Cardiac Arrest Post Resuscitation - 10.054

TREATMENT:

Optimize ventilation, perfusion and oxygenation immediately upon ROSC

Intubate as needed
Titrate oxygen to the lowest level required to achieve an SpO2 between 93 – 99%
Monitor ETCO2 (normal is 35-45 mmHg), DO NOT Hyperventilate (ideal rate is 8-12 breaths/minute)
If MAP < 65 mmHg, administer 500 ml fluid bolus.

Administer appropriate anti-dysrhythmia medication per VF/Pulseless VT protocol

If hypotension is persistent (MAP < 65 mmHg)
Consider Levophed or Epinephrine per Shock
Protocol

Perform 12-lead ECG.

Transport all patients with head elevated 30 degrees to a hospital with emergent interventional capability. Package pt for transported with mechanical CPR device in place, if possible.

If arrest re-occurs, treat per appropriate protocol.

NOTES & PRECAUTIONS:

- A. Hyperventilation reduces venous return and may cause hypotension Additional causes of post-resuscitation hypotension include hypovolemia and pneumothorax especially in the presence of positive pressure ventilation.
- B. The condition of post-resuscitation patients fluctuates rapidly and they require close monitoring. Up to 40% of patients with ROSC will re-arrest before arriving at the hospital. Re-arrest is associated with lower survival rates. Stabilizing measures performed in the immediate post-ROSC period may reduce the risk of re-arrest and should be initiated on-scene, prior to movement of the patient and/or transport.
- C. Transport all post ROSC patients of suspected cardiac nature to SCMC-Bend unless patient needs to be stabilized immediately or not enough resources are available. If post ROSC 12-lead shows STEMI, <u>DO NOT</u> activate HEART 1; inform SCMC-Bend ED via HEAR or phone.