

PEDIATRIC PROTOCOL

ASYSTOLE / PULSELESS ELECTRICAL ACTIVITY (PEA)

3-5 kg	6-7 kg	8-9 kg	10-11 kg	12-14 kg	15-18 kg	19-23 kg	24-29 kg	30-36 kg
6-11 lbs	13-15 lbs	18-20 lbs	22-24 lbs	26-31 lbs	33-40 lbs	42-51 lbs	53-64 lbs	66-81 lbs
18-24 in	24-26 in	26-29 in	29-33 in	33-38 in	38-43 in	43-48 in	48-52 in	52-57 in

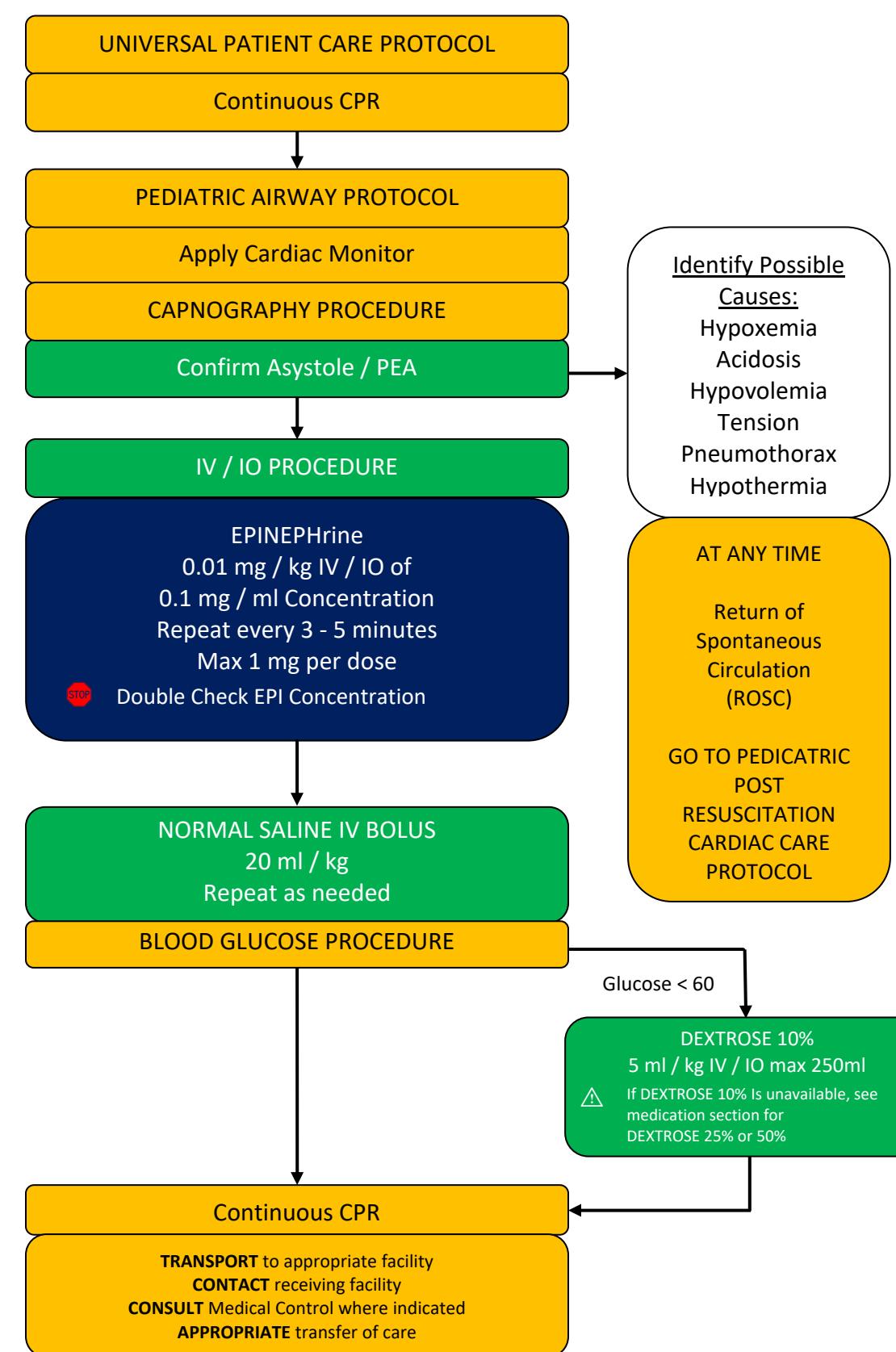
Airway / Breathing

Circulation / Shock

Cardiac

Medical

Trauma



EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

Online Medical Control

ASYSTOLE / PULSELESS ELECTRICAL ACTIVITY (PEA)

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
<ul style="list-style-type: none"> • Time of arrest • Medical history • Medications • Possibility of foreign body • Hypothermia 	<ul style="list-style-type: none"> • Pulseless • Apneic or agonal Respirations • Cyanosis 	<ul style="list-style-type: none"> • Ventricular fibrillation • Pulseless ventricular tachycardia

CONSIDER TREATABLE CAUSES	
<ul style="list-style-type: none"> • Hypovolemia • Tension pneumothorax • Myocardial infarction • Drug overdose • Hypothermia • Acidosis 	<ul style="list-style-type: none"> • Cardiac tamponade • Pulmonary embolism • Tricyclic overdose • Hypoxia • Hypoglycemia • Hyperkalemia

Do Not Confuse EPINEPhrine 1 mg / ml and 0.1 mg / ml

If Dextrose 25% Not Available, Draw 25 ml of Dextrose 50% out of syringe and dilute with additional 25 ml of normal saline

Fluid Resuscitate to systolic of $70 + 2 \times \text{age}$

KEY POINTS
<ul style="list-style-type: none"> • Exam: Mental Status • Always confirm asystole in more than one lead. • Cardiac arrest in children is primarily due to lack of an adequate airway, resulting in hypoxia. • If the patient converts to another rhythm or has a return of circulation, refer to the appropriate protocol and treat accordingly. • When assessing for a pulse, palpate the brachial or femoral arteries for infants and the carotid or femoral artery for children. • Continue BLS procedures throughout the resuscitation. • If the patient is intubated, be sure to routinely reassess tube placement. • If the patient has an IO, routinely reassess for patency. • Consider atropine when evidence of increased vagal stimulation is present.