Cardiac Arrest (Asystole) – 10.051

TREATMENT:

Verify Arrest
Initiate HP CPR
Attach cardiac defibrillator or AED
In suspected opioid overdose, administer **naloxone**, but do not delay chest compressions or shocks.

1:10,000 Epinephrine 1mg IV/IO <u>as soon as access is obtained</u>.

Continue HP CPR; check rhythm every 2 minutes

1:10,000 Epinephrine 1 mg IV/IO, repeat every 3-5 minutes.

PEDIATRIC PATIENTS:

A. Begin CPR and airway management.
B. Administer **1:10,000 Epinephrine 0.01 mg/kg IV/IO**, repeat every 3-5 minutes.
C. Consider and treat other possible causes. Obtain CBG.

NOTES & PRECAUTIONS:

A. If unwitnessed arrest, unknown downtime, and no obvious signs of death, proceed with resuscitation and get further information from family/bystanders.
B. Consider OLMC for advice on continuing resuscitation.
C. If history of traumatic event, consider Death in the Field protocol.
D. DO NOT interrupt CPR when securing patient's airway.
E. Studies have shown no superiority of ET vs Supraglottic airways for survival rates.
F. 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.
G. Continued Epinephrine use after 3 rounds of Epi administration should have a prolonged administration interval (8-10 minute interval instead of 3-5 minutes).

KEY CONSIDERATIONS:

Consider and treat other possible causes:

- Acidosis – High performance CPR, routine administration of sodium bicarbonate not recommended
- Cardiac tamponade – Initiate rapid transport.
- Hyperkalemia – Treat per Hyperkalemia protocol.
- Hypothermia – Treat per Hypothermia protocol
- Hypovolemia – Treat with fluids per Shock protocol.
- Hypoxia – Oxygenate and ventilate
- Pulmonary embolus – Initiate rapid transport.
- Tension pneumothorax – Needle decompression.
- Tri-cyclic antidepressant overdose – **Sodium Bicarbonate 1 mEq/kg IV/IO**