Clinical Setting: 50 y M with CAD s/p CABG, COPD, cirrhosis who presents from his primary care doctor with an abnormal EKG, palpitations.

HR - 160
BP - 125/66
RR - 20
SpO2 - 93% on RA
Temp - 97.8 F

This is a case of **Ventricular Tachycardia**

This EKG shows a regular wide complex tachycardia. With this, the differential for the rhythm is already pretty narrow - VTach vs SVT(or aflutter) with aberrancy, or sinus tachycardia with aberrancy. I don't see p-waves hidden anywhere, so ST or Aflutter are less likely. There are a ton of rules you can follow when differentiating VT and SVT with aberrancy - however, in the ED, its always safest to assume VT when in doubt, and treat as such.

Some easy things to remember that point to VT - age (older is more likely VT - even older than just 35!), prior ischemic history, very wide QRS (over 160 ms - which this one is over 180 ms), fusion or capture beats, AV dissociation (this is, if you see p waves in various locations throughout the rhythm strip, not coordinating with QRS complexes). See this LITFL post for more in depth look at VT vs SVT.

So with just this patient's history,, VT is overwhelmingly more likely. Add in the initial EKG with very-wide QRS complexes, and a previous EKG with a narrow QRS, and its almost definite. This case was taken from Dr. Smith's blog - see the post below. He had a 2nd EKG performed (see below) with multiple capture beats as well. He received procainamide with resolution of his VT.

http://hqmeded-ecg.blogspot.com/2022/04/an-asymptomatic-man-in-his-50s-with.html