

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
2. Administer **Oxygen** prn (*MCG 1302*)
3. Advanced airway prn (*MCG 1302*)
4. Initiate cardiac monitoring prn (*MCG 1308*)  
Perform 12-lead ECG if cardiac ischemia suspected
5. Establish vascular access prn (*MCG 1375*)
6. Check blood glucose
7. For blood glucose < 60 mg/dL:  
**Oral glucose preparation or Glucopaste 15gm PO** if patient awake and alert  
OR  
**Dextrose 10% 125 mL IV/IO** and reassess ❶  
If patient continues to be symptomatic, repeat 125 mL for a total of 250mL  
Document Provider Impression as *Hypoglycemia* ❷  
If unable to obtain venous access, **Glucagon 1mg (1mL) IM**, may repeat x1 in 20 min prn ❸  
  
**CONTACT BASE** for persistent hypoglycemia for repeat dose of Dextrose 10% 250mL IV
8. For blood glucose > 200 mg/dL:  
Document Provider Impression as *Hyperglycemia*  
  
For blood glucose >200 mg/dL and <400 mg/dL with suspected related symptoms: ❹  
**CONTACT BASE** for order for Normal Saline 1L IV rapid infusion  
  
For blood glucose > 400 mg/dL or reading "HIGH" ❺ or for poor perfusion (*MCG 1355*):  
**Normal Saline 1L IV/IO rapid infusion** ❶  
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema);  
stop infusion if pulmonary edema develops  
  
For persistent poor perfusion, treat in conjunction with *TP 1207, Shock/Hypotension*
9. For nausea or vomiting:  
**Ondansetron 4mg ODT/IV/IM**, may repeat x1 in 15 min prn

### SPECIAL CONSIDERATIONS

- ❶ Use judgment based on the clinical status of the patient to determine whether IO placement for dextrose and/or fluid administration prior to hospital arrival is warranted. For altered patients who show signs of shock/poor perfusion and/or extremis with severe *HYPERglycemia* or *HYPOglycemia* and an IV cannot be obtained, an IO may be placed for fluid resuscitation or treatment with dextrose. Refer to [MCG 1375](#).
- ❷ Patients with hypoglycemia who are successfully treated with oral glucose or Dextrose 10% IV and then wish to decline transport to the hospital should be discouraged to do so if they have abnormal vital signs, fever, are taking long-acting hypoglycemic agents, history of alcohol abuse, possible ingestion or poisoning, or if they DO NOT have a history of diabetes mellitus as these patients are at high risk for recurrent hypoglycemic episodes. Patients at low risk are those with diabetes on short acting hypoglycemic agents who have someone with them and are able to tolerate oral intake. Low risk patients can be assessed, treated and released for follow-up as per Ref. No. 834. If a patient is not transported, he/she should be counseled to eat a high protein meal and to call his/her primary care physician.

#### Long Acting hypoglycemic agents

- Sulfonylureas: gliclazide, glimepiride, glipizide, gliquidone, glyburide, glycopyramide,
  - Thiazolidinediones (TZDs): pioglitazone (Actos), rosiglitazone (Avandia), troglitazone (Rezulin)
  - Alpha-glucosidase inhibitors: acarbose, miglitol, voglibose
  - Meglitinides – nateglinide, repaglinide
  - Combination drugs: glipizide and metformin (Metaglip), glyburide and metformin (Glucovance), pioglitazone and glimepiride (Duetact), pioglitazone and metformin (ACTOplus Met), rosiglitazone and metformin (Avandamet), rosiglitazone and glimepiride (Avandaryl)
- ❸ Glucagon is effective only if there are sufficient glycogen stores in the liver. Patients with low glycogen stores such as severe malnutrition, cirrhosis, or adrenal insufficiency may not respond to glucagon.
  - ❹ Consider other potential causes of hyperglycemia such as trauma, infection, or myocardial infarction and treat as per associated protocols.
  - ❺ Patients with prolonged and/or severe hyperglycemia are at risk for significant volume losses leading to dehydration and electrolyte abnormalities. Fluid resuscitation with **Normal Saline** is recommended until their glucose can be lowered with medications.