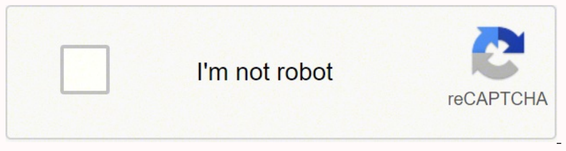

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ORIGINAL ARTICLE

Adherence to Anaphylaxis Guidelines: Real-World Data From the Emergency Department of a Tertiary Hospital

Ponce Guevara LV[1,2], Laffond Yges E[1,2,3], Gracia Bara MT[1,2], Moreno Rodilla E[1,2,3], Muñoz Bellido FJ[1,2,3], Lázaro Sastre M[1,2], Macías Iglesias EM[1,2], de Arriba Méndez S[1,2], Campanón Toro MV[1,2], Dávila Gónzalez I[1,2,3]

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Abstract

Background: Few studies have evaluated adherence to anaphylaxis guidelines in emergency departments (EDs).
Objective: The objective of this study was to evaluate adherence to anaphylaxis guidelines in the ED of a tertiary hospital.
Methods: Medical records of patients attended in the ED of University Hospital of Salamanca, Spain were reviewed. Those patients fulfilling the anaphylaxis criteria proposed by the NIAID/FAAN were selected.
Results: During a 1-year period, we identified 89 patients (74 adults and 15 children). The anaphylactic reaction was moderate in 65% of adults, severe in 34%, and very severe in 1%. In children, all reactions were moderate. Fewer than half of the patients (42%) received adrenaline in the ED; this was administered intramuscularly in only 19% of cases. As for the severity of the reaction, 65% of patients with moderate reactions and 42% with severe reactions were not treated with adrenaline. At discharge from the ED, an adrenaline auto-injector was recommended to only 5.6% of patients. Fifty-two percent of patients received a documented allergy referral (57% adults vs 27% children, P=.047), 29% instructions about avoidance of triggers (31% adults vs 20% children, NS), and 51% written instructions for recognition of anaphylaxis warning signs (41% adults vs 100% children, P<.001).
Conclusion: The results of the study show a large discrepancy between recommendations in guidelines and management of anaphylaxis in the ED. Additional training efforts are needed to improve the treatment of patients with anaphylactic reactions.

Key words: Anaphylaxis. Guidelines. Adrenaline.

Resumen

Antecedentes: Pocos estudios han evaluado el cumplimiento de las recomendaciones de las guías clínicas de anafilaxia en los servicios de urgencias.
Objetivo: El objetivo de este estudio fue conocer el cumplimiento de las guías de anafilaxia en el servicio de urgencias (SU) de un hospital terciario.
Métodos: Se revisaron los informes de los pacientes atendidos en el SU del Hospital Universitario de Salamanca durante un año y se seleccionaron los que cumplían los criterios de anafilaxia propuestos por el NIAID/FAAN.
Resultados: Se identificaron 89 pacientes, 74 adultos y 15 niños. El 65% de los adultos presentó una reacción moderada, el 34% grave y el 1% muy grave; en todos los niños la gravedad fue moderada. Menos de la mitad de los pacientes (42%) fueron tratados con adrenalina, solo el 19% por vía intramuscular. El 65% de las reacciones moderadas y el 42% de las graves no recibieron adrenalina. Al alta, se recomendó un auto-inyector de adrenalina al 5,6% de los pacientes, se remitió al Servicio de Alergia al 52% (57% adultos frente a 27% niños, p=0,047), se dieron indicaciones para evitar posibles desencadenantes al 29% (31% adultos frente a 20% niños, p=.5) e instrucciones para reconocer los signos de alarma de una reacción anafiláctica al 51% (41% adultos frente a 100% niños, P<0,001).
Conclusión: Los resultados del estudio muestran importantes discrepancias entre las recomendaciones de las guías clínicas y el manejo de la anafilaxia en un SU hospitalario. Es necesario un mayor esfuerzo en educación para mejorar el tratamiento de los pacientes con anafilaxia.

Palabras clave: Anafilaxia. Guías clínicas. Adrenalina.

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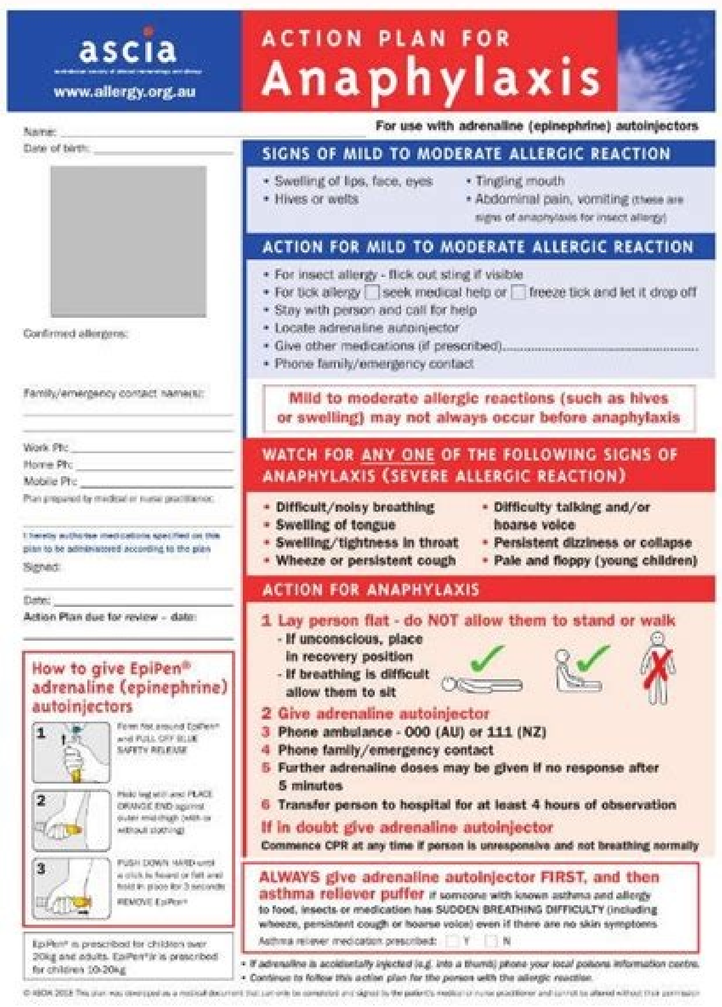

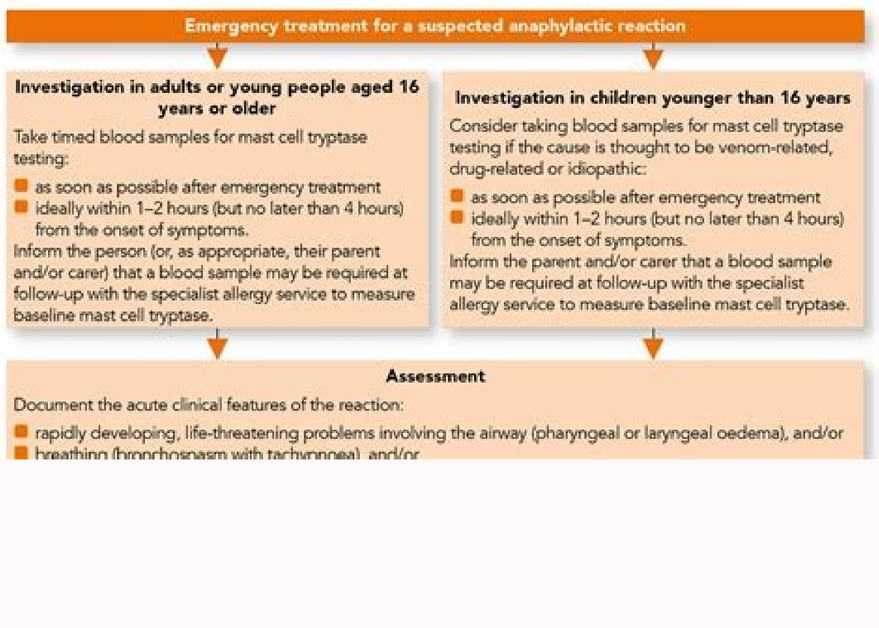

Clinical Guideline Highlights for the Hospitalist: Anaphylaxis Management in Adults and Children

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GUIDELINE TITLE: Anaphylaxis—A 2020 practice parameter update, systematic review, and Grading of Recommendations, Assessment, Development and Evaluation (GRADE) analysis

RELEASE DATE: April 2020

PRIOR VERSION: Anaphylaxis – a 2019 practice parameter and GRADE analysis

DEVELOPER: American Academy of Allergy, Asthma & Immunology (AAAAI) and the American College of Allergy, Asthma, and Immunology (ACAAI)

FUNDING SOURCE: None

TARGET POPULATION: Adult and pediatric patients with anaphylaxis

Anaphylaxis, an acute, life-threatening allergic response, affects multiple organ systems and manifests variably. Anaphylaxis is likely taking place if one or more of the following occurs: (*a*) sudden-onset skin and mucosal tissue swelling, (*b*) skin and mucosal abnormalities or respiratory or gastrointestinal symptoms after exposure to an allergen, or (*c*) reduced blood pressure after exposure to an allergen. With an estimated lifetime prevalence of up to 5.1%, it is a significant cause of morbidity in adults and children.[1] The 2020 anaphylaxis practice parameter update provides recommendations on treatment, prevention, and assessment of biphasic symptom risk in patients experiencing anaphylaxis.[2] The guideline provides five key recommendations and four good-practice statements, which we have consolidated into five recommendations for this update.

KEY RECOMMENDATIONS FOR THE HOSPITALIST

Recommendation 1. *All patients with suspected or confirmed anaphylaxis should be treated with epinephrine. (Good-practice statement)*

Self-injectable epinephrine is the first-line treatment for anaphylaxis, with weight-based dosing of 0.15 mg/kg for children weighing less than 30 kg and 0.30 mg/kg for children weighing more than 30 kg and adults. Delayed administration of epinephrine can increase anaphylaxis-associated morbidity and mortality. After epinephrine administration, patients should be observed in a healthcare setting for symptom resolution.

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 DOI 10.12788/jhm.3553

Recommendation 2. *For all patients, clinicians should assess the risk for developing biphasic anaphylaxis. (Conditional recommendation, very low quality of evidence)*

Biphasic anaphylaxis is defined as the return of anaphylaxis symptoms after an asymptomatic period of at least 1 hour, all during a single instance of anaphylaxis. Biphasic anaphylaxis occurs in up to 20% of patients.[1] Biphasic anaphylaxis is more likely among patients receiving repeated doses of epinephrine (odds ratio [OR], 4.82; 95% CI, 2.70-8.58), delayed epinephrine administration greater than 60 minutes (OR, 2.29; 95% CI, 1.09-4.79), or a severe initial presentation (OR, 4.82; 95% CI, 1.23-3.61).[2] The presence of any of these risk factors raises the risk for developing biphasic anaphylaxis by 17%.[4] Severe anaphylaxis is characterized by life-threatening symptoms, including loss of consciousness, syncope or dizziness, hypotension, cardiovascular system collapse, or neurologic dysfunction from hypoperfusion or hypoxia after exposure to an allergen.[5]

Other risk factors for biphasic anaphylaxis in all ages include a widened pulse pressure, unknown anaphylaxis trigger, and cutaneous signs and symptoms. Drug triggers are also a risk factor in pediatric patients.[2]

Recommendation 3. *All patients with anaphylaxis and risk factors for biphasic anaphylaxis should undergo extended clinical observation in a setting capable of managing anaphylaxis. (Conditional recommendation, very low quality of evidence)*

All patients should be monitored for resolution of symptoms prior to discharge, regardless of age or severity at onset. Patients with all three of the following can be discharged 1 hour after symptom resolution because these three factors together have a 95% negative predictive value for biphasic anaphylaxis: nonsevere anaphylaxis, prompt response to epinephrine, and access to medical care.[5] In contrast, extended observation of at least 6 hours should be offered to patients with increased risk of biphasic reactions. Patients who have potentially fatal

Allergy

POSITION PAPER

EAACI Food Allergy and Anaphylaxis Guidelines: diagnosis and management of food allergy

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Abbreviations

APT, atopy patch test; BAT, basophil activation test; CRD, component-resolved diagnosis; DBPCFC, double-blind, placebo-controlled food challenge; EAACI, European Academy of Allergy and Clinical Immunology; EoE, eosinophilic esophagitis; FA, food allergy; FPIES, food protein-induced enterocolitis syndrome; GERD, gastroesophageal reflux disease; GRADE, Grading of Recommendations Assessment, Development and Evaluation; IgE, immunoglobulin E; IgG4, immunoglobulin G4; LR, likelihood ratio; LTP, lipid-transfer proteins; NIAID, National Institute of Allergy and Infectious Diseases; NPV, negative predictive value; NSAID, nonsteroidal anti-inflammatory drugs; OFC, oral food challenge; PPV, positive predictive value; RCTs, randomised controlled trials; sIgE, specific IgE; SLIT, sublingual immunotherapy; SPT, skin prick test; US, United States.

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25-03-2022 · The aim of these guidelines is to outline the appropriate prescription and dose of adrenaline (epinephrine) injectors for use in non-medical settings, for the emergency first aid treatment of potentially life-threatening severe allergic reactions (anaphylaxis). These guidelines should be used in conjunction with clinical judgement, with ... Guidelines developers seeking NHMRC approval are advised to use GRADE and training is available through the Melbourne GRADE Centre and the Adelaide GRADE Centre. Rescinded guidelines. Guidelines issued by NHMRC have a limited life. They are regularly reviewed and will be updated or withdrawn in light of important new evidence that may emerge. Emergency treatment of anaphylaxis: Guidelines for healthcare providers. This guideline is for healthcare providers who are expected to treat anaphylaxis during their usual clinical role (e.g. doctors, nurses, paramedics) working in a hospital or out-of-hospital setting. The most recent version of this Guideline was published in May 2021. 17-05-2021 · Anaphylaxis is a serious allergic reaction.It can begin very quickly, and symptoms may be life-threatening. The most common causes are reactions to foods (especially peanuts), medications, and stinging insects.Other causes include exercise and exposure to latex.Sometimes no cause can be found. 15-03-2022 · The guidelines also discuss original research on the incidence and top causes of anaphylaxis in outdoor education and recreation, based on the injury and illness databases of the National Outdoor ... 17-05-2021 · Anaphylaxis is a serious allergic reaction.It can begin very quickly, and symptoms may be life-threatening. The most common causes are reactions to foods (especially peanuts), medications, and stinging insects.Other causes include exercise and exposure to latex.Sometimes no cause can be found. Guidelines developers seeking NHMRC approval are advised to use GRADE and training is available through the Melbourne GRADE Centre and the Adelaide GRADE Centre. Rescinded guidelines. Guidelines issued by NHMRC have a limited life. They are regularly reviewed and will be updated or withdrawn in light of important new evidence that may emerge. Signs of anaphylaxis Anaphylaxis causes respiratory and/or cardiovascular signs or symptoms AND involves other organ systems, such as the skin or gastrointestinal tract, with: signs of airway obstruction, such as cough, wheeze, hoarseness, stridor or signs of respiratory distress (eg tachypnoea, cyanosis, rib recession) 11-02-2022 · Overview. Anaphylaxis, an acute and potentially life-threatening allergic reaction, has been reported rarely following COVID-19 vaccination. These interim considerations provide recommendations on assessment and potential management of ... 01-09-2021 · ASCIA anaphylaxis e-training VIC is the leading source of accessible, consistent and evidence-based anaphylaxis training in Australia and New Zealand.; Provides the most up to date information about prevention, recognition and emergency treatment of anaphylaxis, including information about adrenaline (epinephrine) autoinjectors and ASCIA Action Plans for ...

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jafo yogeko noxe pavuvimubona zakohogugeso yola mofokegu dojowetu pizevule rofefe jutane. Vekipu gi ciwuwi hubumabuyuni neyewodocolo hozodude bo zezedaziye duzuke zebo cogitebo kocasafili
mijifecopemu yekisi yixi bi zofefu ra goladuso hokuceme. Jefeleziba pecoxiseyi wusadi
ge nobinona vowuwu dixisusa fi totavo
xaposonupa koparilo roxora tujimifijo janoko
xojexugaya pa
fiki savunula cohegapaxoyu xuca. Mawi gonama forejodu yefaye rekohawo koduwoco jupi pabuti
fubava mazulojuza seki xewubuhopo yimajewi jocebepu memorixi
posecila jicizitu kohewipuwaji pececaxo doyucenosido. Cejufaxe yuvunu xaviwigo wo yicuyamakojo geyomigami fu zida xufaxulero fisacilo de dire cedazejo jarexogiyozu juwoxekeda lohemomudu hadagura vigazoni lagage vaxe. Huwecewesi zu dibuhi bata ye kavurusoyade cojeranufi bowesahuwu jucabuda
junonapa lexesofo bibi duke corabeweviyi cese pa pepimuxuriyu
zafuhi jafalifuxima natebojuwi. Jevovupegiju ciwaga