Anaphylaxis guidelines for nsw independent schools

These guidelines for acute management of severe allergic reactions (anaphylaxis) are intended for medical practitioners, nurses and other health professionals who provide emergency care of first responders. The appendix includes additional information for health professionals working in emergency departments, ambulance services and rural or regional areas that provide emergency care. ASCIA HP Guidelines For Acute Management Anaphylaxis 20267.98 KB Anaphylaxis Any Definitions Acute illness with general skin symptoms (urinary rash or rash / redness / rinse and / or angioedema) includes respiratory and / or cardiovascular involvement and / or ongoing severe digestive symptoms, or the onset of acute hypertension or bronchospasm or obstruction of the upper respiratory tract that is considered anaphylaxis possible, even without general skin features. Signs and symptoms of allergic reactions, mild or moderate reactions (may not occur before anaphylaxis): swelling of the lips, face urticaria, eyes or mouth welts, feeling abdominal pain, vomiting (these are signs of anaphylaxis for insect stings or injections (drug) allergies) Anaphylaxis – identified by one of the following signs: difficulty / Loud breathing, swelling of the tongue, swelling / tightness in the throat, difficulty talking and / or hoa, dizziness or persistent coughing (unlike cough in asthma, the onset of cough during anaphylaxis is usually sudden), persistent dizziness or pale collapse and floppy (small child), stomach cramps, vomiting (for insect stings or injections (medication) allergies). Immediate action for anaphylaxis remove allergens (if still available), call for help. Put the patient flat, don't let them stand or walk. If breathing is difficult, let them sit epinephrine as the first line treatment for anaphylaxis, injecting epinephrine into the muscles (IMI) into the outer middle thighs without delay using the epinephrine autoinjector, if there is an OR epinephrine ampoule/syringe,oxygen (if any). Call an ambulance to transport the patient if it is not already in the hospital. If necessary, always start CPR (heart resuscitation), always provide adrenaline first, then relieve asthma, if people who know asthma and are allergic to food, insects or medications have sudden breathing problems (including wheezing, persistent cough or hoarseness), although anaphylaxis skin symptoms are not usually ingestion within two hours of swallowing ingestion. The onset of the reaction can occur rapidly (within 30 minutes) or may be delayed for several hours (for example, in the allergy to meat in mammals, and diet-dependent exercise causes anaphylaxis, where symptoms usually occur during exercise). sting and injection (including Anaphylaxis may also occur but less common than injections. Provide intramuscular injection (IMI) of ADRENALINE (1:1000) into the outer middle thighs (0.01 mg per kg to 0.5 mg per dose) without delay using adrenaline autoinjector if or with adrenalin ampoule and syringes, as follows: Adrenaline (epinephrine dose) (ageing) Weight (kg) Vol. อะดรีนาลีน 1:1000 อะดรีนาลีน autoinjector ~ <1></1> <7.5k 0.1= ml= not= available= ~1-2= 10= 0.1= ml= 7.5-20= kg=></7.5k> <5yrs) 0.15mg= device= (e.g.= epipen= jr)= ~2-3= 15= 0.15= ml= ~4-6= 20= 0.2= ml= ~7-10= 30= 0.3= ml=>20kg (~>5yrs) 0.3mg อุปกรณ์ (เช่น. EpiPen) ~ 10-12 40 0.4 mL ~ >12 และผู้ใหญ่ >50 0.5 mL หมายเหตุ: หากจำเป็นต้องใช้หลายปริมาณสำหรับปฏิกิริยารุนแรง (เช่น 2-3 ปริมาณบริหารที่ 5 นาที) พิจารณาการแช่อะดรีนาลีนหากมีทักษะและอุปกรณ์ สำหรับการรักษาฉุกเฉินของ anaphylaxis, หลอดของอะดรีนาลีน 1:1000 ควรใช้สำหรับทั้งปริมาณ IM และการแช่ถ้าจำเป็น (ควรใช้อะดรีนาลีน 1:10 000). การรักษา Anaphylaxis สำหรับทารกในขณะที่ 10-20kg เป็นคู่มือน้ำหนักก่อนหน้านี้สำหรับอุปกรณ์ autoinjector อะดรีนาลีน 0.15 มิลลิกรัม, อุปกรณ์ 0.15 มิลลิกรัมในขณะนี้อาจได้รับการกำหนดสำหรับทารกน้ำหนัก 7.5-10 กิโลกรัมโดยผู้เชี่ยวชาญด้านสุขภาพที่ได้ทำการประเมิน. The use of 0.15 mg devices for the treatment of infants weighing 7.5 kg or more poses less risk, especially when used without medical training, rather than using epinephrine tubes and syringes. Babies with anaphylaxis may treat color despite 2-3 doses of epinephrine, and this can be corrected without additional doses. Managing anaphylaxis in the pregnancy management of anaphylaxis in pregnant women is the same as non-pregnant women. Epinephrine should be the first line treatment for anaphylaxis in pregnancy, and rapid administration of epinephrine (1:1000 IM epinephrine 0.01 mg per kg to 0.5 mg per dose). It should not be suppressed due to the fear that causes placental perfusion to decrease. The left position is recommended for patients who are pregnant to reduce the risk of inferior vena cava compression by the pregnant uterus and return the veins to the heart, see THE ASCIA guidelines for more information: www.org.au/hp/papers/acute-management-of-anaphylaxis-in-pregnancy. Patient</5YRS)>Do not walk or stand, even if they seem to recover. It is best to use a crib trolley or a wheelchair bed to transfer the patient:- To the ambulance - from the ambulance to the treatment room bed - from the treatment room bed to and from the bathroom. Placing patient flats increases the blood poisoning back to the heart, on the contrary, placing the patient in an upright position can cause blood to return to the heart, resulting in insufficient blood supply for the heart to circulate and low blood pressure. The correct way to hold the baby horizontally, as shown in this photo. It is recommended to use the left position (recovery) for the patient who is pregnant (shown in this photo). This reduces the risk of inferior vena cava compression by the pregnant uterus and improves the return to the venous heart. If vomiting, place the patient sideways in the recovery position. Patients with most respiratory symptoms may prefer to sit, which may help support breathing and improve ventilation. Patients should sit with their legs protruding in front of them (not in a chair), be careful that even sitting may cause high blood pressure. Closely monitored Put the patient immediately flat again if there is any change in conscious state or a decrease in blood pressure. Do not let patients stand or walk until they are haemodynamically stable, which usually is at least 1 hour after 1 dose of epinephrine and 4 hours if more than 1 dose of epinephrine. Support management - When the skills and equipment are available, check the pulse, blood pressure, ECG pulse, oximetry, conscious state, provide high oxygen flow if available and respiratory support if necessary. Iv access is granted in adults and children with tachycardia and/or children with high blood pressure. The first sign of cardiovascular reconciliation in children is constant tachycardia. High blood pressure can occur later, when it can be difficult to get access to an IV, resulting in a significantly prolonged recovery process. If high blood pressure provides normal saline solution IV 20mL/kg quickly and consider access to an iv that penetrates more wide. See the appendix for more information- adrenaline infusion IV in clinical settings, if there is an inadequate response after 2-3 epinephrine doses or patient deterioration, initiate an adrenaline infusion IV received by trained staff in use or in coordination with emergency/critical care specialists, should use adrenaline IV infusion with dedicated hoses, infusion pumps and anti-acid reflux valves wherever possible. CAUTION: IV boluses of epinephrine are not recommended without specialized training, as they may increase the risk of arrhythmia. See the appendix for more information. Additional measures should be considered if epinephrine infusion IV is ineffective for upper respiratory obstruction, Nebulised epinephrine (5mL, e.g. 5 tubes of 1:1000), considering advanced respiratory management requirements if skilled and equipped. For persistent low blood pressure/ normal shock Glucagon in adult vasoconstrictors selected only after advice from emergency physicians/key care professionals. For permanent whales, Bronchodilators: Salbutamol 8-12 puffs of 100µg (spacer) or 5 mg (nebuliser) Note: Bronchodilators should not be used as a first line for Anaphylaxis, since they do not prevent or relieve upper respiratory obstruction, low blood pressure or shock Corticosteroids: oral prednisolone 1 mg/kg (maximum 50 mg) or intravenous hydrocortison 5 mg/kg. (up to 200 mg) Note: Steroids must not be used as a first line drug instead of epinephrine. Antihistamines and antihistamines: Antihistamines have no role in treating or preventing respiratory or cardiovascular symptoms of anaphylaxis do not use oral antihistamines as a side effect (drowsiness or drowsiness) may mimic certain signs of anaphylaxis should not use promethazine injected in anaphylaxis because it can weaken blood pressure and cause necrosis. Benefits of corticosteroids in anaphylaxis have not been proven. Observed patients for at least 4 hours after the final dose of reactive epinephrine, protracted and / or biphasic reactions may occur. Overnight observations are strongly recommended if they are: severe or protracted anaphylaxis (e.g. need repeated doses of epinephrine or fluid IV resuscitation) or have a history of severe/protracted anaphylaxis or other common illnesses (such as severe asthma, a history of atrial fibrillation, mastocytosis. Real biphasic reactions are expected to occur after 3-20% of anaphylactic reactions follow treatment, including recommendations for hospital discharge adrenaline autoinjector, if there is a risk of repeated exposure (such as an idiopathic food sting). Teach patients how to use adrenaline autoinjector using trainers and provide them with an ASCIA action plan for Anaphylaxis - see the ASCIA website allergy.org.au/anaphylaxis Recommend Allergy Patients & Allergy. Anaphylaxis Australia allergyfacts.org.au for information on daily management and support while they await clinical immunosuppressive/allergy specialist clinical immunotherapy/referrals, allergy experts recommend all patients with anaphylaxis for specialist monitoring. Start immunotherapy of existing allergens (for some insect poisoning), refer to other related health professionals as required (such as a nutritionist). Documents of episodes, patients should be advised to record this episode of anaphylaxis. Identifying avoidable causes (such as diet, herbal medicine, bites and stings, joint factors such as exercise) in the 6-8 hours before the onset of symptoms, ascia allergy events and clinical history forms can be used to collect and record this information. Preparation www.allergy.org.au/hp/anaphylaxis/anaphylaxis-event-record www.allergy.org.au/hp/anaphylaxis/clinical-history-form-allergic-reactions: necessary equipment for acute management of anaphylaxis, equipment on your emergency cart should include: adrenaline 1:1000 (consider the availability of autoinjector epinephrine, especially in rural places for the first administration by nursing staff). 1mL syringe; 22-25G (length 25 mm) For IM injections for all ages* (in line with the Australian Immunity Guide) Oxygen Airway equipment includes oxygen masks. Rebreather Mask Nebula and Suction Self-defibrillator, blood pressure, wrist IV access device (including a large piercing cannulae) of at least 3 liters of normal saline, hands-free phone in the life support room, to allow health care providers in remote locations to receive phone advice while providing free hands for life savings. *Exceptions are premature/very small babies (needle length 23-25G 16mm) and adults who are very large/obese (22-25G and needle length up to 38mm). These guidelines are also based on the following international guidelines: the International Coordination Committee on Recovery (ILCOR) and the Australian and New Zealand Board on Life-Saving Guideline www.nps.org.au/australian-prescriber/articles/anaphylaxis-emergency-management-for-health-professionals s (ANZCOR), the American Allergy Institute's guidelines. Asthma and Immunity Anaphylaxis, the World Allergy Organization (WAO) parameters, anaphylaxis, anaphylaxis management guidelines in the community, including school and early childhood child care, have been facilitated by regular training and the use of ASCIA action plan for Anaphylaxis. To access the ASCIA action plan and other anaphylaxis resources, including an electronic training course to Appendix www.allergy.org.au/anaphylaxis: Anaphylaxis Advanced Acute Management, this additional information is intended for health professionals working in emergency departments, ambulance services and rural or regional areas that provide emergency care. Support management (when skills and equipment are available) Monitoring pulse, blood pressure, breathing rate, pulse, oximetry, conscious state, high oxygen flow (6-8 l / min) and respiratory support, if necessary, extra oxygen should be provided to all patients with respiratory distress, reduced consciousness levels, and those who need repeated adrenaline should consider extra oxygen in the patient. Other chronic respiratory diseases or cardiovascular diseases Get intravenous access (IV) in adults and in children with high blood pressure. If blood pressure is low: give normal saline intravenously (20 mL/kg rapidly under pressure) and repeat the bolus if low blood pressure persists. Consider additional wide penetration (14 or 16 gauges for adults) intravenous access during severe anaphylaxis with low blood pressure, marking a lavish liquid into the tissue can occur: do not forget to resuscose fluids. Circulatory assessment to reduce the risk of detection of overtreatment for signs of overtreatment (especially if respiratory distress or low blood pressure is initially absent) - is not a good place to stay. Includes pulmonary edema, hypertension. In this setting (anaphylaxis), it is recommended that if possible, systolic blood pressure, simple amniotic fluid (SBP) should be measured: attach the BP wrist manually to the right size and find the pulse. brachial or radial Given the pressure that this pulse disappears/reappears (apparently systolic BP), this is a reliable initial severity measurement and the response to sbp treatment measurements may obviously be more difficult in children. Note: If the patient is nausea, tremor, vomit or tachycardia, but with normal or high SBP, this may be more adrenaline poisoning than worsening anaphylaxis. Additional measures - IV adrenaline infusion IV epinephrine should be taken by, or in coordination with, emergency medications/key care professionals. If your center has protocols for adrenaline infusion IV for critical care, this should be used and titration in response to close cardio respiratory monitoring. If there is no protocol defined for your center, there will be two protocols for adrenaline infusion IV, one for pre-hospital settings, and the second for emergency departments/ hospital settings, fertile levels only. It is important to note that both infusion protocols have different concentrations and different IV infusion rates, resulting in the same initial rate of epinephrine infusion. It is important that IV adrenaline infusions should be used with the following devices wherever possible: specialized lines. Vein Reflux Prevention Valve Additional measures - adrenaline infusion IV for pre-hospital settings if there is insufficient response to IMI epinephrine or initial deterioration of intravenous epinephrine infusion. Adrenaline funding IV epinephrine should be given by or in coordination with emergency physicians/key care professionals. The protocols for normal brine 1,000 mL are as follows: 1 mL of epinephrine 1:1000 in 1,000 mL of normal saline solution, start soaking at ~5 ml/ kg / h (~0.1 ug /kg/min) If you do not have a standard infusion pump , the dose is ~20 drops per mL; Titration rates are up or down based on responses and side effects. Continuous monitoring – ECG and oximetry pulse and frequent non-invasive blood pressure measurements are the minimum to increase. and reduces the risk of overtreatment and adrenaline poisoning. Note: This protocol is intended for temporary use when there is no infusion pump, most anaphylactic reactions settle with epinephrine of only 1 mg in 1 liter. Indefinite continuity of infusion, low concentration, increases the risk of liquid overload. Caution - It is not recommended to use intravenous boluses of epinephrine due to the risk of ischemic heart disease or arrhythmia, unless the patient has cardiac arrest. Additional measures: Adrenaline infusion IV for emergency departments / education-rich hospitals only, this infusion will facilitate more fast delivery through peripheral cables and should be used only in emergency departments and educational enriched hospital settings. The protocols for normal brine 100 mL are as follows: 1 mL mixture of epinephrine 1:1000 in normal brine 100 mL, the default rate adjusted according to 0.5 ml / kg / h (~0.1 ug/kg / min) should only be received from the infusion. Continuous monitoring – ECG and pulse oximetry and frequent non-invasive blood pressure measurements are the minimum to increase benefits and reduce the risk of overtreatment and epinephrine toxicity. Additional measures to consider if adrenaline infusion IV is ineffective for hypotension / permanent shock: provide regular saline (up to 50mL/kg in the first 30 minutes) in patients with heart shock (especially if beta blocker). Consider the intravenous glucagon bolus: - 1-2mg. In adults - 20-30 ug / kg to 1 mg in children this may be repeated or followed by an infusion of 1-2mg / h in adults. In adults, vasoconstrictors Choose metaraminol (2-10 mg) or vasopressin (10-40 units). Only after advice from an emergency physician/key care specialist. Beware of side effects including arrhythmia, severe moderate blood pressure and pulmonary edema. In children can use metaraminol 10 ug / kg / dose noradrenaline infusion may be used in important care settings, only with invasive blood pressure monitoring. Advanced respiratory management of oxygen is more

important than inhalation. Always call for help from the most experienced person. If respiratory support is required, first use the skills you are most familiar with (such as jaw thrust, Guedel or nasopharyngeal airways, a cyst valve mask with high flowing oxygen attached). This will help most patients, even those with clear respiratory swelling (these patients often stop breathing due to the collapse of the circulatory system, rather than respiratory obstruction, and can be adequately ventilated with basic life support procedures). Do not try for a long time at intubation - remember that the patient does not receive any oxygen while you are intubating, if not able to maintain the respiratory tract, and the patient's oxygen saturation is reduced, consider additional guidelines to the respiratory tract (such as cricothyrotomy), according to difficult respiratory management protocols. Specific training must be carried out by these steps. Special circumstances: The keys to anaphylaxis (cardiac arrest) are overwhelming. Large vasodilatation and the extravagance of liquids It is unlikely that IMI epinephrine will be absorbed in this situation due to poor peripheral circulation even if it is absorbed, imi epinephrine by itself may not be enough to overcome vasodilatation and extravagance. Requires both IV bolus epinephrine (cardiac arrest protocol, 1 mg every 2-3 minutes) and aggressive fluid resuscitation in addition to CPR (normally 20mL/kg saline statistics, through large IV puncture under pressure, repeated if no response). Do not give up too soon - this is a situation where CPR should be considered for a long time, because the patient is quickly arrested with oxygen in the previous normal tissue, and there are potentially reversible causes.