Cheatography

# ICU Drugs Crib Cheat Sheet

by Claire Badawi (CB1) via cheatography.com/121361/cs/22184/

## Sedation/Analgesia Infusions

| Drug | Dose Range | Additional information |
|---|---|---|
| Fentanyl IV | 25-400-mcg/hr | Opiate of choice in renal impairment |
| Propofol IV | 0-300mg/hr Max 4mg/kg/hr (IBW) | Short acting. No analgesic properties. Hypotensive effect. |
| Midazolam IV | 0-10mg/hr | Accumulates in renal impairment and in obesity – may take days to clear |
| Morphine IV | 1-10mg/hr | Avoid use in renal impairment |
| Thiopentone IV | 3-8mg/-kg/hr (ABW) | Used for raised ICP. Risk of accumulation. Can cause disruption of potassium homeostasis. Aim K+ to be lower end of normal range |

## Sedation/Analgesia Infusions (cont)

| | | |
|---|---|---|
| Ketamine IV (analgesia) | **Loading dose:** 0.2mg/kg (ABW) STAT **Initial maintenance:** 0.3mg/-kg/hr (ABW) and titrate (up to 0.6mg/-kg/hr) | May lower seizure threshold. Very hallucinogenic and can induce catatonia. NOT indicated for 'normal' acute pain. |

Patients should ideally have EEG or BIS monitoring to assess level of sedation. Ketamine: Different vial strengths and administration rates used for bronchospasm & asthma vs analgesia.

## Paralysis

| Drug | Dose Range | Additional information |
|---|---|---|
| Atracurium | | Used for cardiovascularly stable patients at low risk of bronchospasm. Histamine release. Short duration of action |
| Cisatracurium | | Lacks histamine-releasing effects therefore used in cardiovascularly unstable patients at risk of bronchospasm. More potent & slightly longer duration of action than atracurium |
| Rocuronium | | Most rapid onset of non-depolarising agents |

check local guidelines for dose ranges and availability of monitoring such as train of four and BIS. Be aware of renal function and dose adjustments.

## Cardiovascular Drugs

| Drug | Dose Range | Additional information |
|---|---|---|
| Adenosine | 3mg bolus | Rapid intravenous injection. If no response after 1-2 min, give 6mg. If no response after 1-2 min, give 12mg |
| Amiodarone | Loading dose of 300mg over 1 hour (prescribe as a STAT dose). Then start infusion of 900mg over 23 hrs | |
| Digoxin | IV/PO/-Enteral loading dose of 0.5-1mg in 1-2 divided doses 4-8 hours apart, dependent on response | Maintenance dose 62.5-250 mcg/day depending on plasma levels and clinical response. Therapeutic plasma level 0.8 – 2microgram/L |
| GTN IV | 0.5-10 mg/hr | rw every 24hr due to ceiling effect |
| Labetolol IV | 15-120 mg/hr | |

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## Inotropes/Vasopressors

| Drug | Dose Range | Additional information |
|---|---|---|
| Noradrenaline | 0.01 – 1 mcg/kg/min (IBW) | >0.25mcg/kg/min – seek senior review |
| Adrenaline | 0.01 – 1 mcg/kg/min (IBW) | >0.25mcg/kg/min – seek senior review |
| Dobutamine | 2.5 – 20 mcg/kg/min (IBW) | |
| Terlipressin | 0.05-0.2 mg/hour | |

Monitor for excessive peripheral vasoconstriction and raised lactate.

## Respiratory

| Drug | Dose Range | Additional information |
|---|---|---|
| Aminophylline IV | 5mg/kg loading dose then 0.3-1 mg/kg/hr (IBW) | Patients taking oral theophylline / aminophylline should not receive a loading dose. Start continuous infusion at 0.5mg/kg/hr and adjust according to plasma theophylline concentration |
| Salbutamol IV | 0.18 – 1.2 mg/hr | |

## Respiratory (cont)

| | | |
|---|---|---|
| Epoprostenol nebulised | 5 – 20 nanograms/kg/min (ABW) | For pulmonary hypertension or hepato-pulmonary syndrome |
| Ketamine IV (Bronchospasm & asthma) | 0.5 – 2.5 mg/kg/hr (ABW) | Dose should be maintained at the minimum amount providing adequate response; increased adverse cardiovascular effects with increased dose |

Ketamine: Different vial strengths and administration rates used for analgesia

## VTE Prophylaxis

| Renal function | Drug | Patient Weight (ABW) | Dose |
|---|---|---|---|
| eGFR> 30ml/min | Enoxaparin S/C | <50kg | 20mg OD |
| | | 50-100kg | 40mg OD |
| | | 101-150kg | 80mg OD (or 40mg BD) |
| | | >150kg | 120mg OD (or 60mg BD) |
| eGFR < 30ml/min or RRT | Heparin S/C | <100kg | 5000 units BD |
| | | >100kg | 5000units TDS |

## Prokinetics

| Drug | Dose Range | Additional information |
|---|---|---|
| Metoclopramide IV | 10mg TDS (max 3-5 days) | Avoid long-term use, due to risk of neurological side effects |
| Erythromycin IV | 250mg 6hourly | Risk of prolonged QTc syndrome – daily ECGs |

Review daily

## Stress Ulcer Prophylaxis

Pantoprazole 40mg IV OD or Omeprazole 40mg IV.
If patient is absorbing enteral feed for >24 hours or E+D, stop PPI or consider switch to PO PPI.

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