
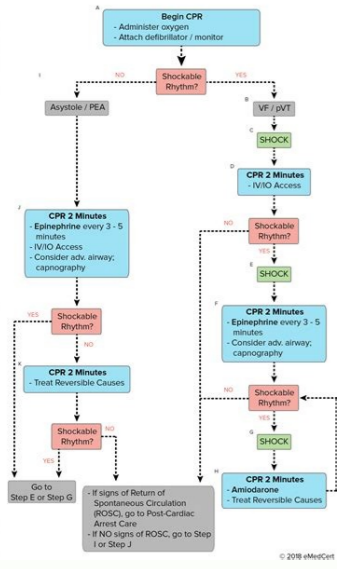


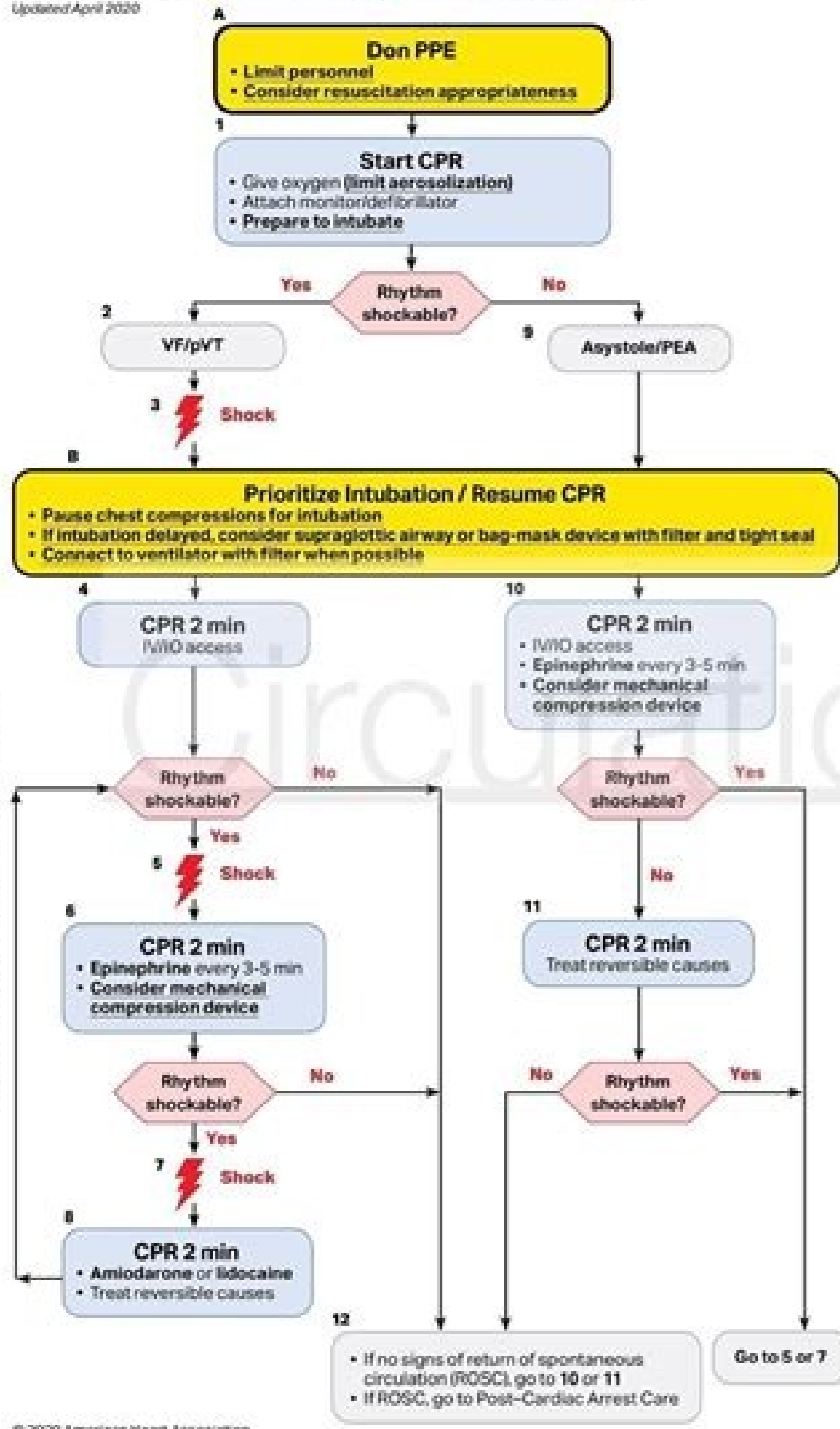
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Adult Cardiac Arrest Algorithm



ACLS Cardiac Arrest Algorithm for Suspected or Confirmed COVID-19 Patients
Updated April 2020

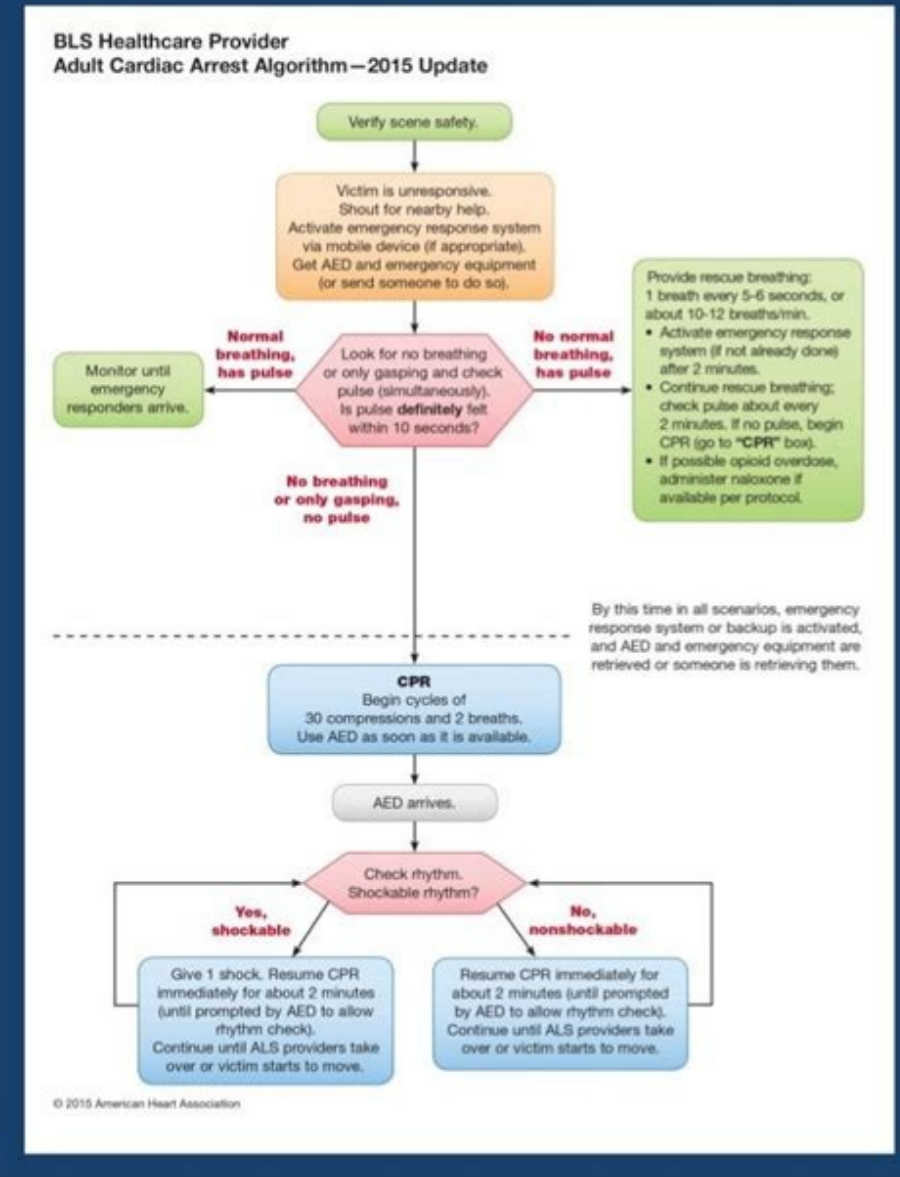


- CPR Quality**
 - Push hard (at least 2 inches [5 cm] and fast [100-120/min] and allow complete chest recoil.
 - Minimize interruptions in compressions.
 - Avoid excessive ventilation.
 - Change compressor every 2 minutes, or sooner if fatigued.
 - If no advanced airway, 30:2 compression-ventilation ratio.
 - Quantitative waveform capnography
 - If P_{ET}CO₂ <10 mm Hg, attempt to improve CPR quality.
 - Intra-arterial pressure
 - If relaxation phase (diastolic) pressure <20 mm Hg, attempt to improve CPR quality.
- Shock Energy for Defibrillation**
 - Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 J; if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
 - Monophasic:** 360 J
- Advanced Airway**
 - Minimize closed-circuit disconnection.
 - Use intubator with highest likelihood of first pass success.
 - Consider video laryngoscopy.
 - Endotracheal intubation or supraglottic advanced airway.
 - Waveform capnography or capnometry to confirm and monitor ET tube placement.
 - Once advanced airway in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions.
- Drug Therapy**
 - Epinephrine IV/IO dose:** 1 mg every 3-5 minutes.
 - Amiodarone IV/IO dose:** First dose: 300 mg bolus. Second dose: 150 mg, or **Lidocaine IV/IO dose:** First dose: 1-1.5 mg/kg. Second dose: 0.5-0.75 mg/kg.
- Return of Spontaneous Circulation (ROSC)**
 - Pulse and blood pressure.
 - Abrupt sustained increase in P_{ET}CO₂ (typically >40 mm Hg).
 - Spontaneous arterial pressure waves with intra-arterial monitoring.
- Reversible Causes**
 - Hypovolemia
 - Hypoxia
 - Hydrogen ion (acidosis)
 - Hypo-/hyperkalemia
 - Hypothermia
 - Tension pneumothorax
 - Tamponade, cardiac
 - Toxins
 - Thrombosis, pulmonary
 - Thrombosis, coronary

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