

Part 6: Alternative Techniques and Ancillary Devices for Cardiopulmonary Resuscitation

2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

Steven C. Brooks, Chair; Monique L. Anderson; Eric Bruder; Mohamud R. Daya; Alan Gaffney; Charles W. Otto; Adam J. Singer; Ravi R. Thiagarajan; Andrew H. Travers

Introduction

Conventional cardiopulmonary resuscitation (CPR) consisting of manual chest compressions with rescue breaths is inherently inefficient with respect to generating cardiac output. A variety of alternatives and adjuncts to conventional CPR have been developed, with the aim of enhancing perfusion during resuscitation from cardiac arrest. Since the publication of the *2010 American Heart Association (AHA) Guidelines for CPR and Emergency Cardiovascular Care (ECC)*,¹ a number of clinical trials have provided additional data on the effectiveness of these alternatives and adjuncts. Compared with conventional CPR, many of these techniques and devices require specialized equipment and training. Some have only been tested in highly selected subgroups of cardiac arrest patients; this context must be considered when rescuers or healthcare systems are considering implementation.

Methodology

The recommendations in this *2015 AHA Guidelines Update for CPR and ECC* are based on an extensive evidence review process that was begun by the International Liaison Committee on Resuscitation (ILCOR) after the publication of the *ILCOR 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations*^{2,3} and was completed in February 2015.^{4,5}

In this in-depth evidence review process, the ILCOR Advanced Life Support (ALS) Task Force examined topics and then generated a prioritized list of questions for systematic review. Questions were first formulated in PICO (population, intervention, comparator, outcome) format,⁶ search strategies and criteria for inclusion and exclusion of articles were defined, and then a search for relevant articles was performed. The evidence was evaluated by the ILCOR ALS Task Force by using the standardized methodological approach proposed by the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) Working Group.⁷

The quality of the evidence was categorized based on the study methodologies and the 5 core GRADE domains of risk

of bias, inconsistency, indirectness, imprecision, and other considerations (including publication bias). Then, where possible, consensus-based treatment recommendations were created.

To create this *2015 AHA Guidelines Update for CPR and ECC*, the AHA formed 15 writing groups, with careful attention to manage conflicts of interest, to assess the ILCOR treatment recommendations, and to write AHA Guidelines and treatment recommendations by using the AHA Class of Recommendation and Level of Evidence (LOE) system. The recommendations made in the *2015 AHA Guidelines Update for CPR and ECC* are informed by the ILCOR recommendations and GRADE classification, in the context of the delivery of medical care in North America. Throughout the online version of this publication, live links are provided so the reader can connect directly to the systematic reviews on the ILCOR Scientific Evidence Evaluation and Review System (SEERS) website. These links are indicated by a superscript combination of letters and numbers (eg, ALS 579). We encourage readers to use the links and review the evidence and appendixes, such as the GRADE tables. For further information, please see Part 2 of this supplement, "Evidence Evaluation and Management of Conflicts of Interest."

The following CPR techniques and devices were last reviewed in 2010^{2,3}: open-chest CPR, interposed abdominal compression, "cough" CPR, prone CPR, precordial thump, percussion pacing, and devices to assist ventilation. The reader is referred to the 2010 Guidelines for details of those recommendations.¹ A listing of all of the recommendations in this 2015 Guidelines Update and the recommendations from "Part 7: CPR Techniques and Devices" of the 2010 Guidelines can be found in the Appendix.

Devices to Support Circulation

Impedance Threshold Device^{ALS 579}

The impedance threshold device (ITD) is a pressure-sensitive valve that is attached to an endotracheal tube (ETT), supraglottic airway, or face mask. The ITD limits air entry into the lungs

The American Heart Association requests that this document be cited as follows: Brooks SC, Anderson ML, Bruder E, Daya MR, Gaffney A, Otto CW, Singer AJ, Thiagarajan RR, Travers AH. Part 6: alternative techniques and ancillary devices for cardiopulmonary resuscitation: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*. 2015;132(suppl 2):S436–S443.

(*Circulation*. 2015;132[suppl 2]:S436–S443. DOI: 10.1161/CIR.0000000000000260.)

© 2015 American Heart Association, Inc.

Circulation is available at <http://circ.ahajournals.org>

DOI: 10.1161/CIR.0000000000000260

during the decompression phase of CPR, enhancing the negative intrathoracic pressure generated during chest wall recoil, thereby improving venous return to the heart and cardiac output during CPR. It does so without impeding positive-pressure ventilation or passive exhalation. The ITD is removed after return of spontaneous circulation (ROSC) is achieved. The ITD has been used alone as a circulatory adjunct as well as in conjunction with active compression-decompression CPR (ACD-CPR) devices. The ITD and ACD-CPR are thought to act synergistically to enhance venous return and improve cardiac output during CPR.^{8,9} Although initially used as part of a circuit with a cuffed ETT during bag-tube ventilation, the ITD can also be used with a face mask, provided that a tight seal is maintained between the face and mask.

2015 Evidence Summary

Three randomized controlled trials (RCTs) in humans have examined the benefits of incorporating the ITD as an adjunct to conventional CPR in out-of-hospital cardiac arrest (OHCA). One small single-site RCT of 22 patients with femoral artery catheters demonstrated that a functioning ITD applied to an ETT significantly increased systolic blood pressures as compared with a sham device, although there was no difference in ROSC rates.¹⁰ The second RCT examined the safety and survival to intensive care unit admission of a functioning versus sham ITD in 230 patients.¹¹ The ITD was initially placed on a face mask and was relocated to the ETT after intubation. This study found no difference in ROSC, intensive care unit admission, or 24-hour survival between the 2 groups. The third and largest RCT examined the impact of a functioning ITD versus a sham device at 10 sites in the United States and Canada as part of the Resuscitation Outcomes Consortium (ROC) Prehospital Resuscitation Impedance Valve and Early Versus Delayed Analysis (PRIMED) study.¹² Of the 8718 patients included in this high-quality RCT, 4345 were randomized to resuscitation with a sham ITD and 4373 were assigned to resuscitation with the functioning ITD. The ROC PRIMED study permitted placement of the ITD on a face mask, supraglottic airway, or ETT. This large multicenter RCT did not show a benefit from the addition of the ITD to conventional CPR for neurologically intact survival to hospital discharge or survival to hospital discharge. There were no differences in adverse events (pulmonary edema or airway bleeding) between the 2 groups.

2015 Recommendation—New

The routine use of the ITD as an adjunct during conventional CPR is not recommended (Class III: No Benefit, LOE A). This Class of Recommendation, new in 2015, indicates that high-quality evidence did not demonstrate benefit or harm associated with the ITD when used as an adjunct to conventional CPR.

Active Compression-Decompression CPR and Impedance Threshold Device^{ALS 579}

ACD-CPR is performed by using a handheld device with a suction cup applied over the midsternum of the chest. After chest compression, the device is used to actively lift up the anterior chest during decompressions. The application of external negative suction during decompression enhances the

negative intrathoracic pressure (vacuum) generated by chest recoil, thereby increasing venous return (preload) to the heart and cardiac output during the next chest compression. ACD-CPR is believed to act synergistically with the ITD to enhance venous return during chest decompression and improves blood flow to vital organs during CPR. Commercially available ACD-CPR devices have a gauge meter to guide compression and decompression forces and a metronome to guide duty cycle and chest compression rate. The use of ACD-CPR in comparison with conventional CPR was last reviewed for the 2010 Guidelines. Since the 2010 Guidelines, new evidence is available regarding the use of ACD-CPR in combination with the ITD.

2015 Evidence Summary

The combination of ACD-CPR with an ITD has been studied in 4 RCTs reported in 5 publications.^{9,13–16} Two of these trials evaluated ACD-CPR with the ITD in comparison with ACD-CPR alone.^{9,13} The first of these used femoral artery catheters to measure improved hemodynamic parameters but found no difference in ROSC, 24-hour survival, or survival to hospital discharge.⁹ In a follow-up RCT of 400 patients, the ACD-CPR with a functioning ITD increased 24-hour survival, but again there was no difference in survival to hospital discharge or survival with good neurologic function as compared with the ACD-CPR with sham ITD group.¹³

The remaining 2 RCTs compared ACD-CPR with the ITD versus conventional CPR. The first was a single-center RCT in which 210 patients were randomly assigned to ACD-CPR+ITD or conventional CPR after intubation by the advanced life support team, which arrived on scene a mean of 9.5 minutes after the 9-1-1 call.¹⁴ The chest compression and ventilation rates in both arms were 100/min and 10 to 12 breaths/min, respectively. The ROSC, 1-hour, and 24-hour rates of survival were all significantly improved in the ACD-CPR+ITD group as compared with conventional CPR, but survival to hospital discharge and survival with favorable neurologic outcome were not significantly different. The second trial is the ResQ trial, which was conducted in 7 distinct geographic regions of the United States. In the ResQ trial, conventional CPR was performed with compressions at 100/min, with a compression-to-ventilation ratio of 30:2 during basic life support and ventilation rate of 10/min after intubation. In the ACD-CPR+ITD group, compressions were performed at a rate of 80/min and ventilation at a rate of 10/min. In the intervention arm, a metronome was used to guide the compression rate, a force gauge was used to guide compression depth and recoil, and timing lights on the ITD were used to guide ventilation rate. Two analyses of data from the ResQ trial have been published; the first was restricted to OHCA of presumed cardiac etiology,¹⁵ and the second included all enrolled patients.¹⁶ The complete trial enrolled 2738 patients (conventional CPR=1335, ACD-CPR+ITD=1403) before it was terminated early because of funding constraints.¹⁶ Survival to hospital discharge with favorable neurologic function (modified Rankin Scale score of 3 or less) was greater in the ACD-CPR+ITD group as compared with the conventional CPR group: 7.9% versus 5.7% (odds ratio, 1.42; 95% confidence interval, 1.04–1.95), and this difference was maintained

out to 1 year. For survival to hospital discharge with favorable neurologic function, this translates into a number needed to treat of 45 with very wide confidence limits (95% confidence interval, 25–333), making interpretation of the true clinical effect challenging. There was no difference in the overall incidence of adverse events, although pulmonary edema was more common with ACD-CPR+ITD as compared with conventional CPR (11.3% versus 7.9%; $P=0.002$). The ResQ Trial had a number of important limitations, including lack of blinding, different CPR feedback elements between the study arms (ie, co-intervention), lack of CPR quality assessment, and early termination. Although improved neurologic function was noted with the use of the ACD-CPR+ITD combination at both hospital discharge and 1-year follow-up, additional trials are needed to confirm these findings.

2015 Recommendation—New

The existing evidence, primarily from 1 large RCT of low quality, does not support the routine use of ACD-CPR+ITD as an alternative to conventional CPR. The combination may be a reasonable alternative in settings with available equipment and properly trained personnel (Class IIb, LOE C-LD).

Mechanical Chest Compression Devices: Piston Device

ALS 782

A mechanical piston device consists of an automated compressed gas- or electric-powered plunger positioned over the sternum, which compresses the chest at a set rate. Some devices incorporate a suction cup at the end of the piston that is designed to actively decompress the chest after each compression, whereas others do not.

2015 Evidence Review

The Lund University Cardiac Arrest System (LUCAS) is a gas- (oxygen or air) or electric-powered piston device that produces a consistent chest compression rate and depth. It incorporates a suction cup on the end of the piston that attaches to the sternum and returns the sternum to the starting position when it retracts. A small pilot RCT found similar survival in patients randomly assigned to mechanical versus manual chest compressions.¹⁷ Subsequently, 2 large RCTs, the Prehospital Randomised Assessment of a Mechanical Compression Device in Cardiac Arrest (PARAMEDIC)¹⁸ and LUCAS in Cardiac Arrest (LINC)¹⁹ trials, have compared the use of LUCAS against manual compressions for patients with OHCA. Together, these studies enrolled 7060 patients, and neither demonstrated a benefit for mechanical CPR over manual CPR with respect to early (4-hour) and late (1- and 6-month) survival.^{18,19} The PARAMEDIC study demonstrated a negative association between mechanical chest compressions and survival with good neurologic outcome (Cerebral Performance Category 1–2) at 3 months as compared with manual compressions.

A number of other mechanical piston devices have been compared with manual chest compressions in studies of OHCA. There are no large-scale RCTs with these devices. Three small (largest sample size of 50 patients) RCTs found no differences in early survival^{20–22} despite improvements in end-tidal CO₂ in patients randomly assigned to mechanical piston devices in 2 of these 3 studies.^{21,22} However, in neither

of these studies did any patient survive to hospital discharge. Time-motion analysis of manual versus mechanical chest compressions showed that it took considerable time to deploy the mechanical piston device, prolonging the no-chest compression interval during CPR.²³

2015 Recommendations—New

The evidence does not demonstrate a benefit with the use of mechanical piston devices for chest compressions versus manual chest compressions in patients with cardiac arrest. Manual chest compressions remain the standard of care for the treatment of cardiac arrest, but mechanical piston devices may be a reasonable alternative for use by properly trained personnel (Class IIb, LOE B-R). The use of mechanical piston devices may be considered in specific settings where the delivery of high-quality manual compressions may be challenging or dangerous for the provider (eg, limited rescuers available, prolonged CPR, during hypothermic cardiac arrest, in a moving ambulance, in the angiography suite, during preparation for extracorporeal CPR [ECPR]), provided that rescuers strictly limit interruptions in CPR during deployment and removal of the devices (Class IIb, LOE C-EO).

Load-Distributing Band Devices

ALS 782

The load-distributing band (LDB) is a circumferential chest compression device composed of a pneumatically or electrically actuated constricting band and backboard.

2015 Evidence Summary

While early case series^{24–26} of patients treated with LDB-CPR were encouraging, an observational study exploring a number of treatments related to new guideline implementation suggested that the use of LDB-CPR was associated with lower odds of 30-day survival when compared with concurrent patients receiving only manual CPR.²⁷ One multicenter prospective RCT²⁸ comparing LDB-CPR (Autopulse device) with manual CPR for OHCA demonstrated no improvement in 4-hour survival and worse neurologic outcome when the device was compared with manual CPR. Site-specific factors²⁹ and experience with deployment of the device³⁰ may have influenced the outcomes in this study. In a high-quality multicenter RCT of 4753 OHCA patients, LDB-CPR (Autopulse device) and manual chest compressions were shown to be equivalent with respect to the outcome of survival to hospital discharge. Both approaches in this study were carefully monitored to minimize hands-off time and to optimize compression technique.³¹

2015 Recommendations—New

The evidence does not demonstrate a benefit with the use of LDB-CPR for chest compressions versus manual chest compressions in patients with cardiac arrest. Manual chest compressions remain the standard of care for the treatment of cardiac arrest, but LDB-CPR may be a reasonable alternative for use by properly trained personnel (Class IIb, LOE B-R). The use of LDB-CPR may be considered in specific settings where the delivery of high-quality manual compressions may be challenging or dangerous for the provider (eg, limited rescuers available, prolonged CPR, during hypothermic cardiac arrest, in a moving ambulance, in the angiography suite,

during preparation for ECPR), provided that rescuers strictly limit interruptions in CPR during deployment and removal of the devices (Class IIb, LOE C-EO).

Extracorporeal Techniques and Invasive Perfusion Devices

Extracorporeal CPR^{ALS 723}

For the purpose of this Guidelines Update, the term *ECPR* is used to describe the initiation of cardiopulmonary bypass during the resuscitation of a patient in cardiac arrest. This involves the emergency cannulation of a large vein and artery (eg, femoral vessels) and initiation of venoarterial extracorporeal circulation and oxygenation. The goal of ECPR is to support patients between cardiac arrest and restoration of spontaneous circulation while potentially reversible conditions are addressed. ECPR is a complex process that requires a highly trained team, specialized equipment, and multidisciplinary support within the local healthcare system.

2015 Evidence Summary

There are no data on the use of ECPR from RCTs. Early observational studies in small numbers of witnessed in-hospital cardiac arrest (IHCA) and OHCA patients younger than 75 years with potentially reversible conditions suggested improved survival when compared with conventional CPR.^{32–36} Patients receiving ECPR in these studies tended to be younger, with more witnessed arrests and bystander CPR.

The 2015 ILCOR ALS Task Force reviewed several observational studies, some of which used propensity matching. The results of the studies are mixed. One propensity-matched prospective observational study enrolling 172 IHCA patients reported greater likelihood of return of spontaneous beating in the ECPR group (compared with ROSC in the conventional CPR group) and improved survival at hospital discharge,

30-day, and 1-year follow-up with the use of ECPR. However, this study showed no difference in neurologic outcomes.³⁷ A retrospective observational study including 120 IHCA patients with historic control reported a modest benefit in both survival and neurologic outcome at discharge and 6-month follow-up with the use of ECPR versus conventional CPR.³⁸ A propensity-matched retrospective observational study enrolling 118 IHCA patients showed no survival or neurologic benefit with ECPR at the time of hospital discharge, 30-day, or 1-year follow-up.³⁶ One post hoc analysis of data from a prospective, observational cohort of 162 OHCA patients, including propensity score matching, showed that ECPR was associated with a higher rate of neurologically intact survival at 3-month follow-up.³⁹ A prospective observational study enrolling 454 OHCA patients demonstrated improved neurologic outcomes with the use of ECPR at 1-month and 6-month follow-up after arrest.⁴⁰

2015 Recommendation—New

There is insufficient evidence to recommend the routine use of ECPR for patients with cardiac arrest. In settings where it can be rapidly implemented, ECPR may be considered for select patients for whom the suspected etiology of the cardiac arrest is potentially reversible during a limited period of mechanical cardiorespiratory support (Class IIb, LOE C-LD). Published series have used rigorous inclusion and exclusion criteria to select patients for ECPR. Although these inclusion criteria are highly variable, most included only patients aged 18 to 75 years, with arrest of cardiac origin, after conventional CPR for more than 10 minutes without ROSC. Such inclusion criteria should be considered in a provider's selection of potential candidates for ECPR.

Disclosures

Part 6: Alternative Techniques and Ancillary Devices for Cardiopulmonary Resuscitation: 2015 Guidelines Update Writing Group Disclosures

Writing Group Member	Employment	Research Grant	Other Research Support	Speakers' Bureau/Honoraria	Expert Witness	Ownership Interest	Consultant/Advisory Board	Other
Steven C. Brooks	Queen's University	Heart and Stroke Foundation†; South Eastern Ontario Academic Medical Organization†; Canadian Institutes of Health Research†; National Institutes of Health Research†; Department of Defense, Canada†; US Military†; Heart and Stroke Foundation of Canada†	None	None	None	None	None	South Eastern Ontario Academic Medicine Organization†
Monique L. Anderson	Duke Clinical Research Institute	None	None	None	None	None	None	None
Eric Bruder	Emergency Medicine	None	None	None	None	None	None	None
Mohamud R. Daya	Oregon Health and Science University	NIH-NHLBI†; NIH*; NIH-NINR*	None	None	None	None	Philips Health Care—Uncompensated*	None
Alan Gaffney	Columbia University Medical Center; University of Arizona	None	None	None	None	None	None	None
Charles W. Otto	University of Arizona College of Medicine	None	None	None	None	None	None	None
Adam J. Singer	Stony Brook University	AHA*; NY State*	None	None	None	None	None	None
Ravi R. Thiagarajan	Children's Hospital, Boston	NHLBI*	None	None	None	None	None	None
Consultant								
Andrew H. Travers	Emergency Health Services, Nova Scotia	None	None	None	None	None	American Heart Association†	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 \$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.

Appendix

2015 Guidelines Update: Part 6 Recommendations

Year Last Reviewed	Topic	Recommendation	Comments
2015	Devices to Support Circulation: Impedance Threshold Device	The routine use of the ITD as an adjunct during conventional CPR is not recommended (Class III: No Benefit, LOE A).	new for 2015
2015	Devices to Support Circulation: Active Compression-Decompression CPR and Impedance Threshold Device	The existing evidence, primarily from 1 large RCT of low quality, does not support the routine use of ACD-CPR+ITD as an alternative to conventional CPR. The combination may be a reasonable alternative in settings with available equipment and properly trained personnel (Class IIb, LOE C-LD).	new for 2015
2015	Devices to Support Circulation: Mechanical Chest Compression Devices: Piston Device	The evidence does not demonstrate a benefit with the use of mechanical piston devices for chest compressions versus manual chest compressions in patients with cardiac arrest. Manual chest compressions remain the standard of care for the treatment of cardiac arrest, but mechanical chest compressions using a piston device may be a reasonable alternative for use by properly trained personnel (Class IIb, LOE B-R).	new for 2015
2015	Devices to Support Circulation: Mechanical Chest Compression Devices: Piston Device	The use of piston devices for CPR may be considered in specific settings where the delivery of high-quality manual compressions may be challenging or dangerous for the provider (eg, limited rescuers available, prolonged CPR, during hypothermic cardiac arrest, in a moving ambulance, in the angiography suite, during preparation for extracorporeal CPR [ECPR]), provided that rescuers strictly limit interruptions in CPR during deployment and removal of the device (Class IIb, LOE C-E0).	new for 2015
2015	Devices to Support Circulation: Load-Distributing Band Devices	The evidence does not demonstrate a benefit with the use of LDB-CPR for chest compressions versus manual chest compressions in patients with cardiac arrest. Manual chest compressions remain the standard of care for the treatment of cardiac arrest, but LDB-CPR may be a reasonable alternative for use by properly trained personnel (Class IIb, LOE B-R).	new for 2015
2015	Devices to Support Circulation: Load-Distributing Band Devices	The use of LDB-CPR may be considered in specific settings where the delivery of high-quality manual compressions may be challenging or dangerous for the provider (eg, limited rescuers available, prolonged CPR, during hypothermic cardiac arrest, in a moving ambulance, in the angiography suite, during preparation for extracorporeal CPR [ECPR]), provided that rescuers strictly limit interruptions in CPR during deployment and removal of the devices (Class IIb, LOE E).	new for 2015
2015	Extracorporeal Techniques and Invasive Perfusion Devices: Extracorporeal CPR	There is insufficient evidence to recommend the routine use of ECPR for patients with cardiac arrest. It may be considered for select patients for whom the suspected etiology of the cardiac arrest is potentially reversible during a limited period of mechanical cardiorespiratory support (Class IIb, LOE C-LD).	new for 2015
The following recommendations were not reviewed in 2015. For more information, see the <i>2010 AHA Guidelines for CPR and ECC</i> , "Part 7: CPR Techniques and Devices"			
2010	Open-Chest CPR	Open-chest CPR can be useful if cardiac arrest develops during surgery when the chest or abdomen is already open, or in the early postoperative period after cardiothoracic surgery (Class IIa, LOE C).	not reviewed in 2015
2010	Open-Chest CPR	A resuscitative thoracotomy to facilitate open-chest CPR may be considered in very select circumstances of adults and children with out-of-hospital cardiac arrest from penetrating trauma with short transport times to a trauma facility (Class IIb, LOE C).	not reviewed in 2015
2010	Interposed Abdominal Compression-CPR	IAC-CPR may be considered during in-hospital resuscitation when sufficient personnel trained in its use are available (Class IIb, LOE B).	not reviewed in 2015
2010	"Cough" CPR	"Cough" CPR may be considered in settings such as the cardiac catheterization laboratory for conscious, supine, and monitored patients if the patient can be instructed and coached to cough forcefully every 1 to 3 seconds during the initial seconds of an arrhythmic cardiac arrest. It should not delay definitive treatment (Class IIb, LOE C).	not reviewed in 2015
2010	Prone CPR	When the patient cannot be placed in the supine position, it may be reasonable for rescuers to provide CPR with the patient in the prone position, particularly in hospitalized patients with an advanced airway in place (Class IIb, LOE C).	not reviewed in 2015
2010	Precordial Thump	The precordial thump should not be used for unwitnessed out-of-hospital cardiac arrest (Class III, LOE C).	not reviewed in 2015

(Continued)

2015 Guidelines Update: Part 6 Recommendations, *Continued*

Year Last Reviewed	Topic	Recommendation	Comments
2010	Precordial Thump	The precordial thump may be considered for patients with witnessed, monitored, unstable ventricular tachycardia including pulseless VT if a defibrillator is not immediately ready for use (Class IIb, LOE C), but it should not delay CPR and shock delivery.	not reviewed in 2015
2010	Automatic Transport Ventilators	During prolonged resuscitation efforts, the use of an ATV (pneumatically powered and time- or pressure-cycled) may provide ventilation and oxygenation similar to that possible with the use of a manual resuscitation bag, while allowing the Emergency Medical Services (EMS) team to perform other tasks (Class IIb, LOE C).	not reviewed in 2015
2010	Manually Triggered, Oxygen-Powered, Flow-Limited Resuscitators	Manually triggered, oxygen-powered, flow-limited resuscitators may be considered for the management of patients who do not have an advanced airway in place and for whom a mask is being used for ventilation during CPR (Class IIb, LOE C).	not reviewed in 2015
2010	Manually Triggered, Oxygen-Powered, Flow-Limited Resuscitators	Rescuers should avoid using the automatic mode of the oxygen-powered, flow-limited resuscitator during CPR because it may generate high positive end-expiratory pressure (PEEP) that may impede venous return during chest compressions and compromise forward blood flow (Class III, LOE C).	not reviewed in 2015
2010	Active Compression-Decompression CPR	There is insufficient evidence to recommend for or against the routine use of ACD-CPR. ACD-CPR may be considered for use when providers are adequately trained and monitored (Class IIb, LOE B).	not reviewed in 2015

References

- Cave DM, Gazmuri RJ, Otto CW, Nadkarni VM, Cheng A, Brooks SC, Daya M, Sutton RM, Branson R, Hazinski MF. Part 7: CPR techniques and devices: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*. 2010;122(suppl 3):S720–S728. doi: 10.1161/CIRCULATIONAHA.110.970970.
- Shuster M, Lim SH, Deakin CD, Kleinman ME, Koster RW, Morrison LJ, Nolan JP, Sayre MR; CPR Techniques and Devices Collaborators. Part 7: CPR techniques and devices: 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation*. 2010;122(suppl 2):S338–S344. doi: 10.1161/CIRCULATIONAHA.110.971036.
- Lim SH, Shuster M, Deakin CD, Kleinman ME, Koster RW, Morrison LJ, Nolan JP, Sayre MR; CPR Techniques, Devices Collaborators. Part 7: CPR techniques and devices: 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Resuscitation*. 2010;81 suppl 1:e86–e92. doi: 10.1016/j.resuscitation.2010.08.026.
- Callaway CW, Soar J, Aibiki M, Böttiger BW, Brooks SC, Deakin CD, Donnino MW, Drajer S, Kloeck W, Morley PT, Morrison LJ, Neumar RW, Nicholson TC, Nolan JP, Okada K, O'Neil BJ, Paiva EF, Parr MJ, Wang TL, Witt J; 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.
- Soar J, Callaway CW, Aibiki M, Böttiger BW, Brooks SC, Deakin CD, Donnino MW, Drajer S, Kloeck W, Morley PT, Morrison LJ, Neumar RW, Nicholson TC, Nolan JP, Okada K, O'Neil BJ, Paiva EF, Parr MJ, Wang TL, Witt J; 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. *Resuscitation*. 2015. In press.
- The Cochrane Collaboration. Higgins JPT, Green S, eds. *Cochrane Handbook for Systematic Reviews of Interventions*. Version 5.1.0. 2011. <http://handbook.cochrane.org/>. Accessed May 6, 2015.
- Schünemann H, Brożek J, Guyatt G, Oxman A. *GRADE Handbook*. 2013. <http://www.guidelinedevelopment.org/handbook/>. Accessed May 6, 2015.
- Lurie KG, Coffeen P, Shultz J, McKnite S, Detloff B, Mulligan K. Improving active compression-decompression cardiopulmonary resuscitation with an inspiratory impedance valve. *Circulation*. 1995;91:1629–1632.
- Plaisance P, Lurie KG, Payen D. Inspiratory impedance during active compression-decompression cardiopulmonary resuscitation: a randomized evaluation in patients in cardiac arrest. *Circulation*. 2000;101:989–994.
- Pirralo RG, Aufderheide TP, Provo TA, Lurie KG. Effect of an inspiratory impedance threshold device on hemodynamics during conventional manual cardiopulmonary resuscitation. *Resuscitation*. 2005;66:13–20. doi: 10.1016/j.resuscitation.2004.12.027.
- Aufderheide TP, Pirralo RG, Provo TA, Lurie KG. Clinical evaluation of an inspiratory impedance threshold device during standard cardiopulmonary resuscitation in patients with out-of-hospital cardiac arrest. *Crit Care Med*. 2005;33:734–740.
- Aufderheide TP, Nichol G, Rea TD, Brown SP, Leroux BG, Pepe PE, Kudenchuk PJ, Christenson J, Daya MR, Dorian P, Callaway CW, Idris AH, Andrusiek D, Stephens SW, Hostler D, Davis DP, Dunford JV, Pirralo RG, Stiell IG, Clement CM, Craig A, Van Ottingham L, Schmidt TA, Wang HE, Weisfeldt ML, Ornato JP, Sopko G; Resuscitation Outcomes Consortium (ROC) Investigators. A trial of an impedance threshold device in out-of-hospital cardiac arrest. *N Engl J Med*. 2011;365:798–806. doi: 10.1056/NEJMoa1010821.
- Plaisance P, Lurie KG, Vicaut E, Martin D, Gueugniaud PY, Petit JL, Payen D. Evaluation of an impedance threshold device in patients receiving active compression-decompression cardiopulmonary resuscitation for out of hospital cardiac arrest. *Resuscitation*. 2004;61:265–271. doi: 10.1016/j.resuscitation.2004.01.032.
- Wolcke BB, Mauer DK, Schoefmann MF, Teichmann H, Provo TA, Lindner KH, Dick WF, Aeppli D, Lurie KG. Comparison of standard cardiopulmonary resuscitation versus the combination of active compression-decompression cardiopulmonary resuscitation and an inspiratory impedance threshold device for out-of-hospital cardiac arrest. *Circulation*. 2003;108:2201–2205. doi: 10.1161/01.CIR.0000095787.99180.B5.
- Aufderheide TP, Frascone RJ, Wayne MA, Mahoney BD, Swor RA, Domeier RM, Olinger ML, Holcomb RG, Tupper DE, Yannopoulos D, Lurie KG. Standard cardiopulmonary resuscitation versus active compression-decompression cardiopulmonary resuscitation with augmentation of negative intrathoracic pressure for out-of-hospital cardiac arrest: a randomised trial. *Lancet*. 2011;377:301–311. doi: 10.1016/S0140-6736(10)62103-4.
- Frascone RJ, Wayne MA, Swor RA, Mahoney BD, Domeier RM, Olinger ML, Tupper DE, Setum CM, Burkhart N, Klann L, Salzman JG, Wewerka SS, Yannopoulos D, Lurie KG, O'Neil BJ, Holcomb RG, Aufderheide TP. Treatment of non-traumatic out-of-hospital cardiac arrest with active compression decompression cardiopulmonary resuscitation plus an impedance threshold device. *Resuscitation*. 2013;84:1214–1222. doi: 10.1016/j.resuscitation.2013.05.002.

17. Smekal D, Johansson J, Huzevka T, Rubertsson S. A pilot study of mechanical chest compressions with the LUCAS™ device in cardiopulmonary resuscitation. *Resuscitation*. 2011;82:702–706. doi: 10.1016/j.resuscitation.2011.01.032.
18. Perkins GD, Lall R, Quinn T, Deakin CD, Cooke MW, Horton J, Lamb SE, Slowther AM, Woollard M, Carson A, Smyth M, Whitfield R, Williams A, Pocock H, Black JJ, Wright J, Han K, Gates S; PARAMEDIC trial collaborators. Mechanical versus manual chest compression for out-of-hospital cardiac arrest (PARAMEDIC): a pragmatic, cluster randomised controlled trial. *Lancet*. 2015;385:947–955. doi: 10.1016/S0140-6736(14)61886-9.
19. Rubertsson S, Lindgren E, Smekal D, Östlund O, Silfverstolpe J, Lichtveld RA, Boomars R, Ahlstedt B, Skoog G, Kastberg R, Halliwell D, Box M, Herlitz J, Karlsten R. Mechanical chest compressions and simultaneous defibrillation vs conventional cardiopulmonary resuscitation in out-of-hospital cardiac arrest: the LINC randomized trial. *JAMA*. 2014;311:53–61. doi: 10.1001/jama.2013.282538.
20. Taylor GJ, Rubin R, Tucker M, Greene HL, Rudikoff MT, Weisfeldt ML. External cardiac compression. A randomized comparison of mechanical and manual techniques. *JAMA*. 1978;240:644–646.
21. Ward KR, Menegazzi JJ, Zelenak RR, Sullivan RJ, McSwain NE Jr. A comparison of chest compressions between mechanical and manual CPR by monitoring end-tidal PCO₂ during human cardiac arrest. *Ann Emerg Med*. 1993;22:669–674.
22. Dickinson ET, Verdile VP, Schneider RM, Salluzzo RF. Effectiveness of mechanical versus manual chest compressions in out-of-hospital cardiac arrest resuscitation: a pilot study. *Am J Emerg Med*. 1998;16:289–292.
23. Wang HC, Chiang WC, Chen SY, Ke YL, Chi CL, Yang CW, Lin PC, Ko PC, Wang YC, Tsai TC, Huang CH, Hsiung KH, Ma MH, Chen SC, Chen WJ, Lin FY. Video-recording and time-motion analyses of manual versus mechanical cardiopulmonary resuscitation during ambulance transport. *Resuscitation*. 2007;74:453–460. doi: 10.1016/j.resuscitation.2007.01.018.
24. Timerman S, Cardoso LF, Ramires JA, Halperin H. Improved hemodynamic performance with a novel chest compression device during treatment of in-hospital cardiac arrest. *Resuscitation*. 2004;61:273–280. doi: 10.1016/j.resuscitation.2004.01.025.
25. Casner M, Andersen D, Isaacs SM. The impact of a new CPR assist device on rate of return of spontaneous circulation in out-of-hospital cardiac arrest. *Prehosp Emerg Care*. 2005;9:61–67. doi: 10.1080/10903120509891714.
26. Ong ME, Ornato JP, Edwards DP, Dhindsa HS, Best AM, Ines CS, Hickey S, Clark B, Williams DC, Powell RG, Overton JL, Peberdy MA. Use of an automated, load-distributing band chest compression device for out-of-hospital cardiac arrest resuscitation. *JAMA*. 2006;295:2629–2637. doi: 10.1001/jama.295.22.2629.
27. Steinmetz J, Barnung S, Nielsen SL, Risom M, Rasmussen LS. Improved survival after an out-of-hospital cardiac arrest using new guidelines. *Acta Anaesthesiol Scand*. 2008;52:908–913. doi: 10.1111/j.1399-6576.2008.01657.x.
28. Hallstrom A, Rea TD, Sayre MR, Christenson J, Anton AR, Mosesso VN Jr, Van Ottingham L, Olsufka M, Pennington S, White LJ, Yahn S, Husar J, Morris MF, Cobb LA. Manual chest compression vs use of an automated chest compression device during resuscitation following out-of-hospital cardiac arrest: a randomized trial. *JAMA*. 2006;295:2620–2628. doi: 10.1001/jama.295.22.2620.
29. Paradis NA, Young G, Lemeshow S, Brewer JE, Halperin HR. Inhomogeneity and temporal effects in AutoPulse Assisted Prehospital International Resuscitation—an exception from consent trial terminated early. *Am J Emerg Med*. 2010;28:391–398. doi: 10.1016/j.ajem.2010.02.002.
30. Tomte O, Sunde K, Lorem T, Auestad B, Souders C, Jensen J, Wik L. Advanced life support performance with manual and mechanical chest compressions in a randomized, multicentre manikin study. *Resuscitation*. 2009;80:1152–1157. doi: 10.1016/j.resuscitation.2009.07.001.
31. Wik L, Olsen JA, Persse D, Sterz F, Lozano M Jr, Brouwer MA, Westfall M, Souders CM, Malzer R, van Grunsven PM, Travis DT, Whitehead A, Herken UR, Lerner EB. Manual vs. integrated automatic load-distributing band CPR with equal survival after out of hospital cardiac arrest. The randomized CIRC trial. *Resuscitation*. 2014;85:741–748. doi: 10.1016/j.resuscitation.2014.03.005.
32. Thiagarajan RR, Brogan TV, Scheurer MA, Laussen PC, Rycus PT, Bratton SL. Extracorporeal membrane oxygenation to support cardiopulmonary resuscitation in adults. *Ann Thorac Surg*. 2009;87:778–785. doi: 10.1016/j.athoracsur.2008.12.079.
33. Chen YS, Chao A, Yu HY, Ko WJ, Wu IH, Chen RJ, Huang SC, Lin FY, Wang SS. Analysis and results of prolonged resuscitation in cardiac arrest patients rescued by extracorporeal membrane oxygenation. *J Am Coll Cardiol*. 2003;41:197–203.
34. Athanasuleas CL, Buckberg GD, Allen BS, Beyersdorf F, Kirsh MM. Sudden cardiac death: directing the scope of resuscitation towards the heart and brain. *Resuscitation*. 2006;70:44–51. doi: 10.1016/j.resuscitation.2005.11.017.
35. 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.
36. Huang SC, Wu ET, Chen YS, Chang CI, Chiu IS, Wang SS, Lin FY, Ko WJ. Extracorporeal membrane oxygenation rescue for cardiopulmonary resuscitation in pediatric patients. *Crit Care Med*. 2008;36:1607–1613. doi: 10.1097/CCM.0b013e318170b82b.
37. Chen YS, Lin JW, Yu HY, Ko WJ, Jerng JS, Chang WT, Chen WJ, Huang SC, Chi NH, Wang CH, Chen LC, Tsai PR, Wang SS, Hwang JJ, Lin FY. 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.
38. Shin TG, Choi JH, Jo JJ, Sim MS, Song HG, Jeong YK, Song YB, Hahn JY, Choi SH, Gwon HC, Jeon ES, Sung K, Kim WS, Lee YT. Extracorporeal cardiopulmonary resuscitation in patients with inhospital cardiac arrest: A comparison with conventional cardiopulmonary resuscitation. *Crit Care Med*. 2011;39:1–7. doi: 10.1097/CCM.0b013e3181feb339.
39. 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.
40. Sakamoto T, Morimura N, Nagao K, Asai Y, Yokota H, Nara S, Hase M, Tahara Y, Atsumi T; 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.

KEY WORDS: cardiac arrest ■ cardiopulmonary resuscitation ■ emergency ■ ventricular fibrillation

Part 6: Alternative Techniques and Ancillary Devices for Cardiopulmonary Resuscitation: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

Steven C. Brooks, Monique L. Anderson, Eric Bruder, Mohamud R. Daya, Alan Gaffney,
Charles W. Otto, Adam J. Singer, Ravi R. Thiagarajan and Andrew H. Travers

Circulation. 2015;132:S436-S443

doi: 10.1161/CIR.0000000000000260

Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231

Copyright © 2015 American Heart Association, Inc. All rights reserved.

Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the
World Wide Web at:

http://circ.ahajournals.org/content/132/18_suppl_2/S436

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Circulation* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the [Permissions and Rights Question and Answer](#) document.

Reprints: Information about reprints can be found online at:
<http://www.lww.com/reprints>

Subscriptions: Information about subscribing to *Circulation* is online at:
<http://circ.ahajournals.org/subscriptions/>