GENERAL COMMENTS: This protocol is intended for patients in the post-arrest period of care. Post ROSC care focuses on hemodynamic support, STEMI detection, prevention of hyperthermia, airway control, and prevention of re-arrest.

BLS SPECIFIC CARE: See Adult General Cardiac Care/ACS Protocol C-3
- Titrate oxygenation and ventilation to 94-98% SPO2
- Follow up vitals every 5 minutes or sooner.
- Obtain post-ROSC 12 lead. STEMI patients should be transported to appropriate PCI capable facilities.
- Leave LUCAS in place on standby

AEMT/O.M. SPECIFIC CARE: See Adult General Cardiac Care/ACS Protocol C-3

ALS SPECIFIC CARE: See Adult General Cardiac Care/ACS Protocol C-3

General Care

General sedation and Airway Management: Secure the airway using means best determined by good clinical decision making.
- See “Appendix 6: Medication Assisted Intubation” as appropriate.
- Consider intubation as needed

Screen for STEMI:
- Acquire 12 lead. (The acquisition of a 12-lead EKG should not significantly delay treatment or transport)
- If STEMI suspected, consider transport to facility with “24-hour cardiac cath lab capabilities”. (See Hospital Destination protocol G-3)

Sedation and Paralytics:
- Midazolam (Versed) – may be used to prevent shivering
  - IV/IO/IM: 0.5-2.5 mg slow IV push every 5-10 minutes (max dose 5 mg)
  - IN: 2.5 mg every 10 minutes (max dose of 5 mg)

- Vecuronium (Norcuron): Use only when patient shivering is witnessed (to prevent heat production)
  - ADMINISTER ONLY AFTER ENDOTRACHEAL TUBE type airway is SECURED and placement confirmed with SPO2 and CONTINUOUS ETCO2
  - IV/IO: 0.1mg/kg, repeated PRN

- Rocuronium Bromide (Zemuron): Paralytic agent used alternatively to Vecuronium. Use only when patient shivering is witnessed (to prevent heat production)
  - ADMINISTER ONLY AFTER ENDOTRACHEAL TUBE type airway is SECURED and placement confirmed with SPO2 and CONTINUOUS ETCO2
  - IV/IO 1mg/kg repeated PRN
Anti-arrhythmic therapy:

- Lidocaine (Xylocaine): To be initiated if V-fib/V-Tach resolves after administration of lidocaine.
  - **Maintenance Infusion**: 2-4 mg/minute titrated for effect (Start @ 2 mg/min & add 1 mg/min for each additional 1 mg/kg IV bolus)
    - 1 mg/kg bolus = 2 mg/min.
    - 1.5-2 mg/kg total bolus = 3 mg/min.
    - 2.5-3 mg/kg total bolus = 4 mg/min.
  - Always give full initial dose, but reduce all subsequent doses by ½ for elderly (>70) or with impaired hepatic function.

- Amiodarone: To be initiated if V-fib/V-Tach resolves after administration of Amiodarone
  - **Loading dose**: A loading dose of 150 mg/10 minutes may also be considered if max 300 mg bolus has not been administered.
  - **Maintenance Infusion**: Consider 1 mg/minute titrated for effect.

**Hypotension:** See Adult Hypotension and Shock Protocol M-03

*Target Systolic Blood Pressure*: >/= 100 mm/Hg

Vasopressors: titrate to a blood pressure of 100 mm/Hg systolic.

- **Dopamine infusion**
  - IV/IO: 2-20 mcg/kg/min
  - Start at 5 mcg/kg/min

- **Epinephrine infusion**
  - IV/IO: 0.05-1 mcg/kg/min

- **Norepinephrine Infusion**
  - IV/IO: 0.01- 2 mcg/kg/min
  - Start at 0.1 mcg/kg/min.

**Physician Pearls:**

Ensure early notification to receiving facility for expeditious coordination of care.

If Vecuronium/Rocuronium is administered, ensure versed is provided for patient sedation.

Cooling/TTM has been removed from the post-ROSC care. Continued research has shown that prehospital cooling largely ineffective and problematic without invasive controls. Instead providers will focus on prevention of hyperthermia.