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Advanced Cardiovascular Life Support Provider Manual

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Print Page Number	Location	Original Text	Change	When Change Was Made
2	Part 1 > Course Prerequisites and Preparation > 2nd paragraph > last sentence	**Print your certificate of completion and bring it with you to the course.**	**Print your certificate of completion and score report and bring them with you to the course.**	At next printing or update after 12/18/20
29	Part 2 > Acute Coronary Syndromes > Rhythms for ACS > 2nd sentence	Anticipate these rhythms, and be prepared for immediate interventions, including defibrillation or cardioversion as well as administration of drugs or pacing for stable bradycardias.	Anticipate these rhythms, and be prepared for immediate interventions, including defibrillation or cardioversion as well as administration of drugs or pacing for unstable bradycardias.	At next printing or update after 11/12/20
42	Part 2 > Acute Coronary Syndromes > STEMI > Adjunctive Treatments > 3rd bullet > sub-bullet, last sentence	The timing of administration of $P2Y_{12}$ should	"{Insert "inhibitors" after "$P2Y_{12}$"} The timing of administration of $P2Y_{12}$ inhibitors should	At next printing or update after 2/12/2021
50	Part 2 > Acute Stroke > Application of the Adult Suspected Stroke Algorithm > Activate EMS Systems Immediately > 2nd paragraph, 5th bullet	EMS can provide prehospital notification,	{Replace "can" with "should"} EMS should provide prehospital notification,	At next printing or update after 2/12/2021
61	Part 2 > Acute Stroke > Fibrinolytic Therapy > Table 8, above the Abbreviations list		{A new sub-table, Alteplase Considerations in the 3- to 4.5-Hour Time Window in Addition to Those in the 0- to 3-Hour Window, was added. See attached PDF.}	At next printing or update after 10/7/2020
66	Part 2 > Bradycardia > Rhythms for Bradycardia > last paragraph > 3rd sentence	Recognizing a stable bradycardia due to AV block is a primary goal, and recognizing the type of AV block is secondary.	Recognizing an unstable bradycardia due to AV block is a primary goal, and recognizing the type of AV block is secondary.	At next printing or update after 11/12/20
70	Part 2 > Bradycardia > Managing Bradycardia: The Bradycardia Algorithm > Applying the Adult Bradycardia	Give atropine as first-line treatment: atropine 1 mg IV	Give atropine as first-line treatment (except for heart transplant patients): atropine 1 mg IV	At next printing or update after 11/29/2021

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	Algorithm > Treatment Sequence Summary > 1st bullet			
71	Part 2 > Bradycardia > Managing Bradycardia > Treatment Sequence: Atropine > 1st paragraph, 1st sentence	If you find no immediately reversible causes, atropine remains the first-line drug for acute stable bradycardia.	{Replace "stable" with "unstable"} If you find no immediately reversible causes, atropine remains the first-line drug for acute unstable bradycardia.	At next printing or update after 2/12/2021
71	Part 2 > Bradycardia > Managing Bradycardia: The Bradycardia Algorithm > Applying the Adult Bradycardia Algorithm > Treatment Sequence: Atropine > 2nd paragraph, 1st sentence	For bradycardia, give atropine 1 mg IV every 3 to 5 minutes	For bradycardia, give atropine 1 mg IV (except for heart transplant patients) every 3 to 5 minutes	At next printing or update after 11/29/2021
71	Part 2 > Bradycardia > Managing Bradycardia: The Bradycardia Algorithm > Applying the Adult Bradycardia Algorithm > Treatment Sequence: Atropine		{A new box was added.} **Critical Concepts: Atropine and Heart Transplant Patients** The "2018 ACC/AHA/HRS Guideline on the Evaluation and Management of Patients With Bradycardia and Cardiac Conduction Delay" states that unstable bradycardia patients who have undergone a heart transplant should not receive atropine for treatment because of the increased likelihood of VF precipitation. These guidelines classify atropine for unstable heart transplant patients as a Class III: Harm. • Avoid using atropine for unstable bradycardia in heart transplant patients. • Treat with pacing and/or dopamine or epinephrine	At next printing or update after 11/29/2021
72	Bradycardia > Treatment Sequence: Epinephrine, Dopamine > 1st	Although β-adrenergic agonists with rate-accelerating effects are not	Although β-adrenergic agonists with rate-accelerating effects are not	At next printing or update after 2/3/2022

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	paragraph > 1st sentence > change "stable" to "unstable."	first-line agents for treating stable bradycardia, …	first-line agents for treating unstable bradycardia, …	
73	Bradycardia > Treatment Sequence: Epinephrine, Dopamine > 3rd paragraph> 1st sentence > change "stable" to "unstable."	Either epinephrine infusions or dopamine infusions may be used for patients with stable bradycardia, …	Either epinephrine infusions or dopamine infusions may be used for patients with unstable bradycardia, …	At next printing or update after 2/3/2022
116	Part 3 > Cardiac Arrest: VF/pVT > Managing VF/pVT: The Adult Cardiac Arrest Algorithm > Asystole/PEA Path > 1st paragraph > 2nd sentence	The asystole/PEA pathway of the algorithm outlines the sequence of actions to perform if the rhythm is nonshockable. You will practice this sequence in the Asystole and PEA Cases.	{Delete the second sentence so that the paragraph is 1 sentence} The asystole/PEA pathway of the algorithm outlines the sequence of actions to perform if the rhythm is nonshockable.	At next printing or update after 2/12/2021
116	Part 3 > Cardiac Arrest: VF/pVT > Managing VF/pVT: The Adult Cardiac Arrest Algorithm > Asystole/PEA Path > 2nd paragraph	During the VF/pVT Case, you will practice performing rapid treatment on the VF/pVT pathway in the Adult Cardiac Arrest Algorithm.	{Delete entire 2nd paragraph.}	At next printing or update after 2/12/2021
132	Part 3 > Cardiac Arrest: PEA and Asystole > Managing Asystole/PEA: The Cardiac Arrest Algorithm > Managing Asystole/PEA > first 2 sentences	This patient has an organized rhythm on the monitor but no pulse. The condition is PEA (Step 9). Resume chest compressions immediately.	{Replace the existing first 2 sentences with 2 new sentences} If this patient has no discernible electrical activity and no pulse, it is asystole (Step 9). If this patient has an organized rhythm on the monitor but no pulse, it is PEA (Step 9).	At next printing or update after 2/12/2021
146	Part 3 > Cardiac Arrest: Selected Special Situations > Cardiac Arrest Associated With Pregnancy > Key Interventions: Prevention of Cardiac Arrest in Pregnancy > 6th bullet > 1st sub-bullet	If no ROSC in 5 minutes, consider immediate perimortem cesarean delivery	If no ROSC, complete perimortem cesarean delivery ideally within 5 minutes after time of arrest.	At next printing or update after 11/29/2021
149	Part 3 > Figure 57 > Cardiac Arrest in Pregnancy In-	If no ROSC in 5 minutes, consider immediate perimortem cesarean delivery	If no ROSC, complete perimortem cesarean delivery	At next printing or update after 11/29/2021

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	Hospital ACLS Algorithm > 2nd green box in right column > bullet		ideally within 5 minutes after time of arrest	
152	Part 3 > Post–Cardiac Arrest Care > Multiple System Approach to Post–Cardiac Arrest Care > second paragraph > 2nd sentence	If the patient is hypotensive (SBP less than 90 mm Hg or mean arterial pressure of greater than 65 mm Hg), you can administer fluid boluses.	If the patient is hypotensive (SBP less than 90 mm Hg or mean arterial pressure of less than 65 mm Hg), you can administer fluid boluses.	At next printing or update after 11/12/20
168	Appendix > Megacode Testing Checklist: Scenarios 1/3/8 > Bradycardia Management > 4th row	Administers correct dose of atropine	Administers correct treatment	At next printing or update after 11/29/2021
180	Appendix > Cardiac Arrest in Pregnancy In-Hospital ACLS Learning Station Checklist > Cardiac Arrest in Pregnancy In-Hospital ACLS Algorithm > 2nd green box in right column > bullet	If no ROSC in 5 minutes, consider immediate perimortem cesarean delivery	If no ROSC, complete perimortem cesarean delivery ideally within 5 minutes after time of arrest	At next printing or update after 11/29/2021
183	Appendix > ACLS Pharmacology Summary Table > Atropine Sulfate > 3rd column, Precautions and contraindications > after 3rd bullet		{Insert a 4th bullet.} • Do not give to heart transplant patients	At next printing or update after 11/29/2021
185	Appendix > Science Summary Table > Bradycardia > 2nd column, 2015 > After 2nd bullet		{Insert a 3rd bullet} • Atropine is the first-line medication for all unstable bradycardias.	At next printing or update after 11/29/2021
185	Appendix > Science Summary Table > Bradycardia > 3rd column, 2020 > After 2nd bullet		{Insert a 3rd bullet} • Give atropine to all unstable bradycardia patients as a first-line medication except heart transplant patients. Use pacing and/or dopamine or epinephrine for heart transplant patients.	At next printing or update after 11/29/2021
186	Appendix > Glossary > Under “C” > Cardiopulmonary	A basic emergency procedure for life support, consisting of mainly manual external	A basic emergency procedure for life support, consisting of mainly manual external	At next printing or update after 11/12/20

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	resuscitation (CPR) definition	cardiac massage and some artificial respiration	compressions and some artificial respiration	
201	Provider Manual > Index > 2nd column > entry "Thrombectomy-Capable Stroke Center (TCSC), 53, 54"	Thrombectomy-Capable Stroke Center (TCSC), 53, 54	Thrombectomy-Capable Stroke Center (TSC), 53, 54	At next printing of update after 03/12/21

Alteplase Considerations in the 3- to 4.5-Hour Time Window in Addition to Those in the 0- to 3-Hour Window*

Indications (COR 1)	
3-4.5 hours†	IV alteplase (0.9 mg/kg, maximum dose 90 mg over 60 min with initial 10% of dose given as bolus over 1 min) is also recommended for selected patients who can be treated within 3 and 4.5 hours of ischemic stroke symptom onset or patient last known well. Physicians should review the criteria outlined in this table to determine patient eligibility.‡ (COR 1; LOE B-R)‖
3-4.5 hours–Age	IV alteplase treatment in the 3- to 4.5-hour time window is recommended for those patients ≤80 years of age, without a history of both diabetes mellitus and prior stroke, NIHSS score ≤25, not taking any OACs, and without imaging evidence of ischemic injury involving more than one third of the MCA territory.‡ (COR 1; LOE B-R)‖
Additional recommendations for treatment with IV alteplase for patients with AIS (COR 2a)	And (COR 2b)
3-4.5 hours–Age	For patients >80 years of age presenting in the 3- to 4.5-hour window, IV alteplase is safe and can be as effective as in younger patients.‡ (COR 2a; LOE B-NR)‖
3-4.5 hours—Diabetes mellitus and prior stroke	In AIS patients with prior stroke and diabetes mellitus presenting in the 3- to 4.5- hour window, IV alteplase may be as effective as treatment in the 0- to 3-hour window and may be a reasonable option.‡ (COR 2b; LOE B-NR)‖
3-4.5 hours—Severe stroke	The benefit of IV alteplase between 3 and 4.5 hours from symptom onset for patients with very severe stroke symptoms (NIHSS score >25) is uncertain.‡ (COR 2b; LOE C-LD)‖
3-4.5 hours—Mild disabling stroke	For otherwise eligible patients with mild disabling stroke, IV alteplase may be reasonable for patients who can be treated within 3 and 4.5 hours of ischemic stroke symptom onset or patient last known well or at baseline state. (COR 2b; LOE B-NR)§