

Dispatch Information	[EMS Unit] dispatched for a possible cardiac arrest, unresponsive patient not breathing, at residence, [EMD Code]. Police and Fire units also responding. Updated while en route from FD providers confirming that this is a cardiac arrest patient.
Subjective Information	On arrival to the scene the patient's residence is located on the third floor with no elevator access. EMS brought in all necessary equipment to run the resuscitation. The patient [a 58 year old male] was found supine on the floor with PD and FD performing CPR. There is an AED attached to the patient which we are informed has had a "No Shock Advised" interpretation once. First responders' report that the patient was found in his bed, bystander CPR was not performed, the wife could not get the patient onto the floor by herself. The wife reports that she woke up to the patient coughing and breathing oddly. She didn't think much of it, rolled over for several minutes, and noticed that the patient was not breathing. She attempted to wake him up several times before calling 911. The wife reported that the patient had back pain and chest pressure off-and-on over the past few days and made an appointment to see his doctor tomorrow.
Objective Information	The patient is supine on the floor, is ashen in appearance with cool skin and perioral cyanosis. There is no pulse or spontaneous respirations present. There are no obvious signs of trauma, no lividity, and no rigor present. EMS directed and coordinated CPR/ resuscitation efforts to ensure high quality CPR. The patient was removed from the AED and placed on the cardiac monitor revealing asystole as the initial rhythm. The patient was initially ventilated with a BVM and an OPA and reported to have no airway obstructions. Two NPAs were added to improve ventilation and compliance with the BVM on high flow oxygen. Capnography was attached in-line with the BVM and registered a value of 17 mmHg with a box waveform in conjunction with ventilations and a two person BVM method was started. Chest compressions were performed in accordance with AHA recommendations attempting to maintain 2 inch compression depth with complete chest recoil and minimal interruptions. An IV was attempted and unsuccessful in the left arm so an IO was placed in the left tibial tuberosity with the 25 mm needle. Normal saline via pressure bag at 300 mmHg was started through the IO site. At next rhythm check, asystole, epinephrine was administered and CPR was resumed. After two minutes of CPR it was noted that the patient was in V-Fib. The patient was defibrillated at 200J biphasic with no changes. CPR was resumed and epinephrine was administered. CPR was stopped for rhythm check and patient was still in V-fib. Patient was defibrillated at 300J, CPR was resumed, and amiodarone was administered. The patient's airway was developing more secretions and possible gastric contents; the airway was cleared and suctioned multiple times. Organized complexes were noted on the cardiac monitor just prior to the rhythm check, CPR was stopped, and the patient was found to have a pulse and be in a sinus tachycardia. The patient's airway is becoming difficult to keep clear of secretions. Equipment [suction, bougie, and rescue airway] were prepped, the patient was pre-oxygenated, and ETT placement was attempted. The first attempt was unsuccessful; the patient is a Mallampati Class IV. The patient was ventilated to pre-oxygenate, bougie, laryngoscope, and ELM were used and the ETT was successful. Confirmation by visual signs of bilateral chest rise, negative epigastric sounds, bilateral lung sounds, and waveform capnography readings of 58 mmHg with a box shaped waveform that corresponds with ventilations. ETT inserted to 23 mm at the teeth and secured with a commercially prepared device. An OG tube was placed with minimal evacuation of gastric contents. The patient was ventilated at a rate of 10 breaths per minute while attempting to maintain normal EtCO2 readings. A cervical collar was placed to minimize compromise to the airway during the EVAC. The patient was moved to a long board, belted, and moved to the ambulance. During EVAC patient was ventilated and capnography was monitored for possible airway dislodgement. Once in the ambulance a second IV was started in the right AC with normal saline wide open. A blood pressure and 12 lead EKG were obtained. There is no evidence of STEMI noted. Patient is placed on SpO2 monitor and vital signs are monitored throughout transport to ER. Blood pressure maintained between 98 – 106 mmHg systolic with normal saline infusions. During transport the patient's appearance has improved and their skin color has "pinked up".
Assessment Information	Cardiac arrest from suspected/possible cardiac etiology
Plan	EMS arrived on scene, performed resuscitation in accordance with AHA and MEMS guidelines. When the patient regained ROSC they were moved to back board for EVAC and to the ambulance while providing ventilations. En route the patient remained obtunded. ETT continually monitored for placement using waveform capnography. Report called into the hospital. On arrival to the ER, report was given the Dr. Somerov to include the 12 lead EKG and confirmation of ETT placement. The EMS crew transferred the patient to the ER stretcher and cleared the call.