

**Florida Poison Information Center/Jacksonville**  
**At Shands Jacksonville**  
**University of Florida Health Science Center**  
**1-800-222-1222**

**VX**

**Mechanism of Action**

The chemical warfare agent VX, is one of the nerve agents in the acetylcholinesterase inhibitor group. These agents affect transmission of nerve impulses in the nervous system by irreversibly binding to the enzyme acetylcholinesterase inhibiting its activity, and causing an accumulation of acetylcholine. They have a very rapid onset, and can manifest severe toxic effects, including death from just a few drops.

**Properties**

VX (O-ethyl S-diisopropylaminomethyl) is non-volatile so it will remain on equipment and terrain for long periods of time. Hence, its classification as a persistent chemical warfare agent. It is a colorless, essentially odorless liquid with a consistency of heavy lubricating oil. Absorption is mainly through the skin, but it can also enter the system through inhalation as a gas or aerosol. Consumption of contaminated liquids or foods will also cause toxicity.

In comparison to the G-agents (Tabun (GA), Sarin (GB), Soman (GD) and GF), VX is at least 10 times more toxic. Estimated lethal doses for 50% of the population of VX are 50 mg-min/m<sup>3</sup> for vapor and 10 mg for skin exposure.

**Clinical Effects**

Symptoms are dependent upon the route, concentration, and duration of exposure. Effects are caused by excess acetylcholine at both muscarinic and nicotinic receptors, resulting in a "cholinergic syndrome." Onset of symptoms can occur anywhere from 10 minutes to 18 hours after exposure. Initial symptoms are usually localized to the contact site, followed by gastrointestinal symptoms and then other systemic manifestations.

Low to moderate doses- Patients may have an asymptomatic period of 20 to 30 minutes after skin exposure. Mild signs and symptoms include localized sweating and muscle twitching in the contaminated area, stomach cramps and nausea, increased salivation and drooling, unexplained runny nose, miosis, visual difficulties (limited night and short range vision) and pain or headache around the eyes. Patients may also complain of chest tightness, difficulty breathing, and fatigue. Moderate exposures cause increasing severity of mild symptoms and may progress to weakness, muscle fasciculations, slurred speech and hallucinations.

High doses- symptoms will be very rapid and severe. With higher doses, severe dyspnea and cough secondary to bronchoconstriction and increased secretions are likely. Pinpoint pupils, severe vomiting, and involuntary urination/defecation can be seen with rapid progression to convulsions, unconsciousness and respiratory failure. Respiratory muscle paralysis or suffocation usually causes death.

## Medical Management

### Decontamination

Rescuers need to wear full protective garments and gloves (Class B or above). Remove any clothing that has been exposed. The potential for secondary contamination is extremely HIGH before decontamination, and LOW if decontamination is thorough.

*Skin*- When skin contact has occurred, the area should be washed well with soap and water.

*Eyes*- Exposed eyes should be irrigated with copious water or saline for 15-20 minutes.

Airway and ventilatory support may be required. If intubation is required, depolarizing neuromuscular blockade with succinylcholine should be avoided.

### Antidotes

*Atropine*- as an anticholinergic agent, it blocks excess acetylcholine at peripheral muscarinic sites. Atropine will not reverse the nicotinic effects.

*Pralidoxime*- breaks the toxin-acetylcholinesterase bond to restore normal activity of the enzyme. Pralidoxime will be most effective if given within 24 hours after the exposure, since the agent-acetylcholinesterase bond undergoes "aging" to become irreversible. However, VX is highly lipid soluble with the ability to slowly leech out of the fat tissue over a long period of time. Therefore, there is benefit to giving it more than 24 hours after the exposure.

*Diazepam*-is administered as needed for seizure activity. Other benzodiazepines may be substituted.

### Field Antidotes

These 3 agents are available in intramuscular autoinjectors and may be utilized at the exposure site and in mass casualty incidents. The MARK I kit contains 2mg of atropine and 600mg of pralidoxime and the CANA kit contains 10 mg of diazepam. CANA kits are not to be self-administered. A person does not need it if they are well enough to give it to him/herself

### Assessment of cholinesterase concentrations

If available, it may be appropriate to obtain red blood cell cholinesterase levels. A significant depression of enzyme activity may be useful in documenting exposure. However, there is a wide range of normal, and levels may still fall within a normal range in spite of significant inhibition. The amount of enzyme inhibition may not correlate with the degree of toxicity. Knowing that acetylcholinesterase regenerates at approximately 1% each day, a post-exposure level may provide a rough estimate as to how long a patient will require ventilatory support or rehabilitation.

## References:

Holstege CP, et al. Chemical Warfare: Nerve Agent Poisoning. Critical Care Clinics. 1997.

Medical Management of Chemical Casualties Handbook. United States Army. 1995.

Call the Florida Poison Information Center Network for information and/or to report exposures.



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**Centers are located in Jacksonville, Tampa, & Miami**