

Persistent tachycardia with hypotension, ischemic chest pain, altered mental status or shock; HR typically > 150 bpm



Start

1. Call for “ANESTHESIOLOGIST STAT” and CODE CART
2. Turn FiO₂ to 100% and decrease volatile anesthetics
3. Analyze rhythm
 - ▶ WIDE complex, IRREGULAR → Treat as VF, go to CHKLST CAV
 - ▶ Otherwise → prepare for cardioversion
4. Terminate or delay procedure if possible
5. Prepare for immediate **SYNCHRONIZED CARDIOVERSION**
 - ▶ Place 3 lead EKG (if needed) and Pads on chest from defibrillator/cardioverter
 - ▶ Sedate patient if applicable
 - ▶ Turn monitor/defibrillator ON, set to defibrillator mode
 - ▶ Push SYNCHRONIZATION button
 - ▶ Look for spike on R-wave indicating synchronization mode
 - ▶ Adjust, if necessary, until SYNC markers seen with each R wave
6. Cardiovert at appropriate energy level
 - ▶ Determine appropriate energy level using **CARDIOVERSION TABLE** at right
 - Begin with lowest energy level and progress as needed
 - ▶ Select energy level
 - ▶ Press charge button
 - ▶ Press and hold shock button
 - ▶ Check monitor. If tachycardia persists, increase energy level
 - ▶ Engage SYNCHRONIZATION mode after delivery of each shock
7. **Post-Resuscitation Care**
 - ▶ Consider Foley catheter, arterial line, central line
 - ▶ Consider labs → potassium, magnesium, cardiac enzymes
 - ▶ Consider cardiology consult
 - ▶ Consider ICU admission. Call Intensivist and PACU charge RN for bed
8. Consider adenosine for regular narrow complex tachycardia

DRUG DOSES and Treatments

Adenosine 1st dose 6 mg IV rapid push
 2nd dose 12mg IV rapid push
 *** Consider for regular narrow complex tachycardia

BIPHASIC CARDIOVERSION energy levels

CONDITION	ENERGY LEVEL (progression)
Narrow complex, regular (SVT)	50 J → 100 J → 150 J → 200 J
Narrow complex, irregular (AFIB)	120 J → 150 J → 200 J
Wide complex, regular (VT)	100 J → 150 J → 200 J
Wide complex, irregular (VF)	Treat as VF: Go to CHKLST VF ***

Note – some older defibrillators require placement of 3 lead EKG AND pads for synchronized cardioversion

During Resuscitation

Airway: Assess and secure

Circulation: Confirm adequate IV or IO access
 Consider IV fluids wide open

Critical Changes

If cardioversion needed and impossible to synchronize shock, use high-energy unsynchronized shocks.

Defibrillation doses:

Biphasic: 200J (120J or 150J for small stature)

Monophasic: 360 J

If PEA Develops: GO TO » CHKLST CAA

If VF/VT Develops: GO TO » CHKLST CAV