WISHAW GENERAL HOSPITAL
ADULT CRITICAL CARE UNIT METARAMINOL GUIDELINE

BACKGROUND

Metaraminol is a vasoconstrictor sympathomimetic, raising blood pressure by acting on alpha-adrenoceptors to constrict peripheral vessels. It can be used as continuous infusion for the treatment of mild/moderate hypotension in association with an Epidural in ACCU in the postoperative period.

RECONSTITUTION AND ADMINISTRATION

Standard concentration is 0.5mg/ml. Dilute two 10mg vials Metaraminol with 38ml sodium chloride 0.9% Normal Saline in a 50ml Syringe. Use the largest vein present unless a central line is available. The cannula should be checked carefully for extravasation prior to starting the infusion. If there is any doubt about the cannula medical review should be sought.

PRESCRIBING, DOSE AND MONITORING

This should be prescribed on the medicines chart as Metaraminol infusion. Non-invasive pressure should be checked every 5 minutes until stable thereafter every hour. Standard Epidural Checks/Obs should be carried out as normal. An Arterial Line is not necessary. The cannula should be checked HOURLY to ensure blanching/extravasation does not occur as this can result in *skin necrosis*. The infusion rate can be changed and titrated to a MAP of >65mm Hg or higher if specified by the anaesthetist. Range of rate is 0 – 20ml/hour. Any higher requirements should prompt immediate review by the prescribing anaesthetist or (if out of hours or not available) by the ACCU-Trainee. The patient must be fully assessed and other causes of hypotension (bleeding, sepsis) actively sought. Avoid abrupt withdrawal. The infusion should not be stopped suddenly but gradually titrated off. In general the duration of the Metaraminol-Infusion should not exceed the duration of the Epidural.

ADVERSE EFFECTS

If a patient becomes hypertensive stop the infusion immediately. If the blood pressure is dangerously high and not coming down quickly – contact an anaesthetist urgently. Hypertension can result in reflex bradycardia. If this occurs and does not resolve following discontinuation of the infusion it can be treated by a bolus of 200 micrograms of glycopyrrolate or 600 micrograms of atropine.

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