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 or Albuterol MDI with spacer or Levalbuterol
- Decrease LOC or unresponsive to Albuterol/Levalbuterol, Epinephrine 1:1,000 IM

Stridor
- **Consider, CPAP**
- Albuterol or Albuterol MDI with spacer or Levalbuterol
- Epinephrine 1:1,000 nebulized

Other systemic symptoms
- **Exit to Anaphylaxis**

Notify receiving facility.
- Consider Base Hospital for medical direction
San Mateo County Emergency Medical Services

Respiratory Distress/Bronchospasm

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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.

Factors Affecting EtCO₂

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<th>Causes of Decreased EtCO₂</th>
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<td>RESPIRATORY SYSTEM</td>
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<td>Increased cardiac output</td>
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