2018 American Heart Association Focused Update on Advanced Cardiovascular Life Support Use of Antiarrhythmic Drugs During and Immediately After Cardiac Arrest
An Update to the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

ABSTRACT: Antiarrhythmic medications are commonly administered during and immediately after a ventricular fibrillation/pulseless ventricular tachycardia cardiac arrest. However, it is unclear whether these medications improve patient outcomes. This 2018 American Heart Association focused update on advanced cardiovascular life support guidelines summarizes the most recent published evidence for and recommendations on the use of antiarrhythmic drugs during and immediately after shock-refractory ventricular fibrillation/pulseless ventricular tachycardia cardiac arrest. This article includes the revised recommendation that providers may consider either amiodarone or lidocaine to treat shock-refractory ventricular fibrillation/pulseless ventricular tachycardia cardiac arrest.

This 2018 American Heart Association (AHA) focused update on the advanced cardiovascular life support (ACLS) guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care (ECC) is based on the systematic review of antiarrhythmic therapy and the resulting “2018 International Consensus on CPR and ECC Science With Treatment Recommendations” (CoSTR) from the Advanced Life Support (ALS) Task Force of the International Liaison Committee on Resuscitation (ILCOR). The draft ALS CoSTR was posted online for public comment, and a summary containing the final wording of the CoSTR has been published simultaneously with this focused update.

AHA guidelines and focused updates are developed in concert with the ILCOR systematic evidence review process. In 2015, the ILCOR process transitioned to a continuous one, with systematic reviews performed as new published evidence warrants them or when the ILCOR ALS Task Force prioritizes a topic. Once the ILCOR ALS Task Force develops a CoSTR statement, AHA ACLS science experts review the relevant topics and update the AHA’s ACLS guidelines as needed, typically on an annual basis. A description of the ILCOR continuous evidence review process is available in the 2017 CoSTR summary.

The ILCOR systematic reviews use the Grading of Recommendations Assessment, Development, and Evaluation methodology and its associated nomenclature to determine the quality of evidence and strength of recommendations in the published CoSTR statement. The expert writing group for this 2018 ACLS guidelines focused update reviewed the studies and analysis of the 2018 CoSTR summary and carefully considered the ILCOR consensus recommendations in light of the structure and resources of the out-of-hospital and in-hospital resuscitation systems and the providers who use AHA guidelines. In addition, the
use of antiarrhythmic drugs during resuscitation from adult VF/pVT cardiac arrest

2018 evidence summary

Amiodarone

Intravenous amiodarone is available in 2 approved formulations in the United States. One formulation contains the diluent polysorbate, which is a vasoactive solvent that can potentially cause hypotension. The other formulation contains captisol, which has no known vasoactive effects. In 2 out-of-hospital, blinded, randomized controlled trials in adults with shock-refractory VF/pVT who received at least 3 shocks and epinephrine, paramedic administration of intravenous amiodarone improved survival to hospital admission. In 1 study, the ARREST trial (Amiodarone in the Out-of-Hospital Resuscitation of Refractory Sustained Ventricular Tachyarhythmias), amiodarone (300 mg) in polysorbate improved survival to hospital admission compared with a polysorbate placebo. In another study, the ALIVE trial (Amiodarone Versus Lidocaine in Prehospital Ventricular Fibrillation Evaluation), 5 mg/kg amiodarone in polysorbate improved survival to hospital admission compared with 1.5 mg/kg lidocaine with polysorbate. Survival to hospital discharge and survival with favorable neurological outcome were not improved by amiodarone, but neither study was powered for those outcomes.

In ROC-ALPS (Resuscitation Outcomes Consortium–Amiodarone, Lidocaine or Placebo Study), a large out-of-hospital randomized controlled trial that compared captisol-based amiodarone with lidocaine or placebo for patients with VF/pVT refractory after at least 1 shock, there was no overall statistically significant difference in survival with good neurological outcome or survival to hospital discharge. In this study, ROSC was higher in patients receiving lidocaine compared with those receiving placebo but not for those receiving amiodarone compared with patients receiving placebo. Survival to hospital admission was higher in patients receiving ei-
ther amiodarone or lidocaine than in those receiving placebo, and this outcome did not differ between the 2 active drugs.

In a prespecified subgroup analysis of patients with bystander-witnessed out-of-hospital cardiac arrest, a significant survival benefit (a 5% absolute improvement compared with placebo) was observed with either amiodarone or lidocaine. In these patients, time from collapse to drug administration was likely shorter than among patients with an unwitnessed arrest. This underscores the potential importance and effects of early recognition and treatment of out-of-hospital cardiac arrest on outcome. There was no statistically significant difference in survival between the 2 active drugs in this subgroup. Neurological status at discharge was not reported in the subgroup analysis. The captisol-based formulation of amiodarone used in this trial is currently marketed
Magnesium for torsades de pointes is supported by only pharmacologically convert polymorphic VT. The use of magnesium administration.

Consistent in showing no benefit associated with magnesium administration. No randomized trials were identified that address the use of amiodarone during in-hospital cardiac arrest.

**Lidocaine**

Intravenous lidocaine is an antiarrhythmic drug of long-standing and widespread familiarity. In the large ROC-ALPS out-of-hospital randomized controlled trial comparing captisol-based amiodarone with lidocaine or placebo for patients with VF/pVT cardiac arrest refractory after at least 1 shock, there was no overall statistically significant difference in survival with good neurological outcome or survival to hospital discharge.**1** ROSC was higher in those receiving lidocaine compared with those receiving placebo. Survival to hospital admission was higher in patients receiving either amiodarone or lidocaine than in those receiving placebo, but there was no statistically significant difference between the 2 active drugs. A prespecified subgroup analysis of patients with bystander-witnessed arrest found that survival to hospital discharge was higher in patients receiving either amiodarone or lidocaine than in those receiving placebo. There was no statistically significant difference in patient survival between the 2 active drugs. This randomized trial did not explore the timing or sequence of lidocaine versus epinephrine administration.

No randomized trials were identified that assessed the efficacy of lidocaine for treatment of in-hospital cardiac arrest.

**Magnesium**

Magnesium acts as a vasodilator and is an important cofactor in regulating sodium, potassium, and calcium flow across cell membranes. In a total of 4 small randomized clinical trials, magnesium administration did not increase ROSC or survival to hospital discharge. Two of the trials compared magnesium with placebo for cardiac arrest with any presenting rhythm,**12,13** and 2 trials compared magnesium with placebo for VF/pVT cardiac arrest.**14,15** Although the 4 trials were underpowered to evaluate long-term outcomes, with a total of only 217 patients randomized to magnesium and 227 randomized to placebo across the 4 studies, the results were consistent in showing no benefit associated with magnesium administration.

Magnesium is commonly used to treat torsades de pointes (ie, polymorphic ventricular tachycardia [VT] associated with long-QT interval), but it actually acts to prevent the reinitiation of torsades rather than to pharmacologically convert polymorphic VT. The use of magnesium for torsades de pointes is supported by only 2 observational studies.**16,17** Magnesium administration was not beneficial in a series of 5 patients with polymorphic VT associated with normal-QT interval.**16** The 2018 ILCOR systematic review identified no published randomized controlled trials of magnesium for torsades de pointes.

**2018 Recommendations for Use of Antiarrhythmic Drugs During Resuscitation From Adult VF/pVT Cardiac Arrest**

**Amiodarone and Lidocaine Recommendation—Updated**

1. Amiodarone or lidocaine may be considered for VF/pVT that is unresponsive to defibrillation. These drugs may be particularly useful for patients with witnessed arrest, for whom time to drug administration may be shorter (Class IIb; Level of Evidence B-R).

**Magnesium Recommendation—Updated**

1. The routine use of magnesium for cardiac arrest is not recommended in adult patients (Class III: No Benefit; Level of Evidence C-LD). Magnesium may be considered for torsades de pointes (ie, polymorphic VT associated with long-QT interval) (Class IIb; Level of Evidence C-LD). The wording of this recommendation is consistent with the AHA’s 2010 ACLS guidelines.**7**

**Discussion**

The writing group recommends that amiodarone or lidocaine may be considered for VF/pVT that is unresponsive to defibrillation. Although no antiarrhythmic drug has yet been shown to increase long-term survival or to improve neurological outcome after VF/pVT cardiac arrest, the writing group also considered the small increase in the short-term outcome of ROSC in those treated with amiodarone in the 1999 ARREST study**6** and in those treated with lidocaine in the most recent ROC-ALPS trial.**11** In addition, the writing group considered the improved survival to hospital admission in patients receiving either amiodarone or lidocaine (compared with placebo) in the most recent ROC-ALPS trial, as well as the improved survival to hospital discharge among patients with witnessed cardiac arrest who received amiodarone or lidocaine.**11** These considerations contributed to the weak recommendation for consideration of amiodarone or lidocaine in the context of a disease process for which there are limited therapeutic options other than CPR and defibrillation.

Lidocaine is now included with amiodarone in the ACLS algorithm for treatment of shock-refractory VF/pVT.
The recommended dose of lidocaine is 1.0 to 1.5 mg/kg IV/IO for the first dose and 0.5 to 0.75 mg/kg IV/IO for a second dose if required. Although the most recent clinical trial of lidocaine used a standard-bolus dose for ease of execution, this 2018 recommended dose is made with a focus on patient safety through weight-based dosing. The recommended dose for amiodarone is unchanged, with randomized tri-
as supporting an initial IV/IO dose of 300 mg with a second IV/IO dose of 150 mg if required. Both the ROC-ALPS and ALIVE trials permitted dose reductions in lower-weight patients; however, higher cumulative bolus doses of amiodarone have not been studied in cardiac arrest. It is also important to note that the captopisol-based formulation of amiodarone is currently marketed only as a premixed infusion, not in concentrated form, making it impractical for rapid administration during cardiac arrest. The polysorbate-based formulation is currently available in concentrated form for rapid administration.

The writing group reaffirms that magnesium should not be used routinely during cardiac arrest management but may be considered for torsades de pointes (ie, polymorphic VT associated with long-QT interval). Unfortunately, these recommendations are based on low-quality evidence, representing a significant knowledge gap concerning the use of magnesium for VF/pVT. Future randomized studies are needed with rigorous evaluation of the impact of magnesium on survival and neurological outcomes to determine the importance of magnesium administration in this condition.

The writing group is aware of increased interest in and early studies of β-adrenergic–blocking drugs used during cardiac arrest. The question of the effectiveness of these drugs has been referred to ILCOR for future systematic review.

**ANTIARRHYTHMIC DRUGS IMMEDIATELY AFTER ROSC FOLLOWING CARDIAC ARREST**

The 2018 ILCOR systematic review sought to determine whether the prophylactic administration of antiarrhythmic drugs after successful termination of VF/pVT cardiac arrest results in better outcome. This prophylaxis includes continuation of an antiarrhythmic medication that was given during the course of resuscitation or the initiation of an antiarrhythmic after ROSC to sustain rhythm stability after VF/pVT cardiac arrest. Although improved survival is the ultimate goal of such treatment, other shorter-term outcomes (even...
in the absence of a survival benefit) may still be important. For example, reducing the risk of recurrent arrhythmias with the use of arrhythmia prophylaxis can reduce the risk of recurrent cardiac arrest and its sequelae during transport, which may be particularly important when transport intervals are prolonged. Treatment for this indication is arguably beneficial even if there are as yet no studies showing long-term survival benefit, provided that the intervention itself is not harmful. The only medications studied in this context are β-adrenergic–blocking drugs and lidocaine. Although both drugs have precedent for use during acute myocardial infarction, the evidence for their use in patients immediately after resuscitation from cardiac arrest is limited. The fact that only 2 observational studies addressing this question have been performed to date underscores a sizeable knowledge gap and limits the conclusions that can be drawn from currently available information.

**2018 Evidence Summary**

**β-Adrenergic–Blocking Drugs**

β-Adrenergic-blocking drugs blunt the heightened catecholamine activity that can precipitate cardiac arrhythmias. These drugs also reduce ischemic injury and may have membrane-stabilizing effects. Conversely, intravenous β-blockers can cause or worsen hemodynamic instability, exacerbate heart failure, and cause bradyarrhythmias, making their routine administration after cardiac arrest potentially hazardous. There are no new studies that address this topic. In 1 observational study that was evaluated for the ACLS guidelines in the 2015 guidelines update, oral or intravenous metoprolol or bisoprolol administration during hospitalization after VF/pVT cardiac arrest was associated with a significantly higher adjusted survival rate in recipients compared with nonrecipients at 72 hours after ROSC and at 6 months.20 This study was not considered by ILCOR in the 2018 evidence review because predefined criteria for the evaluation of post-ROSC prophylactic antiarrhythmic drugs included only drug administration within 1 hour (as opposed to within 72 hours) after ROSC. There is no evidence addressing the use of β-blockers after cardiac arrest precipitated by rhythms other than VF/pVT.

**Lidocaine**

Early studies in patients with acute myocardial infarction found that lidocaine suppressed premature ventricular complexes and nonsustained VT, rhythms that were believed to presage VF/pVT. Later studies noted a disconcerting association between lidocaine and higher mortality after acute myocardial infarction, possibly resulting from a higher incidence of asystole and bradyarrhythmias; thus, the routine practice of administering prophylactic lidocaine during acute myocardial infarction was abandoned.21,22 One observational study with propensity-matched cohorts23 found that lidocaine was not associated with increased survival when administered prophylactically after ROSC in adults with VF/pVT cardiac arrest, although it decreased the recurrence of VF/pVT. Thus, evidence supporting a potential role for prophylactic lidocaine after VF/pVT arrest is relatively weak, limited to short-term outcomes, and nonexistent for cardiac arrest presenting with nonshockable rhythms.

**2018 Recommendations for Antiarrhythmic Drugs Immediately After ROSC Following Cardiac Arrest**

**β-Blocker Recommendation—Updated**

1. There is insufficient evidence to support or refute the routine use of a β-blocker early (within the first hour) after ROSC.

**Lidocaine Recommendations—Updated**

1. There is insufficient evidence to support or refute the routine use of lidocaine early (within the first hour) after ROSC.

2. In the absence of contraindications, the prophylactic use of lidocaine may be considered in specific circumstances (such as during emergency medical services transport) when treatment of recurrent VF/pVT might prove to be challenging (Class IIb; Level of Evidence C-LD).

**Discussion**

Evidence supporting the prophylactic use of lidocaine or β-blockers on ROSC after VF/pVT cardiac arrest is insufficient to support or refute their routine use. However, the writing group acknowledges that there are circumstances (eg, during emergency medical services transport of a resuscitated patient after VF/pVT arrest) when recurrence of VF/pVT might prove logistically challenging to treat; in such situations, the use of lidocaine may be considered to prevent recurrence. There is insufficient evidence to recommend for or against the routine initiation or continuation of other antiarrhythmic medications after ROSC following cardiac arrest. For example, no study has considered or evaluated amiodarone for this indication.

**SUMMARY**

As noted in the ACLS portion of the 2010 guidelines,7 CPR and defibrillation are the only therapies associated with improved survival in patients with VF/pVT. In this
2018 ACLS guidelines focused update, the updated treatment recommendations include consideration of either amiodarone or lidocaine for shock-refractory VF/pVT, whereas previous guidelines favored amiodarone as the first-line therapy. Because no antiarrhythmic drug has yet been shown to increase long-term survival or survival with good neurological outcome, these treatment recommendations are based primarily on potential benefits in short-term outcomes (such as ROSC or survival to hospital admission) and on a potential survival benefit in patients with witnessed arrest, for whom time to drug administration may be shorter.

Finally, the optimal sequence of ACLS interventions for VF/pVT cardiac arrest, including administration of a vasopressor or antiarrhythmic drug, and the timing of medication administration in relation to shock delivery are not known. The sequence and timing of interventions recommended in the current ACLS Adult Cardiac Arrest Algorithms (Figures 1 and 2) will be affected by the number of providers participating in the resuscitation, their skill levels, and the ability to secure intravenous/intraosseous access in a timely manner.
### Writing Group Disclosures Continued

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*Modest.
†Significant.

### Reviewer Disclosures

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REFERENCES


