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Advanced Cardiovascular Life Support (ACLS) 2015 to 2020 Updates

ACLS Recommendation Changes:

- If a patient is receiving Epinephrine and has a non-shockable rhythm, try and stay on the early side of providing Epinephrine doses (every 3 minutes instead of waiting a full 5 minutes).
- Early routine use of a ß-blocker may be considered for those patients hospitalized for a heart attack which presents with VF/pVT.
- Vasopressin has been removed from the ACLS algorithm. (It may still be used when performing a steroid, Epinephrine, and Vasopressin bundle.)
- Steroids possibly provides a benefit when combined with Epinephrine and Vasopressin for in-hospital cardiac arrest (IHCA). However, the use of steroids is not recommended in routine use.
- Extracorporeal CPR (ECPR) implemented quickly can extend the viability of some patients. ECPR can allow for the treatment of reversible conditions that standard CPR cannot accommodate.
- Repeated use of Lidocaine is not recommended. However, if there is a return of spontaneous circulation (ROSC) from a pulseless VF rhythm after the administration of Lidocaine continue to administer the drug if appropriate.
- If a patient is receiving CPR, is intubated, has their ETCO2 being monitored, and the patient shows a poor ETCO2 reading for 20 minutes or more combined with showing other signs of unlikely recovery, it stands as an additional reason for which the physician may terminate resuscitation.

Source: American Heart Association. (2015). https://eccguidelines.heart.org/wp-content/uploads/2015/10/2015-AHA-Guidelines-Highlights-English.pdf. Dallas, TX: Publisher.