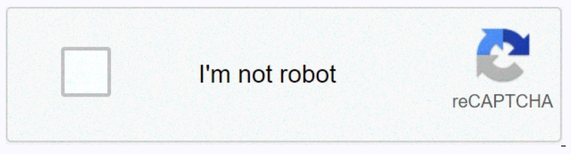

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Digoxin was administered as one intravenous injection of 22 micrograms/kg of six cattle. The serum concentrations were established by both the bi- and triocysal equation, which best corresponded to the data of most animals. It was found that the biological period of half-life of digoxin in cattle is 7.8 hours. This relatively short period of half-seil compared to other animal species dictates that digoxin should be administered more often to livestock to provide therapeutic concentrations in serum without much hesitation in serum concentrations. Computer simulations of different intravenous dosage regimes showed that a loading dose of 22 micrograms/kg followed by an infusion of 0.86 micrograms/kg/h would offer the greatest safety and efficacy in bull patients. The full text of this article, posted on the iucr.org is unavailable due to technical difficulties. Sources used in the Current Review 2020 review by Morgan E. Pacini, MS, Technical/General Manager, LSA Toxicology Laboratory. 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Pathology and Laboratory Medicine, UNC Chapel Hill. Paganka, K. D. and Pagana, T. J. (© 2007). Mosby Diagnostic and Laboratory Testing Help 8th Edition: Mosby, Inc., St. Louis, MO. Pp 361-364. Wu, A. (© 2006). Tietz Clinical Guide to Laboratory Tests, 4th Edition: Saunders Elsevier, St. Louis, MO. Pp 1334-1335. (Revised 2010 January). What is heart failure? National Institute of Heart of Lung and Blood (online information). Available online by . Access to February 2010. A.D.A.M. (Updated February 2009). An overdose of heart gliosine. MedlinePlus Medical Encyclopedia Online Information. Available online by . Access to February 2010. Dugdale, D. (Updated 2009 January 23). Digitalis toxicity. MedlinePlus Medical Encyclopedia Online Information. Available online by . Access to February 2010. Ahmed, A. (2008 May 21). Update on the role of Digoxin in older people with chronic heart failure. Today of geriatrics and aging 2008;11(1):37-41 (online info). Available online by . 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Last updated November 28, 2008. Access to July 26, 2013. Digoxin Oral Interactions. Webmd. Available online by Oral.aspx?drugid=4358&drugname=Digoxin+Oral. Last updated in March 2013. Access to July 31, 2013. 2016 review by Nicholas Heger, Ph.D., CC (NRCC), Assistant Director - Clinical Chemistry, Tufts Medical Center of Boston. Yancy CW, Jessup M, Bozkurt B et al. American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. 2013 ACCF/AHA Guide to Heart Failure Management: Report by the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Circulation. 2013;128(16):e240-e327. Baselt, Randall K. (©2014). Recycling Toxic Drugs and Chemicals in Human 10th Edition: Biomedical Publications, Seal Beach, CA Pp 656-659. Bilbault P1, Oubaassine R, Rahmani H, Lavaux T, Castelain V, Sauder P, Schneider F. Extraordinary turn-based specific immunotherapy for severe digoxin poisoning: observational cohort study. Eur J Emerg Med. 2009 June;16(3):145-9. Jeffery Brent; Kevin Wallace; Keith Burkhart; Phillips, Scott and Donovan, Jay Ward. (© 2005). Critical Toxicology - Diagnosis and Management of a CriticalLy Poisoned Patient, 1st Edition. Mosby, Inc., Philadelphia, PA. Page. 1325-1333. Standard therapy for digitalis intoxication includes the abolition of the drug and the correction of factors can contribute to toxicity such as electrolyte disorders, hypoxia, acid-base disorders, and agents such as catecholamines. In addition, treatment for arrhythmias may include reasonable supplements of potassium, lidocaine, phenytoin, procainemide, and/or or treatment of sinus bradycardia or atrioventricular block may include insertion of atropine or pacemaker. Massive intoxication of digitalis can cause hyperkalemia; the introduction of potassium supplements in conditions of mass intoxication can be dangerous (see Laboratory tests). After treatment digIBIND (digoxin immune fab), the concentration of potassium in the serum can drop rapidly2 and should be controlled frequently, especially within the first few hours after DIGIBIND (digoxin immune fab) is given (see Laboratory tests). Elimination of periods of half-life in conditions of renal failure is not clearly defined. Patients with kidney dysfunction have been successfully treated with DIGIBIND (digoxin immune fab) .4 There is no evidence the time-course therapeutic effect is different in these patients than in patients with normal kidney function, but the secretion of the Fab fragment-digoxin complex from the body is likely to be delayed. In patients who have functionally anefrik, one could foresee the inability to clear the Fab fragment-digoxin complex from the blood by glomerular filtration and kidney secretion. It is unclear whether the failure to eliminate the complex of Digoxin Fab fragments in severe renal failure can leadoxia after the release of recently unreconsed digoxin into the bloodstream. Such patients should be monitored for a long period for a possible recurrence of the toxicity of digitalis. Patients with internal poor cardiac function may worsen after the withdrawal of the inotropic action of digoxin. Animal studies have shown that the reversal of the inotropic effect is relatively gradual, occurring within a few hours. If necessary, additional support may be provided with intravenous inotropics such as dopamine or dobutamine, or vasodilators. You need to be careful in using catecholamines, so as not to exacerbate the disruption of the digital toxic rhythm. Obviously, other types of digitalis glycosides should not be used in this setting. Redihythalization should be delayed, if possible, until Fab fragments are removed from the body, which may take several days. Patients with kidney dysfunction may take a week or longer. Laboratory tests DIGIBIND (digoxin immune fab) will interfere with digitalis immunoanalysis measurements.6 Thus, the standard measurement of serum digoxin concentration can be clinically misleading until a Fab fragment is removed from the body. The concentration of digoxin or digital vkea should be obtained prior to the introduction of DIGIBIND (digoxin immune fab), if at all possible. These measurements can be difficult to interpret if drawn shortly after the last dose of digitalis, since at least 6 to 8 hours are needed to equilibrium digoxin between serum and tissue. Patients should be thoroughly checked, including the temperature pressure, electrocardiogram, and potassium concentration, during and after the introduction of DIGIBIND (digoxin immune fab). The total concentration of digoxin in serum can increase dramatically after DIGIBIND (digoxin immune fab) , but it will be almost entirely related to the Fab fragment and therefore unable to react with receptors in the body. You should keep a close eye on the concentration of potassium. Severe intoxication can cause a life-threatening increase in serum potassium by transferring potassium from within to the outer cell. Increased serum potassium concentrations can lead to increased potassium secretion from the kidneys. Thus, these patients may have hyperkalemia with a complete potassium deficiency. When the effect of digitalis is reversed by DIGIBIND (digoxin immune fab), potassium shifts back inside the cell, resulting in reduced serum potassium concentrations.4 Hypocalemia can thus develop rapidly. For these reasons, the concentration of potassium in the serum should be controlled repeatedly, especially within the first few hours after DIGIBIND (digoxin immune fab) is given, and carefully treated when necessary. Carcinogenesis, Mutagenez, Fertility Disorders There have been no long-term studies conducted in animals to assess carcinogenic potential. Pregnancy Pregnancy Category C. Animal Reproduction Studies have not been conducted with DIGIBIND (digoxin immune fab). It is also not known whether DIGIBIND (digoxin immune fab) can cause fetal harm when administered to a pregnant woman or may affect the ability of reproduction. DIGIBIND (digoxin immune fab) should be given to a pregnant woman only if it is clearly necessary. Nursing mothers are not known whether this drug is excreted in human milk. Since many drugs are excreted in human milk, caution should be exercised when DIGIBIND (digoxin immune fab) is injected by nursing women. The pediatric use of DIGIBIND (digoxin immune fab) has been successfully used in infants without any apparent adverse sequelae. As in all other circumstances, the use of this drug in infants should be based on careful consideration of the benefits of the drug, balanced with potential risk. Geriatric use of 150 items in the open-label study DIGIBIND (digoxin immune fab) , 42% were 65 and older, while 21% were 75 and older. In a post-marketing surveillance study that enrolled 717 adults, 84% were 60 and older, and 60% were 70 and older. There were no overall differences in safety or effectiveness between these subjects and young subjects, and other clinical experiences did not reveal differences in responses between older and younger patients, but the greater sensitivity of some older people could not be ruled out. The kidney secretes a complex of fab fragment-digoxin, and the risk of release of digoxin with a recurrence of toxicity potentially increases when the secretion of the complex is slowed by renal failure. However, a recurrence of toxicity was reported by only 2.8% of patients in the surveillance study and the factor associated with recurrence of toxicity was the inadequacy of the initial dose, not kidney function. The dose calculation is the same for all ages and for patients with normal and impaired kidney function. Since older patients are likely to have lowered kidney function, it may be useful to monitor kidney function and monitor possible recurrence of toxicity. LINKS 2. 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