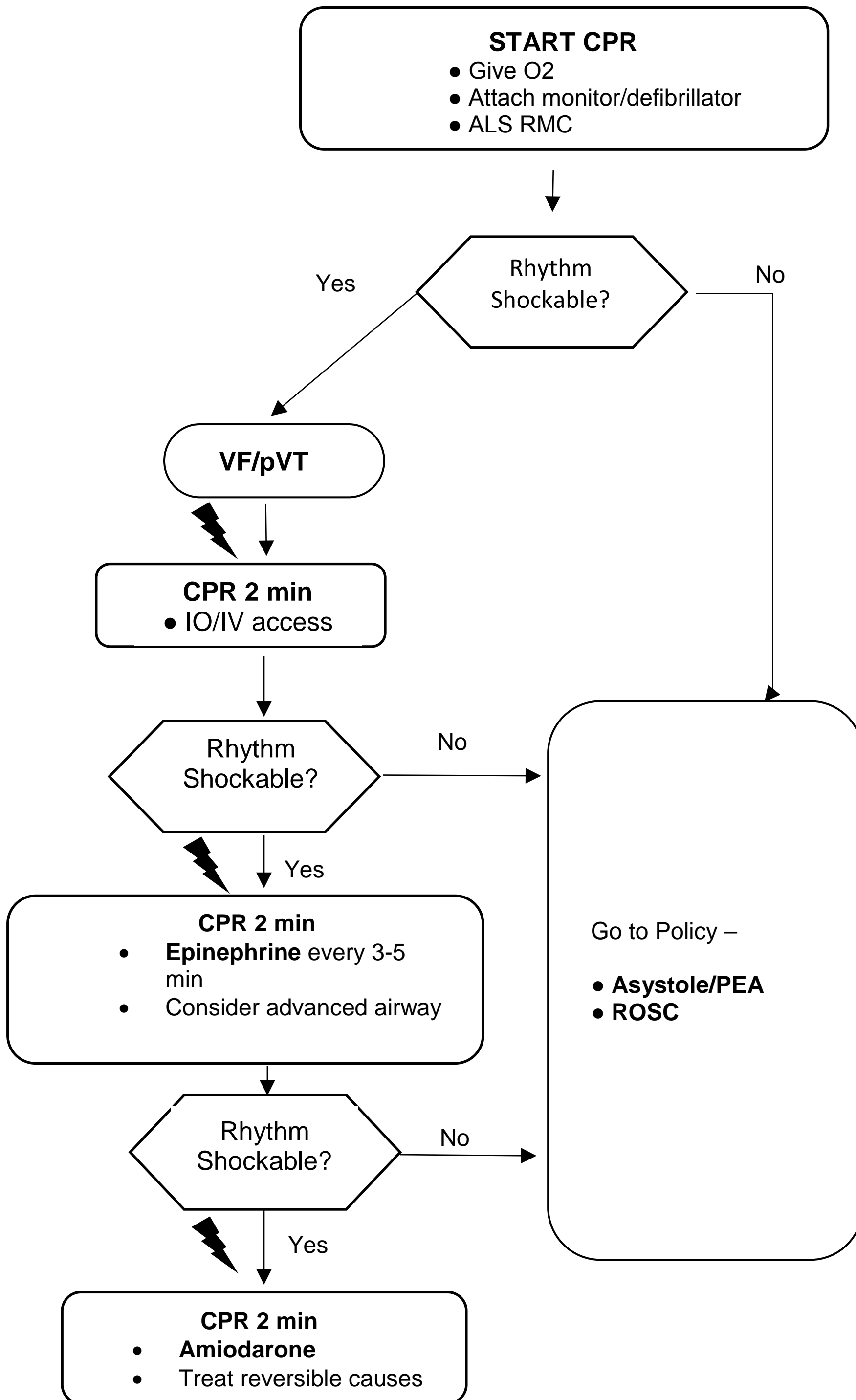
VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

ALWAYS USE STANDARD PRECAUTIONS



For refractory Vfib >30 min, transport to nearest available STEMI Receiving Center

Critical Information:

- Witnessed vs Unwitnessed
- Consider pre-cordial thump if witnessed and defibrillator not immediately available
- Compress at 110 bpm. Use metronome or similar device
- Manual CPR is preferred; mechanical CPR is an acceptable alternative
- Change compressors every 2 minutes
- Minimize interruptions
- If hypothermic <95F, delay compressions for 3 minutes; focus on ventilations and active rewarming
- Defibrillate per manufacturer's recommendations.
- Do not stop compressions while defibrillator is charging
- Resume compressions immediately after shock

BLS Airway Management:

- *BLS airway is preferred during the first 5 minutes*
- Use two-person BLS airway management whenever possible
- Avoid excessive ventilation
- 30:2 compression/ventilation ratio

ALS Airway Management:

- King Airway / Video Laryngoscopy (VL) preferred
- Laryngoscopy for ETT must occur with CPR in progress. Do not interrupt CPR for >10 seconds for tube placement
- Use continuous ETCO2 to monitor CPR effectiveness and advanced airway placement.
- Maintain O2 sat 94-99%
- 1 breath every 6 seconds

Drug Therapy:

- **Epinephrine** 1mg (0.1mg/ml concentration) IV/IO q 3-5 minutes
- **Amiodarone** first dose: 300mg IV/IO; second dose 150mg IV/IO in 3-5 minutes. If rhythm converts to ROSC after Amiodarone, consider infusion of **Amiodarone drip** (150mg in 100ml NS, 1mg/min = 40 gtts/min with 60 gtt/ml tubing)

Reversible Causes:

- Hypovolemia
- Hypoxia
- Hydrogen Ion (Acidosis)
- Hypo-/Hyperkalemia
- Hypothermia
- Tension Pneumothorax
- Tamponade (cardiac)
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary