

<b>Alert</b>	1000 mg magnesium <b>sulfate</b> = 98 mg elemental Mg = 4.1 mmol (8 mEq) of elemental Mg. 500 mg magnesium <b>aspartate</b> = 37.4 mg elemental Mg = 1.5 mmol (3 mEq) of elemental Mg. Intravenous doses should be diluted to a concentration of Mg 20% or less. Calcium chloride/calcium gluconate should be available to reverse adverse effects.
<b>Indication</b>	Hypomagnesaemia (acute and chronic). Pulmonary hypertension when inhaled nitric oxide is not available. Perinatal asphyxia. Resuscitation of torsades de pointes. Neonatal tetany Daily maintenance in parenteral nutrition (beyond scope of this guideline).
<b>Action</b>	Magnesium is an intracellular cation. Calcium and NMDA receptor antagonist. Magnesium is necessary for several steps in glycolysis, the Krebs cycle and in protein and nucleic acid synthesis. It is vital for normal energy storage and transfer. Magnesium plays an important role in neurochemical transmission, and is essential for proper neurochemical functioning. Magnesium has an anticonvulsant effect.
<b>Drug Type</b>	Electrolyte
<b>Trade Name</b>	DBL Magnesium Sulfate Concentrated Injection (Hospira) MagMin Tablets (Blackmores) Mag-Sup Tablets (Petrus)
<b>Presentation</b>	<b>IV/IM:</b> IV: 4.93 g magnesium <b>sulfate</b> /10 mL ampoule (49.3% solution) OR 2.465 g magnesium sulfate /5 mL. Both preparations provide 10 mmol magnesium/5 mL  <b>PO:</b> <ul style="list-style-type: none"> <li>• MagMin 500 mg magnesium <b>aspartate</b> tablets.</li> <li>• Mag-Sup 500 mg magnesium <b>aspartate</b> tablets.</li> </ul> 500 mg magnesium aspartate tablet contains 37.4 mg (1.5 mmol) of elemental Mg.
<b>Dosage/Interval</b>	<b>Hypomagnesaemia</b> 25–50 mg magnesium sulfate/kg IV infusion over 30–60 minutes. Repeat if necessary. <b>Chronic hypomagnesaemia</b> PO: 187 mg of elemental magnesium per m <sup>2</sup> /day in divided doses. (Endocrine team, personal email communication) (=2500 mg magnesium aspartate per m <sup>2</sup> /day)  <b>Body Surface Area (BSA) calculation:</b> $BSA (m^2) = \sqrt{\frac{height (cm) \times weight (kg)}{3600}}$ <b>Pulmonary hypertension:</b> Loading dose of 200 mg magnesium sulfate/kg IV over 60 minutes followed by continuous IV infusion 20–50 mg/kg/hour (target serum magnesium between 3.5 and 5.5 mmol/L) <b>Perinatal asphyxia</b> 250 mg magnesium sulfate/kg/dose of over 1 hour to be commenced within 6 hours of birth. Total 3 doses at 24 hour intervals. <b>Torsades de pointes with pulse</b> 25-50 mg magnesium sulfate/kg IV over 15–20 minutes. <b>Pulseless torsades de pointes</b> 25–50 mg magnesium sulfate/kg IV/Intraosseous (IO) over several minutes. <b>Intramuscular Route (Emergency management of Neonatal tetany/convulsions/Hypocalcaemic convulsion when no IV access)</b> IM: 100 mg magnesium sulfate/kg (0.2 mL/kg of 50% magnesium sulfate). Can be repeated 12 hourly.
<b>Route</b>	IV, IM, oral, Intraosseous.

<b>Preparation/Dilution</b>	<p><b>Hypomagnesaemia/Torsades de pointes</b> Draw up 0.4 mL (200 mg of magnesium sulfate) of 50% solution and add 7.6 mL sodium chloride 0.9% or glucose 5% to make a final volume of 8 mL with a concentration of 25 mg/mL.</p> <p><b>Pulmonary hypertension IV infusion</b> Loading dose: Draw up 2 mL (1000 mg of magnesium sulfate) of the 50% solution and add 8mL of sodium chloride 0.9% or glucose 5% to give a final volume of 10mL with a concentration of 100mg/mL. Maintenance infusion: Draw up 2 mL/kg (1000 mg/kg of magnesium sulfate) of 50% solution and add glucose 5% or sodium chloride 0.9% to make a final volume of 50mL. Infusing at a rate of 1 mL/hour = 20 mg/kg/hour.</p> <p><b>Perinatal asphyxia</b> Draw up 2 mL (1000 mg of magnesium sulfate) of the 50% solution and add 8mL of sodium chloride 0.9% or glucose 5% to give a final volume of 10mL with a concentration of 100mg/mL.</p>
<b>Administration</b>	<p>IV bolus for hypomagnesaemia: Infused over 30–60 minutes. Loading dose for pulmonary hypertension: Administer over 60 minutes. IV dose for perinatal asphyxia: Administer over 60 minutes. Torsades de pointes: Administer the preparation over several minutes to 20 minutes.</p>
<b>Monitoring</b>	ECG and continuous or frequent blood pressure. Monitor magnesium concentrations.
<b>Contraindications</b>	Heart block or myocardial damage.
<b>Precautions</b>	Use with caution in renal impairment.
<b>Drug Interactions</b>	<p>Concurrent use with paralyzing agents may enhance neuromuscular blockade (e.g. succinylcholine, vecuronium, rocuronium, etc).</p> <p>Concomitant use with aminoglycosides may cause neuromuscular weakness (respiratory arrest).</p>
<b>Adverse Reactions</b>	<p>Hypotension, bradycardia and circulatory collapse with rapid infusion. ECG changes (prolonged AV conduction time, sino-atrial block, AV block). Calcium chloride/calcium gluconate should be available to reverse adverse effects. Flushing, sweating, respiratory depression (particularly with higher plasma concentrations), abdominal distension, diarrhoea, urinary retention, CNS depression, muscle relaxation, hyporeflexia.</p>
<b>Compatibility</b>	<p>Sodium chloride 0.9%, sodium chloride 0.45%/glucose 4%, glucose 5%, parenteral nutrition glucose amino acid solution.</p> <p>Y site: Aciclovir, amifostine, amikacin, ampicillin, aztreonam, bivalirudin, caspofungin, cefotaxime, cefoxitin, cefazolin, chloramphenicol, cisatracurium, dexmedetomidine, doripenem, esmolol, gentamicin, granisetron, heparin sodium, hydrocortisone sodium succinate, labetalol, linezolid, metronidazole, milrinone, morphine sulfate, piperacillin-tazobactam (EDTA-free), potassium chloride, remifentanyl, sodium nitroprusside, trimethoprim-sulfamethoxazole, vancomycin.</p>
<b>Incompatibility</b>	<p>Fat emulsion. Incompatible with soluble phosphates and with alkaline carbonates and bicarbonates.</p> <p>Y site: Aminophylline, amiodarone, anidulafungin, azathioprine, calcium chloride, calcium salts, cefepime, ceftriaxone, ciprofloxacin, clindamycin, cyclosporin, dexamethasone, ganciclovir, haloperidol lactate, indometacin, methylprednisolone sodium succinate, pentamidine, phosphate salts, sodium bicarbonate.</p>
<b>Stability</b>	Change the IV preparation every 24 hours.
<b>Storage</b>	Store at room temperature and protect from light.
<b>Special Comments</b>	<p>Serum Mg concentrations do not reflect with whole body stores. Renally excreted.</p>
<b>Evidence summary</b>	<b>Persistent pulmonary hypertension of the newborn (PPHN)</b>

	<p>A single RCT enrolling infants with severe respiratory distress, an oxygen index <math>\geq 25</math> despite HFOV support, and echocardiographic evidence of PPHN assessed the effect of MgSO<sub>4</sub> group 200 mg/kg infused over half an hour with maintenance 50-150 mg/kg/hour to attain a serum magnesium level of 5.0-7.0 mmol versus iNO group at initial concentration of 20 ppm with crossover if no response. There was no difference in the proportion of infants who responded primarily to either vasodilator (MgSO<sub>4</sub> 23.3% versus iNO 33.3%, <math>p=1.0</math>). Of the non-responders, 9 of 10 in the HFOV + IV MgSO<sub>4</sub> group versus 8 / 12 HFOV + iNO group responded. There was a significant difference in mortality, with 8 of 13 (62%) HFOV + IV MgSO<sub>4</sub> group versus 2 of 12 (17%) HFOV + iNO group alive at discharge (<math>p=0.004</math>). Infants who were administered iNO following failed MgSO<sub>4</sub> therapy were associated with a better outcome than those who were administered MgSO<sub>4</sub> following failed iNO therapy. Several small case series have reported that 37 of 42 infants with severe PPHN treated with MgSO<sub>4</sub> responded and survived to discharge.[1-4] Conclusion: The role of MgSO<sub>4</sub> in the management of PPHN is unclear. Further trials are required. (LOE II, GOR D)</p> <p><b>Perinatal asphyxia</b> A systematic review [5] of RCTs that compared magnesium to control in newborns with HIE included 5 studies.[6-10] All used magnesium sulfate given within 24 hours of birth. The dose varied: 250mg/kg every 24 hours for three doses in two studies, 250mg/kg followed by two doses of 125mg/kg every 24 hours for two doses in another two studies and a single dose of 250mg/kg in one study. Magnesium was administered over 30 min in one study, over 1 hour in three studies. There was no difference in the death or moderate-to-severe neurodevelopmental disability at 18 months between the magnesium and the control groups (RR 0.81, 95% CI 0.36 to 1.84). There was significant reduction in the unfavourable short-term composite outcome (survival with abnormalities in any of the following: neurodevelopmental exam, neuroimaging or neurophysiologic studies), (RR 0.48, 95% CI 0.30 to 0.77) but no difference in mortality (RR 1.39, 95% CI 0.85 to 2.27), seizures (RR 0.84, 95% CI 0.59 to 1.19) or hypotension (RR 1.28, 95% CI 0.69 to 2.38) between the magnesium and the control groups. Conclusion: There is insufficient evidence to determine if magnesium therapy given shortly after birth to newborns with HIE reduces death or moderate-to-severe disability. The improvement in short-term outcomes without significant increase in adverse effects supports the need for further adequately powered trials to determine if there are long-term benefits of magnesium and to confirm its safety. (LOE I GOR D) The publication of 3 additional small trials is unlikely to change this conclusion. [11-14]</p> <p><b>Refractory ventricular fibrillation (VF)/pulseless VF (pVF)/ polymorphic ventricular tachycardia (Torsade de pointes)</b> The ANZCOR Guideline on Medications and Fluids in Paediatric Advanced Life Support reported hypomagnesaemia may cause life-threatening ventricular tachyarrhythmia, particularly when associated with hypokalaemia. Magnesium is the preferred antiarrhythmic treatment for polymorphic ventricular tachycardia (Torsade de pointes – “Twisting of peaks”) due to acquired or congenital prolonged QT interval syndromes [LOE IV]. Neither increased return of spontaneous circulation (ROSC) nor survival in adults has been demonstrated in treatment of VF with magnesium [LOE IV]. The intravenous or intraosseous bolus dose of magnesium sulphate is 0.1-0.2 mmol/kg followed by an infusion of 0.3mmol/kg over 4 hours. [15]</p> <p><b>Neonatal tetany/convulsions</b> An RCT of oral calcium gluconate versus oral phenobarbitone versus MgSO<sub>4</sub> 0.2 mL/kg (100 mg/kg) of 50% magnesium sulfate IMI in infants with hypocalcaemic convulsions secondary to feeding with full-cream evaporated milk reported infants treated with magnesium sulphate had higher plasma-calcium concentrations after 48 hours’ treatment and fewer convulsions during and after the treatment period. (LOE II GOR C/D) Magnesium levels</p>
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	increased from 0.59 +/- 0.17 mmol/L pretreatment to 0.87 +/- 0.2 mmol/L post treatment. [16]
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<b>Original version Date:</b> 24/08/2016	<b>Author:</b> NMF Consensus Group
<b>Current Version number:</b> 1.2	<b>Version Date:</b> 19/04/2018

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<b>Risk Rating: Medium</b>	<b>Due for Review: 19/04/2021</b>
<b>Approval by: As per Local policy</b>	<b>Approval Date:</b>

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