

High-quality CPR + the dialysis circuit in parallel · epinephrine + rhythm-based pathway · treat reversible causes

START CPR — push hard & fast 100–120/min, depth 5–6 cm, full recoil · give O₂ · attach monitor / defibrillator

DIALYSIS ACTIONS (in parallel): STOP ultrafiltration · saline bolus 200–500 mL · return blood or clamp & disconnect — KEEP vascular access for drugs · think HYPERKALEMIA early

Rhythm shockable?

SHOCKABLE — VF / PULSELESS VT

SHOCK · biphasic 120–200 J (device-specific) · monophasic 360 J

CPR 2 min · obtain IV / IO access

Rhythm shockable? → **SHOCK**

CPR 2 min · **Epinephrine 1 mg** IV/IO q3–5 min · consider advanced airway + capnography

Rhythm shockable? → **SHOCK**

CPR 2 min · **Amiodarone 300 mg** (then 150 mg) or Lidocaine 1–1.5 mg/kg · treat reversible causes

ROSC? → post-cardiac-arrest care. If not, continue 2-min cycles.

Reversible causes — H's: **HIGH-YIELD** Hyper-/hypokalemia · Hypovolemia (over-UF → saline) · Hydrogen ion / acidosis · Hypoxia · Hypothermia · Hypocalcemia / hypomagnesemia

If hyperkalemia suspected (missed sessions, Monday gap): empiric **Calcium gluconate 10% 1–2 g IV** (or CaCl₂ 1 g) → insulin 10 U + D50 25 g → salbutamol neb → ± bicarbonate → **emergency dialysis, low-K bath**. Calcium and bicarbonate must not share a line.

NON-SHOCKABLE — ASYSTOLE / PEA

CPR 2 min · **Epinephrine 1 mg** IV/IO as soon as possible, q3–5 min · IV/IO access · advanced airway + capnography

Rhythm shockable? → if YES, move to the shockable lane

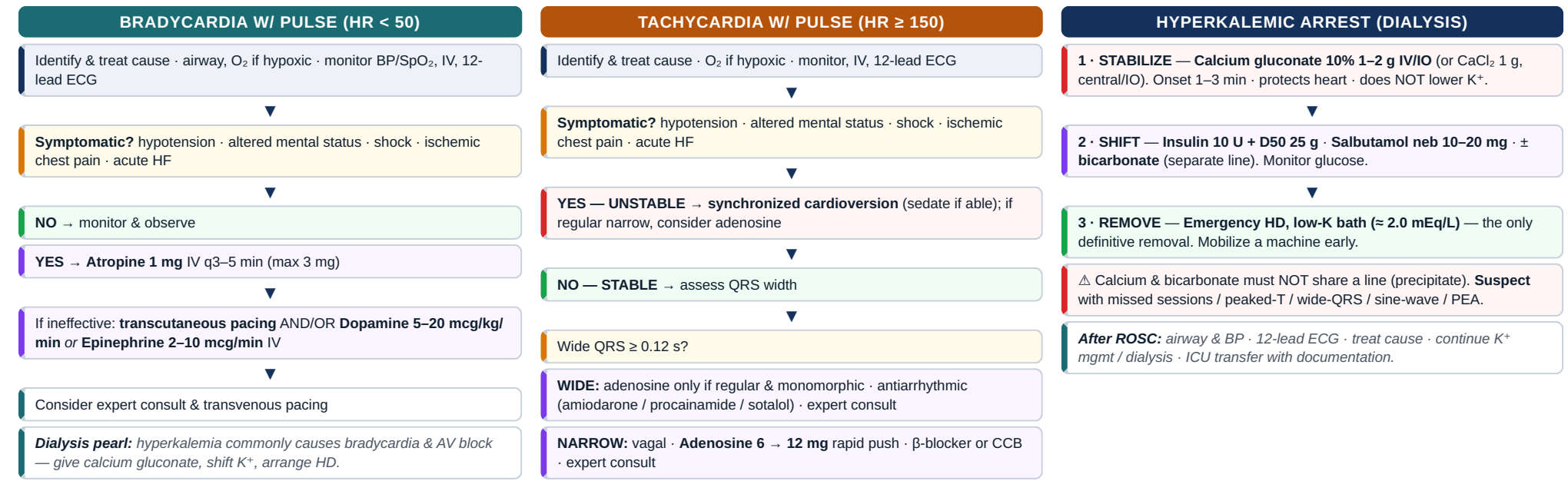
CPR 2 min · treat reversible causes (see below)

ROSC? → post-cardiac-arrest care. If asystole persists despite treating reversible causes, consider termination per team decision.

Reversible causes — T's: Thrombosis (MI / PE) · **AIR EMBOLISM** clamp venous line, left-lateral Trendelenburg · Tamponade · Tension pneumothorax · Toxins

Unsure of the rhythm? See the companion **ACLS Cardiac Rhythm Recognition & Management Cheat Sheet** — williamriveromd.com/downloads/wgmr-acls-rhythm-recognition-cheatsheet.pdf

ACLS algorithms adapted from current AHA guidance for trained personnel. Verify every dose and step against your institution's protocols and the responding physician's judgment. Reference only — not a substitute for ACLS certification.



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