

Michigan ADULT TREATMENT RESPIRATORY DISTRESS

Initial Date: 11/15/2012

Revised Date: 08/11/2023

Section 3-3

Respiratory Distress

For patients < 14 years of age refer to **Pediatric Respiratory Distress-Treatment Protocol**.

- 1. Follow General Pre-hospital Care-Treatment Protocol.
- 2. Allow patient a position of comfort.
- 3. Determine the type of respiratory problem involved.
- 4. Crackles of suspected cardiac etiology or fluid overload (Refer to the **Pulmonary Edema/Cardiogenic Shock-Treatment Protocol**).

CLEAR BREATH SOUNDS:

- 1. Possible metabolic problems, MI, pulmonary embolus, hyperventilation
- 2. Obtain 12-lead ECG (Per MCA selection, may be a BLS or Specialist procedure) follow 12 Lead ECG-Procedure Protocol.

ASYMMETRICAL BREATH SOUNDS:

1. If evidence of tension pneumothorax and patient unstable, consider decompression refer to Pleural Decompression-Procedure Protocol

STRIDOR/UPPER AIRWAY OBSTRUCTION:

- 1. Complete Obstruction:
 - A. Follow Foreign Body Airway Obstruction-Treatment Protocol.
- 2. Partial Obstruction: epiglottitis, foreign body, anaphylaxis, etc.
 - A. Follow Airway Management-Procedure Protocol.
 - B. Consider anaphylaxis see **Anaphylaxis/Allergic Reaction-Treatment Protocol**.
 - C. Transport in position of comfort.

RHONCHI (SUSPECTED PNEUMONIA):

- 1. Sit patient upright.
- 2. Consider CPAP per CPAP-Procedure Protocol.
- S 3. Consider NS or LR IV/IO fluid bolus up to 1 liter, wide open if tachycardia, repeat as needed per Vascular Access and IV Fluid Therapy-Procedure Protocol

CRACKLES):

 Crackles of suspected non cardiac etiology/fluid – follow wheezing, diminished breath sound below. For crackles of suspected cardiac etiology/CHF/cardiogenic shock refer to Pulmonary Edema/Cardiogenic Shock-Treatment Protocol.

WHEEZING, DIMINISHED BREATH SOUNDS (ASTHMA, COPD):

1. Assist the patient in using their own **albuterol** Inhaler, if available

S a. Administer albuterol 2.5 mg/3mL NS nebulized (Per MCA selection may be EMT skill) per Medication Administration-Medication Protocol

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	Nebulized albuterol administration per MCA selection
2 . 3 .	Consider CPAP per CPAP-Procedure Protocol . Administer epinephrine auto-injector (0.3 mg) in patients with impending respiratory failure and unable to tolerate nebulizer therapy,
	MCA Approval of epinephrine auto-injector IM
	MCAs will be responsible for maintaining a roster of the agencies choosing to participate and will submit roster to MDHHS.
§ 4.	Administer epinephrine 1 mg/mL, 0.3 mg (0.3 mL) IM in patients with impending respiratory failure unable to tolerate nebulizer therapy (per MCA selection may be BLS or MFR skill). NOTE: BLS not carrying epinephrine auto-injector MUST participate in draw up epinephrine.
	MCA Approval of draw up epinephrine. MFR BLS Personnel must complete MCA approved training prior to participating in draw up epinephrine. MCAs will be responsible for maintaining a roster of the agencies choosing to
√ 5.	Administer nebulized albuterol 2.5 mg/3 mL NS nebulized and Ipratropium 500 mcg/2.5 mL NS if wheezing and/or airway constriction per Medication
	Administration-Medication Protocol (Per MCA selection may be Specialist skill)
	Nebulized albuterol/ipratropium administration per MCA selection □ Specialist
 €6.	Administer prednisone tablet 50 mg PO to adults and children > 6 years of age (if available per MCA selection)
	Additional Medication Option:
	☐ Prednisone 50 mg tablet PO (Adults and Children > 6 y/o)
	i. If prednisone is not available, patient is \leq 6 years of age, or patient is unable to

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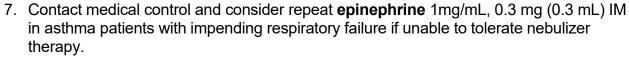
receive medication PO, administer methylprednisolone IV/IO/IM:

a. Adults: 125 mg

b. Pediatrics: 2mg/kg (max 125 mg)









8. Consider **magnesium sulfate** 2gms slow IV in refractory status asthmaticus. Administration of **magnesium sulfate** is best accomplished by adding **magnesium sulfate** 2gm to 100 to 250 mL of **NS** and infusing over approximately 10 minutes.

Medication Protocols

Albuterol
Epinephrine
Ipratropium
Magnesium Sulfate
Methylprednisolone
Prednisone