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Framework For Post-Resuscitation Care		
Management should be individualized based on clinical presentation, neurologic status, hemodynamic profile, and available resources.		
1. Hemodynamics  <ul style="list-style-type: none">• Avoid hypotension; consider MAP \geq 65 mm Hg as an initial target. Individualize goals (consider chronic hypertension and cerebral autoregulation).• Norepinephrine is commonly used as first-line vasopressor.• Consider MCS and transfer to specialized cardiac arrest centers in selected patients with refractory shock.• Treat arrhythmias as indicated.	2. Temperature Management  <ul style="list-style-type: none">• Strict fever prevention and targeted normothermia after ROSC ($<$ 37.5 °C).• Consider deeper hypothermia (32-36 °C) in selected patients (e.g., young, witnessed OHCA, initial shockable rhythm).• Use scheduled acetaminophen and surface/endo vascular cooling as needed.• Controlled rewarming if hypothermia is used.	3. Oxygenation / Ventilation  <ul style="list-style-type: none">• Ensure reliable airway placement and ventilation.• Maintain SpO₂ 92-98%; avoid hypoxemia and unnecessary hyperoxemia.• Maintain normocapnia (PaCO₂ 35-45 mm Hg). Mild hypercapnia remains investigational.
4. Organ Support & Dysfunction  <ul style="list-style-type: none">• Early multidisciplinary management of multiorgan dysfunction.• Consider renal replacement therapy for acute kidney injury or severe metabolic derangements.• Tailor therapy to underlying etiology (e.g., cardiogenic shock, sepsis, toxin exposure).	5. Coronary Evaluation & Intervention  <ul style="list-style-type: none">• Obtain immediate 12-lead ECG and cardiac biomarkers.• Early coronary angiography in patients with STEMI or high suspicion of coronary occlusion.• Individualized decisions for non-STEMI or unstable patients.	6. Neuroprognostication  <ul style="list-style-type: none">• Multimodal assessment: neurologic examination, continuous EEG, SSEP, neuroimaging, and biomarkers (e.g., NSE, NFL).• Prevent and treat seizures.• Definitive neuroprognostication typically deferred \geq 72 h after ROSC/rewarming and in the absence of confounders.
7. Sedation & Analgesia  <ul style="list-style-type: none">• Use sedation and analgesia to ensure comfort and facilitate care.• During TTM, prioritize agents that reduce shivering (e.g., fentanyl, propofol, dexmedetomidine).• Neuromuscular blockade may be considered for refractory shivering.	8. Metabolic Management  <ul style="list-style-type: none">• Correct acid-base and electrolyte disturbances (target pH $>$ 7.20).• Maintain glucose 140-180 mg/dL.• Monitor for and treat infection and other metabolic derangements.	9. Multidisciplinary Care & Goals of Care  <ul style="list-style-type: none">• Early involvement of a multidisciplinary team (critical care, cardiology, neurology, nursing, rehabilitation, palliative care).• Ongoing communication with family and surrogate decision-makers.• Reassess goals of care as clinical information evolves.

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