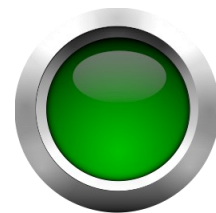


Post cardiac arrest SOP

QPI

Further reading

UK Resus Council guidelines 2021
TTM2 trial 2021
<https://theresusroom.co.uk/rosc/>
COACT trial 2019



Related SOPs

Acute coronary syndrome SOP

Neurological emergencies SOP

Successful return of spontaneous circulation (ROSC) following a medical cardiac arrest marks the beginning of the post cardiac arrest syndrome, characterized by:

1. Post cardiac arrest brain injury
2. Post cardiac arrest myocardial dysfunction
3. Systemic reperfusion response
4. Persistence of the underlying pathology

Consider the cause:

Coronary syndrome - refer to the Acute coronary syndrome SOP

Sepsis - give generous fluids, antibiotics, inotropic support

Pulmonary embolism - pre-alert the receiving ED about possible thrombolysis/thrombectomy

Hypothermia - consider transporting to a hospital capable of providing extracorporeal rewarming

Intracranial event - consider transporting to a neurosurgical centre as per the Neurological emergencies SOP (NB No formal bypass arrangement exists)

Post cardiac arrest SOP

Airway: case-by-case basis

A brief period of cardiac arrest with early ROSC may permit a rapid cognitive recovery and require no airway support. Occasionally a short period of watchful waiting is appropriate if the GCS is rising

In some deeply comatose patients, a well-functioning igel may be left in-situ if the risks of drug-assisted intubation potentially outweigh the benefits



In some patients, drug assisted intubation may be the most optimal airway strategy

Monitor EtCO₂ in all cases

Breathing: case-by-case basis

In comatose patients, paralysis and mechanical ventilation to normocapnia is appropriate in most cases. Be aware of the detrimental effect positive intrathoracic pressures may have on cardiac output

Titrate oxygen to maintain SpO₂ 94-99% in all cases

Circulation

12-lead ECG

Vascular access

Aim for systolic BP > 100mmHg

- Support with fluids +/- titrated adrenaline (50mcg doses in adults)

ECG evidence of STEMI?

No

Yes

In most cases, transfer to nearest receiving ED. In exceptional circumstances, consider direct discussion with a senior cardiologist from scene as to most appropriate destination

Refer to receiving PPCI centre as per Acute coronary syndrome SOP

In all cases:

Avoid fever

Sedation as required (ketamine/midazolam)

Aim for normoglycaemia

Treat seizures promptly



HEMS team only