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Diagnosis/Definition:

An immunologic reaction to medication. The most common reaction is a pruritic skin rash but can be varied. It can include many other organ systems including hepatic, renal, cardiovascular, pulmonary, musculoskeletal, and hematopoietic. Drug fever is another potential manifestation.

Initial Diagnosis and Management:

-Physical examination to characterize rash, mucosal abnormalities, or articular findings.
-History of a drug exposure which correlates temporally with symptoms or laboratory abnormality. Be aware that the reaction can start after the medication has been stopped.
-A CBC may provide supportive information if eosinophilia or other hematologic abnormalities are identified. Renal function and liver enzyme levels may be helpful if involvement of those systems is thought to be present. If the reaction was anaphylaxis, a tryptase level to confirm massive mast cell degranulation may be helpful.
-Chest x-ray for pulmonary hypersensitivity reaction.

Ongoing Management and Objectives:

-Discontinue medications suspected for causing the reaction.
-Find alternative but dissimilar medications for those that are critical for management.
-Milder, typically cutaneous reactions can be controlled by prescribing antihistamines and, if required, corticosteroids.
-If manifestations or drug allergy is acute, anaphylaxis should be treated initially with epinephrine.

Indications for Specialty Care Referral:

-Local anesthetics – clinically significant reactions are very rare. We can test to ascertain if the reaction was from the local anesthetic.
-NSAID hypersensitivity may be present with any of the non-steroidal anti-inflammatory agents. No standardized testing is available. Rarely, desensitization is indicated and referral for assistance with a desensitization protocol is warranted.
-Iodinated contrast – skin testing is not useful. Adequate pretreatment with corticosteroids and antihistamine with use of hyposmolar contrast material is standard of care. Referral is not needed.
-Antibiotic – standardized testing is available only for penicillin, however, it has poor negative predictive value. Alternative antibiotics should be used unless penicillin is required. No accepted skin testing protocols are available for other antibiotics. Thus, all negative tests will be confirmed by open oral challenge, including penicillin. If a medication is needed, we can help with a Desensitization protocol. GENERAL SKIN TESTING TO ESTABLISH THE CERTAINTY OF A DRUG ALLERGY IS USELESS SINCE IT DOES NOT ELIMINATE THE POSSIBILITY OF A SYSTEMIC REACTION. IT IS NOT INDICATED UNLESS THERE IS NO SUITABLE ALTERNATIVE.
-Immunizations – large local reactions are a common side effect of tetanus and influenza vaccines and are not an indication of allergy. If confirmation of allergy is needed, testing can be done. The amount of egg in immunizations is very small, and most egg allergic people can receive these.
-Assistance is available in evaluating perioperative anaphylaxis.

Test(s) to Prepare for Consult:	Test(s) Consultant May Need To Do:

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Criteria for Return to Primary Care:

Completion of skin testing, if indicated, and a challenge or desensitization as necessary.
Acute antibiotic desensitization should be performed under monitored conditions and this is best done through the collaborative efforts of the primary physician and the consultant.

Revision History: Created **Revised**

Disclaimer: Adherence to these guidelines will not ensure successful treatment in every situation. Further, these guidelines should not be considered inclusive of all accepted methods of care or exclusive of other methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the appropriateness of any specific procedure, therapy, or referral must be made by the physician/provider in light of all circumstances presented by an individual patient.