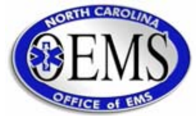
Pediatric Respiratory Distress



History:
- Time of onset
- Possibility of foreign body
- Medical history
- Medications
- Fever or respiratory infection
- Other sick siblings
- History of trauma

Signs and Symptoms:
- Wheezing or stridor
- Respiratory retractions
- Increased heart rate
- Altered level of consciousness
- Anxious appearance

Differential:
- **Asthma**
- **Aspiration**
- **Foreign body**
- **Infection**
  - **Pneumonia**
  - **Croup**
  - **Epiglotitis**
- **Congenital heart disease**
- **Medication or Toxin**
- **Trauma**

Universal Patient Care Protocol

Respiratory insufficiency

Yes → **Pediatric Airway Protocol**

No → Position to patient comfort

Wheezing ?

Yes → **Albuterol** (EMT)

No →

I **IV Protocol if SAO2 < 92%** I

Appropriate dysrhythmia protocol

M **Contact Medical Control** M → I **Consider Epinephrine 1:1000** I

Legend		
	EMT	
I	EMT- I	I
P	EMT- P	P
M	MC Order	M

Pearls:
- **Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro**
- **Pulse oximetry** should be monitored continously if initial saturation is ≤ 96%, or there is a decline in patient status despite normal pulse oximetry readings.
- Do not force a child into a position. They will protect their airway by their body position.
- The most important component of respiratory distress is airway control.
- Croup typically affects children < 2 years of age. It is viral, possible fever, gradual onset, no drooling is noted.
- Epiglottitis typically affects children > 2 years of age. It is bacterial, with fever, rapid onset, possible stridor, patient wants to sit up to keep airway open, drooling is common. Airway manipulation may worsen the condition.