Acutely dyspeptic patient with known or clinically suspected COPD

**INITIAL EVALUATION:**
- Vitals
- Assess airway, respiratory and mental status
- Intervene as clinically indicated:
  - Supplemental O2 to 88-92% O2 Sat
  - NIPPV
  - Intubation

**RECOMMENDED diagnostic evaluation:**
- Full history and physical exam
- CBC, BMP, VBG
- CXR
- EKG

**SUPPLEMENTAL diagnostic evaluation Only as clinically indicated**
- Consider ABG, BNP, Troponin, Lactate, PT/INR/PTT, D-dimer [See Appendix 1](#)
- Consider ultrasound:
  - 10-zone lung
  - Basic cardiac
  - Advanced cardiac
- Lower extremity venous ultrasound

**Initial Interventions:**
- Likely proceeds in parallel with diagnostic evaluation based on patient symptoms and relative diagnostic certainty
- Oxygen: target patient baseline or 88-92% O2 saturation
- Bronchodilators (albuterol), with or without ipratropium, given by nebulizer (or MDI with spacer if patient is able to tolerate)
- Reassess and re-dose as needed
- Steroids: 40 mg prednisone PO if able to tolerate, IV if in distress and unable to tolerate. Generally indicated for ED patients, may withhold if very mild symptoms

**Improved symptoms MILD**
- Did not present in respiratory distress or failure
- Improved symptoms
- Consider waiting O2 sat test

**Persistent symptoms MODERATE**
- E.g., severe initial symptoms or lack of meaningful clinical improvement
- Give antibiotics [Note](#)

**Discharge home with:**
- 5 day total steroid course
- Antibiotics if indicated [Note](#)
- PCP or pulmonology F/U

**Place in ED Observation if:**
- No diagnostic uncertainty
- Minimal new O2 requirement (≥ 2 L/MN additional O2)
- Meets other criteria

**Admit to floor status if:**
- Diagnostic uncertainty
- Recent failed ED obs admission
- Physician concern

**Progressive or severe symptoms SEVERE**
- E.g., altered mental status, failure to respond to therapy, marked laboratory abnormalities, clinical signs of respiratory failure
- Initiate NIPPV (first line if no contraindications for severe dyspnea, respiratory failure) or intubate if indicate

**Give antibiotics [Note](#) [See Appendix 2 for Abx]**

Admit to stepdown or ICU status

**Most recent update: 11/5/2019**

Department(s): Emergency Medicine
COPD APPENDICES:

Appendix 1

<table>
<thead>
<tr>
<th>D-dimer/CTPA evaluation:</th>
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<tbody>
<tr>
<td>• 4ml/kg/%TBSA of LR</td>
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<tr>
<td>• Only deep partial thickness and full thickness burns contribute</td>
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<tr>
<td>• ½ of this volume is given in the first 8 hours post-burn</td>
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<tr>
<td>• Remainder is given over the next 16 hours.</td>
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Appendix 2

<table>
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<tr>
<th>Antibiotics indicated if:</th>
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<tr>
<td>• Mild exacerbation with increased sputum quantity and purulence</td>
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<tr>
<td>• Moderate or severe symptoms</td>
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<tr>
<td>1st line: 5 day course of azithromycin</td>
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<tr>
<td>2nd line oral agents: amoxicillin-clavulanate, doxycycline</td>
</tr>
<tr>
<td>2nd line IV agents: levofloxacin, ceftriaxone</td>
</tr>
<tr>
<td>Alternative/additional agents may be indicated for severe symptoms</td>
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Appendix 3

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<tr>
<th>ED CDU COPD criteria:</th>
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<tr>
<td>• LOS estimated 8-23 hours</td>
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<td>• stable vital signs</td>
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<tr>
<td>• O2 requirement for O2 sat 92 is ≤2LNC if not on home O2 or ≤2 incremental LNC if on home O2 up to a maximum of 4LNC</td>
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<tr>
<td>• patient with few or no comorbidities</td>
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<tr>
<td>• patient has not failed maximal outpatient therapy within a week prior</td>
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<tr>
<td>• CXR is free of radiographic pneumonia unless mild COPD exacerbation and not hypoxic</td>
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