

CytoSorb Therapy

Decision support for septic & vasoplegic shock patients



CytoSorb Therapy - Initiation

Patient's condition



⚡ Diagnosis

Best results achieved when CytoSorb begun within 24 hrs.

MAP normal

MAP low
< 65 mmHg

Vasopressors start

Sepsis bundle
Catecholamine-/
Volume therapy

Arterial line, Central
Venous Catheter,
Antibiotics,
Source control

Vasopressors continue

Lactate > 2 mmol/l

Differentiated volume-/
Catecholamine therapy

Adv. hemodyn. monitoring

Organ support
(Ventilation, CRRT)

CytoSorb?
(early use in anticipation
of ongoing deterioration)

Vasopressors
NE > 0.3 µg/kg/min

Capillary leak
e.g. ELWI > 10 ml/kg

Lactate further
elevated/increasing

IL-6 (> 500 pg/ml)
PCT (> 3µg/l)
if measured

Extracorp. circuit
available / indicated

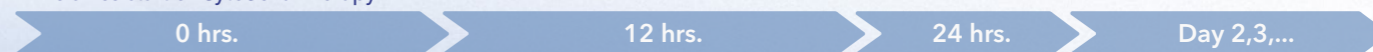
- CRRT
- ECMO
- Hemoperfusion

➤ Start
CytoSorb



CytoSorb Therapy - Continuation

Time since start of CytoSorb Therapy



Beginning of hemo-
dynamic stabilization

Norepinephrine dose / lactate ↓↓

➤ Continue monitoring

Ongoing instability

Decrease of NE dose by less
than 20% in the last 12 hrs

➤ Consider new adsorber

Sufficient stabilization

Decrease of NE dose by more than
90% from baseline

End CytoSorb
Therapy

Insufficient stabilization

Decrease of NE dose by less than 90%
of baseline and lactate > 2.0 mmol/l

➤ Consider new adsorber

Re-evaluate
every 12 to
24 hrs.

Ongoing (hemodynamic)
instability despite 2
adsorbers in 24 hrs.

Consider ending
CytoSorb Therapy

Adequate source control?

Therapeutic target: Shock reversal

Risk: MODS / Mortality

This chart is based on clinical data and best practice gained with CytoSorb 300 and is not transferable to any other blood purification device

Potential Indications for CytoSorb Therapy in the Intensive Care Unit:

- Refractory septic shock
- Vasoplegic shock e.g. postoperatively, with ECMO therapy
- Toxic shock syndrome
- Necrotizing fasciitis
- Meningococcal sepsis
- Hemophagocytic lymphohistiocytosis (HLH)
- Pancreatitis
- Burns
- Trauma
- Liver failure (removal of bilirubin)
- Rhabdomyolysis (removal of myoglobin)

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This decision guidance is non-binding and cannot replace the therapy decisions of the treating physician, who is in all cases responsible for the development and implementation of an adequate diagnostic and therapeutic plan for each individual patient.

The clinical and preclinical data and results obtained with the CytoSorb adsorber are not transferable to other products. CytoSorb should only be administered by personnel who have been properly trained in administration of extracorporeal therapies. CytoSorb is not available for commercial sale in USA.

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