management: - maintain intravascular volume - glucose infusion if hypoglycaemia and correct electrolyte disturbance; vitamin K for hypoprothrombinaemia - sodium bicarbonate for severe acidosis - early determination of levels allows classification into mild (<50mg/L), moderate (50-750mg/L), severe (>750mg/L) - forced alkaline diuresis was used in the past but is no longer recommended - dialysis should be considered in moderate or severe toxicity where levels have not decreased after 2 hours; it is also indicated for fluid overload unresponsive to diuretics

features: - severe toxicity is characterised by coma, respiratory depression, hypotension & convulsions - may result from doses >80mg/kg. Protracted convulsions can cause rhabdomyolysis and ARF

features: - serum concentrations of >3.5-4.0mmol/L, or patients with severe toxicity generally require extracorporeal elimination techniques; nevertheless, the majority of patients respond to supportive measures

features: - serum lithium levels greater than 1.5mmol/L are toxic with the main feature being varied neurological manifestations; severe poisoning may result in permanent neurological damage and nephrogenic DI

features: - methanol and ethylene glycol are essentially non-toxic. The metabolism of these products to their aldehydes and associated acids following a latent period of 12-18 hours accounts for the metabolic acidosis, ocular toxicity & mortality that are occasionally seen.

features: - salicylates have two separate, independent effects on acid-base. The first is respiratory alkalosis as a result of central respiratory stimulation & may result from doses >80mg/kg. Protracted convulsions can cause rhabdomyolysis and ARF

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features: - CNS excitability and convulsions, hypokalaemia, hyperglycaemia, hypomagesaemia and hypocalcaemia, acid-base disturbances and leucocytosis - coagulation disturbances including hypoprothrombinaemia, thrombocytopenia and DIC are seen - more rarely there may be hypoglycaemia, renal failure and hypoglycaemia