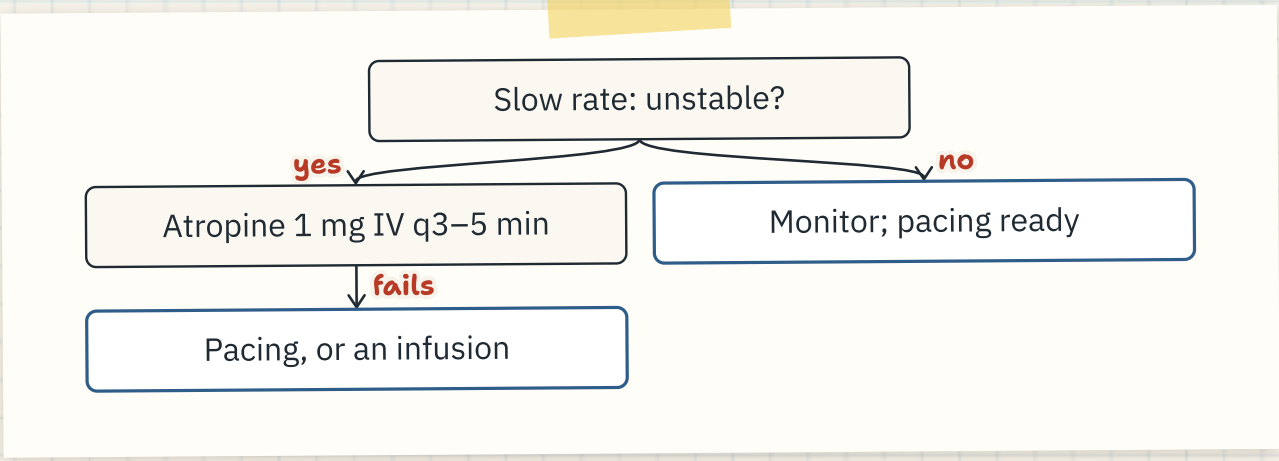
Bradycardia: unstable vs stable

Choose treatment by stability and block type



Step by step

1. Is the patient unstable?
2. Airway, O_2 if low, monitor, IV, 12-lead ECG
3. Hunt for reversible causes
4. Unstable: atropine first
5. Atropine fails: pace or infuse

ATROPINE, US ALGORITHM

1 mg IV, every 3–5 min, max 3 mg

Unstable: atropine first; if it fails, pace, or dopamine 5–20 µg/kg/min, or epinephrine 2–10 µg/min

Block	Key feature	Plan
First-degree	PR over 0.2 s	Usually no treatment
Mobitz I	PR lengthens, then drop	Often benign
Mobitz II	PR constant, sudden drop	Pacemaker
Third-degree, narrow escape	40–50/min, fairly reliable	Monitor, pads ready; pacemaker
Third-degree, wide escape	20–40/min, can fail	Pace; pacemaker

AV block types

Rule of thumb

Node block: vagal, atropine may work

Below the node: atropine will not work

Never let atropine delay pacing

Exam traps

- ! A slow rate alone is not treated; instability is.
- ! Atropine may fail in Mobitz II and complete block.
- ! Anterior MI block: necrosis below the node, straight to pacing.

Bradycardia management: atropine, pacing and AV block types

Video, written lesson, practice question and sources: medservatory.com/usmle-step-2-ck/emergency-acute-care/bradycardia-atropine-pacing-av-block

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