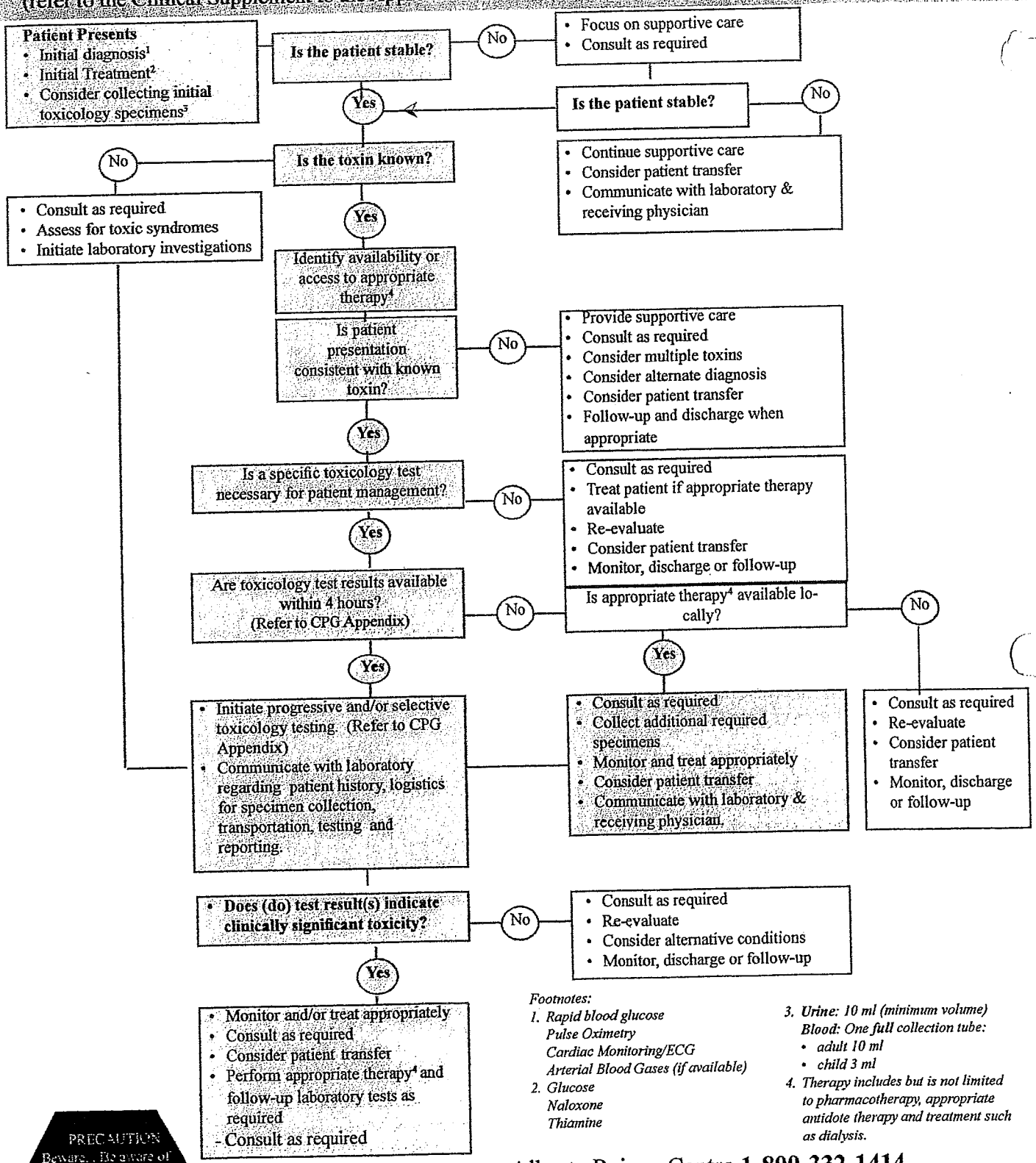
COMMON PROCEDURES

DRUG OVERDOSE

1.	QUESTIONS	• What drug(s) were taken. • Amount of drug(s) taken. • Time that drug(s) were taken. • Was alcohol taken along with drug(s).
2.	ASSESS VITAL SIGNS	• Initiate oxygen and/or IV as appropriate.
3.	ASSESS IF PATIENT IS SUICIDAL	• Follow procedure for Suicidal Patient.
4.	CALL POISON CONTROL	• 1-800-268-9017 • Give them your name • Tell them you are calling from Nursing Station • Give Nursing Station telephone number • Tell them that you have a drug overdose-what pills were taken and how many eg. Tylenol, 325mg tabs, 15 pills
5.	POISON CONTROL WILL GIVE INSTRUCTIONS	• Whether or not to give Activated Charcoal (usually without Sorbitol) other treatments. • They will recommend blood to be drawn for blood level of drugs (will specify).
6.	CALL MD ON CALL	• Give information and instructions as per Poison Control and if patient is suicidal.
7.	FOLLOW MD ORDERS	• Draw blood as ordered. • Start IV if ordered. • Give medications as ordered. • Plan for medivac or follow-up as ordered by MD.
8.	IN-PATIENT RECORD	• Record length of time patient kept in clinic.

Algorithm A: Investigation of the Poisoned Patient

(refer to the Clinical Supplement to the Approach to the Poisoned Patient: Investigation and Management)



Footnotes:

1. *Rapid blood glucose*
   Pulse Oximetry
   Cardiac Monitoring/ECG
   Arterial Blood Gases (if available)
2. *Glucose*
   Naloxone
   Thiamine
3. *Urine: 10 ml (minimum volume)*
   Blood: One full collection tube:
   - *adult 10 ml*
   - *child 3 ml*
4. *Therapy includes but is not limited to pharmacotherapy, appropriate antidote therapy and treatment such as dialysis.*

PRECAUTION
Beware... Be aware of
- The hidden overdose
- The overdose that isn't
- Multiple toxin exposure

Alberta Poison Centre **1-800-332-1414**
Consult the APC for support at any stage of this algorithm.

DrugINFO Supplement

No. 99/1 Sioux Lookout Zone Hospital December 1999

Management of Acetaminophen Overdose:

*Toxic level = 150 mg / Kg

le 1: Stages of Acetaminophen Toxicity

Time	Clinical Presentation
0.5 - 24 hours	Anorexia, nausea, vomiting, malaise, pallor Elevated acetaminophen level
24 - 72 hours	Resolution of stage I symptoms Right upper quadrant pain Acetaminophen level undetectable Increased LFT's (AST, ALT, INR)
72 - 96 hours	Anorexia, nausea, vomiting, malaise may reappear Peak in LFT's Hepatic failure or Recovery begins
> 96 hours	Death or Resolution of hepatic dysfunction

le 2: N-Acetylcysteine Treatment ns

	20 Hour IV Protocol	48 Hour IV Protocol	72 Hour PO Protocol
hase I	150 mg/kg over 30min*	140 mg/kg	140 mg/kg
hase II	50 mg/kg over 4 hours	70 mg/kg q4h x 12 doses	70 mg/kg q4h x 17 doses
hase III	100 mg/kg over 16 hours		
lose	300 mg/kg	980 mg/kg	1330 mg/kg

lly the infusion was set for 15 min, but this has been increased to 30 min to improve the y

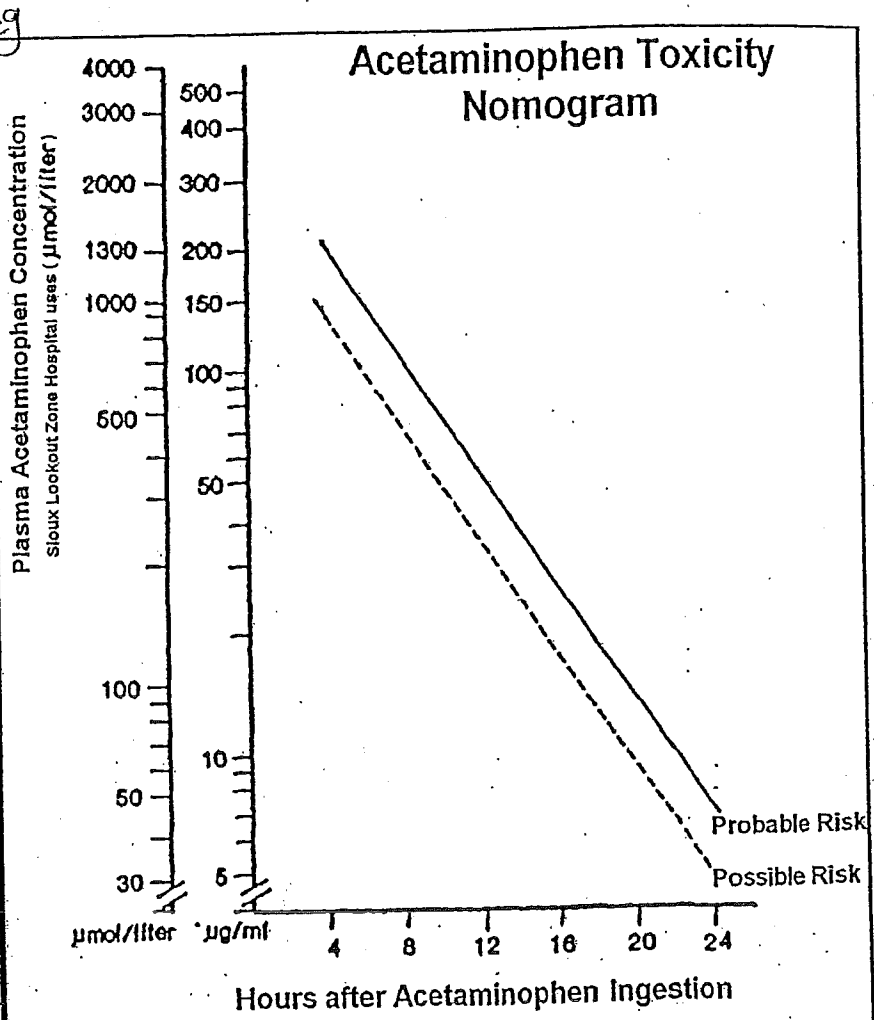


Figure 2

le 4: N-Acetylcysteine Side Effects and agement

toms	Incidence	Management
lushing	87%	Continue NAC infusion; no treatment necessary
/Urticaria	53%	Continue NAC infusion; Give Diphenhydramine (1 mg/kg, max 50mg) if required
dema	30%	Stop NAC infusion; Give Diphenhydramine (1 mg/kg, max 50mg) Re -start NAC at a slower rate is no symptoms after 1 hour
miting	30%	
asm	27%	Stop NAC infusion; Give Supportive care and Diphenhydramine (1 mg/kg, max 50mg)
ardia	13%	Response to initial treatment & No symptoms after 1 hour = Re -start NAC at a slower rate (if still required)
nsion	10%	No response to initial treatment. Responded to additional therapy & No symptoms x 1 hour = Re -start NAC at a slower rate (if still required); consider pre-treatment with cimetidine or ephedrine Cimetidine 5 mg/kg IV (max 300mg); Ephedrine 0.5 mg/kg PO (max 25 mg)

MUCOMYST PROTOCOL

(as per poison control)

1st dose: 150 mg/kg in 100 cc D5W iv over 1 hour.

2nd dose: 50 mg/kg in 500 cc D5W iv over 4 hours.

3rd dose: 100 mg/kg in 1000 cc D5W iv over 16 hours.

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* if allergic-type reaction: *
  - Stop infusion
  - treat w/ benadryl or Atarax etc
  - Restart infusion when reaction subsides

Myths about Suicide and the Truth*

By Dr. Michael Paré, M.D.

* Previous published in the Toronto Star

There are many misconceptions and myths concerning suicide.

Myth #1

Suicide is not a major problem in Canada.

This is false.

The Truth is: Over the past fifteen years there has been an average of over 3,500 recorded suicide deaths each year. That is about ten people a day – everyday. The actual number of suicides is likely significantly higher (estimated at two to three times higher) since it is well known that many "so called" accidental deaths are actually suicides.

Myth #2

People who talk about suicide rarely actually commit suicide.

This is false.

The truth is: People who commit suicide often give a clue or warning of their intentions. The majority of people who attempt suicide say or do something to express their intention before they act. People may offer subtle threats or statements like, *"I wish I wasn't around"* or *"Life hardly seems worth it"*. Always treat even subtle threats seriously. It is estimated that the majority of people who go on to commit suicide have attended their family physician in the two to three months preceding their suicide. This fact points to an important opportunity for family, friends and physicians to uncover and potentially stop the suicidal process. If people recognize the signs given by those contemplating suicide and are aware of other factors that lead an individual to want to take their own life suicide rates may decrease. Yet it is important to point out that many people will not admit to suicidal thoughts or plans and will hide their utter hopelessness and self-destructive intentions behind and apparently placid façade.

Myth #3

The suicidal person wants to die and there is nothing anyone can do: they will eventually do it.

This is false.

Myth #5

People who claim to be depressed are weak or lazy and just need to pull themselves together.

This is false.

The truth is: Depression is a genuine – and seriously disabling – medical condition and is not due to laziness, to a bad attitude, or to moral weakness. People who are depressed need professional treatment. A trained psychotherapist or counselor can help them learn more positive ways to think about themselves, change their behavior, cope with problems, and handle interpersonal relationships. A physician can prescribe medications to help relieve the symptoms of depression. For most people, a combination of psychotherapy and medication is the best available treatment.

Myth #6

Suicide is more common among the poor.

This is false.

The truth is: Suicide affects the poor, the middle class and the rich equally. Nevertheless there are a number of epidemiological factors that act as risk factors. These factors do not predict suicide rather they are part of a suicide assessment because of their demonstrated statistical correlation with suicide.

- Family history of suicide.
- Males more than females.
- History of previous attempts.
- Native Canadian more.
- Psychiatric diagnosis: mood disorder, schizophrenia, alcoholism, etc.
- Single: especially separated, widowed, or divorced.
- Lack of social supports.
- Concurrent medical illness (es).
- Unemployment.
- Decline in socioeconomic status.
- Psychological turmoil.

Myth #7

There are clear cut methods of predicting suicide risk that people should become aware of.

This is false.

The truth is: Many experts have concluded that after reviewing the literature of prediction and prevention that there is no proven scientific bases for specific prediction.

to have given away belongings. Full recovery from depression and suicidal feelings is a gradual thing. It may take months for the person to feel consistently better and in control.

Myth #9

Anyone who tried to kill himself or herself must be crazy.

This is false.

The truth is: Most people have reasons for their suicidal feelings and are not psychotic or insane. Yet their thinking is undeniably distorted. Most people have thoughts of suicide from time to time. Most completed suicides and suicide attempts are made by intelligent, temporarily despairing individuals who are expecting too much of themselves (and/or others), especially in the midst of a crisis. They may be upset, grief-stricken, depressed or despairing, but are not necessarily suffering form emotional illness. Yet many are – in fact – suffering from a mental illness. The following five mental disorders are correlated with suicide and suicidal behavior. More than ninety percent of completed suicides carry a diagnosis of alcoholism, depression, schizophrenia, or some combination of these three.

1. **Mood Disorders** (fifteen percent lifetime risk of suicide): The likelihood of suicide is increased when the patient exhibits: panic attacks; extreme anxiety; or alcohol abuse.

2. **Panic Disorder** (seven to fifteen percent lifetime risk of suicide): suicide rate may be similar to that of mood disorders. Greater likelihood is associated with more severe illness. Suicide does not necessarily occur during a panic attack. Demoralization or significant loss increase the likelihood of suicide. Agitation may increase the likelihood of translating self-destructive impulses into action.

3. **Schizophrenia** (ten percent lifetime risk of suicide): Suicide is relatively uncommon during psychotic episodes. The relationship between command hallucinations and actual suicide is not clearly cause and effect.

4. **Alcoholism** (three percent lifetime risk of suicide): Abusers of alcohol/drugs comprise fifteen to twenty-five percent of suicides. Yet alcohol use is associated with nearly fifty percent of all suicides. Increased suicide potential in an alcoholic patient correlates with: active substance abuse; adolescence; second or third decades of illness; co-existing psychiatric illness; recent or anticipated interpersonal loss. Substance abuse can represent self-treatment to blunt the anxiety or mood disturbance associated with a masked, co-existing psychiatric disorder.

5. **Borderline Personality Disorder** (seven percent lifetime risk of suicide): Borderline personality disorder is associated with increased risk of: impulsivity; hopelessness/despair, antisocial features with dishonesty; interpersonal aloofness; self-mutilating tendencies and psychosis with bizarre suicide attempts.

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Additional Notes: