

RESPIRATORY DISTRESS

EMR

- ❑ Routine Medical Assessment and Interventions
- ❑ Obtain Temperature, SpO₂, ETCO₂, and/or CO readings via non-invasive devices as indicated for the situation and when equipment is available.
- ❑ Oxygen as indicated, if SpO₂ is below 94%
- ❑ If foreign body obstruction, follow AHA guidelines for adult choking.
- ❑ Position of comfort for patient
- ❑ If etiology of condition involves potentially hazardous causes (e.g., CO and etc) the toxic exposure guideline should be used in conjunction with this guideline.

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KNOWN ASTHMATICS/COPD:

- ❑ **Albuterol** unit dose – 2.5mg in 3cc ‘pearl’ administer by small volume nebulizer @ 6 to 8 LPM oxygen flow
 - Dose may be repeated as needed q 20 minutes.
- ❑ **Assist with prescribed metered dose inhaler** – administer as indicated on prescription

BRONCHOSPASM/COPD:

- ❑ **CPAP if indicated and available** – set pressure to approximately **2-5 cmH₂O**

CHF/PULMONARY EDEMA/PNEUMONIA:

- ❑ **CPAP if indicated and available** – set pressure to approximately **2-10 cmH₂O**

EMT

AEMT

- ❑ Initiate vascular access as needed and indicated

BRONCHOSPASM/COPD:

- ❑ Administer nebulized bronchodilator
 - **Duo-neb** unit dose “pearl” - nebulized via SVN in 3mL total solution. May repeat q 10 minutes x 2 for total of 3 doses. Defer to **Albuterol** – as above, if patient is taking Spiriva or has peanut allergy.

PNEUMONIA:

- ❑ May consider nebulized bronchodilator
 - **Albuterol** unit dose – 2.5mg in 3cc ‘pearl’ administer by small volume nebulizer @ 6 to 8 LPM oxygen flow
 - Dose may be repeated as needed q 20 minutes.
- ❑ Consider administration of **Normal Saline 250mL bolus** as needed.

AEMT

EMT-I

- ❑ Obtain ECG as needed and indicated

CHF/PULMONARY EDEMA:

- ❑ **NTG 0.4 mg SL** repeated q 3-5 min, titrated to effect and BP >100 systolic. If more than 4 doses required contact **Medical Control**.

BRONCHOSPASM/COPD:

- ❑ If severe bronchospasm, unresponsive to nebulized bronchodilator, may consider **Epi 1:1,000 0.3 mg IM**
 - If patient <50 years, and no cardiac history. May repeat q 10 min one time. If patient age >50, **contact OLMC** for Epi orders. If more than 2 doses of Epi needed, **contact OLMC**.

EMT-I

RESPIRATORY DISTRESS CONT.

BRONCHOSPASM/COPD:

- ❑ If severe & continued bronchospasm, unresponsive to nebulized bronchodilator and initial dose of IM Epi, may consider **Epi drip at 0.4 mcg/min**, titrate to effect, max 10 mcg/min (where available).
- ❑ When available, administer **Solu-Medrol, 125 mg IV/ IM** following reversal of bronchospasm.
 - **Contact OLMC** for patients >50 years old or who have a history of coronary artery disease.

CHF/PULMONARY EDEMA

- ❑ Where available: **NTG IV drip** (200mcg/mL), begin at **10 mcg/min**, q 5 min, max 100 mcg/min, titrate to BP >100 systolic and resolution of dyspnea. **Contact OLMC for higher drip rate.**

PARAMEDIC

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Clinical Care Pearls

- ❑ Respiratory distress is a common and often life threatening complaint in the pre-hospital setting. Providers should use every tool available to select the appropriate treatment regime. Providers should also continually be aware that many conditions create a symptom of respiratory distress without a disease process of the lungs themselves.
- ❑ Consider the following differential diagnoses while assessing respiratory complaints.
 - Bronchospasm – (asthma, emphysema, bronchitis, COPD), CHF, Pneumonia, AMI, ARDS, Pneumothorax – (simple, tension, and spontaneous), PE, Psychosomatic / Anxiety, Metabolic, Anaphylaxis, Trauma, Croup
- ❑ Concurrent preparation for ETI should occur in every patient placed on CPAP.
- ❑ Patients receiving CPAP who continue or abruptly deteriorate should be immediately evaluated for pneumothorax.
- ❑ To prepare Epi drip mix 8 mg Epi 1:1000 in 1000 ml NS (concentration = 8 mcg/mL)