This information is current as of the date faxed and for the patient specified ONLY. Do not use this information for other patients without contacting the Poison Center at 1-800-222-1222.

UNCONSCIOUS PATIENT – TERRORIST VICTIM: Health Care Information

Several terrorist agents may cause rapid coma or unconsciousness, including **cyanides, nerve agents, organophosphates and opioids.**

Recognition and Triage: Unconscious patients may be triaged as follows:

Immediate: Seizures, fasciculations, hypoxemia, airway compromise
Delayed: Altered level of consciousness with normal vitals signs and protected airway

Personal Protective Equipment (PPE) (at the health care site): Personnel who decontaminate patients should wear splash-proof PPE (waterproof outer garment and chemical-resistant gloves) and a filtered-air respirator. Personnel treating decontaminated patients require no PPE other than universal precautions.

Decontamination (at the health care site): Sufficient decontamination includes removal of ALL clothing and jewelry and thorough washing of the skin and hair with water for 3-5 minutes. If the patient has an inadequate airway or breathing, then bag-valve mask ventilation may be performed during decontamination. Endotracheal intubation prior to decontamination is technically difficult (while wearing PPE) and is not recommended.

Diagnosis and Treatment: Patients with inadequate airways should be immediately intubated after decontamination. Rapid determination of the class of toxin may allow rapid reversal and preclude the need for intubation. All unconscious patients should be evaluated with a bedside **glucose**, given **oxygen**, and receive a trial of **naloxone (1 to 2mg IV, titrated to wakefulness)**. Patients who do not respond, but have tachycardia or evidence of acidosis, may be presumed to be victims of cyanide toxicity and treated with sodium thiosulfate 12.5 grams IV (children 400 mg/kg) over 10 to 20 minutes. Patients who have miosis, copious secretions (lacrimation, salivation, pulmonary edema, diaphoresis), and muscle fasciculations, may be presumed to be victims of organophosphates (nerve agent or pesticide) and treated with intravenous atropine 1 to 2 mg, titrated to a decrease in pulmonary secretions. This dose may be repeated q5min if a positive, but inadequate response is obtained. Contact the **Poison Center (1 800 222 1222)** for specific questions or advice on individual patients.

Patient Monitoring: Comatose patients require continuous monitoring of pulse oximetry and end-tidal carbon dioxide, heart rate, respiratory rate and blood pressure.

Disposition Criteria (when to send patient home): Patients may be considered for discharge if their toxicity has completely resolved, the agent has been identified, and they are observed for four hours to eliminate the chance of delayed toxicity (e.g., liquid nerve agent exposure or opioid with long-lasting effects that may outlast the naloxone required to reverse it).