Presentation suggests COPD: Hx of COPD w. wheezing, prolonged expiratory phase, decreased breath sounds, accessory muscle use

Tritrate oxygen 90-94%, check SpO₂, start IV and place on monitor

Give nebulized albuterol + ipratropium
May give continuous neb for severe respiratory distress

Therapeutic Goals:
- Maximize oxygenation
- Decrease work of breathing
- Identify cardiac ischemia (Obtain 12 lead EKG)
- Identify complications, e.g. pneumothorax

EMT may administer either mdi or nebulized albuterol with base contact for verbal order

Is response to treatment adequate?

Yes

No

- Reassess for pneumothorax
- Consider alternative diagnoses, including cardiac disease
- Consider CPAP if severe distress
- Assist ventilations with BVM as needed
- Consider advanced airway if CPAP contraindicated or not available

Obtain ECG: rule out unstable rhythm, ACS

- Continue continuous cardiac monitoring, SpO2 and capnography, if available
- Be prepared to assist ventilations as needed
- Contact base for medical consult as needed

Special Notes:
- Correct hypoxia: do not withhold maximum oxygen for fear of CO₂ retention
- Consider pulmonary and non-pulmonary causes of respiratory distress: Examples: pulmonary embolism, pneumonia, pulmonary edema, anaphylaxis, heart attack, pneumothorax, sepsis, metabolic acidosis (e.g.: DKA), Anxiety
- Patients with COPD are older and have comorbidities, including heart disease.
- Wheezing may be a presentation of pulmonary edema, “cardiac asthma”
- Common triggers for COPD exacerbations include: Infection, dysrhythmia (e.g.: atrial fibrillation), myocardial ischemia

CPAP may be very helpful in severe COPD exacerbation, however these patients are at increased risk of complications of CPAP such as hypotension and pneumothorax. Cardiopulmonary monitoring is mandatory