

Absolute Contraindications for ECMO

- Prolonged ventilation for > 10 days or with high airway pressure and/or high FiO₂ > 7 days
- Established multi-system organ failure
- Contraindication to anticoagulation
- Refusal to receive blood products
- Ungrafted severe burns
- Quadriplegia
- Bone marrow transplant recipients
- Severe immunosuppressed state (ANC < 400/mm³)

Risk of Rewarming

- Rewarming of the trunk should be undertaken **PRIOR** to the extremities in order to minimize the risk of core temperature afterdrop, hypotension, and acidemia due to arterial vasodilatation.
 - Atropine does **not** work on hypothermic bradycardia.
 - Epinephrine may induce potentially lethal cardiac arrhythmias.
 - No evidence exists to support the use of antiarrhythmic medications.
- When using forced air warming systems, leave the extremities uncovered initially to minimize risk of afterdrop and to allow for proper heat transfer.
- Due to decreased sensation and reduced blood flow, body surface burns may result when using heating pads to rewarm a hypothermic patient.

Reference

- Brown, Douglas J.A., et al. "Accidental Hypothermia." *The New England Journal of Medicine* 367.20 (2012): 1936-1938.
- Herbert, Mel and Doug Brown. "Accidental Hypothermia - Part 1." 15 January 2014. [Emergency Medicine Reviews and Perspectives](#).
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- Mechem, C Crawford and Ken Zafren. "Accidental Hypothermia in Adults." October 2014. [UpToDate](#).

Quality Measures

- ECLS outcome measures
 - Survival to decannulation
 - Survival to discharge
 - CPC score at discharge
- ECLS process measures
 - ED arrival to ECLS consult
 - ED arrival to cannulation
 - Total number of consults for this indication
 - Rate of approval
 - Rate of denial by reason
- LOS for inpatients with accidental hypothermia
- Mortality rate for inpatients with accidental hypothermia

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Disclaimer: Clinical practice guidelines and algorithms at The Ohio State University Wexner Medical Center (OSUWMC) are standards that are intended to provide general guidance to clinicians. Patient choice and clinician judgment must remain central to the selection of diagnostic tests and therapy. OSUWMC's guidelines and algorithms are reviewed periodically for consistency with new evidence; however, new developments may not be represented.

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