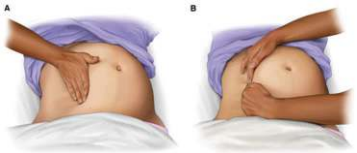
3. Maternal Cardiac Arrest Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

FIRST RESPONDER

- **Activate Resuscitation Team** (if not already present) **AND OBGYN**
- Document time of onset of maternal cardiac arrest
- Place the patient supine and **perform a left uterine displacement (LUD) as below**.



- Start resuscitation as per the **1. Adult & Paediatric Cardiac Arrest Algorithm**; place hands slightly higher on the sternum than usual

SUBSEQUENT RESPONDERS

Maternal Interventions

Treat as per 1. Adult & Paediatric Cardiac Arrest Algorithm

- Do not delay defibrillation
- Give typical ACLS drugs and doses
- Ventilate with 100% oxygen
- Monitor wave form capnography and CPR quality
- Provide post-cardiac arrest care as appropriate. See **2. Post-Cardiac Arrest Care Algorithm**

Maternal Modifications

- Start IV access above the diaphragm
- Assess for hypovolaemia and give fluid bolus when required
- Anticipate difficult airway; experienced provider preferred for advanced airway placement
- If patient receiving IV/IO magnesium prearrest, stop magnesium and give IV/IO calcium chloride 10mL in 10% solution, or calcium gluconate 30 mL in 10% solution
- Continue all maternal resuscitative interventions (CPR, positioning, defibrillation, drugs, and fluids) during and after caesarean section

Obstetric Interventions for Patient With an Obviously Gravid Uterus*

- Perform manual uterine displacement (LUD) – displace uterus to the patient's left to relieve aortocaval compression
- Remove both internal and external foetal monitors if present

Obstetric and neonatal teams should immediately prepare for possible emergency caesarean section

- If no ROSC by **4 minutes** of resuscitative efforts, consider performing immediate emergency caesarean section
- Aim for delivery within **5 minutes** of onset of resuscitative efforts

*An obviously gravid uterus is a uterus that is deemed clinically to be sufficiently large to cause aortocaval compression

Search for and Treat Possible Contributing Factors (BEAU-CHOPS)

Bleeding/DIC
Embolism: coronary/pulmonary/amniotic fluid embolism
Anaesthetic complications
Uterine atony
Cardiac disease (MI/ischaemia/aortic dissection/cardiomyopathy)
Hypertension/preeclampsia/eclampsia
Other: differential diagnosis of standard ACLS guidelines
Placenta abruption/previa
Sepsis