Pediatric Emergencies
P-5 Pediatric Tachycardia with Pulses

Stabilize airway using BLS adjuncts if necessary
Oxygen – High Flow via NRB
Ventilate using BVM if necessary
Vital signs
Pulse Oximetry
Cardiac Monitor
IV/IO Access
Consider **NS** 20mL/kg bolus for hypotension

Narrow Complex Tachycardia?

Probable Sinus Tachycardia
- P waves present and normal
- Variable R-R and consistant P-R
- Infant HR usually <220
- Child HR <180

Treat underlying cause

Monitor and reassess

Probable SVT
- P waves absent or abnormal
- HR not variable
- Infant HR ≥220
- Child HR ≥180

Vagal Maneuver
If no cardiopulmonary compromise

Vagal Maneuver Successful?

Yes → Monitor and reassess

No

Hypotension and shock?

No → Monitor and reassess

Yes

Adenosine 0.1mg/kg rapid IV/IO
Max single dose 6mg

If no response to first Adenosine dose

Adenosine 0.2mg/kg rapid IV
Max single dose 12mg

Synchronized Cardioversion
0.5 – 1J/kg
If not effective, increase to 2J/kg

Wide Complex Tachycardia?

Probable VT

Hypotension and shock?

No → Contact base hospital for further treatment consultation

Yes

Synchronized Cardioversion
0.5 – 1J/kg
If not effective, increase to 2J/kg

Contact base hospital for further treatment consultation

Signs and symptoms of shock
ALOC, hypotension (age appropriate), capillary refill >2 seconds, diaphoresis, SOB

Consider prior to cardioversion

Morphine sulfate 0.1mg/kg IV/IO
for patients >6 months old
Morphine sulfate 0.05mg/kg IV/IO
for patients <6 months old
OR
Fentanyl 1mcg/kg slow IV/IO
over 1-2 minutes
OR
Fentanyl 1mcg/kg IN

Midazolam 0.1mg/kg IV/IO
may repeat in 2 minutes
OR
Midazolam 0.2mg/kg IM/IN
may repeat in 2 minutes

DISRUPTED COMMUNICATIONS
In the event of a "disrupted communications" situation, Solano County Paramedics may utilize all portions of this treatment protocol without Base Hospital Contact as needed to stabilize an immediate patient.