

Emergency Department Useful References

Pretreatment

3 – 5 minutes prior to intubation

- **Fentanyl** 3mcg / kg
 - for High ICP / Vascular (eg dissection) / preclampsia or eclampsia with elevated BP
- Consider **Lignocaine** 1.5mg / kg
 - for High ICP / Vascular with elevated BP

Immediate “push dose” Inotrope or Vasopressor

- Adrenaline 10mcg/ml = 1:100000; dose 0.5-2ml (5-20mcg as required 1-5 minutely)
 - In 10ml syringe draw up 9ml normal saline; now draw up 1ml of **1:10000** adrenaline (from prefilled syringe) and shake = 1:100000.
 - Label syringe “Adrenaline 10mcg/ml”; discard the other syringe.
- Metaraminol 0.5mg/ml; dose 1-2ml (0.5-1mg as required 2-5 minutely)
 - In 20ml syringe draw up 19ml normal saline; now draw up 1ml of 10mg/ml Metaraminol and shake
 - Label syringe “Metaraminol 0.5mg/ml”

Intubation Drugs

	Drug	Normotensive dose	Normotensive dose in 70kg patient	Hypotensive dose
SEDATION	Ketamine	2mg/kg	140mg	0.5mg/kg
	Thiopentone	3-5mg/kg	300mg	0.5-1mg/kg
	Propofol	1.5-3mg/kg	150mg	0.2mg/kg
PARALYSIS	Suxamethonium	1.5-2mg/kg	100mg	2mg/kg
	Rocuronium	For RSI 1.2mg/kg	85mg	1.6mg/kg
	Sugammadex	16mg/kg reversal of rocuronium 2min post administration	1120mg As 100mg/ml solution In 2 or 5ml vials	16mg/kg

Contraindications to Suxamethonium

- Malignant hyperthermia history
- Strokes with hemiparesis > 72 hours
- ICU stay > 2 weeks
- Burns / trauma > 72 hours
- NMJ disease
- Myopathies / Muscular dystrophies
- Hyperkalaemia (known or suspected)
- Guillain-Barre
- Penetrating eye injury and acute glaucoma

Initial Ventilator Settings

Adjust as per clinical & ABG assessment
Seek ICU advice if concerns

	Normal lungs	ARDS / ALI	Asthma / COPD		Metabolic acidosis	Head Injury	Severe obesity
Aim	Lung protection	Recruitment	Avoid breath stacking		Maintain respiratory compensation	Avoid high intrathoracic pressures	Avoid atelectasis and shunting
Position	20-30 degrees head up unless hypotensive and reduced cerebral perfusion a concern						
Mode	VC (SIMV)	VC (SIMV)	PC	VC (SIMV)	VC (SIMV)	VC (SIMV)	VC (SIMV)
Vt (ml/kg)	8 lbw	6 lbw	Monitor	5-8 lbw	8-10 lbw	6-8 lbw	8-10 lbw
Resp rate	14	14	14	8-10	20-30	16	14
I:E ratio	1:2	2:1	2-4:1	1:4-1:5	1:1-1:2	1:2	1:1-2:1
Pinsp	-	-	25-30	-	-	-	-
PEEP (cm H ₂ O)	5	10-15	10-15	Asthma 0 COPD 5	5	5	10-15
FiO ₂	Start at 100% and rapidly titrate down, ideally achieving FiO ₂ 0.4. Avoid significant hyperoxia. Aim for oxygen saturations ≥ 95%; pO ₂ >70. Aim Pplat <30.						
Other	Adjust to ensure O ₂ and CO ₂ normal	Watch pressures; may need to lower Vt and accept higher CO ₂ . Titrate FiO ₂ and PEEP	Minimise derecruitment. Minimal suctioning and deconnections	Watch for breath stacking. Consider permissive hypercapnoea. pH should >7.15. May need to accept higher pressures in asthmatics	Begin with high resp rate; titrate according to blood gases	Avoid high PEEP if possible. Aim PCO ₂ 35-40. Tape ETT.	Minimise derecruitment ie minimise suction and disconnections

Initial post intubation analgesia / sedation infusions

Infusion	Dose	Mixer	Bolus	Rate	Indication
Morphine & Midazolam	50mg 50mg	50ml NS	0.05 ml/kg	0.05-0.1 ml / kg / hr 70kg adult = 5 ml / hr	Maintain analgesia & sedation
Propofol	500mg (50ml)		0.5 mg / kg	20-30 mcg/kg/min 70kg adult = 10 ml / hr	Stable, with severe neurologic injury.
Ketamine	200mg	50ml NS	0.5mg/kg	0.5mg/kg/hr 70kg adult = 9 ml / hr	Unstable

This checklist is for informational purposes only.

ALL information must be vetted with your clinical judgment, pharmacy and hospital committees & regulations