

# Cardiac Arrest - Asystole/PEA

For non-traumatic cardiac arrest in which any resuscitation is initiated, NOT dead on arrival

### History

- Events leading to arrest
- Estimated downtime
- Past medical history
- Medications
- End stage renal disease
- Suspected hypothermia
- Suspected overdose
  - Tricyclic
  - Digitalis
  - Beta blockers
  - Calcium channel blockers
- DNR, POLST, or Living Will

### Signs and Symptoms

- Pulseless
- Apneic or agonal respirations
- No electrical activity on ECG
- No heart tones on auscultation

### Differential

- Hypovolemia (e.g., trauma, AAA or other)
- Cardiac tamponade
- Hypothermia
- Drug overdose (e.g., tricyclic, digitalis, beta blockers, or calcium channel blockers)
- Myocardial infarction
- Hypoxia
- Tension pneumothorax
- Pulmonary embolus
- Acidosis
- Hyperkalemia

Adult Cardiac Arrest – Non-traumatic Treatment Protocols

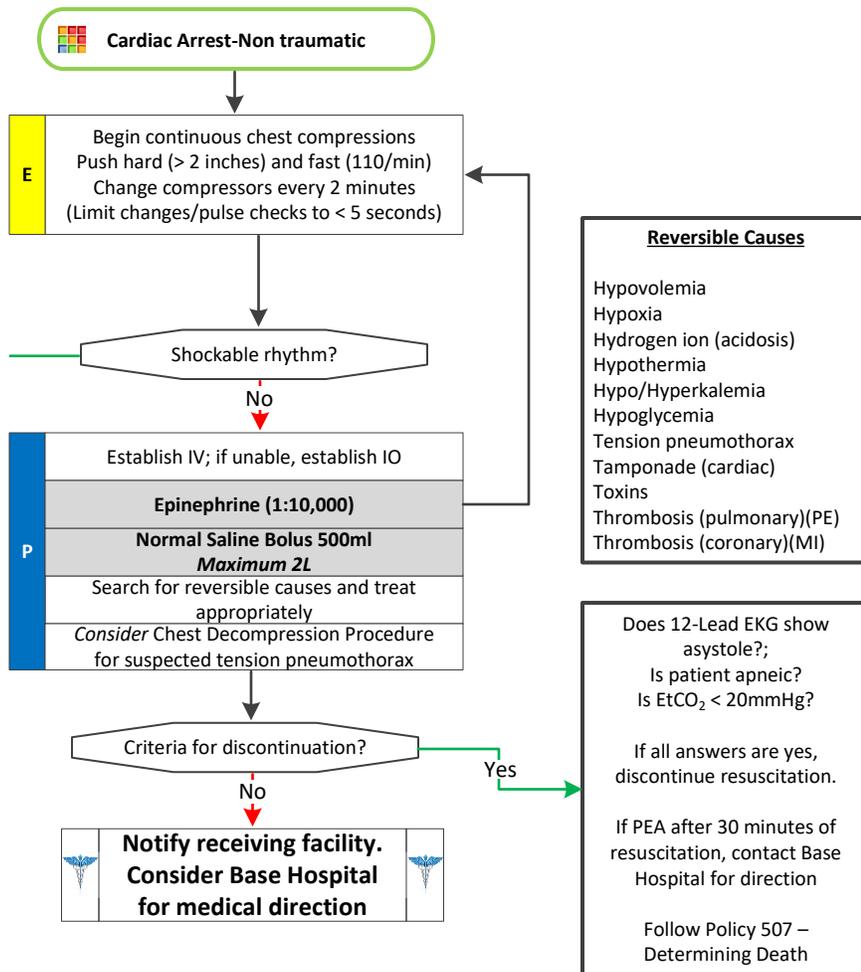
**AT ANY TIME**

Return of spontaneous circulation



Go to Post Resuscitation

 **Appropriate Cardiac Dysrhythmia**



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For non-traumatic cardiac arrest in which any resuscitation is initiated, NOT dead on arrival

## Pearls

- Discussion with the Base Hospital can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.
- Efforts should be directed at high quality and continuous chest compressions with minimal interruptions.
- IV access, including EJ, must be attempted. If unsuccessful, then attempt IO.
- Use pediatric BVM with EtCO<sub>2</sub> and ventilate at a rate of 10 ventilation per minute delivered on compression upstroke.
- Provide resuscitative efforts on scene for 30 minutes to maximize chance of ROSC.
- If resuscitative efforts do not attain ROSC, consider cessation of efforts in accordance with the Determination of Death policy.
- Epinephrine in doses of greater than 3mg has been shown to be detrimental to patient outcome.
- Survival from PEA or Asystole is based on identifying and correcting the CAUSE: consider a broad differential diagnosis with early and aggressive treatment of possible causes.
- Consider breathing and airway management after second shock or two (2) rounds of chest compression (2 minutes each round).
- Potential association of PEA with hypoxia may exist, so placing an effective BLS airway with oxygenation early may provide benefit.
- PEA caused by sepsis or severe volume loss may benefit from higher volume of normal saline administration.
- Return of spontaneous circulation after Asystole/PEA requires continued search for underlying cause of cardiac arrest.
- Treatment of hypoxia and hypotension are important after resuscitation from Asystole/PEA.
- Asystole is commonly an end stage rhythm following prolonged VF or PEA with a poor prognosis.
- Prior to termination of efforts, an advanced airway shall be established.
- Potential protocols used during resuscitation include: Overdose/Toxic Ingestion and Hypoglycemia.
- In the setting of renal failure, dialysis, suspected DKA or hyperkalemia, calcium chloride followed by sodium bicarbonate shall be administered.

