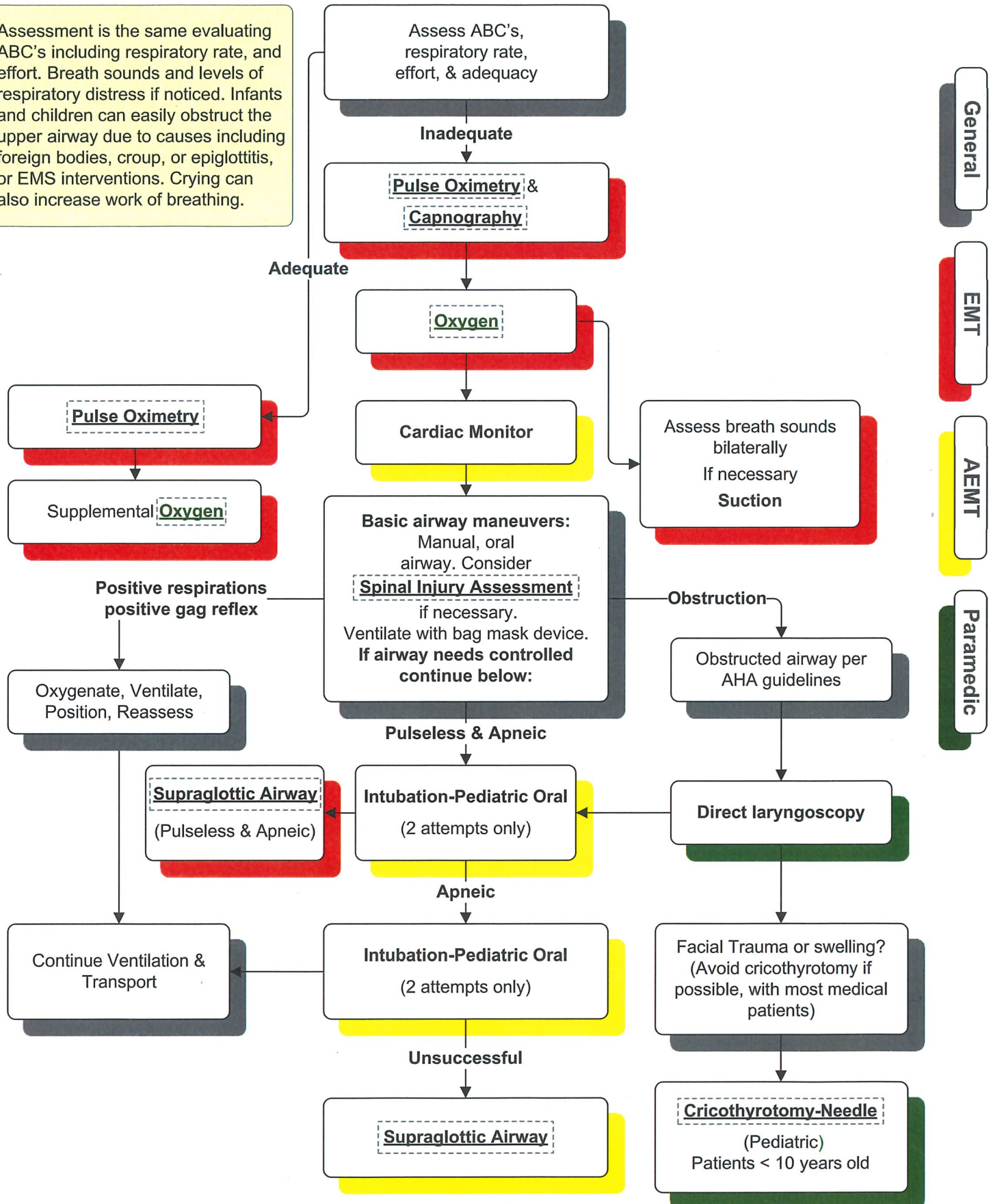


Assessment is the same evaluating ABC's including respiratory rate, and effort. Breath sounds and levels of respiratory distress if noticed. Infants and children can easily obstruct the upper airway due to causes including foreign bodies, croup, or epiglottitis, or EMS interventions. Crying can also increase work of breathing.



Allergic reaction can occur quickly in children due to the small size of the airway. Causes of an allergic reaction can include food, medications, insect stings, pollens and molds.

Routine Transport Orders-Pediatric

Pediatric Airway Protocol

Signs & Symptoms

Hives, rash, itching, nasal congestion, sneezing, throat tightness, hoarseness, coughing, nausea/vomiting, dizziness, tachycardia.

Severe Reaction (Anaphylaxis)

Shortness of breath, chest pain, stridor, syncope, hypotension, unconsciousness, death.

General

EMT

AEMT

Paramedic

Mild/Moderate
Rash only.
No respiratory component.
No tongue, lip,
facial swelling, or hives

Consider

Epinephrine 1:1,000 0.01 ml/kg IM
Maximum 0.3 ml

Diphenhydramine (Benadryl)

1 mg/kg

SLOWLY IVP, IO, IM, PO

*Maximum 25 mg

PO Maximum 50 mg

*Calculator Max. out at 50 mg

Albuterol / Atrovent

2.5 mg & 0.5 mg / 5.5 ml saline
Nebulized. May repeat x 2

(Only administer if airway symptoms)

Reassess patient

Severe
Evidence of impending
respiratory distress or shock

Epinephrine 1:1,000

0.01 ml/kg IM

Diphenhydramine (Benadryl)

1 mg/kg

SLOWLY IVP, IO, IM

Maximum 25 mg

May repeat in 10 minutes

Dexamethasone (Decadron)

0.6 mg/kg IVP, IO, IM, PO

Maximum 10 mg

Assist with Pt's prescribed

Epinephrine Auto-Injector

If wheezing

Albuterol / Atrovent

2.5 mg & 0.5 mg / 5.5 ml saline
Nebulized. May repeat x 2

Cardiac Monitor

Hypotension

Dysrhythmia

Respiratory
Distress

Pediatric Hypovolemic Shock

Protocol

Appropriate
Cardiac Protocol

Pediatric Respiratory Distress (Lower Airway)

Lower Airway includes the trachea below the vocal cords, lungs and bronchioles.

Routine Transport Orders-Pediatric

Common Lower Airway Problems include:
Asthma, Bronchiolitis, Pneumonia.

Cardiac Monitor

Respiratory insufficiency

Yes

No

Pediatric Airway Protocol

Position of patient comfort

Respiratory Distress
(Wheezing)

If received nebulized medications within previous 1 hour.

Epinephrine and MgSO₄ can be given concurrent with EMS nebulized medications.

Albuterol (Proventil) 2.5 mg in 3 ml Saline mixed with
Ipratropium (Atrovent) 0.5 mg 2.5 ml Saline
May repeat in 10 minutes
Dexamethasone (Decadron)
0.6 mg/kg IVP, IO, IM, PO
Maximum 10 mg

Epinephrine 1:1,000

1 mg nebulized
In 2 ml saline
1 time only

Must be transported

If unresponsive to
Albuterol / Atrovent

Epinephrine 1:1,000

0.01 ml/kg IM

Maximum 0.3 ml

If given ET 0.1 ml/kg Max. 0.3 ml

EPINEPHRINE should be withheld in the following situations:

1. No previous history of wheezing
2. Pulse rate greater than 180

If unresponsive to Epinephrine

0.9 NS Fluid Bolus 20 ml/kg

Magnesium Sulfate

50 mg/kg in 100 ml NS over 20 minutes,
IV Infusion. Maximum 2 grams

General

EMT

AEMT

Paramedic

Upper Airway includes the oral and nasal cavities, pharynx, and trachea.

Routine Transport Orders-Pediatric

Cardiac Monitor

**Respiratory insufficiency
Decreased Level of
consciousness**

Yes

No

Pediatric Airway Protocol

Position of patient comfort

Cause of upper airway known?
Is child CALM?

Normal Saline Aerosol 3 ml Saline

Croup

Dexamethasone (Decadron)

0.6 mg/kg IVP, IO, IM, PO

Maximum 10 mg

Epinephrine 1:1,000

1 mg nebulized

In 2 ml saline

1 time only

Must be transported

If child is ventilating obtain complete history prior to a medical intervention*. Keep child with parent, if possible, place child in sitting position. Keep lights and noise to an absolute minimum. If child is showing signs of hypoxia (agitated, restless, etc.) administer **Oxygen** usually by placing O2 connecting tubing directly by their face or through a disposable paper cup. DO NOT cause further agitation or start IV.

Other Clinical Considerations

If child is ventilating obtain complete history prior to a medical intervention*. Keep child with parent, if possible, place child in sitting position. Keep lights and noise to an absolute minimum. If child is showing signs of hypoxia (agitated, restless, etc.) administer **Oxygen** usually by placing O2 connecting tubing directly by their face or through a disposable paper cup. DO NOT cause further agitation or start IV.

General

EMT

AEMT

Paramedic

Isolate

	Epiglottitis	Croup	Foreign Body
Site of Obstruction	Above vocal cords	Below vocal cords	Varies
Cause	Bacterial Infection	Viral infection	Varies
Age range	Generally older child (>2 yrs) but can occur at any age	Younger child (6 months-3 years)	Any (usually under 5 years and in adult years)
Onset	Sudden (6-24 hours), fever may be first sign	24-72 hours	Sudden if upper airway
Toxicity	Child appears very ill; often has high fever	Mild to moderate, low-grade fever	Not ill appearing, no fever
Drooling	Common	Infrequent	May be present
Cough		Rare "barky" or "seal-like"	Common, distinctive, choking, gagging