

Pediatric Respiratory Distress



History

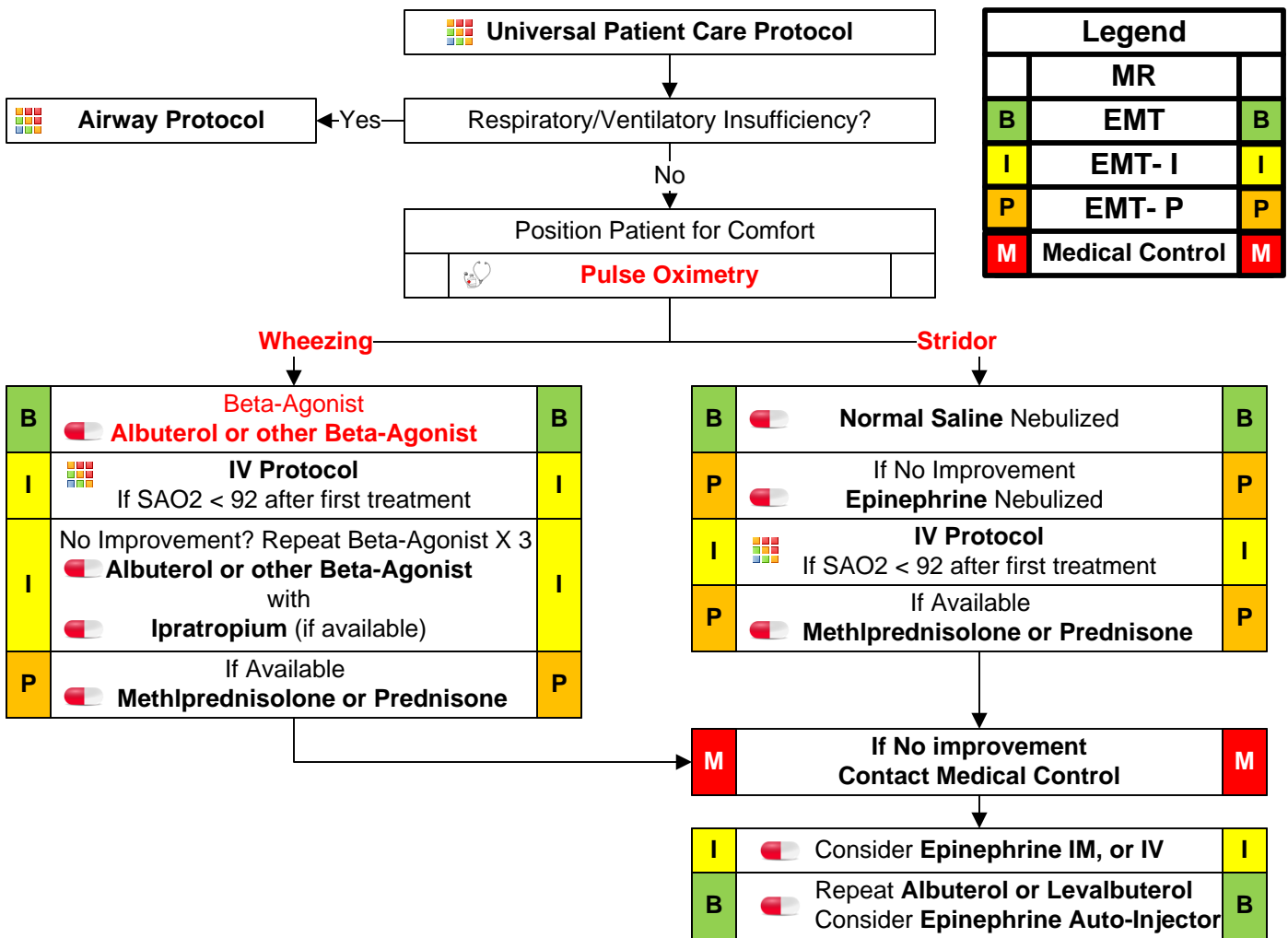
- Time of onset
- Possibility of foreign body
- Medical history
- Medications
- Fever or respiratory infection
- Other sick siblings
- History of trauma

Signs and Symptoms

- Wheezing or stridor
- Respiratory retractions
- Increased heart rate
- Altered level of consciousness
- Anxious appearance

Differential

- Allergic Reaction
- Asthma
- Aspiration
- Foreign body
- Infection
 - Pneumonia
 - Croup
 - Epiglottitis
- Congenital heart disease
- Medication or Toxin
- Trauma



Pediatric and OB Protocols

Pearls

- **Recommended Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro**
- **Items in Red Text are key performance measures used to evaluate protocol compliance and care**
- **Pulse oximetry** should be monitored continuously if initial saturation is $\leq 96\%$, 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.
- Bronchiolitis is a viral infection typically affecting infants which results in wheezing which may not respond to beta-agonists. Consider Epinephrine if patient < 18 months and not responding to initial beta-agonist treatment.
- 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.