Paracetamol overdose presenting 8-24hrs
(Ingested total overdose in ≤1 hour time period)

Estimate the total paracetamol ingested (mg/kg)

*Ingested paracetamol = <150mg/kg

Take baseline bloods (U&Es, HCO3, LFTs, FBC, INR, glucose, paracetamol level)

Don’t start acetylcysteine (NAC)

Plot level on paracetamol nomogram when blood resulted

If above the treatment line then START/continue NAC

Psychiatry liaison referral, see GGC Adult Therapeutics Handbook for local pathway. Referral to be sent by admitting doctor including estimated time to completion of infusion.

Take bloods 2hrs before the end of infusion 2: U&Es, HCO3, LFTs, FBC, INR, glucose and paracetamol level

Discontinue NAC after infusion 2 if: INR ≤1.3 AND ALT <100 AND ALT <2x admission value AND paracetamol level <20

If criteria for discontinuing not met then proceed to infusion 3

Discontinue NAC after infusion 3 (extended) if: INR ≤1.3 AND ALT <100 AND ALT <2x admission value
(Bloods should be checked 2 hours before the end of infusion 3).

If criteria for discontinuing not met then proceed to infusion 4 (and repeat if needed) until: INR ≤1.3, or INR falling on two consecutive bloods AND INR <3.0
(Bloods should be checked 2 hours before the end of infusion 4).

Ingested paracetamol = ≥150mg/kg

Take baseline bloods (U&Es, HCO3, LFTs, FBC, INR, glucose, paracetamol level)

START acetylcysteine (NAC) before bloods resulted

If below the treatment line then NAC not required and can stop**

Psychiatry review

Blood monitoring

• Checking a paracetamol level 2hrs before the end of bag 2 is NEW for this protocol.
• U&Es, HCO3, glu, LFTs, FBC and INR should be done 2hrs before the end of each infusion 2. Ensure results are READY for the end of the infusion.
• If unable to achieve blood sampling at the correct time and a delay of >90 minutes is predicted then proceed to the next infusion to avoid prolonged omission of NAC. Bloods should be checked at the earliest opportunity and discontinuation criteria referred to.
• Capillary Blood Glucose (CBG) 6 hourly while on NAC.
• If rapid or progressive biochemical deterioration then discuss with senior and consider referral to regional transplant centre.
• IV NAC can be associated with minor rise in INR without an acute liver injury.

*Clinical judgement required
• If doubt then assume ≥150mg/kg.

**Clinical judgement required
• Ensure no doubt about time of ingestion or type.
• Some patients have a chronically raised ALT/INR.
• Review old LFTs/INRs and if chronic derangement discuss with a senior clinician before proceeding to NAC.
• If ALT newly abnormal despite normal paracetamol concentration, then consider treating.
• Ensure INR is normal, if not consider treating.
• If uncertainty then treat and review.