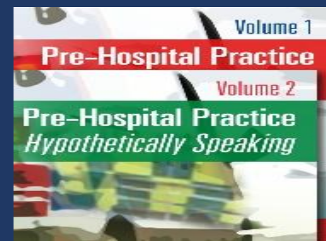
Anaphylaxis
Paramedic case studies #6

Jeff Kenneally www.prehemt.com



Past history

You are attending a 20 year old woman who has a past history of allergies including itching and diarrhoea following dairy product ingestion. This has never required hospitalisation or significant intervention beyond antihistamines.

Today

For the last 24 hours she has been unwell with a productive cough and malaise. She attended her local doctor who commenced her on antibiotic therapy. After picking up the prescription at the pharmacy, she went home and commenced the first tablet. About twenty minutes later she began to feel much more unwell. Her lips are tingling and puffy, she has difficulty breathing and now has abdominal pain and diarrhoea. Her boyfriend called for ambulance help.

On examination

CNS GCS=15 alert, oriented and anxious
CVS flushed, dry, warm P=96 BP=95/50
Resp 28min c/o breathing difficulty and choking feeling, some dyspnoea evident with mild increased effort and retraction and prolonged expiratory phase , on ausc chest wheezing L=R and crackles lower R side. Occasional productive cough
Chest c/o no pain
ECG sinus rhythm
Pulse oximetry 94%

Working assessment

Anaphylaxis – (differentiate from allergy)

Management

Discuss different presentation criteria of anaphylaxis including cutaneous signs such as rash/redness is not always present. May have GIT or not, may have hypotension or not, may have respiratory or not. Revisit the case study to vary presentation changes and still come up with same conclusion. Emphasise err on treating as if it is.
Also discuss causes and speeds of onset – maybe very quick or maybe slower over 30 – 60 minutes
Position – usually supine, sit up only if struggling to breathe. Don't sit up too soon to avoid collapse
Oxygen – needed because of sluggish perfusion and hypoxaemia and not pulse oximetry driven
Salbutamol – can use but don't delay or avoid adrenaline
Adrenaline – dose? Route? Must be IM. Can add nebulised for resp difficulty but not delay or replace IM. Discuss role of IV as only for complete vascular collapse/pre-arrest
Steroids if available but as second line when time is spare
Role of antihistamines – very little in fact if anaphylaxis is the problem
Scene time – minimal with need for treating patient as having strong potential to deteriorate or not improve is important. All pts transported given need for observation

Patient deteriorates

Despite correct initial management, patient becomes altered conscious with increasing antioedema and difficulty breathing
Next management Discuss airway difficulties present – oedema/stridor and obstruction. Difficulties ventilating. Use of NPA perhaps over OPA/LMA. Need for ICP support and perhaps surgical airway if problem persists. Continued adrenaline – dose? Route? Intervals? Not IV unless vascular collapse and profound hypotension Intravenous fluid therapy to support loss of vascular fluid from oedema
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