Protocol 700-R1: Respiratory Distress

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BLS Treatment

- Treat life threats. (See Procedure 701 *Life Threats*)
- Place patient in position of comfort.
- Observe for signs of severe respiratory distress (Table 1)
  - **Epinephrine** Auto-injector (See Procedure 715 *Epinephrine Auto-Injector*)
    - Warning**:** Obtain Base contact for patients > 50 y/o
    - For draw and inject **Epinephrine** see Special Considerations below
- Prepare for transport/transfer of care.

ALS Treatment

- Treat life threats. (See Procedure 701 *Life Threats*)
- Cardiac Monitor and determine rhythm
- Obtain baseline SpO_2 on room air or baseline O_2 usage
  - Titrate O_2 to main SpO_2 above 94%
- 12 lead EKG *(*See Procedure 706 *12 Lead EKG*)
- Treat in accordance with suspected condition (Table 2)
- Transport/Contact Base Station.

Special Considerations

- Both severe fluid overload and severe bronchospasm may present with diminished lung sounds. Differentiating between conditions should be based on the patient's history.
- **Epinephrine** should be reserved for those patients who are unable to generate adequate tidal volume to deliver aerosolized drugs to their bronchial tree.
- In patients who are experiencing severe bronchospasm, breath sounds may sound clear with no audible wheezing. This is due to decreased tidal volume with little to no air movement. Do not withhold **Albuterol** with these patients.
- Provider should take caution to not get Nitro-Paste on skin.
- EMTs accredited for Optional Scope of Practice per Policy 208 *EMS Responder Scope of Practice* may draw and inject epinephrine in accordance with ALS procedures

Table 1: Signs of Severe Respiratory Distress

ALOC	low SpO_2,
Sig. accessory muscle use	poor skin signs
fatigue	Elevated $EtCO_2$
	inability to speak

Table 2: Treatment Protocols for Respiratory Distress	
Suspected Acute CHF	**Bronchospasm (Diffuse Wheezing)**

• **Nitroglycerine** (**NTG**)
  ○ 0.4 mg sublingual every 2 minutes. Hold if hypotensive (SBP < 90)
  ○ Apply 1 inch **Nitro Paste**. Hold if hypotensive.
• Consider CPAP (See Procedure 710 *Continuous Positive Airway Pressure CPAP*)
• If symptomatic hypotension
  ○ Positioning
  ○ 250ml **Normal saline** fluid bolus.
• If persistent hypotension:
  ○ Push-dose **Epinephrine** 0.5 ml (5 mcg) very slow IV/IO every 3-5 minutes prn SBP < 90. See Procedure 708 *Push-dose **Epinephrine** Mixing Instructions*
  ○ Titrate to maintain SBP > 90mmHg
• Warning: Do NOT administer **NTG** if the patient has taken erectile dysfunction agent within the past 24 hours (i.e., Cialis, Levitra, Viagra, Revatio, Tadalafil, etc.).
	• **Albuterol**: 5 mg via nebulizer
	  ○ Repeat **Albuterol** as needed
	  ○ Obtain base contact if HR >160
	  ○ Hold if chest pain or dysrhythmias
	• If the patient is in severe distress and his/her tidal volume decreased,
	  ○ administer **Albuterol** via in-line CPAP, BVM, or ET
	• If, after all other interventions, the patient's condition remains the same or worsens, consider
	  ○ **Epinephrine** (1:1,000) 1mg/1ml: 0.3 mg IM every 3-5 minutes to a max of 0.6mg.
	• Warning: Base Contact required for **Epinephrine** 1:1,000 (0.3 mg) IM for patients > 50 y/o
	  ○ Exception: Unusual communication delay
	  ○ See Policy *M2 - Allergic Reaction*

Allergic Reaction/ Anaphylaxis	**Smoke Inhalation**
• See Policy *M2 - Allergic Reaction*	• See Policy *R2 – Smoke Inhalation*
Suspected Pulmonary Embolus (PE)	**Decompression Illness**
• Place the patient in a position of comfort • Ensure high flow oxygen	• Left lateral Trendelenburg position (patient on left side, body tilted with head lower than torso) • Transport to ED for stabilization. Do not transport directly to hyperbaric chamber