

Amniotic fluid embolism checklist - initial management

NOTE: Each facility should modify the checklist to fit the facility-specific circumstances

Manage circulatory collapse

- ABCs: manage airway, breathing, and circulation
- Designate a timekeeper to call out times at 1-min intervals
- If no pulse, start CPR
 - Manually displace uterus or lateral tilt
 - Use backboard
- Move to operating room only if this can be accomplished in 2 min or less
- If no pulse at 4 min, START perimortem cesarean delivery (resuscitative hysterotomy)
 - Splash prep only, do not wait for antibiotics
 - Goal is to improve chances of resuscitation

Anticipate uterine atony, DIC, hemorrhage

- Oxytocin prophylaxis plus other uterotonics as needed
- Consider intraosseous line if needed for large-bore IV access
- Initiate massive transfusion protocol
 - B Cryoprecipitate preferred over FFP to reduce volume overload
 - Consider thromboelastometry if available
- Tranexamic acid (1 g IV over 10 min) if DIC or hemorrhage occurs

Manage pulmonary hypertension and right ventricular failure (Anesthesiology, Critical Care, or Cardiology)

- Consider echocardiography (thoracic or esophageal)
- Avoid fluid overload (i.e. 500 mL boluses and reassess)
- Vasopressor if needed: norepinephrine 0.05e3.3 mg/kg/min
- Inotropes if needed:
 - Dobutamine 2.5e5.0 mg/kg/min or
 - Milrinone 0.25e0.75 mg/kg/min
- Pulmonary vasodilator if needed to unload right ventricle
 - Inhaled nitric oxide 5e40 ppm or
 - Inhaled epoprostanol 10e50 ng/kg/min) or
 - IV epoprostanol 1e2 ng/kg/min (via central line) or
 - Sildenafil 20 mg orally (if awake/alert)
- Consider ECMO if prolonged CPR or refractory right heart failure
- Wean FiO₂ to maintain O₂ saturation 94% to 98%

Post-event debriefing (entire team)

- Identify opportunities for improvement including any need for revisions to checklist
- Discuss family and staff support needs
- Report case to Amniotic Fluid Embolism Registry