

Supraventricular Tachycardia



History:

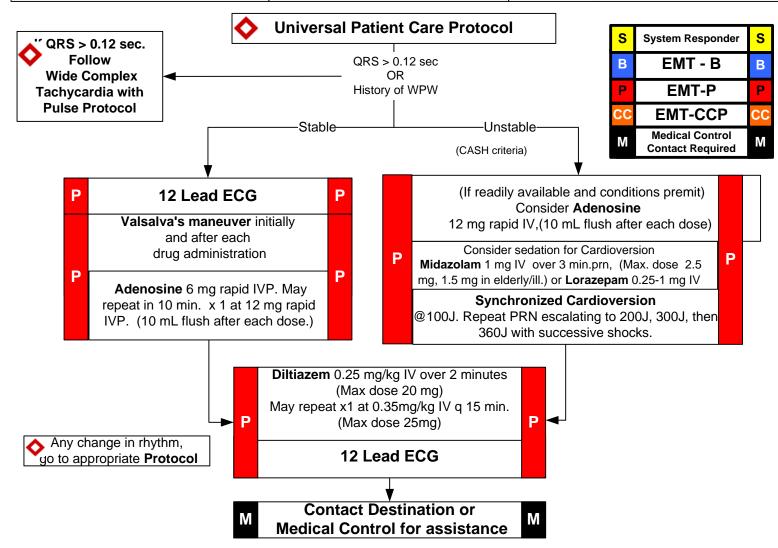
- Medications
 - (Aminophylline, Diet pills, Thyroid supplements, Decongestants, Digoxin)
- Diet (caffeine, chocolate)
- Drugs (nicotine, cocaine)
- Past medical history
- History of palpitations / heart racing
- Syncope / near syncope

Signs and Symptoms:

- HR greater than 150/Min
- QRS less than 0.12 Sec (QRS greater than 0.12 sec go to V-Tach Protocol)
- If history of WPW, go to V-Tach Protocol
- Dizziness, CP, SOB
- Potential presenting rhythm Sinus tachycardia
 - Atrial fibrillation / flutter Multifocal atrial tachycardia

Differential:

- Heart disease (WPW, Valvular)
- Sick sinus syndrome
- Myocardial infarction
- Electrolyte imbalance
- Exertion, Pain, Emotional stress
- Fever
- Hypoxia
- Hypovolemia or Anemia
- Drug effect / Overdose (see Hx)
- Hyperthyroidism
- Pulmonary embolus



Pearls:

- If patient has history of or 12 Lead ECG reveals Wolfe Parkinson White (WPW), DO NOT administer Diltiazem, go to VT with Pulse.
- If patient requires multiple conversion attempts without resolution consider alternative cause of dysrhythmia
- Adenosine may not be effective in identifiable atrial flutter/fibrillation, but is not harmful.
- Monitor for respiratory depression and hypotension associated with Midazolam & Lorazepam. **Pulse OX and Capnography Mandatory! Be prepared to assist ventilations especially if Midazolam is used.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.
- Serious S/S are uncommon with HR < 150. Patients with impaired cardiac function may become symptomatic at lower HR.
- **Lorazepam and Midazolam Doses** are to be titrated to effect, maintaining SBP >100 mmHg and/or peripheral pulses present. Always use **smallest dose** possible to achieve desired effect.