

Structured Approach To Assessment Of Bradycardia In ED



Step 1: Is This Patient Critically ill (Unstable)?



Shock exists on a spectrum

Early Signs of Bradycardic Shock Can Be Subtle. Don't Overlook Occult Bradycardic Shock. Compensatory Mechanisms Can Mask shock with Normal BP.

Step 2: Is This Brady "Driving" Clinical Presentation?



- $\$ Drug overdose, e.g., β-blockers, CCBs.
- Solution $\bullet \uparrow$ ICP (Cushing's reflex).

Step 3: Risk Stratify

Where Is The Likely Anatomic Location Causing Bradycardia? Nodal vs Infra-nodal?

ECG Analysis



Read Rhythm On ECG

Electrolytes Lactate Troponin



QRS Width?

- PRi Prolongation?
- Rate of Escape Rhythm?

In Context of AMI ?

lock: Better prognosis, Good response to atropine.

✓ QRS Width < 120 msec
✓ PRi Prolongation before the block
✓ Rate of Escape Rhytm 40 -60 bpm

Infra-nodal Block: Worse prognosis, Poor response to atropine.

QRS Width > 120 msec No/Minimal PRi Prolongation before the block Rate of Escape Rhytm< 40 bpm

Inferior MI: More likely Nodal block Anterior MI: More likely Infra-nodal block

POCUS ---)) RUSH protocol 🎬

M- Morrison's Pouch

H- Heart

A- Aorta

P- Pulmonary

I-IVC

12-Lead ECG

Con R M Con V V

Conditions With High Risk of Progression To Asystole

Recent asystole.Mobitz type II AV block.Complete AV block with wide QRS.

Ventricular pause > 3 seconds