Angiotensin II

Angiotensin II is FDA approved for patients with septic or other distributive shocks. Our bodies naturally convert angiotensin I into angiotensin II, but this conversion can be impacted when a patient is sick. So by giving patients a synthetic form of angiotensin II this will help the body vasconstrict and increase aldosterone release which will result in an increase in the patient's blood pressure.

Medication Management

- Continuous IV infusion through a central line
- Angiotensin II is in the guardrails of the alaris pump
- Start the infusion at 20 ng/kg/min & monitor the patient's response
- Titrate up increments of 10ng/kg/minute every 5 minutes (max dose is 40 ng/kg/min)
- Once the goal map is reached titrate down on all other catecholamines (phenylephrine, dopamine, or epinephrine) if running except norepinephrine. Once other catecholamines are titrated off, start to down titrate norepinephrine as MAP tolerates to 30 mcg/min. Once norepinephrine reaches 30 mcg/min, discontinue vasopressin. Once norepinephrine is less than 20 mcg/min discuss with the provider team when to consider down titrating angiotensin II.
- When it is time to titrate down, do so in increments of 10 to a dose of 10 ng/kg/min; then from 10 to 5 ng/kg/min, and finally from 5 to 2.5 ng/kg/min before turning the drip off. Down-titration is recommended to occur over a period of 15 minutes

Half-Life

- The half-life of angiotensin II is less than 1 minute, so make sure that you coordinate and appropriately time with pharmacy when you need your next bag.
- If your patient's heart rate dramatically increases upon initiation of the medication, pause the drip and notify the provider. The effect of the drug should wear off in less than 1 minute if the medication caused the increase in the patient's heartrate

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