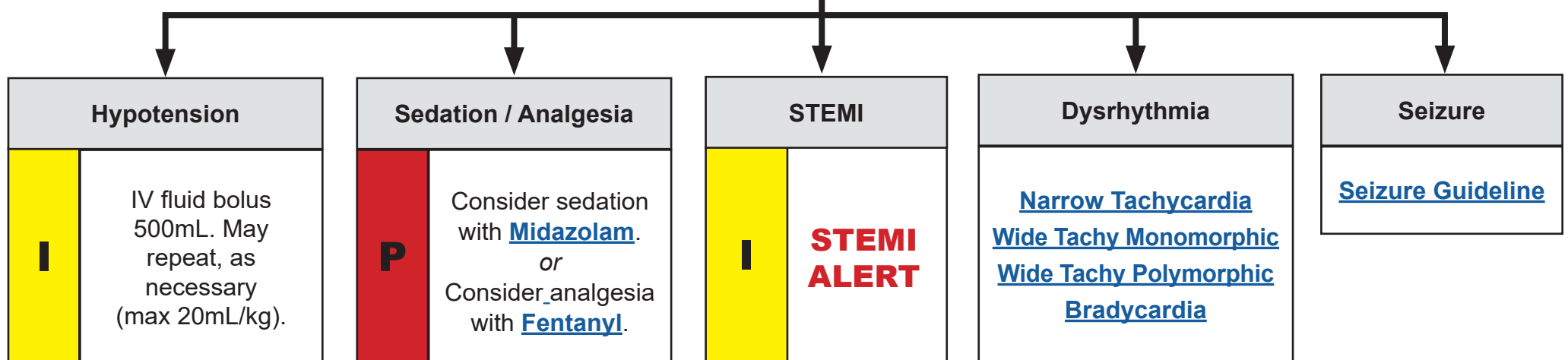


Pediatric Post-Resuscitation Cardiac Arrest

Designation of Condition: Pediatric patient with return of pulses (ROSC) after cardiac arrest.

B	<p>Maintain airway: Suction, as needed. Avoid hyperoxia: Maintain SpO₂ >90%. Frequent reassessment of vital signs (include BGL and temperature) If patient is still breathing spontaneously: assist native respiratory rate If patient is apneic: target EtCO₂ 35-45mmHg (approx. 10-12rpm) Obtain 12-Lead ECG and transmit to destination hospital. Raise head of bed to 30 degrees. Transport with Mechanical Compression Device in position on patient (if size allows).</p>
I	<p>Ensure IV/IO patency. If BGL < 60mg/dL, consider administering Dextrose 10%.</p>



P	<p>If no improvement with fluid bolus, or if fluids are contraindicated view Vasopressor Mixing</p> <p>PREFERRED: Epinephrine Drip: Start at 0.1mcg/kg/min. Titrate 0.1mcg/kg/min q1min to max of 1.5 mcg/kg/min or 16mcg/min, whichever is lowest.</p> <p><u>Second Line:</u> Norepinephrine Drip: Start at 0.1mcg/kg/min. Titrate 0.1mcg/kg/min q1min to max of 1.5 mcg/kg/min or 16mcg/min, whichever is lowest.</p>
	<p>Target SBP = $70 + (\text{Age in Years} / 2)$</p>

<p>***KEY POINTS***</p> <p>Up to 40% of patients with ROSC will re-arrest before arriving at the hospital. Re-arrest is associated with lower survival.</p> <p>Stabilizing actions taken during the post-ROSC period may reduce the risk of re-arrest. It is recommended to stabilize the patient on-scene prior to initiating transport.</p> <p style="text-align: center;">Transport to a core facility with PICU capabilities (UNMH or Presbyterian Downtown).</p>
