Morphine Sulfate:

I. Myocardial infarction
    A. Management
        1. Position of comfort
        2. Pharmacological
            a. Gases
            b. Nitrates
            c. Platelet aggregate inhibitor
            d. Analgesia
            e. Increase or decrease heart rate
            f. Possible antiarrhythmic
            g. Possible antihypertensives
        3. Electrical
            a. Constant ECG monitoring
            b. Defibrillation/ synchronized cardioversion
            c. Transcutaneous pacing
II. Heart failure
    A. Management
        1. Position of comfort
        2. Pharmacological
            a. Gases
            b. Afterload reduction
            c. Analgesia
            d. Diuresis
III. Trauma
    A. Burns
        1. Management
            a. Airway, oxygenation, and ventilation
            b. Circulatory management
            c. Pharmacological support - Analgesia
            d. Non-pharmacological management
            e. Transport considerations
                (1) Appropriate mode
                (2) Appropriate facility
            f. Psychological support/ communication strategies - Patient and family advocacy
    B. Musculoskeletal
        1. Management
            a. Dislocation/ fractures
                (1) Realignment
                    (a) Typically dislocated joints should be immobilized in the position of injury and transported for reduction
                    (b) Delayed or prolonged transport requires a different approach
                    (c) An attempt to reposition any dislocated joint into anatomical position should be made if distal circulation is impaired and if transportation is long or prolonged
                    (d) Check circulation and nerve function before and after any manipulation of any injured bone or joint
                    (e) Discontinue an attempt at repositioning if
                        i. Pain is increased significantly by manipulation, and / or
                        ii. Resistance to movement is encountered
                (2) Limb-threatening injuries
                    (a) Knee dislocation/ fracture
                    (b) Dislocation/ fracture of the ankle
                    (c) Subcondular fractures of the elbow
                (3) Always assess pulses, sensation, and motor function before and after manipulating the injury
                (4) Specific techniques for specific joints
                    (a) Finger realignment

(b) Hand and wrist fractures
    i. Common with direct trauma
    ii. Noticeable deformity
    iii. Significant pain
    iv. High incidence for nerve and vessel damage
    v. Splint on a padded board splint with the hand in position of function
(c) Hip realignment
    i. One attempt if there is severe neurovascular compromise
    ii. As soon as possible after the injury
    iii. Do not attempt if associated with other severe injuries
    iv. Analgesics
    v. Procedure
        (i) Traction
        (ii) Hip 90 degrees
        (iii) Knee 90 degrees
        (iv) Along shaft of femur
        (v) Steady and slow to relax muscle spasm
        (vi) Success
            1. "Pop" into joint
            2. Sudden relief of pain
            3. Leg can easily and painlessly be returned to full extension
    vi. Immobilization, full extension, long backboard, reevaluation of pulses and innervation
    vii. Immobilization, comfortable flexion not to exceed 90 degrees, pillows, chair, cardboard, supine position of patient
(d). Knee realignment - do not confuse with a patella dislocation, this is a limb-threatening injury
    i. One attempt if there is severe neurovascular compromise
    ii. As soon as possible after the injury
    iii. An attempt to reposition a dislocation of the knee into anatomical position should be made if transport time is delayed or prolonged greater than two hours, even if distal circulation is normal
    iv. Do not attempt if associated with other severe injuries
    v. Analgesics
    vi. Procedure
        (i) Apply gentle and steady traction and then move the injured joint into normal position
        (ii) Full extension
        (iii) Steady pull to relax muscle spasm
        (iv) Success
            1. "Pop" into joint
            2. Loss of deformity
            3. Relief of pain
            4. Knee is now more mobile
    v. Immobilization, full extension, backboard, long board splints, no traction, assess pulses, position of greatest comfort, slight flexion
(e) Ankle realignment
    i. One attempt if there is severe neurovascular compromise
    ii. As soon as possible after the injury
    iii. Do not attempt if associated with other severe injuries
    iv. Analgesic
    v. Procedure
        (i) Pull traction on the talus while stabilizing the tibia
        (ii) Slow and steady to relax spasm

(iii) Success, sudden rotation to normal position
(iv) Immobilization, as per fracture, check distal pulse

(f) Shoulder realignment
i. One attempt if there is severe neurovascular compromise
ii. As soon as possible after the injury
iii. Do not attempt if associated with other severe injuries or back injuries
iv. Analgesic
v. Procedure
(i) Pull traction in the anatomical position only