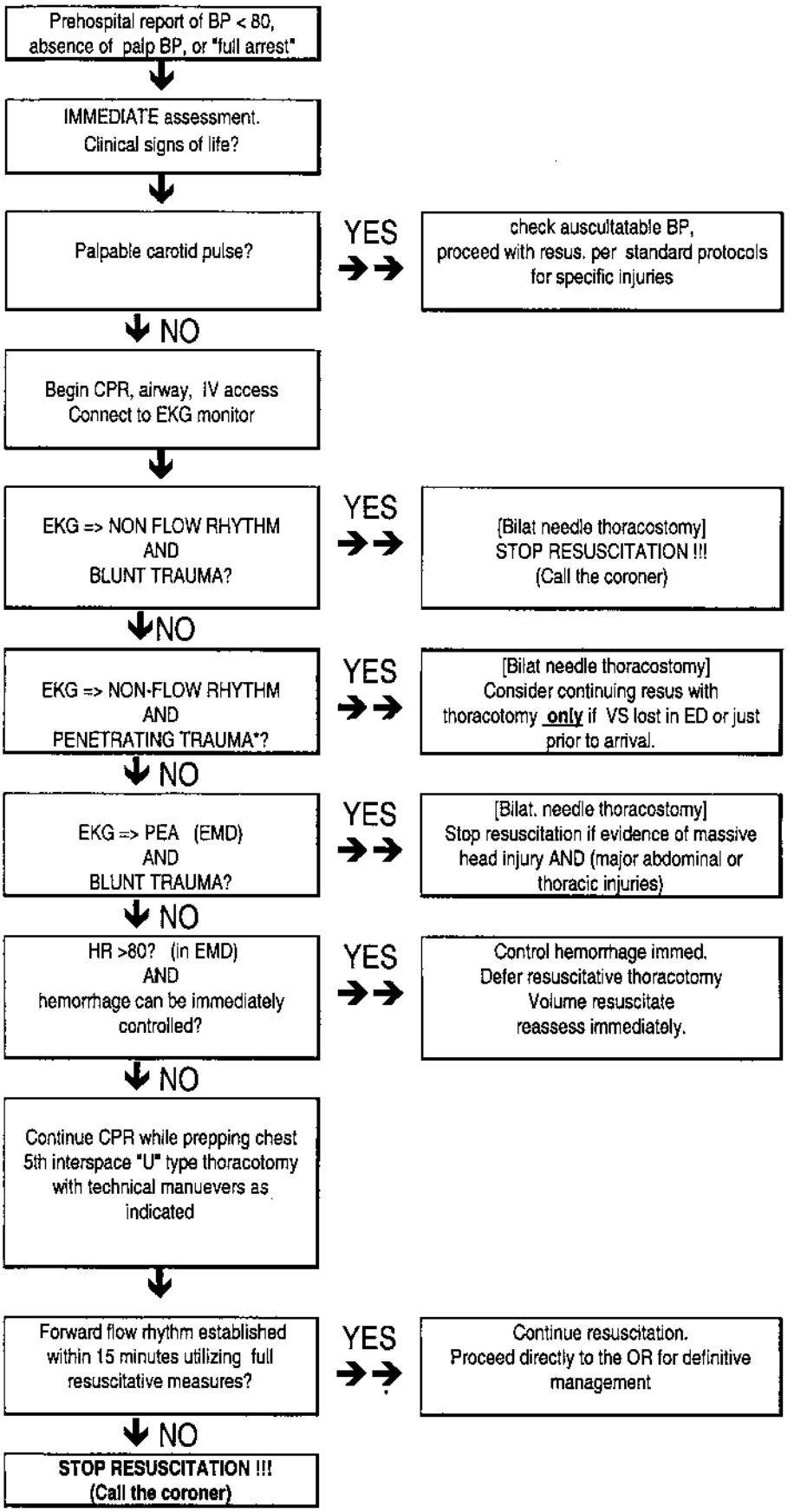

COMMENTS

Assessment under these circumstances should be performed as soon as possible, even during transport from the ambulance bay.

The assumption in this algorithm is that non-flow cardiac rhythms and EMD have resulted from end-stage hemorrhagic shock cardiac tamponade, or tension pneumothorax.

- volume resus. should utilize type 'O' pk. cells
- mass. trans. protocol is usually activated
- correct placement of EKG leads MUST BE VERIFIED

NON FLOW RHYTHMS: (NFR)
- asystole
- V-fib
- agonal bradycardia, BLUNT: HR < 60
- agonal bradycardia, PENETR. : HR < 30

On rare occasions, cardiac arrest is caused by or exacerbated by tension pneumothorax. Althought survival is still extremely low, bilat. needle thoracostomies are recommended.

- ISOLOATED, PULSELESS (EMD) massive head injuries should be resuscitated in the event they are eligible as organ donors.

- Resuscitative thoracotomy may be deferred in carefully selected patients bleeding from known, easily controled sources (e.g.scalp lacs, amputations) IF they are not RELATIVELY bradycardic.

Technical manuevers for RT include:
- open cardiac massage
- aortic X-clamping
- pulmonary hilar X-clamp for severe pulm ing
- pericardial decompression & control of heart wounds for cardiac tamponade
- direct cardiac injection of drugs in needed.
- open chest defibrillation if needed.

The ultimate success of RT will depend on the:
- extent and duration of the shock state
- rapidity of flow restoration to heart & brain
- "fixability" of the traumatic lesion

MANAGEMENT ALGORITHM FOR RESUSCITATIVE THORACOTOMY (RT)

REV. 7/27/96