Anaphylaxis Clinical Update

This Clinical Update complements the latest version of ASCIA anaphylaxis e-training for health professionals, which was first available in 2011. The main purpose of this document is to provide an evidence-based, ‘quick reference guide’ to assist primary health care physicians including general practitioners, paediatricians and nurses in the management of patients with allergy who are at risk of anaphylaxis.

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References
1. What is allergy and anaphylaxis?

Over the last decade, allergy and risk of anaphylaxis has become an increasing health burden. Common causes of anaphylaxis include foods, insect stings and medications. Effective strategies for primary prevention of allergy are currently limited and secondary prevention is restricted to strategies to prevent exposure to known allergens 1.

1.1 Allergen sensitisation

Allergen sensitisation is a process in which a normally harmless protein (allergen) leads to the production of a specific type of allergy antibody (IgE). IgE antibodies are produced by plasma cells (mature B cells) in response to exposure to the allergen. IgE attaches to tissue mast cells in the skin, gastrointestinal tract, and/or respiratory system and peripheral blood basophils. In the absence of further contact with the allergen, binding of IgE to mast cell receptors produces no symptoms.

1.2 Mechanisms of an allergic reaction

Subsequent exposure to the allergen with cross-linking of IgE antibodies can cause rapid mast cell activation in some individuals. This results in the release of histamine and other inflammatory mediators. Multiple inflammatory mediators cause increased vascular permeability, smooth muscle spasm, mucosal oedema and inflammation. This results in clinical effects such as urticaria, angioedema, bronchospasm and anaphylaxis.

1.3 Definition of anaphylaxis

Anaphylaxis is the most severe form of allergic reaction requiring urgent medical treatment. There are a plethora of definitions for anaphylaxis within the literature. For the purposes of recognition and emergency treatment, ASCIA defines anaphylaxis as:

Any acute onset illness with typical skin features (urticarial rash or erythema/flushing, and/or angioedema), plus involvement of respiratory and/or cardiovascular and/or persistent severe gastrointestinal symptoms; or Any acute onset of hypotension or bronchospasm or upper airway obstruction where anaphylaxis is considered possible, even if typical skin features are not present.

1.4 Signs and symptoms of allergic reactions

The following signs and symptoms are as stated on the ASCIA Action Plans:

**Mild or moderate reactions**
- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

**Anaphylaxis**
Watch for any one of the following signs of anaphylaxis:
- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

**Note:** Urticaria, erythema and angioedema may be transient, subtle and easily overlooked. In 1 out of 6 fatal food induced anaphylaxis cases, severe cardiovascular symptoms developed without skin or respiratory symptoms2,3.
2. Triggers of anaphylaxis

Less common causes include latex, exercise (with or without food), cold temperature, immunisation (rare) and unidentified (idiopathic).

2.1 Food allergy

Whilst 90% of food allergic reactions are caused by egg, cow’s milk, peanut, tree nuts, wheat, fish, shellfish, sesame and soy, any food may cause an allergic reaction. It is important to note that not all patients with food allergy are at risk of anaphylaxis.

Food allergy affects 10% of infants <1 year, 4-8% of children <5 years and up to 2% of the adult population in Australia. It is important to note that food allergy can develop at any age not just in childhood. The most common food allergens are:

- Egg, peanut and cow’s milk in children.
- Tree nuts and seafood in adults.

Small amounts of food can cause anaphylaxis in some very sensitive individuals. Touching or smelling may trigger an allergic reaction but it is unlikely to cause anaphylaxis as the food allergen usually needs to be ingested.

2.2 Allergies to stings and bites

The major causes of sting anaphylaxis are honeybees, wasps, Jack Jumper (“hopper”) ants and related ant species. Anaphylaxis to tick bites is rare outside of endemic coastal areas in Eastern Australia. Allergies to stings and bites are rarely inherited and do not commonly coexist with other allergies (e.g. food allergy). Most reactions to bites and stings are local swellings that are not life threatening.

2.3 Drug allergy

Adverse reactions to drugs are a significant problem, however allergic reactions (IgE mediated) are rare. Drug allergy is not more common in those with other allergies and rarely runs in families.

<table>
<thead>
<tr>
<th>NSAIDS</th>
<th>• Majority of reactions are not IgE mediated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Occurs in approximately 1% of general population; 10% in those with asthma</td>
</tr>
<tr>
<td></td>
<td>• IgE mediated reactions to NSAID are characterised by urticaria, angioedema or anaphylaxis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antibiotics</th>
<th>• Uncommon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Occurs in approximately 1/10,000 courses of penicillin</td>
</tr>
<tr>
<td></td>
<td>• Testing is only available for a limited range of antibiotics</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General anaesthetics</th>
<th>• Rare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Occurs in approximately 1/5,000 – 1/10,000</td>
</tr>
<tr>
<td></td>
<td>• Specialised testing required</td>
</tr>
</tbody>
</table>
Vaccines

- Anaphylaxis to vaccines is rare, occurring in approximately 1/250,000 doses
- IgE mediated reactions are often due to vaccine components rather than the vaccine material itself
- Symptoms of IgE mediated allergic reactions to vaccines are similar to other IgE mediated allergic reactions and should be treated the same
- Symptoms usually appear within 5-30 minutes, but delayed reactions can occur

Others

- Rare - local anaesthetics (vasovagal reactions are common) and herbal remedies, x-ray contrast agents, patent blue dye (used in sentinel node biopsies in breast cancer surgery, gelatin colloids.

Ref: Up-to-date, 2010

2.4 Risk factors for fatal anaphylaxis

Whilst mild, moderate and even severe allergic reactions are common, deaths from anaphylaxis are rare\textsuperscript{10}. However, several factors increase the risk of fatal anaphylaxis:\textsuperscript{11-14}

- **Delayed or no administration of adrenaline.** Deaths from anaphylaxis have often occurred in situations where the emergency medication has not been available and/or has not been administered in a timely manner.
- **Upright posture during anaphylaxis.** Therefore it is essential that the person does not stand or walk.
- **Asthma.** Individuals with food allergy and asthma, especially poorly controlled asthma are at increased risk of fatal anaphylaxis.
- **Food allergic individuals eating away from home.** Deaths from anaphylaxis are highest in teenagers and young adults eating away from home.
- **Age:**
  - Teenagers and young adults (food allergy).
  - Adults (insect and drug allergy).
- **Initial misdiagnosis.**
- **Specific food allergens.** Most deaths from food induced anaphylaxis occur from peanuts, tree nuts and shellfish.
- **Heart disease.** Most fatal insect sting reactions occur in older individuals with heart disease.
- **Systemic mastocytosis.**

*Previous mild or moderate reactions do not rule out the possibility of subsequent severe or fatal reactions.*

Living with the risk of anaphylaxis can impair quality of life (QOL), induce great anxiety and lead to significant social and family disruption. The QOL of a child with severe food allergy has been reported as being worse than a child with diabetes\textsuperscript{15,16}. Insect sting anaphylaxis may lead to fear of being outdoors.
3. Diagnosis of allergy and risk of anaphylaxis

3.1 Clinical history and allergy testing

Clinical history along with allergy testing is used in the identification of allergen triggers. Tests to identify IgE sensitisation to an allergen include skin prick testing and serum specific IgE (formerly known as RAST). Medically supervised allergen challenges may also be undertaken to confirm a diagnosis or determine if a patient has outgrown an allergy. Skin prick testing and allergen challenges should be conducted by specialists with allergy training in an environment with the ability to resuscitate if required.

Testing for allergen specific IgE food mixes is not recommended as it does not indicate which foods from the mix that the patient is allergic to and may result in unnecessary avoidance of food/s. Measurements of total IgE are also not useful for diagnosis of food or drug allergy and are not recommended.

Allergen specific IgG testing has no role in the identification of allergic triggers.

3.2 Differential diagnosis of anaphylaxis

The following list has been compiled to assist with differential diagnosis of anaphylaxis versus symptoms due to other conditions that may be mistaken as anaphylaxis.

<table>
<thead>
<tr>
<th>Tissue swelling</th>
<th>Other causes of collapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Idiopathic urticarial</td>
<td>• Vasovagal episodes</td>
</tr>
<tr>
<td>• Isolated angioedema</td>
<td>• Systemic Capillary Leak Syndrome</td>
</tr>
<tr>
<td></td>
<td>• Shock (septic, cardiogenic, haemorrhagic)</td>
</tr>
<tr>
<td>Conditions mistaken for upper airway oedema</td>
<td></td>
</tr>
<tr>
<td>• Dystonic reactions mimicking the sensation of swollen tongue (e.g. anti-nausea medication)</td>
<td>ASTEHA</td>
</tr>
<tr>
<td>• Acute oesophageal reflux (sudden onset of painful throat ‘swelling’, which can trigger laryngospasm)</td>
<td></td>
</tr>
<tr>
<td>Flushing syndromes</td>
<td>Acute respiratory distress</td>
</tr>
<tr>
<td>• Peptide-secreting tumours (e.g. carcinoid syndrome, VIPomas)</td>
<td>• Asthma</td>
</tr>
<tr>
<td>• Alcohol related</td>
<td></td>
</tr>
<tr>
<td>• Medullary carcinoma of thyroid</td>
<td>Panic disorders</td>
</tr>
<tr>
<td>• “Red Man Syndrome” (vancomycin related)</td>
<td>• Globus hystericus</td>
</tr>
<tr>
<td></td>
<td>• Laryngospasm (can be triggered by anxiety but more commonly triggered by oesophageal reflux)</td>
</tr>
<tr>
<td></td>
<td>• Vocal cord dysfunction</td>
</tr>
<tr>
<td>Neurological syndromes</td>
<td>Miscellaneous</td>
</tr>
<tr>
<td>• Epileptic seizures</td>
<td>• Scombroid fish poisoning</td>
</tr>
<tr>
<td>• Strokes</td>
<td>• Systemic mastocytosis</td>
</tr>
<tr>
<td></td>
<td>• Serum sickness</td>
</tr>
<tr>
<td></td>
<td>• Phaeochromocytoma</td>
</tr>
</tbody>
</table>

4. Acute management of anaphylaxis

4.1. Essential steps in acute management of anaphylaxis

The cornerstones of acute management of anaphylaxis include:
- Placing the patient in the supine position to improve blood return to the heart, as fatality can occur within seconds if a patient stands or sits upright suddenly. If the patient is having difficulty breathing, allow them to sit, but do not allow them to stand or walk. Patients who are vomiting or pregnant should be placed in the left lateral position.
- The following infographics are included in ASCIA Action Plans to reinforce correct positioning.
• Intramuscular injection of adrenaline into the lateral mid-thigh (1:1000 or 1mg/mL at a dose of 0.01mg.kg with a maximum dose of 0.5 mg/0.5 mL\(^{19}\)). Adrenaline is the first line treatment of anaphylaxis and acts to reduce airway mucosal oedema, induce bronchodilation, induce vasoconstriction and increase strength of cardiac contraction\(^{20}\).

• Intravenous fluid resuscitation with saline (20 mL/kg)\(^{19}\).

• Airway support and ventilation\(^{19}\).

• Supplementary oxygen\(^{19}\).

**Acute Management of Anaphylaxis**

1. Remove allergen (if still present).
2. Call for assistance. Do not leave patient alone.
3. Lay the patient flat. Do not allow patient to stand or walk. If breathing is difficult allow the patient to sit.
4. Give 1:1000 adrenaline intramuscularly into the lateral mid-thigh without delay (0.01mg/kg – maximum dose 0.5mg). Repeat doses every five minutes as needed. If multiple doses required, contact emergency specialist for advice.
5. Call ambulance.
6. Provide supportive management when skills and equipment are available:
   • Monitor pulse, blood pressure, respiratory rate, pulse oximetry.
   • Give high flow oxygen and airway support if needed.
   • Obtain intravenous access in adults and in hypotensive children.
   • If hypotensive, give intravenous normal saline (20mL/kg rapidly) and consider additional wide bore intravenous access.

Note: It is important not to give food or drink to an individual experiencing anaphylaxis in case they vomit and aspirate.

*(Adapted from Loh et al, Medicine Today, September 2012.)*

ALWAYS give adrenaline autoinjector FIRST, then asthma reliever if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

It is important to note that antihistamines have no role in treating or preventing respiratory or cardiovascular symptoms of anaphylaxis. Oral non-sedating antihistamines may be given to treat itch and urticaria. Oral sedating antihistamines are not recommended as side effects (drowsiness) may be similar to signs of anaphylaxis. Injectable promethazine should not be used in anaphylaxis as it can worsen hypotension and cause muscle necrosis\(^{21}\).

**4.2. Observation after anaphylaxis**

Patients should be observed for at least 4 hours after last the dose of adrenaline.

Patients will require overnight observation in hospital if they:

• Had a severe or protracted anaphylaxis (e.g. required repeated doses of adrenaline or IV fluid resuscitation),
• Have a history of asthma or severe/protracted anaphylaxis,
• Have other concomitant illness (e.g. asthma, history or arrhythmia),
• Live alone or are remote from medical care,
• Present for medical care late in the evening\(^{20}\).
5. Adrenaline (epinephrine) autoinjectors

Adrenaline autoinjectors:
- Are automatic injector devices for emergency first aid treatment of anaphylaxis.
- Contain a SINGLE fixed dose of adrenaline.
- Are designed for self-injection (if patient is well and old enough) or other individuals (medical training is not required).
- Should be injected into the outer mid-thigh muscle.
- Can be administered through a single layer of clothing.
- Should be stored in an easily accessible, unlocked location with an ASCIA Action Plan for Anaphylaxis.

5.1 Types of adrenaline autoinjectors

<table>
<thead>
<tr>
<th>Feature</th>
<th>EpiPen®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline dose</td>
<td>Single pre-measured</td>
</tr>
<tr>
<td>Colour of 0.15 mg dose device label</td>
<td>Green</td>
</tr>
<tr>
<td>Colour of 0.3 mg dose device label</td>
<td>Yellow</td>
</tr>
<tr>
<td>Viewing window to check adrenaline for discolouration or precipitate</td>
<td>Yes</td>
</tr>
<tr>
<td>Availability</td>
<td>S3 (over-the-counter at full price) 2 devices on PBS authority prescription</td>
</tr>
<tr>
<td>Activation of device</td>
<td>Press firmly against outer mid-thigh</td>
</tr>
<tr>
<td>Safety</td>
<td>Blue safety release</td>
</tr>
<tr>
<td></td>
<td>Orange needle end automatically extends over needle after use</td>
</tr>
<tr>
<td>Trainer devices</td>
<td>Available from distributor of device</td>
</tr>
<tr>
<td>Expiry reminder service</td>
<td>EpiClub <a href="http://www.epiclub.com.au">www.epiclub.com.au</a></td>
</tr>
</tbody>
</table>

(Adapted from Vale et al, Australian Prescriber, 2012)

5.2 Adrenaline autoinjector prescription

Adrenaline autoinjectors are available to patients without prescription from pharmacies at full retail price or on PBS authority prescription in Australia. Adrenaline autoinjectors are not currently reimbursed by Pharmac in New Zealand. It is important to teach the patient in the use of the device that has been prescribed. Doctors should complete the ASCIA Action Plan for Anaphylaxis when prescribing an adrenaline autoinjector for a patient.

PBS authority prescription supply of adrenaline autoinjectors in Australia:
- Maximum of 2 for children or adults (additional devices can be purchased over-the-counter if required).
- Initial supply:
  - When risk and clinical need has been assessed by, or in consultation with a clinical immunologist, allergist, paediatrician or respiratory physician.
  - After hospital or emergency department discharge for acute allergic anaphylaxis treated by adrenaline.
- Continuing supply for anticipated emergency treatment of acute allergic reactions with anaphylaxis, where the patient has previously been issued with an authority prescription.
- In some circumstances, a patient can ask for a general prescription and then claim partial reimbursement from their private health fund.
GPs can consult clinical immunology/allergy specialists regarding PBS prescription for adrenaline autoinjectors by telephone if required.

ASCIA adrenaline autoinjector dose recommendations:
- For children under 10kg (under 1 year) adrenaline autoinjectors are not usually recommended. However, in some circumstances a 150 microgram (0.15 mg) adrenaline autoinjector may be prescribed by a clinical immunology/allergy specialist
- 150 microgram (0.15 mg) adrenaline autoinjectors are for children 10-20kg (aged ~1-5 years)
- 300 microgram (0.3 mg) adrenaline autoinjectors are for adults and children over 20kg (aged over ~5 years)
- 500 microgram (0.5 mg) adrenaline autoinjectors may be prescribed for patients over 60 kg (refer to the ASCIA prescribing guidelines for adrenaline autoinjectors for more information)

Whilst the dose recommendations on the product information leaflet differs, ASCIA recommendations are based on consensus and standard practice by ASCIA members and published in the Australian Medicines Handbook and the National Prescribing Service information on adrenaline autoinjectors.

ASCIA adrenaline autoinjector prescribing guidelines can be accessed from the ASCIA website: [www.allergy.org.au/health-professionals/anaphylaxis-resources/adrenaline-autoinjector-prescription](http://www.allergy.org.au/health-professionals/anaphylaxis-resources/adrenaline-autoinjector-prescription)

6. Ongoing management of patients at risk of anaphylaxis

Primary care physicians play an important role in the ongoing management of patients at risk of anaphylaxis including24:
- Providing updated referral for specialist review when required.
- Checking autoinjector expiry and renewing prescription if required.
- In children, checking that autoinjector dose is appropriate for weight/age.
- Reviewing patient/carer knowledge of adrenaline autoinjector administration using a trainer device.
- Reviewing documentation:
  - Update ASCIA Action Plan.
  - Provide ASCIA Travel Plan as required.
- Reviewing appropriate allergen avoidance measures.
- Reviewing and optimising asthma management as poorly managed asthma is a risk factor for fatal anaphylaxis.
- Reviewing and managing other allergic conditions (e.g. allergic rhinitis, atopic dermatitis).
- Providing referral to appropriate allied health practitioners if required (e.g. dietitian).
- Providing resource materials.
- Complete medical jewellery form (if required).

ASCIA Action Plans for Anaphylaxis are an emergency response plan. They provide patients/carers with guidance on when and how to use the adrenaline autoinjector. Every patient who is prescribed an adrenaline autoinjector should be provided with an ASCIA Action Plan for Anaphylaxis. As a medical document, it is important that the ASCIA Action Plan for Anaphylaxis is completed and signed by the patient's medical practitioner. It is important to advise patients to keep their ASCIA Action Plan with their adrenaline autoinjector and provide a copy to their school, childcare or workplace.

The latest electronic versions of the ASCIA Action Plans with type in fields are available from the ASCIA website: [www.allergy.org.au/health-professionals/anaphylaxis-resources](http://www.allergy.org.au/health-professionals/anaphylaxis-resources)

To order hard copies (in colour) email info@allergy.org.au
7. Management of severe insect allergy

Treatment of minor reactions including local swelling

- Flicking the bee sting out as soon as possible may reduce venom dose (wasps and bull ants rarely leave their sting in the skin and jack jumper ant stings retract after stinging).
- In the case of tick anaphylaxis, the tick should be killed (freeze dried) then allowed to drop off.
- Cold packs, paracetamol and soothing creams may relieve symptoms.
- Oral antihistamines may be useful for treating itch.
- Immediate application of high potency topical corticosteroid ointment may reduce swelling in some patients.
- Severe large local swelling may require oral corticosteroids.

Severe allergic reactions can be fatal

- Anaphylaxis to stings and bites should be treated as a medical emergency
- Patients who have a history of anaphylaxis should always be:
  - Prescribed an adrenaline autoinjector and be given an ASCIA Action Plan for Anaphylaxis.
  - Educated to always carry the adrenaline autoinjector with them.
  - Referred to a clinical immunology/allergy specialist for assessment and consideration of immunotherapy.

Venom immunotherapy can reduce the severity of allergy

- Immunotherapy is highly effective at reducing the risk of anaphylaxis to future stings from bees and some wasps.
- Currently there is no commercial allergen extract for immunotherapy to Jack Jumper ants, other species of ants, ticks and some wasps.
- Immunotherapy is not recommended for patients with large local swellings alone.
- Patients should be referred to a clinical immunology/allergy specialist for:
  - Initiating immunotherapy and determining duration. Patients generally undergo immunotherapy for a minimum of 5 years, however this treatment needs to be individualised.
  - Assessing the need for ongoing prescription of adrenaline autoinjector as some patients are at greater risk of anaphylaxis during and after immunotherapy.

Stinging insect allergy: management overview

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Antistamine</th>
<th>Oral corticosteroid</th>
<th>Adrenaline autoinjector</th>
<th>Immunotherapy/Refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor local</td>
<td>✓</td>
<td>×</td>
<td>×</td>
<td>x/x</td>
</tr>
<tr>
<td>Large local</td>
<td>✓</td>
<td>?</td>
<td>×</td>
<td>x/x</td>
</tr>
<tr>
<td>Systemic – no anaphylaxis</td>
<td>✓</td>
<td>×</td>
<td>?</td>
<td>?/✓</td>
</tr>
<tr>
<td>Anaphylaxis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓/✓</td>
</tr>
<tr>
<td>Serum sickness</td>
<td>✓</td>
<td>✓</td>
<td>×</td>
<td>x/?</td>
</tr>
</tbody>
</table>
Tick reactions

- Anaphylaxis to tick bites is rare.
- In patients with tick anaphylaxis, reactions usually occur soon after attempts at tick removal. In such patients, the adrenaline autoinjector should be close to hand before tick removal is considered.
- Ticks should ideally be freeze dried before removing (e.g. using liquid nitrogen, or an ether containing spray such as Wart-Off (used to freeze warts).
- Ticks should NOT be removed with tweezers or killed with kerosene or other irritants as this may trigger injection of tick saliva and trigger anaphylaxis.
- Currently no immunotherapy is available for treatment.
- Confirmatory allergy testing is not yet available, although recent research suggests that most have detectable IgE to a carbohydrate allergen called alpha-galactose, also present in red meat. This is available as a commercial blood allergy test (Immunocap, RAST) from diagnostic pathology laboratories.

Caution:
- If using liquid nitrogen, use caution to prevent burns.
- If using ether containing products, be aware that they are flammable products and should not be used near naked flames or lit cigarettes.

Jack Jumper Ant Allergy

- In areas where Jack Jumper ants are common, 2-3% of people have generalised allergic reactions and approximately half of these reactions can be life threatening.
- Approximately 70% of people with Jack Jumper ant allergy will have another allergic reaction if stung again.
- Specific allergen IgE testing is available through SA Pathology (Flinders Medical Centre, IMVS).
- Skin allergy testing is only available in Tasmania.
- Immunotherapy is only available in some centres in Australia (e.g. Tasmania).

General strategies to prevent stings and bites

- Cover up with clothing as much as possible:
  - When gardening, wear gloves, long sleeves and pants.
  - Always wear shoes.
  - Wear light coloured clothing, as it is less attractive to bees and wasps (avoid dark and bright coloured clothing).
- Use insect repellent.
- After being outdoors, check for ticks in people who are in endemic areas.
- Do not drink from open drink cans as these attract bees and wasps.
- Have nearby nests (ant, bee, wasp) removed by professionals. This is also relevant to schools and childcare, particularly if they have children enrolled with stinging insect allergy.

8. Acknowledgements and further information

ASCIA received an educational grant from NSW Health to develop this Clinical Update.

The information in this document and ASCIA guidelines is consistent with the Australian Prescriber Anaphylaxis Management wall chart www.australianprescriber.com


ASCIA guidelines are based on the following international guidelines:
- International Liaison Committee on Resuscitation (ILCOR) and Australian and New Zealand Committee on Resuscitation (ANZCOR) guidelines
- American Academy of Allergy, Asthma and Immunology (AAAAI) anaphylaxis parameter
- World Allergy Organisation (WAO) anaphylaxis guidelines

Australasian Society of Clinical Immunology and Allergy (ASCIA)

ASCIA is the peak professional body of clinical immunology and allergy specialists in Australia and New Zealand. www.allergy.org.au

ASCIA e-training for health professionals
- Anaphylaxis, food allergy, allergic rhinitis, immunotherapy.

ASCIA anaphylaxis resources webpage
www.allergy.org.au/health-professionals/anaphylaxis-resources includes links to:
- ASCIA Action Plans, Travel Plans, FAQ, Guidelines, Information for parents and other anaphylaxis related resources.
- ASCIA anaphylaxis e-training for schools and childcare.
- ASCIA anaphylaxis e-training for the community.

ASCIA health professionals webpage
www.allergy.org.au/health-professionals
- Includes links to ASCIA Clinical Updates, position papers and guidelines.

ASCIA patients and consumer webpage
www.allergy.org.au/patients/information
- Includes links to more than 60 topics in the ASCIA patient, consumer and carer information series including ASCIA infant feeding advice and allergen minimisation and avoidance strategies.
- ASCIA dietary avoidance information sheets

Patient support organisations

Allergy & Anaphylaxis Australia
www.allergyfacts.org.au
Provides patient resources and phone assistance throughout Australia

Allergy New Zealand
www.allergy.org.nz
Provides patient resources and phone assistance throughout New Zealand
References