Anaphylaxis clinical care standard

Improving how we manage adults with anaphylaxis in Victoria
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</table>
Introduction

The incidence of anaphylaxis in Victoria is on the rise. Between 2012–13 to 2016–17, there were 9,329 emergency presentations reported for anaphylaxis involving 8,322 patients. During this time, anaphylaxis presentations to Victorian public emergency departments grew an average of 15 per cent per year. [1]

Definition

There is no universally accepted definition of anaphylaxis. In this standard, we define anaphylaxis as a severe, potentially life-threatening systemic hypersensitivity reaction.

Symptoms

Anaphylaxis is characterised by:

- rapid onset of a life-threatening airway, breathing or circulatory problems
- (usually, but not always) skin and mucosal changes. [6]

Note: Vomiting and abdominal pain are symptoms of anaphylaxis to insect venom and systemically administered allergens.

Clinical case reviews of anaphylaxis have revealed a large variance in the way anaphylaxis is managed during and after the acute event, and inpatient discharge planning and follow up.

The aim of this standard is to bring some consistency to how adult (16 years of age and over) patients with anaphylaxis are managed, treated and cared for in Victorian hospitals. Part of this is raising awareness of the possibility of anaphylaxis when people present with specific symptoms.

This standard is based on evidence-based information and clinical experiences. It was developed with a panel of experts (Appendix 1) including clinicians who actively manage anaphylaxis, as well as peak bodies and consumers.

How to use this standard

This standard applies to managing anaphylaxis in adults (16 years of age and over) presenting to the emergency department or experiencing anaphylaxis as an inpatient or outpatient in the health service. For managing anaphylaxis in children, please see the Royal Children’s Hospital guideline.

There are three parts to this standard:

1. Recognition
2. Response
3. Review

This standard is to be used in conjunction with online education and in-situ simulation of anaphylaxis scenarios.

We have also developed management cards (Appendix 2 and 3) to be placed on resuscitation trolleys to be used during resuscitation, and in treatment areas. These are intended to be used to manage anaphylaxis after reading this standard and undertaking in-situ training.
EPIDEMIOLOGY
Safer Care Victoria accessed the Victorian Emergency Minimum Dataset (VEMD) for all public emergency department presentations pertaining to anaphylaxis for the financial years 2012–13 to 2016–17. This was analysed for trends in volume, age, geographic location and inciting agent.

2012–13 to 2016–17
- There were 9,329 emergency presentations for anaphylaxis, involving 8,322 patients.
- In four years, Victoria experienced a 75 per cent increase in anaphylaxis presentations to emergency departments, from 1,365 in 2012–13 to 2,388 in 2016–17.
- The largest increases were seen in Melbourne’s growth corridors in the south east and south west. [1]

Figure 1 Number of anaphylaxis presentations to public hospital emergency departments

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>598</td>
<td>734</td>
<td>873</td>
<td>1,028</td>
<td>1,092</td>
</tr>
<tr>
<td>Unspecified</td>
<td>351</td>
<td>328</td>
<td>449</td>
<td>578</td>
<td>720</td>
</tr>
<tr>
<td>Medication</td>
<td>334</td>
<td>362</td>
<td>378</td>
<td>430</td>
<td>463</td>
</tr>
<tr>
<td>Serum/vaccine/immunisation</td>
<td>82</td>
<td>80</td>
<td>99</td>
<td>111</td>
<td>113</td>
</tr>
<tr>
<td>Total</td>
<td>1,365</td>
<td>1,504</td>
<td>1,799</td>
<td>2,147</td>
<td>2,388</td>
</tr>
</tbody>
</table>

The rising incidence of anaphylaxis in developed countries has attracted much attention in recent years. [2] With this increasing incidence comes a need for improved management and a demand for specialty medical services. [3] Lifetime prevalence of anaphylaxis, based on international studies, has been estimated between 0.05–2 per cent. [4]
1. Recognition

CAUSES AND TRIGGERS

There are patterns in the presentations of anaphylaxis that point to specific triggers being more significant at certain ages.

For example, foods are the more common trigger for children, teenagers and young adults. Bronchospasm is a common symptom and there is usually a background of atopy and asthma. [3] Moving into middle age and the elderly, the trigger is more likely to be stings from insects and medication. [4] Venom and medication related anaphylaxis are more common in older adults. [3]

Table 1 Triggers of anaphylaxis [2] [5]

<table>
<thead>
<tr>
<th>Common triggers</th>
<th>Less common triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insect stings</td>
<td>Physical</td>
</tr>
<tr>
<td>• Bees</td>
<td>• Exercise</td>
</tr>
<tr>
<td>• Wasps</td>
<td>• Cold</td>
</tr>
<tr>
<td>• Jack jumper ants</td>
<td>Biological</td>
</tr>
<tr>
<td>Food</td>
<td>• Transfusions</td>
</tr>
<tr>
<td>• Peanuts/treenuts</td>
<td>• Antivenoms</td>
</tr>
<tr>
<td>• Egg</td>
<td>• Monoclonal therapies</td>
</tr>
<tr>
<td>• Fish/shellfish</td>
<td>• Immunoglobulin</td>
</tr>
<tr>
<td>• Cow’s milk (dairy) products</td>
<td>• Semen</td>
</tr>
<tr>
<td>• Soy</td>
<td>Latex</td>
</tr>
<tr>
<td>• Sesame seeds</td>
<td>Tick bites</td>
</tr>
<tr>
<td>• Wheat</td>
<td>Hormonal changes</td>
</tr>
<tr>
<td>Medications</td>
<td>Idiopathic</td>
</tr>
<tr>
<td>• Antibiotics</td>
<td>Other foods</td>
</tr>
<tr>
<td>• Anaesthetic drugs</td>
<td>• Food additives</td>
</tr>
<tr>
<td>• Contrast media</td>
<td>• Other milks</td>
</tr>
<tr>
<td></td>
<td>Topical medications</td>
</tr>
<tr>
<td></td>
<td>• Chlorhexidine</td>
</tr>
</tbody>
</table>
RISK FACTORS
There are individual risk factors that can alter the likelihood and severity of anaphylaxis presentations.

Table 2 Patient risk factors and elements that augment anaphylaxis [4] [6]

<table>
<thead>
<tr>
<th>Patient specific</th>
<th>Pre-existing conditions</th>
<th>Medications</th>
<th>Lifestyle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-related</td>
<td>Respiratory disease</td>
<td>Non-steroidal anti-inflammatory (NSAIDs)</td>
<td>Physical exertion/exercise</td>
</tr>
<tr>
<td>Infection</td>
<td>Asthma</td>
<td>Angiotensin-converting enzymes (ACE) Inhibitors</td>
<td>Quantity of allergen</td>
</tr>
<tr>
<td>Hormonal/menstrual cycle</td>
<td>Chronic respiratory disease</td>
<td>Beta blockers</td>
<td>Composition of diet</td>
</tr>
<tr>
<td>Stress</td>
<td>Cardiovascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mastocytosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased basal tryptase</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe atopic disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DIFFERENTIAL DIAGNOSIS
Common differential diagnoses involve acute asthma, syncope, and anxiety or panic attacks.
Severe asthma has the potential to cause confusion with anaphylaxis by the presence of wheezing, coughing and shortness of breath. It is unlikely that asthma will have associated urticaria, angioedema or abdominal pain.

Table 3 Conditions to consider for differential diagnosis [2] [5-8]

<table>
<thead>
<tr>
<th>Tissue</th>
<th>Respiratory</th>
<th>Cardiovascular</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idiopathic urticaria</td>
<td>Asthma</td>
<td>Pulmonary embolism</td>
<td>Septic shock</td>
</tr>
<tr>
<td>Angioedema with no other features</td>
<td>Laryngospasm</td>
<td>Myocardial infarction</td>
<td>Epileptic seizure</td>
</tr>
<tr>
<td>ACE inhibitor induced angioedema</td>
<td>Vocal cord dysfunction</td>
<td>Cardiac arrhythmia</td>
<td>Stroke</td>
</tr>
<tr>
<td>Flushing syndromes</td>
<td>Breath holding</td>
<td>Cardiogenic shock</td>
<td>Panic attack</td>
</tr>
</tbody>
</table>
2. Response

MANAGEMENT

Responding to anaphylaxis requires:

- administering medication, predominantly adrenaline (epinephrine).
- stepping through actions according to the physiological response, depending on the body systems involved.

This section describes the doses and effect of adrenaline. The accompanying management cards (Appendix 2 and 3) provide a systematic format for managing anaphylaxis irrespective of the clinical location.

Adrenaline (Epinephrine) [2] [4] [9]

- Adrenaline is the most important drug in the treatment of anaphylaxis.
- Given intramuscularly into middle third of lateral thigh, where possible. The dose must be administered into a muscle.
- To be given to all patients with life threatening features of anaphylaxis without delay and repeated at five-minute intervals if not improving.

Caution: IV boluses of adrenaline are not recommended as this route of administration is associated with an increased risk of cardiac arrhythmias, myocardial ischemia and dosing errors, in particular, inadvertent overdosing. [10] Exceptions can be made in the case of critical care specialists.

Table 4 Mechanisms of action of adrenaline

<table>
<thead>
<tr>
<th>Receptor site</th>
<th>Clinical effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha 1 adrenergic receptor</td>
<td>Increases blood pressure</td>
</tr>
<tr>
<td></td>
<td>Prevents or relieves hypotension and shock</td>
</tr>
<tr>
<td>Beta 1 adrenergic receptor</td>
<td>Increases cardiac output</td>
</tr>
<tr>
<td>Beta 2 adrenergic receptor</td>
<td>Decreases urticaria and angioedema</td>
</tr>
<tr>
<td></td>
<td>Decreases upper airway obstruction</td>
</tr>
<tr>
<td></td>
<td>Decreases wheeze</td>
</tr>
</tbody>
</table>

Adrenaline IM dose for adults

- 0.5 mg intramuscular adrenaline (0.5 mg = 0.5 mL of 1 mg/mL)
- OR
- Adrenaline autoinjector (EpiPen® 0.3 mg)

Adrenaline IV infusion for adults

- 6 mg adrenaline in 100 mL (60 mcg/mL) of 0.9% sodium chloride
- Commence at 10 mL/hour = 10 mcg/minute
Management cards
We recommend the use of the Immediate and Ongoing management cards during the anaphylaxis event. The use of cognitive aids, like these management cards, has been shown to improve coordination of team activities during a clinical crisis. [8]

These cards should be used in training scenarios as they would be used in a real anaphylaxis event. This increases familiarisation of staff with the cognitive aid. [11] When managing an anaphylaxis event, assign a reader to the card who will speak up and alert the team to the prompts outlined on the card.

Anaphylaxis immediate management
Refer to Appendix 2 for the Anaphylaxis Immediate Management card. A printable version can be accessed at www.bettersafercare.vic.gov.au.

Immediate actions [2] [7] [9]
Immediate management of anaphylaxis requires a rapid ABC: airway, breathing and circulation assessment.

Administer intramuscular adrenaline (epinephrine) if anaphylaxis is suspected as there are no contraindications to the administration of adrenaline. [12]

- Look for any signs of:
  - acute onset of illness
  - life-threatening airway, breathing or circulatory problems.
- If in cardiac arrest, commence immediate CPR and refer to ALS (Adult) algorithm.
- Call for help relevant to your setting – emergency response team or triple zero (000).
- Stop trigger- such as an infusion of antibiotics.
- Lay patient flat, do not allow them to stand or walk. Where they are breathing difficulties, allow sitting sufficient to reduce respiratory distress.
- Administer intramuscular adrenaline without delay using either an adrenaline ampoule 0.5 mg (0.5 mL of 1 mg/mL) or adrenaline autoinjector, without delay. Adrenaline must be delivered intramuscularly using a needle of appropriate length.
  - Repeat IM adrenaline every five-minutes if not improving.
- Start high flow oxygen.
- Insert large bore IV cannula.
- Reassess ABC, monitor and consider additional therapies:
  - Monitor:
    - pulse oximetry/heart rate
    - blood pressure
    - assess respiratory rate
    - continuous ECG monitoring where possible.
Reassess.

Where there is no improvement or a non-sustained improvement after two doses of IM adrenaline, continue with IM adrenaline every five minutes but where able, consider commencing an adrenaline infusion. This can be run initially through a peripheral IV line. Continuous ECG monitoring is recommended.

It is recommended that critical care trained staff prepare the adrenaline infusion:
- adrenaline infusion 6 mg adrenaline in 100 mL (60 mcg/mL) of 0.9% sodium chloride (dedicated line)
- commence at 10 mL/hr = 10 mcg/min and titrate according to response.

Ongoing anaphylaxis management [9]

Request further assistance such as anaesthetist, intensivist, emergency physician or paramedic.

Continue adrenaline infusion and titrate according to response.

Cardiac or respiratory arrest:
- commence CPR
- refer to ALS cardiac arrest algorithm.

A: Persisting airway swelling
- Call for airway management assistance urgently.
- Nebulised adrenaline 5 mg = 5 mL (5 ampoules of 1 mg/mL).
- Bag and mask ventilation with 100 per cent oxygen where conscious state is deteriorating.
- Secure airway: requires appropriately skilled staff.

B: Resistant bronchospasm or wheeze
- Nebulise salbutamol 5 mg and nebulise ipratropium 0.5 mg.
- Hydrocortisone 100 to 250 mg IV (5 mg/kg up to 250 mg).
- Magnesium sulphate 10 mmol slow IV push.
- Consider securing airway: requires appropriately skilled staff.
C: Resistant hypotension
- Continue adrenaline infusion and titrate according to response.
- Additional fluid bolus 1 litre of 0.9% sodium chloride.
- Glucagon 1-2 mg IV, may be repeated at five minutes (especially for patients on beta blockers or who have heart failure):
- Add second vasopressor – for example:
  - noradrenaline infusion commenced at 10 mcg/min.
- Consider central venous catheter (CVC).

Consider other diagnosis
- Hypovolaemia
- Asthma
- Tension pneumothorax
- Myocardial infarction
- Pulmonary embolism
- Cardiac tamponade
- Pregnancy:
  - manual left uterine displacement
  - consider urgent delivery to save the mother.
3. Review

POST EVENT

Monitoring
Post anaphylaxis management should be determined according to the severity of the anaphylaxis and the trigger, where identified.

The minimal time for observing patients is four hours after the last dose of adrenaline. This allows you to detect any deterioration or a biphasic reaction. Biphasic reactions are estimated to occur after three to 20 per cent of anaphylactic reactions. [9] [13]

Monitoring should include heart rate, blood pressure, respiratory rate and oxygen saturation. Vital signs should be recorded every 15 minutes for two hours, then 30 minutely for two hours. A senior clinician should review the patient prior to discharge, who will consider if further treatment is required or the need for a longer observation period.

Create an allergy alert in the patient’s medical history.

Consider prescribing a two-day course of oral steroids (prednisolone 1 mg/kg, maximum of 50 mg daily) to reduce the risk of recurrence of symptoms following a severe reaction or a reaction that has marked or persistent wheeze. [9]

Consider prescribing an oral antihistamine such as cetirizine 10 mg or fexofenadine 180 mg, especially for a persisting rash.

Patients require overnight observation if they:

- have had a severe or protracted anaphylaxis requiring repeated doses of adrenaline or IV fluid resuscitation or
- have a history of asthma or severe/protracted anaphylaxis or
- have other concomitant illness, such as asthma, chest infection or arrhythmia or
- live alone or are remote from medical care or
- present for medical care late in the evening.

Tests
Mast cell tryptase
Anaphylaxis be confirmed by a blood test to measure mast cell tryptase. Tryptase is a major protein component of mast cell secretory granules. Anaphylaxis leads to mast cell degranulation which results in a rise in tryptase levels in the blood.

Levels increase approximately 30 minutes or more post the onset of symptoms of anaphylaxis and peak at one to two hours from onset. The half-life of tryptase is two hours and levels are normal six to eight hours post event.
Timing of samples

- Sample 1: as soon after resuscitation as possible.
- Sample 2: 1 to 2 hours post symptoms.
- Sample 3: 24 hours post event or with follow up in allergy clinic to give baseline tryptase.

A recent Australian study from emergency departments, showed an optimal sensitivity of 72 per cent and specificity of 72 per cent when a cut-off of 11.2 ng/mL was used and a delta-tryptase (change in level from baseline) of >2 ng/mL. This suggests the sensitivity and specificity of serum mast cell tryptase are relatively poor, and patients should be referred to an allergy specialist for follow up regardless of the level. [14]

Discharge and follow up

When to prescribe an adrenaline autoinjector
Prescribe an adrenaline autoinjector if the patient is at risk of future exposure to the allergen(s) that triggered their anaphylaxis (such as stings or foods) or if the trigger was unknown.

Prescribing an adrenaline autoinjector requires education and training as to when and how to use the device and correct storage. Provide an ASCIA action plan for anaphylaxis for all patients who are prescribed an adrenaline autoinjector. ASCIA action plans and education can be sourced at www.allergy.org.au/anaphylaxis and https://allergyfacts.org.au/resources/videos-from-a-aa.

Advise patients to keep their adrenaline autoinjector with them always, including when in hospital, see Appendix 4.

Patient education
Make sure your patient understands:

- how to recognise early symptoms of anaphylaxis, to call for help immediately and administer their adrenaline autoinjector. Show your patient how to use their adrenaline autoinjector using a training device
- the importance of carrying their adrenaline autoinjector with them always. People close to them should also be trained to use the device
- they should seek urgent medical assistance any time they use their adrenaline autoinjector.
- if they are at high risk of anaphylaxis, they should wear a notification alert such as a bracelet that provides information about their anaphylaxis.

Information for patients, family and carers is available at www.allergy.org.au and www.allergyfacts.org.au.

Referral to a specialist and follow up with a general practitioner
All patients who have experienced anaphylaxis require a specialist review. Where possible this appointment should be made prior to discharge. The patient should also see their local general practitioner within five days after the anaphylaxis event.
Education for clinical staff

Follow up with the allergy specialist will:

- identify or confirm the cause
- educate the patient in relation to prevention and management strategies
- provide an ASCIA action plan for anaphylaxis if one has not been provided on discharge
- initiate allergen immunotherapy where applicable. [9]

Referral and discharge summary should include documentation of the episode of anaphylaxis with identification of the trigger, where known. A detailed description of the treatment should be provided to the patient as well as a prescription for an adrenaline autoinjector and an ASCIA action plan for anaphylaxis.

**Reporting of reaction to the Department of Health and Human Services**

Since 1 November 2018, Victorian public and private hospitals are required by law to notify the Department of Health and Human Services of anaphylaxis presentations.

Where the trigger for the anaphylaxis is **packaged food**, the episode must be reported **immediately** by calling 1300 651 160 (24/7).

Where the cause of anaphylaxis is **not** packaged food, the episode should be reported online within five days of diagnosis via the link [www2.health.vic.gov.au/public-health/anaphylaxis-notifications](http://www2.health.vic.gov.au/public-health/anaphylaxis-notifications).

**Figure 2 Anaphylaxis notification process**

<table>
<thead>
<tr>
<th>Anaphylaxis (due to any allergen, all age groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to packaged food</td>
</tr>
<tr>
<td><strong>Within 24 hours</strong></td>
</tr>
</tbody>
</table>

Health services are accredited against the National Safety and Quality Health Service Standards (NSQHS) (second edition). The intention of Standard 8, Recognising and Responding to Acute Deterioration, is to ensure that a person’s acute deterioration is recognised promptly, and appropriate action is taken.
It is important that a local risk assessment is undertaken to identify the clinical staff for whom anaphylaxis education is relevant. Based on this assessment the different elements of training and the frequency of the training should be determined. This training, according to the risk assessment can include:

1. theoretical training via the ASCIA website www.allergy.org.au/hp/hp-e-training
2. in-situ simulated scenario training using the management cards provided in this clinical standard
3. practice with an autoinjector training device (these can be purchased from a range of sources and are commonly accessed at allergyfacts.org.au/shop/training-accessories)

There are several elements of this standard that can be applied, and provide evidence, to improving the recognition and response to anaphylaxis. They include:

- having a protocol for the management of anaphylaxis
- ensuring clinical staff have the skills and competency to evaluate and respond to acute physiological deterioration of anaphylaxis
- evidence of clinician competency assessment
- training documents about emergency interventions in the event of acute deterioration, including specialist training for responders, such as members of medical emergency teams
- records indicating that clinicians have met the ongoing professional development requirement of a specialist college in relation to responding to acute deterioration
- education is targeted to all clinical staff, particularly staff who work in high risk areas.
Rural and regional settings

In rural and regional settings, it is possible that there will not always be a doctor on site. Where patients present with known allergies and their own adrenaline autoinjector, the nursing staff should administer the patient’s adrenaline autoinjector then call for help (doctor or Ambulance Victoria, according to local protocol). Refer to www.bettersafecare.vic.gov.au for the Use of patients own adrenaline autoinjector in hospital change package for health services.

Training for clinical staff should follow the same process described on the previous page. The ASCIA online training for clinical staff considers rural and remote settings and the absence of medical staff, www.allergy.org.au/hp/hp-e-training.

In Victoria, Remote and Isolated Practice Endorsed Registered Nurse (RIPEN) are authorised to practice according to the protocols set out in The Primary Clinical Care Manual located at publications.qld.gov.au/dataset/primary-clinical-care-manual-9th-edition. Whilst this manual does not replace clinical judgement, the information is provided on the basis that readers will be responsible for making their own assessment. Page 67 of this manual outlines the role of the RIPEN in the management of anaphylaxis.

This endorsement allows RIPERN to administer and supply a range of approved medicines, of which adrenaline is included, where there is no or limited access to general practitioners, nurse practitioners, paramedics or pharmacists.
## Appendix 1 Working party membership

<table>
<thead>
<tr>
<th>Member</th>
<th>Organisation/memberships</th>
</tr>
</thead>
</table>
| Jo Douglass (Chair) | Head, Department of Immunology and Allergy  
MD FRACP FThorSco  
Divisional Director, Neurosciences, Cancer and Infection Medicine  
Honorary Clinical Professor, The University of Melbourne |
| David Armstrong | Head of Respiratory Medicine, Monash Children’s Hospital  
MD, FRACP  
Honorary Associate Professor, Department of Paediatrics, Monash University |
| Jenny Burke     | Deteriorating Patient and Resuscitation Co-ordinator, Melbourne Health  
RN, Dip Applied Science (Nursing)  
Crit. Care Cert.  
B. Nursing (Hons)  
Associate of the Australian Resuscitation Council (ARC) (Victoria Branch)  
Member, Victorian Deteriorating Patient Expert Group (ARC, Victorian Branch) |
| Alan Eade       | Chief Paramedic Officer, Safer Care Victoria  
ASM. FPA  
Adjunct Associate Professor, Monash University  
Intensive Care Paramedic |
| Gerard Fennessy | Specialist Intensive Care Physician, Western Health (Sunshine and Footscray)  
FCICM, RFNZCUC, BHB, MBChB  
PG Dip Community Emergency Medicine  
Inaugural ANZIC Ramesh Nagappan ICU Education Award (2004)  
ANZICS SQAO  
Intensive Care Network Victoria (2012-2016) |
| Helen Kolawole  | Specialist Anaesthetist, Peninsula Health  
MBBS, M ClinEd, FANZCA  
Chair Anaphylaxis Management Group of ANZAAG, Australian and New Zealand Anaesthetic Allergy Group  
Allergy Subcommittee ANZCA, Australian and New Zealand College of Anaesthetists  
Supervisor of Training ANZCA |
| Stuart Marshall | Specialist Anaesthetist, Peninsula Health  
MB. ChB.  
M. Human Factors  
MRCA, FRANZCA, PhD  
Lead Human Factors Clinician, Australian Centre for Health Innovation, Alfred Health  
Senior Research Fellow and NHMRC ECR Practitioner Fellow, Anaesthesia and Perioperative Medicine  
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DRANZCQG, FACEM  
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MBBS, FRACP, PhD  
Honorary Senior Lecturer, University of Melbourne  
Honorary Senior Lecturer, Monash University |
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Grad. Dip Dietetics  
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ASCIA (Associate member), A&AA member |
## Appendix 2 Immediate management

### Anaphylaxis Immediate Management

**Adult (16 years and over)**

<table>
<thead>
<tr>
<th><strong>Clinical features</strong></th>
<th>Severe allergic reaction leading to acute onset:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Stridor, Throat or Tongue swelling OR</td>
</tr>
<tr>
<td></td>
<td>• ‘Asthma’, wheeze OR</td>
</tr>
<tr>
<td></td>
<td>• Low Blood Pressure, Collapse</td>
</tr>
<tr>
<td></td>
<td>• +/- Rash, Abdominal pain, Vomiting</td>
</tr>
</tbody>
</table>

**If in CARDIAC ARREST**

Immediate CPR and Refer to ALS (Adult) Algorithm

**GET HELP**

Call Emergency Response or Triple Zero (000)

**STOP TRIGGER**

Cease Infusion

**POSITION**

- Lay patient flat OR
- Sit if difficulty breathing

**Give IM ADRENALINE** (Epinephrine) (1 mg/mL)

0.5 mg = 0.5 mL IM

REPEAT every 5 minutes if not improving

**All cases:**

- High-flow OXYGEN
- Large bore IV ACCESS

**Assess ABC, Monitor and consider other therapies:**

<table>
<thead>
<tr>
<th><strong>A</strong></th>
<th><strong>B</strong></th>
<th><strong>C</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>AIRWAY swelling or stridor</td>
<td>BRONCHOSPASM wheeze</td>
<td>HYPOTENSION</td>
</tr>
<tr>
<td>• Call for Airway Assistance</td>
<td>• Repeat IM Adrenaline every 5 min prn</td>
<td>• 1 litre 0.9% Sodium Chloride IV bolus</td>
</tr>
<tr>
<td>• Repeat IM Adrenaline every 5 min prn</td>
<td>• Nebulise Salbutamol 5 mg</td>
<td>• Repeat IM Adrenaline every 5 min prn</td>
</tr>
</tbody>
</table>

**REASSESS**

No improvement after 2 doses IM adrenaline continue IM dosing, but where able use IV Adrenaline Infusion

Critical Care trained staff – Prepare Adrenaline Infusion

6 mg adrenaline in 100 mL 0.9% Sodium Chloride

Commence 10 mL/hr = 10 mcg/min

If not improving see ‘Ongoing Anaphylaxis’ overleaf

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A printable version can be accessed at www.bettersafercare.vic.gov.au
# Appendix 3 Ongoing management

<table>
<thead>
<tr>
<th>Ongoing Anaphylaxis</th>
<th>Management if not responding Adult (16 years and over)</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Icon]</td>
<td>REQUEST FURTHER HELP from critical care/anaesthetics team</td>
</tr>
<tr>
<td>![Icon]</td>
<td>Continue adrenaline infusion and consider increasing rate</td>
</tr>
</tbody>
</table>
| **Cardiac or respiratory arrest?** | **Commence CPR**  
**Follow ALS algorithm** |
| **A Persistent Airway swelling** | **Call for airway assistance**  
- Nebulise Adrenaline 5mg = 5mL  
- Bag and mask ventilation with 100% O₂  
- Secure airway |
| **B Resistant Bronchospasm or wheeze** | **- Nebulise Salbutamol 5 mg & Ipratropium 0.5 mg**  
- Hydrocortisone 100-250 mg IV  
- Magnesium sulphate 10 mmol slow IV push |
| **C Resistant Hypotension** | **- Additional bolus 1 litre 0.9% Sodium Chloride**  
- 1-2 mg Glucagon IV  
- Add second vasopressor e.g. Noradrenaline |
| **Consider other diagnosis** | **- Hypovolaemia**  
- Asthma  
- Tension Pneumothorax  
- Myocardial Infarction  
- Pulmonary Embolism  
- Cardiac Tamponade  
- Pregnancy  
  - manual left uterine displacement  
  - consider urgent delivery |

Appendix 4 Use of a patient’s own adrenaline autoinjector in hospital

The Safer Care Victoria *Use of a patient’s own adrenaline autoinjector in hospital* change package, helps health services to develop a local policy for the management of a patient’s own adrenaline autoinjector when they are in hospital. This can be accessed at [www.bettersafercare.vic.gov.au](http://www.bettersafercare.vic.gov.au).

**What has changed?**

Patients in Victorian health services are permitted, and encouraged, to keep their adrenaline autoinjectors with them when in hospital. Treatment can be administered immediately by the patient, their family or carer or clinician. There is no legislation or regulations preventing this occurring. It is the responsibility of the individual health services to ensure safe management of patients own medication with consideration to the best interest of the patient and the safety of other patients in their care.

**Why is change necessary?**

Early administration of adrenaline during anaphylaxis is associated with improved outcomes. [4] There have been several sentinel events and several allergy and anaphylaxis clinical incidents in Victorian health services in recent years. For adrenaline to be given as soon as possible after the onset of symptoms of anaphylaxis, it is important for the patient (carer, family member or clinician) to be able to immediately administer the patient’s own adrenaline autoinjector.

**What does the health service need to do?**

Using the SCV change package, the health service should develop a local policy to ensure patients can keep their adrenaline autoinjector with them and treatment can be given immediately by the patient, their family or carer or clinician as needed.

This policy should include:

- assessment of the patient’s capacity to safely use their adrenaline autoinjector. This assessment should take into consideration the age of the patient as well as their physical and cognitive capacity to safely use the device. (see *What do staff need to do?*)
- assessment of the patient area to ensure a safe place for the adrenaline autoinjector to be stored that allows ease of access for the patient (carer, family, clinical staff) whilst maximising the safety of others
- the ASCIA action plan for anaphylaxis should be stored with the adrenaline autoinjector
- ensure all relevant staff are notified about and receive training (where required) of the change in practice.

[4] Safer Care Victoria *Anaphylaxis clinical care standard*
What do staff need to do?

- Identify patients that have been prescribed an adrenaline autoinjector and have ASCIA action plan for anaphylaxis.

- Undertake an assessment of the patient’s capacity to manage their anaphylaxis by asking the following questions:
  - Are they aware of signs and symptoms of anaphylaxis?
  - Do they have a copy of their ASCIA action plan for anaphylaxis with them in hospital?
  - Have they been prescribed an adrenaline autoinjector or have purchased one over the counter from the pharmacist?
  - Are they confident in using the adrenaline autoinjector and do they know what to do after using it?
  - Do they have an adrenaline autoinjector with them in the health service? (If not, encourage the patient to ask a friend or family member to bring it in for them.)
  - Is the adrenaline autoinjector within its expiry date? Has it been stored at or below 25°C and is the window clear? (If not organise a replacement.)

- Label the autoinjector with the patient’s health service label.

- Ensure the patient (family/carer) knows to notify a staff member immediately after using their adrenaline autoinjector.

- Discuss with the patient (family, carer) the most appropriate place to store the adrenaline autoinjector.

- If the patient administers their own adrenaline autoinjector it will be counted as their first dose of adrenaline and needs to be recorded on the health service medication chart.
## Glossary of terms and abbreviations

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylaxis</td>
<td>Use the decided definition.</td>
</tr>
<tr>
<td>Adrenaline (epinephrine)</td>
<td>A drug with alpha and beta agonist actions that cause peripheral vasoconstriction, reversing hypotension and mucosal oedema, increased rate and force of cardiac contractions, improves hypotension and reversal of bronchoconstriction and reduces release of inflammatory mediators.</td>
</tr>
<tr>
<td>Adrenaline autoinjector</td>
<td>Device containing a metered dose of adrenaline (epinephrine) that is administered intramuscularly and can be done so by a non-clinical person.</td>
</tr>
<tr>
<td>Biphasic</td>
<td>Biphasic anaphylaxis is a recurrence of anaphylaxis after appropriate treatment and happens with no additional exposure to the allergen.</td>
</tr>
<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
</tr>
<tr>
<td>ARV</td>
<td>Adult Retrieval Victoria</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>CVC</td>
<td>Central Venous Catheter</td>
</tr>
<tr>
<td>Hr</td>
<td>Hour</td>
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<tr>
<td>ECG</td>
<td>Electrocardiograph</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>Kg</td>
<td>Kilograms</td>
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<tr>
<td>mcg</td>
<td>Micrograms</td>
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<tr>
<td>mL</td>
<td>Millilitres</td>
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<tr>
<td>mmol</td>
<td>Millimole</td>
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<tr>
<td>ng</td>
<td>Nanogram</td>
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<tr>
<td>NSAIDs</td>
<td>Non-steroidal anti-inflammatory drugs</td>
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</tbody>
</table>
References
