Saskatchewan Health Authority

EMS

Provincial

Ambulance

Medications

In spring of 2023, the Saskatchewan Health Authority, Medical Oversight Team, which consists of the EMS Provincial Medical Director, Advisors along with the EMS Clinical Care, Quality Assurance and Education Division, in consultation with the SHA Pharmacy, finalized the provincial ground EMS approved medications. Throughout this process, consultation with the Saskatchewan College of Paramedics (SCoP) occurred and was fully supported. ***These medications are to be used in association with the SCoP Paramedic Clinical Practice Protocols.*** All medications will be reviewed biannually and/or updated when changes are required.

Version 5: June 2025

Table of Contents

Version Control, Disclaimer, References and Resources

Version Control

The version number and most current date of release are listed on the Drug Reference Cards at the front of the SHA EMS Provincial Ambulance Medications Drug Reference Cards (DRC).

Disclaimer

We encourage all EMS providers to ensure they have downloaded the most up to date version of the Drug Reference Cards and review all updates and associated education. It is up to the individual utilizing this resource to ensure they successfully complete the appropriate training and possess the necessary knowledge and skills to be competent before administering any medication in the DRC's.

The SHA EMS Provincial Ambulance Medications Drug Reference Guide (DRC) undergoes constant review. Changes are made based on the best practice from medical evidence-based research. These medications are intended to support decision-making processes using sound clinical judgment and provide consistent equitable care to all people of Saskatchewan.

The medications within the approved drug classification have been assessed and evaluated based on medical evidence in EMS approved resources, listed below. All medications and dosages have been endorsed by the SHA Medical Oversight Team in collaboration with the SHA Pharmacy.

The DRC's are based on best practice. Best Practice represents quality care which is deemed optimal. Best practices are health practices, methods, interventions, procedures or techniques based on high-quality evidence in order to obtain improved patient and health outcomes.

References and Resources

- SHA EMS Medical Director & Advisors
- Advanced Cardiovascular Life Support (ACLS) Provider Manual 2020
- Advanced Cardiovascular Life Support for Experienced Provider Manual 2017
- Heart and Stroke 2020 Handbook of Emergency Cardiovascular Care for Healthcare Providers
- Pediatric Advanced Life Support (PALS) Provider Manual 2020
- SaskKids Pediatric Parental Manual
- Neonatal Resuscitation Program (NRP) 2021 8th Edition
- Pedi STAT
- AB and BC EMS protocols (for peds MDI)
- Palliative Program (2021)
- Paramedic Clinical Practice Protocols Version 7.0 (2024)
- Lexicomp (incl. SickKids formulary)
- Saskatchewan Parenteral Manual – All Ages
- DynaMed

Background

The need for standardization of medications for ground EMS was driven by a number of underlying requirements:

- SHA EMS Accreditation: A high priority Required Organizational Practice for EMS accreditation through Accreditation Canada is to have a consistent medication management for ground EMS including the standardized ordering of high alert medications. This new process and resulting work standard will address the standard ordering of all medications that fall within the Saskatchewan Paramedic Clinical Practice Protocols.
- The ask from paramedics and ambulance services for greater standardization for both contracted and SHA EMS services
- The request from SHA Pharmacy to have a standard drug inventory or standard list of medications for EMS
- To support frontline EMS with a resource that is kept up to date while aligning with best practice based on medical evidence research

The Drug Reference Cards (DRC) for ground EMS were built directly from the SHA formulary. Information on the DRC's came directly from the SHA Parenteral Manual and when required, adjusted dosages for prehospital medicine based on best practice and medical evidence research. All medications within the approved drug classifications were assessed and evaluated by the SHA Medical Oversight Team that include our provincial EMS Clinical Care EMS Medical Director and EMS Medical Advisors. Through this process, there has been consistent collaboration with both SHA Pharmacy and the Saskatchewan College of Paramedics. The standardized order forms for medications were developed based on patient safety/cost saving and the provision of the best dating on the medication with SHA Pharmacy.

We would like to reiterate that this document is a living document, therefore changes will occur. The intent is to ensure it will be updated when required for scope of practice changes and to have biannual reviews to assess and address any changes required, such as a change in best practice, or a change in supplies to medications.

Instructions - How to utilize the Drug Reference Cards

1. The Drug Reference Cards (DRC) are resources that are to be used in association with the Saskatchewan College of Paramedics, "Paramedic Clinical Practice Protocols". It is the expectation that every practitioner understands and practices within their scope of practice.

2. This document can be saved and downloaded for both iPhone and android. Within the **"Table of Contents"**, you can go directly to the medication by selecting that line and it will bring you directly to that medication.

3. Within the **"Indications"** section of the DRC, the **"EMS Indications"** have the SCoP approved scope of practice indications listed. Each licensure level will still need to understand and know what falls under their scope. Within this section, we have also included other Health Canada Approved and Non Health Canada approved uses of each medication as a reference and source of additional information. These are in place to ensure practitioners understand the full use of the medication, as there may be circumstances where it would be beneficial to know, such as an IFT that may be using it for other approved usages. These are for your information only and not to be used to exceed your approved scope of practice.

    a. If a medication has been approved for palliative patient care, it has been noted in the DRC. This specific indication requires palliative approved training.

4. If any medication has an alert associated with it (ex: ELDER ALERT), it has been added to the DRC. These alerts are noted in the **"Cautions"** sections of the DRC.

5. Dosages for prehospital medicine are based on best practice and medical evidence research. Under the **"Dosing"** section, the approved dose, supply and concentration are listed. Within the section, the **"Provider/Route"** identifies all approved routes for each license level.

    a. Pediatrics - when applicable, the pediatric dosages have been added. Please continue to cross reference dosing with approved sources such as Broselow Tape and Pedi STAT for specific weight based dosing.

6. Compatibility/Stability with IV solutions – all medication are considered stable in D5W or NS for at least 24 hours at room temperature ; Compatible with dextrose, saline, dextrose-saline combinations, Ringer's and lactated Ringer's solutions unless otherwise stated on the DRC.

Updates and Highlights – June 2025

The following information is to address changes to the SHA EMS, Provincial Ambulance Drug Reference Cards. It is the responsibility of each individual utilizing this guide to ensure they have reviewed all changes.

Version Control, Disclaimer, Reference / Resource page – new document

Drug Reference Cards (DRC)

- **NEW**
  - Added new DRC for DiazePAM for Alcohol Withdrawal for ACP only given by IV only as per MOT and the new SCoP Protocol
  - Changed dosing and indications in Thiamine and LORazepam DRCs to reflect the new Alcohol Withdrawal Protocol as per MOT and SCoP
  - Changed indications to hyperkalemia treatment in DRC's Calcium Chloride, Salbutamol and Sodium Bicarbonate
  - Added Pregnancy and Breastfeeding recommendations as per Briggs' Drugs in Pregnancy & Lactation and reference added
  - Added The Hospital for Sick Children Electronic Formulary in resources and for peds info where needed
  - Added HIGH ALERT to medications that have been added to the 2025 SHA High-Alert Medication list will be released in June 2025 (Nitrous Oxide, Sodium Bicarbonate, Tranexamic Acid, TPN)
  - Removed HIGH ALERT warning on Magnesium Sulfate and Naloxone and added for IV only to LORazepam as per 2025 SHA High-Alert Medication list
  - Changed all DRCs to match the following as per policy SHA-08-010P1 Medication-Related Abbreviations, Symbols, Dose Designations and Acronyms Procedure (Effective December 16, 2024)
  - *All @ symbols replaced by "at"
  - *All ↓ symbol in FentaNYL DRC replaced with "low" and in Beta blocker DRC replaced with "decrease"
  - *Epi 1:1 000 had Epi 1 mg/mL added
  - *Epi 1:10 000 had Epi 1 mg/10 mL added
  - *Epi 1:100 000 had Epi 1 mg/100 mL added
  - https://www.saskhealthauthority.ca/system/files/2022-09/List-Corp-Acronyms.pdf
  - https://documentfinder.saskhealthauthority.ca/en/viewer?file=%2fmedia%2fPolicies%2fZ%20Clinical%20Standards%2fClinical%20Documentation%20and%20Communication%20Standards%2fCS-CDCS-0001-Abbreviations.pdf#phrase=false&pagemode=bookmarks

Amiodarone:

- Addition: as per Lexidrug under Dosing Adult/Elderly: Note: if upon ROSC with maintenance infusion running patient goes into VF or pVT you can give another 150 mg IVP.

- Addition: as per Lexidrug under Stable vtach Note: if in stable vtach pt has converted to sinus after 150 mg/10 mins and you have maintenance infusion running and patient goes back into stable vtach you may repeat the 150 mg/10 min dose.
- Addition: as per Lexidrug under Maintenance Infusion: Note: if patient converted post cardiac arrest with defibrillations and no amiodarone was given but then goes into stable vtach they may be given 150 mg/10 mins then the maintenance infusion following that if patient converts.
- Addition: as per Lexidrug under Pediatric stable vtach: Note: may repeat initial loading dose to a maximum of 10 mg/kg over 60 mins if not converted; if converted follow by maintenance dose as below

Calcium Chloride:

Addition: as per SCoP to EMS Indications:

- Treatment of suspected Hyperkalemia based on the presence of the following:
    - **A SOURCE** (one of the following):
        - History of kidney disease
        - Chronic renal insufficiency
        - Another condition that would predispose the patient to a condition of hyperkalemia (i.e. rhabdomyolysis, severe burns, severe trauma/crush trauma, tumor lysis syndrome)

      AND
    - **ELECTROCARDIOGRAPHIC EVIDENCE** (one of the following):
        - ECG changes suggestive of hyperkalemia (peaked T waves, loss of P waves, wide QRS and/or symptomatic bradycardia)
        - Patient is in CARDIAC ARREST
- Change: as per MOT to dosing for hyperkalemia to reflect best practice 1 g
- Addition: as per SHA Parenteral Manual, beta-blocker and calcium channel blocker overdosing to provide a dosing guide after practitioner contacts PADIS

DexAMETHasone:

- Addition: as per MOT under indications asthma and anaphylaxis to create consistency between providers until a formal decision can be made.

Dextrose:

- Change: recommendation as per Medical Oversight Team; use of D10W for peds to reflect best practice; D10W is less necrotic on veins and allows paramedic better control over alertness. The dosing remains the same at 1 g/kg.

DiazePAM:

- New DRC: as per MOT and SCoP protocol for Alcohol Withdrawal
- Highlight: EMS Indications: For Alcohol Withdrawal only
- Highlight: SHA EMS Medical Direction Note: To be given by ACP only and to be given IV only
- Addition: Dosing:

ALCOHOL WITHDRAWAL

Adult 17 years or older:

- BAWS Score of 3 to 7: 10 mg IV every 1 hour PRN
- BAWS Score of 8 or greater: 10 mg IV/PO every 30 minutes PRN
  *Discontinue when 2 consecutive BAWS scores are less than 3

*Brief Alcohol Withdrawal Scale (BAWS): https://www.saskhealthauthority.ca/system/files/2023-09/SHA-0327-Alcohol-Withdrawal-Assessment-Flowsheet.pdf

****Note: Diazepam is preferred benzodiazepine due to quicker onset of action and longer half-life. LORazepam is preferred for frail patients and those with severe liver disease (prolonged sedation can be harmful in hepatic encephalopathy).**

Frail Elderly and Diagnosed with Severe Liver Disease

- Give LORazepam PO instead

DiphenhydrAMINE:

- Change: as per SHA Parenteral Manual under dosing time changed to 20 minutes to reflect best practice

EPINEPHrine:

- Addition: as per SHA policy to concentrations ratio equivalent expressions in mg/mL format

Glucagon:

- Addition: as per Lexidrug under dosing repeat information added to reflect best practice

Ibuprofen:

- Addition: as per Lexidrug under peds dosing for age category 3 to 6 months for more inclusive dosing
- Addition: as per Lexidrug under peds dosing a Dose limit of 40 mg/kg/day or 2400 mg/day whichever is less to increase safety of administration

Ketorolac:

- Removal: as per MOT under indications; “only when PO meds cannot be tolerated” with the expectation to be used in situations such as kidney stones, sciatic back pain and migraines

LORazepam:

- Addition: under EMS Indications: Treatment of acute alcohol withdrawal in Frail Elderly and Diagnosed with Severe Liver Disease
- Addition: under EMS Medical Direction Note: **ACP only** for Alcohol Withdrawal
- Addition: under dosing as per MOT and SCoP protocol
  - ALCOHOL WITHDRAWAL in Frail Elderly and Diagnosed Severe Liver Disease **(ACP ONLY)**
  - BAWS Score of 3 to 7: 2 mg SL/PO every 1 hour PRN
  - BAWS Score of 8 or greater: 2 mg SL/PO every 30 minutes PRN

  *Discontinue when 2 consecutive BAWS scores are less than 3

  *Brief Alcohol Withdrawal Scale (BAWS):

https://www.saskhealthauthority.ca/system/files/2023-09/SHA-0327-Alcohol-Withdrawal-Assessment-Flowsheet.pdf

****Note: Diazepam is preferred benzodiazepine due to quicker onset of action and longer half-life. LORazepam is preferred for frail patients and those with severe liver disease (prolonged sedation can be harmful in hepatic encephalopathy).**

Midazolam:

- Addition: as per MOT under SHA EMS Medical Direction Note: Midazolam is the preferred benzodiazepine for seizures

Magnesium:

- Change: as per MOT under dosing to 50 mg/kg for all indications for ease of administration for practitioner
- Change: as per SHA Parenteral Manual and MOT of 2 g for all dosing to better reflect best practice
- Removal: as per SHA High Alert Medications list under cautions and title of HIGH ALERT

Oxytocin:

- Addition: as per QA and practitioner request under dosing heading of Post Partum/Post Abortion Hemorrhage, Incomplete Abortion or Atony to clarify confusion of when drug can be administered
- Addition: as per MORE OBs committee and QA under dosing that if carbetocin has not been given prior to arrival on scene by EMS (ex, midwife) to include care medications given by all practitioners

Salbutamol:

Addition: as per SCoP under EMS INDICATIONS to align with new Hyperkalemia Protocol:

- Treatment of suspected Hyperkalemia based on the presence of the following:
    - **A SOURCE** (one of the following):
        - History of kidney disease
        - Chronic renal insufficiency
        - Another condition that would predispose the patient to a condition of hyperkalemia (i.e. rhabdomyolysis, severe burns, severe trauma/crush trauma, tumor lysis syndrome)

      AND
    - **ELECTROCARDIOGRAPHIC EVIDENCE** (one of the following):
        - ECG changes suggestive of hyperkalemia (peaked T waves, loss of P waves, wide QRS and/or symptomatic bradycardia)
        - Patient is in CARDIAC ARREST

Sodium Bicarbonate:

Addition: as per SCoP under EMS INDICATIONS to align with new Hyperkalemia Protocol:

- Treatment of suspected Hyperkalemia based on the presence of the following:
    - **A SOURCE** (one of the following):
        - History of kidney disease
        - Chronic renal insufficiency

        - Another condition that would predispose the patient to a condition of hyperkalemia (i.e. rhabdomyolysis, severe burns, severe trauma/crush trauma, tumor lysis syndrome)

    AND

    - **ELECTROCARDIOGRAPHIC EVIDENCE** (one of the following):
        - ECG changes suggestive of hyperkalemia (peaked T waves, loss of P waves, wide QRS and/or symptomatic bradycardia)
        - Patient is in CARDIAC ARREST

Thiamine:

- Addition: as per SCoP alcohol withdrawal protocol and MOT added under EMS INDICATIONS
    - Treatment of acute alcohol withdrawal
- Addition: as per MOT under Dosing under ALCOHOL WITHDRAWAL
    - 300 mg IV over several minutes

EMS Provincial Medications

Acetaminophen/Tylenol

Classification

- Analgesic, Anti-Pyretic

Indications

EMS INDICATIONS

- Severe sepsis/septic shock adult
- Pyrexic child/adult
- Pain control

HEALTH CANADA APPROVED

- *Severe sepsis/septic shock adult*
- *Pyrexic child/adult*
- *Pain control*

Mechanism of Action

- Pyrexic – direct effect on the heat centres of the hypothalamus, causing heat dissipation and vasodilation; Antipyresis is produced from inhibition of the hypothalamic heat-regulating centrer
- Analgesic – inhibits prostaglandin synthesis; the analgesic effects are believed to be due to activation of descending serotonergic inhibitory pathways in the CNS; interactions with other nociceptive systems may be involved as well

Pharmacokinetics

- **Onset:** less than 1 hour
- **Peak:** 10 to 60 minutes
- **Duration:** 4 to 6 hours
- **Half-life:** 1 to 4 hours
- **Absorbed** through the GI tract, **metabolized** by the liver and **excreted** through the kidneys

Contraindications

- Hypersensitivity to Acetaminophen
- Acetaminophen – induced liver disease
- Do not use with any other drug products that contain acetaminophen

Cautions

- Acetaminophen can potentiate effects of Warfarin
- Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with the use of acetaminophen at doses that exceed the maximum daily limits, and often involve more than 1 acetaminophen-containing product.
- Patients with known G6PD deficiency (glucose-6-phosphate dehydrogenase). This enzyme helps red blood cells work correctly. A lack of this enzyme can cause hemolytic anemia. This is when the red blood cells break down faster than they normally would.
- Prophylactic use of acetaminophen to reduce fever and discomfort associated with vaccination is not recommended by the Advisory Committee on Immunization Practices (ACIP). (https://online.lexi.com/lco/action/doc/retrieve/docid/sickkids_f/2996361?cesid=3Q5wYiqQNPY&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dacetaminophen%26t%3Dname%26acs%3Dfalse%26acq%3Daceta#add-pediatric-warn-info)

Pregnancy:

- Although the risk is very low, use of the drug for several weeks or longer has been associated with cryptorchidism, decreased IQ, ADHD, and other problems in neurodevelopment. In contrast, short-term use of APAP, especially when used for maternal fever, was usually beneficial and did not cause these harms. As with all drug use in pregnancy, routine use of acetaminophen should be avoided. However, the drug should not be withheld if required for maternal fever.

Breastfeeding:

- Acetaminophen is recommended to be used at the lowest effective dose for the shortest duration of time to effectively treat the mother and protect the health of the fetus. Acetaminophen is one of the preferred non-narcotic agents and is considered compatible with breastfeeding when used in usual recommended doses.

Adverse Effects

DERMATOLOGIC:

- Erythema of skin, skin blister, skin rash

OTIC:

- Hearing loss

HEPATIC:

- Hepatoxicity - Acute **hepatotoxicity** may result from intentional or unintentional overdose in adult and pediatric patients. In pediatric patients, unintentional overdose can be a result of accidental ingestion, supratherapeutic dosing, more frequent administration than recommended, and use of multiple acetaminophen-containing products; hepatotoxicity has also been rarely reported with recommended dosages

Dosing

***Note: Rectal dosing Absorption is irregular; bioavailability may be reduced by ~10% to 20% relative to oral administration**

ADULT

- **Oral:** 1 g every 6 hours, do not exceed 4000 mg/24 hours
- **Rectal:** 325 to 650 mg 4 to 6 hours, do not exceed 3900 mg/24 hours

ELDERLY 75 years and older

- **Oral:** 500 to 1000 mg every 6 hours, do not exceed 4000 mg/24 hours
    - Older adults with hepatic impairment or history of alcohol abuse being treated for persistent pain, do not exceed a maximum of 2000 to 3000 mg/day.
    - Note: Given its relative safety profile as compared to nonsteroidal anti-inflammatory drugs, acetaminophen remains the mainstay of pain relief for mild pain in the older adult.

PEDIATRIC

- **Oral/Rectal:** 10 to 15 mg/kg every 4 to 6 hours (max 75 mg/kg/24 hours, or 4 g per 24 hours, whichever is less)

- Note: Consider all sources of acetaminophen (eg, prescription, OTC, combination products) when evaluating a patient's maximum daily dose.

Miscellaneous:

Altered Kidney Function:

- No dosage adjustment likely to be necessary.

Altered Liver Function:

- Risk of acetaminophen-induced liver injury with preexisting liver insufficiency has been observed to occur in an increased dose-duration dependent fashion, especially in the presence of certain risk factors (eg, excessive alcohol intake [>3 drinks/day for males; >2 drinks/day for females], malnutrition, fasted state [eg, ≥1 day], low BMI).

Concentration Supplied

Adult: 325 mg tablet

Pediatric:

Infant: 80 mg/1 mL (up to 2 years)

Child: 160 mg/5 mL

Suppository: 120 mg or 325 mg

Provider/Route:

- **EMR:** PO
- **PCP/ICP:** PO/PR
- **ACP:** PO/PR
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- SaskKids Pediatric Parental Manual
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6264?cesid=1RSybwprskA&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dacetaminophen%26t%3Dname%26acs%3Dtrue%26acq%3DACE
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711014

Development – May 2023
Update – June 2025

EMS Provincial Medications

Acetylsalicylic Acid
ASA/Aspirin/Entrofen/Novasen

Classification

- Analgesic
- Anti-Platelet
- Anti-Inflammatory Salicylate (NSAID)

Indications

EMS INDICATIONS

- Ischemic chest pain (crushing, pressure, heavy weight, squeezing)
- Given in addition to if they have already taken their prescribed dose
- Given in addition to if they are currently taking blood thinners

HEALTH CANADA APPROVED

- *Ischemic chest pain*
- *Valvular heart disease*
- *Carotid endarterectomy*
- *Atherosclerotic cardiovascular disease*
- *Anti-inflammatory for arthritis associated with rheumatic disease*
- *Analgesic/Antipyretic*
- *Vascular indications, including ischemic stroke, transient ischemic attack, acute coronary syndromes (ST-elevation myocardial infarction or non-ST-elevation acute coronary syndromes [non-ST-elevation myocardial infarction or unstable angina]), secondary prevention after acute coronary syndromes, and management of stable ischemic heart disease:*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITERATURE

- *Carotid artery stenting*
- *Colorectal cancer risk reduction, primary prevention*
- *Migraine, acute treatment*
- *Pericarditis, acute or recurrent*
- *Polycythemia vera, prevention of thrombosis*
- *Preeclampsia prevention*
- *Venous thromboembolism prevention, indefinite therapy*
- *Venous thromboembolism prophylaxis for total hip or total knee arthroplasty*
- *Venous thromboembolism prophylaxis in lower-risk patients with multiple myeloma receiving immunomodulatory therapy*

Mechanism of Action

- Irreversibly inhibits cyclooxygenase-1 and 2 (COX-1 and 2) enzymes, via acetylation, which results in decreased formation of prostaglandin precursors
- Irreversibly inhibits formation of prostaglandin derivative, thromboxane A_2, via acetylation of platelet cyclooxygenase, thus inhibiting platelet aggregation; has antipyretic, analgesic, and anti-inflammatory properties
- Blocks formation of thromboxane A2, which causes platelets to aggregate and arteries to constrict. This reduces overall ACS mortality, reinfarction, and nonfatal stroke.

Pharmacokinetics

- **Onset:** Chewing nonenteric-coated or enteric-coated tablets results in inhibition of platelet aggregation within 20 minutes
- **Peak:** Chewing nonenteric-coated tablets results in a time to peak concentration of 20 minutes
- **Duration:** Immediate release: 4 to 6 hours, however, platelet inhibitory effects last the lifetime of the platelet (~10 days) due to its irreversible inhibition of platelet COX-1
- **Half-life:** 15 to 20 minutes
- **Metabolized** through the liver and **excreted** through the kidneys as Urine (75% as salicyluric acid, 10% as salicylic acid)

Contraindications

- Hypersensitivity to ASA or other NSAIDS
- Contraindicated in children under 16 years for viral infections, with or without fever.
- Relatively contraindicated in patients with active ulcer disease

Cautions

- Asthmatics (can precipitate bronchospasm)
- Active bleeding ulcers (risk vs benefit)
- Hepatic insufficiency
- Bleeding disorders
- Pregnancy (risk vs benefit in suspected ischemic chest pain)
- Bariatric surgery
- Dehydration: Use with caution in patients with dehydration.
- Ethanol use: Heavy ethanol use (more than 3 drinks/day) can increase bleeding risks.
- Renal impairment
- High potassium like abnormal heartbeat, confusion, dizziness, passing out, weakness, shortness of breath, or numbness or tingling feeling
- Acidosis like confusion, fast breathing, fast heartbeat, abnormal heartbeat, severe abdominal pain, nausea, vomiting, fatigue, shortness of breath, or loss of strength and energy
- Weakness on one side of the body, trouble speaking or thinking, change in balance, drooping on one side of the face, or blurred eyesight
- Severe dizziness
- Passing out
- Severe headache
- Noise or ringing in the ears
- Trouble hearing
- Agitation
- Seizures
- Severe rectal pain
- Rectal bleeding
- Avoid regular or frequent use of nonsteroidal anti-inflammatory drugs (NSAIDs) in patients taking aspirin for cardiovascular protection as these may reduce the cardioprotective effects of aspirin.

DRUG INTERACTIONS

- Thrombolytics: In the treatment of acute ischemic stroke, avoid aspirin for 24 hours following administration of a thrombolytic; administration within 24 hours increases the risk of hemorrhagic transformation.

PREGNANCY

- Except when used in lower doses for pregnancy-related conditions, maternal use of aspirin should be avoided beginning 20 weeks gestation

- Premature closure of the ductus arteriosus may occur in the latter part of pregnancy as a result of maternal consumption of full-dose aspirin. Persistent pulmonary hypertension of the newborn (PPHN) is a potential complication of the closure. If an analgesic or antipyretic is needed, acetaminophen should be considered.

BREASTFEEDING

- Low-dose aspirin may be used in breastfeeding patients; however, standard doses of aspirin should be avoided
- Adverse effects on platelet function in the nursing infant exposed to aspirin via the milk have not been reported but are a potential risk. In 2001, the American Academy of Pediatrics recommended that aspirin should be used cautiously by the mother during lactation because of potential adverse effects in the nursing infant.

Adverse Effects

CARDIOVASCULAR:

- Cardiac arrhythmia, hypotension, tachycardia

ENDOCRINE & METABOLIC:

- Dehydration, hyperglycemia, hyperkalemia, hypoglycemia (children), increased thirst, metabolic acidosis
- Hyperuricemia (doses less than or equal to 325 mg/day)

GASTROINTESTINAL:

- Abdominal pain, dyspepsia, gastrointestinal perforation, gastrointestinal ulcer, heartburn, nausea, vomiting
- Gastrointestinal hemorrhage
- pancreatitis

GENITOURINARY:

- Postpartum hemorrhage, post-term pregnancy, prolonged labor, proteinuria, stillborn infant

HEMATOLOGIC & ONCOLOGIC:

- Disorder of hemostatic components of blood, disseminated intravascular coagulation, hemorrhage, prolonged bleeding time, prolonged prothrombin time, thrombocytopenia

HEPATIC:

- Hepatitis, increased liver enzymes

NERVOUS SYSTEM:

- Agitation, brain edema, coma, confusion, dizziness, headache, hypothermia, lethargy, seizure
- Intracranial hemorrhage, Reye's syndrome

RENAL:

- Increased blood urea nitrogen, increased serum creatinine, interstitial nephritis, renal failure syndrome, renal insufficiency, renal papillary necrosis

RESPIRATORY:

- Hyperventilation, laryngeal edema, pulmonary edema, respiratory alkalosis, tachypnea
- Asthma , bronchospasm

MISCELLANEOUS:

- Fever, low birth weight

DERMATOLOGIC:

- Urticaria

HYPERSENSITIVITY:

- Anaphylaxis, angioedema

IMMUNOLOGIC:

- Drug reaction with eosinophilia and systemic symptoms

NEUROMUSCULAR & SKELETAL:

- Rhabdomyolysis

OPHTHALMIC:

- Macular degeneration

OTIC:

- Hearing loss, tinnitus

SPECIAL POPULATIONS:

- GI bleed patients: An individualized and multidisciplinary approach should be used to manage patients with an acute GI bleed who are on antiplatelet medications. Aspirin for primary prevention of cardiovascular events

should be avoided in most patients with GI bleed who do not have high risk factors for cardiovascular events. However, aspirin for secondary cardiovascular prevention should not be discontinued in patients with established cardiovascular disease, even in the setting of a GI bleed. If held in the setting of a GI bleed, aspirin for secondary cardiovascular prevention should be resumed on the day hemostasis is confirmed by endoscopy (ACG/CAG [Abraham 2022]).

- Older Adults: Older adult patients are at high risk for adverse effects from nonsteroidal anti-inflammatory drugs (NSAIDs). Older adults can develop an asymptomatic peptic ulcer and/or hemorrhage. NSAIDs seem to be a significant risk factor for falls, which can lead to morbidity and mortality in older adults. Therefore, risks and benefits should be balanced carefully in individual patients"

Dosing

ADULT/ELDERLY

- 160 mg, uncoated **chewed and swallowed**

Miscellaneous:

Altered Kidney Function:

- In general the benefit of low-dose aspirin outweighs any risk associated with nephropathy or other adverse effects even in the setting of severe kidney impairment; the recommended aspirin dose should not be reduced in any patient with suspected or documented cardiovascular disease, or other antithrombotic indication.

Altered Liver Function:

- Avoid use in severe liver disease.

Concentration Supplied:

- 80 mg chewable tablet

Provider/Route:

- **EMR:** chew and swallow
- **PCP/ICP:** chew and swallow
- **ACP:** chew and swallow
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- ACLS for Experienced Providers 2017
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6388?cesid=aJm4GiQ0sOO&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dasa%26t%3Dname%26acs%3Dfalse%26acq%3Dasa
- https://web.p.ebscohost.com/nup/detail/detail?vid=10&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009958716&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711083

Development – May 2023
Update – June 2025

EMS Provincial Medications

Charcoal, Activated

Classification

- Antacids and adsorbents
- Antidote

Indications

EMS INDICATIONS

- Used in treatment of most oral poisonings except those caused by corrosive agents (e.g. strong acid or alkalis) or substances for which its absorptive capacity is too low to be clinically useful (e.g. iron salts, lithium, etc.)

HEALTH CANADA APPROVED

- *Used in treatment of most oral poisonings except those caused by corrosive agents (e.g. strong acid or alkalis) or substances for which its absorptive capacity is too low to be clinically useful (e.g. iron salts, lithium, etc.)*
- *Most commonly used agent for GI decontamination poisoned patients*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITERATURE

- *Intracranial hemorrhage associated with oral non-vitamin K antagonist anticoagulants*

Mechanism of Action

- Adsorbs toxic substances, thus inhibiting GI absorption and preventing or limiting systemic toxicity. Administration of multiple doses of charcoal may interrupt enteroenteric, enterohepatic, and enterogastric circulation of some drugs; may also adsorb any unabsorbed drug which remains in the gastrointestinal tract.

Pharmacokinetics

- **Onset:** within minutes
- **Duration:** 4 to 12 hours
- **Peak:** unknown
- Most effective when administered early, preferably within 30 to 60 minutes of poison ingestion
- **Excreted** in feces as charcoal

Contraindications

- Before endoscopy and ingestion of corrosive agents, unless necessary to adsorb another ingested toxin; may obscure endoscopic evaluation of gastroesophageal lesion
- Patients with an unprotected airway, a GI tract that is not anatomically intact, and where risk or severity of aspiration may be increased (e.g. hydrocarbon ingestions)
- Multiple-dose regimen in presence of ileus or bowel obstruction

Cautions

- Not effective in the treatment of poisoning due to ingestion of low molecular weight compounds such as cyanide, iron, ethanol, methanol or lithium.
- Most effective when administered within 30 to 60 minutes of ingestion.
- Vomiting
- Decreased peristalsis
- Peds: Excessive amounts of activated charcoal with sorbitol may cause hypernatremic dehydration in pediatric patients
- Use is not recommended in infants less than 1 year of age.

DRUG INTERACTIONS

- Cathartics (e.g. sorbitol, mannitol, magnesium sulfate)

PREGNANCY

- Activated charcoal is not absorbed systemically following oral administration. Use during pregnancy is not expected to result in significant exposure to the fetus. In general, medications used as antidotes should take into consideration the health and prognosis of the mother; antidotes should be administered to pregnant women if there is a clear indication for use and should not be withheld because of fears of teratogenicity.

BREASTFEEDING

- Activated charcoal is not absorbed systemically following oral administration. Breast-feeding is not expected to result in significant exposure to a nursing child

Adverse Effects

OPHTHALMIC: Corneal abrasion (with direct contact)

GASTROINTESTINAL

- Nausea, vomiting
- Constipation
- Diarrhea
- GI obstruction or fecal impaction in dehydrated patients
- Abdominal distention, appendicitis, constipation, dental discoloration (black; temporary), fecal discoloration (black), intestinal obstruction, mouth discoloration (black; temporary)

PULMONARY

- Aspiration resulting in bronchiolitis obliterans, tissue reaction to suspension agents, and increased lung permeability (rare)
- Respiratory failure

Dosing

***Contact PADIS for treatment recommendations**

ADULT/ELDERLY

- 50 grams **PO**

PEDIATRIC

- Contact PADIS (1 gram per kg as per PADIS)

Miscellaneous:

Altered Kidney Function:

- No dosage adjustment necessary for any degree of kidney dysfunction

Concentration Supplied:

- 50 g/250 mL

Provider/Route:

- **EMR:** oral
- **PCP/ICP:** oral
- **ACP:** oral
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6579?cesid=2psQmMuHzw3&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dactivated%2Bcharcoal%26t%3Dname%26acs%3Dtrue%26acq%3Dactivate
- The Hospital for Sick Children Electronic Formulary
- SaskKids Pediatric Parental Manual

Development – May 2023
Update – June 2025

EMS Provincial Medications

Adenosine High Alert

Classification

- Antiarrhythmic

Indications

EMS INDICATIONS

- For the conversion of paroxysmal supraventricular tachycardia to sinus rhythm, including that associated with accessory bypass tracts (Wolff-Parkinson-White Syndrome). Adenosine does not convert atrial flutter, atrial fibrillation or ventricular tachycardia to normal sinus rhythm
- May administer to hemodynamically stable patients as a diagnostic tool in patients when trying to decipher the type of arrhythmia (e.g. ventricular tachycardia vs supraventricular tachycardia with aberrancy). Do **NOT** administer for irregular or polymorphic wide complex tachycardia.
- For patients whose arrhythmia persists despite successful adenosine-induced AV block, switch to an alternative therapy. Do not use in patients with a known accessory pathway that exhibits retrograde conduction; this can lead to ventricular arrhythmias.

HEALTH CANADA APPROVED

- *For the conversion of paroxysmal supraventricular tachycardia to sinus rhythm, including that associated with accessory bypass tracts (Wolff-Parkinson-White Syndrome). Adenosine does not convert atrial flutter, atrial fibrillation or ventricular tachycardia to normal sinus rhythm*
- *As a diagnostic tool in patients with broad or narrow QRS complex supraventricular tachycardi*a
- *Pharmacologic cardiac stress testing, diagnostic aid*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITURATURE

- *For induction of maximal coronary hyperemia as a diagnostic agent in determining the severity of coronary stenosis*

Mechanism of Action

- Slows conduction time through the AV node, interrupting the re-entry pathways through the AV node, restoring normal sinus rhythm
- **Myocardial perfusion scintigraphy:** Adenosine also causes coronary vasodilation and increases blood flow in normal coronary arteries with little to no increase in stenotic coronary arteries; thallium-201 uptake into the stenotic coronary arteries will be less than that of normal coronary arteries revealing areas of insufficient blood flow.

Pharmacokinetics

- **Onset:** Immediate
- **Peak:** unknown
- **Duration:** approximately 30 seconds
- **Half life:** less than 10 seconds

- **Metabolized** from systemic circulation primarily by vascular endothelial cells and erythrocytes (by cellular uptake) and metabolized by an enzyme on the surface of red blood cells (adenosine deaminase); rapidly metabolized intracellularly.

Contraindications

- Known hypersensitivity to adenosine or any component of formulation
- Second or third degree AV block (except in patients with artificial pacemaker)
- Sick sinus syndrome (except in patients with functioning artificial pacemaker)
- Symptomatic bradycardia (except in patients with a functioning artificial pacemaker)
- Contraindicated in poison/drug-induced tachycardia or second- or third-degree heart block.

Cautions

- **HIGH ALERT**
- ELDERLY: may have diminished cardiac function, nodal dysfunction, concomitant disease, or drug therapy that may alter hemodynamic function and produce severe bradycardia or AV block
- May produce (short lasting) first, second or third degree heart block. Transient asystole may occur, external pacer should be easily accessible
- Warn patient of probable transient side effects (i.e. flushing, chest discomfort, headache and dyspnea), which resolve within one minute
- Patients with asthma, COPD or a history suggestive of bronchospasm; may cause bronchospasm
- A variety of new rhythms may occur at the time of conversion to normal sinus rhythm
- Patients with atrial fibrillation/flutter and an accessory bypass tract may develop increased conduction down the anomalous pathway
- CENTRAL LINE ADMINISTRATION: lower doses should be considered due to decreased degradation by vascular endothelium and blood cells
- Heart transplant patients: clinically profound bradycardia can result. Use greatly decreased doses if at all
- Wolff-Parkinson-White (WPW) syndrome: Adenosine should not be used in patients with WPW syndrome and pre-excited atrial fibrillation/flutter since ventricular fibrillation may result
- Arrhythmia (wide-complex tachycardia): Avoid use in irregular or polymorphic wide-complex tachycardias; may cause degeneration to ventricular fibrillation

DRUG INTERACTIONS

- digoxin or digoxin/verapamil combination: has caused ventricular fibrillation, use with caution
- carBAMazepine – higher degree of heart block may be produced
- dipyridamole – effects of adenosine potentiated. Dose reduction is advised
- Methylxanthines (caffeine, theophylline) – effects of adenosine are antagonized. May require higher doses

PREGNANCY

- Safe and effective
- Adenosine has been used in all stages of pregnancy for maternal and embryo–fetal indications without harming the embryo or fetus. Ordinarily, adverse fetal effects secondary to adenosine would not be expected because of the widespread, natural distribution of this substance in the body. However, the maternal administration of large IV doses of adenosine may potentially produce fetal toxicity, as has been observed with other endogenous agents (e.g., see Epinephrine). The guidelines of three professional organizations recommend adenosine as the preferred treatment for acute supraventricular tachycardia treatment in pregnancy.

BREASTFEEDING

- Because adenosine is used only by IV injection in acute care situations, it is doubtful that any reports will be located describing the use of adenosine during human lactation. Moreover, the serum half-life is so short that it is unlikely that any of the drugs will pass into milk.

MONITORING REQUIRED

- ECG, heart rate, blood pressure, Respirations
- Continuous ECG monitoring during infusion and for 3 to 5 minutes after administration and then until stable

PEDIATRIC/NEONATE

- Defibrillator and personnel competent with procedures requiring such equipment are required at bedside for the safe administration of adenosine.
- Monitor ECG, heart rate, blood pressure, respirations during and for 3 to 5 minutes after administration and then until stable.

Adverse Effects

Reactions appear immediately after administration and usually last less than one minute.

CARDIOVASCULAR

- Facial flushing (common)
- Angina-like chest pain/pressure (common)
- Sweating
- Palpitations
- Headache
- Arrhythmias at time of conversion to normal sinus rhythm: premature ventricular contractions, polymorphic ventricular tachycardia, torsades de pointes, atrial premature contractions, sinus bradycardia, sinus tachycardia, skipped beats, varying degrees of A-V nodal block
- Hypotension (rare)
- Prolonged asystole

RESPIRATORY

- Shortness of breath/dyspnea (common)
- Hyperventilation
- Bronchospasm

CENTRAL NERVOUS SYSTEM

- Light headedness/dizziness
- Tingling and/or heaviness in the arms
- Numbness
- Blurred vision
- Burning sensation
- Neck and back pain

GASTROINTESTINAL

- Nausea (common)
- Metallic taste
- Tightness in throat

Dosing

* Note: A brief period (10-15 seconds) of bradycardia (asystole or third-degree heart block) may ensue after administration of adenosine. Consider warning caregiver and patient, if age appropriate, that bradycardia can be very uncomfortable.

ADULT:
1st dose – 6 mg **IV over 1 to 2 seconds** with rapid 20 mL flush
2nd dose- 12 mg **IV over 1 to 2 seconds** with rapid 20 mL flush

- If initial dose is not effective within 1 to 2 minutes, administer 12 mg over 1 to 2 seconds followed immediately by a 20 mL flush to enhance delivery to the site of action in the heart
- As per ACLS only 2 doses of Adenosine should be given; 6 mg and 12 mg

***Note**:

- Initial dose should be reduced to 3 mg if patient is currently receiving carBAMazepine or dipyridamole.
- If patient has a transplanted heart the initial dose should be reduced to 1 mg; may increase subsequent doses up to 3 mg, if needed.
- If adenosine is administered via central line initial dose should be reduced to 3 mg with subsequent doses of 6 mg, then 9 mg if needed.
- Less effective (larger doses may be required) in patients taking theophylline or caffeine

ELDERLY:
Same dosing as adults but may be more sensitive to effects

PEDIATRICS:
1st dose – 0.1 mg/kg **IV over 1 to 2 seconds** (max 6 mg)
2nd dose – 0.2 mg/kg **IV over 1 to 2 seconds** (max 12 mg)

- if not effective within 1 to 2 minutes, administer 0.2 mg/kg (Maximum single dose: 12 mg)
- if the drug is effective, the rhythm will convert to sinus rhythm within 15 to 30 seconds after administration

*Note: Decrease the initial dose by approximately 75% for patients receiving carbamazepine or dipyridamole or those with transplanted hearts

Concentration Supplied:

- 3 mg/mL (2 mL vial)

Reconstitution/Stability:

- No reconstitution required
- Compatible with NS, D5W, LR, concentrations of KCl up to 40 mmol/L
- Do not refrigerate as crystallization may occur. If crystallization has occurred, dissolve crystals by warming to room temperature

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IV, IO, CVL
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- SaskKids Pediatric Parental Manual
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/adenosine.pdf

- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6288?cesid=1wkT42n9Lee&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dadenosine%26t%3Dname%26acs%3Dtrue%26acq%3Dadenos
- https://web.p.ebscohost.com/nup/detail/detail?vid=14&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535799&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711024
- PALS 2020
- ACLS 2020
- ACLS EP 2017

Development – May 2023
Update – June 2025

EMS Provincial Medications

Amiodarone HIGH ALERT

Classification

- Antiarrhythmic

Indications

EMS INDICATIONS

- Life-threatening recurring ventricular fibrillation (VFib) and hemodynamically unstable ventricular tachycardia (VT)
- Antiarrhythmic during Advanced Cardiac Life Support (VFib/pulseless VT and stable VT)

HEALTH CANADA APPROVED

- *Life-threatening recurring ventricular fibrillation (VFib) and hemodynamically unstable ventricular tachycardia (VT)*

NON HEALTH CANANDA APPROVED BUT SUBSTANTIATED IN THE LITERATURE

- *Antiarrhythmic during Advanced Cardiac Life Support (VFib/pulseless VT and stable VT, supraventricular tachycardia)*
- *Atrial arrhythmias: restoration and maintenance of sinus rhythm, or rate control, in patients with atrial arrhythmias in whom standard therapies were unsuccessful or contraindicated*

Mechanism of Action

- Class III antiarrhythmic agent which inhibits adrenergic stimulation (alpha- and beta-blocking properties), affects sodium, potassium, and calcium channels, prolongs the action potential and refractory period in myocardial tissue; decreases AV conduction and sinus node function.

Pharmacokinetics

- **Onset:** less than 2 hours
- **Peak:** less than 30 to 45 minutes post infusion
- **Duration:** unknown
- **Half-life**: 9 to 36 days
- **Metabolized** primarily by hepatic metabolism and biliary **excretion** as Feces; urine (less than 1% as unchanged drug).

Contraindications

- Hypersensitivity to amiodarone, iodine or any component of the formulation (Note: The FDA-approved product labeling states amiodarone is contraindicated in patients with iodine hypersensitivity. This does not include most patients with allergic reactions to shellfish or contrast media, which are usually not due to iodine itself. However, exercise caution in patients with severe allergies to shellfish or contrast media).
- Marked sinus bradycardia, cardiogenic shock, 2nd or 3rd degree AV block in the absence of a pacemaker

- Wolff-Parkinson-White (WPW) syndrome: Amiodarone should not be used in patients with WPW syndrome and pre-excited atrial fibrillation/flutter since ventricular fibrillation may result

Cautions

- **HIGH ALERT**
- Thyroid dysfunction, pulmonary interstitial abnormalities; as oral amiodarone is contraindicated
- Electrolyte imbalance: especially hypokalemia or hypomagnesemia, hyperkalemia correct prior to use and throughout therapy

DRUG INTERACTIONS

- Drugs metabolized by CYP enzymes: is a potent inhibitor of CYP enzymes and transport proteins (including p-glycoprotein), which may lead to increased serum concentrations/toxicity of a number of medications
- Drugs with QT prolongation potential: particular caution must be used when a drug with QTc-prolonging potential relies on metabolism via enzymes amiodarone inhibits, since the effect of elevated concentrations may be additive with the effect of amiodarone. Carefully assess risk: benefit of co-administration of other drugs which may prolong QTc interval
- Warfarin: risk of increased INR with or without bleeding; monitor INR closely after initiating amiodarone

PREGNANCY

- Fetal adverse effects directly attributable to amiodarone have been observed. Congenital goiter/hypothyroidism and hyperthyroidism may occur after in utero exposure. Newborns exposed to amiodarone in utero should have thyroid function studies performed because of the large proportion of iodine contained in each dose.

BREASTFEEDING

- The manufacturer does not recommend breastfeeding during therapy.
- In 2001, the American Academy of Pediatrics, noting that hypothyroidism is a potential complication, classified amiodarone as a drug for which the effect on nursing infants is unknown but may be of concern.

REQUIREMENTS

- Non-PVC, non-DEHP container for infusion duration longer than 2 hours
- Electronic infusion device. In-line filter (0.2/ 0.22 micron) for intermittent and continuous infusions
- Pediatrics less than 6 kg: Non-PVC, non-DEHP tubing and in-line filter for continuous infusion
- Central line required for infusion durations longer than 1 hour with concentrations greater than 2 mg/mL

MONITORING REQUIRED

DIRECT IV - CARDIAC ARREST:

- HR and ECG monitoring as per cardiac arrest team leader

INTERMITTENT AND CONTINUOUS INFUSION:

- Continuous ECG monitoring. Notify physician if bradycardia and/or marked QTc prolongation occur
- Baseline BP and HR then every 15 minutes x 4 and until stable, for continuous infusion continue every 4 hours during infusion
- Monitor peripheral IV site for pain, redness or swelling prior to initiating infusion and every 4 hours during infusion

RECOMMENDED

- Serum electrolytes and acid-base balance, especially in patients with prolonged diarrhea and those receiving diuretics
- Liver enzymes (AST, ALT, GGT) for elevations indicating progressive injury
- Pulmonary function tests including chest X-rays, serum creatinine and thyroid function tests may be indicated

Adverse Effects

CARDIOVASCULAR

- Clinically significant hypotension. Usually occurs within the first several hours or with daily doses greater than
- 2.1 grams Responds to reduction of infusion rate. May require IV fluids, vasopressors or positive inotropic agents
- Bradycardia. Responds to slowing or temporarily stopping infusion. May require pacing

- Proarrhythmic effect, both bradyarrhythmias and tachyarrhythmias. The most clinically relevant is torsade de pointes, which is often preceded by bradycardia and marked QTc prolongation

EXTRAVASATION

- Irritant: venous thrombosis, irritation and potential tissue necrosis with extravasation at IV site and surrounding infiltrated area, especially with a concentration of 3 mg/mL or greater
- TREATMENT: Discontinue drug immediately and notify physician.

MISCELLANEOUS

- Early and moderate increase in transaminase levels
- Pulmonary edema, severe respiratory failure, nausea, fever

Dosing

ADULT/ELDERLY:

VF/Pulseless VT:

- 300 mg **IV bolus** (repeat 150 mg every 5 mins until converted or max reached); upon ROSC consider starting a maintenance infusion as stated below

  *NOTE: If patient converted post cardiac arrest with defibrillations and no amiodarone was given but then goes into stable vtach they may be given 150 mg/10 min dose then the maintenance infusion following that if patient converts.

VT w/pulse:

- 150 mg in 100 mL D5W **infused IV via pump** over 10 minutes every 10 minutes until converted or max reached

  *NOTE: If pt has converted to sinus after 150 mg/10 min dose and you have the maintenance infusion running and patient goes back into stable vtach you may repeat the 150 mg/10 min dose.

Maintenance Infusion (following ROSC or VT conversion as long as max of 2.2 g in 24 hours not reached):

- 1 mg/min = 450 mg in 250 mL D5W at 33.3 mL/hr for 6 hours **IV infusion on pump** (max 2.2 g in 24 hours)

  *NOTE: If upon ROSC with maintenance infusion running patient goes into VF or pVT you can give another dose of 150 mg IVP

PEDIATRIC:

VF/Pulseless VT:

- 5 mg/kg **IV bolus** (max 300 mg/dose). May repeat twice

VT w/pulse:

- 5 mg/kg (max 300 mg/dose) **infused IV via pump** over 60 mins (mixed in 100 mL D5W); may repeat initial loading dose to a max of 10 mg/kg over 60 mins if not converted; if converted follow by maintenance dose as below

Pediatric greater than 15 kg:

LOADING DOSE:

- 5 mg/kg (max 300 mg/dose) over 60 mins via **IV infusion on pump** (mixed the same as adult loading dose 150 mg in 100 mL D5W)

MAINTENANCE INFUSION (following ROSC or VT conversion as long as max of 20 mg/kg in 24 hr not reached):

- 5 mcg/kg/minute. May increase to maximum rate of 15 mcg/kg/minute (mixed the same as adult maintenance infusion 450 mg/250 mL D5W)

MAXIMUM: 20 mg/kg/24 hours

Miscellaneous:

- Dosage adjustment is probably necessary in substantial hepatic impairment. No specific guidelines available.

Concentration Supplied:

- 50 mg/mL (3 mL vial)
- Undiluted in cardiac arrest

Compatibility/Stability:

- Stable in D5W in PVC infusion bags for 2 hours at room temperature at concentrations between 1 to 6 mg/mL
- Stable in D5W in non-PVC containers, (e.g. polyolefin bags) for at least 24 hours at room temperature in concentrations between 1 to 6 mg/mL. Stability information on higher concentrations is not available at this time
- Due to conflicting stability information in NS, it is recommended to dilute with D5W only

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IV, IO, CVAD, IVAD
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/amiodarone.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6332?cesid=08bHheqOwRX&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Damiodarone%26t%3Dname%26acs%3Dtrue%26acq%3Damiod
- The Hospital for Sick Children Electronic Formulary
- SaskKids Pediatric Parental Manual
- https://web.p.ebscohost.com/nup/detail/detail?vid=20&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535331&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711053
- PALS 2020
- ACLS 2020
- ACLS EP 2017

Development – May 2023
Update – June 2025

EMS Provincial Medications

Atropine

Classification

- Anticholinergic

Indications

EMS INDICATIONS

- Symptomatic Bradycardia
- Antidote for organo-phosphate poisoning
- Reverse cardiac effects (decreased heart rate, blood pressure and systemic vascular resistance) associated with increased vagal tone

HEALTH CANADA APPROVED

- *Antidote for organo-phosphate, muscarine and other anticholinesterase poisoning*
- *Preoperatively as an antisialogogue to reduce salivation and excessive respiratory secretions. Atropine is not needed as commonly with newer anesthetic agents*
- *Prevent cholinergic effects which result from vagal stimulation during surgery (eg, bradycardia, hypotension, cardiac arrhythmias)*
- *Reverse cardiac effects (decreased heart rate, blood pressure and systemic vascular resistance) associated with increased vagal tone*
- *In combination with anticholinesterase agents (e.g., neostigmine) after surgery to terminate curarization*

Mechanism of Action

- Blocks the action of acetylcholine at parasympathetic sites in smooth muscle, secretory glands, and the CNS; increases cardiac output, dries secretions. Atropine reverses the muscarinic effects of cholinergic poisoning due to agents with acetylcholinesterase inhibitor activity by acting as a competitive antagonist of acetylcholine at muscarinic receptors. The primary goal in cholinergic poisonings is reversal of bronchorrhea and bronchoconstriction. Atropine has no effect on the nicotinic receptors responsible for muscle weakness, fasciculations, and paralysis; concurrent administration of pralidoxime is necessary to reverse the nicotinic effects associated with organophosphate insecticide or nerve agent toxicity.

Pharmacokinetics

- **Onset:** Immediate
- **Peak:** 2 to 4 minutes
- **Duration:** 4 to 6 hours
- **Metabolized** through the Hepatic system via enzymatic hydrolysis
- **Excretion:** Excretion: Urine (13% to 50% as unchanged drug and metabolites)

Contraindications

- Hypersensitivity to atropine, or any component of formulation. No contraindications exist in treatment of severe or life threatening muscarinic effects, including life-threatening poisoning
- Narrow-angle glaucoma, myasthenia gravis
- Obstructive disease of gastrointestinal tract, paralytic ileus, intestinal atony
- Unstable cardiovascular status in acute hemorrhage
- Severe ulcerative colitis, toxic megacolon complicating ulcerative colitis

Cautions

- Elderly: may produce excitement, agitation, confusion or drowsiness. May precipitate undiagnosed glaucoma; potential for constipation and urinary retention increased; has potential to increase memory impairment
- Elderly: Atropine is identified in the Beers Criteria as a potentially inappropriate medication to be avoided in patients 65 years and older (independent of diagnosis or condition) due to its highly anticholinergic properties and uncertain effectiveness as an antispasmodic.
- Hepatic and renal disease, ulcerative colitis, hyperthyroidism, autonomic neuropathy
- Coronary heart disease, heart failure, cardiac arrhythmias, tachycardia and hypertension
- Prostatic hypertrophy, hiatus hernia associated with reflex esophagitis
- Heart transplant recipients: Atropine will likely be ineffective in treatment of bradycardia due to lack of vagal innervation of the transplanted heart. Cholinergic reinnervation may occur over time (years), so atropine may be used cautiously; however, some may experience paradoxical slowing of the heart rate and high-degree AV block upon administration (ACLS 2020)
- Use with caution in the presence of myocardial ischemia and hypoxia. Increases myocardial oxygen demand. (ACLS EP 2017)
- Unlikely to be effective for hypothermic bradycardia. (ACLS EP 2017)
- May not be effective for infranodal (type II) AV block and new third-degree block with wide QRS complexes. (In these patients may cause paradoxical slowing. Be prepared to pace or give catecholamines.) (ACLS EP 2017)(2020 Handbook of Emergency Cardiovascular Care)

PREGNANCY

- Although the human data describing pregnancy outcomes are limited, there is no evidence of embryo or fetal harm.

BREASTFEEDING

- The passage of atropine into breast milk is controversial. It has not been adequately documented whether measurable amounts are excreted or, if excretion does occur, whether it may affect the nursing infant. Although neonates are particularly sensitive to anticholinergic agents, no adverse effects have been reported in nursing infants whose mothers were taking atropine. In 2001, the American Academy of Pediatrics classified the agent as compatible with breastfeeding.

REQUIREMENTS

- Flush with NS after each dose
- Heart rate, blood pressure, pulse, mental status; intravenous administration requires a cardiac monitor

MONITORING REQUIRED

- Baseline BP and heart rate, then every 3 minutes x 2, until stable – EXCEPTION: cardiac arrest
- Continuous ECG monitoring while giving dose and until stable

RECOMMENDED

- Bowel sounds and urine output if ordered for longer than 24 hours

Adverse Effects

CARDIOVASCULAR

- Tachycardia
- Palpitations/Arrhythmias
- Bradycardia in adults at doses less than 0.5 mg or if given slowly (more than 2 minutes). Controversial if this is a concern in pediatrics
- Heart block
- Hypertension
- Increased myocardial ischemia and angina

CENTRAL NERVOUS SYSTEM

- Mild dizziness
- Disorientation/ confusion – especially in elderly or debilitated patients
- Excitement/agitation
- Drowsiness

GASTROINTESTINAL

- Dry mouth
- Constipation

GENITOURINARY

- Urinary retention

MISCELLANEOUS

- Flushing, dry skin, increase in body temperature – especially in children and brain-damaged infants
- Blurred vision
- Photophobia

Dosing

*Slow IV administration may cause Paradoxical bradycardia
*Flush with NS after each dose

Bradycardia:

- Adult/Elderly – 1 mg **IV** given undiluted over 30 seconds or less every 3 to 5 minutes (max 3 mg)
- Peds – 0.02 mg/kg **IV** (max singe dose 0.5 mg) given over 1 minute (max concentration: 1 mg/mL) every 3 to 5 minutes *IF SUSPECTED TO BE VAGALLY MEDIATED

Antidote/Organophosphate Poisoning (OPP):

- **Adult/Elderly:** 1 to 2 mg; repeat every 5 to 60 minutes as needed to control muscarinic symptoms, repeat if they reappear
- **Adult/Elderly:** 2 to 6 mg **IV** may be given initially in **severe cases** with doses repeated every 5 to 60 minutes. Continue dosage until definite improvement occurs and is maintained, sometimes for 2 days or more.
- **Children 12 years and older:** 1 mg/dose IV initially then repeated by doubling the dose every 5 minutes until muscarinic symptoms reverse
- **Peds less than 12 years:** 0.05 mg/kg **IV** initially, then doubling the dose every 5 minutes until resolution of muscarinic symptoms (control of excessive bronchial secretions, correction of significant bradycardia and hypotension)

Miscellaneous:

- Can be given via IM and subcutaneous route
- Endotracheal (least preferred route): 2 to 2.5 mg every 3 to 5 minutes

Concentration Supplied:

- 0.2 mg/mL (5 mL preload)

Compatibility/Stability:

- Compatible with D5W, NS, LR and LR solutions
- Further dilution not recommended. If necessary dose may be diluted with NS or SWFI and used immediately

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP**: IV, IO, CVAD, IVAD, ET
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- SaskKids Pediatric Parental Manual
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/atropine.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/5699355?cesid=1xSqaJB82Qg&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Datropine%26t%3Dname%26acs%3Dtrue%26acq%3Datrop
- https://web.p.ebscohost.com/nup/detail/detail?vid=18&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535703&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711090
- Advanced Cardiovascular Life Support (ACLS) Provider Manual 2020
- ACLS for Experienced Providers 2017
- 2020 Handbook of Emergency Cardiovascular Care for Healthcare Providers

Development – May 2023
Update – June 2025

EMS Provincial Medications

Calcium Chloride HIGH ALERT

Classification

- Electrolyte - irritant

Indications

EMS INDICATIONS

- Treatment of hypocalcemia for those conditions requiring a prompt increase in serum calcium concentrations e.g. cardiac arrest or cardiotoxicity in the presence of evidence of hyperkalemia
- Treatment of sine wave pattern ECG
- Treatment of suspected Hyperkalemia based on the presence of the following:
    - **A SOURCE** (one of the following):
        - History of kidney disease
        - Chronic renal insufficiency
        - Another condition that would predispose the patient to a condition of hyperkalemia (i.e. rhabdomyolysis, severe burns, severe trauma/crush trauma, tumor lysis syndrome)

    AND
    - **ELECTROCARDIOGRAPHIC EVIDENCE** (one of the following):
        - ECG changes suggestive of hyperkalemia (peaked T waves, loss of P waves, wide QRS and/or symptomatic bradycardia)
        - Patient is in CARDIAC ARREST

HEALTH CANADA APPROVED

- *Treatment of hypocalcemia for those conditions requiring a prompt increase in serum calcium concentrations e.g. cardiac arrest or cardiotoxicity in the presence of hyperkalemia, hypocalcemia, or hypermagnesemia*
- *Prevention of hypocalcemia during exchange transfusions of citrated blood*

NON HEALTH CANADA APPROVED INDICATION BUT SUBSTANTIATED IN THE LITERATURE

- *Calcium channel blocker overdose; beta-blocker overdose (refractory to glucagon and high-dose vasopressors). Contact Poison and Drug Information Service 1-855-454-1212 for the latest recommendations*

Mechanism of Action

- Moderates nerve and muscle performance via action potential excitation threshold regulation.
- Stabilizes myocardial cell membrane without impacting plasma potassium concentrations; must combine with insulin/dextrose to decrease plasma potassium levels and other therapies to eliminate potassium from body.

Pharmacokinetics

- **Onset:** Immediate
- **Peak:** Immediate
- **Duration:** 0.5 to 2 hours
- **Excretion:** Excretion: Primarily feces (80% as insoluble calcium salts); urine (20%)

Contraindications

- Hypersensitivity to calcium chloride or any component of the formulation
- Hypercalcemia; severe renal disease; calcium loss due to immobilization

Cautions

- **HIGH ALERT**
- **Concentrated electrolyte**
- **For IV use only**; not to be administered IM, subcutaneously or intramyocardially: results in severe tissue necrosis
- Acidosis: patients with respiratory acidosis, renal impairment, or respiratory failure; acidifying effect of calcium chloride may potentiate acidosis
- Severe hyperphosphatemia: elevated levels of phosphorus and calcium may result in soft tissue and pulmonary arterial calcium-phosphate precipitation
- Severe hypokalemia: acute rises in serum calcium levels may result in life-threatening cardiac arrhythmias
- Hypomagnesemia: is a common cause of hypocalcemia; therefore, correction of hypocalcemia may be difficult in patients with concomitant hypomagnesemia. Evaluate serum magnesium and correct hypomagnesemia (if necessary), particularly if initial treatment of hypocalcemia is refractory
- Do not use routinely in cardiac arrest (ACLS EP) (2020 Handbook of Emergency Cardiovascular Care)

DRUG INTERACTIONS

- **cefTRIAXone** may complex with calcium causing precipitation. See cefTRIAXone monograph for specific details
- digoxin: may increase risk of arrhythmias. ECG monitoring is recommended
- Do not mix with sodium bicarbonate (ACLS EP 2017) (2020 Handbook of Emergency Cardiovascular Care)

PREGNANCY

- Calcium crosses the placenta. The amount of calcium reaching the fetus is determined by maternal physiological changes. Calcium requirements are the same in pregnant and nonpregnant females.
- Information related to use as an antidote in pregnancy is limited. In general, medications used as antidotes should take into consideration the health and prognosis of the mother; antidotes should be administered to pregnant women if there is a clear indication for use and should not be withheld because of fears of teratogenicity. Medications used for the treatment of cardiac arrest in pregnancy are the same as in the nonpregnant woman. Doses and indications should follow current Advanced Cardiovascular Life Support guidelines.

BREASTFEEDING

- Calcium is excreted in breast milk. The amount of calcium in breast milk is homeostatically regulated and not altered by maternal calcium intake. Calcium requirements are the same in lactating and nonlactating females.

REQUIREMENTS

- Electronic infusion device for intermittent and continuous infusions.
- Central line preferred for concentrations of 40 mg/mL or greater: exception – life threatening situation

PEDIATRICS

- Consult Critical Care or Transport Team

MONITORING REQUIRED

- ECG monitoring for direct IV administration or rates greater than 50 mg/minute
- Monitor peripheral IV site for pain, redness or swelling prior to initiating infusion and every 15 minutes until completion of infusion
- Perform continuous cardiac monitoring and obtain serial ECGs

RECOMMENDED

- Advise patients to report burning/stinging/pain at IV site promptly. Calcium chloride 100 mg/mL = 2040 mOsm/L
- Additional doses guided by serum calcium and albumin levels

Adverse Effects

CARDIOVASCULAR

- Peripheral vasodilation with moderate decrease in BP
- Bradycardia, cardiac arrhythmias, syncope and cardiac arrest - associated with too rapid rate of injection

MISCELLANEOUS

- Local burning sensation: further dilution and decrease rate of administration may be required
- Tingling sensations
- Sense of oppression or heat waves
- Calcium or chalky taste

EXTRAVASATION

- Irritant: may cause severe necrosis and calcification at IV site and surrounding infiltrated area

TREATMENT:

- discontinue drug immediately and notify physician (there is an antidote)

Dosing

Adult/Elderly:

CARDIAC ARREST OR CARDIOTOXICITY IN THE PRESENCE OF HYPERKALEMIA

- To stabilize the myocardium: 1 g over 2 to 5 minutes, may repeat after 5 minutes if ECG changes persist or recur

BETA-BLOCKER OVERDOSE, REFRACTORY TO GLUCAGON AND HIGH-DOSE VASOPRESSORS

- Note: Optimal dose has not been established. Contact PADIS for the latest recommendations
- 20 mg/kg (max 1 g) **IV** over 5 to 10 minutes

CALCIUM CHANNEL BLOCKER OVERDOSE

- Note: Optimal dose has not been established. Contact PADIS for the latest recommendations
- Initial: 1000 to 2000 mg over 5 minutes; may repeat every 10 to 20 minutes with 3 to 4 additional doses or 1000 mg every 2 to 3 minutes until clinical effect is achieved.

Concentration Supplied:

- 100 mg/mL (10 mL Preload)

Compatibility/Stability:

- Stable in D5W and NS solutions for at least 24 hours at room temperature
- Compatible with dextrose, saline, dextrose-saline combinations and lactated Ringer's solutions

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IV, IO, CVL
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/calcium%20chloride.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6505?cesid=7MbBmlAb1mW&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dcalcium%2Bchloride%26t%3Dname%26acs%3Dtrue%26acq%3Dcalci

- https://web.p.ebscohost.com/nup/detail/detail?vid=22&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009958743&db=nup
- Heart and Stroke ACLS for Experienced Providers 2017
- Heart and Stroke 2020 Handbook of Emergency Cardiovascular Care for Healthcare Providers

Development – May 2023
Update – June 2025

Saskatchewan Health Authority

EMS Provincial Medications

CefTRIAXone

Classification

- 3rd generation cephalosporin antibiotic

Indications

EMS INDICATIONS

- Treatment of infections of the lower respiratory and urinary tract, skin structure and bone: also peritonitis, septicemia and meningitis when caused by susceptible organisms. Only to be administered where there is greater than 45 min delay to administration of antibiotic in hospital.
- Can be administered while on OFFLOAD DELAY if greater than 45 mins and patient meets EMS indications.

HEALTH CANADA APPROVED

- *Treatment of infections of the lower respiratory and urinary tract, skin structure and bone: also peritonitis, septicemia and meningitis when caused by susceptible organisms.*
- *Perioperative prophylaxis*

Mechanism of Action

- Inhibits bacterial cell wall synthesis by binding to one or more of the penicillin-binding proteins (PBPs) which in turn inhibits the final transpeptidation step of peptidoglycan synthesis in bacterial cell walls, thus inhibiting cell wall biosynthesis. Bacteria eventually lyse due to ongoing activity of cell wall autolytic enzymes while cell wall assembly is arrested.

Pharmacokinetics

- **Onset:** Rapid
- **Peak:** End of infusion
- **Duration:** 12 to 24 hours
- **Elimination:** Urine (33% to 67% as unchanged drug); feces (as inactive drug)

Contraindications

- Hypersensitivity to cefTRIAXone, any component of formulation or other cephalosporins
- **DO NOT administer cefTRIAXone simultaneously with IV calcium-containing solutions including continuous infusions** (e.g**. LR**, Hartmann's solution or **parenteral nutrition**) even via different infusion lines or at different infusion sites
- cefTRIAXone and IV calcium-containing solutions MAY be administered sequentially, provided the lines are thoroughly flushed between infusions with a compatible fluid

- If the use of cefTRIAXone is considered necessary in patients requiring continuous nutrition, the infusion of parenteral nutrition solution could be stopped for the period of cefTRIAXone infusion and the infusion lines flushed between solutions
- Do not use in hyperbilirubinemic neonates. Displaces bilirubin from albumin binding sites resulting in higher free serum bilirubin
- NEONATES: Contraindicated if treatment with calcium-containing IV solutions required/ expected to be required, including continuous calcium-containing infusions such as parenteral nutrition, due to risk of precipitation of cefTRIAXonecalcium
    - Cases of fatal reactions with cefTRIAXone-calcium precipitates in the lungs and kidneys of both term and premature neonates have been reported

Cautions

- Previous immediate hypersensitivity to penicillin antibiotics. Cross-sensitivity between penicillins and cephalosporins is estimated to be very low. The beta-lactam subunit is not considered primary allergenic determinant; rather, the side chain predicts cross-reactivity. cefTRIAXone does **NOT** have a structurally related side chain to penicillin, ampicillin or amoxicillin
- Gastrointestinal disease (particularly colitis); may cause pseudomembranous colitis
- Concurrent hepatic and severe renal impairment the Daily Dose should not exceed 2 grams. Close monitoring for toxicity should be provided
- Creatinine clearance less than 10 mL/minute, the daily dose should not exceed 2 grams
- Hemodialysis: Not dialysed. Daily dose should not exceed 2 grams.

DRUG INTERACTIONS

- see contraindications
- Never connect IV infusion of drug to an infusion containing calcium as precipitate can form
- There have been no reports of interactions between intravenous ceftriaxone and oral calcium-containing products

PREGNANCY

- No detectable teratogenic risk with cephalosporin antibiotics was found in a large 2001 study. Cephalosporins are usually not considered to cause embryo/fetal harm during pregnancy.

BREASTFEEDING

- In 2001, the American Academy of Pediatrics classified ceftriaxone as compatible with breastfeeding.

REQUIREMENTS

- Electronic infusion device

MONITORING RECOMMENDED

- Monitor for hypersensitivity and anaphylaxis
- Obtain renal and liver function prior to treatment
- Obtain PT/INR in patients at risk for elevations

Adverse Effects

LOCAL REACTIONS

- Pain on injection, thrombophlebitis
- Fatal particulate precipitation of calcium – cefTRIAXone in the lungs and kidneys of both term and premature neonates

HYPERSENSITIVITY

- Urticaria, pruritus, fever, eosinophilia, cytopenia

GASTROINTESTINAL

- Diarrhea
- Nausea/vomiting
- Abdominal pain

Dosing

Adult/Elderly Dose:

- 2 g in 50 mL NS (after reconstituting in 19.2 mL) **IV infusion with pump** over 20 minutes (best practice) OR
- 2 g reconstituted in 19.2 mL of either NS, SWFI or D5W **IV** over 5 minutes

Miscellaneous:

Altered Kidney Function:

- The renal dosing recommendations are based upon the best available evidence and clinical expertise

Altered Liver Function:

- The hepatic dosing recommendations are based upon the best available evidence and clinical expertise

Concentration Supplied:

- 2 g vial (must be reconstituted with either NS, SWFI or D5W)

Reconstitution/Compatibility/Stability:

- Add 19.2 ml of either NS, SWFI or D5W to 2 g vial
- Stable in D5W and NS solutions for at least 24 hours at room temp and in the fridge
- Protect from light
- Compatible with dextrose, saline, and dextrose-saline combinations solutions
- **Incompatible with LR and other calcium-containing IV solutions**

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice, Monitor IV infusion
- **ACP:** IV, IO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711204
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/cefTRIAXone.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6563?cesid=9FPpdDPSimX&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DcefTRIAXone%26t%3Dname%26acs%3Dtrue%26acq%3Dcef
- https://web.p.ebscohost.com/nup/detail/detail?vid=24&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009565149&db=nup

Development – May 2023
Update – June 2025

EMS Provincial Medications

DexAMETHasone

Classification

- Corticosteroid

Indications

EMS INDICATIONS

- Pediatric - Adjunctive treatment for croup, asthma and anaphylaxis.

SHA EMS Medical Direction Note:

- Preferred steroid treatment for pediatric croup, asthma and anaphylaxis.

HEALTH CANADA APPROVED

- *Treatment of conditions responsive to steroid therapy including adrenocortical insufficiency, cerebral edema associated with brain tumours, allergic states and inflammatory diseases; when oral therapy is not feasible*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITURATURE

- *Prevention and treatment of cancer chemotherapy-induced nausea and vomiting, if unable to give by mouth*
- *Adjunct in the treatment of pediatric bacterial meningitis*
- *Bronchopulmonary dysplasia to facilitate ventilator weaning*

Mechanism of Action

- Dexamethasone is a long-acting corticosteroid with minimal sodium-retaining potential. It decreases inflammation by suppression of neutrophil migration, decreased production of inflammatory mediators, and reversal of increased capillary permeability; suppresses normal immune response. Dexamethasone induces apoptosis in multiple myeloma cells. Dexamethasone's mechanism of antiemetic activity is unknown.

Pharmacokinetics

- **Onset:** Unknown
- **Peak**: 1 to 2 hours PO
- **Duration:** 72 hours
- **Half-life:** 4 hours
- **Metabolism:** Hepatic
- **Excretion:** Urine (~10%)

Contraindications

- Hypersensitivity to dexamethasone or any component of the formulation. Some formulations contain sulfites
- Systemic fungal infections, administration of live virus vaccines

- Gastric and duodenal ulcers; infection with tropical worms; active or suspected ocular or periocular infections; advanced glaucoma in patients with cup to disk ratios greater than 0.8; systemic infection unless specific anti-infective therapy is employed.

Cautions

- Elderly: may be at increased risk of adverse effects such as hypertension, glucocorticoid induced osteoporosis
- Infections (bacterial, fungal, viral), latent or active tuberculosis, without concurrent appropriate antituberculous medications; due to immunosuppression
- Heart failure, hypertension, diabetes mellitus, diverticulitis, intestinal anastomoses, peptic ulcer, ulcerative colitis, myasthenia gravis, recent myocardial infarction, osteoporosis
- Vaccinations should not be given to those on high dose therapy due to possible neurological complications and lack of antibody response

DRUG INTERACTIONS

- Indomethacin –increased incidence of gastrointestinal perforation and GI hemorrhage
- Substrate and inducer of cytochrome P450 isoenzyme 3A4; Interacts with many drugs – contact pharmacy for more information. Review drug profile at time of initiation and with any change in medication regimen

PREGNANCY

- Nonfluorinated corticosteroids are preferred (prednisone)
- Dexamethasone is a corticosteroid with potency similar to betamethasone. Use in the 1st trimester has a small absolute risk of oral clefts. However, depending on the indication, the benefit of therapy may outweigh the risk.

BREASTFEEDING

- Breastfeeding is recommended to be paused for min 4hrs.
- Excretion of dexamethasone into milk should be expected.

RECOMMENDED

- Baseline potassium and blood glucose for short term high dose therapy. Repeat as required during therapy

Adverse Reactions

Occur with use of high doses for prolonged periods and are less likely to occur with short term use

CARDIOVASCULAR

- Transient hypotension
- myocardial rupture following acute myocardial infarction
- Fluid retention
- Hypertension
- Heart failure

CENTRAL NERVOUS SYSTEM

- Depression
- Euphoria

ENDOCRINE

- Growth suppression in children: Cushing's syndrome
- Hyperglycemia or exacerbation of diabetes mellitus: Hypokalemia
- Adrenal suppression; immune system suppression

DERMATOLOGICAL

- Impaired wound healing
- Petechiae/ecchymosis

GASTROINTESTINAL

- Gastrointestinal perforation and GI hemorrhage in neonates
- Nausea (May administer with food or milk to decrease GI adverse effects); pancreatitis

RESPIRATORY

- Bronchospasm; Pulmonary edema: Pulmonary tuberculosis

MUSCULOSKELETAL

- Osteoporosis

OPTHALMIC

- Increased intraocular pressure

HEPATIC IMPAIRMENT ADJUSTMENTS

- Dosage adjustments may be required in patients with cirrhosis due to enhanced effects. No guidelines available at this time

Dosing

Pediatric:

- 0.6 mg/kg **PO** to a max of 16 mg

Concentration Supplied:

- 4 mg/mL
- *Note: the supply of Dexamethasone is in an IV form that is to be given orally, can be given with juice.

Compatibility/Stability:

- Stable in D5W and NS for at least 24 hours at room temperature
- Compatible with dextrose, saline, dextrose-saline combinations and LR solutions

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** PO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- SaskKids Pediatric Parental Manual
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/dexamethasone.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/1772961?cesid=345KtgykygR&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DdexAMETHasone%26t%3Dname%26acs%3Dtrue%26acq%3Ddex
- https://web.p.ebscohost.com/nup/detail/detail?vid=26&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009565192&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711314
- PALS 2020

Development – May, 2023
Update – June 2025

EMS Provincial Medications

Dextrose/D50/D25/D10/Glucose HIGH ALERT

Classification

- Calorie supplement - irritant
- Monosaccharide

Indications

EMS INDICATIONS

- Treatment of insulin hypoglycemia (hyperinsulinism or insulin shock) to restore blood glucose levels when used in concentrations of 50% or 25% or 10%

HEALTH CANADA APPROVED

- *Treatment of insulin hypoglycemia (hyperinsulinism or insulin shock) to restore blood glucose levels when used in concentrations of 50% or 25%*
- *5% and 10% A source of carbohydrate calories*
- *Nutritional support when used in concentrations of 10% or less, when used with other nutrients*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITURATURE

- *Treatment of hyperkalemia when used with concomitant insulin when used at concentrations of 50%*

Mechanism of Action

- Increases glucose levels by minimizing glyconeogenesis
- Dextrose, a monosaccharide, is a source of calories and fluid for patients unable to obtain an adequate oral intake; may decrease body protein and nitrogen losses; promotes glycogen deposition in the liver. When used in the treatment of hyperkalemia (combined with insulin), dextrose stimulates the transient uptake of potassium by cells, especially in muscle tissue, lowering serum potassium.

Pharmacokinetics

- Dispersed through bloodstream
- **Onset:** rapid PO and IV
- **Peak:** rapid PO and IV
- **Duration:** brief PO and IV
- **Metabolism:** Metabolized to carbon dioxide and water

Contraindications

- Hypersensitivity to dextrose solution or any component of formulation
- Hypersensitivity to corn or corn products
- Neonates and children less than 50 kg: **maximum** concentration used is D25W
- Diabetic coma while patient is hyperglycemic; hepatic coma
- Intracranial or intraspinal hemorrhage; glucose-galactose malabsorption syndrome
- In the presence of delirium tremens in dehydrated patients

- Severe dehydration
- Dextrose solutions without electrolytes should not be administered simultaneously with blood through the same infusion set because of risk of pseudoagglutination of red cells. Cautions and contraindications may vary by blood component. Refer to manufacturer for further references

Cautions

- **HIGH ALERT – at 20% concentration or greater**
- Diabetes mellitus or carbohydrate intolerance
- Ischemic stroke, as increased blood-glucose concentrations may worsen cerebral ischemic brain damage and impair recovery
- Hyponatremia may result from low sodium or sodium-free dextrose solutions with no other source of sodium
- Use with caution with patients susceptible to excessive fluid accumulation
- Excessive or rapid dextrose administration in very low birth weight infants have been associated with increased serum osmolality and possible intracerebral hemorrhage
- Rebound hypoglycemia may occur with abrupt withdrawal of a concentrated dextrose solution

MONITORING REQUIRED
DIRECT IV
- Observe injection site for pain, phlebitis or extravasation

RECOMMENDED
- Advise patients to report burning/stinging/pain at IV site promptly
- Blood glucose, serum electrolytes and acid-base balance
- Fluid balance

PREGNANCY/BREAST FEEDING
- Consult pharmacy or specialized on-line references for most recent information

Adverse Effects

METABOLIC
- Fluid and electrolyte imbalances, including hypokalemia and dehydration
- Hyperglycemia (associated with rates of administration over 0.5 g/kg/hour), hyperosmotic syndrome (mental confusion and loss of consciousness)
- Reactive hypoglycemia (after infusion). Reduce rate of administration gradually then follow with infusion of D5W or D10W

MISCELLANEOUS
- Local pain, venous thrombosis or phlebitis. Use a more dilute solution or consider central line administration

EXTRAVASATION
- 50% solution is hypertonic (2526 mOsm/L) and has a low pH (pH 4.2)

TREATMENT:
- Notify physician. Apply cold intermittent compresses. See site specific policy for intravenous therapy practice and clinical standards

*NOTE: reassess the serum glucose concentration after dextrose administration. Provide a continuous infusion of glucose-containing IV fluid to prevent recurrent hypoglycemia. Or have patient eat complex carbs and protein.

**Do not routinely infuse dextrose-containing fluids for volume resuscitation of shock. This can cause hyperglycemia, increase the serum osmolality, and produce an osmotic diuresis that will further exacerbate hypovolemia and shock. Electrolyte imbalances (e.g. hyponatremia) can also develop.

Dosing

ADULT/ELDERLY

- Dose is dependent on use, weight, clinical condition and POCT results
- **Oral** glucose, if conscious and intact gag reflex administer in small amounts until desired effect obtained
- 12.5 to 25 grams **D10W** every 5 minutes **IV over 1 to 5 minutes.** Repeat as required

  *NOTE: 12.5 to 25 grams of D10W = 125 to 250 mL of D10W

ONGOING HYPOGLYCEMIA DUE TO OVERDOSE OF INSULIN SECRETAGOGUES

- Continuous infusions of D10W to D50W may be required
- **Contact Poison and Drug Information Service (PADIS) at 1-866-454-1212 for more information**

PEDIATRIC – 3.3 mmol/L (infants, children and adolescents)

- Dose is dependent on use, weight, clinical condition and POCT results
- **Oral** glucose, if conscious and intact gag reflex administer in small amounts until desired effect obtained
- 2 to 4 mL/kg **D25W** every 5 minutes **IV over 2 to 5 minutes**. Repeat as required **OR**
- 5 to 10 mL/kg **D10W** every 5 minutes **IV over 2 to 5 minutes**. Repeat as required

  *NOTE: the dose of D25W and D10W will be the same dose (0.5 to 1 g/kg) just a more dilute concentration with D10W

NEONATE – 2.6 mmol/L (Preterm and Term neonates)

- 5 to 10 mL/kg **D10W IV over 2 to 5 minutes** prn

Concentration Supplied:

- 25 g/50 mL (D50W)
- Gel 31 g
- 10 g/100 mL (D10W) available in 500 mL and 1000 mL bags

Reconstitution:

- **D25W:** pull 50 mL of saline out of a 100 mL bag into a 60 mL syringe and inject 50 mL of D50W amp into the 100 mL bag
- **D10W:** pull 50 mL of saline out of 250 mL bag and add 50 mL of D50W into 250 mL bag

Compatibility/Stability:

- Do not use unless the solution is clear
- Do not administer through the same infusion equipment as whole blood as hemolysis and clumping can occur

Provider/Route:

- **EMR:** PO (Oral Glucose)
- **PCP/ICP:** PO, IV
- **ACP:** PO, IV, IO, IVAD
- **CCP:** As per scope of practice

MISCELLANEOUS

- Each 100 mL of D50W fluid contains 50 grams of dextrose, which delivers 3.4 kcal/gram (14.3 kJ/gram)
- IO use: may be given IO during resuscitation with no change in maximum concentrations form IV route
- Subcutaneous/IM use: D50W not recommended in all ages due to high osmolarity (2526 mOsm/L) and low pH
- Extravasation - irritant especially when concentrated at 10% or greater

Resources:

- SHA EMS Medical Director & Advisors
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/dextrose.pdf
- SaskKids Pediatric Parental Manual

- The Hospital for Sick Children Electronic Formulary
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6724?cesid=0PvSGPsb1gL&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Ddextrose%26t%3Dname%26acs%3Dtrue%26acq%3Ddex
- https://web.p.ebscohost.com/nup/detail/detail?vid=28&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009565194&db=nup
- Pediatric Advanced Life Support (PALS) Provider Manual 2020

Development – May 2023
Update – June 2025

EMS Provincial Medications

DiazePAM/Valium HIGH ALERT/ELDER ALERT

Classification

- Benzodiazepine - irritant

Indications

EMS INDICATIONS

- For Alcohol Withdrawal **ONLY**

SHA EMS Medical Direction Note:

- To be given by **ACP** only
- To be given IV only

HEALTH CANADA APPROVED

- *Management of anxiety disorders, ethanol withdrawal symptoms or as a skeletal muscle relaxant*
- *Treatment of status epilepticus and recurrent seizures*

NON HEALTH CANADA APPROVED INDICATION BUT SUBSTANTIATED IN LITERATURE

- *Hydroxychloroquine/chloroquine toxicity (severe)*
- *Intoxication (cocaine, methamphetamine, and other sympathomimetics)*
- *Neuroleptic malignant syndrome*
- *Opioid withdrawal (autonomic instability and agitation)*
- *Serotonin syndrome (serotonin toxicity)*
- *Vertigo, acute episodes*

Mechanism of Action

- Long-acting benzodiazepine. Binds to stereospecific benzodiazepine receptors on the postsynaptic GABA neuron at several sites within the central nervous system, including the limbic system, reticular formation. Enhancement of the inhibitory effect of GABA on neuronal excitability results by increased neuronal membrane permeability to chloride ions. This shift in chloride ions results in hyperpolarization (a less excitable state) and stabilization. Benzodiazepine receptors and effects appear to be linked to the GABA-A receptors. Benzodiazepines do not bind to GABA-B receptors

Pharmacokinetics

- **Onset:** IV 1 to 3 minutes
- **Peak:** 15 minutes
- **Duration:** 15 to 60 minutes
- **Excreted** in urine (predominantly as glucuronide conjugates)

Contraindications

- Hypersensitivity to diazepam, other benzodiazepines or any component of the formulation
- Myasthenia gravis: condition may be exacerbated
- Acute narrow angle glaucoma: may have an anticholinergic effect
- Open angle glaucoma unless patients are receiving appropriate therapy

Cautions

- **HIGH ALERT, ELDER ALERT**
- Elderly or debilitated active metabolites with extended half-lives may lead to delayed accumulation and adverse effects; impaired cognition, delirium, falls and fractures
- Respiratory disease; lower dose recommended due to possible apnea
- Neonate and young infants: decreased metabolism of diazepam and active metabolite, both can accumulate with repeated use and cause increased toxicity
- When used as an adjunct in treating convulsive disorders, an increase in frequency/severity of tonic-clonic seizures may occur and require dose adjustment of antiseizure medication. Abrupt withdrawal may result in a temporary increase in the frequency and/or severity of seizures.
- Avoid use in patients with depression because of concerns about worsening mood symptoms, particularly if suicidal risk may be present, except for acute or emergency situations (eg, acute agitation, status epilepticus).
- Use benzodiazepines with caution in obese patients; may have prolonged action when discontinued.
- Use of diazepam is not recommended in place of appropriate therapy.

DRUG INTERATIONS:

- Additive CNS effects with phenothiazines, narcotic analgesics, barbiturates, alcohol, tricyclic antidepressants, and MAO inhibitors
- Is a major substrate of CYP2C19 and 3A4. Interacts with many drugs - contact pharmacy for more information. Review drug profile at time of initiation and with any change in medication regimen

PREGNANCY

- The effects of benzodiazepines, including diazepam, on the human embryo and fetus are controversial. Although a number of studies have reported an association with various types of congenital defects, other studies have not found such associations. Maternal denial of exposure, as reported in one study, and the concurrent exposure to other toxic drugs and substances (e.g., alcohol and smoking) may be confounding factors. If the drug does cause birth defects, the risk appears to be low. Continuous use during gestation has resulted in neonatal withdrawal, and a dose-related syndrome is apparent if diazepam is used close to delivery. Consequently, if the maternal condition requires the use of diazepam during pregnancy, the lowest possible dose should be taken. Moreover, abrupt discontinuance of diazepam should be avoided.

BREASTFEEDING

- Diazepam may accumulate in breastfed infants, and its use in lactating women is not recommended. In 2001, the American Academy of Pediatrics classified the effects of diazepam on the nursing infant as unknown but may be of concern.

MONITORING REQUIRED:

- Baseline RR, BP and HR, mental status, then at 5 and 15 minutes post dose

MONITORING RECOMMENDED:

- Advise patients to report burning/stinging/pain at IV site promptly
- Assess level of consciousness as required
- Assess for postural hypotension prior to ambulation

Adverse Effects

CENTRAL NERVOUS SYSTEM

- Drowsiness and excessive sedation. If treatment required, can be rapidly reversed by flumazenil IV
- Ataxia, vertigo, headache
- Slurred speech, memory impairment, depression, confusion
- Anterograde amnesia

CARDIOVASCULAR

- Hypotension and bradycardia. Cardiac arrest. Associated with excessively rapid IV administration

RESPIRATION

- Respiratory depression and partial airway obstruction. May follow rapid IV administration

MISCELLANEOUS

- Paradoxical reactions, including hyperactive or aggressive behavior, have been reported with benzodiazepines; risk may be increased in adolescent/pediatric, geriatric patients, or patients with a history of alcohol use disorder or psychiatric/personality disorders.
- Hazardous sleep-related activities such as sleep-driving, cooking and eating food, and making phone calls while asleep have been noted with benzodiazepines.

LOCAL REACTIONS/EXTRAVASATION

- Phlebitis, local pain, erythema and a burning sensation.
- Extravasation

Dosing

***Administer slowly into a large vein**

ADULT

ALCOHOL WITHDRAWAL

Adult 17 years or older:

- BAWS Score of 3 to 7: 10 mg IV every 1 hour PRN
- BAWS Score of 8 or greater: 10 mg IV/PO every 30 minutes PRN
  *Discontinue when 2 consecutive BAWS scores are less than 3

*Brief Alcohol Withdrawal Scale (BAWS): https://www.saskhealthauthority.ca/system/files/2023-09/SHA-0327-Alcohol-Withdrawal-Assessment-Flowsheet.pdf

****Note: Diazepam is preferred benzodiazepine due to quicker onset of action and longer half-life. LORazepam is preferred for frail patients and those with severe liver disease (prolonged sedation can be harmful in hepatic encephalopathy).**

Frail Elderly and Diagnosed with Severe Liver Disease

- Give LORazepam PO instead

RENAL IMPAIRMENT ADJUSTMENTS

- Creatinine clearance less than 20 mL/min: use small doses and titrate to effect

HEPATIC IMPAIRMENT ADJUSTMENTS

- Half-life significantly prolonged; no dosing information available at this time
- For Alcohol Withdrawals administer LORazepam PO instead

HEMO/PERITONEAL DIALYSIS

- Not removed by hemodialysis or CAPD: use small doses and titrate to effect

MISCELLANEOUS

- Can be given IM; Oral absorption is more reliable
- Subcutaneous: no information available at this time
- Parenteral form can be used rectally

Reconstitution

- None required

Compatibility/Stability

- Compatible with D5W, NS and lactated Ringer's. Conc.-dependent precipitation occurs. Stability information for preservative free product not available. Stability information on older product is conflicting
- For drug-drug compatibility contact pharmacy

Concentration Supplied:

- 10 mg/2 ml

Provider/Route:

- **EMR:** Not in Scope
- **PCP:** Not in Scope
- **ICP:** IV monitor only for Alcohol withdrawal
- **ACP:** IV
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/diazePAM.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6728?cesid=7i7Au6nEC3q&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DdiazePAM%26t%3Dname%26acs%3Dtrue%26acq%3Ddiazep
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711326
- https://www.saskhealthauthority.ca/system/files/2023-08/CS-OS-9903-ED-AWS-Adults.pdf
- https://www.saskhealthauthority.ca/system/files/2023-09/SHA-0327-Alcohol-Withdrawal-Assessment-Flowsheet.pdf

Development – July 2025
Update –

EMS Provincial Medications

DimenhyDRINATE/Gravol ELDER ALERT

Classification

- Antiemetic (Antihistamine)

Indications

EMS INDICATIONS

- Prevention and treatment of nausea, vomiting and/or vertigo; due to a variety of clinical scenarios including motion sickness, radiation sickness, postoperative vomiting, drug induced nausea and vomiting, Ménière's disease and other labyrinthine disturbances
- Hyperemesis gravidarum (pregnancy-associated nausea and vomiting)

SHA EMS Medical Direction Note:

- **Not the first line choice as an antiemetic unless using to treat vertigo**

HEALTH CANADA APPROVED

- *Prevention and treatment of nausea, vomiting and/or vertigo; due to a variety of clinical scenarios including motion sickness, radiation sickness, postoperative vomiting, drug induced nausea and vomiting, Ménière's disease and other labyrinthine disturbances*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN THE LITERATURE

- *Hyperemesis gravidarum (pregnancy-associated nausea and vomiting)*

Mechanism of Action

- Inhibit vestibular stimulation, acting on otolith system and semicircular canals
- Inhibits acetylcholine (cholinergic stimulation in vestibular and reticular systems may be responsible for motion sickness)
- Competes with histamine for H_1-receptor sites on effector cells in the gastrointestinal tract, blood vessels, and respiratory tract; blocks chemoreceptor trigger zone, diminishes vestibular stimulation, and depresses labyrinthine function through its central anticholinergic activity

Pharmacokinetics

- **Onset:** Rapid IV or 20 to 30 minutes IM
- **Peak:** 1 to 2 hours IM, unknown IV
- **Duration:** 3 to 6 hours IM & IV
- **Metabolism:** Extensive in the liver to metabolites (diphenyl-methoxy-ethylamine, diphenyl-methoxy-acetic, diphenyl-methoxy-N-methylamine)
- **Excretion:** Renal

Contraindications

- Hypersensitivity to dimenhyDRINATE, diphenhydrAMINE, propylene glycol, or any other component of formulation

- Concurrent use of or use within 14 days following therapy with a monoamine oxidase inhibitor; narrow angle glaucoma; chronic pulmonary disease; prostatic hypertrophy; patients less 2 years of age
- Neonates

Cautions

- **ELDER ALERT**
- Elderly: may be inappropriate depending on comorbidities (e.g. dementia, delirium) due to its potential anticholinergic effects (Beers Criteria). May be more sensitive to adverse effects
- May cause CNS depression, which may impair physical or mental abilities; patients must be cautioned about performing tasks which require mental alertness (eg, operating machinery or driving). Other CNS effects which may be observed, particularly at higher dosages include euphoria, hallucinations, confusion, temporary amnesia and paranoia.
- Patients in whom anticholinergic side effects would be detrimental (e.g. prostatic hypertrophy, bladder neck obstruction, narrow-angle glaucoma)
- Cardiovascular disease (including hypertension and ischemic heart disease), asthma or lower respiratory tract symptoms
- **Do not administer with diphenhydrAMINE (Benadryl)**

DRUG INTERACTIONS

- May potentiate CNS depressant effects of opiates, barbiturates or other sedatives and ethanol
- May potentiate anticholinergic effects of drugs (e.g. tricyclic antidepressants)
- Ototoxic medication (e.g. aminoglycosides); may mask the symptoms of ototoxicity

PREGNANCY

- In general, antihistamines are considered low risk in pregnancy. However, exposure near birth of premature infants has been associated with an increased risk of retrolental fibroplasia.

BREASTFEEDING

- No reports describing the use of dimenhydrinate during lactation have been located. The molecular weight (about 470) is low enough that excretion into milk should be expected.

RECOMMENDED

- Monitor elderly patients for anticholinergic side effects (confusion, constipation, etc.)

Adverse Effects

CARDIOVASCULAR

- Tachycardia

CENTRAL NERVOUS SYSTEM

- Sedation – common particularly with high doses
- Dizziness
- Lassitude
- Headache
- Insomnia
- Nervousness
- Restlessness
- Paradoxical CNS stimulation in young children, occasionally in adults (uncommon) Abuse/withdrawal: Has abuse potential due to its hallucinogenic and euphoric effects; discontinuation after chronic abuse may lead to withdrawal symptoms (eg, lethargy, agitation, hostility, hallucinations, confusion, aggression, nausea/vomiting).

RESPIRATORY

- Thickened bronchial secretions

MISCELLANEOUS

- Dry mouth and respiratory airways
- Urinary retention

- Blurred vision

Dosing

*Must dilute before use: is in 50% propylene glycol. Dilute to 10 mL with NS given IV over 2 to 4 minutes or dilute in 50 mL mini bag infused over 20 minutes

ADULT

- 25 to 50 mg **IV over 2 to 4 minutes or IM** every 4 hours PRN
- Maximum 100 mg every 4 hours as required

ELDERLY

- 12.5 mg **IV over 2 to 4 minutes or in 50 mL bag infused over 20 minutes or IM** every 4 hours PRN
- May be more sensitive to side effects. Limit use to short-term therapy

PEDIATRIC

Children less than 12 years:

- 1 mg/kg (max 50 mg) **IV over 2 to 5 minutes or via pump over 20 minutes or IM** every 4 to 6 hours as required

Children 12 years or older:

- 25 to 50 mg **IV over 2 to 5 minutes or via pump over 20 minutes or IM** every 4 to 6 hours as required
- Maximum dose: 300 mg in 24 hours

NEONATE

- Not Recommended

RENAL IMPAIRMENT ADJUSTMENTS

Creatinine Clearance (mL/minute)/Interval

- **10 to 50** every 6 to 8 hours
- **less than 10** every 8 hours

HEPATIC IMPAIRMENT ADJUSTMENTS

- Dose reductions should be considered in patients with acute hepatic impairment since dimenhyDRINATE, is metabolised extensively in the liver

HEMO/PERITONEAL DIALYSIS

- May cause excessive sedation in end stage renal disease
- Hemodialysis: 25 to 50 mg every 8 hours as required. Can be given anytime during dialysis
- CAPD: dose as for creatinine clearance less than 10 mL/min

Concentration Supplied:

- 50 mg/1 mL

Compatibility/Stability:

- Stable in D5W or NS for at least 24 hours at room temperature
- Compatible with dextrose, saline, dextrose-saline combinations, LR

Provider/Route

- **EMR:** Not in scope of practice
- **PCP/ICP:** SC, IM, IV
- **ACP:** SC, IM, IV, IO, IVAD
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary

- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/dimenhyDRINATE.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6754?cesid=7AxwicYbIoD&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DdimenhyDRINATE%26t%3Dname%26acs%3Dtrue%26acq%3Ddim
- SaskKids Pediatric Parental Manual
- https://web.p.ebscohost.com/nup/detail/detail?vid=5&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535290&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711345

Development – May 2023
Update – June 2025

EMS Provincial Medications

DiphenhydrAMINE/Benadryl ELDER ALERT

Classification

- Antihistamine

Indications

EMS INDICATIONS

- Symptomatic relief of allergic symptoms caused by histamine release including nasal allergies and allergic dermatosis
- adjunct to EPINEPHrine in the treatment of anaphylaxis

HEALTH CANADA APPROVED

- *Symptomatic relief of allergic symptoms caused by histamine release including nasal allergies and allergic dermatosis*
- *adjunct to EPINEPHrine in the treatment of anaphylaxis*
- *treatment of motion sickness*
- *management of Parkinsonian syndrome including drug-induced extrapyramidal symptoms (dystonic reactions) alone or in combination with centrally acting anticholinergic agents*

Mechanism of Action

- Competes with histamine for H_1-receptor sites on effector cells in the gastrointestinal tract, blood vessels, and respiratory tract; anticholinergic and sedative effects are also seen

Pharmacokinetics

- **Onset:** 20 to 30 minutes IM; Rapid IV
- **Peak:** 2 to 4 hours IM, unknown IV
- **Duration:** 4 to 8 hours IV and IN
- **Metabolized** rapidly, excreted as metabolites in the urine.

Contraindications

- Hypersensitivity to diphenhydrAMINE or dimenhyDRINATE or any component of formulation.
- Use is contraindicated in neonates and premature infants.

Cautions

- **ELDER ALERT**
- Elderly: due to high sedative and anticholinergic properties
- Patients in whom anti-cholinergic side effects would be detrimental e.g. prostatic hypertrophy, bladder neck obstruction, narrow-angle glaucoma.

- Cardiovascular disease (including hypertension and ischemic heart disease), bronchial asthma
- Toxicity (overdose) in pediatric patients may result in hallucinations, convulsions, or death; neonates and young children are highly sensitive to depressive effects of diphenhydramine

DRUG INTERACTIONS

- May potentiate CNS depressant effects of opiates, barbiturates or other sedatives, tranquilizers, and ethanol
- May potentiate anticholinergic effects of drugs e.g. tricyclic antidepressants
- Is a weak inhibitor of cytochrome P450 isoenzymes CYP2D6; Potential to interact with many drugs – consult pharmacy or specialised on-line references for more information. Review drug profile at time of initiation and with any change in medication regimen
- **Do not administer with dimenhyDRINATE (Gravol)**

PREGNANCY

- Both the animal data and the published human experience suggest that diphenhydramine is safe for use in human pregnancy. The exception is the case–control study discussed below that showed an association with cleft palate. In addition, premature infants exposed within 2 weeks of birth may be at risk for toxicity. At least one review has concluded that diphenhydramine is the drug of choice if parenteral antihistamines are indicated in pregnancy.

BREASTFEEDING

- Diphenhydramine is excreted into human breast milk, but levels have not been reported. Although the levels are not thought to be sufficiently high to affect the infant after therapeutic doses, the manufacturer considers the drug contraindicated in nursing mothers. The reason given for this is the increased sensitivity of newborn or premature infants to antihistamines.

RECOMMENDED

- Ambulate slowly and carefully; may cause dizziness, sedation or disturbed coordination.

Adverse Effects

CARDIOVASCULAR

- Chest tightness
- Xtrasystoles
- Hypotension
- Palpitations
- Tachycardia

CNS

- Sedation - common particularly with high doses, sleepiness
- Dizziness
- Blurred vision
- Headache
- Disturbed coordination
- Paradoxical CNS stimulation in young children, occasionally in adults (uncommon)

MISCELLANEOUS

- Dry mouth and thickening of bronchial secretions (Common)
- Urinary retention

Dosing

*SC administration is not recommended due to risk of local necrosis

ADULT

- 1 mg/kg **IV infusion** (max of 50 mg) in 50 mL NS over 20 min or can be given **IM** undiluted.
- In a few patients up to 100 mg may be required

- Total daily doses of 300 to 400 mg may be required in acute generalized or chronic urticarial, allergic eczema, bronchial asthma and status asthmaticus
- Recommended daily maximum: 400 mg/24 hours

ELDERLY

- 1 mg/kg **IV infusion** (max of 50 mg) in 50 mL NS over 20 min or can be given **IM** undiluted.

***side effects may be more pronounced in elderly**

PEDIATRIC

- 1 mg/kg **IV infusion** (max single dose of 50 mg) in 50 mL NS over 20 min or can be given **IM** undiluted.
- Recommended daily maximum: 300 mg/24 hours

NEONATE

- Not recommended

RENAL IMPAIRMENT ADJUSTMENTS

- May cause urinary retention, use with caution

HEPATIC IMPAIRMENT ADJUSTMENTS

- Is rapidly and almost completely metabolized. Single doses in cirrhosis are safe and effective. A decrease in dosage is recommended with multiple doses. No specific guidelines available at this time.

HEMO/PERITONEAL DIALYSIS

- No dosage adjustment needed however, may cause excessive sedation in end stage renal disease.

Concentration supplied:

- 50 mg/mL (1 mL vial)

Compatibility/Stability:

- Limited stability information available; assume stable in D5W or NS for 24 hours
- Compatible with D5W, D10W, NS, ½NS, LR

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IM, IV
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/diphenhydrAMINE.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/1827019?cesid=2jLTGtF2OGe&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DdiphenhydrAMINE%26t%3Dname%26acs%3Dtrue%26acq%3Ddiphe
- https://web.p.ebscohost.com/nup/detail/detail?vid=3&sid=9eae3cac-5d73-4548-9e94-e9ab86b7f319%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009565201&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711348
- PALS 2020
- ACLS EP 2017

Development – May 2023
Update – June 2025

EMS Provincial Medications

Entonox/Nitrous Oxide HIGH ALERT

Classification

- Gaseous Analgesic – 50% Nitrous Oxide/50% Oxygen

Indications

EMS INDICATIONS

- Pain associated with musculoskeletal injuries
- Cardiac chest pain
- Burns without inhalation injury
- Active labour

HEALTH CANADA APPROVED

- *Pain associated with musculoskeletal injuries*
- *Cardiac chest pain*
- *Burns without inhalation injury*
- *Active labour*

Mechanism of Action

- Causes the release of biochemical substances such as endorphins and serotonin
- Takes effect within the brain, as well as the spinal cord, inhibiting pain impulses by stimulating various receptors and altering pain pathways
- General CNS depressant action; may act similar to inhaled general anesthetics by stabilizing axonal membranes to partially inhibit action potentials leading to sedation; may partially act on opiate receptor systems to cause mild analgesia; central sympathetic stimulating action supports blood pressure, systemic vascular resistance, and cardiac output; it does not depress carbon dioxide drive to breath. Nitrous oxide increases cerebral blood flow and intracranial pressure while decreasing hepatic and renal blood flow; has analgesic action similar to morphine.

Pharmacokinetics

- **Onset:** inhalation 2 to 5 min
- **Absorbed** through the lungs
- **Duration:** rapid ~ 60 seconds
- **Excretion:** Primarily exhaled gases; skin (minimal amounts)
- Does not need to be activated by the body as it is active in its current form

Contraindications

- Head injury with impaired consciousness
- Inebriation
- Heavily sedated (e.g. overdose, street drugs)
- Severe facial injuries
- Inability to self-administer (too young, mentally challenged, senile)
- Chest trauma (e.g. pneumothorax)
- Decompression sickness
- Vitamin B_{12} deficiency, folate, or methionine synthesis or metabolism; patients having undergone vitreoretinal surgery and presence of intraocular gas bubble; and patients with pneumothorax, pneumocephalus, and closed dura, or those at high risk for vascular air embolus.

Cautions

- **HIGH ALERT**
- Invert tank 3 times prior to use
- Patient must self-administer
- Tank must be in horizontal position when in use by patient.
- Tank must be secured while stored in the ambulance.
- Do not use in the outdoor environment if the temperature is below -6◦ C
- Use caution if patient with suspected bowel obstruction
- Addictive: May be associated with abuse and/or addiction (Zafirova 2018).
- Body space volume expansion: Both compliant (e.g. bowel gas, pneumothorax) and poorly compliant (e.g. middle ear) body spaces may be prone to changes in volume due to nitrous oxide transfer; avoid use in pneumothorax, pneumocephalus, middle ear surgery, or bowel obstruction.
- Bone marrow suppression: Prolonged use may produce bone marrow suppression; patients with vitamin B_{12} deficiency (pernicious anemia) and those with other nutritional deficiencies (patients with alcohol use disorder) are at increased risk.
- Nausea/vomiting: Occurs postoperatively in ~15% of patients (Sun 2015); risk may be reduced by antiemetics.
- Neurologic effects: Prolonged use may produce neurologic dysfunction; patients with vitamin B_{12} deficiency (pernicious anemia) and those with other nutritional deficiencies (patients with alcohol use disorder) are at increased risk.
- Vitreoretinal surgery: Detached retina and other ocular disorders treated with vitreoretinal surgery where intraocular gas was used: Nitrous oxide can increase intraocular pressure which may result in retinal artery occlusion, ischemia, or optic nerve damage and vision loss in these patients. Nitrous oxide should not be used in patients who have had an intravitreal gas bubble unless it can be confirmed that the bubble has been completely resorbed.

PREGNANCY

- Short duration of exposure to the pregnant patients during obstetric procedural anesthesia is not associated with an increased risk of adverse events to the fetus.
- The available data do not appear to suggest that acute or chronic exposure to nitrous oxide at any time in pregnancy represents a major risk for structural anomalies.

BREASTFEEDING

- No reports describing the use of nitrous oxide during lactation have been located. The solubility in blood and tissue is low. Moreover, the plasma half-life is very short (less than 3 minutes), and, thus, it is unlikely that a nursing infant would be exposed to the agent in milk or that it would be orally bioavailable to the infant.

RECOMMENDED MONITORING

- Monitor for systemic hypotension, hypoxemia, bradycardia, decreased cardiac output, pulmonary edema and signs/symptoms of impeding cardiac arrest.

Adverse Effects

GASTROINTESTINAL
- Nausea, vomiting

CENTRAL NERVOUS SYSTEM
- Potentiate the effects of other CNS depressants (narcotics, sedatives, alcohol, hypnotics)
- Light-headedness
- Drowsiness

OTIC
- Increased middle ear pressure (with transient auditory impairment, hemotympanum, otalgia, and perforated tympanic membrane), tinnitus.

RESPIRATORY
- Atelectasis, hypoxia

Dosing

ADULT/ELDERLY
- Self-administered via **inhalation** by patient until pain is relieved, PRN

PEDIATRIC
- Self-administered via **inhalation** by patient until pain is relieved, PRN

NOTE: must document amount used by patient (psi) on PCR

Provider/Route:
- **EMR:** Not in scope of practice
- **PCP/ICP:** deep inhalation with hepa filter and mouth piece
- **ACP:** deep inhalation with hepa filter and mouth piece
- **CCP:** As per scope of practice

Resources:
- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- SaskKids Pediatric Parental Manual
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7366?cesid=8oDqdpfOSJA&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dnitrous%2Boxide%26t%3Dname%26acs%3Dtrue%26acq%3Dnitrou
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711794

Development – May 2023
Update – June 2025

EMS Provincial Medications

EPINEPHrine/Adrenalin HIGH ALERT

Classification

- Sympathomimetic

Indications

EMS INDICATIONS

- EMRs can only administer Epi auto-injector for anaphylaxis
- Treatment of anaphylaxis and/or asthmatic attacks
- Treatment of cardiac arrest
- Croup
- Profound bradycardia or hypotension

HEALTH CANADA APPROVED

- *Treatment of severe acute hypersensitivity and/or asthmatic attacks*
- *Treatment of cardiac arrest and/or Adams-Stokes Syndrome*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN THE LITERATURE

- *Profound bradycardia or hypotension*
- *To provoke arrhythmia to diagnose primary cardiac electrical disease (e.g. catecholaminergic ventricular tachycardia)*

Mechanism of Action

- Stimulates alpha-, beta$_1$-, and beta$_2$-adrenergic receptors resulting in relaxation of smooth muscle of the bronchial tree, cardiac stimulation (increasing myocardial oxygen consumption), and dilation of skeletal muscle vasculature; small doses can cause vasodilation via beta$_2$-vascular receptors; large doses may produce constriction of skeletal and vascular smooth muscle. Epinephrine also inhibits histamine release.

Pharmacokinetics

- **Onset:** Immediate IV, 1 to 5 minutes via inhalation, 5 to 15 minutes SC
- **Peak:** 5 minutes IV, 30 minutes SC
- **Duration:** 1 to 4 hours
- **Metabolism:** Disappears rapidly in bloodstream, degraded by the liver enzymes and excreted by urine

Contraindications

- Hypersensitivity to EPINEPHrine or other sympathomimetics or sulfites, or any component of the formulation
- No absolute contraindications to use in life threatening conditions

Cautions

- **HIGH ALERT**
- Elderly: may be more susceptible to beta-adrenergic effects (e.g. hypertension, hypokalemia, tachycardia, tremor)
- Hyperthyroidism, narrow- (closed-) angle glaucoma, diabetes (may transiently increase blood glucose levels)
- Cardiovascular disease such as ischemic heart disease, arrhythmia or tachycardia, occlusive vascular disorders including arteriosclerosis, hypertension or aneurysms
- Chlorobutanol 0.5% is the preservative in the multi-dose vial. Effects of chlorobutanol in neonates is unknown, therefore use of the preserved solution is not recommended
- Hypovolemia: Correct blood volume depletion before administering any vasopressor.
- Parkinson disease: Use with caution in patients with Parkinson disease; psychomotor agitation or temporary worsening of symptoms may occur.
- Pheochromocytoma: Use with caution in patients with pheochromocytoma.
- Patient harm or fatalities have occurred from medication errors with EPINEPHrine. EPINEPHrine is available in various concentrations, strengths, and percentages and is used for different purposes. Packaging labels may be easily confused or the products incorrectly diluted

DRUG INTERACTIONS

- MAO inhibitors and some antihistamines (e.g. diphenhydrAMINE): may potentiate pressor response
- Digoxin or tricyclic antidepressants: may increase risk of cardiac arrhythmias
- Beta-adrenergic blocking agents: may result in mutual inhibition of therapeutic effects

PREGNANCY

- Pregnancy benefits to mom outweigh risks to fetus
- In situations such as maternal hypotension where a pressor agent is required, the use of ephedrine is a better choice than epinephrine.

BREASTFEEDING

- No reports describing the use of epinephrine during human lactation have been located.

REQUIREMENTS FOR **SC/IM ADMINISTRATION**

- Never re-insert the needle
- Do not administer the repeat injections into the same site
- Do not inject the buttocks or into digits, hands, or feet

PEDIATRIC

- Anterolateral aspect of the middle third of the thigh is preferred; IM administration is preferred to SUBQ due to more rapid absorption and higher peak concentrations, especially when administered in the thigh.
- In overweight or obese children; due to skin surface to muscle depth being greater in the upper half of the thigh, administration into the lower half of the thigh may be preferred. In very obese children, injection into the calf will provide an even greater chance of intramuscular administration

MONITORING REQUIRED FOR **IM ADMIN**

- HR, BP, RR, oxygen saturation, level of consciousness continuously or as ordered by responding physician
- Monitor for recurring symptoms of anaphylaxis/hypersensitivity or bronchospasms. May reoccur anywhere between 1 to 36 hours. Experts recommend monitoring for 4 to 8 hours. Follow local policy and procedure

MONITORING REQUIRED FOR **INFUSION**

- Continuous ECG monitoring
- Continuous BP monitoring or every 3 to 5 minutes by cuff until continuous monitoring available
- If peripheral line is used, assess IV site every 15 minutes for signs of extravasation

MONTIORING RECOMMENDED FOR **IM ADMIN**

- Monitor injection site for signs and symptoms of infection

MONITORING RECOMMENDED FOR INFUSION

- Hemodynamic monitoring
- Fluid balance

- Assess extremities for changes in colour and temperature

***Subcutaneous route not preferred**

Adverse Effects

CARDIOVASCULAR

- Excessive rise in BP. A vasodilator (e.g. nitrates), or alpha-adrenergic blocker may be required
- Arrhythmias (PVC's and ventricular tachycardia): a beta-adrenergic blocker (e.g. propranolol) may be required
- Palpitations
- Anginal pain
- Acute myocardial infarction, cardiomyopathy (stress), chest pain, increased cardiac work, peripheral vasoconstriction, supraventricular tachycardia, vasoconstriction, ventricular fibrillation

CENTRAL NERVOUS SYSTEM

- Anxiety
- Dizziness
- Headache
- Cerebral hemorrhage: due to hypertension
- apprehension, asthenia, disorientation, memory impairment, panic, paresthesia, psychomotor agitation, restlessness, tingling sensation

DERMATOLOGIC

- Diaphoresis, gangrene of skin and/or subcutaneous tissue (at injection site), pallor, piloerection

RENAL

- Decreased urine output
- Kidney impairment

MISCELLANEOUS

- Pulmonary edema due to peripheral constriction and cardiac stimulation: a vasodilator (e.g. nitrates), or an alpha-adrenergic blocker (e.g. phentolamine), may be required
- Limb ischemia
- Lactic acidosis
- Insulin resistance

EXTRAVASATION

- Results in sloughing and necrosis

TREATMENT

- Stop infusion and notify physician. Physician to restart at new IV site and infiltrate area of extravasation with phentolamine

Dosing

*Do not stop infusion abruptly; rate should be tapered

*At doses of 0.04 to 0.1 mcg/kg/minute, stimulation of beta-receptors predominates, increasing heart rate, cardiac output and stroke volume and decreasing peripheral vascular resistance. At doses exceeding 0.2 mcg/kg/minute, stimulation of alpha adrenergic receptors produces vasoconstriction and increased total peripheral resistance

ANAPHYLAXIS (NORMOTENSIVE):

ADULTS/ELDERLY

- **IM:** 0.5 mg Epi 1 mg/mL (1:1000) every 5 to 15 minutes prn to a max of 3 doses
  ***Note:** can repeat sooner if clinically indicated if patient does not adequately respond; most patients respond to the first or second dose; if inadequate response, additional measures should be instituted (eg, IV fluids and continuous IV EPINEPHrine infusion. In general, reserve IV administration for patients who are unresponsive (eg, profoundly hypotensive) after several epinephrine IM injections.

PEDS

- **IM** (vastus lateralis)**:** 0.01 mg/kg Epi 1 mg/mL (1:1000) to a maximum of 0.5 mg/dose to a max 3 doses

NEONATES

- **IM** and **SC** routes not recommended

EMR: Epi auto-injector Adult: 0.3 mg **Peds**: 0.15 mg repeat in 5 minutes if symptoms have not improved and you have a second auto-injector

STATUS ASTHMATICUS:

ADULTS/ELDERLY

- **SC route not preferred/IM**: 0.3 mg to 0.5 mg Epi 1 mg/mL (1:1000) every 5 to 15 minutes prn to a max of 3 doses

PEDS

- **SC route not preferred/IM**: 0.01 mg/kg Epi 1 mg/mL (1:1000) to a maximum of 0.5 mg

CROUP:

- **Less than 5 kg:** 0.5 mg/kg Epi 1 mg/mL (1:1000) to maximum 2.5 mg in 2 to 3 mL NS **Nebulized**
- **Greater than 5 kg:** 2.5 to 5 mg Epi 1 mg/mL (1:1000) mixed in 2 to 3 mL NS **Nebulized**

ANAPHYLAXIS (HYPOTENSIVE):

ADULTS/ELDERLY

- **IV:** 100 mcg (10 mL) Epi 1 mg/100 mL (1:100 000) **IV** over 5 to 10 minutes, repeat every 5 minutes if needed.

PEDS

- **IV:** 1 mcg/kg Epi 1 mg/100 mL (1:100 000) **IV** every 2 to 5 minutes if needed

CARDIAC ARREST:

ADULTS/ELDERLY

- **IV Push:** 1 mg Epi 1 mg/10 mL (1:10 000) every 3 to 5 minutes
- **ETT:** 3 mg (add 2 amps of 1 mg/mL (1:1000) to a 1 mg/10 mL (1:10 000) preload)

PEDS

- **IV Push over 1 to 3 seconds:** 0.01 mg/kg (0.1 mL/kg) Epi 1 mg/10 mL (1:10 000) every 3 to 5 minutes (max single dose: 1 mg)
- **ETT:** 0.1 mg/kg (0.1 mL/kg) Epi 1 mg/mL (1:1000) every 3 to 5 minutes

NEONATES (Less than 28 days)

- **IV Push over 1 to 3 seconds**: 0.02 mg/kg Epi 1 mg/10 mL (1:10 000) every 3 to 5 minutes
- **ETT**: 0.1 mg/kg Epi 1 mg/10 mL (1:10 000) every 3 to 5 minutes

SYMPTOMATIC BRADYCARDIA/CARDIOGENIC SHOCK:

ADULTS/ELDERLY (**EPI INFUSION**)

- [Quad strength mixed as follows: Concentration 4 mg/250 mL = 16 mcg/mL, Mix 4 mg Epi 1 mg/mL (1:1000) in 250 mL bag NS or D5W]; run at 0.1 mcg/kg/min, titrate at 0.1 mcg/kg/min every 3 to 5 minutes **via IV infusion on pump**

PEDS

- **IV:** 0.01 mg/kg (0.1 mL/kg) Epi 1 mg/10 mL (1:10 000) every 3 to 5 minutes
- **ETT:** 0.1 mg/kg (0.1 mL/kg) Epi 1 mg/mL (1:1000) every 3 to 5 minutes

NEONATES (Less than 28 days)

- **IV:** 0.02 mg/kg Epi 1 mg/10 mL (1:10 000) every 3 to 5 minutes flush with 3 mL
- **ETT**: 0.1 mg/kg Epi 1 mg/10 mL (1:10 000) every 3 to 5 minutes

PERI/POST ARREST SHOCK (**PUSH DOSE EPI**):

- Must reconstitute to 1 mg/100 mL (1:100 000) [add 1 mL of 1 mg/mL (1:1000) Epinephrine to 100 mL NS], concentration is 10 mcg/mL

ADULT/ELDERLY

- 5 mcg (0.5 mL) to 50 mcg (5 mL) Epi 1 mg/100 mL (1:100 000) every 2 to 5 minutes **IVP**

PEDS

- 1 mcg/kg Epi 1 mg/100 mL (1:100 000) every 2 to 5 minutes **IVP**

MISCELLANEOUS

- Can be given via subcutaneous and/or IM route
- Endotracheal: can be given directly into the bronchial tree via endotracheal tube (ETT) if the patient has been intubated; no flush needed; provide PPV breaths to distribute into lungs
- Intraosseous route may also be used if IV access unavailable, and is preferred over ETT route

Concentration Supplied:

- 0.1 mg/mL (10 mL preload) (1 mg/10 mL)(1:10 000)
- 1 mg/mL (1 mL amp) (1 mg/mL) (1:1000)

Compatibility/Stablility:

- Compatible and stable in D5W, NS, dextrose-saline combinations and LR solutions for at least 24 hours at room temperature
- Discoloured solutions or solutions containing a precipitate should not be used
- **Incompatible with sodium bicarbonate solution**

Provider/Route:

- **EMR:** Auto Injector only
- **PCP/ICP:** IM, SC route not preferred, Nebulized
- **ACP:** IM, SC route not preferred, Nebulized, IV, IO, ET
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/EPINEPHrine.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/5925339?cesid=2YctnSJEVTN&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DEPINEPHrine%26t%3Dname%26acs%3Dtrue%26acq%3Depi
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711401
- ACLS Experienced Provider 2017
- Pediatric Advanced Life Support (PALS) Provider Manual 2020
- Neonatal Resuscitation Program (NRP) 2021 8th Edition

Development – May 2023
Update – June 2025

EMS Provincial Medications

FentaNYL HIGH ALERT

Classification

- Opiate agonist - Narcotic Analgesic

Indications

EMS INDICATIONS

- In anesthesia as an analgesic, an adjunct to general and regional anesthesia, and as an anesthetic for induction and maintenance
- Temporary relief of moderate to severe pain

HEALTH CANADA APPROVED

- *In anesthesia as an analgesic, an adjunct to general and regional anesthesia, and as an anesthetic for induction and maintenance*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN THE LITERATURE

- *Temporary relief of moderate to severe pain and patient controlled analgesia*

Mechanism of Action

- Binds with stereospecific receptors at many sites within the CNS, increases pain threshold, alters pain reception, and inhibits ascending pain pathways.

Pharmacokinetics

- **Onset:** 1 to 2 minutes
- **Peak:** 3 minutes
- **Duration:** 5 to 10 minutes
- **Metabolized** through the liver and other tissues by a combination of reactions

Contraindications

- Hypersensitivity to fentaNYL or any component of formulation. Cross reaction may occur with meperidine and SUFentanil

Cautions

- **HIGH ALERT**
- Elderly: May be more sensitive to adverse effects, including life-threatening respiratory depression. Decrease initial dose. Clearance may also be reduced in older adults (with or without renal impairment) resulting in a narrow therapeutic window and increasing risk for respiratory depression or overdose

- Cachectic or debilitated patients: Is a greater potential for critical respiratory depression, even at therapeutic dosages
- Respiratory disease: Monitor for respiratory depression in patients with significant chronic obstructive pulmonary disease or cor pulmonale and patients having a substantially decreased respiratory reserve, hypoxia, hypercarbia, or preexisting respiratory depression, particularly when initiating therapy and titrating therapy; critical respiratory depression may occur, even at therapeutic dosages
- Hypovolemia, cardiovascular disease (including acute MI), circulatory shock: Potential vasodilation + hypotension
- CNS depression/coma: Are susceptible to intracranial effects of CO2 retention
- Biliary tract dysfunction or acute pancreatitis: May cause constriction of sphincter of Oddi
- Sleep-disordered breathing: Use with caution for chronic pain and titrate dosage cautiously in patients with risk factors for sleep-disordered breathing, including heart failure and obesity
- Head trauma, intracranial lesions, or elevated intracranial pressure: Respiratory depressant effects (with CO2 retention and secondary elevation of CSF pressure) may be markedly exaggerated
- Abdominal conditions: May obscure diagnosis or clinical course
- Adrenocortical insufficiency: including Addison disease. Long-term opioid use may cause secondary hypogonadism
- Delirium tremens, hepatic or renal impairment, obesity, prostatic hyperplasia/urinary stricture, psychosis, thyroid dysfunction. Seizure disorders: May cause or exacerbate preexisting seizures
- Patients on opioids for chronic pain, patient with opioid use disorder, patient on opioid agonist therapy – may require consultation to specialist (e.g. anesthesiology, addictions medicine)
- fentaNYL can accumulate in lipid stores when used for extended periods of time and may result in prolonged sedation and reduced ability to liberate from mechanical ventilator

DRUG INTERACTIONS

- Benzodiazepines or other CNS depressants: May result in profound sedation, respiratory depression, coma, and death
- Is metabolized by cytochrome P450 3A4; concomitant use with any 3A4 inhibitors may result in an increase in fentaNYL plasma concentrations, which could increase or prolong adverse reactions and may cause potentially fatal respiratory depression. Discontinuation of a concomitantly used 3A4 inducer may result in an increase in fentaNYL plasma concentration. Review drug profile at time of initiation and with any change in medication regimen

PREGNANCY

- Respiratory depression in the newborn is a potential complication if fentanyl is used close to delivery. As with all opioids, neonatal withdrawal may occur after chronic, long-term exposure during pregnancy.

BREASTFEEDING

- In 2001, the American Academy of Pediatrics classified fentanyl as compatible with breastfeeding

MONITORING REQUIRED

- As per site policy/standard work

ADULT BASELINE

- RR, HR, BP, sedation scale before dose

DIRECT IV

- RR, HR, BP, sedation scale, at 5 and 15 minutes post dose

PEDIATRIC/NEONATE BASELINE

- RR, HR, BP, sedation scale before dose

DIRECT IV

- RR, HR, BP, sedation scale, at 5 and 15 minutes post dose
- Continuous electronic respiratory monitoring and pulse oximetry during and for 15 minutes post dose
- Observe patient continually for 15 minutes post dose for signs/symptoms of apnea and/or muscle rigidity

RECOMMENDED

- Monitor fluid intake and urine output; check for bladder distension
- Check for abdominal distension, gas or constipation

NEONATE

- Monitor for chest wall rigidity is related to high doses and rapid escalation to moderate doses; rigidity may be prevented by concomitant use of neuromuscular blocking agents with mechanical ventilation
- For Intubation: monitor urine output post dose

Adverse Effects

CARDIOVASCULAR

- Bradycardia; which may be treated with atropine
- Hypotension. Orthostatic hypotension in ambulatory patients
- Peripheral edema

CENTRAL NERVOUS SYSTEM

- Sedation (common)
- Confusion
- Dizziness
- Fatigue

GASTROINTESTINAL

- Nausea/vomiting
- Constipation - diminished propulsive peristaltic waves in GI tract

RESPIRATORY

- Respiratory depression and apnea; may be severe, requiring maintenance of an adequate airway, use of resuscitative equipment, and administration of oxygen, naloxone, and/or other resuscitative drugs
- Muscular rigidity. Treatment: naloxone IV and respiratory support as required. Associated with speed of administration, reduced by use of slow intravenous injection.

NEONATE – INTUBATION

- Possible chest wall rigidity. Muscle relaxation (succinylcholine) overcomes this

MISCELLANEOUS

- Hyperhidrosis (excessive sweating)
- Hypokalemia

NEONATE

- Neonatal withdrawal syndrome: may be life-threatening. Signs and symptoms include irritability, hyperactivity, abnormal sleep pattern, high-pitched cry, tremor, vomiting, diarrhea, and failure to gain weight. Onset, durations and severity depend on the drug used, duration of use, maternal dose, and rate of drug elimination by the newborn.

Dosing

*Optimal analgesic dose varies widely among patients; while doses should be titrated to pain management, consideration of sedation level and respiratory status will also guide dosing

** Best Practice when giving medication that can lower the patient's blood pressure is to start an IV and administer the medication that route. Initial doses situation depending (can not get an IV or BP is adequate) can give other routes but multiple doses should have an IV in place if possible.

*** IN give 0.1 mL overfill to accommodate MAD dead-space volume. Max volume: 1 mL/nostril (children/adults), 0.5 mL/nostril (infants). Larger volumes to be divided between both nostrils.

ADULT:

- **Pain:** 0.5 to 2 mcg/kg **IV over 1 to 3 minutes or IM/IN** every 10 minutes PRN (consider using lower end dose for repeat doses)
- **MFI:** 3.5 mcg/kg (max 250 mcg) (low BP dose 1 to 3 mcg/kg) **over 30 to 60 seconds** approximately 3 minutes prior to induction

- **MFI Maintenance:** 25 to 50 mcg **IVP**

ELDERLY:

- **Pain:** 0.5 to 1 mcg/kg **IV/IM/IN**, repeat 0.25 to 0.5 mcg/kg **IV/IM/IN** every 10 min PRN
  *Elderly have been found to be twice as sensitive as younger patients to effects of fentaNYL. A wide range of doses may be required. Start with a low dose and titrate as tolerated

PEDIATRIC:

- **Pain:** 0.5 to 2 mcg/kg **IV over 3 to 5 minutes or IM** every 10 minutes PRN (consider using lower end for repeat doses); 1.5 to 2 mcg/kg **IN**
- **MFI:** 1 to 2 mcg/kg (max 200 mcg) **IV over 1 to 3 minutes**
- **MFI Maintenance:** 1 mcg/kg (max 25 mcg) **IVP**

MISCELLANEOUS

- 100 mcg fentaNYL is approximately equianalgesic to 10 mg morphine
- May also be given IM or SC

RENAL IMPAIRMENT ADJUSTMENTS

- For short surgical procedures, degree of renal impairment is irrelevant
- For other indications, renal impairment may have a moderate effect on elimination, however as fentaNYL is titrated to response usual dose remains valid. Start with a low dose and titrate as tolerated

Concentration Supplied:

- 50 mcg/mL (2 mL vial)
- 50 mcg/mL (5 mL vial)

Compatibility/Stability:

- Stable in D5W and NS for at least 24 hours at room temperature and in refrigerator when mixed on patient care unit
- Compatible with NS, D5W, Ringer's and LR solutions

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IV, IO, IN, IM, SC, monitor infusion
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711456
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/fentaNYL.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6903?cesid=9HMgqekRc32&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DfentaNYL%26t%3Dname%26acs%3Dtrue%26acq%3Dfentr

Development – May 2023
Update – June 2025

EMS Drug Reference Card (DRC)

Glucagon/BAQSIMI

Classification

- Hyperglycemic agent
- Pancreatic hormone

Indications

EMS INDICATIONS

- Treatment of severe hypoglycemia in patients 4 years of age and greater, who are unable to swallow and who do not have IV access.

SHA EMS MEDICAL DIRECTION

- Treatment of severe hypoglycemic reactions. IV glucose is preferred over glucagon IN
    - Treatment of severe hypoglycemia in patients with a basil skull fracture who do not have intravenous access.

HEALTH CANADA APPROVED

- *Induction of a hypotonic state and smooth muscle relaxation in the radiological examination of the stomach, duodenum, small bowel and colon*
- *Treatment of severe hypoglycemic reactions. IV glucose is preferred over glucagon IV*

NON HEALTH CANADA APPROVED INDICATION BUT SUBSTANTIATED IN THE LITERATURE

- *Beta blocker poisoning: Should be used early in treatment of bradycardia and hypotension*
- *In treatment of bradycardia and hypotension associated with calcium channel blocker poisoning* ***BUT NOT AS FIRST CHOICE AGENT***
- *Treatment of foreign body obstruction in esophagus*

Mechanism of Action

- Stimulates adenylate cyclase to produce an increase in cyclic AMP, which promotes hepatic glycogenolysis and gluconeogenesis causing an increase in blood glucose levels; antihypoglycemic effect requires preexisting hepatic glycogen stores. Extra hepatic effects of glucagon include relaxation of the smooth muscle of the stomach, duodenum, small bowel, and colon.
- In the setting of beta-blocker and calcium channel blocker toxicity, the glucagon-mediated increase in cyclic AMP increases automaticity at the sinoatrial and atrioventricular nodes. In addition, glucagon improves myocardial contractility and produces peripheral vasodilation.

Pharmacokinetics

- **Onset:** approx. 10 minutes IN
- **Peak:** 15 minutes IN, Peds: 15 to 20 minutes IN
- **Duration:** approx. 60 minutes IN
- **Metabolised:** primarily in the liver, kidneys and plasma.
- **Half-life:** 35 minutes, Peds: 21 to 31 minutes
- ***note:** common cold with nasal congestion or use of decongestant did not impact the pharmacokinetics of BAQSIMI

Contraindications

- Hypersensitivity to glucagon or any component of formulation
- Pheochromocytoma: may cause release of catecholamines producing marked hypertension
- Insulinoma: may induce hypoglycemia due to its insulin-releasing effect

Cautions

- BAQSIMI should be given in patients where impaired consciousness precludes oral carbohydrates. After intranasal administration the patient will normally respond within 15 minutes. If the patient does not respond within 15 minutes, intravenous glucose must be administered as soon as IV access can be established.
- Starvation, adrenal insufficiency, and chronic hypoglycemia: due to marked depletion of liver glycogen stores, glucagon is not effective in the treatment of hypoglycemia in these states. IV glucose should be used.
- Alcohol can suppress hepatic gluconeogenesis and chronic alcoholism can deplete liver glycogen stores. Therefore BAQSIMI may be less effective in presence of acute or chronic alcohol ingestion.
- Cardiac disease: Use with caution in patients with cardiac disease.
-
- Insulin or sulfonylurea overdose: Patients with hypoglycemia should immediately be treated with dextrose. If IV access cannot be established or if dextrose is not available, glucagon may be considered as alternative acute treatment until dextrose can be administered.

OVERDOSAGE:

- Symptoms: nausea, vomiting, diarrhea, inhibition of GI tract motility or an increase in blood pressure and pulse rate.
- In case of suspected overdosing, the serum potassium may decrease and should be monitored and corrected if needed.
- For management of a suspected drug overdose, contact PADIS.

PREGNANCY

- In general, medications used as antidotes should take into consideration the health and prognosis of the mother; antidotes should be administered to pregnant females if there is a clear indication for use and should not be withheld because of concerns of teratogenicity.

BREASTFEEDING

- The risk to a nursing infant appears to be negligible

DRUG INTERACTIONS

- BAQSIMI has not been studied for treatment of hypoglycemia in patients treated with sulfonylureas and should not be used in these patients.
- Sulfonylureas (medications used to treat Type 2 Diabetes; Glipizide, glimepiride, glyburide): The pharmacokinetic characteristics of sulfonylureas will result in remaining systemic concentrations for a long time and thus can cause significant and prolonged hypoglycemia. The preferred treatment of severe hypoglycemia in patients taking sulfonylureas is therefore the administration of glucose by IV bolus injection followed by continuous IV infusion until the end of the pharmacologic effects of the sulfonylureas.
- Beta-blockers: Patients taking beta-blockers might be expected to have a greater increase in both pulse and blood pressure when given glucagon, an increase of which will be temporary because of glucagon's short half-life. The increase in blood pressure and pulse rate may require therapy in patients with coronary artery disease.
- Indomethacin: When used with indomethacin, glucagon may lose its ability to raise blood glucose or may even produce hypoglycemia.
- Insulin: Reacts antagonistically towards glucagon.
- Warfarin: Glucagon may increase the anticoagulant effect of warfarin.
- Alcohol induced hypoglycemia is associated with a failure of blood glucose levels to rise normally after glucagon administration.

RECOMMENDED MONITORING

- Blood glucose, blood pressure, ECG, heart rate, mentation

MISCELLANEOUS

- Glucagon depletes glycogen stores.
- Non-medicinal Ingredients: Betadex and dodecylphosphocholine (DPC)

Adverse Effects

GASTROINTESTINAL

- Nausea and vomiting, higher incidence with doses of 2 mg or greater. Antiemetics are indicated when large doses are given

CARDIOVASCULAR

- Transient increase in BP and HR, (with large doses). Responds to IV phentolamine if treatment is required

METABOLIC

- Hypokalemia
- Hyperglycemia (excessive dosage)

MISCELLANOUS

- Headache, weakness, fatigue, drowsiness
- Watery, red or itchy eyes
- Ear, face or neck pain
- Change in sense of taste or smell
- Lack of attention, confusion, anxiety
- Itchy skin, increased sweating
- Mild to moderate upper respiratory tract irritation including rhinorrhea, nasal discomfort, nasal congestion, cough, epistaxis and oropharyngeal pain.

Dosing

Note: IV dextrose should be administered as soon as it is available; if patient fails to respond to glucagon, IV dextrose must be given

- Administered as one actuation of the intranasal device into one nostril. Do not push the plunger or test the device prior to administration. Administer the dose by inserting the tip into one nostril and pressing the device plunger all the way in until the green line is no longer showing. The dose does not need to be inhaled. Each BAQSIMI device contains one dose of glucagon and cannot be reused.
- To avoid relapse of hypoglycemia, give oral carbohydrates to restore the liver glycogen when the patient responds to treatment and are able to safely swallow.
- Usually awakens an unconscious patient within 15 minutes.
- Note: If patient does not respond within 15 minutes, intravenous glucose must be administered as soon as IV access can be established.

ADULT

- **Hypoglycemia:** 3 mg powder **IN;** if no response, may repeat in 15 minutes using a new intranasal device.

ELDERLY

- Not for elderly aged 65 and older

PEDIATRIC

- **Hypoglycemia 4 years of age and older:** 3 mg powder **IN;** if no response after 15 minutes, may repeat dose using a new device in either nostril.

Concentration Supplied:

- Available as glucagon nasal powder 3 mg per single actuation in intranasal single use device

Compatability/Stability:

- Store in shrink wrapped tube at temperatures up to 30 degrees C
- ***note:** Keep BAQSIMI in the shrink wrapped tube until ready to use. IF the tube has been opened, BAQSIMI may have been exposed to moisture. This could cause BAQSIMI to not work as expected.

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** IN
- **ACP:** IN
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/glucagon.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6983?cesid=6iozocXtAED&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dglucagon%26t%3Dname%26acs%3Dtrue%26acq%3Dglu
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711518
- SaskKids Pediatric Parental Manual
- BAQSIMI Product Monograph - https://pi.lilly.com/ca/baqsimi-ca-pm.pdf

Development – November 2024
Update – June 2025

EMS Provincial Medications

Haloperidol/Haldol ELDER ALERT

Classification

- Antipsychotic

Indications

EMS INDICATIONS

- For IM use only
- Acute delirium in emergency situations or where oral access is limited and in the absence of a history of seizures, head injury, the use of QT prolonging drugs (tricyclic anti-depressants, procainamide, stemetil etc.), drug toxicity (use of cocaine, etc)

*EMS INDICATIONS FOR **PALLIATIVE** USE UPON COMPLETING PALLIATIVE TRAINING*

- *For the **Palliative Patient** experiencing restlessness/early delirium*

HEALTH CANADA APPROVED

- *For IM use only*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN THE LITERATURE

- *Acute delirium in emergency situations or where oral access is limited*
- *Antiemetic in cancer chemotherapy*

Mechanism of Action

- Haloperidol is a butyrophenone antipsychotic that nonselectively blocks postsynaptic dopaminergic D_2 receptors in the brain

Pharmacokinetics

- **Onset:** 15 to 30 minutes IM, 3 to 20 minutes IV
- **Peak**: 25 to 30 minutes IM, 30 minutes IV
- **Duration:** 2 hours or greater IM, 3 to 24 hours
- **Half-life:** 20 hours IM, 14 to 26 hours IV
- **Excretion:** Urine (30%, 1% as unchanged drug)
- **Metabolism:** Hepatic

Contraindications

- Hypersensitivity to haloperidol or any component of formulation
- Severe toxic central nervous system depression or comatose states
- Parkinson's syndrome
- Dementia with Lewy bodies

- Previous spastic diseases; young children; patients of childbearing potential; breastfeeding
- Avoid in thyrotoxicosis; severe neurotoxicity (rigidity, inability to walk or talk) may occur with use.

Cautions

- **ELDER ALERT**
- Elderly; sensitivity to postural hypotension, anticholinergic and sedative effects increased. Increased risk of extrapyramidal side effects especially in elderly women
- Elderly patients with dementia-related psychosis; increased risk of mortality and cerebrovascular accidents
- Conditions that prolong QT interval, including electrolyte imbalance (particularly hypokalemia and hypomagnesemia), underlying cardiac abnormalities, hypothyroidism, and familial long QT syndrome
- History of cardiovascular disease, ECG monitoring highly recommended; because of the possibility of transient hypotension and/or precipitation of angina pain.
- History of convulsive disorders; may lower seizure threshold
- Thyrotoxicosis; severe neurotoxicity (e.g. rigidity, inability to walk or talk) may occur
- Additional restraint may be required due to the slow onset of haloperidol (10 to 30 minutes)
- May increase the risk for falls due to somnolence, orthostatic hypotension, and motor or sensory instability.
- May cause CNS depression, which may impair physical or mental abilities; patients must be cautioned about performing tasks that require mental alertness (eg, operating machinery, driving).
- Use with caution in patients with bipolar disorder; when used to control mania, there may be a rapid mood swing to depression. Haloperidol does not possess antidepressant effects.
- Use with caution in patients with myasthenia gravis; may exacerbate condition.

BLACK BOX WARNING:

- Older patients have an increased risk of adverse reactions to antipsychotics and there is a black box warning about increased risk of death in older patients with dementia who are treated with antipsychotics. In light of this risk, and relative to their small beneficial effect in the treatment of dementia-related psychosis and behavioral disorders, patients should be evaluated for possible reversible causes before being started on an antipsychotic. Nonpharmacologic interventions should be tried before initiating an antipsychotic.

DRUG INTERACTIONS

- CNS depressants (e.g. narcotics, benzodiazepines or anaesthetics): additive or potentiating effects
- Drugs that may prolong the QTc interval: possible additive effect. Avoid concurrent use
- EPINEPHrine: haloperidol blocks or reverses pressor effect and further lowers BP
- Is a substrate of cytochrome P450 isoenzymes CYP2D6 (major) and CYP3A4 (major); Interacts with many drugs - contact pharmacy for more information. Review drug profile at time of initiation and with any change in medication regimen

PREGNANCY

- Avoiding 1st trimester exposure, if possible, should be considered due to possible limb defects.
- Haloperidol crosses the placenta in humans. Although haloperidol has not been found to be a major human teratogen, an association with limb malformations following first trimester exposure in humans cannot be ruled out. Antipsychotic use during the third trimester of pregnancy has a risk for abnormal muscle movements (extrapyramidal symptoms) and withdrawal symptoms in newborns following delivery. Symptoms in the newborn may include agitation, feeding disorder, hypertonia, hypotonia, respiratory distress, somnolence, and tremor; these effects may be self-limiting or require hospitalization. If needed, the minimum effective maternal dose should be used in order to decrease the risk of EPS.

BREASTFEEDING

- In 2001, the American Academy of Pediatrics classified haloperidol as an agent whose effect on the nursing infant is unknown but may be of concern.

MONITORING REQUIRED

- Baseline BP, mental status and HR and then at 15 minutes

RECOMMENDED

- Health Canada and the FDA recommend ECG and QTc monitoring. Notify physician if QTc interval is greater than 450 ms or an increase of 10 to 25% in QTc occurs
- Serum magnesium and potassium levels: hypomagnesium and hypokalemia increase risk for QT prolongation
- CBC with differential, liver enzymes with long-term use; serum glucose
- Assess for signs of extrapyramidal side effects, e.g. rigidity, fine tremor of limbs, upward rotation of eyes

Adverse Effects

CARDIOVASCULAR

- Cardiac conduction disturbances e.g. prolonged QTc interval, torsades de pointes; risk increases with IV use or at doses higher than recommended
- Tachycardia
- Hypotension
- Hypertension
- Precipitation of anginal pain

CENTRAL NERVOUS SYSTEM

- Extrapyramidal symptoms: dystonic reactions, akathisia. Symptoms respond to treatment with anticholinergic agents (i.e. IV diphenhydrAMINE or benztropine)
- Neuroleptic malignant syndrome characterized by muscular rigidity, hyperpyrexia, autonomic instability and marked changes in mental status (Rare)

Dosing

ADULT AND OLDER THAN 12YRS

- **IM:** 2.5 to 5 mg

ELDERLY/DEBILITATED

- **IM:** 1 to 2.5 mg

Palliative Patient

Delirium or Restlessness (adult)

- *2.5 to 5 mg **SC or PO** every 30 minutes until desired effect is achieved then follow with maintenance dose of the amount given to achieve desired effect **SC or PO** every 2 hours*

RENAL IMPAIRMENT ADJUSTMENTS

- Creatinine clearance less than 10 mL/minute: start with lower doses
- For single doses use 100% of normal dose
- Accumulation with repeated dosage

MISCELLANEOUS

- When given IM in cumulative doses greater than 35 mg/24 hours: daily ECG and QTc monitoring is recommended. Notify physician if QTc interval is greater than 450 ms or an increase of greater than 25% in QTc occurs
- May be given via subcutaneous route

Concentration Supplied:

- 5 mg/1 mL (1 mL amp)

Compatibility/Stability:

- Stable D5W (max conc. 3 mg/mL) for 24 hours at room temperature
- Dilution in NS is not recommended, however lines may be flushed with NS
- **Incompatible with heparin** - recommended that lines be flushed with NS or D5W before and after injecting haloperidol into an injection port. Administration through a heparin lock would require a similar flushing procedure

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IM, SC, IV if haloperidol lactate
- **CCP:** As per scope of practice

***IM is the recommended route**

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- *Palliative Program (2021)*
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/haloperidol.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7019?cesid=60z7SrsmNuF&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dhaloperidol%26t%3Dname%26acs%3Dtrue%26acq%3Dhal
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711531

Development – May 2023
Update – June 2025

EMS Provincial Medications

HYDROmorphone/Dilaudid HIGH ALERT

Classification

- Opiate Agonist/Narcotic Analgesic

Indications

*EMS INDICATIONS FOR **PALLIATIVE** USE UPON COMPLETING PALLIATIVE TRAINING*

- *Pain management for **Palliative patient** already taking HYDROmorphone*
- *Breathlessness in the **Palliative patient** already taking HYDROmorphone*

HEALTH CANADA APPROVED

- *Relief of moderate to severe pain*

Mechanism of Action

- Binds to opioid receptors in the CNS, causing inhibition of ascending pain pathways, altering the perception of and response to pain; causes cough suppression by direct central action in the medulla; produces generalized CNS depression

Pharmacokinetics

- **Onset:** 15 to 30 minutes PO, 5 minutes IV, 15 minutes SC
- **Peak:** 30 to 60 minutes PO, 10 to 20 minutes IV, 60 to 90 minutes SC
- **Duration:** 3 to 4 hours PO & IV, 4 to 5 hours SC
- **Half-life:** 2 to 4 hours PO**,** IV, SC
- **Excretion:** Urine (primarily as glucuronide conjugates); minimal unchanged drug is excreted in urine (~7%) and feces (1%)

Contraindications

- Hypersensitivity to HYDROmorphone or any component of formulation. Cross sensitivity may occur with codeine, morphine, oxyCODONE or oxymorphone

Cautions

- **HIGH ALERT**
- Elderly: May be more sensitive to adverse effects, including life-threatening respiratory depression. Decrease initial dose. In setting of chronic pain, monitor closely due to an increased potential for risks, including certain risks such as falls/fracture, cognitive impairment, and constipation. Clearance may also be reduced in older adults (with or without renal impairment) resulting in a narrow therapeutic window and increasing risk for respiratory depression or overdose

- Cachectic or debilitated patients: Is a greater potential for critical respiratory depression, even at therapeutic dosages
- Respiratory disease: Monitor for respiratory depression in patients with significant chronic obstructive pulmonary disease or cor pulmonale and patients having a substantially decreased respiratory reserve, hypoxia, hypercarbia, or preexisting respiratory depression, particularly when initiating therapy and titrating therapy; critical respiratory depression may occur, even at therapeutic dosages
- Sleep-disordered breathing: Use with caution for chronic pain and titrate dosage cautiously in patients with risk factors for sleep-disordered breathing, including HF and obesity
- Hypovolemia, cardiovascular disease (including acute MI), circulatory shock: Potential vasodilation + hypotension
- Head trauma, intracranial lesions, or elevated intracranial pressure: Respiratory depressant effects (with CO2 retention and secondary elevation of CSF pressure) may be markedly exaggerated
- CNS depression/coma: Are susceptible to intracranial effects of CO2 retention
- Abdominal conditions: May obscure diagnosis or clinical course
- Adrenocortical insufficiency: including Addison disease. Long-term opioid use may cause secondary hypogonadism
- Biliary tract dysfunction or acute pancreatitis: May cause constriction of sphincter of Oddi
- Delirium tremens, hepatic or renal impairment, obesity, prostatic hyperplasia/urinary stricture, psychosis, thyroid dysfunction
- Seizure disorders: May cause or exacerbate preexisting seizures
- Patients on opioids for chronic pain, patient with opioid use disorder, patient on opioid agonist therapy – may require consultation to specialist (e.g. anesthesiology, addictions medicine)

DRUG INTERACTIONS

- Benzodiazepines or other CNS depressants: May result in profound sedation, respiratory depression, coma, and death
- Other potentially significant interactions may exist, requiring dose or frequency adjustment, additional monitoring, and/or selection of alternative therapy. Consult drug interactions database for more detailed information

PREGNANCY

- The National Birth Defects Prevention Study discussed below found evidence that opioid use during organogenesis is associated with a low absolute risk of congenital birth defects. In addition, withdrawal could occur in infants exposed in utero to prolonged maternal ingestion of hydromorphone. Use of the drug in pregnancy is primarily confined to labor. Respiratory depression in the neonate similar to that produced by meperidine or morphine should be expected.

BREASTFEEDING

- The effect of usual amounts on a nursing infant appears to be clinically insignificant.

MONITORING REQUIRED

All Ages Baseline

- RR, HR, BP and sedation scale before dose

All Ages Direct IV

- RR, HR, BP, sedation scale, at 5 and 15 minutes post dose

Pediatric Direct IV:

In addition to above

- Observe patient continually for 5 minutes post dose for signs/symptoms of respiratory depression

RECOMMENDED

- Monitor fluid intake and output; check for bladder distension
- Check for abdominal distension, gas or constipation

Adverse Effects

CARDIOVASCULAR

- Hypotension
- Bradycardia
- Tachycardia
- Orthostatic hypotension in ambulatory patients

CENTRAL NERVOUS SYSTEM

- Sedation (common)
- Light-headedness/dizziness
- Headache
- Insomnia
- Anxiety
- Confusion
- Euphoria/dysphoria
- Myoclonus
- Seizures
- Mood changes
- Transient hallucinations

GASTROINTESTINAL (common)

- Nausea/vomiting
- Constipation. Diminished propulsive peristaltic waves in GI tract

RESPIRATORY

- Respiratory depression and apnea; may be severe, requiring maintenance of an adequate airway, use of resuscitative equipment, and administration of oxygen, naloxone, and/or other resuscitative drugs

MISCELLANEOUS

- Neonatal withdrawal syndrome: may be life-threatening. Signs and symptoms include irritability, hyperactivity, abnormal sleep pattern, high-pitched cry, tremor, vomiting, diarrhea, and failure to gain weight. Onset, duration, and severity depend on the drug used, duration of use, maternal dose, and rate of drug elimination by the newborn

Dosing

ONLY for Palliative patients who are currently taking Hydromorphone that has been prescribed by a Physician or Nurse Practitioner.

*Optimal analgesic dose varies widely among patients; while doses should be titrated to pain management, consideration of sedation level and respiratory status will also guide dosing

Dilution:

- **Subcut**: none required
- **IV:** 9 mL of NS which yields 0.2 mg/mL

ADULT

BREATHLESSNESS

OPIOID NAÏVE (on HYDROmorphone for less than 5 days)

- 0.5 mg **PO** or 0.3 mg **Subcut**

FOR PALLIATIVE PATIENTS ON HYDROMORPHONE FOR 5 DAYS OR MORE

- Give HYDROmorphone break through dose **PO** or **Subcut**

PAIN

PO

- 1 mg every 1 hour PRN
- **Frail/Reduced dose:** 0.5 mg every 1 hour PRN

Subcut/IV: Max dose is 2 mL of volume at a single time

- 0.5 mg every 30 minutes PRN
- **Frail/Reduced dose:** 0.3 mg every 30 minutes PRN

PEDIATRIC

- Contact pediatric palliative patient's Physician for patient specific dosing.

NEONATE

- Not recommended due to potential central nervous system effects

Concentration Supplied:

- 2 mg/1 mL (1 mL amp)

Compatibility/Stability:

- Stable in dextrose 5% and NS for at least 24 hours at room temperature and in the refrigerator when mixed on ward
- Compatible with dextrose, saline, dextrose-saline combinations and LR

RENAL IMPAIRMENT ADJUSTMENTS

- Initiate with 25% to 50% of the usual starting dose depending on the degree of impairment. Use with caution and monitor closely for respiratory and CNS depression

HEPATIC IMPAIRMENT ADJUSTMENTS

- Mild to severe impairment: Initiate with 25% to 50% of the usual starting dose depending on the degree of impairment
- Use with caution and monitor closely for respiratory and central nervous system depression

HEMO/PERITONEAL DIALYSIS/CRRT

- Hemodialysis: Unknown dialysability. 50% of normal dose. Administer anytime during dialysis
- CAPD: Unknown dialysability. 50% of usual starting dose and titrate according to response

MISCELLANEOUS

- May be given IM or subcutaneously
- Exact morphine to HYDROmorphone potency equivalence ratio is unclear
- Some suggest that 1.3 to 2 mg parenteral HYDROmorphone is equal to 10 mg parenteral morphine

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** PO, Subcut, IV
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711542
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/HYDROmorphone.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7053?cesid=1tiUreAYpt5&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DHYDROmorphone%26t%3Dname%26acs%3Dtrue%26acq%3Dhydro
- *Palliative Program (2021)*

Development – May 2023
Update – June 2025

EMS Provincial Medications

Ibuprofen/Advil

Classification

- Analgesic, Non-opioid
- Nonsteroidal Anti-Inflammatory Drug (NSAID)

Indications

EMS INDICATIONS

- Management of inflammatory diseases and rheumatoid disorders
- Mild to moderate pain
- Fever
- Dysmenorrhea
- Osteoarthritis

SHA EMS Medical Direction Note:

- PO NSAID for use in patients less than 50 kg

HEALTH CANADA APPROVED

- *Management of inflammatory diseases and rheumatoid disorders*
- *Mild to moderate pain*
- *Fever*
- *Dysmenorrhea*
- *Osteoarthritis*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITURATURE

- *Abnormal uterine bleeding*
- *Gout, treatment acute flares*
- *Pericarditis, acute or recurrent*

Mechanism of Action

- The main mechanism of action of NSAIDs is the inhibition of the enzyme cyclooxygenase (COX). Cyclooxygenase is required to convert arachidonic acid into thromboxanes, prostaglandins, and prostacyclins. The therapeutic effects of NSAIDs are attributed to the lack of these eicosanoids.
- Has antipyretic, analgesic, and anti-inflammatory properties
- Other proposed mechanisms not fully elucidated (and possibly contributing to the anti-inflammatory effect to varying degrees), include inhibiting chemotaxis, altering lymphocyte activity, inhibiting neutrophil aggregation/activation, and decreasing proinflammatory cytokine levels.

Pharmacokinetics

- **Onset:** 30 to 60 minutes
- **Peak:** 1 hours
- **Duration:** 6 to 8 hours
- **Half-life:** 1.5 to 2 hours
- **Metabolized** through the liver via oxidation and **excreted** through the kidneys

Contraindications

- Hypersensitivity to Ibuprofen or other NSAIDS
- Ibuprofen is contraindicated during the perioperative setting of coronary artery bypass graft (CABG) surgery.
- Cerebrovascular bleeding or other bleeding disorders
- Active gastric/duodenal/peptic ulcer, active GI bleeding
- Inflammatory bowel disease
- Uncontrolled heart failure
- Deteriorating renal disease
- Active hepatic disease
- Hyperkalemia
- Third trimester of pregnancy
- Systemic lupus erythematosus [oral formulation only];
- Children suffering from dehydration as a result of acute diarrhea, vomiting, or lack of fluid intake

Cautions

- Asthmatics (can precipitate bronchospasm)
- Active bleeding ulcers (risk vs benefit)
- Hepatic insufficiency
- Bleeding disorder
- Renal impairment. Use of ibuprofen lysine (NeoProfen) is contraindicated in preterm infants with significant renal impairment.
- May increase the risk of aseptic meningitis, especially in patients with systemic lupus erythematosus and mixed connective tissue disorders.
- Nonsteroidal anti-inflammatory drugs (NSAIDs) cause an increased risk of serious cardiovascular thrombotic events, including myocardial infarction, and stroke, which can be fatal. This risk may occur early in treatment and may increase with duration of use.
- NSAIDs cause an increased risk of serious gastrointestinal (GI) adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients and patients with a prior history of peptic ulcer disease and/or GI bleeding are at greater risk for serious GI events.

DRUG INTERACTIONS

- Aminoglycosides, caffeine, digoxin and vancomycin clearance may be reduced due to ibuprofen induced renal impairment. Carefully monitor drug levels and observe for signs of toxicity.
- Corticosteroids: Concomitant use may increase risk of intestinal perforation. Do not administer concurrently.

MONITORING

- CBC, chemistry profile, occult blood loss and periodic LFTs; monitor response (pain, range of motion, grip strength, mobility, ADL function), inflammation; observe for weight gain, edema; monitor renal function (urine output, serum BUN and creatinine); observe for bleeding, bruising (especially in patients with coagulation disorders or who are receiving anticoagulants); monitor for anemia with long-term therapy; evaluate GI effects (abdominal pain, bleeding, dyspepsia); mental confusion, disorientation; BP; periodic ophthalmic exams with long-term therapy; signs of infection (ibuprofen lysine); signs of immediate or delayed hypersensitivity reactions.

Adverse Effects

- Headache
- Heartburn
- Increased bleeding time
- Nausea
- Vomiting
- Rash

CENTRAL NERVOUS SYSTEM

- May cause drowsiness, dizziness, blurred vision, and other neurologic effects which may impair physical or mental abilities; patients must be cautioned about performing tasks which require mental alertness (e.g. operating machinery or driving).

HYPERKALEMIA

- Nonsteroidal anti-inflammatory drug (NSAID) use may increase the risk of hyperkalemia, particularly in patients greater than or equal to 65 years of age, in patients with diabetes or renal disease, and with concomitant use of other agents capable of inducing hyperkalemia (e.g. ACE inhibitors). Monitor potassium closely.

OPHTHALMIC EVENTS

- Blurred/diminished vision, scotomata, and changes in color vision have been reported. Discontinue therapy and refer for ophthalmologic evaluation if symptoms occur. Periodically evaluate vision in all patients receiving long-term therapy.

Dosing

*Administer with food or milk to decrease GI upset.
** Oral suspension: Shake suspension well before use. Administer with an accurate measuring device (calibrated oral syringe or measuring cup); do not use a household teaspoon or tablespoon to measure dose (overdosage may occur).

ADULT/ELDERLY

More than 50 kg

- **PO** Naproxen recommended

PEDIATRIC

6 Months to 12 years and Less than 50 kg:

- 10 mg/kg **PO** every 6 to 8 hours

3 to 6 Months

- 10 mg/kg PO every 6 to 8 hours
- **Dose limit:** 40 mg/kg/day or 2400 mg/day; whichever is less

Concentration Supplied:

- 20 mg/mL Suspension

Provider/Route:

- **EMR:** PO
- **PCP/ICP:** PO
- **ACP:** PO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7066?cesid=4Y4cOQfShGS&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dibuprofen%26t%3Dname%26acs%3Dtrue%26acq%3Dibu
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711552

Development – May 2023
Update – June 2025

EMS Provincial Medication

Ipratropium/Atrovent

Classification

- Anticholinergic

Indications

EMS INDICATIONS

- Patient experiencing bronchospasm
- COPD Acute exacerbation: Note: Although similar efficacy exists among formulations, some experts prefer nebulized therapy during severe chronic obstructive pulmonary disease (COPD) exacerbations. May be used in combination with an inhaled short-acting beta agonist
- Asthma, acute exacerbation, moderate to severe (off-label use): Note: May consider for treatment of moderate to severe exacerbations (e.g. critically ill) in combination with a short-acting beta-adrenergic agonist. Nebulized therapy may be preferred in patients who have more severe symptoms or who cannot effectively use an inhaler

HEALTH CANADA APPROVED

- *Patient experiencing bronchospasm*
- *COPD Acute exacerbation: Note: Although similar efficacy exists among formulations, some experts prefer nebulized therapy during severe chronic obstructive pulmonary disease (COPD) exacerbations. May be used in combination with an inhaled short-acting beta agonist*

NON HEALTH CANADA APPROVED BUT SUBSTANTIATED IN LITURATURE

- *Asthma, acute exacerbation, moderate to severe (off-label use): Note: May consider for treatment of moderate to severe exacerbations (e.g. critically ill) in combination with a short-acting beta-adrenergic agonist. Nebulized therapy may be preferred in patients who have more severe symptoms or who cannot effectively use an inhaler*

Mechanism of Action

- Blocks acetylcholine at parasympathetic sites in bronchial smooth muscle causing bronchodilation
- Local application to nasal mucosa inhibits serous and seromucuous gland secretions

Pharmacokinetics

- **Onset:** within 15 minutes
- **Peak effect:** 1 to 2 hours
- **Duration:** 2 to 4 hours MDI, 4 to 8 hours NEB
- **Half-life:** 2 hours
- **Excretion:** Urine (50%)

Contraindications

- Hypersensitivity to ipratropium or atropine (and its derivatives)

Cautions

- Patients with narrow angle glaucoma should wear goggles
- Use caution in patients with myasthenia gravis
- Caution in patients with hypertrophic prostate, obstructed bladder neck
- Older adults may be more susceptible to the anticholinergic side effects of ipratropium (e.g. dry eyes, dry mouth). The elderly may find it difficult to use the metered-dose inhaler. A spacer device may be useful. Monitor urinary function in elderly men with benign prostatic hyperplasia while on this medication.

PREGNANCY

- A number of sources recommend the use of inhaled ipratropium for severe asthma, especially in patients not responding adequately to other therapy. The consensus appears to be that although human data are rare, there is no evidence that the drug is hazardous to the fetus. Moreover, it produces fewer systemic effects than atropine and may have an additive bronchodilatory effect to β_2 agonists

BREASTFEEDING

- Ipratropium is lipid-insoluble and, similar to other quaternary ammonium bases, may appear in milk. The amounts, although unknown, are probably clinically insignificant, however, especially after inhalation.
- Systemic exposure following inhalation is negligible which would limit excretion into breast milk. According to the manufacturer, the decision to breastfeed during therapy should consider the risk of infant exposure, the benefits of breastfeeding to the infant, and the benefits of treatment to the mother.

Adverse Effects

- Headache
- Nausea
- Tremors
- Cough
- Dry mouth
- Bad taste
- Eye pain (can be severe) if given to glaucoma patient without goggles
- Pupil dilation
- Bronchospasm: Paradoxical bronchospasm that may be life-threatening and may occur with use of inhaled bronchodilating agents; this should be distinguished from inadequate response. If paradoxical bronchospasm occurs, discontinue ipratropium and institute alternative therapy.

CENTRAL NERVOUS SYSTEM

- dizziness and blurred vision; patients must be cautioned about performing tasks which require mental alertness (e.g. operating machinery or driving).

HYPERSENSITIVITY REACTIONS

- urticaria, angioedema, rash, bronchospasm, oropharyngeal edema, including anaphylaxis, have been reported.
- Discontinue therapy immediately if patient develops an allergic reaction.

Dosing

*MDI with inline dispenser and extra tubing for ETT administration can be used for intubated patients

ADULT/ELDERLY

NEBULIZED

- 250 to 500 mcg (usually repeated to max of 1 mg)

MDI WITH AERO CHAMBER

- 5 puffs at 20 mcg/puff (no repeats) interspersed with Ventolin puffs (see below for instructions)

PEDIATRIC

NEBULIZED

- 125 to 250 mcg; Dilute to a total of 3 mL with normal saline if required after Ventolin and Atrovent are mixed in neb if total does not make 3 mL

MDI WITH AERO CHAMBER

Patients weighing more than 20 kg:

- 5 puffs at 20 mcg (no repeats) interspersed with Ventolin puffs (see below for instructions)

Patients weighing less than 20 kg:

- 4 puffs at 20 mcg (no repeats) interspersed with Ventolin puffs (see below for instructions)

Patients weighing less than 10 kg:

- MDI not indicated see above for nebulized dose

Dosing of Atrovent and Ventolin should look like this:

- 1 Ventolin puff at a time, waiting 30 to 60 seconds between up to 10 puffs.
- Follow each Ventolin with a puff of Atrovent 10 seconds post Ventolin puff for the first 5 puffs of Ventolin.
- *If the patient in extremis this wait time can be shortened as practitioner feels is appropriate*
- Wait 5 to 10 minutes between sets of 10 puffs Ventolin to observe for effect.
- Repeat sets of 10 puffs Ventolin up to 3 times (30 puffs)
- Atrovent *is only given during the first round of 10 puffs for 5 puffs. Repeat sets are* Ventolin *only*

Concentration Supplied:

- 250 mcg/mL Nebule; 20 mcg/puff MDI

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** inhalation, nebulized
- **ACP:** inhalation, nebulized, ETT
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711600
- SaskKids Pediatric Parental Manual
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/1797824?cesid=53OLAE2pIEV&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dipratropium%26t%3Dname%26acs%3Dtrue%26acq%3Dipat
- PALS 2020
- ACLS EP 2017

Development – May 2023
Update – June 2025

EMS Provincial Medications

Ketamine/Ketalar HIGH ALERT

Classification

- Anaesthetic – general

Indications

EMS INDICATIONS

- Induction and maintenance of anaesthesia
- Dissociative sedation prior to painful and frightening procedures
- Secondary medication for symptomatic relief of moderate to severe pain
- Secondary medication for symptomatic relief for severe agitation

SHA EMS Medical Direction Note:

- Not to be used for first line pain management or first line for severe agitation

HEALTH CANADA APPROVED

- *Induction and maintenance of anaesthesia*

*N**ON HEALTH CANADA APPROVEINDICATIONS BUT SUBSTANTIATED IN THE LITERATURE***

- *Dissociative sedation prior to painful and frightening procedures*
- *Symptomatic relief of moderate to severe pain*
- Adjunctive therapy for severe status asthmaticus, adjunctive 4th line therapy for refractory status epilepticus
- Adjunctive therapy for refractory status epilepticus after conventional therapies have failed
- Sedation/analgesia in mechanically ventilated patients in Critical Care
- Treatment resistant depression

Mechanism of Action

- Produces a cataleptic-like state in which the patient is dissociated from the surrounding environment by direct action on the cortex and limbic system. Ketamine is a non-competitive NMDA receptor antagonist that blocks glutamate
- Low (subanesthetic) doses produce analgesia, and modulate central sensitization, hyperalgesia and opioid tolerance. Reduces polysynaptic spinal reflexes.

Pharmacokinetics

- **Onset:**
  - IV**:** ANESTHETIC EFFECT: Within 30 seconds
  - IM: ANESTHETIC EFFECT: 3 to 4 minutes; ANALGESIA: Within 10 to 15 minutes
  - IN: ANALGESIC EFFECT: Within 10 minutes; SEDATION: Children 2 to 6 years: 5 to 8 minutes
  - PO: ANALGESIA: Within 30 minutes
- **Peak**:
  - IM: 5 to 30 minutes

- IN: ADULT 10 to 14 minutes; CHILDREN 2 TO 9 YEARS: approx. 20 minutes
- PO: approx. 30 minutes

- **Duration:** 5 to 10 minutes IV ANESTHETIC EFFECT
- **Excretion:** Urine (91%); feces (3%)
- **Pharmacotherapy PEARLS:** The analgesia outlasts the general anesthetic component. Bronchodilation is beneficial in asthmatic or chronic obstructive pulmonary disease patients. Laryngeal reflexes may remain intact or may be obtunded. The direct myocardial depressant action of ketamine can be seen in stressed, catecholamine-deficient patients. Ketamine increases cerebral metabolism and cerebral blood flow while producing a noncompetitive block of the glutaminergic postsynaptic NMDA receptor.

Contraindications

- Hypersensitivity to ketamine or any component of the formulation
- Conditions where a significant elevation of blood pressure is hazardous (e.g. patients with poorly controlled hypertension, aneurysms, acute right- or left-sided heart failure, angina, recent myocardial infarction)
- History of cerebrovascular accident; severe cardiac decompensation; surgery of the pharynx, larynx, or bronchial tree unless adequate muscle relaxants are used

Cautions

- **HIGH ALERT**
- Patients with mild-to-moderate hypertension, chronic congestive heart failure, tachyarrhythmias, or myocardial ischemia
- History of psychosis or substance use (schizophrenia, acute psychosis); increased incidence of emergence symptoms
- Age less than 3 months, due to an increased frequency of airway complication
- Acute intermittent porphyria, glaucoma or elevated intraocular pressure, globe injuries
- Hyperthyroidism or patients receiving thyroid replacement (increased risk of hypertension, tachycardia)
- Pulmonary or upper respiratory infection; ketamine sensitises the gag reflex, potentially causing laryngospasm
- Intracranial mass lesions, presence of head injury, hydrocephalus; may increase ICP without adequate ventilation
- Ketamine may cause drug dependence (withdrawal symptoms on discontinuation) and drug tolerance with prolonged use. Multiple case reports of ketamine misuse have been described. A withdrawal syndrome following discontinuation may include symptoms such as shaking, sweating, palpitations, fatigue, decreased appetite, chills, autonomic arousal, lacrimation, restlessness, cravings, dysphoria, anxiety, depressed mood, nightmares, paranoia, delusions, and hallucinations. Typical duration of withdrawal symptoms is ~3 days, with some cases persisting for 2 weeks. Dose- and time-related; development of dependence may be related to the psychological effects of ketamine and tolerance. Ketamine is structurally similar to phencyclidine and the psychological effects contributing to dependence may include euphoria, perceptual changes, dissociation, and hallucinations. Tolerance most likely occurs due to auto-induction of metabolism. Dependence may also be related to N-methyl-D-aspartate (NMDA) glutamate receptor blockade, producing alcohol-like subjective effects, as well as opioid effects. Dependence may evolve over weeks to years. Withdrawal syndrome symptoms usually occur within 24 hours of discontinuation. Risk factors for dependence: Long-term high-dose use, rapid dose escalation, history of multiple substance use disorders (eg, alcohol, cannabis, opioids) and ease of access.

DRUG INTERACTIONS

- CNS depressants including benzodiazepines; will prolong recovery time and may increase risk of apnea
- Is a substrate of cytochrome P450 isoenzymes CYP2B6 (major), CYP2C9 (major), CYP3A4 (major); Interacts with many drugs - contact pharmacy for more information. Review drug profile at time of initiation and with any change in medication regimen

PREGNANCY

- Although ketamine anesthesia close to delivery may induce dose-related, transient toxicity in the newborn, these effects are usually avoided with the use of lower maternal doses. No reports of malformations in humans or in animals attributable to ketamine have been located. Experience with the anesthetic agent during human organogenesis apparently has not been published.

BREASTFEEDING

- Because ketamine is a general anesthetic agent, breastfeeding would not be possible during use of the drug, and no reports have been located that measured the amount of the agent in milk. The elimination half-life of ketamine has been reported to be 2.17 hours in unpremedicated patients (Ref). Thus, the drug should be undetectable in the mother's plasma approximately 11 hours after a dose. Nursing after this time should not expose the infant to pharmacologically significant amounts of ketamine.

MONITORING REQUIRED

- **ADULT:** Baseline: BP, HR, RR, oxygen saturation, sedation scale
- **PEDS:** Baseline and every 15 minutes until recovered: BP, HR, RR, oxygen saturation, sedation scale, ECG monitoring until recovery is well established

DIRECT IV REQUIREMENTS

- ADULT: Doses 0.25 mg/kg to 1.5 mg/kg: intubated patient or if patient not intubated under the direct supervision of a medical professional skilled in airway management (i.e. physician, nurse, respiratory therapist) must be physically present) for the first two doses and to be immediately available to manage airway complications for subsequent boluses
- PEDIATRIC: Doses 2 mg/kg or less: intubated patient or if patient not intubated under the direct supervision of a medical professional skilled in airway management (i.e. physician, nurse, respiratory therapist) must be physically present) for the first two doses and to be immediately available to manage airway complications for subsequent boluses

MONITORING RECOMMENDED

- Monitor for emergence symptoms; Severe emergent reactions may require treatment with a small hypnotic dose of a short or ultrashort acting barbiturate
- Monitor cardiac function in patients with increased blood pressure or cardiac decompensation
- Monitor continuous oxygen saturation in high-risk patients (i.e. airway instability, severe obstructive sleep apnea, severe renal or hepatic disease, home oxygen use)

Adverse Effects

CARDIOVASCULAR

- Increased heart rate
- Elevated blood pressure. Elevation of BP begins shortly after injection, reaches a maximum within a few minutes and usually returns to baseline values within 15 minutes of injection
- Hypotension; Catecholamine depletion
- Arrhythmia
- Bradycardia

CENTRAL NERVOUS SYSTEM

- Elevation of intracranial and intraocular pressures

GASTROINTESTINAL

- Vomiting – occurs late in recovery phase

RESPIRATORY

- Moderate and transient (less than 30 seconds) respiratory depression
- Hypersalivation and increased tracheobronchial secretions
- Severe respiratory depression is associated with an over dosage or too rapid a rate of administration. Mechanical support of respiration is preferred to administration of analeptics.
- Ketamine may rarely cause respiratory depression or apnea, which are usually transient. These adverse reactions are most associated with rapid IV administration but have also been reported with IM administration.

According to the manufacturer, overdose is also a risk factor for these adverse reactions; however, respiratory depression and apnea have been reported in the setting of slow sub-anesthetic IV infusion; typically rapid onset, 1 to 2 minutes after IV administration or 4 to 5 minutes after IM administration. In the case of respiratory depression and apnea in the setting of slow sub-clinical IV infusion, onset occurred 25 minutes after the start of ketamine infusion. Risk factors include: overdose, rapid IV administration, and concurrent use of other CNS depressants (eg, benzodiazepines, opioids).

MISCELLANEOUS

- Emergence reaction; characterised by vivid dreams, dissociative or extracorporeal (out-of-body) experiences, floating sensations, hallucinations, delirium, confusion, or "weird trips". Generally subsides within a few hours. More common in those between 15 to 45 years of age, rapid IV administration and females. Pre-administration of a benzodiazepine may help to diminish incidence.
- Prolonged emergence from anesthesia, which can manifest as vivid dreams, hallucinations, and/or frank delirium commonly occur in all ages. May be dose-related; may occur due to depression of auditory and visual relay nuclei, leading to misperception and/or misinterpretation of auditory and visual stimuli. Emergence reactions may occur up to 24 hours postoperatively. Risk factors: higher doses, rapid IV administration, age greater than 16 years, females, excessive noise or stimulation during recovery, people who normally dream or have a history of a personality disorder, ketamine monotherapy (concurrent use with a benzodiazepine may reduce risk).
- Self-limiting rash
- Random movement of head and extremities
- Rigidity
- Skeletal muscle hypertonicity

Dosing

ADULT/PEDIATRIC

PAIN

- 0.1 to 0.3 mg/kg **IV over at least 1 minute** repeat every 10 minutes
- 1 mg/kg **IN**

***Note:** IV use may be useful for moderately to severely painful procedures and conditions that do not respond optimally to standard analgesics (eg, postoperative, burn, trauma, sickle cell disease vaso-occlusive pain)

MFI

- 1.5 to 2 mg/kg **IV over at least 1 minute** repeat in 3 minutes if needed

MFI MAINTENANCE

- 1 mg/kg **IV over at least 1 minute** PRN

HYPOTENSIVE DOSING

- 0.25 to 1 mg/kg **IV over at least 1 minute** repeat in 3 minutes if needed

SEVERELY AGITATED **ADULT ONLY**

- 3 to 4 mg/kg **IM**

HEPATIC IMPAIRMENT ADJUSTMENTS

- Ketamine is metabolised in the liver and hepatic clearance is required for termination of clinical effects
- Prolonged duration of action may occur in patients with cirrhosis or other type of liver impairment; dose reductions should be considered in these patients

MISCELLANEOUS

- IV - onset of action; immediate. Recovery period typically 1 to 2 hours
- May be given IM. Onset of action: 3 to 4 minutes

- When given IM follow requirements and required monitoring as for IV administration
- Can be given subcutaneously and intranasally

Concentration Supplied:
- 50 mg/mL (10 mL vial)

Compatibility/Stability:
- Compatible with D5W and NS solutions
- Stability for 24 hours at room temperature is assumed
- Compatible in a syringe with atropine or glycopyrolate

Provider/Route:
- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IM, IN, IV, IO, IVAD, monitor infusion
- **CCP:** As per scope of practice

Resources:
- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/ketamine.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7135?cesid=5IMuKI9FjMU&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dketamine%26t%3Dname%26acs%3Dtrue%26acq%3DkETAM
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711620

Development – May 2023
Update – June 2025

EMS Provincial Medications

Ketorolac/Toradol

Classification

- Analgesic

Indications

EMS INDICATIONS

- For the short term management of moderate to severe pain

SHA EMS Medical Direction Note:

- For IM or IV use for the short term management of moderate to severe pain (eg. kidney stones, sciatic back pain, migraines)

HEALTH CANADA APPROVED

- *IM use only, for the short term management of moderate to severe pain. Parenteral therapy should not exceed 2 days.*

NON HEALTH CANADA APPROVED INDICATION BUT SUBSTANTIATED IN THE LITERATURE

- *IV use, for the short term management of moderate to severe pain*

Mechanism of Action

- Non-selective NSAID and acts by inhibiting both COX-1 and COX-2 enzymes which are normally responsible for converting arachidonic acid to prostaglandins
- Has antipyretic, analgesic, and anti-inflammatory properties

Pharmacokinetics

- **Onset:** 10 minutes IM/IV
- **Peak:** 1 to 2 hours IM/IV
- **Duration:** 6 hours or longer IM/IV
- **Metabolized** through glucuronidation and oxidation
- **Excretion:** Urine (92%, ~60% as unchanged drug); feces ~6%.

Contraindications

- Hypersensitivity to ketorolac, any component of formulation, ASA or other non-steroidal anti-inflammatory drugs (NSAIDs)
- Active or history of peptic ulcer disease; recent or history of GI bleeding or perforation, inflammatory bowel disease; may increase risk of gastrointestinal irritation, inflammation, ulceration, bleeding, and perforation
- Suspected or confirmed cerebrovascular bleeding; hemorrhagic diathesis, incomplete hemostasis, or patient at high risk of bleeding; inhibits platelet function
- Patients with advanced renal disease or risk of renal failure due to volume depletion

- Severe hepatic impairment or active hepatic disease
- known hyperkalemia
- Prophylaxis before major surgery; perioperative pain in setting of coronary artery bypass graft (CABG) surgery; risk of MI and stroke may be increased with use following CABG surgery. Wound bleeding and postoperative hematomas have been associated with use in perioperative setting
- Labor and delivery; may inhibit uterine contractions and adversely affect fetal circulation
- The FDA has placed a "black box" warning on ketorolac, stating that the drug is contraindicated during breastfeeding because of the potential adverse effects of prostaglandin-inhibiting drugs on neonates.

Cautions

- Elderly, frail, or debilitated patients: are more sensitive to adverse gastrointestinal and renal effects
- Sepsis, impaired renal function, heart failure and liver dysfunction: are more sensitive to adverse renal effects
- Cardiac decompensation, hypertension, or similar conditions; may cause fluid retention and edema

DRUG INTERACTIONS

- **Salicylates**, especially high dose regimes, may double plasma level of ketorolac; reduce dose of ketorolac by half
- Probenecid; decreases elimination of ketorolac, concomitant use is contraindicated by manufacturer
- **Anticoagulants, heparin** (including prophylactic low doses), thrombolytic agents, **aspirin**, **other NSAID's**, **selective serotonin reuptake inhibitors**; increased risk of bleeding
- High dose **methotrexate** (doses used in cancer therapy) may increase methotrexate levels and cause toxicity; monitor methotrexate levels i.e., longer leucovorin rescue may be required
- **Lithium**; may increase lithium plasma concentrations, monitor and adjust lithium dose as required
- **Diuretics** (e.g. furosemide), **ACE inhibitors**, cycloSPORINE; increase risk of renal impairment

PREGNANCY

- Because ketorolac is a prostaglandin synthesis inhibitor, constriction of the ductus arteriosus in utero and fetal renal impairment are potential complications when multiple doses of the drug are administered during the latter half of pregnancy. Premature closure of the ductus can result in primary pulmonary hypertension of the newborn that, in severe cases, may be fatal. Other complications that have been associated with nonsteroidal anti-inflammatory drugs (NSAIDs) are inhibition of labor and prolongation of pregnancy. Women attempting to conceive should not use any prostaglandin synthesis inhibitor, including ketorolac, because of the findings in a variety of animal models indicating that these agents block blastocyst implantation. Moreover, as noted above, NSAIDs have been associated with spontaneous abortions (SABs) and congenital malformations. The risk for these defects, however, appears to be low.
- In a "black box" warning, the FDA stated that ketorolac was contraindicated in labor and delivery because its prostaglandin synthesis inhibitory effect may adversely affect fetal circulation and inhibit uterine contractions.

BREAST FEEDING

- The FDA has placed a "black box" warning on ketorolac, stating that the drug is contraindicated during breastfeeding because of the potential adverse effects of prostaglandin-inhibiting drugs on neonates.

RECOMMENDED MONITORING

- Baseline serum creatinine

Adverse Effects

GASTROINTESTINAL

- Nausea, vomiting
- Gastric mucosal injury, resulting in ulceration and bleeding, dose-dependent; risk may increase with doses over 20 mg

CENTRAL NERVOUS SYSTEM

- Somnolence
- Dizziness
- Headache

- Sweating

HEMATOLOGICAL

- Prolonged bleeding time and decreased platelet aggregation. No significant effect on prothrombin, partial thromboplastin time or platelet count. Inhibition of platelet function is normalized within 24 to 48 hours after drug is discontinued

RENAL

- Dysuria
- Urinary retention
- Oliguria
- Increased urinary frequency
- Acute renal failure

Dosing

*NOTE: Ketorolac is not indicated for minor or chronic painful conditions. Increasing the dose of ketorolac beyond recommendations will not provide better efficacy but will increase the risk of developing serious adverse events.

ADULT/ELDERLY

65 years or less:

- Initial Dose **IM/IV over at least 15 seconds**:
  - 10 mg (if supply is 10 mg/mL), then 10 mg every 4 to 6 hours
  - 15 mg (if supply is 30 mg/mL), then 15 mg every 4 to 6 hours
  - Total daily dose not to exceed 120 mg

Greater than 65 Years/Less than 50 kg:

- Initial Dose **IM/IV over at least 15 seconds**:
  - 10 mg (if supply is 10 mg/mL), then lowest effective dose every 4 to 6 hours as required
  - 15 mg (if supply is 30 mg/mL), then lowest effective dose every 4 to 6 hours as required
  - Total daily dose should not exceed 60 mg

PEDIATRIC (Do not exceed 5 days of total therapy from all routes)

2 to 16 years

- 0.2 to 0.5 mg/kg **IM/IV over 1 to 5 minutes** every 6 to 8 hours as required. Max 10 mg every 6 hours
  NOTE: not recommended for children less than 2 years

RENAL IMPAIRMENT ADJUSTMENTS:

- Less than 20 mL/minute Creatinine clearance – Avoid if possible, use small doses and monitor closely; use is contraindicated by manufacturer

HEPATIC IMPAIRMENT ADJUSTMENTS:

- Severe impairment or active hepatic disease; Use is contraindicated by manufacturer

HEMO/PERITONEAL DIALYSIS:

- Unlikely to be dialysed. Avoid if possible, use small doses and monitor closely

Concentration Supplied:

- 30 mg/mL or 10 mg/mL
- Note: the ketorolac IM product may be given IV

Compatibility/Stability:

- Stable in D5W and NS solutions for at least 24 hours at room temperature
- Compatible with dextrose 5%, NS, dextrose-saline combinations, Ringer's and LR solutions

Provider/Route:

- **EMR**: Not in scope of practice
- **PCP/ICP**: IM, IV
- **ACP**: IM, IV, IO, CVAD, IVAD
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/ketorolac.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/1797828?cesid=70pmMEjGBcI&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dketorolac%26t%3Dname%26acs%3Dtrue%26acq%3Dket
- SaskKids Pediatric Parental Manual
- Pedi STAT
- https://web.p.ebscohost.com/nup/detail/detail?vid=3&sid=b0066272-0c07-47b4-9b58-5b2829d27cfe%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535428&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711623

Development – December 2022
Update – June 2025

EMS Provincial Medications

Lidocaine HIGH ALERT

Classification

- Anti-arrhythmic

Indications

EMS INDICATIONS

- Cardiac arrest, as per ACLS and PALS guidelines
- IO pain management for conscious patients
- Treatment of ventricular arrhythmias from myocardial infarction or cardiac manipulation (e.g. cardiac surgery)
- Treatment of stable VT
- Use as an aid in Endotracheal Intubation

SHA EMS Medical Direction Note:

- antiarrhythmic of choice for overdose in cases other than torsades

HEALTH CANADA APPROVED

- *Treatment of ventricular arrhythmias from myocardial infarction or cardiac manipulation (e.g. cardiac surgery)*

NON HEALTH CANADA APPROVED BUT SUBSTANTIATED IN THE LITERATURE

- *Cardiac arrest, as per ACLS and PALS guidelines*
- *Severe pain syndrome unresponsive, completely or incompletely to standard therapy including adjuvant therapies*
- *Post-operative pain; especially abdominal surgeries*
- *Refractory neonatal seizures*

Mechanism of Action

- Class Ib antiarrhythmic; suppresses automaticity of conduction tissue, by increasing electrical stimulation threshold of ventricle, His-Purkinje system, and spontaneous depolarization of the ventricles during diastole by a direct action on the tissues; blocks both the initiation and conduction of nerve impulses by decreasing the neuronal membrane's permeability to sodium ions, which results in inhibition of depolarization with resultant blockade of conduction

Pharmacokinetics

- **Onset:** 45 to 90 seconds IVP
- **Peak**: Immediate
- **Duration:** 10 to 20 minutes IVP up to several hours after continuous infusion
- **Half-life:** 1.5 to 2 hours IVP
- **Metabolized** 90% in the liver, **excreted** in urine.

Contraindications

- Hypersensitivity to lidocaine, or any component of formulation
- Cross reaction may occur with amide type local anaesthetics (e.g. bupivacaine, prilocaine, mepivacaine). Cross reaction has not been reported with procainamide or quiNIDine
- Adams-Stokes syndrome, Wolff-Parkinson-White syndrome, severe degrees of sinoatrial, atrioventricular or intraventricular block (except in patients with functioning artificial pacemaker)
- Supraventricular arrhythmias or severe myocardial depression
- Uncontrolled seizures

Cautions

- **HIGH ALERT**
- Elderly: may be a decreased clearance or increased half-life and increased risk for CNS and cardiac effects
- Use **cardiac** lidocaine only, i.e. preservative free and lacking EPINEPHrine
- Bradycardia, severe digitalis intoxication, 1st or 2nd degree heart block in the absence of pacemaker, hypokalemia, severe hypoxia or respiratory depression (correct electrolyte disturbances (hypokalemia or hypomagnesemia) and underlying causes of arrhythmias prior to use)
- Conditions which decrease hepatic blood flow may lead to accumulation with continuous infusion e.g. heart failure, severe liver impairment, hypovolemia, shock

PREGNANCY

- No evidence of an association with large categories of major or minor malformations or to individual defects was found.
- Lidocaine and its metabolites cross the placenta and can be detected in the fetal circulation following maternal injection for anesthesia prior to delivery.
- Adverse reactions in the fetus/neonate may affect the CNS, heart, or peripheral vascular tone. Fetal heart monitoring is recommended by the manufacturer.
- Medications used for the treatment of cardiac arrest in pregnancy are the same as in the nonpregnant woman. Doses and indications should follow current Advanced Cardiovascular Life Support guidelines. Appropriate medications should not be withheld due to concerns of fetal teratogenicity.

BREASTFEEDING

- The potential for harm of the infant from exposure to lidocaine in breast milk is probably very low. In 2001, the American Academy of Pediatrics classified lidocaine as compatible with breastfeeding.
- Lidocaine and its metabolites cross the placenta and can be detected in the fetal circulation following maternal injection for anesthesia prior to delivery.
- Adverse reactions in the fetus/neonate may affect the CNS, heart, or peripheral vascular tone. Fetal heart monitoring is recommended by the manufacturer.
- Medications used for the treatment of cardiac arrest in pregnancy are the same as in the nonpregnant woman. Doses and indications should follow current Advanced Cardiovascular Life Support guidelines. Appropriate medications should not be withheld due to concerns of fetal teratogenicity.
- Available guidelines consider lidocaine to be compatible with breastfeeding when used as an antiarrhythmic or local anesthetic.

DRUG INTERACTIONS

- Potential to interact with many drugs

REQUIREMENTS

- Electronic infusion device for maintenance infusion

MONITORING REQUIRED

DIRECT IV AND CONTINUOUS INFUSION

- Continuous ECG monitoring during administration and until stable
- Notify physician if there is a prolongation of PR interval and QRS complex

INTERMITTENT INFUSION

- Baseline BP, HR and CNS toxicity; then every 10 minutes during infusion, then every 15 minutes x 2
- Potential signs of CNS toxicity; ringing in ears, circumoral numbness, metallic taste, nausea, dizziness, sedation

Adverse Effects

LOCAL ANESTHETIC SYSTEMIC TOXICITY (LAST) presents with both central nervous system and cardiovascular symptoms
TOXICITY EARLY SIGNS

- Tinnitus, metallic taste, circumoral numbness, drowsiness, dizziness, confusion, visual disturbances, behavior changes, myoclonus, tremors, irritability

LATE SIGNS

- Restlessness, seizures, cardiac dysrhythmias, cardiac arrest

CARDIOVASCULAR

- Hypotension
- Myocardial depression (prolongation of PR interval and QRS complex)
- Bradycardia
- Heart block
- Ventricular arrhythmias
- Cardiac arrest
- Edema

CENTRAL NERVOUS SYSTEM

- Restlessness
- Nervousness
- Tremors/shivering
- Drowsiness
- Slurred speech
- Unrest/nervousness
- Facial twitching
- Perspiration
- Seizures
- Dizziness
- Blurred vision

GASTROINTESTINAL

- Vomiting

RESPIRATORY

- Dyspnea
- Apnea

MISCELLANEOUS

- Urticaria
- Tinnitus
- Chills

Dosing

ADULT/ELDERLY IO INSERTION PAIN CONTROL

- 0.5 mg/kg **IO** (max 40 mg) over 1 to 2 minutes

PEDIATRIC IO INSERTION PAIN CONTROL

- 0.5 mg/kg **IO** (max 20 mg) over 1 to 2 minutes

ADULT/ELDERLY VF/PULSELESS VT/WIDE QRS

- 1 to 1.5 mg/kg **IV Push repeat** 0.5 to 0.75 mg/kg every 5 to 10 minutes (max 3 mg/kg)

ADULT/ELDERLY VT with a Pulse

- 1 to 1.5 mg/kg **IV Push repeat** 0.5 to 0.75 mg/kg every 5 to 10 minutes until converted or to a max of 3 mg/kg followed by **maintenance dose** if 3 mg/kg has not been reached

PEDIATRIC VF/PULSELESS VT

- 1 mg/kg **IVP** over 2 to 3 minutes (max 3 mg/kg)

ADULT/ELDERLY MAINTENANCE INFUSION

- 1 to 4 mg/minute **IV infusion via pump** (30 to 50 mcg/kg/min)(15 to 60 mL/hr)
  *Reduce maintenance infusion in patients with heart failure or shock; initiate infusion at 10 mcg/kg/minute (Maximum dose: 1.5 mg/minute or 20 mcg/kg/minute)

HEPATIC IMPAIRMENT ADJUSTMENTS

- Reduce maintenance infusion in patients with heart failure or shock; initiate infusion at 10 mcg/kg/minute
- Initial **IV infusion via pump**: 0.75 mg/minute or 10 mcg/kg/minute
- **Maximum** dose: 1.5 mg/minute or 20 mcg/kg/minute

MISCELLANEOUS

- **Endotracheal** use for cardiac arrest: 2 to 4 mg/kg **ETT** (2 to 2.5 times the IV dose) Dilute in NS or SWFI, absorption greater with sterile water and results in less impairment of PaO2. Instill the drug into the ET tube (briefly pause compressions during instillation or the drug will get pushed back up the tube into your face; follow with a minimum of 5 mL NS flush and "Provide 5 rapid positive-pressure breaths after the drug is instilled
- **PEDS:** Endotracheal (ET) route: 2-3 mg/kg/dose ET (0.1 to 0.15 mL/kg/dose)

LIDOCAINE INTUBATION SPRAY

- Spray until vocal cords and surrounding tissues are coated
- Respiratory tract: 50 to 400 mg (maximum dose: 400 mg for procedure less than 1 minute or 600 mg for procedure greater than 5 minutes).
- Trachea, larynx, bronchi: 50 to 200 mg (maximum dose: 200 mg for procedure less than 1 minute or 400 mg for procedure greater than 5 minutes).
- Topical: Local anesthetic for mucous membrane of the oropharynx; lubricant for intubation;
- Oral topical endotracheal solution, metered-dose spray (10 mg/actuation) [Canadian product]: Attach nozzle and prime pump 5 to 10 times prior to first use; prime ~2 times (to remove air) when switching to a new nozzle. Product should be in upright position while spraying. Do not modify manufacturer supplied nozzle. Discard nozzle after use (do not reuse). Do not use on cuffs or endotracheal tubes made of plastic (may damage cuff).
- Topical oral solution/viscous: When used in mouth or throat, topical anesthesia may impair swallowing and increase aspiration risk. Avoid food for ≥60 minutes following oral or throat application. This is especially important in the pediatric population. Numbness may increase the danger of tongue/buccal biting trauma; ingesting food or chewing gum should be avoided while mouth or throat is anesthetized. Excessive doses or frequent application may result in high plasma levels and serious adverse effects; strictly adhere to dosing instructions. Use measuring devices to measure the correct volume, if applicable, to ensure accuracy of dose.

- Onset Topical: 3 to 5 minutes
- Dose varies with area of application (be sure to add amount used into the total drug maximum)

Concentration Supplied:

- **IV** 20 mg/mL (5 mL Preload)
- **IV infusion:** 1000 mg in 250 mL (concentration: 4 mg/mL)
- **Spray (non aerosol topical anesthetic)** 12 mg/dose (equivalent up to 10 mg) (250 metered doses/30 mL)

COMPATIBILITY/STABILITY

- Stable in 5% Dextrose (preferred) or 0.9% Sodium Chloride in concentration from 1 to 8 mg/mL for at least 24 hours at room temperature and in refrigerator
- Compatible with dextrose, saline, dextrose-saline combinations, and Lactated Ringer's solutions
- Lidocaine, DOBUTamine, DOPamine, nitroGLYCERIN and nitroPRUSSIDE prepared in D5W or NS, are compatible by Y-site in all possible combinations

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IV, IO, Spray, Infusion, ET
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/lidocaine.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/1797832?cesid=avspZeRibhs&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dlidocaine%26t%3Dname%26acs%3Dtrue%26acq%3Dlid
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711650
- ACLS EP 2017
- ACLS 2020
- PALS 2020

Development – May 2023
Update – June 2025

EMS Provincial Medications

LORazepam/Ativan HIGH ALERT

Classification

- Benzodiazepine

Indications

EMS INDICATIONS

- To produce sedation, anterograde amnesia and relief of anxiety
- Treatment of acute alcohol withdrawal in **Frail Elderly** and **Diagnosed with Severe Liver Disease**

EMS Medical Direction Note:

- SL/PO preferred use
- **ACP only** for Alcohol Withdrawal

HEALTH CANADA APPROVED

- *To produce sedation, anterograde amnesia and relief of anxiety*
- *Management of status epilepticus*

NON HEALTH CANADA APPROVED INDICATION BUT SUSTANTIATED IN LITERATURE

- *Treatment of acute alcohol withdrawal*

Mechanism of Action

- Short-to-intermediate-acting benzodiazepine (based on half-life) (Griffin 2013). Binds to stereospecific benzodiazepine receptors on the postsynaptic GABA neuron at several sites within the central nervous system, including the limbic system, reticular formation. Enhancement of the inhibitory effect of GABA on neuronal excitability results by increased neuronal membrane permeability to chloride ions. This shift in chloride ions results in hyperpolarization (a less excitable state) and stabilization. Benzodiazepine receptors and effects appear to be linked to the GABA-A receptors. Benzodiazepines do not bind to GABA-B receptors.

Pharmacokinetics

- **Onset:** 15 to 60 minutes PO; sedative effects 20 to 30 minutes PO
- **Peak:** 1 hour SL; 2 hours PO
- **Duration:** 8 to 12 hours PO
- **Metabolism:** Hepatic; rapidly conjugated to lorazepam glucuronide (inactive).
- **Half-life:** approx. 12 hours
- **Excretion:** Urine (88%; predominantly as inactive metabolites); feces (7%)

Contraindications

- Hypersensitivity to LORazepam, other benzodiazepines (cross-sensitivity with other benzodiazepines may exist), or any component of formulation; untreated acute narrow-angle glaucoma
- Applies to parenteral admin: Hypersensitivity to polyethylene glycol, propylene glycol, or benzyl alcohol; sleep apnea; intra-arterial injection; use in premature infants; severe respiratory insufficiency (except during mechanical ventilation)
- Myasthenia gravis: listed as a contraindication by Canadian manufacturer

Cautions

- **HIGH ALERT for IV administration only**
- Elderly: more sensitive to therapeutic and adverse effects (e.g. ataxia, dizziness, over sedation)
- Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death
- Reduce dose or avoid use in patients receiving opioids or with significant chronic disease (e.g. respiratory compromise, COPD, sleep apnea syndrome, and the very young). Avoid use in patients with a history of substance use, misuse of medications, or depression, except for acute or emergency situations (e.g. acute agitation, status epilepticus)

DRUG INTERACTIONS

- Additive CNS effects with phenothiazines, narcotic analgesics, barbiturates, alcohol, antidepressants, scopolamine, and MAO inhibitors

IV ADMIN MONITORING REQUIRED

- Baseline RR, BP and HR, then at 5 and 15 minutes post dose
- CONTINUOUS INFUSION: Baseline RR, BP and HR, with start of infusion and with any rate increase; then every 15 minutes until stable, then every 1 hour

SC/IM ADMIN MONITORING REQUIRED

- Equipment and personnel necessary for resuscitation and ventilation must be readily available
- RR, BP, HR at baseline, start of treatment, every 15 minutes until stable, then hourly or as directed

IV ADMIN MONITORING RECOMMENDED

- Advise patients to report burning/stinging/pain at IV site promptly
- Assess level of consciousness as required

PREGNANCY

- The long-term effects of in utero exposure on neurobehaviour, especially when the exposure occurs in the latter half of pregnancy, have not been studied but are of concern.

BREASTFEEDING

- Breastfeeding during benzodiazepine therapy is not recommended due to the potential for drowsiness in the breastfeeding infant.
- In 2001, the American Academy of Pediatrics classified the effects of lorazepam on the nursing infant as unknown but may be of concern if exposure is prolonged. The most common adverse reactions observed in adults are sedation, dizziness, weakness, and unsteadiness. If a woman is receiving this drug while breastfeeding, her nursing infant should be monitored for these effects.

Adverse Effects

***higher risk and increased incidence of adverse reaction with parenteral admin and higher dosing**

CENTRAL NERVOUS SYSTEM

- Drowsiness and excessive sedation, especially in patients over 50 years. Can be rapidly reversed by flumazenil IV if treatment required
- Vertigo
- Weakness
- Unsteadiness

- Confusion
- Hallucinations
- Diplopia

CARDIOVASCULAR

- Hypotension

RESPIRATORY

- Respiratory depression and partial airway obstruction; failure and apnea

MISCELLANOUS

- Parenteral admin: Pain at injection site and erythema, anterograde amnesia, neurodevelopmental effects in children, paradoxical reactions, propylene glycol toxicity, withdrawal syndrome

Dosing

ADULT/ELDERLY/GREATER THAN 12 YEARS

- LESS THAN 50 kg: 1 mg **SL/PO** repeat every 4 to 6 hours as needed up to 10 mg/day; adjust dose based on response tolerability.
- GREATER THAN 50 kg: 1 to 2 mg **SL/PO** repeat every 4 to 6 hours as needed up to 10 mg/day; adjust dose based on response tolerability.

ALCOHOL WITHDRAWAL in Frail Elderly and Diagnosed Severe Liver Disease **(ACP ONLY)**

- BAWS Score of 3 to 7: 2 mg SL/PO every 1 hour PRN
- BAWS Score of 8 or greater: 2 mg SL/PO every 30 minutes PRN
  *Discontinue when 2 consecutive BAWS scores are less than 3

*Brief Alcohol Withdrawal Scale (BAWS): https://www.saskhealthauthority.ca/system/files/2023-09/SHA-0327-Alcohol-Withdrawal-Assessment-Flowsheet.pdf

****Note: Diazepam is preferred benzodiazepine due to quicker onset of action and longer half-life. LORazepam is preferred for frail patients and those with severe liver disease (prolonged sedation can be harmful in hepatic encephalopathy).**

Concentration Supplied:

- 1 mg SL/PO dissolving tab

*Oral tablet: May be administered sublingually

**Sublingual tablet: Place under tongue; patient should not swallow for at least 2 minutes.

RECONSTITUTION IV

- None required. Contains polyethylene glycol, propylene glycol and benzyl alcohol

COMPATIBILITY/STABILITY IV

- Refrigerate and protect vial from light. Do not use if discoloured or contains a precipitate
- Compatible with NS, D5W and SWFI

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP:** Not in scope of practice
- **ICP:** SL with Med Control (not to administer for alcohol withdrawal)
- **ACP:** SL, PO, IM, Subcut, IV, IO, CVL
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/LORazepam.pdf

- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7195?cesid=1Pd7dYit7KJ&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DLORazepam%26t%3Dname%26acs%3Dtrue%26acq%3Dlor
- https://web.s.ebscohost.com/nup/detail/detail?vid=6&sid=375b2d26-920e-4610-bd42-15550e019a1a%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535566&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711669
- https://www.saskhealthauthority.ca/system/files/2023-08/CS-OS-9903-ED-AWS-Adults.pdf
- https://www.saskhealthauthority.ca/system/files/2023-09/SHA-0327-Alcohol-Withdrawal-Assessment-Flowsheet.pdf

Development – May 2023
Update – June 2025

EMS Provincial Medications

Magnesium Sulfate

Classification

- Electrolyte, Anticonvulsant, Smooth muscle relaxant

Indications

EMS INDICATIONS

- Treatment of hypomagnesemia
- As a CNS depressant, primarily in preeclampsia and eclampsia of pregnancy
- Torsades de pointes or VF/pulseless VT associated with torsades de pointes
- Adjunctive therapy for moderate to severe reactive airway disease exacerbation

HEALTH CANADA APPROVED

- *Treatment of hypomagnesemia*
- *As a CNS depressant, primarily in preeclampsia and eclampsia of pregnancy*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN THE LITERATURE

- *Torsades de pointes or VF/pulseless VT associated with torsades de pointes*
- *Adjunctive therapy for moderate to severe reactive airway disease exacerbation in pediatrics*
- *Fetal neuroprotection of the preterm infant*

Mechanism of Action

- Decreases acetylcholine in motor nerve terminals and acts on myocardium by slowing rate of S-A node impulse formation and prolonging conduction time. Magnesium is necessary for the movement of calcium, sodium, and potassium in and out of cells, as well as stabilizing excitable membranes.
- Intravenous magnesium may improve pulmonary function in patients with asthma; causes relaxation of bronchial smooth muscle independent of serum magnesium concentration.

Pharmacokinetics

- **Onset:** Immediate
- **Peak**: unknown
- **Duration:** 30 minutes
- **Metabolized** 90% in the liver, **excreted** in urine.

Contraindications

- Hypersensitivity to magnesium sulfate or any component of formulation
- Heart block, myocardial damage

Cautions

- Elderly or patients with renal impairment: excreted renally
- Neuromuscular disease: use with extreme caution those with myasthenia gravis or other neuromuscular disease
- Magnesium toxicity is exacerbated by hypocalcemia
- **Ordering of dosage and labelling of vials may be in grams, milliequivalents or millimoles. Check carefully**

DRUG INTERACTIONS

- Non-depolarising muscle relaxants - potentiation of relaxant effect
- Gentamicin - respiratory arrest in unventilated newborn exposed to magnesium sulfate immediately before birth

PREGNANCY/BREASTFEEDING

- Contact pharmacy or specialised on-line references for most recent information

REQUIREMENTS

- Electronic infusion device

MONITORING REQUIRED

DIRECT IV

- HR and ECG monitoring as per ACLS protocol

INFUSIONS: WHEN INFUSION RATES ARE GREATER THAN 2 GRAMS PER HOUR

- Baseline: BP, HR, RR, bilateral deep tendon reflexes (optional when used for control of tetany spasms), and level of consciousness
- Respirations every 1 hour
- Bilateral deep tendon reflexes every 1 hour or continuous BP and ECG monitoring when used for control of tetany spasms
- Fluid balance every 1 to 4 hours or as ordered by physician
  - **Adults:** notify physician if RR less than 12 per minute, or if urine output less than 120 mL in 4 hours
  - **Pediatrics:** notify physician if RR decreases by 20% of baseline or urine output less than 2 mL/kg/hour, monitor serum urinary magnesium levels, other electrolytes (calcium, potassium, phosphorus) and renal function periodically

OBSTETRICS

- Baseline: BP, HR, RR, bilateral deep tendon reflexes, and level of consciousness; and fetal heart rate
- BP and HR every 15 minutes for a minimum of 4 hours until stabilized, then every 30 minutes
- Continuous pulse oximetry – notify physician if O2 saturation is less than 95%
- Respirations and urine output every 1 hour - notify physician if RR less than 12 per minute, or if urine output less than 120 mL in 4 hours
- Bilateral deep tendon reflexes and level of consciousness
- Continuously monitor fetal heart rate

PEDIATRICS

- HR and rhythm, BP, RR at baseline and every 15 minutes times two
- Monitor urinary out-put
- Notify physician if RR decreases by 20% or if urine output is less than 2 mL/kg/hr
- Serum magnesium post dose
- Calcium, potassium, phosphorus and renal function periodically

MONTORING RECOMMENDED

- Baseline Ca and Mg serum levels: repeat levels as indicated by clinical condition

Adverse Effects

*Related to serum level: Important adverse effects may occur within therapeutic range

SERUM LEVEL approximately 2 to 3 mmol/L:

- Lethargy
- Drowsiness
- Flushing
- Nausea/vomiting
- Diminished deep tendon reflex

SERUM LEVEL approximately 3 to 5 mmol/L:

- Somnolence
- Loss of deep tendon reflexes
- Hypotension
- Bradycardia
- Prolonged PR interval
- Prolonged QRS interval

SERUM LEVEL approximately GREATER THAN 5 mmol/L:

- Respiratory paralysis
- Paralysis
- Refractory hypotension
- AV block
- Cardiac arrest
- Coma
- Death
- Respiratory support, followed by intravenous calcium, is given in magnesium overdose

Dosing

*When IV magnesium is given, an abrupt but temporary elevation in plasma magnesium concentration will partially inhibit stimulus to magnesium reabsorption
*Up to 50% of infused magnesium will be excreted in urine
*Magnesium uptake by cells is slow and so adequate repletion requires sustained correction of hypomagnesemia

ADULT/ELDERLY

ECLAMPSIA

- 4 g in 100 mL NS **infused IV via pump** over 20 minutes

SEVERE BRONCHOCONSTRICTION OR BRONCHOSPASM

- 2 g in 50 mL NS **infused IV via pump** over 20 to 30 minutes

CARDIAC ARREST (DUE TO HYPOMAGNESEMIA OR TORSADES DE POINTES)

- 2 g **IVP** diluted in 10 mL NS

CARDIAC ARREST REFRACTORY VFIB/VT (SUSPECTED TORSADES DE POINTES)

- 2 g **IVP** diluted in 10 mL NS (After max Amio/Lido has been given)

PERFUSING POLYMORPHIC VT (TORSADES DE POINTES ***NOT*** in Cardiac Arrest**)**

- 2 g in 50 mL NS **infused IV via pump** over 15 minutes

PEDIATRIC

SEVERE BRONCHOCONSTRICTION OR BRONCHOSPASM

- 50 mg/kg (max 2 g) in 50 mL NS **infused IV via pump** over 20 minutes

RESUSCITATION (PULSELESS TORSADES)

- 50 mg/kg IV
- Maximum dose 2 g/dose

RENAL IMPAIRMENT ADJUSTMENTS

- Hypomagnesemia: reduce dose by 50%. Use with caution; monitor for hypermagnesemia
- Preeclampsia/eclampsia: severe renal impairment: Per the manufacturer, do not exceed 20 grams during a 48 hour period

Concentration Supplied:

- 20% 200 mg/mL (10 mL vial)

Compatibility/Stability:

- Stable in dextrose, saline and LR solutions for 24 hours, at room temperature
- Stable in potassium containing fluids (with dextrose/saline solution) for 24 hours

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IV, IO, CVAD, IVAD
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/magnesium%20sulfate.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7216?cesid=1RBLtoHYuEY&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dmagnesium%2Bsulfate%26t%3Dname%26acs%3Dtrue%26acq%3Dmag
- https://web.s.ebscohost.com/nup/detail/detail?vid=8&sid=375b2d26-920e-4610-bd42-15550e019a1a%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009958737&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711679
- ACLS 2020
- ACLS EP 2017
- PALS 2020

Development – May 2023
Update – June 2025

EMS Provincial Medications

MethylPREDNISolone/Solu-MEDROL

Classification

- Glucocorticoid - anti-inflammatory

Indications

EMS INDICATIONS

- Adjunctive treatment for anaphylaxis, bronchospasm secondary to asthma, COPD, croup in adults.

HEALTH CANADA APPROVED

- *Treatment of a wide variety of diseases and conditions principally for its effects as an anti-inflammatory and immunosuppressant agent and for its effects on blood and lymphatic systems in the palliative treatment of various disease*

Mechanism of Action

- Corticosteroids exert a wide array of physiologic effects including modulation of carbohydrate, protein, and lipid metabolism and maintenance of fluid and electrolyte homeostasis. Moreover cardiovascular, immunologic, musculoskeletal, endocrine, and neurologic physiology are influenced by corticosteroids. Decreases inflammation by suppression of migration of polymorphonuclear leukocytes and reversal of increased capillary permeability.

Pharmacokinetics

- **Onset:** Rapid
- **Peak:** 48 minutes
- **Duration:** Unknown
- **Metabolism:** Hepatic to metabolites
- **Excretion:** Urine (1.3% [oral], 9.2% [IV succinate] as unchanged drug)

Contraindications

- Hypersensitivity to methylPREDNISolone or any component of the formulation, or any other corticosteroid. Cross hypersensitivity may occur
- Inactive and active tuberculosis, herpes simplex keratitis, vaccinia, varicella, systemic fungal infections
- Acute psychoses
- Cushing's syndrome

Cautions

- Avoid rapid infusion of large doses (i.e. greater than 500 mg over less than 10 minutes), as cardiac arrhythmias, circulatory collapse and cardiac arrest have been reported
- In patients with diabetes, osteoporosis, renal insufficiency, chronic psychosis, diverticulitis, peptic ulcer, hypertension
- May affect growth velocity in the pediatric population

DRUG INTERACTIONS

- Rifampin, **phenobarbital and phenytoin** - increase methylPREDNISolone metabolism
- Antifungals, **grapefruit** and protease inhibitors – decrease methylPREDNISolone metabolism
- May increase toxic effects of live vaccines and diminish the effects of all vaccines

PREGNANCY

- Corticosteroids may be used as needed for disease flares in pregnant patients with inflammatory bowel disease; however, maintenance therapy should be avoided. Risk with chronic high dose usage.

BREASTFEEDING

- Corticosteroids are generally considered acceptable in patients who are breastfeeding when used in usual doses; however, monitoring of the breastfeeding infant is recommended.
- Consult pharmacy or specialised on-line references for most recent information
- If there is concern about exposure to the infant, waiting 2 to 4 hours after administration of methylprednisolone IV decreases exposure via breast milk

REQUIREMENTS

- Electronic IV Infusion Device

MONITORING RECOMMENDED

- Baseline serum potassium for doses of 1 gram or greater

Adverse Effects

Occur with use of high doses for prolonged periods
Less likely to occur with short term use

CARDIOVASCULAR

- Hypotension
- Hypertension
- Bradycardia
- Cardiac arrest
- Arrhythmias

GASTROINTESTINAL

- Peptic ulcer
- Nausea/vomiting
- Altered taste

HEMATOLOGIC

- Sodium and fluid retention
- Potassium loss
- Diuresis
- Carbohydrate intolerance
- Manifestations of latent diabetes mellitus
- Increased requirements for insulin or oral hypoglycemics

RESPIRATORY

- Bronchospasm
- Anaphylaxis

MISCELLANEOUS

- Impaired wound healing
- Petechiae
- Ecchymosis

Dosing

DOSE

Adult/Elderly:

- 1 mg/kg (max 125 mg) in 50 mL NS **infused IV via pump** over 20 minutes
    - Can also be administered direct **IV push** over at least 2 to 3 minutes

Peds:

- 1 mg/kg/dose every 6 hours (Maximum: 60 mg/24 hours) x 48 hours or less

RENAL IMPAIRMENT ADJUSTMENTS

- No change required. May aggravate azotemia, sodium and fluid retention, glucose intolerance and hypertension

HEMO/PERITONEAL DIALYSIS

- Hemodialysis: administer dose post hemodialysis

MISCELLANEOUS

- Can be given IM
- If used for only brief periods (a few days) in emergency situations, may reduce and discontinue dosage quite rapidly

Concentration Supplied:

- 125 mg vial (see vial/package insert for reconstitution instructions)

Reconstitution:

- Type and volume of diluent required may vary with brand. See vial/package insert for reconstitution instructions
- If using Act-O-Vial, use supplied diluent

Compatibility/Stability:

- Stable in D5W, NS or D5-1/2 NS at concentrations of 0.25 mg/mL or greater for at least 24 hours at room temperature
- Compatible with D5NS and Lactated Ringer's solutions
- Compatibility and stability of methylPREDNISolone in solutions and with other drugs in intravenous admixtures is dependent on admixture pH, concentration, time, temperature, and the ability of methylPREDNISolone to solubilise itself Whenever possible it is recommended that methylPREDNISolone be administered separate from other drugs

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IM, IV, IO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/methylPREDNISolone.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7282?cesid=4DkCyNGBL1T&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3DmethylPREDNISolone%26t%3Dname%26acs%3Dtrue%26acq%3Dmeth

- https://web.s.ebscohost.com/nup/detail/detail?vid=3&sid=47472737-1695-40a9-9225-50e67c7719ff%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009565363&db=nup
- ACLS 2020
- ACLS EP 2017
- PALS 2020

Development – May 2023
Update – June 2025

EMS Provincial Medications

Midazolam/Versed HIGH ALERT

Classification

- Benzodiazepine/Sedative

Indications

EMS INDICATIONS

- For sedation/amnesia prior to and during direct current cardioversion
- Induction and maintenance of anesthesia; sedation in MFI
- Seizure control
- Pain control refractory to analgesic
- Moderate to severe agitation/anxiety

SHA EMS Medical Direction Note:

- Frail elderly max of 5 mg
- Midazolam is the preferred benzodiazepine for seizures

*EMS INDICATIONS FOR **PALLIATIVE** USE UPON COMPLETING PALLIATIVE TRAINING*

- *For Restlessness in the **Palliative patient** only when Haloperidol is not effective as the first line treatment. If the palliative patient is violent and a danger to themselves or others, use midazolam first then follow with Haloperidol once under control and if delirium persists.*
- *For Muscle Relaxant in the **Palliative patient***

HEALTH CANADA APPROVED

- *For sedation/anxiolysis/amnesia prior to and during short endoscopic or diagnostic procedures and direct current cardioversion*
- *Induction and maintenance of anesthesia; sedation in intensive care*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN THE LITERATURE

- *Refractory status epilepticus, agitation, intoxication, palliative and end-of-life care*

Mechanism of Action

- Binds to stereospecific benzodiazepine receptors on the postsynaptic GABA neuron at several sites within the central nervous system. Enhancement of the inhibitory effect of GABA on neuronal excitability results by increased neuronal membrane permeability to chloride ions. This shift in chloride ions results in hyperpolarization (a less excitable state) and stabilization
- Benzodiazepine receptors and effects appear to be linked to the GABA-A receptors. Benzodiazepines do not bind to GABA-B receptors

Pharmacokinetics

- **Onset:** 1 to 5 minutes IV, 15 minutes IM, 5 minutes IN
- **Peak:** Rapid IV 3 to 5 minutes, 30 to 60 minutes IM, 10 minutes IN

- **Duration:** 7 to 75 minutes IV, 20 to 120 minutes IM, 20 to 60 minutes IN
- **Metabolism:** Extensively hepatic via CYP3A4; 60% to 70% of biotransformed midazolam is the active metabolite 1-hydroxy-midazolam (or alpha-hydroxymidazolam)
- **Excretion:** Urine (primarily as glucuronide conjugates of the hydroxylated metabolites); IV, IM: Urine (primarily as metabolites)

Contraindications

- Hypersensitivity to midazolam, any component of the formulation or other benzodiazepines
- Acute pulmonary insufficiency or severe COPD, acute narrow angle glaucoma
- Outside of ICU setting: shock, coma, myasthenia gravis, acute alcoholic intoxication or severe depression of vital signs

Cautions

- **HIGH ALERT**
- Elderly, obese or debilitated patient, those with COPD, an impaired gag reflex, heart failure, renal failure or severe alcoholic cirrhosis: decreased dose required
- Neonates: avoid rapid IV injection: severe hypotension and seizures have been reported; risk may be increased with concomitant fentaNYL use

DRUG INTERACTIONS

- CNS depressants including narcotics, barbiturates and alcohol; may enhance hypnotic effect and increase risk of apnea
- Is a substrate of cytochrome P450 3A4 (major); Interacts with many drugs - contact pharmacy for more information. Review drug profile at time of initiation and with any change in medication regimen

PREGNANCY

- Contact pharmacy or specialized online references for most recent information
- No reports have been located that describe the use of midazolam in humans during the 1st or 2nd trimesters. Use immediately near birth has resulted in adverse neonatal neurobehavior. Based on animal data, a warning was issued by the FDA in 2016 about concerns with fetal/child brain development after repeated or lengthy use of general anesthetic and sedation medications during the 3rd trimester and children under 3 years of age
- In utero exposure to benzodiazepines has the potential to cause harm to the fetus. Teratogenic effects have been observed in some studies; however, a clear association has not been reported and additional data are needed. Exposure to a benzodiazepine late in pregnancy may cause neonatal sedation (hypotonia, lethargy, respiratory depression) and/or symptoms of neonatal withdrawal (feeding difficulties, hyperreflexia, inconsolable crying, irritability, restlessness, tremors). Data related to long-term effects on neurodevelopment are inconclusive. Newborns exposed to midazolam in utero should be monitored for feeding problems, respiratory depression, sedation, and withdrawal.

BREASTFEEDING

- In 2001, the American Academy of Pediatrics classified midazolam as a drug for which the effect on a nursing infant is unknown but may be of concern if exposure is prolonged.
- Breastfeeding during benzodiazepine therapy is not recommended due to the potential for drowsiness in the breastfeeding infant. According to the manufacturer, the decision to breastfeed during therapy should consider the risk of infant exposure, the benefits of breastfeeding to the infant, and the benefits of treatment to the mother. Infants exposed to oxazepam via breast milk should be monitored for feeding problems, respiratory depression, and poor weight gain.

MONITORING REQUIRED

DIRECT IV

- Baseline BP, HR and RR and O2. Repeat every 5 minutes x 3 and until stable, then every 15 minutes x 3

CONTINUOUS INFUSION

- Electronic Infusion Device
- Continuous O2 sat and continuous BP or non-invasive BP monitoring every 5 minutes

- HR and RR every 15 minutes until stable, then every 1 hour

PROCEDURAL SEDATION

- Baseline BP, HR, RR, O2 sat and sedation rating, then every 5 to 15 minutes until procedure is complete and every 15 minutes until level 1 on the conscious sedation rating scale

*ANTIDOTE

- Effects can be reversed by flumazenil

SUBCUT/IM ADMIN MONITORING REQUIRED

- Monitor for respiratory depression and hypotension
- Administer IM injection deep in the mid-outer thigh (vastus lateralis muscle) undiluted

Adverse Effects

CARDIOVASCULAR

- Decreased/increased mean arterial pressure
- Increased/decreased pulse rate
- Hypotension
- Anterograde amnesia

CENTRAL NERVOUS SYSTEM

- Headache
- Drowsiness
- Excessive sedation
- Dizziness
- Involuntary movements
- Paradoxical reactions in children (e.g., agitation, restlessness, combativeness); adolescent/pediatric patients, older adults, patients with a history of alcohol use disorder, psychiatric/personality disorders

GASTROINTESTINAL

- Nausea/vomiting

RESPIRATORY

- Decreased respiratory rate/tachypnea
- Apnea
- Respiratory depression
- Airway obstruction
- Respiratory arrest
- Hypoxia
- Desaturation

Dosing

*Dose must be individualized. Use smaller doses in elderly patients or those pre-medicated with narcotics or other CNS depressants

**Note: If IV access is not available, consider IM administration; however, effect will be delayed (~10 minutes or greater)

ADULT

SEIZURE

- 10 mg **IM**
- 2.5 mg **IV** every 2 minutes max 10 mg
- 10 mg **IN** (5 mg/mL in each nare)

MODERATE AGITATION/ANXIETY

- 2.5 to 5 mg **IM** every 5 to 10 minutes; 2.5 to 5 mg **IV** every 3 to 5 minutes (max 20 mg)

SEVERELY AGITATED (14 to 60 YEARS)

- 2 to 10 mg **IM** every 10 minutes; 2.5 to 5 mg **IV** every 3 to 5 minutes (max 20 mg)

PAIN:

- 0.05 mg/kg **IV** every 10 minutes PRN

CARDIOVERSION

- 2 to 5 mg **IV** repeat at 1 mg to max 5 mg

ELDERLY

- Same dosing as adult but **Frail Elderly** to a **max of 5 mg**

PEDIATRIC

SEIZURE

- 0.2 mg/kg **IM**; 0.1 mg/kg **IV**; 0.2 mg/kg **IN** every 10 minutes (max 10 mg)

Palliative Patient

Restlessness (adult)

- *5 mg **SQ** every 30 minutes PRN (if haloperidol is not adequate or patient is violent or a danger to themselves or others) ***should not be used as first line treatment in delirium or restlessness as benzodiazepines can worsen the delirium state.***

Seizures (adult)

- *5 mg **SQ** every 5 minutes until seizure is controlled.*

RENAL IMPAIRMENT ADJUSTMENTS

- Bolus dosing: use sparingly and titrate according to response
- Continuous infusion: may experience prolonged sedation sometimes for days after discontinuation. No dosing guidelines available at this time

HEPATIC IMPAIRMENT ADJUSTMENTS

- Single dose (e.g. induction): No dosage adjustment recommended; may be more sensitive to effects; anticipate longer duration of action
- Multiple dosing or continuous infusion: Expect longer duration of action and accumulation; based on patient response, dosage reduction likely to be necessary

Concentration Supplied:

- 5 mg/mL (2 mL vial)

Compatibility/Stability:

- Stable in D5W and NS for 24 hours at room temperature
- Conflicting information regarding compatibility with LR solution

MISCELLANEOUS

- Intranasal administration has been used; due to low pH burning upon administration is likely
- Administer injection solution intra nasally using mucosal atomization device (MAD).
- Give 0.1 mL overfill to accommodate MAD dead-space volume.
- Max volume: 1 mL/nostril (children/adults), 0.5 mL/nostril (infants). Larger volumes to be divided between both nostrils.

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP:** Not is scope of practice
- **ICP:** IM, IV, IN for seizure; **MED CONTROL** for agitation/anxiety
- **ACP:** IM, IV, IO, IN, Subcut-palliative
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary

- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/midazolam.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7296?cesid=2iVc91wl7st&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dmidazolam%26t%3Dname%26acs%3Dtrue%26acq%3Dmidaz
- https://web.p.ebscohost.com/nup/detail/detail?vid=3&sid=b24815b0-0f6e-4894-a107-a7005ff433bf%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535711&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711732
- *Palliative Program (2021)*

Development – May 2023
Update – June 2025

EMS Provincial Medications

Morphine HIGH ALERT

Classification

- Opiate Agonist/Narcotic Analgesic

Indications

EMS INDICATIONS

- Severe acute or chronic pain.
- Indicated exclusively for symptomatic relief of moderate to severe pain

*EMS INDICATIONS FOR **PALLIATIVE** USE UPON COMPLETING PALLIATIVE TRAINING*

- ***Palliative patients** for pain management and breathlessness with palliative training*

HEALTH CANADA APPROVED

- *Severe acute or chronic pain.*
- *Indicated exclusively for symptomatic relief of moderate to severe pain*

Mechanism of Action

- Binds to opioid receptors in the CNS, causing inhibition of ascending pain pathways, altering the perception of and response to pain; produces generalized CNS depression

Pharmacokinetics

- **Onset:** Rapid IV**,** 10 to 30 minutes IM, 20 minutes SQ
- **Peak:** 20 minutes IV, 30 to 60 minutes IM, 50 to 90 minutes SQ
- **Duration:** 4 to 5 hours IV/IM/SQ (Patient dependent)
- **Metabolism and Excretion:** Mostly metabolized by the liver. Active metabolites excreted renally.

Contraindications

- Hypersensitivity to morphine (rare), or any component of formulation (may contain sulfite preservatives) Cross reaction may occur with codeine, oxyCODONE, HYDROmorphone, oxyMORphone

Cautions

- **HIGH ALERT**
- Elderly: May be more sensitive to adverse effects, including life-threatening respiratory depression. Decrease initial dose. In setting of chronic pain, monitor closely due to an increased potential for risks, including certain risks such as falls/fracture, cognitive impairment, and constipation. Clearance may also be reduced in older

adults (with or without renal impairment) resulting in a narrow therapeutic window and increasing risk for respiratory depression or overdose

- Cachectic or debilitated patients: Is a greater potential for critical respiratory depression, even at therapeutic dosages
- Respiratory disease: Monitor for respiratory depression in patients with significant chronic obstructive pulmonary disease or cor pulmonale and patients having a substantially decreased respiratory reserve, hypoxia, hypercarbia, or preexisting respiratory depression, particularly when initiating therapy and titrating therapy; critical respiratory depression may occur, even at therapeutic dosages
- Sleep-disordered breathing: Use with caution for chronic pain and titrate dosage cautiously in patients with risk factors for sleep-disordered breathing, including HF and obesity
- Hypovolemia, cardiovascular disease (including acute MI), circulatory shock: Potential vasodilation + hypotension
- Head trauma, intracranial lesions, or elevated intracranial pressure: Respiratory depressant effects (with CO2 retention and secondary elevation of CSF pressure) may be markedly exaggerated
- CNS depression/coma: Are susceptible to intracranial effects of CO2 retention
- Abdominal conditions: May obscure diagnosis or clinical course
- Adrenocortical insufficiency: including Addison disease. Long-term opioid use may cause secondary hypogonadism
- Biliary tract dysfunction or acute pancreatitis: May cause constriction of sphincter of Oddi
- Delirium tremens, hepatic or renal impairment, obesity, prostatic hyperplasia/urinary stricture, psychosis, thyroid dysfunction. Seizure disorders: May cause or exacerbate pre-existing seizures
- Patients on opioids for chronic pain, with opioid use disorder or on opioid agonist therapy – may require consultation to specialist (e.g. anesthesiology, addictions medicine)

DRUG INTERACTIONS

- Benzodiazepines or other CNS depressants (alcohol): May result in profound sedation, respiratory depression, coma, and death
- Other potentially significant interactions may exist, requiring dose or frequency adjustment, additional monitoring, and/or selection of alternative therapy. Consult drug interactions database for more detailed information

PREGNANCYBREASTFEEDING

- Consult pharmacy or specialised on-line references for most recent information
- According to some studies, maternal use of opioids may be associated with birth defects (including neural tube defects, congenital heart defects, and gastroschisis), poor fetal growth, stillbirth, and preterm delivery. Opioids used as part of obstetric analgesia/anesthesia during labor and delivery may temporarily affect the fetal heart rate.
- The National Birth Defects Prevention Study discussed below found evidence that opioid use during organogenesis is associated with a low absolute risk of congenital birth defects. Similar to other opioid analgesics, the use of morphine late in pregnancy has the potential to cause respiratory depression and withdrawal in the newborn.
- **[US Boxed Warning]: Prolonged use of morphine during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.** If chronic opioid exposure occurs in pregnancy, adverse events in the newborn (including withdrawal) may occur. Symptoms of neonatal abstinence syndrome (NAS) following opioid exposure may be autonomic (e.g. fever, temperature instability), gastrointestinal (e.g. diarrhea, vomiting, poor feeding/weight gain), or neurologic (e.g. high-pitched crying, hyperactivity, increased muscle tone, increased wakefulness/abnormal sleep pattern, irritability, sneezing, seizure, tremor, yawning). Mothers who are physically dependent on opioids may give birth to infants who are also physically dependent. Opioids may cause respiratory depression and psycho-physiologic effects in the neonate; newborns of mothers receiving opioids during labor should be monitored.

- Morphine injection is commonly used for the treatment of pain during labor and immediately postpartum. Not all dosage forms are appropriate for this use. Agents other than morphine are used to treat chronic non-cancer pain in pregnant women or those who may become pregnant.

BREASTFEEDING

- In 2001, the American Academy of Pediatrics classified morphine as compatible with breastfeeding. However, the long-term effects on neurobehavior and development are unknown.
- Nonopioid analgesics are preferred for breastfeeding females who require pain control peripartum or for surgery outside of the postpartum period. However, when a narcotic is needed to treat maternal pain, morphine is one of the preferred agents. Analgesics delivered by PCA or administered by the epidural route help limit infant exposure. **Note:** Not all formulations are indicated for intermittent pain control.
- When opioids are needed in breastfeeding women, the lowest effective dose for the shortest duration of time should be used to limit adverse events in the mother and breastfeeding infant. In general, a single occasional dose of an opioid analgesic may be compatible with breastfeeding. Breastfeeding women using opioids for postpartum pain or for the treatment of chronic maternal pain should monitor their infants for drowsiness, sedation, feeding difficulties, or limpness. Withdrawal symptoms may occur when maternal use is discontinued, or breastfeeding is stopped.

MONITORING REQUIRED

Baseline

- RR, HR, BP, sedation scale before dose, SPO2

Pediatric/neonate doses given Direct IV + Adult doses greater than 5 mg given direct IV:

- RR, HR, BP, sedation scale, SPO2 at 5 and 15 minutes post dose

Direct IV in pediatrics: In addition to above;

- Observe patient continually for 5 minutes post dose for signs/symptoms of respiratory depression

Direct IV in neonates: In addition to above;

- Observe patient continually for 5 minutes post dose for signs/symptoms of respiratory depression
- Continuous electronic respiratory monitoring during and for 15 minutes post dose

Adult doses Direct IV:

- RR, HR, BP, sedation scale, SPO2 at 5 and 15 minutes post dose, urine output

RECOMMENDED MONITORING

Neonatal intubation:

- Monitor urine output post dose

All patients:

- Monitor fluid intake and urine output; check for bladder distension
- Check for abdominal distension, gas or constipation

Adverse Effects

CENTRAL NERVOUS SYSTEM

- Sedation
- Dizziness
- Visual disturbances
- Mental clouding or depression
- Coma
- Euphoria/dysphoria
- Weakness
- Faintness
- Agitation/restlessness
- Nervousness
- Seizures
- Delirium
- Insomnia

RESPIRATORY

- Respiratory depression
- Apnea

CARDIOVASCULAR

- Hypotension
- Orthostatic hypotension in ambulatory patients
- Increased ventricular response rate through a vagolytic action

GASTROINTESTINAL

- Nausea, vomiting
- Constipation
- Diminished propulsive peristaltic waves in GI tract

MISCELLANEOUS

- Neonatal withdrawal syndrome: may be life-threatening. Signs and symptoms include irritability, hyperactivity, abnormal sleep pattern, high-pitched cry, tremor, vomiting, diarrhea, and failure to gain weight. Onset, duration, and severity depend on the drug used, duration of use, maternal dose, and rate of drug elimination by the newborn

Dosing

*Note: Morphine may be needed in higher doses for patients who take opioids for chronic pain to maintain desired effect.

*Optimal analgesic dose varies widely among patients; while doses should be titrated to pain management consideration of sedation level and respiratory status will also guide dosing

*Best practice IV route; SQ for palliative

*Use higher end of dosing for Sickle cell crisis - Vaso-occlusive crisis in sickle cell disease

*Opioids may be part of a comprehensive, multimodal, patient-specific treatment plan for managing moderate to severe pain. Maximize nonopioid analgesia (when appropriate) prior to initiation of opioid analgesia

*Acute coronary syndrome, refractory ischemic chest pain:

Note: Use only in patients with continued ischemic chest pain despite maximally tolerated anti-ischemic medications (NitroGLYCERIN). Routine use in patients with acute coronary syndrome has been associated with worse clinical outcomes, and concomitant use with oral P2Y12 inhibitors may diminish antiplatelet effects

ADULT/PEDIATRICS

- 0.05 to 0.1 mg/kg **IV/IM/IN** repeat 0.025 to 0.05 mg/kg **IV/IM/IN** every 15 minutes PRN

ELDERLY

- 0.025 to 0.05 mg/kg **IV/IM/IN**, repeat 0.01 mg/kg **IV/IM/IN** every 15 minutes PRN

Palliative Patient

Breathlessness (adult)

- *2.5 to 5 mg **SQ** every 4 hours around the clock and breakthrough of 1.5 to 3 mg **SQ/PO** every 30 minutes PRN*
- *In palliative patient who is already on narcotics for chronic pain starts experiencing breathlessness, give a breakthrough dose of morphine to treat the breathlessness.*

Pain management (adult)

- *In palliative patient who is already on narcotics and is in pain between their regular narcotic doses, consider increasing pain management dose by 10 to 25% or give breakthrough doses for pain.*

RENAL IMPAIRMENT ADJUSTMENTS

- Start cautiously with lower doses; titrating slowly while carefully monitoring for side effects
- Choice of an alternate opioid may be prudent in patients with baseline renal impairment or rapidly changing renal function especially since other analgesics may be safer and reduced initial morphine dosing may result in suboptimal analgesia

HEPATIC IMPAIRMENT ADJUSTMENTS

- Pharmacokinetics unchanged in mild liver disease; substantial extrahepatic metabolism may occur
- Cirrhosis increases in half-life; suggest dosage adjustment required

HEMO/PERITONEAL DIALYSIS

- Avoid use due to potential for accumulation of neurotoxic metabolites

MISCELLANEOUS

- May be given IM or subcutaneously
- Note: IM administration is generally not recommended due to pain associated with injection, variable absorption, and delayed time to peak effect

Concentration Supplied:

- 10 mg/1 mL (1 mL amp)

Compatibility/Stability:

- Stable in D5W and NS for at least 24 hours at room temperature and in the refrigerator when mixed on ward
- Compatible with dextrose, saline, dextrose-saline combinations and LR solutions

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IM, IV, IO, CVAD, IVAD, *SQ Palliative*
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/morphine.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/1799128?cesid=2HyyXZmXHMs&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dmorphine%26t%3Dname%26acs%3Dtrue%26acq%3Dmorp
- https://web.p.ebscohost.com/nup/detail/detail?vid=3&sid=a3a93e99-2103-413f-98ff-7e05fa859d9f%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535598&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711751
- *Palliative Program (2021)*
- ACLS 2020

Development – May 2023
Update – June 2025

Saskatchewan Health Authority

EMS Drug Reference Card (DRC)

Naloxone/Narcan

Classification

- Opioid antagonist

Indications

EMS INDICATIONS

- Complete or partial reversal of narcotic depression, including respiratory depression, induced by opioids
- Diagnosis of suspected acute opioid overdose

SHA EMS Medical Direction Note:

- Oxygenation and ventilation are important prior to admin to reduce hypoxic effects and combativeness of patients**. When possible recommended route is IM**.

HEALTH CANADA APPROVED

- *Complete or partial reversal of narcotic depression, including respiratory depression, induced by opioids*
- *Diagnosis of suspected acute opioid overdose*

NON HEALTH CANADA APPROVED INDICATION BUT SUBSTANTIATED IN THE LITERATURE

- *Opioid-induced pruritus*

Mechanism of Action

- Reverses the effects of narcotics by competing for opiate receptor sites
- Pure opioid antagonist that competes and displaces opioids at opioid receptor sites

Pharmacokinetics

- **Onset:** 1 to 2 minutes IV, 2 to 5 minutes IM/SQ, 8 to 13 minutes IN
- **Peak:** 15 minutes IV/IM/SQ/IN
- **Duration:** dependent on the dose administered, and more prolonged post IM than IV; 45 minutes IV, greater than 45 minutes IM/SQ, unknown IN
- **Metabolism:** Primarily hepatic via glucuronidation
- **Excretion:** Urine (as metabolites)

Contraindications

- Hypersensitivity to naloxone or any other component of the formulation

Cautions

- Cardiovascular disease
- Patients, including newborns of mothers, physically dependant on opioids, as naloxone may precipitate severe withdrawal symptoms, including seizures

- Any newborn with a history of chronic maternal opioid use **should not** be given naloxone, and should be admitted to NICU if ongoing resuscitation and ventilator support is required post birth
- May be considered for infants who exhibit continued respiratory depression following birth only after effective ventilation has been established and there is a history on fentaNYL being administered within the last 4 hours prior to delivery
-

PREGNANCY

- Consult pharmacy or specialised on-line references for most recent information
- Compatible
- Although naloxone may precipitate opioid withdrawal in the fetus in addition to the mother, treatment should not be withheld when needed in cases of maternal opioid overdose. When using the injection, starting at the low end of the dosing range is suggested to help avoid adverse fetal events but still provide treatment to the mother. Use of naloxone to test for opioid dependence during pregnancy is not recommended.

BREASTFEEDING

- No reports describing the use of naloxone during human lactation have been located; however, naloxone has poor oral absorption.
- According to the manufacturer, the decision to continue or discontinue breastfeeding during therapy should consider the risk of infant exposure, the benefits of breastfeeding to the infant, and the benefits of treatment to the mother.

MONITORING REQUIRED

- Baseline vital signs (HR, RR, BP, O2 saturation, pupils and level of consciousness)
- Then every 5 minutes x 3, then every 15 minutes x 3, or until stable
- Observations will depend on the opiate being treated (i.e. varying lengths of action)

NEONATAL REQUIREMENTS

- Baseline vitals as above with addition of tone and grimace
- HR, RR, capillary refill, O2 saturation, tone and grimace every 5 minutes times 3, every 15 minutes times 3, every 30 minutes x 2, then every 1 hour x 2

MONITORING RECOMMENDED

- Reversal of CNS and/or respiratory depression: Monitor patient frequently until effects of opioid wear off. Continued observation after improvement of respiratory rate for 4 to 6 hours has been recommended Opioid toxicity may be delayed in onset and protracted as compared with expected therapeutic actions especially in presence of long acting opioids (e.g. methadone – half-life 8 to 59 hours) or sustained release product. Apparent duration of action of naloxone is 45 to 70 minutes
- Assess level of pain following administration
- Assess for signs and symptoms of too rapid reversal of opioid effect (e.g. nausea, vomiting, sweating, tachycardia), especially when used postoperatively
- Monitor for signs and symptoms of acute withdrawal in opioid-dependent patients (pain, tachycardia, hypertension, fever, sweating, abdominal cramps, diarrhea, nausea, vomiting, agitation, and irritability). Monitor for symptoms of acute withdrawal in opioid-dependent patients (pain, tachycardia, hypertension, fever, sweating, abdominal cramps, diarrhea, nausea, vomiting, agitation, and irritability). Monitor signs and symptoms of cardiovascular instability (ventricular fibrillation) following abrupt reversal of opioid antagonists.

NEONATAL

- Monitor for acute withdrawal and seizures of opioid-dependant birthing people

Adverse Effects

GASTROINTESTINAL

- Nausea, vomiting

CARDIOVASCULAR

- Tachycardia, hypertension, cardiac arrest – associated with abrupt reversal of opioid depression
- Hypo/hypertension, ventricular tachycardia and fibrillation – associated with postoperative use in patients with preexisting cardiovascular disease

MISCELLANEOUS

- Sweating, tremulousness
- Excitement and significant reversal of analgesia – associated with high doses in postoperative patients
- Irritability and increased crying in the newborn
- Seizures in neonates of opioid-dependent mothers, responds to morphine

Dosing

NOTE: requirement for repeat doses is dependent on amount, type, and route of opioid administration

ADULT/ELDERLY

- 0.5 to 1.0 mg **IM/IV/IN** every 2 to 3 minutes titrated until ventilations are adequate

PEDIATRIC/Neonates

- 0.1 mg/kg/dose **IM/IV/IN**, up to 1 mg/dose **IM/IV/IN** every 2 to 3 minutes titrated until ventilations are adequate

****Do not give to Neonates in resuscitation immediately following delivery.**

EMR

- **IN via Nasal Atomizer:** 2 mg or 4 mg (whichever you stock) **IN** repeated after 2 to 3 minutes if no response
- If patient wakes up after initial dose then goes unconscious again; repeat the dose into the other nostril

Concentration Supplied:

- 2 mg/2 mL
- EMR:
  - 2 mg/0.1 mL per Nasal Atomizer
  - 4 mg/0.1 mL per Nasal Atomizer

Compatibility/Stability:

- Stable in D5W and NS for 24 hours at room temperature. Compatibility in dextrose-saline combinations is assumed

MISCELLANEOUS

- Can be administered IM and subcutaneously but onset of action may be delayed especially if patient has poor perfusion
- Intranasal or inhalation via nebulisation are effective alternatives when needleless administration is desired and you have the right equipment
- Can be administered via interosseous and endotracheal route

Provider/Route:

- **Recommended route is IM**
- **EMR:** Nasal Atomizer
- **PCP/ICP:** IM, IV, IN, SQ
- **ACP:** IM, IV, IN, SQ, IO, ET
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/naloxone.pdf
- SaskKids Pediatric Parental Manual
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7338?cesid=5CZLWYbyo9U&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dnaloxone%26t%3Dname%26acs%3Dtrue%26acq%3Dnalox

- https://web.p.ebscohost.com/nup/detail/detail?vid=5&sid=a3a93e99-2103-413f-98ff-7e05fa859d9f%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535772&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711763
- BLS 2020
- ACLS 2020
- ACLS EP 2017
- PALS 2020

Development – May 2023
Update – June 2025

EMS Provincial Medications

Naproxen/Naprosyn/Aleve

Classification

- Non-steroidal, anti-inflammatory drug with analgesic and antipyretic properties, nonopioid

Indications

EMS INDICATIONS

- Muscle-skeletal trauma
- Burns
- Amputation trauma
- Pain management

HEALTH CANADA APPROVED

- *Muscle-skeletal trauma*
- *Burns*
- *Amputation trauma*
- *Pain management*
- *Anti-inflammatory*
- *Dysmenorrhea, primary*
- *Fever (alternate agent)*
- *Gout, prophylaxis during initiation of urate-lowering therapy (alternate agent)*
- *Gout, treatment*

NON HEALTH CANADA APPROVED INDICATION BUT SUBSTANTIATED IN LITURATURE

- *Abnormal uterine bleeding, nonacute*
- *Migraine, acute treatment*

Mechanism of Action

- Inhibition of the enzyme complex prostaglandin synthetase with consequent reduction in the synthesis of prostaglandins from arachidonic acid
- The mechanism of action of naproxen, like that of other NSAIDs, is not completely understood but involves inhibition of cyclooxygenase (COX-1 and COX-2)
- Has antipyretic, analgesic, and anti-inflammatory properties. Other proposed mechanisms not fully elucidated (and possibly contributing to the anti-inflammatory effect to varying degrees), include inhibiting chemotaxis, altering lymphocyte activity, inhibiting neutrophil aggregation/activation, and decreasing pro-inflammatory cytokine levels.

Pharmacokinetics

- **Onset:** 30 to 60 minutes PO
- **Peak:** 2 to 4 hours PO
- **Duration:** less than 12 hours PO
- **Half-life:** 12 to 17 hours PO

- **Metabolized:** in the liver
- **Excreted:** Urine (95%; primarily as metabolites); feces (less than or equal to 3%)

Contraindications

ABSOLUTE

- Hypersensitivity to naproxen, ASA, and NSAIDs
- Pregnancy (all trimesters)
- *Canadian labeling:* Additional contraindications: Active gastric, duodenal, or peptic ulcers; active GI bleeding; cerebrovascular bleeding or other bleeding disorders; active GI inflammatory disease; severe liver impairment or active liver disease; severe renal impairment (CrCl less than 30 mL/minute) or deteriorating renal disease; severe uncontrolled heart failure; known hyperkalemia; breast-feeding
- Asthma: Contraindicated in patients with aspirin-sensitive asthma; severe and potentially fatal bronchospasm may occur. Use caution in patients with other forms of asthma.
- Bariatric surgery: Gastric ulceration: Avoid chronic use of oral nonselective NSAIDs after bariatric surgery; development of anastomotic ulcerations/perforations may occur. Short-term use of celecoxib or IV ketorolac are recommended as part of a multimodal pain management strategy for postoperative pain.

RELATIVE

- During CABG surgery
- Renal failure

Cautions

- Ulcers
- GI bleed; Consider proton pump inhibitor coadministration in patients at risk for GI bleeding (eg, taking dual antiplatelet therapy or an anticoagulant, ≥60 years of age, high doses)
- Risk of thrombotic events (CVA, TIA, MI)
- Use with caution in patients with hepatic impairment.
- Aseptic meningitis: May increase the risk of aseptic meningitis, especially in patients with systemic lupus erythematosus (SLE) and mixed connective tissue disorders.
- Surgical/dental procedures: Withhold for at least 4 to 6 half-lives prior to surgical or dental procedures.

PREGNANCYBREASTFEEDING

- Nonsteroidal anti-inflammatory drugs (NSAIDs) may delay or prevent rupture of ovarian follicles. This may be associated with infertility that is reversible upon discontinuation of the medication.
- The use of NSAIDs close to conception may be associated with an increased risk of miscarriage due to cyclooxygenase-2 inhibition interfering with implantation
- Exposure to nonsteroidal anti-inflammatory drugs (NSAIDs), including naproxen, during the 1st trimester appears to be a risk for structural anomalies and spontaneous abortions (SABs). The structural defects usually involve the heart, especially septal defects, but associations with oral clefts also have been reported. The absolute risk for these defects, however, appears to be low. When used in the 3rd trimester, NSAIDs have the potential to cause premature closure of the ductus arteriosus, which in some cases, may result in primary pulmonary hypertension of the newborn (PPHN). In addition, the use of NSAIDs as tocolytics has been associated with an increased risk of neonatal complications, such as necrotizing enterocolitis, patent ductus arteriosus, and intraventricular hemorrhage (Ref), but further studies are required to confirm the magnitude of these toxicities. Because of the potential newborn toxicity, naproxen should not be used late in the 3rd trimester. Moreover, women attempting to conceive should not use any prostaglandin synthesis inhibitor, including naproxen, because of the findings in various animal models indicating that these agents block blastocyst implantation.

BREASTFEEDING

- In general, breastfeeding is considered acceptable.
- The American Academy of Pediatrics classifies naproxen as compatible with breastfeeding.
- Nonopioid analgesics, including nonsteroidal anti-inflammatory drugs (NSAIDs), are preferred for breastfeeding patients who require pain control peripartum or for surgery outside of the postpartum period. Short-term use of

naproxen is acceptable, but avoid long-term use (longer than 1 week) in breastfeeding patients. NSAIDs are considered compatible for the treatment of rheumatic and musculoskeletal diseases. NSAIDs may be used to treat acute migraine in lactating patients.

- NSAIDs may be used as part of a multimodal approach to pain relief following cesarean delivery

Adverse Effects

GASTROINTESTINAL

- Indigestion, heartburn, stomach pains, nausea
- NSAIDs cause an increased risk of serious gastrointestinal (GI) adverse events, including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients and patients with a prior history of peptic ulcer disease and/or GI bleeding are at greater risk for serious GI events

CENTRAL NERVOUS SYSTEM

- May cause drowsiness, dizziness, blurred vision, and other neurologic effects that may impair physical or mental abilities; patients must be cautioned about performing tasks that require mental alertness (e.g. operating machinery or driving). Discontinue use with blurred or diminished vision and perform ophthalmologic exam. Periodically evaluate vision in all patients receiving long-term therapy.
- Headache
- Ringing ears

HYPERKALEMIA

- NSAID use may increase the risk of hyperkalemia, particularly in patients greater than or equal to 65 years of age, in patients with diabetes or renal disease, and with concomitant use of other agents capable of inducing hyperkalemia (e.g. ACE-inhibitors). Monitor potassium closely.

MISCELLANEOUS

- Bruising, itching, rash

Dosing

Administer with food, milk, or antacids to decrease GI adverse effects.

* **Older adult considerations:** Older adult patients are at high risk for adverse effects from NSAIDs. Up to 60% of older adult patients can develop an asymptomatic peptic ulcer and/or hemorrhage. Using the lowest effective dose for shortest period possible is recommended. Consider renal function decline with age. Use of NSAIDs can compromise existing renal function especially when CrCl is less than or equal to 30 mL/minute.

ADULT/ELDERLY

- 250 to 500 mg **PO** Immediate release tab, followed by 250 to 500 mg every 12 hours as needed for 250 mg every 6 to 8 hours as needed; maximum dose: 1.25 g on day 1 then 1 g/day thereafter

PEDIATRICS

- 250 mg **PO**. Only to be administered in peds greater than 50 kg every 8 to 12 hours; maximum daily dose 1000 mg/day.

Concentration Supplied: 250 mg tablets

Provider/Route:

- **EMR:** PO
- **PCP/ICP:** PO
- **ACP:** PO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7344?cesid=8RwxhOO61NZ&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dnaproxen%26t%3Dname%26acs%3Dtrue%26acq%3Dnapr
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711766
- SaskKids Pediatric Parental Manual

Development – May 2023
Update – June 2025

EMS Provincial Medications

NitroGLYCERIN/Glyceryl Trinitrate HIGH ALERT

Classification

- Vasodilating agent, antianginal

Indications

EMS INDICATIONS

- Congestive heart failure associated with acute myocardial infarction
- Severe unstable angina that cannot be controlled by other measures
- Acute pulmonary edema
- Chest pain of cardiac origin
- If showing clinical signs of ACS

HEALTH CANADA APPROVED

- *Control of blood pressure in preoperative hypertension and in the immediate post-surgical period*
- *Congestive heart failure associated with acute myocardial infarction*
- *Severe unstable angina that cannot be controlled by other measures*
- *To produce controlled hypotension during surgical procedures*

NON HEALTH CANADA APPROVED INDICATION BUT SUBSTANTIATED IN THE LITERATURE

- *Acute pulmonary edema*
- *To induce transient and rapid uterine relaxation*

Mechanism of Action

- Vascular smooth muscle relaxant resulting in general vasodilation
- Decreases cardiac workload/oxygen demand by dilating vessels which reduces the pressure against the pumping of blood (afterload) and the amount of blood that returns (preload)
- Dilates coronary and systemic arteries
- Promotes collateral circulation to ischemic regions where normal blood flow is interrupted
- Nitroglycerin forms free radical nitric oxide. In smooth muscle, nitric oxide activates guanylate cyclase which increases guanosine 3’5’ monophosphate (cGMP) leading to dephosphorylation of myosin light chains and smooth muscle relaxation. Produces a vasodilator effect on the peripheral veins and arteries with more prominent effects on the veins. Primarily reduces cardiac oxygen demand by decreasing preload (left ventricular end-diastolic pressure); may modestly reduce afterload; dilates coronary arteries and improves collateral flow to ischemic regions.

Pharmacokinetics

- **Onset:** 1 to 3 minutes (tab), 2 to 4 minutes (spray), Immediate (IV)
- **Peak:** 4 to 15 minutes (spray), Immediate (IV)
- **Duration:** 25 minutes (spray), 3 to 5 minutes (IV)

- **Metabolism:** Extensive first-pass effect; metabolized hepatically to glycerol di- and mononitrate metabolites via liver reductase enzyme; subsequent metabolism to glycerol and organic nitrate; nonhepatic metabolism via red blood cells and vascular walls also occurs
- **Excretion:** Urine (as inactive metabolites)

Contraindications

- Hypersensitivity to nitroglycerin, any component of formulation or a known idiosyncratic reaction to organic nitrates
- Hypotension or uncorrected hypovolemia (e.g. hemorrhage)
- Severe anemia
- Increased intracranial pressure (e.g. head trauma or cerebral hemorrhage)
- Constrictive pericarditis and pericardial tamponade (IV Nitro)
- Use of phosphodiesterase-5 inhibitors; delay nitrate therapy for 12 hours or more after taking avanafil, 24 hours for sildenafil (viagra) or vardenafil: 48 hours for tadalafil (Cialis) within 48 hours
- When used for management of ST-elevation or non-ST-elevation myocardial infarctions avoid nitroglycerin in the following conditions: Hypotension (SBP less than 90 mmHg or greater than or equal to 30 mmHg below baseline), marked bradycardia (heart rate less than 50 bpm) or tachycardia, and right ventricular infarction
- *Canadian labeling:* Additional contraindications for translingual product: Closed angle glaucoma; heart failure (aortic or mitral stenosis, constrictive pericarditis, or hypertrophic cardiomyopathy with left ventricular outflow tract obstruction).

Cautions

- **HIGH ALERT**
- Elderly: Hypotension is enhanced due to decreased baroreceptor response, decreased venous tone, and often hypovolemia (dehydration) or other hypotensive drug
- Low or normal pulmonary capillary wedge pressure predisposes to the hypotensive effects
- Patients with depleted blood volume may be subject to hypotensive crisis
- Some products contain substantial amounts of propylene glycol +/or ethanol, which may produce toxicity at high doses
- The transdermal patch may contain conducting metal (e.g. aluminum); remove patch prior to MRI

DRUG INTERACTIONS

- Heparin - anticoagulant effect may be decreased, monitor PTT

PREGNANCY

- The use of nitroglycerin during pregnancy does not seem to present a risk to the fetus.
- Consult pharmacy or specialized on-line references for most recent information

BREASTFEEDING

- The molecular weight (about 227) suggests that the drug will be excreted into breast milk, but the short half-life should limit exposure. The most common adverse reaction observed in adults was headache. If a woman is receiving this drug while breastfeeding, her nursing infant should be monitored for these effects.
- Consult pharmacy or specialized on-line references for most recent information

MONITORING REQUIRED

DIRECT IV

- Baseline BP, HR and RR, then every 5 minutes x 2 and until stable
- ECG monitoring

CONTINUOUS INFUSION

- Electronic infusion device
- Continuous ECG monitoring
- Baseline BP, then every 5 minutes x 3 until stable while titrating dose, then at least every 1 hour for duration of therapy

MONITORING RECOMMENDED

- Continuous BP or non-invasive BP monitoring

Adverse Effects

CARDIOVASCULAR
- Hypotension, may be sudden and severe, responds to elevation of the legs, reducing or stopping infusion
- Flushing
- Reflex tachycardia
- Paradoxical bradycardia
- Paradoxical increase of anginal pain

CENTRAL NERVOUS SYSTEM
- Headache (may be severe)
- Dizziness
- Restlessness
- Intracranial hypertension leading to vomiting, blurred vision and bradycardia(rare, associated with high doses)
- Wernicke's encephalopathy (rare, associated with high doses)

GASTROINTESTINAL
- Nausea/vomiting
- Abdominal pain

MISCELLANEOUS
- Immediate hypersensitivity reactions (e.g. itching, tracheobronchitis, wheezing)
- Methemoglobinemia (rare; increased risk with high dose or prolonged therapy)
- Tolerance to anti-anginal and hemodynamic effects, associated with high doses and continuous infusions, may occur within 24 hours

Dosing

* Translingual spray: Do not shake container. Prior to initial use, the pump must be primed by spraying 5 times (Nitrolingual) or 10 times (Nitromist) into the air. Priming sprays should be directed away from patient and others. Release spray onto or under tongue. Close mouth immediately after administration; do not inhale the spray. Do not expectorate or rinse the mouth for 5 to 10 minutes following administration. Content of the container should be checked periodically; when the container is held upright, the end of the pump should be covered by the fluid in the bottle or the remaining sprays will not deliver the intended dose.
* Recommended for acute angina. For prevention of recurrent angina, may use in combination with other anti-anginal therapy (eg, a beta-blocker)

ADULT/ELDERLY
- **Chest pain:**
  - 0.4 mg **SL** every 3 to 5 minutes (max 3 sprays)
- **ACP's prior to IV and PCPs - Pulmonary Edema:**
  - 0.4 mg **SL** every 3 to 5 minutes. If systolic blood pressure falls below 110 mmHg or drops 30 mmHg from the initial blood pressure STOP administering nitro. (PCP's must contact medical control if giving nitro in pulmonary edema of cardiac origin)
- **ACP's ONLY Pulmonary Edema IV Infusion – (Infusion is preferred over SL for ACP's)**
  - Start at 20 mcg/min. Titrate by 10 mcg/min every 5 min PRN to a max of 200 mcg/min. Once systolic pressure falls below 140 mmHg stop increasing the nitro infusion and decrease slowly if needed until blood pressure is steady.

EMR
- Can assist if patient has their own prescription.
- Must contact Medical Control for approval if patient does not have their own prescription
- If patient requires more than 3 sprays contact Medical Control for further dosing.

Concentration Supplied:
- 0.4 mg/dose SL spray
- 50 mg/10 mL vial for infusion

Reconstitution for Infusion:

- Dilute 50 mg in 250 mL D5W or NS; vials contain ethanol; may contain propylene glycol, depending on brand

Compatibility/Stability:

- Compatible with D5W, saline, dextrose-saline combinations, LR and LR solutions
- Commercially available pre-mixed solution is stable until labelled expiry date. Other dilutions in D5W or NS, in PVC infusion bags, are stable for at least 24 hours at room temperature and in the refrigerator
- DOBUTamine, DOPamine, lidocaine, nitroglycerin and sodium nitroPRUSSIDE prepared in D5W or NS, are compatible by Y-site in all possible combinations

Provider/Route:

- *Do not administer IM or SQ
- **EMR:** Assist with patient's own prescription or contact Medical Control (See above instruction under dosing)
- **PCP/ICP:** SL, monitor transdermal patch
- **ACP:** SL, IV infusion, transdermal patch
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/nitroGLYCERIN.pdf
- SaskKids Pediatric Parental Manual
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7377?cesid=3BbOmGDqTZC&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dnitroglycerin%26t%3Dname%26acs%3Dtrue%26acq%3Dnitro
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711792
- ACLS 2020
- ACLS EP 2017

Development – May 2023
Update – June 2025

EMS Provincial Medications

Norepinephrine/Levophed HIGH ALERT

Classification

- Sympathomimetic

Indications

EMS INDICATIONS

- Temporary restoration and maintenance of blood pressure in acute hypotension or shock states, such as surgery, trauma, sepsis

SHA EMS Medical Direction Note:

- When a push dose presser is needed EPINEPHrine is the drug of choice

HEALTH CANADA APPROVED

- *Temporary restoration and maintenance of blood pressure in acute hypotension or shock states, such as surgery, trauma, sepsis*
- *As a temporary adjunct in the treatment of cardiac arrest and profound hypotension*

Mechanism of Action

- Norepinephrine is a vasoconstrictor that predominantly stimulates α_1 receptors to cause peripheral vasoconstriction and increase blood pressure. It also has some β_1 receptor agonist activity that results in a positive inotropic effect on the heart at higher doses.
- Stimulates beta1-adrenergic receptors and alpha-adrenergic receptors causing increased contractility and heart rate as well as vasoconstriction, thereby increasing systemic blood pressure and coronary blood flow; clinically, alpha effects (vasoconstriction) are greater than beta effects (inotropic and chronotropic effects)

Pharmacokinetics

- **Onset:** Immediate
- **Peak:** Rapid, steady state 5 minutes
- **Duration:** 1 to 2 minutes
- **Metabolized** through the liver and other tissues by a combination of reactions; via catechol-o-methyltransferase and monoamine oxidase.
- **Metabolism and Excretion:** Taken up and metabolized rapidly by sympathetic nerve endings.
- **Excretion:** Urine (as inactive metabolites; small amounts as unchanged drug).

Contraindications

- Hypersensitivity to bisulfites or any other component of the formulation
- Suspected mesenteric infarction or thrombosis, due to risk of increasing ischemia and extending area of infarction

Cautions

- **HIGH ALERT**
- Elderly; due to potential for decreased organ function and concomitant disease or drug therapy
- Correct hypovolemia prior to starting norepinephrine. In emergencies, may be given before and concurrently with volume replacement
- Hypercapnia or hypoxia: cardiac arrhythmias may occur
- Occlusive vascular disease avoid - using leg veins for administration

DRUG INTERACTIONS

- MAO inhibitors, tricyclic antidepressants, serotonin/norepinephrine reuptake inhibitors (e.g. venlafaxine): may potentiate pressor response
- Sodium Bicarbonate (or any alkaline solution) through an IV line containing norepinephrine; inactivation of norepinephrine may occur
- Linezolid: May enhance hypertensive effect. Monitor for enhanced pressor response and adjust dose accordingly

PREGNANCY

- Uterine vessels are normally maximally dilated, and they have only α-adrenergic receptors. Use of the α- and β-adrenergic stimulant, norepinephrine, could cause constriction of these vessels and reduce uterine blood flow, thereby producing fetal hypoxia (bradycardia). Norepinephrine may also interact with oxytocics or ergot derivatives to produce severe persistent maternal hypertension. Rupture of a cerebral vessel is possible. If a pressor agent is indicated, other drugs, such as ephedrine, should be considered
- Medications used for the treatment of cardiac arrest in pregnancy are the same as in the non-pregnant woman. Appropriate medications should not be withheld due to concerns of fetal teratogenicity. Norepinephrine use during the post-resuscitation phase may be considered; however, the effects of vasoactive medications on the fetus should also be considered. Doses and indications should follow current Advanced Cardiovascular Life Support guidelines.

BREASTFEEDING

- No reports describing the use of norepinephrine in lactation have been located. Use of the agent during breastfeeding would not be expected because of the indications for use.
- The manufacturer recommends that caution be exercised when administering norepinephrine to breastfeeding women.

REQUIREMENTS

- Electronic infusion device Central venous access device required. Peripheral line may be used only as an interim measure until a central line can be inserted

PEDIATRIC

- Consultation with Critical Care or Transport team

MONITORING REQUIRED

- Continuous ECG monitoring, HR, end-organ function, peripheral perfusion
- Continuous BP monitoring or every 3 to 5 minutes by cuff until continuous monitoring available
- If given peripherally, assess IV site for signs of extravasation (area will appear cold, hard and pale) every 30 minutes until a central line can be inserted

MONITORING RECOMMENDED

- Advise patients to report burning/stinging/pain at IV site promptly
- Ensure adequate intravascular volume
- Assess extremities for changes in colour or temperature

Adverse Effects

CARDIOVASCULAR

- Severe peripheral and visceral vasoconstriction, associated with hypovolemia, decreased renal perfusion and decreased urine output, tissue hypoxia, and metabolic acidosis

- Plasma volume depletion, associated with prolonged use
- Decreased cardiac output due to increased peripheral vascular resistance, associated with prolonged use or large doses
- Hypertension (responds to IV phentolamine), reflex bradycardia
- Potentially fatal cardiac arrhythmias, including ventricular tachycardia and ventricular fibrillation

CENTRAL NERVOUS SYSTEM

- Anxiety
- Headache (may be a symptom of hypertension)

RESPIRATORY

- Dyspnea

EXTRAVASATION

- Results in sloughing and necrosis
- Blanching along vein pathway is preliminary sign of extravasation

TREATMENT

- Stop infusion do not flush or remove IV
- Restart norepinephrine at new IV site and notify physician immediately
- Physician to infiltrate area of extravasation with phentolamine with in 12 hours

Dosing

*Dosage expressed in terms of norepinephrine base

**Do not stop infusion abruptly; rate should be gradually tapered

Must be administered via IV pump – 4 mg/4 mL x 4 vials or 16 mg/250 mL D5W = 64 mcg/mL

If MAP remains below 65 mmHg or systolic blood pressure below 90 mmHg despite norepinephrine infusion greater then or equal to 1 mcg/kg/minute consult expert opinion

ADULT - INITIAL DOSE

- 0.1 mcg/kg/minute **IV Infusion via pump** adjust in 0.05 mcg/kg/minute increments to desired blood pressure response based on monitoring requirements
    - Maximum dose: 1 mcg/kg/minute

  -MAINTENANCE RANGE
    - 0.03 to 0.06 mcg/kg/minute (2 to 4 mcg/minute in a 70 kg patient)
    - However, dosage range varies greatly depending on clinical situation. Use minimum effective dose to achieve clinical targets
    - Doses greater than 1.5 mcg/kg/minute are not commonly required in septic shock dose ranges from 0.01 to 3 mcg/kg/minute (0.7 to 210 mcg/minute in a 70 kg patient) have been used in clinical trials

ELDERLY

- Initial dosage usually should be at low end of adult dosing range

NOT TO BE USED IN PEDIATRICS; PDP EPINEPHrine should be used

*Central venous line must be used in concentration 64 mcg/mL and greater

PEDIATRIC greater than 20 kg

- 0.1 mcg/kg/minute **IV Infusion via pump** titrated to maintain a perfusing blood pressure
    - Maximum dose: 2 mcg/kg/minute
    - 10 percent rule does not apply – all concentrations are mixed to a final volume of 250 mL
    - Bags should only be utilized if the flow rate exceeds 3 mL/hour

Concentration Supplied: 4 mg/4 mL (4 mL vial)

Compatibility/Stability:

- Stable in D5W or NS solutions for at least 24 hours at room temperature. Dilution in NS is not recommended by manufacturer; however, stability in NS has been demonstrated
- Compatible with D5W, NS, D5S, Ringer's and lactated Ringer's solutions
- Do not use if solution is discoloured (pink, yellow or brown) or contains a precipitate

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IV, IO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/norepinephrine.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7381?cesid=0cHnou8SLvg&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dnorepinephrine%26t%3Dname%26acs%3Dtrue%26acq%3Dnor
- https://web.s.ebscohost.com/n up/detail/detail?vid=7&sid=e67d9564-4b9e-4b76-9f75-e6018ac9f9c2%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009565387&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711797
- ACLS EP 2017
- ACLS 2020
- PALS 2020

Development – May 2023
Update – June 2025

EMS Provincial Medications

Ondansetron/Zofran

Classification

- Antiemetic

Indications

EMS INDICATIONS

- Prevention of nausea and vomiting

EMS Medical Direction Note:

- To be used as first line antiemetic
- Buccal dissolving wafer indications:
  - pediatrics for gastroenteritis management; OR
  - patients actively vomiting with no IV access; OR
  - patient requiring an anti-emetic with no oral route and no IV access

HEALTH CANADA APPROVED

- *Prevention of nausea and vomiting associated with emetogenic chemotherapy and radiotherapy*
- *Prevention and treatment of post-operative nausea and vomiting in patients 65 years of age and younger*

Mechanism of Action

- A selective 5-HT3 receptor antagonist, blocking serotonin both peripherally on vagal nerve terminals and centrally in the chemoreceptor trigger zone

Pharmacokinetics

- **Onset:** Rapid IV/PO/IM/Buccal
- **Peak:** 15 to 30 minutes IV/PO/Buccal, 40 minutes IM
- **Duration:** 4 to 8 hours IV/PO/Buccal, Unknown IM
- **Metabolism:** extensively hepatic via hydroxylation
- **Excretion:** Urine (44% to 60% as metabolites, ~5% as unchanged drug); feces (~25%)

Contraindications

- Hypersensitivity to Ondansetron or any component of the formulation
- Concomitant use with apomorphine

Cautions

- Hypersensitivity to other 5-HT3 receptor antagonists, e.g. granisetron, tropisetron
- Elderly: increased risk of QT prolongation, decreased max single dose and rate of administration recommended

- Single doses greater than 16 mg IV (in those less than 75 years of age) or continuous infusions are no longer recommended due to the potential for an increased risk of QT prolongation
- Patients with congenital long QT syndrome or patients with other risk factors for QT prolongation; hypokalemia or hypomagnesemia, heart failure, bradyarrhythmias
- **Not effective in preventing motion-induced nausea and vomiting**
- Serotonin syndrome: Serotonin syndrome (SS) has been reported with 5-HT3 receptor antagonists, predominantly when used in combination with other serotonergic agents (eg, selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, monoamine oxidase inhibitors, mirtazapine, fentanyl, lithium, tramadol, and/or methylene blue). Some of the cases have been fatal. The majority of serotonin syndrome reports due to 5-HT3 receptor antagonist have occurred in a postanesthesia setting or in an infusion center. SS has also been reported following overdose of ondansetron. Signs/symptoms of SS include mental status changes (eg, agitation, hallucinations, delirium, coma); autonomic instability (eg, tachycardia, labile BP, diaphoresis, dizziness, flushing, hyperthermia); neuromuscular changes (eg, tremor, rigidity, myoclonus, hyperreflexia, incoordination); GI symptoms (eg, nausea, vomiting, diarrhea); and/or seizures.

PREGNANCY

- Consequently, ACOG recommends doxylamine–pyridoxine as the treatment of choice for nausea and vomiting in pregnancy. If ondansetron must be used, avoiding the 1st trimester is the safest course.
- Ondansetron crosses the placenta.
- Consult pharmacy or specialised on-line references for most recent information
- Ondansetron can be detected in fetal tissue. The risk of developing a major congenital malformation following first trimester exposure is under study.

BREAST FEEDING

- The molecular weight (about 293) and the moderate elimination half-life (3.5 hours) suggest that the drug will be excreted into breast milk, but the extensive metabolism may limit the amount in milk. The effect of this exposure on a nursing infant is unknown.
- Consult pharmacy or specialised on-line references for most recent information
- According to the manufacturer, the decision to breastfeed during therapy should consider the risk of infant exposure, the benefits of breastfeeding to the infant, and the benefits of treatment to the patient.

DRUG INTERACTION

- Drugs that prolong the QT interval (e.g. amiodarone, macrolides, fluroroquinolones, haloperidol, risperidone), cumulative high-dose anthracycline therapy; clinically relevant QT interval prolongation may occur resulting in Torsade de pointes
- TraMADol: may diminish analgesic effect of TraMADol. Monitor therapy
- Proserotonergic drugs (e.g. antidepressants; especially SSRI and MAO inhibitors) may enhance the serotonergic effect, resulting in serotonin syndrome. Monitor therapy

REQUIREMENTS

- Electronic infusion device
- For IM rotate injection sites

MONITORING RECOMMENDED FOR IV ADMIN

- Baseline ECG if applicable, serum potassium and magnesium
- ECG if applicable (eg, high-risk or elderly patients, concurrent use of other medications known to prolong QT interval, electrolyte abnormalities [hypokalemia or hypomagnesemia], heart failure, bradyarrhythmias, and cumulative high-dose anthracycline therapy); serum potassium and magnesium levels. Monitor for signs/symptoms of serotonin syndrome and hypersensitivity; monitor for decreased bowel activity (particularly in patients at risk for bowel obstruction). Monitor for signs/symptoms of myocardial ischemia.

Adverse Effects

GASTROINTESTINAL

- Constipation
- Abdominal pain
- Stomach cramps

CARDIOVASCULAR

- Dose-dependent QT interval prolongation
- Torsade de pointe has been reported
- Dose-dependent increases in ECG intervals (e.g. PR, QRS duration QT/QTc, JT), usually occurring 1 to 2 hours after IV administration
- Reduction in heart rate

CENTRAL NERVOUS SYSTEM

- Headache, usually mild but may be severe. Responds to Acetaminophen
- Malaise
- Fatigue
- Dizziness or light-headedness
- Drowsiness

HEPATIC

- Transient increases of AST and ALT greater than 2 time upper limit normal

MISCELLANEOUS

- Hypersensitivity reactions: rash, bronchospasm, urticaria, angioedema (rare)
- Dry mouth, fever, chills
- Serotonin syndrome, hypertension, tachycardia, tachypnea, hyperthermia (greater than 41.1◦C)

Dosing

***start at 4 mg dose to reduce risk of QTc prolongation**
****See specific criteria under - Indications - EMS Medical Direction Note for Buccal use**

ADULT

65 years or less

- **IV** - doses 4 mg or less: diluted or undiluted; administer over 2 to 5 minutes every 6 hours
- **IV Infusion** – dilute in 50 mL mini bag; infuse over 20 minutes
- **IM** – 4 mg undiluted
- **PO** – 4 mg (IV supply can be consumed orally; if available mix with juice (it tastes terrible))
- **Buccal** – 4 mg dissolving wafer

ELDERLY

65 years or older

- **IV infusion** – 4 mg diluted in 50 mL mini bag; infuse over 20 minutes every 6 hours
- **IM** – 4 mg (1 mL per muscle group)
- **PO** – 4 mg (IV supply can be consumed orally; if available mix with juice (it tastes terrible))
- **Buccal** – 4 mg dissolving wafer

PEDIATRIC

- Less than 5 years: 2 mg **IV** over 2 to 5 minutes every 6 hours, **IM**
- Greater than 5 years: 4 mg **IV** over 2 to 5 minutes every 6 hours, **IM, Buccal**

HEPATIC IMPAIRMENT ADJUSTMENTS

- Maximum 8 mg/day recommended for severe hepatic insufficiency

Concentration:

- 2 mg/mL in 4 mL vial
- 4 mg per dissolvable wafer
- 8 mg per dissolvable wafer

Compatibility/Stability:

- Stable in D5W and NS solutions for at least 24 hours at room temperature and in the refrigerator
- Compatible with D5W, NS, Ringer's, Ringer's lactate, dextrose-saline combination solutions
- **Incompatible with drugs having alkaline pH (e.g. sodium bicarbonate)**

Provider/Route:

- Recommended route IV or IM if unable to establish IV as PO for vomiting is not best practice.
- **EMR:** Not in scope of practice
- **PCP/ICP:** IM, IV, PO, Buccal
- **ACP:** IM, IV, PO, IO, Buccal
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/ondansetron.pdf
- SaskKids Pediatric Parental Manual
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7399?cesid=0rM0soJ3K2S&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dondansetron%26t%3Dname%26acs%3Dtrue%26acq%3DONDA
- https://web.p.ebscohost.com/nup/detail/detail?vid=3&sid=e8cf2271-9450-4ece-ac37-29733e2c4e1c%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535591&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711816

Development – May 2023
Update – June 2025

EMS Provincial Medications

Oxytocin/Syntocinon HIGH ALERT

Classification

- Oxytocic / Uterotonic

Indications

EMS INDICATIONS

- Postpartum: To produce uterine contractions during the third stage of labour (after delivery of anterior shoulder of last baby) and to control postpartum hemorrhage

HEALTH CANADA APPROVED

- *Antepartum: Induction of labour in patients with a medical indication (e.g., Rh problems, maternal diabetes, preeclampsia, at or near term); stimulation or reinforcement of labour (as in selected cases of uterine inertia); adjunctive therapy in management of incomplete or inevitable abortion*
- *Postpartum: To produce uterine contractions during the third stage of labour and to control postpartum bleeding or hemorrhage*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITURATURE

- *Contraction stress test (oxytocin challenge test) to evaluate the adequacy of fetal-placental function in high risk pregnancies*

Mechanism of Action

- Oxytocin stimulates uterine contractions by acting on receptors that trigger the release of intracellular calcium and local prostaglandin production.

Pharmacokinetics

- **Onset:** 3 to 5 minutes IM; 1 minute IV
- **Duration**: 2 to 3 hours IM; 1 hour IV
- **Half Life:** 1 to 6 minutes
- **Excretion:** Urine (small amount unchanged)

Contraindications

- Hypersensitivity to oxytocin, any component of formulation or carbetocin. **Note: this is the only contraindication when used postpartum**
- Major cephalopelvic disproportion, fetal malpresentation
- Hypertonic uterine contractions, prolonged use in uterine inertia
- Obstetrical emergencies (e.g. abruption placentae), serious medical or obstetrical conditions (past or present), severe toxemia
- Vaginal delivery contraindicated (e.g. active herpes genitalis, cord presentation or prolapse, placental previa)

Cautions

- **HIGH ALERT**
- Hazardous
- Before delivery, the spontaneously labouring uterus is extremely sensitive to oxytocin; avoid high doses. Conversely during mid trimester (13 to 20 weeks) much higher doses (20 units or greater) and rates of administration are tolerated
- Hypotension, patients already hypovolemic from haemorrhage, or with cardiac disease limiting cardiac output; avoid bolus doses as resulting transient hypotension may compound problem

DRUG INTERACTIONS

- Concurrent use of dinoprostone with oxytocin is contraindicated. A dosing interval of at least 30 minutes is recommended for sequential use of oxytocin following removal of dinoprostone vaginal insert, 6 hours after application of dinoprostone gel, and 4 hours after last misoprostol dose

MONITORING REQUIRED

- Infusion device must be used

DIRECT IV

- Monitor as ordered

ALL OTHER INDICATIONS:

CONTINUOUS INFUSION, AT INITIATION, AND WITH RATE INCREASES POSTPARTUM

- BP and HR every 15 minutes or more frequently until postpartum bleeding is controlled

MONITORING RECOMMENDED

- Continuous ECG monitoring in patients with significant cardiac disease with hemodynamic compromise
- Monitor blood pressure, fluid intake and output, fetal heart rate and labor progression if using oxytocin for induction. Record length and duration of contractions. Obtain baseline pulse, respirations, blood pressure, and fetal heart tones

Adverse Effects

CARDIOVASCULAR

- Transient hypotension (1 to 3 minutes), associated with rapid (10 seconds) injection
- Transient but significant decreases in BP, cardiac arrhythmias; associated with large amounts of oxytocin in patients already hypotensive
- Fetal sinus bradycardia, tachycardia, PVCs, permanent CNS or brain damage and death secondary to asphyxia

GASTROINTENSTINAL

- Nausea/vomiting – may be related to labour and not the drug

RENAL

- Dilutional hyponatremia (water intoxication with headache and nausea) if administered in a large volume of electrolyte free aqueous dextrose solution at rates of 40 milliunits/minute or higher

UTERINE

- Uterine tachysystole (more than 5 contractions in 10 minutes averaged over 30 minutes) occurs with greater frequency if oxytocin continuous infusion is increased every 15 to 20 minutes versus every 30 to 60 minutes
- Uterine tachysystole can lead to uterine rupture, utero-placental hypoperfusion and fetal distress from hypoxia

Dosing

*Administer IM injection into large muscle mass
*Higher infusion rates required in mid trimester as uterus has fewer oxytocin receptors; Adjust infusion rate to sustain uterine contraction and control uterine atony

Post Birth:

- 10 units **IM** at the time of delivery of anterior shoulder of the last baby
  *Note: Administer oxytocin after delivery of the placenta, delivery of the anterior shoulder, or after delayed umbilical cord clamping (depending on situation). In patients at high risk for hemorrhage, a second medication (eg, tranexamic acid) may be used

Post Partum/Post Abortion Hemorrhage, Incomplete Abortion or Atony:

*If carbetocin has been **NOT** been given prior to arrival on scene by EMS (ex, midwife)

- PCP/ICP – 10 units **IM** if not immediately post birth

ACP USE ONLY

- 30 units in 500 mL (60 mUnits/mL) NS or LR **IV infusion** 125 – 250 mUnits/minute via pump
  *Maximum recommended cumulative dose: 40 units postpartum. If requiring more than 40 units, consider second line uterotonics

Concentration Supplied:

- 10 units/mL (1 mL amp)

Compatibility/Stability:

- Stable in NS or D5W for 24 hours. Avoid diluting in D5W to prevent dilutional hyponatremia
- Compatible with NS, D5W, dextrose-saline combinations and LR solutions

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** IM, Monitor IV Infusion
- **ACP:** IM, IV, IO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/oxytocin.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7426?cesid=4G7uKx7Ox0p&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Doxytocin%26t%3Dname%26acs%3Dtrue%26acq%3Doxy
- MORE OB Committee

Development – May 2023
Update – June 2025

EMS Provincial Medications

Salbutamol/Albuterol/Ventolin

Classification

- Bronchodilater – Beta 2 – adrenergic stimulant

Indications

EMS INDICATIONS

- Severe bronchospasm associated with acute exacerbations of chronic bronchitis and bronchial asthma
- Bronchospasm in anaphylaxis
- Treatment of status asthmaticus
- Treatment of suspected Hyperkalemia based on the presence of the following:
    - **A SOURCE** (one of the following):
        - History of kidney disease
        - Chronic renal insufficiency
        - Another condition that would predispose the patient to a condition of hyperkalemia (i.e. rhabdomyolysis, severe burns, severe trauma/crush trauma, tumor lysis syndrome)

    AND
    - **ELECTROCARDIOGRAPHIC EVIDENCE** (one of the following):
        - ECG changes suggestive of hyperkalemia (peaked T waves, loss of P waves, wide QRS and/or symptomatic bradycardia)
        - Patient is in CARDIAC ARREST

HEALTH CANADA APPROVED

- *Severe bronchospasm associated with acute exacerbations of chronic bronchitis and bronchial asthma*
- *Treatment of status asthmaticus*

Mechanism of Action

- Produces bronchodilation through stimulation of Beta2-adrenergic receptors in bronchial smooth muscle, which causes relaxation of bronchial smooth muscle fibers from the trachea to the terminal bronchial tree
- Redistributes and induces a transcellular shift of potassium

Pharmacokinetics

- **Onset:** less than 5 minutes NEB, 5 to 8 minutes MDI
- **Peak:** 30 minutes NEB, 25 minutes MDI
- **Duration:** 3 to 6 hours NEB, 4 to 6 hours MDI; 15 to 90 minutes (hyperkalemia)
- **Metabolism:** Hepatic to an inactive sulfate
- **Excretion:** Urine and Feces

Contraindications

- Hypersensitivity to salbutamol or any component of the formulation

Cautions

- Idiopathic hypertrophic sub-valvular stenosis
- Do not exceed recommended dose; serious adverse events, including fatalities, have been associated with excessive use of inhaled sympathomimetics.
- Cardiovascular disorders especially coronary insufficiency, cardiac arrhythmias and hypertension; may cause elevation in blood pressure, heart rate and result in CNS stimulation/excitation. May also increase risk of arrhythmias
- Diabetes mellitus (beta-2 agonists may increase serum glucose and aggravate preexisting diabetes and ketoacidosis), hyperthyroidism (may stimulate thyroid activity), or convulsive disorders (beta-agonists may result in CNS stimulation/excitation).
- Patients unusually responsive to sympathomimetic amines
- Glaucoma: Use with caution in patients with glaucoma; may elevate intraocular pressure.
- Hypokalemia: Use with caution in patients with hypokalemia; beta-2 agonists may decrease serum potassium.
- Renal impairment: Use with caution in patients with renal impairment.
- Bronchospasm (moderate to severe) due to anaphylaxis (adjunct to epinephrine): **Note:** Administer epinephrine first when treating anaphylaxis; administer albuterol for residual respiratory symptoms not responding to epinephrine. Do not use albuterol for initial or sole treatment of anaphylaxis because albuterol does not prevent or relieve upper airway edema, hypotension, or shock.

DRUG INTERACTONS

- MAO inhibitors or tricyclic antidepressants: effect on the vascular system may be potentiated

PREGNANCY

- Contact pharmacy for most recent information
- Albuterol (salbutamol) has not caused structural anomalies, but there is evidence of an association with functional and neurobehavioral toxicity with prolonged use. Similar to other β-mimetics, the drug can cause maternal and fetal tachycardia and hyperglycemia. Nevertheless, the drug should not be withheld because of pregnancy, but excessive use should be avoided.

BREAST FEEDING

- Contact pharmacy for most recent information
- However, the inhaled formulation is probably compatible with breastfeeding because of the low maternal systemic concentrations. Other drugs in the class (see Terbutaline) are considered compatible with breastfeeding, and albuterol, most likely, is compatible. The most common adverse events (greater than 2%) in nonpregnant adults were nervousness, tremor, headache, tachycardia, palpitations, and muscle cramps. If a woman is receiving this drug while breastfeeding, her nursing infant should be monitored for these effects.

MONITORING REQUIRED

- Continuous ECG monitoring, blood pressure, heart rate, and CNS stimulation, lung sounds.

MONITORING RECOMMENDED

- Serum potassium and glucose
- Hypokalemia, tachycardia

Adverse Effects

CARDIOVASCULAR

- Palpitations
- Tachycardia
- Arrhythmias (atrial fibrillation, supraventricular tachycardia and extrasystoles)
- Angina
- Peripheral vasodilation,
- Hypo/hypertension

CENTRAL NERVOUS SYSTEM

- Nervousness
- Muscle tremor
- Headache
- Agitation
- insomnia

HYPERSENSITIVITY

- Urticaria
- Edema
- Rash
- Bronchospasm
- Anaphylaxis

Dosing

***NOTE:** May be mixed with budesonide and ipratropium solutions immediately before.

ADULT/ELDERLY

***Note:** Moderate to severe exacerbations (management in primary or acute care settings): Note: For severe exacerbations, albuterol is used in combination with an inhaled short-acting muscarinic antagonist. Nebulized therapy may be preferred in patients who have more severe symptoms or who cannot effectively use an inhaler.

MDI with AERO Chamber and Face Mask**:**

- 10 puffs at 100 mcg (interspersed with Atrovent for first 5 puffs) may repeat Ventolin up to 3 rounds; **see below

Nebulized:

- 2.5 to 5.0 mg, may repeat PRN
    - Hyperkalemia 10 to 20 mg via inhalation over 10 minutes may repeat

PEDIATRIC

MDI with AERO Chamber and Face Mask**:**

- **Greater than 20 kg**: 10 puffs at 100 mcg (interspersed with Atrovent for first 5 puffs) may repeat Ventolin up to 3 rounds; **see below
- **Less than 20 kg**: 5 puffs at 100 mcg (interspersed with Atrovent for the first 4 puffs) may repeat Ventolin up to 3 rounds; **see below
- **Less than 10 kg**: MDI not indicated; NEB Still indicated

Nebulized:

- 1.25 to 2.5 mg, may repeat PRN
  * Dilute inhalation solution for nebulization to a total of 3 mL with normal saline if required
  * Note: Nebulization is preferred for patients who are unable to effectively use an MDI or DPI due to age, agitation, or severity of the exacerbation

Concentration Supplied:

- 2.5 mg/2.5 mL; MDI 100 mcg per puff

Reconstitution IV:

- Do not inject undiluted
- Reduce concentration by at least 50% before infusing

Compatibility/Stability:

- Stable in D5W and NS for at least 24 hours at room temperature

- Maximum recommendation concentration 0.5 mg/mL (500 mcg/mL)
- Compatible with NS, D5W and D5-NS solutions
- Compatible with ipratropium nebulizer solutions

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** nebulized with 6 to 8 litres of O2, MDI with spacer
- **ACP:** nebulized with 6 to 8 litres O2, MDI with spacer, ETT
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- SCOP Patient Care Plans (2020)
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/salbutamol.pdf
- Pediatric Advanced Life Support (PALS) 2020
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6292?cesid=2I80Sdw85XZ&hitReason=international-brand name&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dsalbutamol%26t%3Dname%26acs%3Dtrue%26acq%3Dsalb
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5711028
- ACLS for Experienced Providers 2017
- AB and BC EMS protocols (for peds MDI)
- PALS 2020

Dosing of Atrovent and Ventolin should look like this:

- **1 ventolin puff at a time, waiting 30 to 60 seconds between up to 10 puffs.**
  Follow each ventolin with a puff of atrovent 10 seconds post for 5 puffs.
  If the patient in extremis this wait time can be shortened as practitioner feels is appropriate
  Wait 5 to 10 minutes between sets of 10 puffs to observe for effect.
  Repeat sets of 10 puffs up to 3 times (30 puffs)
  Atrovent is only given during the first round of 10 puffs for 5 puffs. Repeat sets are ventolin only.

*How do use Metered-dose inhaler: Shake well before use; prime the inhaler prior to first use and whenever it has not been used for greater than 2 weeks or when it has been dropped by releasing 3 to 4 test sprays into the air away from the face. Airomir [Canadian product] labeling recommends releasing a minimum of 4 test sprays when priming. A valved holding chamber or spacer is recommended for use with an MDI in patients with poor technique and is the recommended medication delivery system in all patients less than or equal to 5 years of age, with the addition of a mask for patients less than 3 or 4 years of age or until proper technique is demonstrated. Remove cap from mouthpiece and shake inhaler. Exhale fully prior to bringing inhaler to mouth. Place inhaler or valved holding chamber mouthpiece in mouth, close lips around mouthpiece, and inhale slowly and deeply while pressing down on the canister with your finger. Remove device and hold breath for as long as possible, up to 10 seconds. Breathe out slowly. If prescribed dose is more than 1 inhalation, wait 1 minute between each inhalation and shake inhaler prior to each inhalation.

Development – May 2023
Update – June 2025

EMS Provincial Medications

Sodium Bicarbonate HIGH ALERT

Classification

- Alkalinising agent - irritant

Indications

EMS INDICATIONS

- Known TCA overdose with QRS widening (greater than 0.10 seconds) or hypotension
- Treatment of suspected Hyperkalemia based on the presence of a SINE wave or Cardiac arrest with history of Renal Failure
- Treatment of suspected Hyperkalemia based on the presence of the following:
    - **A SOURCE** (one of the following):
        - History of kidney disease
        - Chronic renal insufficiency
        - Another condition that would predispose the patient to a condition of hyperkalemia (i.e. rhabdomyolysis, severe burns, severe trauma/crush trauma, tumor lysis syndrome)

      AND
    - **ELECTROCARDIOGRAPHIC EVIDENCE** (one of the following):
        - ECG changes suggestive of hyperkalemia (peaked T waves, loss of P waves, wide QRS and/or symptomatic bradycardia)
        - Patient is in CARDIAC ARREST
- **Routine use in cardiac arrest is not recommended**

SHA EMS Medical Direction Note:

- Sodium Bicarbonate should be administered post placement of ETT/SGA

HEALTH CANADA APPROVED

- *Metabolic acidosis associated with many conditions including severe renal disease (e.g. renal tubular acidosis), uncontrolled diabetes (ketoacidosis – low dose insulin preferred), extracorporeal circulation of the blood, cardiac arrest, and lactic acidosis. Routine use in cardiac arrest is not recommended*
- *When urinary alkalisation is required in the treatment of certain drug intoxications, and in hemolytic reactions*
- *In severe diarrhea when loss of bicarbonate has been significant: as an adjunct in the treatment of hyperkalemia*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN LITURATURE

- *Drug overdose with agents that produce cardiotoxic effects involving sodium channel blockade*
- *Urine alkalinization to reduce frequency of contrast medium-induced nephrotoxicity*

Mechanism of Action

- Dissociates to provide bicarbonate ion which neutralizes hydrogen ion concentration and raises blood and urinary pH

Pharmacokinetics

- **Onset:** Rapid
- **Peak:** Rapid
- **Duration:** 8 to 10 minutes
- **Excretion:** Urine (less than 1%)

Contraindications

- Metabolic or respiratory alkalosis; hypocalcemia (because of an increased risk of alkalosis-induced tetany); excessive chloride loss from vomiting or continuous gastrointestinal suction
- States of hypoventilation: patients at risk of developing diuretic-induced hypochloremic alkalosis e.g. receiving thiazide diuretics: treatment of acute ingestion of strong acids.

Cautions

- **HIGH ALERT**
- Elderly – Contains sodium; caution in those with renal or cardiovascular insufficiency with or without heart failure, or volume overload
- Full correction of acidosis should not be attempted in the first 24 hours of therapy
- Cardiac, liver or renal disease; heart failure, fluid/solute overload and postoperative patients with renal or cardiovascular insufficiency, and those receiving corticosteroids
- Use in cardiac arrest indicated only if prolonged resuscitation with effective ventilation or after return of spontaneous circulation after a longer arrest interval. Adequate alveolar ventilation should control acid-base balance in most arrest situations except prolonged cardiac arrest, arrested patient with pre-existing metabolic acidosis, hyperkalemia, or tricyclic or barbiturate overdose

PREGNANCY

- No reports of human 1st trimester use of sodium bicarbonate in pregnancy have been located. Animal studies have not suggested an increased risk for structural anomalies.
- Contact pharmacy or specialised on-line references for most recent information

BREASTFEEDING

- Contact pharmacy or specialised on-line references for most recent information
- Although sodium bicarbonate is known to be excreted into breast milk, no reports describing its use during human lactation have been located. However, chronic or indiscriminate use of the product as an antacid is not recommended during breastfeeding.

REQUIREMENTS

- Flush line before and after administration

MONITORING REQUIRED

- Blood gases and serum electrolyte concentrations, several times daily during intensive treatment and daily in most other situations
- Urine pH, if goal is to alkalinise urine
- Monitor fluid status for fluid overload
- Follow PADIS for monitoring requirements due to drug overdose
- ECG CHANGES CAUSED BY SODIUM CHANNEL BLOCKADE
    - Comparing current ECGs to old ECGs (if available) is currently important to determine the patient's normal QRS duration, presence of a right bundle branch block (RBBB), and to look for other features of sodium channel blockade

MONITORING RECOMMENDED

EXTRAVASATION

- 8.4% sodium bicarbonate is hypertonic: May cause tissue inflammation and necrosis at IV site and surrounding infiltrated area

TREATMENT

- Discontinue drug immediately and notify physician. If extravasation occurs, stop infusion immediately; leave needle/cannula in place temporarily but do NOT flush the line; gently aspirate extravasated solution, then remove needle/cannula; elevate extremity; apply dry warm compresses

Adverse Effects

HEMATOLOGIC

- Excessive alkalosis
- Hypocalcemic tetany
- Paradoxical intracellular acidosis
- Hypokalemia
- Hypernatremia (edema, heart failure)
- Hyperosmolality

Dosing

***** Dosage is determined by severity of acidosis, laboratory tests, age, weight and clinical condition
**Frequent evaluation is essential during therapy, to monitor fluid and electrolyte changes, and acid-balance

ADULT/ELDERLY

- Hyperkalemic cardiac arrest – 1 mEq/kg **IVP**
- Known TCA or Sodium Channel Blockers OD:
    - Physician to contact Poison & Drug Information (PADIS) 1-888-454-1212 for most current information
    - 1 to 2 mEq/kg **IV** over 1 to 2 minutes; repeat every 10 minutes until QRS interval narrows (QRS wider than 0.10 seconds or hypotensive)

RENAL IMPAIRMENT ADJUSTMENTS

- Excessive sodium loading should be avoided in patients with severe renal impairment

HEPATIC IMPAIRMENT ADJUSTMENTS

- Excessive sodium loading should be avoided in patients with severe hepatic impairment

MISCELLANEOUS

- 1 mmol (1 mEq) of sodium bicarbonate = 1 mmol (1 mEq) each of sodium and bicarbonate ions
- 50 mL 8.4% sodium bicarbonate = 50 mmol (50 mEq) sodium bicarbonate
- Extravasation - 8.4% sodium bicarbonate is hypertonic – See ADVERSE REACTIONS
- May be given by subcutaneous injection if diluted to isotonicity (1.5% solution - 0.178 mmol/L)
- IM: not recommended
- May be given via IO cannulation but acid-base analysis is inaccurate

Concentration Supplied:

- 1 mEq/mL (50 mL preload)

Compatibility/Stability:

- Stability in D5W and NS for at least 24 hours at room temperature and in the refrigerator is assumed
- Compatible with sterile water, dextrose, saline and dextrose-saline combination solutions
- **Incompatible with calcium and solutions containing calcium (e.g. Ringer's and lactated Ringer's solutions)**

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice

- **ACP:** IV, IO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/sodium%20bicarbonate.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7677?cesid=99lNVrHOnnH&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dsodium%2Bbicarbonate%26t%3Dname%26acs%3Dtrue%26acq%3Dsod
- https://web.p.ebscohost.com/nup/detail/detail?vid=5&sid=7784f8a3-b581-475b-ac59-6a53fd087633%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535664&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5712027
- ACLS EP
- ACLS 2020

Development – May 2023
Update – June 2025

EMS Provincial Medications

Thiamine/Vitamin B1

Classification

- Vitamin

Indications

EMS INDICATIONS

- Hypoglycemic patients who have received D50W and appear malnourished
- Prophylaxis and treatment of thiamine deficiency, including Wernicke's encephalopathy and beriberi
- Treatment of acute alcohol withdrawal

HEALTH CANADA APPROVED

- *Prophylaxis and treatment of thiamine deficiency, including Wernicke's encephalopathy and beriberi.*

Mechanism of Action

- Coenzyme for various metabolic functions, including fat and carbohydrate metabolism and protein synthesis, used in cell replication and hematopoiesis

Pharmacokinetics

- **Onset:** Hours
- **Peak:** Days
- **Duration:** Days to weeks
- **Metabolism:** In the liver
- **Excretion:** Urine (as unchanged drug and as pyrimidine after body storage sites become saturated)

Contraindications

- Hypersensitivity to thiamine and any other component of formulation

Cautions

- If possible thiamine administration should precede glucose administration when treating patients for Wernicke's encephalopathy, however glucose administration should not be withheld while awaiting thiamine
- Vitamin deficiency: Single vitamin deficiency is rare; evaluate for other deficiencies
- Patients with suspected hypersensitivity, some manufacturers recommend intradermal test doses, however further details on dosing or recommended monitoring are not given

PREGNANCY

- Thiamine is compatible with pregnancy, but doses above the RDA have limited data.

- Consult pharmacy or specialised on-line references for most recent information

BREASTFEEDING

- The National Academy of Sciences' RDA for thiamine during lactation is 1.4 mg. If the diet of the lactating woman adequately supplies this amount, maternal supplementation with thiamine is not needed. Supplementation with the RDA for thiamine is recommended for those women with inadequate nutritional intake. The American Academy of Pediatrics classifies thiamine as compatible with breastfeeding.

Adverse Effects

CENTRAL NERVOUS SYSTEM

- Feeling of warmth
- Sweating
- Weakness

GASTROINTESTINAL

- Nausea

HYPERSENSITIVITY

- Hypersensitivity reactions, e.g. itching, sneezing, wheezing, or anaphylactic shock. Studies have shown that hypersensitivity reactions can occur with equal frequency by any route. Incidence after IV administration is less than 0.1%. May increase in frequency with repeat injections

Dosing

Adults/Elderly/Pediatrics

- 100 mg **IV push** over 1 minute

ALCOHOL WITHDRAWAL

- Adult 17 years of age and older: 300 mg IV over several minutes

Concentration Supplied:

- 100 mg/mL (1 mL amp)

Compatibility/Stability:

- No stability information available at this time; prepare immediately prior to use
- Compatible with D5W, D10W, NS, dextrose-saline combinations, Ringer's and lactated Ringer's solutions
- **Incompatible with alkaline or neutral solutions (i.e. barbiturates or bicarbonates)**
- **Incompatible with oxidizing and reducing agents. In solutions with sulfites or bisulfites**, it is rapidly inactivated

Provider/Route:

- Can be given IM but **recommended route is IV**
- **EMR:** Not in scope of practice
- **PCP/ICP:** Not in scope of practice
- **ACP:** IM, IV, IO
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/thiamine.pdf
- https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7755?cesid=0QCKK8qRQHE&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dthiamine%26t%3Dname%26acs%3Dtrue%26acq%3Dthia
- https://web.p.ebscohost.com/nup/detail/detail?vid=3&sid=c22b2a91-4356-42c2-8e14-4961cd2f6414%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009535406&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5712090

- https://www.saskhealthauthority.ca/system/files/2023-08/CS-OS-9903-ED-AWS-Adults.pdf

Development – May 2023
Update – June 2025

EMS Provincial Medications

Tranexamic Acid/Cyklokapron HIGH ALERT

Classification

- Hemostatic agent

Indications

EMS INDICATIONS

- Trauma-associated hemorrhage
- Treatment of postpartum hemorrhage

SHA EMS Medical Direction Note:

- IV Infusion

HEALTH CANADA APPROVED

- *Hereditary angioneurotic oedema*
- *Increased local fibrinolysis when the diagnosis is indicative of hyperfibrinolysis, as with conization of the cervix, dental extraction in patients with coagulopathies (in conjunction with antihemophilic factor) epistaxis, hyphema, and menorrhagia (hypermenorrhea)*

NON HEALTH CANADA APPROVED INDICATIONS BUT SUBSTANTIATED IN THE LITERATURE

- *Trauma-associated hemorrhage*
- *Treatment of postpartum hemorrhage*
- *Prevention or treatment of bleeding or other symptoms in indications in which local or systemic hyperfibrinolysis or hyperfibrinogenolysis is considered to be involved: including perioperative bleeding in various types of surgery*

Mechanism of Action

- Forms a reversible complex that displaces plasminogen from fibrin resulting in inhibition of fibrinolysis; it also inhibits the proteolytic activity of plasmin
- With reduction in plasmin activity, tranexamic acid also reduces activation of complement and consumption of C1 esterase inhibitor (C1-INH), thereby decreasing inflammation associated with hereditary angioedema.

Pharmacokinetics

- **Onset:** Unknown
- **Peak:** Unknown
- **Duration:** 7 to 8 hours
- **Half-life**: 2 hours
- **Excretion:** Urine (greater than 95% as unchanged drug)

Contraindications

- Hypersensitivity to tranexamic acid or any component of formulation
- Acquired defective color vision; used as an indicator of toxicity
- Active intravascular clotting process

- Subarachnoid hemorrhage; potential occurrence of cerebral ischemic complications
- Patients with active thromboembolic disease, such as deep vein thrombosis, pulmonary embolism, and cerebral thrombosis
- Hematuria
- GI Bleeding

Cautions

- **HIGH ALERT**
- Disseminated intravascular coagulation (DIC): Use with extreme caution in patients with DIC requiring anti-fibrinolytic therapy
- Renal impairment, due to the risk of accumulation
- Massive renal hemorrhage of any cause; risk of clot retention in renal pelvis
- Uncorrected cardiovascular or cerebrovascular disease due to the complications of thrombosis
- The risk for thromboembolic events may be increased in patients using hormonal contraceptives

DRUG INTERACTION

- Anti-inhibitor coagulant complex/factor IX complex concentrates: Concurrent use is not recommended due to increased risk of thrombosis

PREGNANCY

- No adverse effects attributable to use of tranexamic acid during pregnancy, in either animals or humans, have been reported in the fetus or newborn. The drug crosses the placenta to the fetus, but its reported lack of effect on plasminogen activator activity in the vascular wall (vs. its known effect in the peripheral circulation) may protect the fetus and newborn from potential thromboembolic complications.
- Consult pharmacy or specialized on-line references for most recent information

BREASTFEEDING

- Consult pharmacy or specialized on-line references for most recent information
- The amount a nursing infant would absorb is unknown, as is the effect of the small amount of drug present in milk. The most common adverse reactions observed in adults are nausea, vomiting, and diarrhea. If a woman is receiving this drug while breastfeeding, her nursing infant should be monitored for these effects.

REQUIREMENTS

- Electronic infusion device Ensure given at appropriate rate as can cause hypotension if given quickly

MONITORING REQUIRED

- Monitor for hypersensitivity reaction(s)

RECOMMENDED

- In repeated treatment or if treatment will last more than several (2 to 3) days, a complete ophthalmologic examination (visual acuity, color vision, eye ground, visual fields) should be done before and at regular intervals during treatment
- Seizures with higher dosing
- BP

Adverse Effects

All side effects may subside with reduced dosage or rate of administration

CARDIOVASCULAR

- Hypotension, primarily when administered at a rate greater than 100 mg/minute
- Thromboembolic events (e.g. central retinal artery and vein obstruction, pulmonary embolism), have been reported rarely

CENTRAL NERVOUS SYSTEM

- Seizures; most often with intraoperative high dose use (e.g. greater than 50 mg/kg) and in older patients
- Dizziness

GASTROINTESTINAL

- Nausea/vomiting
- Diarrhea

Dosing

TRAUMA ASSOCIATED HEMORRHAGE ADULT

- **IV Infusion via pump:** 2 g in 100 mL NS infused over 20 minutes

POSTPARTUM HEMORRHAGE

- **IV Infusion via pump:** 2 g in 100 mL NS infused over 20 minutes
- **If you don't have an infusion pump or it is being used by oxytocin infusion:** 2 g in 100 mL NS with 15 drop set by gravity over approximately 20 minutes

RENAL IMPAIRMENT ADJUSTMENTS

- Tranexamic acid blood levels are increased in patients with renal insufficiency. Dose modifications are required in patients with renal insufficiency

Concentration Supplied:

- 100 mg/mL (10 mL vial)

Compatibility/Stability:

- Stable in D5W or NS for 24 hours in the fridge
- Compatible in dextrose, normal saline, dextrose-saline combinations and Ringer's solution

Provider/Route:

- **EMR:** Not in scope of practice
- **PCP/ICP:** Monitor Infusion Only
- **ACP:** IV, IO, CVAD
- **CCP:** As per scope of practice

Resources:

- SHA EMS Medical Director & Advisors
- The Hospital for Sick Children Electronic Formulary
- https://collaboration.web.ehealthsask.ca/sites/smartpump/Monographs/tranexamic%20acid.pdf
- https://online.lexi.com/lco/action/search?q=tranexamic%20acid&t=name&acs=true&acq=tra
- https://web.s.ebscohost.com/nup/detail/detail?vid=3&sid=2f9fa652-b268-44bc-984b-d320f8dd5d99%40redis&bdata=JnNpdGU9bnVwLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=2009565501&db=nup
- https://online.lexi.com/lco/action/doc/retrieve/docid/1090/5712125

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