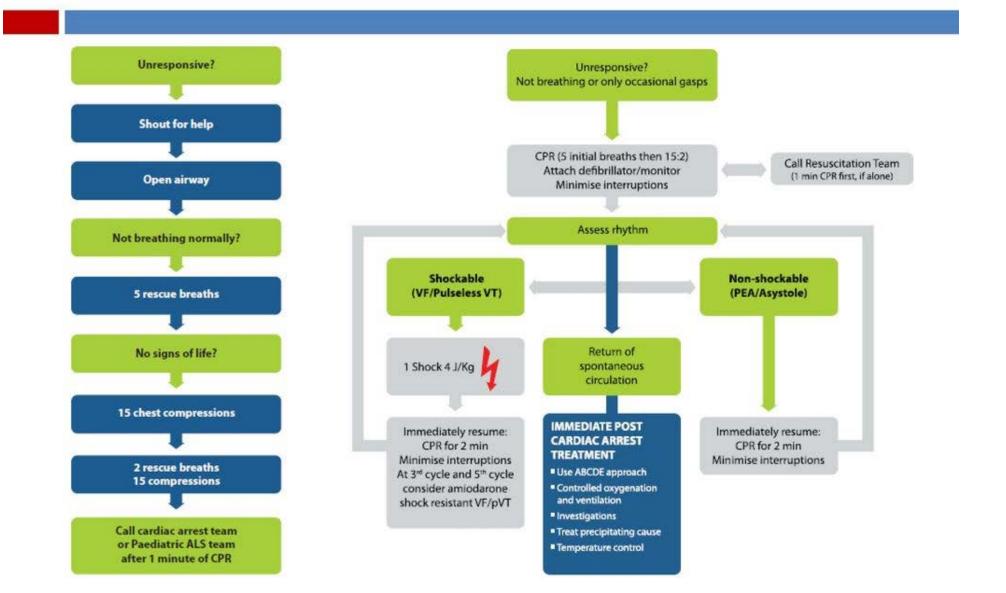
CPR in specific situation

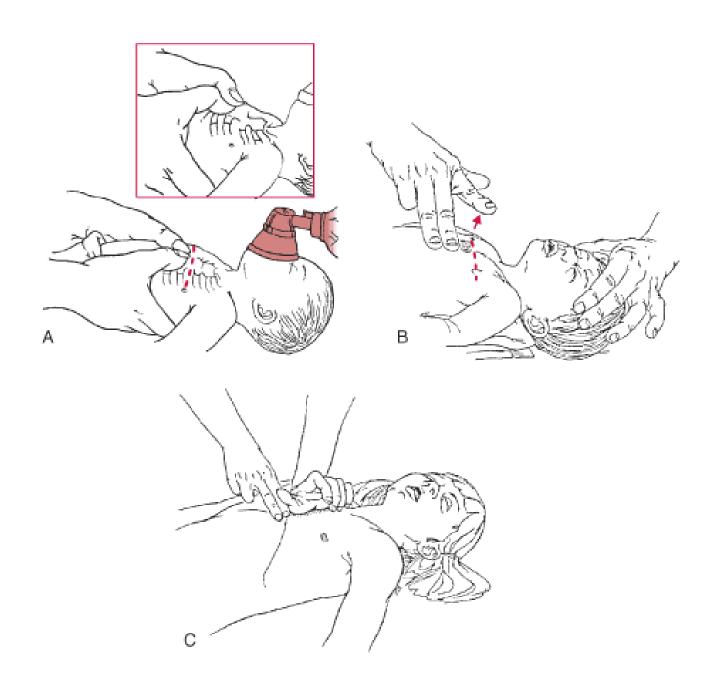
First aid, KARIM FNM

I. Specific group of patients – children ©



BLS Children

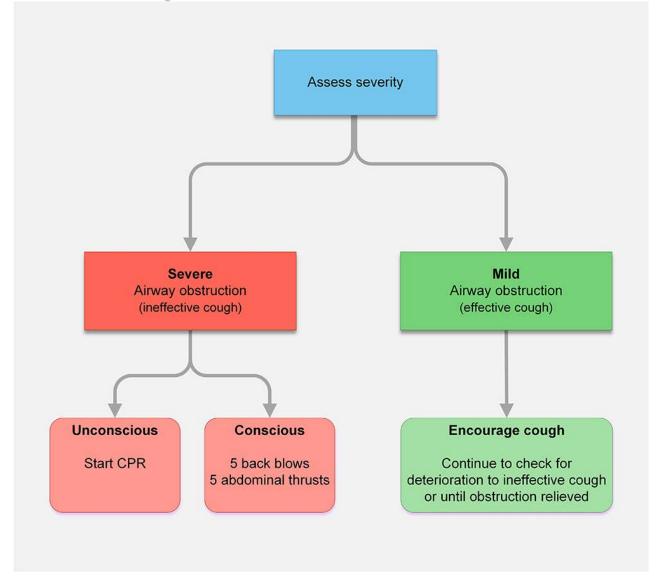


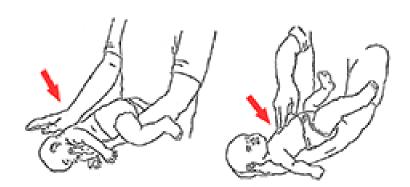






Airway obstruction as a cause of asphyxia

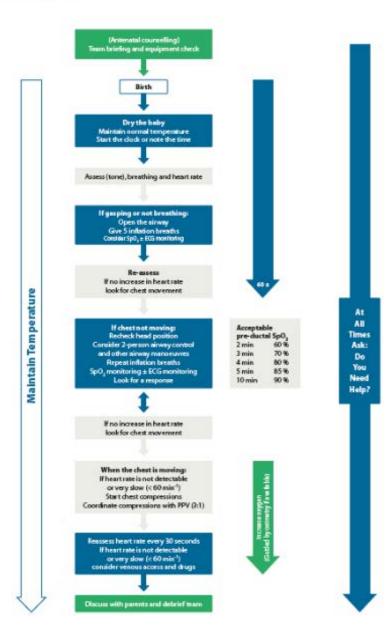






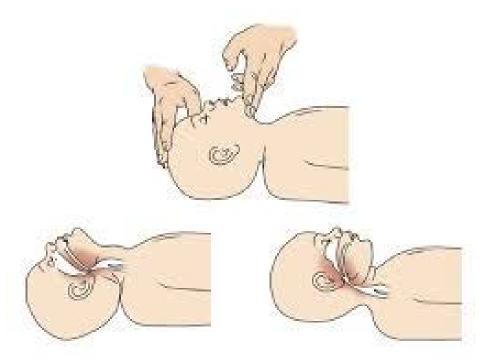


Newborn Life Support





Published October 2015 by European Resuccises on Council van, Emile Vanderveldelaan 35, 2045 Net, Belgium Copyright: 9-European Resuccium on Council van Product reference Porter, N.S., Algorithm ENG, 20150(50)



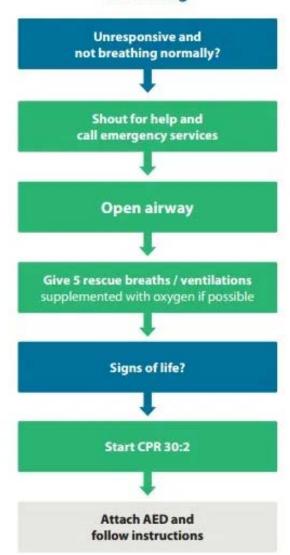
II. Specific environement





Drowning person

Drowning







Liquids are the most common cause of choking in infants, whereas balloons and other small, hard objects are the most common in children



At least one

child dies

from choking on food every five days in

the U.S.

Drowning isn't seasonal, it occurs year round. 70% of the time in the

drowning in Infants and children





deaths from oreign object younger than 5 years old, 65% of them are

Memory of CPR skills and knowledge tends to deteriorate as early as three months after training, even among highly trained professionals including doctors and nurses

14 years or ounger in the U.S. were choking episodes

Children can drown in as little as 1 inch of water

all choking-related emergency department visits for children ages 1 to 4 years



Candy was associated with 19% of all choking-related emergencies for children 14 years or younger

Accidental injuries, including choking and drowning, are the leading cause of death in children and send over 16 million kids a year to the emergency room.

Coins were

involved in 18% of

Fatal drowning remains the second-leading cause of unintentional injury-related death for children ages 1 to 14









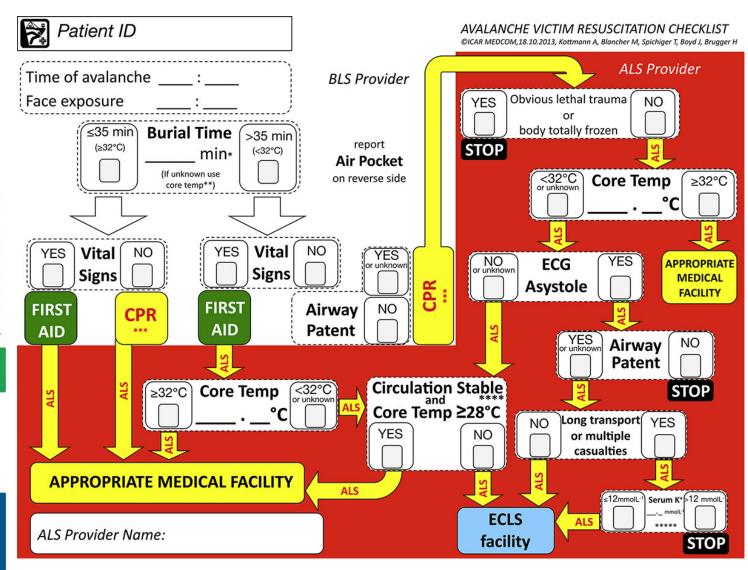
Assess patient at extrication YES Lethal injuries or Do not whole body frozen start CPR NO ≤ 60 min (≥ 30°C) Duration of burial Universal ALS (core temperature)1 algorithm² > 60 min (< 30°C) YES Minimally invasive Signs of life?3 rewarming4 NO VF/pVT/PEA Start CPR⁵ Monitor ECG YES Asystole or UNCERTAIN Consider serum Hospital Patent airway potassium⁶ with ECLS NO > 8 mmol L-1 Consider termination of CPR Core temperature may substitute if duration of burial is unknown Transport patients with injuries or potential complications (e.g. pulmonary oedema) to the most appropriate hospital Check for spontaneous breathing and pulse for up to 1 min

Transport patients with cardiovascular instability or core temperature < 28°C to a hospital with ECLS (extracorporeal life support)

Withold CPR if risk to the rescue team is unacceptably high

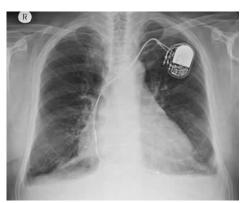
Crush injuries and depolarising neuromuscular blocking drugs may elevate serum potassium

Avalanche victim



III. Specific patient







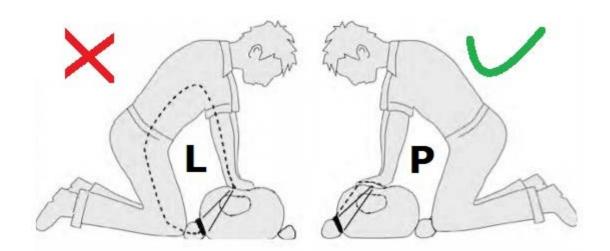




Patient with ICD (implantabile cardioverter defibrilator)

Always go from the right side of patient! (from other side then ICD)

- To minimise a risk of electric charge
- Use a *magnet* to stop defibrilator activity
 - Magnet will cancel defibrillation discharge
- Use specific antielectrical gloves / two layers of normal gloves
- Some ICDs have a *sound signal before discharge*





Pregnant women BLS

Maternal Cardiac Arrest

First Responder

- · Activate maternal cardiac arrest team
- . Document time of onset of maternal cardiac arrest
- · Place the patient supine
- Start chest compressions as per BLS algorithm; place hands slightly higher on sternum than usual

Subsequent Responders

Maternal Interventions

Treat per BLS and ACLS Algorithms

- · Do not delay defibrillation
- · Give typical ACLS drugs and doses
- Ventilate with 100% oxygen
- · Monitor waveform capnography and CPR quality
- · Provide post-cardiac arrest care as appropriate

Maternal Modifications

- · Start IV above the diaphragm
- · Assess for hypovolemia and give fluid bolus when required
- Anticipate difficult airway; experienced provider preferred for advanced airway placement
- If patient receiving IV/IO magnesium preamest, stop magnesium and give IV/IO calcium chloride 10 mL 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 cesarean section

Obstetric Interventions for Patient With an Obviously Gravid Uterus*

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

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

- If no ROSC by 4 minutes of resuscitative efforts, consider performing immediate emergency cesarean 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

Anesthetic complications

Uterine atony

Cardiac disease (MI/ischemia/aortic dissection/cardiomyopathy)

Hypertension/preeclampsia/eclampsia

Other: differential diagnosis of standard ACLS guidelines

Placenta abruptio/previa

Sepsis



>20 weeks gestational size or uterus is palpable or visible



Left Uterine Displacement One handed Technique



Left uterine Displacement - 2 Handed Technique



Figure 4. Platient in a 30" left-lateral tilt using a firm wedge to aupport pelvis and thorax.

Traumatic cardiac arrest — only ALS (doctors) !!!, not for bystanders !

