

## **Academic Emergency Medicine Editor-in-Chief Pick of the Month**

### **Calming Nerves to Reduce Suffering**

"We must learn to suffer more."  
– T.S. Eliot

Some friends and I share the nebulous belief that the first patient you see on a shift sets the tone for the rest of the shift. So, suspend your logical thought for a moment and imagine that make-believe axiom to be true, and that you are guaranteed that your first patient on your next shift is a bounce-back gastroparesis patient. Does that predict a good shift?

For the respect and dignity of patients with gastroparesis, I'll let you answer that one, silently, to yourself.

Part of that visceral reaction (yes, I went there) may be our lack of power over this complex and poorly understood syndrome. Delayed gastric emptying is always blamed, but does not explain everything. Or, in my own experience, anything. Miserable gastroparesis appears to result from a diabolical triangle comprising the autonomic nervous system, the chemoreceptor zone in the brainstem, and the frontal cortex. Neural circuits that conspire to inflict suffering. So, to a simple ER doc, this problem requires a nerve drug: a neuroleptic. One formal definition of a neuroleptic is that which "reduces nervous tension and causes indifference to internal and external stimuli." Perfect. (Sometimes, I think, I could use that effect on shift, or after receiving peer review).

Enter the relatively novel use of Haloperidol (Haldol®) in [this month's AEM](#). Roldan and colleagues [report](#) that compared with gastroparesis patients randomized to placebo, those who received Haldol® had the magnitudes of drop in both pain and nausea scores that matter to patients with suffering. Improvements that were statistically and clinically important, and with no side effects — although in a small sample.

I believe that in his unique objective correlative, that T.S. Elliot meant we must learn to suffer *better*. This paper gives reason to believe that Haldol® may do so for your next patient with gastroparesis.

Best Wishes,  
Jeffrey A. Kline  
Editor-in-Chief, Academic Emergency Medicine

## **Narrative Summary**

**Zachary F. Meisel, MD, Associate Professor of Emergency Medicine at the Perelman School of Medicine at the University of Pennsylvania, places the EIC Pick into perspective in the emergency setting:**

I asked my colleagues to share some stories about treating gastroparesis. They described how patients with this condition are often viewed as "narcotic-seeking." Successful examples of using non-narcotic approaches (hot packs, capsaicin cream, and even haloperidol) were accompanied by the pleasant surprise among the ED staff that patients were sometimes happier with the non-narcotic treatment than was anticipated. One woman with recurrent cyclic vomiting and gastroparesis thanked a colleague for helping her by saying, "I know sometimes doctors and nurses think I am looking for drugs to get high. I'm not."

Is it possible that an effective, and non-addictive treatment for gastroparesis could lead to improved care *and* reduced stigma for this terrible condition?