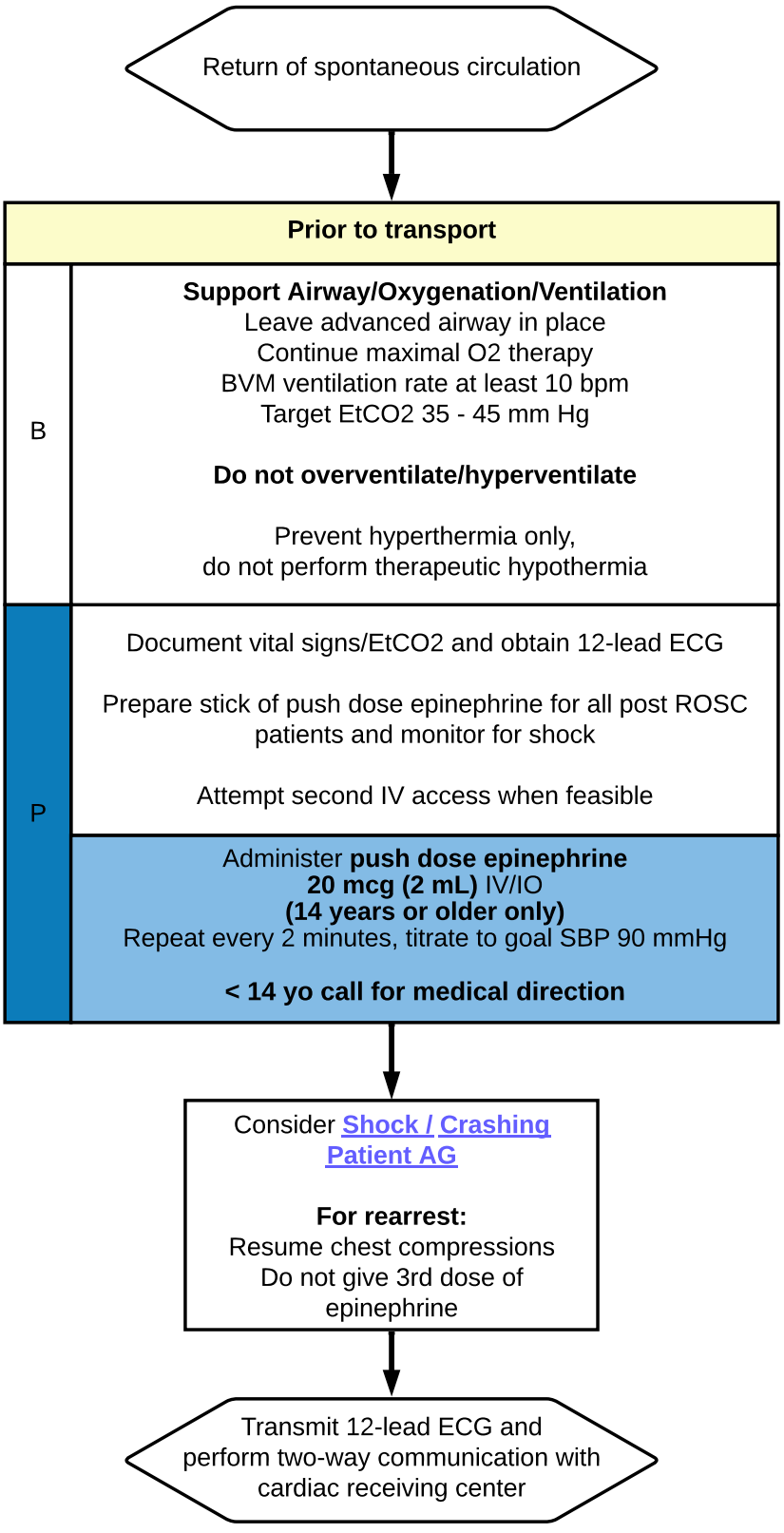

DRUG PREPARATION:

Preparation of push dose epinephrine (14 years or older only):
Mix 1 mL of 1 mg/10 mL (CARDIAC) epinephrine with 9 mL NS. This results in a 10 mcg/mL concentration

Return of Spontaneous Circulation (ROSC): The post-arrest period is dynamic, and re-arrest and dysrhythmias frequently occur. Prioritize vasopressor administration and target oxyen to optimize vital sign parameters. Dysrhythmias in this period are common and usually self-limiting; some warrant no further treatment, especially atrial dysrhythmias. Others, such as worsening bradycardia and wide-complex tachycardia, should be managed emergently. Due to the complex nature of post-arrest care, it is highly recommended to stay on scene to administer the interventions described in the AG.

After arrest,

- Monitor $EtCO_2$; $EtCO_2$ should remain above 20. Lower readings may indicate re-arrest or airway displacement.
- Monitor SpO_2 to maintain saturation between 94-99%
- Obtain a 12-lead; if STEMI, transmit ECG and expedite preparation for transport
- Prepare for transport and assure adequate personnel; once loaded, reassess airway and pulse
- Prepare your pressor; titrate fluid resuscitation and vasopressor administration to maintain SBP of 90-100 mmHg or Mean Arterial Pressure (MAP) of 65-80 mmHg.

Post-arrest Bradycardia: A common post-ROSC rhythm, the first-line treatment is push-dose epinephrine. Titrate the pressor as needed to target a perfusing heart rate (i.e. a SBP >90).

- **Pacing:** Patients in cardiac arrest or who are post-ROSC should not be paced; instead, use chest compressions and push-dose pressors, respectively.

Wide-complex tachyardia: See **Wide Complex Tachycardia AG**