ANA Anaphylaxis

longlives
ANESTHESIA PATHWAYS

Urticaria, cardiovascular collapse, bronchospasm, hypotension, angioedema, cardiac arrest, bradycardia

Start

1. **Call for "ANESTHESIOLOGIST STAT" and CODE CART**
2. **Give EPINEPHRINE bolus**
3. **Remove potential causative agents**
4. **Secure airway, Turn FiO2 to 100%**
5. **Give fluid bolus**
   - Confirm adequate IV access
6. **Consider...**
   - Turn off volatile anesthetics if patient remains unstable
   - Vasopressin for patients with continued hypotension despite repeated doses of epinephrine
   - Epinephrine infusion for patients who initially respond to bolus doses of epinephrine but experience continued symptoms
   - Diphenhydramine
   - H2 Blocker: Ranitidine or Famotidine Albuterol
   - Hydrocortisone
   - Check Serum Tryptase level (Gold top tube): Check within first hour, repeat at 4 hours, and at 18-24 hours post reaction
   - Terminate procedure
   - Referral to allergist for skin testing

DRUG DOSES and Treatments

EPInephrine	300-500 mcg **IM preferred** if pt. not in cardiovascular collapse
	10-100 mcg IV
	Infusion: Start at 2-10 mcg/min IV
Vasopressin	1-2 units IV
Diphenhydramine	25-50 mg IV
H2 Blockers	Famotidine 20 mg IV -or-
	Ranitidine 50 mg IV
Hydrocortisone	100 mg IV
Albuterol	8-10 puffs MDI or 2.5mg nebulized via ETT/ inspiratory limb
Glucagon	50-150 mcg/kg IV if patient on beta-blockers and not responding to epinephrine

Common Causative Agents

Neuromuscular Blockers
Latex
Antibiotics (penicillins, cephalosporins)
IV Contrast

Critical Changes

If ASYSTOLE/PEA develops: Go to » CHKLST CAA If
VF/VT develops: Go to » CHKLST CAV
If BRADYCARDIA develops: Go to » CHKLST BDY
If BRONCHOSPASM develops: Go to » CHKLST BRO

PROVIDENCE
ANESTHESIOLOGY ASSOCIATES