

## This is a “mock” chapter for the writing groups of the GL2025

### General instructions for the GL2025 chapters (published in Resuscitation)

- Please consider this as a draft or example and adapt it to the needs of the chapter.
- [h1], [h2], [h3] please indicate the level of each header using this format.
- Please follow the standard rules of scientific writing; if needed consult the “guide for authors” (<https://www.sciencedirect.com/journal/resuscitation/publish/guide-for-authors>) from the Resuscitation website.
- Add to the Abstract only the absolute needed information that characterises your chapter.
- Add some keywords.
- Introduction: straight forward - you might add some specifics of your writing group and the process of how the specific chapter of the GL2025 was produced, if that differs from the general approach described in the 1<sup>st</sup> chapter.
- The 1<sup>st</sup> chapter - Executive Summary will include a description of the process how the guidelines were made. Including where the evidence for the GL comes from, conflict of interest handling, equity, inclusivity and diversity, public comments, involvement of lay person from the community as advisors for the GL2025 (“survivors and co-survivors”), and collaboration with “sister” societies and NRC.
- One table will summarize “what is new”. Major changes in clinical or other procedures, or new evidence included in the GL2025 for the interested reader to highlight the key changes between the 2021 and 2025 guidelines for a quickly updated. Do not add simple changes of wordings or phrasing expressing the former content in a better way.
- Main text – use tables or figures as much as possible as this may enable the text to be condensed. They should be easy to read and highly informative.
- After the introduction, the chapter will continue with the “concise guidelines for clinical practice” in form of a bullet point list. This is a “to-do-list” for the respective situation; there is no need to include evidence level or references, as these are part of the evidence-informed guideline part of the manuscript. Key points will be included in the “executive summary” as that chapter will be translated by some NRC.
- The evidence-informed guideline section follows next, as it did in the 2021 version of the ERC GL
- We deliver evidence-informed guidelines. It is important to clearly indicate the source and level of evidence for each “guidance”, whether it comes from an ILCOR systematic review or scoping reviews. Evidence from other sources will be described in narrative form.

- Guide to the levels of evidence:

Simplicity is important when describing the source of the evidence. Describe the source of the evidence in clear and simple words for the end-user of the guidelines. Transparent and clear communication where the evidence for a recommendation comes from is key for the evidence guided subchapter.

- a. Recommendations are in general based on high-certainty evidence. They come from:

- An ILCOR systematic review publication, based on a rigorous literature assessment process. In that case mention the ILCOR publication as evidence. OR
- A systematic review from other sources. OR
- High-quality randomized trials directly addressing the topic – it is reasonable to make a recommendation, but you need to state where the evidence comes from (e.g. "... two randomized controlled trials addressed xy. Despite no formal systematic review was performed/found we issue a recommendation based on .....").

- b. ILCOR issues suggestions, which are based on lower certainty of evidence. If that is available, simply describe that level of evidence in your part of the chapter. If there is "lower certainty of evidence" from other sources (form a non-ILCOR review, an ERC review, other randomized or non-randomized controlled studies from elsewhere) simply describe where the evidence comes from. To keep the process simple and to strengthen clarity we do not issue "ERC-suggestions". In this way, we will avoid uncertainty about the difference between a recommendation or suggestion issued by the ERC.

- c. ILCOR issues Good Practice Statements if the available evidence comes from a scoping review, indirect data (e.g. animal studies, only adult data available but used for neonatal guidance, etc.), or only one or "poor" RCT, non-RCTs, or observational studies are available. However, this includes a literature search with a guided assessment of the evidence and when the desirable effects of an intervention clearly outweigh its undesirable effects. In such cases, please add the source of the evidence. To avoid complexity for the WG the ERC is not formulating its own Good Practice Statements. If you use such evidence describe simply that in a narrative way.

- d. In the absence of an ILCOR published evidence summary, we still need to advise the end user on what to do. Again to simplify the wording of the guidelines we do not issue as mentioned above "ERC Good Practice Guidelines" or "Expert Opinions". We simply describe what the evidence is that was found for a certain procedure and mention that evidence in the references.

Summary: In the evidence informed guidelines, state whether an ILCOR statement has been made on this topic, what it was and what the certainty of evidence was. If no direct evidence from literature can be identified you need to describe transparently that only indirect evidence was identified when summarizing the evidence.

- Figures: the WG members are the content experts on the subject and need to deliver what should be presented in figures (proposals needed in form of a sketch, photo, drawing, description, proposal of colours, etc.). Previously published figures can be used – depending on quality or changes required they may be redrawn. The ERC contracted graphics professional who will provide proposals for graphics. For that a list of graphics and the proposals for each chapter is needed.
- Each table or figure needs a header, and all acronyms or abbreviations need to be spelled out in the footnote of the table or figure
- Parts of the chapter content that do not fit easily into the chapter, exceed the word limit, or cover very specific “niche” aspects of resuscitation can be placed into Supplemental Material – this will not be edited or typeset.
- QR-Codes are also possible, which will link to short video clips, instructive videos, slide series placed on the ERC/Elsevier web page. The ERC office will provide the required specifications for videos (format and quality requirement)
- A person from the Writing Group who did not fulfil the 4 ICMJE recommendations (see below) for authors may be included as collaborators (and will be tagged in PubMed). For example, these could be content experts for a specific question or topic, but who were not a WG member.
- Acknowledgement - please include all persons who contributed to the GL2025 and do not qualify as author or collaborator. That might be for example a content expert for a very narrow question or advise, a group member that were not contributing as expected, an information specialist who helped with the literature search for a review, a community member, etc. These individuals will not be tagged in PubMed (i.e. their names will not be searchable in PubMed).
- Conflict of Interest (COI): as each chapter is an individual publication the COI declaration needs to be provided at the end of each chapter.
- The ICMJE recommends that authorship be based on the following 4 criteria:
  1. Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; and
  2. Drafting the work or revising it critically for important intellectual content; and
  3. Final approval of the version to be published; and
  4. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.
- References: please list all references in the style used by Resuscitation (which is the same as that used by the New England Journal of Medicine) citations are placed in the text in superscript after punctuation. Add the EndNote Library for your chapter to the submission of the chapter.

[h1] European Resuscitation Council Guidelines 2025: Title chapter

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**[h1] Abstract**

This Guideline of the European Resuscitation Council on title of the chapter, is based on the 2025 Consensus of Science with Treatment Recommendations (CoSTR) of the International Liaison Committee on Resuscitation (ILCOR). This chapter provides guidelines on the xxxxxxxx prevention of and treatment of title of the chapter for both in-hospital cardiac arrest and out-of-hospital cardiac arrest.

**[h1] Keywords:** GDSFgsd,sfdgsfgs,sfsfhghg,sfdgsdfhghj,äljäckljäljjöh

# GUIDELINES 2025

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## [h1] Introduction

Adult advanced life support (ALS) includes the advanced interventions that follow basic life support (BLS) that includes cardiopulmonary resuscitation (CPR) and use of an automated external defibrillator (AED). Adult BLS is addressed in the chapter xy. [INSERT REF] Basic life support covers the immediate response to cardiac arrest and overlaps with ALS interventions.

This ALS guidelines include the prevention and treatment of both in-hospital cardiac arrest (IHCA) and out-of-hospital cardiac arrest (OHCA), the ALS algorithm, manual defibrillation, airway management during CPR, drugs and their delivery during CPR, and the treatment of peri-arrest arrhythmias. SDFAKDSF SFGsghdgfhgd dghjhjfhj

These Guidelines are based on the International Liaison Committee on Resuscitation (ILCOR) 2025 Consensus on Science and Treatment Recommendations (CoSTR) for title of the chapter. [INSERT REF] For these ERC Guidelines the ILCOR recommendations were supplemented by focused literature reviews undertaken by the ERC title of the chapter Writing Group for those topics not reviewed by ILCOR. When required, the guidelines were informed by a “good clinical practice statement” or “expert consensus” of the writing group members.

These guidelines were drafted and agreed by the title of the chapter Writing Group members and the Guideline Steering Committee, before posting for public comment between DATE and DATE. xy individuals from yz countries made zz comments. Review of these comments led to xy changes. The Guideline was presented to and approved by the ERC General Assembly on DATE. The methodology used for guideline development is presented in the Executive summary. [INSERT REF]

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[h1] Summary of key changes or new evidence

**Table 1.** The major changes in the 2025 guidelines for title of the chapter.

ERC Guidelines 2021	ERC Guidelines on xy 2025
There is a greater recognition that patients with both in- and out-of-hospital cardiac arrest have premonitory signs, and that many of these arrests may be preventable.	
High quality chest compressions with minimal interruption and early defibrillation remain priorities.	
During CPR, start with basic airway techniques and progress stepwise according to the skills of the rescuer until effective ventilation is achieved. If an advanced airway is required, only rescuers with a high tracheal intubation success rate should use tracheal intubation.	
When adrenaline is used it should be used as soon as possible when the cardiac arrest rhythm is non-shockable cardiac arrest, and after 3 defibrillation attempts for a shockable cardiac arrest rhythm.	
<hr style="border: 1px solid red;"/>	<p>In 2025 the evidence supports .... the role of point-of-care ultrasound (POCUS) in peri-arrest care as standard procedure.</p> <p>Hospitals need to take care that proper skilled operators are available.</p> <p><i>Made up fake text.</i></p>
The guideline reflects the increasing evidence for extracorporeal CPR (eCPR) as a rescue therapy for selected patients with cardiac arrest when conventional ALS measures are failing or to facilitate specific interventions in settings in which it can be implemented.	
Etc.	

## [h1] Concise guidelines for clinical practice

### [h2] Prevention of in-hospital cardiac arrest

- The ERC supports shared decision making and advanced care planning.
- Hospitals should use a track and trigger early warning score system for the early identification of patients who are critically ill or at risk of clinical deterioration.
- Hospitals should train staff in the recognition, .....

### [h2] Prevention of out-of-hospital cardiac arrest

- Symptoms such as syncope, palpitations, dizziness and sudden shortness of breath should be investigated.
- Young adults presenting with characteristic symptoms of arrhythmic syncope should have a specialist cardiology assessment.
- Follow current European Society of Cardiology (ESC) guidelines for the diagnosis and management of syncope.

### [h2] Treatment of in-hospital cardiac arrest

- Hospital systems should aim to recognise cardiac arrest, .... , and defibrillate early (<3 minutes).
- All hospital staff should be able to ... , call for help, start CPR .... and defibrillate.
- The hospital resuscitation team should include team members with ALS course.
- Hospitals should standardise resuscitation equipment.

### [h2] Next topic

- Afdsf xfsfsf xggfhd, .... , and adfdf jgklggijldhdth.

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## **[h1] The evidence informing the ALS guidelines**

### **[h2] Prevention of in-hospital cardiac arrest (IHCA)**

In-hospital cardiac arrest (IHCA) occurs in about 1.5 patients per 1000 admitted to hospital. [INSERT REF] There are two main strategies to prevent cardiac arrest and the need for attempted CPR:

- Patient-focussed decision-making to determine if CPR is appropriate.
- Identifying and treating physiological deterioration early to prevent cardiac arrest.

### **[h3] Emergency care treatment and CPR decisions**

Most patients who die in hospital do not have a resuscitation attempt. [INSERT REF] The ERC Ethics guidelines promote shared decision making and advanced care planning which integrates resuscitation decisions with emergency care treatment plans to increase clarity of treatment goals and also prevent inadvertent deprivation of other indicated treatments, besides CPR. Further information is provided in chapter 11 Ethics. [INSERT REF]

### **[h3] Staff education**

Education should include measurement of vital signs, a structured ABCDE-type approach that includes assessment and initial treatment interventions, use of structured communication tools such as Situation-Background-Assessment-Recommendation (SBAR), and how to call for help and escalate care.<sup>15</sup> Staff should also know how to implement local policies about do-not-attempt CPR (DNACPR) decisions, treatment escalation plans, and starting end-of-life care.

### **[h3] Monitoring**

Most cases of IHCA have an initial non-shockable rhythm and preceding signs of respiratory depression or shock are common. [INSERT REF] To help detect deterioration and critical illness early, all patients should have a documented plan for vital sign monitoring that includes which physiological measurements should be recorded and how frequently. This can be addressed by using a standardised early warning score (EWS) system for all patients.

Ect. [INSERT REF]

### **[h3] Epidemiology and pathophysiology of sudden cardiac death**

Coronary heart disease (CHD) accounts for 80% of SCD, especially in older patients, and non-*ischaemic* cardiomyopathies account for another 10-15%. [INSERT REF] In the young, inherited diseases, congenital heart disease, myocarditis and substance abuse are predominant causes. Knowledge of the causes of SCD will assist in early treatment and the prevention of OHCA (Table 2).

**Table 2.** Causes of sudden cardiac arrest (SCD) adapted from Kandala [INSERT REF] and Winkel. [INSERT REF]

<b>Coronary heart disease</b>
ST-segment elevation
Other myocardial infarction
<b>Electrical heart disease, often associated with SCD in the young</b>
Long QT-syndrome (LQTS)
Short QT syndrome
Brugada syndrome
<b>Non-atherosclerotic coronary artery anomalies</b>
<b>Congenital heart disease</b>
Hypertrophic cardiomyopathy (HCM)
<b>Dilated cardiomyopathy (DCM)</b>
<b>Valvular heart disease</b>

[h2] Header for the next main topic

OHCA dsfsfds kskjgöjshg sfhgsjfhgsjhg söfsgökjhgöjshgs. [INSERT REF]

Ect.:

- Adfs gfghdghd dghdghd.
- etc.

[h3] Subheading for explanatory paragraph

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## [h1] Collaborators

The following individuals contributed as collaborators to the 2025 version of this guideline, Mark CB. Abcdef, Bon Sussy, Karl Klöä, N.N.

## [h1] Acknowledgements

RTG is supported by the European Union Health Authority Research Collaboration (EUHARC), Brussels, Belgium. The views expressed are those of the author(s) and not necessarily those of the EUHARC. We like to thank X.Y.Z. for her assistance in retrieving literature for a scoping review by the writing group.

## [h1] Figure legends

**Figure 1.** In-hospital resuscitation algorithm. AED denotes automated external defibrillator; ALS advanced life support; CPR cardiopulmonary resuscitation; SBAR situation, background, assessment, recommendation.

**Figure 2.** Advanced Life Support algorithm. ABCDE denotes airway, breathing, circulation, disability, exposure/environment; CPR cardiopulmonary resuscitation; ECG electrocardiogram; EMS emergency medical system; PEA pulseless electrical activity; PaCO<sub>2</sub> arterial partial pressure of carbon dioxide; ROSC return of spontaneous circulation; SpO<sub>2</sub> arterial oxygen saturation; VF ventricular fibrillation; VT ventricular tachycardia.

**Figure 3.** Etc.

## [h1] Table legends

**Table 1.** The major changes in the 2025 guidelines for title of the chapter.

**Table 2.** Causes of sudden cardiac arrest (SCD)

**Table 3.** ect

## [H1] References

1. Names. Title. Journal year; issue number:pages

## Beyond the GL2025 publication in Resuscitation

### 1. GL2025 Information for the community

- The purpose of this very short and condensed GL2025 version is to inform the communities (general public/ laypersons) in Europe and beyond about the key messages from each chapter.
- Apart from the GL2025 chapter published in *Resuscitation* the ERC is going to publish informative folders out of each chapter to be used to inform members of the communities (4 - 6 - 8 pages). Minimal text, most in form of infographics.
- To develop that, we need a list of key messages/concepts from each WG, as the writing groups are the content experts that can inform the graphics designer what the ERC want to communicate to the wider audience.
- Proposals for these graphics can be outlined in written form, drafted as sketch, use of colours, needed words, etc. to inform the professional graphic designers - which will then provide some proposals of the infographics specifically developed for the ERC.
- These graphics can be used for all forms of dissemination of the GL2025 content (social media campaigns, a slide set library to facilitate presentations of the GL2025, etc). Some of that might be used also as graphics in the GL2025 publication.
- Translation into European languages will be the task of the ERC office with proofreading by contracted persons from NRC/language groups.

### 2. Publication for health care providers/health care institutions: The concise guidelines for clinical practice

- This will be a short version of the GL2025 chapters of BLS, ALS, PLS, NLS, post resuscitation care and relevant special circumstances (and certain key messages from other WGs), to inform health care professionals and the health care services (like hospitals, ICUs, departments, EMS, HEMS, etc.) about the key steps and applications published in the GL2025 chapters.
- It will help to implement the GL2025 in European health care services, available in printed form (PDF or print on demand for languages), as web-based content, and in form of an app.
- After finishing the GL2025 chapters the ERC will provide a draft version to the WGs for reviews and correction. Graphics and tables will be included.
- Translation into European languages will be the task of the ERC office with proofreading by contracted persons from NRC/language groups.

### 3. Version of the GL2025 in lay person terms

- Aim is to inform the general community in lay person terms about resuscitation 2025 beyond the scientific publication, to disseminate that knowledge to all parts of society, which the “standard” ERC publications do not reach.
- To do so the ERC will make the written version of the GL2025 accessible for interested persons, communities, stakeholders and decision makers. That small booklet will provide more background information as the folders. The ERC GL2025 graphics will be used too.
- That Information shall be available in print (PDF) and web-based, and in the European languages.
- After the GL2025 chapters are written – the ERC will ask all lay person from the community who were involved as advisors for the GL2025 in the chapter-WG to participate in the “translation” of the scientific text into lay person terms.
- Kirstie Haywood (UK) agreed to help and assist that process with this group and the ERC. Some office members might be assisting too, and each WG needs to review the product for content correctness.

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