



Pediatric Asystole / PEA

History

- Events leading to arrest
- Estimated downtime
- SAMPLE
- Existence of terminal illness
- Airway obstruction
- Hypothermia
- Suspected abuse

Signs and Symptoms

- Pulseless
- Apneic
- No electrical activity on ECG
- No heart tones on auscultation

Differential

- Respiratory failure
- Foreign body
- Infection (croup, epiglottitis)
- Congenital heart disease
- See Reversible Causes below

Pediatric Pulseless Arrest Protocol

Criteria for Death / No Resuscitation Review DNR / MOST Form

YES

Decomposition
Rigor mortis
Dependent lividity
Blunt force trauma
Injury incompatible with life
Extended downtime with asystole

Do not begin resuscitation

Follow Deceased Persons Policy

NO

	<p>Begin Continuous CPR Compressions Push Hard ($\geq 1/3$ AP Diameter of Chest) (1.5 inches Infant / 2 inches in Children) Push Fast (100 - 120 / min) Change Compressors every 2 minutes (sooner if fatigued) <i>(Limit changes / pulse checks ≤ 10 seconds)</i></p> <p>Ventilation rate: 1 breath every 2 seconds when age < 1 1 breathe every 3 seconds when age ≥ 1 15:2 Compression:Ventilation if no Advanced Airway</p>
	AED Procedure <i>if available</i>
P	Cardiac Monitor
	IV or IO Access Protocol UP 6
A	<p>Epinephrine 1:10,000 0.01 mg/kg IV / IO Maximum Single Dose 1mg -or- Epinephrine 1:1000 0.1 mg / kg IM Maximum Single Dose 1mg Repeat every 3 – 5 minutes x 3 total doses</p>
	<p>Normal Saline Bolus 20 mL/kg IV / IO May repeat as needed Maximum 60 mL/kg</p>
	Search for Reversible Causes
	Blood Glucose Analysis Procedure <i>if applicable</i>

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol

Reversible Causes

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Notify Destination or Contact Medical Control



Pediatric Asystole / PEA

Priorities:

- Immediate Initiation of high quality CPR & rhythm interpretation.
- Rapid (Early) administration of intramuscular, IV, IO Epinephrine
- Goal is to work the code in place and minimize all movement to maximize highest quality CPR
- Minimum 10 minute cool down time after obtaining ROSC.
- Airway and Hemodynamics high priority Post-ROSC

3 total doses of Code Epinephrine per encounter – may use Push Epi or Epi drip for ROSC

Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assigning responders to predetermined tasks.**
- **Refer to optional protocol AC 11 or development of local agency protocol.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated. Compress $\geq 1/3$ anterior-posterior diameter of chest, in infants 1.5 inches and in children 2 inches.**
- **Majority of pediatric arrests stem from a respiratory insult or hypoxic event. Compressions should be coupled with ventilations.**
- **When advanced airway not in place perform 15 compressions with 2 ventilations.**
- **Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric paddles should be used in children < 10 kg.**
- **DO NOT HYPERVENTILATE:**
If advanced airway in place ventilate:
Age < 1 year: 1 breath every 2 seconds with continuous, uninterrupted compressions.
Age ≥ 1 year: 1 breath every 3 seconds with continuous, uninterrupted compressions.
- **Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with BVM or BIAD.**
- **Patient survival is often dependent on proper ventilation and oxygenation / airway Interventions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **High-Quality CPR:**
Make sure chest compressions are being delivered at 100 – 120 / min.
Make sure chest compressions are adequate depth for age and body habitus.
Make sure you allow full chest recoil with each compression to provide maximum perfusion.
Minimize all interruptions in chest compressions to < 10 seconds.
Use AED or apply ECG monitor / defibrillator as soon as available.
- **Defibrillation:** Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.
- **End Tidal CO₂ (EtCO₂)**
If EtCO₂ is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
If EtCO₂ spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation.**
- **IV access is preferred route. Follow IV or IO Access Protocol UP 6.**
- **Special Considerations**
Maternal Arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm.
Defibrillation is safe at all energy levels.
Renal Dialysis / Renal Failure - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
Opioid Overdose - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol UP 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.**