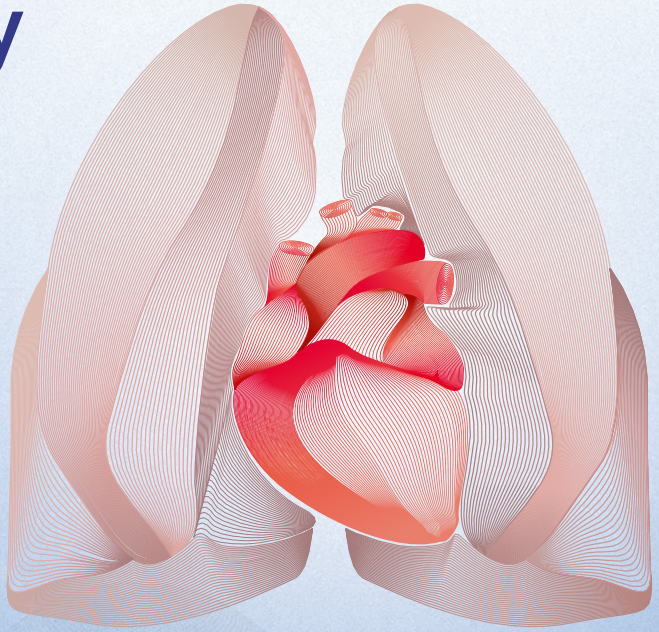
CytoSorbents™

CytoSorb Therapy

Decision support for ECMO/ECLS patients



CytoSorb Therapy – Initiation

Start of ECMO therapy as indicated

Consider early use of CytoSorb in anticipation of ongoing deterioration as well as use of CytoSorbents ECMO Connectors during setup to allow for the safe integration of CytoSorb

Stabilization of clinical and hemodynamic situation → **Recovery**

No control of shock parameters / ongoing shock

Norepinephrine > 0.3µg/kg/min
If measured: IL-6 > 500 pg/ml, PCT > 3µg/l

Consider elevated levels of bilirubin and myoglobin as additional rationale for CytoSorb therapy

➤ **Start CytoSorb**
(integrated into ECMO/separate extracorporeal circuit)

Observation period ideally not longer than 6 hrs. before considering CytoSorb as an adjunctive therapy

CytoSorb Therapy – Continuation

Start of ➤ CytoSorb therapy

Sufficient stabilization

Profound and ongoing reduction of vasopressor demand

→ **Stop CytoSorb therapy**

Insufficient stabilization

Only minor reduction of vasopressor demand

➤ Consider new adsorber after 12 hrs. (early change) or at the latest after 24 hrs.

→ **Re-evaluate every 12 to 24 hrs.**

Ongoing instability despite 2-3 adsorbers in 18 to 36 hrs. → **CytoSorb therapy appears futile**

Adequate causative therapy and technical conditions of ECMO therapy (catheter position, flow rate etc.) are the base for therapeutic success

Potential Indications for CytoSorb Therapy in ECMO/ECLS Patients:

The following clinical conditions are characterized or aggravated by hyperinflammation, often with deterioration and shock. Cytosorb therapy may therefore be considered in addition to standard of care and treatment of the underlying cause in:

- Cardiogenic shock
- ECPR
- Bridge to VAD surgery
- ARDS with high vasopressor demand
- Post cardiotomy syndrome
- Infective endocarditis
- Septic shock
- *Liver failure (removal of bilirubin)*
- *Rhabdomyolysis (removal of myoglobin)*

Visit our literature database for an overview of all references

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