Cardiac Arrest with Pregnancy (>22 weeks) – 10.054

TREATMENT:

Manage rhythm per appropriate cardiac arrest algorithm (V-Fib/Pulseless VT, PEA, Asystole)

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CPR with continuous manual left lateral uterine displacement using the two-handed method shown below (see Note G).

Ensure BVM ventilations are with high flow oxygen utilizing a two-handed technique to prevent gastric inflation. Suction should be readily available.

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Early transport is preferable regardless of ROSC status. The gravid uterus must remain displaced during transport. Continue the two-handed technique for uterine displacement (except in the presence of mechanical CPR when the patient can be attached to a board and the board is lifted 30 degrees in left lateral decubitus position). If patient is in cardiac arrest, notify and transport to the closest facility.

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IV/IO access should be above the diaphragm (humeral IO or upper extremity IV access is preferred).

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Airway management can be performed with extraglottic device or endotracheal tube per standard airway guidelines without interruption of high-performance CPR and should not delay considerations of early transport.

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NOTES & PRECAUTIONS:

A. Consider early transport prior to achieving ROSC, especially if a mechanical CPR device is available.
B. Alert the receiving facility early in order to have an OB team present upon arrival in the emergency department. If you have not achieved ROSC, go to the closest facility regardless of OB capabilities.
C. If ROSC has been achieved and maintained prior to, or during transport, bypass to an OB and NICU capable facility.
D. Lidocaine is preferable (Class B in Pregnancy) to amiodarone (Class C in Pregnancy) in the setting of ventricular fibrillation or pulseless ventricular tachycardia.
E. In the setting of ventricular fibrillation or pulseless ventricular tachycardia, no adjustments need to be made to defibrillation energy settings. Immediately following defibrillation, resume the left lateral uterine displacement.
F. If mechanical CPR is in place, continue the left lateral uterine displacement by tilting the backboard 30° to the left or by continuing manual displacement.
G. If ROSC is achieved continue left lateral uterine displacement by placing the patient in the left lateral decubitus position or by manually displacing the gravid uterus.
H. High flow oxygen needs to be maintained in all peri-arrest patients.
I. Consider OG placement when possible.