

RESPIRATORY DISTRESS - PEDIATRIC

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Information Needed:

- Onset, duration of symptoms
- History of choking, foreign body aspiration, fever, sore throat, sputum production, asthma, exposures (allergens, toxins, smoke), trauma
- Medications
- Utilize the Broselow Tape to measure length and then SMC Pediatric Reference Card for determination of drug dosages, fluid volumes, defibrillation/cardioversion joules and appropriate equipment sizes.

Objective Findings:

- Stridor
- Grunting
- Nasal flaring
- Cyanosis or central cyanosis
- Apnea, bradypnea, tachypnea
- Accessory muscle use
- Drooling
- Wheezing
- Weak, ineffective cough
- Choking
- High-pitch sounds or no sounds during inhalation
- Bradycardia
- Altered mental status
- Absent breath sounds
- Pulse oximetry

Treatment:

- Routine medical care
- Ensure ABC's, oxygenation, ventilation; suction as needed
- Oxygen via blow-by, mask, or high flow as needed; assist ventilations with BVM as needed.
- If a basic airway cannot be established, consider foreign body airway obstruction (FBAO)

Partial Obstruction

- Initiate BLS maneuvers for FBAO following American Heart Association standards

Full Obstruction

- If BLS measures fail, then proceed to Magill Forceps and direct laryngoscopy
- Ensure airway positioning and seal on the BVM. Ventilate and reassess
- Continue BLS measures and Magill forceps enroute to hospital

Lower Airway (Wheezing/Bronchoconstriction)

- Position of comfort
- For mild distress:
 - Inhaled albuterol via nebulizer, repeat as necessary
 - For moderate to severe distress (any of the following: cyanosis, accessory muscle use, inability to speak >2 words, severe wheezing or SOB), inhaled albuterol via nebulizer. Repeat nebulized treatments as necessary
- If in severe distress:
 - Epinephrine (1:1,000) IM
 - Epinephrine IM should be administered prior to attempting IV/IO access and may be repeated in 5 minutes if IV/IO not yet established and patient is still in distress. For further doses, contact Pediatric Base Hospital Physician.
- If the tidal volume is decreased, administer Albuterol via in-line BVM

Suspected Epiglottitis

- Position of comfort
- Avoid invasive procedures or agitation
- Do not manipulate the airway for examination
- Blow-by oxygen as tolerated
- Transport quickly to the closest appropriate ED

Croup

- Position of comfort
- Consider nebulized saline treatment

Precautions and Comments:

- Nebulized albuterol can be administered continuously.
- Consider respiratory failure when a child has a history of increased work of breathing but now presents with altered appearance and a slow or normal respiratory rate without retractions.
- It is important to allow parent or caregiver to interact with child as much as possible in order to avoid unnecessary agitation or stress. Whenever

possible allow them to hold the infants and children and assist with treatments.