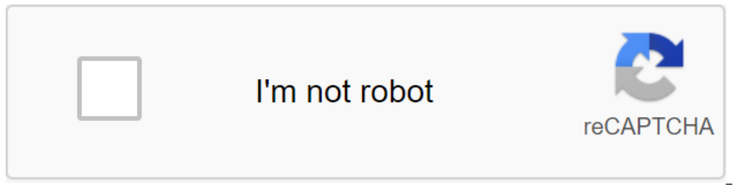
Desfibrilacion y cardioversion pdf



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As Confucius said admirably, No further than the spirit goes, it will never go beyond the heart. Electrical cardioversion consists of transtoracical electrocution of AC. This is a useful procedure in the treatment of various arrhythmias and, despite pharmacological and ablative achievements, cardioversion continues to be the best therapeutic way to restore the sinus rhythm. The term cardioversion implies that discharge is administered by electrocardiographic synchronization, just in the absolute fire-resistant period (peak R-wave), while defibrillation refers to the use of discharge without electrocardiographic synchronization at any time in the heart cycle. Several studies have shown that electric shocks through the chest have been useful for suppressing arrhythmias and, over the years, their use has been expanded to become the main therapeutic tool of modern cardiology. Cardioversy is especially effective at re-entering the dependent tachycardia (atrial flutter, intranodal tachycardia, monomorphic ventricular tachycardia, ventricular flutter and others). The mechanism by which discharge suppresses tachycardia, which depends on several re-entry chains such as FV and FA, is not yet fully understood. It is important to note that electrical cardioversion is not successful in the treatment of arrhythmias that depend on autonomous focus (atrial tachycardia, multifoctal tachycardia of the atrial, etc.) because there is already a previous state of depolarization. But, as Blaise Pascal said, the heart has reasons that the mind ignores. Various studies have shown that electric shocks through the chest have been useful for suppressing arrhythmias and, over the years, their use has been expanded to become the main therapeutic tool of modern cardiology. There are three types of defibrillators depending on the variable used to select the type of discharge, impedance (Ohm), energy (July) or electric current (Amperes). Those based on automatic chest measurement allow for the setting of the energy that will be delivered to this variable, and this approach seems promising. Those based on electric current deliver a set dose of current and have been shown to be successfully equivalent to energy-based defibrillation are the ones using significantly less energy. Finally, the vast majority of current defibrillators are based on the amount of energy that will be supplied for each discharge, which can be adjusted as needed. In that sense, I remember what the great French writer Charles Pinault said The language of the heart is universal: it takes only sensitivity to understand and speak on it. The patient must be informed to his full satisfaction and also had to fast for at least 8 hours. Venous access is required, and all the necessary equipment is ready to initiate basic and advanced cardiopulmonary resuscitation. When everything is ready, analgesia and sedia are given to me, and the action is expected to begin. Before cardioversion, the patient should be pre-saturated with oxygen for 5-10 minutes. The defibrillator is included, the mode (synchronized or out of sync) and the power level are selected. The battery is loaded, the blades are placed with abundant conductive gel, with solid pressure, but without relying on them and checking their proper contact with the skin. In addition, there should be conductive gel on the skin between the two blades. The operator removes the stretcher so as not to have contact with her or the patient and warns all medical equipment with a loud and clear voice when loading. Visually confirmed that there is no physical contact of any team member with the patient or stretcher and 2 discharge buttons are pressed simultaneously. After discharge, success or failure of discharge must be found (patients excluded under CPR, whose compressions should be started immediately after discharge), vital signs are accepted, electrocardiograms and the patient should continue to be monitored until vigilance is fully restored. In the first few minutes of postcardioversion, arrhythmias are common and close observation should be maintained. In the following hours, data on low costs, heart failure or arrhythmia should be monitored, especially in patients with systolic dysfunction. And, for now, let's remember the genius of Albert Einstein, who said that the problem of man is not in the atomic bomb, but in his heart. Indications and energy needs of Toda tachycardia, which produces hemodynamic instability (hypotension, heart failure, impaired alertness, angina data or hypoperfusion) should be treated electrically immediately. The only successful treatment for ventricular fibrillation is defibrillation. Stable, symptomatic and drug-resistant cardiovert arrhythmias are also shown in conditions where tachycardia can lead to deterioration, such as atrial fibrillation associated with acute coronary syndrome. Patients with Wolf Parkinson White syndrome who are accompanied by fibrillation they can develop very high ventricular reactions, so cardioversion is also recommended. Optimal energy levels are still contradictory. They should be high enough to succeed (since recurrence of defibrillation can damage myocardial), but not excessive because they can also be harmful. For these reasons, it is recommended that the amount of energy which will be administered should be minimally effective and no higher than 360 Joules.In of supraventricular arrhythmia, the success of cardioversion is defined as a return to the rhythm of the sinus, while in ventricular fibrillation (VF), success is defined as the cessation of ventricular fibrillation (VF) and the onset of organized rhythm, or asistoia, 5 seconds after discharge, regardless of the discharge. If discharge fails, the energy dose should be increased between discharge and discharge. Atrial fibrillation is the most common cardiovert arrhythmia and is usually required to start with discharges of 100 J in one phase and 25 or 50 J with two-phase. The success of cardioversion ranges from 75 to 90% and back is associated with the duration of arrhythmia. Anticoagulation should be continued in those who are at risk of relapse. Type I atrial flutter meets low energy doses (25 - 50 J with biphase wave or 50-100 J with one phase) and Type II with moderate doses (200 J). Supraventricular tachycardia responds well to vagrancy, adenosine and verapamyl maneuvers, but, if necessary, can be treated with discharges between 25 and 50 J, achieving high success rates, although in some cases high doses are likely associated with deep road location. Antiarty-resistant stable ventricular tachycardia can be a cardiovert with only 25 or 50 J, and this dose is effective up to 90% of cases. Higher doses (100 to 200 J) are generally recommended to avoid the need for repeated discharges. In the case of unstable ventricular tachycardia or ventricular fibrillation, the dose is much higher and recommended from 120 to 200 J with two phases of defibrillator and 300 to 360 J with one phase. In the case of permanent arrhythmias, subsequent discharges can be successful because they reduce transthoracic inaccessibility and, as Moliere said, never penetrate the heart. Factors associated with the success of cardioversion and defibrillation there are several factors that affect the success of cardioversion/defibrillation and usually they can be grouped in: Defibrillator Factors Defibrillation Technique Characteristics of Patient Arrhythmia Service. The duration of arrhythmia (both in atrial fibrillation (FA) and in ventricular fibrillation (VF) determines the degree of organization of electrical impulse and, the longer the duration, the lower the success of discharge. Atrial size is a prediction of the success of cardioversion in atrial fibrillation (FA) and has been shown in animal studies that up to 96% of the energy supplied in each discharge is absorbed by chest structures other than myocardial, so the method of application should be extremely careful to optimize the results. Electrodes can affect the success of cardioversion. Conventionally, they are placed on the front and side of the chest or on the front and back of the chest. While some studies have shown that antero-rear placement is superior, these results have not been widely replicated. The size of the blades is also important, as it is one of the determinants of electric current flow, and it has been shown that the larger the size of the shovel, the greater the success of cardioversion. Blades with a diameter of 12 to 13 cm are recommended to optimize the discharge. The ventilation alters the chest impedance and, in the animal model, is 13% higher in inspiration than in exhalation so if possible, the patient should be asked to exhale before discharge and, as Benjamin Franklin said: the heart of the madman is in the mouth; but the sage's mouth is in the heart. ComplicationsUncomplex cardioversion can be severe and the vast majority can be prevented. They are usually energy dependent and can be physical or even psychological for the patient. At low doses, the risk is low, but at high doses can occur hypotension, arrhythmia and even pulmonary edema, and in such situations let's remember how William Shakespeare said that my crown is in my heart, not in my head. Transitional or intermittent heights of the ST segment were reported after cardioversion in both atrial fibrillation (FA) and ventricular tahirythmia. One study saw a 15% increase in the ST segment and depression of the same segment to 35%, although its clinical impact is questionable. While post-cardioversion height biomarkers of myonecrysis appear to be low, special caution should be done in patients with systolic dysfunction as discharge can cause severe myocardial stun for up to 48 hours, especially in cases of ventricular fibrillation (VF) with CPR. Cardioversion in the case of digital poisoning can lead to ventricular fibrillation (VF), although this is very rare in the absence of signs of poisoning. Cardioembolic risk should be emphasized cardioversion of atrial fibrillation. These phenomena were described in up to 5.3% of patients without anticoagulation versus 0.8% in those who do (47). Embolial risk is high in atrial fibrillation (FA) without anticoagulation, indefinite duration or 48 hours therapeutic oral anticoagulation is currently recommended for at least 3 weeks, allowing dissolution, organization and/or adhesion of preformed blood clots and preventing the formation of new ones. At the same time, a pre-charged transesophageal echocardiogram should be performed to eliminate an intracaviarian clot with special attention in the left atrium and, as Tiberius said, hard hearts are overcome by soft pleas. With proper preparation, vent complications can be minimized, but hypoxia, bronchoa aspiration and other related sedation can occur. The burns are usually superficial, but have been described deeply. The risk is reduced when the gel is properly placed and the hard pressure on the blades is applied. Particular caution should be exercised with different forms of application of nitroglycerin (gel or skin patch) as ignitions have been documented, and as Milan Kundera said: I am underwater and my heartbeat produce circles on the surface. Findings Cardioversion/defibrillation is an extremely important modern cardiology tool for the treatment of various arrhythmias and with a high success rate when properly applied. Diagnosis of the veracity of arrhythmia, including a full medical history and physical examination, is important for identifying the origin of arrhythmia or possible source of complications. The operator must be adequately aware of the technique, basic electrical principles, characteristics of arrhythmia, patient and possible complications in order to get the best results. In addition, all equipment should be available to initiate basic and advanced cardiovascular resuscitation if necessary. No doubt I completely agree with Thomas Jefferson when he stated that the most difficult moments my heart knows are those when he pours his love on a few respected people. 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