Supraventricular Tachycardia

**History**
- Medications (Aminophylline, Diet pills, Thyroid supplements, Decongestants, Digoxin)
- Diet (caffeine, chocolate)
- Drugs (nicotine, cocaine)
- Past medical history
- History of palpitations / heart racing
- Syncope / near syncope

**Signs and Symptoms**
- HR > 150/Min
- QRS < .12 Sec (if QRS >.12 sec, go to V-Tach Protocol)
- If history of WPW, go to V-Tach Protocol
- Dizziness, CP, SOB
- Potential presenting rhythm
  - Atrial/Sinus tachycardia
  - Atrial fibrillation / flutter
  - Multifocal atrial tachycardia
- Adenosine

**Differential**
- Heart disease (WPW, Valvular)
- Sick sinus syndrome
- Myocardial infarction
- Electrolyte imbalance
- Exertion, Pain, Emotional stress
- Fever
- Hypoxia
- Hypovolemia or Anemia
- Drug effect / Overdose (see HX)
- Hyperthyroidism
- Pulmonary embolus

**Legend**
- MR
- B
- EMT
- I
- P
- M

**Universal Patient Care Protocol**

**Pre-arrest**
- (No palpable BP, Altered mental status)

**Stable**
- 12 Lead ECG

**Recommended Exam:** Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro

- If patient has history or 12 Lead ECG reveals Wolfe Parkinson White (WPW), DO NOT administer a Calcium Channel Blocker (e.g., Diltiazem) or Beta Blockers.
- Adenosine may not be effective in identifiable atrial flutter/fibrillation, yet is not harmful.
- Monitor for hypotension after administration of Calcium Channel Blocker or Beta Blockers.
- Monitor for respiratory depression and hypotension associated with Midazolam.
- Continuous pulse oximetry is required for all SVT Patients.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.