CAMU
COLLEGE AQUITAIN
DE MEDECINE D'URGENCE

Congrès du CAMU 2026

ARRÊT CARDIAQUE EXTRAHOSPITALIER

LES CLÉS POUR UNE RÉANIMATION À JOUR

Matthieu HEIDET
SAMU 94 & SAU Mondor


QUELLES NOUVEAUTÉS EN **2026** ?

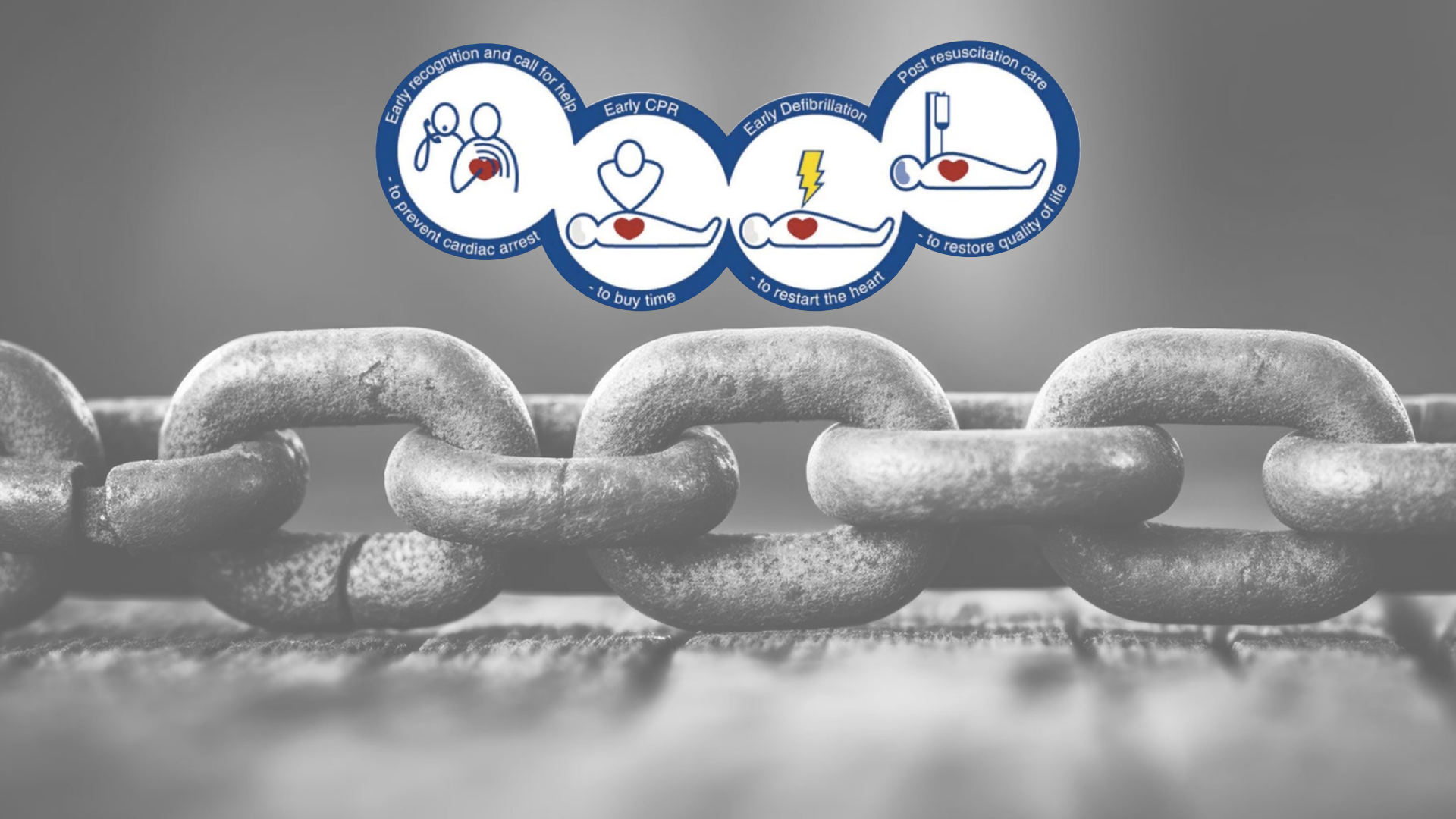
CE QU'ON SAVAIT **DÉJÀ**


MCE PAR TÉMOINS **58 %**

Nishiyama C et al. Resuscitation 2023;186:109757


SURVIE
3 - 35 %

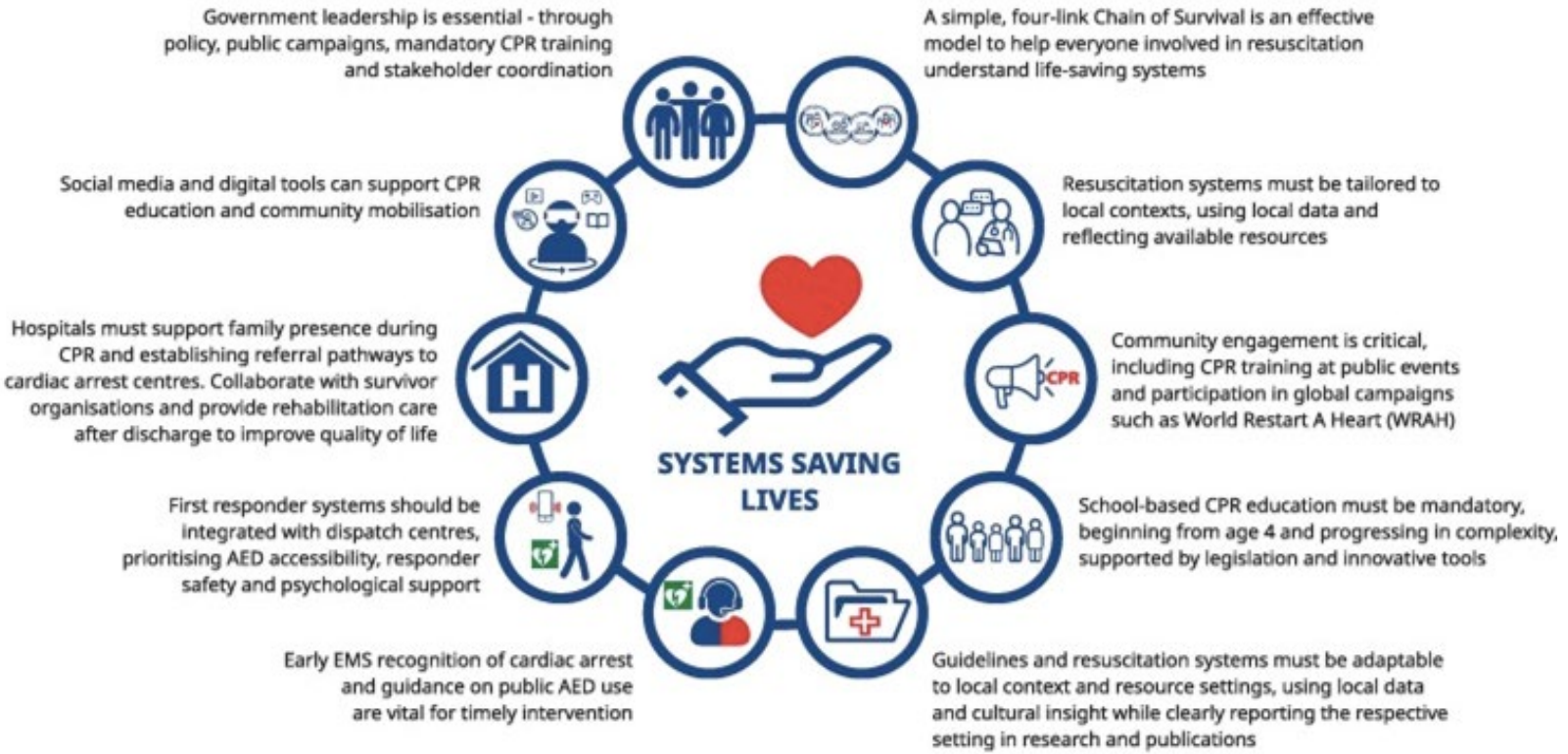
CE QUI A (UN PEU) **CHANGÉ**


Early recognition and call for help
- to prevent cardiac arrest
Early CPR
- to buy time
Early Defibrillation
- to restart the heart
Post resuscitation care
- to restore quality of life


Early recognition and call for help
- to prevent cardiac arrest
Early CPR
- to buy time
Early Defibrillation
- to restart the heart
Post resuscitation care
- to restore quality of life
Early recognition & call for help
Prevent cardiac arrest
Early CPR & defibrillation
AED
Preserve brain & restart the heart
Advanced & post resuscitation care
Optimise brain & heart function
Survival & recovery
Restore quality of life

SYSTEMS SAVING LIVES
KEY MESSAGES

GUIDELINES 2025
EUROPEAN RESUSCITATION COUNCIL©



SYSTEMS SAVING LIVES
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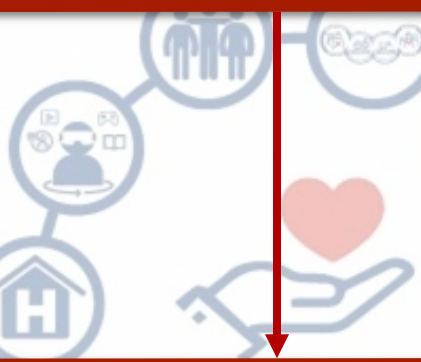
CHAÎNE DE SURVIE



FORMULE DE SURVIE

Gover… an effective
policy, pu… esuscitation

Social media and digital tools can support CPR education and community mobilisation

Resuscitation systems must be tailored to local contexts, using local data and reflecting available resources

Hospitals must support family presence during CPR and establishing referral pathways to cardiac arrest centres. Collaborate with survivor organisations and provide rehabilitation care after discharge to i…

Community engagement is critical, including CPR training at public events and participation in global campaigns such as World Restart A Heart (WRAH)

First resp… ducation must be mandatory, integrat… 4 and progressing in complexity, prioritising AED accessibility, responder safety and psychological support

supported by legislation and innovative tools

Early EMS recognition of cardiac arrest and guidance on public AED use are vital for timely intervention

Guidelines and resuscitation systems must be adaptable to local context and resource settings, using local data and cultural insight while clearly reporting the respective setting in research and publications

UN **CONTINUUM** BLS-ALS-POST-ARRÊT


APPELER **DÈS L'INCONSCIENCE**
ÉVALUER LA RESPIRATION **APRÈS**


RESPIRATION SUBNORMALE
CHEZ LES **SPORTIFS**


PRIORITÉ ABSOLUE AU **MCE**

Clinical paper

Electrical rhythm degeneration in adults with out-of-hospital cardiac arrest according to the no-flow and bystander low-flow time

Alexis Cournoyer[a,b,c,d,e,*], Jean-Marc Chauny[a,b,c], Jean Paquet[b], Brian
Yoan Lamarche[b,i,j,k,l,m], Luc de Montigny[e], Eli Segal[a,n,o],
Yiorgios Alexandros Cavayas[f,p,q], Martin Albert[f,p,q], Judy Morris[a,b,c],
Justine Lessard[a,b,c], Martin Marquis[b], Sylvie Cossette[k,l,m,n,o,p,q,r],
Véronique Castonguay[a,b,c], Raoul Daoust[a,b,c]

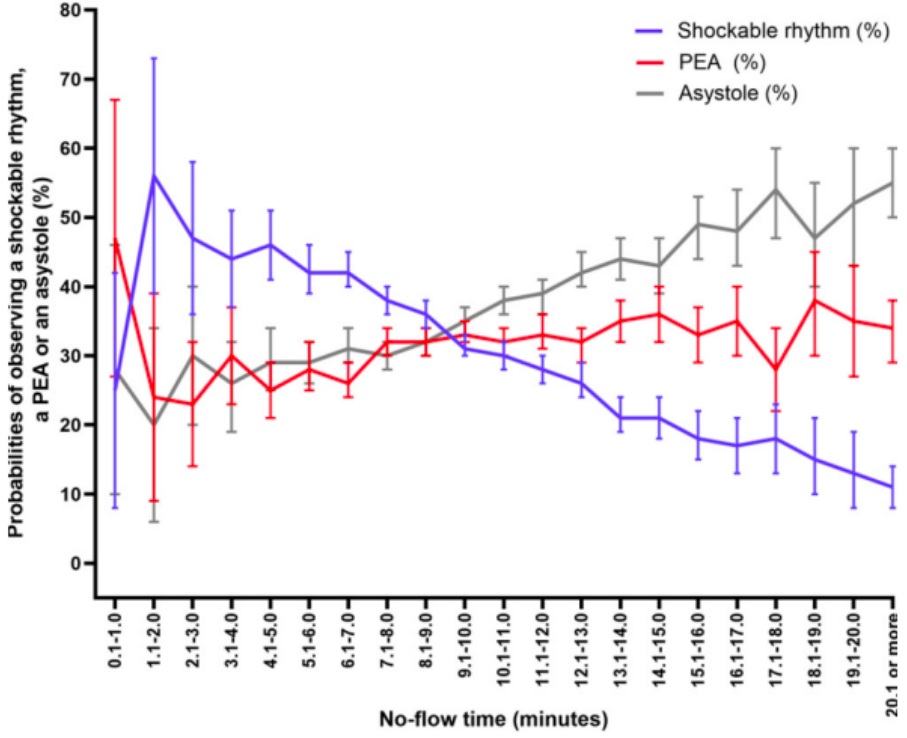
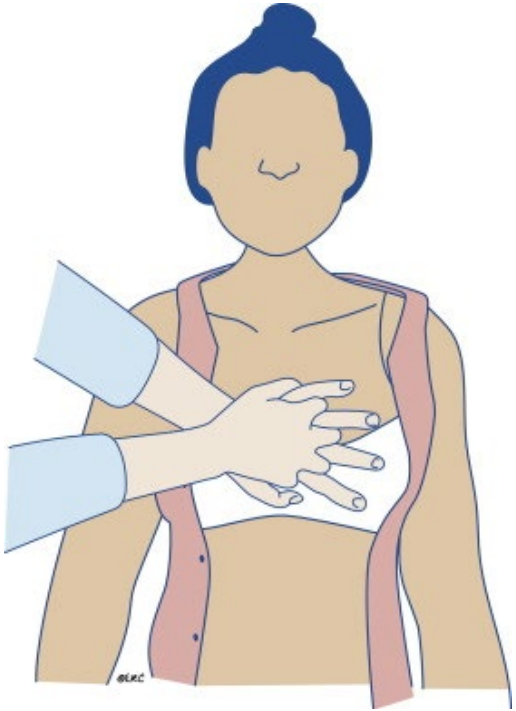


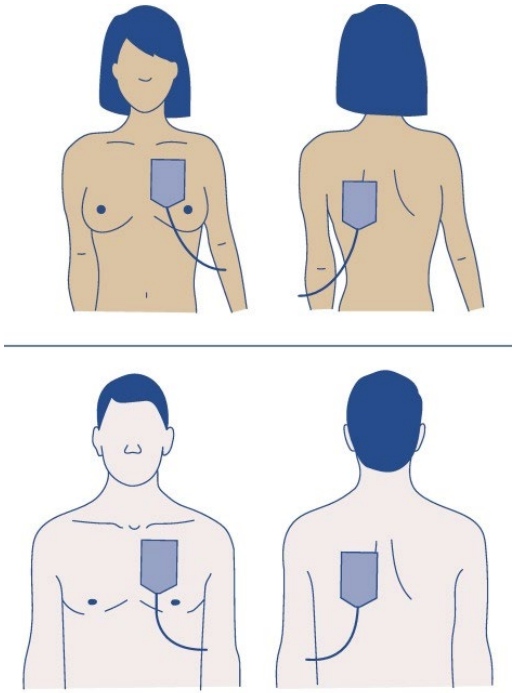
Fig. 2 – Proportions of shockable rhythm, PEA or asystole according to the no-flow time (n = 18,127). PEA: Pulseless electrical activity.

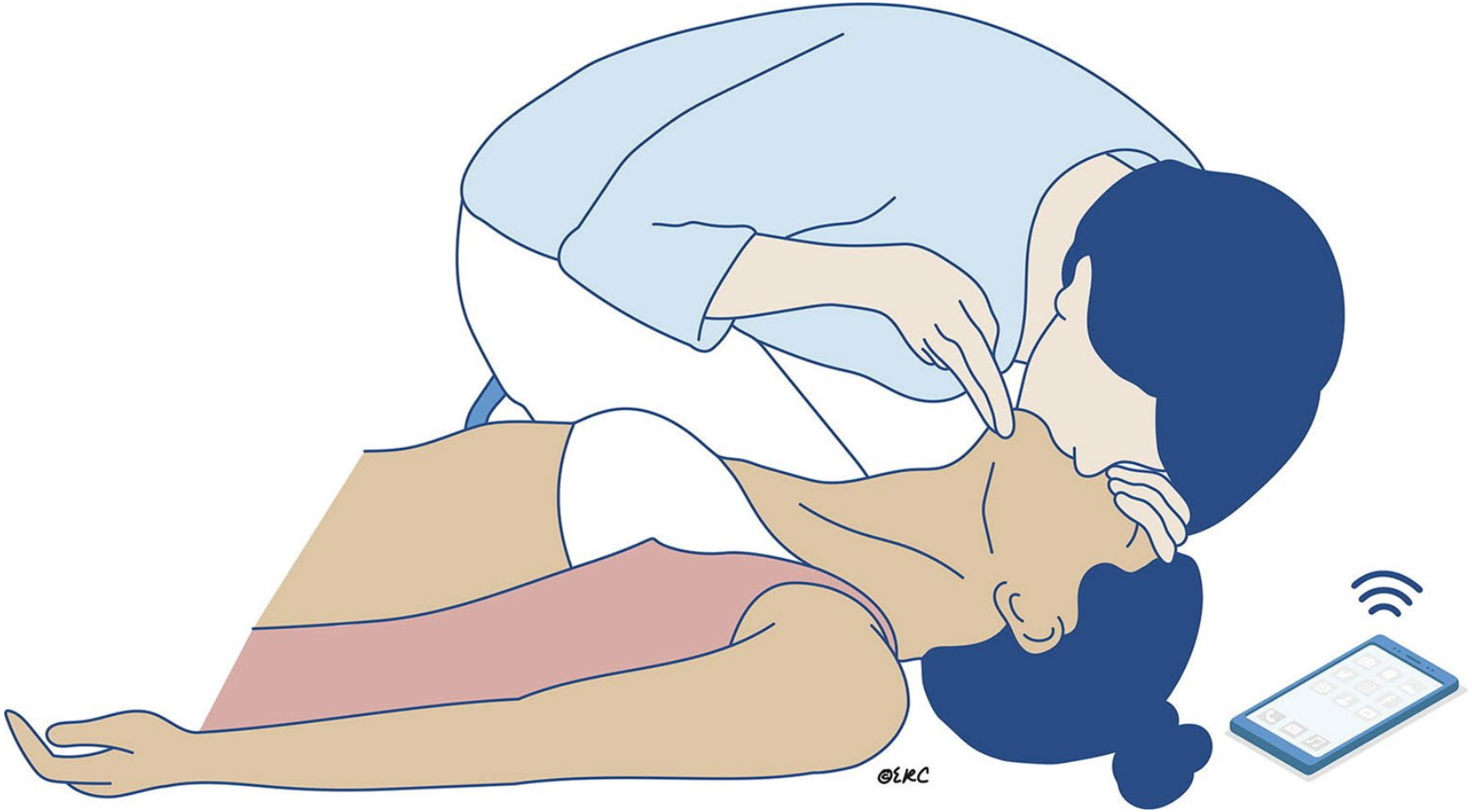
RESEARCH ARTICLE | Originally Published 19 February 2019 |

Public Perceptions on Why Women Receive Less Bystander Cardiopulmonary Resuscitation Than Men in Out-of-Hospital Cardiac Arrest

Sarah M. Perman, MD, MSCE; Shelby K. Shelton, MPH; Christopher Kivlahan, PhD, MSW; Kathryn Rappaport, MD; Daniel D. Matlock, MD, MPH; Kathleen Adelgais, MD, MPH; Edward P. Havranek, MD; and Stacie L. Daugherty, MD, MSPH






©ERC


30:2 Y COMPRIS CHEZ LE PATIENT **OBÈSE**

ACCESSIBLES **H24 7/7**

The impact of time to defibrillation on return of spontaneous circulation in out-of-hospital cardiac arrest patients with recurrent shockable rhythms

Emad Awad [a,b] · Brent Klapthor [a] · Michael H. Morgan [a] · Scott T. Youngquist [a,c]

The impact of time to defibrillation on return of spontaneous circulation in out-of-hospital cardiac arrest patients with recurrent shockable rhythms

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Table 2 – Effect of VF/pVT duration on ROSC: GEE model.

Variable	Beta Coeff	OR	(95% CI)	*P* value
VF/ pVT duration	−0.20	0.81	0.72 – 0.93	<0.001
Age	−0.02	0.99	0.97 – 1.02	0.43
Male sex	−0.43	0.65	0.33 – 1.29	0.21
Response time > 7 min	−0.76	0.47	0.23 – 0.97	0.04
Location	0.68	1.98	1.08 – 3.62	0.03
Witness status	0.62	1.86	0.85 – 4.08	0.12
Bystander CPR	1.03	2.81	1.24 – 6.36	
Anti-Arrhythmic	−0.28	0.76		
Epinephrine	−0.24	0.79		
Pause duration > 15 sec	−0.28	0.75		

*N = 142 (104 had VF as the initial rhythm, and 38 had pVT).

1 minute =

-20% RACS

A Poor Association Between Out-of-Hospital Cardiac Arrest Location and Public Automated External Defibrillator Placement

Matthew J. Levy, DO, MSc;[1,2,3] Kevin G. Seaman, MD;[2] Michael G. Millin, MD, MPH;[1] Richard A. Bissell, PhD;[3] J. Lee Jenkins, MD, MSc[1]

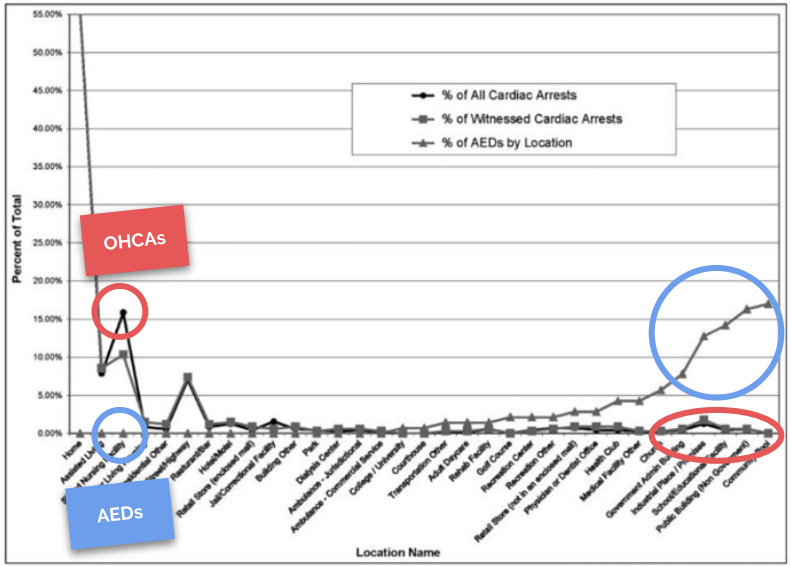


Figure 1. Histogram Showing Cardiac Arrest Event Frequency Compared with Arrest Location and PAD Location
Abbreviation: AED, automated external defibrillator

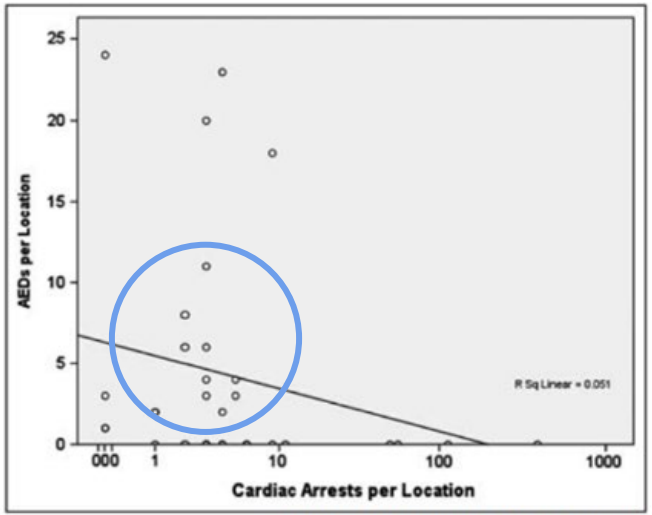


Figure 2. Scatter Diagram of AEDs and Total Cardiac Arrests per Location

Eglises Administrations Ecoles Piscines

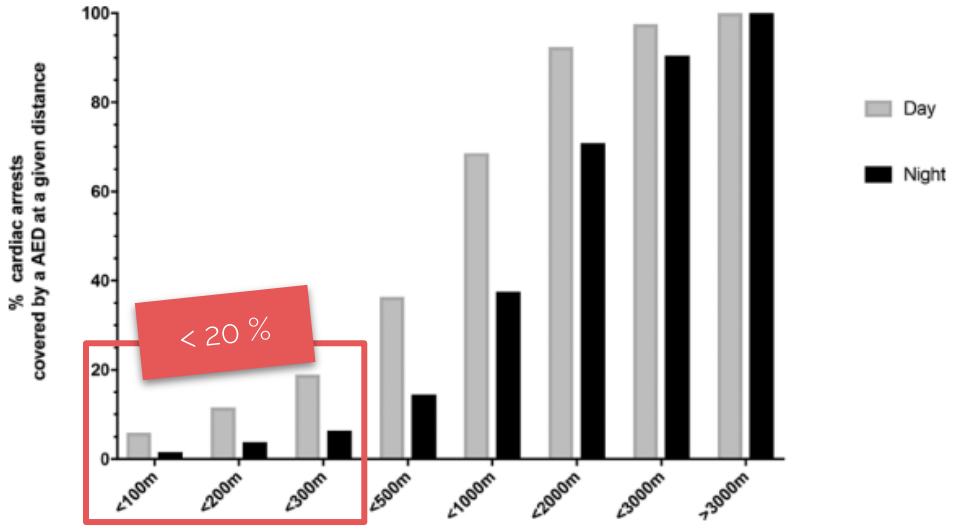
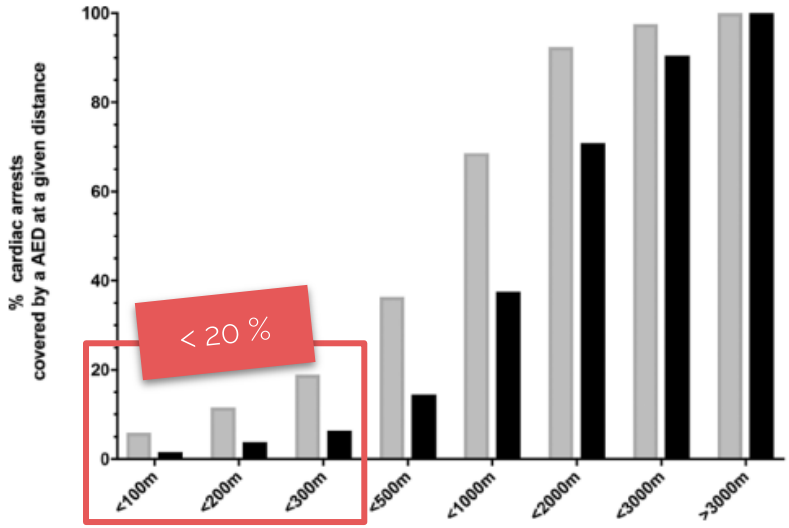


Figure 1 The percentage of cardiac arrests covered by an AED at any given distance, for both daytime (08:00–18:00) and out-of-hours (18:00–08:00) incidents. AEDs, automated external defibrillators.

Deakin CD, Anfield S, Hodgetts GA. Heart 2018;104:1339–1343



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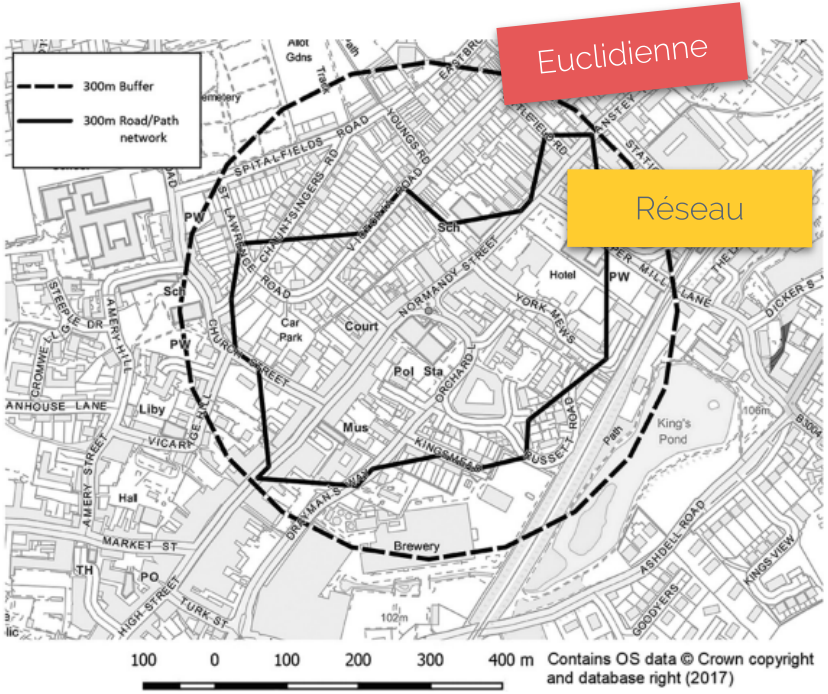
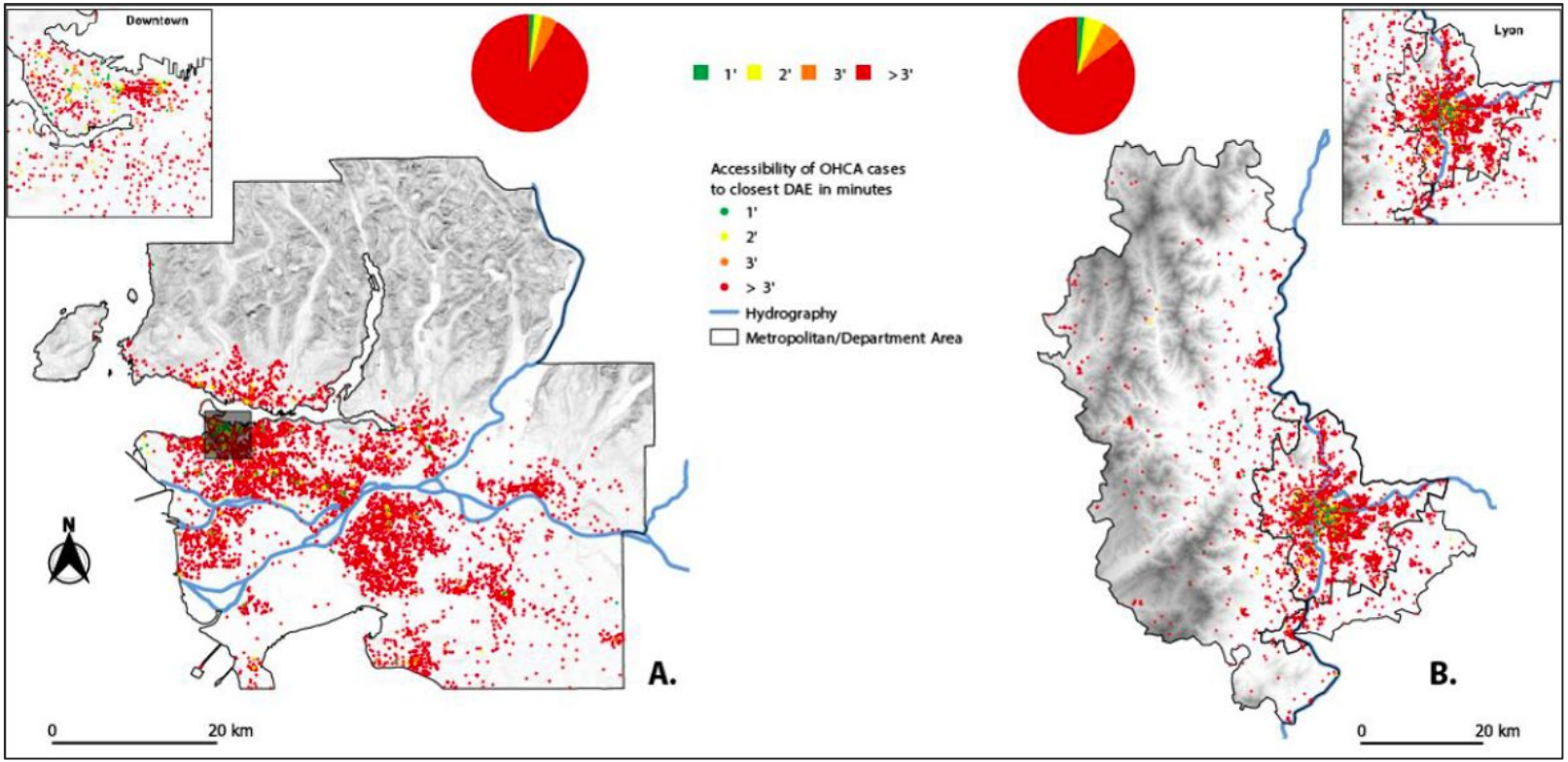


Deakin CD, Anfield S, Hodgetts GA. Heart 2018;104:1339–1343

Fig.1 Spatial distribution of OHCA represented by walking access time



Heidet M, Freyssenge J, Claustre C et al. Resuscitation 2022;181:97-109

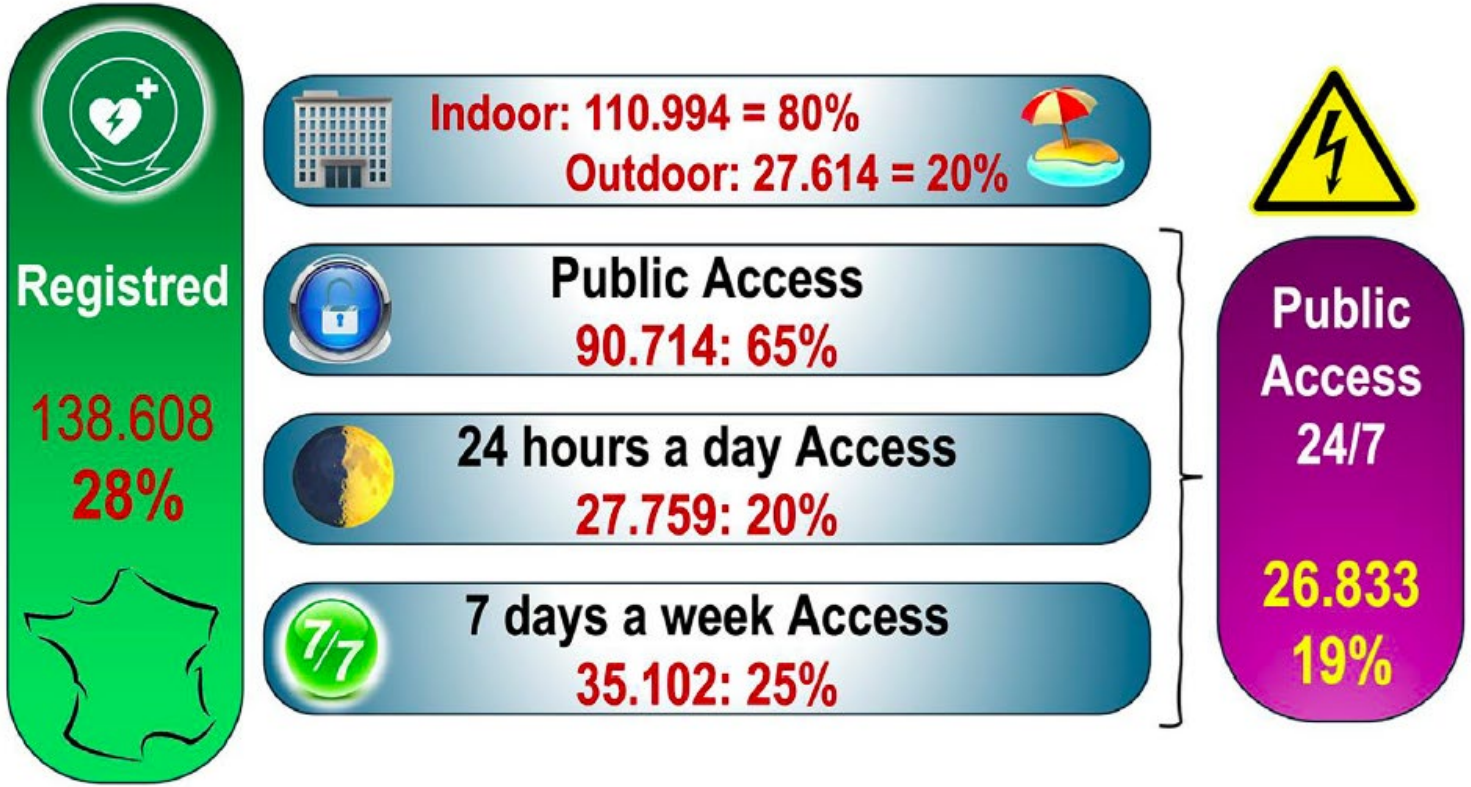


Fig. 1 – Accessibility of the 138.608 AED recorder in the French registry.

Thomas-Lamotte B, Benameur N, Soulat L, Petrovic T, Lapostolle F. Resuscitation. 2025 Feb;207:110502.


EVERDRONE

Drone delivery of automated external defibrillators compared with ambulance arrival in real-life suspected out-of-hospital cardiac arrests: a prospective observational study in Sweden

Sofia Schierbeck, Anette Nord, Leif Svensson, Mattias Ringh, Per Nordberg, Jacob Hollenberg, Peter Lundgren, Fredrik Folke, Martin Jonsson, Sune Forsberg, Andreas Claesson

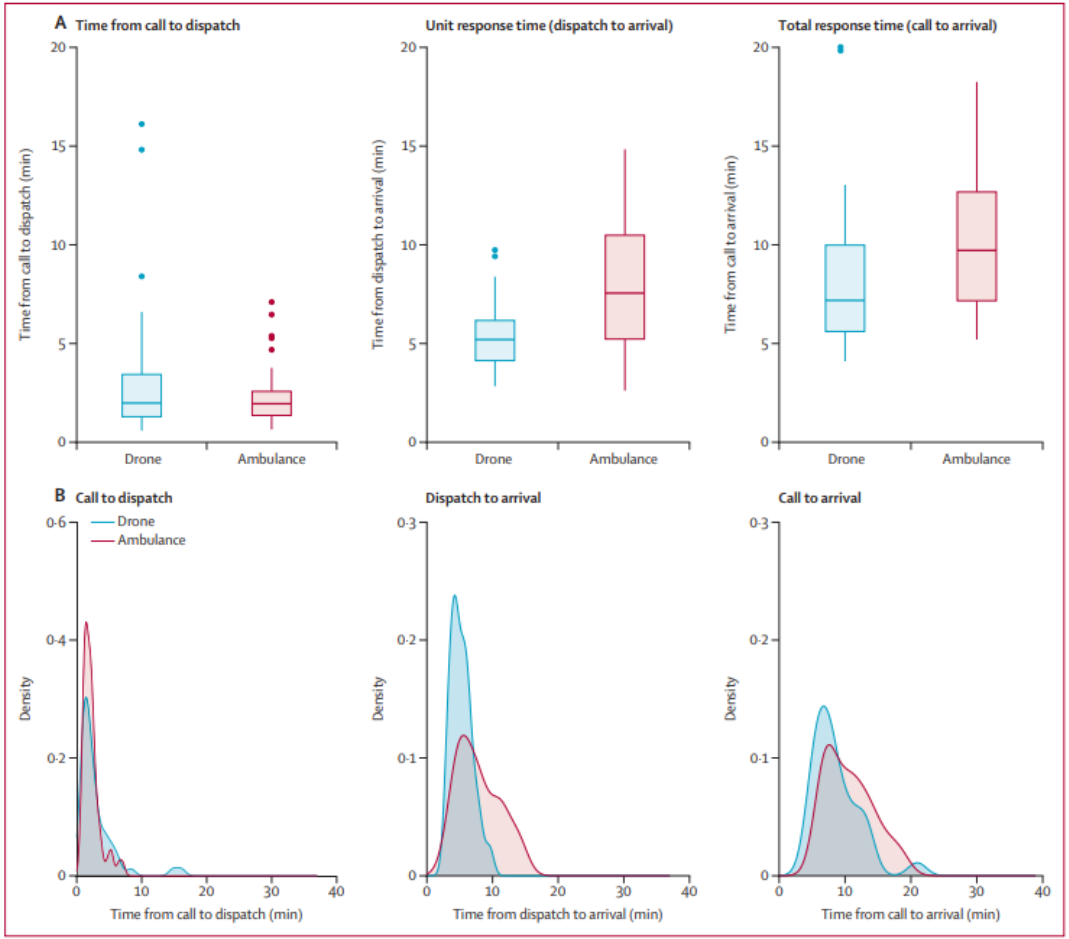


Figure 2: **Response times for AED-drones and ambulances**
(A) Boxplots of response times for AED-drones and ambulances. From the left, call to dispatch, dispatch to arrival, and call to arrival. (B) Density plots of response times for AED-drones and ambulances. From the left, call to dispatch, dispatch to arrival, and call to arrival. AED=automated external defibrillator.

	Ambulance-treated out-of-hospital cardiac arrests (n=68)	Ambulance-treated out-of-hospital cardiac arrests (when drone did not deliver an AED; n=44)	Ambulance-treated out-of-hospital cardiac arrests (in cases with a drone-delivered AED; n=24)	Ambulance-treated out-of-hospital cardiac arrests (when drone arrived first; n=18)
Age, years	74 (64–82)	71 (60–81)	77 (69–82)	77 (69–82)
Females	19 (28%)	8 (18%)	11 (46%)	7 (39%)
Males	49 (72%)	36 (82%)	13 (54%)	11 (61%)
Residential location	59 (87%)	39 (89%)	20 (83%)	15 (83%)
Witnessed	37 (54%)	23 (52%)	14 (58%)	9 (50%)
CPR before ambulance arrival	50 (74%)	30 (68%)	20 (83%)	15 (83%)
AEDs attached before ambulance arrival*				
On-site AEDs	4/58 (7%)	4/43 (9%)	0/15	0/11
First responders' and lay responders' AEDs	5/58 (9%)	4/43 (9%)	1/15 (7%)	1/11 (9%)
Drone AEDs	2/58 (3%)†	0/43	2/15 (13%)†	2/11 (18%)†
Shockable first rhythm	9 (13%)	5 (11%)	4 (17%)	2 (11%)
Defibrillated before ambulance arrival*				
On-site AEDs	1/58 (2%)	1/43 (2%)	0/15	0/11
First responders' and lay responders' AEDs	3/58 (5%)	3/43 (7%)	0/15	0/11
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Return of spontaneous circulation at hospital arrival	20/58 (34%)	14/43 (33%)	6/15 (40%)	4/11 (36%)
Survival past 30 days	6/58 (10%)	4/43 (9%)	2/15 (13%)	1/11 (9%)

Data are median (IQR), n (%), or n/N (%). Data collected from ambulance charts and The Swedish Registry of Cardiopulmonary Resuscitation. Ambulance-treated out-of-hospital cardiac arrest means true cardiac arrest where ambulance personnel performed CPR. AED=automated external defibrillator. CPR=cardiopulmonary resuscitation.
*Data from The Swedish Registry of Cardiopulmonary Resuscitation. 15% of all out-of-hospital cardiac arrests identified in ambulance charts are missing in the registry.
†Four cases of drone-delivered AED attachment missing. ‡One case of defibrillation by drone-delivered AED missing.

Table 2: **Patient characteristics of ambulance-treated out-of-hospital cardiac arrest cases, by drone delivery of AED**

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TAUX D'APPLICATION x 2.5

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TAUX DE CEE
x 4.5

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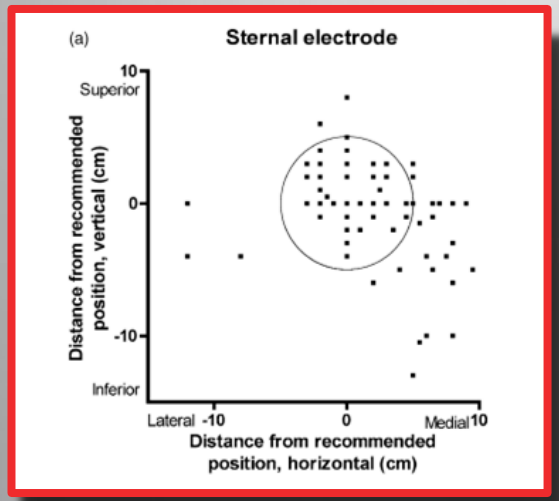
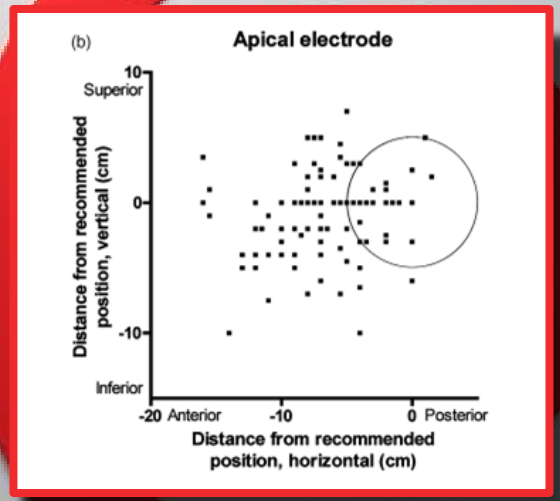
Layperson positioning of defibrillation electrodes guided by pictorial instructions☆

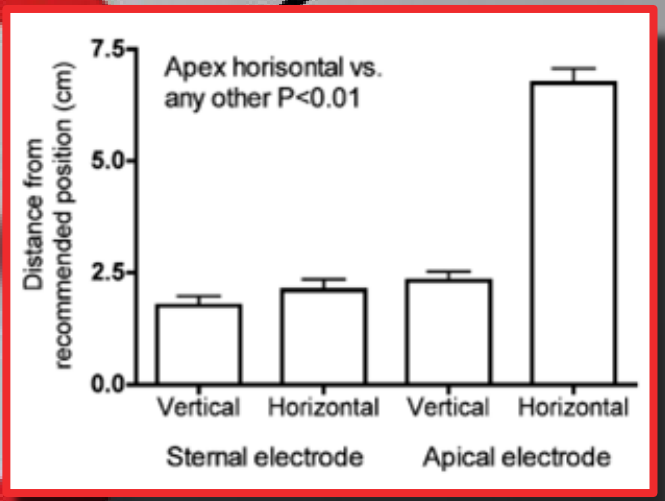
Jouni Nurmi*, Maaret Castrén

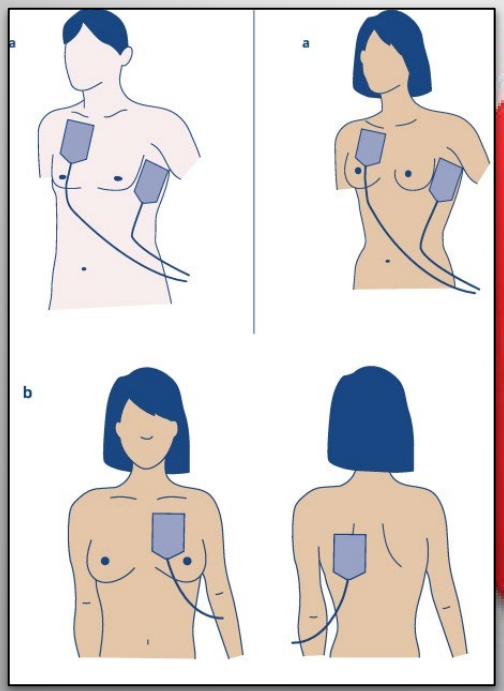
Layperson positioning of defibrillation electrodes guided by pictorial instructions☆

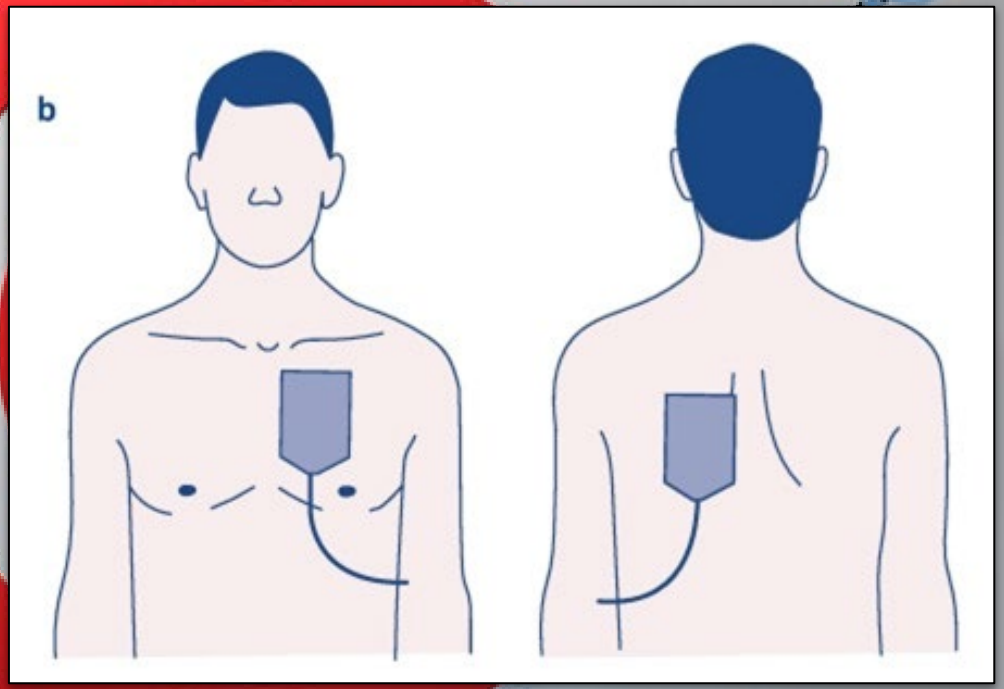
Jouni Nurmi*, Maaret Castrén











GUIDELINES 2025
EUROPEAN RESUSCITATION COUNCIL

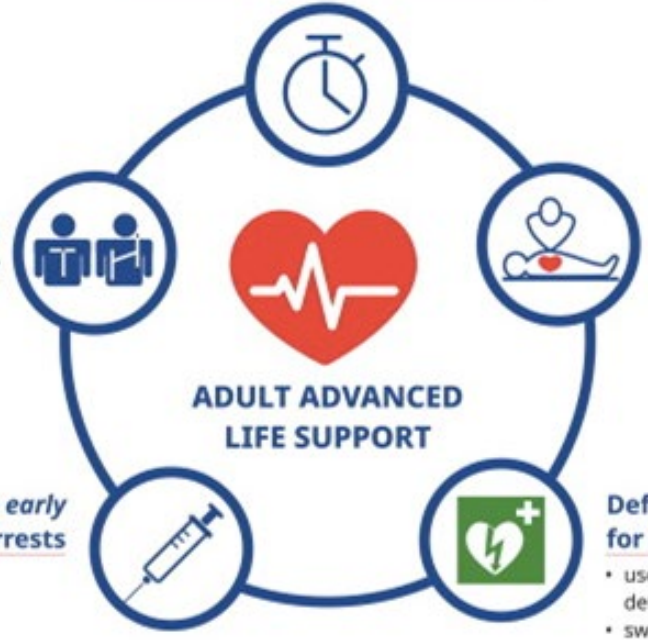

SAMU

ADULT ADVANCED LIFE SUPPORT
KEY MESSAGES

GUIDELINES 2025
EUROPEAN RESUSCITATION COUNCIL©

Start advanced life support *early*

- every second counts!



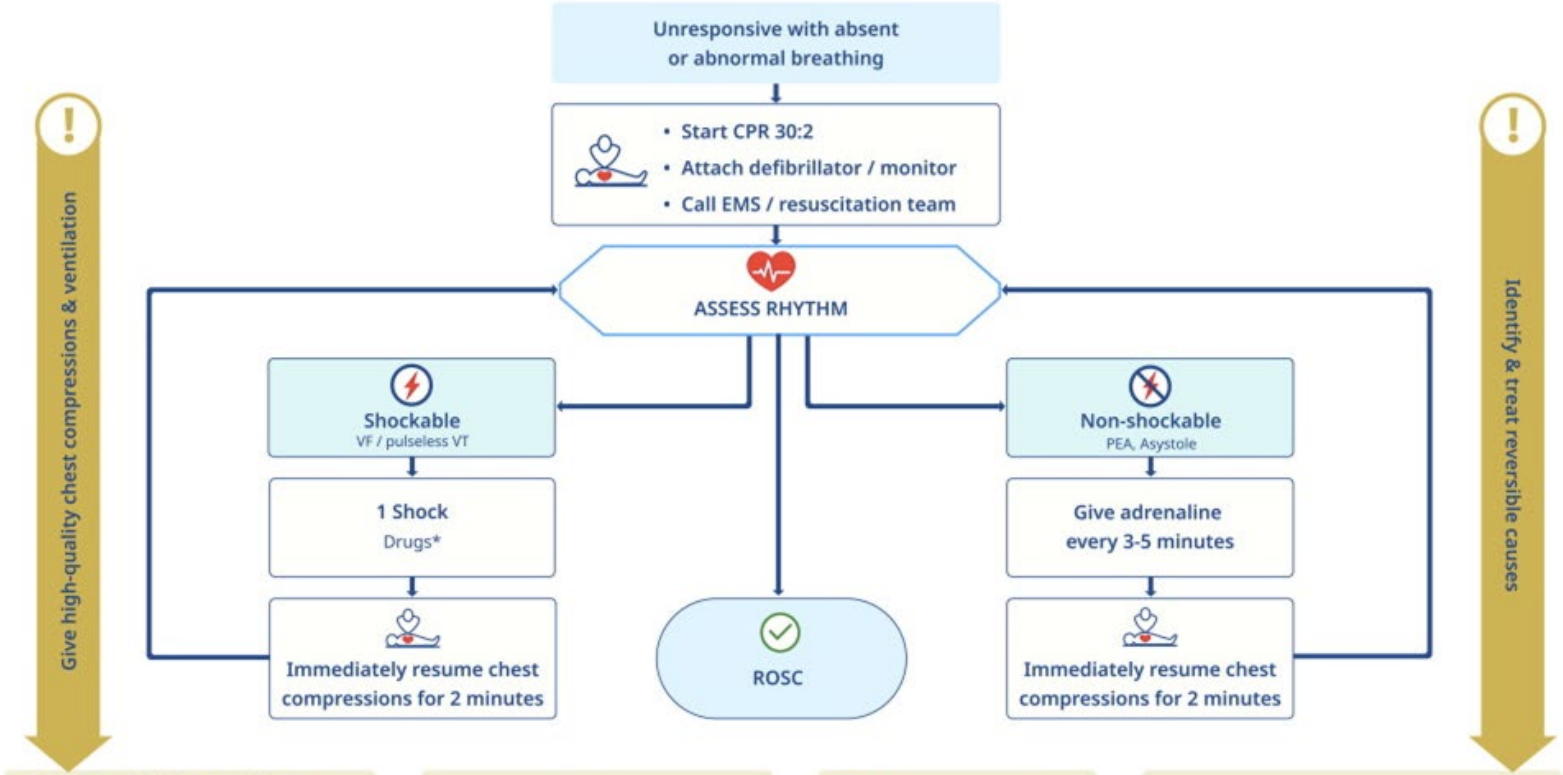
Identify and treat reversible causes *without delay*

Ensure *effective* ventilation and high-quality chest compressions

Give IV adrenaline *early* for non-shockable cardiac arrests

Defibrillate *early* for shockable rhythms

- use *correct* antero-lateral defibrillator pad placement
- switch to antero-posterior pads if 3 shocks are ineffective



- Ensure optimal defibrillator pad placement
- Give oxygen
- Continuous compressions if tracheal tube or supraglottic airway
- Use waveform capnography
- Minimise interruptions to chest compressions
- Early IV access (IO if IV not possible)

* Drugs

- Give 1st adrenaline after 3 shocks, then every 3-5 minutes
- Give amiodarone after 3 shocks

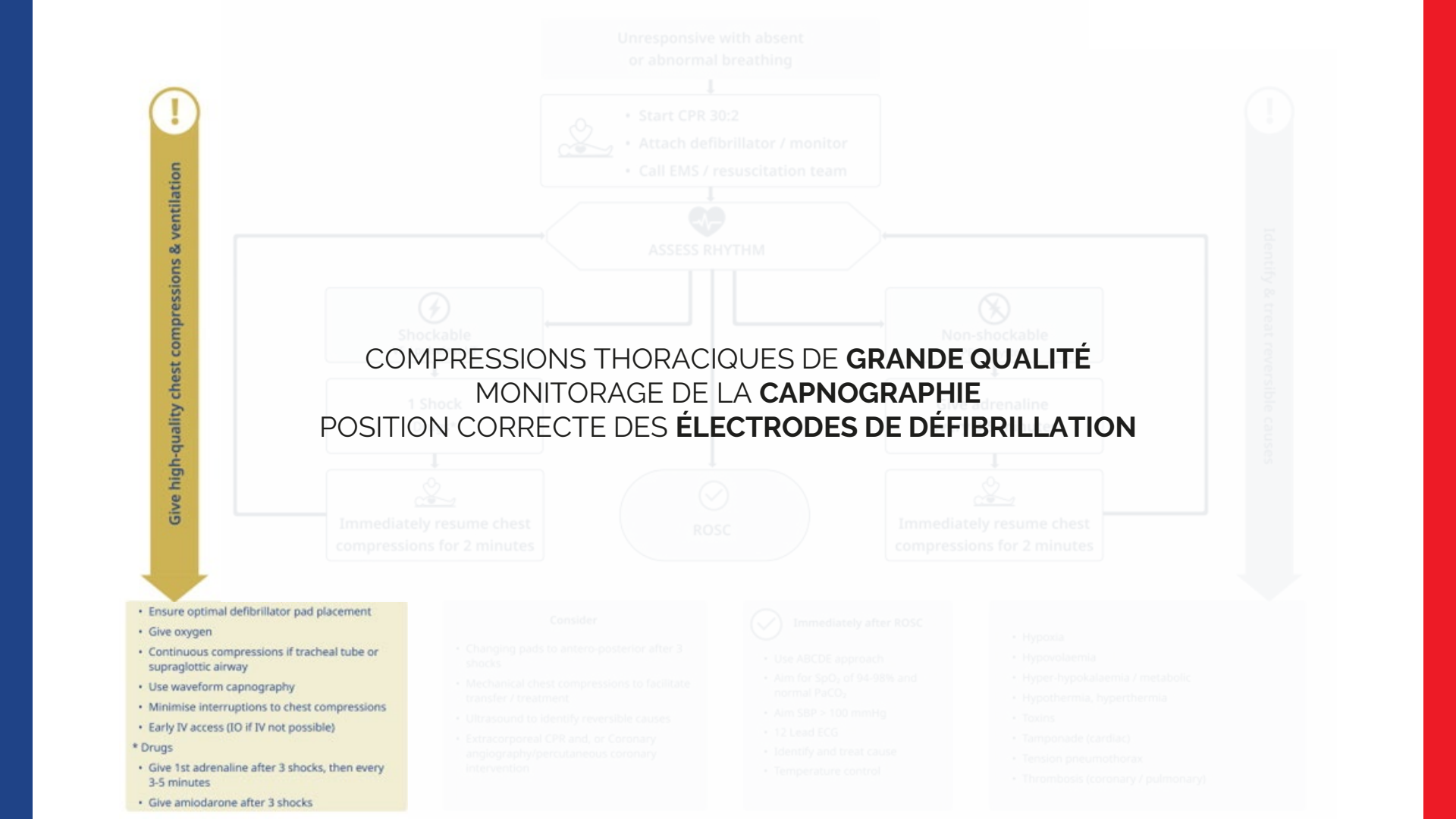
Consider

- Changing pads to antero-posterior after 3 shocks
- Mechanical chest compressions to facilitate transfer / treatment
- Ultrasound to identify reversible causes
- Extracorporeal CPR and, or Coronary angiography/percutaneous coronary intervention

Immediately after ROSC

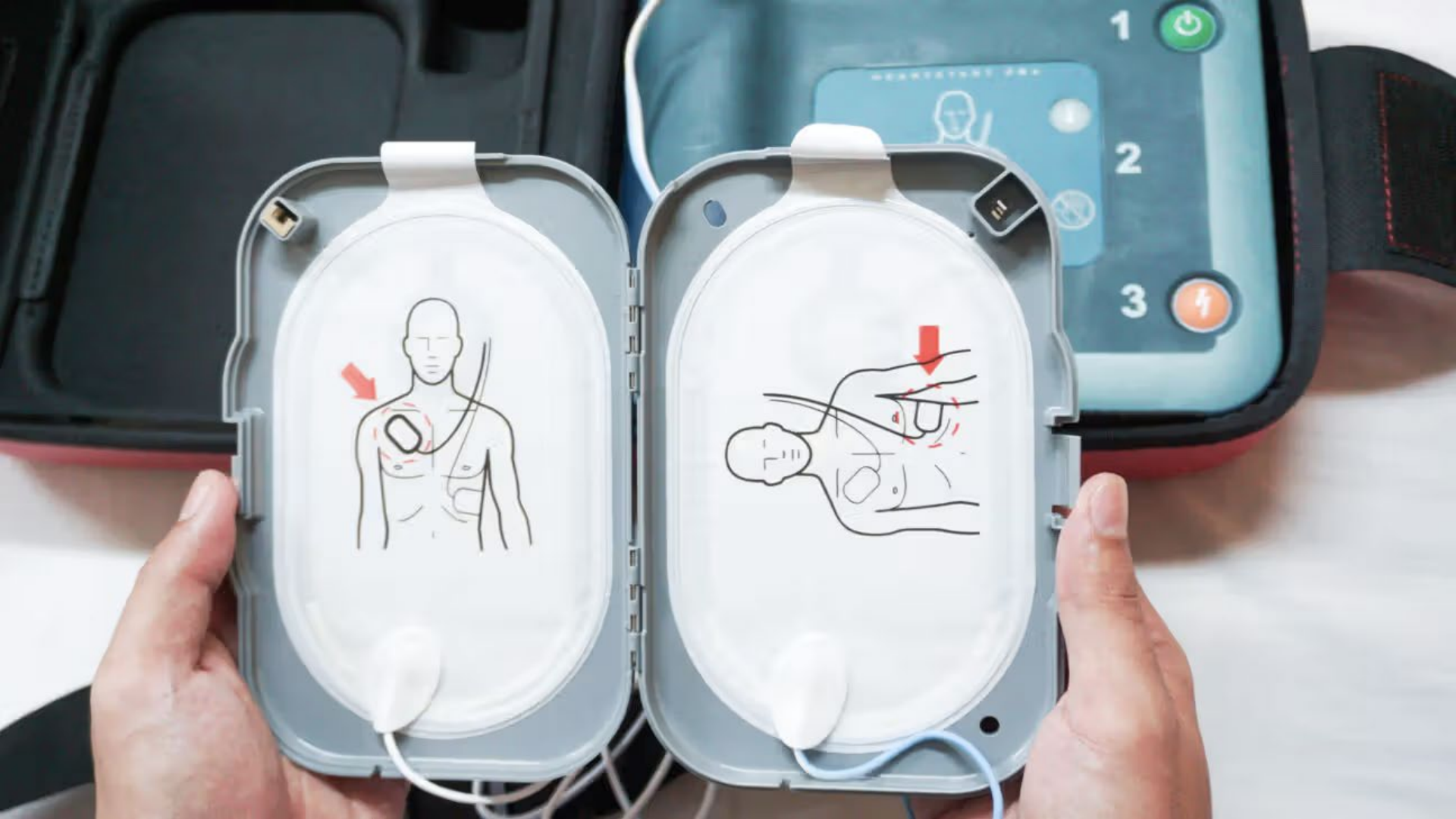
- Use ABCDE approach
- Aim for SpO_2 of 94-98% and normal $PaCO_2$
- Aim SBP > 100 mmHg
- 12 Lead ECG
- Identify and treat cause
- Temperature control

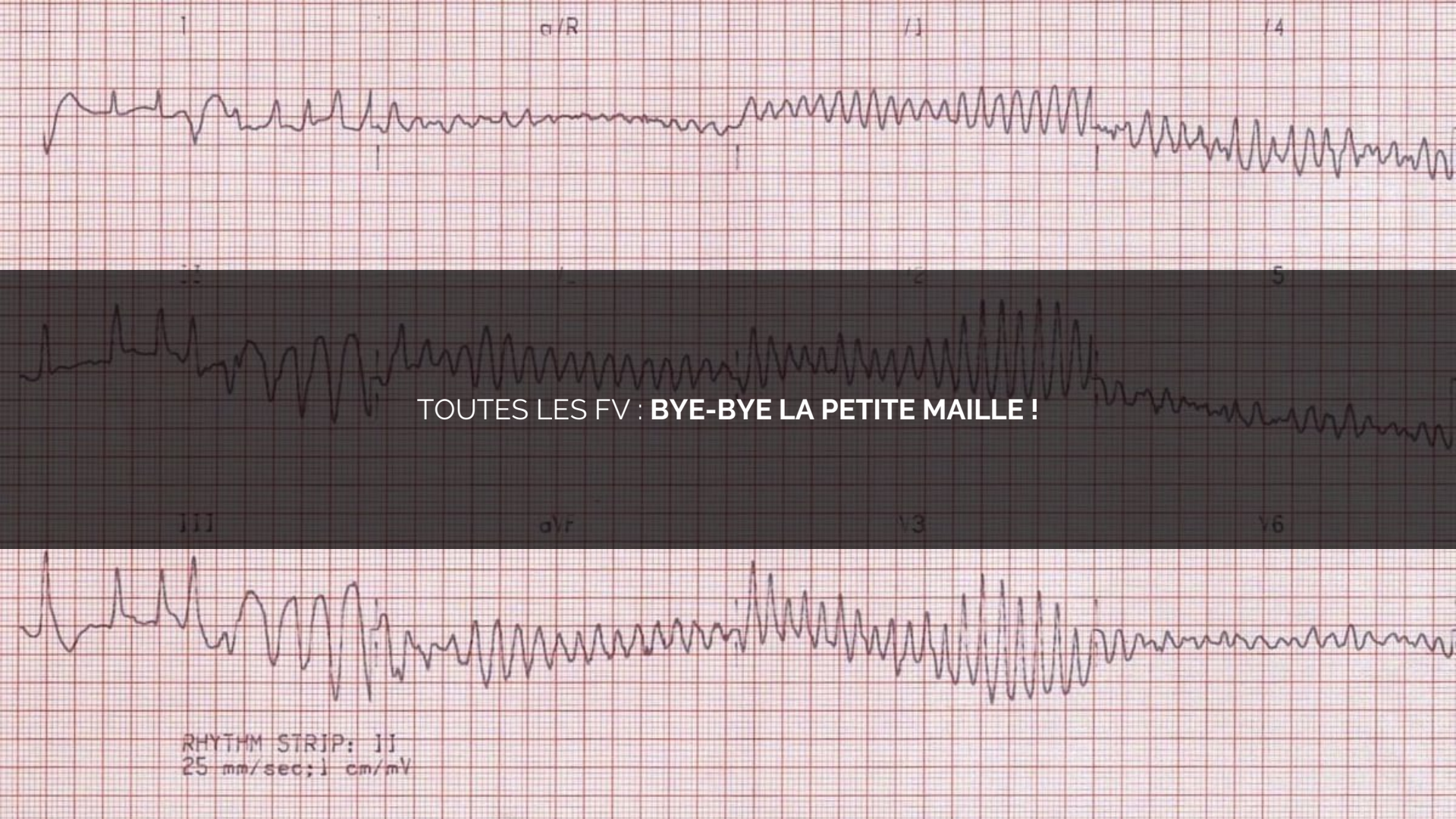
- Hypoxia
- Hypovolaemia
- Hyper-hypokalaemia / metabolic
- Hypothermia, hyperthermia
- Toxins
- Tamponade (cardiac)
- Tension pneumothorax
- Thrombosis (coronary / pulmonary)



COMPRESSIONS THORACIQUES DE **GRANDE QUALITÉ**
MONITORAGE DE LA **CAPNOGRAPHIE**
POSITION CORRECTE DES **ÉLECTRODES DE DÉFIBRILLATION**


SI JE SAIS FAIRE
EN < 5 S


1
2
3



TOUTES LES FV : **BYE-BYE LA PETITE MAILLE !**


1 CEE ?
3 CEE ?


1 CEE - **REPRISE IMMÉDIATE**
DÉLAI CEE - RACS
25% DES RACS APRÈS > 2 MIN D'ASYSTOLIE


COMME VOUS VOULEZ (PUISSANCE MAX D'EMBLÉE)
SI ÉCHEC 1er CEE ET SI POSSIBLE : AUGMENTER LA PUISSANCE

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Defibrillation Strategies for Refractory Ventricular Fibrillation

Sheldon Cheskes, M.D., P. Richard Verbeek, M.D., Ian R. Drennan, A.C.P., Ph.D., Shelley L. McLeod, Ph.D., Linda Turner, Ph.D., Ruxandra Pinto, Ph.D., Michael Feldman, M.D., Ph.D., Matthew Davis, M.D., Christian Vaillancourt, M.D., Laurie J. Morrison, M.D., Paul Dorian, M.D., and Damon C. Scales, M.D., Ph.D.

TV / FV RÉFRACTAIRE (> 3 CEE)

Pad Placement in the Three Defibrillation Strategies

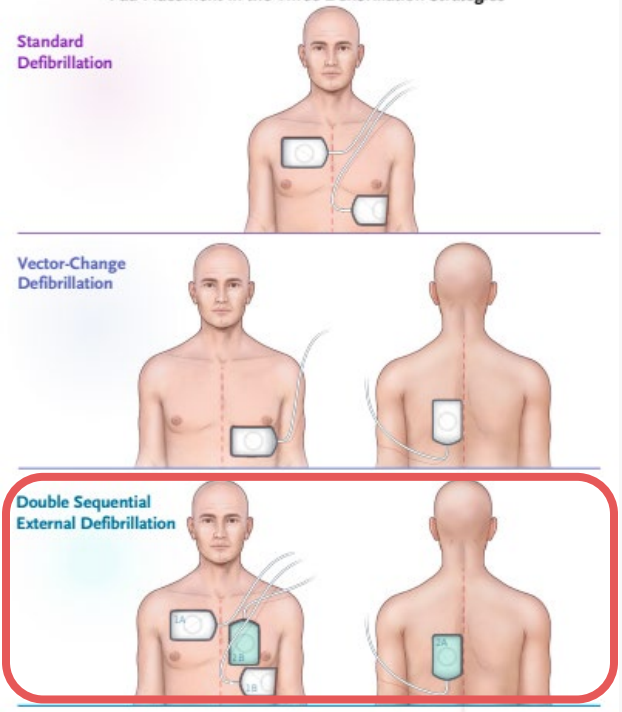
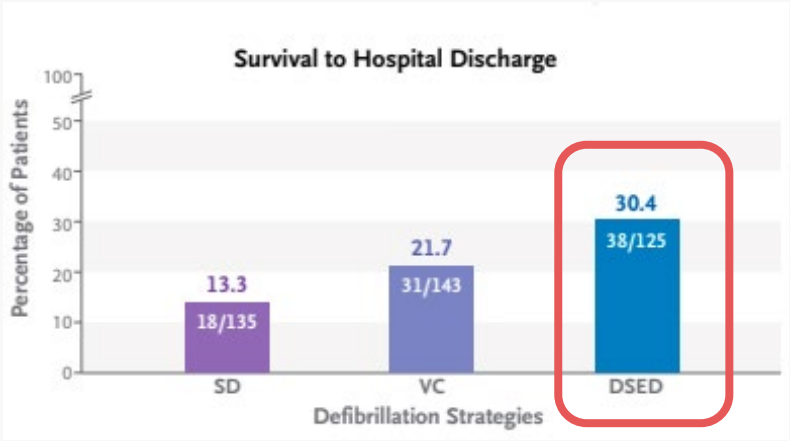


Table 3. Primary and Secondary Outcomes.

Outcome	Standard Defibrillation (N=136)	VC Defibrillation (N=144)	DSED (N=125)	Adjusted Relative Risk (95% CI)*	
				DSED vs. Standard	VC vs. Standard
	number of patients/total number (percent)				
Survival to hospital discharge†	18/135 (13.3)	31/143 (21.7)	38/125 (30.4)	2.21 (1.33–3.67)	1.71 (1.01–2.88)
Termination of ventricular fibrillation	92/136 (67.6)	115/144 (79.9)	105/125 (84.0)	1.25 (1.09–1.44)	1.18 (1.03–1.36)
ROSC	36/136 (26.5)	51/144 (35.4)	58/125 (46.4)	1.72 (1.22–2.42)	1.39 (0.97–1.99)
Modified Rankin scale score ≤2†‡	15/134 (11.2)	23/142 (16.2)	34/124 (27.4)	2.21 (1.26–3.88)	1.48 (0.81–2.71)



The NEW ENGLAND JOURNAL of MEDICINE

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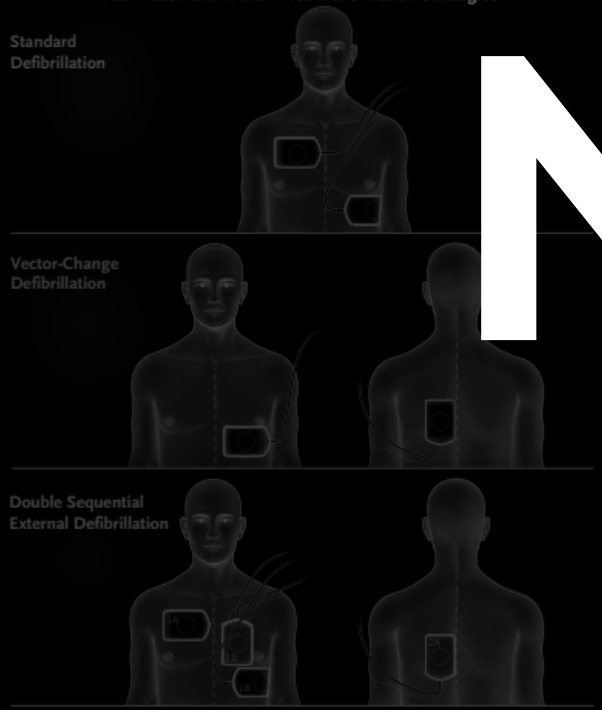

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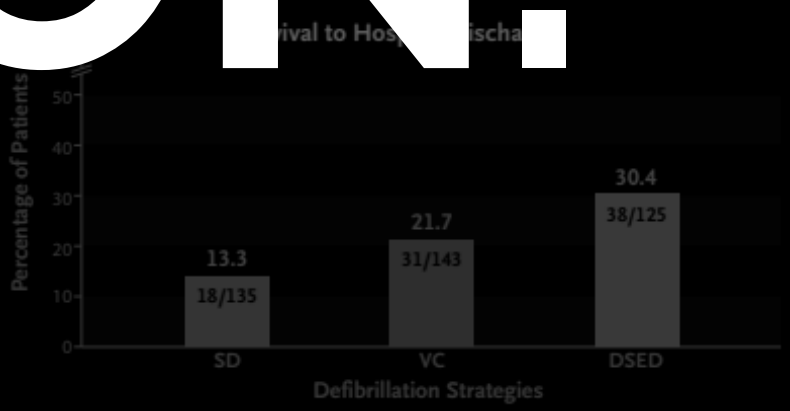
				DSED vs. Standard	VC vs. Standard
	number of patients/total number (percent)				
[illegible] to hospital	1[illegible]3.3)	31/1[illegible].7)	38/125 (30.4)	2.21 (1.33–3.67)	1.71 (1.01–2.88)
[illegible]ation of [illegible]ular fibrillati[illegible]	9[illegible]	115/[illegible].9)	105/125 (84.0)	1.25 (1.09–1.44)	1.18 (1.03–1.36)
[illegible]	3[illegible]	51/1[illegible].4)	58/125 (46.4)	1.72 (1.22–2.42)	1.39 (0.97–1.99)
[illegible]d Ra[illegible]ale score ≤2†‡	1[illegible]	23/1[illegible].2)	34/124 (27.4)	2.21 (1.26–3.88)	1.48 (0.81–2.71)

NON.




CleanLease

Review

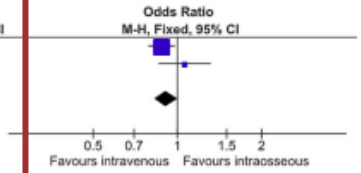
Intraosseous and intravenous vascular access during adult cardiac arrest: A systematic review and meta-analysis

Keith Couper[a,b,], Lars W. Andersen[c,d,e], Ian R. Drennan[f,g,h], Brian E. Grunau[i,j,k], Peter J. Kudenchuk[l,m], Ranjit Lall[a], Eric J. Lavonas[n,o], Gavin D. Perkins[a,b], Mikael Fink Vallentin[c,d], Asger Granfeldt[d,e], On behalf of the International Liaison Committee on Resuscitation Advanced Life Support Task Force*

Panel A: Return of spontaneous circulation at any time

Study or Subgroup	Intraosseous Events	Intraosseous Total	Intravenous Events	Intravenous Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Couper 2024	1092	3031	1186	3035	81.9%	0.88 [0.79, 0.97]
Vallentin 2024	277	731	273	748	18.1%	1.06 [0.86, 1.31]
Total (95% CI)		**3762**		**3783**	**100.0%**	**0.91 [0.83, 1.00]**
Total events	1369		1459			

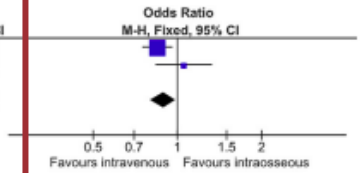
Heterogeneity: Chi² = 2.50, df = 1 (P = 0.11); I² = 60%
Test for overall effect: Z = 1.95 (P = 0.05)



Panel B: Sustained return of spontaneous circulation

Study or Subgroup	Intraosseous Events	Intraosseous Total	Intravenous Events	Intravenous Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Couper 2024	654	3016	744	3023	80.2%	0.85 [0.75, 0.96]
Vallentin 2024	206	731	203	748	19.8%	1.05 [0.84, 1.32]
Total (95% CI)		**3747**		**3771**	**100.0%**	**0.89 [0.80, 0.99]**
Total events	860		947			

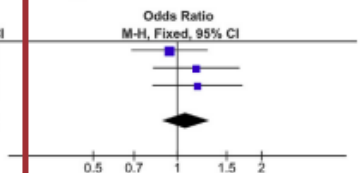
Heterogeneity: Chi² = 2.72, df = 1 (P = 0.10); I² = 63%
Test for overall effect: Z = 2.18 (P = 0.03)



Panel C: Survival to discharge/ 30-days with favourable neurological outcome

Study or Subgroup	Intraosseous Events	Intraosseous Total	Intravenous Events	Intravenous Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Couper 2024	80	2994	85	2986	42.9%	0.94 [0.69, 1.28]
Ko 2024	63	741	73	991	29.6%	1.17 [0.82, 1.66]
Vallentin 2024	67	728	59	746	27.4%	1.18 [0.82, 1.70]
Total (95% CI)		**4463**		**4723**	**100.0%**	**1.07 [0.88, 1.30]**
Total events	210		217			

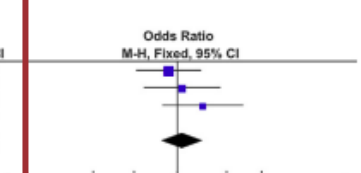
Heterogeneity: Chi² = 1.22, df = 2 (P = 0.54); I² = 0%
Test for overall effect: Z = 0.70 (P = 0.49)



Panel D: Survival to hospital discharge

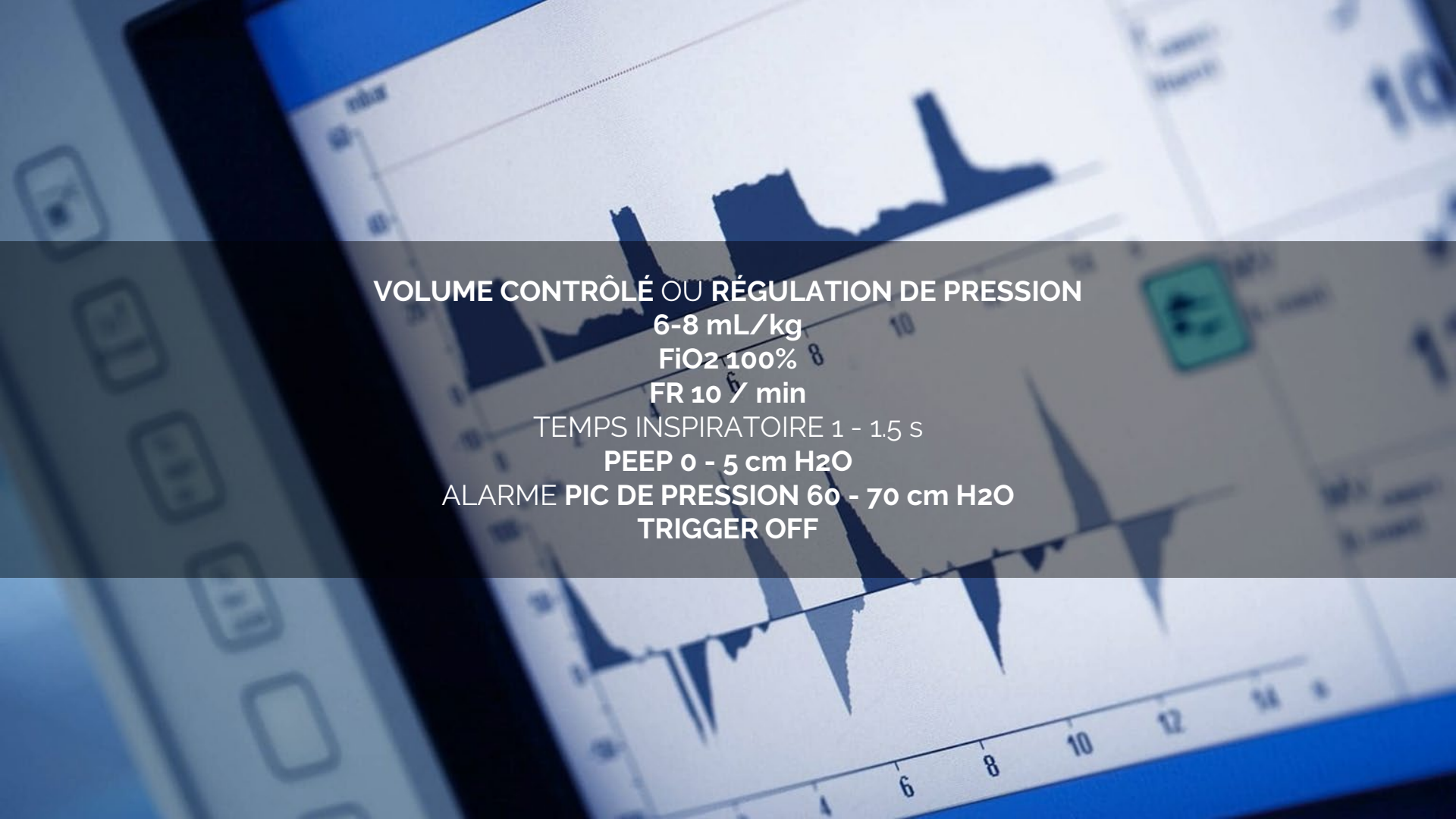
Study or Subgroup	Intraosseous Events	Intraosseous Total	Intravenous Events	Intravenous Total	Weight	Odds Ratio M-H, Fixed, 95% CI
Couper 2024	112	3012	120	3012	44.8%	0.93 [0.72, 1.21]
Ko 2024	79	741	102	991	30.2%	1.04 [0.76, 1.42]
Vallentin 2024	87	730	74	748	25.0%	1.23 [0.89, 1.71]
Total (95% CI)		**4483**		**4751**	**100.0%**	**1.04 [0.88, 1.23]**
Total events	278		296			

Heterogeneity: Chi² = 1.71, df = 2 (P = 0.42); I² = 0%
Test for overall effect: Z = 0.44 (P = 0.66)



BICARBONATES
CALCIUM
CORTICOÏDES

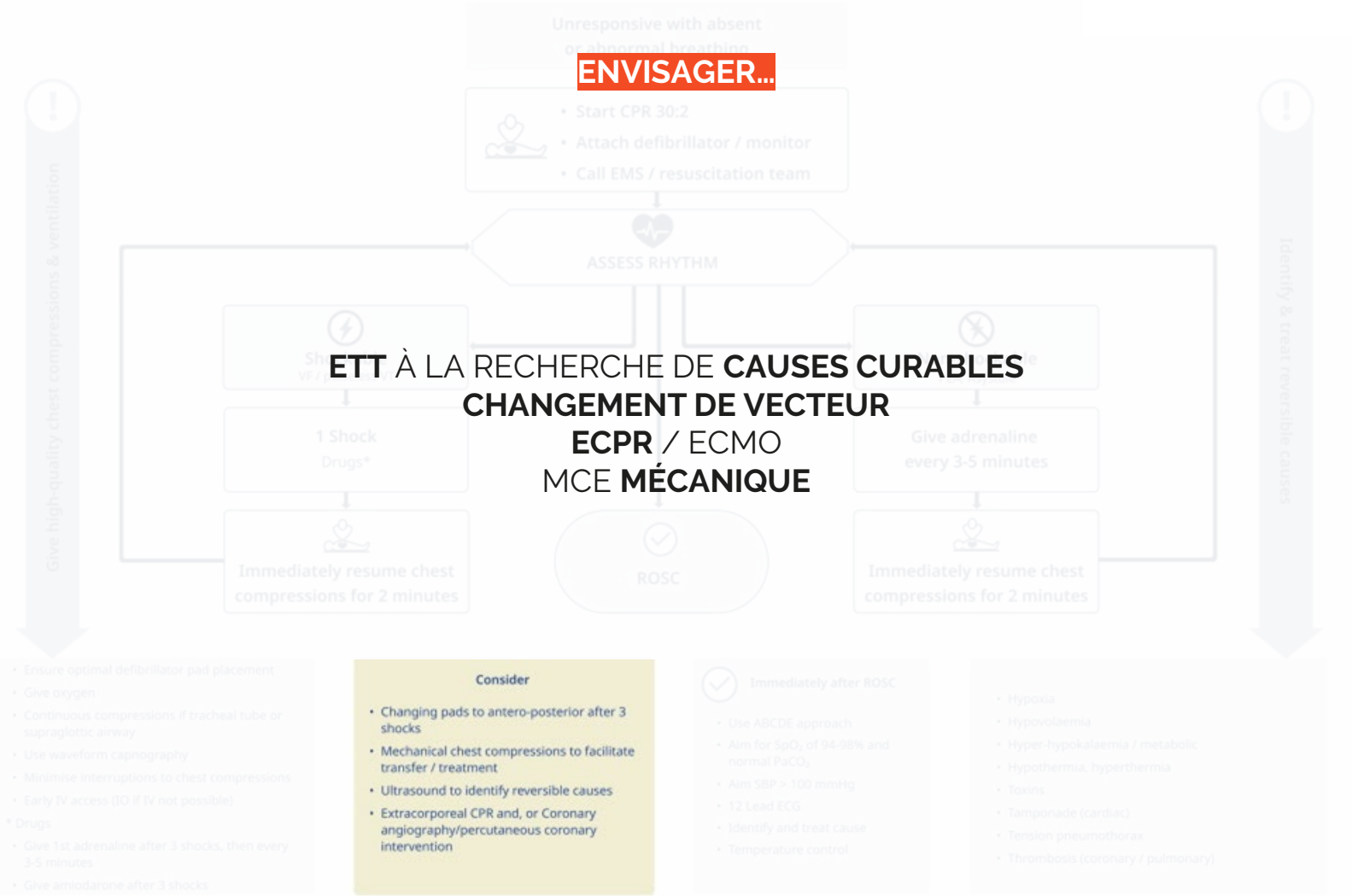

WORLD RUGBY
TRAINER



VOLUME CONTRÔLÉ OU **RÉGULATION DE PRESSION**
6-8 mL/kg
FiO2 100%
FR 10 / min
TEMPS INSPIRATOIRE 1 - 1.5 s
PEEP 0 - 5 cm H2O
ALARME **PIC DE PRESSION 60 - 70 cm H2O**
TRIGGER OFF

ENVISAGER…

ETT À LA RECHERCHE DE **CAUSES CURABLES**
CHANGEMENT DE VECTEUR
ECPR / ECMO
MCE **MÉCANIQUE**




00:07:28
QUIET
PLEASE
Timer and
Screen
Information
LUCAS CPR
Checklists
Timer

Original Article

Prehospital Extracorporeal Cardiopulmonary Resuscitation for Out-of-Hospital Cardiac Arrest: A Systematic Review and Meta-Analysis

Natalie Kruit, MBBS (Hons), FANZCA[*,†,‡,§,¶], Nivedita Rattan, BMed, MD[†], David Tian, MD, PhD[§,‖], Stefan Dieleman, MD, PhD, FANZCA[§,¶], Aidan Burrell, MBBS, FCICM, PhD[#,**], Mark Dennis, MBBS, FRACP, PhD[††,‡‡]

Table 4
Low-Flow Times, Survival, and Neurologic Outcomes for All Studies Included in the Meta-Analysis

Study	Low-Flow Time	Survival, n/N (%)	Neurologic Outcomes, n/N (%)
Petermichl et al. (2021)[14]	CPC 1-2: 40 min (IQR 30-47) CPC 3-4: 56 min (IQR 27-64) Non-survivors: 49 min (IQR 38-64)	21/63 (33)	CPC 1-2: n = 17/63 (27) CPC 3-4: n = 4/63 (6)
Hilker et al. (2013)[15]	61 min (SD ± 14.3)	2/6 (33)	CPC 3-4: n = 1/6 (16)
Bougouin et al. (2020)[13]	90 min (IQR 70-110)	19/123 (15)*	Not reported
Pozzi et al. (2022)[16]	71.1 min (SD ± 15.4)	7/30 (23.3)	CPC 1-2: n = 7/30 (23.3)

OBJECTIF LOW-FLOW
< 60 MIN

Available online at ScienceDirect
Resuscitation
journal homepage: www.elsevier.com/locate/resuscitation

ECMO

Review

Extracorporeal cardiopulmonary resuscitation for cardiac arrest: An updated systematic review

Mathias J. Holmberg[a,b,*], Asger Granfeldt[b,c], Anne-Marie Guerguerian[d], Claudio Sandroni[e], Cindy H. Hsu[f], Ryan M. Gardner[g], Peter C. Lind[b,c], Mark A. Eg[illie M. Johannsen[b], Lars W. Andersen[b,c,h]

Table 4 – Certainty of evidence for randomized trials in adults with out-of-hospital cardiac arrest.

Outcomes	Studies	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other[a]	Overall
Survival to hospital discharge or 30 days	3 studies[11–13]	Not serious	Serious[b]	Not serious	Serious[c]	None	**Low**
Survival to 3 months or 6 months	3 studies[11–13]	Not serious	Serious[b]	Not serious	Serious[c]	None	**Low**
Favorable neurological outcome at hospital discharge or 30 days	3 studies[11–13]	Not serious	Serious[b]	Not serious	Serious[c]	None	**Low**
Favorable neurological outcome at 3 months or 6 months	3 studies[11–13]	Not serious	Serious[b]	Not serious	Serious[c]	None	**Low**

[a] Includes assessment of publication bias and magnitude of the effect
[b] Some inconsistencies in effect sizes
[c] Although no pooled estimate was calculated, the small sample sizes led to wide confidence intervals

MONITORER

CHUTE BRUTALE DE l'**$ETCO_2$** = AC

PAS < 50 mmHg = MCE

SI KTA & BOLUS ADRÉNALINE = **50 - 100 µg IV**

PAD ≥ 30 mmHg & **$EtCO_2$ ≥ 25 mmHg**

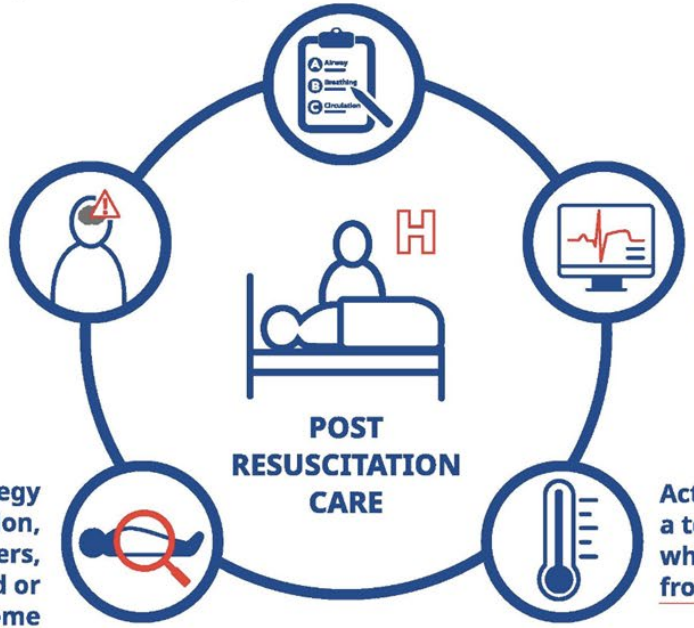
POST RESUSCITATION CARE
KEY MESSAGES

2025
EUROPEAN RESUSCITATION COUNCIL©

After ROSC use ABCDE approach

- Insert an advanced airway (tracheal intubation when skills available)
- As soon as SpO_2 can be measured reliably or arterial blood gas values are obtained, titrate the inspired oxygen to achieve an arterial oxygen saturation of 94-98%, and ventilate lungs to achieve normocapnia
- Aim for a systolic blood pressure > 100 mmHg or a mean arterial pressure > 60–65 mmHg

Perform functional assessments of physical and non-physical impairments before discharge to identify rehabilitation needs and refer to early rehabilitation if indicated



Prioritise immediate coronary angiography for patients with clear ST-elevation on the ECG or other high suspicion of coronary occlusion (e.g. haemodynamic and/or electrical instability)

Use a multimodal strategy including clinical examination, electrophysiology, biomarkers, and imaging to predict good or poor neurological outcome

Actively prevent fever by targeting a temperature ≤ 37.5 °C for patients who remain comatose after ROSC from cardiac arrest

POST-RACS

ADULTE

Rôle : Equipe d'urgence

RACCOURCIS :

A | B | C | D | E

STYLE :

NORMO-TOUT

POUVOIR UNIQUE

Maître circulatoire

Contrôle de la pression artérielle et de l'hématose

OBJECTIF : NEUROPROTECTION

Normoxie : Spo2 94-98%

FiO2 à 100% en post RACS immédiat, puis titration

Normocapnie : EtCO2 entre 30-40mmHg

Gardien de la PAM > 60-65mmHg

Hors trauma crânien & médullaire

Conditionnement

T°C	Glycemie	Tête
< 37.5°C	6-8mmol/L	Relevée 30°

EQUIPEMENT

Ventilation Protectrice
- Vt 6-8ml/kg (poids théorique)
- PEEP ≥ 5 cmH2O
- FR = 15 (12-20) /min

Chimie réfléchie
- Amine : noradrénaline (1mg/h puis titration) +/- dobutamine
- Sédation + analgésie (½ vie courte)

INTERPRÉTATION ECG IMMÉDIATE IMPOSSIBLE
Déverrouillé à partir de 10min post-RACS

QUÊTE PRINCIPALE :

Activité cardiaque récupérée

Vaincre "ACSOS"

QUÊTE SECONDAIRE :

- Identifier la cause + échographie (5H & 5T)
- Coro directe si STEMI
- Du réa + TDM crâne & thorax à minima

BONUS : Occlusion des yeux + registre AC
Monitorage artériel invasif + GdS

SFMU

Crédits : Infographie du Board AC de la SFMU. Idée originale : Dr Pierre BALAZ (BMPM).

VERS : CORO / RÉA

SÉDATION - ANALGÉSIE - CURARISATION


P qp/kp kvkc vkqp"1'kp vgt t wr vkqp"T E R

Annales françaises de
médecine d'urgence

G. Debaty[1], N. Baladi[2],
G. Bois[3], V. Canon[4], T. Chouihed[5],
A. Maluga[6], C. Derkenne[7],
F. Dumas[8,9,10], C. Genbrugge[11,12],
C. Gil-Jardiné[13], M. Heidet[14],
H. Hubert[4], P. Jabre[15,8,9], D. Jaeger[5],
F. Javaudin[16,17], D. Jost[18,8],
L. Lamhaut[15,8,9], E. Perret[19],
L. Quirin[20], A. Renard[21,22],
P.-G. Reuter[23], D. Savary[24,25],
E. Wiel[4,26], A. Chauvin[27]

RECOMMANDATION POUR LA PRATIQUE CLINIQUE / *CLINICAL PRACTICE RECOMMENDATION*

Recommandations de pratiques professionnelles portant sur la gestion d'un appel pour suspicion d'arrêt cardiaque dans un centre d'appel d'urgence

Debaty G, Baladi N, Bois G, Canon V, Chouihed T, Maluga A, Derkenne C, Dumas F, Genbrugge C, Gil-Jardiné C, Heidet M, Hubert H, Jabre P, Jaeger D, Javaudin F, Jost D, Lamhaut L, Perret E, Quirin L, Renard A, Reuter P.-G, Savary D, Wiel E, Chauvin A (2024) Recommandations de pratiques professionnelles portant sur la gestion d'un appel pour suspicion d'arrêt cardiaque dans un centre d'appel d'urgence. Ann Fr Med Urgence 14 :398-412.

R5.1 - Les experts proposent qu'en cas d'AC préhospitalier chez l'adulte, le régulateur peut décider de ne pas faire initier de RCP s'il a, dès l'appel, des éléments en faveur :

1. de présence d'une lésion mortelle évidente ou de mort irréversible (rigidité cadavérique, lividité cadavérique, putréfaction, décapitation, ...) avec l'adhésion de l'appelant à cette décision ;
2. ou des directives anticipées formalisées et/ou une décision médicale claire et certaine de ne pas réanimer avec l'adhésion de l'appelant à cette décision (exemple : directives anticipées du patient notées dans l'espace numérique de santé « *Mon espace santé* ») ;
3. ou devant l'association de plusieurs facteurs pronostiques défavorables et avec l'adhésion de l'appelant à cette décision ;
4. ou d'un danger immédiat pour l'intégrité physique du/des témoin(s) (réel ou perçu) ;
5. ou d'un refus par le(s) témoin(s) de suivre les gestes de RCP guidés par téléphone ;
6. ou d'une incapacité (physique ou psychologique/ émotionnelle) du témoin à entreprendre les gestes de réanimation.

AVIS D'EXPERTS

Lésion mortelle

F kt gevkxgu"c pvkekr Águ"1"f Áekukqp"o Áf kecrng

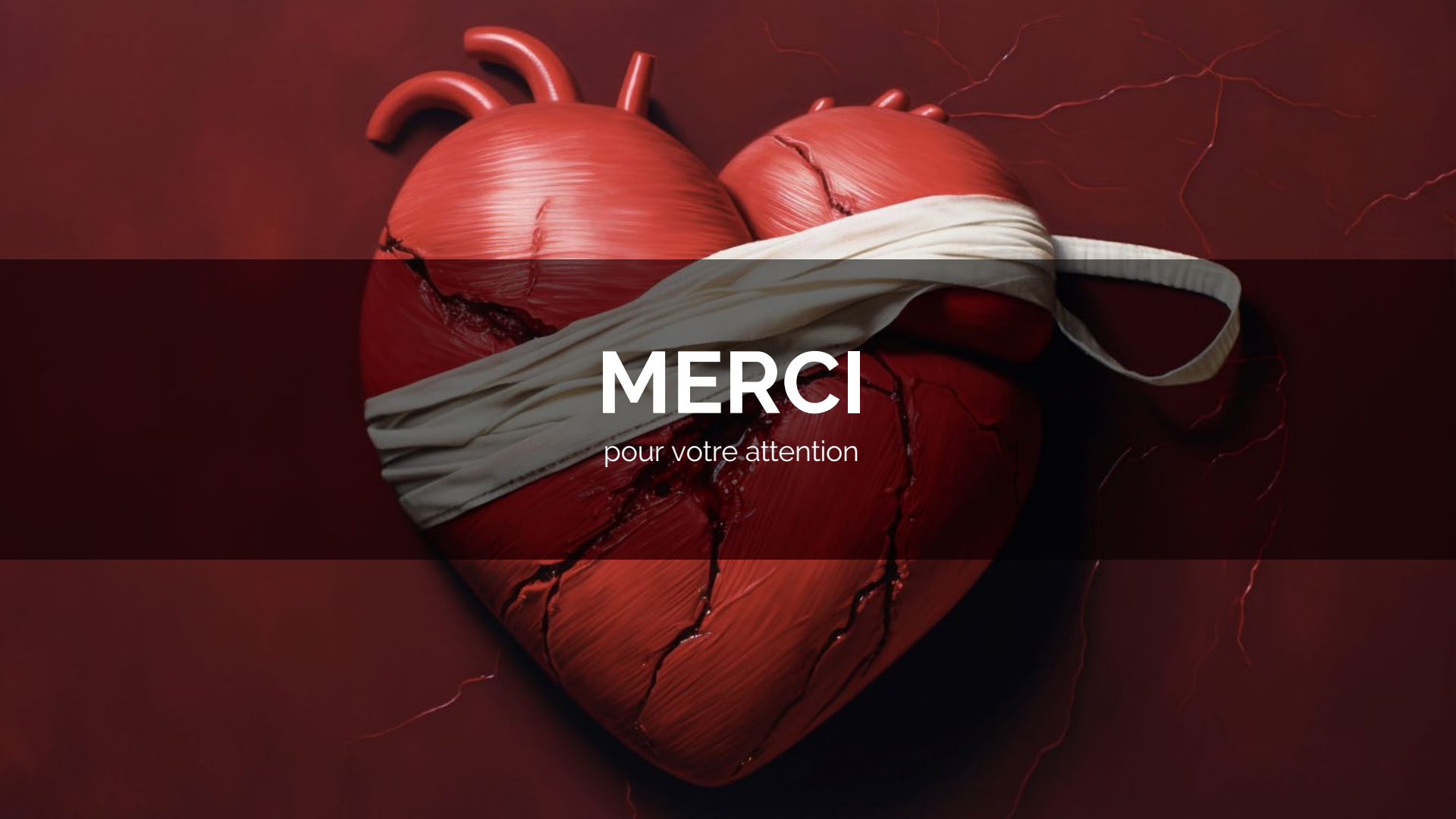
Facteurs pronostiques défavorables

F cpi gt"ko o Áf kcv

Refus témoins

Incapacité physique de RCP

\+ ACCORD APPELANT !!


MERCI
pour votre attention