Inorganic Mercury Compounds/Elemental Mercury

Incident Management

Key Points

General
- elemental mercury is a liquid at room temperature
- odourless
- non-combustible under normal conditions
- emits toxic vapours when heated to decomposition

Health effects
- inhalation is the predominant route of exposure to metallic mercury
- inhalation of mercury vapour causes cough, breathlessness, mild hypoxaemia and chest pain; flu-like symptoms with myalgia and fever, nausea and vomiting may also occur
- ingestion of large amounts of metallic mercury may cause nausea, vomiting and abdominal pain
- ingestion is the main route of exposure for inorganic mercury compounds
- features for ingestion depend on the specific salt
- systemic toxicity may include acute tubular necrosis and neurological features

Casualty decontamination at the scene
- mercuric chloride is a corrosive substance - therefore, following disrobe, improvised wet decontamination should be considered
- for elemental mercury and other inorganic mercury compounds, following disrobe improvised dry decontamination should be considered, unless casualties are demonstrating signs or symptoms of exposure to caustic or corrosive substances

Environment
- hazardous to the environment; inform the Environment Agency where appropriate
- spillages and decontamination run-off should be prevented from entering watercourses
## Hazard Identification

### Standard (UK) dangerous goods emergency action codes

**Mercury compound, liquid, N.O.S. packing group I**

<table>
<thead>
<tr>
<th>UN</th>
<th>2024</th>
<th>Mercury compound, liquid, N.O.S. packing group I</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAC</td>
<td>2X</td>
<td>Use fine water spray. Wear chemical protective clothing with liquid-tight connections for whole body in combination with breathing apparatus*. Spillages and decontamination run-off should be prevented from entering drains and watercourses</td>
</tr>
<tr>
<td>APP</td>
<td>B</td>
<td>Gas-tight chemical protective suit in combination with breathing apparatus†</td>
</tr>
</tbody>
</table>

### Hazards

- **Class**: 6.1 Toxic substance
- **Sub-risks**: –

### HIN

- 66 Highly toxic substance

* UN – United Nations number, EAC – emergency action code, APP – additional personal protection, HIN – hazard identification number
* Chemical protective clothing with liquid tight connections for whole body (type 3) conforming to relevant standards such as BS 8428 or EN 14605, in combination with breathing apparatus BS EN 137
† Chemical protective clothing should be gas-tight conforming to BS EN 943 part 2, in combination with breathing apparatus conforming to BS EN 137

### Reference

**Mercury compound, liquid, N.O.S. packing groups II & III**

<table>
<thead>
<tr>
<th>UN</th>
<th>2024</th>
<th>Mercury compound, liquid, n.o.s. packing groups II &amp; III</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAC</td>
<td>2X</td>
<td>Use fine water spray. Wear chemical protective clothing with liquid-tight connections for whole body in combination with breathing apparatus*. Spillages and decontamination run-off should be prevented from entering drains and watercourses</td>
</tr>
<tr>
<td>APP</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

**Hazards**

| Class | 6.1 | Toxic substance |

**Sub-risks**

| – | – |

**HIN**

| 60 | Toxic or slightly toxic substance |

UN – United Nations number, EAC – emergency action code, APP – additional personal protection, HIN – hazard identification number

* Chemical protective clothing with liquid tight connections for whole body (type 3) conforming to relevant standards such as BS 8428 or EN 14605, in combination with breathing apparatus BS EN 137

**Reference**

### Mercury compound, solid, N.O.S.

<table>
<thead>
<tr>
<th>UN</th>
<th>2025</th>
<th>Mercury compound, solid, N.O.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAC</td>
<td>2X</td>
<td>Use fine water spray. Wear chemical protective clothing with liquid tight connections for whole body in combination with breathing apparatus*. Spillages and decontamination run-off should be prevented from entering drains and watercourses</td>
</tr>
<tr>
<td>APP</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Hazards</td>
<td>Class</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>Sub-risks</td>
<td>–</td>
</tr>
<tr>
<td>HIN</td>
<td>66/60</td>
<td>Highly toxic substance/toxic or slightly toxic substance</td>
</tr>
</tbody>
</table>

UN – United Nations number, EAC – emergency action code, APP – additional personal protection, HIN – hazard identification number

* Chemical protective clothing with liquid-tight connections for whole body (type 3) conforming to relevant standards such as BS 8428 or EN 14605, in combination with breathing apparatus BS EN 137

**Reference**

## Mercury

<table>
<thead>
<tr>
<th>UN</th>
<th>2809</th>
<th>Mercury</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAC</td>
<td>2X</td>
<td>Use fine water spray. Wear liquid-tight chemical protective clothing in combination with breathing apparatus*. Spillages and decontamination run-off should be prevented from entering drains and watercourses</td>
</tr>
</tbody>
</table>

| APP  | –    | –       |

### Hazards

<table>
<thead>
<tr>
<th>Class</th>
<th>8</th>
<th>Corrosive substances</th>
</tr>
</thead>
</table>

| Sub-risks | 6.1 | Toxic substance |

| HIN | 86   | Corrosive or slightly corrosive substance, toxic |

UN – United Nations number, EAC – emergency action code, APP – additional personal protection, HIN – hazard identification number

* Chemical protective clothing with liquid tight connections for whole body (type 3) conforming to relevant standards such as BS 8428 or EN 14605, in combination with breathing apparatus BS EN 137

### Reference

### Classification, labelling and packaging (CLP)*

<table>
<thead>
<tr>
<th>Hazard class and category</th>
<th>Hazard statement</th>
<th>Signal words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Tox. 2</td>
<td>Acute toxicity (inhalation), category 2</td>
<td>DANGER</td>
</tr>
<tr>
<td>Repr. 1B</td>
<td>Toxic to reproduction, category 1B</td>
<td></td>
</tr>
<tr>
<td>STOT RE 1</td>
<td>Specific target organ toxicity following repeated exposure, category 1</td>
<td></td>
</tr>
<tr>
<td>Aquatic Acute 1</td>
<td>Acute hazard to the aquatic environment, category 1</td>
<td></td>
</tr>
<tr>
<td>Aquatic Chronic 1</td>
<td>Chronic hazard to the aquatic environment, category 1</td>
<td></td>
</tr>
</tbody>
</table>

* Implemented in the EU on 20 January 2009

**Reference**

## Physicochemical Properties

<table>
<thead>
<tr>
<th>Property</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS number</td>
<td>7439-97-6</td>
</tr>
<tr>
<td>Molecular weight</td>
<td>200.6</td>
</tr>
<tr>
<td>Empirical formula</td>
<td>Hg</td>
</tr>
<tr>
<td>Common synonyms</td>
<td>Quicksilver, liquid silver</td>
</tr>
<tr>
<td>State at room temperature</td>
<td>Liquid</td>
</tr>
<tr>
<td>Volatility</td>
<td>Vapour pressure = 0.002 mmHg at 25°C</td>
</tr>
<tr>
<td>Relative density</td>
<td>13.5 at 25°C (water = 1)</td>
</tr>
<tr>
<td>Relative vapour density</td>
<td>6.93 (air = 1)</td>
</tr>
<tr>
<td>Flammability</td>
<td>Not combustible</td>
</tr>
<tr>
<td>Lower explosive limit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Upper explosive limit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Water solubility</td>
<td>None</td>
</tr>
<tr>
<td>Reactivity</td>
<td>Reacts violently with ammonia and halogens, generating a fire and explosion hazard. Attacks aluminium and many other metals</td>
</tr>
<tr>
<td>Reaction or degradation products</td>
<td>Decomposes on heating forming toxic fumes</td>
</tr>
<tr>
<td>Odour</td>
<td>Odourless</td>
</tr>
</tbody>
</table>

### References

Reported Effect Levels from Authoritative Sources

**Exposure by inhalation**

**Mercury vapour**

<table>
<thead>
<tr>
<th>mg/m³</th>
<th>Duration</th>
<th>Signs and symptoms</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;44.3</td>
<td>4–8 hours</td>
<td>Chest pains, haemoptysis, dyspnoea, cough and impairment of lung function</td>
<td>a</td>
</tr>
</tbody>
</table>

These values give an indication of levels of exposure that can cause adverse effects. They are not health protective standards or guideline values.

*Reference*


**Exposure by ingestion**

**Mercuric chloride**

<table>
<thead>
<tr>
<th>mg/kg bw</th>
<th>Signs and symptoms</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–30 (adults)</td>
<td>Vomiting, diarrhoea, severe abdominal pain, oropharyngeal pain, ulceration and haemorrhages throughout the length of the gastrointestinal tract</td>
<td>a</td>
</tr>
</tbody>
</table>

These values give an indication of levels of exposure that can cause adverse effects. They are not health protective standards or guideline values.

*Reference*

## Published Emergency Response Guidelines

### Emergency response planning guideline (ERPG) values *(see note)*

<table>
<thead>
<tr>
<th></th>
<th>Listed value (ppm)</th>
<th>Calculated value (mg/m³)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERPG-1*</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>ERPG-2†</td>
<td>0.25</td>
<td>2.0</td>
</tr>
<tr>
<td>ERPG-3‡</td>
<td>0.5</td>
<td>4.1</td>
</tr>
</tbody>
</table>

*Note* Values relate to mercury vapour
* Maximum airborne concentration below which it is believed that nearly all individuals could be exposed for up to 1 hour without experiencing other than mild transient adverse health effects or perceiving a clearly defined, objectionable odour
† Maximum airborne concentration below which it is believed that nearly all individuals could be exposed for up to 1 hour without experiencing or developing irreversible or other serious health effects or symptoms which could impair an individual's ability to take protective action
‡ Maximum airborne concentration below which it is believed that nearly all individuals could be exposed for up to 1 hour without experiencing or developing life-threatening health effects
NA Not appropriate

### Reference

### Acute exposure guideline levels (AEGLs) *(see note)*

<table>
<thead>
<tr>
<th></th>
<th>Concentration (mg/m³)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A EGL-1*</td>
<td>10 min 30 min 60 min 4 hours 8 hours</td>
</tr>
<tr>
<td></td>
<td>NR     NR     NR     NR     NR</td>
</tr>
<tr>
<td>A EGL-2†</td>
<td>3.1    2.1    1.7    0.67    0.33</td>
</tr>
<tr>
<td>A EGL-3‡</td>
<td>16     11     8.9     2.2     2.2</td>
</tr>
</tbody>
</table>

*Note* Values relate to mercury vapour
* Level of the chemical in air at or above which the general population could experience notable discomfort
† Level of the chemical in air at or above which there may be irreversible or other serious long-lasting effects or impaired ability to escape
‡ Level of the chemical in air at or above which the general population could experience life-threatening health effects or death
NR Not recommended due to insufficient data

### Reference
Exposure Standards, Guidelines or Regulations

### Occupational standards *(see note)*

<table>
<thead>
<tr>
<th></th>
<th>LTEL (8-hour reference period)</th>
<th>STEL (15-min reference period)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ppm mg/m³</td>
<td>ppm mg/m³</td>
</tr>
<tr>
<td>WEL</td>
<td>– 0.02</td>
<td>– –</td>
</tr>
</tbody>
</table>

*Note* Values relate to mercury and divalent inorganic compounds including mercuric oxide and mercuric chloride (measured as mercury)

WEL – workplace exposure limit, LTEL – long-term exposure limit, STEL – short-term exposure limit

**Reference**

Public health guidelines

<table>
<thead>
<tr>
<th>Drinking water standard</th>
<th>1 µg/L</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO guideline for drinking-water quality</td>
<td>6 µg/L (inorganic mercury)</td>
</tr>
<tr>
<td>Air quality guideline</td>
<td>1 µg/m³ annual average</td>
</tr>
</tbody>
</table>

References
Health Effects

Major routes of exposure

- inhalation is the predominant route of exposure to metallic mercury
- ingestion is the main route of exposure for inorganic mercury compounds; divalent mercuric (Hg^{2+}) salts are substantially more corrosive than monovalent mercurous (Hg^{+}) salts to the gastrointestinal tract
Immediate signs or symptoms of acute exposure

Elemental mercury

<table>
<thead>
<tr>
<th>Route</th>
<th>Signs and symptoms</th>
</tr>
</thead>
</table>
| Inhalation  | Elemental mercury is volatile, particularly when the ambient temperature is high, and is absorbed rapidly. Patients may develop flu-like symptoms with myalgia and fever. Nausea and vomiting may also occur  
Acute inhalation of mercury vapour causes cough, breathlessness, mild hypoxaemia and non-specific chest pain within a few hours of exposure. Erosive bronchitis and bronchiolitis have been observed. Diffuse infiltrates consistent with pulmonary oedema may be found on chest X-ray. Acute respiratory destress syndrome has been reported  
Metallic taste, gingival erythema, oropharyngeal pain, hypersalivation, gingivostomatitis and hepatic dysfunction can occur  
Fatigue, agitation, headaches, tremor, ataxia, paraesthesiae and peripheral neuropathy have also been reported  
Proteinuria and renal failure secondary to acute tubular necrosis, nephrotic syndrome and hyperchloraemia may occur. Thrombocytopenia, leucocytosis and neutrophilia have been reported  
Personality changes, memory loss and hallucinations may also occur in acute mercury vapour poisoning |
| Ingestion   | Ingestion of small amounts of elemental mercury is unlikely to cause features. If large amounts of elemental mercury are ingested, patients may develop nausea, vomiting and abdominal pain  
Aspiration of mercury is likely during substantial ingestion. Features similar to those seen following inhalation of mercury vapour may follow  
Sequestration of ingested mercury in the appendix has caused appendicitis |
| Dermal      | Discoid eczema, hyperhidrosis, skin erythema and pruritis can develop following dermal exposure to elemental mercury |
| Ocular      | Exposure to mercury vapour may lead to conjunctivitis and ocular irritation. The eyes may develop grey or brown lens discolouration. Blurred vision, photophobia and reduction of the visual field are also possible. Reduction in colour and depth of vision may also occur |

References
### Inorganic mercury compounds

<table>
<thead>
<tr>
<th>Route</th>
<th>Signs and symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inhalation</strong></td>
<td>Inhalational exposures are unusual. However, occupational dermal and inhalational exposure have led to systemic toxicity, particularly the nephrotic syndrome</td>
</tr>
<tr>
<td><strong>Ingestion</strong></td>
<td><strong>Mercuric salts</strong> Features include burning of the mouth and throat, abdominal pain, nausea, vomiting, haematemesis and (sometimes bloody) diarrhoea. Dehydration, acute colitis, intestinal mucosal necrosis, circulatory collapse, coma and death may ensue. Other features described in acute poisoning include ECG changes (atrial fibrillation, broadening of the QRS complex), transient pancytopenia and increased transaminase, amylase and creatine kinase activities, although these are likely, at least in part, to be secondary to the metabolic disturbances present rather than direct inorganic mercury toxicity. Patients surviving the acute gastrointestinal/renal phase of mercuric mercury poisoning may go on to develop renal glomerular and neurological damage; see systemic toxicity. <strong>Mercurous salts</strong> Mercurous chloride (calomel) causes “pink disease” (acrodynia) which is a hypersensitivity reaction characterised by fever, irritability, photophobia, an erythematous desquamating rash, hyperkeratosis of the palms and soles, and lymphadenopathy. Systemic features of mercury poisoning may occur following acute exposure.</td>
</tr>
<tr>
<td><strong>Dermal</strong></td>
<td>Inorganic mercuric compounds, notably “cinnabar” (mercuric sulphide) used as a red dye in tattoos, have caused contact dermatitis and granulomatous reactions. Skin lightening creams and soaps containing mercurous chloride or mercuric chloride cause systemic mercury toxicity, particularly after repeated exposures.</td>
</tr>
<tr>
<td><strong>Ocular</strong></td>
<td>May cause pain, blepharospasm, lacrimation, conjunctivitis, palpebral oedema and photophobia</td>
</tr>
<tr>
<td><strong>Systemic</strong></td>
<td>Systemically absorbed mercuric ions cause acute tubular necrosis (exacerbated after mercuric salt ingestion by hypovolaemic shock). Substantial or repeated exposure may result in glomerular damage, nephrotic syndrome with proteinuria and oedema, and type IV hypersensitivity granulomatous interstitial nephritis. Neurological features including weakness, irritability, weight loss (or failure to thrive in young children), hypersalivation, tremor and paraesthesia</td>
</tr>
</tbody>
</table>

**References**


Decontamination at the Scene

Chemical specific advice

The approach used for decontamination at the scene will depend upon the incident, location of the casualties and the chemicals involved. Therefore, a risk assessment should be conducted to decide on the most appropriate method of decontamination.

Mercuric chloride is a corrosive substance. Therefore, following disrobe, improvised wet decontamination should be considered. For elemental mercury and other inorganic mercury compounds, following disrobe improvised dry decontamination should be considered, unless casualties are demonstrating signs or symptoms of exposure to caustic or corrosive substances (see below for further information).

Emergency services and public health professionals can obtain further advice from Public Health England (Centre for Radiation, Chemical and Environmental Hazards) using the 24-hour chemical hotline number: 0344 892 0555.

General advice on disrobe and decontamination

Disrobe

The disrobe process is highly effective at reducing exposure to HAZMAT/CBRN material when performed within 15 minutes of exposure.

Therefore, disrobe must be considered the primary action following evacuation from a contaminated area.

Where possible, disrobe at the scene should be conducted by the casualty themselves and should be systematic to avoid transferring any contamination from clothing to the skin. Consideration should be given to ensuring the welfare and dignity of casualties as far as possible.

Improvised decontamination

Improvised decontamination is an immediate method of decontamination prior to the use of specialised resources. This should be performed on all contaminated casualties, unless medical advice is received to the contrary. Improvised dry decontamination should be considered for an incident involving chemicals unless the agent appears to be corrosive or caustic.

Improvised dry decontamination

- any available dry absorbent material can be used, such as kitchen towel, paper tissues (e.g. blue roll) and clean cloth
• exposed skin surfaces should be blotted and rubbed, starting with the face, head and neck and moving down and away from the body
• rubbing and blotting should not be too aggressive, or it could drive contamination further into the skin
• all waste material arising from decontamination should be left in situ, and ideally bagged, for disposal at a later stage

**Improvised wet decontamination**
• water should only be used for decontamination where casualty signs and symptoms are consistent with exposure to caustic or corrosive substances such as acids or alkalis
• wet decontamination may be performed using any available source of water such as taps, showers, fixed installation hose-reels and sprinklers
• when using water, it is important to try and limit the duration of decontamination to between 45 and 90 seconds and, ideally, to use a washing aid such as cloth or sponge
• improvised decontamination should not involve overly aggressive methods to remove contamination as this could drive the contamination further into the skin
• where appropriate, seek professional advice on how to dispose of contaminated water and prevent run-off going into the water system

**Additional notes**
• following improvised decontamination, remain cautious and observe for signs and symptoms in the decontaminated person and in unprotected staff
• if water is used to decontaminate casualties this may be contaminated, and therefore hazardous, and a potential source of further contamination spread
• all materials (paper tissues etc) used in this process may also be contaminated and, where possible, should not be used on new casualties
• the risk from hypothermia should be considered when disrobe and any form of wet decontamination is carried out
• people who are contaminated should not eat, drink or smoke before or during the decontamination process and should avoid touching their face
• consideration should be given to ensuring the welfare and dignity of casualties as far as possible. Immediately after decontamination the opportunity should be provided to dry and dress in clean robes/clothes.
• people who are processed through improvised decontamination should subsequently be moved to a safe location, triaged and subject to health and scientific advice. Based on the outcome of the assessment, they may require further decontamination
Interim wet decontamination

Interim decontamination is the use of standard fire and rescue service (FRS) equipment to provide a planned and structured decontamination process prior to the availability of purpose-designed decontamination equipment.

Decontamination at the scene references


Clinical Decontamination and First Aid

Clinical decontamination is the process where trained healthcare professionals using purpose-designed decontamination equipment treat contaminated people individually.

Detailed information on clinical management can be found on TOXBASE – www.toxbase.org.

Important note

- once body surface contaminants have been removed or if your patient was exposed by ingestion or inhalation the risk that secondary care givers may become contaminated is very low. Secondary carers should wear standard hospital PPE as a precaution against secondary contamination from vomit and body fluids.
- if the patient has not been decontaminated following surface contamination, secondary carers must wear appropriate NHS PPE for chemical exposure to avoid contaminating themselves. The area should be well ventilated.

Clinical decontamination following surface contamination

- carry out decontamination after resuscitation.
- this should be performed in a well-ventilated area, preferably with its own ventilation system.
- contaminated clothing should be removed, double-bagged, sealed and stored safely.
- decontaminate open wounds first and avoid contamination of unexposed skin.
- any particulate matter adherent to skin should be removed and the patient washed with copious amounts of water under low pressure for at least 10–15 minutes. The earlier irrigation begins, the greater the benefit.
- pay special attention to mucous membranes, moist areas such as skin folds, fingernails and ears.

Elemental mercury

Dermal exposure

- decontaminate (as above) the patient following surface contamination.
- patients with major skin exposure may have inhaled a significant amount of vapour; in this case manage as for inhalation.
- other measures as indicated by the patient’s clinical condition.

Ocular exposure

- remove contact lenses if present.
• anaesthetise the eye with a topical local anaesthetic (e.g. oxybuprocaine, amethocaine or similar); **however, do not delay irrigation if local anaesthetic is not immediately available**

• immediately irrigate the affected eye thoroughly with 1,000 mL 0.9% saline (e.g. by an infusion bag with a giving set) for a minimum of 10-15 minutes irrespective of initial conjunctival pH. Amphoteric solutions are available and may be used. A Morgan Lens may be used if anaesthetic has been given. Aim for a final conjunctival pH of 7.5–8.0. The conjunctivae may be tested with indicator paper. Retest 20 minutes after irrigation and use further irrigation if necessary

• repeated instillation of local anaesthetics may reduce discomfort and help more thorough decontamination; however, prolonged use of concentrated local anaesthetics is damaging to the cornea

• patients with corneal damage, those who have been exposed to strong acids or alkalis and those whose symptoms do not resolve rapidly should be discussed **urgently** with an ophthalmologist

• other supportive measures as indicated by the patient's clinical condition

**Inhalation**

• maintain a clear airway and ensure adequate ventilation

• give supplemental oxygen

• monitor oxygen saturation, blood pressure, pulse, body temperature, respiratory rate and conscious level

• other supportive measures as indicated by the patient's clinical condition

**Ingestion**

• clinical management is usually not required

• other supportive measures as indicated by the patient's clinical condition

**Inorganic mercury compounds**

**Dermal exposure**

• decontaminate (as above) the patient following surface contamination

• monitor blood pressure, pulse and oxygen saturation

• assess for systemic toxicity, particularly renal and neurological features

• other measures as indicated by the patient’s clinical condition

**Ocular exposure**

• remove contact lenses if present
• anaesthetise the eye with a topical local anaesthetic (e.g. oxybuprocaine, amethocaine or similar); **however, do not delay irrigation if local anaesthetic is not immediately available**

• immediately irrigate the affected eye thoroughly with 1,000 mL 0.9% saline (e.g. by an infusion bag with a giving set) for a minimum of 10-15 minutes irrespective of initial conjunctival pH. Amphoteric solutions are available and may be used. A Morgan Lens may be used if anaesthetic has been given. Aim for a final conjunctival pH of 7.5–8.0. The conjunctivae may be tested with indicator paper. Retest 20 minutes after irrigation and use further irrigation if necessary

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• patients with corneal damage, those who have been exposed to strong acids or alkalis and those whose symptoms do not resolve rapidly should be discussed urgently with an ophthalmologist

• other supportive measures as indicated by the patient’s clinical condition

**Inhalation**

• ensure a clear airway and adequate ventilation

• monitor blood pressure, pulse and oxygen saturation

• assess for systemic toxicity, particularly renal and neurological features

• other measures as indicated by the patient’s clinical condition

**Ingestion**

• **maintain airway and establish haemodynamic stability**

• in severely affected patients critical care input is essential. Urgent assessment of the airway is required. A supraglottic-epiglottic burn with erythema and oedema is usually a sign that further oedema will occur that may lead to airway obstruction

• children are at increased risk of airway obstruction

• do not attempt gastric lavage

• monitor blood pressure, pulse, and oxygen saturation

• other supportive measures as indicated by the patient’s clinical condition

**Clinical decontamination and first aid references**


TOXBASE Mercury inorganic – features and management, 06/2014

TOXBASE Mercury (metallic), 06/2014

TOXBASE Mercury metallic – features and management, 06/2014