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Adult Triage Criteria

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Adult Triage Criteria
(Adapted from the Canadian ED Triage and Acuity Scale)

**LEVEL I: RESUSCITATION**
Conditions that are life or limb threatening (or with imminent risk of deterioration) needing immediate aggressive intervention.

**Time to doctor: IMMEDIATE**

**Usual presenttations:**
1. Cardiac and/or pulmonary arrest
2. Major trauma
3. Shock states
4. Unresponsive patients
5. Severe respiratory distress
6. Status epilepticus
7. Acute coronary syndrome/ chest pain
8. CVA / stroke
9. DKA / HHS
10. Shock states (Trauma haemorrhagic / septic shock)
   - BP <90/60
   - Temp <36°C or >38°C
   - HR >100bpm or <60bpm
11. Hypertensive Emergencies
   - BP >180/110mmHg with blurred vision / vomiting / CVA / confusion
12. GI bleed
13. Severe asthma / attack
14. Dense blood glucose levels
   (≤3nmol/l or >18mmol/l with confusion / seizures / diaphoresis)
15. Pregnancy related complications
16. Severe head injury (GCS 3-8/15)
17. Drug / substance abuse / intoxication with haemodynamic instability

**TRIAGE I RESUSCITATION**

0 IMMEDIATE

**LEVEL II: EMERGENT**
Conditions that are potential threat to life, function or limb, requiring rapid medical intervention.

**Time to doctor < 15min**

**Usual presenttations:**
1. Altered mental state
2. Head injury (mild / moderate with GCS of 9-15)
3. Neonates
4. Eye pain / injuries
5. Drug and/or substance overdose / intoxication / withdrawal with stable vitals
6. Asthma (moderate)
7. Anaphylaxis
8. Heavy vaginal bleeding / acute pelvic or lower abdominal pain
9. Sepsis / pyrexia
10. Severe vomiting and/or diarrhoea
11. Acute psychosis / extreme agitation
12. Severe abdominal / groin pain / acute abdomen
13. Severe hypertension or hypotension (BP > 180/110 mmHg or < 90/60 mmHg)
14. Abuse / neglect / assault (physical / sexual)
15. Patients on chemotherapy
16. Acute pain - severe (pain score 8-10/10)
17. Seizure disorder

**TRIAGE II EMERGENT**

15 MINUTES

**LEVEL III: URGENT**
Conditions could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.

**Time to doctor < 30min**

**Usual presenttations:**
1. Asthma, mild
2. Acute pain - moderate (pain score 4-7/10)
3. Vomiting or diarrhoea with dehydration
4. Dialysis / transplantation (patients)
5. Other diabetic - associated conditions e.g. neuropathy, nephropathy, retinopathy

**TRIAGE III URGENT**

30 MINUTES

**LEVEL IV: LESS URGENT**
Conditions could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.

**Time to doctor ≤ 1 hour**

**Usual presenttations:**
1. Minor trauma with soft tissue injuries
2. Headache (pain score 0-3/10)
3. Ear ache
4. Bladder pain, chronic
5. URTI symptoms with fever
6. Vomiting and/or diarrhoea with no signs of dehydration
7. Acute pain - mild (pain score 0-3/10)

**TRIAGE IV LESS URGENT**

1 HOUR

**LEVEL V: NOT URGENT**
Problem with or without evidence of deterioration.

**Time to doctor ≤ 2 hours**

**Usual Presentations:**
1. Sore throat / URTI without fever
2. Abdominal pain without vomiting
3. Diarrhoea or vomiting alone

**TRIAGE V NON URGENT**

2 HOURS
1. Adult Cardiac Arrest Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Unresponsive
No Breathing or No Normal breathing
(i.e. only gasping)

Activate Resuscitation Team
Get AED/Defibrillator

CHECK PULSE
DEFINITE pulse palpated within 10 secs?

Definite Pulse
• Open and maintain patent airway
• Give 1 breath every 6 seconds
• Recheck pulse every 2 mins
• Go to 2. Post Cardiac Arrest Care Algorithm

No Pulse

AED/Defibrillator ARRIVES
Attach AED Pads or use Defibrillator Paddles to check the rhythm

Yes, shockable
Rhythm Shockable?

Asystole/PEA

VF/Pulseless VT

Shock
• Biphasic 200J (or as recommended by manufacturer)
• Monophasic 360J

Change Chest Compressors - CPR 2min
• IV/Io access – Take bloods for VBG & RBS
• Attach monitor leads; adjust monitor to lead II

No, nonshockable

Yes, shockable
Rhythm Shockable?

Change Chest Compressors - CPR 2min
• Adrenaline 1mg in 9ml NS IV/Io followed with 20ml NS flush
(Repeat dose after 2 CPR cycles)
• Identify and Treat the reversible causes below

No, nonshockable

Yes, shockable
Rhythm Shockable?

Change Chest Compressors - CPR 2min
• Adrenaline 1mg in 9ml NS IV/Io followed with 20ml NS flush
(Second dose after 2 CPR cycles) – 150mg with 20 ml NS flush
• Identify and Treat the reversible causes
• Consider advanced airway, capnography

Reversible causes
• Hypoglycaemia
• Hypovolaemia
• Hypoxia
• Hydrogen ion (acidosis)
• Hyper-/-hyperlactaemia
• Hypothermia

Tension Pneumothorax
Tamponade, cardiac
Toxins
Thrombosis, pulmonary
Thrombosis, coronary

High-Quality CPR
• Compress the centre of the chest with 2 hands at a rate of at least 100-120/min
• Compress to a depth of at least 5-6 cm
• Allow complete chest recoil after each compression
• Minimize interruptions in chest compressions to < 10 seconds
• Avoid excessive ventilation – Give enough volume just to produce visible chest rise. Give 2 breaths after every 30 compressions or if intubated, give 1 breath every 6 seconds
2. Post-Cardiac Arrest Care Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Return of Spontaneous Circulation (ROSC)

- **Activate Resuscitation Team** (if not already present)
- Monitor, support ABCs. Be prepared to provide CPR and defibrillation
- Check vital signs (BP, PR, RR, SPO2, T°C, RBS)

Optimize Ventilation and Oxygenation

- Avoid excessive ventilation.
  - Start at 10 – 12 breaths/min (1 breath every 6 seconds)
  - Titrate FiO2 to minimum necessary to maintain SPO2 ≥ 94%. DO NOT aim for 100%
  - Titrate to target PETCO2 of 35 – 45 mmHg
- Consider an advanced airway and waveform capnography

Treat Hypotension (SBP < 90mmHg)

- **IV/IO Bolus** (if not contraindicated e.g. pulmonary oedema, renal failure): 1-2 L Ringer’s Lactate/Hartmann’s Solution
- **Vasopressor infusion if NO response to fluid bolus or fluid bolus contraindicated:**
  - Adrenaline IV Infusion: 0.1 – 0.5µg/kg/min (7-35µg/min in 70-kg adult)
  - Norepinephrine IV Infusion: 0.1 – 0.5µg/kg/min (7-35µg/min in 70-kg adult)

**Identify and Treat reversible causes**

- Hypoglycaemia
- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalaemia
- Hypothermia
- Tension Pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

Get a 12-lead ECG immediately. If STEMI or Suspected Cardiac Cause of cardiac arrest – Consult an Interventional Cardiologist

If patient is stable, transfer to Critical Care Unit (ICU/CCU) attached to a defibrillator

For patients who are comatose after cardiac arrest (i.e., lacking meaningful response to verbal commands), temperature should be monitored continuously, and fever should be treated aggressively with a target temperature between 32°C and 36°C maintained constantly for at least 24 hours.
3. Maternal Cardiac Arrest Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**FIRST RESPONDER**
- Activate Resuscitation Team (if not already present) AND OBGYN
- Document time of onset of maternal cardiac arrest
- Place the patient supine and perform a left uterine displacement (LUD) with as below.

**Maternal Interventions**
- Treat as per 1. Adult Cardiac Arrest Algorithm
- Do not delay defibrillation
- Give typical ACLS drugs and doses
- Ventilate with 100% oxygen
- Monitor waveform capnography and CPR quality
- Provide post-cardiac arrest care as appropriate. See 2. Post-Cardiac Arrest Care Algorithm

**Maternal Modifications**
- Start IV access above the diaphragm
- Assess for hypovolaemia and give fluid bolus when required
- Anticipate difficult airway; experienced provider preferred for advanced airway placement
- If patient receiving IV/IO magnesium prearrest, stop magnesium and give IV/IO calcium chloride 10mL in 10% solution, or calcium gluconate 30 mL in 10% solution
- Continue all maternal resuscitative interventions (CPR, positioning, defibrillation, drugs, and fluids) during and after caesarean section

**SUBSEQUENT RESPONDERS**

**Obstetric Interventions for Patient with an Obviously Gravid Uterus**
- Perform manual uterine displacement (LUD) – displace uterus to the patient’s left to relieve aortocaval compression
- Remove both internal and external foetal monitors if present

**Obstetric and neonatal teams should immediately prepare for possible emergency caesarean section**
- If no ROSC by 4 minutes of resuscitative efforts, consider performing immediate emergency caesarean section
- Aim for delivery within 5 minutes of onset of resuscitative efforts

*An obviously gravid uterus is a uterus that is deemed clinically to be sufficiently large to cause aortocaval compression

**Search for and Treat Possible Contributing Factors (BEAU-CHOPS)**
- Bleeding/DIC
- Embolism: coronary/pulmonary/amniotic fluid embolism
- Anaesthetic complications
- Uterine atony
- Cardiac disease (MI/ischaemia/aortic dissection/cardio-myopathy)
- Hypertension/preeclampsia/eclampsia
- Other: differential diagnosis of standard ACLS guidelines
- Placenta abruption/previa
- Sepsis
4. Neonatal Resuscitation Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

The most important and effective action in neonatal resuscitation is ventilation of the baby’s lungs.

Airway
- Put baby’s head in “neutral” position
- Suction mouth, then nose
- Suction trachea if meconium-stained and NOT vigorous

Breathing
- Bag-valve-mask ventilation for apnea, gasping, or pulse < 100 bpm
- Ventilate at rate of 40 to 60 breaths/minute
- Listen for rising heart rate, audible breath sounds
- Look for slight chest movement with each breath
- Use CO₂ detector after intubation
- Attach a pulse oximeter

Circulation
- Start compressions if HR is < 60 after 30 secs of effective ventilation
- Give (3 compressions: 1 breath) every 2 seconds
- Compress one-third of the anterior-posterior diameter of the chest

Drugs
- Give epinephrine if HR is < 60 after 45 to 60 seconds of compressions and ventilation
- Caution: epinephrine dosage is different for ET and IV routes

Corrective Steps
- M Mask adjustment.
- R Reposition airway.
- S Suction mouth and nose.
- O Open mouth.
- P Pressure increase.
- A Airway alternative.

Endotracheal intubation

Endotracheal Intubation

Medications Used During or Following Resuscitation of the Newborn

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage/Route*</th>
<th>Concentration</th>
<th>WT (mg)</th>
<th>Total IV Volume (mL)</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epinephrine</td>
<td>IV (UVC preferred route) 0.1 to 0.3 mL/kg</td>
<td>1:10,000</td>
<td>1</td>
<td>0.1-0.3</td>
<td>Give rapidly, Repeat every 3 to 5 minutes if HR &lt; 60 with chest compressions.</td>
</tr>
<tr>
<td>Volume expanders</td>
<td>10 mL/kg IV</td>
<td>1</td>
<td>10</td>
<td>Indicated for shock. Give over 5 to 10 minutes.</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Endotracheal dose may not result in effective plasma concentration of drug, so vascular access should be established as soon as possible. Drugs given endotracheally require higher dosing than when given IV.
5. Rapid Sequence Intubation/Airway Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Preparation**

- **MALLE MESS**
  - **Mask**
  - Airways (oral and nasal)
  - Laryngoscopes, Laryngeal Mask Airway (LMA)
  - Endotracheal tubes – Adult Males 8F, Females 7.5F; Child >1 year (Age/4) + (4 uncuffed) or (3.5 cuffed)
  - Monitoring (pulse oximetry, ECG, capnography), Magill Forceps
  - Emergency drugs/trolley
  - Self-inflating bag valve resuscitator;
  - Suction, Stylet, Bougie
  - Plentiful oxygen supply

- **Identify Predictors of Difficult Intubation (LEMON)**
  - Look for external markers of difficulty of BVM and intubation
  - Evaluate the 3-3-2 rule
  - Mallampati score ≥ 3
  - Obstruction/Obesity
  - Reduced Neck Mobility

If a difficult airway is predicted, IMMEDIATELY consult a clinician experienced in airway management and intubation before proceeding.

**Pre-oxygenation**

- Attach oxygen via nasal prongs. Turn up to MAXIMUM if patient is unconscious or after sedation. Keep this for the entire intubation process.
- Spontaneously breathing patient continue with spontaneous ventilation or at least 60 seconds of non-rebreather facemask
- Patient not breathing or not breathing adequately – Use a Bag-Valve-Mask (BVM) with a reservoir and O2 at 15L/min to provide 1 breath every 6 seconds (synchronized to the patient’s breaths) until you can achieve and sustain the highest possible SpO2
- Avoid positive pressure ventilation if possible

**Position the patient**

Ensure you have 360° access to the patient
- Belt/Belly Height – Head at or just above belt/belly level
- HoE up – Head of Patient up to Head of Bed
- HoE up – Head of Bed up 30°; Reverse Trendelenburg in High BMI, Late Pregnancy, Spinal Immobilisation
- Face Plane parallel to Ceiling (or just 10° tilt back) & Ear level to Sternal Notch

Assistants ready to help add or maintain external laryngeal manipulation, head elevation, jaw thrust, mouth opening

**Paralysis with Induction**

<table>
<thead>
<tr>
<th>Pharmacologic agents and dosages used for rapid sequence intubation</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ketamine (Ketamin) is preferred for patients with hemodynamic instability or renal insufficiency</td>
<td>2 mg/kg IV</td>
</tr>
<tr>
<td>Midazolam</td>
<td>0.15 to 0.2 mg/kg IV (decrease dose in elderly)</td>
</tr>
<tr>
<td>Propofol</td>
<td>1 to 2.5 mg/kg IV (decrease dose in elderly) (titrate the dose)</td>
</tr>
</tbody>
</table>

**Neuromuscular Blocking (NMB) Agents**

<table>
<thead>
<tr>
<th>Contraindications:</th>
<th>Dose</th>
<th>Onset</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Succinylcholine (depolarizing NMB)</td>
<td>1.5 mg/kg IV (adults)</td>
<td>1/2 to 1 min</td>
<td>6-10 min</td>
</tr>
<tr>
<td>2 mg/kg IV (infants)</td>
<td>3 mg/kg IV (new-borns)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rocuronium (nondepolarizing NMB)</td>
<td>1.2 mg/kg IV (shorter onset with longer duration)</td>
<td>1 min</td>
<td>20 mins</td>
</tr>
</tbody>
</table>

**Pass the tube /Laryngeal Mask Airway (LMA)**

Limit attempt to < 30 seconds. Proceed down the algorithm after 30 seconds

**Proof of Intubation / LMA Insertion**

- 5 Point Auscultation – Epigastrum, Bilateral Axillae, Bilateral Lung Bases
- Waveform Capnography - Maintain CO2 level at 35-45mmHg

**Successful**

- Self-inflating bag valve resuscitator ventilation – 1 breath every 6s
- Secure tube at a depth of 3 x ET Tube size at the teeth/gums
- Check vital signs (BP, PR, RR, SPO2, Temp, RBS)
- Connect patient to the ventilator. See 7. Guideline for Initiation of Mechanical Ventilation Algorithm
- Initiate postintubation analgesia and sedation
  - Morphine 0.1 – 0.4mg/kg/hr
  - Ketamine (anesthetic and sedative) 0.05 – 0.4mg/kg/hr
  - Midazolam 0.02 – 0.1mg/kg/hr
  - Dexmedetomidine 0.2 – 0.7 µg/kg/hr
- Obtain portable CXR to Confirm Depth of ET Tube NOT location

**Not Successful**

Resume BVM ventilation - 1 breath every 3 seconds

See 6. Failed Intubation Algorithm
6. Failed Intubation Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Direct Laryngoscopy and Intubation (D.L.)**

- **Failed**
  - Resume BVM ventilation - 1 breath every 3 seconds
  - **CALL Anaesthetist immediately**

**Able to ventilate with BVM?**

- **No**
  - Resume BVM ventilation - 1 breath every 3 seconds
  - Reposition patient to align the airway (sniffing position)
  - One more D.L. attempt. Limit attempt to < 30 seconds

- **Yes**
  - Resume BVM ventilation - 1 breath every 3 seconds
  - **Insert Laryngeal Mask Airway**

**Proof of Intubation**

5 Point Auscultation
- Epigastrium, Bilateral Axillae, Bilateral Bases
- Waveform Capnography
  - Maintain CO₂ level at 35-45mmHg

**Successful**

- **Direct Laryngoscopy and Intubation (D.L.)**

**Failed**

- **Insert Laryngeal Mask Airway**

**Able to ventilate with BVM?**

- **No**
  - **Surgical Cricothyrotomy**

- **Yes**
  - **Maintain ventilation**
    - Advanced Airway Techniques e.g. video laryngoscopy
    - **Consult an Anaesthetist** for fibre optic intubation

**Proof of Intubation**

5 Point Auscultation
- Epigastrium, Bilateral Axillae, Bilateral Bases
- Waveform Capnography
  - Maintain CO₂ level at 35-45mmHg

- Self-inflating bag valve resuscitator ventilation – 1 breath every 6s
- Secure tube at a **depth of 3 x ET Tube size at the teeth/gums**
- Check vital signs (BP, PR, RR, SPO₂, T°C, RBS)
- Connect patient to the ventilator. See 7. Guideline for Initiation of Mechanical Ventilation Algorithm
- Initiate *postintubation analgesia* and sedation
  - Dexmedetomidine 0.2 – 0.7 µg/kg/hr
  - Morphine 0.1 – 0.4mg/kg/hr
  - Midazolam 0.02 - 0.1mg/kg/hr
  - Ketamine (analgesic and sedative) 0.05 – 0.4mg/kg/hr
- Obtain portable CXR to **Confirm Depth of ET Tube NOT location**
7. Guidelines for Initiation of Mechanical Ventilation Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

*Consider non-invasive ventilation for Pulmonary Oedema, COPD, Pneumonia, ARDS, Preintubation oxygenation

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**Obstructive lung disease e.g. Asthma, COPD**

VT 5-6 ml/kg PBW
*for Pressure Control, titrate PIP to achieve an expired VT of 5-6 ml/kg PBW
*titrate to PaO₂ of 60-80 mmHg (8–10.6kPa)

PEEP 3-4 cmH₂O
Keep PIP + PEEP < 30 cm H₂O

Rate 6-8 bpm
*titrate to allow complete expiration

**Other**

VT 6-8 ml/kg PBW
*for Pressure Control, titrate PIP to achieve an expired VT of 8-10 ml/kg PBW

PEEP 5 cmH₂O
*titrate to PaO₂ of 60-80 mmHg (8–10.6kPa)
Keep PIP + PEEP < 30 cm H₂O

Rate – Start at Patient’s Preintubation RR (< 30bpm)
*titrate to PaCO₂ of 35 - 45 mmHg (4.7 - 6 kPa)

**Restrictive lung disease e.g. ARDS**

VT 6 ml/kg PBW
*for Pressure Control, titrate PIP to achieve an expired VT of 6 ml/kg PBW

PEEP 8-10 cmH₂O
*titrate to PaO₂ of 60-80 mmHg (8–10.6kPa)
Keep PIP + PEEP < 30 cm H₂O

Rate – Start at Patient’s Preintubation RR (< 30bpm)
*titrate to PaCO₂ of 35 - 45 mmHg (4.7 - 6 kPa)

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**Additional Settings**
Pressure support – 8-10 cmH₂O
Inspiratory trigger – 2 cmH₂O below the set PEEP
i times – Adults 1 sec; Toddlers/Children 0.7 sec; Neonates 0.5 sec

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**Abbreviations:**
- SIMV, Synchronised Intermittent Mandatory Ventilation; PRVC, Pressure Regulated Volume Control; VT, Tidal Volume; PBW, Predicted Body Weight; PEEP, Positive End Expiratory Pressure; PIP, Peak Inspiratory Pressure

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**The Crashing Intubated Patient (Peri-Arrest or Arrest):**
**DOPES** then **DOTTS:** The first mnemonic is how to diagnose the problem and the second mnemonic is how to fix the problem:

**Diagnosing the Problem:**
- **D** - Displaced Endotracheal Tube or Cuff
- **O** - Obstructed Endotracheal Tube: Patient biting down, kink in the tube, mucus plug
- **P** - Pneumothorax
- **E** - Equipment Check: Follow the tubing from the ETT back to the ventilator and ensure everything is connected
- **S** - Stacked Breaths: Auto-PEEP. Patient unable to get all the air out from their lungs before initiating the next breath. Inspiratory time is much shorter than expiratory time (I/E ratio is anywhere from 1 to 3 or 1 to 4)

**Fixing the Problem (Once you commit to this, do every step even if you fix the problem with one of the earlier letters):**
- **D** - Disconnect the Patient from the Ventilator: This fixes stacked breaths by decreasing intra-thoracic pressure and improving venous return
- **O** - O₂ 100% Bag Valve Mask: The provider should bag the patient not anyone else because this lets you get a sense of what the potential problem is. Look, Listen, and Feel
  - Look: Watch the chest rise and fall, look at ET and ensure it is the same level it was at when it was put in
  - Listen: Air leaks from cuff rupture or cuff above the cords; Bilateral breath sounds; Prolonged expiratory phase
  - Feel: Feel the pressure of pilot balloon of endotracheal tube, crepitus; How is the patient bagging (Hard to bag or too easy to bag)
- **T** - Tube Position/Function: Suction catheter to ensure tube is patent; Can also use bougie if you don’t have suction catheter, but be gentle (If too aggressive can cause potential harms); Ensure the tube is at the same level it was at when it was put in
- **T** - Tweak the Vent: Decrease respiratory rate, decrease tidal volume, decrease inspiratory time. Biggest bang for your buck is decreasing the respiratory rate. This may cause respiratory acidosis (permissive hypercapnia)
- **S** - Sonography: You can diagnose things much faster than waiting for respiratory therapist to come to the bedside or waiting for stat portable chest x-ray to be done.
8. Anaphylaxis Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard.

A patient meets the definition of anaphylaxis when **ANY 1** of the following 3 criteria are fulfilled:

1. **Acute onset** of mucocutaneous signs AND **1** of the following:
   - respiratory compromise (wheezing-bronchospasm, dyspnoea, stridor, hypoxemia),
   - hypotension (syncope), or
   - hypotonia.

2. **Rapid onset** of **2** of the following after exposure to likely allergen:
   - mucocutaneous signs,
   - respiratory compromise,
   - hypotension, or
   - persistent gastrointestinal symptoms.

3. **Hypotension** after exposure to a known allergen.

Patients with **simple allergic reactions** who **DO NOT** meet the criteria for anaphylaxis may be managed similarly **WITHOUT** the use of adrenaline.

---

### Features of Anaphylaxis

**CAREFULLY REMOVE ALLERGEN IF STILL PRESENT** e.g. Bee sting

- Adrenaline (1mg/ml 1:1000) IM anterolateral thigh
  - Adults & Child >12 years: 0.5ml IM
  - Child 6-12 years: 0.3ml IM
  - Child < 6 years: 0.15ml IM
  - Repeat every 5-15 minutes if no improvement

- **Monitor, support ABCs in Resuscitation room.** Be prepared for intubation/cricothyrotomy if necessary
- Check vital signs (BP, PR, RR, SPO2, T°C, RBS)
- Start Oxygen IF SPO2 < 94% or if patient is dyspnoeic. Maintain SPO2 ≥ 94%
- If severe bronchospasms, **start nebulization.** See Establish large bore IV Access
- Perform brief, targeted history, physical exam.

### Antihistamines

- **H1 Receptor Blockers**
  - e.g. Chlorpheniramine 10-20mg IM/IV
- **H2 Receptor Blockers**
  - e.g. Ranitidine 50mg IM/Slow IV

### IV Fluids

- (e.g. Ringer’s Lactate/Hartmann’s Solution)
- Rapid infusion of 20ml/kg if no response to Adrenaline
- Repeat IV infusions as necessary as large amounts may be required
- Adrenaline infusion 0.1-0.5µg/kg/min **ONLY** if unresponsive to IM Adrenaline and fluids

### Steroids

- **Hydrocortisone**
  - 200mg IM/Slow IV

---

Patients with suspected anaphylaxis should be observed for **at least 6 hours**. Patients who are **NOT HIGH-RISK** should be discharged in the care of others. Before discharge from the hospital, all patients with anaphylactic reactions **must be**;

- Given clear indications for immediate return to the emergency department (ED).
- Considered for treatment with **antihistamines** and **oral steroids** for **3 days** to decrease the chance of further reaction.
9. Acute Asthma Exacerbation Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Acute Asthmatic Attack**

- Monitor, support ABCs
- Start Oxygen if SPO₂ < 92%. Maintain SPO₂ ≥ 92%; Oxygen should be provided to all patients with severe asthma, even those with normal oxygenation.
- Perform brief, targeted history, physical exam (auscultation, use of accessory muscles, PR, RR)
- Initiate treatment of underlying cause of exacerbation
- Check Peak Expiratory Flow (PEF) as per PEF Chart below and record predicted or best PEF (%) in patient’s clinical notes. DO NOT measure PEF in patients with impending/actual respiratory arrest, drowsiness, confusion or silent chest. Start treatment immediately.

**DROWSINESS, CONFUSION, OR SILENT CHEST?**

- Give high-dose IV Magnesium, 2gm in 5% Dextrose over 20-min
- Consider intubation (RSI with Ketamine if no C/I) and ventilation with 100% oxygen; anticipate cardiovascular collapse post-intubation
- Get CXR
- Nebulise* with Salbutamol + Ipratropium bromide (doses below) every 20 mins or 3 doses for 1 hour. A combination of 4 mL volume fill with NS and 6 to 8L/min oxygen flow rate is recommended.
- Give IV Hydrocortisone 2mg/kg (maximum 200mg) immediately
- Admit to HDU/ICU

**MILD or MODERATE**

PEF > 50% predicted or best
- Talks in phrases, prefers sitting to lying, not agitated
- O₂ saturation (on air) 90-95%
- Pulse Rate 100-120 bpm
- Nebulise* with Salbutamol + Ipratropium bromide (doses below) every 20 mins or 3 doses for 1 hour. A combination of 4 mL volume fill with NS and 6 to 8L/min oxygen flow rate is recommended.
- Give Oral (if patient can swallow) or IV systemic corticosteroids (dose below) immediately

**SEVERE**

PEF ≤ 50% predicted or best
- Talks in words, sits hunched forwards, agitated
- O₂ saturation (on air) < 90%
- Pulse Rate > 120 bpm
- Nebulise* with Salbutamol + Ipratropium bromide (doses below) every 20 mins or 3 doses for 1 hour. A combination of 4 mL volume fill with NS and 6 to 8L/min oxygen flow rate is recommended.
- Give IV Hydrocortisone 2mg/kg (maximum 200mg) immediately

**Reassess Hourly (or after every 3 doses)**

Symptoms, physical exam + BP, PR, RR, SpO₂, PEF

**Discharge Home**

- Continue treatment with inhaled SABA – 2 puffs QID for 3-5 days
- Give oral systemic corticosteroids: Dexamethasone 0.6mg/kg or 12mg for adults as a single dose or Prednisone (see dose in table below)
- Review medication including inhaler technique
- Consider therapy for underlying cause of exacerbation
- Refer to Chest Physician for follow-up
How to Measure Peak Expiratory Flows (PEF)

DO NOT measure PEF in patients with impending/actual respiratory arrest, drowsiness, confusion or silent chest. Start treatment immediately.

1. Put the pointer on the gauge of the peak flow meter to 0 or the lowest number on the meter.
2. Attach the mouthpiece to the peak flow meter.
3. While standing, take a deep breath.
4. Put the peak flow meter mouthpiece in your mouth and close your lips tightly around the outside of the mouthpiece. Don’t put your tongue inside the mouthpiece.
5. Breathe out as hard and as fast as you can for 1 or 2 seconds. A hard and fast breath usually produces a “huff” sound.
6. Check the number on the gauge and write it down.
7. Repeat the above 3 times and take the patient’s best PEF.
8. Plot the best PEF on the normal values chart and calculate the percentage as below:

\[
\text{Measured PEF} \times 100\% = \frac{\text{Measured PEF}}{\text{Normal PEF}} 
\]

*available in MDCalc

9. Record the PEF in the patient’s clinical notes.
10. Epistaxis Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Wear PPE**

ASK THE PATIENT TO BLOW THEIR NOSE TO REMOVE ANY CLOTS & SPRAY THE NARES WITH OXYMETAZOLINE SPRAY

Have the patient squeeze the distal alae while sitting up, bent forward at the waist over a vomit bucket, and expectorating blood for 15mins. USE A WATCH!! Ask the patient NOT to swallow any blood. A clamping device constructed of four tongue blades secured together by 1-inch tape over the distal alae can be used to clamp the nose closed.

- Monitor, support ABCs
- Check vital signs (BP, PR, RR, SPO2, T° C)
- Perform brief, targeted history, physical exam
  - Nasal trauma from nose picking/blowing is the most common cause of epistaxis.
  - Hypertension DOES NOT cause epistaxis but may prolong it. Therapy should focus on control of the hemorrhage rather than reduction of the blood pressure. DO NOT PRESCRIBE ANTI-HYPERTENSIVE THERAPY FOR EPISTAXIS.
- DO NOT order lab investigations routinely.
- For patients with severe or recurrent haemorrhage with a lot of clots, throwing up blood, or with unstable vital signs or underlying medical conditions, a FBC should be performed, as well as a type and screen.

### Epistaxis Algorithm

**Yes**

- Repeat vital signs (BP, PR, RR, SPO2, T° C)
- Remove any cotton pledgets and observe the patient for bleeding for at least an hour after control. Encourage the patient to walk or perform other activities that he or she will need to resume when returning home.
- Patients with underlying medication use (aspirin, NSAIDS, or renal or hepatic dysfunction, order FBC, UEC & LFTs and coagulation studies - consult an ENT Surgeon/Physician
  - If cause identified to be from nasal picking/blowing with no underlying medication use (aspirin, NSAIDS, warfarin) or nasal or hepatic dysfunction, discharge patient (with ENT follow-up if recurrent).
  - Follow-up instructions - Vaseline or a similar moisturizing agent should be applied liberally in the nose to provide a counterforce to promote tamponade

**Bleeding Controlled**

**No**

- Insert a 15-cm piece of cotton pledget soaked in Adrenaline 1 mg + 5 mL Lignocaine 1% in the bleeding nostril for 10 mins. USE A WATCH!!
  - The tampon should be coated with bacitracin ointment or KY-Jelly to facilitate placement.

**Yes**

- Pack the bleeding nostril with a nasal tampon or a bacitracin ointment-soaked gauze (watch video http://bit.ly/2aTpWfa)
  - Repeat vital signs (BP, PR, RR, SPO2, T° C)
  - Monitor, support ABCs
  - Establish IV access and order FBC, UEC & LFTs, coagulation studies and a type and screen if warranted
  - If cause identified to be from nasal picking/blowing with no underlying medication use (aspirin, NSAIDS, warfarin) or nasal or hepatic dysfunction, consult an ENT Surgeon.
  - Patients with underlying medication use (aspirin, NSAIDS, warfarin) or nasal or hepatic dysfunction - consult a Physician & an ENT Surgeon

**Bleeding Controlled**

**No**

- Pack the contralateral naris with a nasal tampon or a bacitracin ointment-soaked gauze to provide a counterforce to promote tamponade

**Yes**

- Do NOT remove the contralateral nasal pack.
  - Insert a lubricated foley catheter (size 12 or 14 F) until the tip and balloon is entirely in the nasopharynx. Fill the balloon with sterile water (usually 5-10cc) to allow it to be pulled snugly against the posterior nasal choana with anterior traction. The Foley is secured by placing an umbilical or c-clamp on the catheter at the level of the nasal ala with padding in between to prevent pressure injury.

**Bleeding Controlled**

**No**

- While the foley is still in-situ, pack the nostril of the bleeding side using a nasal tampon or a bacitracin ointment-soaked gauze
  - The tampon should be coated with bacitracin ointment or KY-Jelly to facilitate placement.
11. Chest Pain (Acute Coronary Syndrome) Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Chest Discomfort Suggestive of Ischemia (includes anginal equivalents (atypical symptoms) like exertional pain in the ear, jaw, neck, shoulder, arm, back, or epigastric area; exertional dyspnoea; nausea and vomiting; diaphoresis; and fatigue.

- Monitor, support ABCs in the Resuscitation Room (ER). Be prepared to provide CPR, Defibrillation and ?Thrombolysis/Fibrinolysis
- Obtain/review 12-lead ECG within 10 minutes of arrival to ED
  - Do a V4R if ST elevation in lead V1 with simultaneous ST depression in V2 -? Right sided STEMI
  - Do V7 - V9 if ST depressions ≥ 1 mm with upright T-waves in ≥ 2 contiguous anterior precordial leads (V1 to V3) -? Posterior STEMI
  - If there is ST elevation in aVR ≥ 1 mm and aVR ≥ V1 with widespread horizontal ST depression, most prominent in leads I, II and V4-6 – consult an Interventional Cardiologist immediately for PCI (Left main coronary artery occlusion/Proximal LAD lesion/Severe sub endocardial ischaemia, nonlocalized)
  - Sinus Tachycardia, T wave inversion in III & V1, V3 or (S1, Q3, T3) pattern -? See 15. Pulmonary Embolism Algorithm
- Check vital signs (BP, PR, RR, SPO2, T°C, RBS)
- Start Oxygen IF SPO2 < 90% or if patient is dyspnoeic. Maintain SPO2 ≥ 90%
- Perform brief, targeted history, physical exam – Indicate time of symptoms onset

- Consider other life-threatening causes of chest pain (pulmonary embolus, cardiac tamponade, aortic dissection, tension pneumothorax, oesophageal rupture)
- Review initial 12-lead ECG

Sequence of ECG changes seen during evolution of myocardial infarction - In the early stages of acute myocardial infarction the electrocardiogram may be normal or near normal; < ½ of patients with acute myocardial infarction have clear diagnostic changes on their first trace. About 10% of patients with a proved acute myocardial infarction (on the basis of clinical history and enzymatic markers) fail to develop ST segment elevation or depression. In most cases, however, serial electrocardiograms show evolving changes that tend to follow well recognised patterns.

<table>
<thead>
<tr>
<th>ST Elevation</th>
<th>MI Description</th>
<th>Coronaries affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2 – V5</td>
<td>Anterior</td>
<td>LAD</td>
</tr>
<tr>
<td>V1 – V2</td>
<td>Septal</td>
<td>Septal LAD</td>
</tr>
<tr>
<td>II, III, aVF</td>
<td>Inferior</td>
<td>RCx (20%) or RCA (80%)</td>
</tr>
<tr>
<td>V1 – V4</td>
<td>Anterolateral</td>
<td></td>
</tr>
<tr>
<td>V3 – V6, I, aVL</td>
<td>Anteroseptal</td>
<td></td>
</tr>
<tr>
<td>I, aVL, V5, V6</td>
<td>Lateral</td>
<td>LCx</td>
</tr>
<tr>
<td>V7, V8, V9</td>
<td>Posterior</td>
<td>RCx</td>
</tr>
<tr>
<td>V1, V4R</td>
<td>RV</td>
<td>RCA</td>
</tr>
</tbody>
</table>

* LAD, Left Anterior Descending; RCx, Right Circumflex; RCA, Right Coronary Artery; LCx, Left Circumflex; V4R, Right sided V4.

Sgarbossa’s Criteria for patients with Left Bundle Branch Blocks (LBBB) available in MDCalc

ST elevation
ST-Elevation MI (STEMI)

ST depression > 0.5mm or dynamic T-wave inversion ≥ 2mm; strongly suspicious for ischemia
High-Risk Unstable Angina/Non-ST-Elevation MI (UA/NSTEMI)

See 12. STEMI Algorithm

Normal or Non-diagnostic changes in ST segment or T wave
Intermediate/Low Risk UA

See 13. NSTEMI/UA Algorithm

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12. STEMI Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

ST-Elevation MI (STEMI)

- Attach the patient to a DEFIBRILLATOR
- Establish IV access in left forearm or antecubital vein and send blood samples for UEC, & hSTroponin T
- Aspirin 300mg to chew (if not given by EMS, not allergic, no active upper GI bleeding or retinal bleeding, not a haemophiliac)
- Nitroglycerin sublingual spray 0.4mg SL for pain relief every 5mins up to relief of discomfort or MAX 3 doses reached. DO NOT give nitroglycerin if:
  - SBP < 90mmHg (or 30 mm Hg below the patient’s known baseline).
  - Heart rate > 100 bpm, or < 50 bpm.
  - Right ventricular infarction (right ventricular infarction causes a preload dependent state).
  - Use of sildenafil or vardenafil within the previous 24 hours or tadalafil within the previous 48 hours.
- Fentanyl 50µg IV if pain is NOT relieved by the 3 doses of SL nitroglycerin. Repeat once if still in pain after 5 mins. For persistent pain, consult a Cardiologist/Physician. Consider IV Nitroglycerin (see C/I above).

Time from onset of symptoms?

Consult Interventional Cardiologist

> 12 hours

Consult an Interventional Cardiologist to determine if the patient is for Thrombolysis/Fibrinolysis OR Primary PCI

≤ 12 hours

Primary PCI

- Obtain informed consent
- Give:
  1. Clopidogrel (600mg) OR Prasugrel (60mg) OR Ticagrelor (180mg)
  2. Enoxaparin 0.5mg/kg IV bolus
- Transfer to Cath lab CONNECTED TO A DEFIBRILLATOR within 30 minutes of arrival to the ER

Thrombolysis/Fibrinolysis

Give:

1. Clopidogrel 300mg (75 mg if age > 75 years)
2. Enoxaparin:
   - If age < 75 y: 30-mg IV bolus, followed in 15 min by 1 mg/kg SC (max. 100 mg for the first 2 doses)
   - If age ≥ 75 y: no bolus, 0.75 mg/kg SC (max. 75 mg for the first 2 doses)
   - Regardless of age, if C/O < 30 ml/min: 1 mg/kg SC

No contraindications for Thrombolysis/Fibrinolysis

- Obtain informed consent for fibrinolysis/thrombolysis
- Ensure patient is connected to a defibrillator (ECG, SPO2, BP) and repeat baseline vitals. Administer fibrinolysis/thrombolysis within 10 mins of STEMI diagnosis

Fibrinolytic Agent | Dose | Fibrin Specificity* | Antigenic | Patency Rate (90 min TIMI 2 or 3 Flow)
--- | --- | --- | --- | ---
Tenecteplase (TNK-TPA)

*Half dose in patients ≥75 yrs)

To reconstitute, mix the 50-mg vial in 10 mL sterile water (5 mg/mL). Give IV bolus based on weight as below:

- < 60 kg - 30 mg (6 mL)
- 60 to 69 kg - 35 mg (7 mL)
- 70 to 79 kg - 40 mg (8 mL)
- 80 to 89 kg - 45 mg (9 mL)
- ≥ 90 kg - 50 mg (10 mL)

+ + + + No 85%

Retereplase (rPA)

10 U - 10 U IV boluses given 30 min apart

+ + No 84%

Alteplase (tPA)

Bolus 15 mg IV then give infusion of 0.75 mg/kg for 30 min (maximum 50 mg), then 0.5 mg/kg (maximum 35 mg) over the next 60 min; total dose not to exceed 100 mg.

+ + No 73% to 84%

Non-fibrin-specific:

Streptokinase

Set up second IV line for the Streptokinase. The adult dose of streptokinase for STEMI is 1.5 Million U in 50 mL of 5% dextrose in water (D5W) given IV over 30-60 minutes. Allergic reactions force the termination of many infusions before a therapeutic dose can be administered. Run Ringer’s Lactate/Hartmann’s Solution TEVO in other line

No Yes§ 60% to 68%

*Strength of fibrin specificity; “*” + “+” is more strong, “+” + “+” is less strong.
§Streptokinase is highly antigenic and absolutely contraindicated within 6 mo of previous exposure because of the potential for serious allergic reaction.
IV indicates intravenous; rPA, retereplase plasminogen activator; TIMI, Thrombolysis In Myocardial Infarction; TNK-TPA, tenecteplase tissue-type plasminogen activator; and tPA, tissue-type plasminogen activator.

- Monitor vital signs (BP, P, RR, SPO2) every 15 minutes during the infusions
- Continue monitoring patient for 30mins after the end of the infusions
- Transfer patient to CCU/ICU CONNECTED TO A DEFIBRILLATOR
13. NSTEMI/Unstable Angina Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

- ST depression > 0.5mm or dynamic T-wave inversion ≥ 2mm; strongly suspicious for ischemia
  - High-Risk Unstable Angina/Non-ST-Elevation MI (UA/NSTEMI)
- Normal or Non-diagnostic changes in ST segment or T wave
  - Intermediate/Low Risk UA

- Establish IV access and send blood samples for UEC, & hsTroponin T (obtain hsTroponin T at least 4 hours after symptom onset, not before)
- Aspirin 300mg to chew (if not given by EMS, not allergic, no active upper GI bleeding or retinal bleeding, not a haemophiliac)
- Nitroglycerin sublingual spray 0.4mg SL for pain relief every 5mins up to relief of discomfort or MAX 3 doses reached. **DO NOT** give nitroglycerin if:
  - SBP < 90mmHg (or 30 mm Hg below the patient’s known baseline),
  - Heart rate > 100 bpm, or < 50 bpm,
  - Right ventricular infarction (right ventricular infarction causes a preload dependent state)
  - Use of sildenafil or vardenafil within the previous 24 hours or tadalafil within the previous 48 hours.
- Fentanyl 50µg IV if pain is NOT relieved by the 3 doses of SL nitroglycerin. Repeat once if still in pain after 5 mins. For persistent pain, consult a Cardiologist/Physician. Consider IVI nitroglycerin (see C/I above)
- Consider CXR

### The HEART Score for Chest Pain Patients in the ED

<table>
<thead>
<tr>
<th>History</th>
<th>2 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Highly Suspicious</td>
<td>1 point</td>
</tr>
<tr>
<td>• Moderately Suspicious</td>
<td>1 point</td>
</tr>
<tr>
<td>• Slightly Non-Suspicious</td>
<td>0 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ECG</th>
<th>2 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Significant ST-Depression</td>
<td>1 point</td>
</tr>
<tr>
<td>• Non-specific Repolarization</td>
<td>0 points</td>
</tr>
<tr>
<td>• Normal</td>
<td>0 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>2 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ≥ 65 years</td>
<td>1 point</td>
</tr>
<tr>
<td>• &gt; 45 - &lt; 65 years</td>
<td>0 points</td>
</tr>
<tr>
<td>• ≤ 45 years</td>
<td>0 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>2 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ≥ 3 Risk Factors or History of CAD</td>
<td>1 point</td>
</tr>
<tr>
<td>• 1 or 2 Risk Factors</td>
<td>0 points</td>
</tr>
<tr>
<td>• No Risk Factors</td>
<td>0 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Troponin</th>
<th>2 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ≥ 3 x Normal Limit</td>
<td>1 point</td>
</tr>
<tr>
<td>• 1 - &lt; 3 x Normal Limit</td>
<td>0 points</td>
</tr>
<tr>
<td>• ≤ Normal Limit</td>
<td>0 points</td>
</tr>
</tbody>
</table>

| Risk Factors: DM, current or recent (<one month) smoker, HTN, HLP, family history of CAD, & obesity | 2 points |
| Score 0 - 1: 2.5% MACE over next 6 weeks → Discharge Home | 1 point |
| Score 2 - 4: 19.3% MACE over next 6 weeks → Admit for Clinical Observation | 0 points |
| Score 5 - 10: 72.7% MACE over next 6 weeks → Early Invasive Strategies | 0 points |

Repeat 12 lead ECG in 30 mins/Continuous ST-segment monitoring

- hsTroponin T > 14ng/L OR HEART score ≥ 3 points OR ST depression OR Dynamic ECG changes
  - Yes
    - Consult a Cardiologist/Physician
  - No
    - hsTroponin T ≥ 14ng/L

If hsTroponin T done < 4 hours from symptom onset, then repeat the hsTroponin T at least 4 hours after symptom onset.

If no evidence of ischaemia or infarction by testing, can discharge ± cardiology follow-up

**Criteria for Discharge (must meet ALL the criteria)**

- Two ECGs which are Normal and No ST Depression and No Dynamic changes
- hsTroponin T < 14ng/L at ≥ 4 hours from onset of symptoms
- OR 3 hours from admission to ER

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14. Adult Bradycardia (< 50/min)/Tachycardia (> 150/min) (with Pulse)

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Adult Bradycardia (< 50/min)/Tachycardia (> 150/min) (with Pulse)**

**Airway**
- Open and maintain patent airway; protect as necessary

**Breathing**
- Administer Oxygen (if SPO2 < 94%); Assist breathing as necessary

**Circulation**
- Cardiac monitor to identify rhythm; monitor blood pressure, pulse oximetry, T°C, RBS
- Establish IV access and take bloods for UEC, VBG
- Print rhythm strip or 12-lead ECG if available; don't delay therapy

**Identify and Treat underlying cause**
- Hypoglycaemia
- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo/hyperkalaemia
- Hypothermia
- Tension Pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

Any signs of instability
- Hypotension?
- Acutely altered mental status?
- Signs of Shock?
- Ischaemic chest discomfort?
- Acute heart failure?

**Bradyarrhythmia (HR < 50/min) with signs of instability**
- Consult a Cardiologist and continue with the algorithm

**Tachycardia (> 150/min)**
- With signs of instability
- Stable

**Synchronised Cardioversion**
- Consider procedural sedation
- Start with 100J initially escalating by 50J for subsequent shocks until cardioversion. Consult a Cardiologist

**Adenosine**
- (NOT if varying R-R intervals/Atrial fibrillation)
- 6 mg in 20mls NS single syringe rapid IV push; then 12 mg IV after 1-2 mins if required
- Consult a Cardiologist

**Amiodarone**
- 150mg IV over 10 mins then 1mg/min infusion for first 6 hours

**Narrow Complex Tachycardia (QRS complexes < 0.12sec)**
- IV β blockers (esmolol, metoprolol)
- IV CCBs (verapamil, diltiazem)

**Wide Complex Tachycardia (QRS complexes ≥ 0.12sec)**
- Defibrillation (asynchronous)
- Magnesium 2gm IV over 10 mins
- Overdrive pacing

**IF atropine ineffective:**
1. Transcutaneous Pacing (See Transcutaneous Pacing Procedure)
2. Adrenaline IV infusion 2-10 µg/min
3. Dopamine IV infusion 2 -10µg/kg/min
- Consult a Cardiologist
- Alternative: Glucagon if β-blocker or CCB overdose

**If atropine ineffective:**
- Consult a Cardiologist

**Vagal Stimulation**
- (try at least 2 different manoeuvres twice)
- Modified Valsalva manoeuvre
- Carotid sinus massage (C/I if bruits, CVS disease, elderly)

**IV Atropine**
- Exclude: head injury, hypoxia, hypothermia, heart block, hyperkalaemia, heart transplant
- First Dose: 0.5mg bolus
- Repeat every 3-5 minutes
- Maximum: 3 mg
Transcutaneous Pacing Procedure

1. **See 14. Adult Bradycardia (< 50/min)/Tachycardia (> 150/min) (with Pulse)** for indications. *Inotropes* may be used if transcutaneous pacing is **NOT** available. **See 14. Adult Bradycardia (< 50/min)/Tachycardia (> 150/min) (with Pulse)**

2. Place the pacing pads on the chest of the patient as per package instructions

3. Connect the pads cable to the pacing machine if not already connected

4. **Turn the pacer ON.** Observe for markers (●) indicating the R-wave on the screen. Some machines require that you **START pacing** after turning the pacer on. Observe for **pacing spikes (│)** on the baseline.

5. Set the **Rate** to approximately 60-70 bpm.

6. Set **current milliamperes (mA)** output as follows: Increase milliamperes (mA) from minimum setting until **every pacer spike is immediately followed by a wide QRS and a broad T wave** – This is termed as **Electrical Capture**.

7. Confirm by checking the patient’s **femoral pulse** to see if the pulse rate matches the rate set above i.e. 60-70bpm. This is termed as **Mechanical Capture**.

8. Recheck the patient’s vital signs and confirm the patient’s signs of shock are resolving i.e. increase in blood pressure, improved mentation, etc. This is termed as **Physiological Capture**.

9. If all the above is achieved, increase the current milliamperes by **10%** for safety margin

10. Provide adequate sedation and analgesia if the patient experiences any discomfort

11. Transfer care to a **Cardiologist** without delay. **DO NOT STOP PACING** unless instructed to by a **Cardiologist**.

**Trouble Shooting**

- **Pacing Spikes not seen on the base line** – Confirm that you have pressed the **START** button

- **No Electrical Capture** – Confirm that the pads are firmly pressed on the patient’s chest. Continue increasing the milliamperes. There is no set minimum or maximum.

- **No Mechanical Capture** – Increase the milliamperes by increments of 5-10mA and recheck the pulse

- **No Physiological Capture** – Consider hypovolaemia as the cause of shock and give a small fluid bolus (250-500mls) and recheck the patient. If not, increase the set rate to 80bpm, confirm electrical capture and mechanical capture and recheck the patient

- **In all cases, consult a Cardiologist.**
15. Pulmonary Embolism Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Clinical features suggestive of Pulmonary Embolism**

- Monitor/support ABCs in Resuscitation room (ER). Be prepared to provide CPR, Defibrillation and Thrombolysis
- Obtain/review 12-lead ECG – Consider ACS – See 12. STEMI Algorithm
- Features of PE on ECG: Sinus Tachycardia, T wave inversion in III & V1, V3 or S1, Q3, T3 pattern. A normal ECG can be seen in 30% of patients
- Check vital signs (BP, PR, RR, SPO2, T°C, RBS)
- Start Oxygen if SPO2 < 94% or if patient is dyspnoeic. Maintain SPO2 ≥ 94%
- Perform brief, targeted history, physical exam
- IF YEARS Criteria present or PERC Positive establish IV access and send blood samples for FBC, UEC, VBG, Coagulation screen, D-Dimers, hsTroponin T (See 13. NSTEMI/UA Algorithm for interpretation)

**Clinical Gestalt** or Validated clinical decision support tool (Wells score for PE available in MDCalc)

**YEARS Criteria**

1. Clinical signs of DVT
2. Haemoptysis
3. Pulmonary embolism as the most likely diagnosis

**Pulmonary Embolism Rule-Out Criteria (PERC)**

(available in MDCalc)

1. Is the patient > 49 years of age?
2. Is the pulse rate > 99 beats per minute?
3. Is the pulse oximetry reading < 95% while the patient breathes room air?
4. Is there a present history of haemoptysis?
5. Is the patient receiving exogenous oestrogen?
6. Has the patient had recent surgery or trauma (e.g., compression ultrasound of lower extremities) in the previous 4 weeks?
7. Is the RBS < 1.5 x normal or > 20x normal RBS in last 6 months?
8. Has the patient had recent surgery or trauma requiring endotracheal intubation or hospitalization in the previous 4 weeks?
9. Does the patient have unilateral leg swelling (visual observation of asymmetry of the calves)?

Any of the above criteria present?

**Cardiac Arrest or Hypotension**

SBP < 90mmHg or vasopressors required to maintain SBP ≥ 90mmHg despite fluid resuscitation or SBP drop ≥40mmHg lasting >15mins and not caused by new-onset arrhythmia, hypovolaemia or sepsis

Bedside Echocardiogram

Presence of RV/LV diameter >1.0, RV dysfunction, IVS flattening, septal shift, or right heart thrombus?

**Indications for Thrombolysis in PE (rule out contraindication to Thrombolysis)**

- Cardiac Arrest
- SBP < 90mmHg or vasopressors required to maintain SBP ≥90mmHg despite fluid resuscitation or SBP drop ≥40mmHg lasting >15mins and not caused by new-onset arrhythmia, hypovolaemia or sepsis

Streptokinase

250 000 IU over 30 minutes then 100 000 IU/h over 12–24 hours

Accelerated regimen: 1.5 million IU over 2 hours

Alteplase

100 mg over 2 hours; or

Cardiac Arrest: 50mg IV bolus

**Compression ultrasound of lower extremities** can be performed as the initial diagnostic imaging modality in any of the following situations;

- patients with obvious signs of deep vein thrombosis (DVT) for whom venous ultrasound is readily available
- patients with relative contraindications for CT scan (e.g., borderline renal insufficiency, CT contrast agent allergy)
- in pregnant patients
- patients with a moderate to high clinical risk of PE with a negative or inconclusive CTPA or an inconclusive V/Q scan.

A positive finding in a patient with symptoms consistent with PE can be considered evidence for diagnosis of VTE disease and potentially eliminate the need to expose the patient to the radiation from either a CTPA or V/Q scan.

**Notes**

- Failure to comply with this pathway does not represent a breach of the standard of care.
- This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs.
- A positive finding in a patient with symptoms consistent with PE can be considered evidence for diagnosis of VTE disease and potentially eliminate the need to expose the patient to the radiation from either a CTPA or V/Q scan.

---

**Clinical Gestalt** or Validated clinical decision support tool (Wells score for PE available in MDCalc)

**YEARS Criteria**

1. Clinical signs of DVT
2. Haemoptysis
3. Pulmonary embolism as the most likely diagnosis

**Pulmonary Embolism Rule-Out Criteria (PERC)**

(available in MDCalc)

1. Is the patient > 49 years of age?
2. Is the pulse rate > 99 beats per minute?
3. Is the pulse oximetry reading < 95% while the patient breathes room air?
4. Is there a present history of haemoptysis?
5. Is the patient receiving exogenous oestrogen?
6. Has the patient had recent surgery or trauma (e.g., compression ultrasound of lower extremities) in the previous 4 weeks?
7. Is the RBS < 1.5 x normal or > 20x normal RBS in last 6 months?
8. Has the patient had recent surgery or trauma requiring endotracheal intubation or hospitalization in the previous 4 weeks?
9. Does the patient have unilateral leg swelling (visual observation of asymmetry of the calves)?

Any of the above criteria present?

**Cardiac Arrest or Hypotension**

SBP < 90mmHg or vasopressors required to maintain SBP ≥ 90mmHg despite fluid resuscitation or SBP drop ≥40mmHg lasting >15mins and not caused by new-onset arrhythmia, hypovolaemia or sepsis

Bedside Echocardiogram

Presence of RV/LV diameter >1.0, RV dysfunction, IVS flattening, septal shift, or right heart thrombus?

**Indications for Thrombolysis in PE (rule out contraindication to Thrombolysis)**

- Cardiac Arrest
- SBP < 90mmHg or vasopressors required to maintain SBP ≥90mmHg despite fluid resuscitation or SBP drop ≥40mmHg lasting >15mins and not caused by new-onset arrhythmia, hypovolaemia or sepsis

Streptokinase

250 000 IU over 30 minutes then 100 000 IU/h over 12–24 hours

Accelerated regimen: 1.5 million IU over 2 hours

Alteplase

100 mg over 2 hours; or

Cardiac Arrest: 50mg IV bolus

**Notes**

- Failure to comply with this pathway does not represent a breach of the standard of care.
- This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs.
- A positive finding in a patient with symptoms consistent with PE can be considered evidence for diagnosis of VTE disease and potentially eliminate the need to expose the patient to the radiation from either a CTPA or V/Q scan.

---

**Clinical Gestalt** or Validated clinical decision support tool (Wells score for PE available in MDCalc)

**YEARS Criteria**

1. Clinical signs of DVT
2. Haemoptysis
3. Pulmonary embolism as the most likely diagnosis

**Pulmonary Embolism Rule-Out Criteria (PERC)**

(available in MDCalc)

1. Is the patient > 49 years of age?
2. Is the pulse rate > 99 beats per minute?
3. Is the pulse oximetry reading < 95% while the patient breathes room air?
4. Is there a present history of haemoptysis?
5. Is the patient receiving exogenous oestrogen?
6. Has the patient had recent surgery or trauma (e.g., compression ultrasound of lower extremities) in the previous 4 weeks?
7. Is the RBS < 1.5 x normal or > 20x normal RBS in last 6 months?
8. Has the patient had recent surgery or trauma requiring endotracheal intubation or hospitalization in the previous 4 weeks?
9. Does the patient have unilateral leg swelling (visual observation of asymmetry of the calves)?

Any of the above criteria present?

**Cardiac Arrest or Hypotension**

SBP < 90mmHg or vasopressors required to maintain SBP ≥ 90mmHg despite fluid resuscitation or SBP drop ≥40mmHg lasting >15mins and not caused by new-onset arrhythmia, hypovolaemia or sepsis

Bedside Echocardiogram

Presence of RV/LV diameter >1.0, RV dysfunction, IVS flattening, septal shift, or right heart thrombus?

**Indications for Thrombolysis in PE (rule out contraindication to Thrombolysis)**

- Cardiac Arrest
- SBP < 90mmHg or vasopressors required to maintain SBP ≥90mmHg despite fluid resuscitation or SBP drop ≥40mmHg lasting >15mins and not caused by new-onset arrhythmia, hypovolaemia or sepsis

Streptokinase

250 000 IU over 30 minutes then 100 000 IU/h over 12–24 hours

Accelerated regimen: 1.5 million IU over 2 hours

Alteplase

100 mg over 2 hours; or

Cardiac Arrest: 50mg IV bolus

**Notes**

- Failure to comply with this pathway does not represent a breach of the standard of care.
- This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs.
- A positive finding in a patient with symptoms consistent with PE can be considered evidence for diagnosis of VTE disease and potentially eliminate the need to expose the patient to the radiation from either a CTPA or V/Q scan.
16. Hypertension Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**BP > 130/80mmHg**

- Monitor, support ABCs
- Check vital signs (BP, PR, RR, SPO₂, T° C, RBS)
- Start Oxygen IF SPO₂ < 94%. Maintain SPO₂ ≥ 94%
- Perform brief, targeted history and physical exam
- Obtain/review 12-lead ECG (if indicated)
- Send samples for FBC, UEC, TSH and Urinalysis (for proteinuria) and PDT (as applicable)
- **DO NOT ADMINISTER ORAL ANTIHYPERTENSIVES (e.g. nifedipine) TO LOWER THE BLOOD PRESSURE IN THE ED.**
- Allow patient to rest awaiting results. Repeat BP checks hourly.

**Are there any features of progressive or impending end organ damage (especially if BP > 180/110 mmHg)?**

- **a) Neurological**
  - Cerebral vascular accident/cerebral infarction
  - Hypertensive encephalopathy
  - Subarachnoid haemorrhage
  - Intracranial haemorrhage

- **b) Cardiovascular**
  - Acute pulmonary oedema
  - Congestive heart failure
  - Myocardial ischemia/infarction
  - Acute left ventricular dysfunction
  - Aortic dissection

- **c) Other**
  - Acute renal failure/insufficiency
  - Retinopathy
  - Pre-eclampsia/Eclampsia
  - Microangiopathic haemolytic anaemia

**Headache/Epistaxis is NOT a hypertensive emergency, no matter how high the blood pressure. It is likely the headache/epistaxis is causing the hypertension, not the other way around. Treat the headache/epistaxis and the pressure will come down.**

---

**Known Hypertensive – Resume regular treatment; if unknown, low dose thiazide type diuretic for most; may consider ACE inhibitor, ARB, β-blocker, CCB. Follow-up as below (see Guideline for prevention, detection, evaluation and management of high blood pressure in adults)**

**New Onset Hypertension - Final BP prior to discharge**

- **BP > 160/100 – low dose thiazide type diuretic for most; may consider ACE inhibitor, ARB, β-blocker, CCB. (see Guideline for prevention, detection, evaluation and management of high blood pressure in adults).** Follow-up as below

- **BP < 160/100 – Follow-up as below**

**Daily BP checks at nearest clinic and follow-up in a Medical Clinic in 1 week with BP chart**

---

See 17. Hypertensive Emergencies Algorithm
Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

BLOOD PRESSURE MEASUREMENT TECHNIQUES

1. Have the patient relax, sitting in a chair (feet on floor, back supported) for >5 min.
2. The patient should avoid caffeine, exercise, and smoking for at least 30 min before measurement.
3. Ensure patient has emptied his/her bladder.
4. Neither the patient nor the observer should talk during the rest period or during the measurement.
5. Remove all clothing covering the location of cuff placement.
6. Measurements made while the patient is sitting or lying on an examining table do not fulfil these criteria.
7. Use a BP measurement device that has been validated and ensure that the device is calibrated periodically. *
8. Support the patient’s arm (e.g., resting on a desk).
9. Position the middle of the cuff on the patient’s upper arm at the level of the right atrium (the midpoint of the sternum).
10. Use the correct cuff size, such that the bladder encircles 80% of the arm, and note if a larger- or smaller-than-normal cuff size is used.
11. Either the stethoscope diaphragm or bell may be used for auscultatory readings.
12. At the first visit, record BP in both arms. Use the arm that gives the higher reading for subsequent readings.
13. Separate repeated measurements by 1–2 min.
14. For auscultatory determinations, use a palpated estimate of radial pulse obliteration pressure to estimate SBP. Inflate the cuff 20–30 mm Hg above this level for an auscultatory determination of the BP level.
15. For auscultatory readings, deflate the cuff pressure 2 mm Hg per second, and listen for Korotkoff sounds.
16. Record SBP and DBP. If using the auscultatory technique, record SBP and DBP as onset of the first Korotkoff sound and disappearance of all Korotkoff sounds, respectively, using the nearest even number.
17. Note the time of most recent BP medication taken before measurements.
18. Use an average of ≥ 2 readings obtained on ≥2 occasions to estimate the individual’s level of BP.
19. Provide patients the SBP/DBP readings both verbally and in writing.

Categories of BP in Adults*

<table>
<thead>
<tr>
<th>BP Category</th>
<th>SBP</th>
<th>DBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt;120 mm Hg</td>
<td>&lt;80 mm Hg</td>
</tr>
<tr>
<td>Elevated</td>
<td>120–129 mm Hg</td>
<td>&lt;80 mm Hg</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 1</td>
<td>130–139 mm Hg</td>
<td>80–89 mm Hg</td>
</tr>
<tr>
<td>Stage 2</td>
<td>≥140 mm Hg</td>
<td>≥90 mm Hg</td>
</tr>
</tbody>
</table>

*Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.

DIAGNOSTIC WORKUP OF HYPERTENSION

- Assess risk factors and comorbidities
- Reveal identifiable causes of hypertension
- Assess presence of target organ damage
- Conduct history and physical examination
- Obtain/review 12-lead ECG, RBS, FBC, UEC, TSH, Urinalysis for proteinuria, Lipid profile
Blood Pressure (BP) Thresholds and Recommendations for Treatment and Follow-Up

Normal BP (BP <120/80 mm Hg)
- Promote optimal lifestyle habits
- Reassess in 1 y (Class Ila)

Elevated BP (BP 120-129/<80 mm Hg)
- Nonpharmacologic therapy (Class I)
- Reassess in 3-6 mo (Class I)

Stage 1 Hypertension (BP 130-139/80-89 mm Hg)
- Clinical ASCVD or estimated 10-yr CVD risk ≥10%
- Yes: Nonpharmacologic therapy and BP-lowering medication (Class I)
- No: Reassess in 3-6 mo (Class I)

Stage 2 Hypertension (BP ≥ 140/90 mm Hg)
- Nonpharmacologic therapy and BP-lowering medication† (Class I)
- Reassess in 1 mo (Class I)

BP goal met
- Assess and optimize adherence to therapy
- Consider intensification of therapy
- Reassess in 3-6 mo (Class I)

* Using the ACC/AHA Pooled Cohort Equations. Note that patients with DM or CKD are automatically placed in the high-risk category. For initiation of RAS inhibitor or diuretic therapy, assess blood tests for electrolytes and renal function 2 to 4 weeks after initiating therapy.

† Consider initiation of pharmacological therapy for stage 2 hypertension with 2 antihypertensive agents of different classes. Patients with stage 2 hypertension and BP ≥160/100 mm Hg should be promptly treated, carefully monitored, and subject to upward medication dose adjustment as necessary to control BP. Reassessment includes BP measurement, detection of orthostatic hypotension in selected patients (e.g., older or with postural symptoms), identification of white coat hypertension or a white coat effect, documentation of adherence, monitoring of the response to therapy, reinforcement of the importance of adherence, reinforcement of the importance of treatment, and assistance with treatment to achieve BP target.

* Calculate the 10-year risk for first atherosclerotic cardiovascular disease events (ASCVD; nonfatal myocardial infarction, coronary heart disease–related death, or fatal or nonfatal stroke) with the ASCVD Risk Calculator (available in MDCalc)
## Best Proven Nonpharmacologic Interventions for Prevention and Treatment of Hypertension*

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Dose</th>
<th>Approximate Impact on SBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>Weight/body fat</td>
<td>-5 mm Hg</td>
</tr>
<tr>
<td></td>
<td>Ideal body weight is best goal but at least 1 kg reduction in body weight for most adults who are overweight. Expect about 1 mm Hg for every 1 kg reduction in body weight.</td>
<td>-2/3 mm Hg</td>
</tr>
<tr>
<td>Healthy diet</td>
<td>DASH dietary pattern</td>
<td>-1.1 mm Hg</td>
</tr>
<tr>
<td></td>
<td>Diet rich in fruits, vegetables, whole grains, and low-fat dairy products with reduced content of saturated and trans fat.</td>
<td>-3 mm Hg</td>
</tr>
<tr>
<td>Reduced Intake of dietary sodium</td>
<td>Dietary sodium</td>
<td>-5/6 mm Hg</td>
</tr>
<tr>
<td></td>
<td>&lt;1,500 mg/d is optimal goal but at least 1,000 mg/d reduction in most adults</td>
<td>-2/3 mm Hg</td>
</tr>
<tr>
<td>Enhanced Intake of dietary potassium</td>
<td>Dietary potassium</td>
<td>-4/5 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3,500-5,000 mg/d, preferably by consumption of a diet rich in potassium</td>
<td>-2 mm Hg</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Aerobic</td>
<td>-5/8 mm Hg</td>
</tr>
<tr>
<td></td>
<td>• 120–150 min/wk</td>
<td>-2/4 mm Hg</td>
</tr>
<tr>
<td></td>
<td>• 65%–75% heart rate reserve</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dynamic Resistance</td>
<td>-4 mm Hg</td>
</tr>
<tr>
<td></td>
<td>• 90–150 min/wk</td>
<td>-2 mm Hg</td>
</tr>
<tr>
<td></td>
<td>• 50%–60% 1 rep maximum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 6 exercises, 3 sets/exercise, 10 repetitions/set</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isometric Resistance</td>
<td>-5 mm Hg</td>
</tr>
<tr>
<td></td>
<td>• 4 x 2 min (hand grip), 1 min rest between exercises, 30%–40% maximum voluntary contraction, 3 sessions/wk</td>
<td>-4 mm Hg</td>
</tr>
<tr>
<td></td>
<td>• 8–10 wk</td>
<td></td>
</tr>
<tr>
<td>Moderate alcohol intake</td>
<td>Alcohol consumption</td>
<td>-4 mm Hg</td>
</tr>
<tr>
<td></td>
<td>In individuals who drink alcohol, reduce alcohol† to:</td>
<td>-3 mm Hg</td>
</tr>
<tr>
<td></td>
<td>• Men: ≤2 drinks daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Women: ≤1 drink daily</td>
<td></td>
</tr>
</tbody>
</table>

*Type, dose, and expected impact on BP in adults with a normal BP and with hypertension.

† In the United States, one “standard” drink contains roughly 14 grams of pure alcohol, which is typically found in 12 ounces of regular beer (usually about 5% alcohol), 5 ounces of wine (usually about 12% alcohol) and 1.5 ounces of distilled spirits (usually about 40% alcohol).
# Evidence-Based Dosing for Antihypertensive Drugs

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Usual Dose, Range (mg per day)*</th>
<th>Daily Frequency</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Agents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thiazide or thiazide-type diuretics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chlorthalidone</td>
<td>12.5-25</td>
<td>1</td>
<td>• Chlorthalidone preferred based on prolonged half-life and proven trial reduction of CVD</td>
</tr>
<tr>
<td></td>
<td>Hydrochlorothiazide</td>
<td>25-50</td>
<td>1</td>
<td>• Monitor for hypotremia and hypokalemia, uric acid and calcium levels.</td>
</tr>
<tr>
<td></td>
<td>Indapamide</td>
<td>1.25-2.5</td>
<td>1</td>
<td>• Use with caution in patients with history of acute gout unless patient is on uric acid-lowering therapy.</td>
</tr>
<tr>
<td></td>
<td>Metolazone</td>
<td>2.5-10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACE Inhibitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benazepril</td>
<td>10-40</td>
<td>1 or 2</td>
<td>• Do not use in combination with ARBs or direct renin inhibitor</td>
</tr>
<tr>
<td></td>
<td>Captopril</td>
<td>12.5-150</td>
<td>2 or 3</td>
<td>• Increased risk of hyperkalemia, especially in patients with CKD or in those on K+ supplements or K+ sparing drugs</td>
</tr>
<tr>
<td></td>
<td>Enalapril</td>
<td>5-40</td>
<td>1 or 2</td>
<td>• May cause acute renal failure in patients with severe bilateral renal artery stenosis</td>
</tr>
<tr>
<td></td>
<td>Lisinopril</td>
<td>10-40</td>
<td>1</td>
<td>• Do not use if history of angioedema with ACE inhibitors.</td>
</tr>
<tr>
<td></td>
<td>Moexipril</td>
<td>7.5-30</td>
<td>1 or 2</td>
<td>• Avoid in pregnancy</td>
</tr>
<tr>
<td></td>
<td>Perindopril</td>
<td>4-16</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quinapril</td>
<td>10-80</td>
<td>1 or 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ramipril</td>
<td>2.5-10</td>
<td>1 or 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trandolapril</td>
<td>1-4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ARBs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Azilsartan</td>
<td>40-80</td>
<td>1</td>
<td>• Do not use in combination with ACE inhibitors or direct renin inhibitor</td>
</tr>
<tr>
<td></td>
<td>Candesartan</td>
<td>8-32</td>
<td>1</td>
<td>• Increased risk of hyperkalemia in CKD or in those on K+ supplements or K+ sparing drugs</td>
</tr>
<tr>
<td></td>
<td>Eprosartan</td>
<td>600-800</td>
<td>1 or 2</td>
<td>• May cause acute renal failure in patients with severe bilateral renal artery stenosis</td>
</tr>
<tr>
<td></td>
<td>Irbesartan</td>
<td>150-300</td>
<td>1</td>
<td>• Do not use if history of angioedema with ARBs. Patients with a history of angioedema with an ACE I can receive an ARB beginning 6 weeks after ACE discontinued.</td>
</tr>
<tr>
<td></td>
<td>Losartan</td>
<td>50-100</td>
<td>1 or 2</td>
<td>• Avoid in pregnancy</td>
</tr>
<tr>
<td></td>
<td>Olmesartan</td>
<td>20-40</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telmisartan</td>
<td>20-80</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Valsartan</td>
<td>80-320</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CCB—dihydropyridines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amlodipine</td>
<td>2.5-10</td>
<td>1</td>
<td>• Avoid use in patients with HF/EF; amlodipine or felodipine may be used if required</td>
</tr>
<tr>
<td></td>
<td>Felodipine</td>
<td>5-10</td>
<td>1</td>
<td>• Associated with dose-related pedal edema, which is more common in women than men</td>
</tr>
<tr>
<td></td>
<td>Isradipine</td>
<td>5-10</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nicardipine SR</td>
<td>5-20</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nifedipine LA</td>
<td>60-120</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nisoldipine</td>
<td>30-90</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CCB—nondihydropyridines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diltiazem SR</td>
<td>180-360</td>
<td>2</td>
<td>• Avoid routine use with beta blockers due to increased risk of bradycardia and heart block</td>
</tr>
<tr>
<td></td>
<td>Diltiazem ER</td>
<td>120-480</td>
<td>1</td>
<td>• Do not use in patients with HFrEF</td>
</tr>
<tr>
<td></td>
<td>Verapamil IR</td>
<td>40-80</td>
<td>3</td>
<td>• Drug interactions with diltiazem and verapamil (CYP3A4 major substrate and moderate inhibitor)</td>
</tr>
<tr>
<td></td>
<td>Verapamil SR</td>
<td>120-480</td>
<td>1 or 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Verapamil-delayed onset ER (various forms)</td>
<td>100-480</td>
<td>1 (in the evening)</td>
<td></td>
</tr>
</tbody>
</table>
17. Hypertensive Emergencies Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Hypertensive Encephalopathy - Reduce mean arterial pressure (MAP) 25% over 8 hours.

Acute Ischemic Stroke - Evidence exists that patients who have acute strokes have better outcomes with higher BPs. Antihypertensive therapy is not routinely recommended for patients with acute stroke and HTN.
- Patient otherwise eligible for acute reperfusion therapy except that BP is >185/110 mm Hg:
  - Labetalol
  - Other agents (hydralazine, enalaprilat, etc.) may be considered when appropriate
- Management of BP during and after rtPA or other acute reperfusion therapy to maintain BP at or below 180/105 mm Hg:
  - Monitor BP every 15 minutes for 2 hours from the start of rtPA therapy, then every 30 minutes for 6 hours, and then every hour for 16 hours
- If systolic BP >180-230 mm Hg or diastolic BP >105-120 mm Hg:
  - Labetalol
  - If BP not controlled or diastolic BP >140 mm Hg, consider IV sodium nitroprusside

After treatment with fibrinolysis, the SBP should be maintained < 180mmHg and DBP < 105mmHg for 24 hours.
- In patients with markedly elevated blood pressure (SBP > 220 mm Hg or DBP > 120 mm Hg) who do not receive fibrinolysis, a reasonable goal is to lower blood pressure by 15% during the first 24 hours after onset of stroke.

Acute Intracerebral Haemorrhage - No evidence exists to suggest that HTN provokes further bleeding in patients with ICH. A precipitous fall in SBP may compromise cerebral perfusion and increase mortality. The controlled lowering of BP with IV labetalol (in the absence of bradycardia) is currently recommended only when the SBP is ≥1200/80mmHg or the DBP is ≥110mmHg. Treatment based on clinical/radiographic evidence of increased intracranial pressure (ICP).
- If signs of increased ICP, maintain MAP just below 130mmHg (or SBP < 180mmHg) for first 24 hours after onset.
- Patients without increased ICP, maintain MAP < 110mmHg (or SBP < 160mmHg) for first 24 hours after symptom onset.

Subarachnoid Haemorrhage - Maintain SBP < 160mmHg until the aneurysm is treated or cerebral vasospasm occurs. Oral nimodipine is used to prevent delayed ischemic neurological deficits, but it is NOT indicated for treating acute hypertension.

Cardiovascular Emergencies

Aortic Dissection - Immediately reduce the SBP < 120mmHg and maintain it at this level unless signs of end-organ hypo perfusion are present. Preferred treatment includes a combination of:
  a) narcotic analgesics (morphine sulphate),
  b) vasodilators (nicardipine, nitroprusside).
  c) β-blockers (labetalol, esmolol) or calcium channel blockers (verapamil, diltiazem); Avoid β-blockers if there is;
    - aortic valvular regurgitation or
    - suspected cardiac tamponade.

Acute Coronary Syndrome - Treat if SBP >160 mmHg and/or DBP >100 mmHg. Reduce BP by 20-30% of baseline. Thrombolytics are contraindicated if BP is >185/100 mmHg. Preferred medications include β-blockers & Nitroglycerin

Acute Heart Failure - Treatment with vasodilators (in addition to diuretics) for SBP ≥ 140 mmHg. IV or sublingual nitroglycerin is the preferred agent.

Other Disorders

Cocaine toxicity/Pheochromocytoma - Hypertension and tachycardia from cocaine toxicity rarely require specific treatment.
  - Benzodiazepines are the preferred agents for cocaine-associated acute coronary syndromes.
  - Pheochromocytoma treatment guidelines are similar to that of cocaine toxicity. β-blockers can be added for BP control only after α-blockade.

Preferred medications - Hydralazine, Labelatal, Nifedipine
Medications to avoid - Nitroprusside, Angiotensin-converting enzyme inhibitors, Esmolol

Acute stroke in women with eclampsia or preeclampsia, SBP should be < 160 mmHg and DBP <110 mm Hg in the prepartum and intrapartum periods. If the platelet count is < 100,000 cells/mm³, BP should be maintained below 150/100mmHg. Patients with eclampsia or preeclampsia should also be loaded with IV Magnesium sulphate 4gm diluted in 100mL NS over 15 mins then with an infusion of 2gm/hr to avoid seizures.

Preferred medications - Hydralazine, Labelatal, Nifedipine
Medications to avoid - Nitroprusside, Angiotensin-converting enzyme inhibitors, Esmolol
**Hypertensive Emergencies Drug Infusions**

*For adults with a compelling condition (i.e., aortic dissection, severe preeclampsia or eclampsia, or pheochromocytoma crisis), SBP should be reduced to < 140 mm Hg during the first hour and to < 120 mm Hg in aortic dissection. For adults without a compelling condition, SBP should be reduced by no more than 25% within the first hour; then, if stable, to 160/100 mm Hg within the next 2 to 6 hours; and then cautiously to normal during the following 24 to 48 hours.*

<table>
<thead>
<tr>
<th>AGENT</th>
<th>MOA</th>
<th>DOSE</th>
<th>ONSET/DURATION OF ACTION (AFTER DISCONTINUATION)</th>
<th>PRECAUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parenteral Vasodilators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td>Decreases coronary vasospasm, which increases coronary blood flow. Also, induces vessel dilatation, decreasing cardiac workload.</td>
<td>Initial 5 mcg/min; increase in increments of 5 mcg/min every 3–5 min to a maximum of 20 mcg/min.</td>
<td>2-5 min / 5-10 min</td>
<td>Use only in patients with acute coronary syndrome and/or acute pulmonary oedema. Do not use in volume-depleted patients.</td>
</tr>
<tr>
<td>Hydralazine</td>
<td>Decreases systemic resistance through direct vasodilation of arterioles.</td>
<td>Initial 10 mg via slow IV infusion (maximum initial dose 20 mg); repeat every 4–6 h as needed.</td>
<td>10 min / &gt; 1 hr</td>
<td>BP begins to decrease within 10–30 min and the fall lasts 2–4 h. Unpredictability of response and prolonged duration of action do not make hydralazine a desirable first-line agent for acute treatment in most patients.</td>
</tr>
<tr>
<td><strong>Parenteral Adrenergic Inhibitors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labetalol</td>
<td>α, β1, β2 Blocker</td>
<td>Initial 0.3–1.0 mg/kg dose (maximum 20 mg) slow IV injection every 10 min or 0.4–1.0 mg/kg/h IV infusion up to 3 mg/kg/h. Adjust rate up to total cumulative dose of 300 mg. This dose can be repeated every 4–6 h.</td>
<td>5-10 min / 15-30 min</td>
<td>Contraindicated in reactive airways disease or chronic obstructive pulmonary disease. Especially useful in hyperadrenergic syndromes. May worsen HF and should not be given in patients with 2nd or 3rd degree heart block or bradycardia.</td>
</tr>
<tr>
<td>Esmolol</td>
<td>Ultra-short-acting β-adrenergic blocker</td>
<td>Loading dose 500–1,000 mcg/kg/min over 1 min followed by a 50 mcg/kg/min infusion. For additional dosing, the bolus dose is repeated, and the infusion increased in 50 mcg/kg/min increments as needed to a maximum of 200 mcg/kg/min.</td>
<td>1-5 min / 15-30 min</td>
<td>Contraindicated in patients with concurrent beta-blocker therapy, bradycardia and/or decompensated HF. Monitor for bradycardia. May worsen HF. Higher doses may block beta2 receptors and impact lung function in reactive airway disease.</td>
</tr>
</tbody>
</table>
This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

### Identify signs of Possible Acute Stroke

**Patient MUST be seen by the doctor within 10 minutes of arrival**

<table>
<thead>
<tr>
<th>Test</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial Droop:</strong></td>
<td>Have patient show teeth or smile</td>
</tr>
<tr>
<td></td>
<td>Normal – both sides of face move equally</td>
</tr>
<tr>
<td></td>
<td>Abnormal – one side of face does not move as well as the other</td>
</tr>
<tr>
<td><strong>Arm Drift:</strong></td>
<td>Patient closes eyes and extends both arms straight out, with palms up, for 10 seconds</td>
</tr>
<tr>
<td></td>
<td>Normal – both arms move the same or both arms do not move at all</td>
</tr>
<tr>
<td></td>
<td>Abnormal – one arm does not move, or one arm drifts down compared with the other</td>
</tr>
<tr>
<td><strong>Abnormal Speech:</strong></td>
<td>Have the patient repeat a sentence</td>
</tr>
<tr>
<td></td>
<td>Normal – patient uses correct words with no slurring</td>
</tr>
<tr>
<td></td>
<td>Abnormal – patient slurs words, uses the wrong words, or is unable to speak</td>
</tr>
</tbody>
</table>

**Interpretation:** If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%. The presence of ALL 3 findings indicates that the probability of stroke is >85%.

---

- Monitor, support ABCs in the Resuscitation Room (ER)
- Check vital signs (BP, PR, RR, SPO₂, °C).
- Start Oxygen IF SPO₂ ≤ 94%. Maintain SPO₂ > 94%
- Check Glucose and treat if < 3.3mmol/L with 50mL 50% Dextrose bolus. Maintain blood glucose between 7.7-10mmol/L
- Establish 18G IV Access and send samples for FBC, UEC, Coagulation Screen
- Perform brief, targeted history, physical exam, ; indicate time when patient last known normal

---

### Time from onset of symptoms*

*for patients who wake up with stroke symptoms, consider the time the patient went to sleep as the time of symptom onset

- **< 4.5 hours**
  - ER Doctor & Nurse MUST accompany patient to radiology IMMEDIATELY with Stroke Box (must include Stroke Fibrinolysis Protocol & Fibrinolytic) & Monitor
  - Obtain non-contrast enhanced Brain CT Scan within 20 minutes of patient arrival
  - **No Haemorrhage**
    - Consult a Neurologist IMMEDIATELY and start the Stroke Fibrinolysis Protocol in Radiology
    - Haemorrhage
      - Consult a Neurosurgeon
  - **Haemorrhage**
    - Consult a Neurosurgeon

- **≥ 4.5 hours - < 8 hours**
  - ER Doctor & Nurse MUST accompany patient to radiology IMMEDIATELY.
  - Obtain non-contrast enhanced Brain CT Scan & Cerebral Angiogram within 20 minutes of patient arrival
  - **No Haemorrhage**
    - Consult a Neurologist IMMEDIATELY
    - Haemorrhage
      - Consult a Neurosurgeon

- **≥ 8 hours - < 24 hours**
  - ER Nurse MUST accompany patient to radiology & inform ER Doctor IMMEDIATELY the MRI is complete
  - Obtain Brain MRI Limited Stroke Protocol within 20 minutes of patient arrival
  - **No Haemorrhage**
    - Consult a Neurologist IMMEDIATELY
    - Haemorrhage
      - Consult a Neurosurgeon

- **≥ 24 hours**
  - Obtain non-contrast enhanced Brain CT Scan
  - **No Haemorrhage**
    - Give 300mg Aspirin
    - Admit Stroke Unit
  - Haemorrhage
    - Consult a Neurosurgeon

---

[emergencymedicinekenya.org](http://emergencymedicinekenya.org)
# National Institutes of Health Stroke Scale (NIHSS)

(Available in MDCalc)

<table>
<thead>
<tr>
<th>1a. Level of consciousness</th>
<th>7. Limb ataxia</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 = Alert; keenly responsive</td>
<td>□ 0 = Absent</td>
</tr>
<tr>
<td>□ 1 = Not alert, but rousable by minor stimulation</td>
<td>□ 1 = Present in one limb</td>
</tr>
<tr>
<td>□ 2 = Not alert; requires repeated stimulation</td>
<td>□ 2 = Present in two limbs</td>
</tr>
<tr>
<td>□ 3 = Unresponsive or responds only with reflex</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Best gaze</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 = Normal</td>
<td>□ 0 = No abnormality</td>
</tr>
<tr>
<td>□ 1 = Partial gaze palsy</td>
<td>□ 1 = Visual, tactile, auditory, spatial, or personal inattention</td>
</tr>
<tr>
<td>□ 2 = Forced deviation</td>
<td>□ 2 = Profound hemi-inattention or extinction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 = No visual loss</td>
<td>□ 0 = Normal</td>
</tr>
<tr>
<td>□ 1 = Partial hemianopia</td>
<td>□ 1 = Mild to moderate dysarthria</td>
</tr>
<tr>
<td>□ 2 = Complete hemianopia</td>
<td>□ 2 = Severe dysarthria</td>
</tr>
<tr>
<td>□ 3 = Bilateral hemianopia</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Facial palsy</th>
<th>11. Extinction and inattention</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 = Normal symmetric movements</td>
<td>□ 0 = No abnormality</td>
</tr>
<tr>
<td>□ 1 = Minor paralysis</td>
<td>□ 1 = Visual, tactile, auditory, spatial, or personal inattention</td>
</tr>
<tr>
<td>□ 2 = Partial paralysis</td>
<td>□ 2 = Profound hemi-inattention or extinction</td>
</tr>
<tr>
<td>□ 3 = Complete paralysis of one or both sides</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Motor Arm</th>
<th>6. Motor Leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Left Arm (LA)</td>
<td>a. Left Leg (LL)</td>
</tr>
<tr>
<td>b. Right Arm (RA)</td>
<td>b. Right Leg (RL)</td>
</tr>
<tr>
<td>□ 0 = No drift</td>
<td>□ 0 = No movement</td>
</tr>
<tr>
<td>□ 1 = Drift</td>
<td>□ 1 = No effort against gravity; limb falls</td>
</tr>
<tr>
<td>□ 2 = Some effort against gravity</td>
<td>□ 2 = No movement</td>
</tr>
<tr>
<td>□ 3 = No effort against gravity; limb falls</td>
<td>□ 3 = No drift</td>
</tr>
<tr>
<td>□ 4 = No movement</td>
<td>□ 4 = Drift</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Score = 0 - 42**
Stroke Fibrinolysis Protocol

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Probable Acute Ischaemic Stroke
BEGIN 18. STROKE ALGORITHM

Review/Complete Fibrinolysis Checklist

Inclusion and Exclusion Characteristics of Patients With Ischemic Stroke Who Could Be Treated With IV rtPA Within 3 Hours From Symptom Onset

Inclusion criteria
• Diagnosis of ischemic stroke causing measurable neurological deficit
• Onset of symptoms ≤ 3 hours before beginning treatment
• Aged ≥18 years

Exclusion criteria
• Severe head trauma or prior stroke in the previous 3 months
• Symptoms suggest subarachnoid haemorrhage
• History of previous intracranial haemorrhage
• Intracranial neoplasm, AVM, or aneurysm
• Recent intracranial or intraspinal surgery
• Elevated blood pressure (systolic >185 mmHg or diastolic >110 mmHg). Lower BP first before fibrinolysis
• Active internal bleeding
• Seizure at onset with postictal residual neurological impairments secondary to a postictal phenomenon and not a stroke
• Acute bleeding diathesis, including but not limited to
  • Platelet count <100 000/mm³
  • Heparin received within 48 h resulting in abnormally elevated aPTT above the upper limit of normal
  • Current use of anticoagulant with INR >1.7 or PT >15 s
  • Current use of direct thrombin inhibitors or direct factor Xa inhibitors with elevated sensitive laboratory tests (eg, aPTT, INR, platelet count, ECT, TT, or appropriate factor Xa activity assays)
• Blood glucose concentration <50 mg/dL (2.7 mmol/L)
• Mild nondisabling stroke (NIHSS score 0–5)

Relative exclusion criteria
Recent experience suggests that under some circumstances, with careful consideration and weighting of risk to benefit, patients may receive fibrinolytic therapy despite ≥1 relative contraindications. Consider risk to benefit of intravenous rtPA administration carefully if any of these relative contraindications is present
• Pregnancy
• Arterial puncture at non-compressible site in previous 7 days
• Major surgery or serious trauma within previous 14 days
• Recent gastrointestinal or urinary tract haemorrhage (within previous 23 days)
• Recent acute myocardial infarction (within previous 3 months)

Additional Inclusion and Exclusion Characteristics of Patients with Acute Ischemic Stroke Who Could Be Treated With IV rtPA within 3 to 4.5 Hours From Symptom Onset

Main inclusion criteria
• Diagnosis of ischemic stroke causing measurable neurologic deficit
• Onset of symptoms within 3 to 4.5 hours before beginning treatment
• Patients with AIS who awake with stroke symptoms or have unclear time of onset >4.5 h from last known well or at baseline state and who have a DW-MRI lesion smaller than one-third of the MCA territory and no visible signal change on FLAIR.

Exclusion criteria
• Age > 80 years
• Very severe stroke symptoms (NIHSS score >25) or Mild nondisabling stroke (NIHSS score 0–5)
• Taking oral anticoagulant regardless of INR
• History of both diabetes and prior ischemic stroke
• Those with imaging evidence of ischemic injury involving more than one third of the middle cerebral artery territory

NOTES
• A physician with expertise in acute stroke care may modify this list.
• Onset time is defined as either the witnessed onset of symptoms or the time last known normal if symptom onset was not witnessed.
• In patients without recent use of oral anticoagulants or heparin, treatment with IV rtPA can be initiated before availability of coagulation test results but should be discontinued if INR is >1.7 or PT is abnormally elevated by local laboratory standards.
• In patients without history of thrombocytopenia, treatment with IV rtPA can be initiated before availability of platelet count but should be discontinued if platelet count is <100 000/mm³.

Review risks/benefits with patient and family. If acceptable, obtain CONSENT FOR FIBRINOLYSIS
• Ensure patient is attached to monitor (ECG, SPO2, BP) and repeat baseline vitals. Treat BP if indicated!
• Set up second IV line for the fibrinolysis. Run NS/RL TKVO in other line
• ALTEPLASE (give within 60 minutes of patient arrival)
• The recommended dose of alteplase is 0.9 mg/kg (maximum 90 mg) infused over 60 minutes, with 10% of the total dose administered as an initial IV bolus over 1 minute.
• Measure blood pressure and perform neurological assessments every 15 minutes during and after IV rtPA infusion for 2 hours, then every 30 minutes for 6 hours, then hourly until 24 hours after IV rtPA treatment.
• Admit to stroke unit

Admit to stroke unit
• Administer aspirin 325mg PO/PR
• In patients already taking statins, continue treatment
• Monitor blood glucose and temperature and treat if indicated. Maintain blood glucose between 7.7mmol/L and 10mmol/L
• Initiate supportive therapy; treat comorbidities

Candidate

Not a Candidate
19. Transient Ischemic Attack (TIA) Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

The AHA/ASA has endorsed the current definition of TIA as “a transient episode of neurological dysfunction caused by focal brain, spinal cord, or retinal ischemia, without acute infarction.” The new definition of TIA completely eliminates the element of time and emphasizes neuroimaging instead.

Mimics

- Stroke
- Hypoglycaemia / hyperglycaemia
- Seizure with Todd paralysis
- Complicated migraine
- Structural brain lesion (tumour, haemorrhage, aneurysm)
- Demyelinating disease (multiple sclerosis)
- Central nervous system infection (encephalitis, cerebritis, abscess)
- Acute vestibular syndrome (labyrinthine disorders)
- Delirium
- Recrudescence of old stroke
- Syncope (of any aetiology)
- Metabolic disarray (hyponatraemia, hypokalaemia, etc.)
- Peripheral nervous system lesion (radiculopathy, neuropathy, plexopathy)
- Psychogenic (conversion disorder, somatization)

Abbreviations: CT, computed tomography; DMI, diffusion-weighted imaging; ECG, electrocardiogram; ED, emergency department; IV, intravenous; MRI, magnetic resonance imaging; TIA, transient ischaemic attack.
20. Seizures Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**History of Seizure**
- Maintain and support ABCs
- Monitor vital signs (BP, PR, RR, SPO₂, T°C)
- Start Oxygen if SPO₂ < 94%. Maintain SPO₂ ≥ 94%
- Check RBS

**First-time Seizure**

**Known Epileptic or >1 seizure**

- Send samples for MPS, UEC, HIV, Urinalysis if pregnant or post-partum

If pregnant or post-partum, load with IV Magnesium sulphate 4gm diluted in 100mL NS over 15 mins. Continue with an infusion of 2gm/hr

Patients with typical recurrent seizures related to previously treated epilepsy or eclamptic patients are unlikely to have life-threatening structural lesions. These patients DO NOT require MR/CT.

An MRI (or CT scan) should be performed immediately when a provider suspects a serious structural lesion or:
- New focal deficits
- Persistent altered mental status (with or without intoxication)
- Fever
- Recent trauma
- Persistent headache
- History of cancer
- History of anticoagulation
- Suspicion of AIDS

Patients who have completely recovered from their seizure and for whom no clear-cut cause has been identified (e.g., hypoglycaemia, hyponatraemia, drug overdose, eclampsia)

Additionally, for patients with first-time seizure, emergent MRI/CT should be considered if any of the following is present:
- Age > 40 years
- Partial-onset seizure

Additionally, for patients with recurrent seizure (prior history of seizures) emergent MRI/CT should be considered if any of the following is present:
- New seizure pattern or new seizure type
- Prolonged postictal confusion or worsening mental status

- Review with ALL results

**Criteria for discharge:**
- First onset single seizure in a patient < 40 year who has completely recovered from their seizure and for whom no clear-cut cause has been identified (e.g., hypoglycaemia, hyponatraemia, tricyclic overdose) and with normal investigations. No follow-up is necessary unless seizure recurs.
- Known epileptic who has completely recovered from their seizure and for whom a clear-cut cause has been identified (e.g., non-compliance, sub-therapeutic drug levels) and with normal investigations. Patient should be loaded with anticonvulsants if non-therapeutic prior to discharge and adequate follow-up arranged.

Consult a Physician on ALL other patients. Consult an OB/GYN for all pregnant or post-partum patients

**Active seizure / Post ictal / Status Epilepticus**

- Position patient on soft mattress/pillows on trolley in left lateral position and open the airway with head-tilt manoeuvre; maintain this position until patient is awake – Do NOT restrain a seizing patient
- Maintain and support ABCs. Provide O2 by Non-Rebreather mask at 15L/min
- Check RBS

**Post ictal**

- Still Seizing Or Recurrent Seizure

**Still Seizing Or Recurrent Seizure**

- Set up IV access and give Midazolam 0.1mg/Kg
- If difficult or no IV access, give Midazolam 0.1mg/Kg IM
- Send samples for MPS, UEC, HIV, Urinalysis if pregnant or post-partum, Phenytin/Valproate levels as applicable

If pregnant or post-partum, load with IV Magnesium sulphate 4gm diluted in 100mL NS over 15 mins. Continue with an infusion of 2gm/hr

**Post Ictal**

- Monitor vital signs (BP, PR, RR, SPO₂, T°C, RBS)

**Post Ictal**

- Still Seizing Or Recurrent Seizure

**Still Seizing Or Recurrent Seizure**

- Consult a Physician/OBGYN and continue with algorithm
- Repeat Midazolam 0.1mg/Kg IV after 10 minutes from last dose
- Load with phenytoin at 20 mg/kg IV in NS strictly over 30 mins.

**Post Ictal**

- Monitor vital signs (BP, PR, RR, SPO₂, T°C, RBS)

**Post Ictal**

- Still Seizing Or Recurrent Seizure

- Consult a Physician/OBGYN and continue with algorithm
- Repeat Midazolam 0.1mg/Kg IV after 10 minutes from last dose
- Consider hypoglycaemia, hyponatraemia, drug overdose
- If still in seizing, additional phenytoin at 5 mg/kg IV in NS strictly over 10 mins. Repeat again once if necessary. Obtain phenytoin level 30-60 minutes after completion of infusion. ( Aim for ≥ 10mg/L)

**Post Ictal**

- Still Seizing Or Recurrent Seizure

**Still Seizing Or Recurrent Seizure**

- Intubate and ventilate patient; keep T°C ≤ 37°C
- Propofol 1mg/kg IV + Rocuronium 1.2mg/kg
- Start infusion of midazolam 0.1mg/kg/hour IV
- Obtain CT Head (if not pregnant) and review with ALL the results.
- Admit ICU. Consult a Physician/OBGYN
21. Syncope Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

History of Syncope

Syncope is a symptom complex that is composed of a brief loss of consciousness associated with an inability to maintain postural tone that “spontaneously” (i.e., no postictal period with a rapid recovery) and “completely” (no residual neurologic deficit) resolves without medical intervention. Near-syncope is defined as a patient almost losing consciousness, and it is approached in the same way as syncope.

Consider seizure - tongue biting, head turning during loss of consciousness, no recollection of abnormal behaviour, prolonged limb jerking (lasting minutes), incontinence post-event confusion, and prodromal aura.

Check RBS – If RBS < 3.3 mmol/L – see 28. Hypoglycaemia Algorithm

12 lead ECG - Look for evidence of ischemia/infarction, dysrhythmias, atrioventricular blocks, Brugada syndrome (RBBB with J-wave elevation of ≥ 2 mm), prolonged QT interval, ventricular pre-excitation, hypertrophic cardiomyopathy

Consider dangerous causes of syncope

- Neuromediately syncope
  - Subarachnoid haemorrhage
  - Seizure

- Orthostatic hypotension-mediated syncope
  - Ectopic pregnancy
  - Gastrointestinal haemorrhage
  - Medication-induced orthostatic hypotension*

- Cardiovascular-mediated syncope
  - Dysrhythmias
  - Acute coronary syndromes (rare < 2%)
  - Aortic dissection
  - Pulmonary Embolism (rare < 1%)
  - Patients with bradycardia*

* patients who may benefit from intervention.

The San Francisco Syncope Rule (SFSR) (available in MDCalc)
The SFSR uses five factors (CHESS predictors) to predict serious adverse outcomes at 7 or 30 days in patients presenting to the ED.

1. History of Congestive Heart Failure
2. Haematocrit < 30% (Hb < 10g/dL) (test if clinically indicated)
3. ECG abnormality (see above)
4. History of Shortness of breath
5. SBP < 90 mm Hg after arrival in the ED

SFSR is associated with a pooled negative predictive value of 97%, sensitivity of 87%, and negative LR of 0.28. Patients with negative SFSR scores had < 3% risk for serious outcomes.

Does the patient have ANY of the 5 SFSR predictors?

Consult a Physician

Discharge
22. Trauma Management Pathway

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

SAMPLE HISTORY
Signs and Symptoms
Allergies
Medication
Past Medical History/Pregnancy
Last meal/Last Tetanus Injection/Last Medication/Drug/Alcohol intake
Events preceding presentation

ACTIVATE THE TRAUMA TEAM (see on the next page)

PRIMARY SURVEY + RESUSCITATION (C-ABCDE)
STOP ANY EXTERNAL MASSIVE BLEEDING IMMEDIATELY
C-Spine – Cleared Clinically (see 23. C-Spine Clearance Algorithm)? Perform Manual In-Line Stabilization (MILS) then apply Head Blocks or Blanket Rolls taped to the patient’s head and trolley. DO NOT APPLY A C-COLLAR
+ If suspected trauma and not cleared clinically, Head Blocks or Blanket Rolls strapped to the patient’s head and trolley
Airway – Open? Maintainable? Intubate?
+ Rapid Sequence Intubation?
+ Supplementary Oxygenation? – Non-Rebreather mask
+ Immediate decompression for Tension Pneumothorax with subsequent immediate Intercostal Chest Drain Insertion?
+ Emergency Intercostal Chest Drain for Massive Haemothorax or Open sucking chest wound
+ Control Active Bleeding;
  ▪ Apply a Pelvic wrap to an Open Book Pelvic Fracture
+ Insert 2 large bore IV lines and give appropriate fluid resuscitation (NS/RL/whole blood). Give Tranexamic acid loading dose 15mg/kg over 10 min then infusion of 1.5mg/kg/h for 8 hours to ALL trauma patients with, or at risk of, significant bleeding, adults within 3 h of injury with a GCS score of 9-12 or 13-15 with any intracranial bleeding on CT scan
+ FGH, UEC, GXM and request adequate supplementary blood and blood products
+ Extended Focussed Assessment with Sonography in Trauma (EFAST) – ONLY for;
  ▪ Penetrating chest trauma – Pneumothorax? Haemothorax? Pericardial Effusion?
  ▪ Unstable? blunt chest and abdominal trauma – Haemothorax? Hemoperitoneum?
  ▪ Unexplained hypotension - ? Free fluid in pleural, pericardial or peritoneal cavity
Disability – GCS7 (available in MDCalc) Pupils? RBS?
+ Correct Hypoglycaemia – 50mls 50% Dextrose IV
+ Give appropriate analgesia e.g. Fentanyl 1μg/kg IV (see Analgesia Chart and 41. Pain Management Algorithm for Regional Anaesthesia)
+ Give IV Phentoyin (20mg/kg) for Severe Head Injury (GCS ≤ 8)
Expose patient
+ Check temperature and avoid hypo- or hyperthermia

SECONDARY SURVEY (HEAD-TO-TOE SURVEY)
Chest – Lacerations? Rib Fractures?
Limbs – Lacerations? Fractures? Distal Pulses and Neurology?
Log roll patient – Lacerations? Spine tenderness?
Do not forget to CLEAN ALL OPEN WOUNDS with running tap water for at least 10 minute and SPLINT ALL FRACTURES. Give Tetanus Toxoid – see 22. Bites (Animal & Human), Tetanus & Rabies. Give ANTIBIOTICS within 1 hour of Injury for ALL COMPOUND FRACTURES. Therapeutic doses of cefazolin, clindamycin, for 48 hrs are appropriate; with contamination, consider anaerobic antibiotics (penicillins, clindamycin, metronidazole); NO ANTIBIOTICS are required for soft tissue injuries unless there is evidence of an infection.

RADIOLOGICAL INVESTIGATIONS
• C-Spine X-rays (AP, Lateral AND Open Mouth) – see 23. C-Spine Clearance Algorithm. If doing a CT head, do CT Spine instead of C-spine X-rays if indicated.
  ▪ C-spine is NOT cleared on X-rays/CT BUT on resolution of patient symptoms
• Pelvic X-ray – ONLY for patients with;
  – lower abdominal pain
  – lower back pain
  – femur fractures
  – clinically tender pelvis
  – patients unable to mobilize
• CT Head – ONLY for;
  – GCS <15 (for GCS 15 – see 24. Mild Traumatic Brain Injury Algorithm)
  – Skull fractures including Base of Skull Fractures (DO NOT ORDER SKULL X-Rays)
• CT-Abdomen – For the haemodynamically stable patient with suspected blunt abdominal trauma
• Knee X-ray – See Ottawa Knee Rule in MDCalc
• Ankle X-ray – See Ottawa Ankle Rule in MDCalc

Where a reliable clinical assessment is not possible ALL the investigations should be done.
Trauma Team Activation Criteria

The Trauma team comprises a group of emergency department doctors/clinical officers and nurses, surgeons, anaesthetists and theatre staff, radiographers and other support personnel, who work together as a team to assess and manage the trauma patient. Their actions are coordinated by a team leader who should not touch the patient. The aim of the trauma team is to provide a safe and efficient evaluation of the patient. Identify all injuries and instigate the definitive management of such injuries. Most trauma teams will have about 30 minutes to accomplish this and should work towards achieving this goal.

The Trauma Team should be activated immediately a patient who meets ANY of the criteria below arrives:

- Systolic BP < 90 mmHg
- Respiratory rate < 10 breaths/min or > 30 breaths/min
- GCS < 12 with torso or extremity trauma
- Pregnant patient (> 20 weeks) with foetal heart rate < 120 bpm or >160 bpm
- Amputation proximal to elbows or knees
- 2 or more proximal long bone fractures
- Suspected spinal cord injury
- Severe maxillofacial injury with airway compromise
- Burns > 15% TBSA
- Pregnant patient with penetrating injury or significant blunt injury
- Gunshot wound proximal to knee or elbow
- Significant penetrating wound to head, neck, chest, abdomen or groin
- Ejection from vehicle
- Pedestrian thrown (hit by a car) or rolled over
- Fall from a height > 6 metres (20 feet)
- Simultaneous arrival of 3 or more multi-trauma patients
- Emergency Doctor feels trauma team is necessary for an injured patient
This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**C-Spine Clearance Algorithm**

See 22. Trauma Management Pathway
For Alert (Glasgow Coma Scale score = 13) and Stable Trauma Patients
Where Cervical Spine (C-Spine) Injury is a Concern

Perform Manual in-Line Stabilization of the C-Spine
Maintain and support ABCs

(Canadian & Nexus C-Spine Rules available in MDCalc)
- Age ≥ 65 Years
- Glasgow Coma Scale score of 14 or less
- Decreased alertness secondary to intoxication
- Disorientation to person, place, time, or events
- Inability to remember 3 objects at 5 minutes
- Delayed or inappropriate response to external stimuli
- Any focal deficit on motor or sensory examination or paraesthesia in extremities

**NO**

- Midline Neck Pain
- Midline C-spine Tenderness (C1 – T1)
  Provide immediate adequate analgesia

**NO**

- Able to Actively Rotate Neck
  45° Left and Right Without Pain?
The doctor should allow the patient to perform the above movement while maintaining in-line stabilization without moving the patient’s neck

**NO**

- Radiography Necessary
  Document clearly in patient’s clinical notes
  successful completion of ALL the above steps

**YES**

- Perform C-spine immobilization with the patient flat on a trolley with Head Blocks or Blanket Rolls strapped to the patient’s head and trolley. **DO NOT APPLY A C-COLLAR**
- Keep patient immobilized as above **UNTIL** patient is reviewed and C-spine is cleared by the **ED doctor / Orthopaedic surgeon**
- Order **ALL 3 views** C-spine X-rays;
  - a cross-table lateral view - must be of good quality and adequately visualize the base of the occiput to the upper part of T1.
  - an anteroposterior view - must reveal the spinous processes of C2 to C7 and up to C7-T1
  - an open-mouth view to visualize the odontoid process of C2. Must visualize the entire dens and the lateral masses of C1.

**DO NOT INTERPRET INADEQUATE IMAGES**

- Obtain **CT C-spine IF**;
  - patient is to receive an immediate CT head. **No** c-spine X-rays are required initially
  - X-rays are **inadequate**
  - patient has **persistent symptoms** despite analgesia and negative X-rays
  - pathology is noted on c-spine X-rays

Review X-rays and/or CT C-spine images and the patient

C-Spine Cleared on Radiology?

**NO**

- Consult an **Orthopaedic Surgeon**
- Maintain immobilization with the patient flat on a trolley
  with Head Blocks or Blanket Rolls strapped to the patient’s head and trolley

**YES**

Remove Immobilization devices
24. Mild Traumatic Brain Injury Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

See 22. Trauma Management Pathway

Adult in ED with GCS 15

Canadian CT Head Rule available in MDCalc

Assess for:
- Suspected open or depressed skull fracture
- Physical signs of basilar skull fractures (hemotympanum, ‘panda’ eyes, cerebrospinal fluid leakage from the ear or nose, Battle’s sign)
- Vomiting ≥ 2 or more episodes
- Age ≥ 65 years
- Retrograde amnesia ≥ 30 mins
- Dangerous mechanism of injury:
  - Ejection from a motor vehicle
  - Pedestrian struck
  - Fall from a height of > 0.9m or 5 steps
- Coagulopathy, bleeding disorder, or on anticoagulant or anti-platelet agent except aspirin

Any positive finding?

Discharge as below

Obtain Non-Contrast Head CT scan

CT Positive

Consult a Neurosurgeon and assess for admission

Is patient on anticoagulant or anti-platelet agent except aspirin

Yes

No

Discharge as below

- If symptomatic or INR > 3, admit for 24 h observation
- If asymptomatic after 6 h ED observation and INR < 3, discharge with reliable adult
- Close follow-up in out-patient clinic
- Return for repeat CT if new or worsening symptoms

Discharge

A CT interpreted normal by the Radiologist in a neurologically intact person with a normal mental status allows for safe discharge with appropriate instructions and avoids prolonged ER observation or hospital admission. WRITTEN and VERBAL Discharge Instructions (see MINOR HEAD INJURY DISCHARGE ADVICE) must be provided and should include symptoms to expect after a mild TBI, the time course, the overall positive prognosis, activity limitations, and the point at which a patient return to the ED for further testing.
Minor Head Injury Discharge Advice

On returning home it is important that, if possible, you are accompanied by a responsible adult. While unlikely, there is a small risk of developing complications, so if you experience any of the following symptoms in the next few days you should return to ED as soon as possible.

- Loss of consciousness
- New deafness in one or both ears
- Loss of balance or problems walking
- Any weakness in one or both arms or legs
- Any vomiting
- Clear fluid coming out of your ears or nose
- Drowsiness when you would normally be wide awake
- Increasing disorientation
- Problems understanding or speaking
- Blurred or double vision
- Severe headache not relieved by painkillers such as paracetamol
- Bleeding from one or both ears
- Any fits (collapsing or passing out suddenly)
- Inability to be woken

Dos and Don’ts

DO make sure you stay within reach of a telephone and medical help in the next few days
DO have plenty of rest and avoid stressful situations
DO show this factsheet to a friend or family member who can keep an eye on your condition
DO take painkillers such as paracetamol for headaches
DON’T stay at home alone for 48 hours after leaving the hospital
DON’T drink alcohol until you feel better
DON’T take aspirin or sleeping tablets without consulting a doctor
DON’T return to work until you feel ready
DON’T play any contact sport for at least three weeks without consulting your doctor
DON’T return to driving until you feel you have recovered. If in doubt consult your doctor.

While most people recover quickly you may experience some of the following symptoms over the next few days and weeks, which don’t require a return to hospital:

- Headaches
- Feelings of dizziness
- Nausea
- Sensitivity to light or noise
- Sexual difficulties
- Sleep disturbance
- Memory problems
- Thinking and problem-solving
- Irritability
- Restlessness
- Impulsivity and self-control problems
- Difficulties with concentration
- Feeling depressed, tearful or anxious
- Fatigue
- Difficulties

In most cases, these symptoms will resolve themselves within two weeks. However, in some cases, they may persist much longer. Try not to rush back into normal activities, as this may delay recovery. If you still have any symptoms after two weeks we suggest you come back to the ED and take this factsheet with you. It may be possible to seek a referral to a head injury specialist such as a neurologist or neuropsychologist.

For medical advice, contact the Emergency Department on: ________________
25. Bites (Animal & Human), Tetanus & Rabies

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Animal Bites
If rabies is a concern, scrub the wound with soap and water for at least 15 minutes, then rinse and apply a disinfectant (e.g., iodopovidone) as soon as possible after exposure. The use of antibiotics in patients with animal bites is controversial, and some studies have shown little benefit. However, pre-emptive early antimicrobial therapy for 3–5 days is recommended for patients who:
• are immunocompromised;
• are asplenic;
• have advanced liver disease;
• have pre-existing or resultant oedema of the affected area;
• have moderate to severe injuries, especially to the hand or face; or
• have injuries that may have penetrated the periosteum or joint capsule

ALL Human bites should receive:
• prophylactic antibiotics
• consider post-exposure prophylaxis for HIV within 72hrs. The risk associated with bite injuries has not been quantified. The victim is usually at low risk unless the biter’s saliva is contaminated with blood. The risk is greater to the biter if blood is drawn from the victim’s wound because of exposure to mucous membranes.
• Hepatitis B vaccine preferably ≤ 24 hours if not previously immunized

Treatment:
DO NOT SUTURE ANIMAL AND HUMAN BITES. The above wounds should be irrigated copiously, dressed, left open to drain, and examined daily to detect signs of infection. During the first few days after injury, elevation of the injured body part, especially if swollen, accelerates healing. This should be accomplished using a passive method (a sling for outpatients or a tubular stockinet and an intravenous pole for inpatients). ALL infected wounds should be treated. If no signs of infection, delayed primary closure may be done 72 hours after the injury.

Antibiotics
Amoxicillin/Clavulanate 1gm BD x 5-7 days
In Penicillin Allergic Patients:
Clindamycin 300 mg PO QID/600 mg IV TDS OR Azithromycin 500mg PO OD for 3 days
PLUS
Tetanus Toxoid 0.5mg IM

<table>
<thead>
<tr>
<th>Previous doses of Adsorbed Tetanus Toxoid</th>
<th>Clean and minor wounds</th>
<th>All other wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus toxoid</td>
<td>TIG</td>
<td>Tetanus toxoid</td>
</tr>
<tr>
<td>&lt; 3 doses or unknown</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>≥ 3 doses</td>
<td>Only if last dose given ≥10 yrs ago</td>
<td>No</td>
</tr>
</tbody>
</table>

Rabies Post-Exposure Prophylaxis
The WHO rabies exposure categories are:

- Category I: Touching or feeding animals, licks on intact skin
- Category II: Nibbling of uncovered skin, minor scratches or abrasions without bleeding
- Category III: Single or multiple transdermal bites or broken skin with saliva from animal licks, exposure due to direct contact with bats.

Rabies Immunoglobulin (RIG)
No Pre-EP | Pre-EP
---|---
Human Ig - 20U/Kg | None
Equine Ig - 40U/Kg

Rabies Vaccine
No Pre-EP | Pre-EP
---|---

Intradermal (ID)
Recommended sites: left and right deltoids, thigh or suprascapular areas
Days 0, 3, and 7 (2–2–2): injections of two 0.1 ml doses of vaccine at different intradermal sites
One Booster dose (intramuscular or intradermal) at one site on both Days 0 and 3.
OR
One Booster intradermal dose at four sites in one visit.
This consists of four injections of 0.1 ml equally distributed over the left and right deltoids, thigh, or suprascapular areas at a single visit.

Intramuscular (IM)
Dose: 1 vial
Recommended sites: Deltoids, lateral thighs or suprascapular areas that drain into regional lymph glands
Recommended sites for children aged <2 years: the anterolateral thigh
Rabies vaccine should not be administered in the gluteal area, as induction of an adequate immune response is less reliable.
Reduced ‘Essen’ vaccine schedule (1–1–1) on Days 0, 3, 7, and 14 in healthy patients. A fifth dose is recommended for immunocompromised persons, between days 21 and 28.
Zagreb Regimen (2–0–1–0–1) on Days 0, 7, and 21. On day 0, two doses of vaccines are to be injected into two of the deltoid or thigh sites.

Patients bitten by healthy appearing domestic animals may delay rabies post exposure prophylaxis if the animal is quarantined. These animals should be observed for 10 days, and if they show no sign of infection during the observation period they may be released, and the patient does not need to be vaccinated. Signs of infection in an animal include excessive saliva, aggression, paralysis, daytime activity in nocturnal animals, and impaired movement. If the animal shows any signs of infection, the patient should start the vaccination schedule and continue until the animal has been tested at an approved facility.
# Common Venomous Snakes of Kenya

**For all snakebites visit a health facility immediately!**

<table>
<thead>
<tr>
<th>Snake Name</th>
<th>Common Name</th>
<th>Scientific Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eastern Green Mamba</strong></td>
<td>Bitis arietans</td>
<td>Bitis arietans</td>
</tr>
<tr>
<td><strong>Egyptian Cobra</strong></td>
<td>Naja haje</td>
<td>Naja haje</td>
</tr>
<tr>
<td><strong>Forest Cobra</strong></td>
<td>Naja melanoleucus</td>
<td>Naja melanoleucus</td>
</tr>
<tr>
<td><strong>Forest Night Adder</strong></td>
<td>Casinato rhombeatus</td>
<td>Casinato rhombeatus</td>
</tr>
<tr>
<td><strong>Gaboon Viper</strong></td>
<td>Bitis gabonica</td>
<td>Bitis gabonica</td>
</tr>
<tr>
<td><strong>Gold's Tree Cobra</strong></td>
<td>Pseudonaja guttata</td>
<td>Pseudonaja guttata</td>
</tr>
<tr>
<td><strong>Green Bush Viper</strong></td>
<td>Bitis micropsyces</td>
<td>Bitis micropsyces</td>
</tr>
<tr>
<td><strong>Jameson's Mamba</strong></td>
<td>Bitis rhinoceros</td>
<td>Bitis rhinoceros</td>
</tr>
<tr>
<td><strong>Kenya Horned Viper</strong></td>
<td>Bitis kauffeldi</td>
<td>Bitis kauffeldi</td>
</tr>
<tr>
<td><strong>Kenya Montane Viper</strong></td>
<td>Montanoboa kauffeldi</td>
<td>Montanoboa kauffeldi</td>
</tr>
<tr>
<td><strong>Large Brown Splitting Cobra</strong></td>
<td>Monocledops fasciatus</td>
<td>Monocledops fasciatus</td>
</tr>
<tr>
<td><strong>Mount Kenya Bush Viper</strong></td>
<td>Bitis arietis</td>
<td>Bitis arietis</td>
</tr>
<tr>
<td><strong>North East African Carpet Viper</strong></td>
<td>Bitis variola</td>
<td>Bitis variola</td>
</tr>
<tr>
<td><strong>Puff Adder</strong></td>
<td>Bitis atrox</td>
<td>Bitis atrox</td>
</tr>
<tr>
<td><strong>Red Spitting Cobra</strong></td>
<td>Bitis nasicincta</td>
<td>Bitis nasicincta</td>
</tr>
<tr>
<td><strong>Rhombic Night Adder</strong></td>
<td>Bitis rhinocerera</td>
<td>Bitis rhinocerera</td>
</tr>
<tr>
<td><strong>Rough-Scaled Bush Viper</strong></td>
<td>Bitis arietis</td>
<td>Bitis arietis</td>
</tr>
<tr>
<td><strong>Savannah Vine Snake or Twig Snake</strong></td>
<td>Monocledops fasciatus</td>
<td>Monocledops fasciatus</td>
</tr>
<tr>
<td><strong>Small-Scaled Mole Viper</strong></td>
<td>Bitis milii</td>
<td>Bitis milii</td>
</tr>
<tr>
<td><strong>Snouted Night Adder</strong></td>
<td>Bitis arietis</td>
<td>Bitis arietis</td>
</tr>
<tr>
<td><strong>Velvet Green Night Adder</strong></td>
<td>Bitis arietis</td>
<td>Bitis arietis</td>
</tr>
<tr>
<td><strong>Yellow Bellied Sea Snake</strong></td>
<td>Bitis microlepis</td>
<td>Bitis microlepis</td>
</tr>
</tbody>
</table>
Snake Bites

(BIO-KEN SNAKE FARM, +254 718 290 324 for information on correct antivenom. http://www.bio-ken.com/)

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Cytotoxicity (Painful progressive swelling)</th>
<th>Neurotoxicity (Progressive weakness)</th>
<th>Haematotoxicity (Bleeding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important snakes</td>
<td>Puff adder, Gabon viper, Kenya Horned Viper, Rhinoceros Viper, Red Carpet Viper, Ashe’s Spitting Cobra, Black-necked Spitting Cobra, Red Spitting Cobra</td>
<td>Eastern Green Mamba, Jameson’s Mamba, Black Mamba, Egyptian Cobra, Eastern Forest Cobra, Gold’s Tree Cobra</td>
<td>Coastal Boomslang, North East-African Carpet Viper (Echis), Vine Snake, Blanding’s Tree Snake</td>
</tr>
</tbody>
</table>

**Clinical Picture**

**Mild:** slow progressive painful swelling

**Severe:** rapidly progressive swelling and severe pain, ecchymosis, blisters, severe tissue necrosis, abscess formation, pseudo- and true compartment syndrome, nausea and vomiting, hypotension, bleeding tendency, shock, rhabdomyolysis, renal failure

**Painful progressive swelling**

- Ptsosis, diplopia, dilated pupils, difficulties in swallowing, salivation, progressive difficulty breathing, hypoxia

**Progressive weakness**

- Establish IV access
- Give analgesia
- Position the limb at the level of the heart
- Give IV fluid for shock and renal failure
- Treat local complication appropriately

**Bleeding**

- Establish IV access
- Give blood/blood component therapy if indicated
- Heparin, antifibrinolytics, thrombolytics are of no value and may be dangerous

**Indications for Antivenom**

**Polyvalent antivenom**

- Swelling progressive at ≥15cm/hr
- Swelling to a knee or elbow from a foot or hand bite within 4 hours
- Swelling of a whole limb by 8 hours
- Swelling threatening the airway
- An associated coagulopathy
- Unexplained dyspnoea in the absence of painful progressive swelling (mambas)
- Paresis in the presence of significant swelling (non-spitting cobras)

**Polyvalent antivenom**

- Triad of (either)
  1. paraesthesia,
  2. excessive salivation/metallic taste and sweating
  3. dyspnoea

**Monovalent antivenom**

- Active bleeding
- Positive 20 MINUTE WHOLE BLOOD CLOTTING TEST (20WBCT)
  - Take 2 ml of blood from the patient and pour it into a new, clean, dry glass test tube.
  - The test tube must be made of glass and NOT plastic. The tube MUST be new. Avoid old tubes that have been washed in detergent/soap.
  - Leave the test tube undisturbed at ambient temperatures for 20 min.
  - After waiting for 20 min gently tilt the test tube.
  - If the blood is all liquid (no clots) then the patient has incoagulable blood.
  - Laboratory evidence of coagulopathy

**Administration of Antivenom:**

- Give the first dose (10ml) of antivenom intravenously at the slow rate of 1-2 ml per minute. Subsequent doses may be injected into a bag of saline drip, no more than 20 ml per 500ml bag to run in 30 mins. Repeat until symptoms resolve. Monitor breathing and other vital signs continuously. Remember not to have the drip running direct into the wounded limb which is already in danger from the pressure of swelling and should be kept elevated and well protected.

- Remember to have adrenaline (1:1,000) at the bedside in case of anaphylaxis. If the patient has known allergies (asthma etc.), draw up the adrenaline (0.3 - 0.5 ml for adults and 0.1 - 0.3 for children) and have antihistamine available in case allergic symptoms are overwhelming. Antihistamine is NOT recommended as routine treatment for snakebite.

- Monitor breathing and other vital signs continuously.

- DO NOT infiltrate the bite area with antivenom.
26. Burns Resuscitation Pathway (Assessment)

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

SAMPLE HISTORY
Signs and Symptoms
Allergies
Medication
Past Medical History/Pregnancy
Last meal
Events preceding presentation

ACTIVATE THE TRAUMA TEAM (see Trauma Team Activation Criteria)

Primary Survey (C-ABCDE)
• C-Spine – If suspected trauma, Cleared Clinically (see)? Perform Manual In-Line Stabilization (MILS) then apply Head Blocks or Blanket Rolls taped to the patient's head and trolley. DO NOT APPLY A C-COLLAR
• Airway – Open? Maintainable? Intubate? Indications for intubation include presence of pharyngeal burns, air hunger, stridor, carbonaceous sputum and hoarseness, unconscious patients, hypoxic patients with severe smoke inhalation, or patients with flame or flash burns involving the face and neck.
• Breathing – Rate? SPO2? Air entry bilaterally?
• Disability – GCS? Pupils? RBS?
• Expose patient

<table>
<thead>
<tr>
<th>1st Degree Burns</th>
<th>2nd Degree Burns</th>
<th>3rd Degree Burns (Full Thickness Burns)</th>
<th>4th Degree Burns</th>
<th>5th Degree Burns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidermis only</td>
<td>Epidermis + Upper ¼ of Dermis</td>
<td>Full Epidermis + Dermis are destroyed leaving no cells to heal</td>
<td>Muscle involvement</td>
<td>Bone involvement - Especially in epileptics who convulse during burning</td>
</tr>
<tr>
<td>Commonly caused by UV light or very short flash or flame exposure</td>
<td>Commonly caused by scald, flame, chemicals, oil &amp; grease</td>
<td>Commonly caused by scald, steam, flame, chemicals, oil, grease &amp; high voltage electricity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin is red, dry &amp; hypersensitive</td>
<td>Red, moist, weeping, cob blisters that blanche with pressure</td>
<td>Grey to charred &amp; black, insensate, contracted, pale, leathery tissue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No treatment except analgesia</td>
<td>Painful - due to nerve exposure, &amp; heals from 7-14days</td>
<td>Severe scarring &amp; high risk of contractures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaves no scarring on healing</td>
<td>Leaves no scarring on healing but there is potential pigmented changes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Body Surface Area (TBSA) Burn Estimation

<table>
<thead>
<tr>
<th>Lund and Browder Charts for area of body burn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnt area</td>
</tr>
<tr>
<td>Head</td>
</tr>
<tr>
<td>Neck</td>
</tr>
<tr>
<td>Trunk (front)</td>
</tr>
<tr>
<td>Trunk (back)</td>
</tr>
<tr>
<td>Arm (right)</td>
</tr>
<tr>
<td>Arm (left)</td>
</tr>
<tr>
<td>Hand (right)</td>
</tr>
<tr>
<td>Hand (left)</td>
</tr>
<tr>
<td>Shoulder (right)</td>
</tr>
<tr>
<td>Shoulder (left)</td>
</tr>
<tr>
<td>Total burn area</td>
</tr>
</tbody>
</table>

Do not include first degree burns in the calculation of % TBSA. The surface area of a patient's palm (including fingers) is roughly 1% of TBSA. Palmar surface can be used to estimate relatively small burns (< 15% of total surface area) or very large burns (> 85%, when unburnt skin is counted). For medium-sized burns, it is inaccurate.
Burns Resuscitation Pathway (Resuscitation)

CONSULT A SURGEON IMMEDIATELY AS YOU BEGIN RESUSCITATION OF ANY BURNS PATIENT WITH 3RD OR 4TH DEGREE BURNS AND CIRCUMFERENTIAL BURNS (also see Trauma Team Activation Criteria)

C — If suspected C-Spine trauma and NOT cleared clinically, Head Blocks or Blanket Rolls strapped to the patient’s head and trolley?

A — Rapid Sequence Intubation? Avoid succinylcholine in patients with burns > 24hrs due to risk of hyperkalaemia. Indications for intubation include presence of pharyngeal burns, air hunger, stridor, carbonaceous sputum and hoarseness, unconscious patients, hypoxic patients with severe smoke inhalation, or patients with flame or flash burns involving the face and neck.

B — Supplementary Oxygenation? If suspected carbon monoxide poisoning (restlessness, headache, nausea, poor co-ordination, memory impairment, disorientation, or coma), give 100% oxygen via a Non-Rebreather mask at 15L/min for 24 hrs

C — Control Active Bleeding

Do not include first degree burns in the calculation of % TBSA

— Patients with < 10% TBSA burns can be resuscitated orally (unless the patient has an electrical injury or associated trauma). This needs ongoing evaluation and the patient may still require an IV line.

— Patients with burns involving > 20% of TBSA will require intravenous fluid resuscitation. Insert 2 large bore IV/IO lines and give appropriate fluid resuscitation (RL/NS/whole blood). Parkland Formula (available in MDCalc) — Total fluids over 24hrs = 4ml/kg/%TBSA. Give ½ of this volume within the first 8hrs of the burns then the next ½ over the next 16hrs + maintenance fluid for children < 30 kg. Aim for a urine output of 1 ml/kg/hour in children younger than 2 years (or who weigh < 30 kg) and 0.5 ml/kg/hour in adults and older children. If urine output is not adequate, increase fluids for the next hour to 150% of calculated volume until urine output is adequate.

High-voltage electrical injury causes significant muscle injury, so formulas for fluid resuscitation based on percentage of body surface area burned are not applicable. Aggressive fluid resuscitation to maintain adequate urine output (1.0-1.5 ml/kg per hour) should be initiated until the urine is clear of myoglobin (urinary dipstick positive for blood with no red cells in the sediment). Acute myoglobinuric renal failure with life-threatening consequences can occur if fluid resuscitation is delayed.

— GXM and request adequate supplementary blood and blood products if necessary

D — Correct Hypoglycaemia – 50mls 50% Dextrose IV

— Give appropriate analgesia e.g. Fentanyl 1μg/kg IV (see Analgesia Chart); Consider procedural sedation with Ketamine for wound dressing (see 44. Procedural Sedation and Analgesia (PSA))

E — Check temperature and provide warmth to the patient

— Cool any burns < 3 hours old with cold tap water for at least 30 minutes and then dry the patient. In patients undergoing external cooling who have burns covering ≥ 10% of TBSA, monitor body temperature for hypothermia.

— Remove all clothes, jewellery, necrotic tissue & debris

— Wash wound with mild soap and tap water

— DO NOT BURST BLISTERS. Blisters left intact heal faster and become infected less often.

Secondary Survey (Head-to-Toe Survey) and Other Considerations

• In neck burns, a pillow is placed under the patient’s head to hyperextend the neck at the shoulders to prevent contractures

• Chest wall burns - Do a checker-box release - consult a Surgeon

• Upper limb burns should be nursed elevated at 45°

• Evaluate 3rd & 4th Degree Burns and circumferential burns for possible escharotomy, consult a Surgeon

• Give Tetanus Toxoid.

• Topical antimicrobial agents or bioengineered substitutes should be applied to all clean, debrided wounds except superficial burns. Prophylaxis with systemic antibiotics is currently NOT RECOMMENDED for patients with severe burns other than perioperatively.

Disposition

Minimum criteria for transfer to a burns centre (Modified from the Australian and New Zealand Burn Association (ANZBA) protocol)

Burn injury patients who should be referred to a burn unit include the following:

• All burn patients less than 1 year of age

• All burn patients from 1-2 years of age with burns > 5% total body surface area (TBSA)

• Patients in any age group with third-degree burns of any size

• Patients older than 2 years with partial thickness burns greater than 10% TBSA

• Patients with burns of special areas – face, hands, feet, genitalia, perineum or major joints

• Patients with electrical burns, including lightning burns. Admit patients with history of loss of consciousness, documented arrhythmias either before or after arrival to the ED (including cardiac arrest), ECG evidence of ischemia, or high-voltage electrical injury

• Chemical burn patients

• Patients with inhalation injury resulting from fire or scald burns

• Patients with circumferential burns of the limbs or chest

• Burn injury patients with pre-existing medical disorders that could complicate management, prolong recovery or affect mortality

• Any patient with burns and concomitant trauma

• Paediatric burn cases where child abuse is suspected

• Burn patients with treatment requirements exceeding the capabilities of the referring centre

• Septic burn wound cases
27. Post Rape Care (PRC) Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

This algorithm should be used with reference to the documents in the latest National Guidelines on Management of Sexual Violence in Kenya available at www.emergencymedicinekenya.org/rape

**RAPE SURVIVOR**

- Assess, monitor and support ABCs. Monitor vital signs. Get same sex chaperone.
- Fill PRC Consent form.
- Fill PART A of PRC form in triplicate.
- As you examine the patient, collect specimens as detailed below and store them in a secure locked cupboard.
- Put all clothes in BROWN PAPER BAGS (NOT PLASTIC) and label with patient details.
- Give STAT PEP within 72hours.
  - TDF/3TC (300/300mg) 1tab OD + ATV/r (300/100mg)
  - AZT (300mg) can be used when TDF cannot be used. Do NOT delay PEP administration by awaiting lab results.
- Order investigations as PART A of PRC form and fill in results: HIV (do pre-test counselling).

**Treatment**

2. PEP within 72hours (ONLY IF ACCEPTS HIV TESTING)
   - TDF/3TC (300/300mg) 1tab OD + ATV/r (300/100mg) with food 3-tab OD for 28 days.
   - AZT (300mg) can be used when TDF cannot be used. Do NOT delay PEP administration by awaiting lab results.
3. Emergency Contraception within 120 hours (females 15-49 years)
   - Levonorgestrel 0.75mg - 2 tabs stat
4. STI Prevention:
   - I.M Ceftriaxone 250mg stat or PO Cefixime 400mg stat + PO Azithromycin 1g stat + PO Tinidazole/Metronidazole 2g stat. Tinidazole/Metronidazole can be deferred to be taken at home if alcohol ingested or given emergency contraceptives.
   - PO Doxycycline 100mg BD for 14 days + Ciprofloxacin 500mg stat + Tinidazole 2g stat.
5. Hepatitis B Vaccination (If not previously vaccinated and not known HBV positive) should be offered within 14 days.
   - I.M 1.0 mls Hepatitis B vaccine at 0, 1 & 6 months.
6. Tetanus Prophylaxis (Do not give TT if the survivor has received 3 or more doses previously and the last dose is within 5 years)
   - I.M 0.5 mls of T.T stat
7. HPV vaccine females 9-26 years and males 9-21 years.
   - I.M Cervarix 0.5 mls at 0, 1 & 6 months
   - Gardasil®9 at 0, 2 & 6 months
   - Levonorgestrel 0.75mg - 2 tabs stat
8. Refer for IMMEDIATE VOLUNTARY COUNSELLING BEFORE DISCHARGE. The Counsellor MUST complete PART B of PRC form.

**CONTACT THE KENYA POLICE TO COLLECT ALL SPECIMENS & CLOTHES (MUST BE IN LABELLED BROWN PAPER BAGS (NOT PLASTIC))

**Treatment**

1. Emergency Contraception within 120 hours (females 15-49 years)
   - Levonorgestrel 0.75mg - 2 tabs stat
2. STI Prevention:
   - I.M Ceftriaxone 250mg stat or PO Cefixime 400mg stat + PO Azithromycin 1g stat + PO Tinidazole/Metronidazole 2g stat. Tinidazole/Metronidazole can be deferred to be taken at home if alcohol ingested or given emergency contraceptives.
   - PO Doxycycline 100mg BD for 14 days + Ciprofloxacin 500mg stat + Tinidazole 2g stat.
3. Hepatitis B Vaccination (If not previously vaccinated and not known HBV positive) should be offered within 14 days.
   - I.M 1.0 mls Hepatitis B vaccine at 0, 1 & 6 months.
4. Tetanus Prophylaxis (Do not give TT if the survivor has received 3 or more doses previously and the last dose is within 5 years)
   - I.M 0.5 mls of T.T stat
5. HPV vaccine females 9-26 years and males 9-21 years.
   - I.M Cervarix 0.5 mls at 0, 1 & 6 months
   - Gardasil®9 at 0, 2 & 6 months
6. Refer for IMMEDIATE VOLUNTARY COUNSELLING BEFORE DISCHARGE. The Counsellor MUST complete PART B of PRC form.

**On discharge:**

- Confirm PART A & B of PRC form are filled. Attach blue copy to patient’s file and give white copy to patient. Leave the green copy in the PRC booklet.
- Confirm patient understands drug regimen.
- Give patient belongings in well-labelled brown bag.
- Nearest Gender Based Violence Recovery Centre (GBVRC) booking in one week.
- Give patient discharge summary with all the follow-up dates as listed above.

**Follow-up**

- Counselling. Trauma counselling in 2, 4, 6 and 12 weeks + Adherence counselling.
- Gender Based Violence Recovery Centre (GBVRC) for PEP follow-up at 7, 14 and 28 days.
- Repeat CBC, ALT, CR in 2 weeks, PTD in 4 weeks, HIV test in 4, 12 & 24 weeks.
- HIV care clinic if HIV positive.

**On discharge:**

- Confirm PART A & B of PRC form are filled. Attach blue copy to patient’s file and give white copy to patient. Leave the green copy in the PRC booklet.
- Confirm patient understands drug regimen.
- Give patient belongings in well-labelled brown bag.
- Nearest Gender Based Violence Recovery Centre (GBVRC) booking in one week.
- Give patient discharge summary with all the follow-up dates as listed above.

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- Counselling. Trauma counselling in 2, 4, 6 and 12 weeks + Adherence counselling.
- Gender Based Violence Recovery Centre (GBVRC) for PEP follow-up at 7, 14 and 28 days.
- Repeat CBC, ALT, CR in 2 weeks, PTD in 4 weeks, HIV test in 4, 12 & 24 weeks.
- HIV care clinic if HIV positive.
28. Hypoglycaemia Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Hypoglycaemia (RBS < 3.3 mmol/L)**

- Monitor, support ABCs
- Check vital signs (BP, PR, RR, SPO₂, T°C)
- Start Oxygen if SPO₂ < 94%. Maintain SPO₂ ≥ 94%

**Able to tolerate PO**

- Give 15gm of simple carbohydrate PO
  - AND/OR
  - A full complex starchy carbohydrate meal e.g. rice, ugali, wholemeal

**IV Access**

- **50mls 50% Dextrose IV**
  - As soon as IV access is available, give 50mls 50% Dextrose IV

**No IV Access**

- **Glucagon 1mg SC or IM**
  - Treat underlying cause
  - Provide patient with a full complex starchy carbohydrate meal e.g. rice, ugali, wholemeal
  - OR
  - Begin a continuous IV infusion of 10% Dextrose at 110mls/hr
  - Maintain blood glucose level above 4.4 mmol/L
  - Consider thiamine 100mg IV for malnourished and alcoholic patients followed by 100mg PO BD for 6 weeks
  - Consult a Physician appropriately

*Dextrose Rule of 50*

**How to correct hypoglycaemia:**

- Neonate 5 ml/kg of 10% Dextrose (10×5=50)
- Infant 2 ml/kg of 25% Dextrose (25×2=50)
- Older child or Adult 1 ml/kg of 50% Dextrose (50×1=50)

**How to make different Dextrose solutions:**

- 50 ml of 50% Dextrose + 50 ml NS = 25% Dextrose
- 50 ml of 50% Dextrose + 150 ml NS = 12.5% Dextrose
29. Hyperglycaemia Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Hyperglycaemia (RBS > 14mmol/L)

- Monitor, support ABCs
- Check vital signs (BP, PR, RR, SPO2, T°C)
- Start Oxygen IF SPO2 < 94%. Maintain SPO2 ≥ 94%
- Establish IV Access and send samples for Serum Ketones, Venous Blood Gas (VBG)*, UEC and Urinalysis
- Obtain review 12-lead ECG (if indicated)
- Perform brief, targeted, history and physical exam
- **DO NOT GIVE INSULIN**

*ABG Analysis available in MDCalc. A VBG often correlates well with ABG findings (except for PaO2) unless values are extremely abnormal

Normal VBG +
Serum Ketones < 1.5 mmol/L +
Serum Osmolality < 320mOsm/kg

No

Go to
30. Diabetic Ketoacidosis/Hyperosmolar Hyperglycaemic State (HHS) Algorithm

Yes

Uncomplicated Hyperglycaemia

Identify and Treat precipitating illness; consider ACS, Sepsis

Known Diabetic

Newly Diagnosed Diabetic

- Confirm compliance with medication
  - If not compliant, resume previous regimen
  - If compliant, optimize dosages
- Advice on lifestyle Modification
- Review RBS daily at nearest facility and keep record
- Review in out-patient medical clinic after 5 days
- Refer to Diabetic clinic if poorly controlled

- Lifestyle modification advice
- Start on Metformin as below
  - Begin with low-dose metformin - 500 mg BD with meals (breakfast and/or dinner).
  - Review RBS daily at nearest facility and keep record
  - Review in out-patient medical clinic after 5 days
  - After 5–7 days, if GI side effects have not occurred, advance dose to 850mg or 1gm before breakfast and dinner.
  - If GI side effects appear as doses advanced, can decrease to previous lower dose and try to advance dose later.
  - The maximum effective dose is usually 850 mg BD, with modestly greater effectiveness with doses up to 3 g per day. GI side effects may limit the dose that can be used.

- Refer to Diabetic clinic
30. Diabetic Ketoacidosis (DKA) / Hyperosmolar Hyperglycaemic State (HHS) Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

1. Fluid Protocol
   - (Ringer’s Lactate)
   - If Hypovolaemic Shock, give fluid boluses at 15 to 20mL/kg; Repeat until BP stable. Consider inotropes if no response to fluid resuscitation.
   - If Hypovolaemic but No Shock; Give 15 - 20 mL/Kg/hr Ringer’s Lactate
   - DO NOT give > 50 mL/kg of isotonic solution in the first 4 hours of treatment because of the risk of cerebral oedema.
   - If CORRECTED serum sodium is < 135 mmol/L, continue treatment with 0.45% NaCl instead of Ringer’s Lactate at 250-500 mL/hour
   - If CORRECTED serum sodium is ≥ 135 mmol/L, continue treatment with 0.45% NaCl instead of Ringer’s Lactate at 250-500 mL/hour
   - Success in fluid therapy is reflected by an improvement in hemodynamic and hydration status and pH values, a satisfactory urine output of 1 to 2 mL/kg/hour, and clinical progress.

2. Potassium Protocol
   - DO NOT give potassium if patient is anuric or serum K+ > 5.3 mmol/L
   - Serum K+ (mmol/L)
     - > 5.3: DO NOT give K+, but check potassium levels hourly and start replacement when K+ < 5.3 mmol/L
     - 3.3 to 5.3: Add 20-30 mmol K+/1L fluid/hour to IV fluids until K+ > 4.0-5.0 mmol/L range
     - < 3.3: Hold insulin. Add 20-30 mmol K+/1L fluid/hour. Continuous cardiac monitoring until K+ > 3.3 mmol/L

3. Insulin Protocol
   - DO NOT give insulin until you have K+ levels > 3.3 mmol/L
   - Give 0.14u/kg/hr IV Infusion
     - Hourly RBS monitoring
     - Target RBS drop 3-4 mmol/L/hr
     - If the RBS does not fall by 3-4 mmol/L/hr, give a bolus of 0.14u/kg IV and continue with the infusion
     - Change IV fluid infusion to 5 % Dextrose with 0.45% NaCl at 150-250mL/hr
     - Decrease insulin to 0.02-0.05u/kg/hr IV Infusion
     - Maintain glucose between 8.3 – 11.1 mmol/L (DKA)/13.9 - 16.7 mmol/L (HHS) and continue insulin infusion and fluid hydration until ketosis or hyperosmolality resolves

Venous Glucose reaches < 11.1 mmol/L (DKA) < 16.7 (HHS)

Useful formulas in DKA (available in MDCalc)
- Anion gap = Na+ - ([Cl- + HCO3-])
- Serum sodium correction = Na+ measured + 1.6 X (Glucose - 5.6) (all values in mmol/L)
- Serum potassium correction during acidemia = [K+] - (0.6 mmol/L X (7.4 - measured pH) X 10)
- Serum osmolality (mOsm/L) = 2 [(Na+ + K+) (mmol/L) + Glucose (mmol/L) + BUN (mmol/L)]
- Total body water deficit (L) = 0.6 men/children or 0.5 women X body weight (kg) X [serum Na+ /140 - 1]
31. Electrolyte Abnormalities Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

- Monitor, support ABCs
- Check vital signs (BP, PR, RR, SPO2, T° C, RBS)
- Start Oxygen if SPO2 < 94%. Maintain SPO2 ≥ 94%
- Establish IV Access and send blood samples for FBC, UEC
- Obtain/review 12-lead ECG for K⁺ abnormalities
- Perform brief, targeted history, physical exam

<table>
<thead>
<tr>
<th>Hyponatraemia (&lt; 130 mmol/L)</th>
<th>Hypernatremia (&gt; 150 mmol/L)</th>
<th>Hypokalaemia (&lt; 3 mmol/L)</th>
<th>Hyperkalaemia (&gt; 5.5 mmol/L)</th>
</tr>
</thead>
</table>

For hypotensive patients, give NS 20 mL/kg bolus and repeat until vital signs are stable.

Consult a Physician for ALL Patients

For patients with severe symptoms (vomiting, cardiorespiratory distress, abnormal or deep somnolence, seizures or coma (GCS ≤ 8) (usually in the 100 to 110 mmol/L range), regardless of whether hyponatraemia is acute or chronic: Start IV infusion of 150 ml 3% hypertonic saline over 20 min. Repeat infusion checking the serum sodium concentration every 20 min until a target of 5 mmol/L increase in serum sodium concentration is achieved or until the symptoms improve, whichever comes first.

Consider using weight-based (2 ml/kg) rather than the fixed 150 ml infusion volumes of 3% hypertonic saline in case of obviously deviant body composition. Keep in mind that if hypokalaemia is present, correction of the hypokalaemia will contribute to an increase in serum sodium concentration.

Do not expect patients with severe symptoms to completely recover immediately, as it may take some time for the brain to fully recover.

For hypotensive patients, give RL 20 mL/kg bolus and repeat until vital signs are stable.

Consult a Physician for ALL Patients

After the patient is stabilized, change fluids to D5 ½ NS to provide for maintenance requirements and ongoing losses.

For hypotensive patients, give RL 20 mL/kg bolus and repeat until vital signs are stable.

Mild-Moderate hypokalaemia (2 - 3 mmol/L)

Patients who have mild or moderate hypokalaemia may need only oral potassium replacement therapy if nausea or vomiting is not the cause of the hypokalaemia.

Giving 40 to 60 mmol of elemental potassium orally every 2 to 4 hours for 3 days.

Severe hypokalaemia (< 2mmol/L)

Give 40 mmol K⁺ in 1L RL over 1 hour with continuous ECG monitoring.

Additionally, restoration of normokalaemia relies on the establishment of normomagnesemia as both K⁺ and Mg²⁺ co-transport in the kidney.

Give 2gm magnesium sulphate along with potassium replacement.

Consult a Physician for ALL Patients

For hypotensive patients, give NS 20 mL/kg bolus and repeat until vital signs are stable.

Give calcium to protect the heart (not bind K⁺)

Give 10mls 10% CaCl₂ (6.8mmol) over 10mins

OR

30mls 10% Calcium Gluconate (6.6mmol) over 10mins

1. Check RBS. If RBS < 14mmol/L, give 50mls 50% dextrose IV bolus
2. Then give 10units soluble insulin IV bolus

Repeat 1 & 2 above if repeat K⁺ is > 5.5 mmol/L

Re-check RBS hourly

Nebulise Salbutamol 10 to 20 mg in 4 ml of NS over 10 minutes - 25-40% of patients do not respond secondary to tachyphylaxis.

Serum potassium will be lowered approximately 10 to 30 minutes after the above measures are performed, and the effect will last for 2 to 6 hours.

Consult a Physician for ALL Patients

emergencymedicinekenya.org
32. Sepsis & Septic Shock Diagnostic Criteria
(SOFA and qSOFA Scores available on MDCalc)

---

**A) Sequential [Sepsis-Related] Organ Failure Assessment Score**

<table>
<thead>
<tr>
<th>System</th>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(P_{a}O_2/FIO_2) mm Hg</td>
<td></td>
<td>(\geq 400)</td>
<td>(&lt; 400)</td>
<td>(&lt; 300)</td>
<td>(&lt; 200) with respiratory support</td>
<td>(&lt; 100) with respiratory support</td>
</tr>
<tr>
<td>Coagulation</td>
<td></td>
<td>(\geq 150)</td>
<td>(&lt; 150)</td>
<td>(&lt; 100)</td>
<td>(&lt; 10)</td>
<td>(&lt; 0)</td>
</tr>
<tr>
<td>Liver</td>
<td></td>
<td>(1.2-2.0)</td>
<td>(2.0-3.0)</td>
<td>(3.0-4.0)</td>
<td>(4.0-6.0)</td>
<td>(&gt; 6.0)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td>(\geq 70)</td>
<td>(&lt; 70)</td>
<td>(\geq 80)</td>
<td>(\geq 90)</td>
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<tr>
<td>Central nervous system</td>
<td></td>
<td>(15)</td>
<td>(13-14)</td>
<td>(12-13)</td>
<td>(10-11)</td>
<td>(&lt; 10)</td>
</tr>
<tr>
<td>Renal</td>
<td></td>
<td>(1.2-1.9)</td>
<td>(1.9-2.5)</td>
<td>(2.5-3.1)</td>
<td>(3.1-3.7)</td>
<td>(&gt; 3.7)</td>
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<tr>
<td>Urine output, ml/d</td>
<td></td>
<td>(&lt; 500)</td>
<td>(&lt; 200)</td>
<td>(&lt; 150)</td>
<td>(&lt; 100)</td>
<td>(&lt; 70)</td>
</tr>
</tbody>
</table>

*Adapted from Vincent et al.*

---

The baseline Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score should be assumed to be zero unless the patient is known to have preexisting (acute or chronic) organ dysfunction before the onset of infection. qSOFA indicates quick SOFA; MAP, mean arterial pressure.
**Sepsis & Septic Shock Algorithm**

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

See 32. Sepsis & Septic Shock Diagnostic Criteria

---

**TO BE COMPLETED WITHIN 1 HOUR OF IDENTIFICATION OF SEPSIS/SEPTIC SHOCK**

- Monitor, support ABCs
- Check vital signs (BP, PR, RR, SPO₂, T°C, RBS)
- Start Oxygen IF SPO₂ < 94%. Maintain SPO₂ ≥ 94%
- Establish IV Access and send samples for FBC, MPS, LFTs, UEC, VBG, Serum lactate
- Perform brief, targeted history, physical exam
- Obtaining appropriate cultures before antimicrobial therapy is initiated if such cultures do not cause significant delay in the start of antimicrobial(s). Draw 2 sets of blood cultures 10mL each (both aerobic and anaerobic bottles) from different sites.
- Administer 30mL/kg NS or RL for Hypotension or Lactate ≥ 2 mmol/L
- Give ANTIBIOTICS
  - Ceftriaxone 2gm IV stat
  - For probable Neutropenic patients or if patient has been admitted in hospital in the last 3 months (Hospital Acquired Infection)
    - Imipenem 500 mg IV infusion over 3 hrs then QID for general sepsis
    - Meropenem 1gm IV infusion over 3 hrs then TDS for possible CNS infections
- Give antipyretic if indicated (Paracetamol 1gm IV)
- Obtain cultures before antimicrobial therapy is initiated if such cultures do not cause significant delay in the start of antimicrobial(s).
- CXR; Urinalysis + MCS; ? Stool MCS; ? CSF MCS
- Monitor urine output hourly

---

Repeat vital signs (BP, MAP, PR, RR, SPO₂, T°C, Serum lactate) after 1 hour

**Features of SHOCK despite adequate fluid resuscitation (> 30ml/kg)?**
- MAP < 65mmHg
- Signs of Shock (tachypnoea, cool clammy skin, cool peripheries, hypotensive, tachycardia)
- Urine output < 0.5mL/kg/hour
- Hyperlactatemia (> 2 mmol/L)

---

**SEPTIC SHOCK**

- Consult a Physician and continue with the algorithm
- Start peripheral vasopressors if MAP < 65mmHg in the face of life-threatening hypotension, even when hypovolemia has not yet been resolved - Norepinephrine (0.1–1.3 µg/kg/min) and/or Adrenaline (0.05-0.3µg/kg/min).
- Titrate vasopressors to a MAP ≥ 65 mmHg to preserve tissue perfusion.

---

**Hemodynamic stability achieved with adequate fluid resuscitation (> 30ml/kg) and vasopressor therapy?**
- MAP ≥ 65mmHg
- Signs of shock as above
- Urine output < 0.5mL/kg/hour
- Hyperlactatemia (> 2 mmol/L)

---

**Admit HDU/ICU**

---

**Evidence of tissue hypo perfusion persists despite adequate intravascular volume and adequate MAP?**
- Hyperlactatemia (> 2 mmol/L)
- Decreased capillary refill or mottling

---

**Admit HDU/ICU**

---

**Give Dobutamine infusion up to 20 µg/kg/min (+ vasopressor if in use) in the presence of:**
- myocardial dysfunction as suggested by elevated cardiac filling pressures and low cardiac output, or
- ongoing signs of hypo perfusion, despite achieving adequate intravascular volume and adequate MAP

---

**Consult a Physician**

Consider Admission

---

**Admit HDU/ICU**

---

**Give Hydrocortisone 200mg IV bolus**
# 33. Antimicrobial Guide

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

For detailed guidelines and other conditions not listed below, refer to your hospital’s guidelines for antimicrobial use.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comments/Caveats</th>
<th>Recommended Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>URTI/Sinusitis</td>
<td>The most common cause of URTIs is viral and thus no antibiotics are necessary.</td>
<td>Amoxicillin/Clavulanate 1gm PO BD x 5-10 days is the first-line therapy for most adults who meet the criteria for ABRS</td>
</tr>
<tr>
<td></td>
<td>A clinician should diagnose Acute Bacterial Rhinosinusitis (ABRS) when</td>
<td>In Penicillin-Allergic Patients: Azithromycin 500mg PO OD x 3 days</td>
</tr>
<tr>
<td></td>
<td>a) symptoms or signs of Acute Rhinosinusitis (ARS) (purulent nasal drainage</td>
<td>Supportive therapy;</td>
</tr>
<tr>
<td></td>
<td>accompanied by nasal obstruction, facial pain/pain/pressure/fullness, or both)</td>
<td>• Decongestants (α-adrenergic) - xylometazoline hydrochloride for 3 days</td>
</tr>
<tr>
<td></td>
<td>persist without evidence of improvement for at least 10 days beyond the onset of</td>
<td>• Saline irrigation - Nasal saline irrigation, alone or in conjunction with other</td>
</tr>
<tr>
<td></td>
<td>upper respiratory symptoms or</td>
<td>adjunctive measures, may improve quality of life, decrease symptoms, and decrease</td>
</tr>
<tr>
<td></td>
<td>b) symptoms or signs of ARS worsen within 10 days after initial improvement (double</td>
<td>medication use for ABRS, particularly in patients with frequent sinusitis.</td>
</tr>
<tr>
<td></td>
<td>worsening).</td>
<td>• Mucolytics</td>
</tr>
<tr>
<td></td>
<td><strong>DO NOT ORDER A CT SCAN TO DIAGNOSE SINUSITIS</strong></td>
<td>• Antihistamines have no role in the symptomatic relief of ABRS in non-atopic patients.</td>
</tr>
<tr>
<td>Pharyngitis/Tonsillitis</td>
<td>The most predictable clinical parameter for GABHS pharyngitis is reported to be</td>
<td>Adult patients with acute exudative adult pharyngitis who report ≥ 4 Centor Score ONLY</td>
</tr>
<tr>
<td></td>
<td>the Centor Score (available on MDCalc)</td>
<td>Benzaathine penicillin G 1.2MU IM stat</td>
</tr>
<tr>
<td></td>
<td>a) Age &lt; 15 years (+1) or ≥ 45 years (-1)</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>b) History of fever &gt; 38°C</td>
<td>Amoxicillin/Clavulanate 1gm PO BD x 5-10 days</td>
</tr>
<tr>
<td></td>
<td>c) Absence of cough</td>
<td>Consider - Single-dose Prednisone 60 mg PO or Dexamethasone 8 mg IM therapy added to</td>
</tr>
<tr>
<td></td>
<td>d) Swollen and tender anterior cervical lymph nodes</td>
<td>the standard treatment has a more rapid improvement of pain in adult patients with</td>
</tr>
<tr>
<td></td>
<td>e) Tonsillar exudates or swelling</td>
<td>acute exudative adult pharyngitis who report ≥ 4 Centor Score</td>
</tr>
<tr>
<td>Pharyngitis/Tonsillitis</td>
<td><strong>DO NOT ORDER A CT SCAN TO DIAGNOSE SINUSITIS</strong></td>
<td>Patients who are allergic to Penicillin</td>
</tr>
<tr>
<td>Laryngitis</td>
<td>Mostly viral</td>
<td>Azithromycin: 500 mg PO on day 1 followed by 250 mg PO OD for 4 days</td>
</tr>
<tr>
<td>Acute Gastroenteritis</td>
<td>Any diarrhoeal illness lasting &gt; 1 day, especially if accompanied by the following</td>
<td><strong>No Antibiotics necessary</strong></td>
</tr>
<tr>
<td></td>
<td>features should prompt evaluation of a faecal specimen;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• bloody diarrhoe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• moderate-severe disease (systemically ill/toxic appearing patients)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• symptoms lasting &gt;7 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• immunocompromised patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• recent use of antibiotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>A Stool Culture is NOT NECESSARY OR COST-EFFECTIVE</strong> in most cases of diarrhoea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>without systemic disease or dysentery unless an unusual bacterial cause is suspected</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Typhoid - Bone marrow culture is the most sensitive routinely available diagnostic</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>tool. Stool culture is positive only in up to 30-40% of cases but is often</td>
<td></td>
</tr>
<tr>
<td></td>
<td>negative by the time that systemic symptoms bring patients to hospital. Blood</td>
<td></td>
</tr>
<tr>
<td></td>
<td>cultures are positive in 40-80% of patients. Serologic tests e.g. the Widal test</td>
<td></td>
</tr>
<tr>
<td></td>
<td>are of limited clinical utility because positive results may represent a previous</td>
<td></td>
</tr>
<tr>
<td></td>
<td>infection.</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Comments/Caveats</td>
<td>Recommended Therapy</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Urinary Tract Infection (UTI)   | Cloudiness of the urine is most often due to protein or crystal presence, and malodorous urine may be due to diet or medication use. A urinalysis with quantitative urine WBC counts should **NOT be used alone to support a diagnosis of UTI or start antimicrobial therapy** in any patient population.  
  A **negative Leukocyte Esterase AND a negative urine Nitrate** largely rule out infection in pregnant women, elderly patients, family medicine, and urology patients. The combination of a negative leukocyte esterase and negative nitrite test demonstrated a UTI negative predictive value of **88% (95% confidence interval [CI] 84–92%)**.  
  Pyuria in a urine specimen, in the absence of symptoms (**Asymptomatic Bacteriuria**), is **NOT AN INDICATION** for antimicrobial therapy.  
  Urine cultures are **NOT RECOMMENDED** in most cases of uncomplicated UTIs in adult women.  
  **Urinary Cultures ONLY for:**  
  • In patients suspected of having **pyelonephritis**, a urine culture and susceptibility test should always be performed, and initial empiric therapy should be tailored appropriately based on the likely infecting uropathogen.  
  • A urine specimen should be obtained for culture and susceptibility testing before initial antimicrobial therapy for **complicated UTIs**.  
|                                 |                                                                                                                                                                                                                 | **Uncomplicated Cystitis**  
  Ciprofloxacin 500 mg PO BD x 3 days  
  **OR**  
  Nitrofurantoin 100mg TDS x 3 days  

**Uncomplicated Pyelonephritis, Outpatient Therapy**  
Ceftriaxone 1 g IV stat  
**PLUS**  
Ciprofloxacin 500 mg PO BD x 7 days  

**UTI during Pregnancy, Outpatient Therapy**  
Cefuroxime 500 mg PO BD for 7 days  
**OR**  
Nitrofurantoin 100mg TDS x 3 days  

**Complicated UTI**  
Ciprofloxacin 500 mg PO BD x 14 days  

|                                 |                                                                                                                                                                                                                 | **Complicated Pyelonephritis, Inpatient Therapy**  
  Ceftriaxone 1g IV OD 10-14 days  
  **OR**  
  Ciprofloxacin 400 mg IV BD x 10-14 days  

**UTI during Pregnancy, Inpatient Therapy**  
Ceftriaxone 1-2 g IV OD  

| Sepsis & Septic Shock           | See **Sepsis & Septic Shock Algorithm**                                                                                                                                                                           | **Give ANTIBIOTICS as an EMERGENCY** (within the **FIRST HOUR** of recognition of Sepsis/Septic Shock)  
  • Ceftriaxone 2gm IV stat  
  For probable Neutropenic patients or if patient has been admitted in hospital in the last 3 months (Hospital Acquired Infection)  
  • Imipenem 500 mg IV infusion over 3 hrs then QID for **General sepsis**  
  **OR**  
  • Meropenem 1 gm IV infusion over 3 hrs then TDS for possible CNS infections  

|                                 |                                                                                                                                                                                                                 | **See Sepsis & Septic Shock Algorithm**  

---

**Note:**  
- **Urinary Tract Infection (UTI):** Cloudiness of the urine is most often due to protein or crystal presence, and malodorous urine may be due to diet or medication use. A urinalysis with quantitative urine WBC counts **should NOT be used alone to support a diagnosis of UTI or start antimicrobial therapy** in any patient population.  
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  • A urine specimen should be obtained for culture and susceptibility testing before initial antimicrobial therapy for **complicated UTIs**.  

**Complicated UTI**  
- **Male gender**  
- **Structural or functional anatomic abnormalities**  
- Renal stones  
- Indwelling catheters  
- Renal transplant  
- Neurogenic bladder  
- Recent urologic procedure  

**Inpatient therapy**  
- Sepsis  
- Pregnancy  
- Urinary tract obstruction  
- Persistent vomiting  
- Poor outpatient follow-up  

**Sepsis & Septic Shock:** See **Sepsis & Septic Shock Algorithm**  
- **Give ANTIBIOTICS as an EMERGENCY** (within the **FIRST HOUR** of recognition of Sepsis/Septic Shock)  
  • Ceftriaxone 2gm IV stat  
  For probable Neutropenic patients or if patient has been admitted in hospital in the last 3 months (Hospital Acquired Infection)  
  • Imipenem 500 mg IV infusion over 3 hrs then QID for **General sepsis**  
  **OR**  
  • Meropenem 1 gm IV infusion over 3 hrs then TDS for possible CNS infections  

---
Community-Acquired Pneumonia

In addition to a constellation of suggestive clinical features, a demonstrable infiltrate by chest radiograph or other imaging technique, with or without supporting microbiological data, is required for the diagnosis of pneumonia.

The strongest indications for blood cultures are severe CAP and in immunocompromised patients or those with significant co morbidities, as these patients are more likely to be infected with pathogens other than S pneumoniae.

Co morbidities:
- Chronic heart, lung or renal disease
- Diabetes mellitus
- Alcoholism
- Malignancy
- Asplenia
- Immunosuppressant condition or drugs

Inpatient Therapy
- CURB65 ≥ 2 (available in MDCalc)
- Patient factors requiring hospitalization

HCAP risk factors?
- Hospitalization for 2 or more days of the past 90 days
- Resides in nursing home or long-term care facility
- Received chemotherapy, IV antibiotics, or wound care within the prior 30 days
- Attended a hospital or haemodialysis clinic in the last 30 days

Inpatient Treatment
- Amoxicillin/Clavulanate 1.2gm IV T x 7 - 10 days
- PLUS Azithromycin 500mg IV OD x 7 - 10 days

Outpatient Treatment
- Amoxicillin/Clavulanate 1gm PO BD x 7 - 10 days

In Penicillin-Allergic Patients:
- Azithromycin: 500 mg PO on day 1 followed by 250 mg PO OD for 4 days

Healthcare Associated Pneumonia (HCAP)
- Antipseudomonal beta-lactam

Malaria

### Defining Criteria for Severe Malaria

<table>
<thead>
<tr>
<th>Finding</th>
<th>Uncomplicated Malaria</th>
<th>Severe Malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired consciousness (cerebral malaria)</td>
<td>A Glasgow coma score &lt; 11 in adults or a Blantyre coma score &lt; 3 in children</td>
<td>IV Artesunate 2.4mg/kg at 0, 12 and 24 hours and daily until patient can take oral. Children weighing &lt; 20 kg should receive a higher dose of artesunate (3 mg/kg bw per dose) to ensure equivalent exposure to the drug.</td>
</tr>
<tr>
<td>Prostration</td>
<td>Generalized weakness so that the person is unable to sit, stand or walk without assistance</td>
<td></td>
</tr>
<tr>
<td>Multiple convulsions</td>
<td>&gt; 2 episodes within 24 h</td>
<td></td>
</tr>
<tr>
<td>Acidosis</td>
<td>A base deficit of &gt; 8 mEq/L or, if not available, a plasma bicarbonate level of &lt; 15 mmol/L or venous plasma lactate ≥ 5 mmol/L. Severe acidosis manifests clinically as respiratory distress (rapid, deep, laboured breathing).</td>
<td></td>
</tr>
<tr>
<td>Hypoglycaemia</td>
<td>Blood or plasma glucose &lt; 2.2 mmol/L (&lt; 40 mg/dL)</td>
<td></td>
</tr>
<tr>
<td>Severe malarial anaemia</td>
<td>Haemoglobin concentration ≤ 5 g/dL or a haematocrit of ≤ 15% in children &lt; 12 years of age (&lt; 7 g/dL and &lt; 20%, respectively, in adults) with a parasite count &gt; 10 000/µL.</td>
<td></td>
</tr>
<tr>
<td>Renal impairment</td>
<td>Plasma or serum creatinine &gt; 265 µmol/L (3 mg/dL) or blood urea &gt; 20 mmol/L</td>
<td></td>
</tr>
<tr>
<td>Jaundice</td>
<td>Plasma or serum bilirubin &gt; 50 µmol/L (3 mg/dL) with a parasite count &gt; 100 000/µL</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Comments/Caveats</td>
<td>Recommended Therapy</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| Malaria cont... | **Defining Criteria for Severe Malaria** | **Uncomplicated Malaria**
Artemether + Lumefantrine - Coartem® 80/480 1 tablet at 0, 8, 24, 36, 48 and 60 hours (six doses).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comments/Caveats</th>
<th>Recommended Therapy</th>
</tr>
</thead>
</table>
| Pulmonary oedema | Radiologically confirmed or oxygen saturation < 92% on room air with a respiratory rate > 30/min, often with chest in-drawing and crepitations on auscultation. | **Uncomplicated Malaria**
Artemether + Lumefantrine - Coartem® 80/480 1 tablet at 0, 8, 24, 36, 48 and 60 hours (six doses).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comments/Caveats</th>
<th>Recommended Therapy</th>
</tr>
</thead>
</table>
| Significant bleeding | Including recurrent or prolonged bleeding from the nose, gums or venepuncture sites; haematemesia or melena | **Uncomplicated Malaria**
Artemether + Lumefantrine - Coartem® 80/480 1 tablet at 0, 8, 24, 36, 48 and 60 hours (six doses).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comments/Caveats</th>
<th>Recommended Therapy</th>
</tr>
</thead>
</table>
| Shock | **Compensated shock** is defined as capillary refill ≥ 3 s or temperature gradient on the leg (mid to proximal limb), but no hypotension. **Decompensated shock** is defined as systolic blood pressure < 70 mm Hg in children or < 80 mm Hg in adults, with evidence of impaired perfusion (cool peripheries or prolonged capillary refill). | **Severe Malaria**
IV Artesunate 2.4mg/kg at 0, 12 and 24 hours and daily until the patient can take orally. Children weighing < 20 kg should receive a higher dose of artesunate (3 mg/kg bw per dose) to ensure equivalent exposure to the drug.  

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comments/Caveats</th>
<th>Recommended Therapy</th>
</tr>
</thead>
</table>
| Hyperparasitemia | P. falciparum parasitaemia > 10% | **Uncomplicated Malaria**
Artemether + Lumefantrine - Coartem® 80/480 1 tablet at 0, 8, 24, 36, 48 and 60 hours (six doses).

| Community-Acquired Severe Intra-Abdominal Infection, Biliary, and Extra-Biliary Infections | Empiric coverage of Enterococcus is recommended | Piperacillin-Tazobactam 4.5gm IV QID

| Cellulitis/ Abscesses/ Folliculitis/ Carbuncle/ Furuncle | Most abscesses are Staph aureus. Most cellulitis is Group A beta-haemolytic streptococcus (although some are Staph aureus). Empiric therapy for Streptococcus pyogenes (beta-haemolytic streptococcus) is recommended Clindamycin is bacteriostatic, potential for cross-resistance and emergence of resistance in erythromycin-resistant strains; inducible resistance in MRSA Effective treatment of abscesses entails incision, thorough evacuation of the pus, and probing the cavity to break up ovoidations. Gram stain, culture, and systemic antibiotics are rarely indicated unless there is extensive surrounding cellulitis, fever, multiple lesions, severely impaired host defences, or cutaneous gangrene. | **Oral Therapy**
Beta-haemolytic Streptococcus coverage: Amoxicillin/Clavulanate 1gm PO 8D x 7 days  
OR
Clindamycin 450 mg PO QID x 7-10 days  
**Parenteral Therapy (Inpatient)**  
Beta-haemolytic Streptococcus and MSSA Coverage
Cefazolin 1gm IV q8 hours for 7-10 days  
OR
Clindamycin 600 mg IV q8 hours for 7-10 days

| Necrotizing skin & soft tissue infections | Surgical intervention is the major therapeutic modality in cases of necrotizing fasciitis. Necrotizing fasciitis falls into two groups;  
• The spontaneous extremity cellulitis is usually Group A Streptococcus and sometime Staph aureus.  
• The second group includes head and neck, abdominal/groin and is frequently polymicrobial. | **Consult a Surgeon**
<table>
<thead>
<tr>
<th>Condition</th>
<th>Comments/Caveats</th>
<th>Recommended Therapy</th>
</tr>
</thead>
</table>
| **STI – Urethritis, Epididymitis, Orchitis, Proctitis, Cervicitis** | **Minimum criteria for clinical diagnosis of PID (all 3 should be present):**  
  a) Bilateral lower abdominal (uterine) tenderness (sometimes radiating to the legs)  
  b) Cervical motion tenderness - Positive cervical motion tenderness is defined as increased discomfort from a normal pelvic examination, as stated by the patient. Of note, cervical motion tenderness is neither sensitive nor specific for gynaecologic pathology, is a sign of nonspecific peritoneal inflammation,  
  c) Bilateral adnexal tenderness (with or without a palpable mass)  
  One or more of the following additional criteria can be used to enhance the specificity of the minimum criteria and support a diagnosis of PID:  
  • oral temperature >38.3°C;  
  • abnormal cervical or vaginal mucopurulent discharge;  
  • presence of abundant numbers of WBC on saline microscopy of vaginal fluid; and  
  • laboratory documentation of cervical infection with N. gonorrhoea or C. trachomatis. | **STI – Urethritis, Epididymitis, Orchitis, Proctitis, Cervicitis**  
  Ceftriaxone 250mg IM stat  
  **PLUS**  
  Azithromycin 1gm PO stat  
  **PID**  
  **Mild-Moderate disease**  
  Ceftriaxone 250mg IM stat  
  **PLUS**  
  Doxycycline 100mg PO BD x 14 days  
  **WITH or WITHOUT**  
  Metronidazole 500mg PO BD x 14 days  
  **Severe disease/In-patient therapy** - Suggested criteria:  
  • surgical emergencies (e.g., appendicitis) cannot be excluded;  
  • the patient is pregnant;  
  • the patient does not respond clinically to oral antimicrobial therapy;  
  • the patient is unable to follow or tolerate an outpatient oral regimen;  
  • the patient has severe illness, nausea and vomiting, or high fever; or  
  • the patient has a tubo-ovarian abscess.  
  Amoxicillin/Clavulanate 1.2g IV BD  
  **PLUS**  
  Doxycycline 100mg IV/PO BD x 14days |
HIV Post Exposure Prophylaxis (PEP)

- Exposed individual must be HIV negative at baseline.
- Exposure must have occurred within the past 72 hours.
- Exposure must be high-risk. Faeces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomitus are not considered to be infectious unless they are visibly bloody.

**Estimated per- unprotected act risk for acquisition of HIV by exposure route**

<table>
<thead>
<tr>
<th>Exposure route</th>
<th>% Risk</th>
<th>Regimen</th>
<th>Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion</td>
<td>90%</td>
<td>Tenofovir/Lamivudine</td>
<td>TDF/3TC (300/300mg)</td>
<td>Zidovudine (AZT (300mg) can be used as an alternative when TDF cannot be used</td>
</tr>
<tr>
<td>Needle-sharing injection-drug use</td>
<td>0.67%</td>
<td>PLUS Atazanavir/Ritonavir (ATV/r) (300/100mg)</td>
<td>1 tablet OD PLUS 1 tablet OD with food</td>
<td></td>
</tr>
<tr>
<td>Receptive anal intercourse</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percutaneous needle stick</td>
<td>0.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptive penile-vaginal intercourse</td>
<td>0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertive anal intercourse</td>
<td>0.06%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertive penile-vaginal intercourse</td>
<td>0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertive oral intercourse</td>
<td>0.01%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertive oral intercourse</td>
<td>0.005%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The overall rate of HIV transmission through percutaneous inoculation is reported to be 0.3% (95% confidence interval [CI] 0.2–0.5); the risk of acquiring an HIV infection is greater for percutaneous injuries that involve:
- hollow-bore needles that have been in contact with an artery or vein,
- when blood is visible on the device,
- a deep needle stick, and
- when the source patient has advanced HIV disease.

Splashes or infectious material to mucous membranes or broken skin may also transmit HIV infection (estimated risk per exposure, 0.09%; 95% CI 0.006–0.5). Exposure of intact skin to contaminated blood has not been identified as a risk for HIV transmission.

- Counsel on risks and benefits of PEP and obtain verbal consent for testing (HIV, FGH, UEC, LFTs, HBV and HCV)
- Voluntary HIV testing for source individuals
- Offer PEP as soon as high-risk exposure is established and exposed individual tests HIV negative at baseline (if HIV testing not available, can provide 1-2 days of PEP to cover until HIV test performed)
- Pregnancy testing
- Cr (if TDF-containing regimen) and Hb (if AZT-containing regimen), however PEP should be offered even when lab tests are not available. Do not delay administration of PEP while waiting for lab results
- Hepatitis B vaccination (if not previously immunized & not known HBV positive)

PEP should be initiated as soon as possible after exposure, but no later than after 72 hours.

Consult local guidelines for the recommended regimens

PEP should be continued for 28 days (dispense all 28 days of treatment at the first visit)

- Follow up client at 7 days, 14 days, and 28 days after starting PEP
- Follow up HIV antibody testing at 3 months, if negative, test again at 6 months after which annual testing applies
- Assess for and manage side effects due to PEP
- Follow up with gastroenterologist if positive HBV, HCV and/or abnormal LFTs
34. Suicidal & Homicidal Evaluation

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Decision Support Tool for Secondary Screening**

(A “yes” response is equal to 1)

<table>
<thead>
<tr>
<th>TRANSITION QUESTION: CONFIRM SUICIDAL IDEATION</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? (NOTE: Not part of scoring.)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>1. THOUGHTS OF CARRYING OUT A PLAN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recently, have you been thinking about how you might kill yourself? If yes, consider the immediate safety needs of the patient.</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2. SUICIDE INTENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any intention of killing yourself?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3. PAST SUICIDE ATTEMPT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever tried to kill yourself?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4. SIGNIFICANT MENTAL HEALTH CONDITION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>5. SUBSTANCE USE DISORDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>6. IRRITABILITY/AGITATION/AGGRESSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
Brief Suicide Prevention Interventions

For all patients with suicidal ideation who are being discharged:
1. Provide at least one of the following brief suicide prevention interventions prior to discharge.
2. Include crisis center/hotline information with every brief intervention provided.
3. Involve significant other(s) in the intervention if present.

- **Brief Patient Education**: Discuss the condition, risk and protective factors, type of treatment and treatment options, medication instructions, home care, lethal means restriction, follow-up recommendations, and signs of a worsening condition and how to respond. Provide verbal and written information on the nearest crisis hotline.
- **Safety Planning**: Work with the patient to develop a list of coping strategies and resources that he or she can use during or before suicidal crises. Use the Safety Planning resources (paper version or mobile app) provided in the full guide.
- **Lethal Means Counselling**: Assess whether the patient has access to firearms or other lethal means (e.g., prescription medications), and discuss ways to limit access until the patient is no longer feeling suicidal. Follow the Lethal Means Counselling Recommendations for Clinicians sheet available from Means Matter.
- **Rapid Referral**: During the ED visit, schedule an outpatient mental health appointment for the patient within seven days of discharge. If no appointments are available, review additional suggestions in the full guide and/or refer the patient for a follow-up with a primary care provider.
- **Caring Contacts**: Follow up with discharged patients via postcards, letters, e-mail or text messages, or phone calls. See sample messages in the full guide. These communications can be automated.

Discharge Planning Checklist

Involves the patient in the decision-making process. Shared decision-making lowers patient stress, gives patients a sense of control, and leads to better outcomes. Patients with suicide risk report higher satisfaction when they are involved in decisions about their care.

- Patient involved in planning
- Follow-up appointment scheduled for a date within one week of discharge
- Discharge plan reviewed verbally and understood by patient
- Barriers and solutions discussed
- Crisis center phone number provided
- Access to lethal means reviewed and discussed
- Written instructions and education materials provided, including what to do if the patient’s condition worsens and when to return to the ED
- Patient confirms his or her understanding of the patient care plan
- Relevant health information transmitted to referral providers
- Patient senses the provider’s care and concern
Management of the severely agitated or violent patient

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

- Ensure staff safety
- Attempt to calm patient using verbal techniques
- Place physical restraints if necessary
- Monitor, support ABCs.
- Establish IV/O₂ monitor if possible. Check vital signs (BP, PR, RR, SPO₂, T°C, RBS) if possible.

### Is rapid sedation needed?

**No**
- Establish IV/O₂ monitor if not already in place.
- Check vital signs (BP, PR, RR, SPO₂, T°C, RBS)

**Yes**
- Chemical restraint

#### Severe violent patient
- Ketamine 2mg/kg-5mg/kg IM
- Midazolam 5mg to 10mg IV/IM
- Haloperidol 5mg to 10mg IV/IM

#### Intoxication with CNS stimulant or undifferentiated patient
- Midazolam 5mg to 10mg IV/IM
- Haloperidol 5mg IV/IM

#### Intoxication with CNS depressant (e.g. ethanol)
- Midazolam 5mg to 10mg IV/IM
- Haloperidol 5mg IV/IM

#### Known psychotic/psychiatric disorder
- Haloperidol 5mg to 10mg IV/IM
- Midazolam 5mg to 10mg IV/IM

#### Cooperative patient
- Midazolam 5mg to 10mg PO

In elderly patients, reduce the dose of any antipsychotic by half

### Sedation achieved?

**Yes**
- Titrate chemical restraints to desired effect.

**No**
- Establish IV/O₂ monitor if not already in place.
- Check vital signs (BP, PR, RR, SPO₂, T°C, RBS)

### Assess for medical causes of agitation
- Hypoglycaemia
- Hypoxia
- Drug overdose
- Poisoning
- Infection
- Intracranial lesion
- Others

### SEDATION ASSESSMENT TOOL (SAT)

<table>
<thead>
<tr>
<th>SAT</th>
<th>Responsiveness</th>
<th>Speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>combative, violent, out of control</td>
<td>continual loud outbursts</td>
</tr>
<tr>
<td>+2</td>
<td>very anxious &amp; agitated</td>
<td>loud outbursts</td>
</tr>
<tr>
<td>+1</td>
<td>anxious or restless</td>
<td>normal, talkative</td>
</tr>
<tr>
<td>0</td>
<td>awake &amp; calm, cooperative</td>
<td>normal</td>
</tr>
<tr>
<td>-1</td>
<td>asleep, rouses to voice</td>
<td>slurring or marked slowing</td>
</tr>
<tr>
<td>-2</td>
<td>responds to physical stimulation</td>
<td>few recognisable words</td>
</tr>
<tr>
<td>-3</td>
<td>no response to stimulation</td>
<td>nil</td>
</tr>
</tbody>
</table>

### GENERAL PRINCIPLES

Select one sedative (benzo) and one antipsychotic agent and titrate these to a targeted SAT

Avoid switching classes as unpredictable
Use longer acting agents where possible, to avoid the roller coaster effect of agitation/sedation

If using rapid sedation, be prepared to manage the airway inc. RSI & CICO

Assessment should occur in a designated safe area of hospital (available exits & distress alarm)
Assess situation and patient including airway, anaesthesia and risk to self and others

Administer medications with patient supine, one staff member to each limb and one to give drugs

Avoid prone restraint
36. Epigastric Pain Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Adult with Epigastric Pain**
- Monitor and support ABCs
- **Provide immediate analgesia** – Antacid Gel + See Analgesia Chart

- Check vital signs (BP, PR, RR, SPO2, T°C, RBS)
- Start Oxygen IF SPO2 < 94%. Maintain SPO2 ≥ 94%
- Obtain/review 12-lead ECG if > 40 years old, diabetic or hypertensive

**Perform a focused history and physical examination, evaluating:**
- Duration of symptoms
- Risk factors for potentially serious conditions – ACS, Pancreatitis, DKA, Cholecystitis, Perforate Ulcer, Pre-eclampsia/Eclampsia, HELLP

- Send blood samples for FBC, UEC, Lipase.
- Additional testing as indicated;
  - hsTroponin T - ? ACS (elderly (>50yrs), diabetics, hypertensives)
  - LFTs - ? Cholecystitis, Pre-eclampsia/Eclampsia, HELLP
  - Erect CXR - ? Perforated ulcer, Pancreatitis, Pneumonia
  - VBG – Hyperglycaemic patients, Pancreatitis
  - PDT - ? Ectopic pregnancy

**Probable Dyspepsia**
- Stool H. Pylori Antigen Test (see indications)
- Antacid Gel PRN + Ranitidine 50 mg IV

**Other Causes of Epigastric Pain**
Treat accordingly

**H. Pylori Positive**
- Symptomatic Treatment
  - Antacid Gel 20-60mins after meals and at bedtime or PRN (for symptom control)
  - Paracetamol (stop ALL NSAID use)
  - Dietary advice

**Eradication Therapy**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosing</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPI</td>
<td>Standard dose BD*</td>
<td>14 days</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>500 mg BD</td>
<td></td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>1000 mg BD</td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td>400 mg BD</td>
<td></td>
</tr>
</tbody>
</table>

*Standard doses are esomeprazole 20 mg, lansoprazole 30 mg, omeprazole 20 mg, pantoprazole 40 mg, and rabeprazole 20 mg

**Consider OGD (see indications below)**

**H. Pylori Negative**
- Symptomatic Treatment
  - Antacid Gel 20-60mins after meals and at bedtime or PRN (for symptom control)
  - Paracetamol (stop ALL NSAID use)
  - Dietary advice

**Acid Suppression Therapy**
- PPI standard dose x 4 weeks

**Consider OGD (see indications below)**

**Indications for Stool H. pylori Antigen testing**
1. Active peptic ulcer disease (PUD),
2. History of PUD (unless previous cure of H. pylori infection has been documented),
3. Low-grade gastric mucosa-associated lymphoid tissue (MALT) lymphoma,
4. History of endoscopic resection of early gastric cancer (EGC)
5. Patient with un-investigated dyspepsia under the age of 60 years and without alarm features
6. Patients taking long-term, low-dose aspirin
7. Patients with unexplained iron deficiency anaemia despite an appropriate evaluation
8. Adults with idiopathic thrombocytopenic purpura (ITP)

**Indications for Oesophagogastroduodenoscopy (OGD)**
- age ≥ 60 years
- bleeding
- anaemia
- early satiety
- unexplained weight loss (>10% body weight)
- progressive dysphagia
- odynophagia
- persistent vomiting
- a family history of gastrointestinal cancer
- previous oesophagogastroduodenal malignancy
- previous documented peptic ulcer
- lymphadenopathy
- an abdominal mass

**Indications for OGD (see indications below)**
37. Upper Gastrointestinal Bleeding Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Upper Gastrointestinal Bleeding can vary in presentation, but most cases present in one or more of four ways as follows:

a) Melena (69%): the passage of dark and pitchy stools stained with blood pigments or with altered blood. Melena is caused by the passage of at least 50 mL of blood in the upper GI tract. Bacteria degrade the blood into haematin or other haemachromes. Melena should not be confused with the dark stools that result from ingestion of iron or bismuth.

b) Haematemesis (30%): the vomiting of bright red blood and indicates an upper GI site of bleeding, usually above the ligament of Treitz.

c) Coffee-ground emesis (28%): emesis consisting of dark, altered blood mixed with stomach contents

d) Haematochezia (15%): the passage of bloody faeces

SHOCKED (HYPOTENSIVE)
- Monitor, support ABCs in ER; Intubate patient if airway is at risk from massive haematemesis
- Check vital signs (BP, PR, RR, SPO2, T°C, RBS)
- Start Oxygen IF SPO2 < 94%. Maintain SPO2 ≥ 94%
- Establish 2 large bore IV accesses (14-16G).
- Give rapid fluid boluses at 20mL/Kg Ringer’s Lactate/Hartmann’s soln; repeat if necessary.
- Start blood transfusions ONLY if Hb < 7 g/dL
- Send samples for FBC, UEC, LFTs, VBG, Coagulation screen. Crossmatch 6 units of packed cells.
- Perform brief, targeted history, physical exam including a rectal exam
- Insert NGT ONLY if intubated or has recurrent vomiting uncontrolled by anti-emetics

NOT SHOCKED
- Monitor, support ABCs in ER; Intubate patient if airway is at risk from massive haematemesis
- Check vital signs (BP, PR, RR, SPO2, T°C, RBS)
- Start Oxygen IF SPO2 < 94%. Maintain SPO2 ≥ 94%
- Establish a large IV access (14-16G).
- Start IV Fluids TKVO – Ringer’s Lactate (RL)/Hartmann’s soln. Start blood transfusions ONLY if Hb < 7 g/dL
- Send samples for FBC, UEC, LFTs, VBG, Coagulation screen, Blood type & screen.
- Perform brief, targeted history, physical exam including a rectal exam

- IV omeprazole (80-mg bolus followed by 8 mg/h for 72 h). Use pantoprazole if patient is on Clopidogrel.
- Monitor vital signs every 15 min until stable, then hourly.
- Correct hypotension with repeat fluid boluses/blood transfusion
- Monitor urine output - Aim for > 0.5mL/Kg/h

- Consult Gastroenterologist
- Admit HDU/ICU
### 38. Poisoning

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

#### Decontamination

##### Activated Charcoal

<table>
<thead>
<tr>
<th>Indications</th>
<th>Contraindications/Not helpful/Caution</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use ONLY within ONE HOUR of ingestion of a potentially toxic amount of medication. It is NOT effective beyond this period unless in multi-dose indications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple-dose (30gm in 400mls 4-hrly) activated charcoal should only be considered if a patient has ingested a life-threatening amount of: Theophylline, Phenobarbital, Dapsone, Carbamazepine, or Quinine.</td>
<td></td>
<td>The optimal dose of charcoal is unknown. However, the adult dose ranges from 50 to 100 g per dose. Lower doses of 0.5-1gm/kg is used in children. When drug-induced vomiting is anticipated (for example, with a theophylline overdose), an IV antiemetic is recommended. Cathartics such as sorbitol are sometimes added to activated charcoal preparations, but there is no evidence of any additional clinical benefit.</td>
</tr>
<tr>
<td>Decontamination needs. Failure to comply with this pathway does not represent a breach of the standard of care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

##### DO NOT PERFORM GASTRIC LAVAGE

Clinical studies have failed to show that gastric lavage improves the severity of illness, recovery times, or the ultimate medical outcomes and may be associated with life-threatening complications (aspiration pneumonitis, oesophageal or gastric perforation, fluid and electrolyte imbalances, arrhythmia).

#### Antidotes

<table>
<thead>
<tr>
<th>Antidote</th>
<th>Indications</th>
<th>Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-acetylcysteine (NAC)</td>
<td>If it is likely that the patient has ingested &gt; 150 mg/kg (or &gt;10 g) of paracetamol. In contrast, NAC is not recommended for patients with; an unknown ingestion time, a paracetamol concentration below detectable limits along with normal AST levels.</td>
<td>150 mg/Kg IV over 1 hr then 50mg/Kg over the next 4 hrs then 100mg/Kg over the next 16hrs. IV NAC should be infused as a 3% solution (30 g of NAC in D5W to a total volume of 1 L)</td>
<td>Anaphylactoid reaction if given too fast. Excessive doses of atropine can result in delirium, agitation, and tachycardia and hypertension. Tachycardia is not a contraindication to atropine administration.</td>
</tr>
<tr>
<td>Atropine</td>
<td>Organophosphate/Carbamate poisoning causing rhinorrhea, lacrimation, dyspnoea, vomiting, fasciculations, weakness, inability to ambulate, convulsions, respiratory insufficiency, coma. Miosis alone is not an indication for atropine administration.</td>
<td>2mg IV repeated every 5 minutes until the therapeutic endpoint is reached i.e. until pulmonary secretions are dried (reflected by improved oxygenation) and ease of breathing (or ease of ventilation).</td>
<td></td>
</tr>
<tr>
<td>Ethanol</td>
<td>Ethylene Glycol or Methanol poisoning</td>
<td>PD: Loading dose: 0.8g/kg in a 20% ethanol solution diluted in juice. Maintenance dose: 80mg/kg/h; increase to maintain a serum ethanol concentration of 100-150mg/dl. IV: Loading dose: 0.6 - 0.8 g/kg in a 10% ethanol solution in D5W (volume/volume). Maintenance dose: 80 to 130 mg/kg/h</td>
<td>Higher maintenance doses are used in patients with chronic alcoholism or during haemodialysis.</td>
</tr>
<tr>
<td>Flumazenil</td>
<td>Excessive sedation known to be due to the use of benzodiazepines in a patient without known contraindications (e.g., procedural sedation).</td>
<td>10µg/kg IV over 15 seconds. Repeat every 2-3mins to a maximum of 1mg (usual range 0.3 to 0.6mg). * For epinephrine dosing available in MDCalc</td>
<td>The administration of flumazenil to patients with undifferentiated coma can precipitate seizures in benzodiazepine-dependent patients and has been associated with seizures, arrhythmia, and hypotension in patients with co-ingestion of certain medications, such as tricyclic antidepressants.</td>
</tr>
<tr>
<td>Naloxone</td>
<td>Respiratory depression secondary to an opioid overdose</td>
<td>Dilate one ampoule (0.4mg/ml) into 10ml (0.04mg/ml) and give 1 ml every 1 to 2 minutes. A therapeutic effect is usually seen after 3 to 4 ml</td>
<td>Rapid injection may result in an acute withdrawal syndrome, with severe sympathetic effects such as hypertension, tachycardia and pulmonary oedema - can precipitate a myocardial infarction in patients at risk of IHD.</td>
</tr>
</tbody>
</table>
This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**DECONTAMINATION AND PERSONAL PROTECTION**
- Wear Personal Protective Equipment (Gloves, Gowns and Masks)
- Remove all clothing from and gently cleanse the patient with soap and water. Consider clothing and PPEs as hazardous waste and discard accordingly

The action of acetylcholine released into a synaptic cleft or neuromuscular junction is normally terminated when the enzyme acetylcholinesterase cleaves acetylcholine into choline and acetic acid. Organophosphates bind to the active site of the cholinesterase enzymes causing an increase in the acetylcholine concentration and a marked hyper stimulation of the cholinergic system, which is responsible for the predominant signs of toxicity.

**Muscarinic Manifestations**
- Ophthalmic: Conjunctival injection, lacrimation, miosis, blurred vision, diminished visual acuity, ocular pain
- Respiratory: Rhinorrhea, stridor, wheezing, cough, excessive sputum, chest tightness, dyspnoea, apnoea
- Cardiovascular: Bradycardia, tachycardia, hypotension
- Dermal: Flushing, diaphoresis, cyanosis
- Gastrointestinal: Nausea, vomiting, salivation, diarrhoea, abdominal cramping, tenesmus, foecal incontinence
- Genitourinary: Frequency, urgency, incontinence

**Nicotinic Manifestations**
- Cardiovascular: Tachyarythmias, hypertension
- Striated muscle: Fasciculations, twitching, cramping, weakness, paralysis
- Central Nervous System: Anxiety, restlessness, depression, confusion, ataxia, tremors, convulsions, coma, areflexia, respiratory depression

**GIVE IV ATROPINE**
(2 mg IV for adults or 0.02 mg/kg IV for children repeated every 5 minutes)

**Indications for Atropine treatment** (Miosis alone is NOT an indication for atropine administration)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhinorrhea, lacrimation, or mild dyspnoea</td>
<td>Mild</td>
</tr>
<tr>
<td>Inability to ambulate, dyspnoea, vomiting, fasciculations, weakness</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

Convulsions, coma, respiratory insufficiency: Severe

* Tachycardia can occur in organophosphate poisoning due to stimulation of the sympathetic ganglia as well as respiratory distress and hypoxia. Tachycardia is NOT a contraindication to atropine administration.

Atropine doses should be repeated every 5 minutes until the therapeutic endpoint (Atropinisation) is reached i.e. until pulmonary secretions are dried (reflected by improved oxygenation) and ease of breathing (or ease of ventilation). A pulse rate > 80 beats per minute and systolic blood pressure > 80 mmHg. Start atropine infusion when atropinisation achieved – 0.05 mg/kg/hour. E.g. for a 70kg patient give 3.5 mg of atropine per hour as an infusion. Put 10mg of atropine in 200 mLs of fluid run at 40 – 80mLs per hour (2-4mg/hr) depending on response.

Precautions: Excessive doses of atropine can result in deleterious effects including delirium, agitation, and tachycardia and hypertension. Atropine will likely NOT improve miosis or skeletal muscle paralysis (nicotinic receptors); therefore, reversal of these effects is not a therapeutic endpoint. Attempting to reverse these findings with atropine can result in administration of excessive doses of atropine.

**Seizure control**
(Midazolam 0.1mg/kg or Diazepam 0.1mg/kg)

Benzodiazepines are needed to prevent or treat nerve agent–induced seizures in moderate to severe toxicity because anticholinergic treatment is increasingly less effective from 5 – 40 minutes post exposure. Phenytoin does NOT affect GABA-A and has been found to be ineffective in controlling organophosphate–induced seizures. Benzodiazepines should be infused rapidly to unresponsive patients who have been exposed to organophosphates, because such patients may have non-convulsive seizures due to the onset of paralysis.

Pralidoxime (2-PAM)

WHO recommendation is > 30 mg/kg IV/IM bolus followed by > 8 mg/kg/hour IV infusion

(Adults: 2 g IM or slow IV infusion over 15 to 30 minutes followed by a 500-mg/hour infusion)

Neither atropine nor benzodiazepines will alleviate symptoms affecting the nicotinic system (CNS, NMJ, autonomic ganglia). 2-PAM should be given to any patient exposed to an organophosphate nerve agent who is showing any systemic toxicity especially fasciculations or weakness. The initial dose should be given as quickly as possible. Caution: Delivering 2-PAM more rapidly than recommended can result in hypertension. This is usually self-limited, but in extreme cases, phentolamine 5 mg IV may be effective. Laryngospasm and rigidity can also occur with rapid IV administration.

**Disposition**
- Consult a Physician
- Continue atropine infusion until the therapeutic endpoint (Atropinisation) is reached i.e. until pulmonary secretions are dried (reflected by improved oxygenation) and ease of breathing (or ease of ventilation)].
- Admit ALL symptomatic patients. Severe poisoning should be admitted to an ICU

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34. Organophosphate Poisoning Algorithm

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40. Alcohol (Methanol) Poisoning Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Suspected Methanol Poisoning

Methanol toxicity commonly affects the neurological, ophthalmological, and gastrointestinal systems.

a) Within the first 24 hours, central nervous system (CNS) depression, euphoria, and inebriation occur.
b) This is followed by a latent period (between 6 and 30 hours) during which methanol is metabolize to formic acid, which ultimately leads to systemic effects.
c) Ophthalmologic symptoms can range from blurry vision, decreased visual acuity, and photophobia to blindness or the classic “snowstorm” vision. A complaint of blurred vision with a relatively clear sensorium should strongly suggest the diagnosis of methanol poisoning. Initially, visual fields are not affected, and patients may have a central scotoma (blind spot). If unrecognized and not appropriately treated, these changes will result in:
   - permanent blindness,
   - absent papillary response, and
   - permanent optic nerve atrophy.
d) Methanol toxicity causes gastrointestinal symptoms such as abdominal pain with or without evidence of pancreatitis and/or hepatotoxicity.

In severe cases, the odor of formaldehyde may be present on the breath or in the urine. Untreated methanol poisoning is associated with a rate of death of 28% and a rate of visual deficits or blindness of 30% in survivors.

• Monitor, support ABCs; Consider Advanced Airway or nursing in recovery position for airway protection
• Check vital signs (BP, PR, RR, SPO2, T°C, RBS).
  − Start Oxygen if SPO2 < 94%. Maintain SPO2 ≥ 94%
  − If Hypoglycaemic (RBS < 3.3 mmol/L), give 50mls 50% dextrose IV (see 28. Hypoglycaemia Algorithm). Also, give 100mg Thiamine IV followed by 100mg PO BD for 6 weeks.
• Send samples for FBC, UEC, LFTs, Lipase, VBG, toxicology. Correct any electrolyte imbalances (see 31: Electrolyte Abnormalities Algorithm)
• Start IV Fluids – If hypotensive give repeated NS/RL boluses at 20ml/kg until perfusion is restored (MAP > 65) and dehydration is corrected. More rapid administration and large amounts of fluid may be needed in some patients. When stable, start 5% dextrose saline infusion at 3L/24hrs
• Perform brief, targeted history, physical exam
• DO NOT PERFORM GASTRIC LAVAGE. If the patient’s airway is protected, anecdotal evidence supports the use of gastric aspiration if large amounts of alcohol have been ingested and the patient can be treated very quickly (within an hour) after the ingestion.
• DO NOT GIVE ACTIVATED CHARCOAL unless the patient has co-ingested other poisons (see 38. Poisoning for indications and contraindications for activated charcoal)

Give Ethanol (also see 38. Poisoning)

Based on in vitro studies, ethanol’s affinity for alcohol dehydrogenase is more than that of methanol by 15-fold and thus competes for the enzyme preventing methanol from being metabolized to the toxic metabolite, formic acid. Ethanol may be given orally or through an intravenous infusion.

Oral Dose:

Loading dose: 0.8g/kg in a 20% ethanol solution diluted in juice.
Maintenance dose: 80mg/kg/h; increase to maintain a serum ethanol concentration of 100-150mg/dL.

IV Dose:

Loading dose: 0.6 - 0.8 g/kg in a 10% ethanol solution in D5W (volume/volume).
Maintenance dose: 80 to 130 mg/kg/h

Higher maintenance doses are used in patients with chronic alcoholism or during haemodialysis.

Side effects of ethanol treatment include: hypoglycaemia, CNS depression, intoxication, thrombophlebitis, and hypotension.

• Consult a Physician
• Monitor, support ABCs, Vital signs (BP, PR, RR, SPO2, T°C, RBS), UEC and VBG.
• Consider haemodialysis for large methanol ingestions, severe metabolic acidosis (pH < 7.25-7.30), vision abnormalities, renal failure, electrolyte abnormalities not responsive to conventional treatment, haemodynamic instability refractory to intensive care treatment and serum concentration > 50mg/dL.
• Transfer to ICU
41. Pain Management Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

ACUTE SOMATIC PAIN

EVALUATE: Focused history, detailed pain assessment
Assign SEVERITY SCORE (1-10)

MILD PAIN (1-3/10)

PO Paracetamol or NSAID + Adjuvant interventions
(Non-Pharmacologic)

Investigate and treat the cause of
pain.

MODERATE PAIN (4-6/10)

As for mild Pain + Weak opioids
e.g. PO tramadol, codeine, hydrocodeine

See Analgesia Chart
Reassess pain within 15 minutes to ensure relief, monitor patient appropriately, and document
Repeat analgesic, titrate to a higher dose, initiate a more potent analgesic or combine analgesics with different mechanisms of action as is appropriate to relieve pain
Treat the cause of pain as OP/IP, and consult/refer appropriately
Beware of contraindications, allergies, toxicity, interactions with other meds etc. Pethidine (meperidine) has an active metabolite (nor-meperidine) that causes neuro excitation (apprehension, tremors, delirium, and seizures) and may interact with antidepressants (contraindicated with MOI and best avoided with SSRIs), so it is NOT RECOMMENDED for repetitive use. It is also highly addictive.
Use the PO, SC or IV route, except when that is not possible
Adjuvant interventions include IMMOBILIZATION, SPUNTAGE, POSITIONING, ELEVATION, ICE etc.

SEVERE PAIN (7-10/10)

As for mild Pain + Strong opioids
e.g. morphine, fentanyl ± non-opioid analgesics

NSAIDS are the recommended 1st line therapy for Sickle Cell Pain Crisis, Renal Calculi and Acute Gout.
Metoclopramide is the recommended 1st line therapy for Acute Migraine Headaches

REGIONAL ANAESTHESIA

Indications
- Acute pain management for wounds, fractures and dislocations
- Alternative to procedural sedation
- Alternative to narcotics in certain patient populations (e.g. head injured patient, patients with concomitant mental status change, patients given buprenorphine)

Contraindications
- Allergy to local anaesthetic agents
- Active infection at the site of injection
- Injuries at risk of compartment syndrome
- Uncooperative patient
- Pre-existent neurologic deficit
- Anticoagulation (relative)

Technique – www.nysora.com

Types
- Wrist (Ulnar, Median and Radial nerve) block for the hand
- Digital nerve blocks for fingers and toes
- Femoral nerve block for the anterior thigh, femur, knee and skin anaesthesia over the medial aspect of the leg below the knee
- Facial and dental nerve blocks
- Ankle blocks for the foot
- Haematoma blocks

Anaesthetic - Lidocaine
- Dose – 3mg/kg
- Onset of action - < 2 mins
- Duration – 60 mins
This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

**Low Back Pain Algorithm**

**Adult with Low Back Pain (LBP)**
- Monitor and support ABCs
- **Provide immediate analgesia** – see Analgesia Chart

**Perform a focused history and physical examination, evaluating:**
- Duration of symptoms
- Risk factors for potentially serious conditions (tumour, infection, cauda equina syndrome, ankylosing spondylitis or vertebral compression fracture).
- Symptoms suggesting radiculopathy or spinal stenosis
- Presence and level of neurologic involvement - All patients should be evaluated for the presence of rapidly progressive or severe neurologic deficits, including motor deficits at more than 1 level, faecal incontinence, and bladder dysfunction.
- Psychosocial risk factors

**Any potentially serious conditions (RED FLAGS) strongly suspected?**
The possibility of low back pain due to problems outside the back, such as **Ectopic pregnancy**, **Pancreatitis**, **Nephrolithiasis**, or **Aortic Aneurysm**, or **Systemic illnesses**, such as endocarditis or viral syndromes, should be considered.

**Perform diagnostic studies to identify cause**
(see **Diagnostic Work-up for Low Back pain**)
*DO NOT* routinely obtain imaging or other diagnostic tests in patients with nonspecific low back pain. Early, routine imaging and other tests usually cannot identify a precise cause, do not improve patient outcomes, and incur additional expenses.

**Specific cause identified**
- Yes **Consult appropriately**
- No

**Back pain is mild with no substantial functional impairment**
Inform all patients of the generally favourable prognosis of acute low back pain with or without sciatica, including a high likelihood for substantial improvement in the first month

**Advice about self-care:**
- Advice to remain active
- Application of superficial heat

**Discuss non-invasive treatment options:**
- Pharmacologic;
  - 1st line – NSAIDs
  - 2nd line – Tramadol – for severe, disabling pain that is not controlled (or is unlikely to be controlled) with acetaminophen and NSAIDs.
- Non-pharmacologic – Physiotherapy

**Arrive at shared decision regarding therapy trial**
Educate patient

**Patient accepts risks and benefits of therapy**
- Yes
- No **Refer to Orthopaedic Clinic**

**Continue self-care and non-invasive options (analgesia and physiotherapy)**
Discharge and reassess in 4 weeks in **Orthopaedic Clinic** if necessary

**RED FLAGS FOR LOW BACK PAIN (TUNAFISH)**
- Trauma
- Unexplained weight loss
- Neurologic symptoms
- Age > 50 years
- Fever
- Intravenous drug use
- Steroid use
- History of cancer
## Diagnostic Work-up for Low Back Pain

<table>
<thead>
<tr>
<th>Possible cause</th>
<th>Key features on history or physical examination</th>
<th>Imaging*</th>
<th>Additional studies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>History of cancer with new onset of LBP</td>
<td>MRI</td>
<td>ESR</td>
</tr>
<tr>
<td></td>
<td>Unexplained weight loss</td>
<td>Lumbosacral plain radiography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Failure to improve after 1 month</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age &gt;50 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple risk factors present</td>
<td>Plain radiography or MRI</td>
<td></td>
</tr>
<tr>
<td>Vertebral infection</td>
<td>Fever</td>
<td>MRI</td>
<td>ESR and/or CRP</td>
</tr>
<tr>
<td></td>
<td>Intravenous drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recent infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cauda equina syndrome</td>
<td>Urinary retention</td>
<td>MRI</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Motor deficits at multiple levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fecal incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Saddle anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vertebral compression fracture</td>
<td>History of osteoporosis</td>
<td>Lumbosacral plain radiography</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Use of corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Older age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankylosing spondylitis</td>
<td>Morning stiffness</td>
<td>Anterior-posterior pelvis plain radiography</td>
<td>ESR and/or CRP, HLA-B27</td>
</tr>
<tr>
<td></td>
<td>Improvement with exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alternating buttock pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Awakening due to back pain during the second part of the night</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Younger age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe/ progressive neurologic deficits</td>
<td>Progressive motor weakness</td>
<td>MRI</td>
<td>Consider EMG/NCV</td>
</tr>
<tr>
<td>Herniated disc (Recommendation 4)</td>
<td>Back pain with leg pain in an L4, L5, or S1 nerve root distribution</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Positive straight-leg-raise test or crossed straight-leg-raise test</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptoms present &gt;1 month</td>
<td>MRI</td>
<td>Consider EMG/NCV</td>
</tr>
<tr>
<td>Spinal stenosis (Recommendation 4)</td>
<td>Radiating leg pain</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Older age (Pseudoclaudication a weak predictor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptoms present &gt;1 month</td>
<td>MRI</td>
<td>Consider EMG/NCV</td>
</tr>
</tbody>
</table>

*Level of evidence for diagnostic evaluation is variable.
Management of Pain in Sickle Cell Disease Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Patient presents with acute pain

- Monitor and support ABCs
- Check vital signs (BP, PR, RR, SPO2, T°C, RBS).
- Start Oxygen if SPO2 < 92% or if patient is dyspnoeic. Maintain SPO2 ≥ 92%
- Perform brief, targeted history, physical exam
- Determine probable cause and precipitating factors for pain e.g. infection
- Establish IV Access and send blood samples as below.

Related to SCD

No

Perform appropriate work-up

Yes

Start D5 ½ Normal Saline (NS)* at a maintenance rate unless the patient is overtly hypovolemic (sepsis, diarrheal illness, vomiting) in which case resuscitate appropriately.

*In vitro and in vivo studies have shown that lowering of serum osmolality with hypotonic fluid can reduce erythrocyte sickling. Over-hydration — especially with isotonic crystalloid — does not cure crisis and may have detrimental effects.

Mild or Moderate pain

- Administer IV dose of opiate
  - Tramadol IV/SC - 50-100mg over 3-5mins. Max 400mg/d
  - Fentanyl 1μg/kg every 1-2hrs
- Consider adjuvant therapy (IV paracetamol 15mg/kg)

Assess degree of relief every 15-30 mins

Drop in pain score of ≥ 2

Yes

Mild pain

- Manage cause/precipitating factor
- Disposition with short (< 72 hours) opiate/NSAIDs prescription with haematology follow-up

No

Drop in pain score of ≥ 2

Yes

Repeat IV opiate at ½ the initial dose

DO NOT exceed the maximum dose

Assess degree of relief every 15-30 mins

No

Yes

Consult a Physician/Haematologist

Investigations:

Full Blood Count (FBC);
- Most patients with HbSS disease have a baseline haemoglobin level of 6 to 9 g/dL and tolerate this level of anaemia well because of physiologic adaptations.
- WBC is NOT a particularly sensitive nor specific indicator for infection

Reticulocyte count - normally elevated (>5%). Levels < 5% are a serious cause for concern as it signifies bone marrow hypo activity. In patients with worsened scleral icterus, back pain, fever, or signs that suggest haemolysis, additional tests would include; LFTs and LDH

Renal function tests

Blood typing and screening is necessary if haemoglobin has dropped > 1 mg/dL below baseline or if there is concern that the patient may need a transfusion. Indications for blood transfusion; Severe anaemia - ↓ Hb > 2g/dL below steady state or < 6g/dL; Acute chest syndrome; Priapism; CVA in children; Before surgery

emergencymedicinekenya.org
Procedural Sedation and Analgesia (PSA)

Procedural sedation is the technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function.

**Potential indications for procedural in the ED:** fracture reduction, joint reduction, incision and drainage, chest tube placement, electrocardioversion, upper endoscopy (with a gastroenterologist), foreign body removal, burn or wound debridement

**Patient selection:** A pre-procedural history and physical exam, as documented in the ED record, should reflect a focused evaluation of the airway, cardiovascular status, pulmonary status, allergies, and history of prior adverse reactions to sedatives or anaesthetics. PSA may not be ideal for patients with significant chronic morbidities e.g. sleep apnoea, COPD, low baseline oxygen saturations or blood pressure, or anatomic features that would make bag valve mask (BVM) ventilation or maintaining an airway difficult.

**Preparation:** Monitoring equipment (continuous telemetry, pulse oximetry, BP; consider continuous end tidal CO₂ monitoring), peripheral IV, Ringer’s Lactate/Hartmann’s Solution, medications for PSA, naloxone (if opiates are given), equipment for procedure (e.g. scalpel), team (minimum one practitioner for sedation, one for procedure – **ONE OF THEM MUST BE PROFICIENT IN AIRWAY MANAGEMENT**), airway equipment (oxygen source, nasal cannula/face mask, BVM, suction), rescue airway equipment (endotracheal tube, laryngoscope, LMA, nasal trumpet)

**OBTAIN CONSENT for ALL PSA Procedures**

**Medication for PSA - give both an Analgesic AND a Sedative unless using Ketamine which is both**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Analgesic/Sedative</th>
<th>Onset/Peak Effect</th>
<th>Duration of Action</th>
<th>Adverse Effects</th>
<th>Comments/Caveats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ketamine</td>
<td>1 mg/kg IV over 30-60 seconds</td>
<td>Analgesic and Sedative</td>
<td>Onset 1min; Peak effect 1 min</td>
<td>5 - 10mins</td>
<td>Laryngospasm (0.3%), hyper salivation, vomiting, emergence reaction</td>
<td><strong>Ketamine is preferred for patients with hemodynamic instability or renal insufficiency.</strong></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.5 – 3 µg/kg IV over 3-5mins</td>
<td>Analgesic</td>
<td>Immediate onset, Peak effect 2-3mins</td>
<td>30 - 45mins</td>
<td>Chest wall rigidity and respiratory depression may occur with rapid IV administration</td>
<td><strong>Fentanyl is preferred for a rapid onset of analgesia in acutely distressed patients.</strong></td>
</tr>
<tr>
<td>Midazolam</td>
<td>0.05 – 0.15mg/kg IV</td>
<td>Sedative</td>
<td>Onset 3-5 mins; Peak effect 15-30 mins</td>
<td>20 - 60mins</td>
<td>Respiratory depression, hypotension</td>
<td><strong>Midazolam has a rapid onset and short duration and is classed as an ultra-short acting benzodiazepine and is 2 to 3 times more potent than diazepam, so can produce significant respiratory depression. Blood pressure decreases, and heart rate increases as compensation for a decreased SVR, although CO remains unchanged.</strong></td>
</tr>
</tbody>
</table>
Emergency Department
Procedural Sedation and Analgesia
Physician Checklist

Pre-Procedure Assessment

☐ Past medical history (note history of OSA)
☐ Prior problems with sedation/anesthesia
☐ Allergies to food or medications
☐ Procedure
☐ Denutents [none / upper / lower] [should remain in during PSA unless intubation required]
☐ Cardiorespiratory reserve [no or mild impairment / moderate impairment / significant impairment]
☐ Difficult airway features [none / mild concern / significant concern]
☐ Last oral intake (see fasting grid on reverse) [__________] ☐ Will delay procedure until [__________]
☐ [Weight (kg) [__________] ☐ Benefits of proceeding with PSA exceed risks

Difficult Airway Features

Difficult Laryngoscopy: Look externally, Evaluate 3-3-2 rule, Mallampati score, Obstruction, Neck Mobility
Difficult BVM Ventilation: Beard, Obese, No teeth, Elderly, Sleep Apnea / Snoring
Difficult LMA: Restricted mouth opening, Obstruction, Distorted airway, Stiff lungs or c-spine
Difficult Cricothyroidotomy: Surgery, Hematoma, Obesity, Radiation distortion or other deformity, Tumor*

☐ Is this patient a good candidate for ED procedural sedation and analgesia?
The less cardiorespiratory reserve, the more difficult airway features, and the less procedural urgency, the more likely the patient should not receive PSA in the emergency department. If not a good candidate for ED-based PSA, other options include regional or local anesthetic; PSA or GA in the operating room; or endotracheal intubation in the ED.

Pre-procedure Preparation

☐ Analgesia - maximal patient comfort prior to PSA
☐ Informed consent for PSA and procedure
☐ Patient on monitor: telemetry, NIBP, SpO2, ETCO2
☐ Oxygenate with NC O2 and high flow face mask O2
☐ Select and draw up PSA agent(s)
☐ Reversal agents and paralytic viats at bedside
☐ Prepare for endotracheal intubation

Airway Equipment

☒ Ambu bag connected to oxygen
☒ Laryngoscopy handles and blades
☒ Suction, oral & nasal airways
☒ Endotracheal tubes & stylets
☒ LMA with lubricant and syringe
☒ Colorimetric capnometer
☒ Bougie & difficult airway equipment

Agent | Dose* | Contraindications | Comments
--- | --- | --- | ---
Ketamine | 1-2 mg/kg IV over 30-60 sec or 4-6 mg/kg IM, repeat half dose pm | Absolute: age < 3 months, schizophrenia Relative: major posterior oropharyngeal procedures; history of airway instability, tracheal surgery, or tracheal stenosis; active pulmonary infection or disease; cardiovascular disease; CNS masses, abnormalities, or hydrocephalus | Preferred for longer procedures; avoid if hypertension/tachycardia is a concern; have midazolam available to manage emergence distress; muscle tone is preserved or increased; post-procedure emesis may be mitigated by prophylactic ondansetron
Etomidate | 0.1-0.15 mg/kg IV, then 0.05 mg/kg q2-3 min pm | Intra-procedure myoclonus or hypotonicity, as well as post-procedure emesis, are common | Intra-procedure myoclonus or hypotonicity, as well as post-procedure emesis, are common
Fentanyl | 1-2 mcg/kg IV, then 1 mcg/kg q5 min pm | | Comparatively delayed onset of action; do not re-dose too quickly
Midazolam | 0.5 mg/kg IV, then .05 mg/kg q2-3 min pm | Pregnancy, allergy to benzyl alcohol | Comparatively delayed onset of action; do not re-dose too quickly
Pentobarbital | 1 mg/kg IV, then 1 mg/kg q2-3 min pm | Pregnancy, porphyria | Use for painless procedures where analgesia is not needed

Reversal Agent | Dose | Caution
--- | --- | ---
Neostigmine | 0.01-0.1 mg/kg IV or IM (typical adult dose 0.4 mg), max 2 mg | | Only use in benzodiazepine naïve patient
Flumazenil | 0.01 mg/kg IV (typical adult dose 0.2 mg) over 20 seconds, max 1 mg | |

*All doses should be reduced in the elderly and in patients with marginal hemodynamics

R. Shayer / P. Anbari
emulatedatas.com 11.28.2013

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P.S.A. Intervention Sequence

- Proceed down intervention sequence as slowly as patient condition permits
- Jaw thrust as illustrated above - thumb on maxilla, four fingers posterior to ramus
- Laryngospasm notch is behind the earlobe, between mastoid process and condyle of mandible – bilateral, firm pressure medially and cephalad (up and in)
- If rescue ventilation is required, bag slowly and gently
- See emupdates.com/psa for details

Post-procedure Assessment

- Adverse events
- Interventions taken
- Adequacy of P.S.A.
- Procedure
- MD or RN at bedside until patient responds to voice
- Telemetry, EtCO₂, SpO₂ monitoring until patient responding to questions appropriately
- If reversal agent used, observation two hours after answering questions appropriately
- Mental status and ambulation at baseline at time of discharge/disposition

Fasting Grid

<table>
<thead>
<tr>
<th>Oral intake in the prior 3 hours</th>
<th>Emergent Procedure</th>
<th>Urgent Procedure</th>
<th>Semi-urgent Procedure</th>
<th>Non-urgent Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>All levels of sedation</td>
<td>All levels of sedation</td>
<td>All levels of sedation</td>
<td>All levels of sedation</td>
</tr>
<tr>
<td>Clear liquids only</td>
<td>All levels of sedation</td>
<td>All levels of sedation</td>
<td>Up to and including brief deep sedation</td>
<td>Up to and including extended moderate sedation</td>
</tr>
<tr>
<td>Light snack</td>
<td>All levels of sedation</td>
<td>Up to and including brief deep sedation</td>
<td>Up to and including dissociative sedation; non-extended moderate sedation</td>
<td>Minimal sedation only</td>
</tr>
<tr>
<td>Heavier snack or meal</td>
<td>All levels of sedation</td>
<td>Up to and including extended moderate sedation</td>
<td>Minimal sedation only</td>
<td>Minimal sedation only</td>
</tr>
<tr>
<td>Minimal sedation only</td>
<td>Dissociative sedation; brief or intermediate-length moderate sedation</td>
<td>Extended moderate sedation</td>
<td>Brief deep sedation</td>
<td>Intermediate or extended-length deep sedation</td>
</tr>
</tbody>
</table>

Higher-risk patient

<table>
<thead>
<tr>
<th>Oral intake in the prior 3 hours</th>
<th>Emergent Procedure</th>
<th>Urgent Procedure</th>
<th>Semi-urgent Procedure</th>
<th>Non-urgent Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>All levels of sedation</td>
<td>All levels of sedation</td>
<td>All levels of sedation</td>
<td>All levels of sedation</td>
</tr>
<tr>
<td>Clear liquids only</td>
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<tr>
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<td>Up to and including dissociative sedation; non-extended moderate sedation</td>
<td>Minimal sedation only</td>
<td>Minimal sedation only</td>
</tr>
<tr>
<td>Heavier snack or meal</td>
<td>All levels of sedation</td>
<td>Up to and including dissociative sedation; non-extended moderate sedation</td>
<td>Minimal sedation only</td>
<td>Minimal sedation only</td>
</tr>
<tr>
<td>Brief: &lt; 10 min</td>
<td>Intermediate: 10-20 min</td>
<td>Extended: &gt; 20 min</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Comments

MD Name | Sign | Date/Time

R. Strayer / P. Andrus emupdates.com 11.28.2013
<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Equianalgesic dose</th>
<th>Onset/Peak Effect</th>
<th>Duration of Action</th>
<th>Adverse Effects</th>
<th>Comments/Caveats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>IV - 0.1mg/kg; max. 0.3mg/kg</td>
<td>10mg</td>
<td>IV - Onset 3-5 mins; Peak effect 15-30 mins</td>
<td>IV - 3 - 4 hrs</td>
<td>Respiratory depression Hypotension partly due to histamine release</td>
<td>Acute severe pain (trauma) or persistent pain. Morphine is better preferred for obstetric pain.</td>
</tr>
<tr>
<td></td>
<td>SC - 0.1-0.2mg/kg</td>
<td></td>
<td>SC – Onset 15-30 mins</td>
<td>SC – 4 hrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>IV - 0.5 – 3 µg/kg over 3-5mins</td>
<td>100µg</td>
<td>IV - Immediate onset, Peak effect 2-3mins</td>
<td>IV – 30 - 45mins</td>
<td>Chest wall rigidity and respiratory depression may occur with rapid IV administration</td>
<td>Acute severe pain. (trauma) Fentanyl is preferred for a rapid onset of analgesia in acutely distressed patients. Fentanyl is preferred for patients with hemodynamic instability or renal insufficiency</td>
</tr>
<tr>
<td>Pethidine</td>
<td>IV - 0.5-1mg/kg SC - 1-2mg/kg</td>
<td>75 mg</td>
<td>IV - 1-3 mins SC – 30-90 mins</td>
<td>IV – 2 - 4 hrs</td>
<td>High doses may cause respiratory depression, agitation, muscle fasciculations, seizures or histamine induced hypotension</td>
<td>Moderate-to-severe pain (migraine, trauma, acute abdominal pain) It may be used in obstetric practice to relieve labour pain. Pethidine has an analgesic potency approximately equal to one-fifth that of morphine. Pethidine has an active metabolite (nor-meperidine) that causes neuro excitation (apprehension, tremors, delirium, and seizures) and may interact with antidepressants (contraindicated with MOI and best avoided with SSRIs), so it is NOT RECOMMENDED for repetitive use. It is also highly addictive.</td>
</tr>
<tr>
<td>Tramadol</td>
<td>IV/SC - 50-100mg over 3-5mins Max 400mg/d</td>
<td>80mg</td>
<td>IV/SC – 45 mins</td>
<td>IV/SC - 9 – 10 hrs</td>
<td>&gt; 400 mg/d are associated with an increased risk of seizures.</td>
<td>Moderate-to-severe pain. Tramadol is 5 to 10 times less potent than morphine. There is consequently an absence of respiratory depression, a low sedative effect, and less potential for dependence. There is a high incidence of nausea and vomiting. Slow administration over 3 - 5 minutes decreases the incidence of nausea and vomiting. Tramadol does not promote the release of histamine.</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>IV – 15mg/kg</td>
<td>-</td>
<td>IV – 15mins (at end of infusion)</td>
<td>IV – 4hrs</td>
<td>Mild-to-moderate pain Can be used to supplement opioid analgesics</td>
<td></td>
</tr>
<tr>
<td>Didofenac</td>
<td>IV – 75mg IM – 75mg</td>
<td>-</td>
<td>IV – 5-10 mins IM – 15mins</td>
<td>IV – 6-8hrs</td>
<td>• Gastrointestinal bleeding • Bleeding secondary to platelet inhibition, and • Development of renal insufficiency</td>
<td>Mild-to-moderate pain. Can be used to supplement opioid analgesics e.g. renal colic. All NSAIDs elevate SBP (median 5 mmHg). This effect predisposes to the development of congestive heart failure and may contribute to the risk of accelerated atherothrombotic disease. Patients with hypovolemia or hyp perfusion, the elderly, and those with pre-existing renal impairment may be more susceptible to NSAID-induced renal injury.</td>
</tr>
</tbody>
</table>

IM administration is generally NOT RECOMMENDED due to its multiple disadvantages: Painful administration, Unpredictable absorption, Complications involving tissue fibrosis and abscesses, and Rapid declines in analgesic effect. Subcutaneous (SC) administration provides similar pharmacokinetics with greater patient comfort. The SC route should replace the IM route for opioids.
Emergency Care Checklist
(Adapted from the WHO Trauma Checklist)

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient’s individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

### Immediately after primary & secondary surveys:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is further airway intervention needed?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May be needed if:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GCS 8 or below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hypoxaemia or hypercarbia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Respiratory distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Face, neck, chest or any severe trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES, DONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
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</tr>
<tr>
<td><strong>Is there a tension pneumothorax?</strong></td>
<td></td>
<td></td>
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<tr>
<td>YES, chest drain placed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
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<tr>
<td><strong>Is the pulse oximeter placed and functioning?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, not indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Does the patient need oxygen (SPO2 &lt;94%)?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, not indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not available</td>
<td></td>
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</tr>
<tr>
<td><strong>Large-bore IV placed and fluids/blood transfusion started?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>Not indicated, not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not available</td>
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<tr>
<td><strong>Head-to-toe survey for (and control of) external bleeding, including:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scalp</td>
<td></td>
<td></td>
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<tr>
<td>Perineum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
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<tr>
<td><strong>Assess for pelvic fracture by:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Exam, x-ray</td>
<td></td>
<td></td>
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<tr>
<td>CT-scan</td>
<td></td>
<td></td>
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<tr>
<td><strong>Assess for internal bleeding by:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Exam, ultrasound (e-FAST)</td>
<td></td>
<td></td>
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<tr>
<td>CT-scan</td>
<td></td>
<td></td>
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<tr>
<td><strong>Is spinal immobilization needed?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>Not indicated, not indicated</td>
<td></td>
<td></td>
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<tr>
<td><strong>Random blood sugar checked</strong></td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td><strong>Neurovascular status of all 4 limbs checked?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td><strong>Is the patient hypothermic?</strong></td>
<td></td>
<td></td>
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<tr>
<td>Yes, warming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
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</tr>
<tr>
<td><strong>Does the patient need (if no contraindication)?</strong></td>
<td></td>
<td></td>
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<tr>
<td>Urinary catheter, nasogastric tube</td>
<td></td>
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</tr>
<tr>
<td>Chest drain, none indicated</td>
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<td></td>
</tr>
</tbody>
</table>

*Associated with trauma but not specific

### Before TEAM leaves the patient’s bedside:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Has the patient been given:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Tetanus vaccine, analgesics</td>
<td></td>
<td></td>
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<tr>
<td>Antibiotics, none indicated</td>
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<tr>
<td><strong>Have all tests and imaging been reviewed?</strong></td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>No, follow-up plan in place</td>
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<tr>
<td><strong>Which serial examinations are needed?</strong></td>
<td></td>
<td></td>
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<tr>
<td>Neurological, abdominal</td>
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<tr>
<td>Vascular, none</td>
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<td></td>
</tr>
<tr>
<td><strong>Plan of care discussed with:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Patient/family, receiving unit</td>
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<tr>
<td>Primary team, other specialist</td>
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<td></td>
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<tr>
<td><strong>Relevant emergency care chart or form completed?</strong></td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not available</td>
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</tr>
</tbody>
</table>
References


All public and private health facilities have a legal duty to provide you with emergency medical treatment.

Any health institution that fails to provide emergency medical treatment despite having the capacity to do so, could face conviction and fines up to Kshs. 3 Million.