The PALS exam is 50 questions. Passing score is 84% or you may miss 8 questions. All AHA exams are now open resource, so you may use your books and/or handouts for the exam. For those persons taking PALS for the first time or updating/renewing with a current card, exam remediation is permitted should you miss more than 8 questions on the exam. Viewing the PALS book ahead of time with the online resources is very helpful. The American Heart Association link is [www.heart.org/eccstudent](http://www.heart.org/eccstudent) has a pre-course self-assessment, supplementary written materials and videos. The code for these online resources is in the PALS Provider manual page ii. The code is PALS15. Basic Dysrhythmia knowledge is required. The exam has at least 5 strips to interpret. The course is a series of video segments then skills. The course materials well prepare you for the exam.

Basic Dysrhythmias knowledge is required in relation to asystole, ventricular fibrillation, tachycardias in general and bradycardias in general. You do not need to know the ins and outs of each and every one. Tachycardias need to differentiate wide complex (ventricular tachycardia) and narrow complex (supraventricular tachycardia or SVT).

- Airway - child is grunting - immediate intervention.
- Airway - deteriorates after oral airway, next provide bag-mask ventilation
- Airway - snoring with poor air entry bilaterally - reposition, oral airway
- AVPU - findings normal - rated as Alert
- CPR - 1 rescuer. 30:2 compression to ventilation ratio. 2 person 15:2 compression to ventilation
- CPR - after defibrillation resume compressions
- CPR - high quality component - allow complete chest wall recoil after each compression
- CPR - simultaneous pulse and breathing check no more than 10 seconds.
- CPR - you are lone with infant - Begin CPR for 2 minutes then leave to activate emergency response.
- Defibrillation - initial for 20 kg child - 40 J, with pulseless VT, VF 2 to 4 J/kg
- Fluid resuscitation - 20 mL/kg normal saline
- I/O before vascular access - for cardiac arrest.
- Labs - lethargy, Polyuria, onset rapid, deep, labored breathing - assess blood glucose
- Motor vehicle accident, immediate intervention for decreased level of consciousness.
- Oxygen sat - below 90 while on oxygen - immediate intervention, - ideal 94% to 99% (not 94% to 100%)
- Respiratory - distress - audible inspiratory stridor.
- Respiratory - failure - lethargic, rapid respiratory rate, tachycardic, most indicative of a low oxygen saturation.
- Respiratory - failure with fever, antibiotic is the most appropriate medication.
- Respiratory - lower airway - wheezing
- Respiratory - seizures, slow respirations - disordered control of breathing.
- Respiratory - unresponsive, respirations 6 per minute - provide bag-mask ventilation with 100% O2.
- Respiratory - upper airway - increased work of breathing, inspiratory effort with retractions, stridor, nut allergy.
- Respiratory - upper airway obstruction drug - nebulized epinephrine.
- Respiratory distress from long tissue disease - crackles.
- Rhythm - bradycardia, no pulse - pulseless electrical activity
- Rhythm - hypoxia most likely cause of bradycardia in an infant.
- Rhythm - pulse above 180 Narrow complex, regular - Supraventricular tachycardia.
- Rhythm - rate slow, sinus bradycardia.
- Rhythm - Supraventricular tachycardia, hypotensive - synchronized cardioversion.
- Shock - distributive, septic - fever, lactic acidosis, antibiotic as an early intervention.
- Shock - fever, hypotensive - IV 20 mL/kg of isotonic crystalloid over 5 to 10 minutes.
- Shock - hypotensive - best assessment variable is blood pressure, 55/40 for 2 week-old.
- Shock - hypovolemic - history vomiting, diarrhea
- Shock - severity, compensated or not is determined by the blood pressure, not other variables.
- Team dynamics - out of scope: team member should ask for a new task or role.
- Team dynamics - wrong dose by team leader, Respond "I think the correct dose is..... should I give instead?"
- Vital Signs - Heart rate 88 is normal for a 10 year old, respiratory rate 24 normal for 3 year old.
Systematic Approach Algorithm

Initial Impression
- Appearance
- Work of Breathing
- Circulation

Evaluate – Identify - Intervene

Intervene Evaluate

Identify

A continuous sequence.
**Determine if problem is life threatening.

IDENTIFY

- Type and Severity of Potential Problems

<table>
<thead>
<tr>
<th>Respiratory</th>
<th>Circulatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Distress Or Respiratory Failure</td>
<td>Compensated Shock Or Hypotensive Shock</td>
</tr>
<tr>
<td>Upper airway obstruction</td>
<td>Hypovolemic shock</td>
</tr>
<tr>
<td>Lower airway obstruction</td>
<td>Distributive shock</td>
</tr>
<tr>
<td>Lung tissue disease</td>
<td>Cardiogenic shock</td>
</tr>
<tr>
<td>Disordered control of breathing</td>
<td>Obstructive shock</td>
</tr>
</tbody>
</table>

Cardiopulmonary Failure
Cardiac Arrest

INTERVENE

- Positioning the child to maintain a patent airway
- Activating emergency response
- Starting CPR
- Obtaining the code cart and monitor
- Placing the child on a cardiac monitor and pulse oximeter
- Administering 02
- Supporting ventilation
- Starting medications and fluids using nebulizer, IV/IO fluid bolus

An intubated patient’s condition deteriorates; consider the following possibilities (DOPE):

- Displacement of the tube from the trachea
- Obstruction of the tube
- Pneumothorax
- Equipment failure

6 Hs 5 Ts  -Search for Reversible Causes

H ypovolemia
H ypoxia
H ydrogen ion (acidosis)
H ypoglycemia
H ypo /hyperkalemia
H ypothermia

T ension pneumothorax
T amponade, cardiac
T oxins – poisons, drugs
T hrombosis – coronary (AMI)
T hrombosis – pulmonary (PE)
Course Completion Requirements

✓ Actively participate in, practice, and complete all skills stations and learning stations.
✓ Pass the child CPR and AED and infant CPR skills tests
✓ Pass an exam with minimum score of 84%
✓ Pass 2 PALS case scenario test as a team leader

2015 Science Changes

♥ in specific settings with febrile illnesses, use of restrictive volumes of isotonic crystalloid led to improved survival.
♥ routine use of atropine pre-intubation to prevent dysrhythmias is controversial.
♥ If invasive BP monitoring, use to adjust CPR to targets.
♥ amiodarone or lidocaine are acceptable antiarrhythmic agents of VF, Pulseless VT
♥ epinephrine recommended as vasopressor in pediatric cardiac arrest.
♥ extracorporeal CPR (ECPR) may be considered in in-hospital settings with cardiac diagnoses.
♥ avoid fever with ROSC
♥ after ROSC fluids and vasoactive infusions should be used to maintain SBP at fifth percentile for age.
♥ after ROSC normoxemia should be targeted.

Vital Signs in Children - Normal Ranges

<table>
<thead>
<tr>
<th>Age</th>
<th>Systolic BP</th>
<th>Pulse (awake)</th>
<th>Respirations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonate</td>
<td>67-84</td>
<td>100-205</td>
<td></td>
</tr>
<tr>
<td>Infant</td>
<td>72-104</td>
<td>100-180</td>
<td>30-53</td>
</tr>
<tr>
<td>Toddler</td>
<td>86-106</td>
<td>98-140</td>
<td>22-37</td>
</tr>
<tr>
<td>Preschooler</td>
<td>89-112</td>
<td>80-120</td>
<td>20-28</td>
</tr>
<tr>
<td>School-aged</td>
<td>97-115</td>
<td>75-118</td>
<td>18-25</td>
</tr>
<tr>
<td>Adolescent</td>
<td>110-131</td>
<td>60-100</td>
<td>12-20</td>
</tr>
</tbody>
</table>

Treatment of Dysrhythmias - general overview. See book for details

Bradycardia

♥ airway, O2, monitor, IO/IV, 12 lead
♥ hypotension, ALOC, Shock? - CPR if below 60, Epinephrine 0.01 mg/kg, Atropine 0.02 mg/kg, consider pacing, treat underlying causes

Tachycardia with a Pulse

♥ airway, O2, monitor/defib, IO/IV, 12 lead
♥ QRS narrow - infant rate above 220, child above 180 SVT - adenosine 0.1 mg/kg, the 0.2 mg/kg rapid bolus
♥ QRS wide? - V tach - 12 lead, amiodarone 5 mg/kg IV, adenosine, cardioversion 0.5 to 1 J/kg then 2 J/kg

Pediatric Cardiac Arrest - H's T's

- CPR, 02, monitor/defib
- Shockable - VF, VT - shock 2 J/kg, then double to 10 J/kg, CPR 2 min, Epi 0.01 mg/kg, amiodarone 5 mg/kg, lidocaine 1 mg/kg shock - CPR 2 min - Drug repeat
- Non Shockable - Asystole, PEA CPR 2 min, IO/IV, Epi

Note: See current PALS 2015 guidelines textbook as your PRIMARY Source.  Posted November 2016
### Respiratory - see PALS text for full details

<table>
<thead>
<tr>
<th>Condition</th>
<th>Signs</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distress</strong></td>
<td>Open and maintainable airway. Marked tachypnea, respiratory effort,</td>
<td>Open airway&lt;br&gt;Clear airway&lt;br&gt;OP/NP airway&lt;br&gt;02 sat, 02&lt;br&gt;Inhaled meds&lt;br&gt;Bag-mask&lt;br&gt;Advanced airway</td>
</tr>
<tr>
<td><strong>Failure</strong></td>
<td>Very rapid rate or apnea, inadequate respiratory effort, low 02 sat</td>
<td>Position comfort&lt;br&gt;Inhaled epinephrine&lt;br&gt;Decadron&lt;br&gt;heliox</td>
</tr>
<tr>
<td><strong>Upper airway</strong></td>
<td>Inc respiratory rate and effort, inspiratory retractions, accessory muscles, flaring, stridor, hoarseness, barking cough, drooling, snoring, poor chest rise.</td>
<td>Albuterol, sterioids, magnesium sulfate</td>
</tr>
<tr>
<td><strong>Lower airway</strong></td>
<td>Increases respiratory rate, retractions, flaring, prolonged expiration, wheezing, cough</td>
<td>Antibiotics, albuterol, labs, tx&lt;br&gt;pulmonary edema, CPAP</td>
</tr>
<tr>
<td><strong>Lung Tissue</strong></td>
<td>Grunting, crackles, decreased breath sounds.</td>
<td></td>
</tr>
<tr>
<td><strong>Disordered Control breathing</strong></td>
<td>Variable, irregular respiratory rate shallow breathing, apnea, normal or decreased air movement</td>
<td>Poison antidote, ventilatory support.</td>
</tr>
</tbody>
</table>

### Shock - see PALS text for full details

<table>
<thead>
<tr>
<th>Shock</th>
<th>Types</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypovolemic</strong></td>
<td>Nonhemorrhagic - vomiting, diarrhea, urinary</td>
<td>Mild - dry mucous membranes, oliguria&lt;br&gt; Moderate - poor skin turgor, sunken fontanel, tachycardia&lt;br&gt;Severe - marked tachycardia, weak to absent distal pulse, increased respiratory rate</td>
<td>Rapid administration of isotonic crystalloids 20 mL/kg bolus.</td>
</tr>
<tr>
<td></td>
<td>Hemorrhagic</td>
<td>Mild - below 30% volume loss&lt;br&gt;Moderate 30-45% volume loss&lt;br&gt;Severe - above 45% volume loss</td>
<td>Fluids, Colloids, blood</td>
</tr>
<tr>
<td><strong>Distributive</strong></td>
<td>Septic&lt;br&gt;Anaphylactic&lt;br&gt;Neurogenic</td>
<td>ALOC, tachycardia, fever, prolonged cap&lt;br&gt;Angioedema, upper airway obstruction&lt;br&gt;Hypotension, bradycardia, hypothermia</td>
<td>Antibiotics, crystalloid 20 mL/kg&lt;br&gt;Epi, fluid, Albuterol, antihist., steriods&lt;br&gt;Fluid, vasopressors</td>
</tr>
<tr>
<td><strong>Cardiogenic</strong></td>
<td>May have high preload (fluid)</td>
<td>Consult specialists and treat accordingly.</td>
<td>Cautious fluid admin</td>
</tr>
<tr>
<td><strong>Obstructive</strong></td>
<td>C. tamponade&lt;br&gt;Tension pneumo&lt;br&gt;Pulmonary emb.</td>
<td>Consult specialists and treat accordingly.</td>
<td></td>
</tr>
</tbody>
</table>
Signs of compensated shock include (poor perfusion, NORMAL systolic BP)

- Tachycardia
- Increased SVR
  - Skin - cold, pale, mottled, diaphoretic
  - Peripheral circulation - delayed capillary refill
  - Pulses - weak peripheral pulses, narrowed pulse pressure
- Increases renal and splanchnic vascular resistance (redistribution of blood flow)
  - Kidney - decreased urine output, oliguria
  - Intestine - vomiting, ileus
- Cerebral auto regulation - brain, altered mental status, anxiety, coma
- Normal blood pressure

Signs of decompensated shock include
As compensatory mechanisms fail, signs of inadequate end-organ perfusion develop. In addition to the above, these signs include

- Depressed mental status, decreased urine output
- Metabolic acidosis, Tachypnea, Weak central pulses
- Hypotension

The most common cause of shock is hypovolemia, one form of which is hemorrhagic shock. Distributive and cardiogenic shock are seen less often.

- Capillary refill time alone is not a good indicator of circulatory volume, but a capillary refill time of >2 seconds is a useful indicator of moderate dehydration when combined with a decreased urine output, absent tears, dry mucous membranes, and a generally ill appearance.
- Tachycardia also results from other causes (eg, pain, anxiety, fever).
- Pulses may be bounding in anaphylactic, neurogenic, and septic shock.

In compensated shock, blood pressure remains normal; it is low in decompensated shock. Hypotension is a systolic blood pressure less than the 5th percentile of normal for age.

### Pediatric Cardiac Arrest Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epinephrine</td>
<td>Pulseless arrest, symptomatic bradycardia</td>
<td>Doses vary for other conditions and situations</td>
</tr>
<tr>
<td></td>
<td>0.01 mg/kg IV/IO q 3 to 5 min</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.1 mg/kg ET q 3 to 5 min</td>
<td></td>
</tr>
<tr>
<td>Atropine</td>
<td>Bradycardia - 0.02 mg/kg IV/IO q 3 to 5 min</td>
<td>Child max 1 mg total dose Adolescents max 3 mg total dose Dose varies for toxins</td>
</tr>
<tr>
<td></td>
<td>0.04 to 0.06 mg/kg ET</td>
<td></td>
</tr>
<tr>
<td>Adenosine</td>
<td>SVT 0.1 mg/kg IV/IO rapid push max 6 mg Repeat 0.02 mg/kg max 12</td>
<td>Rapid push closest port followed by fluid bolus</td>
</tr>
<tr>
<td>Amiodarone</td>
<td>SVT, VT with pulse 5 mg/kg IV/IO Pulseless arrest 5 mg/kg IV/IO</td>
<td>Load over 20-60 min</td>
</tr>
<tr>
<td>Naloxone</td>
<td>0.1 mg/kg IV/IO/IM bolus q 2 min</td>
<td>max 2 mg</td>
</tr>
<tr>
<td>Lidocaine</td>
<td>VF/ Pulseless VT 1 mg/kg IV/IO bolus. 2 to 2 mg/kg ET</td>
<td>Maintain 20 to 50 mcg/kg/min</td>
</tr>
<tr>
<td>Dextrose Glucose</td>
<td>0.1 to 1 g/kg IV/IO</td>
<td></td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>Asthma refractory 25 to 50 mg/kg IV/IO</td>
<td>Max 2 G</td>
</tr>
</tbody>
</table>