Subject: Treatment Guidelines – ALS Personnel
Other Cardiac Dysrhythmia

Associated Policies:5315,5321,5335,5421, 5439

I. Priorities
- A. ABC's.
- B. Determine type of dysrhythmia and degree of physiological distress. Obtain 12 Lead if available to assist in diagnostics.
- C. Initiate treatment in the field.
- D. Re-assess the rhythm and vital signs.
- E. Transport Code 2 - most patients. Code 3 - if signs of shock, perfusion failure, severe unremitting chest pain.

II. Other Cardiac Dysrhythmia
- A. Sinus Tachycardia:
  Heart rate 100-160, regular.
  1. Oxygen therapy.
  2. Cardiac monitor.
  3. Contact base hospital.
  4. Consider:
     a. IV access TKO, if indicated by clinical presentation. .
     b. Fluid boluses 250cc-500cc as indicated by clinical presentation.
  5. Search for and treat the underlying cause.
- B. Multi-Focal Atrial Tachycardia:
  Heart rate 100-160 or more, irregular variable P wave morphology and PR interval. Most commonly seen in COPD patients.
  1. Treat as sinus tachycardia and COPD.
- C. Premature Atrial Contractions:
  Variable underlying regular sinus rhythm with super-imposed premature, usually narrow-complex beats, not followed by a compensatory pause. Usually due to ingestion of stimulants (caffeine, tobacco, alcohol, amphetamines, theophylline, etc.).
  1. Oxygen therapy.
  2. Cardiac monitor.
  3. Consider:
  4. IV access TKO, if indicated by clinical presentation. Search for and treat the underlying cause.
- D. Atrial Flutter:
  Variable rate depending on block (2:1, 3:1, etc.). Atrial rate between 250-350, in a "saw-tooth" pattern.
  1. Oxygen therapy.
  2. Cardiac monitor. Obtain 12 lead.
  3. Contact base hospital.

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4. IV access TKO. If well tolerated, transport with cardiac monitoring.
5. If poorly tolerated, (BP < 80, unconsciousness or obtundent, severe chest pain or dyspnea etc.), ventricular rate > 140-150, consider synchronized cardioversion at 50 W/S monophasic, or appropriate WS for biphasic. Some may prefer to start at lower energy levels, especially if the patient is taking Digoxin. Pediatric cardioversion should be delivered at 1 Joule/kg monophasic, or appropriate WS for biphasic (refer to length based dosing tape for appropriate defibrillator settings).
6. May consider Amiodarone 150mg over 10 minutes if rhythm is determined to be new onset. If conversion is successful, Amiodarone infusion of 1mg/minute over 1 hour.

E. Atrial Fibrillation:

Variable rate usually 200, irregularly irregular.

1. Oxygen therapy.
2. Cardiac monitor.
3. Contact base hospital.
4. IV access TKO.
5. If well-tolerated, transport with cardiac monitoring.

If poorly tolerated, (BP <80, unconsciousness or obtundent, severe chest pain or dyspnea, etc.), ventricular rate > 140-150, consider synchronized cardioversion 50 W/S monophasic, or appropriate WS for biphasic, with increase in 50 W/S increments until cardioversion is successful or 200 W/S monophasic, or appropriate WS for biphasic is reached. Some may prefer to start at a lower energy level, if the patient is taking Digoxin. Pediatric cardioversion should be initially delivered at 1 Joule/kg monophasic, or appropriate WS for biphasic (refer to length based dosing tape for appropriate defibrillator settings).

6. May Consider Amiodarone 150mg over 10 minutes if rhythm is determined to be new onset. If conversion is successful, Amiodarone infusion of 1mg/minute over 1 hour.

Approved: _____

Approved as to Form: _____

Date: 04/03/2013