

Eagles Bullet Rounds #1

David P. Keseg, MD

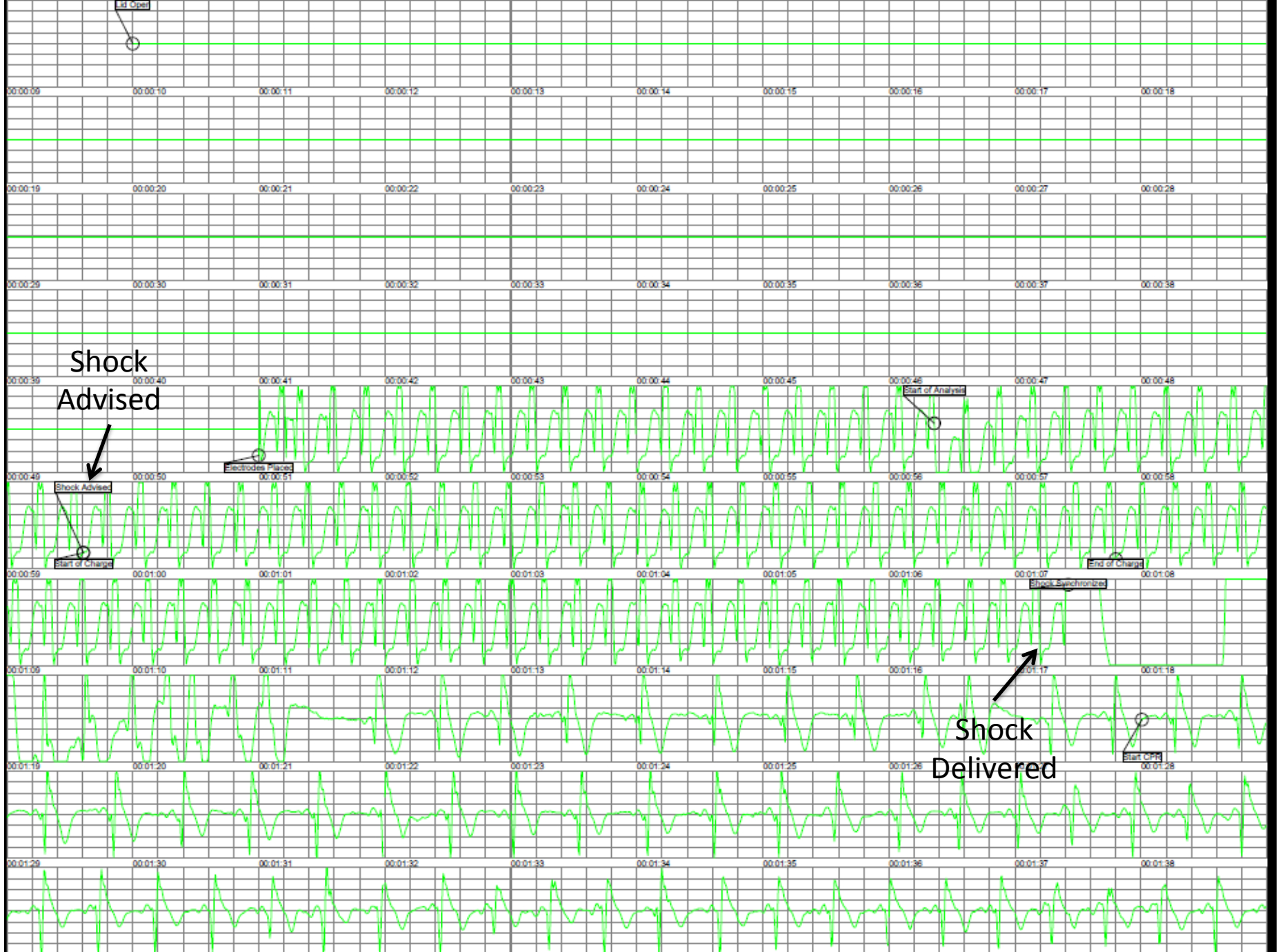
Glenn Asaeda, MD

David E. Persse, MD

J. Brent Myers, MD

Go Blue!





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

Eric Cortez, MD, James Davis, RN, EMT-P, MBOE, David Keseg, MD FACEP

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

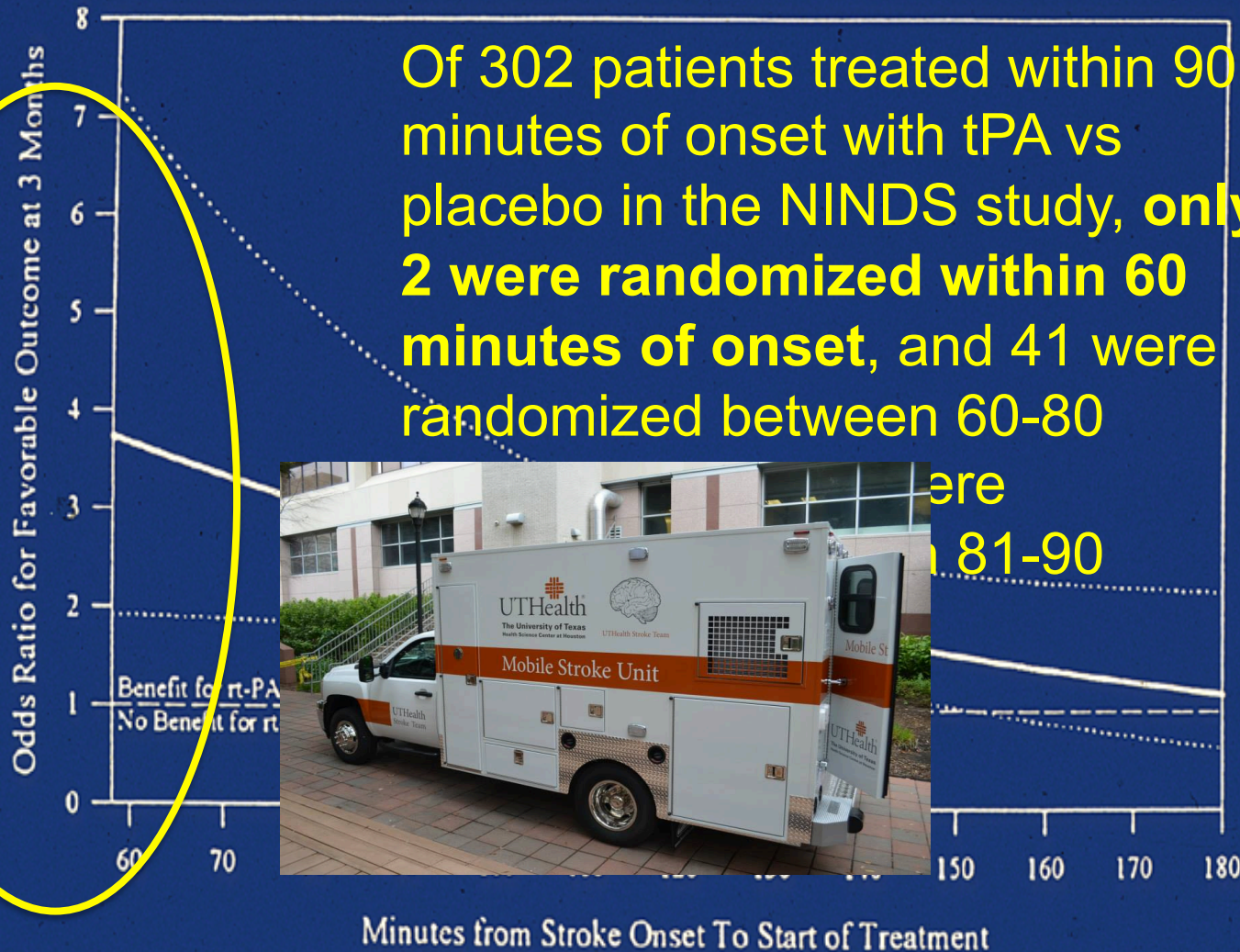


THE UNIVERSITY
of TEXAS
HEALTH SCIENCE CENTER
AT HOUSTON

**A Collaborative Effort to Improve
Emergency Stroke Care:
*Mobile Stroke Unit***

NINDS rt-PA Stroke Study Parts 1 and 2

Relation of Time to Treatment to Odds of Ratio of Favorable Outcome



Data From 622 Patients. Odds Ratio of Minimal or No Disability At 3 Months For rt-PA Compared to Placebo-Treated patients. With 95% Confidence Interval (-----). Range of times from 58 to 180 minutes. Mean time to treatment (μ) was 119.7 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.

MECHANICAL COMPRESSIONS

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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.

PREHOSPITAL TEMPERATURE MANAGEMENT

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

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).

ILCOR ITD

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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.