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## Letter to the Editor

# COVID-19 resuscitation guidelines: A blanket rule for everyone?



To the Editor,

The COVID-19 pandemic has had a profound impact on the management of both in-hospital and out of hospital cardiac arrest. Both the European Resuscitation Council (ERC) and the Resuscitation Council UK<sup>1</sup> have published guidelines for cardiac arrest management in confirmed or suspected COVID-19 cases which differs substantially from the 2015 ALS guidelines.<sup>2</sup> This is primarily due to the need for personal protective equipment (PPE) donning prior to any aerosol generating procedure (AGP). The ILCOR consensus on science highlights the paucity of evidence as to which resuscitation interventions are considered AGPs and supports defibrillation before PPE, but recommends PPE donning before cardiopulmonary resuscitation (CPR).<sup>3,4</sup> This is contradicted by Public Health England guidance which deems CPR not to be an AGP.<sup>5</sup> Anecdotally, there has been varied implementation of the guidelines across the UK, with many hospitals adapting the guidelines to develop their own specific algorithms. Some hospitals have extrapolated, such that all inpatients are considered COVID-19 suspected and the COVID-19 ALS algorithm<sup>1</sup> is applied as a blanket rule irrespective of the probability of COVID-19 infection. Other hospitals use the 2015 ALS algorithm for 'clean' wards and the COVID-19 algorithm for infected wards, with PPE for clean wards being personal preference. This non-standardised approach has created uncertainty which is not in keeping with ALS principles.

As members of hospital cardiac arrest teams, we wish to share our experience of the implementation of COVID-19 resuscitation guidelines. We have witnessed an overall decrease in the number of cardiac arrests outside of intensive care, primarily due to better treatment escalation plans. All resuscitation attempts are treated as potential COVID-19 and are generally terminated sooner than pre-COVID. The variable availability of PPE and rapid donning has added additional stress to a time-critical and already fraught situation. There is considerable uncertainty about what first responders should do, often meaning that basic life support is not initiated until the resuscitation team arrives.

We have experienced some unintended consequences of COVID-19 resuscitation guidance amongst patients without

COVID-19. A recent witnessed arrest with an initially shockable rhythm converted to pulseless electrical activity after a single shock by ward staff. Resuscitation was then withheld until the hospital resuscitation team arrived, donned PPE some 5–8 min later. Whilst in this particular case the patient had a good outcome, there is a risk of harm in future cases from the delayed initiation of resuscitation related to COVID-19 guidelines being applied outside of the context for which they were intended. Resuscitation attempts in the current climate require a dynamic risk assessment incorporating the risk to the patient of delaying CPR versus the risk of staff exposure to COVID-19.

Our experiences highlight two salient questions: Should all hospital inpatients be treated as COVID-19 suspected? Secondly; how and when will standard ALS treatment for non-COVID patients be resumed? This is pertinent as we pass the initial COVID-19 peak, with hospitals testing patients on admission and cohorting accordingly. There is an urgent need for national guidelines that address these questions to re-standardise ALS management nationwide.

## Conflict of interest

CJT is a trainee representative for the ALS Subcommittee for the Resuscitation Council UK. There are no other conflicts of interest to declare.

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