management - supportive management is recommended - atropine, adrenaline or glucagon infusions may be necessary

- more severe features include hypertonia, hyperreflexia, hallucinations & hypertension; supraventricular arrhythmias may follow with coma, convulsions and the risk of haemorrhagic stroke - rhabdomyolysis, metabolic acidosis, acute renal failure, DIC and organ failure may result

features - stimulation of both the peripheral and central nervous systems - clinical features include euphoria, agitation, hyperthermia, seizures, confusion, tachycardia and hypertension - cardiac arrhythmias, cerebral haemorrhage, coagulopathy, cerebral oedema & rhabdomyolysis

- important to reduce the psychomotor agitation, using diazepam iv as required - close monitoring and aggressive resuscitation is essential - beta blockers can result in excessive alpha activity - severe hypertension may required labetol or SNP - a CT scan may be necessary to exclude cerebral haemorrhage

General - Cyanide inhalation is a potentially life-threatening occurrence that requires immediate intervention. - Once inhaled, cyanide rapidly crosses into the blood and disrupts normal cellular utilization of oxygen by binding to cytochrome oxidase, thus interfering with cellular respiration.

- Cyanide is an extremely potent poison, with a high affinity for cytochrome oxidase. - It inhibits the electron transport chain in the mitochondria, leading to cell death.

- Cyanide is a fast-acting poison, with effects visible within minutes of exposure.

Clinical features - Cyanide poisoning can affect multiple organ systems, including the central nervous system, cardiovascular system, and respiratory system.

CNS Features - Symptoms may include:
- Drowsiness and confusion
- Anxiety and agitation
- Seizures
- Coma

Cardiovascular Features - Symptoms may include:
- Hypertension
- Tachycardia
- Arrhythmias
- Heart failure

Respiratory Features - Symptoms may include:
- Shortness of breath
- Cyanosis
- Altered mental status

Management - The management of cyanide poisoning is primarily supportive and may include:
- Administration of 100% oxygen
- Administration of antidotes, such as sodium nitrite
- Administration of hyperbaric oxygen therapy

Specific features:
- Cyanide and converts it to thiocyanate, which is excreted by the kidneys, and
- Hydroxycobalamin which detoxifies cyanide by binding to it, forming cyanocobalamin
- Desferrioxamine can be given by
- The IV and IM routes. The dosage is the same for both routes & the same for adults and children: a 1gm loading dose & then 500mg 4hrly for two doses and thereafter 500mg between 4 and 12 hourly depending on the severity of the poisoning (total dose should not exceed 6gm in 24 hours)

- Management is mainly supportive:
  - intubation and ventilation may be required
  - fluid resuscitation & inotropes may be necessary
  - continue treatment until serum levels and clinical status improve

-Iron salt poisoning is most severe in young children
- stage 1 (acute gastrointestinal disturbances) including epigastric pain, nausea, vomiting, haematemesis which may lead to necrosis and perforation of the stomach. Accompanied by rapid pulse & respiratory rate.
- stage 2 (acute encephalopathy) including headache, confusion, delirium, convulsions & coma. Respirations are deep and rapid. Cardiovascular collapse may supervene. Hyperpyrexia and leukocytosis are features
- stage 3 (acute liver failure) may develop if the patient survives to this stage and leads to death.

NB: severe poisoning is reflected by plasma concentrations >90micromoles/L in children and 145micromoles in adults within 4 hours of ingestion (must be rapid)

- plain AXR will demonstrate the number of tablets & gastric lavage with a large bore tube may facilitate removal of tablets (lavage with 2gm ofdesferrioxamine in 1L of warm water and then leave 10gm in 50ml in the stomach to chelate remaining iron in the GIT - whole bowel irrigation with polyethylene glycol solution especially in children may be helpful desferrioxamine can be given by the IV and IM routes. The dosage is the same for both routes & the same for adults and children: a 1gm loading dose & then 500mg 4hrly for two doses and thereafter 500mg between 4 and 12 hourly depending on the severity of the poisoning (total dose should not exceed 6gm in 24 hours)

- Management is mainly supportive:
  - intubation and ventilation may be required
  - fluid resuscitation & inotropes may be necessary
  - continue treatment until serum levels and clinical status improve

- The drug has extensive protein binding capacity (75-85%) and a large volume of distribution (1.5L/kg), making it relatively inaccessible to active drug elimination

- absorption is slow and unpredictable and maximum serum concentrations may not be reached until 72 hours after ingestion; carbamazepine undergoes enterohepatic recirculation and is metabolised to an active metabolite

- Management is mainly supportive:
  - intubation and ventilation may be required
  - fluid resuscitation & inotropes may be necessary
  - continue treatment until serum levels and clinical status improve

- Clinical features:
  - CNS, cardiovascular and respiratory systems are depressed
  - cardiac depression is due to vasomotor centre depression and a toxic effect on myocardium and peripheral vessels

- Clinical effects in large overdose include tachycardia, hypotension arrhythmias and coma

- Beta blockers can result in excessive alpha activity

- Severe hypertension may required labetol or SNP

- A CT scan may be necessary to exclude cerebral haemorrhage

- Management - treatment is largely supportive although haemoperfusion and urine alkalisation can be used