Yukon-Kuskokwim HEALTH CORPORATION

CLINICAL RESOURCE BOOK

Table of Contents, page 1

CLINICAL GUIDELINES

Arranged by system, and then alphabetical.

PROTOCOLS, REFERENCES, & RESOURCES

Arranged by department.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Consultations

Phone Numbers

ANMC: Consult: *97 or (907) 563-2662
Transfer: (907) 729-2337
PICU Cell for urgent consults: (907) 297-8809
Providence: ED for on-call specialist: (907) 212-3111
Trauma: (907) 212-2525
Alaska Regional Hospital Access Center: (844) 880-5522
VA/JBER: ED: MD consult number (907) 580-5556
Transfer: (907) 580-6420
Admissions 24/7: (907) 580-6423
Operator: (907) 552-1110
Harborview Seattle (burns): (888) 731-4791

Remember: Unless you transfer care of the patient, YOU are responsible for orders, documentation, and notifying the patient and family of the plan of care.

SRC providers do not have the luxury of paging the provider STAT to bedside. However, the SBAR case presentation and the documentation requirements listed on this protocol still apply.

Provider needs consultation about patient at YKHC

Consulting provider located in Bethel?

No

Page the appropriate provider:
1. ANMC for beneficiaries.
2. Providence Hospital or Alaska Regional Hospital for non-beneficiaries.
3. Alaska Regional for prison inmate.
4. VA or JBER (Joint Base Elmendorf/Richardson) for veterans.

Be prepared with the following information:
1. State your name, title, and department (e.g. ED physician, outpatient NP, second year resident, etc.)
2. State purpose of call (e.g. quick question, possible admission, management advice, etc.)
3. Provide name, age, DOB. If the patient is pregnant, give gravity and parity and gestational age in initial sentence. If the patient is a child, give the age in the initial sentence.
4.Use SBAR (see box).
5. Ask a **specific question** about management.
6. If patient is to be transferred, state whether you think that the patient can travel by commercial flight or will require air medevac.
7. If there is a problem getting an accepting physician for a medevac/transfer or with patient management decisions, see NOTE below.

Document consultant advice in the medical record, include date, time, first and last name of consultant and a summary of the advice given.

Yes

Patient is critically ill and the consultant is required at bedside?

No

Page the appropriate provider. Be prepared with the following information:
1. State your name, title, and department (e.g. ED physician, outpatient NP, second year resident, etc.)
2. State purpose of call, including if you want a formal consult (e.g. quick question, possible admission, management advice, etc.)
3. Name, MRN, age, DOB. If the patient is pregnant, give gravity and parity and gestational age in initial sentence. If the patient is a child, give the age in the initial sentence.
4.Use SBAR (see box).
5. Ask a **specific question** about management.

Provider requesting consult must document consultant's advice in the medical record. Include date, time, first and last name of consultant, and a summary of the advice given.

Note: consultants are encouraged to document their recommendations in a separate note or as an addendum to the provider note. If done, this note does not obviate the initial provider's documentation requirements.

At any time in the process, if the primary provider wants support at the bedside, page the consultant and ask them to come to bedside and provide support.

Clear role delineation must occur establishing who is the primary managing provider.

Yes

Page provider STAT to come to bedside and assist in management.

If on-going management is required, a decision must be made immediately and communicated to the team about who will be the primary managing provider giving orders and documenting in the medical record.

Once patient is stabilized, discussion will occur between the primary provider and the consultant regarding further documentation and ongoing management.

SBAR

Situation: a concise statement of the problem, a "one-liner"
"This is a 3 year old otherwise healthy girl with a fever…"
"My patient is a 20 year old G3P2 at 26 weeks with vaginal bleeding…"
""I'm taking care of a 21 year old male with fever and abdominal pain…"
Background: pertinent and brief information related to the situation
"The labs are normal and CXR shows no infiltrate but her pulse is elevated…"
"I have performed a sterile speculum exam and there is frank blood in the vault…"
"The patient's CT show appendicitis and the patient is vomiting all intake…"
Assessment: analysis and consideration of options, what you found/think
"I think she needs a fluid bolus but I am wondering if she also needs a UA…"
"I think this patient might have an active abruption…"
"I think this patient has appendicitis and needs to be transferred to ANMC…"
Recommendation: action requested, what you want
"I want your opinion on how much fluid and the need for a UA…"
"I want you to come in and assess this patient in person…"
"I would like to transfer this patient via medevac to ANMC…"

Note about Disagreements

If there is a disagreement regarding the management of a patient and a consensus cannot be reached, a third opinion shall be obtained. This can either be from another YKHC provider or from a provider from another facility. At any time, the Clinical Director on call can also be notified to assist.

This protocol is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 8/3/21.
Click here to see the supplemental resources for this guideline.
If comments about this protocol, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Guideline Guideline

Miscellaneous

- Guidelines are to be reviewed every two years with revisions and updates as appropriate. Updates may happen sooner as needed.
- The Guideline Coordinator will keep track of the guideline review schedule.
- Deadlines for feedback will generally be a period of two weeks.
- Lack of response by email is viewed as assent/lack of disagreement.
- At any time, anyone may send feedback on a guideline to the point person named in the gray box at the bottom of the guideline or the Guideline Coordinator. This feedback will be saved for the next guideline revision.
- Minor changes including (but not limited to) correction of typos, changes in test names, small additions, updating hyperlinks, and changes in contact information may be made and published without MSEC approval.

Topic identified for new guideline
OR
Guideline due for an update/revision

↓

A member of the clinical staff is identified to be the point person for the new guideline/revision.

↓

The point person works on the guideline in partnership with the Guideline Coordinator.

↓

When a draft has been completed, the pdf is sent to a small group of interested parties.

↓

Feedback is gathered, and the point person and Guideline Coordinator make revisions.

↓

The next draft is sent to the entire medical staff as well as other clinical groups (including pharmacy, RT, and nursing), as appropriate.

↓

Feedback is gathered, and the point person and Guideline Coordinator make revisions.

↓

Final draft is taken to MSEC for approval.

↓

Date of MSEC approval is recorded on the guideline, which is published on the wiki and in the Clinical Resource Book.

↓

Guideline Coordinator sends email to medical staff and interested parties with description of new/updated guidelines.

Wiki

- The long-term goal for the guidelines is for every guideline to have a corresponding supplemental page on the wiki.
- The guideline will be information needed to take care of a patient in the moment.
- The wiki supplement will include references, resources, historical background, past versions, and other information.

Return to Table of Contents.

Yukon-Kuskokwim HEALTH CORPORATION

Critical Care & Emergency Medicine Guidelines

Critical Care & Emergency Medicine

Pediatric Critical Care Weight-Based Guide:
https://yk-health.org/wiki/File:Pediatric_critical_care_guide.pdf

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

Symptoms suggestive of acute coronary syndrome

Perform 12 lead EKG.

Perform immediate interventions. See Box 1.

STEMI? See Box 2.

- Unclear → Consult local expert or cardiologist.
- Yes → <12 hours from symptom onset?
  - No
  - Yes → Complete Fibrinolytic Checklist. Contraindications to fibrinolytics?
    - Yes
    - No → **Initiate fibrinolytic therapy. See Box 5.**
- No → • HS-cTnT, serial EKGs, and COVID test. • Consider critical diagnoses. See Box 3.

Diagnostic ST/T changes OR Diagnostic HS-cTnT elevation or change. See Box 4.

- Unclear → Consult local expert or cardiologist.
- Yes → Diagnosis is NSTE-ACS (Non-ST elevation acute coronary syndrome)
- No → • ACS is ruled out. • Broaden differential diagnosis. • Consider a validated risk-stratification scoring tool (like **HEART** or **TIMI**). • If patient is high-risk for cardiac complications, consider consultation with cardiologist prior to discharge. • Discharge with outpatient follow-up as indicated by level of cardiac risk.

• Administer additional medications. See table on next page.
• Activate medevac if appropriate.

Box 1: Immediate Interventions

• Supplemental oxygen *prn* to maintain SpO_2 90-96%.
• Aspirin 325 mg PO (chewed).
• Nitroglycerin 0.4 mg sublingual *prn* pain (up to three times as BP permits) unless contraindicated. Contraindications: recent phosphodiesterase use, sBP <90, right ventricular infarct (consider when evidence of inferior wall ischemia).

NOTE: pain relief with nitroglycerin (or lack thereof) is not diagnostic of cardiac ischemia.

Disclaimer

• This algorithm is not intended for undifferentiated chest pain without an apparent cause.
• Acute coronary syndrome is defined as acute occlusion of a coronary artery and does not include type 2 MI/ischemia.

Consulting Cardiology

• For all STEMI patients, consult PAMC Cardiology by calling the PAMC ED at (907) 212-3433 and asking for the cardiologist on call. For beneficiary patients, ANMC Cardiology should be made aware of the transfer on a non-urgent basis.
• For NSTE-ACS patients, consult ANMC Cardiology for beneficiary patients and PAMC Cardiology for non-beneficiary patients.

Box 2: STEMI Criteria

Symptoms consistent with acute myocardial ischemia AND (A or B):

New ST-elevation at the J-point in two contiguous leads with the cut-point:
• ≥ 1 mm in all leads other than V2-V3
• V2-V3:
  - ≥ 2 mm in men ≥ 40 years old
  - ≥ 2.5 mm in men < 40 years old
  - ≥ 1.5 mm in women

Box 3: Critical Differential Diagnosis

• Aortic dissection
• Tension pneumothorax
• Pulmonary embolism
• Perforated peptic ulcer

Box 4: HS-cTnT Evaluation for Acute Cardiac Injury

The lowest reported value is "<6 ng/L," which equates to "undetectable."

FDA-approved normal values (99th percentiles in healthy subjects) are:
• Men: <22
• Women: <14
• Change in one hour (Δ1h) : <3

Cutoffs are arbitrary and do not correspond to any evidence-based positive-predictive value for ACS.

Repeat measurements rely on a rate of change; therefore, repeat measurements should be drawn at exactly one hour (or the chosen interval) after the initial.

This information is from data available February 2020. Please see wiki page for further information.

Box 5: Fibrinolytic Therapy (Tenecteplase)

Goal: administer ≤ 30 minutes from arrival.
Rapidly complete the fibrinolytic checklist and consent.

Dosing:
• <60 kg: tenecteplase 30 mg IV bolus
• ≥60 kg to <70 kg: tenecteplase 35 mg IV bolus
• ≥70 kg to <80 kg: tenecteplase 40 mg IV bolus
• ≥80 kg to <90 kg: tenecteplase 45 mg IV bolus
• ≥90 kg: tenecteplase 50 mg IV bolus

Administer concurrent aspirin, clopidogrel, and anticoagulant therapy. See tables 1 and 2.

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Approved by MSEC 12/2/20.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Megan_Young@ykhc.org and Andrew_Swartz@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

Nitroglycerin (NTG)
• Contraindications: PDE-inhibitor use, cardiogenic shock, RV infarct, sBP<90, marked tachycardia or bradycardia.
• Sublingual dosing: 0.4 mg SL Q5 minutes up to three doses
• IV dosing: start at 10-20 mcg/min, titrate Q3-4 minutes to typical range 60-100 mcg/min

Beta-Blockers
• No evidence of benefit from routine immediate beta-blocker.
• Indicated for HTN and/or ongoing ischemia refractory to NTG.
• Contraindications: cardiogenic shock, RV infarct, symptomatic asthma.
• Cautions: risk for cardiogenic shock (bradycardia, HR>110, sBP<120, age>70, increased time since STEMI onset), inferior MI, controlled asthma.

Emergency Department Medication Summary

	STEMI <12 hours	STEMI >12 hours	NSTE-ACS
Oxygen	Maintain SpO_2 90-96%	Maintain SpO_2 90-96%	Maintain SpO_2 90-96%
Nitrates (*prn* pain, HTN)	Sublingual or drip	Sublingual or drip	Sublingual or drip
Fibrinolytic	Tenecteplase See page 1, Box 5	Not indicated	Not indicated
Antiplatelet agents: Aspirin	325 mg PO (chewed)	325 mg PO (chewed)	325 mg PO (chewed)
Antiplatelet agents: $P2Y_{12}$ receptor blocker	Clopidogrel Age ≤75: 300 mg PO Age >75: 75 mg PO	Clopidogrel 600 mg PO	Consult cardiology.
Antiplatelet agents: Glycoprotein IIb/IIIa inhibitor	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.
Anticoagulation	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)
Beta-blocker	Metoprolol 5 mg IV *prn* Q5 minutes (max 15 mg)	Metoprolol 5 mg IV *prn* Q5 minutes (max 15 mg)	Metoprolol 5 mg IV *prn* Q5 minutes (max 15 mg)
Morphine	No longer routinely given; associated with increased mortality. Reserve for significant pain refractory to NTG and beta-blocker.		

At time of Dx unless contraindicated

Enoxaparin Dosing

	Age <75 years and STEMI	Age ≥75 years and STEMI	Any age and NSTE-ACS
Creatinine clearance ≥30 mL/min	30 mg IV + (1 mg/kg SC now then Q12h) Max dose 100 mg	0.75 mg/kg SC Q12h Max dose 75 mg	1 mg/kg SC now then Q12h
Creatinine clearance <30 mL/min	30 mg IV + (1 mg/kg SC now then Q24h) Max dose 100 mg	1 mg/kg SC Q24h Max dose 100 mg	1 mg/kg SC now then Q24h

NOTE: Enoxaparin and unfractionated heparin are NOT dialyzable; ESRD/dialysis patients should receive fondaparinux, which is not on the YKHC formulary. Discuss with cardiologist if appropriate.

Inpatient Medication Summary

NOTE: The following table is meant to be a basic reference as a starting point. Please consult Cardiology for full recommendations in all ACS patients.

ACE-inhibitor	Lisinopril 2.5 – 5 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Statin	Atorvastatin 80 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Beta-blocker	Metoprolol XL 25-50 mg PO Q12-24h *prn* Give unless contraindicated. Typically started prior to hospital discharge.
Clopidogrel	75 mg PO daily
Aspirin	81 mg PO daily
Enoxaparin	Dose above. Consult Cardiology for duration.

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

Fibrinolytic Checklist

INDICATIONS *(initial yes or no)*

YES	NO	
		Presentation consistent with acute coronary syndrome (coronary artery occlusion)
		AND at least one of the following: • 1 mm J-point elevation in two contiguous leads (other than V_2-V_3) • In leads V2-V3 Men ≥ 40 years: ≥ 2 mm J-point elevation Men <40: ≥ 2.5 mm J-point elevation Women: ≥ 1.5 mm J-point elevation

ABSOLUTE CONTRAINDICATIONS *(initial yes or no)*

YES	NO	
		History of any intracranial hemorrhage
		History of prior ischemic stroke, significant closed head injury or facial trauma, or intracranial or spinal surgery in the previous three months
		Presence of a cerebral vascular malformation
		Presence of a primary or metastatic intracranial malignancy
		Symptoms or signs suggestive of an aortic dissection
		Any bleeding diathesis
		Any active bleeding that is severe or has high potential for life-threatening blood loss; this does not include menstrual bleeding
		sBP > 180 and/or dBP >110 at presentation in patient at low risk of cardiac death (age < 55, no prior MI, and Killip class I).
		Terminal illness, defined as end of life care or documented/expressed patient wish to abstain from high risk or invasive procedures

RELATIVE CONTRAINDICATIONS *(initial yes or no) – If any of below are present, used shared decision making with patient.*

YES	NO	
		Age 65-74 (ICH relative risk 3.12 [2.54-3.83]); Age ≥ 75 years (ICH relative risk 5.40 [4.40-6.63])
		History of chronic severe poorly controlled HTN
		sBP > 180 and/or dBP >110 at presentation in patient at high risk of cardiac death (age ≥ 55, Hx prior MI, or Killip class ≥ II).
		History of ischemic stroke more than three months ago
		Dementia OR any known intracranial disease that is not an absolute contraindication
		Traumatic or prolonged (>10 minutes) cardiopulmonary resuscitation
		Major surgery in the previous three weeks
		Internal bleeding in the previous 2-4 weeks
		Active peptic ulcer
		Non-compressible vascular punctures
		Pregnancy
		Current warfarin therapy (the risk of bleeding increases as the INR increases)

This checklist is advisory for clinical decision-making and may not be all-inclusive. Risks and benefits will need to be assessed individually.

Physician signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

PROCEDURE CONSENT

I hereby authorize _____ and such assistants as he/she may designate, to perform the following operation or procedure:

TECHNICAL DESCRIPTION	Intravenous thrombolytic therapy for acute STEMI (ST-elevation myocardial infarction).
LAY DESCRIPTION	Give clot-dissolving medication through an IV to dissolve the clot which is causing a heart attack.

_____ has discussed with me the information briefly summarized below:

BENEFITS	• When PCI is not available within two hours, thrombolytic medication is the "standard of care" for achieving coronary reperfusion within 12 hours of acute STEMI onset. • When administered within 6 hours of pain onset, about 1 in 40 persons will have their life saved. • When administered between 6-12 hours after pain onset, about 1 in 60 persons will have their life saved. • Decreased risk of developing heart failure. • A STEMI patient who receives thrombolytic medication is about 3-5 times more likely to have their life saved than to have brain bleeding (see below).
RISKS *(some, but not all)*	• About 1 in 100 persons will experience non-life-threatening bleeding. • About 1 in 100-250 persons will experience bleeding into the brain which usually results in either death or significant disability.
RISKS OF NOT HAVING THE PROCEDURE	• Higher risk of death. • Higher risk of developing heart failure.
ALTERNATIVE TREATMENTS	None are available at this facility.

Patient signature: _____

Printed name: _____ Date and time: _____

Witness signature: _____

Printed name: _____ Date and time: _____

Physician signature: _____

Printed name: _____ Date and time: _____

Witness signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Expected Death Protocol

Patient with serious illness with expected death.

Preparation, as appropriate

- Complete **Medical Orders for the Scope of Treatment (MOST)** order form. Review with patient and family regularly.
- Review DNR/DNI status at least once an admission.
- Place DNR/DNI order in RAVEN.
- Update code status on RAVEN banner by going to Ad hoc → Code Status form.
- Remember, all decisions regarding end-of-life care may be modified at any time per patient and family wishes.
- Complete **Expected Home Death** form and send to AST/BPD.
- Communicate with village health aides.
- Place on RAVEN banner by going to AdHoc → Patient Registries and check off "Expected Home Death."
- When discharging home, ensure all support is in place, including family care plan, comfort meds (consider sublingual morphine and lorazepam), incontinence supplies, etc.

When death appears imminent

- Communicate with nurses or health aides and family. Speaker phone and/or Vidyo are very helpful for village communication.
- Be supportive of staff, especially health aides. Be as present as possible. Caring for a dying patient is very stressful, especially for newer health aides; good communication can decrease some of the burden they feel.

After a home death has occurred

- Medical providers can pronounce death remotely after speaking with a qualified representative, which includes health aides. Representative must ascertain that there is no heart beat or spontaneous breathing.
- Send **Expected Home Death** form to the State Medical Examiner and AST/BPD. If this form was not completed prior to death but would have been indicated, it is acceptable to fill it out after death. This will expedite things for the family.
- Contact CHAP on call to request support for health aides.

Notifications

- State Medical Examiner (888 332-3273) only if manner of death was unrelated to terminal illness and/or suspicious in any way.
- Life Alaska (888 543-3287) if patient was <85 years. Obtain reference number.
- AST(800 478-9112) if in village or BPD (543-3781). Even if an Expected Home Death form has been completed, law enforcement requests a phone call at the time of death.

Documentation

- Death Note in RAVEN should be an Alert Note that includes: time of death, ME case number (if applicable), Life Alaska reference number, circumstances of death, and documentation that all required notifications have occurred. May use Free Text template and autotext "..death" for a fillable note.
- Forward death note to Chief of Staff and designated Medical Records representative.
- Complete the **Death Certificate Worksheet** for deaths that are not ME cases.
- If death occurred in the hospital, complete **Notification of Death** form.

Helpful Phone Numbers

- Alaska State Medical Examiner: 888 332-3273
- Life Alaska: 888 543-3287
- Alaska State Troopers (AST): 800 478-9112
- Bethel Police Department (BPD): 543-3781

Helpful Forms

Note: Copies of the death packet are also kept on the inpatient unit.

- **Medical Orders for the Scope of Treatment (MOST)**
- **Expected Home Death**
- **Death Certificate Worksheet**
- **Notification of Death**

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 9/2/20.
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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Unexpected Death Protocol

Unexpected patient death occurs.

Fetal/neonatal death: Was there a heartbeat at birth?

No

≥ 21 weeks AND > 500 grams?

No

Diagnosis is miscarriage. Follow appropriate protocols and document in mother's chart.

Yes

Diagnosis is fetal demise. Document in mother's chart. No birth certificate is generated.

- Notify Medical Examiner.
- Notify State Epidemiology.
- Examine fetus. Document exam in mother's chart using Free Text template and autotext "..fetaldemise" for a fillable note.
- Examine placenta, membranes, and cord. Send for pathology.
- See **Stillbirth Procedure** for guidance on additional testing.
- If family requests autopsy or genetic testing, please contact Lab Director during business hours.

Yes

Diagnosis is neonatal death. RAVEN chart made. Birth certificate generated.

Death due to known medical cause

- Communicate with nurses or health aides and family. Speaker phone and/or Vidyo are very helpful for village communication.
- Be supportive of staff, especially health aides. Be as present as possible. Caring for a dying patient is very stressful, especially for newer health aides; good communication can decrease some of the burden they feel.
- If death occurred in a village, contact CHAP on call to provide support to health aides.
- Medical providers can pronounce death remotely after speaking with a qualified representative, which includes health aides. Representative must ascertain that there is no heart beat or spontaneous breathing.

Unknown cause of death (found at home, sudden unexpected infant death (SUID), etc.) or Other cause of death (trauma, homicide, suicide, etc.)

- Leave all medical devices (airway, IV, etc.) in place.
- If in Bethel, ensure that Bethel Police Department has been notified and follow their instructions.
- If in a village, ask if village law enforcement is available. If not, ask a health aide to be the point person for the troopers. Ensure that the scene is safe. Instruct the CHA/P to make sure no one touches or covers the body or anything around it. Call the Alaska State Troopers and make a report. Give the CHA/P's cell phone number to the troopers.
- Whenever possible, talk to the family directly. Express condolences and tell them that no one may touch, cover, or move the body. Explain that this is so that we can help them find answers about what happened.
- If other people in the home may be at risk, notify OCS or APS, as appropriate.

Required Notifications

Ensure you have next of kin's name and phone number prior to making these calls.

- If death occurred outside of hospital, call AST (800 478-9112) if in village and BPD (543-3781) if in Bethel.
- State Medical Examiner (888 332-3273).
- Life Alaska (888 543-3287) if <85 years old. Obtain reference number.

Documentation

- Death Note in RAVEN should be an Alert Note that includes: time of death, ME case number (if applicable), Life Alaska reference number, circumstances of death, and documentation that all required communication has occurred. May use Free Text template and autotext "..death" for a fillable note.
- Forward death note to Chief of Staff and designated Medical Records representative.
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- If death occurred in the hospital, complete **Notification of Death** form.

Helpful Phone Numbers

- Alaska State Medical Examiner: 888 332-3273
- Life Alaska: 888 543-3287
- Alaska State Troopers (AST): 800 478-9112
- Bethel Police Department (BPD): 543-3781
- State Epidemiology: 907 269-8000
- OCS Intake (for reports): 800 478-4444
- APS Intake (for reports): 800 478-9996

Helpful Forms

Note: Copies of the death packet are also kept in the ED and inpatient.

- **Death Certificate Worksheet**
- **Notification of Death**

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Approved by MSEC 9/2/20.
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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Head Injury in Patients < 18 Years Old

Head injury in a child <18 years.

If GCS ≤ 8, intubate and refer to PALS stabilization algorithms.

Low Risk
GCS=15
AND
No risk factors (see Intermediate and High Risk boxes)

Discharge with head injury education and competent caregiver

Intermediate Risk
GCS=15
AND one or more of the following:
- Occipital, parietal, or temporal scalp hematoma
- Loss of consciousness > 5 seconds
- Not acting normal per parent
- **Severe mechanism of injury****
- If older than 2: vomiting or severe headache
- Amnesia

High Risk
One or more of the following:
- GCS≤14
- **Altered mental status***
- Signs of skull fracture
- Focal neurological deficits
- Seizure
- Loss of consciousness > 1 minute

***Altered Mental Status**
- agitation/irritability
- inconsolability
- somnolence/lethargy
- slow response
- repetitive questions

Factors to consider when deciding to observe vs perform head CT:
- Provider experience
- Multiple vs isolated findings
- Worsening signs/symptoms
- Age <3 months
- Parental preference

C-spine Imaging
- Spinal motion restriction should be continued in neurologically abnormal patients until spinal column or cord injury has been excluded.
- See Nexus Criteria for C-spine imaging protocol.

****Severe Mechanism of Injury**
- Fall: >3 feet if younger than 2 years, >5 feet if older than 2 years
- Motor vehicle accident with ejection, rollover, or fatality
- Unhelmeted bike/ pedestrian vs vehicle
- Head struck by high-impact object

Observation
- Observe in the ER 4-6 hours post-injury.
or
- If presenting >4 hours post-injury AND not improving per caregiver, observe 4 hours.

Not improved → **CT Scan**
Perform noncontrast head CT with spinal motion restriction

Improved → Discharge with head injury education and competent caregiver. Consider concussion follow-up (see Concussion Management box).

CT Scan → Normal / Abnormal

Normal → Is patient improving?
- Yes → Discharge with head injury education and competent caregiver. Consider concussion follow-up (see Concussion Management box).
- No → Consult PICU and trauma service.

Abnormal → Consult PICU and trauma service.

Village Management
- If Low Risk: discharge home with head injury education and competent caregiver.
- If Intermediate Risk: consider medevac vs observation with Q1h VS and neuro checks.
If any worsening, activate medevac.
If not improving over 4 hours, activate medevac.
- If High Risk: activate medevac.

Plain films of the skull are not recommended.

Concussion Management
- Complete **Acute Concussion Evaluation** at every visit.
- Follow-up in outpatient clinic in 1-2 weeks.
- Consider balance testing.
- Avoid medications that can worsen somnolence.
- If symptoms persist >3-4 weeks, consider referral to neurologist, psychologist, physical therapy, etc.
- Return to school per **CDC Heads Up Protocol**.
- Return to play per **ASAA Guidelines**.

In all pediatric trauma, consider further evaluation for non-accidental trauma (skeletal survey, dilated eye exam, etc.)

Pediatric Glasgow Coma Scale (GCS)

	Infant	Child	
Eye opening	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain	To pain	2
	No response	No response	1
Best verbal response	Coos, babbles	Orientated, appropriate	5
	Irritable cry	Confused	4
	Cries to pain	Inappropriate words	3
	Moans to pain	Incomprehensible sounds	2
	No response	No response	1
Best motor response	Moves spontaneously	Obeys commands	6
	Withdraws to touch	Localizes painful stimulus	5
	Withdraws to pain	Withdraws to pain	4
	Flexion to pain	Flexion to pain	3
	Extension to pain	Extension to pain	2
	No response	No response	1

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 5/8/19. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

High-Flow Nasal Cannula (Pediatric)

REMEMBER:
- No pediatric patient may be kept at YKDRH on HFNC unless medevac is on weather-hold.
- Maintain patient on HFNC until medevac arrival.
- Requirements for HFNC:
  - □ The patient must have 1:1 nursing care until he/she has stabilized. After stabilization, nursing care may be 2:1 until medevac arrival.
  - □ The patient must have a respiratory therapist at bedside until stabilized.
- Prior to starting HFNC, physicians, bedside nurses, charge nurses, and RT will huddle to determine which unit will care for the patient. This will be decided on a case-by-case basis. Considerations include:
  - □ How long is the patient expected to remain at YKDRH? Will that time exceed the time provided by an H-cylinder?
  - □ How much risk will be added by moving the patient after stabilization on HFNC?
  - □ Experience level of nurses who will care for the patient.
- All newborns on HFNC must remain in the nursery.

Flow Rates
Titrate flow to 0.5-2 LPM/kg.
Younger patients often require higher flow rates per kilogram.
Consult the PICU for any patient requiring >1 LPM/kg.
Listen to lungs with each adjustment. If child is unable to easily exhale or complete an exhalation, decrease flow rate until exhalation is adequate.

Troubleshooting
- Consider NG/OG-tube for decompression.
- Use a pacifier to keep the patient's mouth closed and prevent loss of pressure. Consider Sweet-Ease.
- Try environmental changes to comfort a fussy baby: caregiver may hold patient in semi-recumbent position, patient may be swaddled, patient may be fanned if hot, lights may be dimmed, etc.
- Consider mild anxiolysis in consultation with medical control.
- Consider higher levels of flow to improve washout.

Patient with moderate to severe sustained retractions or sustained hypoxia <88% not improved with SUPPORTIVE MEASURES (see box) and 2 LPM conventional nasal cannula or infant with apnea responsive to stimulation

↓

Page respiratory therapist.

↓

Page pediatrician on-call.

↓

- Determine optimal patient location with team.
- Activate medevac.
- PREPARE PATIENT (see box).

↓

RT to start high-flow nasal cannula with pediatrician consultation.

↓

Initial Settings
See Flow Rates box to left.
FiO2 50%, 37°C.
For newborns, consult neonatologist.

↓

Titrate flow by 1 LPM increments over first 3 minutes until improvement in WOB.
If patient is worsening on high flow rates, consider a lower flow rate.

↓

Titrate FiO2 to maintain sats >92%.

↓

Frequent gentle nasal suction as needed.

↓

Reassess at least every 20-30 minutes.

↓

Signs of Clinical Improvement
- ↓RR
- ↓retractions
- ↓irritability
- improved air movement

↓

Maintain current settings until medevac arrives.

If no improvement, consider obtaining ANMC PICU consult, checking blood gas, increasing supportive measures, intubation, etc.

SUPPORTIVE MEASURES
- Control fever, as it can be an independent cause of respiratory distress.
- Nasal suction.
- IV hydration.
- Consider back-to-back nebs with albuterol or normal saline.
- Consider phenylephrine nasal spray to each nostril once.
- Consider hypertonic saline nebs q6h.

PREPARE PATIENT
- Make patient NPO.
- Ensure reliable IV access.
- Suction nares well.
- Choose a nasal cannula with prongs that do not occlude more than 50% of the nares.
- Position patient: optimal patient position is semi-recumbent, not supine or upright. Consider using blue seat (stored in the ED) with adjustable angle. Use blanket rolls to support position and ensure patient is not slumping over. Caregivers may hold the child if it helps keep him/her calm as long as the child is at a ~45 degree angle.
- To prevent condensation causing problems, place patient at a higher level than unit and clip tubing to patient's clothing.

NOTE:
- Low-flow cartridge to be used with neonatal/ infant cannula and produces flow rates of 1-8 LPM. This should only be used in patients ≤ 4 kg.
- High-flow cartridge to be used with larger cannula and produces flow rates of 5-40 LPM.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 4/14/20.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Intubation (Adult and Pediatric)

Prepare

Predict difficult airway and post-intubation hypotension:
1. Shock Index (SI) = HR/sBP. If >0.8, high likelihood of post-intubation hypotension. Optimize resuscitation with fluids/blood prior to intubation if possible.
2. Have at bedside: BVM with correct size mask, OPA/NPA, suction, LMA/i-Gel, bougie.
3. Predictors of difficult intubation: see next page. ***Consider contacting anesthesiology if difficult airway is anticipated!***
4. Prepare several doses of all medications, including an extra dose of paralytic and boluses of post-intubation sedation.

Pre-oxygenate

Goal SpO_2 > 93% for three minutes. Mask *and* NC in all patients.
Non-rebreather with flush rate O_2 if spontaneously breathing.
Bag-mask ventilation if no spontaneous breathing.
Non-invasive PPV if in ARDS.

Pre-medicate (optional)

FOR ADULTS, may choose one or more:
1. Fentanyl 2-4 mcg/kg
2. Ketamine 0.1-0.3 mg/kg
3. Rocuronium 0.1 mg/kg

FOR PEDIATRICS:
Atropine – onset <1 minute. Use for younger than 12 months. Use doses on Pediatric Critical Care Guide (code sheets).
Consider using in any patient at risk for bradycardia associated with airway manipulation, shock, hypoxia, acidosis, or severe electrolyte abnormalities.

Induce

FOR ADULTS, choose one:
1. Etomidate 0.3 mg/kg: first line for most patients.
2. Ketamine 1-2 mg/kg
3. Propofol 2 mg/kg: caution hypotension.
4. Midazolam 0.1-0.3 mg/kg: caution hypotension.

FOR PEDIATRICS:
Midazolam AND fentanyl, using doses on Pediatric Critical Care Guide (code sheets).
May need to repeat fentanyl dose.

Paralyze

FOR ADULTS, choose one:
1. Rocuronium 1 mg/kg: duration 30-40 minutes.
2. Succinylcholine 1-2 mg/kg: duration 3-5 minutes; see warning on next page.
3. Vecuronium 0.1 mg/kg: duration 45-65 minutes.

FOR PEDIATRICS:
Rocuronium, using doses on Pediatric Critical Care Guide (code sheets).
DO NOT USE SUCCINYLCHOLINE.

Perform video or direct laryngoscopy

Fails → **Bag-mask ventilation ± OPA or supraglottic airway (LMA/i-Gel)**

Succeeds → Consider making changes:
- Try other form of laryngoscopy.
- Change provider doing the procedure.
- Contact anesthesia.
- Change patient position.
- Use bougie.

Succeeds

Fails → **Cricothyrotomy**

Succeeds

Confirm placement:
1. Visualize tube through cords.
2. End tidal CO2 detector turns and remains yellow after 6 breaths.
3. Bilateral breath sounds.
4. No noise over epigastrium.
5. *Normal waveform on $EtCO_2$ capnography (gold standard).*
6. Confirmation on CXR.

PEDIATRICS
- Secure tube with silk tape.
- Do not use a commercial tube holder device for tubes 5.0 and smaller.
- Always place NG/OG tube for decompression.

Continuing sedation/analgesia

FOR ADULTS:
1. Fentanyl 1-4 mcg/kg/hour, bolus 50-100 mcg.
2. Midazolam 0.02-0.1 mg/kg/hour, bolus 1-5 mg.
3. Propofol 5-80 mcg/kg/minute, bolus 1-2 mg/kg.
4. Ketamine 0.5 mg/kg/hour, bolus 1-2 mg/kg.

FOR PEDIATRICS:
- Fentanyl continuous infusion with boluses Q15minutes *prn*, using doses on Critical Care Guide. Give bolus prior to starting drip.
- Consider midazolam boluses if needed. Consider continuous infusion if needed. Watch for hypotension.

Post-intubation care

- Obtain ABG.
- Place NG/OG tube.
- Elevate head of bed 30-45°.
- BP Q3 minutes x30 minutes.
- Place in-line suction.
- Consider nebulized treatments.
- Consider C-collar.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 2/5/20.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Travis_Nelson@ykhc.org or Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Intubation (Adult and Pediatrics)

Supplement I: Predictors of Difficult Intubation

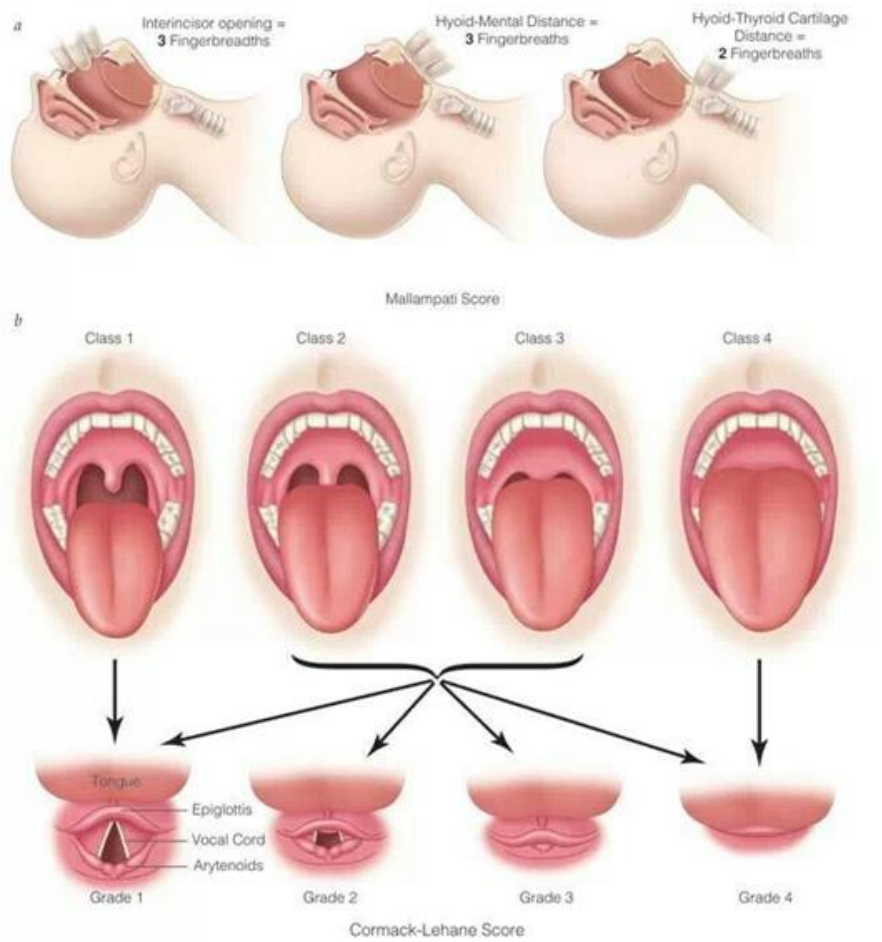
Predictors of Difficult Intubation

- Mallampati grade 3 or 4
- Cormack & Lehane grade 3 or 4
- Wilson score of > 2
- LEMON system; objective/subjective scoring

Wilson Score			
	0	**1**	**2**
Weight (kg)	< 90	90-110	> 110
Head and neck movement	> 90°	~ 90°	< 90°
• Inter-incisor gap (cm) • SL (maximum forward protrusion of lower incisors beyond uppers)	> 5 > 0	= 5 = 0	< 5 < 0
Receding mandible	None	Moderate	Severe
Buck teeth	None	Moderate	Severe

LEMON System	
L	**L**ook: trauma, large tongue
E	**E**valuate 3:3:2 rule.
M	**M**allampati score ≥ 3
O	**O**bstruction
N	**N**eck mobility (limited)

Helpful Resource: **the Difficult Airway App**



Supplement II: Use of Succinylcholine

Absolute contraindications:
Family / personal history of malignant hyperthermia
Hyperkalemia; if unknown K, obtain EKG for peaked T's
Upper motor neuron injury, denerving neuromuscular disease
Use after acute phase of burns, major trauma, crush injury

Relative contraindications:
Elevated ICP
Pseudocholinesterace deficiency

Treatment of malignant hyperthermia:
Dantrolene 2.5 mg/kg IV, redosing based on expert guidance

Resources: Guideline adapted from Strayer Airway Algorithm, Austin Hospital Airway Algorithm
Predictors of Difficult Intubation: **http://medind.nic.in/iad/t05/i4/iadt05i4p257.pdf**

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Approved by MSEC 2/5/20.
Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Travis_Nelson@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Initial Ventilator Settings for an Intubated Adult

ARDS/Protective Ventilation Protocol (appropriate for most patients without indication for alternate ventilation):

Initial Ventilator Settings:
(1) Set Tidal volume (Vt) = 6-8 mL/kg using Ideal Body Weight. See **MDCalc Tidal Volume Calculator**.
(2) Reduce Vt by 1 mL/kg every 1-2 hours until Vt 6 mL/kg.
(3) Set initial rate to 18-35 bpm based on pre-intubation rate.
Obstructive lung disease: Consider lower RR to maximize expiratory phase.
(4) Set initial PEEP at 5 cm H2O.
• If BMI > 30, set PEEP to 8 cm H2O.
• If BMI > 40, set PEEP to 10 cm H2O.
(5) Set initial FiO2 at 30-40%; adjust to SpO2 88-95%.
(6) Set inspiratory flow rate 60-80 lpm.
Obstructive lung disease: Consider inspiratory flow rate 80-100 lpm

Adjust settings based on patient status, blood gases, CXR, and expert consultation.

Oxygenation goal: PaO_2 55-80 mmHg or SpO_2 88-95%.
Use a minimum PEEP of 5 cm H_2O. Consider use of incremental FiO_2/PEEP combinations such as shown below (not required) to achieve goal.

For all modes of ventilation:

• Initial vent setting are based on patient presentation.

• Vent settings are adjusted based on patient tolerance of mechanical ventilation and ABG results.

• Obtain ABG prior to intubation, 30 minutes following intubation, and 30 minutes after vent changes.

• Goal plateau pressure < 30 cm H_2O; decrease Tv to lower PP.
Obese patients may require higher plateau pressure

• Target pH > 7.30; increase RR to control hypercapnia.

• Avoid intubation if possible in patients with obstructive lung disease; maximize use of NIPPV.

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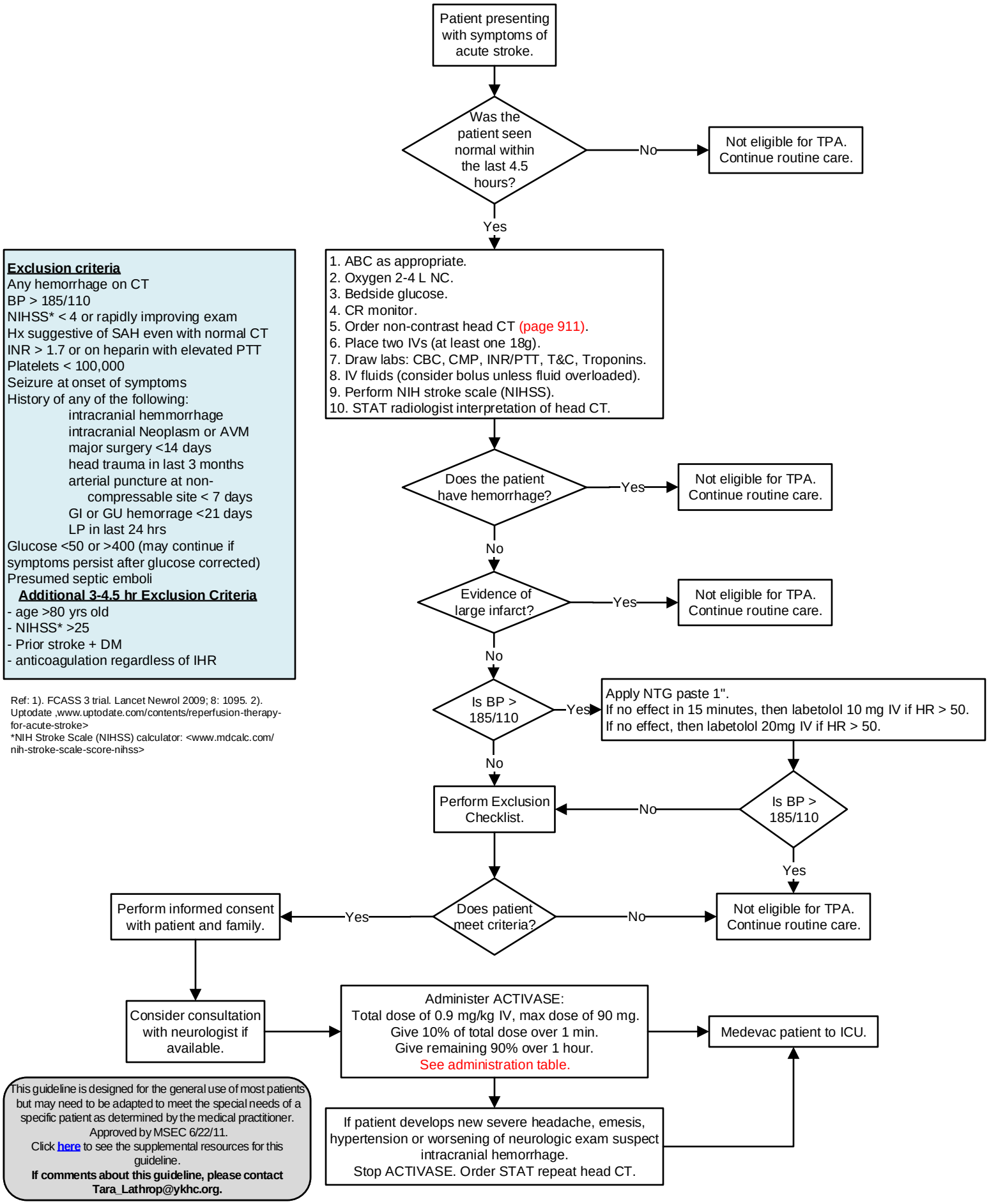
Approved by MSEC 2/5/20.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Travis_Nelson@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Ischemic Stroke, Acute



Exclusion criteria

Any hemorrhage on CT
BP > 185/110
NIHSS* < 4 or rapidly improving exam
Hx suggestive of SAH even with normal CT
INR > 1.7 or on heparin with elevated PTT
Platelets < 100,000
Seizure at onset of symptoms
History of any of the following:
- intracranial hemmorrhage
- intracranial Neoplasm or AVM
- major surgery <14 days
- head trauma in last 3 months
- arterial puncture at non-compressable site < 7 days
- GI or GU hemorrage <21 days
- LP in last 24 hrs

Glucose <50 or >400 (may continue if symptoms persist after glucose corrected)
Presumed septic emboli

Additional 3-4.5 hr Exclusion Criteria

- age >80 yrs old
- NIHSS* >25
- Prior stroke + DM
- anticoagulation regardless of IHR

Ref: 1). FCASS 3 trial. Lancet Newrol 2009; 8: 1095. 2). Uptodate ,www.uptodate.com/contents/reperfusion-therapy-for-acute-stroke>
*NIH Stroke Scale (NIHSS) calculator: <www.mdcalc.com/nih-stroke-scale-score-nihss>

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 6/22/11.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Medevac Activation: Village to YKHC

Indications for medevac:
- Patient is in danger of losing:
  - -Life
  - -Limb
  - -Eyesight
- Preterm labor

NOTE: In the event of multiple medevacs, the ED physician in collaboration with medevac dispatch prioritizes the medevacs.

Occasionally, a charter may be able to fly when a medevac cannot. Consider this option if on weather-hold.

Village to Bethel Collaboration
Village Health Aide collaborates with provider (hospitalist or ED physician) to make decision if medevac is indicated

↓

Consult ED physician for centralized medical control.

If patient is NOT a beneficiary, ask if he/she has a preferred medevac company. If not, suggest they **register for LifeMed insurance online**.

↓

Activation of Medevac

Activating provider calls medevac dispatch with patient's name, DOB, village, and diagnosis. If applicable, dispatch will ask for escort's name and weight.

LifeMed Dispatch 1-800-478-5433

Complete the Patient Transport Order (PTO) and ensure it is faxed to **5-543-1262** and **x6099.**

↓

Managing physician is either ED physician or hospitalist who activated. If hospitalist continues to manage, must keep ED physician updated.

↓

Managing physician calls village Health Aide to get updates and continues to keep records in RAVEN.

↓

Dispatch Process

1. Selected medevac dispatch notifies their medevac team.
If medevac cannot launch (weather, runway lights, etc.) dispatch will notify managing physician. Pilot will continue to check weather.

2. Receiving unit clerk faxes PTO and face sheet to medevac crew.

3. Medevac crew contacts health aide and managing physician as needed.

4. If there is a prolonged delay, medevac crew will contact the managing physician and health aide.

5. In extenuating circumstances, patient may need direct transport to Anchorage from village. After obtaining an accepting physician in Anchorage, managing physician will work with medevac dispatch for transport logistics.

↓

Medevac launches

1. Once in village, medevac crew calls managing physician to give report, establish treatment plan, and give ETA in Bethel.
2. Managing physician keeps receiving charge nurse informed of patient status/ETA of medevac.

↓

Arrival in Bethel
Patient care is transferred to receiving unit and medevac crew gives report to staff.

Consider Transfer Direct to Anchorage ("ramp-to-ramp") when:
1. Obvious need for acute surgical intervention
2. Hemodynamically stable intubated patients
3. Hemodynamically stable acute MI patients
4. Level III Trauma Center indicated.
5. Other extenuating circumstances

Discuss with medevac team if considering ramp transfer.
Remember to call ED at receiving facility to discuss transfer.

In the event that a medevac is cancelled (patient deemed stable to come in on scheduled flight) medevac dispatch and receiving department must be notified by the managing physician immediately.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 2/5/20.
Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Chloe_Wurr@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Medevac Activation: YKHC to Anchorage

Patient in Bethel requires emergency medical transport.

Is patient a beneficiary?

YES → Managing provider contacts ANMC (see below) to consult relevant department.

ANMC physician accepts patient or authorizes transfer to alternate facility. If needed, managing provider arranges accepting physician at alternate facility. If patient is going to an ED, managing provider must arrange accepting ED physician.

Managing provider activates LifeMed and completes Patient Transport Order (PTO) and consent for transfer.

NO → Managing provider elicits patient preferences for medevac company and accepting facility. If no preference, suggest he/she **register for LifeMed insurance online**.

Managing provider arranges accepting physician at selected facility. If patient is going to an ED, managing provider must arrange accepting ED physician.
Note: Accepting Physician for Elmendorf must either be a Military or VA Physician

Managing provider activates selected medevac dispatch and completes Patient Transport Order (PTO) and consent for transfer.

If indicated, managing provider notifies dispatch of need for neonatal team.

Medevac dispatch determines the availability of aircraft. If there will be a medically threatening delay, managing provider may request that dispatch explore other options, which may include other medevac companies.

Medevac dispatch may arrange consultation between managing provider and medevac medical control.

Managing provider notifies YKHC ED physician for centralized medical control and prioritization of medevacs.

Medevac dispatch notifies referring unit regarding ETA and/or delays.

Upon arrival in referring unit, medevac team assumes care. Managing provider may request consultation with medevac medical control physician.

Copies of the PTO, consent for transfer, radiology studies, and patient chart accompany the patient. Consider faxing relevant information to receiving unit prior to arrival.

Information to Have Prepared for Dispatch
- Patient's name, DOB, weight, and diagnosis.
- Any drips or special equipment.
- Accepting provider and hospital.
- Escort's name and weight.

Phone Numbers
- LifeMed Dispatch: 1-800-478-5433 or dial *96.
- Alaska Native Medical Center:
  - Transfer Center (open 10 am – 10 pm): (907) 729-2337. May send Tiger Text to ANMC Transfer Center Coordinator.
  - After hours, call main operator at *97 or (907) 563-2662
  - ED: (907) 729-1729
- Providence Alaska Medical Center:
  - Trauma Transfer: (907) 212-2525
  - ED: (907) 212-3111
  - Main line: (907) 562-2211
- Alaska Regional Hospital Transfer Center: (884) 880-5522
- Joint Base Elmendorf Richardson Hospital ED: (907) 580-5556 or (907) 580-5554
- Department of Corrections On Call: (844) 751-4588

If patient is an inmate:
Physician must contact the Department of Corrections On Call line so that arrangements can be made for public safety.

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Approved by MSEC 2/5/20.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Chloe_Wurr@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Military Transport for Emergencies

Medevac has been activated for a sick patient in a village, but LifeMed cannot accept the flight.

Is the patient is in danger of losing life, limb, or eyesight (LLE)?

Yes

Explore other options:
- Ask health aides about transport to SRC or other villages with more resources or better accessibility.
- Explore if chartering a plane is an option.
- See if travel by boat, snow machine, or ATV is possible.
- Ask LifeMed dispatch to talk to the local crew about other creative ideas.
- Discuss with seasoned YK providers to ask for ideas.
- Discuss options with ER physician.

No other option is viable

- Notify Clinical Director (CD) on call and discuss transport options.
- Is activating the Rescue Coordination Center (RCC) appropriate?

No

- Make a plan with the health aides to provide appropriate care for the patient until a regular transport can be safely arranged.
- Plan for frequent reassessments.
- Prepare to change the plan if the patient's status deteriorates.

Yes

Call the RCC at (800) 420-7230 to begin the process of activating military transport.

Call LifeMed Dispatch to ask if LifeMed crew will be able to go with the military on the flight. **DO NOT CALL THE CREW DIRECTLY.**

Can LifeMed crew go?

Yes

Communicate with LifeMed per usual procedures.

No

Ask RCC about medical capabilities of the anticipated crew. GET DETAILS.

Do arrangements sound appropriate to deliver the necessary level of care?

Yes

Proceed with plan per RCC. Communicate appropriately.

No

- Discuss with CD on call.
- Consider sending YKHC clinical staff.
- If approved, ask for volunteers with appropriate backgrounds.
- Strongly consider calling local LifeMed crew to help assess the risk and safety of the plan.

No

Things to Consider

The local LifeMed team can sometimes go on a military flight. This decision is up to the local team and their administration and depends on many factors.

If the transport team is all military:
- Will military transport inappropriately lower the level of care the patient is receiving?
- What are the capabilities of the military team? Are they pararescue jumpers (PJs), paramedics, EMTs, etc.?
- What kind of equipment will the military team have?
- Does the military team have pediatric experience and equipment, if applicable?

If you are sending a team from YK:
- Will sending a team of YK employees impact the normal operations of the hospital? (You should avoid sending anyone scheduled to work the current or next shift.)
- An ideal YK team includes an ER RN and/or paramedic. Transport/EMS experience is a must.
- **A YK team must be entirely voluntary.**
- Ensure the team will have all appropriate drugs, weight-based equipment, monitors, pumps, stretchers/backboards, etc.
- Make a plan to keep the patient warm – the military will usually not supply blankets, Doctor Downs, etc.
- **If military transport is used, no YK trainees (residents, students, visitors, etc.) or other "ride-alongs" are allowed to go.** Ride-alongs may only go on LifeMed transports with the local team on their fixed wing aircraft.

Things to Know
- The RCC coordinates military missions. They will connect you with the appropriate people from the branch responding, which may be the National Guard, the Coast Guard, or the Air Force.
- You may have to retell the story to several people, including people with minimal medical knowledge. It helps to involve another provider to help coordinate the many phone calls without negatively impacting patient care.
- The process often takes 6-8 hours or more. If the Blackhawk and a full crew are not physically in Bethel, the military may have to send aircrafts from elsewhere in Alaska, which can lengthen the process to 10-12 hours.

Definitions

LLE: life, limb, or eyesight in danger
CD: clinical director
RCC: Rescue Coordination Center
PJ: pararescue jumpers. These are military medics with ACLS and ATLS training who are not trained to provide further critical care. (For example, ventilator management and infusion of medications are not typically part of their scope of practice.)

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/11/19.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Pediatric Medevacs: Bethel to Anchorage

Call YKHC pediatric hospitalist via Tiger Connect "Peds Wards On Duty" for all potentially critical pediatric patients.

Remember: non-beneficiary patients are transferred to Providence Alaska Medical Center.
Call their PICU at (907) 212-3133 to obtain accepting physician (PICU or hospitalist).
Ask about medevac insurance coverage. May suggest family **register for LifeMed insurance** online, which can be done just prior to activation.

Use the **Pediatric Critical Care Guide** and ED Peds Critical Care PowerPlan.

Pediatric patient in Bethel requires medevac.

- Critical pediatric patient (including patients on HFNC, with suspected sepsis, in status epilepticus, etc.)
  - YKHC pediatric hospitalist (or other physician in consultation with YKHC pediatric hospitalist) can call ANMC PICU consultant at (907) 297-8809 for advice, management, and accepting physician.
    This phone is held by the PICU physician or NP. You may request the physician.
    Ensure the ANMC Transfer Center has been contacted by calling (907) 729-2337 or by Tiger Connect.
    - YKHC provider activates LifeMed. *96 or (800) 478-5433
      - ANMC PICU consultant stays available to support ongoing patient management as needed.

        YKHC provider may request that ANMC PICU consultant update LifeMed Medical Control if able.
        - YKHC provider remains in control of management until patient leaves facility.
- Trauma, surgical, or orthopedic emergency
  - ED provider calls ANMC Transfer Center for accepting physician at (907) 729-2337 or contacts Transfer Center Coordinator by Tiger Connect.
    - For all pediatric trauma cases and surgical cases in children >4 years, call the ANMC general surgeon on call.
      For surgical cases in children ≤4 years, call the pediatric surgeon on call through the ANMC operator or their office at (907) 929-7337.
      - ED provider activates LifeMed. *96 or (800) 478-5433
        - ED provider updates LifeMed Medical Control as needed.
- Noncritical: for bed space, diagnostic or specialty services not available at YKHC, etc.
  - ED provider calls ANMC Transfer Center for accepting physician at (907) 729-2337 or contacts Transfer Center Coordinator by Tiger Connect.
    - Please remember to update the YKHC pediatric hospitalist for any Chronic Peds Patient (CPP) being transferred.
      - ED provider activates LifeMed. *96 or (800) 478-5433
        - ED provider updates LifeMed Medical Control as needed.

Neonatal Transfers

Contact PAMC neonatologist at (907) 212-3614 for advice, management recommendations, etc.
Notify ANMC pediatric hospitalist on-call for any beneficiary infant transferred to PAMC NICU.

When to Transfer to PAMC NICU:
- GA <32 weeks
- BW <1500 grams
- Any newborn who required intubation
- Newborns requiring prompt surgical or medical subspecialty care
- No beds available at ANMC or non-beneficiary infant requiring transfer
- Discretion of NNP

When to Transfer to ANMC NICU:
- GA 32-34 weeks
- BW 1500-2200 grams
- Any baby who meets criteria for transfer per the Late Preterm guideline
- Term or early term babies with temperature instability, respiratory distress, supplemental O_2 requirement, hypoglycemia requiring IV treatment, need for IV antibiotics, etc.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 6/8/21. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Protocol

Procedural Sedation and Analgesia Outside the OR

Does provider have privileges for procedural sedation? — No → Seek out colleague with privileges or Page CRNA on call.

Yes ↓

Patient has a condition that meets indications.

There are no contraindications.

Perform Airway Risk Assessment. See box. Determine Expected Sedation Risk Level and plan accordingly. See box.

Discuss risks and benefits of procedural sedation with patient/guardian. Obtain written consent.

Ensure all equipment is present for Expected Sedation Risk Level. (See box.)

Choose appropriate sedation medication. See page 2. Calculate appropriate dose and confirm with team.

Perform time out:
- Correct patient
- Correct procedure
- Correct site

Administer medication.

RN documents medication administration time and effect and patient assessments on flowsheet.

Perform procedure.

Monitor patient through recovery. RN remains at bedside until patient is fully alert.

Indications for Procedural Sedation

Any procedure that cannot be accomplished with patient's current level of cooperation or pain tolerance.

Examples:
- Nonemergent chest tube placement
- Cardioversion
- I&D
- Laceration repair
- Fracture or joint dislocation reduction
- Pediatric foreign body removal
- Imaging

Contraindications

- Patient or caregiver refusal
- Hemodynamic instability
- Respiratory distress

Note: if benefits of procedure outweigh risk despite contraindications, refer to higher level of care or consult a local airway expert and discuss risks with patient/caregiver.

Airway Risk Assessment

See **Intubation guideline** for resources.

High-Risk History
- Stridor
- Obstructive sleep apnea
- Hx Trisomy 21
- Dysmorphic facial features
- Active respiratory tract infection
- Hx of difficult intubation
- Hx of cervical spine pathology

Exam
- Check that patient can open mouth fully and that TMJ function is normal.
- Look for micrognathia, loose teeth, dental appliance, and craniofacial abnormalities.
- Check that patient is able to extend neck >70°.
- Determine Mallampati Score and check 3-3-2 rule (in adults).

Note: Per ACEP, NPO times should not affect decision-making about procedural sedation.

Expected Sedation Risk Level

Airway Risk Assessment combined with expected depth of sedation should guide level of rescue preparation.

1. No risk factors present: No high risk findings in airway assessment and exam, ASA I-II.
Plan: standard monitoring and equipment, including:
- Cardiopulmonary monitor (three lead ECG & RR)
- Pulse-oximetry
- Supplemental oxygen should be prepared but not given unless otherwise indicated.
- BVM in room.
- Suction.
- End-tidal CO_2 monitor
- Reversal agents in room.

2. Risk factors present: some concern for airway status based on airway assessment and exam, but patient not expected to decompensate, and benefits of sedation outweigh risks.
Plan: discuss risks with patient/caregiver.
In addition to standard monitoring and personnel, the following must also be present:
- A healthcare provider dedicated to airway management (preferably an RT)
- Oral airway – correct size open and at bedside
- Nasal trumpet – correct size open and at bedside
- BVM with appropriately-sized mask should be open and prepared at bedside

Note: Consider CRNA at bedside.

Levels of Sedation

- Moderate sedation: patient responds to light tactile stimulation. Spontaneous ventilation is adequate. An IV is required only if IV medication is to be given. (For example, if ketamine is to be given IM with no IV agents planned, an IV is not necessary.)
- Deep sedation: noxious stimuli are required to elicit a response. Spontaneous ventilation and ability to maintain airway may be impaired. Not routinely performed in the ED outside of life-threatening situations.

Other Scenarios

Use of a single, non-dissociative agent is not considered sedation. This protocol does not apply to the following:

- Anxiolysis with a benzodiazepine: patient may be drowsy but responds appropriately to verbal commands.
- Analgesia with opioids: pain control with intact decision-making.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/6/21. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

Agent	Bolus Dose	Titration Dose	Onset	Duration	Reversal Agent	Comments
Etomidate	Patients >10 years: 0.2 mg/kg Patients ≤10 years: 0.2 mg/kg (0.1-0.3 mg/kg) Slow IV push over 30-60 seconds.	0.05 mg/kg Q3-5 min 0.05 mg/kg Q3-5 min	30-60 seconds 30 seconds	3-5 minutes 2-10 minutes	Time	• No analgesic effect. • Use IBW if BMI>30. • Consider lower dose (0.1 mg/kg) for age >60 years, concurrent opioids, or if recent alcohol use. • Administer via larger vessel. (antecubital or larger). • Precautions: 30% have myoclonus with transient skeletal/eye movements.
Ketamine	Adults: 1-2 mg/kg IV over 1-2 min 4-5 mg/kg IM Children >3 mo: 1-2 mg/kg IV over 1 min 4-5 mg/kg IM 5 mg/kg PO		30 seconds 3-4 min 30-120 seconds 5-10 min 20-45 min	10-20 min 20-30 min 20-60 min 30-90 min 60-120 min	• Time • For laryngospasm: Succinylcholine 0.25-0.5 mg/kg IV or 3-4 mg/kg IM	• Local anesthetic (eg. lidocaine) can increase effective duration. • Consider lower dose range for >60 years, concurrent opioids/alcohol. • Consider dosing by adjusted body weight if BMI>30. • Precautions: emergence reactions (treat with benzodiazepines), nausea/vomiting (pre-treat with ondansetron), transient increase in salivation. • Contraindications: pregnancy, age <3 months.
Propofol	Patients >2 yrs: IV load 0.5-1 mg/kg Children 6 mos – 2 yrs: IV load 1-2 mg/kg	Repeat 0.1-0.3 mg/kg Q30-60 seconds Repeat 0.1-0.3 mg/kg Q30-60 seconds Max cumulative dose 3 mg/kg	30-60 seconds	3-10 min	Time	• No analgesia. • Consider low dose for age >60, concurrent opioids/alcohol. • Consider dosing by adjusted body weight if BMI>30. • Separate administration of opioid and propofol by >20 minutes to decrease respiratory depression. • Pre-oxygenate with high flow supplemental oxygen at least 3 minutes prior to procedure. • Precautions: burning sensation during administration, hypotension, ↓CO, or bradyarrhythmias. • High risk of respiratory depression/failure. • Contraindications: allergies to egg, soybean, fat emulsion.
Morphine	Adults: 1-4 mg IV 10 mg PO Pediatrics: 0.05-0.1 mg/kg IV Max 4 mg		5-10 min IV 30 min PO 5-10 min	3-5 hours 2-3 hours	Naloxone 0.1 mg/kg IV. May repeat Q2 minutes.	• Reduce dose when combining with a benzodiazepine. • As opioids provide sedation and analgesia, administer them prior to benzodiazepines.
Fentanyl	Adults: 0.5 mcg/kg if given with other sedatives 0.5-1 mcg/kg Max 100 mg Pediatrics: 1 mcg/kg IV up to 50 mcg/dose	May repeat dose Q2min until desired sedation and analgesia achieved	<1 min 3-5 min	30-60 min	Naloxone 0.1 mg/kg IV. May repeat Q2 minutes.	• Reduce dose when combining with a benzodiazepine. • As opioids provide sedation and analgesia, administer them prior to benzodiazepines.
Midazolam	Adults: 2-5 mg IV Pediatrics (6 mos - 12 yrs): 0.2-0.3 mg/kg/dose IN 0.05 mg/kg IV	May repeat dose Q2min until adequate sedation. Max 0.3 mg/kg. May repeat dose Q5min until max dose of 0.5 mg/kg is reached. Age <5 max 6 mg; age >5 max 10 mg.	3-5 min	15-20 min	Flumazenil 0.01 mg/kg (up to 0.2 mg) IV over 15 seconds. May repeat Q1 minute.	• No analgesia. • Consider lower dose range for >60 years, concurrent opioids/alcohol. • Watch for dose-related hypotension.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sepsis (Adult)

qSOFA – 2 or more of the following:
RR > 22
altered mental status (GCS<15)
SBP < 100

Consider sepsis EARLY in *any* patient with suspected infection.

Does pt meet criteria for sepsis or septic shock?

No

Reassess after initial evaluation:
Consider
• fever, leukocytosis, hypotension?
• unexplained altered mental status?
• tachypnea? especially if lungs CTA and SaO_2 WNL?
• unexplained organ dysfunction?
• clinical concern during ongoing care?

Yes

Airway stable?

No

ET intubation with target tidal volume 6 mL/kg for pts without ARDS

Yes

Large bore IV x2.
LABS INCLUDING LACTATE & BLOOD CULTURES.
START FLUID RESUSCITATION immediately: Give 1 L NS or LR bolus with target at least 30 mL/kg within 1-3 hours.

START EMPIRIC ANTIBIOTICS (see guidelines) within 1 hour of recognition of sepsis/septic shock.

REASSESS FREQUENTLY
Assess for adequacy of fluid resuscitation or complications from fluid therapy.

Monitor vital signs, UOP, shock index (HR/SBP > 0.7), mental status, and clinical exam.

Use more than one method to assess resuscitation adequacy and use dynamic variables if possible.

CONSIDER CONSULT/TRANSFER if unstable or not improving and **ACTIVATE MEDEVAC EARLY** if needed.

Is MAP > 65 after 3L of IVF or is patient having complications from volume therapy?

Yes

START NOREPINEPHRINE or other vasopressor (see guidelines) and **TITRATE** fluids and pressors to **MAP >65.**

Place a central line ASAP but do NOT delay pressors — a well-secured large bore peripheral IV may be used to initiate pressors.

Consider intubation to facilitate appropriate volume resuscitation.

Consider hydrocortisone (see guidelines) *only* for septic shock not responsive to adequate fluid resuscitation and vasopressors.

No

If initial lactate is > 2:

RECHECK LACTATE 1-2 hours after starting resuscitation.

GUIDE RESUSCITATION TO NORMALIZE LACTATE.
Primary goal should be to achieve a relative lactate clearance of at least 10% in 1-2 hours.

Lactate > 4 may indicate hypoperfusion and the need for aggressive/continued fluid resuscitation.

GET SOURCE CONTROL and obtain additional cultures PRN.

Continue to reassess frequently while awaiting admission or transfer.

Village Management
• Aggressive hydration. PO if you can't get an IV, and the patient is alert enough to drink.
• Supplemental oxygen via nasal cannula.
• Consider Ceftriaxone 2 grams IM.
• Activate medevac.
• Consider VTC.

SEPSIS 3 & ACEP NOTES

4-6 L of total IVF is often needed during the first 6 hours. After 2 L of NS consider switch to LR. Remember that if the patient fails to respond after the first 2-3 L, pressors should be considered.

In patients with concern for fluid overload (Hx CHF or renal or liver failure) or complications from fluid resuscitation, use less total fluid or smaller boluses with more frequent reassessment of volume status, but **DO NOT DELAY FLUID AND VASOPRESSOR TREATMENT.**

Persistence of elevated lactate, even in the absence of hypotension, is associated with poor outcomes.

CRP and procalcitonin may be elevated but cannot effectively guide ED sepsis care — CHECK (and RECHECK) LACTATE.

In the absence of extenuating circumstances (MI, severe hypoxia, acute blood loss, etc.) transfusion is no longer recommended unless Hgb < 7.

Consider insulin if 2 consecutive blood glucose levels are > 180.

Sodium bicarbonate is not recommended to improve hemodynamics or decrease vasopressor requirements in patients with hypoperfusion-induced lactic acidemia with pH≥7.15.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 7/12/17.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sepsis Antibiotics (Adult)

Empiric Antibiotic Recommendations by Source of Infection

If possible, first dose of antibiotics should be administered as a 30 minute infusion to reduce time to therapeutic concentration.

Unknown Source

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam[3] 4.5 grams IV Q8h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Gentamicin[2] 7 mg/kg IV Q24h. Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

Community-Acquired Pneumonia

Ceftriaxone 1 gram IV Q24h. (2 grams if >80 kg.)
OR
Ampicillin-sulbactam 3 grams IV Q6h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Azithromycin 500 mg PO/IV Q24h.

If at risk for aspiration, consider adding:

Metronidazole 500 mg IV Q8h.

Hospital-Acquired Pneumonia or High Risk for Multi-Drug Resistant (MDR) Organisms

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam[3] 4.5 grams IV Q6h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Gentamicin[2] 7 mg/kg IV Q24h. Consult pharmacy for max dosing.

Meningitis

Dexamethasone 10 mg IV prior to antibiotics.

AND

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.

AND

Ceftriaxone 2 grams IV Q12h.

If >50 years, ADD

Ampicillin 2 grams IV Q6h.

Urinary Tract Infection

Ceftriaxone 1 gram IV Q24h. (2 grams if >80 kg.)

AND consider adding:

Gentamicin[2] 7 mg/kg IV Q24h. Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

If urological interventions or MDR risk factors, consider adding:
Piperacillin-tazobactam[3] 3.375 grams IV Q6h.
OR
Cefepime 1 gram IV Q6h.

If at risk of ESBL, ADD:
Meropenem 500 g IV Q8h.

Intra-abdominal or Pelvic Infection

Piperacillin-tazobactam[3] 3.375 grams IV Q6h.

OR

Cefepime 1 gram IV Q6h.
AND
Metronidazole 500 mg IV Q6h.

OR

Ciprofloxacin 400 mg IV Q12h.
AND
Metronidazole 500 mg IV Q8h.

Skin and Soft Tissue or Necrotizing Infections

IF PURULENT:
Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.

IF NON-PURULENT:
Cefazolin 2 grams IV Q8h.
OR
Ceftriaxone 1-2 grams IV Q24h.
OR
Ampicillin-sulbactam 3 grams IV Q6h.

If necrotizing, ADD:

Piperacillin-tazobactam[3] 3.375 grams IV Q6h.
AND
Clindamycin 900 mg IV Q8h.

OR

Ceftriaxone 2 grams IV Q12h.
AND
Metronidazole 500 mg IV Q6h.

Neutropenic Cancer Patients (ANC <500)

Piperacillin-tazobactam[3] 4.5 grams IV Q6-8h.
OR
Cefepime 1 gram IV Q6h.

AND

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.

If concerned for HSV or VZV, consider adding:

Acyclovir 10 mg/kg Q8h. Consult pharmacy for max dosing.

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Approved by MSEC 7/12/17.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

[1] Linezolid may be substituted for vancomycin in patients with relative contraindication to vancomycin for high risk for acute kidney injury.
[2] Gentamicin dosing based on ideal body weight.
[3] May substitute ampicillin-sulbactam 3 gram IV Q6h for piperacillin-tazobactam if not concerned for pseudomonas.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sepsis Vasoactive Medications (Adult)

Vasopressors

All vasoactive medications should be infused via central line with the exception of dopamine, which can be infused via a peripheral IV at rates less than 10 mcg/kg/minute.

• Norepinephrine 8-12 mcg/min IV initial infusion rate.	First-line vasopressor of choice in sepsis.
• Epinephrine 1-10 mcg/min initially, titrated to effect.	May be added or used in place of norepinephrine to maintain adequate BP.
• Dopamine 2-20 mcg/kg/min.	Second-line option in highly select patients as it causes more tachycardia.
• Phenylephrine 100-180 mcg/min IV initial infusion until stabilized. Titrate to goal of 60-200 mcg/min. (Max dose range 80-360 mcg/min.)	Can be used as salvage therapy for refractive hypotension associated with tachycardia.
• Vasopressin 0.03-0.04 units/min.	May be added to norepinephrine to increase MAP or decrease norepinephrine dose. DO NOT use as a single agent.
• Dobutamine 2-20 mcg/kg/min IV infusion.	May be used for inoptropic support in the presence of severe myocardial dysfunction or hypoperfusion with depressed cardiac output.

Corticosteroids

Corticosteroids should NOT be administered for the treatment of sepsis in the absence of shock. Steroids are beneficial in those experiencing adrenal insufficiency in the presence of septic shot; however ACTH testing is not routinely recommended in adult patients. If hemodynamic stability is not achieved after adequate fluid resuscitation and vasopressor therapy, the use of IV hydrocortisone alone at a dose of 200 mg/day can be considered regardless of adrenal insufficiency status. Hydrocortisone should be tapered when vasopressors are no longer required.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline
Sepsis (Pediatric)

Shock Criteria

2 or more of the following:
- Temp <96.8 or >100.4
- Abnormal WBC count (<5 or >15)
- Abnormal HR
- Abnormal RR

AND

Signs of End-Organ Involvement:
- Altered mental status
- Delayed cap refill
- Cold/mottled extremities
- Weak pulses
- Difference between central and peripheral pulses
- Significantly decreased UOP
- Hypotension
- Bounding/brisk pulses with rapid cap refill

Patient meets criteria for severe sepsis/shock → Call pediatric hospitalist. Page pharmacist and RT. → Consult PICU by direct line: (907) 297-8809.

Place on CR monitor.
Start supplemental oxygen. Prepare BVM.
Get access: IV/IO x2.
Bolus: NS 20 mL/kg x2 over ≤ 10 minutes.
Reassess volume status after each bolus.

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan for all medication dosing.

Labs: bedside glucose, blood culture, electrolytes, CBC, lactate, ionized calcium, procalcitonin.

Order empiric antibiotics STAT.

Is patient maintaining airway? — No → Intubate per Pediatric Intubation Guideline.

Yes

If not improving, give third bolus of NS 20 mL/kg.
Correct hypoglycemia.
Correct hypocalcemia.

Is there continuing hypotension, poor pulses, change in mental status, or delayed cap refill?

Yes → Start vasopressor and consider methylprednisolone for fluid-refractory shock in consultation with the PICU.

Continue to reassess and give boluses of NS 20 mL/kg unless patient develops rales, respiratory distress, hepatomegaly, or a gallop.

If shock persists, consider a second pressor, calcium chloride, etc. in consultation with PICU.

No → Monitor closely per Continuing Management Box while awaiting medevac.

Village Management
- Consult pediatric hospitalist.
- Aggressive hydration: IV or PO.
- Supplemental oxygen via nasal cannula.
- Monitor glucose.
- Treat hypoglycemia with Insta-Glucose tubes buccally – NOT rectally.
- Ceftriaxone 100 mg/kg IM.
- May give Epinephrine 0.01mg/kg SC.
- Activate medevac.
- Consider VTC.

See Wiki RMT Section for more detailed recommendations.

Continuing Management
- VS (including BP) at least Q15min.
- Blood glucose Q30 min.
- Maintenance IVF with DNS.
- Consider Foley.

Goals
Cap refill <2 sec
Normal BP for age
Normal pulses
Warm extremities
UOP > 1 mL/kg/hour
Normal mental status

Empiric Antibiotic Choice

≤28 days
Ampicillin 50 mg/kg AND gentamicin 4 mg/kg. If concern for meningitis, give cefepime 50 mg/kg IV. If concerned about HSV or neurologic impairment, add acyclovir 20 mg/kg.

>28 days
Ceftriaxone 100 mg/kg (max 2000 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If CVL in place, immunocompromised, or significant Hx antibiotics in past 30 days
Cefepime 50 mg/kg (max 2000 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If allergic to PCN
Meropenem 15 mg/kg (max 500 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If suspecting Staph or Strep:
Consider adding clindamycin 13 mg/kg IV for anti-toxin effect.

Age	HR (beats/minute)		RR (breaths/minute)		Hypotension (sBP in mmHg)
	Bradycardia	Tachycardia	Low	High	
0 days – 1 week	<100	>200	<30	>70	<60
1 week – 1 month	<100	>200	<30	>70	<60
1 – 3 months	<100	>180	<20	>60	<70
3 – 12 months	<100	>180	<20	>60	<70
1 – 2 years	<90	>160	<20	>40	<70
2 – 6 years	<60	>160		>40	<80
6 – 13 years	<60	>120		>23	<90
13 – 18 years	<60	>110		>23	<90

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 10/9/19.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Status Epilepticus Treatment (Pediatric)

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan to check all medication dosing.

- ABCs. Ensure BVM at bedside and pediatric code cart within reach.
- **Bedside glucose STAT.**
- Obtain IV.
- Consult pediatrics.
- Obtain brief history.
- Prepare first-line medication. If in the ED or NW, get the Peds Seizure Kit (see box).

Seizure lasting ≥3 minutes
OR
More than one seizure in 24 hours without return to baseline.

No → Go to Pediatric Post-Seizure Evaluation guideline.

Yes

Peds Seizure Kit

- In the ED and Peds NW Pyxis.
- Type "seizure" and override.
- Includes:
  - Midazolam 10 mg/2 mL
  - Levetiracetam
  - Phenobarbital 130 mg/mL
  - Dosing cards from the pediatric critical care guide

Benzodiazepine (choose ONE)
- Midazolam 0.2 mg/kg IN/IM (max dose 10 mg) – single dose only.
- Lorazepam 0.1 mg/kg IV/IO (max dose 4 mg) – up to two doses Q5 minutes.
- Diastat home dose – up to two doses Q5 minutes.

Seizure continues 5 more minutes.

Village Management

See Emergency RMT Seizure Scenario on the wiki.
- ABCs.
- **Bedside glucose STAT.**
- If unable to get a glucose measurement, give glucose buccally.
- Get BVM with appropriate sized mask to bedside.
- Follow flow to the left, using these drugs with dosing found on Pediatric Critical Care Guide:
  - Diastat home dose PR if available or midazolam 0.2 mg/kg intranasal (max dose 10 mg) or diazepam 0.5 mg/kg (max 10 mg) IV solution given RECTALLY.
  - Phenobarbital or fosphenytoin (kept refrigerated) IM. If giving either second-line drug, consult pediatrics and strongly consider activating a medevac.
- Consider placing IV and giving NS bolus 20 mL/kg.
- Low threshold to activate medevac for atypical or prolonged seizure.

Consult ANMC PICU at (907) 297-8809.

Age ≤ 2 months

Phenobarbital 20 mg/kg IV/IM.
If IV, give over 15 minutes or
1 mg/kg/minute (max 60 mg/min).

Seizure continues 5 minutes after infusion complete.

Phenobarbital 10 mg/kg IV/IM.
If IV, give over 15 minutes or
1 mg/kg/minute (max 60 mg/min).

Seizure continues 5 minutes after infusion complete.

Levetiracetam 40 mg/kg IV/IM.
If IV, give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Levetiracetam 20 mg/kg IV/IM.
If IV, give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Start midazolam or propofol infusion with PICU consultation.

Age >2 months

Levetiracetam 60 mg/kg IV/IM.
Max dose 4500 mg.
If IV, give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Fosphenytoin 20 mg PE/kg IV.
Max dose 1000 mg.
Give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Fosphenytoin 10 mg PE/kg IV.
Max dose 1000 mg.
Give over 5-10 minutes.

Seizure continues 5 minutes after infusion complete.

Phenobarbital 20 mg/kg IV or IM.
Max dose 1000 mg.
If IV, give over 15 minutes.

Seizure continues 5 minutes after infusion complete.

Phenobarbital 10 mg/kg IV or IM.
Max dose 1000 mg.
If IV, give over 15 minutes.

Seizure continues 5 minutes after infusion complete.

Start midazolam or propofol infusion with PICU consultation.

In all ages, if hemodynamic instability or myocardial dysfunction, avoid phenobarbital and use alternate agents.

In all ages, in consultation with the PICU, consider preparing for intubation and continuous infusion after second-line drug has been given. Continue giving medications as detailed in the flow while infusion is being prepared.

If giving midazolam, make drip of 1 mg/mL and start at rate 0.1 mg/kg/hour.

Indications for Admission or Transfer:
-Status epilepticus
-Cluster of seizures
-Increased intracranial pressure
-CNS infection
-Structural lesion
-Patient does not return to baseline mental status

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If comments about this guideline, please contact Jennifer_Hampton@ykhc.org.

Return to Table of Contents.

Yukon-Kuskokwim HEALTH CORPORATION

Abuse/Assault Guidelines

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sexual Assault Guideline (Adults ≥ 18 years)

**Note: When an adult patient discloses a sexual assault, it is his or her choice to report to law enforcement. Reporting without a patient's consent may breech his or her confidentiality.
A SART exam/kit can only be conducted by a trained SAFE/ SANE. Law enforcement must be involved, unless the patient wishes to have an anonymous kit collection.

Adult victim reports sexual assault to ED or clinic staff.

If patient is <18 years, please see **Pediatric Sexual Abuse Procedure**.

Does patient want to report to law enforcement? (See **Note.)

No

Yes

Adult victim reports sexual assault to law enforcement.

Provide patient with a private space to call law enforcement with jurisdiction. Provide support as needed.
- If assault occurred in a village, call Alaska State Troopers.
- If assault occurred in Bethel, call the Bethel Police Department.

Law enforcement performs preliminary interview.

Is the patient willing to cooperate with an investigation?

No

- The SART team will not respond.
- It may be appropriate to request a TWC advocate at 543-3444.
- Patient is offered a medical exam with ED or clinic provider for testing and treatment of STIs and emergency contraception.
- For any questions, contact the SART Adult on-call phone at 545-4273.
- SANE/SAFE may do an anonymous kit collection in certain circumstances.

Yes

Law enforcement activates SART team response if further investigation is indicated.

SART team performs interview.

Does the patient want a SART exam?

No

Yes

- SART team performs a forensic medical exam with evidence collection.
- Team offers emergency contraception and testing and treatment of STIs.

SART Team Members

- Law enforcement
- SANE/SAFE (Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner)
- TWC advocate

Contact Information

- Tundra Women's Coalition:
  - Business Line: (907) 543-3444
  - Crisis Line: (907) 543-3456
  - Toll Free: (800) 478-7799
- Law Enforcement:
  - Bethel Police Department: (907) 543-3781
  - Bethel Post of Alaska State Troopers: (907) 543-2294
  - Aniak Post of Alaska State Troopers: (907) 675-4459
  - Emmonak Post of Alaska State Troopers: (866) 949-1303
  - St. Mary's Post of Alaska State Troopers: (907) 438-2019
- National Sexual Assault Helpline:
  - (800) 656-4673
  - Available 24 hours a day, 7 days a week.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/2/20. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Jennifer_Prince3@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Suspected Physical Abuse Procedure (Pediatric)

Indicators of Abuse: History

- No/vague explanation of significant injury
- Important details of explanation change dramatically
- Explanation of injury is inconsistent with the child's physical and/or developmental capabilities
- Injury occurred as a result of inadequate supervision
- Delay in seeking medical care without reasonable explanation
- Children with injuries resulting from family/ domestic violence incident
- Previous history of inflicted injury
- Inappropriate caretaker behavior that places child at risk

Indicators of Abuse: Physical Exam

Bruising
- Bruising in infants < 6months of age or non-ambulatory infants
- Bruising in unusual locations in any age child: ear pinna, neck, under chin, torso, buttock
- Pattern Bruises: loop marks, hand print, subgaleal hematoma due to hair pulling

Bite Marks
- Semi-circular/oval pattern
- May have associated bruising

Burns
- Pattern contact burns
- Cigarette burns
- Stocking/glove pattern
- Mirror image burns on extremities
- Symmetrical burns on buttock
- Immersion burns

Facial Injury
- Unexplained torn frenulum in non-ambulatory child
- Unexplained oral injury
- Ear injury

Injuries Suggestive of Abuse

Skeletal
- Rib fractures
- Multiple fractures
- Long bone fractures in < 6 months
- Any fracture (including femur) in non-ambulatory child
- Scapular fracture
- Sternum fracture
- Fractures of hands and feet

Head
- Subdural hematoma with or without skull fracture
- Unexplained intracranial injury (Note: Infants with intracranial injuries frequently have no or non-specific symptoms)

Poisoning
- Any illegal drug exposure, prescribed controlled substance, ethanol, or marijuana

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Approved by MSEC 7/6/21. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Jennifer_Prince3@ykhc.org.

Suspicion, allegation, disclosure, or confession of child physical abuse. **Please see Indicators of Abuse AND Injuries Suggestive of Abuse.**

↓

Treat acute issues as appropriate. If patient is in village and stable please arrange to have patient sent to ED via next commercial flight. If unstable then activate medevac.

↓

Mandatory reporters must report via phone to: **OCS** AND law enforcement (**AST** if incident occurred in village or **BPD** if incident occurred in Bethel).

↓

- Complete appropriate work-up (see table). Use Child Abuse Power Plan.
- Take photos of any injury visible on exam, especially bruising. Take photos at a distance AND close-up to establish relative size and landmarks.

↓

Send RAVEN communication to Child Abuse Pool detailing reports made to Law Enforcement and **OCS**. May contact **Child Abuse On-Call** via Tiger Connect if any questions or concerns.

↓

If unable to reach a discharge plan with OCS that YOU think is safe, then consider admission for safety and send message to **Child Abuse On-Call** to help reach a safe discharge plan.

Contacts

- Child Abuse On-Call via Tiger Connect
- Office of Children's Services (**OCS**): (800) 478-4444
- Alaska State Troopers (**AST**): (907) 543-2294
- Bethel Police Department (**BPD**): (907) 543-3781
- Alaska CARES: (907) 561-8301

Mandatory Reporters include: Medical providers, nurses, health aides, teachers, social workers, law enforcement officers, and mental health professionals.

Report should be made by every mandated reporter who has a concern - even if you think a report has already been made. This helps keep reports up to date with new information.

Note: Minor injuries (single bruise on forehead, occasional bruises on shins, minor oral trauma, etc.) in a child able to cruise or sit independently can be part of normal development.
Always ask caregivers for story behind injuries.
If history does not match injury or child's observed developmental level, strongly consider child abuse injury surveillance.

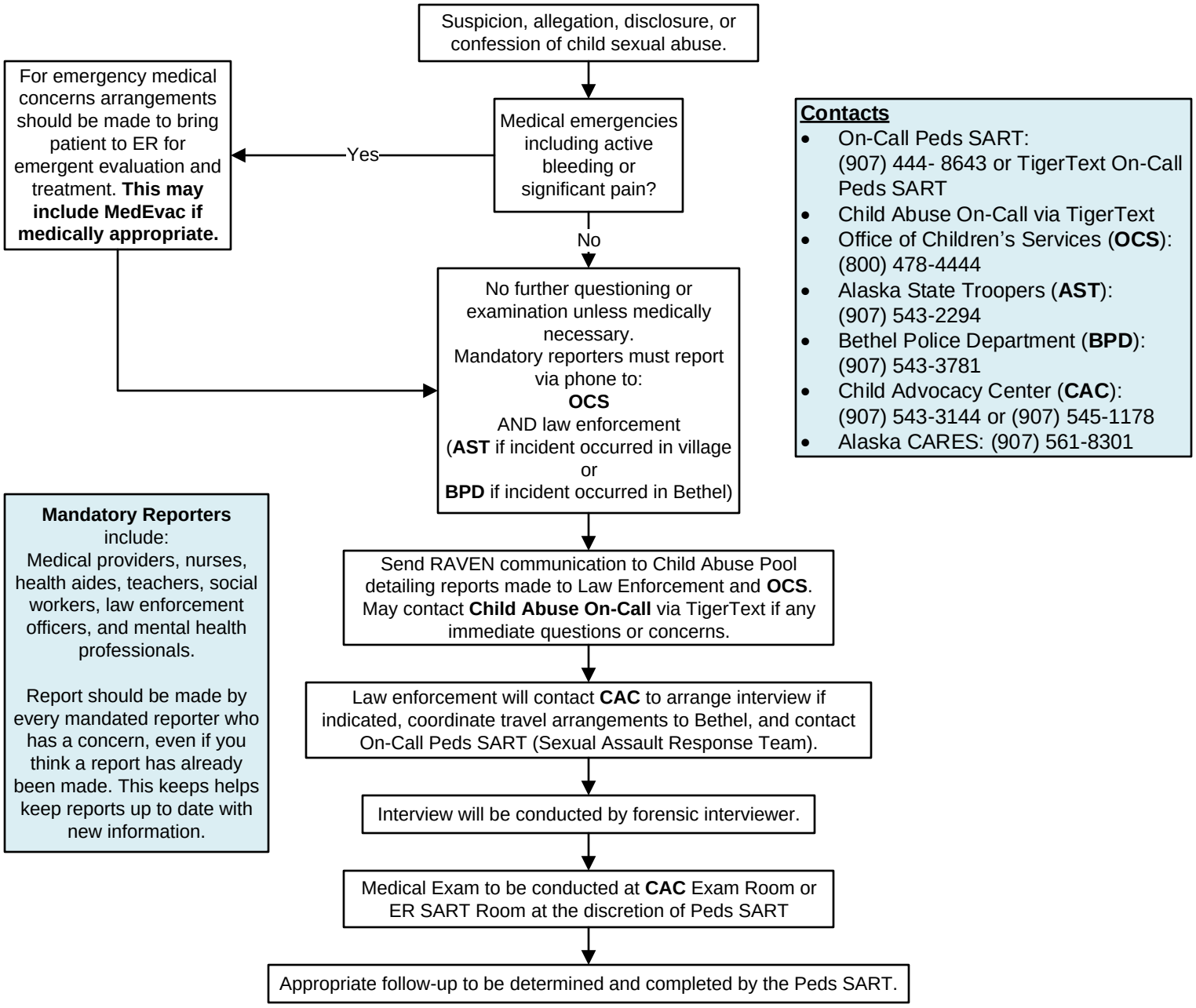
Child Abuse Injury Surveillance Table (Use Child Abuse Power Plan.)

	<6 months	6-24 months	2-5 years	>5 years
Full exam	Yes	Yes	Yes	Yes
Skeletal survey Including oblique rib films	Yes	Yes	If highly suspicious of severe abuse	If highly suspicious of severe abuse
Head CT Request 3D reconstruction and 3 mm slices	Yes	If neurological exam abnormal	If neurological exam abnormal	If neurological exam abnormal
Abdominal labs AST, ALT, amylase, lipase	Yes	Yes	Yes	If abdominal trauma
Bone labs Calcium, magnesium, phosphorus, alkaline phosphatase, intact PTH, 25-OH	If fracture	If fracture	If fracture	If fracture
Coagulation studies PT/INR, PTT, factor VIII & IX activity levels, VWF activity & antigen, CBC with diff. Consider CK if significant bruising. If head trauma PT/INR, PTT, thrombin time, fibrinogen, D-dimer	If bruising	If concerning bruising	If concerning bruising	If concerning bruising
Head circumference	Yes	Yes	N/A	N/A
Urine drug screen ± expanded state screen (contact Child Abuse On Call if considering expanded screen)	Consider	Consider	Consider	No
Optometry consult (within 24 hours)	If head injury	If head injury	If head injury	N/A

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Suspected Sexual Abuse Procedure (Pediatric)



Contacts

- On-Call Peds SART: (907) 444- 8643 or TigerText On-Call Peds SART
- Child Abuse On-Call via TigerText
- Office of Children's Services (**OCS**): (800) 478-4444
- Alaska State Troopers (**AST**): (907) 543-2294
- Bethel Police Department (**BPD**): (907) 543-3781
- Child Advocacy Center (**CAC**): (907) 543-3144 or (907) 545-1178
- Alaska CARES: (907) 561-8301

Mandatory Reporters include:
Medical providers, nurses, health aides, teachers, social workers, law enforcement officers, and mental health professionals.

Report should be made by every mandated reporter who has a concern, even if you think a report has already been made. This keeps helps keep reports up to date with new information.

Return to Table of Contents.

Yukon-Kuskokwim HEALTH CORPORATION

Cardiovascular Guidelines

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

Symptoms suggestive of acute coronary syndrome

Perform 12 lead EKG.

Perform immediate interventions. See Box 1.

STEMI? See Box 2.

- Unclear → Consult local expert or cardiologist.
- Yes → <12 hours from symptom onset?
  - No → Diagnosis is NSTE-ACS (Non-ST elevation acute coronary syndrome)
  - Yes → Complete Fibrinolytic Checklist. Contraindications to fibrinolytics?
    - Yes → Diagnosis is NSTE-ACS (Non-ST elevation acute coronary syndrome)
    - No → **Initiate fibrinolytic therapy. See Box 5.**
- No → • HS-cTnT, serial EKGs, and COVID test. • Consider critical diagnoses. See Box 3.

Diagnostic ST/T changes OR Diagnostic HS-cTnT elevation or change. See Box 4.

- Unclear → Consult local expert or cardiologist.
- Yes → Diagnosis is NSTE-ACS (Non-ST elevation acute coronary syndrome)
- No → • ACS is ruled out. • Broaden differential diagnosis. • Consider a validated risk-stratification scoring tool (like **HEART** or **TIMI**). • If patient is high-risk for cardiac complications, consider consultation with cardiologist prior to discharge. • Discharge with outpatient follow-up as indicated by level of cardiac risk.

Diagnosis is NSTE-ACS (Non-ST elevation acute coronary syndrome) → • Administer additional medications. See table on next page. • Activate medevac if appropriate.

Box 1: Immediate Interventions

- Supplemental oxygen *prn* to maintain SpO_2 90-96%.
- Aspirin 325 mg PO (chewed).
- Nitroglycerin 0.4 mg sublingual *prn* pain (up to three times as BP permits) unless contraindicated. Contraindications: recent phosphodiesterase use, sBP <90, right ventricular infarct (consider when evidence of inferior wall ischemia).

NOTE: pain relief with nitroglycerin (or lack thereof) is not diagnostic of cardiac ischemia.

Disclaimer

- This algorithm is not intended for undifferentiated chest pain without an apparent cause.
- Acute coronary syndrome is defined as acute occlusion of a coronary artery and does not include type 2 MI/ischemia.

Consulting Cardiology

- For all STEMI patients, consult PAMC Cardiology by calling the PAMC ED at (907) 212-3433 and asking for the cardiologist on call. For beneficiary patients, ANMC Cardiology should be made aware of the transfer on a non-urgent basis.
- For NSTE-ACS patients, consult ANMC Cardiology for beneficiary patients and PAMC Cardiology for non-beneficiary patients.

Box 2: STEMI Criteria

Symptoms consistent with acute myocardial ischemia AND (A or B):

New ST-elevation at the J-point in two contiguous leads with the cut-point:
- ≥ 1 mm in all leads other than V2-V3
- V2-V3:
  - ≥ 2 mm in men ≥ 40 years old
  - ≥ 2.5 mm in men < 40 years old
  - ≥ 1.5 mm in women

Box 3: Critical Differential Diagnosis

- Aortic dissection
- Tension pneumothorax
- Pulmonary embolism
- Perforated peptic ulcer

Box 4: HS-cTnT Evaluation for Acute Cardiac Injury

The lowest reported value is "<6 ng/L," which equates to "undetectable."

FDA-approved normal values (99th percentiles in healthy subjects) are:
- Men: <22
- Women: <14
- Change in one hour (Δ1h) : <3

Cutoffs are arbitrary and do not correspond to any evidence-based positive-predictive value for ACS.

Repeat measurements rely on a rate of change; therefore, repeat measurements should be drawn at exactly one hour (or the chosen interval) after the initial.

This information is from data available February 2020. Please see wiki page for further information.

Box 5: Fibrinolytic Therapy (Tenecteplase)

Goal: administer ≤ 30 minutes from arrival.
Rapidly complete the fibrinolytic checklist and consent.

Dosing:
- <60 kg: tenecteplase 30 mg IV bolus
- ≥60 kg to <70 kg: tenecteplase 35 mg IV bolus
- ≥70 kg to <80 kg: tenecteplase 40 mg IV bolus
- ≥80 kg to <90 kg: tenecteplase 45 mg IV bolus
- ≥90 kg: tenecteplase 50 mg IV bolus

Administer concurrent aspirin, clopidogrel, and anticoagulant therapy. See tables 1 and 2.

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Approved by MSEC 12/2/20.
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If comments about this guideline, please contact Megan_Young@ykhc.org and Andrew_Swartz@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

Nitroglycerin (NTG)
• Contraindications: PDE-inhibitor use, cardiogenic shock, RV infarct, sBP<90, marked tachycardia or bradycardia.
• Sublingual dosing: 0.4 mg SL Q5 minutes up to three doses
• IV dosing: start at 10-20 mcg/min, titrate Q3-4 minutes to typical range 60-100 mcg/min

Beta-Blockers
• No evidence of benefit from routine immediate beta-blocker.
• Indicated for HTN and/or ongoing ischemia refractory to NTG.
• Contraindications: cardiogenic shock, RV infarct, symptomatic asthma.
• Cautions: risk for cardiogenic shock (bradycardia, HR>110, sBP<120, age>70, increased time since STEMI onset), inferior MI, controlled asthma.

Emergency Department Medication Summary

	STEMI <12 hours	STEMI >12 hours	NSTE-ACS
Oxygen	Maintain SpO_2 90-96%	Maintain SpO_2 90-96%	Maintain SpO_2 90-96%
Nitrates (*prn* pain, HTN)	Sublingual or drip	Sublingual or drip	Sublingual or drip
Fibrinolytic	Tenecteplase See page 1, Box 5	Not indicated	Not indicated
Antiplatelet agents: Aspirin	325 mg PO (chewed)	325 mg PO (chewed)	325 mg PO (chewed)
Antiplatelet agents: $P2Y_{12}$ receptor blocker	Clopidogrel Age ≤75: 300 mg PO Age >75: 75 mg PO	Clopidogrel 600 mg PO	Consult cardiology.
Antiplatelet agents: Glycoprotein IIb/IIIa inhibitor	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.	Eptifibatide (Integrilin) Per cardiologist. Typically given after PCI.
Anticoagulation	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)	Enoxaparin (see table for dose)
Beta-blocker	Metoprolol 5 mg IV *prn* Q5 minutes (max 15 mg)	Metoprolol 5 mg IV *prn* Q5 minutes (max 15 mg)	Metoprolol 5 mg IV *prn* Q5 minutes (max 15 mg)
Morphine	No longer routinely given; associated with increased mortality. Reserve for significant pain refractory to NTG and beta-blocker.		

At time of Dx unless contraindicated

Enoxaparin Dosing

	Age <75 years and STEMI	Age ≥75 years and STEMI	Any age and NSTE-ACS
Creatinine clearance ≥30 mL/min	30 mg IV + (1 mg/kg SC now then Q12h) Max dose 100 mg	0.75 mg/kg SC Q12h Max dose 75 mg	1 mg/kg SC now then Q12h
Creatinine clearance <30 mL/min	30 mg IV + (1 mg/kg SC now then Q24h) Max dose 100 mg	1 mg/kg SC Q24h Max dose 100 mg	1 mg/kg SC now then Q24h

NOTE: Enoxaparin and unfractionated heparin are NOT dialyzable; ESRD/dialysis patients should receive fondaparinux, which is not on the YKHC formulary. Discuss with cardiologist if appropriate.

Inpatient Medication Summary

NOTE: The following table is meant to be a basic reference as a starting point. Please consult Cardiology for full recommendations in all ACS patients.

ACE-inhibitor	Lisinopril 2.5 – 5 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Statin	Atorvastatin 80 mg PO daily Give unless contraindicated. Typically started prior to hospital discharge. Unclear if ED initiation is beneficial.
Beta-blocker	Metoprolol XL 25-50 mg PO Q12-24h *prn* Give unless contraindicated. Typically started prior to hospital discharge.
Clopidogrel	75 mg PO daily
Aspirin	81 mg PO daily
Enoxaparin	Dose above. Consult Cardiology for duration.

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

Fibrinolytic Checklist

INDICATIONS *(initial yes or no)*		
YES	**NO**	
		Presentation consistent with acute coronary syndrome (coronary artery occlusion)
		AND at least one of the following: • 1 mm J-point elevation in two contiguous leads (other than V_2-V_3) • In leads V2-V3 Men ≥ 40 years: ≥ 2 mm J-point elevation Men <40: ≥ 2.5 mm J-point elevation Women: ≥ 1.5 mm J-point elevation
ABSOLUTE CONTRAINDICATIONS *(initial yes or no)*		
YES	**NO**	
		History of any intracranial hemorrhage
		History of prior ischemic stroke, significant closed head injury or facial trauma, or intracranial or spinal surgery in the previous three months
		Presence of a cerebral vascular malformation
		Presence of a primary or metastatic intracranial malignancy
		Symptoms or signs suggestive of an aortic dissection
		Any bleeding diathesis
		Any active bleeding that is severe or has high potential for life-threatening blood loss; this does not include menstrual bleeding
		sBP > 180 and/or dBP >110 at presentation in patient at low risk of cardiac death (age < 55, no prior MI, and Killip class I).
		Terminal illness, defined as end of life care or documented/expressed patient wish to abstain from high risk or invasive procedures
RELATIVE CONTRAINDICATIONS *(initial yes or no) – If any of below are present, used shared decision making with patient.*		
YES	**NO**	
		Age 65-74 (ICH relative risk 3.12 [2.54-3.83]); Age ≥ 75 years (ICH relative risk 5.40 [4.40-6.63])
		History of chronic severe poorly controlled HTN
		sBP > 180 and/or dBP >110 at presentation in patient at high risk of cardiac death (age ≥ 55, Hx prior MI, or Killip class ≥ II).
		History of ischemic stroke more than three months ago
		Dementia OR any known intracranial disease that is not an absolute contraindication
		Traumatic or prolonged (>10 minutes) cardiopulmonary resuscitation
		Major surgery in the previous three weeks
		Internal bleeding in the previous 2-4 weeks
		Active peptic ulcer
		Non-compressible vascular punctures
		Pregnancy
		Current warfarin therapy (the risk of bleeding increases as the INR increases)

This checklist is advisory for clinical decision-making and may not be all-inclusive. Risks and benefits will need to be assessed individually.

Physician signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acute Coronary Syndrome (ACS) Management

PROCEDURE CONSENT

I hereby authorize _____ and such assistants as he/she may designate, to perform the following operation or procedure:

TECHNICAL DESCRIPTION	Intravenous thrombolytic therapy for acute STEMI (ST-elevation myocardial infarction).
LAY DESCRIPTION	Give clot-dissolving medication through an IV to dissolve the clot which is causing a heart attack.

_____ has discussed with me the information briefly summarized below:

BENEFITS	• When PCI is not available within two hours, thrombolytic medication is the "standard of care" for achieving coronary reperfusion within 12 hours of acute STEMI onset. • When administered within 6 hours of pain onset, about 1 in 40 persons will have their life saved. • When administered between 6-12 hours after pain onset, about 1 in 60 persons will have their life saved. • Decreased risk of developing heart failure. • A STEMI patient who receives thrombolytic medication is about 3-5 times more likely to have their life saved than to have brain bleeding (see below).
RISKS *(some, but not all)*	• About 1 in 100 persons will experience non-life-threatening bleeding. • About 1 in 100-250 persons will experience bleeding into the brain which usually results in either death or significant disability.
RISKS OF NOT HAVING THE PROCEDURE	• Higher risk of death. • Higher risk of developing heart failure.
ALTERNATIVE TREATMENTS	None are available at this facility.

Patient signature: _____

Printed name: _____ Date and time: _____

Witness signature: _____

Printed name: _____ Date and time: _____

Physician signature: _____

Printed name: _____ Date and time: _____

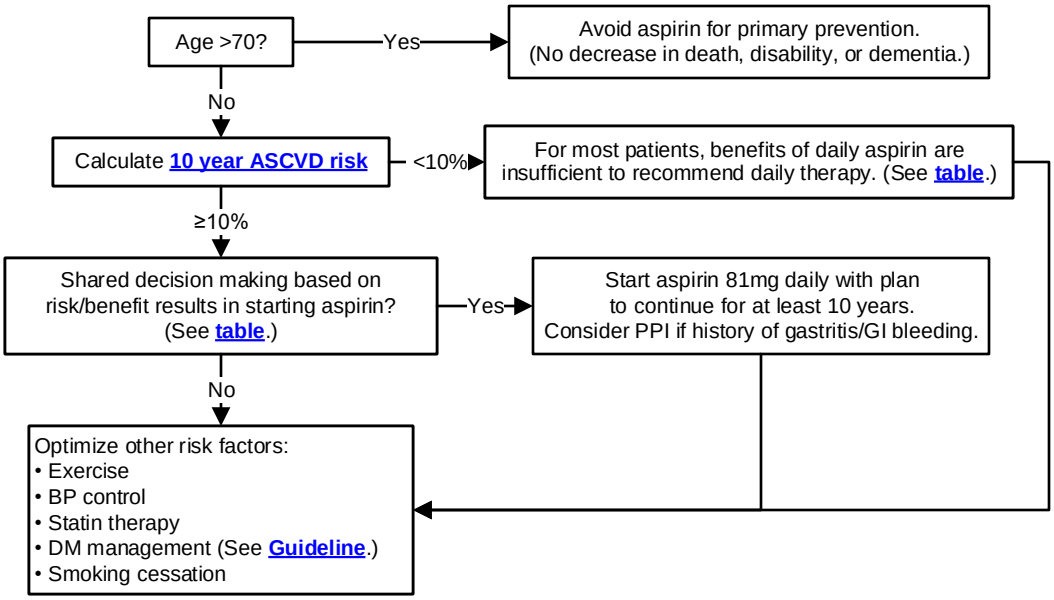
Witness signature: _____

Printed name: _____ Date and time: _____

Place patient ID sticker here.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline
Aspirin for Adults >40 Without Known Cardiovascular Disease



Notes

Aspirin produces significant reductions in mortality amongst survivors of cardiovascular disease, but its role in the primary prevention of cardiovascular disease amongst healthy adults is less clear.

See **table under "Possible Benefits"** for summary of RCT data for low dose aspirin in the primary prevention of cardiovascular disease.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Atrial Fibrillation and Atrial Flutter

Consult ANMC Cardiology to confirm indication, consider alternative, and discuss need for antiarrythmic drugs prior to procedure.

Ensure that patient had no solid food x 6 hours and no clear liquids x 3 hours.

1. Obtain BMP, magnesium, CBC, PT/PTT: patient should have no significantly abnormal electrolytes, decompensated COPD, or active infections.
2. Obtain digoxin level if applicable.

Procedure may be done on patient with therapeutic digoxin level and no evidence of toxicity.

Obtain consent for procedure.

Anesthesia present with full ACLS setup, including meds and temporary pacer. Anesthesia obtains consent for sedation/anesthesia.

Position conductive pads or paddles with adequate gel (pads preferred).

- Shave off significant hair.
- Note: Position posteriorly below left scapula and anteriorly just to right of sternum and over right upper parasternal to left cardiac apex.

Set defibrillator to SYNCHRONIZED shock. Verify that device is correctly synchronizing on the QRS complex.

Administer anesthesia/sedation

Deliver synchronized shock at 50 J

- Note: Rare complication: V-tach or V-Fib usually occurs when shock delivered in UNSYNCHRONIZED MODE. Brief ventricular ectopy occurring post shock is of no clinical significance. If sustained V-tach or V-fib, deliver an UNSYNCHRONIZED SCHOCK AT 360 J.
- Note: Try to deliver all shocks during expiration.

Restoration of sinus rhythm?

- Yes → Patient with a new or changed prescription for an antiarrhythmic drug?
  - Yes → Monitor patient for 48 hours and consult ANMC cardiology for further future treatment plan.
  - No → Patient to be observed and discharged per post-anesthesia criteria.
- No → RESYNCHRONIZE. Repeat shock at 100 J.

Restoration of sinus rhythm?

- Yes → Patient with a new or changed prescription for an antiarrhythmic drug? (Yes / No as above)
- No → RESYNCHRONIZE Repeat shock at 100 J, consider increase to 200 J

Restoration of sinus rhythm?

- Yes → Patient with a new or changed prescription for an antiarrhythmic drug? (Yes / No as above)
- No → Move anterior pad to left parasternal, RESYNCHRONIZE and repeat shock at 360 J. *A total of 4 shocks will be given before the procedure is declared unsuccessful.

Severe bradycardia (<20 bpm) or asystole >10 sec?

- Yes → Set defibrillator to PACE mode. → Begin with 80 mA and increase every 5 sec until Ventricular capture obtained.
- No → Persistent bradycardia with hypotension?
  - Yes → Atropine 0.5 mg IV x 2 if needed. → Continued bradycardia or hypotension?
    - Yes → Dopamine 5-10 µg/kg per minute for vasopressor dose.
    - No → Refer to ACLS protocol
  - No → Refer to ACLS protocol

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 6/22/11.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Congestive Heart Failure, page 1

Concern for congestive heart failure

Are risk factors present?

No → Box 1: Initiate education for Health Seeking Behaviors:

- No smoking, limit alcohol, avoid illicit drug use.
- Eat a diet low in saturated fat and rich in fruits and vegetables.
- Educate regarding risk factors.
- Keep BMI < 25.
- Encourage physical activity 120-180 min/week.
- Limit sugar-sweetened beverages.

Yes →

Major Risk Factors:
- Hypertension
- Prior MI
- Diabetes
- Valvular heart disease
- Obesity

Minor Risk Factors:
- Alcohol abuse
- Cigarette smoking
- Dyslipidemia
- Renal insufficiency
- Sleep-disordered breathing
- Low physical activity
- Lower socioeconomic status
- Depression
- Increased dietary salt intake

Monitor for signs/symptoms:
- Shortness of breath
- Activity intolerance
- Orthopnea
- Frothy sputum
- Peripheral edema
- Sudden weight gain >2-3 lbs
- Nocturia
- Altered mental status
- Hypoxemia
- Chest pain

→ Consider urgent/ emergent evaluation in the ED if last three symptoms are present.

Are positive findings present?

No → Box 2: Plan of care for CHF patients

- Encourage patient to collaborate with provider to treat known risk factors.
- Evaluate patient at regular intervals for signs/symptoms of heart failure.
- Teach patient to report weight gain >2-3 lbs and changes in heart rhythm.
- Instruct patient to comply with LV function testing.
- Encourage medication compliance, especialy with ACE-I/ARB.
- Patient education from Box 1.

Yes → Follow plan of care for diagnosis/ management of CHF.

Seek to exclude CHF as diagnosis/cause of symptoms:
- ECG (acute ischemic findings, new LBBB)
- BNP

→ Transfer to ED if signs/symptoms of acute coronary syndrome are present.

Both normal?

No →
- CXR, CBC, CMP, thyroid function testing, Hgb A1c, lipids, spirometry, microalbumin.
- Refer for echocardiogram.
- Lifestyle management with Box 1 and Box 2.

→ See page 2 for Heart Failure Management

Yes → CHF unlikely cause of symptoms. Consider CXR, CT chest, venous doppler, etc.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 7/12/17. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Congestive Heart Failure, page 2

Stage A
At high risk for heart failure without structural heart disease or symptoms.

Patients with
- Hypertension
- Atherosclerotic disease
- DM
- Obesity
- Metabolic syndrome
- Patients on cardiotoxins
- Patients with FHx of cardiomyopathy

Goals:
- Heart healthy lifestyle
- Prevent coronary and vascular disease
- Prevent LV structural abnormalities

Drugs:
- ACE-I or ARB +/- thiazide
- Statin as appropriate
- Aspirin as appropriate

Stage B
Structural heart disease but without signs or symptoms of heart failure

Patients with
- Previous MI
- LV remodeling including LVH and low EF
- Asymptomatic valvular disease

Goals:
- Prevent heart failure symptoms
- Prevent further cardiac remodeling

Drugs:
- ACE-I or ARB
- Beta-blocker as appropriate
- Thiazide diuretics
- Statin as appropriate
- Aspirin as appropriate

In select patients:
- ICD
- Revascularization or valvular surgery as appropriate

Stage C
Structural heart disease with prior or current symptoms of heart failure

Patients with
- Known structural heart disease
AND
- Signs and symptoms of heart failure

Preserved EF

Goals:
- Control symptoms
- Improve quality of life
- Prevent hospitalizations
- Prevent mortality

Treatment:
- Identify and follow guidelines to treat co-morbidities (DM, HTN, CAD, afib)
- Diuresis to relieve symptoms of congestion

Drugs:
- ACE-I or ARB
- Beta-blocker
- Loop diuretic
- Statin as appropriate
- Aspirin as appropriate

Reduced EF

Goals:
- Control symptoms
- Improve quality of life
- Prevent hospitalizations
- Prevent mortality

Drugs:
- Diuretic
- ACE-I or ARB
- Beta-blocker
- Aldosterone antagonists**
- Statin as appropriate
- Aspirin as appropriate

For selected patients:
- Hydralazine/isosorbide dinitrate
- Digoxin
- Cardiac resynchronization therapy
- ICD
- Revascularization or valvular surgery

Stage D
Refractory heart failure

Patients with marked heart failure symptoms at rest

Goals:
- Control symptoms
- Improve quality of life
- Reduce hospitalizations
- Establish end-of-life goals

Options:
- Heart transplant
- Chronic inotropes
- Temporary or permanent mechanical circulatory support
- Experimental surgery or drugs
- Palliative care/hospice
- ICD deactivation

Calcium channel blocker contraindicated in Stage C.

**Aldosterone antagonists:
- Use for estimated creatinine clearance > 30 and potassium < 5.
- Check BMP at baseline, day 2, day 7, monthly x3, Q3 mo x1 year, then Q6 mo

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Hypertension, Adults

BP Technique

- Use the appropriate sized cuff after 5 minutes of rest.
- Patient should be sitting or semi-reclining (not fully reclining).
- Confirm elevated levels at subsequent visits.

Patient >18 years, not pregnant

- Review meds for causes of increased BP.
- Implement lifestyle modifications.
- Set BP goal.

Definitions

- Normal: sBP <120 and dBP <80 mmHg
- Elevated: sBP 120-129 and dBP <80 mmHg
- HTN stage 1: sBP 130-139 or dBP 80-89 mmHg
- HTN stage 2: sBP ≥ 140 or dBP ≥90 mmHg
- Clinical CVD defined as: CHD, CHF, and stroke

Normal BP

Promote healthy lifestyle. Reassess yearly.

Elevated BP

Non-pharmacological interventions (see box). Reassess in 3-6 months.

HTN Stage 1

DM, CKD, known CVD, or **10-year ASCVD event risk** ≥ 10%?

Yes

For all ages, BP goal is <130/80 mmHg.
- Consider home BP monitoring.
- Non-pharmacological interventions (see box).
- Start anti-hypertensive.
- Reassess monthly until control is achieved.

At goal?

- **Yes** → Reassess Q3-6 months.
- **No** → Optimize/assess adherence. Consider intensification of therapy.

No

- Consider home BP monitoring.
- Non-pharmacological interventions (see box).
- For age ≥65, noninstitutionalized, ambulatory patients: sBP goal <130 mmHg. Use caution if starting two agents.
- For other populations, medication threshold is ≥140/90 mmHg.

Consider a more flexible BP goal if...

- Labile or postural hypotension
- History of side effects to multiple antihypertensives
- Older than 75, with a high burden of comorbidities or diastolic BP less than 55mmHg

HTN Stage 2

For all ages, BP goal <130/80mmHg.
- Consider home BP monitoring.
- Non-pharmacological interventions (see box).
- Start anti-hypertensive.
- Reassess monthly until control is achieved.

At goal?

- **Yes** → Reassess Q3-6 months.
- **No** → Optimize/assess adherence. Consider intensification of therapy.

For Difficult-to-Control BP

- Consider referral to cardiologist or nephrologist.
- If requiring three or more medications, screen for secondary causes of HTN.

Initial Monitoring

- FBS/A1c
- Complete blood count
- Lipid profile
- Serum creatinine with eGFR
- Na, K
- TSH
- Urinalysis
- EKG

Initial Drugs of Choice

- Thiazide diuretic (chlorthalidone is recommended first-line)
- CCB
- ACE-I
- ARB

Beta-blocker NOT first line except in pregnancy or women who may become pregnant.

With ACE-I, ARB, and thiazides, check BMP 2-4 weeks after initiating treatment, 2-4 weeks after dose increases, and at least yearly if stable.

Compelling Indications for Certain Drug Classes

- DM: thiazide diuretic, CCB, ACE-I, or ARB
- DM with albuminuria: ACE-I or ARB
- CKD with albuminuria: ACE-I or ARB
- Heart failure with reduced ejection fraction: GDMT βB (carvediolol or metoprolol succinate) and ACE-I or ARB, then spironolactone
- Heart failure with preserved ejection fraction: βB and ACE-I or ARB
- Stable ischemic heart disease: GDMT βB (carvedilol, metoprolol succinate, nadolol, or propranolol; avoid βB with intrinsic sympathomimetic activity; do not use atenolol), ACE-I or ARB (CCB if angina)
- Secondary stroke prevention: thiazide diuretic, ACE-I or ARB
- Pregnancy: methyldopa, nifedipine, and/or labetalol
- Race and ethnicity: black patients without HF or CKD (with or without DM): Thiazide diuretic or CCB. Of note, two or more BP lower medications are recommended in most black adults with hypertension to reach a goal of <130/80 mmHg.

GDMT: guideline-direct management and therapy

Non-Pharmacological Interventions

- Smoking cessation
- Control blood glucose and lipids
- Diet
  - Weight loss in adults who are overweight or obese
  - Healthy diet (e.g., DASH) that facilitates achieving desirable weight
  - Reduce sodium intake <1500 mg/day or aim for at least a 1000 mg/day reduction in most adults
  - Potassium supplementation (3500-5000 mg/day) preferably in diet, unless contraindicated
  - Limit alcohol to two drinks/day for men and one drink/day for women
- Physical activity: increase physical activity with a structured exercise program 90-150 minutes/week

References

1. Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Hypertension. 2018 Jun;71(6):e13-e115.
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3. Wald DS, Law M, Morris JK, Bestwick JP, Wald NJ. Combination therapy versus monotherapy in reducing blood pressure: meta-analysis on 11,000 participants from 42 trials. Am J Med. 2009 Mar;122(3):290-300.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 7/6/21. Click **here** to see the supplemental resources for this guideline.

If comments about this guideline, please contact Jason_Barrett@ykhc.org or Marsha_Dunkley@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Post-MI Management

Patient discharged from hospital with acute MI (STEMI and NSTEMI).

Appointment made in outpatient clinic or SRC within 1-2 weeks of discharge:
- Review cardiology plan, including medication list; echo with EF; and timeline for cardiology f/up, stress test, or diagnostic testing
- EKG
- CMP*
- Lipid panel*
- A1c*

*if not available from recent hospitalization

How was patient revascularized?

- PCI
  - Drug-eluting stent → Aspirin + $P2Y_{12}$ inhibitor, Goal >1 year, Minimum 6 months
  - Bare metal stent → Aspirin + $P2Y_{12}$ inhibitor, Goal >1 year, Minimum 1 month
- CABG → Aspirin + $P2Y_{12}$ inhibitor, Goal >1 year, Minimum per surgeon discretion
- None, medical management → Aspirin + $P2Y_{12}$ inhibitor, Goal >1 year, No minimum

For All Patients (See Post-MI Medication Box):
- Beta blocker
- ACEi or ARB
- Statin

EF <40%? Yes → Aldosterone antagonist (See box.)

No

- Give PPSV23 if not previously given.
- Counsel about smoking cessation.

PCP follow up in 4-6 weeks:
- EKG if not done at first visit
- BMP
- Titrate medications as needed to reach goals.

Angina Treatment

- Sublingual nitroglycerin as needed.
- Uptitrate metoprolol to goal HR 55-60.
- Consult cardiology for consideration of long-acting nitrates, calcium channel blockers, and/or ranolazine, repeat stress testing if needed.

Long-Term Follow-Up

- PCP follow up every 4-8 weeks as needed to obtain goal medical management.
- Cardiology follow up scheduled in 3-6 months, then per specialist.

Post-MI Medication Box

1. Antiplatelet therapy
- aspirin 81-162mg daily for life
- $P2Y_{12}$ inhibitor
  - clopidogrel 75mg daily
  - ticagrelor 90mg BID
  - prasugrel 5-10mg daily

Note: discuss with cardiology if considering stopping or holding DAPT within 1 year of MI with drug eluting stent.

2. Beta blocker: Goal HR 55-70. Avoid in patients with SBP <90, conduction abnormalities.
- metoprolol succinate starting dose 25-50 mg, target dose 200 mg daily (or maximum tolerated without side effects)
- atenolol starting dose 25 mg BID, target dose 50 mg BID
- carvedilol starting dose 6.25 mg BID, target dose 25 mg BID

3. ACEi/ARB: Goal BP <130/80. Continue at low dose even if at goal at baseline.
- lisinopril 5-40 mg daily
- losartan 25-100 mg daily

4. Statin therapy: Goal LDL<70
- high intensity (all patients age <75 yo)
  - atorvastatin 40-80 mg daily
  - rosuvastatin 20-40 mg daily
- moderate intensity (patients age >75 OR intolerant of high intensity)
  - atorvastatin 10-20 mg daily
  - rosuvastatin 5-10 mg daily
  - simvastatin 20-40 mg daily

Note: if not at LDL goal <70, consider adding second agent (ezetimibe, fibrate, PCSK9 inhibitor, etc.).

5. Aldosterone antagonist: Monitor BMP. Avoid if K>5, CrCl <30.
- spironolactone 12.5-50mg daily
- eplerenone 25-50mg daily

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Approved by MSEC 6/8/21.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Return to Table of Contents.

Yukon-Kuskokwim HEALTH CORPORATION

Gastrointestinal, Hematologic, & Endocrine Guidelines

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Diabetes Mellitus, Type 2

Disclaimer: Diabetes is a complex disease; however, the management of diabetes is considered an essential skill of ambulatory care. Please be familiar with the ADA guidelines for treatment **here**, and the abbreviated version **here**.

Diagnostic Criteria

Unequivocal symptoms of hyperglycemia (thirst, polyuria, weight loss, and blurry vision) and either any one of the following OR any two of the following. (Take confirmatory test as close as possible to initial lab value to avoid treatment delays.)

- FPG* ≥ 126mg/dl
- 2 hour PG ≥ 200mg/dl during OGTT
- Hgb A1c ≥ 6.5
- RPG ≥ 200mg/dl and symptoms of hyperglycemia or hyperglycemic crisis

Note: Fasting is defined as no caloric intake for at least 8 hours.

Causal Factors

- Dietary pattern: liquid calories, processed foods/carbohydrates, to lesser extent fat intake.
- Physical inactivity.
- Excessive cortisol: usually past trauma or chronic stress.
- Iatrogenic: psychiatric meds or corticosteroids.

Lifestyle Management

- Self-care through sleep hygiene, mindfulness, nature, and similar efficacious stress reduction techniques.
- Advise developing a positive, supportive social network.
- Use patient centered SMART goals, including consideration of individualized targets, impact on weight, hypoglycemia risk, side effect profile of medications, and complexity of regimen. Choose regimen to optimize adherence and persistence.
- Exercise is medicine: Titrate to 150 min/week minimum.
- Advise 7-10% weight loss if obese.
- Recommend traditional Alaska Native diet with emphasis on maximizing plants and high fiber foods.

Screen all overweight or obese adults with one or more other **risk factors** and all adults >45 years for type 2 diabetes mellitus.

↓

See diagnostic criteria.

↓

Confirm diagnosis and add to problem list in RAVEN.

↓

- Refer all new diagnoses of diabetes or prediabetes to the Diabetes Department.
- In RAVEN, order "Refer to Diabetes Program Internal" and select appropriate reason. Add additional comments/ questions/requests.
- Call 543-6133 for same-day counseling appointments.

↓

Schedule follow up appointment for 2-4 weeks and coordinate with diabetes department if possible.

↓

At initial and annual diabetes visits:

- Perform health measures (see box).
- Discuss and educate on pathophysiology in patient centered terms.
- Identify and quantify causal factors (see box).
- Initiate lifestyle management (see box).
- Set **A1c target** based on age and risk factors or complication risk.
- Set BG Monitoring goals and methods.
- Risk stratify patient by comorbidities and ASCVD risk (see box).
- Refer to appropriate diabetes resources (see box). Refer to Diabetes Department for all new diagnoses and annually (or more frequently) if not meeting A1c or lifestyle goals.

Comorbidities and ASCVD Risk

Comorbidities must be evaluated before medication initiation and at least annually. Document in chart and address in visit Assessment and Plan where appropriate. May use the 10 year ASCVD **Risk Calculator**.

- Heart failure
- CKD: classified based on cause, GFR, and albuminuria. See **link**.
- Hypertension
- Obesity
- Obstructive sleep apnea

Health Measures

- Review Health Maintenance in RAVEN.
- Give diabetes-related and dosed immunizations if due.
- Foot exam.
- Mental health screen (refer to BH if needed).
- Sexual health screen and family planning discussion.
- Labs if not already done: A1c, lipids, CMP, urine microalbumin.
- Refer to optometry.
- Refer to dental.

Remember: language matters. See this **ADA resource**.

Diabetes Resources

- Diabetes Self-Management Education and Support (DSMES)
- Medical Nutrition Therapy (MNT)
- Continuous Glucose Monitor (CGM): usually for those with A1c >9, those on insulin, or those not achieving A1c goals. See **ADA paper**.
- Other (DM support group, exercise physiology for exercise Rx)

Abbreviations/Acronyms

ADA = American Diabetes Association
ASCVD = Arteriosclerotic cardiovascular disease
BH = Behavioral Health
CKD = chronic kidney disease
CMP = Complete Metabolic Profile
DM = Diabetes mellitus
FPG = Fasting Plasma Glucose
Hgb A1c or A1c for short = Hemoglobin A1c or glycosylated hemoglobin
HTN = Hypertension
OGTT = Oral Glucose Tolerance Test
OSA = Obstructive sleep apnea
PG = Plasma Glucose
RPG = Random Plasma Glucose
SMART = Specific, Measurable, Achievable, Realistic, Time-limited

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Approved by MSEC 9/2/20.
Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Elizabeth_Tressler@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Type 2 Diabetes Mellitus Management

Abbreviations

- DPP-4i = dipeptidyl peptidase 4 inhibitor or gliptins. YKHC formulary saxagliptin (Onglyza).
- GLP-1 RA = glucagon-like peptide-1 receptor agonist. YKHC formulary liraglutide (Victoza).
- SGLT2i = sodium-glucose co-transporter-2 inhibitor. YKHC formulary empagliflozin (Jardiance).
- SU = sulfonylureas. YKHC formulary glipizide.
- TZD = thiazolidinedione. YKHC formulary pioglitazone.

Medication selection is based on comorbidities and patient centered goals.

Always begin with lifestyle interventions. These are essential as medication response is often dependent on lifestyle measures.

Metformin: always first-line unless true allergy. If not tolerated, allow patient a break and then re-try.

Indicators of high-risk for ASCVD or established ASCVD, CKD, or HF?

Yes

Consider using a SGLT2i or GLP-1 RA independent of baseline A1c or A1c target. SGLT2i for CKD or HF and GLP-1 RA if ASCVD predominates.

No

Using shared decision making with patient, choose from any of the four classes: GLP-1 RA, SGLT2i, DPP-4i, TZD
Use GLP-1 RA or SGLT2i if weight loss/maintenance a goal.

Follow-up in 1-3 months.

If not achieving targets, continue to add classes of medications
GLP-1 RA or SGLT2i
+
DPP-4i (do not combine with GLP-1 RA) or TZD (do not use if HF present)
+
SU or basal Insulin
(Always maximize non-insulin medications first, including injectable GLP-1 RA unless the patient has significant hyperglycemia and weight loss. Then add insulin early.)

Follow up visits at least every three months until lifestyle and A1c goals achieved.

If not achieving A1c goals, consider using CGM, revise SMART goals, utilize DSMES, DM support group, screen for Diabetes Distress or other psychosocial issues.

- If not achieving A1c goals and on four classes of medication including basal insulin, consider referral to ANMC Diabetes program and/or multidisciplinary discussion with diabetes team.
- Add prandial insulin as needed and ensure insulin teaching, self-management goals, and that patient is performing appropriate monitoring
- Continue to utilize a patient centered approach with shared decision making. Revisit lifestyle behaviors, patient specific motivators, psychosocial factors, and address medical comorbidities.

Lifestyle Management

- Self-care through sleep hygiene, mindfulness, nature, and similar efficacious stress reduction techniques.
- Advise developing a positive, supportive social network.
- Use patient centered SMART goals, including consideration of individualized targets, impact on weight, hypoglycemia risk, side effect profile of medications, and complexity of regimen. Choose regimen to optimize adherence and persistence.
- Exercise is medicine: Titrate to 150 min/week minimum.
- Advise 7-10% weight loss if obese.
- Recommend traditional Alaska Native diet with emphasis on maximizing plants and high fiber foods.

Shared decision making includes an educated and informed patient and their family/caregiver, patient preference, motivational interviewing, goal setting, ensuring access to DSMES, and empowering the patient.

Diabetes Distress refers to negative psychological reactions to the emotional burden and patient worries specific to their experience of managing a complicated and demanding chronic disease. See ADA **position statement**.

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Approved by MSEC 9/2/20.
Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Elizabeth_Tressler@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

H pylori/Dyspepsia (Adult and Pediatric)

Background Information:
- 75% of the AN/AI population is colonized with H. Pylori (range 61-84%).
- Screening or testing for H. Pylori for routine evaluation of dyspepsia or other GI symptoms is not clinically useful or supported by evidence for high prevalence populations.
- For routine clinical practice, there **is insufficient evidence-based data** to support community-wide eradication as a mechanism for gastric cancer prevention.
- Current literature **DO NOT** support a test and treat method with noninvasive tests.

Pediatrics:
- Goal is to determine underlying cause of symptoms, not solely the presence of *H pylori* infection.
- Principles of testing and treatment are the same as for adults.
- Diagnostic testing is NOT recommended with functional abdominal pain or iron-deficiency anemia.
- Consult pediatrics if considering this diagnosis.

Pregnancy and Lactation:
- Delay treatment until after pregnancy
- DO NOT use in Pregnancy: bismuth and tetracycline
- DO NOT use in lactation: bismuth, metronidazole, levofloxacin

Testing/Treatment strategy

Dyspepsia

Weight loss/ fecal blood?

Yes

No

Empiric Treatment with H2 Blocker or PPI

Improvement?

No

If adult: Perform Upper Endoscopy. If child: Consult pediatrics.

Yes

Follow up for recurrence of clinical symptoms

H. Pylori identified by histology and/or CLO test from EGD
AND
Endoscopy reveals the following:
- Duodenal ulcers
- Gastric ulcer
- MALT lymphoma
- Intestinal metaplasia

Treat for H. Pylori with antibiotics

****All treatment is for 14 days****

Adult Dosing
Preferred Treatment:
Metronidazole 500 mg PO QID
Amoxicillin 1000 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID

PCN allergic (anaphylactic):
Metronidazole 500 mg PO QID
Doxycycline 100 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID

Recurrence/Failure:
Metronidazole 500 mg PO QID
Doxycycline 100 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID
OR
Amoxicillin 1000 mg PO BID
Levofloxacin 500 mg PO daily (FDA Black Box)
Omeprazole 20 mg PO BID

Pediatric Dosing
Metronidazole 10 mg/kg PO BID
Amoxicillin 45 mg/kg PO BID
Omeprazole 1 mg/kg PO BID
Bismuth subsalicylate
<10 years: 262 mg PO QID
>10 years: 524 mg PO QID

Other causes of dyspepsia that antibiotics will NOT help, EVEN IF H. Pylori is detected:
- GERD
- Irritable Bowel Syndrome
- Mild/moderate gastritis
- Excessive/chronic NSAID use
- Heavy alcohol use
- Poor gastric mobility

Symptomatic Relief Medications:
Adults:
Ranitidine 150 mg PO BID
Omeprazole 20 mg PO BID

Children:
Ranitidine 5-10 mg/kg PO divided BID

Eradication Testing:
- Urea Breath Test for *Test of Cure* is necessary to determine need for retreatment. It can be performed on children as young as 3. The stool antigen test available at YKHC is not recommended for test of cure.
- 10-35% of individuals will fail treatment.
- Serologic testing is not recommended due to prolonged antibody persistence beyond date of cure and false positive results.
- Must be off PPI for ≥ 2 weeks prior to Urea Breath Test.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/26/18. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline
Iron Infusion for Chronic Iron-Deficiency Anemia (Adult & Pediatrics)

Iron-Deficiency Anemia Work-Up

- Evaluate for blood loss.
- Evaluate for dietary deficiencies.
- Labwork classically shows:
  - ↓ Hgb
  - MCV < 80
  - Ferritin < 30
  - ↑ TIBC

Causes of Iron-Deficiency Anemia

- Decreased dietary intake.
- Severe/ongoing blood loss (especially GI or uterine).
- In toddlers: excess milk intake. (Recommended daily milk intake is <16 ounces.)
- History of gastric bypass.
- Malabsorption syndromes.
- Coexisting inflammatory state that interferes with iron homeostasis (example: rheumatoid arthritis or lupus).

Diagnosis of iron-deficiency has been established.

↓

Patient meets criteria for iron infusion, and patient or parent has agreed to infusion.

↓

Provider places order "Refer to Infusion – Internal." Include patient's phone number.

↓

Provider places future orders using "AMB IV Iron" or "PEDS IV Iron" Power Plans.

↓

- Provider updates Problem List with Iron-Deficiency Anemia.
- In the comments, provider states the plan (iron infusion with date ordered) and includes goal hemoglobin after infusions.

↓

Infusion clinic nurse schedules patient for infusion. Case Managers write Letter of Medical Necessity. Village clinic arranges travel.

↓

- Infusion(s) given per orders.
- All patients should have a follow-up hemoglobin level checked one month after infusion.
- If not at goal hemoglobin, patient should return to Bethel outpatient clinic for further evaluation.

See **Anemia in Pregnancy** guideline for indications in pregnancy.

Indications for Iron Infusion

If patient is hemodynamically unstable due to anemia, consider transfusion regardless of hemoglobin level. Ensure iron studies have been sent prior to transfusion.

- Hemoglobin between 5 and 7 in a hemodynamically stable, asymptomatic patient:
  - -Patients <18 years: iron infusion likely indicated. Consult pediatric hematologist.
  - -Patients ≥18 years: consider iron infusion alone vs transfusion followed by iron infusion based on clinical judgment.
- Hemoglobin between 7 and 8 with failure of oral iron therapy. Failure is defined as:
  - - Minimal improvement in hemoglobin level despite at least two months of compliance with oral iron (in children 6 mg/kg/day; in adults ferrous sulfate 325 mg PO daily with ascorbic acid 250 mg PO daily)
  - - Intractable GI side effects
  - - Non-compliance after at least three attempts at oral iron therapy.
- Other patients may receive iron infusion if recommended by a hematologist.

Note: Patients <2 should have a hematology consult prior to beginning an infusion. The Infusion Center does not generally treat children <2, so they are generally admitted to Inpatient Pediatrics for iron infusions.

Iron Replacement Dose Calculation

$$Total\ Iron\ Replacement\ Dose\ (in\ mg) = 0.6\ x\ weight\ x\ \left[100 - \left(\frac{actual\ hemoglobin}{desired\ hemoglobin}\right) x\ 100\right]$$

For pediatric patients:
- Using iron sucrose, this dose should be given in aliquots of 5-7 mg/kg until the full replacement dose has been given. Max dose is 100 mg for initial dose and 300 mg for repeat doses.
- Per Pediatric Hematology, may give children two iron sucrose doses 24 hours apart and then repeat in 1-2 weeks. Giving more frequent dosing or more than two daily doses in a row results in decreased absorption and increased side effects in children.

For adult patients:
- Dose is typically iron sucrose 300 mg IV daily x3 doses.

Side Effects/Reactions

Efficacy and safety have been evaluated in adults and children older than two years. Consult pediatric hematologist for children younger than two years.

Specific reactions (rare):
- Hypersensitivity, including anaphylaxis and angioedema. Stop infusion immediately and treat as anaphylaxis.
- Hypotension (related to high total doses or rapid infusions). Stop infusion and treat with IVF, as appropriate.
- Infection: avoid administering if active systemic infection.
- For IV infiltrates, place cold pack.

Resources

- Consult Peds Wards On Duty by Tiger Connect.
- A pediatric hematologist can be reached for further questions at Alaska Pediatric Oncology at (907) 929-3773.
- ANMC Adult Hematology Oncology can be reached at (907) 729-1180.

Last reviewed 7/6/21. Click **here** to see the supplemental resources for this guideline.

If comments about this resource, please contact Leslie_Herrmann@ykhc.org.

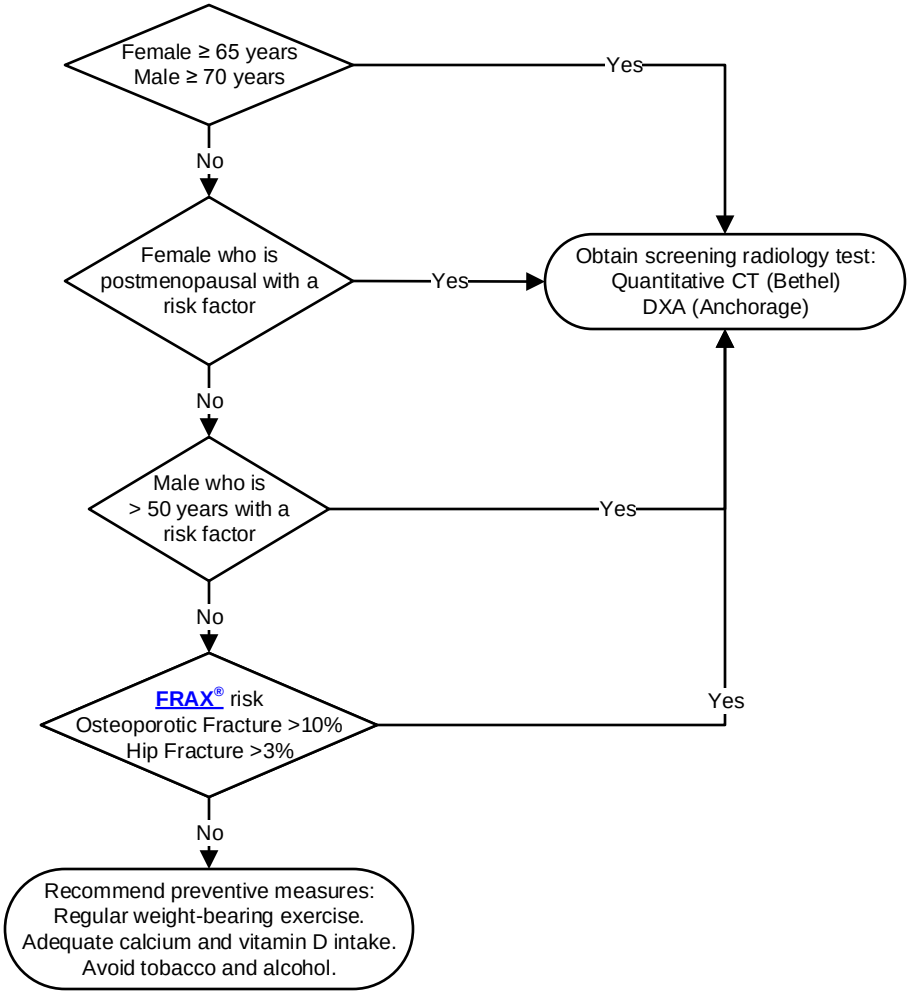
Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Osteoporosis Screening

Risk Factors
- Osteopenia on X-ray.
- History of fracture without trauma.
- Tobacco use.
- Excessive alcohol use.
- Height loss more than ½ inch in one year.
- Height loss more than 1.5 inches total.
- At risk medication use (see box below).
- BMI < 20.
- Premature menopause.

At Risk Medications
- Systemic steroids >3 months
- Methotrexate
- Aromatase inhibitor
- Selective estrogen receptor modulator
- Proton pump inhibitor
- Heparin
- SSRI



Recommended Calcium Intake

Age	Sex	RDA mg/day
9-18	M+F	1300
19-50	M+F	1000
51-70	M	1000
51-70	F	1200
>71	M+F	1200

Recommended Vitamin D Intake

Age	Sex	RDA IU/day
14-70	M+F	600
>71	M+F	600

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If comments about this guideline, please contact David_Compton@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Osteoporosis Treatment

Abbreviations
BMD – Bone mineral density
BTM – Bone turnover markers
FRAX® – Risk scoring algorithm

FRAX® High Risk for Fracture
10 year risk of major osteoporotic fracture ≥ 20% or hip fracture risk ≥ 3%.

If patient has one or more of the following:
- Lumbar spine or femoral neck or total hip T score ≤ -2.5
- CT bone density < 80 mg/cm^3
- History of a fragility fracture
- High FRAX® fracture probability

Evaluate for secondary causes of osteoporosis.

Some Secondary Causes of Osteoporosis
- Drugs
- GI-related illness
- Bone marrow disease
- Endocrine disorder
- Organ transplant

Correct calcium/vitamin D deficiency and address secondary causes of osteoporosis.

Educate patient on lifestype measures, fall prevention, and benefits and risks of medications.

Obtain dental evaluation of and treatment for risk of osteonecrosis of jaw.

Consider endocrinology consultation.

Prior fragility fracture

No → Start alendronate.

Reassess at least yearly.

Worsening?

Yes → Assess compliance. Reevaluate for secondary causes of osteoporosis.

Switch to zoledronic acid or denosumab.

No → Consider drug holiday after five years.

Resume therapy when fracture occurs, BMD declines, or BTM rises.

Yes → Start zoledronic acid or denosumab.

Place note in RAVEN that includes autotext "..OsteoporosisPreTreat" at least two weeks prior to visit for medication.

Reassess at least yearly.

Worsening?

Yes → Consult adult endocrinologist.

No → Consider drug holiday after six years with zoledronic acid.

Adapted from AACE/ACE 2016 Postmenopausal Osteoporosis Treatment Algorithm.

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If comments about this guideline, please contact David_Compton@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Infectious Disease Guidelines

Infectious Disease

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Amoxicillin Allergy Trials (Pediatric)

Background

• Only 4-9% of those...labeled [penicillin-allergic] are currently allergic. It is important to identify those who are not allergic, because children mislabeled as penicillin-allergic have more medical visits, receive more antibiotic prescriptions, and have longer hospitalizations with more antibiotic-related complications.[1]
• Up to 10% of children develop rashes while receiving antibiotics. Most are diagnosed...as allergic to the implicated antibiotic, and most continue to avoid the suspect antibiotic in favor of alternatives, which may be less effective, more toxic, and more expensive.[2]
• Do not label a patient as allergic to penicillin/ amoxicillin unless he or she has true hives, anaphylaxis, or a life-threatening reaction. Please include photos of rashes in RAVEN.
• Children labelled as allergic to penicillin/amoxicillin often carry that label for the rest of their lives.
• Please consult a pediatrician with any questions.

Anaphylaxis

• Acute onset – several minutes to hours from exposure.
• Generalized hives, pruritis or flushing, swelling of lips/tongue/uvula, and at least one of the following:
  Dyspnea, bronchospasm, stridor
  Hypotension
  Evidence of hypoperfusion of end-organs
  Persistent crampy abdominal pain, and/or vomiting or diarrhea

Hives vs Viral Rash

• True hives are raised, itchy, larger than dime-sized, come and go, move around the body, and change shape and size. True hives are uncomfortable. Ask if the rash bothered the child.
• Keep in mind that many parents refer to any rash as "hives." Get a description every time.
• A viral exanthem is typically diffuse, fine, pinpoint red dots and can be dense, coalesced, larger raised lesions. The rash typically covers the face and chest but can cover the whole body. The rash typically worsens and takes days to clear.

Patient labeled with a penicillin/ amoxicillin allergy.

→ Review history. (See box.)

→ Was the reaction anaphylaxis (see box) or other life-threatening reaction (eg Stevens-Johnson syndrome, etc.)?

Yes → • Do not give drug or perform trial.
• Update chart, including the Problem List and a comment on the allergy.
• Refer to Allergy & Immunology at 5.

No → What was the reaction?

History

Chart review:
• Review notes in allergy alert. Find date allergy was added, and then review notes from that day. Was ED visit or hospital admission required?
• Review Multimedia Manager photos.
• Were steroids or other treatment given?
• Has patient received a drug of the same class since the allergy was reported? Was it tolerated? Were there symptoms?

History from patient/family:
What was the reaction?
- Vomiting and/or diarrhea?
- Rash?
  Age? Time from first dose?
  Hives? (See box.) Was it itchy?
  Blistering or peeling?
  Photos from family?
- Trouble breathing?
- Swelling of tongue/lips?
- Joint swelling or fever?
- Mucous membrane involvement?

Rash

True hives, skin blistering/peeling, or mucous membrane involvement → • Do not give drug or perform trial.
• Update chart, including the Problem List and a comment on the allergy.
• Refer to Allergy & Immunology at 5.

Viral-appearing rash or other type of rash → **Not a true allergy.**
• Educate and perform Amoxicillin Trial (see box).
• If patient/family refuses trial, update Problem List.
• Offer future trial or refer to Allergy & Immunology at age 5 for amoxicillin allergy testing.

Vomiting and/or diarrhea without any other S/Sx anaphylaxis

→ **Not a true allergy.**
• Educate and perform Amoxicillin Trial (see box).
• If patient/family refuses trial, update Problem List.
• Offer future trial or refer to Allergy & Immunology at age 5 for amoxicillin allergy testing.

Other

→ Get more history. Consider pediatric consult.

Amoxicillin Trial Procedure[2]

Use AMB Amoxicillin Trial Power Plan.

1. Obtain VS. Perform physical exam, including lung exam. Have appropriate dose of EpiPen or epinephrine. Epinephrine (1 mg/mL): 0.01 mg/kg (or 0.01 mL/kg) IM Q5-15 minutes.
Per AAP recommendations:
  • 7.5-25 kg: use EpiPen Jr (0.15 mg)
  • ≥ 25 kg: use EpiPen (0.3 mg)
2. Calculate weight-based dose of amoxicillin. Give patient 10% of that dose.
3. Place patient in nearby room and instruct caregiver to notify staff of any changes in status.
4. If no reaction by 20 minutes, give patient remaining 90% of weight-based dose of amoxicillin.
5. Observe another 60 minutes. If no reaction, check VS and physical exam. If all stable, discharge home with regular course of drug.
6. Give patient and family amoxicillin trial education sheet.
7. Update allergy alert in RAVEN. Click the allergy in the banner. Right click over the drug name and choose "cancel." On the "reason" drop-down menu, choose "OK on Retrial."

Notes:
• If patient is on a beta-blocker, stop this for 24 hours prior to procedure, if possible. Beta-blockers can interfere with treatment for anaphylaxis, if it occurs.
• Ensure that patients with asthma have optimal control prior to this procedure.

References
1. Kelso JM. "Provocation challenges to evaluate amoxicillin allergy in children." JAMA Pediatrics 2016;170(6):e160282.
2. Mill C, et al. "Assessing the diagnostic properties of a graded oral provocation challenge for the diagnosis of immediate and nonimmediate reactions to amoxicillin in children." JAMA Pediatrics. 2016;170(6):e160033.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 8/3/21. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Suspected Botulism

Potential exposure to botulism:
• Ingestion of fish/food fermented in an anaerobic environment or seal oil.
• Development of concerning symptoms thereafter (12-36 hours typical, but can be 6 hours to 10 days).

↓

Clinical paradigm suggesting botulism?
• GI symptoms with autonomic or neurologic abnormality
• Cranial nerve deficit with no apparent cause
• Descending symmetrical paralysis or weakness with no apparent cause

AND

At least three of the five following symptoms present (botulism "diagnostic pentad")?
• Dilated or fixed pupils
• Diplopia
• Dry throat
• Dysphagia
• Nausea or vomiting

Other Symptoms

• Sore throat
• Dysarthria
• Hyporeflexia
• Urinary retention
• Ileus

No → Suspected Botulism

• Obtain appropriate labs (below).
• Admit for close clinical monitoring.

Yes → High Risk for Botulism

• Obtain blood for botulism testing before starting BAT.
• Start BAT. Watch for signs of anaphylaxis.
• Complete **BAT packet** found on State Epi website.
• Supportive care based on clinical picture.
• If not requiring higher level of care, admit for close clinical monitoring.

↓

All cases:
• Contact AK State Office of Epidemiology.
• Collect lab specimens for testing at state lab:
  -Collect 5-10 ml of serum (or 20 ml whole blood) for botulism testing (before BAT)
  -Collect any stool (10-50 ml) and emesis (20 ml) for botulism testing
  -When possible, also collect suspect food (50 g, keep cold)
• Monitor clinically as an inpatient (Rapidly-progressing illness. 24 hours likely adequate):
  -Watch for "diagnostic pentad" symptoms above. Start BAT as appropriate.
  -Obtain FVC at baseline every 1-2 hours. Intubate if FVC declines 30%.
• Standard precautions are appropriate (not transmitted person-to-person).

Botulism Anti-Toxin (BAT)

• BAT does not reverse current anticholinergic symptoms but prevents progression by binding the toxin in the blood.
• No adverse effects of BAT have been reported thus far.
• Pharmacy can assist with the BAT packet forms to be completed when administered.

Resources

• AK State Office of Epidemiology **Website**:
  -907-269-8000 (M-F, 8-5) and 800-478-0084 (after hours)
• State Lab **Website**:
  -1-855-222-9918
Division of Public Health Healthcare Provider **Checklist**

Note: Botulism toxin only causes flaccid paralysis. Patients are awake, alert, and aware. Procedures should be explained and appropriate pain control and sedation for intubated patients should be provided.

Infant Botulism:

This is rare, with only 5 reported cases in AK in the past 65 years. If suspected, see Epi Procedure Manual, Botulism at State website.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/2/20. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Lisa_Evans@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Bronchiectasis/Chronic Cough (<18 years)

Definitions

• Bronchiectasis is a lung condition with chronic wet cough and lung infections and is diagnosed by CT scan.
Use ICD10 code J47 – "Bronchiectasis."
• Bronchiectasis risk is defined as ≥3 episodes of wet cough >4 weeks in the past 2 years, often in a setting of persistent infiltrates and recurrent pneumonia.
Use ICD10 code J41.1 – "Chronic purulent bronchitis."

Bronchiectasis or Bronchiectasis Risk

Add to CPP registry.
Update Problem List with ICD10 code.

Chronic Management

Acute Management

Comorbidity Management

• Aspiration: trial thickener if <3 years, feed with swaddling in side-lying position at 45 degrees with slow-flow nipple, consider speech therapy.
• TB: place PPD, send sputum/gastric aspirates if indicated (see Pediatric TB Evaluation & Treatment guideline).
• Asthma: bronchodilators, inhaled steroids.
• CF: confirm that negative on newborn screen.

Maintenance Management

• Follow-up with pulmonology clinic Q3-6mo and pediatrician or health aide Q2-3mo to check symptoms and medications. At every visit:
  - Patient and caregiver should repeat diagnosis.
  - Review plan for exacerbations.
  - Check that bronchiectasis is on Problem List.
• Annual PFTs if >5 years.
• Annual flu vaccine.
• Pneumococcal vaccines: PCV-13 series followed by one dose of PPSV-23 (Pneumovax) at ≥ 2 years.
• Treat dental caries.
• Optimize environmental health with woodstove safety, vents, irritant reduction, smoking cessation, etc.
• Airway clearance: P&PD/chest PT, consider acapella.
• Consider allergy testing.

Transition of Care

• Review diagnosis and management with patient and caregiver at each visit. Patient and caregiver should verbalize diagnosis, treatment, and exacerbation plan.
• At age 17, a pediatrician should review chart and refer patient to pediatric pulmonology for chest CT, treatment plan, and handoff visit.
• At age 18, a pediatrician should schedule a transition of care appointment with family medicine, write an Alert Note that includes a summary of medical history and current treatment plan, and refer to adult pulmonologist.

• Persistent infiltrate >6 weeks
or
• Chronic wet cough ≥4 weeks
or
• Fever, increased wet cough, dyspnea, etc.

Treat with Augmentin 45 mg/kg/dose BID or cefdinir 14 mg/kg/dose daily for at least 2 weeks.
Chest physiotherapy TID.
Recheck after two weeks.
Consider systemic steroids if significant bronchospasm.

Improved

Stop antibiotics.
Follow-up in 2-3 months.
Restart antibiotics for additional 2 week course if cough recurs.

Not improved

Continue antibiotics and recheck after two more weeks.

Improved

Stop antibiotics.
Follow-up in 2 months.
Restart antibiotics if cough recurs.

Not improved

Consult pulmonologist.
Do sputum culture (via RT in Bethel) and adjust antibiotics per sensitivities.
Consider repeat CXR.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 9/2/20. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Bronchiolitis/Wheezing (3–24 months)

NOTE:
- If <3 months or history of prematurity, keep patient in Bethel and have low threshold for admission.
- RSV increases risk of apnea in these patients.
- If patient is <90 days and febrile, please see fever guidelines.

Wheezing in a 3-24 mo patient

Institute SUPPORTIVE MEASURES. Then reassess respiratory distress.

Moderate to severe respiratory distress
Sustained tachypnea, increased work of breathing, and/or hypoxia

Mild respiratory distress
Intermittent tachypnea, increased work of breathing, and/or hypoxia

Obtain CXR

Evidence of pneumonia?

Yes

See Pediatric Community-Acquired Pneumonia Clinical Guideline

No

- Requires >2 L supplemental oxygen to prevent hypoxia or improve WOB?
- Requires neb treatments more frequently than Q3-4h for >8 hours?
- Has sustained tachycardia, tachypnea, or respiratory distress despite treatment?

Yes

Transfer to Anchorage. Consider high flow nasal cannula.

No

Admit to YKHC Peds Inpatient Unit with IV fluids.

After 48-72 hours

- Patient improving with increased appetite and activity, less WOB, and decreasing fever curve?
- No hypoxia on room air?
- Tolerating home therapy with competent caregivers?
- Immunizations UTD?

Yes

Discharge home with close follow-up within a week

No

Consider:
- Nasal steroids (Pred-Forte 1 spray each nostril BID x5 days) and/or Neo-Synephrine (1 spray each nostril BID x3 days).
- More frequent albuterol/hypertonic saline nebs.
- Racemic epinephrine neb.

Improvement?

Yes

No

Continue SUPPORTIVE MEASURES with close follow-up as needed

SUPPORTIVE MEASURES
- Control fever, as it can be an independent cause of respiratory distress and tachycardia.
- Nasal suction with nasal bulb syringe and olive tip plus saline.
- Hydration by IV or enteral (including NG and G-tube).
- Gentle P&PD/CPT if helpful.
- Saline neb (either 0.9% or hypertonic 3%).
- Consider albuterol trial even if no wheezing heard, especially in Alaska Native patients as they have high rates of RAD.

Village Management
- Institute SUPPORTIVE MEASURES, especially fever control, nasal suction, IV or PO hydration, and several albuterol nebs.
- Have low threshold to refer to Bethel for further evaluation if no improvement with supportive measures or any concerns.
- If no improvement after 2-3 days of village management, refer to Bethel for further care.
- If unable to bring to Bethel and worsening, consult a pediatrician and consider systemic steroids.

Hypoxia
<90% while awake
<88% while asleep
Sustained for >10 minutes

Pulse-Oximetry Monitoring:
- Pulse-ox may be ordered Q4h (not continuously) if age >6 months and patient is stable.
- Being on oxygen does not mandate continuous pulse-oximetry if patient is stable.

When Admitting, Use Power Plan to Order:
- IVF
- Nasal suction
- Nebs prn
- Consider scheduled nebs
- No deep (nasopharyngeal) suctioning
- Respiratory assessments
- Consider hypertonic (3%) saline – may need to use with albuterol

NOTE ABOUT STEROIDS:
National guidelines recommend against systemic steroids as the potential harm is generally greater than the potential benefit.
If considering starting steroids, please consult a pediatrician.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 5/8/19. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Croup/Stridor (6 months – 3 years)

Signs of Impending Airway Compromise

- Drooling
- Lethargy
- Tripod position
- Marked retractions
- Tachycardia
- Cyanosis or pallor
- Rapid progression of symptoms

NOTE: Use extra caution in children with airway anomalies or ANY history of prior intubation.

Important Supportive Measures

1. Keep child upright or in position of comfort.
2. Turn lights down and minimize unpleasant interventions.
3. May take child outside for cool air.
4. Minimize invasive measures – keep child CALM!
5. **DO NOT** give albuterol; this can worsen croup.

Child with stridor → Are there signs of impending airway compromise?

Yes → **Be prepared for possible intubation**:
- Activate medevac if in village.
- Page CRNA and pediatrician on-call.
- Obtain IV access x2.
- Prepare ET tubes 0.5 and 1.0 sizes smaller than what the Critical Care Guide recommends.

No → Do not routinely obtain CXR or airway imaging.

Dexamethasone 0.6 mg/kg by least invasive method possible (PO/IM/IV). (Max dose 16 mg.)

→ May use IV/IM form (10 mg/mL) orally (with flavoring or sugar) to minimize volume.

Is there stridor at REST?

Yes → Give nebulized racemic epinephrine:
<10 kg: 0.25 mL mixed with 3 mL NS
≥10 kg: 0.5 mL mixed with 3 mL NS
Monitor pulse during and after administration.

In Village

If no racemic epinephrine available, mix 0.5 mL/kg of 1 mg/mL (1:1000) epinephrine (max dose 5 mL) with 1 bullet of NS and give via nebulizer.

Is there rapid improvement?

No →
- If in village, bring to Bethel by fastest means possible.
- Consider repeating racemic epinephrine with CRM, budesonide neb, transfer, etc.
- Consult PICU if considering intubation.
- Consider alternate diagnoses (see DDx box).

Yes → Monitor in clinic or ED for 4 hours. → Does patient meet Low-Risk Criteria?

No → (same as above)

Yes →
- Discharge home with follow-up within 24 hours.
- May need to re-dose dexamethasone in 24 hours.
- Counsel parents to return for recurrent stridor and/or increased WOB.
- Give PEDS Custom Croup Education Handout.

No → Does patient meet Low-Risk Criteria?

The **Croup Severity Score** may be helpful in clinical decision making.

Low-Risk Criteria

- No stridor at rest
- Normal pulse-oximetry
- No increased WOB
- Good air exchange
- Normal color
- Normal mental status
- Tolerating PO
- Caregivers understand to return to clinic for recurrent stridor and/or increased WOB.

DDx Stridor

- Croup (most common in ages 6 months to 3 years)
- Foreign body
- Tracheomalacia
- Angioedema
- Tracheitis
- Epiglottitis
- Abscess

Note: if prolonged symptoms (>3-5 days without any improvement), consider diagnosis other than croup.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Fever ≥ 100.4°F in Infants 0-90 Days

Infant 0-90 days with recorded or reported rectal temperature ≥100.4°F.

Village Management

- If well-appearing and meets criteria for evaluation in Bethel, send on next commercial flight. If travel to Bethel will be delayed, infant must have recheck with health aide within 12 hours and be followed at least daily until seen in Bethel.
- If infant is not well-appearing, consult peds to discuss treatment options.
- If giving ceftriaxone IM in the village, DO NOT say "ceftriaxone per CHAM." Give the health aide the exact dose.

Sick-appearing

- Evaluate patient in Bethel ED.
- Perform immediate work-up:
  - CBC with manual differential
  - Procalcitonin
  - Blood culture
  - U/A, urine culture
  - CXR
  - LP if stable
  - RSV/flu/COVID swabs

Admit or medevac, as appropriate. Give antibiotics. (See box.)

Well-appearing

0-28 days

- Evaluate patient in Bethel ED.
- Perform immediate work-up:
  - CBC with manual differential
  - Procalcitonin
  - Blood culture
  - U/A, urine culture
  - CXR
  - LP if stable
  - RSV/flu/COVID swabs

Admit or medevac, as appropriate. Give antibiotics. (See box.)

29-60 days

- Evaluate patient in Bethel ED.
- Perform work-up:
  - CBC with manual differential
  - Procalcitonin
  - Blood culture
  - U/A, urine culture
  - Consider CXR, RSV/flu/COVID swabs

Meets all Low Risk Criteria (see box)?

No

- Perform LP.
- Give antibiotics. (See box.)
- Consider admission.

Yes

Evidence of UTI, AOM, or PNA?

Yes

- Consider LP based on clinical status, age, etc. LP not mandatory in well-appearing infants.
- Admission or daily follow-up until blood culture negative at least 36 hours.
- If UTI, treat with ceftriaxone (see box).
- If AOM or PNA, use clinical judgment to decide on antibiotic treatment. If treating, give ceftriaxone per box.

No

- LP and antibiotics unnecessary unless clinical status changes.
- Daily follow-up until blood culture negative at least 36 hours.

61-90 days

Any temp >102.2
OR
Temp >100.4 x48 hours
OR
Does not meet all Low Risk History & Exam Criteria?

Yes

- Evaluate patient in Bethel.
- Perform work-up:
  - U/A, urine culture
  - Consider bloodwork and LP based on history, exam, and risk factors.

No

- Daily rechecks in village, outpatient clinic, or ED until improving.
- Low threshold to bring to Bethel ED if any concerns.

Low Risk Criteria

History & Exam
- Well-appearing (soothable, feeding well, etc.)
- No significant prior hospitalization.
- Gestational age >37 weeks.
- No antibiotics in the past 7 days.
- No evidence of invasive bacterial infection like cellulitis or osteomyelitis.

Lab
- Absolute neutrophil count (ANC) <4000
- Procalcitonin <0.5

CSF

- Consider Multiplex PCR if any suspicion for meningitis.
- See Harriet Lane (not the results in RAVEN) for normal results by day of life.
- Do not use correction formulas for traumatic LPs.

Special Circumstances

1. Immunizations within 24 hours of single fever <102.2 and meets all history & exam low-risk criteria: no work-up necessary but must follow-up in village or Bethel within 12-24 hours. If fevers recur, rise above 102.2, or infant is not well-appearing, perform evaluation as above.

2. Pre-treatment with antibiotics but otherwise meeting low-risk criteria: infant must be observed a full 48 hours off antibiotics.

3. Unsuccessful LP: treat if appropriate and consider a repeat LP in 12-24 hours and determine treatment course based on cell counts. If repeat LP not performed or unsuccessful, either treat for 10-14 days with meningitic dosing of IV antibiotics or stop antibiotics at 48 hours and observe infant for an additional 48 hours off antibiotics. Consider admission.

If concerned for bacterial meningitis:

- If suspicion for bacterial meningitis, consult pediatrics and strongly consider medevac.
- If transferring patient, send any extra CSF on ice with patient.

HSV Work-up

- CSF HSV PCR
- CSF Multiplex PCR
- Blood HSV PCR
- CMP
- Nasopharyngeal, conjunctival, and anal swabs and vesicle fluid for HSV PCR.

Acetaminophen

- Acetaminophen should NOT be given prior to vaccines, as there is some evidence it blunts the immune response.
- Acetaminophen should NOT be given around-the-clock in this age group.
- Acetaminophen MAY be given after a fever has been documented and the infant evaluated by a health aide or provider **EXCEPT in babies 61-90 days old who are being managed in the village as this may blunt the fever curve. If a child in the village is already scheduled to come to Bethel for further evaluation, appropriate dosing of acetaminophen may be given.**

Antibiotic Treatment

- 0-7 days: please consult a pediatrician, pharmacist, or Neofax.
- 8-28 days:
  - -If well-appearing and low suspicion for meningitis: ampicillin 50 mg/kg IV Q8h AND gentamicin 4 mg/kg IV Q24h.
  - -If well-appearing and any suspicion for meningitis: ampicillin 75 mg/kg IV Q6h AND cefepime 50 mg/kg IV Q12h.
  - -If ill-appearing and/or positive CSF Gram stain: please consult a pediatrician and/or a pharmacist.
- 29-90 days: ceftriaxone 50 mg/kg IV/IM Q24h OR if worried about meningitis 100 mg/kg IV once then 50 mg/kg IV Q12h.
- Continue IV/IM antibiotics until cultures are negative at least 36 hours and patient is clinically stable or until specific organism and sensitivities are available to direct therapy.
- Dose #2 of ceftriaxone may be given 12-24 hours after dose #1.
- If known HSV exposure, seizures, or severe illness: acyclovir 20 mg/kg IV Q8h with IVF, perform HSV work-up (see box), and consult pediatrics.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 7/6/21. Click here to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Influenza (Adult and Pediatric)

Testing Recommendations

Suspected Influenza in the Ambulatory Setting:
• Patients considered High Risk for Complications (See below.)
• Adults >65 years of age
• Children <2 years of age
• Patients with complicated influenza-like illness that may warrant treatment
• Individuals with febrile illness of unclear etiology or as part of a sepsis evaluation

It is not recommended to perform testing in most ambulatory patients who present with uncomplicated flu-like illness.

Suspected Influenza in the Inpatient Setting:
All patients admitted with febrile illness or respiratory symptoms should be tested.

High Risk for Influenza Complications:
• **Chronic Pulmonary Disease** (including asthma and pediatric patients with chronic lung disease and recurrent respiratory infections)
• **Cardiovascular Disease** (except for hypertension)
• **Diabetes Mellitus**, or other metabolic disorders
• **Immunosuppressed** (chronic steroids/biologics, chemotherapy, AIDS, etc.)
• **Pregnant** or **Postpartum up to 2 weeks**
• **Morbid Obesity** (BMI >40)
• <19 years of age receiving **long-term aspirin therapy**
• **Renal, hepatic, hematologic impairment/disease**
• **Neurologic and neurodevelopment conditions** (cerebral palsy, epilepsy, moderate-severe developmental delay, neurodegenerative disorders, etc.)

Treatment Recommendations

Indications for Treatment
• All patients with confirmed influenza, regardless of timing, who:
  - Have severe, complicated, or progressive illness.
  - Require hospitalization.
  - Are high risk for influenza complications (see above).
• Can be considered based on supply and clinical judgment in low risk patients within 48 hours of symptom onset.

Treatment NOT Recommended
• Non-institutionalized (hospital or other health care facility) patients age 2-64 years not at high risk for influenza complications.
• Patients with uncomplicated illness after 48 hours of symptom onset.

Chemoprophylaxis Recommendations

Chemoprophylaxis of household members is not routinely recommended except for:
-Medically high-risk (see above) close contacts within 48 hours of exposure

** For neonates born to mothers with influenza, defer to Seattle Children's Hospital Infectious Disease Physician Consult Line for formal recommendations: (206) 987-7777.*

Influenza Treatment Dosing for Oseltamivir

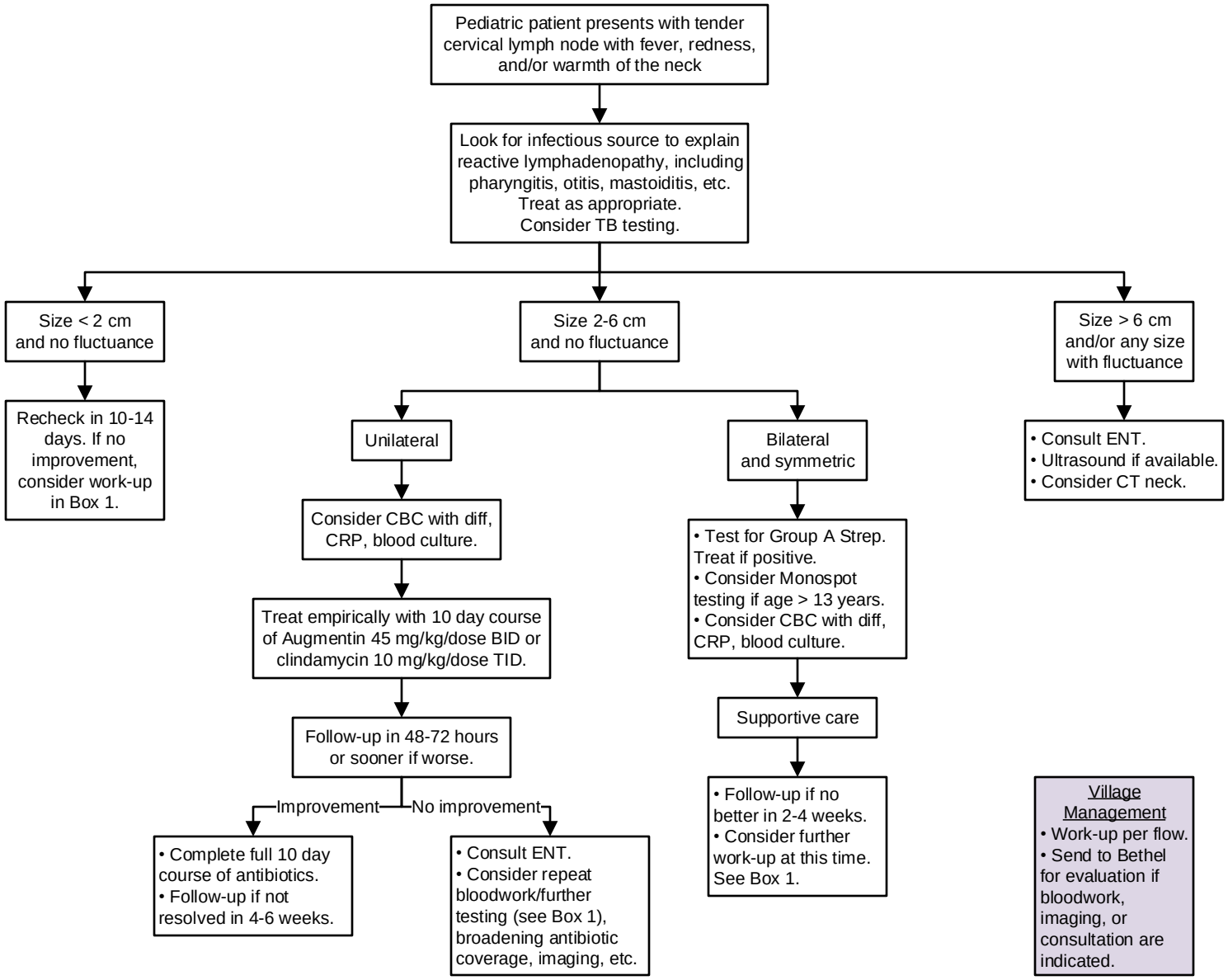
	Age/Weight	Dose	Renal Dose Adjustments	Duration
Neonates	**PMA <38 weeks**: 1 mg/kg/dose PO q12hr **PMA 38-40 weeks**: 1.5 mg/kg/dose PO q12hr **PMA >40 weeks**: 3 mg/kg/dose PO q12hr **>2 weeks**: 3 mg/kg/dose PO q12hr *Confirm with Seattle Children's Hospital Infectious Disease Physician Consult Line (206) 987-7777.*		CrCl <30mL/min: usual dose given q24hr *additional dose adjustment needed for hemodialysis (consult pediatric nephrology in all cases)	5 days
Infants	Term, 3-8 months 9-11 months	3 mg/kg/dose PO q12hr 3.5 mg/kg/dose PO q12hr		5 days
Children 1-12 years	<15 kg 15-23 kg 23-40 kg	30 mg PO q12hr 45 mg PO q12hr 60 mg PO q12hr		5 days
Adults and Children ≥ 12 years	>40 kg or >12 years	75mg PO q12hr	CrCl 30-60 mL/min: 75mg PO q24hr CrCl 10-30mL/min: 30 mg PO q24hr Hemodialysis: Consult nephrology	5 days

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/14/20. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Megan_Young@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Lymphadenitis, Acute Cervical (Pediatric)



Village Management
- Work-up per flow.
- Send to Bethel for evaluation if bloodwork, imaging, or consultation are indicated.

Box 1: Further Work-up

Perform careful exam for lymphadenopathy of other locations. For any child with nontender lymphadenopathy or lack of improvement after specified period, consider, as appropriate:
- PPD/TB work-up
- CBC
- CRP
- LFTs
- Blood culture
- HIV testing
- RPR
- Toxoplasmosis testing
- Bartonella testing
- EBV, CMV titers
- LDH, uric acid
- CXR
- Hematology/oncology consult
- Infectious disease consult

Most Common Causes
- Reactive lymphadenopathy due to local infection (may take 4-6 weeks to resolve).
- Unilateral: *Staph aureus*, Group A Strep, Group B Strep, anaerobes, TB/MAC
- Bilateral: respiratory viruses (enterovirus, adenovirus, influenza, etc.), Group A Strep, HSV (primary), EBV, CMV, *Mycoplasma*, *Arcanobacterium*, TB

Less Common Causes to Consider
- Kawasaki disease; periodic fever with aphthous stomatitis, pharyngitis, and adenitis (PFAPA); leukemia; lymphoma

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/13/17; reviewed and reapproved 10/2019.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Otitis Media, Acute (3 months – 12 years)

Box 1: AOM Decision-Making Principles
- If observation is warranted, do not prescribe antibiotics.
- Always treat pain with acetaminophen and ibuprofen, as appropriate.
- If patient has not received amoxicillin within 30 days, start with amoxicillin to treat new infection.
- For AOM with otorrhea, use otic drops if >6 months. Do not use oral antibiotics unless the other ear is infected without perforation.
- Do not treat fluid that develops after AOM if child is asymptomatic – observe up to 3 months.
- Do not use azithromycin, erythromycin, cephalexin (Keflex), or Septra for AOM.
- Do not use antibiotic prophylaxis.
- Do not send ear drainage for culture.

Box 2: Eligibility for Observation for 48-72 hours
- 6-24 month old with mild, uncertain, or unilateral AOM
- >24 month old with mild/moderate (non-bulging) AOM
- Caregiver comfortable withholding antibiotics
- Follow-up assured
- Antibiotics can be started promptly if symptoms persist or worsen
- No fever >102°F and only mild otalgia

Box 3: AOM Treatment

Antibiotic duration, by age:
- < 2 years: 10 day course of oral antibiotic
- 2-5 years: 7 day course of oral antibiotic
- ≥ 6 years: 5 day course of oral antibiotic
- Note: in patients with history of recurrent, complicated, or chronic infections, may consider up to 10 days of treatment.

Antibiotic choice:

1st line: amoxicillin 45 mg/kg/dose PO BID
2nd line: Augmentin 45 mg/kg/dose PO BID
3rd line: ceftriaxone 50 mg/kg IV/IM QD for 3 days

Otitis-conjunctivitis syndrome

Augmentin 45 mg/kg/dose PO BID

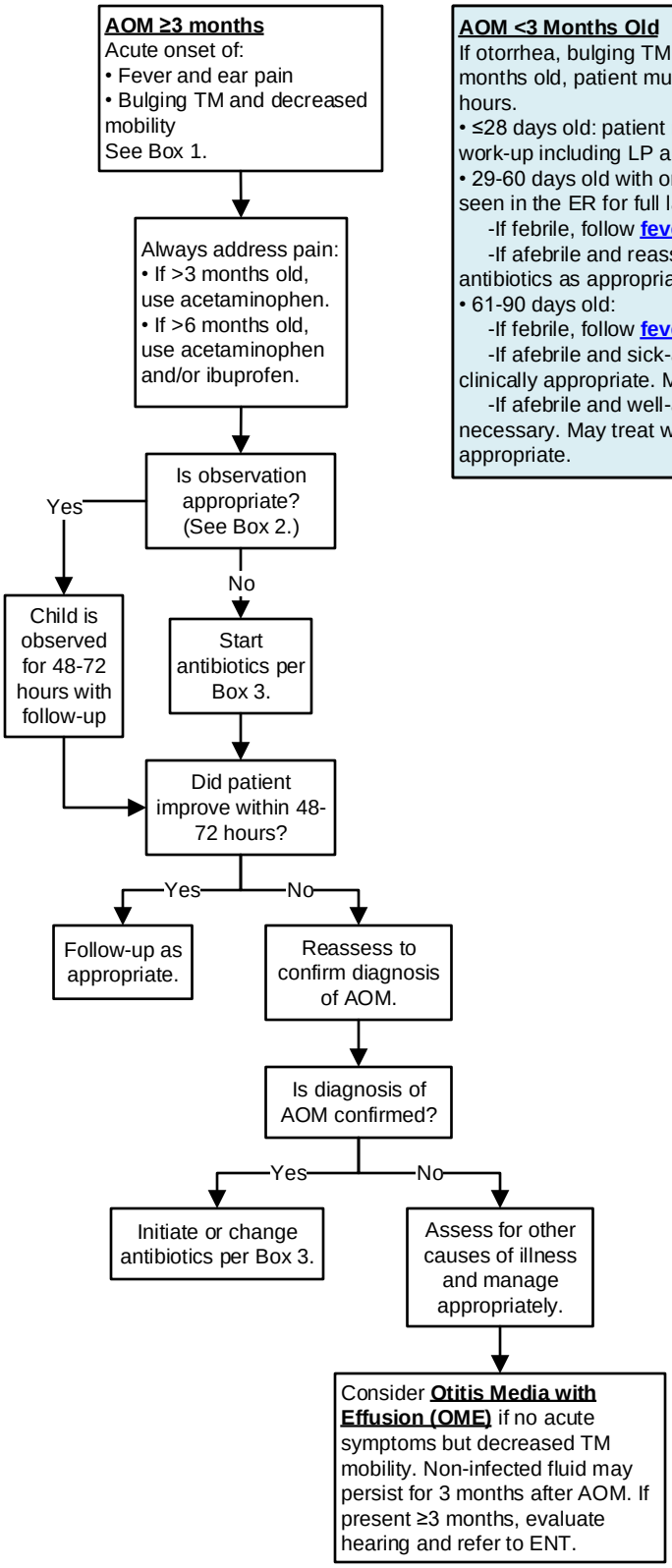
Try to avoid using cephalosporins. They are less effective at treating the most common organisms that cause OM.

For PCN allergy: Please refer the patient for an allergy trial if not already done.

cefdinir 14 mg/kg/dose PO QD
OR
ceftriaxone 50 mg/kg IV/IM QD for 1-3 days

For ruptured TM/tube drainage:

Wick ears prior to giving drops.
- Ofloxacin 5 drops BID
- Ciprodex 4 drops BID



AOM <3 Months Old

If otorrhea, bulging TM, or other suspicion of AOM <3 months old, patient must be seen by provider within 24 hours.
- ≤28 days old: patient must be seen in the ER for full lab work-up including LP and treatment with IV antibiotics.
- 29-60 days old with or without fever, patient must be seen in the ER for full lab work-up including LP.
  - -If febrile, follow **fever < 90 days clinical guideline**.
  - -If afebrile and reassuring work-up, may treat with oral antibiotics as appropriate.
- 61-90 days old:
  - -If febrile, follow **fever < 90 days clinical guideline**.
  - -If afebrile and sick-appearing, perform work-up as clinically appropriate. May consult peds as needed.
  - -If afebrile and well-appearing, lab work-up not necessary. May treat with oral or otic antibiotics as appropriate.

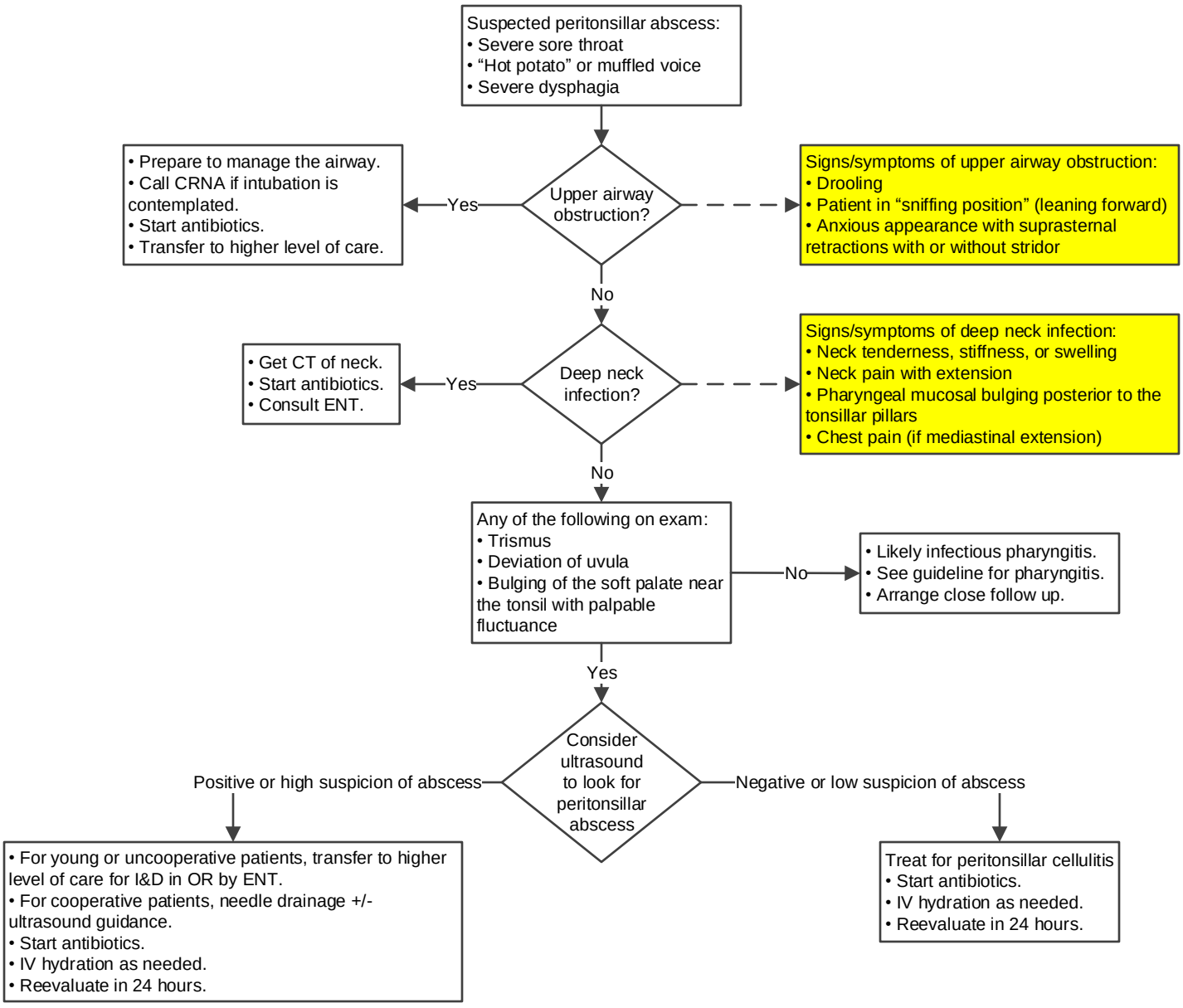
This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 2/5/20. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

When to Refer to ENT
- 3 episodes of AOM in 6 months
- 4 episodes of AOM in 12 months
- OME or otorrhea for ≥3 months
- Hearing loss >20 dB

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Peritonsillar Abscess (Adult and Pediatric)



Antibiotics for peritonsillar abscess:
Ampicillin-sulbactam 3 grams IV q6h for adults and 50 mg/kg/dose (based on ampicillin, max 3 grams) IV q6h for pediatrics.

If penicillin allergic:
Clindamycin 600 mg IV q6h for adults and 13 mg/kg/dose (max 600 mg) IV q8h for pediatrics.

If severe disease:
Consider coverage for MRSA with vancomycin.

Once able to transition to oral:
Amoxicillin-clavulanate 875 mg PO BID for adults and 45 mg/mg/dose (max 875 mg) PO BID for pediatrics.

If penicillin allergic:
Clindamycin 300 mg PO 4 times daily for adults and 13 mg/kg/dose PO 3 times daily for pediatrics.

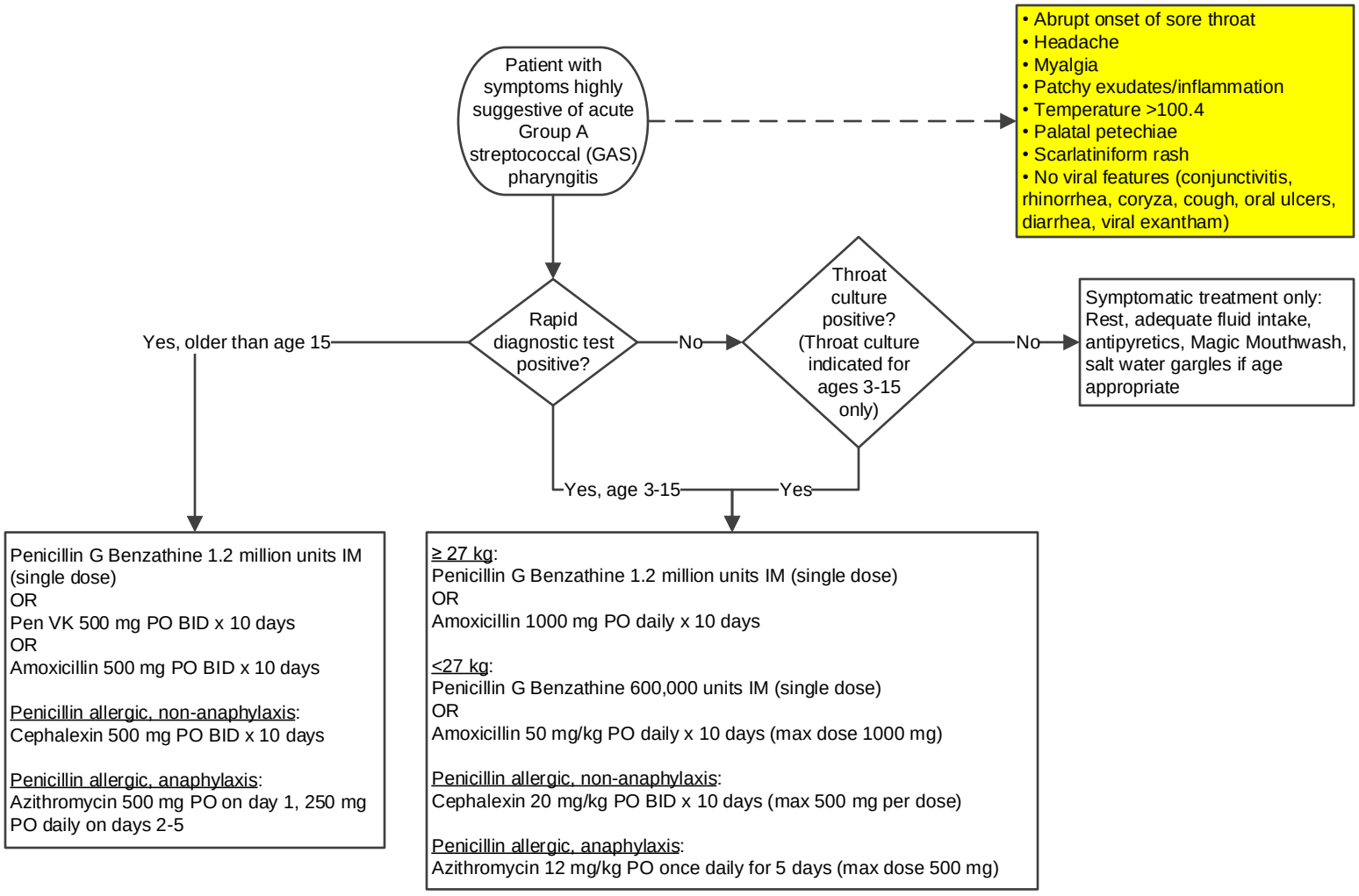
Total duration of treatment: 14 days

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/14/20. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Elizabeth_Bates@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Pharyngitis (Adult and Pediatric)



Considerations:
- Consider testing for oral GC/CT in at-risk populations.
- Testing for Group A streptococcal (GAS) pharyngitis is NOT recommended for acute pharyngitis with clinical features that strongly suggest viral etiology.
- Routine use of back-up cultures for those with a negative rapid test is not needed for adults; there is a low incidence of GAS in adults and risk of subsequent acute rheumatic fever is exceptionally low.
- It is NOT recommended to test for GAS in patients under the age of 3; the risk of rheumatic fever in this age group is exceptionally low.
- Patients are contagious for 24 hours after starting antibiotic treatment.
- Treatment for asymptomatic GAS carriers is not recommended, nor is testing or empiric treatment of household contacts.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/14/20. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Elizabeth_Bates@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Pneumonia (Adult)

Patient presents with symptoms suggesting Community Acquired Pneumonia:
Cough, sputum, dyspnea, pleuritic chest pain, fever

If multiple TB risk factors, see Adult TB guideline.

Obtain CXR especially if patient has ≥ 2 of these signs: Temp. > 100.4, HR > 100/min, abnormal chest exam, RR> 20/min, 02 Sat <90%, history of chronic lung disease

CXR shows infiltrate?

No → Chronic lung disease?

No →
A. Patient Education.
B. Rational for no antibiotics.
C. Follow-up if patient worsens.
D. Treat bronchospasm if present.
E. Verify TB and HIV status.

Yes

If yes, consider

Patient Education
1. Smoking Cessation
2. Immunizations
   - Influenza
   - Pneumovax
3. PPD
4. Follow-up

One or more of the following: Comorbid condition or abnormal physical exam findings from PSI or Age ≥ 60?

No →
Outpatient Antibiotics
1. Amoxicillin 1000 mg PO TID for 5-7 days
   AND
2. Azithromycin 500 mg PO daily for 3 days

If anaphylaxis to PCN:
3. Doxycycline 100 mg PO BID for 5-7 days is reasonable for patient without comorbid conditions.
4. Levofloxacin 750 mg PO daily for 5 days

If patient is in a village and CXR isn't available, OR the patient refuses to travel for CXR, consider using doxycycline as the YK Delta still has good pneumococcal coverage with doxycycline.

Yes

Labs
1. CBC with diff
2. Comprehensive Metabolic Panel
3. +/- Blood culture x 2 (prior to ABX)
4. +/- Sputum
5. +/- ABG
6. +/- HIV
7. Procalcitonin

Consider procalcitonin to differentiate bacterial causes of symptoms.

PSI ≤ 70

Yes → (to Outpatient Antibiotics)

No

PSI 71-90

Yes → Probable outpatient treatment. Management to be based on clinical judgement as above.

No

PSI ≥ 91

Yes →
Inpatient Antibiotics
1. Ceftriaxone 1gram IV daily
   AND
2. Azithromycin 500 mg IV/PO daily x 3 days

If anaphylaxis to PCN:
3. Levofloxacin 750 mg IV/PO daily for 5 days

- Consult pharmacists for any questions/concerns.
- Consider consultation with respiratory therapy for admitted patients.

Suspect Aspiration : ampicillin-sulbactam 3 grams IV Q6hrs **OR** Ceftriaxone 1 gram IV Q24hrs **AND** metronidazole 500 mg IV every 8 hours
Suspect Pseudomonas: Cefepime 1 gram IV Q 8hours, extended infusion.
Suspect early onset HAP: within first 4 days of hospitalization, treat as CAP
Suspect late onset HAP or VAP: Vancomycin IV dosed per protocol **AND** Cefepime 1 gram IV Q 8 hours, extended infusion

Remember to order a follow up chest x-ray in 6-8 weeks to ensure resolution of infiltrate

Pneumonia Severity Index (PSI)
http://pda.ahrq.gov/clinic/psi/psicalc.asp
Score = Total points accumulated below

Demographic Factors	
Age of Males in years	age (years)
Age of Female in years	age (years) - 10
Nursing home resident	+10
Comorbid Illnesses	
Neoplastic disease[1]	+30
Liver disease[2]	+20
Congestive heart failure[3]	+10
Cerebrovascular disease[4]	+10
Renal disease[5]	+10
Physical Examination Findings	
Altered mental status	+20
Respiratory rate > 30/minute	+20
Systolic BP < 90 mmHg	+15
Temperature < 95°F (35°C) or > 104°F (40°C)	+15
Pulse >125/minute	+10
Laboratory Findings	
pH < 7.35	+30
BUN > 20 mg/dl (11 mmol/L)	+20
Sodium < 130 mEq/L	+20
Glucose > 250 mg/dL (14 mmol/L)	+10
Hgb < 9 gm (Hematocrit < 30%)	+10
PO2< 60, Sp 02 sat < 90%(room air)	+10
Pleural effusion	+10

Patient with 02 sat < 90%, homelessness, multilobar pneumonia, or risk for aspiration may warrant hospitalization despite their risk classification.

1. Neoplastic disease – any cancer, except basal or squamous cell carcinoma of the skin active at the time presentation.
2. Liver disease – clinical or histologic cirrhosis or chronic active hepatitis.
3. CHF – documented with history, physical exam, or CXR findings; echo, MUGA; or left ventriculogram.
4. CVD – clinical diagnosis of stroke or TIA or documented stroke on CT or MR.
5. Renal disease – chronic renal disease or abnormal BUN or creatinine.

CAP = Community Acquired Pneumonia
HAP = Healthcare Associated Pneumonia
VAP = Ventilator Associated Pneumonia

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 9/21/18.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Pneumonia (>3 months)

REMEMBER:
- If patient is <90 days and febrile, please see fever guidelines.
- Pneumonia is a clinical diagnosis and does not require X-ray findings.

Hypoxia
<90% while awake
<88% while asleep
Sustained for >10 minutes

Pulse-Oximetry Monitoring:
- Pulse-ox may be ordered Q4h (not continuously) if age >6 months and patient is stable.
- Being on oxygen does not mandate continuous pulse-oximetry if patient is stable.

Cough + fever

Institute SUPPORTIVE MEASURES
Then reassess respiratory distress

Moderate to severe respiratory distress
Sustained tachypnea, increased work of breathing, and/or hypoxia

Mild or no respiratory distress
Intermittent tachypnea, increased work of breathing, and/or hypoxia

- CXR (PA & lateral)
- CBC, CRP, and blood culture
- RSV and flu if <3 years
- Place PPD

Consider CXR if <5 years old given high rates of pneumonia in Alaska Native population.

Infiltrate / No infiltrate

Begin antibiotics per Treatment box.

- If <1 year old: requires >2 L supplemental oxygen to prevent hypoxia or improve WOB?
- If ≥1 year old: requires >3 L supplemental oxygen to prevent hypoxia or improve WOB?
- Requires neb treatments more frequently than Q2-3h for >8 hours?
- Sustained tachycardia, tachypnea, or respiratory distress despite treatment?
- Significant pleural effusion?

Yes / No

Transfer to Anchorage

- Admit to YKHC Peds Inpatient Unit, using PED Admission/Respiratory Infection PowerPlan.
- Place PPD if older than 6 months and no PPD in past 6 months.

After 48-72 hours

Improvement? (No / Yes)

- Patient improving with increased appetite and activity, less WOB, and decreasing fever curve?
- No hypoxia on room air?
- Tolerating home therapy with competent caregivers?
- Immunizations UTD?
- Negative PPD?

No / Yes

- Consult pediatrics.
- Consider repeating CXR and labs.
- Consider IVF.

- Change to oral antibiotics for total of 10 days of treatment.
- Discharge home with follow-up within 48-72 hours.
- No routine follow-up CXR unless recurrent infiltrate in same lobe; in that case, repeat CXR in 4-6 weeks.

Consider other diagnoses: RAD, bronchiolitis, TB, acidosis, toxins, etc.

Prescribe antibiotics for 10 days per Treatment box.

- Place PPD if older than 6 months and no PPD in past 6 months.
- Discharge home with follow-up within 48-72 hours.
- No routine follow-up CXR unless recurrent infiltrate in same lobe; in that case, repeat CXR in 4-6 weeks.

SUPPORTIVE MEASURES
- Control fever, as it can be an independent cause of respiratory distress and tachycardia.
- Nasal suction with nasal bulb syringe and olive tip plus saline.
- Hydration by IV or enteral (including NG and G-tube).
- Gentle P&PD/CPT if helpful.
- Saline neb (either 0.9% or hypertonic 3%).
- Consider albuterol trial, especially in Alaska Native patients as they have high rates of RAD.

Village Management
- Any child <5 years with suspected pneumonia should be evaluated in Bethel or an SRC.

Treatment

Outpatient
1st line: amoxicillin 45 mg/kg/dose PO BID
2nd line: Augmentin 45 mg/kg/dose PO BID
3rd line: cefdinir 7 mg/kg/dose PO BID

Inpatient
1st line: ampicillin 50 mg/kg/dose IV Q6h
2nd line: Unasyn 50 mg/kg/dose IV Q6h
3rd line: ceftriaxone 75 mg/kg/dose IV Q24h

If not fully immunized, suspicion for *H influenzae*, or complicated pneumonia (pleural effusion, multilobar involvement, concern for bacteremia, etc.): Start with ceftriaxone. When improving, complete 10 day course with narrower spectrum oral antibiotic, as appropriate.

For H influenzae type A: At least one dose of ceftriaxone or four days of rifampin is necessary for decolonization. Remainder of course may be completed with a penicillin, if sensitive.

For PCN allergy: If reaction was non-anaphylactic, may trial amoxicillin with monitoring. If reaction was anaphylaxis, treat with a cephalosporin. If any questions, please obtain a pediatrics consult.

Azithromycin: Do not prescribe azithromycin unless there is evidence of an atypical pathogen and child is >5 years. Must be prescribed in addition to primary treatment above.

RUL infiltrate: consider starting with Augmentin/Unasyn to cover for oral anaerobes. Consider thickener.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 5/8/19.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Procalcitonin in Lower Respiratory Tract Infections (Adult)

Procalcitonin in Adults with Lower Respiratory Tract Infections				
Initial Value (Baseline)				
Procalcitonin Value	<0.1 ng/mL	0.1-0.24 ng/mL	0.25-0.5 ng/mL	>0.5 ng/mL
Antibiotic START recommendation	Initiation strongly discouraged	Initiation discouraged	Initiation encouraged	Initiation strongly encouraged
Comments	• Hold on giving antibiotics. • Consider alternate diagnosis. • Repeat procalcitonin in 6-12 hours if antibiotics not initiated and no clinical improvement. • If clinically unstable, immunosuppressed, or high-risk, consider overruling. (PSI Class IV-V, CURB-65 >3).		• Start antibiotics. • Repeat every 2-3 days to consider early antibiotic cessation. See follow-up table below. • If initial value is >5-10 ng/mL, assess for reduction of 90% from peak values.	
Follow-Up (Repeat procalcitonin level Q48-72 hours)				
Procalcitonin Value	<0.1 ng/mL or ↓ by >90%	0.1-0.24 ng/mL or ↓ by >80%	0.25-0.5 ng/mL	>0.5 ng/mL
Antibiotic STOP recommendation	Cessation strongly encouraged	Cessation encouraged	Cessation discouraged	Cessation strongly discouraged
Comments	• Stop antibiotics. • Consider continuing if clinically unstable.		• Continue antibiotics. • If procalcitonin is rising or not adequately decreasing, consider possible treatment failure and evaluate for need for expanding antibiotic coverage or further diagnostic evaluation.	

Procalcitonin in Adults with Sepsis without a Source				
Follow-Up (Repeat procalcitonin level Q24h or with morning labs daily x3 days)				
Procalcitonin Value	<0.25 ng/mL	0.25-0.49 ng/mL or ↓ by >80%	≥ 0.5 ng/mL AND ↓ by >80%	≥ 0.5 ng/mL AND rising or stable
Antibiotic STOP recommendation	Cessation strongly encouraged	Cessation encouraged	Cessation discouraged	Cessation strongly discouraged
Comments	• Stop antibiotics. • Consider continuing if clinically unstable.		• Continue antibiotics. • A procalcitonin value which is rising or not declining at least 10% per day is a poor prognostic indicator and suggests infection is not controlled. • Consider expanding antibiotic coverage or further diagnostic evaluation.	

Exclusion Criteria: <18 years old; pregnant/breastfeeding; CrCl <30 mL/min or hemodialysis (renally excreted biomarker); severe immunosuppression (eg ANC <500, HIV with CD4 <200, transplant patients, or on immune modulators); severe trauma, burn, or major surgery within 24 hours (particularly abdominal surgery); chronic infections necessitating antibiotics (eg endocarditis, osteomyelitis, tuberculosis); cystic fibrosis; small cell lung cancer or medullary thyroid cancer; receipt of OKT-3 and/or anti-thymocyte globulin; end-stage cancer; concurrent infections.

Source: ANMC Clinical Guidelines. Click for hyperlink to full guideline, including accompanying resources.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Rabies

Patient reports animal bite (or exposure to brain tissue) from animal who is a possible reservoir for rabies (dog, fox, bat, wolf)

Does the patient require rabies post-exposure prophylaxis? See Box 1.

No → Provide usual wound treatment. Consider amoxicillin-clavulanate prophylaxis for open wounds.

If patient needs extensive wound care, recommend immediate travel to ED for treatment.

Yes or maybe

Patient in village?

No →
1. Patient presents to ED or outpatient clinic.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Provider forwards the final note to the OEH department pool.

Patient is given Day 0 vaccine, and the wound is infiltrated with immunoglobulin.

Appointment is made for the outpatient clinic for Days 3, 7, and 14.
If any of these fall on a weekend, patient is seen in the ED.

Yes →
1. Health Aide completes visit in RAVEN.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Patient is reported to RMT provider.
4. Provider forwards the final note to the OEH department pool.

1. RMT provider orders the vaccine for HAND CARRY to village clinic – 3 doses.
2. Contact inpatient pharmacy on call to arrange the HAND CARRY to the village.

Patient is given Day 0 vaccine in village clinic.

Day 3 vaccine and immunoglobulin given in Bethel outpatient clinic unless it is the weekend (then patient goes to ED). At that visit:
-Wound is assessed.
-Immunoglobulin is infiltrated directly into wound site.

Day 7 & 14 vaccine given in village.

Box 1

Indications for rabies prophylaxis:
1. The bite was from a fox, bat, coyote, skunk, woodchuck, or wolf, and this animal is not available to test.
2. The bite was from a dog who was behaving abnormally.
3. The bite was from a dog not available for quarantine.
4. If the dog is available for quarantine, do not start post-exposure prophylaxis regardless of vaccination status. OEH (Office of Environmental Health) will initiate a 10-day quarantine. Please check under "all documents" for Alert Note or for the rabies investigation report from OEH.
5. If consultation is needed, call OEH at 543-6420 or State Section of Epidemiology 907-269-8000 or 800-478-0084 after hours.

Other Resources

- See the **supplement** to this guideline on the wiki.
- **State of Alaska DHSS Rabies** page.
- Use the Power Plans "AMB/ED Rabies Prophylaxis" to find all necessary orders.

Notes:
- Day Zero is the first day the vaccine is given, not the day of the exposure.
- Immunoglobulin must be given within seven days of first vaccine dose.

If patient is immunocompromised, he/she requires an additional dose on day 28.

Required Notifications:

- The Rabies Investigation Report is an ad hoc form that is started by the CHA/P in village clinic or by the ED/outpatient clinic provider when the patient first presents for care. This is sent electronically to the OEH (Office of Environmental Health) who will follow up on the status of the dog. Please check under "all documents" for this and for recommendations from OEH.
- Forward your PowerChart note to Rabies Control Officer Pool and OEH Department Pool.

Animals in Alaska that have tested positive for rabies:
1. Arctic fox
2. Caribou
3. Cat
4. Coyote
5. Dog
6. Keen's myotis bat
7. Little brown bat
8. Red fox
9. Reindeer
10. River otter
11. Wolf
12. Wolverine

For village patient:
Day 0 dose: Given in village from HAND CARRY.
Day 3 dose: Given in Bethel.
Day 7 dose: Given in village from HAND CARRY.
Day 14 dose: Given in village from HAND CARRY.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/2/20. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Abigail_Klager@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sepsis (Adult)

qSOFA – 2 or more of the following:
RR > 22
altered mental status (GCS<15)
SBP < 100

Consider sepsis EARLY in *any* patient with suspected infection.

Does pt meet criteria for sepsis or septic shock?

No → *Reassess after initial evaluation:*
Consider
• fever, leukocytosis, hypotension?
• unexplained altered mental status?
• tachypnea? especially if lungs CTA and SaO_2 WNL?
• unexplained organ dysfunction?
• clinical concern during ongoing care?

Yes

Airway stable?

No → ET intubation with target tidal volume 6 mL/kg for pts without ARDS

Yes

Large bore IV x2.
LABS INCLUDING LACTATE & BLOOD CULTURES.
START FLUID RESUSCITATION immediately: Give 1 L NS or LR bolus with target at least 30 mL/kg within 1-3 hours.

START EMPIRIC ANTIBIOTICS (see guidelines) within 1 hour of recognition of sepsis/septic shock.

REASSESS FREQUENTLY
Assess for adequacy of fluid resuscitation or complications from fluid therapy.

Monitor vital signs, UOP, shock index (HR/SBP > 0.7), mental status, and clinical exam.

Use more than one method to assess resuscitation adequacy and use dynamic variables if possible.

CONSIDER CONSULT/TRANSFER if unstable or not improving and **ACTIVATE MEDEVAC EARLY** if needed.

Is MAP > 65 after 3L of IVF or is patient having complications from volume therapy?

Yes → **START NOREPINEPHRINE** or other vasopressor (see guidelines) and **TITRATE** fluids and pressors to **MAP >65.**

Place a central line ASAP but do NOT delay pressors — a well-secured large bore peripheral IV may be used to initiate pressors.

Consider intubation to facilitate appropriate volume resuscitation.

Consider hydrocortisone (see guidelines) *only* for septic shock not responsive to adequate fluid resuscitation and vasopressors.

No

If initial lactate is > 2:

RECHECK LACTATE 1-2 hours after starting resuscitation.

GUIDE RESUSCITATION TO NORMALIZE LACTATE.
Primary goal should be to achieve a relative lactate clearance of at least 10% in 1-2 hours.

Lactate > 4 may indicate hypoperfusion and the need for aggressive/continued fluid resuscitation.

GET SOURCE CONTROL and obtain additional cultures PRN.

Continue to reassess frequently while awaiting admission or transfer.

Village Management
• Aggressive hydration. PO if you can't get an IV, and the patient is alert enough to drink.
• Supplemental oxygen via nasal cannula.
• Consider Ceftriaxone 2 grams IM.
• Activate medevac.
• Consider VTC.

SEPSIS 3 & ACEP NOTES

4-6 L of total IVF is often needed during the first 6 hours. After 2 L of NS consider switch to LR. Remember that if the patient fails to respond after the first 2-3 L, pressors should be considered.

In patients with concern for fluid overload (Hx CHF or renal or liver failure) or complications from fluid resuscitation, use less total fluid or smaller boluses with more frequent reassessment of volume status, but **DO NOT DELAY FLUID AND VASOPRESSOR TREATMENT.**

Persistence of elevated lactate, even in the absence of hypotension, is associated with poor outcomes.

CRP and procalcitonin may be elevated but cannot effectively guide ED sepsis care — CHECK (and RECHECK) LACTATE.

In the absence of extenuating circumstances (MI, severe hypoxia, acute blood loss, etc.) transfusion is no longer recommended unless Hgb < 7.

Consider insulin if 2 consecutive blood glucose levels are > 180.

Sodium bicarbonate is not recommended to improve hemodynamics or decrease vasopressor requirements in patients with hypoperfusion-induced lactic acidemia with pH≥7.15.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 7/12/17.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sepsis Antibiotics (Adult)

Empiric Antibiotic Recommendations by Source of Infection

If possible, first dose of antibiotics should be administered as a 30 minute infusion to reduce time to therapeutic concentration.

Unknown Source

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam[3] 4.5 grams IV Q8h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Gentamicin[2] 7 mg/kg IV Q24h. Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

Community-Acquired Pneumonia

Ceftriaxone 1 gram IV Q24h. (2 grams if >80 kg.)
OR
Ampicillin-sulbactam 3 grams IV Q6h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Azithromycin 500 mg PO/IV Q24h.

If at risk for aspiration, consider adding:

Metronidazole 500 mg IV Q8h.

Hospital-Acquired Pneumonia or High Risk for Multi-Drug Resistant (MDR) Organisms

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.
OR
Linezolid 600 mg IV Q12h.

AND

Piperacillin-tazobactam[3] 4.5 grams IV Q6h.
OR
If in shock: **Cefepime** 2 grams IV Q8h.

AND

Levofloxacin 750 mg IV Q24h.
OR
Gentamicin[2] 7 mg/kg IV Q24h. Consult pharmacy for max dosing.

Meningitis

Dexamethasone 10 mg IV prior to antibiotics.

AND

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.

AND

Ceftriaxone 2 grams IV Q12h.

If >50 years, ADD

Ampicillin 2 grams IV Q6h.

Urinary Tract Infection

Ceftriaxone 1 gram IV Q24h. (2 grams if >80 kg.)

AND consider adding:

Gentamicin[2] 7 mg/kg IV Q24h. Consult pharmacy for max dosing.
OR
Levofloxacin 750 mg IV Q24h.

If urological interventions or MDR risk factors, consider adding:
Piperacillin-tazobactam[3] 3.375 grams IV Q6h.
OR
Cefepime 1 gram IV Q6h.

If at risk of ESBL, ADD:
Meropenem 500 g IV Q8h.

Intra-abdominal or Pelvic Infection

Piperacillin-tazobactam[3] 3.375 grams IV Q6h.

OR

Cefepime 1 gram IV Q6h.
AND
Metronidazole 500 mg IV Q6h.

OR

Ciprofloxacin 400 mg IV Q12h.
AND
Metronidazole 500 mg IV Q8h.

Skin and Soft Tissue or Necrotizing Infections

IF PURULENT:
Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.

IF NON-PURULENT:
Cefazolin 2 grams IV Q8h.
OR
Ceftriaxone 1-2 grams IV Q24h.
OR
Ampicillin-sulbactam 3 grams IV Q6h.

If necrotizing, ADD:

Piperacillin-tazobactam[3] 3.375 grams IV Q6h.
AND
Clindamycin 900 mg IV Q8h.

OR

Ceftriaxone 2 grams IV Q12h.
AND
Metronidazole 500 mg IV Q6h.

Neutropenic Cancer Patients (ANC <500)

Piperacillin-tazobactam[3] 4.5 grams IV Q6-8h.
OR
Cefepime 1 gram IV Q6h.

AND

Vancomycin[1] 25-30 mg/kg loading dose followed by 20 mg/kg Q8-12h. Max dose 2 grams.

If concerned for HSV or VZV, consider adding:

Acyclovir 10 mg/kg Q8h. Consult pharmacy for max dosing.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 7/12/17.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

[1] Linezolid may be substituted for vancomycin in patients with relative contraindication to vancomycin for high risk for acute kidney injury.
[2] Gentamicin dosing based on ideal body weight.
[3] May substitute ampicillin-sulbactam 3 gram IV Q6h for piperacillin-tazobactam if not concerned for pseudomonas.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sepsis Vasoactive Medications (Adult)

Vasopressors

All vasoactive medications should be infused via central line with the exception of dopamine, which can be infused via a peripheral IV at rates less than 10 mcg/kg/minute.

• Norepinephrine 8-12 mcg/min IV initial infusion rate.	First-line vasopressor of choice in sepsis.
• Epinephrine 1-10 mcg/min initially, titrated to effect.	May be added or used in place of norepinephrine to maintain adequate BP.
• Dopamine 2-20 mcg/kg/min.	Second-line option in highly select patients as it causes more tachycardia.
• Phenylephrine 100-180 mcg/min IV initial infusion until stabilized. Titrate to goal of 60-200 mcg/min. (Max dose range 80-360 mcg/min.)	Can be used as salvage therapy for refractive hypotension associated with tachycardia.
• Vasopressin 0.03-0.04 units/min.	May be added to norepinephrine to increase MAP or decrease norepinephrine dose. DO NOT use as a single agent.
• Dobutamine 2-20 mcg/kg/min IV infusion.	May be used for inoptropic support in the presence of severe myocardial dysfunction or hypoperfusion with depressed cardiac output.

Corticosteroids

Corticosteroids should NOT be administered for the treatment of sepsis in the absence of shock. Steroids are beneficial in those experiencing adrenal insufficiency in the presence of septic shot; however ACTH testing is not routinely recommended in adult patients. If hemodynamic stability is not achieved after adequate fluid resuscitation and vasopressor therapy, the use of IV hydrocortisone alone at a dose of 200 mg/day can be considered regardless of adrenal insufficiency status. Hydrocortisone should be tapered when vasopressors are no longer required.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sepsis/Shock (Pediatric)

Shock Criteria

2 or more of the following:
- Temp <96.8 or >100.4
- Abnormal WBC count (<5 or >15)
- Abnormal HR
- Abnormal RR

AND

Signs of End-Organ Involvement:
- Altered mental status
- Delayed cap refill
- Cold/mottled extremities
- Weak pulses
- Difference between central and peripheral pulses
- Significantly decreased UOP
- Hypotension
- Bounding/brisk pulses with rapid cap refill

Patient meets criteria for severe sepsis/shock → Call pediatric hospitalist. Page pharmacist and RT. → Consult PICU by direct line: (907) 297-8809.

Place on CR monitor.
Start supplemental oxygen. Prepare BVM.
Get access: IV/IO x2.
Bolus: NS 20 mL/kg x2 over ≤ 10 minutes.
Reassess volume status after each bolus.

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan for all medication dosing.

Labs: bedside glucose, blood culture, electrolytes, CBC, lactate, ionized calcium, procalcitonin.

Order empiric antibiotics STAT.

Is patient maintaining airway? — No → Intubate per Pediatric Intubation Guideline.

Yes

If not improving, give third bolus of NS 20 mL/kg.
Correct hypoglycemia.
Correct hypocalcemia.

Is there continuing hypotension, poor pulses, change in mental status, or delayed cap refill?

Yes → Start vasopressor and consider methylprednisolone for fluid-refractory shock in consultation with the PICU.

Continue to reassess and give boluses of NS 20 mL/kg unless patient develops rales, respiratory distress, hepatomegaly, or a gallop.

If shock persists, consider a second pressor, calcium chloride, etc. in consultation with PICU.

No → Monitor closely per Continuing Management Box while awaiting medevac.

Village Management
- Consult pediatric hospitalist.
- Aggressive hydration: IV or PO.
- Supplemental oxygen via nasal cannula.
- Monitor glucose.
- Treat hypoglycemia with Insta-Glucose tubes buccally – NOT rectally.
- Ceftriaxone 100 mg/kg IM.
- May give Epinephrine 0.01mg/kg SC.
- Activate medevac.
- Consider VTC.

See Wiki RMT Section for more detailed recommendations.

Continuing Management
- VS (including BP) at least Q15min.
- Blood glucose Q30 min.
- Maintenance IVF with DNS.
- Consider Foley.

Goals
Cap refill <2 sec
Normal BP for age
Normal pulses
Warm extremities
UOP > 1 mL/kg/hour
Normal mental status

Empiric Antibiotic Choice

≤28 days
Ampicillin 50 mg/kg AND gentamicin 4 mg/kg. If concern for meningitis, give cefepime 50 mg/kg IV. If concerned about HSV or neurologic impairment, add acyclovir 20 mg/kg.

>28 days
Ceftriaxone 100 mg/kg (max 2000 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If CVL in place, immunocompromised, or significant Hx antibiotics in past 30 days
Cefepime 50 mg/kg (max 2000 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If allergic to PCN
Meropenem 15 mg/kg (max 500 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If suspecting Staph or Strep:
Consider adding clindamycin 13 mg/kg IV for anti-toxin effect.

Age	HR (beats/minute)		RR (breaths/minute)		Hypotension (sBP in mmHg)
	Bradycardia	Tachycardia	Low	High	
0 days – 1 week	<100	>200	<30	>70	<60
1 week – 1 month	<100	>200	<30	>70	<60
1 – 3 months	<100	>180	<20	>60	<70
3 – 12 months	<100	>180	<20	>60	<70
1 – 2 years	<90	>160	<20	>40	<70
2 – 6 years	<60	>160		>40	<80
6 – 13 years	<60	>120		>23	<90
13 – 18 years	<60	>110		>23	<90

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 10/9/19.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sexually Transmitted Infections, Screening

Universal Screening Recommendations

- All sexually active patients starting at age 14: annual screening for GC/CT, HIV, and syphilis.
- Any time GC and CT are tested for, HIV and syphilis screening should also be performed if not done in the last 12 months.
- Regardless of sexual activity, all teenagers should be screened for HIV by the age of 18. Additionally, all teenagers should undergo yearly GC/CT screening with, at minimum, a dirty urine.

Symptoms of Genital Infection

- Sores (genital, oral, or anal)
- Discharge or burning
- Dysuria
- Groin pain
- Pelvic pain
- Sore throat
- Rectal itching
- Discomfort or pain with bowel movement
- Vaginal itching or odor
- Testicular pain, swelling, or twisted feeling
- Pain with ejaculation or sex

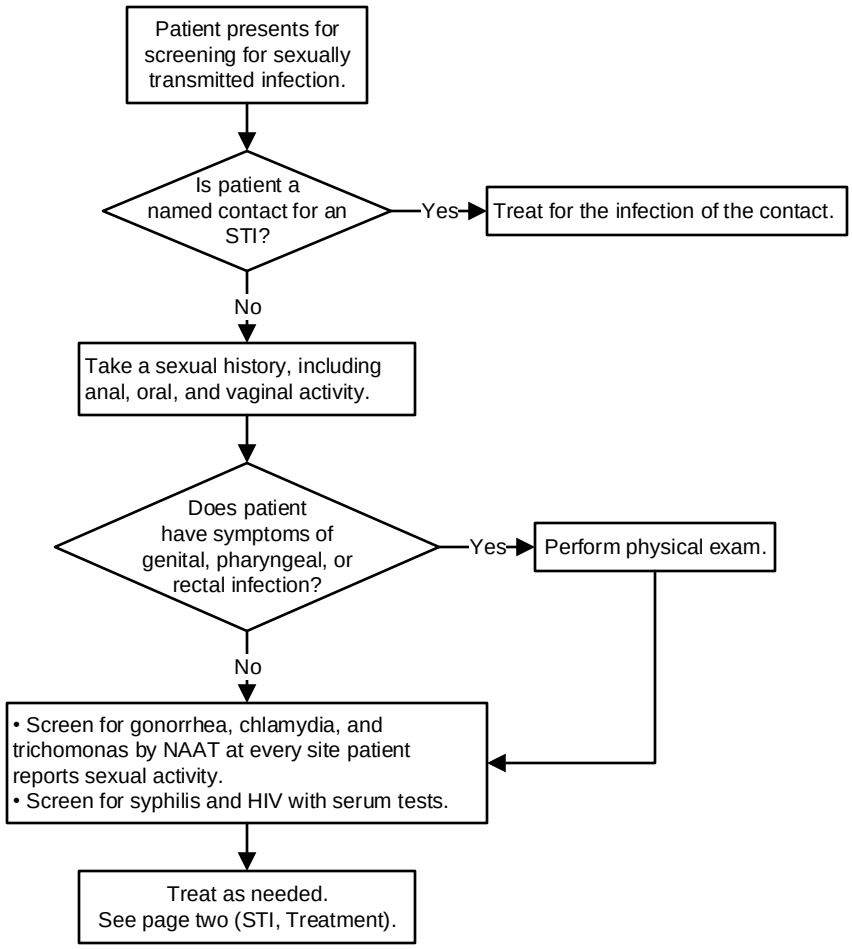
Age of Consent in the State of Alaska

Two people who are both 16 or older can legally agree to have sex with each other. When a person involved in sex is under the age of 16, Alaska law looks at the difference in ages to decide whether consent can be legally given.

- No person over 16 can legally have sex with someone who is 13 or younger.
- No person under 16 can legally have sex with someone who is 4 or more years older.
- No person under 16 can legally have sex with a person in a position of authority over them (including a teacher, coach, or minister).

A positive STI test in a patient who fits the above scenarios should be reported to OCS, law enforcement (BPD if in Bethel or AST if in a village), and the Child Abuse Pool in RAVEN.

Please note: There is no lower age limit for STI testing. Any patient may be tested, regardless of age, without special consent.



Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sexually Transmitted Infections, Treatment

Patient has a positive test for **Gonorrhea** (GC) from pharynx, rectum, or genitalia.

Is the infection pharyngeal?

Yes → • Treat with ceftriaxone:
- Patient ≥ 100 kg: 1 gram
- Patient < 100 kg: 500 mg

• If patient has history of severe beta-lactam allergy, call HROB or STI case manager to discuss treatment.

→ Perform test of cure in two weeks.

No

Is the patient severely allergic to cephalosporins?

Yes → Treat with gentamicin 240 mg IM and azithromycin 2000 mg PO.

No

• Treat with ceftriaxone:
- Patient ≥ 100 kg: 1 gram
- Patient < 100 kg: 500 mg

• If ceftriaxone not available, treat with cefixime 800 mg PO for all weights.

Test for reinfection in three months.

Expedited Partner Therapy (EPT)

EPT is a method of treating partners by asking the patient to take the doses to the partner. This is the standard of care for chlamydia at YKHC.

Process:
1. Treat the patient with azithromycin 1000 grams PO.
2. Give the patient pre-packaged doses for each sexual contact in the last three months. Give a handout explaining the process. This can be found under Patient Education→All→ "EPT Partner Chlamydia (Custom)."

Patient has a positive test for **Chlamydia trachomatis** (CT).

Is the infection rectal?

Yes → Treat with doxycycline 100 mg PO BID x7 days.

No

Treat with azithromycin 1 gram PO x1.

Provide EPT for partner treatment.

Provide patient education handouts for the patient and all partners.

• If infection was pharyngeal or rectal, perform test of cure in one month.
• For other sites, test for reinfection in three months.

Patient has a positive test for **Trichomonas**.

Treat with metronidazole 2 grams PO x1.

Provide EPT for partner treatment.

Provide patient education handouts for the patient and all partners.

Test for reinfection in three months.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 8/3/21. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact David_Compton@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Sinusitis (>5 years)

Differential Diagnosis
-foreign body
-seasonal/environmental allergies
-recurrent/back-to-back viral rhinitis or nasopharyngitis

Fever and rhinorrhea in **>5 years old**

Consider sinusitis

If considering the diagnosis of sinusitis in a child younger than 5, please consult a pediatrician.

Persistent Illness
Nasal discharge and daytime cough for >10 days **with no improvement**

Observe for 3 days. Follow-up by phone or by appointment.

Worsening Course
One week of worsening nasal discharge, daytime cough, and fever after initial improvement

Severe Onset
Fever >102 and purulent nasal discharge for >3 consecutive days

If no improvement

Treatment

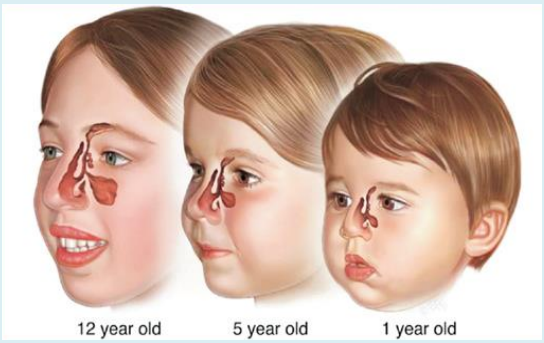
1st line	High-dose amoxicillin 45 mg/kg/dose PO BID for 14 days
2nd line	High-dose Augmentin 45 mg/kg/dose PO BID for 14 days
3rd line	Cefdinir 14 mg/kg/dose PO daily for 14 days

Try to avoid using cephalosporins. They are less effective at treating the most common organisms that cause sinusitis. Additionally, cefdinir takes 3-5 days to reach the villages.
For PCN allergy: Please obtain a pediatrics consult. Do not prescribe azithromycin or Septra. The most common pathogens in pediatric sinusitis have high resistance rates to these antibiotics.

Follow-up by phone or by appointment at 3 days. If no improvement, consider broadening to next line of treatment.

Follow-up 10-14 days after starting treatment. If still symptomatic, consider lengthening course to total 21-28 days of treatment.

Sinus Development in Children



- Maxillary: present at birth, fully developed at 12 years
- Ethmoid: present at birth, fully developed at 12 years
- Frontal: present at 3 years, fully developed at 18-20 years
- Sphenoid: present at 8 years, fully developed at 12-15 years

Source: https://www.google.com/search?biw=1536&bih=740&tbm=isch&sa=1&ei=rTiHWt3rCIHRjAP4hKaICA&q=sinus+development&oq=sinus+development&gs_l=psy-ab.3..0i67k1j0l5j0i5i30k1l3j0i8i30k1.34240.34657.0.35299.2.2.0.0.0.0.200.398.0j1j1.2.0....0...1c.1.64.psy-ab..0.2.395...0i30k1.0.rSFh1aHIq74#imgrc=IDSBxCfrF0AkWM:&spf=1518811500752

Imaging
Do not routinely obtain imaging studies in suspected sinusitis unless there is concern for a complication like orbital or CNS involvement.
Do not treat sinusitis, in the absence of symptoms, if it is an incidental finding on an imaging study.

Adjuvant Therapies
-Saline nasal spray
-Steam
-Oral hydration
-Tylenol and ibuprofen
-Do not routinely give decongestants and antihistamines (especially Benadryl). They have been proven ineffective in children and are unsafe under 6 years old.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/26/18; reviewed and reapproved 10/2019. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Skin and Soft Tissue Infection, page 1

Skin and Soft Tissue infection identified

DO NOT use guideline for the following:
- Diabetic ulcer
- Vascular ulcer
- Necrotizing fasciitis
- Human or animal bite cellulitis
- Thrombophlebitis
- Erythema nodosum
- Toxic shock syndrome
- Herpes zoster
- Fish finger
- Bacteremia
- Periorbital or orbital cellulitis
- Osteomyelitis
- Perineal/vulvar/perianal infections

If considering an above diagnosis, management must be individualized, and this guideline may not apply.

Abscess present?

Yes → Cutaneous abscess → Perform incision and drainage. Obtain wound culture. Place drain if possible (Derma-stent or Penrose). Hot pack. Soak q2h. Schedule NSAIDs. Update Tdap. Elevate if extremity.

No → Purulent drainage or exudate?

Yes → Purulent cellulitis

No → Non-purulent cellulitis → See Page 2

Cellulitis >10 cm or >1% BSA in child (size of child's palm)

Empiric Oral Antibiotic Therapy

Adults
Septra DS 1 tab PO q12 hours (do not give to pregnant women)

Children
Septra 4-6 mg/kg PO q12 hours (based on TMP component)

Adults with sulfa allergy
Doxycycline 100 mg PO q12 hours

Children with sulfa allergy
≥ 8 years: Doxycycline 2 mg/kg PO q12 hours (max 100 mg/dose)
< 8 years: Clindamycin 10-13 mg/kg PO q8 hours

Pregnant or breastfeeding women
Clindamycin 450 mg PO TID

***Antibiotic duration 5-7 days**
***Doxycycline does not cover *Strep pyogenes*.**
Discharge with topical chlorhexidine wash if recurrent abscess and patient has no running water.

Yes → Consider empiric oral antibiotic therapy

No, antibiotics not indicated → Outpatient management with daily follow up until continuous improvement is demonstrated

Does patient meet all criteria for outpatient management (see Box 2)?

Yes → Outpatient management with daily follow up until continuous improvement is demonstrated

No →
- Admission with IV antibiotics. (See box.)
- Recommend blood cultures, CBC, basic metabolic panel.
- Elevation and heating pad.
- Consider IV fluids.
- Scheduled NSAIDs if no contraindication.
- Consider imaging.
- If patient meets criteria for sepsis, follow sepsis guideline.
- Calculate LRINEC score.

Empiric IV Antibiotic Therapy
1. Vancomycin:
   - <12 years: 15 mg/kg IV q6h. Trough before 6th dose.
   - 12–18 years: 15 mg/kg IV q8h. Trough before 6th dose.
   - Adults: 1 gram IV q12h. For obese patients, dose 15 mg/kg IV q12h using ideal body weight. No troughs if therapy <72 hours.
   - Dosing changes to be made by pharmacy using AUC/MIC or clincalc.com/vancomycin
2. Clindamycin 600 mg IV q8h. Restricted to vancomycin allergy.
3. Linezolid 600 mg IV/PO q12h. Restricted to MRSA resistance/allergy. ID consult recommended.
4. Consider coverage for *H. influenzae* A/B in children with rapidly progressing cellulitis/abscess, temp >104°F, systemic symptoms (listlessness, lethargy): ceftriaxone 75 mg/kg IV/IM q24 hours in addition to above.

Patient improving?

Yes → Manage as inpatient until meets criteria for outpatient management

No →
- Review culture and sensitivities
- Consider imaging.
- Consider repeat incision and drainage

Vancomycin:
Strongly consider inpatient admission if vancomycin is considered.
Remember, no outpatient vancomycin may be prescribed to patients <18 years old.

BOX 2: Criteria for Outpatient Management:
- Afebrile and non-toxic
- Ambulatory and able to commute to hospital for outpatient treatment
- Able to care for self
- Tolerating PO fluids
- Pain controlled with oral pain meds
- Doesn't require hospitalization for elevation of extremity

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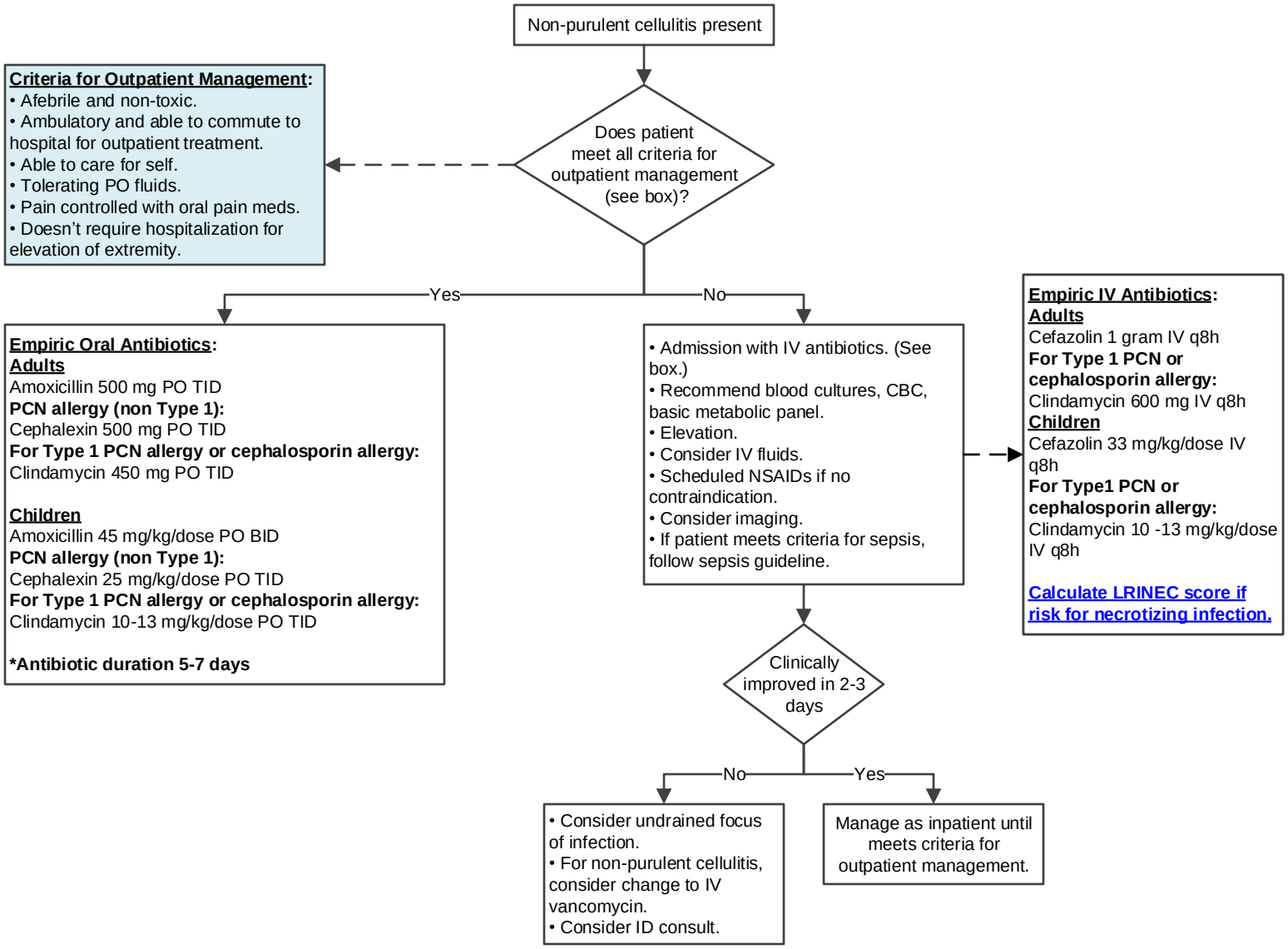
If comments about this guideline, please contact Elizabeth_Bates@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Skin and Soft Tissue Infection, Page 2



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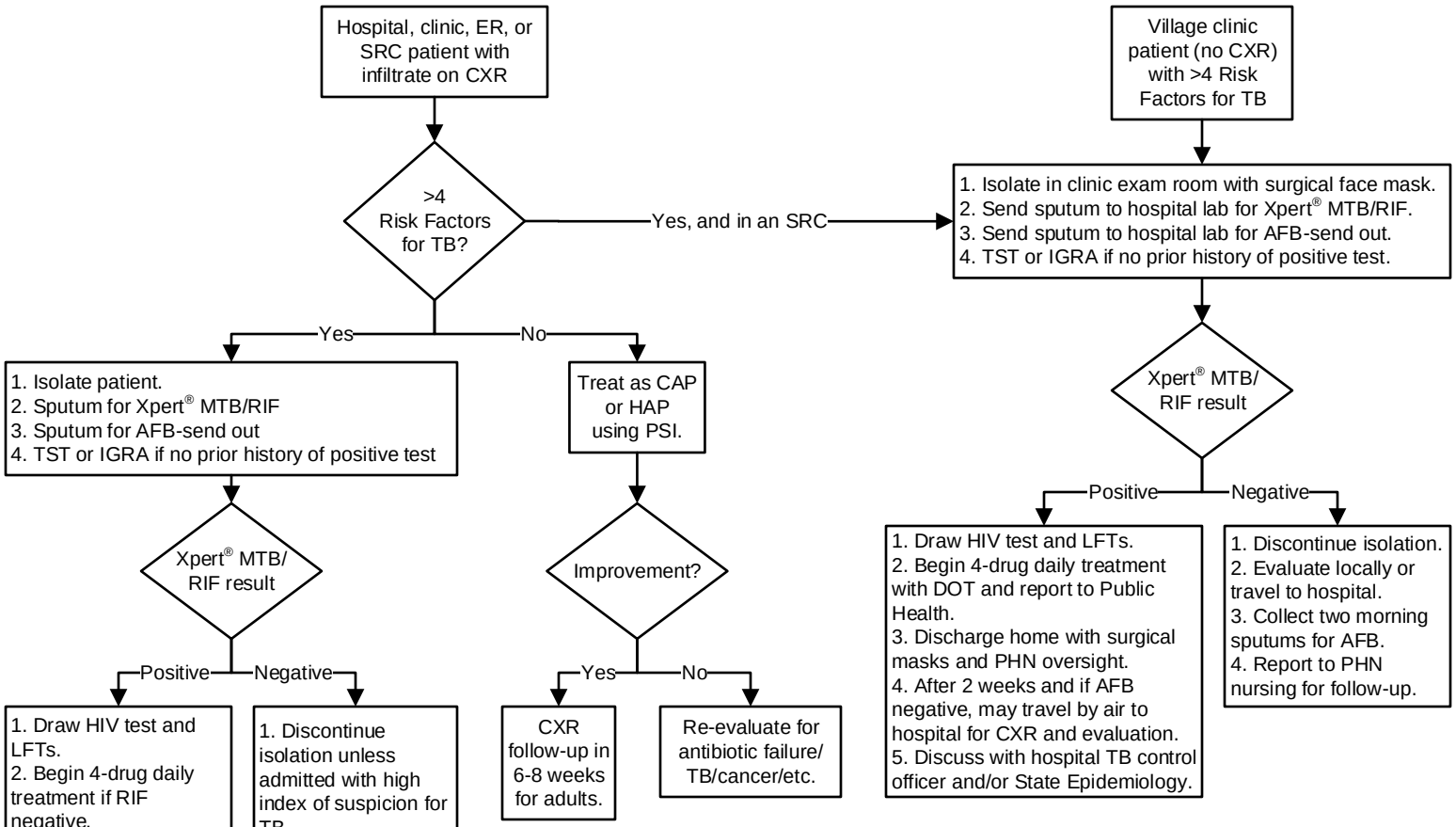
Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Tuberculosis, Active Pulmonary(>14 Years)



Risk Factors for TB

- persist cough >3wks
- fever
- night sweats
- weight loss
- hemoptysis
- immunosuppression (HIV/DM/other)
- atypical CXR
- foreign born from endemic area
- prior active or latent TB infection
- household contact of active TB
- persistent pneumonia
- born before 1960 and long-term resident of western Alaska or other endemic area

PSI

See www.mdcalc.com/psi-port-score-pneumonia-severity-index-adult-cap/

- PSI ≤70 stable for outpatient therapy
- PSI 71-90 likely outpatient therapy but may consider inpatient
- PSI ≥91 advise inpatient therapy

Abbreviations: AFB-acid fast bacilli; CA-cancer; CAP-community acquired pneumonia; CXR-chest x-ray; DM-diabetes mellitus; DOT-direct observational therapy; ER-emergency room; LFTs-liver function tests; HAP-healthcare associated pneumonia; HIV-human immunodeficiency virus; IGRA-interferon gamma release assay; PHN-public health nurse; PSI-pneumonia severity index; SRC-subregional clinic; RIF-rifampin resistance; TB-tuberculosis; TST-tuberculin skin test

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/13/16. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Elizabeth_Roll@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guidelines/Treatment Protocols

Tuberculosis, Latent (≥14 years)

If patient has symptoms concerning for TB, see **Active TB Guideline**. Do not send patient to Bethel unless patient is medically unstable.

Patient ≥14 years with:
New positive TB skin test
OR
New positive Quantiferon-Gold

At least one symptom? — Yes → Patient in village? — Yes → DO NOT PUT A PATIENT WHO MAY HAVE ACTIVE TB ON A PLANE UNLESS ACUTELY ILL; this could expose the other passengers. Perform evaluation in village, as able.

At least one symptom? — No → Thirty minute appointment in Bethel for:
- Physical exam
- Chest X-ray
- Labs: LFTs, HIV, and hCG if female

Patient in village? — No →
- Patient must wear surgical mask AND stay in a negative pressure room, if available, until MTB-RIF result is negative.
- Collect sputum samples using the "AMB NEW +PPD/ LTBI" Power Plan. This generates orders for all three sputum samples, including the 2nd and 3rd day samples.
- First collect one sputum sample (3 mL in a urine cup) for MTB-RIF and send to lab.
- Next collect three sputum samples for AFB smear and TB culture (5 mL in a conical tube) at least eight hours apart.
- Obtain labwork: LFTs, HIV, and hCG if female.
- Chest X-ray if available.

Abnormal chest X-ray? — Yes → (same as above)

Abnormal chest X-ray? — No → LTBI
- Call PHN with plan of care.
- Begin treatment per box, using LTBI Power Plan.
- Print LTBI prescriptions and fax to PHN.
- Follow-up sputum smears and cultures, if indicated.

MTB-RIF positive? — No → LTBI

MTB-RIF positive? — Yes → Active TB. Contact TB officer and see **Active TB Guideline**.

Sputum smear or culture positive? — Yes → Active TB. Contact TB officer and see **Active TB Guideline**.

Sputum smear or culture positive? — Not positive or not indicated → LTBI. Continue full course of treatment per Public Health.

Symptoms
- Cough for more than three weeks
- Weight loss
- Fever
- Night sweats
- Hemoptysis

What is a positive TB skin test?
- At least 10 mm of induration OR >5 mm of induration for patients who are high risk for TB (See box).
- Must be read 48-72 hours after placement to be a true negative.
- If positive, the induration can remain up to seven days and can be read until then.

High Risk for Tuberculosis
1. Immunosuppressed, HIV positive, prednisone >15 mg/day for >1 month, TNF-α blocker.
2. Suspicious chest X-ray.
3. Household contact with active TB.

LTBI Treatments: Choose one option

1. 3HP: INH 15 mg/kg PO weekly, rounding to nearest 50 mg (max dose 900 mg) x 12 weeks
AND
Rifapentine PO weekly x12 weeks.
Rifapentine Dosing:
  - 32.1-49.9 kg: 750 mg
  - >50 kg: 900 mg (max dose)

DOT optional.

2. Rifampin 10 mg/kg PO daily (max dose 600 mg) x4 months.

3. INH 5 mg/kg PO daily (max dose 300 mg) x9 months.

If on INH, give pyridoxine (vitamin B6) 50 mg PO daily to prevent neuropathy.

If patient is pregnant or HIV infected, contact TB Officer.

Abbreviations
3HP: three month regimen of INH and rifapentine
AFB: acid-fast bacilli
DOT: directly-observed therapy
hCG: pregnancy test
HIV: human immunodeficiency virus
INH: isoniazid
LFT: liver function tests
LTBI: latent tuberculosis infection
MTB-RIF: mycobacterium tuberculosis nucleic acid amplification test that also tests for rifampin resistance
PHN: Public Health Nursing
TB: tuberculosis
TNF-α: tumor necrosis factor alpha

TB Officers
- Philip Johnson MD
- Elizabeth Roll MD
- Robert Tyree MD
- Mien Chyi MD (pediatrician)
- Kimberly Fisher DO (pediatrician)
- Cynthia Mondesir MD (pediatrician)

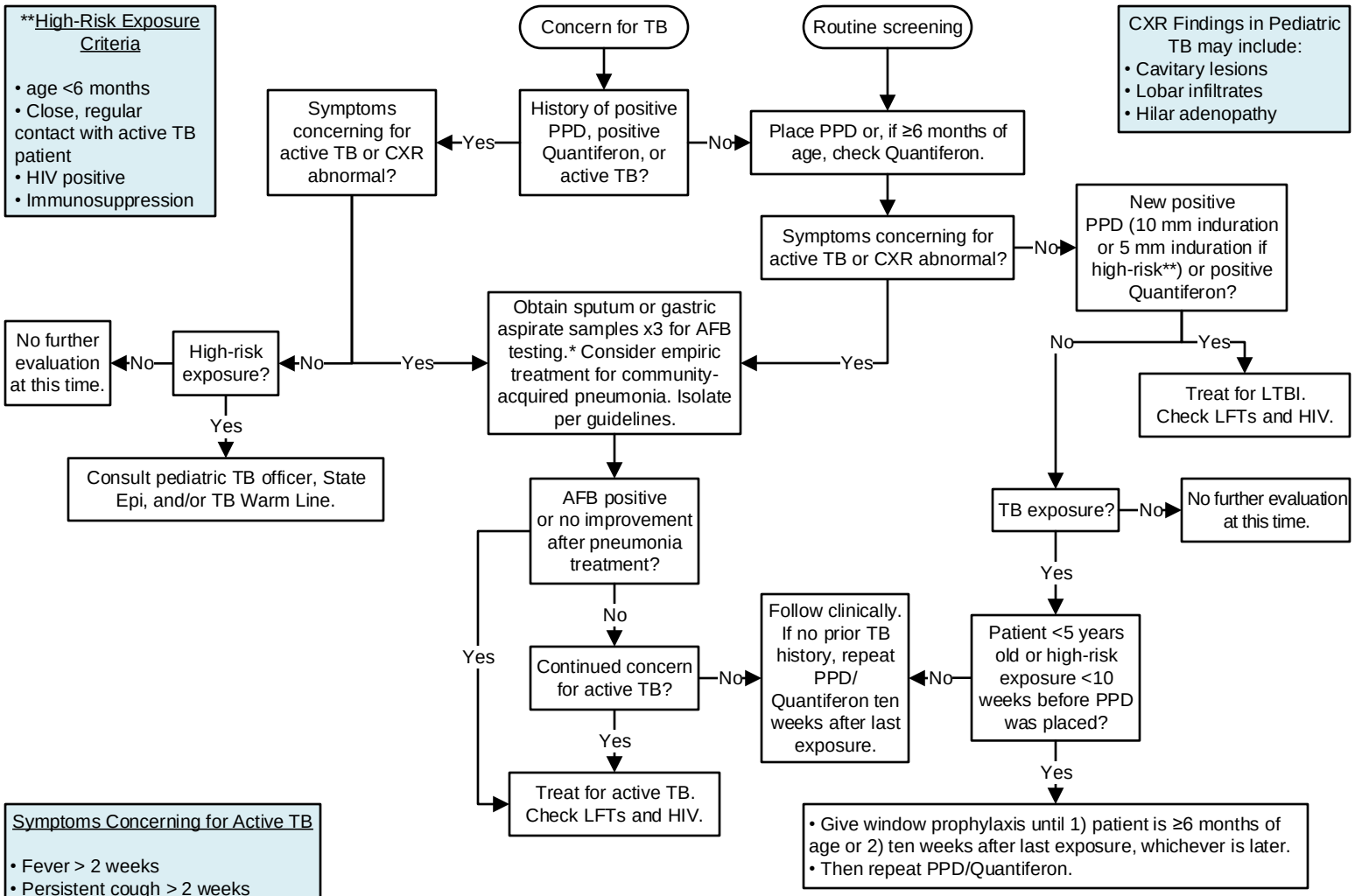
Contact Information
- Public Health Nursing (PHN):
  Phone: 543-2110
  Fax: 543-0435
  All directly-observed therapy (DOT) will be arranged by PHN.
- Curry Center TB Warm Line: (877) 390-6682
- State Epidemiology: (907) 269-8000
- State Epidemiology Lab: (907) 334-2100

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/14/20. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Robert_Tyree@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Tuberculosis Evaluation & Treatment (≤14 years)



Symptoms Concerning for Active TB

- Fever > 2 weeks
- Persistent cough > 2 weeks
- Failure to thrive/weight loss
- Hemoptysis (uncommon in kids)

***Samples**

Induced sputum samples are preferred over gastric aspirations. Induced sputums should be collected at least eight hours apart. Three samples should be sent for AFB Smear and Culture and two should be sent for Xpert MTB-RIF.
See the **Pediatric Induced Sputum Collection Protocol**.

Contact Information

YKHC Pediatric TB Officer: Mien Chyi MD
- Please ensure she is aware of any child with possible TB.
- Non-urgent questions can be sent by email, which will be addressed on the next business day.

Alaska State Epidemiology: (907) 269-8000
TB Warm Line/Curry Center: (415) 502-4700 or (877) 390-6682

- Medications are typically prescribed by a TB officer in partnership with Public Health.
- Please see the **Alaska Pediatric TB Manual** or the **Curry Center TB Reference** for more information.

Abbreviations: TB- tuberculosis; CXR- chest X-ray; PPD- purified protein derivative; AFB- acid-fast bacilli; HIV- human immunodeficiency virus; LFTs- liver function tests; Xpert MTB-RIF- rapid test for Mycobacterium tuberculosis and rifampin resistance.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/2/20. Minor updates 4/8/21.
Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Mien_Chyi@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

UTI (Adult)

Abnormal clean catch UA:
< 5 squamous epithelial cells AND ONE of the following:
• >5 WBCs
• Positive leukocyte esterase
• Positive nitrite
• Bacteria

Patient presents with signs/ symptoms of acute cystitis and a urinalysis suggestive of UTI. If complicated or catheter associated, see below.

If acute onset of dysuria, urinary frequency or urinary urgency, don't forget to test for STI if appropriate.

Signs or symptoms of acute pyelonephritis?

No

1. Nitrofurantoin 100 mg PO BID for 5 days OR
2. Cephalexin 500 mg PO BID for 7 days (use first for patients >65)
If no other options exist:
3. Ciprofloxacin 250 mg PO BID for 3 days

UTI associated with fever, chills, back/flank pain, suprapubic pain

Yes

• Always obtain culture and sensitivities.
• Consider blood cultures if ill/septic.

Able to be treated as outpatient?

No

1. Ceftriaxone 1 gram IV daily
OR
2. Levofloxacin 750 mg IV/PO daily

• Narrow therapy when culture data allows.
• If not improving within 48-72 hours, consider imaging to rule out obstruction or other complications.
• Duration of therapy as for outpatient.

• Must NOT BE PREGNANT.
• Able to tolerate PO.
• Not septic.
• Able to recheck within 24 hours.

Yes

Give a single dose of either:
Ceftriaxone 1 gram IV/IM
OR
Gentamycin 3 mg/kg IV/IM

AND one of the following oral options:
1. Cephalexin 1 gram PO BID for 14 days OR
2. Levofloxacin 750 mg PO daily for 5 days

TMP/SMX DS PO BID for 14 days is acceptable if culture is sensitive.

• If known ESBL: use nitrofurantoin first (not for complicated ESBL or for age >65).
• If sensitive: TMP/SMX or fluoroquinolne.
• If allergic to susceptible antibiotics may use fosfomycin 3 g PO q48 hours x3 doses.

Complicated UTI/catheter-associated UTI

UTI with coexisting functional anomalies of urinary tract: BPH, calculi, obstruction, neurogenic bladder, chronic catheter transplant, neutropenia.

Obtain culture and sensitivities.

Able to be treated as outpatient?

Yes

• If old culture results available use empirically while awaiting new culture and sensitivities
• Definitive treatment when culture available.
• If no old culture results, use outpatient pyelonephritis treatment above
• Duration of therapy 3-5 days after defervescence or elimination of catheter.
• If female </= 65 consider 3 day course for catheter associated infection if catheter is removed.

No

• Obtain imaging studies if critically ill.
• If no risk for MDRO:
1. Ceftriaxone 1 gram IV q24h OR
2. Levofloxacin 750 mg IV q24h
• If risk for MDRO:
1. Cefepime 1 gram IV q8h extended infusion OR
2. Pip/Tazo 3.375 gram IV q6h or Q8h extended infusion +/- gentamycin 3 mg/kg IV q24h
3. Consider adding MRSA coverage if septic shock is present (get blood cultures from 2 sites).
• If known ESBL:
Meropenem 500 mg IV Q6h

• Narrow therapy when culture data allows and patient is clinically improved.
• Duration of therapy: 5-14 days depending on agent and rapidity of response.
• If nidus of infection (stone, catheter) will need longer treatment.
• Prostatitis may require as long as 6 weeks of oral therapy.

MDRO: Multi-Drug Resistant Organism
MRSA: Methicillin-Resistant Staph Aureus
ESBL: Extended Spectrum Beta Lactam

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 10/15/18. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

UTI in Children 3 months – 5 years

Child less than 5 years of age with concern for UTI

Obtain catheterized or true clean catch urine sample for urinalysis (UA) AND culture.

UA positive for leukocyte esterase and/or nitrites and/or microscopy >5 WBC/HPF.

Ensure urine culture is sent.

Patient appearing toxic?

Yes → Empiric antibiotic treatment: ceftriaxone 75mg/kg/day IV/IM

No → Consider empiric treatment with cephalexin 20 mg/kg/dose Q8h x10 days.
May defer empiric treatment and await culture sensitivities.

Once clinically improved and sensitivities established, switch to oral antibiotics

Positive urine culture with single species ≥50,000 CFU/mL in a catheterized sample or ≥100,000 CFU/mL in a clean catch sample?

No → No UTI. Stop antibiotics.

Yes → Begin empiric treatment and narrow coverage per sensitivities.

If first UTI, renal ultrasound at first opportunity to evaluate anatomy.

Renal abnormality identified.

- If mild pelviectasis identified, repeat ultrasound in 3 months.
- If any other anomaly identified, consult pediatrics.

Signs and Symptoms of UTI
- fever
- dysuria
- vomiting
- abdominal pain
- new daytime or nighttime wetting
- increased frequency of voiding
- malodorous urine

Differential Dx for Dysuria
- UTI
- vulvovaginitis
- Candida infection
- poor hygiene
- sexual abuse
- age-appropriate self-exploration

Resistance
- Empiric drug choice is based on local resistance patterns and consultation with ID specialist.
- If urine culture grows an Extended-Spectrum Beta-Lactamase (ESBL) producing organism, please obtain a pediatrics consult and add ESBL to Problem List.

Symptomatic Care
- If dysuria, irritation, etc. recommend A+D ointment and instruct family to do soaks/baths with warm water and no soap.
- May consider baking soda ¼ cup per tub.

Village Management
- Do not treat any child under 5 years of age empirically in the village.
- If patient has dysuria, increased frequency, new-onset enuresis, and/or abnormal clean catch urinalysis, consider further evaluation in Bethel.
- Consider symptomatic care (see box) for possible vulvovaginitis.

DO NOT …
- treat any child under 5 years of age empirically in the village.
- routinely collect urine via bag.
- treat a UTI without a culture in progress.
- routinely perform a test of cure.
- routinely start UTI prophylaxis.
- perform suprapubic taps.
- routinely obtain bloodwork for uncomplicated UTI.
- add UTI to Problem List until confirmed by culture.

Indications for VCUG:
- Recurrent UTI in child <6 years. Note: study available in Bethel 1-2 times per year when radiologist in-house.
- Major anomaly on ultrasound. Consult pediatric urologist and consider obtaining VCUG in Anchorage.

NOTE: Any infant with a fever <90 days must go to the Emergency Department for evaluation.
See the Fever in Infants 0-90 Days Guideline.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 5/8/19.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Varicella, Suspected

True Varicella infection is RARE in our region:

1. **DO NOT diagnose Varicella** without confirmatory lab testing.
2. Per the CDC:
   - Two doses of VZV vaccine are 88-98% effective at preventing all VZV infections.
   - One dose of VZV vaccine is 85% effective at preventing all VZV infections.
3. All confirmed Varicella must be confirmed to State Epidemiology with this form: **http://dhss.alaska.gov/dph/Epi/Documents/pubs/conditions/frmInfect.pdf**

Differential Diagnosis

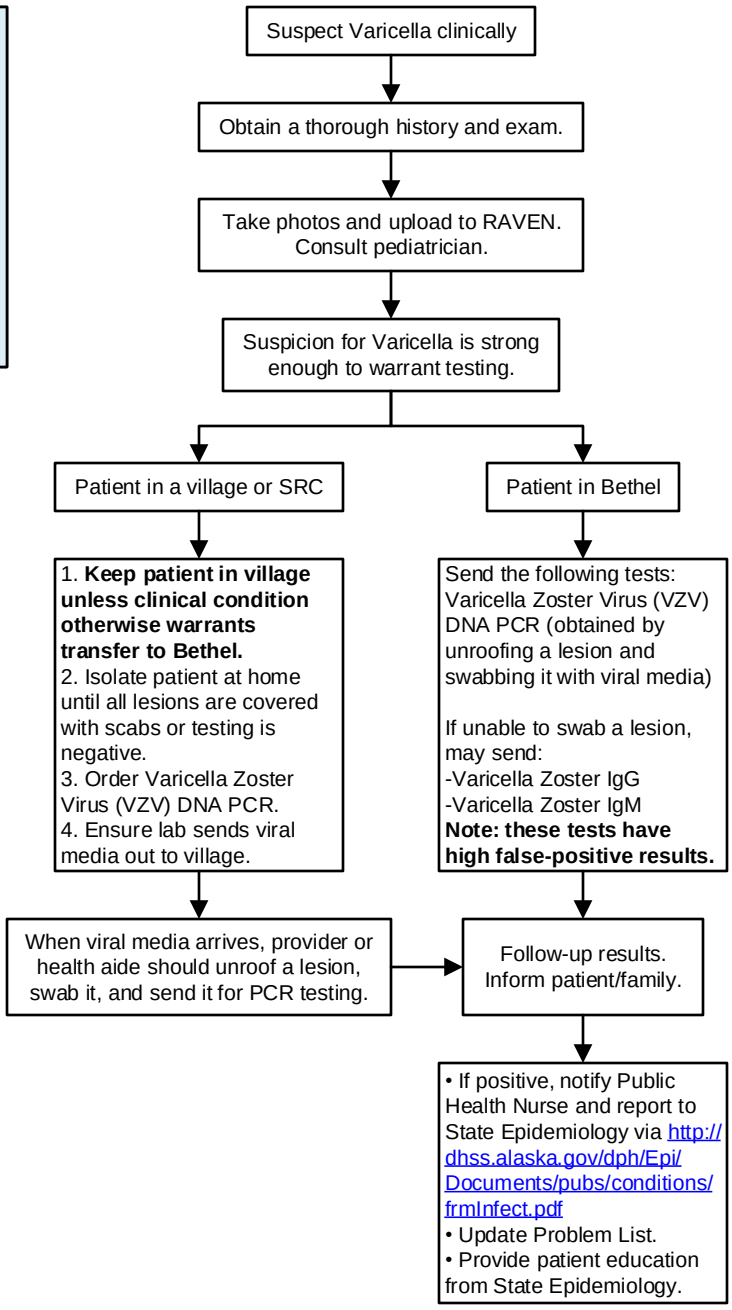
- Hand-foot-mouth disease
- Scabies
- Stomatitis
- Eczema herpeticum
- Diffuse impetigo

Provider Documentation for Suspected Varicella Infection

- Date of symptom onset
- Date of suspected diagnosis
- Date of rash onset
- Location of rash, including where first noted
- Number of lesions
- Photos of lesions
- Evolution of rash (including appearance of new groups of lesions)
- Appearance of lesions (are there lesions in all stages of development at once?)

High Risk Exposures

- Inquire if any pregnant women or immunocompromised people have been exposed.
- For pregnant women: find out if she has a history of varicella or has received the vaccine. If not, then consult HROB to consider further treatment.
- For immunocompromised patients: refer to a provider for evaluation.



Typical Presentation for Chickenpox/Varicella

- Exposure occurs.
- 10-21 days after exposure, fever appears, followed by rash.
- Rash appears in successive crops over several days.
- Rash begins as macular and then progresses to vesicular, then pustular, then crusted.
- There are lesions in different stages of development on different parts of the body.
- New vesicles stop forming within four days.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/11/19. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Jane_McClure@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

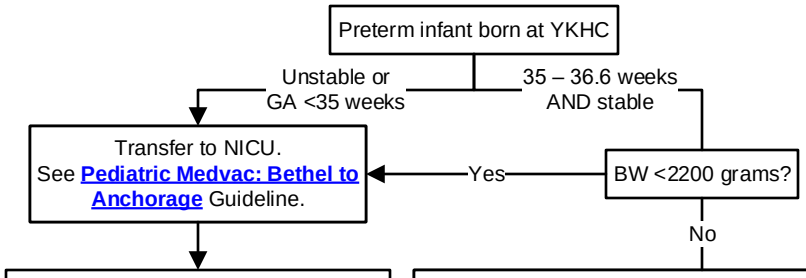
Neonatal Guidelines

Neonatal

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Care of Late Preterm Newborns



- Encourage mother to express breastmilk.
- If infant is stable, encourage bonding and breastfeeding while awaiting medevac.

NOTE: If infant of any GA is unstable at any time, please contact the pediatric hospitalist (Tiger Connect Peds Wards on Duty) and prepare for transfer.

- Admit patient to OB using the Late Preterm Power Plan.
- Infant is observed in the mother's room or in the Newborn Treatment Room for at least four hours to ensure stability.
- VS Q4h, including temperature, throughout entire stay.
- Blood glucose screening per **protocol** for full first 24 hours of life.
- Establish feeding plan with parents (see box).
- Ensure parents are educated (see box).
- Follow Late Preterm Goals of Care worksheet (to be placed on baby's hard chart).
- On day of birth, schedule outpatient appointment for DOL 4-5 to ensure appointment availability.

Parent Education

- Educate parents regarding vulnerability of late preterm neonate and late preterm protocol.
- Attach completed Late Preterm Crib Card to crib.
- Ensure parents have received the Late Preterm Handout and use as a resource.
- Emphasize need for follow-up with outpatient appointment prior to return to village.
- Ensure and encourage proper pediatric follow-up.
- Education regarding feeding plan and follow-up resources.

Huddle at 24 hours of Life

(to include bedside nurse, charge nurse, family medicine hospitalist, and pediatric hospitalist if needed)

- Points to discuss: how the baby is feeding, %weight loss, can we safely manage the baby's needs, unit acuity/staffing ratios, does the baby need to be transferred at this time, time for next huddle (if needed).
- If infant receives three "strikes" on the Late Preterm Goals of Care worksheet, there must be a huddle to discuss if the infant should be transferred.

Infant Stability

- Temperature ≥97.7 (axillary) for 6 hours in open crib.
- Cardiovascular and respiratory stability as determined by the medical team.
- Able to tolerate oral feeds without color change or increased WOB: breastfeeding or tolerating 5-10 ml EBM or formula at a minimum of every 3 hours.

Goals for Discharge

- Weight loss <8% below BW.
- Temperature ≥97.7°F x24 hours in an open crib.
- Well-established feeding plan.
- Follow-up appointment scheduled in outpatient clinic in Bethel in 24-48 hours. If weekend, may have this follow-up on OB by pediatric hospitalist.
- Must have warm handoff with message sent to provider seeing patient for follow-up that includes minimal requirements to be met for discharge back to village.
- Follow-up weekly in village or outpatient clinic until corrected GA of 40 weeks.

Definitions

- GA: gestational age at birth
- Late preterm: GA 34 weeks 0 days to 36 weeks 6 days
- Early term: GA 37 weeks 0 days to 38 weeks 6 days
- Term: GA 39 weeks 0 days to 40 weeks 6 days

Characteristics of Late Preterm Infants

- Low birth weight
- Low body fat
- Poor thermoregulation
- Low glycogen stores
- Low tone
- Poor state regulation
- Immature immune system
- Immature suck and swallow
- Delay in bilirubin metabolism

Late Preterm Infants Are at Risk For:

- Hypothermia
- Hypoglycemia
- Sepsis
- Poor feeding and infrequent feeds can lead to inadequate maternal milk supply
- Breast feeding failure
- Poor suck and swallow may lead to inadequate milk intake
- Excessive weight loss, failure to thrive
- Hyperbilirubinemia with late rise (expect peak on DOL 5)
- Increased readmission rate (5-13 times that of term infants)
- Respiratory instability in upright car safety seats or other upright infant devices
- Hospital readmission

Feeding Plan

Infants meeting any of the following criteria should be assessed for the need for supplementation:

- Birth weight <2500 grams
- Poor reserve (evidenced by temperature instability or hypoglycemia)
- Poor feeding (LATCH <7 or <10 minutes at breast)
- Weight loss >3% per day or >8% total

If Breastfeeding

- Lactation evaluation within 24 hours of birth.
- **LATCH score** documented at least Qshift.
- Infant should be put to breast at least Q3h.
- Use Supplemental Nursing System (SNS) to ensure measurable amounts each feed with the following volumes:
  - 0-24 hours: 5-10 mL
  - 25-48 hours: 10-20 mL
  - 29-96 hours: 20-30 mL

Supplementation

- Supplementation should be given by SNS (preferred), cup, or finger feeds rather than nipple and bottle. May receive formula if milk volume not meeting fluid needs.
- Mother to pump every 3 hours after nursing unless infant nursing vigorously.
- Bedside nurse and medical team should re-evaluate feeding plan daily.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 8/3/21. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Newborn Early Onset Sepsis/GBS

Is infant ≥ 35 weeks?

- No → This guideline does not apply to infants <35 weeks. Consult pediatrics. See **this link** for resources.
- Yes ↓

Is one or more of the following present?

- Any maternal fever during antepartum period
- Prolonged rupture of membranes
- GBS positive or unknown

- No → Routine care. Consult pediatric hospitalist with any questions or concerns.
- Yes ↓

- Go to the **Kaiser Neonatal Early-Onset Sepsis Calculator**.
- Enter infant and maternal information.
- The first question will ask your local incidence of newborn sepsis. In the drop-down box, choose the CDC national incidence.

↓

- Follow recommendations for blood culture, antibiotics, and vital sign frequency based on early-onset sepsis risk for infant's clinical status.
- "Well-appearing," "equivocal," and "clinical illness" are defined **here**.
- Note: If the calculator recommends observation, this should be for at least 48 hours with vital signs Q4h.

→ If any clinical concerns about infant, consult pediatric hospitalist.

↓

If giving antibiotics:
- Send CBC with differential and CRP.
- Order ampicillin and gentamicin, using **Neofax** or the **Neonatal Resuscitation Summary** for dosing.
- Consult pediatric hospitalist and prepare to transfer infant to NICU.

Note: CBC and CRP are not routinely recommended anymore. However, they can be useful to trend if starting antibiotics. Thus, we recommend they be obtained if starting antibiotics.

Signs of Neonatal Sepsis

- Temp ≥ 100.4 or ≤ 97.5
- Irritability
- Poor Feeding
- Hypoglycemia
- Hypothermia
- Tachypnea
- Tachycardia
- "Not acting right"

If any of these signs are present, consider obtaining a pediatrics consult.

References

- *Pediatrics* 2019: **Management of Infants at Risk for Group B Streptococcal Disease**
- ***Pediatrics*** **2018: Management of Neonates Born at ≥ 35 0/7 Weeks' Gestation with Suspected or Proven Early-Onset Bacterial Sepsis**

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Jaundice in a Baby <4 Weeks

Routine screening of newborns at 24 hours of life

Well-appearing infant ≥ 35 weeks presents with new or worsening jaundice

If infant is not well-appearing, consider sepsis, consult pediatric hospitalist, and follow recommendations on **fever <90 days guideline**.

Newborn in the nursery

Post-hospital discharge

Check transcutaneous bilirubin level.
Note: check level immediately if jaundice noted in a baby <24 hours old.

Enter level into **BiliTool.org**.

Is level ≥3 mg/dL below phototherapy threshold when gestational age (GA) and neurotoxicity risk factors are considered?

No

Yes

Evaluate infant in Bethel in outpatient clinic or ED.

• Check serum total and direct bilirubin level.
• If direct bilirubin >1 mg/dL or >20% of total bilirubin, do not start phototherapy. (See Direct Hyperbilirubinemia Box.)
• Consider venous blood draw to maximize chances of getting a non-hemolyzed specimen.

≥7 days old

• Bilitool does not apply.
• Consider phototherapy if serum total bilirubin >18 and no risk factors.
• If risk factors present, consider starting phototherapy at a lower level.

< 7 days old

Enter serum level into **BiliTool.org**.

• Incorporate recommendations from Bilitool into clinical decision making.
• It is an option to give phototherapy if the total bilirubin level is 2-3 mg/dL below the treatment level. Used shared decision making with mother.
• if Bilitool recommends repeat level in 48 hours, consider checking this earlier (in 24 hours) for patients who live in villages.

Direct Hyperbilirubinemia

If direct bilirubin >1 mg/dL or >20% of total bilirubin, do not start phototherapy.
Direct hyperbilirubinemia requires a work-up and often gastroenterology consultation. Phototherapy is contraindicated. Obtain pediatrics consult.

Differential Diagnosis

• Benign neonatal hyperbilirubinemia
• Breastfeeding jaundice (<7 days of life)
• Breastmilk jaundice (>7 days of life)
• Ongoing hemolysis
• Sepsis or TORCH infections
• Biliary atresia
• Intestinal obstruction
• Idiopathic neonatal hepatitis
• Genetic causes (G6PD, etc.)

How to Use Bilitool.org

1. Enter infant's age and total bilirubin level.
2. You will be brought to a Risk Stratification page with two recommendation tables.
3. The first table is recommended follow-up. It refers to the risk factors for development of severe hyperbilirubinemia.
4. The second table is recommendations for phototherapy. It refers to the risk factors for neurotoxicity.
5. Pay close attention to both tables. For example, infants with intermediate levels sometimes require phototherapy due to GA<38 weeks and/or neurotoxicity risk factors.

Risk Factors for Development of Severe Hyperbilirubinemia

Use this list when determining follow-up.

• Jaundice < 24 hours of life
• ABO or Rh incompatibility, especially with positive antibodies
• GA less than 38 weeks
• Previous sibling received phototherapy
• Cephalohematoma or significant bruising

Breastmilk Jaundice

• Resolves by 3 weeks of age in 65% of infants.
• Another 20% may continue to have jaundice until 4 weeks of age.
• Consider this diagnosis of exclusion in a well-appearing breastfeeding infant with no risk factors for hemolysis with persistent hyperbilirubinemia without an upward trend.
• Confirm with serial measurements over two days. Admission not required.

Phototherapy

1. Order using one of the following:
   • PED Pediatric Admission Power Plan→PED Phototherapy sub-phase
   • OB/Newborn orders folder→OB Newborn Phototherapy Power Plan
2. Check serum total bilirubin level Q12h (or more frequently if needed). If level is trending up, consult pediatrician and consider broadening differential and work-up. Note: Transcutaneous bilirubin is not reliable after phototherapy has been started. Check serum levels only.
3. Encourage frequent feeding, but try to limit time out of phototherapy to no more than 20 minutes Q3h.
4. IV fluids are unnecessary unless infant has signs of dehydration.
5. Keep infant supine with eye protection while under phototherapy.
6. May stop phototherapy when serum total bilirubin level is at least 3 mg/dL below the phototherapy initiation level, using the current hour of life.
7. **Obtain rebound bilirubin level 12 hours after stopping phototherapy if patient <72 hours old or if concern for hemolysis.**

Neurotoxicity Risk Factors

Use this list when determining need for phototherapy.

• Isoimmune hemolytic disease
• G6PD deficiency
• Asphyxia
• Significant lethargy
• Temperature instability
• Sepsis
• Acidosis

Note: GA <38 weeks lowers the threshold at which BiliTool will recommend starting phototherapy.

Labs for Expanded Work-up

Consider obtaining for infants who develop jaundice at <24 hours of life, have rising levels despite phototherapy, or have recurrent jaundice.

• Blood type, DAT (Direct Antibody Test, or Coombs)
• CBC with manual differential, and reticulocyte count
• Electrolytes (to assess hydration and acidosis)
• Thyroid studies (if prolonged or recurrent)
• LFTs and GGT
• G6PD

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 4/6/21. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Neonatal Glucose Screening

Target Glucose Levels for Age

Birth to 4 hours of life	>35 mg/dl
>4 – 24 hours of life	>45 mg/dl
>24 – 48 hours of life	>50 mg/dl

Symptoms of Hypoglycemia in Newborns:

Irritability
Tremors
Jitteriness
Exaggerated Moro Reflex
High Pitched Cry
Seizures
Lethargy
Floppiness
Cyanosis
Apnea
Poor Feeding

0-4 HOURS OF AGE

At Risk Infants (See Box)
Begin feeding within one hour of birth. First glucose should be obtained 30 minutes after completion of first feed.

<35

1. Administer Dextrose Gel immediately per dosing chart.
2. Place skin to skin and feed again.
3. Repeat BG at 1 hour after Dextrose Gel (NOT one hour after feed).

>35

1. Continue feeds q 2-3 hours as long as BG >35.
2. Assess for hypoglycemia by obtaining and documenting pre-feed BG.
3. **Move to algorithm below once > 4 hours of life.**

<35

<25

1. Administer Dextrose Gel immediately per dosing chart.
2. Notify provider immediately.
3. Obtain IV, start D10 infusion, and transfer to a higher level of care.

25-35

1. Administer Dextrose Gel immediately per dosing chart.
2. Place skin to skin and feed again.
3. Repeat BG at 1 hour after Dextrose Gel (NOT one hour after feed).
4. **Move to algorithm below once > 4 hours of life.**

Risk Factors and Indications for Screening of Asymptomatic Newborns:

SGA (<10%ile BW)
LGA (>90%ile BW)
Infant of Diabetic Mother
Late Preterm (34 0/7 – 36 6/7)
Other clinical situation per physician discretion

DEXTROSE (40%) GEL DOSING

Birth Weight	Dose
≤ 2 kg	1 mL
>2-2.5 kg	1.25 mL
>2.5-3 kg	1.5 mL
>3-3.5 kg	1.75 mL
>3.5-4 kg	2 mL
>4-4.5 kg	2.25 mL
>4.5-5 kg	2.5 mL

> 4 - 48 HOURS OF AGE

1. Continue feeds q 2-3 hours.
2. Assess for hypoglycemia by obtaining and documenting pre-feed BG.

At or Above Target BG?

No

≤ 35?

Yes

1. Administer Dextrose Gel immediately per dosing chart.
2. Notify provider immediately.
3. Obtain IV, start D10 infusion, and transfer to a higher level of care.

Yes

1. Continue feeds q 2-3 hours.
2. Assess for hypoglycemia by obtaining and documenting pre-feed BG.

No

1. Administer Dextrose Gel immediately per dosing chart.
2. Place skin to skin and feed again.
3. Repeat BG at 1 hour after Dextrose Gel (NOT one hour after feed).

No

At or Above Target BG?

Yes

Is this 3rd dose of Dextrose Gel?

Yes

No

At or Above Target BG?

Yes

STOP when you have four CONSECUTIVE BGs in Target Range for Age

If infant has severe symptoms or BG is <25 after first Dextrose Gel dose:

THIS SCREENING PROTOCOL NO LONGER APPLIES.

- Give Dextrose Gel dose.
- Start IV.
- Give D10 2 mL/kg bolus at 1 mL/minute.
- Start D10 infusion at 80 mL/kg/day.
- Goal is to keep baby's serum glucose at 60.
- Check glucose 30 minutes after each bolus or rate change and Q1-2h until stable.
- If glucose remains low, give another D10 2 mL/kg bolus and increase hourly rate by 1 mL/hour.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/11/19.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Jennifer_Prince3@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Neonatal Resuscitation Summary

NICU (907) 212-3614 – Ask for attending neonatologist on call.

GESTATIONAL AGE (weeks)	24	26	28	30	32	34	36	38	40
ESTIMATED WEIGHT (grams)	**700**	**900**	**1100**	**1350**	**1650**	**2100**	**2600**	**3000**	**3500**
EQUIPMENT/SUPPLIES: NG/OG Tube - 5 French ♦ UVC <32 weeks - 3.5 French ♦ UVC ≥32 weeks - 5 French ♦ UAC - 3.5 French for all gestational ages									
Laryngoscope Blade	00	00	00	0	0	0	0	0-1	0-1
ETT Size	2.5	2.5	2.5-3.0	3.0	3.0	3.0-3.5	3.5	3.5-4.0	3.5-4.0
ETT Depth lip to tip. *Place at T2 above the carina.*	6.5-7 cm	6.5-7 cm	7 cm	7-7.5 cm	7.5 cm	8 cm	8.5 cm	9 cm	9.5 cm
UVC insertion. *Place just above diaphragm. Add umbilical stump length.* **May insert UVC 2-4 cm for emergency access.**	6.5 cm	6.9 cm	7.2 cm	7.5 cm	8 cm	8.7 cm	9.4 cm	10 cm	10.8 cm
UAC insertion. *Add umbilical stump length.* **High line at T6-T9 (preferred).**	11.1 cm	11.7 cm	12.3 cm	13 cm	14 cm	15.3 cm	16.8 cm	18 cm	19.5 cm
UAC insertion. Low line at L3-L4. *Add umbilical stump length.*	7.7 cm	7.9 cm	8.1 cm	8.4 cm	8.7 cm	9.1 cm	9.6 cm	10 cm	10.5 cm
Needle decompression. *See kit and protocol in neonatal code cart.*	18 gauge	18 gauge	18 gauge	18 gauge	18 gauge	16 gauge	16 gauge	16 gauge	16 gauge
VITAL SIGNS: Heart Rate 120-160 ♦ Respiratory Rate 30-60 ♦ Mean Blood Pressure = Gestational age in weeks									
INITIAL VENTILATOR SETTINGS									
Positive Inspiratory Pressure (PIP) cm H_2O	16-22	16-22	16-22	16-22	18-24	18-24	18-24	20-28	20-28
Positive End Expiratory Pressure (PEEP) cm H_2O	4-6	4-6	4-6	4-6	4-6	5-6	5-6	5-6	5-6
Inspiratory Time (seconds)	0.3-0.35	0.3-0.35	0.3-0.35	0.3-0.35	0.3-0.35	0.3-0.35	0.35-0.4	0.35-0.4	0.35-0.4
Respiratory Rate (breaths per minute)	30-45	30-45	30-45	30-45	20-40	20-40	20-40	20-40	20-40
Saturation Goal after 10 Minutes	88-95%	88-95%	88-95%	88-95%	88-95%	88-95%	88-95%	95-98%	95-98%
MEDICATIONS									
Epinephrine **IV/IO 0.1 mg/mL** 0.1-0.3 mL/kg. *May repeat every 3 minutes for asystole.*	0.1-0.2 mL	0.1-0.3 mL	0.1-0.3 mL	0.1-0.4 mL	0.2-0.5 mL	0.2-0.6 mL	0.3-0.8 mL	0.3-0.9 mL	0.4-1 mL
Epinephrine **ET ONLY 0.1 mg/mL** 1 mL/kg. *May repeat every 3 minutes for asystole.*	0.7 mL	0.9 mL	1.1 mL	1.3 mL	1.6 mL	2.1 mL	2.6 mL	3 mL	3.5 mL
Curosurf (poractant alfa 80 mg/mL) 2.5 mL/kg. Give Curosurf <26 weeks OR 26-29 weeks requiring ≥40% FiO_2 OR >29 weeks with CXR-proven RDS.	1.8 mL	2.2 mL	2.8 mL	3.4 mL	4 mL	5.2 mL	6.6 mL	7.6 mL	8.8 mL
FOR HYPOGLYCEMIA: Give D10 bolus 2 mL/kg IV/IO at 1 mL/min. Increase D10 maintenance fluid rate by 1 mL/hour for <2 kg or 2 mL/hour for ≥2 kg.	1.4 mL	1.8 mL	2.2 mL	2.7 mL	3.3 mL	4.2 mL	5.2 mL	6 mL	7 mL
Ampicillin **(Dilute to 100 mg/mL)** 50 mg/kg IV/IM	35 mg (0.35 mL)	45 mg (0.45 mL)	55 mg (0.55 mL)	68 mg (0.68 mL)	83 mg (0.83 mL)	105 mg (1.05 mL)	130 mg (1.3 mL)	150 mg (1.5 mL)	175 mg (1.75 mL)
Gentamicin (2 mg/mL) 5 mg/kg IV as one-time dose. May give IM. **DO NOT USE IN VILLAGE.**	3.5 mg (1.75 mL)	4.5 mg (2.25 mL)	5.5 mg (2.75 mL)	6.8 mg (3.4 mL)	8.2 mg (4.1 mL)	10.4 mg (5.2 mL)	13 mg (6.5 mL)	15 mg (7.5 mL)	17.6 mg (8.8 mL)
Volume Expanders: NS or albumin 10 mL/kg IV/IO. Give over 15-30 minutes; give faster if unstable; give slower for extreme premies.	7 mL	9 mL	11 mL	13.5 mL	16.5 mL	21 mL	26 mL	30 mL	35 mL
D10 Maintenance Fluids: <750 grams give 90-100 mL/kg/24 hours ♦ ≥750 grams give 80 mL/kg/24 hours. Goal blood glucose is 35-110 mg/dL.	3 mL/hour	3 mL/hour	3.7 mL/hour	4.5 mL/hour	5.5 mL/hour	7 mL/hour	8.7 mL/hour	10 mL/hour	12 mL/hour
Phenobarbital (130 mg/mL) 10 mg/kg IV/IO/IM/PR. May give additional 10 mg/kg dose.	7 mg (0.05 mL)	9 mg (0.07 mL)	11 mg (0.08 mL)	13.5 mg (0.1 mL)	16.5 mg (0.13 mL)	21 mg (0.16 mL)	26 mg (0.2 mL)	30 mg (0.23 mL)	35 mg (0.27 mL)

Reviewed and updated by YKHC Pediatrics, OB Nursing, and Pharmacy in conjunction with Providence Alaska Medical Center NICU Staff. MSEC approved 8/3/21.

Epinephrine 0.1 mg/mL

• This is the pre-filled syringe concentration.
• Draw up doses by inserting needle through the thick rubber stopper.

Ampicillin 100 mg/mL

Products needed:
• Ampicillin 500 mg vial
• Sterile water for injection, 10 mL vial

How to mix:
1. Reconstitute 500 mg vial with 4.8 mL sterile water for injection. This will result in a 100 mg/mL final concentration.
2. The Neonatal Resuscitation Summary (page 1) lists the total dose and volume – draw up dose from vial.
3. Dose must be used within 1 hour of reconstitution.

Administration:
• Doses less than 500 mg can be injected via slow IV push over 3 to 5 minutes.
• Not compatible with D10W.
• Administer before gentamicin – do not administer at the same time.

Gentamicin 2 mg/mL

Product needed:
• Gentamicin 100 mg/50 mL pre-mixed bag.

DO NOT ADMINISTER THE BAG – the dose will be administered via syringe pump.
The Neonatal Resuscitation Summary (page 1) lists the total dose and volume – draw up this volume from the bag and **immediately dispose of the bag.**

Administration:
• Administer after ampicillin – do not administer at the same time.
• Administer via **syringe pump** over 30 minutes.
• Compatible with D10W.

Return to Table of Contents.

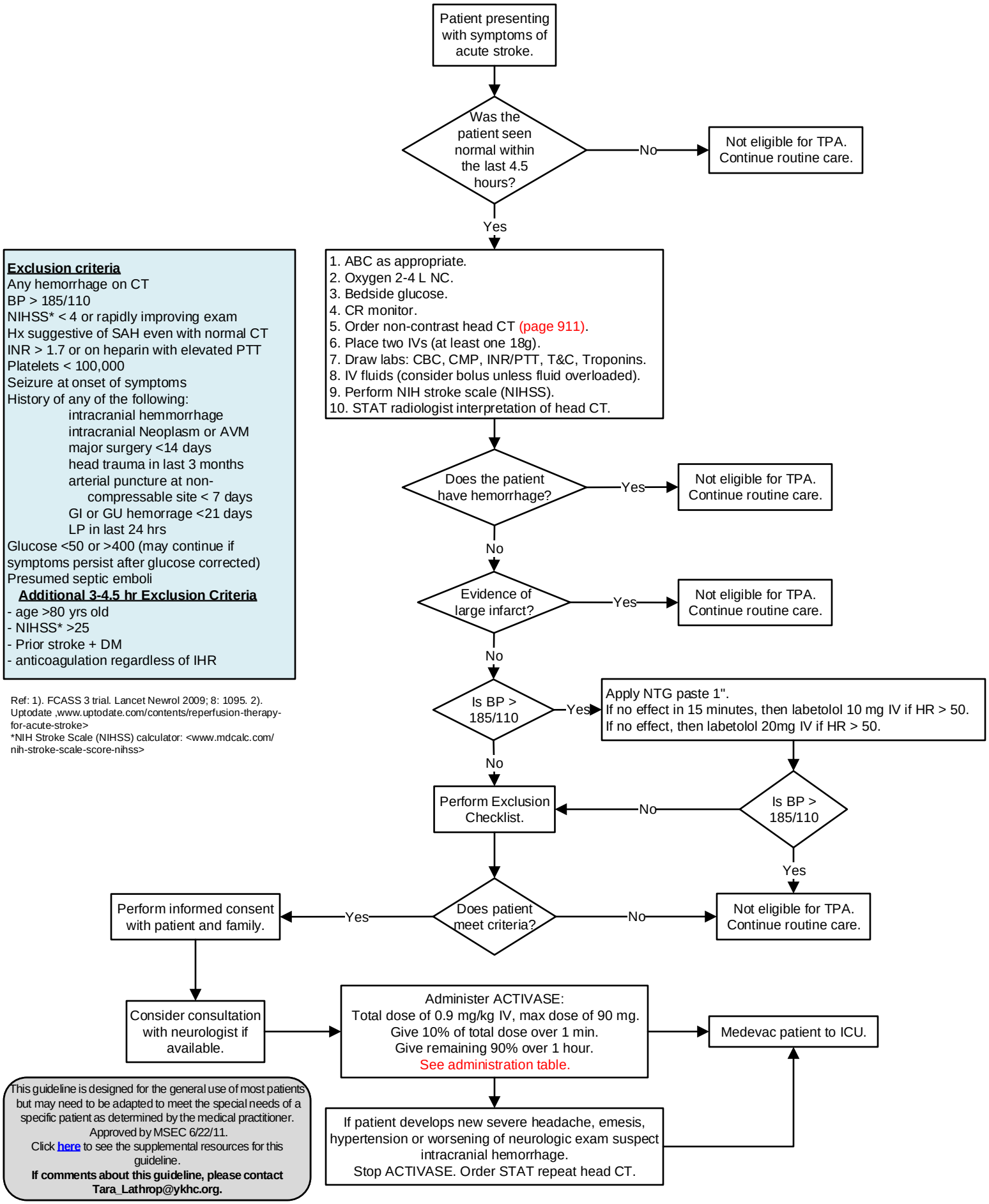
Yukon-Kuskokwim HEALTH CORPORATION

Neurology Guidelines

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Ischemic Stroke, Acute



Exclusion criteria

Any hemorrhage on CT
BP > 185/110
NIHSS* < 4 or rapidly improving exam
Hx suggestive of SAH even with normal CT
INR > 1.7 or on heparin with elevated PTT
Platelets < 100,000
Seizure at onset of symptoms
History of any of the following:
- intracranial hemmorrhage
- intracranial Neoplasm or AVM
- major surgery <14 days
- head trauma in last 3 months
- arterial puncture at non-compressable site < 7 days
- GI or GU hemorrage <21 days
- LP in last 24 hrs

Glucose <50 or >400 (may continue if symptoms persist after glucose corrected)
Presumed septic emboli

Additional 3-4.5 hr Exclusion Criteria

- age >80 yrs old
- NIHSS* >25
- Prior stroke + DM
- anticoagulation regardless of IHR

Ref: 1). FCASS 3 trial. Lancet Newrol 2009; 8: 1095. 2). Uptodate ,www.uptodate.com/contents/reperfusion-therapy-for-acute-stroke>
*NIH Stroke Scale (NIHSS) calculator: <www.mdcalc.com/nih-stroke-scale-score-nihss>

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 6/22/11.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Head Injury in Patients < 18 Years Old

Head injury in a child <18 years.

If GCS ≤ 8, intubate and refer to PALS stabilization algorithms.

Low Risk
GCS=15
AND
No risk factors (see Intermediate and High Risk boxes)

Discharge with head injury education and competent caregiver

Intermediate Risk
GCS=15
AND one or more of the following:
- Occipital, parietal, or temporal scalp hematoma
- Loss of consciousness > 5 seconds
- Not acting normal per parent
- **Severe mechanism of injury****
- If older than 2: vomiting or severe headache
- Amnesia

Factors to consider when deciding to observe vs perform head CT:
- Provider experience
- Multiple vs isolated findings
- Worsening signs/symptoms
- Age <3 months
- Parental preference

High Risk
One or more of the following:
- GCS≤14
- **Altered mental status***
- Signs of skull fracture
- Focal neurological deficits
- Seizure
- Loss of consciousness > 1 minute

***Altered Mental Status**
- agitation/irritability
- inconsolability
- somnolence/lethargy
- slow response
- repetitive questions

**Severe Mechanism of Injury
- Fall: >3 feet if younger than 2 years, >5 feet if older than 2 years
- Motor vehicle accident with ejection, rollover, or fatality
- Unhelmeted bike/ pedestrian vs vehicle
- Head struck by high-impact object

C-spine Imaging
- Spinal motion restriction should be continued in neurologically abnormal patients until spinal column or cord injury has been excluded.
- See Nexus Criteria for C-spine imaging protocol.

Observation
- Observe in the ER 4-6 hours post-injury.
or
- If presenting >4 hours post-injury AND not improving per caregiver, observe 4 hours.

Not improved → CT Scan: Perform noncontrast head CT with spinal motion restriction

Improved → Discharge with head injury education and competent caregiver. Consider concussion follow-up (see Concussion Management box).

CT Scan → Normal / Abnormal

Is patient improving? Yes → Discharge with head injury education and competent caregiver. Consider concussion follow-up (see Concussion Management box).

Is patient improving? No → Consult PICU and trauma service.

Village Management
- If Low Risk: discharge home with head injury education and competent caregiver.
- If Intermediate Risk: consider medevac vs observation with Q1h VS and neuro checks.
If any worsening, activate medevac.
If not improving over 4 hours, activate medevac.
- If High Risk: activate medevac.

Plain films of the skull are not recommended.

Concussion Management
- Complete **Acute Concussion Evaluation** at every visit.
- Follow-up in outpatient clinic in 1-2 weeks.
- Consider balance testing.
- Avoid medications that can worsen somnolence.
- If symptoms persist >3-4 weeks, consider referral to neurologist, psychologist, physical therapy, etc.
- Return to school per **CDC Heads Up Protocol**.
- Return to play per **ASAA Guidelines**.

In all pediatric trauma, consider further evaluation for non-accidental trauma (skeletal survey, dilated eye exam, etc.)

Pediatric Glasgow Coma Scale (GCS)

	Infant	Child	
Eye opening	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain	To pain	2
	No response	No response	1
Best verbal response	Coos, babbles	Orientated, appropriate	5
	Irritable cry	Confused	4
	Cries to pain	Inappropriate words	3
	Moans to pain	Incomprehensible sounds	2
	No response	No response	1
Best motor response	Moves spontaneously	Obeys commands	6
	Withdraws to touch	Localizes painful stimulus	5
	Withdraws to pain	Withdraws to pain	4
	Flexion to pain	Flexion to pain	3
	Extension to pain	Extension to pain	2
	No response	No response	1

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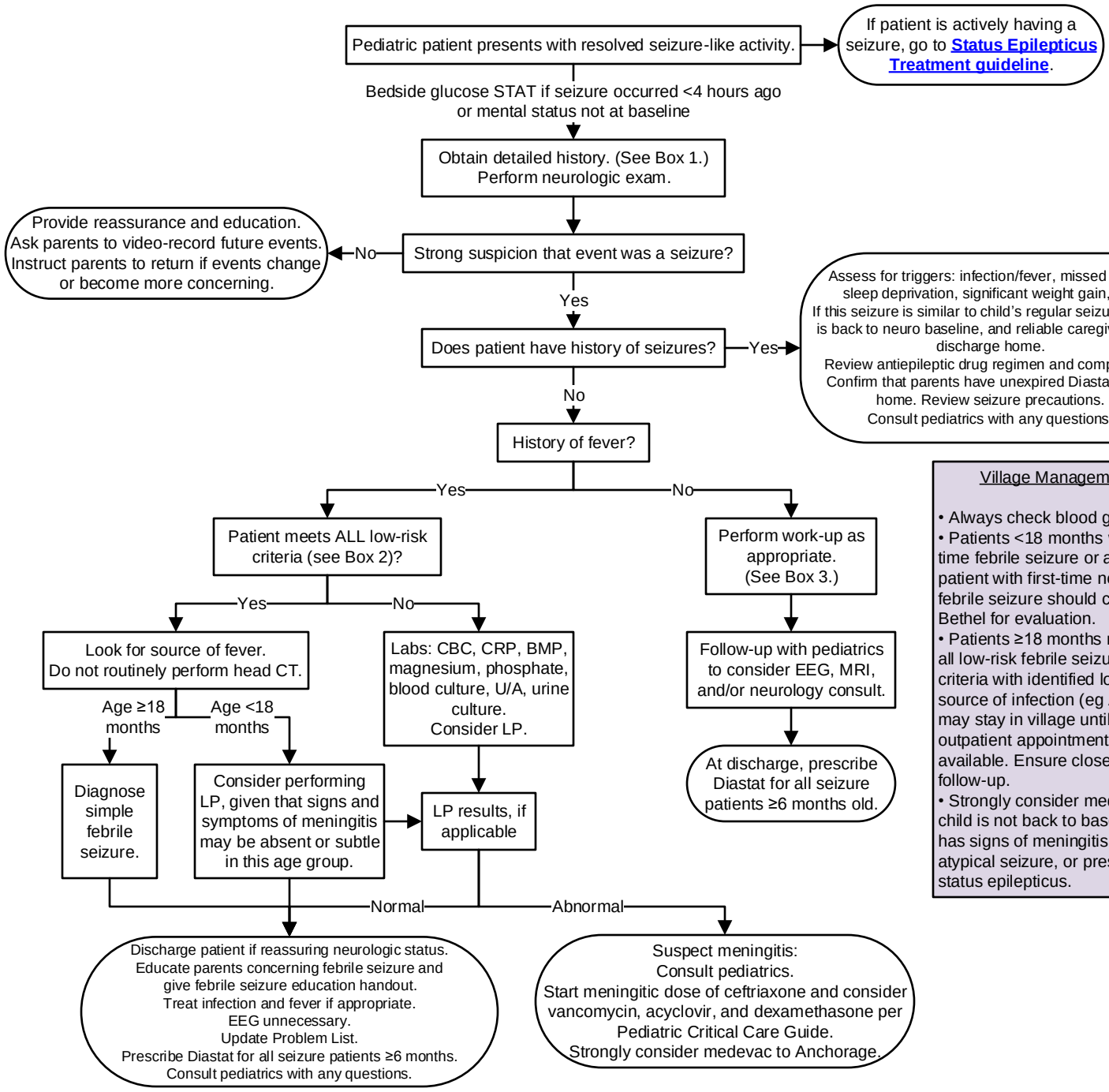
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Seizure Evaluation (<18 years)



Village Management

- Always check blood glucose.
- Patients <18 months with first-time febrile seizure or any patient with first-time non-febrile seizure should come to Bethel for evaluation.
- Patients ≥18 months meeting all low-risk febrile seizure criteria with identified low-risk source of infection (eg AOM) may stay in village until outpatient appointment available. Ensure close village follow-up.
- Strongly consider medevac if child is not back to baseline, has signs of meningitis, had an atypical seizure, or presented in status epilepticus.

Box 1: Detailed History

- When/where did it occur? Awake or asleep?
- What proceeded the event (eg head trauma, crying, etc.)?
- How long did it last?
- Ask caregiver to recount, step-by-step, what happened.
- Type of movement and what part of body? Symmetric?
- Interventions?
- Incontinence?
- Behavior after event? How long till back to baseline?

HPI

- Intercurrent illness/fevers
- Medications
- Recent intake, including free water and diluted formula
- Ingestions
- Trauma

PMH

- Prior history of seizures
- History of breathholding

Family Hx: Seizures, febrile seizures, breathholding, etc.

Box 2: Low risk febrile seizure criteria

1. 6 months to 5 years of age.
2. Fever present.
3. Seizure generalized (nonfocal).
4. Seizure duration <15 minutes.
5. Child has normal neurologic examination.
6. Child has no history of previous neurologic or CNS abnormality.
7. Only one seizure in a 24 hour period.
8. Child has returned to baseline.
9. No meningeal signs:
   - Irritability or inconsolability
   - Nuchal rigidity
   - Bulging fontanelle
   - Lethargy or somnolence
   - Focal neurologic findings
10. Child has NOT received antibiotics in the past 72 hours.

Box 3: Work-up

- Bedside glucose
- EKG for first event
- CBC, BMP, magnesium, phosphate
- Urine drug screen
- Perform LP if persistent altered mental status, meningitis suspected, or <18 months of age and delayed return to baseline.

Radiological studies:
Obtain head CT without contrast prior to LP if concerning neurologic status, persistently altered mental status, history of trauma, focal neurological findings, or focal seizure.

Consider using the Bacterial Meningitis Score for Children to help rule-out meningitis.

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If comments about this guideline, please contact Jennifer_Hampton@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Status Epilepticus Treatment (Pediatric)

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan to check all medication dosing.

- ABCs. Ensure BVM at bedside and pediatric code cart within reach.
- **Bedside glucose STAT.**
- Obtain IV.
- Consult pediatrics.
- Obtain brief history.
- Prepare first-line medication. If in the ED or NW, get the Peds Seizure Kit (see box).

Seizure lasting ≥3 minutes
OR
More than one seizure in 24 hours without return to baseline.

No → Go to Pediatric Post-Seizure Evaluation guideline.

Yes

Peds Seizure Kit

- In the ED and Peds NW Pyxis.
- Type "seizure" and override.
- Includes:
  - Midazolam 10 mg/2 mL
  - Levetiracetam
  - Phenobarbital 130 mg/mL
  - Dosing cards from the pediatric critical care guide

Benzodiazepine (choose ONE)
- Midazolam 0.2 mg/kg IN/IM (max dose 10 mg) – single dose only.
- Lorazepam 0.1 mg/kg IV/IO (max dose 4 mg) – up to two doses Q5 minutes.
- Diastat home dose – up to two doses Q5 minutes.

Seizure continues 5 more minutes.

Village Management

See Emergency RMT Seizure Scenario on the wiki.
- ABCs.
- **Bedside glucose STAT.**
- If unable to get a glucose measurement, give glucose buccally.
- Get BVM with appropriate sized mask to bedside.
- Follow flow to the left, using these drugs with dosing found on Pediatric Critical Care Guide:
  - Diastat home dose PR if available or midazolam 0.2 mg/kg intranasal (max dose 10 mg) or diazepam 0.5 mg/kg (max 10 mg) IV solution given RECTALLY.
  - Phenobarbital or fosphenytoin (kept refrigerated) IM. If giving either second-line drug, consult pediatrics and strongly consider activating a medevac.
- Consider placing IV and giving NS bolus 20 mL/kg.
- Low threshold to activate medevac for atypical or prolonged seizure.

Consult ANMC PICU at (907) 297-8809.

Age ≤ 2 months

Phenobarbital 20 mg/kg IV/IM.
If IV, give over 15 minutes or
1 mg/kg/minute (max 60 mg/min).

Seizure continues 5 minutes after infusion complete.

Phenobarbital 10 mg/kg IV/IM.
If IV, give over 15 minutes or
1 mg/kg/minute (max 60 mg/min).

Seizure continues 5 minutes after infusion complete.

Levetiracetam 40 mg/kg IV/IM.
If IV, give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Levetiracetam 20 mg/kg IV/IM.
If IV, give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Start midazolam or propofol infusion with PICU consultation.

Age >2 months

Levetiracetam 60 mg/kg IV/IM.
Max dose 4500 mg.
If IV, give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Fosphenytoin 20 mg PE/kg IV.
Max dose 1000 mg.
Give over 10 minutes.

Seizure continues 5 minutes after infusion complete.

Fosphenytoin 10 mg PE/kg IV.
Max dose 1000 mg.
Give over 5-10 minutes.

Seizure continues 5 minutes after infusion complete.

Phenobarbital 20 mg/kg IV or IM.
Max dose 1000 mg.
If IV, give over 15 minutes.

Seizure continues 5 minutes after infusion complete.

Phenobarbital 10 mg/kg IV or IM.
Max dose 1000 mg.
If IV, give over 15 minutes.

Seizure continues 5 minutes after infusion complete.

Start midazolam or propofol infusion with PICU consultation.

In all ages, if hemodynamic instability or myocardial dysfunction, avoid phenobarbital and use alternate agents.

In all ages, in consultation with the PICU, consider preparing for intubation and continuous infusion after second-line drug has been given. Continue giving medications as detailed in the flow while infusion is being prepared.

If giving midazolam, make drip of 1 mg/mL and start at rate 0.1 mg/kg/hour.

Indications for Admission or Transfer:
-Status epilepticus
-Cluster of seizures
-Increased intracranial pressure
-CNS infection
-Structural lesion
-Patient does not return to baseline mental status

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 8/3/21. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Jennifer_Hampton@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

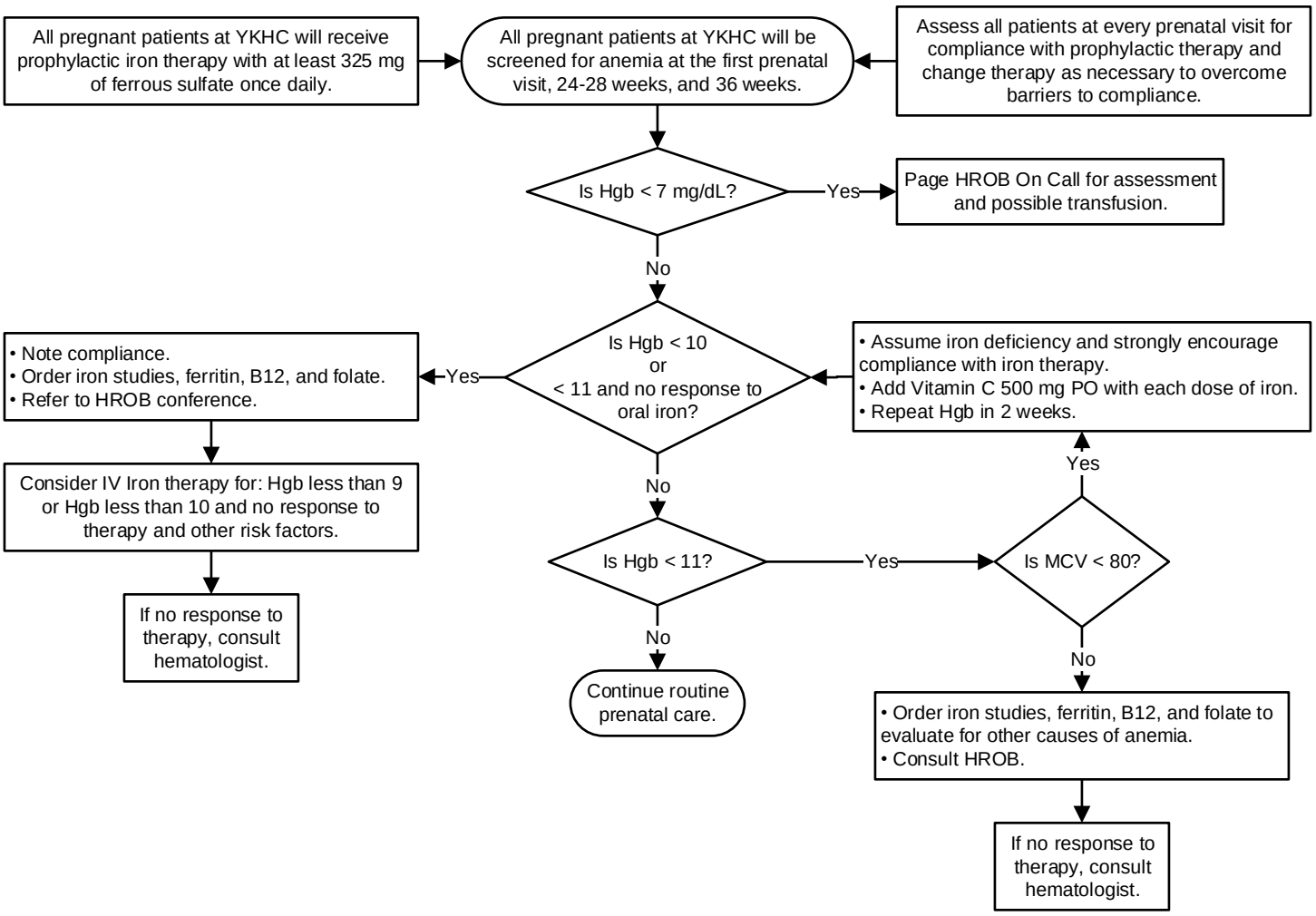
Obstetrics Guidelines

Obstetrics

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Anemia in Pregnancy



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If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Anti-D Immune Globulin

Reference Lab Policy
Rh Immune Globulin Work-up
Fetal Screen

Screening:
All patients will have a Blood Type and Antibody Screen done at their first visit.

Rh Negative?

No

- Blood Type on newborn after birth as indicated.
- No further testing of the patient for blood type.

Yes

At the time of diagnosis:
- Note Diagnosis on problem list.
- Educate the patient.

Other situations which require anti-D Immune Globulin:
- Miscarriage/Abortion
- Ectopic Pregnancy
- Maternal Trauma: consult OB/GYN.
- Threatened abortion
- Maternal hemorrhage in 2nd or 3rd trimester
- External cephalic version
- Amniocentesis

The dose is always 300mcg at YKDRH due to blood bank stocking.

Third Trimester:
- Obtain Blood Type and Antibody screen at 28 weeks.
- Give 300 mcg anti-D Immune Globulin IM at 28 weeks after antibody screen.

On OB in Labor:
- Obtain Blood Type and Antibody Screen on admission.

On OB after delivery:
- Obtain ABO and Rh on newborn.
- Obtain Fetal Screen on mother.

Fetus Rh positive?

No

No further workup or treatment.

Yes

Fetal Screen positive?

Yes

- Give two 300 mcg doses of anti-D Immune Globulin.
- Send Kleinhauer-Betke (KB) test.
- Consult OB/GYN.
- Give additional doses as needed based on KB results.

No

Give the mother 300 mcg of anti-D Immune Globulin IM.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 10/30/17.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Diabetes, Gestational

First prenatal visit: Screen all women with a HgA1C

- ≥6.5% → Add diagnosis of diabetes.
- <6.4 % → If the first prenatal screen is before 24-28 weeks and is negative, at 24-28 weeks screen below.

Screening test: fasting or fed plasma glucose value one hour after 50 gram glucose load.

- ≥180 mg/dL → Go directly to SMBG or offer GTT if patient resists testing.
- 140 - 179 mg/dL → Fasting 2 hour oral glucose tolerance test: 75 gram load scheduled within one week

Diagnostic Criteria for GDM utilizing two hour 75g GTT

Gestational Diabetes Mellitus
Pregnancy with one or more of the following levels:

- Fasting ≥92 mg/dL
- 1 hour glucose ≥180 mg/dL
- 2 hour glucose ≥153 mg/dL

- Add appropriate diagnosis to problem list i.e. GDM or pre-gestational diabetes
- Give patient log book to document goals, blood glucose, and food plan.
- Dispense glucose meter and supplies.
- Refer to DM educator (543-6133) for education and Medical Nutrition Therapy.
- Consider referral to diabetes department for Continuous Glucose Monitor placement.
- Patient will record blood glucose levels fasting and 2 hours after 3 meals.
- Review nutrition and physical activity goals.

75% of Self-Monitoring Blood Glucose (SMBG) targets (fasting glucose <95 mg/dL and 2 hour post-prandial glucose <120 mg/dL) within target range after 1-2 weeks?

- Yes →
  - Weekly phone follow up by DM educators.
  - Weekly review at high risk OB (HROB) rounds.
  - HROB team will change testing and treatment plans as needed.
- No → **Initiate Medical Therapy.** Consult OB/GYN for assistance. Refer to Anchorage for delivery.

Patient to record SMBG levels before breakfast and two hours after start of three meals. Weekly follow-up by DM educators and weekly review at HROB rounds.

SMBG targets reached after one week?

- Yes → Patient to record SMBG levels before breakfast and two hours after start of three meals. Weekly follow-up by DM educators and weekly review at HROB rounds.
- No → Reassess medication dose and choice. Consult DM education team/OB/GYN.

Non-Adherent Patients

- Send letter after two weeks of not sending in sugar logs or two weeks of <25% of expected readings.
- Consider Northwing admission to monitor blood sugars.
- Consider transfer to ANTHC at 32 weeks.

All patients with GDM get tested at the 6 week post-partum visit with two hour 75 gram GTT. A_1C can be performed as an alternative at >12 weeks post-partum.

Fetal Monitoring

- **Diet-controlled**: kick counts at 28 weeks. Normal labor management.
- **Diet-poor control**: kick counts at 28 weeks. Biweekly NST and weekly AFI after 32 weeks. Consult OB and consider induction at 38 weeks.
- **Insulin-controlled**: kick counts at 28 weeks. Biweekly NST and AFI after 32 weeks. Consult OB for induction at 38 weeks.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 7/12/17. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Ectopic Pregnancy Treatment

D&C Prior to Methotrexate?

This is NOT necessary prior to treatment with Methotrexate (MTX) for a plateau or abnormally rising HCG level. MTX will treat an abnormal pregnancy in the uterus or any other location.

Typical side effects of MTX.

Less than 30% of patients will experience minor, self-limited side effects from the medication, including nausea, mouth ulcers, and GI cramps.
Most patients have some lower abdominal pain on the 3-6th day after treatment. This is not a problem if ibuprofen or acetaminophen relieves the pain.

Contraindication to MTX.

Absolute contraindications
- Breast Feeding
- Overt or Laboratory evidence of immunodeficiency
- Alcoholism, alcoholic liver disease, or other chronic liver disease
- Preexisting blood dyscrasias, such as bone marrow hypoplasia, leukopenia, thrombocytopenia or significant anemia
- Known sensitivity to MTX
- Active pulmonary disease
- Peptic ulcer disease
- Hepatic, renal or hematologic dysfunction

Relative contraindications
- Gestational sac larger that 3.5cm
- Embryonic cardiac motion

Ectopic Pregnancy diagnosed after consultation with HROB or OB/GYN

Obtain:
- Quantitative HCG
- Type and Screen
- CBC
- Comprehensive Metabolic Panel
- Transvaginal Pelvic Ultrasound (US)

Hemodynamically stable?
- No → Consult HROB for immediate surgery or transfer
- Yes

Adnexal Mass ≥ 3cm
Cardiac activity
Pregnancy in location other than a tube
- Yes → Consult HROB for immediate surgery or transfer
- No

Platelets, kidney and liver function normal?
- No → Consult HROB for immediate surgery or transfer
- Yes

Is the hCG >5000?
- No

Single-dose regimen
- Single dose MTX 50mg/m2 IM day 1
- Measure hCG level on post treatment days 4 and 7
- Check for 15% hCG decrease between days 4 and 7
- Then measure hCG level weekly until reaching the nonpregnant level
- If results are less than the expected 15% decrease, readminister MTX 50mg/m2 and repeat hCG measurement on days 4 and 7 after second dose.

- Yes

Two-dose regimen
- Administer 50 mg/m^2 on day 0.
- Repeat 50mg/m^2 on day 4.
- Measure hCG levels on days 4 and 7, and expect a 15% decrease between days 4 and 7.
- If the decrease is greater than 15%, measure hCG levels weekly until reaching non pregnant level.
- If less than a 15% decrease in hCG levels, readminister MTX 50mg/m^2 on days 7 and 11, measuring hCG levels.
- If hCG levels decrease 15% between days 7 and 11, continue to monitor weekly until non pregnant hCG levels are reached.

If at any time the hCG level rises during the monitoring of weekly hCG levels, consult a GYN Oncologist for further treatment.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

First Trimester Bleeding, Ectopic Pregnancy Diagnosis, and Treatment of Non-Viable Early Pregnancy

1
Nomenclature

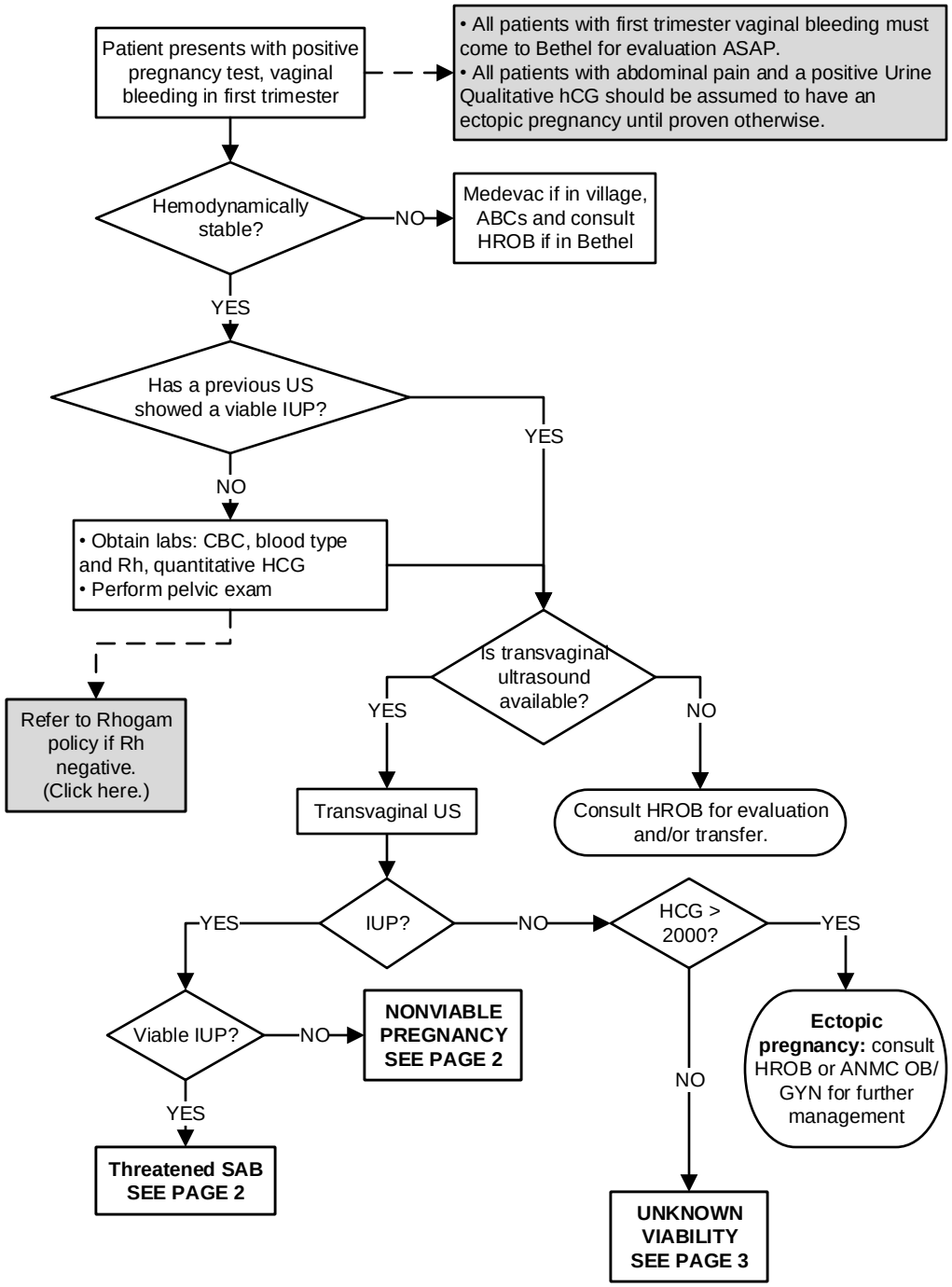
- **Viable** – A pregnancy is vialble if it can potentially result in a liveborn baby.
- **Nonviable** – A pregnancy is nonviable if it cannot possibly result in a liveborn baby. Ectopic pregnancies and failed intrauterine pregnancies are nonviable.
- **Intrauterine pregnancy of uncertain viability** – A woman is considered to have this if a transvaginal ultrasound shows an intrauterine gestational sac with no embryonic heartbeat and no findings of definite pregnancy failure.
- **Pregnancy of unknown location** – A woman is considered to have this if she has a positive urine or serum pregnancy test and no intrauterine or ectopic pregnancy on transvaginal ultrasound.

2
Findings diagnostic of Pregnancy Failure

- Crown-rump length of ≥7mm and no heartbeat
- Mean sac diameter of ≥25mm and no embryo
- Absence of embryo with heartbeat ≥14 days after an US that showed a gestational sac without a yolk sac
- Absence of embryo with a heartbeat ≥11 days after an US that showed a gestational sac with a yolk sac

Comments

- In a woman with a positive urine or serum pregnancy test, an intrauterine fluid collection with rounded edges containing no yolk sac is most likely a gestational sac; it is certain to ba a gestational sac if it contains a yolk sac or embryo.
- Transabdominal imaging without transvaginal scanning my be sufficient for diagnosing early pregnancy failure when an embryo whose crown-rump length is 15mm or more has no visible cardiac activity.



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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

First Trimester Bleeding, Ectopic Pregnancy Diagnosis, and Treatment of Non-Viable Early Pregnancy

Threatened SAB

MUST remain in Bethel until bleeding improves.
MUST be seen by a provider at least weekly with ultrasound.
No further hCG levels are needed.

Viable pregnancy?

YES → Return to Village

NO

NONVIABLE PREGNANCY

Consult HROB for management plan
No further US or Quantitative HCG are necessary

Options:
1. D&C
2. Misoprostol
3. Wait and see

Following hCG to negative*

- A provider or case manager MUST be responsible for this.
- Contact GYN CM at 543-6557 or communicate in RAVEN for assistance and instruction.
- Patient can be discharged from care when ectopic pregnancy is ruled out by falling hCG values and normal exam.

If patient elects wait and see option
• Must be reliable patient.
• Must stay in Bethel.
• Must be followed up every 48 hours for repeat hCG.
• Must follow hCG to negative*

If patient elects Misoprostol option:
• Consult HROB.
• Must be reliable patient.
• Must stay in Bethel.
• Dose is 800 mcg placed in posterior fornix of vagina (may consider 400mcg buccally but not as effective).
• Patient is followed every 24 hours until uterus is empty and bleeding subsides.
• Offer ibuprofen for cramping.
• Dose can be repeated in 24 hours if uterus is not empty.
• Must follow hCG to negative*

If patient elects D&C option:
• Consult HROB.
• Dr. Elizabeth Roll is also available for D&C.
• Consider office-based D&C.
• If during daytime hours and HROB agrees, call 6177 to schedule procedure.
• If on weekend, have patient remain NPO after midnight on Sunday and provider to call 6177 at 8am on Monday morning to schedule procedure.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

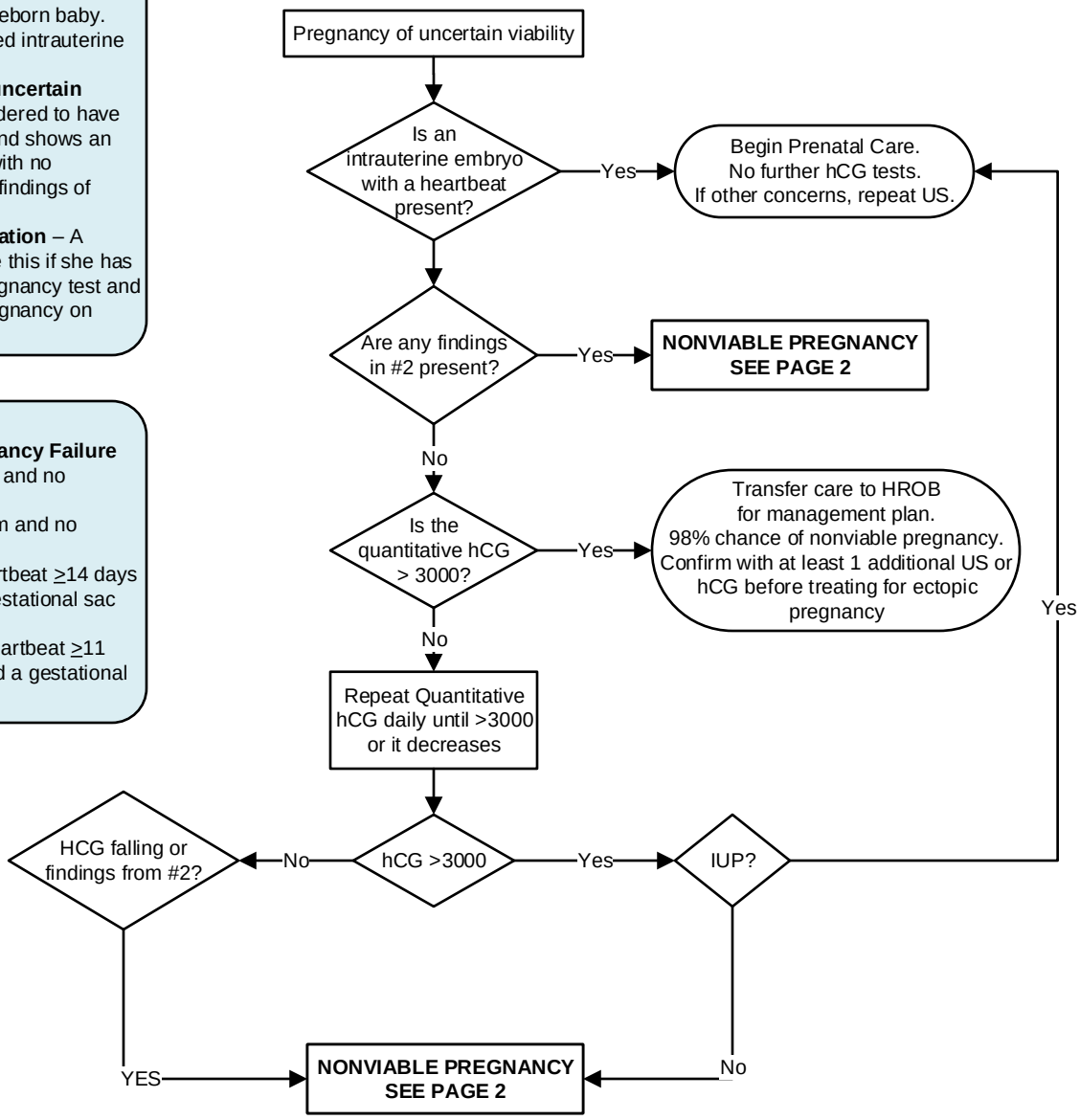
First Trimester Bleeding, Ectopic Pregnancy Diagnosis, and Treatment of Non-Viable Early Pregnancy

1
Nomenclature

- **Viable** – A pregnancy is vialble if it can potentially result in a liveborn baby.
- **Nonviable** – A pregnancy is nonviable if it cannot possibly result in a liveborn baby. Ectopic pregnancies and failed intrauterine pregnancies are nonviable.
- **Intrauterine pregnancy of uncertain viability** – A woman is considered to have this if a transvaginal ultrasound shows an intrauterine gestational sac with no embryonic heartbeat and no findings of definite pregnancy failure.
- **Pregnancy of unknown location** – A woman is considered to have this if she has a positive urine or serum pregnancy test and no intrauterine or ectopic pregnancy on transvaginal ultrasound.

2
Findings diagnostic of Pregnancy Failure

- Crown-rump length of ≥7mm and no heartbeat
- Mean sac diameter of ≥25mm and no embryo
- Absence of embryo with heartbeat ≥14 days after an US that showed a gestational sac without a yolk sac
- Absence of embryo with a heartbeat ≥11 days after an US that showed a gestational sac with a yolk sac



Comments

- In a woman with a positive urine or serum pregnancy test, an intrauterine fluid collection with rounded edges containing no yolk sac is most likely a gestational sac; it is certain to ba a gestational sac if it contains a yolk sac or embryo.
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GBS Prophylaxis of the Mother at Term

Use the

GBS App

to determine need for prophylaxis and antibiotic of choice for GBS prevention

Web version: **https://www2a.cdc.gov/vaccines/m/gbs3/gbs.html**

or

Download for your smartphone.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

HIV Prenatal Screening and Care

OPT OUT

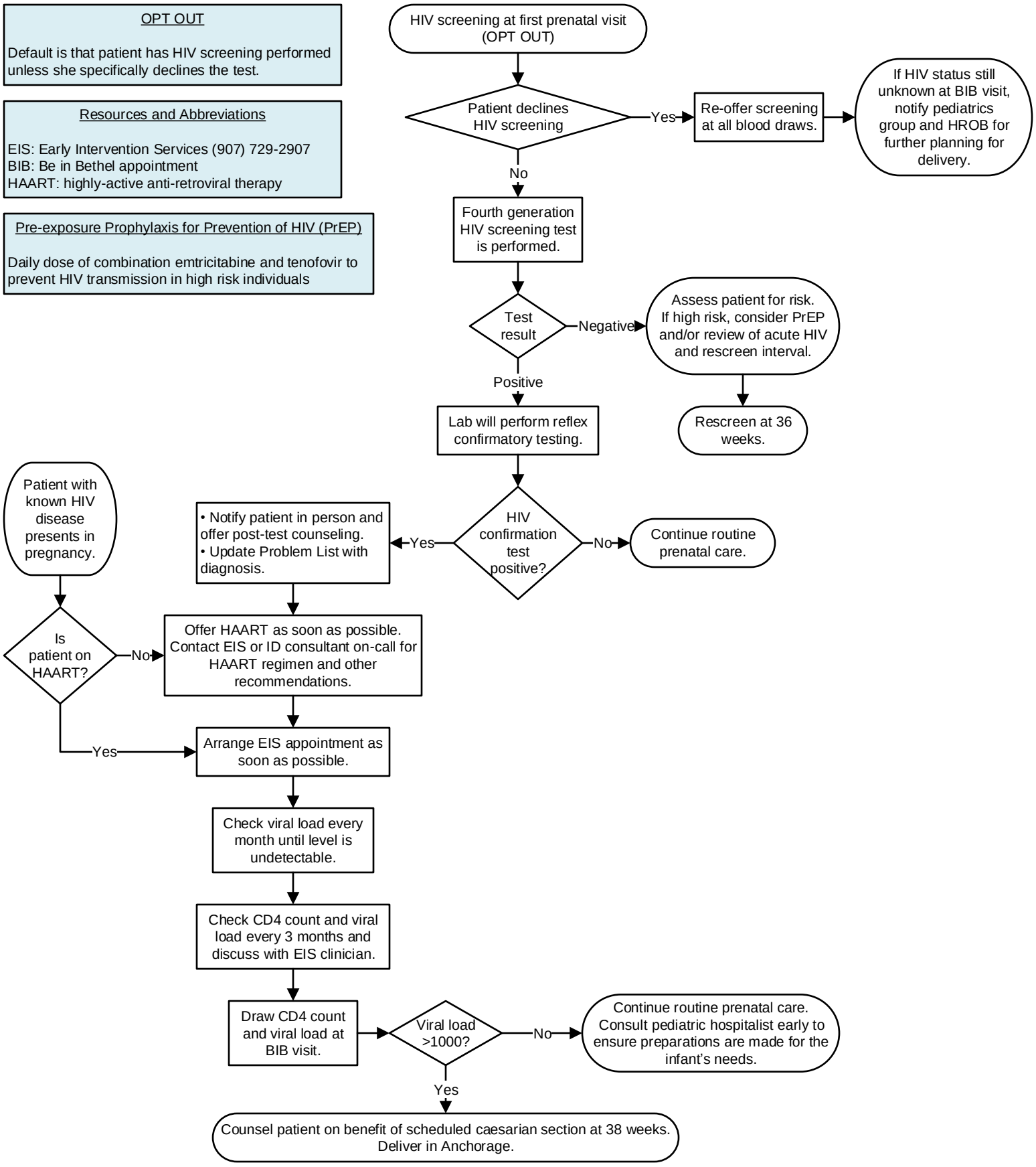
Default is that patient has HIV screening performed unless she specifically declines the test.

Resources and Abbreviations

EIS: Early Intervention Services (907) 729-2907
BIB: Be in Bethel appointment
HAART: highly-active anti-retroviral therapy

Pre-exposure Prophylaxis for Prevention of HIV (PrEP)

Daily dose of combination emtricitabine and tenofovir to prevent HIV transmission in high risk individuals



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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Hypertension in Pregnancy, Chronic

Diagnostic Criteria
History of hypertension (BP ≥ 140/90) prior to pregnancy
or
Persistent hypertension (BP > 140/90) prior to 20 weeks gestation
or
Hypertension (BP > 140/90) persisting beyond 12 weeks post-partum

First Prenatal Visit with history of Chronic Hypertension
Obtain GH labs†. Refer to HROB meeting for discussion.

†**GH labs**:
CBC, creatinine, ALT, AST, uric acid, Urine Protein/Creatinine Ratio, CCUA

First Trimester
1. Monitor BP every 2-4 weeks.
2. Fetal ultrasound to confirm EDC prior to 14 weeks gestation.

Second Trimester
1. Monitor BP every 2-4 weeks.
2. If patient with symptoms of severe features of preeclampsia‡, obtain GH labs†.
3. Aspirin 81 mg daily between 12-37 weeks gestation to prevent complications.

‡ **Severe Features of Preeclampsia**
- Severe hypertension (160/110)
- Thrombocytopenia (<100K)
- Impaired liver function
- Progressive renal insufficiency
- Pulmonary edema
- New-onset cerebral or visual disturbances
- Oligohydramnios

Serial fetal U/S every 4 weeks after 28 weeks to evaluate growth.

Superimposed preeclampsia present?

Yes → Refer to Gestational Hypertension Guideline

No

* **Signs/Symptoms of Superimposed Preeclampsia**
- Any signs/symptoms of severe features
- Worsening proteinuria
- Worsening hypertension

Third Trimester
1. Monitor BP every two weeks.
2. If patient with symptoms of severe preeclampsia‡, obtain GH labs.
3. BPP weekly after 34 weeks gestation.
4. NST/AFI anytime patient is in Bethel between 28-36 weeks.

Severe HTN, renal, cardiac, or connective tissue disorders?

Yes → Refer to ANMC OB Service.

No

Consult OB/GYN at 37 weeks for timing of delivery.
MUST be delivered by the EDC or transferred to Anchorage.

Any patient with hypertension in pregnancy should have blood pressure monitored for at least two weeks post-partum.

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Hypertension, Gestational

†How to take a BP
Patient should be seated for 15 minutes and calm.
She should not chew or smoke.
The appropriate sized BP cuff should be used.

Gestational Hypertension (GH) Diagnostic Criteria
BP ≥ 140/90 measured on two occasions at least six hours apart. (See Box 1.)
Only one elevated BP is needed to proceed with this guideline.

If patient < 20 weeks, refer to Chronic Hypertension in Pregnancy Guideline.

Box 1: Severe Features of Preeclampsia
- BP > 160/110
- Renal insufficiency
- Pulmonary edema
- Thrombocytopenia (platelets <100K)
- Impaired liver function
- IUGR
- Cerebral or visual symptoms

GH labs:
CBC, creatinine, ALT, AST, uric acid, CCUA, random urine protein to creatinine ratio

Full maternal/fetal evaluation including: GH labs, Test for Fetal Wellbeing, ultrasound for growth

Any signs or symptoms from Box 1?

Yes

Preeclampsia/Gestation Hypertension with Severe Features

Admit and consult OBGYN.

- Magnesium Sulfate:4g IV bolus over 20 min, then 2g IV/hr
- GH labs
- Monitor fetal wellbeing
- Obtain OB ultrasound to evaluate for IUGR or oligohydramnios
- Monitor for signs and symptoms of Magnesium toxicity

Transfer to Anchorage

No

Protein/ creatinine ratio >0.3*?

No

Gestational Hypertension

*Protein/creatinine ratio >0.15 <0.3: Obtain 24 hour urine protein.

Yes

Preeclampsia
Consult HROB on call.

Is patient compliant?

No

Consider inpatient monitoring versus transfer to Anchorage.

Yes

Outpatient monitoring in Bethel
- Daily kick counts
- Office visit 1-2 times per week
- NST twice weekly
- AFI and GH labs once a week
- Ultrasound for growth every 3 weeks
- Transfer care to NW at 38 weeks for delivery or transfer to Anchorage.

Any signs or symptoms from Box 1?

No

Yes

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Yukon-Kuskokwim HEALTH CORPORATION

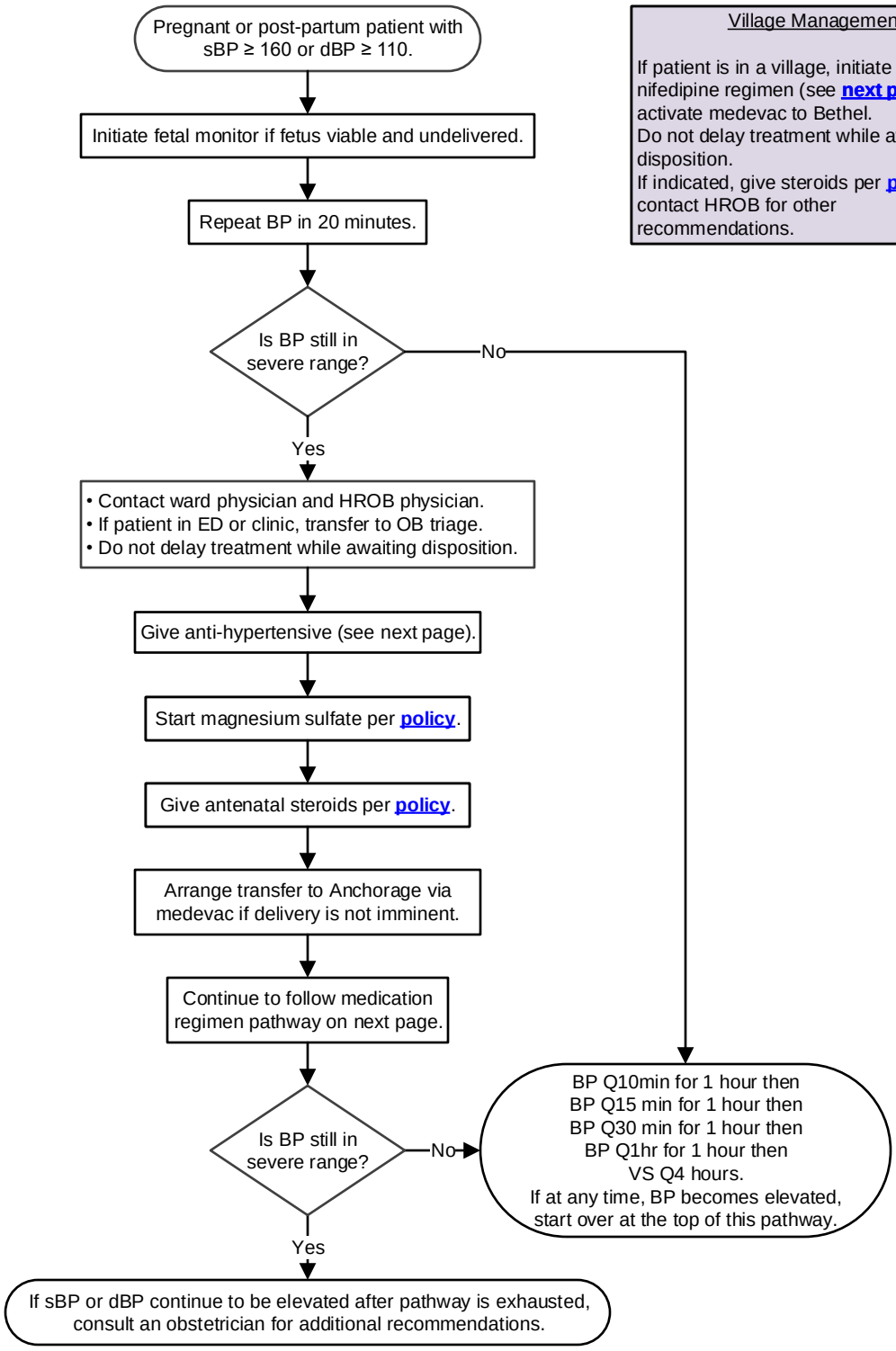
Clinical Guideline

Hypertension in Pregnant and Post-partum Patients, Severe

BP Technique

- Use the appropriate sized cuff after 5 minutes of rest.
- Patient should be sitting or semi-reclining (not fully reclining).
- Repeat with manual cuff after a minimum of 20 minutes if sBP ≥ 160 or dBP ≥ 110.

Severe range BP is defined as sBP ≥ 160 or dBP ≥ 110.



Village Management

If patient is in a village, initiate the nifedipine regimen (see **next page**) and activate medevac to Bethel.
Do not delay treatment while awaiting disposition.
If indicated, give steroids per **policy** and contact HROB for other recommendations.

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Clinical Guideline

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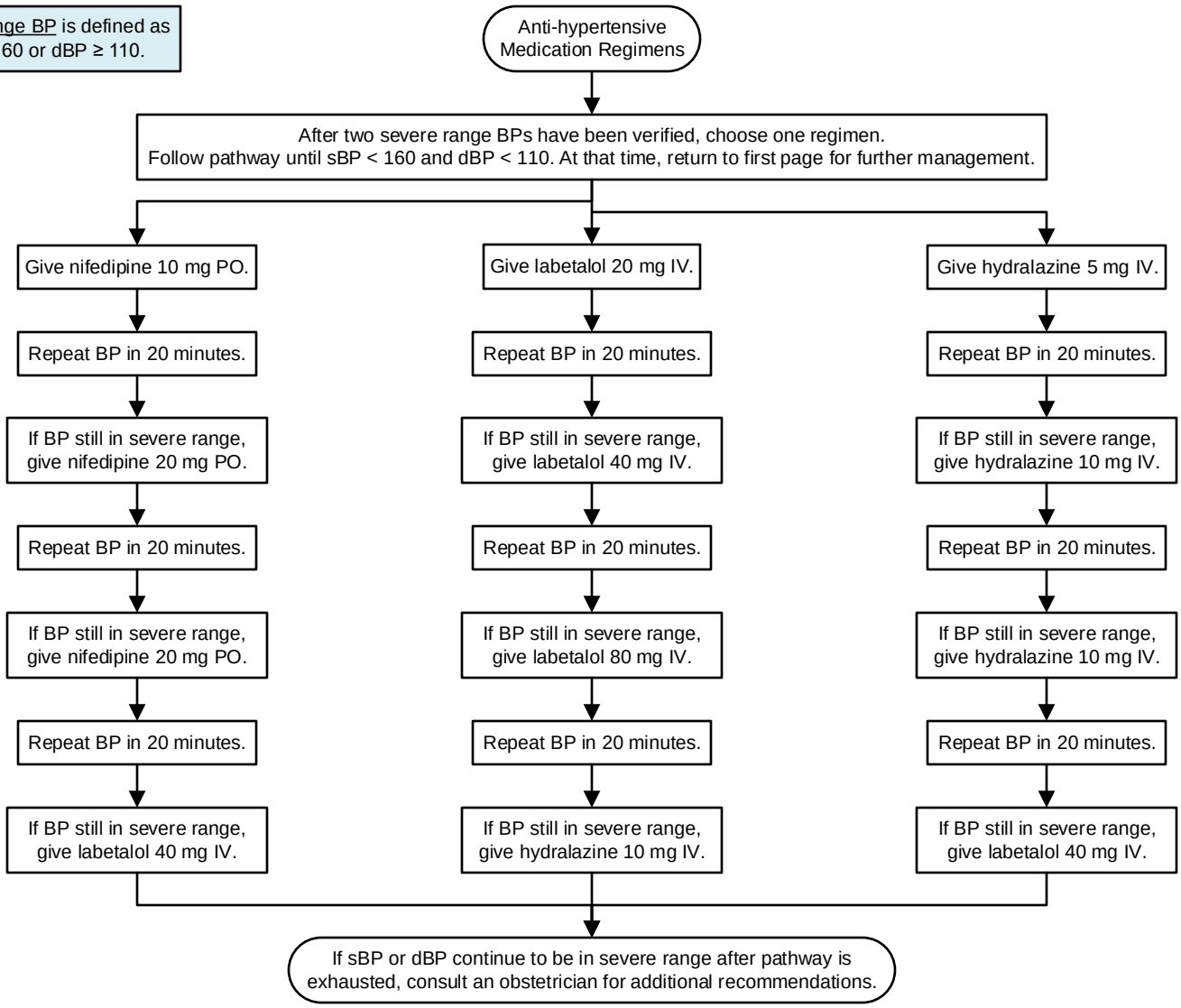

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If patient is in a village, initiate the nifedipine regimen and activate medevac to Bethel.
Do not delay treatment while awaiting disposition.
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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Induction of Labor

Patient identified for induction.

Clinic staff transfers care of the patient to the ward physician.
Ward physician coordinates clinical decision making with OB nursing staff to begin the induction or transfer the patient.

Bishop's Score > 8?

No → Cervical Ripening

Options:
- Foley bulb, preferred as outpatient.
- Vaginal or oral misoprostol.

Bishop's Score ≥ 8?

Yes → Start Pitocin

No

Bishop's Score ≥ 6?

Yes → Start Pitocin

No

Contact HROB or ANMC OB to develop plan for delivery.

Options include:
Pitocin
Foley Bulb
Vaginal Misoprostol
Cesarean Section
Transfer to Anchorage

Yes → Start Pitocin

Start Pitocin → Follow OB Induction Policy

Discuss and document progress and plan on a regular basis.

Documentation of progress will be made in the patient's record every 2 hours.

Follow OB Induction Policy → Delivered?

Delivered? No → Is progress being made every 2 hours?

Is progress being made every 2 hours? No → Contact HROB or ANMC OB for advice.

Is progress being made every 2 hours? Yes → Continue to monitor and adjust dose until delivery.

Delivered? Yes → Begin active management of 3rd stage.

Continue to monitor and adjust dose until delivery. → Delivered?

Delivered? No → Contact HROB or ANMC OB for advice.

Delivered? Yes → Begin active management of 3rd stage.

Induction time frames for Diagnoses:
- Preeclampsia or gestational hypertension: 38 weeks, must be delivered or transferred by due date.
- Preeclampsia or gestational hypertension with severe features: Medical Evacuation to Anchorage.
- Chronic hypertension: 39 weeks, must be delivered or transferred by due date.
- IHCP mild: 39 weeks.
- IHCP severe: must be transferred prior to 37 weeks or induced or transferred immediately if diagnosed after 37 weeks.
- Post-dates: 41 weeks. Consult HROB if patient declines induction.
- History of stillbirth: 38 weeks.

Bishops Score

Score	Dilatation	Effacement	Station	Position	Consistency
0	closed	0 – 30%	-3	posterior	firm
1	1-2 cm	40 -50%	-2	mid-position	medium
2	3-4 cm	60 -70%	-1,0	anterior	soft
3	5+ cm	80+%	+1,+2		

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Intrahepatic Cholestasis of Pregnancy (IHCP)

Intrahepatic Cholestasis of Pregnancy (IHCP)
- Abnormal bile acid (BA) metabolism in pregnancy resulting in severe pruritus without rash.
- Mostly genetic etiology.
- 5% incidence in Yup'ik population.
- 5% incidence of stillbirth.
- MUST have elevated bile acids or LFTs.
- 40-70% recurrence in subsequent pregnancies.

Early Pregnancy: Consider the diagnosis if:
- History of severe pruritus in past pregnancy
- Unexplained stillbirth
- Hx of IHCP

Severe Pruritus:
- Insomnia.
- Worse on palms of hands and soles of feet.
- Excoriation present.
- Scratching during the exam.

Draw baseline BA & LFTs.

Abnormal → **IHCP:**
- Begin Ursodiol 15mg/kg/day.
- Schedule antenatal surveillance at 32 weeks.

Normal → Repeat BA at 32 weeks or at onset of pruritus.

2nd or 3rd Trimester with pruritus

Is the pruritus severe?

Yes → Are the BA & LFTs normal?

Yes →
- Stop Ursodiol if started.
- Repeat BA & LFT in two weeks.

No → **IHCP**
- Begin Ursodiol 15mg/kg/day.
- Increase to 25mg/kg/day in one week if still itching.
- Antihistamines for sleep.
- Eucerin cream for itching.

No → Are the BA & LFTs normal?

Yes → **Pruritus Gravidarum:**
- Weekly BPP after 32 weeks.
- Symptomatic treatment.
- Deliver for usual indications.
- Recheck BA & LFTs weekly.

No → **HROB meeting referral. Begin fetal surveillance at 32 weeks:**
- BPP weekly, may stay in village and return weekly.
- Fetal Kick Counts 3x per day.

Are TBA >40?

No → **Mild IHCP**: Induce at 39 weeks.

YES → **Severe IHCP**: Transfer to Anchorage for Delivery at 37 weeks.

Abnormal Lab levels

Total Bile Acids (TBA)	>10 µmol/L
Cholic Acid	> 3 µmol/L
AST/ALT	>40 units/L
Bilirubin	> 1 mg/dL
Alkaline Phosphatase	>300 units/L

Biophysical Profile (BPP)
- NST
- US including: fetal breathing, tone, gross body motion, and AFI

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Intrauterine Growth Restriction (IUGR)

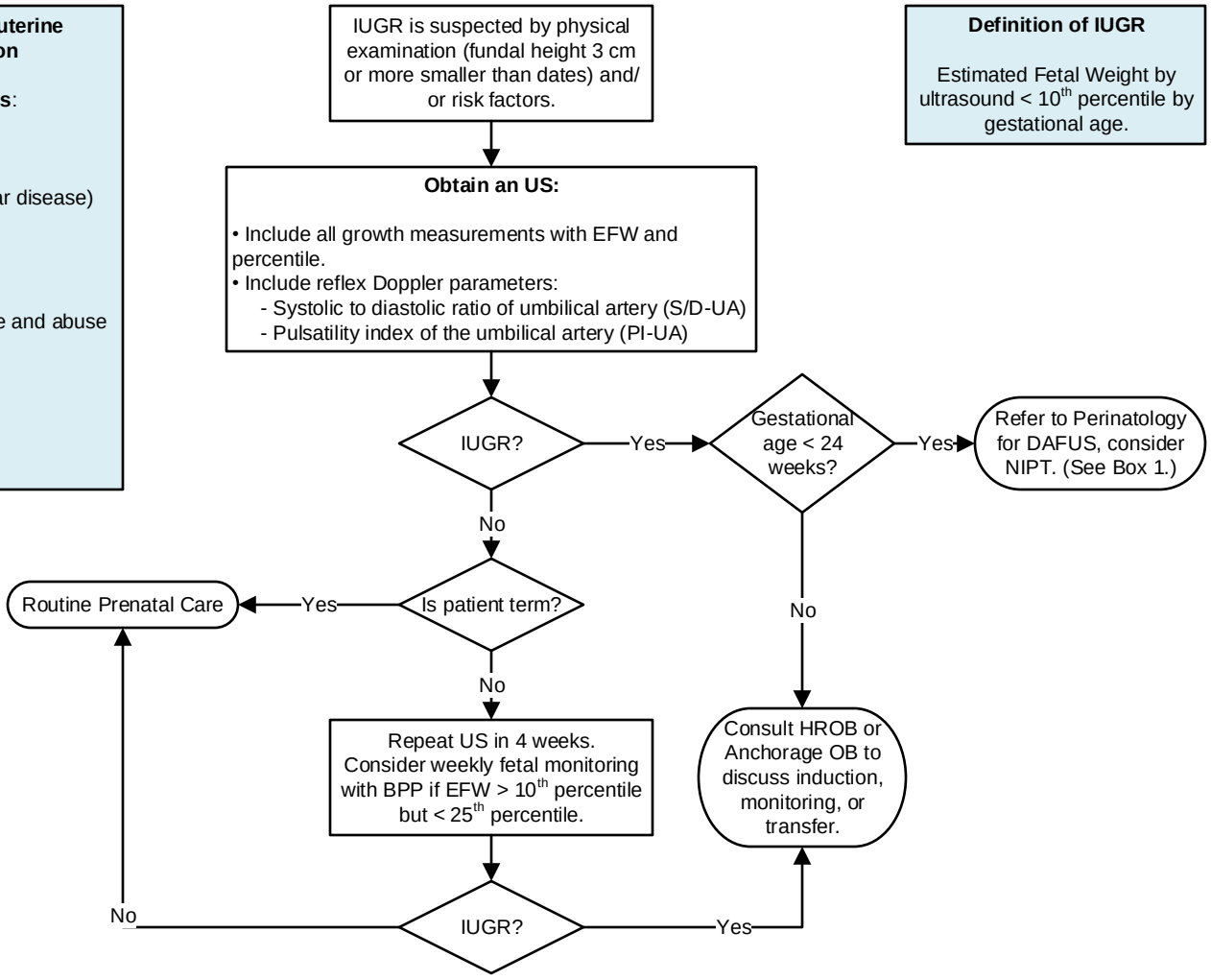
Risk Factors for Intrauterine Growth Restriction

Maternal medical conditions:
- Hypertension
- Renal disease
- Restrictive lung disease
- Diabetes (with microvascular disease)
- Cyanotic heart disease
- Antiphospholipid syndrome
- Auto-immune disease

- Smoking and substance use and abuse
- Severe malnutrition
- Primary placental disease
- Multiple gestation
- Infections (viral, protozoal)
- Genetic disorders
- Exposure to teratogens

Definition of IUGR

Estimated Fetal Weight by ultrasound < 10th percentile by gestational age.



Box 1: NIPT
Non-invasive prenatal testing is a way to detect fetal chromosome abnormalities from a maternal blood draw. Our current test is InformaSeq from LabCorp.

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Labor Patient: Village

Things to Consider

Risk factors:
- History of maternal complications, parity
- Placental location
- No availability of continuous fetal monitoring in the village

Management considerations:
- Check U/A
- Monitor BP closely

Do not place a patient on a commercial flight if she could deliver en route regardless of gestational age.

Village health aide or SRC provider calls urgent RMT with a patient having contractions, vaginal bleeding, or other Sx suggestive of labor

Is the patient past her Be In Bethel (BIB) date?

Yes → Is there a problem that will be a threat to the patient or newborn's life if left in the village?

Yes → Contact HROB and pediatrician and activate a medevac.

No → No medevac. RMT provider assists with birth by phone or VTC.

Do problems arise during the birth?

No → Send the mother and newborn to Bethel on the next commercial flight.

Yes → Contact HROB and pediatrician and activate a medevac.

No → RMT provider determines if the patient could be in labor

No → Evaluate per CHAM with RMT guidance.

Consult HROB for disposition.

Yes →
- Start IV and hydrate with 1 L of IV fluid.
- Give nifedipine (preferred) OR terbutaline.
- Consider ceftriaxone 1 gram IM AND betamethasone 12 mg IM (preferred) OR dexamethasone 6mg IM.

Did the contractions stop?

Yes → Complete evaluation per CHAM and RMT guidance. Observe in clinic at least 1 hour.

Send the patient on the next commercial flight to Bethel for full evaluation

No →
- Reassess every 30 minutes.
- Repeat tocolytic for up to 3 doses of nifedipine OR terbutaline.
- Give ketorolac 60 mg IM OR ibuprofen 800mg PO.

Did the contractions stop?

Yes → Complete evaluation per CHAM and RMT guidance. Observe in clinic at least 1 hour.

No → Give steroid and ceftriaxone if not already given.

Dosing Schedule for Tocolytics
- Nifedipine
  - Dose 1: 30 mg PO
  - Dose 2: 20 mg PO
  - Dose 3: 10 mg PO
- Terbutaline: 0.25 mg SC x3

If activating a medevac for village labor…

- Do not send a resident.
- Ensure that all Tiger Connect roles are covered by back-up physician.
- Notify E1/E2 physician, as they are medical control.
- Get OB/Pediatric **Village Delivery Backpack** from OB. Ensure it contains unexpired FFN, GC/CT swab, GBS swab, sterile speculum, etc.
- Discuss with pediatrician the need to bring surfactant.
- Bring warm clothing (extra gear in peds call room under the bed), snacks, drinks, money, motion sickness medication, etc.
- Coordinate with pediatrician and plan to meet at LifeMed hangar at 3600 Tower Road. Tell LifeMed Dispatch if there will be a delay of >20 minutes.

Care After Birth
(If commercial flight not immediately available)

Mother: VS and fundal checks Q15 minutes x1 hour, then Q30 minutes x2 hours, then Q1h x3 hours. If all is well, may leave clinic with instructions to return immediately for return of bleeding or passing clots.

Baby: VS with axillary temperatures Q30 minutes x2 hours, then Q1h x4 hours. Low threshold for blood glucose after first feed. Ensure vitamin K, erythromycin, and hepatitis B vaccine are given. If all is well, may leave clinic with instructions to return immediately for any concerns, especially trouble breathing, fast breathing, pauses in breathing, etc.

In the village…

- Help the crew, follow their instructions, and expect to carry equipment.
- If GA<34 weeks, perform a sterile speculum exam, obtain FFN, swab for GBS and GC/CT, and obtain urine sample for culture.
- If no concern for placenta previa, check cervix after obtaining cultures.
- Make decision about disposition based on cervical exam, possible complications, and risk/benefit of travel. Discuss with HROB if any uncertainty.
- Notify OB charge nurse of disposition ASAP so they can prepare.
- If village delivery is anticipated, see **Village Deliveries (Pediatrics) Resource** for newborn care and preparation.

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline
Molar Pregnancy

-Quantitative βhCG >100,000
-Vaginal bleeding
-Hyperemesis
-Cystic enlargement of ovaries

Suspect Molar Pregnancy: no intrauterine embryo or ultrasound suspicious for Molar Pregnancy.

Administer Rhogam if Rh negative

Testing:
CBC, CMP, PT/PTT, Blood type, and Rh factor, Quantitative hCG, pelvic ultrasound, chest X-ray. Consider TSH, free T4 if signs/symptoms of hyperthyroidism.

Signs or symptoms of medical complications, hyperthyroid, severe anemia, coagulopathy, PIH

Yes → Stabilize, consult with ANMC OB/GYN service, and transfer to ANMC via medevac.

No

Suction D&C.
Consider transfer if uterus is >16 week size due to increased risk of complications.

Confirm pathology: molar pregnancy, complete or partial

Yes

Quantitative βhCG 48 hours after D&C and weekly

Plateau ± 10% over three weeks rise ≥ 10% over two weeks. Quantitative HCG + at six months.

Yes → **Post molar GTN:**
-CT chest, CBC, PT/PTT, CMP.
Consult GYN ONC in Anchorage.

No

Weekly Quantitative βhCG until negative x3 (<5)

Monthly Quantitative βhCG for 6 months

Contraception:
Encourage Depo Provera, Nexplanon, IUD

Definitions

GTN – gestational trophoblastic neoplasm
Complete Mole – a form of aberrant fertilization with proliferation of trophoblastic tissue with a normal karotype, no fetus, diffuse villous edema, and diffuse proliferation.
Partial Mole – a form of aberrant fertilization with proliferation of trophoblastic tissue with triploid karotype, a fetus may be present, focal villous edema, and focal proliferation.
Choriocarcinoma – a malignant neoplasm arising from cytotrophoblast.
Placental site trophoblastic tumor – a malignant neoplasm arising from intermediate trophoblast.
Post Molar GTN – persistent hCG detection after the treatment of a complete or partial molar pregnancy.
Invasive Mole – detection of tumors within the uterus on imaging.
Malignant GTN – post molar gestational trophoblastic neoplasm.
Metastatic GTN – post molar GTN with imaging evidence of distant metastasis. The most common sites are vagina, lung, and brain.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Oligohydramnios

Differential Diagnosis by Trimester

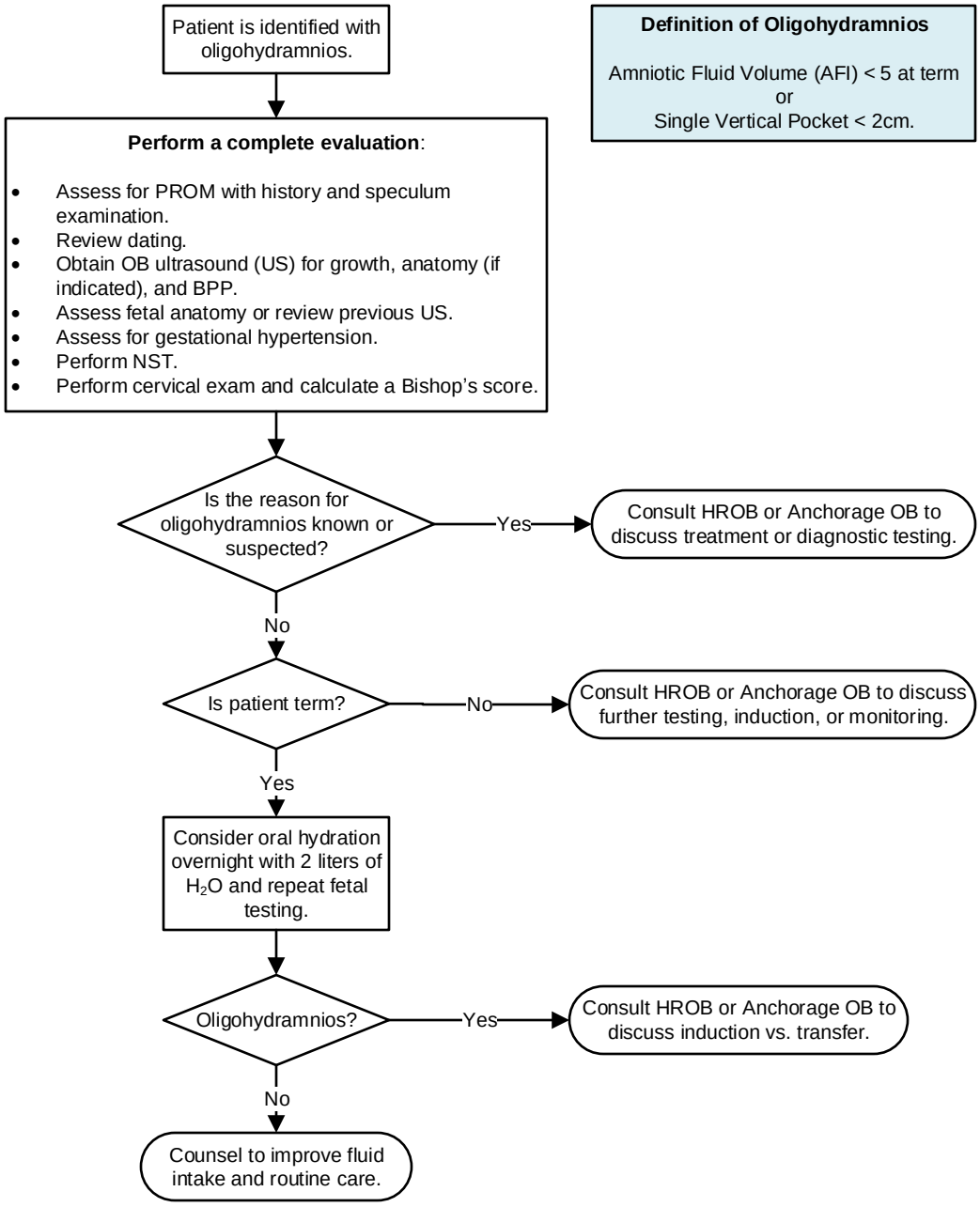
First
- Aneuploidy
- Fetal Anomaly

Second
- Aneuploidy
- Fetal Anomaly
- Preterm premature rupture of membranes (PPROM)
- Placental abruption
- Fetal growth restriction
- Amniocentesis
- Elevated maternal serum alpha fetoprotein

Third
- Preterm premature rupture of membranes
- Placental abruption
- Fetal growth restriction
- Utero-placental insufficiency
- Preeclampsia
- Maternal vascular diseases
- Fetal anomaly
- Post-term
- Suboptimal maternal hydration

Definition of Oligohydramnios

Amniotic Fluid Volume (AFI) < 5 at term
or
Single Vertical Pocket < 2cm.



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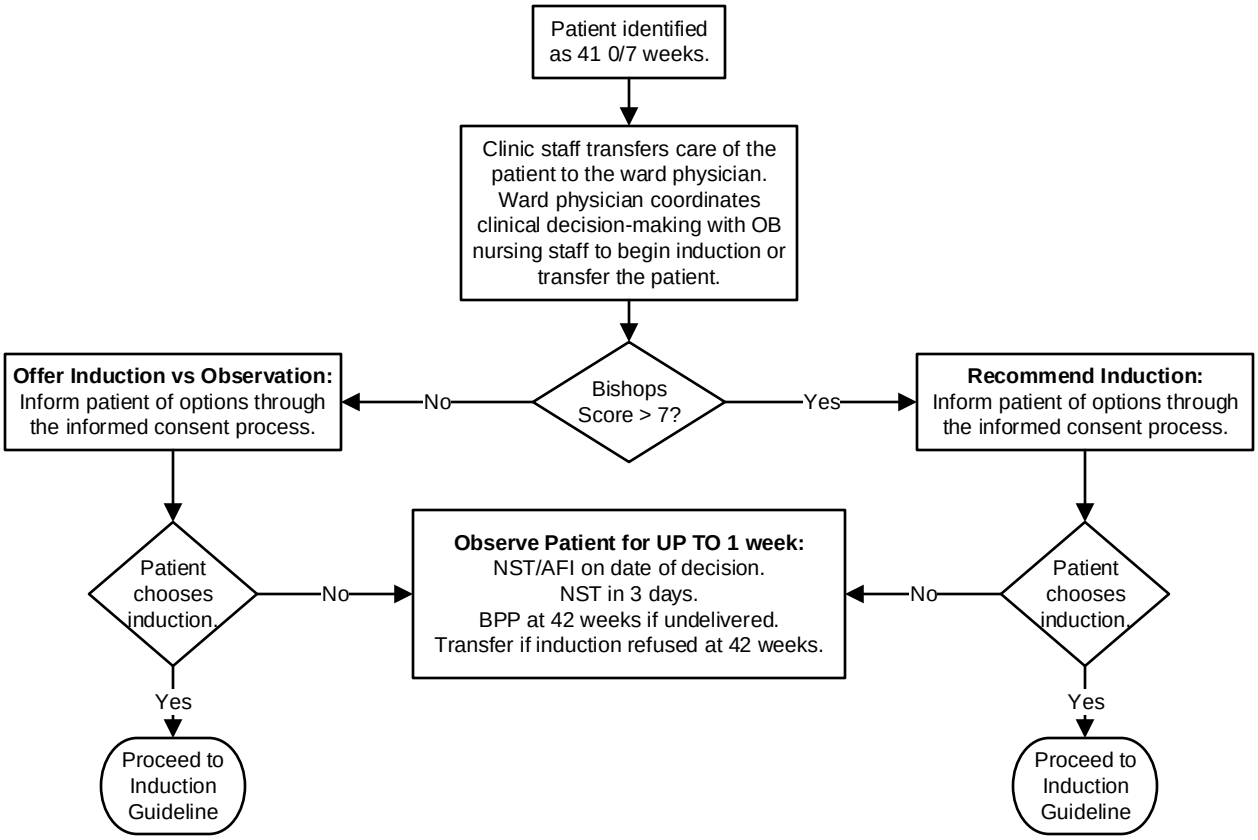
Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Post-Dates Pregnancy



Bishops Score

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3	5+ cm	80+%	+1,+2		

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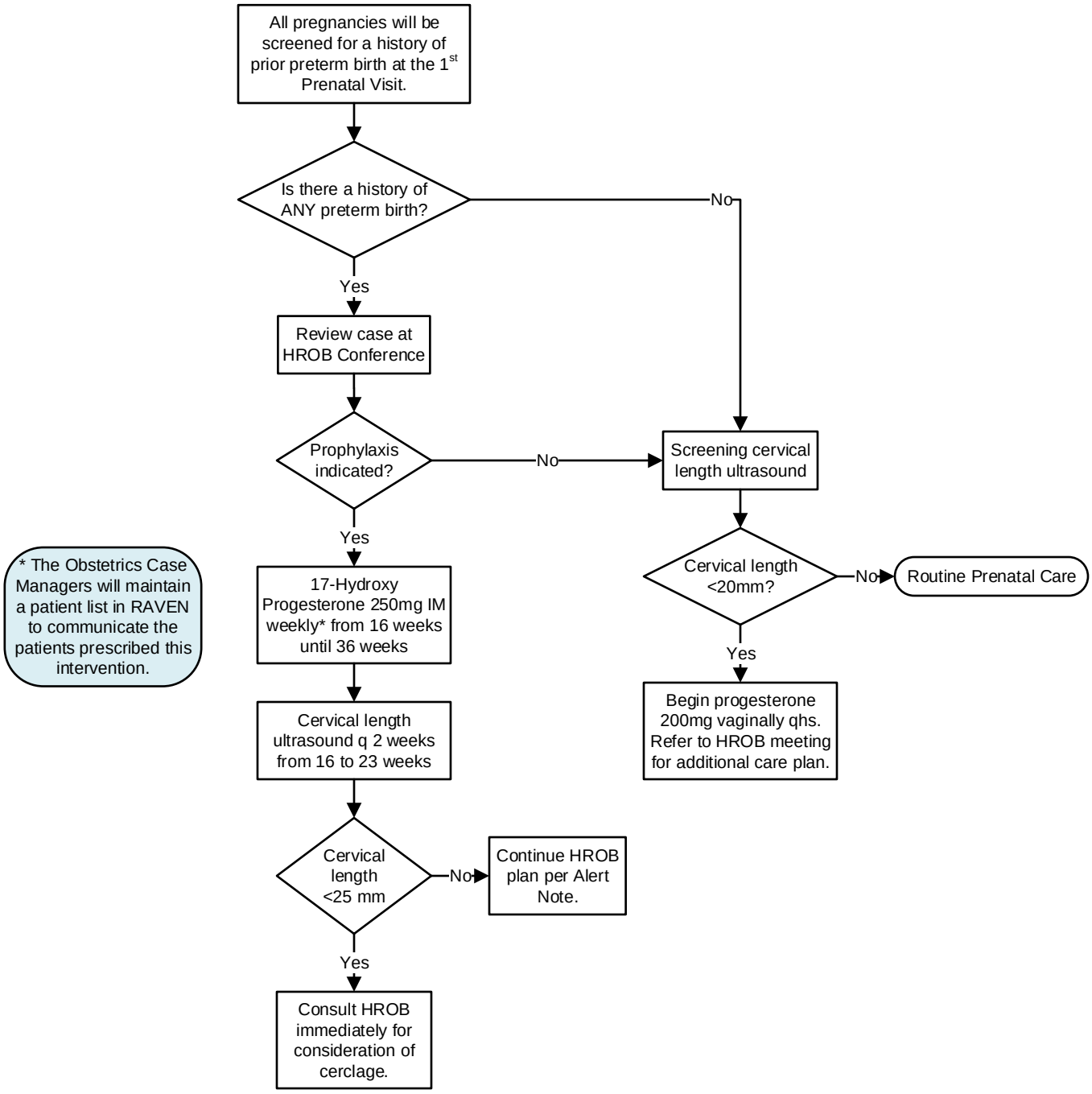
Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Preterm Labor: Screening and Prevention



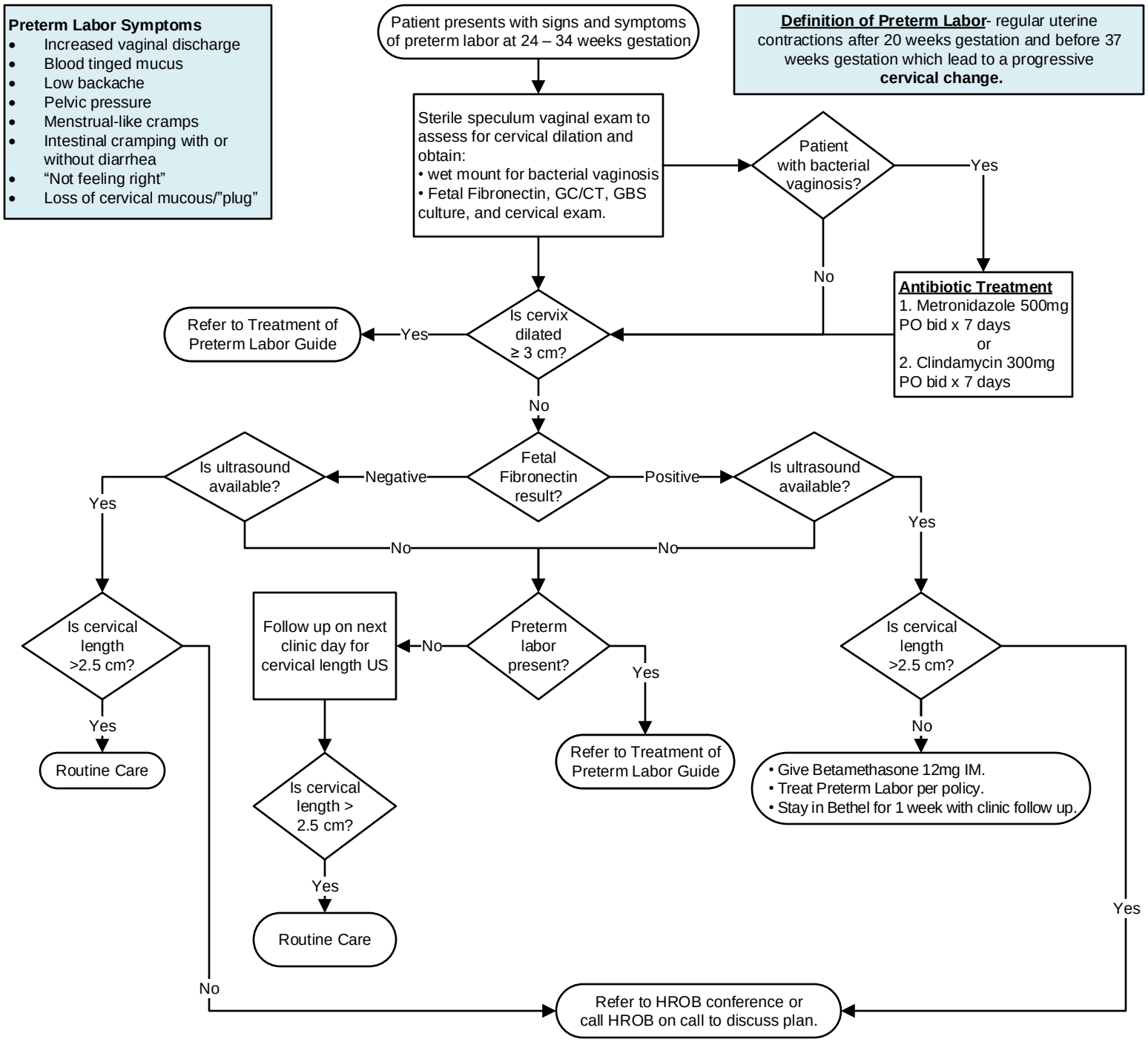
Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Preterm Labor: Evaluation

Preterm Labor Symptoms
- Increased vaginal discharge
- Blood tinged mucus
- Low backache
- Pelvic pressure
- Menstrual-like cramps
- Intestinal cramping with or without diarrhea
- "Not feeling right"
- Loss of cervical mucous/"plug"

Definition of Preterm Labor- regular uterine contractions after 20 weeks gestation and before 37 weeks gestation which lead to a progressive **cervical change.**



There is no need to treat contractions with tocolytics in the absence of cervical change.

Yukon-Kuskokwim HEALTH CORPORATION

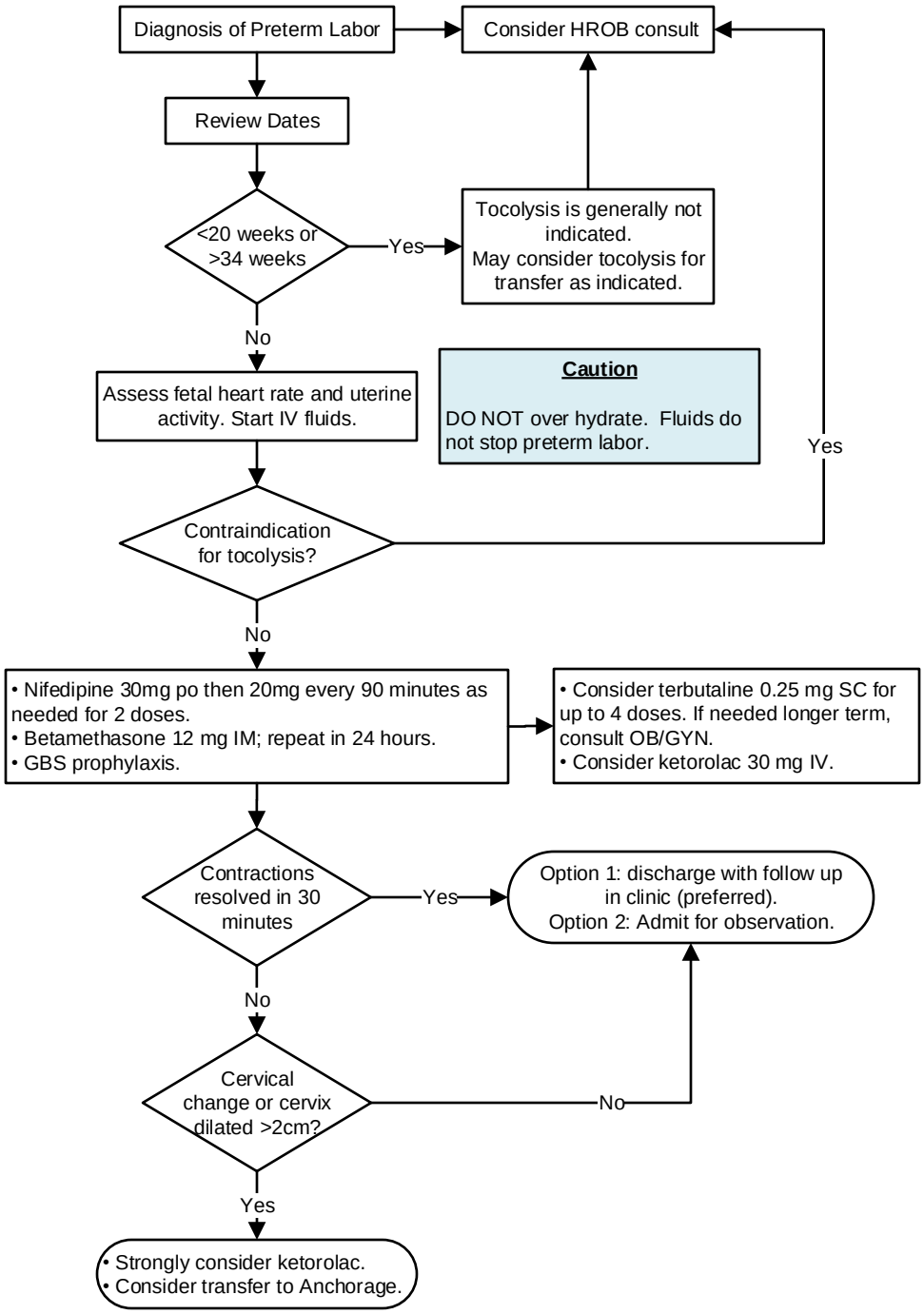
Clinical Guideline

Preterm Labor: Treatment

Definition of Preterm Labor-regular uterine contractions after 20 weeks gestation and before 37 weeks gestation which lead to a progressive **cervical change**

Contraindications to tocolysis:
- IUFD
- Lethal fetal anomaly
- Non-reassuring fetal assessment
- Severe IUGR
- Chorioamnionitis, relative
- Maternal hemorrhage with hemodynamic instability
- Severe preeclampsia or eclampsia
- PPROM

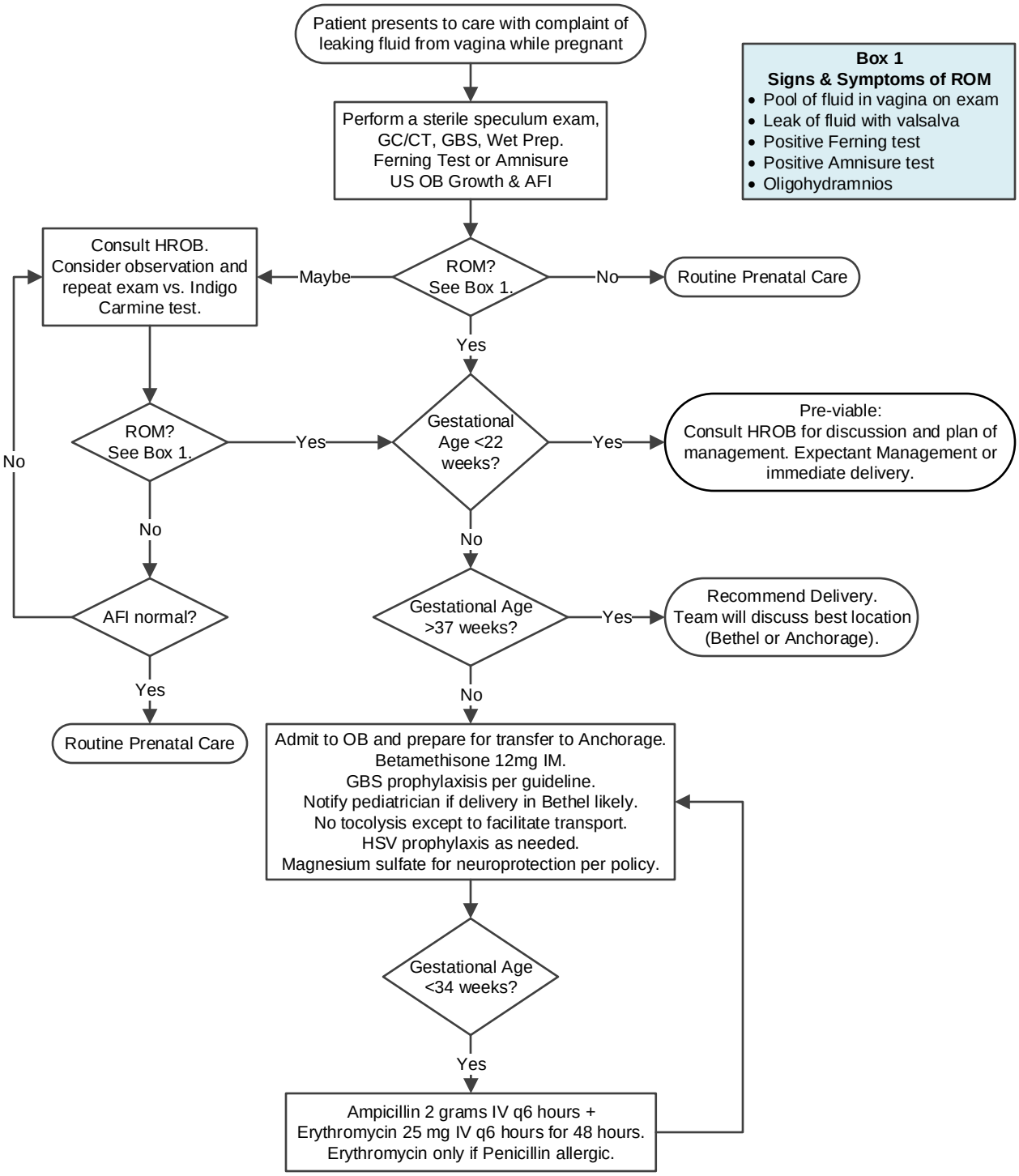
Contraindications to terbutaline
- Diabetes
- HTN
- Suspected placental abruption (relative)



Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Preterm Premature Rupture of Membranes



Box 1
Signs & Symptoms of ROM

- Pool of fluid in vagina on exam
- Leak of fluid with valsalva
- Positive Ferning test
- Positive Amnisure test
- Oligohydramnios

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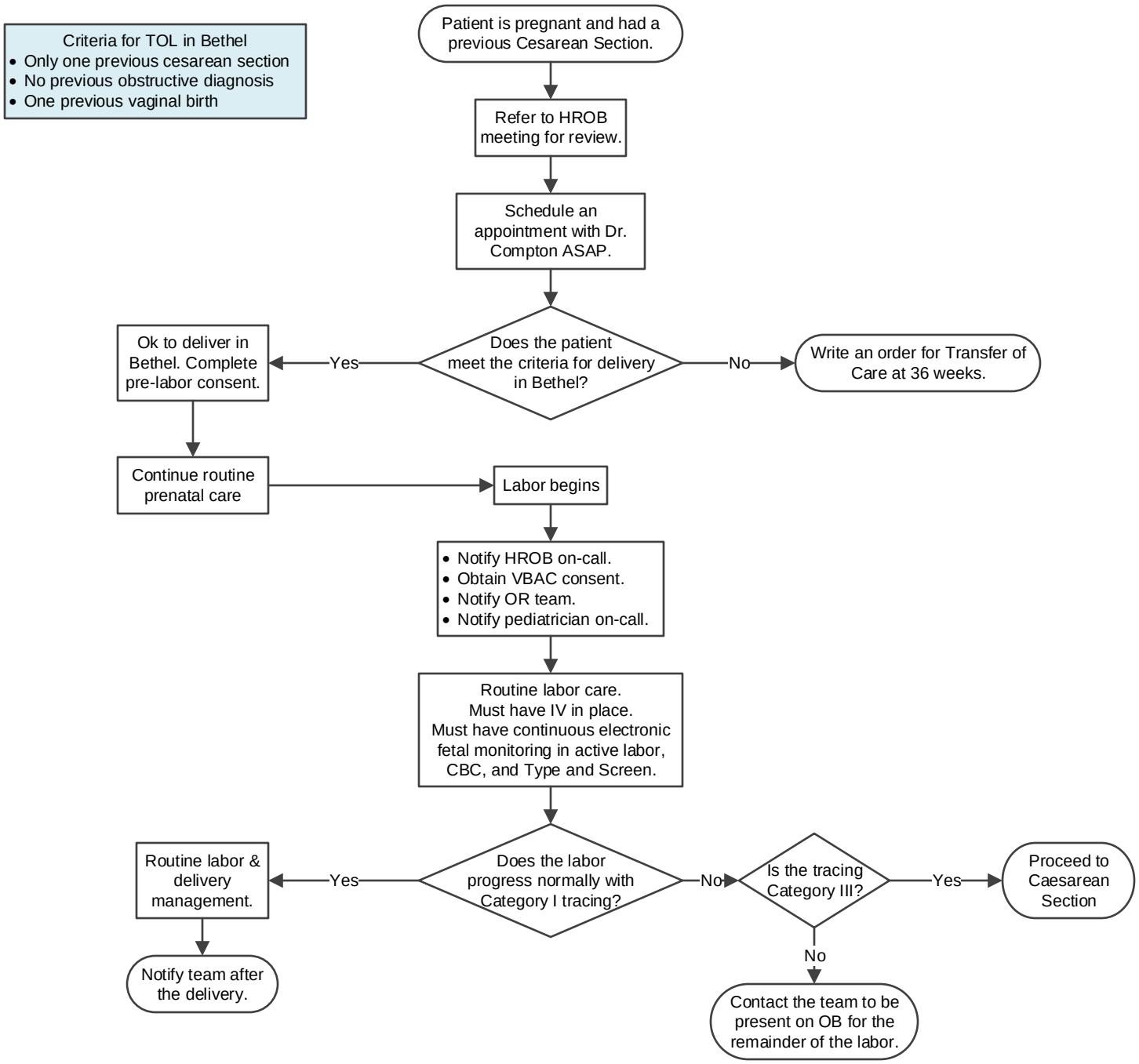
Approved by MSEC 7/26/17.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Vaginal Birth after Caesarean Section



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Approved by MSEC unknown date.
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Yukon-Kuskokwim HEALTH CORPORATION

Preventative Health Care Guidelines

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Amoxicillin Allergy Trials (Pediatric)

Background

• Only 4-9% of those...labeled [penicillin-allergic] are currently allergic. It is important to identify those who are not allergic, because children mislabeled as penicillin-allergic have more medical visits, receive more antibiotic prescriptions, and have longer hospitalizations with more antibiotic-related complications.[1]
• Up to 10% of children develop rashes while receiving antibiotics. Most are diagnosed...as allergic to the implicated antibiotic, and most continue to avoid the suspect antibiotic in favor of alternatives, which may be less effective, more toxic, and more expensive.[2]
• Do not label a patient as allergic to penicillin/ amoxicillin unless he or she has true hives, anaphylaxis, or a life-threatening reaction. Please include photos of rashes in RAVEN.
• Children labelled as allergic to penicillin/amoxicillin often carry that label for the rest of their lives.
• Please consult a pediatrician with any questions.

Anaphylaxis

• Acute onset – several minutes to hours from exposure.
• Generalized hives, pruritis or flushing, swelling of lips/tongue/uvula, and at least one of the following:
  Dyspnea, bronchospasm, stridor
  Hypotension
  Evidence of hypoperfusion of end-organs
  Persistent crampy abdominal pain, and/or vomiting or diarrhea

Hives vs Viral Rash

• True hives are raised, itchy, larger than dime-sized, come and go, move around the body, and change shape and size. True hives are uncomfortable. Ask if the rash bothered the child.
• Keep in mind that many parents refer to any rash as "hives." Get a description every time.
• A viral exanthem is typically diffuse, fine, pinpoint red dots and can be dense, coalesced, larger raised lesions. The rash typically covers the face and chest but can cover the whole body. The rash typically worsens and takes days to clear.

Patient labeled with a penicillin/ amoxicillin allergy.

→ Review history. (See box.)

→ Was the reaction anaphylaxis (see box) or other life-threatening reaction (eg Stevens-Johnson syndrome, etc.)?

Yes → • Do not give drug or perform trial.
• Update chart, including the Problem List and a comment on the allergy.
• Refer to Allergy & Immunology at 5.

No → What was the reaction?

History

Chart review:
• Review notes in allergy alert. Find date allergy was added, and then review notes from that day. Was ED visit or hospital admission required?
• Review Multimedia Manager photos.
• Were steroids or other treatment given?
• Has patient received a drug of the same class since the allergy was reported? Was it tolerated? Were there symptoms?

History from patient/family:
What was the reaction?
- Vomiting and/or diarrhea?
- Rash?
  Age? Time from first dose?
  Hives? (See box.) Was it itchy?
  Blistering or peeling?
  Photos from family?
- Trouble breathing?
- Swelling of tongue/lips?
- Joint swelling or fever?
- Mucous membrane involvement?

Rash

True hives, skin blistering/peeling, or mucous membrane involvement → • Do not give drug or perform trial.
• Update chart, including the Problem List and a comment on the allergy.
• Refer to Allergy & Immunology at 5.

Viral-appearing rash or other type of rash → **Not a true allergy.**
• Educate and perform Amoxicillin Trial (see box).
• If patient/family refuses trial, update Problem List.
• Offer future trial or refer to Allergy & Immunology at age 5 for amoxicillin allergy testing.

Vomiting and/or diarrhea without any other S/Sx anaphylaxis

→ **Not a true allergy.**
• Educate and perform Amoxicillin Trial (see box).
• If patient/family refuses trial, update Problem List.
• Offer future trial or refer to Allergy & Immunology at age 5 for amoxicillin allergy testing.

Other

→ Get more history. Consider pediatric consult.

Amoxicillin Trial Procedure[2]

Use AMB Amoxicillin Trial Power Plan.

1. Obtain VS. Perform physical exam, including lung exam. Have appropriate dose of EpiPen or epinephrine. Epinephrine (1 mg/mL): 0.01 mg/kg (or 0.01 mL/kg) IM Q5-15 minutes.
Per AAP recommendations:
  • 7.5-25 kg: use EpiPen Jr (0.15 mg)
  • ≥ 25 kg: use EpiPen (0.3 mg)
2. Calculate weight-based dose of amoxicillin. Give patient 10% of that dose.
3. Place patient in nearby room and instruct caregiver to notify staff of any changes in status.
4. If no reaction by 20 minutes, give patient remaining 90% of weight-based dose of amoxicillin.
5. Observe another 60 minutes. If no reaction, check VS and physical exam. If all stable, discharge home with regular course of drug.
6. Give patient and family amoxicillin trial education sheet.
7. Update allergy alert in RAVEN. Click the allergy in the banner. Right click over the drug name and choose "cancel." On the "reason" drop-down menu, choose "OK on Retrial."

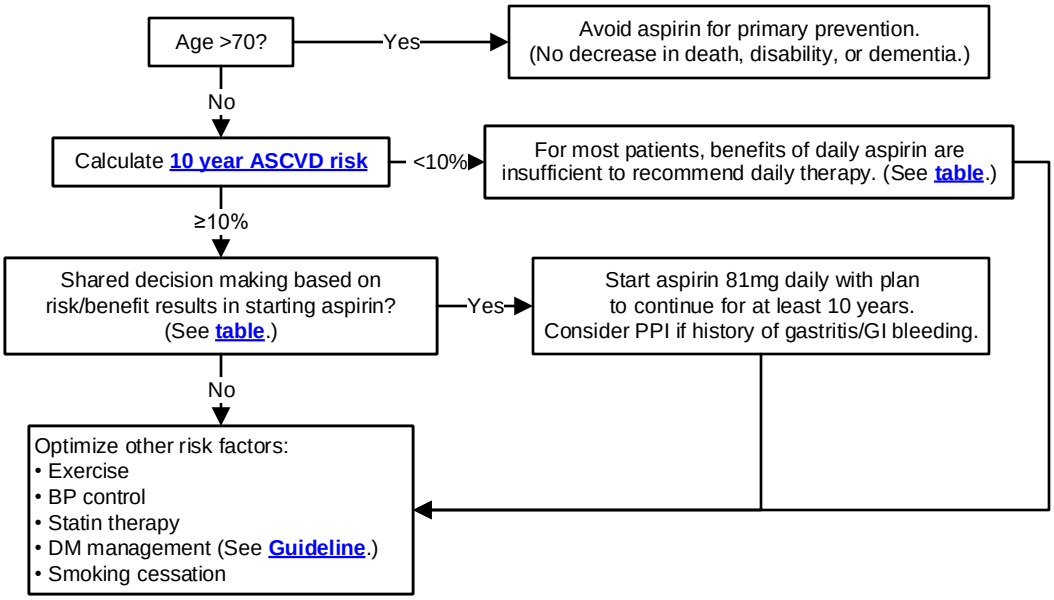
Notes:
• If patient is on a beta-blocker, stop this for 24 hours prior to procedure, if possible. Beta-blockers can interfere with treatment for anaphylaxis, if it occurs.
• Ensure that patients with asthma have optimal control prior to this procedure.

References
1. Kelso JM. "Provocation challenges to evaluate amoxicillin allergy in children." JAMA Pediatrics 2016;170(6):e160282.
2. Mill C, et al. "Assessing the diagnostic properties of a graded oral provocation challenge for the diagnosis of immediate and nonimmediate reactions to amoxicillin in children." JAMA Pediatrics. 2016;170(6):e160033.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 8/3/21. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline
Aspirin for Adults >40 Without Known Cardiovascular Disease



Notes

Aspirin produces significant reductions in mortality amongst survivors of cardiovascular disease, but its role in the primary prevention of cardiovascular disease amongst healthy adults is less clear.

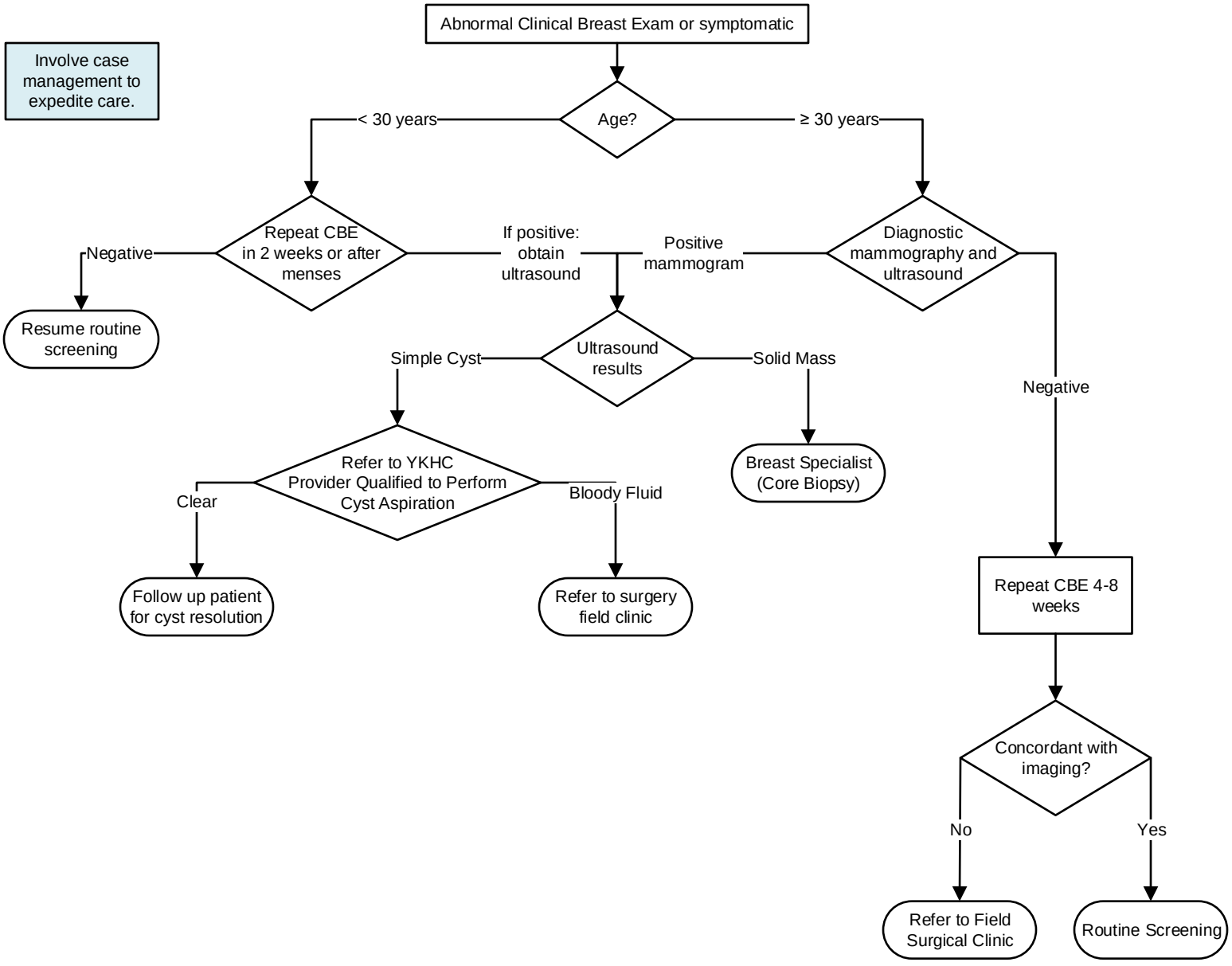
See **table under "Possible Benefits"** for summary of RCT data for low dose aspirin in the primary prevention of cardiovascular disease.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Breast Cancer Screening

Clinical Breast Exam Screening Recommendations:
1. Breast self-examination: at provider's discretion
2. Clinical breast examination: at provider's discretion
3. Mammography: start age 45
   screen every 2 years
   end screening at age 70, based on health status



This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 6/22/11. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

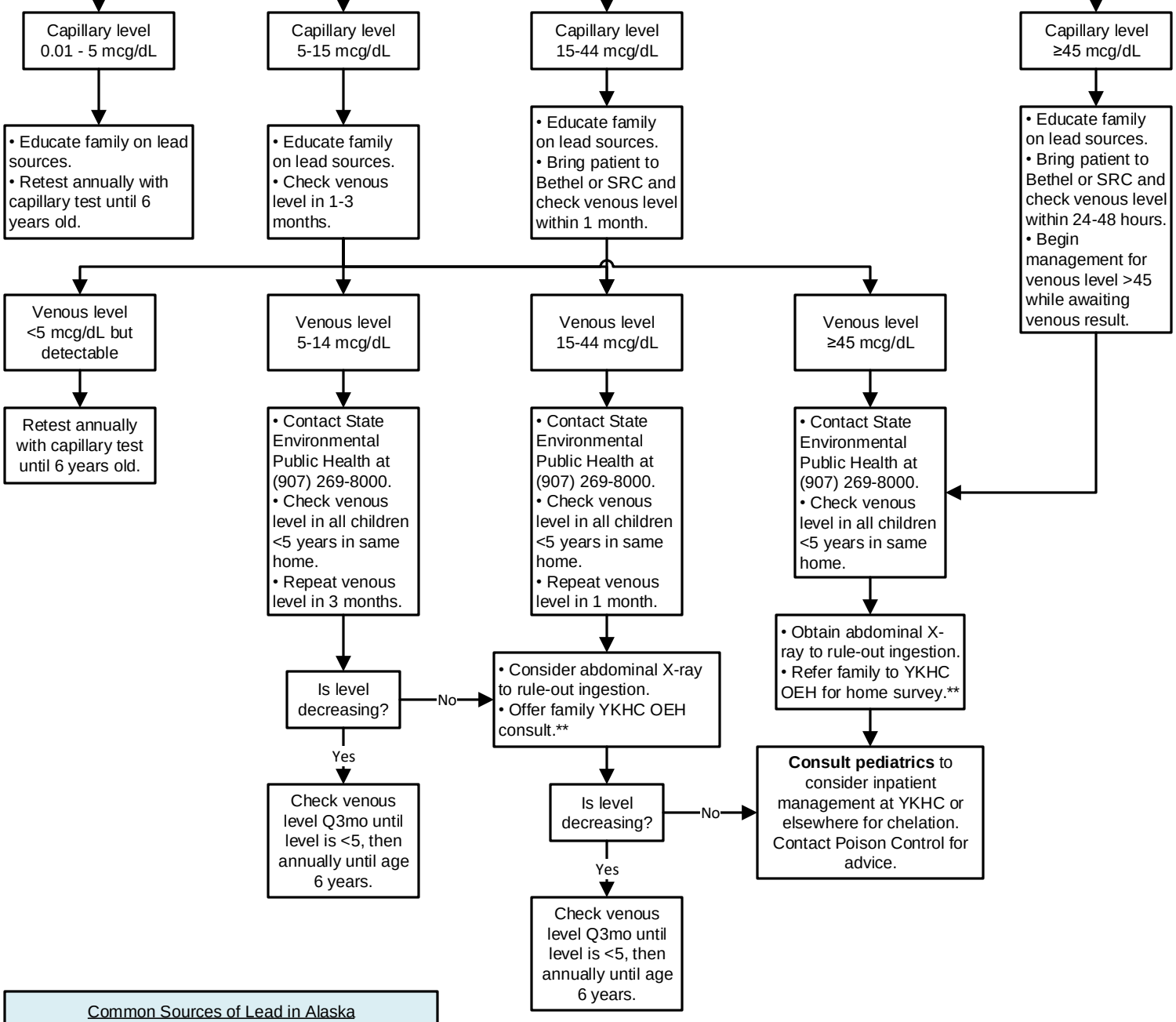
Clinical Guideline

Lead Evaluation (Pediatric)

RAVEN Orders
- Capillary lead level: order "Lead, State (Capillary)"
- Venous lead level: order "Lead Level, Venous Send Out"

Perform capillary lead screening:
- on all children at 1st and 2nd year well check
- if child <5 years with no prior screening or has unexplained developmental delays
- consider in anemia evaluation

Note: This guideline is for asymptomatic patients only. If patient is symptomatic, please consult pediatrics.



Common Sources of Lead in Alaska
- Mining lead, zinc, silver, or gold ore
- Lead paint in homes or buildings built before 1978
- Firearms and ammunition
- Shooting ranges
- Game meat shot with lead ammunition
- Fishing weights
- Leaded aviation gas
- Marine paint
- Soldering, welding, or craft-making
- Pica or "mouthing" (eating dirt)
- Imported household objects
- Lead or brass pipes/faucets
- Batteries and automobile repair sites

**To consult YK Office of Environmental Health (OEH), email Jennifer_Dobson@ykhc.org with patient's name and DOB, lead levels, and parent's contact information. OEH can review environmental risk factors with family and offer a home visit if appropriate.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/11/19. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Kimberly_Fisher@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

COVID-19 Clinical Guideline

Sports Clearance for Pediatric Patients with History of COVID-19

Pediatric patient with h/o COVID-19 infection presents for sports physical in SRC or outpatient clinic.

Patient must be at least 10 days from diagnosis.

Perform ECG.
May fax to Pediatric Cardiology at (907) 339-1994.

How severe were symptoms?

Symptom Severity Classification for this Guideline

- Mild: no fever, <3 days of symptoms
- Moderate: prolonged fevers and bedrest, hospitalization not required, no abnormal cardiac testing throughout course
- Severe: hospitalized, abnormal cardiac testing, or MIS-C

Asymptomatic or Mild

Moderate or Severe

Screen for Current or Recent Symptoms

- SOB or dyspnea on exertion?
- Chest pain?
- Palpitations?
- Early fatigue?
- Syncope or pre-syncope?

Yes to ≥1 symptom

Consult Pediatric Cardiology.
If questions or urgent referral, call first.
Otherwise, refer using "Refer to Peds Cardiology External/Internal" order in RAVEN.

No to all symptoms

Was ECG abnormal?

Yes

No

- Routine care with anticipatory guidance to return immediately if any of the above symptoms develop.
- Instruct patient to follow a plan for **Graduated Return to Play**.

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If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

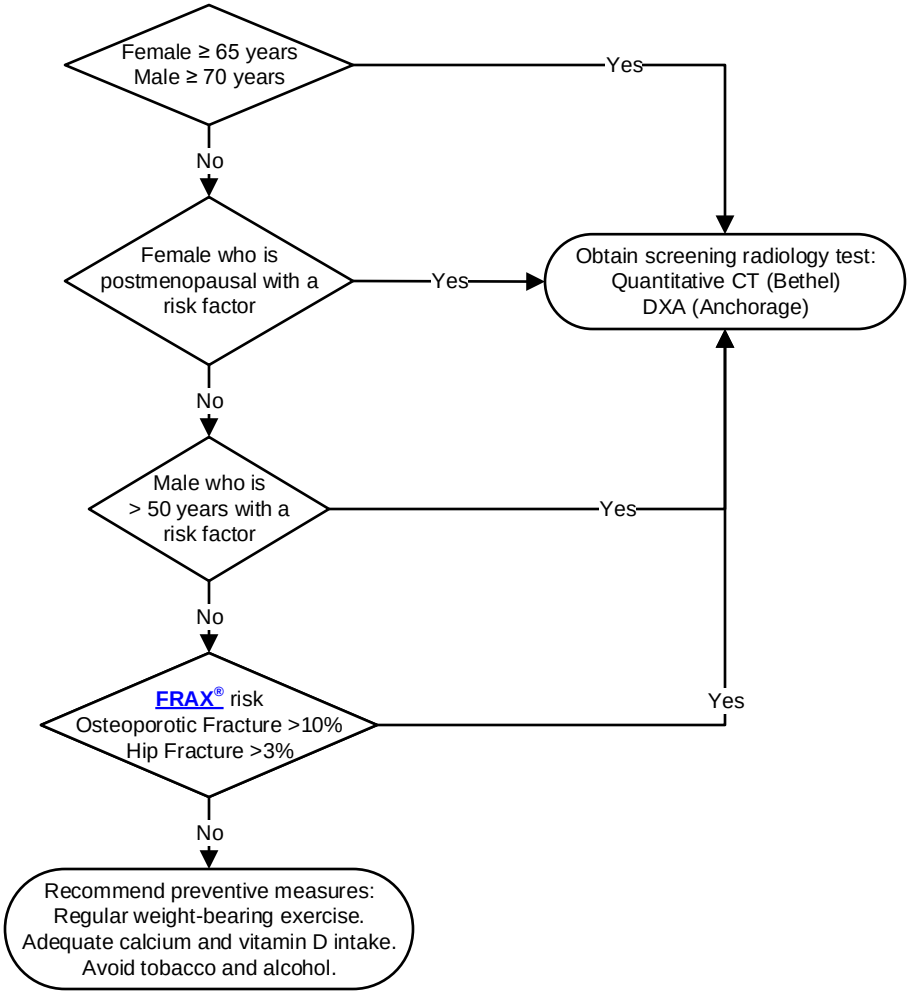
Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Osteoporosis Screening

Risk Factors
- Osteopenia on X-ray.
- History of fracture without trauma.
- Tobacco use.
- Excessive alcohol use.
- Height loss more than ½ inch in one year.
- Height loss more than 1.5 inches total.
- At risk medication use (see box below).
- BMI < 20.
- Premature menopause.

At Risk Medications
- Systemic steroids >3 months
- Methotrexate
- Aromatase inhibitor
- Selective estrogen receptor modulator
- Proton pump inhibitor
- Heparin
- SSRI



Recommended Calcium Intake

Age	Sex	RDA mg/day
9-18	M+F	1300
19-50	M+F	1000
51-70	M	1000
51-70	F	1200
>71	M+F	1200

Recommended Vitamin D Intake

Age	Sex	RDA IU/day
14-70	M+F	600
>71	M+F	600

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If comments about this guideline, please contact David_Compton@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Osteoporosis Treatment

Abbreviations
BMD – Bone mineral density
BTM – Bone turnover markers
FRAX® – Risk scoring algorithm

FRAX® High Risk for Fracture
10 year risk of major osteoporotic fracture ≥ 20% or hip fracture risk ≥ 3%.

If patient has one or more of the following:
- Lumbar spine or femoral neck or total hip T score ≤ -2.5
- CT bone density < 80 mg/cm^3
- History of a fragility fracture
- High FRAX® fracture probability

Evaluate for secondary causes of osteoporosis.

Some Secondary Causes of Osteoporosis
- Drugs
- GI-related illness
- Bone marrow disease
- Endocrine disorder
- Organ transplant

Correct calcium/vitamin D deficiency and address secondary causes of osteoporosis.

Educate patient on lifestype measures, fall prevention, and benefits and risks of medications.

Obtain dental evaluation of and treatment for risk of osteonecrosis of jaw.

Consider endocrinology consultation.

Prior fragility fracture

No → Start alendronate.

Start alendronate. → Reassess at least yearly.

Reassess at least yearly. → Worsening?

Worsening? Yes → Assess compliance. Reevaluate for secondary causes of osteoporosis.

Assess compliance. Reevaluate for secondary causes of osteoporosis. → Switch to zoledronic acid or denosumab.

Switch to zoledronic acid or denosumab. → Place note in RAVEN that includes autotext "..OsteoporosisPreTreat" at least two weeks prior to visit for medication.

Worsening? No → Consider drug holiday after five years.

Consider drug holiday after five years. → Resume therapy when fracture occurs, BMD declines, or BTM rises.

Resume therapy when fracture occurs, BMD declines, or BTM rises. → Reassess at least yearly.

Yes → Start zoledronic acid or denosumab.

Start zoledronic acid or denosumab. → Place note in RAVEN that includes autotext "..OsteoporosisPreTreat" at least two weeks prior to visit for medication.

Place note in RAVEN that includes autotext "..OsteoporosisPreTreat" at least two weeks prior to visit for medication. → Reassess at least yearly.

Reassess at least yearly. → Worsening?

Worsening? Yes → Consult adult endocrinologist.

Worsening? No → Consider drug holiday after six years with zoledronic acid.

Consider drug holiday after six years with zoledronic acid. → Reassess at least yearly.

Adapted from AACE/ACE 2016 Postmenopausal Osteoporosis Treatment Algorithm.

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If comments about this guideline, please contact David_Compton@ykhc.org.

Return to Table of Contents.

Psychiatry

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Alcohol Hangover/Withdrawal

Table 1: Alcohol Hangover (F10.120)
- Poorly defined but universally understood; occurs the morning after a night of heavy drinking.
- In general, starts <12 hours after a binge of <24 hours.
- Sx: fatigue, thirst, headache, nausea, concentration problems, apathy, loss of appetite, dizziness, vomiting, heart pounding/racing.
- Requirements: HR<130, BP<160/100, RR<24, T<100.4, ambulatory, GCS=15, appropriate history, no tremor, no anxiety, no significant comorbidities.

Table 2: Inpatient Criteria
- CIWA>12, despite treatment with PB/BZD.
- Requiring high-dose sedatives or IV infusion to maintain CIWA<12.
- GCS<8 or hemodynamic instability.
- Persistent hyperthermia (T>100.4 F).
- Respiratory insufficiency (hypoxia, hypercapnia, etc.).
- Marked acid-base disturbance.
- Cardiac disease (heart failure, arrhythmia, evidence of ischemia, etc.).
- Severe electrolyte abnormality.
- Severe renal insufficiency or requiring high volume fluids.
- Evidence of rhabdomyolysis.
- Potentially serious infection (PNA, wounds, etc.).
- Severe GI pathology (GI bleed, pancreatitis, etc.).
- Severe psychomotor agitation (high risk to self or others, gravely disabled, etc.).
- Evidence concerning for Wernicke-Korsakoff Syndrome (oculomotor dysfunction, ataxia, severe malnutrition).
- Withdrawal despite very elevated serum ethanol.

Table 3: Phenobarbital Contraindications
Absolute: Hx allergy, adverse reactions, or porphyria
Relative: current significant sedative level (including EtOH, BZD, or anti-psychotics)

Table 4: Phenobarbital (PB) Protocol
- Phenobarbital 260 mg IV

then phenobarbital 130 mg IV every 30-40 minutes until CIWA score ≤ 12. No discharge meds.

OR (for very large/small patients)
- Phenobarbital 4 mg/kg IV (rounded to nearest 130 mg)

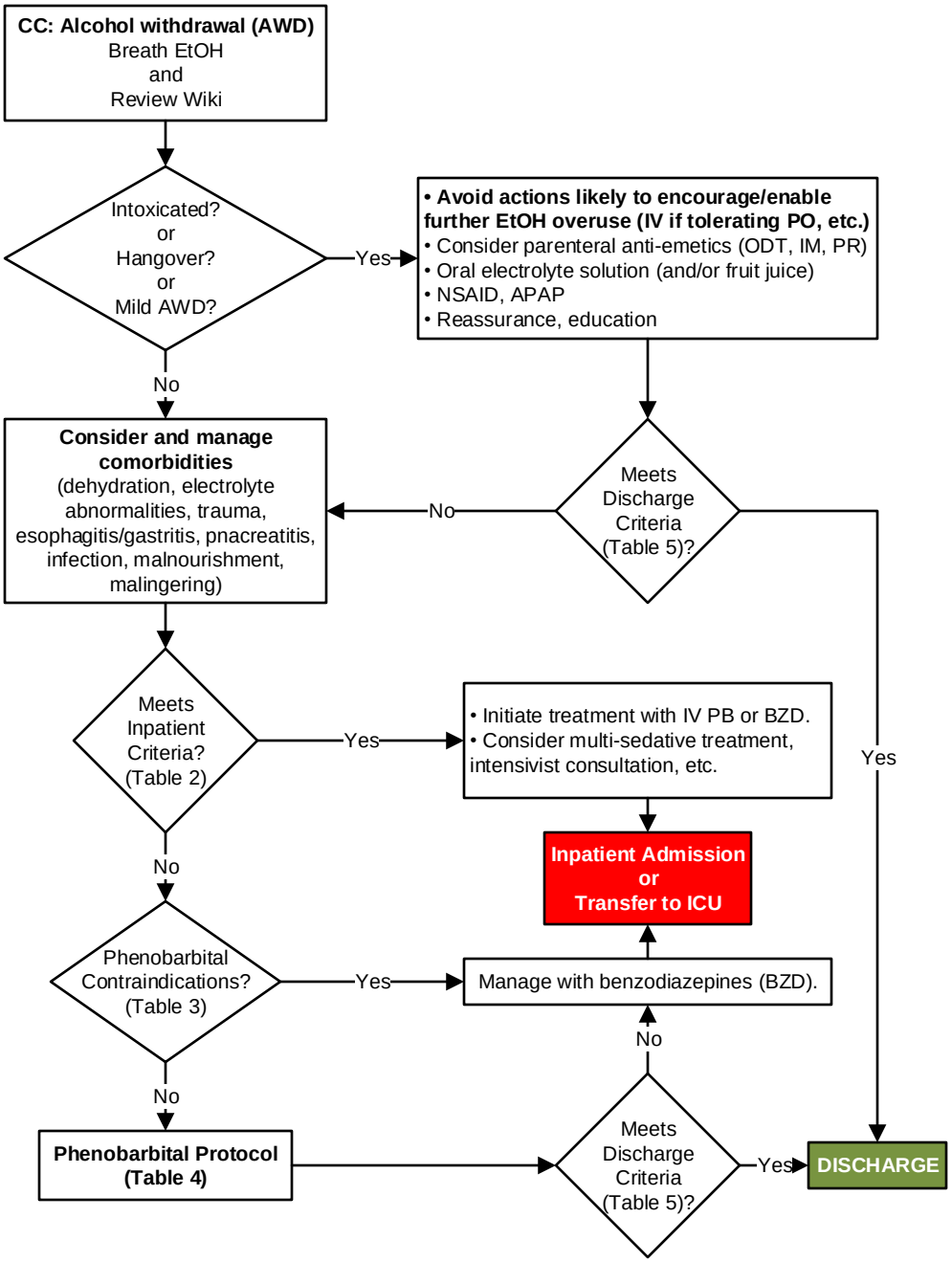
then phenobarbital 2 mg/kg IV every 30 minutes until CIWA score ≤ 12. No discharge meds.

OR
- Either of the above via IM injection, with subsequent doses very 60-90 minutes.

Adverse Effects:
- Transient asymptomatic hypotension
- Transient ataxia
- Transient lethargy

Table 5: Discharge Criteria
- No inpatient criteria present (Table 2).
- CIWA score <12.
- Awakens to voice or light touch.
- Oriented with no delirium.
- Ambulatory without assistance.
- Taking liquids without vomiting.
- No co-administered sedatives/anti-psychotics.
- No seizures after treatment.
- Likely compliant with important outpatient medications (including antibiotics, etc.).

Please see the Wiki for more information:
Alcohol Withdrawal in the YK Delta
Phenobarbital for Alcohol Withdrawal



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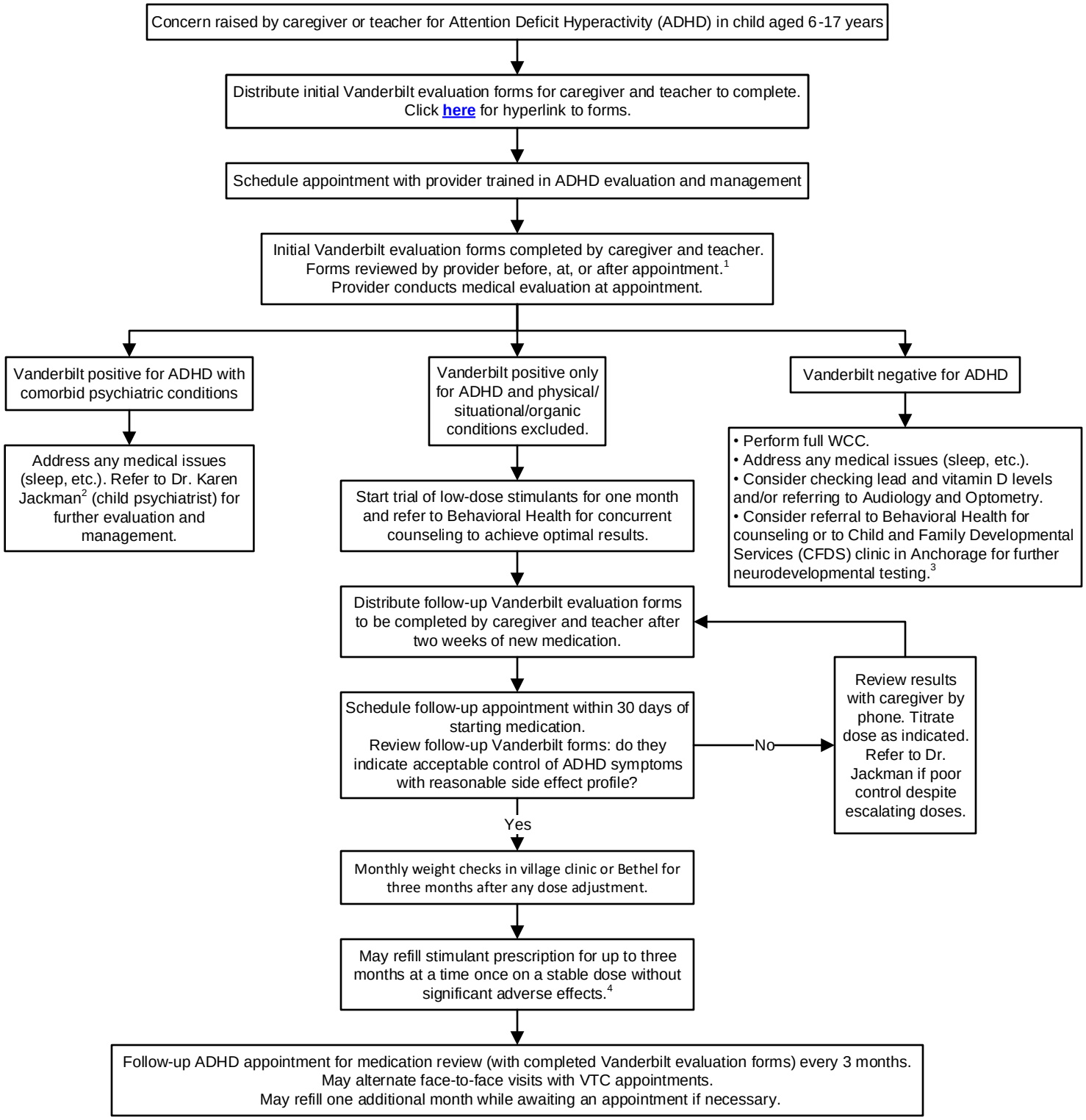
If comments about this guideline, please contact Megan_Young@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Attention Deficit Hyperactivity Disorder (Pediatric)



1. Scan completed Vanderbilt forms into MultiMedia Manager under "Continuity of Care."
2. To refer to Dr. Jackman: use "Refer to Peds Psychiatry Internal" order. Dr. Jackman may be contacted at (907) 230-3765 or jackman@alaska.net.
3. To refer to **CFDS** or other private psychologist: use "Refer to Other External" order and send a message to the case manager to process the referral.
4. E-prescribe three separate 30 day prescriptions after checking Alaska PDMP. Include the month the medicine is to be filled in the comments or special instructions section.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Intoxicated Patient

Mode of Arrival:
1. Bethel Police Department
2. Community Service Patrol
3. Alaska State Troopers
4. Walked in
5. Emergency Medical Services

Patient arrives in Emergency Department

Vital signs taken

Provider assesses patient

Patient is a minor

Patient is kept in Emergency Department

Discharged to home when a sober adult relative is located

Once sober, if no sober adult available to take custody, then OCS notified and will take custody of patient if they cannot locate a guardian.

Patient is a T-47

Patient is kept in Emergency Department

Behavioral Health on-call is notified

- Admit to inpatient unit
- Discharged to home
- Transferred to another facility

Patient is an adult with a medical problem

Patient is kept in Emergency Department

Medical tests are ordered and interpreted, patient is treated for medical condition and stabilized.

- Admit to inpatient unit
- Discharged to home
- Transferred to another facility
- Taken to jail when medically cleared
- Discharge to sober adult willing to take custody of the patient prior to the patient being sober.

Patient is an adult without a medical problem

- Patient is taken to jail after medical screening exam
- If jail is full, patient remains in the Emergency Department until clinically sober
- Discharge to sober adult willing to take custody of the patient prior to the patient being sober.

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Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Title 47 Hold

Village Referral
Transportation plan and pre-hospital communication plan per Behavioral Health

↓

Emergency Department Triage
- Police/ VPSO or physician to complete form MC-105 (official Title 47).
- Notify behavioral health clinician.
- One to one observation, patient undresses and belongings secured.
- Behavioral health may assist with obtaining mental health records.

↓

ER Physician Evaluation

↓

Assess (1) degree of suicidality, (2) risk of harm to self/others, or (3) grave disability.

↓

TITLE 47? — No → Discharge from Emergency Department once behavioral health plan is in place.

↓ Yes

- Discuss with admitting physician; may transfer to Anchorage directly from ER if necessary.
- Complete standardized orders.
- Consider chemical sedation if agitated:
  - Haloperidol 2.5 mg - 12 mg IM/PO titrate to effect
  - Lorazapam 2 mg - 5 mg IM/PO titrate to effect
- Consider physical restraints.
- Intoxicated patients require repeat evaluation of suicidality once sober.
- Conduct lab tests (Utox, tylenol/aspirin levels, EKG).

↓

Psychosis present? — No → Proceed with admission if Title 47

↓ Yes

- Prevent harm and control disturbed behavior.
- Consider consultation and/ or antipsychotic medication.
  - Olanzapine 5 mg - 10 mg Po q 24 hours
  - Haloperidol 5 mg IM/PO and lorazepam 2 mg IM/PO titrate to effect
- If first diagnosis of psychosis consider referral for CT/MRI.
- Conduct lab tests (CBC, Chem 8, LFT, TSH, RPR, Utox, HIV).

↓

Admit to NorthWing
- Close observation with behavioral health attendant.
- Patient undresses, belongings secured.
- Admission to observation room with standardized orders, complete observation/seclusion form.
- Understand and anticipate elopement protocols.

↓

- Admitting physician to determine treatment setting and plan of treatment; complete H&P within 24 hours.
- Collaboration with behavioral health clinician is essential for plan of care.
- Address substance use disorders.
- Establish a multiaxial diagnosis.

↓

Transfer to API, North Star, or Providence? — No → Establish outpatient treatment and follow-up plan in conjunction with Behavioral Health

↓ Yes

Discuss case with accepting physician.
Complete H&P with transfer plan.
Completed transfer packet.
Consider chemical sedation in transport.
Establish outpatient treatment and follow-up plan.

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If comments about this guideline, please contact Tara_Lathrop@ykhc.org.

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Yukon-Kuskokwim HEALTH CORPORATION

Trauma/Injury/Ingestion Guidelines

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Acetaminophen Overdose (Adult and Pediatric)

Contact Poison Control at 800-222-1222 for:
- pediatric patients <12 years of age
- polysubstance or Tylenol PM overdose
- any questions or advice

Patient presents with acute acetaminophen ingestion.

Intentional overdose → Notify BH on call.

Hours post-ingestion

< 4 hours:
- Consider activated charcoal if airway intact.
- If history is complete and toxicity is likely, start acetylcysteine 30-60 minutes after activated charcoal.
- Draw acetaminophen level and LFTs at 4 hours post ingestion.
- Consider UDS and aspirin level.

> 4 hours or unknown:
- Draw acetaminophen level, BMP, LFTs, and INR.
- Consider starting acetylcysteine while awaiting results.
- Consider UDS and aspirin level.

Plot results on nomogram.

Below toxicity → LFTs normal?
- Yes → Behavioral Health evaluation if intentional; otherwise discharge.
- No → Consider delayed diagnosis of overdose and other causes of elevated LFTs (hepatitis, etc.). Treat as appropriate.

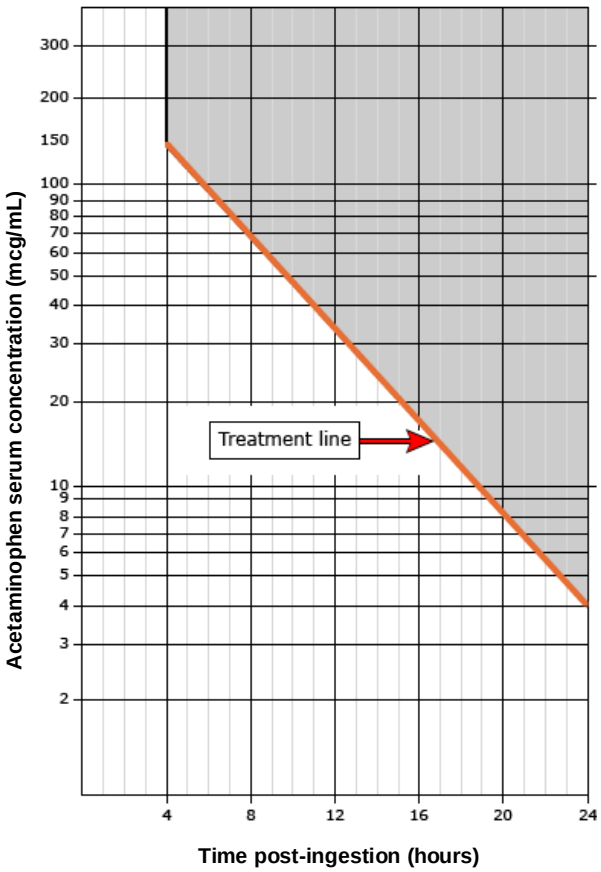
Above toxicity → Admit to hospital for IV or PO acetylcysteine. Consider consult with toxicologist/Poison Control.

Recheck acetaminophen level, BMP, LFTs, and INR Q6h.

- Acetaminophen level undetectable and normal LFTs and INR → Discontinue therapy.
- Acetaminophen level or LFTs elevated, INR>2, or hepatic encephalopathy → Continue acetylcysteine and consult Poison Control. Consider transfer.

Note:
- Remember history may be unreliable.
- If polysubstance ingestion, other substances such as diphenhydramine may affect absorption, so this guideline may be less relevant.

Rumack-Matthew Nomogram for Single Acute Acetaminophen Poisoning



Village Management
- If patient in village and toxicity is at all possible, start treatment with oral acetylcysteine and draw blood at 4 hours post ingestion. Instruct health aide to draw 2 mL (minimum 200 microliters) in a gold/SST or green top tube.
- Consider activated charcoal.
- Transport patient and blood work to Bethel on next available commercial flight, if stable.

Acetylcysteine Administration Protocols

1. IV 21 Hour Protocol: Dose is 150 mg/kg (max 15 grams) over 60 minutes immediately followed by 50 mg/kg (max 5 grams) over 4 hours immediately followed by 100 mg/kg (max 10 grams) over 16 hours.
Dilute with D5W or ½ NS. See **http://acetadote.com/dosecalc.php** for details on dose and dilution, especially in children under 40 kg.

2. PO 72 Hour Protocol: Dilute with strongly-flavored juice or soda. Mix one part medication with three parts juice/soda.
Loading dose is 140 mg/kg.
Maintenance dose of 70 mg/kg Q4h for up to 72 hours.
The villages carry vials of inhalation/oral solution that is 200 mg/mL in 30 mL vials.
See **this resource** for details on dosing, including diluent and dosing volumes for weight.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 2/5/20. Minor changes 4/8/21.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Burns (Adult and Pediatric)

Patient presents with a burn injury.

Assess VS, circulation, airway, and breathing.

Are there signs of impending airway compromise? See Box. — Yes → Consider early endotracheal intubation.

No

Assess total body surface area (TBSA) affected by partial or full thickness burns.

Adult TBSA > 10%? Child TBSA > 5%? Severe criteria? See Box. — Yes →
- IV access
- Analgesia
- Labs: CBC with diff, CMP, UDS, EtOH, CK, coags.
- If inhalation injury, add ABG, carboxyhemoglobin.
- If TBSA >15% in adult or >10% in child, give IVF per Parkland formula. See Box.

No

Wound Care
- Debridement as appropriate. Consider sedation.
- Cleanse in dilute chlorhexidine solution.
- Apply bacitracin or mupirocin and cover with Adaptic.
- Wrap with dry gauze.
- Elevate/compress affected extremities.

Consult General Surgeon.

Determine disposition. See Box.

Severe Criteria
- Circumferential burns
- Burns across joints
- Burns of face, neck, or groin
- Electrical/chemical burns
- Inhalation injuries/respiratory distress
- Trauma (refer to ATLS)
- Any full-thickness (3rd degree) burns

Signs of Impending Airway Compromise
- History of enclosed space fire (including house fire)
- Burn injury or soot in oropharynx
- Stridor or wheezing
- Circumferential burn of neck

Village Management

For any burn that warrants travel to Bethel, instruct health aides to apply bacitracin and NOT silvadene to avoid painful cleaning of wounds in Bethel.

Disposition Considerations/Criteria

Village: *wound care by health aides over RMT, consider PT by telehealth.*
- Pain controlled on PO regimen.
- No sign of wound infection.
- Unlikely to require further debridement.
- Patient/caregiver/health aide able to perform dressing changes.

Outpatient (ED/Outpatient Clinic/PT): *daily follow-up for wound management and ROM exercises.*
- Wound infection improving on PO antibiotic regimen.
- Debridement not more than once/day.
- Dressing changes not more than twice/day.
- Need for PT assessment not more than twice/week.

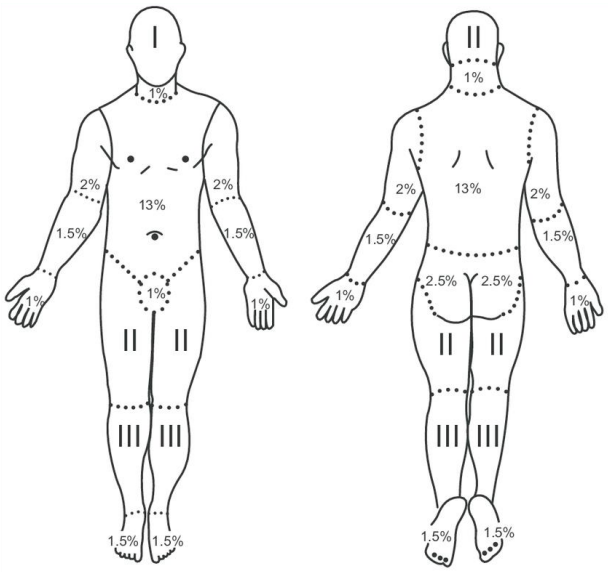
Inpatient YKHC:
- Pain uncontrolled on oral medications.
- Dressing changes more than twice/day.
- Wound infection requiring IV antibiotics.
- Nonambulatory (including wounds on both feet).

Inpatient ANMC:
- Critical illness.
- Wound requiring operative debridement or grafting.
- Surgeon recommends higher level of care.
- Child with severe criteria.
- If expected wound care exceeds currently available resources at YKHC.

Findings Concerning for Abuse
- Delay in seeking care
- Variations in history
- Injuries inconsistent with history
- Immersion injuries
- Uniform depth
- Well-demarcated burn margins
- Geometric pattern/object imprint

If any concern for abuse, send a message to Child Abuse on Call by Tiger Connect.

Lund and Browder Chart to Estimate TBSA in Adults and Children



Age	0	1	5	10	15	Adult
Front or back half	(%)	(%)	(%)	(%)	(%)	(%)
I (Head)	9½	8½	6½	5½	4½	3½
II (Thigh)	2¾	3¼	4	4¼	4½	4¾
III (Leg)	2½	2½	2¾	3	3¼	3½

Modified Brooke/Parkland Formula

Only used if TBSA >15% in adults or >10% in children.

(weight in kg) x 2-4 mL x %TBSA = total fluid to be given over 24 hours
Do not convert %TBSA to a decimal. For example, 15% TBSA would be 15.

Give half in first eight hours from time of burn. Give other half over the next sixteen hours.

LR to be used unless mitigating circumstances.

Classification of Burns by Depth

Burns evolve over time; initial TBSA and depth classification can change and often the difference between deep partial thickness and full thickness can only be determined operatively.

- Superficial (1st degree): epidermis only, dry, red, blanches with pressure, no blisters, painful.
- Superficial partial-thickness (2nd degree): epidermis and part of dermis, blisters, moist, red, weeping, blanches with pressure, painful.
- Deep partial-thickness (2nd degree): epidermis and deep dermis, blisters, wet or waxy dry, patchy white to red, does not blanch, pressure sensation only.
- Full-thickness (3rd degree): epidermis and entire dermis, waxy white to leathery gray to charred/black, dry and inelastic, does not blanch, sensation to deep pressure only, may be defined as 4th degree with extension into underlying fascia, muscle, or bone.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/2/20. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Travis_Nelson@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Frostbite (Adult and Pediatric)

Patient identified as having potential frostbite

For patients in village clinic, see CHAM.

Immediate Emergent Treatment

STABILIZE PATIENT: Airway, Breathing, Circulation → Assess for and treat hypothermia

Consider Photos
1. Initials, date, and time with tape measure.
2. Post-debridement for monitoring.

RAPID REWARMING of affected area using warm water bath at **98.6-102.2° F** → Consideration should be given for thrombolytics in the first 24 hours, consult with ANMC orthopedics

1. LABS:CBC, CMP
2. IV Fluids for hydration and pain control with IV Morphine → **Strongly Consider Hospital Admission, especially with extremity frostbite**

Wound care referral upon admission

TOPICAL TREATMENT:
1. Aloe Cream (Dermaide) Q 6 hours
2. Unless infection is strongly suspected **do not use** topical antibiotics
3. If infection is suspected, use bacitracin
4. For exposed skin layers, use adaptic to prevent adhesion and then use Kerlex fluff roll gently wrapped around affected area to protect.
5. Soaking with mild bleach bath: 10-15 min BID – 1.5 mL of 6% sodium hypochlorite per gallon of bath water (60 mL for the 40 gallon tub)

DEBRIDEMENT
1. Clear Bulla may be debrided or aspirated at time of admission or initial treatment.
2. Leave hemorrhagic blister and bulla intact as that indicates deeper, more vascular tissue damage.

Note: people in crises such as frostbite have lots of time to think and are open to change. Alcohol, nicotine, and behavior modification counseling are very effective during these times.

REFERRALS AND CONSULTS:
1. Behavioral Health referral for severe frostbite or if alcohol is involved.
2. Nutrition consult
3. Tobacco cessation referral

NURSING ORDERS:
1. Elevate area
2. Non weight-bearing – this includes blankets AVOID ANY PRESSURE

MEDICATION:
1. Pain management
2. Ibuprofen 400 mg QID
3. Protein Supplement, if indicated
4. Vitamin C 500 mg daily
5. Multivitamin one daily
6. Stool softener

LONG TERM CONSIDERATIONS:
1. Neurontin for nerve pain – start with 300 mg TID
2. Grief counseling if loss of body part at appropriate time
3. Physical Therapy for rehabilitative care
4. Referrals as needed for surgery (3 months)
5. DME for supplies.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Head Injury in Patients < 18 Years Old

Head injury in a child <18 years.

If GCS ≤ 8, intubate and refer to PALS stabilization algorithms.

Low Risk
GCS=15
AND
No risk factors (see Intermediate and High Risk boxes)

→ Discharge with head injury education and competent caregiver

Intermediate Risk
GCS=15
AND one or more of the following:
- Occipital, parietal, or temporal scalp hematoma
- Loss of consciousness > 5 seconds
- Not acting normal per parent
- **Severe mechanism of injury****
- If older than 2: vomiting or severe headache
- Amnesia

High Risk
One or more of the following:
- GCS≤14
- **Altered mental status***
- Signs of skull fracture
- Focal neurological deficits
- Seizure
- Loss of consciousness > 1 minute

*__Altered Mental Status__
- agitation/irritability
- inconsolability
- somnolence/lethargy
- slow response
- repetitive questions

__Factors to consider when deciding to observe vs perform head CT__:
- Provider experience
- Multiple vs isolated findings
- Worsening signs/symptoms
- Age <3 months
- Parental preference

__C-spine Imaging__
- Spinal motion restriction should be continued in neurologically abnormal patients until spinal column or cord injury has been excluded.
- See Nexus Criteria for C-spine imaging protocol.

**__Severe Mechanism of Injury__
- Fall: >3 feet if younger than 2 years, >5 feet if older than 2 years
- Motor vehicle accident with ejection, rollover, or fatality
- Unhelmeted bike/ pedestrian vs vehicle
- Head struck by high-impact object

__Observation__
- Observe in the ER 4-6 hours post-injury.
or
- If presenting >4 hours post-injury AND not improving per caregiver, observe 4 hours.

Not improved → __CT Scan__: Perform noncontrast head CT with spinal motion restriction

Improved → Discharge with head injury education and competent caregiver. Consider concussion follow-up (see Concussion Management box).

CT Scan → Normal / Abnormal

Normal → Is patient improving? Yes → Discharge with head injury education and competent caregiver. Consider concussion follow-up (see Concussion Management box).

Is patient improving? No → Consult PICU and trauma service.

__Village Management__
- If Low Risk: discharge home with head injury education and competent caregiver.
- If Intermediate Risk: consider medevac vs observation with Q1h VS and neuro checks.
If any worsening, activate medevac.
If not improving over 4 hours, activate medevac.
- If High Risk: activate medevac.

Plain films of the skull are not recommended.

In all pediatric trauma, consider further evaluation for non-accidental trauma (skeletal survey, dilated eye exam, etc.)

__Concussion Management__
- Complete **Acute Concussion Evaluation** at every visit.
- Follow-up in outpatient clinic in 1-2 weeks.
- Consider balance testing.
- Avoid medications that can worsen somnolence.
- If symptoms persist >3-4 weeks, consider referral to neurologist, psychologist, physical therapy, etc.
- Return to school per **CDC Heads Up Protocol**.
- Return to play per **ASAA Guidelines**.

Pediatric Glasgow Coma Scale (GCS)

	Infant	Child	
Eye opening	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain	To pain	2
	No response	No response	1
Best verbal response	Coos, babbles	Orientated, appropriate	5
	Irritable cry	Confused	4
	Cries to pain	Inappropriate words	3
	Moans to pain	Incomprehensible sounds	2
	No response	No response	1
Best motor response	Moves spontaneously	Obeys commands	6
	Withdraws to touch	Localizes painful stimulus	5
	Withdraws to pain	Withdraws to pain	4
	Flexion to pain	Flexion to pain	3
	Extension to pain	Extension to pain	2
	No response	No response	1

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 5/8/19. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Leslie_Herrmann@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Rabies

Patient reports animal bite (or exposure to brain tissue) from animal who is a possible reservoir for rabies (dog, fox, bat, wolf)

Does the patient require rabies post-exposure prophylaxis? See Box 1.

No → Provide usual wound treatment. Consider amoxicillin-clavulanate prophylaxis for open wounds.

If patient needs extensive wound care, recommend immediate travel to ED for treatment.

Yes or maybe

Patient in village?

No →
1. Patient presents to ED or outpatient clinic.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Provider forwards the final note to the OEH department pool.

Patient is given Day 0 vaccine, and the wound is infiltrated with immunoglobulin.

Appointment is made for the outpatient clinic for Days 3, 7, and 14.
If any of these fall on a weekend, patient is seen in the ED.

Yes →
1. Health Aide completes visit in RAVEN.
2. Ad hoc form in RAVEN entitled "Rabies Investigation Report" is started.
3. Patient is reported to RMT provider.
4. Provider forwards the final note to the OEH department pool.

1. RMT provider orders the vaccine for HAND CARRY to village clinic – 3 doses.
2. Contact inpatient pharmacy on call to arrange the HAND CARRY to the village.

Patient is given Day 0 vaccine in village clinic.

Day 3 vaccine and immunoglobulin given in Bethel outpatient clinic unless it is the weekend (then patient goes to ED). At that visit:
-Wound is assessed.
-Immunoglobulin is infiltrated directly into wound site.

Day 7 & 14 vaccine given in village.

Box 1

Indications for rabies prophylaxis:
1. The bite was from a fox, bat, coyote, skunk, woodchuck, or wolf, and this animal is not available to test.
2. The bite was from a dog who was behaving abnormally.
3. The bite was from a dog not available for quarantine.
4. If the dog is available for quarantine, do not start post-exposure prophylaxis regardless of vaccination status. OEH (Office of Environmental Health) will initiate a 10-day quarantine. Please check under "all documents" for Alert Note or for the rabies investigation report from OEH.
5. If consultation is needed, call OEH at 543-6420 or State Section of Epidemiology 907-269-8000 or 800-478-0084 after hours.

Other Resources

- See the **supplement** to this guideline on the wiki.
- **State of Alaska DHSS Rabies** page.
- Use the Power Plans "AMB/ED Rabies Prophylaxis" to find all necessary orders.

Notes:
- Day Zero is the first day the vaccine is given, not the day of the exposure.
- Immunoglobulin must be given within seven days of first vaccine dose.

If patient is immunocompromised, he/she requires an additional dose on day 28.

Required Notifications:

- The Rabies Investigation Report is an ad hoc form that is started by the CHA/P in village clinic or by the ED/outpatient clinic provider when the patient first presents for care. This is sent electronically to the OEH (Office of Environmental Health) who will follow up on the status of the dog. Please check under "all documents" for this and for recommendations from OEH.
- Forward your PowerChart note to Rabies Control Officer Pool and OEH Department Pool.

Animals in Alaska that have tested positive for rabies:
1. Arctic fox
2. Caribou
3. Cat
4. Coyote
5. Dog
6. Keen's myotis bat
7. Little brown bat
8. Red fox
9. Reindeer
10. River otter
11. Wolf
12. Wolverine

For village patient:
Day 0 dose: Given in village from HAND CARRY.
Day 3 dose: Given in Bethel.
Day 7 dose: Given in village from HAND CARRY.
Day 14 dose: Given in village from HAND CARRY.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 12/2/20. Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Abigail_Klager@ykhc.org.

Return to Table of Contents.

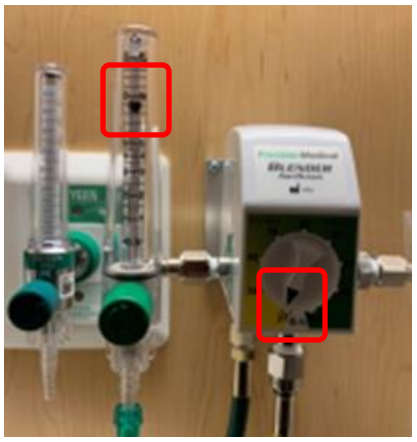
Neonatal Reference

Yukon-Kuskokwim HEALTH CORPORATION

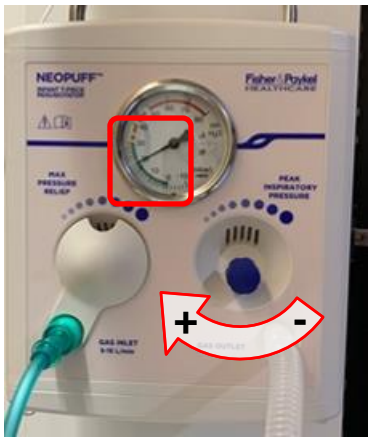
Clinical Resource

Setting Up the Neopuff™ T-piece Resuscitator in Patient Rooms on OB

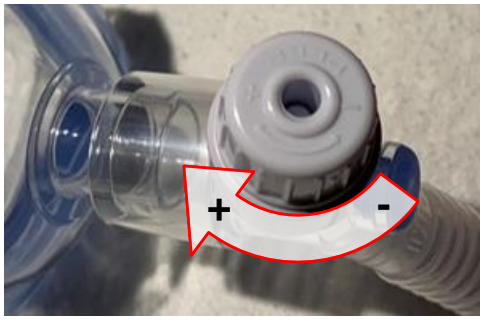
Attach the oxygen tubing to a 15 L flow meter.
Set blender to 21% and consider increasing depending on clinical status.
Set the flow meter to **10 L**.

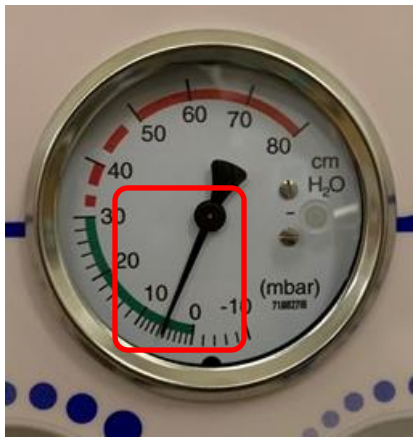


Occlude both the mask and the hole.
Set the PIP: Turn the knob labeled Peak Inspiratory Pressure until the arrow on the dial points to **20**.



Occlude only the mask.
Set the PEEP: Turn the PEEP knob until the arrow on the dial points to **5**.





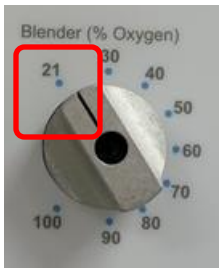
Troubleshooting: If you cannot achieve the desired pressures, try changing the liters on the flow meter or turning the Max Pressure Relief knob located under the flap.

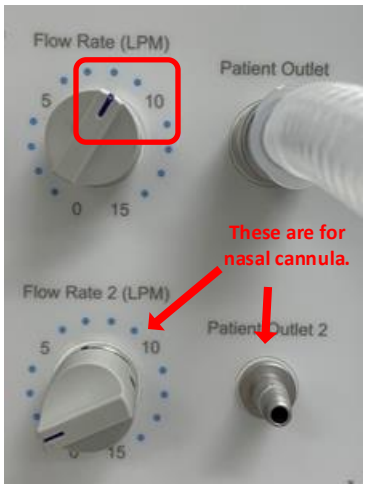
Yukon-Kuskokwim HEALTH CORPORATION

Clinical Resource

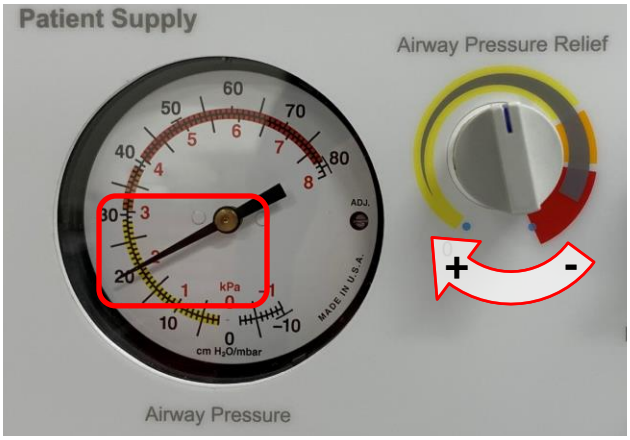
Setting Up the Neopuff™ T-piece Resuscitator in the Nursery

- To use suction, ensure that both the Suction and Gas Supply ON/OFF switches are ON.
- Set blender to 21% and consider increasing depending on clinical status.
- Set the top flow meter to **10 L**.
- The bottom flow meter is for use with nasal cannula.

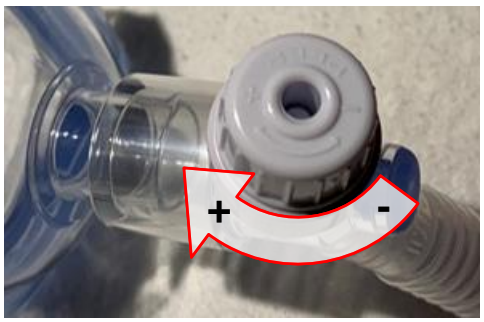


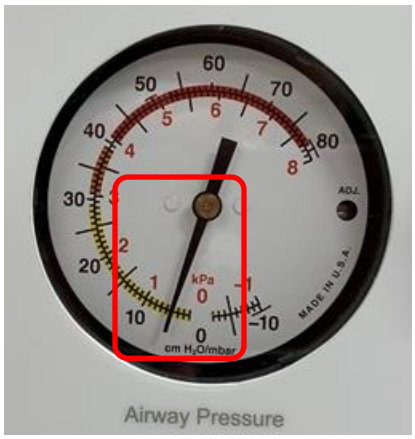


- Occlude both the mask and the hole.
- Set the PIP: Turn the knob labeled Airway Pressure Relief until the arrow on the dial points to **20**.



- Occlude only the mask.
- Set the PEEP: Turn the PEEP knob until the arrow on the dial points to **5**.





Troubleshooting: If you cannot achieve the desired pressures, try changing the liters on the flow meter.

Coming soon...

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Resource

Surfactant Administration Protocol

Indications for Curosurf®

- GA<26 weeks.
- GA 26-29 weeks with supplemental oxygen requirement ≥ 40%.
- GA>29 weeks with CXR-proven RDS.

Curosurf® Storage

- Curosurf® is stored at 36-46°F.
- If warmed and not opened or used, may be returned to refrigerated storage one time.
- Curosurf® is located in the OB medication refrigerator. If going on a medevac, ask the nurses to get the Curosurf®. It can be stored in a pink thermal bag that is kept next to it in the refrigerator.

Reference:

See this **YouTube video** for a demonstration of the Y catheter.

Preparation of Curosurf®

- Warm to room temperature and gently invert. Do not shake.
- Choose Curosurf® dose using the **Neonatal Resuscitation Summary** using estimated gestational age. If weight is known, calculate dose to be 2.5 mL/kg.
- Draw up total Curosurf® dose using a 20 gauge or larger needle.

Preparation of Equipment and Patient

- Prior to intubation, if possible, check the ETT cap and make sure it comes on and off easily.
- Make sure you have the correct size Y cap for the ETT size.
- Check fit of Y cap on ETT. Attach catheter and feed it down the tube until it is ½ cm past the tip. Look for the number or color that will tell you the depth of the catheter at this point.
- Intubate patient with ETT cap on tube.
- Verify placement and secure tube.

Administration of Curosurf®

- Infant should be supine.
- Disconnect Neopuff, bag, or ventilator.
- Remove ETT cap and replace with Y cap. (If ETT cap is stuck, cut the tube as high as possible and then place the Y cap.)
- Attach the Neopuff or bag to the larger port on the Y cap.
- Attach the catheter to the smaller port on the Y cap and advance it until it is at the desired depth.
- Inject the syringe of Curosurf® through the catheter.
- Pull the catheter all the way out but leave attached.
- Bag the baby at a rate of 40-60 breaths/minute for one minute.
- Allow the baby to recover.
- Remove the Y cap and replace the ETT cap.
- Resume ventilation.
- Do not suction for one hour after administration unless required for obstruction.
- Remember to adjust pressure on Neopuff as lung compliance improves.

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Resource

Village Deliveries (Pediatrics)

Preparation in the Village for the Health Aides

• Turn the heat up until everyone is sweating. May need extra space heaters.
• In the warmest part of the clinic, prepare a table with clean blankets, towels, etc.
• If the clinic has a dryer, instruct the health aides to warm the blankets there prior to birth.
• Ensure the following are prepared and functional: suction, oxygen tanks and tubing, BVM with smallest available mask, bulb suction.
• If available, set up desk lamps with old-style bulbs (not the spiral energy-efficient bulbs) to generate more heat.
• Seek out extra health aides or former health aides to help.

Preparation for Medevac

• Review prenatal history and note risk factors for the baby.
• Coordinate with family medicine hospitalist activating the medevac and LifeMed crew about when to meet at the hangar. The LifeMed hangar is located at 3600 Tower Road.
• Turn over the Tiger Connect role for "Peds Wards on Duty" to another pediatrician or the family medicine hospitalist staying behind.
• Establish roles with LifeMed crew. Discuss doses and equipment based on estimated GA.

What to Bring

• Curosurf if GA <32 weeks or unknown: located in the OB medication refrigerator. Place in pink thermal case.
• OB & Pediatric Village Delivery Backpack containing OB and pediatric supplies located in the nursery.
• Resources: **Neonatal Resuscitation Summary**, **Surfactant Administration**, **Neopuff Set Up Guide**, **Pneumothorax Evacuation**, **Neonatal Glucose Screening Guideline**.
• Warm clothing. (There is extra warm gear under the bed in the peds call room)
• Snacks, drinks, money, motion sickness medication.

Delivery is Imminent

• Set up monitor, Neopuff, and intubation equipment (all carried by LifeMed), using sizes recommended by **Neonatal Resuscitation Summary**.
• Activate chemical mattress just prior to delivery. Cover with single baby blanket.

For High Risk Deliveries, including GA <32 weeks:
• Discuss with neonatologist early – call (907) 212-3614.
• Activate medevac to Anchorage. Consider direct transfer from village, ramp transfer in Bethel, or further stabilization with NICU team in Bethel, as appropriate.
• Prepare polyurethane bag.

Delivery is not Imminent

• Hospitalist assesses mother, does vaginal exam, obtains cultures, etc.
• LifeMed crew cares for mother.
• Pediatrician should help however possible and otherwise stay out of the way.
• Occasionally a mother will be transported to Bethel dilated and in labor. This decision is made if the benefit of being at a higher level of care outweighs the risks of potential delivery en route.

Resuscitation

• Resuscitate per NRP algorithm. Remember that CPAP is a great tool for non-invasive respiratory support for transport.

For infants <32 weeks:
• Place infant directly into polyurethane bag without drying. If intubated, bag may cover face/head.
• Attempt IV or UVC access early.
• See **Surfactant Protocol**, if indicated.

Prior to Transport

• Communicate with OB staff so they are prepared.
• Ensure an Anchorage team has been activated, if needed.

Medications

• Give erythromycin to eyes and vitamin K IM if infant is stable.
• Hepatitis B and HBIg can wait until arrival in Bethel.
• Give ampicillin per Neonatal Resuscitation Summary for all preterm and high risk infants.
• Gentamicin should not be given in the village, as it is high-risk.

Temperature

• Hypothermia in newborns is defined as temp <97.7°F.
• Cold babies do very poorly.
It is better to over-prepare (use a polyurethane bag in term babies, etc.) rather than under-prepare.
• The baby pod carried by LifeMed does not have a heat source. It will not generate heat. Avoid placing the baby into it until it has warmed from being outside.
• Check axillary temperature at 5 minutes of life and then Q30 minutes.
• Place a hat and/or saran wrap on the baby as soon as possible.
• Do not remove hat, chemical mattress, or polyurethane bag until arrived at YKHC.
• You may tear holes in the bag to gain access to the baby for procedures.
• Avoid weighing premature babies, as this frequently contributes to heat loss in the village.

Glucose

• Check glucose as soon as possible.
• See **Neonatal Glucose Screening Guideline**. Goal glucose is >35 in first four hours of life.
• On babies <32 weeks, start D10 maintenance as soon as IV access has been established.
• If unable to get a glucose, have a low threshold to give sugar in preterm or high risk infants.
• If oral dextrose gel unavailable, may give Sweetease, oral glucose, colostrum, formula, or homemade sugar paste. May smear on gums for buccal absorption.

Procedures

Intubation
• Prepare equipment.
• Wipe upper lip and rest of face.
• If need for sedation is anticipated, use morphine 0.05 mg/kg.
• Intubate and confirm placement with auscultation and $ETCO_2$ detector.
• Tape tube with Benzoin and tape.
• Consider using Neopuff to ventilate en route rather than ventilator.

UVC *(Always attempt PIV placement first unless infant is very unstable.)*
• Use sterile technique.
• Flush catheter and stopcock with sterile saline. NOTE: the syringes for premade saline flushes are not sterile. You will have to use a sterile syringe to draw up flushes from a NS bag.
• If baby is in polyurethane bag, tear a small opening in the plastic.
• Place the UVC just far enough to get blood return.
• Cover skin around umbilicus with Tegaderm. Tape the UVC to the Tegaderm to secure it.

See **Surfactant Administration** and **Pneumothorax Evacuation** Resources.

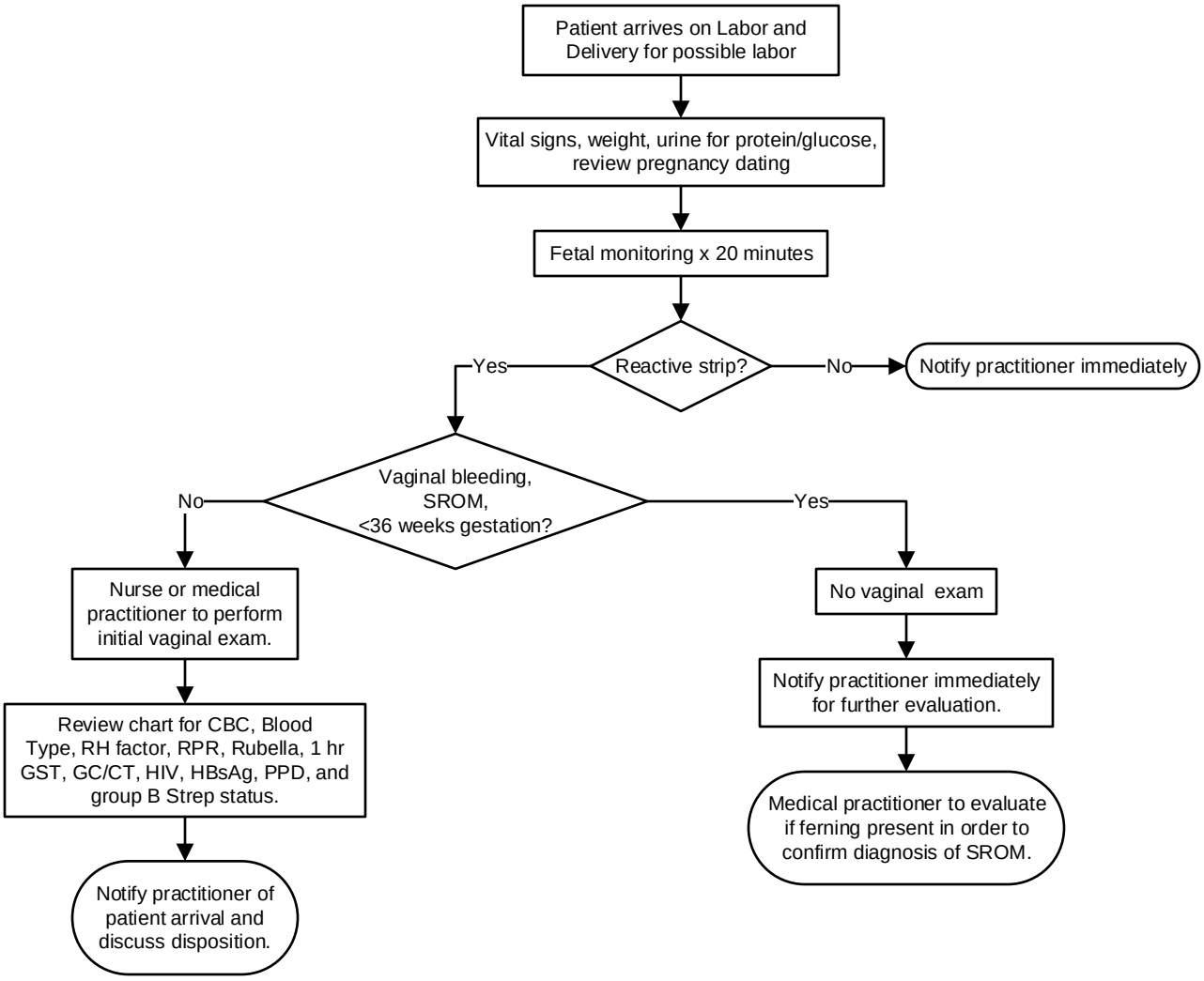
Yukon-Kuskokwim HEALTH CORPORATION

Obstetrics Protocols/Reference

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Antepartum Patient



This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 6/22/11.
Click here to see the supplemental resources for this protocol.
If comments about this resource, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Prenatal Care Guidelines

BASICS

- Review the chart EVERY visit for incomplete lab or other required testing.
- Review the Problem List EVERY visit for needed testing or intervention items.
- Patient should see a Bethel provider or CHA/P monthly from first visit to 32 weeks.
- Patient should see a Bethel provider or CHA/P every two weeks after 32 weeks and then weekly at 36 weeks.
- If there is any question of EDC, see guideline or refer to HROB meeting for decision.

First Prenatal

NURSING/CASE MANAGER

- Order First Trimester Transvaginal OB Ultrasound (>6 weeks) for dating.
- Patient to initiate paperwork:
  - Residential Information Sheet.
  - Pregnancy Verification Sheet – use LMP if no EDC from ultrasound.
  - Quad screen consent form.
  - FAS & Drug Assessment Screening questionnaire.
  - 36 Week BIB/Medevac Policy.
- Review TB screening status – patient MUST HAVE a negative Quantiferon or PPD prior to 36 weeks to stay at Prematernal Home. Place PPD if needed.
- Labs: urinalysis, urine culture, blood type and screen, HBsAg, Hepatitis C antibody, CBC, Rubella titer, HIV testing, treponemal testing, HgA1c, 25-OH vitamin D.
- Set up room for pelvic to do PAP (only do a PAP if it is due), GC/CT and trichomonas (with verbal consent).
- Routine patient handouts: WIC handout.

PROVIDER

- Prenatal H&P and Prenatal Education.
- Chart review.
- Offer flu vaccine October through the end of the flu season.
- Discuss and sign BIB/Medevac Policy contract.
- Update the Problem List and include EDC and gravida/para in one problem.
- Refer to HROB meeting if needed.
- Ask about S/Sx of IHCP; if present, add bile acids and LFTs to lab draw.

PATIENT

- Go to the Medicaid office to file for Medicaid.
- Go to the WIC office to file for WIC.

15-21 Weeks

- If desired, quad screen must be drawn between 15 and 21 weeks gestation.
- Review TB status.

20 Weeks

- Ultrasound to screen for anomalies: US OB anatomy and cervical length.
  - Only one is needed no matter where it is done.
  - Aim for 20 weeks.
  - If anatomy is incomplete, order US OB follow-up for the next visit to complete the anatomy exam.

24-28 Weeks

NURSING

- Labs: GST, CBC.
- Tdap after 24 weeks.
- GST – 50 g:
  - If result >140 mg/dL, schedule 2 hour GTT ASAP.
  - If the result >179, no GTT; refer directly to diabetes education.
- Attempt to keep the patient until the results of the GST are back.
- Review TB status. Draw Quantiferon if failed to have PPD read.

PROVIDER

- After 28 weeks, ask about preeclampsia symptoms.
- After 24 weeks, ask about preterm labor symptoms and IHCP symptoms.
  - Back pain.
  - Sudden increase in vaginal discharge.
  - Pelvic pressure.
  - Cramps/contractions.
- Educate patient on fetal movement count.

36 Weeks/BIB Date

- Labs: CBC, treponemal testing, HIV testing, GBS culture, GC/CT and trichomonas.
- Review TB status. Draw Quantiferon if status unknown.
- Schedule appointments to be seen each week by Bethel provider through 41 weeks.
- Complete Prematernal Home/Medical Clearance paperwork.
- Ask about any symptoms of:
  - Rupture of membranes.
  - Preeclampsia.
  - Labor.
  - Itching.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 7/6/21.
Click here to see the supplemental resources for this protocol.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

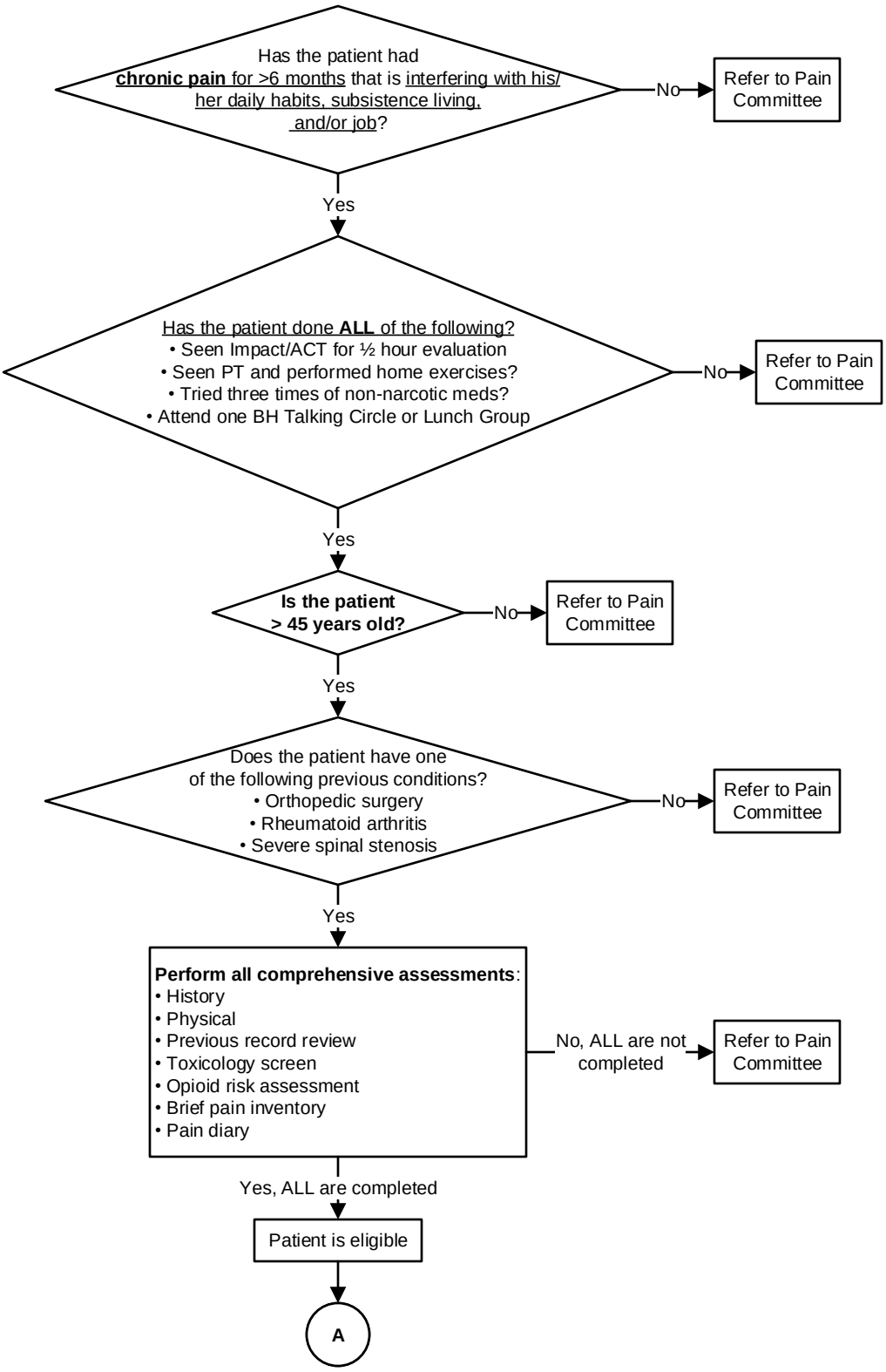
Outpatient Protocols

Outpatient Protocols/Reference

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Chronic Pain: Narcotic Treatment Eligibility



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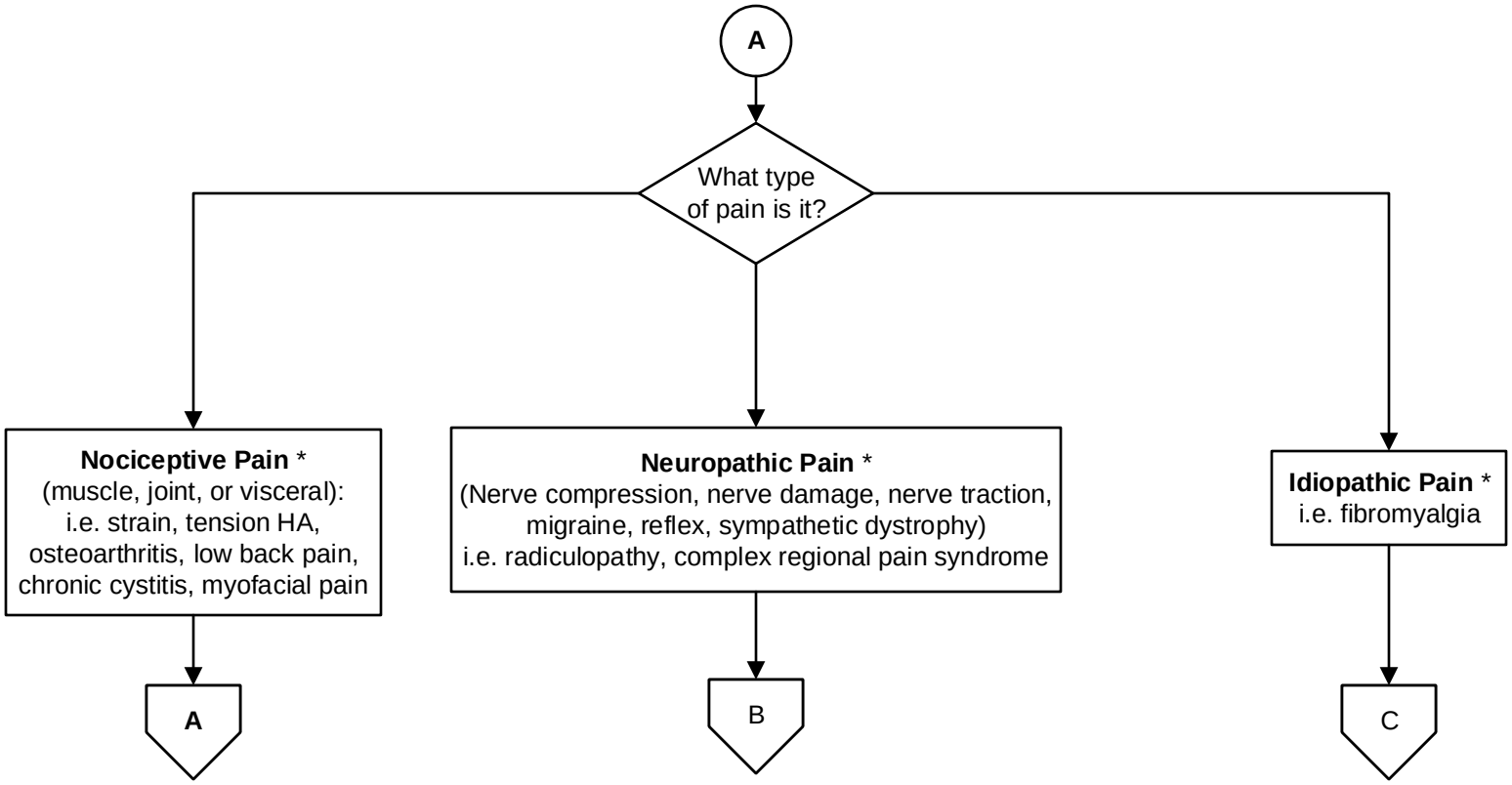
Approved by MSEC 1/21/15.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Chronic Pain: Non-Narcotic Treatment



***Treatment Options for all types of pain:**
Sleep Hygiene, Yoga, Meditation

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Approved by MSEC 1/21/15.
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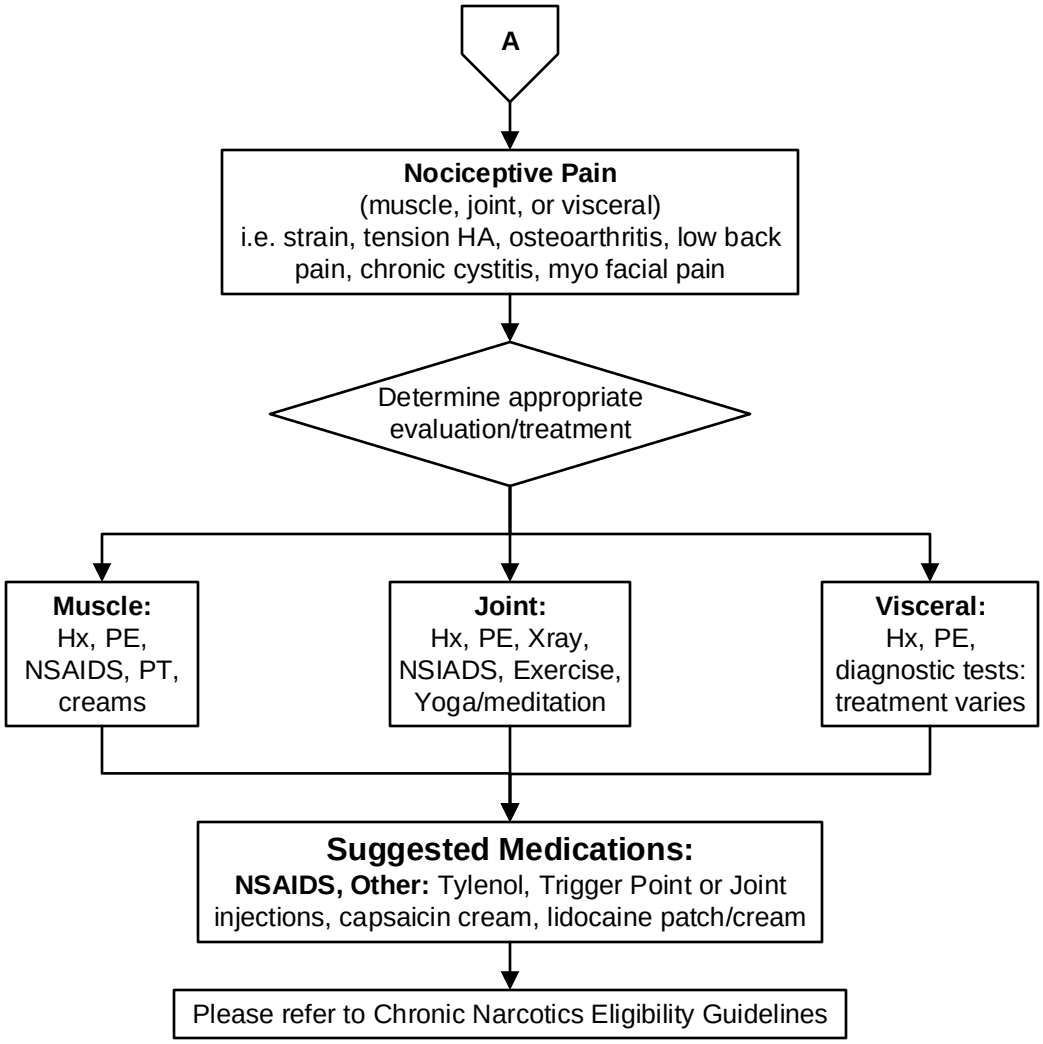
Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Chronic Pain: Non-Narcotic Treatment



Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Chronic Pain: Non-Narcotic Treatment

B

Neuropathic Pain
(Nerve compression, nerve damage, nerve traction, migraine, reflex, sympathetic dystrophy)
i.e. radiculopathy, complex regional pain syndrome

Determine appropriate evaluation/treatment

Nerve Compression: Hx, PE, EMG's/MRI, consider surgical decompression

Nerve Damage: Hx, PE, labs, EMG's, antidepressants, Gabapentin

Nerve Traction: Hx, PE, EMG's, NSAIDS, PT, Yoga/Meditation

Migraine: Hx, PE, NSAIDS, triptans, prophylactic drugs

Reflex, Sympathetic Dystrophy: Hx, PE, Lidocaine patches

Suggested Medications:

Antidepressants:
First line TCAs, duloxetine

Gabapentin, NSAIDS

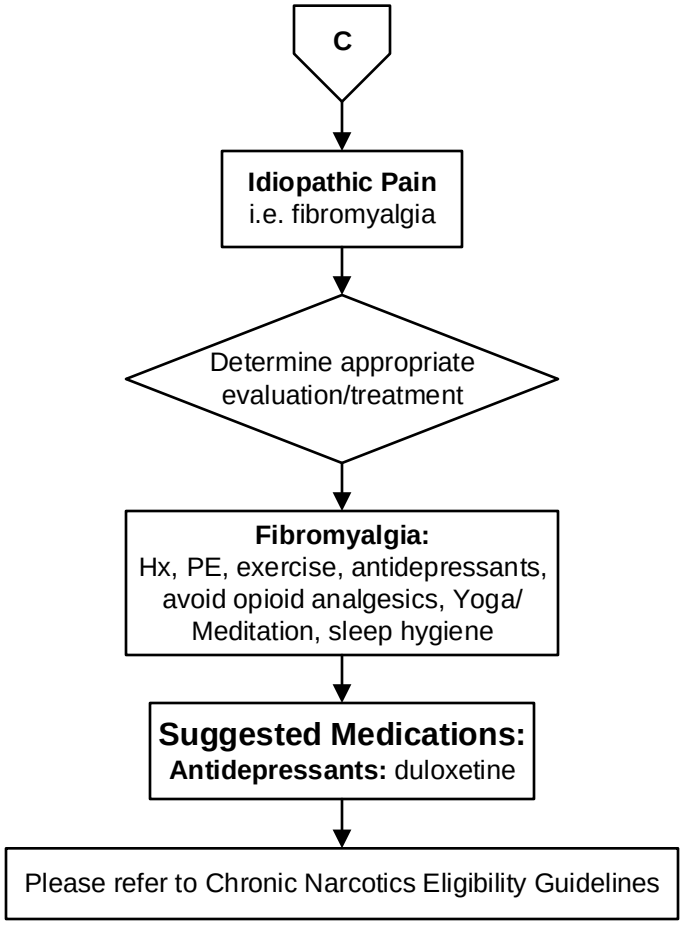
Migraine Specific:
Cafegot, dihydroergotamine, Midrin, Imitrex, beta blockers, other prophylactic medications

Please refer to Chronic Narcotics Eligibility Guidelines

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Chronic Pain: Non-Narcotic Treatment



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Treatment Protocol

Case Manager/Pharmacy Re-assessment and Follow-up of Chronic Pain

Follow up and reevaluation:
Assess for:
1. functionality
2. adverse effects
3. achievement of goals
4. analgesia
5. behaviors of concern: see flow sheet

Behaviors of Concern
1. ETOH abuse
2. Poly-drug abuse
3. Cocaine abuse (+tox screen)
4. Forgery
5. Stealing. Buying from the street.
6. Negative tox screen for prescribed opioid/benzodiazepine.
7. Hospitalization related to substance abuse.
8. Drug overdose.
9. Injection oral medications.
10. Visit to ED with intoxication.
11. Specific opioid/benzodiazepine (by name) request.
12. Multiple unsanctioned opioid/benzodiazepine dose escalations.
13. Recurring loss/stolen opioid/benzodiazepine prescriptions.

Were goals achieved?

Yes → Reassess q 6 months, review agreement, revisit goals, taper as indicated.

No, 1st time → Reevaluate diagnosis, goals, Tx.

No, 2nd time → Reevaluate diagnosis, goals, Tx.

No, 3rd time → **Assess goal failure:**
1. Opioid non-responsive pain
2. Incorrect diagnosis
3. Psychiatric illness
4. Unrealistic goal-setting
5. Secondary gain (e.g. litigation)
6. Diversion and/or abuse
7. Consider Behavioral Health Consult

Behaviors of concern (see box)?

Yes →
- Refer to committee for review via pain committee order
- Consider stopping outpatient opiates while under review
- Monitor and use Compliance Tools (eg pill audits, UDS)
- Review at pain review.
- Evaluate strikes; if three, cancel contract.
- Reassess with patient's request letter.
- If significant efforts of treatment, consider restarting agreement.

No, 1st time → Consider Toxicology Screen → Change treatment/ agreement.

No, 2nd time → Consider Toxicology Screen → Change treatment/ agreement.

No, 3rd time → Consider Toxicology Screen → Consider referral to pain specialist, behavioral health, addiction therapy. → Refer to Pain Committee via order

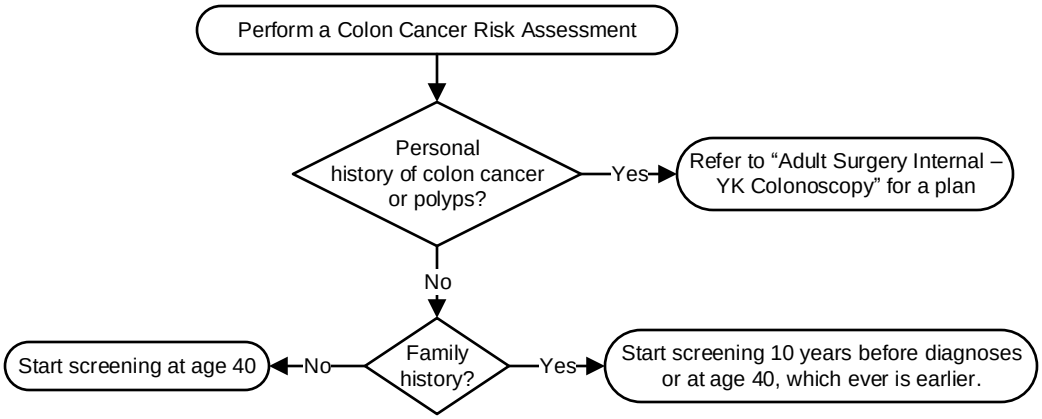
For terminal cancer patients (with life expectancy less than or equal to 6 months) who have previously demonstrated good compliance with Chronic Medication agreement, documentation of titration for pain control as appropriate is acceptable without requiring new agreement. Continue to monitor for achievement of goals/behaviors of concern.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 1/21/15.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

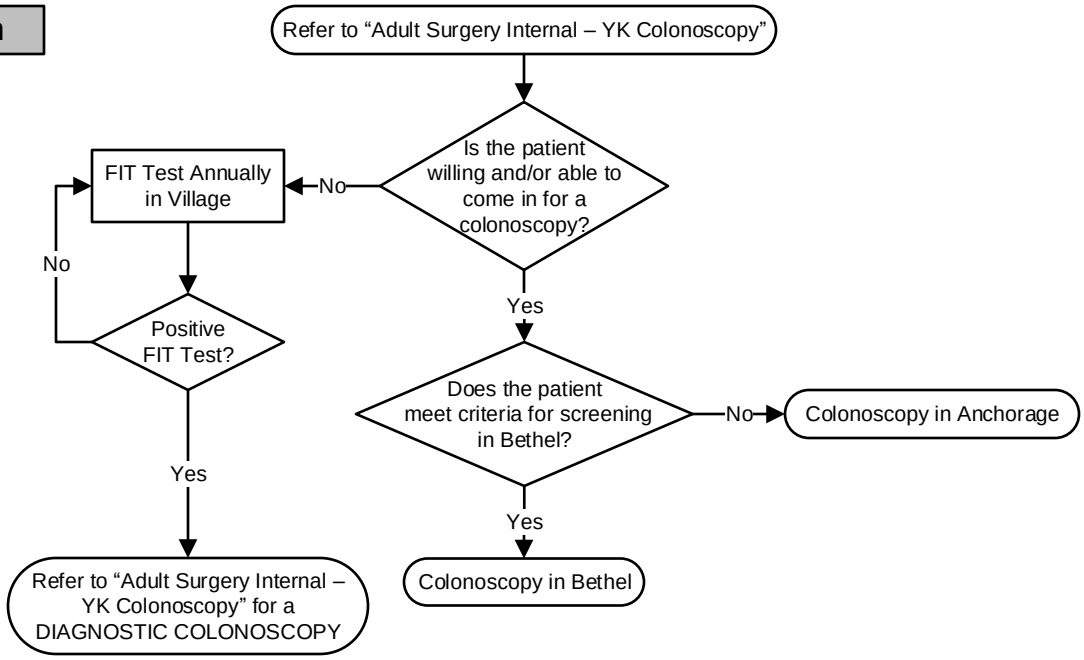
Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol
Colon Cancer Screening

When to Screen



How to Screen



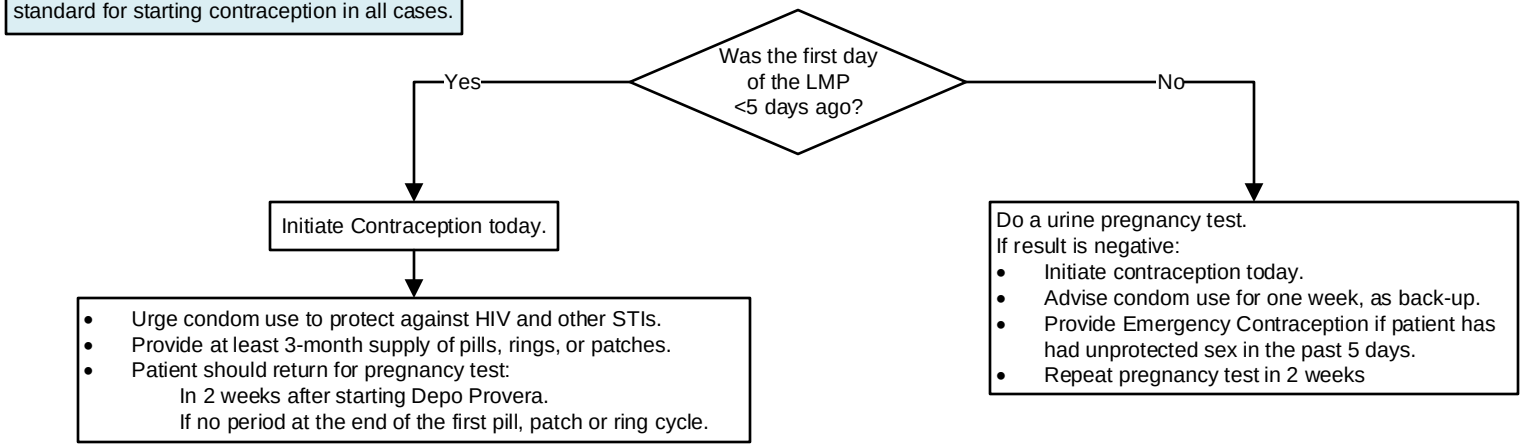
This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 12/14/16.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Contraception – Quick Start

This guideline is designed to establish a standard for starting contraception in all cases.



This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 3/25/13.
If comments about this guideline, please contact Ellen_Hodges@ykhc.org.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Pre-Anesthesia Management

Age	Hb/Hct	Coags	Lytes	BUN/Cr	Glucose	LFTs	EKG	CXR	T&S
0 – 59 years	No routine testing needed in this age group.								
60 – 74 years							X		
75 – 99 years	X		X	X	X		X		

Disease	Hb/Hct	Coags	Lytes	BUN/Cr	Glucose	LFTs	EKG	CXR	T&S
Hypertension			X				X		
Card – moderate	X		X	X			X		
Card – severe	X		X	X			X	X	
Pulm – mild									
Pulm – severe	X						X	X	
Smoker > 20 years	X								
Malignancy	X								
Lymphoma								X	
Hepatic	X	X	X			X			
Renal	X	X	X	X					
Bleeding	X (CBC)	X							
Diabetes			X	X	X		X		
Expected blood loss	X								X

Medication	Hb/Hct	Coags	Lytes	BUN/Cr	Glucose	LFTs	EKG	CXR	T&S
Diuretic			X	X					
Antihypertensive			X	X			X		
Cardiac medication			X	X			X		
Steroid			X		X				
Anticoagulant	X	X							

Other

Urine hCG: obtain within 48 hours of surgery in women of childbearing age (13-50).
Drug Levels: draw level on all patients on digoxin or phenytoin.
CXR: obtain if recent change in sputum quality or color, pneumonia in past three months, chronic home oxygen use, planned intrathoracic surgery, or if exam reveals rales, rhonchi, or wheezes.

Surgical Risk Screening Protocol Orders

1. Patients who are not to be scheduled at YKHC:
    a. Patients with BMI > 45 (up to BMI of 45 is acceptable if no significant unstable CV, respiratory, or endocrine pathology is present).
    b. Obstructive sleep apnea perioperative risk score of 5 or 6.
2. Preventative antibiotic therapy will be administered within one hour prior to skin incision per protocol pre-operatively based on procedure type and patient's allergies unless otherwise ordered by physician.
3. DVT/VTE prevention methods will be implemented using SCIP Mechanical Prophylaxis Protocol unless ocntraindicated or otherwise documented in orders by physician.

Diabetes Management

1. Discontinue all oral agents the evening prior to surgery except Metformin, which can be taken the evening prior to surgery but not the day of surgery.
2. Discontinue insulin after midnight for AM surgeries.
3. Take half usual dose of insulin the morning of surgery if surgery is scheduled to start at noon or later.
4. Take full dose of Lantus insulin up to time of surgery.
5. Consume apple or cranberry juice up to two hours prior to arrival to surgery if insulin was given.
6. For insulin pumps, set to basal rate and continue throughout pre-operative period.
7. Upon arrival to Holding Area, obtain glucose level. Anesthesia will treat results.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Pre-Anesthesia Management

NPO Guidelines

The preoperative nurse will instruct all patients to be NPO after midnight and to follow the surgeon's instructions if they differ from this.
The surgeon who gives different instructions will be responsible for thorough patient instruction of anything other than these guidelines.

1. All patients are equal with regard to NPO guidelines (eg gastric emptying time, obesity).
2. Clear liquids may be consumed up to two hours prior to scheduled arrival time.
3. Clear liquids are water, black coffee, and beverages not cloudy that can be seen through. Sugar and artificial sweeteners are acceptable. All broths are NOT acceptable.
4. Patient may brush his/her teeth but should not swallow toothpaste.
5. Gum and candy of any type are not allowed.
6. All patients will be allowed to eat a full, regular diet (solids) up to eight hours prior to surgery. Patients going to the OR at 0730 who were NPO after midnight are considered to meet this standard.
7. Infants up to 24 months of age will be allowed breast milk up to four hours prior to the arrival to the hospital. Infant formula is considered a solid.

Estimated Energy Requirements for Various Activities, Based on Duke Activity Status Index*		
1 MET	**Can you...**	
		...take care of yourself?
		...eat, dress, or use the toilet?*
		...walk indoors around the house?
		...walk one or two blocks on level ground at 2-3 mph (3.2-4.8 kph)?
< 4 METs	**Can you...**	
		...do light work around the house, such as dusting or washing dishes?
≥ 4 METs	**Can you...**	
		...climb a flight of stairs or walk up a hill?
		...walk on level ground at 4 mph (6.4 kph)?
		...run a short distance?
		...do heavy work around the house, such as scrubbing floors or lifting or moving furniture?
		...participate in moderate recreational activities, such as golf, bowling, dancing, doubles tennis, or throwing a baseball or football?
≥ 10 METs	**Can you...**	
		...participate in strenuous sports, such as swimming, singles tennis, football, basketball, or skiing?
* MET = metabolic equivalent		
Adapted from J AM Coll Cardiol, with permission from Elsevier.		

Pediatric Protocols/Reference

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Resource

PAMC/YKHC Post-NICU Caffeine Protocol

IF ANY CONCERN FOR APNEA, please consult a pediatrician immediately to determine need for further evaluation, transfer, medevac, etc.

Recommendations on Management of Caffeine After NICU Discharge

- Recommended dose of caffeine is 12 mg/kg PO daily.
- Patient should be seen in Bethel by a pediatric provider within one week of returning to the region.
- Dose should be weight-adjusted every 1-2 weeks. This can occur in outpatient clinic with a pediatric provider or a pediatric consult, in an SRC with a pediatric consult, or in a village by RMT to Chronic Peds.
- Stop the caffeine when the baby is 42 weeks corrected gestational age.
- Discontinuation of caffeine may be delayed for another week so as not to coincide with immunizations, recent URI, or planned anesthesia (as all of these events can cause re-emergence of intermittent hypoxia with periodic breathing).

Note

When a baby is discharged from the NICU on caffeine, update the Problem List with the plan, including the target dose, how often to weight-adjust, and the expected end date (when 42 weeks corrected gestational age will be).

Rationale

- In the past, premature infants were given caffeine until about 34 weeks post-menstrual age. Some needed caffeine past this point and went home on caffeine and an apnea monitor.
- Recent studies have shown that many preterm infants who have been taken off caffeine will go on to have intermittent hypoxia and subclinical apnea and bradycardia events after discharge from the hospital.
- Evidence is also building that prolonged use of caffeine results in better neurodevelopmental outcomes.
- As of January 2019, caffeine has been continued in preterm infants after discharge from the PAMC NICU.
- The PAMC NICU stopped the routine use of apnea monitors for babies discharged on caffeine due to sub-optimal monitor technology and frequent frustration among parents and providers. They prefer to emphasize the importance of giving caffeine rather than use of apnea monitors.

Source

Adapted from letter from Alaska Neonatology Associates, Inc., Pediatrix Medical Group, an affiliate of MEDNAX.
1/10/2019
Providence Alaska Medical Center (PAMC)
Neonatal Intensive Care Unit (NICU)

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Resource

Checklist for Complex Pediatric Patients Returning to YKHC Region

□ Has YKHC pediatric group been briefed and asked for feedback on concerns or issues?	□ N/A
□ Prior to patient returning, has care conference been scheduled with 1-2 pediatricians to represent group/consensus recommendations? Other key participants include: case managers, SRC providers, health aides, and family members.	□ N/A
□ Where will primary care occur – village, SRC, Bethel, or Anchorage?	□ N/A
□ Does home have electricity, running water, and a refrigerator?	□ N/A
□ Is there a back-up plan in place if electricity goes down?	□ N/A
□ Have family/caregivers received CPR training?	□ N/A
□ Does the family have needed emergency equipment? Ex: ambu bag (if no CHA available), suction, pulse-oximeter, oxygen, etc. Have they received training on how to use this equipment?	□ N/A
□ Does the family have needed supplies: medications, beds, commodes, syringes, dressings, wheelchair, lotions, etc.?	□ N/A
□ If the patient is at risk for seizures, has the family received Diastat or intranasal midazolam and received the appropriate training?	□ N/A
□ If the patient has a G-tube, are the caregivers comfortable replacing it? Do they have emergency supplies, including an extra G-tube and Foley catheters in the same French size and smaller sizes?	□ N/A
□ If the patient has a port, are the caregivers comfortable accessing it? Have they received the appropriate training? Do they have all the supplies needed to access it?	□ N/A
□ Has an Informed Consent to Return to Village been customized for this patient and approved by Risk Management (contact is Linda Weisweaver as of 11/2019)? [See Peds Folder → Informed Consent to Return to Village for template.]	□ N/A
□ Have the caregivers completed the Informed Consent to Return to Village?	□ N/A
□ If patient is returning to the village against medical advice, have Risk Management, Clinical Director, and appropriate administrators been made aware?	□ N/A
□ If the patient is DNR/DNI/Comfort Care, have the **Expected Home Death Forms** been completed? Has the **MOST Form** been completed? Does family have enough medications needed for comfort care?	□ N/A
□ Have all current and anticipated prescriptions with refills been ordered on the YKHC RAVEN Medication List?	□ N/A
□ Has the YKHC RAVEN Problem List been updated with care plans, follow-up needs, therapeutic parameters, etc.?	□ N/A
□ Has a clinic appointment been scheduled to establish care at YKHC?	□ N/A
□ Have the health aides been notified of the complex needs of this patient?	□ N/A
□ Have the nearest SRC providers been notified of the complex needs of this patient?	□ N/A
□ After the care conference: has a detailed note been placed in the chart summarizing the care conference? Has this note been sent by email to the pediatric group, case managers, and SRC providers?	□ N/A
□ Has family referral to YKHC BH been offered?	□ N/A
□ Have VTC appointments been set up for patient and family?	□ N/A

Yukon-Kuskokwim HEALTH CORPORATION

Clinical Resource

Dexamethasone in Meningitis

*The following is adapted from the "**ANMC Pediatrics Statement on Dexamethasone and Hearing Screening in Meningitis**," dated 2/4/20.*

Haemophilus influenzae type A

In recent years, *Haemophilus influenzae* type A (HiA) meningitis has been more common than other causes of bacterial meningitis in children admitted to ANMC. Many of these children have been transferred from YKHC. See this **State Epidemiology Bulletin** for information about Alaska cases in 2014-2018, including the outbreak in 2018.

The pattern of disease in HiA is similar to that seen in *Haemophilus influenzae* type B (HiB) meningitis. In HiB meningitis, dexamethasone has been shown to decrease the incidence of severe hearing loss. In Alaska, there have been multiple cases of sensorineural hearing loss associated with HiA meningitis. It is suspected that dexamethasone may confer similar benefits in HiA meningitis. As a result, our local experts (including infectious disease and endocrinology experts) recommend giving dexamethasone with all cases of suspected bacterial meningitis.

Dexamethasone

- Indications: A child >6 weeks old with clinical meningitis or visibly purulent spinal fluid.
- Timing: First dose should be given 10-20 minutes prior to or concurrent with the first dose of antibiotics; if given after antibiotics have been given, there is no evidence that dexamethasone will improve outcomes.
- Dose: Dexamethasone 0.15 mg/kg/dose IV.
- Course: If dexamethasone is initiated and HiA/HiB is confirmed, continue dexamethasone 0.15 mg/kg/dose IV Q6h for 2-4 days. If CSF culture/PCR show a different pathogen or are negative, stop the dexamethasone.

Hearing Screening

- All children with bacterial meningitis should be referred to audiology.
- Hearing evaluation should be scheduled one month after hospital discharge.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Pediatric Diabetic Ketoacidosis Management Protocol

General Guidelines and Definitions

Disclaimer: These are guidelines—not hard and fast rules. Some patients, such as younger children (<5 years) and poorly controlled diabetics (HbA1c >10%), may not adhere to the usual course and guidelines may need to be modified. The below categorizations of mild, moderate, and severe are not the consensus-statement published definitions, but are more "real-world" categorizations.

DKA: A state of *insulin deficiency* and characterized by *severe depletion of water and electrolytes* (see Appendix 1).The primary goals are to **treat the insulin deficiency** (which will correct the acidosis and reverse the ketosis) and to **replace fluids and electrolytes**. Other goals include gradually achieving euglycemia, monitoring for complications of DKA, and identifying and treating any precipitating event.

Clinical signs of DKA: dehydration, tachycardia, tachypnea, Kussmaul respirations, acetone breath odor, nausea, vomiting, abdominal pain, blurry vision, confusion, drowsiness, progressive decrease in level of consciousness, loss of consciousness.

Biochemical criteria for DKA: hyperglycemia (BG > 200mg/dl); venous PH <7.3 or serum bicarb <15, beta-hydroxybutyrate ≥3 or moderate/large ketonuria

Diabetic ketosis without significant acidosis: Urine ketones moderate/large, nausea +/- vomiting, pH >7.3, Bicarb >15
Management:
• Oral or IV hydration, depending on vomiting, ability to tolerate PO.
• Supplemental insulin (Novolog, SQ: 0.1-0.2 units/kg every 4 hours) in addition to patient's usual long-acting insulin (ie Lantus, Tresiba).
• Often managed as outpatient at home or in Emergency Department.
• In established patient with good family support, sometimes managed at home by phone under guidance from on-call physician with no knowledge of laboratory results other than self-monitored blood glucose and urinary ketones.

Mild-moderate DKA: Urine ketones mod/large, persistent vomiting, pH 7.2-7.3, Bicarb 10-15
Management:
• Oral or IV hydration (usually IV).
• Supplemental insulin should be used (Novolog SQ 10% of total daily insulin dose or 0.1-0.2 units/kg every 2 hours[*]) in addition to the patient's usual long-acting insulin (ie Lantus, Tresiba).
• May require admission and management with IV regular insulin infusion (0.05-0.1 units/kg/hr).

Severe DKA: Urine Ketones Large, pH <7.2, Bicarb <10 *OR* mild/moderate DKA with other organ system impairment (altered mental status, impaired renal function, respiratory distress, compromised circulation) (published definition: pH <7.1, bicarb <5)
Management:
• Admit to hospital for therapy and intensive monitoring.
• PICU status may be appropriate in some cases (altered mental status, hypokalemia, hyponatremia (after sodium corrected for glucose[†]), young age (<5 years), hypotension, per admitting physician).
• IV hydration (3 L/m^2/day)[¥]
• IV insulin (0.1 units/kg/hour).
• Intensive monitoring for improvement and signs of cerebral injury.
• Follow guidelines as given in the remainder of this protocol.

Some useful formulas:
[*]Total daily insulin dose approx. = Lantus dose x 2 (In general, Lantus dose is 50% of patient's total daily insulin)
[†]Corrected sodium = [((Glucose -100)/100) x 1.6] + Pt's Na [glucose is mg/dL]
[¥]BSA (m^2)= sq root [(wt(kg) x ht(cm))/3600]; estimated BSA = (wt(kg) x 4 + 7)/(90 + wt(kg))
[‡]Anion Gap = Na – (Cl + HCO_3); normal is 12 +/- 2 mmol/L
[€]Effective osmolality = 2 x (Na + K) + glucose/18 [glucose is mg/dl]

Fluid Management (2 bag system)
• Total fluids should not exceed about 3500 mL/m^2/day.
• Volume expansion (fluid bolus) should be initiated prior to insulin administration, and insulin should be initiated at least 1 hour after the fluid administration has begun.
  ▫ Initial bolus of NS or LR with 20 mL/kg over 1-2 hours.
  ▫ If poor peripheral perfusion, hypotension, or shock persist after the initial 20ml/kg, it may be appropriate to repeat with a second 10-20 mL/kg NS bolus.
• Rehydration: assume 10% dehydration and plan to replace the deficit over 24 hours. (See Appendix 2.)
  ▫ This can often be accomplished by running IV fluids at 1.5 x maintenance or 3000 mL/m^2/day.
  ▫ Initial IVF with ½NS + 20 mEq/L K-phosphate + 20 mEq/L K-acetate (or KCl if K-acetate is not available). **Note: there is zero dextrose in this fluid.
    ♦ Consider NS if measured Na level is low and does not rise with the fall in glucose.
    ♦ If K is >6, repeat the BMP and add the K to the fluids when the K is <6; If K is low, may need up to 60 mEq/L K total (typically 30 and 30 of the two types of K solution).
  ▫ "Y-in" D10 ½NS + 20 mEq/L K-phosphate + 20 mEq/L K-acetate (or KCl) when the serum glucose is less than 250 mg/dL or if glucose falls faster than 100mg/dL per hour.
  ▫ 2 bag method: Use 2 separate bags of IV rehydration fluid with identical electrolyte composition; one bag has NO dextrose and the other has 10% dextrose. Increase and decrease the rate of each bag reciprocally so that the total rate is constant at the desired rehydration rate (ie, 3 L/m^2/day) and the glucose is maintained between 150 and 250.
    ♦ Typically, when the BG is ≤ 250, run the 2 fluids at 50/50 rates and when the BG is <200, stop running the fluid without the dextrose and run the D10 fluid at 100% of the desired rate.
    ♦ DO NOT REDUCE INSULIN INFUSION RATE BECAUSE OF FALLING BLOOD GLUCOSE UNTIL THE REDUCTION IS INDICATED BASED ON RESOLUTION OF KETOACIDOSIS; *If the patient is still acidotic, they still need the insulin*—increase the dextrose content instead (can use D12.5% fluids prn).
• **Do not administer sodium bicarbonate to correct the acidosis** (***cautious*** administration may be ***considered*** if pH <6.9 and the acidosis is so profound as to adversely affect the action of epinephrine during resuscitation, decreased cardiac contractility, impaired tissue perfusion from vasodilation, or life-threatening hyperkalemia; dose should be 1-2 mmol/kg over 60 minutes).

This protocol is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
If comments about this protocol, please contact Jane_McClure@ykhc.org.

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Treatment Protocol

Pediatric Diabetic Ketoacidosis Management Protocol

Insulin Therapy

• "Low-dose continuous IV insulin infusion" = 0.1 units/kg/ hour regular insulin, IV (conc. 1 unit/mL).
  ▫ Start insulin 1 hour after initial fluids have been started but do not further delay in starting insulin.
• Do not give intravenous insulin bolus or subcutaneous insulin bolus when starting the continuous infusion. (*If a delay in starting the insulin infusion is expected to be longer than 1 hour (i.e. more than 2 hours after IVF have been started, then a SQ insulin dose may be warranted.)
• CONTINUE IV INSULIN INFUSION AT 0.1 UNITS/KG/HOUR UNTIL THE KETOACIDOSIS IS RESOLVED, bicarb >18, the anion gap is closed (AG <12)‡, and the patient is awake and can tolerate PO fluids.
  ▫ A lower continuous rate (0.05 – 0.08 units/kg/hr may be needed in patients with marked insulin sensitivity.
• Usually, long-acting basal insulin (ie Lantus, Tresiba) should be given at the usual time, even if the patient is on an insulin infusion (this is most frequently given at bedtime; its onset of action is approx. 1-2 hours).
  ▫ Administering basal insulin while on the insulin infusion allows us to d/c the insulin infusion when it is appropriate (see above) without waiting for subcutaneous insulin to be given; it also provides background insulin so that DKA does not recur after the insulin infusion is discontinued (remember: without SQ insulin, once the IV insulin infusion is stopped, the patient has no other insulin on board!)
  ▫ In new-onset diabetes, the usual starting total daily dose of insulin is 0.5-1 units/kg/day, 50% of which should be given as basal insulin; in known diabetes, the patient's home dose of basal can be used.
  ▫ For those patients on insulin pumps, they will not be on a long-acting basal insulin, so do not need to receive this unless there is a plan to not restart the patient's pump while they are hospitalized. Otherwise, they can simply be restarted on their pump when the IV insulin infusion is completed.

Cerebral Injury in DKA

The most common cause of death during DKA in children is clinically apparent cerebral injury, which occurs in about 0.5-0.9% of cases and manifests as sudden neurologic decline. It often occurs early in the course of DKA (sometimes even before treatment has been started) and when it is clinically apparent, the prognosis is usually poor; mortality rate is up to 21-24%. The pathogenesis is incompletely understood, but may result from cerebral hypoperfusion and the effects of reperfusion,along with neuroinflammation. Cerebral *edema* is likely a consequence (rather than the cause) of cerebral injury, and often develops hours or days after the diagnosis of brain injury.

• Risk factors include:
  ▫ Younger age; New-onset diabetes; Longer duration of symptoms
  ▫ ***Sodium bicarbonate treatment for correction of acidosis***
  ▫ Administration of insulin in the first hour of fluid treatment
  ▫ Increased BUN at presentation
  ▫ Greater hypocapnia at presentation after adjusting for degree of acidosis
  ▫ More severe acidosis at presentation
  ▫ An attenuated rise in measured serum sodium concentrations during therapy
• Children with DKA are frequently sleepy, but **warning signs and symptoms of cerebral injury include**:
  ▫ Worsening of Glasgow Coma Scale (GCS) Score
  ▫ Slowing of heart rate, rising blood pressure, decreased O_2 saturation (Cushing's Triad)
  ▫ Change in neurological status (restlessness, irritability, increased drowsiness, incontinence)
  ▫ Headache, vomiting, focal neurological signs, dilated/unresponsive/sluggish/unequal pupils, papilledema
  ▫ Decreasing urine output without clinical improvement or tapering of fluids

• CEREBRAL INJURY IS A LIFE THREATENING MEDICAL EMERGENCY REQUIRING IMMEDIATE AGGRESSIVE INTERVENTION AND IMMEDIATE TRANSFER TO AN INTENSIVE CARE UNIT SETTING.

• Treatment includes:
  ▫ Give Mannitol 0.5-1 gm/kg over 10-15 min and repeat if no initial response in 30 minutes to 2 hours.
    ♦ Hypertonic saline (3% saline) 2.5-5ml/kg over 30 min may be an alternative or 2nd line.
  ▫ Elevate the head of the bed to 30 degrees and keep the head in a midline position.
  ▫ Adjust fluid administration as indicated to maintain normal BP and optimize cerebral perfusion; avoid hypotension that might compromise cerebral perfusion pressure.
  ▫ Administer oxygen as needed to maintain normal oxygen saturation.
  ▫ Intubation may be necessary if impending respiratory failure, but aggressive hyperventilation to hypocarbia (pCO_2 <22 mmHg) has been associated with poor outcome and is not recommended.
  ▫ Head CT scan should be obtained to rule out other possible intracerebral causes of neurologic deterioration AFTER treatment for cerebral injury has been started (DO NOT DELAY TREATMENT TO GET THE HEAD CT!); changes that will be detectable on head CT often occur late in the development of cerebral injury.

Monitoring and Other Recommendations

• Height and weight are both needed in order to calculate body surface area.
• Vital Signs Q1 hour for at least first 12 hours, then Q2 hours; HR monitor and pulse oximetry.
• Neuro checks/GCS score Q1 hour.
• Strict monitoring of Intake and Output is essential (Strict I/O).
• Check blood sugar (bedside glucose) every hour while on insulin infusion.
• NPO until acidosis is resolved in order to strictly monitor total intake, avoid excessive fluid administration, and decrease the risk of aspiration should consciousness be altered.
• BMP, Magnesium, Phosphorus, beta-hydroxybutyrate initially and q4-6 hours.
• I-Stat-7 Q2 hours until pH >7.25, then q4-6 hours.
• After first 12-18 hrs of DKA treatment, check urine ketones every void until negative twice in a row.
• Mannitol 1 gm/kg or 3% Saline at bedside (and ready to be given for acute change in mental status).
• Two peripheral IV catheters should be placed for fluid and insulin administration and for blood sampling.
• A flow sheet with lab results and clinical response can be a useful guide to therapy.
• Initial labs should include: Hemoglobin A1c, BMP, Mg, Phos, Beta-hydroxybutyrate, diabetes autoantibodies (islet cell antibody, insulin antibody, glutamic acid decarboxylase (GAD-65) antibody, ZnT8 antibody), celiac panel (total IgA and TTG), TSH and free T4 (if patient is very ill, the TSH and free T4 should wait until child is more stable to avoid abnormalities of "sick euthyroid syndrome"), insulin and c-peptide (do not measure insulin if patient has already been started on insulin), CBC, cultures if indicated (fever, etc; **leukocytosis is a common finding in DKA and does not alone indicate infection).
• Call 907-563-2662, ask to speak with pediatric endocrinologist on call any time of the day or night.

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Treatment Protocol

Pediatric Diabetic Ketoacidosis Management Protocol

Prevention of DKA is key

- In patients with newly diagnosed diabetes, education of the public and health care providers to recognize early signs of diabetes can lead to diagnosis of type 1 diabetes before DKA develops.
- In patients with known diabetes, sick day reeducation with diabetes educator is important to discuss factors that led to DKA in this situation and how to avoid it in the future (ie urine ketone monitoring with illness or high blood glucose, avoiding insulin omission, appropriate use of insulin pump and trouble-shooting with pump problems).
- Appropriately manage sick days and ketones at home or in the hospital to prevent progression to DKA (see below).

Sick day management guide when a patient has ketones based on amount of ketones and the blood sugar			
Urine Ketones	Blood Glucose		
	<100	100-200	Over 200
Neg/Trace/Small	Push sugar-containing fluids	Push fluids (sugar and sugar-free)	Push sugar free fluids; continue to check ketones while ill; give correction dose if BG>250-300
Moderate	Push ~30-60g carBG to get BG over 200, consider mini-dose glucagon (see below)	Push ~30g carbs to get BG over 200 (recheck BG q 30-60min)	Give extra NovoLog (10% of total daily dose or 0.1 units/kg or double the BG correction dose); check BG and ketones in 2 hrs; repeat Novolog dose in 2 hrs if ketones do not decrease
Large, but well patient (not continuously vomiting, no difficulty breathing, awake)	Push fluids (30-60g carBG), consider mini-dose glucagon	Push ~30 g carbs to get BG over 180-200 (recheck BG q30-60 min)	Give extra Novolog (20% of total daily insulin dose or double the BG correction); check BG and ket in 2 hrs ; repeat Novo-Log dose in 2 hours if ketones do not decrease
Large, and sick pt (cont vomiting, difficulty breathing, lethargy)	Bring to ER, consider mini-dose glucagon on the way	Bring to ER Cont to push fluids if possible on the way	Bring to ER (can give an extra insulin dose while on their way to the ER if they live far away)

Total daily insulin dose approx. = 2 x Lantus/Tresiba dose

Double the correction: calculate what insulin dose would be based on their BG correction factor and give 2 x that dose

References:

Kuppermann et al, N Engl J Med. 2018: 378(24):2275-87
Woflsdorf et al, Ped Diab. 2018:19 (Suppl 27):155-77 Wolfsdorf et al, Diab Care. 2006:29(5):1150-59
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Appendix 1

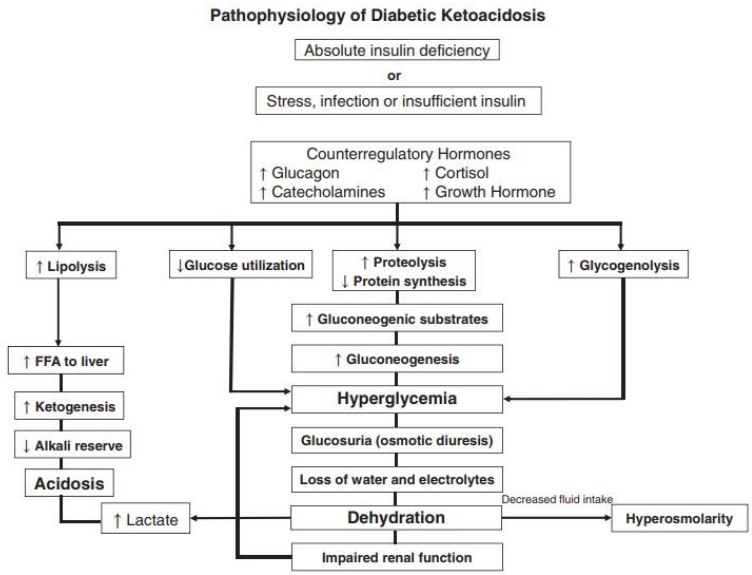

FIGURE 1 Pathophysiology of diabetic ketoacidosis. Copyright© 2006 American Diabetes Association. From diabetes care, Vol. 29, 2006:1150-1159. Reprinted with permission of *The American Diabetes Association*

Appendix 2: Fluid maintenance and replacement volumes based on body weight and an assumption of 10% dehydration

Body weight (kg)	Maintenance (mL/24 h)	DKA: give maintenance +5% of body weight/24 h	
		mL/24 h	mL/h
4	325	530	22
5	405	650	27
6	485	790	33
7	570	920	38
8	640	1040	43
9	710	1160	48
10	780	1280	53
11	840	1390	58
12	890	1490	62
13	940	1590	66
14	990	1690	70
15	1030	1780	74
16	1070	1870	78
17	1120	1970	82
18	1150	2050	85
19	1190	2140	89
20	1230	2230	93
22	1300	2400	100
24	1360	2560	107
26	1430	2730	114
28	1490	2890	120
30	1560	3060	128
32	1620	3220	134
34	1680	3360	140
36	1730	3460	144
38	1790	3580	149
40	1850	3700	154
45	1980	3960	165
50	2100	4200	175
55	2210	4420	184
60	2320	4640	193
65	2410	4820	201
70	2500	5000	208
75	2590	5180	216
80	2690	5380	224

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Treatment Protocol

Pediatric Endocrine Emergency Protocols

Hypoglycemia

If low BG and cause unknown, ***GET CRITICAL SAMPLE PRIOR TO TREATMENT!***

Labs tested during hypoglycemia are critical to identifying cause and preventing recurrence.

- Serum critical sample:
  - BMP, insulin, C-peptide, Cortisol, GH
  - Free fatty acids, β-hydoxybutyrate, acetoacetate
  - Lactate, ammonia, Save serum (sulfonylureas), total and free carnitine
- At any time:
  - Acylcarnitine profile, serum amino acids
- Urine – as quickly after hypoglycemia as possible
  - Urine ketones
  - Urine organic acids
- If suspect hyperinsulinism, perform glucagon stim test (administer 0.03 mg/kg, max 1 mg) and measure lab glucose at 0, 15, and 30 minutes.

Acute Treatment: obtain critical sample and correct hypoglycemia within 10-15 minutes.

- Glucose gel per eCHAM guidelines.
- IV or IO dextrose bolus (D10% or D25%) followed by continuous infusion of dextrose IVF and frequent blood sugar checks (Q1-2h or more frequently initially)
  - D25%: 2-4 mL/kg; D10%: 5-10 mL/kg. (For neonates, give D10% 2 mL/kg.)
- If insulin-mediated, treat with glucagon 0.03 mg/kg up to 1 mg OR for patients < 20 kg give 0.5 mg IM and for patients > 20 kg give 1 mg IM.

Adrenal Insufficiency

Critical Sample before treatment: cortisol

- If suspect primary adrenal insufficiency, include ACTH, renin, aldosterone.
- If suspect CAH, include 17OH-progesterone or CAH-6b panel (send-outs).
- Also check BMP, CBC, U/A.

Treat while awaiting results.

- Normal Saline Bolus 20 mL/kg.
- Hydrocortisone 50-100 mg/m^2 IV bolus (lower end of range if less sick, higher end of range if more sick) followed by 50-65 mg/m^2/day, divided q6h
  - If no IV access, SoluCortef IM or Dexamethasone IM
  - SoluCortef 50-65 mg/m^2 IV/IM – short acting
    - ♦ At this dose, adequate mineralocorticoid activity to replace moderate doses of oral fludrocortisone (80 mg HC = 0.2 mg fludrocortisone)
  - Dexamethasone 1.5-2 mg/m^2 IV/IM—long acting
    - ♦ *No mineralocorticoid activity*
    - ♦ Does not cross react with cortisol in lab assay so can use Dex if unable to get cortisol before treatment and then do Cortrosyn stimulation test after treatment
  - SoluMedrol 10-15 mg/m^2 IV/IM–intermediate acting
    - ♦ *No mineralocorticoid activity*
- For milder presentation, ex. known diagnosis with flu symptoms, but hemodynamically stable, can skip load, use 50-65/m^2/day, divided every 6 hours.

Known adrenal insufficiency (ie CAH or hypopituitarism) and adrenal crisis

- Loading dose hydrocortisone IV or IM 50 mg/m^2 x1 then 50 mg/m^2/day divided q6h
- If BSA unknown or for more rapid dosing, can use age:
  - **<3 y.o.: 25 mg IM/IV bolus followed by 25-30mg/day divided q6h**
  - **3-12 y.o.: 50 mg IM/IV bolus followed by 50-60mg/day divided q6h**
  - **>12 y.o.: 100 mg IM/IV bolus followed by 100mg/day divided q6h**
- If severely ill or unable to take PO due to continued emesis, but no IV, can give SoluCortef 30-50 mg/m^2 IM (better for CAH because has fludrocortisone activity at high doses, but only lasts about 6 hours), or Dexamethasone 1.5-2 mg/m^2 IM.
- If less ill (ie, not in crisis but needs stress doses because of fever or vomiting), can give double or triple oral dose (usually double if fever, triple if vomiting or more sick).
- Normal saline bolus 20 mL/kg/ IV then D5NS or D10NS (depending on blood sugar) at 1.5 x maintenance.
- Monitor electrolytes, BP.
- For anesthesia: begin triple dose the night before the procedure, then 30-50 mg/m^2 IV or IM on call to the OR prior to anesthesia; and continue stress doing for 24 hours after procedure.

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Treatment Protocol

Pediatric Endocrine Emergency Protocols

Hypercalcemia

Critical sample: Ca, Phos, iPTH
• Other labs: 25-OH-D, 1,25 $(OH)_2$ D, urine Ca/Cr, CBC
Treatment for severe hypercalcemia (Ca >14): same initial treatment independent of the cause
• Saline diuresis: NS bolus followed by 2.5-3 L/m^2/day
    ▫ Saline diuresis generally works rapidly, but only as long at it is continued, and usually does not normalize calcium.
• Consider calcitonin 4 units/kg IV/IM/SQ q12h
    ▫ Tachyphylaxis common (often 2nd-line therapy y
    ▫ Common side effects: nausea, vomiting, flushing
• May need bisphosphonates.
• Discontinue any medications known to cause or worsen hypercalcemia.
• Avoid immobilization.

If mild/moderate (Ca <13-14) and no contraindication to PO: 2-3 L/day water plus PO salt to promote Ca excretion.

Therapy specific for underlying disorder
• Hyperparathyroidism → parathyroidectomy
• Glucocorticoids → effective if associated with hematologic malignancy or diseases with increased 1,25 $(OH)_2$ vitamin D.

Hypocalcemia

Critical sample: Calcium, Phosphorus, Magnesium, intact PTH before treatment.
• Ca and PTH need to be simultaneous, and PTH *MUST* be obtained while Ca is low.
• Collect urine Ca/Cr while Ca low if possible.
• If there is reason to suspect low albumin, check ionized calcium or calculate corrected calcium using albumin
    ▫ Corr Ca = measured calcium + [0.8 (4-albumin)]
• Other useful labs: CMP (kidney, liver, bone function), 25-OH-D, 1,25 $(OH)_2$ D, urine Ca/Cr.

Treatment if Symptomatic - tetany, seizure, apnea, heart failure, laryngospasm.
• *Slow* (<1 ml/min) IV infusion 10% Ca gluconate 1 mL/kg
    ▫ 100 mg/ml Ca Gluconate = 9 mg/mL elemental Ca
    ▫ Cardiac monitoring (bradycardia, shortened QT_c); close attention to infusion site if not central IV (risk of tissue necrosis if peripheral IV infiltration)
• If Mg low, replace with 0.1-0.2 mL/kg 50% Mg Sulfate

If not acutely symptomatic, can do more comprehensive evaluation first to determine cause and appropriate oral treatment.

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Treatment Protocol

Pediatric Endocrine Emergency Protocols

Thyroid Storm (Thyrotoxic Crisis)

Score ≥45 → highly suggestive of thyroid storm; 25–44 →thyroid storm; and <25 → thyroid storm unlikely.

Thermoregulatory dysfunction	Score
Temperature (C)	
37-37.7	5
37.7-38.3	10
38.3-38.8	15
38.8-39.3	20
39.4-39.9	25
40	30
Central nervous system effects	
Mild - agitation	10
Moderate - delirium, psychosis, extreme lethargy	20
Severe - seizure, coma	30
Gastrointestinal-hepatic dysfunction	
Moderate - diarrhea, nausea/vomiting, abdominal pain	10
Severe - unexplained jaundice	20
Cardiovascular dysfunction	
Tachycardia (heart rate/min)	
99-109	5
110-119	10
120-129	15
130-139	20
≥ 140	25
Congestive heart failure	
Mild - pedal edema	5
Moderate - bibasilar rales	10
Severe - pulmonary edema	15
Atrial fibrillation	10
Precipitant history	
Negative	0
Positive	10

Critical Sample: **Free T4 and TSH,** run STAT
• Other labs: TBII, TSI, TPO antibodies
• Useful to measure: CMP (glucose, liver function), CBC (acute infection?), urine pregnancy test

Acute Treatment
• Oxygen
• Adrenergic blockade (if not in CHF) - goal HR<100
    ▫ Propranolol (PO 2 mg/kg/day div q6-8h or IV 0.01 mg/kg/dose (max 5mg) over 10-15 min).
    ▫ If contraindication to propranolol (ie asthma), can use atenolol (cardioselective) with caution.
• IV fluids (cooled if necessary)
• Cooling blankets
• Antipyretics should be avoided when possible.
• Sedation – phenobarbital stimulated thyroid hormone clearance.
• Hemodynamic support/treat CHF if present.

Longer term treatment:
• Block thyroid hormone synthesis and release
    ▫ Thionamides – block thyroid hormone synthesis
        ♦ PTU (propylthiouracil): black box warning in peds
        ♦ Methimazole : ~0.8 mg/kg up to 60 mg loading, then ~0.4 mg/kg up to 30 mg every 6 hours (5, 10 mg tabs)
    ▫ High Dose Iodine – blocks release of already formed thyroid hormone
        ♦ Should be delayed until 1-2 hours after thionamide, to prevent transient increase in thyroid hormone levels
        ♦ SSKI (Lugol solution) 5 drops every 6-12 hours
        ♦ Use will necessitate delay in radioactive iodine treatment if that is desired
• Block peripheral conversion of T4 to T3
    ▫ Corticosteroids (stress dose HC or equivalent)
    ▫ Propranolol
    ▫ Iodinated contrast agents

Identify and treat precipitating event causing severe decompensation.
• Infection, pregnancy, emotional stress, DKA, pulmonary embolism, CVA, trauma, hypoglycemia.

Assess for underlying cause
• Grave's disease, functioning thyroid nodule ("hot nodule").

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Treatment Protocol

Pediatric Endocrine Non-emergency Recommendations

Please remember that this is just a list of lab tests often recommend prior to seeing patients. These are not physician orders. However, they are recommended prior to specialty appointments.

Congenital Adrenal Hyperplasia (CAH): meds are often adjusted based on labs/growth/bone age
- 17-OH-P (17-OH hydroxyprogesterone) often every 3-6 months Infants/toddlers often ordered q 1-3 months. (Goal: ~300-900)
- Androstenedione: Often every 3-6 months. Infants/toddlers often ordered every 1-3 months. (Goal: w/in normal range)
- Renin Activity: Often every 3-6 months. Renin hard to obtain in villages as must be sent frozen. (Goal: w/in normal range)
- Bone age after 2-3 years of age, then annually
- Accurate height and weight measurements each visit
- F/u in endo clinic every 3 to 6 months

Newborn with + FH of CAH but no ambiguous genitalia (ie no physical s/s of CAH):
- Newborn screen after 24hrs of life (in all infants).
- Serum 17OHP around day 3-4 of life (17OHP levels are normally high during the first 2-3 days after birth but by the 3rd day, levels in healthy infants fall and levels in affected infants rise to diagnostic levels).
- Alert state newborn screening program of patient at risk of CAH.
- Measure serum electrolytes prior to hospital discharge and at 5 and 10 days of age (hyponatremia and hyperkalemia are usually not present before 7 days of age and salt-losing crisis will typically occur in the second week of life).
- After newborn is sent home, parents should be cautioned to watch for signs of salt-losing crisis including vomiting, diarrhea, lethargy, dehydration, decreased PO intake.
- If positive newborn screen or elevated 17OHP, patient should be seen immediately and consult endocrinologist on call.

Congenital Hypothyroid/Hashimoto Thyroiditis/Goiter: meds are usually adjusted based on labs
General Information
- When a med dosage change is made, labs are usually repeated in 4-6 weeks and then again before the next clinic visit.
- Under certain circumstances, a thyroid ultrasound is sometimes ordered – not routine.
- Growth records on all children with any thyroid condition should be plotted.
- Often other thyroid labs are done as part of initial workup, but depends on what the presumptive diagnosis is. (TSI, Antithyroid peroxidase AB, etc.)

Specific Labs – Goal: normal Free T4 and TSH (infants should have a free T4 at least once).

Congenital Hypothyroidism
- FT4 & TSH 2weeks after dose started.
- 0-6 Months: FT4 & TSH every month
- 6-12 Months: FT4 & TSH every 2 months
- 1-3 Years: FT4 & TSH every 3 months

Acquired Hypothyroidism
- FT4 & TSH 4-6 weeks after starting med or after dose change
- FT4 & TSH every 6 months routinely

Central Hypothyroidism (ie, hypopituitarism)
- Free T4 every 4-6 months routinely

Hypopituitarism/Septooptic dysplasia/Optic nerve hypoplasia: (any combination of deficiencies of GH, TSH, ACTH, LH/FSH, ADH)
- Labs to follow depend on deficiency
- If panhypopituitarism
    - IGF-1 every 6-12 months if on GH (see below).
    - Free T4 every 4-6 months (see above).
    - May check BMP if concerns about inadequate adrenal hormone replacement.
    - Na levels if DI depend on thirst—if intact thirst, Na level every 3-4 months; if non-intact thirst, may need Na every 2-4 weeks.
    - LH/FSH pediatric, estradiol ultrasensitive or total testosterone at approximately age 12.
    - Accurate height and weight plotted on growth chart.

Work-up of Short Stature
- X-ray: bone age XR left hand/wrist
- bloodwork: TSH, free T4, TTG IgA, IgA, CMP, CBC, IGF-1, IGFBP-3, ESR. Also do chromosome microarray if a girl.
- urine: urinalysis (looking for RTA)

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Treatment Protocol

Pediatric Endocrine Non-emergency Recommendations

Children on Growth Hormone Injections: (GH deficiency/Turners/Noonan's/Prader-Willi Syn/SGA/Panhypopituitarism/CRF)

- Free T4 and IGF-1
  - Usually obtained q 6-12 months. Other labs including these may be done for initial diagnosis which may include GH stimulation tests.
  - GH dose will be adjusted based on IGF-1, growth pattern and weight.
- Bone age: includes left hand and wrist – please have radiology send via PACS to ANMC.
  - Initially and approximately every year.
- Accurate height and weight
  - Crucial to have correct plotting on growth record. (Lengths are done on infants and toddlers less than 2 years of age or if not able to stand well; plotted on 0-24mo WHO growth chart; heights are done when the child is over age 2 and plotted on the CDC 2-20 growth chart.)

Insulin Resistance/Obesity: goal is to prevent these children from becoming diabetic; not usually managed in endocrine clinic unless there is an endocrine condition (diabetes, prediabetes, PCOS, dyslipidemia); hypertension is managed by PCP or nephrology.

** Refer to publications in *Pediatrics*.

- Screening fasting plasma glucose, HbA1c every 2 yrs. OGTT if needed (Fasting Insulin **not** routine).
  - Fasting plasma glucose <100 is normal; 100-125 = prediabetes, >125 = diabetes.
  - OGTT-fasting plasma glucose, then drink 1.75 g/kg (max 75 g) of Glucola (within 10-15 min) and repeat plasma glucose in 2 hours.
    - Fasting 101-125 = impaired fasting glucose; over 125 = diabetes
    - 2 hour 141-199 = impaired glucose tolerance; over 199 = diabetes
  - HbA1c: 5.7% to 6.4% = prediabetes; >6.4%, likely diabetes but not necessarily diagnostic in children
- Fasting lipids initially and then per recommendation, usually every 2 years
  - If abnormal, repeat after 2 weeks but before 3 months (see below).
  - If still abnormal, dietitian referral.
- Liver function tests-AST/ALT every 2 years.
- Growth records with accurate height & weight plotted-also calculate and plot BMI.
  - Only obtain TSH & Free T4 initially if patient is showing growth deceleration.
- All patients should have initial evaluation and then monthly appointments with a dietitian whenever possible.
  - Daily activity, one hour/day with lifestyle change.
  - The more they see their primary provider and dietician, the more likely they are to comply with changes in dietary and activity levels.

Type 2 Diabetes

- At diagnosis: HgbA1C. Other labs depend on the individual case.
  - Criteria for dx of diabetes (per ADA):
    - FPG > 125 (no caloric intake for 8 hrs)
    - OR 2-hr glucose >199 during an OGTT
    - OR HbA1c >6.4% (**controversial for dx in children)
    - **the above 3 criteria require repeat testing in the absence of unequivocal hyperglycemia)
    - OR classic symptoms of hyperglycemia or hyperglycemic crisis and a random plasma glucose >199
- HbA1c every 3 months: Goal A1c <7%
- Fasting lipid panel soon after diagnosis and every 5 years if normal.
  - If abnormal, repeat after 2 weeks but before 3 months (see below).
  - If still abnormal, dietitian referral.
- Random urine microalbumin/creatinine soon after diagnosis and annually.
  - If abnormal, repeat with first morning urine MA/Cr or overnight collection; if still abnormal, referral to nephrology.
- Eye exam soon after diagnosis and annually.
- Dental exam annually.
- Dietician visit q 3-6 months.
- RN-CDE for education.

Yukon-Kuskokwim HEALTH CORPORATION

Treatment Protocol

Pediatric Endocrine Non-emergency Recommendations

Type I Diabetes Mellitus

New Diagnosis: HbA1c, BMP, c-peptide, insulin level, other labs depending on patient and presentation (for diagnostic criteria, see above; type 1 distinguished from type 2 based on presentation, physical exam, sometimes on labs such as c-peptide and diabetes antibodies)

- Hemoglobin A1C: Every 3 months (lifetime standard of care for DM)
  - This lab helps determine the overall status of blood glucose readings over a 3 month period and gives an average of all readings.
  - A1c goal is generally 7%; infants and toddlers, tolerate A1c goal of ~8%.
- Fasting Lipid Panel
  - Initial check soon after diagnosis, once blood sugars stabilized, if over 2 years old.
  - Repeat fasting lipid panel every 5 years if initial is normal (starting at 9 years old).
  - If abnormal, fasting lipid panel should be repeated at least 2 weeks later but less than 3 months later to confirm.
  - If confirmed abnormal, referral to dietician for lifestyle/diet modification.
- Thyroid and Thyroid Auto Antibodies
  - Obtain Free T4 & TSH at diagnosis and annually.
  - Antibodies not routine, but if done it includes thyroid peroxidase AB.
- Celiac screening
  - TTG IgA and total serum IgA soon after diagnosis.
  - Annually for the first 5 years, more frequent if symptoms.
- Eye exam
  - Initial eye exam soon after diagnosis to detect cataracts or major refractive errors
  - Annual eye exam should start at:
    - 9 years if 5-year duration diabetes.
    - 11 years if 2-year duration diabetes.
    - After 2 years duration if diabetes diagnosed in an adolescent.
- Urine microalbumin/creatinine screen
  - Spot urine microalbumin/creatinine annually after age 10 years.
  - If abnormal, repeat with first morning void or an overnight urine collection.
- Flu Vaccine recommended yearly.
- Dental evaluation recommended yearly.
- RN CDE referral for all aspects of Diabetes education. Work closely with CDE if patient is on Lantus + rapid acting insulin intensive regimen-ideally.
- Dietitian CDE for dietary/CHO counting/activity/insulin (learning to count carbs).
- All children should see Pediatric Endocrinologist every 3 months (may alternate depending on needs of family/primary provider).
  - Families need to know when to do Urine Ketones: if BS over 300 or if ill.

Table 8–1. Acceptable, Borderline-High, and High Plasma Lipid, Lipoprotein and Apolipoprotein Concentrations (mg/dL) For Children and Adolescents*

NOTE: Values given are in mg/dL; to convert to SI units, divide the results for TC, LDL-C, HDL-C and non-HDL-C by 38.6; for TG, divide by 88.6.

Category	Acceptable	Borderline	High+
TC	< 170	170-199	≥ 200
LDL-C	< 110	110-129	≥ 130
Non-HDL-C	< 120	120-144	≥ 145
ApoB	< 90	90-109	≥ 110
TG			
0-9 years	< 75	75-99	≥ 100
10-19 years	< 90	90-129	≥ 130

Category	Acceptable	Borderline	Low*
HDL-C	> 45	40-45	< 40
ApoA-I	>120	115-120	<115

*Values for plasma lipid and lipoprotein levels are from the National Cholesterol Education Program (NCEP) Expert Panel on Cholesterol Levels in Children. Non-HDL-C values from the Bogalusa Heart Study are equivalent to the NCEP Pediatric Panel cut points for LDL-C. Values for plasma apoB and apoA-I are from the National Health and Nutrition Examination Survey III.

+The cut points for high and borderline-high represent approximately the 95th and 75th percentiles, respectively. Low cut points for HDL-C and apoA-I represent approximately the 10th percentile.

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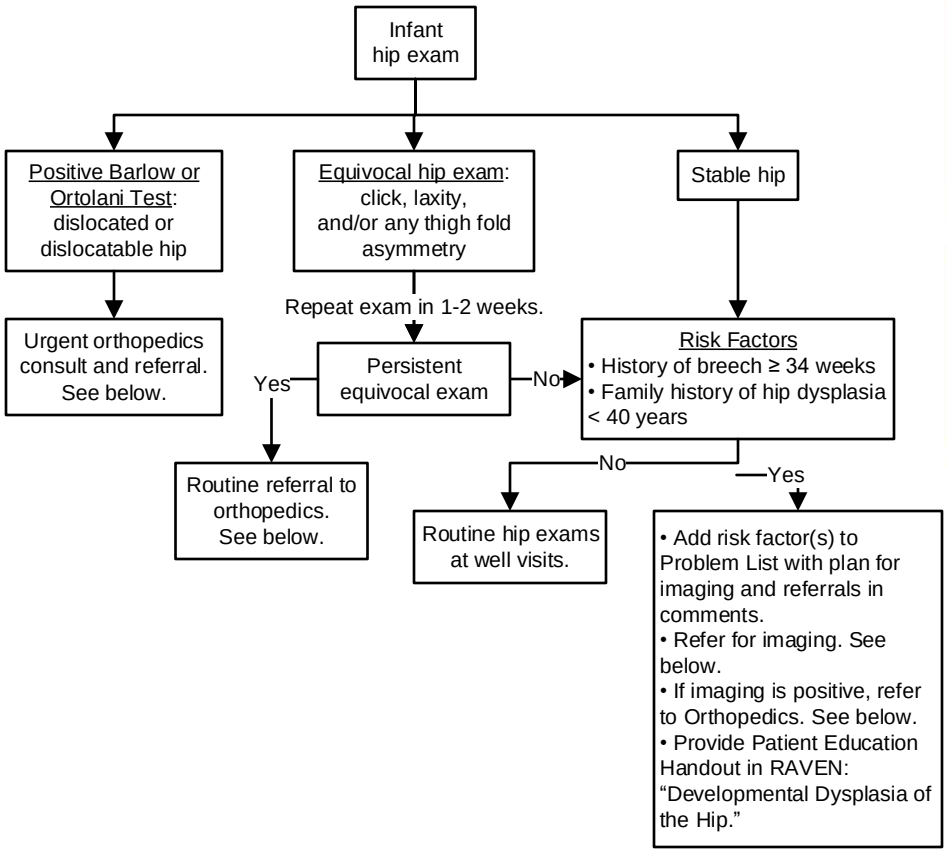
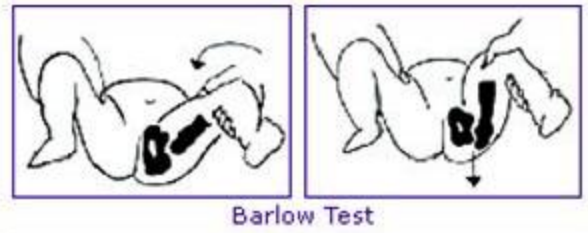
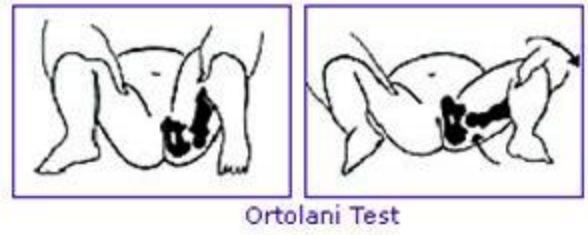
Treatment Protocol

Infant Hip Exam and Surveillance Protocol







The Barlow test is an attempt to dislocate the hip. If positive, you will feel the hip sublux or dislocate. The Ortolani test is the maneuver to reduce a dislocated hip. If positive, you will feel a clunk.

Orthopedics Consults & Referrals

1. Consultation:
   - Beneficiary patients: contact ANMC orthopedic surgeon on call at (907) 563-2662 (*97) or send message through Tiger Connect.
   - Non-beneficiary patients: contact Ken Thomas, MD at Anchorage Fracture & Orthopedics at (907) 563-3145.

2. Referral:
   - Place an order for "Refer to Orthopedics External" with brief history. Note the orthopedist who was consulted. Indicate where the referral should be sent.
   - Send a RAVEN Communication to Chronic Peds Case Manager Pool about the referral and level of importance.

Imaging

Patient must have either ultrasound or X-ray, as below.

1. Hip ultrasound: 6 weeks to 4 months of age.
   - Performed at Alaska Regional Hospital.
   - Place order for "Refer to Pediatric Clinic External (MRI / EEG / VFSS / Hip US)" with brief history.
   - If patient is a beneficiary, request follow-up appointment at Southcentral Foundation Team B.
   - If patient is not a beneficiary, request follow-up appointment with a pediatric provider in Bethel.
   - Send a RAVEN Communication to Chronic Peds Case Manager Pool about the referral and level of importance.

2. X-ray, AP pelvis: over 4 months of age. (Note: in premature infants, ossification of femoral heads is delayed. May use corrected gestational age of 4 months or later.)
   - Performed at YKHC.
   - Place an order for "XR Pelvis (Pelvis AP only)" and put in comments "AP view with hips in neutral position to rule-out developmental dysplasia of the hip."
   - Send a RAVEN Communication to Chronic Peds Case Manager Pool stating the order was placed and requesting an appointment for this with a pediatric provider in Bethel.

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Treatment Protocol

Induced Sputum Collection Protocol

POLICY: To obtain sputum samples safely and effectively in pediatric patients

PROCEDURE: Induced Sputum Collection in Pediatric Patients

1. Premedicate with albuterol 2.5 mg/3mL (0.083%) solution – 3 mL via nebulizer to induce bronchodilation and better facilitate delivery of hypertonic saline. This can help prevent the development of bronchospasm during delivery of hypertonic saline. An MDI with a mask and spacer is an acceptable substitution.

2. Give 5 mL of 3% hypertonic saline solution via nebulizer over period of at least 10 minutes. Prolonged administration has been shown to yield better samples.

3. If patient has copious nasal secretions, consider nasal suction with olive tip.

4. Obtain mucus specimen trap with suction catheter appropriate for patient size. Measure from tip of nose to the tragus for depth of catheter insertion and obtain sample via suction of the nasopharynx. The goal is to induce a gag and then a cough. Sample is expected to be blood-tinged.

Note: This process may induce a vagal response. The patient should be sitting up with feet supported or lying down, NOT standing. If vasovagal syncope does occur, immediately place the patient supine with the legs elevated.

5. Place specimen in appropriate collection container for desired test. Precise labeling is essential to prevent specimen rejection from state lab.

   a. For rule-out pulmonary tuberculosis, collect 3 induced sputum samples at least 8 hours apart – one must be first morning sample. Send for Acid Fast Bacilli Smear and Culture. Sample must be in an AFB container (conical with orange top), with a minimum volume of 5 mL; add sterile water to dilute if necessary. Two samples should also be sent for Xpert MTB-RIF. These samples should be 3-5 mL of mucous in a sterile specimen cup. Do not dilute, or "saline wash" nares during suction for this specimen. AFB and Xpert may be obtained at the same time; if quantity not sufficient for both tests, prioritize the AFB.

   b. Standard sputum cultures do not have a minimum volume and can be placed in a sterile specimen cup.

   c. Label must contain full user name of collector and date and time of the collection. **This should be written below the barcode, NOT beside it.**

   d. Collect specimen in RAVEN. Confirm the correct accession number and deselect any additional (future) accession numbers. Ensure the collector ID, date, and time entered into RAVEN are an exact match to the written label.

***Contraindications to above procedure**: oxygen saturation of <92% despite supplemental oxygen therapy, inability to protect the airway, severe bronchospasm, or designation as inappropriate by the clinician for another reason (eg., midface trauma). After exclusion or resolution of these conditions, sputum induction can be considered.

Note: This procedure can also be used for patients who are able to follow instructions but do not have a productive cough. In these cases, suction may or may not be necessary.

Documentation Requirements for Pediatric Nutritional Supplements

The following resource is from the Medicaid Certificate of Medical Necessity.

Medicaid, Medicare, and other insurers have specific requirements for medical provider documentation. If those requirements are not met, nutritional supplements will not be covered.

Documentation Requirements for the Prescription of Nutritional Supplements:

The following objective documentation is required to show the medical necessity of the orthotic services being prescribed.

This information needs to appear in the body of the medical provider's chart notes:

- Diagnosis of the patient.
- Product being prescribed and why it is needed. (Example: Pediasure)
- Goal or target weight for the patient.
- Total daily caloric requirement.
- Total daily calories obtained from ingestion (oral) foods.
- Total daily calories to be obtained from nutritional supplement.

Documentation Example

Pediasure is medically necessary for this child.
Diagnosis: dysphagia (R13.10), G-tube dependence
Product: Pediasure
Medical Necessity: Patient has severe dysphagia. He is undergoing oral feeding therapy but is unable to take any degree of sufficient calories by mouth and is thus entirely dependent on a G-tube for nutrition. Pediasure will give him the nutrition he needs to survive.
Goal/target Weight: currently at target weight of XX kg (XXth percentile for age when corrected for prematurity). Target weight along this trajectory in one year will be XX kg.
Total Daily Caloric Requirement: XX calories/day (usually estimate 100-120 cal/kg/day – adjust based on growth)
Total Calories Obtained from Oral Intake: 0 calories/day
Total Daily Calories to be Obtained from Nutritional Supplement: XX calories/day

Documentation Requirements for Pediatric Orthotics

The following resource is from Northern Orthopedics, Inc.

Medicaid, Medicare, and other insurers have specific requirements for medical provider documentation. If those requirements are not met, orthotic devices will not be covered.

Documentation Requirements for the Prescription of Orthotic Devices:

The following objective documentation is required to show the medical necessity of the orthotic services being prescribed.

This information needs to appear in the body of the medical provider's chart notes:

- Diagnosis of the patient.
- Item being prescribed and why it is needed.
- How long the patient is expected to use the item.
- If this is to be custom or non-custom item. (When custom, please specify why a non-custom item will not work.)

If you are prescribing repairs/adjustments or a replacement to an existing orthosis:

- Document that the patient still requires a functioning orthosis.
- Explain why the current orthosis is no longer able to function as intended.

Please fax chart notes documenting this required information to Northern Orthopedics, Inc. Fax: (907) 561-2157.

If you have any questions about this required documentation feel free to call Northern Orthopedics, Inc. at (907) 561-1777.

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Clinical Resource

Suspected Septic Arthritis & Osteomyelitis

Please see the **ANMC Pediatric Acute Hematogenous Septic Arthritis/Osteomyelitis Guideline**.

- Please note: this guideline was designed at ANMC, where recommended labs, MRI, and operative management are immediately available and antibiotics can be started after these interventions.
- When evaluating a patient at YKHC with possible septic arthritis or osteomyelitis, strongly consider empiric antibiotics if there is going to be a delay of >6 hours to perform the recommended work-up (joint aspiration, surgical drainage, etc.), as noted in ANMC's guideline.
- Always discuss antibiotics with ANMC consultants and advocate for empiric usage if appropriate. Keep in mind possible delays, including weather, transport difficulties, and other emergencies. If deferring antibiotics, ensure that patient is closely monitored for development of worsening infection.
- Always feel free to consult YKHC pediatric hospitalist with any questions.