

# CMG 35a – POISONING AND OVERDOSE

(Revised: September 2016)



## GENERAL CARE FOR THE POISONED/OVERDOSED PATIENT

ICP	Take care not to become contaminated, and consider the possibility of other affected workers, occupants or first-aiders (if applicable). Remove the patient from the dangerous area if safe to do so.	AP
ICP	Airway / ventilatory support as necessary	AP
ICP	Specific antidotes and treatment as appropriate (see below)	AP
ICP	Consider the need for Emergency Apprehension (and Statement of Action Taken)	AP
ICP	Monitor ECG and treat arrhythmias (as per CMG 6, 7, 8)	AP
ICP	IV fluid as per CMG 14	AP
ICP	Consider adrenaline infusion for patients who are profoundly hypotensive and have not responded to fluid replacement	
ICP	Consider contacting Poisons Information (call 13-11-26) for specifics of particular poison/medication, if appropriate	AP
ICP	Symptomatic management as per appropriate CMGs e.g. temperature abnormalities (CMG 11), suspected ACS (CMG 16), seizures (CMG 22), hyperkalaemia (CMG 27), etc.	AP
ICP	Consider prolonging resuscitative efforts in these patients	AP
ICP	Do not delay on scene – some poisons/medications are time critical for treatment to be effective	AP

## TRICYCLIC ANTIDEPRESSANTS

ICP	Treat wide QRS, seizure activity and/or cardiac arrest secondary to tricyclic overdose, with sodium bicarbonate	
ICP	Decreased LOC – consider hyperventilation if ventilated	AP
ICP	Consider monitoring EtCO <sub>2</sub> – aim for <35mmHg	AP

continues over

## CMG 35a (cont) – POISONING, ENVENOMATION AND OVERDOSE



### ORGANOPHOSPHATES

<b>ICP</b>	Where feasible – remove contaminated clothing, wash skin with soap and water	<b>AP</b>
If cholinergic effects are present (salivation, sweating, nausea, bradycardia):		
<b>ICP</b>	administer IM atropine (no upper limit on doses) or	<b>AP</b>
<b>ICP</b>	administer IV atropine – doubling each repeat dose (e.g. 1mg → 2mg → 4mg → 8mg) (no upper limit on doses)	
<b>ICP</b>	Ensure hospital is notified of contaminated patient	<b>AP</b>

### SUSPECTED ALCOHOL INTOXICATION

<b>ICP</b>	Consider other causes of altered LOC (i.e. AEIOUTIPS – see CMG 15) even if there is a history of alcohol consumption. Thoroughly assess patient and document all findings.	<b>AP</b>
<b>ICP</b>	Consider appropriate ongoing management of patient: e.g. hospital, sobering up shelter, at home in the care of a non-intoxicated adult	<b>AP</b>

### CARBON MONOXIDE / SMOKE INHALATION

<b>ICP</b>	Beware of hazards – self-asphyxiation and/or explosion. Remove patient from danger	<b>AP</b>
<b>ICP</b>	Treat according to respiratory distress or upper airway obstruction guideline	<b>AP</b>
<b>ICP</b>	100% oxygen with PEEP if carbon monoxide is suspected	<b>AP</b>
<b>ICP</b>	Any person who has suffered an inhalation injury of toxic substances is to be transported to hospital (pulmonary oedema may be a late complication)	<b>AP</b>
<b>ICP</b>	Urgently transport if there is a decreased level of consciousness	<b>AP</b>

### OPIOIDS

<b>ICP</b>	IM naloxone	<b>AP</b>
<b>ICP</b>	Follow with IV naloxone	
<b>ICP</b>	With long-acting or synthetic opioids, regardless of initial response to naloxone, strongly encourage transport or close monitoring	<b>AP</b>