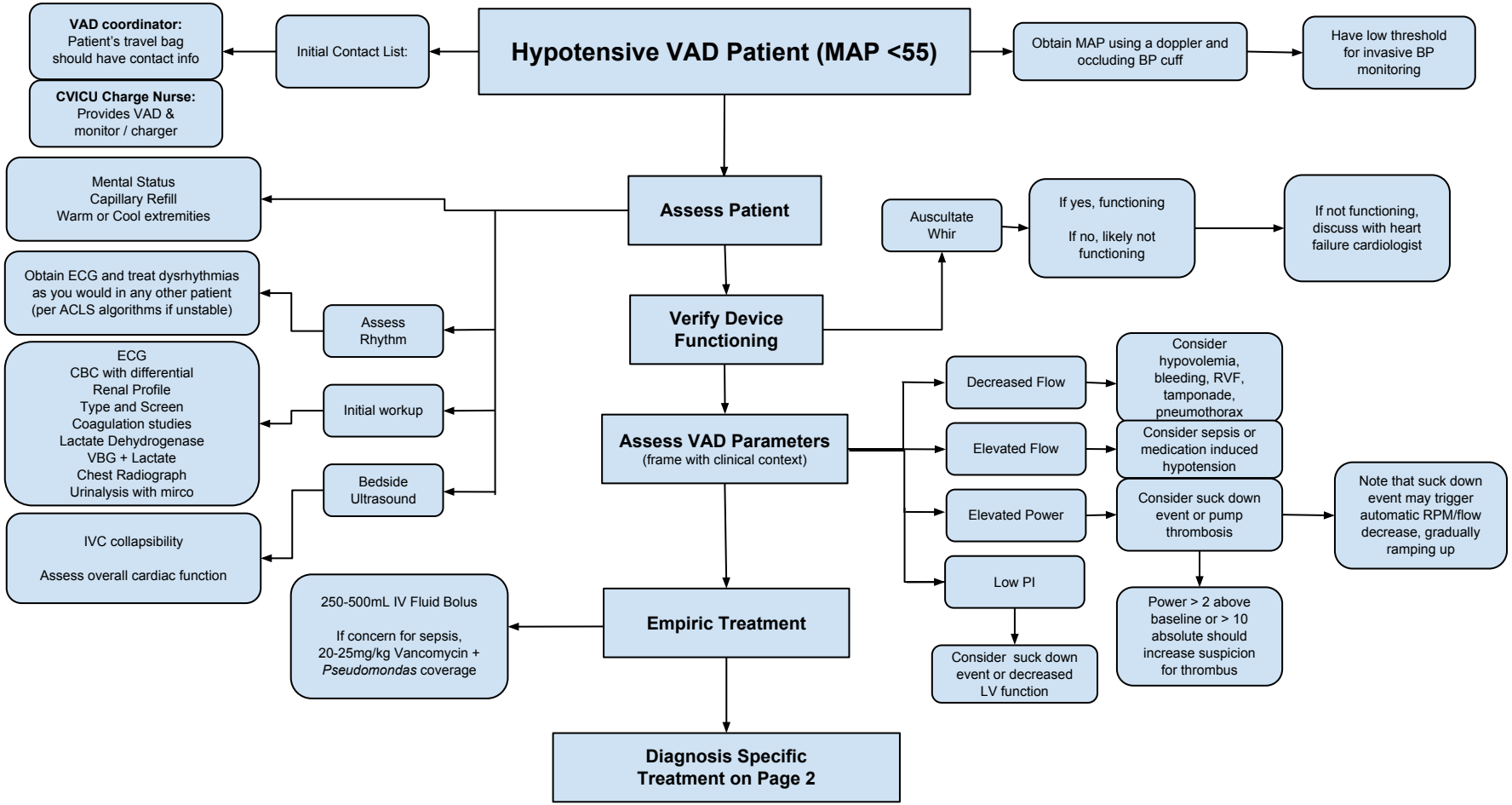
Hypotensive VAD Patient (MAP <55)
Initial Contact List:
VAD coordinator: Patient's travel bag should have contact info
CVICU Charge Nurse: Provides VAD & monitor / charger
Obtain MAP using a doppler and occluding BP cuff
Have low threshold for invasive BP monitoring
Assess Patient
Mental Status
Capillary Refill
Warm or Cool extremities
Verify Device Functioning
Auscultate Whir
If yes, functioning
If no, likely not functioning
If not functioning, discuss with heart failure cardiologist
Assess Rhythm
Obtain ECG and treat dysrhythmias as you would in any other patient (per ACLS algorithms if unstable)
Initial workup
ECG
CBC with differential
Renal Profile
Type and Screen
Coagulation studies
Lactate Dehydrogenase
VBG + Lactate
Chest Radiograph
Urinalysis with mirco
Bedside Ultrasound
IVC collapsibility
Assess overall cardiac function
Assess VAD Parameters
(frame with clinical context)
Decreased Flow
Consider hypovolemia, bleeding, RVF, tamponade, pneumothorax
Elevated Flow
Consider sepsis or medication induced hypotension
Elevated Power
Consider suck down event or pump thrombosis
Note that suck down event may trigger automatic RPM/flow decrease, gradually ramping up
Power > 2 above baseline or > 10 absolute should increase suspicion for thrombus
Low PI
Consider suck down event or decreased LV function
Empiric Treatment
250-500mL IV Fluid Bolus
If concern for sepsis, 20-25mg/kg Vancomycin + Pseudomondas coverage
Diagnosis Specific Treatment on Page 2