Stabilisation for Diagnosis of Death using Neurological Criteria (Paediatric)

University Hospital Southampton NHS Foundation Trust

Is URINE OUTPUT >4ml/kg/hr?

Consider diabetes insipidus

Treat with vasopressin (add 2 units to 1L 0.9% or 0.45% sodium chloride depending on serum Na). Use to replace previous hour's urine output, minus the amount given as maintenance. Titrate to achieve urine output 1-3 ml/kg/hr.

See acute central diabetes insipidus guideline for more details.

Is SODIUM >150 mmol/L?

Hypernatraemia is common.

Treat with enteral water if patient absorbing.

Review sodium-containing fluids, consider use of 5% dextrose to make up infusions.

Caution with effervescent tablets (high sodium content).

Is PHOSPHATE <1mmol/L?

Hypophosphataemia is common.

Replace if required (consider IV). https://www.sort.nhs.uk/Media/Guidelines/Electrolytereplacementguidelines.pdf

NB: Phosphate absorption/replacement takes some time and therefore increasing the phosphate level quickly is not possible.

Is TEMPERATURE <36.0°C?

Re-warm if hypothermia

Consider warming blankets, fluid warmers, heated humidifier in ventilator circuit.

What else?

Sedation must be off for at least 6 hours pre-neurological death testing. Pause propofol (or short-acting sedatives) at least 6 hours prior to testing. Longer periods of time off sedation may be required, depending on the duration and type/dose of sedation used and renal function – discuss with consultant/pharmacy.

One of the tests involves injecting ice-cold water into both ear canals. Someone trained to use an otoscope should assess both ear canals for the **presence of cerumen (wax).** The tympanic membrane must be clearly visible & intact for this test to be undertaken. Debris may need removal by ENT.

Acceptable ranges at the time of testing:

Sodium	125 – 160mmol/L
Phosphate	0.5 – 3.0mmol/L
Potassium	> 2mmol/L
Magnesium	0.5 – 3.0mmol/L
Glucose	3 – 20mmol/L