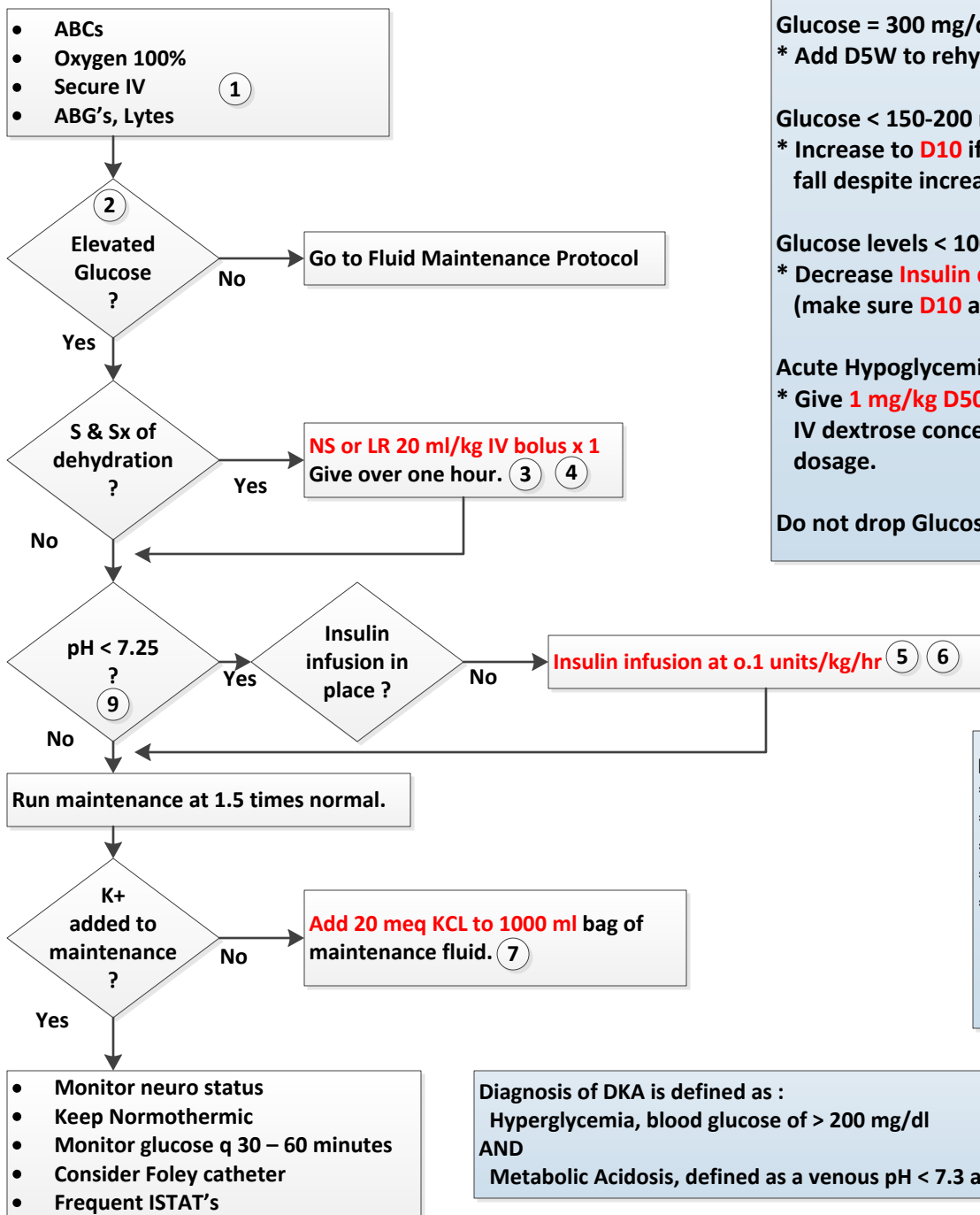


Pediatric DKA Protocol



Glucose = 300 mg/dl ?(around or close to 300)

* Add D5W to rehydrating fluid

Glucose < 150-200 mg/dl

* Increase to **D10** if Glucose levels continue to fall despite increasing the Dextrose

Glucose levels < 100 mg/dl

* Decrease **Insulin dose to 0.05 units/kg/hr** (make sure **D10** added to rehydrating solution)

Acute Hypoglycemia

* Give **1 mg/kg D50** or **1-2 ml/kg D25** and raise IV dextrose concentrations or decrease insulin dosage.

Do not drop Glucose too quickly. Goal is 100 mg/dl/hr

Indicators of Shock:

- * Altered LOC
- * Capillary refill > 3 seconds.
- * HR increased for age
- * Quality of pulses
- * Decreased urine output
 - Infant: 2ml/kg/hr
 - Child: 1-2 ml/kg/hr
 - Adolescent 0.5-1 ml/kg/hr

Diagnosis of DKA is defined as :

Hyperglycemia, blood glucose of > 200 mg/dl

AND

Metabolic Acidosis, defined as a venous pH < 7.3 and plasma bicarbonate <15 mEq/L.

1. DKA patients with low pH rarely require intubation. The pH corrects itself with treatment of DKA.
2. Glucose > 300 mmol with associated symptoms (may or may not be ketotic).
3. Only repeat fluid bolus if patient still showing signs of dehydration. Give over a 2nd hour. Give enough fluid to ensure normovolemia. Giving too much fluid, or giving it too rapidly can contribute to cerebral edema.
4. Fluid therapy can also help with glucose and pH. Insulin bolus' are not recommended.
5. **Insulin gtt: Add 100 units of Regular Insulin to 100 ml of NS. Dose of 0.1 unit/kg/hr.**
6. Glucose values are corrected long before DKA has been corrected. Insulin is required to treat DKA even though hypoglycemia may be corrected.
7. To be done even if K+ normal to high. Insulin and higher glucose will drive the K+ intracellularly.
8. Watch for signs of cerebral edema. Call receiving MD if pt develops sign of increasing cerebral edema.
9. Do not give Sodium Bicarbonate even for lower pH. Has been linked with increasing chances of Cerebral Edema. Call receiving or Medical Control if questions.