Pediatric Respiratory Distress, Failure or Arrest

1. Follow **Pediatric Assessment and Treatment Protocol.**
2. Assess the patient's airway; if the airway is obstructed, refer to **Emergency Airway Procedure**
   A. Consider possibility of partial airway obstruction presents with acute respiratory distress of sudden onset accompanied by fever, drooling, hoarseness, stridor, and tripod positioning.
   B. If unable to ventilate patient after airway repositioning, assume airway obstruction.
3. Allow the patient a position of comfort
4. Titrate oxygen saturation to 94% (Having a parent assist with blow by may be necessary)
5. Airway should be managed by least invasive method possible.
6. Suction as needed if excessive secretions are present.
7. Consider CPAP if available, per **CPAP/BiPAP Procedure**.
8. Do not delay transport for interventions.
9. Attempt vascular access only if necessary for patient treatment.

Suspected Bronchospasm (Wheezing):

1. Assist the patient in using their own Albuterol Inhaler, if available
2. Administer inhaled medications according to **Nebulized Bronchodilators Procedure**.
3. Consider CPAP, if available, per **CPAP/BiPAP Procedure.**
4. In cases of respiratory failure:

   A. If child appears to weigh less than 10 kg (approx. 20 lbs.), contact medical control prior to Epinephrine is psossible

   B. If child weighs between 10-30 kg (approx. 60 lbs.); administer administer Epinephrine 1 mg/mL, 0.15 mg (0.15 ml) IM OR via pediatric epinephrine auto-injector

   C. Child weighing greater than 30 kg; administer Epinephrine 1 mg/mL 0.3 mg (0.3 ml) IM or Epinephrine Auto-Injector.

5. Per MCA selection, if a second nebulized treatment is needed also administer Prednisone **OR** Methylprednisolone

Medication Options:

Prednisone
50 mg tablet PO
(Children 6 and above, if tolerated)

☒ YES ☐ NO

Methylprednisolone
2 mg/kg IV/IO
(Maximum dose 125 mg)

☒ YES ☐ NO

6. For MCA with both selected, Prednisone PO is the preferred medication. Methylprednisolone is secondary and reserved for when a patient can't take a PO medication.
7. If patient is in respiratory failure:
    A. If child appears to weigh less than 10 kg (approx. 20 lbs.), contact medical control prior to Epinephrine if possible.
    B. If child weighs between 10- 30 kg (approx. 60 lbs.); administer Epinephrine 1:1000, 0.15 mg (0.15 ml) IM OR via Pediatric Epinephrine Auto-injector, if available.
    C. Child weighing greater than 30 kg; administer Epinephrine 1mg/ 1mL, 0.3 mg (0.3 ml) IM OR via Epinephrine Auto-Injector, if available.

Suspected Croup:

1. Notes:
    A. Croup is most common in the fall and winter with the onset of symptoms at night.
    B. Croup is most common in children 6 months to 6 years of age.
    C. Patients will likely have a recent history of upper airway infection or fever.
    D. If foreign body is suspected, contact Medical Control prior to administration of epinephrine.
2. Consider humidified oxygen
3. If patient presents with moderate to severe croup, contact medical control, administer Epinephrine per MCA selection:

MCA Selection

☒Racepinephrine 2.25% inhalation solution via nebulizer

Administer by placing 0.5 mL of Racepinephrine 2.25% inhalation solution in nebulizer and dilute with 3 mL of normal saline.

☐ Epinephrine 5 mg (1mg/1ml) nebulized

4. Do not delay transport.
5. Symptom improvement should occur within 10 to 30 minutes.

Respiratory Failure or Arrest:

1. Ventilate the patient using an appropriately sized BVM with supplemental oxygen.
    A. Chest rise is the best indicator of successful ventilation
    B. Ventilate at a rate appropriate for the patient:
        i. Infant: 30 breaths per minute
        ii. Child: 20 breaths per minute
2. Airway management should take place in order of least invasive to most invasive, titrating to effective ventilation and oxygenation.
3. If opioid overdose is suspected, administer Naloxone according to MI-MEDIC cards. If MI-MEDIC is unavailable, administer Naloxone 0.1 mg/kg IV/IO/IN/IM while ventilating with the BVM.