Anaphylactic shock management pdf

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These acute management guidelines for severe allergy (aergic allergies) are intended for medical practitioners, nurses and other health professionals who provide emergency care to the first responder. The annex contains additional information for health professionals working in emergency departments, ambulance services and rural or regional areas, who provide emergency care. ASCIA HP Acute Anaphylaxis Management Guidelines 2020267.98 KB Allergic Allergic Reactions Any Acute Onset Disease with Typical Skin Features (Paper Rash or Redness/Redness, and/or Angioedema), in addition to involvement of the respiratory and/or cardiovascular and/or persistent acute gastrointestinal symptoms; Or any severe onset of hypotension, bronchial spasm or blockage of the upper airway where anaphylaxis is possible, even if typical skin features are not present. Signs and symptoms of allergic reactions mild or moderate reactions (may not always occur before anaphylaxis): swelling of the lips and face, eye cells or bruises, tingling abdominal pain mouth, vomiting (these are signs of allergy to insect bite or drug injection (drug) allergy (allergy) – referred to by any of the following signs: difficulty/noisy breathing swelling of the tongue / tight throat difficulty in talking and / Or hoarse sound Wheeze or persistent cough (unlike coughing in asthma, the onset of cough during anaphylaxis is usually sudden) persistent dizziness or pale breakdown and flexible (young children) abdominal pain or vomiting (for insect stings or injectable drug allergy (medication). Don't let them stand or walk. Do not carry erect infants. If breathing is difficult, allow them to sit. An adrenaline injector if it is available or an adrenaline urinating/syringe. Give oxygen (if available). Call an ambulance to transport the patient if he is not already in hospital mode. If necessary at any time, start CPR (CPR). Always give adrenaline first, then relieve asthma if someone with known asthma and allergies to food, insects or medication has difficulty breathing suddenly (including whistling, constant cough or hoarse sound) even if there are no skin symptoms. Hypersensitivity triggers and the most common reaction times of anaphylaxis are foods, insect stings and medications (medications). Less common triggers include latex and ticks. Allergies usually occur within an hour or two of ingestion in food allergies. Reaction may occur quickly (within 30 minutes) or be delayed by several hours (e.g., in breast meat allergy and exercise of food allergies caused by anaphylaxis, where symptoms usually occur during exercise). Anaphylaxis and injectable medications (including Agents and vaccines) usually occur within 5-30 minutes but may be delayed. Anaphylaxis can also occur for oral drugs but is less common than drugs that are injected. Adrenaline management and adrenaline dosing is the first line treatment for anaphylaxis and works to reduce the edema of mokosal airway, induce bronchi, induce vasoconstriction and increase the strength of heart shrinkage. Administer intramuscular injections (IMI) of adrenaline (1:1000) in the middle of the outer thigh (0.01 mg per kg up to 0.5mg per dose) without delay using an adrenaline injector if available or adrenaline ampoule and syringe, as follows: adrenaline (epinephrine) doses of life (years) weight (kg) adrenaline bean 1 :1000 adrenaline autoinjector ~ <1><7.5k 0.1 = 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 (~gt;5yrs) 0.3mg device (for example). EpiPen) ~ 10-12 40 0.4 ml ~ >12 and adults >50 0.5 ml note: if multiple doses are needed for severe reaction (e.g. 2-3 doses administered at intervals of 5 minutes), consider pumping adrenaline if skills and equipment are available. To treat emergency allergies, 1:1000 adrenaline ampoules should be used for both chat and infusion doses if necessary (adrenaline 1:10 000 should not be used). Treatment of anaphylaxis for infants while the previous weight guide for the adrenaline monitor was 1.15mg, the 0.15mg device now can also be prescribed to an infant weight of 7.5-10kg by health professionals who made a vision assessment. Using a 0.15 mg device to treat infants weighing 7.5 kg or more poses a lower risk, especially when used without medical training, than using adrenaline and syringes. Infants with anaphylaxis may retain pallor despite 2-3 doses of adrenaline, and this can be resolved without further doses. More than 2-3 doses of adrenaline in infants may cause high blood pressure and tachycardia, which is often misinterpreted as an ongoing cardiovascular compromise or anaphylaxis. Blood pressure measurement can provide a guide to effective treatment, to check if additional doses of adrenaline are needed. 46. Pregnancy allergy management is the same as anaphylaxis management in pregnant women. Adrenaline should be the first line treatment for anaphylaxis in pregnancy, and the speed of giving adrenaline (1:1000 IM adrenaline 0.01mg per kg up to 0.5mg per dose) should not be withheld due to fear of causing a decrease in placental flop. The left side position of pregnant patients is recommended to reduce the risk of lower vein pressure from the pregnant uterus and thereby weaken the venous return to the heart. Refer to the ASCIA guidelines for more information: www.allergy.org.au/hp/papers/acute-management-of-anaphylaxis-in-pregnancy location of a patient's mortality can occur within minutes if the patient stands, walks or sits suddenly. Patients </5yrs)>Don't walk or stand, even if she has recovered. A wheelchair, stretcher or trolley bed should be used to transport the patient to the ambulance. Putting the patient's flat will improve the return of venous blood to the heart. By contrast, the patient can be placed in a straight position, weakening the return of blood to the heart, leading to insufficient blood for the heart to circulate and lower blood pressure. The correct way to hold the baby horizontally, as shown in this picture. It should not be placed upright on the shoulder. Left side (recovery) position is recommended for pregnant patients (shown here). This reduces the risk of lower vein compression of kava from the pregnant uterus and improves venous return to the heart. If vomiting, put the patient on their side in a recovery position. Patients with respiratory symptoms may mostly prefer sitting, which may help support breathing and improve ventilation. The patient should sit with their legs outstretched in front of them (not on a chair). Beware that even sitting may lead to low blood pressure. Closely monitor. Immediately put the patient's apartment back if there is any change in the conscious condition or a decrease in blood pressure. Do not allow the patient to stand or walk until they are stable in a howdy form, which is usually at least 1 hour after 1 dose of adrenaline and 4 hours if more than 1 dose of adrenaline. Supportive management - when the available skills and equipment are pulse screening, blood pressure, ECG, pulse oxidation measurement, conscious condition. Give high oxygen flow if available and support the airway if necessary. Get the fourth arrival in adults and children tachycardia and/or low blood pressure. The first sign of cardiovascular compromise in children is ongoing tachycardia. Low blood pressure can occur later, when it can then be difficult to get IV access, resulting in a largely long recovery process. If blood pressure is low, give the regular saline IV 20mL/kg quickly and consider entering an additional wide IV. See appendix for additional information. Additional measures - the fourth adrenaline injection in the clinical setting if there is an insufficient response after 2-3 adrenaline doses, or patient deterioration, start pumping the fourth adrenaline, provided by staff trained to use it or in contact with an emergency/critical care specialist. The fourth adrenaline pump should be used with a dedicated line, pump pump and anti-reflux valves whenever possible. Caution: Intravenous bolols of adrenaline are not recommended without specialized training as they may increase the risk of arrhythmias. See appendix for additional information. Additional measures to consider whether the fourth adrenaline pumpist is ineffective for blocking the upper airway of adrenaline napolisde (5mL such as 5 ampoules of 1:1000). Consider the need for advanced sewage management if skills and equipment are available. For constant low blood pressure/shock giving normal (Maximum 50 ml/kg in the first 30 minutes). Glucagon in adults, selective blood vessels only after advice from an emergency medicine specialist/critical care. See appendix for additional dose and information. For bronchodilators constantly shaken: salbutamol 8-12 puffs of 100µg (spacer) or 5mg (airbrush). Note: Bronchodilators should not be used as a first-line drug for anaphylaxis because they do not prevent or relieve the blockage of the upper airway, low blood pressure or shock. Corticosteroids: Oral prednisolone 1 mg/kg (up to a maximum of 50 mg) or hydrocortisone intravenously 5 mg/kg (max 200 mg). Note: Steroids should not be used as a first-line drug instead of adrenaline. Antihistamines and antihistamines: Antihistamines have no role in treating or preventing respiratory or cardiovascular symptoms from anaphylaxis. Do not use oral antihistamines because side effects (drowsiness or lethargy) may mimic some signs of anaphylaxis. Promethazine injections should not be used in anaphylaconeasis because it can exacerbate low blood pressure and cause muscle necrosis. Corticosteroids: The benefit of corticosteroids in anaphylaxis is unproven. Monitor the patient for at least 4 hours after the last dose of adrenaline relapse, prolonged reactions and/or may occur. It is highly recommended to observe overnight if: they have severe or prolonged anaphylaxis (e.g. repeated doses of adrenaline or fourth fluid resuscitation), or have a history of severe/prolonged anaphylaxis, or have another concurra disease (e.g. severe asthma, history of arrhythmia, systemic phenomenon), live alone or away from medical care, or provide medical care late in the evening. It is estimated that phased bi-phase reactions occur after 3-20% of allergic reactions. Follow-up treatment including discharge advice in the hospital adrenaline self-injection if there is a risk of exposure again (such as stings and foods, and an unknown cause) then prescribes and if possible dispensing with the adrenaline injector before going out, awaiting a specialized review. Teach the patient how to use an adrenaline critic using a trainer device and provide them with an ASCIA action plan for anaphylaxis - see the ASCIA website allergy.org.au/anaphylaxis Reference to Allergy and Allergy Australia allergyfacts.org.au for information about management and daily support while they await clinical review of immunity/allergies. Referral of a clinical immunologist/allergist to all patients with anaphylaxis for specialized review. Clinical immunologist/allergy: will determine/confirm the cause. Education on avoidance/prevention strategies and managing common morbidity. Present ing the ASCIA Action Plan for Allergy - Preparing for Future Reactions. Start allergenic immunotherapy where available (for some insect toxins). Refer to other relevant health professionals as appropriate (e.g. dietitian). Documenting episodes patients should be recommended for documenting anaphylactic episodes. This one Identify avoidable causes (such as food, medications, herbal remedies, bites and stings, and common factors such as exercise) in 6-8 hours before symptoms appear. ASCIA sensitivity event log and clinical history forms can be used to collect and document this information. www.allergy.org.au/hp/anaphylaxis/anaphylaxis-event-record www.allergy.org.au/hp/anaphylaxis/clinical-history-form-allergic-reactions preparation: Equipment for acute management of anaphylaxis should include equipment on your emergency vehicle: adrenaline 1:1000 (consider the availability of automatic adrenaline connector, especially in rural locations, for initial management by nursing staff) syringes 1mL; 22-25G needles (length 25 mm) are recommended for chat injections for all ages* (in accordance with the Australian Immunization Guide). Earl's oxygen equipment, including re-oxidation masks, oxygen masks, spray masks and suction. Manual removal of defibrillator suppter ingesting of blood pressure equipment access (including large canola bearing) at least 3 liters of regular saline and hands-free phone in the recovery room, to allow health care providers in remote locations to receive instructions by phone while keeping hands free for resuscitation. * Exceptions are preterm/very young infants (23-25g needle length 16mm) and adults are very large/obese (22-25g needle length up to 38mm). The recognition of information in these guidelines is consistent with Australian sensitivity descriptor sparse choral arterial arterial arterial www.nps.org.au/australian-prescriber/articles/anaphylaxis-emergency-management-for-health-professionals these guidelines are also based on the following international guidelines: The International Communication Commission on Recovery (ILCOR) and the Australian and New Zealand Recovery Committee (ANZCOR) American Academic Guidelines for Allergy, Asthma and Immunity (AAAAI) Allergy Teacher Global Allergy Organization (WAO) guidelines for the management of anaphylaxis in the community, including schools and early childhood education/care, is facilitated through regular training and the use of the ASCIA Allergy Action Plan. The instructions in this plan are in line with the information contained in these guidelines. To access ASCIA's action plans and other anointing resources, including e-training courses, go to the www.allergy.org.au/anaphylaxis Supplement: Advanced Acute Hypersensitivity Management, this additional information is intended for health professionals working in emergency departments, ambulance services, and rural or regional areas, who provide emergency care. Supportive management (when skills and equipment available) monitor pulse, blood pressure, respiratory rate, pulse measurement, and state-conscious. Give oxygen high flow (6-8 liters/min) and support the airway if necessary. Supplemental oxygen should be given to all patients with respiratory distress, low level conscious and those requiring frequent doses of adrenaline. Supplemental oxygen should be considered in patients who have Other chronic respiratory diseases, or cardiovascular diseases. Get vein (IV) in adults and children low blood pressure. If blood pressure: give natural venous salt (20 ml/ kg quickly under pressure), repeat bulus if pressure is constant. Consider an additional wide load (14 or 16 measures for adults) intravenous access. During severe allergic reactions with low blood pressure, noticeable liquid extravagance can occur in tissues: do not forget fluid resuscitation. Evaluation of blood circulation to reduce the risk of over-treatment of the monitor for signs of over-treatment (especially if respiratory tightness or low blood pressure is initially absent) – including pulmonary edema, hypertension. In this setting (anaphylaxis) it is recommended that if it is possible to measure the concrete simple systolic blood pressure (SBP): attach a manual BP cuff of a suitable size and find a bone or radial pulse. Determine the pressure at which this pulse disappears/reappears (concrete systolic BP). This is a reliable measure of initial severity and response to the treatment sbp clear measurement may be more difficult in children. Note: If the patient is nausea, vibrating, vomiting, or tachycardia but has a normal or elevated SBP, this may be adrenaline toxicity instead of exacerbating anaphylaxis. Additional measures - the IV adrenaline injection vein should only be given by, or in contact with, emergency medicine specialist/critical care. If your center has a protocol for injecting intravenous adrenaline for critical care, this procedure should be used and response care with cardiac and respiratory surveillance. If there is no established protocol for your center, two protocols are provided for the fourth adrenaline pumping, one for pre-hospital settings and the other for emergency departments/hospital settings iii only. It is important to note that the two infusion protocols have different concentrations and different rates of intravenous fluid infusion, leading to the same initial rate of adrenaline infusion. It is important that iv adrenaline injection should be used with the following equipment whenever possible: custom line. Infusion pump. Anti-reflux valves in the vein line. Additional measures - the fourth adrenaline infusion of pre-hospital environments if there is an insufficient response to IMI adrenaline or deterioration, start pumping adrenaline into the vein. The fourth adrenaline infusion should be given only by, or in contact with, an emergency doctor/critical care specialist. The regular 1000 ml saline protocol is as follows: a 1 ml combination of 1:1000 adrenaline per 1000 ml of regular saline. Start pumping at ~5 ml/kg/h (~0.1 µg/kg/min). If you don't have a pump pump, the standard giving kit runs ~20 drops per ml; Therefore, start from ~ 2 drops per second for adults. The rate of ati is higher or lower according to the response and side effects. Continuous monitoring - measurement of heart and pulse oxidation and recurrent non-invasive blood pressure measurements at a minimum to maximize Reduce the risk of over-treatment and adrenaline toxicity. Note: This protocol is intended for temporary use, when no pump is available. Most allergic reactions settle with only 1 mg of adrenaline per 1 liter. Unlimited perinatal low concentration infusion increases the risk of fluid overload. Caution - Intravenous bolbulies are not recommended for adrenaline because of the risk of heart anemia or arrhythmia unless the patient is in cardiac arrest. Additional measures: Intravenous adrenaline pumping for emergency departments/third hospitals only this infusion will facilitate faster delivery through the perimeter line and should be used only in emergency departments and the third hospital. The regular 100 ml saline protocol is as follows: a 1 ml combination of 1:1000 adrenaline in 100 ml regular saline. Accordingly, the initial rate rate is 0.5 ml/kg/h (~0.1 µg/kg/min). It should be given only by pumping the pump. Continuous monitoring - ECG, pulse measurement of oxymeters and the frequency of non-invasive blood pressure measurements at a minimum to maximize benefit and reduce the risk of excessive treatment and adrenaline toxicity. Additional measures to consider whether the fourth adrenaline infusion is ineffective for low blood pressure/persistent shock: giving regular saline (max 50mL/kg in the first 30 minutes). In patients with heart trauma (especially if taking beta-blockers) consider venous bolus glucagon of:- 1-2mg in adults - 20-30 µg/kg up to 1mg in childrenIf it can be repeated or followed by an infusion of 1-2mg/hour in adults. In adults, selective vasoconstors metaraminol (2-10mg) or vasoprecin (10-40 units) only after advice from an emergency medicine specialist/critical care. Beware of side effects including arrhythmias, severe low blood pressure and pulmonary edema. In children, metanine can be used 10 µg/kg/dose. Nodrinlini infusion can be used in critical care mode, only with invasive blood pressure monitoring. Advanced airway management oxygen is more important than seizures. Always call for help from the most experienced person available. If there is a need to support the airway, first use skills that are more familiar with them (e.g. jaw push force, Guedel, nasopharyngeal airway and bag valve mask with high oxygen flow attached). This will save most patients, even those with clear airway swelling (these patients often stopped breathing due to a breakdown of blood circulation instead of clogging the airway and can be adequately ventilated with basic life support procedures). Do not make prolonged attempts at seizures - remember that the patient does not get any oxygen while you are intubating. If it is unable to maintain the airway and the patient's oxygen saturation decreases, further approaches to the airway (such as cretan removal) should be considered in accordance with the difficult airway management protocols in place. Specific training is needed to implement these actions. Special condition: anaphylaxis (cardiac arrest) key Expansion of large vessels and liquid extravagance. IMI adrenaline is unlikely to be absorbed in this mode due to poor peripheral circulation. Even if absorbed, imi adrenaline on its own may not be enough to overcome vasodilation and extravagance. You need both the fourth adrenaline beats (heart attack protocol, 1 mg every 2-3 minutes) and aggressive fluid resuscitation in addition to CPR (normal saline 20mL/kgstat, through a large bear IV under pressure, repeat if not responsive). Do not give up too early - this is a situation that should be considered for prolonged CPR, because the patient is quickly arrested with previously normal tissue oxygen and has a reversible cause. © ASCIA 2020 IS THE PINNACLE OF THE PROFESSIONAL BODY OF CLINICAL IMMUNOLOGISTS/ALLERGY SPECIALISTS IN AUSTRALIA AND NEW ZEALAND ASIA RESOURCES BASED ON PUBLISHED LITERATURE AND EXPERT REVIEW, HOWEVER, ARE NOT INTENDED TO REPLACE MEDICAL ADVICE. Ascia resource content is not affected by any commercial organizations. For more information go to www.allergy.org.au to donate to allergy and immunology research go to www.allergyimmunology.org.au www.allergyimmunology.org.au

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