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Acid-Base, Fluids, Lytes Pocketcard Set

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Acid-Base Disorders Basics

	Normal ranges		Simple acid-base disorders			
	Arterial	Venous	Met acid	Resp acid	Met alk	Resp alk
pH	7.38-7.44	7.33-7.43	7	7	7	7
pCO ₂	36-44 mmHg	36-48 mmHg	0	0	0	0
HCO ₃ ⁻	21-27 mEq/L	23-29 mEq/L	0	0	0	0
pO ₂	70-100 mmHg	37-47 mmHg				
O ₂ sat	>95%	80%-85%				
BE	-2 to 3					

Examples

- Diarrhea
- CHF
- Resp depress
- CPD
- Resp depress
- Diuretics
- Stimulants
- Hypervent
- PE

Algorithm for Determining Acid-Base Status

Measure blood pH, HCO₃⁻, PaCO₂, Na⁺, and O₂⁻

pH < 7.36 (Abnormal)

- Arterial PaCO₂ < 36 mmHg: Metabolic Acidosis
- Arterial PaCO₂ > 44 mmHg: Respiratory Acidosis

pH 7.36-7.44

- Normal OR mixed acid-base disorders

pH > 7.44 (Abnormal)

- Arterial PaCO₂ > 44 mmHg: Respiratory Alkalosis
- Arterial PaCO₂ < 36 mmHg: Metabolic Alkalosis

DR. BOOLES (Base excess gap metabolic acidosis)

- B** - Diarrhea (loss of HCO₃⁻) / sepsis / low urine Na⁺
- R** - Renal tubular acidosis (RTA)
- D** - Drugs: acetazolamide or topiramate (primary HCO₃⁻ wasting); tenofovir or disulfiram (RTA)
- O** - Oxidative: sepsis
- O** - Other: Recovery from hyperventilation (low HCO₃⁻ after pH) / mixed, expansion acidosis / rapid dilution of serum HCO₃⁻ by IV saline
- F** - Folate: renal conduit for Mdr1b replacement or uricase-catabolic; Folate U - Uremia in early stages; S - Sufficing glia (insulin poisoning)

DR. MAPLES (Anion gap metabolic acidosis)

- D** - Diabetic ketoacidosis
- R** - Renal failure
- M** - Methanol
- A** - Acetone
- P** - Paraldehyde, propylene glycol, pyroglutamic acid or 5-oxoprolidone, acylsulfonamide toxicity (the common culprit)
- L** - Lactic acid
- E** - Ethylene glycol, ethylene glycol, ethylene glycol
- S** - Starvation ketoacidosis

Normal values: pH = 7.38-7.44, PaCO₂ = 36-44 mmHg, HCO₃⁻ = 21-27 mEq/L (arterial), 23-29 mEq/L (venous), pO₂ = 70-100 mmHg, O₂ sat > 95%, BE = -2 to 3.
*Anion gap (AG) = Na⁺ - (Cl⁻ + HCO₃⁻) = 8-12 mEq/L.
*Primary respiratory acidosis/alkalosis are comparatively asymptomatic as the process is gradual and compensatory occurs to correct the acid-base disorder (due to a normal blood and O₂ pH).
*Acute respiratory acidosis is usually symptomatic due to low pH and compensatory hyperventilation. Symptoms may include headache, blurred vision, restlessness, anxiety, and with increasing severity, tremor, asterixis, asterixis, somnolence, and coma with ↑ intracranial pressure and papilloedema of optic nerves.
*Acute respiratory alkalosis is usually symptomatic due to low pH and compensatory hypoventilation. Symptoms may include dizziness, confusion, paraesthesiae, circumoral numbness, a sense of numbness of breath, and with increasing severity, tetanic and clonic with Chvostek sign or carpal/pedal spasm on exertion. Lab may show hypokalaemia, hypomagnesaemia, and mild acute hypocalcaemia. RTA = renal tubular acidosis.
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Synopsis

This quick reference guide contains essential and systematically arranged information to determine the acid-base status of a patient in a stepwise manner. It also contains a section on normal fluid and electrolyte distribution and its management in case of depletion. Highlights: Acid-base normal values and abnormalities chart. Determination of acid-base status in a step by step approach. Formula for anion gap, estimation of fluid requirement in burn (Parkland formula), algorithm explaining diagnostic workup in metabolic alkalosis, hypernatremia, and hyponatremia. Diagnostic algorithms of acidosis, alkalosis, electrolyte abnormalities. Assessment and common causes of acid-base disorders. Diagrammatic representation of body water and electrolyte distribution, and information on electrolyte repletion. Information on fluid and electrolyte management the 4-2-1 rule, electrolyte formulations, and typical fluid intake and output values. For physicians, physician assistants, nurses, students, and all other healthcare professionals.

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