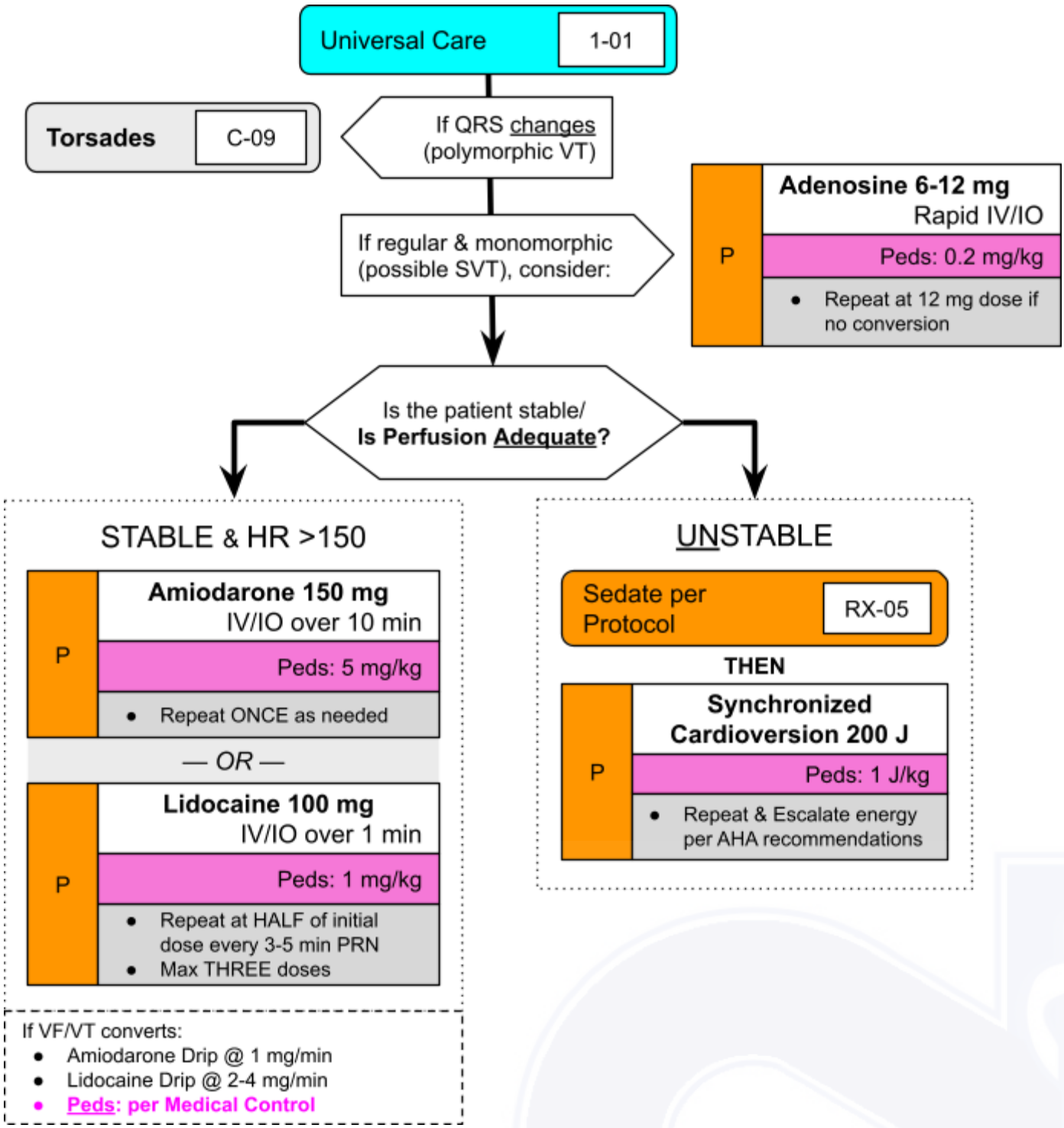
C-08 WIDE-COMPLEX TACHYCARDIA	**Peds: Consult Online Medical Control prior to any meds or cardioversion when possible**	First Responder EMT AEMT Paramedic



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With known Preexcitation Syndromes (e.g. Wolff-Parkinson-White/WPW), AHA recommends AGAINST most prehospital medications.
Consult Online Medical Control prior to medication in stable but symptomatic patients.

"Unstable" Definition:

- UNSTABLE does NOT mean (just) hypotension
- UNSTABLE = **significant inadequate perfusion** of vital organs:
  - Hypotension with significantly altered LOC (i.e. an alert and talking patient should generally be considered stable).
  - Symptoms and 12-lead EKG suggesting acute coronary syndrome (severe chest pain, SOB, diaphoresis, etc.).
  - Any BP with significant pulmonary edema and hypoxia.
- Bottomline: *significant* clinical symptoms + clinical signs (i.e hypotension & tachycardia) = inadequate perfusion

NOTES:

- **Wide-complex Rates > 150:**
  - Generally should be considered abnormal and treated per the above guidelines unless otherwise discussed with online medical control.
  - Treatment should generally be with a medication that will slow ventricular conduction (i.e. amiodarone, lidocaine or procainamide as available).
  - Regular WCT > 150 = typically V-Tach or SVT with aberrancy.
    - Adenosine may be given if regular and monomorphic (i.e probably SVT) and if a defibrillator is available.
  - Irregular WCT > 150 = likely A-fib with aberrancy (or A-fib with LBBB)
    - **If QRS complexes are changing (i.e. Torsades de Pointe), treat per Torsades/Polymorphic V-Tach [C-XXXX]**
    - Do NOT administer medications that slow the AV node (i.e. beta-blockers or calcium channel blockers (e.g., Diltiazem).
    - **2025 AHA Guidelines: Avoid Amiodarone (or similar medications) with preexcitation syndromes.**

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NOTES (*continued*):

- Wide-complex Rates 100-150:
  - Consider a “normal” rhythm with a chronic bundle-branch block (BBB)
  - Consider close observation and/or fluid bolus rather than immediate treatment with an antiarrhythmic medication.
  - Regular = consider sinus tachycardia with BBB (should see P-waves)
    - Consider/treat underlying condition causing the sinus tach (see *below*).
  - Irregular = consider new-onset or chronic A-fib (irregular without P-waves)
    - A-fib with a rapid ventricular response may be pathologic OR may be is a sign of an underlying disturbance (similar to sinus tachycardia).
    - If chronic A-fib with tachycardia, consider underlying cause as above.
    - If **known history of A-fib and BBB** with WCT <150, you may consider treatment with diltiazem as per Narrow-Complex Tachycardia [C-07].

- Causes of elevated heart rate (i.e. sinus tach or chronic A-fib with elevated rate)
  - If pain-induced, treat per Pain Management guideline [**RX-02**].
  - If substance-abuse related (meth, cocaine, etc.), treatment is with benzodiazepines per the Severe Agitation/Delirium [**P-01**]/Sedation guideline [**RX-03**].
  - Other worrisome causes stimulating increased cardiac output include sepsis, pulmonary embolism, dehydration, etc. Most should be initially treated with a fluid bolus unless signs of pulmonary edema are present.
  - Trauma: consider hemorrhage or tension pneumothorax.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.
- Maximum dose of antiarrhythmic should be given before changing antiarrhythmic (if applicable).