

Brief Clinical Practice Guideline for Toxic Jellyfish
Emergency Room or In-Hospital care

1. **Standard resuscitative care**
2. **Blocking of venom discharge:** pour vinegar (4–6 % acetic acid) immediately and continuously throughout the wound for at least 30 seconds
***EXCEPT eye exposure: rinse with 0.9% normal saline for 15–30 minutes**
(Should consult Ophthalmologist)
 - * Tentacles usually fall out after vinegar application. If needed, use forceps or gloved hand to remove remaining tentacles
 - * If possible, place tentacle on transparent sticky tape and fold it to seal tentacle like vacuum for nematocyst identification of dangerous jellyfish groups (Vacuum Sticky tape technique) or keep the tentacle in 95% ethanol/ 3% formalin for jellyfish identification*** If the injured has no pulse or stop breathing, start CPR first**
3. Standard resuscitative care
4. ABCDE (E= remove cloths by CUTTING to prevent possible firing of remaining nematocysts)
5. Ventilation and intravenous access
6. Hypotension presents: IV fluids
7. Hypertensive emergency (physician judgment): Nitroglycerin IV or Nicardipine IV
(Continuous cardiac monitoring if necessary)



Pain relief:

Mild to moderate case: Oral acetaminophen or NSAIDs

Severe case (or if require): IV narcotics (avoid pethidine)



Wound care:

Use standard wound dressing as fresh wound or burn wound (depends on wound characteristics in each stage) without tight cover

1. Antihistamine: H1 (Chlorpheniramine) antihistamine is recommended (not due to anaphylactic shock)
 2. If available H1 combine with H2 (Ranitidine) antihistamine is preferable
 3. Tetanus immunization
 4. Antibiotics: prophylaxis antibiotic is not recommended
 5. If suspect infected wound, prescribe the antibiotic which covers aerobic and anaerobic bacteria e.g. co-amoxiclav
 6. If immunocompromised hosts or liver disease: add antibiotic cover vibrio spp.
 7. Observe digital gangrene and compartment syndrome (advice before discharge if need)
- ** Avoid pressured dressing
- ** Topical steroid and antibiotic ointment are not recommended in first few days
- ** Corticosteroid is not recommended



Disposition:

Mild pain, small affected area, normal V/S and no systemic sign and symptom:

* Observe vital sign every 15 min for at least 1 hr, if stable then discharge and ADVICE

If Severe pain or large affected area or systemic sign and symptom:

* Admit for further investigation and treatment

1. Lab: electrolyte, EKG and CXR

* If indicated: CBC, BS, BUN, Cr, LFT, continuous cardiac monitoring

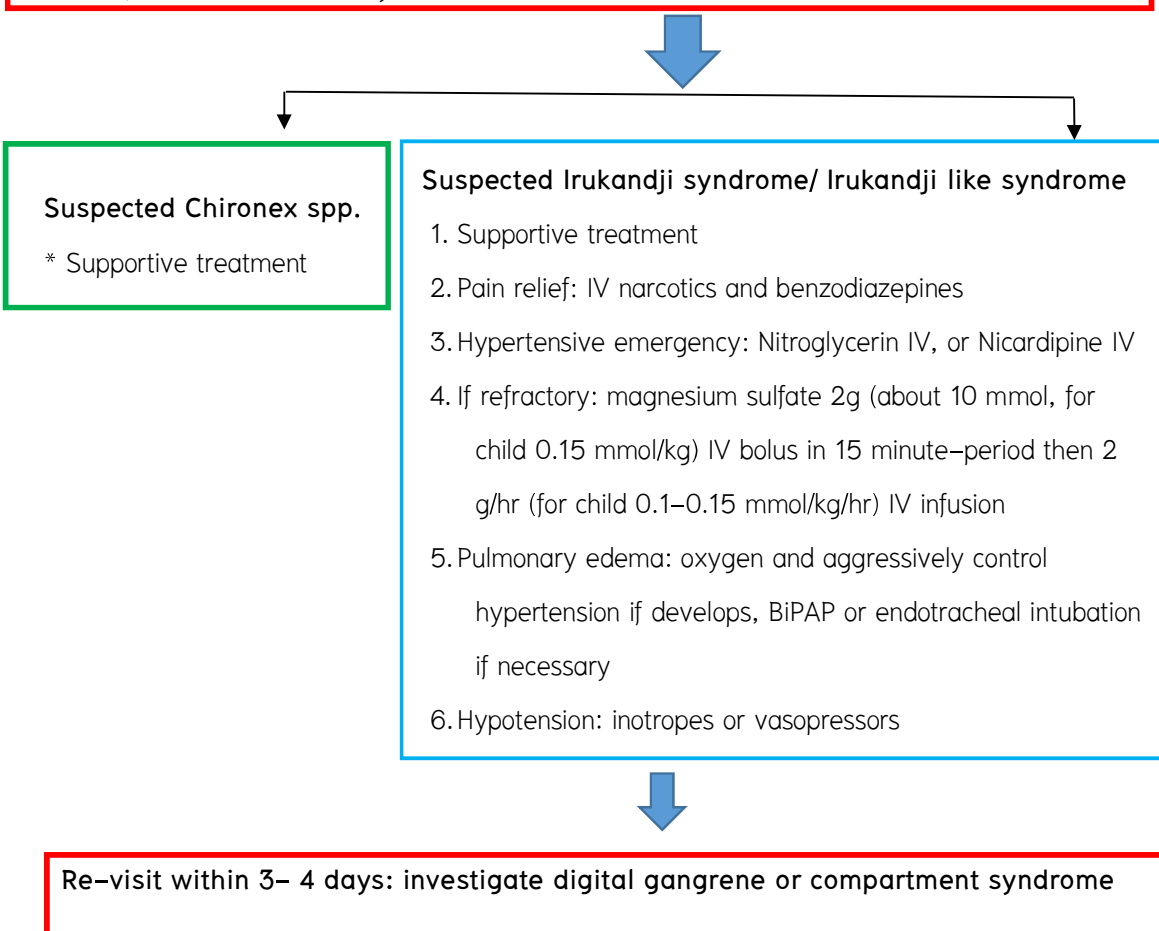
* If suspected cardiovascular toxicity: Trop I/T, CKMB and echocardiogram

* If suspected rhabdomyolysis, or persistent pain: CPK and/or UA

2. Monitoring: V/S and

* If indicated: systemic toxicity lab tests

* If cardiovascular toxicity: Serial cardiac markers



Suspected Chironex spp.
* Supportive treatment

Suspected Irukandji syndrome/ Irukandji like syndrome

1. Supportive treatment
2. Pain relief: IV narcotics and benzodiazepines
3. Hypertensive emergency: Nitroglycerin IV, or Nicardipine IV
4. If refractory: magnesium sulfate 2g (about 10 mmol, for child 0.15 mmol/kg) IV bolus in 15 minute-period then 2 g/hr (for child 0.1-0.15 mmol/kg/hr) IV infusion
5. Pulmonary edema: oxygen and aggressively control hypertension if develops, BiPAP or endotracheal intubation if necessary
6. Hypotension: inotropes or vasopressors

Re-visit within 3- 4 days: investigate digital gangrene or compartment syndrome

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