# PC02 Pediatric Asystole & Pulseless Electrical Activity

**Objectives:**

- Early recognition and appropriate intervention for pediatric patients in asystole or PEA

**General Information:**

- During CPR
  a) Push hard, push fast (100/min)
  b) Ensure full chest recoil
  c) Minimize interruptions in compressions
  d) One person CPR: 30 compressions: 2 breaths, two minutes = 5 cycles
  e) Two person CPR: 15 compressions: 2 breaths, two minutes = 10 cycles
  f) Avoid hyperventilation
  g) After an advanced airway is in place, rescuers no longer deliver "cycles" of CPR. Give continuous compressions without pauses for breaths (Give 8-10 breaths per minute)
  h) Check rhythm every two minutes
  i) A two-thumb encircling technique is preferred for infants
- Epinephrine
  a) IV/IO 0.01 mg/kg (1:10,000 0.1ml/kg) every 3-5 minutes
  b) ETT 0.1 mg/kg (1:1000 0.1 ml/kg added to 2-5 ml NS max of 10 ml of fluid)
- Atropine is not routinely used for pediatric asystole/PEA
- Endotracheal administration of medications should be used ONLY when IV/IO access is not available
- A BLS airway is an adequate airway. A brief attempt at an advanced airway by an experienced provider is appropriate
- Search for and treat possible contributing factors:
  a) Hypovolemia
  b) Hypoxia
  c) Hydrogen ion (acidosis)
  d) Hypoglycemia
  e) Hypo-/hyperkalemia
  f) Hypo-/hyperthermia
  g) Tension pneumothorax
  h) Toxins
  i) Tamponade, cardiac
  j) Thrombosis (coronary or pulmonary)
  k) Trauma

## Warnings/Alerts:

- CPR may still be required in the presence of an organized rhythm

**OMD Notes:**

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**References:**

AHA Pediatric Advanced Life Support Provider Manual, 2006, p. 166-168

**Performance Indicators:**

| | | |
|---|---|---|
| Onset of Arrest Time | Initial Rhythm | Bystander/FR CPR/AED |
| Time of Initial Treatment | Changes in EKG Rhythm | Confirmation of Airway |
| Consistency of CPR | Patient Packaging | Patient Disposition |

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