



BUNDLE

Anaphylaxis

Recognise, adrenaline IM, refractory pathway, observation and discharge



EM Orbit

Patient reference

Date

Time zero

Completed by

Adrenaline IM is the only first-line drug. Antihistamines and steroids are not treatments for anaphylaxis.

Recognise

- ☐ **Sudden onset and rapid progression of life-threatening Airway, Breathing or Circulation problems**

Usually with skin or mucosal changes — but skin changes can be absent, and skin changes alone are not anaphylaxis.

- ☐ **Call for help. Remove the trigger (stop the infusion, remove the sting)**
- ☐ **Lie the patient flat with legs raised; sit up only if breathing is the main problem. Never stand or walk them**

Sudden standing can cause cardiac arrest in anaphylaxis.

Adrenaline

- ☐ **Adrenaline IM 1 mg/mL (1:1,000) into the anterolateral mid-thigh — adult and child over 12 years: 500 mcg (0.5 mL)**

6–12 years: 300 mcg (0.3 mL) · 6 months–6 years: 150 mcg (0.15 mL) · under 6 months: 100–150 mcg (0.1–0.15 mL).

- ☐ **Repeat IM after 5 minutes if no improvement**
Most patients respond to one or two doses.
- ☐ **High-flow oxygen; monitor SpO₂, ECG, blood pressure**
- ☐ **IV crystalloid bolus 500–1,000 mL adult (10 mL/kg child); repeat as needed**

Large volumes may be required in shock.

Refractory anaphylaxis (no improvement after two IM doses)

- ☐ **Start a low-dose IV adrenaline infusion, by clinicians experienced in its use, per local protocol**

Continue IM adrenaline every 5 minutes until the infusion is running. IV bolus adrenaline is for cardiac arrest only, outside expert hands.

Peri-operative or IV-drug anaphylaxis: stop the agent, and consider that neuromuscular blockers, antibiotics and chlorhexidine are common triggers. · Pregnancy: left lateral tilt; adrenaline doses are unchanged.

- ☐ **Rapid IV fluid: further boluses, up to 3–5 L in adults**
- ☐ **Bronchospasm: nebulised salbutamol ± ipratropium; stridor: nebulised adrenaline 5 mg**
These are additions, never substitutes for IM adrenaline.
- ☐ **On beta-blockers with poor response: glucagon 1–2 mg IV**
- ☐ **Call ICU / anaesthesia early — airway swelling can progress fast**

After the emergency

- ☐ **Mast cell tryptase: first sample as soon as feasible after treatment starts, second at 1–2 hours, third at ≥ 24 hours (baseline)**

Do not delay treatment for the sample.

- ☐ **Antihistamine for persisting skin symptoms only (non-sedating oral preferred); steroids are not routine**

RCUK 2021: neither treats the life-threatening features.

- ☐ **Observe: minimum 2 hours if resolved quickly with one dose · 6 hours if two doses or previous biphasic reaction · 12 hours if severe, refractory, more than two doses, severe asthma, or late presentation**

Biphasic reactions occur in up to 5%.

- ☐ **Discharge with two adrenaline auto-injectors, hands-on training, a written action plan and allergy-clinic referral**

Document the suspected trigger and the doses given.



A drafted aid to memory, awaiting senior review. It does not replace your local protocol or your clinical judgement. Source: Resuscitation Council UK 2021.

EM Orbit · Emergency medicine, in one orbit · anaphylaxis · red rows are the steps that must not be missed