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Lanoxin and digoxin

What are the effects of digoxin. Digoxin and lanoxin interaction. Action of lanoxin and digoxin. Difference between lanoxin and digoxin. Furosemide (lasix) and digoxin (lanoxin). Digoxin (lanoxin) and spironolactone (aldactone). Lanoxin and digoxin are same.

Updated October 30, 2020 If you are a consumer or patient visit this version. Highlights of the prescription information These highlights do not include all the necessary information for use lanoxin safe and effective way. See the full prescription information for Lanoxin. LANOXINÃÃO (digoxin) Injection, intravenously or intramuscular useInitial Approval USA: 1954 Lanoxin is a cardiac glucose indicated by: One Â Â ¢ Treatment of cardiac insufficiency Mild to moderate in adults. (1,1) Â ¢ â € ¢ increasing the contraction of myocidadium in pediatric patients with cardiac insufficiency. (1,2) â € ¢ Rest control ventricular frequency in adults with critical atrial fibrillation. (1,3) Lanoxin dose is based on patient's specific factors (age, lean body weight, renal function, etc.). See the complete prescription information. Toxicity monitor and therapeutic effect. (2) Intravenous administration is preferable to intramuscular route. Avoid bolus administration. (2) LANOXINÃO INJECTION: Ampoule containing 500 mcg (0.5 mg) in 2 ml. (3) LANOXINÃO INJECTION: test tubes containing 500 mcg (0.5 mg) in 2 ml. (3) Injection Loanoxyna, Pedetry: 100 mcg (0.1 mg) ampoule in 1 ml. (3) Injection LANOXINÃO, PEDIATORY: The 100 mcg (0.1 mg) bottles in 1 ml. (3) one â € ¢ ventricular fibrillation. (4) An ¢ hypersensitivity known to digoxin or other forms of digitalin. (4) An Â ¢ risk of rapid ventricular response leading ventricular fibrillation in patients with AV accessory. (5.1) Availability of advanced full heart block or in patients with sinus disease and AV blockade. (5.2) Â ¢ Â ¢ digoxin toxicity: Indicated by nÃ¡useas, vÃ³mitos, visual perturbaÃ§Ãµes and cardÃacas arrhythmias. The advanced age, low body weight, disorders of renal and electronic functions abnormalities predisposed toxicity. (5.3) At the risk of ventricular arrhythmias during the cardioversion element. (5,4) Â ¢ â € ¢ Not recommended in patients with acute myocidadium (5.5) â € ¢ â € ¢ Avoid lanoxin in patients with myocarditis. (5.6) The overall incidency of adverse reactions with digoxin was reported as 5-20%, with 15-20% of adverse events considered. Cardiac toxicity is responsible for about half, gastrointestinal disturbances in about a room, and CNS and other types of toxicity to about a quarter of these adverse events. (6.1) Report suspicions of adverse reactions, Contact Covis Pharma in 1-866-488-4423 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch Ã ¢ â € ¢ PGP inducers / inhibitors: Drugs that induce PGP inhibition have the potential of pharmacokines of digoxine alter. (7,1) The potential of fan interactions are to be considered, before and during drug therapy. See the complete prescription information. (7.2, 7.3, 12.3) Pedetal patients: the newborns exhibit variability in tolerance to Lanoxin. (8,4) Gerienic patients: Consider renal function in dosage selection, and carefully to control side effects. (8.5) Renal In Safety: Lanoxin is excreted by the kidneys. Consider renal function during dosing selection. (8,6) See 17 for information for the patient counseling. Revised: 10/2020 à ndice 1 Indications and use 1.1 Card insufficiency in adults Lanoxin is indicated for the treatment of slight to moderate cardiac insufficiency in adults. Lanoxin increases the fraction of ventricular ejection and improves symptoms of cardiac insufficiency, as evidenced by improving exercise capacity and decreased hospitalizations for issuance related cardiac and emergency care, not having none effect on mortality. Whenever possible, Lanoxin should be used in combination with an inhibitor of a conversion enzyme of angiotensin (ACE) and diurances. 1.2 Pedetal cardiac insufficiency in patients Lanoxin increases the contractility of myocidadium in pediatric patients with cardiac insufficiency. 1.3 to Atrial in adults Lanoxin is indicated for the control of the ventricular response rate in adult patients with critical atrial fibrillation. 2 dosage 2.1 important dosage and information administration in choosing a lanoxin posolagic regimen, it is important to consider factors that affect digoxin digoxin (for example, body weight, age, renal function, concomitant functions) since levels of digoxin thunders are only slightly higher than therapeutic levels. The dosage can be started either with a load dose followed by maintenance dosage if it is then desired or initiated with dosing maintenance without a load dose. The parenteral administration of digoxin should be used only when the need for rapidly urgent digitization or when the medicament can not be taken orally. Intramuscular injection can lead to intense pain at the site of the injection, is preferred the intravenous administration. If the drug must be administered intramuscularly, it should be injected into the deep muscle followed by massage. For adults, no more than 500 mcg of Lanoxin injection must be injected into a local single. For pediatric patients, no more than 200 mcg of Lanoxin pedicinal injection must be injected into a local single. Managing the dose over a period of 5 minutes or more and the administration of bolus avoid to prevent systemic and coronary vasoconstriction. Injection mixture Lanoxin and pedicinal injection with other drugs in the same container or simultaneous administration in the same intravenous path is not recommended. Injection Lanoxin and pedicinal injection may be administered not diluted or diluted with one or four times higher water volume for injection, 0.9% Sister chloride or 5% dextrose injection. The use of less than a volume of 4 times diluent could lead to digoxin precipitation. Immediate use of the diluted product is recommended. Consider switch or reduction of the Lanoxin dose before cardioversion element [warnings and precautions SEAA (5.4)]. 2.2 Loading dosage regimen in adults and pediatric patients 2.3 Dosing maintenance in adults and pediological patients more than 10 years, the maintenance dose is based on lean body weight, the function Renal, age, and concomitant products [see clinical pharmacology (12,3)]. The initial maintenance doses recommended in adults and pediological patients more than 10 years of age with a normal renal function are given in. Doses can be increased, every 2 weeks according to the clinical response, the serum phonic levels, and toxicity. Table 3 provides the (once a day) recommended maintenance dose for adults and pediological patients more than 10 years of age (to be given once a day), according to the lean body weight and Renal function. Doses are based on studies in adult patients with cardiac insufficiency. Alternatively, the maintenance dose can be estimated by the following graphic (peak peak reserves every day through elimination): Total maintenance dose = loading dose (this Is, peak body stores) x% loss / 100 (% daily daily loss = 14 + creatinine clearance / 5) reduce the dose of lanoxin in patients whose lean weight is an abnormally small fractions that of its total body mass because of obesity or edema. 2.4 Dosing maintenance in pediatric patients with less than 10 years, the initial dose of maintenance for cardiac insufficiency in pediatric patients with less than 10 years of age is based on body weight lean, renal function, age, and concomitant products [see clinical pharmacology (12,3)]. The initial maintenance doses recommended for pediatric patients are presented in Table 4. These recommendations take on the presence of normal renal function. Table 5 provides daily daily daily requirements for pediatric patients with less than 10th years (to be given twice a day) with cardiac insufficiency based on age, Lean body weight, and renal function. 2.5 Monitoring to evaluate security, efficacy, and therapeutic levels of blood monitor by signs and symptoms of digoxin toxicity and clinical response. Adjust the dose on the basis of Efficacy, and blood. Digoxin levels in serum less than 0.5 ng / ml were associated with efficacy decreased, whereas the levels above 2 ng / ml were associated with increased toxicity without increased benefit. Interpret the concentration of digoxin in serum in the general clinical context, and do not use an isolated isolated of Semic Concentration of Digoxin as the basis for increasing or decreasing the dose of lanÃ³xin. The concentrations of sore digoxin may be falsely high by substances similar to endogene digoxin [see drug interactions (7.4)]. If the assay is sensitive to these substances, consider obtaining a basal digoxine level before launching lanoxin and correctly fixed values by the reported baseline level. Get serious concentrations of digoxin prior to the next dose of programmed lanoxin or at least 6 hours after the last dose. The concentration of digoxin is likely to be 10-25% lower when sampled just before the next dose (24 hours after dosing) in comparison with sampling 8 hours after dosing (using One daily daily dose). However, there will be only small differences in the concentrations of digoxin using the dosage twice a day if the sampling is made to 8 or 12 hours after a dose. 2.6 Muddy of intravenous digoxin for oral digoxin by changing intravenous formation to oral digoxin formulations, make evidence for differences in bioavailability when calculating maintenance dosages (see Table 6). 3 Dosage and strong injection of lanoxin: 500 mcg ampoule (0.5 mg) in 2 ml (250 mcg [0.25 mg] by injection .lanoxin: 500 mcg bottles (0.5 mg) in 2 ml (250 mcg [0.25 mg] per 1 mL). Lanoxin injection pediatric: 100 mcg ampules (0.1 mg) in 1 ml.Lanoxin Injection Pediatrics: 100 mcg bottles (0.1 mg) in 1 ml. 4 contraindications lanoxin is contraindicated in patients with: ventricular fibrillation [see warnings and precaution (5.1)] â € â € â € â € ¢ Hypersensitivity known to digoxin (views views include inexplicable eruption, mouth swelling, lips or throat or a difficulty breathing). A hypersensitivity reaction to other digital preparations generally constitutes a contraindiction to digoxin. 5 advice and precautions 5.1 Ventricular fibrile in patients with AV accessory (Wolff-White Syndrome) Patients with Sundrome Wolff-White White developing atrial fibrillation are at high risk D and ventricular fibrile. The treatment of these patients with digoxin leads to a greater leaning of atrioventricular conduction than in the accessories, and the risks of rapid ventricular response that thus lead to ventricular fibrillation. 5.2 The Sinus Bradycardia and the lanaboxine of the bell-atrial block can cause severe sinus bradycardia or synatrial block particularly in patients with node disease prano -existent and can cause advanced or complete cardist block in patients with incomplete AV block Existing. Consider insertion of a pacemaker prior to treatment with digoxin. . atrial tachycardia with block; Dissociation AV; accelerated rhythm (nodal); Unifocal or multiform ventricular premature contractions (especially BigFiny or Triglessy); ventricular tachycardia; and ventricular fibrileness]. Toxicity is usually associated with levels of digoxin greater than 2 ng / ml, although symptoms may also occur at lower levels. Low body weight, advanced age or impaired renal function, hypokalemia, hypercalcemia or hypomagnesemia may predispose to the toxicity of digoxin. It obtains fewer digoxin levels in patients with signals or symptoms of digoxin therapy and interruption or adjusting the dose, if necessary [see adverse reactions (6) and overdosage (10)]. Evaluate serious electronics and renal function periodically. The oldest and most frequent manifestation of digoxin toxicity in babies and children is the appearance of cardiac arrhythmias, including Sinus Bradycardia. In children, the use of digoxin can produce any arrhythmia. The most common are of adraventricular takyarrhythmias, such as atrial tachycardia (with or without block) and junctional tachycardia (nodal). Ventricular arrhythmias are less less The Sinus Bradycardia can be a sign of impending poisoning digoxin, especially in babies, even in the absence of first degree cardadk block. Any arrhythmias or changes in the cardiac conduction that develops in a child taking out digoxin must be initially assumed as a consequence of digoxin intoxication. Given that adult patients with cardiac insufficence have some symptoms in common with digoxin toxicity, it may be difficult to distinguish the toxicity of digoxin from cardiac insufficiency. The erratic identification of your etiology can lead the clinic to continue or increase the dosage of the lanÃ³xin, when the dosage must be suspended. When the etiology of these signs and symptoms is not clear, Semic Level of Digoxin. 5.4 Risk of ventricular arrhythmias during the electronic cardiovers may be desirable to reduce the dose or discontinue lanoxin for 1-2 days before the cardioversion of atrial fibrillation to avoid Ventricular arrhythmias, but the physicians should consider the consequences of increasing the ventroscory response if digoxin is reduced or withdrawn. If digital toxicity is suspected, the elective cardiovership should be delayed. If it is not prudent to delay cardioversion, the lowest possible energy level should be selected to avoid causing ventricular arrhythmias. 5.5 risk of ischemia in patients with acute myocidadium infarction lanoxin is not recommended in patients with acute myocidadium infarction because digoxin may increase the demand for myocidadium oxygen and take ischemia. 5.6 Vasoconstriction in patients with myocarditis lanoxin may precipitate vasoconstriction and can promote production of early inflammatory cytokines; Therefore, avoid use in patients with myocarditis. 5.7 Decreased cardiac production in patients with patients with left ventricular systems preserved with cardiac insufficiency associated with preserved left ventricular ejection fraction may have decreased Cardboard production with the use of lanoxin. Such disturbances include restrictive cardiomyopathy, constrictive pericarditis, amyloid cardiac disease and acute lung. Patients with idiopathic hypertronomic subortic stenosis may have worsening the obstruction of the vibration due to the inotropic effects of digoxin. Patients with amyloid cardiac disease may be more susceptible to digoxin toxicity in therapeutic levels due to a greater digoxine connection to extracellular amyloid fibrils. Lanoxin should generally be avoided in these patients, although it has been used for ventricular control of the rate in the subgroup of patients with atrial fibrillation. 5.8 Reduced efficacy in patients with hypocalcemia hypocalcemia can nullify the effects of digoxin in humans; Thus, digoxin can be ineffective until the sane rico is restored to normal. These interactions are related to the fact that digoxin affects the contractility and excitability of the heart in a similar way of calcium. 5.9 Altered response in thyroid distances and hypermetabolic states Hypothyroidism can reduce requirements for Digoxin. Atriacial cardiac insufficiency and / or arrhythmias resulting from hypermetabolic or hyperdommic states (eg hyperthyroidism, hypoxy or arteriovenous derivation) are best treated, addressing the underlying condition. Atrial arrhythmias associated with hypermetabolic states are particularly resistant to treatment with digoxin. Patients with heart disease Beri may fail to respond adequately to digoxin if the deficiency of underlying thiamine is not treated concomitantly. 6 Adverse Reactions The following adverse reactions are included in more detail in the Section Warnings and Raple Precautions: â € â € â € œGrhythmias Cardiac [See Notices and Precautions (5.1 , 5.2)] Digoxin's toxicity [view warnings and precautions (5.3)]] 6.1 Experience of clinical trials because the clinical trials are Under widely variable conditions, adverse reaction rates observed in the clinical tests of a medicament can not be directly compared to the rates in the clinical trials of another medicine and may Reflect the rates observed in the Clinical Protica. In general, the adverse reactions of lanoxin are dependent on the dose and occur in upper doses are necessary to achieve a therapeutic effect. Thus, the adverse reactions are less common when lanoxin is used within the recommended dose range, is maintained within the therapeutic concentration range, and when there is careful attention to medicines and simultaneous conditions. In the test (a judgment investigating the effect of digoxine in mortality and morbidity in patients with cardiac insufficiency), the incidence of hospitalization for suspicion of digoxin toxicity was 2% in patients taking lanoxin in comparison with 0.9% in patients taking placebo [see clinical studies (14.1)]. The overall incidency of adverse reactions with digoxin was reported as 5 to 20%, with 15-20% of adverse events considered serious. The cardiac toxicity represents about medium, gastrointestinal disturbances for about one bedroom and CNS and another toxicity for about a quarter of these adverse events. Gastrointestinal: In addition to nausea and vos, the use of digoxin has been associated with abdominal pain, intestinal ischemia and hemorrhetic necrosis of intestines. CNS: digoxin can cause headache, weakness, dizziness, apathy, confusion and mental distances (such as anxiety, depression, deluge and hallucintion). Other: Gynecomastia was occasionally observed after the prolonged use of digoxin. Thrombocytopenia and maculospapular eruption and other skin reactions were rarely observed. 7 drug interactions Digoxin has a narrow therapeutic index, increasing monitoring of day-to-day concentrations of digoxin and for potential signals and clinical toxicity symptoms is necessary to start, adjust or discontinue drugs that They can interact with digoxin. Prescribers should consult the prescribed information of any drug that is co-prescribed with Digoxin for potential drug interaction information. 7.1 P-glycoprotein (PGP) Inducers / inhibitors Digoxin is a substrate of p-glycoprotein, on the intestinal absorption level, renal tubular section and biliary-intestinal secretion. Therefore, drugs that induce / inhibit glycoprotein P have the potential to change the pharmacokine of digoxin. 7.2 Pharmacokinetic interactions The pharmacocyclic interactions were observed and reported mainly when digoxin is co-administered by oral. There are very few studies that evaluated drug interaction when Digoxin is administered via Rota IV. The magnitude of the exhibition change to digoxin through the route IV is generally smaller than oral route. The table below provides available interaction data using DIGOXIN IV (as not available) formulation. 7.3 Potentially significant pharmacodynamic drug interactions due to the considerable variability of the pharmacodynamic interactions, dosage of digoxin should be individualized when patients receive these medicines simultaneously. 7.4 Drug / laboratory testing interactions End -gen substances of the unknown composition (immunoreactive substances similar to digoxine [DLIS]) may interfere with standard radioimmunoassays for digoxin. Interference often causes the results to be falsely positive or falsely high, but sometimes causes the results to be falsely reduced. Some trials are more subject to these failures than others. Various MÃ © All LC / MS / MS are available that can provide less susceptibility to DLIS interference. DLIS are present in respect of all neonates and in varied percentages of gravy women, patients with hyperthropic cardiomyopathy, patients with renal or hepatic dysfunction, and other patients who are expanded by volume for any reason. DLIS measured levels (such as digoxin equivalents) are usually low (0.2-0.4 ng / ml), but sometimes they reach which would be considered therapeutic or even thunders. In some trials, Spironolactone, Canrenona and potassium canrenoate can be falsely detected as digoxin, at 0.5 ng / ml levels. Some Substances of Chinese medicine and Ayurveda like Chan Su, Siberian Ginseng, Asian Ginseng, Ashwagandha, or Danshen can cause similar interference. The Spironolactone and DLIS are much wider than the digoxin connected to the protein. As a result, tests of free digoxine levels in the ultrafiltrate free of protein (which tend to be about 25% less than the total levels, according to the usual measure of connection protein) are less affected by Spironolactone or DLIS. It should be noted that ultrafiltration does not solve all interference problems with alternative drugs. The use of a LC / MS / MS / MS method may be the best option according to the good results that it provides, especially in terms of specificity and quantification limit. 8 Use in Specific Populations 8.1 Pregnancy Risk Summary Experience with digoxin In gravy women over several days, based on published retrospective clinical studies and cases, did not take the identification Of a drug associated risk of large birth defects, spontaneous abortion or maternal adverse and fetal adverse. Conditions are not treated underlying maternal, such as cardiac insufficiency and atrial fibrillation, during pregnancy to represent a risk to the mother and the fetus (see clinical consideration). Animal reproduction studies have not been performed with digoxin. The estimated risk of the main birth and abortion defects for the indicated population (s) are unknown. All pregnancies have a risk of deconse defect, loss or other adverse background results. In the general US population, the estimated risk of funding major birth defects and abortion in clinically recognized pregnancies is 2-4% and 15-20%, respectively. CLINIC CONTENTS The maternal and / or fetal embryst / fetal risk disease with cardiac insufficiency have increased premature labor. Clinical classification of cardiac disease can worsen with pregnancy and lead to maternal or fetal death. Gravida women with atrial fibrillation have an increased risk of delivering a low birth weight baby. Atrial fibrillation can worsen with pregnancy and can lead to maternal or fetal death. Fetal / Neonatal adverse reactions Digoxine was shown to cross the placenta and is found in the amniotic fluid. Neonates monitor signs and symptoms of digoxin toxicity, including vospitos and cardiac arrhythmias [see warnings and precautions (5.3)]. Dose adjustments during pregnancy and lanoxin requirements Pós-delivery can increase during pregnancy and decrease in the pose period. Digoxin levels in the serum of the monitor during pregnancy and the pallet period [see dosage and administration (2.5)]. Work or delivery risk of arrhythmias can increase during labor. Patients monitor continuously during labor [see warnings and precautions (5.1 and 5.2)]. 8.2 Summary Risks Abstract Digoxine Dose received through breastfeeding is 4% of neonatal maintenance dosage, which is unlikely to be clinically relevant . There are no data on the effects of digoxin on infant or the effects on milk production. Data based on data from two lactation studies in a total of 13 breastfed children, concentrations of digoxin in breast milk were between 0.4 to 1.0 ng / ml after 0.25 mg Once per daily dose of digoxin in mother to breastfeed. Thus, the amount of digoxin ingested daily by the children is estimated to be between 0.03-0.16 Ug / kg / day. This translates into a relative dose of the digoxin infant between 1 to 7% of the dose adjusted to the maternal weight and about 0.2 to 4% of the neonatal maintenance dose. 8.4 Pedial use Lanoxin's security and efficacy in the control of ventricular frequency in atrial fibrillation children have not been established. The security and efficacy of Lanoxin in the treatment of cardiac insufficiency in have not been established in appropriate and well-controlled studies. However, in the literature of children with cardiac insufficiency of various etiologies (eg defects of the ventricular septum, ventricular, Toxicity, from the patent arterial channel), treatment with digoxin was associated with improvements in hemodynamic parameters and clinical signs and symptoms. The newborns exhibit considerable variability in their tolerance to digoxin. Premature and immature babies are particularly sensitive to the effects of digoxin, and the dosage of the medicine should not only be reduced, but should be individualized according to their degree of maturity. 8.5 Geriatric Use most of the clinical experience acquired with digoxin has been in the elderly population. This experience did not identify differences in response or adverse effects between elderly and younger patients. However, this drug is known to be substantially excreted by the kidney, and the risk of thoxic reactions for this drug may be higher in patients with impaired renal function. As the elderly patients are more likely to have a decrease in renal function, care should be taken in the selection of the dose, which should be based on renal operation, and may be useful to monitor the renal function [see dosage and administration (2.1)]. 8.6 Renal insufficiency The Digoxin debug may be correlated mainly with renal function, as indicated by the creatinine debug. Table 3 and Table 5 provide the usual daily daily maintenance requirements for digoxin on the basis of creatinine debugging [see dosage and administration (2,3)]. Digoxin is primarily excreted by the kidneys; Consequently, patients with impaired renal function require less than the normal doses of digoxine maintenance [see dosage and administration (2,3)]. Due to the semi-life of prolonged elimination, a longer period of time is necessary to achieve an initial concentration or new stationary serum in patients with renal insufficiency, than in patients with normal renal function. If appropriate care is not done to reduce dosage of digoxin, such patients are at high risk of toxicity and tubic effects will last longer in these patients than in patients with normal renal function. 8.7 Digoxin concentrations in plasma hepatic dysfunction in patients with acute hepatitis usually fall within the profile range in a group of healthy subjects. 8.8 Absorption The absorption of digoxin is reduced in some conditions of absorption, such as chronic diarrhea. 10 Overdose 10.1 Signs and Symptoms in Adults and Children Signs and toxicity symptoms are generally similar to those previously described [See Adverse Reactions (6.1)], but may be more frequent and may be more serious . The signs and symptoms of digoxin toxicity become more frequent with levels above 2nd ng / ml. However, when deciding whether the symptoms of a patient is due to digoxin, the clinical state in conjunction with serum electrometer levels and the tire function are important factors [see dosage and administration ¢ (2)]. Adults: The most common signs and symptoms of digoxin toxicity are neuseas, vãos, anorexia and fatigue that occur in 30-70% of patients who are overdose. Extremely high concentrations occupry produce hypercalemia especially in patients with impaired renal function. Almost all kinds of cardiac arrhythmias has been associated with digoxin overdose and various rhythm disturbances in the same patient are common. Pico Card Effects 3-6 hours after ingestion and can persist during 24th hours or more. Arrhythmias that are considered more characteristic of digoxin toxicity are recent initium mobitz type an AV block, accelerated junction rhythms, no-fibrile tachycardia with the AV block, and bi-directional ventricular tachycardia. Cards of ventricular fibrillation or assistolia is generally fatal. Digoxin toxicity is related to the serum concentration. As significant levels of digoxin increase above 1.2A ng / ml, there is a potential for increased reactions In addition, lower potting levels increases the risk of adverse reactions. In adults with heart disease, clinical observations suggest that an excessive dose of digoxin of 10-15 mg results in the death of half of A dose above 25 mg ingested by an adult without cardiac disease seemed to be evenly fatal if no Fabio Digoxin Imunune (Digibindâ®, DigiFabã ¢) was administered. Among the extra-cardiac manifestations, gastrointestinal symptoms (for example, nausea, vitos, anorexia) are very common (even 80% of incidence) and precede cardiac manifestations in approximately half of the patients In most relatives of literature. Neurological manifestations (eg dizziness, various SNC disturbances), fatigue and malaise are very common. Visual manifestations can also occur with aberration in the color vision (predominance of yellow green) the most frequent. Neurological and visual symptoms may persist after other signs of toxicity solve. In the chronic toxicity, the extra-specific symptoms of the cardacy, such as malaise and weakness, can predominate. Children: In pediological patients, signs and toxicity symptoms may occur during or soon after the dose of digoxin. The effects are not frequent cardiacs are similar to those observed in adults, although neuseas and vicles are not seen frequently in babies and small pedigic patients. Other demonstrations reported from overdose are weight loss in older ether groups, fails to thrive in babies, abdominal pain caused by ischemia of mesentemic arthouse, sleepiness and behavioral disturbances, including psychotic episode. Arrhythmias and combinations of arrhythmias occurring in adult patients can also occur in pediatric patients, although sinus tachycardia, supraventricular tachycardia, and fast atrial fibrillation are less frequently seen in pediam patients Trics. The pediological patients are more likely to develop distances of A-V conduction, or sinus bradycardia. Any arrhythmia in a child treated with digoxin should be considered related to digoxin until it is otherwise discarded. In pediatric patients aged 1-3 years without cardiac disease, clinical observations suggest that a 6-10 mg evergoxine would result in half-death of patients. In the same population, a dose above 10 mg resulted in death if no fabio immune digoxin was administered. 10.2 Crystal Overdose Treatment If there are suspected toxicity, discontinue lanoxin and put the patient on a cardotel monitor. Correct factors such as electronic abnormalities, thyroid dysfunction and concomitant drugs [see dosage and administration (2.5)]. Correct hypopalemia by potassium administration so that the sane potassium is maintained between 4.0 and 5.5 mmol / l. Potassium is usually administered orally, but when the correction of the arrhythmia is urgent and the concentration of poor potassium is low, the potassium can be administered through the intravenous pathway. Monitor the electrocardiogram for any evidence of potassium toxicity (for example, wave peak t) and observe the effect on arrhythmia. Avoid potassium salts in patients with bradycardia or cardboard block. Symptomatic arrhythmias can be treated with Digoxin Immune Fab. Acute overdose patients who have intentionally or accidentally ingested Solid doses of digoxin should receive orally activated carvan or nasogastric tube, regardless of time from ingestion The, since digoxine recircles to the intestine by entero-hepatic circulation. Alemon of cardiac monitoring, temporarily discontinue lanoxin until the adverse reaction is solved. Correct factors that may be contributing to adverse reactions [see warnings and precautions (5)]. In particular, correct hypocalemia and hypomagnesemia. Digoxin is not effectively removed from the body by diálise due to its large extravascular volume of distribution. Life threatening arrhythmias (ventricular tachycardia, ventricular fibrillation, high-grade A-V block, braditarthythma, sinus stop) or hypercalemia requires Digoxin Immune Fab administration. A Immune Fab was shown to be 80 to 90% effective in reversing signs and symptoms of digoxin toxicity. The bradycardia and the card capacity caused â € â € â €

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