



Poison HOTLINE

1-800-222-1222

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Did you know

Identification of a mushroom via the characteristics and descriptions given over the phone or by looking at pictures in a book or on the internet is not reliable. Positive identification of a mushroom requires an experienced mycologist, often with the help of a spore print from the mushroom.

The IPCC works with a local mycologist as a consultant in Iowa when a mushroom case requires identification.

The IPCC's standard recommendations for mushroom cases involving a child eating a mushroom from the lawn are to send the child to the ER for oral activated charcoal.

Sulfonylureas for Diabetes

The sulfonylurea class of oral hypoglycemic agents stimulates the beta cells of the pancreas to secrete insulin, resulting in a lowering of blood glucose. In an overdose, sulfonylureas can produce a severe and prolonged drop in blood glucose levels. This may result in significant neurological symptoms and even death. An ingestion of even one pill in a child can produce significant hypoglycemia.

Sulfonylureas are metabolized by the liver and most have active metabolites, increasing their duration of action. Only glipizide does not have an active metabolite. Sulfonylureas are renally excreted. Glyburide has significant biliary excretion and undergoes some degree of enterohepatic recirculation.

Drug	Therapeutic Duration of Action (hours)
Glimepiride	24
Glipizide	16-24
Glyburide	18-24

Symptoms: Patients can present with a wide range of symptoms. Patients may have hypoglycemia, confusion, blurry vision, diaphoresis, tremors, tachycardia, headache, nausea, chest pain, palpitations, lethargy, seizures, and coma.

Monitoring: Patients ingesting sulfonylureas need to be monitored for at least 24 hours due to the risk of delayed hypoglycemia. Initially, blood glucose levels should be checked at least every hour. Once the blood glucose has stabilized for several hours, the frequency of blood glucose monitoring may be decreased. Monitor renal function and electrolytes (especially potassium and phosphorus).

Treatment: If a patient is awake and able to protect their airway, feed them a calorie-rich meal. Both symptomatic hypoglycemia and a low blood glucose on a finger stick are treated with IV dextrose. Do not give IV dextrose prophylactically (i.e. before symptomatic hypoglycemia or a documented low blood glucose level), as this could increase length of patient stay and can lead to delayed hypoglycemia. Consider octreotide if multiple boluses of 50% dextrose (D₅₀W) are required. Dialysis is not effective for sulfonylureas.

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