For all patients with confirmed or suspected hypothermia:
- Remove wet clothing
- Maintain horizontal position
- Avoid rough movement and any excess activity
- Monitor core temperature
- Protect against further heat loss
- Monitor cardiac rhythm

Assess responsiveness, respiration, and pulse.

Pulse or respiration present?

- Start CPR
- Defibrillate VF/VT only if needed**
  - If patient does not respond to the first shock(s), consider initiating the process to start ECMO/ECLS
- Intubate
- Ventilate with warm, humid air (42-46°C or 107.6-114.8°F)
- Establish IV and infuse warm normal saline (43°C or 109.4°F)

Is core temperature < 34°C (93.2° F)?

- Mild Hypothermia
  - Passive rewarming
  - Active external rewarming
  - Bair Hugger Blanket System

Is core temperature < 30°C (86° F)?

- Moderate Hypothermia
  - Passive rewarming
  - Active external rewarming of truncal areas ONLY
  - If core temperature is <90º, consider use of Zoll Catheter*.  
  *For guidance on use of Zoll catheter, refer to Appendix G.

Severe Hypothermia
- Active internal rewarming

Active internal warming: (Also refer to Heated Infusions on Appendix E):
- Warm IV fluids (43°C or 109.4°F)***
- Warm, humid oxygen (42-46°C or 107.6-114.8°F)
- Initiate Zoll Catheter
- Initiate ECMO as noted below
- Heated Peritoneal lavage (KCl-free fluid, warmed NS preferred)¥
- Left-sided Thoracic Lavage with 2 chest tubes and warmed fluid (warmed NS preferred)¥

Continue active internal warming until:
- Core temperature ≥ 35°C (95° F) or
- Return of spontaneous circulation or
- Resuscitative efforts cease

Indications for extracorporeal membrane oxygenation (ECMO):
- Consider for patients with hypothermia who have cardiac instability and are not responding to medical treatment
- Consider for intractable cardiac arrest (VF or asystole) in a person with hypothermia
- When calling for Extracorporeal life support (ECLS) consult (614-293-ECMO), please establish a right-sided femoral venous line (8-French Cordis Introducer) and a right-sided arterial line with 5 French sheath, then specify which access is obtained when calling.

**Defibrillation is usually ineffective until body temperature > 30°C (86°F)
***Warm IV fluids alone have minimal effect with the exception for prevention of more heat loss.
¥Consider these if ECMO is not possible or will be delayed

Key Points

- Hypothermia occurs when the core body temperature falls to ≤ 35°C (95.0°F)
- If hypothermia is expected, use a low-reading core thermometer as standard oral
  - thermometers do not read < 34°C (93.2°F)
- Hypothermia can be classified into three levels of severity based on the core temperature:
  - Mild Hypothermia: 35°C - 32°C (95.0°F - 89.6°F)
  - Moderate hypothermia: 32°C - 28°C (89.6°F - 82.4°F)
  - Severe hypothermia: < 28°C (82.4°F)
- See Appendix A for predisposing factors.

Clinical Presentation

At patient presentation, be vigilant for vital signs inconsistent with the patient’s presumed degree of hypothermia. Such inconsistencies may suggest an alternative diagnosis.

<table>
<thead>
<tr>
<th>Degree of Hypothermia</th>
<th>Clinical Assessment</th>
</tr>
</thead>
</table>
| Mild                  | Clear cognitive function  
  • Shivering |
| Moderate              | Impaired cognitive function  
  • No shivering |
| Severe                | Unconscious  
  • No shivering |

NOTE: See Appendix B for table detailing clinical manifestations of hypothermia.

Physical Evaluation

- Total body survey
  - Evaluate patient for local cold-induced injuries and signs of trauma.
  - Use caution when performing the physical evaluation.
  - The hypothermic heart is sensitive to movement and rough handling of the patient may precipitate adverse health outcomes such as arrhythmias and ventricular fibrillation.
  - Slow atrial fibrillation is a common arrhythmia among patients with mild hypothermia and will spontaneously resolve with rewarming.
- Core temperature
  - Use low-reading thermometers only
  - Esophageal probe inserted into the lower one-third of the esophagus is appropriate for intubated patients.
  - Bladder, rectal, and temporal thermometers should not be used.

Lab Evaluation

Patients who are previously healthy and are diagnosed with mild, accidental hypothermia may not require laboratory evaluation.

- The laboratory evaluations below should be considered for patients with moderate to severe hypothermia:
  - If post arrest, Troponin
  - Arterial blood gas (See Appendix C)
  - Chem 10
  - Chest X-ray
  - ECG
  - Lipase
  - Partial thromboplastin and prothrombin times
  - Serum electrolytes*
  - CBC

*Rewarming can lead to rapid changes in electrolyte concentrations. Reassess electrolyte levels every four hours during rewarming.

NOTE: See Appendix D for table detailing laboratory findings.

Treatment

The initial management of hypothermia focuses on resuscitation, assessment of the extent of injuries, and rewarming. See Appendix E for table detailing the recommended rates for various rewarming modalities.

<table>
<thead>
<tr>
<th>Types of Rewarming</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| Passive External Rewarming (PER)  | • Cover patient in blankets or other types of insulation  
  • Maintain room temperature of 28°C |
| Active External Rewarming (AER)   | • Use combination of blankets (e.g., Bair Hugger Heating Blankets), heating pads, radiant heat, warm baths, or forced warm air applied directly to patient’s skin* |
| Active Internal Rewarming (AIR)   | • IV administration of warmed crystalloid**  
  • Warm humidified oxygen  
  • Peritoneal and pleural irrigation with warmed isotonic crystalloid  
  • Extracorporeal blood rewarming*** |

* Rewarm the trunk PRIOR to the extremities to minimize risk of adverse outcomes.

**It is best to use a stepwise approach starting with less invasive rewarming techniques. Extracorporeal blood rewarming is performed in only extreme cases or when rewarming is inadequate despite all other therapies. See OSUWMC Extracorporeal Life Support (ECLS) guideline.

***Warmed IVF are useful only in trying to prevent further heat loss. They are NOT effective to significantly raise body temperature. (only 0.33°C to 0.66°C/hr for IVF heated to 42°C /108°F.)
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 systematic anticoagulation
- Refusal to receive blood products
- Unergrafted 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 academia 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


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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- Bryan Whitson, MD
- David Mast
- David Stahl, MD

Guideline Approved


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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## Appendix A

### Predisposing Factors for Hypothermia

<table>
<thead>
<tr>
<th>Predisposing Factors</th>
<th>Clinical Examples</th>
</tr>
</thead>
</table>
| **Increased Heat Loss** | - Environmental  
  o Immersion  
  o Non-immersion  
  - Induced vasodilatation  
  o Pharmacologic  
  o Toxicologic  
  - Erythrodermas  
  o Burns  
  o Psoriasis  
  o Ichthyosis  
  o Exfoliative dermatitis  
  - Iatrogenic  
  o Emergency childbirth  
  o Cold infusion  
  o Heatstroke treatment |
| **Decreased Heat Production** | - Endocrine failure  
  o Hypopituitarism  
  o Hypoadrenalism  
  o Lactic acidosis  
  o DKA/EIOH KA  
  - Insufficient Fuel  
  o Hypoglycemia  
  o Malnutrition  
  o Extreme exertion  
  - Neuromuscular Physical Exertion  
  o Age extremes  
  o Impaired shivering  
  o Inactivity  
  o Lack of adaptation |
| **Impaired Thermoregulation** | - Peripheral Failure  
  o Neuropathies  
  o Acute cord transection  
  o Diabetes  
  - Central Failure/Neurologic  
  o SAH or CVA  
  o CNS trauma  
  o Metabolic  
  o Pharm/Tox  
  o Hypothalamic dysfunction  
  o Parkinson’s disease  
  o Anorexia nervosa  
  o Cerebellar lesion  
  o Neoplasm  
  o Congenital intracranial path  
  o Multiple Sclerosis |
| **Miscellaneous** | - Sepsis  
  - Multisystem Trauma Bacterial, viral, parasitic Pancreatitis  
  Cardiopulmonary disease Vasculopathy  
  - Uremia  
  - Paget’s disease Giant cell arteritis Sarcoidosis  
  - SLE  
  - Wernicke-Korsakoff Hodgkin’s disease Shock  
  - Sickle cell anemia  
  - SIDS |
## Appendix B
### Pathological Changes in Hypothermia

<table>
<thead>
<tr>
<th>Level of Hypothermia</th>
<th>°C</th>
<th>°F</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MILD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37.6</td>
<td>99.6</td>
<td>Normal rectal temperature</td>
<td></td>
</tr>
<tr>
<td>37.0</td>
<td>98.6</td>
<td>Normal oral temperature</td>
<td></td>
</tr>
<tr>
<td>36.0</td>
<td>96.8</td>
<td>Increase in metabolic rate and blood pressure and pre-shivering muscle tone</td>
<td></td>
</tr>
<tr>
<td>35.0</td>
<td>95.0</td>
<td>Urine temperature 34.8°C; maximum shivering thermogenesis</td>
<td></td>
</tr>
<tr>
<td>34.0</td>
<td>93.2</td>
<td>Amnesia, dysarthria, and poor judgment develop; maladaptive behavior; normal blood pressure; maximum respiratory stimulation; tachycardia, then progressive bradycardia</td>
<td></td>
</tr>
<tr>
<td>33.0</td>
<td>91.4</td>
<td>Ataxia and apathy develop; linear depression of cerebral metabolism; tachypnea, then progressive decrease in respiratory minute volume; cold diuresis</td>
<td></td>
</tr>
<tr>
<td>32.0</td>
<td>89.6</td>
<td>Stupor; 25% decrease in oxygen consumption</td>
<td></td>
</tr>
<tr>
<td><strong>MODERATE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.0</td>
<td>87.8</td>
<td>Extinguished shivering thermogenesis</td>
<td></td>
</tr>
<tr>
<td>30.0</td>
<td>86.0</td>
<td>Atrial fibrillation and other arrhythmias develop; poikilothermia; cardiac output two-thirds of normal; insulin ineffective</td>
<td></td>
</tr>
<tr>
<td>29.0</td>
<td>85.2</td>
<td>Progressive decrease in level of consciousness, pulse, and respiration; pupils dilated; paradoxical undressing</td>
<td></td>
</tr>
<tr>
<td>28.0</td>
<td>82.4</td>
<td>Decreased ventricular fibrillation threshold; 50% decrease in oxygen consumption and pulse; hypoventilation</td>
<td></td>
</tr>
<tr>
<td><strong>SEVERE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.0</td>
<td>80.6</td>
<td>Loss of reflexes and voluntary motion</td>
<td></td>
</tr>
<tr>
<td>26.0</td>
<td>78.8</td>
<td>Major acid-base disturbances; no reflexes or response to pain</td>
<td></td>
</tr>
<tr>
<td>25.0</td>
<td>77.0</td>
<td>Cerebral blood now one third of normal; loss of cerebrovascular autoregulation; cardiac output 45% of normal; pulmonary edema may develop</td>
<td></td>
</tr>
<tr>
<td>24.0</td>
<td>75.2</td>
<td>Significant hypotension and bradycardia</td>
<td></td>
</tr>
<tr>
<td>23.0</td>
<td>73.4</td>
<td>No corneal or oculocephalic reflexes; areflexia</td>
<td></td>
</tr>
<tr>
<td>22.0</td>
<td>71.6</td>
<td>Maximum risk of ventricular fibrillation; 75% decrease in oxygen consumption</td>
<td></td>
</tr>
<tr>
<td>20.0</td>
<td>68.0</td>
<td>Lowest resumption of cardiac electromechanical activity; pulse 20% of normal</td>
<td></td>
</tr>
<tr>
<td>19.0</td>
<td>66.2</td>
<td>Electroencephalographic silencing</td>
<td></td>
</tr>
<tr>
<td>18.0</td>
<td>64.4</td>
<td>Asystole</td>
<td></td>
</tr>
<tr>
<td>16.0</td>
<td>60.8</td>
<td>Lowest adult accidental hypothermia survival</td>
<td></td>
</tr>
<tr>
<td>15.2</td>
<td>59.2</td>
<td>Lowest infant accidental hypothermia survival</td>
<td></td>
</tr>
<tr>
<td>10.0</td>
<td>50.0</td>
<td>92% decrease in oxygen consumption</td>
<td></td>
</tr>
<tr>
<td>9.0</td>
<td>48.2</td>
<td>Lowest therapeutic hypothermia survival</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Management of Acid-Base Status in the Hypothermic Patient

• Resuscitation in a hypothermic patient should be titrated to pH. The person who is hypothermic has a slower metabolism and produces fewer waste products during normal function. It may be very normal for somebody who’s core temperature is in the mid to low eighties to have a blood pressure that is low and a heart rate that is bradycardic (slow A-Fib) along with a respiratory rate < 6.

• If the blood gas shows a normal pH in a hypothermic patient, and they have a respiratory rate that is slow, they likely do not need to have their respiratory rate augmented by intubation. They are physiologically at the place that they need to be as long as their pH is normal. Acidosis or alkalosis promotes arrhythmia in these patients.

• Likewise, an 80°F patient with a heart rate of 18 who has a normal pH does not need CPR. This is more likely to generate an arrhythmia than it is to be useful. The heart rate and respiratory rate will come up as the temperature rises.

Appendix D

Laboratory Findings Indicative of Accidental Hypothermia

<table>
<thead>
<tr>
<th>Laboratory Test</th>
<th>Clinical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial blood gas</td>
<td>Metabolic acidosis, respiratory alkalosis, or both</td>
</tr>
<tr>
<td>Electrolytes</td>
<td>No consistent abnormality</td>
</tr>
<tr>
<td>Glucose</td>
<td>Increased, decreased, or no change</td>
</tr>
<tr>
<td>White blood cell and platelet counts</td>
<td>Decreased due to splenic sequestration</td>
</tr>
<tr>
<td>Hemoglobin, hematocrit</td>
<td>Increased due to hemoconcentration</td>
</tr>
<tr>
<td>Lipase</td>
<td>May be increased due to hypothermia-induced pancreatitis</td>
</tr>
<tr>
<td>Prothrombin and partial thromboplastin times</td>
<td>Increased in vivo due to inhibition of coagulation cascade despite normal reported values</td>
</tr>
<tr>
<td>ECG</td>
<td>Prolongation of PR, QRS, or QT intervals. ST segment elevation, T wave inversions, atrial fibrillation or sinus bradycardia.</td>
</tr>
<tr>
<td>Chest X-ray</td>
<td>Aspiration pneumonia, vascular congestion, pulmonary edema.</td>
</tr>
</tbody>
</table>

## Recommended Rewarming Rate by Modality

<table>
<thead>
<tr>
<th>Modality</th>
<th>Indications</th>
<th>Rate of Rewarming</th>
<th>Additional Comments</th>
</tr>
</thead>
</table>
| Passive External Rewarming (PER)  | • The stable patient with a core temperature > 32°C (89.6°F) is the ideal candidate for this treatment.  
• It is appropriate in mild hypothermia or as adjunctive to active rewarming | 0.5-1°C (0.9-1.8°F) per hour         | • In order for this technique to cause an increase in body temperature, the patient must be able to generate heat.  
  o The patient will lose this ability at a core temperature < 32°C (89.6°F).  
• This method is focused on preventing any further loss of heat from a body by providing insulation and removing the patient from the offending environment.  
  o No outside heat is added to the patient and peripheral vasoconstriction is maintained.  
  o PER may be used in any patient as initial treatment in the field, or to prevent further heat loss in the ED. |
| Active External Rewarming (AER)   | • Cardiovascular instability  
• Moderate to severe hypothermia T° < 32°C (89.6°F)  
• Failure to rewarm externally  
• Endocrinologic insufficiency  
• Traumatic or toxicologic peripheral vasodilatation  
• Secondary hypothermia impairing thermoregulation  
• Additional modalities should be added if T° fails to rise by at least 1-2°C (1.8 -3.6°F) per hour | Variable based on modality used:  
  o Radiant heat  
  o Hot water bottles  
  o Plumbed garments  
  o Electric heating pads and blankets  
  o Forced circulated hot air  
  o Immersion in warm water | • The application of AER alone must be done cautiously with close monitoring for adverse thermic and BP changes.  
• Application should be limited to the trunk only.  
• Truncal AER may be used safely in conjunction with active core rewarming. |
| Heated Humidified Oxygen          | • All patients with moderate to severe hypothermia.                           | 1-2.5°C (1.8-4.3°F) per hour         | • The ideal temperature of the air to be delivered is 45°C (113°F).  
  o Minor modification of respiratory equipment may be required to achieve this temperature.  
• Although shivering may be reduced with this method of core rewarming, the core temperature is elevated nonetheless. |
| Heated Infusions                  | • Any moderate to severe hypothermic patient                                 | 0.33°C (0.66°F) per liter of fluid warmed to 42°C (107.6°F) | • IV fluids should be heated to 40-42°C (104-107.6°F).  
  o A 1 L bag of NS should be heated on high for ≈ 2 minutes in the microwave.  
  o Blood can be warmed in the Level One Infusor® to 35-38°C (95-100.4°F).  
  Never microwave blood. |
<table>
<thead>
<tr>
<th>Modality</th>
<th>Indications</th>
<th>Rate of Rewarming</th>
<th>Additional Comments</th>
</tr>
</thead>
</table>
| Heated Irrigation of Hollow Viscous  | • Moderate to severely hypothermic patients as an adjunct to other methods of rewarming. | • 1-1.5°C (1.8-2.7°F) per hour | • **DO NOT USE** heated irrigation in patients with GI tract injuries.  
  • Warmed fluids used for direct irrigation should have a dwell time of ≤15 minutes.  
  • The patient should be intubated before gastric lavage is performed as airway protection. |
| Heated Irrigation of the Peritoneum* | • Moderate to severely hypothermic patients                                  | • 1-3°C (1.8-5.4°F) per hour | • Through a DPL catheter, normal saline, LR or 1.5% dextrose dialysate heated to 40-45°C (104-113°F), may be instilled into the peritoneum 2 liters at a time.  
  • The fluid is left to dwell for 20-30 minutes and then exchanged.  
  • Using dialysate, effective detoxification of certain substances and manipulation of certain electrolytes can be attained. |
| Heated Irrigation of the Thoracic Cavity* | • This technique is best reserved for patients who are not perfusing, unless extracorporeal warming is immediately available. | • 20°C (36°F) per hour       | • The thoracic cavity can be irrigated with saline heated to 40-42°C (104-107.5°F) via anterior and posterior chest tubes (ant-MCL at 2 or 3 ICS; post-posterior axillary line at 5 or 6 ICS).  
  • Irrigation with this inflow/outflow system can be done using a Level One Infuser® (180-550 ml/min) or by hanging heated IV bags.  
  • Care must be taken so as to not cause a tension hydrothorax by not allowing for enough time for adequate drainage of the posterior chest tube.  
  • Single chest tube lavage can be done infusing 200-300 cc of saline at a time and removing the fluid by suction after each aliquot.  
  • The technique of thoracic irrigation has the advantage of allowing for preferential heating of the mediastinal structures.  
  • The “thoracic pump model” of CPR is preserved so as to facilitate blood movement in what may be a very hard, non-compliant heart.  
  • Placing chest tubes may precipitate a malignant rhythm.  
  • Right-sided tubes may help to avoid this complication. |
<table>
<thead>
<tr>
<th>Modality</th>
<th>Indications</th>
<th>Rate of Rewarming</th>
<th>Additional Comments</th>
</tr>
</thead>
</table>
| *Heated Irrigation of the Mediastinum* | • Patients in cardiac arrest  
• Non-perfusing rhythms or severe hypothermia in patients for who bypass is available. | • Irrigation of the mediastinum can be done via a left sided thoracotomy (or median sternotomy), and the heart can be directly irrigated with saline warmed to 40-42°C (104-107.5°F).  
• Unless a perfusing rhythm is obtained, irrigation can be performed until the heart reaches a temperature of 32°C (89.6°F).  
• Defibrillation can be attempted at 1-2°C (1.8-3.6°F) intervals once the temperature has reached 26°C (78.8°F). | |
| Extracorporeal Blood Rewarming | • Severe hypothermia with either cardiac arrest or failure of less invasive methods to increase temperature at an acceptable rate. | • Varies depending on the system used and the maximum attainable flow rate  
• Generally, temperature increases of up to 1-2°C (1.8-3.6°F) every 3-5 min is attainable. | • *Extracorporeal Blood Rewarming (ECR):* ECR is a process in which blood is removed from the circulatory system, heated, and subsequently returned to the body.  
  o All of the systems offer the advantage of rapid rewarming at a controllable rate up to 2°C/3.6°F every 5 minutes.  
  o May be used with or without an oxygenator (by Fem-Fem, AV (without pump) or venovenous (without pump) or by hemodialysis with heat exchanger).  
• *Extracorporeal Membrane Oxygenation (ECMO):* ECMO is a technique for providing both cardiac and respiratory support.  
  o It can be very effective in providing circulation, oxygenation and warming for a severely hypothermic patient.  
  o Consider for patients with hypothermia who have cardiac instability and are not responding to medical treatment.  
  o It should be considered for intractable cardiac arrest (VF or asystole) in a person with hypothermia. | |

* The peritoneal, thoracic and mediastinal cavities, via DPL, tube thoracostomy, and thoracotomy respectively, can all be irrigated with warmed solutions. In ascending order, these methods have progressively greater ability to raise core temperature rapidly. They are, however, more invasive than previously described methods.
Appendix F

Emergencies in the Hypothermic Patient

Table 1. Interventions for Cardiac Emergencies

<table>
<thead>
<tr>
<th>Cardiac Emergency</th>
<th>Treatment Recommendations</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial arrhythmias</td>
<td>• Atrial arrhythmias resolve spontaneously as temperature rises to normal.</td>
<td>• Atrial arrhythmias do not produce a rapid ventricular response.</td>
</tr>
<tr>
<td></td>
<td>• They are common in moderate and severe hypothermia and do not require treatment.</td>
<td></td>
</tr>
<tr>
<td>Bradycardia</td>
<td>• Bradycardia is not responsive to atropine.</td>
<td>• Slow heart rate is a normal response in hypothermia.</td>
</tr>
<tr>
<td></td>
<td>• If the clinical condition requires, symptomatic bradycardia may be treated with external pacing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Internal pacing may trigger a malignant ventricular arrhythmia.</td>
<td></td>
</tr>
<tr>
<td>Ventricular arrhythmias</td>
<td>• Electrical defibrillation at up to 200J should be tried one time at the onset of VF at any temperature.</td>
<td>• These include ectopy and fibrillation.</td>
</tr>
<tr>
<td></td>
<td>o Subsequent shocks will not likely restore a perfusing rhythm until the core T° &gt; 30°C (86°F).</td>
<td>o Most cases of preexisting ectopy (frequent PVCs) will disappear with hypothermia.</td>
</tr>
<tr>
<td></td>
<td>o In the thoracic lavage and extracorporeal rewarming protocols, defibrillation can be attempted at 1-2°C (1.8-3.6°F) intervals starting at a temperature of 26°C (78.8°F).</td>
<td>o Ventricular fibrillation can be induced by cardiac stimulation, ranging from jolts and bumps to CPR, to Swan-Ganz (or introducer wire) placement. Likewise, it can be spontaneous.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Prophylaxis with drugs has not, as of yet been adequately studied in humans.</td>
</tr>
<tr>
<td>Asystole</td>
<td>• Treat asystole per ACLS protocols</td>
<td>• Asystole, especially in the field, may be difficult to differentiate from fine VF.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asystole may actually be the presenting rhythm of a hypothermic patient, completely bypassing VF.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Many patients have been successfully resuscitated from hypothermic asystole.</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
<td>• Perform CPR is no sign of life is present</td>
<td>• CPR in contraindicated when:</td>
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<td></td>
<td></td>
<td>o DNR status is established.</td>
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<td>o The chest wall is immobile due to decreased compliance.</td>
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<td>o Any pulse is present by palpation or Doppler.</td>
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<tr>
<td>Hypotension</td>
<td>• If the patient is hypotensive despite fluid therapy and rewarming, and blood loss is not considered a possible cause, dopamine infusion may be started and titrated to SBP of ~100 mmHg.</td>
<td>• Hypothermia will decrease mean arterial pressure and cardiac index.</td>
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<td>o Cardiac output drops to ~45% of normal at 25°C (77°F).</td>
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<td>o Peripheral vasoconstriction will occur increasing the SVR.</td>
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<td>• Evaluation of what should be a normal BP will be difficult.</td>
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</tbody>
</table>
Table 2. Additional Interventions for Medical Emergencies

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Indications</th>
<th>Comments</th>
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</thead>
</table>
| **Intubation**                     | • Airway protection is needed for lavage or altered mental status.  
• Respiratory rate or depth is inadequate to keep the uncorrected pH at 7.4.  
• The patient is unable to adequately oxygenate.  
• Airway bronchorrhea interferes with lung function. | • CO₂ production decreases by 50% for each 8°C (14.4°F) drop in temperature.  
• Patients may have RR of 4-10 and still adequately oxygenate and ventilate.                                                                                                                   |
| **Ventilation and oxygenation**    | • 100% oxygen should be used during resuscitations and it should be heated to 45°C (113°F), if possible.  
• Ventilation rate of the hypothermic patient by BVM is usually slower than in normothermic patients but rate should be adequate to keep the uncorrected pH at 7.4. |                                                                                                                                                                                                             |
| **Termination or resuscitation efforts** | • DNR status is documented and verified, or obvious signs of death exist.  
• All efforts at resuscitation have failed and the patient's T° >32°C (89.6°F).  
• Studies show that a potassium > 10 is an extremely poor prognostic factor.  
  o If confirmed, a potassium at this level can be used as a criteria to terminate resuscitation.                                           |                                                                                                                                                                                                             |
## Appendix G: Zoll Catheter Based Endovascular Rewarming

<table>
<thead>
<tr>
<th>Appendix G: Zoll Catheter Based Endovascular Rewarming</th>
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<tbody>
<tr>
<td><strong>Indications:</strong></td>
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</table>
| **Duration:** | • Continue active rewarming with catheter until body temperature > 35° C  
• **Maximum use period is 4 days per manufacturer** |
| **Contraindications:** | • Bleeding diathesis  
• Infection or active bleeding at site of catheter insertion  
• Presence of implanted devices, such as IVC filters, that would impair placement |
| **Supplies:** | • Kit contains all required components necessary for insertion  
• Kit will indicate what vessels it is designed to be used in (i.e. femoral versus internal jugular/subclavian veins) |
| **Placement/Insertion:** | • Process is the same as insertion of standard triple lumen catheter except there are two extra ports for the temperature management system. These are both orange and labeled “IN” and “OUT”. They should not be primed or utilized except for with the temperature management system.  
• Nursing team will set up the Zoll Thermogard XP Temperature Management System and connect to the catheter |
| **Removal:** | • Disconnect heating system to stop circulation of saline through the catheter  
• Uncap the IN and OUT luers of the catheter and attach a 20 cc syringe. Pull back on the syringe to create a vacuum for 15 seconds to evacuate the saline  
• **Stop removing the catheter if you feel resistance** |