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 Executive Director

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 Medical Director

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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 a patient treatment standard for EMT-Is and Paramedics within their scope of practice.
- 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.

STANDING ORDERS	
ASSESS	CAB.
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation/perilaryngeal airway. Refer to General Procedures Protocol 554.00.
OXYGEN	Oxygen delivery as appropriate
IV ACCESS	TKO
	<u>Unstable: Systolic BP less than 90mmHg AND severe chest pain, shortness of breath, decreased level of consciousness, or congestive heart failure:</u>
MIDAZOLAM	2.0 mg IV push. Do not delay cardioversion for IV access or sedation if the patient is unconscious.
CARDIOVERT	SYNCHRONIZED at 100 J, 200 J, 300 J, 360 J (or clinically equivalent biphasic energy doses). Reduce power by half for patient taking digitalis. If delays in synchronization occur, and clinical conditions are critical, go to immediate unsynchronized shocks.
REASSESS	Treat as appropriate for rhythm.
	<u>Borderline: Systolic BP 90 mmHg or greater AND severe chest pain, shortness of breath, decreased level of consciousness, or congestive heart failure:</u>
	Establish Base Hospital contact early in uncertain rhythms!
ADENOSINE	6 mg rapid IV push followed immediately by normal saline flush. 12 mg rapid IV push followed immediately by normal saline flush may be administered as a second dose if necessary.
LIDOCAINE	1.5 mg/kg IV push.

STANDING ORDERS CONTINUED

LIDOCAINE

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

LIDOCAINE

If patient converts:
Give either multiple-bolus or drip:
a) Lidocaine 0.5 mg/kg IV. Repeat every 10 minutes, OR;
b) Lidocaine 2 mg/minute IV drip. Increase to maximum 4 mg/minute if ventricular ectopy persists.