

Before submitting this referral please refer to Useful MIDAS Docs for Managing Inpatients [click here](#) or RMO Pathways [click here](#)

Request:

Spoken To: ★

Clinical Information: ★

Request/ Question ★

Patient vital signs at time of referral

Resp Rate ★

Oxygen Sats ★

Heart Rate ★

Blood Pressure ★

Temperature ★

GCS ★

EWS Score ★

If EWS score >7 please tick to confirm patient has been seen by surgical regic consultant TODAY (referral will be declined otherwise)

Primary surgical problem ★

Date of Surgery (if applicable)

Admission Date ★

Acute Admission ★

Has the patient been seen by a Surgical Consultant? ★ Yes No Please enter LAST SEEN date

Medical problem seeking help with

Respiratory Yes No Chest xray result

Cardiac Yes No ECG result

Renal

Renal Referrals must include the information below

Urinalysis

Creatinine

eGFR

Other test results eg. ABG if acute desaturation <92%, CT head, renal USS

Resus Status ★

Requesting Consultant ★ Display All

Further Correspondence:

Supporting Document(s): Browse...

i Note that a confirmation message will be displayed on successful submission. You can also confirm a successful submission by reviewing on the my requests or search tabs. In the unlikely circumstance that the message is not displayed, please attempted to resubmit after closing and reopening the application. If problems continue please contact system support.

Acutely wheezy patient with asthma and no
known diagnosis of COPD



| Symptoms | Mild | Moderate | Severe and life-threatening* |
|--------------------------------|-----------|----------------|------------------------------|
| Altered consciousness | No | No | Yes |
| Physical exhaustion | No | No | Yes |
| Speech | Sentences | Words | Unable to speak |
| Pulse | <100/min | 100-120/min | >120/min |
| Respiratory rate | <20/min | 20-30/min | >30/min |
| Central cyanosis | Absent | May be present | Likely to be present # |
| Wheeze intensity | Variable | Moderate-loud | Often quiet |
| PEFR (% of best) | >60% | 40-60% | <40% or <100 l/m |
| FEV ₁ (% predicted) | >60% | 40-60% | <40% or <1.0 L |
| SaO ₂ | >94% | 90-94% | <90% |

Cyanosis and paradoxical pulse may be absent, but when present indicate severe obstruction

* Any of these features indicates that the episode is severe. The absence of any feature does not exclude a severe attack.

1. Establish severity

2. Start treatment

If **mild**, start inhaled or nebulised salbutamol and consider oral prednisone

If **moderate**, check ABG and:

Start high flow oxygen aiming sats >93% (4-6L/min Hudson or 2-4L/min NP if >50 years old or smoker)

and nebulised/inhaled salbutamol or duolin q20-30 mins

and 40mg prednisone od or 100mg IV hydrocortisone qid

and IV antibiotics if febrile or infective symptoms

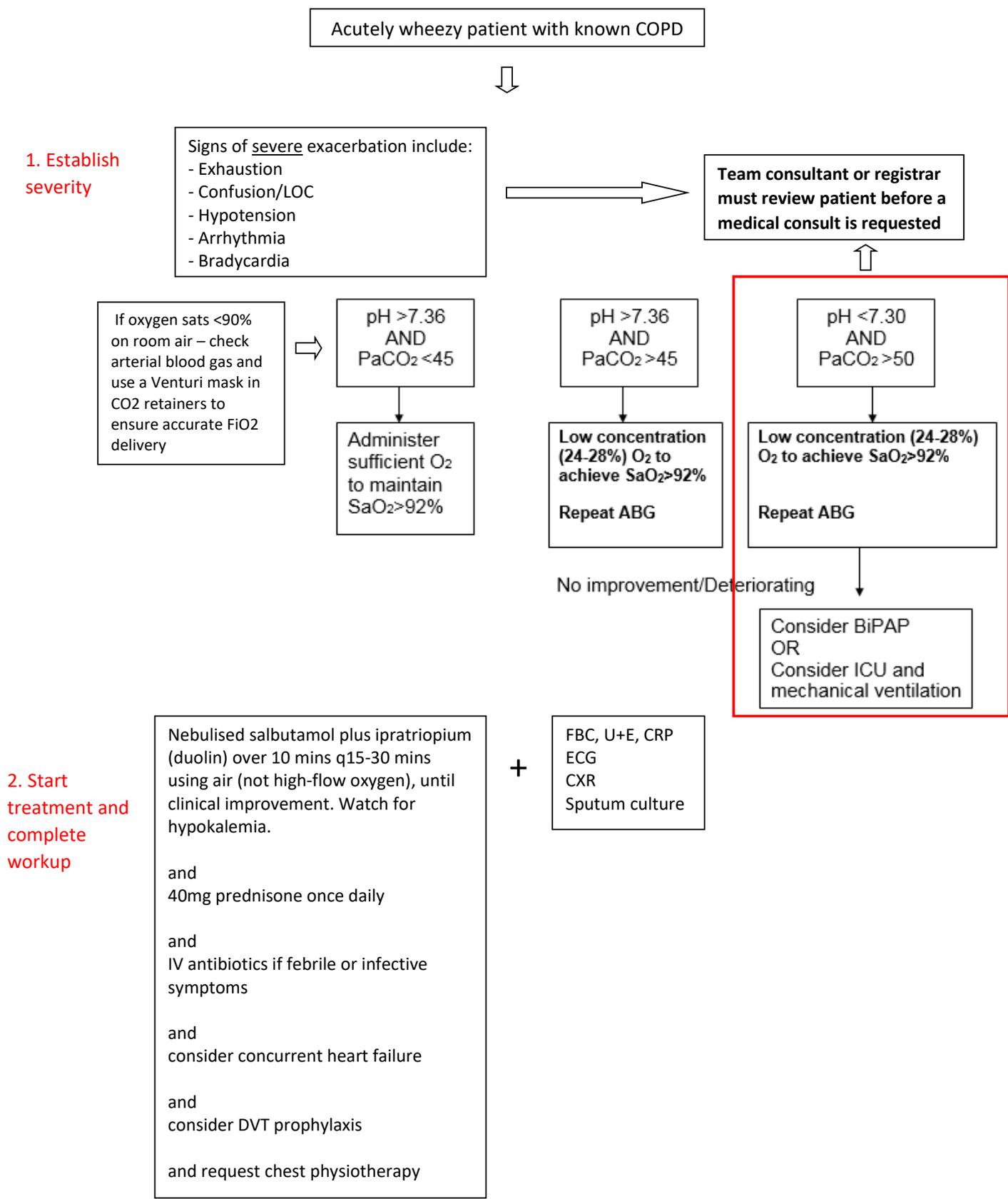
and monitor PEFR q2hrly until >60%

use this link to calculate predicted PEFR:
<https://www.mdcalc.com/estimated-expected-peak-expiratory-flow-peak-flow>

If **severe**, start treatment as for moderate asthma and obtain urgent review by team registrar or SMO before asking for a medical consult

If no response to initial treatment

Chest xray to rule out pneumothorax or if clinical evidence of pneumonia/effusion. Consider 'cardiac wheeze' if evidence of CHF



1. Confirm the diagnosis

Confused patient

Confirm delirium with 4A's test

<https://www.mdcalc.com/4-test-delirium-screening>

or similar. Consider collateral history. Examine the patient.

2. Identify the cause

Infection?

- High or low temp
- Septic screen
- Consider biofilm infection if in-dwelling device (eg IDC, drain, CVC)

Dehydration?

- JVP, urine outpt
- Postural BP
- Tachycardia?
- Daily weighs
- Diuretics?

Drug/Alcohol withdrawal?

- Collateral hx.
- Review all meds
- Drug levels (eg. digoxin, lithium, anticonvulsants)
- Steroids?

Metabolic?

- Glucose, U+Es, Ca/Mg/PO₄, LFTs, INR, TFTs, B12/Folate, CK, troponin, blood gas, ECG

Urinary retention?

- Bladder scan if not obvious clinically

Pain?

- Check use of analgesia, minimise opioids and give regular paracetamol

3. If focal neurology or no cause found

CT head +/- lumbar puncture

ESR

Autoimmune screen

VDRL serology

4. Manage underlying cause and agitation, if present

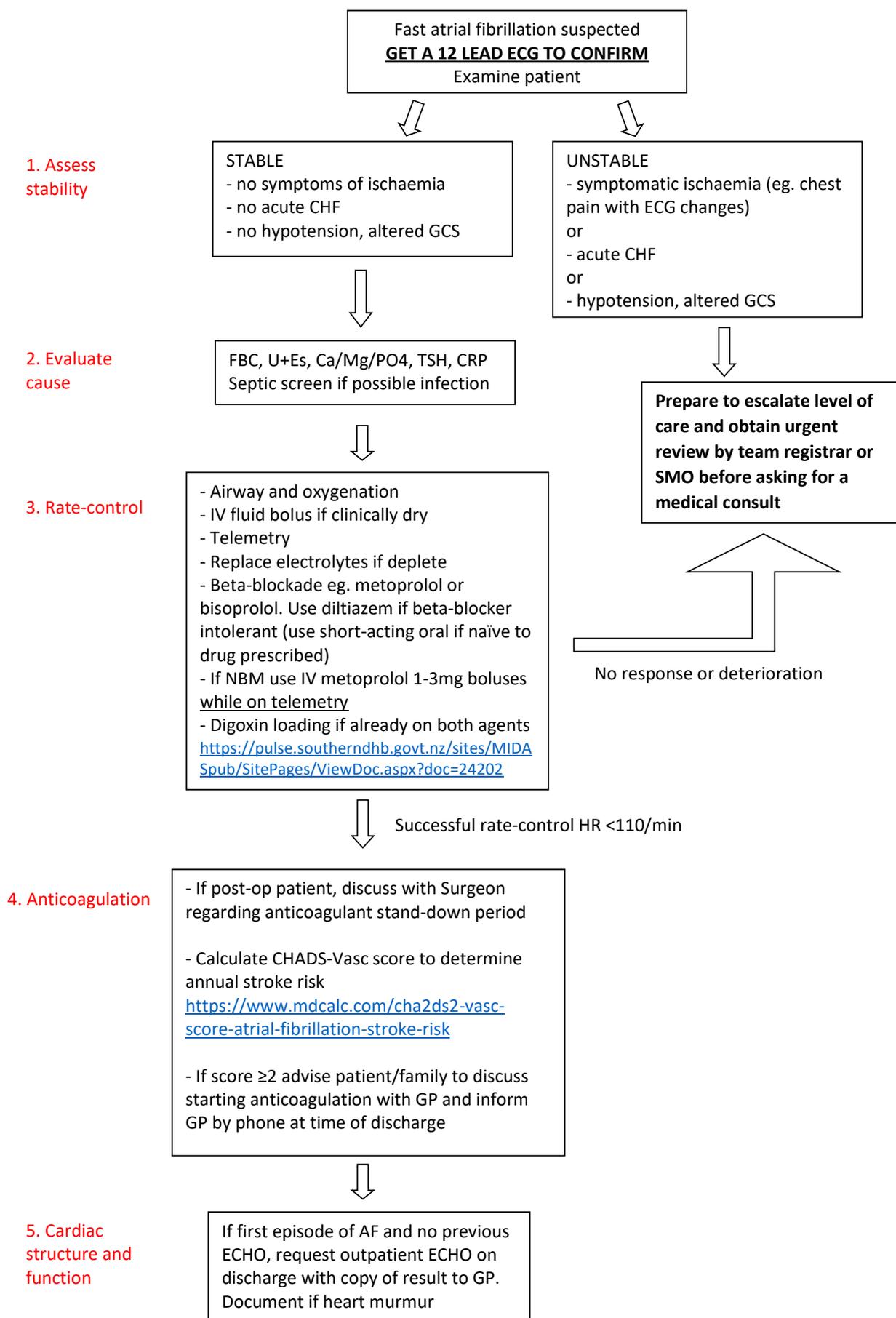
- Involve family, provide low-stimulus environment, optimise nutrition and hydration, provide glasses and hearing aids, allow natural sleep pattern + consider melatonin if disrupted

- Avoid sedatives unless necessary, **DON'T USE BENZOS unless EtOH withdrawal**

- Haloperidol 0.25-0.5mg q30mins, up to 5-10mg in total

- Use quetiapine 6.25mg per dose if Parkinsons or other contraindication to haloperidol

- Minimise unnecessary interventions eg. IV drips, catheters, oxygen tubing



References:

1. Atrial Fibrillation 2016 (Management of) ESC Clinical Practice Guidelines. European Heart Journal 2016;37(38):2893-2962
<https://doi.org/10.1093/eurheartj/ehw210>
2. <http://www.med.umich.edu/1info/FHP/practiceguides/Afib/afibfinal.pdf>