

SUPRAVENTRICULAR TACHYCARDIA															
ADULT	PEDIATRIC (≤ 34Kg)														
BLS															
<ul style="list-style-type: none"> • Universal Protocol #601 • Pulse Oximetry <ul style="list-style-type: none"> ○ O₂ administration per Airway Management Protocol #602 	<p>Same as Adult</p>														
ALS Standing Orders															
<p style="text-align: center;">Stable</p> <ul style="list-style-type: none"> • Attempt vagal maneuvers • Adenosine 6 mg IV followed by 20 mL NS bolus • Adenosine 12 mg followed by 20 mL NS bolus <ul style="list-style-type: none"> ○ May repeat once <p style="text-align: center;">Unstable</p> <ul style="list-style-type: none"> • Synchronized cardioversion (see notes) • Midazolam up to 2 mg slow IV or 5 mg IN (split into two doses 2.5 mg each nostril) to pre-medicate prior to cardioversion 	<p style="text-align: center;">Stable</p> <ul style="list-style-type: none"> • Attempt vagal maneuvers • Adenosine 0.1 mg/kg IV followed by 20 mL NS bolus • Adenosine 0.2 mg/kg IV followed by 20 mL NS bolus <p style="text-align: center;">Unstable</p> <ul style="list-style-type: none"> • Synchronized cardioversion (see notes) • Midazolam 0.1 mg/kg slow IV/IN, not to exceed 2 mg to pre-medicate prior to cardioversion 														
Base Hospital Orders Only															
<ul style="list-style-type: none"> • Cardioversion of unstable Atrial Fibrillation with RVR • As needed 	<ul style="list-style-type: none"> • As needed 														
Notes															
<ul style="list-style-type: none"> • Obtain 12-lead ECG before and after conversion if possible • Preferred IV site for Adenosine administration is in a proximal vein with a large bore catheter • Vascular access may be omitted prior to cardioversion if in extremis • Typical SVT in adults is a QRS < 0.12 seconds • Typical SVT in pediatric patients is a QRS < 0.09 seconds with rates >180 for children and >220 in infants • Avoid Adenosine in atrial fibrillation and atrial flutter • Consider and treat underlying causes in unstable patients with atrial fibrillation and atrial flutter, i.e. sepsis, dehydration/hypovolemia, medication errors, etc. • Synchronized/Unsynchronized Sequences (if synchronized mode is unable to capture use unsynchronized cardioversion) • Use manufacturer recommended energy settings if different from below 															
<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="width: 50%;">ADULT</th> <th style="width: 50%;">PEDIATRIC</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">50 J</td> <td style="text-align: center;">1 J/kg</td> </tr> <tr> <td style="text-align: center;">70/75 J</td> <td style="text-align: center;">2 J/kg</td> </tr> <tr> <td style="text-align: center;">100 J</td> <td style="text-align: center;">2 J/kg</td> </tr> <tr> <td style="text-align: center;">120 J</td> <td></td> </tr> <tr> <td style="text-align: center;">150 J</td> <td></td> </tr> <tr> <td style="text-align: center;">200 J</td> <td></td> </tr> </tbody> </table>		ADULT	PEDIATRIC	50 J	1 J/kg	70/75 J	2 J/kg	100 J	2 J/kg	120 J		150 J		200 J	
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50 J	1 J/kg														
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<p>(start at 120J in adult patient with unstable Atrial Fibrillation with RVR)</p>															