Pediatric Bradycardia

History
- Past medical history
- Foreign body exposure
- Respiratory distress or arrest
- Apnea
- Possible toxic or poison exposure
- Congenital disease
- Medication (maternal or infant)

Signs and Symptoms
- Decreased heart rate
- Delayed capillary refill or cyanosis
- Mottled, cool skin
- Hypotension or arrest
- Altered level of consciousness

Differential
- Respiratory failure
- Foreign body
- Secretions
- Infection (croup, epiglottitis)
- Hypovolemia (dehydration)
- Congenital heart disease
- Trauma
- Tension pneumothorax
- Hypothermia
- Toxin or medication
- Hypoglycemia
- Acidosis

Universal Patient Care Protocol

Pediatric Airway Protocol

Poor perfusion
- Decreased blood pressure
- Respiratory insufficiency

Yes
- IV Protocol
  - Normal Saline Bolus
  - May Repeat

No
- Monitor and Reassess

Consider
- D10 or Glucagon (if no IV)
- NS bolus
- Naloxone

Notify Destination or Contact MC

Consider External Cardiac Pacing
Consider Glucagon for suspected Beta-Blocker Toxicity
Consider Calcium for Calcium Channel Blocker Toxicity

Legend
- MR
- B EMT B
- I EMT-I I
- P EMT-P P
- M Medical Control M

Pearls
- Recommended Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Use Broselow-Luten Tape for Drug Dosages.
- Infant = < 1 year of age
- The majority of pediatric arrests are due to airway problems.
- Most maternal medications pass through breast milk to the infant.
- Hypoglycemia, severe dehydration and narcotic effects may produce bradycardia.
- Pediatric patients requiring external transcutaneous pacing require the use of pads appropriate for pediatric patients per the manufacturers guidelines.
- Minimum Atropine dose is 0.1 mg IV.