Adult Reactive Airway Disease

**Designation of Condition:** Most commonly associated with asthma, COPD, bronchitis, and bronchiolitis (RSV). For all anaphylactic/allergic reactive airway issues, refer to appropriate guideline. This condition is caused by small, lower airway obstruction usually secondary to hyperactive bronchial smooth muscle constriction (bronchospasm) and/or peribronchial inflammation. Common clinical findings include wheezing, tachypnea, and a prolonged expiratory phase. If airflow is severely compromised, wheezing may be absent and/or the patient may be hypoxic (O2 sat <90%).

**ABC’s**
- Manage airway as necessary
- Oxygen titrated to a saturation of >90%
- **CPAP** as needed
- **Capnography**
- Allow patient to assume a position of comfort
- Administer DuoNeb
  - *(Albuterol 5mg with Ipratropium Bromide 0.5mg)*

**IV/IO**
- Fluids titrated to patient’s condition, max of 20ml/kg

If cyanosis, inability to speak, or respiratory extremis present:
- Administer **Epinephrine 0.3mg 1:1000 IM** and repeat every 5 minutes until clinical improvement

**P**
- Administer **Dexamethasone 10mg IV/IO/PO**
  - SIVP over 2 minutes
- If RAD refractory to **Albuterol**, administer
  - **Magnesium Sulfate 2gm IV/IO over 10 minutes**
- IF continued severe respiratory distress after second IM epi dose consider:
  - **Epi drip:** 2 mcg/min IV/IO infusion, increase 2 mcg/min q 5 min to a max of 10 mcg/min
  - **MINI BOLUS:** 0.5 to 1 cc of 1:100,000 IV/IO every minute as needed

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*****KEY POINT***

**IN CASES OF STATUS ASTHMATICUS GIVE EPI EARLY AND AS OFTEN AS NEEDED FOR CLINICAL IMPROVEMENT**

Reactive airway disease is best managed with **BVM** and **CPAP**. Intubation should not be considered as a first line airway management and should only be considered in pending respiratory arrest.