Propranolol Overdose: An Emergency Medicine Simulation Scenario

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Abstract

Simulation-based medical education is continually expanding and evolving to foster a better and more comprehensive learning environment. With particular regard to emergency medicine, the use of simulation in training has been shown to increase learners' knowledge and skills [1]. To a lesser extent, this has also improved patient outcomes [1]. Despite this evidence, the development of emergency medicine simulation training in a majority of residency programs is either not formalized or is still in its initial phases [2]. In this report, a simulation training session used to familiarize emergency medicine residents with the presentation, management, and treatment of a beta-blocker overdose, specifically propranolol, using a human patient simulator is described.

Introduction

Propranolol is a sympatholytic non-selective beta-blocker used in the treatment of hypertension; it can be used in the treatment of anxiety and panic disorder. Signs and symptoms of toxicity are generally non-specific and may include coma, generalized tonic-clonic seizures, cardiac arrhythmias, and respiratory distress [3-4]. Beta-blocker overdose is not uncommon, given its widespread use. More than one-third of overdoses using anti-hypertensive medications have been attributed to beta-blocker intoxication with 1.5% of those cases being fatal if left untreated [5]. It is thus important for emergency medicine residents to familiarize themselves with the presentation and management of a beta-blocker overdose.

This technical report outlines a simulation teaching session developed for a group of postgraduate emergency residency trainees in the third and final year of their training program. The objectives of this report are to familiarize learners with the clinical presentation, investigation, and management of a patient with suspected propranolol overdose, and complications that may arise.

Technical Report

Technical report

The simulation training session was conducted in a lab using a high-fidelity mannequin simulator, Gaumard Noelle S575 human patient simulator (Gaumard Scientific, Miami, FL).
Prior to the session, a stepwise, detailed scenario template developed by the Clinical Learning and Development Centre (CLDC), our in-house simulation laboratory, was filled by one of the clinical educators and authors on this paper (KA). The template was then submitted to the simulation laboratory technical staff, who then programmed the mannequin and supplied required materials for the scenario’s execution.

The scenario was prepared to be a team learning activity with two to four learners who would role-play various health professionals. However, the scenario can be adapted to be interprofessional if various learners, representing multiple disciplines, are included. As outlined below, the overall objectives of this session were explained during the pre-scenario briefing. During the pre-scenario briefing, the case was described and the roles of individual learners were identified.

In addition to the technical staff that operated the human patient simulator, two trained instructors executed the scenario. One instructor ensured that the technical staff adhered to the template, provided all supporting learning materials (Figure 1), and used previous clinical experience to troubleshoot any possible deviations from the scenario template. The other instructor was given the role of a “scribe” and noted individual and team performances using a-priori developed checklists (Figure 2) for formative assessment and debriefing at the end of the scenario. Both instructors participated in the debriefing of the trainee(s).

<table>
<thead>
<tr>
<th>Pre-Scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are an emergency room physician in a tertiary-care hospital. A 28-year-old female arrives in the ER, brought in by her husband. She is unresponsive on arrival. Her husband found her in their bedroom along with an empty bottle of his propranolol. Her husband last saw her 5 hours prior when they ate dinner.</td>
</tr>
<tr>
<td>History</td>
</tr>
<tr>
<td>Allergies</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Past Medical Hx</td>
</tr>
<tr>
<td>Social Hx</td>
</tr>
<tr>
<td>Family Hx</td>
</tr>
<tr>
<td>Initial Vitals</td>
</tr>
<tr>
<td>HEENT</td>
</tr>
<tr>
<td>CNS</td>
</tr>
<tr>
<td>Chest</td>
</tr>
<tr>
<td>Abdomen</td>
</tr>
<tr>
<td>Expected Actions</td>
</tr>
<tr>
<td>Place patient on telemetry</td>
</tr>
<tr>
<td>Obtain IV access</td>
</tr>
<tr>
<td>Administer 100% O2, non-rebreather mask</td>
</tr>
</tbody>
</table>
Order EKG

Order Labs: Electrolytes, CBC, BUN, Cr, Glucose, Ca, Mg and serum levels of acetaminophen, ASA & EtOH

Administer IV Normal Saline Bolus

Prepare for intubation

Begin Scenario

**Objective 1: Airway/Breathing/Circulation**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Vitals</th>
<th>Expected Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intubated with appropriate or no agent given</td>
<td>T 37°C / HR35 / BP68/40</td>
<td></td>
</tr>
<tr>
<td>Intubated and/or if given propofol</td>
<td>T 37°C / HR35 / BP50/30</td>
<td></td>
</tr>
</tbody>
</table>

**Objective 2: Circulation**

<table>
<thead>
<tr>
<th>Intubated with appropriate agents given in objective 1</th>
<th>T 37°C / HR35 / BP68/40</th>
<th>Give normal saline bolus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intubated with propofol given in objective 1</td>
<td>T 37°C / HR35 / BP50/30</td>
<td>Give normal saline bolus</td>
</tr>
<tr>
<td>If normal saline given</td>
<td>T 37°C / HR38 / BP70/40</td>
<td>Give 5mg glucagon IV</td>
</tr>
<tr>
<td>If glucagon given</td>
<td>T 37°C / HR45 / BP72/38</td>
<td>Consider atropine</td>
</tr>
<tr>
<td>If atropine given</td>
<td>T 37°C / HR50 / BP75/40</td>
<td></td>
</tr>
<tr>
<td>If glucagon infusion not started</td>
<td>After 5 minutes: T 37°C / HR40 / BP68/35</td>
<td>Start glucagon infusion</td>
</tr>
</tbody>
</table>

**Objective 3: Making the diagnosis**

<table>
<thead>
<tr>
<th>Laboratory Results</th>
<th>Expected Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolytes, Ca, Mg, BUN, Cr – Na 140 / K 3.8 / Cl 97 / Ca 9.5 / Mg 2 / BUN 15 / Cr 1.3  Acetaminophin, ASA, EtOH – Nil Significant CBC – WBC 9 / Hgb 12/ Plts 400  Glucose – 4.8  EKG – Sinus Bradycardia (See Figure 1)</td>
<td>Identify bradycardia, hypotension and history and consolidate all factors together to solidify the diagnosis of propranolol overdose.</td>
</tr>
</tbody>
</table>

**Objective 4: Managing Complications**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Vitals</th>
<th>Expected Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If no glucagon</td>
<td></td>
<td>Start glucagon infusion (3-5mg/kg)</td>
</tr>
</tbody>
</table>
infusion started in objective 2

| If glucagon infusion started in objective 2 | T 37°C / HR50 / BP75/40 |
| Patient begins to seize | T 37°C / HR65 / BP78/35 |
| After benzodiazepines patient stops seizing | T 37°C / HR60 / BP75/35 |
| Repeat Vitals | T 37°C / HR52 / BP75/30 |

Objective 5: Managing Beta-Blocker Overdose

<table>
<thead>
<tr>
<th>Stage</th>
<th>Vitals</th>
<th>Expected Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give high-dose insulin</td>
<td>T 37°C / HR50 / BP78/35</td>
<td>Administer insulin 1u/kg with D5/D10 infusion Also consider: Ca gluconate (30mls 10% solution) or CaCl (1ml 10% solution) via central line</td>
</tr>
<tr>
<td>Repeat vitals after insulin</td>
<td>T 37°C / HR52 / BP75/30</td>
<td>Obtain central access for vasopressors</td>
</tr>
<tr>
<td>Repeat Vitals after vasopressors</td>
<td>T 37°C / HR50 / BP90/40</td>
<td>Consider alternative therapies: lipid emulsion and PDE inhibitors</td>
</tr>
</tbody>
</table>

Scenario Conclusion (Endpoints)

Stabilization and transfer to ICU if: Bradycardia is addressed Hypotension is addressed Seizure is resolved

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**TABLE 1:** A stepwise, detailed scenario template submitted to the simulation laboratory technical staff who programmed the mannequin and supplied required material for the scenario.
FIGURE 1: An electrocardiogram (EKG or ECG) demonstrating sinus bradycardia typically seen in a beta-blocker overdosed patient.
100% O2 NRB
Order EKG
Order Labs
Administer NS Bolus IV
Prepare for Intubation

Objective 1: Airway and Breathing
Intubated with appropriate medications

Objective 2: Circulation
Normal saline bolus administered
Glucagon 5mg IV administered
Atropine administered
Glucagon infusion started

Objective 3: Making the diagnosis
Obtained all ordered labs
Correctly diagnosed as a beta-blocker overdose

Objective 4: Managing Complications
Glucagon infusion started if not completed in Objective 2
IV benzodiazepines given to cease seizure
Vitals repeated following benzodiazepines

Objective 5: Managing beta-blocker overdose
High dose insulin administered
Vitals repeated after high dose insulin
Vasopressors given for hypotension
Vitals repeated after vasopressors
Lipid emulsion and phosphodiesterase (PDE) inhibitors considered

Conclusion
Supportive care until ICU arrives

**TABLE 2: Checklist of objective criteria completed by trainee(s) to be used for formative assessment or completed by instructor for trainee(s) testing purposes.**
Pre-briefing

Prior to the beginning of the scenario, a pre-briefing was held with the trainees. During the pre-briefing, a team lead for the case was identified. Any limitations of the simulation pertaining specifically to technical issues of the mannequin and resource availability were outlined and reviewed in detail. Additionally, the fiction contract – the agreement between participants and instructors to proceed as if the simulation was real, while simultaneously acknowledging it was not – was reviewed and a mutual understanding between the trainee and instructor was reached on any points of contention. Lastly, the trainees were notified as to the purpose of the session. Generally, most scenarios were strictly formative in nature, but there exists the possibility of using simulation scenarios as an evaluation tool using an objective based checklist, such as the one displayed in Table 2.

Case

This simulation case involves a 28-year-old female patient presenting unresponsive to the emergency department in a tertiary-care hospital after being found by her husband in their bedroom. The patient was discovered with a bottle of her husband’s propranolol lying nearby. Upon request by the trainee, information was provided around the patient’s allergies, medications, social history, family history, and a past medical history of depression.

At the beginning of the scenario, the patient was connected to cardiac monitors with a full suite of vital signs provided indicating bradycardia and hypotension. The scenario is set in a resuscitation bay with a resuscitation cart, defibrillator, and airway equipment immediately accessible. Medications utilized in advanced cardiac life support and rapid sequence intubation was also on-hand. Additionally, glucagon and benzodiazepines were available. One or more confederates were recruited to play the part of a nurse or other health care professionals who assisted with any resuscitation measures directed by the trainee.

The scenario was completed in a stepwise fashion with the mannequin programmed to display pre-determined vital signs and symptoms that change as selected treatments were either initiated or overlooked by the trainee.

In order to facilitate a streamlined session for the trainee, an instructor completed a full run-through of the scenario prior to its implementation. This allowed identification of limitations of the simulation scenario as well as addressed technical issues. During the scenario, checklists were used which allowed instructors to assess trainees’ performance and identify frame errors that may have occurred. The task of recording trainees’ actions and critical points during the scenario was assigned to one instructor. A second instructor served as the overall lead for the session as well as the subsequent debriefing.

Debriefing

At the conclusion of the scenario, the trainee(s) were provided with a formal debriefing that was limited to a debriefer-to-learner ratio of no greater than 1:1. This imposed ratio limit ensured that trainees were encouraged to speak freely about any issues or problems that they may have faced during the course of the scenario. An in-house model developed based on frame discovery [6-7] and the 3D model of debriefing [8] was used in these sessions. The debriefing process aimed to solicit the trainee’s thought process through an advocacy-inquiry technique. This allowed the identification of knowledge gaps and process errors.

Post-scenario didactics

Following the debriefing, a didactic session was conducted. This was used to address any
knowledge gaps identified during the training session. Additionally, it enabled the trainee to consolidate knowledge gained as a result of the simulation exercise.

During this session, the pathophysiology of beta-blocker overdose was highlighted and other interventions the trainee should consider, specifically addressing the use of glucagon, high-dose insulin, and lipid emulsion therapy were explored.

Glucagon is a first line antidote in treating beta-blocker toxicity. It increases cAMP, subsequently aiding myocardial contractility and providing both inotropic and chronotropic effects [9]. Phosphodiesterase (PDE) inhibitors employ a similar method, and while not fully understood, are thought to decrease cAMP breakdown.

In recent years, high-dose insulin therapy has emerged as a treatment for poison-induced cardiac shock. Its main mechanism lies in its inotropic effect, thought to result from increased intracellular glucose transportation within cardiac muscle. In particular, this inotropic effect occurs without increasing myocardial oxygen demand [10].

Lipid emulsion therapy, while not as effective in beta-blocker poisoning as in calcium channel blocker overdose, is thought to provide a lipid sink to surround the lipophilic molecule and render it ineffective, while at the same time providing a substrate for myocytes [11].

Discussion

The management of beta-blocker overdose is complex and, if inadequately addressed, may lead to significant mortality. While there may be a wide range of clinical presentatons of beta-blocker toxicity, the differential diagnosis of a hypotensive and bradycardic patient is narrow and thus this condition should be considered in the ER [12]. It is thus important that physicians in an emergency department be aware of the signs, symptoms, treatments and management plan of patients experiencing beta-blocker overdose.

The specific learning objectives of this case are premised mainly on:

1. Airway management of the comatose patient;
2. Addressing hypotension and bradycardia in the setting of beta-blocker toxicity; and
3. Controlling seizures arising from propanolol toxicity

Using a stepwise algorithm to develop the scenario allows the simulation to change in a predetermined manner in response to trainee decisions. An instructor run-through ensures that the case is not excessively demanding of the trainee, as well as facilitates the identification of the scenario’s limitations. Lastly, a formalized debriefing model as well as a post-scenario didactic session allows instructors to unearth and address trainee’s knowledge gaps and process errors.

Conclusions

Teaching emergency medicine trainees to identify, treat, and manage the complications of beta-blocker toxicity is an important task. Using simulation to facilitate this may be an effective method of teaching. Research shows that the ability to use simulation to repeatedly practice a skill helps trainees improve on and excel at that skill in the future [13]. Here, a stepwise algorithm developed to augment the completion of a propranolol overdose case simulation is described. Additionally, an integrated teaching session incorporating simulation and didactics
with components of debriefing used to train emergency medicine residents is outlined.

**Additional Information**

**Disclosures**

**Human subjects:** All authors have confirmed that this study did not involve human participants or tissue. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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**References**