

SUPRAVENTRICULAR TACHYCARDIA															
ADULT	PEDIATRIC ($\leq 34\text{Kg}$)														
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 	Same as Adult														
ALS															
<p>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>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>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>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"> 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 Synchronized/Unsynchronized Sequences (if synchronized mode is unable to capture use unsynchronized cardioversion) Use manufacturer recommended energy settings if different from below 															
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