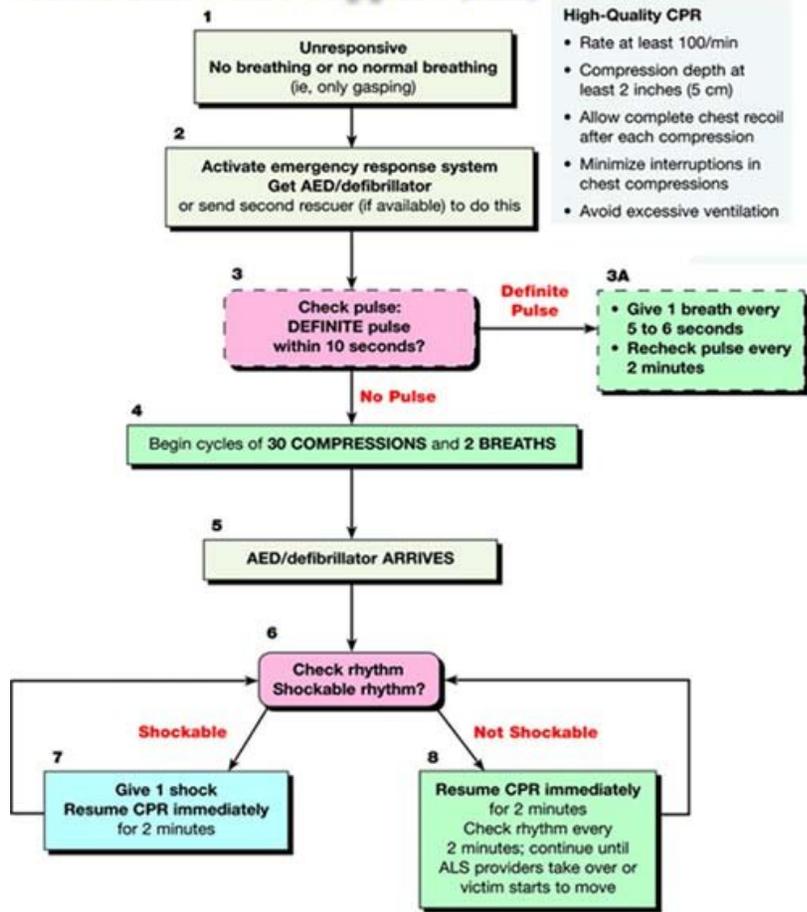


Adult Basic Life Support (BLS)

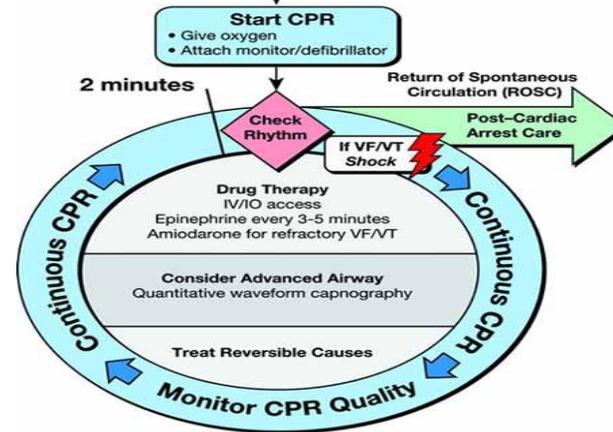


Note: The boxes bordered with dashed lines are performed by healthcare providers and not by lay rescuers

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Adult Cardiac Arrest

Shout for Help/Activate Emergency Response



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CPR Quality

- Push hard (≥ 2 inches [5 cm]) and fast (≥ 100 /min) and allow complete chest recoil
- Minimize interruptions in compressions
- Avoid excessive ventilation
- Rotate compressor every 2 minutes
- If no advanced airway, 30:2 compression-ventilation ratio
- Quantitative waveform capnography
 - If $PETCO_2 < 10$ mm Hg, attempt to improve CPR quality
 - Intra-arterial pressure
 - If relaxation phase (diastolic) pressure < 20 mm Hg, attempt to improve CPR quality

Return of Spontaneous Circulation (ROSC)

- Pulse and blood pressure
- Abrupt sustained increase in $PETCO_2$ (typically ≥ 40 mm Hg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

Shock Energy

- **Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
- **Monophasic:** 360 J

Drug Therapy

- **Epinephrine IV/IO Dose:** 1 mg every 3-5 minutes
- **Vasopressin IV/IO Dose:** 40 units can replace first or second dose of epinephrine
- **Amiodarone IV/IO Dose:** First dose: 300 mg bolus. Second dose: 150 mg.

Advanced Airway

- Supraglottic advanced airway or endotracheal intubation
- Waveform capnography to confirm and monitor ET tube placement
- 8-10 breaths per minute with continuous chest compressions

Reversible Causes

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

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CPR Quality

- Push hard (≥2 inches [5 cm]) and fast (≥100/min) and allow complete chest recoil
- Minimize interruptions in compressions
- Avoid excessive ventilation
- Rotate compressor every 2 minutes
- If no advanced airway, 30:2 compression-ventilation ratio
- Quantitative waveform capnography
 - If PETCO₂ <10 mm Hg, attempt to improve CPR quality
- Intra-arterial pressure
 - If relaxation phase (diastolic) pressure <20 mm Hg, attempt to improve CPR quality

Return of Spontaneous Circulation (ROSC)

- Pulse and blood pressure
- Abrupt sustained increase in PETCO₂ (typically ≥40 mm Hg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

Shock Energy

- **Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
- **Monophasic:** 360 J

Drug Therapy

- **Epinephrine IV/IO Dose:** 1 mg every 3-5 minutes
- **Vasopressin IV/IO Dose:** 40 units can replace first or second dose of epinephrine
- **Amiodarone IV/IO Dose:** First dose: 300 mg bolus. Second dose: 150 mg.

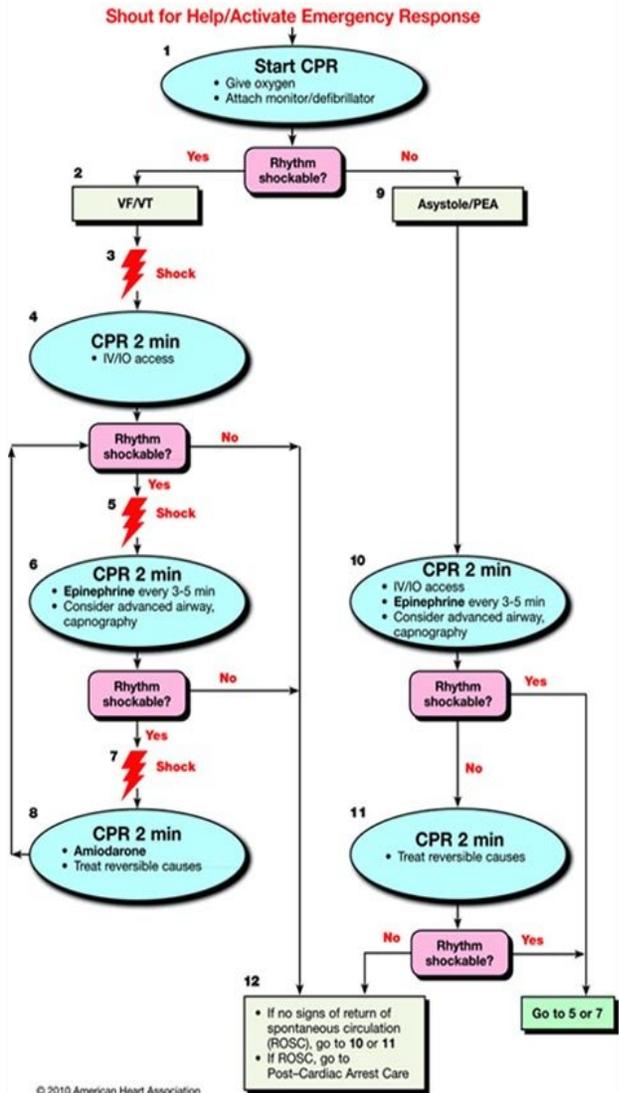
Advanced Airway

- Supraglottic advanced airway or endotracheal intubation
- Waveform capnography to confirm and monitor ET tube placement
- 8-10 breaths per minute with continuous chest compressions

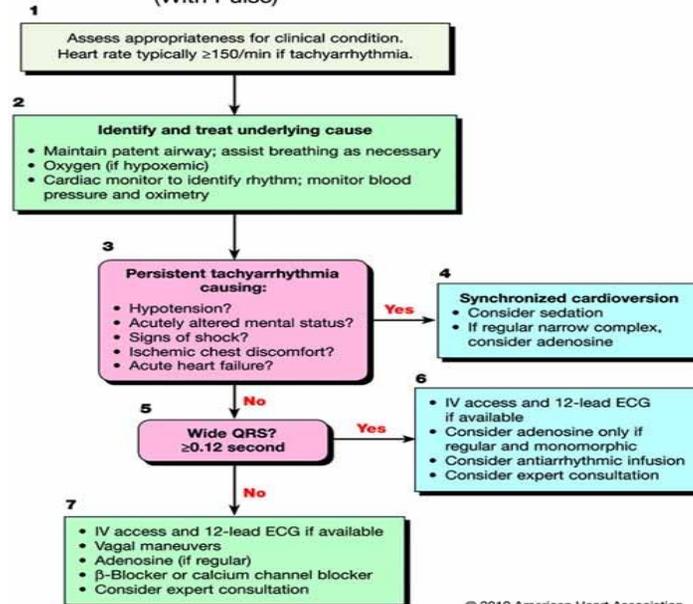
Reversible Causes

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

Adult Cardiac Arrest



Adult Tachycardia (With Pulse)



Doses/Details

Synchronized Cardioversion

- Initial recommended doses:
- Narrow regular: 50-100 J
 - Narrow irregular: 120-200 J biphasic or 200 J monophasic
 - Wide regular: 100 J
 - Wide irregular: defibrillation dose (NOT synchronized)

Adenosine IV Dose:
First dose: 6 mg rapid IV push; follow with NS flush.
Second dose: 12 mg if required.

Antiarrhythmic Infusions for Stable Wide-QRS Tachycardia

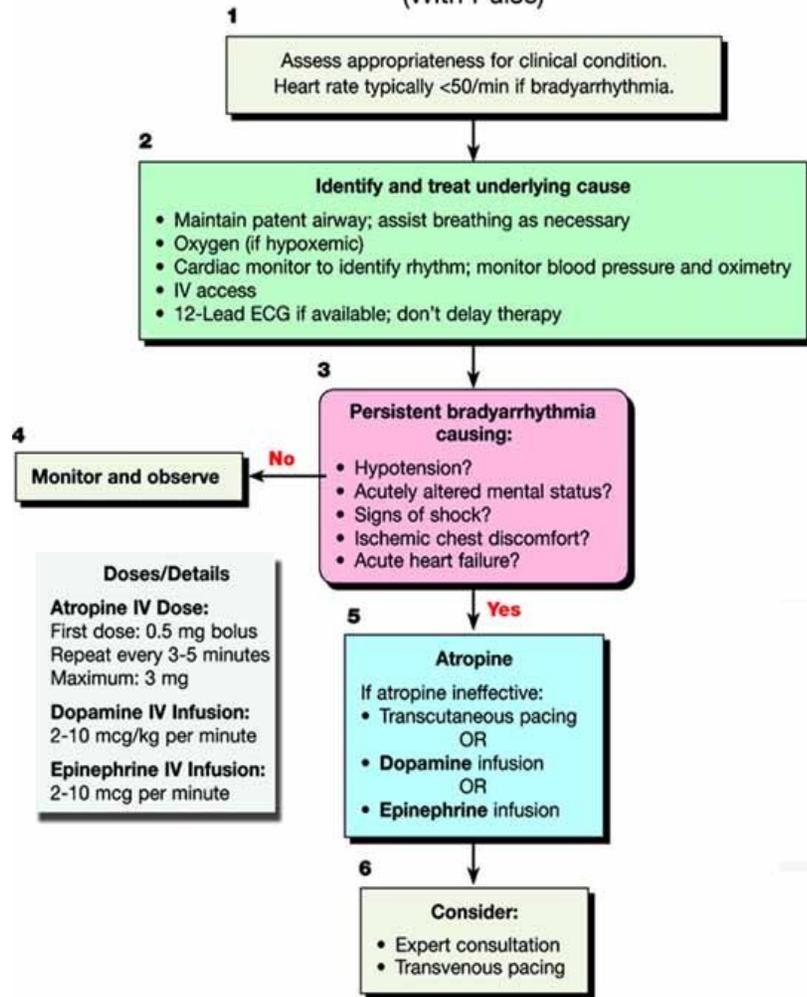
Procainamide IV Dose:
20-50 mg/min until arrhythmia suppressed, hypotension ensues, QRS duration increases >50%, or maximum dose 17 mg/kg given. Maintenance infusion: 1-4 mg/min. Avoid if prolonged QT or CHF.

Amiodarone IV Dose:
First dose: 150 mg over 10 minutes. Repeat as needed if VT recurs. Follow by maintenance infusion of 1 mg/min for first 6 hours.

Sotalol IV Dose:
100 mg (1.5 mg/kg) over 5 minutes. Avoid if prolonged QT.

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**Adult Bradycardia
(With Pulse)**



Doses/Details

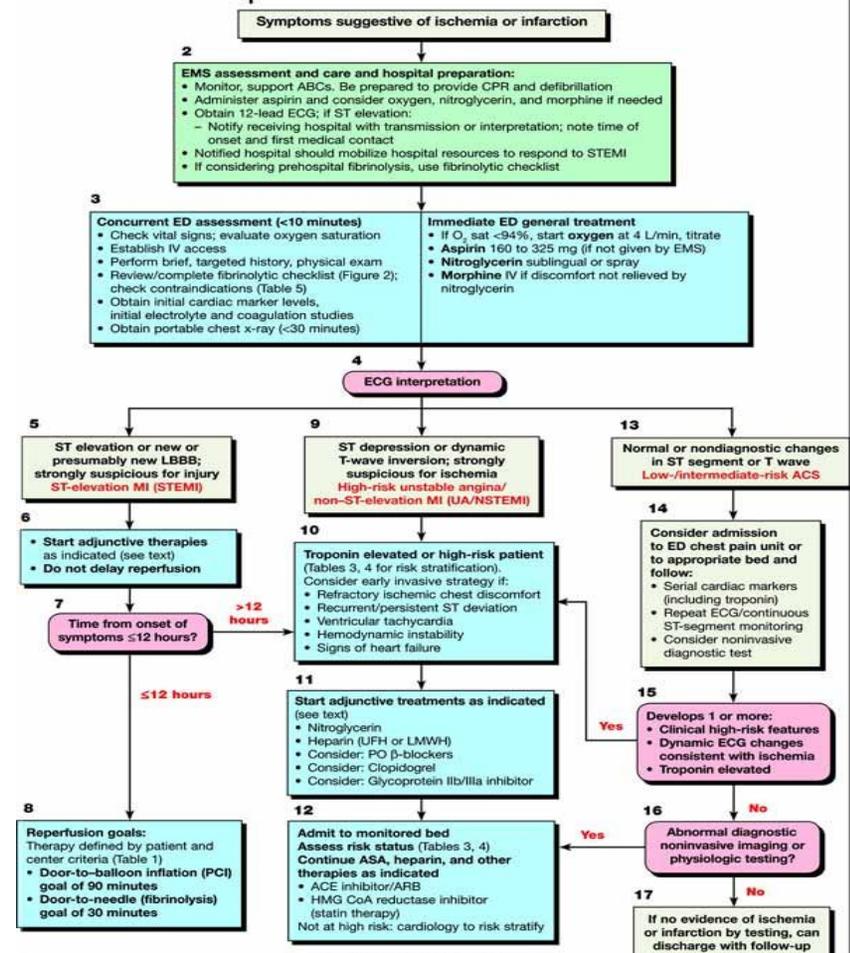
Atropine IV Dose:
First dose: 0.5 mg bolus
Repeat every 3-5 minutes
Maximum: 3 mg

Dopamine IV Infusion:
2-10 mcg/kg per minute

Epinephrine IV Infusion:
2-10 mcg per minute

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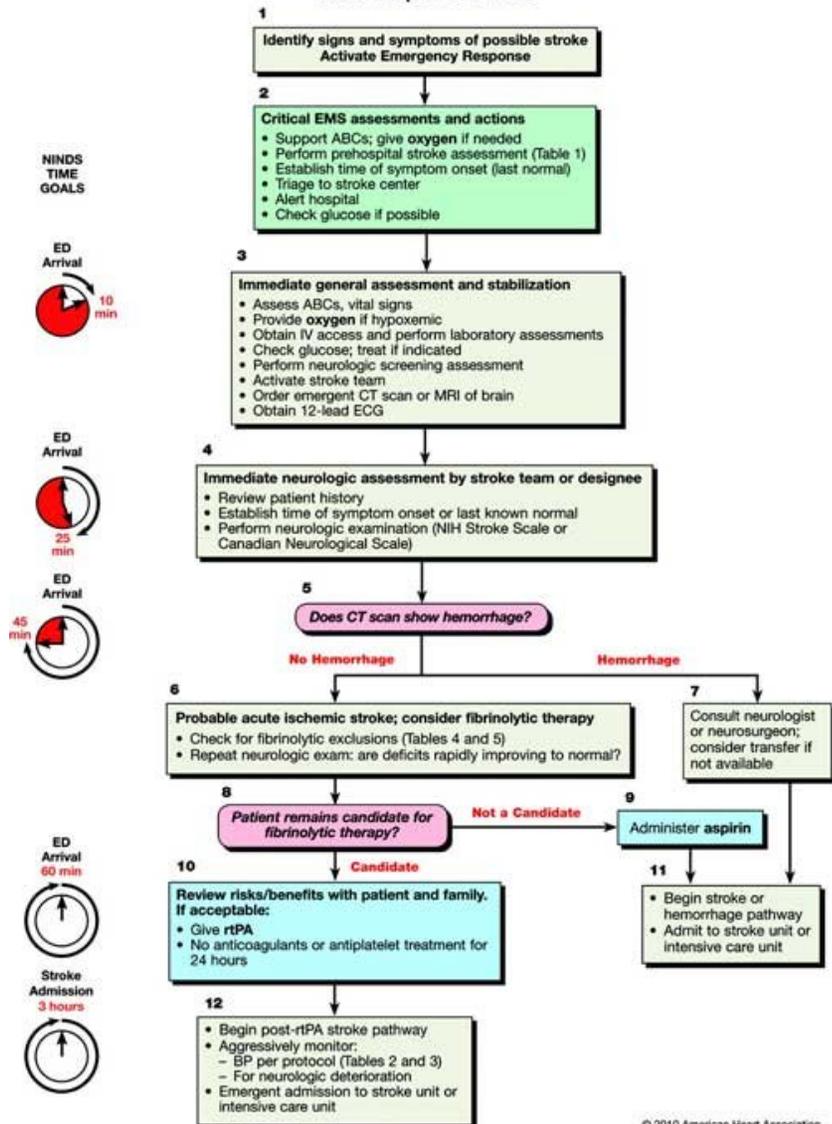
Acute Coronary Syndromes



Alteplase: Review exclusion criteria. >67kg: total dose 100mg over 1.5hrs → 15mg over 1-2min, then 50mg over 30min, then 35mg over next hour. ≤67kg: 15mg over 1-2 min → 0.75 mg/kg (max 50mg) over 30min, then 0.5 mg/kg over next 60 min (max 35mg). NOTE: all pts get ASA 162-325mg x1, then qd.
 Heparin 60 units/kg bolus (max 4000), then 12 units/kg/hr (max 1000/hr) – target APTT 50-70 or 1.5 -2x control.
 Plavix: STEMI, NSTEMI, UA: 300mg x1, f/b 75mg qd + ASA. PCI-ACS: 600mg x1, f/b 75mg qd + ASA 81mg. May consider maint dose 150mg x 6 days, then 75mg.

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Adult Suspected Stroke



Use of IV rTPA for Acute Ischemic Stroke: Inclusion and Exclusion Characteristics

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Patients Who Could Be Treated With rTPA Within 3 Hours From Symptom Onset*

Inclusion Criteria

- Diagnosis of ischemic stroke causing measurable neurologic deficit
- Onset of symptoms <3 hours before beginning treatment
- Age ≥18 years

Exclusion Criteria

- Head trauma or prior stroke in previous 3 months
- Symptoms suggest subarachnoid hemorrhage
- Arterial puncture at noncompressible site in previous 7 days
- History of previous intracranial hemorrhage
- Elevated blood pressure (systolic >185 mm Hg or diastolic >110 mm Hg)
- Evidence of active bleeding on examination
- Acute bleeding diathesis, including but not limited to
 - Platelet count <100 000/mm³
 - Heparin received within 48 hours, resulting in aPTT >upper limit of normal
 - Current use of anticoagulant with INR >1.7 or PT >15 seconds
- Blood glucose concentration <50 mg/dL (2.7 mmol/L)
- CT demonstrates multilobar infarction (hypodensity >1/3 cerebral hemisphere)

Relative Exclusion Criteria

Recent experience suggests that under some circumstances—with careful consideration and weighing of risk to benefit—patients may receive fibrinolytic therapy despite 1 or more relative contraindications. Consider risk to benefit of rTPA administration carefully if any one of these relative contraindications is present:

- Only minor or rapidly improving stroke symptoms (clearing spontaneously)
- Seizure at onset with postictal residual neurologic impairments
- Major surgery or serious trauma within previous 14 days
- Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)
- Recent acute myocardial infarction (within previous 3 months)

Patients Who Could Be Treated With rTPA From 3 to 4.5 Hours From Symptom Onset†

Inclusion Criteria

- Diagnosis of ischemic stroke causing measurable neurologic deficit
- Onset of symptoms 3 to 4.5 hours before beginning treatment

Exclusion Criteria

- Age >80 years
- Severe stroke (NIHSS >25)
- Taking an oral anticoagulant regardless of INR
- History of both diabetes and prior ischemic stroke

Notes

- The checklist includes some US FDA-approved indications and contraindications for administration of rTPA for acute ischemic stroke. Recent AHA/ASA guideline revisions may differ slightly from FDA criteria. A physician with expertise in acute stroke care may modify this list.
- Onset time is either witnessed or last known normal.
- In patients without recent use of oral anticoagulants or heparin, treatment with rTPA can be initiated before availability of coagulation study results but should be discontinued if INR is >1.7 or PT is elevated by local laboratory standards.
- In patients without history of thrombocytopenia, treatment with rTPA can be initiated before availability of platelet count but should be discontinued if platelet count is <100 000/mm³.

Stroke Assessment

The Cincinnati Prehospital Stroke Scale

Facial Droop (have patient show teeth or smile):

- Normal—both sides of face move equally
- Abnormal—one side of face does not move as well as the other side



Left: Normal. Right: Stroke patient with facial droop (right side of face).

Arm Drift (patient closes eyes and extends both arms straight out, with palms up, for 10 seconds):

- Normal—both arms move the same or both arms do not move at all (other findings, such as pronator drift, may be helpful)
- Abnormal—one arm does not move or one arm drifts down compared with the other



Left: Normal. Right: One-sided motor weakness (right arm).

Abnormal Speech (have the patient say "you can't teach an old dog new tricks"):

- Normal—patient uses correct words with no slurring
- Abnormal—patient slurs words, uses the wrong words, or is unable to speak

Interpretation: If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%.

Modified from Kothari RJ, Pancioli A, Liu T, Brett T, Broderick J. Cincinnati Prehospital Stroke Scale: reproducibility and validity. *Ann Emerg Med.* 1999;33:373-378. With permission from Elsevier.

Drug Dosing:

Amiodarone: I.V. DOSE RECOMMENDATIONS -- FIRST 24 HOURS --

Loading infusions. The recommended starting dose of Cordarone I.V. is about 1000 mg over the first 24 hours of therapy, delivered by the following infusion regimen. **First Rapid: 150 mg over the FIRST - 10 minutes (15 mg/min).** Add 3 mL of Cordarone I.V. (150 mg) to 100 mL D5W. Infuse 100 mL over 10 minutes. **Followed by Slow: 360 mg over the NEXT 6 hours (1 mg/min).** Add 18 mL of Cordarone I.V. (900 mg) to 500 mL D5W (conc = 1.8 mg/mL). **Maint infusion: 540 mg over the REMAINING 18 hours (0.5 mg/min).**

Cisatracium: Intermittent IV dosing: initial dose 0.15 - 0.2 mg/kg IV bolus, followed by 0.03 mg/kg IV q40-60 minutes. Continuous infusion: 0.15-0.2 mg/kg bolus, followed by 1 to 3 mcg/kg/min. (range: 0.5 to 10 mcg/kg/min). Based on a standard dilution of 1 mg/ml (eg 100mg/100ml or 200mg/200ml) and a weight of 70kg: 1 mcg/kg/min =4.2 ml/hr. 3 mcg/kg/min =12.6 ml/hr. 0.15 mg/kg =10.5 mg. 0.2 mg/kg=14 mg

Digoxin: Loading dose: **CHF:** 8-12 mcg/kg in divided doses (q4-8h) over 12 to 24 hours. [Normally, give 50% of the total digitalizing dose in the initial dose, then give 25% of the total dose in each of the two subsequent doses at 8 to 12 hr intervals- Obtain EKG 6 hours after each dose to assess potential toxicity (AV block, sinus bradycardia, atrial or nodal ectopic beats, ventricular arrhythmias); Other: vision changes, confusion.] If pt has renal insufficiency give 6 to 10 mcg/kg IBW. **A-fib:** 10 to 15 mcg/kg IBW given as above. (If given IVPush-admin over at least 5 min)

Diltiazem 0.25 mg/kg over 2min. If no response c/in 15min, give 2nd bolus of 0.35 mg/kg over 2min. Subsequent doses should be individualized. If effective start continuous infusion: 5-15 mg/hr.

Dopamine: Calculation of drip rate (ml/hr) 400mg/250 ml: wt(kg) x mcg/min x 0.0375. Refractory CHF: ini 0.5 to 2 mcg/kg/min Renal: 1 to 5 mcg/kg/min. Severely ill pt: ini 5 mcg/kg/min, inc by 5 to 10 mcg/kg/min (q10 to 30 min) up to max of 50 mcg/kg/min. [0.5 to 2 mcg/kg/min-dopa; 2-10-dopa/beta; >10-primarily alpha. Used to support BP, CO and renal perfusion in shock.

Esmolol: Dosing: PSVT: 500 mcg/kg over 1 min, then 50 mcg/kg/min x 4 to 5min. If heart rate not controlled, rpt load of 500 mcg/kg and increase inf to 100 mcg/kg/min. Rpt load and increase infusion q5 to 10min as needed to max of 200 (up to 300?) mcg/kg/min. Watch BP. Calculation of drip rate (ml/hr): 2.5 grams/250 ml: wt (kg) x mcg/min x 0.006

Fenoldopam (Corlopam): severe HTN: Dosing: Usu initial rate: 0.1 mcg/kg/min, increased by increments of 0.05 to 0.1 mcg/kg/min at 15-20min intervals until target BP reached. Usual effective doses: 0.1 to 1.6 mcg/kg/min. Generally, lower initial doses (0.03 to 0.1 mcg/kg/min) titrated slowly, have been assoc c less reflex tachycardia. Never given by IV bolus. 10mg/250 ml NS/D5W

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Hydralazine: Parenteral (IV/IM) (Inject over 1 minute) Hypertension: Initial: 10-20 mg/dose every 4-6h prn, may increase to 40 mg/dose; change to oral therapy as soon as possible. Route is indicated only when oral therapy is not feasible. HTN emergency: 10 to 40 milligrams, repeated prn (q20-60 minutes), with frequent blood pressure monitoring.

Ibutalide: 1 mg over 10 min. May rpt x 1 after 10 min. Class III agent—prolongs action potential (inc atrial and ventricular refractoriness.).

Labetalol: Dosing: ini 20 mg IVP over 2 min. May rpt 20 to 80 mg q10min (up to 300 mg total dose) until desired BP is reached or start continuous infusion: 2 mg/min (range: 1 to 3 mg/min)-titrate to BP.

Natrecor: IV bolus of 2 mcg/kg (over 1 minute) followed by a continuous infusion of 0.01 mcg/kg/min. Withdraw bolus dose from the infusion bag. Higher initial dosages are not recommended. At intervals of 3 hours, the dosage may be increased by 0.005 mcg/kg/minute (preceded by a bolus of 1 mcg/kg), up to a maximum of 0.03 mcg/kg/minute. Patients experiencing hypotension during the infusion: Hold infusion. May attempt to restart at a lower dose (reduce initial infusion dose by 30% and omit bolus). No adjustment required in renal failure.

Nitroglycerin: (HTN/ CHF/ angina): ini inf rate 5 mcg/min. May inc by 5 mcg/min q3 to 5 min until response. If 20 mcg/min is inadequate, inc by 10 to 20 mcg/min q3 to 5min. Calculation of drip rate (50 mg/250 ml) ml/hr = mcg/min x 0.3 (eg 5 mcg/min=@ 2ml/hr ; 20mcg/min = 6 ml/hr etc.)

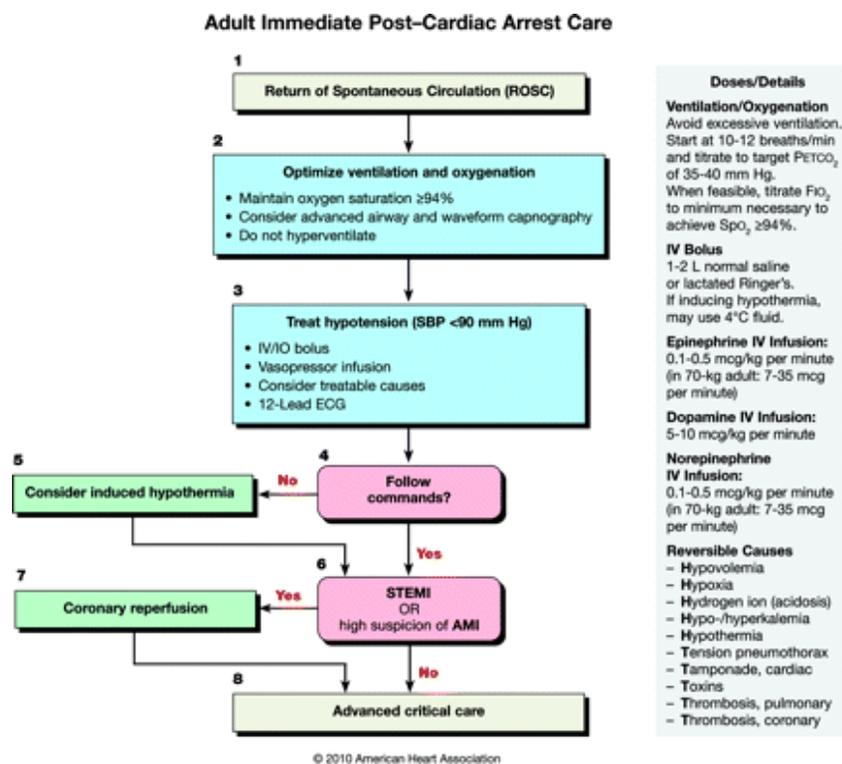
Nitroprusside: Onset: immediate Duration: 1 to 10min. Tx htn emer. IV infusion rate: 0.5 to 10 mcg/ kg/ min-titrate to BP. Dosing: **Initial:** 0.3 to 0.5 mcg/kg/min— increase by 0.5 mcg/kg/min increments. (usual dose: 3 mcg/kg/min-rarely need > 4 mcg/kg/min). Note: when > 500 mcg/kg is admin by continuous infusion at > 2 mcg/kg/min-cyanide is produced faster than can be handled by endogenous mechanisms. Maximum infusion rate: 10 mcg/kg/min. Calculation of drip rate 50 mg/250 ml (ml/hr) = wt (kg) x mcg/min x 0.3

Norepinephrine: Used to maintain BP in hypotensive states. Most potent vasoconstrictor (Norepi >>> phenylephrine). Dosage: ini 8 to 12 mcg/min –titrate to BP (Usual target: SB:80-100 or MAP=80). Usual maint: 2 to 4 mcg/min. Note: doses as high as 0.5 to 1.5 mcg/kg/min for 1-10days have been used in septic shock.) Calculation of drip rate 8 mg/ 250 ml (ml/hr) = mcg/min x 1.875

Phenylephrine: Alpha agonist). May be given IM,SC, Ivpush, or by cont inf. TX mild/moderate hypotension, also PSVT. **IV bolus tx:** usu ini dose 0.5 mg [range: 0.1 to 1 mg (max)] rpt q10-15 min prn. **IV infusion:** usu ini rate: 0.1 to 0.18 mg/min (titrate). Maximum rate: 10-15 mcg/kg/min?. PSVT: 0.5 mg rapid Ivpush, subsequent doses may be inc in increments of 0.1 to 0.2mg. Calculation of drip rate (40 mg/250) (ml/hr) = (mg/min) x 375.

Succinylcholine: Usual dosage: 0.6 mg/kg (range: 0.3 to 1.1 mg/kg) over 10-30 seconds (up to total dose of 150mg). Maintenance: 0.04-0.07 mg/kg q5-10 minutes prn. Continuous infusion: 0.5 to 10 mg/min. Add 500mg/250ml D5W or NS.

Alteplase – Acute Ischemic Stroke: (Activase®): within 3 hours of symptom onset (or within 3 – 4.5 hrs – see ACLS criteria): Recommended total dose = 0.9 mg/kg (MAXIMUM total dose 90mg). **Patients <100 kg:** load with 0.09 mg/kg (10% of 0.9 mg/kg dose) as an IV bolus over 1 minute, followed by 0.81 mg/kg (90% of 0.9 mg/kg dose) as a continuous infusion over 60 minutes. **Patients ≥100 kg:** load with 9 mg/kg (10% of 90 mg) as an IV bolus over 1 minute, followed by 81 mg (90% of 90mg) as a continuous infusion over 60 minutes.



Quick calculations:

Dopamine: 400 mg/250ml or 800 mg/500ml: Rate (ml/hr) mcg/kg/min = wt(kg) x mcg/min x 0.0375 Usual initial starting dose: 5 mcg/kg/min.

Norepinephrine: 4 mg/250ml: Rate (ml/hr) mcg/kg/min = wt(kg) x mcg/min x 3.75 Usual initial starting range: 0.1-0.5 mcg/kg/min.

Drug	Standard dose	ROSC / Comments	D. McAuley 2014
Cardiac arrest - VF - Pulseless VT			
Epinephrine	1 mg q3-5 min. Drip: 0.1-0.5 mcg/kg/min	Drip: 1mg/250ml --> (ml/hr) = wt x mcg/kg x 15. 1mg/100ml --> wt x mcg/kg x 6. Endotracheal: 2-2.5 mg diluted with 10ml NS	
Vasopressin	40 units IV x 1	0.01 - 0.03 units/min. Drip: 40 units/100ml NS 0.01 units/min = 1.5 ml/hr; 0.03 units/min = 4.5 ml/hr.	
Amiodarone	300mg IV over 1-2 seconds May repeat 150 mg IV x 1.	Drip: 1 mg/min x 6 hrs, then 0.5 mg/min x 18 hrs.	
Lidocaine	1 - 1.5 mg/kg over 2-3 min, then may repeat 0.5-0.75 mg/kg in 5-10 min. Max: 3 mg/kg.	Drip: 1 - 4 mg/min. 1 gram/250ml (ml/hr) = mg/min x 15	
Calcium Chloride	5-10 ml (0.5-1 gm) over 2-5min	Calc gluc: 15-30 ml over 2 to 5 minutes.	
Dopamine	5 - 10 mcg/kg/min.	Drip: 400mg/250ml (ml/hr) = (wt) x (mcg/min) x 0.0375	
Norepinephrine	0.1 - 0.5 mcg/kg/min	Drip: 4 mg/250ml (ml/hr) = (wt) x (mcg/min) x 3.75	
Magnesium	VF/pulseless VT: 1-2 grams/10ml D5W over 2-5 minutes.		
Ventricular tachycardia (VT)			
Procainamide	25-50 mg/min until arrhy suppressed or hypoten or QRS prolonged by 50%	Max cumulative dose: 17 mg/kg... Alt: 100mg q5min until arrhythmia is controlled or side effects listed. Hemodynamically stable monomorphic VT	
Amiodarone	150mg/100 ml D5W IV over 10 min. Repeat if necessary.	F/b 1 mg/min IV x 6hrs, then 0.5 mg/min IV x 18hr. (900mg/500 ml D5W).	
Lidocaine	See above.		
Magnesium	Polymorphic VT: 1-2 grams/50-100ml D5W over 15 min.		
Supraventricular tachycardia - narrow complex tachycardias			
Adenosine	6mg rapid iv, may repeat after 1-2 min 12mg rapid IV	2nd 12mg dose may be given if needed in 1-2 minutes. Max cumulative dose: 30 mg.	
Diltiazem	15 to 20 mg (0.25 mg/kg) IV over 2 minutes; additional 20 to 25 mg (0.35 mg/kg) IV in 15 minutes if needed; 5 to 15 mg/hour IV maintenance infusion (titrated to AF heart rate if given for rate control)		
Verapamil	2.5 to 5 mg IV over 2 minutes; may repeat 5 to 10 mg q15-30 min to total dose of 20-30 mg		
Esmolol	500 mcg/kg (0.5 mg/kg) IV over 1 min, f/b 50 mcg/kg/min; if response is inadequate, repeat load, f/b 100 mcg/kg/min. Max rate of 300 mcg/kg/min.		
Metoprolol	5 mg over 1 to 2 min repeat as needed q5min to max dose of 15 mg		
Amiodarone	See under VT		
Digoxin	8 to 12 mcg/kg total loading dose, give 50% IV over 5 min, then 25% of dose x 2 at 4-8hr intervals		

Bradycardia	
Atropine	0.5 mg rapid IV. May repeat q3-5min as needed up to max cumulative dose of 3 mg.
Dopamine	Refractory hypotension: IV infusion: 2-10 mcg/kg/minute- titrate dosage to desired effect.
Epinephrine	Continuous IV infusion: 2-10 mcg/min- titrate dosage to desired effect.
Other Meds	
Cisatracurium (Nimbex)	100 mg/250 mL D5W or NS. Loading dose: 0.1 to 0.2 mg/kg IV f/b infusion at 1-3 mcg/kg/min (0.06-0.18 mg/kg/hour) and adjust rate accordingly
Etomidate	Peak effect: 1 min. Duration: 3-5 min. Procedural sedation (unlabeled use): I.V.: Initial: 0.1-0.2 mg/kg, followed by 0.05 mg/kg q3-5min pm. Other: 0.2-0.6 mg/kg IV over 30-60 sec for induction
Phenylephrine	Shock/hypotension: I.V. bolus: 100- 500 mcg/dose q10-15min prn as needed. I.V. infusion: Ini dose: 100-180 mcg/min, or alt 0.5 mcg/kg/min; titrate. Dosing ranges between 0.4-9.1 mcg/kg/min.
Propofol	Induction: Healthy adults <65 yrs: I.V.: 2-2.5 mg/kg (~40 mg q10 sec) [Elderly, debilitated: 1-1.5 mg/kg (~20 mg q10 sec)]. ICU sedation: 5 mcg/kg/min (0.3 mg/kg/hour); jnc by 5-10 mcg/kg/min (or 0.3-0.6 mg/kg/hour) q5-10 min desired sedation. usu maint: 5-50 mcg/kg/min (or 0.3-3 mg/kg/hr)
Fentanyl	Pain management: Adults: Bolus at start of infusion: 1-2 mcg/kg or 25-100 mcg/dose; continuous infusion rate: 1-2 mcg/kg/hour or 25-200 mcg/hour. Severe: I.M., I.V.: 50-100 mcg/dose every 1-2 hours as needed; patients with prior opioid exposure may tolerate higher initial doses
Succinylcholine	Duration: I.V.: 4-6 minutes. I.V.: Intubation: 0.6 mg/kg (range: 0.3-1.1 mg/kg).
Vecuronium (Norcuron®)	Ini bolus dose: 0.08-0.1 mg/kg, f/b cont IV infusion 0.8-1.7 mcg/kg/min (0.048-0.102 mg/kg/hr)
MI / Stroke	
Alteplase	ST-elevation MI (STEMI): I.V. Accelerated regimen: Maximum total dose: 100 mg. Patients >67 kg: Total dose: 100 mg over 1.5 hours --> [15 mg I.V. bolus over 1-2 minutes] then [50 mg over 30 min], then [35 mg over 1 hour]. Patients <=67 kg: [15 mg I.V. bolus over 1-2 minutes] then [0.75 mg/kg (not to exceed 50 mg) over 30 minutes] then [0.5 mg/kg (not to exceed 35 mg) over 1 hour]. Note: Thrombolytics should be administered within 30 minutes of hospital arrival. Administer concurrent aspirin, clopidogrel, and anticoagulant therapy (ie, unfractionated heparin, enoxaparin, or fondaparinux) with alteplase. Acute ischemic stroke: Alteplase within 3-4.5 hrs of sx onset. Note: Perform noncontrast- enhanced CT or MRI prior to admin. Recom total dose: 0.9 mg/kg (max total dose 90 mg) Patients <100 kg: Load with 0.09 mg/kg (10% of 0.9 mg/kg dose) as an I.V. bolus over 1 minute, f/b 0.81 mg/kg (90% of 0.9 mg/kg dose) as a cont infusion over 60 min. Patients ≥100 kg: Load with 9 mg (10% of 90 mg) as an I.V. bolus over 1 min, f/b 81 mg (90% of 90 mg) as a continuous infusion over 60 min.

