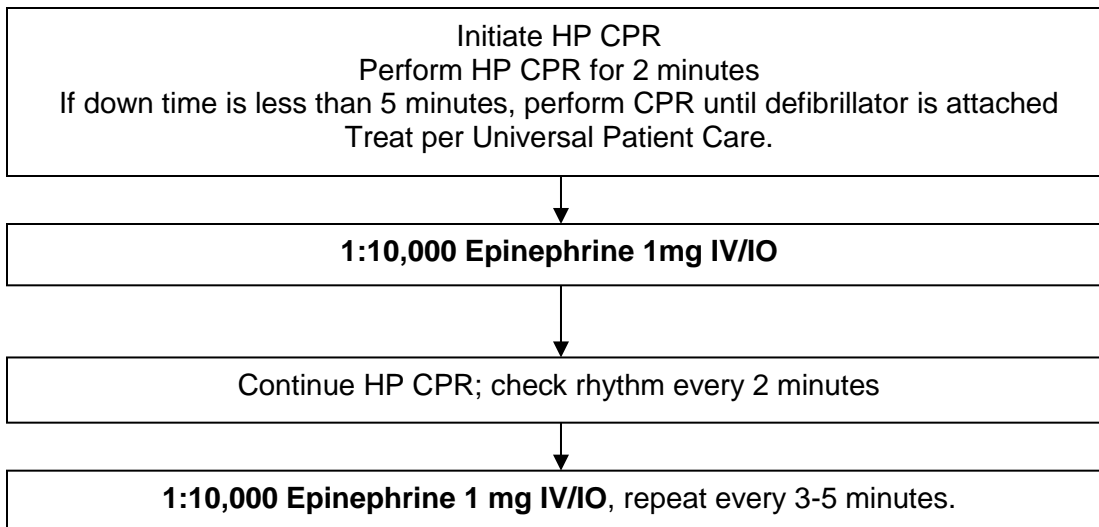


## Cardiac Arrest (Asystole) – 10.051

### TREATMENT:



### PEDIATRIC PATIENTS:

- Begin CPR and airway management.
- 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).
- Consider and treat other possible causes.

### NOTES & PRECAUTIONS:

- If unwitnessed arrest, unknown downtime, and no obvious signs of death, proceed with resuscitation and get further information from family/bystanders.
- Consider OLMC for advice on continuing resuscitation.
- If history of traumatic event, consider Death in the Field protocol.
- DO NOT interrupt CPR when securing patient's airway.
- Studies have shown no superiority of ET vs Supraglottic airways for survival rates.
- 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, **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/IO**.
- 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**