

Stroke: Ischemic RRG

RRG: M-83-RRG (ISC)

[Link to Codes](#)

MCG Health

Inpatient & Surgical Care
30th Edition

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Clinical Indications for Admission

Observation Care	Inpatient Care
• Observation care is indicated for 1 or more of the following[A][B]: ◦ Vital sign abnormality ◦ Appropriate evaluation (brain MRI, echocardiogram, carotid imaging) cannot be completed in emergency department time frame (3 to 4 hours). ◦ Cardiac embolic source suspected requiring cardiac telemetry monitoring beyond emergency department care time frame (eg, to detect atrial fibrillation)[C] ◦ National Institutes of Health Stroke Scale (NIHSS) score of 2 or less and monitoring of neurologic findings (eg, for worsening or recurrence of findings) beyond emergency department time frame (3 to 4 hours) needed[D]	• Admission is indicated for 1 or more of the following[A]: ☐ Acute ischemic stroke[A] with neurologic findings that warrant inpatient care, as indicated by 1 or more of the following: ▪ National Institutes of Health Stroke Scale (NIHSS) score greater than 2[D] ▪ Evidence of hemorrhagic transformation ▪ Altered mental status ▪ Dysphagia that warrants evaluation (eg, aspiration risk suspected) ▪ Significant arm or leg weakness (eg, limiting movement against gravity) ▪ Aphasia ▪ Gait impairment ▪ Finding on brain imaging that requires inpatient care (eg, edema, threatened herniation) ▪ Clinical monitoring for neurologic worsening needed (eg, large infarct, posterior circulation infarct)[E] ▪ Clinical stability unclear (eg, recurrent or worsening findings)

- ☐ Acute ischemic stroke[A] with clinical need for inpatient care or monitoring, as indicated by **1 or more** of the following:
- Hemodynamic instability
 - Cardiac arrhythmias of immediate concern
 - Clinically significant cardiac or vascular disorder identified (eg, on echocardiogram, imaging) that requires inpatient care (eg, severe valvular disease, atrial myxoma, cervical artery dissection)
 - Ischemic stroke due to cerebral venous thrombosis[F]
 - Respiratory abnormalities (eg, Hypoxemia, impaired airway protection)
 - Severe hypertension (SBP greater than 180 mm Hg or DBP greater than 120 mm Hg, or greater than the 95th percentile for age, sex, and height plus 30 mm Hg in pediatric patients[G][H])
 - Prolonged cardiac telemetry monitoring needed (eg, beyond observation care time frame) due to concern for Dangerous arrhythmia (ie, not in effort to detect atrial fibrillation)[C]
 - Suspected vasculitis
- Thrombolysis or thrombectomy performed or planned[I]

See Stroke: Ischemic [ISC](#) Optimal Recovery Guideline for complete guideline and further supporting content such as Supplemental Medicare Criteria (ie, CMS' Two-Midnight Rule exceptions), Alternatives to Admission or Procedure, Optimal Recovery Course, and Evidence Summary.

Level of Care Criteria

For patient conditions requiring more than routine inpatient care, documentation of need may be done using the [Level of Care] chart.

Intensive Care	Intermediate Care	Telemetry Care
- ICU admission may be indicated when need is demonstrated by 1 or more of the following: ☐ Vital sign abnormalities, including 1 or more of the following[G]: ■ Systolic arterial blood pressure less than 90 mm Hg, or 20 mm Hg below patient's	Intermediate care admission may be indicated after intensive care treatment (eg, as "step-down" care) or to provide higher level of care than general hospital ward (eg, as "step-up" care in absence of intensive care admission needs) (see Intensive Care Guidelines ISC), as	- Telemetry care admission[J][K][L] may be indicated for 1 or more of the following: ☐ Suspected or proven acute ischemic cardiac event, including 1 or more of the following: ■ Acute coronary syndrome

usual pressure in adult or child older than 10 years

- Systolic arterial blood pressure less than 60 mm Hg in neonate (younger than 1 month), 70 mm Hg in infant (1 month to 1 year of age), or less than the sum of 70 mm Hg plus twice the patient's age in child 2 to 10 years of age
- Mean arterial pressure less than 65 mm Hg in adult or child age 10 years or older[J]  MAP Calculator
- Mean arterial pressure[J] drop of greater than 30 mm Hg from baseline attributable to cardiovascular dysfunction (eg, cardiogenic shock)  MAP Calculator
- Pulse less than 45 or greater than 130 beats per minute in adult
- Pulse less than 40 or greater than 140 beats per minute in adolescent age 16 years or older
- Pulse less than 70 or greater than 150 beats per minute in child 2 to 15 years of age
- Pulse less than 90 or greater than 160 beats per minute in infant younger than 2 years

☐ Laboratory findings (new), including **1 or more** of the following:

- Pulse oximetry or arterial oxygen saturation less than 90%, or partial pressure of oxygen less than 60 mm Hg (8.0 kPa) despite oxygen supplementation[K]
- Rising partial pressure of carbon dioxide with acute or uncompensated respiratory acidosis
- Arterial pH less than 7.2 or greater than 7.65
- Serum sodium less than 110 mEq/L (mmol/L) or greater than 160 mEq/L (mmol/L)

indicated by **1 or more** of the following[FF]:

☐ Intermediate level monitoring or care needed, as indicated by **1 or more** of the following:

- Care requiring nurse to patient ratio of 1:2 or 1:3 (eg, complex wound management, postoperative high-risk patient, profound neuromuscular weakness)
- Frequent (but less frequent than hourly) monitoring, such as vital signs, vascular checks, or neurologic checks
- Stable chronic mechanical ventilator or long-term weaning needs
- Noninvasive ventilation[GG][N]
- High-flow oxygen therapy[HH]
- Peritoneal dialysis
- Frequent pulmonary therapy with endotracheal suctioning (nonintubated or chronic tracheostomy patient)
- Rapid diuresis for fluid overload
- Electrolyte, metabolic, or other problem requiring frequent laboratory testing or treatment adjustments
- Monitoring of continuous high-level epidural anesthesia
- Monitoring after toxic ingestion with risk for neurologic, cardiac, or respiratory compromise
- Titration of IV vasodilator or antiarrhythmic agents
- Low-dose inotropic or vasodilator therapy without need for frequent titration

- Post-acute MI
- Suspected vasospastic angina (to establish diagnosis with ST monitoring)
- Suspected MI (until it is ruled out)
- Newly diagnosed left main coronary artery lesion (until revascularization)

☐ Cardiac rhythm disorder or conduction abnormality, including **1 or more** of the following:

- Dangerous arrhythmia diagnosed or suspected (until controlled or diagnosed as not requiring intervention)
- New-onset or recurrent atrial tachyarrhythmia
- Wolff-Parkinson-White syndrome with rapid conduction (until controlled by antiarrhythmic agent or ablation)
- Symptomatic Bradycardia [MM]
- Chronic atrial fibrillation with medical condition that may affect ventricular rate (eg, autonomic dysfunction)[NN]
- High-risk ECG findings (eg, bifascicular block, abnormal QT interval, ventricular pre-excitation, other conduction abnormality)
- Firing of implantable cardioverter-defibrillator[OO]
- Suspected pacemaker or implantable cardioverter-defibrillator malfunction[PP]

☐ New administration or adjustment of treatment affecting cardiac rhythm or conduction, including **1 or more** of the

- Serum sodium less than 125 mEq/L (mmol/L) with Altered mental status, seizure, or respiratory arrest
- Serum sodium more than 145 mEq/L (mmol/L) with Altered mental status, seizure, diabetes insipidus requiring close monitoring of fluid balance and resuscitation, or severe dehydration requiring large-volume fluid resuscitation
- Serum potassium less than 2 mEq/L (mmol/L) or greater than 7 mEq/L (mmol/L)
- Serum potassium less than 2.5 mEq/L (mmol/L) with severe clinical or ECG manifestations (eg, paralysis, cardiac arrhythmia, delayed depolarization, flat T-waves, or U-waves)
- Serum potassium greater than 6.5 mEq/L (mmol/L) with ECG changes of hyperkalemia (eg, peaked T-waves, widened QRS, cardiac arrhythmia; for patient with permanent pacemaker: widened paced QRS, increased pacemaker stimulus to QRS interval, or failure to capture)
- Calcium[L] greater than 14 mg/dL (3.5 mmol/L) or ionized calcium greater than 10.0 mg/dL (2.50 mmol/L)
- Calcium[L] greater than 12 mg/dL (3.0 mmol/L) or ionized calcium greater than 8.0 mg/dL (2.0 mmol/L) with Altered mental status, severe volume depletion requiring large-volume IV fluid resuscitation, Hypotension, significant arrhythmia, heart block, or digitalis toxicity
- Serum phosphorus less than 1 mg/dL (0.32 mmol/L)
- Toxic drug level or poisoning causing or likely to cause neurologic abnormalities or Hemodynamic instability
- Less severe or other laboratory abnormalities (eg, hyperphosphatemia,

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- Continuous pulse oximetry monitoring
- Short-term electroencephalographic monitoring
- Patient who requires short-term inpatient monitoring (eg, cardiac, wound site, perfusion)

☐ **Neurology** diagnoses or procedures, including **1 or more** of the following:

- Acute ischemic stroke[III]
- Drug ingestion with Hemodynamic stability requiring frequent clinical or laboratory monitoring
- Need for frequent neurologic monitoring (eg, q2 hour) beyond capability of medical or pediatric floor (eg, seizure responsive to therapy requiring short-term EEG monitoring)
- Neuromuscular weakness requiring frequent monitoring of pulmonary vital capacity (eg, myasthenia gravis, Guillain-Barre syndrome) or administration of noninvasive ventilation

following:

- New administration or adjustment of antiarrhythmic drug[QQ]
- New administration or adjustment of rate control therapy for atrial tachyarrhythmia
- New administration or adjustment of negative chronotropic agent (eg, beta-blocker) in patient with baseline Bradycardia
- New administration or adjustment of QTc-prolonging medications[RR]
- New wearable (external) cardioverter-defibrillator for indication anticipated to be temporary (eg, myocarditis, untreated heart failure meeting implantable cardioverter-defibrillator criteria but expected to improve with therapy, indication for implantable cardioverter-defibrillator with temporary contraindication to implantation, bridge to transplant or other advanced heart failure therapy)

☐ Following cardiac or major thoracic procedure, including **1 or more** of the following:

- Cardiac surgery (first 48 to 72 hours unless complications occur)
- Noncardiac thoracic surgery (eg, pulmonary lobectomy; first 48 to 72 hours unless complications occur)
- Nonurgent percutaneous coronary intervention with

hypomagnesemia, or hypermagnesemia) contributing to **1 or more** of the following:

- Seizure
- Altered mental status
- Muscle weakness or severe spasms
- Arrhythmias
- Hemodynamic instability
- Other significant clinical manifestations

☐ ECG (or cardiac monitoring) findings, including **1 or more** of the following:

- Inherently unstable or life-threatening arrhythmia (eg, sustained ventricular tachycardia, ventricular fibrillation, asystole)
- Arrhythmia causing Hypotension (eg, Bradycardia, Tachycardia)
- Complete heart block causing Hypotension
- Other findings indicative of need for intensive care (eg, acute cardiac ischemia, myocardial infarction)

☐ Physical findings, including **1 or more** of the following:

- Threatened airway
- Altered mental status that is severe or persistent
- Repeated or prolonged seizures
- New-onset anuria (urine output less than 0.1 mL/kg/hour over 4 hours)
- Cyanosis (new)
- Cardiac tamponade
- Status post respiratory or cardiac arrest
- Findings consistent with abdominal emergency (eg, peritoneal signs)

☐ Imaging findings, such as dissecting aneurysm or ruptured viscus

☐ Severe burns, as indicated by **1 or more** of the following[M]:

- Hemodynamic instability

complications or suboptimal results (for at least 24 hours or until complication is resolved)

▪ Short-term monitoring after cardiac procedure, as indicated by **1 or more** of the following[SS]:

- Electrophysiologic studies
- Implantable cardioverter-defibrillator placement
- Nonurgent percutaneous coronary intervention without complications until sheath is pulled
- Temporary pacemaker placement (until removed or permanent pacemaker placed)
- Permanent pacemaker placement
- Arrhythmia ablation (up to 24 hours for complex ablations (eg, pulmonary vein isolation), atrioventricular nodal ablations, or serious comorbidities)
- Implantation of ventricular assist device
- Transcatheter procedures (eg, aortic valve replacement, valvuloplasty, atrial or ventricular septal defect closure)
- Percutaneous left atrial appendage

- Hypotension or requirement for aggressive fluid resuscitation
- Inhalation injury
- Respiratory insufficiency with requirement for high-flow oxygen, mechanical ventilation, or extracorporeal membrane oxygenation
- Need for intubation or mechanical ventilation due to high risk of airway obstruction (eg, laryngeal injury seen on fiberoptic laryngoscopy, oropharyngeal burn, soot in nares or oropharynx, deep circular neck burn, stridor, change in voice, or facial burn with extensive burn involving total body surface area of 40% or greater in adult or 60% or greater in child)
- Need for intubation or mechanical ventilation due to reduced level of consciousness (eg, Glasgow coma scale less than 8)  GCS Calculator
- Requirement for frequent or intensive debridement and dressing changes
- Serious chemical burn
- High-voltage (eg, 1000 volts or more) electrical burn
- Carbon monoxide poisoning
- Cyanide toxicity
- Infant younger than 1 year
- Multiple comorbidities
- Severe infection or sepsis (eg, skin and soft tissue, pneumonia, urinary infection)
- Life-threatening cardiac, renal, pulmonary, or neurologic dysfunction
- Concomitant trauma, organ failure, arrhythmia, or other medical condition requiring ICU care

☐ Specific intervention or monitoring needed, as indicated by **1 or more** of the following:

- New need for assisted ventilation, invasive or noninvasive[N]

closure (6 hours if performed under general anesthesia, shorter duration if performed under moderate sedation)

- Short-term monitoring of suspected cardiac contusion (eg, chest trauma with new abnormality (ST elevation, tachyarrhythmia, bundle branch block) on ECG)[TT]

☐ Electrical injury and **1 or more** of the following:

- Loss of consciousness
- Dysrhythmia
- New ECG abnormality
- Troponin elevation
- Direct lightning injury

☐ Cardiac disease, including **1 or more** of the following:

- Acute myocarditis or pericarditis
- Acute decompensated heart failure[UU]
- Takotsubo cardiomyopathy (aka stress cardiomyopathy or apical ballooning syndrome)
- Infectious endocarditis
- Patient admitted with ventricular assist device (for cardiac or noncardiac problems)

☐ Drug overdose or poisoning with substance that causes Bradycardia, arrhythmia, QT prolongation, or QRS widening (eg, greater than 120 msec) (eg, beta-blockers, methadone, phenothiazines, sympathomimetic agents, cyclic antidepressants, digitalis, antiarrhythmic drugs)[RR]

- Short-term cardiac monitoring after therapeutic or diagnostic procedure

- New need for intubation (eg, to protect airway)
- New tracheostomy (less than 48 hours old)
- Hourly vital signs or neurologic checks
- Pulmonary artery line monitoring needed (eg, for refractory heart failure, diagnostic uncertainty (eg, uncertain fluid status), guidance of device selection and utilization of mechanical circulatory support, assessment of pulmonary arterial pressure and vasodilator responses in pulmonary hypertension, and other select conditions)
- Continuous arterial line monitoring needed
- Continuous IV vasoactive medications
- Continuous IV antiarrhythmics
- Large volume IV fluid resuscitation (eg, greater than 6 L per day)
- Large or rapid transfusion needs (eg, more than 6 units within 24 hours)
- High-risk IV treatment, such as thrombolysis, hypertonic saline, or mannitol infusion
- Rapid desensitization or graded drug provocation challenge for high-risk hypersensitivity reaction to required medication (eg, penicillin, aspirin, monoclonal antibody)
- Acute cardiac pacing
- Temporary mechanical circulatory support (eg, aortic balloon pump, ventricular assist device)
- Extracorporeal membrane oxygenation device
- Pericardiocentesis
- Hemodialysis in unstable patient
- Continuous renal replacement therapy (eg, continuous venovenous hemodialysis)
- Continuous fluid removal via hemofiltration (eg, continuous

requiring conscious sedation or anesthesia

- Acute cerebrovascular event^[VV]
- Short-term cardiac monitoring during treatment with medications that increase risk of arrhythmia or Bradycardia (eg, lidocaine infusion for pain, neostigmine infusion for treatment of acute colonic pseudo-obstruction, phenytoin infusion for seizure without status epilepticus)

☐ Uncorrected electrolyte abnormalities associated with increased risk of dangerous arrhythmia (until corrected), as indicated by **1 or more** of the following:

- Hyperkalemia with attributable ECG changes
- Potassium less than 3.0 mEq/L (mmol/L)
- Potassium greater than or equal to 6.0 mEq/L (mmol/L) but less than 6.5 mEq/L (mmol/L) in patient with acute kidney injury, acute illness, or anticipated rapid rise in potassium
- Potassium 6.5 mEq/L (mmol/L) or greater
- Magnesium less than 1.3 mEq/L (0.65 mmol/L)
- Magnesium greater than 6 mEq/L (3 mmol/L) or prolonged PR, QRS, or QT attributed to hypermagnesemia
- Calcium^[WW] less than 8.6 mg/dL (2.15 mmol/L) or ionized calcium less than 4.65 mg/dL (1.16 mmol/L) with acute symptoms requiring IV repletion (eg, convulsions, severe

venovenous hemofiltration)

- Peritoneal dialysis initiation
- Emergency bronchoscopic therapy (eg, for hemoptysis)
- Emergency endoscopic therapy for bleeding
- Balloon tamponade for variceal bleeding
- Intracranial pressure monitoring or tissue oxygen monitoring
- Ventriculostomy monitoring
- Treatment of ongoing seizures
- Induced hypothermia or coma
- Ongoing frequent testing and treatment for acute conditions, including **1 or more** of the following:
 - Correction of severe metabolic acidosis or alkalosis
 - Frequent glucose checks (ie, more frequent than performable at lower level of care)
 - Severe fluid overload
 - Cerebral edema
 - Monitoring or suctioning for respiratory insufficiency or acidosis
 - Monitoring for active bleeding
- Other need for treatment or monitoring not available outside the ICU

☐ **Systemic conditions**, including **1 or more** of the following:

- Severe electrolyte or metabolic disturbance causing or likely to cause **1 or more** of the following:
 - Life-threatening cardiac dysrhythmia
 - Respiratory insufficiency
 - Altered mental status
 - Seizures
 - Hemodynamic instability
 - Muscular weakness
- Severe Hypothermia, as indicated by **1 or more** of the following:

muscle spasms, cardiac conduction disturbance)

- Prolonged QT attributed to hypokalemia, hypomagnesemia, or hypocalcemia
- Other clinically significant electrolyte abnormality associated with increased risk of arrhythmia

☐ Unexplained syncope or other neurologic event suspected of being due to arrhythmia or of cardiac origin, as indicated by **1 or more** of the following:

- Hemodynamic instability
- Outflow tract obstruction (eg, hypertrophic cardiomyopathy)
- Structural abnormality (eg, certain congenital heart defects, ventricular dysfunction, cardiomyopathy)
- Valvular disease (eg, aortic stenosis, prosthetic valve dysfunction)
- Myocarditis
- Patient reported palpitations or tachycardia preceding syncope
- Syncope occurring during exercise
- Syncope sudden and without prodrome
- Syncope while supine
- Suspected dysfunction of implantable pacemaker or defibrillator
- History of Dangerous arrhythmia
- History of previous syncope due to arrhythmia
- Use of medication known to cause Dangerous arrhythmia
- Family history of sudden death

- Temperature 89.6 degrees F (32 degrees C) or lower
- Temperature 95 degrees F (35 degrees C) or lower and severe organ dysfunction, as indicated by **1 or more** of the following:
 - Altered mental status
 - Hemodynamic instability
 - Respiratory depression
 - Pulmonary edema
 - Arrhythmia (eg, Bradycardia, atrial fibrillation, ventricular fibrillation)
 - Acute kidney injury (stage 2) or Acute renal failure (stage 3 acute kidney injury)
 - Other new end organ dysfunction attributable to hypothermia
- Heatstroke and **1 or more** of the following^[O]:
 - Hemodynamic instability
 - Altered mental status
 - Seizures
 - Rhabdomyolysis
 - Acute kidney injury (stage 2) or Acute renal failure (stage 3 acute kidney injury)
 - Acute liver injury (eg, new INR elevation of 1.5 or greater; aspartate aminotransferase, alanine aminotransferase, or gamma-glutamyl transpeptidase greater than 100 units/L (1.67 mkat/L); new direct bilirubin greater than 2 mg/dL (34 micromoles/L); or new total bilirubin greater than

- Presentation consistent with acute coronary syndrome (eg, chest pain, cardiac ischemia)
- Multiple syncopal episodes within last 6 months
- Known channelopathy (eg, long QT syndrome, Brugada syndrome, or catecholaminergic paroxysmal ventricular tachycardia)
- High-risk ECG findings (eg, bifascicular block, Bradycardia, abnormal QT interval, ventricular pre-excitation, other conduction abnormality)

- 5 mg/dL (86 micromoles/L)
attributable to hyperthermia)
- Disseminated intravascular coagulation
- Diffuse pulmonary infiltrates with Hypoxemia (eg, acute respiratory distress syndrome) attributable to hyperthermia
- Environmental injuries, such as electrical injuries, or near drowning
- Anaphylaxis with respiratory compromise, Hypotension, or other end organ dysfunction
- Confirmed or suspected malignant hyperthermia as evidenced by exposure to volatile anesthetic agent or succinylcholine and **1 or more** of the following[P]:
 - Hypermetabolism as evidenced by inappropriately increased CO₂ production, O₂ consumption, or acute mixed metabolic and respiratory acidosis
 - Unexplained Tachycardia
 - Cardiac tachyarrhythmias, ectopic ventricular beats, or ventricular bigeminy
 - Masseter spasm
 - Muscle rigidity
 - Rapid increase in core body temperature
 - Acute rise in serum potassium, creatine kinase, or myoglobin
- Neuroleptic malignant syndrome as evidenced by exposure to neuroleptic drug (eg, phenothiazine, butyrophenone) or dopamine-depleting drug (eg, alpha-methyltyrosine), or withdrawal of dopaminergic agent (eg, levodopa, amantadine) and **1 or more** of the following[P]:
 - Muscle rigidity

- Akathisia (uncontrollable movement)
- Hyperthermia
- Altered mental status
- Dysautonomia (eg, fluctuating blood pressure, tachycardia, hypersalivation, diaphoresis)
- Hemodynamic instability
- Acute rise in creatine kinase
- Rhabdomyolysis
- Serotonin syndrome (serotonin toxicity) as evidenced by exposure to medication(s) that increases level of serotonin in CNS (eg, some antidepressants including serotonin reuptake inhibitors, monoamine oxidase inhibitors, opioids, stimulants, triptans, antiseizure medications, linezolid) and **1 or more** of the following:
 - Significant neurologic finding (eg, agitation, hypomania, hallucinations, Altered mental status, seizures)
 - Significant autonomic nervous system-related hyperactivity (eg, Hemodynamic instability, hypertension, blood pressure fluctuation, sweating, hyperthermia, tachycardia, vomiting, diarrhea)
 - Significant musculoskeletal findings (eg, rigidity, myoclonus, hyperreflexia, tremor, rhabdomyolysis, elevated creatinine kinase)
- Severe alcohol withdrawal with **1 or more** of the following:
 - Hemodynamic instability
 - Cardiac arrhythmias of immediate concern
 - Uncontrolled seizures
 - Respiratory depression with need for, or high likelihood of

- requiring, mechanical ventilation
- Need for anesthetic agent to control agitation (eg, dexmedetomidine, propofol, ketamine, IV phenobarbital)
- Delirium tremens as evidenced by **ALL** of the following:
 - Cessation of, or reduction in, heavy and prolonged alcohol use
 - Delirium (eg, fluctuating disturbance in attention, awareness, orientation, language)
 - Signs or symptoms of alcohol withdrawal, as indicated by **2 or more** of the following:
 - Autonomic hyperactivity (diaphoresis, tachycardia, hypertension)
 - Tremor
 - Nausea or vomiting
 - Hallucinations
 - Increased anxiety
 - Psychomotor agitation
 - Generalized tonic-clonic seizures

☐ **Neurology** diagnoses or procedures, including **1 or more** of the following:

- Intracranial hypertension requiring **1 or more** of the following:
 - Induced barbiturate coma

- Pharmacologic paralysis or deep sedation and mechanical ventilation
- Intracranial pressure or cerebral perfusion pressure monitoring
- IV hyperosmolar therapy (eg, hypertonic saline (preferred) or mannitol)
- Frequent serum osmolality measurements
- IV vasoactive medication (eg, labetalol for hypertension, norepinephrine for hypotension)
- Ventriculostomy drainage
- Therapeutic hypothermia
- Surgical decompression
- Seizures with **1 or more** of the following:
 - Status epilepticus
 - Severe electrolyte abnormalities causing seizures
 - Airway compromise requiring or likely to require mechanical ventilation
- Progressive acute neurologic dysfunction requiring or likely to require **1 or more** of the following:
 - Mechanical ventilation
 - Intracranial pressure or cerebral perfusion pressure monitoring
- Guillain-Barre syndrome (variants include acute inflammatory demyelinating polyradiculoneuropathy (AIDP), acute motor axonal neuropathy (AMAN), or Miller Fisher syndrome) with **1 or more** of the following:
 - Progressive weakness (risk for respiratory deterioration and need for intubation and mechanical ventilation)
 - Progressive decrease in respiratory function (eg, vital capacity, maximum inspiratory or expiratory pressure)

- Fall in vital capacity of more than 30% below the predicted baseline over 24 hours
- Single breath count less than 20 (inability to count from 1 to 20 in a single breath)
- Bulbar muscle involvement (risk for aspiration and need for intubation and mechanical ventilation)
- Modified Erasmus GBS respiratory insufficiency scale score of 25 or higher^[Q]
- Severe autonomic dysregulation, including **1 or more** of the following:
 - Hypertensive crisis
 - Severe hypertension
 - Bradycardia
 - Tachycardia
 - Cardiac arrhythmias of immediate concern
- Myasthenia gravis crisis with **1 or more** of the following:
 - Respiratory insufficiency requiring, or likely to require, intubation and mechanical ventilation^[R]
 - Bulbar muscle involvement (risk for aspiration and need for intubation and mechanical ventilation)
- CNS infection (eg, meningitis, encephalitis, intracranial abscess) with **1 or more** of the following^[S]:
 - Hemodynamic instability
 - Altered mental status that is severe or persistent
 - Respiratory insufficiency
 - Rapidly evolving rash
 - Elevated intracranial pressure
 - Hydrocephalus
 - Refractory seizures

- Focal neurologic deficits
 - Agitation requiring sedation
 - Sepsis and end organ failure or dysfunction
 - Stroke with **1 or more** of the following^[T]:
 - Need for observation after thrombolysis or endovascular treatment^[U]
 - Altered mental status
 - Need for mechanical ventilation
 - Elevated intracranial pressure
 - Hypertensive emergency
 - High risk of progressive infarction or deterioration based on CT scan or MRI
 - Large hemispheric or cerebellar infarct
 - Arterial dissection
 - New seizure
 - Hemorrhage
 - Child with acute stroke
 - Acute coma
 - Acute paraplegia or tetraplegia^[V]
 - Acute spinal cord compression (eg, epidural abscess, hematoma, tumor)
 - Acute spinal cord infarction
 - Acute flaccid paralysis^[W]
 - Acute spontaneous intracranial hemorrhage^[X]
 - Acute subarachnoid hemorrhage^[Y]
 - Traumatic brain injury with **1 or more** of the following:
 - Altered mental status that is severe or persistent or Glasgow coma scale score less than 10
-  GCS Calculator
- Cerebral edema
 - Cerebral hemorrhage
 - Increased intracranial pressure
 - Need for intracranial pressure and cerebral perfusion pressure

- monitoring, tissue oxygen monitor, or ventriculostomy
- Need for arterial catheter for blood pressure monitoring
- Need for intubation and mechanical ventilation
- Symptomatic hyponatremia (eg, sodium level less than 135 mEq/L (mmol/L) with Altered mental status or seizure)[Z]
- Severe hypernatremia (sodium level greater than 155 mEq/L (mmol/L))[AA]
- Symptomatic hypernatremia (eg, sodium level greater than 145 mEq/L (mmol/L) with Altered mental status or seizure)[AA]
- Acute vestibular syndrome with **1 or more** of the following:
 - Posterior circulation stroke requiring thrombolytic therapy or acute endovascular surgery
 - Elevated intracranial pressure or edema at high risk of brainstem compression
 - Hemorrhagic conversion
- Drug ingestion or toxic exposure with **1 or more** of the following:
 - Hemodynamic instability
 - Respiratory depression (eg, new partial pressure of carbon dioxide greater than 45 mm Hg (6.0 kPa))
 - Patient requires or is likely to require mechanical ventilation.
 - Arrhythmia
 - Seizures
 - Altered mental status that is severe or persistent
 - Significant risk for acute deterioration (eg, toxic drug

- level or ingestion of overdose of sustained-release preparation)
- Drug-induced Hypothermia or hyperthermia
- Significant or worsening metabolic acidosis
- Severe hypoglycemia requiring glucose infusion with frequent adjustment or glucagon administration beyond the capabilities of a lower level of care
- Ongoing antidote administration (eg, continuous naloxone infusion, organophosphate toxicity treatment)
- Acute kidney injury (stage 2) or Acute renal failure (stage 3 acute kidney injury)
- Acute liver failure
- Drug-induced rhabdomyolysis requiring high-volume IV fluid resuscitation
- Need for pharmacologic restraints
- Emergency intervention need (eg, dialysis, hemoperfusion, plasma exchange, restraints)
- Parkinson hyperpyrexia syndrome, as evidenced by **1 or more** of the following after reduction or discontinuation of anti-Parkinsonian medication, or following direct brain stimulation discontinuation or malfunction:
 - Muscle rigidity
 - Hyperthermia
 - Altered mental status
 - Hemodynamic instability
 - Elevated creatine kinase
- Status dystonicus (generalized sustained severe dystonic spasms with end organ decompensation or failure)[BB]
- Cerebral venous thrombosis[CC]

- Autoimmune or paraneoplastic encephalitis with **1 or more** of the following^[DD]:
 - Altered mental status that is severe or persistent
 - Hemorrhage
 - Elevated intracranial pressure
 - Refractory seizures
 - Respiratory insufficiency
 - Severe hyponatremia (eg, serum sodium less than 110 mEq/L (mmol/L) or serum sodium less than 125 mEq/L (mmol/L) with Altered mental status or seizure)
 - Severe autonomic dysregulation, including **1 or more** of the following:
 - Hemodynamic instability
 - Severe hypertension
 - Bradycardia
 - Tachycardia
 - Cardiac arrhythmias of immediate concern
- Posterior reversible encephalopathy syndrome, as indicated by **ALL** of the following^[EE]:
 - Acute or subacute symptoms (headache, encephalopathy, Altered mental status, visual disturbance, or seizure)
 - Risk factor (eg, chronic renal disease, autoimmune disorder, malignancy, immunotherapy, chemotherapy) or acute precipitating event (eg, acute renal failure, severe hypertension, sepsis, blood pressure fluctuation, radiation therapy, or eclampsia)
 - Brain imaging consistent with diagnosis (eg, bilateral

- | | | |
|---|--|--|
| vasogenic edema)
■ Brain death with preparation for organ donation | | |
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Hospitalization

Goal Length of Stay: 2 days

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Discharge Readiness

- Discharge readiness is indicated by patient meeting Recovery Milestones, including **ALL** of the following:
 - **Hemodynamic stability**
 - **Mental status at baseline or stable**
 - **Neurologic deficits absent or stable**
 - **Unimpaired swallowing**
 - **Dangerous arrhythmia absent**
 - **Ambulatory or acceptable for next level of care**
 - **Oral hydration^[XX]**
 - **Oral medications or regimen acceptable for next level of care**
 - **Oral diet or acceptable for next level of care**
 - **Discharge plans and education understood**

See Stroke: Ischemic Optimal Recovery Course [ISC](#) for full optimal recovery management information.

Extended Stay

Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Extended stay beyond goal length of stay may be needed for:
 - Failure to meet discharge criteria (recovery milestones within final day in Optimal Recovery Course)
 - Expect brief stay extension.
 - Major deficit or clinical deterioration
 - Patient presenting with severe manifestations (eg, hemiplegia, aphasia, progression in neurologic deficits, impaired cognitive or swallowing function) may require ongoing inpatient care.
 - Anticipate use of feeding tube, continuing physical therapy, and possible mechanical ventilation.
 - Anticipate permanent feeding tube placement and possible tracheostomy in patient with severe persistent dysphagia or impaired cognitive function.
 - Expect brief to moderate stay extension.
 - Seizures
 - Patients with cerebral venous thrombosis and those undergoing thrombolytic or catheter-directed reperfusion therapy may be at higher risk of seizure.

- Anticipate parenteral and oral antiseizure therapy and possible continuous EEG monitoring.
- Expect brief stay extension.
- Bleeding (eg, cerebral or postprocedural)
 - Bleeding may occur after thrombolytic or antithrombotic therapy or following endovascular thrombectomy.
 - Factors that may increase the risk of hemorrhagic transformation of ischemic stroke include large infarct size, thrombocytopenia, more than 10 cerebral microbleeds on imaging, and renal impairment.
 - Anticipate need for extended observation if bleeding occurs.
 - Expect brief to moderate stay extension.
- Increased intracranial pressure
 - Anticipate hyperosmolar agents, diuretics, hyperventilation, intracranial pressure monitoring, and possible external ventricular drainage.
 - Decompressive surgical craniectomy may be needed for select patients (eg, refractory intracranial hypertension, neurologic deterioration, brainstem compression, or ventricular obstruction).
 - Expect moderate to prolonged stay extension.
- Surgical intervention
 - Ischemic stroke with brain edema and progressive neurologic compromise may prompt surgical decompression (eg, ventriculostomy or craniotomy).
 - Children or adults with focal cerebral arteriopathy (eg, moyamoya) may require surgical revascularization.
 - Expect moderate to prolonged stay extension.
 - See Craniotomy, Supratentorial  ISC guideline as indicated.
- Hospital-acquired infection (eg, urinary tract infection, pneumonia)
 - Poststroke pneumonia is more common among patients older than 75 years with comorbid heart failure, dysarthria, and dysphagia.
 - Anticipate parenteral antibiotics and supportive care.
 - Expect brief to moderate stay extension.
- Noninfectious poststroke fever
 - Expect laboratory and radiologic evaluation for infectious and noninfectious etiologies.
 - Anticipate treatment with antipyretic medications and possible treatment of underlying cause (eg, withdrawal of possibly contributing drugs, chest physiotherapy for atelectasis).
 - Expect brief stay extension.
- Venous thromboembolism
 - Anticipate local external measures, anticoagulation, and possible vena cava filter.
 - See Venous Thrombosis and Pulmonary Embolism: Common Complications and Conditions  ISC for further information.
 - Expect brief to moderate stay extension.
- Severe electrolyte abnormality (eg, hypernatremia, hyponatremia)
 - Anticipate careful fluid management and close monitoring of electrolytes and mental status.
 - Expect brief stay extension.
- Respiratory failure
 - Intubation and mechanical ventilation may be needed for obtundation, coma (eg,  GCS Calculator less than 8), agitation or combativeness, loss of protective airway reflexes, significant elevation in intracranial pressure, brain herniation, or non-neurologic respiratory complications (eg, severe aspiration pneumonia, acute respiratory distress syndrome).
 - Tracheostomy may be needed for patient with Altered mental status that is severe or persistent, ongoing need for mechanical ventilation, or failure of extubation.
 - Anticipate brief stay extension.
- Myocardial ischemia

- Anticipate pharmacologic treatment and possible cardiac catheterization and intervention.
- Expect brief stay extension.
- Dangerous arrhythmia
 - Anticipate telemetry monitoring, possible electrophysiologic study, and antiarrhythmic medications or ablation procedure.
 - Expect brief stay extension.
 - See Arrhythmia: Common Complications and Conditions [ISC](#) guideline as appropriate.
- Cerebral hyperperfusion syndrome[YY]
 - Anticipate ICU monitoring, transcranial duplex ultrasound, and brain imaging studies.
 - Anticipate intensive blood pressure control, prophylactic antiseizure medications, and possible hyperosmolar agents for cerebral edema.
 - Intracranial hemorrhage may occur.
 - Stay extension varies.
- Poststroke delirium
 - Poststroke delirium is associated with worse poststroke function and higher mortality.
 - Expect brief stay extension.
- Unstable comorbidities (heart failure, Acute kidney injury (stage 2), Acute renal failure (stage 3 acute kidney injury))
 - Unstable comorbidities may require ongoing inpatient care.
 - Expect brief stay extension.
- ☐ Other complication or condition, including:
 - ☐ Anemia
 - Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Active blood loss absent
 - Signs and symptoms of anemia absent or acceptable for next level of care
 - Mental status normal or at baseline
 - Hgb/Hct level stable and acceptable for next level of care
 - Etiology of anemia requiring inpatient care absent
 - ☐ Arrhythmia
 - Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Arrhythmia evaluation completed
 - Reversible causes of arrhythmia eliminated or mitigated
 - Specific antiarrhythmia treatment initiated as appropriate
 - Anticoagulation requirements addressed (or anticoagulation not required). See Anticoagulation Requirement: Common Complications and Conditions [ISC](#) for further information.
 - ☐ Electrolyte disorder
 - Extended stay beyond goal length of stay for primary condition may be needed until **1 or more** of the following is present:
 - Electrolyte abnormality manageable at next level of care[ZZ]
 - No electrolyte abnormality, as indicated by **ALL** of the following:
 - Potassium greater than 3.5 mEq/L (mmol/L) and less than 5.0 mEq/L (mmol/L)
 - Sodium greater than 135 mEq/L (mmol/L) and less than 145 mEq/L (mmol/L)
 - Calcium greater than 8.5 mg/dL (2.13 mmol/L) and less than 10.5 mg/dL (2.63 mmol/L)

- Phosphorus greater than 2.5 mg/dL (0.81 mmol/L) and less than 5.0 mg/dL (1.62 mmol/L)
- Magnesium greater than 1.5 mEq/L (0.75 mmol/L) and less than 3.0 mEq/L (1.5 mmol/L)

☐ Fever

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Hypoxemia absent
 - Tachypnea absent
 - ☐ Temperature status acceptable, as indicated by **1 or more** of the following:
 - Temperature less than 100.5 degrees F (38.1 degrees C) (oral)
 - Temperature as expected for disease process and acceptable for next level of care
 - Cultures negative or infection identified and under adequate treatment
 - No condition, organ dysfunction (eg, renal failure), or laboratory finding (eg, acidosis) identified that requires inpatient care
 - Behavior or mental status abnormalities absent or manageable at next level of care. See Mental Status Change: Common Complications and Conditions [ISC](#) for further information.
 - Adequate diet tolerated
 - Medical comorbidities absent or manageable at next level of care

☐ Gastrointestinal bleeding

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Bleeding absent
 - Stable Hgb/Hct
 - Platelet count, prothrombin time, and partial thromboplastin time acceptable for next level of care
 - Surgical or other acute intervention not needed
 - Mental status at baseline
 - Oral hydration and diet tolerated

☐ Hyperglycemia and diabetes control

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Mental status at baseline
 - No precipitating cause identified, or cause manageable at next level of care
 - Acidosis absent
 - Blood glucose under acceptable control
 - Dehydration absent
 - Electrolyte abnormalities absent or acceptable for next level of care
 - Renal function at baseline or acceptable for next level of care
 - Outpatient diabetic medication regimen established
 - Oral hydration
 - Oral medications or regimen acceptable for next level of care
 - Oral diet or acceptable for next level of care

☐ Mental status change

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Underlying medical etiology of mental status change absent, or manageable at next level of care

- Danger to self or others absent or manageable at next level of care
- Behavioral crisis management, including physical restraint or emergent pharmacologic treatment of agitation, not required or available at next level of care
- Substance or alcohol withdrawal absent or manageable at next level of care
- Behavioral symptoms (eg, agitation, somnolence, inappropriate behavior) absent or manageable at next level of care

☐ Psychiatric disorders

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Danger to self or others absent or manageable at next level of care
 - Behavior crisis management, including physical or chemical restraints, not required or available at next level of care
 - Behavioral symptoms (eg, agitation, somnolence, inappropriate behavior) absent or manageable at next level of care
 - Functional status is sufficient to participate at available next level of care.
 - Patient and supports understand follow-up treatment and crisis plan.
 - Provider and supports are sufficiently available at next level of care.
 - Patient can participate (eg, verify absence of plan for harm) in needed monitoring.

☐ Respiratory insufficiency

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Suctioning, pulmonary toilet, or other therapy not needed or available at next level of care
 - Respiratory insufficiency resolved or manageable at next level of care
 - Anticoagulation treatment not needed or available at next level of care

☐ Urinary complications

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Mental status at baseline
 - Antibiotic regimen for next level of care established
 - Voiding adequately or with urinary catheter, percutaneous suprapubic tube, or plan for intermittent self-catheterization, and management regimen performable at next level of care
 - Urine output adequate
 - Renal function at baseline or acceptable for next level of care
 - Pain absent or managed
 - Oral intake adequate
 - Afebrile or temperature acceptable for next level of care

☐ Venous thrombosis and pulmonary embolism

- Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Dyspnea absent
 - New oxygen requirement absent or supplementation can be performed at next level of care
 - Tachypnea absent
 - Dangerous arrhythmia absent
 - No bleeding or evidence of new emboli
 - Pain absent or managed
 - No evidence of cardiac dysfunction (eg, right ventricular heart failure)
 - Lower extremity examination at baseline, stable, or improved

- Anticoagulation tolerated (eg, no allergic reaction)
 - Outpatient anticoagulation plan established
- ☐ Wound and skin care
 - Extended stay beyond goal length of stay for primary condition may be needed until **ALL** of the following are present:
 - Hemodynamic stability
 - Volume status acceptable (eg, not dehydrated)
 - Mental status at baseline
 - Hypoxemia absent
 - Tachypnea absent
 - Fistulas, tunneling, or infection absent or manageable at next level of care
 - Surgical management requiring inpatient care absent
 - Afebrile or temperature appropriate for next level of care
 - Pain absent or managed
 - Wound care needs manageable at next level of care
 - Drain absent or drain care manageable at next level of care
 - Wound hematoma or seroma absent or manageable at next level of care

See Common Complications and Conditions [↗](#) ISC for further information.

See Stroke: Ischemic [↗](#) ISC Optimal Recovery Guideline for complete guideline and further supporting content such as Supplemental Medicare Criteria (ie, CMS' Two-Midnight Rule exceptions), Alternatives to Admission or Procedure, Optimal Recovery Course, and Evidence Summary.

Discharge Destination

- Post-hospital levels of admission may include:
 - Home.
 - Home healthcare. See Home Care Indications for Admission Section [↗](#) HC in Stroke guideline in Home Care.
 - Recovery facility care. See Recovery Facility Care Indications for Admission Section [↗](#) RFC in Stroke guideline in Recovery Facility Care.
 - Inpatient rehabilitation facility. See Inpatient Rehabilitation Facility (Acute Rehabilitation) Indications for Admission Section [↗](#) RFC in Inpatient Rehabilitation Facility (Acute Rehabilitation): Stroke guideline in Recovery Facility Care.

Footnotes

[A] An ischemic stroke is defined as an episode of neurologic dysfunction caused by focal cerebral, spinal, or retinal infarction. Central nervous system infarction is defined as brain, spinal cord, or retinal cell death attributable to ischemia based on either (a) pathologic, imaging, or other objective evidence of cerebral, spinal cord, or retinal focal ischemic injury in a defined vascular distribution; or (b) clinical evidence of cerebral, spinal cord, or retinal focal ischemic injury based on symptoms persisting for 24 or more hours, and other etiologies have been excluded. [A in Context Link 1, 2, 3, 4, 5, 6]

[B] Patients with ischemic stroke that is known or presumed to be new (this guideline applies to patients diagnosed with acute ischemic stroke), but who have minimal signs and symptoms, may not require inpatient care. Specifically, if there is no need for monitoring beyond the observation care time frame and there is no other need for inpatient level of treatment (eg, thrombolysis, rehabilitation that requires inpatient setting), there may not be a need for inpatient care. For example, if the clinical situation is such that there are no rehabilitative needs appropriate for an inpatient setting and treatment will consist of risk factor modifications such as cholesterol reduction (eg, statin), blood pressure control, and initiation of an antiplatelet agent or anticoagulant, absent other indications, inpatient care may not be necessary. [B in Context Link 1]

[C] Telemetry monitoring beyond observation care so as to detect atrial fibrillation is not recommended. Specialty society guidelines state that, in patients with TIA or stroke in whom a cardioembolic source is suspected, longer-term ambulatory rhythm monitoring (eg, wearable external monitor, or implantable monitor for those at high risk for atrial fibrillation) is appropriate to detect previously undiagnosed atrial fibrillation. In stroke patients, a specialty society guideline recommends that, even if atrial fibrillation is detected, anticoagulation should not be initiated within 4 days of stroke onset and that initiation 4 to 14 days after stroke onset is appropriate. [C in Context Link 1, 2]

[D] The National Institutes of Health Stroke Scale (NIHSS) is a validated tool to measure neurologic function in stroke patients. The NIHSS includes 15 individual elements that measure motor and sensory function, language and speech production, vision, level of consciousness, and attention. The elements are summed to provide an overall assessment of stroke severity, with the score ranging from 0 to 42. A calculator is available online at www.mdcalc.com/nih-stroke-scale-score-nihss. [D in Context Link 1, 2]

[E] Patients with large territorial infarctions and those with posterior circulation strokes are at high risk for developing brain swelling and herniation. Measures to lessen the risk of swelling and close monitoring of the patient for signs of neurologic worsening during the first days after stroke are recommended. [E in Context Link 1]

[F] Cerebral venous thrombosis causes occlusion of venous structures in the brain that may include intracranial venous sinuses, the deep venous system of the cerebral cortex, or cortical veins. This venous occlusion may present with ischemic cerebral infarction, cerebral hemorrhage, vasogenic edema, or intracranial hypertension. [F in Context Link 1]

[G] Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture. [G in Context Link 1, 2]

[H] The reference supporting this content on pediatric hypertension has age-adjusted, sex-adjusted, and height-adjusted blood pressure reference tables to identify the 95th percentile (tables 4 and 5). The full article with the tables (<https://pediatrics.aappublications.org/content/pediatrics/140/3/e20171904.full.pdf/>) is publicly available. [H in Context Link 1]

[I] An evidence-based guideline recommends that if urgent carotid revascularization is indicated, it should not be performed within 48 hours of stroke onset and that any time within the window of 48 hours to 7 days after stroke onset is appropriate. Thus, absent other indications for inpatient care, outpatient care and follow-up may be appropriate for patients with acute ischemic stroke requiring carotid stenting or endarterectomy. [I in Context Link 1]

[J] The mean arterial pressure (MAP) takes into account both systolic and diastolic blood pressure readings. [J in Context Link 1, 2]

[K] Pulse oximetry (SpO₂) may underestimate arterial saturation (SaO₂), especially in people with dark skin pigmentation, thick skin, cold body temperature, or who are wearing colored nail polish, and thus may not accurately detect hypoxemia. Where appropriate, pulse oximetry should be measured after warming fingers or removing nail polish. Pulse oximetry results should be assessed within the context of the patient's clinical presentation, and performance of an arterial blood gas

considered for a more accurate assessment of oxygenation if indicated. Specific target values may require adjustment when care is delivered at high altitude. [K in Context Link 1]

[L] An ionized calcium level may be more accurate than a total serum calcium level, especially in the setting of acidosis, renal failure, multiple transfusions, hypoalbuminemia, or the presence of a paraprotein. [L in Context Link 1, 2]

[M] A dedicated burn unit is recommended. [M in Context Link 1]

[N] Ventilatory assistance includes noninvasive methods (eg, high-flow nasal cannula (HFNC), CPAP, BPAP) and invasive methods (intubation with mechanical ventilation). [N in Context Link 1, 2]

[O] The definition of heatstroke commonly includes a core body temperature of 104 degrees F (40 degrees C); however, hyperthermia-related organ failure may occur at lower temperatures. [O in Context Link 1]

[P] Expert advice in management of malignant hyperthermia or neuroleptic malignant syndrome is available from the Malignant Hyperthermia Association of the United States through their website at www.mhaus.org/healthcare-professionals/managing-a-crisis/ or at their 24-hour hotline 1-800-644-9737. [P in Context Link 1, 2]

[Q] The modified Erasmus GBS respiratory insufficiency scale predicts the likelihood of respiratory insufficiency and need for mechanical ventilation based on factors for days between onset and hospitalization, the presence or absence of facial or bulbar weakness, and the sum Medical Research Council (MRC) strength scores of 6 muscle groups. A calculator can be found at https://qxmd.com/calculate/calculator_527/erasmus-gbs-respiratory-insufficiency-score-egris#. [Q in Context Link 1]

[R] The decision to intubate a patient with myasthenia gravis is a clinical one based on signs of respiratory distress, paradoxical breathing pattern, tachypnea, declining lung volumes and respiratory muscle strength on bedside testing, and difficulty protecting the airway. Parameters that may help guide this clinical decision include decreasing vital capacity (eg, less than 20 mL/kg of ideal body weight or drop in vital capacity of 30% or greater from baseline), a negative inspiratory force measurement less than -30 cm H₂O (-2942 Pa), or a positive expiratory force measurement greater than 40 cm H₂O (3923 Pa). Noninvasive ventilation may be attempted; however, it is frequently not tolerated due to bulbar dysfunction. [R in Context Link 1]

[S] Respiratory isolation for 24 hours may be needed for patients with suspected meningococcal infection. [S in Context Link 1]

[T] If available, a neurocritical care or stroke unit that incorporates rehabilitation is preferred. [T in Context Link 1]

[U] Patients receiving thrombolytic agents may be transferred out of the ICU after 24 hours if there is no evidence of hemorrhagic conversion on examination and 24-hour post-thrombolysis brain imaging study and no other indications for ICU monitoring. [U in Context Link 1]

[V] Patients with acute spinal cord injury may experience hemodynamic instability due to hypovolemia, cardiac dysfunction, and neurogenic shock. A specialty society guideline recommends targeted blood pressure augmentation (mean arterial pressure 75 to 80 mm Hg) with vasoactive agents for 3 to 7 days to optimize spinal cord perfusion. Patients with cervical spine injury may have impaired diaphragm function with resultant respiratory insufficiency that may require mechanical ventilation. [V in Context Link 1]

[W] Acute flaccid paralysis is historically caused by myelitis due to poliovirus but has more recently been associated with some enterovirus and coxsackie virus strains. Affecting the anterior spinal horn cells, it presents with rapid onset of limb weakness and can cause respiratory failure in about 1/3 of patients. Other manifestations include acute mental status change and autonomic dysfunction including labile blood pressure and arrhythmia. [W in Context Link 1]

[X] If available, a neurocritical care unit with neurosurgical capabilities is preferred. [X in Context Link 1]

[Y] A dedicated neurocritical care unit is recommended. [Y in Context Link 1]

[Z] Hyponatremia following acute traumatic brain injury may occur due to syndrome of inappropriate antidiuresis (SIAD), cerebral salt wasting, pituitary injury (acute adrenocorticotrophic hormone (ACTH) deficiency), or iatrogenic due to inappropriate IV fluid therapy. Symptomatic hyponatremia should be treated in an ICU setting with hypertonic saline. [Z in Context Link 1]

[AA] Hypernatremia following traumatic brain injury is associated with higher in-hospital mortality and is most commonly caused by arginine vasopressor deficiency (AVP-D, formerly called central diabetes insipidus). AVP-D may require desmopressin, large-volume fluid resuscitation, frequent urine output, and serum sodium measurements. [AA in Context Link 1, 2]

[BB] Status dystonicus is a life-threatening movement disorder that can either occur in patients with pre-existing dystonic conditions (eg, cerebral palsy, monogenic dystonia) with precipitation by a triggering event (eg, acute illness, fever, or dehydration), or can present as a first manifestation of a genetic dystonia, metabolic disorder (eg, Lesch-Nyhan syndrome), or an infection or inflammatory disorder affecting the central nervous system. Status dystonicus may cause hyperpyrexia, rhabdomyolysis, acute kidney injury, aspiration, severe pain, and respiratory failure. ICU monitoring is recommended for respiratory monitoring with potential need for intubation due to both the dystonia and the need for high doses of respiratory depressant medications. [BB in Context Link 1]

[CC] Initial treatment is systemic anticoagulation with close observation for signs of progression, seizures, and elevated intracranial pressure. Patients with clot propagation despite anticoagulation may require endovascular intervention. Decompressive craniectomy may be needed for impending herniation. Septic cerebral venous thrombosis (most commonly cavernous sinus thrombosis) is a type of cerebral venous thrombosis that is associated with local infection (eg, sinusitis or mastoiditis). Treatment requires both anticoagulation and antibiotics. [CC in Context Link 1]

[DD] Example diagnoses include the Marburg, tumefactive, and Balo variants of multiple sclerosis; lupus encephalitis; limbic encephalitis; anti-N-methyl-D-aspartate (NMDA) receptor encephalitis; steroid-responsive encephalopathy with autoimmune thyroiditis; acute disseminated encephalomyelitis; and neuromyelitis optica spectrum disorder. [DD in Context Link 1]

[EE] A systematic review recommends ICU transfer for suspected posterior reversible encephalopathy syndrome due to expected need for close monitoring of cerebral edema, intensive care interventions for symptom control and continuous IV blood pressure medications, seizure management, or possible need for intracranial pressure monitoring or mechanical ventilation. [EE in Context Link 1]

[FF] The Intermediate Care guideline should not be used independently but in conjunction with the appropriate Inpatient & Surgical Care or General Recovery Care guideline. [FF in Context Link 1]

[GG] Noninvasive ventilation may be administered in some intermediate care units depending on unit capabilities, staffing, and policies. [GG in Context Link 1]

[HH] A specialty society guideline recommends the use of high-flow nasal oxygen over conventional oxygen therapy for patients with acute hypoxic respiratory failure because it decreases the risk of subsequent intubation and mechanical ventilation. High-flow oxygen is also recommended over conventional oxygen therapy for postextubation hypoxic respiratory failure due to a slightly lower likelihood for reintubation and improved patient comfort. [HH in Context Link 1]

[II] Dedicated intermediate-level stroke care units are recommended for acute ischemic stroke. A unit that incorporates rehabilitation is preferred. Telemetry should include blood pressure, pulse, respirations, and pulse oximetry. [II in Context Link 1]

[JJ] For the purposes of the Inpatient & Surgical Care guidelines, telemetry care is defined as inpatient ECG monitoring not performed in an intensive or intermediate care unit. It is presumed that the patient meets clinical indications for admission or continued hospital stay, as the presence of a diagnosis or clinical

situation listed in the Telemetry Care Guidelines does not necessarily indicate a need for inpatient care and monitoring. Telemetry care includes arrhythmia monitoring and may include continuous ST-segment ischemia monitoring and monitoring for QTc prolongation. [JJ in Context Link 1]

[KK] The continued need for telemetry care monitoring, including ST-segment monitoring and QTc prolongation monitoring, should be reassessed at least daily. Indications for telemetry care are often time-limited. Inappropriate use of telemetry care can be reduced by incorporating indication-based ordering into electronic ordering systems, excluding telemetry care from order sets when monitoring is not usually indicated, daily reviewing telemetry care orders and need for ongoing monitoring, using automated advisories suggesting discontinuation based on diagnosis and duration of telemetry, and educating the healthcare team on appropriate telemetry care indications. [KK in Context Link 1]

[LL] The Telemetry Care guideline should not be used independently but in conjunction with the appropriate Inpatient & Surgical Care or General Recovery Care guideline. [LL in Context Link 1]

[MM] Telemetry care monitoring is not indicated for patients with Bradycardia who are hemodynamically stable and admitted for another reason. [MM in Context Link 1]

[NN] Telemetry care monitoring is not indicated for patients with chronic atrial fibrillation admitted for a reason other than arrhythmia or rate and who are hemodynamically stable. [NN in Context Link 1]

[OO] Appropriate defibrillator detection and firing require monitoring until treatment of the inciting event. Inappropriate firing requires monitoring until the device is interrogated. [OO in Context Link 1]

[PP] Telemetry care monitoring is not indicated for patients with a presumably functional defibrillator or pacemaker who are admitted for another reason. [PP in Context Link 1]

[QQ] The initiation of certain antiarrhythmic medications may require continuous ECG monitoring because of proarrhythmic effects. [QQ in Context Link 1]

[RR] Lists of agents associated with QT prolongation may be found at www.crediblemeds.org. [RR in Context Link 1, 2]

[SS] Routine uncomplicated cardiac procedures, such as coronary angiography, do not require cardiac monitoring once the femoral sheath is pulled post procedure. [SS in Context Link 1]

[TT] The majority of life-threatening arrhythmias or heart failure episodes caused by cardiac contusion occur within 48 hours of chest trauma. [TT in Context Link 1]

[UU] Patients admitted with acute heart failure have multiple risk factors for arrhythmia, including diuretic-induced electrolyte abnormalities, myocardial injury, hypoxemia, and structural heart disease. [UU in Context Link 1]

[VV] Dedicated intermediate-level stroke care units that incorporate rehabilitation are recommended over a telemetry care unit for acute ischemic stroke, if available. Specialty society guidelines recommend long-term telemetry (eg, 2 to 4 weeks) for patients with acute transient ischemic attack or stroke in whom a cardioembolic source is suspected and who are candidates for anticoagulation. Absent other indications (eg, unstable arrhythmia), this does not require extended inpatient care, as monitoring is usually performed in the outpatient setting using wearable or implantable monitors. [VV in Context Link 1]

[WW] An ionized calcium level may be more accurate than a total serum calcium level, especially in the setting of acidosis, renal failure, multiple transfusions, or hypoalbuminemia or in the presence of a paraprotein. [WW in Context Link 1]

[XX] Some patients may have their hydration needs met via alternative means (eg, percutaneous endoscopic gastrostomy tube). [XX in Context Link 1]

[YY] Cerebral hyperperfusion syndrome manifests as an increase in cerebral blood flow following a revascularization procedure such as carotid stenting, endarterectomy, or thrombectomy. Symptoms may include new-onset headache, facial and eye pain, and lethargy; severe cases may present with seizure, neurologic deficits, intracerebral hemorrhage, cerebral edema, or coma. Patients are usually hypertensive. The diagnosis is made by evidence of increased cerebral blood flow on transcranial duplex scan and lack of evidence for postoperative carotid occlusion or new ischemic event on brain imaging studies. [YY in Context Link 1]

[ZZ] Patients with chronic disease (eg, renal failure with potassium greater than 5 mEq/L (mmol/L) or liver disease with sodium less than 135 mEq/L (mmol/L)) with chronically abnormal electrolytes are often manageable on an outpatient basis. [ZZ in Context Link 1]

Definitions

Acute kidney injury (stage 2)

- Acute kidney injury (stage 2) with significant clinical findings, as indicated by **ALL** of the following(1)(2)(3):
 - Acute[A] kidney injury (stage 2), as indicated by **1 or more** of the following[B]:
 - Acute[A] rise in serum creatinine between 2 and 2.9 times its baseline value[C] (increase of 3 times baseline would qualify as stage 3 acute kidney injury)
 - Decreased urine output,[D] as indicated by **ALL** of the following:
 - Assessment of urine output appropriate (eg, adequate volume status, no urinary obstruction)
 - Urine output less than 0.5 mL/kg/hr for 12 hours
 - Significant clinical findings, as indicated by **1 or more** of the following[B]:
 - Hemodynamic instability
 - Worsening clinical status despite observation care (eg, rising creatinine or urine output remains less than 0.5 mL/kg/hr)
 - Altered mental status
 - Cardiac arrhythmias of immediate concern
 - Severe hypertension (SBP greater than 180 mm Hg or DBP greater than 120 mm Hg in adults or greater than the 95th percentile for age, gender, and height plus 30 mm Hg in pediatric patients)(4)(5)
 - Significant respiratory findings (eg, pulmonary edema) that are severe (eg, Hypoxemia) or persist despite observation care
 - Clinically significant electrolyte abnormality that is severe (eg, hyperkalemia with severe ECG findings)[E] or persists despite observation care
 - Clinically significant metabolic abnormality (eg, metabolic acidosis) that is severe or persists despite observation care

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Footnotes

- A. A specialty society practice guideline defines acute kidney injury as a change in renal function that is known or presumed to have occurred over the previous 7 days.(1)
- B. In determining the stage of acute kidney injury (eg, stage 2 vs stage 3), patients should be staged according to the criteria that give them the highest stage.(1)
- C. If the baseline serum creatinine is not known, absent known or suspected chronic kidney disease, a baseline serum creatinine can be approximated by assuming an estimated GFR of 75 mL/min/1.73m² (1.25 mL/sec/1.73m²).⁽¹⁾  eGFR - Adult Calculator  eGFR - Pediatric Calculator
- D. The use of urine output as an indicator of acute kidney injury is important, as change in urine output can occur before a noticeable rise in creatinine.⁽¹⁾⁽³⁾ It is also suggested that urine output can identify patients with acute kidney injury that may otherwise be missed.⁽¹⁾⁽³⁾ However, urine output as a metric is only valid under the appropriate conditions. For example, the patient must not be hypovolemic, there must not be urinary obstruction, and the collection and measurement of urinary output must be complete and accurate.⁽¹⁾⁽³⁾ Use of urinary output to define acute kidney injury can be inaccurate in obese patients due to the nonlinear relationship between body weight and urine output. For example, in a 100-kg (220-lb) patient, urine output of 45 mL/hr over 12 hours (adequate output) would qualify as stage 2 acute kidney injury.⁽¹⁾⁽³⁾
- E. ECG findings include peaked T-waves, PR interval greater than 0.20 seconds, QRS interval greater than 0.12 seconds, and arrhythmia.⁽⁶⁾⁽⁷⁾

Acute renal failure (stage 3 acute kidney injury)

- Acute^[A] kidney injury (stage 3),^[B] as indicated by **1 or more** of the following^[C](1)(2)(3):
 - Acute^[A] rise in serum creatinine to 3 times its baseline value^[D] or higher
 - Acute^[A] rise in serum creatinine to at least 1.5 times its baseline value^[D] (increase of 50%) and serum creatinine is greater than 4 mg/dL (354 micromoles/L)
 - In child younger than 18 years, estimated GFR less than 35 mL/min/1.73m² (0.58 mL/sec/1.73m²)  eGFR - Pediatric Calculator and **1 or more** of the following:
 - Acute^[A] rise in serum creatinine to at least 1.5 times its baseline value^[D] (increase of 50%)
 - Within past 48 hours, rise in serum creatinine greater than 0.3 mg/dL (26.5 micromoles/L)
 - Decreased urine output,^[E] as indicated by **ALL** of the following:
 - Assessment of urine output appropriate (eg, adequate volume status, no urinary obstruction)
 - Oligoanuria, as indicated by **1 or more** of the following:
 - Urine output less than 0.3 mL/kg/hr for 24 hours
 - Anuria (urine output less than 0.1 mL/kg/hr) for 12 hours
 - Initiation of renal replacement therapy required⁽⁴⁾

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Footnotes

- A. A specialty society practice guideline defines acute kidney injury as a change in renal function that is known or presumed to have occurred over the previous 7 days.(1)
- B. For purposes of these criteria, the term acute renal failure can be viewed as stage 3 acute kidney injury in the KDIGO classification system.(1) Of note, in the ICD-10 diagnostic coding system (main coding scheme used in labeling diagnoses), the relevant codes covering the clinical entity of significant acute kidney injury use the term acute kidney failure (eg, code N17.9).
- C. In determining the stage of acute kidney injury (eg, stage 2 vs stage 3), patients should be staged according to the criteria that give them the highest stage.(1)
- D. If the baseline serum creatinine is not known, absent known or suspected chronic kidney disease, a baseline serum creatinine can be approximated by assuming an estimated GFR of 75 mL/min/1.73m² (1.25 mL/sec/1.73m²).(1)  eGFR - Adult Calculator  eGFR - Pediatric Calculator
- E. The use of urine output as an indicator of acute kidney injury is important, as change in urine output can occur before a noticeable rise in creatinine.(1)(3) It is also suggested that urine output can identify patients with acute kidney injury that may otherwise be missed.(1)(3) However, urine output as a metric is only valid under the appropriate conditions. For example, the patient must not be hypovolemic, there must not be urinary obstruction, and the collection and measurement of urinary output must be complete and accurate.(1)(3) Use of urinary output to define acute kidney injury can be inaccurate in obese patients due to the nonlinear relationship between body weight and urine output. For example, in a 100-kg (220-lb) patient, urine output of 45 mL/hr over 12 hours (adequate output) would qualify as stage 2 acute kidney injury.(1)(3)

Altered mental status

- Altered mental status (ie, different from baseline), as indicated by **1 or more** of the following(1)(2)(3)(4):
 - Confusional state (eg, disorientation, difficulty following commands, deficit in attention)
 - Lethargy (eg, awake or arousable, but with drowsiness; reduced awareness of self and environment)
 - Obtundation (ie, arousable only with strong stimuli, lessened interest in environment, slowed responses to stimulation)
 - Stupor (ie, may be arousable but patient does not return to normal baseline level of awareness)
 - Coma (ie, not arousable)

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Altered mental status that is severe or persistent

- Altered mental status (ie, different from baseline) that is severe or persistent, as indicated by **1 or more** of the following(1)(2)(3)(4):
 - Confusional state (eg, disorientation, difficulty following commands, deficit in attention) that persists despite appropriate treatment (eg, of underlying cause, despite observation care)
 - Lethargy (eg, awake or arousable, but with drowsiness; reduced awareness of self and environment) that persists despite appropriate treatment (eg, of underlying cause, despite observation care)
 - Obtundation (ie, arousable only with strong stimuli, lessened interest in environment, slowed responses to stimulation)
 - Stupor (ie, may be arousable but patient does not return to normal baseline level of awareness)
 - Coma (ie, not arousable)

References

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Bradycardia

- Bradycardia^[A], as indicated by **1 or more** of the following(1)(2)(3):
 - Heart rate less than 50 beats per minute in adult (age 18 years or older)^[B]
 - Heart rate less than 55 beats per minute in adolescent 13 to 17 years of age
 - Heart rate less than 60 beats per minute in child or adolescent 6 to 12 years of age
 - Heart rate less than 65 beats per minute in child 3 to 5 years of age
 - Heart rate less than 70 beats per minute in child 1 to 2 years of age
 - Heart rate less than 80 beats per minute in infant 6 to 11 months of age
 - Heart rate less than 90 beats per minute in infant 3 to 5 months of age

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Footnotes

- A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no

- or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. An evidence-based specialty society guideline has defined bradycardia in adults as less than 50 beats per minute.(1)

Cardiac arrhythmias of immediate concern

- Cardiac arrhythmias or findings of immediate concern, as indicated by **1 or more** of the following(1)(2)(3):
 - Heart rhythms that are inherently dangerous or unstable, as indicated by **1 or more** of the following(4)(5)(6):
 - Resuscitated ventricular fibrillation or cardiac arrest
 - Ventricular escape rhythm
 - Sustained ventricular tachycardia (30 seconds or more of ventricular rhythm at greater than 100 beats per minute)
 - Nonsustained ventricular tachycardia and **1 or more** of the following:
 - Suspected cardiac ischemia as cause or consequence of ventricular tachycardia
 - Acute myocarditis
 - Unstable cardiac conduction defects, as indicated by **1 or more** of the following(7)(8):
 - Type II second-degree atrioventricular block
 - Third-degree atrioventricular block
 - New-onset left bundle branch block with suspected myocardial ischemia(9)
 - Any heart rhythm and **1 or more** of the following(5)(8)(10)(11)(12)(13):
 - Continuous long-term ECG monitoring needed (eg, initiation of drug requiring monitoring beyond observation care)
 - Patient has automatic implantable cardioverter-defibrillator that is repeatedly firing, malfunctioning, or in need of immediate adjustment of settings beyond scope of observation care.
 - Heart rhythms of concern due to **1 or more** of the following(8):
 - Hypotension
 - Respiratory distress
 - Association with other significant symptoms (eg, syncope)(10)(11)

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Dangerous arrhythmia

- Dangerous arrhythmia, as indicated by **1 or more** of the following(1)(2)(3)(4):
 - Heart rhythms that are inherently dangerous or unstable, as indicated by **1 or more** of the following(5)(6):
 - Resuscitated ventricular fibrillation or cardiac arrest
 - Ventricular escape rhythm
 - Sustained ventricular tachycardia (30 seconds or more of ventricular rhythm at greater than 100 beats per minute)
 - Nonsustained ventricular tachycardia and **1 or more** of the following:
 - Acute myocarditis
 - Myocardial ischemia
 - Unstable cardiac conduction defects, as indicated by **1 or more** of the following(7):
 - Type II second-degree atrioventricular block
 - Third-degree atrioventricular block
 - New-onset left bundle branch block with suspected myocardial ischemia
 - Heart rhythms of concern due to **1 or more** of the following(8):
 - Hypotension
 - Respiratory distress
 - Association with other significant symptoms (eg, syncope)(7)(9)(10)(11)

References

1. Curtis AB, Tomaselli GF. Approach to the patient with cardiac arrhythmias. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:1145-1162.e7.
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Dangerous arrhythmia absent

- Dangerous arrhythmia absent, as indicated by absence of **ALL** of the following(1)(2)(3)(4)(5)(6)(7)(8)(9)(10):
 - Resuscitated ventricular fibrillation or cardiac arrest
 - Ventricular escape rhythm
 - Sustained ventricular tachycardia (30 seconds or more of ventricular rhythm at greater than 100 beats per minute)
 - Nonsustained ventricular tachycardia with myocarditis or ischemia
 - Type II second-degree atrioventricular block
 - Third-degree atrioventricular block
 - New-onset left bundle branch block with suspected myocardial ischemia
 - Heart rhythms of concern due to association with Hypotension, Respiratory distress, or other significant symptoms (eg, syncope)

References

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Hemodynamic instability

- Hemodynamic instability, as indicated by **1 or more** of the following:
 - Vital sign abnormality not corrected by appropriate treatment, as indicated by **1 or more** of the following[A]:
 - Tachycardia that persists despite appropriate treatment (eg, treatment of underlying cause, despite observation care)[A]
 - Hypotension that persists despite appropriate treatment (eg, treatment of underlying cause, despite observation care)[A]
 - Orthostatic hypotension that persists despite appropriate treatment (eg, treatment of underlying cause, despite observation care)[A]
 - Severe hypotension in adult patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure less than 80 mm Hg(1)[A]
 - Shock index greater than 1.0 (shock index is the heart rate divided by systolic blood pressure)[A](2)(3)(4)
 - Mean arterial pressure[B] less than 65 mm Hg  MAP Calculator[A](1)(6)
 - IV inotropic or vasopressor medication required to maintain adequate blood pressure or perfusion(3)(6)
 - Hypoperfusion due to hypotension, as indicated by **ALL** of the following:
 - Hypotension
 - Evidence of hypoperfusion, as indicated by **1 or more** of the following:
 - Lactate of 2.0 mmol/L (18 mg/dL) or more secondary to hypotension (ie, hypoperfusion)[C](3)(6)(8)
 - Metabolic acidosis (arterial or venous[D] pH less than 7.35) not otherwise explained(3)(6)(8)
 - Significant end organ dysfunction due to hypotension (eg, Altered mental status, myocardial ischemia, 2-fold or higher acute increase in serum creatinine)(3)(6)
 - Severe hypotension in pediatric patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure less than 80 mm Hg in child 6 to 17 years of age[A](14)
 - Systolic blood pressure less than 75 mm Hg in child 6 months to 5 years of age[A](14)
 - Shock index greater than 0.9 in child 13 to 17 years of age (shock index is the heart rate divided by systolic blood pressure)[A](2)(15)
 - Shock index greater than 1.0 in child 7 to 12 years of age (shock index is the heart rate divided by systolic blood pressure)[A](2)(15)
 - Shock index greater than 1.2 in child 4 to 6 years of age (shock index is the heart rate divided by systolic blood pressure)[A](2)(15)
 - IV inotropic or vasopressor medication required to maintain adequate blood pressure or perfusion(5)(6)
 - Hypoperfusion due to hypotension, as indicated by **ALL** of the following:
 - Hypotension
 - Evidence of hypoperfusion, as indicated by **1 or more** of the following:
 - Lactate of 2.0 mmol/L (18 mg/dL) or more secondary to hypotension (ie, hypoperfusion)[C](6)(8)
 - Metabolic acidosis (arterial or venous pH less than 7.35) not otherwise explained[D](5)(6)(14)
 - Significant end organ dysfunction due to hypotension (eg, Altered mental status, myocardial ischemia, 2-fold or higher acute increase in serum creatinine)(5)(6)(14)

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Footnotes

- A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.(3)(5)
- C. There are numerous causes of an elevated lactate level. The most common are cardiogenic or hypovolemic shock, severe heart failure, severe trauma, or sepsis. However, there are also other etiologies to consider such as vigorous exercise, seizures, liver disease, or medication use (eg, metformin, beta2-agonists); therefore, interpretation of elevated lactate levels requires consideration of the clinical context (eg, well-appearing post exercise vs hypotensive). The severity and persistence of the elevation can sometimes be helpful in this differentiation. In most instances of lactic acidosis, blood pH is less than 7.35, with a serum bicarbonate level of 20 mEq/L (mmol/L) or lower. However, a coexisting respiratory or metabolic alkalosis can mask these findings.(7)(8)
- D. Analyses have concluded that venous and arterial pH measurements are highly correlated, with small differences between them that are usually not clinically significant.(9)(10)(11)(12)(13) If a mixed acid-base disorder is suspected, an arterial blood gas is indicated.(10)

Hemodynamic stability

- Hemodynamic stability, as indicated by **1 or more** of the following:
 - Hemodynamic abnormalities at baseline or acceptable for next level of care
 - Patient hemodynamically stable, as indicated by **ALL** of the following(1)(2):
 - Tachycardia absent
 - Hypotension absent
 - No evidence of inadequate perfusion (eg, no myocardial ischemia)
 - No other hemodynamic abnormalities (eg, no Orthostatic hypotension)

References

- Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
- Ramgopal S, Sepanski RJ, Martin-Gill C. Empirically derived age-based vital signs for children in the out-of-hospital setting. Annals of Emergency Medicine 2023;81(4):402-412. DOI: 10.1016/j.annemergmed.2022.09.019.

Hypotension

- Hypotension, as indicated by **1 or more** of the following:
 - Hypotension in adult patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure less than 90 mm Hg[A][B](1)
 - Mean arterial pressure[C] less than 70 mm Hg[A][B]  MAP Calculator(1)(2)
 - Decrease in baseline systolic blood pressure of 30 mm Hg or more, with significant signs or symptoms due to lower blood pressure (eg, near syncope, syncope, chest pain)[A][B](1)
 - Hypotension in pediatric patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure less than 110 mm Hg in child 13 to 17 years of age[A][D](3)
 - Systolic blood pressure less than 100 mm Hg in child 6 to 12 years of age[A][D](3)
 - Systolic blood pressure less than 95 mm Hg in child 3 to 5 years of age[A][D](3)
 - Systolic blood pressure less than 90 mm Hg in child 1 or 2 years of age[A][D](3)
 - Systolic blood pressure less than 80 mm Hg in infant 6 to 11 months of age[A][D](3)
 - Systolic blood pressure less than 70 mm Hg in infant 3 to 5 months of age[A][D](3)
 - Systolic blood pressure less than 65 mm Hg in infant 1 or 2 months of age[A][D](3)

References

- Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
- Puskarich MA, Jones AE. Shock. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:34-41.e1.
- Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. Interpretation of blood pressure requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline blood pressure, medications, and clinical impact. For example, an elderly patient with heart failure may be prescribed medication with the intentional goal of a reduced pressure. If the patient's baseline SBP is 92 mm Hg to 96 mm Hg, absent signs or symptoms of hypotension, an emergency department SBP of 86 mm Hg should not automatically be categorized as hypotensive. This would hold for mean arterial pressure (MAP) as well. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term hypotension. Whether a blood pressure below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.
- C. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.
- D. Interpretation of blood pressure requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline blood pressure, medications, and clinical impact. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term hypotension. Whether a blood pressure below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Hypotension absent

- Hypotension absent,[A] as indicated by **1 or more** of the following:
 - Hypotension absent in adult patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure greater than or equal to 90 mm Hg[A](1)
 - Mean arterial pressure[B] greater than or equal to 70 mm Hg  MAP Calculator[A](1)(2)
 - Blood pressure at patient's baseline (eg, healthy adult with low systolic blood pressure), at intentional therapeutic goal (eg, patient with heart failure), or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)
 - Hypotension absent in pediatric patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure greater than or equal to 110 mm Hg in child 13 to 17 years of age[A](3)
 - Systolic blood pressure greater than or equal to 100 mm Hg in child 6 to 12 years of age[A](3)
 - Systolic blood pressure greater than or equal to 95 mm Hg in child 3 to 5 years of age[A](3)
 - Systolic blood pressure greater than or equal to 90 mm Hg in child 1 or 2 years of age[A](3)
 - Systolic blood pressure greater than or equal to 80 mm Hg in infant 6 to 11 months of age[A](3)
 - Systolic blood pressure greater than or equal to 70 mm Hg in infant 3 to 5 months of age[A](3)
 - Systolic blood pressure greater than or equal to 65 mm Hg in infant 1 or 2 months of age[A](3)
 - Blood pressure at patient's baseline (eg, healthy child with low systolic blood pressure), at intentional therapeutic goal, or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Puskarch MA, Jones AE. Shock. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:34-41.e1.
3. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.

Hypothermia

- Hypothermia indicated by core (eg, rectal) body temperature less than or equal to 95 degrees F (35 degrees C)(1)

References

1. Zafren K, Danzl DF. Hypothermia, frostbite, and nonfreezing cold injuries. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:1750-1770.e2.

Hypoxemia

- Hypoxemia, as indicated by **1 or more** of the following(1):
 - Patient without baseline need for supplemental oxygen with oxygen saturation (SpO₂) of less than 90% or arterial blood gas partial pressure of oxygen (PaO₂) of less than 60 mm Hg (8.0 kPa) on room air[A][B]
 - Patient without baseline need for supplemental oxygen who now requires supplemental oxygen to keep SpO₂ greater than 89% or PaO₂ greater than 59 mm Hg (7.9 kPa)[A]
 - Patient with baseline need for supplemental oxygen who now requires increased supplemental oxygen to maintain oxygenation at baseline or acceptable level

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Jamali H, et al. Racial disparity in oxygen saturation measurements by pulse oximetry: evidence and implications. Annals of the American Thoracic Society 2022;19(12):1951-1964. DOI: 10.1513/AnnalsATS.202203-270CME.
3. Rojas-Camayo J, et al. Reference values for oxygen saturation from sea level to the highest human habitation in the Andes in acclimatised persons. Thorax 2018;73(8):776-778. DOI: 10.1136/thoraxjnl-2017-210598.

Footnotes

- A. Pulse oximetry (SpO₂) may underestimate arterial saturation (SaO₂), especially in people with dark skin pigmentation, thick skin, cold body temperature, or who are wearing colored nail polish, and thus may not accurately detect hypoxemia.(2) Where appropriate, pulse oximetry should be measured after warming fingers or removing nail polish. Pulse oximetry results should be assessed within the context of the patient's clinical presentation, and performance of an arterial blood gas considered for a more accurate assessment of oxygenation if indicated.(2) Specific target values may require adjustment when care is delivered at high altitude.(3)
- B. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no

or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

Hypoxemia absent

- Hypoxemia absent, as indicated by **1 or more** of the following(1):
 - Arterial oxygen saturation (SpO₂) of 90% or greater or arterial partial pressure of oxygen (PaO₂) of 60 mm Hg (8.0 kPa) or greater on room air[A][B]
 - Oxygen requirements are stable and arranged for at next level of care.

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Rojas-Camayo J, et al. Reference values for oxygen saturation from sea level to the highest human habitation in the Andes in acclimatised persons. Thorax 2018;73(8):776-778. DOI: 10.1136/thoraxjnl-2017-210598.

Footnotes

- A. Specific target values (ie, 90% or 60 mm Hg (8.0 kPa)) may require adjustment when care is delivered at high altitude.(2)
- B. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

Orthostatic hypotension

- Orthostatic hypotension,[A][B] as indicated by **1 or more** of the following(1)(2)(3):
 - Fall in SBP of 20 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position
 - Fall in DBP of 10 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position

References

1. Shibao C, Lipsitz LA, Biaggioni I, American Society of Hypertension Writing Group. Evaluation and treatment of orthostatic hypotension. Journal of the American Society of Hypertension 2013 Jul-Aug;7(4):317-324. DOI: 10.1016/j.jash.2013.04.006.
2. Dalal AS, Van Hare GF. Syncope. In: Kliegman RM, et al., editors. Nelson Textbook of Pediatrics. 22nd ed. Elsevier; 2025:592-599.
3. Fang JC, O'Gara PT. History and physical examination: an evidence-based approach. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:123-140.

Footnotes

- A. Concomitant measurements of the heart rate are important to measure to help diagnose subtypes of orthostatic hypotension (eg, the lack of a compensatory increase in heart rate is typical of autonomic failure and an exaggerated tachycardia may be reflective of volume depletion). However, the heart rate is not a component of the definition of orthostatic hypotension, which relies upon blood pressure alone.(1)(2)(3)
- B. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no

or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

Respiratory distress

- Respiratory distress, as indicated by **ALL** of the following(1)(2)(3)(4):
 - Patient with **1 or more** of the following:
 - Dyspnea (difficulty breathing)
 - Tachypnea
 - Abnormal breathing pattern (eg, chest retractions)
 - Other evidence of difficulty breathing
 - Evidence of respiratory compromise, as indicated by **1 or more** of the following:
 - Hypoxemia
 - Altered mental status
 - Other evidence of respiratory compromise (eg, respiratory acidosis)

References

1. Braithwaite SA, Wessel AL. Dyspnea. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:194-201.e2.
2. Naureckas ET, Solway J. Disturbances of respiratory function. In: Loscalzo J, Fauci A, Kasper D, Hauser S, Longo D, Jameson JL, editors. Harrison's Principles of Internal Medicine. 21st ed. McGraw Hill Education; 2022:2133-2139.
3. Matthay MA, Ware LB. Acute respiratory failure. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:642-652.
4. Rakoczy K. Acute respiratory failure. In: Gershel JC, Rauch DA, editors. Caring for the Hospitalized Child: A Handbook of Inpatient Pediatrics. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2023:749-754.

Tachycardia

- Tachycardia,[A][B] as indicated by **1 or more** of the following:
 - Heart rate greater than 100 beats per minute in adult[A][B](1)
 - Heart rate greater than 85 beats per minute in child 13 to 17 years of age[A][C](2)
 - Heart rate greater than 95 beats per minute in child 6 to 12 years of age[A][C](2)
 - Heart rate greater than 110 beats per minute in child 1 to 5 years of age[A][C](2)
 - Heart rate greater than 120 beats per minute in infant 3 to 11 months of age[A][C](2)
 - Heart rate greater than 150 beats per minute in infant 1 or 2 months of age[A][C](2)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. Interpretation of heart rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline heart rate, medications, and clinical impact. For example, an elderly patient on a beta-blocker medication with a baseline resting heart rate of 60 beats per minute may be clinically tachycardic at a heart rate of 94 beats per minute. Likewise, a patient who is upset, in pain, or nervous in the emergency department with a heart rate of 106 beats per minute may meet the technical definition of tachycardia, but this tachycardia (absent associated findings such as chest pain or hypotension) may not be clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachycardia. Whether a heart rate above or below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.
- C. Interpretation of heart rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline heart rate, medications, and clinical impact. A patient who is upset, in pain, or nervous in the emergency department with an elevated heart rate may meet the technical definition of tachycardia, but this tachycardia (absent associated findings such as hypotension) may not be clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachycardia. Whether a heart rate above or below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Tachycardia absent

- Tachycardia[A][B] absent, as indicated by **1 or more** of the following:
 - Heart rate less than or equal to 100 beats per minute in adult[A][B](1)
 - Heart rate less than or equal to 85 beats per minute in child 13 to 17 years of age[A][B](2)
 - Heart rate less than or equal to 95 beats per minute in child 6 to 12 years of age[A][B](2)
 - Heart rate less than or equal to 110 beats per minute in child 1 to 5 years of age[A][B](2)
 - Heart rate less than or equal to 120 beats per minute in infant 3 to 11 months of age[A][B](2)
 - Heart rate less than or equal to 150 beats per minute in infant 1 or 2 months of age[A][B](2)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

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- B. Interpretation of heart rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline heart rate, medications, and clinical impact. For example, an elderly patient on a beta-blocker medication with a baseline resting heart rate of 60 beats per minute may be clinically tachycardic at a heart rate of 94 beats per minute. Likewise, a patient who is upset, in pain, or nervous in the emergency department with a heart rate of 106 beats per minute may meet the technical definition of tachycardia, but this tachycardia (absent associated findings such as chest pain or hypotension) may not

be clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachycardia. Whether a heart rate above or below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Tachypnea

- Tachypnea^{[A][B]} as indicated by **1 or more** of the following:
 - Respiratory rate greater than 20 breaths per minute in adult^{[A][B]}(1)
 - Respiratory rate greater than 18 breaths per minute in child 13 to 17 years of age^{[A][B]}(2)
 - Respiratory rate greater than 22 breaths per minute in child 6 to 12 years of age^{[A][B]}(2)
 - Respiratory rate greater than 25 breaths per minute in child 3 to 5 years of age^{[A][B]}(2)
 - Respiratory rate greater than 30 breaths per minute in child 1 or 2 years of age^{[A][B]}(2)
 - Respiratory rate greater than 40 breaths per minute in infant 6 to 11 months of age^{[A][B]}(2)
 - Respiratory rate greater than 45 breaths per minute in infant 3 to 5 months of age^{[A][B]}(2)
 - Respiratory rate greater than 55 breaths per minute in infant 1 or 2 months of age^{[A][B]}(2)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. Interpretation of respiratory rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline respiratory rate and whether the respiratory rate is indicative of significant underlying respiratory or other pathology. A mildly increased respiratory rate (eg, 20 to 22 breaths per minute in an adult), absent other indications of serious illness (eg, hypoxemia, metabolic acidosis, decreased tidal volume, pain), may be transitory and not clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachypnea. Whether a respiratory rate above the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment. In addition, the measurement of the respiratory rate is subject to error. A medical textbook states that because there can be significant breath-to-breath variation in respiratory rate, the rate should be assessed for at least 30 seconds, preferably for a full minute.⁽¹⁾ This same textbook also states that new technologies designed to measure the respiratory rate have not proved to be clinically useful.⁽¹⁾

Tachypnea absent

- Tachypnea^{[A][B]} absent, as indicated by **1 or more** of the following:
 - Respiratory rate less than or equal to 20 breaths per minute in adult^{[A][B]}(1)
 - Respiratory rate less than or equal to 18 breaths per minute in child 13 to 17 years of age^{[A][B]}(2)
 - Respiratory rate less than or equal to 22 breaths per minute in child 6 to 12 years of age^{[A][B]}(2)

- Respiratory rate less than or equal to 25 breaths per minute in child 3 to 5 years of age^{[A][B](2)}
- Respiratory rate less than or equal to 30 breaths per minute in child 1 or 2 years of age^{[A][B](2)}
- Respiratory rate less than or equal to 40 breaths per minute in infant 6 to 11 months of age^{[A][B](2)}
- Respiratory rate less than or equal to 45 breaths per minute in infant 3 to 5 months of age^{[A][B](2)}
- Respiratory rate less than or equal to 55 breaths per minute in infant 1 or 2 months of age^{[A][B](2)}

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

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- B. Interpretation of respiratory rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline respiratory rate and whether the respiratory rate is indicative of significant underlying respiratory or other pathology. A mildly increased respiratory rate (eg, 20 to 22 breaths per minute in an adult), absent other indications of serious illness (eg, hypoxemia, metabolic acidosis, decreased tidal volume, pain), may be transitory and not clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachypnea. Whether a respiratory rate above the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment. In addition, the measurement of the respiratory rate is subject to error. A medical textbook states that because there can be significant breath-to-breath variation in respiratory rate, the rate should be assessed for at least 30 seconds, preferably for a full minute.⁽¹⁾ This same textbook also states that new technologies designed to measure the respiratory rate have not proved to be clinically useful.⁽¹⁾

Vital sign abnormality

- Vital sign abnormality, as indicated by **ALL** of the following⁽¹⁾⁽²⁾:
 - Vital sign findings not as expected for chronic patient condition or baseline (eg, intentionally low blood pressure in heart failure)
 - Vital sign abnormality, as indicated by **1 or more** of the following:
 - Tachycardia
 - Hypotension
 - Orthostatic hypotension

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Codes

ICD-10 Diagnosis: I63.00, I63.011, I63.012, I63.013, I63.019, I63.02, I63.031, I63.032, I63.033, I63.039, I63.09, I63.10, I63.111, I63.112, I63.113, I63.119, I63.12, I63.131, I63.132, I63.133, I63.139, I63.19, I63.20, I63.211, I63.212, I63.213, I63.219, I63.22, I63.231, I63.232, I63.233, I63.239, I63.29, I63.30, I63.311, I63.312, I63.313, I63.319, I63.321, I63.322, I63.323, I63.329, I63.331, I63.332, I63.333, I63.339, I63.341, I63.342, I63.343, I63.349, I63.39, I63.40, I63.411, I63.412, I63.413, I63.419, I63.421, I63.422, I63.423, I63.429, I63.431, I63.432, I63.433, I63.439, I63.441, I63.442, I63.443, I63.449, I63.49, I63.50, I63.511, I63.512, I63.513, I63.519, I63.521, I63.522, I63.523, I63.529, I63.531, I63.532, I63.533, I63.539, I63.541, I63.542, I63.543, I63.549, I63.59, I63.6, I63.81, I63.89, I63.9 [Hide]

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