V-Fib/Pulseless V-Tach

Cardiac Arrest (Pediatric)

CRITERIA

- Patient unresponsive, without pulse, and a shockable rhythm evident on ECG
- Patients with rigor mortis, lividity, decomposition or injuries inconsistent with survival (e.g., decapitation or obvious mortal injury) are excluded
- Determine DNR status

PROTOCOL

EMR	Follow *General – Universal Patient Care/Initial Patient Contact Protocol.*	**EMR**
	If ***"NO SHOCK ADVISED"*** refer to *Cardiac Arrest – Asystole Protocol.*	
EMR	If ***"SHOCK ADVISED"***, defibrillate once, resume CPR. Analyze after 5 cycles.	**EMR**
I	If VF or VT present, defibrillate once at ***2 J/kg.*** (AED usage allowed per manufacturers recommendation only.) Resume CPR immediately.	**I**
EMR	Follow American Heart Association guidelines for CPR.	**EMR**
I	Administer ***Epinephrine 1:10,000 0.01 mg/kg (0.1 mL/kg) IV/IO.***	**I**
I	After CPR, defibrillate at ***4 J/kg***. Resume CPR immediately.	**I**
I	Administer antidysrhythmic: ***With vascular access***: administer ***Amiodarone HCL* (Cordarone) *5 mg/kg bolus*** (diluted in ***0.9% Normal Saline 10 mL)*** to a maximum single dose of ***300 mg IV/ IO*** ***If Amiodarone unavailable*:** administer ***Lidocaine (*Xylocaine*) 1 mg/kg IV/IO*** Subsequent antidysrhythmic therapy must be consistent with the first antidysrhythmic delivered. i.e.: **DO NOT** give Lidocaine if Amiodarone has already been administered.	**I**
I	After CPR, defibrillate at ***4 J/kg***. Resume CPR immediately.	**I**
I	Repeat ***Epinephrine 1:10,000 0.01 mg/kg (0.1 mL/kg) IV/IO***, CPR and defibrillation.	**I**
[I]	Repeat antidysrhythmic, CPR and defibrillation.	**[I]**
EMR	Consider spinal immobilization.	**EMR**

PEARLS

If there is no ***Epinephrine 1:10,000 preloaded syringe***, combine in a ***10 mL syringe***: ***1 mg (1 mL) of Epinephrine 1:1,000 with 0.9% Normal Saline 9 mL***. This creates the same as an ***Epinephrine 1:10,000 preloaded syringe***.

The American Heart Association guidelines emphasize the importance of effective uninterrupted CPR during cardiac arrest. The following points are applicable in the shockable cardiac arrest protocol:

- Unwitnessed arrest: Provide CPR prior to first defibrillation
- Witnessed arrest: Proceed quickly to first defibrillation
- Do not compromise CPR to obtain an advanced airway. Consider Blind Insertion Airway Device

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- Once advanced airway is obtained, perform asynchronous CPR
- Ensure full chest recoil during CPR
- Obtain IV/IO access at earliest opportunity
- Consider reversible causes:
  - Hypoxia
  - Hyperkalemia or hypokalemia
  - Preexisting acidosis
  - Drug overdose
  - Hypothermia
  - Tension Pneumothorax
- Following IV/IO access:
- Medication should be given without the interruption of CPR
- Each medication delivery is separated by a defibrillation and CPR
- Medication cycle is Epinephrine, Antidysrhythmic, Epinephrine, Antidysrhythmic, Epinephrine, etc.

🔔 Ensure high quality CPR and effective compressions for key to survival

🔔 ALS care should be obtained as rapidly as possible, but do not delay transport waiting for ALS

🔔 ALS providers arriving on scene shall not interrupt defibrillation in progress