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Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

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PAGE: 1 of 1

WIDE COMPLEX TACHYCARDIA OF UNCERTAIN TYPE

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL

Wide complex tachyarrhythmia in which V-Tach and SVT cannot be distinguished. Risk factors are useful in distinguishing V-Tach from supraventricular tachycardia. Age greater than 70 years and prior history of ischemic heart disease strongly suggest V-Tach. Age less than 40 years and no history of ischemic heart disease strongly suggest SVT. Low blood pressure is not useful to distinguish between the two rhythms.

Currently, cardiologists stress rhythm diagnosis of the WCT family over field treatment. Treat only the sickest patients. Many more effective therapies are available in the ED than in the field, for borderline-stable patients. Field drug therapy may interfere with in-hospital treatment. Establish Base Hospital contact early in these cases - many physicians will prefer transport with close observation only. Consider Code 2 transport.

STANDING ORDERS

ABCs

SECURE AIRWAY As appropriate. Confirm tube placement, if intubated, with end-tidal CO₂ monitor and esophageal detector device. **Continuous waveform capnography shall be used in all intubated patients if available.**

OXYGEN

IV ACCESS

TKO

ASSESS

For serious signs and symptoms: severe chest pain, shortness of breath, decreased level of consciousness or congestive heart failure.

Unstable: Systolic BP less than 90mmHg AND any of the above symptoms:

Midazolam 2.0 mg IV push. Do not delay cardioversion for IV access or sedation if the patient is unconscious.

Cardiovert SYNCHRONIZED at 100J, 200 J, 300 J, 360 J (or clinically equivalent biphasic energy doses). Reduce power by half for patients on digitalis. If delays in synchronization occur and clinical conditions are critical, to immediate unsynchronized shocks.

go

REASSESS

Treat as appropriate for rhythm.

Borderline: Systolic BP greater than or equal to 90 mmHg AND any of the above symptoms:
Establish Base Hospital contact early in uncertain rhythms!

Lidocaine 1.5 mg/kg IV push.

REASSESS

If patient does not convert:
Lidocaine 0.75 mg/kg IV push. Repeat once in 5 minutes to a total of 3 mg/kg.

If rhythm converts:

Lidocaine. Give either multiple-bolus or drip:

Lidocaine 0.5 mg/kg IV/IO (or 1.0 mg/kg ET tube - Flush with 5 ml NS). Repeat every 10 minutes, OR;
Lidocaine 2 mg/minute IV drip. Increase to maximum 4 mg/minute if ventricular ectopy persists.