Tachycardia With Pulses

C-4 (LALS)

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Approval: Victoria Pinette – Executive Director	Next Review: 01/2022

- **Unstable pts with persistent tachycardia require immediate cardioversion (AEMT II).**
- **It is unlikely that symptoms of instability are caused primarily by the tachycardia if the HR is < 150/min.**

BLS

- Manage airway and assist ventilations as necessary
- Assess V/S, including SpO_2
- O_2 at appropriate rate if hypoxemic (SpO_2 < 94%), short of breath, or signs of heart failure or shock

LALS

- Cardiac monitor **(AEMT II)**, 12-lead ECG **(AEMT II)** at appropriate time - do not delay therapy

- Establish vascular access at appropriate time (may bolus up to 1000 mL NS)

Persistent tachycardia causing (any):

- Hypotension?
- Acutely altered mental status?
- Signs of shock?
- Ischemic chest discomfort
- Acute heart failure?

NO →

- Monitor and reassess
- Contact base/ modified base hospital for consultation if necessary

YES ↓

Synchronized Cardioversion (AEMT II)

- Initial synchronized cardioversion doses:
  - Narrow regular: 50 - 100 J
  - Narrow irregular: 120 - 200 J
  - Wide regular: 100 J
- Consider pre-cardioversion sedation/pain control*
- If no response to initial shock, increase dose in a stepwise fashion for subsequent attempts
- If rhythm is wide-irregular or monitor will not synchronize, and the pt is critical, treat as VF with unsynchronized defibrillation doses (C-1)

***Sedation/Pain Control**

For pts in need of sedation/pain control, consider of the following:

Midazolam:
2 - 5 mg IV;

<u>OR</u>

Morphine:
2 - 5 mg IV