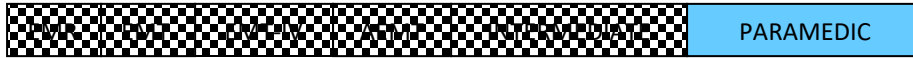


1090 SYNCHRONIZED CARADIOVERSION



Unstable tachyarrhythmia with a pulse

- Check:**
- Apply Defib Pads
 - O₂ via NRB facemask
 - Functioning IV line
 - Suction
 - Advanced airway equipment ready

Sedate with [Lorazepam](#) or [Midazolam](#) if not contraindicated

Perform Synchronized Cardioversion

CONFIRM SYNC IS ON EACH ATTEMPT

Adult	Pediatric
120J, 150J, then 200J	0.5-1 J/kg, 2.0 J/kg

Continue treatment according to [Tachyarrhythmia](#)

Precautions:

If rhythm is AV nodal reentrant tachycardia (AVNRT, historically referred to as "PSVT") it is preferred to attempt a trial of [Adenosine](#)

- prior to electrical cardioversion, even if signs of poor perfusion are present, due to rapid action of [Adenosine](#)
- If defibrillator does not discharge in "synch" mode, then deactivate "synch" and reattempt
- If sinus rhythm achieved, however briefly, then dysrhythmia resumes immediately, repeated attempts at cardioversion at higher energies are unlikely to be helpful. First correct hypoxia, hypovolemia, etc. prior to further attempts at cardioversion
- If pulseless, treat according to [Pulseless Arrest](#)
- Chronic atrial fibrillation is rarely a cause of hemodynamic instability, especially if rate is < 150 bpm. First correct hypoxia, hypovolemia, before considering cardioversion of chronic atrial fibrillation, which may be difficult, or impossible and poses risk of stroke
- Sinus tachycardia rarely exceeds 150 bpm in adults or 180 bpm in children and does not require or respond to cardioversion. Treat underlying causes.
- Transient dysrhythmias or ectopy are common immediately following cardioversion and rarely require specific treatment other than supportive care
- **Ventricular fibrillation and asystole are rare complications of cardioversion and usually occur in the setting of a digitalis toxic patient.**