Sickle Cell Pain Protocol for BUMC

This protocol is designed for patients who present to the emergency department with pain potentially related to sickle cell crisis.

1. Determine if patient has medical emergency other than sickle cell crisis
    a. Full set of vital signs including temperature and O2 saturation
    b. Utilize appropriate diagnostics
    c. Provide any emergent therapeutics necessary
    d. Address pain management plan upon arrival
    e. If other emergencies and painful conditions ruled out, proceed with sickle cell pain protocol
2. Include standard ED medical assessment for sickle cell crisis.
        i. Diagnostics
            1. CBC, CMP, Retic Count
            2. CXR for any cardiovascular or respiratory complaint; EKG as needed
        ii. If new sickle cell patient, or if something suspicious, consider hemoglobin electrophoresis to confirm diagnosis
3. SICKLE CELL PAIN PROTOCOL
    a. If no vomiting, consider:
        i. Tylenol 1000mg PO
        ii. Ibuprofen 600 PO
        iii. oral morphine 30mg IR
    b. IV access
        i. IV access may be problematic in some of these patients.
            1. Access mediport as needed
            2. Consider IN fentanyl and IM antiemetics while iv pending
    c. NS fluid bolus for any dehydration
        i. Then, D5 ½ NS maintenance fluid
    d. Toradol 10 mg IV
    e. Dilaudid 2mg in NS 50ml. Infuse over 15 minutes IV q 2 hours prn severe pain x 2 doses. ****NO IV PUSHES
    f. Ketamine low dose infusion protocol
    g. Antiemetics
        i. Zofran 4 mg iv prn nausea
        ii. Phenergan 12.5-25 mg iv dilution (no iv push)
        iii. Compazine and Reglan may also be considered
    h. Benadryl 25 mg **PO** q 4 hours prn pruritus
    i. May consider ketamine 0.1-0.3 mg/kg iv
    j. NO IV PUSH OPIATES OR PHENERGAN

4. If patient with intractable symptoms and unable to be discharged,
    a. Admit patient