“My Patient is Hypotensive Despite Fluids and Norepinephrine...Now What Do I Do?”

1) **Call for Help!**

2) **Reassess the situation:**
   - Are the blood pressure measurements accurate?
   - Do I have the correct diagnosis?
   - Do I have source control? (e.g., is there a surgical infection that requires drainage or debridement, does the patient have a parapneumonic effusion?)
   - Is my antimicrobial coverage appropriate?

3) **Start vasopressin at 0.03 units/minutes if norepinephrine > 0.2 mcg/kg/min**

4) **Consider placing arterial line and central venous catheter, if not already present**

5) **Next steps:**
   - Evaluate for sepsis-induced or primary cardiomyopathy with bedside ultrasound or formal echocardiogram, electrocardiogram, and ScvO2 (provided the patient has a central line)
   
   If echocardiogram consistent with cardiomyopathy or ScvO2 < 60%:
   - Consider inotrope (dobutamine 2.5 mcg/kg/min)
   - Consider repleting calcium to normal (ionized calcium > 1.0. mmol/L)

   - Consider stress-dose steroids (hydrocortisone 50 mg q8 hours IV). Spot cortisol or ACTH stimulation testing are usually not helpful

   - Re-evaluate fluid tolerance and responsiveness. Consider judicious 500 mL boluses

   - Evaluate acid-base status: Consider continuous renal replacement therapy or bicarbonate infusion if the patient has a severe metabolic acidosis and pH <7.1

6) **If vasopressor needs continue to increase, consider Palliative Care Consultation for goals of care discussion**