

PROTOCOL FOR: Anaphylaxis: Care of the Patient

SUPPORTIVE DATA: Anaphylaxis is an immediate hypersensitivity reaction, mediated by antibodies, response to exposure to an antigen.

Oncologic emergencies display symptoms that progress along a continuum and the goal is to identify and intervene early before a true emergent situation develops.

DESIRED

PATIENT OUTCOMES: Patients are assessed for signs and symptoms of oncologic emergencies.

Interventions are implemented promptly before a true emergent situation develops.

ASSESSMENT
AND GENERAL
NURSING CARE:

1. Assess for risk factors:

PATIENTS AT RISK

- a. Antineoplastic agents such as L-asparaginase, cisplatin, bleomycin, paclitaxil
- b. Biologic agents such as monoclonal antibodies (Rituxan, interferon)
- c. Agents in clinical trials
- d. Previous exposure to agents
- e. History of allergic reactions (blood products, latex sensitivity)

2. SIGNS AND SYMPTOMS: assess and report for:

- a. anxiety, flushing, burning and tingling sensations, pruritus, cough, dyspnea, diaphoresis, periorbital edema, maculopapular rash, hypotension, fever, chills, visual changes, headache, seizures.

3. MANAGEMENT

- a. Administer pharmacologic agents - glucocorticoids, antihistamines, epinephrine as ordered
- b. Stop drug and KVO line. Maintain airway, assess patient, notify physician, provide for patient safety, and provide emotional support.
- c. Hemodynamic support as ordered
- d. Oxygen as ordered
- e. Ventilatory support as ordered
- f. Report to ADR hotline

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 6/01

REVISION DATE: 3/02