Use cardiac pacing only when there is insufficient cardiac rate to maintain adequate perfusion, and rate is unaffected by atropine (when indicated) and adequate oxygen and ventilation.

Indications

1. Symptomatic bradyarrhythmia (includes A-V block).
2. Patients with witnessed degeneration from a perfusing rhythm into asystole.

Precautions

1. Capture can be difficult in some patients.
2. Patient may experience discomfort; consider sedation.
3. Use the same precautions as with defibrillation.
4. Patients in atrial fibrillation may require higher energy settings for capture than others.
5. Pacing is indicated without Atropine in patients with high degree blocks.

Technique

1. Apply electrodes as per manufacturer specifications: (-) left anterior, (+) left posterior.
2. Turn pacer unit on and select pacing rate at 60-80 beats per minute (BPM).
3. Consider sedation as necessary.
4. Confirm that pacer senses intrinsic cardiac activity by adjusting ECG size. If not, pacer may discharge on an existing complex.
5. Set initial current to 40 mAmps.
6. Increase current 20 mAmps until capture then decrease by 5 mAmps till capture is lost the increase until consistent capture.
7. Check for pulses with capture.
8. If there are no pulses with capture, consider a fluid challenge or vasopressors.
9. If no capture occurs with maximum output, discontinue pacing and resume ACLS.

Notes:

1. V-fib and V-tach are rare complications; follow appropriate protocols if either occurs.
2. Pacing is rarely indicated in patients under the age of 12 years.
3. Muscle tremors may complicate evaluation of pulses. SPO2 pulse with a good waveform is a good sign of success.
4. Pacing may cause diaphragmatic stimulation.