



CLINICAL GUIDELINES

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Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol Consultations

Phone Numbers

ANMC: Consult: *97 or (907) 563-2662
 Transfer: (907) 729-2337
 PICU Cell for urgent consults: (907) 297-8809
 Providence: ED for on-call specialist: (907) 212-3111
 Trauma: (907) 212-2525
 Alaska Regional Hospital Access Center: (844) 880-5522
 VA/JBER: ED: MD consult number (907) 580-5556
 Transfer: (907) 580-6420
 Admissions 24/7 (907) 580-6423
 Operator: (907) 552-1110
 Harborview Seattle (burns): (888) 731-4791

Remember: Unless you transfer care of the patient, YOU are responsible for orders, documentation and notifying the patient and family of the plan of care.

If you're an SRC provider, you do not have the luxury of paging the provider STAT to bedside. For the purposes of this protocol, the SBAR case presentation and the documentation requirements apply.

Page the appropriate provider in Anchorage

1. ANMC for beneficiaries
2. Providence Hospital or Alaska Regional Hospital for non-beneficiaries
3. Alaska Regional for prison inmate
4. VA or JBER (Joint Base Elmendorf/Richardson) for veterans

Once speaking with the appropriate provider be able to:

1. State your name, title and department (i.e. ER physician, outpatient NP, second year resident, etc)
2. State purpose of call (i.e. quick question, possible admission, management advice.)
3. Provide name, MRN, age, DOB. If the patient is pregnant, give gravity and parity and gestational age in initial sentence, if the patient is a child, give the age in the initial sentence.
4. Be able to use the SBAR method to communicate patient details (see box below)
5. Ask a **specific question** about management.
6. Let accepting physicians know whether you think that the patient can travel by commercial flight or will require air medevac
7. If there is a problem getting an accepting physician for a medevac/transfer or with patient management decisions, see NOTE below

Document consultant advice in the medical record, include date, time, first and last name of consultant and a summary of the advice given.

Provider needs consultation about patient at YKHC

Consult provider is located in Bethel?

No

Yes

Patient is critically ill and the consultant is required at bedside?

Yes

Page provider STAT to come to bedside and assist in management.

If on-going management is required, a decision must be made **immediately** and **communicated** about who will be the primary managing provider giving orders and documenting in the medical record.

Once patient is stabilized, discussion will occur between the primary provider and the consultant regarding documentation of the patient's medical care in the record and ongoing management.

Page the appropriate provider. Have ready the following information:

1. State your name, title and department (i.e. ER physician, outpatient NP, second year resident, etc)
2. State purpose of call (i.e. quick question, possible admission, management advice.)
3. Name, MRN, age, DOB. If the patient is pregnant, give gravity and parity and gestational age in initial sentence, if the patient is a child, give the age in the initial sentence.
4. Be able to use the SBAR method to communicate patient details (see box below)
5. Ask a **specific question** about management.

Provider requesting consult must document consultant's advice in the medical record. Include date, time, first and last name of consultant and a summary of the advice given.

At any time in the process, if the primary provider wants support at the bedside, page the consultant and ask them to come to bedside and provide support

Clear role delineation must occur establishing who is the primary managing provider.

SBAR:

Situation: a concise statement of the problem, a "one-liner"

"This is a 3 year old otherwise healthy girl with a fever..."
 "My patient is a 20 year old G3P2 at 26 weeks with vaginal bleeding..."
 "I'm taking care of a 21 year old male with fever and abdominal pain..."

Background: pertinent and brief information related to the situation

"The labs are normal and CXR shows no infiltrate but her pulse is elevated..."
 "I have performed a sterile speculum exam and there is frank blood in the vault..."
 "The patient's CT show appendicitis and the patient is vomiting all intake..."

Assessment: analysis and consideration of options, what you found/think

"I think she needs a fluid bolus but I am wondering if she also needs a UA..."
 "I think this patient might have an active abortion..."
 "I think this patient has appendicitis and needs to be transferred to ANMC..."

Recommendation: action requested, what you want

"I want your opinion on how much fluid and the need for a UA..."
 "I want you to come in and assess this patient in person..."
 "I would like to transfer this patient via medevac to ANMC..."

NOTE:

If there is a disagreement regarding the management of a patient between the consultant and the primary provider, the primary provider will advise the consultant as to the reason for the disagreement. If a consensus cannot be reached, a third opinion shall be obtained. This can either be from a YK based provider or from a provider from another facility. At any time the Clinical Director on call can also be notified.

This protocol is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by MSEC 11/8/17; updated 3/7/19.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this protocol, please contact
 Ellen_Hodges@ykhc.org.

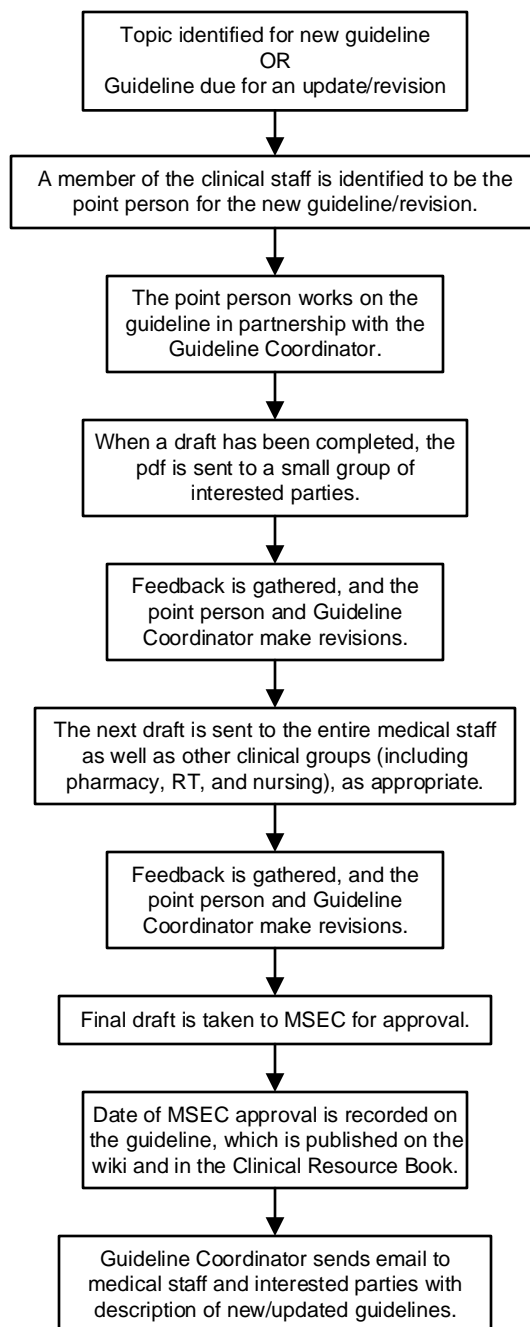


Miscellaneous

- Guidelines are to be reviewed every two years with revisions and updates as appropriate. Updates may happen sooner as needed.
- The Guideline Coordinator will keep track of the guideline review schedule.
- Deadlines for feedback will generally be a period of two weeks.
- Lack of response by email is viewed as assent/lack of disagreement.
- At any time, anyone may send feedback on a guideline to the point person named in the gray box at the bottom of the guideline or the Guideline Coordinator. This feedback will be saved for the next guideline revision.
- Minor changes including (but not limited to) correction of typos, changes in test names, small additions, updating hyperlinks, and changes in contact information may be made and published without MSEC approval.

Wiki

- The long-term goal for the guidelines is for every guideline to have a corresponding supplemental page on the wiki.
- The guideline will be information needed to take care of a patient in the moment.
- The wiki supplement will include references, resources, historical background, past versions, and other information.





Critical Care & Emergency Medicine

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Pediatric Critical Care Weight-Based Guide:

https://yk-health.org/wiki/File:Pediatric_critical_care_guide.pdf



Box 1: Immediate Interventions

- Supplemental oxygen *prn* to maintain SpO₂ 90-96%.
- Aspirin 325 mg PO (chewed).
- Nitroglycerin 0.4 mg sublingual *prn* pain (up to three times as BP permits) unless contraindicated. Contraindications: recent phosphodiesterase use, sBP <90, right ventricular infarct (consider when evidence of inferior wall ischemia).

NOTE: pain relief with nitroglycerin (or lack thereof) is not diagnostic of cardiac ischemia.

Consulting Cardiology

- For all STEMI patients, consult PAMC Cardiology by calling the PAMC ED at (907) 212-3433 and asking for the cardiologist on call. For beneficiary patients, ANMC Cardiology should be made aware of the transfer on a non-urgent basis.
- For NSTEMI-ACS patients, consult ANMC Cardiology for beneficiary patients and PAMC Cardiology for non-beneficiary patients.

Box 2: STEMI Criteria

Symptoms consistent with acute myocardial ischemia AND (A or B):

New ST-elevation at the J-point in two contiguous leads with the cut-point:

- ≥ 1 mm in all leads other than V2-V3
- V2-V3:
 - ≥ 2 mm in men ≥ 40 years old
 - ≥ 2.5 mm in men < 40 years old
 - ≥ 1.5 mm in women

Box 4: HS-cTnT Evaluation for Acute Cardiac Injury

The lowest reported value is "<6 ng/L," which equates to "undetectable."

FDA-approved normal values (99th percentiles in healthy subjects) are:

- Men: <22
- Women: <14
- Change in one hour ($\Delta 1h$) : <3

Cutoffs are arbitrary and do not correspond to any evidence-based positive-predictive value for ACS.

Repeat measurements rely on a rate of change; therefore, repeat measurements should be drawn at exactly one hour (or the chosen interval) after the initial.

This information is from data available February 2020. Please see [wiki page](#) for further information.

Symptoms suggestive of acute coronary syndrome

Perform 12 lead EKG.

Perform immediate interventions. See Box 1.

Consult local expert or cardiologist.

STEMI?
See Box 2.

Yes

No

• HS-cTnT, serial EKGs, and COVID test.
• Consider critical diagnoses. See Box 3.

Consult local expert or cardiologist.

Diagnostic ST/T changes
OR
Diagnostic HS-cTnT elevation or change. See Box 4.

Yes

No

• ACS is ruled out.
• Broaden differential diagnosis.
• Consider a validated risk-stratification scoring tool (like [HEART](#) or [TIMI](#)).
• If patient is high-risk for cardiac complications, consider consultation with cardiologist prior to discharge.
• Discharge with outpatient follow-up as indicated by level of cardiac risk.

Box 3: Critical Differential Diagnosis

- Aortic dissection
- Tension pneumothorax
- Pulmonary embolism
- Perforated peptic ulcer

Disclaimer

- This algorithm is not intended for undifferentiated chest pain without an apparent cause.
- Acute coronary syndrome is defined as acute occlusion of a coronary artery and does not include type 2 MI/ischemia.

<12 hours from symptom onset?

Yes

No

Complete [Fibrinolytic Checklist](#).
Contraindications to fibrinolytics?

No

Yes

Initiate fibrinolytic therapy.
See Box 5.

- Administer additional medications. See table on next page.
- Activate medevac if appropriate.

Diagnosis is NSTEMI-ACS (Non-ST elevation acute coronary syndrome)

Box 5: Fibrinolytic Therapy (Tenecteplase)

Goal: administer ≤ 30 minutes from arrival.
Rapidly complete the fibrinolytic checklist and consent.

Dosing:

- <60 kg: tenecteplase 30 mg IV bolus
- ≥ 60 kg to <70 kg: tenecteplase 35 mg IV bolus
- ≥ 70 kg to <80 kg: tenecteplase 40 mg IV bolus
- ≥ 80 kg to <90 kg: tenecteplase 45 mg IV bolus
- ≥ 90 kg: tenecteplase 50 mg IV bolus

Administer concurrent aspirin, clopidogrel, and anticoagulant therapy. See tables 1 and 2.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by MSEC 12/2/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Megan_Young@ykhc.org and Andrew_Swartz@ykhc.org.



Nitroglycerin (NTG)
 • **Contraindications:** PDE-inhibitor use, cardiogenic shock, RV infarct, sBP<90, marked tachycardia or bradycardia.
 • **Sublingual dosing:** 0.4 mg SL Q5 minutes up to three doses
 • **IV dosing:** start at 10-20 mcg/min, titrate Q3-4 minutes to typical range 60-100 mcg/min

Beta-Blockers
 • No evidence of benefit from routine immediate beta-blocker.
 • Indicated for HTN and/or ongoing ischemia refractory to NTG.
 • **Contraindications:** cardiogenic shock, RV infarct, symptomatic asthma.
 • **Cautions:** risk for cardiogenic shock (bradycardia, HR>110, sBP<120, age>70, increased time since STEMI onset), inferior MI, controlled asthma.

Emergency Department Medication Summary

	STEMI <12 hours	STEMI >12 hours	NSTE-ACS
Oxygen	Maintain SpO ₂ 90-96%	Maintain SpO ₂ 90-96%	Maintain SpO ₂ 90-96%
Nitrates (<i>prn</i> pain, HTN)	Sublingual or drip	Sublingual or drip	Sublingual or drip
Fibrinolytic	Tenecteplase See page 1, Box 5	Not indicated	Not indicated
Aspirin	325 mg PO (chewed)	325 mg PO (chewed)	325 mg PO (chewed)
P2Y ₁₂ receptor blocker	Clopidogrel Age ≤75: 300 mg PO Age >75: 75 mg PO	Clopidogrel 600 mg PO	Consult cardiology.
Glycoprotein IIb/IIIa inhibitor	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.
Anticoagulation	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)
Beta-blocker	Metoprolol 5 mg IV <i>prn</i> Q5 minutes (max 15 mg)	Metoprolol 5 mg IV <i>prn</i> Q5 minutes (max 15 mg)	Metoprolol 5 mg IV <i>prn</i> Q5 minutes (max 15 mg)
Morphine	No longer routinely given; associated with increased mortality. Reserve for significant pain refractory to NTG and beta-blocker.		

Antipletelet agents

At time of Dx unless contraindicated

Enoxaparin Dosing

	Age <75 years and STEMI	Age ≥75 years and STEMI	Any age and NSTE-ACS
Creatinine clearance ≥30 mL/min	30 mg IV + (1 mg/kg SC now then Q12h) Max dose 100 mg	0.75 mg/kg SC Q12h Max dose 75 mg	1 mg/kg SC now then Q12h
Creatinine clearance <30 mL/min	30 mg IV + (1 mg/kg SC now then Q24h) Max dose 100 mg	1 mg/kg SC Q24h Max dose 100 mg	1 mg/kg SC now then Q24h

NOTE: Enoxaparin and unfractionated heparin are NOT dialyzable; ESRD/dialysis patients should receive fondaparinux, which is not on the YKHC formulary. Discuss with cardiologist if appropriate.

Inpatient Medication Summary

**NOTE: The following table is meant to be a basic reference as a starting point.
Please consult Cardiology for full recommendations in all ACS patients.**

ACE-inhibitor	Lisinopril 2.5 – 5 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Statin	Atorvastatin 80 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Beta-blocker	Metoprolol XL 25-50 mg PO Q12-24h <i>prn</i> Give unless contraindicated. Typically started prior to hospital discharge.
Clopidogrel	75 mg PO daily
Aspirin	81 mg PO daily
Enoxaparin	Dose above. Consult Cardiology for duration.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/2/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Megan_Young@ykhc.org and Andrew_Swartz@ykhc.org.



Fibrinolytic Checklist

INDICATIONS (initial yes or no)

YES	NO	
		Presentation consistent with acute coronary syndrome (coronary artery occlusion)
		<p><u>AND</u> at least one of the following:</p> <ul style="list-style-type: none"> • 1 mm J-point elevation in two contiguous leads (other than V₂-V₃) • In leads V₂-V₃ <ul style="list-style-type: none"> Men ≥ 40 years: ≥ 2 mm J-point elevation Men <40: ≥ 2.5 mm J-point elevation Women: ≥ 1.5 mm J-point elevation

ABSOLUTE CONTRAINDICATIONS (initial yes or no)

YES	NO	
		History of <u>any</u> intracranial hemorrhage
		History of prior ischemic stroke, significant closed head injury or facial trauma, or intracranial or spinal surgery in the previous three months
		Presence of a cerebral vascular malformation
		Presence of a primary or metastatic intracranial malignancy
		Symptoms or signs suggestive of an aortic dissection
		Any bleeding diathesis
		Any active bleeding that is severe or has high potential for life-threatening blood loss; this does not include menstrual bleeding
		sBP > 180 and/or dBP > 110 at presentation in patient at low risk of cardiac death (age < 55, no prior MI, and Killip class I).
		Terminal illness, defined as end of life care or documented/expressed patient wish to abstain from high risk or invasive procedures

RELATIVE CONTRAINDICATIONS (initial yes or no) – If any of below are present, used shared decision making with patient.

YES	NO	
		Age 65-74 (ICH relative risk 3.12 [2.54-3.83]); Age ≥ 75 years (ICH relative risk 5.40 [4.40-6.63])
		History of chronic severe poorly controlled HTN
		sBP > 180 and/or dBP > 110 at presentation in patient at high risk of cardiac death (age ≥ 55, Hx prior MI, or Killip class ≥ II).
		History of ischemic stroke more than three months ago
		Dementia OR any known intracranial disease that is not an absolute contraindication
		Traumatic or prolonged (>10 minutes) cardiopulmonary resuscitation
		Major surgery in the previous three weeks
		Internal bleeding in the previous 2-4 weeks
		Active peptic ulcer
		Non-compressible vascular punctures
		Pregnancy
		Current warfarin therapy (the risk of bleeding increases as the INR increases)

This checklist is advisory for clinical decision-making and may not be all-inclusive. Risks and benefits will need to be assessed individually.

Physician signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.



PROCEDURE CONSENT

I hereby authorize _____ and such assistants as he/she may designate, to perform the following operation or procedure:

TECHNICAL DESCRIPTION

Intravenous thrombolytic therapy for acute STEMI (ST-elevation myocardial infarction).

LAY DESCRIPTION

Give clot-dissolving medication through an IV to dissolve the clot which is causing a heart attack.

_____ has discussed with me the information briefly summarized below:

BENEFITS

- When PCI is not available within two hours, thrombolytic medication is the "standard of care" for achieving coronary reperfusion within 12 hours of acute STEMI onset.
- When administered within 6 hours of pain onset, about 1 in 40 persons will have their life saved.
- When administered between 6-12 hours after pain onset, about 1 in 60 persons will have their life saved.
- Decreased risk of developing heart failure.
- A STEMI patient who receives thrombolytic medication is about 3-5 times more likely to have their life saved than to have brain bleeding (see below).

RISKS

(some, but not all)

- About 1 in 100 persons will experience non-life-threatening bleeding.
- About 1 in 100-250 persons will experience bleeding into the brain which usually results in either death or significant disability.

**RISKS OF NOT HAVING THE
PROCEDURE**

- Higher risk of death.
- Higher risk of developing heart failure.

ALTERNATIVE TREATMENTS

None are available at this facility.

Patient signature: _____

Printed name: _____ Date and time: _____

Witness signature: _____

Printed name: _____ Date and time: _____

Physician signature: _____

Printed name: _____ Date and time: _____

Witness signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.



Consult ANMC Cardiology to confirm indication, consider alternative, and discuss need for antiarrhythmic drugs prior to procedure.

Ensure that patient had no solid food x 6 hours and no clear liquids x 3 hours.

1. Obtain BMP, magnesium, CBC, PT/PTT: patient should have no significantly abnormal electrolytes, decompensated COPD, or active infections.
2. Obtain digoxin level if applicable.
Procedure may be done on patient with therapeutic digoxin level and no evidence of toxicity.

Obtain consent for procedure.

Anesthesia present with full ACLS setup, including meds and temporary pacer. Anesthesia obtains consent for sedation/anesthesia.

Shave off significant hair.

Position conductive pads or paddles with adequate gel (pads preferred).

Note: Position posteriorly below left scapula and anteriorly just to right of sternum and over right upper parasternal to left cardiac apex.

Set defibrillator to SYNCHRONIZED shock. Verify that device is correctly synchronizing on the QRS complex.

Administer anesthesia/sedation

Note

Rare complication: V-tach or V-Fib usually occurs when shock delivered in UNSYNCHRONIZED MODE. Brief ventricular ectopy occurring post shock is of no clinical significance. If sustained V-tach or V-fib, deliver an UNSYNCHRONIZED SHOCK AT 360 J.

Deliver synchronized shock at 50 J

Note

Try to deliver all shocks during expiration.

Persistent bradycardia with hypotension?

No

Yes

Refer to ACLS protocol

Atropine
0.5 mg
IV x 2 if needed.

No

Continued bradycardia or hypotension?

Yes

Dopamine
5-10 µg/kg per minute for vasopressor dose.

Severe bradycardia (<20 bpm) or asystole >10 sec?

No

Yes

Set defibrillator to PACE mode.

Begin with 80 mA and increase every 5 sec until Ventricular capture obtained.

Restoration of sinus rhythm?

No

RESYNCHRONIZE.
Repeat shock at 100 J.

Restoration of sinus rhythm?

No

RESYNCHRONIZE
Repeat shock at 100 J, consider increase to 200 J

Restoration of sinus rhythm?

No

Move anterior pad to left parasternal, RESYNCHRONIZE and repeat shock at 360 J.
*A total of 4 shocks will be given before the procedure is declared unsuccessful.

Yes

Yes

Yes

Patient with a new or changed prescription for an antiarrhythmic drug?

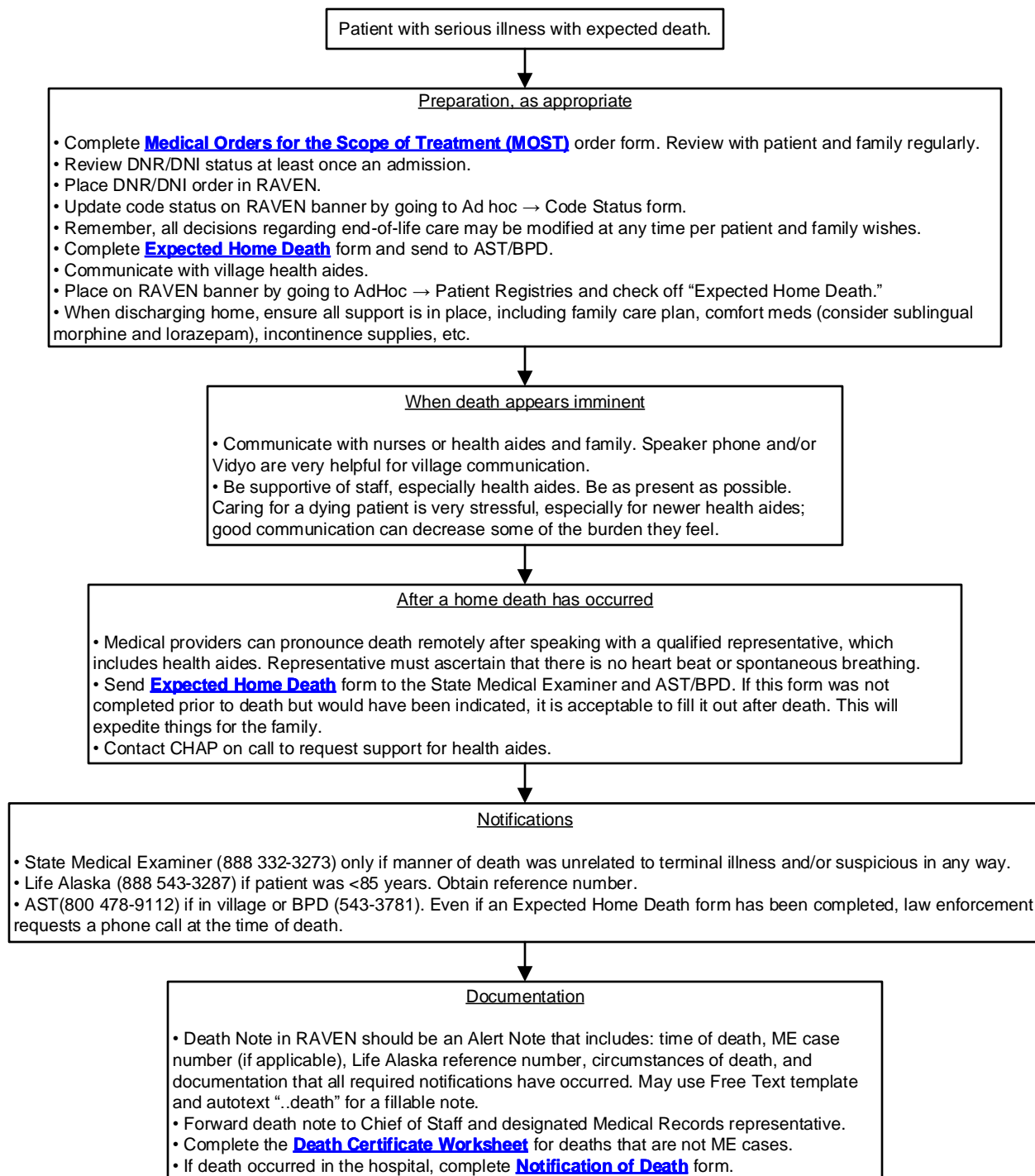
Yes

Monitor patient for 48 hours and consult ANMC cardiology for further future treatment plan.

No

Patient to be observed and discharged per post-anesthesia criteria.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 6/22/11.
Click [here](#) to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.



Helpful Phone Numbers

- Alaska State Medical Examiner: 888 332-3273
- Life Alaska: 888 543-3287
- Alaska State Troopers (AST): 800 478-9112
- Bethel Police Department (BPD): 543-3781

Helpful Forms

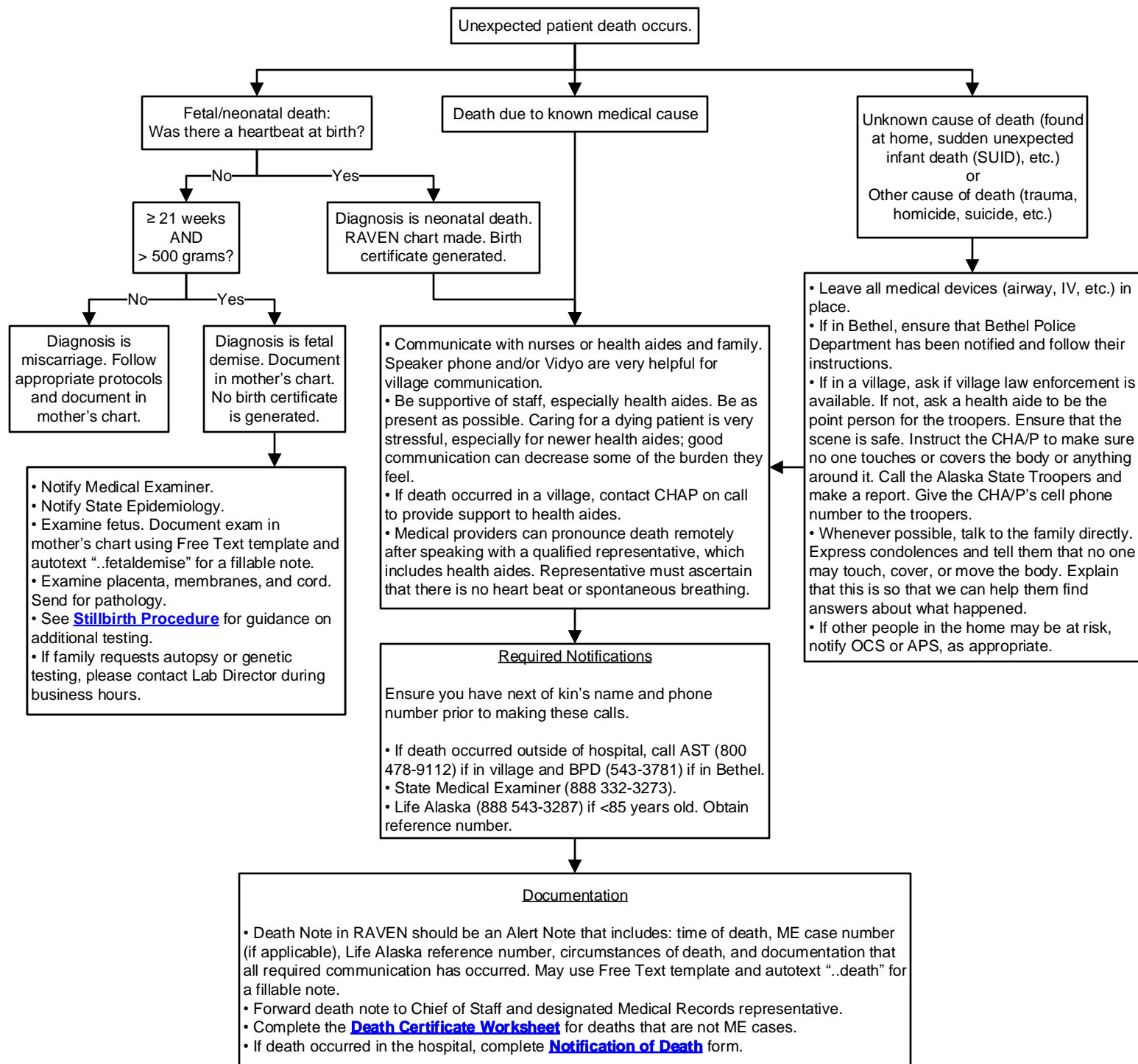
Note: Copies of the death packet are also kept on the inpatient unit.

- [Medical Orders for the Scope of Treatment \(MOST\)](#)
- [Expected Home Death](#)
- [Death Certificate Worksheet](#)
- [Notification of Death](#)

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 9/2/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.



Helpful Phone Numbers

- Alaska State Medical Examiner: 888 332-3273
- Life Alaska: 888 543-3287
- Alaska State Troopers (AST): 800 478-9112
- Bethel Police Department (BPD): 543-3781
- State Epidemiology: 907 269-8000
- OCS Intake (for reports): 800 478-4444
- APS Intake (for reports): 800 478-9996

Helpful Forms

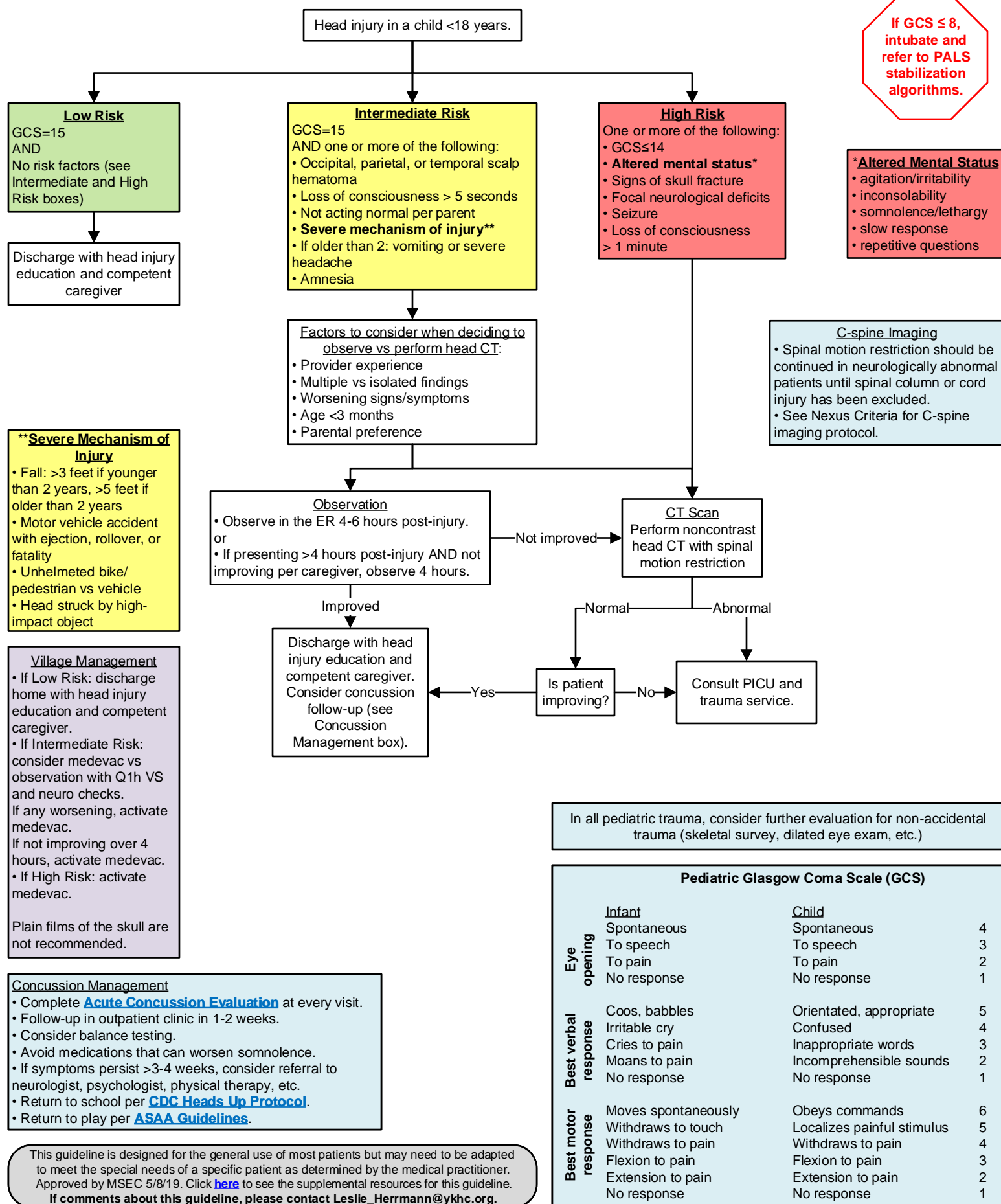
Note: Copies of the death packet are also kept in the ED and inpatient.

- [Death Certificate Worksheet](#)
- [Notification of Death](#)

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Approved by MSEC 9/2/20.

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**REMEMBER:**

- No pediatric patient may be kept at YKDRH on HFNC unless medevac is on weather-hold.
- Maintain patient on HFNC until medevac arrival.
- Requirements for HFNC:

- The patient must have 1:1 nursing care until he/she has stabilized. After stabilization, nursing care may be 2:1 until medevac arrival.
- The patient must have a respiratory therapist at bedside until stabilized.

- Prior to starting HFNC, physicians, bedside nurses, charge nurses, and RT will huddle to determine which unit will care for the patient. This will be decided on a case-by-case basis.

Considerations include:

- How long is the patient expected to remain at YKDRH? Will that time exceed the time provided by an H-cylinder?
- How much risk will be added by moving the patient after stabilization on HFNC?
- Experience level of nurses who will care for the patient.

- All newborns on HFNC must remain in the nursery.

Flow Rates

Titrate flow to 0.5-2 LPM/kg.

Younger patients often require higher flow rates per kilogram.

Consult the PICU for any patient requiring >1 LPM/kg.

Listen to lungs with each adjustment. If child is unable to easily exhale or complete an exhalation, decrease flow rate until exhalation is adequate.

Troubleshooting

- Consider NG/OG-tube for decompression.
- Use a pacifier to keep the patient's mouth closed and prevent loss of pressure. Consider Sweet-Ease.
- Try environmental changes to comfort a fussy baby: caregiver may hold patient in semi-recumbent position, patient may be swaddled, patient may be fanned if hot, lights may be dimmed, etc.
- Consider mild anxiolysis in consultation with medical control.
- Consider higher levels of flow to improve washout.

Patient with moderate to severe sustained retractions or sustained hypoxia <88% not improved with **SUPPORTIVE MEASURES** (see box) and 2 LPM conventional nasal cannula or infant with apnea responsive to stimulation

Page respiratory therapist.

Page pediatrician on-call.

- Determine optimal patient location with team.
- Activate medevac.
- **PREPARE PATIENT** (see box).

RT to start high-flow nasal cannula with pediatrician consultation.

Initial Settings

See Flow Rates box to left.

FiO2 50%, 37°C.

For newborns, consult neonatologist.

Titrate flow by 1 LPM increments over first 3 minutes until improvement in WOB. If patient is worsening on high flow rates, consider a lower flow rate.

Titrate FiO2 to maintain sats >92%.

Frequent gentle nasal suction as needed.

Reassess at least every 20-30 minutes.

Signs of Clinical Improvement

- ↓RR
- ↓retractions
- ↓irritability
- improved air movement

Maintain current settings until medevac arrives.

If no improvement, consider obtaining ANMC PICU consult, checking blood gas, increasing supportive measures, intubation, etc.

SUPPORTIVE MEASURES

- Control fever, as it can be an independent cause of respiratory distress.
- Nasal suction.
- IV hydration.
- Consider back-to-back nebs with albuterol or normal saline.
- Consider phenylephrine nasal spray to each nostril once.
- Consider hypertonic saline nebs q6h.

PREPARE PATIENT

- Make patient NPO.
- Ensure reliable IV access.
- Suction nares well.
- Choose a nasal cannula with prongs that do not occlude more than 50% of the nares.
- Position patient: optimal patient position is semi-recumbent, not supine or upright. Consider using blue seat (stored in the ED) with adjustable angle. Use blanket rolls to support position and ensure patient is not slumping over. Caregivers may hold the child if it helps keep him/her calm as long as the child is at a ~45 degree angle.
- To prevent condensation causing problems, place patient at a higher level than unit and clip tubing to patient's clothing.

NOTE:

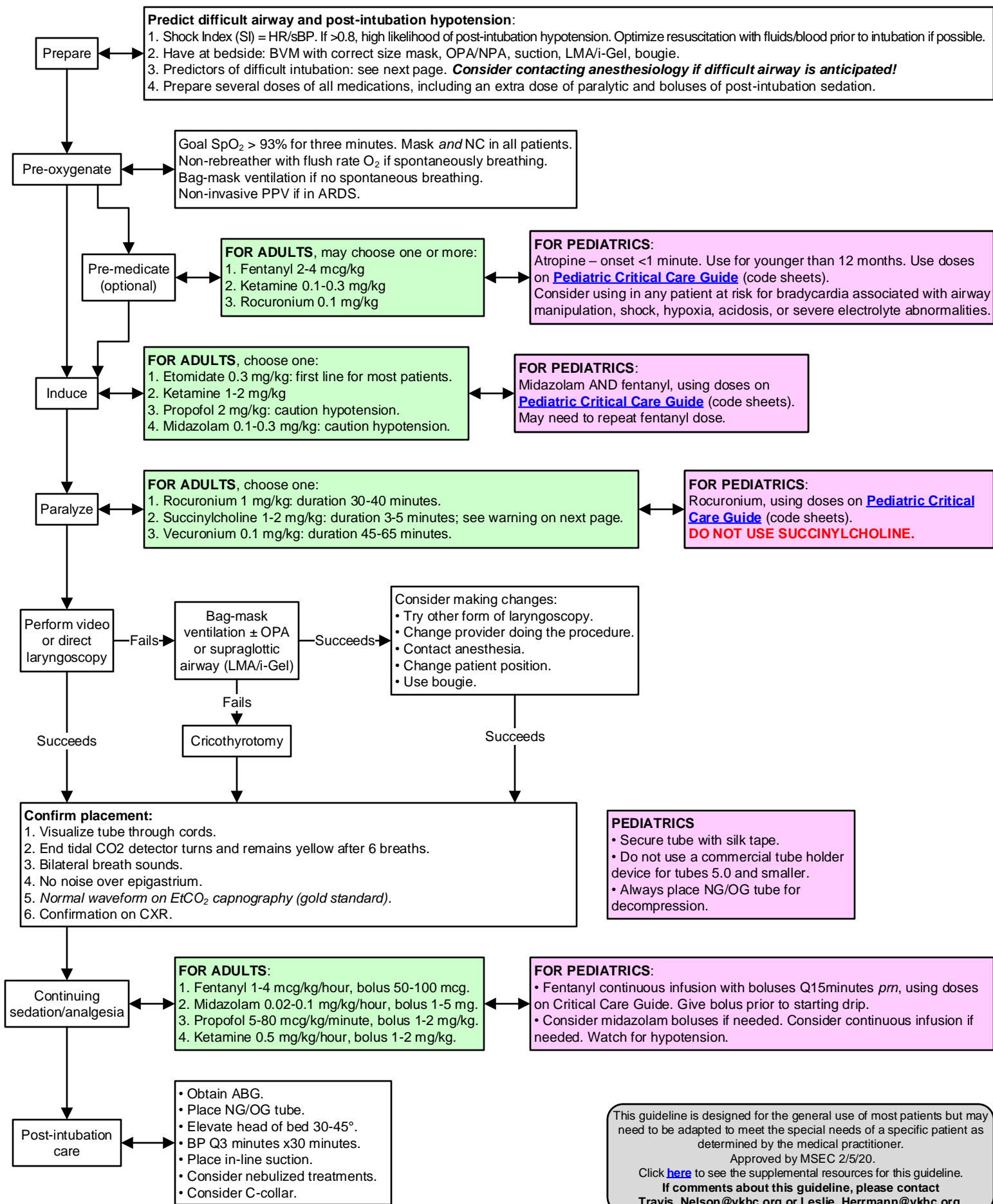
- Low-flow cartridge to be used with neonatal/ infant cannula and produces flow rates of 1-8 LPM. This should only be used in patients ≤ 4 kg.
- High-flow cartridge to be used with larger cannula and produces flow rates of 5-40 LPM.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by MSEC 4/14/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Leslie_Herrmann@ykhc.org.





Supplement I: Predictors of Difficult Intubation

Predictors of Difficult Intubation

- Mallampati grade 3 or 4
- Cormack & Lehane grade 3 or 4
- Wilson score of > 2
- LEMON system; objective/subjective scoring

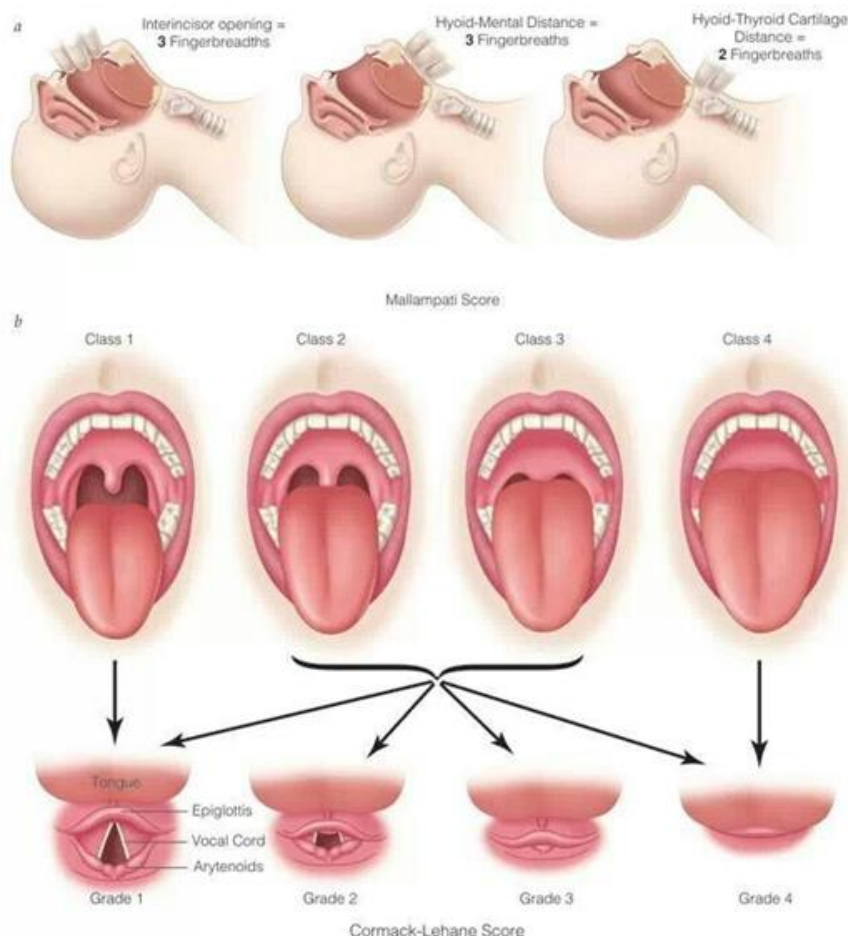
Wilson Score

	0	1	2
Weight (kg)	< 90	90-110	> 110
Head and neck movement	> 90°	~ 90°	< 90°
• Inter-incisor gap (cm)	> 5	= 5	< 5
• SL (maximum forward protrusion of lower incisors beyond uppers)	> 0	= 0	< 0
Receding mandible	None	Moderate	Severe
Buck teeth	None	Moderate	Severe

LEMON System

L	Look: trauma, large tongue
E	Evaluate 3:3:2 rule.
M	Mallampati score ≥ 3
O	Obstruction
N	Neck mobility (limited)

Helpful Resource: [the Difficult Airway App](#)



Supplement II: Use of Succinylcholine

Absolute contraindications:

Family / personal history of malignant hyperthermia
Hyperkalemia; if unknown K, obtain EKG for peaked T's
Upper motor neuron injury, denervating neuromuscular disease
Use after acute phase of burns, major trauma, crush injury

Relative contraindications:

Elevated ICP
Pseudocholinesterase deficiency

Treatment of malignant hyperthermia:

Dantrolene 2.5 mg/kg IV, redosing based on expert guidance

**ARDS/Protective Ventilation Protocol (appropriate for most patients without indication for alternate ventilation):****Initial Ventilator Settings:**

(1) Set Tidal volume (V_t) = 6-8 mL/kg using Ideal Body Weight. See [MDCalc Tidal Volume Calculator](#).

(2) Reduce V_t by 1 mL/kg every 1-2 hours until V_t 6 mL/kg.

(3) Set initial rate to 18-35 bpm based on pre-intubation rate.

Obstructive lung disease: Consider lower RR to maximize expiratory phase.

(4) Set initial PEEP at 5 cm H₂O.

• If BMI > 30, set PEEP to 8 cm H₂O.

• If BMI > 40, set PEEP to 10 cm H₂O.

(5) Set initial FiO₂ at 30-40%; adjust to SpO₂ 88-95%.

(6) Set inspiratory flow rate 60-80 lpm.

Obstructive lung disease: Consider inspiratory flow rate 80-100 lpm

Adjust settings based on patient status, blood gases, CXR, and expert consultation.

Oxygenation goal: PaO₂ 55-80 mmHg or SpO₂ 88-95%.

Use a minimum PEEP of 5 cm H₂O. Consider use of incremental FiO₂/PEEP combinations such as shown below (not required) to achieve goal.

For all modes of ventilation:

- Initial vent setting are based on patient presentation.
- Vent settings are adjusted based on patient tolerance of mechanical ventilation and ABG results.
- Obtain ABG prior to intubation, 30 minutes following intubation, and 30 minutes after vent changes.
- Goal plateau pressure < 30 cm H₂O; decrease T_v to lower PP.
Obese patients may require higher plateau pressure
- Target pH > 7.30; increase RR to control hypercapnia.
- Avoid intubation if possible in patients with obstructive lung disease; maximize use of NIPPV.

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Approved by MSEC 2/5/20.

Click [here](#) to see the supplemental resources for this guideline.

**If comments about this guideline, please contact
Travis_Nelson@ykhc.org.**



Exclusion criteria

Any hemorrhage on CT
BP > 185/110
NIHSS* < 4 or rapidly improving exam
Hx suggestive of SAH even with normal CT
INR > 1.7 or on heparin with elevated PTT
Platelets < 100,000
Seizure at onset of symptoms
History of any of the following:

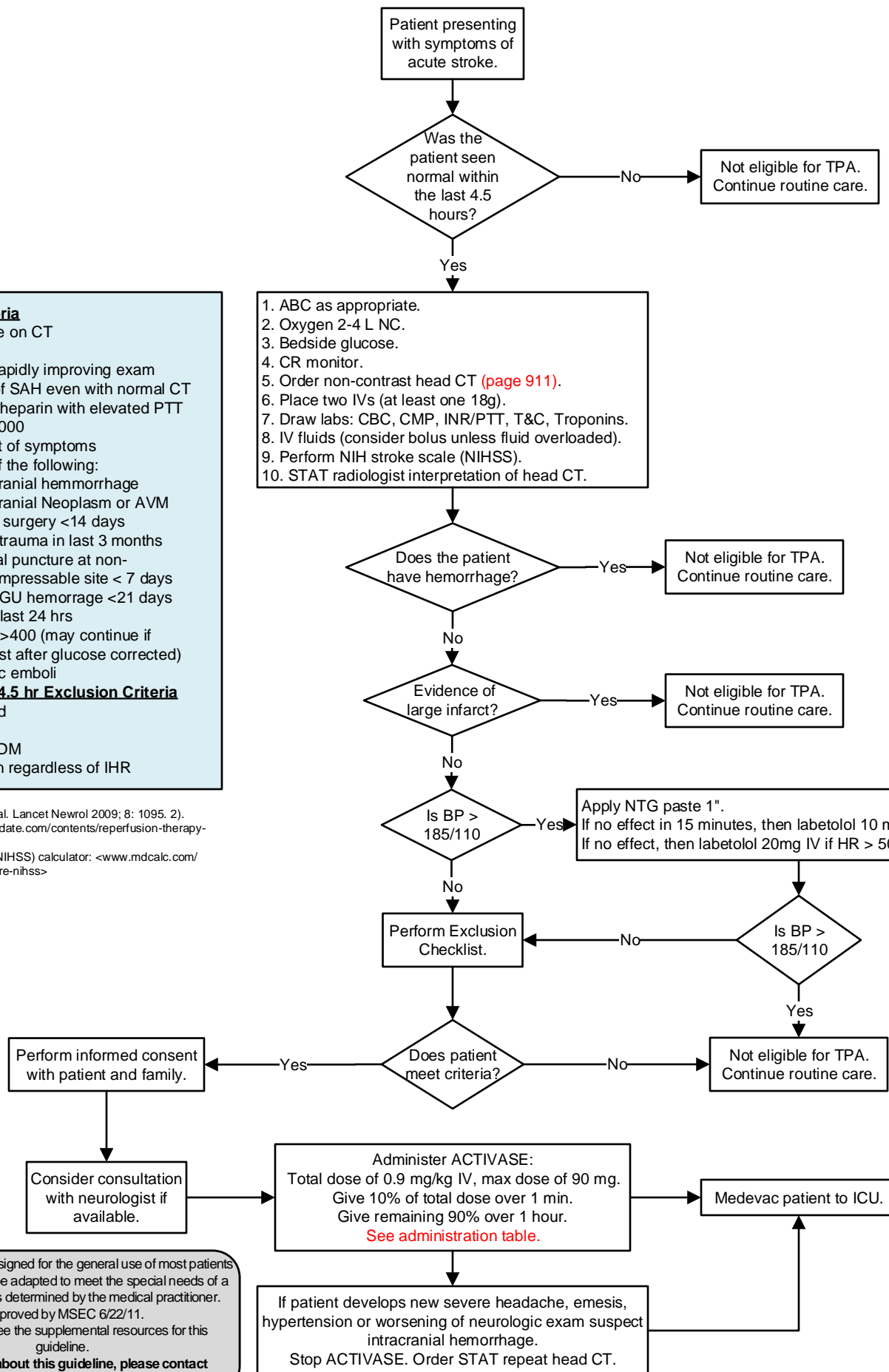
- intracranial hemorrhage
- intracranial Neoplasm or AVM
- major surgery < 14 days
- head trauma in last 3 months
- arterial puncture at non-compressible site < 7 days
- GI or GU hemorrhage < 21 days
- LP in last 24 hrs

Glucose < 50 or > 400 (may continue if symptoms persist after glucose corrected)
Presumed septic emboli

Additional 3-4.5 hr Exclusion Criteria

- age > 80 yrs old
- NIHSS* > 25
- Prior stroke + DM
- anticoagulation regardless of IHR

Ref: 1). FCASS 3 trial. Lancet Neurol 2009; 8: 1095. 2).
Uptodate .www.uptodate.com/contents/reperfusion-therapy-for-acute-stroke>
*NIH Stroke Scale (NIHSS) calculator: <www.mdcalc.com/nih-stroke-scale-score-nihss>



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Approved by MSEC 6/22/11.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Tara_Lathrop@ykhc.org.

Indications for medevac:

- Patient is in danger of losing:
 - Life
 - Limb
 - Eyesight
- Preterm labor

NOTE: In the event of multiple medevacs, the ED physician in collaboration with medevac dispatch prioritizes the medevacs.

Occasionally, a charter may be able to fly when a medevac cannot. Consider this option if on weather-hold.

Village to Bethel Collaboration

Village Health Aide collaborates with provider (hospitalist or ED physician) to make decision if medevac is indicated

Consult ED physician for centralized medical control.

If patient is NOT a beneficiary, ask if he/she has a preferred medevac company. If not, suggest they [register for LifeMed insurance online](#).

Activation of Medevac

Activating provider calls medevac dispatch with patient's name, DOB, village, and diagnosis. If applicable, dispatch will ask for escort's name and weight.

LifeMed Dispatch 1-800-478-5433

Complete the Patient Transport Order (PTO) and ensure it is faxed to **5-543-1262** and **x6099**.

Managing physician is either ED physician or hospitalist who activated. If hospitalist continues to manage, must keep ED physician updated.

Managing physician calls village Health Aide to get updates and continues to keep records in RAVEN.

Dispatch Process

1. Selected medevac dispatch notifies their medevac team.
If medevac cannot launch (weather, runway lights, etc.) dispatch will notify managing physician. Pilot will continue to check weather.
2. Receiving unit clerk faxes PTO and face sheet to medevac crew.
3. Medevac crew contacts health aide and managing physician as needed.
4. If there is a prolonged delay, medevac crew will contact the managing physician and health aide.
5. In extenuating circumstances, patient may need direct transport to Anchorage from village. After obtaining an accepting physician in Anchorage, managing physician will work with medevac dispatch for transport logistics.

In the event that a medevac is cancelled (patient deemed stable to come in on scheduled flight) medevac dispatch and receiving department must be notified by the managing physician immediately.

Medevac launches

1. Once in village, medevac crew calls managing physician to give report, establish treatment plan, and give ETA in Bethel.
2. Managing physician keeps receiving charge nurse informed of patient status/ETA of medevac.

Arrival in Bethel

Patient care is transferred to receiving unit and medevac crew gives report to staff.

Consider Transfer Direct to Anchorage ("ramp-to-ramp") when:

1. Obvious need for acute surgical intervention
 2. Hemodynamically stable intubated patients
 3. Hemodynamically stable acute MI patients
 4. Level III Trauma Center indicated.
 5. Other extenuating circumstances
- Discuss with medevac team if considering ramp transfer.**
Remember to call ED at receiving facility to discuss transfer.

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Approved by MSEC 2/5/20.

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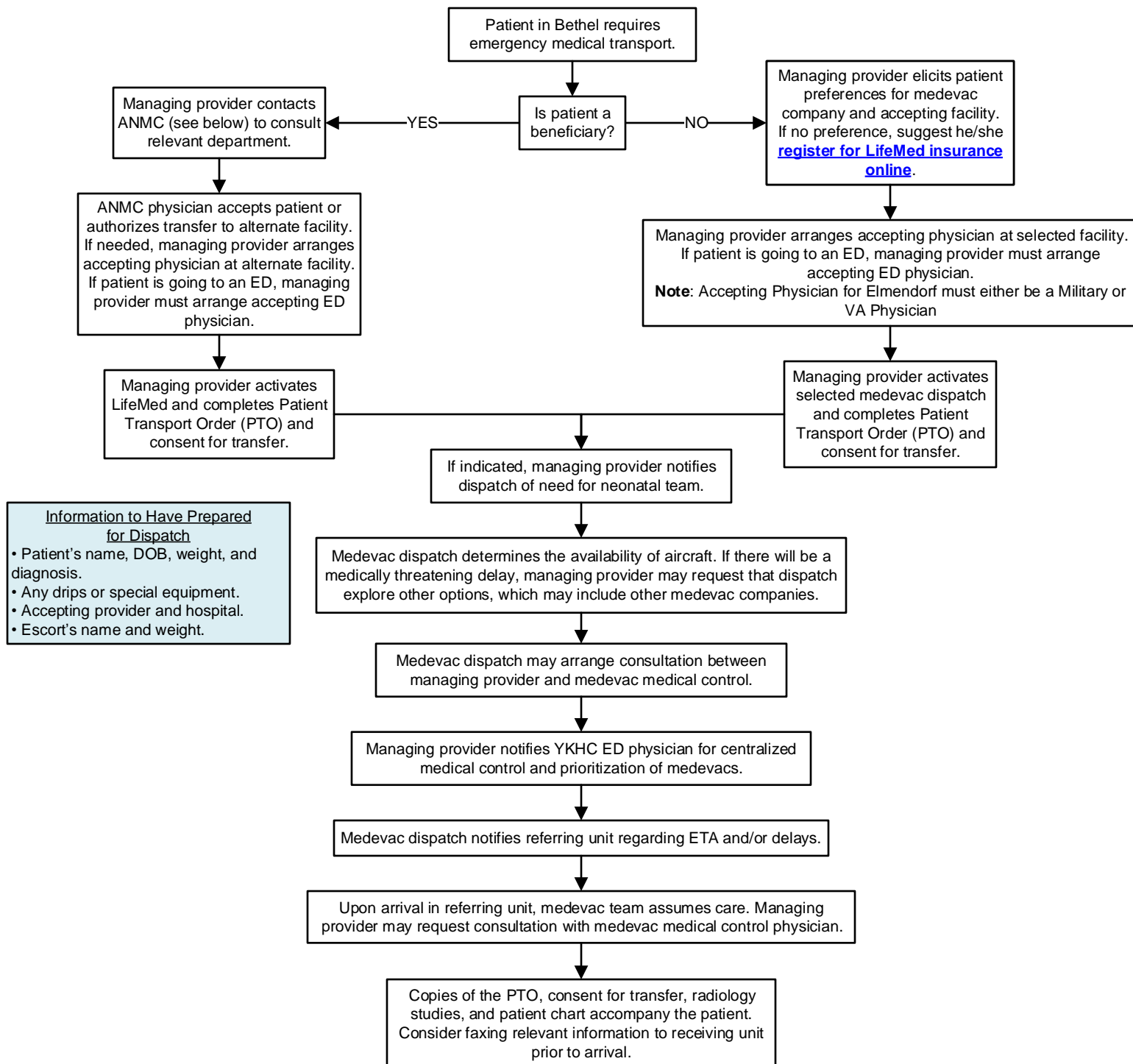
If comments about this guideline, please contact
Chloe_Wurr@ykhc.org.



Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Medevac Activation: YKHC to Anchorage



Phone Numbers

- **LifeMed Dispatch:** 1-800-478-5433 or dial *96.
- **Alaska Native Medical Center:**
Transfer Center (open 10 am – 10 pm): (907) 729-2337. May send Tiger Text to ANMC Transfer Center Coordinator.
After hours, call main operator at *97 or (907) 563-2662
ED: (907) 729-1729
- **Providence Alaska Medical Center:**
Trauma Transfer: (907) 212-2525
ED: (907) 212-3111
Main line: (907) 562-2211
- **Alaska Regional Hospital Transfer Center:** (884) 880-5522
- **Joint Base Elmendorf Richardson Hospital ED:** (907) 580-5556 or (907) 580-5554
- **Department of Corrections On Call:** (844) 751-4588

If patient is an inmate:

Physician must contact the Department of Corrections On Call line so that arrangements can be made for public safety.

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Approved by MSEC 2/5/20.

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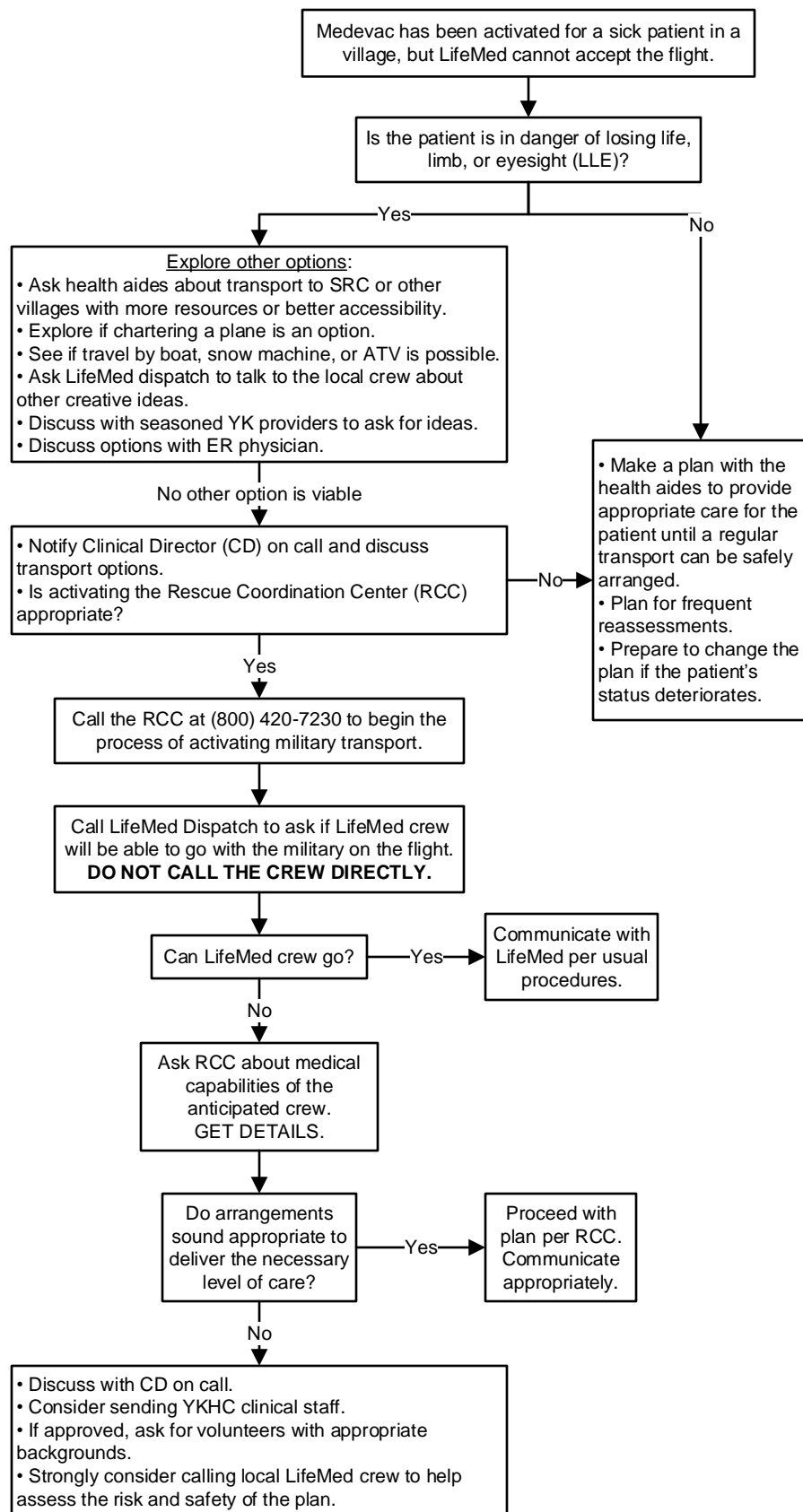
If comments about this guideline, please contact
Chloe_Wurr@ykhc.org.



Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Military Transport for Emergencies



Things to Consider

The local LifeMed team can sometimes go on a military flight. This decision is up to the local team and their administration and depends on many factors.

If the transport team is all military:

- Will military transport inappropriately lower the level of care the patient is receiving?
- What are the capabilities of the military team? Are they pararescue jumpers (PJs), paramedics, EMTs, etc.?
- What kind of equipment will the military team have?
- Does the military team have pediatric experience and equipment, if applicable?

If you are sending a team from YK:

- Will sending a team of YK employees impact the normal operations of the hospital? (You should avoid sending anyone scheduled to work the current or next shift.)
- An ideal YK team includes an ER RN and/or paramedic. Transport/EMS experience is a must.
- **A YK team must be entirely voluntary.**
- Ensure the team will have all appropriate drugs, weight-based equipment, monitors, pumps, stretchers/backboards, etc.
- Make a plan to keep the patient warm – the military will usually not supply blankets, Doctor Downs, etc.
- **If military transport is used, no YK trainees (residents, students, visitors, etc.) or other “ride-alongs” are allowed to go.** Ride-alongs may only go on LifeMed transports with the local team on their fixed wing aircraft.

Things to Know

- The RCC coordinates military missions. They will connect you with the appropriate people from the branch responding, which may be the National Guard, the Coast Guard, or the Air Force.
- You may have to retell the story to several people, including people with minimal medical knowledge. It helps to involve another provider to help coordinate the many phone calls without negatively impacting patient care.
- The process often takes 6-8 hours or more. If the Blackhawk and a full crew are not physically in Bethel, the military may have to send aircrafts from elsewhere in Alaska, which can lengthen the process to 10-12 hours.

Definitions

LLE: life, limb, or eyesight in danger
 CD: clinical director
 RCC: Rescue Coordination Center
 PJ: pararescue jumpers. These are military medics with ACLS and ATLS training who are not trained to provide further critical care. (For example, ventilator management and infusion of medications are not typically part of their scope of practice.)

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
 Approved by MSEC 12/11/19.

Click [here](#) to see the supplemental resources for this guideline.

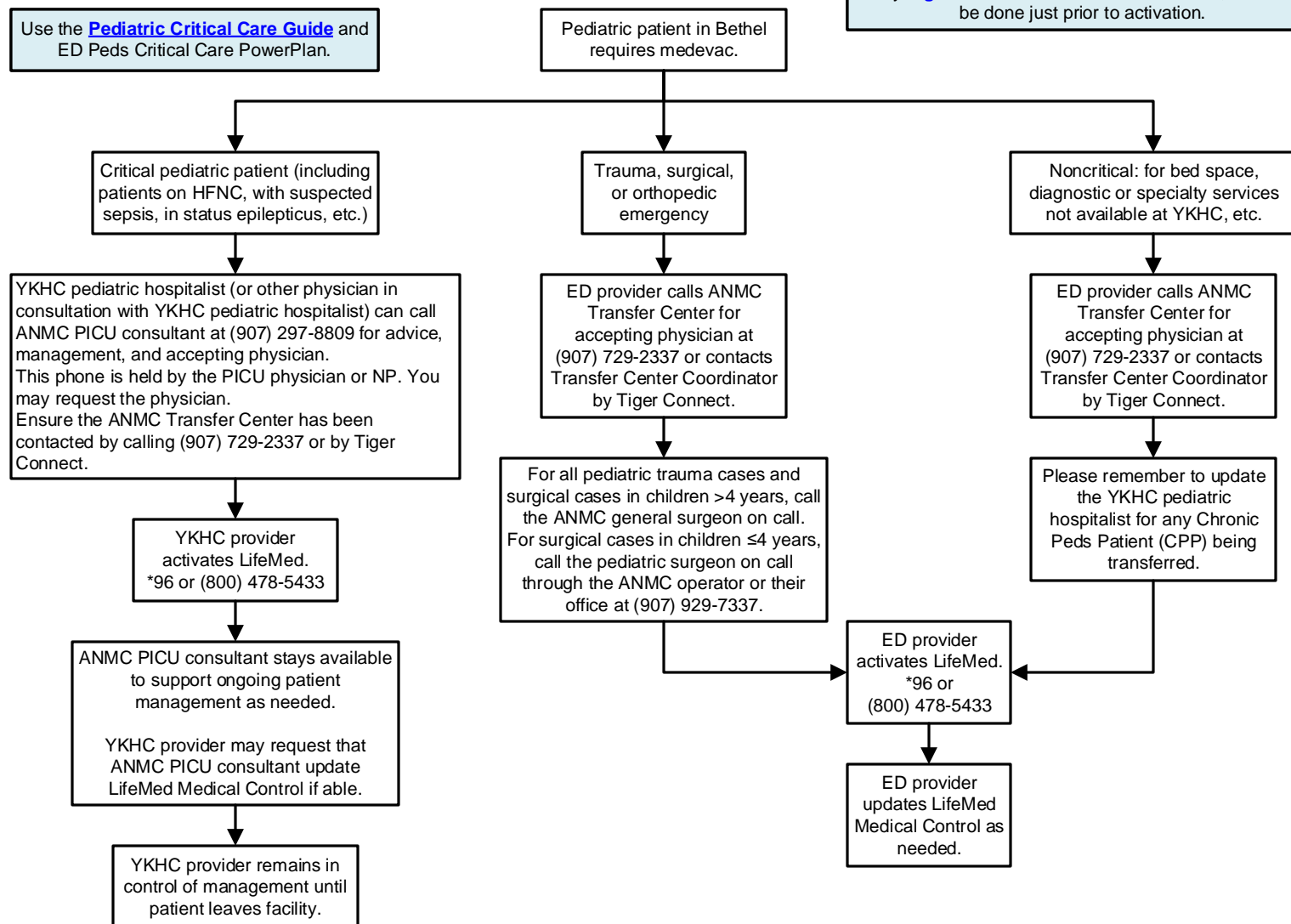
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.



Call YKHC pediatric hospitalist via Tiger Connect "Peds Wards On Duty" for all potentially critical pediatric patients.

Use the [Pediatric Critical Care Guide](#) and ED Peds Critical Care PowerPlan.

Remember: non-beneficiary patients are transferred to Providence Alaska Medical Center. Call their PICU at (907) 212-3133 to obtain accepting physician (PICU or hospitalist). Ask about medevac insurance coverage. May suggest family [register for LifeMed insurance](#) online, which can be done just prior to activation.



Neonatal Transfers

Contact PAMC neonatologist at (907) 212-3614 for advice, management recommendations, etc.

Notify ANMC pediatric hospitalist on-call for any beneficiary infant transferred to PAMC NICU.

When to Transfer to PAMC NICU:

- GA <32 weeks
- BW <1500 grams
- Any newborn who required intubation
- Newborns requiring prompt surgical or medical subspecialty care
- No beds available at ANMC or non-beneficiary infant requiring transfer
- Discretion of NNP

When to Transfer to ANMC NICU:

- GA 32-34 weeks
- BW 1500-2200 grams
- Any baby who meets criteria for transfer per the Late Preterm guideline
- Term or early term babies with temperature instability, respiratory distress, supplemental O₂ requirement, hypoglycemia requiring IV treatment, need for IV antibiotics, etc.

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Indications for Procedural Sedation

Any procedure that cannot be accomplished with patient's current level of cooperation or pain tolerance.

Examples:

- Nonemergent chest tube placement
- Cardioversion
- I&D
- Laceration repair
- Fracture or joint dislocation reduction
- Pediatric foreign body removal
- Imaging

Airway Risk Assessment

See [Intubation guideline](#) for resources.

High-Risk History

- Stridor
- Obstructive sleep apnea
- Hx Trisomy 21
- Dysmorphic facial features
- Active respiratory tract infection
- Hx of difficult intubation
- Hx of cervical spine pathology

Exam

- Check that patient can open mouth fully and that TMJ function is normal.
- Look for micrognathia, loose teeth, dental appliance, and craniofacial abnormalities.
- Check that patient is able to extend neck >70°.
- Determine Mallampati Score and check 3-3-2 rule (in adults).

Expected Sedation Risk Level

Airway Risk Assessment combined with expected depth of sedation should guide level of rescue preparation.

1. **No risk factors present:** No high risk findings in airway assessment and exam, ASA I-II.
Plan: standard monitoring and equipment, including:
 - Cardiopulmonary monitor (three lead ECG & RR)
 - Pulse-oximetry
 - Supplemental oxygen should be prepared but not given unless otherwise indicated.
 - BVM in room.
 - Suction.
 - End-tidal CO₂ monitor
 - Reversal agents in room.

2. **Risk factors present:** some concern for airway status based on airway assessment and exam, but patient not expected to decompensate, and benefits of sedation outweigh risks.

Plan: discuss risks with patient/caregiver.

In addition to standard monitoring and personnel, the following must also be present:

- A healthcare provider dedicated to airway management (preferably an RT)
- Oral airway – correct size open and at bedside
- Nasal trumpet – correct size open and at bedside
- BVM with appropriately-sized mask should be open and prepared at bedside

Note: Consider CRNA at bedside.

Does provider have privileges for procedural sedation?

No → Seek out colleague with privileges or Page CRNA on call.

Yes

Patient has a condition that meets indications.

There are no contraindications.

Perform Airway Risk Assessment. See box.
Determine Expected Sedation Risk Level and plan accordingly. See box.

Discuss risks and benefits of procedural sedation with patient/guardian.
Obtain written consent.

Ensure all equipment is present for Expected Sedation Risk Level.
(See box.)

Choose appropriate sedation medication. See page 2.
Calculate appropriate dose and confirm with team.

Perform time out:
• Correct patient
• Correct procedure
• Correct site

Administer medication.

RN documents medication administration time and effect and patient assessments on flowsheet.

Perform procedure.

Monitor patient through recovery.
RN remains at bedside until patient is fully alert.

Contraindications

- Patient or caregiver refusal
- Hemodynamic instability
- Respiratory distress

Note: if benefits of procedure outweigh risk despite contraindications, refer to higher level of care or consult a local airway expert and discuss risks with patient/caregiver.

Note: Per ACEP, NPO times should not affect decision-making about procedural sedation.

Levels of Sedation

- **Moderate sedation:** patient responds to light tactile stimulation. Spontaneous ventilation is adequate. An IV is required only if IV medication is to be given. (For example, if ketamine is to be given IM with no IV agents planned, an IV is not necessary.)
- **Deep sedation:** noxious stimuli are required to elicit a response. Spontaneous ventilation and ability to maintain airway may be impaired. Not routinely performed in the ED outside of life-threatening situations.

Other Scenarios

Use of a single, non-dissociative agent is not considered sedation. This protocol does not apply to the following:

- Anxiolysis with a benzodiazepine: patient may be drowsy but responds appropriately to verbal commands.
- Analgesia with opioids: pain control with intact decision-making.

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Approved by MSEC 4/6/21. Click [here](#) to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.



Procedural Sedation and Analgesia Outside the OR

Agent	Bolus Dose	Titration Dose	Onset	Duration	Reversal Agent	Comments
Etomidate	<u>Patients >10 years:</u> 0.2 mg/kg <u>Patients ≤10 years:</u> 0.2 mg/kg (0.1-0.3 mg/kg) Slow IV push over 30-60 seconds.	0.05 mg/kg Q3-5 min	30-60 seconds	3-5 minutes	Time	<ul style="list-style-type: none"> No analgesic effect. Use IBW if BMI>30. Consider lower dose (0.1 mg/kg) for age >60 years, concurrent opioids, or if recent alcohol use. Administer via larger vessel. (antecubital or larger). Precautions: 30% have myoclonus with transient skeletal/eye movements.
Ketamine	<u>Adults:</u> 1-2 mg/kg IV over 1-2 min 4-5 mg/kg IM <u>Children >3 mo:</u> 1-2 mg/kg IV over 1 min 4-5 mg/kg IM 5 mg/kg PO		30 seconds 3-4 min 30-120 seconds 5-10 min 20-45 min	10-20 min 20-30 min 20-60 min 30-90 min 60-120 min	• Time • For laryngospasm: Succinylcholine 0.25-0.5 mg/kg IV or 3-4 mg/kg IM	<ul style="list-style-type: none"> Local anesthetic (eg. lidocaine) can increase effective duration. Consider lower dose range for >60 years, concurrent opioids/alcohol. Consider dosing by adjusted body weight if BMI>30. Precautions: emergence reactions (treat with benzodiazepines), nausea/vomiting (pre-treat with ondansetron), transient increase in salivation. Contraindications: pregnancy, age <3 months.
Propofol	<u>Patients >2 yrs:</u> IV load 0.5-1 mg/kg <u>Children 6 mos – 2 yrs:</u> IV load 1-2 mg/kg	Repeat 0.1-0.3 mg/kg Q30-60 seconds Repeat 0.1-0.3 mg/kg Q30-60 seconds Max cumulative dose 3 mg/kg	30-60 seconds	3-10 min	Time	<ul style="list-style-type: none"> No analgesia. Consider low dose for age >60, concurrent opioids/alcohol. Consider dosing by adjusted body weight if BMI>30. Separate administration of opioid and propofol by >20 minutes to decrease respiratory depression. Pre-oxygenate with high flow supplemental oxygen at least 3 minutes prior to procedure. Precautions: burning sensation during administration, hypotension, ↓CO, or bradyarrhythmias. High risk of respiratory depression/failure. Contraindications: allergies to egg, soybean, fat emulsion.
Morphine	<u>Adults:</u> 1-4 mg IV 10 mg PO <u>Pediatrics:</u> 0.05-0.1 mg/kg IV Max 4 mg		5-10 min IV 30 min PO 5-10 min	3-5 hours 2-3 hours	Naloxone 0.1 mg/kg IV. May repeat Q2 minutes.	<ul style="list-style-type: none"> Reduce dose when combining with a benzodiazepine. As opioids provide sedation and analgesia, administer them prior to benzodiazepines.
Fentanyl	<u>Adults:</u> 0.5 mcg/kg if given with other sedatives 0.5-1 mcg/kg Max 100 mg <u>Pediatrics:</u> 1 mcg/kg IV up to 50 mcg/dose	May repeat dose Q2min until desired sedation and analgesia achieved	<1 min	30-60 min	Naloxone 0.1 mg/kg IV. May repeat Q2 minutes.	<ul style="list-style-type: none"> Reduce dose when combining with a benzodiazepine. As opioids provide sedation and analgesia, administer them prior to benzodiazepines.
Midazolam	<u>Adults:</u> 2-5 mg IV <u>Pediatrics (6 mos - 12 yrs):</u> 0.2-0.3 mg/kg/dose IN 0.05 mg/kg IV	May repeat dose Q2min until adequate sedation. Max 0.3 mg/kg. May repeat dose Q5min until max dose of 0.5 mg/kg is reached. Age <5 max 6 mg; age >5 max 10 mg.	3-5 min	15-20 min	Flumazenil 0.01 mg/kg (up to 0.2 mg) IV over 15 seconds. May repeat Q1 minute.	<ul style="list-style-type: none"> No analgesia. Consider lower dose range for >60 years, concurrent opioids/alcohol. Watch for dose-related hypotension.

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If comments about this guideline, please contact Tara_Lathrop@ykhc.org.



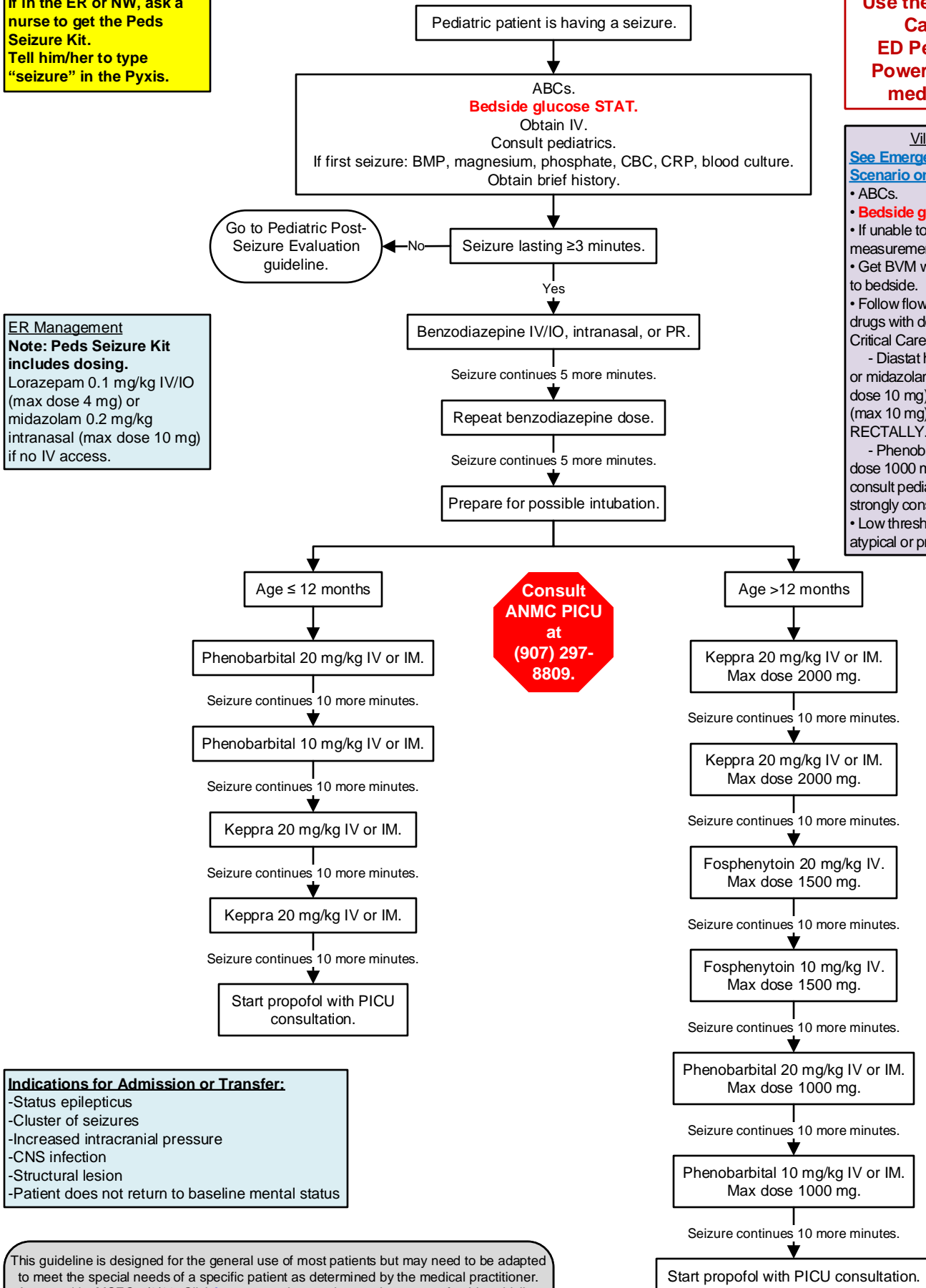
If in the ER or NW, ask a nurse to get the Peds Seizure Kit. Tell him/her to type "seizure" in the Pyxis.

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan to check all medication dosing.

ER Management
Note: Peds Seizure Kit includes dosing.
Lorazepam 0.1 mg/kg IV/IO (max dose 4 mg) or midazolam 0.2 mg/kg intranasal (max dose 10 mg) if no IV access.

Village Management
See Emergency RMT Seizure Scenario on the wiki.

- ABCs.
- **Bedside glucose STAT.**
- If unable to get a glucose measurement, give glucose buccally.
- Get BVM with appropriate sized mask to bedside.
- Follow flow to the left, using these drugs with dosing found on Pediatric Critical Care Guide:
 - Diastat home dose PR if available or midazolam 0.2 mg/kg intranasal (max dose 10 mg) or diazepam 0.5 mg/kg (max 10 mg) IV solution given RECTALLY.
 - Phenobarbital 20 mg/kg IM (max dose 1000 mg). If giving phenobarbital, consult pediatrics, notify ER, and strongly consider activating a medevac.
- Low threshold to activate medevac for atypical or prolonged seizure.



Note: If febrile seizure with status epilepticus, consider giving phenobarbital after benzodiazepines prior to Keppra in any age group.

Indications for Admission or Transfer:

- Status epilepticus
- Cluster of seizures
- Increased intracranial pressure
- CNS infection
- Structural lesion
- Patient does not return to baseline mental status

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 5/8/19. Click [here](#) to see the supplemental resources for this guideline. If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.



qSOFA – 2 or more of the following:

RR > 22
altered mental status (GCS < 15)
SBP < 100

SEPSIS 3 & ACEP NOTES

4-6 L of total IVF is often needed during the first 6 hours. After 2 L of NS consider switch to LR. Remember that if the patient fails to respond after the first 2-3 L, pressors should be considered.

In patients with concern for fluid overload (Hx CHF or renal or liver failure) or complications from fluid resuscitation, use less total fluid or smaller boluses with more frequent reassessment of volume status, but **DO NOT DELAY FLUID AND VASOPRESSOR TREATMENT.**

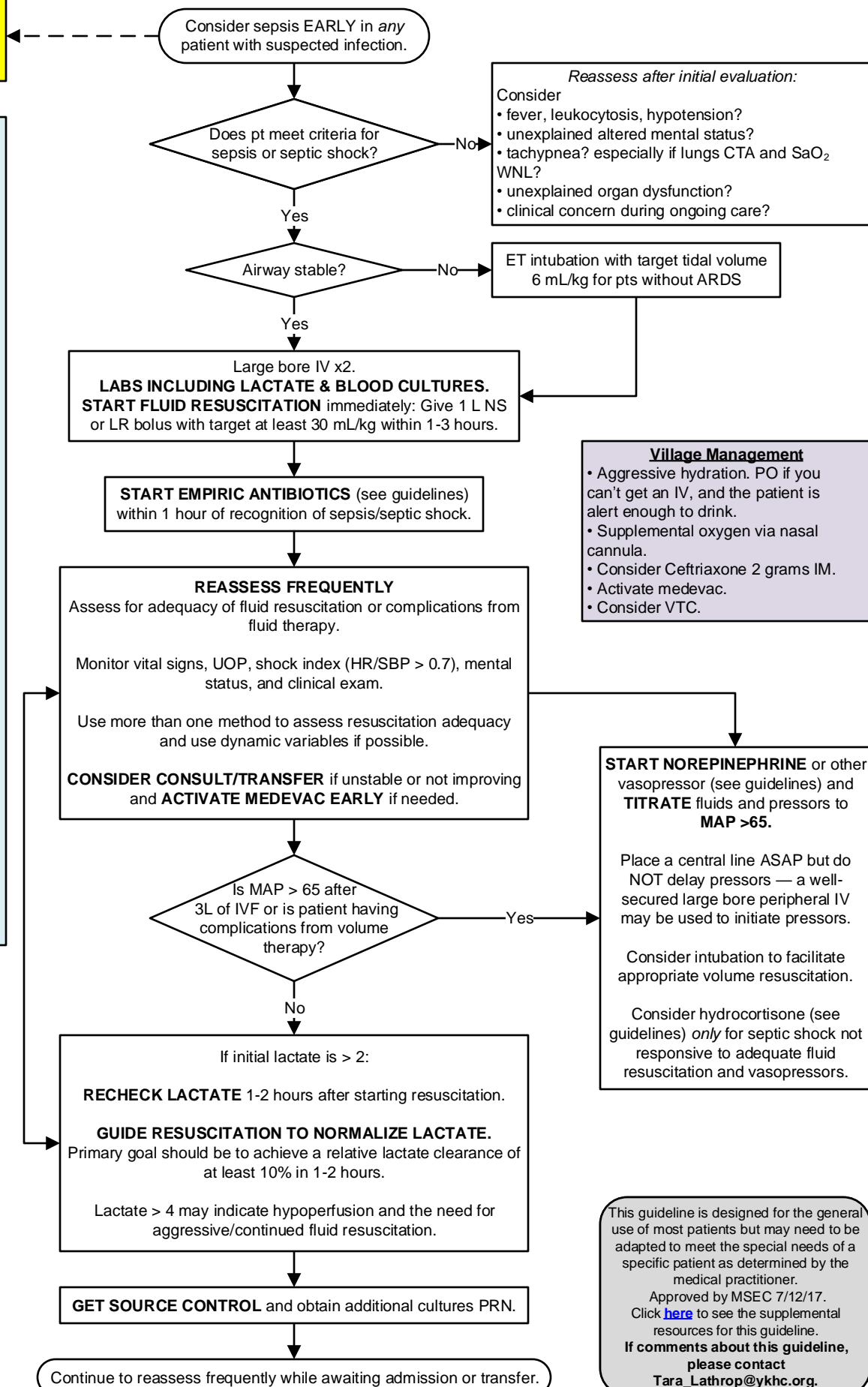
Persistence of elevated lactate, even in the absence of hypotension, is associated with poor outcomes.

CRP and procalcitonin may be elevated but cannot effectively guide ED sepsis care — CHECK (and RECHECK) LACTATE.

In the absence of extenuating circumstances (MI, severe hypoxia, acute blood loss, etc.) transfusion is no longer recommended unless Hgb < 7.

Consider insulin if 2 consecutive blood glucose levels are > 180.

Sodium bicarbonate is not recommended to improve hemodynamics or decrease vasopressor requirements in patients with hypoperfusion-induced lactic acidemia with pH ≥ 7.15.



Village Management

- Aggressive hydration. PO if you can't get an IV, and the patient is alert enough to drink.
- Supplemental oxygen via nasal cannula.
- Consider Ceftriaxone 2 grams IM.
- Activate medevac.
- Consider VTC.

START NOREPINEPHRINE or other vasopressor (see guidelines) and **TITRATE** fluids and pressors to **MAP > 65**.

Place a central line ASAP but do NOT delay pressors — a well-secured large bore peripheral IV may be used to initiate pressors.

Consider intubation to facilitate appropriate volume resuscitation.

Consider hydrocortisone (see guidelines) only for septic shock not responsive to adequate fluid resuscitation and vasopressors.

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Approved by MSEC 7/12/17.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Tara_Lathrop@ykhc.org.



Empiric Antibiotic Recommendations by Source of Infection

If possible, first dose of antibiotics should be administered as a 30 minute infusion to reduce time to therapeutic concentration.

Unknown Source

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam³ 4.5 grams IV Q8h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Gentamicin² 7 mg/kg IV Q24h.
Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

Community-Acquired Pneumonia

Ceftriaxone 1 gram IV Q24h.
(2 grams if >80 kg.)
OR
Ampicillin-sulbactam 3 grams IV Q6h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Azithromycin 500 mg PO/IV Q24h.

If at risk for aspiration, consider adding:

Metronidazole 500 mg IV Q8h.

Hospital-Acquired Pneumonia or High Risk for Multi-Drug Resistant (MDR) Organisms

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam³ 4.5 grams IV Q6h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Gentamicin² 7 mg/kg IV Q24h.
Consult pharmacy for max dosing.

Meningitis

Dexamethasone 10 mg IV prior to antibiotics.

AND

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.

AND

Ceftriaxone 2 grams IV Q12h.

If >50 years, ADD

Ampicillin 2 grams IV Q6h.

Urinary Tract Infection

Ceftriaxone 1 gram IV Q24h.
(2 grams if >80 kg.)

AND consider adding:

Gentamicin² 7 mg/kg IV Q24h.
Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

If urological interventions or MDR risk factors, consider adding:

Piperacillin-tazobactam³ 3.375 grams IV Q6h.
OR
Cefepime 1 gram IV Q6h.

If at risk of ESBL, ADD: **Meropenem** 500 g IV Q8h.

Intra-abdominal or Pelvic Infection

Piperacillin-tazobactam³ 3.375 grams IV Q6h.

OR

Cefepime 1 gram IV Q6h.
AND
Metronidazole 500 mg IV Q6h.

OR

Ciprofloxacin 400 mg IV Q12h.
AND
Metronidazole 500 mg IV Q8h.

Skin and Soft Tissue or Necrotizing Infections

IF PURULENT:
Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.

IF NON-PURULENT:
Cefazolin 2 grams IV Q8h.
OR
Ceftriaxone 1-2 grams IV Q24h.
OR
Ampicillin-sulbactam 3 grams IV Q6h.

If necrotizing, ADD:

Piperacillin-tazobactam³ 3.375 grams IV Q6h.
AND
Clindamycin 900 mg IV Q8h.

OR

Ceftriaxone 2 grams IV Q12h.
AND
Metronidazole 500 mg IV Q6h.

Neutropenic Cancer Patients (ANC <500)

Piperacillin-tazobactam³ 4.5 grams IV Q6-8h.
OR
Cefepime 1 gram IV Q6h.

AND

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.

If concerned for HSV or VZV, consider adding:

Acyclovir 10 mg/kg Q8h.
Consult pharmacy for max dosing.

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Approved by MSEC 7/12/17.

If comments about this guideline, please contact Tara_Lathrop@ykhc.org

¹ Linezolid may be substituted for vancomycin in patients with relative contraindication to vancomycin for high risk for acute kidney injury.

² Gentamicin dosing based on ideal body weight.

³ May substitute ampicillin-sulbactam 3 gram IV Q6h for piperacillin-tazobactam if not concerned for pseudomonas.



Vasopressors

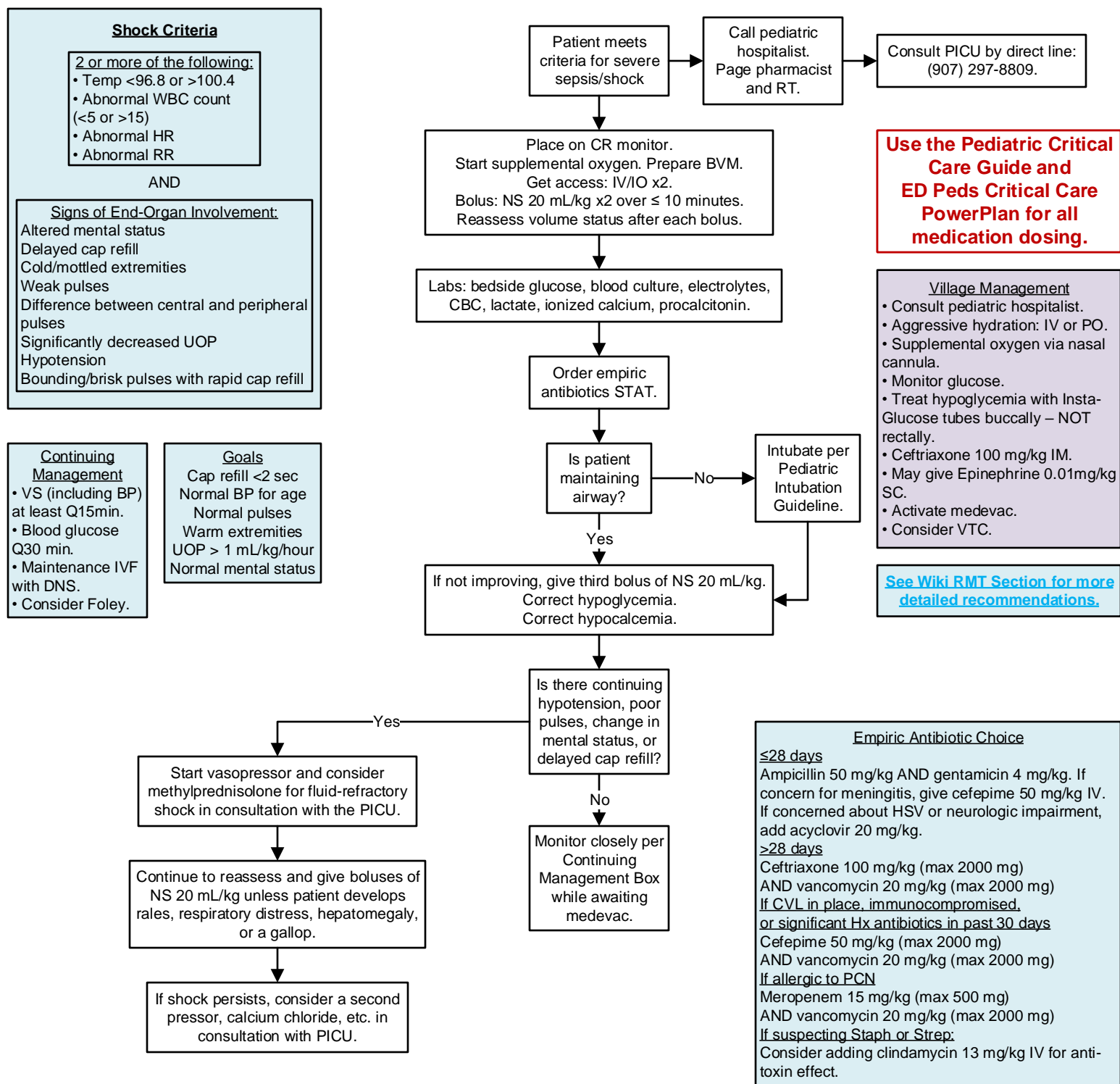
All vasoactive medications should be infused via central line with the exception of dopamine, which can be infused via a peripheral IV at rates less than 10 mcg/kg/minute.

- | | |
|---|--|
| • Norepinephrine 8-12 mcg/min IV initial infusion rate. | First-line vasopressor of choice in sepsis. |
| • Epinephrine 1-10 mcg/min initially, titrated to effect. | May be added or used in place of norepinephrine to maintain adequate BP. |
| • Dopamine 2-20 mcg/kg/min. | Second-line option in highly select patients as it causes more tachycardia. |
| • Phenylephrine 100-180 mcg/min IV initial infusion until stabilized.
Titrate to goal of 60-200 mcg/min.
(Max dose range 80-360 mcg/min.) | Can be used as salvage therapy for refractive hypotension associated with tachycardia. |
| • Vasopressin 0.03-0.04 units/min. | May be added to norepinephrine to increase MAP or decrease norepinephrine dose.
DO NOT use as a single agent. |
| • Dobutamine 2-20 mcg/kg/min IV infusion. | May be used for inotropic support in the presence of severe myocardial dysfunction or hypoperfusion with depressed cardiac output. |

Corticosteroids

Corticosteroids should NOT be administered for the treatment of sepsis in the absence of shock. Steroids are beneficial in those experiencing adrenal insufficiency in the presence of septic shock; however ACTH testing is not routinely recommended in adult patients. If hemodynamic stability is not achieved after adequate fluid resuscitation and vasopressor therapy, the use of IV hydrocortisone alone at a dose of 200 mg/day can be considered regardless of adrenal insufficiency status. Hydrocortisone should be tapered when vasopressors are no longer required.

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Approved by MSEC 7/12/17.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.



Age	HR (beats/minute)		RR (breaths/minute)		Hypotension (sBP in mmHg)
	Bradycardia	Tachycardia	Low	High	
0 days – 1 week	<100	>200	<30	>70	<60
1 week – 1 month	<100	>200	<30	>70	<60
1 – 3 months	<100	>180	<20	>60	<70
3 – 12 months	<100	>180	<20	>60	<70
1 – 2 years	<90	>160	<20	>40	<70
2 – 6 years	<60	>160		>40	<80
6 – 13 years	<60	>120		>23	<90
13 – 18 years	<60	>110		>23	<90

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by MSEC 10/9/19.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.



Abuse/Assault	
Sexual Assault (≥18 Years).....	31
Suspected Physical Abuse Procedure (Pediatric).....	32
Suspected Sexual Abuse Procedure (Pediatric).....	33



****Note:** When an adult patient discloses a sexual assault, it is his or her choice to report to law enforcement. Reporting without a patient's consent may breach his or her confidentiality. A SART exam/kit can only be conducted by a trained SAFE/SANE. Law enforcement must be involved, unless the patient wishes to have an anonymous kit collection.

Adult victim reports sexual assault to ED or clinic staff.

If patient is <18 years, please see [Pediatric Sexual Abuse Procedure](#).

Does patient want to report to law enforcement? (See ****Note**.)

No

Yes

Adult victim reports sexual assault to law enforcement.

Law enforcement performs preliminary interview.

Provide patient with a private space to call law enforcement with jurisdiction. Provide support as needed.
• If assault occurred in a village, call Alaska State Troopers.
• If assault occurred in Bethel, call the Bethel Police Department.

Is the patient willing to cooperate with an investigation?

No

Yes

Law enforcement activates SART team response if further investigation is indicated.

SART team performs interview.

Does the patient want a SART exam?

No

Yes

• SART team performs a forensic medical exam with evidence collection.
• Team offers emergency contraception and testing and treatment of STIs.

• The SART team will not respond.
• It may be appropriate to request a TWC advocate at 543-3444.
• Patient is offered a medical exam with ED or clinic provider for testing and treatment of STIs and emergency contraception.
• For any questions, contact the SART Adult on-call phone at 545-4273.
• SANE/SAFE may do an anonymous kit collection in certain circumstances.

SART Team Members

- Law enforcement
- SANE/SAFE (Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner)
- TWC advocate

Contact Information

- **Tundra Women's Coalition:**
Business Line: (907) 543-3444
Crisis Line: (907) 543-3456
Toll Free: (800) 478-7799
- **Law Enforcement:**
Bethel Police Department: (907) 543-3781
Bethel Post of Alaska State Troopers: (907) 543-2294
Aniak Post of Alaska State Troopers: (907) 675-4459
Emmonak Post of Alaska State Troopers: (866) 949-1303
St. Mary's Post of Alaska State Troopers: (907) 438-2019
- **National Sexual Assault Helpline:**
(800) 656-4673
Available 24 hours a day, 7 days a week.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/2/20. Click [here](#) to see the supplemental resources for this guideline. If comments about this guideline, please contact Jennifer_Prince3@ykhc.org.



Indicators of Abuse: History

- No/vague explanation of significant injury
- Important details of explanation change dramatically
- Explanation of injury is inconsistent with the child's physical and/or developmental capabilities
- Injury occurred as a result of inadequate supervision
- Delay in seeking medical care without reasonable explanation
- Children with injuries resulting from family/domestic violence incident
- Previous history of inflicted injury
- Inappropriate caretaker behavior that places child at risk

Indicators of Abuse: Physical Exam

Bruising

- Bruising in infants < 6 months of age or non-ambulatory infants
- Bruising in unusual locations in any age child: ear pinna, neck, under chin, torso, buttock
- Pattern Bruises: loop marks, hand print, subgaleal hematoma due to hair pulling

Bite Marks

- Semi-circular/oval pattern
- May have associated bruising

Burns

- Pattern contact burns
- Cigarette burns
- Stocking/glove pattern
- Mirror image burns on extremities
- Symmetrical burns on buttock
- Immersion burns

Facial Injury

- Unexplained torn frenulum in non-ambulatory child
- Unexplained oral injury
- Ear injury

Injuries Suggestive of Abuse

Skeletal

- Rib fractures
- Multiple fractures
- Long bone fractures in < 6 months
- Any fracture (including femur) in non-ambulatory child
- Scapular fracture
- Sternum fracture
- Fractures of hands and feet

Head

- Subdural hematoma with or without skull fracture
- Unexplained intracranial injury (Note: Infants with intracranial injuries frequently have no or non-specific symptoms)

Poisoning

- Any illegal drug exposure, prescribed controlled substance, ethanol or marijuana

Suspicion, allegation, disclosure, or confession of child physical abuse.
Please see Indicators of Abuse AND Injuries Suggestive of Abuse

Treat any acute issues as medically appropriate. If patient is in village and stable please arrange to have patient sent to ER via next commercial flight.
If unstable then activate MedEvac.

Mandatory reporters must report via phone to:
OCS AND law enforcement (AST if incident occurred in village or BPD if incident occurred in Bethel)

Complete Non-Accidental Trauma (NAT) Work-up

- Skeletal Survey (See Box)
- CT Head if <6 months, symptomatic, or evidence of Closed Head Injury
- Laboratory Testing for Occult Injuries (See Box)
- Take photos of any injury visible on exam, especially bruising. Take a photograph of the injury at a distance, followed up by a close-up photo to establish relative size and landmarks.

Send RAVEN communication to Child Abuse Pool detailing reports made to Law Enforcement and **OCS**.
May contact **Child Abuse On-Call** via TigerText if any questions or concerns.

If unable to reach a discharge plan with OCS that YOU think is safe, then consider admission for safety and TigerText **Child Abuse On-Call** to help reach a safe discharge plan.

Contacts

- Child Abuse On-Call via TigerText
- Office of Children's Services (**OCS**): (800) 478-4444
- Alaska State Troopers (**AST**): (907) 543-2294
- Bethel Police Department (**BPD**): (907) 543-3781
- Alaska CARES: (907) 561-8301

Mandatory Reporters include:

Medical providers, nurses, health aides, teachers, social workers, law enforcement officers, and mental health professionals.

Report should be made by every mandated reporter who has a concern - even if you think a report has already been made. This helps keep reports up to date with new information.

Laboratory Testing for Occult Injuries

All Patients ≤ 7 years or >7 if clinically indicated

- CBC
- CMP
- Amylase/Lipase
- UA

Fractures

- Above labs and Magnesium & Phosphorus

Bruising or Intracranial Hemorrhage

- Above labs plus PT/PTT
- If patient needs blood, obtain vWF (von Willebrand) antigen and activity, Factor VII and IX

Altered Mental Status/Drug Ingestion

- Urine Drug Screen
- Ethanol level
- Tylenol level
- Aspirin level

Obtain Skeletal Survey For:

Children 0-24 months if concerns for child abuse or any of the following are present:

- History of confessed abuse
- Injury occurred during domestic violence
- Report of impact from toy/object causing fracture
- Delay in seeking care >24 hours in child with signs of distress
- Additional injuries unrelated to chief complaint (i.e. bruising, burns)
- No history of trauma to explain fracture. However, it is not necessary to get **skeletal survey** in ambulatory patients >12 months with distal buckle fracture of radius/ulna or distal spiral or buckle fracture of the tibia/fibula

ALL children 0-11 months with any type of fracture except the following:

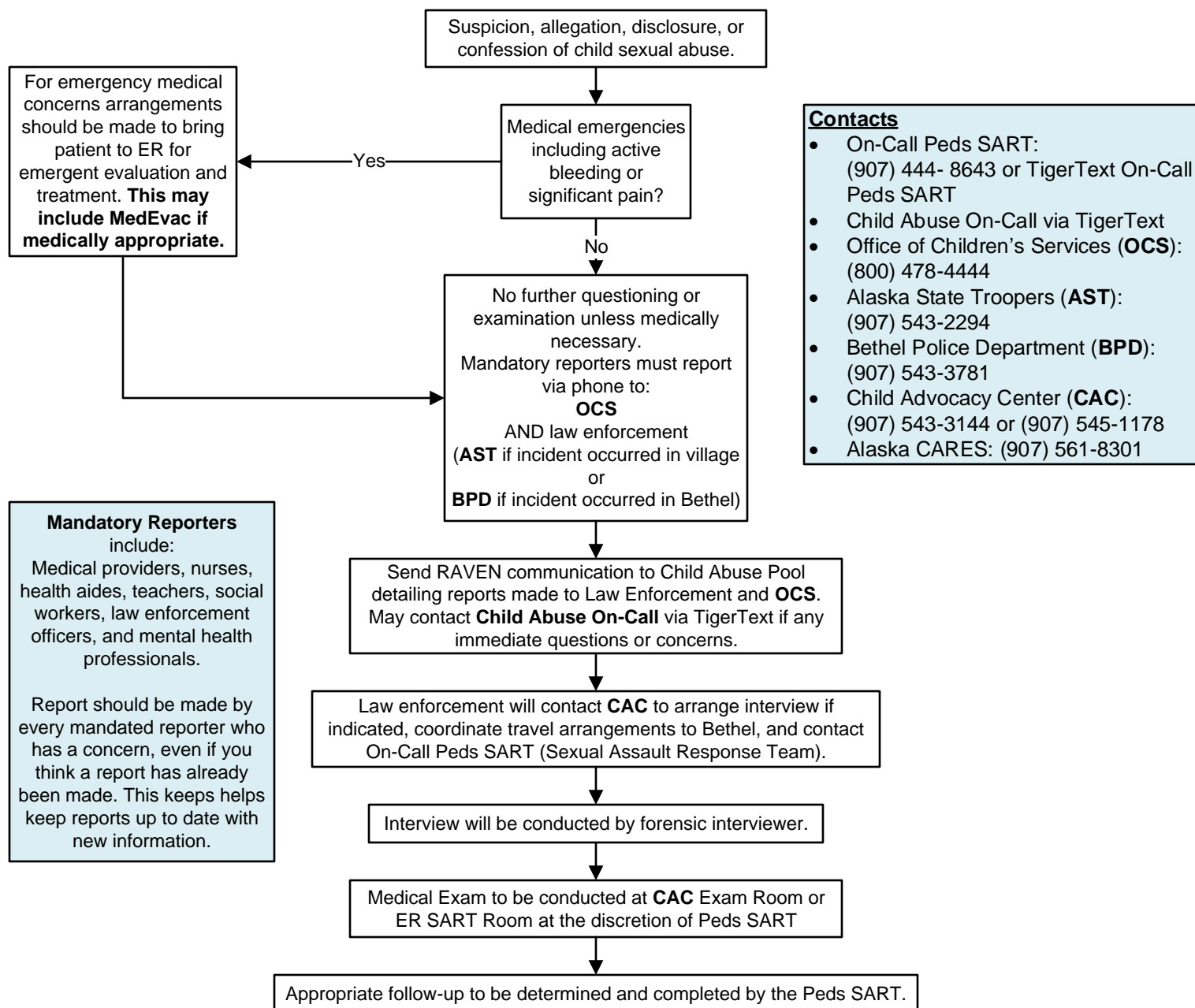
- Distal radial/ulna fracture or spiral fracture of the tibia/fibula (Toddler fracture) in a cruising child > 9 months with history of fall
- Linear, unilateral skull fracture in child >6 months with history of significant fall (fall from height > 3 feet or fall with caregiver landing on child)
- Clavicle fracture likely attributed to birth (acute fracture in infants <22 days old or healing fracture in infant <30 days old)

Children 0-24 months with any of the following fractures:

- Rib fracture
- Complex or ping pong skull fracture
- Humeral fracture with epiphyseal separation attributed to short fall (< 3 feet)
- Femur diaphyseal fracture attributed to fall from any height

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Approved by MSEC 6/1/19. Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Jennifer_Prince3@ykhc.org.





Cardiovascular	
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Box 1: Immediate Interventions

- Supplemental oxygen *prn* to maintain SpO₂ 90-96%.
- Aspirin 325 mg PO (chewed).
- Nitroglycerin 0.4 mg sublingual *prn* pain (up to three times as BP permits) unless contraindicated. Contraindications: recent phosphodiesterase use, sBP <90, right ventricular infarct (consider when evidence of inferior wall ischemia).

NOTE: pain relief with nitroglycerin (or lack thereof) is not diagnostic of cardiac ischemia.

Consulting Cardiology

- For all STEMI patients, consult PAMC Cardiology by calling the PAMC ED at (907) 212-3433 and asking for the cardiologist on call. For beneficiary patients, ANMC Cardiology should be made aware of the transfer on a non-urgent basis.
- For NSTEMI-ACS patients, consult ANMC Cardiology for beneficiary patients and PAMC Cardiology for non-beneficiary patients.

Box 2: STEMI Criteria

Symptoms consistent with acute myocardial ischemia AND (A or B):

New ST-elevation at the J-point in two contiguous leads with the cut-point:

- ≥ 1 mm in all leads other than V2-V3
- V2-V3:
 - ≥ 2 mm in men ≥ 40 years old
 - ≥ 2.5 mm in men < 40 years old
 - ≥ 1.5 mm in women

Box 4: HS-cTnT Evaluation for Acute Cardiac Injury

The lowest reported value is "<6 ng/L," which equates to "undetectable."

FDA-approved normal values (99th percentiles in healthy subjects) are:

- Men: <22
- Women: <14
- Change in one hour ($\Delta 1h$) : <3

Cutoffs are arbitrary and do not correspond to any evidence-based positive-predictive value for ACS.

Repeat measurements rely on a rate of change; therefore, repeat measurements should be drawn at exactly one hour (or the chosen interval) after the initial.

This information is from data available February 2020. Please see [wiki page](#) for further information.

Symptoms suggestive of acute coronary syndrome

Perform 12 lead EKG.

Perform immediate interventions. See Box 1.

Consult local expert or cardiologist.

STEMI?
See Box 2.

Yes

No

- HS-cTnT, serial EKGs, and COVID test.
- Consider critical diagnoses. See Box 3.

Consult local expert or cardiologist.

Diagnostic ST/T changes
OR
Diagnostic HS-cTnT elevation
or change. See Box 4.

Yes

No

- ACS is ruled out.
- Broaden differential diagnosis.
- Consider a validated risk-stratification scoring tool (like [HEART](#) or [TIMI](#)).
- If patient is high-risk for cardiac complications, consider consultation with cardiologist prior to discharge.
- Discharge with outpatient follow-up as indicated by level of cardiac risk.

Box 3: Critical Differential Diagnosis

- Aortic dissection
- Tension pneumothorax
- Pulmonary embolism
- Perforated peptic ulcer

Disclaimer

- This algorithm is not intended for undifferentiated chest pain without an apparent cause.
- Acute coronary syndrome is defined as acute occlusion of a coronary artery and does not include type 2 MI/ischemia.

<12 hours from symptom onset?

Yes

No

Complete [Fibrinolytic Checklist](#).
Contraindications to fibrinolytics?

No

Yes

Initiate fibrinolytic therapy.
See Box 5.

- Administer additional medications. See table on next page.
- Activate medevac if appropriate.

Diagnosis is NSTEMI-ACS (Non-ST elevation acute coronary syndrome)

Box 5: Fibrinolytic Therapy (Tenecteplase)

Goal: administer ≤ 30 minutes from arrival.
Rapidly complete the fibrinolytic checklist and consent.

Dosing:

- <60 kg: tenecteplase 30 mg IV bolus
- ≥ 60 kg to <70 kg: tenecteplase 35 mg IV bolus
- ≥ 70 kg to <80 kg: tenecteplase 40 mg IV bolus
- ≥ 80 kg to <90 kg: tenecteplase 45 mg IV bolus
- ≥ 90 kg: tenecteplase 50 mg IV bolus

Administer concurrent aspirin, clopidogrel, and anticoagulant therapy. See tables 1 and 2.

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Approved by MSEC 12/2/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Megan_Young@ykhc.org and Andrew_Swartz@ykhc.org.



Nitroglycerin (NTG)
 • **Contraindications:** PDE-inhibitor use, cardiogenic shock, RV infarct, sBP<90, marked tachycardia or bradycardia.
 • **Sublingual dosing:** 0.4 mg SL Q5 minutes up to three doses
 • **IV dosing:** start at 10-20 mcg/min, titrate Q3-4 minutes to typical range 60-100 mcg/min

Beta-Blockers
 • No evidence of benefit from routine immediate beta-blocker.
 • Indicated for HTN and/or ongoing ischemia refractory to NTG.
 • **Contraindications:** cardiogenic shock, RV infarct, symptomatic asthma.
 • **Cautions:** risk for cardiogenic shock (bradycardia, HR>110, sBP<120, age>70, increased time since STEMI onset), inferior MI, controlled asthma.

Emergency Department Medication Summary				
		STEMI <12 hours	STEMI >12 hours	NSTE-ACS
Oxygen		Maintain SpO ₂ 90-96%	Maintain SpO ₂ 90-96%	Maintain SpO ₂ 90-96%
Nitrates (<i>prn</i> pain, HTN)		Sublingual or drip	Sublingual or drip	Sublingual or drip
Fibrinolytic		Tenecteplase See page 1, Box 5	Not indicated	Not indicated
Antiplatelet agents	Aspirin	325 mg PO (chewed)	325 mg PO (chewed)	325 mg PO (chewed)
	P2Y ₁₂ receptor blocker	Clopidogrel Age ≤75: 300 mg PO Age >75: 75 mg PO	Clopidogrel 600 mg PO	Consult cardiology.
	Glycoprotein IIb/IIIa inhibitor	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.
	Anticoagulation	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)
Beta-blocker		Metoprolol 5 mg IV <i>prn</i> Q5 minutes (max 15 mg)	Metoprolol 5 mg IV <i>prn</i> Q5 minutes (max 15 mg)	Metoprolol 5 mg IV <i>prn</i> Q5 minutes (max 15 mg)
Morphine		No longer routinely given; associated with increased mortality. Reserve for significant pain refractory to NTG and beta-blocker.		

At time of Dx unless contraindicated

Enoxaparin Dosing			
	Age <75 years and STEMI	Age ≥75 years and STEMI	Any age and NSTE-ACS
Creatinine clearance ≥30 mL/min	30 mg IV + (1 mg/kg SC now then Q12h) Max dose 100 mg	0.75 mg/kg SC Q12h Max dose 75 mg	1 mg/kg SC now then Q12h
Creatinine clearance <30 mL/min	30 mg IV + (1 mg/kg SC now then Q24h) Max dose 100 mg	1 mg/kg SC Q24h Max dose 100 mg	1 mg/kg SC now then Q24h

NOTE: Enoxaparin and unfractionated heparin are NOT dialyzable; ESRD/dialysis patients should receive fondaparinux, which is not on the YKHC formulary. Discuss with cardiologist if appropriate.

Inpatient Medication Summary	
NOTE: The following table is meant to be a basic reference as a starting point. Please consult Cardiology for full recommendations in all ACS patients.	
ACE-inhibitor	Lisinopril 2.5 – 5 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Statin	Atorvastatin 80 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Beta-blocker	Metoprolol XL 25-50 mg PO Q12-24h <i>prn</i> Give unless contraindicated. Typically started prior to hospital discharge.
Clopidogrel	75 mg PO daily
Aspirin	81 mg PO daily
Enoxaparin	Dose above. Consult Cardiology for duration.

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 Approved by MSEC 12/2/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Megan_Young@ykhc.org and Andrew_Swartz@ykhc.org.



Fibrinolytic Checklist

INDICATIONS (initial yes or no)

YES	NO	
		Presentation consistent with acute coronary syndrome (coronary artery occlusion)
		<p><u>AND</u> at least one of the following:</p> <ul style="list-style-type: none"> • 1 mm J-point elevation in two contiguous leads (other than V₂-V₃) • In leads V₂-V₃ <ul style="list-style-type: none"> Men ≥ 40 years: ≥ 2 mm J-point elevation Men <40: ≥ 2.5 mm J-point elevation Women: ≥ 1.5 mm J-point elevation

ABSOLUTE CONTRAINDICATIONS (initial yes or no)

YES	NO	
		History of <u>any</u> intracranial hemorrhage
		History of prior ischemic stroke, significant closed head injury or facial trauma, or intracranial or spinal surgery in the previous three months
		Presence of a cerebral vascular malformation
		Presence of a primary or metastatic intracranial malignancy
		Symptoms or signs suggestive of an aortic dissection
		Any bleeding diathesis
		Any active bleeding that is severe or has high potential for life-threatening blood loss; this does not include menstrual bleeding
		sBP > 180 and/or dBP > 110 at presentation in patient at low risk of cardiac death (age < 55, no prior MI, and Killip class I).
		Terminal illness, defined as end of life care or documented/expressed patient wish to abstain from high risk or invasive procedures

RELATIVE CONTRAINDICATIONS (initial yes or no) – If any of below are present, used shared decision making with patient.

YES	NO	
		Age 65-74 (ICH relative risk 3.12 [2.54-3.83]); Age ≥ 75 years (ICH relative risk 5.40 [4.40-6.63])
		History of chronic severe poorly controlled HTN
		sBP > 180 and/or dBP > 110 at presentation in patient at high risk of cardiac death (age ≥ 55, Hx prior MI, or Killip class ≥ II).
		History of ischemic stroke more than three months ago
		Dementia OR any known intracranial disease that is not an absolute contraindication
		Traumatic or prolonged (>10 minutes) cardiopulmonary resuscitation
		Major surgery in the previous three weeks
		Internal bleeding in the previous 2-4 weeks
		Active peptic ulcer
		Non-compressible vascular punctures
		Pregnancy
		Current warfarin therapy (the risk of bleeding increases as the INR increases)

This checklist is advisory for clinical decision-making and may not be all-inclusive. Risks and benefits will need to be assessed individually.

Physician signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.



PROCEDURE CONSENT

I hereby authorize _____ and such assistants as he/she may designate, to perform the following operation or procedure:

TECHNICAL DESCRIPTION

Intravenous thrombolytic therapy for acute STEMI (ST-elevation myocardial infarction).

LAY DESCRIPTION

Give clot-dissolving medication through an IV to dissolve the clot which is causing a heart attack.

_____ has discussed with me the information briefly summarized below:

BENEFITS

- When PCI is not available within two hours, thrombolytic medication is the "standard of care" for achieving coronary reperfusion within 12 hours of acute STEMI onset.
- When administered within 6 hours of pain onset, about 1 in 40 persons will have their life saved.
- When administered between 6-12 hours after pain onset, about 1 in 60 persons will have their life saved.
- Decreased risk of developing heart failure.
- A STEMI patient who receives thrombolytic medication is about 3-5 times more likely to have their life saved than to have brain bleeding (see below).

RISKS
(some, but not all)

- About 1 in 100 persons will experience non-life-threatening bleeding.
- About 1 in 100-250 persons will experience bleeding into the brain which usually results in either death or significant disability.

**RISKS OF NOT HAVING THE
PROCEDURE**

- Higher risk of death.
- Higher risk of developing heart failure.

ALTERNATIVE TREATMENTS

None are available at this facility.

Patient signature: _____

Printed name: _____ Date and time: _____

Witness signature: _____

Printed name: _____ Date and time: _____

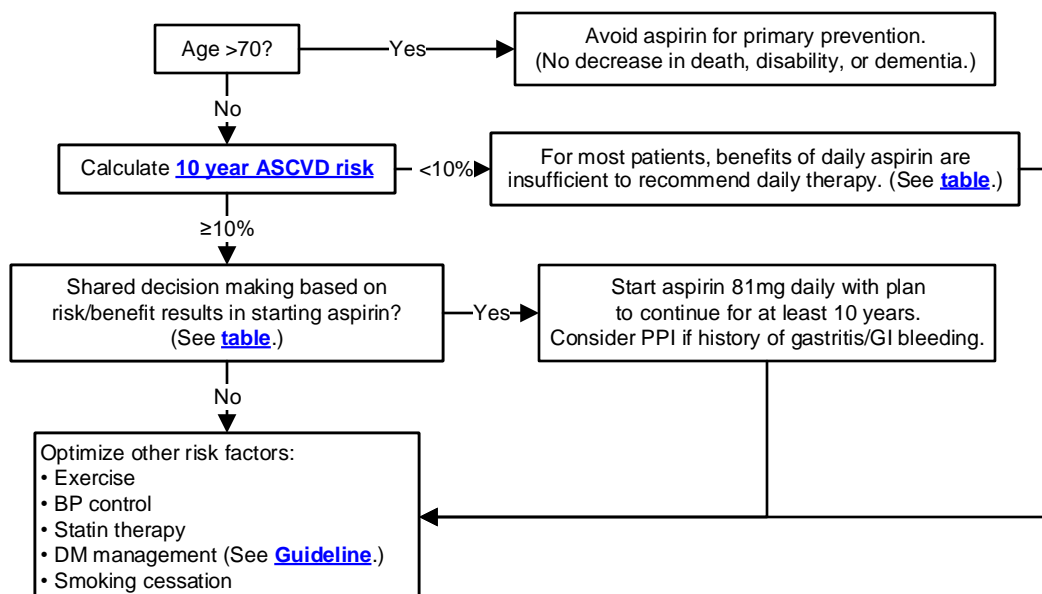
Physician signature: _____

Printed name: _____ Date and time: _____

Witness signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.



Notes

Aspirin produces significant reductions in mortality amongst survivors of cardiovascular disease, but its role in the primary prevention of cardiovascular disease amongst healthy adults is less clear.

See [table under "Possible Benefits"](#) for summary of RCT data for low dose aspirin in the primary prevention of cardiovascular disease.



Consult ANMC Cardiology to confirm indication, consider alternative, and discuss need for antiarrhythmic drugs prior to procedure.

Ensure that patient had no solid food x 6 hours and no clear liquids x 3 hours.

1. Obtain BMP, magnesium, CBC, PT/PTT: patient should have no significantly abnormal electrolytes, decompensated COPD, or active infections.
2. Obtain digoxin level if applicable.
Procedure may be done on patient with therapeutic digoxin level and no evidence of toxicity.

Obtain consent for procedure.

Anesthesia present with full ACLS setup, including meds and temporary pacer. Anesthesia obtains consent for sedation/anesthesia.

Shave off significant hair.

Position conductive pads or paddles with adequate gel (pads preferred).

Note: Position posteriorly below left scapula and anteriorly just to right of sternum and over right upper parasternal to left cardiac apex.

Set defibrillator to SYNCHRONIZED shock. Verify that device is correctly synchronizing on the QRS complex.

Administer anesthesia/sedation

Note

Rare complication: V-tach or V-Fib usually occurs when shock delivered in UNSYNCHRONIZED MODE. Brief ventricular ectopy occurring post shock is of no clinical significance. If sustained V-tach or V-fib, deliver an UNSYNCHRONIZED SHOCK AT 360 J.

Deliver synchronized shock at 50 J

Note

Try to deliver all shocks during expiration.

Persistent bradycardia with hypotension?

No

Yes

Refer to ACLS protocol

Atropine 0.5 mg IV x 2 if needed.

Continued bradycardia or hypotension?

No

Yes

Dopamine 5-10 µg/kg per minute for vasopressor dose.

Severe bradycardia (<20 bpm) or asystole >10 sec?

No

Yes

Set defibrillator to PACE mode.

Begin with 80 mA and increase every 5 sec until Ventricular capture obtained.

Restoration of sinus rhythm?

No

RESYNCHRONIZE. Repeat shock at 100 J.

Restoration of sinus rhythm?

No

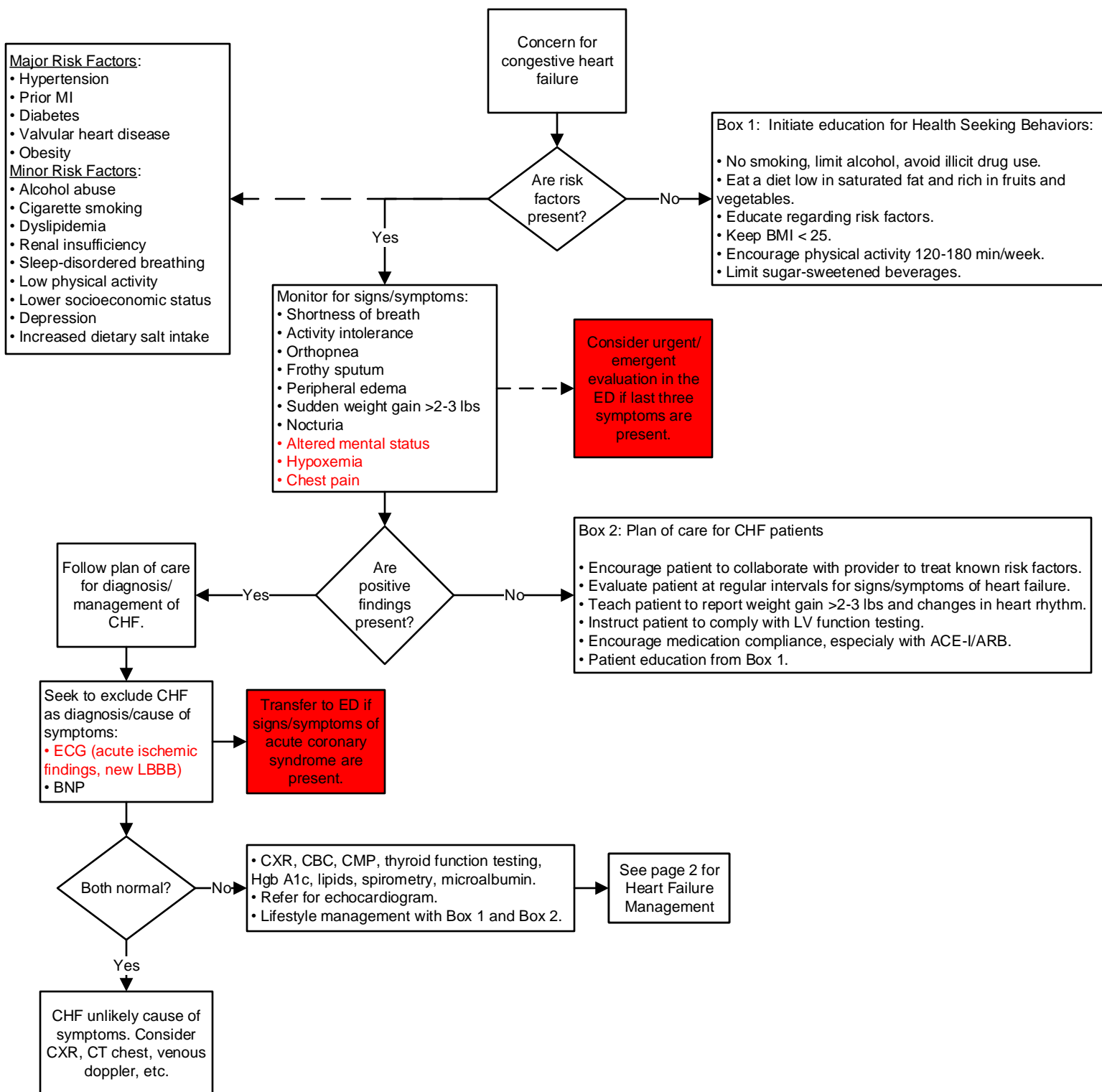
RESYNCHRONIZE Repeat shock at 100 J, consider increase to 200 J

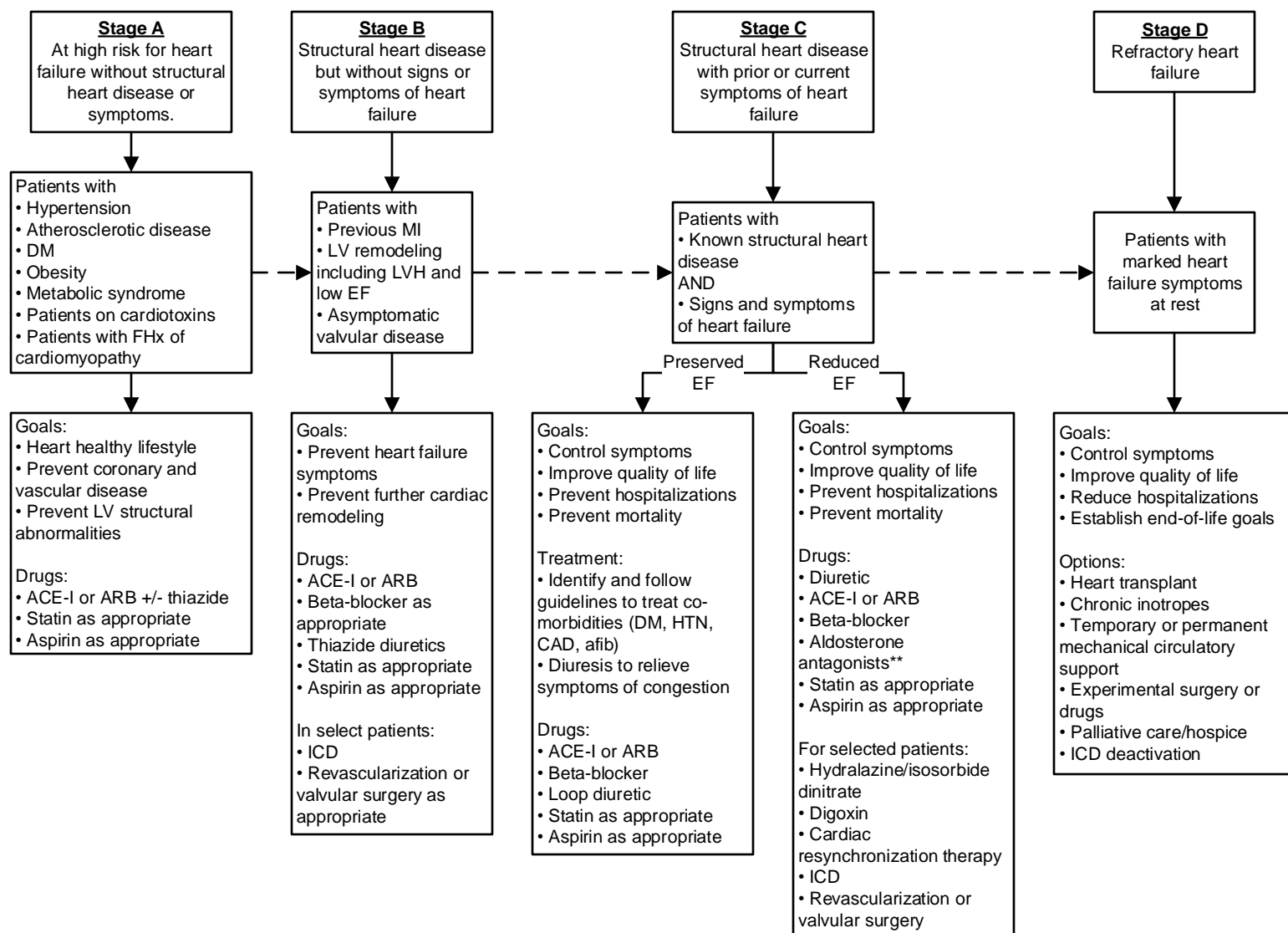
Restoration of sinus rhythm?

No

Move anterior pad to left parasternal, RESYNCHRONIZE and repeat shock at 360 J.
*A total of 4 shocks will be given before the procedure is declared unsuccessful.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 6/22/11.
Click [here](#) to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

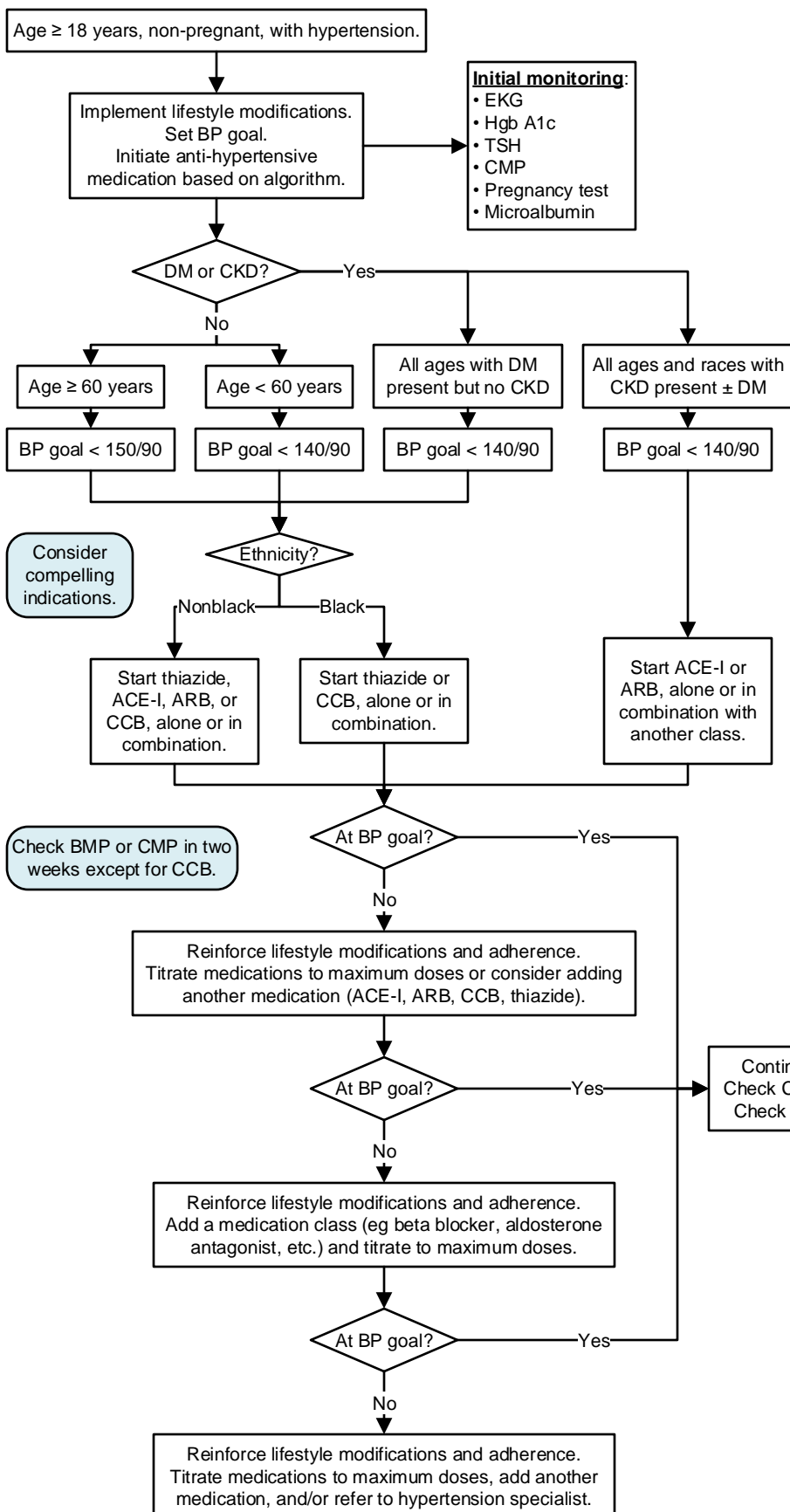




Calcium channel blocker contraindicated in Stage C.

****Aldosterone antagonists:**

- Use for estimated creatinine clearance > 30 and potassium < 5.
- Check BMP at baseline, day 2, day 7, monthly x3, Q3 mo x1 year, then Q6 mo



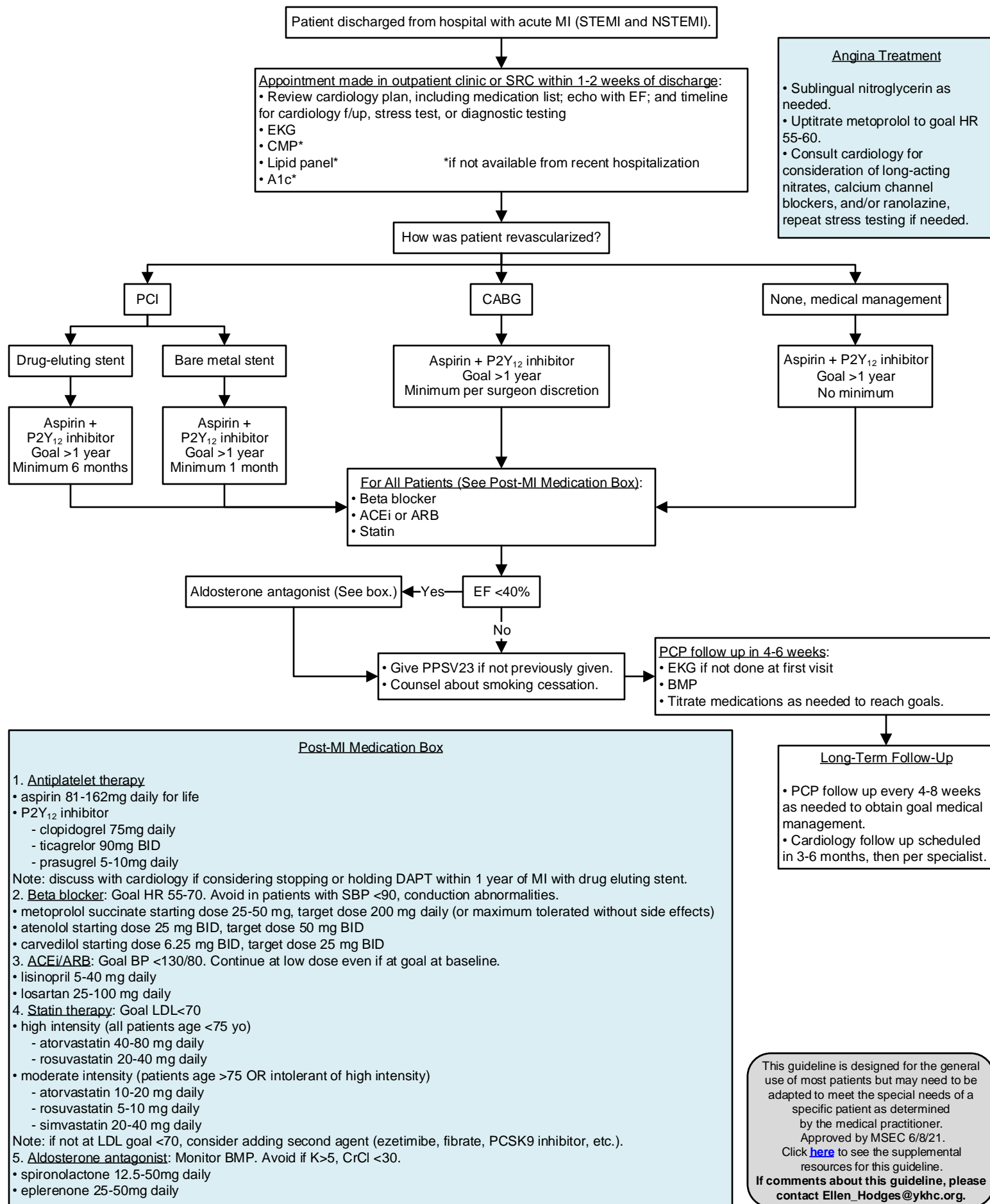
Initial Drugs of Choice for Hypertension

- ACE-inhibitor (ACE-I)
- Angiotensin receptor blocker (ARB)
- Thiazide diuretic
- Calcium channel blocker (CCB)
- Beta blocker (not first-line except in pregnancy or women who may become pregnant)

Strategy	Description
A	Start one drug. Titrate to maximum dose, and then add a second drug.
B	Start one drug. Add a second drug before reaching max dose of first drug.
C	Begin two drugs at the same time as separate pills or combination pill. Initial combination therapy is recommended if BP is $>20/20$ mmHg above goal.

Lifestyle Modifications:

- Smoking cessation
- Control blood glucose and lipids
- Diet:
 - DASH diet recommended.
 - Moderate alcohol consumption.
 - Reduce sodium intake to no more than 2400 mg/day.
 - Limit alcohol to two drinks/day for men and one drink/day for women.
- Physical activity
 - Moderate-to-vigorous activity for 120-180 min/week.





Gastrointestinal & Endocrine	
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Disclaimer: Diabetes is a complex disease; however, the management of diabetes is considered an essential skill of ambulatory care. Please be familiar with the ADA guidelines for treatment [here](#), and the abbreviated version [here](#).

Diagnostic Criteria

Unequivocal symptoms of hyperglycemia (thirst, polyuria, weight loss, and blurry vision) and either any one of the following OR any two of the following. (Take confirmatory test as close as possible to initial lab value to avoid treatment delays.)

- FPG* ≥ 126 mg/dl
- 2 hour PG ≥ 200 mg/dl during OGTT
- Hgb A1c ≥ 6.5
- RPG ≥ 200 mg/dl and symptoms of hyperglycemia or hyperglycemic crisis

Note: Fasting is defined as no caloric intake for at least 8 hours.

Causal Factors

- Dietary pattern: liquid calories, processed foods/carbohydrates, to lesser extent fat intake.
- Physical inactivity.
- Excessive cortisol: usually past trauma or chronic stress.
- Iatrogenic: psychiatric meds or corticosteroids.

Lifestyle Management

- Self-care through sleep hygiene, mindfulness, nature, and similar efficacious stress reduction techniques.
- Advise developing a positive, supportive social network.
- Use patient centered SMART goals, including consideration of individualized targets, impact on weight, hypoglycemia risk, side effect profile of medications, and complexity of regimen. Choose regimen to optimize adherence and persistence.
- Exercise is medicine: Titrate to 150 min/week minimum.
- Advise 7-10% weight loss if obese.
- Recommend traditional Alaska Native diet with emphasis on maximizing plants and high fiber foods.

Screen all overweight or obese adults with one or more other **risk factors** and all adults >45 years for type 2 diabetes mellitus.

See diagnostic criteria.

Confirm diagnosis and add to problem list in RAVEN.

- Refer all new diagnoses of diabetes or prediabetes to the Diabetes Department.
- In RAVEN, order "Refer to Diabetes Program Internal" and select appropriate reason. Add additional comments/questions/requests.
- Call 543-6133 for same-day counseling appointments.

Schedule follow up appointment for 2-4 weeks and coordinate with diabetes department if possible.

At initial and annual diabetes visits:

- Perform health measures (see box).
- Discuss and educate on pathophysiology in patient centered terms.
- Identify and quantify causal factors (see box).
- Initiate lifestyle management (see box).
- Set **A1c target** based on age and risk factors or complication risk.
- Set BG Monitoring goals and methods.
- Risk stratify patient by comorbidities and ASCVD risk (see box).
- Refer to appropriate diabetes resources (see box). Refer to Diabetes Department for all new diagnoses and annually (or more frequently) if not meeting A1c or lifestyle goals.

Comorbidities and ASCVD Risk

Comorbidities must be evaluated before medication initiation and at least annually. Document in chart and address in visit Assessment and Plan where appropriate. May use the 10 year ASCVD **Risk Calculator**.

- Heart failure
- CKD: classified based on cause, GFR, and albuminuria. See [link](#).
- Hypertension
- Obesity
- Obstructive sleep apnea

Health Measures

- Review Health Maintenance in RAVEN.
- Give diabetes-related and dosed immunizations if due.
- Foot exam.
- Mental health screen (refer to BH if needed).
- Sexual health screen and family planning discussion.
- Labs if not already done: A1c, lipids, CMP, urine microalbumin.
- Refer to optometry.
- Refer to dental.

Remember: language matters.
See this [ADA resource](#).

Diabetes Resources

- Diabetes Self-Management Education and Support (DSMES)
- Medical Nutrition Therapy (MNT)
- Continuous Glucose Monitor (CGM): usually for those with A1c >9, those on insulin, or those not achieving A1c goals. See [ADA paper](#).
- Other (DM support group, exercise physiology for exercise Rx)

Abbreviations/Acronyms

ADA = American Diabetes Association
 ASCVD = Arteriosclerotic cardiovascular disease
 BH = Behavioral Health
 CKD = chronic kidney disease
 CMP = Complete Metabolic Profile
 DM = Diabetes mellitus
 FPG = Fasting Plasma Glucose
 Hgb A1c or A1c for short = Hemoglobin A1c or glycosylated hemoglobin
 HTN = Hypertension
 OGTT = Oral Glucose Tolerance Test
 OSA = Obstructive sleep apnea
 PG = Plasma Glucose
 RPG = Random Plasma Glucose
 SMART = Specific, Measurable, Achievable, Realistic, Time-limited

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Approved by MSEC 9/2/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Elizabeth_Tressler@ykhc.org.



Abbreviations

- DPP-4i = dipeptidyl peptidase 4 inhibitor or gliptins. YKHC formulary saxagliptin (Onglyza).
- GLP-1 RA = glucagon-like peptide-1 receptor agonist. YKHC formulary liraglutide (Victoza).
- SGLT2i = sodium-glucose co-transporter-2 inhibitor. YKHC formulary empagliflozin (Jardiance).
- SU = sulfonylureas. YKHC formulary glipizide.
- TZD = thiazolidinedione. YKHC formulary pioglitazone.

Medication selection is based on comorbidities and patient centered goals.

Always begin with lifestyle interventions. These are essential as medication response is often dependent on lifestyle measures.

Metformin: always first-line unless true allergy. If not tolerated, allow patient a break and then re-try.

Indicators of high-risk for ASCVD or established ASCVD, CKD, or HF?

Yes

No

Consider using a SGLT2i or GLP-1 RA independent of baseline A1c or A1c target. SGLT2i for CKD or HF and GLP-1 RA if ASCVD predominates.

Using shared decision making with patient, choose from any of the four classes: GLP-1 RA, SGLT2i, DPP-4i, TZD. Use GLP-1 RA or SGLT2i if weight loss/maintenance a goal.

Follow-up in 1-3 months.

If not achieving targets, continue to add classes of medications
GLP-1 RA or SGLT2i
+
DPP-4i (do not combine with GLP-1 RA) or TZD (do not use if HF present)
+
SU or basal Insulin
(Always maximize non-insulin medications first, including injectable GLP-1 RA unless the patient has significant hyperglycemia and weight loss. Then add insulin early.)

Follow up visits at least every three months until lifestyle and A1c goals achieved.

If not achieving A1c goals, consider using CGM, revise SMART goals, utilize DSMES, DM support group, screen for Diabetes Distress or other psychosocial issues.

Lifestyle Management

- Self-care through sleep hygiene, mindfulness, nature, and similar efficacious stress reduction techniques.
- Advise developing a positive, supportive social network.
- Use patient centered SMART goals, including consideration of individualized targets, impact on weight, hypoglycemia risk, side effect profile of medications, and complexity of regimen. Choose regimen to optimize adherence and persistence.
- Exercise is medicine: Titrate to 150 min/week minimum.
- Advise 7-10% weight loss if obese.
- Recommend traditional Alaska Native diet with emphasis on maximizing plants and high fiber foods.

Shared decision making includes an educated and informed patient and their family/caregiver, patient preference, motivational interviewing, goal setting, ensuring access to DSMES, and empowering the patient.

Diabetes Distress refers to negative psychological reactions to the emotional burden and patient worries specific to their experience of managing a complicated and demanding chronic disease. See ADA [position statement](#).

- If not achieving A1c goals and on four classes of medication including basal insulin, consider referral to ANMC Diabetes program and/or multidisciplinary discussion with diabetes team.
- Add prandial insulin as needed and ensure insulin teaching, self-management goals, and that patient is performing appropriate monitoring
- Continue to utilize a patient centered approach with shared decision making. Revisit lifestyle behaviors, patient specific motivators, psychosocial factors, and address medical comorbidities.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by MSEC 9/2/20.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Elizabeth_Tressler@ykhc.org.

**Background Information:**

- 75% of the AN/AI population is colonized with *H. Pylori* (range 61-84%).
- Screening or testing for *H. Pylori* for routine evaluation of dyspepsia or other GI symptoms is not clinically useful or supported by evidence for high prevalence populations.
- For routine clinical practice, there is **insufficient evidence-based data** to support community-wide eradication as a mechanism for gastric cancer prevention.
- Current literature **DO NOT** support a test and treat method with noninvasive tests.

Pediatrics:

- Goal is to determine underlying cause of symptoms, not solely the presence of *H. pylori* infection.
- Principles of testing and treatment are the same as for adults.
- Diagnostic testing is NOT recommended with functional abdominal pain or iron-deficiency anemia.
- Consult pediatrics if considering this diagnosis.

Pregnancy and Lactation:

- Delay treatment until after pregnancy
- DO NOT use in Pregnancy: bismuth and tetracycline
- DO NOT use in lactation: bismuth, metronidazole, levofloxacin

H. Pylori identified by histology and/or CLO test from EGD
AND

Endoscopy reveals the following:

- Duodenal ulcers
- Gastric ulcer
- MALT lymphoma
- Intestinal metaplasia

Treat for H. Pylori with antibiotics

****All treatment is for 14 days****

Adult Dosing**Preferred Treatment:**

Metronidazole 500 mg PO QID
Amoxicillin 1000 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID

PCN allergic (anaphylactic):

Metronidazole 500 mg PO QID
Doxycycline 100 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID

Recurrence/Failure:

Metronidazole 500 mg PO QID
Doxycycline 100 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID
OR
Amoxicillin 1000 mg PO BID
Levofloxacin 500 mg PO daily (FDA Black Box)
Omeprazole 20 mg PO BID

Pediatric Dosing

Metronidazole 10 mg/kg PO BID
Amoxicillin 45 mg/kg PO BID
Omeprazole 1 mg/kg PO BID
Bismuth subsalicylate
<10 years: 262 mg PO QID
>10 years: 524 mg PO QID

Other causes of dyspepsia that antibiotics will NOT help,
EVEN IF H. Pylori is detected:

- GERD
- Irritable Bowel Syndrome
- Mild/moderate gastritis
- Excessive/chronic NSAID use
- Heavy alcohol use
- Poor gastric mobility

Symptomatic Relief Medications:

Adults:
Ranitidine 150 mg PO BID
Omeprazole 20 mg PO BID

Children:
Ranitidine 5-10 mg/kg PO divided BID

Eradication Testing:

- Urea Breath Test for *Test of Cure* is necessary to determine need for retreatment. It can be performed on children as young as 3. The stool antigen test available at YKHC is not recommended for test of cure.
- 10-35% of individuals will fail treatment.
- Serologic testing is not recommended due to prolonged antibody persistence beyond date of cure and false positive results.
- Must be off PPI for ≥ 2 weeks prior to Urea Breath Test.

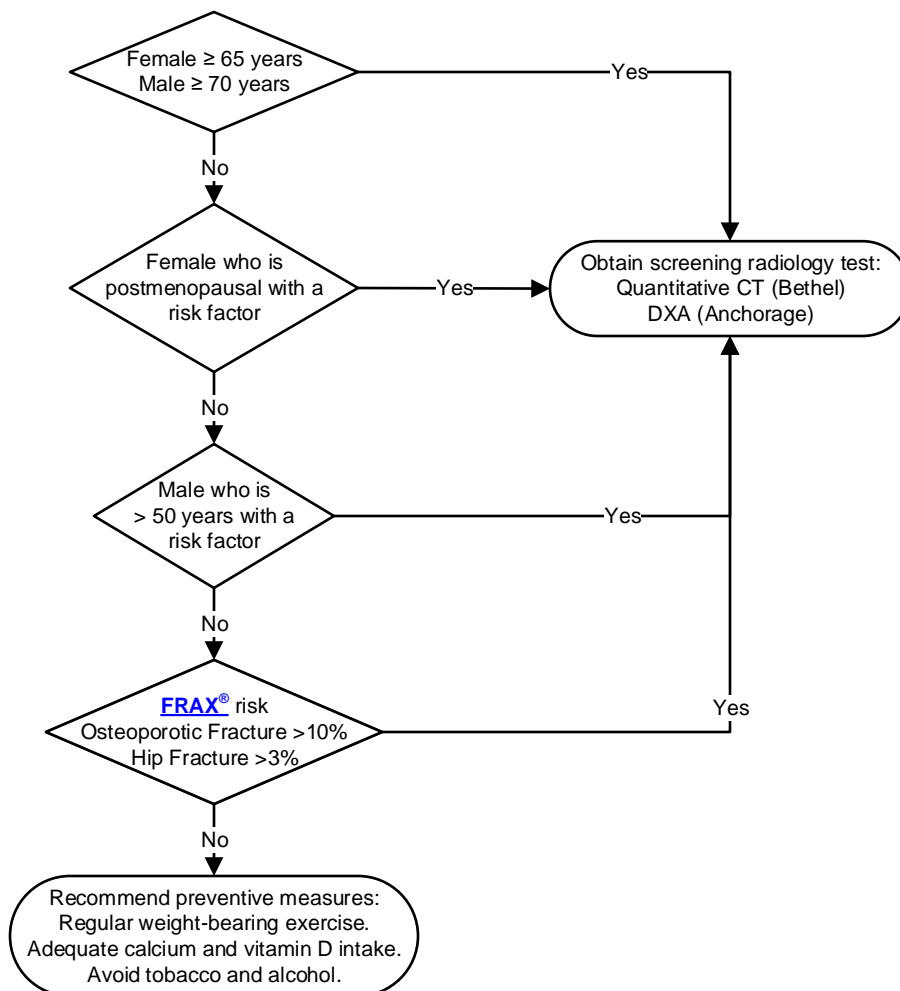


Risk Factors

- Osteopenia on X-ray.
- History of fracture without trauma.
- Tobacco use.
- Excessive alcohol use.
- Height loss more than ½ inch in one year.
- Height loss more than 1.5 inches total.
- At risk medication use (see box below).
- BMI < 20.
- Premature menopause.

At Risk Medications

- Systemic steroids >3 months
- Methotrexate
- Aromatase inhibitor
- Selective estrogen receptor modulator
- Proton pump inhibitor
- Heparin
- SSRI



Recommended Calcium Intake

Age	Sex	RDA mg/day
9-18	M+F	1300
19-50	M+F	1000
51-70	M	1000
51-70	F	1200
>71	M+F	1200

Recommended Vitamin D Intake

Age	Sex	RDA IU/day
14-70	M+F	600
>71	M+F	600



Abbreviations

BMD – Bone mineral density
BTM – Bone turnover markers
FRAX® – Risk scoring algorithm

FRAX® High Risk for Fracture

10 year risk of major osteoporotic fracture $\geq 20\%$ or hip fracture risk $\geq 3\%$.

If patient has one or more of the following:

- Lumbar spine or femoral neck or total hip T score ≤ -2.5
- CT bone density $< 80 \text{ mg/cm}^3$
- History of a fragility fracture
- High **FRAX®** fracture probability

Evaluate for secondary causes of osteoporosis.

Correct calcium/vitamin D deficiency and address secondary causes of osteoporosis.

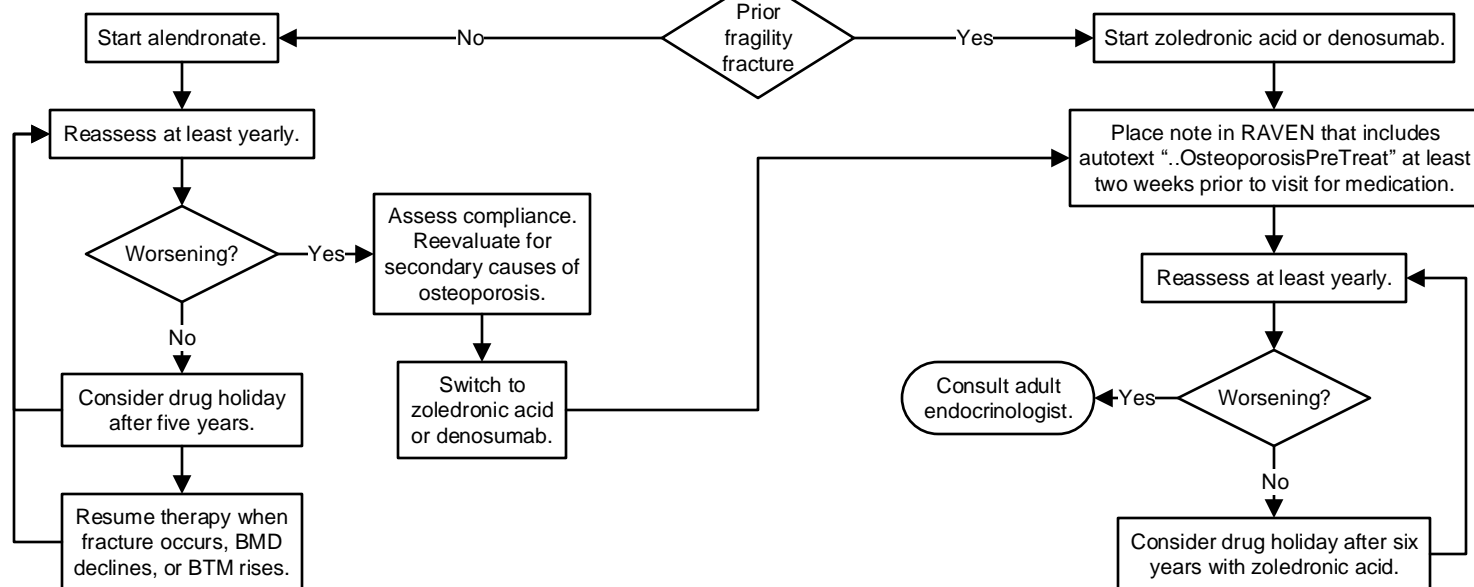
Educate patient on lifestyle measures, fall prevention, and benefits and risks of medications.

Obtain dental evaluation of and treatment for risk of osteonecrosis of jaw.

Consider endocrinology consultation.

Some Secondary Causes of Osteoporosis

- Drugs
- GI-related illness
- Bone marrow disease
- Endocrine disorder
- Organ transplant





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Background

- Only 4-9% of those...labeled [penicillin-allergic] are currently allergic. It is important to identify those who are not allergic, because children mislabeled as penicillin-allergic have more medical visits, receive more antibiotic prescriptions, and have longer hospitalizations with more antibiotic-related complications.¹
- Up to 10% of children develop rashes while receiving antibiotics. Most are diagnosed...as allergic to the implicated antibiotic, and most continue to avoid the suspect antibiotic in favor of alternatives, which may be less effective, more toxic, and more expensive.²
- Do not label a patient as allergic to penicillin/amoxicillin unless he or she has true hives, anaphylaxis, or a life-threatening reaction. Please include photos of rashes in RAVEN.
- Please consult a pediatrician with any questions.

Anaphylaxis

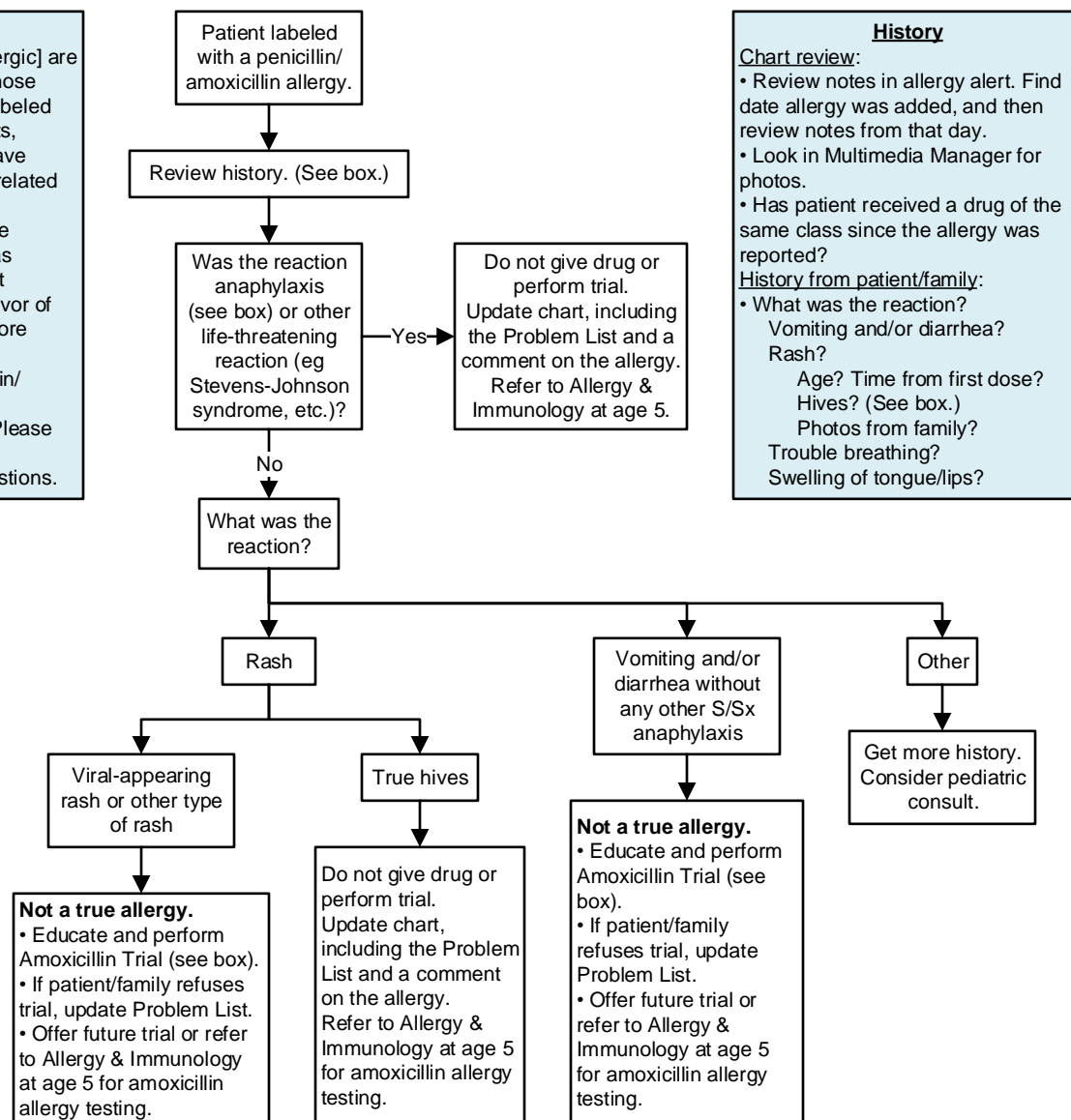
- Acute onset – several minutes to hours from exposure.
- Generalized hives, pruritis or flushing, swelling of lips/tongue/uvula, and at least one of the following:
 - Dyspnea, bronchospasm, stridor
 - Hypotension
 - Evidence of hypoperfusion of end-organs
 - Persistent crampy abdominal pain and/or vomiting

Hives vs Viral Rash

- True hives are raised, itchy, larger than dime-sized, come and go, move around the body, and change shape and size.
- Keep in mind that many parents refer to any rash as "hives." Get a description every time.
- A viral exanthem is typically diffuse, fine, pinpoint red dots and can be dense, coalesced, larger raised lesions. The rash typically covers the face and chest but can cover the whole body. The rash typically worsens and takes days to clear.

References

1. Kelso JM. "Provocation challenges to evaluate amoxicillin allergy in children." JAMA Pediatrics 2016;170(6):e160282.
2. Mill C, et al. "Assessing the diagnostic properties of a graded oral provocation challenge for the diagnosis of immediate and nonimmediate reactions to amoxicillin in children." JAMA Pediatrics. 2016;170(6):e160033.



Amoxicillin Trial Procedure²

1. Obtain VS. Perform physical exam, including lung exam. Have appropriate dose of EpiPen or epinephrine available.
Epinephrine (1 mg/mL): 0.01 mg/kg (or 0.01 mL/kg) IM q5-15 minutes.
Per AAP recommendations:
 - 7.5-25 kg: use EpiPen Jr (0.15 mg)
 - ≥ 25 kg: use EpiPen (0.3 mg)
2. Calculate weight-based dose of amoxicillin. Give patient 10% of that dose.
3. Place patient in nearby room and instruct caregiver to notify staff of any changes in status.
4. If no reaction by 20 minutes, give patient remaining 90% of weight-based dose of amoxicillin.
5. Observe another 60 minutes. If no reaction, check VS and physical exam. If all stable, discharge home with regular course of drug.
6. Give patient and family amoxicillin trial education sheet.
7. Update allergy alert in RAVEN. Click the allergy in the banner. Right click over the drug name and choose "cancel." On the "reason" drop-down menu, choose "OK on Retrial."



Potential exposure to botulism:

- Ingestion of fish/food fermented in an anaerobic environment or seal oil.
- Development of concerning symptoms thereafter (12-36 hours typical, but can be 6 hours to 10 days).

Clinical paradigm suggesting botulism?

- GI symptoms with autonomic or neurologic abnormality
- Cranial nerve deficit with no apparent cause
- Descending symmetrical paralysis or weakness with no apparent cause

AND

At least three of the five following symptoms present (botulism "diagnostic pentad")?

- Dilated or fixed pupils
- Diplopia
- Dry throat
- Dysphagia
- Nausea or vomiting

Other Symptoms

- Sore throat
- Dysarthria
- Hyporeflexia
- Urinary retention
- Ileus

No

Yes

Suspected Botulism

- Obtain appropriate labs (below).
- Admit for close clinical monitoring.

High Risk for Botulism

- Obtain blood for botulism testing before starting BAT.
- Start BAT. Watch for signs of anaphylaxis.
- Complete **BAT packet** found on State Epi website.
- Supportive care based on clinical picture.
- If not requiring higher level of care, admit for close clinical monitoring.

All cases:

- Contact AK State Office of Epidemiology.
- Collect lab specimens for testing at state lab:
 - Collect 5-10 ml of serum (or 20 ml whole blood) for botulism testing (before BAT)
 - Collect any stool (10-50 ml) and emesis (20 ml) for botulism testing
 - When possible, also collect suspect food (50 g, keep cold)
- Monitor clinically as an inpatient (Rapidly-progressing illness. 24 hours likely adequate):
 - Watch for "diagnostic pentad" symptoms above. Start BAT as appropriate.
 - Obtain FVC at baseline every 1-2 hours. Intubate if FVC declines 30%.
- Standard precautions are appropriate (not transmitted person-to-person).

Botulism Anti-Toxin (BAT)

- BAT does not reverse current anticholinergic symptoms but prevents progression by binding the toxin in the blood.
- No adverse effects of BAT have been reported thus far.
- Pharmacy can assist with the BAT packet forms to be completed when administered.

Note: Botulism toxin only causes flaccid paralysis. Patients are awake, alert, and aware. Procedures should be explained and appropriate pain control and sedation for intubated patients should be provided.

Infant Botulism:

This is rare, with only 5 reported cases in AK in the past 65 years. If suspected, see Epi Procedure Manual, Botulism at State website.

Resources

- AK State Office of Epidemiology [Website](#):
-907-269-8000 (M-F, 8-5) and 800-478-0084 (after hours)
 - State Lab [Website](#):
-1-855-222-9918
- Division of Public Health Healthcare Provider [Checklist](#)

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/2/20. Click [here](#) to see the supplemental resources for this guideline. If comments about this guideline, please contact Lisa_Evans@ykhc.org.



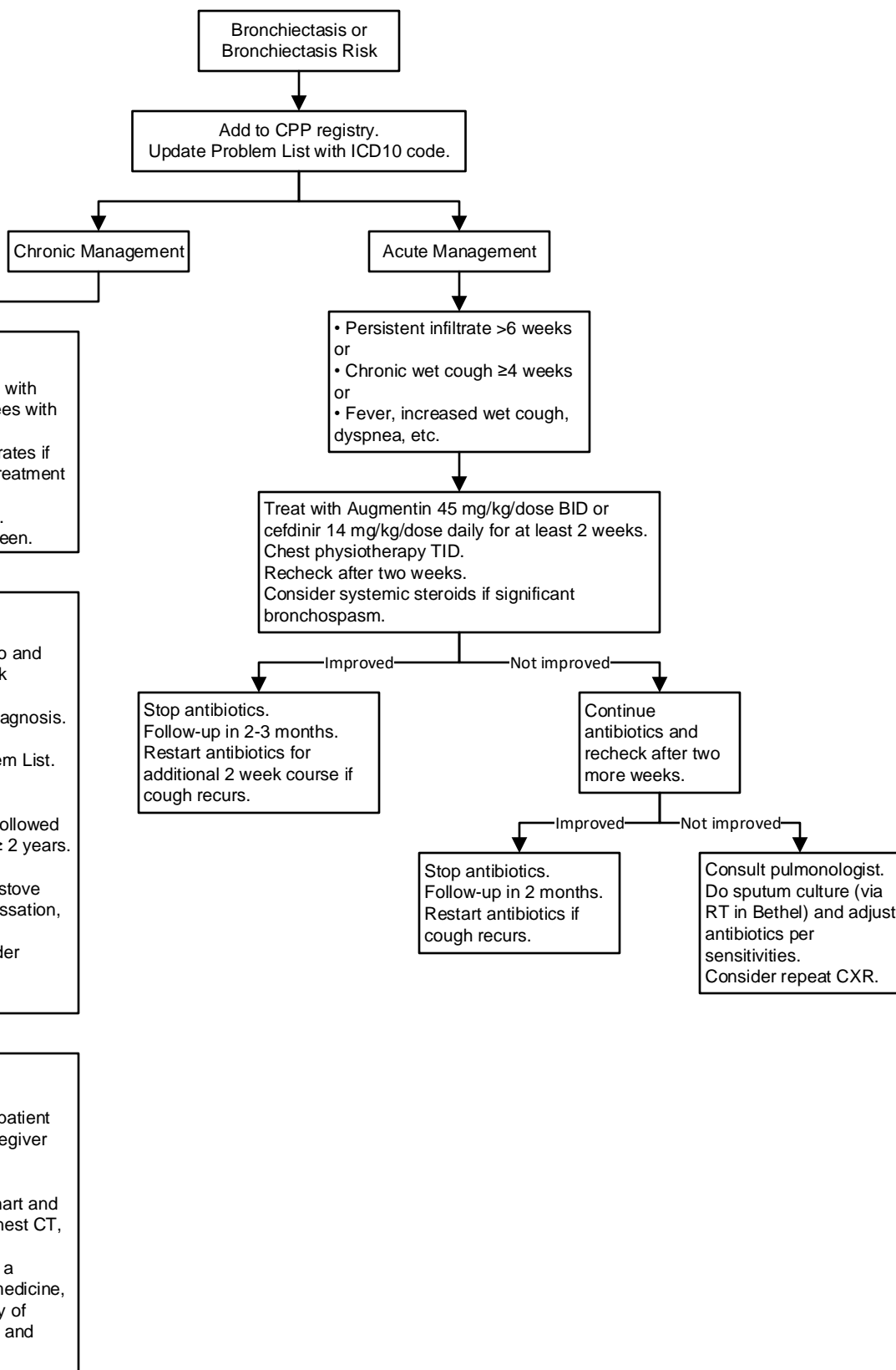
Definitions

• Bronchiectasis is a lung condition with chronic wet cough and lung infections and is diagnosed by CT scan.

Use ICD10 code J47 – “Bronchiectasis.”

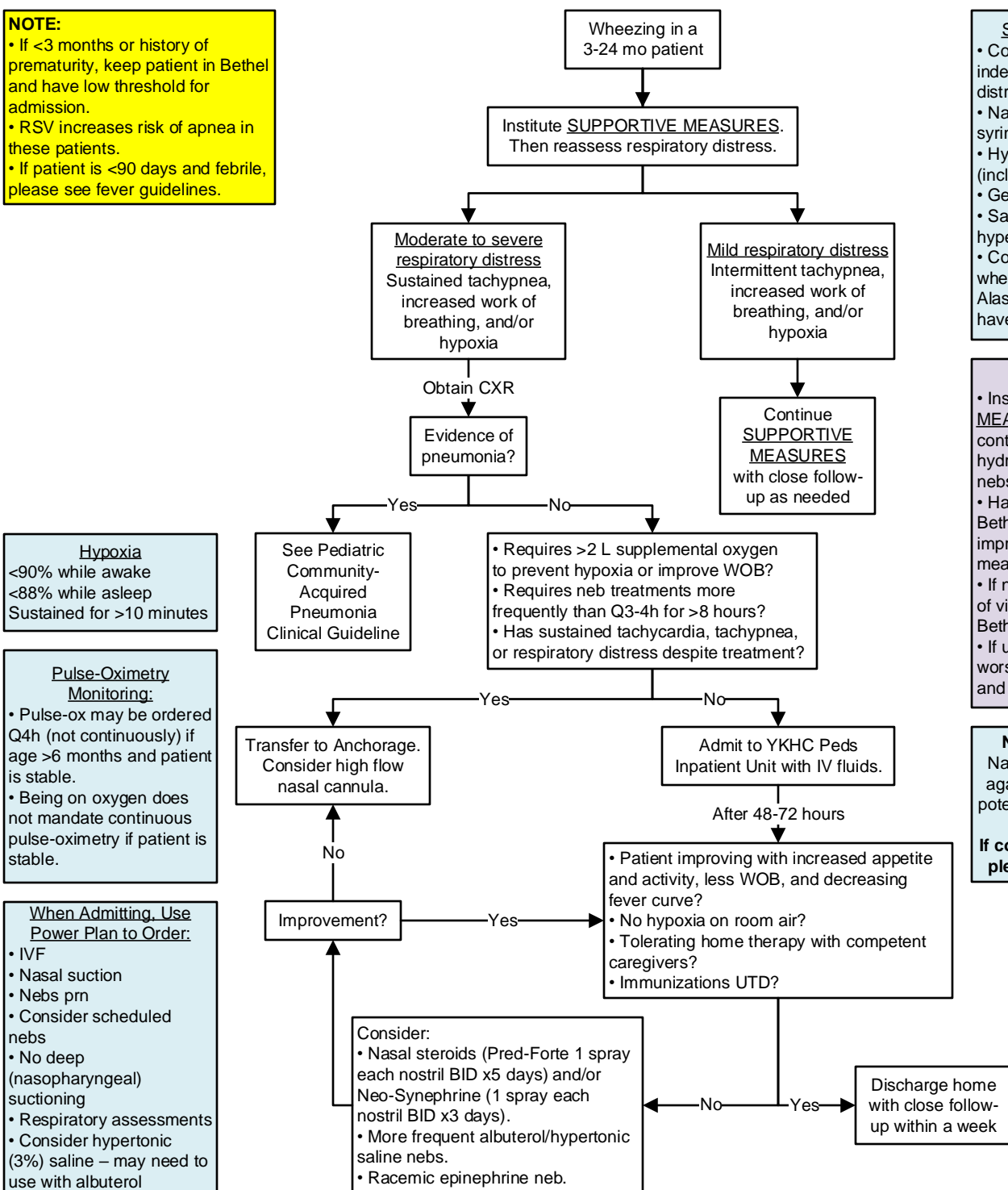
• Bronchiectasis risk is defined as ≥ 3 episodes of wet cough >4 weeks in the past 2 years, often in a setting of persistent infiltrates and recurrent pneumonia.

Use ICD10 code J41.1 – “Chronic purulent bronchitis.”



**NOTE:**

- If <3 months or history of prematurity, keep patient in Bethel and have low threshold for admission.
- RSV increases risk of apnea in these patients.
- If patient is <90 days and febrile, please see fever guidelines.

**SUPPORTIVE MEASURES**

- Control fever, as it can be an independent cause of respiratory distress and tachycardia.
- Nasal suction with nasal bulb syringe and olive tip plus saline.
- Hydration by IV or enteral (including NG and G-tube).
- Gentle P&PD/CPT if helpful.
- Saline neb (either 0.9% or hypertonic 3%).
- Consider albuterol trial even if no wheezing heard, especially in Alaska Native patients as they have high rates of RAD.

Village Management

- Institute **SUPPORTIVE MEASURES**, especially fever control, nasal suction, IV or PO hydration, and several albuterol nebs.
- Have low threshold to refer to Bethel for further evaluation if no improvement with supportive measures or any concerns.
- If no improvement after 2-3 days of village management, refer to Bethel for further care.
- If unable to bring to Bethel and worsening, consult a pediatrician and consider systemic steroids.

NOTE ABOUT STEROIDS:

National guidelines recommend against systemic steroids as the potential harm is generally greater than the potential benefit.
If considering starting steroids, please consult a pediatrician.

Hypoxia
<90% while awake
<88% while asleep
Sustained for >10 minutes

Pulse-Oximetry Monitoring:

- Pulse-ox may be ordered Q4h (not continuously) if age >6 months and patient is stable.
- Being on oxygen does not mandate continuous pulse-oximetry if patient is stable.

When Admitting, Use Power Plan to Order:

- IVF
- Nasal suction
- Nebs prn
- Consider scheduled nebs
- No deep (nasopharyngeal) suctioning
- Respiratory assessments
- Consider hypertonic (3%) saline – may need to use with albuterol



Signs of Impending Airway Compromise

- drooling
- lethargy
- tripod position
- marked retractions
- tachycardia
- cyanosis or pallor
- rapid progression of symptoms

Important Supportive Measures

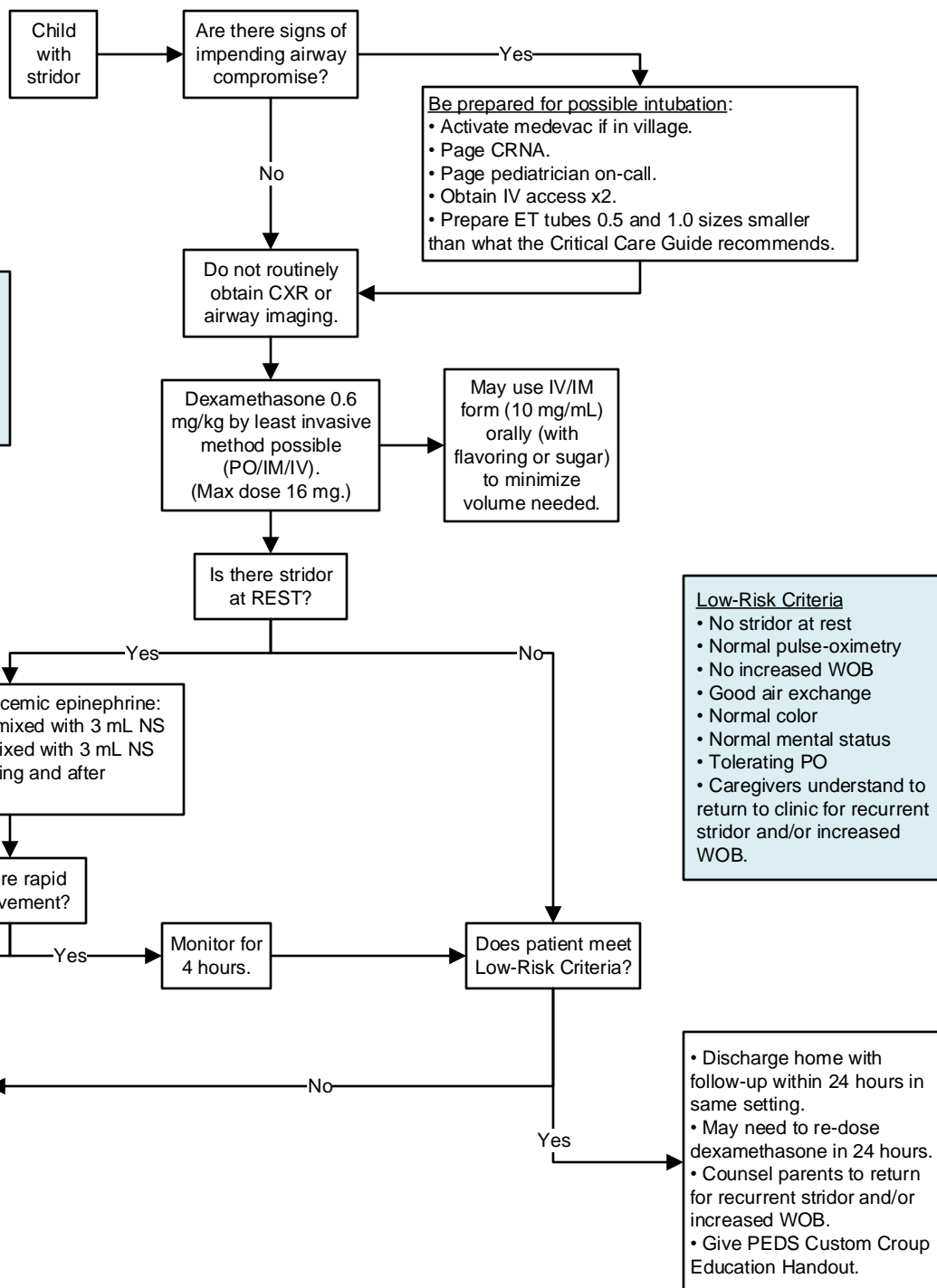
1. Keep child upright or in position of comfort.
2. Turn lights down and minimize unpleasant interventions.
3. May take child outside for cool air.
4. Minimize invasive measures – keep child CALM!
5. **DO NOT** give albuterol; this can worsen croup.

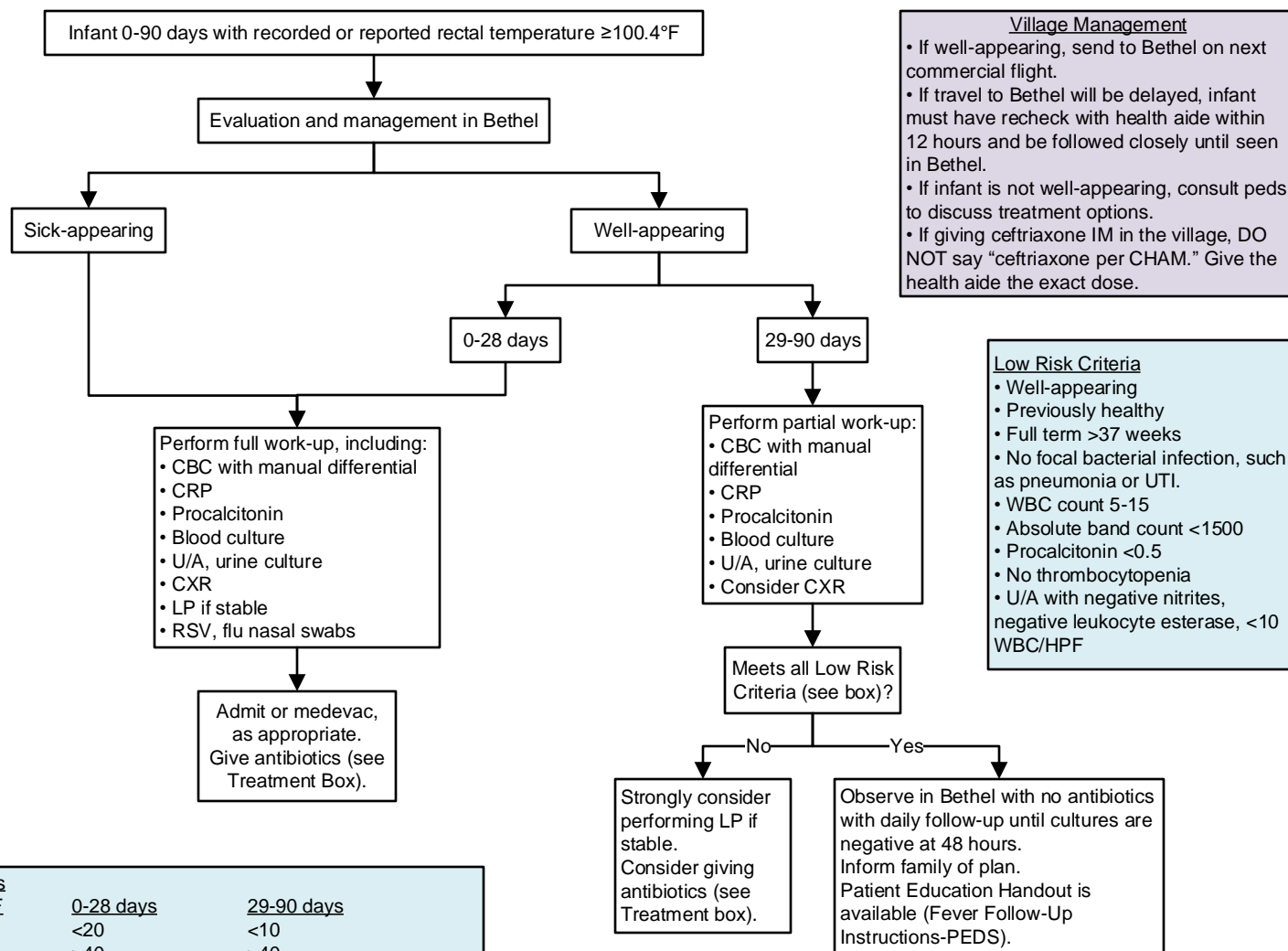
DDx Stridor

- croup (most common in ages 6 months to 3 years)
- foreign body
- tracheomalacia
- angioedema
- tracheitis
- epiglottitis
- abscess

In Village

If no racemic epinephrine available, mix 1 mL of 1:1000 epi with 1 bullet of NS and give via nebulizer.



**CSF Results**

Normal CSF	0-28 days	29-90 days
WBC	<20	<10
Glucose	>40	>40
Protein	<100	<75

Absence of neutrophils (polys) makes bacterial meningitis unlikely. CSF neutrophils (polys) $>75\%$ increases likelihood of bacterial meningitis.

Do not use correction formulas for traumatic LPs.

Special Circumstances

1. Immunizations within 24 hours of fever <101 and well-appearing: no work-up necessary but must follow-up in village or Bethel within 12-24 hours. If fevers persist or infant is not well-appearing, perform work-up as above.

2. Pre-treatment with antibiotics with no focal bacterial infection: infant must be observed a full 48 hours off antibiotics. This may require staying in Bethel for 48 hours of antibiotics followed by another 48 hours of observation off antibiotics with daily follow-up. Consider ordering CSF Multiplex PCR, a send-out test.

3. Unsuccessful LP: treat if appropriate and consider a repeat LP in 12-24 hours and determine treatment course based on cell counts. If repeat LP not performed or unsuccessful, either treat for 10-14 days with meningitic dosing of IV antibiotics or stop antibiotics at 48 hours and observe infant for an additional 48 hours off antibiotics. Consider admission.

HSV Work-up

- CSF HSV PCR
- Blood HSV PCR
- CMP
- Nasopharyngeal, conjunctival, and anal swabs and vesicle fluid for HSV PCR.

Risk-Stratification Resource:

[Kaiser Neonatal Sepsis Calculator](#)

Treatment

No febrile infant <90 days should receive antibiotics without an LP.

• 0-7 days: please consult a pediatrician, pharmacist, or Neofax.

• 8-28 days:

-If well-appearing and low suspicion for meningitis: ampicillin 50 mg/kg IV Q8h AND gentamicin 4 mg/kg IV Q24h

-If well-appearing and any suspicion for meningitis: ampicillin 75 mg/kg IV Q6h AND cefepime 50 mg/kg IV Q12h

-If ill-appearing and/or positive CSF Gram stain: please consult a pediatrician and/or a pharmacist.

• 29-90 days: ceftriaxone 75 mg/kg IV/IM Q24h OR if worried about meningitis 100 mg/kg IV once then 50 mg/kg IV Q12h

• Continue IV/IM antibiotics until cultures are negative and patient is clinically stable x48-72 hours or until specific organism and sensitivities are available to direct therapy.

• If known HSV exposure, seizures, or severe illness: acyclovir 20 mg/kg IV Q8h with IVF, perform HSV work-up (see box), and consult pediatrics.

• If suspicion for bacterial meningitis, strongly consider medevac.

• If transferring patient, send any extra CSF on ice with patient.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 5/8/19. Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.



Testing Recommendations

Suspected Influenza in the Ambulatory Setting:

- Patients considered High Risk for Complications (See below.)
- Adults >65 years of age
- Children <2 years of age
- Patients with complicated influenza-like illness that may warrant treatment
- Individuals with febrile illness of unclear etiology or as part of a sepsis evaluation

****It is not recommended to perform testing in most ambulatory patients who present with uncomplicated flu-like illness.***

Suspected Influenza in the Inpatient Setting:

All patients admitted with febrile illness or respiratory symptoms should be tested.

High Risk for Influenza Complications:

- **Chronic Pulmonary Disease** (including asthma and pediatric patients with chronic lung disease and recurrent respiratory infections)
- **Cardiovascular Disease** (except for hypertension)
- **Diabetes Mellitus**, or other metabolic disorders
- **Immunosuppressed** (chronic steroids/biologics, chemotherapy, AIDS, etc.)
- **Pregnant or Postpartum up to 2 weeks**
- **Morbid Obesity** (BMI >40)
- <19 years of age receiving **long-term aspirin therapy**
- **Renal, hepatic, hematologic impairment/disease**
- **Neurologic and neurodevelopment conditions** (cerebral palsy, epilepsy, moderate-severe developmental delay, neurodegenerative disorders, etc.)

Treatment Recommendations

Indications for Treatment

- All patients with confirmed influenza, regardless of timing, who:
 - Have severe, complicated, or progressive illness.
 - Require hospitalization.
 - Are high risk for influenza complications (see above).
- Can be considered based on supply and clinical judgment in low risk patients within 48 hours of symptom onset.

Treatment NOT Recommended

- Non-institutionalized (hospital or other health care facility) patients age 2-64 years not at high risk for influenza complications.
- Patients with uncomplicated illness after 48 hours of symptom onset.

Chemoprophylaxis Recommendations

Chemoprophylaxis of household members is not routinely recommended except for:

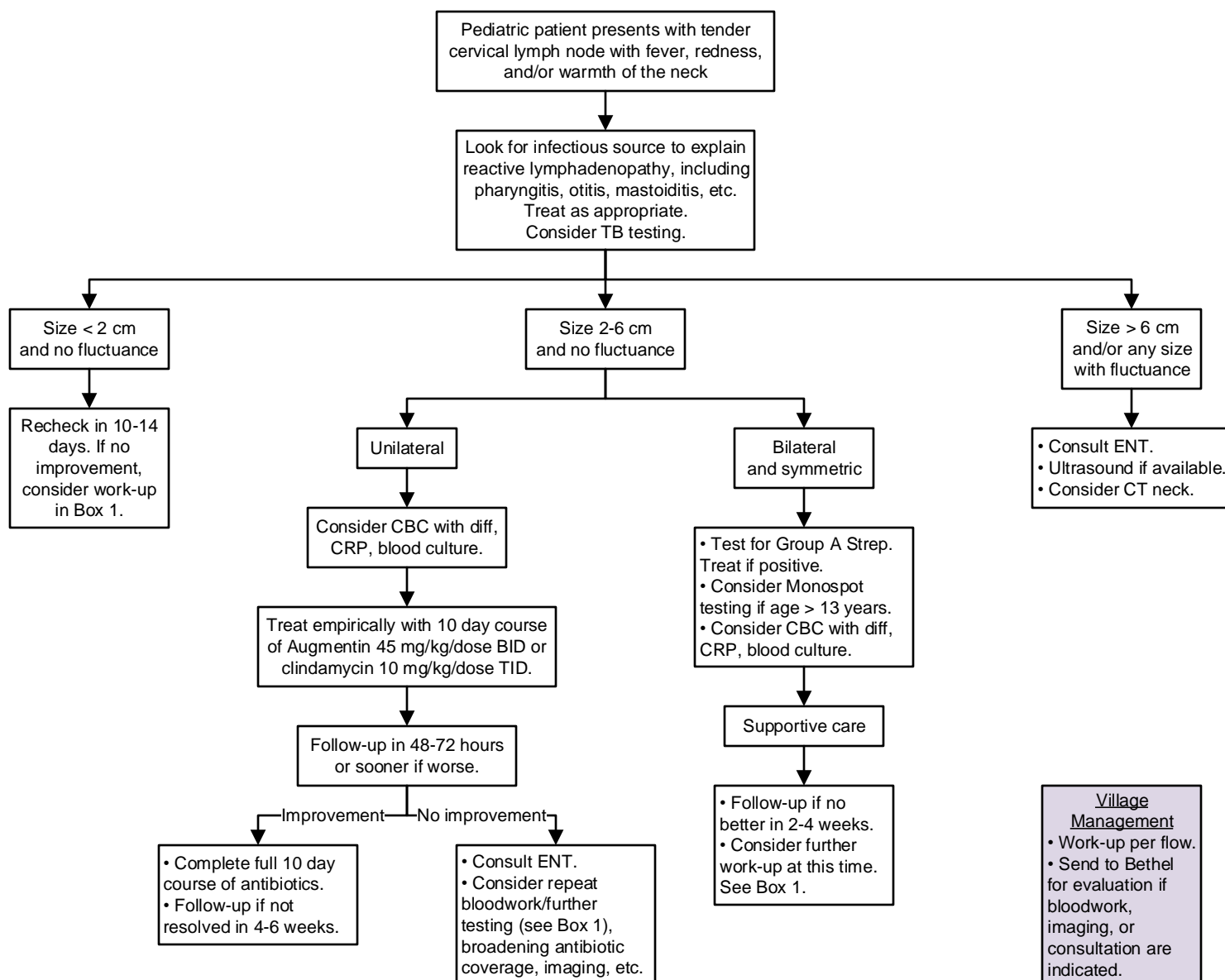
-Medically high-risk (see above) close contacts within 48 hours of exposure

** For neonates born to mothers with influenza, defer to Seattle Children's Hospital Infectious Disease Physician Consult Line for formal recommendations: (206) 987-7777.*

Influenza Treatment Dosing for Oseltamivir

	Age/Weight	Dose	Renal Dose Adjustments	Duration
Neonates	PMA <38 weeks: 1 mg/kg/dose PO q12hr PMA 38-40 weeks: 1.5 mg/kg/dose PO q12hr PMA >40 weeks: 3 mg/kg/dose PO q12hr >2 weeks: 3 mg/kg/dose PO q12hr <i>Confirm with Seattle Children's Hospital Infectious Disease Physician Consult Line (206) 987-7777.</i>		CrCl <30mL/min: usual dose given q24hr *additional dose adjustment needed for hemodialysis (consult pediatric nephrology in all cases)	5 days
Infants	Term, 3-8 months 9-11 months	3 mg/kg/dose PO q12hr 3.5 mg/kg/dose PO q12hr		5 days
Children 1-12 years	<15 kg 15-23 kg 23-40 kg	30 mg PO q12hr 45 mg PO q12hr 60 mg PO q12hr		5 days
Adults and Children ≥ 12 years	>40 kg or >12 years	75mg PO q12hr	CrCl 30-60 mL/min: 75mg PO q24hr CrCl 10-30mL/min: 30 mg PO q24hr Hemodialysis: Consult nephrology	5 days

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Box 1: Further Work-up

Perform careful exam for lymphadenopathy of other locations. For any child with nontender lymphadenopathy or lack of improvement after specified period, consider, as appropriate:

- PPD/TB work-up
- CBC
- CRP
- LFTs
- Blood culture
- HIV testing
- RPR
- Toxoplasmosis testing
- Bartonella testing
- EBV, CMV titers
- LDH, uric acid
- CXR
- Hematology/oncology consult
- Infectious disease consult

Most Common Causes

- **Reactive lymphadenopathy** due to local infection (may take 4-6 weeks to resolve).
- **Unilateral:** *Staph aureus*, Group A Strep, Group B Strep, anaerobes, TB/MAC
- **Bilateral:** respiratory viruses (enterovirus, adenovirus, influenza, etc.), Group A Strep, HSV (primary), EBV, CMV, *Mycoplasma*, *Arcanobacterium*, TB

Less Common Causes to Consider

- Kawasaki disease; periodic fever with aphthous stomatitis, pharyngitis, and adenitis (PFAPA); leukemia; lymphoma

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Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

**Box 1: AOM Decision-Making Principles**

- If observation is warranted, do not prescribe antibiotics.
- Always treat pain with acetaminophen and ibuprofen, as appropriate.
- If patient has not received amoxicillin within 30 days, start with amoxicillin to treat new infection.
- For AOM with otorrhea, use otic drops if >6 months. Do not use oral antibiotics unless the other ear is infected without perforation.
- Do not treat fluid that develops after AOM if child is asymptomatic – observe up to 3 months.
- Do not use azithromycin, erythromycin, cephalexin (Keflex), or Septra for AOM.
- Do not use antibiotic prophylaxis.
- Do not send ear drainage for culture.

Box 2: Eligibility for Observation for 48-72 hours

- 6-24 month old with mild, uncertain, or unilateral AOM
- >24 month old with mild/moderate (non-bulging) AOM
- Caregiver comfortable withholding antibiotics
- Follow-up assured
- Antibiotics can be started promptly if symptoms persist or worsen
- No fever >102°F and only mild otalgia

Box 3: AOM Treatment**Antibiotic duration, by age:**

- < 2 years: 10 day course of oral antibiotic
- 2-5 years: 7 day course of oral antibiotic
- ≥ 6 years: 5 day course of oral antibiotic
- Note: in patients with history of recurrent, complicated, or chronic infections, may consider up to 10 days of treatment.

Antibiotic choice:

- 1st line: amoxicillin 45 mg/kg/dose PO BID
- 2nd line: Augmentin 45 mg/kg/dose PO BID
- 3rd line: ceftriaxone 50 mg/kg IV/IM QD for 3 days

Otitis-conjunctivitis syndrome

Augmentin 45 mg/kg/dose PO BID

Try to avoid using cephalosporins. They are less effective at treating the most common organisms that cause OM.

For PCN allergy: Please refer the patient for an allergy trial if not already done.

cefdinir 14 mg/kg/dose PO QD

OR

ceftriaxone 50 mg/kg IV/IM QD for 1-3 days

For ruptured TM/tube drainage:

Wick ears prior to giving drops.

- Ofloxacin 5 drops BID
- Ciprodex 4 drops BID

AOM ≥3 months

Acute onset of:

- Fever and ear pain
 - Bulging TM and decreased mobility
- See Box 1.

Always address pain:

- If >3 months old, use acetaminophen.
- If >6 months old, use acetaminophen and/or ibuprofen.

Is observation appropriate?
(See Box 2.)

Yes

Child is observed for 48-72 hours with follow-up

No

Start antibiotics per Box 3.

Did patient improve within 48-72 hours?

Yes

Follow-up as appropriate.

No

Reassess to confirm diagnosis of AOM.

Is diagnosis of AOM confirmed?

Yes

Initiate or change antibiotics per Box 3.

No

Assess for other causes of illness and manage appropriately.

Consider **Otitis Media with Effusion (OME)** if no acute symptoms but decreased TM mobility. Non-infected fluid may persist for 3 months after AOM. If present ≥3 months, evaluate hearing and refer to ENT.

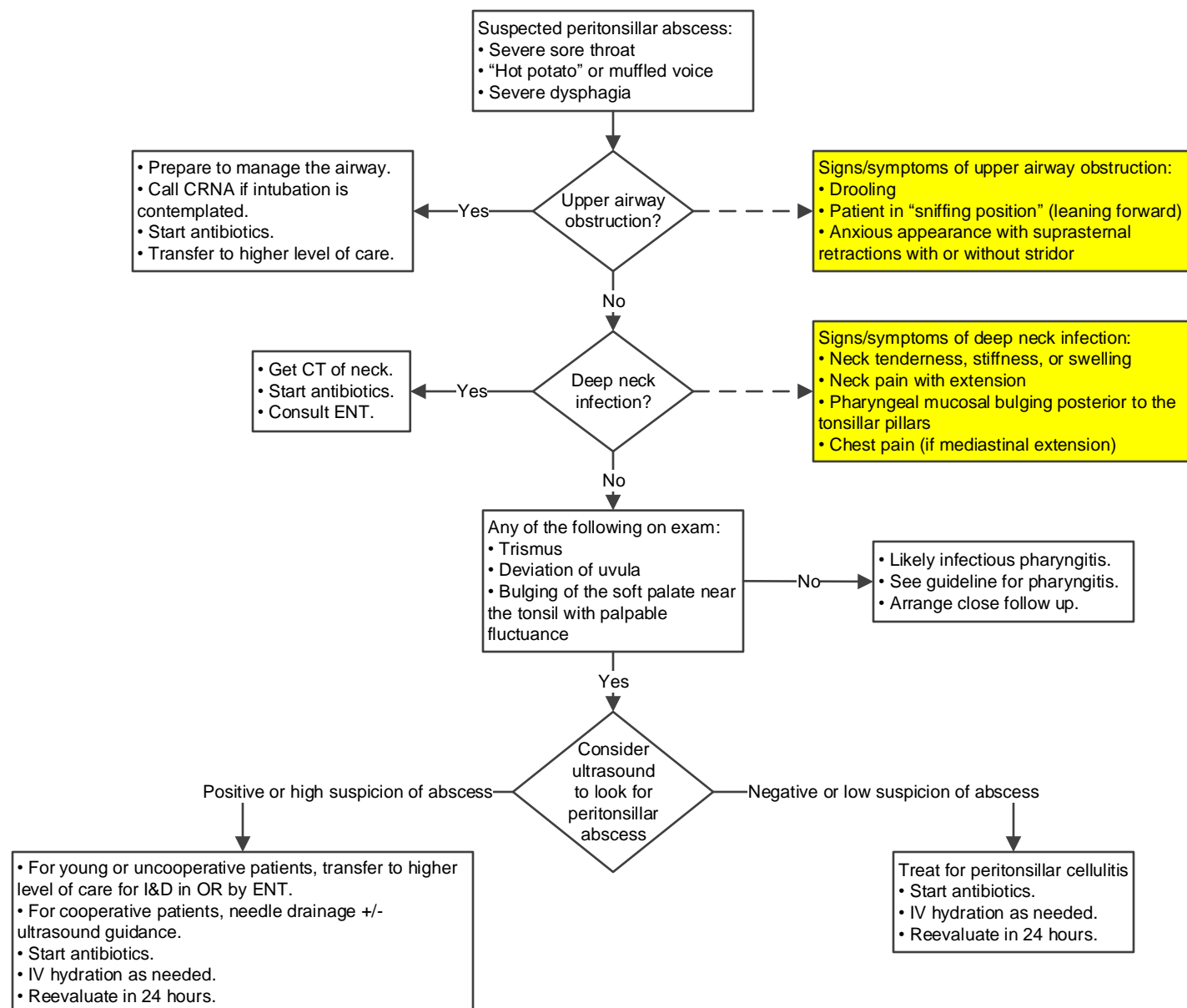
AOM <3 Months Old

If otorrhea, bulging TM, or other suspicion of AOM <3 months old, patient must be seen by provider within 24 hours.

- ≤28 days old: patient must be seen in the ER for full lab work-up including LP and treatment with IV antibiotics.
- 29-60 days old with or without fever, patient must be seen in the ER for full lab work-up including LP.
 - If febrile, follow [fever < 90 days clinical guideline](#).
 - If afebrile and reassuring work-up, may treat with oral antibiotics as appropriate.
- 61-90 days old:
 - If febrile, follow [fever < 90 days clinical guideline](#).
 - If afebrile and sick-appearing, perform work-up as clinically appropriate. May consult peds as needed.
 - If afebrile and well-appearing, lab work-up not necessary. May treat with oral or otic antibiotics as appropriate.

When to Refer to ENT

- 3 episodes of AOM in 6 months
- 4 episodes of AOM in 12 months
- OME or otorrhea for ≥3 months
- Hearing loss >20 dB



Antibiotics for peritonsillar abscess:

Ampicillin-sulbactam 3 grams IV q6h for adults and 50 mg/kg/dose (based on ampicillin, max 3 grams) IV q6h for pediatrics.

If penicillin allergic:

Clindamycin 600 mg IV q6h for adults and 13 mg/kg/dose (max 600 mg) IV q8h for pediatrics.

If severe disease:

Consider coverage for MRSA with vancomycin.

Once able to transition to oral:

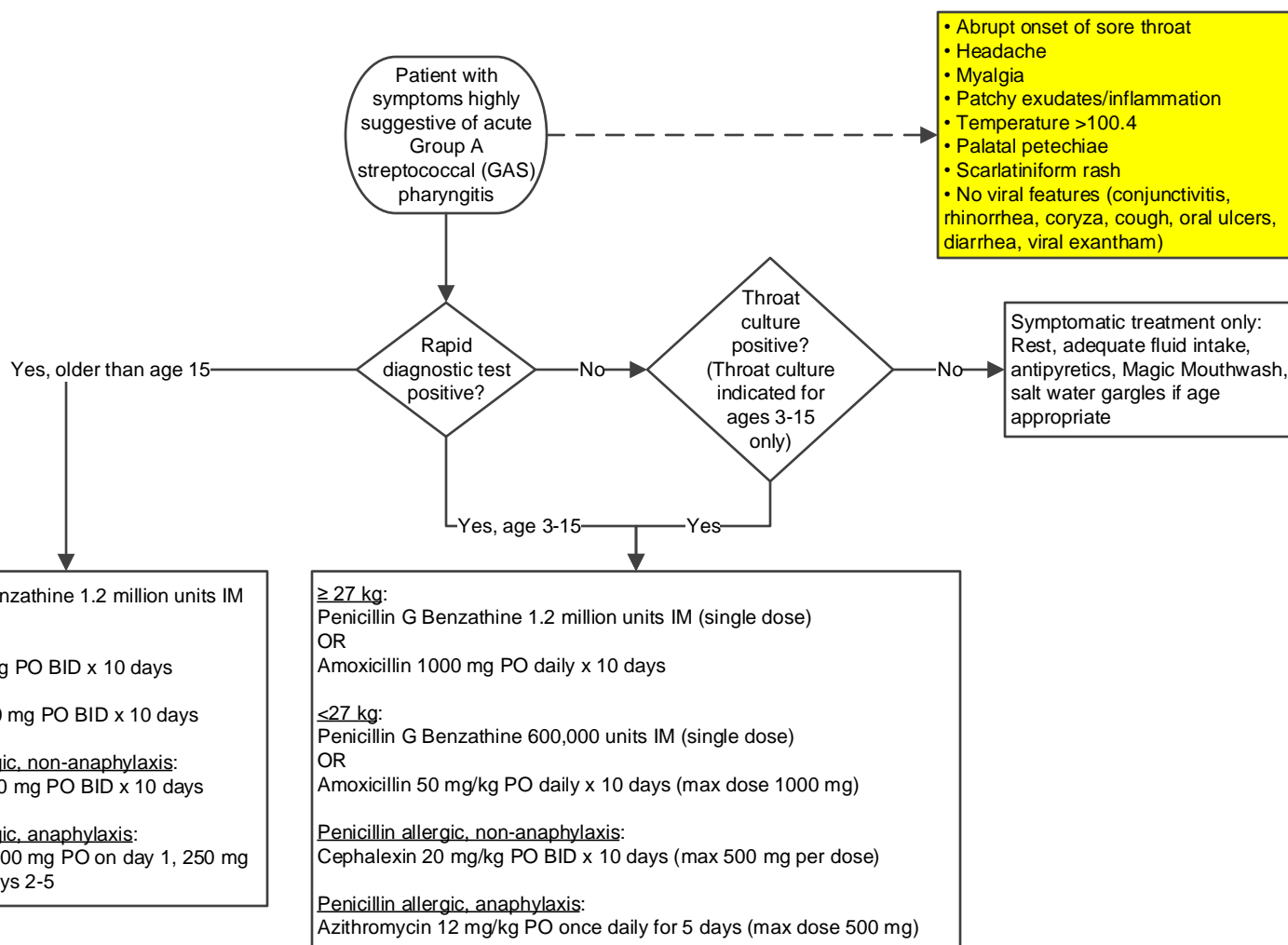
Amoxicillin-clavulanate 875 mg PO BID for adults and 45 mg/kg/dose (max 875 mg) PO BID for pediatrics.

If penicillin allergic:

Clindamycin 300 mg PO 4 times daily for adults and 13 mg/kg/dose PO 3 times daily for pediatrics.

Total duration of treatment: 14 days

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Considerations:

- Consider testing for oral GC/CT in at-risk populations.
- Testing for Group A streptococcal (GAS) pharyngitis is NOT recommended for acute pharyngitis with clinical features that strongly suggest viral etiology.
- Routine use of back-up cultures for those with a negative rapid test is not needed for adults; there is a low incidence of GAS in adults and risk of subsequent acute rheumatic fever is exceptionally low.
- It is NOT recommended to test for GAS in patients under the age of 3; the risk of rheumatic fever in this age group is exceptionally low.
- Patients are contagious for 24 hours after starting antibiotic treatment.
- Treatment for asymptomatic GAS carriers is not recommended, nor is testing or empiric treatment of household contacts.

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline Pneumonia (Adult)

Patient presents with symptoms suggesting
Community Acquired Pneumonia:
Cough, sputum, dyspnea, pleuritic chest pain, fever

Obtain CXR especially if patient has ≥ 2 of these signs:
Temp. > 100.4 , HR $> 100/\text{min}$, abnormal chest exam,
RR $> 20/\text{min}$, O₂ Sat $< 90\%$, history of chronic lung disease

If multiple TB risk
factors, see Adult
TB guideline.

CXR shows
infiltrate?

No

Chronic lung
disease?

No

A. Patient Education.
B. Rational for no antibiotics.
C. Follow-up if patient worsens.
D. Treat bronchospasm if
present.
E. Verify TB and HIV status.

If yes, consider

Pneumonia Severity Index (PSI)

<http://pda.ahrq.gov/clinic/psi/psicalc.asp>

Score = Total points accumulated below
Demographic Factors

Age of Males in years age (years)
Age of Female in years age (years) - 10
Nursing home resident +10

Comorbid Illnesses

Neoplastic disease¹ +30
Liver disease² +20
Congestive heart failure³ +10
Cerebrovascular disease⁴ +10
Renal disease⁵ +10

Physical Examination Findings

Altered mental status +20
Respiratory rate $> 30/\text{minute}$ +20
Systolic BP $< 90 \text{ mmHg}$ +15
Temperature $< 95^\circ\text{F}$ (35°C)
or $> 104^\circ\text{F}$ (40°C) +15
Pulse $> 125/\text{minute}$ +10

Laboratory Findings

pH < 7.35 +30
BUN $> 20 \text{ mg/dl}$ (11 mmol/L) +20
Sodium $< 130 \text{ mEq/L}$ +20
Glucose $> 250 \text{ mg/dL}$ (14 mmol/L) +10
Hgb $< 9 \text{ gm}$ (Hematocrit $< 30\%$) +10
PO₂ < 60 , Sp O₂ sat $< 90\%$ (room air) +10
Pleural effusion +10

*Patient with O₂ sat $< 90\%$, homelessness,
multilobar pneumonia, or risk for aspiration
may warrant hospitalization despite their risk
classification.*

1. Neoplastic disease – any cancer, except basal or squamous cell carcinoma of the skin active at the time presentation.
2. Liver disease – clinical or histologic cirrhosis or chronic active hepatitis.
3. CHF – documented with history, physical exam, or CXR findings; echo, MUGA; or left ventriculogram.
4. CVD – clinical diagnosis of stroke or TIA or documented stroke on CT or MR.
5. Renal disease – chronic renal disease or abnormal BUN or creatinine.

CAP = Community Acquired Pneumonia

HAP = Healthcare Associated Pneumonia

VAP = Ventilator Associated Pneumonia

One or
more of the
following: Comorbid
condition or abnormal
physical exam
findings from
PSI or Age
 ≥ 60 ?

Yes

Labs
1. CBC with diff
2. Comprehensive
Metabolic Panel
3. +/- Blood culture x 2
(prior to ABX)
4. +/- Sputum
5. +/- ABG
6. +/- HIV
7. Procalcitonin

Consider procalcitonin
to differentiate bacterial
causes of symptoms.

PSI ≤ 70

No

PSI 71-90

Yes

Probable outpatient treatment. Management to
be based on clinical judgement as above.

No

PSI ≥ 91

Yes

Inpatient Antibiotics

1. Ceftriaxone 1gram IV daily
AND
2. Azithromycin 500 mg IV/PO daily x 3 days

If anaphylaxis to PCN:

3. Levofloxacin 750 mg IV/PO daily for 5 days

Patient Education

1. Smoking Cessation
2. Immunizations
 - Influenza
 - Pneumovax
3. PPD
4. Follow-up

If patient is in a village and CXR isn't
available, OR the patient refuses to
travel for CXR, consider using
doxycycline as the YK Delta still has
good pneumococcal coverage with
doxycycline.

Suspect Aspiration: ampicillin-sulbactam 3 grams IV Q6hrs **OR** Ceftriaxone
1 gram IV Q24hrs **AND** metronidazole 500 mg IV every 8 hours
Suspect Pseudomonas: Cefepime 1 gram IV Q 8hours, extended infusion.
Suspect early onset HAP: within first 4 days of hospitalization, treat as CAP
Suspect late onset HAP or VAP: Vancomycin IV dosed per protocol **AND**
Cefepime 1 gram IV Q 8 hours, extended infusion

- Consult pharmacists for any questions/concerns.
- Consider consultation with respiratory therapy for admitted patients.

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but may need to be adapted to meet the special needs of a
specific patient as determined by the medical practitioner.

Approved by MSEC 9/21/18.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Ellen_Hodges@ykhc.org.

Remember to order a follow up chest x-ray in 6-8
weeks to ensure resolution of infiltrate

**REMEMBER:**

- If patient is <90 days and febrile, please see fever guidelines.
- Pneumonia is a clinical diagnosis and does not require X-ray findings.

Hypoxia

- <90% while awake
- <88% while asleep
- Sustained for >10 minutes

Pulse-Oximetry Monitoring:

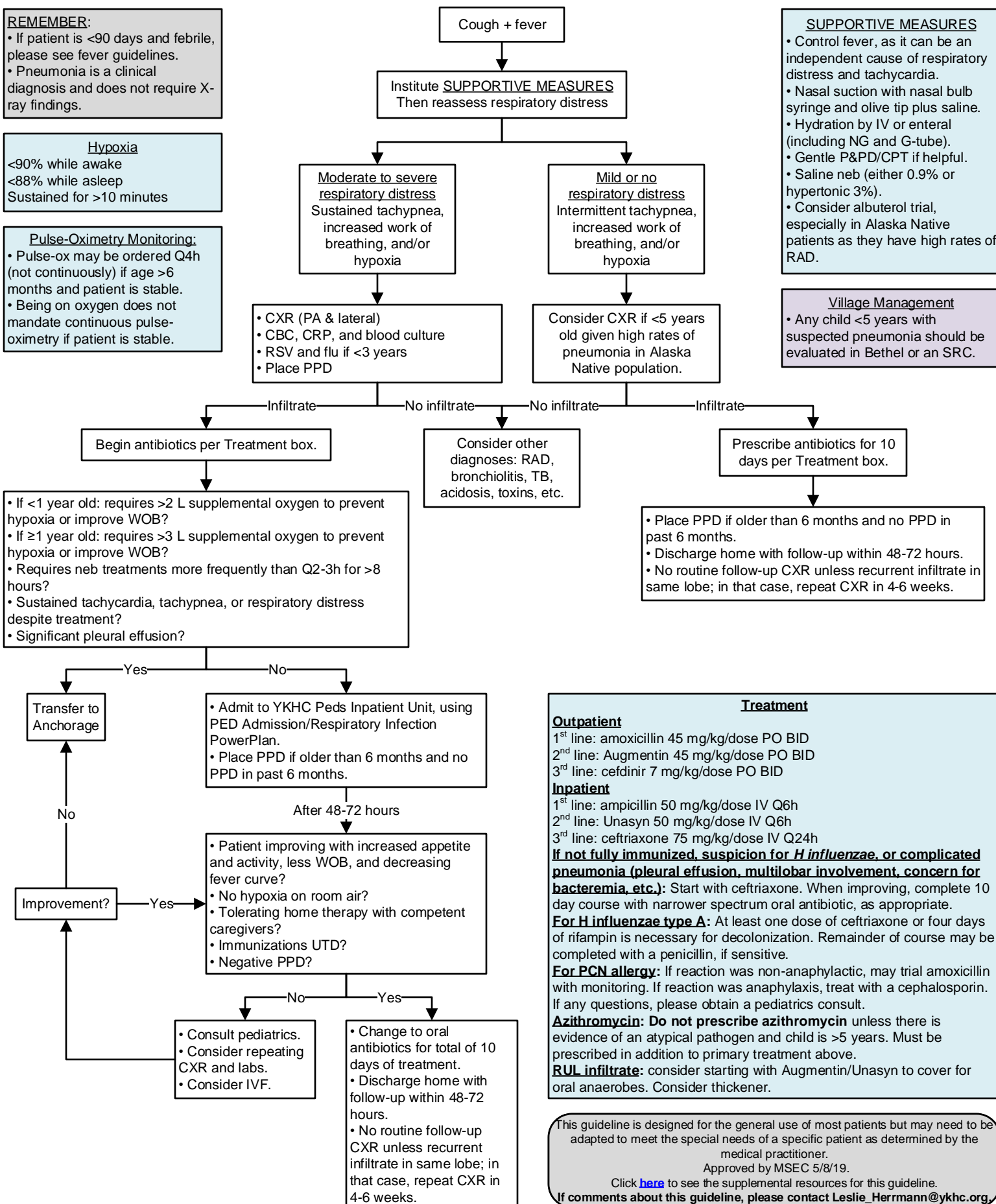
- Pulse-ox may be ordered Q4h (not continuously) if age >6 months and patient is stable.
- Being on oxygen does not mandate continuous pulse-oximetry if patient is stable.

SUPPORTIVE MEASURES

- Control fever, as it can be an independent cause of respiratory distress and tachycardia.
- Nasal suction with nasal bulb syringe and olive tip plus saline.
- Hydration by IV or enteral (including NG and G-tube).
- Gentle P&PD/CPT if helpful.
- Saline neb (either 0.9% or hypertonic 3%).
- Consider albuterol trial, especially in Alaska Native patients as they have high rates of RAD.

Village Management

- Any child <5 years with suspected pneumonia should be evaluated in Bethel or an SRC.





Procalcitonin in Adults with Lower Respiratory Tract Infections

Initial Value (Baseline)

Procalcitonin Value	<0.1 ng/mL	0.1-0.24 ng/mL	0.25-0.5 ng/mL	>0.5 ng/mL
Antibiotic START recommendation	Initiation strongly discouraged	Initiation discouraged	Initiation encouraged	Initiation strongly encouraged
Comments	<ul style="list-style-type: none"> • Hold on giving antibiotics. • Consider alternate diagnosis. • Repeat procalcitonin in 6-12 hours if antibiotics not initiated and no clinical improvement. • If clinically unstable, immunosuppressed, or high-risk, consider overruling. (PSI Class IV-V, CURB-65 >3). 		<ul style="list-style-type: none"> • Start antibiotics. • Repeat every 2-3 days to consider early antibiotic cessation. See follow-up table below. • If initial value is >5-10 ng/mL, assess for reduction of 90% from peak values. 	

Follow-Up (Repeat procalcitonin level Q48-72 hours)

Procalcitonin Value	<0.1 ng/mL or ↓ by >90%	0.1-0.24 ng/mL or ↓ by >80%	0.25-0.5 ng/mL	>0.5 ng/mL
Antibiotic STOP recommendation	Cessation strongly encouraged	Cessation encouraged	Cessation discouraged	Cessation strongly discouraged
Comments	<ul style="list-style-type: none"> • Stop antibiotics. • Consider continuing if clinically unstable. 		<ul style="list-style-type: none"> • Continue antibiotics. • If procalcitonin is rising or not adequately decreasing, consider possible treatment failure and evaluate for need for expanding antibiotic coverage or further diagnostic evaluation. 	

Procalcitonin in Adults with Sepsis without a Source

Follow-Up (Repeat procalcitonin level Q24h or with morning labs daily x3 days)

Procalcitonin Value	<0.25 ng/mL	0.25-0.49 ng/mL or ↓ by >80%	≥ 0.5 ng/mL AND ↓ by >80%	≥ 0.5 ng/mL AND rising or stable
Antibiotic STOP recommendation	Cessation strongly encouraged	Cessation encouraged	Cessation discouraged	Cessation strongly discouraged
Comments	<ul style="list-style-type: none"> • Stop antibiotics. • Consider continuing if clinically unstable. 		<ul style="list-style-type: none"> • Continue antibiotics. • A procalcitonin value which is rising or not declining at least 10% per day is a poor prognostic indicator and suggests infection is not controlled. • Consider expanding antibiotic coverage or further diagnostic evaluation. 	

Exclusion Criteria: <18 years old; pregnant/breastfeeding; CrCl <30 mL/min or hemodialysis (renally excreted biomarker); severe immunosuppression (eg ANC <500, HIV with CD4 <200, transplant patients, or on immune modulators); severe trauma, burn, or major surgery within 24 hours (particularly abdominal surgery); chronic infections necessitating antibiotics (eg endocarditis, osteomyelitis, tuberculosis); cystic fibrosis; small cell lung cancer or medullary thyroid cancer; receipt of OKT-3 and/or anti-thymocyte globulin; end-stage cancer; concurrent infections.

Source: ANMC Clinical Guidelines.
Click for hyperlink to full guideline,
including accompanying resources.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by MSEC unknown date.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

**Box 1**

Indications for rabies prophylaxis:

1. The bite was from a fox, bat, coyote, skunk, woodchuck, or wolf, and this animal is not available to test.
2. The bite was from a dog who was behaving abnormally.
3. The bite was from a dog not available for quarantine.
4. If the dog is available for quarantine, do not start post-exposure prophylaxis regardless of vaccination status. OEH (Office of Environmental Health) will initiate a 10-day quarantine. Please check under "all documents" for Alert Note or for the rabies investigation report from OEH.
5. If consultation is needed, call OEH at 543-6420 or State Section of Epidemiology 907-269-8000 or 800-478-0084 after hours.

Patient reports animal bite (or exposure to brain tissue) from animal who is a possible reservoir for rabies (dog, fox, bat, wolf)

Does the patient require rabies post-exposure prophylaxis?
See Box 1.

Yes or maybe

Patient in village?

Yes

1. Health Aide completes visit in RAVEN.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Patient is reported to RMT provider.
4. Provider forwards the final note to the OEH department pool.

1. RMT provider orders the vaccine for HAND CARRY to village clinic – 3 doses.
2. Contact inpatient pharmacy on call to arrange the HAND CARRY to the village.

Patient is given Day 0 vaccine in village clinic.

Day 3 vaccine and immunoglobulin given in Bethel outpatient clinic unless it is the weekend (then patient goes to ED). At that visit:
-Wound is assessed.
-Immunoglobulin is infiltrated directly into wound site.

Day 7 & 14 vaccine given in village.

Other Resources

- See the [supplement](#) to this guideline on the wiki.
- [State of Alaska DHSS Rabies](#) page.
- Use the Power Plans "AMB/ED Rabies Prophylaxis" to find all necessary orders.

Provide usual wound treatment.
Consider amoxicillin-clavulanate prophylaxis for open wounds.

If patient needs extensive wound care, recommend immediate travel to ED for treatment.

1. Patient presents to ED or outpatient clinic.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Provider forwards the final note to the OEH department pool.

Patient is given Day 0 vaccine, and the wound is infiltrated with immunoglobulin.

Appointment is made for the outpatient clinic for Days 3, 7, and 14.
If any of these fall on a weekend, patient is seen in the ED.

Notes:

- Day Zero is the first day the vaccine is given, not the day of the exposure.
- Immunoglobulin must be given within seven days of first vaccine dose.

If patient is immunocompromised, he/she requires an additional dose on day 28.

Required Notifications:

- The Rabies Investigation Report is an ad hoc form that is started by the CHA/P in village clinic or by the ED/outpatient clinic provider when the patient first presents for care. This is sent electronically to the OEH (Office of Environmental Health) who will follow up on the status of the dog. Please check under "all documents" for this and for recommendations from OEH.
- Forward your PowerChart note to Rabies Control Officer Pool and OEH Department Pool.

For village patient:

- Day 0 dose: Given in village from HAND CARRY.
Day 3 dose: Given in Bethel.
Day 7 dose: Given in village from HAND CARRY.
Day 14 dose: Given in village from HAND CARRY.

Animals in Alaska that have tested positive for rabies:

1. Arctic fox
2. Caribou
3. Cat
4. Coyote
5. Dog
6. Keen's myotis bat
7. Little brown bat
8. Red fox
9. Reindeer
10. River otter
11. Wolf
12. Wolverine

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/2/20. Click [here](#) to see the supplemental resources for this guideline.
If comments about this guideline, please contact Abigail_Klager@ykhc.org.



qSOFA – 2 or more of the following:

RR > 22
altered mental status (GCS < 15)
SBP < 100

SEPSIS 3 & ACEP NOTES

4-6 L of total IVF is often needed during the first 6 hours. After 2 L of NS consider switch to LR. Remember that if the patient fails to respond after the first 2-3 L, pressors should be considered.

In patients with concern for fluid overload (Hx CHF or renal or liver failure) or complications from fluid resuscitation, use less total fluid or smaller boluses with more frequent reassessment of volume status, but **DO NOT DELAY FLUID AND VASOPRESSOR TREATMENT.**

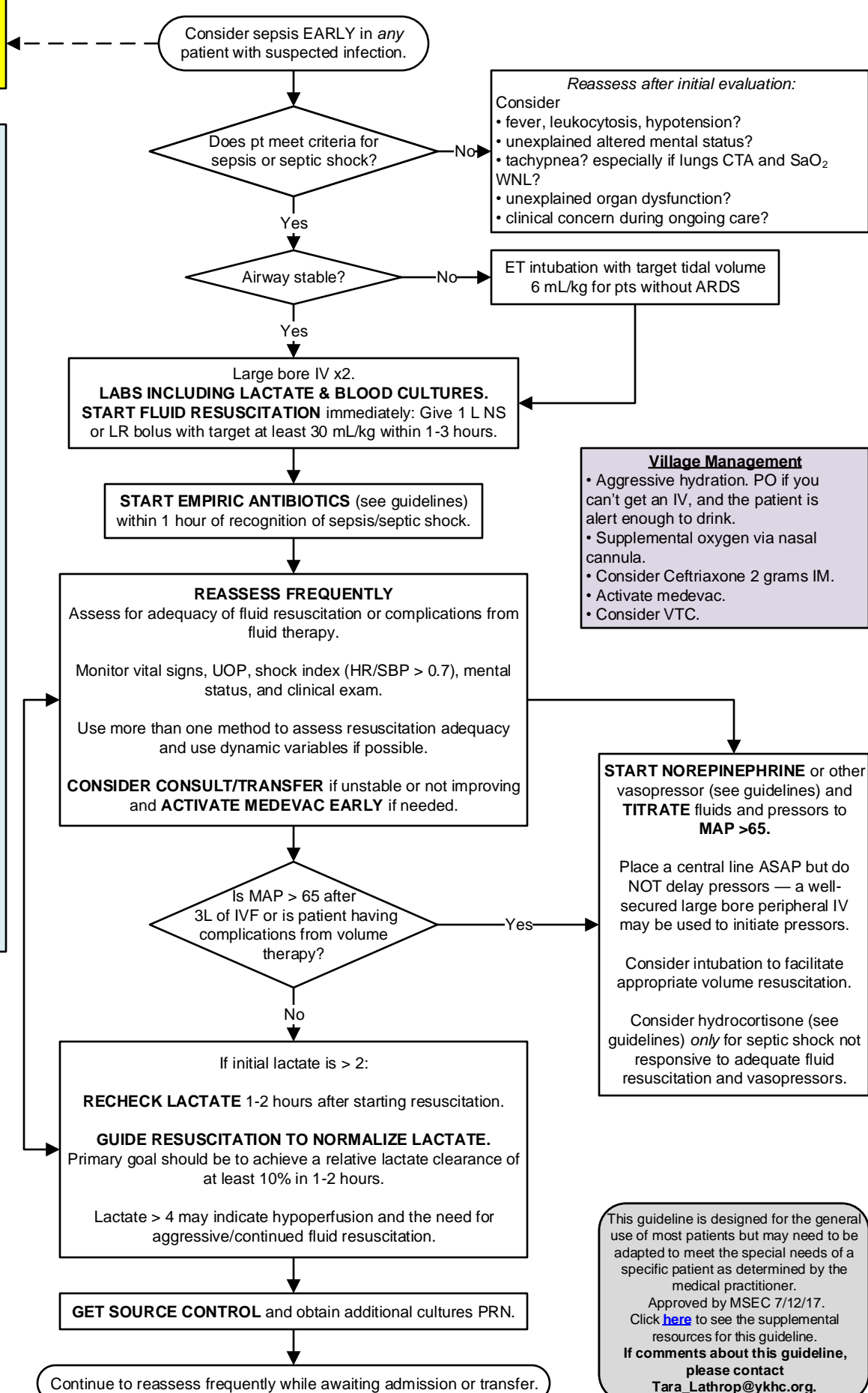
Persistence of elevated lactate, even in the absence of hypotension, is associated with poor outcomes.

CRP and procalcitonin may be elevated but cannot effectively guide ED sepsis care — CHECK (and RECHECK) LACTATE.

In the absence of extenuating circumstances (MI, severe hypoxia, acute blood loss, etc.) transfusion is no longer recommended unless Hgb < 7.

Consider insulin if 2 consecutive blood glucose levels are > 180.

Sodium bicarbonate is not recommended to improve hemodynamics or decrease vasopressor requirements in patients with hypoperfusion-induced lactic acidemia with pH ≥ 7.15.



Village Management

- Aggressive hydration. PO if you can't get an IV, and the patient is alert enough to drink.
- Supplemental oxygen via nasal cannula.
- Consider Ceftriaxone 2 grams IM.
- Activate medevac.
- Consider VTC.

START NOREPINEPHRINE or other vasopressor (see guidelines) and **TITRATE** fluids and pressors to **MAP > 65.**

Place a central line ASAP but do NOT delay pressors — a well-secured large bore peripheral IV may be used to initiate pressors.

Consider intubation to facilitate appropriate volume resuscitation.

Consider hydrocortisone (see guidelines) only for septic shock not responsive to adequate fluid resuscitation and vasopressors.

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Approved by MSEC 7/12/17.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Tara_Lathrop@ykhc.org.



Empiric Antibiotic Recommendations by Source of Infection

If possible, first dose of antibiotics should be administered as a 30 minute infusion to reduce time to therapeutic concentration.

Unknown Source

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam³ 4.5 grams IV Q8h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Gentamicin² 7 mg/kg IV Q24h.
Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

Community-Acquired Pneumonia

Ceftriaxone 1 gram IV Q24h.
(2 grams if >80 kg.)
OR
Ampicillin-sulbactam 3 grams IV Q6h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Azithromycin 500 mg PO/IV Q24h.

If at risk for aspiration, consider adding:

Metronidazole 500 mg IV Q8h.

Hospital-Acquired Pneumonia or High Risk for Multi-Drug Resistant (MDR) Organisms

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam³ 4.5 grams IV Q6h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Gentamicin² 7 mg/kg IV Q24h.
Consult pharmacy for max dosing.

Meningitis

Dexamethasone 10 mg IV prior to antibiotics.

AND

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.

AND

Ceftriaxone 2 grams IV Q12h.

If >50 years, ADD

Ampicillin 2 grams IV Q6h.

Urinary Tract Infection

Ceftriaxone 1 gram IV Q24h.
(2 grams if >80 kg.)

AND consider adding:

Gentamicin² 7 mg/kg IV Q24h.
Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

If urological interventions or MDR risk factors, consider adding:

Piperacillin-tazobactam³ 3.375 grams IV Q6h.
OR
Cefepime 1 gram IV Q6h.

If at risk of ESBL, ADD: **Meropenem** 500 g IV Q8h.

Intra-abdominal or Pelvic Infection

Piperacillin-tazobactam³ 3.375 grams IV Q6h.

OR

Cefepime 1 gram IV Q6h.
AND
Metronidazole 500 mg IV Q6h.

OR

Ciprofloxacin 400 mg IV Q12h.
AND
Metronidazole 500 mg IV Q8h.

Skin and Soft Tissue or Necrotizing Infections

IF PURULENT:
Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.

IF NON-PURULENT:
Cefazolin 2 grams IV Q8h.
OR
Ceftriaxone 1-2 grams IV Q24h.
OR
Ampicillin-sulbactam 3 grams IV Q6h.

If necrotizing, ADD:

Piperacillin-tazobactam³ 3.375 grams IV Q6h.
AND
Clindamycin 900 mg IV Q8h.

OR

Ceftriaxone 2 grams IV Q12h.
AND
Metronidazole 500 mg IV Q6h.

Neutropenic Cancer Patients (ANC <500)

Piperacillin-tazobactam³ 4.5 grams IV Q6-8h.
OR
Cefepime 1 gram IV Q6h.

AND

Vancomycin¹ 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h.
Max dose 2 grams.

If concerned for HSV or VZV, consider adding:

Acyclovir 10 mg/kg Q8h.
Consult pharmacy for max dosing.

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Approved by MSEC 7/12/17.

If comments about this guideline, please contact
Tara_Lathrop@ykhc.org.

¹ Linezolid may be substituted for vancomycin in patients with relative contraindication to vancomycin for high risk for acute kidney injury.

² Gentamicin dosing based on ideal body weight.

³ May substitute ampicillin-sulbactam 3 gram IV Q6h for piperacillin-tazobactam if not concerned for pseudomonas.



Vasopressors

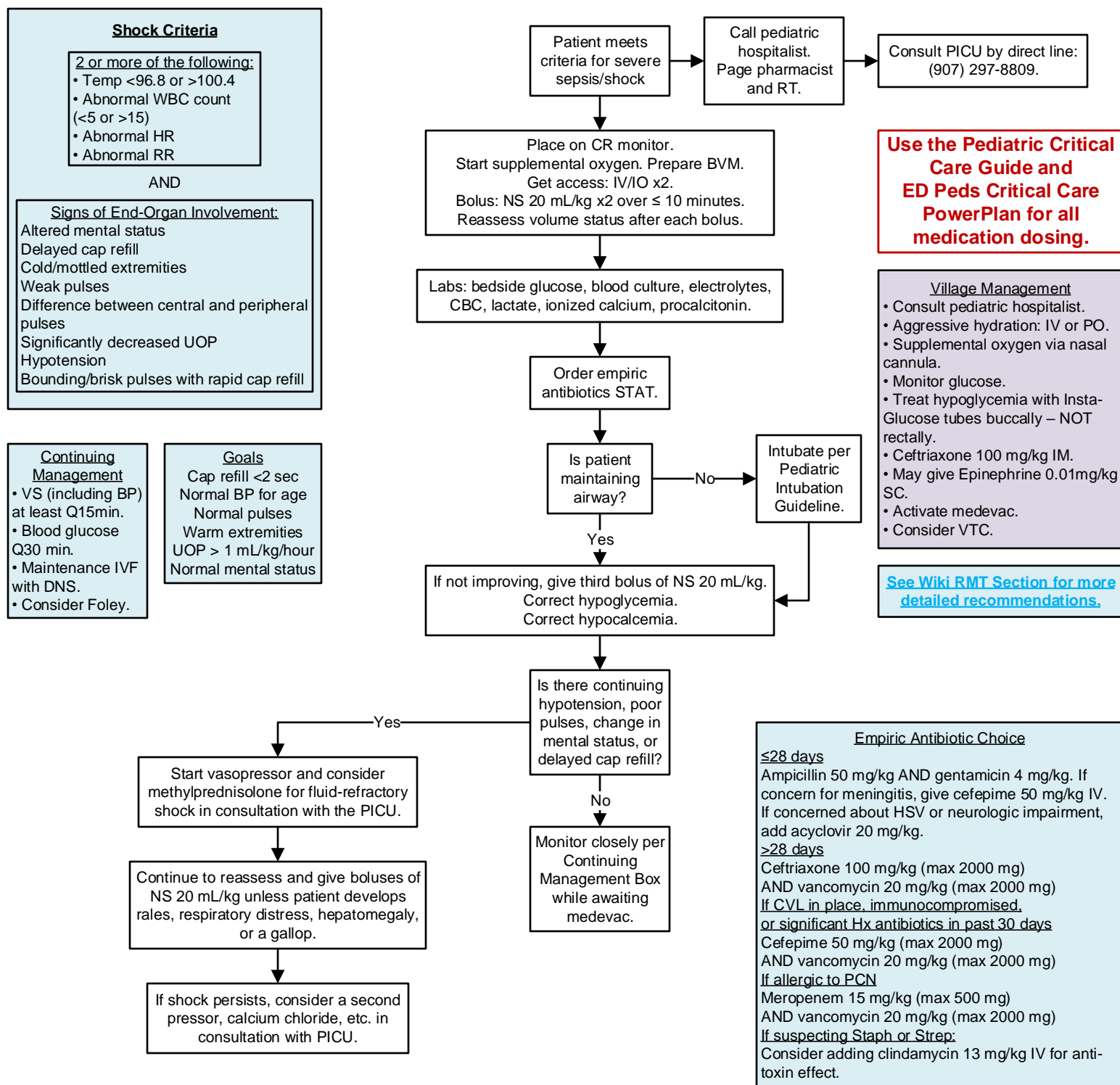
All vasoactive medications should be infused via central line with the exception of dopamine, which can be infused via a peripheral IV at rates less than 10 mcg/kg/minute.

- | | |
|---|--|
| • Norepinephrine 8-12 mcg/min IV initial infusion rate. | First-line vasopressor of choice in sepsis. |
| • Epinephrine 1-10 mcg/min initially, titrated to effect. | May be added or used in place of norepinephrine to maintain adequate BP. |
| • Dopamine 2-20 mcg/kg/min. | Second-line option in highly select patients as it causes more tachycardia. |
| • Phenylephrine 100-180 mcg/min IV initial infusion until stabilized.
Titrate to goal of 60-200 mcg/min.
(Max dose range 80-360 mcg/min.) | Can be used as salvage therapy for refractive hypotension associated with tachycardia. |
| • Vasopressin 0.03-0.04 units/min. | May be added to norepinephrine to increase MAP or decrease norepinephrine dose.
DO NOT use as a single agent. |
| • Dobutamine 2-20 mcg/kg/min IV infusion. | May be used for inotropic support in the presence of severe myocardial dysfunction or hypoperfusion with depressed cardiac output. |

Corticosteroids

Corticosteroids should NOT be administered for the treatment of sepsis in the absence of shock. Steroids are beneficial in those experiencing adrenal insufficiency in the presence of septic shock; however ACTH testing is not routinely recommended in adult patients. If hemodynamic stability is not achieved after adequate fluid resuscitation and vasopressor therapy, the use of IV hydrocortisone alone at a dose of 200 mg/day can be considered regardless of adrenal insufficiency status. Hydrocortisone should be tapered when vasopressors are no longer required.

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Approved by MSEC 7/12/17.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.



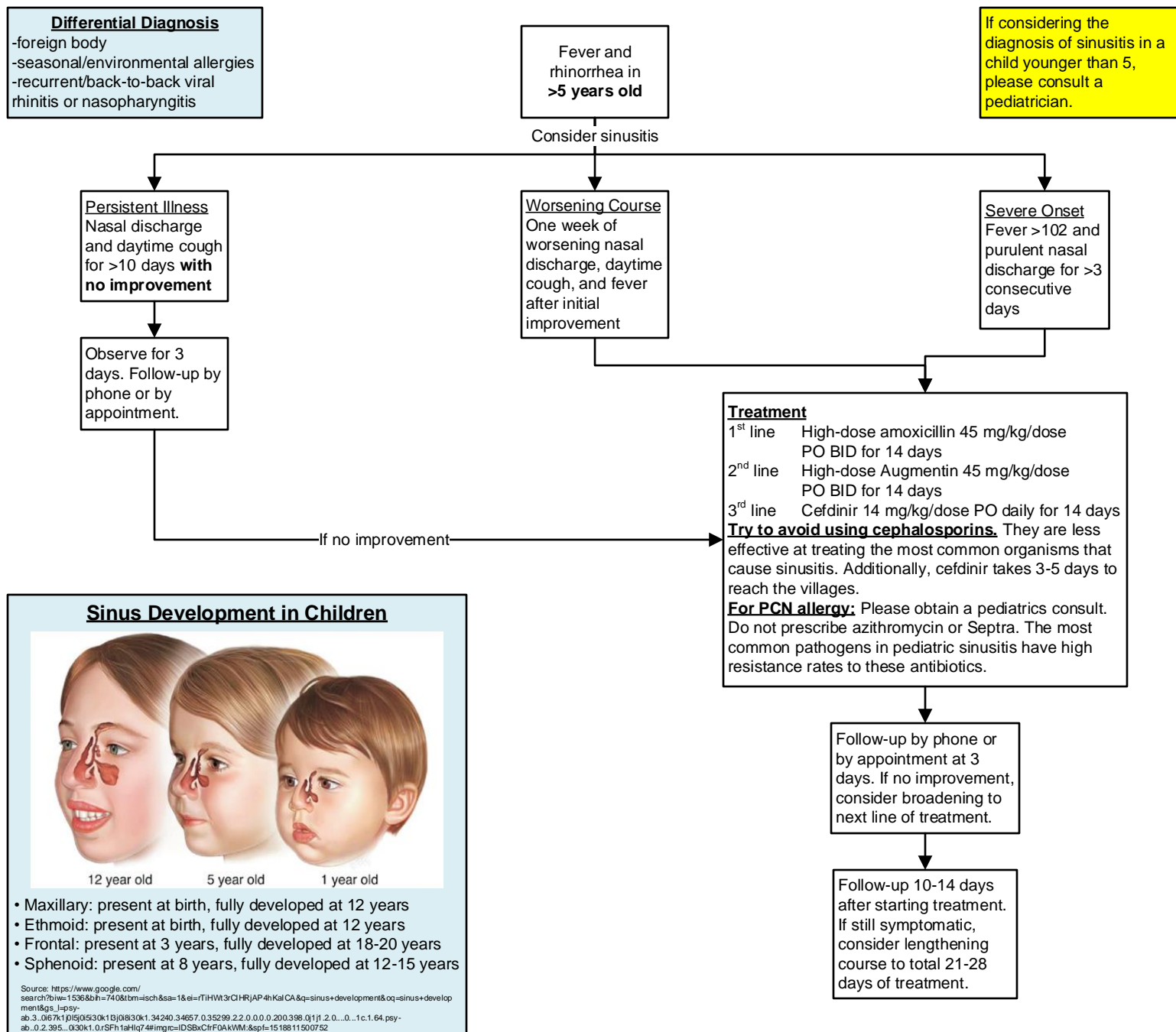
Age	HR (beats/minute)		RR (breaths/minute)		Hypotension (sBP in mmHg)
	Bradycardia	Tachycardia	Low	High	
0 days – 1 week	<100	>200	<30	>70	<60
1 week – 1 month	<100	>200	<30	>70	<60
1 – 3 months	<100	>180	<20	>60	<70
3 – 12 months	<100	>180	<20	>60	<70
1 – 2 years	<90	>160	<20	>40	<70
2 – 6 years	<60	>160		>40	<80
6 – 13 years	<60	>120		>23	<90
13 – 18 years	<60	>110		>23	<90

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Approved by MSEC 10/9/19.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.



Imaging

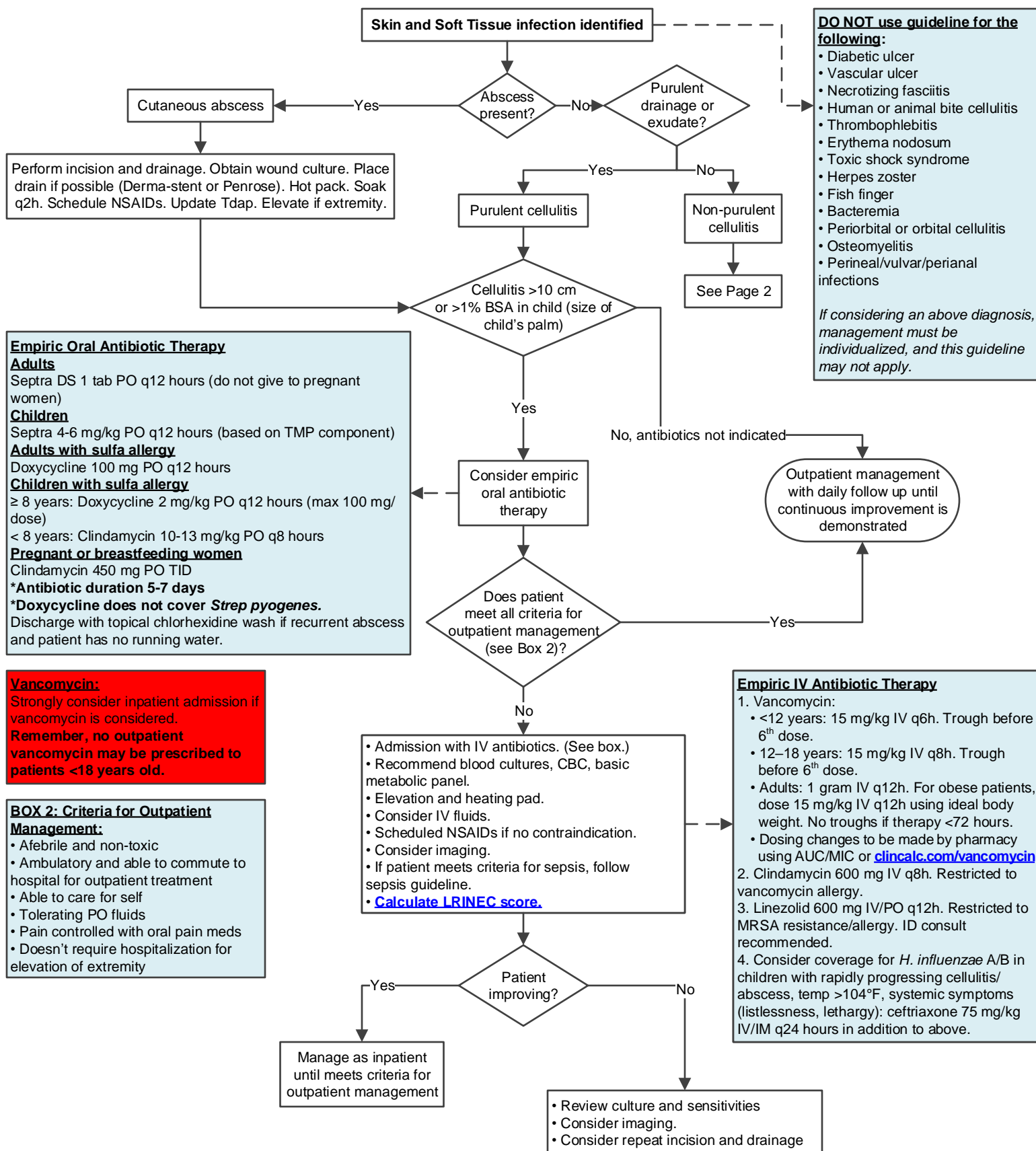
Do not routinely obtain imaging studies in suspected sinusitis unless there is concern for a complication like orbital or CNS involvement.

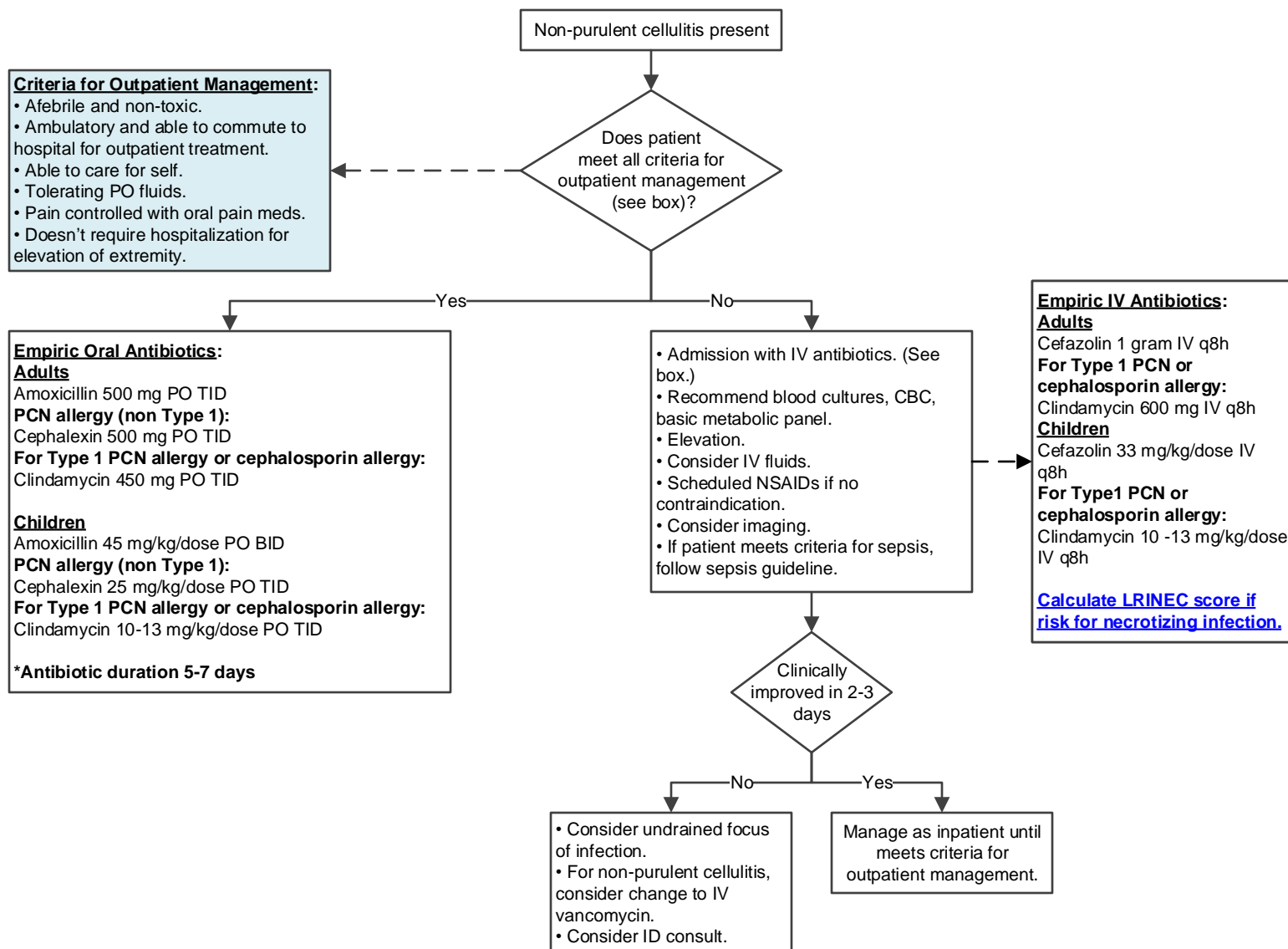
Do not treat sinusitis, in the absence of symptoms, if it is an incidental finding on an imaging study.

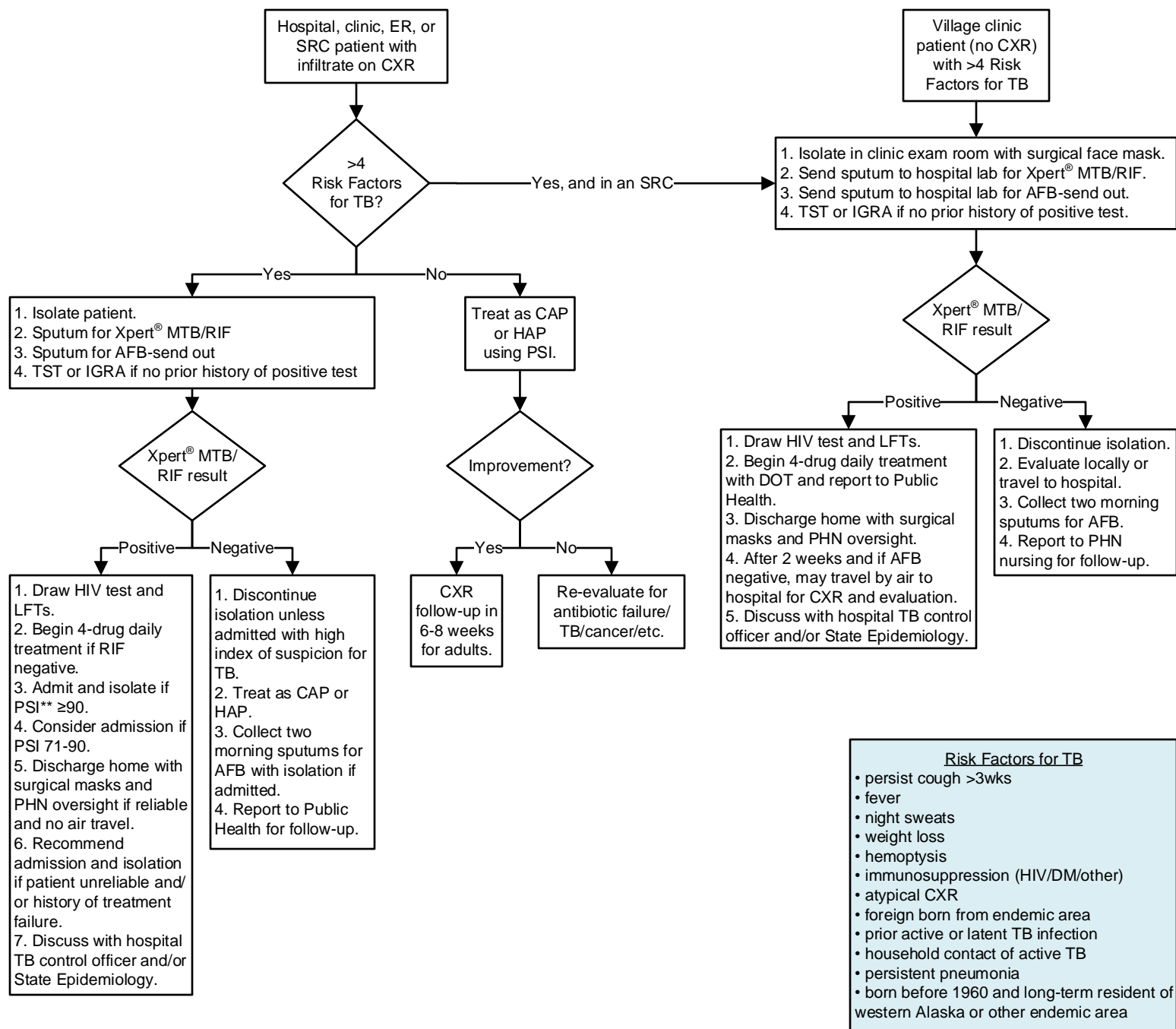
Adjuvant Therapies

- Saline nasal spray
- Steam
- Oral hydration
- Tylenol and ibuprofen
- Do not routinely give decongestants and antihistamines (especially Benadryl). They have been proven ineffective in children and are unsafe under 6 years old.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/26/18; reviewed and reapproved 10/2019. Click [here](#) to see the supplemental resources for this guideline. If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.







Risk Factors for TB

- persist cough >3wks
- fever
- night sweats
- weight loss
- hemoptysis
- immunosuppression (HIV/DM/other)
- atypical CXR
- foreign born from endemic area
- prior active or latent TB infection
- household contact of active TB
- persistent pneumonia
- born before 1960 and long-term resident of western Alaska or other endemic area

PSI

See www.mdcalc.com/psi-port-score-pneumonia-severity-index-adult-cap/

- PSI ≤70 stable for outpatient therapy
- PSI 71-90 likely outpatient therapy but may consider inpatient
- PSI ≥91 advise inpatient therapy

Abbreviations: AFB-acid fast bacilli; CA-cancer; CAP-community acquired pneumonia; CXR-chest x-ray; DM-diabetes mellitus; DOT-direct observational therapy; ER-emergency room; LFTs-liver function tests; HAP-healthcare associated pneumonia; HIV-human immunodeficiency virus; IGRA-interferon gamma release assay; PHN-public health nurse; PSI-pneumonia severity index; SRC-subregional clinic; RIF-rifampin resistance; TB-tuberculosis; TST-tuberculin skin test



Tuberculosis, Latent (≥14 years)

If patient has symptoms concerning for TB, see [Active TB Guideline](#). Do not send patient to Bethel unless patient is medically unstable.

Patient ≥14 years with:
New positive TB skin test
OR
New positive Quantiferon-Gold

At least one symptom

No

Thirty minute appointment in Bethel for:
• Physical exam
• Chest X-ray
• Labs: LFTs, HIV, and hCG if female

Abnormal chest X-ray?

No

LTBI

- Call PHN with plan of care.
- Begin treatment per box, using LTBI Power Plan.
- Print LTBI prescriptions and fax to PHN.
- Follow-up sputum smears and cultures, if indicated.

Sputum smear or culture positive?

Yes

Not positive or not indicated

LTBI.
Continue full course of treatment per Public Health.

Patient in village?

No

- Patient must wear surgical mask AND stay in a negative pressure room, if available, until MTB-RIF result is negative.
- Collect sputum samples using the "AMB NEW +PPD/ LTBI" Power Plan. This generates orders for all three sputum samples, including the 2nd and 3rd day samples.
- First collect one sputum sample (3 mL in a urine cup) for MTB-RIF and send to lab.
- Next collect three sputum samples for AFB smear and TB culture (5 mL in a conical tube) at least eight hours apart.
- Obtain labwork: LFTs, HIV, and hCG if female.
- Chest X-ray if available.

DO NOT PUT A PATIENT WHO MAY HAVE ACTIVE TB ON A PLANE UNLESS ACUTELY ILL; this could expose the other passengers. Perform evaluation in village, as able.

MTB-RIF positive?

No

Yes

Active TB.
Contact TB officer and see [Active TB Guideline](#).

Symptoms

- Cough for more than three weeks
- Weight loss
- Fever
- Night sweats
- Hemoptysis

What is a positive TB skin test?

- At least 10 mm of induration OR >5 mm of induration for patients who are high risk for TB (See box).
- Must be read 48-72 hours after placement to be a true negative.
- If positive, the induration can remain up to seven days and can be read until then.

High Risk for Tuberculosis

1. Immunosuppressed, HIV positive, prednisone >15 mg/day for >1 month, TNF-α blocker.
2. Suspicious chest X-ray.
3. Household contact with active TB.

LTBI Treatments: Choose one option

1. 3HP: INH 15 mg/kg PO weekly, rounding to nearest 50 mg (max dose 900 mg) x 12 weeks AND Rifapentine PO weekly x12 weeks.
Rifapentine Dosing:
• 32.1-49.9 kg: 750 mg
• >50 kg: 900 mg (max dose)
DOT optional.
2. Rifampin 10 mg/kg PO daily (max dose 600 mg) x4 months.
3. INH 5 mg/kg PO daily (max dose 300 mg) x9 months.

If on INH, give pyridoxine (vitamin B6) 50 mg PO daily to prevent neuropathy.

If patient is pregnant or HIV infected, contact TB Officer.

Abbreviations

3HP: three month regimen of INH and rifapentine
AFB: acid-fast bacilli
DOT: directly-observed therapy
hCG: pregnancy test
HIV: human immunodeficiency virus
INH: isoniazid
LFT: liver function tests
LTBI: latent tuberculosis infection
MTB-RIF: mycobacterium tuberculosis nucleic acid amplification test that also tests for rifampin resistance
PHN: Public Health Nursing
TB: tuberculosis
TNF-α: tumor necrosis factor alpha

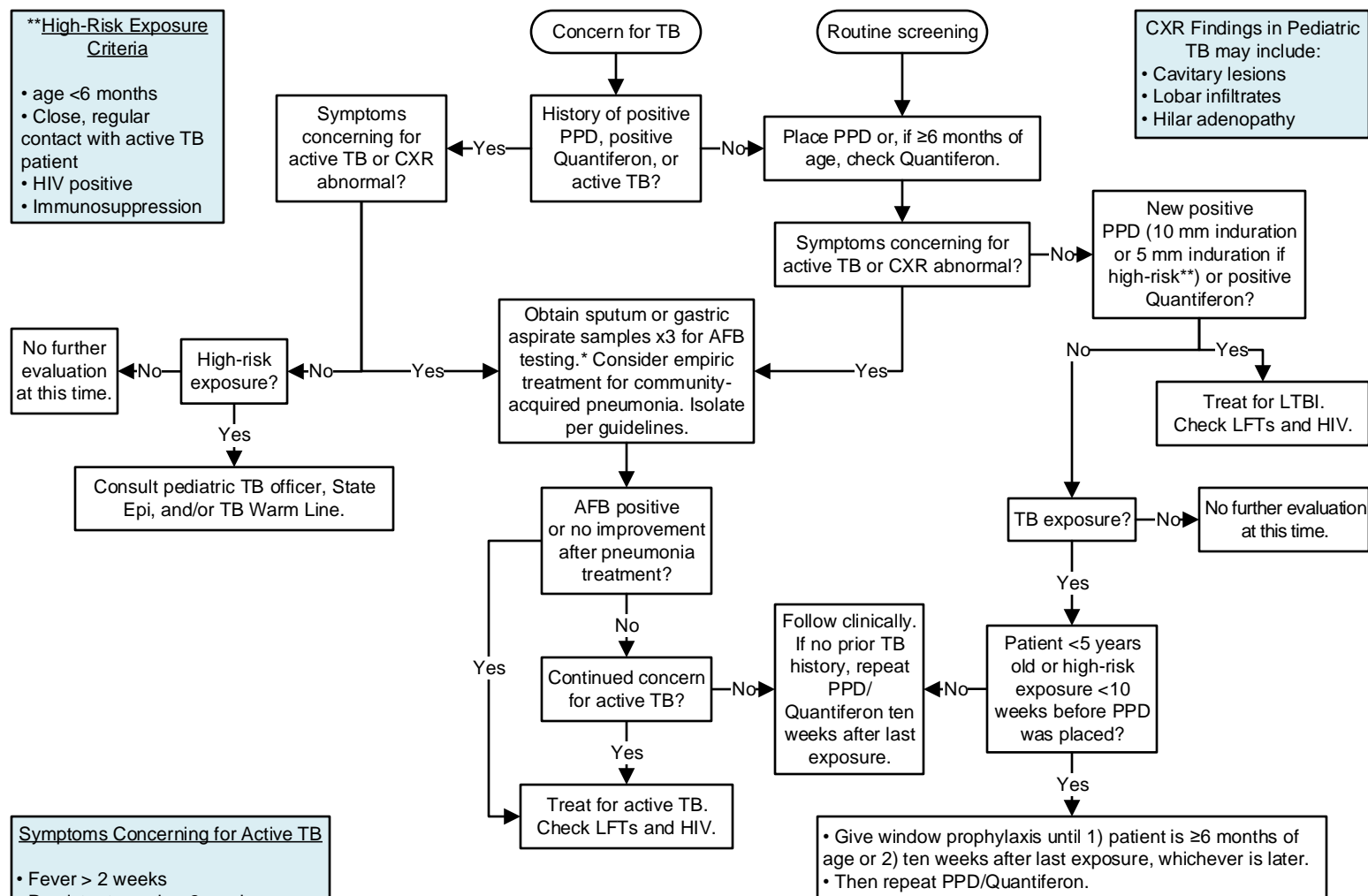
TB Officers

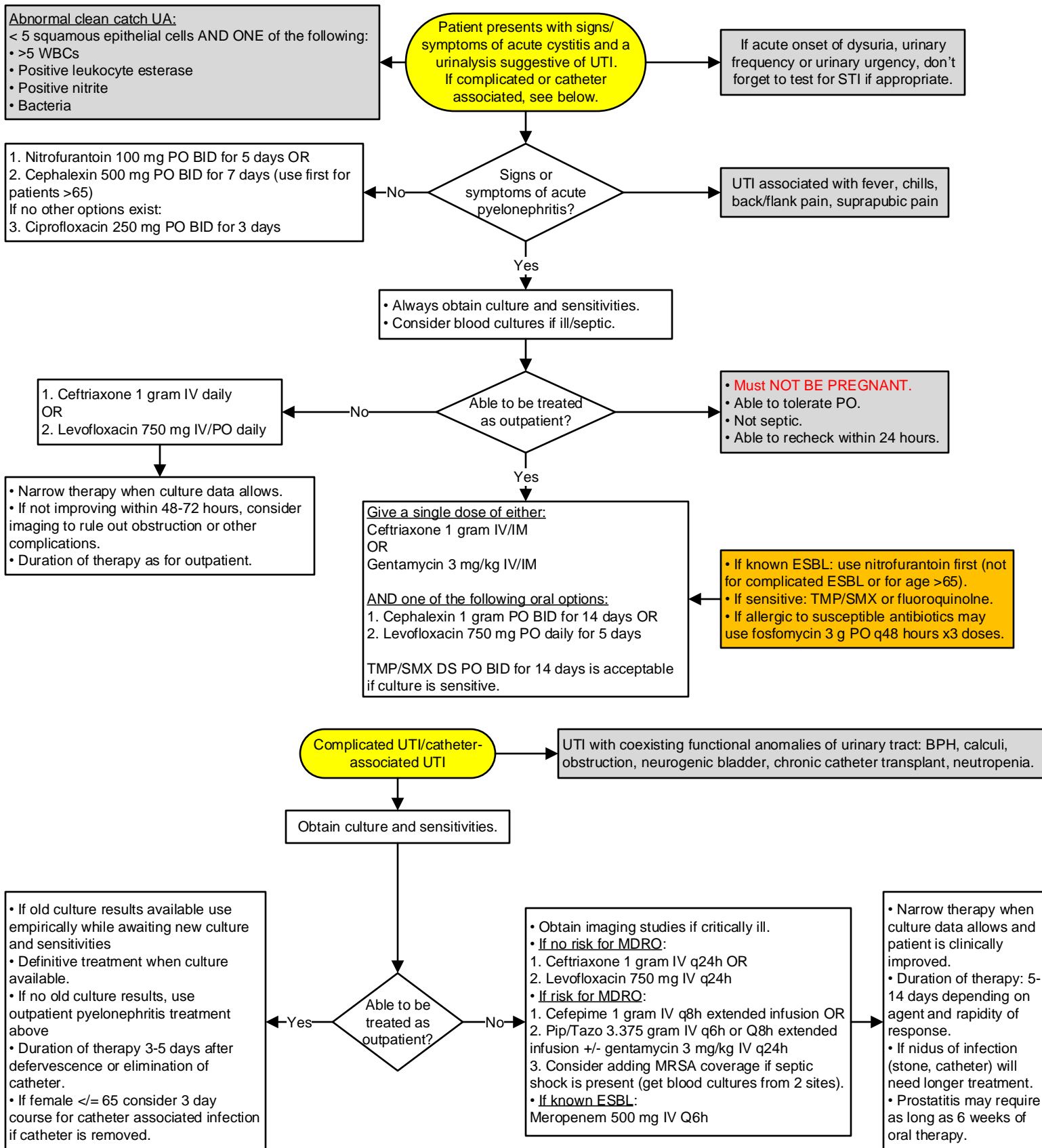
- Philip Johnson MD
- Elizabeth Roll MD
- Robert Tyree MD
- Mien Chyi MD (pediatrician)
- Kimberly Fisher DO (pediatrician)
- Cynthia Mondesir MD (pediatrician)

Contact Information

- Public Health Nursing (PHN):
Phone: 543-2110
Fax: 543-0435
All directly-observed therapy (DOT) will be arranged by PHN.
- Curry Center TB Warm Line: (877) 390-6682
- State Epidemiology: (907) 269-8000
- State Epidemiology Lab: (907) 334-2100

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MDRO: Multi-Drug Resistant Organism
MRSA: Methicillin-Resistant Staph Aureus
ESBL: Extended Spectrum Beta Lactam

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Approved by MSEC 10/15/18. Click [here](#) to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.



Signs and Symptoms of UTI

- fever
- dysuria
- vomiting
- abdominal pain
- new daytime or nighttime wetting
- increased frequency of voiding
- malodorous urine

Differential Dx for Dysuria

- UTI
- vulvovaginitis
- Candida infection
- poor hygiene
- sexual abuse
- age-appropriate self-exploration

Resistance

- Empiric drug choice is based on local resistance patterns and consultation with ID specialist.
- If urine culture grows an Extended-Spectrum Beta-Lactamase (ESBL) producing organism, please obtain a pediatrics consult and add ESBL to Problem List.

Symptomatic Care

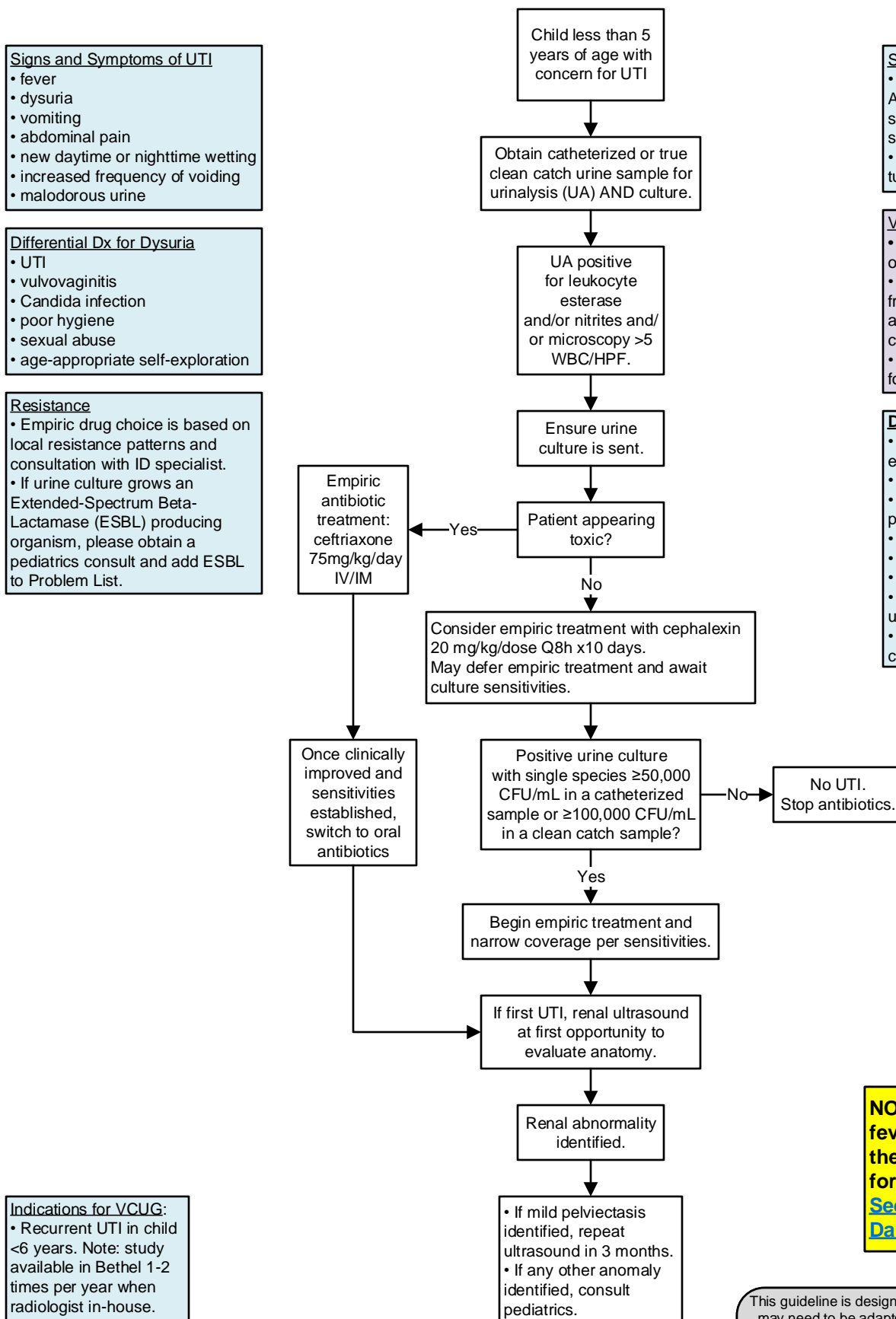
- If dysuria, irritation, etc. recommend A+D ointment and instruct family to do soaks/baths with warm water and no soap.
- May consider baking soda ¼ cup per tub.

Village Management

- Do not treat any child under 5 years of age empirically in the village.
- If patient has dysuria, increased frequency, new-onset enuresis, and/or abnormal clean catch urinalysis, consider further evaluation in Bethel.
- Consider symptomatic care (see box) for possible vulvovaginitis.

DO NOT ...

- treat any child under 5 years of age empirically in the village.
- routinely collect urine via bag.
- treat a UTI without a culture in progress.
- routinely perform a test of cure.
- routinely start UTI prophylaxis.
- perform suprapubic taps.
- routinely obtain bloodwork for uncomplicated UTI.
- add UTI to Problem List until confirmed by culture.



Indications for VCUG:

- Recurrent UTI in child <6 years. Note: study available in Bethel 1-2 times per year when radiologist in-house.
- Major anomaly on ultrasound. Consult pediatric urologist and consider obtaining VCUG in Anchorage.

NOTE: Any infant with a fever <90 days must go to the Emergency Department for evaluation.

[See the Fever in Infants 0-90 Days Guideline.](#)

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Approved by MSEC 5/8/19.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.



True Varicella infection is RARE in our region:

1. **DO NOT diagnose Varicella** without confirmatory lab testing.
2. Per the CDC:
 - Two doses of VZV vaccine are 88-98% effective at preventing all VZV infections.
 - One dose of VZV vaccine is 85% effective at preventing all VZV infections.
3. All confirmed Varicella must be confirmed to State Epidemiology with this form: <http://dhss.alaska.gov/dph/Epi/Documents/pubs/conditions/frmlInfect.pdf>

Differential Diagnosis

- Hand-foot-mouth disease
- Scabies
- Stomatitis
- Eczema herpeticum
- Diffuse impetigo

Provider Documentation for Suspected Varicella Infection

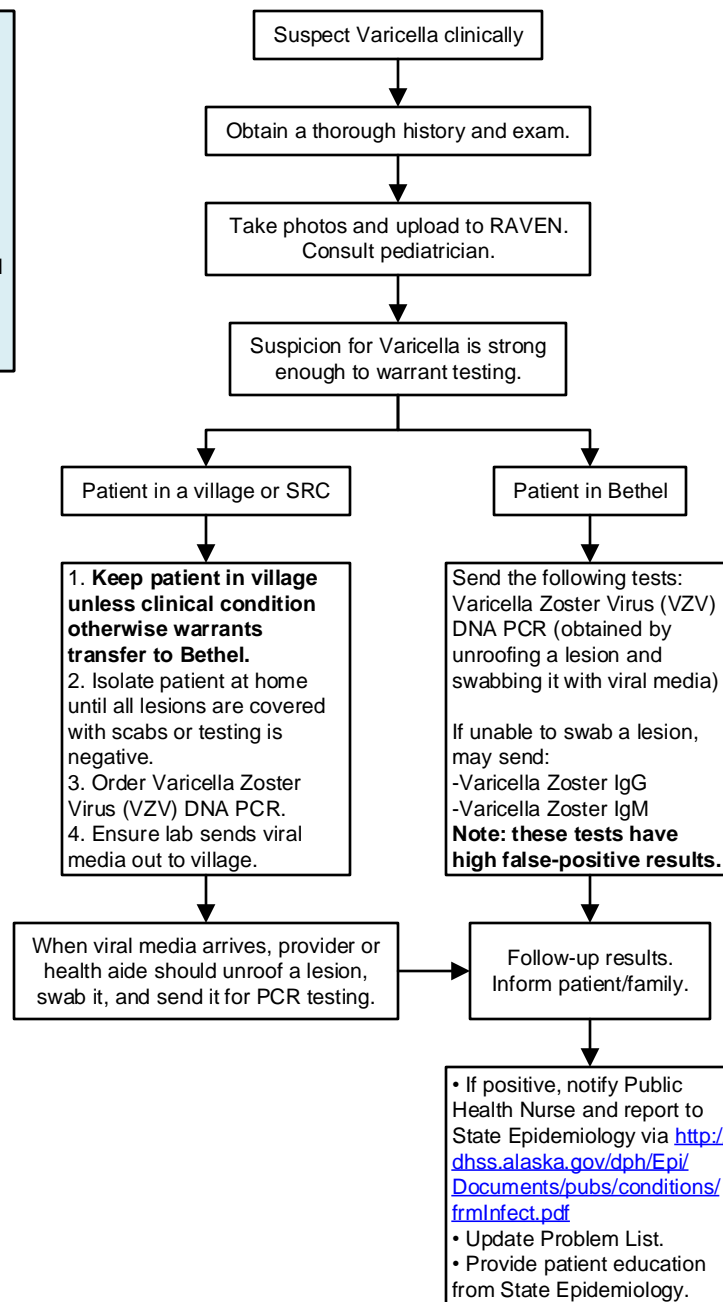
- Date of symptom onset
- Date of suspected diagnosis
- Date of rash onset
- Location of rash, including where first noted
- Number of lesions
- Photos of lesions
- Evolution of rash (including appearance of new groups of lesions)
- Appearance of lesions (are there lesions in all stages of development at once?)

High Risk Exposures

- Inquire if any pregnant women or immunocompromised people have been exposed.
- For pregnant women: find out if she has a history of varicella or has received the vaccine. If not, then consult HROB to consider further treatment.
- For immunocompromised patients: refer to a provider for evaluation.

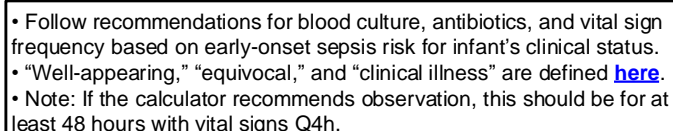
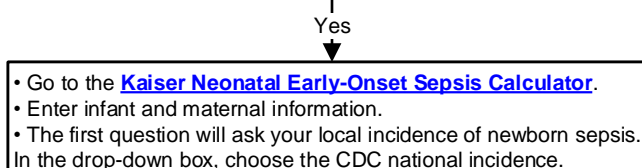
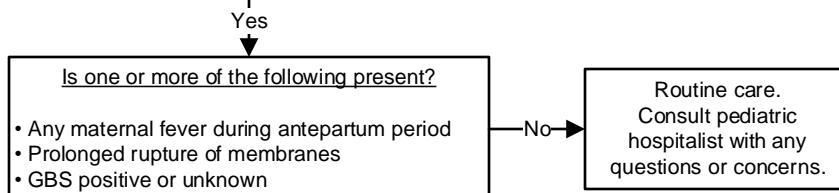
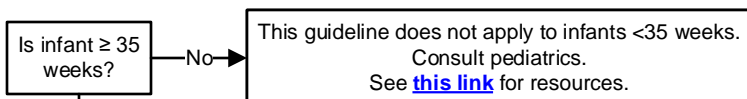
Typical Presentation for Chickenpox/Varicella

- Exposure occurs.
- 10-21 days after exposure, fever appears, followed by rash.
- Rash appears in successive crops over several days.
- Rash begins as macular and then progresses to vesicular, then pustular, then crusted.
- There are lesions in different stages of development on different parts of the body.
- New vesicles stop forming within four days.

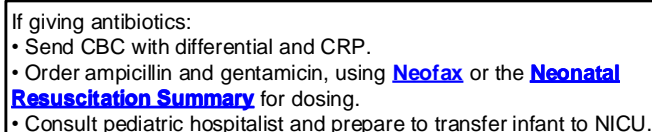




Neonatal	
Newborn Early-Onset Sepsis/GBS.....	81
Neonatal Jaundice.....	82
Neonatal Glucose Screening.....	83
Neonatal Resuscitation Summary.....	84
https://yk-health.org/images/e/e4/Neonatal_resuscitation_summary.pdf	



If any clinical concerns about infant, consult pediatric hospitalist.



Note: CBC and CRP are not routinely recommended anymore. However, they can be useful to trend if starting antibiotics. Thus, we recommend they be obtained if starting antibiotics.

Signs of Neonatal Sepsis

- Temp ≥ 100.4 or ≤ 97.5
- Irritability
- Poor Feeding
- Hypoglycemia
- Hypothermia
- Tachypnea
- Tachycardia
- "Not acting right"

If any of these signs are present, consider obtaining a pediatrics consult.

References

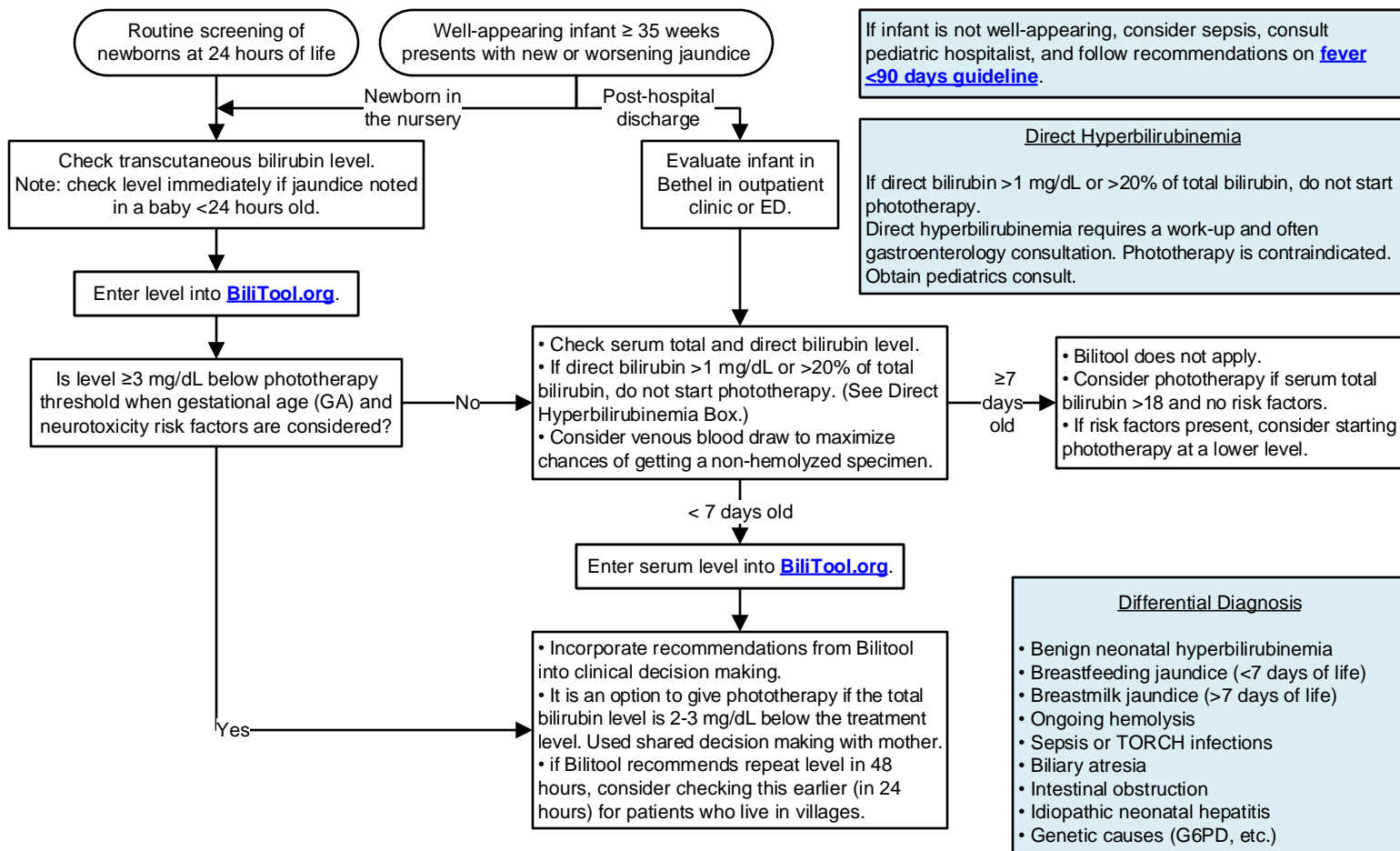
- Pediatrics* 2019: [Management of Infants at Risk for Group B Streptococcal Disease](#)
- Pediatrics* 2018: [Management of Neonates Born at \$\geq 35\$ 0/7 Weeks' Gestation with Suspected or Proven Early-Onset Bacterial Sepsis](#)



Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Jaundice in a Baby <4 Weeks



How to Use BiliTool.org

1. Enter infant's age and total bilirubin level.
2. You will be brought to a Risk Stratification page with two recommendation tables.
3. The first table is recommended follow-up. It refers to the risk factors for development of severe hyperbilirubinemia.
4. The second table is recommendations for phototherapy. It refers to the risk factors for neurotoxicity.
5. Pay close attention to both tables. For example, infants with intermediate levels sometimes require phototherapy due to GA<38 weeks and/or neurotoxicity risk factors.

Phototherapy

1. Order using one of the following:
 - PED Pediatric Admission Power Plan → PED Phototherapy sub-phase
 - OB/Newborn orders folder → OB Newborn Phototherapy Power Plan
2. Check serum total bilirubin level Q12h (or more frequently if needed). If level is trending up, consult pediatrician and consider broadening differential and work-up. Note: Transcutaneous bilirubin is not reliable after phototherapy has been started. Check serum levels only.
3. Encourage frequent feeding, but try to limit time out of phototherapy to no more than 20 minutes Q3h.
4. IV fluids are unnecessary unless infant has signs of dehydration.
5. Keep infant supine with eye protection while under phototherapy.
6. May stop phototherapy when serum total bilirubin level is at least 3 mg/dL below the phototherapy initiation level, using the current hour of life.
7. Obtain rebound bilirubin level 12 hours after stopping phototherapy if patient <72 hours old or if concern for hemolysis.

Risk Factors for Development of Severe Hyperbilirubinemia

Use this list when determining follow-up.

- Jaundice < 24 hours of life
- ABO or Rh incompatibility, especially with positive antibodies
- GA less than 38 weeks
- Previous sibling received phototherapy
- Cephalohematoma or significant bruising

Neurotoxicity Risk Factors

Use this list when determining need for phototherapy.

- Isoimmune hemolytic disease
- G6PD deficiency
- Asphyxia
- Significant lethargy
- Temperature instability
- Sepsis
- Acidosis

Note: GA <38 weeks lowers the threshold at which BiliTool will recommend starting phototherapy.

Breastmilk Jaundice

- Resolves by 3 weeks of age in 65% of infants.
- Another 20% may continue to have jaundice until 4 weeks of age.
- Consider this diagnosis of exclusion in a well-appearing breastfeeding infant with no risk factors for hemolysis with persistent hyperbilirubinemia without an upward trend.
- Confirm with serial measurements over two days. Admission not required.

Labs for Expanded Work-up

Consider obtaining for infants who develop jaundice at <24 hours of life, have rising levels despite phototherapy, or have recurrent jaundice.

- Blood type, DAT (Direct Antibody Test, or Coombs)
- CBC with manual differential, and reticulocyte count
- Electrolytes (to assess hydration and acidosis)
- Thyroid studies (if prolonged or recurrent)
- LFTs and GGT
- G6PD

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/6/21. Click [here](#) to see the supplemental resources for this guideline. If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.



Target Glucose Levels for Age

Birth to 4 hours of life	>35 mg/dl
>4 – 24 hours of life	>45 mg/dl
>24 – 48 hours of life	>50 mg/dl

Symptoms of Hypoglycemia in Newborns:

Irritability
Tremors
Jitteriness
Exaggerated Moro Reflex
High Pitched Cry
Seizures
Lethargy
Floppiness
Cyanosis
Apnea
Poor Feeding

0-4 HOURS OF AGE

At Risk Infants (See Box)

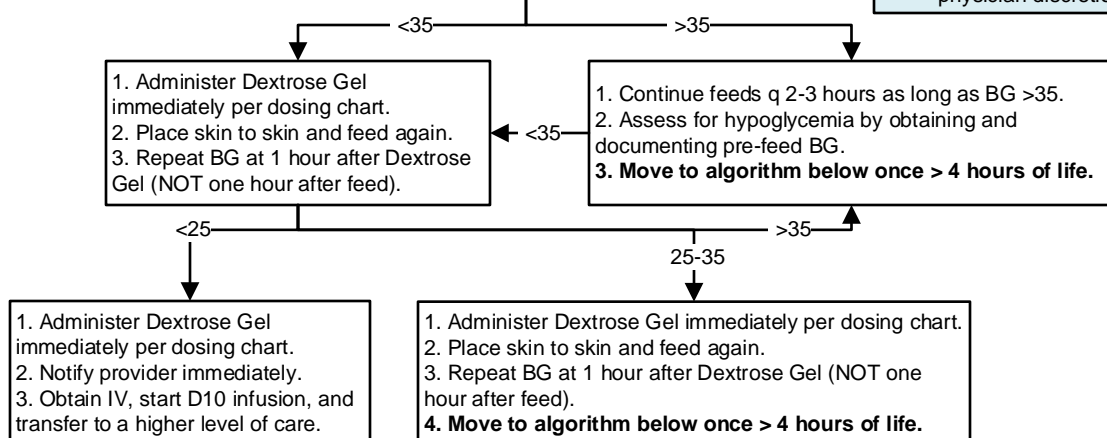
Begin feeding within one hour of birth. First glucose should be obtained 30 minutes after completion of first feed.

Risk Factors and Indications for

Screening of Asymptomatic

Newborns:

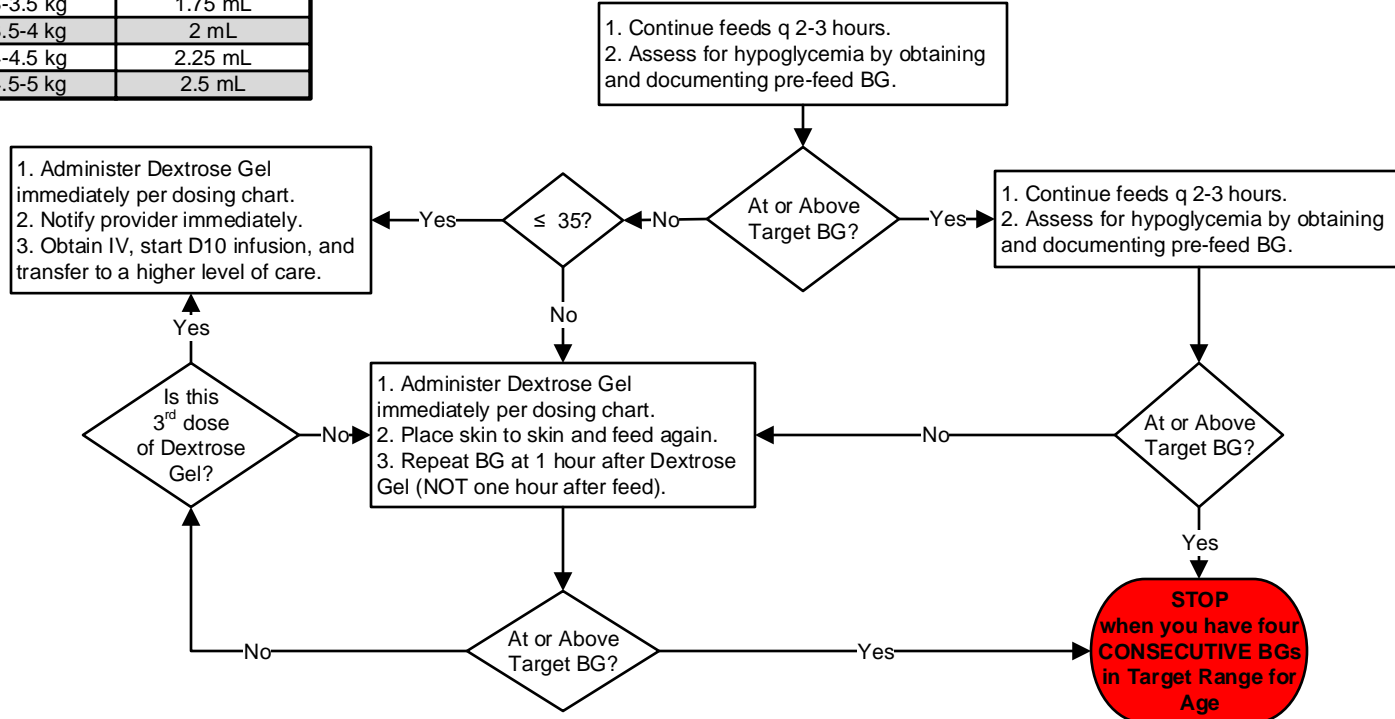
SGA (<10%ile BW)
LGA (>90%ile BW)
Infant of Diabetic Mother
Late Preterm (34 0/7 – 36 6/7)
Other clinical situation per physician discretion



DEXTROSE (40%) GEL DOSING

Birth Weight	Dose
≤ 2 kg	1 mL
>2-2.5 kg	1.25 mL
>2.5-3 kg	1.5 mL
>3-3.5 kg	1.75 mL
>3.5-4 kg	2 mL
>4-4.5 kg	2.25 mL
>4.5-5 kg	2.5 mL

> 4 - 48 HOURS OF AGE



If infant has severe symptoms or BG is <25 after first Dextrose Gel dose:

THIS SCREENING PROTOCOL NO LONGER APPLIES.

- Give Dextrose Gel dose.
- Start IV.
- Give D10 2 mL/kg bolus at 1 mL/minute.
- Start D10 infusion at 80 mL/kg/day.
- Goal is to keep baby's serum glucose at 60.
- Check glucose 30 minutes after each bolus or rate change and Q1-2h until stable.
- If glucose remains low, give another D10 2 mL/kg bolus and increase hourly rate by 1 mL/hour.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by MSEC 12/11/19.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Jennifer_Prince3@ykhc.org.



GESTATIONAL AGE (weeks)	24	26	28	30	32	34	36	38	40
ESTIMATED WEIGHT (grams)	700	900	1100	1350	1650	2100	2600	3000	3500
EQUIPMENT/SUPPLIES: NG/OG Tube - 5 French + UVC <32 weeks - 3.5 French + UVC ≥32 weeks - 5 French + UAC - 3.5 French for all gestational ages									
Laryngoscope Blade	00	00	00	0	0	0	0	0-1	0-1
ETT Size	2.5	2.5	2.5-3.0	3.0	3.0	3.0-3.5	3.5	3.5-4.0	3.5-4.0
ETT Depth lip to tip. <i>Place at T2 above the carina.</i>	6.5-7 cm	6.5-7 cm	7 cm	7-7.5 cm	7.5 cm	8 cm	8.5 cm	9 cm	9.5 cm
UVC insertion. <i>Place just above diaphragm. Add umbilical stump length.</i> May insert UVC 2-4 cm for emergency access.	6.5 cm	6.9 cm	7.2 cm	7.5 cm	8 cm	8.7 cm	9.4 cm	10 cm	10.8 cm
UAC insertion. <i>Add umbilical stump length.</i> High line at T6-T9 (preferred).	11.1 cm	11.7 cm	12.3 cm	13 cm	14 cm	15.3 cm	16.8 cm	18 cm	19.5 cm
UAC insertion. <i>Low line at L3-L4.</i> <i>Add umbilical stump length.</i>	7.7 cm	7.9 cm	8.1 cm	8.4 cm	8.7 cm	9.1 cm	9.6 cm	10 cm	10.5 cm
Needle decompression. <i>See kit and protocol in neonatal code cart.</i>	18 gauge	18 gauge	18 gauge	18 gauge	18 gauge	16 gauge	16 gauge	16 gauge	16 gauge
VITAL SIGNS: Heart Rate 120-160 + Respiratory Rate 30-60 + Mean Blood Pressure = Gestational age in weeks									
INITIAL VENTILATOR SETTINGS									
Positive Inspiratory Pressure (PIP) cm H ₂ O	16-22	16-22	16-22	16-22	18-24	18-24	18-24	20-28	20-28
Positive End Expiratory Pressure (PEEP) cm H ₂ O	4-6	4-6	4-6	4-6	4-6	5-6	5-6	5-6	5-6
Inspiratory Time (seconds)	0.3-0.35	0.3-0.35	0.3-0.35	0.3-0.35	0.3-0.35	0.3-0.35	0.35-0.4	0.35-0.4	0.35-0.4
Respiratory Rate (breaths per minute)	30-45	30-45	30-45	30-45	20-40	20-40	20-40	20-40	20-40
Saturation Goal after 10 Minutes	88-95%	88-95%	88-95%	88-95%	88-95%	88-95%	88-95%	95-98%	95-98%
MEDICATIONS									
Epinephrine IV/IO 0.1 mg/mL 0.1-0.3 mL/kg. <i>May repeat every 3 minutes for asystole.</i>	0.1-0.2 mL	0.1-0.3 mL	0.1-0.3 mL	0.1-0.4 mL	0.2-0.5 mL	0.2-0.6 mL	0.3-0.8 mL	0.3-0.9 mL	0.4-1 mL
Epinephrine ET ONLY 0.1 mg/mL 1 mL/kg. <i>May repeat every 3 minutes for asystole.</i>	0.7 mL	0.9 mL	1.1 mL	1.3 mL	1.6 mL	2.1 mL	2.6 mL	3 mL	3.5 mL
Curosurf (poractant alfa 80 mg/mL) 2.5 mL/kg. Half dose given to each side. Give Curosurf <26 weeks OR 26-29 weeks requiring ≥40% FiO ₂ OR >29 weeks with CXR-proven RDS.	1.8 mL (0.9 mL/side)	2.2 mL (1.1 mL/side)	2.8 mL (1.4 mL/side)	3.4 mL (1.7 mL/side)	4 mL (2 mL/side)	5.2 mL (2.6 mL/side)	6.6 mL (3.3 mL/side)	7.6 mL (3.8 mL/side)	8.8 mL (4.4 mL/side)
FOR HYPOGLYCEMIA: Give D10 bolus 2 mL/kg IV/IO at 1 mL/min. Increase D10 maintenance fluid rate by 1 mL/hour for <2 kg or 2 mL/hour for ≥2 kg.	1.4 mL	1.8 mL	2.2 mL	2.7 mL	3.3 mL	4.2 mL	5.2 mL	6 mL	7 mL
Ampicillin (Dilute to 100 mg/mL) 50 mg/kg IV/IM	35 mg (0.35 mL)	45 mg (0.45 mL)	55 mg (0.55 mL)	68 mg (0.68 mL)	83 mg (0.83 mL)	105 mg (1.05 mL)	130 mg (1.3 mL)	150 mg (1.5 mL)	175 mg (1.75 mL)
Gentamicin (2 mg/mL) 5 mg/kg IV as one-time dose. May give IM. DO NOT USE IN VILLAGE.	3.5 mg (1.75 mL)	4.5 mg (2.25 mL)	5.5 mg (2.75 mL)	6.8 mg (3.4 mL)	8.2 mg (4.1 mL)	10.4 mg (5.2 mL)	13 mg (6.5 mL)	15 mg (7.5 mL)	17.6 mg (8.8 mL)
Volume Expanders: NS or albumin 10 mL/kg IV/IO. Give over 15-30 minutes; give faster if unstable; give slower for extreme premies.	7 mL	9 mL	11 mL	13.5 mL	16.5 mL	21 mL	26 mL	30 mL	35 mL
D10 Maintenance Fluids: <750 grams give 90-100 mL/kg/24 hours + ≥750 grams give 80 mL/kg/24 hours. Goal blood glucose is 35-110 mg/dL.	3 mL/hour	3 mL/hour	3.7 mL/hour	4.5 mL/hour	5.5 mL/hour	7 mL/hour	8.7 mL/hour	10 mL/hour	12 mL/hour
Phenobarbital (130 mg/mL) 10 mg/kg IV/IO/IM/PR. May give additional 10 mg/kg dose.	7 mg (0.05 mL)	9 mg (0.07 mL)	11 mg (0.08 mL)	13.5 mg (0.1 mL)	16.5 mg (0.13 mL)	21 mg (0.16 mL)	26 mg (0.2 mL)	30 mg (0.23 mL)	35 mg (0.27 mL)



Epinephrine 0.1 mg/mL

- This is the pre-filled syringe concentration.
- Draw up doses by inserting needle through the thick rubber stopper.

Ampicillin 100 mg/mL

Products needed:

- Ampicillin 500 mg vial
- Sterile water for injection, 10 mL vial

How to mix:

1. Reconstitute 500 mg vial with 4.8 mL sterile water for injection. This will result in a 100 mg/mL final concentration.
2. The Neonatal Resuscitation Summary (page 1) lists the total dose and volume – draw up dose from vial.
3. Dose must be used within 1 hour of reconstitution.

Administration:

- Doses less than 500 mg can be injected via slow IV push over 3 to 5 minutes.
- Not compatible with D10W.
- Administer before gentamicin – do not administer at the same time.

Gentamicin 2 mg/mL

Product needed:

- Gentamicin 100 mg/50 mL pre-mixed bag.

DO NOT ADMINISTER THE BAG – the dose will be administered via syringe pump.

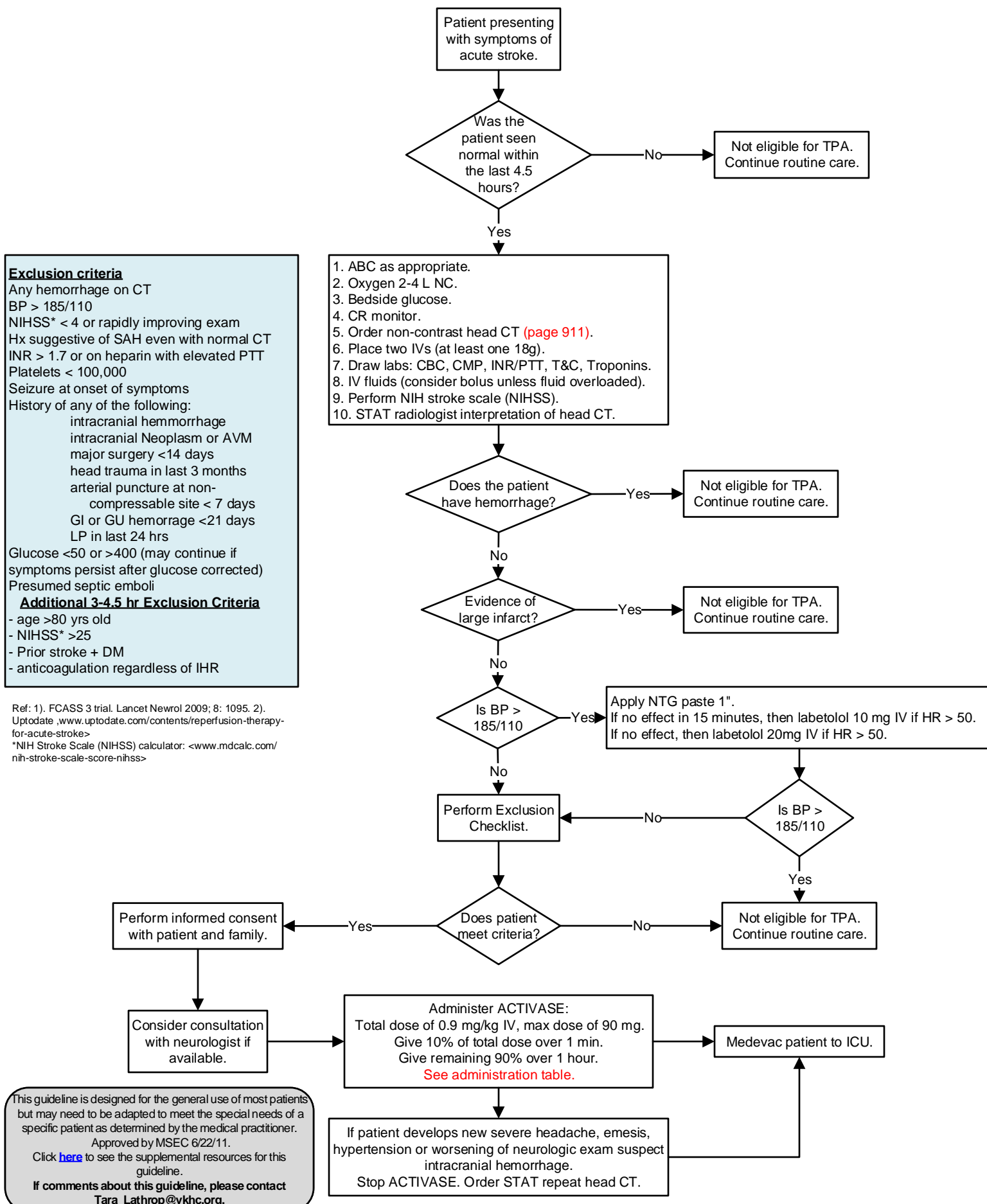
The Neonatal Resuscitation Summary (page 1) lists the total dose and volume – draw up this volume from the bag and **immediately dispose of the bag.**

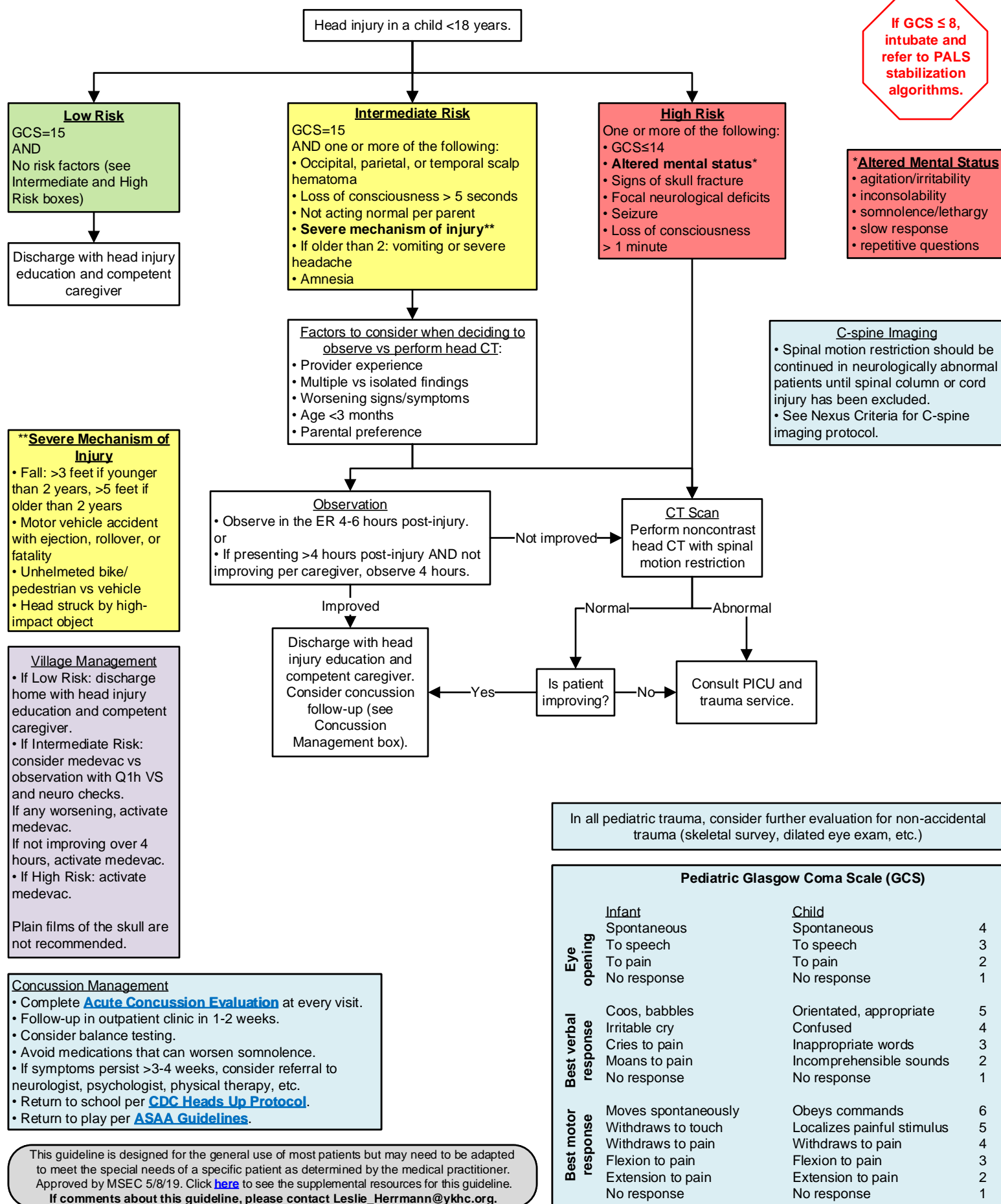
Administration:

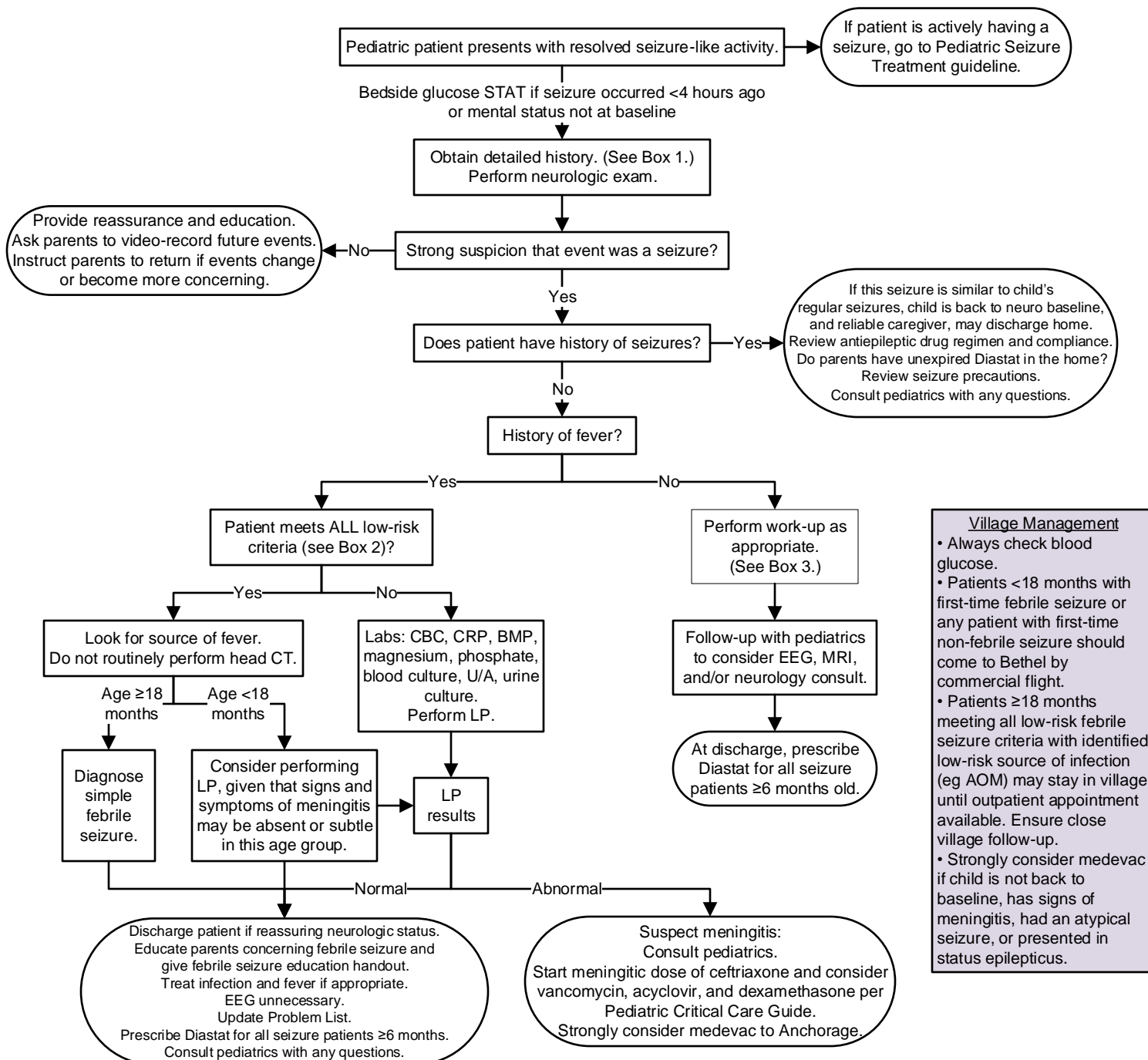
- Administer after ampicillin – do not administer at the same time.
- Administer via **syringe pump** over 30 minutes.
- Compatible with D10W.



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Village Management

- Always check blood glucose.
- Patients <18 months with first-time febrile seizure or any patient with first-time non-febrile seizure should come to Bethel by commercial flight.
- Patients ≥18 months meeting all low-risk febrile seizure criteria with identified low-risk source of infection (eg AOM) may stay in village until outpatient appointment available. Ensure close village follow-up.
- Strongly consider medevac if child is not back to baseline, has signs of meningitis, had an atypical seizure, or presented in status epilepticus.

Box 1: Detailed History

- When/where did it occur? Awake or asleep?
- What preceded the event (eg head trauma, crying, etc.)?
- How long did it last?
- Ask caregiver to recount, step-by-step, what happened.
- Type of movement and what part of body? Symmetric?
- Interventions?
- Incontinence?
- Behavior after event? How long till back to baseline?

HPI

- Intercurrent illness/fevers
- Medications
- Recent intake, including free water and diluted formula
- Ingestions
- Trauma

PMH

- Prior history of seizures
- History of breathholding

Family Hx: Seizures, febrile seizures, breathholding, etc.

Box 2: Low risk febrile seizure criteria

1. 6 months to 4 years of age.
2. Fever present.
3. Seizure generalized (nonfocal).
4. Seizure duration <5 minutes.
5. Child has normal neurologic examination.
6. Child has no history of previous neurologic or CNS abnormality.
7. Only one seizure in a 24 hour period.
8. Child has returned to baseline.
9. No meningeal signs:
 - Irritability or inconsolability
 - Nuchal rigidity
 - Bulging fontanelle
 - Lethargy or somnolence
 - Focal neurologic findings
10. Child has NOT received antibiotics in the past 72 hours.

Box 3: Work-up

- Bedside glucose
- EKG for first event
- BMP, magnesium, phosphate
- Urine drug screen
- Perform LP if persistent altered mental status, meningitis suspected, or <18 months of age and delayed return to baseline.

Radiological studies:

- Obtain head CT prior to LP if concerning neurologic status, persistently altered mental status, history of trauma, or focal neurological findings.

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Approved by MSEC 5/8/19. Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.



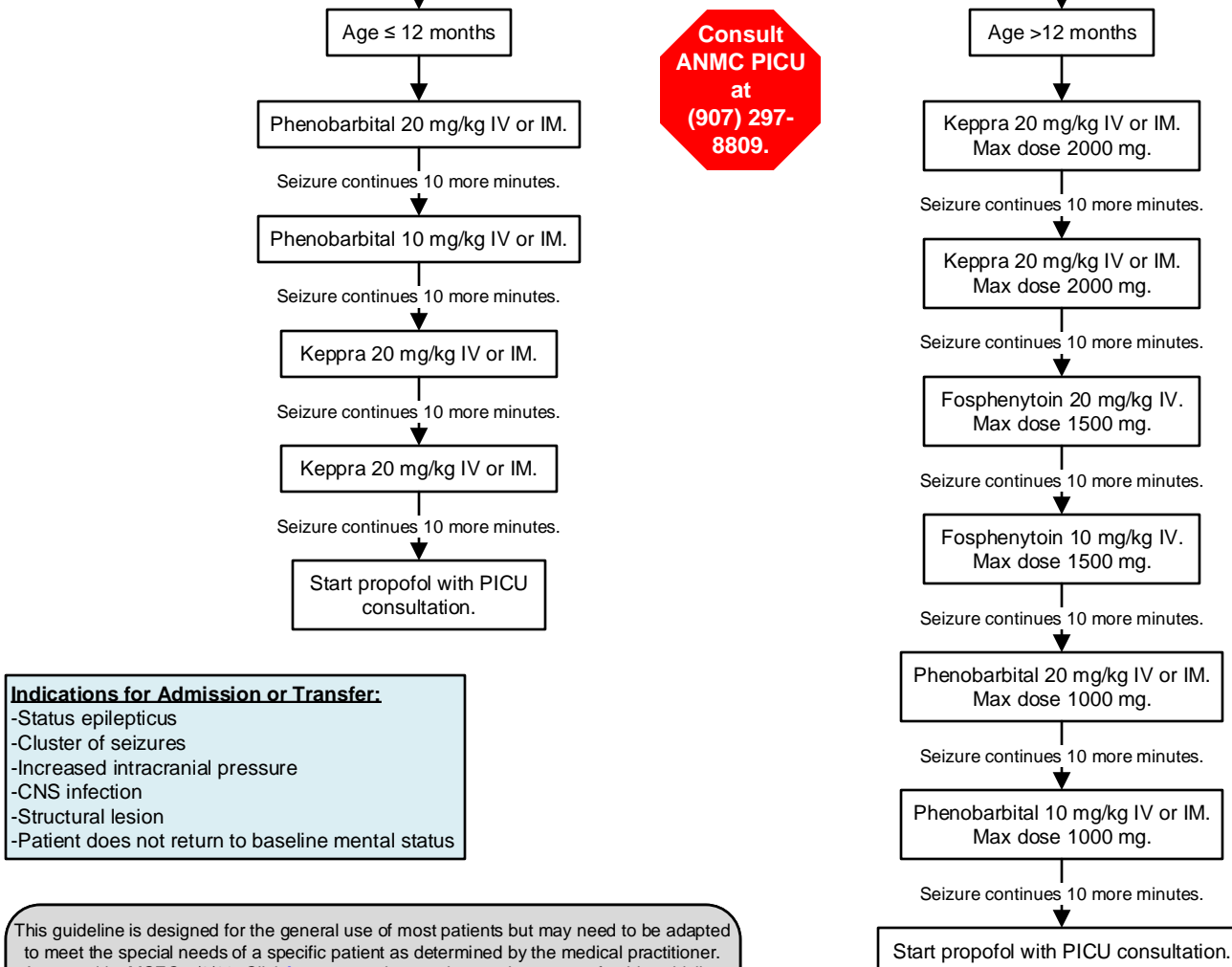
If in the ER or NW, ask a nurse to get the Peds Seizure Kit. Tell him/her to type "seizure" in the Pyxis.

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan to check all medication dosing.

ER Management
Note: Peds Seizure Kit includes dosing.
Lorazepam 0.1 mg/kg IV/IO (max dose 4 mg) or midazolam 0.2 mg/kg intranasal (max dose 10 mg) if no IV access.

Village Management
See Emergency RMT Seizure Scenario on the wiki.

- ABCs.
- **Bedside glucose STAT.**
- If unable to get a glucose measurement, give glucose buccally.
- Get BVM with appropriate sized mask to bedside.
- Follow flow to the left, using these drugs with dosing found on Pediatric Critical Care Guide:
 - Diastat home dose PR if available or midazolam 0.2 mg/kg intranasal (max dose 10 mg) or diazepam 0.5 mg/kg (max 10 mg) IV solution given RECTALLY.
 - Phenobarbital 20 mg/kg IM (max dose 1000 mg). If giving phenobarbital, consult pediatrics, notify ER, and strongly consider activating a medevac.
- Low threshold to activate medevac for atypical or prolonged seizure.



Note: If febrile seizure with status epilepticus, consider giving phenobarbital after benzodiazepines prior to Keppra in any age group.

Indications for Admission or Transfer:

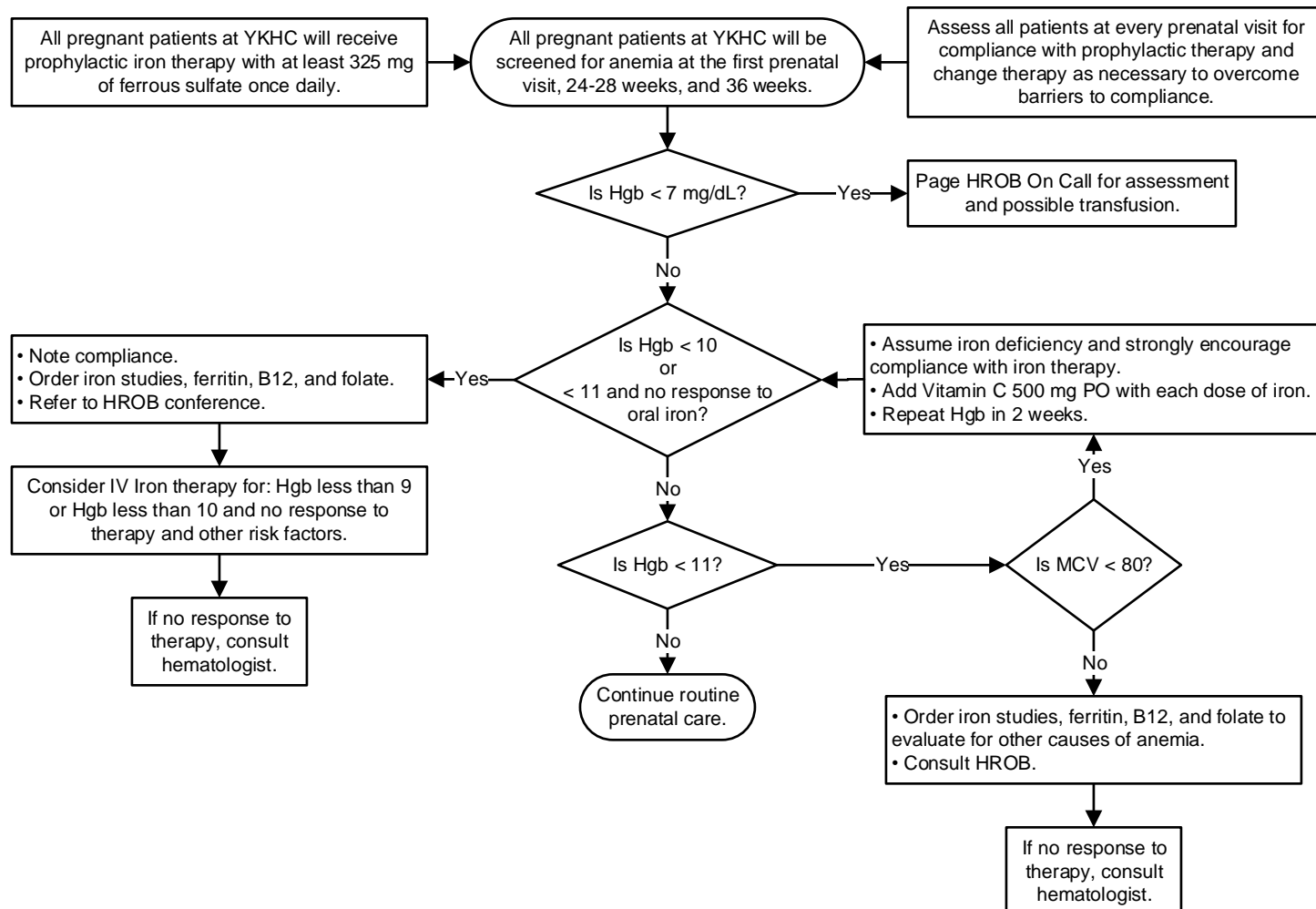
- Status epilepticus
- Cluster of seizures
- Increased intracranial pressure
- CNS infection
- Structural lesion
- Patient does not return to baseline mental status

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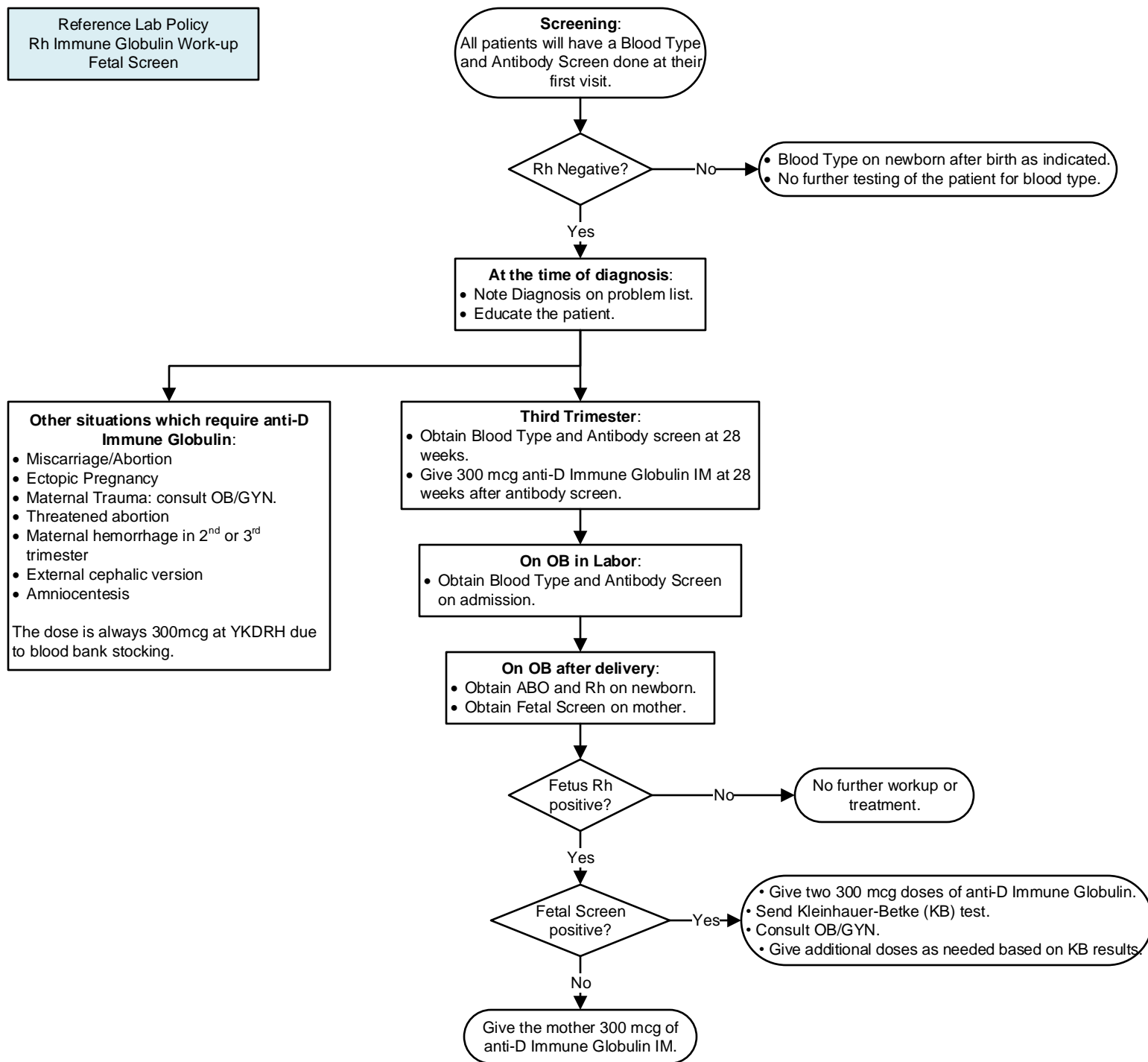
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Reference Lab Policy
Rh Immune Globulin Work-up
Fetal Screen

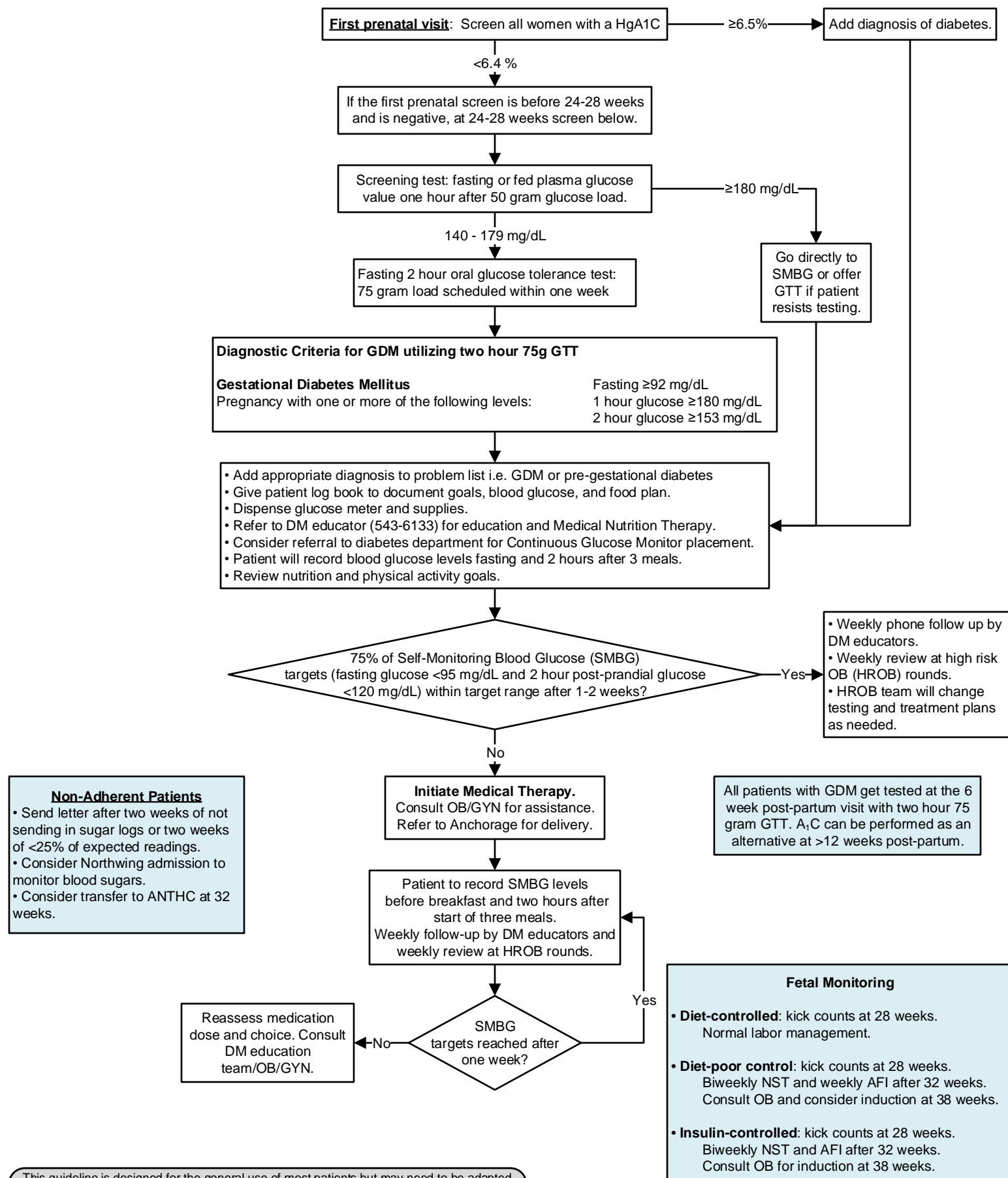


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Approved by MSEC 10/30/17.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact
Ellen_Hodges@ykhc.org.





D&C Prior to Methotrexate?

This is NOT necessary prior to treatment with Methotrexate (MTX) for a plateau or abnormally rising HCG level. MTX will treat an abnormal pregnancy in the uterus or any other location.

Typical side effects of MTX.

Less than 30% of patients will experience minor, self-limited side effects from the medication, including nausea, mouth ulcers, and GI cramps.

Most patients have some lower abdominal pain on the 3-6th day after treatment. This is not a problem if ibuprofen or acetaminophen relieves the pain.

Contraindication to MTX.

Absolute contraindications

Breast Feeding
Overt or Laboratory evidence of immunodeficiency
Alcoholism, alcoholic liver disease, or other chronic liver disease
Preexisting blood dyscrasias, such as bone marrow hypoplasia, leukopenia, thrombocytopenia or significant anemia

Known sensitivity to MTX
Active pulmonary disease
Peptic ulcer disease
Hepatic, renal or hematologic dysfunction

Relative contraindications

Gestational sac larger than 3.5cm
Embryonic cardiac motion

Single-dose regimen

- Single dose MTX 50mg/m² IM day 1
- Measure hCG level on post treatment days 4 and 7
- Check for 15% hCG decrease between days 4 and 7
- Then measure hCG level weekly until reaching the nonpregnant level
- If results are less than the expected 15% decrease, readminister MTX 50mg/m² and repeat hCG measurement on days 4 and 7 after second dose.

If at any time the hCG level rises during the monitoring of weekly hCG levels, consult a GYN Oncologist for further treatment.

Ectopic Pregnancy diagnosed after consultation with HROB or OB/GYN

Obtain:

- Quantitative HCG
- Type and Screen
- CBC
- Comprehensive Metabolic Panel
- Transvaginal Pelvic Ultrasound (US)

Hemodynamically stable?

No

Consult HROB for immediate surgery or transfer

Yes

Adnexal Mass \geq 3cm
Cardiac activity
Pregnancy in location other than a tube

Yes

No

Platelets, kidney and liver function normal?

No

Yes

Is the hCG >5000?

No

Yes

Two-dose regimen

- Administer 50 mg/m² on day 0.
- Repeat 50mg/m² on day 4.
- Measure hCG levels on days 4 and 7, and expect a 15% decrease between days 4 and 7.
- If the decrease is greater than 15%, measure hCG levels weekly until reaching non pregnant level.
- If less than a 15% decrease in hCG levels, readminister MTX 50mg/m² on days 7 and 11, measuring hCG levels.
- If hCG levels decrease 15% between days 7 and 11, continue to monitor weekly until non pregnant hCG levels are reached.



1

Nomenclature

- **Viable** – A pregnancy is viable if it can potentially result in a liveborn baby.
- **Nonviable** – A pregnancy is nonviable if it cannot possibly result in a liveborn baby. Ectopic pregnancies and failed intrauterine pregnancies are nonviable.
- **Intrauterine pregnancy of uncertain viability** – A woman is considered to have this if a transvaginal ultrasound shows an intrauterine gestational sac with no embryonic heartbeat and no findings of definite pregnancy failure.
- **Pregnancy of unknown location** – A woman is considered to have this if she has a positive urine or serum pregnancy test and no intrauterine or ectopic pregnancy on transvaginal ultrasound.

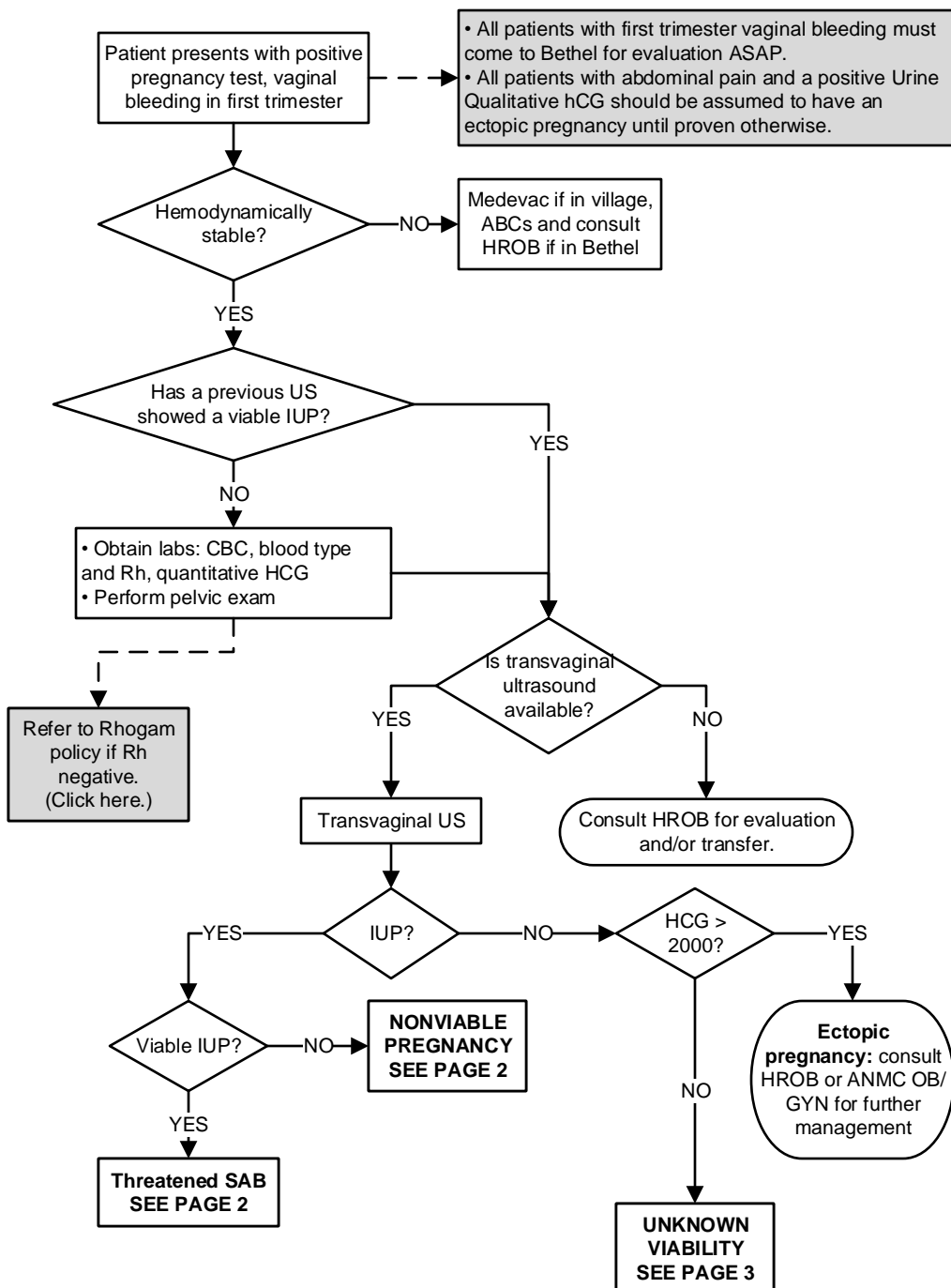
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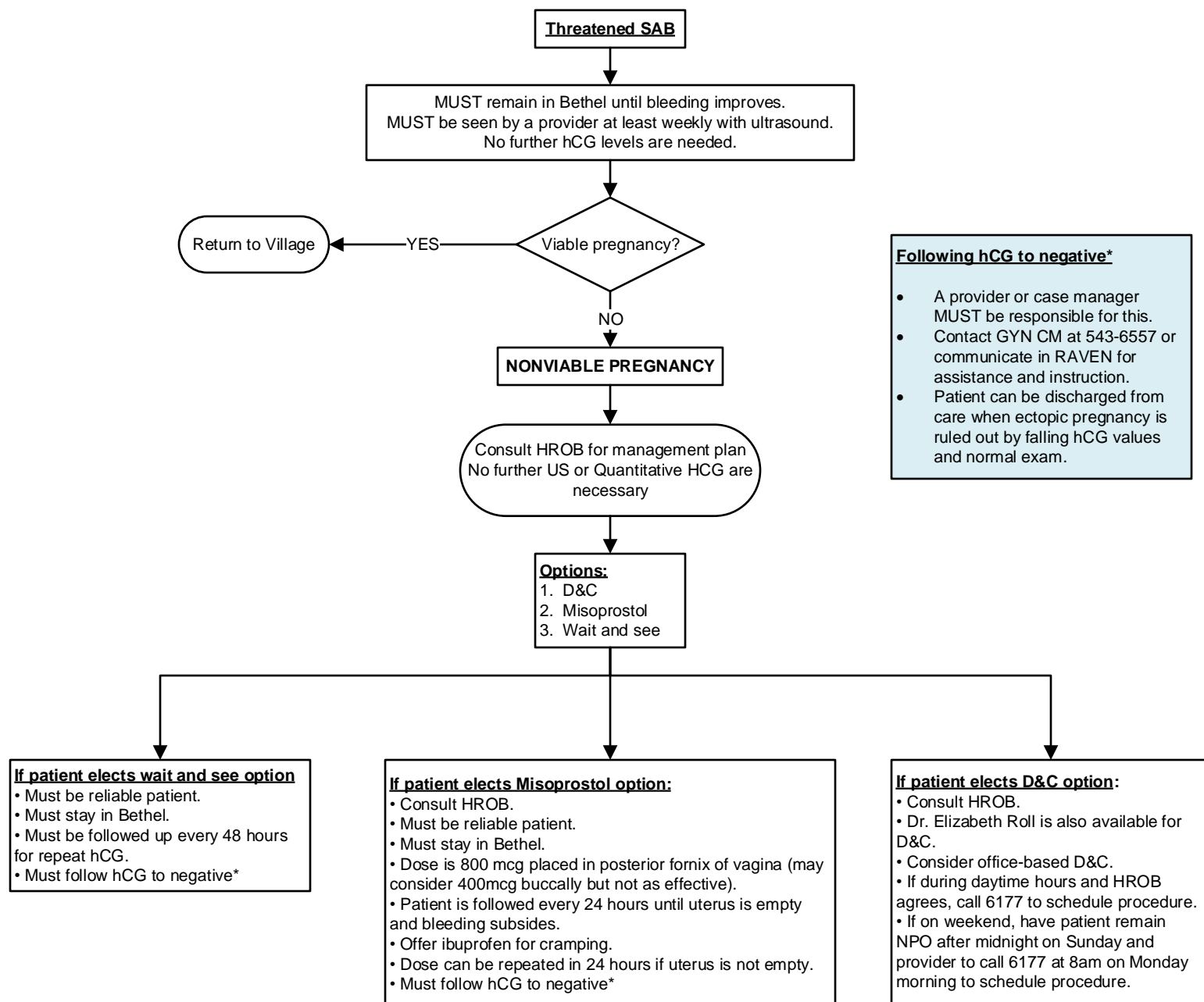
Findings diagnostic of Pregnancy Failure

- Crown-rump length of ≥ 7 mm and no heartbeat
- Mean sac diameter of ≥ 25 mm and no embryo
- Absence of embryo with heartbeat ≥ 14 days after an US that showed a gestational sac without a yolk sac
- Absence of embryo with a heartbeat ≥ 11 days after an US that showed a gestational sac with a yolk sac

Comments

- In a woman with a positive urine or serum pregnancy test, an intrauterine fluid collection with rounded edges containing no yolk sac is most likely a gestational sac; it is certain to be a gestational sac if it contains a yolk sac or embryo.
- Transabdominal imaging without transvaginal scanning may be sufficient for diagnosing early pregnancy failure when an embryo whose crown-rump length is 15mm or more has no visible cardiac activity.







1

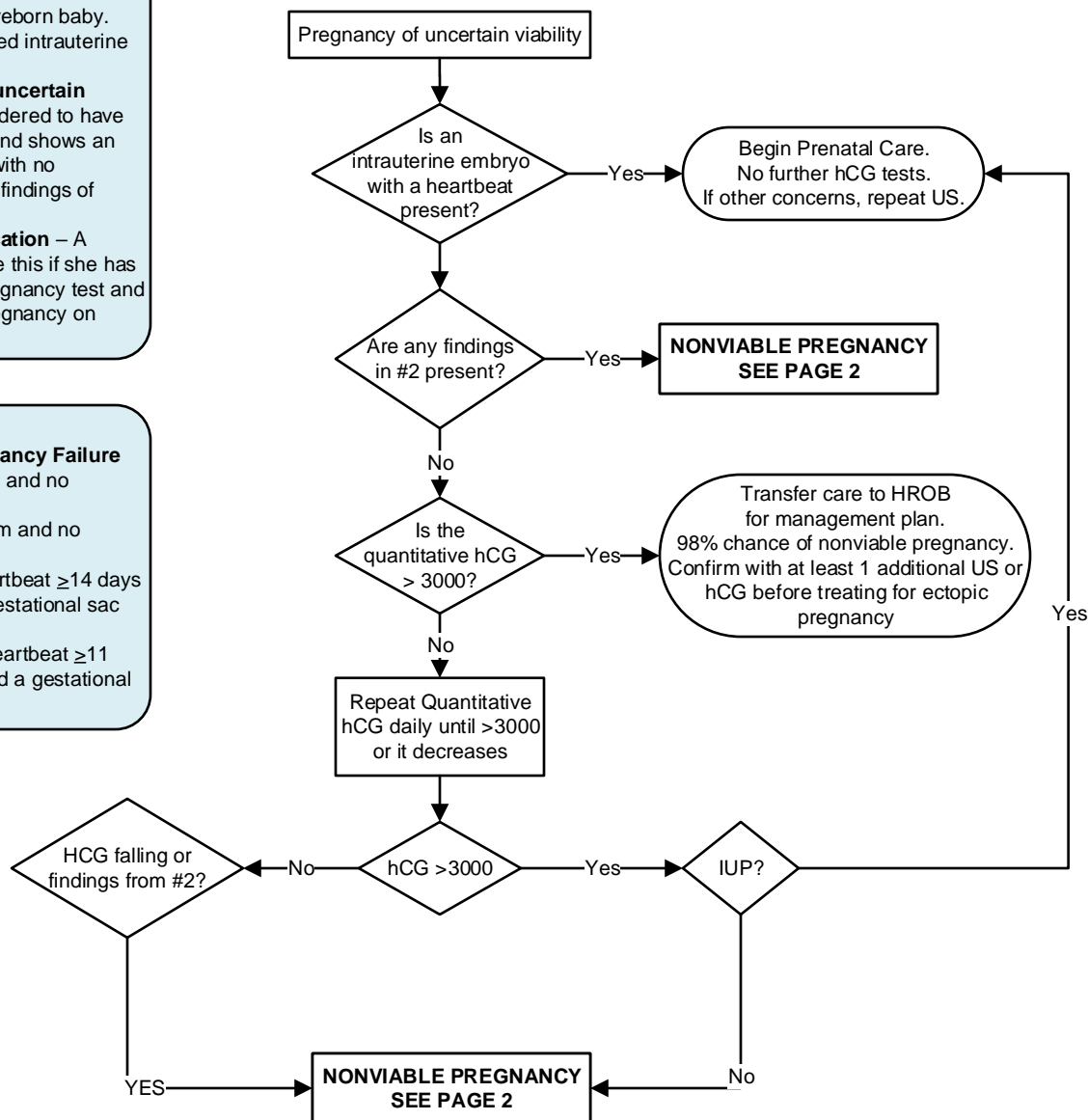
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2

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- Transabdominal imaging without transvaginal scanning may be sufficient for diagnosing early pregnancy failure when an embryo whose crown-rump length is 15mm or more has no visible cardiac activity.



GBS Prophylaxis of the Mother at Term

Use the
GBS App

to determine need for prophylaxis and antibiotic of choice for GBS prevention

Web version: <https://www2a.cdc.gov/vaccines/m/gbs3/gbs.html>

or

Download for your smartphone.

OPT OUT

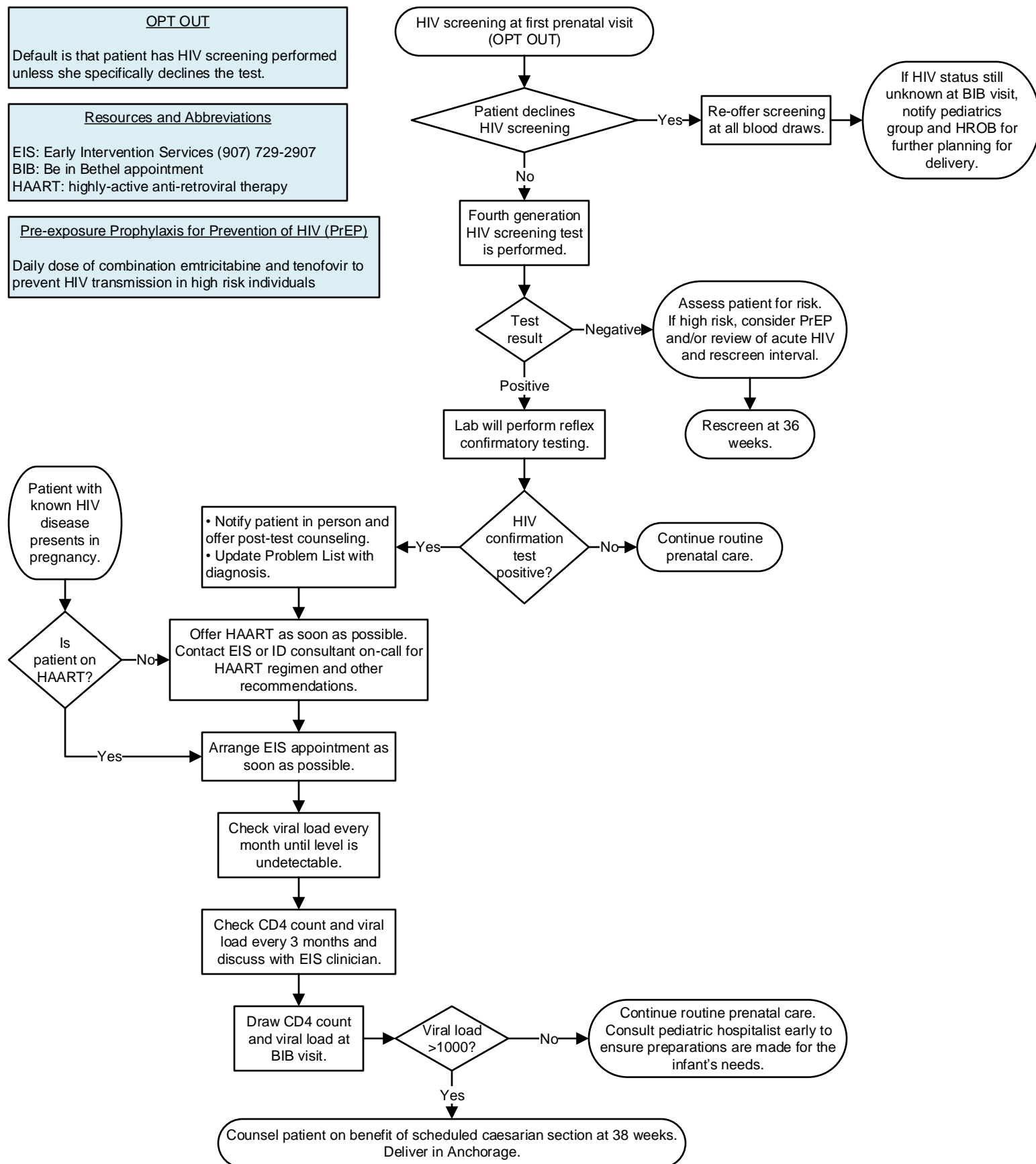
Default is that patient has HIV screening performed unless she specifically declines the test.

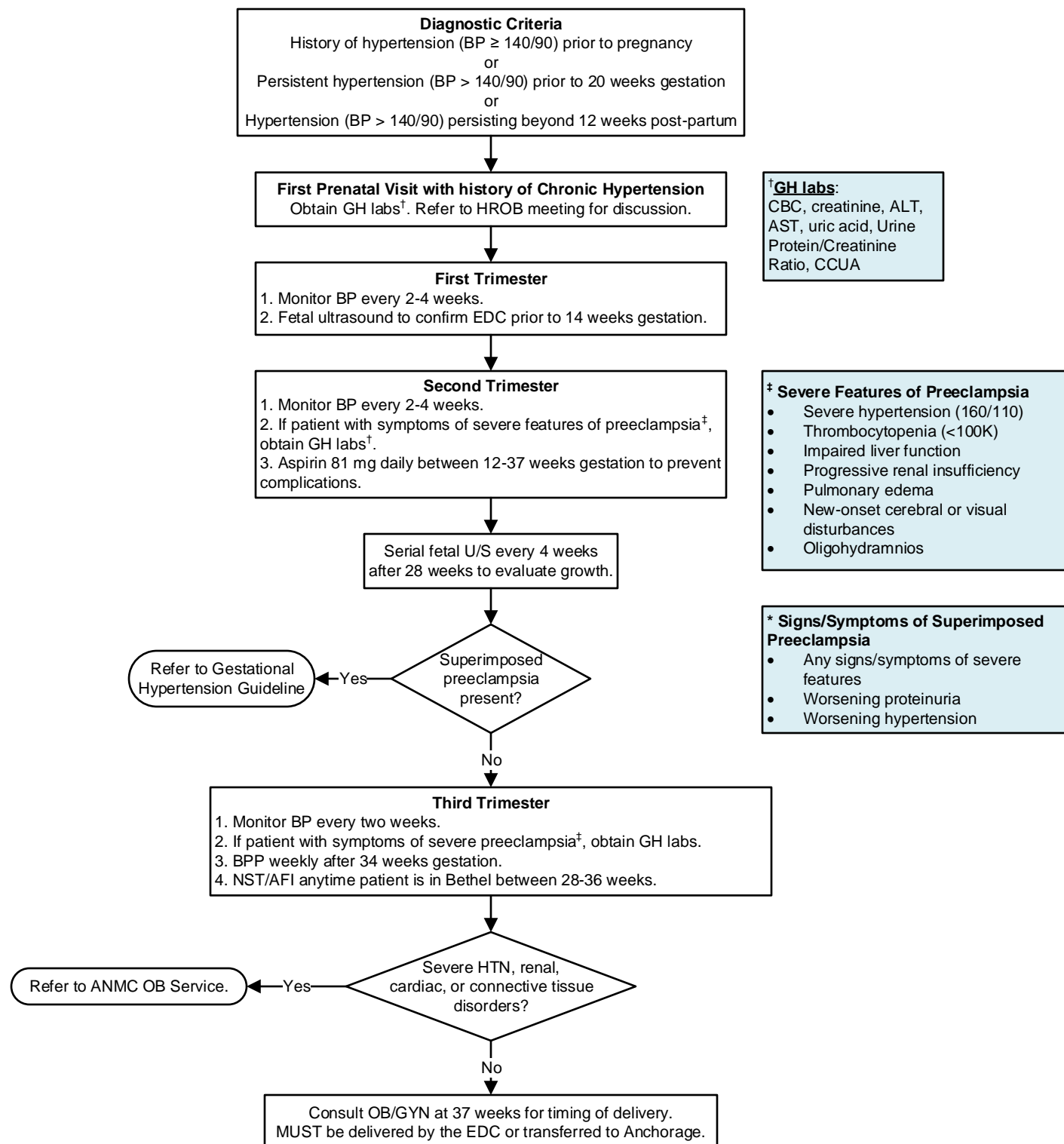
Resources and Abbreviations

EIS: Early Intervention Services (907) 729-2907
BIB: Be in Bethel appointment
HAART: highly-active anti-retroviral therapy

Pre-exposure Prophylaxis for Prevention of HIV (PrEP)

Daily dose of combination emtricitabine and tenofovir to prevent HIV transmission in high risk individuals





Any patient with hypertension in pregnancy should have blood pressure monitored for at least two weeks post-partum.

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Approved by MSEC 7/12/17.
Click [here](#) to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.



†How to take a BP

Patient should be seated for 15 minutes and calm. She should not chew or smoke. The appropriate sized BP cuff should be used.

Box 1: Severe Features of Preeclampsia

- BP > 160/110
- Renal insufficiency
- Pulmonary edema
- Thrombocytopenia (platelets <100K)
- Impaired liver function
- IUGR
- Cerebral or visual symptoms

Gestational Hypertension (GH) Diagnostic Criteria

BP \geq 140/90 measured on two occasions at least six hours apart. (See Box 1.) Only one elevated BP is needed to proceed with this guideline.

If patient < 20 weeks, refer to Chronic Hypertension in Pregnancy Guideline.

Full maternal/fetal evaluation including: GH labs, Test for Fetal Wellbeing, ultrasound for growth

GH labs:

CBC, creatinine, ALT, AST, uric acid, CCUA, random urine protein to creatinine ratio

Any signs or symptoms from Box 1?

Yes

Preeclampsia/Gestation Hypertension with Severe Features

Admit and consult OBGYN.

- Magnesium Sulfate: 4g IV bolus over 20 min, then 2g IV/hr
- GH labs
- Monitor fetal wellbeing
- Obtain OB ultrasound to evaluate for IUGR or oligohydramnios
- Monitor for signs and symptoms of Magnesium toxicity

Transfer to Anchorage

Yes

No

Protein/creatinine ratio >0.3*?

Gestational Hypertension

*Protein/creatinine ratio >0.15 <0.3: Obtain 24 hour urine protein.

Yes

Preeclampsia Consult HROB on call.

Is patient compliant?

No

Consider inpatient monitoring versus transfer to Anchorage.

Yes

Outpatient monitoring in Bethel

- Daily kick counts
- Office visit 1-2 times per week
- NST twice weekly
- AFI and GH labs once a week
- Ultrasound for growth every 3 weeks
- Transfer care to NW at 38 weeks for delivery or transfer to Anchorage.

Any signs or symptoms from Box 1?

No

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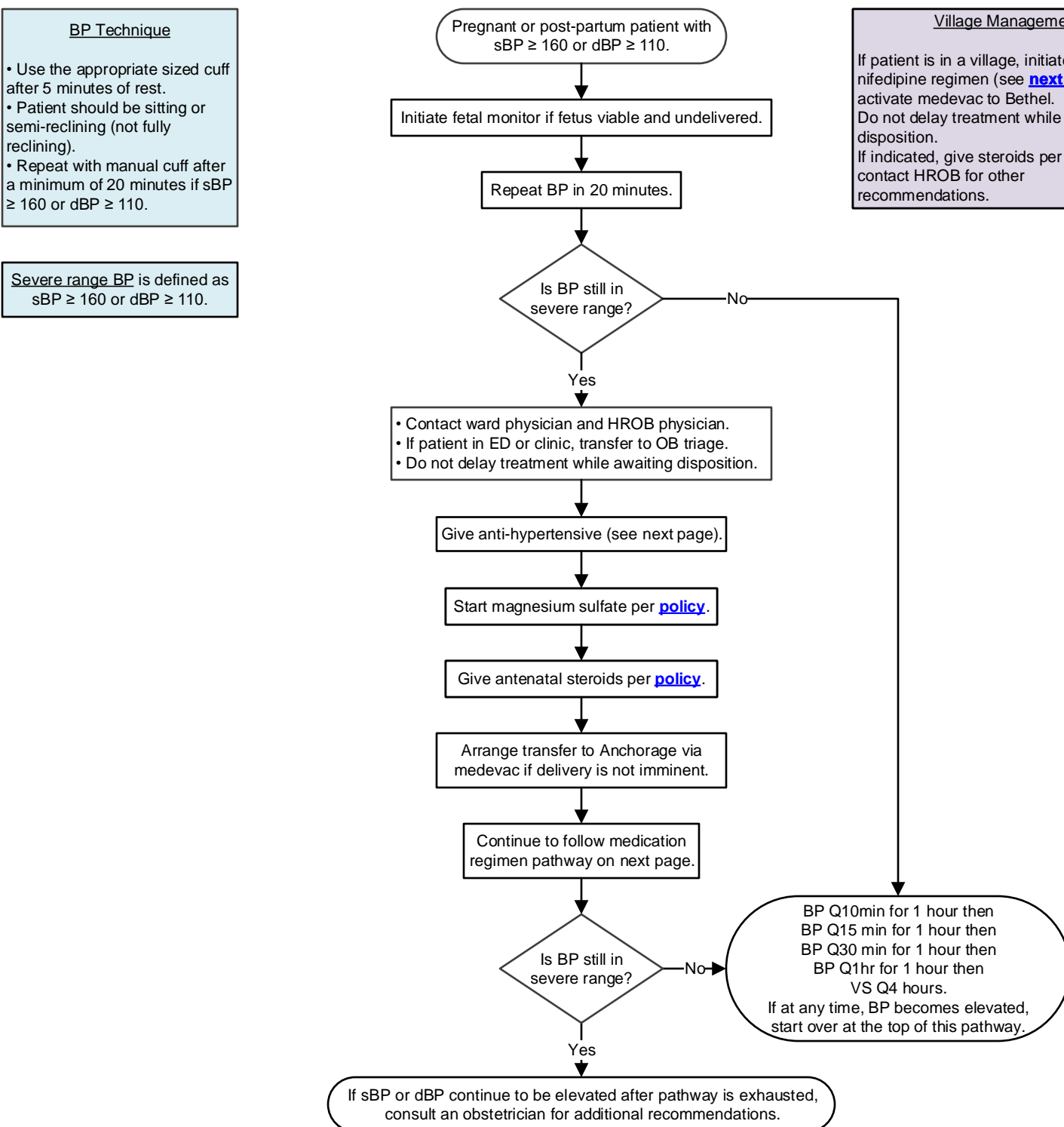
BP Technique

- Use the appropriate sized cuff after 5 minutes of rest.
- Patient should be sitting or semi-reclining (not fully reclining).
- Repeat with manual cuff after a minimum of 20 minutes if sBP ≥ 160 or dBP ≥ 110 .

Severe range BP is defined as sBP ≥ 160 or dBP ≥ 110 .

Village Management

If patient is in a village, initiate the nifedipine regimen (see [next page](#)) and activate medevac to Bethel. Do not delay treatment while awaiting disposition. If indicated, give steroids per [policy](#) and contact HROB for other recommendations.

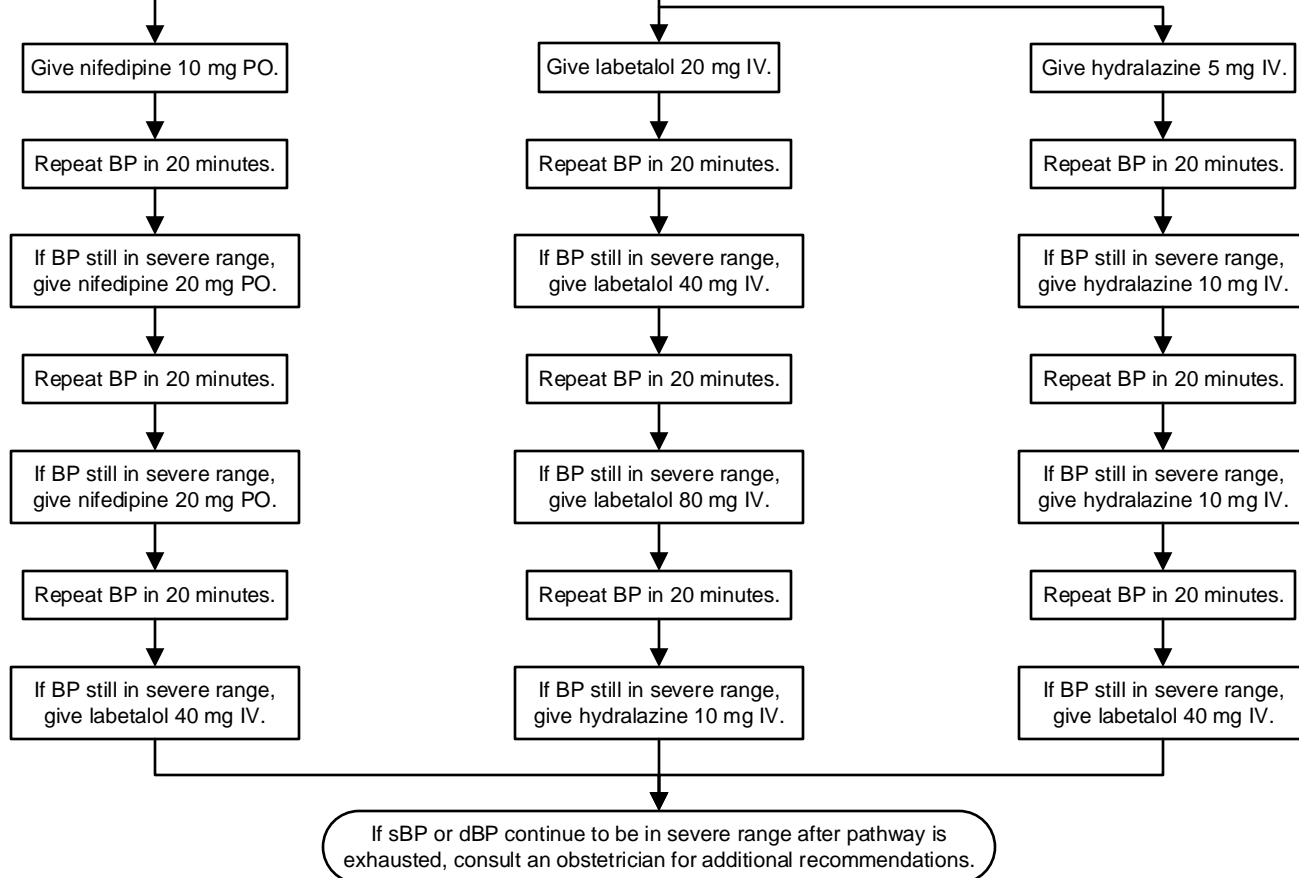




Severe range BP is defined as
sBP \geq 160 or dBP \geq 110.

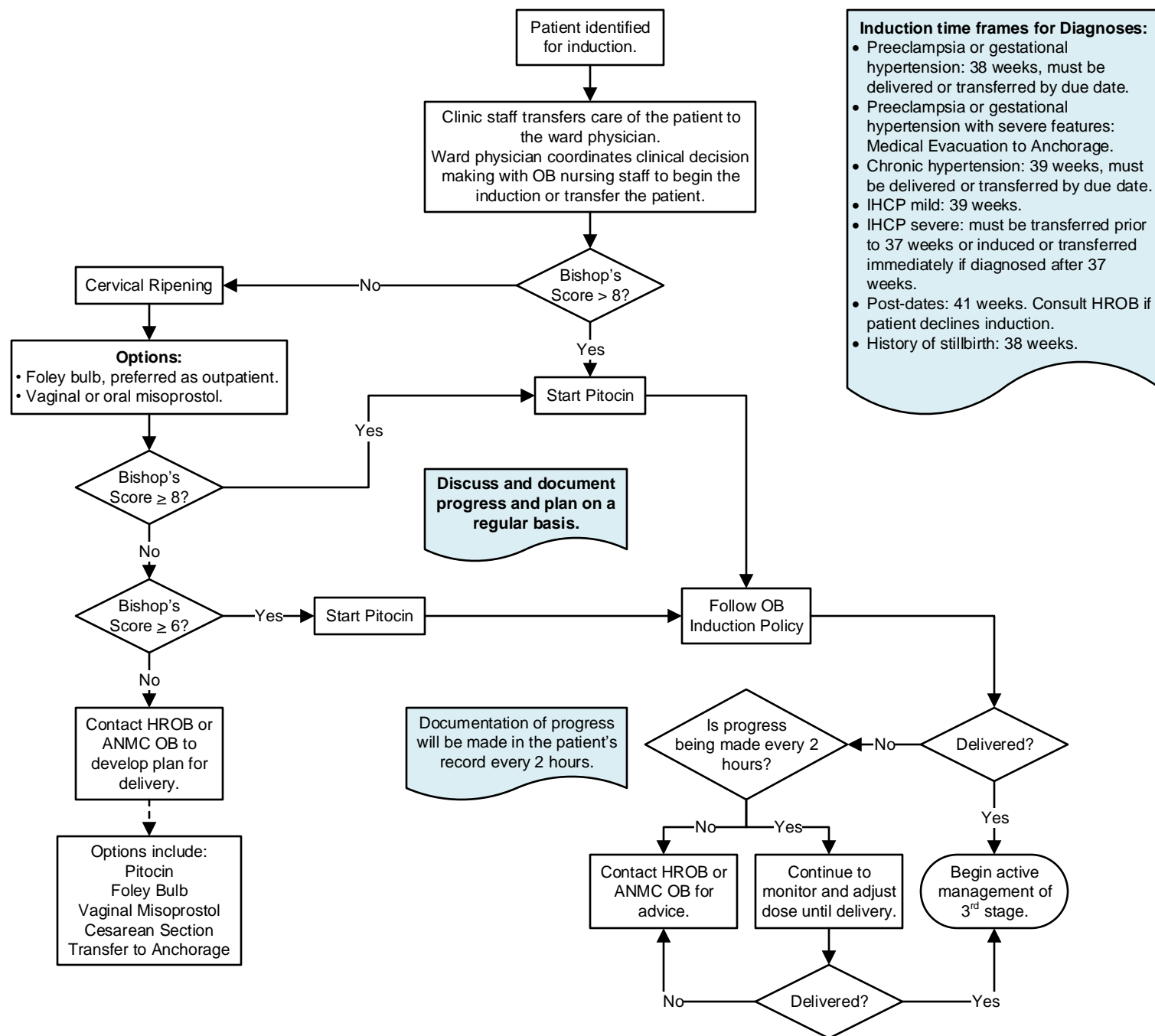
Anti-hypertensive
Medication Regimens

After two severe range BPs have been verified, choose one regimen.
Follow pathway until sBP < 160 and dBP < 110. At that time, return to first page for further management.



Village Management

If patient is in a village, initiate the nifedipine regimen and activate medevac to Bethel.
Do not delay treatment while awaiting disposition.
If indicated, give steroids per [policy](#) and contact HROB for other recommendations.



Bishop's Score					
Score	Dilatation	Effacement	Station	Position	Consistency
0	closed	0 – 30%	-3	posterior	firm
1	1-2 cm	40 -50%	-2	mid-position	medium
2	3-4 cm	60 -70%	-1,0	anterior	soft
3	5+ cm	80+%	+1,+2		

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Intrahepatic Cholestasis of Pregnancy (IHCP)

- Abnormal bile acid (BA) metabolism in pregnancy resulting in severe pruritus without rash.
- Mostly genetic etiology.
- 5% incidence in Yup'ik population.
- 5% incidence of stillbirth.
- MUST have elevated bile acids or LFTs.
- 40-70% recurrence in subsequent pregnancies.

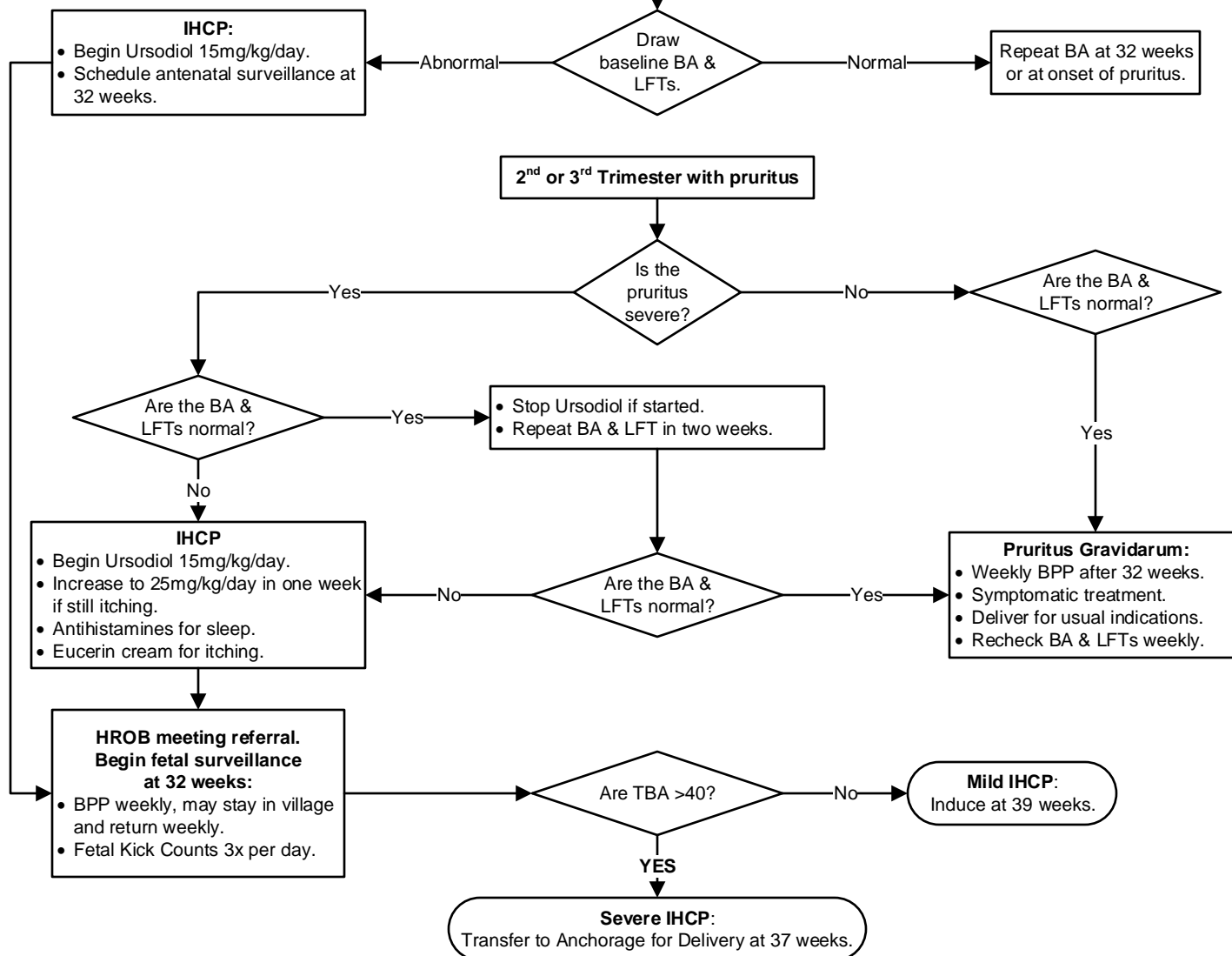
Early Pregnancy:

Consider the diagnosis if:

- History of severe pruritus in past pregnancy
- Unexplained stillbirth
- Hx of IHCP

Severe Pruritus:

- Insomnia.
- Worse on palms of hands and soles of feet.
- Excoriation present.
- Scratching during the exam.



Abnormal Lab levels

Total Bile Acids (TBA)	>10 µmol/L
Cholic Acid	> 3 µmol/L
AST/ALT	>40 units/L
Bilirubin	> 1 mg/dL
Alkaline Phosphatase	>300 units/L

Biophysical Profile (BPP)

- NST
- US including: fetal breathing, tone, gross body motion, and AFI

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Risk Factors for Intrauterine Growth Restriction

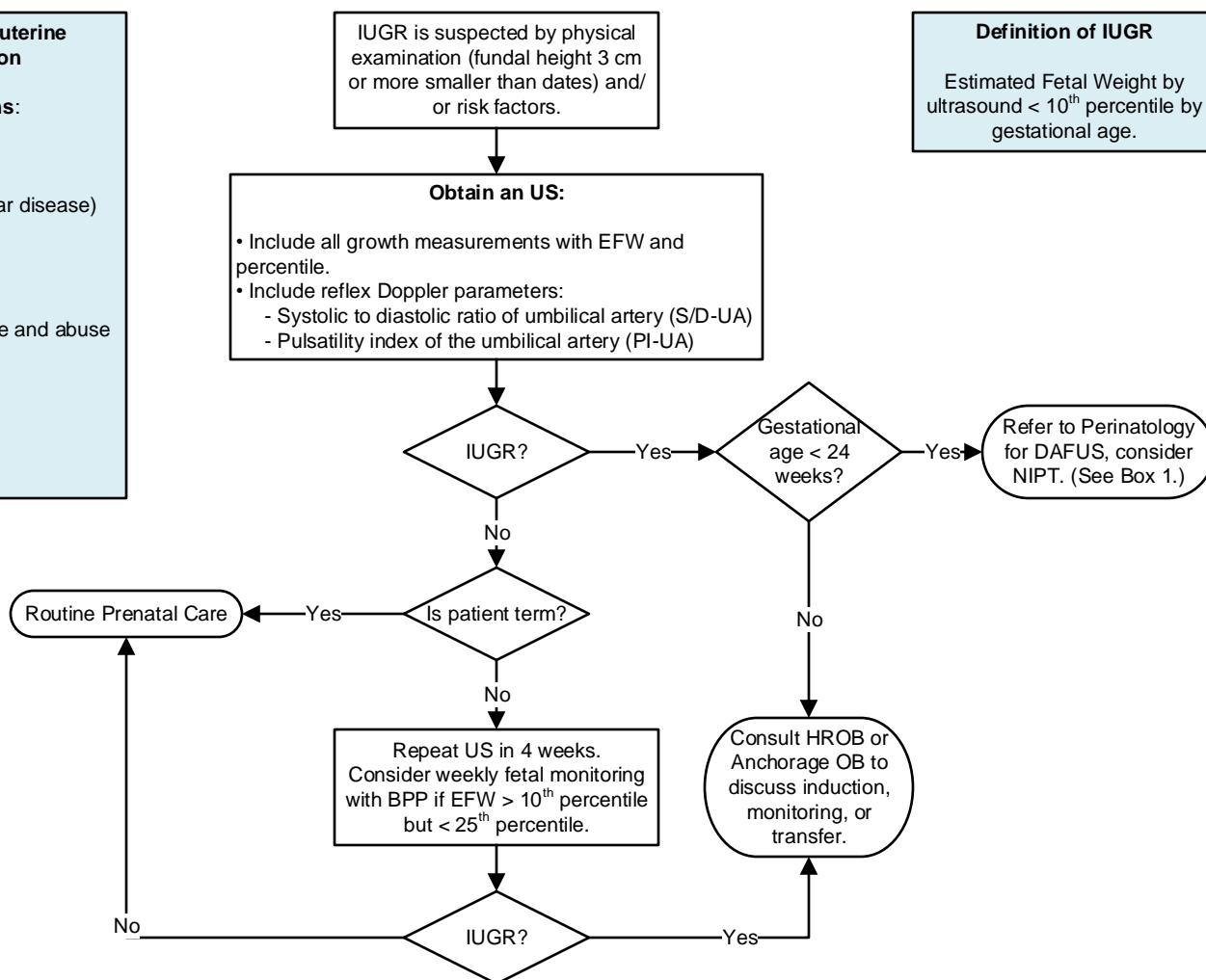
Maternal medical conditions:

- Hypertension
- Renal disease
- Restrictive lung disease
- Diabetes (with microvascular disease)
- Cyanotic heart disease
- Antiphospholipid syndrome
- Auto-immune disease

- Smoking and substance use and abuse
- Severe malnutrition
- Primary placental disease
- Multiple gestation
- Infections (viral, protozoal)
- Genetic disorders
- Exposure to teratogens

Definition of IUGR

Estimated Fetal Weight by ultrasound < 10th percentile by gestational age.



Box 1: NIPT

Non-invasive prenatal testing is a way to detect fetal chromosome abnormalities from a maternal blood draw. Our current test is InformaSeq from LabCorp.

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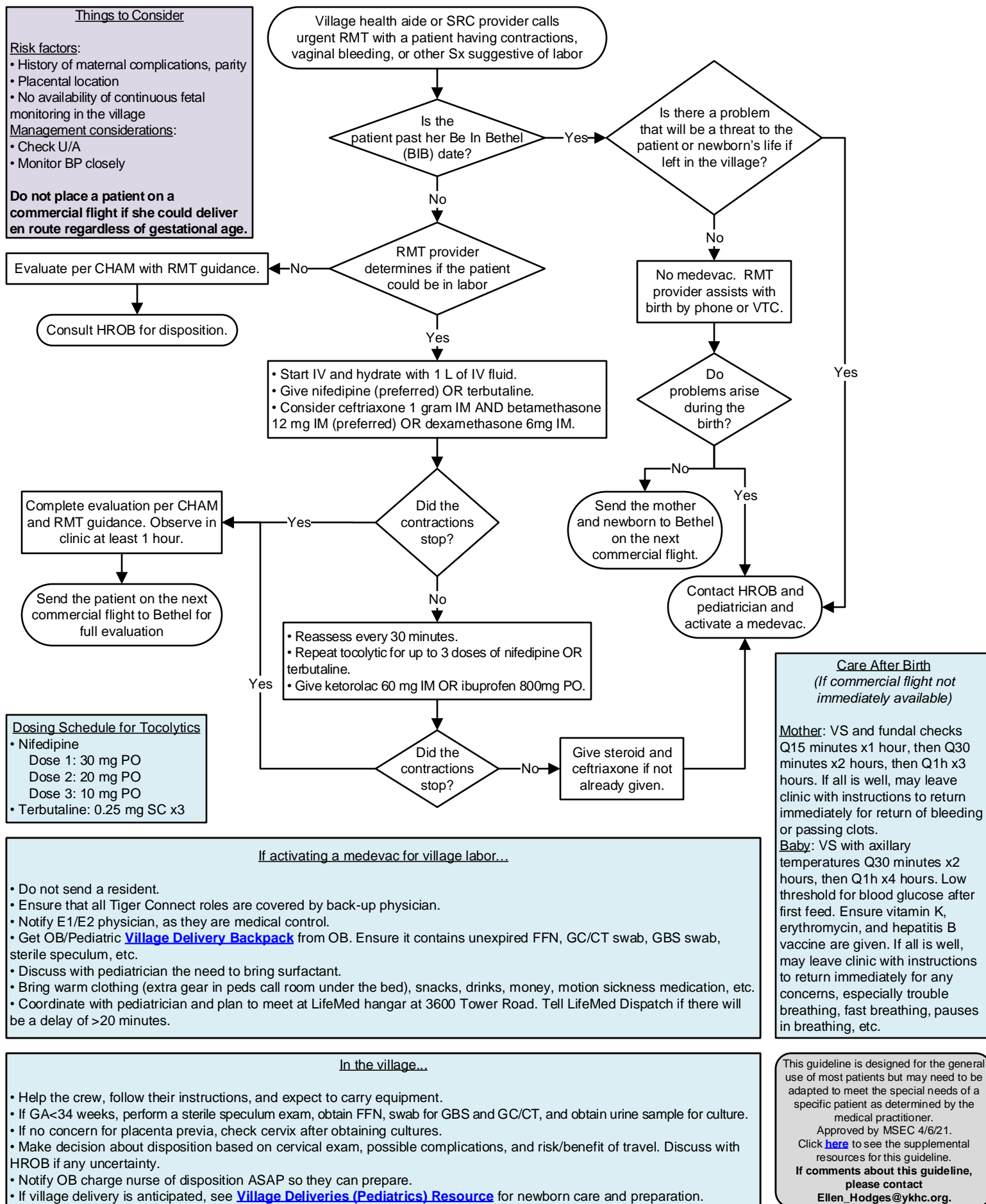
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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline Labor Patient: Village





-Quantitative β hCG >100,000
-Vaginal bleeding
-Hyperemesis
-Cystic enlargement of ovaries

Suspect Molar Pregnancy: no intrauterine embryo or ultrasound suspicious for Molar Pregnancy.

Administer Rhogam if Rh negative

Testing:
CBC, CMP, PT/PTT, Blood type, and Rh factor, Quantitative hCG, pelvic ultrasound, chest X-ray. Consider TSH, free T4 if signs/symptoms of hyperthyroidism.

Signs or symptoms of medical complications, hyperthyroid, severe anemia, coagulopathy, PIH

Yes → Stabilize, consult with ANMC OB/GYN service, and transfer to ANMC via medevac.

No

Suction D&C.
Consider transfer if uterus is >16 week size due to increased risk of complications.

Confirm pathology: molar pregnancy, complete or partial

Yes

Quantitative β hCG 48 hours after D&C and weekly

Plateau \pm 10% over three weeks rise \geq 10% over two weeks.
Quantitative HCG + at six months.

Post molar GTN:

-CT chest, CBC, PT/PTT, CMP.
Consult GYN ONC in Anchorage.

No

Weekly Quantitative β hCG until negative x3 (<5)

Monthly Quantitative β hCG for 6 months

Contraception:
Encourage Depo Provera, Nexplanon, IUD

Definitions

GTN – gestational trophoblastic neoplasm

Complete Mole – a form of aberrant fertilization with proliferation of trophoblastic tissue with a normal karyotype, no fetus, diffuse villous edema, and diffuse proliferation.

Partial Mole – a form of aberrant fertilization with proliferation of trophoblastic tissue with triploid karyotype, a fetus may be present, focal villous edema, and focal proliferation.

Choriocarcinoma – a malignant neoplasm arising from cytotrophoblast.

Placental site trophoblastic tumor – a malignant neoplasm arising from intermediate trophoblast.

Post Molar GTN – persistent hCG detection after the treatment of a complete or partial molar pregnancy.

Invasive Mole – detection of tumors within the uterus on imaging.

Malignant GTN – post molar gestational trophoblastic neoplasm.

Metastatic GTN – post molar GTN with imaging evidence of distant metastasis. The most common sites are vagina, lung, and brain.

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Differential Diagnosis by Trimester

First

- Aneuploidy
- Fetal Anomaly

Second

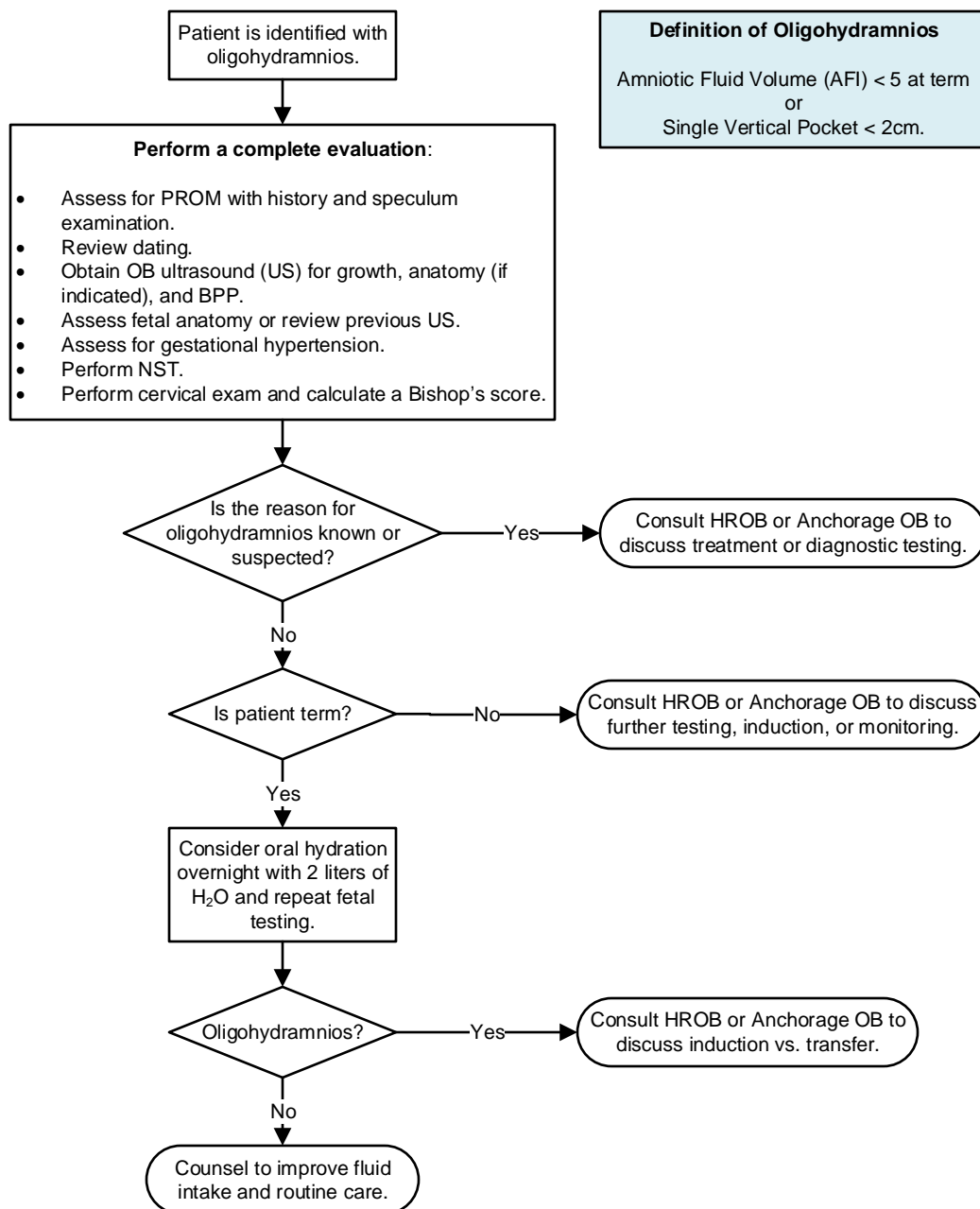
- Aneuploidy
- Fetal Anomaly
- Preterm premature rupture of membranes (PPROM)
- Placental abruption
- Fetal growth restriction
- Amniocentesis
- Elevated maternal serum alpha fetoprotein

Third

- Preterm premature rupture of membranes
- Placental abruption
- Fetal growth restriction
- Utero-placental insufficiency
- Preeclampsia
- Maternal vascular diseases
- Fetal anomaly
- Post-term
- Suboptimal maternal hydration

Definition of Oligohydramnios

Amniotic Fluid Volume (AFI) < 5 at term
or
Single Vertical Pocket < 2cm.

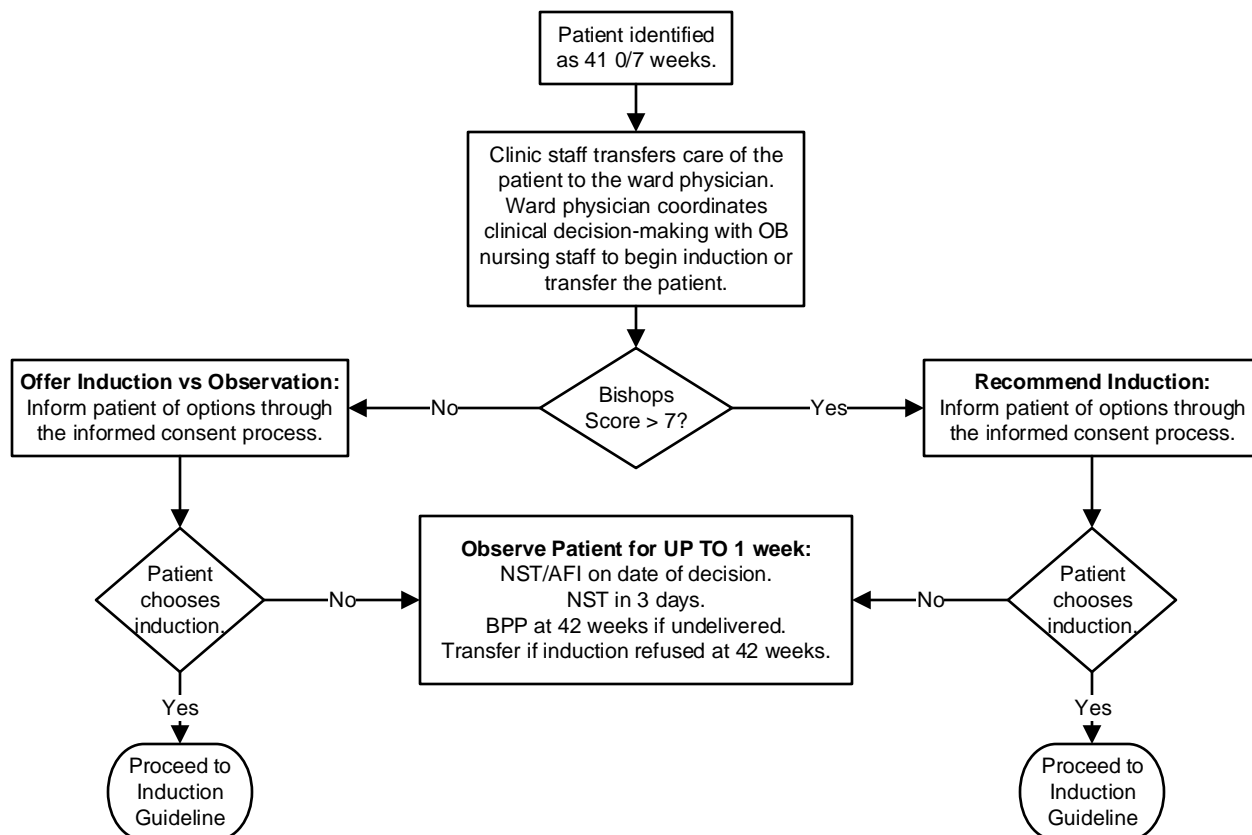


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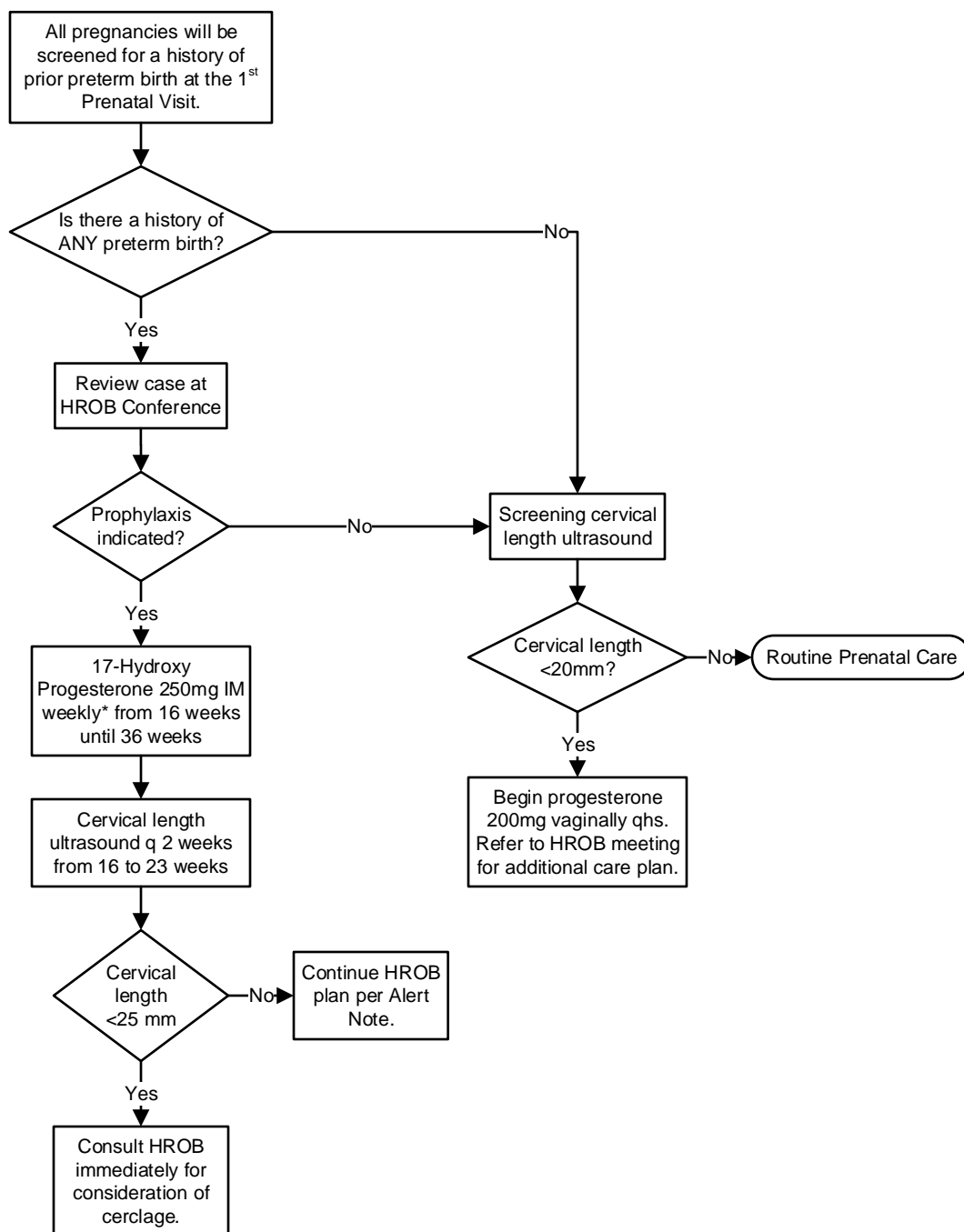
Bishops Score					
Score	Dilatation	Effacement	Station	Position	Consistency
0	closed	0 – 30%	-3	posterior	firm
1	1-2 cm	40 -50%	-2	mid-position	medium
2	3-4 cm	60 -70%	-1,0	anterior	soft
3	5+ cm	80+%	+1,+2		

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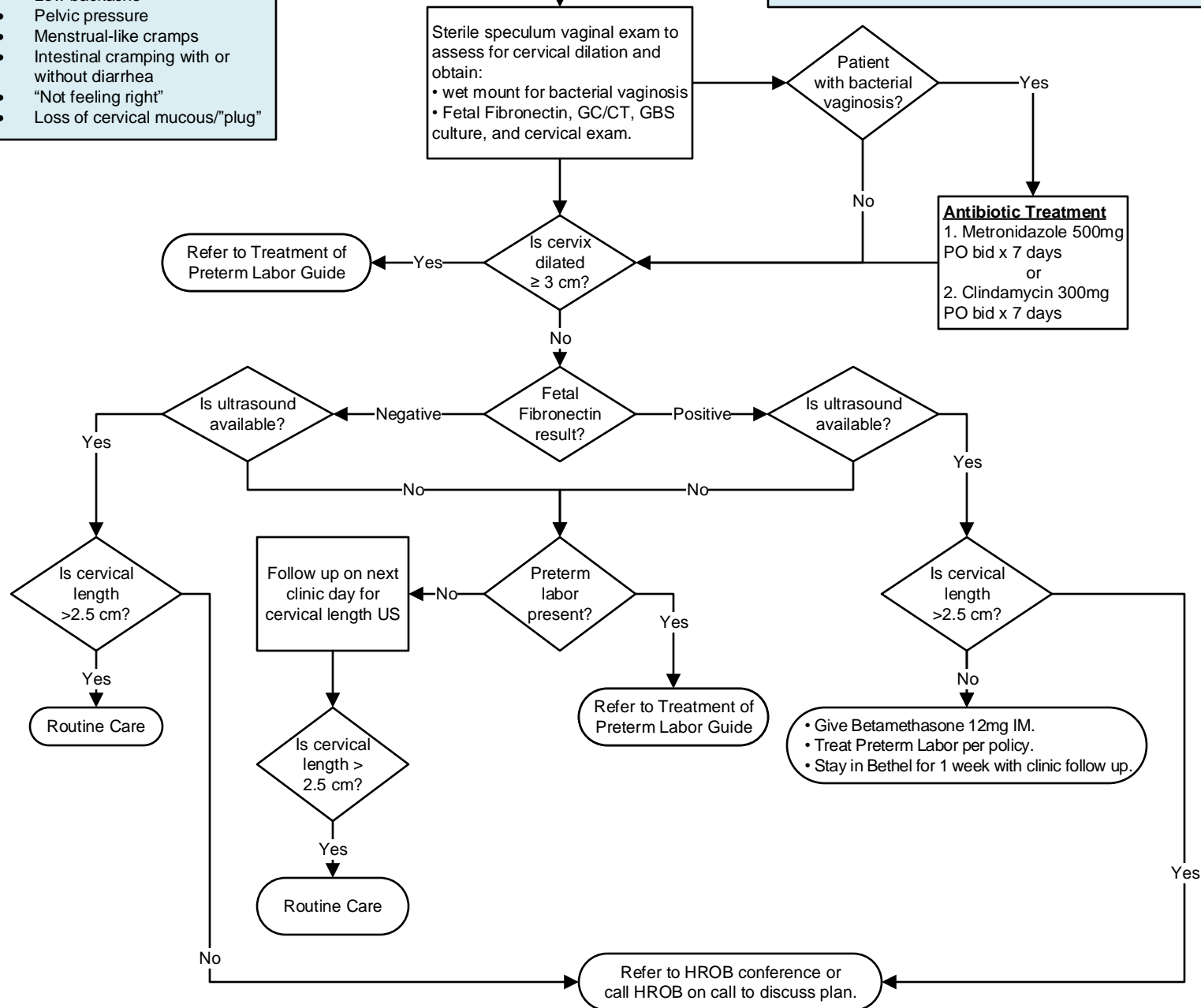
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Definition of Preterm Labor- regular uterine contractions after 20 weeks gestation and before 37 weeks gestation which lead to a progressive cervical change.



There is no need to treat contractions with tocolytics in the absence of cervical change.

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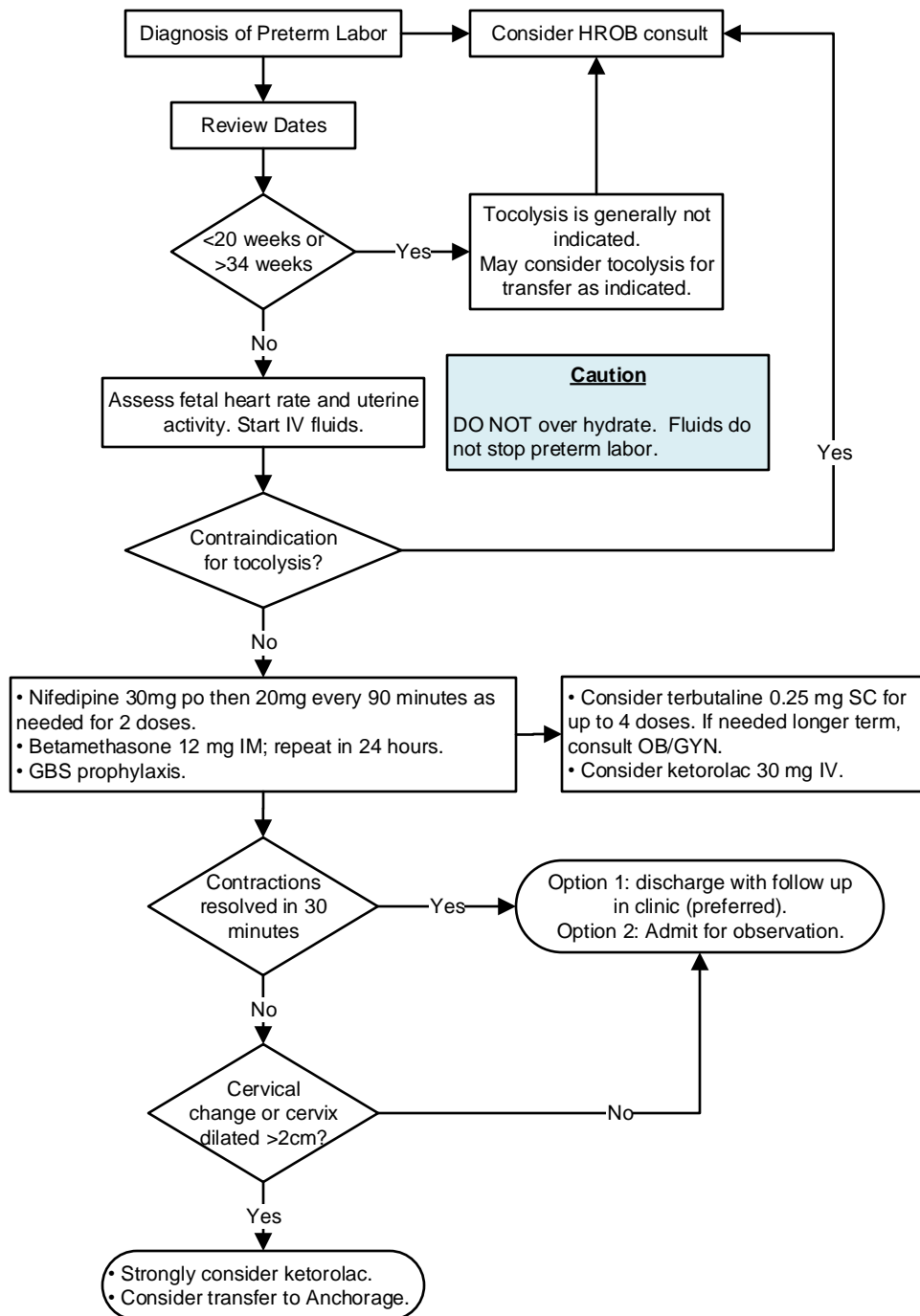
Definition of Preterm Labor-regular uterine contractions after 20 weeks gestation and before 37 weeks gestation which lead to a progressive cervical change

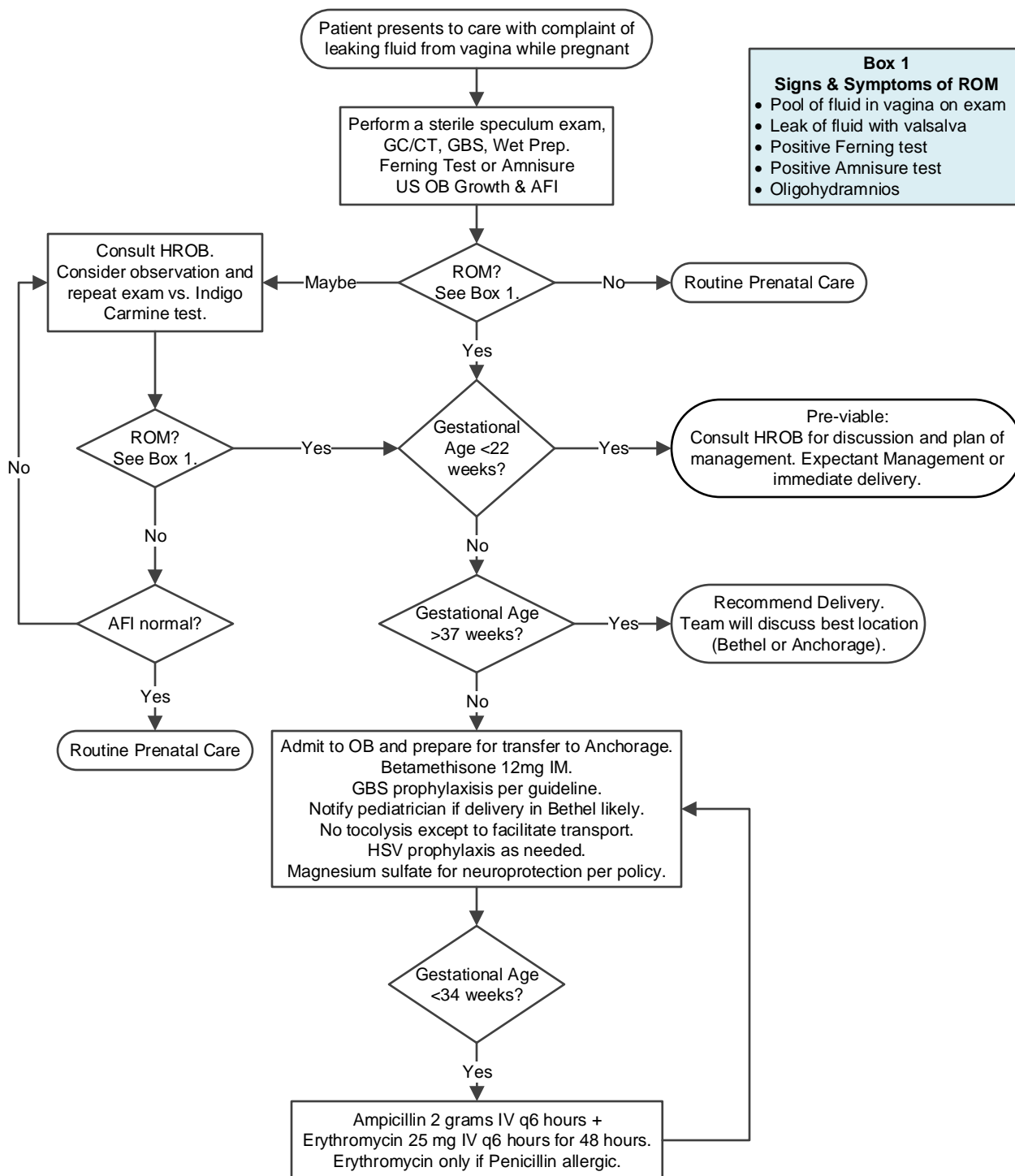
Contraindications to tocolysis:

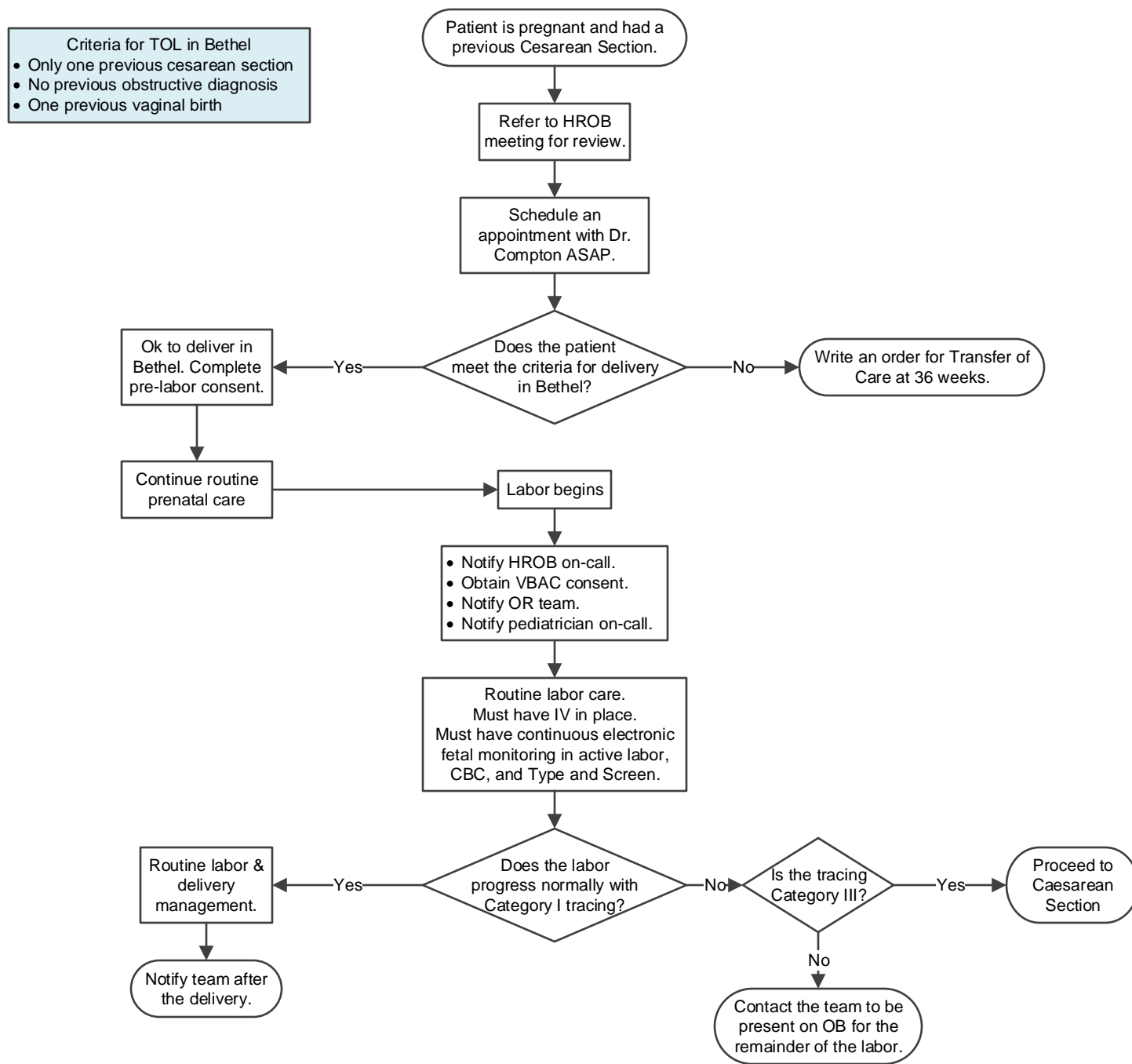
- IUFD
- Lethal fetal anomaly
- Non-reassuring fetal assessment
- Severe IUGR
- Chorioamnionitis, relative
- Maternal hemorrhage with hemodynamic instability
- Severe preeclampsia or eclampsia
- PPROM

Contraindications to terbutaline

- Diabetes
- HTN
- Suspected placental abruption (relative)









Preventative Health Care	
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Osteoporosis Screening and Treatment.....	123



Background

- Only 4-9% of those...labeled [penicillin-allergic] are currently allergic. It is important to identify those who are not allergic, because children mislabeled as penicillin-allergic have more medical visits, receive more antibiotic prescriptions, and have longer hospitalizations with more antibiotic-related complications.¹
- Up to 10% of children develop rashes while receiving antibiotics. Most are diagnosed...as allergic to the implicated antibiotic, and most continue to avoid the suspect antibiotic in favor of alternatives, which may be less effective, more toxic, and more expensive.²
- Do not label a patient as allergic to penicillin/amoxicillin unless he or she has true hives, anaphylaxis, or a life-threatening reaction. Please include photos of rashes in RAVEN.
- Please consult a pediatrician with any questions.

Anaphylaxis

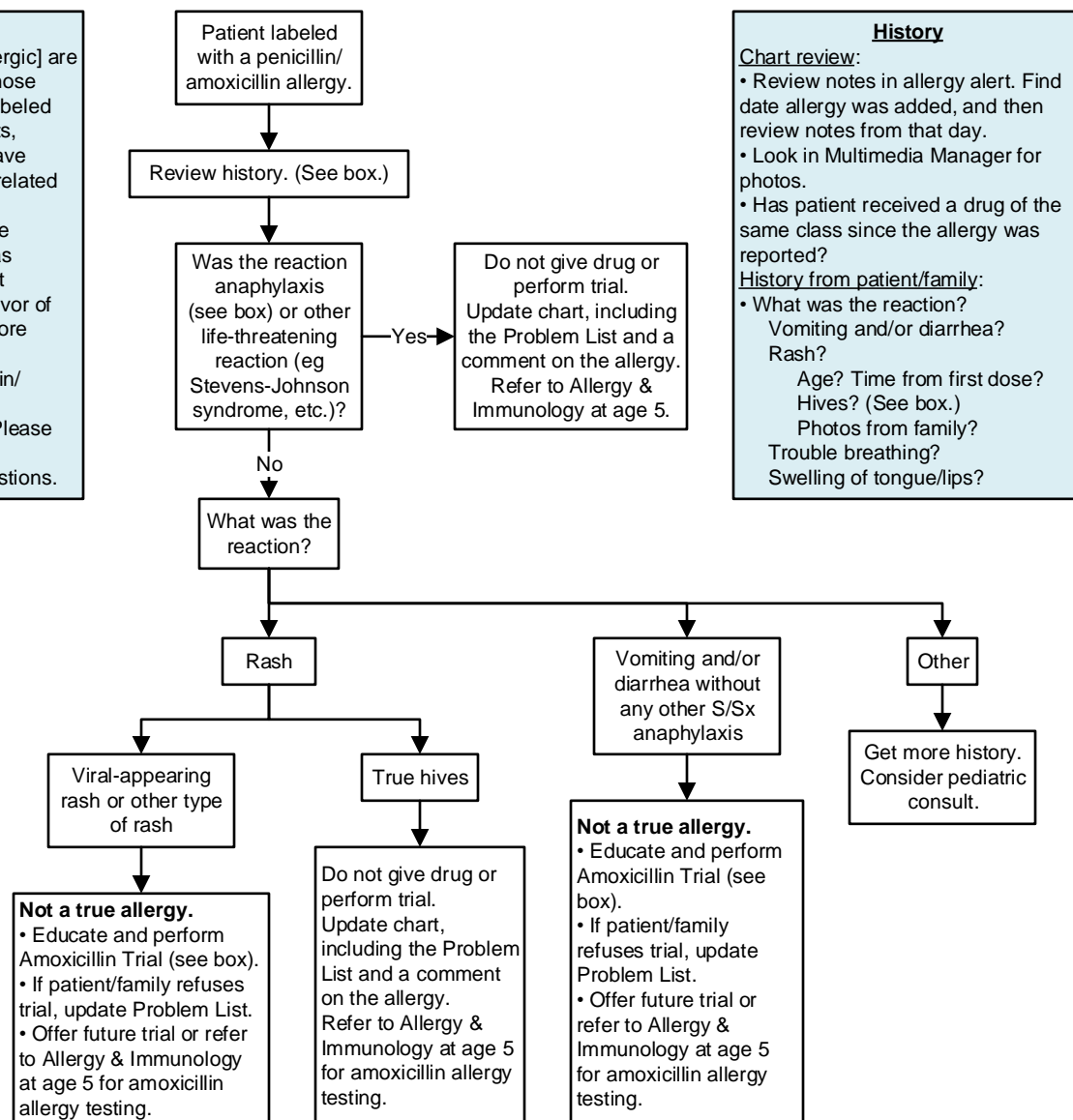
- Acute onset – several minutes to hours from exposure.
- Generalized hives, pruritis or flushing, swelling of lips/tongue/uvula, and at least one of the following:
 - Dyspnea, bronchospasm, stridor
 - Hypotension
 - Evidence of hypoperfusion of end-organs
 - Persistent crampy abdominal pain and/or vomiting

Hives vs Viral Rash

- True hives are raised, itchy, larger than dime-sized, come and go, move around the body, and change shape and size.
- Keep in mind that many parents refer to any rash as "hives." Get a description every time.
- A viral exanthem is typically diffuse, fine, pinpoint red dots and can be dense, coalesced, larger raised lesions. The rash typically covers the face and chest but can cover the whole body. The rash typically worsens and takes days to clear.

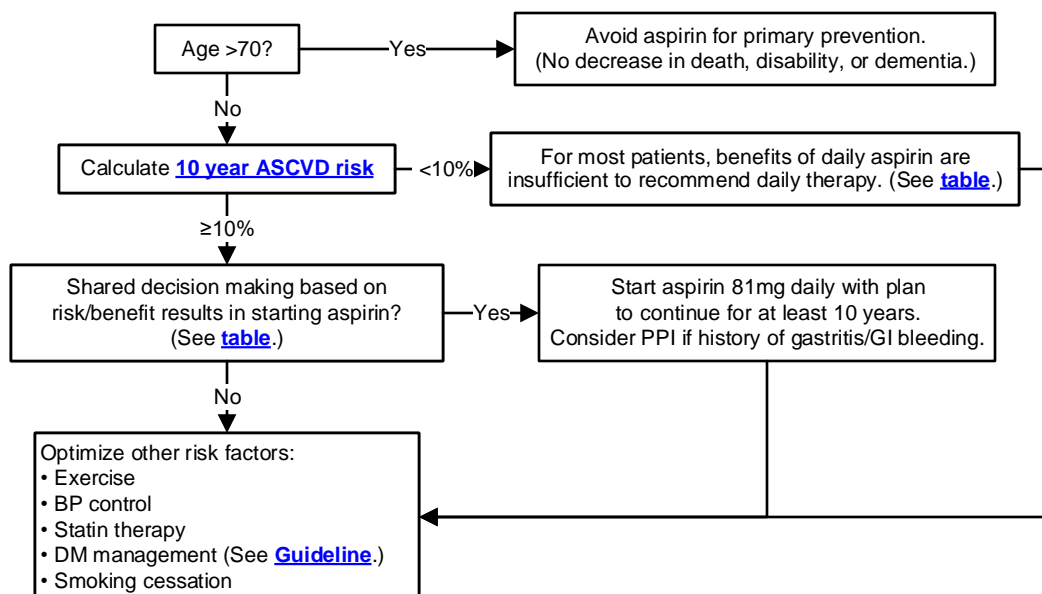
References

1. Kelso JM. "Provocation challenges to evaluate amoxicillin allergy in children." JAMA Pediatrics 2016;170(6):e160282.
2. Mill C, et al. "Assessing the diagnostic properties of a graded oral provocation challenge for the diagnosis of immediate and nonimmediate reactions to amoxicillin in children." JAMA Pediatrics. 2016;170(6):e160033.



Amoxicillin Trial Procedure²

1. Obtain VS. Perform physical exam, including lung exam. Have appropriate dose of EpiPen or epinephrine available.
Epinephrine (1 mg/mL): 0.01 mg/kg (or 0.01 mL/kg) IM q5-15 minutes.
Per AAP recommendations:
 - 7.5-25 kg: use EpiPen Jr (0.15 mg)
 - ≥ 25 kg: use EpiPen (0.3 mg)
2. Calculate weight-based dose of amoxicillin. Give patient 10% of that dose.
3. Place patient in nearby room and instruct caregiver to notify staff of any changes in status.
4. If no reaction by 20 minutes, give patient remaining 90% of weight-based dose of amoxicillin.
5. Observe another 60 minutes. If no reaction, check VS and physical exam. If all stable, discharge home with regular course of drug.
6. Give patient and family amoxicillin trial education sheet.
7. Update allergy alert in RAVEN. Click the allergy in the banner. Right click over the drug name and choose "cancel." On the "reason" drop-down menu, choose "OK on Retrial."



Notes

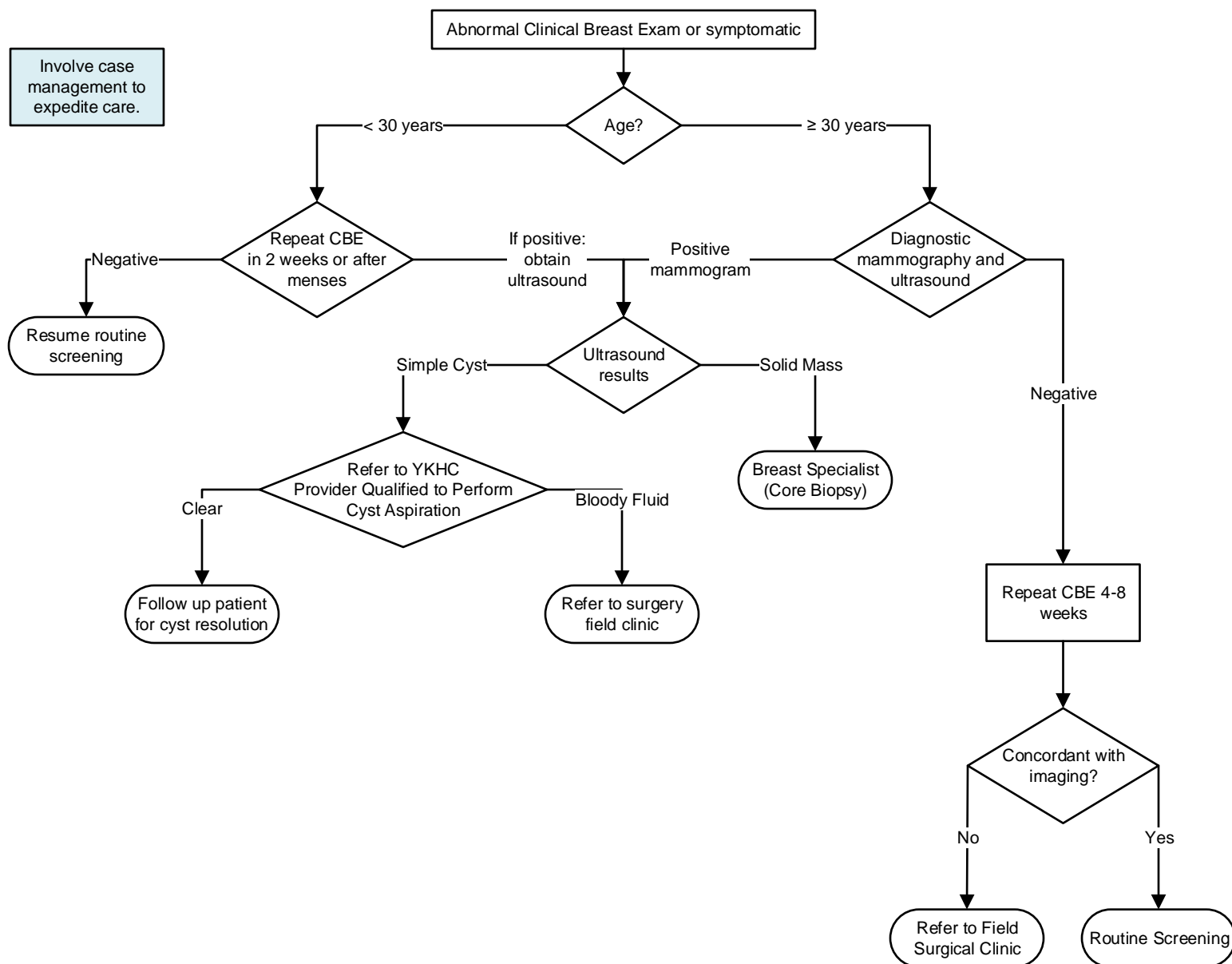
Aspirin produces significant reductions in mortality amongst survivors of cardiovascular disease, but its role in the primary prevention of cardiovascular disease amongst healthy adults is less clear.

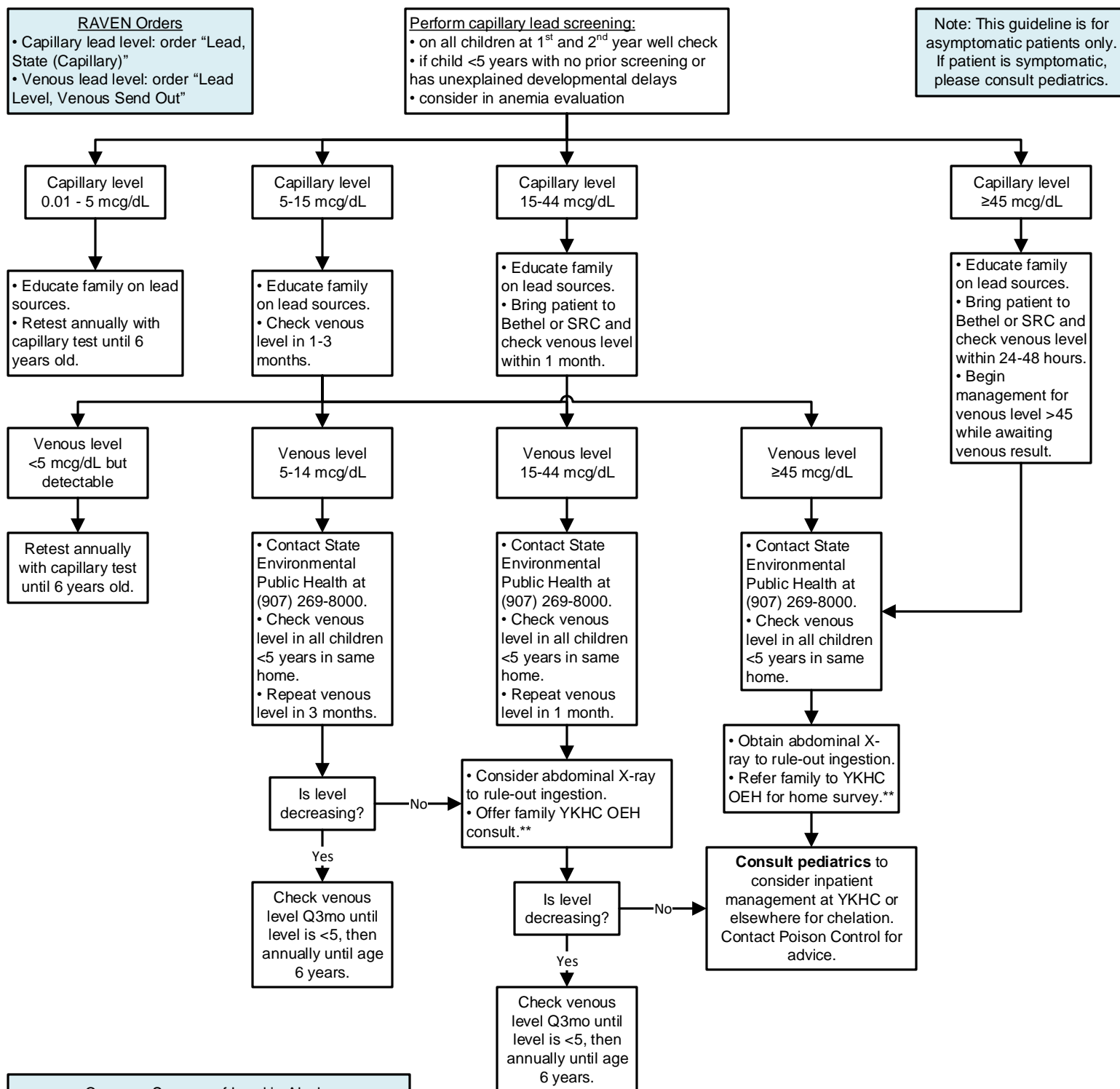
See [table under "Possible Benefits"](#) for summary of RCT data for low dose aspirin in the primary prevention of cardiovascular disease.

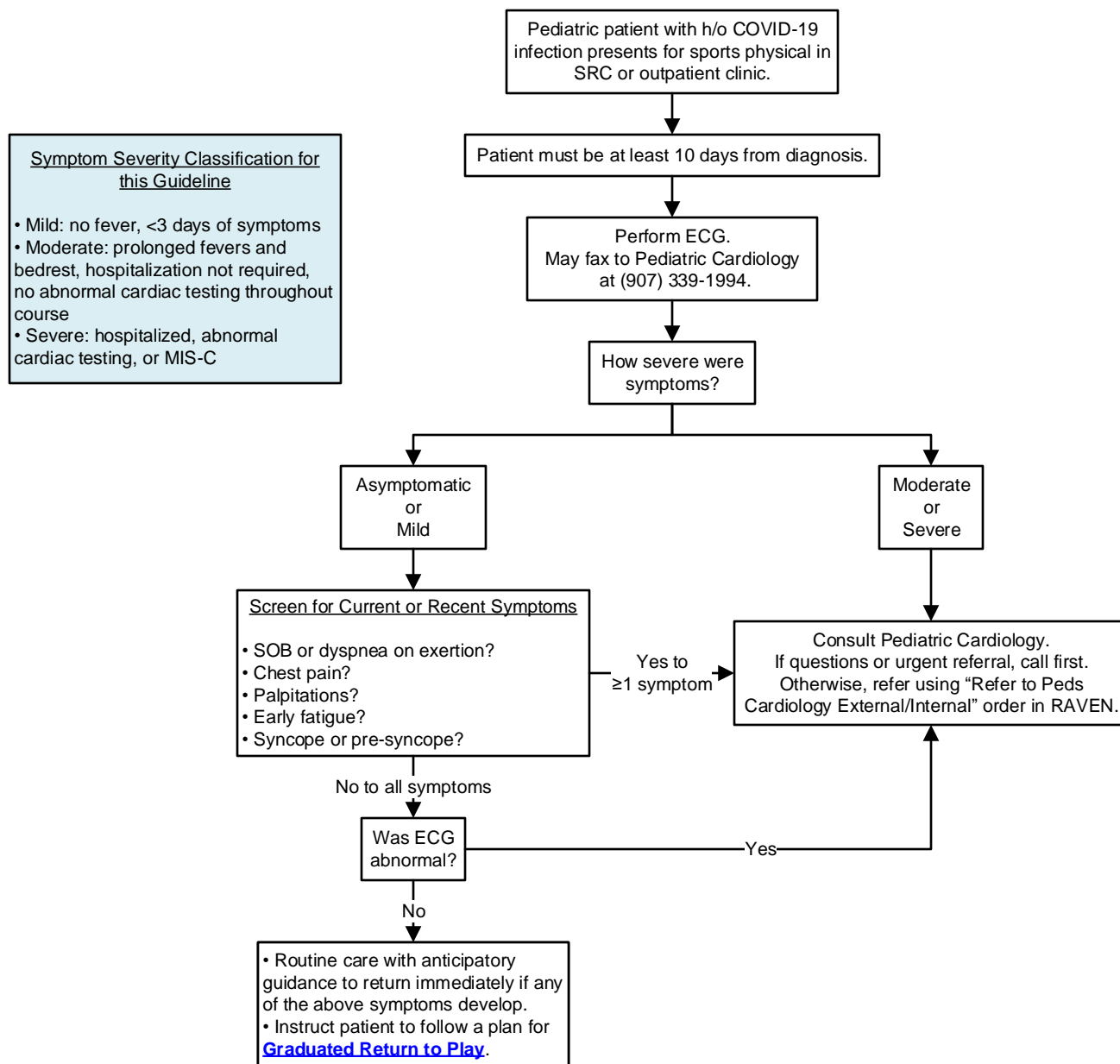


Clinical Breast Exam Screening Recommendations:

1. Breast self-examination: at provider's discretion
2. Clinical breast examination: at provider's discretion
3. Mammography:
 - start age 45
 - screen every 2 years
 - end screening at age 70, based on health status







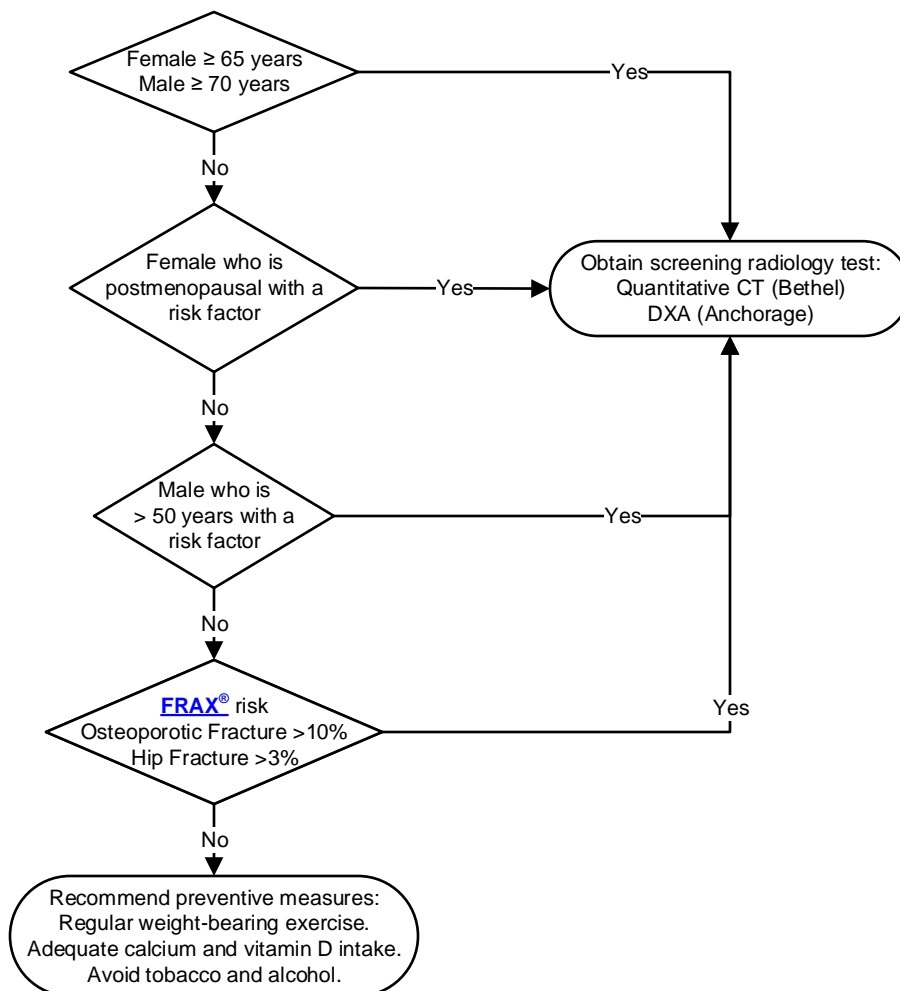


Risk Factors

- Osteopenia on X-ray.
- History of fracture without trauma.
- Tobacco use.
- Excessive alcohol use.
- Height loss more than ½ inch in one year.
- Height loss more than 1.5 inches total.
- At risk medication use (see box below).
- BMI < 20.
- Premature menopause.

At Risk Medications

- Systemic steroids >3 months
- Methotrexate
- Aromatase inhibitor
- Selective estrogen receptor modulator
- Proton pump inhibitor
- Heparin
- SSRI



Recommended Calcium Intake

Age	Sex	RDA mg/day
9-18	M+F	1300
19-50	M+F	1000
51-70	M	1000
51-70	F	1200
>71	M+F	1200

Recommended Vitamin D Intake

Age	Sex	RDA IU/day
14-70	M+F	600
>71	M+F	600



Abbreviations

BMD – Bone mineral density
BTM – Bone turnover markers
FRAX® – Risk scoring algorithm

FRAX® High Risk for Fracture

10 year risk of major osteoporotic fracture $\geq 20\%$ or hip fracture risk $\geq 3\%$.

If patient has one or more of the following:

- Lumbar spine or femoral neck or total hip T score ≤ -2.5
- CT bone density $< 80 \text{ mg/cm}^3$
- History of a fragility fracture
- High **FRAX®** fracture probability

Evaluate for secondary causes of osteoporosis.

Correct calcium/vitamin D deficiency and address secondary causes of osteoporosis.

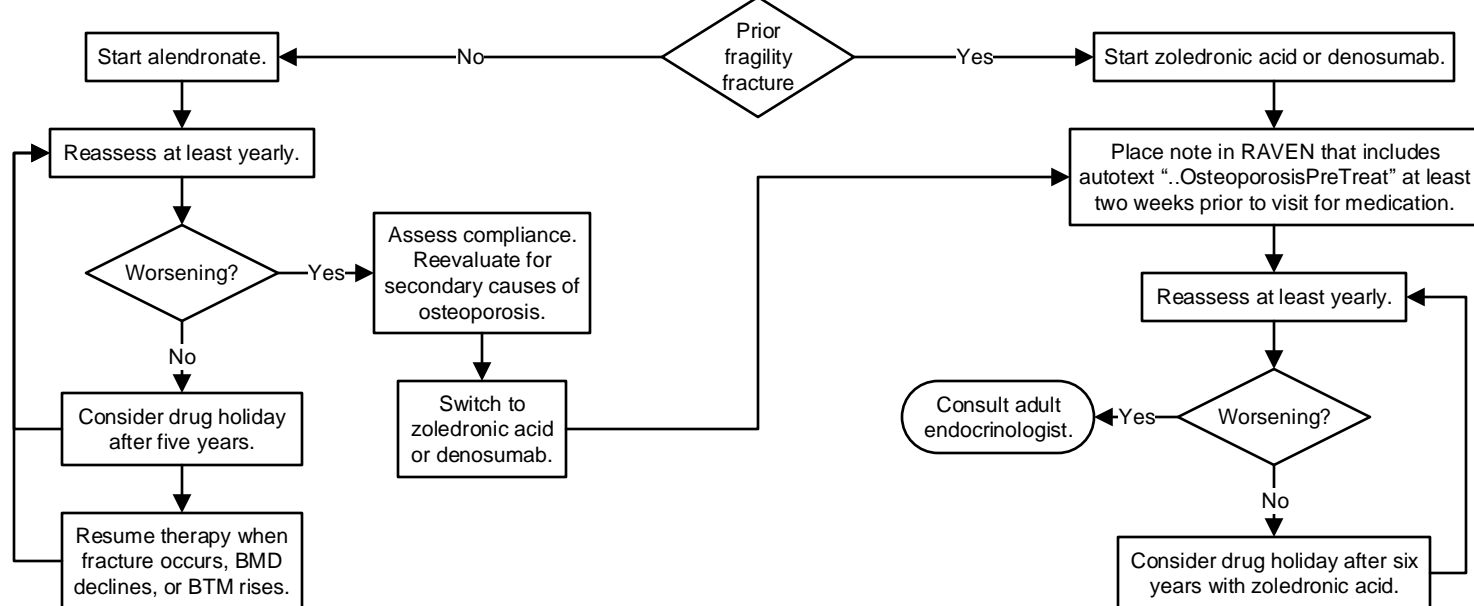
Educate patient on lifestyle measures, fall prevention, and benefits and risks of medications.

Obtain dental evaluation of and treatment for risk of osteonecrosis of jaw.

Consider endocrinology consultation.

Some Secondary Causes of Osteoporosis

- Drugs
- GI-related illness
- Bone marrow disease
- Endocrine disorder
- Organ transplant





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Table 1: Alcohol Hangover (F10.120)

- Poorly defined but universally understood; occurs the morning after a night of heavy drinking.
- In general, starts <12 hours after a binge of <24 hours.
- Sx: fatigue, thirst, headache, nausea, concentration problems, apathy, loss of appetite, dizziness, vomiting, heart pounding/racing.
- Requirements: HR<130, BP<160/100, RR<24, T<100.4, ambulatory, GCS=15, appropriate history, no tremor, no anxiety, no significant comorbidities.

Table 2: Inpatient Criteria

- CIWA>12, despite treatment with PB/BZD.
- Requiring high-dose sedatives or IV infusion to maintain CIWA<12.
- GCS<8 or hemodynamic instability.
- Persistent hyperthermia (T>100.4 F).
- Respiratory insufficiency (hypoxia, hypercapnia, etc.).
- Marked acid-base disturbance.
- Cardiac disease (heart failure, arrhythmia, evidence of ischemia, etc.).
- Severe electrolyte abnormality.
- Severe renal insufficiency or requiring high volume fluids.
- Evidence of rhabdomyolysis.
- Potentially serious infection (PNA, wounds, etc.).
- Severe GI pathology (GI bleed, pancreatitis, etc.).
- Severe psychomotor agitation (high risk to self or others, gravely disabled, etc.).
- Evidence concerning for Wernicke-Korsakoff Syndrome (oculomotor dysfunction, ataxia, severe malnutrition).
- Withdrawal despite very elevated serum ethanol.

Table 3: Phenobarbital Contraindications

Absolute: Hx allergy, adverse reactions, or porphyria
Relative: current significant sedative level (including EtOH, BZD, or anti-psychotics)

Table 4: Phenobarbital (PB) Protocol

- Phenobarbital 260 mg IV then phenobarbital 130 mg IV every 30-40 minutes until CIWA score \leq 12. No discharge meds.
OR (for very large/small patients)
- Phenobarbital 4 mg/kg IV (rounded to nearest 130 mg) then phenobarbital 2 mg/kg IV every 30 minutes until CIWA score \leq 12. No discharge meds.
OR
- Either of the above via IM injection, with subsequent doses very 60-90 minutes.

Adverse Effects:

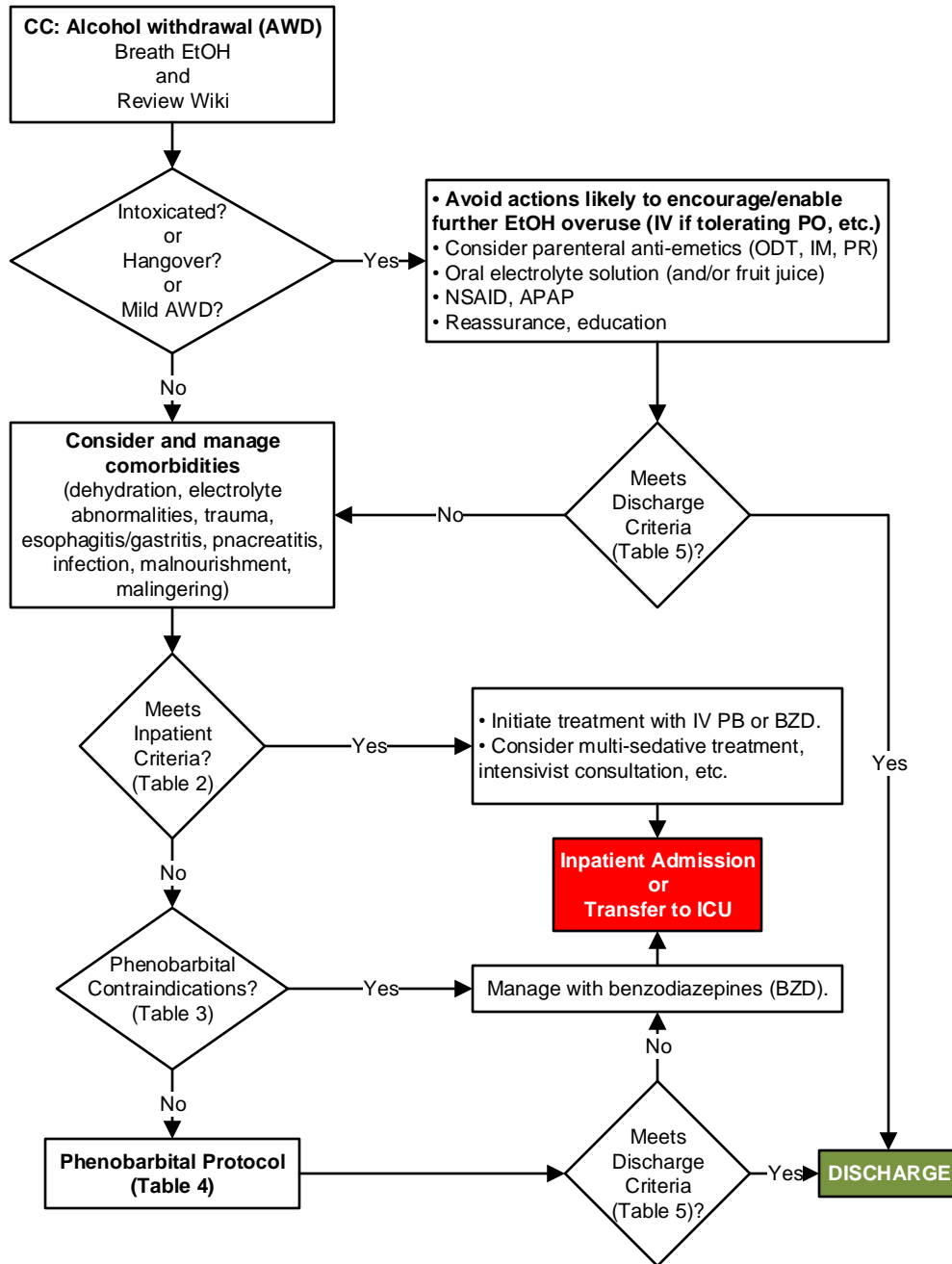
- Transient asymptomatic hypotension
- Transient ataxia
- Transient lethargy

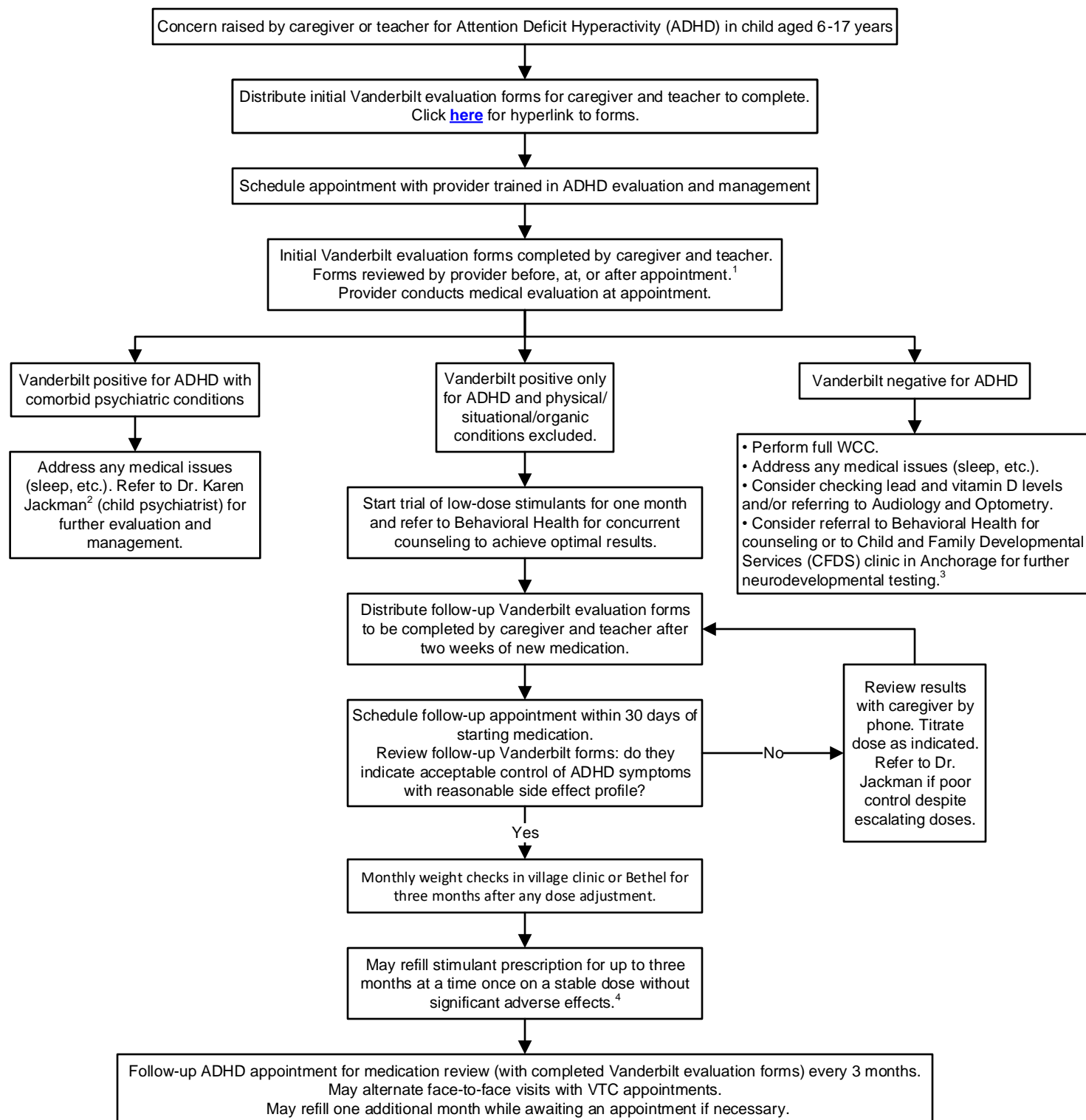
Table 5: Discharge Criteria

- No inpatient criteria present (Table 2).
- CIWA score <12.
- Awakens to voice or light touch.
- Oriented with no delirium.
- Ambulatory without assistance.
- Taking liquids without vomiting.
- No co-administered sedatives/anti-psychotics.
- No seizures after treatment.
- Likely compliant with important outpatient medications (including antibiotics, etc.).

Please see the Wiki for more information:

[Alcohol Withdrawal in the YK Delta Phenobarbital for Alcohol Withdrawal](#)





1. Scan completed Vanderbilt forms into MultiMedia Manager under "Continuity of Care."

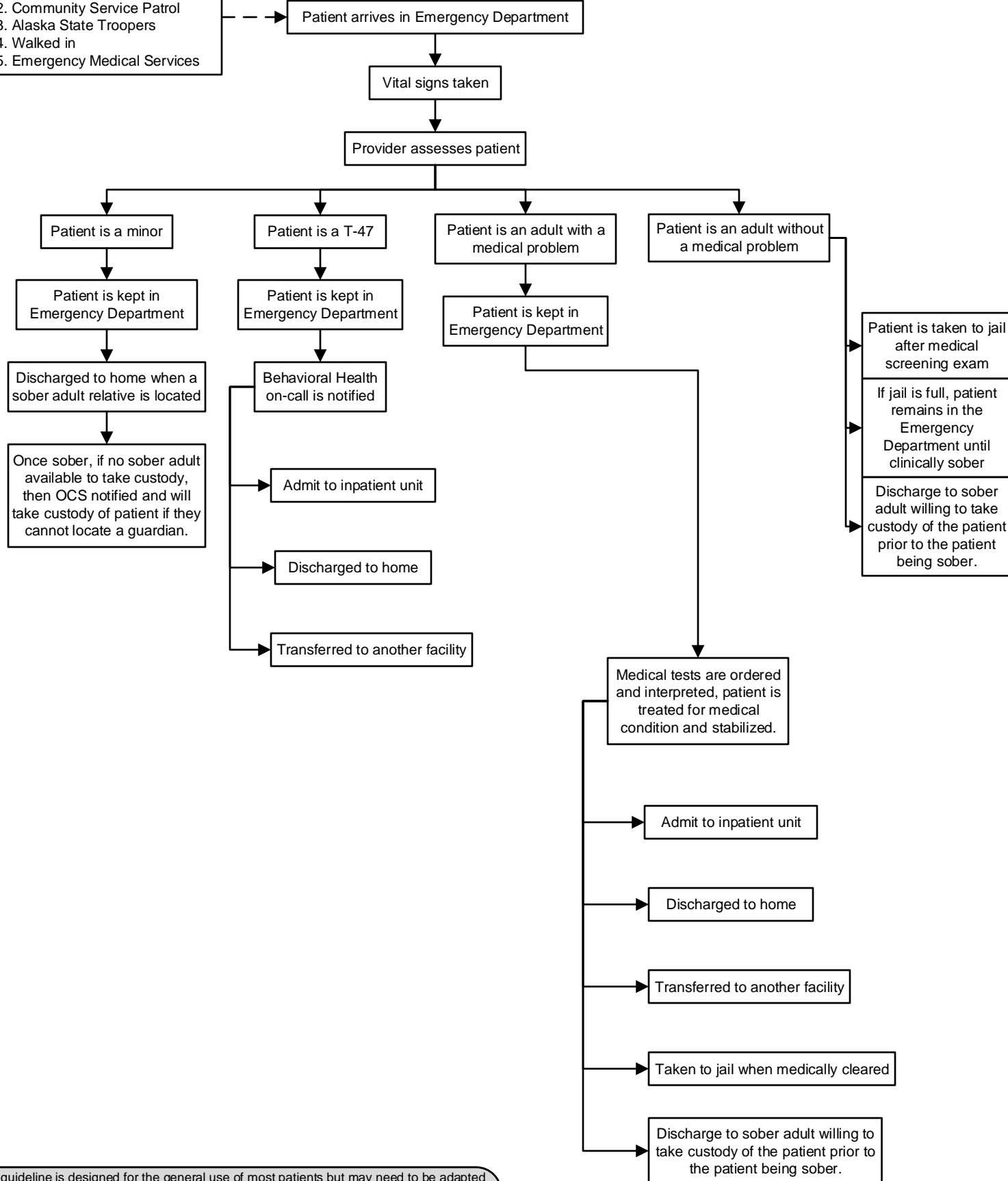
2. To refer to Dr. Jackman: use "Refer to Peds Psychiatry Internal" order. Dr. Jackman may be contacted at (907) 230-3765 or jackman@alaska.net.

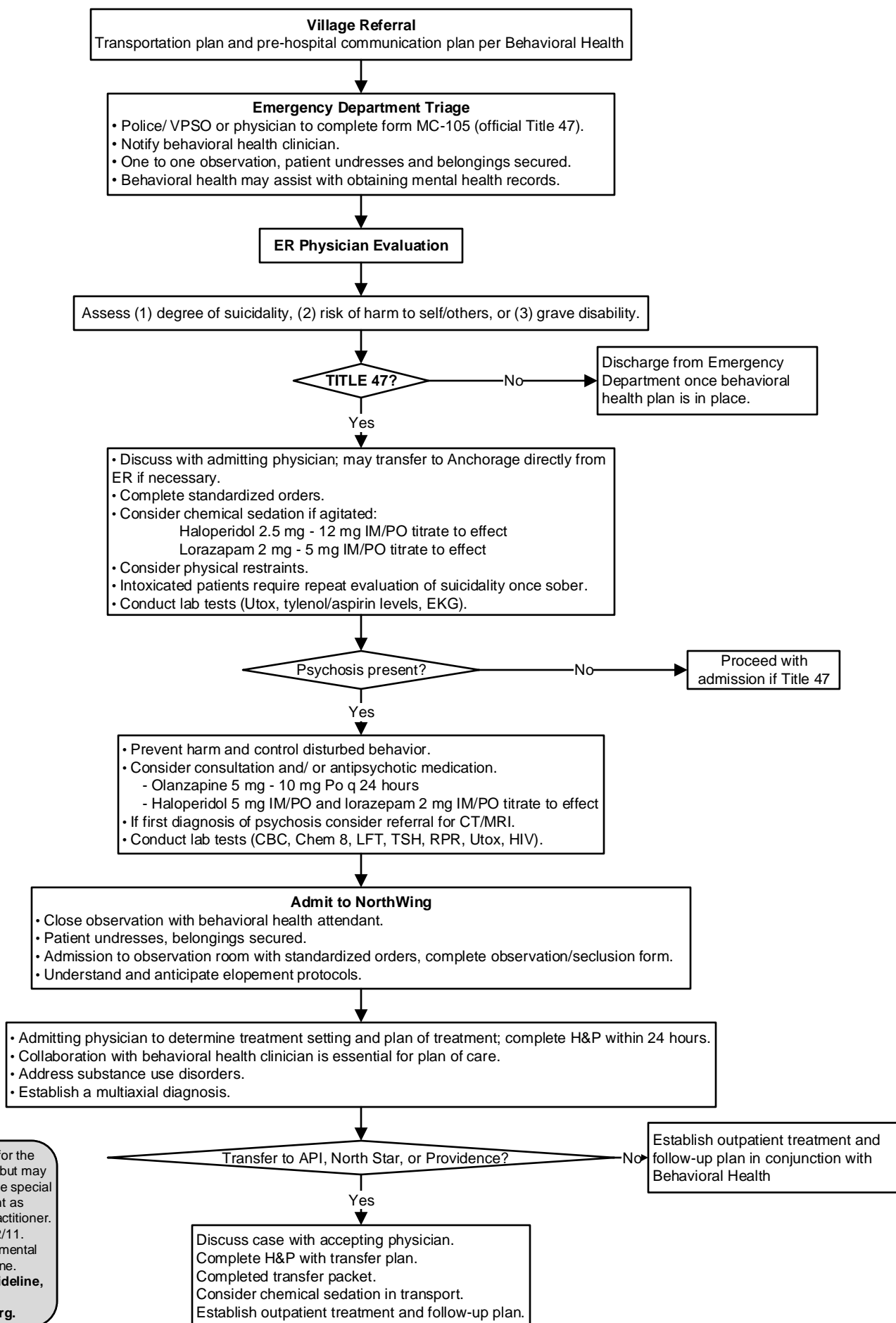
3. To refer to [CFDS](#) or other private psychologist: use "Refer to Other External" order and send a message to the case manager to process the referral.

4. E-prescribe three separate 30 day prescriptions after checking Alaska PDMP. Include the month the medicine is to be filled in the comments or special instructions section.

**Mode of Arrival:**

1. Bethel Police Department
2. Community Service Patrol
3. Alaska State Troopers
4. Walked in
5. Emergency Medical Services





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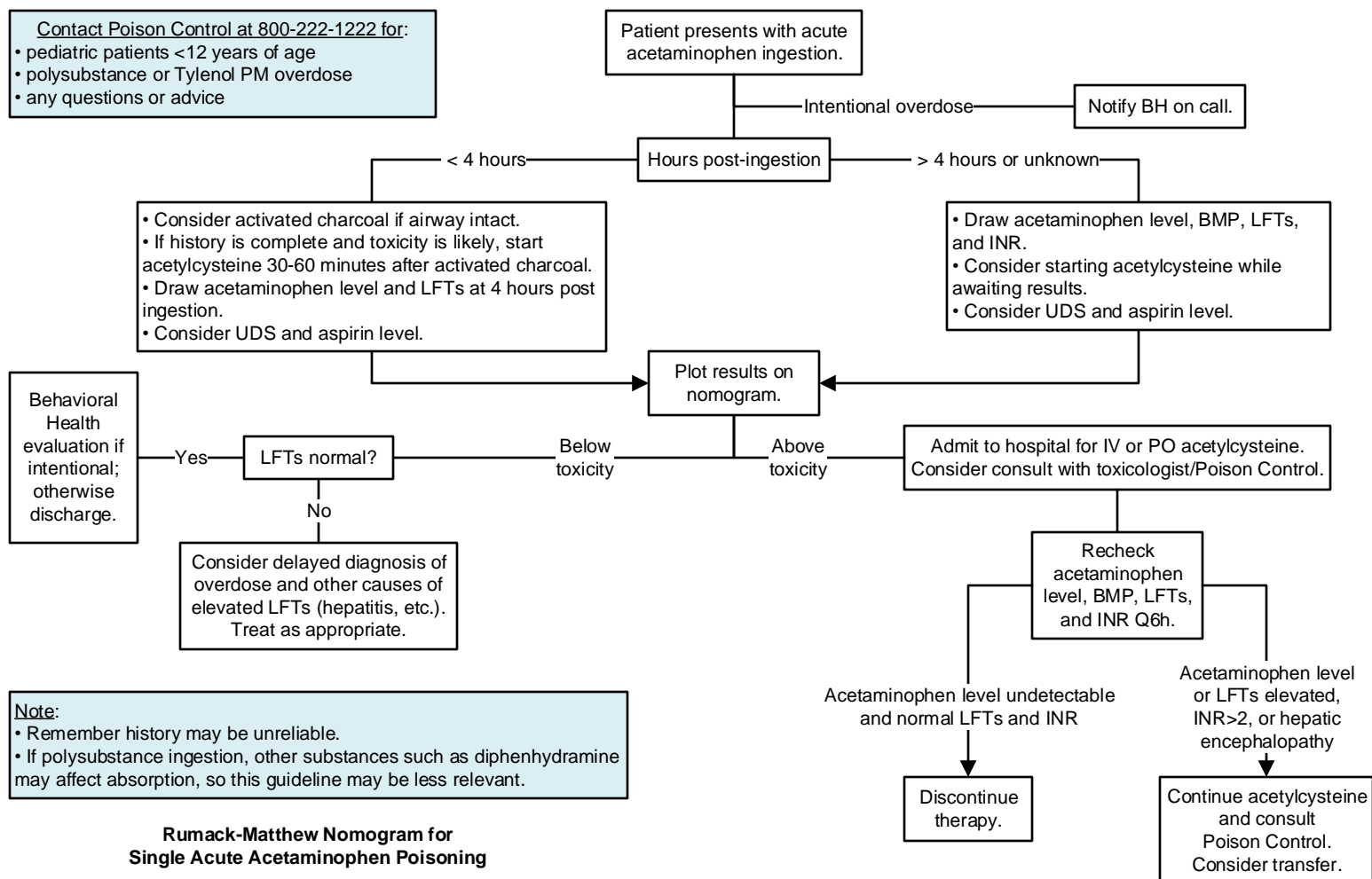
Approved by MSEC 6/22/11.

Click [here](#) to see the supplemental resources for this guideline.

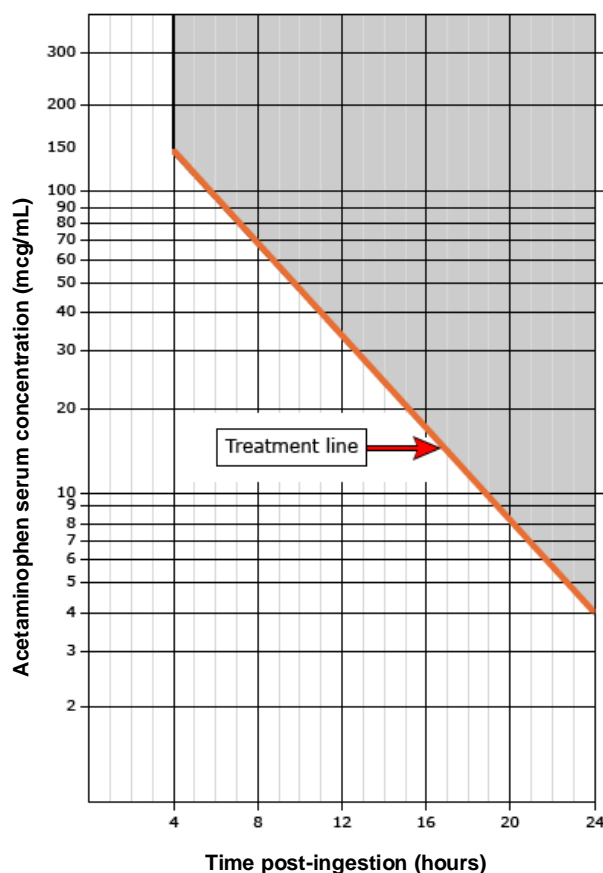
If comments about this guideline, please contact
Tara_Lathrop@ykhc.org.



Trauma/Injury/Ingestion	
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**Rumack-Matthew Nomogram for
Single Acute Acetaminophen Poisoning**



Village Management

- If patient in village and toxicity is at all possible, start treatment with oral acetylcysteine and draw blood at 4 hours post ingestion. Instruct health aide to draw 2 mL (minimum 200 microliters) in a gold/SST or green top tube.
- Consider activated charcoal.
- Transport patient and blood work to Bethel on next available commercial flight, if stable.

Acetylcysteine Administration Protocols

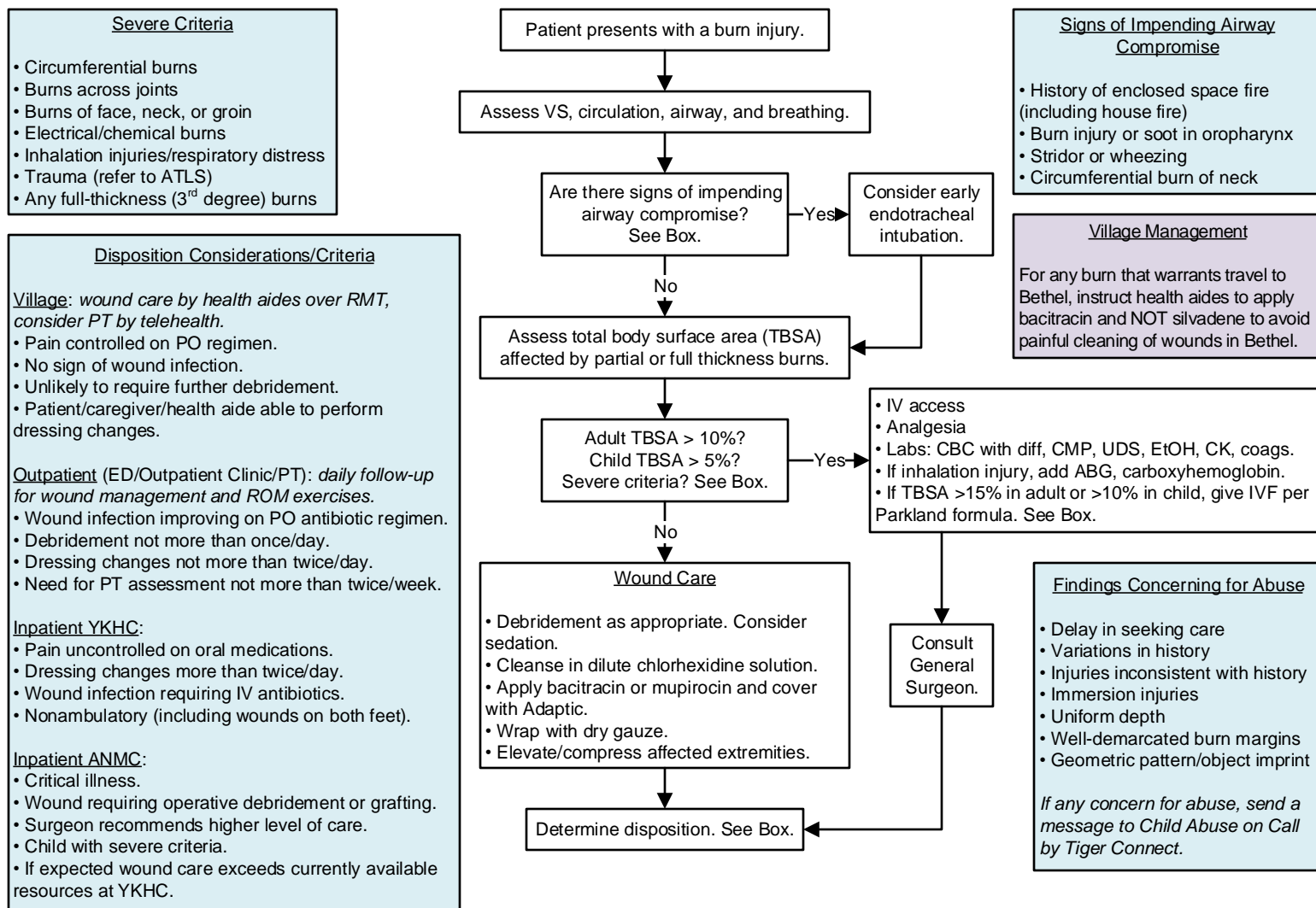
- IV 21 Hour Protocol:** Dose is 150 mg/kg (max 15 grams) over 60 minutes immediately followed by 50 mg/kg (max 5 grams) over 4 hours immediately followed by 100 mg/kg (max 10 grams) over 16 hours. Dilute with D5W or ½ NS. See <http://acetadote.com/dosecalc.php> for details on dose and dilution, especially in children under 40 kg.
- PO 72 Hour Protocol:** Dilute with strongly-flavored juice or soda. Mix one part medication with three parts juice/soda. Loading dose is 140 mg/kg. Maintenance dose of 70 mg/kg Q4h for up to 72 hours. The villages carry vials of inhalation/oral solution that is 200 mg/mL in 30 mL vials. See [this resource](#) for details on dosing, including diluent and dosing volumes for weight.

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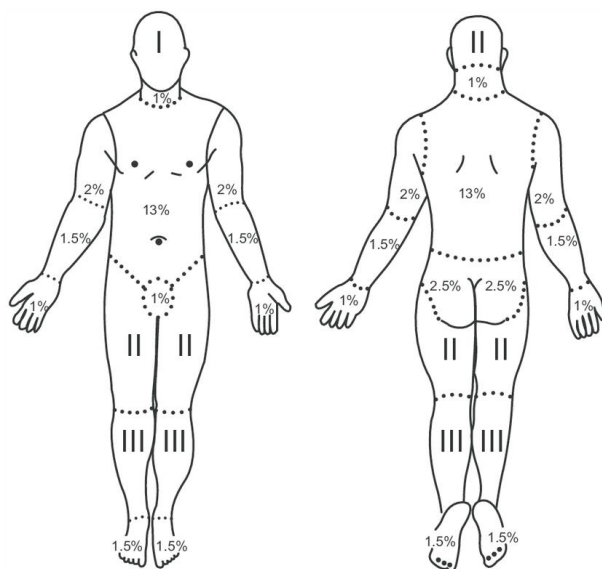
Approved by MSEC 2/5/20. Minor changes 4/8/21.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.



Lund and Browder Chart to Estimate TBSA in Adults and Children



Age	0	I	5	10	15	Adult
Front or back half	(%)	(%)	(%)	(%)	(%)	(%)
I (Head)	9½	8½	6½	5½	4½	3½
II (Thigh)	2¼	3¼	4	4¼	4½	4¼
III (Leg)	2½	2½	2¼	3	3¼	3½

Modified Brooke/Parkland Formula

Only used if TBSA >15% in adults or >10% in children.

(weight in kg) x 2-4 mL x %TBSA = total fluid to be given over 24 hours
Do not convert %TBSA to a decimal. For example, 15% TBSA would be 15.

Give half in first eight hours from time of burn. Give other half over the next sixteen hours.

LR to be used unless mitigating circumstances.

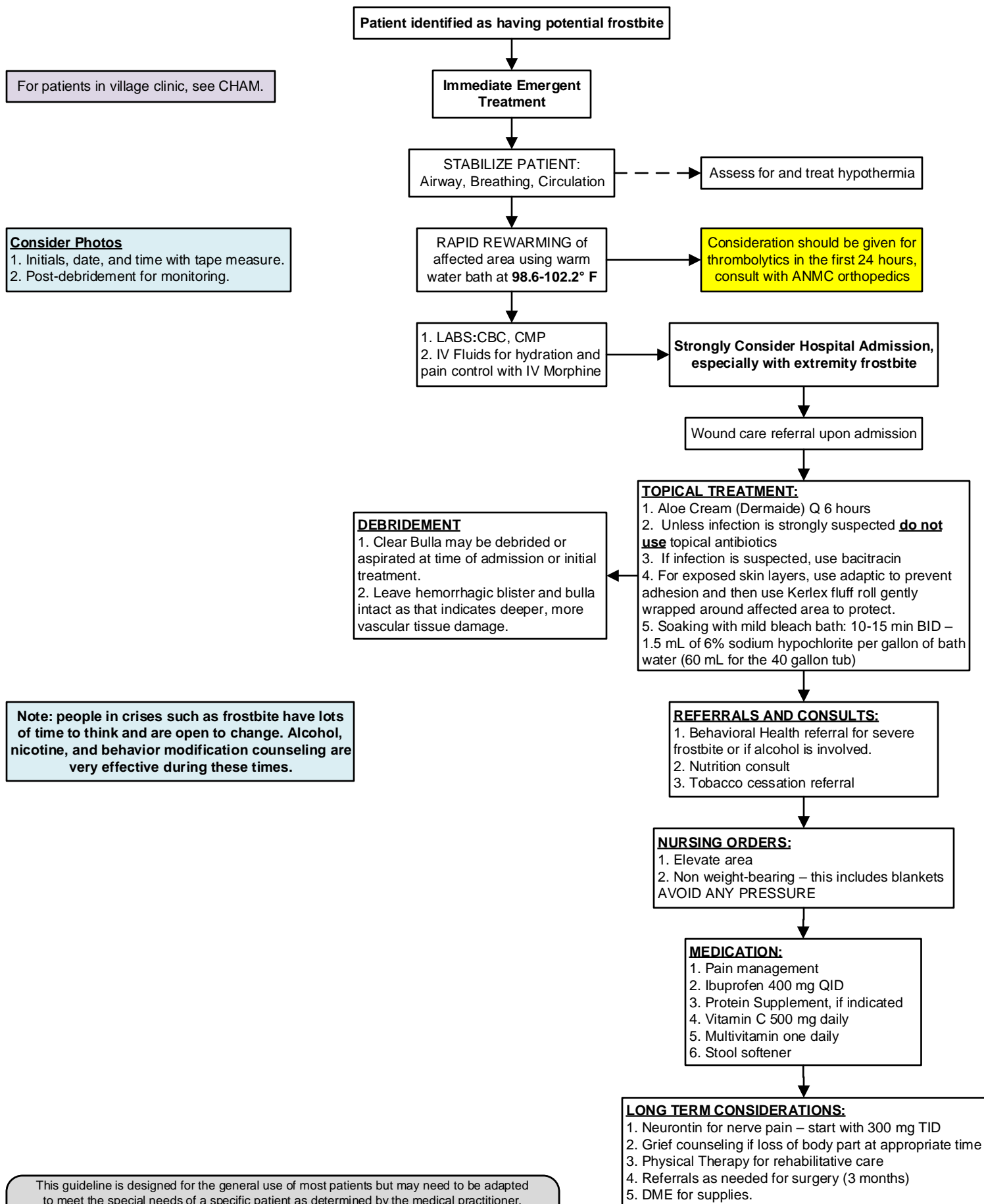
Classification of Burns by Depth

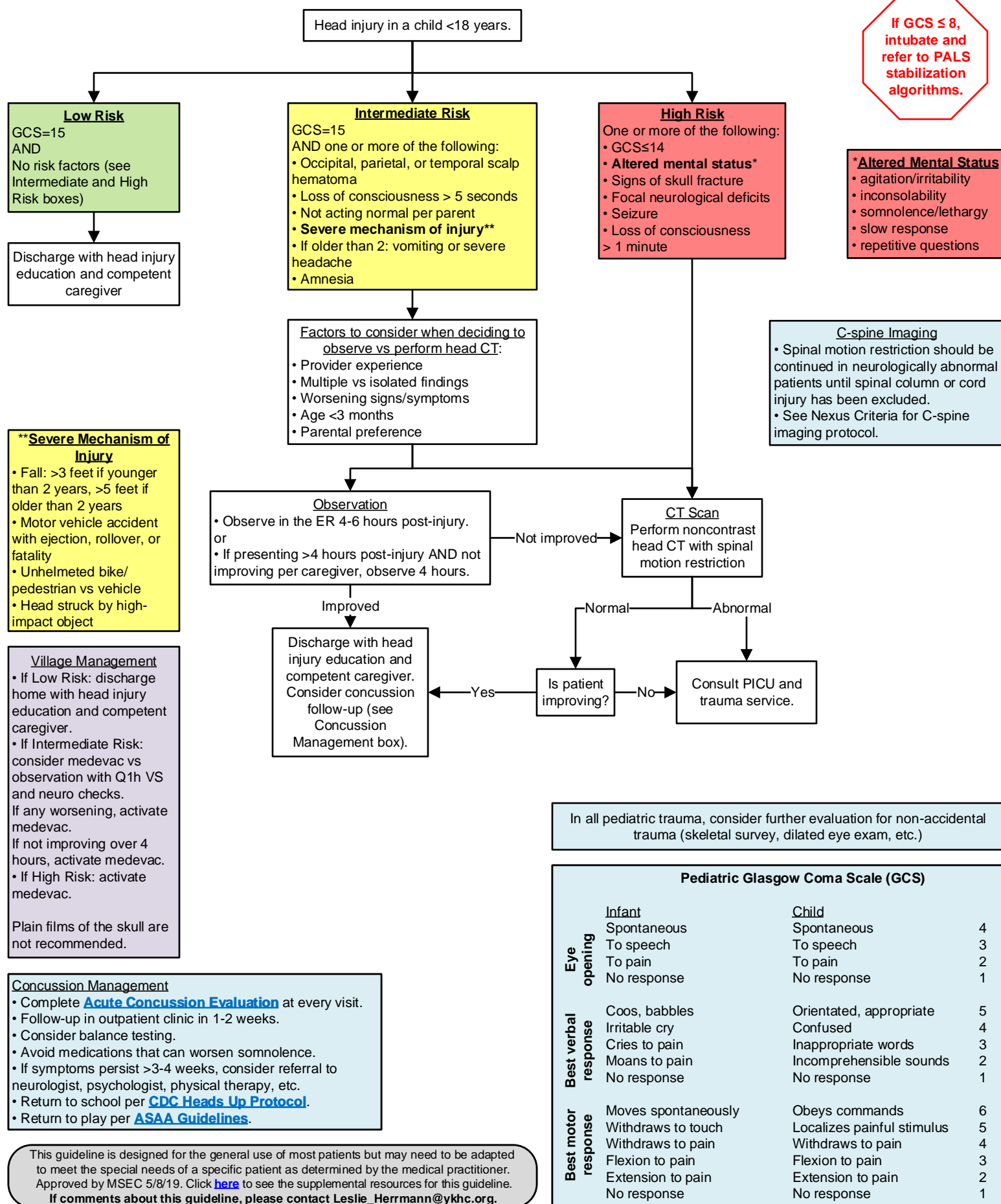
Burns evolve over time; initial TBSA and depth classification can change and often the difference between deep partial thickness and full thickness can only be determined operatively.

- Superficial (1st degree): epidermis only, dry, red, blanches with pressure, no blisters, painful.
- Superficial partial-thickness (2nd degree): epidermis and part of dermis, blisters, moist, red, weeping, blanches with pressure, painful.
- Deep partial-thickness (2nd degree): epidermis and deep dermis, blisters, wet or waxy dry, patchy white to red, does not blanch, pressure sensation only.
- Full-thickness (3rd degree): epidermis and entire dermis, waxy white to leathery gray to charred/black, dry and inelastic, does not blanch, sensation to deep pressure only, may be defined as 4th degree with extension into underlying fascia, muscle, or bone.

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Approved by MSEC 12/2/20. Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Travis_Nelson@ykhc.org.





**Box 1**

Indications for rabies prophylaxis:

1. The bite was from a fox, bat, coyote, skunk, woodchuck, or wolf, and this animal is not available to test.
2. The bite was from a dog who was behaving abnormally.
3. The bite was from a dog not available for quarantine.
4. If the dog is available for quarantine, do not start post-exposure prophylaxis regardless of vaccination status. OEH (Office of Environmental Health) will initiate a 10-day quarantine. Please check under "all documents" for Alert Note or for the rabies investigation report from OEH.
5. If consultation is needed, call OEH at 543-6420 or State Section of Epidemiology 907-269-8000 or 800-478-0084 after hours.

Patient reports animal bite (or exposure to brain tissue) from animal who is a possible reservoir for rabies (dog, fox, bat, wolf)

Does the patient require rabies post-exposure prophylaxis?
See Box 1.

Yes or maybe

Patient in village?

Yes

1. Health Aide completes visit in RAVEN.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Patient is reported to RMT provider.
4. Provider forwards the final note to the OEH department pool.

1. RMT provider orders the vaccine for HAND CARRY to village clinic – 3 doses.
2. Contact inpatient pharmacy on call to arrange the HAND CARRY to the village.

Patient is given Day 0 vaccine in village clinic.

Day 3 vaccine and immunoglobulin given in Bethel outpatient clinic unless it is the weekend (then patient goes to ED). At that visit:
-Wound is assessed.
-Immunoglobulin is infiltrated directly into wound site.

Day 7 & 14 vaccine given in village.

Other Resources

- See the [supplement](#) to this guideline on the wiki.
- [State of Alaska DHSS Rabies](#) page.
- Use the Power Plans "AMB/ED Rabies Prophylaxis" to find all necessary orders.

Provide usual wound treatment.
Consider amoxicillin-clavulanate prophylaxis for open wounds.

If patient needs extensive wound care, recommend immediate travel to ED for treatment.

1. Patient presents to ED or outpatient clinic.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Provider forwards the final note to the OEH department pool.

Patient is given Day 0 vaccine, and the wound is infiltrated with immunoglobulin.

Appointment is made for the outpatient clinic for Days 3, 7, and 14.
If any of these fall on a weekend, patient is seen in the ED.

Notes:

- Day Zero is the first day the vaccine is given, not the day of the exposure.
- Immunoglobulin must be given within seven days of first vaccine dose.

If patient is immunocompromised, he/she requires an additional dose on day 28.

Required Notifications:

- The Rabies Investigation Report is an ad hoc form that is started by the CHA/P in village clinic or by the ED/outpatient clinic provider when the patient first presents for care. This is sent electronically to the OEH (Office of Environmental Health) who will follow up on the status of the dog. Please check under "all documents" for this and for recommendations from OEH.
- Forward your PowerChart note to Rabies Control Officer Pool and OEH Department Pool.

For village patient:

- Day 0 dose: Given in village from HAND CARRY.
Day 3 dose: Given in Bethel.
Day 7 dose: Given in village from HAND CARRY.
Day 14 dose: Given in village from HAND CARRY.

Animals in Alaska that have tested positive for rabies:

1. Arctic fox
2. Caribou
3. Cat
4. Coyote
5. Dog
6. Keen's myotis bat
7. Little brown bat
8. Red fox
9. Reindeer
10. River otter
11. Wolf
12. Wolverine

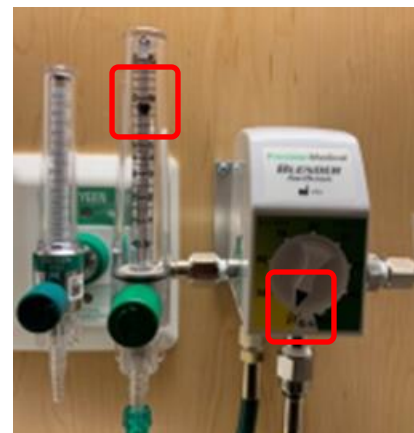
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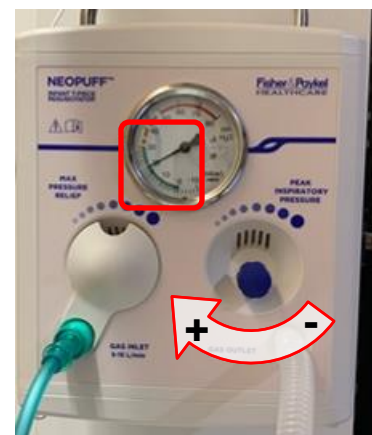
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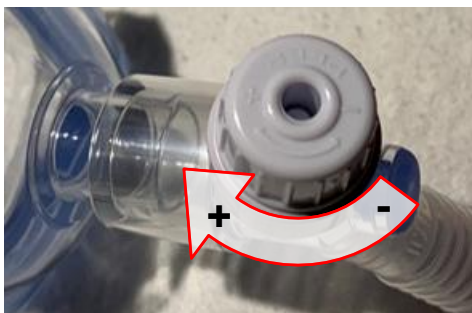
Attach the oxygen tubing to a 15 L flow meter.
Set blender to 21% and consider increasing depending on clinical status.
Set the flow meter to **10 L**.



Occlude both the mask and the hole.
Set the PIP: Turn the knob labeled Peak Inspiratory Pressure until the arrow on the dial points to **20**.



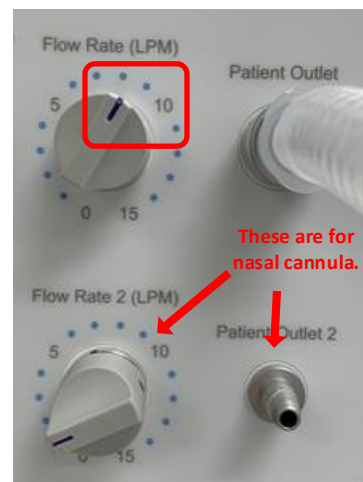
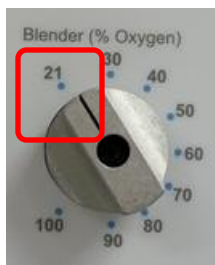
Occlude only the mask.
Set the PEEP: Turn the PEEP knob until the arrow on the dial points to **5**.



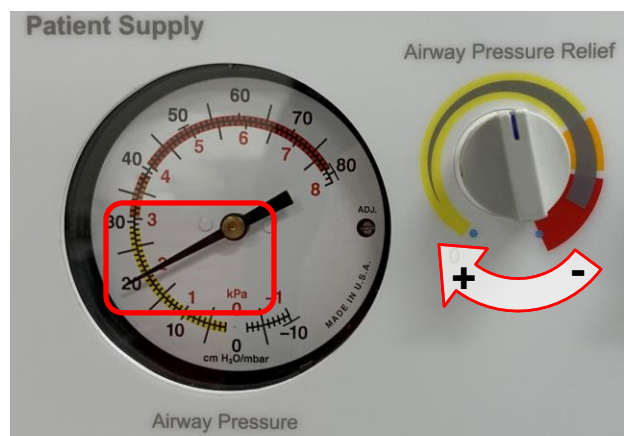
Troubleshooting: If you cannot achieve the desired pressures, try changing the liters on the flow meter or turning the Max Pressure Relief knob located under the flap.



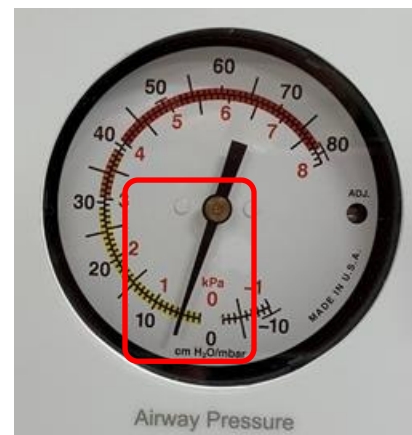
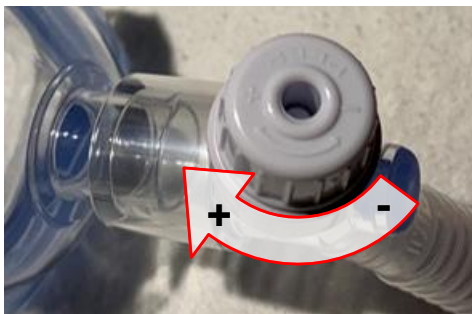
- To use suction, ensure that both the Suction and Gas Supply ON/OFF switches are ON.
- Set blender to 21% and consider increasing depending on clinical status.
- Set the top flow meter to **10 L**.
- The bottom flow meter is for use with nasal cannula.



- Occlude both the mask and the hole.
- Set the PIP: Turn the knob labeled Airway Pressure Relief until the arrow on the dial points to **20**.



- Occlude only the mask.
- Set the PEEP: Turn the PEEP knob until the arrow on the dial points to **5**.



Troubleshooting: If you cannot achieve the desired pressures, try changing the liters on the flow meter.



Coming soon...



Surfactant Administration Protocol

Indications for Curosurf®

- GA < 26 weeks.
- GA 26-29 weeks with supplemental oxygen requirement $\geq 40\%$.
- GA > 29 weeks with CXR-proven RDS.

Curosurf® Storage

- Curosurf® is stored at 36-46°F.
- If warmed and not opened or used, may be returned to refrigerated storage one time.
- Curosurf® is located in the OB medication refrigerator. If going on a medevac, ask the nurses to get the Curosurf®. It can be stored in a pink thermal bag that is kept next to it in the refrigerator.

Reference:

See this [YouTube video](#) for a demonstration of the Y catheter.

Preparation of Curosurf®

- Warm to room temperature and gently invert. Do not shake.
- Choose Curosurf® dose using the [Neonatal Resuscitation Summary](#) using estimated gestational age. If weight is known, calculate dose to be 2.5 mL/kg.
- Draw up total Curosurf® dose using a 20 gauge or larger needle. Divide the dose between two syringes with half the dose in each.



Preparation of Equipment and Patient

- Prior to intubation, if possible, check the ETT cap and make sure it comes on and off easily.
- Make sure you have the correct size Y cap for the ETT size.
- Check fit of Y cap on ETT. Attach catheter and feed it down the tube until it is ½ cm past the tip. Look for the number or color that will tell you the depth of the catheter at this point.
- Intubate patient with ETT cap on tube.
- Verify placement and secure tube.



Administration of Curosurf®

- Disconnect Neopuff, bag, or ventilator.
- Remove ETT cap and replace with Y cap. (If ETT cap is stuck, cut the tube as high as possible and then place the Y cap.)
- Attach the Neopuff or bag to the larger port on the Y cap.
- Attach the catheter to the smaller port on the Y cap and advance it until it is at the desired depth.
- Turn the baby onto one side.
- Inject one of the syringes of Curosurf® through the catheter.
- Pull the catheter all the way out but leave attached.
- Bag the baby at a rate of 40-60 breaths/minute for one minute.
- Allow the baby to recover.
- Turn the baby to the other side. Administer the other syringe of Curosurf®, as above.
- Place the baby in the supine position. Allow the baby to recover.
- Remove the Y cap and replace the ETT cap.
- Resume ventilation.
- Do not suction for one hour after administration unless required for obstruction.
- Remember to adjust pressure on Neopuff as lung compliance improves.



Village Deliveries (Pediatrics)

Preparation in the Village for the Health Aides

- Turn the heat up until everyone is sweating. May need extra space heaters.
- In the warmest part of the clinic, prepare a table with clean blankets, towels, etc.
- If the clinic has a dryer, instruct the health aides to warm the blankets there prior to birth.
- Ensure the following are prepared and functional: suction, oxygen tanks and tubing, BVM with smallest available mask, bulb suction.
- If available, set up desk lamps with old-style bulbs (not the spiral energy-efficient bulbs) to generate more heat.
- Seek out extra health aides or former health aides to help.

Preparation for Medevac

- Review prenatal history and note risk factors for the baby.
- Coordinate with family medicine hospitalist activating the medevac and LifeMed crew about when to meet at the hangar. The LifeMed hangar is located at 3600 Tower Road.
- Turn over the Tiger Connect role for "Peds Wards on Duty" to another pediatrician or the family medicine hospitalist staying behind.
- Establish roles with LifeMed crew. Discuss doses and equipment based on estimated GA.

What to Bring

- Curosurf if GA <32 weeks or unknown: located in the OB medication refrigerator. Place in pink thermal case.
- OB & Pediatric Village Delivery Backpack containing OB and pediatric supplies located in the nursery.
- Resources: [Neonatal Resuscitation Summary](#), [Surfactant Administration](#), [Neopuff Set Up Guide](#), [Pneumothorax Evacuation](#), [Neonatal Glucose Screening Guideline](#).
- Warm clothing. (There is extra warm gear under the bed in the peds call room)
- Snacks, drinks, money, motion sickness medication.

Resuscitation

- Resuscitate per NRP algorithm. Remember that CPAP is a great tool for non-invasive respiratory support for transport.

For infants <32 weeks:

- Place infant directly into polyurethane bag without drying. If intubated, bag may cover face/head.
- Attempt IV or UVC access early.
- See [Surfactant Protocol](#), if indicated.

Delivery is Imminent

- Set up monitor, Neopuff, and intubation equipment (all carried by LifeMed), using sizes recommended by [Neonatal Resuscitation Summary](#).
- Activate chemical mattress just prior to delivery. Cover with single baby blanket.

For High Risk Deliveries, including GA <32 weeks:

- Discuss with neonatologist early – call (907) 212-3614.
- Activate medevac to Anchorage. Consider direct transfer from village, ramp transfer in Bethel, or further stabilization with NICU team in Bethel, as appropriate.
- Prepare polyurethane bag.

Delivery is not Imminent

- Hospitalist assesses mother, does vaginal exam, obtains cultures, etc.
- LifeMed crew cares for mother.
- Pediatrician should help however possible and otherwise stay out of the way.
- Occasionally a mother will be transported to Bethel dilated and in labor. This decision is made if the benefit of being at a higher level of care outweighs the risks of potential delivery en route.

Prior to Transport

- Communicate with OB staff so they are prepared.
- Ensure an Anchorage team has been activated, if needed.

Medications

- Give erythromycin to eyes and vitamin K IM if infant is stable.
- Hepatitis B and HbIg can wait until arrival in Bethel.
- Give ampicillin per Neonatal Resuscitation Summary for all preterm and high risk infants.
- Gentamicin should not be given in the village, as it is high-risk.

Temperature

- Hypothermia in newborns is defined as temp <97.7°F.
- Cold babies do very poorly. It is better to over-prepare (use a polyurethane bag in term babies, etc.) rather than under-prepare.
- The baby pod carried by LifeMed does not have a heat source. It will not generate heat. Avoid placing the baby into it until it has warmed from being outside.
- Check axillary temperature at 5 minutes of life and then Q30 minutes.
- Place a hat and/or saran wrap on the baby as soon as possible.
- Do not remove hat, chemical mattress, or polyurethane bag until arrived at YKHC.
- You may tear holes in the bag to gain access to the baby for procedures.
- Avoid weighing premature babies, as this frequently contributes to heat loss in the village.

Glucose

- Check glucose as soon as possible.
- See [Neonatal Glucose Screening Guideline](#). Goal glucose is >35 in first four hours of life.
- On babies <32 weeks, start D10 maintenance as soon as IV access has been established.
- If unable to get a glucose, have a low threshold to give sugar in preterm or high risk infants.
- If oral dextrose gel unavailable, may give Sweetease, oral glucose, colostrum, formula, or homemade sugar paste. May smear on gums for buccal absorption.

Procedures

Intubation

- Prepare equipment.
- Wipe upper lip and rest of face.
- If need for sedation is anticipated, use morphine 0.05 mg/kg.
- Intubate and confirm placement with auscultation and ET/CO₂ detector.
- Tape tube with Benzoin and tape.
- Consider using Neopuff to ventilate en route rather than ventilator.

UVC (Always attempt PIV placement first unless infant is very unstable.)

- Use sterile technique.
- Flush catheter and stopcock with sterile saline. NOTE: the syringes for premade saline flushes are not sterile. You will have to use a sterile syringe to draw up flushes from a NS bag.
- If baby is in polyurethane bag, tear a small opening in the plastic.
- Place the UVC just far enough to get blood return.
- Cover skin around umbilicus with Tegaderm. Tape the UVC to the Tegaderm to secure it.

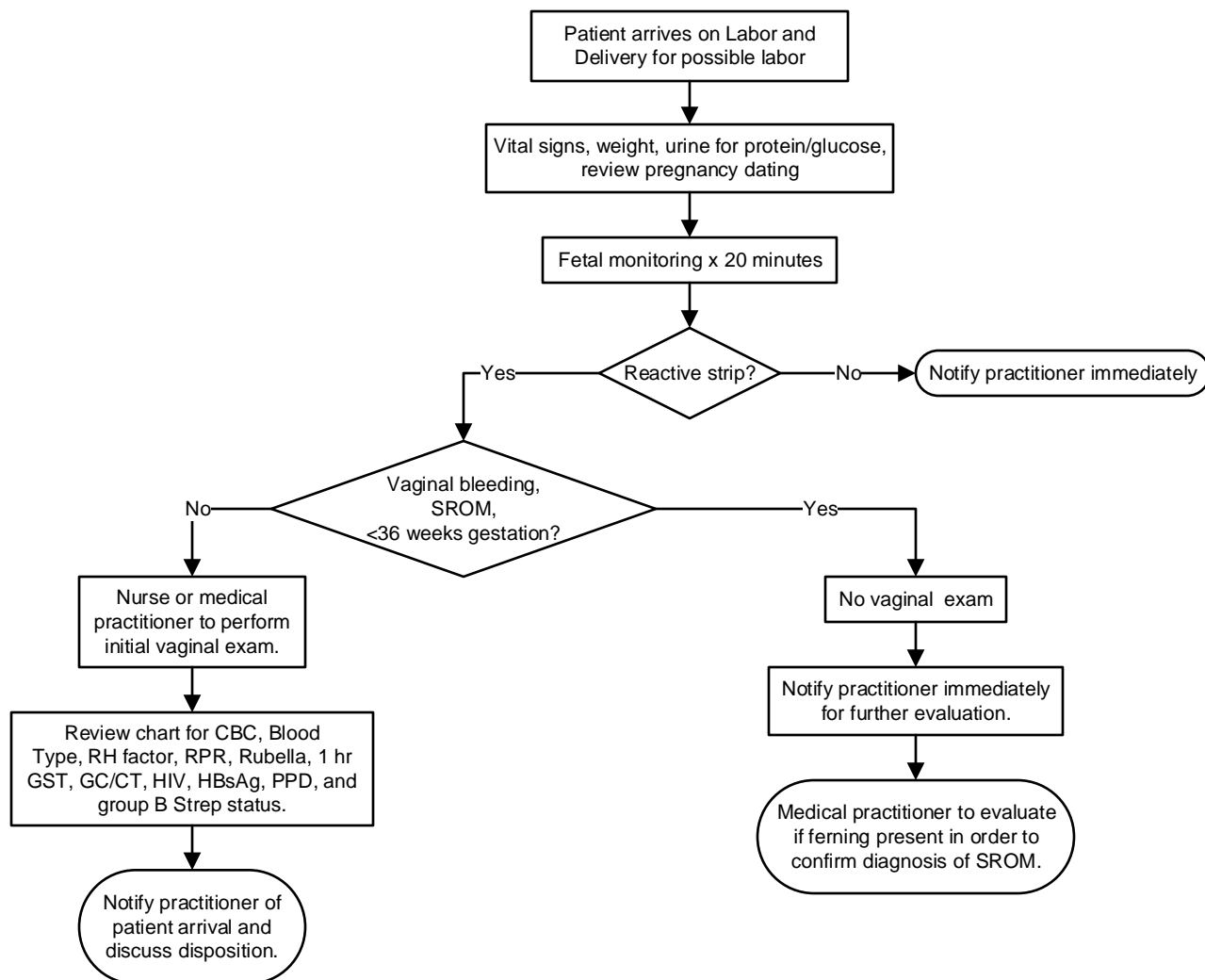
See [Surfactant Administration](#) and [Pneumothorax Evacuation](#) Resources.

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If comments about this resource, please contact Leslie_Herrmann@ykhc.org.



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BASICS

- Review the chart EVERY visit for incomplete lab or other required testing.
- Review the Problem List EVERY visit for needed testing or intervention items.
- Patient should see a Bethel provider or CHA/P monthly from first visit to 32 weeks.
- Patient should see a Bethel provider or CHA/P every two weeks after 32 weeks and then weekly at 36 weeks.
- If there is any question of EDC, see guideline or refer to HROB meeting for decision.

First Prenatal

NURSING/CASE MANAGER

- Order First Trimester Transvaginal OB Ultrasound (>6 weeks) for dating.
- Patient to initiate paperwork:
 - Residential Information Sheet.
 - Pregnancy Verification Sheet – use LMP if no EDC from ultrasound.
 - Quad screen consent form.
 - FAS & Drug Assessment Screening questionnaire.
 - 36 Week BIB/Medevac Policy.
- Review TB screening status – patient MUST HAVE a negative Quantiferon or PPD prior to 36 weeks to stay at Prematernal Home. Place PPD if needed.
- Send patient for labs: urinalysis with reflex, blood type and screen, HBsAg, CBC, Rubella titer, RPR, HIV testing, HgA1c, 25-OH vitamin D.
- Set up room for pelvic to do PAP (only do a PAP if it is due), wet prep, GC/CT (with verbal consent).
- Routine patient handouts: WIC handout.

PROVIDER

- Prenatal H&P and Prenatal Education.
- Chart review.
- Offer flu vaccine October through the end of the flu season.
- Discuss and sign BIB/Medevac Policy contract.
- Update the Problem List and include EDC and grvida/para in one problem.
- Refer to HROB meeting if needed.
- Ask about S/Sx of IHCP; if present, add bile acids and LFTs to lab draw.

PATIENT

- Go to the Medicaid office to file for Medicaid.
- Go to the WIC office to file for WIC.

15-21 Weeks

- If desired, quad screen must be drawn between 15 and 21 weeks gestation.
- Review TB status.

20 Weeks

- Ultrasound to screen for anomalies: US OB anatomy and cervical length.
 - Only one is needed no matter where it is done.
 - Aim for 20 weeks.
 - If anatomy is incomplete, order US OB follow-up for the next visit to complete the anatomy exam.

24-28 Weeks

NURSING

- Labs: GST, CBC, 25-OH vitamin D.
- Tdap after 24 weeks.
- GST – 50 g (½ bottle or 5 ounces):
 - If result >140 mg/dL, schedule 3 hour GTT ASAP.
 - If the result >179, no GTT; refer directly to diabetes education.
- Attempt to keep the patient until the results of the GST are back.
- Review TB status. Send to lab for Quantiferon if failed to have PPD read.

PROVIDER

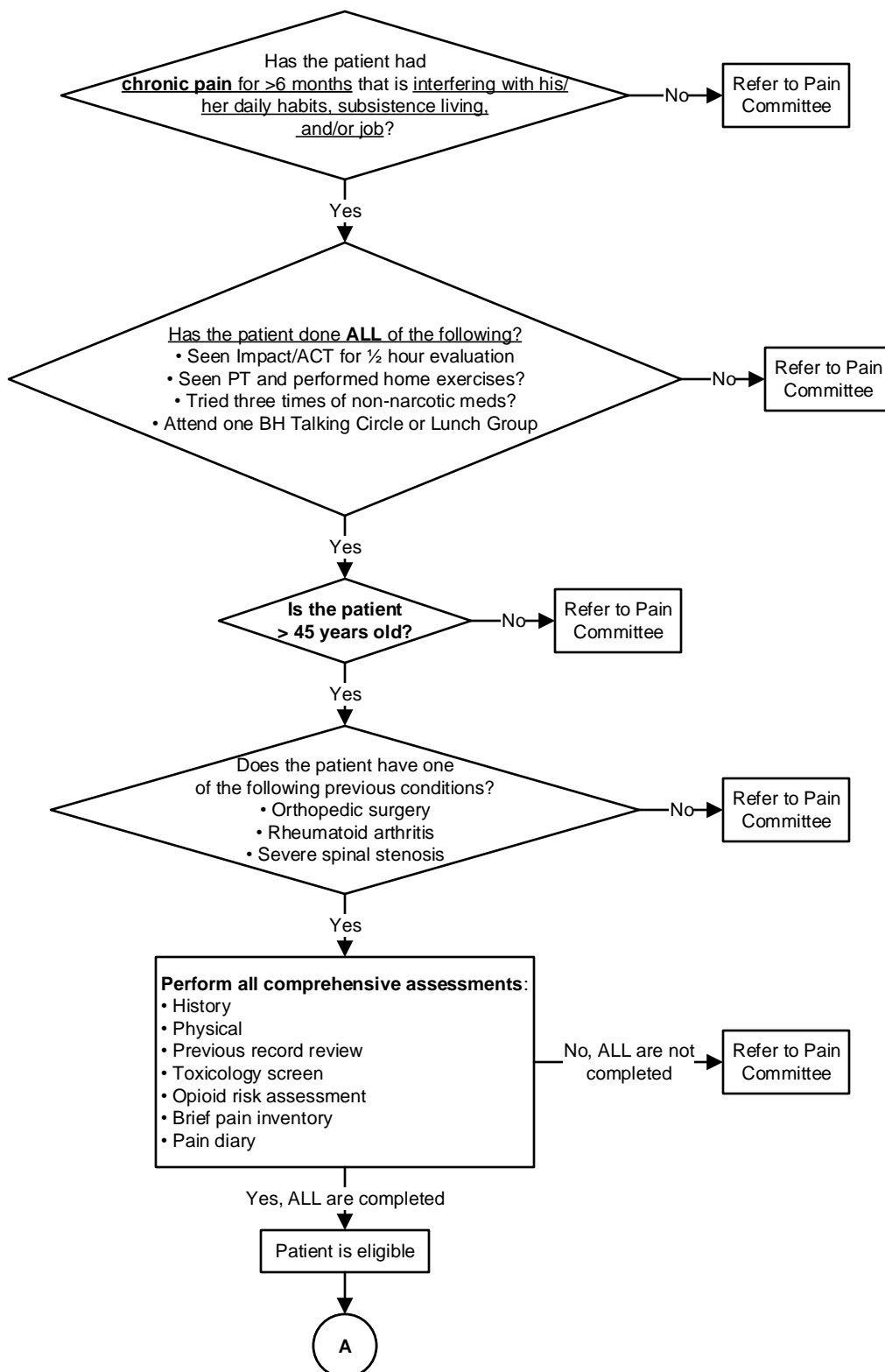
- After 28 weeks, ask about preeclampsia symptoms.
- After 24 weeks, ask about preterm labor symptoms and IHCP symptoms.
 - Back pain.
 - Sudden increase in vaginal discharge.
 - Pelvic pressure.
 - Cramps/contractions.
- Educate patient on fetal movement count.

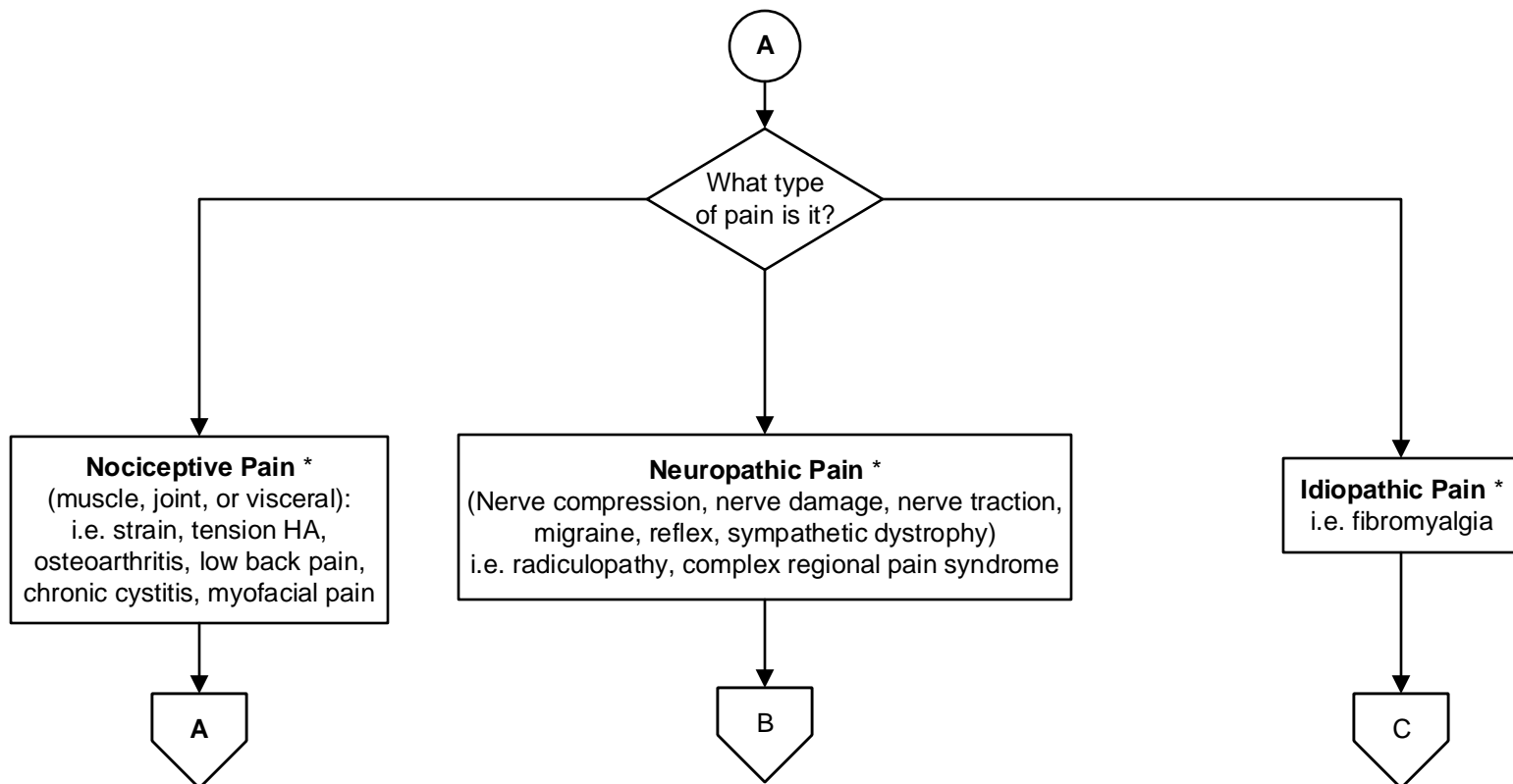
36 Weeks/BIB Date

- Labs: CBC, RPR, pelvic exam with GBS culture, GC/CT, wet mount if concerns.
- Review TB status. Send to lab for Quantiferon if status unknown.
- Schedule appointments to be seen each week by Bethel provider through 41 weeks.
- Complete Prematernal Home/Medical Clearance paperwork.
- Ask about any symptoms of:
 - Rupture of membranes.
 - Preeclampsia.
 - Labor.
 - Itching.



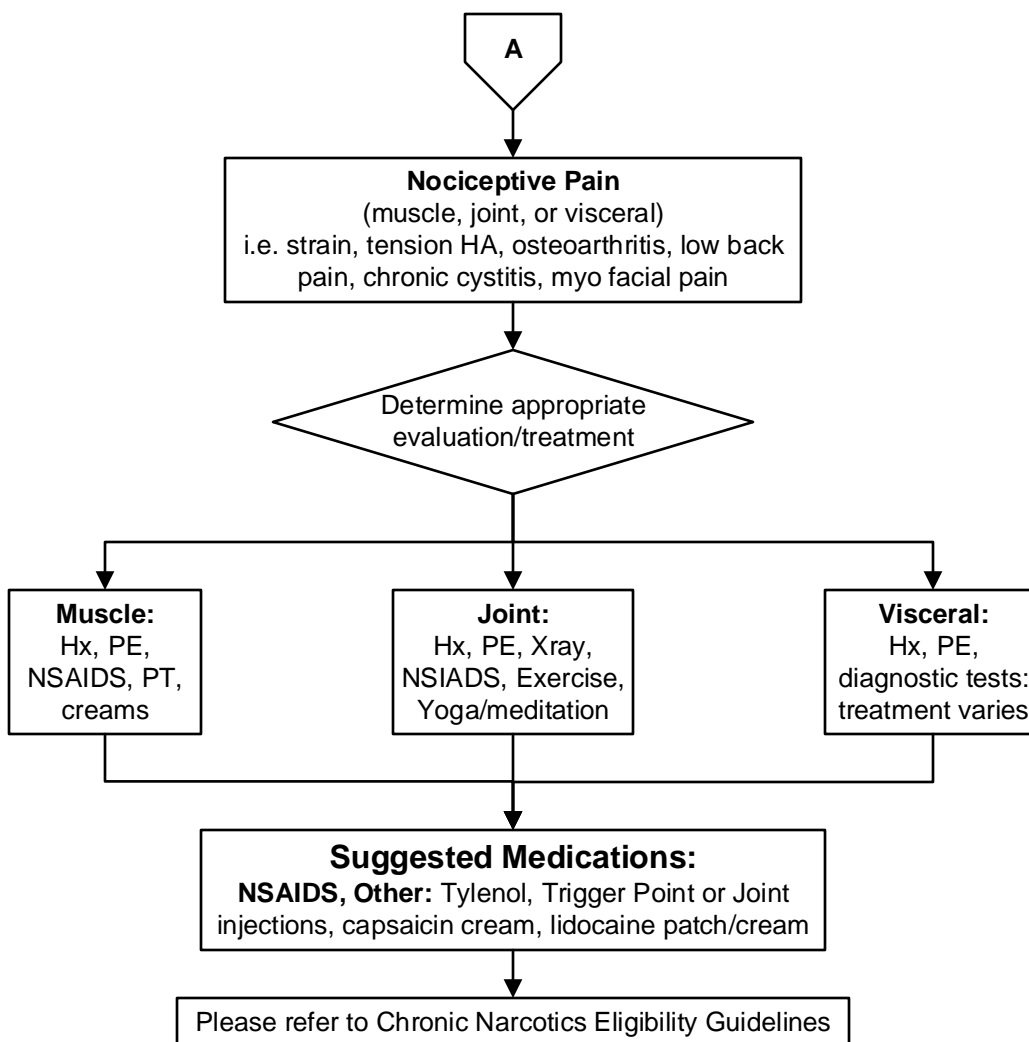
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***Treatment Options for all types of pain:**
Sleep Hygiene, Yoga, Meditation

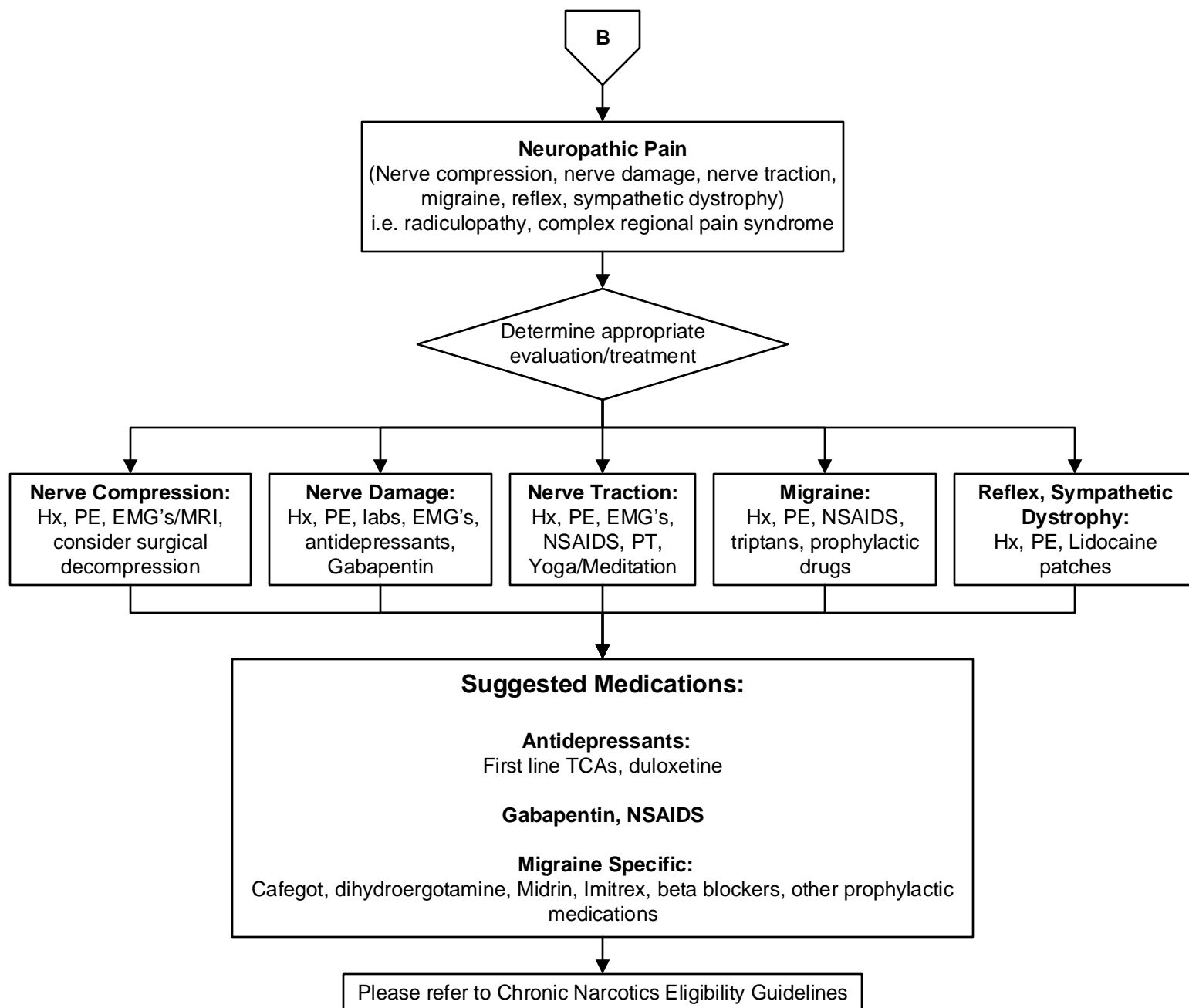
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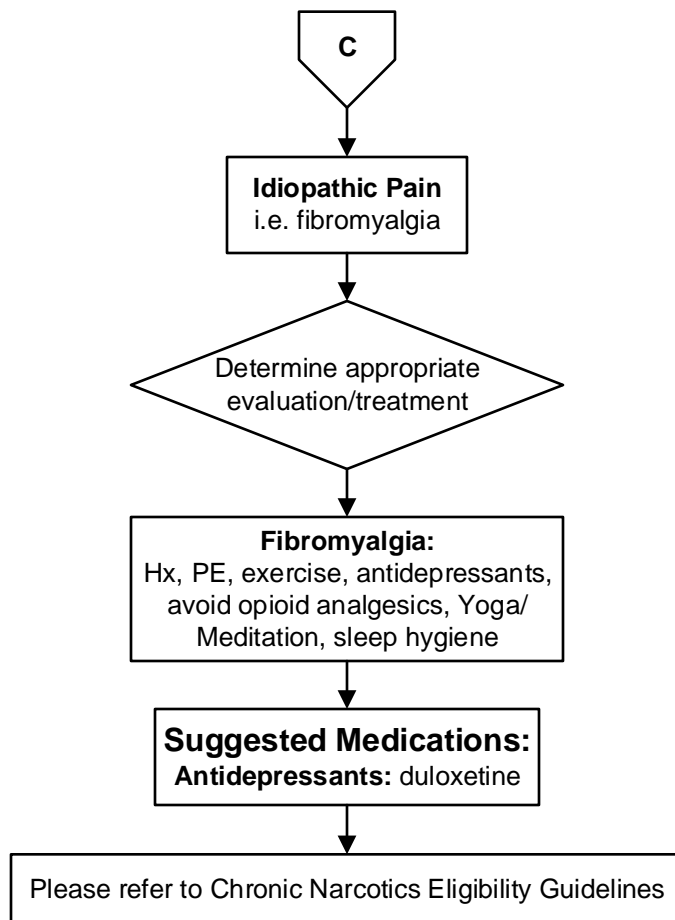


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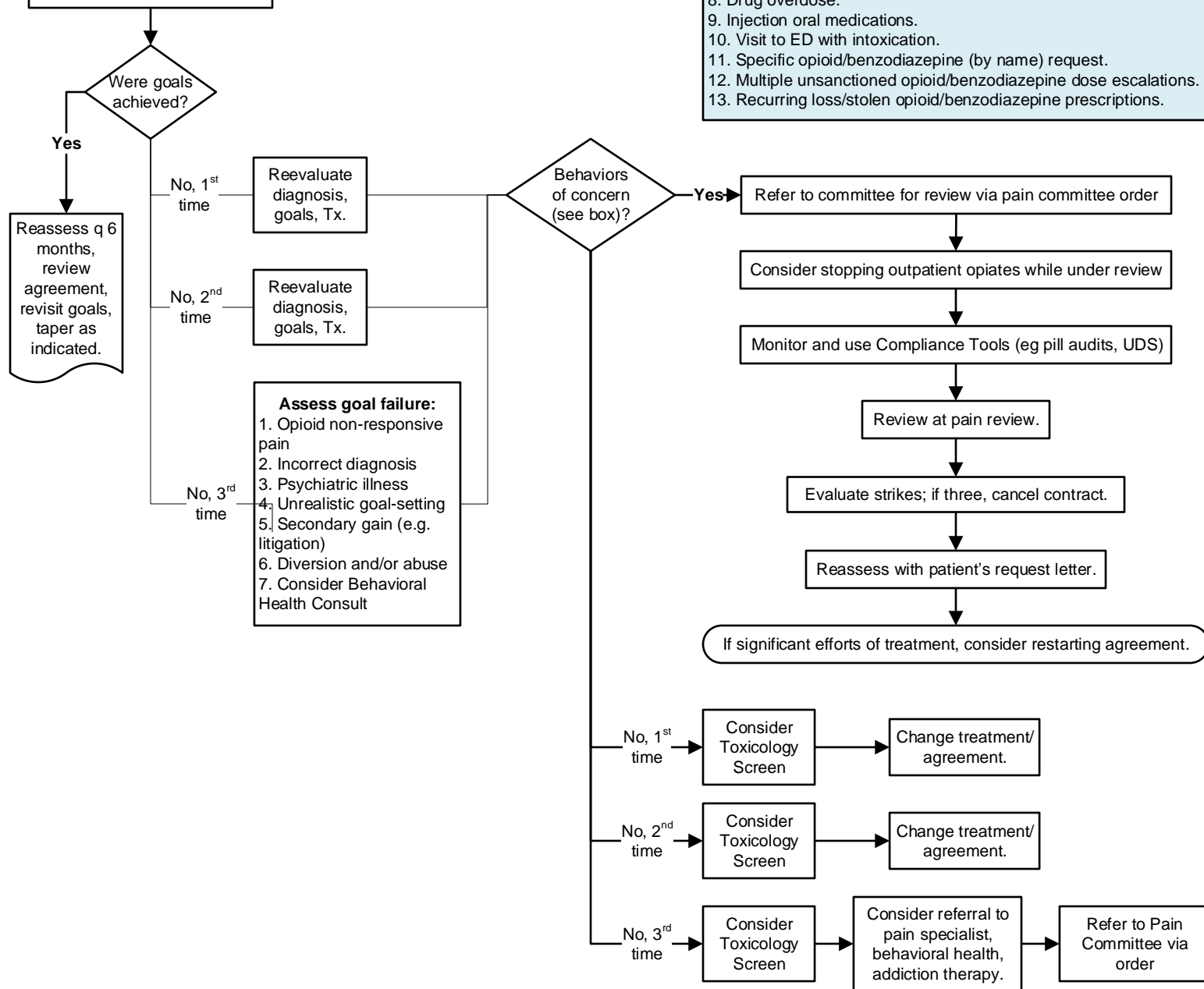
Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol Case Manager/Pharmacy Re-assessment and Follow-up of Chronic Pain

Follow up and reevaluation:

Assess for:

1. functionality
2. adverse effects
3. achievement of goals
4. analgesia
5. behaviors of concern: see flow sheet

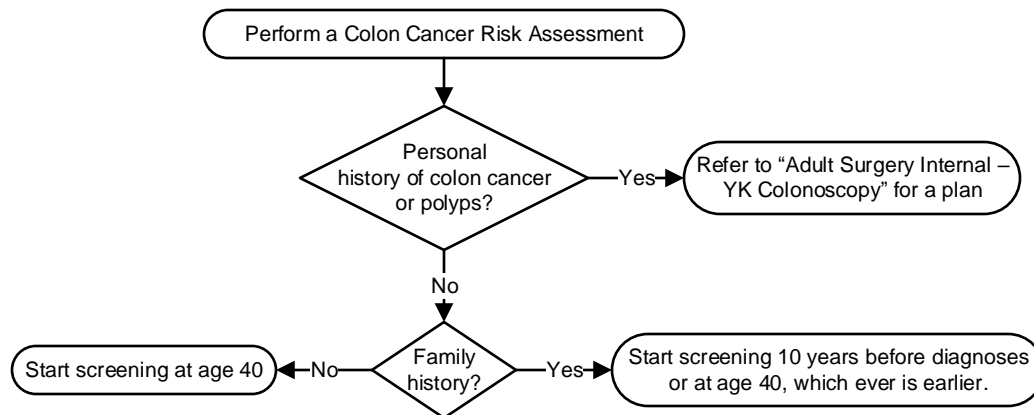


For terminal cancer patients (with life expectancy less than or equal to 6 months) who have previously demonstrated good compliance with Chronic Medication agreement, documentation of titration for pain control as appropriate is acceptable without requiring new agreement. Continue to monitor for achievement of goals/behaviors of concern.

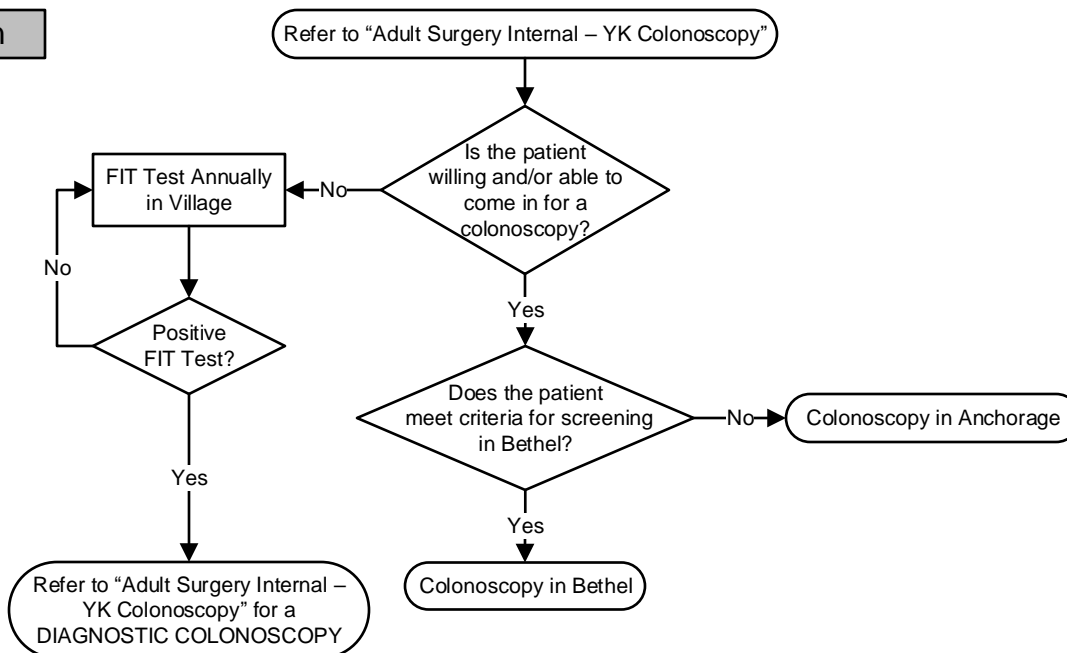
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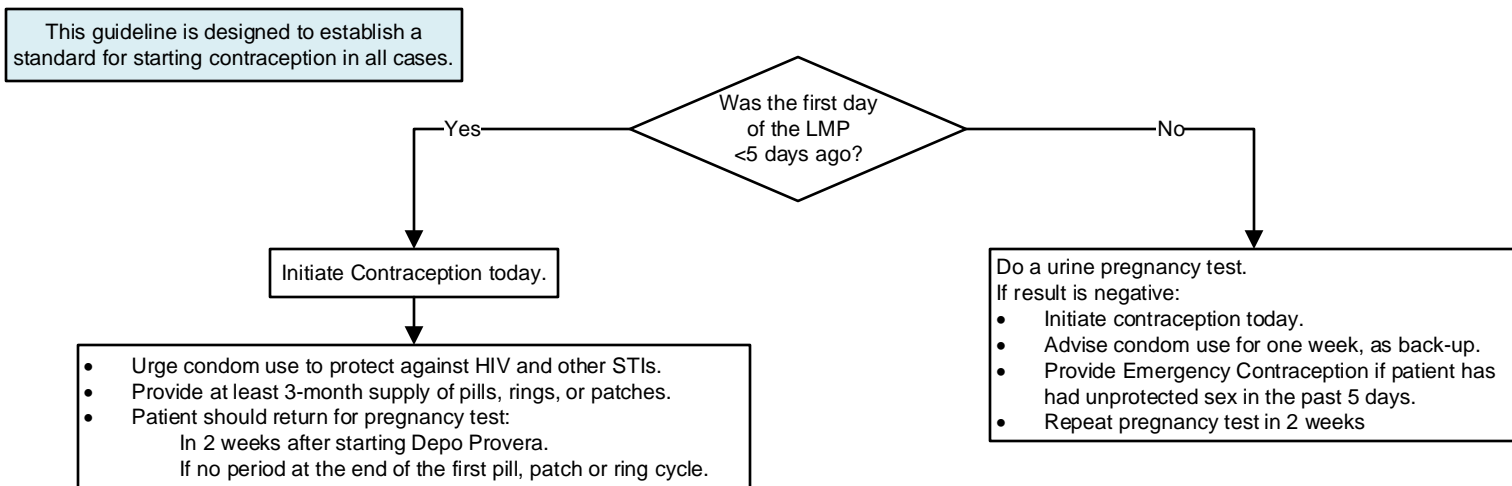


When to Screen



How to Screen







Age	Hb/Hct	Coags	Lytes	BUN/Cr	Glucose	LFTs	EKG	CXR	T&S
0 – 59 years	No routine testing needed in this age group.								
60 – 74 years							X		
75 – 99 years	X		X	X	X		X		

Disease	Hb/Hct	Coags	Lytes	BUN/Cr	Glucose	LFTs	EKG	CXR	T&S
Hypertension			X				X		
Card – moderate	X		X	X			X		
Card – severe	X		X	X			X	X	
Pulm – mild									
Pulm – severe	X						X	X	
Smoker > 20 years	X								
Malignancy	X								
Lymphoma								X	
Hepatic	X	X	X			X			
Renal	X	X	X	X					
Bleeding	X (CBC)	X							
Diabetes			X	X	X		X		
Expected blood loss	X								X

Medication	Hb/Hct	Coags	Lytes	BUN/Cr	Glucose	LFTs	EKG	CXR	T&S
Diuretic			X	X					
Antihypertensive			X	X			X		
Cardiac medication			X	X			X		
Steroid			X		X				
Anticoagulant	X	X							

Other

Urine hCG: obtain within 48 hours of surgery in women of childbearing age (13-50).

Drug Levels: draw level on all patients on digoxin or phenytoin.

CXR: obtain if recent change in sputum quality or color, pneumonia in past three months, chronic home oxygen use, planned intrathoracic surgery, or if exam reveals rales, rhonchi, or wheezes.

Surgical Risk Screening Protocol Orders

- Patients who are not to be scheduled at YKHC:
 - Patients with BMI > 45 (up to BMI of 45 is acceptable if no significant unstable CV, respiratory, or endocrine pathology is present).
 - Obstructive sleep apnea perioperative risk score of 5 or 6.
- Preventative antibiotic therapy will be administered within one hour prior to skin incision per protocol pre-operatively based on procedure type and patient's allergies unless otherwise ordered by physician.
- DVT/VTE prevention methods will be implemented using SCIP Mechanical Prophylaxis Protocol unless contraindicated or otherwise documented in orders by physician.

Diabetes Management

- Discontinue all oral agents the evening prior to surgery except Metformin, which can be taken the evening prior to surgery but not the day of surgery.
- Discontinue insulin after midnight for AM surgeries.
- Take half usual dose of insulin the morning of surgery if surgery is scheduled to start at noon or later.
- Take full dose of Lantus insulin up to time of surgery.
- Consume apple or cranberry juice up to two hours prior to arrival to surgery if insulin was given.
- For insulin pumps, set to basal rate and continue throughout pre-operative period.
- Upon arrival to Holding Area, obtain glucose level. Anesthesia will treat results.



NPO Guidelines

The preoperative nurse will instruct all patients to be NPO after midnight and to follow the surgeon's instructions if they differ from this. The surgeon who gives different instructions will be responsible for thorough patient instruction of anything other than these guidelines.

1. All patients are equal with regard to NPO guidelines (eg gastric emptying time, obesity).
2. Clear liquids may be consumed up to two hours prior to scheduled arrival time.
3. Clear liquids are water, black coffee, and beverages not cloudy that can be seen through. Sugar and artificial sweeteners are acceptable. All broths are NOT acceptable.
4. Patient may brush his/her teeth but should not swallow toothpaste.
5. Gum and candy of any type are not allowed.
6. All patients will be allowed to eat a full, regular diet (solids) up to eight hours prior to surgery. Patients going to the OR at 0730 who were NPO after midnight are considered to meet this standard.
7. Infants up to 24 months of age will be allowed breast milk up to four hours prior to the arrival to the hospital. Infant formula is considered a solid.

Estimated Energy Requirements for Various Activities, Based on Duke Activity Status Index*

1 MET	Can you...	
		...take care of yourself?
		...eat, dress, or use the toilet?*
		...walk indoors around the house?
		...walk one or two blocks on level ground at 2-3 mph (3.2-4.8 kph)?
< 4 METs	Can you...	
		...do light work around the house, such as dusting or washing dishes?
≥ 4 METs	Can you...	
		...climb a flight of stairs or walk up a hill?
		...walk on level ground at 4 mph (6.4 kph)?
		...run a short distance?
		...do heavy work around the house, such as scrubbing floors or lifting or moving furniture?
		...participate in moderate recreational activities, such as golf, bowling, dancing, doubles tennis, or throwing a baseball or football?
≥ 10 METs	Can you...	
		...participate in strenuous sports, such as swimming, singles tennis, football, basketball, or skiing?

* MET = metabolic equivalent

Adapted from J AM Coll Cardiol, with permission from Elsevier.



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IF ANY CONCERN FOR APNEA, please consult a pediatrician immediately to determine need for further evaluation, transfer, medevac, etc.

Recommendations on Management of Caffeine After NICU Discharge

- Recommended dose of caffeine is 12 mg/kg PO daily.
- Patient should be seen in Bethel by a pediatric provider within one week of returning to the region.
- Dose should be weight-adjusted every 1-2 weeks. This can occur in outpatient clinic with a pediatric provider or a pediatric consult, in an SRC with a pediatric consult, or in a village by RMT to Chronic Peds.
- Stop the caffeine when the baby is 42 weeks corrected gestational age.
- Discontinuation of caffeine may be delayed for another week so as not to coincide with immunizations, recent URI, or planned anesthesia (as all of these events can cause re-emergence of intermittent hypoxia with periodic breathing).

Note

When a baby is discharged from the NICU on caffeine, update the Problem List with the plan, including the target dose, how often to weight-adjust, and the expected end date (when 42 weeks corrected gestational age will be).

Rationale

- In the past, premature infants were given caffeine until about 34 weeks post-menstrual age. Some needed caffeine past this point and went home on caffeine and an apnea monitor.
- Recent studies have shown that many preterm infants who have been taken off caffeine will go on to have intermittent hypoxia and subclinical apnea and bradycardia events after discharge from the hospital.
- Evidence is also building that prolonged use of caffeine results in better neurodevelopmental outcomes.
- As of January 2019, caffeine has been continued in preterm infants after discharge from the PAMC NICU.
- The PAMC NICU stopped the routine use of apnea monitors for babies discharged on caffeine due to sub-optimal monitor technology and frequent frustration among parents and providers. They prefer to emphasize the importance of giving caffeine rather than use of apnea monitors.

Source

Adapted from letter from Alaska Neonatology Associates, Inc., Pediatric Medical Group, an affiliate of MEDNAX.
1/10/2019
Providence Alaska Medical Center (PAMC)
Neonatal Intensive Care Unit (NICU)

This resource is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Last reviewed 12/2/20.

If comments about this resource, please contact Leslie_Herrmann@ykhc.org.



<input type="checkbox"/> Has YKHC pediatric group been briefed and asked for feedback on concerns or issues?	<input type="checkbox"/> N/A
<input type="checkbox"/> Prior to patient returning, has care conference been scheduled with 1-2 pediatricians to represent group/consensus recommendations? Other key participants include: case managers, SRC providers, health aides, and family members.	<input type="checkbox"/> N/A
<input type="checkbox"/> Where will primary care occur – village, SRC, Bethel, or Anchorage?	<input type="checkbox"/> N/A
<input type="checkbox"/> Does home have electricity, running water, and a refrigerator?	<input type="checkbox"/> N/A
<input type="checkbox"/> Is there a back-up plan in place if electricity goes down?	<input type="checkbox"/> N/A
<input type="checkbox"/> Have family/caregivers received CPR training?	<input type="checkbox"/> N/A
<input type="checkbox"/> Does the family have needed emergency equipment? Ex: ambu bag (if no CHA available), suction, pulse-oximeter, oxygen, etc. Have they received training on how to use this equipment?	<input type="checkbox"/> N/A
<input type="checkbox"/> Does the family have needed supplies: medications, beds, commodes, syringes, dressings, wheelchair, lotions, etc.?	<input type="checkbox"/> N/A
<input type="checkbox"/> If the patient is at risk for seizures, has the family received Diastat or intranasal midazolam and received the appropriate training?	<input type="checkbox"/> N/A
<input type="checkbox"/> If the patient has a G-tube, are the caregivers comfortable replacing it? Do they have emergency supplies, including an extra G-tube and Foley catheters in the same French size and smaller sizes?	<input type="checkbox"/> N/A
<input type="checkbox"/> If the patient has a port, are the caregivers comfortable accessing it? Have they received the appropriate training? Do they have all the supplies needed to access it?	<input type="checkbox"/> N/A
<input type="checkbox"/> Has an Informed Consent to Return to Village been customized for this patient and approved by Risk Management (contact is Linda Weisweaver as of 11/2019)? [See Peds Folder → Informed Consent to Return to Village for template.]	<input type="checkbox"/> N/A
<input type="checkbox"/> Have the caregivers completed the Informed Consent to Return to Village?	<input type="checkbox"/> N/A
<input type="checkbox"/> If patient is returning to the village against medical advice, have Risk Management, Clinical Director, and appropriate administrators been made aware?	<input type="checkbox"/> N/A
<input type="checkbox"/> If the patient is DNR/DNI/Comfort Care, have the Expected Home Death Forms been completed? Has the MOST Form been completed? Does family have enough medications needed for comfort care?	<input type="checkbox"/> N/A
<input type="checkbox"/> Have all current and anticipated prescriptions with refills been ordered on the YKHC RAVEN Medication List?	<input type="checkbox"/> N/A
<input type="checkbox"/> Has the YKHC RAVEN Problem List been updated with care plans, follow-up needs, therapeutic parameters, etc.?	<input type="checkbox"/> N/A
<input type="checkbox"/> Has a clinic appointment been scheduled to establish care at YKHC?	<input type="checkbox"/> N/A
<input type="checkbox"/> Have the health aides been notified of the complex needs of this patient?	<input type="checkbox"/> N/A
<input type="checkbox"/> Have the nearest SRC providers been notified of the complex needs of this patient?	<input type="checkbox"/> N/A
<input type="checkbox"/> After the care conference: has a detailed note been placed in the chart summarizing the care conference? Has this note been sent by email to the pediatric group, case managers, and SRC providers?	<input type="checkbox"/> N/A
<input type="checkbox"/> Has family referral to YKHC BH been offered?	<input type="checkbox"/> N/A
<input type="checkbox"/> Have VTC appointments been set up for patient and family?	<input type="checkbox"/> N/A



The following is adapted from the "[ANMC Pediatrics Statement on Dexamethasone and Hearing Screening in Meningitis](#)," dated 2/4/20.

Haemophilus influenzae type A

In recent years, *Haemophilus influenzae* type A (HiA) meningitis has been more common than other causes of bacterial meningitis in children admitted to ANMC. Many of these children have been transferred from YKHC. See this [State Epidemiology Bulletin](#) for information about Alaska cases in 2014-2018, including the outbreak in 2018.

The pattern of disease in HiA is similar to that seen in *Haemophilus influenzae* type B (HiB) meningitis. In HiB meningitis, dexamethasone has been shown to decrease the incidence of severe hearing loss. In Alaska, there have been multiple cases of sensorineural hearing loss associated with HiA meningitis. It is suspected that dexamethasone may confer similar benefits in HiA meningitis. As a result, our local experts (including infectious disease and endocrinology experts) recommend giving dexamethasone with all cases of suspected bacterial meningitis.

Dexamethasone

- **Indications:** A child >6 weeks old with clinical meningitis or visibly purulent spinal fluid.
- **Timing:** First dose should be given 10-20 minutes prior to or concurrent with the first dose of antibiotics; if given after antibiotics have been given, there is no evidence that dexamethasone will improve outcomes.
- **Dose:** Dexamethasone 0.15 mg/kg/dose IV.
- **Course:** If dexamethasone is initiated and HiA/HiB is confirmed, continue dexamethasone 0.15 mg/kg/dose IV Q6h for 2-4 days. If CSF culture/PCR show a different pathogen or are negative, stop the dexamethasone.

Hearing Screening

- All children with bacterial meningitis should be referred to audiology.
- Hearing evaluation should be scheduled one month after hospital discharge.



General Guidelines and Definitions

Disclaimer: These are guidelines—not hard and fast rules. Some patients, such as younger children (<5 years) and poorly controlled diabetics (HbA1c >10%), may not adhere to the usual course and guidelines may need to be modified. The below categorizations of mild, moderate, and severe are not the consensus-statement published definitions, but are more “real-world” categorizations.

DKA: A state of *insulin deficiency* and characterized by *severe depletion of water and electrolytes* (see Appendix 1). The primary goals are to **treat the insulin deficiency** (which will correct the acidosis and reverse the ketosis) and to **replace fluids and electrolytes**. Other goals include gradually achieving euglycemia, monitoring for complications of DKA, and identifying and treating any precipitating event.

Clinical signs of DKA: dehydration, tachycardia, tachypnea, Kussmaul respirations, acetone breath odor, nausea, vomiting, abdominal pain, blurry vision, confusion, drowsiness, progressive decrease in level of consciousness, loss of consciousness.

Biochemical criteria for DKA: hyperglycemia (BG > 200mg/dl); venous PH <7.3 or serum bicarb <15, beta-hydroxybutyrate ≥3 or moderate/large ketonuria

Diabetic ketosis without significant acidosis: Urine ketones moderate/large, nausea +/- vomiting, pH >7.3, Bicarb >15

Management:

- Oral or IV hydration, depending on vomiting, ability to tolerate PO.
- Supplemental insulin (Novolog, SQ: 0.1-0.2 units/kg every 4 hours) in addition to patient's usual long-acting insulin (ie Lantus, Tresiba).
- Often managed as outpatient at home or in Emergency Department.
- In established patient with good family support, sometimes managed at home by phone under guidance from on-call physician with no knowledge of laboratory results other than self-monitored blood glucose and urinary ketones.

Mild-moderate DKA: Urine ketones mod/large, persistent vomiting, pH 7.2-7.3, Bicarb 10-15

Management:

- Oral or IV hydration (usually IV).
- Supplemental insulin should be used (Novolog SQ 10% of total daily insulin dose or 0.1-0.2 units/kg every 2 hours) in addition to the patient's usual long-acting insulin (ie Lantus, Tresiba).
- May require admission and management with IV regular insulin infusion (0.05-0.1 units/kg/hr).

Severe DKA: Urine Ketones Large, pH <7.2, Bicarb <10 OR mild/moderate DKA with other organ system impairment (altered mental status, impaired renal function, respiratory distress, compromised circulation) (published definition: pH <7.1, bicarb <5)

Management:

- Admit to hospital for therapy and intensive monitoring.
- PICU status may be appropriate in some cases (altered mental status, hypokalemia, hyponatremia (after sodium corrected for glucose[†]), young age (<5 years), hypotension, per admitting physician).
- IV hydration (3 L/m²/day)[‡]
- IV insulin (0.1 units/kg/hour).
- Intensive monitoring for improvement and signs of cerebral injury.
- Follow guidelines as given in the remainder of this protocol.

Some useful formulas:

[†]Total daily insulin dose approx. = Lantus dose x 2 (In general, Lantus dose is 50% of patient's total daily insulin)

[‡]Corrected sodium = $[(\text{Glucose} - 100)/100] \times 1.6 + \text{Pt's Na}$ [glucose is mg/dL]

[§]BSA (m²) = $\text{sq root} [(wt(kg) \times ht(cm))/3600]$; estimated BSA = $(wt(kg) \times 4 + 7)/(90 + wt(kg))$

[¶]Anion Gap = Na – (Cl + HCO₃); normal is 12 +/- 2 mmol/L

[¶]Effective osmolality = $2 \times (\text{Na} + \text{K}) + \text{glucose}/18$ [glucose is mg/dl]

Fluid Management (2 bag system)

- Total fluids should not exceed about 3500 mL/m²/day.
- Volume expansion (fluid bolus) should be initiated prior to insulin administration, and insulin should be initiated at least 1 hour after the fluid administration has begun.
 - Initial bolus of NS or LR with 20 mL/kg over 1-2 hours.
 - If poor peripheral perfusion, hypotension, or shock persist after the initial 20mL/kg, it may be appropriate to repeat with a second 10-20 mL/kg NS bolus.
- Rehydration: assume 10% dehydration and plan to replace the deficit over 24 hours. (See Appendix 2.)
 - This can often be accomplished by running IV fluids at 1.5 x maintenance or 3000 mL/m²/day.
 - Initial IVF with ½NS + 20 mEq/L K-phosphate + 20 mEq/L K-acetate (or KCl if K-acetate is not available). **Note: there is zero dextrose in this fluid.
 - ◆ Consider NS if measured Na level is low and does not rise with the fall in glucose.
 - ◆ If K is >6, repeat the BMP and add the K to the fluids when the K is <6; If K is low, may need up to 60 mEq/L K total (typically 30 and 30 of the two types of K solution).
 - “Y-in” D10 ½NS + 20 mEq/L K-phosphate + 20 mEq/L K-acetate (or KCl) when the serum glucose is less than 250 mg/dL or if glucose falls faster than 100mg/dL per hour.
 - 2 bag method: Use 2 separate bags of IV rehydration fluid with identical electrolyte composition; one bag has NO dextrose and the other has 10% dextrose. Increase and decrease the rate of each bag reciprocally so that the total rate is constant at the desired rehydration rate (ie, 3 L/m²/day) and the glucose is maintained between 150 and 250.
 - ◆ Typically, when the BG is ≤ 250, run the 2 fluids at 50/50 rates and when the BG is <200, stop running the fluid without the dextrose and run the D10 fluid at 100% of the desired rate.
 - ◆ **DO NOT REDUCE INSULIN INFUSION RATE BECAUSE OF FALLING BLOOD GLUCOSE UNTIL THE REDUCTION IS INDICATED BASED ON RESOLUTION OF KETOACIDOSIS;** If the patient is still acidotic, they still need the insulin—increase the dextrose content instead (can use D12.5% fluids prn).
- **Do not administer sodium bicarbonate to correct the acidosis** (cautious administration may be **considered** if pH <6.9 and the acidosis is so profound as to adversely affect the action of epinephrine during resuscitation, decreased cardiac contractility, impaired tissue perfusion from vasodilation, or life-threatening hyperkalemia; dose should be 1-2 mmol/kg over 60 minutes).

This protocol is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
If comments about this protocol, please contact Jane_McClure@ykhc.org.



Insulin Therapy

- "Low-dose continuous IV insulin infusion" = 0.1 units/kg/ hour regular insulin, IV (conc. 1 unit/mL).
 - Start insulin 1 hour after initial fluids have been started but do not further delay in starting insulin.
- Do not give intravenous insulin bolus or subcutaneous insulin bolus when starting the continuous infusion. (*If a delay in starting the insulin infusion is expected to be longer than 1 hour (i.e. more than 2 hours after IVF have been started, then a SQ insulin dose may be warranted.)
- **CONTINUE IV INSULIN INFUSION AT 0.1 UNITS/KG/HOUR UNTIL THE KETOACIDOSIS IS RESOLVED**, bicarb >18, the anion gap is closed (AG <12)[†], and the patient is awake and can tolerate PO fluids.
 - A lower continuous rate (0.05 – 0.08 units/kg/hr may be needed in patients with marked insulin sensitivity.
- Usually, long-acting basal insulin (ie Lantus, Tresiba) should be given at the usual time, even if the patient is on an insulin infusion (this is most frequently given at bedtime; its onset of action is approx. 1-2 hours).
 - Administering basal insulin while on the insulin infusion allows us to d/c the insulin infusion when it is appropriate (see above) without waiting for subcutaneous insulin to be given; it also provides background insulin so that DKA does not recur after the insulin infusion is discontinued (remember: without SQ insulin, once the IV insulin infusion is stopped, the patient has no other insulin on board!)
 - In new-onset diabetes, the usual starting total daily dose of insulin is 0.5-1 units/kg/day, 50% of which should be given as basal insulin; in known diabetes, the patient's home dose of basal can be used.
 - For those patients on insulin pumps, they will not be on a long-acting basal insulin, so do not need to receive this unless there is a plan to not restart the patient's pump while they are hospitalized. Otherwise, they can simply be restarted on their pump when the IV insulin infusion is completed.

Cerebral Injury in DKA

The most common cause of death during DKA in children is clinically apparent cerebral injury, which occurs in about 0.5-0.9% of cases and manifests as sudden neurologic decline. It often occurs early in the course of DKA (sometimes even before treatment has been started) and when it is clinically apparent, the prognosis is usually poor; mortality rate is up to 21-24%. The pathogenesis is incompletely understood, but may result from cerebral hypoperfusion and the effects of reperfusion, along with neuroinflammation. Cerebral edema is likely a consequence (rather than the cause) of cerebral injury, and often develops hours or days after the diagnosis of brain injury.

• Risk factors include:

- Younger age; New-onset diabetes; Longer duration of symptoms
- **Sodium bicarbonate treatment for correction of acidosis**
- Administration of insulin in the first hour of fluid treatment
- Increased BUN at presentation
- Greater hypocapnia at presentation after adjusting for degree of acidosis
- More severe acidosis at presentation
- An attenuated rise in measured serum sodium concentrations during therapy
- Children with DKA are frequently sleepy, but **warning signs and symptoms of cerebral injury include:**
 - Worsening of Glasgow Coma Scale (GCS) Score
 - Slowing of heart rate, rising blood pressure, decreased O₂ saturation (Cushing's Triad)
 - Change in neurological status (restlessness, irritability, increased drowsiness, incontinence)
 - Headache, vomiting, focal neurological signs, dilated/unresponsive/sluggish/unequal pupils, papilledema
 - Decreasing urine output without clinical improvement or tapering of fluids
- **CEREBRAL INJURY IS A LIFE THREATENING MEDICAL EMERGENCY REQUIRING IMMEDIATE AGGRESSIVE INTERVENTION AND IMMEDIATE TRANSFER TO AN INTENSIVE CARE UNIT SETTING.**
- Treatment includes:
 - Give Mannitol 0.5-1 gm/kg over 10-15 min and repeat if no initial response in 30 minutes to 2 hours.
 - ◆ Hypertonic saline (3% saline) 2.5-5ml/kg over 30 min may be an alternative or 2nd line.
 - Elevate the head of the bed to 30 degrees and keep the head in a midline position.
 - Adjust fluid administration as indicated to maintain normal BP and optimize cerebral perfusion; avoid hypotension that might compromise cerebral perfusion pressure.
 - Administer oxygen as needed to maintain normal oxygen saturation.
 - Intubation may be necessary if impending respiratory failure, but aggressive hyperventilation to hypocarbia (pCO₂ <22 mmHg) has been associated with poor outcome and is not recommended.
 - Head CT scan should be obtained to rule out other possible intracerebral causes of neurologic deterioration AFTER treatment for cerebral injury has been started (**DO NOT DELAY TREATMENT TO GET THE HEAD CT!**); changes that will be detectable on head CT often occur late in the development of cerebral injury.

Monitoring and Other Recommendations

- Height and weight are both needed in order to calculate body surface area.
- Vital Signs Q1 hour for at least first 12 hours, then Q2 hours; HR monitor and pulse oximetry.
- Neuro checks/GCS score Q1 hour.
- Strict monitoring of Intake and Output is essential (Strict I/O).
- Check blood sugar (bedside glucose) every hour while on insulin infusion.
- NPO until acidosis is resolved in order to strictly monitor total intake, avoid excessive fluid administration, and decrease the risk of aspiration should consciousness be altered.
- BMP, Magnesium, Phosphorus, beta-hydroxybutyrate initially and q4-6 hours.
- I-Stat-7 Q2 hours until pH >7.25, then q4-6 hours.
- After first 12-18 hrs of DKA treatment, check urine ketones every void until negative twice in a row.
- Mannitol 1 gm/kg or 3% Saline at bedside (and ready to be given for acute change in mental status).
- Two peripheral IV catheters should be placed for fluid and insulin administration and for blood sampling.
- A flow sheet with lab results and clinical response can be a useful guide to therapy.
- Initial labs should include: Hemoglobin A1c, BMP, Mg, Phos, Beta-hydroxybutyrate, diabetes autoantibodies (islet cell antibody, insulin antibody, glutamic acid decarboxylase (GAD-65) antibody, ZnT8 antibody), celiac panel (total IgA and TTG), TSH and free T4 (if patient is very ill, the TSH and free T4 should wait until child is more stable to avoid abnormalities of "sick euthyroid syndrome"), insulin and c-peptide (do not measure insulin if patient has already been started on insulin), CBC, cultures if indicated (fever, etc; **leukocytosis is a common finding in DKA and does not alone indicate infection).
- Call 907-563-2662, ask to speak with pediatric endocrinologist on call any time of the day or night.



Prevention of DKA is key

- In patients with newly diagnosed diabetes, education of the public and health care providers to recognize early signs of diabetes can lead to diagnosis of type 1 diabetes before DKA develops.
- In patients with known diabetes, sick day reeducation with diabetes educator is important to discuss factors that led to DKA in this situation and how to avoid it in the future (ie urine ketone monitoring with illness or high blood glucose, avoiding insulin omission, appropriate use of insulin pump and trouble-shooting with pump problems).
- Appropriately manage sick days and ketones at home or in the hospital to prevent progression to DKA (see below).

Sick day management guide when a patient has ketones based on amount of ketones and the blood sugar			
Urine Ketones	Blood Glucose		
	<100	100-200	Over 200
Neg/Trace/Small	Push sugar-containing fluids	Push fluids (sugar and sugar-free)	Push sugar free fluids; continue to check ketones while ill; give correction dose if BG>250-300
Moderate	Push ~30-60g carBG to get BG over 200, consider mini-dose glucagon (see below)	Push ~30g carbs to get BG over 200 (recheck BG q 30-60min)	Give extra NovoLog (10% of total daily dose or 0.1 units/kg or double the BG correction dose); check BG and ketones in 2 hrs; repeat Novolog dose in 2 hrs if ketones do not decrease
Large, but well patient (not continuously vomiting, no difficulty breathing, awake)	Push fluids (30-60g carBG), consider mini-dose glucagon	Push ~30 g carbs to get BG over 180-200 (recheck BG q30-60 min)	Give extra Novolog (20% of total daily insulin dose or double the BG correction); check BG and ket in 2 hrs ; repeat Novo-Log dose in 2 hours if ketones do not decrease
Large, and sick pt (cont vomiting, difficulty breathing, lethargy)	Bring to ER, consider mini-dose glucagon on the way	Bring to ER Cont to push fluids if possible on the way	Bring to ER (can give an extra insulin dose while on their way to the ER if they live far away)

Total daily insulin dose approx. = 2 x Lantus/Tresiba dose

Double the correction: calculate what insulin dose would be based on their BG correction factor and give 2 x that dose

References:

Kuppermann et al, N Engl J Med. 2018; 378(24):2275-87
 Wolford et al, Ped Diab. 2018;19 (Suppl 27):155-77 Wolford et al, Diab Care. 2006;29(5):1150-59
 White NH, Washington Univ in St Louis; 1989 (rev 2003)

Appendix 2: Fluid maintenance and replacement volumes based on body weight and an assumption of 10% dehydration

Body weight (kg)	Maintenance (mL/24 h)	DKA: give maintenance +5% of body weight/24 h	
		mL/24 h	mL/h
4	325	530	22
5	405	650	27
6	485	790	33
7	570	920	38
8	640	1040	43
9	710	1160	48
10	780	1280	53
11	840	1390	58
12	890	1490	62
13	940	1590	66
14	990	1690	70
15	1030	1780	74
16	1070	1870	78
17	1120	1970	82
18	1150	2050	85
19	1190	2140	89
20	1230	2230	93
22	1300	2400	100
24	1360	2560	107
26	1430	2730	114
28	1490	2890	120
30	1560	3060	128
32	1620	3220	134
34	1680	3360	140
36	1730	3460	144
38	1790	3580	149
40	1850	3700	154
45	1980	3960	165
50	2100	4200	175
55	2210	4420	184
60	2320	4640	193
65	2410	4820	201
70	2500	5000	208
75	2590	5180	216
80	2690	5380	224

Appendix 1

Pathophysiology of Diabetic Ketoacidosis

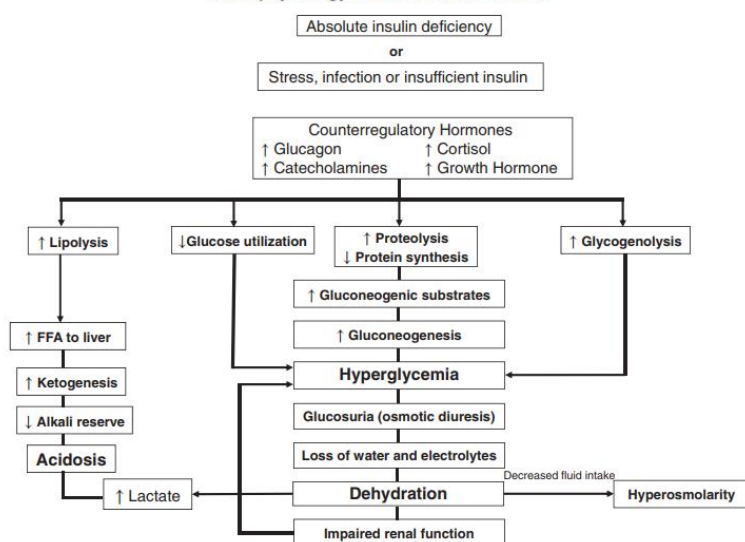


FIGURE 1 Pathophysiology of diabetic ketoacidosis. Copyright© 2006 American Diabetes Association. From diabetes care, Vol. 29, 2006:1150-1159. Reprinted with permission of The American Diabetes Association



Hypoglycemia

If low BG and cause unknown, **GET CRITICAL SAMPLE PRIOR TO TREATMENT!**

Labs tested during hypoglycemia are critical to identifying cause and preventing recurrence.

- Serum critical sample:
 - BMP, insulin, C-peptide, Cortisol, GH
 - Free fatty acids, β -hydroxybutyrate, acetoacetate
 - Lactate, ammonia, Serum (sulfonyleureas), total and free carnitine
- At any time:
 - Acylcarnitine profile, serum amino acids
- Urine – as quickly after hypoglycemia as possible
 - Urine ketones
 - Urine organic acids
- If suspect hyperinsulinism, perform glucagon stim test (administer 0.03 mg/kg, max 1 mg) and measure lab glucose at 0, 15, and 30 minutes.

Acute Treatment: obtain critical sample and correct hypoglycemia within 10-15 minutes.

- Glucose gel per eCHAM guidelines.
- IV or IO dextrose bolus (D10% or D25%) followed by continuous infusion of dextrose IVF and frequent blood sugar checks (Q1-2h or more frequently initially)
 - D25%: 2-4 mL/kg; D10%: 5-10 mL/kg. (For neonates, give D10% 2 mL/kg.)
- If insulin-mediated, treat with glucagon 0.03 mg/kg up to 1 mg OR for patients < 20 kg give 0.5 mg IM and for patients > 20 kg give 1 mg IM.

Adrenal Insufficiency

Critical Sample before treatment: cortisol

- If suspect primary adrenal insufficiency, include ACTH, renin, aldosterone.
- If suspect CAH, include 17OH-progesterone or CAH-6b panel (send-outs).
- Also check BMP, CBC, U/A.

Treat while awaiting results.

- Normal Saline Bolus 20 mL/kg.
- Hydrocortisone 50-100 mg/m² IV bolus (lower end of range if less sick, higher end of range if more sick) followed by 50-65 mg/m²/day, divided q6h
 - If no IV access, SoluCortef IM or Dexamethasone IM
 - SoluCortef 50-65 mg/m² IV/IM – short acting
 - ◆ At this dose, adequate mineralocorticoid activity to replace moderate doses of oral fludrocortisone (80 mg HC = 0.2 mg fludrocortisone)
 - Dexamethasone 1.5-2 mg/m² IV/IM—long acting
 - ◆ No mineralocorticoid activity
 - ◆ Does not cross react with cortisol in lab assay so can use Dex if unable to get cortisol before treatment and then do Cortrosyn stimulation test after treatment
 - SoluMedrol 10-15 mg/m² IV/IM—intermediate acting
 - ◆ No mineralocorticoid activity
- For milder presentation, ex. known diagnosis with flu symptoms, but hemodynamically stable, can skip load, use 50-65/m²/day, divided every 6 hours.

Known adrenal insufficiency (ie CAH or hypopituitarism) and adrenal crisis

- Loading dose hydrocortisone IV or IM 50 mg/m² x1 then 50 mg/m²/day divided q6h
- If BSA unknown or for more rapid dosing, can use age:
 - <3 y.o.: 25 mg IM/IV bolus followed by 25-30mg/day divided q6h
 - 3-12 y.o.: 50 mg IM/IV bolus followed by 50-60mg/day divided q6h
 - >12 y.o.: 100 mg IM/IV bolus followed by 100mg/day divided q6h
- If severely ill or unable to take PO due to continued emesis, but no IV, can give SoluCortef 30-50 mg/m² IM (better for CAH because has fludrocortisone activity at high doses, but only lasts about 6 hours), or Dexamethasone 1.5-2 mg/m² IM.
- If less ill (ie, not in crisis but needs stress doses because of fever or vomiting), can give double or triple oral dose (usually double if fever, triple if vomiting or more sick).
- Normal saline bolus 20 mL/kg/ IV then D5NS or D10NS (depending on blood sugar) at 1.5 x maintenance.
- Monitor electrolytes, BP.
- For anesthesia: begin triple dose the night before the procedure, then 30-50 mg/m² IV or IM on call to the OR prior to anesthesia; and continue stress dosing for 24 hours after procedure.

**Hypercalcemia**

Critical sample: Ca, Phos, iPTH

• Other labs: 25-OH-D, 1,25 (OH)₂ D, urine Ca/Cr, CBC

Treatment for severe hypercalcemia (Ca >14): same initial treatment independent of the cause

- Saline diuresis: NS bolus followed by 2.5-3 L/m²/day
 - Saline diuresis generally works rapidly, but only as long as it is continued, and usually does not normalize calcium.
- Consider calcitonin 4 units/kg IV/IM/SQ q12h
 - Tachyphylaxis common (often 2nd-line therapy)
 - Common side effects: nausea, vomiting, flushing
- May need bisphosphonates.
- Discontinue any medications known to cause or worsen hypercalcemia.
- Avoid immobilization.

If mild/moderate (Ca <13-14) and no contraindication to PO: 2-3 L/day water plus PO salt to promote Ca excretion.

Therapy specific for underlying disorder

- Hyperparathyroidism → parathyroidectomy
- Glucocorticoids → effective if associated with hematologic malignancy or diseases with increased 1,25 (OH)₂ vitamin D.

Hypocalcemia

Critical sample: Calcium, Phosphorus, Magnesium, intact PTH before treatment.

- Ca and PTH need to be simultaneous, and PTH *MUST* be obtained while Ca is low.
- Collect urine Ca/Cr while Ca low if possible.
- If there is reason to suspect low albumin, check ionized calcium or calculate corrected calcium using albumin
 - Corr Ca = measured calcium + [0.8 (4-albumin)]
- Other useful labs: CMP (kidney, liver, bone function), 25-OH-D, 1,25 (OH)₂ D, urine Ca/Cr.

Treatment if Symptomatic - tetany, seizure, apnea, heart failure, laryngospasm.

- *Slow* (<1 ml/min) IV infusion 10% Ca gluconate 1 mL/kg
 - 100 mg/ml Ca Gluconate = 9 mg/mL elemental Ca
 - Cardiac monitoring (bradycardia, shortened QT_c); close attention to infusion site if not central IV (risk of tissue necrosis if peripheral IV infiltration)
- If Mg low, replace with 0.1-0.2 mL/kg 50% Mg Sulfate

If not acutely symptomatic, can do more comprehensive evaluation first to determine cause and appropriate oral treatment.



Thyroid Storm (Thyrotoxic Crisis)

Score ≥ 45 → highly suggestive of thyroid storm; 25–44 → thyroid storm; and < 25 → thyroid storm unlikely.

Thermoregulatory dysfunction	Score
Temperature (C)	
37-37.7	5
37.7-38.3	10
38.3-38.8	15
38.8-39.3	20
39.4-39.9	25
40	30
Central nervous system effects	
Mild - agitation	10
Moderate - delirium, psychosis, extreme lethargy	20
Severe - seizure, coma	30
Gastrointestinal/hepatic dysfunction	
Moderate - diarrhea, nausea/vomiting, abdominal pain	10
Severe - unexplained jaundice	20
Cardiovascular dysfunction	
Tachycardia (heart rate/min)	
99-109	5
110-119	10
120-129	15
130-139	20
≥ 140	25
Congestive heart failure	
Mild - pedal edema	5
Moderate - bibasilar rales	10
Severe - pulmonary edema	15
Atrial fibrillation	10
Precipitant history	
Negative	0
Positive	10

Critical Sample: **Free T4 and TSH**, run STAT

- Other labs: TBII, TSI, TPO antibodies
- Useful to measure: CMP (glucose, liver function), CBC (acute infection?), urine pregnancy test

Acute Treatment

- Oxygen
- Adrenergic blockade (if not in CHF) - goal HR < 100
 - Propranolol (PO 2 mg/kg/day div q6-8h or IV 0.01 mg/kg/dose (max 5mg) over 10-15 min).
 - If contraindication to propranolol (ie asthma), can use atenolol (cardioselective) with caution.
- IV fluids (cooled if necessary)
- Cooling blankets
- Antipyretics should be avoided when possible.
- Sedation – phenobarbital stimulated thyroid hormone clearance.
- Hemodynamic support/treat CHF if present.

Longer term treatment:

- Block thyroid hormone synthesis and release
 - Thionamides – block thyroid hormone synthesis
 - ◆ PTU (propylthiouracil): black box warning in peds
 - ◆ Methimazole : ~0.8 mg/kg up to 60 mg loading, then ~0.4 mg/kg up to 30 mg every 6 hours (5, 10 mg tabs)
 - High Dose Iodine – blocks release of already formed thyroid hormone
 - ◆ Should be delayed until 1-2 hours after thionamide, to prevent transient increase in thyroid hormone levels
 - ◆ SSKI (Lugol solution) 5 drops every 6-12 hours
 - ◆ Use will necessitate delay in radioactive iodine treatment if that is desired
- Block peripheral conversion of T4 to T3
 - Corticosteroids (stress dose HC or equivalent)
 - Propranolol
 - Iodinated contrast agents

Identify and treat precipitating event causing severe decompensation.

- Infection, pregnancy, emotional stress, DKA, pulmonary embolism, CVA, trauma, hypoglycemia.

Assess for underlying cause

- Grave's disease, functioning thyroid nodule ("hot nodule").



Please remember that this is just a list of lab tests often recommend prior to seeing patients. These are not physician orders. However, they are recommended prior to specialty appointments.

Congenital Adrenal Hyperplasia (CAH): meds are often adjusted based on labs/growth/bone age

- 17-OH-P (17-OH hydroxyprogesterone) often every 3-6 months Infants/toddlers often ordered q 1-3 months. (Goal: ~300-900)
- Androstenedione: Often every 3-6 months. Infants/toddlers often ordered every 1-3 months. (Goal: w/in normal range)
- Renin Activity: Often every 3-6 months. Renin hard to obtain in villages as must be sent frozen. (Goal: w/in normal range)
- Bone age after 2-3 years of age, then annually
- Accurate height and weight measurements each visit
- F/u in endo clinic every 3 to 6 months

Newborn with + FH of CAH but no ambiguous genitalia (ie no physical s/s of CAH):

- Newborn screen after 24hrs of life (in all infants).
- Serum 17OHP around day 3-4 of life (17OHP levels are normally high during the first 2-3 days after birth but by the 3rd day, levels in healthy infants fall and levels in affected infants rise to diagnostic levels).
- Alert state newborn screening program of patient at risk of CAH.
- Measure serum electrolytes prior to hospital discharge and at 5 and 10 days of age (hyponatremia and hyperkalemia are usually not present before 7 days of age and salt-losing crisis will typically occur in the second week of life).
- After newborn is sent home, parents should be cautioned to watch for signs of salt-losing crisis including vomiting, diarrhea, lethargy, dehydration, decreased PO intake.
- If positive newborn screen or elevated 17OHP, patient should be seen immediately and consult endocrinologist on call.

Congenital Hypothyroid/Hashimoto Thyroiditis/Goiter: meds are usually adjusted based on labs

General Information

- When a med dosage change is made, labs are usually repeated in 4-6 weeks and then again before the next clinic visit.
- Under certain circumstances, a thyroid ultrasound is sometimes ordered – not routine.
- Growth records on all children with any thyroid condition should be plotted.
- Often other thyroid labs are done as part of initial workup, but depends on what the presumptive diagnosis is. (TSH, Antithyroid peroxidase AB, etc.)

Specific Labs – Goal: normal Free T4 and TSH (infants should have a free T4 at least once).

Congenital Hypothyroidism

- FT4 & TSH 2weeks after dose started.
- 0-6 Months: FT4 & TSH every month
- 6-12 Months: FT4 & TSH every 2 months
- 1-3 Years: FT4 & TSH every 3 months

Acquired Hypothyroidism

- FT4 & TSH 4-6 weeks after starting med or after dose change
- FT4 & TSH every 6 months routinely

Central Hypothyroidism (ie, hypopituitarism)

- Free T4 every 4-6 months routinely

Hypopituitarism/Septooptic dysplasia/Optic nerve hypoplasia: (any combination of deficiencies of GH, TSH, ACTH, LH/FSH, ADH)

- Labs to follow depend on deficiency
- If panhypopituitarism
 - IGF-1 every 6-12 months if on GH (see below).
 - Free T4 every 4-6 months (see above).
 - May check BMP if concerns about inadequate adrenal hormone replacement.
 - Na levels if DI depend on thirst—if intact thirst, Na level every 3-4 months; if non-intact thirst, may need Na every 2-4 weeks.
 - LH/FSH pediatric, estradiol ultrasensitive or total testosterone at approximately age 12.
 - Accurate height and weight plotted on growth chart.

Work-up of Short Stature

- X-ray: bone age XR left hand/wrist
- bloodwork: TSH, free T4, TTG IgA, IgA, CMP, CBC, IGF-1, IGFBP-3, ESR. Also do chromosome microarray if a girl.
- urine: urinalysis (looking for RTA)



Children on Growth Hormone Injections: (GH deficiency/Turners/Noonan's/Prader-Willi Syn/SGA/Panhypopituitarism/CRF)

- Free T4 and IGF-1
 - Usually obtained q 6-12 months. Other labs including these may be done for initial diagnosis which may include GH stimulation tests.
 - GH dose will be adjusted based on IGF-1, growth pattern and weight.
- Bone age: includes left hand and wrist – please have radiology send via PACS to ANMC.
 - Initially and approximately every year.
- Accurate height and weight
 - Crucial to have correct plotting on growth record. (Lengths are done on infants and toddlers less than 2 years of age or if not able to stand well; plotted on 0-24mo WHO growth chart; heights are done when the child is over age 2 and plotted on the CDC 2-20 growth chart.)

Insulin Resistance/Obesity: goal is to prevent these children from becoming diabetic; not usually managed in endocrine clinic unless there is an endocrine condition (diabetes, prediabetes, PCOS, dyslipidemia); hypertension is managed by PCP or nephrology.

** Refer to publications in *Pediatrics*.

- Screening fasting plasma glucose, HbA1c every 2 yrs. OGTT if needed (Fasting Insulin **not** routine).
 - Fasting plasma glucose <100 is normal; 100-125 = prediabetes, >125 = diabetes.
 - OGTT-fasting plasma glucose, then drink 1.75 g/kg (max 75 g) of Glucola (within 10-15 min) and repeat plasma glucose in 2 hours.
 - ◆ Fasting 101-125 = impaired fasting glucose; over 125 = diabetes
 - ◆ 2 hour 141-199 = impaired glucose tolerance; over 199 = diabetes
 - HbA1c: 5.7% to 6.4% = prediabetes; >6.4%, likely diabetes but not necessarily diagnostic in children
- Fasting lipids initially and then per recommendation, usually every 2 years
 - If abnormal, repeat after 2 weeks but before 3 months (see below).
 - If still abnormal, dietitian referral.
- Liver function tests-AST/ALT every 2 years.
- Growth records with accurate height & weight plotted-also calculate and plot BMI.
 - Only obtain TSH & Free T4 initially if patient is showing growth deceleration.
- All patients should have initial evaluation and then monthly appointments with a dietitian whenever possible.
 - Daily activity, one hour/day with lifestyle change.
 - The more they see their primary provider and dietician, the more likely they are to comply with changes in dietary and activity levels.

Type 2 Diabetes

- At diagnosis: HgbA1C. Other labs depend on the individual case.
 - Criteria for dx of diabetes (per ADA):
 - ◆ FPG > 125 (no caloric intake for 8 hrs)
 - ◆ OR 2-hr glucose >199 during an OGTT
 - ◆ OR HbA1c >6.4% (**controversial for dx in children)
 - ◆ **the above 3 criteria require repeat testing in the absence of unequivocal hyperglycemia)
 - ◆ OR classic symptoms of hyperglycemia or hyperglycemic crisis and a random plasma glucose >199
- HbA1c every 3 months: Goal A1c <7%
- Fasting lipid panel soon after diagnosis and every 5 years if normal.
 - If abnormal, repeat after 2 weeks but before 3 months (see below).
 - If still abnormal, dietitian referral.
- Random urine microalbumin/creatinine soon after diagnosis and annually.
 - If abnormal, repeat with first morning urine MA/Cr or overnight collection; if still abnormal, referral to nephrology.
- Eye exam soon after diagnosis and annually.
- Dental exam annually.
- Dietician visit q 3-6 months.
- RN-CDE for education.



Type 1 Diabetes Mellitus

New Diagnosis: HbA1c, BMP, c-peptide, insulin level, other labs depending on patient and presentation (for diagnostic criteria, see above; type 1 distinguished from type 2 based on presentation, physical exam, sometimes on labs such as c-peptide and diabetes antibodies)

- Hemoglobin A1C: Every 3 months (lifetime standard of care for DM)
 - This lab helps determine the overall status of blood glucose readings over a 3 month period and gives an average of all readings.
 - A1c goal is generally 7%; infants and toddlers, tolerate A1c goal of ~8%.
- Fasting Lipid Panel
 - Initial check soon after diagnosis, once blood sugars stabilized, if over 2 years old.
 - Repeat fasting lipid panel every 5 years if initial is normal (starting at 9 years old).
 - If abnormal, fasting lipid panel should be repeated at least 2 weeks later but less than 3 months later to confirm.
 - If confirmed abnormal, referral to dietician for lifestyle/diet modification.
- Thyroid and Thyroid Auto Antibodies
 - Obtain Free T4 & TSH at diagnosis and annually.
 - Antibodies not routine, but if done it includes thyroid peroxidase AB.
- Celiac screening
 - TTG IgA and total serum IgA soon after diagnosis.
 - Annually for the first 5 years, more frequent if symptoms.
- Eye exam
 - Initial eye exam soon after diagnosis to detect cataracts or major refractive errors
 - Annual eye exam should start at:
 - ◆ 9 years if 5-year duration diabetes.
 - ◆ 11 years if 2-year duration diabetes.
 - ◆ After 2 years duration if diabetes diagnosed in an adolescent.
- Urine microalbumin/creatinine screen
 - Spot urine microalbumin/creatinine annually after age 10 years.
 - If abnormal, repeat with first morning void or an overnight urine collection.
- Flu Vaccine recommended yearly.
- Dental evaluation recommended yearly.
- RN CDE referral for all aspects of Diabetes education. Work closely with CDE if patient is on Lantus + rapid acting insulin intensive regimen-ideally.
- Dietitian CDE for dietary/CHO counting/activity/insulin (learning to count carbs).
- All children should see Pediatric Endocrinologist every 3 months (may alternate depending on needs of family/primary provider).
 - Families need to know when to do Urine Ketones: if BS over 300 or if ill.

Table 9-1. Acceptable, Borderline-High, and High Plasma Lipid, Lipoprotein and Apolipoprotein Concentrations (mg/dL) For Children and Adolescents*

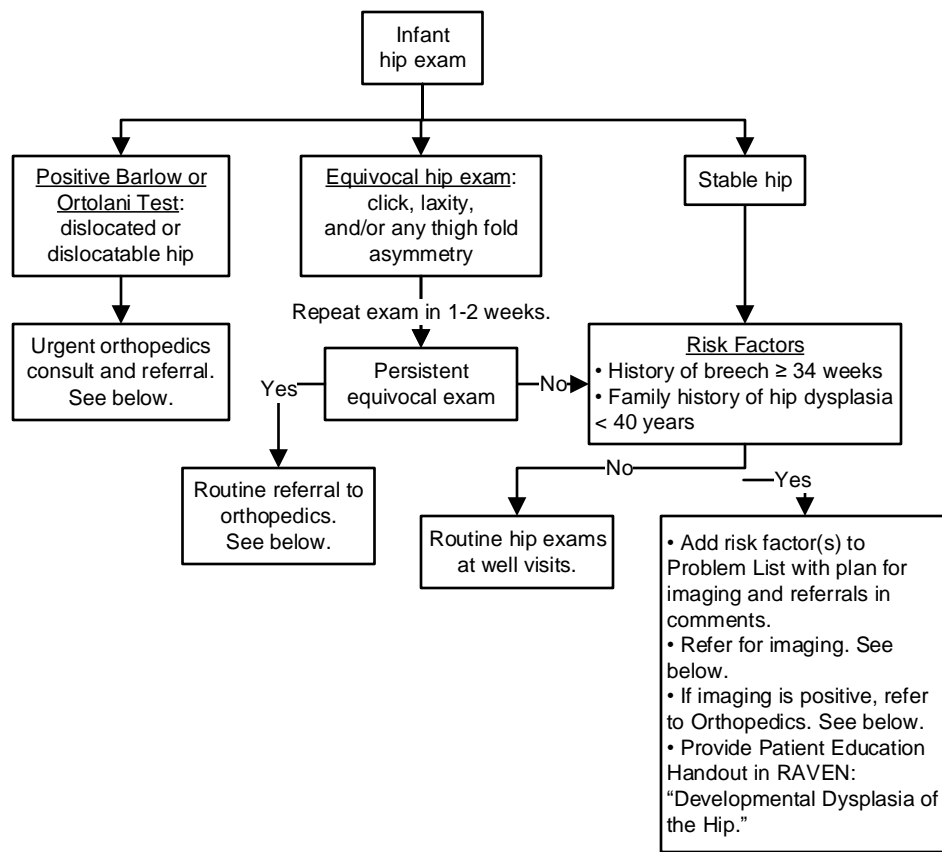
NOTE: Values given are in mg/dL; to convert to SI units, divide the results for TC, LDL-C, HDL-C and non-HDL-C by 38.6; for TG, divide by 88.6.

Category	Acceptable	Borderline	High+
TC	< 170	170-199	≥ 200
LDL-C	< 110	110-129	≥ 130
Non-HDL-C	< 120	120-144	≥ 145
ApoB	< 90	90-109	≥ 110
TG			
0-9 years	< 75	75-99	≥ 100
10-19 years	< 90	90-129	≥ 130

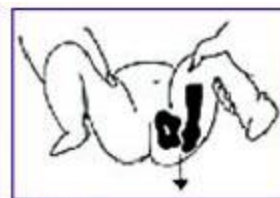
Category	Acceptable	Borderline	Low*
HDL-C	> 45	40-45	< 40
ApoA-I	> 120	115-120	< 115

*Values for plasma lipid and lipoprotein levels are from the National Cholesterol Education Program (NCEP) Expert Panel on Cholesterol Levels in Children. Non-HDL-C values from the Bogalusa Heart Study are equivalent to the NCEP Pediatric Panel cut points for LDL-C. Values for plasma apoB and apoA-I are from the National Health and Nutrition Examination Survey III.

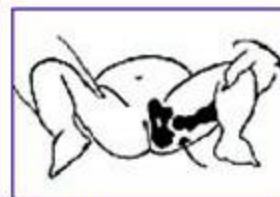
*The cut points for high and borderline-high represent approximately the 95th and 75th percentiles, respectively. Low cut points for HDL-C and apoA-I represent approximately the 10th percentile.



Barlow Test



Ortolani Test



The Barlow test is an attempt to dislocate the hip. If positive, you will feel the hip sublux or dislocate. The Ortolani test is the maneuver to reduce a dislocated hip. If positive, you will feel a clunk.

Orthopedics Consults & Referrals

1. Consultation:

- Beneficiary patients: contact ANMC orthopedic surgeon on call at (907) 563-2662 (*97) or send message through Tiger Connect.
- Non-beneficiary patients: contact Ken Thomas, MD at Anchorage Fracture & Orthopedics at (907) 563-3145.

2. Referral:

- Place an order for "Refer to Orthopedics External" with brief history. Note the orthopedist who was consulted. Indicate where the referral should be sent.
- Send a RAVEN Communication to Chronic Peds Case Manager Pool about the referral and level of importance.

Imaging

Patient must have either ultrasound or X-ray, as below.

1. Hip ultrasound: 6 weeks to 4 months of age.

- Performed at Alaska Regional Hospital.
- Place order for "Refer to Pediatric Clinic External (MRI / EEG / VFSS / Hip US)" with brief history.
- If patient is a beneficiary, request follow-up appointment at Southcentral Foundation Team B.
- If patient is not a beneficiary, request follow-up appointment with a pediatric provider in Bethel.
- Send a RAVEN Communication to Chronic Peds Case Manager Pool about the referral and level of importance.

2. X-ray, AP pelvis: over 4 months of age. (Note: in premature infants, ossification of femoral heads is delayed. May use corrected gestational age of 4 months or later.)

- Performed at YKHC.
- Place an order for "XR Pelvis (Pelvis AP only)" and put in comments "AP view with hips in neutral position to rule-out developmental dysplasia of the hip."
- Send a RAVEN Communication to Chronic Peds Case Manager Pool stating the order was placed and requesting an appointment for this with a pediatric provider in Bethel.



POLICY: To obtain sputum samples safely and effectively in pediatric patients

PROCEDURE: Induced Sputum Collection in Pediatric Patients

1. Premedicate with albuterol 2.5 mg/3mL (0.083%) solution – 3 mL via nebulizer to induce bronchodilation and better facilitate delivery of hypertonic saline. This can help prevent the development of bronchospasm during delivery of hypertonic saline. An MDI with a mask and spacer is an acceptable substitution.
2. Give 5 mL of 3% hypertonic saline solution via nebulizer over period of at least 10 minutes. Prolonged administration has been shown to yield better samples.
3. If patient has copious nasal secretions, consider nasal suction with olive tip.
4. Obtain mucus specimen trap with suction catheter appropriate for patient size. Measure from tip of nose to the tragus for depth of catheter insertion and obtain sample via suction of the nasopharynx. The goal is to induce a gag and then a cough. Sample is expected to be blood-tinged.

Note: This process may induce a vagal response. The patient should be sitting up with feet supported or lying down, NOT standing. If vasovagal syncope does occur, immediately place the patient supine with the legs elevated.

5. Place specimen in appropriate collection container for desired test. Precise labeling is essential to prevent specimen rejection from state lab.
 - a. For rule-out pulmonary tuberculosis, collect 3 induced sputum samples at least 8 hours apart – one must be first morning sample. Send for Acid Fast Bacilli Smear and Culture. Sample must be in an AFB container (conical with orange top), with a minimum volume of 5 mL; add sterile water to dilute if necessary. Two samples should also be sent for Xpert MTB-RIF. These samples should be 3-5 mL of mucous in a sterile specimen cup. Do not dilute, or "saline wash" nares during suction for this specimen. AFB and Xpert may be obtained at the same time; if quantity not sufficient for both tests, prioritize the AFB.
 - b. Standard sputum cultures do not have a minimum volume and can be placed in a sterile specimen cup.
 - c. Label must contain full user name of collector and date and time of the collection. **This should be written below the barcode, NOT beside it.**
 - d. Collect specimen in RAVEN. Confirm the correct accession number and deselect any additional (future) accession numbers. Ensure the collector ID, date, and time entered into RAVEN are an exact match to the written label.

***Contraindications to above procedure:** oxygen saturation of <92% despite supplemental oxygen therapy, inability to protect the airway, severe bronchospasm, or designation as inappropriate by the clinician for another reason (eg., midface trauma). After exclusion or resolution of these conditions, sputum induction can be considered.

Note: This procedure can also be used for patients who are able to follow instructions but do not have a productive cough. In these cases, suction may or may not be necessary.



Documentation Requirements for Pediatric Nutritional Supplements

The following resource is from the Medicaid Certificate of Medical Necessity.

Medicaid, Medicare, and other insurers have specific requirements for medical provider documentation. If those requirements are not met, nutritional supplements will not be covered.

Documentation Requirements for the Prescription of Nutritional Supplements:

The following objective documentation is required to show the medical necessity of the orthotic services being prescribed.

This information needs to appear in the body of the medical provider's chart notes:

- Diagnosis of the patient.
- Product being prescribed and why it is needed. (Example: Pediasure)
- Goal or target weight for the patient.
- Total daily caloric requirement.
- Total daily calories obtained from ingestion (oral) foods.
- Total daily calories to be obtained from nutritional supplement.

Documentation Example

Pediasure is medically necessary for this child.

Diagnosis: dysphagia (R13.10), G-tube dependence

Product: Pediasure

Medical Necessity: Patient has severe dysphagia. He is undergoing oral feeding therapy but is unable to take any degree of sufficient calories by mouth and is thus entirely dependent on a G-tube for nutrition. Pediasure will give him the nutrition he needs to survive.

Goal/target Weight: currently at target weight of XX kg (XXth percentile for age when corrected for prematurity). Target weight along this trajectory in one year will be XX kg.

Total Daily Caloric Requirement: XX calories/day (usually estimate 100-120 cal/kg/day – adjust based on growth)

Total Calories Obtained from Oral Intake: 0 calories/day

Total Daily Calories to be Obtained from Nutritional Supplement: XX calories/day



Documentation Requirements for Pediatric Orthotics

The following resource is from Northern Orthopedics, Inc.

Medicaid, Medicare, and other insurers have specific requirements for medical provider documentation. If those requirements are not met, orthotic devices will not be covered.

Documentation Requirements for the Prescription of Orthotic Devices:

The following objective documentation is required to show the medical necessity of the orthotic services being prescribed.

This information needs to appear in the body of the medical provider's chart notes:

- Diagnosis of the patient.
- Item being prescribed and why it is needed.
- How long the patient is expected to use the item.
- If this is to be custom or non-custom item. (When custom, please specify why a non-custom item will not work.)

If you are prescribing repairs/adjustments or a replacement to an existing orthosis:

- Document that the patient still requires a functioning orthosis.
- Explain why the current orthosis is no longer able to function as intended.

Please fax chart notes documenting this required information to Northern Orthopedics, Inc. Fax: (907) 561-2157.

If you have any questions about this required documentation feel free to call Northern Orthopedics, Inc. at (907) 561-1777.



Please see the [ANMC Pediatric Acute Hematogenous Septic Arthritis/Osteomyelitis Guideline](#).

- Please note: this guideline was designed at ANMC, where recommended labs, MRI, and operative management are immediately available and antibiotics can be started after these interventions.
- When evaluating a patient at YKHC with possible septic arthritis or osteomyelitis, strongly consider empiric antibiotics if there is going to be a delay of >6 hours to perform the recommended work-up (joint aspiration, surgical drainage, etc.), as noted in ANMC's guideline.
- Always discuss antibiotics with ANMC consultants and advocate for empiric usage if appropriate. Keep in mind possible delays, including weather, transport difficulties, and other emergencies. If deferring antibiotics, ensure that patient is closely monitored for development of worsening infection.
- Always feel free to consult YKHC pediatric hospitalist with any questions.