Pediatric Asystole / PEA

**History**
- Events leading to arrest
- Estimated downtime
- Past medical history
- Medications
- Existence of terminal illness
- Airway obstruction
- Hypothermia
- Suspected abuse (shaken baby syndrome, pattern of injuries)
- SIDS

**Signs and Symptoms**
- Apneic
- Pulseless

**Differential**
- Respiratory failure
- Foreign body
- Hypothermia
- Infection
- Congenital heart disease
- Trauma
- Tension pneumothorax
- Toxin or medication
- Acidosis
- Hyperkalemia
- Hypoglycemia

---

**Decomposition**
- Rigor mortis
- Dependent lividity

**Injury incompatible with life or unwitnessed traumatic arrest with asystole**

- Do not begin resuscitation
- Follow Policy 1004 – Determination of Death

**Follow rhythm appropriate TG**

---

**Search for reversible causes**

- Establish IV/IO
- Epinephrine (1:10,000) IO/IV
  - Repeat every 3 to 5 minutes
  - Use Pediatape and refer to dosing guide
- Normal saline fluid bolus IO/IV
  - Use Pediatape and refer to dosing guide
- Consider Chest Decompression Procedure

---

**Criteria for discontinuation?**

- Yes

---

**AT ANY TIME**

**Return of spontaneous circulation**

**Go to Post Resuscitation TG**

---

**Reversible Causes**

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypothermia
- Hypo / Hyperkalemia
- Hypoglycemia
- Tension pneumothorax
- Tamponade (cardiac)
- Toxins
- Thrombosis (pulmonary)(PE)
- Thrombosis (coronary)(MI)

---

**Discontinue Resuscitation**

- Follow Policy 1004 – Determination of Death

---

**Pearls**

- Patients with a rapid pulseless rate are most likely hypovolemic. Fluid will likely reverse this condition.
- In order to be successful in pediatric arrests, a cause must be identified and corrected.
- Respiratory arrest is a common case of cardiac arrest. Unlike adults, early airway intervention is critical.
- In most cases, pediatric airways can be maintained with basic interventions.