

WEB TABLE II INVESTIGATIONS TO IDENTIFY SIDE-EFFECTS OF DRUGS AND TO PICK-UP COMPLICATIONS OF STATUS EPILEPTICUS

<i>Condition</i>	<i>Drugs</i>	<i>Test</i>
Propylene glycol toxicity	Lorazepam and barbiturates	Lactic acidosis, and osmolar gap calculation
Propofol infusion syndrome	Propofol	ABG, lactate, CPK, ECG monitoring, Serum electrolytes, creatinine clearance
Immunosuppression	Barbiturates	Screening for infections: Culture of body fluids, C-reactive protein level, procalcitonin level, white blood cell count, and differential count
Valproate toxicity	Valproate	Liver function tests, Platelet count
<i>Complications</i>	<i>Test</i>	<i>Comments</i>
Hyperglycemia	RBS- 6 th hourly; Maintaining blood glucose 140- 180 mg/dL	Massive increase in catecholamine can lead to hyperglycemia and damages the brain through worsening lactate acidosis. Glucose is controlled, preferably with insulin infusion, starting at a threshold not higher than 180 mg/dL; levels <110 mg/dL not safe
Metabolic acidosis	ABG every 6-8 hourly	
Dyselectrolytemia	Serum electrolytes at least daily	To identify SIADH and hyperkalemia
Renal failure	Urea, creatinine daily and calculation of creatinine clearance	Acute nonoliguric renal failure can result due to rhabdomyolysis, may become apparent with acutely rising serum creatinine, hyperkalemia, and hyperphosphatemia
Respiratory complications	Chest radiograph/ USG	To look for pneumonia and pleural effusions
Cardiac arrhythmia	ECG	Continuous or twice a day
Hypotension	Echocardiography	For apical ballooning cardiomyopathy (Takutsu cardiomyopathy) due to massive release of catecholamines
Rhabdomyolysis	ABG	Metabolic acidosis not entirely explained by lactate accumulation, hyperkalemia, increased serum aldolase, hypocalcemia, and myoglobinuria
Infections	As per euscipcion	Common are pneumonia, sepsis, pseudomembranous colitis, and urinary tract infections. Gastrointestinal problems may be seen and often lead to adynamic ileus.