
Information and recommendations for
doctors at hospitals/emergency departments

- Patients whose clothing or skin is contaminated with liquid sulfuric acid can cause secondary contamination of rescue and medical personnel by direct contact. Patients exposed only to sulfuric acid vapor do not pose a significant risk of secondary contamination.
 - Sulfuric acid is rapidly corrosive to all tissues. Eye contact causes severe burns and loss of vision. Contact with the skin cause severe burns, which may be delayed. Mists are irritating to the skin, eyes, and respiratory tract and causing irritation, coughing, chest pain and dyspnea. Laryngospasm and pulmonary edema (shortness of breath, cyanosis, expectoration, cough) may occur.
 - There is no antidote to be administered to counteract the effects of sulfuric acid. Treatment consists of supportive measures.
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1. Substance information

Sulfuric acid (H₂SO₄), CAS 7664-93-9

Synonyms: oil of vitriol, battery acid.

Sulfuric acid is a clear, colorless nonflammable oily liquid with a choking odor when hot. Its brownish color may be due to organic impurities, which have been charred by the high affinity for water. Sulfuric acid is used as a feedstock in the manufacture of other chemical commodities, synthetic fertilizers, nitrate explosives, artificial fibers, dyes, pharmaceuticals, detergents, glue, paint, and paper. It is an electrolyte in storage batteries. It is used in the leather, fur, food processing, wool, manufacture of plastics, petroleum refining, metal cleaning and pickling, and uranium industries, for gas drying, and as a laboratory reagent.

2. Routes of exposure*Inhalation*

Exposures may occur by inhalation of mists. Sulfuric acid's odor and upper respiratory tract irritant properties generally provide adequate warning of hazardous concentrations.

Skin/eye contact

Most exposures occur by direct contact of the skin and the eyes with liquid sulfuric acid. Contact with the skin and the eyes causes severe burns which may be delayed in onset.

Ingestion

Ingestion causes severe corrosive injury of the mucous membranes of the throat and esophagus.

3. Acute health effects*Respiratory*

Sulfuric acid exposure usually causes sore throat and coughing. Rapid development of respiratory distress with chest pain, dyspnea, laryngospasm and pulmonary edema may occur. Lung injury may progress over several hours. Sulfuric acid exposure may cause respiratory failure.

Dermal

Deep burns of the skin and mucous membranes may be caused by contact with sulfuric acid; disfiguring scars may result. Contact with less concentrated sulfuric acid vapor or mist can cause burning pain, redness, inflammation, and blisters.

Ocular

Eye contact causes severe burns and loss of vision. Contact with sulfuric acid mists cause burning discomfort, spasmodic blinking or involuntary closing of the eyelids, redness, and tearing.

Dose-effect relationships

Dose-effect relationships are as follows:

<u>Sulfuric acid concentration</u>		<u>Effect</u>
1 mg/m ³	-	Odor threshold
5 mg/m ³	-	objectionable, producing coughing
80 mg/m ³	-	immediately dangerous to life

Potential sequelae

If the patient survives the initial 48 hours after exposure, recovery is likely. After acute exposure, pulmonary function usually returns to normal in 7 to 14 days. Complete recovery is usual; however, symptoms and pulmonary deficits may persist. Airways hyperreactivity to non-specific irritants may persist, resulting in bronchospasm and chronic inflammation of the bronchi. Sequelae of the pulmonary tissue destruction and scarring may result in chronic dilation of the bronchi and increased susceptibility to infection. Chronic or prolonged exposure to sulfuric acid gas or mist has been associated with abnormal pulmonary function, chronic bronchial inflammation, nasal ulceration, skin and eye inflammation, and corrosion of the teeth.

Carcinogenicity

Occupational exposure to strong-inorganic-acid mists containing sulfuric acid is carcinogenic to humans (IARC Group 1).

4. Actions*Self-protection*

Patients exposed only to sulfuric acid mists do not pose a significant risk of secondary contamination. Patients whose clothing or skin is contaminated with liquid sulfuric acid can secondarily contaminate other people by direct contact.

Decontamination

Patients exposed only to sulfuric acid mists who have no evidence of skin or eye irritation do not need decontamination. All others require decontamination.

Patients who are able and cooperative may assist with their own decontamination. If the exposure involved liquid sulfuric acid and if clothing is contaminated, remove and double-bag the clothing.

Assure that exposed or irritated eyes have been irrigated with plain water or saline for at least 20 minutes, and that the pH of the conjunctival fluid has returned to normal (7.0). If not, continue eye irrigation during other basic care and transport. If eye irrigation is impaired by blepharospasm, one to two drops of oxybuprocaine 0.4 % may be instilled into affected eyes to allow adequate irrigation. Remove contact lenses, if present and easily removable, without additional trauma to the eye.

Assure that exposed skin and hair have been flushed with plain water for at least 15 minutes. If not, continue flushing during other basic care and transport. Protect eyes during flushing of skin and hair.

Initial treatment

Therapy will be empiric; there is not a specific antidote to be administered to counteract the effects of sulfuric acid.

The following measures are recommended if the exposure dose is 5 mg/m³ or greater (depending on time exposed), if symptoms, e. g. eye irritation or pulmonary symptoms have developed, or if no exposure dose can be estimated but exposure has possibly occurred.

If not already done, initially, administration of 8 puffs of beclomethasone from a metered dose inhaler.

Thereafter, administration of 4 puffs every 2 hours for 24 hours. Administration of humidified 100% oxygen.

At exposure concentrations of 5 mg/m³ or greater (depending on time exposed), establishment of intravenous access and intravenous administration of 1.0 g methylprednisolone (or an equivalent steroid dose), should be considered, if not already administered.

Note: Efficacy of corticosteroid administration has not yet been proven in controlled clinical studies.

Intubation of the trachea or an alternative airway management should be considered in cases of respiratory compromise. When the patient's condition precludes this, consider cricothyrotomy if equipped and trained to do so.

If sulfuric acid was in contact with the skin, chemical burns may result; treat as thermal burns: adequate fluid resuscitation and administration of analgesics, maintenance of the body temperature, covering of the burn with a sterile pad or clean sheet.

After eye exposure chemical burns may result; treat as thermal burns. Immediately consult an ophthalmologist.

Note: Any facial exposure to liquid sulfuric acid should be considered as a serious exposure.

Further evaluation and treatment

To the standard intake history, physical examination, and vital signs add pulse oximetry monitoring and a PA chest X-ray.

Spirometry should be performed. Routine laboratory studies should include a complete blood count, blood glucose and electrolyte determinations.

Check for **evidence of pulmonary edema** - hilar enlargement, and ill-defined, central-patch infiltrates on chest radiography - **is a late finding that may occur 6 to 8 hours or later after exposure. The chest X-ray is typically normal on first presentation to the emergency department even with severe exposures.**

Patients who have possible exposure or who develop serious signs or symptoms should be observed for a minimum of 24 hours and reexamined frequently before confirming the absence of toxic effects. Delayed effects are unlikely in patients who have minor upper respiratory symptoms (mild burning or a slight cough) that resolve quickly.

If oxygen saturation is less than 93 % or if it appears to drop, immediately check arterial blood gasses and repeat the chest X-ray. If blood gasses begin to show deterioration and/or if the chest X-ray begins to show pulmonary edema start additional oxygen supplementation.

Should it become clear that pulmonary edema is worsening positive end-expiratory pressure (PEEP) therapy should be started immediately. PEEP therapy can be established either by mechanical ventilation via a tightly fixed mask in the conscious patient or by endotracheal intubation followed by mechanical ventilation in the sedated patient.

Early indication for PEEP therapy is tachypnea (>30/min) with a simultaneous decrease of the partial pressure of carbon dioxide.

An inadequate increase or a relative decrease of the partial pressure of oxygen despite hyperventilation indicates the development of pulmonary edema. Fluid intake/output and electrolytes should be monitored closely.

Avoid net positive fluid balance. Central line or Swan-Ganz catheterization might be considered, to optimize fluid management.

As long as signs of pulmonary edema are present, intravenous administration of 1.0 g methylprednisolone (or an equivalent steroid dose) should be continued in intervals of 8-12 hours.

Patients with bronchospasm should be treated as follows:

a) Aerosolized β_2 -selective adrenergic agonist, e.g. 4 puffs of terbutaline, or salbutamol, or fenoterol from a metered dose inhaler (1 puff usually contains 0.25 mg terbutaline sulfate, or 0.1 mg salbutamol, or 0.2 mg fenoterol, respectively); may be repeated once after 10 min.

If inhalation is not possible, terbutaline sulfate (0.25-0.5 mg) subcutaneously or salbutamol (0.2-0.4 mg over 15 min) intravenously.

b) If a) is not effective or insufficient: theophylline (5 mg/kg body weight intravenously over 20-30 min).

*Patient release/
follow-up instructions*

c) If a) and b) are not effective or insufficient: 2 puffs of epinephrine (0.4 mg per puff) from a metered dose inhaler; may be repeated after 5 min.

If required, provide adequate pain treatment, e.g. 10 mg morphine sulfate intravenously.

Prophylactic antibiotics are not routinely recommended, but may be used based on the results of sputum cultures. Pneumonia can complicate severe pulmonary edema.

Asymptomatic patients exposed to a concentration of **less than 5 mg/m³** (depending on the period of time exposed) as well as patients who have a **normal examination and no signs or symptoms of toxicity after observation for 12 hours** may be discharged in the following circumstances:

a) The evaluating physician is experienced in the evaluation of individuals with sulfuric acid exposure.

b) Information and recommendations for patients with follow-up instructions are provided verbally and in writing. Patients are advised to seek medical care promptly if symptoms develop or recur.

c) The physician is comfortable that the patient understands the health effects of sulfuric acid.

d) Site medical is notified, so that the patient may be contacted at regular intervals in the 24-hour period following release from the emergency department.

e) Heavy physical work should be precluded for up to 24 hours.

f) Exposure to cigarette smoke should be avoided for 72 hours; the smoke may worsen the conditions of the lungs.

Patients who have serious skin or eye injuries should be reexamined in 24 hours.

Post discharge spirometry should be repeated until values return to the patient's baseline values.

In this document BASF has made a diligent effort to ensure the accuracy and currency of the information presented but makes no claim that the document comprehensively addresses all possible situations related to this topic. This document is intended as an additional resource for doctors at hospitals/emergency departments in assessing the condition and managing the treatment of patients exposed to sulfuric acid. It is not, however, a substitute for the professional judgement of a doctor and must be interpreted in the light of specific information regarding the patient available to such a doctor and in conjunction with other sources of authority.

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