Anaphylaxis

Anaphylaxis gets the adrenaline going

A F T Brown

Andrenaline and now atropine for anaphylactic shock

A naphylaxis today still generates as much excitement, fear, rhetoric, and ripostes as it must have done for Charles Richet and Paul Portier at the turn of the 19th century. While they were guests on board Prince Albert of Monaco’s yacht in the Mediterranean, they reported on their experiments on dogs rechallenged with Physalia extracts, and first coined the phrase “anaphylaxis”, literally meaning “against protection”, when some dogs unexpectedly died. Since then, anaphylaxis has come to synthesise one of medicine’s great clinical bedside challenges, demanding rapid recognition without the benefit of an immediate laboratory test, and urgent management to avert a potentially fatal outcome usually in an otherwise healthy, young patient. Its evanescent nature has mitigated against the development of a solid scientific database to guide clinicians, and has generated as spiritedly polarised views on management as any therapeutic topic. No more so than when the use, views on management as any therapeutic and sympathetic nervous systems.

Neurocardiogenic syncope may also explain Pumphrey’s personal observations on 214 anaphylactic fatalities, where some deaths clearly followed a change in the victim’s posture to a more upright position, either sitting or standing. He exhorts us to keep victims of anaphylaxis lying down, even those self-administering adrenaline, and to support or raise their legs to maintain vena caval filling at all costs.

What Brown did show unequivocally was the efficacy of intravenous adrenaline and fluid to successfully treat all his subjects with anaphylactic shock, without the use of any antihistamines or corticosteroids in the acute phase. The adrenaline was given cautiously at a dilution of 1:100 000 (that is, 10 µg/ml), starting at 5–15 µg/min to a total dose of around 5–20 µg/kg, with more adrenaline being required the more severe the hypotension. This approach gratifyingly supports the hereto intuitive (non-evidence based) recommendations of several authors including this editorial’s writer. It also supports the perennial warning of others to always administer adrenaline for significant anaphylaxis with care, suitably diluted, given slowly and titrated against response in an adequately monitored patient.

The limitations of Brown’s paper are to be aware that certain patients were excluded from the study as mentioned previously, and that as there were few life threatening respiratory complications, extrapolating the universal success of intravenous adrenaline to all forms of severe anaphylaxis, although highly likely to be efficacious, still effectively remains an eminence based recommendation. Likewise, there

Neurocardiogenic syncpe, vasodepressor or vasovagal syncpe, is notable for its variable afferent limb and threshold, with triggers ranging from posture, pain, fear, and psychological stress to the use of vasodilators, inferior myocardial ischaemia (Bezold-Jarisch reflex), and severe haemorrhage. However, the efferent response is uniform with a vagally mediated bradycardia, and paradoxical vasodilatation with the concurrent interruption of sympathetic vasoconstriction. Thus sensory input from arterial baroreceptors as well as cardiac mechanoreceptors appear to modulate the balance of the parasympathetic and sympathetic nervous systems.

A neurocardiogenic mechanism was further supported by a dramatic response to intravenous atropine 600 µg in two of Brown’s most parlous patients in virtual cardiac arrest. Rather than ascribing this to near terminal hypoxia, the successful use of atropine in these situations to counter vagal tone deserves further study.
seemed to be no clear answer as to how much fluid should be being given at the same time for hypotension, with Brown’s dose comparatively small at one litre of normal saline (with only one patient receiving a total of three litres). Also, as Brown mentions, the early use of intramuscular adrenaline, particularly prehospital or in the unmonitored patient, still warrants direct comparison with intravenous adrenaline to quantify their relative efficacy compared with complication rates.

The other paper on suspected allergy in this issue is a far more sanguine reminder that “all is not gold that glitters”. Goodyear et al describe a case of orbital cellulitis in a 14 year old boy that was initially diagnosed and treated as an allergic reaction on the strength of unilateral periorbital oedema and a history of known dog hair allergy. Two days later, despite a high temperature of 39.3°C the condition was still considered to be allergic, delaying the final referral to an ophthalmology specialist until day 4 when the serious, true infective diagnosis was rapidly made. As the authors pointed out, a delay in diagnosing orbital cellulitis contributes to a higher rate of serious complications such as blindness or even death from cavernous venous thrombosis. A useful table highlighting the differences expected between an infective or allergic presentation of periorbital swelling is given, and the authors emphasise the pivotal role of the CT scan in investigating suspected orbital cellulitis.

Anaphylaxis naturally has a potentially vast differential diagnosis, although the rapid onset, accompanying cutaneous features, and direct relation to a potential trigger or particular iatrogenic precipitant suggest the diagnosis in most cases. In this instance, the authors did emphasise that unilateral orbital swelling is more likely to be attributable to infection than allergy. I agree with this, and unfortunately on this occasion I am unable to blame a dog for this unfortunate boy’s illness!

REFERENCES


EDITORIAL

The reality of emergency medicine in the war arena

T J Hodgetts

I would not regard myself as superstitious, but 13 April 2003 was not what I would call a lucky day. It was the 22nd day of the ground war in Iraq and I was the officer in command of the emergency department of 34 Field Hospital. Seventeen days previously this had moved into Iraq in support of the 1st (UK) Armoured Division and had begun treating battle casualties on 27 March. Unusually the hospital was collocated far forward with the infantry and armour units on a disused military airfield close to the city of Al Basrah. By this time in the war the explosions around the perimeter had become less frequent, and the hostile incoming mortar and artillery fire had stopped. Challenger II tanks of the Scots Dragoon Guards and 2 Royal Tank Regiment could no longer be seen racing across the desert and engaging targets; and the nightly firework display of tracer from heavy artillery lobbing rounds across our accommodation tents had also ceased (an event that would wake even the heaviest sleeper, and cover the tent in gunpowder).

The day had started inspiringly at 0700 hours with a medley of marching music from the attached military band. An hour later the first routine of the day was the heads of department attending the Commanding Officer’s briefing (“Orders Group”). Serious business in hand, the Regimental Sergeant Major had stated that the stethoscope was not an article of uniform, and was not to be worn around a doctor’s neck outside clinical areas. Predictably this was to precipitate a flurry of fluorescent and improvised striped tubes worn defiantly by the senior clinicians. In turn I briefed A&E clinical staff with the latest intelligence and assigned daily tasks, then flicked through the week old newspapers in the department. Later I reflected in my journal on the impact of the plethora of personal tributes in the tabloids to our soldiers killed in action. Dealing with death regularly in A&E, I considered, was often by dissociation and reliance on the fact that there is little opportunity to form any substantial relationship with a patient or their family. But I could not mentally dismiss those soldiers on whom I had pronounced death and placed in our temporary mortuary (a refrigerated ISO container, or “reefer”, known as the Grim Reeper) and whose images repeatedly appeared in print.

Since 2001 I had spent five months in the deserts of Oman, Afghanistan, and Kuwait where the weather could change in an instant, and today was to be a striking example. Imperceptibly to those working in the dim artificial light inside the green tented hospital complex a storm had rapidly closed in and was heralded by a “dust devil” (a euphemism for a small tornado). This proceeded with divine direction through the senior officers’ accommodation tents, most of which were unoccupied, miraculously sparing the near capacity 200 bed hospital. A young female soldier in the shower tent was witnessed to be lifted and transported spinning in canvas, Dorothy-like, some 50 metres sustaining serious chest injuries on landing. My own tent was forcibly moved, pulling free the securing bolts drilled in the runway, with the contents churned in an action akin to a giant
an outbreak of Norwalk-like virus at Bagram airbase in Afghanistan when small numbers of soldiers incapacitated by an enteric disease were learned by 34 Field Hospital at Oak Hospital, Birmingham B29 6JD, UK; Centre for Defence Medicine, K Block, Selly Oak Hospital, Birmingham B29 6JD, UK; timothy.hodgetts@uhb.nhs.uk doi: 10.1136/emj.2003.009639

COMMENTARY

Experience in Oman in 2001, Afghanistan in 2002, and again in Iraq in 2003 has confirmed that a substantial proportion of a field hospital’s work will be soldiers incapacitated by an enteric virus. Particularly important lessons were learned by 34 Field Hospital at Bagram airbase in Afghanistan when an outbreak of Norwalk-like virus manifested in a novel and severe form among the hospital’s 76 staff. Forty per cent of the staff were ill and a further 20% quarantined, with five cases of meningitis (two requiring ventilation, and one with DIC). This was particularly clear in my own mind as I had been the emergency physician and had required to take the additional roles of consultant ITU, consultant general medicine, and junior doctor for the whole hospital because of staff shortages. It is convenient to point the finger at “poor hygiene” in both instances, but this group of viruses is notorious for its high attack rate among institutions, including NHS hospitals. Traditional cases of dysentery (salmonellosis, shigellosis, amoebiasis) were very rare compared with historical precedents in war because of improvements in field hygiene and perhaps, as the Professor of Military Medicine observed, this was simply nature expanding to fill a vacuum. This experience was translated into a process of assessing infectious disease patients separately from conventional patients. A bay assessment tent was placed adjacent to A&E and infectious patients streamed to this area for assessment by staff with appropriate protective equipment. The broader concern was for recognising and separating those patients showing the first symptoms of biological warfare (particularly those highly contagious conditions such as smallpox and pneumonic plague). Distant from us our NHS colleagues had the real and present threat of controlling the global SARS crisis, no doubt working through similar thought processes.

With domestic normality at 34 Field Hospital rapidly restored after the morning’s storm, focus was drawn to the clinical activity. It was lunchtime when we had an influx of critical patients over 90 minutes. A soldier with an acute onset dilated cardiomyopathy and fast atrial fibrillation. Two escaping prisoners of war with gunshot wounds, one with damage to a popliteal artery and a shattered tibia, the other with multiple limb wounds. A 15 year old Iraqi boy with multiple compound tibia fractures after a road accident. A 12 year old Iraqi girl with 20% burns from two weeks ago and septicaemic shock. And a prisoner of war with appendicitis.

So what? Nothing you could not cope with in your own practice. But what if the nearest CT scanner and neurosurgeon is in another country? Would your general surgeons perform burr holes or a craniotomy on clinical grounds alone? What if your burns services are also in another country: can you really spare an anaesthetist for the inter-hospital transfer, as it may take a day for them to return? How will you manage the patients in A&E when your two surgical teams are occupied; there are no surgical reinforcements? How will you improvise if your paediatric resuscitation equipment is “limited”? And what if your intensive care unit is full? These were a day’s worth of challenges.

So few words cannot do justice to the intensity of this experience, of frustrations balanced with fulfilment and spiced with a little anxiety. Nothing has yet been said of the effort required to simply sustain yourself in a desert environment, without climate control, washing out of a mess tin, and eating packet meals (termed Meals Ready to Eat, or less charitably Meals Rejected by Everyone). The personal challenge to anticipate and manage the requirements of equipment, people, and procedures to provide the emergency medicine service across three field hospitals and within the medical regiment was enormous, is not one I would have missed, and was only achievable with the quality and resourcefulness of my staff. It is quite amazing, I thought as I lay on my sleeping bag under the mosquito net that night of 13 April listening to the tanks trundling behind the protective berm (a wall of sand), the wind and rain, and the indiscernible crackle of the tannoy, how quickly you can adapt to the most bizarre circumstances. And almost regard them as normal.