



# Pediatric Cardiac Arrest

## History

- Time of arrest
- Medical history
- Medications
- Possibility of foreign body
- Hypothermia

## Signs and Symptoms

- Unresponsive
- Cardiac arrest

## Differential

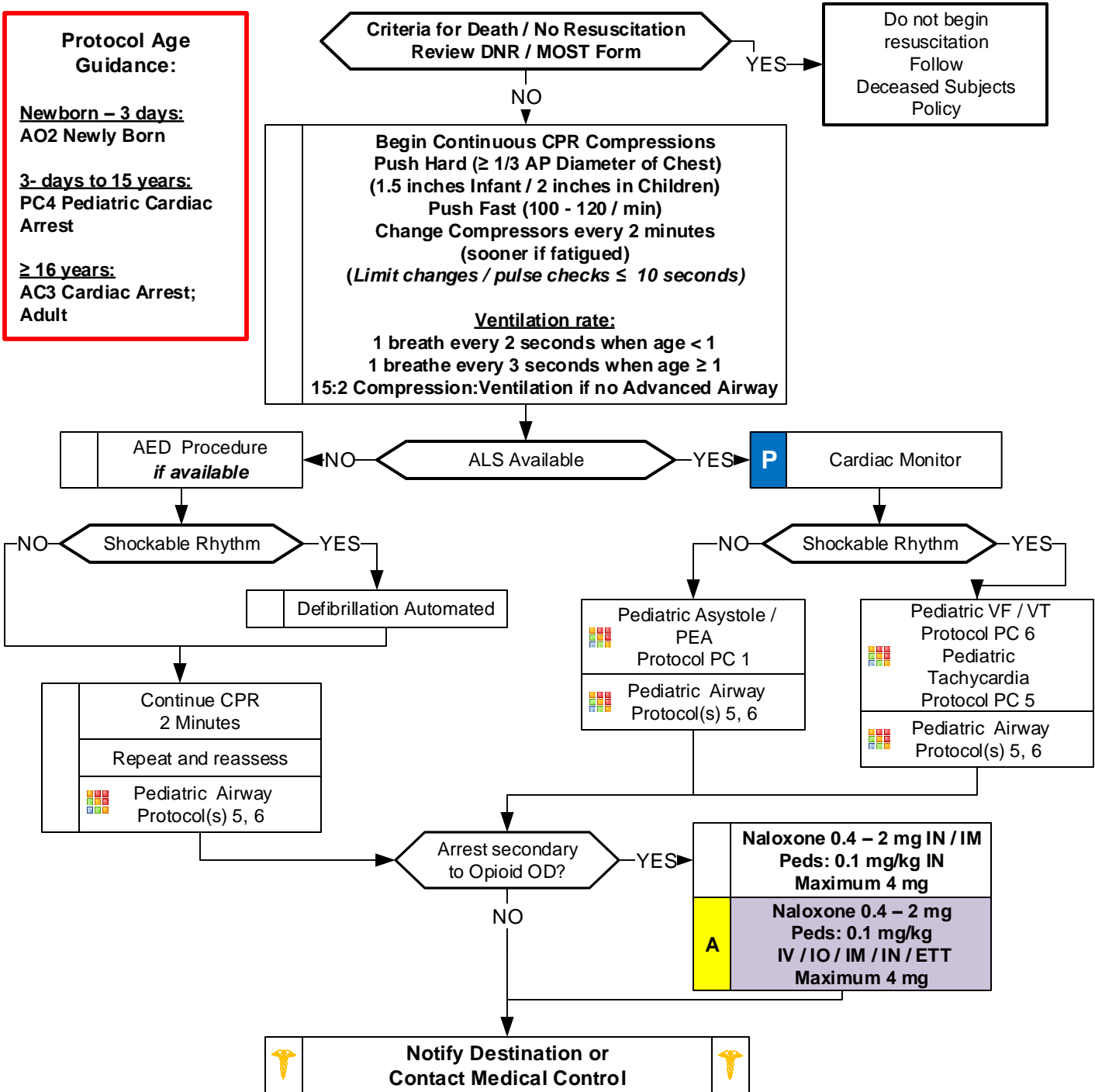
- Respiratory failure: Foreign body, Secretions, Infection (croup, epiglottitis)
- Hypovolemia (dehydration)
- Congenital heart disease
- Trauma
- Tension pneumothorax, cardiac tamponade, pulmonary embolism
- Hypothermia
- Toxin or medication
- Electrolyte abnormalities (Glucose, K)
- Acidosis

**Protocol Age Guidance:**

**Newborn – 3 days:**  
AO2 Newly Born

**3- days to 15 years:**  
PC4 Pediatric Cardiac Arrest

**≥ 16 years:**  
AC3 Cardiac Arrest;  
Adult





# Pediatric Cardiac Arrest

## Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assigning responders to predetermined tasks. Refer to optional protocol or development of local agency protocol.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated. Compress  $\geq 1/3$  anterior-posterior diameter of chest, in infants 1.5 inches and in children 2 inches.**
- **Majority of pediatric arrests stem from a respiratory insult or hypoxic event. Compressions should be coupled with ventilations.**
- **When advanced airway not in place perform 15 compressions with 2 ventilations.**
- **Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric paddles should be used in children < 10 kg.**
- **DO NOT HYPERVENTILATE:**  
If advanced airway in place ventilate:  
**Age < 1 year: 1 breath every 2 seconds with continuous, uninterrupted compressions.**  
**Age  $\geq 1$  year: 1 breath every 3 seconds with continuous, uninterrupted compressions.**
- **Patient survival is often dependent on proper ventilation and oxygenation / airway Interventions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **High-Quality CPR:**  
Make sure chest compressions are being delivered at 100 – 120 / min.  
Make sure chest compressions are adequate depth for age and body habitus.  
Make sure you allow full chest recoil with each compression to provide maximum perfusion.  
Minimize all interruptions in chest compressions to < 10 seconds.  
Use AED or apply ECG monitor / defibrillator as soon as available.
- **Defibrillation:**  
Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.  
Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause.  
Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
- **End Tidal CO<sub>2</sub> (EtCO<sub>2</sub>)**  
If EtCO<sub>2</sub> is < 10 mmHg, improve chest compressions. Goal is  $\geq 20$  mmHg.  
If EtCO<sub>2</sub> spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation.**
- **IV access is preferred route. Follow IV or IO Access Protocol UP 6.**
- **Special Considerations**  
**Maternal Arrest** - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.  
**Renal Dialysis / Renal Failure** - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.  
**Opioid Overdose** - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol UP 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.  
**Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike** – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.**