

**SAGINAW VALLEY
MEDICAL CONTROL AUTHORITY
PRACTICE PARAMETER**

PEDIATRIC ASYSTOLE

- I. Assessment Information**
 - A. **ASYSTOLE IS VERIFIED IN TWO EKG LEADS.**
 - B. Consider possible causes.¹

FIRST RESPONDER

- II. Management**
 - A. Initiate or continue **CPR**
 - B. **Evaluate and maintain airway**, provide oxygen and support ventilations.
 - C. Assess circulation and perfusion by measuring heart rate and observing skin color and temperature, capillary refill time, and the quality of central and peripheral pulses. Blood pressure should be measured in children older than three.

BASIC LIFE SUPPORT

- D. Arrange for ALS intercept
- E. Initiate transport toward ALS intercept, if transporting unit.

NOTIFY RECEIVING FACILITY

ADVANCED LIFE SUPPORT

- G. **Intubate²**
- H. Monitor **EKG**
- I. **IV/IO NORMAL SALINE @ TKO**
 - 1. If intravenous access cannot be obtained, in three attempts or 90 seconds has elapsed, proceed with intraosseous access.

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- J. **EPINEPHRINE³**
1. **IV/IO=0.01 MG/KG of 1:10,000(10ml) IVP q 3-5min.⁴**
 - a. Flush the medication port with 10 to 20 ml of intravenous fluid following each IV medication administration to aid entry of drugs into central circulation.

CONTACT MEDICAL CONTROL

- K. While epinephrine is now considered the drug of choice to treat asystole, **ATROPINE 0.02 MG/KG (minimum dose: 0.1 mg)** may be considered.
- L. Consider **CALCIUM CHLORIDE 20MG/KG IV/IO** with suspected hyperkalemia (history of renal failure).
- L. Asystole that does not respond to the above treatment sequences may be considered refractory. It may be appropriate to discontinue resuscitative efforts in refractory asystole as permitted.

¹ Potentially treatable cause of asystole in the pediatric patient include hypoxia, hyperkalemia (renal failure), acidosis, hypothermia, or severe bradycardia.

² Endotracheal intubation can help correct respiratory failure (frequently the underlying cause of asystole) as well as providing an alternate route for medication administration if vascular access is difficult to obtain.

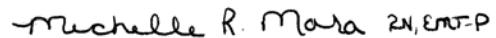
³ Maybe given either IV, IO or endotracheal. When given endotracheal, chest compression should be stopped. The drug solution should be sprayed quickly down the endotracheal tube and several quick insufflations should be given to aerosolize the medication and hasten absorption. Epinephrine may be repeated by doses identified above.

⁴ If IV/IO access is unsuccessful, **ENDOTRACHEAL= 0.1 MG/KG of 1:1000 (use multidose vial with 1mg/cc concentration)**. If vascular access is obtained after giving an initial dose of epinephrine via endotracheal tube, give the second dose intravenously 3 to 5 minutes after the endotracheal dose.

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Medical Director



EMS Manager