

SECTION: PM-6

PROTOCOL TITLE: PEDIATRIC HYPOGLYCEMIA

REVISED: September 14, 2010

BLS SPECIFIC CARE: See General Pediatric Care Protocol PM-1

- Protect the patient from harm and keep the patient calm (if not unresponsive)
- Aggressively monitor and protect the airway. Administer supplemental oxygen as tolerated by the patient
- While current state of Idaho BLS regulations do not permit use of a glucometer by BLS personnel, it is acceptable to encourage a family member to obtain a glucometer reading if one is available. Document as appropriate

Simple carbohydrates/sugars:

- If the patient can hold a cup or plate without assistance, and can swallow on command, encourage the patient to consume simple carbohydrates. Attempt to document volume of food/liquid ingested. If grams of sugar are known, document this as well
- Oral Glucose
 - o If simple carbohydrates are not readily available or not feasible
 - o Only if patient retains an intact and self-maintained airway
 - o 5-45 g of glucose paste administered orally (providing the patient can swallow on command). Glucose paste may be mixed in a liquid to make it more palatable for the patient. The EMT may stop administration when the patient returns to a full state of awareness and baseline status. NOTE: a full 45 g is not likely to be needed
- Determine patient's color category on length based resuscitation tape (Broselow Tape)
- If hypoglycemia is confirmed by glucometry: (BG < 60 mg/dl with symptoms) Normal Newborn/Neonate BG = 50-110 mg/dl
 - Assess patient's ability to orally consume carbohydrates
 - If patient is able to eat or drink effectively without **any** assistance, administer oral glucose
 - Oral Glucose
 - o 5-15 g oral glucose (approximately one-half of a 24 gram tube) self administered by patient
 - o Re-assess BGL following administration
 - o Repeat if BGL remains < 60 mg/dl with symptoms

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ILS SPECIFIC CARE: *See General Pediatric Care Protocol PM-1*

ALS SPECIFIC CARE: *See General Pediatric Care Protocol PM-1*

- Dextrose:
 - If hypoglycemia present
 - 0.5 to 1 g/kg of a 25% solution D25W (D50 diluted with 1:1 NS)
Max dosage 25 g
 - Birth to 3 months; use D10 10ml/kg slow IV/IO push
 - >3 months; use D25 4 ml/kg slow IV/IO push
 - See Pediatric Hypoglycemia Protocol (PM-6)

- Glucagon IM:
 - If unable to obtain IV/IO access
 - 0.1 mg (U)/kg
 - Maximum of 1 mg (Unit)
 - Treat and release
 - Complete, Treat and Release,” checklist
 - Complete, “Refusal of Treatment and/or Transport,” form

PHYSICIAN PEARLS:

An inadequate amount of glucose for heat production, combined with profound diaphoresis, many hypoglycemic patients are at risk for hypothermia. Keep patient warm.

Patients who are consuming beta-blockers, or oral diabetic medications, that experience hypoglycemia are at a greater risk for relapse. These patients should have a responsible party with them after release.

Diabetics ages <12 and >65 tend to be more difficult to regulate.

The absence/presence of SZ during hypoglycemia should be assessed, and if present transport should be strongly encouraged.

The following checklist is reproduced as a reference from the *Ada County Emergency Medical Services, Treat and Release Check Sheet for Hypoglycemic Patients.*

All items in this section must have a YES answer:

YES NO

		1. Is there a clear reason for the hypoglycemic episode?
		2. Is the patient alert and oriented?
		3. Is the patient's repeat BG above 80 mg/dl?
		4. Has the patient's BG been well controlled prior to this episode?
		5. Is the patient able to eat a complex carbohydrate meal?
		6. Does the patient have regular, on-going physician care?
		7. Is the patient comfortable with non-transport?
		8. Is the patient/guardian willing to sign a release form?
		9. Is there another responsible person with the patient?
		10. Is the patient's temperature within normal limits? (95 - 100.4 Fahrenheit)
		11. The patient is free of the influence of alcohol or other CNS altering drugs?

ANY NO ANSWER ABOVE, REQUIRES CONTACT WITH MEDICAL CONTROL PRIOR TO RELEASE.

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