

Appendix C:

Urgent surgical intervention after suspected perioperative anaphylaxis and prior to allergy investigations: NAP6 suggested management plan

It is possible to provide safe anaesthesia in almost every case and unnecessary to postpone urgent surgery.

- ✓ It is important to discuss the case with a consultant Allergist or Clinical Immunologist as soon as possible after the suspected anaphylactic event
- ✓ Regional anaesthesia, where practical, may be a sensible option to enable avoidance of most drugs suspected to have caused anaphylaxis during previous general anaesthesia
- ✓ If anaesthesia was induced with propofol and general anaesthesia is required, the choice of induction agents includes inhalational agents, thiopental, etomidate (non-lipid formulation) and ketamine.
- ✓ If tracheal intubation is required and an NMBA is contra-indicated:
 - A remifentanyl infusion, magnesium sulphate and topical anaesthesia are helpful adjuncts to deep anaesthesia in facilitating laryngoscopy and intubation
 - Where remifentanyl was used in the previous anaesthetic, consider the use of alfentanil
 - Awake intubation under topical anaesthesia is an alternative
- ✓ If local anaesthetics are not contra-indicated, sufficient surgical muscle relaxation can usually be provided if necessary with an adequate depth of anaesthesia and adjunct neuraxial block, transversus abdominis blocks, rectus sheath blocks or other peripheral nerve block
- ✓ Pre-warn the theatre team beforehand, and be prepared to diagnose and treat anaphylaxis promptly. Consult appropriate guidelines in advance
- ✓ Premedication with antihistamines and steroids may reduce the severity of reactions caused by non-specific histamine release but will not prevent anaphylaxis.

Avoid the following if administered/exposed during the 60 minutes prior to the suspected anaphylactic event:

- All drugs to which the patient was exposed, with the exception of inhalational anaesthetic agents
- All antibiotics of the same class that was administered (beta lactams; macrolides; fluoroquinolones; aminoglycosides; monobactams; carbapenems). The surgical and anaesthetic team should discuss antibiotic choice with a microbiologist
- If an NMBA was administered during this period, all NMBAs should be avoided unless it is absolutely impossible to do so, due to the risk of cross-sensitivity
- Chlorhexidine (including chlorhexidine antiseptic wipes, medical gel (e.g. used before catheter insertion) and chlorhexidine-coated intravascular lines/catheters)
- IV colloids
- Radiological contrast and dyes used for lymph node identification
- Latex
- Local anaesthetics of the same class (amides; esters)
- Histamine-releasing drugs (morphine and codeine) as the previous reaction may have been due to non-specific histamine-release

If past anaesthetic records are not available, in addition to the above:

- Assume that the patient previously received an antibiotic. Antibiotics are the most common cause of perioperative anaphylaxis in the UK. Discuss antibiotic prophylaxis with a microbiologist beforehand
- Assume that the patient was previously exposed to propofol, morphine, chlorhexidine, latex, IV colloid, and an NMBA
- If possible, use local or regional anaesthesia in patients who have had a previous suspected anaphylactic event during general anaesthesia, and vice versa