Clinical Practice Guidelines: 
Cardiac/Tachycardia – narrow complex

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<table>
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<tr>
<th>Date</th>
<th>April, 2018</th>
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<tbody>
<tr>
<td>Purpose</td>
<td>To ensure consistent management of patients with Tachycardia – narrow complex.</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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<td>Information security</td>
<td>This document has been security classified using the Queensland Government Information Security Classification Framework (QGISCF) as UNCLASSIFIED and will be managed according to the requirements of the QGISF.</td>
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Narrow complex tachycardia (NCT) is defined as a heart rate > 100 bpm with a QRS width < 0.12 seconds\(^1\) and can be classified into cardiac or non-cardiac aetiology.

**Cardiac** – usually supraventricular or atrial in origin:
- SVT – Re-entry mechanism caused by:
  - stimulants (e.g. drugs, alcohol, coffee, energy drinks)
  - increase in sympathetic tone
  - electrolyte or acid-base disorders
  - hyperventilation
  - emotional stress or pre-excitation syndromes (e.g. WPW)
- Atrial
  - AF
  - multiple atrial ectopics
  - atrial flutter.

**Non-cardiac** – the presence of a P-wave indicates a sinus tachycardia that can result from:
- pain/anxiety
- hyperthermia/fever
- drug induced
- anaemia
- shock.

**Clinical features**
- Palpitations
- Chest pain and/or discomfort (described as burning, pressure or tightness) often rate related
- Dyspnoea
- ALOC
- Haemodynamic instability

**Risk Assessment**
- Pre-hospital synchronised cardioversion is RARELY required for NCT.
- AF patients (> 24 hour history) are at risk of thrombus formation and therefore if appropriate a delayed approach to synchronised cardioversion should be considered.\(^2\)

**Additional information**
- Modified Valsalva manoeuvre should only be considered for patients with a regular NCT.
Consider:
- Oxygen
- Aspirin (if myocardial ischaemia suspected)
- Modified Valsalva manoeuvre

Note: Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.