TREATMENT:

<table>
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<tr>
<th>Initiate HP CPR</th>
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<tr>
<td>Perform HP CPR for 2 minutes</td>
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<tr>
<td>If down time is less than 5 minutes, perform CPR until defibrillator is attached</td>
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<tr>
<td>Treat per Universal Patient Care.</td>
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1:10,000 epinephrine 1mg IV/IO

Continue HP CPR; check rhythm every 2 minutes

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

PEDRIATRIC PATIENTS:
A. Begin CPR and airway management.
B. Administer 1:10,000 epinephrine 0.01 mg/kg IV/IO, repeat every 3-5 minutes. If no IV access, give 1:1,000 epinephrine 0.1 mg/kg in 4 cc normal saline via ET (ET epinephrine should be considered a last resort after attempts at IV/IO have failed).
C. Consider and treat other possible causes.

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. If patient has return of spontaneous circulation, start cooling per Induced Hypothermia protocol.
F. Transport all post ROSC patients of suspected cardiac nature to SCMC-Bend unless patient needs to be stabilized immediately or not enough resources available. If post ROSC 12-Lead shows STEMI, DO NOT activate Heart 1; inform SCMC-Bend ED via HEAR or phone.

KEY CONSIDERATIONS:
Consider and treat other possible causes:
- Acidosis - Sodium bicarbonate 1 mEq/kg IV.
- 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.
Cardiac Arrest (Asystole) – 10.050