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PART II: MEDICAL EMERGENCIES

CMBT MEDIC POCCKET GUIDE

91B
**MEDICAL EMERGENCY: ANGINA**

**PATIENT ASSESSMENT**
- Chest pain, radiating to arms, neck jaw, or shoulder
- Nausea, vomiting
- Moist skin
- Pain goes away with rest
- Shortness of breath
- Pain lasts 3 - 5 minutes

**MEDICAL EMERGENCY: ACUTE MYOCARDIAL INFARCTION (AMI)**

**PATIENT ASSESSMENT**
- Chest pain
- Pain does not go away with rest
- Feeling of impending doom
- Pain lasts 30 minutes to several hours
- Nausea, vomiting
- Moist, pale skin
- Shortness of breath

**PATIENT CARE - ANGINA AND AMI**
- Give high-flow oxygen
- Position to facilitate breathing
- Calm and reassure patient
- Assist patient with prescribed dose of nitroglycerin if systolic B/P is < 90
- Transport and monitor

**MEDICAL EMERGENCY: STROKE (CVA)**

**PATIENT ASSESSMENT**
- Confusion and/or dizziness
- Paralysis (usually on one side of body)
- Impaired speech
- Facial paralysis
- Headache
- Unequal pupil size
- Impaired vision
- Rapid, full pulse
- Respiratory pattern changes
- Convulsions
- Coma
- Loss of bladder and bowel control

**PATIENT CARE - CONSCIOUS PATIENT**
- Ensure an open airway
- Keep patient calm
- Administer high-flow oxygen
- Monitor vital signs
- Transport in semireclined position
- Give nothing by mouth
- Keep warm

**PATIENT CARE - UNCONSCIOUS PATIENT**
- Ensure an open airway
- Administer high-flow oxygen via BVM
- Keep warm
- Place in recovery position
- Be prepared for vomiting and/or seizures
- Monitor vital signs
<table>
<thead>
<tr>
<th>MEDICAL EMERGENCY: ASTHMA</th>
<th>MEDICAL EMERGENCY: CHRONIC BRONCHITIS</th>
<th>MEDICAL EMERGENCY: EMPHYSEMA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT ASSESSMENT</strong></td>
<td><strong>PATIENT ASSESSMENT</strong></td>
<td><strong>PATIENT ASSESSMENT</strong></td>
</tr>
<tr>
<td>Persistent cough</td>
<td>Shortness of breath</td>
<td>Rapid pulse, may be irregular</td>
</tr>
<tr>
<td>Wheezing and coughing</td>
<td>Tightness in the chest</td>
<td>Breathing through pursed lips</td>
</tr>
<tr>
<td>Increased pulse rate</td>
<td>Edema of the lower extremities</td>
<td>Barrel-chest appearance</td>
</tr>
<tr>
<td>Patient's face becomes red</td>
<td>Cyanosis</td>
<td>Wheezing</td>
</tr>
<tr>
<td>Distended (bulging) neck veins</td>
<td>Cyanosis</td>
<td></td>
</tr>
<tr>
<td>Cyanosis (a late sign)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT CARE</strong></td>
<td><strong>PATIENT CARE</strong></td>
<td><strong>PATIENT CARE</strong></td>
</tr>
<tr>
<td>Calm and reassure the patient</td>
<td>Assist the patient in taking any</td>
<td>Position to facilitate breathing</td>
</tr>
<tr>
<td>Lasso restrictive clothing</td>
<td>prescribed asthma medications</td>
<td></td>
</tr>
<tr>
<td>Position to facilitate breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administer high-flow oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport ASAP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**DIABETIC EMERGENCY**
**DIABETIC COMA**
**(HYPERGLYCEMIA)**

**PATIENT ASSESSMENT**
- Gradual onset of signs and symptoms, over a period of days
- Complaint of dry mouth and intense thirst
- May appear intoxicated
- Abdominal pain and vomiting common
- Gradually increasing restlessness, confusion, followed by stupor
- Coma with these signs
  - Signs of air hunger—deep, sighing respirations
  - Weak, rapid pulse
  - Warm, red, dry skin
  - Eyes appear sunken
  - Normal or slightly low blood pressure
  - Breath smells of acetone—sickly sweet, like nail polish remover

**PATIENT CARE**
- Administer high concentration of oxygen
- Immediately transport to a medical facility
- Arrange for ALS intercept

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**DIABETIC EMERGENCY**
**INSULIN SHOCK**
**(HYPOGLYCEMIA)**

**PATIENT ASSESSMENT**
- Rapid onset of signs and symptoms, over a period of minutes
- Dizziness and headache
- Abnormal hostile or aggressive behavior may appear to be acute alcoholic intoxication
- Fainting, seizures, and occasionally coma
- Normal blood pressure
- Full, rapid pulse
- Intensely hungry
- Skin cold, pale, and clammy, perspiration may be profuse
- Copious saliva, drooling

**PATIENT CARE**
- Conscious patient
  - Administer granular sugar, honey, Lifesaver, or other candy placed under the tongue, orange juice, or glucose
- Unconscious patient
  - Avoid giving liquids, provide "sprinkle" of granulated sugar under tongue, or dab of glucose if protocols permit
- Turn head to side or place in lateral recumbent (recovery) position
- Provide a high concentration of oxygen
- Transport to a medical facility
- Arrange for ALS intercept

**NOTE:** If in doubt, give sugar
# Seizure Disorders

## Patient Assessment
- **Tonic phase**: The body becomes rigid, the patient may be confused and want to sleep.
- **Clonic phase**: The body jerks violently.
- **Postconvulsive phase**: Seizure ends. The patient may be confused and want to sleep.
- **Diagnosis**: Seizure disorder.

## Patient Care
- **Warning**: Two or more seizures without regaining full consciousness and lasting 5 to 10 minutes or more is known as status epilepticus.
- **Assist ventilations with BVM, suction as needed**: DO NOT restrain the patient.
- **Loosen restrictive clothing**: Remove objects that may harm the patient.
- **Protect the patient from injury**: Keep the patient at rest and have suction available.
- **Administer high-flow oxygen**: Avoid if possible, bright lights and the use of sirens.

## Acute Abdominal Distress

### Patient Assessment
- **Diarrhea and vomiting**
- **Diarrhea or constipation**
- **Rapid pulse**
- **Low blood pressure**
- **Rapid and shallow breathing**
- **Distention of the abdomen**
- **Tenderness**
- **Rigidity of abdomen**
- **Abdominal wall muscle guarding**
- **An obvious protrusion seen or felt in the abdominal wall**

### Patient Care
- **Maintain an open airway**: Be alert for vomiting.
- **Position the patient**
- **Transport and continue to monitor**
- **Administer high-flow oxygen**
- **DO NOT give anything by mouth**
- **Save all vomitus**
INGESTED POISONS

PATIENT ASSESSMENT
- Burns or stains around the patient's mouth.
- Unusual breath odors, body odors, or odors on the patient's clothing or at the scene.
- Abnormal breathing.
- Abnormal pulse rate and character.
- Sweating - often profuse.
- Dilated or constricted pupils.
- Excessive tear formation.
- Excessive salivation or foaming at the mouth.
- Painful mouth, throat, or swallowing.
- Abdominal pain, tenderness.
- Nausea, vomiting.
- Diarrhea.
- Seizures.
- Altered states of consciousness.
- Any signs of shock.

PATIENT CARE OF CONSCIOUS PATIENT
- Maintain an open airway.
- Administer high-flow oxygen.
- Contact Poison Control or Medical Control. If ordered:
  - Dilute the poison with glass of water or milk.
  - Administer Syrup of Ipecac followed by glass of water, if local protocol permits.
  - Dose of Syrup of Ipecac:
    - 30 ml or 2 tablespoons (adult).
    - 15 ml or 1 tablespoon (child).

PATIENT CARE OF UNCONSCIOUS PATIENT
- Maintain an open airway.
- Administer high-flow oxygen.
- Give nothing by mouth.
- Treat for shock.
- DO NOT induce vomiting with:
  - Patient not fully awake and alert (unconscious).
  - Patient who ingested a corrosive or petroleum-based product.

NOTE: Under 1 year, DO NOT give ipecac.
- May repeat Syrup of Ipecac dose 1 time if no vomiting occurs within 20 minutes.
- Save all vomitus.
- Treat for shock.
- Transport ASAP and monitor.
**INHALED POISONS**

### PATIENT CARE
- Remove the patient from the source.
- Avoid touching contaminated clothing.
- Maintain an open airway.
- Provide needed basic life support measures.
- Administer a high concentration of oxygen.
- Remove contaminated clothing.
- Call Medical Control or the Poison Control Center.
- Be prepared for vomiting.
- Put patient in the lateral recumbent position.
- Transport ASAP.

### PATIENT ASSESSMENT FOR A VARIETY OF INHALED POISONS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>(early sign)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Nausea, shortness of breath</td>
</tr>
<tr>
<td>Fainting</td>
<td>Coughing, mild discomfort in cough</td>
</tr>
<tr>
<td>Cyanosis</td>
<td>Severe headache, nausea and vomiting</td>
</tr>
<tr>
<td>Unconsciousness</td>
<td>Cyanosis, severe cases, cherry red skin color (rare, late sign)</td>
</tr>
<tr>
<td>Severe cases</td>
<td></td>
</tr>
</tbody>
</table>
**ABSORBED POISONS**

**PATIENT ASSESSMENT**
- Skin reactions (from mild irritations to chemical burns).
- Itching.
- Irritation of the eyes.
- Headache.
- Increased relative skin temperature.
- Abnormal pulse and/or respiration rates.
- Anaphylactic shock (rare).

**PATIENT CARE**
- Move the patient from the source, avoiding contact with the substances.
- Use water to flood all the areas of the patient's body that have been exposed to the poison.
- Dry chemicals should be brushed from the skin before washing.
- Contact Poison Control or Medical Control.
- Remove all contaminated clothing (including jewelry) and wash the affected areas of the skin again.
- Be alert for anaphylactic shock.
- Transport ASAP.

**SNAKEBITE**

**PATIENT ASSESSMENT**
- A noticeable bite on the skin.
- Pain and swelling in the bite area.
- Rapid pulse and labored breathing.
- Progressive general weakness.
- Vision problems (dim or blurred).
- Nausea and vomiting.
- Seizures.
- Drowsiness or unconsciousness.

**PATIENT CARE**
- Contact Poison Control or Medical Control.
- Keep the patient calm.
- Treat for shock and conserve body heat.
- Locate the fang marks.
- Remove any rings, bracelets, or other constricting items on the bitten extremity.
- Keep any bitten extremities immobilized and at heart level or below.
- Apply a light constricting band above and below the wound.
- Transport the patient, carefully monitoring vital signs.
<table>
<thead>
<tr>
<th>Age</th>
<th>Blood Pressure</th>
<th>Pulse Rate</th>
<th>Respiratory Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Systolic</td>
<td>Mean Diastolic</td>
<td></td>
</tr>
<tr>
<td>Neonates</td>
<td>80</td>
<td>60</td>
<td>30 - 50</td>
</tr>
<tr>
<td>6 - 12 months</td>
<td>89</td>
<td>66</td>
<td>20 - 30</td>
</tr>
<tr>
<td>1 year</td>
<td>96</td>
<td>64</td>
<td>14 - 22</td>
</tr>
<tr>
<td>2 years</td>
<td>98</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>6 years</td>
<td>100</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>12 years</td>
<td>114</td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>
# PEDIATRICS: GLASGOW COMA SCALE

## EYE OPENING:

<table>
<thead>
<tr>
<th>INFANTS</th>
<th>CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
<td>Spontaneous</td>
</tr>
<tr>
<td>To speech</td>
<td>To speech</td>
</tr>
<tr>
<td>To pain</td>
<td>To pain</td>
</tr>
<tr>
<td>No response</td>
<td>No response</td>
</tr>
</tbody>
</table>

## BEST MOTOR RESPONSE:

<table>
<thead>
<tr>
<th>INFANTS</th>
<th>CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal spontaneous movement</td>
<td>Normal spontaneous movement</td>
</tr>
<tr>
<td>Withdraws to touch</td>
<td>Withdraws to touch</td>
</tr>
<tr>
<td>Withdraws to pain</td>
<td>Withdraws to pain</td>
</tr>
<tr>
<td>Abnormal flexion</td>
<td>Abnormal flexion</td>
</tr>
<tr>
<td>Abnormal extension</td>
<td>Abnormal extension</td>
</tr>
<tr>
<td>No response</td>
<td>No response</td>
</tr>
</tbody>
</table>

## BEST VERBAL RESPONSE:

<table>
<thead>
<tr>
<th>INFANTS</th>
<th>CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coos and babbles</td>
<td>Oriented</td>
</tr>
<tr>
<td>Irritable, cries</td>
<td>Confused</td>
</tr>
<tr>
<td>Cries to pain</td>
<td>Inappropriate word</td>
</tr>
<tr>
<td>Moans to pain</td>
<td>Non-specific sounds</td>
</tr>
<tr>
<td>No response</td>
<td>No response</td>
</tr>
</tbody>
</table>

## TOTAL COMA SCALE POINTS:

- 14 to 15 = 5 coma scale points
- 11 to 13 = 4 coma scale points
- 8 to 10 = 3 coma scale points
- 5 to 7 = 2 coma scale points
- 3 to 4 = 1 coma scale point
<table>
<thead>
<tr>
<th>PEDIATRIC EMERGENCY: FEBRILE SEIZURES</th>
<th>PATIENT ASSESSMENT</th>
<th>PATIENT CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever &gt; 10³ (may be as high as 106)</td>
<td>Active seizure or postictal state</td>
<td>Cool with tepid water. (DO NOT allow child to shiver.) Administer oxygen. Transport and monitor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT ASSESSMENT</th>
<th>PATIENT CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe respiratory distress</td>
<td>Sit child up. Transport IMMEDIATELY.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEDIATRIC EMERGENCY: RESPIRATORY DISORDERS: EPIGLOTTIS</th>
<th>PATIENT ASSESSMENT</th>
<th>PATIENT CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>High fever and excessive drooling; tripod position (sitting up and leaning forward). Severe respiratory distress.</td>
<td>External life-threatening condition. DO NOT place anything in or attempt to look into mouth. Hold high-flow oxygen held at child's face.</td>
<td>Sit child up. Transport IMMEDIATELY.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT ASSESSMENT</th>
<th>PATIENT CARE</th>
</tr>
</thead>
</table>
**NEWBORN VITAL SIGNS**

- Pulse rate, 140 - 180 per minute.
- Respiratory rate, 40 - 60 per minute.

**Normal Delivery Procedures**

- Check for crowning.
- Prevent explosive delivery.
- Support head.
- Suction mouth and nose.
- Aid in delivering the shoulders.
- Support the trunk.
- Support the feet.
- Position for drainage.
- Clamp cord 6-8 inches from baby; place second clamp 2 inches from first clamp.
- Cut cord between clamps.
- Maintain airway, suction as needed.
- Keep baby warm. Keep head covered.
- Do APGAR 1 minute after birth.
- Do APGAR 5 minutes after birth.

(See chart on this page.)

<table>
<thead>
<tr>
<th>Sign</th>
<th>Score</th>
<th>1 min</th>
<th>5 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate</td>
<td>0</td>
<td>Absent</td>
<td>Absent</td>
</tr>
<tr>
<td>Respiration</td>
<td>1</td>
<td>Below 100</td>
<td>Slow and irregular</td>
</tr>
<tr>
<td>Effort</td>
<td>2</td>
<td>Over 100</td>
<td>Normal; crying</td>
</tr>
<tr>
<td>Muscle tone</td>
<td>1</td>
<td>Limp</td>
<td>Active; good motion in extremities</td>
</tr>
<tr>
<td>Irritability</td>
<td>0</td>
<td>No response</td>
<td>Activity; grimace</td>
</tr>
<tr>
<td>Skin color</td>
<td>1</td>
<td>Pink or typical newborn color; blue hands and feet</td>
<td></td>
</tr>
</tbody>
</table>

**Table 1. The APGAR Scoring Method.**