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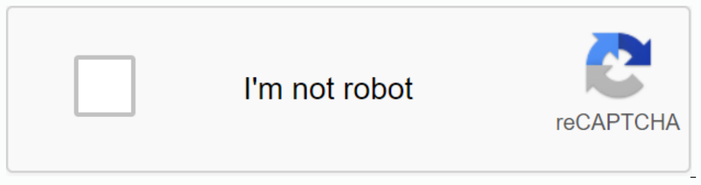

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Format : eBook Product code: 15-2331 ISBN 13 : 978-1-61669-624-5_ES Publication Date : 2017-11-21 SVAP / PALS Provider Book in electronic version is the electronic equivalent of the AHA SVAP / PALS Provider Book. It is an alternative to printed book courses and is intended for use by one student before, during and after the SVAP/PALS course. This electronic version contains all the information students need to successfully complete the SVAP/PALS course. It also serves as a clinical reference. Based on a series of video simulations and child emergencies, the SVAP/PALS course reinforces important concepts of a systematic approach to child evaluation, basic life support, SVAP/PALS treatment algorithms, effective resuscitation, and team dynamics. The purpose of the SVAP/PALS course is to improve the quality of care provided to children with serious illnesses or injuries for better results. With the purchase of SVAP/PALS Vendor Books in electronic versions, a separate additional tool is included: SVAP/PALS digital reference card. This reference card is equivalent to an electronic SVAP/PALS reference card. NOTE: Before purchasing an AHA eBook for a face-to-face course, students should consult an instructor or training center coordinator if a mobile device is allowed in the classroom. November 15, 2018 Gustavo Flores Update 2018 for the American Heart Association ACLS and PALS Guides for Emergency Cardiovascular Care focuses on the use of antiarimic pharmacological agents for the treatment of ventricular fibrillation (VF) heart attack or ventricular tachycardia without pulse (TV). This applies to ACLS and PALS courses. Summary of changes in administration of amiodarone or lidocaine may be considered in the management of patients in cardiac arrest by FV or TV without pulse. Regular use of magnesium in heart attacks is not recommended. There is no evidence to recommend or dispute the use of beta blockers in direct postparous (within the first hour of spontaneous circulation return (RCE). There is no evidence to recommend or refute the use of lidocaine in direct postparous (within the first hour of rce return). For your convenience, the American Heart Association releases a summary of the highlights of the update. You can download it in 17 different languages, although in Spanish it's on this link. Update process As we have previously reported, the guide update process will no longer be a publication every 5 years, but continuous publication of evidence When there is significant new evidence, ILCOR conducts a systematic review of the literature. After analysis of the literature, the panel decides whether there is consensus in the publication of new recommendations. You can see The Science Consensus and Treatment Recommendations (CoSTR) by following this link. To see which CoRR was open to public opinion before publication, you can see more of this link. After ILCOR published its recommendations, the AHA made an update to its guidelines. Although the publication of ILCOR recommendations was carried out in conjunction with the AHA, the recommendations went through a period of public analysis. Therefore, it is possible to look at the process currently being carried out and get an idea of decisions that may occur in the future. American Heart Association Center Portal Guide The easiest way to see the latest information and be presented uniformly is to visit the American Heart Association portal of the Emergency Cardiovascular Care Guide, . The Amiodarone versus Lidocaine ROC-ALPS study, published in 2016, compared the use of amiodarone, lidocaine or a placebo in an out-of-hospital heart attack. The study showed: There was no difference between amiodarone, lidocaine or a placebo in the neurologically viable hospital exit of patients suffering a heart attack outside the hospital. Patients receiving amiodarone or lidocaine had a higher return of spontaneous circulation. This benefit occurs exclusively in groups of patients witnessed by a witness. Watch this ancient episode of ECCpodcast related to this study. Although the ultimate goal of heart attack management is to exit the hospital with a functional neurological state, achieving a return to spontaneous circulation is an important first step in the process. Although the use of antiarthythmics does not improve survival in outgoing hospitals with a neurological functional state, the use of heart attack antiarthythmics increases the likelihood of getting a return to spontaneous circulation in patients with FV and TV without the pulse witnessed by a witness. The new algorithm As a result, two new ACLS algorithms, available for download from the integrated AHA Guide page, are as follows: The Adult Heart Capture Algorithm Circular Heart Attack Algorithm in Adults Similarly, the PALS algorithm (also downloadable from the AHA Integrated Guide website), is here. The effect on the book and material class changes proposed by these new recommendations can be easily incorporated into the current material. Participants in our class receive science update documents. Reference Panchal AR, Berg KM, Kudenchuk PJ, Del Rios M, Hirsch KG, Link MS, Kurz MC, Chan PS, JG Cabins, Morley PT, Hazinski MF, Donnino MW. 2018 American Heart Association focuses update on advanced cardiovascular life supporting the use of antiarik drugs and immediately after a heart attack: an update to the American Heart Association's guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. Circulation. 2018;138:e•••e••. DOI: 10.1161/CIR.0000000000000613. Duff JP, Topjian A, Berg MD, Chan M, Haskell SE, Joyner BL Jr, Lasa JJ, SJ Law, Raymond TT, Sutton RM, Hazinski MF, Atkins DL. The 2018 American Heart Association focuses its updates on child support: updates to american heart association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care Circulation. 2018;138:e••–e•••. DOI: 10.1161/CIR.0000000000000612. Resuscitation. 2018 Nov;132:63-72. doi: 10.1016/j.resuscitation.2018.08.025. Epub 2018 Sep 1. N Engl J Med 2016; 374:1711-1722 DOI: 10.1056/NEJMoa1514204 The AHA Algorithm 2018 Spanish Adult PediatricsEsto is due since 2015, ILCOR began the ongoing process of reviewing evidence. This results in a practice where recommendations are no longer made every 5 years, but ongoing updates are made. Recommendations on Basic Life Support for adults and pediatricians were updated last year. And yesterday recommendations on Advanced Cardiovascular Life Support for adults and pediatricians were updated. Major changes and updates made to ACLS correspond to the use of antiar rhythms after the revision of the new study. Most are not major changes and address changes in recommendation classes or evidence levels. Major changes and updates made by the AHA to ACLS in 2018 are in accordance with the use of antiar rhythms. Click to tweetCommunication about amiodarone and lidocaineMyodarone and lidocaine should be considered for ventricular fibrillation and ventricular tachycardia without pulses that do not respond to defibrillation. These drugs can be very useful in patients with cardiorespiratory capture (PCR) witnessed where the time of administration of the drug is short (Class IIb, LOE B-R). Previously they only said that amiodarone could be considered in the same arrhythmias described above and that they did not respond to CPR, defibrillation and vasopresor. And they say that lidocaine can be considered an alternative to it but with different levels of evidence: formerly Class IIb, LOE C-LD and now class IIb, LOE B-R (switching from limited to random data). They introduced this change in the normal PCR algorithm and in a circular recommending amiodarone (already existing) or lidocaine as an alternative (lidocaine did not previously appear) but still did so after the third exit. Available studies do not show improved hospital discharge survival (or neurological improvement for discharge). But if the percentage of patients who have spontaneous circulation recovery (CTE) increases in those given amiodarone or lidocaine in Placebo. Recommendations of Regular Magnesium use of magnesium in PCR are not recommended in adult patients. We went from Grade III: No Benefits, LOE B-R to Grade III: No Benefits, LOE C-LD). We were also told that magnesium could be considered for torsades de pointes (e.g. polymorphic TVs associated with long QT intervals). We went from Class IIb, LOE C to Class IIb, LOE C-LD. The words of this recommendation are in accordance with the AHA guidelines for ACLS 2010. These guidelines are: bolus IV or IoT magnesium sulfate 1 to 2 g diluted in 10 ml SG 5%. The change only affects the level of evidence based on a new study that confirms that it should not be used regularly. Recommendations on antiarithmics after immediate recovery of spontaneous circulation in adultsBetablockers There is insufficient evidence to support or refute the routine use of early administration (in the first hour) of beta blockers after recovery from spontaneous circulation. We were previously told that there was insufficient evidence to support the use of beta blockers under the same circumstances as described above. However, we are told that, we may consider starting or resuming oral doses or intravenous beta blockers at stops due to VVF and TV. We were told that there were no further studies on this but that they had made detailed assessments of the literature already available to simplify previous recommendations. And in the end they haven't been able to provide recommendations or new levels of evidence because they haven't found enough evidence to do so. Lidokain There is not enough evidence to support or refute the routine use of early administration (within the first hour) of lidocaine after recovery from spontaneous circulation. In the absence of contraindications, the use of lidocaine prophylaxis can be considered under certain circumstances (such as during the transport of Medical Emergency Services) when repeated VVF/TV treatment can be challenging (Class IIb, LOE C-LD). They have not reviewed further studies on this topic and since there is still not enough evidence, they only recommend that their use be considered for such specific situations. Changes to the algorithm They have made two changes to the normal and circular algorithm. They have added lidocaine next to amiodarone and introduced its dosage. In phrase: Play the person you compress every 2 minutes or earlier if you're tired of changing the word spin to change. New ACLS AHA 2018 algorithm with small changes from previous PALS CHANGES Changes Changes made to child advanced life support has fundamentally modified some point algorithms so that there are fewer differences between adults and pediatricians. Use of antiarrrhythmic drugs during resuscitation by ventricular fibrillation and child ventricular tachycardiaAmiodarone and lidocaine resuscitationNo compared to 2015: in the case of ventricular fibrillation and ventricular tachycardia without reflictorial pulse, amiodarone or lidocaine (Class IIb, LOE C-LD) can be used. Unlike previous revisions, only pediatric studies have been considered in 2018. No studies have been identified to address the use of antiarithythmic drugs after cardiac arrest resuscitation. Regarding recommendations for using it in PCR, only one study identified comparing results associated with the use of amiodarone or lidocaine for intrahospital resuscitation with a heart attack. The study found no significant difference in hospital discharge survival in patients receiving amiodarone versus lidocaine. So now you can choose between the two. The algorithm changesintroduce at the point of the drug PCR behind amiodarone, or lidocaine and puts a dose. In the AESP/asistolia section, in Box 10, to the phrase Consider advanced airways, they add capnography. Box 12 changes point to 1 that says asistolia/AESP: 10 or 11 to If there are no signs of CPR, open 10 or 11. Also in Box 12 they put together the second and third points with one that says if RCE goes to the postpaid cardiac care algorithm. New PALS algorithm AHA 2018. Minor modifications Have been made Last update: 29/12/2019 29/12/2019

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