

ILCOR SUMMARY STATEMENT

2019 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations

Summary From the Basic Life Support; Advanced Life Support; Pediatric Life Support; Neonatal Life Support; Education, Implementation, and Teams; and First Aid Task Forces

ABSTRACT: The International Liaison Committee on Resuscitation has initiated a continuous review of new, peer-reviewed, published cardiopulmonary resuscitation science. This is the third annual summary of the International Liaison Committee on Resuscitation International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. It addresses the most recent published resuscitation evidence reviewed by International Liaison Committee on Resuscitation Task Force science experts. This summary addresses the role of cardiac arrest centers and dispatcher-assisted cardiopulmonary resuscitation, the role of extracorporeal cardiopulmonary resuscitation in adults and children, vasopressors in adults, advanced airway interventions in adults and children, targeted temperature management in children after cardiac arrest, initial oxygen concentration during resuscitation of newborns, and interventions for presyncope by first aid providers. Members from 6 International Liaison Committee on Resuscitation task forces have assessed, discussed, and debated the certainty of the evidence on the basis of the Grading of Recommendations, Assessment, Development, and Evaluation criteria, and their statements include consensus treatment recommendations. Insights into the deliberations of the task forces are provided in the Justification and Evidence to Decision Framework Highlights sections. The task forces also listed priority knowledge gaps for further research.

Jasmeet Soar, MA, MB,
BChir, FRCA, FFICM,
FRCP
et al

Full author list is available on page e864.

Downloaded from <http://ahajournals.org> by on May 25, 2022

Key Words: AHA Scientific Statements
■ airway management
■ cardiopulmonary resuscitation
■ child ■ epinephrine ■ extracorporeal
circulation ■ heart arrest ■ infant

© 2019 American Heart Association, Inc.,
and the European Resuscitation Council.

<https://www.ahajournals.org/journal/circ>

This is the third in a series of annual International Liaison Committee on Resuscitation (ILCOR) International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations (CoSTR) summary publications that summarize the ILCOR task force analyses of published resuscitation evidence. The review this year addresses 12 topics by 6 task forces. Draft CoSTRs were posted online between November 12, 2018, and March 20, 2019,¹ and included the data reviewed and draft treatment recommendations, with comments accepted through April 4, 2019. The 12 draft CoSTR statements are now available online¹ and have been viewed 23 654 times since the first posting.

This summary statement contains the final wording of the CoSTR statements as approved by the ILCOR task forces and ILCOR member councils. This statement differs in several respects from the website draft CoSTRs: The language used to describe the evidence is not restricted to standard Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) terminology,² making it more transparent to a wider audience; the Justification and Evidence to Decision Framework Highlights sections have been expanded to provide more information about the rationale for treatment recommendations; and finally, the task forces have prioritized knowledge gaps requiring future research studies.

The CoSTRs are based on task force analysis of the data, with the GRADE approach used to answer specific research questions. Each analysis has been detailed in a systematic review (SR), published by a Knowledge Synthesis Unit or systematic reviewer and the ILCOR topic experts.^{3–12} The GRADE approach rates the certainty of the evidence for an intervention and for each outcome as high, moderate, low, or very low. Data from randomized controlled trials (RCTs) are initially rated as high-certainty evidence; data from observational studies, as low-certainty evidence. Five factors may lead to downgrading of the certainty of evidence, and 3 factors may enable an upgrade of the certainty of the evidence (Tables 1 and 2).

For each topic, the consensus on science generally includes the pertinent outcome data listing relative risk (RR) with 95% CI and risk difference with 95% CI or absolute risk difference (ARD) with 95% CI and patients with outcome per 1000 patients with 95% CI. For clarity, much of this information is presented in tables. The consensus on science is followed by the treatment recommendation, the task force justification for the treatment recommendation, and the important knowledge gaps identified by the task force.

The following topics are addressed in this CoSTR summary:

- Basic life support
 - Dispatch instruction in adult cardiopulmonary resuscitation (CPR)

- Advanced life support (ALS)
 - Advanced airway interventions during adult cardiac arrest
 - Use of vasopressors in cardiac arrest
 - Extracorporeal CPR (ECPR) for cardiac arrest in adults
- Pediatric life support
 - Dispatcher-assisted CPR (DA-CPR) in pediatrics
 - Advanced airway interventions in pediatric cardiac arrest
 - ECPR in infants and children
 - Targeted temperature management (TTM) after cardiac arrest
- Neonatal life support (NLS)
 - Initial oxygen concentration for term infants at birth
 - Initial oxygen concentration for preterm infants at birth
- Education, Implementation, and Teams (EIT) and ALS
 - Cardiac Arrest Centers (CACs) versus non-CACs
- First aid
 - Presyncope

Readers are encouraged to monitor the ILCOR website¹ to provide feedback about planned SRs and to provide comments when additional draft reviews are posted.

BASIC LIFE SUPPORT

Dispatcher Instruction in CPR: DA-CPR—Adults

The emergency medical dispatcher is an essential link in the chain of survival.^{13,14} In addition to dispatching emergency medical services (EMS) resources to medical emergencies, emergency medical dispatchers are increasingly being trained to recognize cardiac arrest, to assist bystanders in initiating resuscitation, and to support bystanders in optimizing resuscitation efforts. The international community is continuing to explore ways to increase bystander CPR for cardiac arrests. One such strategy involves dispatchers providing CPR instruction to callers/bystanders: DA-CPR. For such a strategy to be successful, it requires the EMS system to be configured to support the dispatcher to offer DA-CPR and the bystander to deliver CPR with support from the dispatcher.

ILCOR commissioned an SR to address the effect of DA-CPR on outcomes for patients in out-of-hospital cardiac arrest (OHCA).³ A draft CoSTR was posted for public comment on the ILCOR website¹⁵; the draft was viewed 1516 times during the public comment period. The task force reviewed the 1 comment posted during this public commenting period.

Table 1. GRADE Terminology for Strength of Recommendation and Criteria for Evidence Certainty Assessment

Strength of Recommendation			
Strong Recommendation=We Recommend		Weak Recommendation=We Suggest	
Assessment Criteria for Certainty of Effect			
Study Design	Certainty of Effect Begins at This Level	Lower if	Higher if
Randomized trial	High or moderate	Risk of bias	Large effect
Observational trial	Low or very low	Inconsistency Indirectness Imprecision Publication bias	Dose response All plausible confounding would reduce demonstrated effect or would suggest a spurious effect when results show no effect

GRADE indicates Grading of Recommendations, Assessment, Development, and Evaluation.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Adults with presumed cardiac arrest in out-of-hospital settings

Intervention: Patients/cases or EMS systems where DA-CPR is offered

Comparators: Studies with comparators where either systems or specific cardiac arrest cases not offered DA-CPR are included

Outcomes: Critical: survival with favorable neurological function (at hospital discharge, 1 month, or 6 months), survival (to hospital discharge, 1 month, or 1 year), short-term survival (return of spontaneous circulation [ROSC], hospital admission), and provision of bystander CPR. Important: initial shockable rhythm and time to CPR

Study designs: RCTs and nonrandomized studies (non-RCTs, interrupted time series, controlled before-and-after studies, cohort studies) eligible for inclusion

Time frame: All years and all languages included with the last search performed July 1, 2018; ongoing

or unpublished studies identified through a search of ClinicalTrials.gov online registry¹⁶

PROSPERO registration: CRD42018091427

Note: The pediatric information is summarized elsewhere in this document (see the Dispatcher Instruction in CPR: DA-CPR—Pediatrics section).

Consensus on Science

More than 5000 citations were reviewed, and 33 were identified as eligible for inclusion. These studies were classified into 2 categories: (1) systems, the comparison of outcomes when DA-CPR was offered versus not offered, and (2) bystander delivery, the comparison of outcomes for patients receiving DA-CPR versus those receiving no bystander CPR or unassisted bystander CPR. No randomized clinical trials were identified. Given that the only available data consisted of observational studies, we separately listed data when they came from an analysis adjusted for known confounders because we felt that this provided a better estimate of effect. The reliance on nonrandomized trials in the evidence review also means that the reported

Table 2. GRADE Terminology

Risk of bias	Study limitations in randomized trials include lack of allocation concealment, lack of blinding, incomplete accounting of patients and outcome events, selective outcome reporting bias, and stopping early for benefit. Study limitations in observational studies include failure to apply appropriate eligibility criteria, flawed measurement of exposure and outcome, failure to adequately control confounding, and incomplete follow-up.
Inconsistency	Criteria for inconsistency in results include the following: Point estimates vary widely across studies; CIs show minimal or no overlap; statistical test for heterogeneity shows a low P value; and the I ² is large (a measure of variation in point estimates resulting from among-study differences).
Indirectness	Sources of indirectness include data from studies with differences in population (eg, OHCA instead of IHCA, adults instead of children), differences in the intervention (eg, different CV ratios), differences in outcome, and indirect comparisons.
Imprecision	Low event rates or small sample sizes will generally result in wide CIs and therefore imprecision.
Publication bias	Several sources of publication bias include tendency not to publish negative studies and the influence of industry-sponsored studies. An asymmetrical funnel plot increases the suspicion of publication bias.
Good practice statements	Guideline panels often consider it necessary to issue guidance on specific topics that do not lend themselves to a formal review of research evidence. The reason might be that research into the topic is unlikely to be located or would be considered unethical or infeasible. Criteria for issuing a nongraded good practice statement include the following: There is overwhelming certainty that the benefits of the recommended guidance will outweigh harms, and a specific rationale is provided; the statements should be clear and actionable to a specific target population; the guidance is deemed necessary and might be overlooked by some providers if not specifically communicated; and the recommendations should be readily implementable by the specific target audience to whom the guidance is directed.

CV indicates compression-ventilation; GRADE, Grading of Recommendations, Assessment, Development, and Evaluation; IHCA, in-hospital cardiac arrest; and OHCA, out-of-hospital cardiac arrest.

Table 3. Systems: Studies Comparing Outcomes for Adults When DA-CPR Instruction Was Offered With Outcomes for Adults When DA-CPR Was Not Offered

Outcome	Unadjusted Analysis				Adjusted Analysis			
	Studies (Patients), n	Evidence Certainty	Odds Ratio (95% CI)	Absolute Difference	Studies (Patients), n	Evidence Certainty	Odds Ratio (95% CI)	Absolute Difference
Survival with favorable neurological outcome at 1 mo	3 (44 698) ^{21,26,32}	Very low	1.10 (1.03–1.17)	9 more per 1000 (3–15 more)	2 (6799) ^{21,26}	Very low	1.47 (1.03–2.09)	11 more per 1000 (1–25 more)
Survival with favorable neurological outcome at hospital discharge	2 (5533) ^{18,22}	Very low	1.70 (1.21–2.37)	14 more per 1000 (4–27 more)	1 (5288) ¹⁸	Very low	1.67 (1.13–2.47)	14 more per 1000 (3–30 more)
Survival at 1 mo	2 (6799) ^{21,26}	Very low	1.20 (0.99–1.45)	11 more per 1000 (1 fewer–25 more)	2 (6799) ^{21,26}	Very low	1.45 (1.09–1.94)	25 more per 1000 (5–51 more)
Survival at hospital discharge	7 (14 139) ^{17–20,23,24,28}	Very low	1.23 (0.99–1.53)	33 more per 1000 (2 fewer–73 more)	1 (5288) ¹⁸	Very low	1.33 (1.07–1.66)	21 more per 1000 (5–42 more)
Survival at hospital admission	6 (9548) ^{18,20–22,29,30}	Very low	1.08 (0.95–1.23)	12 more per 1000 (8 fewer–33 more)	1 (2493) ²¹	Very low	0.97 (0.70–1.34)	4 fewer per 1000 (39 fewer–40 more)
ROSC	5 (49 229) ^{18,20,21,28,32}	Very low	1.17 (1.08–1.27)	27 more per 1000 (13–42 more)	1 (2493) ²¹	Very low	1.14 (0.88–1.48)	26 more per 1000 (24 fewer–83 more)

DA-CPR indicates dispatcher-assisted cardiopulmonary resuscitation; and ROSC, return of spontaneous circulation.

findings are best regarded as associated with the CPR provided, or not, rather than necessarily caused by the interventions.

Systems: Studies Comparing Outcomes for Patients When DA-CPR Instruction Was Offered With Outcomes for Patients When DA-CPR Was Not Offered

For the comparison of outcomes in systems with DA-CPR programs, we identified 16 studies. These included 5 before-and-after studies^{17–21} and 11 cohort studies.^{22–32} Only 4 of these studies adjusted in some way for confounding variables.^{21,26,28,32} Table 3 provides a summary of the unadjusted and adjusted meta-analyses.

Survival With Favorable Neurological Outcomes. Six studies involving 50395 patients reported survival with favorable neurological outcome at time points from hospital discharge to 6 months after cardiac arrest.^{18,21,22,26,28,32} The certainty of evidence was assessed as very low (downgraded for serious risk of bias, indirectness, and imprecision).

With the exception reported in 1 small series,²⁸ systems offering DA-CPR were associated with increased favorable neurological outcome at 1 month after cardiac arrest and at hospital discharge compared with systems not offering DA-CPR. These effects persisted after adjustment for confounding variables.

Survival Including All Neurological Outcomes. Nine studies including 20938 patients addressed survival (regardless of neurological outcome) at time points such as hospital discharge and 1 month and 1 year after

cardiac arrest.^{17–21,23,24,26,28} The certainty of evidence for these studies was assessed as very low, downgraded for serious risk of bias and imprecision.

With the exception reported in a single small series,²⁸ systems offering DA-CPR were associated with increased survival at 1 month after cardiac arrest and at hospital discharge (Table 3) compared with systems not offering DA-CPR. These associations were strengthened after adjustment for confounding variables.

Short-Term Survival: ROSC, Hospital Admission.

Eight studies including 45 474 patients addressed short-term survival, including ROSC and survival to hospital admission.^{18,20–22,28–30,32} The certainty of evidence was assessed as very low, downgraded for serious risk of bias and imprecision.

With a single exception reported in a small series,²¹ systems offering DA-CPR were associated with sustained ROSC but not increased survival to hospital admission (Table 4) compared with systems not offering DA-CPR.

Bystander Delivery: Comparison of Outcomes From Patients Receiving DA-CPR Versus Those Receiving Either No Bystander CPR or Unassisted Bystander CPR

This evidence evaluation compared outcomes of patients who received bystander CPR as a result of DA-CPR with 2 groups of patients: those receiving no bystander CPR or those who received bystander CPR that was performed without dispatch assistance. Twenty observational cohort studies were identified,^{21,23,26–28,31–38,40–46}

Table 4. Bystander Delivery: Comparison of Outcomes From Adults Receiving DA-CPR and Those Receiving No Bystander CPR or Unassisted Bystander CPR

Outcome	DA-CPR vs No CPR (Adjusted Analysis)			DA-CPR vs Unassisted Bystander CPR (Adjusted Analysis)		
	Studies (Patients), n	Evidence Certainty	Odds Ratio (95% CI)	Studies (Patients), n	Evidence Certainty	Odds Ratio (95% CI)
Survival with favorable neurological outcome at 1 mo	1 (4306) ²⁶	Very low	1.81 (1.23–2.67)	1 (78 112) ²⁷	Very low	1.00 (0.91–1.10)
Survival with favorable neurological outcome at hospital discharge	3 (35 921) ^{33–35}	Very low	1.54 (1.35–1.76)	1 (17 209) ³⁴	Very low	1.12 (0.94–1.34)
Survival at 1 mo	1 (4306) ²⁶	Very low	1.63 (1.32–2.01)	2 (78 697) ^{27,36}	Very low	1.13 (1.06–1.20)
Survival at hospital discharge	5 (43 550) ^{33,34,37–39}	Very low	1.40 (1.09–1.78)	1 (17 209) ³⁴	Very low	0.95 (0.83–1.09)
ROSC at hospital admission	NA	NA	NA	1 (78 150) ²⁷	Very low	1.09 (1.04–1.14)
ROSC	1 (32 506) ³⁴	Very low	1.51 (1.32–1.73)	3 (34 811) ^{32,34,36}	Very low	1.04 (0.94–1.14)

CPR indicates cardiopulmonary resuscitation; DA-CPR, dispatcher-assisted cardiopulmonary resuscitation; NA, not applicable; and ROSC, return of spontaneous circulation.

but only 10 of these studies included adjusted analysis.^{26,27,31–38} Because the clinical features of patients who received DA-CPR differed markedly from those of both the group who received no CPR and the group who received bystander CPR without dispatch assistance, only adjusted outcomes are reported. Table 4 summarizes the study characteristics and results of the adjusted meta-analysis.

Receipt of DA-CPR Versus No Bystander CPR.

Improvements in survival with favorable neurological function at hospital discharge^{31,33,34} and at 1 month²⁶ were reported among patients with OHCA who received bystander DA-CPR compared with those who received no bystander CPR. In addition, improved survival (regardless of neurological status) was reported at hospital discharge^{31,33,34,37,38} and at 1 month.²⁶ Recipients of DA-CPR were also more likely to achieve sustained ROSC than those who received no bystander CPR.³⁴

Receipt of Bystander CPR With DA-CPR Versus Bystander CPR Without Dispatch Assistance (ie, Unassisted Bystander CPR).

The findings were inconsistent when we compared patients who received bystander CPR with DA-CPR with patients who received bystander CPR that was performed without dispatch assistance. Survival with favorable neurological function did not differ either at hospital discharge³⁴ or at 1 month²⁷ between patients who received bystander DA-CPR and those who received bystander CPR without dispatch assistance. Overall survival at hospital discharge did not differ between these groups,³⁴ although survival at 1 month favored patients who received bystander DA-CPR.^{27,36} Recipients of bystander DA-CPR were also more likely to have ROSC on hospital arrival than when bystander CPR was rendered without dispatch assistance.²⁷ Although these studies do not prove equivalence or noninferiority, they suggest that DA-CPR could

possibly be as effective as spontaneously provided (unassisted) CPR.

Treatment Recommendations

We recommend that emergency medical dispatch centers have systems in place to enable call handlers to provide CPR instructions for adult patients in cardiac arrest (strong recommendation, very low certainty of evidence).

We recommend that emergency medical call-takers provide CPR instructions (when deemed necessary) for adult patients in cardiac arrest (strong recommendation, very low certainty of evidence).

Justification and Evidence to Decision Framework Highlights

Whereas the strength of these recommendations is greater than the certainty of the supporting evidence, taken together, the preponderance of the evidence evaluated in this review suggests that clinical outcomes after OHCA are more likely to be improved when DA-CPR is available, offered, and provided. The similarity in outcomes when CPR is initiated spontaneously without the need for dispatch assistance (perhaps performed by a more skilled or trained bystander) and when DA-CPR is performed (perhaps with a less skilled or untrained bystander) exemplifies the potential positive impact of such point-of-care instruction. At a minimum, DA-CPR increases the likelihood that bystander CPR will be performed,³ itself an important predictor of favorable outcome from OHCA.⁴⁷ The SR also found that DA-CPR favored not only bystander CPR but also time to CPR, ROSC, and initial shockable rhythm.³ These considerations, along with the recognition that randomized clinical trials addressing this question are unlikely to be forthcoming, led to the task force's consensus that DA-CPR should be strongly recommended.

Knowledge Gaps

This evidence evaluation did not address training, logistical, operational, or economic issues pertaining to DA-CPR. The task force identified several knowledge gaps requiring further investigation, including the following:

- Optimal dispatcher training (and retraining) in recognizing OHCA and in providing DA-CPR
- The essential elements of a quality improvement program focused on DA-CPR
- The preferred CPR instruction sequence for DA-CPR
- The potential impact of dispatcher or call-taker's background or prior experience (nonhealthcare professional versus paramedic or nurse) on DA-CPR performance
- The role of automated external defibrillators during the course of DA-CPR
- The integration of adjunct technologies (eg, artificial intelligence or video) for clinical decision support

ADVANCED LIFE SUPPORT

Advanced Airway Interventions During Adult Cardiac Arrest

It is important to identify those airway interventions most likely to improve outcomes for both OHCA and IHCA. Chest compressions alone do not provide adequate ventilation during prolonged cardiac arrest. Airway management is therefore required to facilitate ventilation and to reduce the risk of gastric regurgitation and aspiration. The best airway strategy for improving patient outcomes is uncertain. On the basis of the evidence available at the time, the 2015 CoSTR suggested using either an advanced airway or a bag-mask device for airway management during CPR (weak recommendation, very low certainty of evidence) for cardiac arrest in any setting.⁴⁸

Advanced airway management is common during cardiac arrest. The American Heart Association Get With The Guidelines–Resuscitation registry of in-hospital cardiac arrest (IHCA) reports that 60% to 70% of patients underwent tracheal intubation (TI) within the first 15 minutes of cardiac arrest.⁴⁹ The US CARES registry (Cardiac Arrest Registry to Enhance Survival) of OHCA⁵⁰ showed that 52% of patients underwent TI, 29% received a supraglottic airway (SGA), and in 18% no advanced airway was inserted. In the recent AIRWAYS-2 RCT (Effect of a Strategy of a Supraglottic Airway Device Versus Tracheal Intubation During Out-of-Hospital Cardiac Arrest on Functional Outcome),⁵¹ which compared i-gel (Intersurgical Ltd, Berkshire, UK) with TI for OHCA, 17.3% of patients did not receive an advanced airway.

Since 2015, 3 new RCTs investigating airway management during cardiac arrest have been published.^{51–53} This topic was given a high priority for review by the ILCOR ALS Task Force, and ILCOR commissioned an SR to identify and analyze all published evidence on advanced airway interventions during OHCA and IHCA.⁴ The ALS Task Force analyzed and discussed the SR and all of the studies identified by the SR. A draft ALS CoSTR for advanced airway interventions during cardiac arrest was posted online on March 20, 2019, and included the data reviewed and draft treatment recommendations with comments accepted through April 4, 2019.⁵⁴ There were 6798 visits and 16 posted comments during the 2-week comment period. The ALS Task Force reviewed all comments and, in the light of these, reevaluated and finalized the draft CoSTR.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Adults any setting (in-hospital or out-of-hospital) with cardiac arrest from any cause

Intervention: A specific advanced airway management method (eg, TI or an SGA device) during cardiac arrest

Comparators: A different advanced airway management method or no advanced airway management method (eg, bag-mask ventilation [BMV]) during cardiac arrest

Outcomes: Survival to hospital discharge/28 days with favorable neurological outcome and survival to hospital discharge/28 days ranked as critical outcomes; ROSC ranked as an important outcome

Study designs: RCTs and nonrandomized studies (non-RCTs, interrupted time series, controlled before-and-after studies, cohort studies) that compared at least 2 airway strategies eligible for inclusion; studies with ≤10 patients in either group excluded

Time frame: All years and all languages included; unpublished studies (eg, conference abstracts, trial protocols) excluded; literature search updated to October 30, 2018

PROSPERO registration: CRD42018115556

Consensus on Science

Seventy-one observational studies with 121 combinations of different airway management strategies were included in the SR.⁴ Of the 71 comparative studies, 61 included OHCA, 9 included IHCA, and 1 combined both. Because of the risk of bias, heterogeneity between studies, and the availability of RCTs, no meta-analyses were performed for observational studies.

The SR identified 11 controlled trials of airway management in patients with OHCA.^{51–53,55–62} Of these, 8 were phase 2/feasibility trials with small sample sizes, generally with a high risk of bias, including some that were published >15 years ago.^{55–62} Therefore, only 3 trials, all published in 2018, were used for the SR be-

cause they were larger and powered for more relevant outcomes.^{51–53} Because of different comparisons and heterogeneity, no meta-analyses of these RCTs were undertaken (Table 5).

Jabre et al⁵² compared BMV with TI in a physician-based system, whereas Bengner et al⁵¹ and Wang et al⁵³ compared SGA devices with TI in non-physician-based systems. The TI success rates were 98% in the Jabre et al trial, 70% in the Bengner et al trial, and 52% in the Wang et al trial. Success rates were not defined identically in the 3 studies; this led to concerns about generalizability of the findings. As a result, the task force considered 2 different settings when evaluating the overall certainty of evidence (ie, the GRADE approach): a setting with a low TI success rate (similar to the systems in the Bengner et al and Wang et al studies) and a setting with a high TI success rate (similar to the Jabre et al system).

Overall, there is no high-certainty evidence to recommend an advanced airway strategy over BMV and no high-certainty evidence to recommend a specific advanced airway device over another (Table 5).

Treatment Recommendations

We suggest using BMV or an advanced airway strategy during CPR for adult cardiac arrest in any setting (weak recommendation, low to moderate certainty of evidence).

If an advanced airway is used, we suggest an SGA for adults with OHCA in settings with a low TI success rate (weak recommendation, low certainty of evidence).

If an advanced airway is used, we suggest an SGA or TI for adults with OHCA in settings with a high TI success rate (weak recommendation, very low certainty of evidence).

If an advanced airway is used, we suggest an SGA or TI for adults with IHCA (weak recommendation, very low certainty of evidence).

Justification and Evidence to Decision Framework Highlights

This topic was given high priority by the ILCOR ALS Task Force, following the publication of 3 new RCTs^{51–53} since the previous CoSTR in 2015.^{48,63}

The 3 new RCTs have enabled the ALS Task Force to provide more specific treatment recommendations. The 2015 treatment recommendation was based on evidence from only observational studies with critical or serious risk of bias, primarily confounding and selection bias.^{48,63}

There is currently no supporting evidence that an advanced airway (ie, SGA or TI) during CPR improves survival or survival with a favorable neurological/functional outcome after adult cardiac arrest in any setting compared with BMV.

This ILCOR 2019 CoSTR addresses airway management during CPR in adults; it does not address airway

management after ROSC. After ROSC, survivors requiring mechanical ventilation and postresuscitation care will eventually require TI.

We have used the term *advanced airway strategy* because advanced airway device placement usually starts with a variable period of BMV. The timing and reasons for transitioning to an advanced airway device will vary, depending on the clinical scenario. In the 3 recent RCTs,^{51–53} patients treated with advanced airways had a period of BMV while providers prepared for device insertion; in some patients, an SGA was inserted as the first airway intervention without BMV. The term *advanced airway strategy* includes all of these options.

We have not provided a precise value or range of values for low and high intubation success rate or an agreed-on definition. Studies have used different definitions of TI success. We considered the Wang et al⁵³ and Bengner et al⁵¹ RCTs as having a low TI success rate (51.6% and 69.8%, respectively) and the Jabre et al⁵² RCT as having a high success rate (97.9%).

We assumed that TI success rates are high in the in-hospital setting, but there is limited evidence to support this, and success is likely to be site dependent. The recommendations for IHCA are based primarily on indirect evidence from the OHCA studies. There are no airway RCTs for IHCA, and the task force did consider the findings of 1 large (n=71 615) observational study of IHCA that TI within any given minute during the first 15 minutes of resuscitation, compared with no intubation during that minute, was associated with decreased survival to hospital discharge.⁴⁹ This study used a time-dependent propensity score but did not eliminate confounding by indication and provided only very-low-certainty evidence.

We have not expressed a preference for a particular SGA device of those currently available (i-gel was used in the Bengner et al⁵¹ RCT, and the Laryngeal Tube [VBM Medizintechnik GmbH, Sulz am Neckar, Germany] was used in the Wang et al⁵³ RCT). The performance of individual SGA devices varies; therefore, we did not pool data from these 2 studies.

BMV can be difficult to perform, and effectiveness varies according to provider skills. We have not evaluated the optimal bag-mask technique (eg, 1-person or 2-person methods) and the use of adjuncts such as oropharyngeal or nasopharyngeal airways.

The task force considered that the preferred airway option is likely to depend on the skills of the provider and the specific patient circumstances. In addition, patients may require different airway interventions at different stages of resuscitation.

ALS Task Force Knowledge Gaps

The task force identified several knowledge gaps requiring further investigation:

- A prospective comparison of BMV with SGA use

Table 5. Summary of the Evidence From the 3 RCTs Studying Adult Advanced Airway Management During Cardiac Arrest

Study, Year	Intervention	Comparator	Setting	Outcome	Risk Difference (95% CI)	Certainty in Evidence
Wang et al, ⁵³ 2018	Laryngeal tube	TI	OHCA	Survival to hospital discharge	27 more per 1000 (6–48 more)	Low in low TI success setting (OHCA) Very low in high TI success setting (OHCA) Very low (IHCA)
Wang et al, ⁵³ 2018	Laryngeal tube	TI	OHCA	Survival to hospital discharge with a favorable neurological outcome	21 more per 1000 (3–38 more)	Low in low TI success setting (OHCA) Very low in high TI success setting (OHCA) Very low (IHCA)
Benger et al, ⁵¹ 2018	i-gel	TI	OHCA	Survival to hospital discharge	4 fewer per 1000 (14 fewer–8 more)	Low in low TI success setting (OHCA) Very low in high TI success setting (OHCA) Very low (IHCA)
Benger et al, ⁵¹ 2018	i-gel	TI	OHCA	Survival to hospital discharge with a favorable neurological outcome	6 more per 1000 (16 fewer–4 more)	Low in low TI success setting (OHCA) Very low in high TI success setting (OHCA) Very low (IHCA)
Jabre et al, ⁵² 2018	BMV	TI	OHCA	28-d survival	1 more per 1000 (18 fewer–21 more)	Low in low TI success setting (OHCA) Moderate in high TI success setting (OHCA) Low (IHCA)
Jabre et al, ⁵² 2018	BMV	TI	OHCA	28-d survival with a favorable neurological outcome	1 more per 1000 (13 fewer–23 more)	Low in low TI success setting (OHCA) Moderate in high TI success setting (OHCA) Low (IHCA)

BMV indicates bag-mask ventilation; IHCA in-hospital cardiac arrest; OHCA, out-of-hospital cardiac arrest; RCT, randomized controlled trial; and TI, tracheal intubation.

- The optimal airway management strategy for IHCA
- The impact on outcome of using an advanced airway (SGA or TI) without prior BMV
- The optimal SGA for use during cardiac arrest
- The optimal time point during CPR to change to different airway techniques
- The impact of different airway strategies on CPR quality (no-flow time), as well as oxygenation and ventilation during CPR
- The training and clinical experience required to maintain proficiency in an airway technique

Use of Vasopressors in Cardiac Arrest

Vasopressors have been used in CPR since animal experiments in the 1960s, despite a lack of RCT evidence in humans at the time.^{64,65} In the past 20 years, several human RCTs have provided evidence for vasopressor use for cardiac arrest. ILCOR has reviewed the use of vasopressors regularly, with the most recent update in 2015.^{48,63} The ILCOR ALS Task Force targeted the current update after the 2018 publication of a new large RCT on the use of epinephrine in OHCA.⁶⁶ This updated CoSTR summary is derived from an ILCOR-commissioned SR and meta-analysis completed in 2019.⁵ The ALS Task Force analyzed and discussed the SR and all of the studies identified by the SR. A draft CoSTR for vasopressors in cardiac arrest was posted online on March 20, 2019, and included the data reviewed and draft treatment recommendations with comments accepted through April 4, 2019.⁶⁷ This site was viewed 3861 times during the comment period, and 6 comments were posted.

The ALS Task Force reviewed the comments and, in light of these comments, reevaluated and finalized the draft CoSTR.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Adults (age >18 years) with cardiac arrest in any setting (out of hospital or in hospital)

Intervention: Vasopressor or a combination of vasopressors provided intravenously or intraosseously during CPR

Comparators: No vasopressor, a different vasopressor, or a combination of vasopressors provided intravenously or intraosseously during CPR

Outcomes: Short-term survival (ROSC and survival to hospital admission), midterm survival (survival to hospital discharge, 28 days, 30 days, or 1 month), midterm favorable neurological outcomes (Cerebral Performance Category [CPC] 1–2 or modified Rankin Scale score 0–3 at hospital discharge, 28 days, 30 days, or 1 month), and long-term unfavorable and poor (modified Rankin Scale score 4–5) neurological outcomes (after 1 month)

Study designs: Randomized trials, nonrandomized trials, and observational studies (cohort and case-control studies) with a comparison group included

Time frame: From inception of databases to November 23, 2018

PROSPERO registration: CRD42018116989

Consensus on Science

Epinephrine Compared With Placebo

For the comparison of epinephrine with placebo, there are 2 RCTs with a total of >8500 patients with OHCA

Table 6. RR and ARD for Each Outcome With Epinephrine Compared With Placebo

Study, Year	Outcome	RR (95% CI)	ARD (95% CI)	Certainty in Evidence
Perkins et al, ⁶⁶ 2018	Favorable neurological outcome at 3 mo	1.30 (0.94–1.80)	5 more per 1000 (1 fewer–13 more)	Low
Perkins et al, ⁶⁶ 2018	Survival at 3 mo	1.40 (1.07–1.84)	9 more per 1000 (2–18 more)	Moderate
Jacobs et al, ⁶⁸ 2011 Perkins et al, ⁶⁶ 2018	Favorable neurological outcome at hospital discharge	1.21 (0.90–1.62)	4 more per 1000 (2 fewer–12 more)	Moderate
Jacobs et al, ⁶⁸ 2011 Perkins et al, ⁶⁶ 2018	Survival to hospital discharge	1.44 (1.11–1.86)	10 more per 1000 (2–19 more)	Moderate
Jacobs et al, ⁶⁸ 2011 Perkins et al, ⁶⁶ 2018	ROSC	3.09 (2.82–3.39)	243 more per 1000 (211–277 more)	High

ARD indicates absolute risk difference; ROSC, return of spontaneous circulation; and RR, relative risk.

that provide evidence on our critical and important outcomes^{66,68} but no RCTs of IHCA. The PARAMEDIC2 trial (A Randomized Trial of Epinephrine in Out-of-Hospital Cardiac Arrest) is a recent RCT that randomized ≈8000 patients with OHCA managed by paramedics in the United Kingdom,⁶⁶ and the PACA trial (Placebo-Controlled Trial of Adrenaline in Cardiac Arrest) randomized ≈500 patients with OHCA managed by paramedics in Western Australia.⁶⁸ A meta-analysis of these studies was conducted to update the CoSTR for epinephrine use during CPR.⁵

The findings of the SR and meta-analysis for all initial rhythms are summarized in Table 6. Only the most recent study reported 3-month survival.⁶⁶ That study found a statistically significant increase in survival at 3 months in the epinephrine group but no statistical differences in survival with favorable or unfavorable neurological outcome at 3 months. The meta-analysis of the 2 studies found no benefit in favorable neurological outcome at discharge but showed higher rates of survival to discharge, survival to admission, and ROSC in the epinephrine group.^{66,68}

In the subgroup of patients with nonshockable rhythms, combined evidence from the 2 RCTs showed benefit of epinephrine for survival to discharge (moderate certainty; RR, 2.56 [95% CI, 1.37–4.80]; ARD, 0.6% [95% CI, 0.1–1.5]) and ROSC (high certainty; RR, 4.45 [95% CI, 3.91–5.08]; ARD, 25.4% [95% CI, 21–30]).^{66,68} There was no difference in survival to discharge with favorable neurological outcome (low certainty).⁶⁶ In data pending publication from the larger, more recent trial, the subgroup with nonshockable rhythms showed no difference in survival to 3 months with favorable neurological outcome, although this result approached significance (very low certainty; RR, 3.03 [95% CI, 0.98–9.38]; ARD, 0.3% [95% CI, 0–1.1]).^{66,69}

In the subgroup of patients with shockable rhythms, combined evidence from the 2 RCTs showed benefit of epinephrine for ROSC (moderate certainty; RR, 1.68 [95% CI, 1.48–1.92]; ARD, 18.5% [95% CI, 13.0–25.0]) but no difference for survival to discharge.^{66,68} In

data pending publication from the larger, more recent trial, the subgroup with shockable rhythms showed no difference in survival to 3 months with favorable neurological outcome.⁶⁹

Vasopressin Compared With Epinephrine

Three RCTs with >1500 patients with OHCA compared vasopressin with epinephrine; all were published >10 years ago.^{70–72} The combined results of these studies showed no benefit of vasopressin compared with epinephrine across all outcomes and initial rhythms.

One RCT included 200 patients with IHCA randomized to vasopressin or epinephrine with any initial rhythm and showed no benefit from the use of vasopressin compared with epinephrine.⁷³

Initial Epinephrine Plus Vasopressin Compared With Epinephrine Only

Three RCTs with >3000 patients with OHCA compared epinephrine plus vasopressin with epinephrine only; all were published >8 years ago.^{74–76} The combined results of these studies showed no benefit across all outcomes and initial rhythms. There were no in-hospital studies of this comparison.

Treatment Recommendations

We recommend administration of epinephrine during CPR (strong recommendation, low to moderate certainty of evidence).

For nonshockable rhythms (pulseless electrical activity/asystole), we recommend administration of epinephrine as soon as feasible during CPR (strong recommendation, very low certainty of evidence).

For shockable rhythms (ventricular fibrillation/pulseless ventricular tachycardia), we suggest administration of epinephrine after initial defibrillation attempts are unsuccessful during CPR (weak recommendation, very low certainty of evidence).

We suggest against the administration of vasopressin in place of epinephrine during CPR (weak recommendation, very low certainty of evidence).

We suggest against the addition of vasopressin to epinephrine during CPR (weak recommendation, low certainty of evidence).

Justification and Evidence to Decision Framework Highlights

The ILCOR ALS Task Force prioritized this population, intervention, comparator, outcome, study design, and time frame after the recent publication of a large RCT comparing administration of epinephrine with placebo in >8000 patients with OHCA.⁶⁶ The collective evidence from the recent trial and a small earlier RCT showed that epinephrine for OHCA increases ROSC, survival to discharge, and survival at 3 months, but epinephrine has not been shown definitively to increase survival to discharge with favorable neurological outcome.^{5,66,68} The more recent trial, which was also the only one reporting outcomes at 3 months, found no difference in survival with favorable or unfavorable neurological outcome at the 3-month time point.⁶⁶ The lack of statistical difference in survival with favorable and unfavorable outcome at 3 months may reflect the low event rates for these outcomes and the consequent failure to achieve the optimal sample size for these outcomes, resulting in low power to detect a difference. The increase in survival with favorable neurological outcome at 3 months approaches statistical significance for nonshockable initial rhythms, with the lower limit of the CI being very close to 1. Whether the difference in neurological outcome would be larger in a patient population with higher overall survival than that seen in the PARAMEDIC2 trial is unknown. A very high value is placed on the apparent life-preserving benefit of epinephrine, even if the absolute effect size is likely to be small. Although the PARAMEDIC2 study raised concerns about increasing the number of survivors with unfavorable neurological outcome, the opinion of the ALS task force is that the data at 3 months do not support this assertion. Overall, the impact of epinephrine administration on neurological outcome for patients with OHCA remains uncertain, but the available data are more suggestive of benefit than harm. Whether the administration of epinephrine earlier than in the available OHCA trials would have a larger beneficial effect also remains uncertain but is suggested by observational data. That stated, the ALS Task Force acknowledged the importance of considering the cost burden incurred with a potential increase in short-term survival with unfavorable neurological outcome. Conversely, an increase in ROSC may allow the development of other treatments to prevent or mitigate neurological injury. The opportunity for families to see patients before death and the possibility for organ donation were additional potential benefits of the increase in short-term survival that were considered. The task force recognized that different healthcare systems and different cultures may weigh these costs and benefits

differently. A formal cost-effectiveness analysis was not performed, and this remains a knowledge gap.

The use of vasopressin alone or in combination with epinephrine was not shown to be beneficial compared with epinephrine alone; thus, epinephrine alone is recommended because it reduces complexity.

There is a statistically significant benefit of standard-dose epinephrine compared with placebo on survival to hospital discharge in patients with OHCA with nonshockable initial rhythms but not in those with shockable initial rhythms (although epinephrine improved ROSC in all rhythms). Because these are subgroup comparisons, however, and were not separately randomized, the results should be interpreted with some caution. For example, the lack of a statistically significant difference in shockable rhythms may result from inadequate power because there were far fewer patients in this subgroup than in the nonshockable rhythms groups.

In most cases of nonshockable rhythms, there are limited alternative interventions, and survival is very poor unless a reversible cause is identified and treated. Therefore, we recommend provision of epinephrine as soon as feasible in cardiac arrest with nonshockable rhythms. Exceptions may exist when a clear reversible cause can be addressed rapidly.

The optimal timing for epinephrine in patients with shockable rhythms is unknown. The studies evaluating administration of epinephrine used protocols for epinephrine administration after the third shock. The task force agrees that it seems prudent to wait to administer epinephrine until initial defibrillation attempts have been unsuccessful. However, the optimal timing and number of shocks after which epinephrine should be administered remain unclear.

There are also very limited data to guide the specific dosing of epinephrine during CPR. The 2 OHCA RCTs comparing epinephrine with placebo used standard-dose epinephrine (1 mg intravenously or intraosseously every 3–5 minutes). Although this CoSTR did not separately evaluate high-dose epinephrine because no new evidence was found, a previous ILCOR review did not find evidence of a survival benefit for high-dose epinephrine. Thus, the evidence to date supports the dosing used in the 2 RCTs included in the meta-analysis in the current review.

There is limited RCT evidence on the use of epinephrine for IHCA. No studies have assessed the use of standard-dose epinephrine compared with placebo in the in-hospital setting, and only 1 study examined the use of vasopressin compared with epinephrine.⁷⁷ There was no statistical benefit or harm from the administration of vasopressin compared with epinephrine for in-hospital CPR. Therefore, using the evidence for OHCA, the ILCOR ALS Task Force decided to make the same recommendations for epinephrine administration for IHCA and OHCA.

ALS Task Force Knowledge Gaps

With the recent publication of a large RCT comparing epinephrine with placebo in OHCA, we have greater confidence in the benefit of epinephrine for survival to discharge and ROSC. However, the effect of epinephrine on neurological outcomes is still uncertain and remains an important knowledge gap. The task force identified several other knowledge gaps requiring further investigation:

- The long-term neurological benefit of epinephrine in cardiac arrest
- The optimal dose of epinephrine and dosing interval
- The use and optimal timing of epinephrine administration in patients with shockable rhythms
- The use of epinephrine for IHCA
- The cost-effectiveness of epinephrine
- The effect of different routes of administration (intravenous versus intraosseous)
- The effect of increased ROSC on organ donation
- Effective therapies to prevent or mitigate against neurological injury associated with cardiac arrest

ECPR for Cardiac Arrest: Adults

ECPR is used to support circulation in patients with cardiac arrest refractory to conventional CPR.⁷⁸ ECPR maintains vital organ perfusion while potential reversible causes of the cardiac arrest can be identified and treated. ECPR can be considered in select patients when rapid expert deployment is possible; however, the optimal patient selection and timing of the therapy are not well defined. An SR was undertaken by ILCOR to assess the effectiveness of ECPR, compared with manual or mechanical CPR, for OHCA and IHCA of all causes in adults and children.⁶ A draft CoSTR posted for public comment was viewed 1169 times in the 2-week comment period.⁷⁹ The task force reviewed the 4 posted comments and considered the suggestions when finalizing the Justification and Evidence to Decision Framework Highlights section.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Adults (age ≥ 18 years) and children (age < 18 years) with cardiac arrest in any setting (out of hospital or in hospital)

Intervention: ECPR, including extracorporeal membrane oxygenation (ECMO) or cardiopulmonary bypass, during cardiac arrest

Comparator: Manual CPR and/or mechanical CPR

Outcomes: Clinical outcomes, including short-term survival and neurological outcomes (eg, hospital discharge, 28 days, 30 days, and 1 month) and long-term survival and neurological outcomes (eg, 3 months, 6 months, and 1 year)

Study design: Randomized trials, non-RCTs, and observational studies (cohort studies and case-control studies) with a control group included; animal studies, ecological studies, case series, case reports, reviews, abstracts, editorials, comments, and letters to the editor not included

Time frame: All years and all languages included

PROSPERO registration: CRD42018085404

Note: The pediatric information is summarized in a later section of this document (see the ECPR: Infants and Children section).

Consensus on Science

No randomized clinical trials were identified. Selected summary data are included in Table 7. Fifteen of the included studies were in adult OHCA.^{80,82,85,87-89,91-94,97-101} Three studies included both patients with OHCA and those with IHCA.^{82,89,99} Most studies defined the exposure as ECPR use; 1 study⁹³ defined the exposure as ECPR availability; and 2 studies^{100,101} defined the exposure as an ECPR strategy. Twelve studies reported survival to hospital discharge^{80,82,85,87-89,91-93,97-99}; 6 studies reported long-term survival^{82,88,91,93,97,98}; 8 studies reported favorable neurological outcome at hospital discharge^{85,87,88,92,93,97,100,101}; and 6 studies reported long-term favorable neurological outcomes.^{88,91,93,94,97,98}

Seven of the included studies were in adult IHCA.^{81,83,84,86,90,95,96} Most of these studies defined the exposure as ECPR use, although 2 studies^{95,96} defined the exposure as an ECPR attempt. Six studies reported survival to hospital discharge^{81,83,86,90,95,96}; 6 studies reported long-term survival^{81,83,86,90,95,96}; 5 studies reported favorable neurological outcome at hospital discharge^{81,83,90,95,96}; and 5 studies reported long-term favorable neurological outcome.^{81,83,90,95,96} Four studies reported survival analyses with length of follow-up ranging from 1 to 3 years.^{81,83,84,90}

For studies in both OHCA and IHCA, the overall certainty of evidence was rated as very low for all outcomes. All individual studies were at a very serious risk of bias, mainly because of confounding. As a result of this confounding and a high degree of heterogeneity, no meta-analyses could be performed, and individual studies are difficult to interpret.

Treatment Recommendations

We suggest that ECPR may be considered as a rescue therapy for selected patients with cardiac arrest when conventional CPR is failing in settings in which it can be implemented (weak recommendation, very low certainty of evidence).

Justification and Evidence to Decision Framework Highlights

In making this weak recommendation, we have considered the extremely high mortality rate of patients with cardiac arrest, particularly when the arrest is

Table 7. Summary of Adult EPCR Studies

Study, Year	Country	Years of Patient Inclusion	IHCA vs OHCA	Inclusion Criteria	Patients Analyzed, n	Covariates Included in Adjusted Analysis	Hospital Discharge/1 mo		
							Exposed, n (%)	Unexposed, n (%)	Adjusted Results, OR or RR (95% CI)
Agostinucci et al, ⁸⁰ 2011	France	2005–2010	OHCA	Use of load-distributing band	285	NA	0/27 (0)	3/258 (1)	NR
Blumenstein et al, ⁸¹ 2015	Germany	2009–2013	IHCA	Cardiovascular admission, witnessed	353	Age, APACHE II score, CPR duration, obesity, dyslipidemia, coronary artery disease, lactate, creatine kinase, eGFR, creatinine, ICU, OR, dose of norepinephrine	14/52 (27)	9/52 (17)	1.76 (0.68–4.53) (calculated)
Cesana et al, ⁸² 2018	Italy	2011–2015	Combined	Age 18–75 y, witnessed, proven ischemic origin, absence of severe comorbidities that would have precluded ICU admission and conditioning in the short-term prognosis	148	NA	13/63 (21)	49/85 (58)	NR
Chen et al, ⁸³ 2008	Taiwan	2004–2006	IHCA	Age 18–75 y, CPR for >10 min, cardiac origin, witnessed	92	Age, sex, initial cardiac rhythm, time point of CPR, CPR duration, comorbidities	15/46 (33)	8/46 (17)	2.30 (0.86–6.13) (calculated)
Cho et al, ⁸⁴ 2014	Korea	2001–2013	IHCA	Pulmonary embolism	20	Hypertension, CPR duration	NR	NR	NR
Choi et al, ⁸⁵ 2016	Korea	2011–2015	OHCA	Nontraumatic, age ≤75 y, witnessed cardiac arrest, bystander administration of CPR or no-flow time ≤5 min, prehospital low-flow time ≤30 min and refractory arrest >10 min of conventional CPR in the ED, known absence of severe comorbidities that preclude admission to the intensive care unit	60	NA	3/10 (30)	4/50 (8)	NR
Chou et al, ⁸⁶ 2014	Taiwan	2006–2010	IHCA	Age >18 y, acute myocardial infarction in the ED, CPR for >10 min	66	NA	NR	NR	1.93 (0.60–6.23) (unadjusted)
Hase et al, ⁸⁷ 2005	Japan	1999–2003	OHCA	Presumed cardiac cause	100	NA	13/38 (34)	27/62 (44)	NR
Kim et al, ⁸⁸ 2014	Korea	2006–2013	OHCA	Age >18 y, not traumatic	104	Age, sex, comorbidity score, bystander CPR, witnessed cardiac arrest, first documented arrest rhythm, presumed cause of arrest, interval from arrest to CPR started by EMS provider, CPR duration, and therapeutic hypothermia	9/52 (17)	11/52 (21)	0.78 (0.29–2.08) (calculated)
Lee et al, ⁸⁹ 2015	Korea	2009–2014	Combined	NR	955	Age, main diagnosis, location, CPR duration, initial rhythm, hypertension, malignancy, stroke, chronic renal failure, cardiovascular disease	18/81 (22)	120/874 (14)	0.37 (0.13–1.06)

(Continued)

Table 7. Continued

Study, Year	Country	Years of Patient Inclusion	IHCA vs OHCA	Inclusion Criteria	Patients Analyzed, n	Covariates Included in Adjusted Analysis	Hospital Discharge/1 mo		
							Exposed, n (%)	Unexposed, n (%)	Adjusted Results, OR or RR (95% CI)
Lin et al, ⁹⁰ 2010	Taiwan	2004–2006	IHCA	Age 18–75 y, cardiac origin, CPR duration >10 min, ROSC	54	Age, sex, initial rhythm, CPR duration, timing and location, comorbidities (diabetes mellitus, hypertension, dyslipidemia, malignancy, COPD, cardiovascular or cerebrovascular, abnormal liver function, dialysis)	8/27 (30)	5/27 (19)	1.85 (0.52–6.63) (calculated)
Maekawa et al, ⁹¹ 2013	Japan	2000–2004	OHCA	Presumed cardiac origin, age >16 y, witnessed, CPR duration >20 min	48	Not clear but probably age, sex, activities of daily living, location of OHCA, bystander CPR, initial rhythm, number of shocks, airway insertion, venous access, physician-staffed ambulance, ROSC during transport, times, TTM, IABP, PCI, CPR duration, time from arrest to ALS	9/24 (38)	3/24 (13)	4.20 (0.97–18.2) (calculated)
Poppe et al, ⁹² 2015	Austria	2013–2014	OHCA	Age >18 y, ongoing CPR	96	NA	2/12 (17)	8/84 (10)	NR
Sakamoto et al, ⁹³ 2014	Japan	2008–2011	OHCA	Shockable rhythm, cardiac arrest on arrival, within 45 min from reception of the emergency call or the onset of cardiac arrest to the hospital arrival, no ROSC at least during the 15 min after hospital arrival	454	NA	69/260 (27)	12/193 (6)	NR
Schober et al, ⁹⁴ 2017	Austria	2002–2012	OHCA	Cardiac origin, CPR duration >30 min	239	NA	NR	NR	NR
Shin et al, ⁹⁵ 2011, Shin et al, ⁹⁶ 2013	Korea	2003–2009	IHCA	Age 18–80 y, CPR duration >10 min, witnessed	120	Age, sex, comorbidities, clinical situation, cause of the arrest, location, year, time during day and week, initial rhythm, CPR duration, prearrest SOFA score, Deyo-Charlson score, post-CPR variables	19/60 (32)	6/60 (10)	4.17 (1.53–11.4) (calculated)
Siao et al, ⁹⁷ 2015	Taiwan	2011–2013	OHCA	Age 18–75 y, ventricular fibrillation, no-flow <5 min, refractory cardiac arrest	60	Age, CPR duration, defibrillation, female sex, use of therapeutic hypothermia	10/20 (50)	11/40 (28)	4.10 (0.79–21.3)
Tanno et al, ⁹⁸ 2008	Japan	2000–2004	OHCA	Age >16 y, cardiac origin	398	NA	14/66 (21)	25/332 (8)	NR
Venturini et al, ⁹⁹ 2017	United States	2011–2016	Combined	CPR in cardiac catheterization laboratory, mechanical chest compression	31	NA	1/14 (7)	3/17 (18)	NR

(Continued)

Table 7. Continued

Study, Year	Country	Years of Patient Inclusion	IHCA vs OHCA	Inclusion Criteria	Patients Analyzed, n	Covariates Included in Adjusted Analysis	Hospital Discharge/1 mo		
							Exposed, n (%)	Unexposed, n (%)	Adjusted Results, OR or RR (95% CI)
Yannopoulos et al, ¹⁰⁰ 2016	United States	2015–2016	OHCA	Age 18–75 y, cardiac cause, initial shockable rhythm, minimum 3 direct-current shocks without ROSC, received amiodarone 300 mg, eligible for mechanical CPR, transfer time from scene to catheterization laboratory <30 min	188	NA	10/18 (53)	NR	NR
Yannopoulos et al, ¹⁰¹ 2017	United States	2015–2016	OHCA	Age 18–75 y, cardiac cause, initial shockable rhythm, minimum 3 direct-current shocks without ROSC, received amiodarone 300 mg, eligible for mechanical CPR, transfer time from scene to catheterization laboratory <30 min	232	NA	28/62 (45)	NR	NR

ALS indicates advanced life support; APACHE II, Acute Physiology, Age, Chronic Health Evaluation II; COPD, chronic obstructive pulmonary disorder; CPR, cardiopulmonary resuscitation; ECPR, extracorporeal cardiopulmonary resuscitation; ED, emergency department; eGFR, estimated glomerular filtration rate; EMS, emergency medical services; IABP, intra-aortal balloon pump; ICU, intensive care unit; IHCA, in-hospital cardiac arrest; NA, not applicable; NR, not reported; OHCA, out-of-hospital cardiac arrest; OR, odds ratio; PCI, percutaneous coronary intervention; ROSC, return of spontaneous circulation; RR, relative risk; SOFA, sequential organ failure assessment; and TTM, targeted temperature management.

refractory to standard advanced cardiac life support interventions (ie, cardiac arrest when conventional CPR is failing). Therefore, the potential for benefit and the value of this intervention remain despite the overall low certainty of supporting evidence and lack of randomized trials.

The published studies used select patients for ECPR, not the general population of all cardiac arrest cases. Guidelines for ECPR use in clinical practice should ideally apply to similar populations, although RCTs have not been performed to define the optimal population.

We acknowledge that ECPR is a complex intervention that requires considerable resources and training that are not universally available, but we also acknowledge the value of an intervention that may be successful in individuals in whom usual CPR techniques have failed. ECPR can sustain perfusion while another intervention such as coronary angiography and percutaneous coronary intervention can be performed.

ALS Task Force Knowledge Gaps

There are currently no published randomized trials of ECPR, although several are pending. The task force identified several knowledge gaps requiring further investigation:

- The optimal post-cardiac arrest care strategy for patients resuscitated with ECPR

- The patient groups most likely to benefit from ECPR
- The optimal ECPR techniques
- The optimal timing to initiate ECPR during resuscitation (ie, early, late, when in the sequence)
- The potential role of ECPR during the periarrest period
- The population-specific differences in indications for ECPR for IHCA and OHCA
- The differences in quality of life (QOL) between survivors of ECPR and survivors of conventional CPR
- The cost-effectiveness of ECPR

PEDIATRIC LIFE SUPPORT

The Pediatric Life Support Task Force reviewed 4 topics for this 2019 CoSTR: DA-CPR, advanced airway interventions in pediatric cardiac arrest, ECMO CPR (ECPR), and TTM during post-cardiac arrest care. An SR was published for each of these topics.^{3,6–8} The Pediatric Life Support Task Force then reviewed the SR and the studies identified by the SR and generated a CoSTR that was posted on the ILCOR website for public comments for each topic. This document contains a summary of the 4 CoSTRs, including information about task force deliberations and insights.

Dispatcher Instruction in CPR: DA-CPR—Pediatrics

ILCOR commissioned an SR to identify and analyze all published evidence reporting outcomes of offering DA-CPR for OHCA in infants and children.³ The Pediatric Life Support Task Force analyzed and discussed the SR and all of the studies identified by the SR, developed a draft CoSTR, and posted it online for public comment.¹⁰² The draft CoSTR was visited 1736 times during the 2-week comment period. The task force reviewed the 2 posted comments; both endorsed the summary of science and treatment recommendation.

The emergency medical dispatcher is an essential link in the chain of survival. In addition to dispatching EMS resources to medical emergencies, EMS dispatchers are increasingly being trained to recognize cardiac arrest, to assist bystanders in initiating resuscitation, and to support bystanders in optimizing resuscitation efforts. The international community is continuing to explore ways to increase bystander CPR for cardiac arrests. One such strategy involves dispatchers providing CPR instruction to callers/bystanders: DA-CPR. For such a strategy to be successful, it requires the EMS system to be configured to support the dispatcher to offer DA-CPR and the bystander to deliver CPR with support from the dispatcher.

This CoSTR explores the impact of DA-CPR on survival and neurological outcomes after OHCA in infants and children.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Infants and children with presumed cardiac arrest in out-of-hospital settings

Intervention: Patients/cases or EMS systems where DA-CPR is offered

Comparators: Studies with comparators where either systems or specific cardiac arrest cases are not offered dispatch-assisted CPR

Outcomes (critical outcomes included): Survival with favorable neurological function (at hospital discharge, 1 month, or 6 months), survival (hospital discharge, 1 month, or 1 year), short-term survival (ROSC, hospital admission), and provision of bystander CPR; important outcomes were initial shockable rhythm and time to CPR

Study designs: RCTs and nonrandomized studies (non-RCTs, interrupted time series, controlled before-and-after studies, cohort studies) eligible for inclusion

Time frame: All years and all languages included with the last search performed July 1, 2018; ongoing or unpublished studies identified through a search of ClinicalTrials.gov online registry¹⁶

PROSPERO registration: CRD42018091427

Consensus on Science

Four studies were included in the SR comparing the outcomes for children with OHCA when bystanders were offered DA-CPR.^{25,26,39,103} All the studies were cohort studies of registry data: 2 from the same registry in Japan and 2 from the same registry in Korea. When the overlapping populations from the same source (registry) were reported for the same outcome, the larger of the 2 studies was used in the analysis.^{26,39} The studies by Goto and colleagues²⁶ and Chang and colleagues³⁹ included adjusted analyses.

There were 2 major groups for outcome comparisons:

- Those patients from systems that included DA-CPR compared with those from systems that offered no dispatcher CPR assistance; in 1 study, 25% of bystanders who were offered DA-CPR did not actually provide CPR.²⁶
- Those patients who actually received DA-CPR compared with those who did not receive DA-CPR; the group who did not receive DA-CPR was subdivided into those who received unassisted CPR and those who received no CPR.

Because all studies the task force evaluated were non-randomized, any reported findings must be considered as occurring in association with the CPR (the intervention) provided rather than as caused by it.

Cardiac Arrest Outcomes in EMS Systems With and Without DA-CPR

One study from the All-Japan Utstein Registry²⁶ reported neurological outcome at 1 month in a cohort of 4306 infants and children with OHCA. There was no association in either adjusted or unadjusted analysis between favorable neurological outcome at 1 month and systems offering DA-CPR compared with such outcomes in systems not offering DA-CPR. The same study from Japan did not document any association between improved survival at 1 month and DA-CPR in the unadjusted analysis, but such an association was suggested in the adjusted analysis. In a separate analysis, there was no association between the incidence of shockable pediatric arrest rhythms and systems offering DA-CPR.²⁶

Three studies examined the delivery of bystander CPR in systems that offered DA-CPR compared with those that did not. In addition to the All-Japan study reported by Goto et al,²⁶ 2 studies^{25,31} included unadjusted analysis of 3309 children with OHCA. These studies reported a significantly higher rate of CPR in the cohorts offered DA-CPR in both unadjusted and adjusted analyses. In addition, the Goto et al All-Japan study reported earlier time to CPR initiation associated with systems that offered DA-CPR compared with those that did not.²⁶ Table 8 provides additional information.

Table 8. Comparison of Outcomes of Infants and Children With OHCA in EMS Systems With and Without DA-CPR Programs (ie, DA-CPR Offered Versus Not Offered)

Outcomes (Importance)	Pediatric Participants (Studies), n	Certainty of Evidence (GRADE)	OR or RR (95% CI)*	RD With DA-CPR and No DA-CPR
Survival with favorable neurological outcome at 1 mo (critical)	4306 (1 cohort study) ²⁶	Very low	RR, 1.03 (0.73–1.46)	1 more per 1000 (8 fewer–14 more)
			AOR, 1.45 (0.98–2.15); <i>P</i> =0.06	
Survival to 1 mo (critical)	4306 (1 cohort study) ²⁶	Very low	RR, 1.15 (0.95–1.40)	14 more per 1000 (4 fewer–35 more)
			AOR, 1.46 (1.05–2.03); <i>P</i> =0.02	
Delivery of bystander CPR (critical)	3309 (2 studies) ^{25,31}	Low	RR, 2.25 (2.05–2.47)	315 more per 1000 (188–437 more)
	4306 (1 cohort study) ²⁶	Moderate	AOR, 7.51 (6.58–8.57); <i>P</i> <0.0001	
Shockable initial rhythm (important)	4306 (1 cohort study) ²⁶	Very low	RR, 0.82 (0.61–1.10)	8 fewer per 1000 (5–18 fewer)
Arrest to CPR initiation (important)	4306 (1 cohort study) ²⁶	Very low	Shorter time to CPR: median, 4 (IQR, 1–9) min with DA-CPR vs 11 (IQR 7–16) min; <i>P</i> <0.000	

AOR indicates adjusted odds ratio; CPR, cardiopulmonary resuscitation; DA-CPR, dispatcher-assisted cardiopulmonary resuscitation; EMS, emergency medical services; GRADE, Grading of Recommendations, Assessment, Development, and Evaluation; IQR, interquartile range; OHCA, out-of-hospital cardiac arrest; OR, odds ratio; RD, risk difference; and RR, relative risk.

*RRs are presented for unadjusted analyses, and ORs are presented for adjusted analyses.

Cardiac Arrest Outcomes in Infants and Children With OHCA Who Received Bystander DA-CPR Compared With Those Who Received No CPR

Goto and colleagues²⁶ and Chang and colleagues³⁹ reported the association of significantly improved neurological outcomes and DA-CPR compared with no CPR. In both unadjusted and adjusted data from the Goto et al series, there were significantly higher rates of favorable neurological outcome (CPC 1 and 2) at 1 month associated with those who received DA-CPR compared with those who received no CPR. There were also significantly higher rates of survival to 1 month in the DA-CPR cohort in both unadjusted and adjusted analyses.²⁶ In both adjusted and unadjusted analyses, the Chang et al observational study of 1661 children with OHCA reported an association between significantly improved likelihood of favorable neurological outcome at hospital discharge and survival to hospital discharge and DA-CPR compared with no CPR.³⁹ Table 9 gives further information.

In comparisons of infants and children receiving DA-CPR with those receiving unassisted bystander CPR, Goto et al²⁶ reported lower rates of favorable neurological outcome and survival at 1 month in the DA-CPR group. Chang et al,³⁹ however, found no difference in either survival or favorable outcome at discharge between those receiving DA-CPR and those receiving unassisted bystander CPR. Chang et al reported an increase in rates of sustained ROSC associated with DA-CPR compared with no CPR but documented no such increase when comparing those who received DA-CPR with those who received unassisted bystander CPR.³⁹

Both the Goto et al²⁶ and Chang et al³⁹ studies examined the presence of a shockable rhythm as an outcome. The pooled data did not document an association between an increased presence of shockable

rhythm and receipt of DA-CPR compared with those who received no CPR, and there was a negative association when those receiving DA-CPR were compared with those receiving unassisted CPR.

Not surprisingly, Goto et al²⁶ and Chang et al³⁹ reported an association between DA-CPR and shorter times to CPR initiation compared with the group with no bystander CPR. These 2 studies, however, reported that time to CPR initiation was longer in the DA-CPR than in the unassisted bystander CPR cohort. Table 10 provides further information.

Treatment Recommendations

We recommend that EMS dispatch centers offer dispatch CPR instruction (DA-CPR) for presumed pediatric cardiac arrest (strong recommendation, very low certainty of evidence).

We recommend that emergency dispatchers provide CPR instruction for pediatric cardiac arrest when no bystander CPR is in progress (strong recommendation, very low certainty of evidence).

We cannot make a recommendation for or against emergency dispatch provision of CPR instructions for pediatric cardiac arrest when bystander CPR is already in progress (no recommendation, very low certainty of evidence).

Justification and Evidence to Decision Framework Highlights

This topic was prioritized by the Pediatric Life Support Task Force after publication of several new studies since the previous pediatric SR was published in 2011. The 2011 review found limited evidence to support DA-CPR.¹⁰⁴ In considering the importance of this topic, the Pediatric Life Support Task Force noted that bystander CPR significantly improves the likelihood of survival after OHCA, but bystander CPR rates remain very low.¹⁰⁵

Table 9. Comparison of Outcomes of Infants and Children With OHCA Who Received Bystander DA-CPR Compared With Those Who Received No CPR

Outcomes (Importance)	Participants (Studies), n	Certainty of Evidence (GRADE)	OR or RR (95% CI)*	RD With DA-CPR and No CPR
Survival with favorable neurological outcome at 1 mo (critical)	4306 (1 cohort study) ²⁶	Very low	RR, 1.47 (1.05–2.07)	12 more per 1000 (1–26 more)
			AOR, 1.81 (1.23–2.67); P=0.003	
Survival with favorable neurological outcome at hospital discharge (critical)	1661 (1 cohort study) ³⁹	Low	RR, 3.43 (2.10–5.59)	54 more per 1000 (25–99 more)
			AOR, 2.22 (1.27–3.88); P=0.005	
Survival at 1 mo (critical)	4306 (1 cohort study) ²⁶	Very low	RR, 1.38 (1.15–1.65)	31 more per 1000 (12–53 more)
			AOR, 1.63 (1.32–2.01); P<0.0001	
Survival to hospital discharge (critical)	1661 (1 cohort study) ³⁹	Moderate	RR, 2.87 (2.02–4.06)	84 more per 1000 (47–132 more)
		Low	AOR, 2.23 (1.47–3.38); P=0.002	
Sustained ROSC (critical)	1661 (1 cohort study) ³⁹	Very low	RR, 2.68 (1.94–3.70)	89 more per 1000 (51–137 more)
Shockable initial rhythm (important)	5967 (2 cohort studies) ^{26,39}	Very low	RR, 1.52 (0.81–2.86)	26 more per 1000 (10 fewer–89 more)
Arrest to CPR initiation (important)	4306 (1 cohort study) ²⁶	Very low	Shorter time with DA-CPR: median, 1 (IQR, 0–5) vs 11 (IQR, 7–15) min	
	1265 (1 cohort study) ³¹		Shorter time with DA-CPR: median, 4 (IQR, 0–13) vs 10 (IQR, 6–18) min; P=0.01	

AOR indicates adjusted odds ratio; CPR, cardiopulmonary resuscitation; DA-CPR, dispatcher-assisted cardiopulmonary resuscitation; GRADE, Grading of Recommendations, Assessment, Development, and Evaluation; IQR, interquartile range; OHCA, out-of-hospital cardiac arrest; OR, odds ratio; RD, risk difference; ROSC, return of spontaneous circulation; and RR, relative risk.

*RRs are presented for unadjusted analyses, and ORs are presented for adjusted analyses.

In developing the CoSTR, the Pediatric Life Support Task Force agreed that consideration of both unadjusted and adjusted analyses was essential to adequately evaluate the published evidence. We recognize that unadjusted analysis might be confounded by tempo-

ral changes and systematic and patient care differences between and within EMS systems.

In making a strong recommendation for dispatch centers to offer DA-CPR despite very-low-certainty evidence, the Pediatric Life Support Task Force considered

Table 10. Outcomes of Infants and Children With OHCA Who Received Bystander DA-CPR Compared With Those Who Received Unassisted Bystander CPR

Outcomes (Importance)	Participants (Studies), n	Certainty of Evidence (GRADE)	RR (95% CI)*	RD With DA-CPR and Unassisted CPR
Survival with favorable neurological outcome at 1 mo (critical)	2722 (1 cohort study) ²⁶	Very low	0.59 (0.41–0.84)	26 fewer per 1000 (9–37 fewer)
Survival with favorable neurological outcome at hospital discharge (critical)	970 (1 cohort study) ³⁹	Very low	0.97 (0.61–1.56)	2 fewer per 1000 (32 fewer–43 more)
Survival at 1 mo (critical)	2722 (1 cohort study) ²⁶	Very low	0.77 (0.62–0.95)	34 fewer per 1000 (6–57 fewer)
Survival at hospital discharge (critical)	1661 (1 cohort study) ³⁹	Very low	0.99 (0.69–1.41)	2 fewer per 1000 (42 fewer–51 more)
Sustained ROSC (critical)	1661 (1 cohort study) ³⁹	Very low	0.84 (0.62–1.16)	26 fewer per 1000 (26 more–66 fewer)
Shockable initial rhythm	3692 (2 cohort studies) ^{26,39}	Very low	0.54 (0.35–0.82)	61 fewer per 1000 (31–83 fewer)
Arrest to CPR initiation	2722 (1 cohort study) ²⁶	Very low	Longer time with DA-CPR: median, 4 (IQR, 0–13) vs 1 (IQR, 0–5) min	
	766 (1 cohort study) ³¹	Very low	Longer time with DA-CPR: median, 4 (IQR, 0–13) vs 2 (IQR, 0–10) min	

CPR indicates cardiopulmonary resuscitation; DA-CPR, dispatcher-assisted cardiopulmonary resuscitation; GRADE, Grading of Recommendations, Assessment, Development, and Evaluation; IQR, interquartile range; OHCA, out-of-hospital cardiac arrest; RD, risk difference; ROSC, return of spontaneous circulation; and RR, relative risk.

*RRs are presented for unadjusted analyses.

the benefit for the critical outcome of survival in the adjusted analyses and the large positive effect of increased bystander CPR and reduced time to initiation of CPR when DA-CPR was offered. Implementation of DA-CPR appears to be acceptable and feasible, as many EMS systems have demonstrated. However, its cost-effectiveness and impact on health equity have not been evaluated and, until documented, may present barriers to implementation in underresourced regions. In addition, successful implementation of any program of DA-CPR requires a process of continuous quality improvement to ensure that dispatchers can quickly identify a likely cardiac arrest and assist the bystander in starting CPR in a very short time.¹⁰⁶

In making a strong recommendation despite low-certainty evidence, the task force valued the consistency of results indicating benefit for all critical and important outcomes, with the exception of shockable rhythm (no benefit). This failure to demonstrate contributions of DA-CPR to improvement in likelihood of shockable initial rhythm aligns with the adult meta-analysis.³

In abstaining from recommending for or against DA-CPR when bystander CPR is already in progress, the task force noted the very-low-certainty evidence available, the consistency of inferior and neutral results for all of the critical outcomes, and the lack of any adjusted analyses for this group. The negative results associated with DA-CPR compared with unassisted bystander CPR may have several potential explanations: Bystander CPR was initiated earlier than DA-CPR because the bystander did not experience the delay resulting from calling a dispatcher and receiving instruction, or the bystanders who performed CPR and refused dispatch assistance were likely trained in CPR and may have provided a higher quality of CPR than that provided by the untrained bystander who required remote dispatch assistance. This particular finding suggests the potential benefits of widespread community-based CPR training.

Consideration of types of DA-CPR systems or interventions to improve the quality of DA-CPR was beyond the scope of this review. A limitation of the evidence that forms the basis of these treatment recommendations is that data are derived from only 2 countries: Japan and Korea. The EMS systems involved may differ in their response to OHCA compared with EMS systems and responses in other regions. Thus, caution is required in attempts to extrapolate these results to different EMS systems of care.

Although this review did not address the content of CPR instructions, we elected to specify that CPR instructions should include rescue breaths for pediatric patients with cardiac arrest to be consistent with previous CoSTRs¹⁰⁷ and to draw attention to this important distinction from adult CPR instructions.

Knowledge Gaps

The Pediatric Life Support Task Force identified several knowledge gaps requiring further investigation. The overall challenge is the need to determine whether dispatchers can effectively guide untrained bystanders to provide effective conventional CPR for a child in cardiac arrest. To ensure that consistent analysis is included in all future studies of DA-CPR in children, we recommend the research include/address the following:

- Optimal dispatcher training (and retraining) in recognizing OHCA and in providing DA-CPR for children
- Identification of the specific scripted language used by dispatchers and its effects on the initiation of bystander CPR
- Indication of how CPR instructions are provided (by the phrasing and enunciation of words, video adjuncts via cellphone, etc)
- Report of the certainty of bystander CPR (including the time required for identification of cardiac arrest, time to initiation of CPR, and whether conventional CPR or chest compression-only CPR was given)
- Inclusion of subsequent in-hospital (postarrest) factors
- Indication of specific dispatcher guidance provided (eg, to pace the compression rate) when bystander CPR is already initiated
- EMS response times
- Analysis of the cost-effectiveness of DA-CPR
- Content of CPR/DA-CPR instructions, specifically addressing the role of ventilation in infant and child CPR
- Report of long-term outcomes, including QOL outcomes
- Adjustment for variables such as bystander CPR characteristics, patient, age, sex, and previous bystander CPR training

Advanced Airway Interventions in Pediatric Cardiac Arrest

The management of the airway is central in pediatric resuscitation, particularly because respiratory conditions are a frequent cause of pediatric cardiac arrest. Placement of an advanced airway device such as an SGA or TI may allow more effective resuscitation than the alternative of BMV. However, uncertainties remain about the risk and benefit of each method of managing the airway during CPR. Persistent challenges surround issues of the provision of effective (but not excessive) ventilation; delivery of continuous chest compressions; and risks of failed intubation attempts, unrecognized esophageal intubation, prolonged interruptions in chest compressions, and inadvertent exces-

sive ventilation. These issues can affect the quality of resuscitation.

ILCOR commissioned an SR to identify and analyze all published evidence reporting outcomes of advanced airway placement during CPR in infants and children during OHCA and IHCA.⁷ The Pediatric Task Force analyzed and discussed the SR and all of the studies identified by the SR, developed a draft CoSTR, and posted it online for public comment.¹⁰⁸ The draft CoSTR was viewed 341 times during the 2-week comment period. The 4 posted comments endorsed the CoSTR, and all acknowledged the complexity of the issues surrounding use of an advanced airway during pediatric resuscitation and the need for adequate training in all techniques.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Infants and children in any setting (in hospital or out of hospital) who have received chest compressions or a defibrillation dose on whom CPR is being performed

Intervention: Placement of an advanced airway device

Comparators: Primary—BMV alone or with non-advanced airway interventions; secondary—another advanced airway device

Outcomes: Any clinical outcome

Study designs: RCTs and nonrandomized studies (non-RCTs, interrupted time series, controlled before-and-after studies, cohort studies) of pediatric patients eligible for inclusion; if insufficient studies available from which to draw a conclusion, case series of ≥ 4 may be included; case reports, unpublished studies, and nonhuman studies excluded

Time frame: All years and all languages included (as long as there is an English abstract); unpublished studies (eg, conference abstracts, trial protocols) excluded; the last search was performed on September 24, 2018

PROSPERO registration: CRD42018102430

Consensus on Science

The task force reviewed the evidence of outcomes with the following comparisons: TI with BMV, SGA with BMV, and TI with SGA during pediatric cardiac arrest. Detailed information from all studies reviewed is summarized in Table 11. Summative results from 8 of the studies are included in Table 12, which excluded cohort studies with results too heterogeneous to enable meta-analysis.

Studies Comparing TI With BMV Alone

Fourteen studies were included in the SR comparing TI with BMV, including 1 clinical trial¹⁰⁹ and 13 observational studies.^{110–122}

Although the clinical trial was excellent in design and execution, it was downgraded to low certainty as a result of indirectness. The study was conducted in 1994 to 1996, before more recent revisions in resuscitation

guidelines that emphasize minimally interrupted chest compressions as part of high-quality CPR. This study assigned 591 children with OHCA to TI or BMV on an odd- and even-day basis. The use of TI resulted in no difference in likelihood of survival with the critical outcome of favorable neurological function or survival to hospital discharge.¹⁰⁹

The 13 identified observational studies provided evidence of very low or low certainty. Three of these observational studies^{110–112} used propensity matching to attempt to control for factors driving the decision to intubate. However, a limitation of all 3 studies was the failure to distinguish patients with unsuccessful attempts at advanced airway placement from those who were managed with BMV alone. When combined, these studies found a reduced likelihood of survival with favorable neurological function or survival to hospital discharge associated with TI.^{110–112} The other 10 observational studies found no statistically significant association between TI and these outcomes.^{113–120,122,124}

Studies Comparing SGA With BMV Alone

The 4 observational studies comparing SGA with BMV provided very-low-certainty evidence. Two studies used propensity matching to reduce bias, but both had the limitation of failure to distinguish between patients who had unsuccessful attempts at SGA insertion and those who were managed with BMV without attempted SGA insertion.^{111,112} Two other observational studies reported only unadjusted data.^{113,120} None of these studies found a significant association between SGA use and survival with favorable neurological function or survival to hospital discharge.

Studies Comparing TI With SGA

The evidence comparing TI with SGA during pediatric resuscitation comes from 4 observational studies of OHCA^{111–113,120}; 2 of these studies used propensity matching.^{111,112} When combined, neither the propensity-matched studies^{111,112} nor the unadjusted cohort studies^{113,120} found a significant association between the choice of advanced airway and survival with favorable neurological function or survival to hospital discharge.

Treatment Recommendations

We suggest the use of BMV rather than TI or SGA in the management of children during cardiac arrest in the out-of-hospital setting (weak recommendation, very low certainty of evidence).

There is insufficient evidence to support any recommendation about the use of TI or SGA in the management of children with cardiac arrest in the in-hospital setting.

Justification and Evidence to Decision Framework Highlights

Advanced airway interventions have been long-established components of the advanced life support bundle of care

Table 11. Pediatric Studies Comparing Use of BMV With Advanced Airways During Cardiac Arrest

Study	Years Conducted	Setting	Location	Patients/Total Treated, n (%)					
				Survival With Good Neurological Function			Survival to Hospital Discharge		
				TI	BMV	SGA	TI	BMV	SGA
Clinical trials									
Gausche et al, ¹⁰⁹ 2000	1994–1997	OHCA	United States	10/290 (3.4)	15/301 (5.0)	...	24/290 (8.3)	24/301 (8.0)	...
Observational studies with propensity matching									
Andersen et al, ¹¹⁰ 2016	2000–2014	IHCA	United States	185/987 (18.7)	211/983 (21.4)	...	411/1135 (36.2)	460/1135 (40.7)	...
Hansen et al, ¹¹¹ 2017	2013–2015	OHCA	United States	34/727 (4.7)	89/781 (11.4)	13/215 (6.0)	51/727 (7.0)	110/781 (14.1)	22/215 (10.2)
Ohashi-Fukuda et al, ¹¹² 2017	2011–2012	OHCA	Japan	0/31 (0.0)	16/346 (4.6)	12/315 (3.8)	4/31 (12.9)	37/346 (11.0)	47/315 (14.9)
Simple observational studies									
Abe et al, ¹¹³ 2012	2005–2008	OHCA	Japan	...	...	...	12/185 (6.5)	243/2734 (8.9)	9/270 (3.3)
Aijian et al, ¹¹⁴ 1989	1984–1987	OHCA	United States	...	...	...	1/28 (3.6)	1/14 (7.1)	...
Deasy et al, ¹¹⁵ 2010	1999–2007	OHCA	Australia	...	...	...	13/154 (7.8)	2/26 (7.7)	...
Del Castillo et al, ¹¹⁶ 2015	2007–2009	IHCA	Argentina, Brazil, Columbia, Chile, Ecuador Honduras, Italy, Paraguay, Portugal, Spain	44/71 (71.0)	43/53 (81.1)	...	...	...	...
Guay and Lorti, ¹¹⁷ 2004	1983–1987	IHCA	Canada	...	...	...	20/90 (22.2)	30/55 (54.5)	...
Pitetti et al, ¹¹⁸ 2002	1995–1999	OHCA	United States	...	...	...	5/150 (3.3)	0/39 (0.0)	...
Sirbaugh et al, ¹¹⁹ 1999	1992–1995	OHCA	United States	5/229 (2.2)	0/26 (0.0)	...	6/229 (2.6)	0/26 (0.0)	...
Tham et al, ¹²⁰ 2018	2009–2012	OHCA	Japan, Korea, Malaysia, Singapore, Taiwan, Thailand, United Arab Emirates	3/18 (16.7)	29/791 (3.7)	3/109 (2.8)	3/18 (16.7)	68/791 (8.6)	9/109 (8.3)
Simple observational studies without raw data (analyzed separately from meta-analysis)									
Fink et al, ¹²¹ 2016	2007–2012	OHCA	United States	...	...	...	AOR, 0.64 (95% CI, 0.37–1.13) favoring BMV over AAW*		...
Tijssen et al, ¹²² 2015	2005–2012	OHCA	Canada, United States	...	...	...	AOR, 0.69 (95% CI, 0.43–1.10) favoring BMV over AAW†		...

AAW indicates advanced airway; AOR, adjusted odds ratio; BMV, bag-mask ventilation; IHCA, in-hospital cardiac arrest; OHCA, out-of-hospital cardiac arrest; SGA, supraglottic airway; and TI, tracheal intubation.

*In the study by Fink et al,¹²¹ 92% of AAW attempts were TI attempts.

†In the study by Tijssen et al,¹²² 93% of AAW attempts were TI attempts.

in adults and children. As a result of inherent limitations in their design and data sources, the available studies provide only very-low-certainty evidence about whether attempting advanced airway placement during resuscitation (ie, before ROSC) improves resuscitation outcomes. The best available data show no benefit from advanced airway interventions, and some suggested association with harm

for the critical outcomes of survival with favorable neurological outcome and survival to hospital discharge. The effects of placement of an advanced airway are uncertain for the short-term resuscitation outcomes of survival to hospital admission and ROSC. Although these short-term outcomes do not ultimately benefit the patient, they may benefit the family.

Table 12. Summative Results of Studies Used in the Pediatric Airway Systematic Review for Each Comparison and Grouped by Outcome

Outcomes (Importance)	Participants (Studies), n	Certainty of Evidence (GRADE)	RR (95% CI)	Absolute Risk With Comparator	ARD With Intervention
TI (I) vs BMV (C)*					
Survival, favorable neurological outcome (critical)	591 (1 RCT) ¹⁰⁹	Low	0.69 (0.32–1.52)	50/1000	15 fewer per 1000 (48 fewer–17 more)
	3855 (3 propensity-matched observational) ^{110–112}	Very low	†	150/1000	49 fewer per 1000 (77–21 fewer)
Survival to hospital discharge (critical)	591 (1 RCT) ¹⁰⁹	Low	1.04 (0.6–1.79)	80/1000	3 more per 1000 (41 fewer–47 more)
	4155 (3 propensity-matched observational) ^{110–112}	Very low	‡	268/1000	53 fewer per 1000 (20–87 fewer)
	3992 (2 observational studies) ^{121,122}	Very low	‡	Fink et al ¹²¹ : AOR, 0.64 (0.37–1.13) Tijssen et al ¹²² : AOR, 0.69 (0.43–1.1)	
Survival to hospital admission (important)	1508 (1 propensity-matched observational) ¹¹¹	Very low	0.99 (0.83–1.17)	257/1000	3 fewer per 1000 (47 fewer–41 more)
ROSC (important)	4155 (3 propensity-matched observational) ^{110–112}	Very low	‡	417/1000	12 more per 1000 (15 fewer–39 more)
SGA (I) vs BMV (C)*					
Survival, favorable neurological outcome (critical)	1657 (2 propensity-matched observational) ^{111,112}	Very low	†	93/1000	29 fewer per 1000 (75–fewer to 17 more)
	900 (1 nonadjusted observational study) ¹²⁰	Very low	0.75 (0.23–2.42)	37/1000	9 fewer per 1000 (43 fewer–24 more)
Survival to hospital discharge (critical)	3904 (2 observational studies) ^{113,120}	Very low	†	88/1000	35 fewer per 1000 (88 fewer–18 more)
Survival to hospital admission (important)	996 (1 propensity-matched observational) ¹¹¹	Very low	1.25 (0.99–1.57)	257/1000	64 more per 1000 (6 fewer–133 more)
	900 (1 observational study) ¹²⁰	Very low	0.85 (0.44–1.87)	97/1000	15 fewer per 1000 (70 fewer–41 more)
ROSC (important)	900 (1 observational study) ¹²⁰	Very low	1.26 (0.82–1.92)	171/1000	40 more per 1000 (41 fewer–121 more)
TI (I) vs SGA (C)*					
Survival, favorable neurological outcome (critical)	1288 (2 propensity-matched observational) ^{111,112}	Very low	†	47/1000	22 fewer per 1000 (51 fewer–6 more)
	127 (1 nonadjusted observational study) ¹²⁰	Very low	6.06 (1.32–27.7)	28/1000	139 more per 1000 (36 fewer–314 more)
Survival to hospital discharge (critical)	1288 (2 propensity-matched observational) ^{111,112}	Very low	†	130/1000	31 fewer per 1000 (73 fewer–11 more)
	582 (2 observational studies) ^{113,120}	Very low	†	47/1000	34 more per 1000 (6 fewer–75 more)
Survival to hospital admission (important)	942 (1 propensity-matched observational) ¹¹¹	Very low	0.79 (0.63–1.0)	321/1000	67 fewer per 1000 (136 fewer–4 more)
	127 (1 observational study) ¹²⁰	Very low	4.33 (2.28–8.2)	128/1000	472 more per 1000 (198–665 more)
ROSC (important)	1288 (2 propensity-matched observational) ^{111,112}	Very low	†	162/1000	26 fewer per 1000 (129 fewer–78 more)
	127 (1 observational study) ¹²⁰	Very low	3.42 (2.16–5.44)	211/1000	511 more per 1000 (291–732 more)

AOR indicates adjusted odds ratio; ARD, absolute risk difference; BMV, bag-mask ventilation; C, comparator; GRADE, Grading of Recommendations, Assessment, Development, and Evaluation; I, intervention; RCT, randomized controlled trial; ROSC, return of spontaneous circulation; RR, relative risk; SGA, supraglottic airway; and TI, tracheal intubation.

Summative results of studies used in the systematic review are shown for each comparison and grouped by outcome.

*Cohort studies, amenable to meta-analysis, were not reported in this table if they produced results that were too heterogeneous (I^2 index >75%). Studies included in this table were therefore 1 clinical trial,¹⁰⁹ 3 propensity-matched observational studies,^{110–112} and 4 nonadjusted observational studies.^{113,120–122}

†To minimize ambiguity, RR calculations were reported only for single studies, not for meta-analyses. RR calculations were considered less informative and sometimes produced divergent results, likely a consequence of zero-numerator cells.¹²³

‡The first 2 studies^{121,122} provided retrospective cohort data in adjusted form only (AOR), not amenable to meta-analysis.

Effective BMV, TI, and insertion of an SGA are all difficult skills that require good initial training, retraining, and quality control to be performed con-

sistently, safely, and effectively. To be effective, pediatric advanced airway programs require a moderate investment in equipment and a significant invest-

ment in training, skills maintenance, and quality control programs.

The benefit or harm associated with advanced airway-based resuscitation may differ across settings. The available data do not inform the questions of whether better outcomes might be achieved by advanced airway-based strategies by highly trained and experienced airway operators, during long distance transport, or in prolonged resuscitation situations. The analyzed data are relevant only to advanced airway interventions during CPR and do not pertain to airway management after ROSC or in other critical situations.

Knowledge Gaps

This evidence evaluation did not identify any clinical trials addressing airway management during cardiac arrest in the in-hospital setting, and future studies are needed to address this knowledge gap. In addition, the only randomized clinical trial undertaken in the out-of-hospital setting¹⁰⁹ was performed before major changes in resuscitation guidelines; future studies are needed in the out-of-hospital setting. The task force identified several additional knowledge gaps requiring further investigation:

- Prehospital, emergency department-based, and in-hospital studies of similar design comparing TI, SGA, and BMV with planned subgroup analyses based on patient age and cause of arrest
- Studies of advanced airway use in specific contexts such as long-distance transport and prolonged resuscitation situations in the hands of highly trained and experienced airway operators; we have no knowledge about these subgroups, which are likely to be important

ECPR: Infants and Children

ECPR has been used with increasing frequency as rescue therapy for refractory cardiac arrest. In pediatrics, ECPR is used most frequently after postoperative IHCA associated with congenital heart disease and progression of low cardiac output or arrhythmias, although there are recent reports of applications for cardiac arrest from other causes. This topic was last reviewed by the Pediatric Life Support Task Force in 2015.¹²⁵

ILCOR commissioned an SR to identify and analyze all published evidence reporting outcomes of ECPR in infants, children, and adults after OHCA and IHCA.⁶ The Pediatric Life Support Task Force analyzed and discussed the SR and all of the pediatric studies identified by the SR, developed a draft CoSTR, and posted it online for public comment.¹²⁶ The draft document was viewed 264 times during the 2-week comment period. The task force reviewed the single posted comment, which endorsed the CoSTR.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Adults (age ≥ 18 years) and children (age < 18 years) with cardiac arrest in any setting (out of hospital or in hospital)

Intervention: ECPR, including ECMO or cardiopulmonary bypass, during cardiac arrest

Comparator: Manual and/or mechanical CPR

Outcomes: Clinical outcomes, including short-term survival and neurological outcomes (eg, hospital discharge, 28 days, 30 days, and 1 month) and long-term survival and neurological outcomes (eg, 3 months, 6 months, and 1 year)

Study design: Randomized trials, non-RCTs, and observational studies (cohort studies and case-control studies) with a control group included; animal studies, ecological studies, case series, case reports, reviews, abstracts, editorials, comments, and letters to the editor not included

Time frame: All years and all languages included (as long as there was an English abstract); unpublished studies, published abstracts (eg, conference abstracts), and trial protocols excluded; literature search conducted on December 19, 2017, and updated May 22, 2018

PROSPERO registration: CRD42018085404

Note: Information about outcomes of ECPR use in adults is addressed elsewhere in this article (see ECPR for Cardiac Arrest: Adults).

Consensus on Science

In-Hospital Cardiac Arrest

For the critical outcomes of favorable longer-term neurological outcome or of longer-term survival, no pediatric studies were identified.

For the critical outcome of favorable neurological outcome at hospital discharge, we identified very-low-certainty evidence (downgraded for very serious risk of bias) from 1 observational study; this study associated improved outcomes with ECPR compared with conventional CPR (conditional logistic analysis adjusted odds ratio [AOR], 2.64 [95% CI, 1.91–3.67]; propensity analysis AOR, 1.78 [95% CI, 1.31–2.41]).¹²⁷

For the critical outcome of survival to hospital discharge, we identified very-low-certainty evidence (downgraded for very serious risk of bias and inconsistency) from 3 studies with pediatric populations. Two studies associated improved survival with ECPR compared with conventional CPR (AOR, 2.76 [95% CI, 2.08–3.66]¹²⁷; AOR, 3.80 [95% CI, 1.40–10.32] in medical cardiac patients; and AOR, 2.50 [95% CI, 1.3–4.81] in surgical cardiac patients).¹²⁸

Out-of-Hospital Cardiac Arrest

No studies were identified that addressed this question.

Treatment Recommendations

We suggest that ECPR may be considered as an intervention for selected infants and children (eg, cardiac

populations) with IHCA refractory to conventional CPR in settings where resuscitation systems allow ECPR to be well performed and implemented (weak recommendation, very low certainty of evidence).

There is insufficient evidence in pediatric OHCA to formulate a recommendation for the use of ECPR.

Justification and Evidence to Decision Framework Highlights

In making a weak recommendation about the use of ECPR for pediatric IHCA, we recognize that despite a lack of comparative prospective studies identified in infants and children, patients with IHCA refractory to conventional CPR have a high probability of death unless therapies such as ECPR are used.

Providers should carefully consider the fact that the pediatric ECPR studies from which these recommendations are drawn consist predominantly of children with cardiac disease. This population may not adequately represent the local population for which guidelines may be implemented, so regional resuscitation councils must consider how generalizable the evidence can be to their regional systems of care.

The results of ECPR studies conducted in adults cannot be extrapolated to pediatric OHCA given the difference in causes of cardiac arrest between children and adults, the techniques and equipment applied for ECPR, and the post-cardiac arrest care interventions.

As noted, ECPR has been studied in very selected populations (eg, cardiac surgical or cardiac medical) and more rarely for pediatric cardiac arrest in general (ie, across all diseases and in all hospital settings).¹²⁷ In addition, it has been used in organizations with a strong institution-based commitment to sustaining a resuscitation system that includes ECPR with appropriate quality improvement systems.^{129,130} Such improvement systems include ongoing internal audits and iterative evaluation of performance and outcomes.^{129–133} As a result, these findings may not be broadly generalizable to other organizations.

ECPR is a complex resuscitation intervention that requires long-term commitment to sustain the expertise, resources, training, and systems to provide support for patients and their families. Delivering this complex intervention involves added up-front investment and costs.^{134,135}

The healthcare resources necessary to provide high-quality pediatric ECPR are likely to limit its broad adoption.

Knowledge Gaps

No published randomized trials have compared the outcomes of ECPR and conventional CPR in infants and children. Because some high-volume organizations have adopted ECPR for selected pediatric populations, this comparison may not be perceived as hav-

ing sufficient equipoise to allow randomization. As a result, alternative comparative study designs may be necessary to conduct clinical trials to study the following:

- Comparison of the probability of survival between ECPR and conventional CPR in IHCA
- Comparison of the likelihood of favorable neurological and functional outcome between ECPR and conventional CPR in IHCA

The timing and type of cannulation strategy for optimal transition from conventional CPR to ECPR remain to be studied to optimize neuro-CPR outcomes. The Pediatric Life Support Task Force identified the following unresolved issues:

- Optimal timing for ECPR cannulation during conventional CPR
- Conditions (eg, pulmonary blood flow obstruction) for which ECPR, rather than conventional CPR, should be considered earlier in the resuscitation attempt
- Type and anatomic approach for cannulation for ECPR that allows best cerebral-CPR
- Identification of other technical aspects of ECPR that enable optimal cerebral-CPR, including ideal temperature management strategy, best circuit prime solution (reconstituted whole blood versus crystalloid), optimal fraction of device oxygenation to be delivered by the membrane lung, target oxygenation and decarboxylation to be delivered during ECPR, and the inotrope or vasoactive medications delivered during ECPR that will optimize neurological and cardiopulmonary outcomes

The post-cardiac arrest care strategies after cannulation for ECPR remain to be studied, including how post-cardiac arrest care therapies should be adapted in the context of ongoing ECPR.

There is an important gap in comparative studies of resuscitation for OHCA in special circumstances such as submersion or drowning, deep hypothermia or cold environment, respiratory arrest, or in the context of trauma. The Pediatric Life Support Task Force identified the following challenges for studies of ECPR for pediatric OHCA in special circumstances:

- Identification of ideal select populations and circumstances to be considered for initial studies of ECPR for OHCA: Should these include children with cold-water drowning, people in an avalanche, or individuals with cold exposure?
- Optimal timing for initiation of ECPR: Should it be initiated at the scene of the arrest (ie, cannulation in the field) or immediately on arrival at the hospital?

There are no published comparative studies on longer-term functional outcomes or QOL outcomes in pediatric patients and in their families and caregivers after ECPR.

The Pediatric Life Support Task Force identified the following issues to be addressed:

- How longer-term functional and QOL outcomes compare between ECPR and conventional CPR for the pediatric population and their families and caregivers
- How bereavement outcomes compare between families and caregivers of nonsurvivors of cardiac arrest with ECPR compared with outcomes of families and caregivers of nonsurvivors of conventional CPR

Whereas the cost-effectiveness of ECMO has been addressed in pediatric and adult publications, the cost-effectiveness of ECPR versus conventional CPR in pediatric cardiac arrest populations is not known and should be studied.

TTM After Cardiac Arrest

The last ILCOR Pediatric Life Support CoSTR review of pediatric TTM was published in 2015.¹²⁵ Since that review, additional studies of pediatric TTM have been published, particularly in the in-hospital target population. ILCOR commissioned an SR to identify and analyze all published evidence reporting outcomes of TTM in children who achieved ROSC after OHCA and IHCA.⁸ The Pediatric Life Support Task Force analyzed and discussed the SR and all of the studies identified by that review, developed a draft CoSTR, and posted it online for public comment.¹³⁶ In response to the 2 posted comments, the task force included additional information in the Justification and Evidence to Decision Framework Highlights section.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Pediatric patients (age >24 hours–18 years) who achieved ROSC after OHCA or IHCA

Intervention: TTM with a target temperature of 32°C to 36°C

Comparators: No TTM or TTM at an alternative target temperature range

Outcomes:

- Critical: favorable neurological outcome (good behavioral survival) at 1 year such as Pediatric CPC 1 or 2¹³⁷ and Vineland Adaptive Behavior Scales (Vineland-II) ≥ 70 .¹³⁸
- Important: favorable neurological outcome (at other time intervals), overall survival, and health-related QOL at 3 time intervals: long term (1–3 years), intermediate term (3–6 months), and short term (28–30 days or hospital discharge)
 - Health-related QOL was defined with the use of pediatric-specific QOL tools (eg, the Pediatric QOL Inventory,¹³⁹ the Infant Toddler QOL Questionnaire,¹⁴⁰ or equivalent). Potential

in-hospital adverse outcomes were also captured, including infection (culture proven), recurrent cardiac arrest, serious bleeding (red blood cell transfusion), and any arrhythmias (not leading to cardiac arrest).

Study designs: RCTs, quasi-RCTs (qRCTs), and non-randomized cohort studies eligible to be included; animal studies, unpublished studies, published abstracts (eg, conference abstracts), and case series excluded

Time frame: All years to December 13, 2018

Languages: All languages included (if English abstract was available)

A priori subgroups to be examined: Location of cardiac arrest (in hospital and out of hospital), age groups, presumed type of cardiac arrest (cardiac, asphyxial, other), and use of ECMO

PROSPERO registration: CRD42018108441

Consensus on Science

The review identified 2 RCTs^{141,142} with moderate clinical heterogeneity (different settings), low methodological heterogeneity (same methods and in-hospital management), and low or moderate statistical heterogeneity, allowing pooling of the results in the meta-analyses and separate subgroup analyses. The 2 RCTs were downgraded to low certainty of effect as a result of inconsistency and imprecision. Because only 2 relatively small RCTs were available, observational comparative data were considered, but we did not combine the RCT and non-RCT data. The observational studies that reported adequately adjusted results were pooled, whereas unadjusted results are shown, when relevant, without pooling (Table 13).

Favorable Neurobehavioral Survival

For the primary outcome of long-term favorable neurological outcome (1 year), a pooled analysis of the 2 RCTs (low certainty of evidence) found no statistically significant benefit of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{141,142} Two adjusted cohort studies reported no statistically significant benefit in either intermediate-term¹⁴⁹ or short-term favorable neurological outcome associated with use of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.¹⁴³

Survival

For the secondary outcome of overall survival, a pooled analysis of the 2 RCTs (very low certainty of effect, downgraded for inconsistency and imprecision) found no statistically significant benefit in either long-term or short-term survival of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{141,142} One retrospective cohort study found no benefit in adjusted intermediate-term survival associated with TTM 32°C to 34°C versus TTM 36°C to 37.5°C.¹⁴⁹ Three cohort studies also reported no associated increase in adjusted short-term

Table 13. Pediatric TTM in Children With OHCA Who Are Comatose After ROSC: Summary of Studies and Findings

Study, Year	Study Type; Years Enrolled	n	Enrollment Criteria	GCS/Neurological	Target Temperature Intervention	Temperature Comparison Control	TTM Duration	Outcomes	Comments
Chang et al, ¹⁴³ 2016	Retrospective review of national OHCA database; nonrandomized; January 1, 2008–December 31, 2014	663 Total, 81 TTM; stratified by shockable vs nonshockable presenting rhythm	OHCA surviving to hospital admission (excluding deaths in ED, alert status after ED resuscitation, or unknown neurological status at discharge)	Not specified	32°C–34°C based on intention to treat regardless of achieved temperature or duration; actual temperature measures not included; no standard care protocol	No standard care protocol; temperature measures not included	Minimum 12 h	No difference in survival to hospital discharge between TTM (48.1%) and control (40.2%); no difference in good neurological recovery (CPC 1 or 2 at discharge) between TTM (22.2%) and control (18.7%); no difference in effect of TTM between shockable and nonshockable presenting rhythm groups	Very low certainty resulting from lack of temperature data and nonrandomized treatment allocation
Cheng et al, ¹⁴⁴ 2018	Retrospective; historic and concurrent; controls 2013–2015; included neonates (23%–33%)	81 Events in 75 patients; IHCA	CHD+CPR >5 min or ECPR (excluded intracranial hemorrhage)	Not specified	Mean, 33.6±0.2°C; 0 had fever; 4/30 had temperature <32°C; TTM reached in 1.4 h (median)	Mean, 34.7±0.8°C; 2/51 had fever; 12/51 had temperature <32°C; TTM reached in 1.4 h (median)	<1 y=72 h (actual median: 63.1 h), ≥1 y=48 h (actual median: 45.9 h); 14/30 TTM patients rewarmed early	Survival: Control, 59.1%; TTM, 61.5%; no significant difference in survival or LOS; follow-up to 26.5 mo; fewer patients with TTM had seizures (significant)	Control group included more patients with single ventricles and had low mean temperature with nearly half with temperature <32°C
Fink et al, ¹²⁴ 2010	Retrospective cohort; patients with TTM after 2002	181 Total, 40 TTM; OHCA and IHCA	Admission to ICU with ROSC after cardiac arrest (even brief) who remained comatose after ROSC (excluded CHD, respiratory arrest no ROSC, brain death before arrest)	Consistent with AHA comatose; specific neurological criteria not reported	33.5°C–34.8°C; mean, 34.1±0.8°C; reached in 2.7±4.5 h (mean, 0–4 h); 18% had fever, 15% had temperature <32°C (associated with higher mortality)	Standard 33.6°C–36.3°C; mean, 31.6±19.5 h; 38% had fever in first 4 d	24 h (range 16–48 h); 60% of patients with TTM presented at or below target temperature, so some were warmed to target temperature)	55% Survival with no difference between TTM and control; those with <36°C or >38°C on admission had significantly higher mortality than those with temperature 36°C–38°C; temperature <32°C in 15% and associated with higher mortality; no difference in hospital mortality, LOS	
Lin et al, ¹⁴⁵ 2013	Retrospective chart review; January 1, 2010–June 30, 2012	43 Total, 15 TTM; both OHCA and IHCA	At least 3 min of compression; only those surviving 12 h included; CHD excluded	TTM GCS mean score 4.67±1.94; control GCS score 5±2.35	33.5±0.5°C	39% Needed active rewarming to normothermia	24–72 h	57% Overall survival; higher (78.6%) in TTM group vs 46.4% in control group (significant)	Some internal inconsistencies in numbers throughout article
Lin et al, ¹⁴⁶ 2018	Retrospective cohort 2010–2017	64 Total; 25 TTM, all asphyxial OHCA	CPR at least 3 min and survival at least 12 h; excluded 45 children, including 10 who died within 12 h, 10 not in coma after ROSC, 8 with preexisting neurological disease, and 8 with TBI	GCS score ≤8; TTM GCS score 3.4±1.04; control GCS score 3.2±0.76	33°C within 6 h of arrest	35.5°C–37.5°C; 56.4% needed active warming; 12.8% needed treatment for temperature >37.5°C	72 h	Overall 1-mo survival, 42.2%; 1-mo survival significantly higher in TTM (60%) vs control (30.8%) group; TTM group had significantly better neurological outcomes; TTM group had longer LOS	
Moler et al, ¹⁴² 2015	International, multi-institutional prospective RCT (September 1, 2009–December 31, 2012)	74 With OHCA drowning ≥2 min of CC, remained comatose (GCS motor score 3 or 4) and ventilator dependent after ROSC; 46 randomized to TTM group	48 h to <18 y of age; excluded if GCS motor score 5 or 6, major trauma, inability to randomize within 6 h, decision to withhold aggressive treatment	GCS motor score 3 or 4, comatose and ventilator dependent after ROSC	33°C (32°C–34°C)	36.8°C (36°C–37.5°C)	120 h	No difference in 28-d mortality or 12-mo survival with favorable neurological outcome or other secondary outcomes; culture-proven bacterial infection more common in TTM group; the 25 survivors at 12 mo who received >30 min of CC had poor functional outcomes (PCPC ≥4)	CPR duration longer in TTM 36°C–37.5°C group and fewer had bystander CPR; blinding of caregivers impossible

(Continued)

Table 13. Continued

Study, Year	Study Type; Years Enrolled	n	Enrollment Criteria	GCS/ Neurological	Target Temperature Intervention	Temperature Comparison Control	TTM Duration	Outcomes	Comments
Moler et al, ¹⁴² 2015	International, multi-institutional prospective RCT (September 1, 2009–December 31, 2012)	295 Randomized; 260 subjects with data, all OHCA who required ≥ 2 min of CC, remained comatose and ventilator dependent; 155 assigned to TTM	48 h to <18 y of age; excluded if GCS motor score 5 or 6, major trauma, inability to randomize within 6 h, decision to withhold aggressive treatment	GCS motor score 3 or 4, comatose and ventilator dependent after ROSC	33°C (32°C–34°C)	36.8°C (36°C–37.5°C)	120 h	No difference in 28-d mortality (57% in TTM, 67% in control group, $P=0.08$), 12-mo survival (38% in TTM vs 29% in control) or in 12-mo survival with favorable neurological outcome or other secondary outcomes; no difference in complications (eg, bleeding, arrhythmias, infections), although hypokalemia and thrombocytopenia occurred more frequently in TTM group and renal replacement treatment used more often in control group; significant difference in survival time with TTM group, although this was a secondary outcome	Witnessed arrest, 39%, and 66% of these received bystander CPR; 72% of patients had respiratory cause of arrest; blinding of caregivers was impossible
Moler et al, ¹⁴¹ 2017	International, multi-institutional prospective RCT (September 1, 2009–February 27, 2015; stopped for futility)	329 Patients randomized; 166 to control (IHCA)	48 h to <18 y of age; excluded if GCS motor score 5 or 6, major trauma, inability to randomize within 6 h, decision to withhold aggressive treatment	GCS motor score 3 or 4; comatose and ventilator dependent after ROSC	33°C (32°C–34°C)	36.8°C (36°C–37.5°C)	120 h	Survival at 28 d and survival with VABS-II ≥ 70 at 1 y: 36% TTM vs 39% control (no difference); no difference in secondary outcomes, including alive at 1 y or change in VABS-II score from baseline; no difference in infection, blood product use, serious arrhythmias within 7 d	65% had either cardiac cause of arrest or CHD; blinding of caregivers was impossible
Scholefield et al, ¹⁴⁷ 2015	Retrospective cohort enrolled January 2004–December 2010 after OHCA	73 Patients; 38 randomized to TTM	1 d to 16 y of age, admitted after OHCA with ROSC	Not stated although cited the ILCOR guidance for TTM for patients who remain comatose after ROSC from cardiac arrest	32°C–34°C; 4 patients (11%) experienced “overshoot” cooling to <32°C and all died; only 3% (1 patient) developed temperature >38°C	Called standard temperature management with rescue temperature-controlling measures to keep temperature $\leq 38^\circ\text{C}$; 38% had fever >38°C	22.5 h	Overall survival was 29% and was not significantly different between TTM (34%) and control (23%) groups; study was underpowered to detect significant difference in hospital survival; TTM group had more bradycardia and hypotension and had longer LOS	Significantly more patients in TTM group (81% vs 47%) had bystander CPR; TTM used more often in patients with unknown cause of arrest and higher predicted mortality and used less in those with traumatic arrest (including TBI), so control group had more patients with traumatic arrest; study enrollment bridged a period of major change in basic life support guidelines

(Continued)

Table 13. Continued

Study, Year	Study Type; Years Enrolled	n	Enrollment Criteria	GCS/ Neurological	Target Temperature Intervention	Temperature Comparison Control	TTM Duration	Outcomes	Comments
Torres-Andres et al, ¹⁴⁸ 2018	Retrospective observational study of all witnessed OHCA and IHCA between May 2007 and July 2015 treated with ECPR	58	Consecutive patients receiving ECPR; 28 also treated with TTM	Witnessed IHCA (only 3/58 patients) or OHCA; receipt of advanced CPR, no ROSC within 15 min of CPR; no contraindication to mechanical circulatory support; hypothermia was at discretion of care team	Not stated	34°C–35°C	Controlled normothermia avoiding body temperature >37°C	Overall survival to hospital discharge, 65.5%; 3-y survival, 62.1%; survival to hospital discharge significantly higher among those treated with TTM (75%) vs control subjects (55%) with good QOL inventory and family functioning; 50% of survivors had evidence of intracranial injuries (vs 58.3% of nonsurvivors)	Nonsurvivors more likely to have >1 ECPR event

AHA indicates American Heart Association; CC, chest compressions; CHD, congenital heart disease; CPC, Cerebral Performance Category; CPR, cardiopulmonary resuscitation; ECPR, extracorporeal cardiopulmonary resuscitation; ED, emergency department; GCS, Glasgow Coma Scale; ICU, intensive care unit; IHCA, in-hospital cardiac arrest; ILCOR, International Liaison Committee on Resuscitation; LOS, length of stay; OHCA, out-of-hospital cardiac arrest; PCPC, Pediatric Cerebral Performance Category; QOL, quality of life; RCT, randomized controlled trial; ROSC, return of spontaneous circulation; TBI, traumatic brain injury; TTM, targeted temperature management; and VABS-II, Vineland Adaptive Behavior Scales II.¹³⁸

survival associated with the use of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{124,143,149}

Adverse Outcomes: Infection

A pooled analysis of the 2 RCTs found no statistical difference in culture-proven infection from TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{141,142} Four cohort studies reported infection; unadjusted outcomes were not pooled, but none of the studies showed a statistically significant difference in infection with use of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{124,144,146,149}

Adverse Outcomes: Recurrent Cardiac Arrest

Pooled analysis of the 2 RCTs found no difference in the rate of recurrent cardiac arrest from TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{141,142} Two cohort studies reported unadjusted recurrent cardiac arrest rates that could not be pooled; none of the individual studies showed statistically significant association of increased recurrent arrest with the use of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{124,149}

Adverse Outcomes: Serious Bleeding

Pooled analysis of the 2 RCTs found a significant increase in serious bleeding from TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{141,142} Two observational cohort studies reported unadjusted odds ratios for serious bleeding; none of the individual studies showed association of statistically significant increase in bleeding with the use of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{124,149}

Adverse Outcomes: Arrhythmias

Pooled analysis of the 2 RCTs found no statistical increase in arrhythmias from TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{141,142} Five observational studies reported unadjusted outcomes for arrhythmias; 1 reported an association of a statistically significant

increase in arrhythmias; the other 3 studies reported no statistically significant increase or decrease in arrhythmias associated with the use of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.^{124,144,146,147,149}

Subgroup Analysis: Location of Cardiac Arrest

For the predetermined subgroup analysis by location of arrest (OHCA or IHCA), no meta-analyses could be completed because there is only 1 RCT for each subgroup and the observational studies had methodological heterogeneity.

For OHCA, the single RCT did not find statistically significant benefit of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.¹⁴² One of the 3 cohort studies found (in unadjusted results) association of increased survival and good behavioral survival with 72 hours of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.¹⁴⁶ The other 2 cohort studies did not report statistically significant benefit or harm.^{143,147} An exploratory analysis was conducted to determine whether the addition of a hypothetical OHCA RCT that yielded results similar to the THAPCA OHCA study (Therapeutic Hypothermia After Pediatric Cardiac Arrest) would change the pooled analysis CI to favor TTM 32°C to 34°C.¹⁴² Enrollment of 200 patients in such a hypothetical RCT would be required to demonstrate a statistically significant benefit for favorable neurological outcome at 1 year.

The IHCA RCT did not find statistical benefit or harm of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.¹⁴¹ The point estimates for outcomes of 3 different observational cohort studies are on both sides of the null effect.^{144,148,149} An exploratory analysis indicated that an additional hypothetical RCT of 6000 patients with an outcome similar to the THAPCA IHCA RCT¹⁴¹ would be required to demonstrate a statistically significant harm of TTM 32°C to 34°C in favorable neuro-

logical outcome at 1 year compared with TTM 36°C to 37.5°C.

Subgroup Analysis: Cause of Arrest

Two retrospective observational cohort studies of cardiac arrest with presumed cardiac cause could not be pooled but separately reported no significant benefit or harm in short-term survival associated with TTM 32°C to 36°C compared with TTM 36°C to 37.5°C (or no TTM).^{144,148}

Two observational cohort studies (and a pilot publication of one of those studies) reported favorable neurological outcome and survival outcomes for patients with predominantly (>80%) presumed asphyxial origin.^{124,145,146} A high risk of bias and lack of adjusted outcomes precluded the pooling of data. One OHCA study found a statistically significant benefit for both favorable neurological outcome and survival associated with TTM 32°C to 36°C for 72 hours.¹⁴⁶ All of the point estimates for outcomes favored TTM 32°C to 36°C.

The THAPCA OHCA study published a nonrandomized subgroup analysis of drowning as a cause.¹⁵⁰ There was no statistically significant benefit of the intervention for survival or favorable neurological outcome.

Subgroup Analysis: ECMO

Although some patients in several of the studies underwent ECMO, outcome data were available from only 2 studies. The THAPCA IHCA RCT (nonrandomized cointervention, of low-certainty evidence) found no statistically significant difference in long-term favorable neurological outcome (at 1 year) for TTM 32°C to 34°C compared with TTM 36°C to 37.5°C.¹⁴¹ In 1 observational cohort study, all patients received ECMO; that study reported no statistical increase in short-term survival.¹⁴⁸

Treatment Recommendations

We suggest that for infants and children with OHCA, TTM be used in the post-cardiac arrest period to maintain a central temperature <37.5°C (weak recommendation, moderate certainty of evidence). On the basis of 2 randomized trials and 8 retrospective observational cohort studies that provided comparative data on favorable neurological outcome, survival, and in-hospital adverse events, there is inconclusive evidence to support or refute the use of TTM 32°C to 34°C compared with TTM 36°C to 37.5°C (or an alternative temperature) for children who achieve ROSC after cardiac arrest.

Justification and Evidence to Decision Framework Highlights

The evidence in this review is dominated by the 2 THAPCA RCTs.^{141,142} These studies included only children 2 days to 18 years of age who had received at least 2 minutes of CPR and who remained comatose and ventilator dependent after ROSC. There were many patient

exclusions, including the use of ECMO, severe trauma, previous cardiac arrest, preexisting life-limiting conditions, severe bleeding, and continuous epinephrine infusion. The findings of this review should be considered in the context of this limitation.

In making this recommendation, the task force preferred the use of TTM 32°C to 34°C as opposed to TTM 36°C to 37.5°C because, although the THAPCA OHCA study¹⁴² did not demonstrate success for the primary outcome (favorable neurological status at 1 year), it was underpowered to show a significant difference for survival, for which the lower 95% CI approached 1. The point estimates for survival in the 3 cohort studies of OHCA or presumed asphyxial arrest^{124,145,146} favored TTM 32°C to 34°C. There were insufficient data on patients with IHCA, who represent a population with different preexisting conditions and cause of arrest.

The task force noted that hyperthermia occurs frequently in the postarrest period; fever is potentially harmful and should be avoided. Finally, the provision of TTM can be resource intensive. These resources, the associated expertise necessary to deliver and maintain TTM, and the presence of appropriate systems of critical care are required to provide optimal post-ROSC care. The task force noted that the application of TTM may require sedation, analgesia, and neuromuscular blocking drugs that will modify neurological assessment.

Knowledge Gaps

This evidence evaluation did not address training, logistical, operational, or economic issues pertaining to TTM. It also did not compare other temperature ranges and did not address the duration of TTM. In addition, the task force identified knowledge gaps requiring further investigation:

- The use of TTM 32°C to 34°C for children after OHCA
- Asphyxial arrest and the use of TTM 36°C to 37.5°C in patients with IHCA

NLS TASK FORCE

Initial Oxygen Concentration for Term Infants at Birth

Administration of high oxygen concentrations leads to free radical formation and may be toxic to lungs, eyes, brains, and other organs of the newborn.^{151,152} In 2010, the ILCOR NLS Task Force CoSTR update noted that it was best to start with 21% oxygen when term newborns received positive-pressure ventilation in the delivery room. The recommendation was based on a meta-analysis that found lower mortality when room air instead of 100% oxygen was used.¹⁵³ The evidence review for this question did not use GRADE methodology² to analyze the published studies. This topic was

not addressed for term infants in the 2015 CoSTR update.¹⁵⁴ Questions remain about the risks of hypoxemia versus hyperoxemia for late preterm and term newborns who receive respiratory support in the delivery room. As a consequence, the ILCOR NLS Task Force undertook an SR with meta-analysis of the relevant available evidence using GRADE methodology² on the topic of lower versus higher concentrations of oxygen for the initiation of resuscitation of newborn infants at ≥ 35 weeks' gestation.⁹

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Newborn infants (≥ 35 weeks' gestation) who receive respiratory support at birth

Intervention: Lower initial oxygen concentration ($\leq 50\%$ O₂)

Comparison: Higher initial oxygen concentration ($> 50\%$ O₂)

Outcomes:

- Primary: All-cause short-term mortality (in hospital or 30 days)
- Secondary: All-cause long-term mortality (13 years); long-term neurodevelopmental impairment (NDI; 13 years); hypoxic-ischemic encephalopathy (Sarnat stage 2–3)¹⁵⁵

Study designs: RCTs, qRCTs, and nonrandomized cohort studies included; animal studies, unpublished studies, and published abstracts (eg, conference abstracts) excluded

Time frame: 1980 to August 10, 2018

A priori subgroups to be examined: Gestational age (≥ 35 , ≥ 37 weeks); grouped lower and higher oxygen concentrations; explicit oxygen saturation targeting versus no oxygen saturation targeting

PROSPERO registration: CRD42018084902

Consensus on Science

The SR identified 10 trials and 2 follow-up studies involving 2164 newborns, but 3 of the trials had critical risk of bias and were included in only the sensitivity analyses.⁹ Data from 1469 term and late preterm infants (≥ 35 weeks' gestation) in 7 randomized and qRCTs were included. All identified studies compared 21% (or air) with 100% oxygen concentration; no other initial oxygen concentrations were reported. No data specific to ≥ 37 weeks' gestation were found, and none of the studies used targeted oxygen saturation (SpO₂) monitoring.

A draft CoSTR document based on the SR was posted for a 2-week public commenting period on January 15, 2019.¹⁵⁶ During the comment period, the draft CoSTR was viewed 3564 times. The NLS Task Force received 47 comments that were subsequently sorted into 4 main categories: (1) agreement with the CoSTR as written; (2) responses that demonstrated a need for more explicit emphasis that the intent of the

population, intervention, comparator, outcome, study design, and time frame was to address initial oxygen concentration (not a static delivery concentration); (3) questions about special situations such as oxygen use during cardiac compressions or in the unique circumstance of newborns with anomalies such as pulmonary hypoplasia or congenital diaphragmatic hernia; and (4) a desire for stronger emphasis on the need for more evidence using current methods of oxygen monitoring and titration and additional interval oxygen concentrations for infants at ≥ 35 weeks' gestation. In response to the public comments, the NLS Task Force included additional information to address questions and comments about the 3 main categories of concerns.

Short-Term Mortality (In Hospital or 30 Days)

For this critical outcome, evidence of low certainty (downgraded for risk of bias and imprecision) from 7 RCTs (and qRCTs) involving 1469 newborn infants at ≥ 35 weeks' gestation receiving respiratory support at birth showed benefit of starting with 21% oxygen compared with 100% oxygen (RR, 0.73 [95% CI, 0.57–0.94]; $I^2=0\%$); 46 of 1000 fewer (95% CI, 73–10 fewer) babies died when respiratory support at birth was started with 21% compared with 100% oxygen.^{157–163}

Long-Term Mortality (1–3 Years)

For this critical outcome, no evidence was identified.

NDI (13 Years)

Among survivors who were assessed for this critical outcome, evidence of very low certainty (downgraded for risk of bias and imprecision) from 2 RCTs (and qRCTs) involving 360 term and late preterm newborns (≥ 35 weeks) who received respiratory support at birth showed no statistically significant benefit or harm of starting with 21% compared with 100% oxygen (RR, 1.41 [95% CI, 0.77–2.60]; $I^2=0\%$): 36 of 1000 more (95% CI, 20 fewer–142 more) babies with NDI when respiratory support at birth was started with 21% compared with 100% oxygen.^{161,164}

Hypoxic-Ischemic Encephalopathy (Sarnat Stage 2–3)¹⁵⁵

For this critical outcome, evidence of low certainty (downgraded for risk of bias and imprecision) from 5 RCTs (and qRCTs) involving 1359 term and late preterm newborns (≥ 35 weeks' gestation) receiving respiratory support at delivery showed no statistically significant benefit or harm of 21% compared with 100% oxygen (RR, 0.90 [95% CI, 0.71–1.14]; $I^2=8\%$): 20 per 1000 fewer (95% CI, 57 fewer–27 more) babies with hypoxic-ischemic encephalopathy when respiratory support at birth was started with 21% compared with 100% oxygen.^{157,158,160,161,163}

Subgroup Infants ≥ 37 Weeks' Gestation

No data for the planned subgroup analysis for infants of ≥ 37 weeks' gestation were found.

Intermediate Initial Oxygen Concentrations

No studies were identified that compared any intermediate initial oxygen concentrations.

Oxygen Saturation Targeting Versus No Oxygen Saturation Targeting

No studies were identified that used SpO₂ targeting.

Treatment Recommendations

For newborn infants at ≥ 35 weeks' gestation receiving respiratory support at birth, we suggest starting with 21% oxygen (air; weak recommendation, low certainty of evidence). We recommend against starting with 100% oxygen (strong recommendation, low certainty of evidence).

Justification and Evidence to Decision Framework Highlights

Parents and clinicians rate mortality as a critical outcome. Despite the low certainty of the evidence, the large reduction in the primary outcome of short-term mortality (number needed to treat, 22) with no demonstrated adverse effects favors the use of 21% oxygen as the initial gas for resuscitation for newborns at ≥ 35 weeks' gestation. Although there are no published cost data, it is likely that initiating resuscitation with 21% oxygen does not add cost and might result in cost savings compared with the use of initial 100% oxygen in some settings. Babies born in low-resource settings demonstrate increased mortality and morbidity. Therefore, it is plausible that using 21% oxygen compared with 100% oxygen has greater impact in low-resource settings. Use of 21% oxygen for initial resuscitation is universally feasible.

To be clear, we emphasize that the recommendation for 21% oxygen refers to the initial concentration of oxygen at the initiation of respiratory support. It does not address the question of how to titrate the oxygen concentration as resuscitation progresses; no evidence was found to guide this aspect of oxygen delivery. Once such evidence is published, the NLS Task Force will initiate an SR to assess the effect and optimal methods of titration of oxygen concentrations during resuscitation. We found no studies that evaluated the initial oxygen concentration for specific special circumstances such as congenital diaphragmatic hernia or pulmonary hypoplasia.

Knowledge Gaps

The NLS Task Force identified the following knowledge gaps requiring further investigation:

- Studies in late preterm (35–36 weeks' gestation) infants: few of these infants were included in the published studies, leading to lower certainty in the evidence for this gestational age group
- Research to assess the impact of titration of oxygen to oxyhemoglobin saturation (SpO₂) targets as

the resuscitation progresses: monitoring SpO₂ and titration of oxygen concentration were not routinely used in the studies included in the SR for this CoSTR

- Comparison of initial oxygen concentrations intermediate between 21% and 100%: in the SR for this CoSTR, no studies were found that compared any oxygen concentrations other than 21% versus 100%
- Determination of whether delayed cord clamping affects the impact of initial inspired oxygen concentration
- The effect of initial oxygen concentrations on long-term NDI; studies published to date have been of very low certainty of evidence
- The optimal initial oxygen concentrations needed in special circumstances such as newborns with pulmonary hypoplasia, congenital diaphragmatic hernia, and other anomalies

Initial Oxygen Concentration for Preterm Infants at Birth

Preterm newborn infants are particularly vulnerable to oxidative stress resulting from reduced antioxidant defenses and frequent exposure to oxygen during stabilization in the delivery room.¹⁶⁵ Many common complications of prematurity are associated with oxygen toxicity, including bronchopulmonary dysplasia, retinopathy of prematurity, and intraventricular hemorrhage. Medical practitioners who stabilize preterm infants at birth must try to prevent hypoxia while limiting excess oxygen to prevent toxic effects. In 2015, the ILCOR NLS Task Force CoSTR update recommended starting with 21% to 30% oxygen for preterm newborns needing respiratory support in the delivery room.¹⁵⁴ This was based on meta-analysis findings of no benefit for any important or critical outcomes when high oxygen concentrations were used. Additional studies are now available, so the ILCOR NLS Task Force undertook an SR with meta-analysis using GRADE methodology² of the relevant available evidence on the effects of lower versus higher oxygen concentrations for initiation of resuscitation of preterm newborn infants.¹⁰

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Preterm newborn infants (<35 weeks' estimated gestational age) who receive respiratory support at birth

Intervention: Lower initial oxygen concentration ($\leq 50\%$ O₂)

Comparison: Higher initial oxygen concentration ($> 50\%$ O₂)

Outcomes:

- Primary: All-cause short-term mortality (in hospital or 30 days)

- Secondary: All-cause long-term mortality (1–3 years); long-term NDI (1–3 years); retinopathy of prematurity (stages III–V);¹⁶⁶ necrotizing enterocolitis stage II (pneumatosis) or III (surgical)¹⁶⁷; bronchopulmonary dysplasia (moderate to severe)¹⁶⁸; major intraventricular hemorrhage (grade III–IV)¹⁶⁹; and time to heart rate >100 bpm

Study designs: RCTs, qRCTs, and nonrandomized cohort studies included; animal studies, case series, unpublished studies, and published abstracts (eg, conference abstracts) excluded

Time frame: 1980 to August 10, 2018

A priori subgroups to be examined: Gestational age (≤ 32 , ≤ 28 weeks); grouped lower and higher initial oxygen concentrations (21% O₂ compared with 100% O₂, 21%–30% compared with 80%–100% only, 30% compared with 90%–100%, 50% compared with 100%, 30% compared with 60%–65%); and explicit Spo₂ targeting versus no Spo₂ targeting

PROSPERO registration: CRD42018084902

Consensus on Science

The SR found 16 eligible studies that included 5697 preterm newborns.¹⁰ This constituted 10 RCTs, 2 follow-up studies, and 4 observational cohort studies. The majority (9 of 10) of the RCTs used 21% to 30% as the initial low oxygen concentration,^{170–178} with only 1 small RCT using 50% for the initial low oxygen group.¹⁷⁹ All observational studies used 21% oxygen as the initial low oxygen concentration.^{180–183} Six of 10 RCTs used 100% oxygen,^{171,173–175,178,179} 1 RCT used 90%,¹⁷² 1 RCT used 80%,¹⁷⁰ and 2 RCTs used >60%^{176,177} as the high initial oxygen concentration. All observational studies used 100% as the high initial oxygen concentration. A majority of RCTs (8 of 10)^{171–178} and all of the observational cohort studies^{180–183} used Spo₂ targeting as a cointervention. All results are presented as RR with 95% CI and absolute difference with 95% CI.

A draft CoSTR document based on the SR was posted for a 2-week public commenting period on January 15, 2019.¹⁸⁴ During the comment period, the draft CoSTR was viewed 7387 times, suggesting intense interest within the global neonatal community. The NLS Task Force received 52 comments that were subsequently grouped into 3 categories: those that agreed with the draft CoSTR as written, those that wanted clarification on what “no benefit or harm” truly meant, and those that expressed disappointment that the science does not yet provide a clearer answer. As a result of the public comments, the NLS Task Force included additional information to address these concerns.

All Preterm Gestational Ages Combined (<35 Weeks' Gestation)

Overall, evidence of very low certainty (downgraded for risk of bias and imprecision) for newborn infants at <35 weeks' gestation receiving respiratory support at birth

showed no statistically significant benefit or harm of lower initial oxygen concentration ($\leq 50\%$) compared with higher initial oxygen concentration ($>50\%$) for the following critical outcomes (see Table 14 for data): all-cause short-term mortality (in hospital or 30 days), all-cause long-term mortality (1–3 years), long-term NDI (moderate to severe, 1–3 years), retinopathy of prematurity (grade III–V),¹⁶⁶ necrotizing enterocolitis (Bell grade II–III),¹⁶⁷ bronchopulmonary dysplasia (moderate to severe),¹⁶⁸ or major intraventricular hemorrhage (grade III–IV).¹⁶⁹ For the important outcome of time to heart rate >100 bpm after delivery, the limitation of the direct evidence for newborn infants at <35 weeks' gestation precluded meta-analysis.

Subgroup Newborn Infants at ≤ 32 Weeks' Gestation

For the critical outcome of all-cause short-term mortality (in hospital or 30 days), the evidence of very low certainty (downgraded for risk of bias and imprecision) from 8 RCTs with 837 newborn infants at ≤ 32 weeks' gestation receiving respiratory support at birth showed no statistically significant benefit or harm of lower initial oxygen concentration compared with higher initial oxygen concentration (RR, 0.93 [95% CI, 0.55–1.55]; $I^2=15\%$): 6 of 1000 fewer (95% CI, 39 fewer–47 more) with short-term mortality when lower compared with higher initial oxygen concentration was used.^{171–173,175–179}

Subgroup Newborn Infants at ≤ 28 Weeks' Gestation

For the subgroup analysis of newborn infants at ≤ 28 weeks' gestation receiving respiratory support at birth, evidence of very low certainty (downgraded for risk of bias and imprecision) showed no statistically significant benefit or harm of lower initial oxygen concentration ($\leq 50\%$) compared with higher initial oxygen concentration ($>50\%$) for the following critical outcomes (see Table 15 for data): short-term mortality (in hospital or 30 days), long-term mortality (1–3 years), long-term NDI (moderate to severe, 1–3 years), retinopathy of prematurity (grade III–V),¹⁶⁶ necrotizing enterocolitis (Bell grade II–III),¹⁶⁷ bronchopulmonary dysplasia (moderate to severe),¹⁶⁸ or major intraventricular hemorrhage (grade III–IV).¹⁶⁹

Subgroup of 21% Compared With 100% Oxygen Concentration (<35 Weeks' Gestation)

For the critical outcome of all-cause short-term mortality (in hospital or 30 days), evidence of very low certainty (downgraded for risk of bias and imprecision) from 4 RCTs with 484 newborn infants at <35 weeks' gestation receiving respiratory support at birth showed no statistically significant benefit or harm of initial room air (21% O₂) compared with initial 100% oxygen concentration (RR, 1.58 [95% CI, 0.70–3.55]; $I^2=4\%$): 26 per 1000 more (95% CI, 14 fewer–115 more) with short-term mortality when lower initial oxygen concentration

Table 14. Meta-Analysis of RCTs Comparing Initial Low and High Oxygen Concentration for All Preterm Gestational Ages Combined (<35 Weeks' Gestation)

Outcome	Article With Outcome of Interest	Total, n	Certainty of Evidence	RR (95% CI); I ²	Absolute Difference (95% CI)
Short-term mortality (in hospital or 30 d)	Lundstrøm et al, ¹⁷⁰ 1995 Harling et al, ¹⁷⁹ 2005 Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Rabi et al, ¹⁷³ 2011 Armanian and Badiee, ¹⁷⁴ 2012 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	968	Very low	0.83 (0.50–1.37); 18%	15/1000 fewer deaths when lower vs higher initial oxygen concentration was used (44 fewer–32 more)
Long-term mortality (1–3 y)	Boronat et al, ¹⁸⁵ 2016 Thamrin et al, ¹⁸⁶ 2018	491	Very low	1.05 (0.32–3.39); 79%	5/1000 more deaths when lower vs higher initial oxygen concentration was used (71 fewer–248 more)
NDI (moderate to severe at 1–3 y)	Boronat et al, ¹⁸⁵ 2016 Thamrin et al, ¹⁸⁶ 2018	389	Very low	1.14 (0.78–1.67); 0%	27/1000 more with NDI when lower vs higher initial oxygen concentration was used (42 fewer–129 more)
Retinopathy of prematurity (grade III–V)	Lundstrøm et al, ¹⁷⁰ 1995 Harling et al, ¹⁷⁹ 2005 Vento et al, ¹⁷² 2009 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	806	Very low	0.73 (0.42–1.27); 0%	19/1000 fewer with retinopathy of prematurity (grade III–V) when lower vs higher initial oxygen concentration was used (42 fewer–19 more)
Necrotizing enterocolitis (Bell grade II–III)	Lundstrøm et al, ¹⁷⁰ 1995 Harling et al, ¹⁷⁹ 2005 Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	847	Very low	1.34 (0.63–2.84); 0%	12/1000 more with necrotizing enterocolitis when lower initial vs higher initial oxygen concentration was used (13 fewer–65 more)
Bronchopulmonary dysplasia (moderate to severe)	Harling et al, ¹⁷⁹ 2005 Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Rabi et al, ¹⁷³ 2011 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	843	Very low	1.00 (0.71–1.40); 47%	0/1000 fewer with bronchopulmonary dysplasia when lower vs higher initial oxygen concentration was used (77 fewer–107 more)
Major intraventricular hemorrhage (grade III–IV)	Lundstrøm et al, ¹⁷⁰ 1995 Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	795	Very low	0.96 (0.61–1.51); 0%	3/1000 fewer with major intraventricular hemorrhage (grade III–IV) when lower vs higher initial oxygen concentration was used (32 fewer–42 more)

NDI indicates neurodevelopmental impairment; RCT, randomized controlled trial; and RR, relative risk.

(21%) compared with higher initial oxygen concentration (100%) was used.^{171,173,175,178}

- For the critical outcome of all-cause long-term mortality (1–3 years), in newborns at <35 weeks' gestation, the results are the same as for all groups at <35 weeks' gestation.
- For the critical outcome of long-term NDI (moderate to severe, 1–3 years) in preterm newborns (<35 weeks' gestation), the results are the same as for all groups at <35 weeks' gestation.

Additional subgroup analyses that evaluated the effect of varying the definition of low and high oxygen con-

centration (21%–30% compared with 80%–100% only; 30% compared with 90%–100%; 50% compared with 100%; 30% compared with 60%–65%) and whether Spo₂ targeting as a cointervention had any impact found no differences in primary and secondary outcomes.¹⁰ When data from 2 observational cohort studies with 1225 newborns^{182,183} were pooled, initiating resuscitation with lower oxygen was associated with a statistically significant benefit in long-term mortality for all preterm newborns and the subgroup of ≤28 weeks' gestation (RR, 0.77 [95% CI, 0.59–0.99]; I²=6%).¹⁰

Table 15. Meta-Analysis of RCTs Comparing Initial Low and High Oxygen Concentration for ≤ 28 -Week Gestational Age Subgroup

Outcome	Article With Outcome of Interest	Total, n	Certainty of Evidence	RR (95% CI); I^2	Absolute Difference (95% CI)
Short-term mortality (in hospital or 30 d)	Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Rabi et al, ¹⁷³ 2011 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	467	Very low	0.92 (0.43–1.94); 45%	10/1000 fewer with short-term mortality when lower vs higher initial oxygen concentration was used (70 fewer–116 more per 1000)
Long-term mortality (1–3 y)	Thamrin et al, ¹⁸⁶ 2018	86	Very low	2.11 (0.86–5.19); NA	145/1000 more with long-term mortality when lower vs higher initial oxygen concentration was used (18 fewer–547 more per 1000)
NDI (moderate to severe at 1–3 y)	Thamrin et al, ¹⁸⁶ 2018	69	Very low	1.08 (0.58–2.03); NA	28/1000 more with long-term NDI when lower vs higher initial oxygen concentration was used (147 fewer–360 more per 1000)
Retinopathy of prematurity (grade III–V)	Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	441	Very low	0.75 (0.43–1.33); 0%	30/1000 fewer with retinopathy of prematurity when lower vs higher initial oxygen concentration was used (67 fewer–39 more per 1000)
Necrotizing enterocolitis (Bell grade II–III)	Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	441	Very low	1.62 (0.66–3.99); 0%	20/1000 more with necrotizing enterocolitis when lower vs higher initial oxygen concentration was used (11 fewer–95 more per 1000)
Bronchopulmonary dysplasia (moderate to severe)	Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Rabi et al, ¹⁷³ 2011 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	467	Very low	0.90 (0.64–1.28); 31%	37/1000 fewer with bronchopulmonary dysplasia when lower vs higher initial oxygen concentration was used (132 fewer–102 more per 1000)
Major intraventricular hemorrhage (grade III–IV)	Wang et al, ¹⁷¹ 2008 Vento et al, ¹⁷² 2009 Kapadia et al, ¹⁷⁵ 2013 Aguar et al, ¹⁷⁶ 2013 Rook et al, ¹⁷⁷ 2014 Oei et al, ¹⁷⁸ 2017	441	Very low	0.84 (0.50–1.40); 12%	23/1000 fewer with major intraventricular hemorrhage (grade III–IV) when lower vs higher initial oxygen concentration was used (73 fewer–58 more per 1000)

NDI indicates neurodevelopmental impairment; RCT, randomized controlled trial; and RR, relative risk.

Treatment Recommendations

For preterm newborn infants (<35 weeks' gestation) who receive respiratory support at birth, we suggest starting with a lower oxygen concentration (21%–30%) rather than higher initial oxygen concentration (60%–100%; weak recommendation, very low certainty of evidence). We suggest the range of 21% to 30% oxygen because all trials but one used this for the low oxygen concentration group. Subsequent titration of oxygen concentration using pulse oximetry is advised (weak recommendation, very low certainty of evidence).

Until further evidence is available, implementation of the suggested initial oxygen concentration between 21% and 30% should be based on local practice considerations and should be reevaluated with ongoing audit of care.

Justification and Evidence to Decision Framework Highlights

Balancing the benefits and serious potential harm of low versus high oxygen concentrations in neonatal care

is a continuing concern, particularly for preterm infants. Decades of research clearly demonstrate that oxygen exposure is a determinant of critical neonatal outcomes in preterm infants. Concern remains that if the preterm infant requires resuscitation immediately after birth, the initial oxygen concentration to which the infant is exposed may be a critical contributor to outcomes, regardless of subsequent oxygen exposure. Both parents and clinicians rate the outcomes assessed in this SR as either critical or important. For all of the critical outcomes assessed in the meta-analyses of RCTs, the 95% CIs of RRs were wide enough to include both potential harm and potential benefit. Thus, it is unclear whether initial low or high oxygen concentrations may have undesirable effects. In suggesting starting with low oxygen concentrations (21%–30%), we place value on avoiding exposure of preterm babies to additional oxygen without proven benefit for critical or important outcomes because we are cognizant of harms in newborn animals and in-

creased neonatal mortality in term infants exposed to high initial oxygen concentration.^{151,187} This review addressed only the initial concentration of oxygen and therefore does not include any recommendation for subsequent administration or titration of oxygen. Subsequent titration of supplementary oxygen should be based on published SpO₂ target ranges.

The a priori comparisons evaluated only an initial oxygen concentration of 21% to 30% versus 80% to 100%, which therefore influences the recommendation. We recognize that no studies have compared the safety or efficacy of beginning resuscitation with 21% oxygen and intermediate concentrations such as 30% oxygen. We emphasize that the included studies measured only the effect of varying initial inspired oxygen concentrations and were not designed to assess the safety or efficacy of different SpO₂ targets. As outlined above, careful attention should be paid to the initial and cumulative oxygen loads under the investigated regimens. Therefore, starting at a lower oxygen concentration (21%–30%) with the option to titrate according to SpO₂ aiming for published SpO₂ target ranges provides an option of minimizing oxygen exposure at birth.

Knowledge Gaps

The NLS Task Force identified the following knowledge gaps requiring further investigation:

- High-quality studies with appropriate power to determine optimal initial oxygen because the 95% CI for the primary outcome in most studies identified in this review includes both harm and benefit
- Further evidence from randomized studies on long-term NDI outcomes
- Studies to address the actual oxygen requirements for specific gestational age groups
- Further evidence to identify the optimal SpO₂ targets for preterm infants
- Evidence to identify the optimal methods of titrating oxygen for preterm infants in the delivery room
- Potential effects of delayed cord clamping on the impact of initial inspired oxygen concentration for preterm infants

EIT AND ALS TASK FORCES

CACs Versus Non-CACs

CACs are hospitals providing evidence-based resuscitation treatments, including emergency interventional cardiology, bundled critical care with TTM, and protocolized cardiorespiratory support and prognostication.^{48,63}

This population, intervention, comparator, outcome, study design, and time frame was prioritized for review by the EIT and ALS Task Forces on the basis

of the publication of several large registry studies^{188,189} since the 2015 ILCOR ALS^{48,63} and EIT CoSTRs.^{190,191} In the following sections, we present a summary of the evidence identified by the ILCOR SR¹¹ and the web-posted CoSTR about the effects of CACs.¹⁹² One question was posted during the comment period on the definition of CACs, and we have provided that in this introduction.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Adults with attempted resuscitation after nontraumatic IHCA or OHCA

Intervention: Specialized CAC care

Comparators: Care at non-CAC

Outcomes:

- Primary outcome: survival at 30 days or hospital discharge with favorable neurological outcome (CPC 1 or 2 or modified Rankin Scale score 0–3)
- Secondary outcomes: ROSC after hospital admission for patients with ongoing CPR and survival at 30 days or hospital discharge

Study designs: Published RCTs and nonrandomized studies (non-RCTs, interrupted time series, controlled before-and-after studies, cohort studies) reporting data from adult patients

Time frame: All years and all languages included (provided there was an English abstract); literature search updated on August 1, 2018

PROSPERO registration: CRD42018091427

Consensus on Science

A total of 21 observational studies^{188,189,193–211} and 1 pilot randomized trial²¹² were included in the SR.¹¹ Of these, 17 observational studies were ultimately included in the meta-analysis.^{188,189,193–199,204–211} All studies were in OHCA cohorts; 1 study²⁰⁰ also included patients with IHCA, but outcomes were not reported separately.

The observational studies provided very low certainty of evidence for all outcomes. The included studies all reported outcomes from patients with OHCA who were cared for at a CAC compared with those cared for at a non-CAC. The manner of arrival at a CAC or non-CAC varied greatly across studies (ie, prehospital triage of all patients to the closest hospital, prehospital triage of select patients to a CAC, prehospital triage of all patients to a CAC, secondary interhospital transfer from a non-CAC to a CAC, or not described). Given the potential for referral bias and other confounding variables, only data from studies reporting adjusted measures of association were pooled in the meta-analysis.

CACs were associated with favorable neurological outcome and survival when examined at hospital discharge, but this was nonsignificant when examined at 30 days (Table 16).

In addition to the pooled data, 3 observational studies looking exclusively at long-term outcomes of patients

Table 16. Summary of Evidence on Outcomes Associated With Care in CACs

Outcomes (Importance)	Studies (Participants), n	Certainty of the Evidence (GRADE)	Odds Ratio (95% CI)	Anticipated Absolute Effects, n	
				Care at Other Hospital, n (%)	Risk Difference for Care at CAC
Survival to 30 d with favorable neurological outcome (critical)	2 studies ^{188,189} (45 956)	Very low	2.92 (0.68–12.48)	359/25 617 (1.4)	26 more per 1000 (4 fewer–137 more)
Survival to hospital discharge with favorable neurological outcome (critical)	2 studies ^{194,195} (3673)	Very low	2.22 (1.74–2.84)	47/584 (8.0)	82 more per 1000 (52–119 more)
Survival to 30 d (critical)	2 studies ^{198,210} (2693)	Very low	2.14 (0.73–6.29)	123/1695 (7.3)	71 more per 1000 (19 fewer–257 more)
Survival to hospital discharge (critical)	5 studies ^{194,195,205–207} (11 662)	Very low	1.85 (1.46–2.34)	587/4117 (14.3)	93 more per 1000 (53–138 more)

CAC indicates cardiac arrest centers; and GRADE, Grading of Recommendations, Assessment, Development, and Evaluation.

discharged alive from hospitals reported that care at a CAC was associated with better patient survival.^{199,200,202}

Preplanned subgroup analyses identified additional information about the effects of primary transport versus secondary transfer of patients to CACs and about the outcomes of patients with shockable versus nonshockable rhythms. Four observational studies examined the potential impact of transfer on patient outcomes after OHCA.^{189,199,209,211} One study²¹¹ reported higher adjusted patient survival associated with direct transfer to a CAC compared with patient survival among those who underwent secondary interfacility transfer (odds ratio, 1.97 [95% CI, 1.13–3.43]). Two other studies^{189,199} reported no difference in survival between direct transport and secondary transfer of patients to a CAC. One study²⁰⁹ reported higher adjusted survival in patients who underwent a secondary transfer to a CAC compared with those who remained at the initial treating non-CACs (odds ratio, 1.59 [95% CI, 1.30–1.93]). One additional observational study¹⁹⁴ reported higher adjusted patient survival to hospital discharge associated with bypassing the nearest non-CAC and transporting patients directly to a CAC compared with transporting patients to non-CACs (odds ratio, 3.02 [95% CI, 2.01–4.53]).

Eight observational studies reported outcomes stratified by arresting rhythm into shockable or nonshockable cohorts, but the findings were inconsistent, most reported unadjusted data, and the studies were too heterogeneous to pool.^{189,193,195,199,203,205,206,208}

Treatment Recommendations From the EIT and ALS Task Forces

We suggest that adult patients with nontraumatic OHCA be cared for in CACs rather than in non-CACs (weak recommendation, very low certainty of evidence).

We cannot make a recommendation for or against regional triage by primary EMS transport of patients with OHCA to a CAC (bypass protocols) or secondary interfacility transfer to a CAC. The current evidence is inconclusive, and confidence in the effect estimates is currently too low to support an EIT and ALS Task Forces recommendation.

For patients with IHCA, we found no evidence to support an EIT and ALS Task Forces recommendation.

For the subgroup of patients with shockable or nonshockable initial cardiac rhythm, the current evidence is inconclusive, and the confidence in the effect estimates is currently too low to support an EIT and ALS Task Forces recommendation.

Justification and Evidence to Decision Framework Highlights

In making this recommendation, the EIT and ALS Task Forces concluded that the potential benefits in clinical outcomes outweighed the potential risks and logistical issues with implementation.

We specifically considered the consistency of improved outcomes in patients treated at CACs across most studies, the desirability of patients receiving evidence-based postresuscitation care, the evidence supporting specialized care for other emergency conditions (eg, trauma, stroke, and ST-segment–elevation myocardial infarction), the lack of evidence suggesting clinical harm associated with longer transport times,²¹³ the potential for referral bias (ie, transporting patients most likely to survive), and the implementation challenges of this recommendation.

Regionalized systems of care for cardiac arrest may not be feasible in all areas as a result of resource constraints, cost, and inherent regional differences in healthcare delivery. In making a weak recommendation in support of CACs, the task forces acknowledge the lack of high-level evidence.

EIT and ALS Task Forces Knowledge Gaps

Numerous knowledge gaps were identified in this SR. Key gaps include the following:

- There is no universal definition of a CAC.
- The precise aspects of CACs that improve outcomes have not been identified (eg, if there are specific bundles of care that CACs offer that improve outcomes).
- The effect of delayed secondary interfacility transfer to a CAC is unknown.

- The potential benefit of CACs for IHCA and other subgroups (eg, cardiac pathogenesis, shockable rhythm) has not been reported.

FIRST AID TASK FORCE

Presyncope

Presyncope, or near-syncope, is the prodrome of syncope and is characterized by light-headedness, nausea, diaphoresis, and a feeling of impending loss of consciousness. A progression to syncope results in global cerebral hypoperfusion and transient loss of consciousness; loss of postural tone can result in physical injury in up to 30% of patients.²¹⁴ This review evaluated nonpharmacological first aid interventions that can be applied at the onset or immediately after the onset of presyncope symptoms. ILCOR commissioned an SR,¹² and the task force studied all evidence cited in the SR and developed a draft CoSTR. The draft CoSTR was posted for public comment on the ILCOR website; the draft was viewed 285 times during the comment period, and no comments were posted.²¹⁵ This document summarizes the final CoSTR for first aid treatment of presyncope.

Population, Intervention, Comparator, Outcome, Study Design, and Time Frame

Population: Adults and children with signs and symptoms of faintness or presyncope of suspected vasovagal or orthostatic origin

Intervention: Physical counterpressure maneuvers (PCMs), body positioning, hydration, or other

Comparison: Compared with no intervention or 1 intervention compared with another

Outcomes:

- Abortion of syncope (termination of progression from presyncope to syncope; critical)
- Injuries or adverse events (critical)
- Symptom improvement (important)
- Change in heart rate (important)
- Change in systolic blood pressure (important)
- Change in diastolic blood pressure (important)

Study designs: RCTs and nonrandomized studies (non-RCTs, interrupted time series, controlled before-and-after studies, cohort studies) eligible for inclusion; case series and unpublished studies, published abstracts (eg, conference abstracts), and trial protocols excluded

Time frame: All years and all languages included (provided an English abstract was available)

PROSPERO registration: CRD42018107726

Consensus on Science

Studies Comparing Use of PCMs With a Control or No Use of PCMs

Eight studies were included in the SR, all evaluating the use of PCMs compared with no use of PCMs. PCMs

involved the contraction of the large muscles of the legs, arms, or abdomen and included leg or arm tensing, crossing, or squeezing; squatting; handgrip; and abdominal compression. Studies included 2 RCTs^{216,217} and 6 observational studies,^{216,218–222} enrolling a total of 246 participants between 15 and 75 years of age with a history of vasovagal or orthostatic-related syncope. Forms of PCMs evaluated included handgrip, squatting, leg crossing with tensing, and abdominal/core muscle tensing. Evidence from the Brignole et al²¹⁶ RCT was downgraded to very low certainty as a result of risk of bias, inconsistency, indirectness, and imprecision, whereas evidence from the Alizadeh et al²¹⁷ RCT was downgraded to low certainty as a result of risk of bias, inconsistency, and indirectness. The observational studies all provide very-low-certainty evidence.^{216,218–222} Table 17 gives a summary of studies.

Termination of Syncope. Use of handgrip PCMs in 19 participants with vasovagal syncope and a positive tilt-table test increased the likelihood of terminating syncope in 1 RCT.²¹⁶ However, no association was found between the termination of syncope and any form of PCM in 4 observational studies in laboratory settings with tilt-table testing.^{218–221} In 2 observational follow-up studies of 37 participants in settings of daily life,^{216,222} use of handgrip and arm-tensing PCMs was associated with termination of syncope in 99% of episodes involving subjects with known vasovagal origin presyncope. No adverse events or complications related to the use of handgrip PCMs were reported in any of these studies.

Alleviation of Symptoms of Presyncope. One RCT with 96 participants evaluated in daily life settings reported that the use of lower-body PCMs (squatting) or upper-body PCMs (handgrip) resulted in more alleviation of symptoms of presyncope than no PCMs.²¹⁷ A second smaller RCT²¹⁶ in a tilt-table test setting found more symptom improvement with the use of handgrip PCMs compared with no PCMs. One observational follow-up study²¹⁹ found symptom improvement in all 21 participants with syncope of vasovagal origin in association with the use of lower-body PCMs (squatting and abdominal tension).

Increase in Heart Rate and Blood Pressure. An increase in heart rate after the use of handgrip PCMs was reported in a single RCT,²¹⁶ although 4 observational studies^{218–221} did not report consistent changes in heart rate. The same single RCT²¹⁶ found improved systolic blood pressure with the use of handgrip PCMs, and 2 pooled observational studies^{219,220} reported increased systolic and diastolic blood pressures associated with the use of lower-body PCMs.

Subgroup Analysis. A subgroup weighted meta-analysis of 64 adults with vasovagal presyncope only

Table 17. Summary Data From Presyncope Studies

Outcomes	Intervention: Comparison	Participants (Studies), n	RR (95% CI)	Certainty of Evidence (GRADE)	Risk With Control/No PCM	Risk With Intervention (Risk Difference)
Prevention of syncope	Any PCM vs control (no use of PCM or standing only)	92 OH and VVS pathogenesis (4 observational) ²¹⁸⁻²²¹	1.31 (0.98–1.75)	Very low	594 per 1000	184 more per 1000 (12 fewer–445 more) Risk difference, 0.19 (0.01–0.37)
		64 VVS pathogenesis (3 observational) ²¹⁸⁻²²⁰	2.20 (0.96–5.05)	Very low	277 per 1000	222 more per 1000 (11 fewer–1000 more)
	Lower-body PCM vs control (no use of PCM or standing only)	36 VVS pathogenesis (1 observational) ²²⁰	2.20 (0.96–5.05)	Very low		333 more per 1000 (3–586 more)
	Upper-body PCM vs control (no use of PCM or standing only)	19 VVS pathogenesis (1 RCT) ²¹⁶	1.80 (1.16–2.79)	Very low	526 per 1000	421 more per 1000 (84 –942 more)
		14 VVS pathogenesis (1 observational) ²¹⁸	29.00 (1.90–443.25)	Very low		
		37 VVS pathogenesis (2 observational) ^{216,222}	99.4% of episodes (349/351) (RR not estimable, no comparisons)	Very low		
	Lower-body PCM vs upper-body PCM	27 VVS pathogenesis (1 observational) ²²¹	7.00 (1.10–44.61)	Very low		1000 more per 1000 (88–1000)
Injuries or adverse events	Upper-body PCM vs control (no use of PCM or standing only)	37 VVS pathogenesis (2 observational) ^{216,222}	0/37 (0%) (RR not estimable, no comparisons)	Very low		0 fewer per 1000 (0–0 fewer)
Symptom improvement	Any PCM vs control (no use of PCM or standing only)	21 VVS pathogenesis (1 observational) ²¹⁹	20/20 (RR not estimable; 1 patient lost to follow-up)	Very low		
		96 VVS pathogenesis (1 RCT) ²¹⁷	1.57 (0.98–2.51)	Very low	440 per 1000	251 more per 1000 (26–409 more)
	Lower-body PCM vs control (no use of PCM or standing only)	96 VVS pathogenesis (1 RCT) ²¹⁷	1.66 (1.02–2.69)	Very low		290 more per 1000 (9–744 more)
	Upper-body PCM vs control (no use of PCM or standing only)	19 VVS pathogenesis (1 RCT) ²¹⁶	6.00 (1.55–23.26)	Low		526 more per 1000 (58–1000 more)
		96 VVS pathogenesis, follow-up phase (1 RCT) ²¹⁷	1.47 (0.89–2.44)	Very low		207 more per 1000 (48 fewer–634 more)
	Lower-body PCM vs upper-body PCM	96 VVS pathogenesis (1 RCT) ²¹⁷	0.89 (0.65–1.22)	Very low		80 fewer per 1000 (30 fewer–130 more)
Heart rate	Upper-body vs control (no use of PCM or standing only)	19 VVS pathogenesis (1 RCT) ²¹⁶		Very low		MD, 8 bpm higher (6.4–22.4 higher)
	Lower-body PCM vs upper-body PCM	27 VVS pathogenesis, handgrip vs squatting (1 observational) ²²¹		Very low		MD, 0.8 bpm lower (5.5 lower–3.9 higher)
		27 VVS pathogenesis, leg crossing vs handgrip (1 observational) ²²¹		Very low		MD, 6.3 bpm higher (3.0–9.5 higher)
Systolic blood pressure	Any PCM vs control (no use of PCM or standing only)	39 VVS pathogenesis (2 observational) ^{219,220}		Very low		MD, 21 mmHg higher (18.25–23.41 higher)
	Lower-body PCM vs control (no use of PCM or standing only)	18 VVS pathogenesis (1 observational) ²²⁰		Very low		MD, 19 mmHg higher (16.31–21.69 higher)
	Upper-body PCM vs control (no use of PCM or standing only)	19 VVS pathogenesis (1 RCT) ²¹⁶		Low		MD, 32 mmHg higher (12.48–51.52 higher)

(Continued)

Table 17. Continued

Outcomes	Intervention: Comparison	Participants (Studies), n	RR (95% CI)	Certainty of Evidence (GRADE)	Risk With Control/No PCM	Risk With Intervention (Risk Difference)
Systolic blood pressure Continued	Lower-body PCM vs upper-body PCM	27 VVS pathogenesis, squatting vs handgrip (1 observational) ²²¹		Very low		MD, 12.5 mmHg higher (5.69–19.31 higher)
		27 VVS pathogenesis, leg crossing vs handgrip (1 observational) ²²¹		Very low		MD, 11.6 mmHg higher (4.3–18.8 higher)
	Lower-body PCM vs abdominal PCM	9 neurogenic OH pathogenesis (1 observational) ²²³		Very low		MD, 36.5 higher (15.00–57.99 higher)
	Lower-body PCM vs neck PCM	9 neurogenic OH pathogenesis (1 observational) ²²³		Very low		MD, 28.2 higher (10.79–45.61 higher)
Diastolic blood pressure	Any PCM vs control (no use of PCM or standing only)	39 VVS pathogenesis (2 observational) ^{219,220}		Very low		MD, 11 mmHg higher (9.39–13.10 higher)
	Lower-body PCM vs control (no use of PCM or standing only)	18 VVS pathogenesis (1 observational) ²²⁰		Very low		MD, 10 mmHg higher (8.04–11.96 higher)
	Upper-body PCM vs control (no use of PCM or standing only)	19 VVS pathogenesis (1 RCT) ²²¹		Very low		MD, 20 mmHg higher (5.95–34.05 higher)
	Lower-body PCM vs upper-body PCM	27 VVS pathogenesis (1 observational) ²²¹		Very low		MD, 3.3 mmHg higher (2.28 lower–8.88 higher)
		27 VVS pathogenesis (1 observational) ²²¹		Very low		MD, 1.3 mmHg higher (6.88 lower–4.28 mmHg higher)

GRADE indicates Grading of Recommendations, Assessment, Development, and Evaluation; MD, mean difference; OH, orthostatic hypotension; PCM, physical counterpressure maneuvers; RCT, randomized controlled trial; RR, relative risk; and VVS, vasovagal syncope.

from 3 observational studies^{219–221} failed to find an association between the use of PCMs and reduced likelihood of progression from presyncope to syncope but did show an association with a greater likelihood of symptom improvement and an increase in heart rate and blood pressure.

Upper-Body Compared With Lower-Body PCMs.

The use of upper-body PCMs compared with lower-body PCMs was evaluated by 1 observational study²²¹ that reported a greater likelihood for termination of syncope and increase in heart rate and blood pressure associated with the use of lower-body PCMs. Results from 1 RCT²¹⁷ did not find greater improvement in symptoms of presyncope with the use of lower-body PCMs compared with upper-body PCMs.

Additional Interventions for Presyncope. No studies were identified that evaluated the use of other interventions such as hydration or change of position applied at the onset of symptoms of presyncope.

Treatment Recommendations

We recommend the use of any type of PCM by individuals with acute symptoms of presyncope from vasovagal or orthostatic causes in the first aid setting (strong recommendation, low and very low certainty of evidence).

We suggest that lower-body PCMs such as leg crossing and tensing or squatting are preferable to upper-body and abdominal PCMs (weak recommendation, very low certainty of evidence).

Justification and Evidence to Decision Framework Highlights

Despite the mixed results and low- or very-low-certainty evidence identified in this review, using the Evidence to Decision Framework²¹⁵ and discussing all evidence, the First Aid Task Force concluded that the use of PCMs for acute symptoms of presyncope warranted a strong recommendation because, together, the included studies suggest that the use of PCMs results in better outcomes with no reported adverse events. In addition, PCM interventions are simple and inexpensive, and they may prevent the progression from

presyncope to syncope and risks of subsequent injury. Successful treatment of presyncope may improve the QOL for those with recurrent vasovagal or orthostatic syncope, and it may ultimately decrease associated healthcare costs. Included studies demonstrated that training of participants in the use of PCMs at symptom onset was feasible and similar to a first aid situation, making it likely that first aid providers can also be trained in their use.

Although there is little evidence comparing different methods of PCMs, observational studies suggested that the use of lower-body PCMs may have an advantage over upper-body PCMs for the outcome of terminating presyncope. Despite this, the task force recognizes the practicality of the use of a variety of PCM techniques for first aid, particularly when PCM interventions may be limited by patient location and position.

Knowledge Gaps

The task force identified several knowledge gaps requiring further investigation:

- Validity of conventional first aid recommendation to place a person with symptoms of presyncope into a sitting or supine position with or without a combination of PCMs
- Effectiveness of additional interventions such as hydration
- Clinical outcomes related to the use of PCMs and possible variation based on age, sex, and cause of presyncope
- Ability of first aid providers to recognize vasovagal and orthostatic presyncope and to assess clinical outcomes after instruction in and use of PCMs

ARTICLE INFORMATION

The devices listed here serve only to illustrate examples of these types of devices. This is not intended to be an endorsement of any commercial product, process, service, or enterprise by the American Heart Association.

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This document was approved by the American Heart Association Science Advisory and Coordinating Committee on July 19, 2019, and the American Heart Association Executive Committee on August 9, 2019. A copy of the document is available at <https://professional.heart.org/statements> by using either "Search for Guidelines & Statements" or the "Browse by Topic" area. To purchase additional reprints, call 843-216-2533 or e-mail kelle.ramsay@wolterskluwer.com.

The American Heart Association requests that this document be cited as follows: Soar J, Maconochie I, Wyckoff MH, Olasveengen TM, Singletary EM, Greif R, Aickin R, Bhanji F, Donnino MW, Mancini ME, et al. 2019 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations: summary from the Basic Life

Support; Advanced Life Support; Pediatric Life Support; Neonatal Life Support; Education, Implementation, and Teams; and First Aid Task Forces. *Circulation*. 2019;140:e826–e880. doi: 10.1161/CIR.0000000000000734.

This article has been copublished in *Resuscitation*.

The expert peer review of AHA-commissioned documents (eg, scientific statements, clinical practice guidelines, systematic reviews) is conducted by the AHA Office of Science Operations. For more on AHA statements and guidelines development, visit <https://professional.heart.org/statements>. Select the "Guidelines & Statements" drop-down menu, then click "Publication Development."

Permissions: Multiple copies, modification, alteration, enhancement, and/or distribution of this document are not permitted without the express permission of the American Heart Association. Instructions for obtaining permission are located at <https://www.heart.org/permissions>. A link to the "Copyright Permissions Request Form" appears in the second paragraph (<https://www.heart.org/en/about-us/statements-and-policies/copyright-request-form>).

Authors

Jasmeet Soar, MA, MB, BChir, FRCA, FFICM, FRCP; Ian Maconochie, FRCPCH, FRCEM, FRCP, PhD; Myra H. Wyckoff, MD; Theresa M. Olasveengen, MD, PhD; Eunice M. Singletary, MD; Robert Greif, MD, MME; Richard Aickin, BMedSc, MBChB; Farhan Bhanji, MD, MSc, FRCP, FAHA; Michael W. Donnino, MD; Mary E. Mancini, RN, PhD, FAHA; Jonathan P. Wyllie, MBChB, BSc, FERC; David Zideman, LVO, MBBS; Lars W. Andersen, MD, MPH, PhD, DMSc; Dianne L. Atkins, MD, FAHA; Khalid Aziz, MA, MEd, FRCP; Jason Bendall, MBBS, MM, PhD; Katherine M. Berg, MD; David C. Berry, PhD, MHA, AT, ATC; Blair L. Bigham, MD, MSc, ACP; Robert Bingham, MD, BS, FRCA; Thomaz Bittencourt Couto, MD, PhD; Bernd W. Böttiger, MD, ML, DEAA, FESC, FERC, FAHA; Vere Borra, PhD; Janet E. Bray, RN, PhD, FAHA; Jan Breckwoldt, MD, MME; Steven C. Brooks, MD, MHSc, FRCP; Jason Buick, MSc, ACP; Clifton W. Callaway, MD, PhD, FAHA; Justin N. Carlson, MD, MS; Pascal Cassan, MD; Maaret Castrén, MD, PhD, FERC; Wei-Tien Chang, MD, PhD; Nathan P. Charlton, MD; Adam Cheng, MD; Sung Phil Chung, MD, PhD; Julie Considine, RN, PhD; Keith Couper, RN, PhD; Katie N. Dainty, PhD; Jennifer Anne Dawson, RN, PhD; Maria Fernanda de Almeida, MD, PhD; Allan R. de Caen, MD; Charles D. Deakin, MD, FRCA, FERC; Ian R. Drennan, ACP, BScHK, PhD; Jonathan P. Duff, MD, FRCP, MEd; Jonathan L. Epstein, MEMS, NRP; Raffo Escalante, MD; Raúl J. Gazmuri, MD, PhD, FCCM; Elaine Gilfoyle, MD, MMed, FRCP; Asger Granfeldt, MD, PhD, DMSc; Anne-Marie Guerguerian, MD, PhD, FAHA, FRCP; Ruth Guinsburg, MD, PhD; Tetsuo Hatanaka, MD, PhD; Mathias J. Holmberg, MD, MPH; Natalie Hood, MD, MBBS, FACEM; Shigeharu Hosono, MD, PhD; Ming-Ju Hsieh, MD, MSc, PhD; Tetsuya Isayama, MD, MSc, PhD; Taku Iwami, MD, PhD; Jan L. Jensen, ACP, MAHSR; Vishal Kapadia, MD, MSc; Han-Suk Kim, MD, PhD; Monica E. Kleinman, MD; Peter J. Kudenchuk, MD, FAHA; Eddy Lang, MD; Eric Lavonas, MD, MS; Helen Liley, MBChB, FRACP; Swee Han Lim, MBBS, FRCP, FRCPed; Andrew Lockey, MB, ChB, MMedEd; Bo Lofgren, MD, PhD, FAHA; Matthew Huei-Ming Ma, MD, PhD; David Markenson, MD, MBA; Peter A. Meaney, MD, MPH; Daniel Meyran, MD; Lindsay Mildenhall, MBChB; Koenraad G. Monsieurs, MD, PhD, FAHA, FERC; William Montgomery, MD, FAHA; Peter T. Morley, MBBS, FAHA; Laurie J. Morrison, MD, MSc, FRCP; Vinay M. Nadkarni, MD, FAHA; Kevin Nation, NZRN; Robert W. Neumar, MD, PhD, FAHA; Kee-Chong Ng, MD, MBBS, MMed, FRCP; Tonia Nicholson, MBBS, BScPsych, FRCP, FACEM; Nikolaos Nikolaou, MD; Chika Nishiyama, RN, DrPH; Gabrielle Nuthall, MBChB, FRACP, FCICM; Shinichiro Ohshimo, MD, PhD; Deems Okamoto, MD; Brian O'Neil, MD, FACEP, FAHA; Gene Yong-Kwang Ong, MBBS, MRCP; Edison F. Paiva, MD, PhD; Michael Parr, MB, BS, FRCP, FRCA, FANZCA, FCICM; Jeffrey L. Pellegrino, PhD, MPH; Gavin D. Perkins, MD, FERC, FRCP, FFICM; Jeffrey Perlman, MB ChB; Yacov Rabi, MD, FRCP; Amelia Reis, MD, PhD; Joshua C. Reynolds, MD, MS; Giuseppe Ristagno, MD, PhD; Charles C. Roehr, MD, PhD; Tetsuya Sakamoto, MD, PhD; Claudio Sandroni, MD; Stephen M. Schexnayder, MD; Barnaby R. Scholefield, MBBS, MRCP, PhD; Naoki Shimizu, MD, PhD; Markus B. Skrifvars, MD, PhD; Michael A. Smyth, MSc, PhD; David Stanton, CCA; Janel Swain, BSc, BEd, ACP; Edgardo Szlyd, MD, MSc; Janice Tijssen, MD, MSc, FRCP; Andrew Travers, MD, MSc, FRCP; Daniele Trevisanuto, MD; Christian Vaillancourt, MD, MSc; Patrick Van de Voorde, MD, PhD; Sithembiso Velaphi, MBChB, FC Paed, PhD; Tzong-Luen Wang, MD, PhD, JM, FESC, FACC, FCAPSC; Gary Weiner, MD; Michelle Welsford, BSc, MD, FRCP; Jeff A. Woodin, NRP, FAHA; Joyce Yeung, MBChB, PhD; Jerry P. Nolan, FRCA, FRCP, FFICM, FRCEM; Mary Fran Hazinski, RN, MSN, FAHA

Disclosures

Writing Group Disclosures

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Jasmeet Soar	Southmead Hospital North Bristol NHS Trust (United Kingdom)	None	None	None	None	None	None	None
Richard Aickin	Starship Children's Hospital (New Zealand)	None	None	None	None	None	None	None
Lars W. Andersen	Aarhus University (Denmark)	Amomed Pharma GmbH (PI on a clinical trial involving vasopressin and methylprednisolone. The trial is funded by government. Vasopressin is provided free of charge by Amomed Pharma GmbH, which provides no funding and has no role in the trial.)*	None	None	None	None	None	None
Dianne L. Atkins	University of Iowa	None	None	None	None	None	None	None
Khalid Aziz	University of Alberta (Canada)	Canadian Institutes of Health Research (Parent-EPIQ quality improvement research†; family-integrated care 18-mo follow-up)†; Alberta Children's Hospital Research Institute (family-integrated care 6-mo follow-up)†	None	None	CMPA*	None	None	University of Alberta (professor)†
Jason Bendall	University of Newcastle School of Medicine & Public Health (Australia)	None	None	None	None	None	None	None
Katherine M. Berg	Beth Israel Deaconess Medical Center	NIH*	None	None	None	None	None	None
David C. Berry	Saginaw Valley State University	None	None	None	None	None	None	None
Farhan Bhanji	McGill University (Canada)	None	None	None	None	None	None	None
Blair L. Bigham	McMaster University (Canada)	None	None	None	None	None	None	None
Robert Bingham	Great Ormond Street Hospital NHS Foundation Trust (United Kingdom)	None	None	None	None	None	None	None
Vere Borra	Belgian Red Cross Centre for Evidence-Based Practice (Belgium)	None	None	None	None	None	None	Belgian Red Cross (researcher; unpaid)*
Bernd W. Böttiger	University of Cologne (Germany)	None	None	Bayer Vital GmbH*; Baxalta Deutschland GmbH*; Boehringer Ingelheim Pharma GmbH & Co KG*; ZOLL Medical Deutschland GmbH*; Forum für medizinische Fortbildung (FoMF)*; C.R. Bard GmbH*; GS Elektromedizinische Geräte G. Stemple GmbH*; Novartis Pharma GmbH*; Phillips GmbH Market DACH*	None	None	None	None

(Continued)

Downloaded from <http://ahajournals.org> by on May 25, 2022

Writing Group Disclosures Continued

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Janet E. Bray	Monash University (Australia)	None	None	None	None	None	None	None
Jan Breckwoldt	University Hospital of Zurich Institute for Anesthesiology (Switzerland)	None	None	None	None	None	None	None
Steven C. Brooks	Queen's University (Canada)	Canadian Institutes of Health Research (peer-reviewed grant to study the PulsePoint mobile device application in a randomized trial)†	None	None	Borden Ladner Gervais†	None	None	None
Jason Buick	University of Toronto Institute of Health Policy, Management and Evaluation (Canada)	None	None	None	None	None	None	None
Clifton W. Callaway	University of Pittsburgh	NIH (grants to university)†	None	None	None	None	None	None
Jestin N. Carlson	Allegheny Health Network	American Heart Association (funds for intubation research)†	None	None	None	None	AHA†	None
Pascal Cassan	Emergency physician (private practice); International Federation of Red Cross and Red Crescent National Societies	None	None	None	None	None	None	None
Maaret Castrén	Helsinki University Hospital (Finland)	None	None	None	None	None	None	None
Wei-Tien Chang	National Taiwan University Hospital and College of Medicine (Taiwan)	None	None	None	None	None	None	None
Nathan P. Charlton	University of Virginia	None	None	None	None	None	None	None
Adam Cheng	Alberta Children's Hospital (Canada)	None	None	None	None	None	None	University of Calgary (professor)†
Sung Phil Chung	Yonsei University College of Medicine (Republic of Korea)	None	None	None	None	None	None	None
Julie Considine	Deakin University School of Nursing & Midwifery (Australia)	None	None	None	None	None	Helsinki University Hospitals†	Deakin University-Eastern Health (professor of nursing)†; College of Emergency Nursing Australasia (senior editor)*
Keith Couper	University of Warwick, Warwick Medical School (United Kingdom)	None	None	None	None	None	None	None
Thomaz Bittencourt Couto	Hospital Israelita Albert Einstein and Universidade de São Paulo (Brazil)	None	None	None	None	None	None	None
Katie N. Dainty	North York General Hospital	Canadian Institutes of Health Research (resuscitation grants from CIHR)*	None	None	None	None	None	None

(Continued)

Writing Group Disclosures Continued

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Jennifer Anne Dawson	The Royal Women's Hospital Newborn Research Centre (Australia)	None	None	None	None	None	None	None
Maria Fernanda de Almeida	Universidade Federal de Sao Paulo (Brazil)	None	None	None	None	None	None	None
Allan R. de Caen	University of Alberta (Canada)	None	None	None	None	None	None	None
Charles D. Deakin	NIHR, University Hospital Southampton (United Kingdom)	None	None	None	None	None	None	None
Michael W. Donnino	Beth Israel Deaconess Medical Center	Kaneka (investigator-initiated study with CoQ10)*; GE (investigator-initiated study with VO ₂)*	None	None	None	None	None	None
Ian R. Drennan	St. Michael's Hospital Rescu, Li Ka Shing Knowledge Institute (Canada)	None	None	None	None	None	None	None
Jonathan P. Duff	University of Alberta and Stollery Children's Hospital	None	None	None	None	None	None	None
Jonathan L. Epstein	American Red Cross	None	None	None	None	None	None	None
Raffo Escalante	Inter-American Heart Foundation (Peru)	None	None	None	None	None	None	None
Raúl J. Gazmuri	Rosalind Franklin University of Medicine and Science Resuscitation Institute	DoD (sustained V1A receptor activation for prolonged hemodynamic support and neurological protection after noncompressible hemorrhage and traumatic brain injury)†; VA Merit Review (cyclophilin D: a regulator of mitochondrial oxidative phosphorylation)†; Zoll Foundation (myocardial effects of shock burden during defibrillation attempts)†	None	None	None	None	None	None
Elaine Gilfoyle	Alberta Children's Hospital (Canada)	Zoll Corp (in-kind donation of equipment (defibrillator with CPR feedback) for research project)*	None	None	None	None	None	None
Asger Granfeldt	Aarhus University Hospital (Denmark)	None	None	None	None	None	None	None
Robert Greif	Bern University Hospital, and University of Bern (Switzerland)	Department of Anesthesia, Bern University Hospital (departmental research grant)*; Storz Co*	European Resuscitation Council (board director of education and training)*; ILCOR (task force chair Education, Implementation, Team)*	None	None	None	None	Bern University Hospital (professor of anesthesiology)†; University of Bern (vice chair of Cantonal Ethic Committee Bern)*
Anne-Marie Guerguerian	The Hospital for Sick Children (Canada)	None	None	None	None	None	None	None

(Continued)

Writing Group Disclosures Continued

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Ruth Guinsburg	Federal University of Sao Paulo (Brazil)	None	None	None	None	None	None	None
Tetsuo Hatanaka	Emergency Life Saving Technique Academy (Japan)	None	None	None	None	None	None	None
Mary Fran Hazinski	Vanderbilt University School of Nursing	None	None	None	None	None	AHA Emergency Cardiovascular Care Program†	None
Mathias J. Holmberg	Aarhus University (Denmark)	None	None	None	None	None	None	None
Natalie Hood	Monash Medical Centre (Australia)	None	None	None	None	None	None	None
Shigeharu Hosono	Jichi Medical University, Saitama Medical Center (Japan)	None	None	None	None	None	None	None
Ming-Ju Hsieh	National Taiwan University Hospital (Taiwan)	None	None	None	None	None	None	None
Tetsuya Isayama	National Center for Child Health and Development (Japan)	Nihon-Kohden Corp (member of research project led by researcher at Nihon-Kohden. The topic of the research is an application of a respiratory monitoring device in neonatal resuscitation that has been developed by Nihon-Kohden.)*	None	None	None	None	None	None
Taku Iwami	Kyoto University Health Service (Japan)	Grants-in-aid for scientific research, KAKENHI Scientific Research (Japanese national research grant)†; Zoll Medical Corp (donation to enhance studies for out-of-hospital cardiac arrests)†; Hamamatsu Photonics (joint research grant)†	None	None	None	None	None	None
Jan L. Jensen	Emergency Health Services, Dalhousie University (Canada)	None	None	None	None	None	None	None
Vishal Kapadia	UT Southwestern	None	None	None	None	None	None	None
Han-Suk Kim	Seoul National University College of Medicine (Republic of Korea)	None	None	None	None	None	None	None
Monica E. Kleinman	Boston Children's Hospital	None	None	None	2018–2019 defense, pediatric critical care*	None	Up-to-Date*	Boston Children's Hospital (medical director ICU)†
Peter J. Kudenchuk	University of Washington Medical Center	NIH/NINDS (PI at the University of Washington for the NIH/NINDS-supported SIREN Network)†	None	None	None	None	None	None
Eddy Lang	University of Calgary (Canada)	None	None	None	None	None	None	None
Eric Lavonas	Denver Health	None	None	None	None	None	None	None
Helen Liley	Mater Mothers' Hospital (Australia)	None	None	None	None	None	None	None

(Continued)

Writing Group Disclosures Continued

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Swee Han Lim	Singapore General Hospital (Singapore)	None	None	None	None	None	None	None
Andrew Lockey	European Resuscitation Council (United Kingdom)	None	None	None	None	None	None	None
Bo Lofgren	Aarhus University Hospital Institute of Clinical Medicine (Denmark)	None	None	None	None	None	None	None
Matthew Huei-Ming Ma	National Taiwan University Hospital (Taiwan)	None	None	None	None	None	None	None
Ian Maconochie	Imperial College Healthcare Trust (United Kingdom)	None	None	None	None	None	None	None
Mary E. Mancini	University of Texas at Arlington College of Nursing and Health Innovation	None	None	Stryker*	None	None	None	None
David Markenson	Sky Ridge Medical Center	None	American Red Cross (chair, SAC and CMO Training Services)†	None	None	None	American Red Cross†	None
Peter A. Meaney	Stanford University School of Medicine	None	None	None	None	None	None	None
Daniel Meyran	French Red Cross (France)	None	None	None	None	None	None	None
Lindsay Mildenhall	Middlemore Hospital (New Zealand)	None	None	None	None	None	None	None
Koenraad G. Monsieurs	Antwerp University Hospital (Belgium)	None	None	None	None	None	None	None
William Montgomery	Straub Clinic and Hospital	None	None	None	None	None	None	None
Peter T. Morley	University of Melbourne Clinical School, Royal Melbourne Hospital (Australia)	None	None	None	None	None	None	None
Laurie J. Morrison	Rescu Li Ka Shing Knowledge Institute (Canada)	The Canadian Institutes of Health Research (CIHR)†	None	None	None	None	None	None
Vinay M. Nadkarni	Children's Hospital Philadelphia	NIH (research grant: cardiac arrest)*; Zoll Medical (unrestricted research grant: quality of CPR)*; American Heart Association (research grant: quality of CPR)*; Nihon-Kohden (research grant to his institution)*	None	None	None	None	None	None
Kevin Nation	New Zealand Resuscitation Council (New Zealand)	None	None	None	None	None	None	None
Robert W. Neumar	University of Michigan	NIH (R34 HL130738†, R44 HL091606*, R01 HL133129†, K12 HL133304*); PhysioControl (equipment support for laboratory and clinical research)*	None	None	None	None	None	None

(Continued)

Writing Group Disclosures Continued

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Kee-Chong Ng	KK Hospital (Singapore)	None	None	None	None	None	None	None
Tonia Nicholson	Waikato Hospital (New Zealand)	None	None	None	None	None	None	None
Nikolaos Nikolaou	Konstantopouleio General Hospital (Greece)	None	None	None	None	None	None	None
Chika Nishiyama	Kyoto University (Japan)	None	None	None	None	None	None	None
Jerry P. Nolan	Warwick Medical School, University of Warwick, Anaesthesia Royal United Hospital (United Kingdom)	NIHR grants for PARAMEDIC-2 and AIRWAYS-2 trials*	None	None	None	None	None	None
Gabrielle Nuthall	Starship Children's Hospital (New Zealand)	None	None	None	None	None	None	None
Shinichiro Ohshimo	The JAPAN Foundation for Aging and Health (no significant conflict of interest with the manuscript)*	None	None	None	None	None	None	None
Deems Okamoto	Self-employed	None	None	None	None	None	None	None
Theresa M. Olasveengen	Oslo University Hospital (Norway)	Zoll Foundation*; Laerdal Foundation* (unrestricted grants for research project)	None	None	None	None	None	None
Brian O'Neil	Wayne State University	Zoll Circulation (study PI)*; SIREN Network (hub PI)*	None	Zoll Circulation*; Bard Corp*	None	None	None	None
Gene Yong-Kwang Ong	KK Women's and Children's Hospital (Singapore)	None	None	None	None	None	None	None
Edison F. Paiva	Hospital das Clinicas (Brazil)	None	None	None	None	None	None	None
Michael Parr	Liverpool Hospital (Australia)	None	None	None	None	None	None	None
Jeffrey L. Pellegrino	Aultman College of Nursing & Health Sciences	American Red Cross (research in first aid educational development)*	American Red Cross (volunteer member of Science Advisory Council)*	None	None	None	International Red Cross (unpaid)*	None
Gavin D. Perkins	Warwick Medical School and Heart of England NHS Foundation Trust (United Kingdom)	None	National Institute for Health Research (grant to evaluate effectiveness of adrenaline for out-of-hospital cardiac arrest)t	None	None	None	None	None
Jeffrey Perlman	Weill Cornell Medical College	None	None	None	None	None	None	None
Yacov Rabi	University of Calgary, Foothills Medical Center (Canada)	None	None	None	None	Masimo Corp*	None	None
Amelia Reis	Inter-American Heart Foundation (Brazil)	None	None	None	None	None	None	None
Joshua C. Reynolds	Michigan State University College of Human Medicine	None	None	None	None	None	None	None

(Continued)

Writing Group Disclosures Continued

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Giuseppe Ristagno	Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milan, University of Milan (Italy)	None	None	None	None	None	None	None
Charles C. Roehr	University of Oxford, John Radcliffe Hospital, Oxford University Hospitals (United Kingdom)	NIHR/HTA Project 15/188/106, NeoCLEAR; Health Technology Assessment Grant by NIHR (UK): competitive, peer-reviewed governmental grant scheme (as chief investigator of a UK national RCT study on the efficacy and safety of a novel way to perform neonatal lumbar punctures [nonpharmaceutical or other] trial, received a fraction of his salary through this national, peer-reviewed grant)*	None	Received small honoraria for speaking at university and industry-initiated symposia by Chiesi Farmaceutici (Italy) and Abbvie (UK)*	None	None	Chair of Data Monitoring Board for a pharmaceutical study investigating nebulized surfactant (after stabilization, not as a medication/route used for resuscitation of preterm infants)*	NIHR/HTA project 15/188/106, NeoCLEAR; Health Technology Assessment Grant by NIHR (UK): competitive, peer-reviewed governmental grant scheme (as chief investigator of a UK national RCT study on the efficacy and safety of a novel way to perform neonatal lumbar punctures [nonpharmaceutical or other] trial; received a fraction of his salary through this national, peer-reviewed grant)*
Tetsuya Sakamoto	Teikyo University School of Medicine (Japan)	Japan MHLW*	None	None	None	None	None	None
Claudio Sandroni	Università Cattolica del Sacro Cuore, Policlinico Gemelli (Italy)	None	None	None	None	None	None	None
Stephen M. Schexnayder	University of Arkansas/Arkansas Children's Hospital	None	None	None	None	None	None	None
Barnaby R. Scholefield	University of Birmingham Institute of Inflammation and Ageing (United Kingdom)	NIHR grant funding (awarded academic NIHR Clinician Scientist Fellowship by the National Institute of Health Research [NHS, UK])†	None	None	None	None	None	NIHR Clinician Scientist Fellowship (clinician scientist [academic, non-commercial])†
Naoki Shimizu	St. Marianne University School of Medicine (Japan)	None	None	None	None	None	None	None
Eunice M. Singletary	University of Virginia	None	None	None	None	None	None	None
Markus B. Skrifvars	Helsinki University Hospital and University of Helsinki (Finland)	Several unrestricted research grants in the field of postarrest care†; GE Healthcare (research grant for project performed 2015–2017)*	None	BARD*; Covidien (INVOS)*	None	None	None	None
Michael A. Smyth	University of Warwick (United Kingdom)	None	None	None	None	None	None	None
David Stanton	Resuscitation Council of Southern Africa (South Africa)	None	None	None	None	None	None	None
Janel Swain	Emergency Health Services Nova Scotia (Canada)	None	None	None	None	None	None	None

(Continued)

Writing Group Disclosures Continued

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Edgardo Szyld	University of Oklahoma	None	None	None	None	None	None	None
Janice Tijssen	London Health Sciences Center (Canada)	MedEvac Foundation (for transport research)*	None	None	None	None	None	None
Andrew Travers	Emergency Health Services, Nova Scotia (Canada)	None	None	None	None	None	None	None
Daniele Trevisanuto	University of Padova (Italy)	None	None	None	None	None	None	None
Christian Vaillancourt	University of Ottawa, Ottawa Hospital Research Institute (Canada)	Heart and Stroke Foundation of Canada (grant funding for dispatch-assisted CPR interventions)†	University of Ottawa (chair of Emergency Cardiac Resuscitation [salary support])†	None	None	None	None	None
Patrick van de Voorde	NA	None	None	None	None	None	None	None
Sithembiso Velaphi	Resuscitation Council of Southern Africa (South Africa)	None	None	None	None	None	None	None
Tzong-Luen Wang	Chang Bing Show Chwang Memorial Hospital (Taiwan)	None	None	None	None	None	None	None
Gary Weiner	University of Michigan	None	None	None	None	None	None	None
Michelle Welsford	Centre for Paramedic Education and Research, Hamilton Health Sciences Centre (Canada)	None	None	None	None	None	None	None
Jeff A. Woodin	Tualatin Valley Fire & Rescue Operations	None	None	None	None	None	None	None
Myra H. Wyckoff	UT Southwestern	None	None	None	None	None	None	None
Jonathan P. Wyllie	James Cook University Hospital (United Kingdom)	NIHR (BABY OSCAR ISRCTN is: 84264977)†	None	None	NHS case reviews*	None	None	None
Joyce Yeung	University of Warwick, Warwick Medical School (United Kingdom)	None	None	None	None	None	None	None
David Zideman	Thames Valley Air Ambulance (United Kingdom)	None	None	None	None	None	None	None

This table represents the relationships of writing group members that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit. A relationship is considered to be "significant" if (a) the person receives \$10000 or more during any 12-month period, or 5% or more of the person's gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns \$10000 or more of the fair market value of the entity. A relationship is considered to be "modest" if it is less than "significant" under the preceding definition.

*Modest.

†Significant.

Reviewer Disclosures

Reviewer	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Jonathan Bengler	University of the West of England, Bristol (United Kingdom)	National Institute for Health research grant (chief investigator for randomized trial considered in this review (AIRWAYS-2)†	None	None	None	None	None	None
John J.M. Black	South Central Ambulance Service (United Kingdom)	None	None	None	None	None	None	None
Alain Cariou	Cochin University Hospital (APHP) and Paris Descartes University (France)	None	None	Bard*	None	None	None	None
Robin Davies	Heart of England NHS Foundation Trust (United Kingdom)	None	None	None	None	None	None	None
Mohamud Daya	Oregon Health & Science University	None	None	None	None	None	None	None
Judith Finn	Curtin University (Australia)	NHMRC (director of the Australian Resuscitation Outcomes Consortium [Aus-ROC], an NHMRC Centre of Research Excellence)*	None	None	None	None	None	None

This table represents the relationships of reviewers that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all reviewers are required to complete and submit. A relationship is considered to be "significant" if (a) the person receives \$10 000 or more during any 12-month period, or 5% or more of the person's gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns \$10 000 or more of the fair market value of the entity. A relationship is considered to be "modest" if it is less than "significant" under the preceding definition.

*Modest.

†Significant.

REFERENCES

- International Liaison Committee on Resuscitation (ILCOR). Consensus on Science With Treatment Recommendations (CoSTR). <https://costr.ilcor.org/document>. Accessed May 22, 2019.
- Guyatt G, Oxman AD, Akl EA, Kunz R, Vist G, Brozek J, Norris S, Falck-Ytter Y, Glasziou P, DeBeer H, et al. GRADE guidelines, 1: introduction: GRADE evidence profiles and summary of findings tables. *J Clin Epidemiol*. 2011;64:383–394. doi: 10.1016/j.jclinepi.2010.04.026
- Nikolaou N, Dainty KN, Couper K, Morley P, Tijssen J, Vaillancourt C; on behalf of the International Liaison Committee on Resuscitation's (ILCOR) Basic Life Support and Pediatric Task Forces. A systematic review and meta-analysis of the effect of dispatcher-assisted CPR on outcomes from sudden cardiac arrest in adults and children. *Resuscitation*. 2019;138:82–105. doi: 10.1016/j.resuscitation.2019.02.035
- Granfeldt A, Avis SR, Nicholson TC, Holmberg MJ, Moskowitz A, Coker A, Berg KM, Parr MJ, Donnino MW, Soar J, et al; on behalf of the International Liaison Committee on Resuscitation Advanced Life Support Task Force Collaborators. Advanced airway management during adult cardiac arrest: a systematic review. *Resuscitation*. 2019;139:133–143. doi: 10.1016/j.resuscitation.2019.04.003
- Holmberg MJ, Issa MS, Moskowitz A, Morley P, Welsford M, Neumar RW, Paiva EF, Coker A, Hansen CK, Andersen LW, et al; on behalf of the International Liaison Committee on Resuscitation Advanced Life Support Task Force Collaborators. Vasopressors during adult cardiac arrest: a systematic review and meta-analysis. *Resuscitation*. 2019;139:106–121. doi: 10.1016/j.resuscitation.2019.04.008
- Holmberg MJ, Geri G, Wiberg S, Guerguerian AM, Donnino MW, Nolan JP, Deakin CD, Andersen LW; on behalf of the International Liaison Committee on Resuscitation's (ILCOR) Advanced Life Support and Pediatric Task Forces. Extracorporeal cardiopulmonary resuscitation for cardiac arrest: a systematic review. *Resuscitation*. 2018;131:91–100. doi: 10.1016/j.resuscitation.2018.07.029
- Lavonas EJ, Ohshimo S, Nation K, Van de Voorde P, Nuthall G, Maconochie I, Torabi N, Morrison LJ; on behalf of the International Liaison Committee on Resuscitation (ILCOR) Pediatric Life Support Task Force. Advanced airway interventions for paediatric cardiac arrest: a systematic review and meta-analysis. *Resuscitation*. 2019;138:114–128. doi: 10.1016/j.resuscitation.2019.02.040
- Buick JE, Wallner C, Aickin R, Meaney PA, de Caen A, Maconochie I, Skrifvars MB, Welsford M; on behalf of the International Liaison Committee on Resuscitation Pediatric Life Support Task Force. Paediatric targeted temperature management post cardiac arrest: a systematic review and meta-analysis. *Resuscitation*. 2019;139:65–75. doi: 10.1016/j.resuscitation.2019.03.038
- Welsford M, Nishiyama C, Shortt C, Isayama T, Dawson JA, Weiner G, Roehr CC, Wyckoff MH, Rabi Y; on behalf of the International Liaison Committee on Resuscitation Neonatal Life Support Task Force. Room air for initiating term newborn resuscitation: a systematic review with meta-analysis. *Pediatrics*. 2019;143. doi: 10.1542/peds.2018-1825
- Welsford M, Nishiyama C, Shortt C, Weiner G, Roehr CC, Isayama T, Dawson JA, Wyckoff MH, Rabi Y; on behalf of the International Liaison Committee on Resuscitation Neonatal Life Support Task Force. Initial oxygen use for preterm newborn resuscitation: a systematic review with meta-analysis. *Pediatrics*. 2019;143:e20181828. doi: 10.1542/peds.2018-1828
- Yeung J, Matsuyama T, Bray J, Reynolds J, Skrifvars MB. Does care at a cardiac arrest centre improve outcome after out-of-hospital cardiac arrest? A systematic review. *Resuscitation*. 2019;137:102–115. doi: 10.1016/j.resuscitation.2019.02.006
- Jensen JL, Ohshimo S, Cassan P, Meyran D, Greene J, Ng KG, Singletary E, Zideman D. Immediate interventions for presyncope of vasovagal or orthostatic origin: a systematic review. *Prehosp Emerg Care*. 2019;1–63. doi: 10.1080/10903127.2019.1605431
- Perkins GD, Travers AH, Berg RA, Castren M, Considine J, Escalante R, Gazmuri RJ, Koster RW, Lim SH, Nation KJ, et al; on behalf of the Basic Life Support Chapter Collaborators. Part 3: adult basic life support and automated external defibrillation: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations. *Resuscitation*. 2015;95:e43–e69. doi: 10.1016/j.resuscitation.2015.07.041
- Travers AH, Perkins GD, Berg RA, Castren M, Considine J, Escalante R, Gazmuri RJ, Koster RW, Lim SH, Nation KJ, et al; on behalf of the Basic

Life Support Chapter Collaborators. Part 3: adult basic life support and automated external defibrillation: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2015;132(suppl 1):S51–S83. doi: 10.1161/CIR.0000000000000272

15. Olasveengen TM, Mancini ME, Vaillancourt C, Brooks SC, Castren M, Chung SP, Couper K, Dainty KN, Escalante R, Gazmuri RJ, et al. Emergency care: dispatcher instruction in CPR for adults: Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) Basic Life Support Task Force. February 25, 2019. <https://costr.ilcor.org/document/emergency-care-dispatcher-instruction-in-cpr>. Accessed May 22, 2019.
16. US National Library of Medicine. ClinicalTrials.gov database. <https://www.clinicaltrials.gov>. Accessed April 10, 2019.
17. Culley LL, Clark JJ, Eisenberg MS, Larsen MP. Dispatcher-assisted telephone CPR: common delays and time standards for delivery. *Ann Emerg Med*. 1991;20:362–366. doi: 10.1016/s0196-0644(05)81655-5
18. Song KJ, Shin SD, Park CB, Kim JY, Kim DK, Kim CH, Ha SY, Eng Hock Ong M, Bobrow BJ, McNally B. Dispatcher-assisted bystander cardiopulmonary resuscitation in a metropolitan city: a before-after population-based study. *Resuscitation*. 2014;85:34–41. doi: 10.1016/j.resuscitation.2013.06.004
19. Stipulante S, Tubes R, El Fassi M, Donneau AF, Van Troyen B, Hartstein G, D'Orio V, Ghuyssen A. Implementation of the ALERT algorithm, a new dispatcher-assisted telephone cardiopulmonary resuscitation protocol, in non-Advanced Medical Priority Dispatch System (AMPDS) emergency medical services centres. *Resuscitation*. 2014;85:177–181. doi: 10.1016/j.resuscitation.2013.10.005
20. Vaillancourt C, Verma A, Trickett J, Crete D, Beaudoin T, Nesbitt L, Wells GA, Stiell IG. Evaluating the effectiveness of dispatch-assisted cardiopulmonary resuscitation instructions. *Acad Emerg Med*. 2007;14:877–883. doi: 10.1197/j.aem.2007.06.021
21. Harjanto S, Na MX, Hao Y, Ng YY, Doctor N, Goh ES, Leong BS, Gan HN, Chia MY, Tham LP, et al; on behalf of the PAROS Study Group. A before-after interventional trial of dispatcher-assisted cardio-pulmonary resuscitation for out-of-hospital cardiac arrests in Singapore. *Resuscitation*. 2016;102:85–93. doi: 10.1016/j.resuscitation.2016.02.014
22. Besnier E, Damm C, Jardel B, Veber B, Compere V, Dureuil B. Dispatcher-assisted cardiopulmonary resuscitation protocol improves diagnosis and resuscitation recommendations for out-of-hospital cardiac arrest. *Emerg Med Australas*. 2015;27:590–596. doi: 10.1111/1742-6723.12493
23. Bång A, Biber B, Isaksson L, Lindqvist J, Herlitz J. Evaluation of dispatcher-assisted cardiopulmonary resuscitation. *Eur J Emerg Med*. 1999;6:175–183.
24. Kuisma M, Boyd J, Väyrynen T, Repo J, Nousila-Wiik M, Holmström P. Emergency call processing and survival from out-of-hospital ventricular fibrillation. *Resuscitation*. 2005;67:89–93. doi: 10.1016/j.resuscitation.2005.04.008
25. Akahane M, Ogawa T, Tanabe S, Koike S, Horiguchi H, Yasunaga H, Imamura T. Impact of telephone dispatcher assistance on the outcomes of pediatric out-of-hospital cardiac arrest. *Crit Care Med*. 2012;40:1410–1416. doi: 10.1097/CCM.0b013e31823e99ae
26. Goto Y, Maeda T, Goto Y. Impact of dispatcher-assisted bystander cardiopulmonary resuscitation on neurological outcomes in children with out-of-hospital cardiac arrests: a prospective, nationwide, population-based cohort study. *J Am Heart Assoc*. 2014;3:e000499. doi: 10.1161/JAHA.113.000499
27. Japanese Circulation Society Resuscitation Science Study Group. Chest-compression-only bystander cardiopulmonary resuscitation in the 30:2 compression-to-ventilation ratio era: nationwide observational study. *Circ J*. 2013;77:2742–2750.
28. Hiltunen PV, Silfvast TO, Jääntti TH, Kuisma MJ, Kurola JO; on behalf of the FINNRESUSCI Prehospital Study Group. Emergency dispatch process and patient outcome in bystander-witnessed out-of-hospital cardiac arrest with a shockable rhythm. *Eur J Emerg Med*. 2015;22:266–272. doi: 10.1097/MEJ.0000000000000151
29. Fukushima H, Panczyk M, Hu C, Dameff C, Chikani V, Vadeboncoeur T, Spaite DW, Bobrow BJ. Description of abnormal breathing is associated with improved outcomes and delayed telephone cardiopulmonary resuscitation instructions. *J Am Heart Assoc*. 2017;6:e005058. doi: 10.1161/JAHA.116.005058
30. Moriwaki Y, Tahara Y, Kosuge T, Suzuki N. The effect of telephone advice on cardiopulmonary resuscitation (CPR) on the rate of bystander CPR in out-of-hospital cardiopulmonary arrest in a typical urban area *Hong Kong J Emerg Med*. 2016;23:220–226. doi: <https://doi.org/10.1177/102490791602300403>
31. Ro YS, Shin SD, Song KJ, Hong KJ, Ahn KO, Kim DK, Kwak YH. Effects of dispatcher-assisted cardiopulmonary resuscitation on survival outcomes in infants, children, and adolescents with out-of-hospital cardiac arrests. *Resuscitation*. 2016;108:20–26. doi: 10.1016/j.resuscitation.2016.08.026
32. Takahashi H, Sagisaka R, Natsume Y, Tanaka S, Takyu H, Tanaka H. Does dispatcher-assisted CPR generate the same outcomes as spontaneously delivered bystander CPR in Japan? *Am J Emerg Med*. 2018;36:384–391. doi: 10.1016/j.ajem.2017.08.034
33. Wu Z, Panczyk M, Spaite DW, Hu C, Fukushima H, Langlais B, Sutter J, Bobrow BJ. Telephone cardiopulmonary resuscitation is independently associated with improved survival and improved functional outcome after out-of-hospital cardiac arrest. *Resuscitation*. 2018;122:135–140. doi: 10.1016/j.resuscitation.2017.07.016
34. Ro YS, Shin SD, Lee YJ, Lee SC, Song KJ, Ryou HW, Ong MEH, McNally B, Bobrow B, Tanaka H, Myklebust H, Birkenes TS. Effect of dispatcher-assisted cardiopulmonary resuscitation program and location of out-of-hospital cardiac arrest on survival and neurologic outcome. *Ann Emerg Med*. 2017;69:52–61.e1. doi: 10.1016/j.annemergmed.2016.07.028
35. Chang I, Lee SC, Shin SD, Song KJ, Ro YS, Park JH, Kong SY. Effects of dispatcher-assisted bystander cardiopulmonary resuscitation on neurological recovery in paediatric patients with out-of-hospital cardiac arrest based on the pre-hospital emergency medical service response time interval. *Resuscitation*. 2018;130:49–56. doi: 10.1016/j.resuscitation.2018.06.029
36. Viereck S, Möller TP, Ersbøll AK, Bækgaard JS, Claesson A, Hollenberg J, Folke F, Lippert FK. Recognising out-of-hospital cardiac arrest during emergency calls increases bystander cardiopulmonary resuscitation and survival. *Resuscitation*. 2017;115:141–147. doi: 10.1016/j.resuscitation.2017.04.006
37. Shah M, Bartram C, Irwin K, Vellano K, McNally B, Gallagher T, Swor R. Evaluating dispatch-assisted CPR using the CARES registry. *Prehosp Emerg Care*. 2018;22:222–228. doi: 10.1080/10903127.2017.1376133
38. Rea TD, Eisenberg MS, Culley LL, Becker L. Dispatcher-assisted cardiopulmonary resuscitation and survival in cardiac arrest. *Circulation*. 2001;104:2513–2516. doi: 10.1161/hc4601.099468
39. Chang I, Ro YS, Shin SD, Song KJ, Park JH, Kong SY. Association of dispatcher-assisted bystander cardiopulmonary resuscitation with survival outcomes after pediatric out-of-hospital cardiac arrest by community property value. *Resuscitation*. 2018;132:120–126. doi: 10.1016/j.resuscitation.2018.09.008
40. Takei Y, Kamikura T, Nishi T, Maeda T, Sakagami S, Kubo M, Inaba H. Recruitments of trained citizen volunteering for conventional cardiopulmonary resuscitation are necessary to improve the outcome after out-of-hospital cardiac arrests in remote time-distance area: a nationwide population-based study. *Resuscitation*. 2016;105:100–108. doi: 10.1016/j.resuscitation.2016.05.021
41. Lewis M, Stubbs BA, Eisenberg MS. Dispatcher-assisted cardiopulmonary resuscitation: time to identify cardiac arrest and deliver chest compression instructions. *Circulation*. 2013;128:1522–1530. doi: 10.1161/CIRCULATIONAHA.113.002627
42. Dami F, Heymann E, Pasquier M, Fuchs V, Carron PN, Hugli O. Time to identify cardiac arrest and provide dispatch-assisted cardio-pulmonary resuscitation in a criteria-based dispatch system. *Resuscitation*. 2015;97:27–33. doi: 10.1016/j.resuscitation.2015.09.390
43. Oman G, Bury G. Use of telephone CPR advice in Ireland: uptake by callers and delays in the assessment process. *Resuscitation*. 2016;102:6–10. doi: 10.1016/j.resuscitation.2016.02.006
44. Eisenberg MS, Cummins RO, Litwin P, Hallstrom AP, Hearne T. Dispatcher cardiopulmonary resuscitation instruction via telephone. *Crit Care Med*. 1985;13:923–924. doi: 10.1097/00003246-198511000-00017
45. Park JH, Ro YS, Shin SD, Song KJ, Hong KJ, Kong SY. Dispatcher-assisted bystander cardiopulmonary resuscitation in rural and urban areas and survival outcomes after out-of-hospital cardiac arrest. *Resuscitation*. 2018;125:1–7. doi: 10.1016/j.resuscitation.2018.01.026
46. Gotz J, Petutschnigg B, Wasler A, Wrán-Schumer D, Hansak P. Bystander resuscitation as a measure of success [in German]. *Notfall Rettungsmed*. 2017;20:470–476.
47. Hasselqvist-Ax I, Riva G, Herlitz J, Rosenqvist M, Hollenberg J, Nordberg P, Ringh M, Jonsson M, Axelsson C, Lindqvist J, et al. Early cardiopulmonary resuscitation in out-of-hospital cardiac arrest. *N Engl J Med*. 2015;372:2307–2315. doi: 10.1056/NEJMoa1405796
48. Soar J, Callaway CW, Aibiki M, Böttiger BW, Brooks SC, Deakin CD, Donnino MW, Drajer S, Kloeck W, Morley PT, et al; on behalf of the Advanced Life Support Chapter Collaborators. Part 4: advanced life support: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergen-

- cy Cardiovascular Care Science with Treatment Recommendations. *Resuscitation*. 2015;95:e71–e120. doi: 10.1016/j.resuscitation.2015.07.042
49. Andersen LW, Granfeldt A, Callaway CW, Bradley SM, Soar J, Nolan JP, Kurth T, Donnino MW; on behalf of the American Heart Association's Get With The Guidelines-Resuscitation Investigators. Association between tracheal intubation during adult in-hospital cardiac arrest and survival. *JAMA*. 2017;317:494–506. doi: 10.1001/jama.2016.20165
 50. McMullan J, Gerecht R, Bonomo J, Robb R, McNally B, Donnelly J, Wang HE; on behalf of the CARES Surveillance Group. Airway management and out-of-hospital cardiac arrest outcome in the CARES registry. *Resuscitation*. 2014;85:617–622. doi: 10.1016/j.resuscitation.2014.02.007
 51. Bengier JR, Kirby K, Black S, Brett SJ, Clout M, Lazaroo MJ, Nolan JP, Reeves BC, Robinson M, Scott LJ, et al. Effect of a strategy of a supraglottic airway device vs tracheal intubation during out-of-hospital cardiac arrest on functional outcome: the AIRWAYS-2 randomized clinical trial. *JAMA*. 2018;320:779–791. doi: 10.1001/jama.2018.11597
 52. Jabre P, Penaloza A, Pinero D, Duchateau FX, Borron SW, Javaudin F, Richard O, de Longueville D, Bouilleau G, Devaud ML, et al. Effect of bag-mask ventilation vs endotracheal intubation during cardiopulmonary resuscitation on neurological outcome after out-of-hospital cardiorespiratory arrest: a randomized clinical trial. *JAMA*. 2018;319:779–787. doi: 10.1001/jama.2018.0156
 53. Wang HE, Schmicker RH, Daya MR, Stephens SW, Idris AH, Carlson JN, Colella MR, Herren H, Hansen M, Richmond NJ, et al. Effect of a strategy of initial laryngeal tube insertion vs endotracheal intubation on 72-hour survival in adults with out-of-hospital cardiac arrest: a randomized clinical trial. *JAMA*. 2018;320:769–778. doi: 10.1001/jama.2018.7044
 54. Soar J, Nicholson TC, Parr MJ, Berg KM, Böttiger BW, Callaway CW, Deakin CD, Drennan I, Neumar RW, O'Neil BJ, et al. Advanced airway management during adult cardiac arrest: Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) Advanced Life Support Task Force. April 4, 2019. <https://costr.ilcor.org/document/advanced-airway-management-during-adult-cardiac-arrest>. Accessed May 22, 2019.
 55. Goldenberg IF, Campion BC, Siebold CM, McBride JW, Long LA. Esophageal gastric tube airway vs endotracheal tube in prehospital cardiopulmonary arrest. *Chest*. 1986;90:90–96. doi: 10.1378/chest.90.1.90
 56. Staudinger T, Brugger S, Röggla M, Rintelen C, Atherton GL, Johnson JC, Frass M. Comparison of the Combitube with the endotracheal tube in cardiopulmonary resuscitation in the prehospital phase [in German]. *Wien Klin Wochenschr*. 1994;106:412–415.
 57. Rumball CJ, MacDonald D. The PTL, Combitube, laryngeal mask, and oral airway: a randomized prehospital comparative study of ventilatory device effectiveness and cost-effectiveness in 470 cases of cardiorespiratory arrest. *Prehosp Emerg Care*. 1997;1:1–10.
 58. Rabitsch W, Schellongowski P, Staudinger T, Hofbauer R, Dufek V, Eder B, Raab H, Thell R, Schuster E, Frass M. Comparison of a conventional tracheal airway with the Combitube in an urban emergency medical services system run by physicians. *Resuscitation*. 2003;57:27–32.
 59. Maignan M, Koch FX, Kraemer M, Lehodey B, Viglino D, Monnet MF, Pham D, Roux C, Genty C, Rolland C, et al. Impact of laryngeal tube use on chest compression fraction during out-of-hospital cardiac arrest: a prospective alternate month study. *Resuscitation*. 2015;93:113–117. doi: 10.1016/j.resuscitation.2015.06.002
 60. Ono Y, Hayakawa M, Maekawa K, Mizugaki A, Katabami K, Wada T, Sawamura A, Gando S. Should laryngeal tubes or masks be used for out-of-hospital cardiac arrest patients? *Am J Emerg Med*. 2015;33:1360–1363. doi: 10.1016/j.ajem.2015.07.043
 61. Bengier J, Coates D, Davies S, Greenwood R, Nolan J, Rhys M, Thomas M, Voss S. Randomised comparison of the effectiveness of the laryngeal mask airway supreme, i-gel and current practice in the initial airway management of out of hospital cardiac arrest: a feasibility study. *Br J Anaesth*. 2016;116:262–268. doi: 10.1093/bja/aev477
 62. Fiala A, Lederer W, Neumayr A, Egger T, Neururer S, Toferer E, Baubin M, Paal P. EMT-led laryngeal tube vs. face-mask ventilation during cardiopulmonary resuscitation: a multicenter prospective randomized trial. *Scand J Trauma Resusc Emerg Med*. 2017;25:104. doi: 10.1186/s13049-017-0446-1
 63. Callaway CW, Soar J, Aibiki M, Böttiger BW, Brooks SC, Deakin CD, Donnino MW, Drajer S, Kloeck W, Morley PT, et al; on behalf of the Advanced Life Support Chapter Collaborators. Part 4: advanced life support: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2015;132(suppl 1):S84–S145. doi: 10.1161/CIR.0000000000000273
 64. Pearson JW, Redding JS. Epinephrine in cardiac resuscitation. *Am Heart J*. 1963;66:210–214. doi: 10.1016/0002-8703(63)90036-x
 65. Redding JS, Pearson JW. Resuscitation from ventricular fibrillation: drug therapy. *JAMA*. 1968;203:255–260.
 66. Perkins GD, Ji C, Deakin CD, Quinn T, Nolan JP, Scopin C, Regan S, Long J, Slowther A, Pocock H, et al; PARAMEDIC2 Collaborators. A randomized trial of epinephrine in out-of-hospital cardiac arrest. *N Engl J Med*. 2018;379:711–721. doi: 10.1056/NEJMoa1806842
 67. Welsford M, Berg KM, Neumar RW, Paiva EF, Andersen LW, Böttiger BW, Callaway CW, Deakin CD, Drennan I, Kleinman M, et al. Vasopressors in adult cardiac arrest: Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) Advanced Life Support Task Force. April 4, 2019. <https://costr.ilcor.org/document/vasopressors-in-adult-cardiac-arrest>. Accessed May 22, 2019.
 68. Jacobs IG, Finn JC, Jelinek GA, Oxer HF, Thompson PL. Effect of adrenaline on survival in out-of-hospital cardiac arrest: a randomised double-blind placebo-controlled trial. *Resuscitation*. 2011;82:1138–1143. doi: 10.1016/j.resuscitation.2011.06.029
 69. Perkins GD, Kenna C, Ji C, Deakin CD, Nolan JP, Quinn T, Fothergill R, Gunson I, Pocock H, Rees N, et al. The effects of adrenaline in out of hospital cardiac arrest with shockable and non-shockable rhythms: findings from the PACA and PARAMEDIC-2 randomised controlled trials. *Resuscitation*. 2019;140:55–63. doi: 10.1016/j.resuscitation.2019.05.007
 70. Lindner KH, Dirks B, Strohmenger HU, Prengel AW, Lindner IM, Lurie KG. Randomised comparison of epinephrine and vasopressin in patients with out-of-hospital ventricular fibrillation. *Lancet*. 1997;349:535–537. doi: 10.1016/S0140-6736(97)80087-6
 71. Wenzel V, Krismer AC, Arntz HR, Sitter H, Stadlbauer KH, Lindner KH; European Resuscitation Council Vasopressor during Cardiopulmonary Resuscitation Study Group. A comparison of vasopressin and epinephrine for out-of-hospital cardiopulmonary resuscitation. *N Engl J Med*. 2004;350:105–113. doi: 10.1056/NEJMoa025431
 72. Mukoyama T, Kinoshita K, Nagao K, Tanjoh K. Reduced effectiveness of vasopressin in repeated doses for patients undergoing prolonged cardiopulmonary resuscitation. *Resuscitation*. 2009;80:755–761. doi: 10.1016/j.resuscitation.2009.04.005
 73. Stiell IG, Hebert PC, Weitzman BN, Wells GA, Raman S, Stark RM, Higginson LA, Ahuja J, Dickinson GE. High-dose epinephrine in adult cardiac arrest. *N Engl J Med*. 1992;327:1045–1050. doi: 10.1056/NEJM199210083271502
 74. Callaway CW, Hostler D, Doshi AA, Pinchalk M, Roth RN, Lubin J, Newman DH, Kelly LJ. Usefulness of vasopressin administered with epinephrine during out-of-hospital cardiac arrest. *Am J Cardiol*. 2006;98:1316–1321. doi: 10.1016/j.amjcard.2006.06.022
 75. Gueugniard PY, David JS, Chanzy E, Hubert H, Dubien PY, Mauriacourt P, Bragança C, Billères X, Clotteau-Lambert MP, Fuster P, et al. Vasopressin and epinephrine vs. epinephrine alone in cardiopulmonary resuscitation. *N Engl J Med*. 2008;359:21–30. doi: 10.1056/NEJMoa0706873
 76. Ducros L, Vicaut E, Soleil C, Le Guen M, Gueye P, Poussant T, Mebazaa A, Payen D, Plaisance P. Effect of the addition of vasopressin or vasopressin plus nitroglycerin to epinephrine on arterial blood pressure during cardiopulmonary resuscitation in humans. *J Emerg Med*. 2011;41:453–459. doi: 10.1016/j.jemermed.2010.02.030
 77. Stiell IG, Hébert PC, Wells GA, Vandemheen KL, Tang AS, Higginson LA, Dreyer JF, Clement C, Battram E, Watpool I, et al. Vasopressin versus epinephrine for in-hospital cardiac arrest: a randomised controlled trial. *Lancet*. 2001;358:105–109. doi: 10.1016/S0140-6736(01)05328-4
 78. Conrad SA, Broman LM, Taccone FS, Lorusso R, Malfertheiner MV, Pappalardo F, Di Nardo M, Belliato M, Grazioli L, Barbaro RP, et al. The Extracorporeal Life Support Organization Maastricht Treaty for Nomenclature in Extracorporeal Life Support: a position paper of the Extracorporeal Life Support Organization. *Am J Respir Crit Care Med*. 2018;198:447–451. doi: 10.1164/rccm.201710-2130CP
 79. Donnino MW, Andersen LW, Deakin CD, Berg KM, Böttiger BW, Callaway CW, Drennan I, Neumar RW, Nicholson TC, O'Neil BJ, et al. Extracorporeal cardiopulmonary resuscitation (ECPR) for cardiac arrest—adults: Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) Advanced Life Support Task Force, March 21, 2019. <https://costr.ilcor.org/document/extracorporeal-cardiopulmonary-resuscitation-ecpr-for-cardiac-arrest-adults>. Accessed May 22, 2019.
 80. Agostinucci JM, Ruscev M, Galinski M, Gravelo S, Petrovic T, Carneaux C, Haouache H, Roussin F, Adnet F, Lapostolle F. Out-of-hospital use of an automated chest compression device: facilitating access to extracorporeal life support or non-heart-beating organ procurement. *Am J Emerg Med*. 2011;29:1169–1172. doi: 10.1016/j.ajem.2010.06.029

81. Blumenstein J, Leick J, Liebetrau C, Kempfert J, Gaede L, Groß S, Krug M, Berkowitsch A, Nef H, Rolf A, et al. Extracorporeal life support in cardiovascular patients with observed refractory in-hospital cardiac arrest is associated with favourable short and long-term outcomes: a propensity-matched analysis. *Eur Heart J Acute Cardiovasc Care*. 2016;5:13–22. doi: 10.1177/2048872615612454
82. Cesana F, Avalli L, Garatti L, Coppo A, Righetti S, Calchera I, Scanziani E, Cozzolino P, Malafronte C, Mauro A, et al. Effects of extracorporeal cardiopulmonary resuscitation on neurological and cardiac outcome after ischaemic refractory cardiac arrest. *Eur Heart J Acute Cardiovasc Care*. 2018;7:432–441. doi: 10.1177/2048872617737041
83. Chen YS, Lin JW, Yu HY, Ko WJ, Jerng JS, Chang WT, Chen WJ, Huang SC, Chi NH, Wang CH, et al. Cardiopulmonary resuscitation with assisted extracorporeal life-support versus conventional cardiopulmonary resuscitation in adults with in-hospital cardiac arrest: an observational study and propensity analysis. *Lancet*. 2008;372:554–561. doi: 10.1016/S0140-6736(08)60958-7
84. Cho YH, Kim WS, Sung K, Jeong DS, Lee YT, Park PW, Kim DK. Management of cardiac arrest caused by acute massive pulmonary thromboembolism: importance of percutaneous cardiopulmonary support. *ASAIO J*. 2014;60:280–283. doi: 10.1097/MAT.0000000000000063
85. Choi DH, Kim YJ, Ryou SM, Sohn CH, Ahn S, Seo DW, Lim JY, Kim WY. Extracorporeal cardiopulmonary resuscitation among patients with out-of-hospital cardiac arrest. *Clin Exp Emerg Med*. 2016;3:132–138. doi: 10.15441/ceem.16.145
86. Chou TH, Fang CC, Yen ZS, Lee CC, Chen YS, Ko WJ, Wang CH, Wang SS, Chen SC. An observational study of extracorporeal CPR for in-hospital cardiac arrest secondary to myocardial infarction. *Emerg Med J*. 2014;31:441–447. doi: 10.1136/emered-2012-202173
87. Hase M, Tsuchihashi K, Fujii N, Nishizato K, Kokubu N, Nara S, Kurimoto Y, Hashimoto A, Uno K, Miura T, et al. Early defibrillation and circulatory support can provide better long-term outcomes through favorable neurological recovery in patients with out-of-hospital cardiac arrest of cardiac origin. *Circ J*. 2005;69:1302–1307.
88. Kim SJ, Jung JS, Park JH, Park JS, Hong YS, Lee SW. An optimal transition time to extracorporeal cardiopulmonary resuscitation for predicting good neurological outcome in patients with out-of-hospital cardiac arrest: a propensity-matched study. *Crit Care*. 2014;18:535. doi: 10.1186/s13054-014-0535-8
89. Lee SH, Jung JS, Lee KH, Kim HJ, Son HS, Sun K. Comparison of extracorporeal cardiopulmonary resuscitation with conventional cardiopulmonary resuscitation: is extracorporeal cardiopulmonary resuscitation beneficial? *Korean J Thorac Cardiovasc Surg*. 2015;48:318–327. doi: 10.5090/kjtcs.2015.48.5.318
90. Lin JW, Wang MJ, Yu HY, Wang CH, Chang WT, Jerng JS, Huang SC, Chou NK, Chi NH, Ko WJ, et al. Comparing the survival between extracorporeal rescue and conventional resuscitation in adult in-hospital cardiac arrests: propensity analysis of three-year data. *Resuscitation*. 2010;81:796–803. doi: 10.1016/j.resuscitation.2010.03.002
91. Maekawa K, Tanno K, Hase M, Mori K, Asai Y. Extracorporeal cardiopulmonary resuscitation for patients with out-of-hospital cardiac arrest of cardiac origin: a propensity-matched study and predictor analysis. *Crit Care Med*. 2013;41:1186–1196. doi: 10.1097/CCM.0b013e31827ca4c8
92. Poppe M, Weiser C, Holzer M, Sulzgruber P, Datler P, Keferböck M, Zeiner S, Lobmeyr E, van Tulder R, Ziegler A, et al. The incidence of “load&go” out-of-hospital cardiac arrest candidates for emergency department utilization of emergency extracorporeal life support: a one-year review. *Resuscitation*. 2015;91:131–136. doi: 10.1016/j.resuscitation.2015.03.003
93. Sakamoto T, Morimura N, Nagao K, Asai Y, Yokota H, Nara S, Hase M, Tahara Y, Atsumi T, and the SAVE-J Study Group. Extracorporeal cardiopulmonary resuscitation versus conventional cardiopulmonary resuscitation in adults with out-of-hospital cardiac arrest: a prospective observational study. *Resuscitation*. 2014;85:762–768. doi: 10.1016/j.resuscitation.2014.01.031
94. Schober A, Sterz F, Herkner H, Wallmueller C, Weiser C, Hubner P, Testori C. Emergency extracorporeal life support and ongoing resuscitation: a retrospective comparison for refractory out-of-hospital cardiac arrest. *Emerg Med J*. 2017;34:277–281. doi: 10.1136/emered-2015-205232
95. Shin TG, Choi JH, Jo IJ, Sim MS, Song YB, Jeong YK, Song YB, Hahn JY, Choi SH, Gwon HC, et al. Extracorporeal cardiopulmonary resuscitation in patients with in-hospital cardiac arrest: a comparison with conventional cardiopulmonary resuscitation. *Crit Care Med*. 2011;39:1–7. doi: 10.1097/CCM.0b013e3181feb339
96. Shin TG, Jo IJ, Sim MS, Song YB, Yang JH, Hahn JY, Choi SH, Gwon HC, Jeon ES, Sung K, et al. Two-year survival and neurological outcome of in-hospital cardiac arrest patients rescued by extracorporeal cardiopulmonary resuscitation. *Int J Cardiol*. 2013;168:3424–3430. doi: 10.1016/j.ijcard.2013.04.183
97. Siao FY, Chiu CC, Chiu CW, Chen YC, Chen YL, Hsieh YK, Lee CH, Wu CT, Chou CC, Yen HH. Managing cardiac arrest with refractory ventricular fibrillation in the emergency department: conventional cardiopulmonary resuscitation versus extracorporeal cardiopulmonary resuscitation. *Resuscitation*. 2015;92:70–76. doi: 10.1016/j.resuscitation.2015.04.016
98. Tanno K, Itoh Y, Takeyama Y, Nara S, Mori K, Asai Y. Utstein style study of cardiopulmonary bypass after cardiac arrest. *Am J Emerg Med*. 2008;26:649–654. doi: 10.1016/j.ajem.2007.09.019
99. Venturini JM, Retzer E, Estrada JR, Friant J, Beiser D, Edelson D, Paul J, Blair J, Nathan S, Shah AP. Mechanical chest compressions improve rate of return of spontaneous circulation and allow for initiation of percutaneous circulatory support during cardiac arrest in the cardiac catheterization laboratory. *Resuscitation*. 2017;115:56–60. doi: 10.1016/j.resuscitation.2017.03.037
100. Yannopoulos D, Bartos JA, Martin C, Raveendran G, Missov E, Conterato M, Frascione RJ, Trembley A, Sipprell K, John R, et al. Minnesota Resuscitation Consortium’s advanced perfusion and reperfusion cardiac life support strategy for out-of-hospital refractory ventricular fibrillation. *J Am Heart Assoc*. 2016;5:003732. doi: 10.1161/JAHA.116.003732
101. Yannopoulos D, Bartos JA, Raveendran G, Conterato M, Frascione RJ, Trembley A, John R, Connett J, Benditt DG, Lurie KG, et al. Coronary artery disease in patients with out-of-hospital refractory ventricular fibrillation cardiac arrest. *J Am Coll Cardiol*. 2017;70:1109–1117. doi: 10.1016/j.jacc.2017.06.059
102. Tijssen JA, Aickin RP, Atkins D, Bingham R, Couto TB, de Caen AR, Guerguerian A-M, Hazinski MF, Meaney PA, Nadkarni VM, et al. Dispatcher instruction in CPR (pediatrics): Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) Pediatrics Task Force. February 25, 2019. <https://costr.ilcor.org/document/dispatcher-instruction-in-cpr-pediatrics>. Accessed May 22, 2019.
103. Ro YS, Shin SD, Song KJ, Hong SO, Kim YT, Cho SI. Bystander cardiopulmonary resuscitation training experience and self-efficacy of age and gender group: a nationwide community survey. *Am J Emerg Med*. 2016;34:1331–1337. doi: 10.1016/j.ajem.2015.12.001
104. Bohm K, Vaillancourt C, Charette ML, Dunford J, Castrén M. In patients with out-of-hospital cardiac arrest, does the provision of dispatch cardiopulmonary resuscitation instructions as opposed to no instructions improve outcome: a systematic review of the literature. *Resuscitation*. 2011;82:1490–1495. doi: 10.1016/j.resuscitation.2011.09.004
105. Leong BS. Bystander CPR and survival. *Singapore Med J*. 2011;52:573–575.
106. Lerner EB, Rea TD, Bobrow BJ, Acker JE 3rd, Berg RA, Brooks SC, Cone DC, Gay M, Gent LM, Mears G, et al; on behalf of the American Heart Association Emergency Cardiovascular Care Committee; Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation. Emergency medical service dispatch cardiopulmonary resuscitation prearrival instructions to improve survival from out-of-hospital cardiac arrest: a scientific statement from the American Heart Association. *Circulation*. 2012;125:648–655. doi: 10.1161/CIR.0b013e31823ee5fc
107. Olasveengen TM, de Caen AR, Mancini ME, Maconochie IK, Aickin R, Atkins DL, Berg RA, Bingham RM, Brooks SC, Castrén M, et al; on behalf of the ILCOR Collaborators. 2017 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations summary. *Circulation*. 2017;136:e424–e440. doi: 10.1161/CIR.0000000000000541
108. Nuthall G, Van de Voorde P, Atkins DL, Aickin RP, Bingham R, Couto TB, de Caen AR, Guerguerian A-M, Meaney PA, Nadkarni VM, et al. Advanced airway interventions in pediatric cardiac arrest: Paediatric Consensus on Science With Treatment Recommendations. January 2019. <https://costr.ilcor.org/document/advanced-airway-interventions-in-pediatric-cardiac-arrest>. Accessed March 27, 2019.
109. Gausche M, Lewis RJ, Stratton SJ, Haynes BE, Gunter CS, Goodrich SM, Poore PD, McCollough MD, Henderson DP, Pratt FD, et al. Effect of out-of-hospital pediatric endotracheal intubation on survival and neurological outcome: a controlled clinical trial. *JAMA*. 2000;283:783–790.
110. Andersen LW, Raymond TT, Berg RA, Nadkarni VM, Grossestreuer AV, Kurth T, Donnino MW; on behalf of the American Heart Association’s Get With The Guidelines–Resuscitation Investigators. Association between

- tracheal intubation during pediatric in-hospital cardiac arrest and survival. *JAMA*. 2016;316:1786–1797. doi: 10.1001/jama.2016.14486
111. Hansen ML, Lin A, Eriksson C, Daya M, McNally B, Fu R, Yanez D, Zive D, Newgard C; and the CARES Surveillance Group. A comparison of pediatric airway management techniques during out-of-hospital cardiac arrest using the CARES database. *Resuscitation*. 2017;120:51–56. doi: 10.1016/j.resuscitation.2017.08.015
 112. Ohashi-Fukuda N, Fukuda T, Doi K, Morimura N. Effect of prehospital advanced airway management for pediatric out-of-hospital cardiac arrest. *Resuscitation*. 2017;114:66–72. doi: 10.1016/j.resuscitation.2017.03.002
 113. Abe T, Nagata T, Hasegawa M, Hagihara A. Life support techniques related to survival after out-of-hospital cardiac arrest in infants. *Resuscitation*. 2012;83:612–618. doi: 10.1016/j.resuscitation.2012.01.024
 114. Aijian P, Tsai A, Knopp R, Kallsen GW. Endotracheal intubation of pediatric patients by paramedics. *Ann Emerg Med*. 1989;18:489–494. doi: 10.1016/s0196-0644(89)80830-3
 115. Deasy C, Bernard SA, Cameron P, Jaison A, Smith K, Harriss L, Walker T, Masci K, Tibballs J. Epidemiology of paediatric out-of-hospital cardiac arrest in Melbourne, Australia. *Resuscitation*. 2010;81:1095–1100. doi: 10.1016/j.resuscitation.2010.04.029
 116. Del Castillo J, López-Herce J, Matamoros M, Cañadas S, Rodríguez-Calvo A, Cecchetti C, Rodríguez-Núñez A, Álvarez AC; Iberoamerican Pediatric Cardiac Arrest Study Network RIBEPCI. Long-term evolution after in-hospital cardiac arrest in children: prospective multicenter multinational study. *Resuscitation*. 2015;96:126–134. doi: 10.1016/j.resuscitation.2015.07.037
 117. Guay J, Lortie L. An evaluation of pediatric in-hospital advanced life support interventions using the pediatric Utstein guidelines: a review of 203 cardiorespiratory arrests. *Can J Anaesth*. 2004;51:373–378. doi: 10.1007/BF03018242
 118. Pitetti R, Glustein JZ, Bhende MS. Prehospital care and outcome of pediatric out-of-hospital cardiac arrest. *Prehosp Emerg Care*. 2002;6:283–290.
 119. Sirbaugh PE, Pepe PE, Shook JE, Kimball KT, Goldman MJ, Ward MA, Mann DM. A prospective, population-based study of the demographics, epidemiology, management, and outcome of out-of-hospital pediatric cardiopulmonary arrest. *Ann Emerg Med*. 1999;33:174–184. doi: 10.1016/s0196-0644(99)70391-4
 120. Tham LP, Wah W, Phillips R, Shahidah N, Ng YY, Shin SD, Nishiuchi T, Wong KD, Ko PC, Khunklai N, et al. Epidemiology and outcome of paediatric out-of-hospital cardiac arrests: a paediatric sub-study of the Pan-Asian Resuscitation Outcomes Study (PAROS). *Resuscitation*. 2018;125:111–117. doi: 10.1016/j.resuscitation.2018.01.040
 121. Fink EL, Prince DK, Kaltman JR, Atkins DL, Austin M, Warden C, Hutchison J, Daya M, Goldberg S, Herren H, et al; on behalf of the Resuscitation Outcomes Consortium. Unchanged pediatric out-of-hospital cardiac arrest incidence and survival rates with regional variation in North America. *Resuscitation*. 2016;107:121–128. doi: 10.1016/j.resuscitation.2016.07.244
 122. Tijssen JA, Prince DK, Morrison LJ, Atkins DL, Austin MA, Berg R, Brown SP, Christenson J, Egan D, Fedor PJ, et al; on behalf of the Resuscitation Outcomes Consortium. Time on the scene and interventions are associated with improved survival in pediatric out-of-hospital cardiac arrest. *Resuscitation*. 2015;94:1–7. doi: 10.1016/j.resuscitation.2015.06.012
 123. Friedrich JO, Adhikari NK, Beyene J. Inclusion of zero total event trials in meta-analyses maintains analytic consistency and incorporates all available data. *BMC Med Res Methodol*. 2007;7:5. doi: 10.1186/1471-2288-7-5
 124. Fink EL, Clark RS, Kochanek PM, Bell MJ, Watson RS. A tertiary care center's experience with therapeutic hypothermia after pediatric cardiac arrest. *Pediatr Crit Care Med*. 2010;11:66–74. doi: 10.1097/PCC.0b013e3181c58237
 125. de Caen AR, Maconochie IK, Aickin R, Atkins DL, Biarent D, Guerguerian AM, Kleinman ME, Kloock DA, Meaney PA, Nadkarni VM, et al; on behalf of the Pediatric Basic Life Support and Pediatric Advanced Life Support Chapter Collaborators. Part 6: pediatric basic life support and pediatric advanced life support: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2015;132(suppl 1):S177–S1203. doi: 10.1161/CIR.0000000000000275
 126. Guerguerian AM, de Caen AR, Aickin RP, Tijssen JA, Atkins DL, Bingham R, Couto TB, Meaney PA, Nadkarni VM, Ng KC, et al. Extracorporeal cardiopulmonary resuscitation (ECPR) for cardiac arrest—pediatrics: Pediatric Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) Advanced Life Support Task Force. April 15, 2019. <https://costr.ilcor.org/document/extracorporeal-cardiopulmonary-resuscitation-ecpr-for-cardiac-arrest-pediatrics>. Accessed May 22, 2019.
 127. Lasa JJ, Rogers RS, Localio R, Shults J, Raymond T, Gaies M, Thiagarajan R, Laussen PC, Kilbaugh T, Berg RA, et al. Extracorporeal cardiopulmonary resuscitation (E-CPR) during pediatric in-hospital cardiopulmonary arrest is associated with improved survival to discharge: a report from the American Heart Association's Get With The Guidelines-Resuscitation (GWTG-R) Registry. *Circulation*. 2016;133:165–176. doi: 10.1161/CIRCULATIONAHA.115.016082
 128. Ortmann L, Prophan P, Gossett J, Schexnayder S, Berg R, Nadkarni V, Bhutta A; on behalf of the American Heart Association's Get With The Guidelines-Resuscitation Investigators. Outcomes after in-hospital cardiac arrest in children with cardiac disease: a report from Get With The Guidelines-Resuscitation. *Circulation*. 2011;124:2329–2337. doi: 10.1161/CIRCULATIONAHA.110.013466
 129. Alsoufi B, Al-Radi OO, Nazer RI, Gruenewald C, Foreman C, Williams WG, Coles JG, Caldarone CA, Bohn DG, Van Arsdell GS. Survival outcomes after rescue extracorporeal cardiopulmonary resuscitation in pediatric patients with refractory cardiac arrest. *J Thorac Cardiovasc Surg*. 2007;134:952–959.e2. doi: 10.1016/j.jtcvs.2007.05.054
 130. Turek JW, Andersen ND, Lawson DS, Bonadonna D, Turley RS, Peters MA, Jaggors J, Lodge AJ. Outcomes before and after implementation of a pediatric rapid-response extracorporeal membrane oxygenation program. *Ann Thorac Surg*. 2013;95:2140–2146. doi: 10.1016/j.athoracsur.2013.01.050
 131. del Nido PJ, Dalton HJ, Thompson AE, Siewers RD. Extracorporeal membrane oxygenator rescue in children during cardiac arrest after cardiac surgery. *Circulation*. 1992;86(suppl):II300–II304.
 132. Dalton HJ, Siewers RD, Fuhrman BP, Del Nido P, Thompson AE, Shaver MG, Dowhy M. Extracorporeal membrane oxygenation for cardiac rescue in children with severe myocardial dysfunction. *Crit Care Med*. 1993;21:1020–1028. doi: 10.1097/00003246-199307000-00016
 133. Duncan BW, Ibrahim AE, Hraska V, del Nido PJ, Laussen PC, Wessel DL, Mayer JE Jr, Bower LK, Jonas RA. Use of rapid-deployment extracorporeal membrane oxygenation for the resuscitation of pediatric patients with heart disease after cardiac arrest. *J Thorac Cardiovasc Surg*. 1998;116:305–311.
 134. Mahle WT, Forbess JM, Kirshbom PM, Cuadrado AR, Simsic JM, Kanter KR. Cost-utility analysis of salvage cardiac extracorporeal membrane oxygenation in children. *J Thorac Cardiovasc Surg*. 2005;129:1084–1090. doi: 10.1016/j.jtcvs.2004.08.012
 135. Lowry AW, Morales DL, Graves DE, Knudson JD, Shamszad P, Mott AR, Cabrera AG, Rossano JW. Characterization of extracorporeal membrane oxygenation for pediatric cardiac arrest in the United States: analysis of the kids' inpatient database. *Pediatr Cardiol*. 2013;34:1422–1430. doi: 10.1007/s00246-013-0666-8
 136. Aickin RP, de Caen AR, Atkins DL, Bingham R, Couto TB, Guerguerian A-M, Hazinski MF, Lavonas E, Meaney PA, Nadkarni VM, et al; on behalf of the International Liaison Committee on Resuscitation Pediatric Life Support Task Force. Pediatric targeted temperature management post cardiac arrest 2019. <https://costr.ilcor.org/document/pediatric-targeted-temperature-management-post-cardiac-arrest>.
 137. Fiser DH. Assessing the outcome of pediatric intensive care. *J Pediatr*. 1992;121:68–74. doi: 10.1016/s0022-3476(05)82544-2
 138. Sparrow SS, Cicchetti DV, Balla DA. *Vineland Adaptive Behavior Scales (Vineland-II)*. Circle Pines, MN: American Guidance Service; 2005.
 139. Varni JW, Seid M, Rode CA. The PedsQL: measurement model for the Pediatric Quality of Life Inventory. *Med Care*. 1999;37:126–139.
 140. Raat H, Landgraf JM, Oostenbrink R, Moll HA, Essink-Bot ML. Reliability and validity of the Infant and Toddler Quality of Life Questionnaire (ITQOL) in a general population and respiratory disease sample. *Qual Life Res*. 2007;16:445–460. doi: 10.1007/s11136-006-9134-8
 141. Moler FW, Silverstein FS, Holubkov R, Slomine BS, Christensen JR, Nadkarni VM, Meert KL, Browning B, Pemberton VL, Page K, et al; on behalf of the THAPCA Trial Investigators. Therapeutic hypothermia after in-hospital cardiac arrest in children. *N Engl J Med*. 2017;376:318–329. doi: 10.1056/NEJMoa1610493
 142. Moler FW, Silverstein FS, Holubkov R, Slomine BS, Christensen JR, Nadkarni VM, Meert KL, Clark AE, Browning B, Pemberton VL, et al; THAPCA Trial Investigators. Therapeutic hypothermia after out-of-hospital cardiac arrest in children. *N Engl J Med*. 2015;372:1898–1908. doi: 10.1056/NEJMoa1411480
 143. Chang I, Kwak YH, Shin SD, Ro YS, Lee EJ, Ahn KO, Kim DK. Therapeutic hypothermia and outcomes in paediatric out-of-hospital cardiac arrest:

- a nationwide observational study. *Resuscitation*. 2016;105:8–15. doi: 10.1016/j.resuscitation.2016.04.021
144. Cheng HH, Rajagopal SK, Sansevere AJ, McDavitt E, Wigmore D, Mecklosky J, Andren K, Williams KA, Danehy A, Soul JS. Post-arrest therapeutic hypothermia in pediatric patients with congenital heart disease. *Resuscitation*. 2018;126:83–89. doi: 10.1016/j.resuscitation.2018.02.022
 145. Lin JJ, Hsia SH, Wang HS, Chiang MC, Lin KL. Therapeutic hypothermia associated with increased survival after resuscitation in children. *Pediatr Neurol*. 2013;48:285–290. doi: 10.1016/j.pediatrneurol.2012.12.021
 146. Lin JJ, Lin CY, Hsia SH, Wang HS, Chiang MC, Lin KL; iCNS Group. 72-H therapeutic hypothermia improves neurological outcomes in paediatric asphyxial out-of-hospital cardiac arrest: an exploratory investigation. *Resuscitation*. 2018;133:180–186. doi: 10.1016/j.resuscitation.2018.08.019
 147. Scholefield BR, Morris KP, Duncan HP, Perkins GD, Gosney J, Skone R, Sanders V, Gao F. Evolution, safety and efficacy of targeted temperature management after pediatric cardiac arrest. *Resuscitation*. 2015;92:19–25. doi: 10.1016/j.resuscitation.2015.04.007
 148. Torres-Andres F, Fink EL, Bell MJ, Sharma MS, Yablonsky EJ, Sanchez-de-Toledo J. Survival and long-term functional outcomes for children with cardiac arrest treated with extracorporeal cardiopulmonary resuscitation. *Pediatr Crit Care Med*. 2018;19:451–458. doi: 10.1097/PCC.0000000000001524
 149. Doherty DR, Parshuram CS, Gaboury I, Hoskote A, Lacroix J, Tucci M, Joffe A, Choong K, Farrell R, Bohn DJ, et al; on behalf of the Canadian Critical Care Trials Group. Hypothermia therapy after pediatric cardiac arrest. *Circulation*. 2009;119:1492–1500. doi: 10.1161/CIRCULATIONAHA.108.791384
 150. Moler FW, Hutchison JS, Nadkarni VM, Silverstein FS, Meert KL, Holubkov R, Page K, Slomine BS, Christensen JR, Dean JM; and the Therapeutic Hypothermia After Pediatric Cardiac Arrest Out-of-Hospital Trial Investigators. Targeted temperature management after pediatric cardiac arrest due to drowning: outcomes and complications. *Pediatr Crit Care Med*. 2016;17:712–720. doi: 10.1097/PCC.0000000000000763
 151. Saugstad OD. Room air resuscitation: two decades of neonatal research. *Early Hum Dev*. 2005;81:111–116. doi: 10.1016/j.earlhumdev.2004.10.009
 152. Lorente-Pozo S, Parra-Llorca A, Núñez-Ramiro A, Cernada M, Hervás D, Boronat N, Sandoval J, Vento M. The oxygen load supplied during delivery room stabilization of preterm infants modifies the DNA methylation profile. *J Pediatr*. 2018;202:70–76.e2. doi: 10.1016/j.jpeds.2018.07.009
 153. Perlman JM, Wyllie J, Kattwinkel J, Atkins DL, Chameides L, Goldsmith JP, Guinsburg R, Hazinski MF, Morley C, Richmond S, et al; on behalf of the Neonatal Resuscitation Chapter Collaborators. Part 11: neonatal resuscitation: 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2010;122(suppl 2):S516–S538. doi: 10.1161/CIRCULATIONAHA.110.971127
 154. Perlman JM, Wyllie J, Kattwinkel J, Wyckoff MH, Aziz K, Guinsburg R, Kim HS, Liley HG, Mildenhall L, Simon WM, et al; on behalf of the Neonatal Resuscitation Chapter Collaborators. Part 7: neonatal resuscitation: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2015;132(suppl 1):S204–S241. doi: 10.1161/CIR.0000000000000276
 155. Sarnat HB, Sarnat MS. Neonatal encephalopathy following fetal distress: a clinical and electroencephalographic study. *Arch Neurol*. 1976;33:696–705. doi: 10.1001/archneur.1976.00500100030012
 156. Isayama T, Dawson JA, Roehr CC, Rabi Y, Weiner GM, Aziz K, Kapadia VS, de Almeida MF, Trevisanuto D, Mildenhall L, et al. Initial oxygen concentration for term neonatal resuscitation. International Liaison Committee on Resuscitation (ILCOR) Neonatal Life Support Task Force. April 1, 2019. <https://costr.ilcor.org/document/initial-oxygen-concentration-for-term-neonatal-resuscitation>. Accessed May 22, 2019.
 157. Ramji S, Ahuja S, Thirupuram S, Rootwelt T, Rooth G, Saugstad OD. Resuscitation of asphyxiated newborn infants with room air or 100% oxygen. *Pediatr Res*. 1993;34:809–812. doi: 10.1203/00006450-199312000-00023
 158. Saugstad OD, Rootwelt T, Aalen O. Resuscitation of asphyxiated newborn infants with room air or oxygen: an international controlled trial: the Resair 2 study. *Pediatrics*. 1998;102:e1. doi: 10.1542/peds.102.1.e1
 159. Vento M, Asensi M, Sastre J, Lloret A, Garcia-Sala F, Viña J. Oxidative stress in asphyxiated term infants resuscitated with 100% oxygen. *J Pediatr*. 2003;142:240–246.
 160. Ramji S, Rasaily R, Mishra PK, Narang A, Jayam S, Kapoor AN, Kambo I, Mathur A, Saxena BN. Resuscitation of asphyxiated newborns with room air or 100% oxygen at birth: a multicentric clinical trial. *Indian Pediatr*. 2003;40:510–517.
 161. Bajaj N, Udani RH, Nanavati RN. Room air vs. 100 per cent oxygen for neonatal resuscitation: a controlled clinical trial. *J Trop Pediatr*. 2005;51:206–211. doi: 10.1093/tropej/fmh086
 162. Vento M, Sastre J, Asensi MA, Viña J. Room-air resuscitation causes less damage to heart and kidney than 100% oxygen. *Am J Respir Crit Care Med*. 2005;172:1393–1398. doi: 10.1164/rccm.200412-1740OC
 163. Toma AI, Nanea M, Scheiner M, Mitu R, Petrescu I, Matu E. Effects of the gas used in the resuscitation of the newborn in the post-resuscitation haemodynamics. *Asfixia Perinatala Primul Congres National de Neonatologie*. 2006:33–44.
 164. Saugstad OD, Ramji S, Irani SF, El-Meneza S, Hernandez EA, Vento M, Talvik T, Solberg R, Rootwelt T, Aalen OO. Resuscitation of newborn infants with 21% or 100% oxygen: follow-up at 18 to 24 months. *Pediatrics*. 2003;112:296–300. doi: 10.1542/peds.112.2.296
 165. Kapadia V, Wyckoff MH. Oxygen therapy in the delivery room: what is the right dose? *Clin Perinatol*. 2018;45:293–306. doi: 10.1016/j.clp.2018.01.014
 166. International Committee for the Classification of Retinopathy of Prematurity. The International Classification of Retinopathy of Prematurity revisited. *Arch Ophthalmol*. 2005;123:991–999. doi: 10.1001/archophth.123.7.991
 167. Walsh MC, Kliegman RM. Necrotizing enterocolitis: treatment based on staging criteria. *Pediatr Clin North Am*. 1986;33:179–201.
 168. Higgins RD, Jobe AH, Koso-Thomas M, Bancalari E, Viscardi RM, Hartert TV, Ryan RM, Kallapur SG, Steinhorn RH, Konduri GG, et al. Bronchopulmonary dysplasia: executive summary of a workshop. *J Pediatr*. 2018;197:300–308. doi: 10.1016/j.jpeds.2018.01.043
 169. Papile LA, Burstein J, Burstein R, Koffler H. Incidence and evolution of subependymal and intraventricular hemorrhage: a study of infants with birth weights less than 1,500 gm. *J Pediatr*. 1978;92:529–534. doi: 10.1016/s0022-3476(78)80282-0
 170. Lundström KE, Pryds O, Greisen G. Oxygen at birth and prolonged cerebral vasoconstriction in preterm infants. *Arch Dis Child Fetal Neonatal Ed*. 1995;73:F81–F86.
 171. Wang CL, Anderson C, Leone TA, Rich W, Govindaswami B, Finer NN. Resuscitation of preterm neonates by using room air or 100% oxygen. *Pediatrics*. 2008;121:1083–1089. doi: 10.1542/peds.2007-1460
 172. Vento M, Moro M, Escrig R, Arruzal L, Villar G, Izquierdo I, Roberts LJ 2nd, Arduini A, Escobar JJ, Sastre J, et al. Preterm resuscitation with low oxygen causes less oxidative stress, inflammation, and chronic lung disease. *Pediatrics*. 2009;124:e439–e449. doi: 10.1542/peds.2009-0434
 173. Rabi Y, Singhal N, Nettel-Aguirre A. Room-air versus oxygen administration for resuscitation of preterm infants: the ROAR study. *Pediatrics*. 2011;128:e374–e381. doi: 10.1542/peds.2010-3130
 174. Armanian AM, Badiee Z. Resuscitation of preterm newborns with low concentration oxygen versus high concentration oxygen. *J Res Pharm Pract*. 2012;1:25–29. doi: 10.4103/2279-042X.99674
 175. Kapadia VS, Chalak LF, Sparks JE, Allen JR, Savani RC, Wyckoff MH. Resuscitation of preterm neonates with limited versus high oxygen strategy. *Pediatrics*. 2013;132:e1488–e1496. doi: 10.1542/peds.2013-0978
 176. Aguar M, Brugada M, Escobar J, Cubells E, Kuligowski J, Cernada M, Escrig R, Saenz P, Vento M. Resuscitation of ELBW infants with initial FiO₂ of 30% vs. 60%, a randomized, controlled, blinded study: the REOX trial. In: 2013 PAS Annual Meeting; May 4–7, 2013; Washington, DC.
 177. Rook D, Schierbeek H, Vento M, Vlaardingerbroek H, van der Eijk AC, Longini M, Buonocore G, Escobar J, van Goudoever JB, Vermeulen MJ. Resuscitation of preterm infants with different inspired oxygen fractions. *J Pediatr*. 2014;164:1322–6.e3. doi: 10.1016/j.jpeds.2014.02.019
 178. Oei JL, Saugstad OD, Lui K, Wright IM, Smyth JP, Craven P, Wang YA, McMullan R, Coates E, Ward M, et al. Targeted oxygen in the resuscitation of preterm infants, a randomized clinical trial. *Pediatrics*. 2017;139:e20161452. doi: 10.1542/peds.2016-1452
 179. Harling AE, Beresford MW, Vince GS, Bates M, Yoxall CW. Does the use of 50% oxygen at birth in preterm infants reduce lung injury? *Arch Dis Child Fetal Neonatal Ed*. 2005;90:F401–F405. doi: 10.1136/adc.2004.059287
 180. Dawson JA, Kamlin CO, Wong C, te Pas AB, O'Donnell CP, Donath SM, Davis PG, Morley CJ. Oxygen saturation and heart rate during delivery room resuscitation of infants <30 weeks' gestation with air or 100% oxygen. *Arch Dis Child Fetal Neonatal Ed*. 2009;94:F87–F91. doi: 10.1136/adc.2008.141341

181. Rabi Y, Lodha A, Soraisham A, Singhal N, Barrington K, Shah PS. Outcomes of preterm infants following the introduction of room air resuscitation. *Resuscitation*. 2015;96:252–259. doi: 10.1016/j.resuscitation.2015.08.012
182. Soraisham AS, Rabi Y, Shah PS, Singhal N, Synnes A, Yang J, Lee SK, Lodha AK. Neurodevelopmental outcomes of preterm infants resuscitated with different oxygen concentration at birth. *J Perinatol*. 2017;37:1141–1147. doi: 10.1038/jp.2017.83
183. Kapadia VS, Lal CV, Kakkilaya V, Heyne R, Savani RC, Wyckoff MH. Impact of the Neonatal Resuscitation Program-recommended low oxygen strategy on outcomes of infants born preterm. *J Pediatr*. 2017;191:35–41. doi: 10.1016/j.jpeds.2017.08.074
184. Roehr CC, Weiner GM, Isayama T, Dawson JA, Rabi Y, Kapadia VS, de Almeida MF, Trevisanuto D, Mildenhall L, Liley HG, et al. Initial oxygen concentration for preterm neonatal resuscitation. International Liaison Committee on Resuscitation (ILCOR) Neonatal Life Support Task Force. February 25, 2019. <https://costr.ilcor.org/document/initial-oxygen-concentration-for-preterm-neonatal-resuscitation>. Accessed May 22, 2019.
185. Boronat N, Aguar M, Rook D, Iriondo M, Brugada M, Cernada M, Nuñez A, Izquierdo M, Cubells E, Martinez M, et al. Survival and neurodevelopmental outcomes of preterms resuscitated with different oxygen fractions. *Pediatrics*. 2016;138. doi: 10.1542/peds.2016-1405
186. Thamrin V, Saugstad OD, Tarnow-Mordi W, Wang YA, Lui K, Wright IM, De Waal K, Travadi J, Smyth JP, Craven P, et al. Preterm infant outcomes after randomization to initial resuscitation with FiO_2 0.21 or 1.0. *J Pediatr*. 2018;201:55–61.e1. doi: 10.1016/j.jpeds.2018.05.053
187. Munkeby BH, Børke WB, Bjørnland K, Sikkeland LI, Borge GI, Halvorsen B, Saugstad OD. Resuscitation with 100% O_2 increases cerebral injury in hypoxemic piglets. *Pediatr Res*. 2004;56:783–790. doi: 10.1203/01.PDR.0000141988.89820.E3
188. Matsuyama T, Kiyohara K, Kitamura T, Nishiyama C, Nishiuchi T, Hayashi Y, Kawamura T, Ohta B, Iwami T. Hospital characteristics and favourable neurological outcome among patients with out-of-hospital cardiac arrest in Osaka, Japan. *Resuscitation*. 2017;110:146–153. doi: 10.1016/j.resuscitation.2016.11.009
189. Tagami T, Hirata K, Takeshige T, Matsui J, Takinami M, Satake M, Satake S, Yui T, Itabashi K, Sakata T, et al. Implementation of the fifth link of the chain of survival concept for out-of-hospital cardiac arrest. *Circulation*. 2012;126:589–597. doi: 10.1161/CIRCULATIONAHA.111.086173
190. Bhanji F, Finn JC, Lockey A, Monsieurs K, Fregley R, Iwami T, Lang E, Ma MH, Mancini ME, McNeil MA, et al; on behalf of the Education, Implementation, and Teams Chapter Collaborators. Part 8: education, implementation, and teams: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2015;132(suppl 1):S242–S268. doi: 10.1161/CIR.0000000000000277
191. Finn JC, Bhanji F, Lockey A, Monsieurs K, Fregley R, Iwami T, Lang E, Ma MH, Mancini ME, McNeil MA, et al; on behalf of the Education, Implementation, and Teams Chapter Collaborators. Part 8: education, implementation, and teams: 2015 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations. *Resuscitation*. 2015;95:e203–e224. doi: 10.1016/j.resuscitation.2015.07.046
192. Yeung J, Bray J, Reynolds J, Matsuyama T, Skrifvars M, Lang E, Singletary E, Lockey A, Pellegrino J, Gilfoyle E, et al; on behalf of the ALS and EIT Task Forces. Cardiac arrest centers versus non-cardiac arrest centers—adults: Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) EIT and ALS Task Forces. April 15, 2019. <https://costr.ilcor.org/document/cardiac-arrest-centers-versus-non-cardiac-arrest-centers-adults>. Accessed May 22, 2019.
193. Seiner J, Polasek R, Lejssek J, Strycek M, Karasek J. Cardiac arrest center: one-year experience of the Regional Hospital Liberec. *Cor et Vasa*. 2018;60:e234–e238.
194. Kragholm K, Malta Hansen C, Dupre ME, Xian Y, Strauss B, Tyson C, Monk L, Corbett C, Fordyce CB, Pearson DA, et al. Direct transport to a percutaneous cardiac intervention center and outcomes in patients with out-of-hospital cardiac arrest. *Circ Cardiovasc Qual Outcomes*. 2017;10:e003414. doi: 10.1161/CIRCOUTCOMES.116.003414
195. Spaite DW, Bobrow BJ, Stolz U, Berg RA, Sanders AB, Kern KB, Chikani V, Humble W, Mullins T, Stacyszynski JS, et al; on behalf of the Arizona Cardiac Receiving Center Consortium. Statewide regionalization of postarrest care for out-of-hospital cardiac arrest: association with survival and neurologic outcome. *Ann Emerg Med*. 2014;64:496–506.e1. doi: 10.1016/j.annemergmed.2014.05.028
196. Couper K, Kimani PK, Gale CP, Quinn T, Squire IB, Marshall A, Black JMM, Cooke MW, Ewings B, Long J, et al. Patient, health service factors and variation in mortality following resuscitated out-of-hospital cardiac arrest in acute coronary syndrome: analysis of the Myocardial Ischaemia National Audit Project. *Resuscitation*. 2018;124:49–57. doi: 10.1016/j.resuscitation.2018.01.011
197. Sjøholm H, Kjaergaard J, Bro-Jeppesen J, Hartvig-Thomsen J, Lippert F, Køber L, Nielsen N, Engsig M, Steensen M, Wanscher M, et al. Prognostic implications of level-of-care at tertiary heart centers compared with other hospitals after resuscitation from out-of-hospital cardiac arrest. *Circ Cardiovasc Qual Outcomes*. 2015;8:268–276. doi: 10.1161/CIRCOUTCOMES.115.001767
198. Harnod D, Ma MHM, Chang WH, Chang RE, Chang CH. Mortality factors in out-of-hospital cardiac arrest patients: a nationwide population-based study in Taiwan. *Int J Gerontology*. 2013;7:216–220.
199. Elmer J, Callaway CW, Chang CH, Madaras J, Martin-Gill C, Nawrocki P, Seaman KAC, Sequeira D, Traynor OT, Venkat A, et al. Long-term outcomes of out-of-hospital cardiac arrest care at regionalized centers. *Ann Emerg Med*. 2019;73:29–39. doi: 10.1016/j.annemergmed.2018.05.018
200. Elmer J, Rittenberger JC, Coppler PJ, Guyette FX, Doshi AA, Callaway CW; and the Pittsburgh Post-Cardiac Arrest Service. Long-term survival benefit from treatment at a specialty center after cardiac arrest. *Resuscitation*. 2016;108:48–53. doi: 10.1016/j.resuscitation.2016.09.008
201. Brooks SC, Scales DC, Pinto R, Dainty KN, Racz EM, Gaudio M, Amaral AC, Gray SH, Friedrich JO, Chapman M, et al. The Postcardiac Arrest Consult Team: impact on hospital care processes for out-of-hospital cardiac arrest patients. *Crit Care Med*. 2016;44:2037–2044. doi: 10.1097/CCM.0000000000001863
202. Andrew E, Nehme Z, Wolfe R, Bernard S, Smith K. Long-term survival following out-of-hospital cardiac arrest. *Heart*. 2017;103:1104–1110. doi: 10.1136/heartjnl-2016-310485
203. Mumma BE, Diercks DB, Wilson MD, Holmes JF. Association between treatment at an ST-segment elevation myocardial infarction center and neurologic recovery after out-of-hospital cardiac arrest. *Am Heart J*. 2015;170:516–523. doi: 10.1016/j.ahj.2015.05.020
204. Tranberg T, Lippert FK, Christensen EF, Stengaard C, Hjort J, Lassen JF, Petersen F, Jensen JS, Bäck C, Jensen LO, et al. Distance to invasive heart centre, performance of acute coronary angiography, and angioplasty and associated outcome in out-of-hospital cardiac arrest: a nationwide study. *Eur Heart J*. 2017;38:1645–1652. doi: 10.1093/eurheartj/ehx104
205. Cournoyer A, Notebaert É, de Montigny L, Ross D, Cossette S, Londei-Leduc L, Iseppon M, Lamarche Y, Sokoloff C, Potter BJ, et al. Impact of the direct transfer to percutaneous coronary intervention-capable hospitals on survival to hospital discharge for patients with out-of-hospital cardiac arrest. *Resuscitation*. 2018;125:28–33. doi: 10.1016/j.resuscitation.2018.01.048
206. Lick CJ, Aufderheide TP, Niskanen RA, Steinkamp JE, Davis SP, Nygaard SD, Bemenderfer KK, Gonzales L, Kalla JA, Wald SK, et al. Take Heart America: a comprehensive, community-wide, systems-based approach to the treatment of cardiac arrest. *Crit Care Med*. 2011;39:26–33. doi: 10.1097/CCM.0b013e3181fa7ce4
207. Stub D, Smith K, Bray JE, Bernard S, Duffy SJ, Kaye DM. Hospital characteristics are associated with patient outcomes following out-of-hospital cardiac arrest. *Heart*. 2011;97:1489–1494. doi: 10.1136/hrt.2011.226431
208. Chocron R, Bougouin W, Beganton F, Juvin P, Loeb T, Adnet F, Lecarpentier E, Lamhaut L, Jost D, Marijon E, et al. Are characteristics of hospitals associated with outcome after cardiac arrest? Insights from the Great Paris registry. *Resuscitation*. 2017;118:63–69. doi: 10.1016/j.resuscitation.2017.06.019
209. Lai CY, Lin FH, Chu H, Ku CH, Tsai SH, Chung CH, Chien WC, Wu CH, Chu CM, Chang CW. Survival factors of hospitalized out-of-hospital cardiac arrest patients in Taiwan: a retrospective study. *PLoS One*. 2018;13:e0191954. doi: 10.1371/journal.pone.0191954
210. Sjøholm H, Wachtell K, Nielsen SL, Bro-Jeppesen J, Pedersen F, Wanscher M, Boesgaard S, Møller JE, Hassager C, Kjaergaard J. Tertiary centres have improved survival compared to other hospitals in the Copenhagen area after out-of-hospital cardiac arrest. *Resuscitation*. 2013;84:162–167. doi: 10.1016/j.resuscitation.2012.06.029
211. McKenzie N, Williams TA, Ho KM, Inoue M, Bailey P, Celenza A, Fatovich D, Jenkins I, Finn J. Direct transport to a PCI-capable hospital is associated with improved survival after adult out-of-hospital cardiac arrest of medical aetiology. *Resuscitation*. 2018;128:76–82. doi: 10.1016/j.resuscitation.2018.04.039

212. Patterson T, Perkins GD, Joseph J, Wilson K, Van Dyck L, Robertson S, Nguyen H, McConkey H, Whitbread M, Fothergill R, et al. A Randomised trial of Expedited transfer to a cardiac arrest centre for non-ST elevation ventricular fibrillation out-of-hospital cardiac arrest: the ARREST pilot randomised trial. *Resuscitation*. 2017;115:185–191. doi: 10.1016/j.resuscitation.2017.01.020
213. Geri G, Gilgan J, Wu W, Vijendira S, Ziegler C, Drennan IR, Morrison L, Lin S. Does transport time of out-of-hospital cardiac arrest patients matter? A systematic review and meta-analysis. *Resuscitation*. 2017;115:96–101. doi: 10.1016/j.resuscitation.2017.04.003
214. Bartoletti A, Fabiani P, Bagnoli L, Cappelletti C, Cappellini M, Nappini G, Gianni R, Lavacchi A, Santoro GM. Physical injuries caused by a transient loss of consciousness: main clinical characteristics of patients and diagnostic contribution of carotid sinus massage. *Eur Heart J*. 2008;29:618–624. doi: 10.1093/eurheartj/ehm563
215. Jensen JL, Cassan P, Meyran D, Ng KC, Ohshimo S, Singletary EM, Zideman DA, Epstein JL, Bendall J, Berry DC, et al; on behalf of the International Liaison Committee on Resuscitation (ILCOR) First Aid Task Force and Pediatric Task Force. First aid interventions for presyncope: Consensus on Science With Treatment Recommendations. International Liaison Committee on Resuscitation (ILCOR) First Aid and Pediatric Task Forces. February 25, 2019. <https://costr.ilcor.org/document/first-aid-interventions-for-presyncope>. Accessed May 22, 2019.
216. Brignole M, Croci F, Menozzi C, Solano A, Donateo P, Oddone D, Puggioni E, Lolli G. Isometric arm counter-pressure maneuvers to abort impending vasovagal syncope. *J Am Coll Cardiol*. 2002;40:2053–2059. doi: 10.1016/s0735-1097(02)02683-9
217. Alizadeh A, Peighambari M, Keikhavani A, Emkanjoo Z, Rad M, Ghadroost B, Khabazian M. The role of acute physical maneuver in preventing vasovagal syncope: a randomized clinical trial. *Clin Cardiol Electrophysiol*. 2016;1:e5348.
218. Clarke DA, Medow MS, Taneja I, Ocon AJ, Stewart JM. Initial orthostatic hypotension in the young is attenuated by static handgrip. *J Pediatr*. 2010;156:1019–1022.e1. doi: 10.1016/j.jpeds.2010.01.035
219. Krediet CT, van Dijk N, Linzer M, van Lieshout JJ, Wieling W. Management of vasovagal syncope: controlling or aborting faints by leg crossing and muscle tensing. *Circulation*. 2002;106:1684–1689. doi: 10.1161/01.cir.0000030939.12646.8f
220. Krediet CT, Go-Schön IK, van Lieshout JJ, Wieling W. Optimizing squatting as a physical maneuver to prevent vasovagal syncope. *Clin Auton Res*. 2008;18:179–186. doi: 10.1007/s10286-008-0481-0
221. Kim KH, Cho JG, Lee KO, Seo TJ, Shon CY, Lim SY, Yun KH, Sohn IS, Hong YJ, Park HW, et al. Usefulness of physical maneuvers for prevention of vasovagal syncope. *Circ J*. 2005;69:1084–1088.
222. Croci F, Brignole M, Menozzi C, Solano A, Donateo P, Oddone D, Puggioni E, Lolli G. Efficacy and feasibility of isometric arm counter-pressure manoeuvres to abort impending vasovagal syncope during real life. *Europace*. 2004;6:287–291. doi: 10.1016/j.eupc.2004.03.008
223. Bouvette CM, McPhee BR, Opfer-Gehrking TL, Low PA. Role of physical countermeasures in the management of orthostatic hypotension: efficacy and biofeedback augmentation. *Mayo Clin Proc*. 1996;71:847–853. doi: 10.4065/71.9.847