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methanol poisonings causing blindness in 2 New Mexicans and death in 7. Although methanol outbreaks are historically well established, associations with hand sanitizer consumption have been poorly reported in the peer-reviewed literature. Outbreaks tend to occur when access to alcohol is limited, as observed in the prohibition era and in resource-poor populations turning to alternative alcohol sources.² The Food and Drug Administration issued an advisory on June 19, 2020, to notify the public about the dangers of 9 formulations of hand sanitizers marketed by a manufacturer in Mexico. These products were found to contain up to 81% methanol, which was not listed as an ingredient.³ At article submission, our cases appear to align with hand sanitizer consumption, but not with products specifically identified thus far by the Food and Drug Administration.⁴ As such, noncommercial sources of hand sanitizer and drinking alcohol are also being considered.

Emergency physicians must have a heightened awareness for methanol toxicity in at-risk populations, given the possibility of this outbreak to spread geographically in this time of the online marketplace and heightened product demand. Methanol toxicity has been observed in doses as small as 15 mL and may lead to blindness and death if not promptly treated. Because methanol is less lipophilic than ethanol, toxicity can present without the typical intoxicating features of ethanol. An anion gap metabolic acidosis is commonly observed in large ingestions but, like serum osmolar gap, does not rule out toxic alcohol poisoning.⁵ As soon as the diagnosis is suspected, treatment with fomepizole in tandem with poison center consultation is imperative. Ethanol is second line for treatment when fomepizole is unavailable and has been shown to improve out-of-hospital outcomes, with hemodialysis often necessary for toxin elimination.^{2,5}

We urge the emergency medicine community to remain vigilant regarding this developing threat.

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A Walk-through COVID-19 Screening Station Can Preserve Personal Protective Equipment and Quickly Process Patients



To the Editor:

Our original outdoor screening station in response to the coronavirus 2019 pandemic included only several single rooms and one chest radiography room, which were set up according to experience with the severe acute respiratory syndrome epidemic. Similarly, current preparedness for coronavirus 2019 requires health care workers to wear personal protective equipment (PPE) while in direct contact with patients with suspected or confirmed coronavirus 2019.^{1,2} Such an approach to screening patients consumes a considerable amount of PPE and time for the screening.

PPE is an essential but scarce commodity in the hospital because of the rapid consumption of inventory during the pandemic. To address this problem, we previously described a PPE-conserving chest radiography setting.³ We further developed a walk-through screening station adjacent to our emergency department, with separate passageways for patients and health care workers that safely segregate the latter from patients through physical barriers and allow processing of patients sequentially.

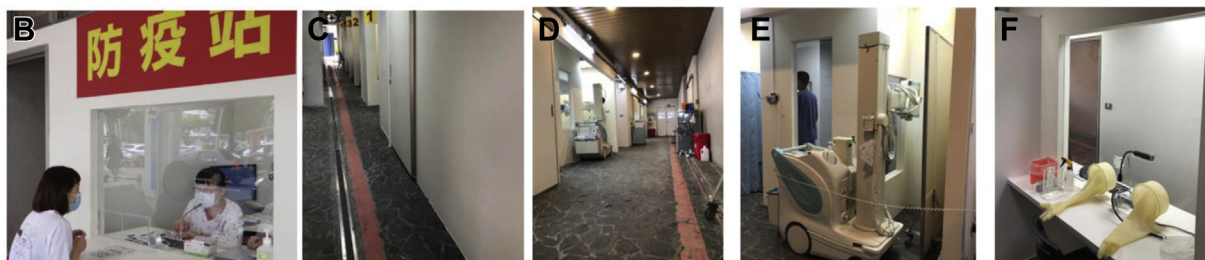
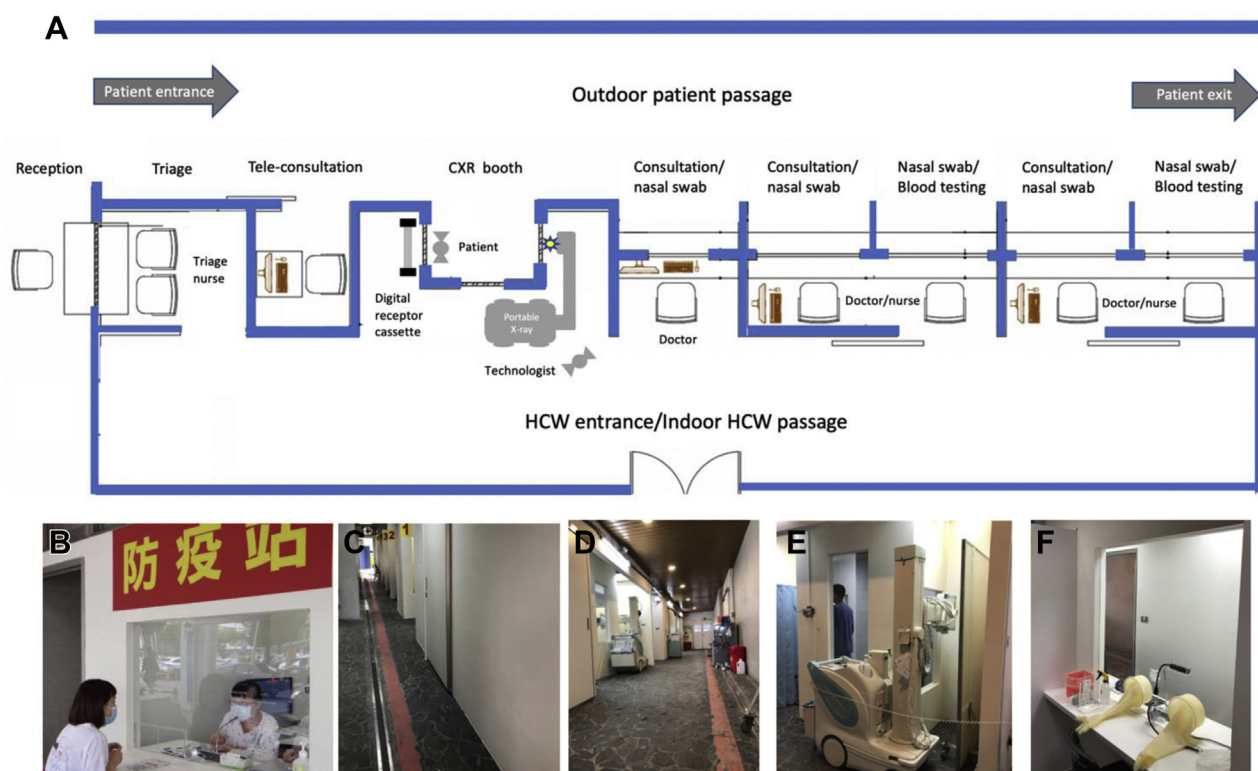


Figure. A, Schematic view of the walk-through coronavirus disease 2019 screening station. B, Reception and triage. C, Patient passage. D, View from the enclosed health care worker space and hallway. E, A personal protective equipment-free radiography booth as viewed from the enclosed technician side. F, Consultation cubicle for collecting nasal swabs and blood sampling as viewed from the patient side.

The screening station integrates a quarantine triage, a patient teleconsulting room, a chest radiography booth, and consultation cubicles for nasal sampling. The patient passageway is an outdoor space, whereas the health care worker area is an enclosed space protected by physical barriers (Figure, A to D). All assessments, including chest radiography, consultation, and nasal swabs, are conducted behind acrylic windows, without the need for PPE. Health care workers can communicate with patients through an audio system. Standing chest radiography is performed in a built-in booth wherein the patient faces a window behind which is a bucky stand with a digital cassette holder (Figure, E). Without wearing PPE, technicians can adjust the position of the digital cassette and the portable radiographic unit from their side.⁵ Nasal swabs and blood samples can be collected through window panels that have fixed glove ports. Specimen tubes and vials can be safely passed to health care workers through a sealed port with collection bag (Figure, F). Personnel on the health care worker side can disinfect surfaces of the patient cubicle with alcohol or sodium hypochlorite before and after each sample collection.

After implementation of the walk-through screening station, the average consumption of N95 respirators

decreased 87% (from 22 to 3 per day) and that of isolation gowns decreased 93% (from 39 to 3 per day). The time required for screening patients (time from registration to discharge) decreased 83% (from 215 to 38 minutes per patient).

The use of a walk-through screening station that segregates health care workers from patients may prevent transmission of severe acute respiratory syndrome coronavirus 2 to health care workers, conserve PPE, and reduce workforce demands. The patient side is an open outdoor space with natural ventilation that reduces the need for negative-pressure or single rooms and rooms closed for ventilation and disinfection after each patient screening. Moreover, patients are screened in sequential order, thus reducing congestion of patients and accelerating the screening process, which can be crucial during high-demand periods of a pandemic.

The walk-through screening station is limited to ambulatory patients. Furthermore, it may come at a price in terms of a loss of fidelity in assessment of patients and the cost of setting up the rooms and radiographic facilities.

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Destigmatizing Naloxone: Associations of Perceived Availability on Opioid Use Patterns



To the Editor:

Naloxone, most commonly known as Narcan, is a potent opioid antagonist that can readily rescue individuals with opioid overdose by displacing the offending opioid agonist from the complementary receptors in the brainstem. As such, it has saved thousands of lives and is increasingly used by first responders and hospital emergency departments to revive individuals with suspected opioid poisoning.¹ However, its uptake as a primary intervention in the opioid crisis is not without criticism. The most serious concern among critics is that opioid users will perceive that naloxone is readily available

Table. Perceptions of naloxone and influences on opioid use patterns.

Question	No. (%)	Response Option
When you were last using opioids, how confident were you that, if you overdosed, a first responder (eg, police officer, EMT, firefighter) would have naloxone (Narcan) to revive you?	30 (10.1) 48 (16.2) 44 (14.9) 66 (22.3) 108 (36.5)	Completely confident Fairly confident Somewhat confident Slightly confident Not confident at all
When you were last using opioids, how confident were you that, if you overdosed, someone you knew would have naloxone (Narcan) to revive you?	21 (7.1) 14 (4.7) 26 (8.8) 35 (11.8) 200 (67.6)	Completely confident Fairly confident Somewhat confident Slightly confident Not confident at all
Were you more or less likely to use opioids when you believed or knew naloxone (Narcan) would be used to revive you if you overdosed?	19 (6.4) 17 (5.7) 222 (75.0) 13 (4.4) 25 (8.4)	A lot more likely Somewhat more likely No more or less likely Somewhat less likely A lot less likely
Did you use opioids more often or in greater quantities when you believed or knew naloxone (Narcan) would be used to revive you if you overdosed?	5 (1.7) 10 (3.4) 261 (88.5)	Yes, I always used more opioids when I believed or knew naloxone would be used to revive me. Yes, I sometimes used more opioids when I believed or knew naloxone would be used to revive me. I did not change my opioid use based on my belief or knowledge that naloxone would be used.
	19 (6.4)	No, I used fewer opioids when I believed or knew naloxone would be used to revive me.

EMT, Emergency medical technician.

to reverse an accidental overdose, and therefore opioid users can and will push the limits of their opioid dosage or frequency of use.^{2,3} This assertion, however, is largely based on anecdotal data, with systematic data lacking, a deficit we aimed to address.