

Goals of Care

- Focus on maternal resuscitation
- Early transport as opposed to care on the scene of arrest (for OHCA)
- High-quality CPR
- Early involvement of obstetrical and neonatal teams
- Perform RCD by 5 min

Defibrillation Energy Doses

Biphasic:
Per manufacturer's recommendations (e.g., 120 to 200 J) or if unknown, max available; subsequent doses equal to or greater than first dose

Monophasic:
360 J for all doses

Medications

Epinephrine

- 1 mg IV/IO bolus every 3 to 5 min

Amiodarone

- First dose: 300 mg IV/IO bolus
- Second dose: 150 mg IV/IO after 3 to 5 min

Lidocaine

- First dose: 1 to 1.5 mg/kg IV/IO
- Subsequent doses: 0.5 to 0.75 mg/kg IV/IO every 5 to 10 min, up to a max dose of 3 mg/kg

Causes of Cardiac Arrest in Pregnancy

- A:** Anesthesia complication
- B:** Bleeding
- C:** Cardiovascular cause
- D:** Drugs
- E:** Embolism
- F:** Fever
- G:** General
- H:** Hypertension

Prehospital Assessment and Care

- Prioritize transport over care at the scene (follow local protocols for destination decision)
- Provide high-quality CPR, including airway management and continuous LUD during transport. Provide continuous LUD until the infant is delivered, even if ROSC is achieved
- Alert receiving hospital and follow protocols for maternal cardiac arrest arrival

Indications for Resuscitative Cesarean Delivery (RCD)

- No ROSC after 2 cycles of CPR in a pregnant patient with a fundus at or above umbilicus or fetal age known to be ≥ 20 weeks
- Intermittent ROSC after 2 cycles of CPR
- Nonshockable rhythm
- Immediately upon arrival to an emergency department without ROSC (for OHCA)
- Although RCD should be performed at 4 min CPR/2 cycles, preparation needs to start as early in resuscitation as possible to allow this goal to be met.

High-Quality CPR

- Compress at a rate of 100 to 120 compressions per min and a depth of at least 2 inches (5 cm); allow for full chest recoil
- Minimize interruptions to chest compressions to less than 10 sec
- Avoid excessive ventilations. Each ventilation should last about 1 sec and make the chest begin to rise
- **Without advanced airway:** 30 compressions: 2 ventilations
With advanced airway: continuous compressions; deliver 1 ventilation every 6 sec without pausing compressions
- Rotate compressor every 2 min
- Monitor CPR quality with ETCO₂ or arterial blood pressure (if available)

Left Uterine Displacement (LUD)

- When the fundus is at or above the umbilicus, provide continuous LUD until the infant is delivered, even if return of spontaneous circulation (ROSC) is achieved
- LUD relieves pressure placed on the inferior vena cava by the gravid uterus, increasing venous return to the heart to maximize cardiac output
- In most cases, two hands are needed to provide the necessary displacement
- From the patient's left side, reach across the patient, place both hands on the right side of the uterus, and pull the uterus to the left and up (**Fig. 1**)
- From the patient's right side, place both hands on the right side of the uterus and push the uterus to the left and up (**Fig. 2**)

Fig. 1

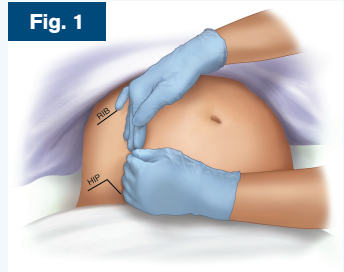


Fig. 2

