

Who can administer

May be administered by registered competent doctor or nurse/midwife

Important information

- See monitoring requirements
- In situations where the inhaled route is not appropriate for bronchodilation, the preferred route is the intramuscular or subcutaneous route

Available preparations

Bricanyl 2,500 microgram per **5mL** ampoule (2.5mg in 5mL)

Bricanyl 500 microgram per **1mL** ampoule

Reconstitution

Already in solution

- **Must be further diluted before use - diluent depends on indication**
- **Draw up using a 5 micron filter needle**

Infusion fluids

- **Bronchodilator:** can use either Glucose 5% or Sodium chloride 0.9%
- **Management of premature labour: Glucose 5% ONLY**
 - Sodium chloride should be avoided during pregnancy due to increased risk of pulmonary oedema. If it must be used, patients should be carefully monitored

Methods of intravenous administration

Bronchodilator dose

- **Slow intravenous injection** ^(ref 1)
 - Dilute to 10mL with infusion fluid and administer required dose over 3 to 5 minutes
- **Continuous intravenous infusion (administer using an electronically controlled infusion device)**
 - Add 1.5 to 2.5mg to 500mL infusion fluid and administer over several hours (see 'dose')

Premature labour

- **Continuous intravenous infusion (administer using an electronically controlled infusion device)**
 - Use a small volume of infusion, with a syringe driver to avoid the risk of maternal pulmonary oedema e.g. add 5mg (5,000 micrograms) to 40mL Glucose 5% to produce a concentration of 100 micrograms/mL
 - Dose as per schedule below
 - Rate does not usually exceed 10 micrograms/minute, with a maximum rate of 20

micrograms/minute

Dose in adults

Bronchodilator dose

- Slow intravenous injection dose: 0.25 to 0.5mg up to four times daily
- Infusion dose: Add 1.5 to 2.5mg to 500mL infusion fluid and administer at 30 to 60mL/hour for 8 to 10 hours (more than one bag may be required depending on each patient's individual requirements)

Premature labour dose

- Prepare a concentration of 100 micrograms/mL as above
- Initial dose 5 micrograms per minute for the first 20 minutes, increasing by 2.5 micrograms per minute at 20 minute intervals until the contractions stop
- Rate does not usually exceed 10 micrograms/minute, with a maximum rate of 20 micrograms/minute
- The infusion should be stopped if labour progresses despite treatment at the maximum dose
- If successful, the infusion should continue for 1 hour at the chosen rate and then be decreased by 2.5 micrograms per minute, every 20 minutes to the lowest dose that produces suppression of contractions
- Duration of treatment should not exceed 48 hours
- A maximum maternal heart rate of 120 beats per min should not be exceeded

Monitoring

- Patients at risk of hypokalaemia should have serum potassium levels monitored
- Diabetic patients should have additional blood glucose measurements performed when therapy is initiated
- Lactic acidosis has been reported with high doses of intravenous terbutaline, particularly in patients being treated for acute asthma exacerbation
- **Premature labour**
 - The amount of IV fluids administered and rate of administration should be monitored to avoid fluid overload
 - A maternal heart rate of more than 120bpm should be avoided
 - Dose should be individually titrated with reference to suppression of contractions, increases in pulse rate and changes in blood pressure, which are limiting factors
 - To minimise the risk of hypotension, keep patient in left or right lateral position throughout the infusion ^(ref 1)

Storage

Store below 25°C

References

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1: Injectable medicines guide, downloaded from Medusa 28th Oct 2021

Therapeutic classification

Selective beta2-adrenoreceptor agonist