**EMERGENCY NUMBERS:**

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To report adverse events & near misses: [HTTP://WWW.AQIAIRS.ORG](HTTP://WWW.AQIAIRS.ORG)

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**EMERGENCY MANUAL**

COGNITIVE AIDS FOR PERIOPERATIVE CRITICAL EVENTS 2016, V3.0

STANFORD ANESTHESIA COGNITIVE AID GROUP
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How this work came to be:

This Emergency Manual has a long history, evolving from decades of prior work on both Crisis Resource Management (CRM) concepts and cognitive aids for critical incidents. The 1994 book entitled ‘Crisis Management in Anesthesiology’ by Dr. David Gaba, Dr. Steven Howard, and Dr. Kevin Fish provided the initial foundations for this project. Their simulation group has been involved in developing cognitive aids for operating rooms in the Palo Alto VA and then a national VA project, each with bulleted points for many critical events. Observing that practitioners often miss key actions under stress, Drs. Harrison and Goldhaber-Fiebert along with Dr. Geoff Lighthall, Dr. Ruth Fanning, Dr. Howard, and Dr. Gaba developed several iterations of pocket cards for perioperative critical events, including some with rhythm strips, icons, and color design. In 2004, Dr. Larry Chu conceived of adapting crisis management cognitive aids to a more visually striking format for a new book he envisioned for today’s highly visual millennial learners. This became The Manual of Clinical Anesthesiology, published in 2011. To create the current Emergency Manual, the Stanford Anesthesia Cognitive Aid Group was formed. All team members have had integral roles. Dr. Larry Chu, who directs the Stanford AIM (Anesthesia Informatics Management) lab provided the new graphics and layout, applying his design skills and an understanding of user interface to make the content more easily usable. Drs. Sara Goldhaber-Fiebert, Kyle Harrison, Steven Howard, and David Gaba worked jointly to provide the content, including exact phrasing, ordering, and emphasis, as well as iterative simulation testing to revise both content and design elements. Observing how cognitive aids are used by teams during hundreds of simulated crises has been crucial for pilot testing throughout. We hope that this Emergency Manual will support both education and patient safety efforts. Effective use has included pre-event review, post-event team debriefing, and ‘during’ critical event management—the latter particularly after adequate help has arrived or when the patient is sufficiently stable for a clinician to pause from acute care actions. We encourage the use of this Manual and welcome feedback from all practitioners.

Acknowledgments: We appreciate the faculty and residents at Stanford and VA Palo Alto anesthesia departments for their support of the development and implementation of the emergency manual. We are especially grateful to our chair, Dr. Ron Pearl, for helping us make this project a reality. We are grateful to Barbara Burian for her expertise in human factors and cognitive aid design reflected in the design of Version 3. While references are not written on each event for space, we have tried to integrate the most pertinent clinical information from published literature for each event, including practical publications e.g. A-ACLS modifications to AHA ACLS algorithms, ASA difficult airway algorithms, ASRA LAST guidelines, MHAUS poster, and appreciate the work of their developers. We thank all our colleagues from the Emergency Manuals Implementation Collaborative (EMIC), a global group fostering the dissemination, implementation, and effective use of emergency manuals to enhance patients’ safety. Join EMIC at www.emergencymanuals.org.

Disclaimer: The material in this Manual is not intended to be a substitute for sound medical knowledge and training. Clinicians should always use their clinical judgment and decision making for patient management. Since treatment for the medical conditions described in this Manual can have variable presentations, departure from the information presented here is encouraged when appropriate.

Appropriate citation of this emergency manual:

Manual of Clinical Anesthesiology

Much of the work in this Anesthesia Emergency Manual was adapted from cognitive aids originally published in Appendix of Crisis Management Algorithms in Anesthesia in the Manual of Clinical Anesthesiology, edited by Larry Chu and Andrea Fuller, published by Lippincott Williams & Wilkins, 2011. The authors were*: Harrison TK (21), Goldhaber-Fiebert SN (21), and Chu L (21), as well as on specific cognitive aids, contributions by: Lighthall G (2),

Produced by the Stanford Anesthesia Informatics and Media Lab (AIM)

Http://AIM.Stanford.EDU

Tested by the Stanford Simulation Group and the Stanford Anesthesia Informatics and Media (AIM) Lab
# ASYSTOLE

By Stanford Anesthesia Cognitive Aid Group

## SIGNS

**FLAT LINE:**

- CPR:
  1. 100–120 compressions/minute; ≥ 2” deep. Allow complete chest recoil.
  2. Minimize breaks in CPR.
  3. Rotate Compressors q2 Min.

- **PULSE**

**Assess CPR quality, improve IF:**
- ETCO₂ < 10 mmHg
- Arterial line Diastolic < 20 mmHg

## IMMEDIATE

1. **CALL FOR HELP.**
2. **CALL FOR CODE CART.**
3. **INFORM TEAM.**

**1. Turn OFF vasodilating volatile & IV drips; Increase to 100% O₂, high flow.**

**2. Ventilate 10 breaths/minute; do not over ventilate.**

**3. Ensure IV access (or consider intraosseous).**

**4. Epinephrine – 1 mg IV push q 3-5 minutes.**

**5. If rhythm changes to VF/VT (shockable rhythm) → Immediate Defibrillation. Go To VF/VT, event #6.**

**6. Consider ECMO if available and reversible cause.**

**7. Consider TTE or TEE Echocardiography to evaluate cause.**

## DIAGNOSIS

Consider common perioperative Ddx:

1. Hemorrhage
2. Anesthetic overdose
3. Septic or other shock states
4. Auto PEEP
5. Anaphylaxis
6. Medication error
7. High spinal
8. Pneumothorax
9. Local anesthetic toxicity
10. Vagal stimulus
11. Pulmonary Embolus

**Find and Treat Causes – H’s and T’s: Expanded on next page.**
ASYSTOLE continued

1. Hypovolemia: Give rapid bolus of IV fluid. Check hemoglobin/hematocrit. If anemia or massive hemorrhage, give blood. Consider relative hypovolemia: Auto-PEEP (disconnect circuit); High Spinal; or Shock States (e.g. anaphylaxis). Go To relevant event.


3. Tension pneumothorax: Unilateral breath sounds, possible distended neck veins and deviated trachea (late signs). Perform emergent needle decompression (2nd intercostal space at mid-clavicular line) then chest tube placement. Call for chest x-ray, but do NOT delay treatment. Go To Pneumothorax, event #21.

4. Thrombosis – Coronary: Consider transesophageal (TEE) or transthoracic (TTE) echocardiography to evaluate ventricle wall motion abnormalities of the ventricles. Consider emergent coronary revascularization. Go To Myocardial Ischemia, event #19.

5. Thrombosis – Pulmonary: Consider TEE or TTE to evaluate right ventricle. Consider fibrinolytic agents or pulmonary thrombectomy.

6. Toxins (e.g. infusions): Consider medication error. Confirm no infusions running and volatile anesthetic off. If local anesthetic toxicity Go To Local Anesthetic Toxicity, event #17.

7. Tamponade – Cardiac: Consider placing TEE or TTE to rule out tamponade. Treat with pericardiocentesis.


9. Hyperthermia 🔄: If Malignant Hyperthermia, call for MH Cart. Give Dantrolene immediately: start at 2.5 mg/kg. MH Hotline: (800) 644-9737. Go To Malignant Hyperthermia, event #18.

10. Obtain ABG to rule out:
   • Hyperkalemia 🔄: Give Calcium Chloride 1 g IV; D50 1 Amp IV (25 g Dextrose) + Regular Insulin 10 units IV. Monitor glucose. Sodium Bicarbonate 1 Amp IV (50 mEq).
   • Hypokalemia 🔄: Controlled infusion of potassium & magnesium.
   • Hypoglycemia: If ABG delay, check Fingerstick. Give D50 1 Amp IV (25 g Dextrose). Monitor glucose.
   • H+ Acidosis: If profound, consider Sodium Bicarbonate 1 Amp IV (50 mEq). May consider increasing ventilation rate (but can decrease CPR effectiveness so monitor).
   • Hypocalcemia: Give Calcium Chloride 1 g IV.
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BRADYCARDIA – UNSTABLE

By Stanford Anesthesia Cognitive Aid Group

SIGNS

1. CHECK FOR PULSE
   • If NO pulse, Go To PEA event #3.
   • If pulse present but hypotensive, proceed with treatment.

1. CALL FOR HELP.
2. CALL FOR CODE CART.
3. HALT SURGICAL STIMULATION.

TREATMENT

1. Increase to 100% O₂, high flow.
2. Confirm adequate ventilation and oxygenation.
3. Consider turning down or OFF all anesthetics.
4. Atropine: 0.5 to 1 mg IV, may repeat up to 3 mg.
   Consider infusions below.
5. Consider transcutaneous pacing:
   • Set rate to at least 80 bpm.
   OR
   • Increase current until capture achieved.
   ↓
   • Confirm patient has pulse with capture.
6. Consider Infusions:
   • Dopamine: 2 to 20 μg/kg/min
   • Epinephrine: 2 to 10 μg/min

SECONDARY

1. Place arterial line.
2. Send labs: ABG, hemoglobin, electrolytes.
3. Rule out ischemia: Consider EKG, troponins.

END
PULSELESS ELECTRICAL ACTIVITY

By Stanford Anesthesia Cognitive Aid Group

**SIGNS**

- CPR:
  1. 100–120 compressions/minute; ≥ 2” deep. Allow complete chest recoil.
  2. Minimize breaks in CPR.
  3. Rotate Compressors q2 Min.

Assess CPR quality, improve IF:
- ETCO₂ < 10 mmHg
- Arterial line Diastolic < 20 mmHg

**IMMEDIATE**

1. Turn OFF vasodilating volatile & IV drips; Increase to 100% O₂, high flow.
2. Ventilate 10 breaths/minute; do not over ventilate.
3. Ensure IV access (or consider intraosseous).
4. Epinephrine – 1 mg IV push q 3-5 minutes.
5. If rhythm changes to VF/VT (shockable rhythm) → Immediate Defibrillation.
   Go To VF/VT, event #6.
6. Consider ECMO if available and reversible cause.
7. Consider TTE or TEE Echocardiography to evaluate cause.

**SECONDARY**

Consider common perioperative Ddx:
1. Hemorrhage
2. Anesthetic overdose
3. Septic or other shock states
4. Auto PEEP
5. Anaphylaxis
6. Medication error
7. High spinal
8. Pneumothorax
9. Local anesthetic toxicity
10. Vagal stimulus
11. Pulmonary Embolus

Find and Treat Causes – H’s and T’s: Expanded on next page.
1. Hypovolemia: Give rapid bolus of IV fluid. Check hemoglobin/hematocrit. If anemia or massive hemorrhage, give blood. Consider relative hypovolemia: Auto-PEEP (disconnect circuit); High Spinal; or Shock States (e.g. anaphylaxis). Go To relevant event.


3. Tension pneumothorax: Unilateral breath sounds, possible distended neck veins and deviated trachea (late signs). Perform emergent needle decompression (2nd intercostal space at mid-clavicular line) then chest tube placement. Call for chest x-ray, but do NOT delay treatment. Go To Pneumothorax, event #21.

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    • Hypokalemia : Controlled infusion of potassium & magnesium.
    • Hypoglycemia: If ABG delay, check Fingerstick. Give D50 1 Amp IV (25 g Dextrose). Monitor glucose.
    • H⁺ Acidosis: If profound, consider Sodium Bicarbonate 1 Amp IV (50 mEq). May consider increasing ventilation rate (but can decrease CPR effectiveness so monitor).
    • Hypocalcemia: Give Calcium Chloride 1 g IV.
SUPRAVENTRICULAR TACHYCARDIA – STABLE

By Stanford Anesthesia Cognitive Aid Group

1. CHECK FOR PULSE.
   • If NO pulse, Go To PEA, event #3.
   • If Unstable, Go To SVT – UNSTABLE event #5.
     Prepare for Synchronized Cardioversion.
     UNSTABLE = ANY OF: Sudden and/or continuing sharp decrease in BP; Acute Ischemia; SBP <75.

2. Sinus Tachycardia is NOT SVT. May be compensatory. Search for and treat underlying cause(s).

3. More likely SVT THAN SINUS if any of:
   • Rate >150.
   • Irregular.
   • Sudden onset.

1. CALL FOR HELP.
2. CALL FOR CODE CART?
3. INFORM TEAM.

1. Increase to 100% O₂, high flow.
2. Confirm adequate ventilation, oxygenation.
3. Consider 12-lead EKG or Print Rhythm Strip, then treat per rhythm (Go To next page).
4. If UNSTABLE at any point: Go To SVT – UNSTABLE, event #5.
5. Consider placing defibrillator pads.
6. If still STABLE Supraventricular Tachycardia consider:
   • arterial line.
   • check ABG & electrolytes.
7. Consider STAT cardiology consult.
8. Go To next page.

Go To Next Page
SUPRAVENTRICULAR TACHYCARDIA – STABLE
continued

Narrow Complex and Regular
1. Adenosine 6 mg IV push with flush. May give 2nd dose: 12 mg IV (Avoid adenosine if asthma or WPW).
2. If NOT converted, may Rate Control.
   Choose beta blocker or calcium channel blocker:
   - Beta Blocker: (consider avoiding if asthma)
     - Esmolol: Start 0.5 mg/kg IV over 1 min. May repeat after 1 min and may start infusion 50 μg/kg/min.
     - Metoprolol: Start 1-2.5 mg IV. May repeat or double after 2.5 min.
   - Calcium Channel Blocker:
     - Diltiazem: 5-10 mg IV over 2 min. May repeat after 5 min.

Narrow Complex and Irregular
1. Choose beta blocker or calcium channel blocker:
   - Beta Blocker: (Consider avoiding if asthma)
     - Esmolol: Start 0.5 mg/kg IV over 1 min. May repeat after 1 min and may start infusion 50 μg/kg/min.
     - Metoprolol: Start 1-2.5 mg IV. May repeat or double after 2.5 min.
   - Calcium Channel Blocker:
     - Diltiazem: 5-10 mg IV over 2 min. May repeat after 5 min.
2. Amiodarone: 150 mg IV SLOWLY over 10 min. May repeat once. Start infusion 1 mg/min for first 6 hours.

Wide Complex and Regular (monomorphic)
1. If SVT with aberrancy Adenosine: 6 mg IV push with flush. May give 2nd dose: 12 mg IV (avoid adenosine if asthma or WPW).
2. If VT or uncertain VT versus SVT with aberrancy:
   Amiodarone: 150 mg IV SLOWLY over 10 min. May repeat once. Start infusion 1 mg/min for first 6 hours.
   May also consider Procainamide or Sotalol.

Wide Complex and Irregular
(Likely Polymorphic VT)
If Unstable, immediate defibrillation.
If Stable, have defibrillator pads on and consult cardiology.
END
This space intentionally left blank
SUPRAVENTRICULAR TACHYCARDIA – UNSTABLE

By Stanford Anesthesia Cognitive Aid Group

1. CHECK FOR PULSE.
   • If NO pulse, Go To PEA, event #3.

2. UNSTABLE = ANY OF: Sudden and/or continuing sharp decrease in BP; Acute Ischemia; SBP <75.

3. Sinus Tachycardia is NOT SVT. May be compensatory. Search for and treat underlying cause(s).

4. More likely SVT THAN SINUS if any of:
   • Rate >150.
   • Irregular.
   • Sudden onset.

1. CALL FOR HELP.
2. CALL FOR CODE CART.
3. INFORM TEAM.

TREATMENT

1. Increase to 100% O₂, high flow. Decrease volatile anesthetic.
2. Confirm adequate ventilation, oxygenation.
3. If unstable SVT, IMMEDIATE SYNCHRONIZED CARDIOVERSION – biphasic doses.
   • Narrow complex and Regular: 50-100J.
   • Narrow complex and Irregular: 120-200J.
   • Wide complex and Regular: 100J.
   • Wide complex and Irregular requires Unsynchronized Defibrillation: 200J.

4. If unsuccessful cardioversion: Re-SYNC and increase Joules incrementally for Synchronized Cardioversion.

5. While preparing to cardiovert (do NOT delay), if narrow-complex and regular, consider Adenosine 6 mg rapid IV push with flush, via access closest to heart. May give 2nd dose of 12 mg IV.

END
VENTRICULAR FIBRILLATION
VENTRICULAR TACHYCARDIA – PULSELESS

By Stanford Anesthesia Cognitive Aid Group

SIGNS

V-TACH:

V-FIB:

CPR:

1. 100–120 compressions/minute; ≥ 2” deep.
   Allow complete chest recoil.
2. Minimize breaks in CPR.
3. Rotate compressors q2 min.

Assess CPR quality, improve IF:

• ETCO₂ < 10 mmHg.
• Arterial line Diastolic < 20 mmHg.

1. CALL FOR HELP.
2. CALL FOR CODE CART.
3. INFORM TEAM.

TREATMENT

1. DEFIBRILLATE: 120-200 J (biphasic, per manufacturer).
2. RESUME CPR IMMEDIATELY.
3. REPEAT SHOCK q 2 minutes, reasonable to increase energy with subsequent shocks, resume CPR.
4. AFTER 2nd SHOCK EPINEPHRINE: 1 mg IV push q 3-5 minutes.

CHECK

1. In OR: Turn OFF volatile; Increase to 100% O₂, high flow.
2. Ventilate 10 breaths/minute; do not overventilate.
3. Ensure IV access (or consider intraosseous).

CONSIDER

Consider Antiarrhythmics:

• If pulseless: Amiodarone 300 mg IV PUSH or Lidocaine 100 mg IV PUSH.
• If HypoMg or Torsades + prolonged QT: Magnesium sulfate 2 grams IV.
• If HyperK: Calcium, insulin & glucose, sodium bicarbonate.

Search for Treatable Causes (H’s & T’s on next page).

Go To Next Page
VENTRICULAR FIBRILLATION
VENTRICULAR TACHYCARDIA – PULSELESS
continued

If still VF/VT, keep shocking q2 minutes.

1. Hypovolemia: Give rapid bolus of IV fluid. Check hemoglobin/hematocrit. If anemia or massive hemorrhage, give blood. Consider relative hypovolemia: Auto-PEEP (disconnect circuit); High Spinal; or Shock States (e.g. anaphylaxis). Go To relevant event.


3. Tension pneumothorax: Unilateral breath sounds, possible distended neck veins and deviated trachea (late signs). Perform emergent needle decompression (2nd intercostal space at mid-clavicular line) then chest tube placement. Call for chest x-ray, but do NOT delay treatment. Go To Pneumothorax, event #21.

4. Thrombosis – Coronary: Consider transesophageal (TEE) or transthoracic (TTE) echocardiography to evaluate ventricle wall motion abnormalities of the ventricles. Consider emergent coronary revascularization. Go To Myocardial Ischemia, event #19.

5. Thrombosis – Pulmonary: Consider TEE or TTE to evaluate right ventricle. Consider fibrinolytic agents or pulmonary thrombectomy.

6. Toxins (e.g. infusions): Consider medication error. Confirm no infusions running and volatile anesthetic off. If local anesthetic toxicity Go To Local Anesthetic Toxicity, event #17.

7. Tamponade – Cardiac: Consider placing TEE or TTE to rule out tamponade. Treat with pericardiocentesis.


9. Hyperthermia ↑: If Malignant Hyperthermia, call for MH Cart. Give Dantrolene immediately: start at 2.5 mg/kg. MH Hotline: (800) 644-9737. Go To Malignant Hyperthermia, event #18.

10. Obtain ABG to rule-out:
   • Hyperkalemia ↑: Give Calcium Chloride 1 g IV; D50 1 Amp IV (25 g Dextrose) + Regular Insulin 10 units IV. Monitor glucose. Sodium Bicarbonate 1 Amp IV (50 mEq).
   • Hypokalemia ↓: Controlled infusion of potassium & magnesium.
   • Hypoglycemia: If ABG delay, check Fingerstick. Give D50 1 Amp IV (25 g Dextrose). Monitor glucose.
   • H+ Acidosis: If profound, consider Sodium Bicarbonate 1 Amp IV (50 mEq). May consider increasing ventilation rate (but can decrease CPR effectiveness so monitor).
   • Hypocalcemia: Give Calcium Chloride 1 g IV.

If still VF/VT, keep shocking q2 minutes.

END
AMNIOTIC FLUID EMBOLISM

By Stanford Anesthesia Cognitive Aid Group

SIGNs

Consider amniotic fluid embolism if there is the sudden onset of the following in a pregnant or post-partum patient:
1. Respiratory distress, decreased O₂ saturation.
2. Cardiovascular collapse: hypotension, tachycardia, arrhythmias, cardiac arrest.
3. Coagulopathy +/- Disseminated intravascular coagulation (DIC).
4. Seizures.
5. Altered mental status.
6. Unexplained fetal compromise.

1. CALL FOR HELP.
2. CALL FOR CODE CART.
3. INFORM TEAM.

TREATMENT

1. Anticipate possible cardiopulmonary arrest and emergent C-section.
2. Place patient in left uterine displacement (LUD).
3. Increase to 100% O₂, high flow.
4. Establish large volume IV access (upper body best).
5. Support circulation with IV fluid, vasopressors, and inotropes.
6. Prepare for emergent intubation.
7. When possible, place arterial line. Consider central venous access or IO line in humerus.
8. Anticipate massive hemorrhage and DIC. Go To Hemorrhage – MTG, event #14.
9. Consider circulatory support: IABP/ECMO/CPB.

RULE OUT

Rule out other causes that might present in a similar fashion:
1. Eclampsia.
2. Hemorrhage.
3. Air embolism.
5. Anaphylaxis.
6. Pulmonary embolism.
7. Anesthetic overdose.
8. Sepsis.
9. Cardiomyopathy/cardiac valvular abnormality/MI.
10. Local anesthetic toxicity.
11. Total Spinal.

END
ANAPHYLAXIS

By Stanford Anesthesia Cognitive Aid Group

Some signs may be absent in an anesthetized patient:

1. Hypoxemia, difficulty breathing, tachypnea.
2. Rash/hives.
3. Hypotension (may be severe).
4. Tachycardia.
5. Bronchospasm/wheezing.
6. Increase in peak inspiratory pressure (PIP).
7. Angioedema (potential airway swelling).

1. CALL FOR HELP.
2. CALL FOR CODE CART.
3. INFORM TEAM.
4. CONSIDER PAUSING SURGERY.

1. If patient becomes pulseless, start CPR, continue epinephrine 1 mg IV boluses and large volume IV fluid.
2. Also Go To PEA, event #3.

Consider and rule out other causes:

- Pulmonary embolus.
- Myocardial infarction.
- Anesthetic overdose.
- Pneumothorax.
- Hemorrhage.
- Aspiration.

For anaphylaxis treatment, Go To Next Page
**TREATMENT**

1. **Discontinue potential allergens:** muscle relaxants, latex, antibiotics, colloids, protamine, blood, contrast, chlorhexidine.

2. **Discontinue volatile anesthetic** if hypotensive. Consider amnestic agent.

3. Increase to **100% O₂**, high flow.

4. **Give IV fluid bolus.** May require many liters!

5. **Give epinephrine IV in escalating doses** every two minutes. Start at 10-100 μg IV and increase dose every 2 minutes until clinical improvement is noted. **Start early epinephrine infusion.** May require large doses > 1 mg.

6. **IF no improvement:** continue treatment, but consider other causes (*Go To Hypotension, event #15, and Hypoxemia, event #16 – consider Differential Diagnoses*).

7. Consider **vasopressin** bolus IV or **norepinephrine** infusion.

8. Treat **bronchospasm** with **albuterol** and **epinephrine** (if severe).

9. Consider **additional IV access** and **invasive monitors** (arterial line).

10. If signs of **angioedema**, consider **early intubation** to secure airway.

11. After stable consider **H₁ antagonist** (e.g. Diphenhydramine 25-50 mg IV), **H₂ antagonist** (e.g. Ranitidine 50 mg IV), and **corticosteroids** (e.g. Methylprednisolone 125 mg IV).

---

**POST EVENT**

Consider the following interventions when patient stable:

1. Send serum tryptase level (peaks <60 min post-event).

2. Send serum histamine (peaks <30 min post-event).

3. If the event was severe, consider keeping patient intubated and sedated.


5. Refer the patient for postoperative allergy testing.

END
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BRONCHOSPASM
(INTUBATED PATIENT)

By Stanford Anesthesia Cognitive Aid Group

SIGNS

1. Increased peak airway pressures.
2. Wheezing on lung exam.
3. Increased expiratory time.
4. Increased ETCO₂ with upsloping ETCO₂ waveform.
5. Decreased tidal volumes if pressure control.

1. CALL FOR HELP.
2. CALL FOR CODE CART?
3. INFORM TEAM.

Bronchospastic patients who develop sudden hypotension may be airtrapping – disconnect patient from circuit to allow for complete exhalation.

TREATMENT

1. Increase to 100% O₂, high flow.
2. Change I:E ratio to allow for adequate exhalation.
3. Deepen anesthetic (sevoflurane or propofol).
4. Rule out problems with ETT via auscultation & suction catheter (mainstem intubation, kinked ETT, mucus plug).
5. Give inhaled agents: Beta 2 agonist (albuterol, multiple puffs required) +/- anticholinergic (Ipratropium).
6. If severe consider epinephrine (start with 10 μg IV and escalate, monitor for tachycardia and hypertension).
7. Consider ketamine: 0.2 – 1.0 mg/kg IV.
8. Consider hydrocortisone 100 mg IV.
9. Consider nebulized racemic epinephrine.
10. Rule out anaphylaxis (hypotension/tachycardia/rash). Go To Anaphylaxis, event #8.
11. Consider ABG.

END
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1. Confirm that all anesthetic agents (inhalation/IV) are **OFF**.
2. Check for residual muscular paralysis (if patient is asleep, use twitch monitor), and reverse accordingly.

**Consider:**
1. Opioid reversal: start with **naloxone** 40 μg IV; repeat every 2 minutes, increasing up to 400 μg.
2. Benzodiazepine reversal: start with **flumazenil** 0.2 mg IV every 1 minute; max dose = 1 mg.
3. Scopolomine reversal (e.g. Patch): **Physostigmine** 1 mg IV (Potential cholinergic crisis, including severe bradycardia, so have atropine ready).

**CHECK**
1. Monitors: Check **Hypoxemia**? **Hypercarbia**? **Hypothermia**?
2. Complete **Neuro exam**, as able, for focal neurologic deficits (if intubated look for: pupils, asymmetric movement, gagging, etc.)
   - If abnormal exam or **suspect stroke**, obtain **stat Head CT scan** and consult neurology/neurosurgery.
3. **Hypoglycemia**: check glucose (glucometer).
4. Labs: **ABG plus electrolytes**. Rule out CO₂ narcosis from Hypercarbia, Hypo- or Hypernatremia.
5. Check for **medication swap** or dosing error.

**TREATMENT**
1. Correct any abnormalities in oxygenation, ventilation, laboratory values, or temperature.
2. If residual mental status abnormalities, monitor the patient in the ICU with **neurological follow up**, including serial exams. Repeat Head CT or MRI as needed.

**END**
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If unable to see vocal cords or pass ET tube during first Direct Laryngoscopy (DL):
1. Consider External Laryngeal Manipulation, BURP (Backwards Upwards Rightwards Pressure).
2. Consider placing Bougie introducer.
3. Limit total number of DL attempts to 2.
4. Recommend Video Assisted Laryngoscopy.
5. Before repeating DL, consider mask ventilation with oral/nasal airways.
6. Consider optimizing patient position and/or blade selection.
7. If successful, confirm placement with ETCO$_2$ and bilateral breath sounds.

If ventilation remains adequate, CONSIDER:
1. Awakening patient.
2. Complete case with LMA or face mask.
3. Video assisted Laryngoscopy.
5. LMA as conduit for intubation or intubating LMA.
6. Retrograde wire intubation.

Emergency Airway Ventilation
1. Call for Surgical Help.
2. Perform Cricothyrotomy.
3. Confirm successful placement with ETCO$_2$ and bilateral breath sounds.

For more details, see latest ASA Practice Guidelines for the Management of Difficult Airway
FIRE – AIRWAY

FOR NON-AIRWAY FIRE: Go To Fire – Patient, event #13

By Stanford Head & Neck Anesthesia & Surgery, Stanford Anesthesia Cognitive Aid Group

SIGNS

SUSPECT FIRE if:
Sudden pop, spark, flame, smoke, heat, or odor.

1. CALL FOR HELP.
2. INFORM TEAM.

SURGEON:

1. REMOVE ENDOTRACHEAL TUBE.
2. Remove airway foreign bodies e.g. ETT pieces.
3. Pour saline or water into patient’s airway.
4. Examine entire airway (including bronchoscopy) to assess injury and remove residual debris.

ANESTHESIOLOGIST:

1. STOP ALL AIRWAY GAS FLOW BY DISCONNECTING THE BREATHING CIRCUIT FROM THE ANESTHESIA MACHINE.
2. When sure fire is extinguished: Re-establish ventilation; avoid supplemental O₂ if possible.
3. Consider prompt reintubation prior to swelling and coordinated with surgeon’s bronchoscopy.
4. Inspect ETT pieces to verify none left in airway.
5. Save all materials for later investigation.

For prevention of airway fires, see next page.

GO TO NEXT PAGE
If high risk procedures, including those listed below:
  • Discuss fire prevention & management with team during time-out.
  • Avoid $\text{FiO}_2 > 0.3$ and avoid $\text{N}_2\text{O}$.

For **laser** surgery of vocal cord or larynx:
  • Use laser resistant ETT (single or double cuff).
  • Assure ETT cuff sufficiently deep below vocal cords.
  • Fill proximal ETT cuff with methylene blue-tinted saline.
  • Ensure Laser in STANDBY when not in active use.
  • Surgeon protects ETT cuff with WET gauze.
  • Surgeon confirms $\text{FiO}_2 < 0.3$ and no $\text{N}_2\text{O}$ prior to laser use.

For **non-laser** surgery in oropharynx:
  • Regular PVC ETT may be used.
  • Consider packing wet gauze around ETT to minimize $\text{O}_2$ leakage.
  • Consider continuous suctioning of the operating field inside oropharynx.

END
FIRE – PATIENT

FOR AIRWAY FIRE: Go To Fire – Airway, event #12

By Stanford Anesthesia Cognitive Aid Group, Stanford Head & Neck Anesthesia & Surgery

SIGNS

SUSPECT FIRE if:
Sudden pop, spark, flame, smoke, heat, or odor.

IMMEDIATE

1. INFORM TEAM.
2. CALL FOR HELP.
3. CALL FOR FIRE EXTINGUISHER.

1. Stop flow of all airway gases to patient.
2. Remove burning or flammable materials from patient immediately for other team member to extinguish.
3. Extinguish patient fire:
   • If electrical equipment burning, use only CO$_2$ fire extinguisher (safe in wounds).
   • If non-electrical, attempt to extinguish with saline and soaked gauze.
4. Care for the patient: ventilate with room air, control bleeding, assess injuries and vital signs.
5. Consider evacuating patient and OR if smoke or continued fire, per local protocol.
6. Close OR doors.
7. Turn OFF external gas supply to OR.
8. Alert fire department.

For prevention of airway fires, see next page.
• Team Communication at Time Out if high risk procedure.

• Highest risk in MAC head and neck procedures
  – Use nasal cannula instead of face mask, if able.
  – Configure drapes to avoid O₂ build-up, consider active scavenging if required.
  – Use minimum O₂ concentration for adequate SpO₂.

• If high O₂ concentration required, use an LMA or ETT.

• Allow complete drying of Alcohol skin prep solutions.

• Consider coating patient’s head hair and facial hair with water soluble surgical lubricating jelly.

Remember: Fuel Source + Oxidizer + Spark = FIRE
HEMORRHAGE
MASSIVE TRANSFUSION GUIDELINES
By Stanford Anesthesia Cognitive Aid Group

1. CALL FOR HELP.
2. CALL FOR CODE CART?
3. INFORM TEAM.

IMMEDIATE

1. Follow local protocol to order Massive Transfusion Guideline (MTG) or equivalent.
2. Increase to 100% O₂, high flow.
3. Treat hypotension with IV fluid bolus.
4. Consider Trendelenburg or elevation of patient’s legs.
5. Use vasopressor boluses (ephedrine, phenylephrine, epinephrine) as a temporizing measure. Consider accepting low normal blood pressure until bleeding is controlled.
6. Call for rapid infuser.
7. Establish additional IV access as needed. Consider intraosseous if needed.
8. Ask surgeon: “Should we page a vascular surgeon or other additional help for you?”
9. Send Type and Cross sample. TS will provide emergency release Type O PRBC until crossmatched blood is available.
11. Place arterial line as indicated.
12. Follow patient’s acid/base status by ABG as indicator of adequate resuscitation. Monitor for hypocalcemia.
13. Place Foley Catheter when able.
14. Call for cell-saver (if non-contaminated, non-malignant case).

Replace products EARLY! until current lab data available:
• If > 1 blood volume of loss expected: give 1 unit FFP for every 1 unit PRBC. Give 1 apheresis unit of platelets (= old ‘6-pack’) for every 6 units PRBC.
• When labs back: replace factors, platelets, fibrinogen as indicated on next page, but do not wait if blood loss is too rapid.

GO TO NEXT PAGE
HEMORRHAGE
MASSIVE TRANFUSION GUIDELINES continued

COMPONENTS

PRBC: **Give** for Hgb <7-10 (CAD? Rate of blood loss?) Each unit PRBC raises Hgb ~ 1g/dL.

PLATELETS: **Give** for <50,000-100,000 per μL with signs of ongoing bleeding. Each apheresis unit raises platelets ~50,000 per μL.

FRESH FROZEN PLASMA: **Give** for INR (PT) or PTT >1.5X normal. Give 10-15 cc FFP per kg body weight, then recheck labs and continue with 1:1 FFP:PRBC ratio.

CRYOPRECIPITATE: **Give** for fibrinogen <80-100 mg/dL. Each 10 units of cryoprecipitate raises fibrinogen ~50 mg/dL.

VOLUMES

Est. Blood Loss = EBV x \( \frac{HCT_{\text{starting}} - HCT_{\text{measured}}}{HCT_{\text{starting}}} \)

Estimated Blood Volume (EBV) ~65-70 ml per kg body weight (~4.5 L for 70 kg)

END
1. CALL FOR HELP.
2. CALL FOR CODE CART?
3. INFORM TEAM.

Immediate Actions:
1. Feel for pulse and check monitors. If no pulse, slow or abnormal rhythm, Go To appropriate ACLS event.
2. Inspect surgical field for blood loss or manipulation. Consider pausing surgery if non-bleeding cause.
4. Give phenylephrine or ephedrine to temporize.
   • If severe refractory hypotension, consider: epinephrine 10-100 μg and/or vasopressin 1-4 units.
5. If bleeding, consider lower normal MAP until surgeon controls source. Consider ordering blood.
6. Turn down or off anesthetic agent.
7. Consider Trendelenburg or elevation of patient’s legs.
8. Increase to 100% O₂, high flow.
9. Consider terminating surgical procedure or getting surgical help.
10. Consider code cart if severe. Monitor all vitals continuously.
11. If pulseless: alert team, start CPR, Go To PEA, event #3.

First Rule out Rapidly Lethal Causes:
1. Hemorrhage ?occult (Go to Hemorrhage – MTG, event #14).
2. Vasodilators (volatile, IV anesthetics, or drips).
3. Auto-PEEP (disconnect circuit).
4. Pneumothorax (Go to Pneumothorax, event #21).
5. Anaphylaxis (Go to Anaphylaxis, event #8).
6. Cardiac event: Myocardial infarction/ischemia (Go to Myocardial Ischemia, event #19), Low Ejection Fraction, Systolic Anterior Motion of mitral valve, Hypertrophic Obstructive Cardiomyopathy. TEE to assess.
7. Pneumoperitoneum or surgical manipulation.
8. IVC Compression e.g. prone, obese, pregnant, or surgical.
Physiological Differential Diagnosis of Hypotension

MAP = CO x SVR  
CO = SV x HR  
(SV components: preload, contractility, afterload)

1. **Decreased Preload** e.g. Auto-PEEP, hypovolemia including hemorrhage, arrhythmias, IVC compression, embolism (air, blood, fat, AFE), pneumothorax, pericardial tamponade, venodilators.

2. **Low SVR** e.g. vasodilation (medications, neuraxial block), shock (anaphylaxis, sepsis, spinal, neurogenic), endocrine abnormalities.

3. **Decreased Contractility** e.g. medications, low EF, myocardial ischemia, valvular disease, increased afterload, hypoxemia, local anesthetic toxicity.

4. **Low HR**: including vagal stimulus.

Depending on likely diagnosis, consider:

1. Treat the problem, if diagnosed. **Go To relevant event** if ACLS, Anaphylaxis, Hemorrhage, Hypoxemia, Local Anesthetic Toxicity, Myocardial Ischemia, Pneumothorax, Total Spinal Anesthesia, Transfusion Reaction, Venous Air Embolism. For sepsis: refer to local guidelines (IV fluids, invasive monitoring?, send lactate, blood cultures, appropriate antibiotics).

2. **Transesophageal echo** if unclear cause.

3. More **IV access**.

4. Place **arterial line**.

5. Steroid for adrenal insufficiency.  
   (e.g. **hydrocortisone** 100 mg IV).


7. **Foley catheter** if not present. Monitor urine output.

END
HYPOXEMIA

By Stanford Anesthesia Cognitive Aid Group and Geoff Lighthall, MD

1. CALL FOR HELP.
2. CALL FOR CODE CART?
3. INFORM TEAM.

**IMMEDIATE**

Immediate actions:
1. Increase to 100% O₂, high flow.
2. Check gas analyzer to rule out low FiO₂ or high N₂O.
   If concerned, Go To Oxygen Failure, event #20.
3. Check other vitals (cycle NIBP) and PIP. Feel for pulse.
4. Check for ETCO₂ (?extubated, disconnected, low BP).
6. Listen for breath sounds (bilateral? clear?). Check position ETT.
7. Suction catheter via ETT (to clear secretions and check obstructions).
8. Consider Pneumothorax, event #21.
9. Consider Code Cart if severe.

**DDX**

Differential diagnosis: See next page for details.
1. Hypoventilation.
2. Low FiO₂.
3. V/Q mismatch or shunt.
5. Increased metabolic O₂ demand.

**SECONDARY**

Depending on likely diagnosis, consider:
1. Large recruitment breaths, consider PEEP – caution if hypotensive.
2. Bronchodilators (e.g. albuterol MDI or nebulizer).
3. Additional neuromuscular blockade if indicated.
4. Increase FRC: head up (if BP ok), desufflate abdomen.
5. Check placement of ETT:
   • Fiberoptic to confirm tracheal rings, rule out mainstem intubation or ETT obstruction.
   • Ultrasound: bilateral sliding pleura are reassuring.
6. ABG and/or CXR.
7. Consider terminating procedure for refractory hypoxemia.
8. Plan for postop care: remain intubated? ICU bed?
Physiological differential diagnosis of hypoxemia:

1. **Low FiO₂**: If gas analyzer states low FiO₂ while on ‘100% O₂’ likely have O₂ failure or pipeline crossover of gases. **Go To Oxygen Failure, event #20** immediately.

2. **Hypoventilation**: Check for **signs** of low minute ventilation:
   - Low TV or RR.
   - High or low ETCO₂.
   - Poor chest rise.
   - Decreased breath sounds.
   - Patient bucking ventilator.

**Rule out** or fix equipment and patient causes:
   - Circuit leak.
   - Obstructed or kinked ETT.
   - High PIP.
   - Residual neuromuscular blockade.
   - Patient breathing asynchronously with ventilator.

**Postoperative respiratory failure** common causes: residual nmb, opioid, anesthetic, laryngospasm (sudden), bronchospasm, pulmonary edema, high spinal, pain.

3. **V/Q Mismatch or Shunt**: A-a Gradient common causes:
   - Atelectasis.
   - Aspiration.
   - Bronchospasm
   - Mucus plug.
   - Pleural effusion.

**CONSIDER** rare but critical:
   - **Pneumothorax**.
   - **Hypotension** – any cause of poor perfusion.
   - **Embolus** – air, blood, fat, AFE.

4. **Diffusion abnormality**: Usually chronic lung disease.

5. **Methemoglobinemia** (O₂ Sat ≈85%), **COHgb** (O₂ Sat often normal). **If suspect, send for co-oximetry**.

6. **Increased metabolic O₂ demand**: MH, thyrotoxicosis, sepsis, hyperthermia, neuroleptic malignant syndrome.

7. **Artifacts**: finally, confirm by ABG. e.g. poor waveform (probe malposition, cold extremity, light interference, cautery), dyes (methylene blue, indigo carmine, blue nail polish).

END
LOCAL ANESTHETIC TOXICITY

By Stanford Anesthesia Cognitive Aid Group

SIGNS
1. Symptoms: Tinnitus, metallic taste, or circumoral numbness.
2. Altered mental status.
4. Hypotension.
5. Bradycardia.
7. Cardiovascular collapse.

1. CALL FOR HELP.
2. Alert possible CPB.
3. CALL FOR CODE CART.
4. INFORM TEAM.

TREATMENT
1. Call for Intralipid kit.
2. If pulseless, start CPR and give <1 mcg/kg epinephrine.
3. Avoid vasopressin.
4. Stop local anesthetic injection and/or infusion.
5. Establish airway – ensure adequate ventilation and oxygenation. Consider endotracheal intubation.
6. Treat seizure activity with benzodiazepines.

7. If signs persist or patient unstable: Rapidly give 1.5 mL/kg bolus of 20% Intralipid IV (70 kg adult gets 105 mL fast) then start infusion at 0.25 mL/kg/min. May repeat loading dose (max 3 total doses). May increase infusion rate (max 0.5 mL/kg/min).

8. Monitor for hemodynamic instability – treat hypotension (see next page for details).
1. **Variable arrhythmias:** Go to appropriate ACLS event with the following **modifications per ASRA** Practice Advisory:
   - **CONSIDER** reducing Epinephrine doses <1 mcg/kg IV.
   - **AVOID:** Vasopressin, calcium channel blockers, beta blockers, and local anesthetics.

2. If refractory to treatment, alert personnel for **potential cardiopulmonary bypass.**

3. May require **prolonged resuscitation.**

4. Monitor the patient post event in **ICU.**

For latest recommendations, see ASRA website (http://www.asra.com).

---

**CPR:**

1. **100–120** compressions/minute; ≥ 2” deep.
   Allow complete chest recoil.

2. **Minimize breaks in CPR.**

3. Rotate Compressors q2 min.

**Assess CPR quality, improve IF:**

- ETCO$_2$ < 10 mmHg.
- Arterial line Diastolic < 20 mmHg.

**END**
# MALIGNANT HYPERTHERMIA

By Stanford Anesthesia Cognitive Aid Group and Henry Rosenberg, MD

## SIGNS

<table>
<thead>
<tr>
<th>EARLY:</th>
<th>May be LATER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increased ETCO₂.</td>
<td>1. Hyperthermia.</td>
</tr>
<tr>
<td>3. Tachypnea.</td>
<td>3. Myoglobinuria.</td>
</tr>
<tr>
<td>5. Masseter spasm/trismus.</td>
<td>5. Cardiac Arrest.</td>
</tr>
<tr>
<td>6. Sudden cardiac arrest in young person due to hyperkalemia.</td>
<td></td>
</tr>
</tbody>
</table>

## 1. CALL FOR HELP.

2. CALL FOR MH CART.

3. INFORM TEAM.

4. START PREPARING DANTROLENE or RYANODEX!

## DDX

- Light anesthesia.
- Hypoventilation.
- Insufflation of CO₂.
- Over-heating (external).
- Hypoxemia.
- Thyroid Storm.
- Pheochromocytoma.
- Neuroleptic Malignant Syndrome (NMS).
- Serotonin Syndrome.

## TREATMENT

1. Discontinue anesthetic triggers (volatiles and succinylcholine). Do **NOT** change machine or circuit.
2. Increase to **100% O₂, high flow** 10 L/min.
3. *Halt procedure* if possible. If emergent, continue with non-triggering anesthetic.
4. **Increase minute ventilation** (but avoid air trapping).
5. Assign several people to prepare **2.5 mg/kg IV Dantrolene or Ryanodex bolus**:
   - **Dantrolene**: Dilute each 20 mg Dantrolene vial in 60 mL preservative-free sterile water (for 70 kg person give 175 mg so prepare 9 vials of 20 mg Dantrolene each as above).
   - **Ryanodex** (new formulation of Dantrolene): Dilute **250 mg Ryanodex vial in 5 mL** preservative-free sterile water (for 70 kg person give 175 mg).
6. **Rapidly give Dantrolene or Ryanodex**. Continue giving until patient stable (may need >10 mg/kg, call MHAUS 800-644-9737 for advice).
7. For metabolic acidosis, give **sodium bicarbonate 1-2 mEq/kg**.

MH Treatment continued on next page.
8. Hyperkalemia – or suspect from EKG, treat with:
   • Calcium chloride 10 mg/kg IV; Max dose 2000 mg or Calcium gluconate 3 mg/kg IV, Max dose 3000 mg.
   • D50 1 Amp IV (25 g or 50 ml Dextrose) + Regular Insulin 10 units IV (monitor glucose).
   • Sodium Bicarbonate 1-2 mEq/kg, Max dose 50 mEq.

9. Arrhythmias are usually secondary to Hyperkalemia. Treat as needed except avoid calcium channel blockers. Go to ACLS events as relevant and return.

10. Actively cool patient with ice packs, lavage if open abdomen. Stop cooling at 38°C.

11. Send labs for ABG, Potassium, CK, urine myoglobin, coagulation studies, lactate.

12. Place Foley catheter. Monitor UO. Goal 1-2 mL/kg per hour. Can give IV fluid and diuretics.

13. Consider alkalinizing urine if CK or urine myoglobin elevated (Sodium Bicarbonate 1mEq/kg/hour).

14. Arrange ICU bed. Mechanical ventilation usually required.

15. Continue Dantrolene or Ryanodex: 1 mg/kg every 4-6 hours or 0.25 mg/kg/hr infusion for at least 24 hours (25 % of MH events relapse). Observe patient in ICU for at least 24 hours.

16. Call MH hotline (below) for any suspected case with any questions.

Contact the Malignant Hyperthermia Association of the United States (MHAUS hotline) at any time for consultation if MH is suspected:

1-800-MH-HYPER (1-800-644-9737)

or see suggestions online at http://www.mhaus.org

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MYOCARDIAL ISCHEMIA

By Stanford Anesthesia Cognitive Aid Group

SIGNS

Suspect myocardial ischemia if:
1. Depression or elevation of ST segment.
2. **Arrhythmias**: conduction abnormalities, **unexplained tachycardia, bradycardia, or hypotension**.
3. Regional wall motion abnormalities or new/worse mitral regurgitation on TEE/TTE.
4. In **awake patient**: chest pain, etc.

1. CALL FOR HELP.
2. CALL FOR CODE CART.
3. INFORM TEAM.

TREATMENT

1. If **hypoxemic**, increase to 100% O₂, high flow.
2. Verify ischemia (expanded monitor view vs 12-lead EKG).
3. Treat **hypotension** or hypertension.
4. Be prepared for **Arrhythmias** and have **Code Cart** at bedside. Consider applying pads.
5. **Beta-blocker** to slow heart rate. Hold for bradycardia or hypotension.
6. Discuss with surgeon: **aspirin** 160-325mg PR, PO, NG.
7. Consider **STEMI team** or **consult Cardiology** – stat. Discuss among cardiology, surgery, anesthesia:
   - Heparin +/- Clopidogrel.
8. Treat pain with **narcotics** (fentanyl or morphine).
9. Consider **nitroglycerin** infusion (hold until hypotension treated).
10. Place **arterial line** and send **Labs**: ABG, CBC, Troponin.
11. If **Anemic**, treat with packed red blood cells.
12. Consider TTE or TEE **Echocardiography** for monitoring volume status and regional wall motion abnormalities.
13. Consider central venous access.
14. If hemodynamically unstable, consider **Intra-Aortic Balloon Pump**.

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OXYGEN FAILURE
$O_2$ CROSS OVER / PIPELINE FAILURE

By Stanford Anesthesia Cognitive Aid Group and Seshadri C. Mudumbai, MD

**SIGNS**
- Hear $O_2$ failure alarm.
- OR
- Inappropriately low $FiO_2$ value on gas analyzer.

**Immediate Actions:**

1. Disconnect the patient from the machine and ventilate with an Ambu™ bag on Room Air. Do not connect the patient to auxiliary flowmeter on machine – comes from SAME central source!
2. Open $O_2$ tank on back of anesthesia machine (check not empty) and disconnect pipeline oxygen to force flow from tank into circuit.
   **Alternative:** Obtain full E cylinder of $O_2$ with a regulator. Ventilate with Ambu™ bag or Jackson Rees circuit attached to new $O_2$ tank.
3. Connect gas sampling adaptor to allow monitoring of respiratory gases:
   - Is the patient receiving 100% oxygen?
4. Maintain anesthesia (if necessary) with IV drugs

**1. CALL FOR HELP.**
**2. CALL FOR CODE CART?**
**3. INFORM TEAM.**

**Secondary**

1. Reduce $O_2$ flow rates to minimum needed to conserve oxygen.
2. Obtain extra backup sources of $O_2$.
3. When patient more stable, contact Bioengineers to alert them to problem and enlist help with machine diagnosis while you focus on patient.
4. Inform OR leadership, ICU, hospital of potential large-scale $O_2$ problem.
5. Discuss with surgeon implications of $O_2$ failure for this patient’s management and OR schedule.

END
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PNEUMOTHORAX

By Stanford Anesthesia Cognitive Aid Group

SIGNS
1. Increased peak inspiratory pressures.
2. Tachycardia.
3. Hypotension.
4. Hypoxemia.
5. Decreased or asymmetric breath sounds.
6. Hyperresonance of chest to percussion.
7. Tracheal deviation (late sign).
8. Increased JVD/CVP.
9. Have high index of suspicion for pneumothorax in trauma patients and COPD patients.

1. CALL FOR HELP.
2. CALL FOR CODE CART?
3. INFORM TEAM.

TREATMENT
1. Increase to 100% O₂, high flow.
2. Rule out mainstem intubation.
3. Consider Ultrasound or stat CXR.
4. Do Not Delay Treatment If Hemodynamically Unstable.
5. Place 14 or 16 gauge needle mid clavicular line 2nd intercostal space on affected side, may hear a whoosh of air if under tension.
6. Immediately follow up needle decompression with thoracostomy (chest tube).

END
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IMMEDIATE LIFESAVING ACTIONS:

1. Get additional light sources:
   - Laryngoscopes, cell phones, flashlights, etc.

2. Open doors and shades to let in ambient light.

3. Confirm ventilator is working and if not, ventilate patient with Ambu\textsuperscript{TM} bag and switch to TIVA.

4. If monitors fail, check pulse and manual blood pressure.

5. Request Transport Monitor or defibrillator monitor.

6. Confirm adequate backup \(O_2\) supply:
   - Power failure may affect oxygen supply or alarms.

7. Check extent of power failure:
   - Call bio-med or engineering.
   - Is the problem in one OR, all ORs, or hospital-wide?
   - If only in your OR, check if circuit breaker has been tripped.

END
AFTER NEURAXIAL ANESTHESIA BLOCK:

1. Unexpected rapid rise in sensory blockade.
2. Numbness or weakness in upper extremities (check hand grip).
3. Dyspnea.
4. Bradycardia.
5. Hypotension (or nausea/vomiting).
7. Apnea.
8. Cardiac arrest.

1. CALL FOR HELP.
2. CALL FOR CODE CART.
3. INFORM TEAM.

TREATMENT

1. If Cardiac Arrest: Start CPR, immediate epinephrine, Go To appropriate ACLS event.
2. Support ventilation and intubate if necessary.
3. Treat significant bradycardia or hypotension with immediate epinephrine (start 10-100 μg, increase as needed). If mild bradycardia, consider atropine (0.5-1 mg), but progress quickly to epinephrine if needed.
4. Give IV fluid bolus.
5. If parturient: Left uterine displacement, call OB and neonatology, prepare for possible emergent C-section, monitor fetal heart rate.

END
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# TRANSFUSION REACTIONS

By Stanford Anesthesia Cognitive Aid Group

## SIGNS

<table>
<thead>
<tr>
<th>Hemolytic Reaction</th>
<th>Febrile</th>
<th>Anaphylactic</th>
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</thead>
<tbody>
<tr>
<td>3. Tachycardia.</td>
<td>3. Headache.</td>
<td>3. Wheezing.</td>
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<tr>
<td>5. Hypotension.</td>
<td></td>
<td></td>
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<tr>
<td>6. Dark urine.</td>
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<tr>
<td>7. Oozing – DIC?</td>
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</tr>
</tbody>
</table>

## TREATMENT

1. **CALL FOR HELP.**
2. **CALL FOR CODE CART?**
3. **INFORM TEAM.**

1. **Stop the transfusion.**
2. Support blood pressure with IV fluids and vasoactive medications if needed.
3. Retain blood product bag and notify Transfusion Service. Additional patient samples will need to be drawn.
4. Consult Transfusion Medicine MD if advice needed.
5. Consider TRALI or volume overload if evidence of lung injury (hypoxemia, pulmonary edema). May require post-operative ventilation.

## Hemolytic Reaction
- Maintain urine output – IV fluids, diuretics, renal dose dopamine.
- Monitor for signs of DIC.

## Febrile
- Treat with antipyretics.
- Rule out hemolysis.
- Rule out bacterial contamination.

## Anaphylactic
- Epinephrine infusion.
- Give antihistamines.
- Go To Anaphylaxis event #8.

END
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VENOUS AIR EMBOLUS

By Stanford Anesthesia Cognitive Aid Group

OBSERVE SUDDEN:

1. Air on TEE or change in Doppler tone (if monitoring).
2. Decrease in ETCO₂.
3. Decrease in BP.
4. Decrease in SpO₂.
5. Rise in CVP.
6. Onset of dyspnea and respiratory distress or cough in awake patient.

1. CALL FOR HELP.
2. CALL FOR CODE CART?
3. INFORM TEAM.

TREATMENT

1. Increase to 100% O₂, high flow.
2. Flood surgical field with saline.
3. Place surgical site below heart (if able).
4. Aspirate air from the central line if present.
5. Give rapid fluid bolus to increase CVP.
6. Turn down or off volatile anesthetic.
7. Give epinephrine (start 10-100 μg) to maintain cardiac output.
8. Start CPR if BP catastrophically low.
9. Consider TTE or TEE Echocardiography to assess air & RV function.
10. Consider left lateral decubitus.
11. If severe, terminate procedure if able.

END
## Crisis Resource Management

### Call for Help Early
- Call for help early enough to make a difference
- Err on the side of getting more help
- Mobilize early personnel with special skills if they may be needed

### Designate Leadership
- Establish clear leadership
- Inform team members who is in charge
- ‘Followers’ should be active in asking who is leading

### Anticipate and Plan
- Plan & prepare for high work-load periods during low work-load periods
- Know where you are likely headed during the crisis and make backup plans early

### Know the Environment
- Maintain situational awareness
- Know how things work and where things are
- Be aware of strengths and vulnerabilities of environment

### Establish Role Clarity
- Determine who will do what
- Assign areas of responsibility appropriate to knowledge, skills, and training
- Active followers may offer specific roles

### Use All Available Information
- Monitor multiple streams of data and information
- Check and cross check information

### Distribute the Workload
- Assign specific tasks to team members according to their abilities
- Revise the distribution if there is task overload or failure

### Allocate Attention Wisely
- Eliminate or reduce distractions
- Monitor for task saturation & data overload
- Avoid getting fixated
- Recruit others to help w/ monitoring

### Communicate Effectively
- Command and request clearly
- Seek confirmation of request (close the loop)
- Avoid “thin air” statements
- Foster input and atmosphere of open information exchange among all personnel

### Mobilize Resources
- Activate all helpful resources including equipment and additional personnel

### Use Cognitive Aids
- Be familiar with content, format, and location
- Support the effective use of cognitive aids
