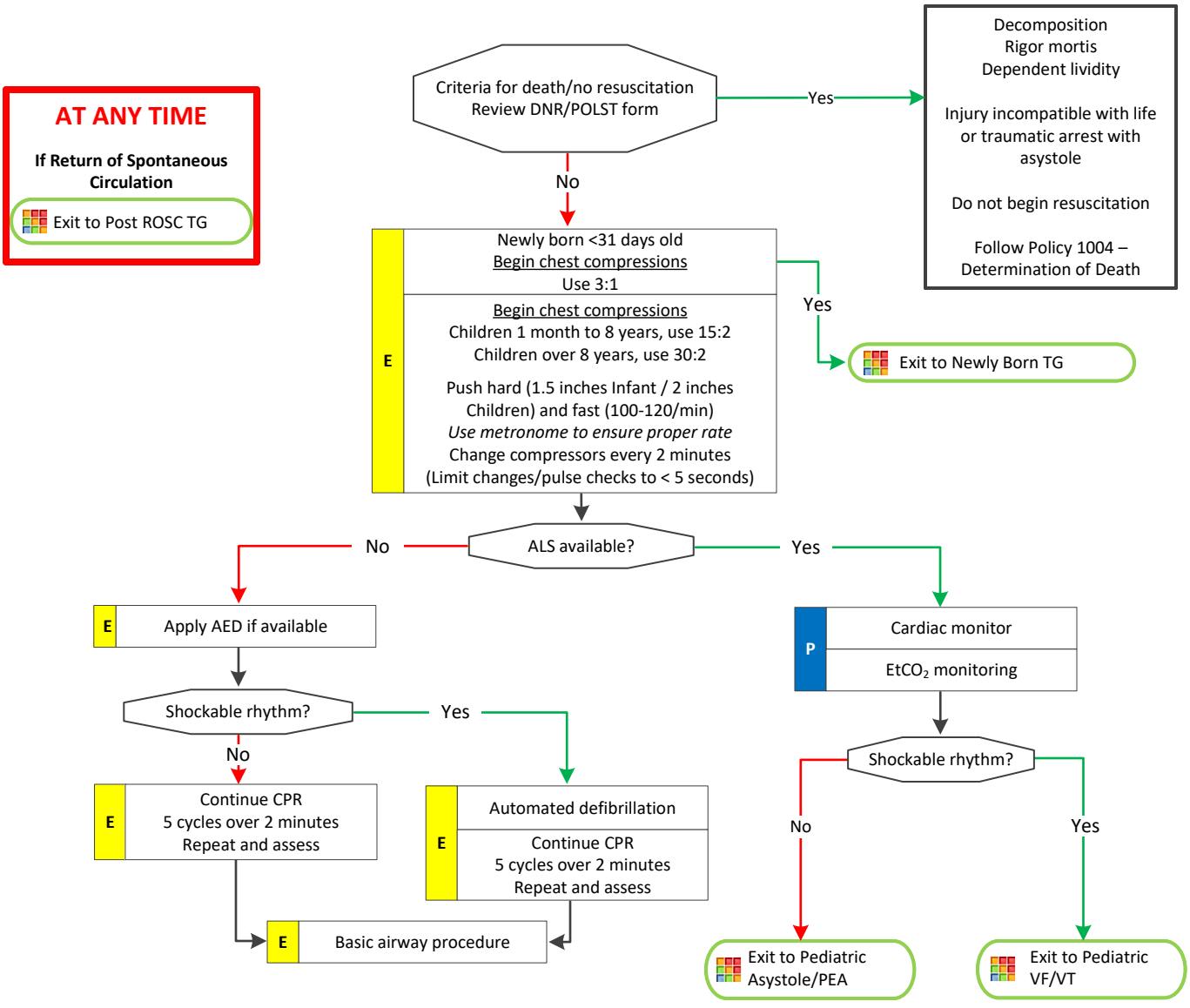
Pediatric Cardiac Arrest

History
- Code status (DNR or POLST)
- Events leading to arrest
- Estimated downtime
- Prior resuscitation attempts
- Past medical history
- Medications
- Existence of terminal illness
- Suspected physical abuse

Signs and Symptoms
- Unresponsive
- Apneic
- Pulseless

Differential
- Respiratory failure (foreign body, secretions, infection)
- Hypovolemia (dehydration)
- Congenital heart disease
- Trauma
- Hypothermia
- Tension pneumothorax, cardiac tamponade, or PE
- Toxin or medication
- Electrolyte abnormalities (glucose, potassium)
- Acidosis



Pediatric Treatment Guidelines

Pediatric Cardiac Arrest

- DO NOT HYPERVENTILATE.
- Do not delay chest compressions while applying any device or intervention.
- Use a metronome during chest compression to ensure proper rate.

Pearls

- Efforts should be directed at high quality chest compressions with limited interruptions and early defibrillation when indicated. Compress 1.5 inches in infants and 2 inches in children. Consider early IO placement if available or direct IV access if anticipated.
- In cases of clear-cut traumatic arrest, epinephrine is not indicated in PEA or asystole. Epinephrine will not correct arrest caused by a tension pneumothorax, cardiac tamponade, or hemorrhagic shock. If there is any doubt as to the cause of arrest, treat as a non-traumatic arrest.
- Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with a BVM and appropriately sized mask. Patient survival is often dependent on proper ventilation and oxygenation.
- Resuscitation is based on proper planning and organized execution. Procedures require space and patient access. Make room to work. Utilize team focused approach assigning responders to predetermined tasks.
- Prevent hypothermia by moving to a warm environment and avoid unnecessary exposure.