## Alert

**Indication**
Resuscitation of the newborn infant. If adequate ventilation and chest compressions have failed to increase the heart rate to > 60 beats per minute within about a minute, then adrenaline should be given intravenously as soon as possible. [1]

**Action**
Catecholamine with alpha and beta-adrenergic actions.

**Drug Type**
Inotropic vasopressor.

**Trade Name**
Aspen Adrenaline 1:10,000 injection.

**Presentation**
1:10,000 ampoule [1 mg/10 mL]

**Dosage / Interval**
10–30 microgram/kg (0.1–0.3 mL/kg of a 1:10,000 solution) intravenous injection. This dose can be repeated every few minutes if the heart rate remains < 60 beats per minute despite effective ventilation and cardiac compressions. [1–3]

**Maximum daily dose**
The maximum single dose is 1 mg.

**Route**
Intravenous.

**Preparation/Dilution**
Draw up 0.1–0.3 mL.kg of adrenaline 1:10,000 ampoule [1 mg/10 mL] undiluted. [1 mL contains 0.1 mg (100 microgram) of adrenaline].

**Administration**
Intravenous as a rapid bolus ideally through a central venous catheter followed by a sodium chloride 0.9% flush. [1]

**Monitoring**
Assessment throughout the resuscitation is based on the infant’s heart rate, breathing, tone and oxygenation. A prompt increase in heart rate remains the most sensitive indicator of resuscitation efficacy. [4]

For babies requiring resuscitation and/or respiratory support, pulse oximetry is recommended both to monitor heart rate and to assess oxygenation. The sensor should be placed on the infant’s right hand or wrist before connecting the probe to the instrument. Heart rate monitored using an oximeter should be checked intermittently during resuscitation by auscultation. [4]

**Contraindications**
Nil.

**Precautions**
Infants with arrhythmias, hypertension or hyperthyroidism. Infants with dilated or ischaemic cardiac disease. Intra-arterial and intramuscular administration should be avoided as it may cause local ischaemic damage.

**Drug Interactions**
Hypotension may be observed with concurrent use of vasodilators such as glyceryl trinitrate, nitroprusside and calcium channel blockers. Concurrent use of digitalis glycosides may increase the risk of cardiac arrhythmias. Concurrent use of IV phenytoin with adrenaline may result in dose dependent, sudden hypotension and bradycardia.

**Adverse Reactions**
Tachycardia and arrhythmia. Systemic hypertension and lactic acidosis especially at higher doses. Tissue ischaemia and necrosis especially if administered intra-arterially, intramuscularly or with extravasation.

**Compatibility**
Fluids: Glucose 5%, glucose 10%, Hartmann’s, sodium chloride 0.9%

Y-site: Amino acid solutions. Amiodarone, anidulafungin, atracurium, bivalirudin, caspofungin, cisatracurium, dexmedetomidine, dobutamine, dopamine, ethanol, fentanyl, glyceryl trinitrate, heparin sodium, milrinone, morphine sulfate, pancuronium, potassium chloride, ranitidine, remifentanil, sodium nitroprusside, tigecycline, tirofiban, vecuronium.
# Adrenaline (epinephrine) intravenous bolus

2016

| Incompatibility | Fluids: Sodium bicarbonate.  
Y-site: Aciclovir, aminophylline, ampicillin, atropine, azathioprine, calcium chloride, calcium gluconate, cefalotin, chloramphenicol, digoxin, ergometrine, ganciclovir, hyaluronidase, hydrocortisone sodium succinate, indomethacin, noradrenaline, phenobarbitone sodium, sodium bicarbonate, thiopentone, vancomycin. |
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<tbody>
<tr>
<td>Stability</td>
<td>Not for dilution. Discard remainder after use.</td>
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<tr>
<td>Storage</td>
<td>Ampoule: Store below 25°C. Protect from light.</td>
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<tr>
<td><strong>Evidence summary</strong></td>
<td>ILCOR treatment recommendation: If adequate ventilation and chest compressions have failed to increase the heart rate to &gt; 60 beats per minute, then it is reasonable to use adrenaline despite the lack of human neonatal data. If adrenaline is indicated, a dose of 0.01–0.03 mg/kg should be administered intravenously as soon as possible. If adequate ventilation and chest compressions have failed to increase the heart rate to &gt; 60 beats per minute and intravenous access is not available, then it is reasonable to administer tracheal adrenaline. (LOE IV, GOR B) If adrenaline is administered by the tracheal route, it is likely that a larger dose of 0.05–0.1 mg/kg will be required to achieve an effect similar to that of the 0.01 mg/kg intravenous dose. Higher intravenous doses cannot be recommended and may be harmful. [3] (LOE IV, GOR C) Pharmacokinetics: The plasma half-life of intratracheal adrenaline for newborn resuscitation is likely to average ~50 minutes. [5]</td>
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<thead>
<tr>
<th>Original version Date: 31/03/2016</th>
<th>Author: NMF Consensus Group</th>
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<tbody>
<tr>
<td>Current Version number: 1</td>
<td>Current Version Date: 31/03/2016</td>
</tr>
<tr>
<td>Risk Rating: High</td>
<td>Due for Review: 9/11/2018</td>
</tr>
<tr>
<td>Approval by: RHW Drugs and Therapeutics Committee</td>
<td>Approval Date: 5/05/2016</td>
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This RHW document is a modification of Neomed version. Dosage schedules remain the same. However, information on the commercial preparations not used at RHW is deleted. The risk rating is modified as per the local health district policy.