

Adult Cardiac Section

Introduction: The cardiac patient must be reassessed frequently and prior to/post each therapeutic intervention. Consider the possibility that an underlying medical condition or medications may be contributing to the problem.

- All cardiac patients will be given oxygen at a flow rate sufficient to treat any component of shortness of breath or hypoxia. If the patient IS NOT short of breath or hypoxic, supplemental oxygen is not recommended. Cardiac patients should be allowed to seek a position of comfort, usually Fowler's, unless they are in shock, in which case the supine position is preferred
- An IV/IO of NS or saline lock should be initiated
- Patients in cardiac arrest should be managed in the field; all other cardiac patients require minimal scene times and expeditious transport
- If the patient has a return of spontaneous circulation (ROSC) (sustained palpable pulses and measurable blood pressure), s/he should be transported to a core facility (Pres DT, UNMH, or Heart Hospital of New Mexico; see current hospital capabilities report for VAMC). All other patients in cardiac arrest should be transported to the nearest appropriate medical facility. The transporting crew may opt to transport to nearest facility depending on circumstances
- All patients in cardiac arrest require immediate CPR, basic airway management and ventilations with oxygen. CPR and initial defibrillation (if indicated) take precedence over advanced airway management unless the airway cannot be managed with BLS maneuvers
- Defibrillation of the VF/pVT patient should occur ASAP on all arrests
- In all cardiac arrest situations, consider treatable causes, [H's and T's](#):

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|--------------------------------------|--------------------------|
| • Hypoxia | • Tension pneumothorax |
| • Hypovolemia | • Tamponade |
| • Hypothermia | • Thrombosis (AMI or PE) |
| • Hyper/Hypokalemia | • Toxins / Tablets |
| • Hydrogen ions (metabolic acidosis) | • Trauma |

Resuscitation efforts may be terminated in the field with [MCEP](#) approval if the following conditions apply:

- ALS interventions have been implemented for at least 30 minutes, and
- No return of spontaneous circulation (ROSC) occurred, and
- The terminal rhythm is [Asystole/PEA](#) <40/IVR
- The arrest is not the result of hypothermia
- Any patient who presents in the following rhythm at any point during the resuscitation will be resuscitated on scene for a minimum of 40 minutes:
 - [Ventricular Fibrillation](#)
 - [Ventricular Tachycardia](#)
 - PEA >40 bpm
- All [VAD](#) patients in cardiac arrest must be transported

Continuous Quantitative Waveform EtCO₂ Monitoring in Cardiac Arrest (if available)

- All patients in cardiac or respiratory arrest shall be placed on [Continuous Quantitative Waveform Capnography](#)
- An abrupt sustained increase in EtCO₂ during CPR should be considered an indicator of ROSC in all patients with an advanced airway (ETT or [Extraglottic Airway Device](#)) and continuous quantitative capnographic monitoring in place. If providers see an organized rhythm with an abrupt, sustained increase in Et CO₂, complete cycle of CPR, check pulse and try to auscultate heart tones in an attempt to confirm [cardiogenic shock](#)
- If no pulse is palpable but the increase in EtCO₂ is sustained, resume CPR and treat as [cardiogenic shock](#) rather than PEA. Conversely, an abrupt, sustained decrease in EtCO₂ after ROSC may indicate re-arrest. If this occurs, assess patient status