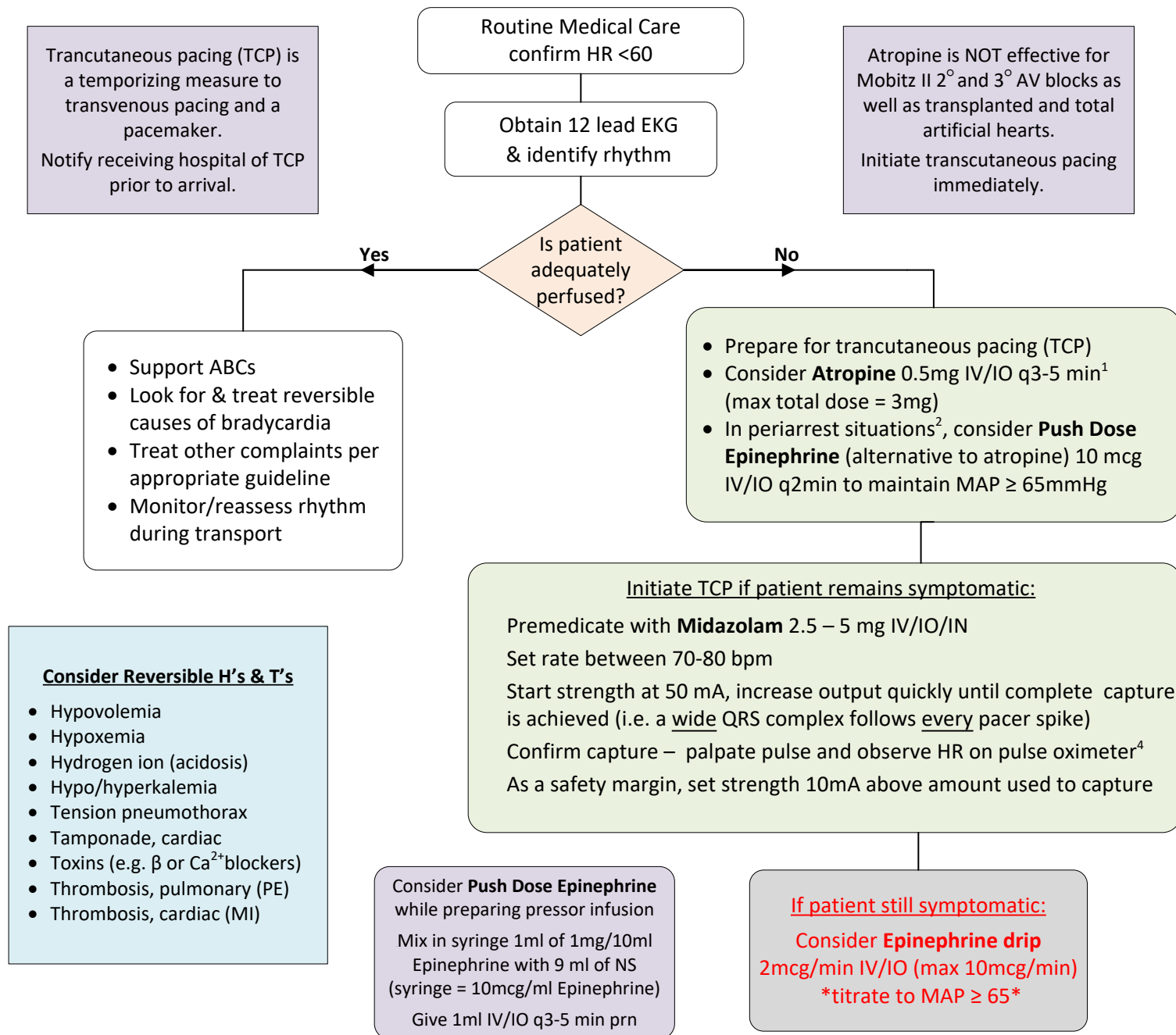


Bradycardia

This Protocol is intended for symptomatic patients

(e.g. altered LOC, chest pain, pulmonary edema, seizure, syncope, shock, pallor, diaphoresis)

Bradycardic individuals who are perfusing well and do not have symptoms usually do not require emergency treatment.



The differential diagnosis for bradycardia is broad - consider MI, hypoxia, pacemaker failure, hypothermia, overdose, cholinergic agents, head injury with increased ICP, stroke, spinal cord lesion, hyperkalemia, sick sinus syndrome, AV blocks, sinus bradycardia, athleticism.

¹ Do not delay pacing in order to administer atropine. Caution using atropine in the setting of acute MI; most cases of bradycardia during STEMI are due to heart block and may involve the right ventricle. Pacing +/- epinephrine is preferred in these instances.

² Bradycardic periarrest occurs when patients are in a decompensated state with progressive instability and deteriorating vital signs. These patients require emergent therapy to avert progression to full arrest. Start with aggressive treatments in these patients.

³ If patient is alert, explain to them the procedure you are about to do. Look for a wide QRS complex with tall, broad T-waves as a sign of successful capture; do not be fooled by pacing artifact and false capture. Document the time, rate, current, and response to treatment.

⁴ During TCP, the monitor's heart rate reading should not be considered reliable. Use the heart rate on the pulse oximeter. If unable to obtain a heart rate, look for other signs and symptoms to determine if patient's perfusion is improving.