Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company’s public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
and she was discharged again. Two weeks after discharge, she came again with chest pain CCS III. In the emergency room she developed a ventricular fibrillation. Cardiopulmonary resuscitation was undertaken for over 30 min. Due to refractory ventricular fibrillation a total of 12 defibrillations were required and rescue i.v.-thrombolysis was administered on the suspicion of a pulmonary embolism. The return of spontaneous circulation could finally be achieved under highly dosed catecholamines. Her coronary angiography showed a 99% stenosis of the LAD, which was treated with angioplasty and bare-metal-stenting. After therapeutic hypothermia of 24 h, the patient recovered rapidly without neurological damage. Discussion/conclusion: According to the ESC Guidelines 2011 there is a IIaC class recommendation for an invasive procedure in patients with risk factors. Radiation doses exceeding a threshold of 100 mGy can cause mental retardation or malformations. The fetal exposure can be decreased when lead shielding is used. If stenting is required, then a bare metal stent should be used. Clopidogrel is the only thienopyridin antiplatelet drug that is currently recommended.

http://dx.doi.org/10.1016/j.resuscitation.2013.08.044

Advanced Life Support

AP013

Recommendations for rapid sequence induction in Europe – How standardized is the standard of care?

Wolfgang Wetsch, Jochen Hinkelbein

Department of Anaesthesiology and Intensive Care Medicine, University Hospital of Cologne, Cologne, Germany

Introduction: Induction of anaesthesia in non-fasting emergency patients is associated with a high risk of aspiration. It may severely damage lung tissue, lead to oxygenation disturbances, and even cause an acute respiratory distress syndrome, known as Mendelson’s syndrome.1 To prevent gastric aspiration, Rapid Sequence Induction (RSI) is the accepted standard technique used for induction of anaesthesia. However, RSI itself is not standardized and may include different drugs and procedures (head-up-position, head-down-position, cricoid pressure).2–3 The aim of this study was to evaluate the current situation of national recommendations on RSI in Europe.

Methods: In fall 2011, a standardized questionnaire was sent to the national anaesthesia societies of all European countries by postal mail. If no reply was received within 4 months, the questionnaire was sent another time by mail and the societies were contacted by e-mail up to three times. It was evaluated whether the societies publish national guidelines on RSI, whether they recommend guidelines published by another society, whether they recommend other guidelines (e.g. a scientific publication), and in which year the last update was published. Descriptive statistics were used for interpretation of the data.

Results: Of 35 societies contacted (response rate 71.4%). From 10 societies, no reply was received after two postal and three e-mail contacts. Three of 25 societies (12%) had published their own guidelines on RSI; one society (4%) had published a national guideline on RSI in children. Six societies (24%) stated that they recommend guidelines of other societies. However, five of them only recommended the guideline from the “difficult airway society”, which is strictly not about RSI. The four societies (16%) that recommended other guidelines also recommended the “difficult airway society” in three cases and a scientific paper about muscle relaxants in one case. The most recent published guidelines date from 2004. Experts or subcommittees for airway management only exist in 3 of the 25 (12%) societies replying to our questions.

Conclusions: National guidelines on Rapid Sequence Induction for adults only exist in few European countries. Thus, this “standardized” procedure may be performed totally different throughout Europe.

References

1. Mendelson CL. Am J Obstet Gynecol 1946;52:191–205.
2. Baird CR, et al. Emerg Med J 2009;26:576–8.
3. Jensen AG, et al. Acta Anaesthesiol Scand 2010;54:922–50.

http://dx.doi.org/10.1016/j.resuscitation.2013.08.045

AP014

Does the introduction of new resuscitation guidelines increase survival after cardiac arrest?

Jaume Fontanals Dotras1,*, Marta Magaldi Mendaña1, Montserrat Fontanals Caravaca1, Montserrat Tió Felip1, Jaume Fontanals Jorba2, Comission of IntraHospitalary Cardiac Arrest of Hospital Clinic1

1 Hospital Clinic y Provincial de Barcelona, Barcelona, Spain
2 Universidad de Navarra, Facultad de Medicina, Navarra, Spain

Purpose of study: The incidence of cardiac arrest (CA) in the U.S. is around 400,000, being survival rate between 5 and 15%. Survival and return of spontaneous circulation in CA due to non-shockable rhythm is related to the cardiac output generated during cardiopulmonary resuscitation (CPR). For this reason the new consensus guidelines (European Resuscitation Council) published in 2010 emphasize chest compressions over ventilation and try to reduce the pause pre and post-shock.

The aim of this study is to determine whether changes in the new guidelines have led to an improvement in survival after CA.

Materials and methods: Retrospective observational study conducted during 1992–2011 in adults with consecutive in-hospital CA. Exclusion criteria were: CA in intensive care units, operating rooms and emergency rooms. Data collected were: demographic data, etiology and classification of CA, internal control data, time, place, methods and results after resuscitation (immediate survival and survival at discharge). Two groups were compared in relation to the implementation of the new guidelines: G1 (before 2005 = 1992–2004) and G2 (after 2005 = 2005–2011). Data analysis was performed by using statistical software package (SPSS v.15).

Results: A total of 1124 in-hospital CA were analyzed. Results are showed in Table 1.

Conclusions:

- In our center, survival after CA, both initial and final, is higher than in the literature.