Respiratory Distress/Bronchospasm

For COPD/asthma exacerbations and any bronchospasms/wheezing not from pulmonary edema

**History**
- Asthma
- COPD – chronic bronchitis, emphysema
- Home treatment (e.g., oxygen or nebulizer)
- Medications (e.g., Theophylline, steroids, inhalers)
- Frequency of inhaler use

**Signs and Symptoms**
- Shortness of breath
- Pursed lip breathing
- Decreased ability to speak
- Increased respiratory rate and effort
- Wheezing or rhonchi/diminished breath sounds
- Use of accessory muscles
- Cough
- Tachycardia

**Differential**
- Asthma
- Anaphylaxis
- Aspiration
- COPD (emphysema or bronchitis)
- Pleural effusion
- Pneumonia
- Pulmonary embolus
- Pneumothorax
- Cardiac (MI or CHF)
- Pericardial tamponade
- Hyperventilation
- Inhaled toxin (e.g., carbon monoxide, etc.)

**Breathing adequate?**
- Yes
  - Apply Oxygen to maintain goal SpO₂ ≥ 92%
  - Airway support
  - Cardiac monitor
  - Consider, 12-Lead ECG
  - Consider, EtCO₂ monitoring
  - Establish IV/IO

- No
  - Respiratory Arrest/Respiratory Failure

**Wheezing**
- Consider, CPAP
- Albuterol
- Decrease LOC or unresponsive to Albuterol, Epinephrine 1:1,000 IM

**Stridor**
- Consider, CPAP
- Albuterol
- Epinephrine 1:1,000 nebulized

**Other systemic symptoms**
- Exit to Anaphylaxis

**Notify receiving facility. Consider Base Hospital for medical direction**
Pearls

- A silent chest in respiratory distress is a pre-respiratory arrest sign.
- Patients receiving epinephrine should receive a 12-Lead ECG at some point in their care in the prehospital setting, but this should NOT delay the administration of Epinephrine.
- Pulse oximetry monitoring is required for all respiratory patients.