

2015 AHA Guideline Updates
Vermont Statewide Emergency Medical Services Protocols

| Protocol | Update | Rational |
|---|---|---|
| Obstetrical Emergencies 2.16 | Add Pearl: Use manual left uterine displacement during CPR | When resuscitating pregnant patients manual left uterine displacement should be used during CPR as this technique is the most compatible with high quality CPR as vs. Tilt technique. |
| Cardiac Arrest 3.2 A | Remove vasopressin from adult cardiac arrest algorithm. | In an effort to simplify cardiac arrest algorithms, vasopressin has been removed. Epinephrine and vasopressin have equivalent outcomes with no additional benefit from combined use. Existing supplies of vasopressin may continue to be utilized until expiration dates. |
| Cardiac Arrest 3.2 A,P | Administer 100% oxygen. | Use maximum FiO2 during CPR. Titrate oxygen after ROSC to ≥ 94%. |
| Cardiac Arrest 3.2 P (Pediatric) | Add lidocaine as alternative to amiodarone if no response after 2 nd defibrillation: Lidocaine 1 mg/kg rapid IV/IO push (max 100mg) | Amiodarone OR Lidocaine. Both anti-arrhythmics are acceptable for treatment of shock-refractory VF or pulseless VT in pediatric patients. |
| Induced Mild Hypothermia for Comatose Survivors of Cardiac Arrest 3.4 | Protocol is SUSPENDED pending release of more favorable research | Recently published high-quality studies demonstrated no benefit to prehospital cooling and also identified potential complications when using cold IV fluids for prehospital cooling. |
| Rapid Sequence Intubation (RSI) 7.2 | Adjust pediatric dose of atropine to weight based dosing: Atropine 0.02 mg/kg IV/IO for pediatric patients with increased risk of bradycardia. | There is no evidence to support the routine use of atropine as a premedication to prevent bradycardia in emergency pediatric intubations. It may be considered in situations where there is an increased risk of bradycardia. There is no evidence to support a minimum dose of atropine when used as a premedication for emergency intubation. |

General CPR recommendations: Updated guidelines continue to emphasize high-quality CPR: compressing the chest at an adequate rate and depth, allowing complete chest recoil after each compression, minimizing interruptions in compressions, and avoiding excessive ventilation. The recommended chest compression rate is 100 to 120/min (updated from *at least* 100/min). The clarified recommendation for chest compression depth for adults is at least 2 inches (5cm) but not greater than 2.4 inches (6cm). Integrated teams of highly trained rescuers may use a choreographed approach that accomplishes multiple steps and assessments simultaneously rather than the sequential manner used by individual rescuers. Where EMS systems have adopted bundles of care involving continuous chest compressions, the use of passive ventilation techniques may be considered as part of that bundle for victims of out of hospital cardiac arrest (OHCA).

