

RESPIRATORY DISTRESS - PEDIATRIC

EMR	<ul style="list-style-type: none"> ❑ 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. ❑ 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. 	EMR
EMT	<p>KNOWN ASTHMATICS:</p> <ul style="list-style-type: none"> ❑ Albuterol unit dose – 2.5mg in 3cc ‘pearl’ administer by small volume nebulizer @ 6 to 8 LPM oxygen flow <ul style="list-style-type: none"> ○ Dose may be repeated as needed q 15 minutes. ❑ Assist with prescribed metered dose inhaler – administer as indicated on prescription <p>BRONCHOSPASM:</p> <ul style="list-style-type: none"> ❑ CPAP if indicated and available – set pressure to approximately 2-5 cmH₂O ❑ If suspected allergic reaction may consider 0.01mg/kg Epi 1:1000 IM – See allergic reaction guideline. 	EMT
AEMT	<ul style="list-style-type: none"> ❑ Initiate vascular access in those patients in extreme distress. Consider withholding so as not to further agitate the pediatric patient and worsen distress. ❑ May consider administration of Normal Saline 10 – 20ml/kg for those patients who’s respiratory distress may be caused by dehydration and/or other volume losses. <p>BRONCHOSPASM:</p> <ul style="list-style-type: none"> ❑ Administer nebulized bronchodilator <ul style="list-style-type: none"> ○ Duo-neb unit dose - 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. 	AEMT
EMT-I	<ul style="list-style-type: none"> ❑ Obtain ECG as needed and indicated <p>BRONCHOSPASM:</p> <ul style="list-style-type: none"> ❑ If severe bronchospasm, unresponsive to nebulized bronchodilator, may consider Epi 1:1,000 0.01 mg/kg IM 	EMT-I
PARAMEDIC	<p>BRONCHOSPASM:</p> <ul style="list-style-type: none"> ❑ 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. <p>CROUP:</p> <ul style="list-style-type: none"> ❑ Consider nebulized Epi 1:1000 0.5 ml/kg (max 5ml) in patients with moderate to severe symptoms contact OLMC. ❑ When available, administer Solu-Medrol, 2 mg/kg IV/IO or IM max of 125mg following reversal of bronchospasm. 	PARAMEDIC

RESPIRATORY DISTRESS – PEDIATRIC CONT.

Clinical Care Pearls

- ❑ Bronchiolitis is most common in children < 2 years of age, and may be indistinguishable from asthma.
- ❑ Epiglottitis is caused by bacterial influenza, typically effects 3-8 year olds and is usually accompanied by high fever. Patients will not talk, eat, or drink, and may be drooling, as their epiglottis is swollen to the point of blocking the trachea. Avoid manipulation and transport to the ED for care.
- ❑ Croup is characterized by barking cough and is the most common infectious disease in children. Croup is a viral infection of the larynx which typically affects children between the ages of 6 months to 3 years. Albuterol and/or Duoneb are unlikely to be helpful unless patient is additionally a known asthmatic.
- ❑ Concurrent preparation for ETI should occur in every patient placed on CPAP.