

| SUPRAVENTRICULAR TACHYCARDIA | | | | | | | | | | | | | | | |
|--|--|-------|-----------|------|--------|---------|--------|-------|--------|-------|--|-------|--|-------|--|
| ADULT | PEDIATRIC (≤ 34Kg) | | | | | | | | | | | | | | |
| BLS | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Universal Protocol #601 • Pulse Oximetry <ul style="list-style-type: none"> ○ O₂ administration per Airway Management Protocol #602 | Same as Adult | | | | | | | | | | | | | | |
| ALS Standing Orders | | | | | | | | | | | | | | | |
| <p style="text-align: center;">Stable</p> <ul style="list-style-type: none"> • Attempt vagal maneuvers • Adenosine 6 mg IV followed by 20 mL NS bolus • Adenosine 12 mg followed by 20 mL NS bolus <ul style="list-style-type: none"> ○ May repeat once <p style="text-align: center;">Unstable</p> <ul style="list-style-type: none"> • Synchronized cardioversion (see notes) • Midazolam up to 2 mg slow IV or 5 mg IN (split into two doses 2.5 mg each nostril) to pre-medicate prior to cardioversion | <p style="text-align: center;">Stable</p> <ul style="list-style-type: none"> • Attempt vagal maneuvers • Adenosine 0.1 mg/kg IV followed by 20 mL NS bolus • Adenosine 0.2 mg/kg IV followed by 20 mL NS bolus <p style="text-align: center;">Unstable</p> <ul style="list-style-type: none"> • Synchronized cardioversion (see notes) • Midazolam 0.1 mg/kg slow IV/IN, not to exceed 2 mg to pre-medicate prior to cardioversion | | | | | | | | | | | | | | |
| Base Hospital Orders Only | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Cardioversion of unstable Atrial Fibrillation with RVR • As needed | <ul style="list-style-type: none"> • As needed | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • Obtain 12-lead ECG before and after conversion if possible • Preferred IV site for Adenosine administration is in a proximal vein with a large bore catheter • Vascular access may be omitted prior to cardioversion if in extremis • Typical SVT in adults is a QRS < 0.12 seconds • Typical SVT in pediatric patients is a QRS < 0.09 seconds with rates >180 for children and >220 in infants • Avoid Adenosine in atrial fibrillation and atrial flutter • Consider and treat underlying causes in unstable patients with atrial fibrillation and atrial flutter, i.e. sepsis, dehydration/hypovolemia, medication errors, etc. • Synchronized/Unsynchronized Sequences (if synchronized mode is unable to capture use unsynchronized cardioversion) • Use manufacturer recommended energy settings if different from below <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse; width: 60%;"> <thead> <tr> <th style="width: 50%; text-align: center;">ADULT</th> <th style="width: 50%; text-align: center;">PEDIATRIC</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">50 J</td> <td style="text-align: center;">1 J/kg</td> </tr> <tr> <td style="text-align: center;">70/75 J</td> <td style="text-align: center;">2 J/kg</td> </tr> <tr> <td style="text-align: center;">100 J</td> <td style="text-align: center;">2 J/kg</td> </tr> <tr> <td style="text-align: center;">120 J</td> <td></td> </tr> <tr> <td style="text-align: center;">150 J</td> <td></td> </tr> <tr> <td style="text-align: center;">200 J</td> <td></td> </tr> </tbody> </table> <p style="text-align: center;">(start at 120J in adult patient with unstable Atrial Fibrillation with RVR)</p> | | ADULT | PEDIATRIC | 50 J | 1 J/kg | 70/75 J | 2 J/kg | 100 J | 2 J/kg | 120 J | | 150 J | | 200 J | |
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