Supraventricular Tachycardia

COG A-28

History:	Signs and Symptoms:	Differential:
• 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	• 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	• 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

Universal Patient Care Protocol

If QRS > 0.12 sec. Follow Wide Complex Tachycardia with Pulse Protocol

QRS > 0.12 sec
OR
History of WPW

Stable

Unstable

(CASH criteria)

	System Responder	
S		S
B	EMT - B	B
P	EMT-P	P
CC	EMT-CCP	CC
M	Medical Control Contact Required	M

P

12 Lead ECG

Valsalva's maneuver initially and after each drug administration

Adenosine 6 mg rapid IVP. May repeat in 10 min. x 1 at 12 mg rapid IVP. (10 mL flush after each dose.)

P

(If readily available and conditions premit)
Consider **Adenosine**
12 mg rapid IV,(10 mL flush after each dose)

Consider sedation for Cardioversion
Midazolam 1 mg IV over 3 min.prn, (Max. dose 2.5 mg, 1.5 mg in elderly/ill.) or **Lorazepam** 0.25-1 mg IV

Synchronized Cardioversion
@100J. Repeat PRN escalating to 200J, 300J, then 360J with successive shocks.

P

Diltiazem 0.25 mg/kg IV over 2 minutes
(Max dose 20 mg)
May repeat x1 at 0.35mg/kg IV q 15 min.
(Max dose 25mg)

12 Lead ECG

P

Any change in rhythm, go to appropriate **Protocol**

M

Contact Destination or Medical Control for assistance

M

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.