2040 PEDIATRIC WHEEZING

EMR | EMT | EMT-IV | AEMT | INTERMEDIATE | PARAMEDIC

Pediatric Respiratory Distress protocol

Assess: Respiratory rate, lung sounds, accessory muscle use and mental status

Assess: SpO_2

Ascertain cause of wheezing before initiating specific therapy

Initial best indicator is age. If patient ≤ 2 years old, bronchiolitis is most likely. Age > 2 reactive airways disease is more likely.

Although bronchiolitis and asthma are the most common causes of wheezing in infants and children, respectively, you should consider pulmonary and non-pulmonary causes of respiratory distress, especially if patient not responding as expected to treatment:

Examples: pneumonia, pulmonary edema, congenital heart disease, anaphylaxis, pneumothorax, sepsis, metabolic acidosis (e.g.: DKA, toxic ingestion), foreign body aspiration, and croup.

Age ≤ 2 years old

Bronchiolitis most common

- Viral illness characterized by fever, copious secretions and respiratory distress typically seen November through April
- Most important interventions are to provide supplemental oxygen and suction secretions adequately
- Bronchodilators and steroids do not work

- Administer oxygen to obtain saturations > 90% Ref. Oxygen
- Nasal suction
- Transport in position of comfort
- Monitor RR, retractions, mental status

Monitor SpO2

If worsening respiratory distress despite above therapies, re-suction nostrils and assist ventilations with BVM

BLS airway preferred in pediatrics

Age > 2 years old

Asthma most common

Presentation suggests asthma: *wheezing, prolonged expiratory phase, decreased breath sounds, accessory muscle use, known hx of asthma or albuterol use*

Albuterol

DuoNeb (Albuterol + Ipratropium)

May give continuous neb of Albuterol for severe respiratory distress.

Is response to treatment adequate — Yes

No

Severe exacerbation

- Start IV
- Ref. Medical Shock

IM Epinephrine if no response to neb and pt in severe distress

IV Methylprednisolone

Is response to treatment adequate? — Yes

No

Assess for pneumothorax

Assist ventilations with BVM

BLS airway preferred in pediatrics

- Continue monitoring and assessment en route
- Be prepared to assist ventilations as needed
- **Contact Base** for medical consult if deterioration

IV Methylprednisolone

Will help resolve acute asthma exacerbation over hours, without immediate effect. In severe exacerbations, it may be given prehospital but should not be given for mild attacks responding well to bronchodilators.

IM Epinephrine

Is indicated for the most severe attacks deemed life-threatening and not responding to inhaled bronchodilators.

Approved by EMS Medical Director October 1, 2020