PEDIATRIC PROTOCOL

DIABETIC EMERGENCIES

3-5 kg	6-7 kg	8-9 kg	10-11 kg	12-14 kg	15-18 kg	19-23 kg	24-29 kg	30-36 kg
6-11 lbs	13-15 lbs	18-20 lbs	22-24 lbs	26-31 lbs	33-40 lbs	42-51 lbs	53-64 lbs	66-81 lbs
18-24 in	24-26 in	26-29 in	29-33 in	33-38 in	38-43 in	43-48 in	48-52 in	52-57 in

UNIVERSAL PATIENT CARE PROTOCOL

IV / IO PROCEDURE

BLOOD GLUCOSE PROCEDURE

Glucose < 60

ORAL GLUCOSE
7.5 – 18.75 g (1/2 Tube)
Only of alert

May Repeat prn

OR

DEXTROSE 10%
5 ml / kg IV / IO max 250 ml

OR

If no IV / IO Access
GLUCAGON
< 20 kg 0.5 mg
≥ 20 kg 1 mg
IM
q 15 min prn if no response
Max 2 mg

STOP EMT may administer only with proper training

⚠ Long time to onset of actions

Glucose > 250

Check for Hypotension, Tachycardia, Poor Cap Refill

NORMAL SALINE
10 ml / kg Bolus
Over 60 minutes

Recheck Blood Glucose

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Control where indicated
APPROPRIATE transfer of care

EMT Intervention	AEMT Intervention	PARAMEDIC Intervention	Online Medical Control

DIABETIC EMERGENCIES

HYPOGLYCEMIA

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
• Known diabetic, medic alert tag • Past medical history • Medications • Recent BGL	• Altered level of consciousness • Dizziness • Irritability • Diaphoresis • Convulsions • Hunger • Confusion	• ETOH • Toxic overdose • Trauma • Seizure • Syncope • CSN disorder • Stroke • Tumor • Pre-existing condition

HYPERGLYCEMIA

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
• Known diabetic, medic alert tag • Past medical history • Medications • Recent BGL	• Altered level of Consciousness / coma • Abdominal pain • Nausea / vomiting • Dehydration • Frequent thirst and urination • General weakness malaise • Hypovolemic shock • Hyperventilation • Deep / rapid respirations	• ETOH • Toxic overdose • Trauma • Seizure • Syncope • CSN disorder • Stroke • Diabetic ketoacidosis

Fluid Resuscitate to systolic of 70 + 2 x age

KEY POINTS
Hyperglycemia: • Diabetic Ketoacidosis (DKA) is a complication of diabetes mellitus. It can occur when insulin levels become inadequate to meet the metabolic demands of the body for a prolonged amount of time (onset can be within 12 - 24 hours). Without enough insulin the blood glucose increases, and cellular glucose depletes. The body removes excess blood glucose by dumping it into the urine. Pediatric patients in DKA should be treated as hyperglycemic under the Pediatric Diabetic Emergencies Protocol. • Patients can have Hyperglycemia without having DKA. **Hypoglycemia:** • Always suspect Hypoglycemia in patients with an altered mental status. • If a blood glucose analysis is not available, a patient with altered mental status and signs and symptoms consistent with hypoglycemia should receive Dextrose, or Glucagon.   o Dextrose is used to elevate BGL but it will not maintain it. The patient will need to follow up with a meal, if not transported to a hospital. • If the patient is alert and can swallow; consider administering oral glucose, have patient drink orange juice with sugar or a sugar containing beverage, or have the patient eat a candy bar or meal. • Check the patient's BGL after the administration of Dextrose, Glucagon, or after any attempt to raise the patient's BGL. **Miscellaneous:** • If IV access is successful after Glucagon IM and the patient is still symptomatic, Dextrose should be administered. • Glucagon unlikely to be useful in malnourished patients.