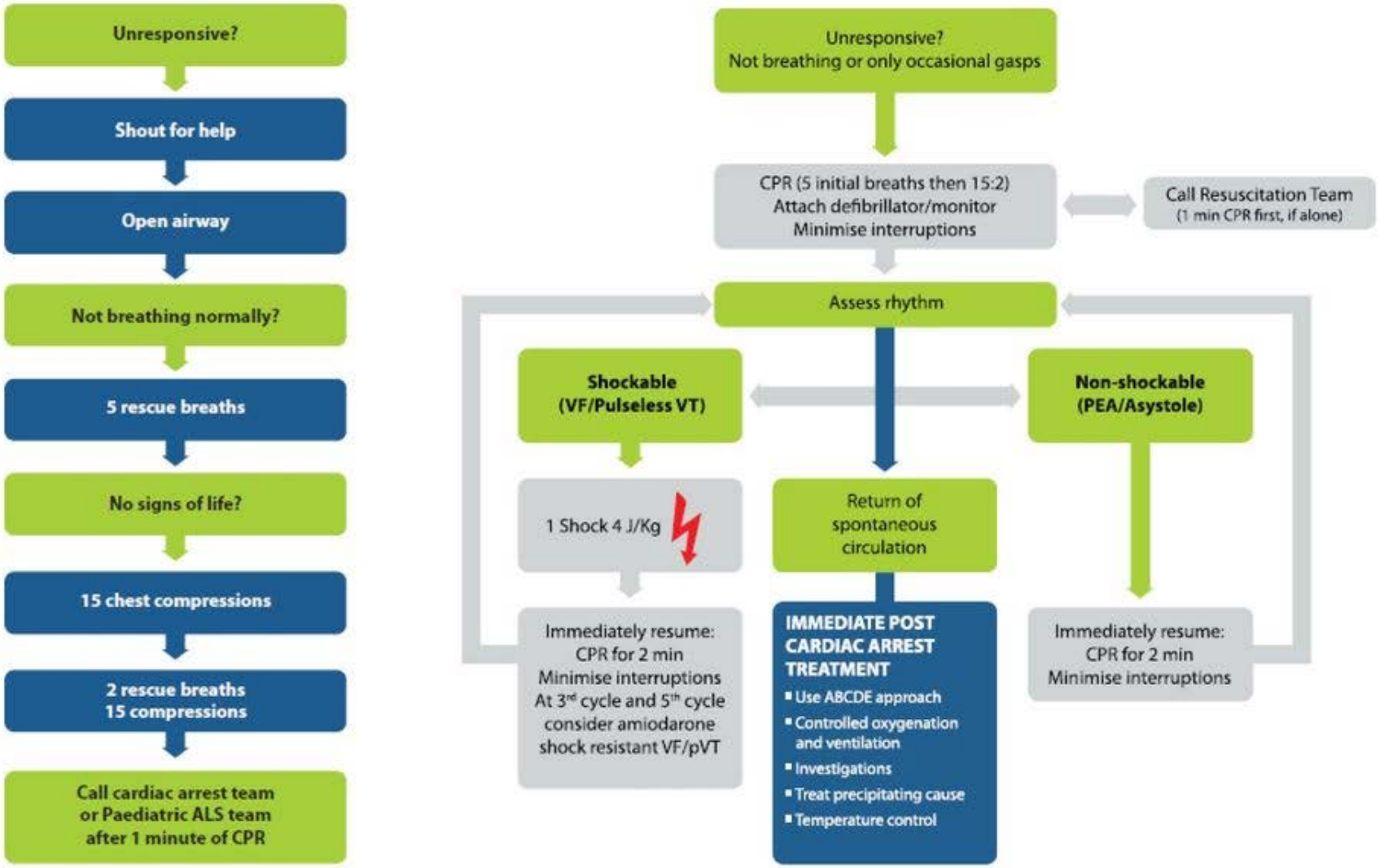
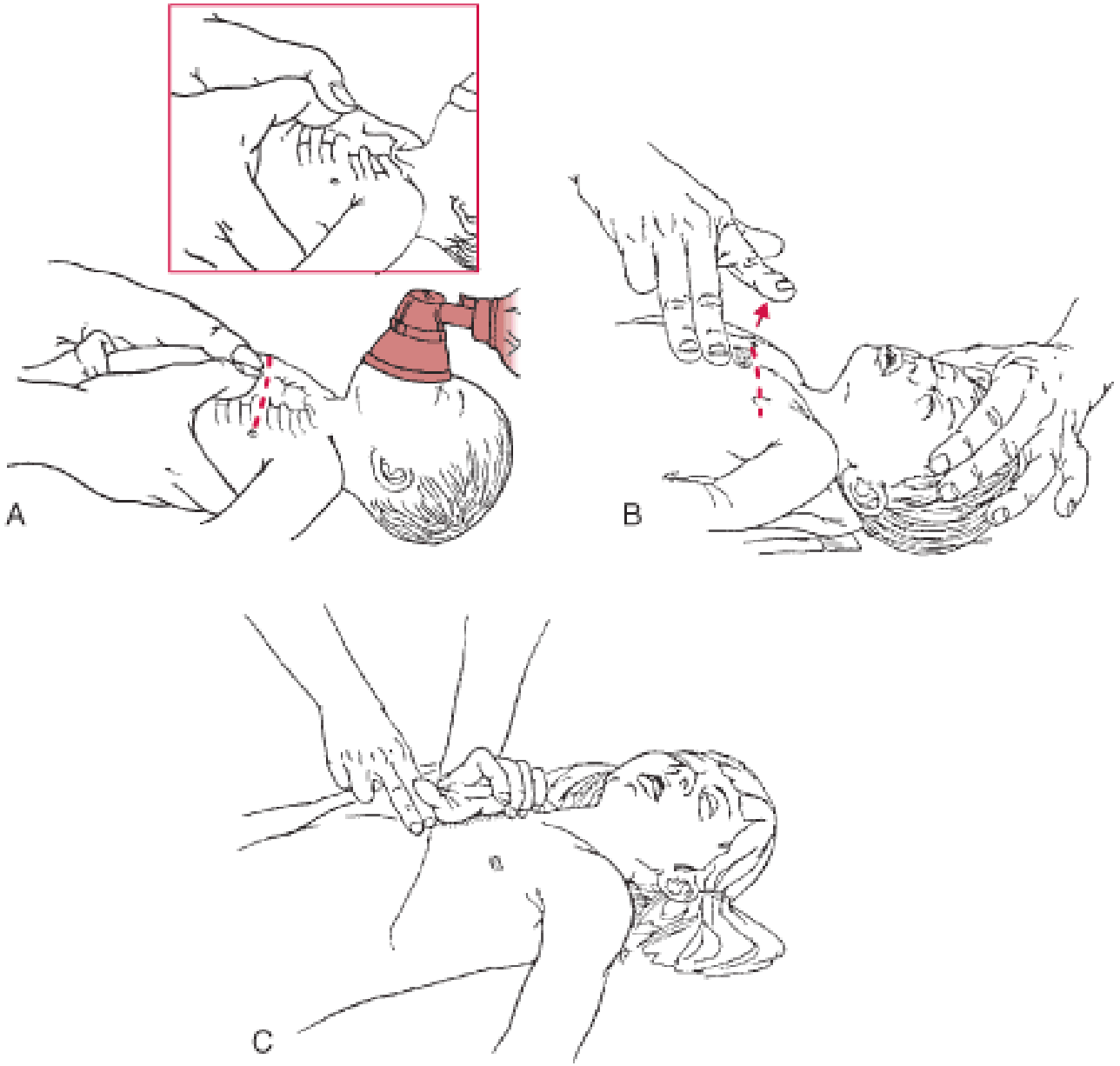
CPR in specific situation

First aid, KARIM FNM

I. Specific group of patients – children ☺

BLS Children




A
B
C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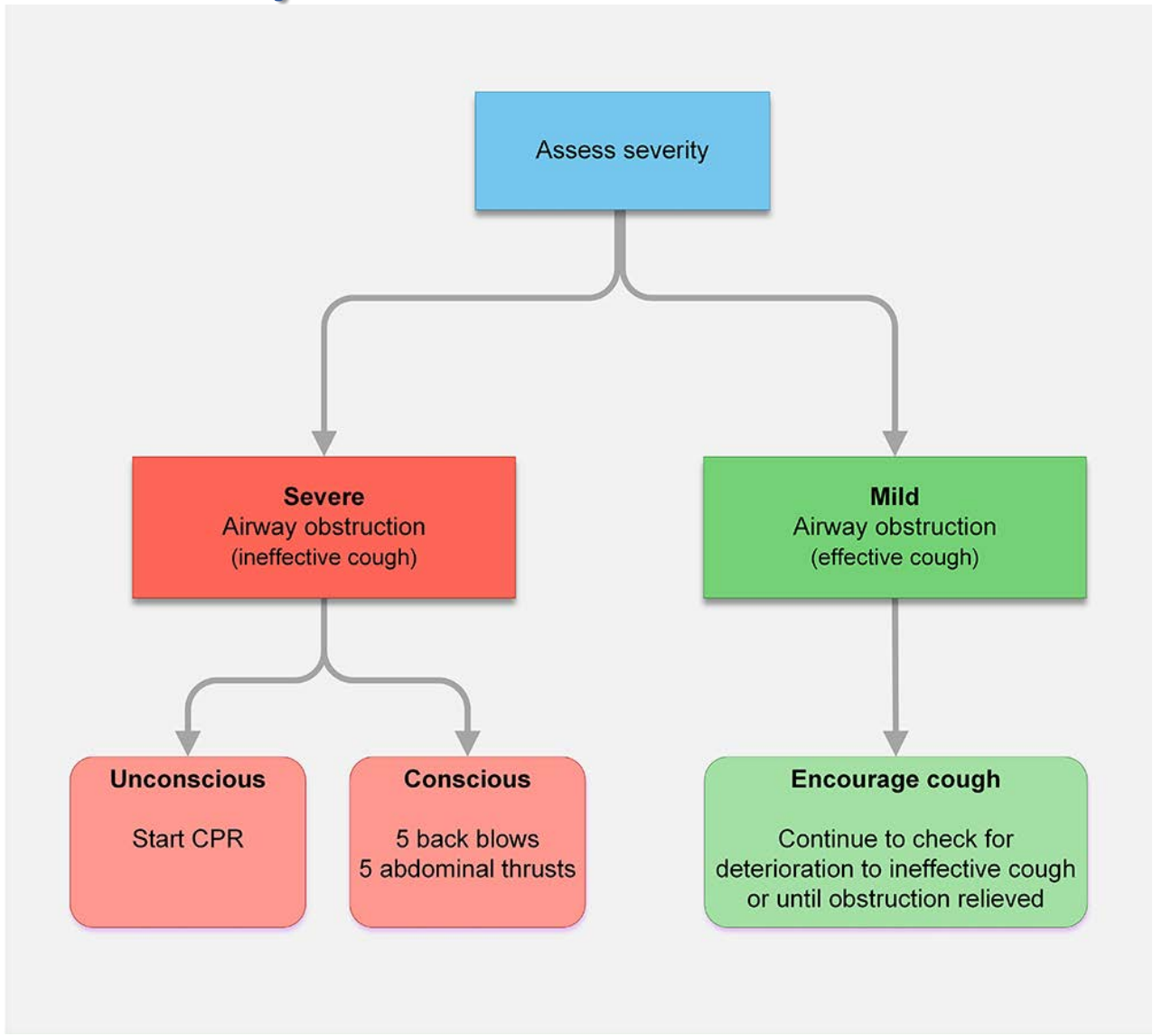
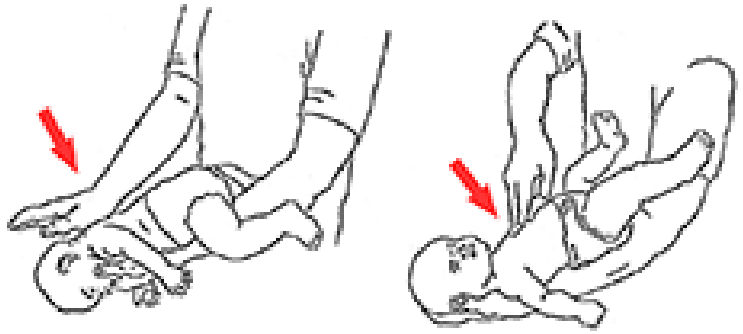
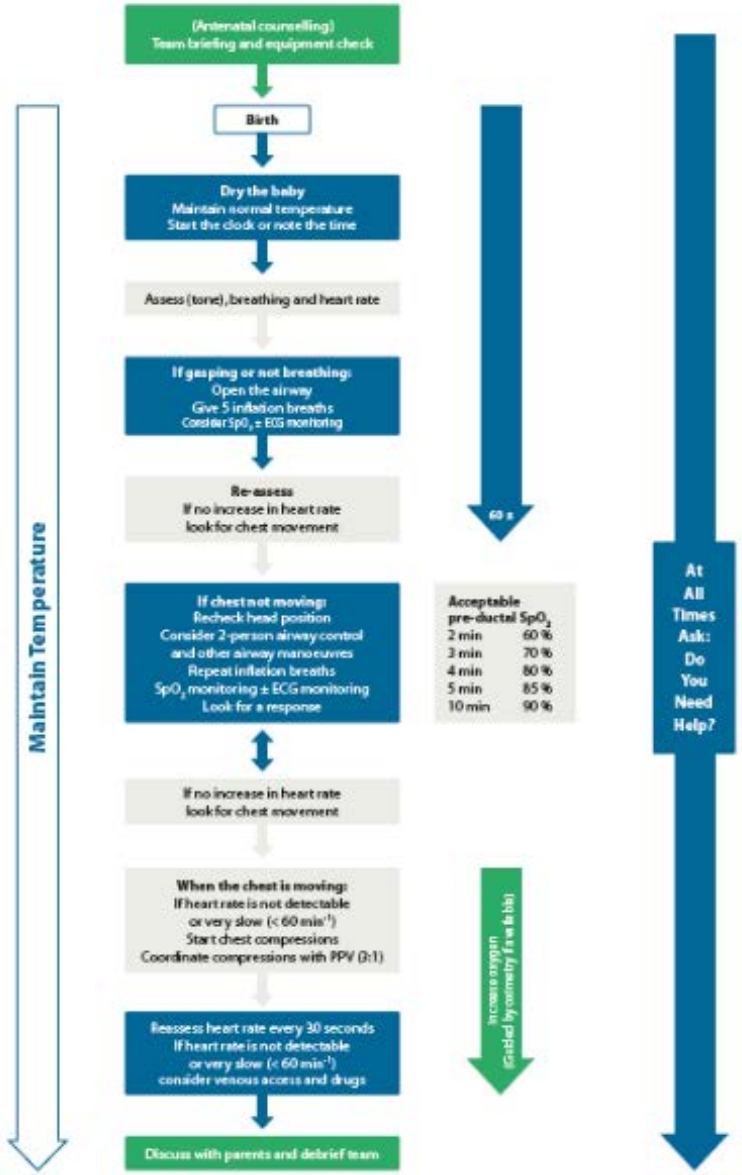
Airway obstruction as a cause of asphyxia

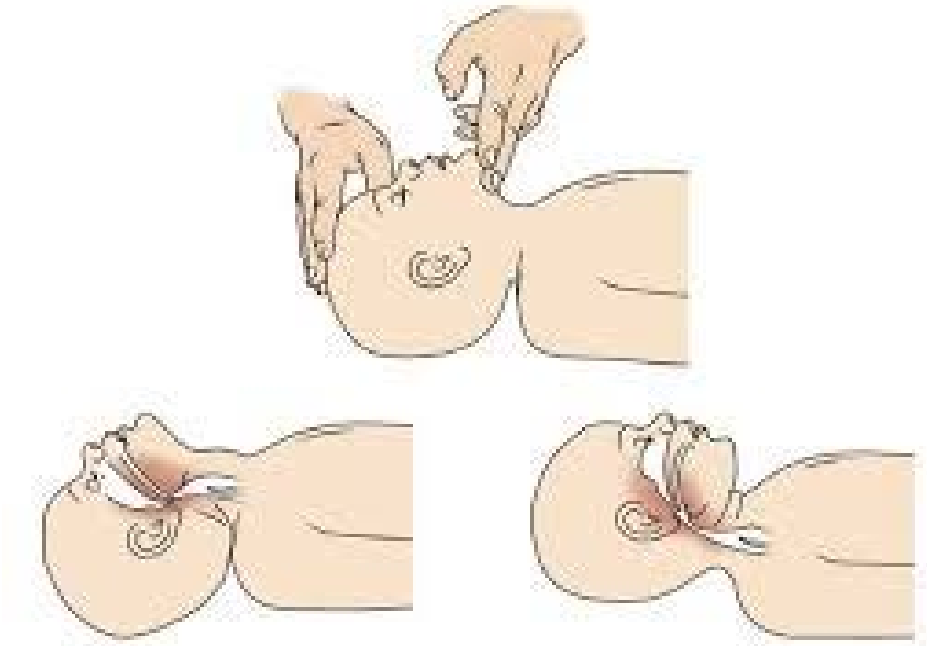




EUROPEAN RESUSCITATION COUNCIL

Newborn Life Support





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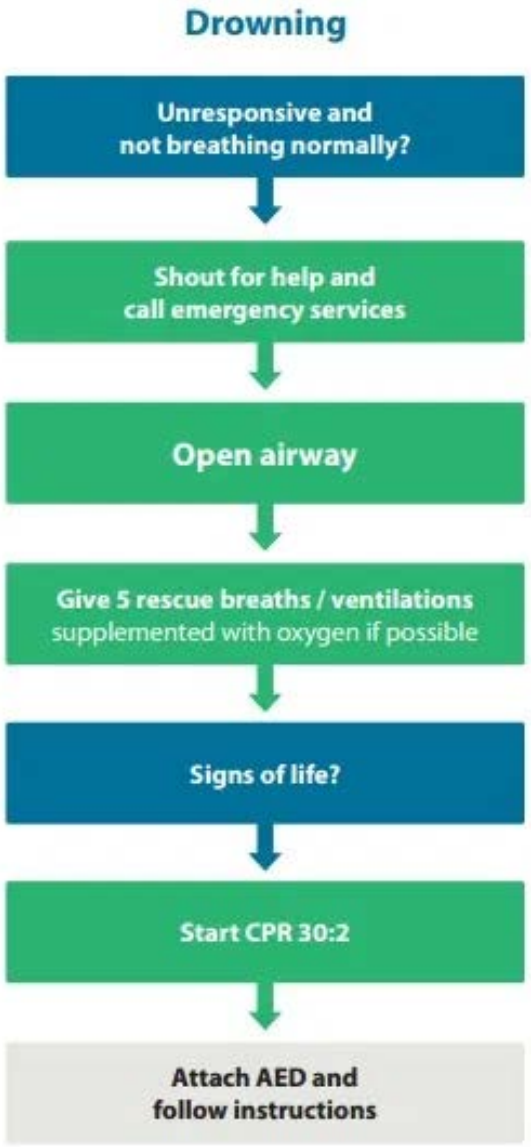
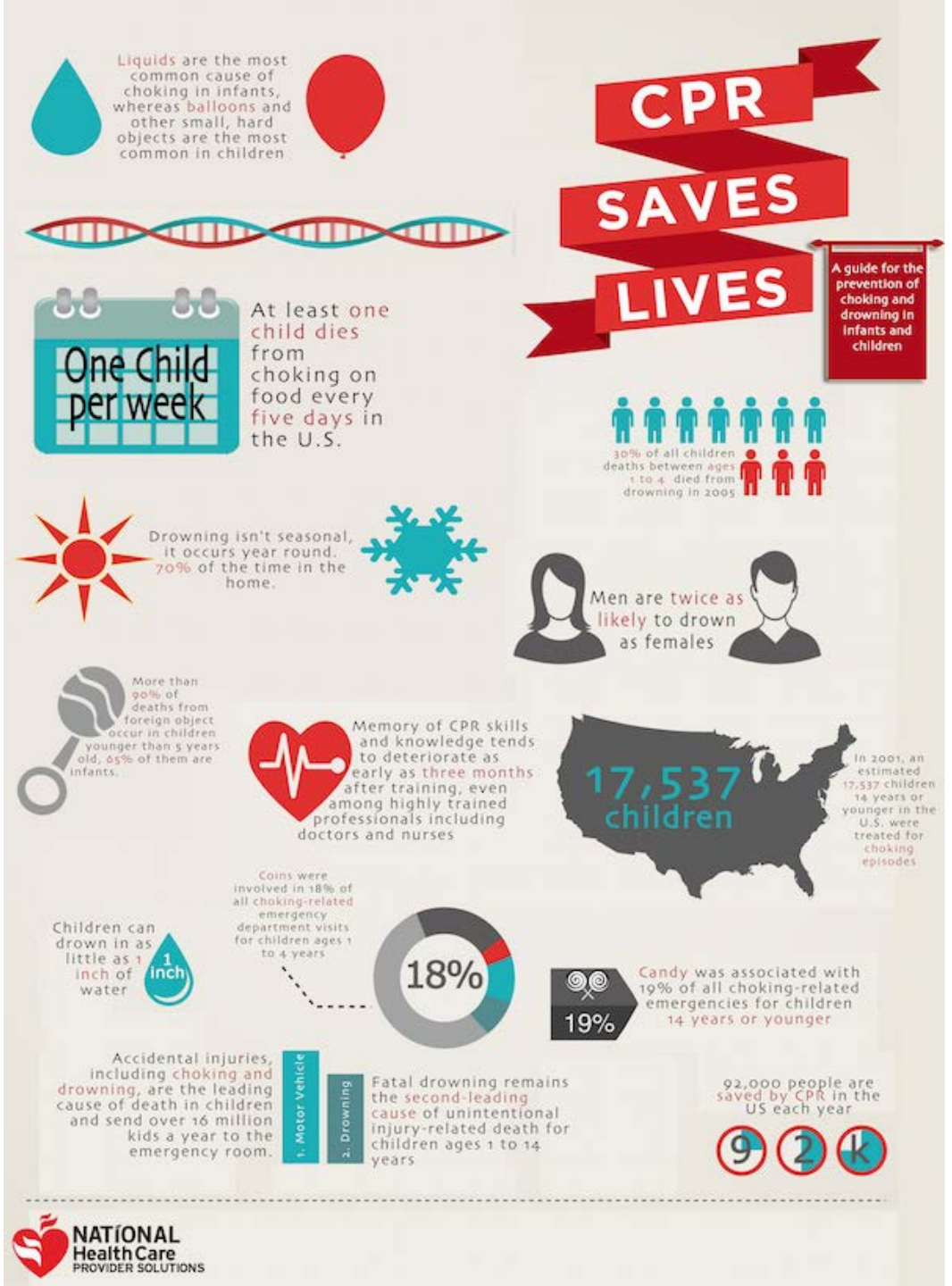
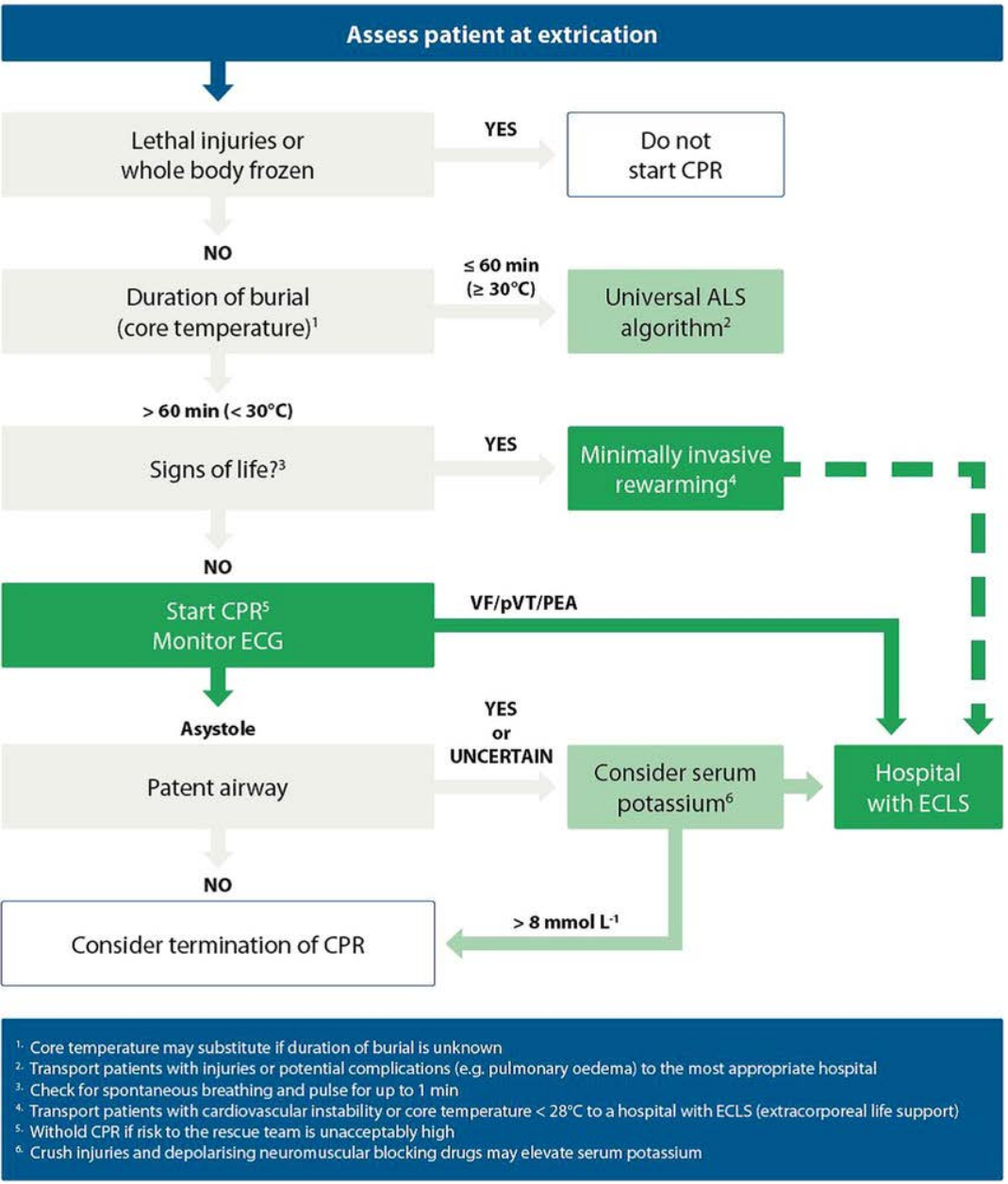
II. Specific environement

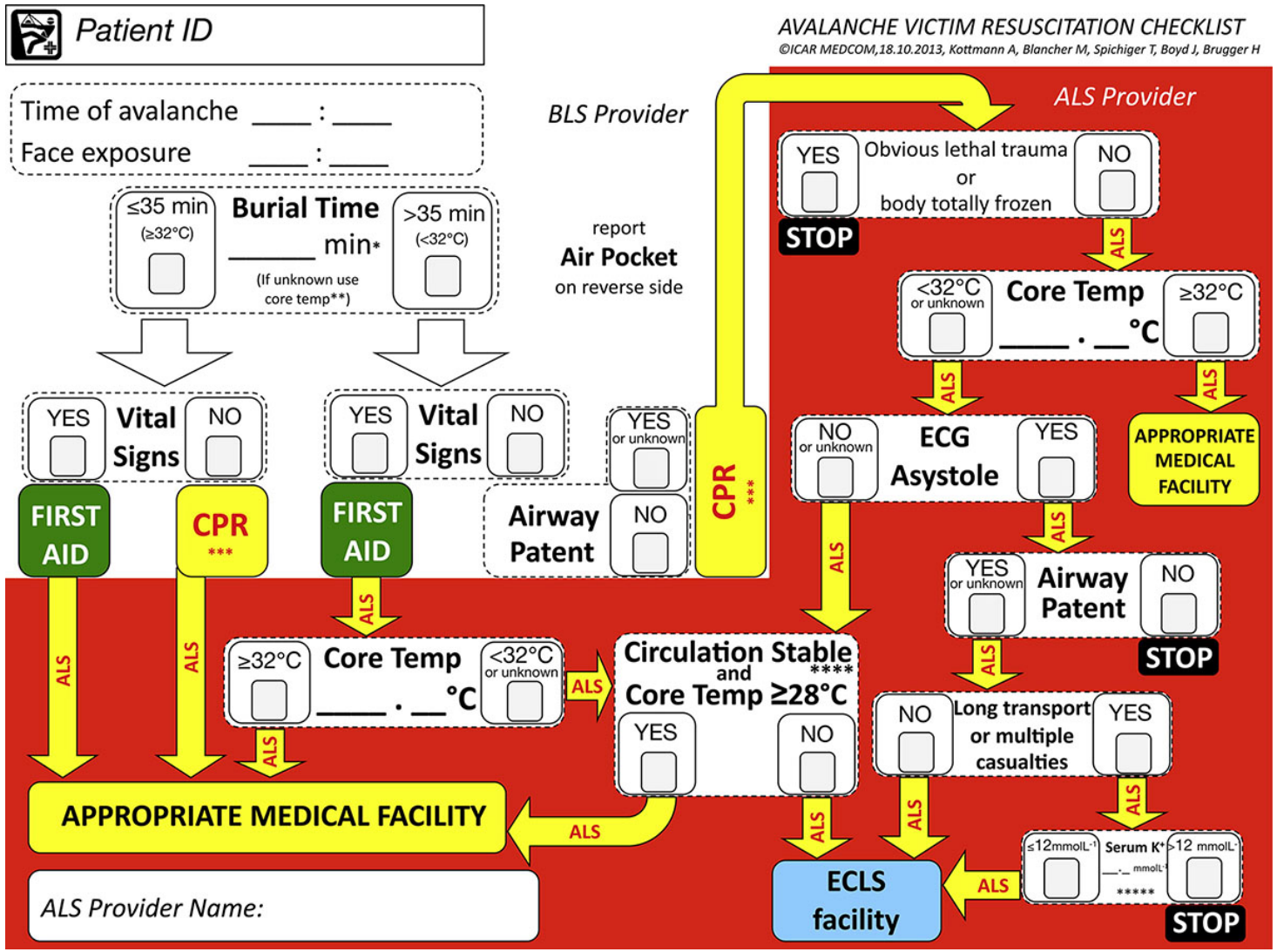
Drowning person



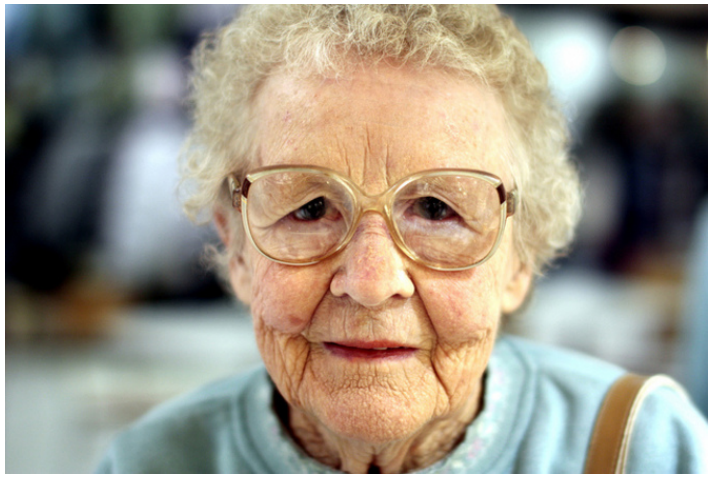


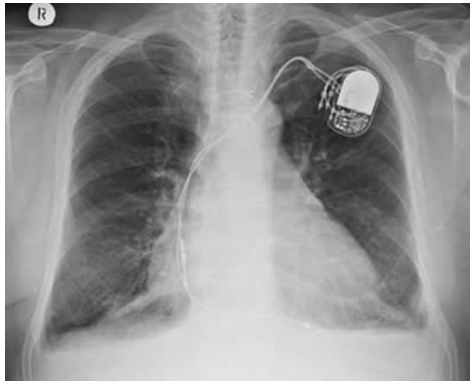
Avalanche victim





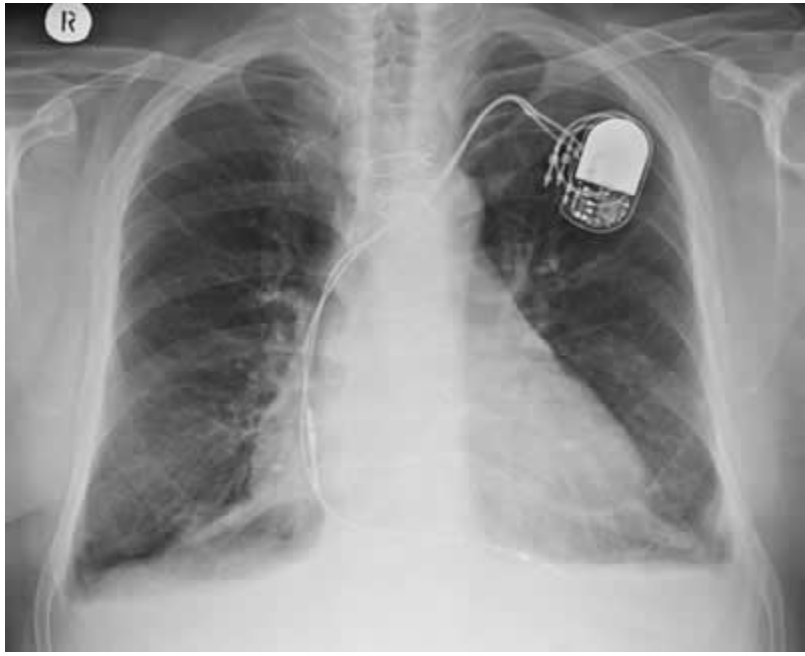
III. Specific patient

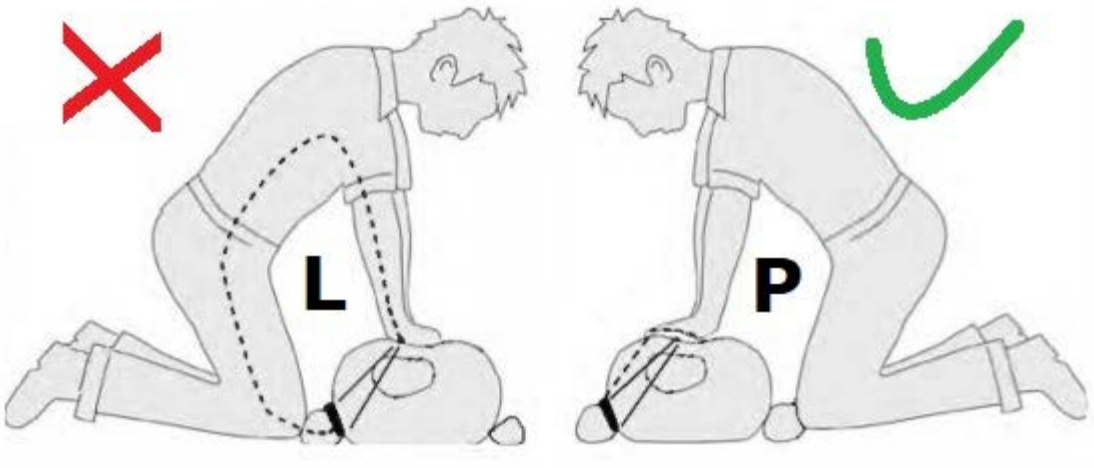




Patient with ICD (implantabile cardioverter defibrilator)

- 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 prearrest, 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. Patient in a 30° left-lateral tilt using a firm wedge to support pelvis and thorax.

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