TACHYCARDIA- PEDIATRIC

EMR

- Routine Medical Assessment and Intervention.
- **Oxygen** per guideline if needed and appropriate.
- Obtain SpO_2
- **Immediately initiate CPR at a rate of at least 100 per minute** per current AHA guidelines if signs/symptoms of poor perfusion and/or no pulse present.
- Ensure concurrent use of Airway guideline(s).

EMT

- If patient has no gag reflex, may consider placement of appropriately sized **King airway** if authorized and trained.
- Initiate **capnography** if available/trained and appropriate (King Airway placed).
- If equipment is available and trained, may acquire **12-Lead ECG**.

AEMT

- Obtain IV/IO access
- Consider and treat underlying causes of tachycardia.

EMT-I

- Obtain and interpret limb-lead **ECG**
  - Evaluate for **Wide QRS** (>0.08 sec) vs. **Narrow QRS** (< 0.08 sec**)**

NARROW COMPLEX:

- ***Probable Sinus Tachycardia (infants <220/min – children <180/min):***
  - Consider/treat root causes within scope
- ***Probable Supraventricular Tachycardia (infants ≥220/min – children***
  - May consider **Vagal** maneuvers

WIDE COMPLEX:

- ***Stable Ventricular Tachycardia:***
  - May consider **Amiodarone 5mg/kg over 20 to 60 minutes** only after **OLMC** consultation.

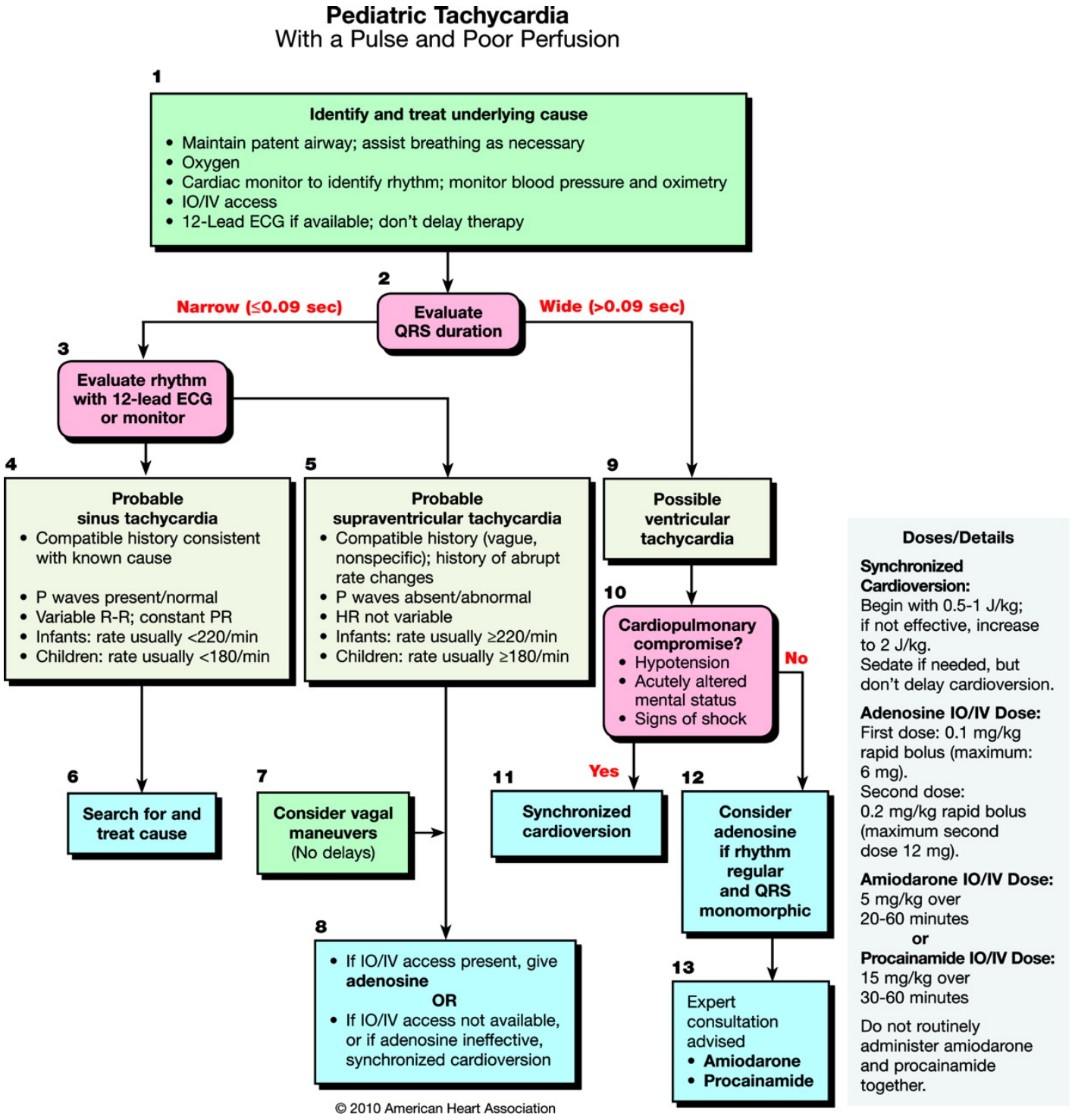
PARAMEDIC

NARROW COMPLEX:

- ***Probable Supraventricular Tachycardia (infants ≥220/min – children***
  - May consider **Adenosine 0.1mg/kg (max 6mg)** may repeat x 1 at **0.2mg/kg (max 12mg)**

WIDE COMPLEX:

- ***Stable Ventricular Tachycardia:***
  - If regular and QRS monomorphic may consider **Adenosine 0.1mg/kg (max 6mg)** may repeat x 1 at **0.2mg/kg (max 12mg)**
  - If no response and remains stable may consider **Amiodarone 5mg/kg over 20 to 60 minutes**.
- ***Unstable Ventricular Tachycardia:***
  - **Synchronized Cardioversion – 0.5 to 1 J/kg may repeat at 2J/kg**
  - Consider the use of sedation during cardioversion with **Versed 0.1mg/kg IV or 0.2mg/kg IM**

TACHYCARDIA CONTINUED

Clinical Care Pearls