DOSES BELOW

Pulmonary hypertensive crisis and right ventricular failure

START HERE · Support RV perfusion and remove triggers
Treat hypoxemia, hypercapnia and acidosis. Maintain systemic pressure and use echo or invasive data to assess the RV.

↓

Which mechanism is limiting perfusion?

Interrupted pulmonary vasodilator	→ Restore the verified continuous therapy with the specialist and check the pump and line. Pulmonary vasodilator withdrawal can provoke rebound.
High RV afterload with low output	→ Use an inhaled pulmonary vasodilator when indicated. Maintain coronary perfusion, select inotropy and avoid indiscriminate volume loading.
Shock persists or pulse is lost	→ Escalate early for arrest or extracorporeal support per local pathways. Start ALS if pulseless. Cardiac arrest in the operating room

DOSE AND ADMINISTRATION

Inhaled nitric oxide · specialist range Guideline	**Inhaled nitric oxide 10-40 ppm per ISHLT perioperative consensus. Titrate under local specialist protocol.** [41] [50] [58]
Established pulmonary vasodilator Local order	**Continue the verified agent, concentration and dose per specialist order. Arrange pump and drug backup.** [41] [50]
Vasopressor or inotrope Local order	**IV vasopressor or inotrope dose and target per individual prescription.** [41] [50]

Reassess and escalate · Trend systemic pressure, RV size and output. Wean inhaled vasodilators under monitoring and avoid abrupt withdrawal.

Clinical scope · Select support by the mechanism and local capability. The inhaled nitric oxide range comes from general perioperative consensus. Use the local delivery and monitoring protocol.

Sources [6] RCUK ALS 2025 • [41] ILTS PoPH 2026 • [50] ISHLT perioperative PH 2022 • [58] INOmax safety label