interests of the person ²⁷.

Where the consent of a parent or guardian is required for these procedures, it is not necessary for the parent or guardian to be at the police station or hospital to give that consent. However, where the consent of the juvenile only (Gillick competent) is required it must be obtained in the presence of an appropriate adult, who may be the parent or guardian or some other suitable person over the age of 18 years ²⁸.

Where a LDCT is not therapeutic i.e. forensic in nature for determining presence of drug packages then consent from a person with parental responsibility is required for anyone under 18 years of age. This is because the findings of the LDCT may be used as evidence in court proceedings.

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels

1. Evidence from at least one systematic review of multiple well-designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well-designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well-designed, non-experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.



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