Out-of-hospital cardiac arrest in countries of the Gulf Cooperation Council: a scoping review

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Abstract

Background: Published data are lacking on response to and outcomes of out-of-hospital cardiac arrest in the Middle East. What data there are have not been comprehensively analysed.

Aims: This study aimed to assess the characteristics of people with out-of-hospital cardiac arrest in Gulf Cooperation Council (GCC) countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates) and the response to and outcomes of such incidents.

Methods: This was a scoping review of published and grey literature on out-of-hospital cardiac arrest in GCC countries from 1990 to June 2019. Studies in English and Arabic were eligible for inclusion. MEDLINE, CINAHL, Web of Science and EMBASE were searched as well as relevant non-indexed journals. Google searches were also done. References of included studies were scanned for relevant articles. Experts on the subject in the region were consulted.

Results: Of 647 citations retrieved, 24 studies were included for data extraction and analysis. No literature was identified for Bahrain. People with out-of-hospital cardiac arrest in the region were younger, predominantly male and had more comorbidity than reported in other regions of the world. Use of emergency medical services was low across the GCC countries, as was bystander cardiopulmonary resuscitation, return of spontaneous circulation and survival to discharge.

Conclusions: A coordinated effort to address out-of-hospital cardiac arrest, including the generation of research, is lacking within and among GCC countries. Establishment of lead agencies responsible for developing and coordinating strategies to address out-of-hospital cardiac arrest, such as community response, public education and reporting databases, is recommended.

Key words: out-of-hospital cardiac arrest, emergency medical services, cardiopulmonary resuscitation, Gulf Cooperation Council, Middle East

Introduction

Out-of-hospital cardiac arrest is a major cause of mortality worldwide, with variable survival reported across countries and systems. In particular, Middle-Eastern and South Asian countries report low survival rates (1). Reported reasons for low survival from out-of-hospital cardiac arrest in these settings include unique demographic, cultural and logistical challenges related to the management of out-of-hospital cardiac arrest. At the same time, most of the evidence used to inform resuscitation guidelines for out-of-hospital cardiac arrest comes, for the most part, from very different systems, and applying this evidence and guidelines in Middle-Eastern settings may also present a challenge.

Characteristics and outcomes of out-of-hospital cardiac arrest in Middle-Eastern countries are still poorly researched, thus compounding these challenges. The resulting lack of knowledge prevents us from understanding the factors related to out-of-hospital cardiac arrest, and thereby prevents us from improving response to and outcomes of out-of-hospital cardiac arrest in these countries. Thus, to meaningfully tackle out-of-hospital cardiac arrest in the Middle East, we first need to understand the issue within this context.

The Gulf Cooperation Council (GCC) was established in 1981 and comprises the governments of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates. The countries in the GCC are predominantly Islamic and they share a common cultural and historical background (2). Another shared trait is their economic reliance on expatriate workforces (3), estimated at 48% of the total regional population of 53 million (4,5). Within this regional population, life expectancy has risen substantially from 42–61 years in the 1960s to 74–80 years in 2018 (5). However, increased population numbers, the health care needs of groups with different demographics and increased life expectancy have led to a rise in health care demand. This rise is predominantly due to high rates of noncommunicable diseases such as
diabetes, cardiovascular disease and obesity, attributable to unhealthy lifestyles and a general lack of coordinated public health programmes (4,6). In order to reduce the risk of mortality associated with such morbidity, most GCC member countries have initiated public health strategies, which include the recording and reporting of noncommunicable diseases.

The first report on out-of-hospital emergency care in a GCC country was for Abu Dhabi in 2004 (7), when emergency medicine within GCC countries was rudimentary. This study observed no real medical oversight of out-of-hospital care provision, no treatment policies, a lack of training and education, and no quality assurance policies. However, emergency medicine and prehospital care have developed across the GCC countries in the past 15 years.

Reporting of out-of-hospital cardiac arrest rates, response and outcomes are benchmarks of emergency medical response readiness. Therefore, we conducted a review of studies on out-of-hospital cardiac arrest in the GCC to understand their characteristics and properties, and to identify any gaps in the literature and areas for further research.

Methods

Study design

We conducted a scoping review, which enabled us to identify, map and present an overview of a heterogeneous body of literature (8,9). We considered a scoping review to be appropriate given the predicted lack of published data (and potential reliance on sources from the grey literature), the anticipated heterogeneity among studies and the expected variability in reporting.

Review process

We performed a systematic literature search for studies that investigated out-of-hospital cardiac arrest in the GCC region. We used a five-stage framework (8), which included: (i) identifying the research question; (ii) identifying relevant studies; (iii) refining the study selection criteria; (iv) collecting relevant data from each article; and (v) collating, summarizing, reporting and interpreting the results. We also implemented a recommended additional stage: (vi) consultation with experts. We reported our process according to the PRISMA extension for scoping reviews (10).

First, we identified three research questions. 

1. What are the characteristics of cases of out-of-hospital cardiac arrest in the GCC region?
2. How do these studies differ from other international studies?
3. What insights can be gained from these findings in order to better inform policy and practice in the GCC region?

Second, to identify relevant studies we undertook a systematic search of the literature. An information scientist (MA) developed the search strategy. We used this to search the electronic databases MEDLINE, CINAHL, Web of Science and EMBASE from 1990 until June 2019. The search strategy was modified accordingly for each database they do not all have the same subject headings. Relevant non-indexed journals were identified and searched, and we performed multiple Google web and Google Scholar searches. We searched the grey literature with guidance from the Grey Matters checklist (11). References of included studies were scanned for relevant articles. See Appendix I for search terms and a list of non-indexed sources.

Third, we established the eligibility criteria. Studies in English and Arabic were eligible for inclusion if they reported out-of-hospital cardiac arrest in the GCC. We excluded studies that were not related to out-of-hospital cardiac arrest (e.g. in-hospital cardiac arrest), case reports, studies that reported only on out-of-hospital cardiac arrest caused by a trauma, studies that were related to cardiopulmonary resuscitation training and those not conducted in GCC countries.

We (AB and CL) reviewed titles and abstracts of studies retrieved in the search. We resolved disagreements through discussion until we reached consensus. Where disagreement remained or there was insufficient evidence to make a decision, we included the citation for full text review and subsequent decision.

Fourth, to support the full-text review, we developed a standardized data extraction form to organize information, confirm relevance and extract study characteristics (See Appendix II) (12). Two reviewers (AB and CL) abstracted general study characteristics such as authorship, year of publication, country, study design, sample size, outcomes measures and characteristics of out-of-hospital cardiac arrest. We compiled all data for analysis into a single spreadsheet in Microsoft Excel 2013.

Fifth, we summarized and synthesised the data. Because of variations in study designs, terminology used and reporting conventions, we needed to identify common areas for reporting summarized results. We selected a number of demographic, process and outcome measures that reflect key components of an effective response to and management of out-of-hospital cardiac arrest. We abstracted and reported the findings for each measure per study where possible, and we report on them under the headings of characteristics, process and outcomes measures.

In line with the scoping review framework, we did not conduct a critical appraisal (8).

Sixth, in addition to our own experience and expertise with out-of-hospital cardiac arrest in the region, we invited a number of experts on out-of-hospital cardiac arrest in the GCC to contribute additional material and unpublished studies. Two of these individuals subsequently joined the research team (DA and AA).
**Ethical considerations**

This was a scoping review of completed studies and hence no ethics approval was required.

**Results**

**Search results and study selection**

The search yielded 590 citations. We identified an additional 57 citations through searches of the grey literature and hand searching. After elimination of duplicates, we screened 284 citations at the title and abstract level. This led to the exclusion of 236 citations. After full-text review of 48 citations, we included 24 full-texts for data extraction and analysis (Figure 1). Not all are referenced (some were unpublished at the time, or duplicate reference to technical report) – the full citation for these are included in Appendix III. See Appendix III for details of adult out-of-hospital cardiac arrest studies, and Appendix IV for details of paediatric out-of-hospital cardiac arrest studies.

**Characteristics of studies**

The included studies were published between 1999 and 2019 (13–30). The studies were: 16 full-text articles (both published and unpublished manuscripts), three technical reports or theses, three conference abstracts, and two letters to the editor. Ten studies were from the United Arab Emirates, six from Qatar, four from Saudi Arabia, three from Kuwait, one from Oman and one for the region. We did not identify any literature from Bahrain despite consultation with an expert on the subject in the country. Of the 24 studies, 16 (13–27, plus unpublished studies given in Appendix III) described adult cases or all cases of out-of-hospital cardiac arrest. Four studies reported data on paediatric out-of-hospital cardiac arrest (13,28–30) and we report these separately in our results; one study is reported as both an adult and a paediatric study on out-of-hospital cardiac arrest (13). Where results were published in more than one source (for example a technical report and a peer-reviewed manuscript), we only abstracted the most complete version. See Appendix III for details the sources abstracted.

**Adult cases**

**Characteristics**

Adults who experienced out-of-hospital cardiac arrest in the GCC region were consistently young, predominantly male and often had underlying comorbidities, such as diabetes. Most cases of out-of-hospital cardiac arrest occurred at home (ranging from 54% to 85% of all cases of out-of-hospital cardiac arrest). Table 1 and Figure 2 give further characteristics (see Appendix III for details).

We found differences in the characteristics of people who experienced out-of-hospital cardiac arrest among ethnic groups in the region (e.g. Arab, South Asian and North African). For example, compared with GCC nationals with out-of-hospital cardiac arrest, South Asian and North African people with out-of-hospital cardiac arrest were more likely to smoke but had lower levels of comorbidities (17,22). Despite this finding, South Asian and North African people with out-of-hospital cardiac arrest were generally younger and accounted for a large percentage of the total number of cases of out-of-hospital cardiac arrest.

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**Figure 1 Flow chart of search results**

- Records identified through database searching and backchaining (590)
- Additional records identified through other sources (57)
- Records after duplicates removed (284)
- Records screened (284)
- Full-text articles assessed for eligibility (48)
- Publications included in review (24)
- Records excluded (236)
  - Exclusion criteria: published before 1990; in-hospital cardiac arrest; conducted outside Gulf Cooperation Council countries
  - Full-text articles excluded (24): 11 on CPR training, 7 on ACS management, 5 did not provide enough data for abstraction, 1 on traumatic OHCA

(CPR: cardiopulmonary resuscitation; ACS: acute coronary syndrome; OHCA: out-of-hospital cardiac arrest)
Table 1 Characteristics of the sample, and process and outcome measures for out-of-hospital cardiac arrest in Gulf Cooperation Council countries reported in the selected studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>No. in sample</th>
<th>Median age, years</th>
<th>Mean age, years</th>
<th>Males, %</th>
<th>Females, %</th>
<th>Cardiac arrest at home, %</th>
<th>Bystander CPR, %</th>
<th>Bystander AED, %</th>
<th>ROSC, %</th>
<th>Survival to discharge, %</th>
<th>Survival at 30 days, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al Hasan, 2019 (4)</td>
<td>Kuwait</td>
<td>314</td>
<td>–</td>
<td>54.7 (GP); 61 (EMS)</td>
<td>70 (GP); 67 (EMS)</td>
<td>30 (GP); 33 (EMS)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>7 (GP); 3 (EMS)</td>
<td>–</td>
<td>7 (GP); 1 (EMS)</td>
</tr>
<tr>
<td>Al Hasan, 2019 (5)a</td>
<td>Kuwait</td>
<td>332</td>
<td>–</td>
<td>59 (pre); 63 (post)</td>
<td>74 (pre); 61.7 (post)</td>
<td>26 (pre); 38.3 (post)</td>
<td>75 (pre); 84.7 (post)</td>
<td>14 (pre); 12 (post)</td>
<td>–</td>
<td>6 (pre); 1.6 (post)</td>
<td>2 (pre); 0.8 (post)</td>
<td>0 (pre); 0.8 (post)</td>
</tr>
<tr>
<td>Al Hasan, 2019 (6)</td>
<td>Kuwait</td>
<td>286</td>
<td>63</td>
<td>61.1</td>
<td>67.1</td>
<td>32.9</td>
<td>76</td>
<td>8.7</td>
<td>–</td>
<td>3.5</td>
<td>–</td>
<td>–</td>
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<tr>
<td>Alqahtani, 2019 (7)</td>
<td>United Arab Emirates</td>
<td>715</td>
<td>50</td>
<td>63</td>
<td>59 (pre); 62 (SA)</td>
<td>65 (ME); 88 (SA)</td>
<td>77</td>
<td>23</td>
<td>69.9</td>
<td>27.5</td>
<td>1.8</td>
<td>9.2</td>
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<td>Arabi, 2013 (17)</td>
<td>Qatar</td>
<td>987</td>
<td>–</td>
<td>49 (ME); 62 (SA)</td>
<td>63 (ME); 83 (SA)</td>
<td>37 (ME); 12 (SA)</td>
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<tr>
<td>Batt, 2016 (18)</td>
<td>United Arab Emirates</td>
<td>384</td>
<td>53</td>
<td>50.9</td>
<td>76</td>
<td>24</td>
<td>54.2</td>
<td>30</td>
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<td>3.1</td>
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<tr>
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<td>United Arab Emirates</td>
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<td>–</td>
<td>75</td>
<td>25</td>
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<tr>
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<td>62.5</td>
<td>37.5</td>
<td>74</td>
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<tr>
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<td>Saudi Arabia</td>
<td>39</td>
<td>–</td>
<td>55.4</td>
<td>57.3</td>
<td>42.7</td>
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<tr>
<td>Irfan, 2016 (21)</td>
<td>Qatar</td>
<td>447</td>
<td>51</td>
<td>–</td>
<td>80.5</td>
<td>19.5</td>
<td>61.3</td>
<td>20.6</td>
<td>2.7</td>
<td>13</td>
<td>8.1</td>
<td>–</td>
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<tr>
<td>Irfan, 2018 (22)</td>
<td>Qatar</td>
<td>397</td>
<td>71 (GCC); 52 (NA)</td>
<td>–</td>
<td>60 (GCC); 84.8 (NA)</td>
<td>40 (GCC); 15.2 (NA)</td>
<td>88.8 (GCC); 72.3 (NA)</td>
<td>17.2 (GCC); 61 (NA)</td>
<td>–</td>
<td>10.2 (GCC); 9.9 (NA)</td>
<td>4.9 (GCC); 10.7 (NA)</td>
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<td>Nadar, 2018 (23)</td>
<td>Oman</td>
<td>216</td>
<td>–</td>
<td>55</td>
<td>69.4</td>
<td>30.6</td>
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<td>–</td>
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<td>39.4</td>
<td>13</td>
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<td>Ong, 2015 (24)</td>
<td>United Arab Emirates</td>
<td>405</td>
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<td>49.7</td>
<td>82.7</td>
<td>17.3</td>
<td>54.3</td>
<td>10.5</td>
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<td>Patel, 2014 (25)</td>
<td>Qatar</td>
<td>987</td>
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<td>57</td>
<td>72.7</td>
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<td>–</td>
<td>40.2</td>
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<td>Salam, 2013 (26)</td>
<td>Qatar</td>
<td>801</td>
<td>–</td>
<td>56</td>
<td>–</td>
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<td>–</td>
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<tr>
<td>Salam, 2018 (27)</td>
<td>Regional</td>
<td>89</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
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<tr>
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<td>United Arab Emirates</td>
<td>14</td>
<td>4</td>
<td>–</td>
<td>43</td>
<td>57</td>
<td>36</td>
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<tr>
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<td>Saudi Arabia</td>
<td>23</td>
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<td>4</td>
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<td>30.4</td>
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<td>5.9</td>
<td>5.9</td>
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N-dash (-): not reported.
aPre and post refers to pre and post implementation of dispatcher-assisted CPR.
bUnpublished manuscript; pre-print available on request.
cardiac arrest in several studies (16,18,21). Data on specific process and outcome measures for national populations were not well reported in the studies.

**Process and outcome characteristics**

The use of emergency medical services was low, as was bystander cardiopulmonary resuscitation, rates of return of spontaneous circulation and survival to hospital discharge compared with international figures. The rate of use of emergency medical services was rarely reported, and ranged from 1.4% (23) to 31% (20). The rate of bystander cardiopulmonary resuscitation ranged from 5.1% (13) to 30% (18). The rate of use of an automated external defibrillator by a bystander was reported at less than 3% for any study that reported such data. The rate of return of spontaneous circulation ranged from 1.6% (13) to 39.4% (23) but most studies reported this rate at less than 10%. The rate of survival to hospital discharge was often not reported and ranged from 2% (15) to 40.2% (25); however, most studies reported rates less than 10% (Figure 2).

**Paediatric cases**

**Characteristics**

Only four studies reported paediatric out-of-hospital cardiac arrest. Children who experienced out-of-hospital cardiac arrest in the GCC were mostly male and the out-of-hospital cardiac arrest in a significant proportion of the cases had a non-medical etiology (23.5–45.0%), including drowning. Most cases of paediatric out-of-hospital cardiac arrest occurred at home, ranging from 36% (28) to 87% (29) of all cases of paediatric out-of-hospital cardiac arrest (Table 1 and Figure 3; see Appendix IV for details).

**Process and outcome characteristics**

We observed low rates of: bystander cardiopulmonary resuscitation rates; return of spontaneous circulation rates; survival to hospital discharge rates across the paediatric out-of-hospital cardiac arrest studies in the region (Figure 3). Bystander cardiopulmonary resuscitation ranged from 0% (13) to 26% (28). No studies of paediatric out-of-hospital cardiac arrest cases reported the use of automated external defibrillator by bystander. Two studies reported the rate of return of spontaneous circulation, 5.9% (30) and 14% (28). Two studies reported a survival to discharge rate of about 6% (13,30). Pre-existing medical conditions were reported for cases of paediatric out-of-hospital cardiac arrest in several studies and varied from 23.5% (30) to almost 70% (29).

**Discussion**

The causes of lower survival from out-of-hospital cardiac arrest in the GCC than reported in international studies are anecdotally related to unique demographic, cultural and logistical contexts of the region. Given these challenges, and the lack analysis of the literature, we explored out-of-hospital cardiac arrest in the GCC in a scoping review. The studies we included reported low rates of survival to discharge for out-of-hospital cardiac arrest (1–13%) when compared with other international studies, e.g. 10–23% (31). After examining studies from countries in the GCC, we suggest several unique characteristics are associated with out-of-hospital cardiac arrest in the region including characteristics related to process and outcomes. Despite the mortality associated with out-of-hospital cardiac arrest in the region, this condition remains poorly researched, with a lack of a coordinated effort to improve process and outcomes.
Characteristics of out-of-hospital cardiac arrest in GCC countries

People experiencing out-of-hospital cardiac arrest in GCC countries are predominantly male, and younger and with more co-morbid conditions than those with out-of-hospital cardiac arrest elsewhere (15,18,20; see Appendix III for details). We suggest a number of reasons for these findings. One proposed cause for the observed level of cardiac conditions is the so-called obesogenic urbanization that has occurred rapidly in the region as a result of oil wealth (32). A number of studies in our review reported high rates of cardiac risk factors including diabetes mellitus, hypertension, hyperlipidaemia, chronic renal failure and acute coronary syndrome (17,18,22,23,24,27). In addition, the large expatriate populations living in some GCC countries, and their unique lifestyle risk factors (such as high rates of smoking) may have contributed to the observed young age and male dominance of cases of out-of-hospital cardiac arrest in our review (16,18,21). We also observed differences in the demographics of out-of-hospital cardiac arrest in these expatriate populations compared with the national populations (16,18,21; see Appendix III for details). For example, expatriates were normally younger and more likely to smoke compared with nationals (17,22).

Pre-hospital resuscitation

Research shows that early response before the arrival of emergency medical services is crucial in the outcomes of out-of-hospital cardiac arrest, i.e. recognizing out-of-hospital cardiac arrest, calling for help and providing bystander cardiopulmonary resuscitation and automated external defibrillation (34,35). We observed low levels of use of emergency medical services (reported in two studies, range 1.4–35%), low bystander cardiopulmonary resuscitation rates (reported in 10 studies, range 3–30%) and very low bystander use of automated external defibrillators in the studies in our review. Variation in response times and an absence of integrated community response systems mean that death from out-of-hospital cardiac arrest in GCC countries is likely to occur at the scene. These findings highlight a weakness in the public response to out-of-hospital cardiac arrest in the region. Anecdotal reasons for such challenges include a lack of defibrillators in public places, so-called good Samaritan laws that stipulate only certified people should provide medical assistance, lack of governing bodies to oversee all aspects of the medical emergency response, the rural residence of significant portions of the population, and cultural norms (18). Cultural challenges include a lack of knowledge of cardiopulmonary resuscitation, a lack of confidence to intervene, and barriers to cardiopulmonary resuscitation and the use of automated external defibrillators, especially on females experiencing out-of-hospital cardiac arrests (36). We also observed over-reliance on private transport rather than emergency medical services to transport patients with out-of-hospital cardiac arrest, which mirrors results of non-out-of-hospital cardiac arrest studies in the region (37). Attempts to address such challenges are bringing results, as evidenced in the reported increased use of emergency medical services for out-of-hospital cardiac arrest (16,18,19). However, public perceptions on recognizing and intervening in...
out-of-hospital cardiac arrest have yet to be studied in GCC countries.

In other regions, developing integrated community response models has led to substantial improvements in outcomes of out-of-hospital cardiac arrest. Ireland is a good example, and it shares characteristics of rurality in common with GCC countries (38,39), despite their obvious geographical differences. In 2018, 2,442 cases of out-of-hospital cardiac arrest were reported in Ireland. Of these cases, 81% received bystander cardiopulmonary resuscitation (excluding cases witnessed by the emergency medical services), 22% received bystander automated external defibrillation, 26% had return of spontaneous circulation and 7.2% survived to discharge, most of whom had cerebral performance scores of 1 or 2 (40). These results are a significant improvement on the national figures from only 5 years before when 1,885 cases out-of-hospital cardiac arrest were recorded, of whom 69% received bystander cardiopulmonary resuscitation (excluding cases witnessed by the emergency medical services), 16% received bystander automated external defibrillation, 23% had return of spontaneous circulation and 6.3% survived to discharge (41). In that 5-year period, Ireland had developed a national network of integrated community response schemes, focused on the provision of early cardiopulmonary resuscitation, including dispatcher-assisted cardiopulmonary resuscitation. As a result, continued improvements in measures of out-of-hospital cardiac arrest are likely in the future. Given the challenges we observed in this review in relation to access to emergency medical services, bystander cardiopulmonary resuscitation, bystander use of automated external defibrillators and cultural and logistical barriers, rates of return of spontaneous circulation and survival to hospital discharge were low across the region. In other words, lower survival as an outcome is reflective of process issues in the resuscitation attempt, particularly in the pre-arrival phase.

**Lack of research and coordinated efforts**

The processes and outcomes related to out-of-hospital cardiac arrest are well researched in a number of countries, in part due to established, coordinated cardiac arrest registries. These registries may be national (39) or regional (31), and they allow researchers to examine trends, correlations and concerns related to out-of-hospital cardiac arrest with large prospectively collected datasets. Another example is the Pan-Asian Resuscitation Outcomes Study (PAROS), an international cardiac arrest registry study of which the United Arab Emirates is a reporting member (24). Our review also showed that out-of-hospital cardiac arrest research efforts across the GCC are infrequent, and even within countries, research efforts on out-of-hospital cardiac arrest are not strategically coordinated. For example, none of the existing PAROS studies in the United Arab Emirates reported on out-of-hospital cardiac arrest in Abu Dhabi. Thus, these publications do not present a complete account of out-of-hospital cardiac arrest in the United Arab Emirates. The heterogeneity of populations within PAROS across Asia and the Middle East is a challenge as the aggregated data are not always useful for informing strategies in particular regions such as the GCC (42). In some GCC countries, outcomes of out-of-hospital cardiac arrest are unknown due to a complete lack of reporting. Despite a previous call for a regional initiative for data collection and sharing (43), no concerted effort has been made to create reporting databases for out-of-hospital cardiac arrests in GCC countries. As a result of this lack of coordinated effort, we cannot provide scientific answers to research questions, which creates a barrier to evidence-informed policy- and decision-making in the GCC. Furthermore, the provision of public education, coordination of public information campaigns, improved bystander and community response to out-of-hospital cardiac arrest, strategic planning of emergency medical response and the coordination of research efforts are (where they exist) spread across many local or national agencies within each country. This makes it more difficult to achieve a coordinated effort in the management of out-of-hospital cardiac arrest. Without such strategic oversight, there is potential for duplication of effort, missed opportunities to strengthen the response to out-of-hospital cardiac arrest and a lack of compatibility of findings both within and between countries in the region.

**Conclusion**

Given our findings on the characteristics of people experiencing out-of-hospital cardiac arrest in the GCC countries and the response to and management of such incidents, efforts are needed to reduce the burden of cardiac arrest in GCC countries. Such efforts, which largely reflect the recommendations of the Global Resuscitation Alliance (44), include: (i) creation of a lead agency in each country for strategic oversight of preparedness, response, management and research for out-of-hospital cardiac arrest; (ii) development of community response models; (iii) legislation of equivalents to the so-called good Samaritan law (45,46); (iv) implementation of public health initiatives to reduce cardiac risk factors; (v) coordination of public information campaigns on recognition and management of out-of-hospital cardiac arrest, including early access to emergency medical services and early cardiopulmonary resuscitation (47,48); (vi) improvement in access to automated external defibrillators in high-risk locations and creation of national automated external defibrillator registries (49,50); and (vii) establishment and maintenance of registries of out-of-hospital cardiac arrest in each country and the GCC region which align with international conventions (51).

Our findings need to be interpreted in the context of certain limitations. We may not have identified all relevant studies despite our attempts to make a comprehensive search. Our search and review was restricted to articles published in English and Arabic, but this does not inherently bias a review (52). The Google Scholar searches were limited to the first 300 results which is considered adequate for grey literature searches.
Further grey literature sources may exist that we did not identify; however, we attempted to minimize this risk by using the Grey-Matters checklist (11), contacting experts on out-of-hospital cardiac arrest in the region and searching non-indexed sources. A number of studies included data on presumed cardiac etiology as well as traumatic out-of-hospital cardiac arrest. We attempted to identify and report only data on non-traumatic out-of-hospital cardiac arrest where possible, but this was not always possible. Finally, there are a few studies on paediatric out-of-hospital cardiac arrest in our review. Despite the limitations associated with such a small number of paediatric studies, we report them here to provide some collective insight into paediatric out-of-hospital cardiac arrest in GCC countries.

Despite these limitations, our review is the first to collate and comprehensively report data on out-of-hospital cardiac arrest in the GCC region and highlights the considerable burden associated with out-of-hospital cardiac arrest in the region. We highlighted unique demographic traits and challenges related to processes and outcomes of out-of-hospital cardiac arrest in the region, as well as the paucity of research on the topic and the lack of a coordinated effort within the region in responding to and managing out-of-hospital cardiac arrest.

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Arrêt cardiaque extrahospitalier dans les pays du Conseil de Coopération du Golfe : étude exploratoire

Résumé

Contexte : Les données publiées sont insuffisantes en ce qui concerne les interventions en cas d’arrêts cardiaques extrahospitaliers et leurs conséquences au Moyen-Orient. Les données disponibles quelles qu’elles soient n’ont pas été analysées de manière exhaustive.

Objectifs : La présente étude avait pour objectif d’évaluer des personnes ayant été victimes d’un arrêt cardiaque extrahospitalier dans les pays membres du Conseil de Coopération du Golfe (Arabie saoudite, Bahreïn, Émirats arabes unis, Koweït, Oman et Qatar) ainsi que les interventions pour ces incidents et leurs conséquences.


Conclusions : Il existe un manque d’efforts coordonnés pour faire face à l’arrêt cardiaque extrahospitalier, notamment en matière de recherche, au sein des pays du Conseil de Coopération du Golfe et entre eux. Il est recommandé de mettre en place des organismes chefs de file responsables de l’élaboration et de la coordination des stratégies de lutte contre les arrêts cardiaques extrahospitaliers, telles que la riposte communautaire, l’éducation du public et les bases de données de signalement.
السكتة القلبية خارج المستشفى في بلدان مجلس التعاون الخليجي: استعراض استكشافي

الخلاصة:
هناك نقص في البيانات المنشورة حول الاستجابة للسكتة القلبية خارج المستشفى ومخرجاتها في الشرق الأوسط. ولم يتم تحليل البيانات الموجودة تحليلًا شاملًا.

الأهداف: هدف هذه الدراسة إلى تقييم خصائص الأشخاص الذين أصيبوا بالسكتة القلبية خارج المستشفى في بلدان مجلس التعاون الخليجي (البحرين والكويت وعُمان والمملكة العربية السعودية والإمارات العربية المتحدة) والاستجابة لهذه الأحداث وخرجاتها.

طرق البحث: كان هذا استعراضًا استكشافيًا للمؤلفات غير الرسمية والنشرة حول السكتة القلبية خارج المستشفى في بلدان مجلس التعاون الخليجي في الفترة من عام 1990 إلى يونو/حزيران 2019. وكانت الدراسات باللغتين العربية والإنجليزية مؤهلة للإدراج في الاستعراض. وتم البحث باستخدام قاعدة بيانات EMBASE، وموقع شبكة العلوم، وقاعدة بيانات CINAHL، وقاعدة بيانات MEDLINE، بالإضافة إلى المجلات غير المفهرسة ذات الصلة بالموضوع. كما أجريت عمليات بحث باستخدام محرك Google.

نتيجة: من بين 648 استخدامًا تم استرجاعها، أُدرجت 647 نشرة من بانغ. الأشخاص الذين أصيبوا بالسكتة القلبية خارج المستشفى في الاقليم أصغر سنًا وأغلبهم من الذكور، والمصابون بحالات مرضية مصاحبة. وكانت الاستجابة ال จาก الأحداث الطارئة غير متناسقة، وأندية الحياة حتى التخرج من المستشفى. وأيضًا نقص في الجهود المنسقة لمعالجة السكتة القلبية خارج المستشفى، بما يشمل إنشاء هياكل مسؤولة عن وضع استراتيجيات لمعالجة السكتة القلبية خارج المستشفى، وتسهيلها، مثل الاستجابة المجتمعية وتثقيف العامة وقواعد بيانات الإبلاغ.

References


