

Pediatric Post Resuscitation

History

- Respiratory arrest
- Cardiac arrest

Signs/Symptoms

- Return of pulse

Differential

- Continue to address specific differentials associated with the original dysrhythmia

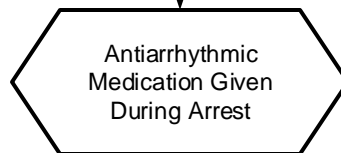
	Pediatric Airway Protocol(s) AR 5 - 7 <i>as needed</i>
	Monitor Vital Signs / Reassess
	Blood Glucose Analysis Procedure
	Optimize Ventilation and Oxygenation <ul style="list-style-type: none"> • Maintain SpO2 ≥ 90% • Preferably SpO2 ≥ 94% • Advanced airway if indicated • Age Appropriate Respiratory Rate • Remove Impedence Threshold Device DO NOT HYPERVENTILATE
	ETCO2 ideally 35 – 45 mm Hg
B	12 Lead ECG Procedure
A	IV / IO Procedure
P	Cardiac Monitor
	Pediatric Diabetic Protocol PM 2 <i>if indicated</i>
	Pediatric Hypotension / Shock Protocol PM 3 <i>if indicated</i>
	Pediatric Bradycardia Protocol PC 2 <i>if indicated</i>
	Pediatric Tachycardia Protocol PC 5 <i>if indicated</i>

**Hypotension
Age Based**

0 – 31 Days
< 60 mmHg

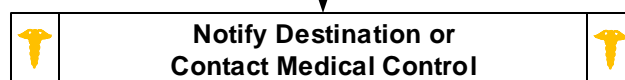
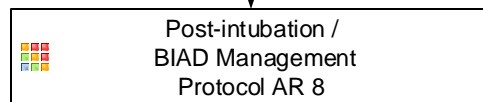
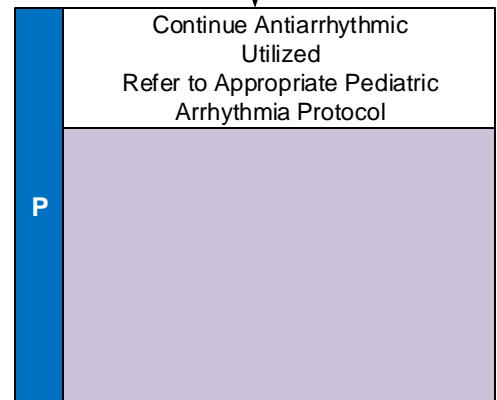
1 Month to 1 Year
< 70 mmHg

> than 1 Year
< 70 + (2 x age) mmHg



YES

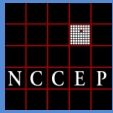
NO



Arrhythmias are common and usually self limiting after ROSC



If Arrhythmia Persists follow Rhythm Appropriate Protocol



Pediatric Post Resuscitation

Pearls

- **Recommended Exam: Mental Status, Neck, Skin, Lungs, Heart, Abdomen, Extremities, Neuro**
- **Goals of care are to preserve neurologic function, prevent secondary organ damage, treat the underlying cause of illness, and optimize prehospital care. Frequent reassessment is necessary.**
- **Hyperventilation is a significant cause of hypotension / recurrence of cardiac arrest in post resuscitation phase and must be avoided.**
- **Target oxygenation to $\geq 94\%$. 100% FiO₂ is not necessary, titrate oxygen accordingly.**
- **EtCO₂ should be continually monitored with advanced airway in place.**
- **Administer resuscitation fluids and vasopressor agents to maintain SBP at targets listed on page 1. This table represents minimal SBP targets.**
- **Targeted Temperature Management is recommended in pediatrics, but prehospital use is not associated with improved outcomes. Transport to facility capable of intensive pediatric care.**
- **Antiarrhythmic agents:**
 - Adenosine: First dose: 0.1 mg / kg (Maximum 6 mg) Second dose: 0.2 mg / kg (Maximum 12 mg)
 - Amiodarone 5 mg / kg IV / IO (single dose Maximum 300 mg). May repeat x 2 to a Maximum of 15 mg / kg.
 - Lidocaine 1 mg / kg IV / IO. Infusion 20 – 50 mcg / kg / min. If infusion is initiated > 15 minutes from first bolus, repeat 0.5 mg / kg bolus.
 - Magnesium Sulfate 40 mg / kg IV / IO over 10 – 20 minutes. In Torsades de pointes give over 1 – 2 minutes. Maximum 2 g.
 - Procainamide 15 mg / kg IV / IO over 30 – 60 minutes. Monitor for increased QRS and increased QT.
- **Vasopressor agents:**
 - Dopamine 2 – 20 mcg / kg / min IV / IO
 - Epinephrine 0.1 – 1 mcg / kg / min IV / IO
 - Norepinephrine 0.1 – 2 mcg / kg / min IV / IO
 - Dose Calculation: mL / hour = kg x dose(mcg / kg / min) x 60 (min / hr) / concentration (mcg / mL)
- If pediatric weight is known, use in drug and fluid calculations. Use actual body weight for calculating initial medication dosages. If unknown then use a body length tape system.
- Appropriate post-resuscitation management may best be planned in consultation with medical control.