1. Management of cardiac arrest :

 Cardiac arrest is a common medical emergency. It usually occurs suddenly and results in irreversible brain damage unless prompt, effective treatment is instituted. One plan for dealing effectively with this emergency consists of seven steps of cardiopulmonary resuscitation: (1) establishing the diagnosis and deciding whether to resuscitate; (2) administering a precordial thump, noting the time and summoning aid; (3) establishing a patent airway and performing artificial ventilation and external cardiac compression; (4) instituting general supportive measures; (5) diagnosing the cardiac arrhythmia responsible for the arrest; (6) treating the arrhythmia; and (7) managing the patient after resuscitation.

* 2. Management of carbon monoxide poisoning :

 Promptly remove the patient from continued exposure and immediately institute oxygen therapy with a non rebreather mask.

Perform intubation for the comatose patient or, if necessary for airway protection, and provide 100% oxygen therapy.

Institute cardiac monitoring. Pulse oximetry, although not useful in detecting carboxyhemoglobin (HbCO), is still important because a low saturation causes even greater apprehension in this setting.

Give notification to the emergency department for comatose or unstable patients because rapid or direct transfer to a hyperbaric center may be indicated.

If possible, obtain ambient carbon monoxide (CO) measurements from fire department or utility company personnel, when present.

Early blood samples may provide much more accurate correlation between HbCO and clinical status; however, do not delay oxygen administration to acquire them.

Obtain an estimate of exposure time, if possible.

Avoid exertion to limit tissue oxygen demand.

3. Management of epistaxis :

Initial management includes compression of the nostrils (application of direct pressure to the septal area) and plugging of the affected nostril with gauze or cotton that has been soaked in a topical decongestant. Direct pressure should be applied continuously for at least five minutes, and for up to 20 minutes. Tilting the head forward prevents blood from pooling in the posterior pharynx, thereby avoiding nausea and airway obstruction. Hemodynamic stability and airway patency should be confirmed. Fluid resuscitation should be initiated if volume depletion is suspected.

Every attempt should be made to locate the source of bleeding that does not respond to simple compression and nasal plugging. The examination should be performed in a well-lighted room, with the patient seated and clothing protected by a sheet or gown. The physician should wear gloves and other appropriate protective equipment (e.g., surgical mask, safety glasses). A headlamp or head mirror and a nasal speculum should be used for optimal visualization.

4. Management of foreign body in the eye:

 The most common location for a foreign object is under the upper eyelid. To remove a foreign object in this position:

* Immerse the side of your face with the affected eye in a flat container of water. While the eye is under water, open and close the eye several times to flush out the object.
* The same results can be accomplished using an eyecup purchased from a drugstore.
* If the object is stuck, pull out the upper lid and stretch it over the lower lid to loosen the object.

To treat a foreign object located beneath the lower eyelid:

* Pull out the lower eyelid or press down on the skin below the eyelid to see underneath it.
* If the object is visible, try tapping it with a damp cotton swab.
* For a persistent object, try to flush it out by flowing water on the eyelid as you hold it open.
* You also can try using an eyecup to flush out the object.