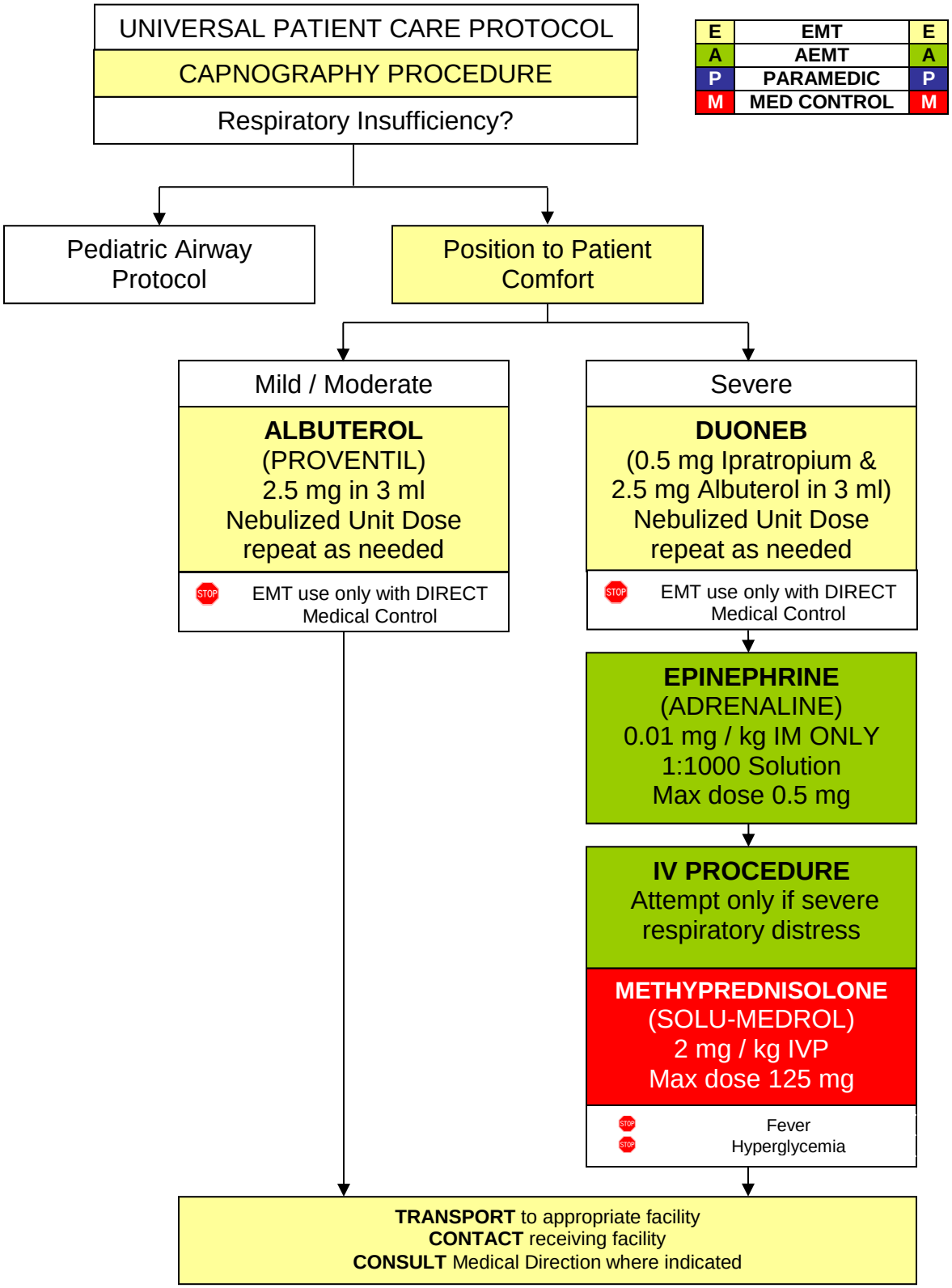
PEDS AIRWAY/RESP : RESPIRATORY DISTRESS LOWER AIRWAY



PEDS AIRWAY/RESP : RESPIRATORY DISTRESS LOWER AIRWAY-Cont.

PEARLS and KEY POINTS

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL
• Time of onset • Possibility of foreign body • Medical history • Medications • Fever or respiratory infection • Other sick siblings • History of trauma	• Wheezing or stridor • Respiratory retractions • Increased heart rate • Altered level of consciousness • Anxious appearance	• Asthma • Aspiration • Foreign body • Infection • Pneumonia • Croup • Epiglottitis • Congenital heart disease • Medication or toxin • Trauma

- **Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro**
- 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.
- DO NOT attempt an invasive airway procedures unless the patient is in respiratory arrest.
- For some patients in severe respiratory distress, wheezing may not be heard. Consider Albuterol (Proventil) and Ipratroprium (Atrovent) for the known asthmatic in severe respiratory distress.
- Stridor, gagging or choking in the breathing patient with respiratory distress may indicate upper airway obstruction.
- Wheezing in the breathing patient with respiratory distress indicates lower airway disease, which may come from a variety of causes. The patient with severe lower airway disease may have altered LOC, be unable to talk, may have absent or markedly decreased breath sounds and severe retractions with accessory muscle use.
- If the patient has signs of respiratory failure, begin to assist ventilations with BVM, even when they are breathing.
- Contact Medical Direction for patients with a cardiac history.