

**Location:** Emergency room

**Vitals:** BP 100/60 mm Hg; HR is 50/min, regular; RR is 10/min; Temp. 37C(98.6).

**HPI:**

28-yr old white female is brought to ER in unconscious state. Family reports that she is a very healthy female, has no medical problems, not on any medications, and did not find any empty bottles. She has no allergies. She doesn't smoke or drink alcohol. She has a boyfriend. She has never been pregnant. Her father is very healthy except borderline hypertension. Mother has diabetes. No other history is available.

**How do you approach this patient?**

**Discussion:**

Step I: Emergent management: This patient is hemodynamically unstable, so A, B, C, D is the most important component of the management of this patient.

A: Airway suction, pulse oximetry, stat, and continuous monitoring, O<sub>2</sub>

B: Endotracheal intubation is indicated in patients who cannot protect their airway or if O<sub>2</sub> saturation does not improve with O<sub>2</sub> nasal/face mask, or PaO<sub>2</sub><55, or PCO<sub>2</sub>>50 on ABG.

C: IV access; continuous cardiac monitor; place a Foley; obtain a finger stick glucose.

D: Drugs: Administer thiamine, dextrose 50%, and naloxone - all are IV bolus one time dose

**Exam:**

Respiratory (assess the breathing pattern)

**Order review:**

Suction airway, stat

Pulse oximetry, stat and continuous

Oxygen, inhalation, stat or Intubation

IV access, stat

Cardiac monitor, continuous

Finger stick glucose, stat

Thiamine, IV stat, one time

Dextrose 50%, stat, one time

Naloxone, IV stat, one time

Normal saline 0.9% NaCl, stat, continuous

ABG, stat

\*She is slightly awake with the above treatment

**Step II: Physical Examination:**

General

HEENT/Neck

Heart/CVS

Skin

Chest/Lung

Abdomen

Extremities

Neurological exam

**Results:**

On examinations she found to have pinpoint pupils. She is very drowsy.

So, she has bradycardia, hypotension, and pinpoint pupils, which are classic symptoms for narcotic overdose.

**Step III: Diagnostic Investigations:**

EKG 12 lead, stat

CBC with differential, stat

BMP, stat  
CXR, portable, PA, stat  
LFT's, stat  
UA, stat  
Urine toxicology screen, stat  
B-HCG, serum, qualitative, stat  
Blood alcohol, stat

**Initial Treatment:**

NG tube, gastric lavage, stat (which revealed pill fragments)  
Activated charcoal, oral, one time  
Naloxone, IV, stat, continuous

**Step IV:**

Decision about changing patient location  
Move patient to ICU  
NPO  
Bed rest, complete  
Urine output  
BMP, next day

\*Once the patient is better

D/C oxygen, NG tube, cardiac monitor, IV fluids, and naloxone  
Regular diet

**Step V: Educate patient and family:**

Psychiatry consult, stat (Reason: 28-year-old with suicide attempt)  
Suicide precautions  
Suicide contract  
Patient counseling  
Reassurance  
No alcohol  
No smoking  
Safe sex  
No illegal drug use  
Regular exercise  
Seat belts use

\*Start the patient on antidepressant if needed

**Final Diagnosis:**

Narcotic overdose

**Discussion:**

- Orthostatic hypotension resulting from mild peripheral vasodilation is common. However, persistent or severe hypotension should raise the suspicion of co-ingestants.
- In all patients with moderate-to-severe toxicity, it is important to obtain baseline studies, including a CBC with diff, basic metabolic panel, LFT's, ABG, and CK (Creatine kinase level).
- Positive urine drug screens are observed up to 36-48 hours postexposure.
- A 12 lead EKG should be obtained on all patients with intentional overdose, as there is always a possibility of cardiotoxic co-ingestants.
- Chest x-ray is important to rule out any pulmonary edema or aspiration especially in a patient with an unprotected airway.
- Naloxone should be given to patients with significant CNS and/or respiratory depression.
- Continuous IV infusion of naloxone is very safe in patients who were not opioid dependent. However, in patients who are opioid dependent this practice is dangerous

and may precipitate withdrawal symptoms.

- Activated charcoal should be administered to all patients with opiate intoxication following ingestion. Because of the delayed gastric emptying produced by opiate intoxication, it is effective even in patients who present late following ingestion. Orogastric lavage is indicated if the patient presents within one hour of ingestion.
- All patients with significant respiratory depression, recurrent sedation should be observed in the hospital for at least a period of 12-24 hours. Most physicians admit the patients if they require a second dose of naloxone. Patients should have continuous cardio respiratory monitoring.

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