Acute Myocardia Infarction (AMI)

CAB's (Formally ABC's)
Start "OMI"
O- Oxygenation M- Monitors I - IV
- Determine Unstable vs Stable & utilize appropriate algorithm
- Twelve Lead EKG ASAP & diagnostic labs
- Consider ASA, Analgesia, Anticoagulant
- Consider fibrinolytics (ST^a, Hx, S/S)
- Consider other tx (i.e. antiarrythmics, Beta blockers, ACE inhibitors, Group IIb/IIIa receptor antagonists)

VF (Refractory) / Pulsesless VT CAB's

(formerly ABC's) - No pulse - Call for code cart
"ICEM " (until defibrillator arrives)
I - IV
C - CPR E - Endotracheal intubation
M- Monitoring equipment
- Verify VF w/defibrillator and initiate the following tx: Electrical Therapy
Defib 360j w/clear (monophasic), use Rx dose (biphasic)
Simultaneously complete ICEM and initiate following tx:
Drug Therapy -
Epinephrine- (1mg q 3-5 min) or *Vasopressin* 40 U IV (once)* followed by Epinephrine in 3-5 minutes
Amiodaron- e 300 mg IV push, repeat ONCE in 3-5 minutes at 150 mg IV bolus
Lidocaine- (1.5 mg/kg to max 3 mg/kg)
*Magnesiu*m Sulfate (1-2 gm over 1-2 min) Consider and Treat Causes (Volume, Rhythm, Pump)

Pulseless Electrical Activity

- CAB's (formerly ABC's) - if no pulse, call for code cart
- "ICEM"
- Drug Therapy -
Epinephrin- e (1mg q 3-5 min) or *Vasopressin* 40 U IV* (once) followed by Epinephrine in 3-5 minutes Consider and Treat Causes (Volume, Rhythm, Pump)

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ALGORITHM SUMMARY PAGE©
AHA guidelines

Asystole

- ABC's - if no pulse, call for code cart
- "ICEM" (*Confirm rhythm and pulse asystolic)* - Drug Therapy

Epinephrine- (1mg q 3-5 min) or *Vasopressi*n 40 U IV* (once) followed by Epinepherine in 3-5 minutes

Bradycardia -- Rate < 60 bpm & inadequate for clinical condition

- CAB's (formerly ABC's) - call for code cart - Start "OMI"
- Determine Stable vs Unstable

If adequate perfusion, observe and monitor

If inadequate perfusion,
- Transcutaneous Pacing (TCP)
- Consider Atropine (1 mg → 3 mg) while awaiting pacer
- Consider Epinephrine (2-10 µg /min) or
- Dopamine (5-20 µg/kg/min) Consider and Treat Causes

Tachycardia

- CAB's (formerly ABC's) - call for code cart - "OMI"
- Stable vs Unstable

Narrow Complex (Stable)

Regular
- Vagal manuevers
- Adenosine (6 mg, 12 mg & 12 mg)
- Diltiazem
- Beta blockersIrregular
- Diltiazem
- Beta blockers

Narrow Complex (Unstable

If unstable, sedate and cardiovert
- A-Fib initial dose 100-200 j
- A-flutter & SVT initial dose 50-100 j

SVT *(with aberrancy)*

- Adenosine 6mg, 12mg and 12 mg

Irregular
A-Fib (with aberrancy)
- Cardizem
- Beta Blockers

A-Fib with WPW (look for delta wave)
Avoid adenosine, digoxin, cardizem, verapamil
- Consider amiodarone 150 mg IV over 10 min

Wide Complex Tachycardia (Stable)

Ventricular Tachycardia (monomorphic) - Amiodarone 150 mg IV over 10 min. - Consider cardioversion Ventricular Tachycardia (polymorphic)
- Magnesium Sulfate 1-2 g over 1-2 min

Wide Complex (Unstable)

V-Tach (monomorphic)
- Sedate and cardiovert initial dose 100 j, then stepwise progression to

200, 300, 360 j (monophasic) Use Rx dose (biphasic)

V-Tach (polymorphic)
- Debrillate at 360 j (monophasic), Rx dose (biphasic)

Acute Stroke

First 10 Minutes
- CAB's (formerly ABC's) - call for code cart - "OMI"
- Determine rhythm & tx if unstable, obtain 12 lead
- Begin R/O of other causes (glucose, ETOH, trauma, et al)
- General neurological screening
- Alert Stroke Team

First 25 minutes (*include protocol for the first 10 minutes*) - Establish onset (less than 3 hours since symptom onset) - Physical/neurological exam (LOC, stroke severity)
- Urgent non-contrast CT (read with 45 min from arrival)

* Taken out of protocol due to "simplicity purposes" by AHA.

Revised 09/2025