Bradycardia

Medical

CRITERIA

Heart rate less than 60 beats per minute documented by ECG recording **and signs or symptoms of decreased perfusion**, such as:

- Chest pain
- Dyspnea
- Decreased level of consciousness
- CHF
- Hypotension

The patient should be evaluated as a whole and not just by the presence of one of the above symptoms

PROTOCOL

Stable Bradycardia		
EMR	Follow *General – Universal Patient Care/Initial Patient Contact protocol.*	**EMR**
EMT	Monitor cardiac status and obtain 12-Lead ECG, consider right-sided ECG, 15-Lead ECG	**EMT**
Unstable Bradycardia		
I	If time and patient condition permits, administer ***Midazolam (Versed) 2 mg IN/IM/IV/IO***	**I**
I	Consider ***Atropine Sulfate 0.5 mg IV/IO*** every 3 - 5 minutes until signs and symptoms resolve, up to a ***maximum dose of 3 mg***	**I**
I	Activate external pacer; set at 60 BPM, titrate amperage to capture	**I**
[I]	If no response to previous treatments, consider: • **Suspected hypovolemia** – ***20 mL/kg 0.9% Normal Saline, up to 1000 mL bolus***, continuously reassessing need for further fluid administration • **Refractory hypotension** –***Dopamine (Intropin) 2-20 mcg/kg/min infusion*** (**400 mg in *0.9% Normal Saline 250 mL***) titrated to effect • **Impending cardiac arrest** –***Epinephrine infusion 2-10 mcg/min*** (**1 mg of 1:1,000 in *0.9% Normal Saline 250 mL***) titrated to effect	**[I]**

PEARLS

- **DO NOT** delay pacing an unstable patient to obtain IV/IO access
- If capture observed on monitor, use right arm to check for corresponding pulse and blood pressure
- For larger patients (greater than 220lbs) consider anterior-posterior defibrillation pad placement
- Use Atropine cautiously in the presence of acute coronary ischemia or Myocardial Infarction (MI)
- **DO NOT** place combo pads or electrodes directly on top of an Automated Internal Cardiac Defibrillator (AICD), implanted pacemaker or medication patch.