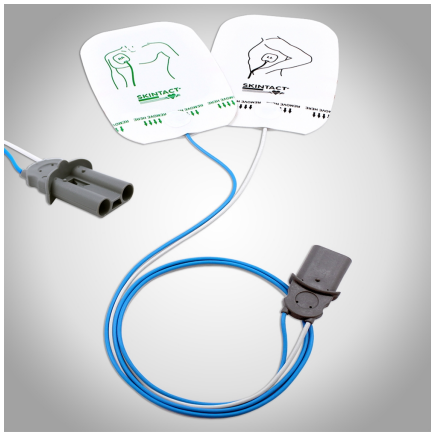
RESUSCITATION
TRANSCUTANEOUS PACING

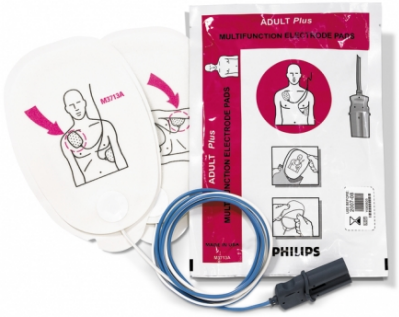
INDICATIONS

- Symptomatic bradycardia unresponsive to atropine – chest pain, hypotension (systolic BP<90 mmHg, reduced GCS, syncope, chest pain, ischaemic ECG, signs of cardiac failure.
- Complete heart block
- Mobitz II heart block (consecutively conducted p waves followed by a p wave with no corresponding QRS complex and PR intervals constant otherwise) with haemodynamic instability
- Asystole
- Failed intrinsic pacemaker

PROCEDURE

- Ensure monitoring has been applied with pulse oximetry, noninvasive BP cuff or an arterial line waveform is available
- Connect defibrillator pads to defibrillator
- Place defibrillator pads in anteroposterior (recommended) or anterolateral position
- Administer sedation with midazolam (or propofol)
- Set defibrillator to pacing
- Current applied starting at 10 milliamps and increasing by 10 milliamp increments
- Continue until electrical capture (usually 50-100mA) - seen as wide QRS complexes
- Target rate normally 60-80 bpm
- Ideal current set at 1.25x what was required for capture





HOW TO TELL IT IS EFFECTIVE

- Improved BP
- Palpable pulse
- Improved GCS (may take time if sedation has been given)
- Improved skin color

PITFALLS

- Skeletal muscle contraction may occur and does NOT suggest electrical or mechanical capture.
- Not adequately increasing the current - should be increased as much as necessary for electrical capture.
- Pacing thresholds may change without warning and capture can readily be lost
- CPR can be performed, if required, despite current with pacing