LETTERS TO THE EDITOR

Intramuscular or intravenous adrenaline in acute, severe anaphylaxis?

EDITOR,—The consensus guidelines on the emergency medical treatment of anaphylactic reactions by the Project Team of the Resuscitation Council (UK) are an excellent guide for first medical responders, whether general practitioners or emergency department staff.1 They are pragmatic, safe, and emphasise the importance of first line treatment with oxygen, adrenaline (epinephrine) and fluids, and as Hughes and Fitzharris in their BMJ editorial suggest, rightly deserve to “ ... adorn the walls of emergency departments, general practitioners’ surgeries, and outpatient clinics.”

The guidelines usefully remind us that a panic attack or a vasovagal syncopal episode may be confused with anaphylaxis with the danger of inappropriate treatment. Additional differentiating features not mentioned in the text that suggest a faint rather than anaphylactic collapse are the rapidity of onset, maintenance of a central pulse, and prompt response to the recumbent position.2

It is refreshing to see the debate over the delivery of adrenaline move forward a stage, with the subcutaneous route no longer recommended as the absorption is delayed and variable, at least in well children with a history of systemic anaphylaxis, when compared with the intramuscular route.3 The guidelines thus quite correctly favour the early administration of intramuscular adrenaline at a dose of 0.5 ml of 1:1000 for adults, to all patients with clinical signs of shock, airway swelling, or definite breathing difficulty. Intramuscular adrenaline given early, or when venous access is difficult and if the patient is unmonitored, is safe and effective even in less experienced hands.

With respect to also reappraise some of the perennial dogma that limits the use of intravenous adrenaline in acute, severe anaphylaxis. The introduction’s criticism of the inappropriate use of intravenous adrenaline, shining out accident and emergency department’s unjustified. It is presumably based on rare, outdated reports that include a questionnaire circulated to junior resident staff showing that in the 10% who responded there was misunderstanding about the dosage, route, and dilution of adrenaline, and a purely anecdotal letter castigating the use of intravenous adrenaline as it is “...a hazardous procedure rarely warranted in anaphylactic reactions”4. As has been pointed out before, published reports on the apparent dangers of intravenous adrenaline consistently fail to emphasise that other causes such as hypoxia, hypotension, or the direct actions of the inflammatory mediators themselves released during anaphylaxis may be responsible for the cardiovascular complications. In addition, adverse outcomes to adrenaline occur when it has been given too rapidly, inadequately diluted or in excessive dosage.

Also, the statement that intravenous adrenaline should only be reserved for profound shock or special indications, for example during anaesthesia, is perplexing. Seventy-five per cent of anaphylactic deaths are due to anaphylaxis from upper airway oedema and hypoxia from bronchospasm, many within the first hour of onset of symptoms and only 25% from circulatory collapse.5 In addition, there is nothing unique about anaphylaxis during anaesthesia other than the standard model of delivery of all drugs is intravenously, and thus unexpected anaphylactic reactions may be rapid and catastrophic.

However, many of the same drugs are also used regularly in emergency medicine departments and intensive care units to facilitate interventional airway care. Continuous electrocardiographic, blood pressure, and pulse oximetry monitoring are now routine in all these areas and, if necessary, for the safe use of intravenous adrenaline. As Hughes and Fitzharris point out, the guidelines are somewhat vague in empirically recommending repeated intramuscular adrenaline every five minutes, or intravenous adrenaline as slowly as seems reasonable in the absence of clinical improvement or if deterioration occurs, particularly with profound shock.6

Emergency medicine has come a long way in the last decade and includes a much higher level of senior supervision, routine access to the minimum standards of monitoring suggested above, and widespread collective expertise in managing anaphylaxis. It is now time to consider the safety of the intravenous route, whether the emergency department, intensive care unit, or high dependency unit, in experienced hands low dose, high dilution intravenous adrenaline is the optimal care for a patient with severe or rapidly progressive, life threatening anaphylaxis whether from shock or acute respiratory distress. Administration of 0.75–1.5 µg/kg of 1:100,000 adrenaline intravenously at 1 ml per minute reverses all the life threatening effects of anaphylaxis and inhibits further mast cell mediator release by raising intracellular cyclic AMP.7 The 1:100,000 dilution, as the guideline suggests, not only allows precise titration to response, but avoids inadvertent rapid or excessive dosage. In addition, the therapeutic response to the adrenaline is immediate and assured.

The Project Team of the Resuscitation Council (UK) must be congratulated on an important document that will undoubtedly improve first responders’ knowledge and outcome, and indeed be of benefit to us all.

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Professor Chamberlain replies on behalf of the Anaphylaxis Project Team

We are grateful to Dr Brown for his kind general remarks about our consensus guidelines, and also for giving us the opportunity to clarify one sentence in our introduction. We said “There has been a vague for inappropriate use of intravenous epinephrine (adrenaline), both by paramedics in accident and emergency departments, when epinephrine...
(adrenaline) should have been given intramuscularly8. We believe this to be true, but it was most certainly not our intention to condemn all use of intravenous adrenaline by experienced medical practitioners either in emergency departments or elsewhere. In retrospect we believe adrenaline should have been more explicitly reserved for the subcutaneous route, and many are afraid to make the habit of always using adrenaline (adrenaline) 1:10,000 solution. This is clearly:

its use”.

must be administered with extreme care, and profound shock that is immediately life threatening. They say that they “believe very strongly that the advice against using intravenous adrenaline restricted to emergencies judged to be immediately life threatening.”

The concerns of Mr Gavalas and his colleagues were similar, but there seems also to be an element of misreading of our document. They say that they “believe very strongly that the advice against using intravenous adrenaline (epinephrine) is potentially very dangerous”. We must reiterate that we did not advise against its use, but urged only that adrenaline should have been given intramuscularly. We performed an audit of patients admitted to our observation ward with the primary diagnosis of minor head injury. From October 1997 to July 1999, 668 such patients were admitted under our care. Of these patients, only two were subsequently transferred to the regional neurosurgical unit after the finding of intracranial haematoma on computed tomography. This finding, and our general experience, leads us to agree that patients with an admitting diagnosis of minor head injury do not require neurosurgical referral, in the first instance. However, we suspect, given that only 12% of responding accident and emergency (A&E) departments (71% response rate) in the UK have on-site neurosurgical facilities,9 this practice is not widespread anyway.

Pau and Buxton’s conclusion is in keeping with the recommendation of the Report of Working Party on the Management of Patients with Head Injuries.1 One of the logistical concerns raised by this report, and highlighted in Pau and Buxton’s letter, is the fact that observation wards have a finite capacity. Our current position on the management of these patients is that when the observation ward is full, these patients are admitted under the general surgeons. The Way Ahead document recommends that A&E observation wards should be within, or immediately adjacent to, the A&E department. We feel that it is inevitable, when the only specialty admitting patients with isolated minor head injuries is A&E, that problems will arise when the observation ward is full. It goes against the spirit of the report of the working party to then admit these patients under other specialties, just because the observation ward is full. If these patients are to be admitted to elsewhere there are beds within the hospital, but still under the care of A&E, we fear a major step backwards in the standards of our practice if, when a seriously ill or injured patient arrives in the A&E department at 5 am, the only A&E doctor on duty is at the far end of the hospital, assessing a head injured patient.

The recommendations of the report have provoked widespread debate and polarity of views within the specialty. It probably represents a watershed in the management of A&E departments that do not currently accept

Future inpatient management of patients with minor head injuries

The use of epinephrine (adrenaline) by the intravenous route in the special circumstances given in paragraph 4.4 should usually be reserved for medically qualified personnel who have experience of it, who know that it must be administered with extreme care, and who are aware of the hazards associated with its use”.

The footnote to the legends state very clearly: “Grocery consider slow intravenous (IV) ephrine (adrenaline) 1:10 000 solution. This is hazardous and is recommended only for an experienced practitioner who can also obtain IV access without delay”.

There is some practitioners who have made the habit of always using adrenaline intravenously, while others have preferred the subcutaneous route, and many are afraid to give it at all. We believe that we have given the correct advice that—intramuscular adrenaline is the norm for the emergency treatment

by first medical responders, with IV adrenaline reserved for special and life threatening situations. This is far from advising against its use!

There is one charge to which we must plead guilty. Of course we were aware of the previous paper published in the Journal of Accident & Emergency Medicine in 1998, and it was indeed our intention to reference it together with the other specialist recommendations. That omission was not deliberate, and one of us (DAC) must take responsibility for that important last minute oversight.

We do not accept that the guidelines need urgent revision. Neither does the Project Team with its wide representation accept that the recommendations as they stand are insulating to the specialty of accident and emergency. We are conscious that we all have the same aims: better and safer treatment of an important medical emergency.

Cycle helmets

Playing in the back seat

EDITOR,—We read with interest the letter of fatal intra-abdominal injury associated with incorrect use of a seat belt and would like to present another aspect of seat belt misuse.1 A pair of 7 year old identical twins presented to the accident and emergency (A&E) department after being involved in a head-on road traffic accident. Both had been restrained in four point child seats in the back of the car. In the department, one was complaining of abdominal pain, the other none. On examination of the twins, both were haemodynamically unstable. Twin 1 had bruising to her abdomen, the other none. This bruising was linear in nature across her abdomen, “the seat belt sign”. She had no focal tenderness.

In view of the seat belt sign, twin 1 was admitted and an abdominal ultrasound was performed at this stage. The ultrasound showed a small amount of fluid in the pouch of Douglas, but no other free fluid or lacerations of visceral organs. Overnight she remained painful, but haemodynamically normal. A further ultrasound was performed the next day which showed free fluid within her abdomen.

It was then performed that confirmed turbid fluid and this was converted to a laparotomy. Three lesions were found in her jejunum, one full thickness and two partial. A 15 cm resection of her jejunum was performed with anastomosis. She made an uneventful recovery.

On detailed questioning while in the A&E department, she stated that she had been playing a game with her twin sister and had wriggled out of her shoulder straps. This had converted her four point child seat into a lap belt. Twin 2 had remained properly restrained in her child seat.

Lap belt use has been recognised as a mechanism of blunt injury to the small bowel. The seat belt sign is associated with an increased likelihood of intestinal injury.2 This lap belt injury in children usually occurs when children are too large for their safety seats and too small for adult seat belts.3 This case highlights the importance of the seat belt sign, but more importantly that children within their own safety seats need to be restrained properly within them. Incorrect usage results in injury similar to adult lap belts.

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1 Carnall D. Cycle helmets should not be compulsory. BMJ 1999;318:1905.

Oesophageal rupture

EDITOR,—Drs Onyeka and Booth present an interesting case of tension pneumothorax associated with Boerhaave’s syndrome.1 We have previously described a similar case in a 47 year old man who survived his ordeal in 1996.2 As the authors note, awareness of the condition is the mainstay of diagnosis.

Aside from these two cases, tension pneumothorax has been described in association with rupture of a Barrett’s oesophagus3 and after rupture of an oesophageal diverticulum.4 It is worth noting that by far the commonest cause of oesophageal rupture is after endoscopy. Regardless of the cause of rupture I agree with the authors that a gastrografin oesophagram is the diagnostic procedure of choice.

Conservative management of oesophageal rupture is now a well established option in iatrogenic rupture and has been described in Boerhaave’s syndrome,5 although as the authors note, immediate surgery comprising drainage and repair is the mainstay of curative treatment.

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Carbon monoxide poisoning

EDITOR,—I read with interest the article by Turner et al, providing an update on carbon monoxide poisoning.1 The authors correctly point out that hyperbaric therapy remains controversial, and that no controlled clinical trial had been performed comparing hyperbaric oxygen (HBO) with normobaric oxygen (NBO). Since the date of acceptance of their paper a prospective, blinded, randomised trial comparing NBO with HBO has been published.2 This trial also included severely poisoned patients and incorporated sham treatments. This study found in 191 patients that three days of HBO (2.8 atmospheres for 60 minutes) offered no advantages compared with three days of NBO (100 minutes 100%). Another study is continuing in the United States and the interim results have found no difference in the incidence of persistent neurological sequelae between those treated with HBO compared with NBO, although there is an increased incidence of delayed sequelae in one of the blinded treatment arms.

The authors also recommend careful neurological and cognitive re-examination. It is worth highlighting that cognitive testing in carbon monoxide poisoning is far from stand-ardised. Many studies utilise different screening tests, different time intervals to re-screening, and different HBO regimens. This lack of standardisation makes it difficult to compare studies and no doubt contributes to our inability to provide definitive recommendations in the management of carbon monoxide poisoning.

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The authors reply

We also read with interest the paper by Scheinkestel et al, which was published after acceptance of our article.1 Scheinkestel’s paper was accompanied by a detailed editorial which documented a number of criticisms that preclude implementation of its findings until further data are forthcoming.2 Recommendations from poison information centres, as described in our article, have not been changed and still provide useful guidance on selecting patients for hyperbaric oxygen.

We believe that careful neurological examination, including specific testing of cognitive function, is vital in the management of patients. Physicians should use tests with which they are familiar and apply them serially to the same patient. Standardisation of formal cognitive testing for trials was beyond the scope of our clinically orientated article.


Evidence based and guideline based medicine

EDITOR,—Evidence based and guideline based medicine is justifiably emphasised in current accident and emergency (A&E) medicine practice. At St James’s University Hospital in Leeds, the A&E trainees participate in regular evidence based critical appraisal sessions as part of education development, and such skills are assessed in our Faculty of Accident and Emergency Medicine exit examination.

One source of valued literature is Sackett et al; particularly their appraisal cards on the validity, importance, and applicability of a particular type of study. Lacking a photographic memory, I put forward simple acronyms that have helped me to facilitate timely and efficient appraisal for everyday use when selectively scanning relevant journals. Preceding these specific acronyms is a “stand-
ards acronym that follows Crombie’s suggestion that standard questions should be used as a filter for all papers.

I hope they are of use to fellow practitioners of evidence based medicine, and further suggestions will be gratefully received.

**Standards**

- Stated aims?
- Tests and measures appropriate?
- Arithmetic (do the numbers add up?)
- Design appropriate?
- Relevance to your practice?
- Different results from previous reports?
- Sample size/power adequate?

**Diagnosis**

- Diagnostic test needed?
- Independent blind comparison?
- Gold standard used regardless of test result?
- Numerogram (2×2 table) constructable?
- Sensitivity and specificity important?
- Inferences possible?
- Safe, cheap, and helpful?

**Prognosis**

- Prospective study?
- Representative sample?
- Objective and blinded outcome criteria?
- Groups adjusted for prognostic factors?
- Numbers recruited and followed up adequate?
- Outcomes likely?

- Study findings precise?
- Inferences possible?
- Similar patients to your own?

**Guidelines**

- Guidelines needed?
- User friendly?
- Identified risks and benefits?
- Decision options clear?
- Evidence based decisions?
- Large variations in current practice?
- Implementable?
- NHS benefit?
- Economical?
- Safe?

**Therapy**

- Trial ethically approved?
- High recruitment and follow up?
- Equal treatment and assessment in each group?
- Randomised and how?
- Appropriate population?
- Potential benefits for patients?
- End points applicable?
- Absolute risk reduction/number needed to treat?

**Systematic review**

- Systematic search strategy?
- Randomised and relevant trials?
- Each trial assessed?
- Valid results in all trials?
- Inconsistent populations or results?
- Evidence of benefit via odds ratios/number needed to treat?
- Was hypothesis satisfied by the review results?

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**Weekly web review**

Editor.—A noteworthy web site exists for emergency department evidence based medicine enthusiasts. The Weekly Web Review in Emergency Medicine (www.wwrem.com/) is dedicated to the critical analysis of current clinical literature on topics relevant to the practice of emergency medicine. It has a useful rating system for each of the articles reviewed and an archive database. It dovetails with this journal’s journal scan and has useful links, notably with the Centre for Evidence Based Medicine at Oxford. I recommend it as a useful adjunct to any emergency physician’s continual professional development.

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