**Abstract:**

BACKGROUND: Peri-intubation cardiac arrest and hypotension in patients with septic shock occur often in the emergency department (ED) and ultimately lead to worse clinical outcomes. In recent years, the use of push-dose, or bolus-dose, vasopressors in the ED have become common practice for transient hypotension and bridging to continuous infusion vasopressors. Push-dose epinephrine and phenylephrine are the agents used most frequently in this scenario.

CASE REPORT: A 63-year-old woman who was apneic and pulseless presented to our ED. After 4 min of cardiopulmonary resuscitation, spontaneous circulation was achieved, and the patient was intubated for airway protection. She became hypotensive with a blood pressure of 55/36 mm Hg. After receiving a 1-L bolus of lactated Ringer solution, she remained hypotensive with blood pressure of 80/51 mm Hg and a pulse of 129 beats/min. One unit of intravenous vasopressin push bolus was administered. Within 1 min, her hemodynamics improved to a blood pressure of 141/102 mm Hg and pulse of 120 beats/min. Over the next 2 h, her mean arterial pressure slowly and progressively declined from 120 to 80. No further vasoactive medications were required for approximately 120 min until norepinephrine and vasopressin was initiated for septic shock.

WHY SHOULD AN EMERGENCY PHYSICIAN BE AWARE OF THIS?: This case report discusses the use of push-dose vasopressin as an alternate vasoactive medication to improve hemodynamics in a patient with vasodilatory septic shock.

**Reference:**