

Pediatric V-Fib/Pulseless V-Tach

History

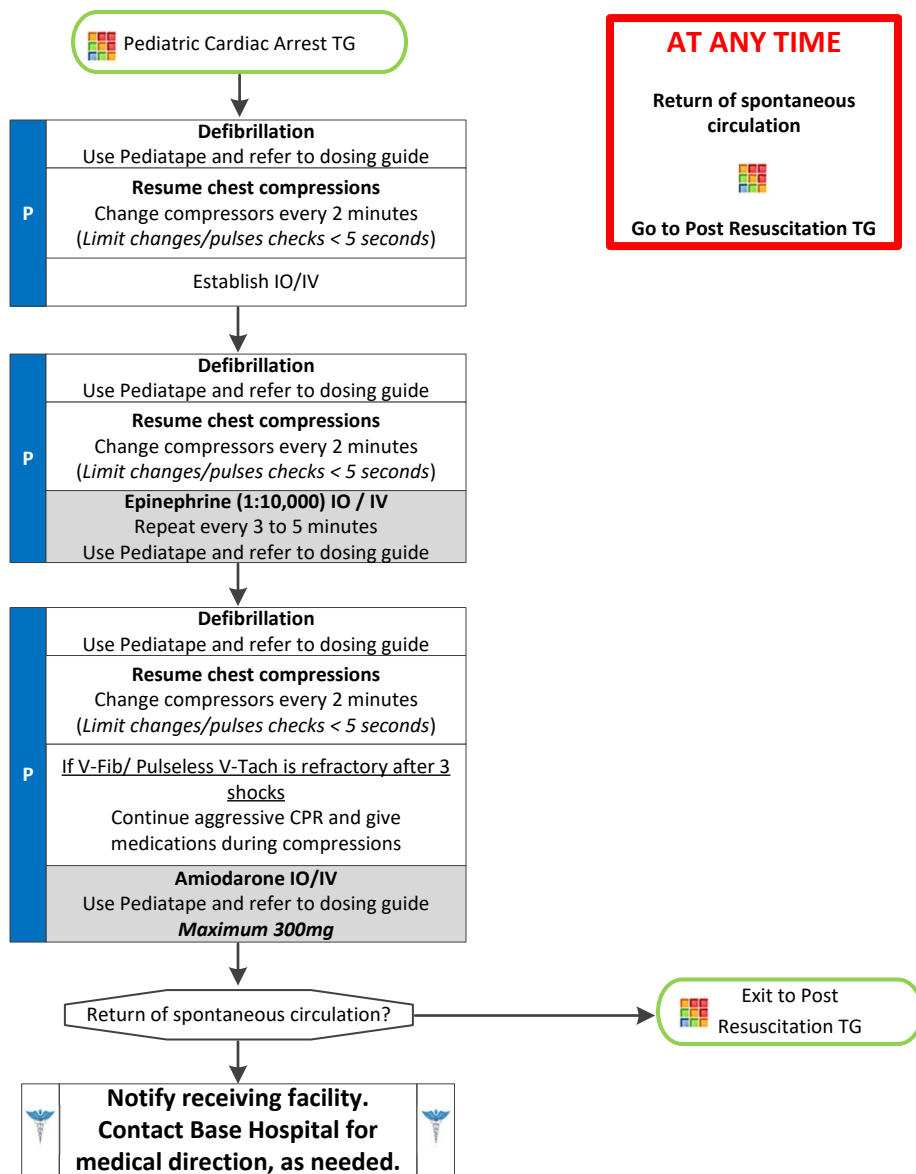
- Events leading to arrest
- Estimated downtime
- Past medical history
- Medications
- Existence of terminal illness
- Airway obstruction
- Hypothermia

Signs and Symptoms

- Apneic
- Pulseless

Differential

- Respiratory failure/airway obstruction
- Hyper/hypokalemia
- Hypovolemia
- Hypothermia
- Hypoglycemia
- Acidosis
- Tension pneumothorax
- Tamponade
- Toxin or medication
- Thrombosis: Coronary or Pulmonary Embolism
- Congenital heart disease



Pediatric Treatment Guidelines



Pediatric V-Fib/Pulseless V-Tach

Pearls

- Efforts should be directed at high quality chest compressions with limited interruptions and early defibrillation when indicated. Compress 1.5 inches in infants and 2 inches in children. Consider early IO placement if available or direct IV access if anticipated.
- DO NOT HYPERVENTILATE.
- Use a metronome during chest compression to ensure proper rate.
- Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with a BVM. Patient survival is often dependent on proper ventilation and oxygenation with airway intervention.
- In order to be successful in pediatric arrests, a cause must be identified and corrected.
- Respiratory arrest is a common cause of cardiac arrest. Unlike adults, early ventilation intervention is critical.
- In most cases, pediatric airways can be managed by basic intervention with a BVM.
- Reassess and document ETT placement (patients above 40kg) and EtCO₂ frequently, after every move, and at transfer of care.
- Do not stop chest compressions to check for placement of ETT or to give medications.

