Initial Date: 8/31/2023
Revised Date: 5/12/2025

Respiratory Distress

For patients < 14 years of age refer to **4.5 Pediatric Respiratory Distress-Treatment Protocol**.

1. Follow **1.1 General Pre-hospital Care-Treatment Protocol.**
2. Allow patient a position of comfort.
3. Determine the type of respiratory problem involved.
4. Refer to the **7.24 End Tidal Carbon Dioxide Monitoring** 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 **7.1 12 Lead ECG-Procedure Protocol**.

ASYMMETRICAL BREATH SOUNDS:

1. If evidence of tension pneumothorax and patient unstable, consider decompression refer to **7.18 Pleural Decompression-Procedure Protocol.**

STRIDOR/UPPER AIRWAY OBSTRUCTION:

1. Complete Obstruction:
   A. Follow **1.10 Foreign Body Airway Obstruction-Treatment Protocol**.
2. Partial Obstruction: epiglottitis, foreign body, anaphylaxis, etc.
   A. Follow **7.9 Airway Management-Procedure Protocol**.
   B. Consider anaphylaxis see **1.6 Anaphylaxis/Allergic Reaction-Treatment Protocol**.
   C. Transport in position of comfort.

RHONCHI (SUSPECTED PNEUMONIA):

1. Sit patient upright.
2. Consider CPAP per **7.5 CPAP-Procedure Protocol.**
3. Consider **NS** or **LR** IV/IO fluid bolus up to 1 liter, wide open if tachycardia, repeat as needed per **7.23 Vascular Access and IV Fluid Therapy-Procedure Protocol.**

CRACKLES:

1. Crackles of suspected cardiac etiology/CHF/cardiogenic shock refer to **5.4 Pulmonary Edema/Cardiogenic Shock-Treatment Protocol**.
2. Crackles of suspected non cardiac etiology/fluid – follow wheezing, diminished breath sound below.

WHEEZING, DIMINISHED BREATH SOUNDS (ASTHMA, COPD):

EMT	PARAMEDIC
1. Assist the patient in using their own **albuterol** Inhaler, if available a. Administer **albuterol** 2.5 mg/3mL NS nebulized (Per MCA selection may be EMT skill) per **9.1 Medication Administration-Medication Protocol. May repeat one time.** Nebulized **albuterol** administration per MCA selection ☒ EMT	1. 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 **9.1 Medication Administration-Medication Protocol** (Per MCA selection may be Specialist skill) Nebulized **albuterol/ipratropium** administration per MCA selection ☒ Specialist 2. Administer **albuterol** 2.5 mg/3mL NS nebulized for ongoing wheezing after albuterol/ipratropium 3. Continue **albuterol** 2.5 mg/3mL NS nebulized every 10 minutes for continued wheezing 4. 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 ≤ 6 years of age, or patient is unable to receive medication PO, administer **methylprednisolone** IV/IO/IM: a. Adults: 125 mg b. Pediatrics: 2mg/kg (max 125 mg)

1. Consider CPAP per **7.5 CPAP-Procedure Protocol**.
2. 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
☒ MFR

MCAs will be responsible for maintaining a roster of the agencies choosing to participate and will submit roster to MDHHS.

3. 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 participate and will submit roster to MDHHS.

4. Contact medical control and consider repeat **epinephrine** 1mg/mL, 0.3 mg (0.3 mL) IM in asthma patients with impending respiratory failure if unable to tolerate nebulizer therapy.
5. 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.

Protocol Source/Reference: Michigan 3.3 Respiratory Distress; Version 8/11/23