Preface

The ESA and EBA Helsinki Declaration on Patient Safety in Anaesthesiology\(^1\) requires to have protocols available for the management of perioperative complications. Based on the book “The Anaesthetic Crisis Manual”\(^2\) by David Borshoff and the previous ESA project “OLEH” (Online Electronic Help) by Azriel Perel, the Task Force Patient Safety has developed checklists for various emergencies that appear similar to reference guides used in aviation for in-flight emergencies.

The first draft has been made available on the webpage of the European Society of Anaesthesiology at the end of the year 2012 for open feedback by every ESA member. Taking all the different and very valuable feedbacks into account, these emergency quick reference guidelines have been produced with prudence. Nevertheless, each practitioner is advised to pay careful attention when using these checklists as we do not take responsibility for the consequences out of their application. Furthermore we continue to invite everyone to give us qualified feedback for any possible improvement of these checklists in the future.

These checklists are thought to be a service for the ESA and EBA members and every anaesthetist or national anaesthesia society should feel free to adopt them to their local or national practice.

Our special thanks goes to Anja Sandemose (Norway), Flavia Petrini (Italy), Janusz Andres (Poland), Helmut Trimmel (Austria), Julio Cortinas (Spain), Nick Toff (UK) and Filippo Bressan (Italy) for valuable feedback and suggestions for improvement. Furthermore, various colleagues from the Task Force members and Co-authors have read and corrected the first draft. Thank you very much to all of them.

Sven Staender
[Chairman ESA/EBA Task Force Patient Safety]

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INTRAOPERATIVE MYOCARDIAL ISCHAEMIA

Sign
ECG: ST-Segment depression/elevation, new T-wave inversion, new dysrhythmias

Goal
Reduction in myocardial oxygen consumption and increase in myocardial oxygen delivery

Oxygenation
- Increase FiO2 100% (SpO2 > 94%)
- Correct anaemia.
  Check Hb and consider transfusion (aim Hb 7 – 9 g/dl)

Stress Response
- Check depth of anaesthesia (avoid stimulation if possible)
- Sufficient analgesia

Myocardial Perfusion Pressure
- Increase perfusion pressure
  Consider Noradrenalin 5 – 10 mcg i.v. if HR > 90/min
  Consider Ephedrin 5 mg i.v. if HR < 90/min

Heart Rate
- Titrate to desired heart rate while avoiding hypotension
- Goal 60 – 80 beats/min
  Consider Esmolol 0.25 – 0.5 mg/kg i.v. (± 50 – 200 mcg/kg/min)
  Consider Metoprolol 2.5 mg i.v.

Contractility
- Increase contractility
  Consider Dobutamin 2 – 4 mcg/kg/min

Preload
- Decrease preload
  Consider sublingual Nitroglycerine (NTG) initially or
  NTG infusion 0.5 – 1 mcg/kg/min
  Monitor carefully

Volume status
- Avoid hypovolaemia
  Consider volume load 20 ml/kg

Consider further actions
- Anticoagulation (Heparin and/or Aspirin)
- HDU/ICU admission
  Multi-lead ECG monitoring, invasive monitoring, TEE, 12-lead ECG asap, repeated lab check for troponin, CK, CK-Mb etc.
- Coronary intervention
- Intra-aortal balloon pump (IABP)
Sign:
- Hypotension
- Pulmonary edema
- Bronchospasm (increased insp. pressure, decreased compliance)
- Hypoxia
- Erythema / flush
- Angioedema
- Nausea / vomiting in awake patients

Call for support / inform surgeon

Stop all potential triggering substances
- e.g. drugs, colloids, blood products, latex products

Full resuscitation (start chest compression if no carotid pulse for \( \rightarrow \) 10 sec)
- Adrenaline 1 mcg/kg i.v.
  - Start adrenaline infusion 0.1 mcg/kg/min titrated to maintain systolic blood pressure at least 90 mmHg
- In Cardiovascular collapse:
  - Adrenaline 1 mg i.v. ADULT
  - Arenaline 10 mcg/kg i.v. CHILD
  - Consider Vasopressin 2 U i.v. ADULT

Consider endotracheal intubation and FiO2 100%

Increase preload
- Volume load (min. 20 ml/kg)
- Trendelenburg-Position (leg elevation, head down)

Monitoring
- Place arterial line
- Take arterial blood gases

Consider further actions
- Hydrocortisone bolus i.v. or i.m.
  - \( > \) 12 years: 200mg
  - 6-12 years: 100mg
  - \( < \) 6 years: 50 mg
- H-1-blocker:
  - Clemastine 2 mg bolus i.v. or i.m.
  - Diphenhydramine bolus i.v. or i.m.
    - \( < \) 12 years: 1-2 mg/kg max 50 mg
    - \( > \) 12 years: 25–50 mg max 100mg
- H-2-blocker: Famotidine 20 mg i.v.
- Aminophylline bolus up to 5 mg/kg i.v. or i.m.
- Take blood samples for tryptase levels
  - when patient is stabilized
  - after 2 hrs and 24 hrs
- Arrange for allergy testing after one month
Signs in the patient under anaesthesia:

- Hypotension, tachycardia, circulatory instability
- Bronchospasm, wheezing, decreased pulmonary compliance,
- Hypoxia
- Urticaria, edema formation
- Bleeding from infusion sites and membranes
- Dark-coloured urine

Call for support / inform surgeon

Stop transfusion, keep iv-line open (flush with saline)

Full resuscitation (airway, breathing, circulation)

- Adrenaline 1 mcg/kg i.v.
  Start adrenaline infusion 0.1 mcg/kg/min titrated to maintain systolic blood pressure at least 90 mmHg
- In Cardiovascular collapse:
  Adrenaline 1 mg i.v. ADULT
  Adrenaline 10 mcg/kg i.v. CHILD

Consider endotracheal intubation and FiO2 100%

Treat bronchospasm (see reference No.13)

Volume load (min. 20 ml/kg)

Trendelenburg-Position (leg elevation, head down)

Maintain urinary output

- Use diuretics:
  Mannitol 25% 0.5 - 1 g/kg i.v.
  Furosemide 0.5 mg/kg i.v.

Monitoring

- Place arterial line
- Take arterial blood gases

Further actions

- Consider Methylprednisolone 1- 3 mg/kg i.v.
- Take care of developing coagulopathy:
  - coagulation lab
  - consult transfusion services/laboratory
- Collect and return all transfusion products
- Check ID of patient & blood documentation
- Take fresh urine and blood samples for analysis
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**Call for support / inform surgeon**

**Prevent further entrainment of air**
- Flood operative field with saline
- Compress bleeding sites

**Tilt table head down and left lateral**
- Caution: side supports on table?!
- In CPR: tilt table for operation side lower than level of heart (if possible)

**Switch to FiO₂ 100% (stop N₂O, if in use)**

**Relief pneumoperitoneum (if in use)**

**Cardiac support, avoid hypovolaemia**
- Maintain systemic arterial pressure with vasopressors/inotropic agents
- Increase venous pressure with fluids (20 ml/kg) and vasopressors
- Use RV failure algorithm (18b)

**Consider PEEP (controversial)**

**If central line in place: aspirate**

**Consider Closed Cardiac Massage**
- Comment: to break up large volumes of air
- Early TEE to rule out other treatable causes of pulmonary embolism

**Consider hyperbaric oxygen**
- Comment: Useful up to 6 hrs after the event
  Espescially in patent foramen ovale (up to 30% of general population)
Call for support / inform surgeon

Ask for Suxamethonium to be prepared

Ask for endotracheal tube to be prepared

Children desaturate quickly

100% Oxygen

Cease all stimulation (surgeon, nurses, orderlies etc.)

Remove any airway device and clear the airway

Jaw thrust and gentle CPAP (20 – 30 cm H2O)

- Guedel airway may be considered
- No forced inflation attempts. May increase laryngospasm and may lead to aspiration

Consider deepening anaesthesia

- In children extreme caution! Go directly to Suxamethonium

Suxamethonium if SpO2 still decreases

- ADULT: Suxamethonium 1 mg/kg i.v.
- CHILD: Suxamethonium 1.5 mg/kg i.v.
- Consider Atropine 0.02 mg/kg i.v. in advance to Suxamethonium

Intubate if necessary

Consider Atropine when going into CV collapse

- ADULT: Atropine 0.5 mg i.v.
- CHILD: Atropine 0.02 mg/kg i.v.

Stomach deflation after event
MALIGNANT HYPERTHERMIA

Clinical Signs:
- Hyperthermia
- Hypercapnia
- Increase etCO2 without hypoventilation
- Tachycardia
- Sweating
- Masseter-Spasm
- Muscle rigidity

Personal History:
In conjunction with congenital disease (Strabism, Muscle disease e.g. Duchenne)
- Trigger
- Volatile anaesthetics
- Suxamethonium
- Muscle relaxants

Rapid Diagnosis
- Art. blood gases: combined respiratory & metabolic acidosis?
- Core temperature
- Temperature of absorber cannister (not specific)

Differential Diagnosis
- Hypercapnia, tachycardia, sweating
  - Rebreathing (Deadspace spec. in children [long tube, extensions...])
  - Exhausted Absorber
  - Low fresh gas flow
- Metabolic acidosis
  - Hypothermia, Shock, Sepsis, Hyperchloraemia
- Hyperthermia
  - Fever, external heating, Malignant Neuroleptic Syndrome, MAO-inhibitors, Atropine, Hyoscine, Cocain
- Further differential diagnosis
  - Hypoventilation, anaphylactic reaction, Pheochromocytoma, thyroid storm, cerebral ischaemia, neuromuscular disease, Capnoperitoneum, Ecstasy

If in doubt, treat

Stop any trigger
- Switch off volatiles, switch to Propofol
- Exchange absorber
- Flush circuit with high flow oxygen

Switch to 100% oxygen
MALIGNANT HYPERTHERMIA

Increase minute ventilation
- Increase minute ventilation at least 3 times
- High fresh gas flow 100% O2

Dantrolene 2.5 – 8 (max. 10) mg/kg i.v.
- Titrate according to heart rate, rigidity and patient temperature

Cooling
- Stop cooling at < 38.5° C

Treat hyperkalaemia
- 200 ml Glucose 20% with 20 U regular Insulin over 20 min i.v.
- 10 ml Calcium chloride 10% over 10 min i.v.
- Calcium-Gluconat (100 mg/kg i.v.)
- Inhalative Beta-2 Agonist (Salbutamol)
- Consider Dialysis

Treat acidosis
- Hyperventilation
- Sodium-Bicarbonate (1 mEq/kg, max 50 – 100 mEq)

Monitoring
- Core temperature, minimum 2 peripheral lines
- Consider arterial and central line, foley catheter
- Monitor liver- and renal function
- Beware of compartment syndrome

Laboratory values
- Arterial blood gases
- Na, K
- CK

Your national MH-hotline
Tel.-number:
At all stages ask: Do you need help?

Dry the baby
Remove any wet towels and cover
Start the clock or note the time

Assess (tone),
breathing and heart rate

If gasping or not breathing
Open the airway
Give 5 inflation breaths

Re-assess
If no increase in heart rate look for chest movement

If chest not moving
Recheck head position
Consider two-person airway control
or other airway manoeuvres

Repeat inflation breaths
Consider SpO2 monitoring
Look for a response

If no increase in heart rate
Look for chest movement

When the chest is moving
If the heart rate is not detectable or slow (< 60)
Start chest compressions. 3 compressions to each breath

Reassess heart rate every 30 seconds
If the heart rate is not detectable or slow (< 60)
Consider venous access and drugs

Acceptable* pre-ductal SpO2
2min: 60%
3min: 70%
4min: 80%
5min: 55%
10min: 90%

Birth
30 sec
60 sec

SEVERE BRONCHOSPASM

Mild Bronchospasm:
- Check airway position
- Deepen anaesthesia
- Use inhalational bronchodilator therapy

Commence manual ventilation, deepen anaesthesia

Check ...
- Correct airway position
- Capnography
- Airway pressure

Rule out ...
- Severe allergic reaction
- Pneumothorax (previous central line placement?)
- Left heart failure

Switch to 100% oxygen

2 - 3 puffs Salbutamol
- Use adaptor for circuit or ETT (endotracheal tube)
- Repeat if required
- Consider Salbutamol i.v. bolus (4 mcg/kg i.v. or s.c.), repeat if necessary

Ventilator settings
- Long expiration phase
- Intermittent disconnection to avoid overinflation of the lungs and allow for CO2 escape
- Low grade PEEP

Monitor treatment response
- Capnography
- Airway pressure

Consider further actions
- Adrenaline bolus 0.1 - 1 mcg/kg i.v. (titrate)
- Magnesium 50 mg/kg over 20 min (max. 2 g) i.v.
- Aminophylline 5 - 7 mg/kg over 15 min i.v.
- Hydrocortisone 1 - 2 mg/kg i.v.
- S-Ketamine 0.5 – 1 mg/kg i.v.
- Expanded monitoring with arterial line and serial blood gases
- HDU / ICU admission
LOCAL ANAESTHETIC TOXICITY

Signs:
- Seizures
- Slurred speech
- Numb tongue
- Tinnitus
- Metallic taste
- Higher degree AV-block during/after LA-Injection
- Hypotension
- Wide QRS complex
- Bradycardia deteriorating into PEA and asystole

Stop LA-drug administration

Commence CPR if necessary
- Small doses of epinephrine if LA toxicity is strongly suspected (10 – 100 mcg i.v.)
- Vasopressin is NOT recommended

Treat convulsions (beware of cardiovascular instability)
- Midazolam 0.05 - 0.1 mg/kg  [70 kg: 5 - 10 mg]
  [20 kg: 1 - 2 mg]
- Thiopentone 1 mg/kg
- Propofol 0.5 - 2 mg/kg  [70 kg: 50 - 100 mg]
  [20 kg: 20 - 40 mg]

Intralipid 20%
- 1.5 mg/kg bolus i.v. over 1 minute (100 ml in adults) repeat every 5 min up to a max of 3
- Followed by 15 ml/kg/h (1000 ml per h in adults)

Treat cardiac arrhythmias
- Avoid Lidocaine
- Caution with Betablockers (Myocardial depression)
- Consider Amiodarone
- Consider transcutaneous or intravenous pacemaker for symptomatic bradycardic rhythm with pulse

Consider additionally
- H1 blocker: Diphenhydramin 50 mg i.v.
- H2 blocker: Famotidine 20 mg i.v.
- Sodium bicarbonate to maintain pH > 7.25
- Continue CPR for a prolonged period (at least 60 min)
- ECMO
EKG-signs:
- Peaked T-Waves
- Loss of P-Waves
- Prolonged PR-Interval
- Widened QRS-complex
- Loss of R-Amplitude
- Asystoly

**Stop any further K+ administration**

**Hyperventilation (K+ shift)**

**Drugs**
- Adult:
  - 10 ml Calcium chloride 10% over 10 min i.v.
  - Sodium bicarbonate 8.4% 50 ml i.v.
  - 200 ml Glucose 20% with 20 U regular Insulin over 20 min i.v.
- Child:
  - Calcium chloride 10% 0.2 ml/kg over 10 min i.v.
  - Glucose 20% 0.5 g/kg with regular Insulin 0.1 U/kg i.v.

**Consider further actions**
- Nebulized Salbutamol
- Diuretics (Furosemide)
- Potassium-exchange resins (sodium polystyrene sulfonate)
- Hemodialysis
Airway manoeuvres

- Suction oropharynx
- Tilt surgical table “head down” position
- No cricoid pressure (Sellick) during active vomiting (risk of esophageal rupture)
- Perform laryngoscopy
- Suction pharynx
- Intubate and suction bronchial tree through endotracheal tube BEFORE first manual ventilation

Adjust FiO2 and PEEP according to oxygenation

Suction stomach before emergence

Consider further actions

- Consider bronchoscopy
- In severe aspiration, surgery should only be performed if really urgent
- Consider HDU/ICU admission
- If patient is asymptomatic 2 hrs after event with normal saturation and chest x-ray, ICU admission is not necessary
- NO lavage
- NO steroids
- NO antibiotics
Preparation / Monitoring

- 2 large bore i.v. catheters
- Foley catheter (urine output)
- Temperature-probe
- **Warm Patient actively!**
- Consider arterial and central line [use ultrasound in impaired coagulation]
- Consider rapid-infusion device and cell-salvage system
- Consider anaesthesia induction with already running norepinephrine pump

Laboratory aspects

- Contact and coordinate with blood bank early
- Cross match and antibody screen [Type & screen]
- Blood count (Haemoglobin, haematocrit, thrombocytes)
- Coagulation status [incl. Fibrinogen]
- Art. blood gases (pH, Hb, ionised Ca, Lactate)

Basic therapy

- Keep normothermic (> 36 °C)
- Keep normocalcaemic (1.1 - 1.3 mmol/l, titrate Ca 1 - 2 g i.v.)
- Correct acidosis (keep normovolaemia)
- Keep haematocrit at 21% - 24%
- Aim for MAP 55 - 65 mmHg [severe head trauma MAP 80 - 90 mmHg]

Advanced therapy

- **Fibrinogen** 2 g up to max. 6 g Aim for: Fbg > 2 g/l
- **FFP** init. 15 - 20 ml/kg (~ 2 - 4 bags) Aim for: INR < 1.5
- **Tranexamic acid** 15 mg/kg bolus slowly i.v.
  [especially in local hyperfibrinolysis, e.g. uterine atony or abortion!]
- **Thrombocytes**: aim for > 50'000/ul
  [Tc > 100’000/ul in severe head trauma]
1. DISTINGUISH

**Circuit**
- Respirator settings
- Kinked tubing
- Valve failure
- Failure of high pressure valve
- Failure of O2-flush

**Airway**
- Laryngospasm (if not intubated)
- Tube position
- Tube size
- Blocked or kinked tube (patient biting on tube)

**Patient**
- Bronchospasm
- Laryngospasm (if not intubated)
- Pneumothorax
- Pneumoperitoneum
- Tracheal pathology
  - Foreign body (e.g. chewing gum)
  - Secretions
  - Tumor
- Chest wall rigidity
- Obesity
- Alveolar pathology
  - Oedema
  - Infection
  - ARDS
  - Contusion
  - Fibrosis

**Most likely**
- Insufficient relaxation
- endotracheal tube position
- Laryngospasm (if not intubated)
- Respirator settings

2. ACTIONS

**Check**
- Muscle relaxation
- Depth of anaesthesia
- Capnogram
  - Bronchospasm ?
  - Kinked endotracheal tube ?
- Spirometry
  - Endobronchial intubation ?
  - Kinked endotracheal tube ?
- Tubing circuit
  - Kinked tubing ?
  - Obstructed tubing ?

**Do**
- Auscultate
- Manually ventilate
- Suction bronchial tree
- Flexible bronchoscopic exam
- If LMA in place consider endotracheal tube

**If problems persist**
- Review possible patient causes
- Call for assistance
- Repeat checklist together
**Differential Diagnosis**

**Hypocapnia / Low etCO₂**

**No etCO₂**
- No etCO₂ - NO VENTILATION, NO PATENT AIRWAY !!!
- Oesophageal intubation?
- Disconnection of tubing, complete failure of respirator
- Apnea
- Cardiac arrest

**Diminished production of CO₂**
- Hypothermia
- Deep anaesthesia
- Hypothyroidism

**Enhanced excretion of CO₂**
- (Spontaneous) hyperventilation
- Inappropriate ventilator setting

**Reduced transport of CO₂ in blood**
- Severe hypotension
- Anaphylaxis
- Cardiac arrest
- Pulmonary embolus

**Reduced transport of CO₂ in lung**
- Endotracheal tube obstruction
- Incorrect airway placement [endobronchial intubation]
- Laryngospasm
- Severe bronchospasm

**Sampling dilution**
- Disconnection of respirator
- Dilution of sampling gas with room-air
- Gas sampler placed wrong
- High fresh gas flow in circuit

**Most likely**
- Rule out MALPLACED AIRWAY [oesophageal]
- Hyperventilation [too high minute ventilation]
- Bronchospasm
- Laryngospasm
- Hypotension
Increased production of $CO_2$

a. Exogenous:
   - CO2 insufflation (e.g. laparoscopy)
   - Bicarbonate administration
   - Re-breathing (valves, Soda lime, fresh gas-flow)

b. Endogenous:
   - Painful stimulus
   - Increased body temperature
   - Reperfusion after Tourniquet
   - Sepsis, Malignant Hyperthermia
   - Thyroid storm, Malignant Neuroleptic Syndrome

Reduced excretion of $CO_2$

a. Lungs:
   - Hypoventilation (spont. or respirator settings)
   - Bronchospasm, asthma
   - COPD (chronic airway disease)

b. Breathing circuit:
   - Increased dead space
   - Inadequate fresh gas flow
   - Valve malfunction
   - Incorrect respirator settings

Most likely
- Hypoventilation (spontaneous or respirator settings)
- Exhausted soda lime
- Fresh gas flow setting
Differential Diagnosis

Bradycardia

Primary causes
- Atrioventricular block
- Pacemaker malfunction
- Cardiomyopathy
- Sick sinus syndrome
- Myocarditis
- Pericarditis
- Valvular heart disease
- Pumonary Hypertension

Secondary causes
- Elektrolyte abnormalities
- Antiarryhtmic medication
- Hypothyroidism
- Hypothermia
- Hypervagal
- Increased intracranial pressure
- Temponade
- Tension pneumothorax

Anaesthetic causes
- Hypoxia
- Volatile agent side effects
- Muscle relaxant side effects
- Narcotic
- Anticholinesterase drugs
- High spinal/ epidural anaesthesia
- Local anaesthetic toxicity
- Hyper- Hypokaemia
- Vasopressor reflex
- Auto-PEEP
- Malignant Hyperthermia

Most likely
- Drug related
- Hypervagal
- Spinal anaesthesia
- Fitness
Check / rule out
- Pulse oxymetry, Oxymeter, Skin and field blood colour: rule out hypoxia
- Hypovolaemia
- Auto-PEEP
- Gas/air embolism? Thrombo/fat embolism?
- High spinal/epidural
- Tension pneumothorax
- Tamponade
- Other primary, secondary or anaesthetic causes (see Reference Guide 16)

In severe hypotension, poor perfusion, or low etCO2
- Start CPR
- Improve oxygenation
- Assist ventilation (avoid hyperventilation)
- Volume load (20 ml/kg), repeat if necessary
- Treat potential underlying cause (see check / rule out list above)
- Consider Atropine 0.5 mg i.v. (may repeat up to 3 mg in total)
- Consider Epinephrine 10 to 100 mcg i.v. (may repeat while awaiting pacer)
  - Consider Epinephrine infusion (0.05 – 0.1 mcg/kg/min)
  - Consider Dopamine infusion (2 – 10 mcg/kg/min)
- Consider Isoproterenol 4 mcg i.v. (may repeat while awaiting pacer)
- Consider arterial- and central venous line

If the above is ineffective (use without delay in high-degree block)
- Transcutaneous pacing
- Esophageal pacing
- Transvenous pacing

Consider expert consultation

Primary causes
• Cardiomyopathy
• Sick sinus syndrome
• Accessory conduction pathways (Re-entry)
• Myocarditis
• Pericarditis
• Valvular disease
• Congenital heart disease

Secondary causes
• Hypovolaemia
• Anaesthetic depth
• Drugs
• Anxiety
• Pain
• Electrolyte abnormalities
• Cardiac tamponade
• Sepsis
• Thyreotoxicosis
• Lung disease
• Malignant hyperthermia

Most likely
• Anaesthetic depth and surgical stimulation
• Anxiety and pain
• Hypovolaemia
Check / rule out

- Light anaesthesia
- Hypovolaemia
- Auto-PEEP
- Early hypoxia or hypercapnea
- Other primary or secondary causes (see Reference Guide 17)

In severe hypotension or poor perfusion

- Consider synchronized cardioversion

Narrow QRS

- Rhythm regular
  - Consider vagal maneuvers
  - Consider Adenosine 6 mg i.v. push
    if no response give Adenosine 12 mg i.v. push
  - If still no conversion:
    consider beta blocker (e.g. Metoprolol 2.5 mg i.v.) or Ca channel blocker

- Rhythm irregular
  - Low ejection fraction (EF) or severe hypotension
    consider synchronized cardioversion
    consider load Amiodarone 150 mg i.v. over 10 min
  - Normal EF or acceptable blood pressure
    consider beta blocker (e.g. Metoprolol 2.5 mg i.v.) or Ca channel blocker

Wide QRS

- Rhythm regular
  - If ventricular tachycardia or uncertain rhythm
    consider load Amiodarone 150 mg i.v. over 10 min and Calcium chloride 1 g i.v.
    if no Amiodarone available: Lidocaine 1 – 1.5 mg/kg i.v

- Rhythm irregular
  - If Torsade-de-Pointes
    Consider Magnesium Sulfate 2 g i.v. over 5 min (consider repeat)
  - If pre-excited atrial fibrillation
    consider load Amiodarone 150 mg i.v. over 10 min

Consider expert consultation

Preload Reduction
- Blood loss
- Hypovolaemia
- Decreased venous return (caval vein?)
- Elevated intrathoracic pressure
- Cardiac Tamponade
- Embolism

Reduced Contractility
- Drugs (including volatile agents)
- Ischaemic heart disease
- Cardiomyopathy
- Myocarditis
- Arrhythmia
- Valvular heart disease

Reduced Systemic Vascular Resistance
- Volatile anaesthetics
- Narcotics
- Vasodilators
- Antihypertensive drugs
- Regional blockade (spinal/epidural)
- Sepsis
- Release of tourniquet
- Anaphylaxis
- Addison’s disease
- Thyroid disease

Most likely
- Depth of anaesthesia and volatile anaesthetics
- Narcotics
- Regional blockade (spinal/epidural)
- Hypovolaemia
- Transducer height (invasive monitoring)
SPV = systolic pressure variation
SVR = systemic vascular resistance in dyne sec-1cm5m2
PTX = pneumothorax
IABP = intraaortic balloon pump
VAD = ventricular assist device
PEEP = positive end-expiratory pressure
ACEi = angiotensin-converting enzyme inhibitor


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TEE = Trans esophageal echo
CVP = central venous pressure
pRBC = packed red blood cells
SVO2 = systemic oxygen consumption
ScvO2 = central venous oxygen saturation
PEEP = positive end-expiratory pressure
iNO = inhaled Nitric oxide
PVR: pulmonary vascular resistance

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Differential Diagnosis Hypertension

**Anaesthesia related causes**
- Too light anaesthesia
- Pain
- Hypoxia
- Hypercapnia
- Malignant hyperthermia
- Drugs (Cocain)
- Transducer height (invasive monitoring)

**Surgery related causes**
- Tourniquet
- Aortic clamping
- Carotid endarterectomy
- Baroreceptor stimulation
- Pneumoperitoneum

**Patient related causes**
- Essential hypertension
- Rebound-Hypertension (sudden stop betablocker)
- Full bladder
- Pre-eclampsia
- Renal disease
- Phaeochromocytoma
- Thyroid storm
- Raised intracranial pressure

**Most likely**
- Intubation and emergence from anaesthesia
- Inadequate anaesthesia, analgesia
- Pneumoperitoneum
- Drugs
- Essential hypertension
Airway
• Endobronchial intubation
• Airway obstruction
• One lung ventilation
• Laryngospasm
• Aspiration

Breathing / Ventilator
• Low fresh gas flow
• Bronchospasm
• Respirator malfunction/setting
• Circuit obstruction/disconnection
• Pulmonary oedema
• Contusion
• Atelectasis
• Pneumothorax
• Pneumonia
• Sepsis / ARDS

Circulation
• Cardiac arrest
• Cardiac failure
• Anaphylaxis
• Pulmonary embolism
• Hypothermia
• Poor peripheral circulation
• Methaemoglobinaemia (Prilocain, Lidocain, Benzocain)

Most likely
• Probe displacement
• Apnea and hypoventilation
• Tube position
• Laryngospasm
• Bronchospasm