# TREATMENT PROTOCOL: TACHYCARDIA WITH PULSES (ADULT)

1. Basic airway
2. Pulse oximetry
3. Oxygen prn
4. Cardiac monitor: document rhythm and attach ECG strip
5. Advanced airway prn
6. Venous access
7. Consider underlying causes (e.g., dehydration, sepsis, trauma, etc.)

<table>
<thead>
<tr>
<th>NARROW QRS</th>
<th>WIDE QRS</th>
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<tbody>
<tr>
<td><strong>Adequate Perfusion</strong></td>
<td><strong>Poor Perfusion</strong></td>
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<tr>
<td>8. If hypovolemia is suspected, treat by Ref. No. 1246, Non-Traumatic Hypotension Treatment Protocol.</td>
<td>8. If atrial fibrillation/flutter is identified, establish base contact.</td>
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<tr>
<td>9. If heart rate equal to or greater than 150bpm: Valsalva maneuver.</td>
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<tr>
<td>Adenosine 6mg rapid IV push. Immediately follow with 10-20ml normal saline rapid IV flush.</td>
<td>Adenosine 12mg rapid IV push. Immediately follow with 10-20ml normal saline rapid IV flush.</td>
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<tr>
<td>10. If unresponsive to Valsalva</td>
<td>10. Synchronized cardioversion. May repeat one time.</td>
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<td>Adenosine 12mg rapid IV push. Immediately follow with 10-20ml normal saline rapid IV flush.</td>
<td>11. ESTABLISH BASE CONTACT (ALL)</td>
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<tr>
<td>12. If awake, consider sedation prior to cardioversion: Midazolam 1-2mg slow IV push, titrate for sedation. 2.5mg IM or IN if unable to obtain venous access. May repeat every 5min, maximum total adult dose 10mg.</td>
<td>12. ESTABLISH BASE CONTACT (ALL)</td>
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<tr>
<td>13. Synchronized cardioversion. May repeat to a total of 4.</td>
<td>13. If awake, consider sedation prior to cardioversion: Midazolam 1-2mg slow IV push, titrate for sedation. 2.5mg IM or IN if unable to obtain venous access. May repeat every 5min, maximum total adult dose 10mg.</td>
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SPECIAL CONSIDERATIONS

1. Contraindications: 2\textsuperscript{nd} or 3\textsuperscript{rd} Degree Heart Blocks; History of Sick Sinus Syndrome

2. Use caution if patient is taking Persantine or Tegretol.

3. Consider cardioversion for uncontrolled atrial fibrillation with hemodynamic instability. Consult base hospital physician for all patients experiencing atrial fibrillation.

4. Cardioversion preferred if unconscious.

5. If atrial flutter identified or digitalis toxicity suspected, consider reduced energy (50J) or consult with base hospital.

6. Biphasic settings may vary; refer to manufacturer’s guidelines, if unknown, use highest setting. Monophasic at 100J, 200J, 300J, 360J.

7. If monitor does not discharge on “sync”, turn off sync and defibrillate.