PEDIATRIC TACHYCARDIA WITH A PULSE AND ADEQUATE PERFUSION

Identify and treat underlying cause

- Maintain patient airway: assist breathing as necessary
- Oxygen
- Cardiac monitor to indentify rhythm, monitor blood pressure and oximetry
- IO/IV access
- 12 lead ECG if available. Don't delay the therapy

QRS Wide QRS Narrow Evaluate Rhythm (> 0.09 sec)(< 0.09 sec) **Probable sinus Probable Possible Probable** tachycardia supraventricular supraventricular Ventricular tachycardia (with tachycardia Compatible history tachycardia QRS aberrancy) Compatible history • R-R interval regular known cause (vague, nonspecific), history of abrupt rate • Uniform QRS changes morphology

- consistent with
- P waves present or normal
- Variable R R or constant PR
- Infants rate usually < 220/min
- Children rate usually < 180/min
- P waves absent or abnormal
- Heart rate not variable
- Infants rate usually > 220/min
- Children rate usually > 180/min

Consider vagal Search for maneuver and treat (no delays)

- Establish vascular access
- Consider adenosine (0.1 mg/kg IV (maximum first dose 6 mg
- May give second dose of 0.2 mg/kg IV (maximum second does 12 mg) Use rapid bolus technique

• Expert consultation strongly recommended

- Search for and treat reversible causes
- Obtain 12 lead ECG
- Consider pharmacologic conversion
 - o Amiodarone IV 5 mg/kg over 20-60 min or
 - o **Procainamide IV**:15 mg/kg over 30-60 min\
 - Do not routinely administer these 2 drugs together
 - May attempt adenosine if not already administered
- Consider electrical cardioversion
 - o Consult pediatric cardiologist
 - o Attempt cardioversion with 0.5-1 J/kg if initial dose ineffective