Respiratory Distress / Failure

REFRESHER

RECOGNIZE IT

- Distress: short of breath, increased rate and effort, accessory muscle use, pursed-lip breathing, difficulty speaking
- Wheeze, rhonchi, fever and cough point toward asthma, COPD, infection, or CHF — keep the wide differential (guideline p.70)
- Failure is distress that is losing: exhaustion, slowing rate, falling SpO2, altered mentation, apnea
- A silent chest in respiratory distress is a pre-respiratory arrest sign (guideline p.71)

ASSESS

- Continuous pulse oximetry and waveform capnography in persistent distress — both required
- Lung sounds, work of breathing, and the recommended exam: mental status, HEENT, skin, neck, heart, lungs, neuro
- Cardiac monitor and 12-lead when indicated — respiratory and cardiac causes overlap
- History: asthma/COPD, CHF, home oxygen, inhalers, steroids, toxic or smoke exposure

ACT — FIRST MOVES

1. Oxygen, monitor, and ventilate early with iGel or BVM if ventilation is inadequate
2. Bronchospasm: albuterol 2.5 mg nebulized (continue as needed) or DuoNeb x1
3. CPAP for the distressed patient who qualifies — BiPAP is always preferred over CPAP when available
4. Severe asthma: consider epinephrine 0.3 mg IM; magnesium sulfate 1–2 g IV/IO and Solu-Medrol 125 mg per guideline
5. If you ventilate: use an extended expiratory phase and minimize PEEP to avoid dynamic hyperinflation
6. Notify the destination or contact Medical Control; reassess continuously

PEARLS

- Caution with epinephrine when the heart rate is 150 or more — get the 12-lead, but never delay the epinephrine for it
- Distress is compensation; failure is fatigue. Treat the trend, not the snapshot
- Nebulized medications may be given by BLS, but ALS should attend the patient in transport when available

Take Home Message:

Distress is compensation, failure is collapse: support early, prefer BiPAP, respect the silent chest, and never let a tiring patient keep working.

[Guideline/Source: Mercy EMS Guidelines pp.70–71]