General Approach to Managing Overdose

NHS
University Hospitals Sussex
NHS Foundation Trust

A	Assess airway Contact Anesthetic team if required
B	• **RR** – If depressed and suspicious for opioid toxicity consider Naloxone 400 mcg initial dose (see Naloxone prompt card) • **O2 saturations** – Aim saturations 94-98% in all patients • Carbon monoxide poisoning suspected – high flow oxygen (15 L/min via non-rebreather mask)
C	• **BP** – Hypotensive 250-500 mL 0.9% NaCl IV boluses, assess response. • Hypertensive + tachycardia – consider Beta blockers • **HR** – Bradycardic – 500 mcg atropine / external pacing. • For tachyarrhythmia - consider metoprolol 2.5-5 mg IV, consider magnesium sulphate 2 g IV • **VBG / ABG** – If elevated lactate give IV fluids, and replace electrolytes as appropriate • **Venous bloods** – FBC, U+Es, LFTs, clotting, CK, paracetamol + salicylate levels • **ECG** – Assess QT interval, tachy/brady-arrhythmias, ischaemic changes – consider magnesium sulphate and calcium gluconate. • **NB:** Remember sodium bicarbonate for TCA overdose.
D	• **GCS** <8 requires intubation and ventilation • **Agitation** – Diazepam 5-10 mg PO / lorazepam 1-2 mg IV, titrate according to response – for anxiolysis **NOT** sedation • **Pupils** – Useful in determining toxidrome (see Toxidrome prompt card) • **BM** – For severe hypoglycaemia give 150 mL 10% dextrose or 75 mL 20% dextrose IV over 10 mins • **Temp** – For hyperthermia, cool with IV fluids and ice packs • **Catheterise** – urine dip + send
E	**Expose** and assess for other pathology – **DO NOT** miss traumatic injury or compartment syndrome after long lie.