Background:
Given the rising cost of vasopressin, the evidence behind its use has been critically evaluated to develop guidelines for prescribing. Overall, the VASST study did not show a difference in mortality when vasopressin was added to norepinephrine in septic shock. While the VASST study did provide a trend toward improved outcomes with vasopressin in patients with less severe sepsis, it does not provide strong data to support using vasopressin at low doses of norepinephrine. As a result, we reserve the use of vasopressin to more refractory clinical conditions.

Below are the prescribing guidelines for vasopressin on the trauma service:

1. Septic Shock
2. Norepinephrine ≥ 20 mcg/min
3. MAP < 65

If norepinephrine requirement increases to ≥ 20 mcg/min

Can consider initiating vasopressin 0.03 units/min

When norepinephrine ≤ 12 mcg/min

Turn off vasopressin

**After 2 failed attempts to discontinue vasopressin, may continue vasopressin along with norepinephrine

- **NOT FOR USE** in patients with hemorrhagic or neurogenic shock.
- Do **NOT** use vasopressin to reach MAP goals for spinal cord injuries.
- Do **NOT** use vasopressin to reach CPP goals in patient with ICH.
- Do **NOT** run vasopressin as the only vasopressor.

References: