IRC 2021

CONGRESSO NAZIONALE

16•17•18 DICEMBRE

NUOVE LINEE GUIDA 2021: RIANIMAZIONE CARDIOPOLMONARE POST-LOCKDOWN

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Rimini IRC 2021 CONGRESSO NAZIONALE 16•17•18 DICEMBRE POST-LOCKDOWN

EUROPEAN RESUSCITATION COUNCIL GUIDELINES 2021

ADVANCED LIFE SUPPORT

Algoritmo ALS

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“Non è necessario rinunciare al passato per entrare nel futur
Quando si cambiano le cose non è necessario perderle.”

ALS 2021

5 TOP MESSAGES

1. High-quality chest compression with minimal interruption, early defibrillation, and treatment of reversible causes remain the priority

2. Premonitory signs and symptoms often occur before cardiac arrest in- or out-of-hospital - cardiac arrest is preventable in many patients

3. Use a basic or advanced airway technique - only rescuers with a high success rate should use tracheal intubation

4. Use adrenaline early for non-shockable cardiac arrest

5. In select patients, if feasible, consider extracorporeal CPR (eCPR) as a rescue therapy when conventional ALS is failing

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Rimangono prioritarie le compressioni toraciche di alta qualità con minima interruzione e defibrillazione percoce

KEY RECOMMENDATIONS

Give a shock as early as possible for a shockable cardiac arrest

Deliver shocks with minimal interruption to chest compression, and minimise the pre-shock and post-shock pause – with a manual defibrillator aim for a total pause of less than 5 seconds

Aim for less than a 5 second interruption in chest compression for tracheal intubation

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HIGH-QUALITY CPR WITH MINIMAL INTERRUPTION

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KEY EVIDENCE

Early CPR, early defibrillation when appropriate, and high-quality CPR with minimal interruption improves survival from cardiac arrest

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PREVENTION OF CARDIAC ARREST

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Riconosciuta l'importanza dei segni premonitori, probabilmente prevedibili

KEY EVIDENCE

In-hospital cardiac arrest is often preceded by physiological deterioration

Sudden cardiac death in the community is often preceded by unrecognised signs and symptoms

This provides an opportunity to recognise those at risk and prevent the cardiac arrest

KEY RECOMMENDATIONS

Hospitals should have a clear policy for the clinical response to abnormal vital signs and critical illness

Symptoms such as chest pain, or syncope (especially during exercise, while sitting or supine), should be investigated

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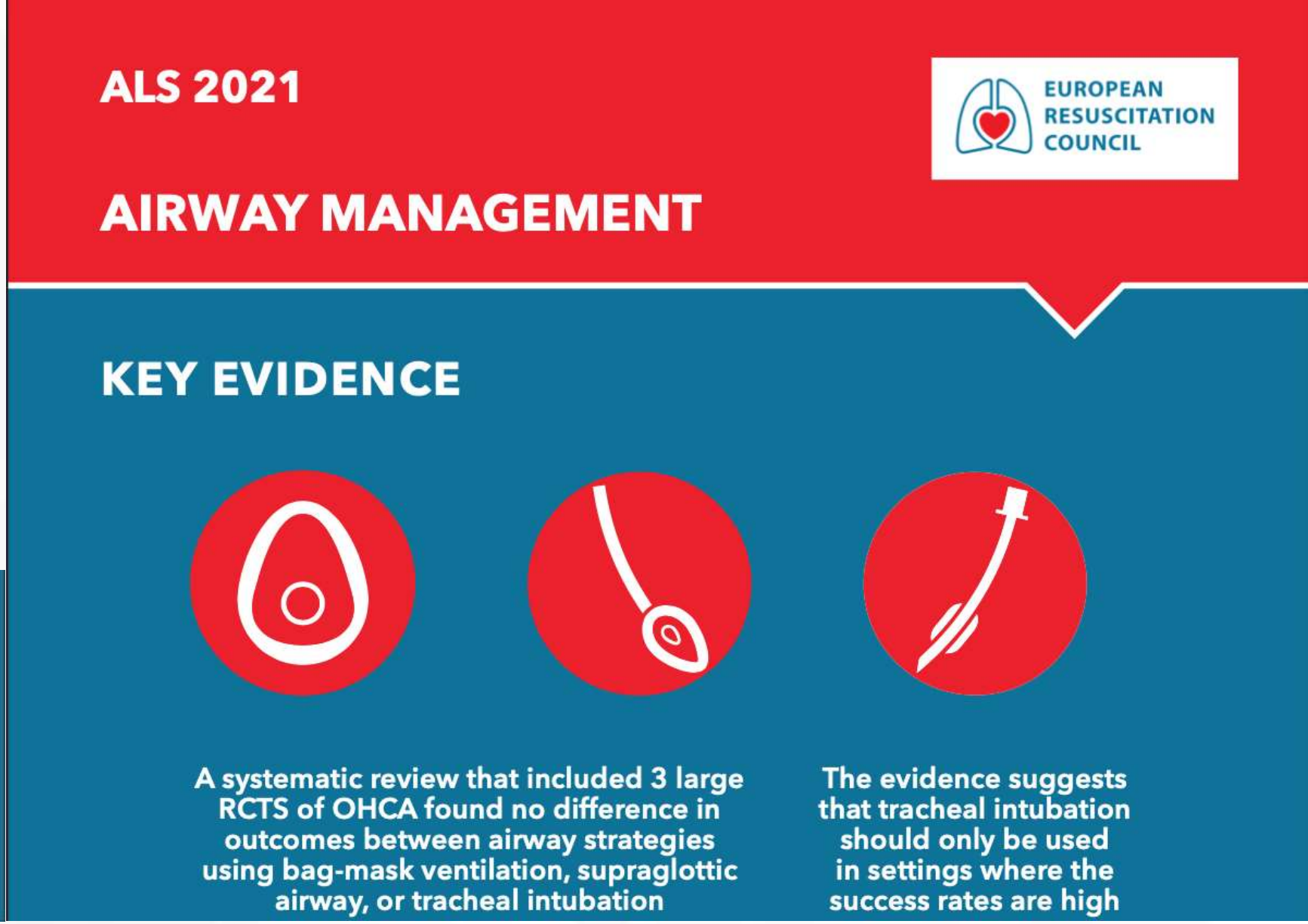
Iniziare con tecniche di intubazione di base per proseguire in accordo con l'abilità del soccorritore



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ASAP quando l'arresto è da ritmo non defibrillabile, dopo il 3° shock nel paziente con ritmo defibrillabile

KEY RECOMMENDATIONS

Give adrenaline 1 mg IV (IO) as soon as possible for adult patients in cardiac arrest with a non-shockable rhythm

Give adrenaline 1 mg IV (IO) after the 3rd shock for adult patients in cardiac arrest with a shockable rhythm

Repeat adrenaline 1 mg IV (IO) every 3-5 minutes whilst ALS continues

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ADRENALINE

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KEY EVIDENCE

If used, adrenaline is most likely to be beneficial when given early

Any benefit from adrenaline is likely to to be greater for a non-shockable rhythm cardiac arrest

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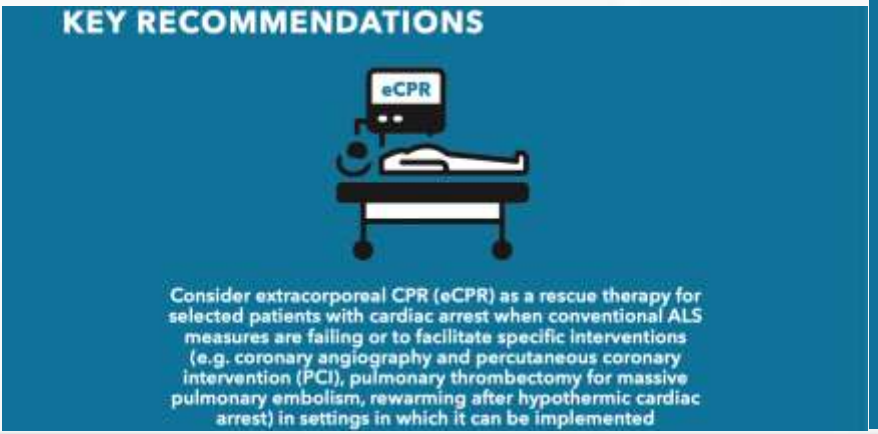
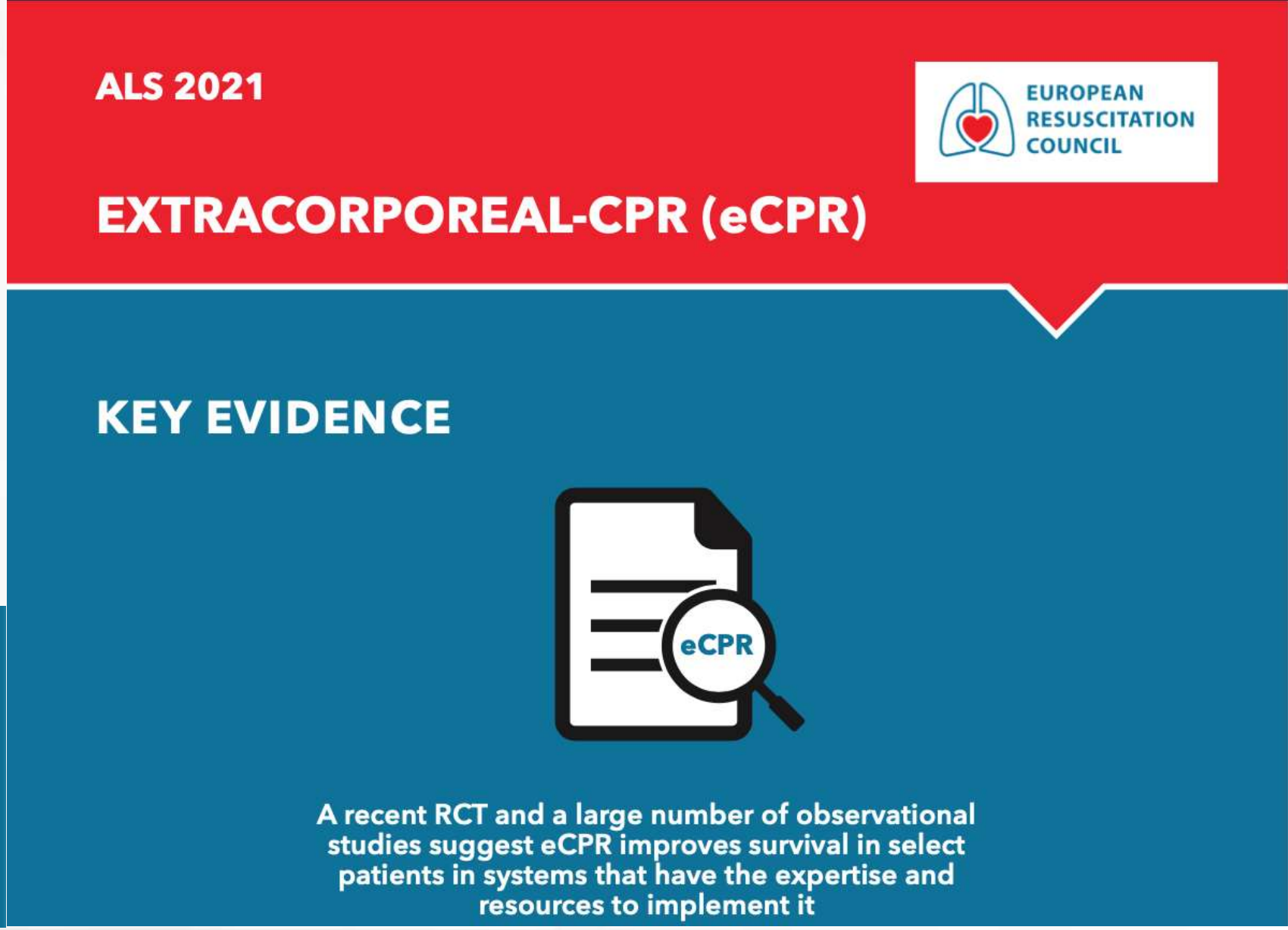
Evidenza della RCP extracorporea (eCPR) come trattamento per pazienti selezionati





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Algoritmo ALS

Unresponsive with absent
or abnormal breathing

Give high-quality chest compressions and

- Give oxygen
- Use waveform capnography
- Continuous compressions if advanced airway
- Minimise interruptions to compressions
- Intravenous or intraosseous access
- Give adrenaline every 3-5 min
- Give amiodarone after 3 shocks
- Identify and treat reversible causes

Identify and treat reversible causes

- Hypoxia
- Hypovolaemia
- Hypo-/hyperkalemia/metabolic
- Hypo-/hyperthermia
- Thrombosis – coronary or pulmonary
- Tension pneumothorax
- Tamponade- cardiac
- Toxins

Consider ultrasound imaging to identify reversible causes

Consider

- Coronary angiography/percutaneous coronary intervention
- Mechanical chest compressions to facilitate transfer/treatment
- Extracorporeal CPR

After ROSC

- Use an ABCDE approach
- Aim for SpO_2 of 94-98% and normal $PaCO_2$
- 12 Lead ECG
- Identify and treat cause
- Targeted temperature management

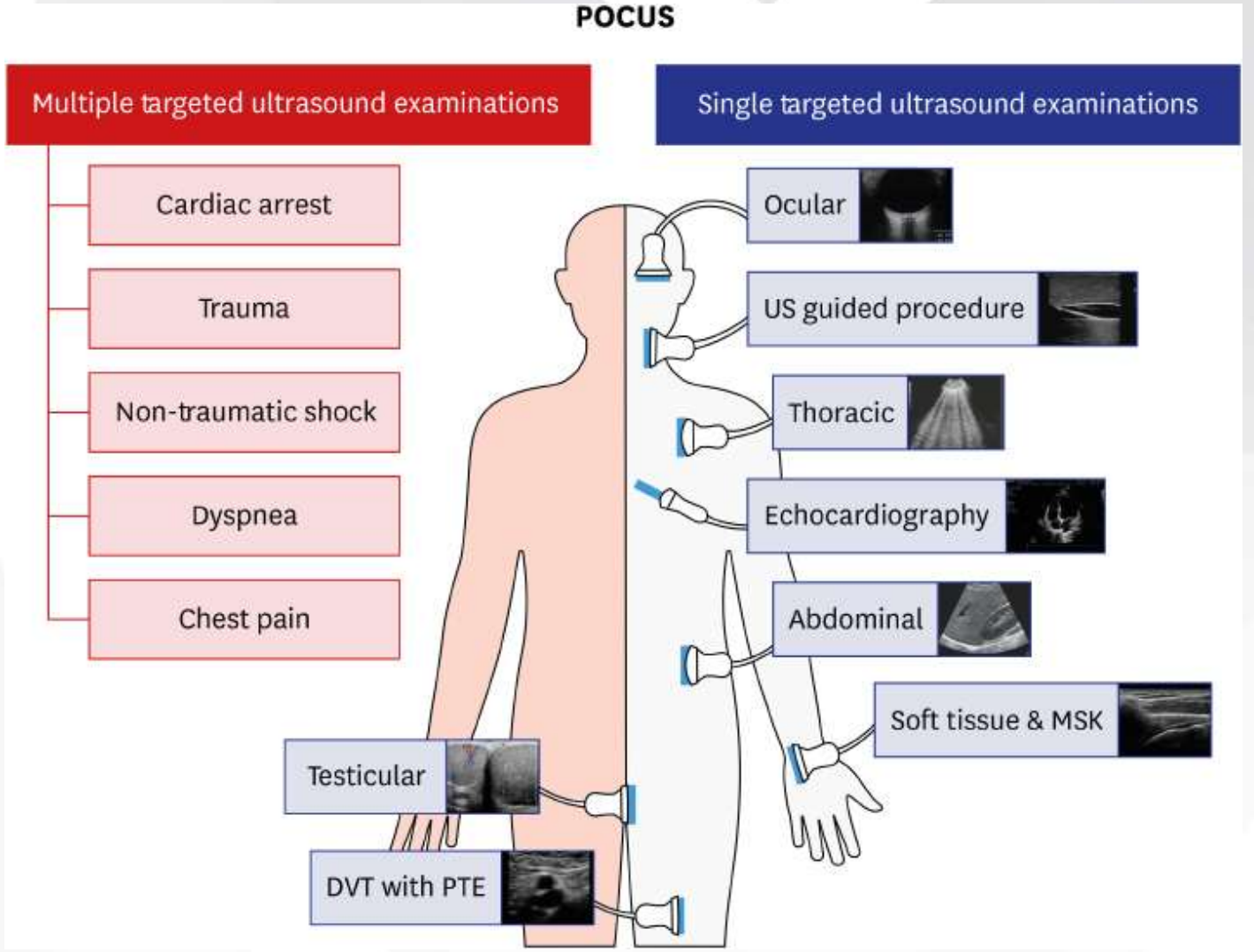
POCUS ultrasound imaging

- **Solo operatori esperti**

che non comporti ulteriori interruzioni al massaggio

Utile nella diagnosi di cause reversibili

Non utilizzare la contrattilità miocardica come unico indicatore per terminare la RCP



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End-of-life care

- Non ci sono indicazioni universali per la l'interruzione delle manovre di rianimazione

Il luogo in cui ci si trova, la cultura e il contesto legale devono essere valutati

Va considerata la sospensione della RCP dopo un'asistole prolungata (>20 minuti) in assenza di confounding bias, ritmo iniziale non defibrillabile o severa comorbidità

Non rianimare se non è in accordo con la volontà del paziente, se ci sono segni certi di morte o lesioni incompatibili con la vita, o se c'è pericolo per i soccorritori

I seguenti riscontri non devono essere utilizzati come unico indicatore per la sospensione della RCP

Pupille midriatiche o non reattive
RCP prolongata
$ETCO_2$
Comorbidità
Tentato suicidio

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