Wide Complex Regular Tachycardias
Presumed Ventricular Tachycardia

Relatively Stable

Mentating well; good perfusion
No or little chest pain

Monomorphic

Amiodarone
150 mg/over 10 minutes
(preferred for patients with poor LV function)

Or

Procainamide
20 -50 mg/min (to a maximum of 17 mg/kg; stop if hypotension or QRS widens > 50%)
1-4 mg/min infusion rate (after dysrhythmia suppressed)

Torsades
Prolonged Q-T induced Vtach

Magnesium Sulfate
2 gram over 1 minute

Unstable (*Nonpalpable pulse, hypotension,, altered mental status, seizure, pulmonary edema, chest pain, EKG with evidence of ischemia)*

Palpable Pulse:

Sedate, then shock 100 J Biphasic or 200 J Monophasic

Once patient converts: consider loading with **Amiodarone** (150 mg/over 10 minutes)

Or

Procainamide 20 -50 mg/min (to a maximum of 17 mg/kg; stop if hypotension or QRS widens > 50%)

If QT prolonged: **Magnesium** (2 grams IV over 1-2 min)

No Pulse:

Shock 200 Joules - follow pulseless V tach algorithm

Note: Patients with V tach due to a hyper sympathetic state (e.g. alcohol withdrawal or cocaine) should receive high dose benzodiazepines also