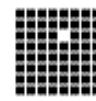




**Emergency Care
and Safety Institute**



**American College of
Emergency Physicians®**

2005 ACLS Guidelines

Action	2005 Guidelines
Confirming ET Tube Placement	<ul style="list-style-type: none">• Use clinical assessment plus “additional” confirmation methods (eg, ETCO₂ detector, esophageal detector devices (EDD))¹• Assess tube placement:<ul style="list-style-type: none">▪ Immediately after insertion▪ After securing tube▪ During transport▪ After any patient movement <p>¹ ETCO₂ detector and EDDs no longer considered “secondary” confirmation devices.</p>
Endotracheal (ET) Drug Administration	<ul style="list-style-type: none">• IV/IO routes preferred over ET route¹<ul style="list-style-type: none">▪ Drug delivery more predictable when given IV/IO versus ET• Certain medications may be given via ET tube in absence of IV/IO:<ul style="list-style-type: none">▪ Lidocaine, epinephrine, atropine, naloxone, vasopressin<ul style="list-style-type: none">○ Exact ET dose unknown; typically 2—2.5 times recommended IV/IO dose○ Dilute with 5—10 mL saline prior to administration <p>¹ Greater emphasis on IV/IO routes; lesser emphasis on ET route.</p>
Ventilation duration, rate, and depth	<ul style="list-style-type: none">• All breaths delivered over 1 second (basic or advanced airway)<ul style="list-style-type: none">▪ Emphasis placed on producing <i>visible</i> chest rise• Ventilation rates:<ul style="list-style-type: none">▪ Apneic with pulse: 10—12 breaths/min▪ Pulseless and apneic: 8—10 breaths/min
Symptomatic Bradycardia	<ul style="list-style-type: none">• Atropine 0.5 mg q 3—5 min.<ul style="list-style-type: none">▪ Maximum dose: 3 mg• Consider epinephrine (2—10 µg/min) or dopamine (2—20 µg/kg/min) infusion while awaiting TCP or if TCP is ineffective• TCP without delay for high-degree AV block (second degree type II or third-degree AV block) <p><i>Note: Isoproterenol (Isuprel) removed from algorithm</i></p>
VF/Pulseless VT	<ul style="list-style-type: none">• Deliver one shock (monophasic: 360J; biphasic: 120—200J device specific)<ul style="list-style-type: none">▪ Begin CPR immediately after shock▪ Reassess rhythm after 5 cycles (about 2 minutes) of CPR; repeat shock as needed▪ Assess for pulse if organized rhythm appears on monitor• Witnessed arrest: immediate defibrillation• Unwitnessed arrest (call-to-arrival interval > 4 to 5 min): 5 cycles (about 2 minutes) of CPR before defibrillation• Consider 40U vasopressin (one-time dose) to replace <i>first or second dose</i> of epinephrine
Asystole/PEA	<ul style="list-style-type: none">• Atropine 1 mg q 3—5 min (give atropine if PEA rate < 60)<ul style="list-style-type: none">▪ Maximum dose: 3 mg• Consider 40U vasopressin (one-time dose) to replace <i>first or second dose</i> of epinephrine

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