

DEFINITION:

Systolic blood pressure < 90, when accompanied by signs and symptoms of decreased tissue perfusion, such as weakness, syncope, decreased mentation, pallor, cool extremities, and diaphoresis (variable). Signs may vary depending upon cause, generally divided into hypovolemia (severe dehydration, hemorrhage), sepsis, and pump failure (cardiogenic shock). Severe tachy and brady dysrhythmias may also present with shock and while fluids can be helpful treatment of the arrhythmia is vital. History and examination may suggest one or the other cause, and is important in guiding treatment.

Patients in cardiogenic shock are often experiencing massive acute myocardial infarction with chest pain typical of myocardial ischemia, diaphoresis and dyspnea. At initial onset lung sounds will often remain clear. Distended neck veins may precede rales. If rales present refer to Acute Pulmonary Edema/CHF Protocol. STEMI patients with cardiogenic shock and/or acute CHF have very high mortality and gain the most benefit from immediate transfer to a STEMI receiving facility.

Shock accompanied by distended neck veins may also indicate obstruction to venous return caused by massive PE, pericardial tamponade, and tension pneumothorax. Massive PE and pericardial tamponade are not easily diagnosed in the field, but will gain some benefit from fluid boluses. If either condition is suspected and findings are consistent (clear lungs with or without distended neck veins), proceed with NS fluid boluses. Tension pneumothorax must also be considered and treated if suspected. Again, management will vary depending upon your assessment of the likely cause – these patients are critically ill and must be assessed in a problem oriented fashion.

