Contingency Medical Countermeasures for Treating Nerve Agent Poisoning

Goal: Nerve agent attacks can overwhelm available resources including pharmaceutical antidote stocks. The guidelines presented here are intended to provide the medical and first responder community with information about contingency pharmaceutical options when conventional therapies are exhausted or preferred formulations or routes of administration are not available for all who require therapy.

Setting: A resource depleted environment on the scene of the incident or at a health care facility.

Process: These guidelines represent a subject matter expert (SME) panel consensus of contingency i) anticholinergic medications and ii) benzodiazepine anticonvulsant medications that could be substituted for conventional therapies. A review of the medical literature on the contingency pharmaceutical’s efficacy against nerve agent and equivalent effective dosing by contingency routes of administration was performed. The Chemical Integrated Program Team (Chem IPT), an SME-membered federal interagency group addressing chemical defense issues, contributed and approved these guidelines, which align with a position statement by the American College of Medical Toxicology endorsing the consideration of contingency therapies for nerve agent poisoning when conventional therapies are not available (https://www.acmt.net/_Library/Positions/ACMT_Position_Acet.pdf).

The types of contingency pharmaceuticals described here are FDA approved drugs (depending on the manufacturer) AND are currently available in the formulation listed; however, their use as a contingency for the treatment of nerve agent-exposed patients would be considered off-label. Thus, the decision to use these medications and the amount to use must be at the sole discretion of the treating medical provider or medical authority.

Preferred routes of medical countermeasure (MCM) administration typically include intravenous (IV) and intramuscular (including autoinjectors). The IV route is preferred and should be used as soon as possible, especially in critically ill patients. In a resource depleted environment, additional routes of administration include sublingual, inhaled, and intranasal. In many cases, the Chem IPT has endorsed these alternative routes in MCM development criteria due to their speed and ease of administration by responders faced with multiple patients requiring rapid treatment. Dosing information was based on best available evidence from human and animal studies along with pharmacokinetic data. The guidelines represent starting doses and should be titrated to a decrease in respiratory secretions or termination of convulsions. This information is intended to augment decision making in a low resource state when faced with patients who are deemed in need of treatment for nerve agent toxicity. Conventional therapies should be administered if adequate supplies are available. In the event that these contingency MCMs are also insufficient, crisis standards of care may need to be applied.¹

Expected Actions:

- Utilize conventional therapies as long as they are available; consider adoption of contingency options when conventional therapies are exhausted.
- Prioritize treatment to control respiratory secretions and ensure seizure termination.
- Triage to definitive acute medical care based on symptom severity and clinical necessity.

Signs and Symptoms of Nerve Agent Exposure

**Mild**
- 1 DuoDote Al

**Moderate**
- 2 DuoDote Al
- 1 DuoDote Al And 1 AtroPen 2mg AI

**Severe**
- 3 DuoDote Al
- AtroPen 2mg Al q 3-5 min
- Diazepam 10mg Al or IV/IM/IO

Conventional MCMs

**Mild**
- 1 DuoDote Al

**Moderate**
- 2 DuoDote Al
- 1 DuoDote Al And 1 AtroPen 2mg AI

**Severe**
- 3 DuoDote Al
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**Pharmaceutical Interchangeable Products**

DuoDote™ = Mark 1 Kit = ATNAA
AtroPen™ = Rafa Atropine Al

**Conversions** – Atropine 1% and Cyclopentolate 1% Ophthalmic (Ophth) Solutions

1ml = 20gtt
1% solution = 10mg/ml

**Definitions**

**Mild**: No respiratory symptoms, but rhinorrhea, blurred vision, miosis, eye pain, lacrimation, salivation, cough, nausea, vomiting, fasciculations

**Moderate**: Respiratory symptoms of shortness of breath, chest tightness, wheezing, dyspnea +/- non-respiratory symptoms of mild category

**Severe**: Bronchorrhea, severe dyspnea, respiratory arrest, urination, defecation, muscle weakness, paralysis, altered mental status, coma

*Seizures are possible with all exposures but typically in the moderate or severe category*

*Alternative MCM allows for dose flexibility but should be titrated to respiratory secretions (anticholinergics) and seizure termination (benzodiazepines).*
## Pediatric Nerve Agent Medical Countermeasure (MCM) Treatment

### Conventional MCMs

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild</strong></td>
<td>1 DuoDote AI</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Atropine 1% Ophth 5gtt SL Or Cyclometolate 1% Ophth 20gtt SL Or Glycopyrrolate 0.4mg IV/IM/IO</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>2 DuoDote AI Or 1 DuoDote AI and 1 AtroPen 2mg AI</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Atropine 1% Ophth 10gtt SL Or Cyclometolate 1% Ophth 40gtt SL Or Glycopyrrolate 0.8mg IV/IM/IO And Ipratropium inhaler 4-6 puffs Or Tiotropium inhaler – 2 capsules</td>
</tr>
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### Contingency MCMs

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severe</strong></td>
<td>3 DuoDote AI AND AtroPen 2mg AI q 3-5 minutes AND Diazepam 10mg AI/IV/IM/IO (&gt;40kg) IF LESS THAN 40 kg Midazolam IV/IM/IO &lt;13kg – 70mcg/kg 13-40kg - 5mg &gt;40kg - 10mg</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Atropine 1% Ophth 20gtt SL Or Cyclometolate 1% Ophth 80gtt SL Or Glycopyrrolate 2mg IV/IM/IO AND Pralidoxime 2g IV/IM/IO AND Midazolam IV/IM/IO &lt;13kg – 70mcg/kg 13-40kg - 5mg &gt;40kg -10mg</td>
</tr>
<tr>
<td><strong>Seizures</strong></td>
<td>Diazepam (&gt;40kg) 10mg AI or IV/IM/IO or Midazolam IV/IM/IO &lt;13kg – 70mcg/kg 13-40kg - 5mg &gt;40kg -10mg</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Midazolam 0.2mg/kg IN (Max 10mg) Or Lorazepam 0.1mg/kg IN (Max 6mg) Or Lorazepam (≥40kg) 6mg IM/IO (&lt;40kg) 4mg IM/IO</td>
</tr>
</tbody>
</table>

### Equivalent Dosing of Conventional Therapies

- **DuoDote**: Mark 1 Kit = ATNAA
- **AtroPen**: Rafa Atropine AI

### Definitions

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**Moderate**: Respiratory symptoms of shortness of breath, chest tightness, wheezing, dyspnea +/- non-respiratory symptoms of mild category

**Severe**: Bronchorrhea, severe dyspnea, respiratory arrest, urination, defecation, muscle weakness, paralysis, altered mental status, convulsions

- Seizures are possible with all exposures but typically in the moderate or severe category*
- Caveat: Scant literature exists on auto-injectors in pediatrics and listed dosing reflects those recommendations. Alternative MCM allows for dose flexibility but should be titrated to respiratory secretions (anticholinergics) and seizure termination (benzodiazepines).

### Additional Dosing

**Severe** – atropine 2mg IV/IM/IO or contingency agent and route q 3-5 min until resolution of bronchorrhea; adequate ventilation

**Ongoing Seizures** – Diazepam or Midazolam 10mg IV/IM/IO or contingency agent and route q 3-5 min until seizure termination

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*Symptom classification and standard MCM Guidelines adapted from United States Army Medical Research Institute of Chemical Defense (USAMRICD) "Medical Management of Chemical Casualties" and Advanced HazMat Life Support (AHLS) "Insecticide Poisoning" Table 18-1 Classification of OP Induced Signs & Symptoms