

CAA Cardiac Arrest – Asystole/PEA

Non-shockable pulseless cardiac arrest



Start

1. Call for “ANESTHESIOLOGIST STAT” and CODE CART

- ▶ Say: “The top priority is high-quality CPR”

2. Put backboard under patient, supine position

3. Turn FiO₂ to 100%, turn off anesthetics

4. Start CPR - Assessment cycle:

5. Attach defibrillator to patient simultaneously with CPR

- ▶ Perform CPR
 - “Hard and Fast”; 100 compressions/min
 - Ensure full chest recoil with minimal interruptions
 - If ETCO₂ < 10 or DBP < 20mm Hg, consider improved quality compressions
 - 10 breaths / minute, do not over ventilate (30:2 ratio of compressions to breaths if not intubated)
- ▶ Give Epinephrine
 - Repeat epinephrine every 3-5 minutes
- ▶ Assess every 2 minutes
 - Change CPR compression provider
 - Treat reversible causes, read aloud Hs & Ts (see list in right column)
 - Check rhythm; if rhythm organized check pulse

If: Asystole/PEA continues:

- Resume CPR - Assessment Cycle (restart Step 4 above)
- Reversible causes: Read aloud Hs & Ts (see list in right column)

If: VF/VT:

- Resume CPR
- Go to » CHKLST CAV

▶ Critical Changes

If VF/VT: Go to » CHKLST CAV

DRUG DOSES and treatments

EPinephrine 1 mg IV, repeat every 3 - 5 minutes

Vasopressin 40 units IV x 1 may replace 1st or 2nd dose of epinephrine

TOXIN treatment

Local anesthetic:	Intralipid Go to » CHKLST LST
Beta-blocker:	Glucagon 2-4 mg IV push
Calcium Channel Blocker or Hyperkalemia	Calcium Chloride 1g IV

Hs & Ts (possible causes)

Hypovolemia	Trauma (hemorrhage)
Hypoxia	Thrombosis (coronary/PE)
Hydrogen ion (acidosis)	Tension pneumothorax
Hyper/ Hypokalemia	Tamponade (cardiac)
Hypothermia	Toxins (local anesthetic, beta blockers, calcium channel blockers)
Hypoglycemia	

During CPR

Airway: Bag-mask sufficient (if ventilation adequate)
Consider advance airway

Circulation: Confirm adequate IV or IO access
Consider IV fluids wide open

Assign Roles: Chest compressions, Airway, Vascular access, Documentation, Code cart, Time keeping