

HR < 50 bpm and symptomatic; hypotension, altered mental status, shock, ischemic chest discomfort, acute heart failure



Start

1. Call for "ANESTHESIOLOGIST STAT" and CODE CART
2. Turn FiO₂ to 100%
 - ▶ Verify adequate oxygenation / ventilation
3. Stop surgical stimulation (if laparoscopy, desufflate)
4. Give atropine
5. Prepare for transcutaneous pacing
6. If atropine ineffective:
 - ▶ Start transcutaneous PACING; while preparing for pacing -
 - ▶ Start EPINEPHRINE or DOPAMINE infusion
7. Consider...
 - ▶ Turning off anesthetics if patient remains unstable
 - ▶ CARDIOLOGY consultation
 - ▶ Assess for causes (ischemia, drug induced, surgical)
 - ▶ Identification / capture of rhythm (12-lead ECG if available)
 - ▶ Arterial line if pulse or BP difficult to assess
 - ▶ CVC for transvenous pacing (Cordis or MAC Catheter)

▶ Critical Changes

If PEA develops: Go to » CHKLST CAA

DRUG DOSES and treatments

Atropine	0.5 mg IV, may repeat q 3-5 min up to 3 mg total
EPIneprine	2-10 mcg/min IV
- or -	
DOPamine	2-20 mcg/kg/min IV
<u>OVERDOSE treatments</u>	
Beta-Blocker	Glucagon 2-4 mg IV push
Calcium Channel Blocker	Calcium Chloride 1g IV
Digoxin	Digoxin Immune FAB (consult pharmacy for dosing)

TRANSCUTANEOUS PACING instructions

1. Place pacing electrodes front and back
2. Turn monitor / defibrillator to PACER mode
3. Set PACER RATE (ppm) to 80/minute
(Adjust based on clinical response once pacing established)
4. Increase PACER OUTPUT until electrical capture (pacer spikes aligned with QRS complex)
5. Set final Pacer Output to 10 mA above initial capture level
6. Confirm effective capture
 - Electrically: assess ECG tracing
 - Mechanically: palpate femoral pulse (carotid unreliable)

During RESUSCITATION

Airway	Assess and secure
Circulation	Confirm adequate IV or IO access Continue to check for adequate pulses Consider IV fluids wide open