

# **Pediatric Asthma Respiratory Distress**

### **History**

- Time of onset •
- Possibility of foreign body •
- Past Medical History
- Medications
- Fever / Illness .
- Sick Contacts ٠
- History of trauma •
- History / possibility of choking •
- Ingestion / OD
- Congenital heart disease



- Wheezing / Stridor / Crackles / Rales
- Nasal Flaring / Retractions / Grunting •
- **Increased Heart Rate**
- AMS •

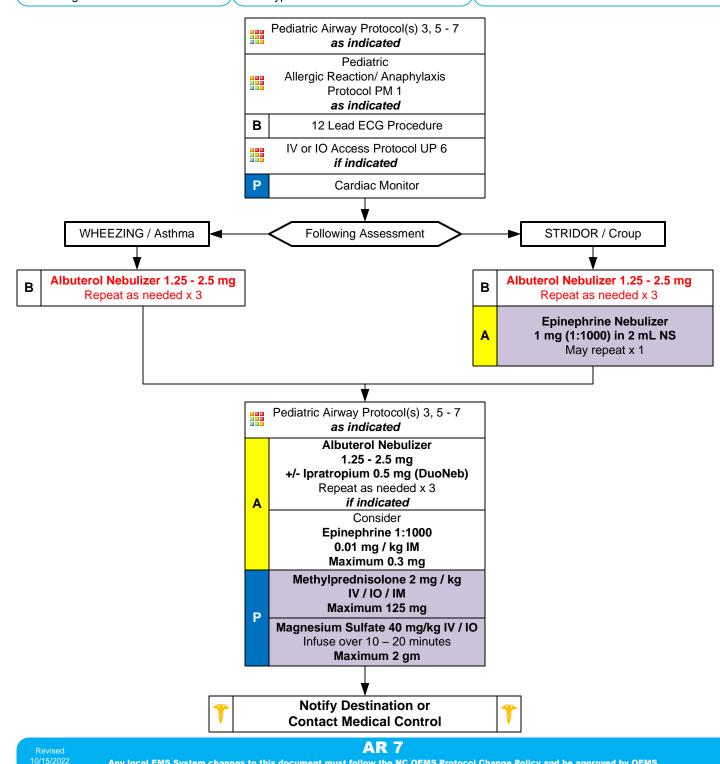
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- Anxiety •
- Attentiveness / Distractability
- Cyanosis •
  - Poor feeding
- • JVD / Frothy Sputum
- Hypotension

#### Differential ٠

- Asthma / Reactive Airway Disease
- Aspiration •
- Foreign body
- Upper or lower airway infection
- Congenital heart disease
- OD / Toxic ingestion / CHF ٠
- Anaphylaxis .
- Trauma





## Pediatric Asthma Respiratory Distress

#### Pearls

- Recommended Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro
- Items in Red Text are key performance measures used to evaluate protocol compliance and care.
- This protocol includes all patients with respiratory distress, Asthma, Reactive Airway Disease, croup, or bronchospasm.
- Patients may also have wheezing and respiratory distress with viral upper respiratory tract infections and pneumonia.
- Pulse oximetry should be monitored continuously and consider End-tidal CO2 monitoring if available.
- Paramedics can administer Methylprednisolone to Pediatric patients. Even when on a AEMT Certified Ambulance.
- <u>Combination nebulizers containing albuterol and ipratropium (DuoNeb):</u>
   Patients may require more than 3 nebulizer treatments, treatments should continue until improvement.
   Following 3 combination nebulizers (DuoNeb), it is preferable to continue albuterol solely with subsequent treatments as there is no proven benefit to continual use of ipratropium.
- Epinephrine:
  - If allergic reaction or anaphylaxis is suspected, give immediately and repeat until improvement. If allergic reaction is not suspected, administer with no improvement and/ or impending respiratory failure.
- Consider Magnesium Sulfate with impending respiratory failure and/ or no improvement.
- Consider IV access when Pulse oximetry remains ≤ 92 % after first beta-agonist nebulizer treatment.
- Do not force a child into a position, allow them to assume position of comfort, typically the tripod position.
- Bronchiolitis is a viral infection typically affecting infants which results in wheezing which may not respond to beta agonists. Consider Epinephrine nebulizer if patient < 18 months and not responding to initial beta agonist treatment.
- Croup typically affects children < 2 years of age. It is viral, possible fever, gradual onset, no drooling is noted.
- Epiglottitis typically affects children > 2 years of age. It is bacterial, with fever, rapid onset, possible stridor, patient wants to sit up airway open, drooling is common. Airway manipulation may worsen the condition.
- In patients using levalbuterol (Xopenex) you may use Albuterol for the first treatment then use the patient's supply for repeat nebulizers or agency's supply.
- A silent chest in respiratory distress is a pre-respiratory arrest sign.
- EMR/EMT:
  - The use of Epinephrine IM is limited to the treatment of anaphylaxis and may be given only by autoinjector, unless manual draw-up is approved by the Agency Medical Director and the NC office of EMS. Administration of diphenhydramine is limited to the oral route only.
- EMT administration of beta-agonist is limited to only patients currently prescribed the medication, unless Agency Medical Director and the NC office of EMS.
- Agency Medical Director may require contact of medical control prior to EMT/ EMR administering any medication(s).

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