AAGBI Safety Guideline

Management of Severe Local Anaesthetic Toxicity

1
Recognition

Signs of severe toxicity:

- Sudden alteration in mental status, severe agitation or loss of consciousness, with or without tonic-clonic convulsions
- Cardiovascular collapse: sinus bradycardia, conduction blocks, asystole and ventricular tachyarrhythmias may all occur
- Local anaesthetic (LA) toxicity may occur some time after an initial injection

2 Immediate management

- Stop injecting the LA
- Call for help
- Maintain the airway and, if necessary, secure it with a tracheal tube
- Give 100% oxygen and ensure adequate lung ventilation (hyperventilation may help by increasing plasma pH in the presence of metabolic acidosis)
- Confirm or establish intravenous access
- Control seizures: give a benzodiazepine, thiopental or propofol in small incremental doses
- Assess cardiovascular status throughout
- Consider drawing blood for analysis, but do not delay definitive treatment to do this

3 Treatment

IN CIRCULATORY ARREST

- Start cardiopulmonary resuscitation (CPR) using standard protocols
- Manage arrhythmias using the same protocols, recognising that arrhythmias may be very refractory to treatment
- Consider the use of cardiopulmonary bypass if available

GIVE INTRAVENOUS LIPID EMULSION

(following the regimen overleaf)

- Continue CPR throughout treatment with lipid emulsion
- Recovery from LA-induced cardiac arrest may take >1 h
- Propofol is not a suitable substitute for lipid emulsion
- Lidocaine should not be used as an anti-arrhythmic therapy

WITHOUT CIRCULATORY ARREST

Use conventional therapies to treat:

- hypotension,
- bradycardia,
- tachyarrhythmia

CONSIDER INTRAVENOUS LIPID EMULSION

(following the regimen overleaf)

- Propofol is not a suitable substitute for lipid emulsion
- Lidocaine should not be used as an anti-arrhythmic therapy

4 Follow-up

- Arrange safe transfer to a clinical area with appropriate equipment and suitable staff until sustained recovery is achieved
- Exclude pancreatitis by regular clinical review, including daily amylase or lipase assays for two days
- Report cases as follows:

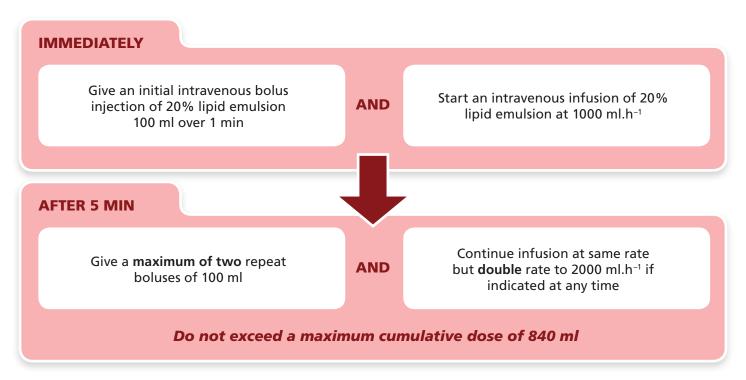
in the United Kingdom to the National Patient Safety Agency (via www.npsa.nhs.uk)

in the Republic of Ireland to the Irish Medicines Board (via www.imb.ie)
If Lipid has been given, please also report its use to the international registry at www.lipidregistry.org. Details may also be posted at www.lipidrescue.org

Your nearest bag of Lipid Emulsion is kept_____

IMMEDIATELY Give an initial intravenous bolus Start an intravenous infusion of 20% injection of 20% lipid emulsion AND lipid emulsion at 15 ml.kg⁻¹.h⁻¹ 1.5 ml.kg⁻¹ over 1 min **AFTER 5 MIN** Give a maximum of two repeat Continue infusion at same rate, but: boluses (same dose) if: Double the rate to 30 ml.kg⁻¹.h⁻¹ at • cardiovascular stability has not any time after 5 min, if: been restored or • cardiovascular stability has not been AND • an adequate circulation restored or deteriorates • an adequate circulation deteriorates Leave 5 min between boluses Continue infusion until stable and A maximum of three boluses can be adequate circulation restored or given (including the initial bolus) maximum dose of lipid emulsion given Do not exceed a maximum cumulative dose of 12 ml.kg⁻¹

An approximate dose regimen for a 70-kg patient would be as follows:



This AAGBI Safety Guideline was produced by a Working Party that comprised:
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This Safety Guideline is endorsed by the Australian and New Zealand College of Anaesthetists (ANZCA).

GGC Obstetrics Lead Author Drew Smith, Consultant The Association of Anaesthetists of Great Britain & Ireland 2010
Anaesthetist. Review 4.2021