ACUTE PULMONARY EDEMA

History may include: an older patient, heart problems, orthopnea, symptoms of acute MI, taking "water pills," cough with watery or foamy sputum.

Physical Findings: rales and/or rhonchi, distended neck veins, pedal and/or presacral edema, hemoptysis

Medications: digoxin, lanoxin, digitoxin, diuril, esidrix, bumex or (other diuretics or antihypertensives)

Field Treatment - BLS

OXYGEN:	High Flow, as tolerated
POC & VITALS	Keep patient in POC, preferably sitting upright with legs dependent, assess vitals

Field Treatment - ALS

MONITOR:	Treat rhythm as appropriate
IV ACCESS:	TKO
NITROGLYCERINE:	0.4 mg sublingual, if systolic B.P. 100-120 mmHg. May repeat q 5 min.* 0.8 mg sublingual if systolic B.P. 120-180 mmHg. May repeat q 5 min.* 1.2 mg sublingual if systolic B.P. Greater than 180 mmHg. May repeat q 5 min.*
NTG PASTE:	1" if systolic BP 100 - 120 mmhg 2" if systolic BP greater than 120 mmhg
CPAP:	Severe Respiratory Distress: *Apply* CPAP beginning at 10cm H2O decresing to 5cm H2O if possible. Titrated to patient response.

Considerations:

DOPAMINE:	Drip @ 5- 20 ug/kg/min. for hypotensive patients (not secondary to nitrate therapy). Titrate to systolic B.P. about 100.

Base Hospital Order:

MORPHINE*:	**2 - 4 mg increments slow IVP (if Systolic BP greater than 100 mmhg). May repeat as needed not to exceed 20 mg in 30 min.**

***Note: Differentiation of COPD from cardiogenic pulmonary edema and pneumonia can be extremely difficult. If in doubt as to the etiology, follow the COPD/Bronchospasm protocol.**

*** Recheck vitals before repeating dose**