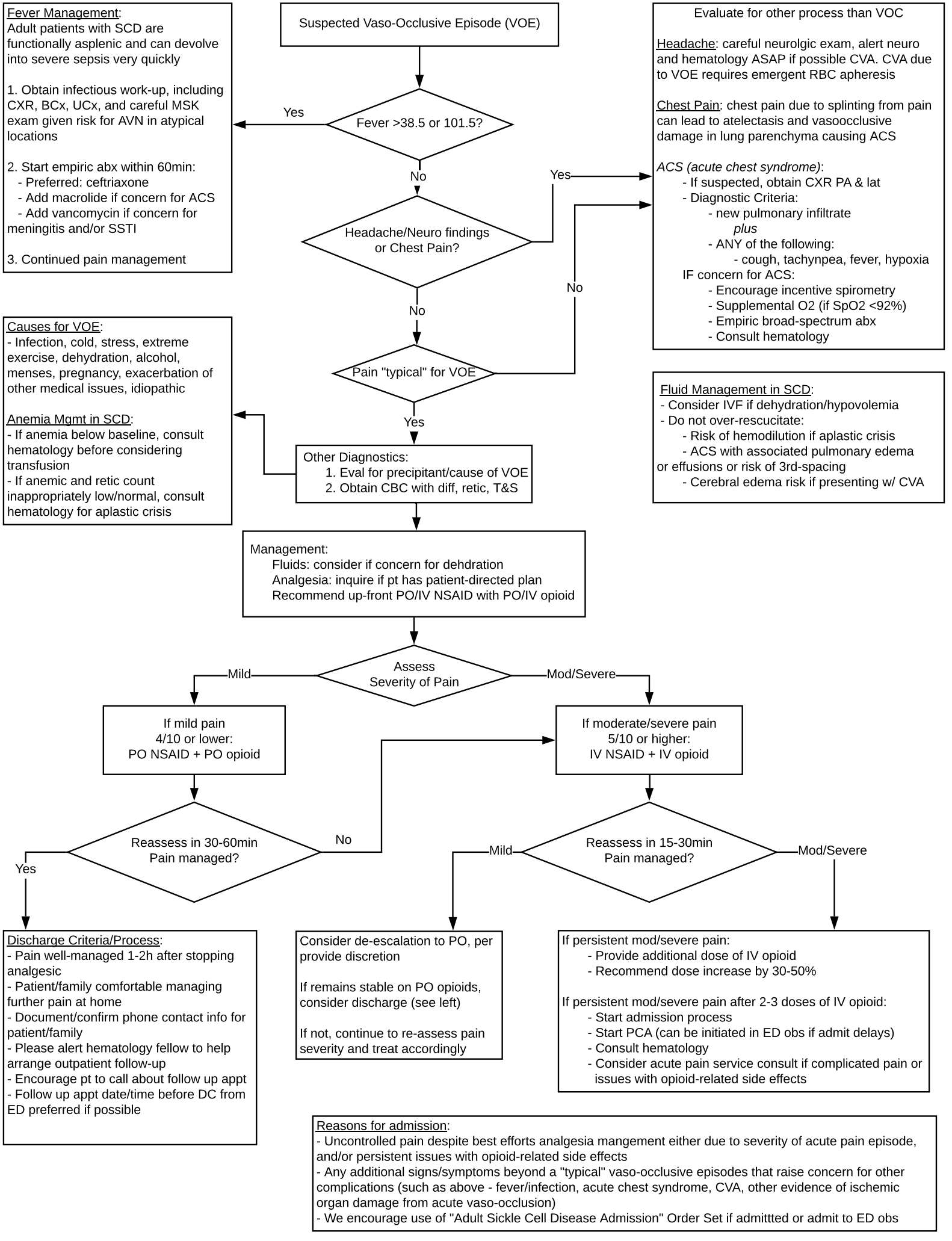
Fever Management:
Adult patients with SCD are functionally asplenic and can devolve into severe sepsis very quickly
1. Obtain infectious work-up, including CXR, BCx, UCx, and careful MSK exam given risk for AVN in atypical locations
2. Start empiric abx within 60min:
- Preferred: ceftriaxone
- Add macrolide if concern for ACS
- Add vancomycin if concern for meningitis and/or SSTI
3. Continued pain management
Suspected Vaso-Occlusive Episode (VOE)
Fever >38.5 or 101.5?
Yes
No
Headache/Neuro findings or Chest Pain?
Yes
No
Pain "typical" for VOE
No
Yes
Evaluate for other process than VOC
Headache: careful neurolgic exam, alert neuro and hematology ASAP if possible CVA. CVA due to VOE requires emergent RBC apheresis
Chest Pain: chest pain due to splinting from pain can lead to atelectasis and vasoocclusive damage in lung parenchyma causing ACS
ACS (acute chest syndrome):
- If suspected, obtain CXR PA & lat
- Diagnostic Criteria:
- new pulmonary infiltrate
plus
- ANY of the following:
- cough, tachynpea, fever, hypoxia
IF concern for ACS:
- Encourage incentive spirometry
- Supplemental O2 (if SpO2 <92%)
- Empiric broad-spectrum abx
- Consult hematology
Causes for VOE:
- Infection, cold, stress, extreme exercise, dehydration, alcohol, menses, pregnancy, exacerbation of other medical issues, idiopathic
Anemia Mgmt in SCD:
- If anemia below baseline, consult hematology before considering transfusion
- If anemic and retic count inappropriately low/normal, consult hematology for aplastic crisis
Other Diagnostics:
1. Eval for precipitant/cause of VOE
2. Obtain CBC with diff, retic, T&S
Fluid Management in SCD:
- Consider IVF if dehydration/hypovolemia
- Do not over-rescuitate:
- Risk of hemodilution if aplastic crisis
- ACS with associated pulmonary edema or effusions or risk of 3rd-spacing
- Cerebral edema risk if presenting w/ CVA
Management:
Fluids: consider if concern for dehdration
Analgesia: inquire if pt has patient-directed plan
Recommend up-front PO/IV NSAID with PO/IV opioid
Assess Severity of Pain
Mild
Mod/Severe
If mild pain 4/10 or lower: PO NSAID + PO opioid
If moderate/severe pain 5/10 or higher: IV NSAID + IV opioid
Reassess in 30-60min Pain managed?
Yes
No
Reassess in 15-30min Pain managed?
Mild
Mod/Severe
Discharge Criteria/Process:
- Pain well-managed 1-2h after stopping analgesic
- Patient/family comfortable managing further pain at home
- Document/confirm phone contact info for patient/family
- Please alert hematology fellow to help arrange outpatient follow-up
- Encourage pt to call about follow up appt
- Follow up appt date/time before DC from ED preferred if possible
Consider de-escalation to PO, per provide discretion
If remains stable on PO opioids, consider discharge (see left)
If not, continue to re-assess pain severity and treat accordingly
If persistent mod/severe pain:
- Provide additional dose of IV opioid
- Recommend dose increase by 30-50%
If persistent mod/severe pain after 2-3 doses of IV opioid:
- Start admission process
- Start PCA (can be initiated in ED obs if admit delays)
- Consult hematology
- Consider acute pain service consult if complicated pain or issues with opioid-related side effects
Reasons for admission:
- Uncontrolled pain despite best efforts analgesia mangement either due to severity of acute pain episode, and/or persistent issues with opioid-related side effects
- Any additional signs/symptoms beyond a "typical" vaso-occlusive episodes that raise concern for other complications (such as above - fever/infection, acute chest syndrome, CVA, other evidence of ischemic organ damage from acute vaso-occlusion)
- We encourage use of "Adult Sickle Cell Disease Admission" Order Set if admittted or admit to ED obs