Arrhythmias in Children: Bradycardia and Tachycardia — Diagnosis and Treatment

The most common form of cardiac arrhythmia in children is sinus tachycardia which can be caused by fever. Bradycardia can occur in children due to a depressed sinus node as is seen in hypoxemia, acidosis, or structural heart disease. A complete heart block is another possible cause of a slow heart rate in children. Patients can present with palpitations, presyncope, syncope, dizziness, and confusion. Diagnostic workup should focus on the identification of the exact type of the arrhythmia by performing an electrocardiogram, identifying the etiology, and ordering advanced electrophysiology studies. Treatment should be tailored against the possible etiology of the arrhythmia whenever possible.

Overview

**Bradycardia** can be defined as a heart rate that is slower than the lower limit for a normal heart rate after accounting for the child’s age.

- Infants: < 100 bpm
- Young children (3—9 years): < 60 bpm
- Older children (9—16 years): < 50 bpm

**Tachycardia** is defined as a heart rate that is faster than the upper limit of a normal heart rate for the child’s age.

Bradycardia can be caused by metabolic causes, such as metabolic acidosis, drug-induced or hypoxemia due to depression of the sinus node or a block in the conduction system. Tachycardia can originate from ectopic foci in the atria as seen in atrial ectopic beats, atrial flutter or atrial fibrillation, from the atrioventricular (AV) node as part of re-entrant tachycardia or from the ventricles in the case of ventricular arrhythmias which is the less common cause of arrhythmia in children.
Epidemiology of Bradycardia and Tachycardia in Children

Cardiac arrhythmia is quite common in children with an estimated incidence of 55 per 100,000 children presenting to the emergency department. The most common form of cardiac arrhythmia in children is sinus tachycardia, followed by the collective disorders known as supraventricular tachycardia and finally bradycardia. Atrial fibrillation is rare in children.

Etiology and Pathophysiology of Bradycardia and Tachycardia in Children

The most common form of cardiac arrhythmias in children is sinus tachycardia. Sinus tachycardia can be caused by any febrile illness, can be a consequence to dehydration or can be related to respiratory distress. Atrial fibrillation in children can happen because of atrial dilatation. Atrial dilatation is a possible complication of large atrial septal defects, mitral valve stenosis, or mitral valve insufficiency.

Sinus bradycardia is most commonly caused by hypoxemia. Respiratory failure, inadequate oxygenation of the blood due to congenital heart disease or lung disease, and hypothermia are commonly associated with a depressed sinus node and sinus bradycardia. Metabolic acidosis is another common cause of bradycardia in children.

Patients with increased intracranial pressure due to tumors or other obstructive lesions can present with hypertension and bradycardia, a sign of impending brain tonsillar herniation.

Complete heart block can be an isolated disease in children or can be a complication of structural heart disorders. Cardiac surgery, for instance, catheter-alcohol ablation of the left ventricular wall in hypertrophic cardiomyopathy is a common cause of complete AV block. Maternal history of systemic lupus erythematosus or scleroderma has been also linked to an increased risk of complete heart block in the offspring. Hypothyroidism should be excluded in any child presenting with bradycardia due to AV block.

Infective endocarditis and viral myocarditis can be also associated with bradycardia but are more commonly associated with ventricular arrhythmia. Electrolyte disturbances such as hypocalcemia or hyperkalemia can also cause bradycardia.

The most common cause of ventricular arrhythmia is ventricular fibrosis and scarring. Postoperative ventricular tachycardia can happen as a complication of any heart surgery involving the ventricles. The most common mechanisms for ventricular arrhythmia are reentrant arrhythmia or automatic ventricular pacemakers such as seen in ventricular ectopic beats. Atrial arrhythmia is also caused by spontaneous depolarization and electrical automaticity of the myocardium.
Clinical Presentation of Bradycardia and Tachycardia in Children

Patients with bradycardia might be asymptomatic. The most common symptoms of bradycardia can be explained by decreased cardiac output and include presyncope and syncope, dizziness, confusion, and decreased exercise tolerance. Young children and infants with a complete heart block might present with congestive heart failure.

Patients with ventricular tachycardia or other ventricular arrhythmias usually complain of palpitations, presyncope, syncope, or dizziness and confusion. Respiratory distress is also commonly seen. Sudden cardiac death due to ventricular fibrillation can be the presenting feature of a ventricular arrhythmia especially in children with hypertrophic cardiomyopathy.

Patients who have an ongoing infection or a febrile illness might present with sinus tachycardia. Such patients will complain of palpitations, shortness of breath and other symptoms that are specific to the site of infection. Chest pain can be related to myocarditis and can be associated with ventricular arrhythmia.

The most common presenting feature of supraventricular tachycardia is palpitations followed by dizziness and shortness of breath. These types of arrhythmia are less likely to be associated with syncope.

Finally, patients who have atrial fibrillation might present with symptoms and signs suggestive of the embolic disease, such as ischemic stroke.

Diagnostic Workup for Bradycardia and Tachycardia in Children

The first step in the evaluation of a child presenting with palpitations is to perform an electrocardiogram. The electrocardiogram can help the treating physician in identifying the type of the arrhythmia, and the seriousness of the condition.

Because of the association between myocyte damage and ventricular arrhythmia, it is recommended to check troponins levels in children presenting with suspected myositis as it elevates myocyte damage. A complete blood count is also indicated to exclude anemia, a common cause of sinus tachycardia, leukocytosis which is suggestive of an ongoing infection and an elevated erythrocyte sedimentation rate which is linked to myocarditis or endocarditis.

Patients with a complete heart block should be evaluated for possible Lyme disease. They should undergo a throat swab test and an anti-streptolysin O test to evaluate for a possible strep throat and rheumatic fever.

Patients should also undergo an echocardiography when myocarditis or endocarditis is suspected. Serum electrolytes should be checked. Hypocalcemia has been linked with ventricular arrhythmia and complete heart block. Hyper and hypokalemia are also associated with an increased risk of ventricular ectopic beats and ventricular tachycardia.

Thyroid function tests are indicated to exclude hypothyroidism, a common cause of bradycardia in children. Arterial blood gasses should be assessed because acidosis and hypoxemia have been both linked with bradycardia.
Patients who complain of palpitations but are found to have a normal electrocardiogram might need Holter monitoring. Holter monitoring makes it possible to identify the type of the arrhythmia the child might have.

Finally, cardiac electrophysiology studies are indicated to evaluate the heart for possible abnormal conduction pathways, and automatic ectopic ventricular or atrial paces.

**Treatment of Bradycardia and Tachycardia in Children**

Asymptomatic children with bradycardia should be monitored closely and the cause of the bradycardia should be corrected. For instance, if the child has acidosis, the cause of acidosis needs to be determined and promptly corrected. Symptomatic patients, on the other hand, should be treated with atropine or **isoproterenol**. These drugs should be used temporarily in children with a complete heart block until a permanent pacemaker is implanted.

When the cause of bradycardia is obvious such as hypothyroidism or an electrolyte imbalance, correction of the cause can also be adequate in the treatment of the bradycardia.

Patients with a ventricular arrhythmia should be started on **verapamil** or **diltiazem** especially if the cause of the arrhythmia can be attributed to hypertrophic cardiomyopathy. **Amiodarone** can be also used for the treatment of ventricular arrhythmia in children. It should be noted that the pharmacological treatment of ventricular arrhythmia in children has not be associated with a decreased mortality rate.

Patients with recurrent ventricular tachycardia and hypertrophic cardiomyopathy might be candidates for the implantation of an implantable **cardioverter-defibrillator**. The use of these devices has been proved to be lifesaving in children with hypertrophic cardiomyopathy and has been linked to a decreased risk of sudden cardiac death.

Children who have sinus tachycardia due to dehydration or a febrile illness usually respond well to the treatment of the etiology. For instance, the use of adequate analgesia and antibiotic therapy for an infectious etiology is known to bring down the fever in the child which in turn might correct the sinus tachycardia.

Patients who have frequent atrial arrhythmia or supraventricular tachycardia should be evaluated for possible automaticity of the atria and myocardium. Ablation of the automatic focus might be curative in some patients. Beta-blockers and calcium channel blockers can be also used in the treatment of supraventricular tachycardia but care must be taken to exclude Wolf-Parkinson-White syndrome before the administration of calcium channel blockers such as verapamil. Verapamil has a selective effect on the AV node.

By slowing conduction at the AV node in patients with an accessory atroventricular pathway, conductance is usually improved in the accessory pathway. This can explain the increased risk of ventricular arrhythmias after the use of calcium channel blocks in patients with atrial fibrillation and Wolf-Parkinson-White syndrome.

**Finally, patients with atrial fibrillation should receive digoxin, diuretics, and beta-blockers or calcium channel blockers. Additionally, anticoagulation therapy might be needed to prevent the formation of intramural thrombi within the atria.**
References


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