

MANAGEMENT OF SHOCK AFTER ROSC ALGORITHM

OPTIMIZE VENTILATION AND OXYGENATION

- Titrate FI_{O_2} to maintain oxyhemoglobin saturation 94%-99%; if possible, wean FI_{O_2} if saturation is 100%
- Consider advanced airway placement and waveform capnography



ASSESS FOR AND TREAT PERSISTENT SHOCK

- Identify, treat contributing factors*
- Consider 20 mL/kg IV/IO boluses of isotonic crystalloid. Consider smaller boluses (eg. 10 mL/kg) if poor cardiac function suspected.
- Consider the need for inotropic and/or vasopressor support for fluid-refractory shock.

*POSSIBLE CONTRIBUTING FACTORS

Hypovolemia
Hypoxia
Hydrogen Ion (acidosis)
Hypoglycemia
Hypo-/hyperkalemia
Hypothermia
Tension pneumothorax
Tamponade, cardiac
Toxins
Thrombosis, pulmonary
Thrombosis, coronary
Trauma



HYPOTENSIVE SHOCK

- > Epinephrine
- > Dopamine
- > Norepinephrine

NOMOTENSIVE SHOCK

- > Dobutamine
- > Dopamine
- > Epinephrine
- > Milrinone



- > Monitor for and treat agitation and seizures
- > Monitor for and treat hypoglycemia
- > Assess blood gas, serum electrolytes, calcium
- > If patient remains comatose after resuscitation from cardiac arrest, consider therapeutic hypothermia (32°C-34°C)
- > Consider consultation and patient transport to tertiary care center

