Acute Myocardial Infarction (AMI)

CAB
"OMI"
O - Oxygenation
M - Monitoring equipment (EKG/capnography)
I - IV/IO
Stable versus Unstable
- Utilize appropriate algorithm
- Twelve lead EKG ASAP & diagnostic labs
- Consider ASA (162-325 mg), analgesia, anticoagulants
- Consider fibrinolytics
- Consider other tx (i.e. antiarrhythmics, β blockers, ACE inhibitors, Group IIb/IIIa receptor antagonists)

VF / Pulseless VT

CAB – call for code cart
"ICEM" (until defibrillator arrives)
I - IV / IO
C - CPR
E - Endotracheal intubation or supraglottic device
M - Monitoring equipment (EKG / capnography)
Stable versus Unstable
- Defib q 2 minutes until successful or non-shockable rhythm appears. **Use manufacturer dose or, if unknown, utilize max defibrillation dose.*
- Pharmacologic Therapy (after 2nd unsuccessful defib)
  - Epinephrine - (1mg q 3-5 min – consider q 4) or Vasopressin 40 U IV (once)
  - Amiodarone 300 mg IV push, repeat once in 3-5 minutes w/150 mg IV push
  - Lidocaine - 1.5 mg/kg to max 3 mg/kg
- Consider and treat causes (hypomagnesemia, pH, hypoxia, pH, temp, trauma, electrolytes, AMI, etc.)

Asystole/Pulseless Electrical Activity (PEA)

CAB - call for code cart
"ICEM"
I - IV / IO
C - CPR
E - Endotracheal intubation or supraglottic device
M - Monitoring equipment (EKG / capnography)
Stable versus Unstable
- Pharmacologic Therapy
  - Epinephrine (1mg q 3-5 min) or Vasopressin 40 u IV (once)
- Consider and treat causes (hypovolemia, pH, temp, electrolytes, pH, hypoxia, traumas, AMI, etc.)

**Confirm asystole in at least two leads*

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ACLS Algorithm Summary Page©

2025 AHA guidelines

Bradycardia (< 60 bpm)

CAB
"OMI"
Stable versus Unstable
- **Stable but symptomatic**
  Pharmacologic Therapy
  - Atropine (1 mg, max 3 mg)
  - Epinephrine (2-10 µg /min)
  - Dopamine (5-20 µg/kg/min)
- **Unstable**
  Electrical Therapy
  - Transcutaneous Pacing (TCP)
- Consider and Treat Causes (opioids, β blockers, vasovagal, hypothyroid, hypothermia, etc.)

Supraventricular Tachycardia (> 150 bpm)

CAB
"OMI"
Stable vs Unstable
- **Stable Narrow Complex and Regular**
  Pharmacological Therapy / Vagal Interventions
  - Vagal maneuvers
  - Adenosine (6 mg, followed by 12 mg & 12 mg)
  - Diltiazem 0.25 mg/kg IV bolus over 2 min
  - β blockers (caution w/alpha/β stimulants)
- **Unstable Narrow Complex and Regular**
  Electrical Therapy
  - Cardioversion at 100 J

Atrial Fibrillation / Flutter

(w/o pre-excitation/left ventricular dysfunction)
CAB
"OMI"
Stable versus Unstable
- **Stable**
  Pharmacologic Therapy
  - Diltiazem 0.25 mg/kg IV bolus over 2 min
  - β Blockers (see specific dose recommendations)
- **Unstable**
  Electrical Therapy
  – Cardiovert at ≥200 J

Wide Complex Tachycardia

CAB
"OMI"
Stable versus Unstable
- **Stable**
  Pharmacologic Therapy
  - Adenosine only if regular and monomorphic
  - Amiodarone 150 mg IV over 10 min
  - Procainamide 20-50 mg over 10 min
    **Caution: D/C drip if hypotension occurs, QRS duration increases by > 50%, or max dose 17 mg/kg*
- **Unstable**
  Electrical Therapy
  – Cardiovert at 100 J

**If polymorphic, treat with defibrillation dose.*

Acute Stroke

First 10 Minutes
CAB - call for code cart
"OMI"
Stable versus Unstable
- Determine rhythm & tx if unstable, obtain 12 lead EKG
- Consider other causes of symptoms (glucose, ETOH, trauma, hypoxia, infection, substance abuse, etc.)
- General neurological screening
- Alert Stroke Team

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

Revised October 2025 – Material subject to change