Use of the human dive reflex for the management of supraventricular tachycardia: a review of the literature

Gavin Smith,1 Amee Morgans,2 David McD Taylor,3 Peter Cameron4

ABSTRACT

Background The human dive reflex (HDR), a physiological phenomenon similar to the bradycardia reflex used by marine mammals during prolonged submersion, can be employed in managing paroxysmal supraventricular tachycardia (PSVT). This review aims to identify a standardised HDR technique for haemodynamically stable PSVT, to determine the effectiveness of the HDR and to define its usefulness in the prehospital setting.

Methods A review of the Medline, EMBASE and CINAHL databases was conducted. Articles were included if they described the use of the HDR to revert PSVT in the prehospital or emergency medical setting, the nature of the effectiveness of the HDR for PSVT or historically significant developments of HDR techniques for PSVT reversion. Articles not available in English or describing the use of HDR in animal studies only were excluded.

Results 211 articles were identified, of which 21 were found to be relevant. These included 10 studies of HDR effectiveness in PSVT and three physiological studies of HDR effect. No standardised model of performance exists for the HDR. Elements of performance include: a cold stimulus applied to the entire face, a specific temperature of the cold stimulus, application duration, breath holding during HDR and posture assumed to perform the procedure. There are also safety and logistics issues with using the HDR in prehospital care.

Conclusions The HDR represents an effective method of terminating PSVT in the hospital emergency department. Its usefulness in prehospital care requires further evaluation of the elements of the manoeuvre to determine appropriateness to this setting.

BACKGROUND

The dive reflex was originally observed in aquatic animals, specifically seals. It is a cardiovascular reflex, mediated through increased vagal tone, that results in more efficient oxygen utilisation and a slower heart rate while ensuring adequate cerebral perfusion (through maintenance of mean arterial pressure) and redistribution of core blood flow.1–3 When precipitated in humans by immersion in cold water, the human dive reflex (HDR) primarily results in a reflex bradycardia response.4 5 This bradycardia, and an associated increase in myocardial refractoriness, can be harnessed in a simple and non-invasive manoeuvre for the termination of paroxysmal supraventricular tachycardia (PSVT).

The HDR manoeuvre in humans has resulted in a reappraisal of the HDR and its potential usefulness in prehospital emergency care. Although use of the HDR has gained acceptance for the management of haemodynamically stable PSVT, the combination of respiratory, circulatory, and neuromuscular responses generated by the HDR alone has been reported to be insufficient to revert PSVT.6–7 Hence, the HDR has been used in conjunction with the carotid sinus massage and deep breath holding during HDR and posture assumed to elicit the HDR (a reflex common to both the Valsalva manoeuvre and the carotid sinus massage techniques).8 10 It is likely that the combination of breath holding and cold stimulus provides the HDR with an increased effect for PSVT termination; however, this is yet to be quantified in clinical studies.

METHODS

A comprehensive search strategy was developed, incorporating both the peer reviewed and non-peer reviewed literature, and was based on the Cochrane Prehospital Search Filter V2.0.17 This was used to search the electronic databases Medline (1948 to October 2011), EMBASE (1966 to October 2011), CINAHL (1937 to October 2011), the Cochrane Library of Systematic Reviews and the Cochrane Database of Abstracts of Reviews of Effects (DARE). In addition, the reference sections of articles identified were scrutinised and relevant papers examined.
The following key terms were used in the search strategy: dive reflex, human dive reflex, diving reflex, paramedic, ambulance, emergency medical technician, emergency medicine, tachyarrhythmia, supraventricular tachycardia, paroxysmal supraventricular tachycardia, atrioventricular nodal re-entrant tachycardia and atrioventricular re-entrant tachycardia.

Articles were included if they discussed use of the HDR to revert PSVT in humans of any age in the prehospital or emergency medicine setting. Articles were also included if they described specific attributes or the nature of effectiveness of the HDR on regular narrow complex tachyarrhythmias, or the historical significance of the development of knowledge of HDR therapies for regular narrow complex tachyarrhythmia reversion.

Articles were excluded if they were not available in English or described the use of HDR in animal studies only.

RESULTS
A total of 211 articles were identified during the search and none reported investigations undertaken in the prehospital setting. After cross referencing to eliminate duplications and sorting the results according to technique, effectiveness and application, 21 articles were selected for further analysis (figure 1). Ten clinical studies were found to be of relevance, as they dealt specifically with the use of the HDR in the management of PSVT (table 1). Three physiological studies were also identified which assist in defining responses to the HDR in healthy subjects. A single review article provided a description of the elements of the HDR which may be quantified within a standardised model of application.

The techniques used to elicit the HDR varied greatly, comprising five essential elements:
- A cold stimulus applied to the entire face.
- A specific temperature of the cold stimulus.
- A duration of application.
- Breath holding during performance of the HDR.
- A posture assumed to perform the procedure.

A single review article suggested a method for optimising the HDR response for the management of PSVT. The authors described the elements of the HDR (as above), and also included ‘emotion’ as a component of effectiveness. This element focuses on the nature of increased sympathetic response to anxiety, and encourages a quiet and calm patient prior to commencement of the procedure. Many of the aspects of the suggested HDR technique were taken from physiological studies and require examination within clinical studies using patients with PSVT to quantify effectiveness.

<table>
<thead>
<tr>
<th>Author</th>
<th>Sample size</th>
<th>Age range (years)</th>
<th>Study type</th>
<th>‘Cold’ tool</th>
<th>Temperature (°C)</th>
<th>Apnoea employed</th>
<th>Duration (s)</th>
<th>Reversion success</th>
<th>History of previous SVT</th>
<th>PAT</th>
<th>PAT</th>
<th>PAT</th>
<th>PAT</th>
<th>Supreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wildenthal</td>
<td>2</td>
<td>2-86</td>
<td>Prospective intervention, non-randomised</td>
<td>Cold water</td>
<td>2</td>
<td>Breath holding during facial immersion</td>
<td>15-35</td>
<td>Yes (4), No (3)</td>
<td>PSVT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Wayne</td>
<td>10</td>
<td>0-53</td>
<td>Prospective intervention, non-randomised</td>
<td>Cold water</td>
<td>0</td>
<td>Breath holding during facial immersion</td>
<td>15-38</td>
<td>Yes (3), No (7)</td>
<td>PSVT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mehta et al.</td>
<td>13</td>
<td>16-69</td>
<td>Prospective intervention, non-randomised</td>
<td>Water</td>
<td>5-7</td>
<td>Breath holding during facial immersion</td>
<td>35</td>
<td>Yes</td>
<td>PSVT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Wen et al.</td>
<td>9</td>
<td>18-72</td>
<td>Prospective intervention, non-randomised</td>
<td>Ice and water in plastic bag</td>
<td>5</td>
<td>Not stated</td>
<td>20</td>
<td>Yes (4), No (5)</td>
<td>PSVT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

HDR, human dive reflex; PAT, paroxysmal atrial tachycardia; PSVT, paroxysmal supraventricular tachycardia; SVT, supraventricular tachycardia.
Comparison of results is challenged by each identified study utilising a variety of cold stimuli at differing temperatures, with various postures and durations of application employed. The use of apnoea is common across techniques, although this is achieved through unavoidable obstruction of the mouth and nose by the cold stimulus rather than as an objective element of the technique. The results have identified studies where the aim was to determine HDR effectiveness in PSVT using subjects with arrhythmia, and also physiological studies of the impact of the HDR on healthy subjects in the absence of arrhythmia. These physiological studies are valuable in determining haemodynamic responses to the HDR, yet can only hint at the potential for PSVT reversion effectiveness using the HDR. Blinding of subjects and investigators to outcomes or procedures was not undertaken within any of the studies identified, presumably because of the impracticability of blinding both the therapist and patient to the procedure. Where stated in the original article, the diagnosis of PSVT for subjects within each study was made through medical examination and ECG confirmation of the arrhythmia.

Within the four adult studies listed in table 1, the HDR performance method varied considerably (duration between 15 and 35 s, cold stimulus between 2°C and 10°C where stated), as did patient age (10–69 years) and reversion effectiveness (5–90%). This range of effectiveness demonstrates the impact of small sample size and variation of elements of technique, and requires larger clinical studies with a standardised therapy to demonstrate an effect which would be useful in the clinical setting.

Six articles described reversion success and a specific side effect of the HDR in paediatric patients (table 2). Two articles described the reversion effect of HDR in three case studies, with reversion times ranging from ‘immediate’ to a maximum of 6 s post immersion in iced water.3 20 A third case study described an incidence of cold burn injury sustained by a 4-day-old baby post ice pack application for performance of the HDR.21 Two of the articles also described potential side effects such as apnoea, transient arrhythmias (sinus arrest, nodal and ventricular escape beats, and ventricular tachycardia), prolonged periods of sinus arrest or asystole.2 6 The temperature of the cold stimulus used for the HDR was not stated in these articles.3 20 21 The magnitude of vagal tone generated by the HDR was also not assessed in these studies, and consequently onset or severity of cardiovascular side effects is unpredictable. In response to this, one study suggested that the HDR should only be used where adequate resuscitation and monitoring facilities are available.6

Three physiological studies, which measured the effect of HDR on vagal tone using bradycardia as an outcome measure, also demonstrated a range of performance techniques. Table 3 highlights these variations of technique. Importantly, Furedy et al5 demonstrated that a temperature of 10°C maximises the bradycardia effect. They also noted that a brief sympathetic response occurred during the initial 12 s period of the manoeuvre. However, it was the 12–40 s period of the manoeuvre that resulted in the most significant effect on heart rate, demonstrating mean bradycardia responses of 5–17 bpm, attributable to increased vagal tone.5 This finding has implications for standardising performance of the HDR. The absence of a standardised technique and small sample sizes may account for the variance of reversion rates across the physiological studies examined. Arnold also demonstrated that HDR resulted in a greater bradycardia effect than other vagal manoeuvres although failed to quantify the impact of age on reversion success.4

Table 2: Studies of the effectiveness of the human dive reflex in paediatric subjects presenting with supraventricular tachycardia

<table>
<thead>
<tr>
<th>Author</th>
<th>Sample size</th>
<th>Age range</th>
<th>Study type</th>
<th>‘Cold’ tool</th>
<th>Temperature (°C)</th>
<th>Reversion success (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honda et al5</td>
<td>10</td>
<td>1 day–15 years</td>
<td>Prospective intervention, non-randomised</td>
<td>Ice and water in plastic bag</td>
<td>Not stated</td>
<td>100</td>
</tr>
<tr>
<td>Sperandeo et al2</td>
<td>7</td>
<td>100 Yes (5), No (5)</td>
<td>Retrospective case review</td>
<td>Ice water</td>
<td>Not stated</td>
<td>99.8</td>
</tr>
<tr>
<td>Whitman et al2</td>
<td>1</td>
<td>7 and 10 days (2 cases)</td>
<td>Case study</td>
<td>Ice and water</td>
<td>Not stated</td>
<td>6 and 4–5</td>
</tr>
<tr>
<td>Craig et al17</td>
<td>1</td>
<td>14 days</td>
<td>Case study</td>
<td>Ice and water</td>
<td>Not stated</td>
<td>6–7</td>
</tr>
<tr>
<td>Whitman et al2</td>
<td>1</td>
<td>14 days–5 months</td>
<td>Case study</td>
<td>Ice to face</td>
<td>Not stated</td>
<td>6–5</td>
</tr>
<tr>
<td>Honda et al5</td>
<td>10</td>
<td>1 day–15 years</td>
<td>Prospective intervention, non-randomised</td>
<td>Ice and water in plastic bag</td>
<td>Not stated</td>
<td>100</td>
</tr>
</tbody>
</table>

HDR, human dive reflex; PAT, paroxysmal atrial tachycardia; PSVT, paroxysmal supraventricular tachycardia; SVT, supraventricular tachycardia.

Table 3: Studies of the effectiveness of the human dive reflex in healthy subjects presenting with supraventricular tachycardia

<table>
<thead>
<tr>
<th>Author</th>
<th>Sample size</th>
<th>Age range</th>
<th>Rhythm</th>
<th>Study type</th>
<th>‘Cold’ tool</th>
<th>Duration (s)</th>
<th>Reversion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honda et al14</td>
<td>10</td>
<td>1 day–15 years</td>
<td>PAT</td>
<td>Prospective intervention, non-randomised</td>
<td>Ice and water in plastic bag</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Sperandeo et al2</td>
<td>1</td>
<td>100 Yes (5), No (5)</td>
<td>PSVT</td>
<td>Retrospective case review</td>
<td>Ice water</td>
<td>15</td>
<td>99.8</td>
</tr>
<tr>
<td>Whitman et al2</td>
<td>1</td>
<td>6 and 4–5</td>
<td>PSVT</td>
<td>Case study</td>
<td>Ice and water</td>
<td>6</td>
<td>6 and 4–5</td>
</tr>
<tr>
<td>Craig et al17</td>
<td>1</td>
<td>6–7</td>
<td>PSVT</td>
<td>Case study</td>
<td>Ice and water</td>
<td>7</td>
<td>6–7</td>
</tr>
<tr>
<td>Whitman et al2</td>
<td>1</td>
<td>6–5</td>
<td>PSVT</td>
<td>Case study</td>
<td>Ice to face</td>
<td>7–10</td>
<td>6–5</td>
</tr>
<tr>
<td>Honda et al5</td>
<td>10</td>
<td>1 day–15 years</td>
<td>PSVT</td>
<td>Prospective intervention, non-randomised</td>
<td>Ice and water in plastic bag</td>
<td>15</td>
<td>100</td>
</tr>
</tbody>
</table>

HDR, human dive reflex; PAT, paroxysmal atrial tachycardia; PSVT, paroxysmal supraventricular tachycardia; SVT, supraventricular tachycardia.
Table 3  Physiological studies of the effectiveness of the human dive reflex in healthy subjects without arrhythmia

<table>
<thead>
<tr>
<th>Author</th>
<th>Sample size</th>
<th>Age range (years)</th>
<th>Study type</th>
<th>'Cold' tool</th>
<th>Temperature (°C)</th>
<th>Apnoea employed</th>
<th>Duration (s)</th>
<th>History of previous SVT</th>
<th>Subject rhythm</th>
<th>HDR position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnold et al.</td>
<td>58</td>
<td>10–71</td>
<td>Prospective, randomised to various vagal manoeuvres</td>
<td>Ice water in plastic bag or facial immersion</td>
<td>1</td>
<td>Covered nose and mouth or apnoea during facial immersion</td>
<td>30</td>
<td>No</td>
<td>SR</td>
<td>Supine</td>
</tr>
<tr>
<td>Kaijser et al.</td>
<td>15</td>
<td>60–80</td>
<td>Mixed methods case control study</td>
<td>Iced water</td>
<td>Not stated</td>
<td>Breath holding during facial immersion</td>
<td>10</td>
<td>No</td>
<td>SR</td>
<td>Sitting</td>
</tr>
<tr>
<td>Furedy et al.</td>
<td>48</td>
<td>Adults (&gt;18 but not stated)</td>
<td>Prospective interventional, non-randomised</td>
<td>Water</td>
<td>10, 20, 40</td>
<td>Breath holding during facial immersion</td>
<td>40</td>
<td>No</td>
<td>SR</td>
<td>Prone</td>
</tr>
</tbody>
</table>

*These studies used bradycardia measured from resting heart rate as a clinical outcome measure to describe the magnitude of vagal tone in healthy subjects with no arrhythmia present.

HDR, human dive reflex; SR, sinus rhythm; SVT, supraventricular tachycardia.

DISCUSSION

The use of vagal manoeuvres as a first-line treatment for PSVT in the prehospital setting provides a simple and acceptable method of attempting initial termination of the arrhythmia. As a precursor to pharmacological agents, vagal manoeuvres may allow paramedics to avoid some of the significant side effects of these agents. The published literature demonstrates a range of HDR inducing techniques which essentially focus on providing a cold stimulus to the face in order to promote increased vagal tone. However, the lack of ideal techniques within this area is due to the increased vagal tone generated by deep inspiration (and subsequent triggering of baroreceptors in the thoracic aortic arch and carotid bodies). This may influence the effectiveness and the subsequent impact on the ECG. The importance of posture in HDR performance is also of interest. The Valvassori manoeuvre uses supine posturing to induce hypotension and vagal stimulation of the HDR. The HDR is not possible to determine with any certainty, therefore, the best combination of cold tool (e.g., ice bag, water) and temperature (such as Wolf chospasm in the asthma patient) in the early stages of PSVT effect (or onset of side effects) for the HDR, which to date has not been examined. Use of the HDR technique is associated with an increased risk of hypotension, which also requires examination. The nature of patient movement in this environment, with electrical cardiac monitoring equipment and the subsequent artefact generated on the ECG, would also be unacceptable in prehospital care.

Both paediatric-specific clinical studies demonstrated reversion success in excess of 80% in subjects under 1 year of age. However, the concept of improved reversion effectiveness in younger patients may be unacceptable in prehospital care. A bowl of water precludes itself from use in this setting, with electrical cardiac monitoring equipment and the subsequent artefact generated on the ECG, would also be unacceptable in prehospital care. Although the HDR due to the increased vagal tone generated by deep inspiration (and subsequent triggering of baroreceptors in the thoracic aortic arch and carotid bodies) has been noted to affect physiological responses within the HDR as a temperature of 1°C, it is not possible to determine with any certainty, therefore, the best combination of cold tool (e.g., ice bag, water) and temperature (such as Wolf chospasm in the asthma patient) in the early stages of PSVT effect (or onset of side effects) for the HDR, which to date has not been examined. Use of breath holding as a component of the HDR is one of the cold stimulus has been moved to affect the temperature of the cold stimulus. The temperature of the cold stimulus has been moved to affect the temperature of the cold stimulus. This may influence the effectiveness and the subsequent impact on the ECG. The importance of posture in HDR performance is also of interest. The Valvassori manoeuvre uses supine posturing to induce hypotension and vagal stimulation of the HDR. The HDR is not possible to determine with any certainty, therefore, the best combination of cold tool (e.g., ice bag, water) and temperature (such as Wolf chospasm in the asthma patient) in the early stages of PSVT effect (or onset of side effects) for the HDR, which to date has not been examined. Use of the HDR technique is associated with an increased risk of hypotension, which also requires examination. The nature of patient movement in this environment, with electrical cardiac monitoring equipment and the subsequent artefact generated on the ECG, would also be unacceptable in prehospital care. A bowl of water precludes itself from use in this setting, with electrical cardiac monitoring equipment and the subsequent artefact generated on the ECG, would also be unacceptable in prehospital care. Although the HDR due to the increased vagal tone generated by deep inspiration (and subsequent triggering of baroreceptors in the thoracic aortic arch and carotid bodies) has been noted to affect physiological responses within the HDR as a temperature of 1°C, it is not possible to determine with any certainty, therefore, the best combination of cold tool (e.g., ice bag, water) and temperature (such as Wolf chospasm in the asthma patient) in the early stages of PSVT effect (or onset of side effects) for the HDR, which to date has not been examined. Use of breath holding as a component of the HDR is one.
<5°C may stimulate pain fibres and a sympathetic response.\textsuperscript{8–19}\textsuperscript{22} This would be counterproductive to the aim of the HDR as an antiarrhythmic therapy. Conversely, when the cold stimulus rises above 20°C, little effect is noted through reduced stimulation of the trigeminal nerve (and thus reduced vagal response). The work of Furedy et al\textsuperscript{8} has added value to the evaluation of the manoeuvre through studying the effect of water temperature on the effectiveness of the bradycardia response. However, their work raises new questions regarding the potential impact of ambient temperature (and its relationship to the cold stimulus) generated during the manoeuvre on effect in the clinical setting. Variation in ambient temperature is not usually an issue in the hospital setting. However, ambient temperature in the prehospital setting may vary considerably and the importance of this variable in this setting is unknown. Other prehospital specific requirements of the HDR include its appropriateness when used to manage PSVT patients in rural or remote areas. The long transport times associated with these areas suggest a need to provide a cold stimulus tool that can be maintained at a specific temperature (or replaced) over a prolonged period of time. This provides challenges in requiring a device which can demonstrate prolonged use, is cost effective and is able to be stored for long periods of time in a vehicle where temperatures may vary considerably according to season.

The paediatric studies indicate high success rates for this patient group. However, the use of cold stimulus and involuntary apnoea combined with patients whose age precludes appropriate discussion and understanding of the procedure would likely result in a heightened anxiety response or produce other side effects (such as apnoea and arrhythmias) and reduce the effectiveness of the HDR in this patient group. This point requires further investigation to determine the impact of emotion on effectiveness of the HDR in infants and young children with PSVT, as suggested by Goode.\textsuperscript{19} Careful assessment, including the use of 12 lead ECG to diagnose the arrhythmia, is required prior to contemplation of the use of vagal manoeuvres such as the HDR.

Across the 10 clinical studies, 18 patients required subsequent HDR interventions during the study for recurrent PSVT.\textsuperscript{1–5}\textsuperscript{5}\textsuperscript{21}\textsuperscript{23} Prehospital management of PSVT (and indeed all other aspects of care) by paramedics is limited by statutory regulation and authority to practice. Thus even those patients successfully reverted to sinus rhythm using the HDR may require transport to hospital. This challenges the need to treat rather than transport and impacts on health system cost. Although studies have not clearly defined the harm of prolonged PSVT,\textsuperscript{24–26} early termination serves to reduce patient discomfort, reduce hospital stay times following assessment and enables electrophysiology studies and further definitive procedures to be carried out if required. The value of 12 lead ECG in prehospital care also assists in later electrophysiological assessment within the hospital environment.

RECOMMENDATIONS

Due to the paucity of research in this area, only limited conclusions can be drawn regarding the use of the HDR in the prehospital setting. The studies reviewed suggest that a substantial HDR may be elicited by:

\begin{itemize}
  \item Complete facial immersion, or coverage of the whole face by a cold pack.
  \item Breath holding during the manoeuvre.
  \item Water/cold pack temperature of 10°C (at room temperature of approximately 22°C).
  \item A duration of 50–40 s.
\end{itemize}

Also, the environment where the HDR is conducted should ideally be optimal for both the patient and the treating paramedic with regard to environment, equipment and hazard control. This would be a room with normal ambient temperature and adequate lighting, where continuous cardiac monitoring is available and the risk of electrical hazard is low. The provision of cardiac defibrillation and synchronised cardioversion equipment, oxygen and mechanical ventilation devices, and frontline resuscitation drugs should be a minimum standard for the procedure. This environment, albeit in a more rudimentary form, exists within the confines of many stationary ambulances. However, the nature of training and competency of the paramedic impacts on the overall safety of the procedure.

These essential elements do not suggest an evidence based standard but rather provide the basis for further study into the composition of the HDR to standardise the technique. The assessment of other variables such as posture, breath holding and ambient temperature will provide further detail to enable quantification of its usefulness in the prehospital setting. The effectiveness of the HDR to terminate PSVT has, within the reviewed studies, provided limited evidence with regard to prevention of recurrence of the arrhythmia. It would be prudent to suggest that subsequent HDR attempts may be required, and that these be attempted only after a restitutio period consistent with other vagal manoeuvres (approximately 5 min) and physical examination to ensure that no injury has developed as a result of application of the cold stimulus.

LIMITATIONS

The ability to ascertain the effectiveness of the HDR is confounded by the range of techniques used to perform the manoeuvre, small sample sizes and potential for publication bias. Articles included in this review had large variations in performance components, including posture, duration, temperature of the cold stimulus and type of cold stimulus. The lack of standardisation of these elements of HDR technique limits comparison of results between studies.

CONCLUSION

Evidence relating specifically to the effectiveness of the HDR for termination of PSVT is limited. Notwithstanding this, it appears that complete facial immersion in iced water, or covering the face with an ice pack or cold stimulus of 10°C, for at least 30 s, may result in the best reversion rates until more evidence becomes available. Larger studies with appropriate sample sizes, standardised methods, specific age groups and examining the effects of ambient temperature would assist in evaluating the effectiveness of the HDR for use in the prehospital setting.

Competing interests None.

Contributors GS designed and conducted the search, compiled and analysed the results, and composed the manuscript. AM, DT and PC analysed the results, and composed the manuscript. AM reviewed the search strategy, results and draft paper, with input into style and content of each stage. DT reviewed the search strategy, results and draft paper, with input into style and content of each stage. PC reviewed the search strategy, results and draft paper, with input into style and content of each stage.

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REFERENCES

Review


