

Advanced Life Support (Child)

Table 2.12 – ASSESSMENT and MANAGEMENT of:

Advanced Life Support (Child) *continued*

ASSESSMENT	MANAGEMENT
<ul style="list-style-type: none"> Consider and correct reversible causes: 4Hs 4Ts 	<ol style="list-style-type: none"> Hypoxia Hypovolaemia Hyper/hypokalaemia Hypothermia Tension pneumothorax Tamponade Toxic/therapeutic disturbance Thromboembolism
<p>6. Shockable (VF/pulseless VT) These rhythms are less common in paediatric practice but more likely when there has been a witnessed and sudden collapse or in children with underlying cardiac disease</p>	<p>Defibrillate the heart:</p> <ul style="list-style-type: none"> Give 1 shock of 4 Joules/kg if using a manual defibrillator, rounding the shock up as necessary to the machine settings (this energy level is appropriate for both biphasic and the older monophasic defibrillators). If using an AED in a child over the age of 8 years, use the adult shock energy – paediatric attenuation is not required. If using an AED in a child under the age of 8 years, use a machine with paediatric attenuation (according to the manufacturer's instructions) when available. <p>An AED should not routinely be attached to infants unless they have a history of cardiac problems. Where an infant is found to have a shockable rhythm, use a manual defibrillator to administer 4 Joules/kg. (In infants, if a manual defibrillator is not available, a paediatric attenuated AED may be used.) If no paediatric attenuated AED is available, use the adult shock energy at all ages.</p> <ul style="list-style-type: none"> Resume CPR: without re-assessing the rhythm or feeling for a pulse, resume CPR immediately, starting with chest compressions. Continue CPR for 2 minutes.
<ul style="list-style-type: none"> Then pause briefly to check the monitor 	<p>If still VF/pulseless VT:</p> <ul style="list-style-type: none"> Give a 2nd shock at 4 Joules/kg as for the 1st shock (see start of step 6). Resume CPR immediately after the second shock.
<ul style="list-style-type: none"> Consider and correct reversible causes 	<ul style="list-style-type: none"> 4Hs 4Ts (see above.) Continue CPR for 2 minutes.
<ul style="list-style-type: none"> Pause briefly to check the monitor 	<p>If still VF/pulseless VT:</p> <ul style="list-style-type: none"> Give a 3rd shock followed by adrenaline 10 micrograms/kg PLUS an intravenous or intraosseous bolus of amiodarone 5 milligrams/kg (refer to amiodarone guideline for further information). Resume CPR immediately and continue for another 2 minutes.
<ul style="list-style-type: none"> Pause briefly to check the monitor 	<p>If still VF/pulseless VT:</p> <ul style="list-style-type: none"> Give a 4th shock. Resume CPR, and continue giving shocks every 2 minutes, minimising the breaks in chest compressions as much as possible. Give adrenaline after every other shock (i.e. every 3–5 minutes) and a second dose of amiodarone following the 5th shock (refer to amiodarone guideline for further information) until ROSC.
<ul style="list-style-type: none"> After each 2 minutes of uninterrupted CPR, pause briefly to assess the rhythm 	<p>If still in VF/VT:</p> <ul style="list-style-type: none"> Continue CPR with the shockable rhythm (VF/VT) sequence. <p>If asystole:</p> <ul style="list-style-type: none"> Continue CPR and switch to the non-shockable (asystole/PEA) sequence as above.
<ul style="list-style-type: none"> If an organised rhythm appears at any time, check for a central pulse 	<ul style="list-style-type: none"> If there is return of a spontaneous circulation (ROSC) begin post-resuscitation care. If there is NO pulse, and there are no other signs of life, or you are not sure, continue CPR as for the non-shockable sequence as above.

Methodology

For details of the methodology used in the development of this guideline refer to the guideline webpage.

[Further related reading includes 63, 75]