Yellow Section Change Document PRE MDPB

Location Section/Page #	Change	Purpose of Change (Provider Input, Stakeholder Input, Evolution of Evidence, Best Practice, etc.)	Evidence for Change	Expected Impact (Operational, Educational, Financial, QI, Medical Direction, Communication, etc.)	Size of Change (Small/Medium/ Large)	Outcome
Yellow 1/99	"Some drugs such as prolonged release opioids, buprenorphine or methadone may require doses greater than 4 mg." Change to "Some drugs are longer acting opioids and may require many repeated doses which could exceed 4 mg (i.e. buprenorphine, methadone, fentanyl patch)."	Lost this language – added back for clarity and clinical care		Educational – need to review what are long-acting opioids (Dr. Nash to assist with list for education)	Small	Accepted
Yellow2/100	Consider calcium gluconate for calcium channel blocker OD 60 mg/kg dose (4-6 grams)	Offers treatment to sick Ca-channel blocker patients; dosing would require 6-8 vials; will explore further when discuss Crush injuries		Educational/Cost Currently carry 1 gram;approx $8/vial Requires: space, dilution/administer via drip.	Medium	Tabled. Will come back after discuss crush Injuries, hyperkalemia (in cardiac arrest); will also need to add pediatric dose
Yellow2/100	Add to PEARL: **Do not** give naloxone to a patient who is in cardiac arrest. This practice is not helpful and may be harmful as it distracts from the best performance of tasks that are necessary for the successful resuscitation of	Provider input	Still being seen in some areas and clarification needed.	Educational	Small	Accepted

	cardiac arrest. Refer to the 2019 Naloxone White Paper for more information.					
Yellow/100	Bullet “e” under TCA add: “consider 2 grams magnesium sulfate IV/IO over 5 minutes for arrhythmia that does not respond to bicarbonate” Add Pediatric dosing: 50 mg/kg (max dose of 2 grams) IV/IO over 5 minutes Add that sodium bicarb in should be administered IV “push” Add to sodium bicarbonate pediatric dosing – that bicarb needs to be diluted in D5W May repeat bicarb until QRS <100 msec.	Additional treatment option, clarification and inclusion of pediatric dosing	Tricyclic antidepressant poisoning treated by magnesium sulfate: a randomized, clinical trial. Emamhadi M, Mostafazadeh B, Hassanijirdehi M Drug Chem Toxicol. 2012;35(3):300. Epub 2012 Feb 7. Efficacy of long duration resuscitation and magnesium sulfate treatment in amitriptyline poisoning Citak A, Soysal DD, Uçsel R, Karaböcüoğlu M, Uzel N Eur J Emerg Med. 2002;9(1):63. Effects of magnesium sulfate and lidocaine in the treatment of ventricular arrhythmias in experimental amitriptyline poisoning in the rat. Knudsen K, Abrahamsson J Crit Care Med. 1994;22(3):494.	operational	medium	Accepted

Yellow Section Change Document PRE MDPB

Yellow/100	Bullet “e” under TCA, change QRS goal from 120 to 100 msec	Lower threshold for QRS duration based on toxicity research	Demographic and electrocardiographic factors associated with severe tricyclic antidepressant toxicity. Caravati EM, Bossart J Toxicol Clin Toxicol. 1991;29(1):31. Value of the QRS duration versus the serum drug level in predicting seizures and ventricular arrhythmias after an acute overdose of Tricyclic antidepressants. Boehnert MT, Lovejoy FH Jr N Engl J Med. 1985;313(8):474.	Operational	Medium	Accepted; will confirm with toxicologist
Yellow/100	Bullet “e” under TCA add “refer to seizure protocol for TCA induced seizure activity”	Best practice. Points out potential for seizure and clarify it is treated the same way	NA	Operational	Small	Accepted
Yellow/100	Bullet “e” under TCA add “consider norepinephrine infusion in patients with hypotension refractory to bicarbonate and/or fluid bolus”	Best Practice. Improves treatment of hypotensive patients with TCA overdose.	Response to dopamine vs norepinephrine in tricyclic anti-depressant induced hypotension. Tran et al. Acad Emerg.	Operational	Medium	Accepted

Yellow Section Change Document PRE MDPB

	Add pediatric norepi dose here as well.		1997;4(9):864.			
Yellow/101	Add pearl "prophylactic benzodiazepines have been shown to improve outcomes in nerve agent toxicity"	Improve understanding of treatment provided	Pharmacokinetic studies of intramuscular Midazolam in guinea pigs challenged with soman. Capacio et. al. Drug Chem Toxicol. 2004;27(2):95 Anticonvulsant treatment of nerve agent seizures: anticholinergic vs diazepam in soman intoxicated guinea pigs. McDonough et al. Epilepsy Res. 2000;38(1):1 Organophosphate Induced Convulsions and Prevention of neuropathological Damages. Tuovinen. Toxicology. 2004;196(1-2:31.	education	small	Rejected: General thoughts that the midaz is already highlighted and adding language may not be necessary….
Yellow/102	Delete OLMC for Cyanokit in moderate exposure category	Best practice Lower threshold for treatment of symptomatic patients	NA; NNEPC interested in lactate or ABG, but we cannot do that.	operational	medium	Tabled; waiting for Toxicology input
Yellow/105	Add to EMT "7. Apply clean dry dressings to frostbitten extremities and between involved fingers and toes. 8. Consider transport to ~~IR~~ capable facility for cases of	Draw attention to treatment of concomitant frostbite and also suggest appropriate dispo for severely	Wilderness Medical Society Clinical Practice Guidelines for the Prevention and Treatment of Frostbite: 2019 Update	Operational; follow the regional trauma desitation protocol	Medium	Yes to dressings; Passed with - Trauma system hospital (rather than IR capable hospital) - + Add

	moderate to severe frostbite.	frostbitten extremities; Improve immediate treatment of frostbite				definitions for moderate to severe, put in PEARLS rather than as #8 in the protocol as it is guidance.
Yellow/105 *new suggestion for 5/20/20 MDPB meeting based on 4/15/20 motion above	Moderate to severe frostbite is defined as any of the following: 1. Frostbite involving the hands, feet, face or genitals, 2. Frostbite associated with cyanotic tissue, blisters (clear or hemorrhagic) or skin necrosis, 3. Frostbite associated with loss of sensation or weakness in the involved areas.	Definition for moderate to severe frostbite as noted being needed in the PEARL above	There has never been a definitive categorization of initial frostbite aside from the standard 1st, 2nd 3rd and 4th degree frostbite which isn't applicable since many of these clinical findings can be delayed (hours to days). Suggest using more broader guidelines if recommending transport to a trauma/burn facility.	Educational Operational Consider pictures of blisters and necrosis in the education product vs. in the protocol	Medium	Accepted
Yellow/106	Add to pearl "Massaging the extremities will not significantly increase body temperature and it may worsen the damage caused by frostbite."	Remove ambiguity, point potential harm. Avoid unnecessary trauma to frostbitten tissue	Wilderness Medical Society Clinical Practice Guidelines for the Prevention and Treatment of Frostbite: 2019 Update	education	small	Accepted
Yellow/109	add #4 "Pay close attention for circum-rescue collapse; the drop in catecholamines and mental relaxation that occurs just before, during or after rescue that may lead to life threatening hypotension or arrhythmia	Highlight this potentially life threatening phenomena that may not be considered in the process of rescue or immediately after	Wilderness Medical Society Clinical Practice Guidelines for the Out-of-Hospital Evaluation and Treatment of Accidental Hypothermia: 2019 Update	educational	small	Accepted: Pearl in submersion & hypothermia – add definition – hemodynamic collapse + Kate's language in the

	(i.e. VF)					draft
Yellow/109	Change #9 to "refer to blue 10 Anxiolysis in CPAP"	Less ambiguous, links and reminds of anxiety with CPAP protocol	NA	operational	small	Accepted: Link to Blue 10; discussion re: concern for benzos in the pop'n, however, cannot do without OLMC which is another safeguard. Not unanimous (2 opposed, 1 abstained).