Funky Rhythm	Info	Treatment
PVCs	We worry when > 6 per minute, multi-focal, couplets; really bad if it falls on the T wave.	**Amiodarone** used to treat PVCs that are close to the T-wave **Procainamide** can be used to prevent recurrence
Idioventricular Rhythm	Rate 20-40, cardiac output is too low to support metabolic demands, regular rhythm, no P	CPR **Epinephrine** + **Atropine** maybe a pacemaker maybe **Dopamine**
Accelerated Idioventricular Rhythm	Rate 40-100, pt can tolerate this well, fairly common after MI and as a re-perfusion dysrhythmia	**Atropine** High flow O2
Agonal Rhythm	Dying heart, irregular rhythm, rate < 20, funky QRS, no P	CPR **Atropine** **Epinephrine** **Dopamine** Packemaker Intubation
Ventricular Tachycardia (wide)	Rate > 100, usually regular, no P, funky QRS, T wave slopes in opposite direction of QRS	Cardioversion 50-100 *OR* **Amiodarone (push then drip)** *OR* **Lidocaine (push then drip)** **Procainamide** for persistent or recurrent V-tach
Ventricular Tachycardia (narrow)		*if stable...* **Adenosine 6, 6, 12 (limit 18)** *if unstable...* Cardioversion 50-100
Pulseless V-Tach / V-Fib	V-fib is totally chaotic	CPR until defibrillator arrives Defibrillate **Epinephrine** q 3-5 x 3 if shockable, then defibrillate **Amiodarone** OR **Lidocaine** Consider **Magnesium**
Torsades de Pointes	Looks like a party streamer	**IV Magnesium** Defibrillation Maybe epi, amiodarone, lidocaine Isoproterenol if nothing else works

Funky Rhythm	Info	Treatment
Asystole	flat line	CPR **Epinephrine** **Atropine** **Dopamine** Fluid Bolus Pacemaker (if implemented early)
First-degree heart block	the least problematic of the blocks; long PR interval; usually regular rhythm	none
Second-degree heart block, Type I	most difficult to identify; seems erratic; gradual lengthening of PR over 3-4 cycles until the P wave fires and there's no QRS; rate is different between atrium and ventricle; CCB and digitalis can make this worse!	if rate is < 50, **Atropine** most do not require intervention
Second-degree heart block, Type II	can be very dangerous; P waves without QRS, AV node is very sick, rate varies between atrium and ventricle; caused by ischemia, digitalis, BB, anti-arrhythmics; tx is aggressive	**Atropine** Pacing **Dopamine** (if still hypotensive)
Third-degree heart block	aka AV dissociation or complete heart block; very dangerous; no impulses getting through; two different rhythms running, no P before the QRS; no consistent PR interval; caused by ischemia to AV, digitalis, BB, hypoxia	Pacing (then a permanent one) **Dopamine** (if still hypotensive)
Myocardial Infarction	don't forget to push the "button"	Oxygen **Nitro** **Aspirin** **Morphine** *Adjuvants:* **Beta-Blocker** **Anti-PLT (Clopidogrel)** **Anti-Coagulant (Heparin)** maybe **Glycoprotein IIb/IIIa inhib.** **Thrombolytics** if within 6 hr
Angina	pain relieved by rest or nitro; if not, consider MI.	**Nitro**

Black, Joyce M., and Jane Hokanson Hawks. *Medical-Surgical Nursing: Clinical Management for Positive Outcomes - Single Volume (Medical Surgical Nursing- 1 Vol (Black/Luckmann))*. St. Louis: Saunders, 2009. Print.