Abdominal Aortic Aneurysm (AAA) Protocol

Assessment and Indications

- Acute, severe abdominal, back or flank pain (ripping, tearing, stabbing or sharp)
- High risk history (connective tissue disease, genetic markers, known aneurysm, recent aortic manipulation, family Hx of AAA, smoker).
- Clinical findings (pulsatile abdominal mass, lower extremity pulse deficits)
- CT abdomen/pelvis without contrast STAT, and CT abdomen/pelvis with IV contrast (no oral), thinnest cuts possible
- Obtain 12 lead EKG and labs (Lactate, D-dimer, Type & Cross, BMP, CBC, INR)
- Transmit CT images, and/or send with patient upon transfer

Initial Management

- Contact Minneapolis Heart Institute® at 612-863-3911 for an Abdominal Aortic Aneurysm consult
- Activate emergency transport team via fastest route possible
- NPO, monitor, place 2 large bore IVs, draw labs
- Do not place foley cath

Maintain Systolic BP between 90-110 mmHg and HR < 60

- 1st Option: Esmolol: 500 mcg/kg IVP over 1 min followed by continuous infusion at 25-50 mcg/kg/min, increase every 4 min by 25 mcg/kg/min to max rate of 300 mcg/kg/min
- 2nd Option: Metoprolol: 5 mg IVP over 5 min, may repeat X 2 if necessary

- Oxygen: to maintain SpO2 ≥ 92%
- Consider IV Vitamin K if patient is on Coumadin
- For ruptured AAA, implement permissive hypotension by targeting systolic blood pressure 70-90 mmHg and restriction of fluid resuscitation in the conscious patient.

Learn More

"Guidelines are not meant to replace clinical judgment or professional standards of care. Clinical judgment must take into consideration all the facts in each individual and particular case, including individual patient circumstances and patient preferences. They serve to inform clinical judgment, not act as a substitute for it. These guidelines were developed by a Review Organization under Minn. Stat. §145.61 et. seq., and are subject to the limitations described at Minn. Stat. §145.65."

This information is intended only as a guideline. Please use your best judgment in the treatment of patients.