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Aha acls guideline 2015 pdf

2015 ILCOR, AHA and ERC advanced ACLS guidelines are now at 2. This will be a brief overview of what I think are the most important or interesting changes to the guidelines, based on my first reading. (I noticed some small differences between the AHA and ERC versions of these guidelines, but nothing is worth devoting much time to.) If I had to take only 2 study points, they would be: These ACLS guidelines are very similar to the ACLS 2010 guidelines. There are not enough important changes to guarantee payment for another ACLS course. If you know the 2010 ACLS guidelines, just keep providing good patient care. As always, science is weak. Only 1% of the recommendations are A-level, which means that high-quality evidence from more than one RCT. The most common phrase I encountered with reading through these guidelines could be reasonable. This phrase is essentially meaningless and can be easily translated into can not be reasonable. Be careful. With this in mind, let's look at several areas where they have made some changes to the guidelines. CPR The main points for CPR have not changed. Continue with good compressions at 30:2, increasing the compression time without stopping for more than 10 seconds. However, they have made some small changes to the descriptions of good CPR: Not too fast. Maximum compression rate 120. They don't want compressions spinning too fast, as there is evidence that quality decreases by more than 120 compressions per minute. The new goal is 100-120 compressions per minute (instead of at least 100)Not too deep. Maximum compression depth 6 cm. The new target is 5-6cm in adults (instead of at least 5cm) 10 breaths per minute. If an enlarged airway (endotracheal tube, LMA, etc.) is in place, everyone receives only 10 breaths per minute. This applies to children and infants, and CAB is the alphabet. No change, just a statement of support. Start with compression to reduce the delay to the first compression. Compression is not only approved for CPR. If you are a trained provider, keep giving rescue breaths. They point out our confidence in equivalence between breast compression only and standard CPR is not enough to change the current practice The drug bezospressin is OUT. A change that is unlikely to affect many providers. This change is not because asoppressin is in anyway worse than epinephrine, but because it has equivalent results so that they only list epinephrine to simplify the algorithm. (I'm not going to start here on the question of whether epinephrine actually provides every benefit.) Give epinephrine early in non-shock rhythms. Based on an observational study, they say if you're going to give epinephrine, you should probably get epinephrine on board as soon as possible in non-shocking rhythms. (For a full review of the evidence of epinephrine, see this post.) 1. epinephrine, the combination of steroids is not recommended. They discuss the trials they see as very low quality evidence. They say we offer against routine steroid use during CPR for OHCA (weak recommendation, very low quality evidence). The guidelines recognise the balance in terms of the role of medicines in improving cardiac arrest outcomes. Personally, I think most of the evidence shows that drugs are more likely to be harmful (putting patients in intensive care just to die anyway) than they are useful. Naloxone has been added to the guidelines. In patients with known or suspected dependence on opioids who do not breathe normally but have a pulse, it is reasonably trained thnethe rescuers and BLS providers to administer naloxone. The listed doses are 2mg intranasally or 0.4mg IM. They suggest a standard after the standard ALS algorithm if the patient does not have a pulse, but indicate that the provision of a dose of naloxone may be reasonable based on the possibility that the patient may be in respiratory distress. 2015 adult cardiac arrest ALS algorithm Capnography wave caponography gets a little more attention than in the past. They say: Wave capnography is the most reliable method of confirming and continuously monitoring the tracheal placement of the tubesUnion tidal tube, less CO2, after 20 minutes is associated with an extremely low chance of survival, but should not be used independently in the decision to stop resuscitationWaveform capnography can be used to monitor the speed of ventilationWaveform capnography can be used to monitor the quality of CPRPRPR. (High quality compressions must produce final CO2 of at least 12-15 mmHg). Increasing final CO2 can be used as an early indication of ROSC Technology Social media has a role in stopping cardiac activity. Or maybe there is. In particular, they say: It may be wise for communities to incorporate social media technologies that call rescuers who are in close proximity to a victim of the alleged OHCA and are ready and able to perform CPR. Mechanical chest compresses are not recommended. At least not routinely. The evidence shows no benefit from the use of mechanical piston devices for chest compression against manual chest compressions in cardiac arrest patients. They argue that mechanical compression is a reasonable alternative if sustainable high-quality compresses are impractical or compromising the safety of the supplier. Do not use (routinely) devices with an impedance threshold. It's no surprise here. Although I know that some people absolutely love them, most of the evidence so far is completely inconclusive. The IMO is narrow. They argue that ECMO is a reasonable alternative to sire, if etiology is considered reversible. Ultrasound: Added as an additional method of ETT confirmation. It's probably not big. Great. changer for most with quantitative extreme tidal, TIDAL ultrasonicators may have a role in identifying reversible causes of arrest in addition to myocardial contractiles, although it is not clear whether this affects clinical results after resuscitation care oxygen They are looking for the Goldilocks zone: not too little, not too much. They recommend specifically against hypoxia and hyperoxia in the period after resuscitation. Basically, follow your O2 sadd when arresting when O2 were unreliable, they recommend using 100% Fio2 cardiac catheterization There is a greater emphasis on the need for an emergency coronary catheter, if arrest is likely to be cardiac in nature Temperature They recommend choosing and maintaining the target temperature, based on data with low or very low quality target temperatures, which now recommend, are between 32 and 36 degrees Celsius the recommendation to prevent fever is based on very low quality evidenceDogged cooling special circumstances Pregnancy No more tilting the patient. It is no longer recommended to use a wedge or attempt to side-tilt the patient, because this will interfere with the quality of CPR. Just manually shift the uterus to the left. (Most people already teach this) Perimortem C-sections are still recommended after 4 minutes of CPR without ROSC. However, if the mother apparently will not survive, such as with non-surviving trauma, they recommend to immediately start the C-section of hypothermia ECLS for unstable hypothermia. Patients with hypothermia without signs of cardiac instability can be re-welded externally, using minimally invasive techniques. Patients with symptoms of cardiac instability should be transferred directly to a center that can be used for extracorporeal life support (ECLS). Trauma They added a specific algorithm for traumatic arrest. Immediate actions are aimed at the key reversible causes: hypoxia, stretch motorax, tamponade and hypovolemia. The ERC 2015 Pediatrics Traumatic Arrest Algorithm should be 15:2 if there are multiple providers, but 30:2 if there is only one provider. Do not use CPR alone. Adhere to standard CPR (with breathing) due to the high rate of asphyxia. However, if the rescuer does not wish to provide life-saving breaths, advise compression only CPR When advanced airways on site, give 10 breaths per minute (as adults) no matter what the patient's age. Atropine No routine atropine for endotracheal intubationDizing now strictly based on weight (0,02 mg /kg). No confusing minimum dose single cardioversion of electric dose. At EDM, there were many different doses for cardioversion. It is now recommended only to use 1 joule /kg. 2015 Pediatric Cardiac Arrest Alogrithm Neonatal Resuscitation The NRP Algorithm is Actually with the biggest changes, as far as I can tell. I go into more detail about resuscitation post for newborns. One big change that people need to know about is that the presence of mekonium does not require intubation unless tracheal obstruction is suspected. No matter what the fluid is, they want us to start ventilation as soon as possible. Examination of the evidence suggests that resuscitation should follow the same principles for infants with methniium-colored liquid as for those with clear liquid; that is, if there is poor muscle tone and inadequate breathing, the initial steps of resuscitation (warming and maintaining the temperature, positioning the baby, clearing the airways, if necessary, drying and stimulating the baby) should be completed under a reheating bottom. 2015 Neonatal Resuscitation Algorithm References and Resources Full AHA ACLS Guidelines are published in Circulation The ERC Guidelines are published in Resuscitation or may be accessed through the European Resuscitation Council: Summary of major changes to the ERC Guidelines 2015 AHA ACLS Guidelines: Highlights Cite this article as: Justin Morgenstern, The 2015 ILCOR/AHA/ERC Advanced Life Support Guidelines (ACLS), First10EM blog, October 21, 2015. Available on: . .

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