

## RV Failure Management Priorities

### Optimize fluid status

- Volume administration can precipitate clinical deterioration in patients with elevated RV afterload
- Patients with chronic PH and/or RVD often require diuresis
- In patient with depressed RV contractility and normal RV afterload, may consider gentle volume boluses with frequent reassessments

### Support systemic blood pressure

- Even transient hypotension can be problematic; low threshold to initiate early vasopressors and invasive blood pressure monitoring
- Vasopressin and epinephrine are optimal, norepinephrine is also reasonable
- Patients with elevated PA pressures may require higher MAP targets to optimize RV coronary perfusion pressures

### Decrease RV afterload

- Correct of hypoxemia, hypercarbia, and acidemia
- Initiation of an inhaled pulmonary vasodilator

### Support RV contractility

- After correction of systemic hypotension, consider additional inotropic support particularly if failing to respond to diuretic challenge
- Epinephrine reasonable first line, can also consider addition of milrinone versus dobutamine if systemic blood pressures have normalized

### Extreme caution with intubation

- High risk of hemodynamic deterioration with ETI
- ETI rarely has a role in the management of patients whose acute decompensation is due *primarily* to ADRVF; if ETI is required as appropriate management for an acute condition in a patient with comorbid PH and/or RVD it should be undertaken with careful hemodynamic management