

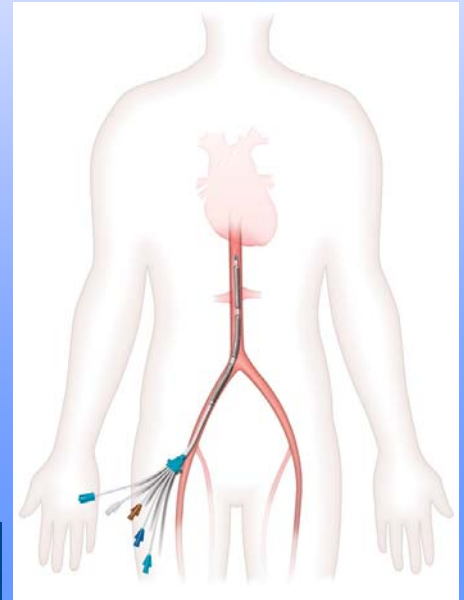
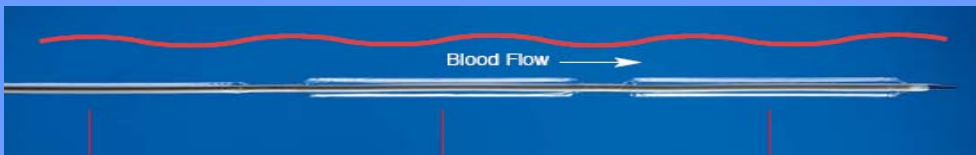
ALSIUS “The Coolest Technology” Around

For Instant Patient Temperature Reduction

When your patient requires rapid cooling, the ALSIUS Icy® catheter reduces patient temperature...STAT! Plus, it gives you the power and flexibility of a triple lumen design.

And like a standard central venous catheter, the Icy® catheter easily inserts into the femoral vein. Set-up is simple, too. Just insert the catheter and connect it to the CoolGard 3000® system via the CoolGard® Start-Up kit. All you have to do is input the target patient temperature and the CoolGard® system automatically delivers temperature-controlled saline in a closed loop to the Icy catheter for rapid temperature reduction, tight temperature maintenance and controlled re-warming. Cooling has never been this easy.

Now available with choice of 1 or 3 lumen for clinical flexibility.



US Indications for Use: The CoolGard 3000®/ALSIUS Thermal Regulation System, using the Icy™ model catheter, is indicated for use in cardiac surgery patients to achieve and/or maintain normothermia during surgery and recovery/intensive care, and, to induce, maintain and reverse mild hypothermia in neurosurgery patients in surgery and recovery/intensive care.

Breaking News!

American Heart Association Recommendations

- ⇒ Unconscious adult patients with return of spontaneous circulation (ROSC) after out-of hospital cardiac arrest should be cooled to 32°C to 34°C (89.6°F to 93.2°F) for 12 to 24 hours when the initial rhythm was ventricular fibrillation (VF). *Class IIa*
- ⇒ Similar therapy may be beneficial for patients with non-VF arrest out of hospital or for in-hospital arrest. *Class IIb*

More recent studies AHA suggests that internal cooling techniques (eg, cold saline, endovascular cooling catheter) can also be used to induce hypothermia. Providers should continuously monitor the patient's temperature during cooling.

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Please visit www.alsius.com or contact us at 1-877-2ALSIUS (877-225-7487)



"Surface cooling is slow, uncomfortable, labor intensive, often requiring intubation and paralysis to control shivering. We utilize the ALSIUS intravascular heat exchange method to induce mild hypothermia, as an adjunctive therapy to improve neurological outcomes in stroke patients in Neuro ICU."

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RESUSCITATIVE HYPOTHERMIA AFTER CARDIAC ARREST: PERFORMANCE IN A COMMUNITY HOSPITAL

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PURPOSE: Induced hypothermia improves outcome after cardiac arrest due to ventricular fibrillation. We studied induced hypothermia in a community hospital setting after cardiac arrest due to any cause.

METHODS: A case-control study was conducted in a publicly owned, non-academic, acute care hospital. Thirty-eight patients who underwent induced hypothermia were compared to 103 patients who did not undergo hypothermia. After resuscitation from cardiac arrest, patients underwent hypothermia using an established protocol at the discretion of the treating clinicians. Hypothermia was achieved with either external devices or an intravascular cooling catheter system. Outcome measures included mortality, neurologic recovery, and length of stay (LOS).

RESULTS: The groups were similar in age, sex, APACHE III score, and Glasgow Coma Score (GCS). Hospital mortality in the hypothermia group was 53% versus 71% in the control group ($p=0.07$). Hospital mortality in 10 patients treated with intravascular cooling was 40%. Compared to Apache III predicted mortality, the hypothermia group mortality ratio was 0.76, versus 1.4 for the control group. Among survivors, the change in GCS from admission to ICU discharge was 7.2 ± 4.0 (baseline 4.4, discharge 11.7) in the hypothermia group and 6.6 ± 4.3 (baseline 4.0, discharge 10.6) in the control group ($p=0.32$). Also among survivors, the ICU LOS was 2.6 ± 3.5 days less than Apache III predicted in the hypothermia group versus 0.5 ± 6.8 days less in the control group ($p=0.08$).

CONCLUSION: Induced hypothermia following cardiac arrest performs well in a community hospital setting. The intravascular cooling catheter was a safe, effective means of inducing hypothermia with a trend towards improved outcomes. Induced hypothermia may be applicable to all cardiac arrest patients regardless of cause¹.

CLINICAL IMPLICATIONS: Induced hypothermia is safe, simple, and inexpensive. Hospital protocols may help to ensure timely application of this important intervention. Intravascular cooling techniques show promise in terms of ease of use, effectiveness of cooling, and maintaining accessibility to the patient. Further study is needed to determine the optimal patients and techniques for therapeutic hypothermia.

DISCLOSURE: Kenneth Hurwitz, None.

CHEST

Cardiac Issues in Critical Care

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**Therapeutic Hypothermia Procedure:
3 Phases**



Therapeutic Hypothermia:
Old Therapy... New Application

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