Eagles Bullet Rounds #1

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Go Blue!
SUPRAVENTRICULAR TACHYCARDIA CARDEOVERTED BY AN AUTOMATED EXTERNAL DEBRILLATOR IN A 9-YEAR-OLD MALE WITH A HISTORY OF WOLFF-PARKINSON-WHITE SYNDROME

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Prehospital Emergency Care January/ March 2015
NYC Direct to Cath Lab
AHA/Duke
Getting Real STEMI patients to cath labs faster
12-Lead ECG transmitted from the field to OLMC – verified then notification and transport to one of 23 PCI facilities
Good Outcomes
Decreased D2B and FMC to Device times
A Collaborative Effort to Improve Emergency Stroke Care: Mobile Stroke Unit
Of 302 patients treated within 90 minutes of onset with tPA vs placebo in the NINDS study, only 2 were randomized within 60 minutes of onset, and 41 were randomized between 60-80 minutes. The rest were randomized between 81-90 minutes.
t-PA Treatments- First 12 run weeks

- **42** Treated with rt-PA
- **14** More Transported (but not treated)
  - 6 ICH
  - 3 Sz
  - 3 Too mild
  - 1 Uncertain onset time
  - 1 Other (SDH)
- Avg. on-scene time- **22-24 min**
- Symptom onset to t-PA treatment
  - **42%** 0-60 min
  - **31%** 61-80 min
  - **27%** 81-270 min
TEMPERATURE MANAGEMENT

The information provided is currently in DRAFT format and is NOT a FINAL version

Treatment Recommendation:
We recommend targeted temperature management as opposed to no targeted temperature management for adults with OHCA with an initial shockable rhythm who remain unresponsive after ROSC (strong recommendation, low-quality evidence).

We suggest targeted temperature management as opposed to no targeted temperature management for adults with OHCA with an initial nonshockable rhythm (weak recommendation, very low-quality evidence) who remain unresponsive after ROSC.

We suggest targeted temperature management as opposed to no targeted temperature management for adults with IHCA (weak recommendation, very low-quality evidence) with any initial rhythm who remain unresponsive after ROSC.

We recommend selecting and maintaining a constant, target temperature between 32°C and 36°C for those patients in whom temperature control is used (strong recommendation, moderate-quality evidence). Whether certain subpopulations of cardiac arrest patients may benefit from lower (32-34°C) or higher (36°C) temperatures remains unknown, and further research may help elucidate this.
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Treatment Recommendation:
We suggest mechanical chest compression devices should not be considered the standard of care for cardiac arrest patients, but can be considered a reasonable alternative to high quality manual chest compressions in some settings (weak recommendation, moderate quality of evidence).

Values and Preferences Statement:

In making this recommendation we place value on data from a large, high-quality RCT demonstrating equivalence between high quality manual chest compressions and mechanical chest compressions. Local considerations such as relative costs and resource availability for maintenance of high quality manual chest compressions and mechanical chest compression device implementation should guide decisions around which mode of chest compression delivery is most appropriate. Also, there may be scenarios not directly addressed in the literature reviewed to support this treatment recommendation such as CPR in a moving ambulance, in the angiography suite or during preparation for ECLS, where mechanical chest compressions are more practical.
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Treatment Recommendation:
We recommend against routine use of prehospital cooling with rapid infusion of large volumes of cold intravenous fluid immediately after ROSC (strong recommendation, moderate-quality evidence).
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Treatment Recommendation:
Impedance Threshold Device + Standard CPR (I) vs Standard CPR (C):
We recommend against routine use of ITD in addition to standard CPR (strong recommendation, high quality of evidence). Values and preferences statement: In making this recommendation we place a higher value on not allocating resources to an ineffective intervention over any yet to be proven benefit for critical or important outcomes.

Impedance Threshold Device + Active Compression Decompression CPR (I) vs Active Compression Decompression CPR (C):
We suggest against the routine use of ITD in addition to Active Compression-Decompression CPR (weak recommendation, very low quality of evidence). Values and preferences statement: In making this recommendation we place a higher value on not allocating resources to an ineffective intervention over any yet to be proven benefit for critical or important outcomes.

Impedance Threshold Device + Active Compression Decompression CPR (I) vs Standard CPR (C):
We suggest against the routine use of ITD with Active Compression-Decompression CPR as an alternative to standard CPR (weak recommendation, very low quality of evidence). Values and preferences statement: In making this recommendation we place a higher value on not allocating resources to an intervention with equivocal benefit for critical or important outcomes.