

2010 Recommendation	2005 Recommendation	Explanation
<b>First Aid</b>		
<p>New in 2010 is the recommendation that if symptoms of anaphylaxis persist despite epinephrine administration, first aid providers should seek medical assistance before administering a second dose of epinephrine. However, if advanced medical assistance is not available and symptoms of anaphylaxis persist after a few minutes, a second dose of a prescribed epinephrine auto-injector should be given.</p>	<p>As in 2005, the 2010 guidelines recommend that first aid providers learn the signs and symptoms of anaphylaxis and the proper use of an epinephrine auto-injector so they can aid the victim.</p>	<p>The diagnosis of anaphylaxis can be a challenge, even for professionals, and excessive epinephrine administration may produce complications if given to individuals who do not have anaphylaxis.</p>
<p>First aid providers should activate the EMS system first for anyone with chest discomfort. While waiting for EMS to arrive, first aid providers should advise the person to chew one adult (non-enteric-coated) or two low-dose “baby” aspirins if the person has no history of allergy to aspirin and no recent gastrointestinal bleeding or other contraindications.</p>		<p>Aspirin is beneficial if persistent chest discomfort is due to a heart attack (or acute coronary syndrome). It can be very difficult even for professionals to determine whether chest discomfort is of cardiac origin. The administration of aspirin must therefore never delay EMS activation.</p>
<p>The <i>routine</i> use of hemostatic (clotting) agents to control bleeding as a first aid measure by first aid providers is not recommended at this time.</p>		<p>Despite the fact that a number of hemostatic agents have been effective in controlling bleeding, their use is not recommended as a routine first aid method of bleeding control because of significant variability in effectiveness and the potential for adverse effects.</p>
<p>For snakebites: Applying a pressure immobilization bandage with a pressure between 40 and 70 mm Hg in the upper extremity and between 55 and 70 mm Hg in the lower extremity around the entire length of the bitten extremity is an effective and safe way to slow lymph flow and therefore the dissemination of venom. Snugness is adequate if the bandage is comfortably tight and a finger can pass</p>	<p>In 2005, use of pressure immobilization bandages to slow the spread of the toxin was recommended only for victims of bites by snakes with neurotoxic venom such as the coral snake.</p>	<p>Effectiveness of pressure immobilization has now also been demonstrated for bites by other venomous American snakes.</p>

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easily, but not loosely, under the bandage.		
For jellyfish stings: To inactivate venom load and prevent further envenomation, jellyfish stings should be liberally washed with vinegar (4% to 6% acetic acid solution) as soon as possible and for at least 30 seconds. After the nematocysts are removed or deactivated, the pain from jellyfish stings should be treated with hot-water immersion when possible.		A number of topical treatments have been used, but a critical evaluation of the literature shows that vinegar is most effective for inactivation of the nematocysts. Immersion with water, as hot as tolerated for about 20 minutes, is most effective for treating the pain.