

Cardiac Arrest – ROSC – Therapeutic Hypothermia

EMT

- Ice packs in axilla and groin; change every 15 minutes or when no longer cold

EMT STOP

INTERMEDIATE

- Chilled normal saline to a total of 30 mL/kg or 2 L max

INTERMEDIATE STOP

CCT

PARAMEDIC

- Cardiac Monitor with 12 lead as soon as possible
- Treatment for appropriate rhythm with medications given in normothermic IV
- Complete neurologic exam including specific GCS items and pupillary response
- Amiodarone 300 mg over 10 minutes (maximum total dose 600 mg)
- Maintain MAP > 80 (SBP >100)
 - Dopamine 5 mcg/kg/min titrate to 10 mcg/kg/min as needed
- Prevent shivering
 - Versed 2 mg IV every 5 minutes as needed (SBP > 100)
 - Etomidate 10 mg IV every 10 minutes (SBP < 80)

CCT AND PARAMEDIC STOP

PHYSICIAN OPTIONS

- Fentanyl 50 mcg IV over 5 minutes every 5 minutes as needed (SBP > 80)
- Vecuronium 0.1 mg/kg to a max of 10 mg if shivering or ventilatory problems
- Management of hypertension SBP > 200 with either
 - Nitroglycerin 0.4 mg SL
 - Metoprolol 5 mg IV over 5 min to a max of 15 mg (DO NOT BOLUS)

Key Points/Considerations

- **INCLUSION CRITERIA:** Patients with ROSC following cardiac arrest who have a GCS of < 8 and who have an advanced airway in place with an EtCO₂ > 20
- Care and transport must be performed by a paramedic or CCT with on-line medical control from receiving facility as soon as possible after ROSC
- Transmit EKG to receiving facility as soon as possible
- Protocol begins with ROSC
- Maintain ventilations to keep EtCO₂ > 35
- ALL Patients who remain in ROSC must be transported to a facility that can maintain the therapeutic hypothermia as long as transport time is projected to be less than 60 minutes
- Patients who are in persistent or recurrent cardiac arrest must be transported to the closest hospital