

Purpose: To provide the process for the assessment and management of the patient who potentially, or currently, is experiencing shock due to any causes other than cardiogenic.

I. Assessment Information and Differential Diagnosis

A. Hypovolemic Shock

1. History:
 - a. Past Medical History: GI tract problems, AAA, problems with pregnancy.
 - b. Current History: trauma, GI tract problems, possible dehydration, pregnancy, burns.
 - 1) Associated symptoms: nausea and vomiting, thirst, skin (cool, moist and pale), a change in vitals, decreased level of consciousness.
2. Specific Objective Findings:
 - a. Rapid Pulse
 - b. Delayed capillary refill
 - c. Skin: pale, moist, cool
 - d. Restlessness
 - e. Decreased level of consciousness
 - f. Hypotension
 - g. Signs of external or internal bleeding
 - h. Signs of trauma
 - i. Abdominal tenderness

B. Neurogenic Shock

1. History:
 - a. Past Medical History: seizures, diabetes, cardiovascular disease, cerebral vascular disease, medications
 - b. Current History: possible head or spinal trauma, onset of symptoms, presentation of symptoms (i.e.: headache, seizure, altered LOC, focal deficit)
2. Specific Objective Findings:
 - a. Hypotension
 - b. Bradycardia
 - c. Skin: warm to cool, pink to pale
 - d. Altered ability to move
 - e. Altered sensation
 - f. Signs of trauma
 - g. Altered respiratory pattern
 - h. Bladder or bowel incontinence
 - i. Priapism

C. Septic Shock

1. History:
 - a. Past Medical History: diabetes, cardiovascular disease, renal disease, and medications
 - b. Current History: drug abuse, alcohol consumption, recent surgery, infection, fever, chills, altered mental status.
2. Specific Objective Findings:
 - a. Patient weak
 - b. Skin warm: may be pale, diaphoretic, or clammy
 - c. Rapid, thready pulse
 - d. Hypotension
 - e. Altered mental status

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- M B S P**
- II. Management**
- A. Utilize universal precautions.
- B. Establish and maintain an airway, provide oxygenation and support ventilations as needed.
1. For patient with decreasing LOC, hyperventilate at 20/min. with high concentration oxygen.
- C. Control major bleeding
1. Evaluate all head wounds for fracture and CSF leak, use gentle diffuse pressure to control bleeding (in case of underlying fracture).
- D. Position patient:
1. Immobilize CNS injured. If patient sustained trauma, go to Trauma Protocol.
 2. Left lateral recumbent if pregnant.
 3. Elevate legs 10-12 inches.
- E. Immediate load and transport for unstable patients.**
- S P**
- F. Start 1 large bore **IV of Normal Saline** in a manner that will not delay transport.
1. Administer 300ml bolus (20 ml/kg in peds) with repeat as needed, titrating to signs of adequate perfusion.
- G. Consider second large bore IV of Normal Saline established enroute to hospital.
- H. Monitor EKG
- P**
- I. If patient demonstrates altered mental status and cause is unknown, refer to Altered Mental Status Protocol for further testing and possible medication administration.

CONTACT MEDICAL CONTROL

- S P**
- J. **Possible orders post radio contact:**
1. Additional IVs and change of rate

III. Special Considerations

- A. Consider all causes of neurologic deficit, such as: hypoxia, trauma, CVA, hypoglycemia, hypothermia, hypotension, sepsis, drug intoxication, and seizure.
- B. The value of a reliable history cannot be overlooked.