

Madigan Army Medical Center Referral Guidelines

Anaphylaxis and Anaphylactoid Reactions

Diagnosis/Definition

- Any severe allergic reaction to foods, medications, insect venoms, and a variety of other stimuli causing potentially life threatening symptoms such as hypotension, bronchospasm, and laryngeal edema.

Initial Diagnosis and Management

- A reliable history of respiratory distress, hypotension or symptoms typical of hypotension such as loss of consciousness or near syncope, after an exposure to a foreign substance. Cutaneous manifestations such as flushing or urticaria are also present in > 80% of cases. Exposure may be by ingestion, contact, or parenteral injection. Symptom onset is typically within minutes after exposure, but can be delayed for several hours.
- Aggressive treatment with epinephrine, airway management as necessary, volume expansion, and use of pressors as necessary. Epinephrine is first line therapy. Addition of corticosteroids may help prevent late phase or rebound reactions. And addition of antihistamines helps with cutaneous symptoms, but they should not be considered as substitutes for epinephrine.
 - Dosing of epinephrine: Adult dose = 0.3 ml of 1/1,000 IM; Child dose = 0.01ml/kg of 1/1,000 IM. Or 0.3ml if > 65 pounds and 0.10 to 0.15ml if < 65 pounds. Dosing may be repeated every 5 to 15 minutes if symptoms persist

Ongoing Management and Objectives

- Following discharge from acute care, all individuals should have an epinephrine autoinjector (Epi-pen or Twinject) in their possession whenever there is a possibility of subsequent exposure to whatever caused anaphylaxis. This would typically be the case with venom reactions, food reactions, exercise induced anaphylaxis, and idiopathic anaphylaxis. Drug reactions, on the other hand, are inherently more avoidable and would not commonly suggest the need for immediate self-resuscitation. Dose of epinephrine autoinjector for children < 65lb is 1.5mg and dose for adults and children > 65lb is 3.0mg. Each individual given an epinephrine autoinjector should be given competent instruction on both when and how to use it.
- Medical records should be appropriately annotated with the information on the known allergies and medical warning jewelry or written documentation should be carried on the person.

Indications for Specialty Care Referral

- Referral to Allergy Service is recommended for all cases of anaphylaxis to help identify or confirm allergic trigger through skin testing or serum studies and to consider desensitization options.
- Skin testing is available for a variety of substances to include foods and hymenoptera. Skin tests are less available for medications.
- Desensitization has been reliably performed for hymenoptera stings. Food desensitization is not practiced because of its inherent dangers.

- Large local reactions to hymenoptera stings without any historical evidence for anaphylaxis should not be referred.
- Drug desensitization may be performed by the allergist for certain drugs (mostly antibiotics). This is only considered when there is no alternative antibiotic and after Infectious Disease Service consultation due to the complexity and risks of drug desensitization procedures.
- In depth education is also provided through the Allergy Service to assist patients with avoidance.

Criteria for Return to Primary Care

- Completion of the initial evaluation, unless desensitization is begun.
- Hymenoptera desensitization may last for 3-years or longer. Once such a course is completed, the patient can be returned to primary care for that condition.
- Patients may be referred immediately back to primary care following drug desensitization. Most of such desensitizations are not permanent, which may necessitate future referral.

Last Review for this Guideline: **September 2009**
Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator