

Anaphylaxis—a 2020 practice parameter update, systematic review, and Grading of Recommendations, Assessment, Development and Evaluation (GRADE) analysis



Marcus S. Shaker, MD, MSc,^a Dana V. Wallace, MD,^b David B. K. Golden, MD,^c John Oppenheimer, MD,^d Jonathan A. Bernstein, MD,^e Ronna L. Campbell, MD, PhD,^f Chitra Dinakar, MD,^g Anne Ellis, MD,^h Matthew Greenhawt, MD, MBA, MSc,ⁱ David A. Khan, MD,^j David M. Lang, MD,^k Eddy S. Lang, MD,^l Jay A. Lieberman, MD,^m Jay Portnoy, MD,ⁿ Matthew A. Rank, MD,^o David R. Stukus, MD,^p and Julie Wang, MD,^q

Collaborators: Natalie Riblet, MD, MPH,^r Aiyana M. P. Bobrownicki, MPH, MBA,^r Teresa Bontrager, RN, BSN, MSNed, CPEN,^s Jarrod Dusin, MS, RD, LD,^s Jennifer Foley, RT(R)(N), CNMT,^s Becky Frederick, PharmD,^s Eyitemi Fregene, MD, MPH,^r Sage Hellerstedt, MPH,^r Ferdaus Hassan, PhD,^s Kori Hess, PharmD,^s Caroline Horner, MD,^t Kelly Huntington, RN, BSN, CPN,^s Poojita Kasireddy, MPH,^r David Keeler, RN, BSN, CPN,^s Bertha Kim, MPH,^r Phil Lieberman, MD,^m Erin Lindhorst, MS, RD, LD,^s Fiona McEnany, MPH,^r Jennifer Milbank, MPH,^r Helen Murphy, BHS RRT AE-C,^s Oriana Pando, MPH,^r Ami K. Patel, MPH,^r Nicole Ratliff, BS RT(R),^s Robert Rhodes, MHA, RRT-NPS,^s Kim Robertson, MBA, MT-BC,^s Hope Scott, RN, CPEN,^s Audrey Snell, MS, RD, CSP, LD,^s Rhonda Sullivan, MS, RD, LD,^s Varahi Trivedi, MPH,^r and Azadeh Wickham, MS, FNP-BC^s

Chief Editors: Marcus S. Shaker and Dana V. Wallace

Workgroup Contributors: Marcus S. Shaker, Dana V. Wallace, Jonathan A. Bernstein, Ronna L. Campbell, Chitra Dinakar, Anne Ellis, David B. K. Golden, Matthew Greenhawt, Jay A. Lieberman, Matthew A. Rank, David R. Stukus, and Julie Wang

Joint Task Force on Practice Parameters Reviewers: Marcus S. Shaker, Dana V. Wallace, David B. K. Golden, Jonathan A. Bernstein, Chitra Dinakar, Anne Ellis, Matthew Greenhawt, Caroline Horner, David A. Khan, Jay A. Lieberman, John Oppenheimer, Matthew A. Rank, Marcus S. Shaker, David R. Stukus, and Julie Wang, *Lebanon and Hanover, NH; Fort Lauderdale, Fla; Baltimore, Md; Morristown, NJ; Cincinnati, Cleveland, and Columbus, Ohio; Rochester, Minn; Stanford, Calif; Kingston, Ontario, and Calgary, Alberta, Canada; Denver, Colo; Dallas, Tex; Memphis, Tenn; Kansas City and St Louis, Mo; Scottsdale, Ariz; and New York, NY*

Anaphylaxis is an acute, potential life-threatening systemic allergic reaction that may have a wide range of clinical manifestations. Severe anaphylaxis and/or the need for repeated

doses of epinephrine to treat anaphylaxis are risk factors for biphasic anaphylaxis. Antihistamines and/or glucocorticoids are not reliable interventions to prevent biphasic anaphylaxis,

From ^athe Section of Allergy and Clinical Immunology, Dartmouth-Hitchcock Medical Center, Geisel School of Medicine at Dartmouth, Lebanon; ^bthe Nova Southeastern Allopathic Medical School, Fort Lauderdale; ^cthe Division of Allergy-Clinical Immunology, Johns Hopkins University, Baltimore; ^dthe Department of Internal Medicine, Pulmonary and Allergy, University of Medicine and Dentistry of New Jersey–Rutgers New Jersey Medical School and Pulmonary and Allergy Associates, Morristown; ^ethe Department of Internal Medicine, Division of Immunology, Allergy Section, University of Cincinnati College of Medicine; ^fthe Department of Emergency Medicine, Mayo Clinic, Rochester; ^gthe Allergy, Asthma, and Immunodeficiency, Division of Pulmonary, Allergy, and Critical Care Medicine, Stanford University School of Medicine; ^hthe Division of Allergy and Immunology, Department of Medicine, Queen's University, Kingston; ⁱthe Section of Allergy and Immunology, Children's Hospital Colorado, University of Colorado School of Medicine, Denver; ^jthe Department of Internal Medicine, Division of Allergy and Immunology,

University of Texas Southwestern Medical Center, Dallas; ^kthe Department of Allergy and Clinical Immunology, Respiratory Institute, Cleveland Clinic; ^lthe Department of Emergency Medicine, Cumming School of Medicine, University of Calgary; ^mthe Department of Pediatrics, The University of Tennessee Health Science Center, Memphis; ⁿthe Pediatric Allergy and Immunology, Children's Mercy Hospital, Kansas City School of Medicine; ^othe Division of Allergy, Asthma, and Clinical Immunology, Mayo Clinic in Arizona, Scottsdale; ^pthe Division of Allergy and Immunology, Nationwide Children's Hospital and The Ohio State University College of Medicine, Columbus; ^qthe Division of Allergy and Immunology, Icahn School of Medicine at Mount Sinai, New York; ^rThe Dartmouth Institute for Health Policy and Clinical Practice, Hanover; ^sthe Office of Evidence-Based Practice, Children's Mercy Hospital, Kansas City; ^tthe Department of Pediatrics, Division of Allergy, Immunology, and Pulmonary Medicine, Washington University School of Medicine, St. Louis.

although evidence supports a role for antihistamine and/or glucocorticoid premedication in specific chemotherapy protocols and rush aeroallergen immunotherapy. Evidence is lacking to support the role of antihistamines and/or glucocorticoid routine premedication in patients receiving low- or iso-osmolar contrast material to prevent recurrent

Disclosure of potential conflict of interest: The JTFPP members and work group members' conflict of interest disclosure forms can be found at www.allergyparameters.org. Jonathan Bernstein has received financial support from Sanofi, Regeneron, AstraZeneca, Merck, Optinose, Takeda, CSL Behring, Biocryst, Pharming, the National Institutes of Health, Taylor Francis, INEOS; is Editor in Chief of the *Journal of Asthma*, INEOS Medical Immunosurveillance Director, Vice Chair and Lectureship Chair of the American Academy of Allergy, Asthma & Immunology (AAAAI) Foundation, Chairman of Allergists for Israel, American College of Asthma, Allergy, and Immunology (ACAAI) Asthma Chair, Scientific Chair, and Young Investigator Award Chair; and serves of the Board of Directors and Scientific Committee of Interasma. Ronna Campbell has served as a peer reviewer for EB Medicine and an author for UpToDate. Chitra Dinakar has received financial support from Propeller Health, ACAAI (stipend for Editorial Board of *AllergyWatch*), the American Association of Allergists of Indian Origin; serves on the Board of Directors of the AAAAI and on the Medical Advisory Board of Food Equity Initiative; is Assistant Editor of *AllergyWatch*. Anne Ellis has received financial support from ALK-Abello, AstraZeneca, Green Cross, Merck, Novartis, Nuvo, PediaPharm, Pfizer, Kaleo, Novartis, Sanofi, Regeneron; serves on the Board of Directors of the Canadian Allergy Society of Allergy and Clinical Immunology. David Golden has received financial support from Aquestive, Sandoz, ALK-Abello, Sandoz, Genentech, Stallergenes-Greer, and UpToDate. Matthew Greenhawt has received financial support from Aquestive, Merck, Allergenis, Allergy Therapeutics, Sanofi Genzyme, Genentech, Aravax, Prota, Before Brands, the Institute for Clinical and Economic Review, ACAAI, DBV, Intromune; is supported by the Agency of Healthcare Research and Quality; has served on the advisory board of International Food Protein-Induced Enterocolitis Syndrome Association, the Asthma and Allergy Foundation of America, and the National Peanut Board; and is Associate Editor of the *Annals of Allergy, Asthma, and Immunology*. Caroline Horner has served as committee chair for the AAAAI Asthma Diagnosis and Treatment Interest Section, Interest Section Coordinating Committee, and In-Training Exam Coordinating Committee. David Khan has received financial support from UpToDate and Aimmune; serves on the Board of Directors of the AAAAI, ACAAI Chair of Literature Review, Co-Chair of Conjoint Board Review, Texas Allergy, Asthma, and Immunology Society Chair of Meetings Committee; and is Associate Editor of the *Journal of Allergy and Clinical Immunology In Practice*. Eddy Lang received an honorarium from the Joint Task Force on Practice Parameters for Grading of Recommendations, Assessment, Development and Evaluation methods support. Jay Lieberman has received financial support from the ACAAI, Aquestive, Aimmune, DBV, Biotech Pharma, and Regeneron; is Associate Editor of the *Annals of Allergy, Asthma, and Immunology*, Vice Chair for the ACAAI Food Allergy Committee, and Medical Director for Food Allergy Alliance of the Mid-South. John Oppenheimer has received financial support from DBV, Teva Pharmaceutical Industries, GlaxoSmithKline adjudication/data safety monitoring board, AstraZeneca, Novartis, and Sanofi; is Associate Editor of the *Annals of Allergy, Asthma, and Immunology* and *AllergyWatch*, an American Board of Internal Medicine Council Member and American Board of Allergy and Immunology Liaison to the American Board of Internal Medicine, UpToDate Reviewer, American College of Clinical Pharmacy Cough Guideline Committee Member, and WebMD Editor. Jay Portnoy has received financial support from Thermo Fisher Scientific, Kaleo, Teva Pharmaceutical Industries, Novartis, Hycor, and Boehringer-Ingelheim. Matthew Rank has received financial support from the ACAAI, National Institutes of Health, and Levin Family Foundation; has served as Chair of the AAAAI Health outcomes, Education, Delivery, and Quality Interest Section; and is Research Director of the Phoenix Children's Hospital Breathmobile. Marcus Shaker has received financial support from the Eastern Allergy Conference and has a family member who is Chief Executive Officer of Altrix Medical. David Stukus has received financial support from Aimmune, Before Brands, Abbott Nutrition, the American Academy of Pediatrics, ACAAI; has served as Committee Chair for the AAAAI and ACAAI. Dana Wallace has received financial support from Mylan, Kaleo, Optinose, ALK-Abello, Bryan, and Sanofi; is Education Council Chair and Rhinitis/Sinusitis/Ocular Committee Chair for the ACAAI; is Website Content Editor and ESP/WAT's Committee Chair for the World Allergy Organization. Julie Wang has received financial support from ALK-Abello, Regeneron, DBV, Aimmune; is an UpToDate author; serves on the Executive Committee of the American Academy of Pediatrics Section on Allergy and Immunology; and serves as Vice Chair of the AAAAI Anaphylaxis, Dermatitis, Drug Allergy Interest Section. David Lang declares that he has no relevant conflicts of interest.

Reprints: *Joint Task Force on Practice Parameters Liaison*: Peris Flagg (American Academy of Allergy, Asthma, and Immunology, 555 E. Wells Street, Suite 1100,

radiocontrast media anaphylaxis. Epinephrine is the first-line pharmacotherapy for uniphasic and/or biphasic anaphylaxis. After diagnosis and treatment of anaphylaxis, all patients should be kept under observation until symptoms have fully resolved. All patients with anaphylaxis should receive education on anaphylaxis and risk of recurrence, trigger avoidance,

Milwaukee, WI 53202. E-mail: pflagg@aaaai.org; JTFPP.allergy@gmail.com.

Previously published practice parameters of the Joint Task Force on Practice Parameters for Allergy & Immunology are also available at <http://www.allergyparameters.org>, <http://www.AAAAI.org>, and <http://www.ACAAI.org>.

The Joint Task Force on Practice Parameters (JTFPP) is committed to ensuring that the practice parameters are based on the best scientific evidence at the time of publication, and that such evidence is free of commercial bias to the greatest extent possible. The JTFPP recognizes that experts in a field are likely to have interests that could come into conflict with the development of a completely unbiased and objective practice parameter. To take advantage of their expertise, a process has been developed to acknowledge potential conflicts of interest (COI) and attempt to prevent them from influencing the final document in a negative way. To preserve the greatest transparency regarding potential COI, all members of the JTFPP and the practice parameters work groups will complete a standard potential COI disclosure form prior to the development of each document, which will be available for external review by the sponsoring organization and any other interested individual. In addition, before confirming the selection of the work group chairperson and members, the JTFPP will discuss and resolve all relevant potential COI associated with this selection. Finally, all members of parameter work groups will be provided a written statement regarding the importance of ensuring that the parameter development process is free of commercial bias. During the review process there are additional measures to avoid bias. At the workgroup level, all the sections are reviewed by all work group members to ensure that content is appropriate and without apparent bias. If a section is deemed to have apparent bias, it will be appropriately revised without the section author's involvement, in an attempt to remove potential bias. In addition, the entire document is then reviewed by the JTFPP, and any apparent bias is acknowledged and removed at that level. For each and every recommendation, a vote is required by the work group and JTFPP, and any member with any perceived COI is recused from that vote (and so explained in the document). Any dissenting votes that cannot be resolved are described and explained in the document. In a final stage of review, the practice parameter is sent to invited expert reviewers for review, selected by the American Academy of Allergy, Asthma & Immunology (AAAAI) and the American College of Allergy, Asthma, and Immunology (ACAAI). The document is also posted on the AAAAI and ACAAI websites for general membership and the public-at-large to review and offer comment. All reviewers must provide statements of potential COI. Although the JTFPP has the final responsibility for the content of the documents submitted for publication, each reviewer's comments will be discussed and reviewers will receive written responses to comments when appropriate.

Disclaimer: The AAAAI and the ACAAI have jointly accepted responsibility for establishing "Anaphylaxis—a 2019 practice parameter update, systematic review and Grading of Recommendations, Assessment, Development and Evaluation (GRADE) analysis." This is a complete and comprehensive document and is current at the time of publication. The medical environment is rapidly changing and not all recommendations will be appropriate or applicable to all patients and may change over time. Because this document incorporated the efforts of many participants, no single individual, including members serving on JTFPP, are authorized to provide an official AAAAI or ACAAI interpretation of these practice parameters. Any request for information or interpretation of this practice parameter by the AAAAI or ACAAI should be directed to the executive offices of the AAAAI and the ACAAI. These parameters are not designed for use by the pharmaceutical industry in drug development or promotion.

Contributors: The Joint Task Force has made a concerted effort to acknowledge all contributors to this parameter. If any contributors have been excluded inadvertently, the Task Force will ensure that appropriate recognition of such contributions is made subsequently.

Received for publication October 2, 2019; revised December 21, 2019; accepted for publication January 2, 2020.

Available online January 28, 2020.

Corresponding author: Marcus S. Shaker, MD, MSc, FAAAAI, FAAAAI, FAAP, Section of Allergy and Clinical Immunology, Dartmouth-Hitchcock Medical Center, One Medical Center Drive, Lebanon, NH 03756-0001. E-mail: Marcus.shaker@dartmouth.edu.

 The CrossMark symbol notifies online readers when updates have been made to the article such as errata or minor corrections

0091-6749/\$36.00

© 2020 American Academy of Allergy, Asthma & Immunology

<https://doi.org/10.1016/j.jaci.2020.01.017>

self-injectable epinephrine education, referral to an allergist, and be educated about thresholds for further care. (J Allergy Clin Immunol 2020;145:1082-123.)

Key words: Anaphylaxis, GRADE, epinephrine, risk factors, biphasic, severity, glucocorticoids, antihistamines, pretreatment-radiocontrast media, chemotherapy, mAb, infliximab, allergen immunotherapy, systematic meta-analysis, evidence to recommendations, guideline, practice parameter

The Joint Task Force on Practice Parameters would like to dedicate this guideline to Chitra Dinakar for her ongoing contributions and dedication to the field of allergy and immunology.

EXECUTIVE SUMMARY

Anaphylaxis is an acute, life-threatening systemic allergic reaction that may have a wide range of clinical manifestations.¹ The clinical criteria proposed in 2006 by National Institute of Allergy and Infectious Diseases (NIAID) continue to provide a helpful framework in approaching patients with acute allergic symptoms, because diagnosis and management of anaphylaxis must occur rapidly and confirmatory testing for anaphylaxis has poor sensitivity.² While NIAID anaphylaxis diagnostic criteria have a sensitivity of 95% with a specificity of 71% in an emergency department (ED) setting,³ fulfilling diagnostic criteria is not a prerequisite for epinephrine administration in a patient experiencing an acute allergic reaction.

The lifetime prevalence of anaphylaxis has been estimated at 1.6% to 5.1%.^{1,4} Risk factors for severe anaphylaxis include cardiovascular disease, asthma, older age, and additional coexisting, comorbid conditions.⁵⁻⁹ Medications and stinging insects are the leading triggers in adults, with foods and stinging insects the most frequently implicated triggers in children and adolescents.^{1,10-12} Food allergy impacts 8% to 11% of children and adults in the United States,¹³⁻¹⁵ while adverse drug reactions (ADRs) affect up to 10% of the population (and 20% of hospitalized patients), with hypersensitivity reactions (HSRs) accounting for 10% of all ADRs.¹⁶ Although medical complexity increases for patients with prior HSRs to radiocontrast media (RCM), fortunately the prevalence of RCM ADRs has decreased in recent decades.¹⁷ Systemic reactions to Hymenoptera venom occur in 0.5% to 3.3% of the US population, with most fatalities occurring in patients who have no prior history of systemic allergic reaction to Hymenoptera.¹⁶

IgE binding and cross-linking of the high affinity IgE receptor (FcεRI) on the surface of mast cells and basophils is an important mechanism in many cases of anaphylaxis.¹⁸ Some patients with anaphylaxis have low or undetectable circulating allergen-specific IgE.¹⁹ Anaphylaxis involves additional cell types that may include neutrophils, monocytes, macrophages, and platelets and signaling through mediators that include complement components, cysteinyl leukotrienes (LTs), platelet activating factor, IL-6, IL-10, and TNF-receptor 1.^{20,21}

Epinephrine administered intramuscularly (in a dose of 0.01 mg/kg of a 1:1000 [1 mg/mL] solution to a maximum of 0.5 mg in adults and 0.3 mg in children) into the anterolateral thigh is the first-line treatment for anaphylaxis.²² Epinephrine is the cornerstone of anaphylaxis management but continues to be

Abbreviations used

AAAAI:	American Academy of Allergy, Asthma & Immunology
ACAAI:	American College of Allergy, Asthma, and Immunology
ADR:	Adverse drug reaction
C3a (4a, 5a):	Complement 3a (4a, 5a)
DHR:	Drug hypersensitivity reaction
ED:	Emergency department
EMS:	Emergency medical services
FAAN:	Food Allergy and Anaphylaxis Network
FIA:	Food-induced anaphylaxis
GRADE:	Grading of Recommendations, Assessment, Development and Evaluation
H1 (2, 3, 4):	Histamine 1 (2, 3, 4)
HSR:	Hypersensitivity reaction
HVA:	Hymenoptera venom allergy
I ² :	Inconsistency of studies' results
IQR:	Interquartile range
JTFPP:	Joint Task Force on Practice Parameters
LL:	Large local
LT:	Leukotriene
NIAID:	National Institute of Allergy and Infectious Diseases
NNT:	Number needed to treat
NPV:	Negative predictive value
OR:	Odds ratio
PAF:	Platelet-activating factor
PEER:	Patient expected event rate
PRISMA:	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCM:	Radiocontrast media
RIT:	Rush immunotherapy
RR:	Relative risk

underutilized.²³⁻²⁵ As a nonselective adrenergic agonist, epinephrine works rapidly to increase peripheral vascular resistance through vasoconstriction, to increase cardiac output, to reverse bronchoconstriction and mucosal edema, and to stabilize mast cells and basophils.^{26,27} Despite underuse of rapidly acting epinephrine as first-line treatment, fatal anaphylaxis is a rare outcome, with population prevalence rates between 0.47 and 0.69 per million persons (0.25%-0.33% of anaphylaxis hospitalizations or ED visits).^{9,28-31} Antihistamine agents are considered second-line treatment for anaphylaxis, given their slow onset of action and inability to stabilize or prevent mast cell degranulation or to target additional mediators of anaphylaxis.³² Unlike epinephrine, antihistamines will not effectively treat cardiovascular and respiratory symptoms such as hypotension or bronchospasm. Although glucocorticoids are frequently used as an adjunctive therapy for anaphylaxis, evidence is lacking to support clinical benefit, and they should not be administered in place of epinephrine in the treatment of acute anaphylaxis.^{33,34}

Biphasic anaphylaxis is recurrent anaphylaxis occurring 1 to 72 hours after resolution of an initial anaphylactic episode, though an outside limit of 78 hours has also been suggested.^{35,36} Estimates of biphasic anaphylaxis vary from <1% to 20% of patients; however, the ability of antihistamines and glucocorticoids to affect this outcome is unclear.³⁷⁻⁴⁴ Despite a lack of clear evidence supporting the role of antihistamines and glucocorticoids in anaphylaxis, these agents continue to be routinely used in anaphylaxis management. To evaluate the role for these second-line, supplemental therapies, the Joint Task

Box 1. Key questions assessed by this systematic review on anaphylaxis

Topic area 1. Identification and mitigation of risk factors for biphasic anaphylaxis

Question 1. What risk factors should clinicians take into consideration in determining the likelihood of biphasic anaphylaxis?

Topic area 2. Evaluation of the use of supplemental glucocorticoids and/or antihistamine premedication for the prevention of anaphylaxis

Question 2. Should antihistamines and/or glucocorticoids be used to prevent biphasic anaphylaxis?

Question 3. Should antihistamine and/or glucocorticoid premedication be used to prevent index hypersensitivity/infusion reactions to chemotherapy?

Question 4. Should antihistamine and/or glucocorticoid premedication be used to prevent recurrent HSRs to RCM?

Question 5. Should antihistamine and/or glucocorticoid premedication be used to prevent HSRs to allergen immunotherapy or other agents?

Force on Practice Parameters (JTFPP) undertook a systematic review and Grading of Recommendations, Assessment, Development and Evaluation (GRADE) analysis of antihistamines and glucocorticoids in anaphylaxis. Specifically, the JTFPP sought to better inform the practice of anaphylaxis prevention in 2 broad topic areas through (1) identification and mitigation of risk factors for biphasic anaphylaxis and (2) evaluation of the use of supplemental glucocorticoid and/or antihistamine premedication (see [Box 1](#)). Although the goal of the JTFPP was to rigorously evaluate the literature to form evidence-based recommendations, there are limits to the available evidence in human anaphylaxis due to ethical considerations and the absence of double-blind studies in a potentially fatal, acute condition. This GRADE analysis incorporated the balance of relative benefits and harms of treatments under consideration, the certainty of the evidence, and the impact of patient preferences and values. [Box 2](#) provides a summary of key clinical advice.

Question 1. What risk factors should clinicians take into consideration in determining the likelihood of biphasic anaphylaxis?

Recommendation 1. We suggest that a clinician incorporate severity of anaphylaxis presentation and/or the administration of >1 dose of epinephrine for the treatment of initial anaphylaxis as a guide to determining a patient's risk for developing biphasic anaphylaxis. Conditional recommendation. Certainty rating of evidence: very low.

Even though the ability to accurately predict which patients with resolved initial anaphylaxis will experience biphasic anaphylaxis is imperfect, an understanding of risk factors allows a more tailored approach to patient management. Risk factors also provide useful parameters to incorporate into decision making regarding duration of observation following initial resolution of anaphylaxis.

The JTFPP findings suggest biphasic anaphylaxis is associated with a more severe initial presentation of anaphylaxis (odds ratio [OR], 2.11; 95% CI, 1.23-3.61) or repeated epinephrine doses (ie, >1 dose of epinephrine) required with the initial presentation (OR, 4.82; 95% CI, 2.70-8.58). Additional risk factors include wide pulse pressure (OR, 2.11; 95% CI, 1.32-3.37), unknown anaphylaxis trigger (OR, 1.63; 95% CI, 1.14-2.33), cutaneous signs and symptoms (OR, 2.54; 95% CI, 1.25-5.15), and drug trigger in children (OR, 2.35; 95% CI, 1.16-4.76). While presence of dyspnea on presentation was associated with a decreased risk for anaphylaxis, overall confidence in this estimate was low (OR,

0.6; 95% CI, 0.38-0.96). Prompt and adequate treatment of anaphylaxis appears central to reducing biphasic anaphylaxis risk, in the opinion of the JTFPP. While the possibility of biphasic anaphylaxis should be emphasized in this higher risk group, it is important to educate all patients regarding the chance of a biphasic reaction as well as avoiding known triggers, identification of symptoms of anaphylaxis, the use of auto-injector epinephrine for the treatment of anaphylaxis, and timely follow-up with an allergist.

Recommendation 2. We suggest extended clinical observation in a setting capable of managing anaphylaxis (to detect a biphasic reaction) for patients with resolved severe anaphylaxis and/or those who need >1 dose of epinephrine. Conditional recommendation. Certainty rating of evidence: very low.

While wide pulse pressures may be considered a marker for severe anaphylaxis, the clinician may also consider extended observation for patients with an unknown anaphylaxis trigger and children with a drug trigger. Incorporating cutaneous signs and symptoms into a clinical decision for extended observation may be limited by the common occurrence of cutaneous signs and symptoms in patients presenting with anaphylaxis. The estimated number needed to monitor with extended observation to be able to detect 1 episode of biphasic anaphylaxis before discharge would be 41 (range, 18-195) for patients with a more severe initial presentation of anaphylaxis and 13 (range, 7-27) for patients with multiple epinephrine doses. The implication for the clinician, based on this systematic review and meta-analysis, is that the patient presenting with severe anaphylaxis and/or requiring more aggressive treatment (eg, >1 dose of epinephrine) should be considered for longer observation time for a potential biphasic reaction following complete resolution of signs and symptoms. At present, evidence is lacking to clearly define the optimal duration of observation (eg, number of hours) that would prove to be cost-effective for patients with initial resolution of severe anaphylaxis and/or those requiring multiple doses of epinephrine. However, for patients without severe risk features, discharge after a 1-hour asymptomatic observation may be reasonable. If the clinical impression is that a patient has a higher risk of biphasic reaction (ie, 17% or greater) or risk factors for anaphylaxis fatality (eg, cardiovascular comorbidity, lack of access to epinephrine, lack of access to emergency medical services (EMS), poor self-management skills), then extended observation of up to 6 hours or longer (including hospital admission) may be appropriate. Regardless of severity, after diagnosis and treatment of anaphylaxis, all patients should be kept under observation until signs and symptoms have fully resolved.

Box 2. Suggested key clinical advice

- Severe anaphylaxis and/or the need for >1 dose of epinephrine to treat anaphylaxis are risk factors for biphasic anaphylaxis. Additional risk factors include wide pulse pressure, unknown anaphylaxis trigger, cutaneous signs and symptoms, and drug trigger in children.
- Extended observation is suggested for patients with resolved severe anaphylaxis and/or those with need for >1 dose of epinephrine.
- Antihistamines and/or glucocorticoids are not reliable interventions to prevent biphasic anaphylaxis but may be considered as secondary treatment.
- Evidence supports a role for antihistamine and/or glucocorticoid premedication in specific chemotherapy protocols and rush aeroallergen immunotherapy.
- Evidence is lacking to support the routine use of antihistamines and/or glucocorticoid premedication in patients receiving low- or iso-osmolar contrast material to prevent recurrent RCM anaphylaxis.
- Administer epinephrine as the first-line pharmacotherapy for uniphasic and/or biphasic anaphylaxis.
- Do not delay the administration of epinephrine for anaphylaxis.
- After diagnosis and treatment of anaphylaxis, all patients should be kept under observation until symptoms have fully resolved.
- All patients with anaphylaxis should receive education about anaphylaxis, risk of recurrence, trigger avoidance, self-injectable epinephrine, and thresholds for further care, and they should be referred to an allergist for follow-up evaluation.

Question 2. Should antihistamines or glucocorticoids be used to prevent biphasic anaphylaxis?

Recommendation. We suggest against administering glucocorticoids or antihistamines as an intervention to prevent biphasic anaphylaxis. **Conditional recommendation. Certainty rating of evidence: very low.**

Although we suggest against the use of antihistamines and/or glucocorticoids as an intervention to prevent biphasic anaphylaxis, these may be considered for the secondary treatment of anaphylaxis.⁴⁵ In particular, antihistamines may treat urticaria and itching to improve comfort during anaphylaxis, but if used prior to epinephrine administration, antihistamine administration could lead to a delay in first-line treatment of anaphylaxis. The JTFPP analysis did not identify clear benefit in prevention of biphasic anaphylaxis from histamine 1 (H1) antihistamines (OR, 0.71; 95% CI, 0.47-1.06), H2 antihistamines (OR, 1.21; 95% CI, 0.80-1.83), or glucocorticoids (OR, 0.87; 95% CI, 0.74-1.02). An interaction was identified between age and glucocorticoid use, with glucocorticoids actually increasing risk for biphasic anaphylaxis in children (OR, 1.55; 95% CI, 1.01-2.38); however, a confounding effect of severity could not be excluded. At a biphasic anaphylaxis patient expected event rate (PEER) of 5%, the number needed to treat (NNT) for H1 antihistamines and glucocorticoids is 72 and 161 to prevent 1 episode of biphasic anaphylaxis, with significant uncertainty in the estimate.

Question 3. Should antihistamine and/or glucocorticoid premedication be used to prevent index hypersensitivity/infusion reactions to chemotherapy?

Recommendation. We suggest in favor of administering glucocorticoids and/or antihistamines to prevent anaphylaxis or infusion-related reactions when indicated for specific agents in chemotherapy protocols. **Conditional recommendation. Certainty rating of evidence: very low.**

The JTFPP analysis did identify a significant change in rates of anaphylaxis and/or infusion reactions for some chemotherapy

protocols. The use of premedication was associated with a decreased rate of HSRs for chemotherapy (OR, 0.49; 95% CI, 0.37-0.66). In contrast to chemotherapy premedication, benefit was not observed when using premedication to prevent anaphylaxis in the setting of infliximab without prior reaction to the administered agent (relative risk [RR], 1.58; 95% CI, 0.87-2.87). We did not evaluate premedication in the context of desensitization to chemotherapy agents and to monoclonal antibodies. Furthermore, the use of premedication in patients who had previously experienced anaphylaxis from these agents was not evaluated.

Question 4. Should antihistamine and/or glucocorticoid premedication be used to prevent recurrent HSRs to RCM?

Recommendation. We suggest against routinely administering glucocorticoids and/or antihistamines to prevent anaphylaxis in patients with prior radiocontrast HSRs when readministration of a low- or iso-osmolar, nonionic RCM agent is required. **Conditional recommendation. Certainty rating of evidence: very low.**

The JTFPP analysis did not identify significant benefit from the use of premedication prior to RCM administration to prevent anaphylaxis (RR, 1.07; 95% CI, 0.67-1.71). The absence of benefit of premedication in patients with prior immediate HSRs to RCM who are receiving a different low- or iso-osmolar agent is consistent with prior literature; however, it is important to distinguish the immediate index reaction associated with RCM from a severe, delayed, cutaneous T-cell-mediated reaction, where premedication may add value to management.¹⁷ Given the diversity of clinical circumstances evaluated and low confidence in the literature base, higher certainty evidence is needed to better inform practice, and future recommendations could potentially change as a result of new information. As such, clinicians may reasonably consider premedication in clinical circumstances associated with a high level of perceived risk of anaphylaxis or comorbidities associated with greater anaphylaxis fatality risk (such as underlying cardiovascular disease, use of beta-blockers, or prior severe anaphylaxis), although evidence is lacking to clearly support this practice.

This analysis evaluated patients with both mild and severe prior RCM reactions, but we were unable to stratify prophylaxis by severity of index reaction. Furthermore, only low- and iso-osmolar nonionic radiocontrast agents were evaluated because these are the most commonly used agents at present. This recommendation does not apply to patients receiving high-osmolar contrast agents for whom prophylaxis may be appropriate in some circumstances.

Question 5. Should antihistamine and/or glucocorticoid premedication be used to prevent HSRs to allergen immunotherapy or other agents?

Recommendation. We suggest the administration of glucocorticoids and/or antihistamines as an intervention to prevent anaphylaxis in patients undergoing aeroallergen rush immunotherapy (RIT). **Conditional recommendation. Certainty rating of evidence: very low.**

Evidence suggests that in the setting of aeroallergen RIT, premedication may provide value in reducing systemic reactions and anaphylaxis (immunotherapy analysis including RIT: RR, 0.62; 95% CI, 0.41-0.94). The evidence base for premedication before conventional aeroallergen immunotherapy is limited; however, 1 study⁴⁶ suggested some benefit with fexofenadine pretreatment 2 hours before conventional immunotherapy using cedar pollen or dust mite allergens. The JTFPP is unable to exclude the possibility that specific situations and subpopulations may exist where premedication could provide benefit to immunotherapy in those with concomitant risk factors (eg, in situations associated with higher rates of systemic reactions). As such, clinicians may reasonably consider immunotherapy premedication in other clinical circumstances associated with a high level of perceived risk of anaphylaxis or comorbidities associated with greater anaphylaxis fatality risk (such as underlying cardiovascular disease or use of beta-blockers), although high-certainty evidence is lacking to support this practice.

Additional good practice statements

Good practice statement 1. Administer epinephrine as the first-line pharmacotherapy for uniphasic and/or biphasic anaphylaxis.

Good practice statement 2. Do not delay the administration of epinephrine for anaphylaxis, as doing so may be associated with higher morbidity and mortality.

Good practice statement 3. After diagnosis and treatment of anaphylaxis, all patients should be kept under observation in a setting capable of managing anaphylaxis until symptoms have fully resolved.

Good practice statement 4. All patients with anaphylaxis should receive education on anaphylaxis, including avoidance of identified triggers, presenting signs and symptoms, biphasic anaphylaxis, treatment with epinephrine, and the use of epinephrine auto-injectors, and they should be referred to an allergist. Of note, there may be some circumstances where self-injectable epinephrine is deferred (ie, resolved anaphylaxis and drug trigger with high likelihood of successful avoidance) and shared decision making may play a role in some circumstances.

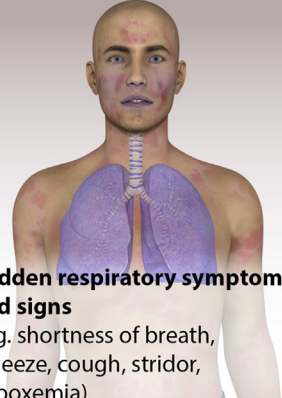
INTRODUCTION TO AND DIAGNOSIS OF ANAPHYLAXIS

Anaphylaxis is an acute, life-threatening systemic allergic reaction associated with different mechanisms, triggers, clinical presentations, and severity.¹ The wide range of clinical manifestations and complex underlying mechanisms of anaphylaxis contribute to the difficulty in establishing a definition and diagnostic criteria for anaphylaxis. The poor sensitivity of confirmatory laboratory testing further complicates accurate diagnosis of anaphylaxis. Furthermore, a lack of use of established diagnostic criteria plays a major role in the underdiagnosis and inconsistent management of anaphylaxis.⁴⁷⁻⁴⁹ In 2005, a multinational and multidisciplinary work group that included allergist-immunologists, emergency physicians, pediatricians, critical care specialists, internists, and key stakeholders was assembled by the NIAID and Food Allergy and Anaphylaxis Network (FAAN) to address the need for universally accepted anaphylaxis diagnostic criteria. The diagnostic criteria proposed by this work group were published in 2006²² and describe anaphylaxis as likely when 1 of 3 criteria are fulfilled: (1) acute onset of an illness (minutes to hours) with involvement of the skin, mucosal tissue, or both with either respiratory involvement or reduced blood pressure and/or associated symptoms of end-organ dysfunction; or (2) 2 or more of the following that occur rapidly after exposure to a likely allergen for the patient, including (i) involvement of skin-mucosal tissue, (ii) respiratory involvement, (iii) reduced blood pressure or associated symptoms, or (iv) gastrointestinal symptoms; or (3) reduced blood pressure as a result of exposure to a known allergen trigger. These criteria have since been recognized and endorsed by the American Academy of Allergy, Asthma & Immunology (AAAAI), American College of Allergy, Asthma, and Immunology (ACAAI),⁵⁰ and the World Allergy Organization.⁵¹

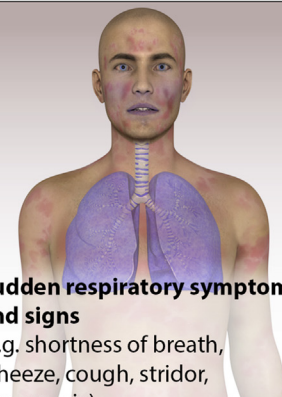
The NIAID/FAAN criteria were developed to facilitate rapid diagnosis of anaphylaxis. The criteria (shown in Fig 1) incorporate features related to the onset of the reaction, exposure to an inciting trigger, as well as signs and symptoms. Importantly, using these criteria, anaphylaxis can be identified among patients lacking hemodynamic compromise, patients lacking cutaneous manifestations, and patients with mild presentations (eg, those with a rash and vomiting after exposure to a likely trigger). The NIAID/FAAN anaphylaxis diagnostic criteria were prospectively validated in patients seeking care for an allergic reaction and possible anaphylaxis in an ED setting and were shown to provide a positive likelihood ratio of 3.26 and negative likelihood ratio of 0.07.³ Thus, although these criteria are helpful clinically, they should not replace clinician judgment. It is important to recognize, as acknowledged by those who developed the criteria, that epinephrine administration is not limited to those patients meeting the NIAID/FAAN diagnostic criteria. For example, a patient undergoing immunotherapy who immediately develops generalized urticaria after an injection may appropriately receive epinephrine if impending anaphylaxis is suspected, despite the fact that the diagnostic criteria for anaphylaxis have not yet been met. In such instances, management relies heavily on clinical judgment. However, the role of preemptive epinephrine prior to the development of anaphylaxis has been questioned.⁵²⁻⁵⁴ Isolated allergen-associated urticaria, which may respond to antihistamines, should be distinguished from anaphylaxis for which prompt epinephrine administration is indicated.

Anaphylaxis is highly likely when any one of the following three criteria is fulfilled

- 1** Sudden onset of an illness (minutes to several hours), with involvement of the skin, mucosal tissue, or both (e.g. generalized hives, itching or flushing, swollen lips-tongue-uvula)

 AND AT LEAST ONE OF THE FOLLOWING:	 Sudden respiratory symptoms and signs (e.g. shortness of breath, wheeze, cough, stridor, hypoxemia)	 Sudden reduced BP or symptoms of end-organ dysfunction (e.g. hypotonia [collapse], incontinence)
--	--	--

- OR 2** Two or more of the following that occur suddenly after exposure to a *likely allergen or other trigger** for that patient (minutes to several hours)

 Sudden skin or mucosal symptoms and signs (e.g. generalized hives, itch-flush, swollen lips-tongue-uvula)	 Sudden respiratory symptoms and signs (e.g. shortness of breath, wheeze, cough, stridor, hypoxemia)	 Sudden reduced BP or symptoms of end-organ dysfunction (e.g. hypotonia [collapse], incontinence)	 Sudden gastrointestinal symptoms (e.g. crampy abdominal pain, vomiting)
--	--	--	--

- OR 3** Reduced blood pressure (BP) after exposure to a *known allergen*** for that patient (minutes to several hours)

 Infants and children: low systolic BP (age specific) or greater than 30% decrease in systolic BP ***	 Adults: systolic BP of less than 90 mm Hg or greater than 30% decrease from that person's baseline
--	--

* For example, immunological but IgE-independent, or non-immunologic (direct mast cell activation)

** For example, after an insect sting, reduced blood pressure might be the only manifestation of anaphylaxis; or after allergen immunotherapy, generalized hives might be the only initial manifestation of anaphylaxis.

*** Low systolic blood pressure for children is defined as less than 70 mm Hg from 1 month to 1 year, less than (70 mm Hg + [2 x age]) from 1 to 10 years and less than 90 mm Hg from 11 to 17 years. Normal heart rate ranges from 80 - 120 beats/minute at age 3 years; and from 70 - 115 beats/minute after age 3 years. In infants and children, respiratory compromise is more likely than hypotension or shock and shock is more likely to be manifest initially by tachycardia than by hypotension.

FIG 1. Clinical criteria for the diagnosis of anaphylaxis. Anaphylaxis is likely when 1 of 3 criteria are fulfilled: (1) acute onset of an illness (minutes to hours) with involvement of the skin, mucosal tissue, or both with either respiratory involvement or reduced blood pressure (BP)/associated symptom of end-organ dysfunction; or (2) ≥ 2 of the following that occur rapidly after exposure to a likely allergen for the patient, including (i) involvement of skin-mucosal tissue, (ii) respiratory involvement, (iii) reduced blood pressure or associated symptoms, or (iv) gastrointestinal symptoms; or (3) reduced blood pressure as a result of exposure to a known allergen trigger. Adapted from Simons et al.⁶¹

Additionally, in the ED, a stable, asymptomatic patient who provides a history of symptoms meeting NIAID/FAAN anaphylaxis diagnostic criteria but whose symptoms have completely resolved prior to arrival, should still be given an anaphylaxis diagnosis despite the fact that epinephrine administration is no longer acutely indicated.

Biphasic anaphylaxis is a well-recognized potential complication of anaphylaxis and has been defined as recurrent anaphylaxis after complete improvement; this has been reported to occur between 1 and 78 hours after the onset of the initial anaphylactic reaction, and this must be clinically differentiated from a reaction that does not fully respond to initial treatment and persists or quickly returns.^{35,36,55,56} Some earlier studies of biphasic reactions, prior to the NIAID/FAAN criteria, which included patients with severe anaphylaxis, reported rates of biphasic anaphylaxis as high as 20%.³⁷⁻³⁹ More contemporary studies of biphasic anaphylaxis utilizing the NIAID/FAAN diagnostic criteria or similar criteria for diagnosis of both the initial anaphylactic reaction and the biphasic reaction have demonstrated lower rates of biphasic reactions closer to 4% to 5% (range, 0.18%-14.7%).⁴⁰⁻⁴⁴ No studies have systematically evaluated therapies for the second-phase reaction; however, therapy for the second phase is similar to that for the initial phase.³⁶ Optimal duration of extended observation following resolution of biphasic anaphylaxis is unknown.³⁶ One recent meta-analysis⁵⁷ of 12 studies including 2890 adult patients with anaphylaxis suggested the pooled negative predictive value (NPV) of 1-hour observation was 95%, with an NPV for biphasic anaphylaxis after ≥ 6 hours of observation (following resolved anaphylaxis) of 97.3%. A recent cost-effectiveness analysis suggested that extended observation could be cost-effective (ie, not exceeding \$10 million per death prevented) at high rates of fatality risk reduction (76%) from an additional 5 hours of asymptomatic observation.⁵⁸

EPIDEMIOLOGY AND RISK FACTORS

Prevalence estimates of anaphylaxis vary widely, and many studies suggest that the prevalence is increasing, particularly in developed countries. The lifetime prevalence of anaphylaxis has been estimated at 1.6% to 5.1%,^{1,4,11} with an incidence rate of 42 per 100,000 person-years, but estimates may be susceptible to ascertainment bias.⁵⁹ Data from a European anaphylaxis registry revealed that over one-quarter of cases occurs in patients under 18 years of age.⁶⁰ As indicated in an international consensus on anaphylaxis document, cardiovascular disease and asthma are well-recognized risk factors for severe anaphylaxis.⁵ Additional risk factors potentially associated with severe or fatal anaphylaxis include older age, mast cell disorder, and beta-blocker or angiotensin-converting enzyme inhibitor use.⁶⁻⁹ Atopy is a risk factor for anaphylaxis triggered by food, exercise, and latex.⁶¹ While 1 survey⁶² of Turkish beekeepers (n = 29 subjects with systemic reactions, 9 with anaphylaxis, of 444 subjects with a history of a sting exposure in the prior 12 months) suggested atopic disease as a risk factor for systemic reactions (OR, 3.3; 95% CI, 1.2-8.7), it has not been otherwise established that atopic disease increases the risk for Hymenoptera sting-associated anaphylaxis.

Medications and stinging insect venom are leading causes of adult anaphylaxis,¹ while foods and stinging insect venom are the most common triggers of anaphylaxis in children and adolescents.¹⁰⁻¹² In the middle-age adult population, anaphylaxis

most often occurs at home.¹ Medications most frequently implicated in the United States are antibiotics, nonsteroidal anti-inflammatory drugs, immunomodulators, and biological agents.⁶³ In contrast, in Portugal, a review⁶⁴ of 313 patients with a history of drug-induced anaphylaxis revealed the most common trigger to be nonsteroidal anti-inflammatory drugs, followed by antibiotics and anesthetics. An anaphylaxis registry⁶⁵ of German-speaking countries (Germany, Austria, and Switzerland) reported the most common trigger to be insect venom, followed by food and drugs, respectively (when all age groups are considered). In studies of food-induced anaphylaxis (FIA), incidence ranges from as low as 1 per 100,000 to as high as 70 per 100,000 have been reported by using data from hospitalizations, ED visits, and medical record reviews.⁶⁶⁻⁶⁸ When examining anaphylaxis etiology, the proportion due to foods varied between 13% and 65% depending on age and study.⁶⁶⁻⁷¹ The specific trigger may not be identified during the acute anaphylactic event or in subsequent evaluations, especially if the reaction is occurring for the first time, and the trigger may only be identified retrospectively at a follow-up evaluation. For example, 1 study⁷² of ED records in Florida found that only 37% of patients could pinpoint a specific trigger on initial presentation. Furthermore, initial suspected culprits are often not confirmed on subsequent allergy testing, which suggests caution in presumption of potential triggers and supports the necessity of follow-up evaluation by an allergy specialist.^{47,73,74}

With respect to treatment, delayed use of epinephrine has been associated with increased risk for fatality, and several observational studies and case reports series^{48,75-88} suggest a continued disparity between the diagnosis of anaphylaxis and frequency of appropriate epinephrine treatment. In 1 study⁷⁶ of drug-induced anaphylaxis evaluated and managed in an ED, only 8% of patients received epinephrine. While early epinephrine is the bedrock of anaphylaxis management, anaphylaxis fatality is fortunately a rare outcome. The overall prevalence of fatal anaphylaxis in recent years in the United States and United Kingdom is between 0.47 and 0.69 per million persons.^{8,9,28-30} The 3 leading causes of fatal anaphylaxis are drugs (29%-58.5%),^{8,28,89,90} insect stings (3.3%-54%),^{8,28,89,90} and food (2%-6.7%).^{8,28,90} While anaphylaxis-related hospitalizations have increased, general case fatality rates have been stable in the range of 0.25% to 0.33% of hospitalizations or ED presentations for anaphylaxis.³¹ However, in contrast to other causes of fatal anaphylaxis, drug-induced anaphylaxis rates have increased.⁸ In the United Kingdom, fatal drug anaphylaxis has been reported to be mostly due to general anesthetics,⁹¹ whereas antibiotics predominate in Australia²⁸ and France.⁹² A review by Pichichero et al⁹³ described the population incident risk of anaphylaxis to penicillin between 0.004% and 0.015% with a fatality rate of 0.0002% to 0.0015%. The UK fatal anaphylaxis registry reported that while those dying from food anaphylaxis often have a prior history of a food reaction, those with fatal Hymenoptera venom and drug anaphylaxis usually do not.^{91,94} Additional observational case series have shown patients dying from food anaphylaxis often have a history of previous food-induced allergic reactions.^{28,38,95} Notably, respiratory arrest may occur more commonly with foods (86% of fatalities in the UK registry), with shock more common in fatalities due to medications and venom reactions.⁹¹ It is important to note that most fatal reactions are unpredictable and statistically occur very rarely; however, appropriate trigger identification after

recovery from a severe reaction may decrease the risk for a subsequent severe reaction, including fatality.⁹⁴ Referral to an allergy specialist after recovery from anaphylaxis is recommended to confirm the diagnosis, evaluate for potential triggers, and educate the patient on the risk of future reactions and measures to reduce that risk, including self-injectable epinephrine access and auto-injector education.

BURDEN OF DISEASE

Food-induced anaphylaxis

Prevalence. Food allergy (or presumed food allergy) is a leading cause of anaphylaxis presenting to US EDs, with an estimated 30,000 cases per year.⁹⁶ Food allergy (assessed through a nationally representative Internet self-report study) is estimated to affect up to 8% to 11% of the US population.¹³⁻¹⁵ Food allergens may be attributed to upward of 50% of ED-reported anaphylaxis cases in developed countries, including the United States.⁹⁷

Trends. According to the Centers for Disease Control and Prevention, rates of food allergies in US children increased by about 50% between 1997 and 2011.⁹⁸ Whereas Clark et al⁹⁹ reported stable trends in the frequency of US ED visits for food allergy in the period of 2001 to 2009, they did find a statistically significant decline among individuals ≥ 18 years of age. In a retrospective cohort study¹⁰⁰ of 37 pediatric hospitals from 2007 to 2012, an increasing rate of FIA-related ED visits was reported but without any increase in the proportion of ED patients hospitalized or admitted to the intensive care unit. This decrease in the proportional rate of ED visits to utilization of inpatient and intensive care unit facilities may be due to the increased utilization of ED or inpatient observation units, as approximately 36% of US EDs reported having observation units in 2007.¹⁰¹ More recently, Motosue et al¹⁰² reported a fourfold increase in FIA-related ED visits for adolescents from 2005 through 2014.

Economic burden. Food allergies can burden patients and families by affecting finances, social relationships, and personal perceptions of health.¹⁰³ Patients with food allergies and their families experience anxiety and other stresses that affect quality of life given the risk of potentially severe reactions and inability to completely control these risks.¹⁶ The impact of food allergies is not limited to just the patients and their families but can also lead to a significant economic effect on society and the health care system. Food-induced anaphylaxis can result in prehospital emergency care by ambulance personnel, ED visits, hospitalizations, or even death. Mild as well as more severe allergic reactions require comprehensive evaluation, including diagnostic studies, and regular follow-up outpatient visits.¹⁰⁴

In 2011, Patel et al¹⁰⁴ estimated total annual direct medical costs of food allergy and anaphylaxis at \$225 million (2007 US dollars). Office visits accounted for 52.5% of direct medical costs, and the remaining was split among ED visits (20%), inpatient hospitalizations (11.8%), outpatient department visits (3.9%), ambulance runs (3%), and epinephrine devices (8.7%). Children accounted for 46.6% of the total inpatient costs, 31.5% of the ED visit costs, 67.3% of the office visit costs, and 97.7% of the total outpatient department visit costs. US national estimates for epinephrine auto-injector use after a suspected reaction triggered by a food allergy obtained from the published literature suggest that between 30% and 86% of patients at risk for a severe allergic

reaction are prescribed an epinephrine auto-injector and have it available when needed.^{95,105} Prevalence estimates and mean costs for office, inpatient, and ED visits have the largest effect on total societal direct costs. Indirect costs have been estimated at \$115 million¹⁰⁴ with morbidity-related costs accounting for 85% of indirect costs, resulting from disease-related sick days (lost productivity and wages).¹⁰⁴ Simulations from probabilistic sensitivity analyses have generated mean annual direct costs of \$307 million and indirect costs of \$203 million in the United States.¹⁰⁴ While evidence suggests that activation of EMS and prolonged ED observation of resolved food anaphylaxis is a low-value practice, prompt EMS activation is appropriate for patients who do not immediately completely respond to timely epinephrine, or for recurrence of symptoms.¹⁰⁶

Drug-induced anaphylaxis

ADRs may affect up to one-tenth of the general population and up to 20% of all hospitalized patients. More than 10% of all ADRs are drug hypersensitivity reactions (DHRs). In a systematic review, 53 observational studies were synthesized to estimate that 8% of patients self-report drug allergy, and that 11% of self-reported drug allergy is reported to be anaphylaxis.¹⁰⁷ The most common DHR involves antibiotics such as penicillins, cephalosporins, sulfonamides, aspirin, and other nonsteroidal anti-inflammatory drugs. DHRs can be severe and life-threatening and are associated with significant mortality rates. The incidence of anaphylaxis due to medication triggers is increasing over time.⁵⁹ DHRs have a significant socioeconomic impact related to both direct costs (management of reactions and hospitalizations) and indirect costs (missed work and/or school days; alternative drugs); however, there is, overall, a major gap in the literature for summarizing the economic burden of DHRs.¹⁶ A US nationwide cross-sectional telephone self-reported survey¹ reported a prevalence of anaphylaxis in the general population of 1.6% with medications being the most common trigger (35%). Excluding pediatric cohorts (where food is the most common trigger), medications are the most frequent cause of fatal anaphylaxis in reports from the United States, as well as the United Kingdom, Australia, and New Zealand.^{8,16} Perioperative anaphylaxis presents unique challenges. Recently, the 6th National Audit Project of the Royal College of Anaesthetists reviewed 266 reports of grades 3 to 5 anaphylaxis across all UK National Health Service hospitals over the course of 1 year, reporting prompt recognition and treatment of anaphylaxis in 83% of cases.¹⁰⁸ Cardiac arrest occurred in 15% of cases reviewed, with fatalities occurring in 3.8% of patients.¹⁰⁸ Risk factors for perioperative anaphylaxis fatality included older age and cardiovascular disease.¹⁰⁸

ADRs from RCM occur less frequently now than they did prior to 1990 when patients received high-osmolar, ionic RCM. Prior ADRs to RCM can contribute to burden of disease by creating medical complexity associated with premedication; however, while glucocorticoid premedication has become common practice for patients with prior RCM hypersensitivity, evidence supporting the use of prophylaxis in high-risk patients receiving low- or iso-osmolar, nonionic contrast agents is lacking. ADRs associated with RCM do not relate to iodine, and the term "iodine allergy" should not be used in the context of RCM reactions.

Insect-venom anaphylaxis

Hymenoptera venom allergy (HVA) describes both anaphylactic and nonanaphylactic HSRs to stings. Reaction types include sting-induced large local (LL) or systemic allergic reactions. LL reactions last over 24 hours in which signs and symptoms are confined to tissues contiguous with the sting site. In contrast to LL reactions, acute onset systemic reactions involve generalized signs and symptoms and include a spectrum of manifestations, ranging from mild urticarial reactions to life-threatening anaphylaxis. It is estimated that 2% to 3% of adults and up to 1% of children have had a systemic reaction to a sting, and LL reactions occur in >5% of adults.¹⁰⁹ In a review of 10 studies published between 2001 and 2009, Bilo et al¹¹⁰ found that 23% of 2577 cases of anaphylaxis were caused by an insect sting. Fatal anaphylaxis can result from HVA; the reported average of 40 deaths per year in the United States is highly suspected to underestimate the true event rate.^{53,111} Even the first reaction can be fatal, but no validated screening test is available because of the very high frequency of asymptomatic sensitization (>20% of adults have detectable venom-specific IgE).^{112,113} Patients often express fears of anaphylaxis because of their family history or atopic history, but HVA has not been shown to be familial.¹¹²

Patients often present with concern about potential anaphylaxis after having LL or generalized cutaneous systemic reaction.¹¹⁴ The morbidity of living with HVA may be underestimated.¹¹⁴ Fear of life-threatening anaphylaxis whenever one is outdoors, and the burden of ensuring that injectable epinephrine is readily accessible at all times, affects the daily activities and level of stress in affected individuals.¹¹⁵ Even people with nonanaphylactic (LL or cutaneous systemic) reactions to stings share the same concerns and can be impacted as severely as the patients with anaphylactic reactions.¹¹⁴ These concerns persist in these mild reactors even though their risk of severe anaphylaxis is quite low, and the prescription of injectable epinephrine is not cost-effective in such cases.⁵³ Whether it is mild or severe, HVA impairs long-term quality of life and may be a cause of substantial socioeconomic impairment.¹¹⁶ HVA can impact career choices, especially in beekeepers, groundskeepers, gardeners, and greenhouse workers.¹¹⁷ HVA has important adverse consequences in terms of employment, earning capacity, and leisure and sporting activities.¹¹⁷ For these reasons, discussion of HVA usually includes not only anaphylactic, but also mild systemic and nonanaphylactic reactions.¹⁰⁹

PATHOGENESIS OF ANAPHYLAXIS

Data regarding pathophysiologic mechanisms and effector cells are limited on humans but mouse models have offered some insight.¹¹⁸ IgE binding and cross-linking of FcεRI on the surface of mast cells and basophils is an important mechanism in many cases of anaphylaxis. This causes the immediate release of preformed mediators, as well as *de novo* synthesis of inflammatory mediators.¹⁸ Interestingly, some patients with life-threatening anaphylaxis have low or undetectable circulating allergen-specific IgE and mouse models have demonstrated a potential role for IgG-dependent anaphylaxis.¹⁹ Furthermore, the complement (C) system, anaphylatoxins C3a, C4a, C5a, and neutrophils¹¹⁹ have also been shown to be involved in anaphylaxis in human subjects. Lastly, a newly recognized form of anaphylaxis

occurring in patients receiving chemotherapy suggests a mixed type of reaction with both features of IgE and non-IgE-dependent anaphylaxis.¹²⁰ Cytokine storm-like reactions have recently been described for patients with chemotherapy-induced anaphylaxis.¹²⁰

Animal and human studies have linked multiple mediators to the signs and symptoms of anaphylaxis. The most important effector cells involved in anaphylaxis are mast cells, but basophils, neutrophils, monocytes, macrophages, and platelets have also been implicated.^{118,121} Histamine is an important mediator of anaphylaxis, and studies have demonstrated that intravenous histamine can induce symptoms of anaphylaxis, including flushing, airway obstruction, systemic hypotension, and tachycardia.^{122,123} While histamine appears to play a significant role, other mediators have also been implicated. Therefore, pharmacologic targeting of histamine alone (eg, administration of antihistamines) is not appropriate and is thus considered second-line treatment for anaphylaxis and should not be used in place of epinephrine. Given the slow onset of antihistamine agents, ineffectiveness in treating cardiovascular and respiratory symptoms such as hypotension or bronchospasm, and the inability to stabilize or prevent mast cell degranulation, these agents should not delay definitive treatment of anaphylaxis.

Elevated tryptase levels have been less consistently found in patients presenting with anaphylaxis, particularly in cases triggered by allergic response to food.¹²⁴ While the positive predictive value of an elevated serum tryptase is high (93%), the NPV of a serum tryptase is low (17%).² However, several studies¹²⁵⁻¹²⁹ have reported an association between elevation of tryptase and severity of anaphylaxis from food and other causes. In a study²⁰ of prospectively recruited ED patients with anaphylaxis, mediators in addition to tryptase correlated with hypotension, a symptom of severe anaphylaxis. These included histamine, IL-6, IL-10, and TNF-receptor 1.^{20,21} Several other mediators have been shown to be important in murine models of anaphylaxis, but their contribution in human anaphylaxis has not been clearly demonstrated—these include platelet-activating factor (PAF), cysteinyl LTs, and anaphylatoxins. PAF is a lipid-derived mediator elevated in serum of patients with cold urticaria during cold challenge.¹³⁰ The role of PAF is supported by studies demonstrating that injection of PAF into the skin of healthy volunteers can induce early wheal and flare and late-phase flare responses.¹³¹ These responses are not associated with increased dermal histamine levels,¹³² suggesting that the effects of PAF are independent of mast cell degranulation. While some evidence suggests antihistamine attenuation of experimental intradermally injected PAF-mediated wheal and flare response, antihistamines had no protective effect against PAF-mediated bronchoconstriction during PAF bronchial provocation.¹³³ Associations have been noted with increased PAF in cases of anaphylaxis.¹²⁵ In 1 study,¹³⁴ increased PAF levels demonstrated the highest correlations with severe anaphylaxis (when compared with histamine and tryptase levels), with PAF elevations in 20%, 67%, and 100% of patients with grades 1, 2, and 3 allergic reactions, respectively (grade 1: acute allergic reactions with cutaneous signs and symptoms only; grade 2: mild to moderate anaphylaxis; grade 3: severe anaphylaxis). Data to support the role of cysteinyl LTs stem from studies showing that intradermal injection of LTB₄, LTC₄, and LTD₄ can induce wheal and flare responses¹³⁵ and aerosolized LTC₄ and LTD₄ can trigger

bronchoconstriction.^{136,137} In a small study of insect sting challenges, elevated serum C3a was associated with severe anaphylaxis.¹³⁸ Additional studies suggest that specific allergens such as peanut can contribute to anaphylaxis by activating complement,¹³⁹ and tryptase can generate anaphylatoxins under specific conditions.¹⁴⁰ These findings are important because they demonstrate some of the pathophysiologic explanations that underpin why antihistamine use may be ineffective in management of anaphylaxis.

Less is understood about the pathophysiology of protracted reactions.¹⁴¹ A prospective study of anaphylaxis cases seen in EDs in Australia reported delayed deterioration (defined as any worsening of the reaction while under observation in the ED) in 17% of reactions.²¹ Of the delayed deteriorations, 53% were treated with epinephrine and 69% of these started within 4 hours of arriving in the ED. A delay in the administration of epinephrine or too small a dose of epinephrine are considered risk factors for delayed deterioration, though the “optimal” time frame for epinephrine delivery to prevent delayed deterioration has not been established.^{36,142} Principal component analysis revealed an association between delayed deterioration with elevated levels of histamine, tryptase, IL-6, IL-10, and TNF-receptor 1 (peak concentrations on serial assessment at ED arrival, 1 hour later, and discharge). These are the same mediators found to be correlated with severe anaphylaxis,^{20,21} lending support to the hypothesis that severity of the initial reaction may be intrinsically linked to protracted symptoms.

TREATMENT STRATEGIES AND PARADIGMS

Role of epinephrine

An understanding of the pathophysiology and effector cells involved in anaphylaxis reinforces the recommendation to use epinephrine as first-line treatment, while antihistamines and glucocorticoids are considered solely second-line therapy. Anaphylaxis is a clinical diagnosis that can present with any combination of symptoms affecting various organ systems.²² The clinical presentation and severity of symptoms differ among individuals and may change over time within the same individual.

There is international consensus that the most effective treatment for anaphylaxis is epinephrine, with evidence supporting clinical guidelines based on observational studies, extrapolation from retrospective case reports, and limited clinical trials. However, a thorough understanding of the pathophysiology of anaphylaxis, existing evidence, and mechanisms of action for various medications provides the basis for treatment recommendations.

Epinephrine administered intramuscularly (in a dose of 0.01 mg/kg of a 1:1000 [1 mg/mL] solution to a maximum of 0.5 mg in adults and 0.3 mg in children) into the anterolateral thigh is the first-line treatment for anaphylaxis.²² The availability of newer auto-injector dose formulations (0.1 mg for infants) allows greater epinephrine dosing accuracy; however, a 0.15-mg intramuscular dose is also widely prescribed for infants at risk for anaphylaxis.^{105,143} Particularly in settings where a 0.1-mg auto-injector dose is not available, the speed and precision gained from a 0.15-mg auto-injector dose compared with having caregivers draw up doses using an ampule and syringe method may justify trade-offs in dosing accuracy, especially in infants weighing >7.5 kg.^{105,143} Depending on response to the initial injection,

the dose can be repeated every 5 to 15 minutes.⁶¹ Epinephrine is a nonselective agonist of all adrenergic receptors, which are present within every organ system affected by anaphylaxis.²⁶ By increasing peripheral resistance via α -1 receptors and increasing cardiac output via β -1 receptors, epinephrine treats hypotension, shock, urticaria, angioedema, and upper airway mucosal edema. Epinephrine can reverse bronchoconstriction and treat lower respiratory symptoms through its effect on β -2 adrenergic receptors. In addition, epinephrine has been shown to activate β -2 adrenergic receptors on mast cells and basophils and prevent additional release of histamine and other mediators.²⁷ Thus, epinephrine not only treats all symptoms associated with anaphylaxis but also can prevent the escalation of symptoms.

US, European, and international anaphylaxis guidelines recommend intramuscular epinephrine in the anterolateral thigh rather than subcutaneous epinephrine in the deltoid region of the upper arm for the treatment of anaphylaxis.^{5,75,144} This is based on a limited number of pharmacodynamic studies in volunteers (not in anaphylaxis) that demonstrated that when administered intramuscularly into the thigh, epinephrine works rapidly and reaches maximal pharmacodynamic efficacy within 10 minutes of injection, though no proof exists that subcutaneous delivery is not effective.²⁶ A small study¹⁴⁵ conducted in children 4 to 12 years of age demonstrated a higher mean peak plasma concentration (2136 ± 351 vs. 1802 ± 214 pg/mL) and faster onset of action (8 ± 2 vs. 34 ± 14 minutes) for intramuscular compared with subcutaneous administration of epinephrine. A similar study in adult males also demonstrated higher mean peak plasma concentration for intramuscular epinephrine in the thigh (9722 ± 4801 pg/mL) compared with both intramuscular administration in the deltoid (1821 ± 426 pg/mL) and subcutaneous administration in the deltoid region (2877 ± 567 pg/mL).¹⁴⁶ From these limited data, experts have advocated the intramuscular rather than the subcutaneous route of delivery, though for years subcutaneous delivery was the mainstay, without any evidence that it was not effective. Importantly, studies comparing intramuscular and subcutaneous injections in the thigh have not been completed.¹⁴⁶ Furthermore, the studies described above were conducted in healthy adults and children who were not experiencing anaphylaxis and were taken from small samples, and thus the generalizability of these findings to the clinical setting has not been established.¹⁴⁴ There are also no data that have evaluated whether the peak plasma concentration, the time to peak plasma concentration, or the area under the curve is the most important feature to effective epinephrine delivery in anaphylaxis. For pediatric patients, administration of epinephrine into the anterolateral thigh is preferred to the deltoid region as this likely decreases the risk for inadvertent intraosseous administration due to needle length.¹⁴⁷⁻¹⁵⁰ Efforts to develop alternative epinephrine delivery routes (such as sublingual and intranasal epinephrine formulations) are underway.¹⁵¹⁻¹⁵⁴ Intravenous administration of epinephrine is also not recommended as first-line treatment of acute anaphylaxis, even in a medical setting, due to risk for cardiac adverse events such as arrhythmias and myocardial infarction.¹⁵⁵ However, for patients with inadequate response to intramuscular epinephrine and intravenous saline, intravenous epinephrine can be given by continuous infusion by microdrip, preferably using an infusion pump in a monitored hospital setting. In more remote settings when immediate treatment is required on an outpatient basis, one might consider adding 1 mg (1 mL of 1:1000) of epinephrine to 1000 mL of 0.9 normal saline; starting the infusion at 2 μ g/min

(2 mL/min, equivalent of 120 mL/h) and increase up to 10 μ g/min (10 mL/min, equivalent of 600 mL/h); titrating the dose continuously according to blood pressure, cardiac rate, and oxygenation. Although potential epinephrine-related adverse events must be balanced in high-risk patients (ie, elderly patients with multiple comorbidities and patients with complex congenital heart disease, pulmonary hypertension, prior epinephrine-associated cardiomyopathy), there is no absolute contraindication to epinephrine use in the treatment of anaphylaxis.^{61,156} Providers should be aware of the need to appropriately counsel patients when using epinephrine. It is important to discuss technique of administration and the need to appropriately restrain young children and infants to avoid inadvertent epinephrine needle injuries.¹⁵⁷ While there is a lack of evidence to inform treatment approaches to biphasic anaphylaxis, the same treatment recommended for initial anaphylactic events applies to the biphasic response, with prompt epinephrine the cornerstone of management.³⁶

An interesting conundrum surrounds those individuals who recover fully without sequelae despite never receiving treatment for anaphylaxis. Variations in the cause and severity of their symptoms and metabolism of mediators are likely involved but this remains poorly understood.¹¹⁸ Given the inability to identify which individual is at risk for life-threatening or fatal anaphylaxis, particularly in the acute setting, and the well-recognized significant benefit from rapid administration of epinephrine, treatment should never be withheld for ongoing symptoms and this should be advocated as a best-practice strategy.²² The mortality from anaphylaxis, though real, is remarkably low at <0.5% per episode of anaphylaxis.¹⁵⁸ Herein lies the anaphylaxis paradox—patients having anaphylaxis may survive despite lack of treatment (or “inappropriate” treatment), but delay in treatment is widely presumed to be associated with death (though limited by lack of studies that compare fatality to nonfatality situations where provoking conditions and treatment factors were identical to determine a relative risk).^{31,158}

Role of antihistamines and glucocorticoids

Antihistamines are often included as adjunctive therapy for cutaneous signs and symptoms associated with anaphylaxis but should not be administered before, or in place of, epinephrine. Histamine is an important mediator released during anaphylaxis and can cause anaphylaxis when administered intravenously or when ingested (ie, scombroid poisoning).^{122,159} There are 4 histamine receptors located throughout the body (H1, H2, H3, and H4), but H1 receptors are the most clinically relevant during anaphylaxis. H2 receptors are mostly found within the gastrointestinal tract with limited distribution in the vascular smooth muscle cells and play a minor role in the pathophysiology of anaphylaxis. H1 and H2 antihistamine medications are widely available and often administered concurrently for the treatment of anaphylaxis, without supporting data for their efficacy, in particular with H2 antihistamines. Compared with older first-generation H1 antihistamines, second-generation H1 antihistamines have a longer duration of action, less anticholinergic effects, and less sedation, yet similar onset of action.³² Antihistamines act as inverse agonists at histamine receptors; they are effective therapy for patients with urticaria and can treat many of the cutaneous signs and symptoms associated with

anaphylaxis including pruritus, flushing, and urticaria.¹⁶⁰ Unlike epinephrine, antihistamines are poorly effective in treating cardiovascular and respiratory symptoms such as hypotension or bronchospasm when used acutely as monotherapy. Epinephrine is the first-line treatment of anaphylaxis because it has a faster onset of action and more appropriate and robust pharmacologic action compared with antihistamines. When given orally, the onset of action of antihistamines may occur within 30 minutes,¹⁶¹ but peak plasma concentrations are not reached until 60 to 120 minutes, and an additional 60 to 90 minutes may be necessary for diffusion of the medication into extravascular tissues to exert maximal effect.^{32,162,163} Given the rapid and potentially fatal nature of anaphylaxis, the timing of onset for antihistamines is considered too slow and could lead to incomplete or ineffective treatment. Furthermore, antihistamines lack the vasoconstrictive, bronchodilatory, ionotropic, and mast cell stabilization properties of epinephrine. While intravenous administration of H1 antihistamines may be used in a medical setting or by EMS, it should never be utilized in place of timely intramuscular epinephrine administration, but it may have an adjunct role in treatment after epinephrine has been administered.¹⁶⁴

Glucocorticoids are also frequently used as adjunctive (or sometimes primary) therapy in the treatment of anaphylaxis but also should not be administered prior to, or in place of, epinephrine. Glucocorticoids have no proven role in the treatment of an acute reaction as they work with slow onset of action by binding to the glucocorticoid receptor on cell membranes, translocating the glucocorticoid/glucocorticoid receptor complex to the nucleus, and inhibiting gene expression and production of new inflammatory mediators. They are nonselective, ineffective in treating acute symptoms, and have multiple adverse effects related to high doses and prolonged use. There is a scarcity of data demonstrating the efficacy of glucocorticoids in the treatment of acute anaphylaxis despite common anecdotal administration in this setting, and no studies have clearly established their benefit when combined with epinephrine and/or antihistamines.^{34,164} Studies investigating the use of glucocorticoids for treatment of anaphylaxis have shown that their use is associated with reduced length of hospital stay but have not shown any benefit of preventing return visits to the ED following discharge.^{165,166}

Given the mechanism of action, glucocorticoids may not result in clinical improvement for 4 to 6 hours after administration, regardless of route. Although animal studies and *in vitro* data have demonstrated inhibitory effects within 5 to 30 minutes through upregulation of anti-inflammatory mediators and by decreasing mast cell mediator release on a cellular level,^{33,167} there are no data demonstrating similar rapid onset of action or clinical improvement in human subjects. As such, given the slow onset of action and inability to reverse acute symptoms, it is again emphasized that glucocorticoids have a limited role in the acute management of anaphylaxis.

REVIEW OF EVIDENCE FOR SUPPLEMENTAL THERAPIES IN ANAPHYLAXIS TREATMENT

Despite a lack of clear evidence supporting the use of antihistamines and glucocorticoids in anaphylaxis, these treatments continue to be a part of anaphylaxis management in routine practice. While it is critical to ensure that use of these agents does

not delay administration of epinephrine, the question of whether use of these therapies adds value in the management of anaphylaxis has not been subjected to rigorous methodologic assessment in previous anaphylaxis practice parameters. To evaluate the role of these supplemental therapies, the JTFPP undertook systematic reviews to better inform practitioners' treatment of anaphylaxis.

Methods and overview

The Anaphylaxis Workgroup that developed this guideline was composed of volunteers from the AAAAI and the ACAAI with a specific interest in the topic and the guideline process. The JTFPP and Anaphylaxis Workgroup were asked to submit questions regarding anaphylaxis that they considered to be of importance for both the clinician and the patient for which currently there was not a clear-cut answer. The work group used the Population, Intervention, Comparator, Outcome (PICO) evidence-based framework for formulating each question.¹⁶⁸ After all questions were discussed and informal preliminary searches completed, the work group used the modified Delphi process^{169,170} to select and list top questions in priority order prior to presenting them to the AAAAI/ACAAI for consideration. The top questions chosen by the AAAAI/ACAAI were then submitted to the work group for GRADE analysis.¹⁷¹

Literature search: Design, inclusion and exclusion criteria, and databases

The work group agreed to include cohort and observational studies, nonrandomized clinical trials, and articles with multiple case studies provided a comparator was reported. While review articles, guidelines, and editorials were excluded from analysis, they were reviewed to locate primary research studies within the bibliography. The search was limited to human subjects and to articles published in the English language. For each of the questions, the described databases were searched and duplicates removed, the abstracts were uploaded into Covidence (Melbourne, Australia) or Rayyan (Doha, Qatar), web-based software platforms used by guideline writing groups (eg, Cochrane Reviews) to streamline the production of systematic reviews. Each abstract was reviewed by 2 work group members or collaborators and categorized as relevant or irrelevant based on the predetermined inclusion and exclusion criteria. When required, a third work group member resolved any disagreement by consensus. For all relevant abstracts, full-text articles were uploaded into Covidence or Rayyan. Two members assessed each full-text article for eligibility for qualitative analysis with any disagreement resolved by consensus of a third member. Supplemental searches were performed to address questions in more targeted areas including prophylaxis to prevent recurrence of anaphylaxis to nonionic low-osmolar or iso-osmolar, RCM, and prevention of index anaphylaxis with chemotherapeutic agents. The resultant studies were extracted by JTFPP members and methodology groups, who assessed each article to determine whether they were appropriate for quantitative meta-analysis. In that each question used varying databases, dates, and inclusion and exclusion criteria, these were discussed within the methodological review for each question. The evidence is summarized in this document with supplemental detail included in this article's Online Repository at www.jacionline.org.

Certainty assessment of the included studies: Risk of bias using GRADE analysis

An assessment of risk of bias factors (random sequence generation, allocation concealment, blinding adequacy, completeness of data, reporting, and other potential biases) that may contribute to risk of bias was performed by the JTFPP/methodology groups. The work groups and the JTFPP reviewed draft assessments, applied assessments of clinical importance for each patient-important outcome, and determined an overall certainty of evidence across outcomes. The level of methodologic certainty for the identified literature is summarized after each clinical question.

Certainty of the body of evidence using GRADE analysis

For GRADE analysis of the certainty of the evidence,¹⁷¹ 5 areas were evaluated: inconsistency, indirectness, imprecision, risk of bias, and publication bias. For the purpose of this analysis, inconsistency, indirectness, and imprecision were defined as follows:

Inconsistency: Studies are reviewed in terms of populations, interventions, and outcomes for similarity, or consistency, among the compared studies.

Indirectness: Analysis occurs around comparisons, populations, and outcomes among intervention studies. Indirectness in comparisons occurs when one drug is compared with placebo and another drug is compared with placebo, but the researchers do not compare the first drug and the second drug in a head-to-head comparison. Indirectness in populations means that the population in which the drug was studied does not reflect the population in which the study drug would be used. Indirectness of outcome refers to a primary or secondary outcome that does not exactly measure the intended outcome and thus is not powered for the outcome of choice.

Imprecision: When too few study participants were enrolled or too few events occurred in the study, imprecision is detected as studies do not meet optimal information size (OIS). However, low OIS may be offset by critical versus important outcome or valued trade-off desirable/undesirable consequences. In systematic reviews, if the confidence interval crosses a threshold of 1.0, there will usually be downgrading for imprecision.

Levels of certainty of evidence

High (⊕⊕⊕⊕): The team is very confident that the true effect lies close to the estimate of the effect.

Moderate (⊕⊕⊕○): The team is moderately confident in the effect estimate. The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

Low (⊕⊕○○): The team confidence in the effect estimate is limited. The true effect may be substantially different from the estimate of the effect.

Very low (⊕○○○): The team has very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.

Implications of strong and weak recommendations.
The implications of a *strong* recommendation are:

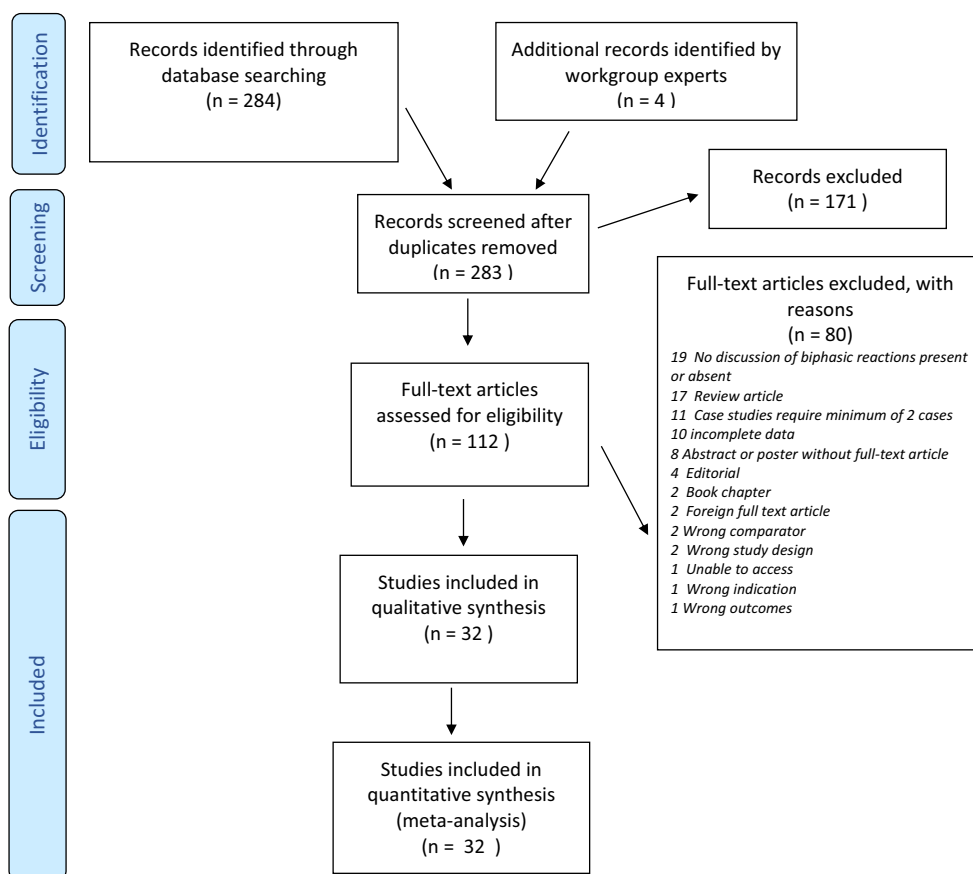


FIG 2. Topic area 1 PRISMA flow diagram.

For patients: Most people in this situation would want the recommended course of action and only a small proportion would not; patients should request discussion if the intervention is not offered.

For clinicians: Most patients should receive the recommended course of action.

For policy makers: The recommendation can be adopted as a policy in most situations.

The implications of a *weak (conditional)* recommendation (suggestion) are:

For patients: Most people in this situation would want the recommended course of action, but many would not.

For clinicians: Clinicians should recognize that different choices will be appropriate for different patients and that clinicians must help each patient to arrive at a management decision consistent with her or his values and preferences.

For policy makers: Policy making will require substantial debate and involvement of many stakeholders.

Reaching work group consensus on certainty of evidence, recommendations, clinical statement profiles and conclusions

To achieve consensus and resolve any differences in judgment within the work group and JTFPP, a modified Delphi method was used. The Delphi method is a structured, interactive, decision-making process used by a panel of experts to

arrive at a consensus when there are differing views and perspectives.^{169,170,172} The work group and/or JTFPP members discussed all the answers and were encouraged to modify their answers on the next round(s) of e-mail voting and anonymous “summary of the experts” feedback until a consensus was reached.

Determination of certainty of evidence for a specific outcome and across critical outcomes

The certainty of evidence indicates the extent to which one can be confident that an estimate of effect is correct. The GRADE system for evaluating the certainty of evidence (<http://gdt.guidelinedevelopment.org/app>) defines the elements that guideline writing groups need to consider when evaluating the certainty of references that address a specific outcome. These elements include factors that assess the risk of bias and the certainty of evidence as described above, as well as the article design (eg, randomized controlled trial or observation study). Methodology groups may designate a method of rating the certainty of individual references to assist in this analysis. Following a determination of the certainty of each individual reference, the GRADE handbook recommends that in the final analysis for each outcome of interest, the certainty of evidence for the entire group of references should be determined by the guideline writing group, using their collective expert opinion. The outcomes of interest are then categorized as “critical” or “important but not critical” to reaching a decision for a recommendation. For the

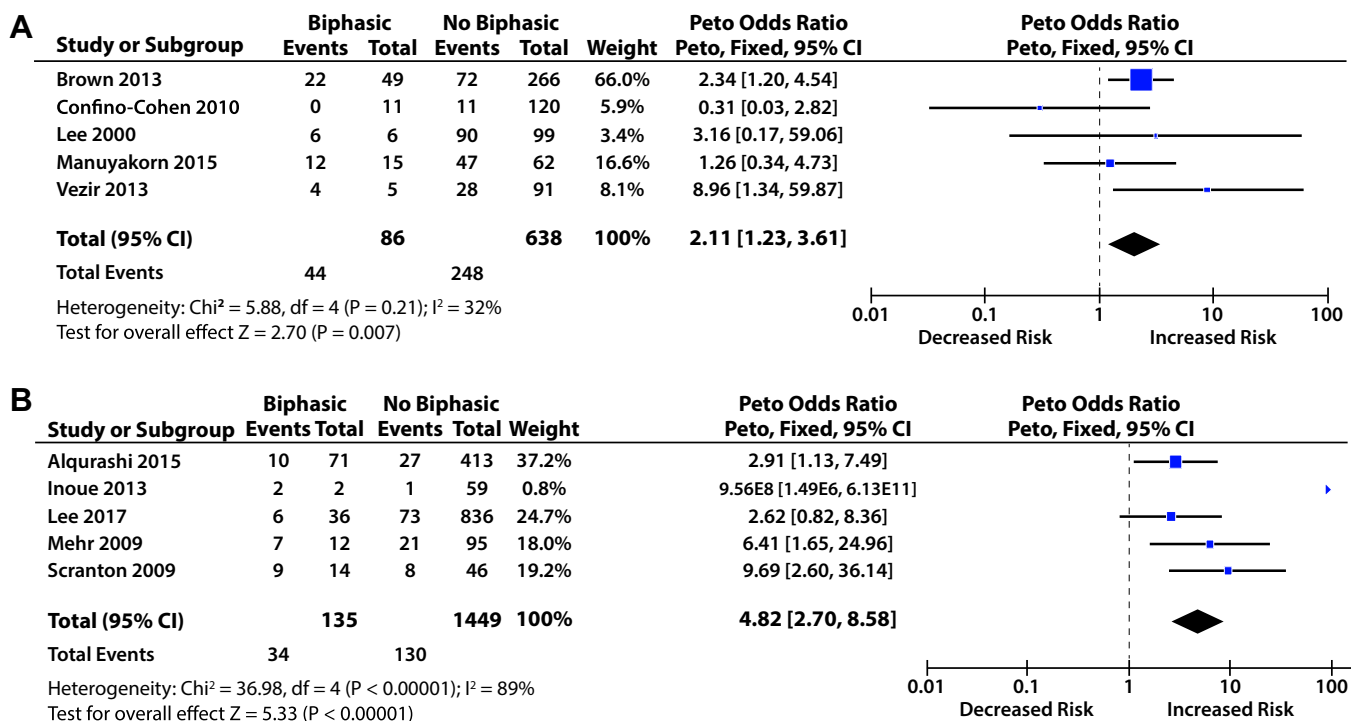


FIG 3. Question 1: Risk factors for biphasic anaphylaxis. Comparisons of biphasic versus no biphasic anaphylaxis. **A**, Outcome for severe initial symptoms. **B**, Outcomes for ≥ 1 dose of epinephrine.

determination of the “overall certainty of evidence” supporting a recommendation, all “critical” outcomes are reviewed together, and the lowest certainty grade assigned to any critical outcome of interest will determine the certainty assigned for the “overall certainty of evidence” to support a recommendation.

GRADE: FROM CERTAINTY OF EVIDENCE TO RECOMMENDATIONS FOR DIAGNOSIS, TREATMENT, OR COURSE OF ACTION

The strength of a recommendation indicates the extent to which one can be confident that adherence to the recommendation will do more good than harm. After the certainty of evidence is evaluated, and before recommending or suggesting in favor or against a certain diagnostic strategy, therapeutic approach, or course of action, the GRADE analysis continues to consider additional factors: balance of desirable and undesirable effects, certainty of evidence, safety of the intervention, cost, likelihood of achieving adherence, acceptability, feasibility, equity, and patient’s preference. The JTFPP primarily focused on the US population when reaching these conclusions. Therefore, the GRADE analysis is not only a system focused on grading the level of evidence but also a much more complete system aimed at formulating recommendations for specific populations. Individual subgroups drafted the recommendations and justifications based on the GRADE analysis. Subsequently, all recommendations were reviewed by the work group and JTFPP. Both groups were provided the opportunity to comment, propose changes, and approve or disapprove each statement. Consensus was sought and reached for each recommendation’s direction and strength. Actual or potential conflicts of interest were disclosed semiannually and at the completion

of the guideline with transparency maintained during all discussions.

External review

External peer review was through appointed official reviewers and membership at large of the AAAAI and the ACAAI. All comments were discussed by the JTFPP, and revisions made when the work group and JTFPP believed this to be appropriate.

Topic area 1: Identification and mitigation of risk factors for biphasic anaphylaxis

Topic area 1 deals solely with question 1.

Question 1. What risk factors should clinicians take into consideration in determining the likelihood of biphasic anaphylaxis?

- Patients: Adults and children treated for anaphylaxis.
- Intervention: Any treatment or characteristic associated with a decreased risk of biphasic anaphylaxis including medication or other trigger; epinephrine, antihistamine, glucocorticoid, or other treatment; age, severity, physical examination finding, or other patient characteristic.
- Comparator: Dichotomous comparator of characteristic under evaluation.
- Outcome: Occurrence of biphasic anaphylaxis.

Background. A prior single-center review of biphasic anaphylaxis in 103 patients suggested biphasic reactions were more common in patients who received less epinephrine ($P = .048$) and possibly less glucocorticoid ($P = .06$) treatment.³⁹ A systematic review by Lee et al.⁴³ found 27 observational studies

TABLE I. Question 1: GRADE summary of findings table: What are the risk factors are associated with biphasic anaphylaxis?

Certainty assessment							Summary of findings				
No. of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	Study event rates (%)		Relative effect (95% CI)	Anticipated absolute effects	
							With no biphasic	With biphasic		Risk with no biphasic	Risk difference with biphasic
Unknown trigger											
4275 (21 observational studies)	Very serious*†‡§	Serious	Not serious	Not serious	None	⊕○○○ Very low	624 of 4005 (15.6%)	56 of 270 (20.7%)	OR 1.63 (1.14 to 2.33)	156 per 1000	75 more per 1000 (18 more to 145 more)
Drug trigger ≤18 y old											
996 (5 observational studies)	Very serious*†	Serious	Not serious	Serious†	None	⊕○○○ Very low	135 of 886 (15.2%)	18 of 110 (16.4%)	OR 2.35 (1.16 to 4.76)	152 per 1000	145 more per 1000 (20 more to 309 more)
Cutaneous signs and symptoms											
1949 (6 observational studies)	Very serious*†‡	Very serious #	Not serious	Very serious¶**	None	⊕○○○ Very low	1546 of 1838 (84.1%)	104 of 111 (93.7%)	OR 2.54 (1.25 to 5.15)	841 per 1000	90 more per 1000 (28 more to 123 more)
Dyspnea symptoms											
1841 (6 observational studies)	Serious*†	Serious††	Not serious	Serious¶	None	⊕○○○ Very low	831 of 1743 (47.7%)	34 of 98 (34.7%)	OR 0.60 (0.38 to 0.96)	477 per 1000	123 fewer per 1000 (220 fewer to 10 fewer)
Wide pulse pressure											
1356 (2 observational studies)	Serious*	Not serious	Not serious	Serious¶	None	⊕○○○ Very low	247 of 1249 (19.8%)	40 of 107 (37.4%)	OR 2.11 (1.32 to 3.37)	198 per 1000	144 more per 1000 (48 more to 256 more)
Severe initial symptoms											
724 (5 observational studies)	Very serious*†‡	Very serious ‡‡	Not serious	Serious¶	None	⊕○○○ Very low	248 of 638 (38.9%)	44 of 86 (51.2%)	OR 2.11 (1.23 to 3.61)	389 per 1000	184 more per 1000 (50 more to 308 more)
>1 Dose of epinephrine											
1584 (5 observational studies)	Very serious*†	Very serious††	Not serious	Serious¶	None	⊕○○○ Very low	130 of 1449 (9.0%)	34 of 135 (25.2%)	OR 4.82 (2.70 to 8.58)	90 per 1000	232 more per 1000 (120 more to 368 more)
Glucocorticoids ≤18 y old											
1203 (7 observational studies)	Very serious*†‡	Not serious	Not serious	Serious¶	None	⊕○○○ Very low	632 of 1089 (58.0%)	78 of 114 (68.4%)	OR 1.55 (1.01 to 2.38)	580 per 1000	102 more per 1000 (2 more to 187 more)

*Retrospective data may introduce selection bias and increase possible confounding errors.

†Included study or studies with limited follow-up of 24 hours or no follow-up resulting in possible missed biphasic patients.

‡Included study or studies with limited patient selection including patients from inpatient setting or from a specialty clinic.

§Included study or studies with larger exclusion of patients due to missing data.

||Moderate heterogeneity as evidence by I^2 of 30% to 60%.

¶Low number of events (<250 biphasic reactions).

#Different definitions of cutaneous signs and symptoms.

**Wide confidence interval.

††Substantial heterogeneity as evidence by I^2 of 50% to 90%.

‡‡Different scales for measuring severity of anaphylactic reaction.

that reviewed predictors of biphasic anaphylactic reactions. Of the studied predictors, food as an anaphylactic trigger was associated with a decreased risk of a biphasic reaction (OR, 0.62; 95% CI, 0.4-0.94) and the “unknown” anaphylactic trigger was associated with increased risk of a biphasic reaction (OR, 1.72; 95% CI, 1.0-2.95). An initial presentation with hypotension was also associated with an increased risk of a biphasic reaction (OR, 2.18; 95% CI, 1.14-4.15).

Study characteristics. The search for suitable studies was completed by the JTFPP. In the search 283 articles were identified after removal of duplicates, with full text eligibility assessed in

112 studies, and 32 studies included in the quantitative evidence synthesis. Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) system was used (see Fig 2 for PRISMA diagram).

Question 1 included studies. The following studies were included in the analysis of question 1: Alqurashi et al,⁴² Brady et al,¹⁷³ Brazil and MacNamara,¹⁷⁴ Brown et al,²¹ Calvani et al,¹⁷⁵ Cianferoni et al,¹⁷⁶ Confino-Cohen and Goldberg,¹⁷⁷ Douglas et al,¹⁷⁸ Ellis and Day,³⁹ Grunau et al,⁴⁰ Inoue and Yamamoto,¹⁷⁹ Jirapongsananuruk et al,¹⁸⁰ Ko et al,¹⁸¹ Lee et al,¹⁸² Lee et al,⁵⁹ Lertnawapan and Maek-a-nantawat,¹⁸³

TABLE II. Evidence to recommendations: Topic area 1

Identification and mitigation of risk factors for biphasic anaphylaxis		
Population:	Adults and children with anaphylaxis.	
Intervention:	Using the presence of risk factors associated with biphasic anaphylaxis to advise regarding medical observation time following resolution of the initial phase of anaphylaxis.	
Comparison:	Standard medical observation without risk factor stratification following resolved initial anaphylaxis.	
Main outcomes:	The occurrence of biphasic anaphylaxis.	
Setting:	Emergency departments, allergy clinics, and primary care offices.	
Perspective:	Health care providers and patients want to know what risk factors predict biphasic anaphylaxis and how best to prevent it.	
Background:	Biphasic reactions may occur in up to 20% of patients with anaphylaxis but can be difficult to predict. Because biphasic anaphylaxis may occur from 1 to 78 h after anaphylaxis resolution, there is uncertainty as to optimal medical observation to detect biphasic reactions. Prior studies have suggested more severe initial presentation (including hypotension) is associated with a greater risk for biphasic anaphylaxis.	
Conflict of interests:	None	
Clinical statement		
Very low-certainty evidence suggests patients with severe initial anaphylaxis and those requiring >1 dose of epinephrine are at risk for biphasic anaphylaxis after resolution of initial anaphylaxis.		
Very low-certainty evidence suggests extended observation is appropriate for patients with severe initial anaphylaxis and/or who have required >1 dose of epinephrine. For patients with resolved nonsevere anaphylaxis who are without significant comorbidities that would increase the risk for fatal anaphylaxis, who have had a prompt response to epinephrine, and will have reliable access to medical care following discharge, a 1-h observation may be reasonable. Prior to discharge all patients should be prescribed and receive education on how and when to use self-injectable epinephrine, the risk of biphasic anaphylaxis, trigger avoidance, and the need for follow-up care with an allergist.		
Assessment		
Judgment	Research evidence	Additional considerations
Problem: Is the problem a priority?		
No	The lifetime prevalence of anaphylaxis is estimated between 1.6% to 5.1%, and biphasic anaphylaxis may occur in up to 20% of patients. ^{1,4} Medications are a leading trigger of anaphylaxis in adults. ^{1,11} The prevalence of fatal anaphylaxis is between 0.47 to 0.69 per million persons 0.25% to 0.33% of ED visits or hospitalizations. ^{9,10,29-31}	There is some uncertainty as to the exact rate of biphasic anaphylaxis and evidence regarding optimal treatment for biphasic anaphylaxis is scant.
Probably no		
Probably yes		
Yes		
Varies		
Do not know		
Desirable effects: How substantial are the desirable anticipated effects?		
Trivial	Understanding risk factors that could predict patients more likely to have biphasic reactions may allow more focused triage for patients who could benefit from additional education or medical observation. Very low-certainty evidence suggests biphasic anaphylaxis is associated with: (1) severe initial anaphylaxis symptoms, OR = 2.11 (95% CI, 1.23-3.61); (2) >1 dose of epinephrine, OR = 4.82 (95% CI, 2.70-8.58); and (3) wide pulse pressures, OR = 2.11 (95% CI, 1.32-3.37). Additional associations include: (4) anaphylaxis caused by any drug in patients <18 y of age, OR = 2.35 (95% CI, 1.16-4.76); (5) anaphylaxis caused by an unknown trigger, OR = 1.63 (95% CI, 1.14-2.33); (6) anaphylaxis symptoms with cutaneous manifestations, OR = 2.54 (95% CI, 1.25-5.15); and (7) anaphylaxis in patients <18 y of age treated with glucocorticoids, OR = 1.55 (95% CI, 1.01-2.38).	More severe anaphylaxis carries a greater risk for biphasic anaphylaxis. Additional associations are quite broad (eg, cutaneous signs and symptoms) or may be confounded by anaphylaxis severity (eg, wide pulse pressure and children receiving glucocorticoids).
Small		
Moderate		
Large		
Varies		
Do not know		
Undesirable effects: How substantial are the undesirable anticipated effects?		
Large	For ED or hospital presentations of anaphylaxis, the case-fatality rate is estimated at 0.25% to 0.33%, including both uniphasic and biphasic anaphylaxis. ³¹ To reduce the fatality rate for biphasic anaphylaxis, one would ideally have the patient under direct observation; however, it is not cost-effective to observe all patients for a prolonged time following resolution of uniphasic anaphylaxis. Furthermore, it has been shown that the majority of patients monitored for 1 asymptomatic hour after resolved anaphylaxis will not experience a biphasic reaction. ⁵⁷ Therefore the risks and benefits need to be balanced. While harm may result from missed cases of anaphylaxis in	Patients identified to have risk factors may be observed much longer in the ED or admitted, increasing the cost of anaphylaxis treatment. Patients with these risk factors may be reluctant to go the ED for fear of having an extended stay.
Moderate		
Small		
Trivial		
Varies		
Do not know		

(Continued)

TABLE II. (Continued)

Assessment		
Judgment	Research evidence	Additional considerations
	discharged patients, an overly cautious observation time for patients at low risk for both biphasic anaphylaxis and anaphylaxis fatality would be very costly. Depending on how evidence is incorporated into clinical practice, undesirable effects could include adoption of prolonged periods of medical observation, which would be unnecessary for the majority of patients with resolved anaphylaxis.	
Certainty of evidence (intentional vagueness): What is the overall certainty of the evidence of effects?		
Very low	Across variables evaluated, heterogeneity ranged from low ($I^2 = 0\%$) to high ($I^2 = 89\%$). Due to very low certainty of evidence and absence of a randomized controlled trial to address this question, there remains uncertainty as to the degree of benefit and fatality risk reduction obtained from extended observation in patients with resolved anaphylaxis. However, when comparing a 1-h to a ≥ 6 h observation, the NNT by extended observation to prevent 1 biphasic reaction following discharge is 41 (range, 18-195) for patients presenting with severe anaphylaxis and 13 (range, 7-27) for those requiring >1 dose of epinephrine. ^{57,195}	Patients with severe initial anaphylaxis are likely to experience the greatest potential benefit from more extended observation.
Low		All patients should receive anaphylaxis education, including the risk for biphasic anaphylaxis. Patients should be prescribed self-injectable epinephrine and provided with an action plan, instructing them on how and when to administer epinephrine.
Moderate		On discharge, patients should be instructed to see an allergist-immunologist. ⁴⁵
High		
No included studies		
Values (value judgments): Is there important uncertainty about or variability in how much people value the main outcomes?		
Important uncertainty or variability	All patients would prefer to avert biphasic anaphylaxis. Apart from prompt and appropriate treatment of initial anaphylaxis with epinephrine, evidence is lacking to support a clear role for any additional therapy or management strategy to decrease biphasic anaphylaxis risk. However, if initial anaphylaxis was severe, if the clinical impression is that a patient has a higher risk of biphasic reaction (ie, 17% or greater), or if risk factors for anaphylaxis fatality are present (eg, cardiovascular comorbidity, lack of access to epinephrine, lack of access to EMS, poor self-management skills) then extended observation of up to 6 h or longer (including hospital admission) may be appropriate. ⁵⁸ There is an absence of patient-preference sensitive evidence to inform physicians of the relative valuation of trade-offs when prolonged observation is compared with the risk of biphasic anaphylaxis following discharge.	While all patients would choose to minimize biphasic anaphylaxis, a differential value may be placed on the importance of prolonged observation even for patients having experienced severe anaphylaxis. Conversely, patients with nonsevere anaphylaxis may prefer more extended observation (beyond 1 h). Development of a patient-decision aid could facilitate shared decision making.
Possibly important uncertainty or variability		
Probably no important uncertainty or variability		
No important uncertainty or variability		
No important uncertainty or variability		
Balance of effects (benefit-harm assessment): Does the balance between desirable and undesirable effects favor the intervention or the comparison?		
Favors the comparison	Potential harm could result from overreliance of risk factors.	Biphasic anaphylaxis may occur in any patient with anaphylaxis and all patients should seek care if anaphylaxis recurs after initial resolution.
Probably favors the comparison	While universal prolonged observation could lead to patients delaying medical care (or avoiding medical observation all together), triage of patients with severe index anaphylaxis may facilitate a balance of benefits and harms.	
Does not favor either the intervention or the comparison		
Probably favors the intervention		
Favors the intervention		
Varies		
Do not know		
Resources required: How large are the resource requirements (costs)?		
Large costs	Direct and indirect costs may vary depending on how risk factors are incorporated into patient management. Prolonged ED observation or inpatient admission could dramatically increase costs of anaphylaxis management. Biphasic anaphylaxis occurring outside of medical observation may be more severe and life-threatening, leading to greater costs of care; however, availability of self-injectable epinephrine would be expected to mitigate these risks and costs.	Anaphylaxis patient education, referral to an allergist, and prescription of an epinephrine auto-injector at discharge are important for all patients with anaphylaxis. ⁴⁵
Moderate costs		
Negligible costs		
and savings		
Moderate savings		
Large savings		
Varies		
Do not know		
Certainty of evidence of required resources: What is the certainty of the evidence of resource requirements (costs)?		
Very low	There is low certainty in evidence of resource requirements due to variation in treatment setting, costs, duration of observation, and incorporation of risk factors. However, a time-dependent	Indirect costs involve job-related opportunity costs and may vary significantly across patient populations. Additional costs would
Low		
Moderate		

(Continued)

TABLE II. (Continued)

Assessment		
Judgment	Research evidence	Additional considerations
High	activity-based cost strategy can be used to estimate hourly	be incurred for patients receiving overnight hospital admission
No included studies	costs from allergy clinic or ED observation. ^{196,197}	for postanaphylaxis monitoring.
Cost effectiveness: Does the cost-effectiveness of the intervention favor the intervention or the comparison?		
Favors the comparison	Medical observation of patients with severe anaphylaxis for ≥6 h can be a cost-effective strategy if it provides at least a 76% fatality risk reduction compared with a shorter, for example, 1 h, observation. ⁵⁸	Cost-effectiveness may be sensitive to rates of biphasic reactions, cost of observation, hospitalization rates, and anaphylaxis fatalities.
Probably favors the comparison		
Does not favor either the intervention or the comparison		
Probably favors the intervention		
Favors the intervention		
Varies		
Do not know		
No included studies		
Equity: What would be the impact on health equity?		
Reduced	The impact on equity may vary depending on how risk factors are incorporated into patient management. Prolonged periods of medical observation in patients with resolved anaphylaxis could negatively impact equity and may discourage patients from seeking medical care.	All patients experiencing anaphylaxis should be closely observed until they are stable and suitable for discharge. Recognizing that a biphasic anaphylaxis may only develop many hours following total resolution of symptoms, it is difficult to determine the most appropriate and cost-effective time for medical observation. A risk-stratified approach to observation following resolved anaphylaxis should include a shared decision-making conversation with the patient and family, as both the medical risks and patient values and preference must be taken into consideration.
Probably reduced		
Probably no impact		
Probably increased		
Increased		
Varies		
Do not know		
Acceptability and quality improvement opportunity: Is the intervention acceptable to key stakeholders?		
No	Evidence suggests that a 1-h symptom-free observation period of nonsevere anaphylaxis has a 95% NPV for biphasic anaphylaxis. ⁵⁷	The concept that more severe anaphylaxis is associated with a greater risk for biphasic anaphylaxis is intuitive and would be acceptable to most stakeholders.
Probably no		
Probably yes		
Yes		
Varies		
Do not know		
Feasibility: Is the intervention feasible to implement?		
No	One recent meta-analysis suggests a 95% NPV associated with a 1-h medical observation, and a 97.3% NPV associated with an observation period of at least 6 h. ⁵⁷	Given the prolonged duration of possible biphasic reactions, it would not be feasible to observe all patients for the entire duration of risk (up to 78 h).
Probably no		
Probably yes		
Yes		
Varies		
Do not know		
Intentional vagueness		
No	Evidence was drawn from a heterogeneous population of nonrandomized clinical studies and is susceptible to methodologic bias. The optimal extended observation time following resolved anaphylaxis is poorly defined. While a ≥6-h observation period could be suggested in higher-risk patients, uncertainty remains regarding the cost-effectiveness of such an approach in many circumstances. ⁵⁸	Due to very low certainty of evidence and absence of a randomized controlled trial to address this question, there remains uncertainty and potential bias. A role for shared decision making in relation to extended observation may exist in some clinical situations of resolved anaphylaxis.
Probably no		
Probably yes		
Yes		
Varies		
Do not know		
Role of patient preference		
No	Patients with resolved severe anaphylaxis may reasonably choose to defer prolonged observation beyond 6 h. ⁵⁸ Furthermore, an aversion to prolonged medical observation may deter some patients from seeking appropriate care. However, other patients, including those with less severe anaphylaxis, may prefer an extended period of observation based on fear, anxiety, past experiences, or specific psychosocial circumstances.	While patients with more severe anaphylaxis have a greater risk for biphasic reactions, the management of this increased risk may warrant practice variation based on a construct of shared decision making. In addition, patients with nonsevere anaphylaxis should have the option for more extended observation.
Probably no		
Probably yes		
Yes		
Varies		
Do not know		

(Continued)

TABLE II. (Continued)

Judgment	Assessment	
	Research evidence	Additional considerations
Exclusions		
No	It is important to distinguish biphasic anaphylaxis from uniphasic anaphylaxis without complete resolution (protracted anaphylaxis). Specific subpopulations were not excluded.	Additional factors associated with biphasic anaphylaxis would be difficult to incorporate into clinical triage strategies, such as anaphylaxis caused by a drug trigger in children, anaphylaxis with cutaneous signs and symptoms, and use of glucocorticoids in children. Some clinical associations identified may be confounded by anaphylaxis severity. Given the low certainty of evidence it is not possible to completely exclude that subpopulations may benefit from extended observation.
Probably no		
Probably yes		
Yes		
Varies		
Do not know		
Policy level		
No	We would not recommend policy-level interventions to mandate specific observation times or incorporate specific risk factors to predict biphasic anaphylaxis, as the certainty of evidence relating to this question is very low.	Well-performed future randomized controlled trials would better inform practice and understanding of risk factors to predict biphasic anaphylaxis.
Probably no		
Probably yes		
Yes		
Varies		
Do not know		

Boldface indicates guideline group judgement in each domain.

Manivannan et al,¹⁸⁴ Manuyakorn et al,¹⁸⁵ Mehr et al,¹⁸⁶ Noone et al,¹⁸⁷ Orhan et al,¹⁸⁸ Poachanukoon and Paopairochanakorn,¹⁸⁹ Rohacek et al,⁴¹ Sampson et al,³⁸ Scranton et al,¹⁹⁰ Smit et al,¹⁹¹ Sricharoen et al,⁵⁵ Stark and Sullivan,³⁷ Vezir et al,¹⁹² Yang et al.¹⁹³

Key results. Based on very low-certainty evidence, the following associated factors significantly increase the risk of biphasic anaphylaxis: (1) anaphylaxis caused by any drug in patients <18 years of age (Peto OR, 2.35; 95% CI, 1.16-4.76); (2) anaphylaxis caused by an unknown trigger (Peto OR, 1.63; 95% CI, 1.14-2.33); (3) anaphylaxis symptoms with cutaneous manifestations (Peto OR, 2.54; 95% CI, 1.25-5.15); (4) wide pulse pressures (Peto OR, 2.11; 95% CI, 1.32-3.37); (5) severe initial anaphylaxis symptoms (Peto OR, 2.11; 95% CI, 1.23-3.61); (6) anaphylaxis in patients <18 years of age treated with glucocorticoids (Peto OR, 1.55; 95% CI, 1.01-2.38); and (7) patients requiring >1 dose of epinephrine (Peto OR, 4.82; 95% CI, 2.70-8.58) (see Fig 3). The bias of the studies ranged from moderate to high due to retrospective data, exclusions due to missing data, limited patient populations, and limited follow-up (Table I). The evidence to recommendations (Table II) and summary of judgements (Table III) assessments were used to develop strength of recommendations.¹⁹⁴⁻²⁰²

Summary by predictive variable. Twenty-six predictive variables were analyzed. Nine outcomes showed a positive or negative association with biphasic anaphylaxis. Of these outcomes, time to first epinephrine was reviewed qualitatively due to the heterogeneity of the data.

Unknown trigger. Twenty-one retrospective observational studies (n = 4275) are included for this outcome: Alqurashi et al,⁴² Brady et al,¹⁷³ Brazil and MacNamara,¹⁷⁴ Cianferoni et al,¹⁷⁶ Douglas et al,¹⁷⁸ Ellis and Day,³⁹ Grunau et al,⁴⁰ Inoue and Yamamoto,¹⁷⁹ Jirapongsananuruk et al,¹⁸⁰ Lee and Greenes,¹⁴² Lee et al,¹⁹⁴ Lertnawapan and Maek-a-nantawat,¹⁸³ Manivannan et al,¹⁸⁴ Manuyakorn et al,¹⁸⁵ Mehr et al,¹⁸⁶ Rohacek et al,⁴¹ Smit et al,¹⁹¹ Sricharoen et al,⁵⁵ Stark and Sullivan,³⁷ Vezir et al,¹⁹² Yang et al.¹⁹³ The pooled Peto OR was 1.63 (95% CI, 1.14-2.33). Using a fixed-effect analysis, patients with anaphylaxis from an unknown trigger have a higher risk of having

a biphasic reaction. The evidence is graded very low certainty based on very serious risk of bias and serious inconsistency between the included studies. Biases include (1) the use of retrospective data, (2) limited or no follow-up, (3) limited patient selection (inpatient setting), and (4) exclusion of subjects due to missing data. Inconsistency was graded as serious due to moderate heterogeneity as evidenced by an $I^2 = 45\%$.

Drug trigger in patients ≤18 years of age. Five retrospective observational studies (n = 996) measured this outcome: Alqurashi et al,⁴² Manuyakorn et al,¹⁸⁵ Mehr et al,¹⁸⁶ Orhan et al,¹⁸⁸ Vezir et al.¹⁹² The pooled Peto OR was 2.35 (95% CI, 1.16-4.76). Using a fixed-effect analysis, patients ≤18 years of age who have anaphylaxis from a drug trigger are at a higher risk of having a biphasic reaction than patients ≥18 years of age with a drug trigger. The evidence is graded very low certainty based on (1) very serious risk of bias as the studies were retrospective in nature with limited or no follow-up, (2) serious inconsistency as the studies had moderate heterogeneity ($I^2 = 46\%$), and (3) serious imprecision as the studies had a low number of events.

Cutaneous signs and symptoms. Six retrospective observational studies (n = 1949) are included for this outcome: Alqurashi et al,⁴² Grunau et al,⁴⁰ Inoue and Yamamoto,¹⁷⁹ Lee et al,¹⁸² Manuyakorn et al,¹⁸⁵ Mehr et al.¹⁸⁶ The pooled Peto OR was 2.54 (95% CI, 1.25-5.15). Using a fixed-effect analysis, patients with cutaneous signs and symptoms are at higher risk of having a biphasic reaction than are patients without cutaneous signs and symptoms. The evidence is graded very low certainty based on very serious risk of bias and inconsistency, as well as serious imprecision. The biases include (1) the use of retrospective data, (2) limited or no follow-up, and (3) limited patient selection (inpatient setting). Inconsistency is graded as very serious because the definition of cutaneous signs and symptoms varied across studies and the $I^2 = 43\%$. Finally, the included studies are downgraded for serious imprecision, as there was a low number of events and the confidence interval for the summary statistic is wide.

Dyspnea. Six retrospective observational studies (n = 1841) are included for this outcome: Brazil and MacNamara,¹⁷⁴ Inoue and Yamamoto,¹⁷⁹ Lee et al,¹⁹⁴ Rohacek et al,⁴¹ Smit et al,¹⁹¹

TABLE III. Topic area 1: Summary of judgments

				Judgment			
Problem is a priority	No	Probably no	Probably yes	Yes	Varies	Do not know	
Desirable effects	Trivial	Small	Moderate	Large	Varies	Do not know	
Undesirable effects	Large	Moderate	Small	Trivial	Varies	Do not know	
Certainty of evidence	Very low	Low	Moderate	High	No included studies		
Values	Important uncertainty or variability	Possibly important uncertainty or variability	Probably no important uncertainty or variability	No important uncertainty or variability			
Balance of effects, benefits, harms and burdens	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	Do not know
Resources required	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	Varies	Do not know
Certainty of evidence of required resources	Very low	Low	Moderate	High	No included studies		
Cost effectiveness	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	No included studies
Equity	Reduced	Probably reduced	Probably no impact	Probably increased	Increased	Varies	Do not know
Acceptability	No	Probably no	Probably yes	Yes	Varies	Do not know	
Feasibility	No	Probably no	Probably yes	Yes	Varies	Do not know	

Boldface indicates guideline group judgment in each domain.

Sricharoen et al.⁵⁵ The pooled Peto OR was 0.6 (95% CI, 0.38-0.96). Using a fixed-effect analysis, patients with dyspnea are at lower risk of having a biphasic reaction than are patients without dyspnea. The evidence is graded very low certainty based on (1) serious risk of bias as the studies are retrospective observational studies and included studies had limited or no follow-up, (2) serious inconsistency as the studies had substantial heterogeneity ($I^2 = 73\%$) and (3) serious imprecision as the studies had a low number of events.

Wide pulse pressure. Two retrospective observational studies ($n = 1356$) are included for this outcome: Alqurashi et al,⁴² Lee et al.¹⁹⁴ The pooled Peto OR was 2.11 (95% CI, 1.32-3.37). Using a fixed-effect analysis, patients with a wide pulse pressure are at higher risk of having a biphasic reaction than are patients without a wide pulse pressure. The evidence is graded very low certainty based on (1) serious risk of bias as the studies are retrospective observational studies and (2) serious imprecision as the studies had a low number of events.

Severe initial anaphylaxis. Five retrospective observational studies ($n = 724$) are included for this outcome: Brown et al,²¹ Confino-Cohen and Goldberg,¹⁷⁷ Lee and Greenes,¹⁴² Manuyakorn et al,¹⁸⁵ Vezir et al.¹⁹² The pooled Peto OR was 2.11 (95% CI, 1.23-3.61). Using a fixed-effect analysis, patients with a severe initial anaphylaxis are at higher risk of having a biphasic reaction than are patients without severe anaphylaxis. The evidence is graded very low certainty based on (1) very serious risk of bias as the studies are retrospective observational studies and included studies with limited or no follow-up, (2) serious inconsistency as the studies used different definitions for severe anaphylaxis, and (3) serious imprecision as the studies had a low number of events.

Greater than 1 epinephrine treatment. Five retrospective observational studies ($n = 1584$) are included for this outcome: Alqurashi et al,⁴² Inoue and Yamamoto,¹⁷⁹ Lee et al,²⁰³ Mehr et al,¹⁸⁶ Scranton et al.¹⁹⁰ The pooled Peto OR was 4.82 (95% CI, 2.70-8.58). Using a fixed-effect analysis,

patients who receive >1 epinephrine treatment initially are at increased risk of having a biphasic reaction. The evidence is graded very low certainty based on (1) very serious risk of bias as the studies are retrospective observational studies and included studies with limited or no follow-up and (2) serious imprecision as the studies had a low number of events.

Glucocorticoid treatment in patients ≤ 18 years of age. Seven retrospective observational studies ($n = 1203$) are included for this outcome: Alqurashi et al,⁴² Calvani et al,¹⁷⁵ Inoue and Yamamoto,¹⁷⁹ Lee and Greenes,¹⁴² Manuyakorn et al,¹⁸⁵ Mehr et al,¹⁸⁶ Vezir et al.¹⁹² The pooled Peto OR was 1.55 (95% CI, 1.01-2.38). Using a fixed-effect analysis, patients ≤ 18 years of age who receive glucocorticoid treatment are at a higher risk of having a biphasic reaction than are patients ≥ 18 years of age who receive glucocorticoid treatment. The evidence is graded very low certainty based on (1) very serious risk of bias as the studies are retrospective observational studies, included studies with limited or no follow-up, and included limited patient selection (inpatient setting) and (2) serious imprecision as the studies had a low number of events.

Time to first epinephrine. Eight retrospective observational studies ($n = 1469$) are included for this outcome: Alqurashi et al,⁴² Ko et al,¹⁸¹ Lee et al,¹⁸² Lee et al,¹⁹⁴ Lee and Greenes,¹⁴² Lertnawapan and Maek-a-nantawat,¹⁸³ Poachanukoon and Paopairochanakorn,¹⁸⁹ and Scranton et al.¹⁹⁰ Reviewers were unable to perform an analysis for this outcome because the investigators provided interquartile range (IQR) and median values and therefore this outcome could not be pooled together. Three of the 8 studies showed delayed administration of epinephrine resulted in higher rates of biphasic anaphylaxis while the other 5 studies showed no statistical difference. Lee et al¹⁹⁴ identified 872 anaphylaxis-related visits to an ED from 2008 to 2015. There was a statistically significant association with biphasic reactions when the first dose of epinephrine was administered >60 minutes after symptoms developed (OR, 2.29; 95% CI, 1.09-4.79). Lee and Greenes¹⁴² also performed a retrospective

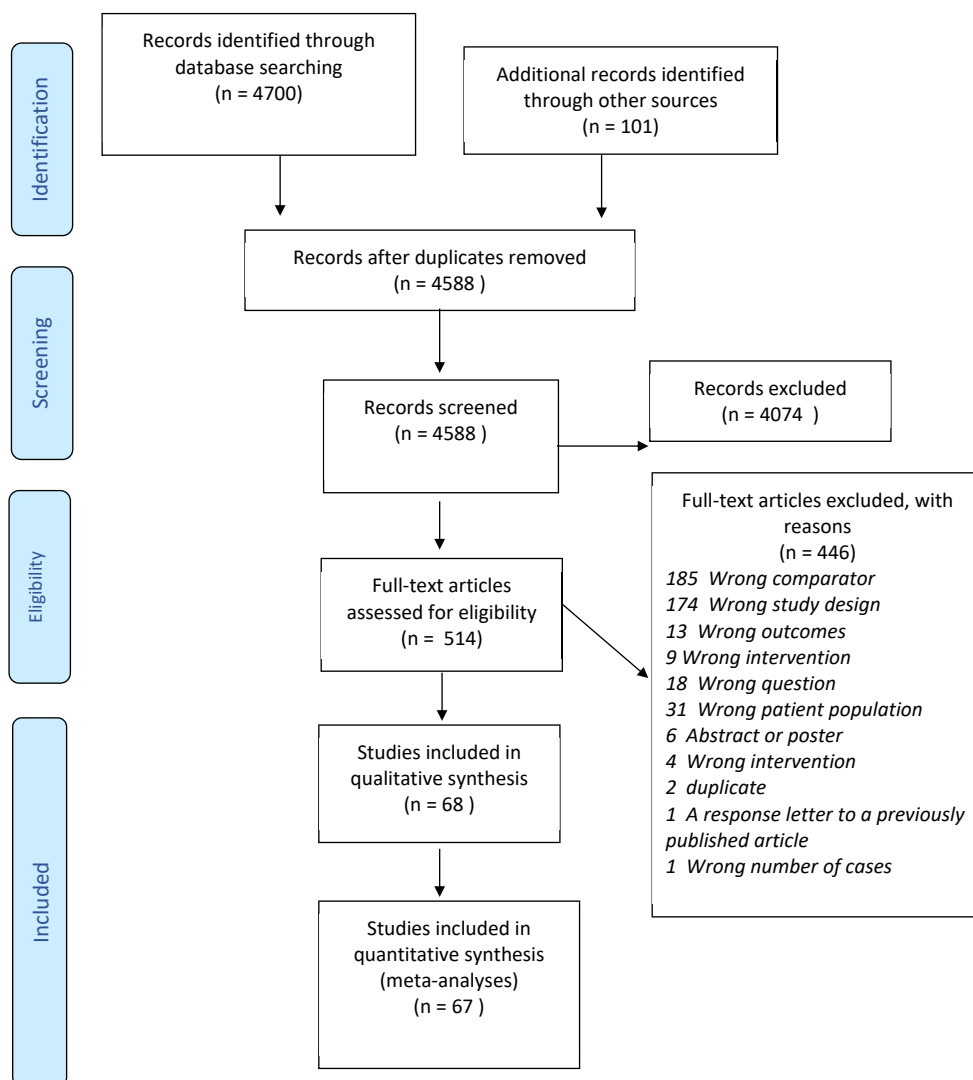


FIG 4. Topic area 2 PRISMA flow diagram.

analysis of 108 children admitted to a children's hospital. The median time from initial symptoms to initial dose of epinephrine for patients with a biphasic reaction was 190 minutes and 48 minutes for patients without a biphasic reaction ($P = .03$). Lertnawapan and Maek-a-nantawat¹⁸³ conducted an observational study on patients ($n = 208$) presenting to an ED with anaphylaxis. Time from symptom onset to administration of epinephrine was significantly longer in the biphasic group than in the nonbiphasic group (240 minutes [IQR, 122.5-380 minutes] vs 70 minutes [IQR, 40-135 minutes]; $P = .002$). Alqurashi et al⁴² found median time from the onset of the reaction to first dose of epinephrine was not statistically different between patients with biphasic reactions (64 minutes [IQR, 25-175 minutes]) and without biphasic reactions (59 minutes [IQR, 25-105 minutes]; $P = .35$). In a subgroup analysis of subjects who received epinephrine for the initial reaction, Alqurashi et al⁴² identified a protective effect from early epinephrine (a time delay of epinephrine >90 minutes increased biphasic risk; $P = .01$). Ko et al¹⁸¹ showed no association between the timing of epinephrine and the occurrence

of biphasic reactions ($P = .52$). Median time from symptoms to epinephrine was 30 minutes (IQR, 20-60) in the nonbiphasic group and 70 minutes (IQR, 20-570) in the biphasic groups. Poachanukoon and Paopairochanakorn¹⁸⁹ found the median time from the onset of symptoms to the initial administration of epinephrine in the patients with biphasic reactions was longer than in the nonbiphasic group but the difference did not reach statistical significance. Median time to initial dose of epinephrine in the nonbiphasic group was 82 minutes and 263 minutes in the biphasic group. No range was given. Scranton et al¹⁹⁰ found no difference in mean time to epinephrine between the nonbiphasic group (8.5 ± 13.8 minutes) and the biphasic group (8.2 ± 12.8 minutes; $P = .94$). Lee et al¹⁸² found no difference in time from first reaction onset to first epinephrine dose between the nonbiphasic group (23.0 minutes) and the biphasic group (28.5 minutes; $P = .60$).

Food trigger. Although previously found to be associated with a decreased risk for biphasic anaphylaxis,⁴³ the current analysis did not find a significant association of foods with

TABLE IV. Question 2 GRADE summary of findings table: Should glucocorticoids or antihistamines be used to prevent biphasic anaphylaxis?

No. of studies	Study design	Risk of bias	Certainty assessment			Other considerations	No. of patients		Effect		Certainty	Importance
			Inconsistency	Indirectness	Imprecision		Biphasic	Uniphasic	Relative (95% CI)	Absolute (95% CI)		
Glucocorticoids to prevent biphasic anaphylaxis												
26	Observational studies	Very serious*	Serious†	Serious‡	Serious§	All plausible residual confounding would reduce the demonstrated effect	616 of 871 (70.7%)	10,270 of 14,762 (69.6%)	OR 0.87 (0.74-1.02)	30 fewer per 1000 (from 4 more to 67 fewer)	⊕○○○ Very low	Important
H1 Antihistamines to prevent biphasic anaphylaxis												
16	Observational studies	Very serious*	Serious†	Serious‡	Serious§	All plausible residual confounding would reduce the demonstrated effect	210 of 245 (85.7%)	2875 of 3304 (87.0%)	OR 0.71 (0.47-1.06)	44 fewer per 1000 (from 6 more to 111 fewer)	⊕○○○ Very low	Important
H2 Antihistamines to prevent biphasic anaphylaxis												
10	Observational studies	Very serious*	Not serious	Serious†	Serious	All plausible residual confounding would reduce the demonstrated effect	60 of 173 (34.7%)	763 of 1955 (39.0%)	OR 1.21 (0.80-1.83)	46 more per 1000 (from 52 fewer to 149 more)	⊕○○○ Very low	Important

Boldface indicates guideline group judgment in each domain.

*Risk of bias across studies related to lack of blinding, lack of randomization, potential confounding by severity of presentation, practice variation, and differential use of epinephrine.

†Significant heterogeneity across studies.

‡Endpoint included outcomes reported as surrogate to biphasic reactions included ED revisits.

§Several studies with wide ranging 95% CIs.

decreased risk for biphasic anaphylaxis (Peto OR, 0.89; 95% CI, 0.68-1.17).

Topic area 2. Should antihistamines or glucocorticoids be used to prevent anaphylactic reactions?

Question 2. Should antihistamines and/or glucocorticoids be used to prevent biphasic anaphylaxis?

Question 3. Should antihistamine and/or glucocorticoid premedication be used to prevent index hypersensitivity/infusion reactions to chemotherapy?

Question 4. Should antihistamine and/or glucocorticoid premedication be used to prevent recurrent HSRs to RCM?

Question 5. Should antihistamine and/or glucocorticoid premedication be used to prevent HSRs to allergen immunotherapy or other agents?

- Patients: Adults and children experiencing anaphylaxis who are treated with glucocorticoids, antihistamines, or both to (1) prevent biphasic anaphylaxis, (2) prevent index anaphylaxis with chemotherapeutic, (3) prevent recurrence of anaphylaxis to nonionic low- or iso-osmolar RCM, and (4) prevent index anaphylaxis with nonchemotherapeutic agent. The analysis did not include patients with prior reactions attributed to chemotherapy or preventative treatment for children receiving chemotherapy.

- Intervention: Use of antihistamine and/or glucocorticoid.
- Comparator: Management without antihistamine and/or glucocorticoid.
- Outcome: Occurrence of (1) biphasic anaphylaxis and (2-4) anaphylaxis.

Background. A systematic review by Alqurashi and Ellis⁴⁴ found 31 observational studies that reviewed the role of glucocorticoids for the treatment of anaphylaxis, suggesting that biphasic reactions were more likely to occur in moderate to severe anaphylaxis or when anaphylaxis was not treated with timely epinephrine. The investigators concluded there was a lack of compelling evidence to support the routine use of glucocorticoids to prevent biphasic anaphylaxis.⁴⁴ Similar to the assumption that glucocorticoids provide proven benefit in acute anaphylaxis management, common practice has adopted the use of antihistamines, glucocorticoids, or both prior to chemotherapy, radiocontrast dye administration, and many other procedures or medications thought to involve risk of allergic reactions or anaphylaxis. However, the actual rigor to which these therapies have been evaluated is questionable. Paclitaxel, an antitumor agent, is an example, with HSRs to this agent reported since early clinical use. In an early report¹⁹⁸ of 301 patients treated, 32 patients had definite (27 patients) or possible (5 patients) HSRs and all but 1 patient had the reaction from the

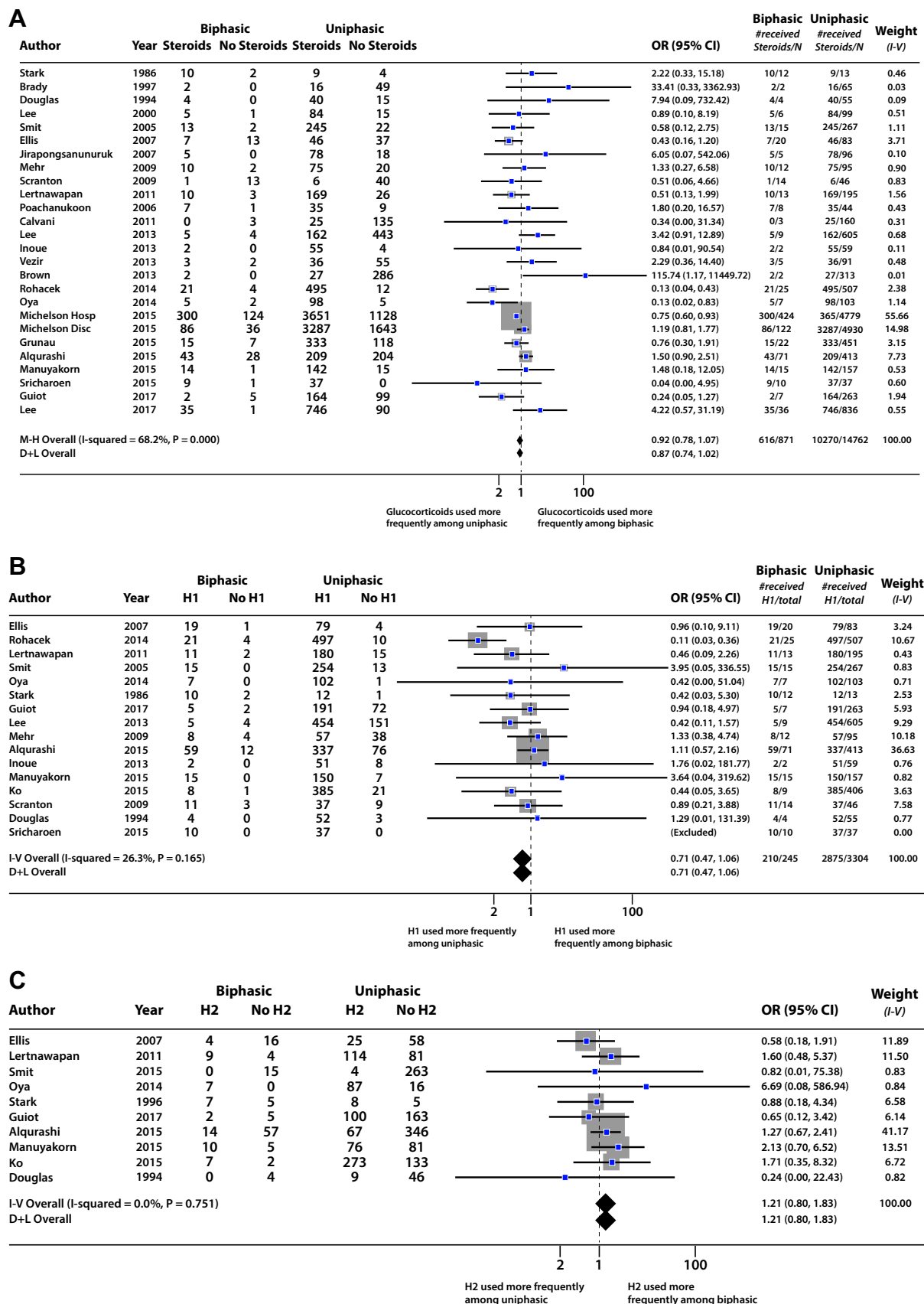


FIG 5. Should glucocorticoids or antihistamines be used to prevent biphasic anaphylaxis? **A**, Use of glucocorticoids among patients with biphasic versus uniphaseic outcomes. **B**, Use of H1 antihistamines among patients with biphasic versus uniphaseic outcomes. **C**, Use of H2 antihistamines among patients with biphasic versus uniphaseic outcomes. *D+L*, DerSimonian-Laird; *I-V*, inverse variance; *M-H*, Mantel-Haenszel.

TABLE V. Question 3 GRADE summary of findings table: Should antihistamine and/or glucocorticoid premedication be used to prevent index hypersensitivity/infusion reactions to chemotherapy?

Rate of premedication use in subjects with or without reactions to chemotherapy													
No. of studies	Study design	Risk of bias	Certainty assessment				No. of patients		Effect		Certainty	Importance	
			Inconsistency	Indirectness	Imprecision	Other considerations	Premedication	No premedication	Relative (95% CI)	Absolute (95% CI)			
Rate of premedication use in subjects with or without reactions to chemotherapy													
11	Observational studies	Serious*	Serious†	Serious‡	Serious§	None	132 of 2579 (5.1%)	181 of 1430 (12.7%)	OR 0.49 (0.37-0.66)	60 fewer per 1000 (from 76 fewer to 39 fewer)	⊕○○○ Very low	Important	

Boldface indicates guideline group judgment in each domain.

*Some inconsistency in protocol design could affect outcome assessments.

†Moderate heterogeneity identified in meta-analysis.

‡Studies evaluated nonselected patient populations without identified risk factors. Various protocols for premedication were evaluated. The relevance of findings to specific at risk populations is unclear.

§Several studies with wide ranging 95% CIs.

first or second exposure. Of interest, 13 patients (41%) had received premedication to prevent toxicity but nonetheless experienced HSRs. While prolongation of infusion time appears to have decreased the rate of HSRs, the addition of premedication has also become common practice in some circumstances.¹⁹⁸ Premedication is also used in patients with prior reactions to RCM; however, it has been suggested that the most important change in decreasing rates of HSR associated with RCM has been use of alternative low- or iso-osmolar nonionic agents.¹⁷ Evidence supporting the use of premedication in the setting of nonionic RCM agents for high-risk patients is poorly described, and there is concern that the routine use of glucocorticoid premedication in the setting of prior HSR to RCM may cause more morbidity than benefit.¹⁷

Study characteristics. The search for suitable studies was completed by the JTFPP (Fig 4). Sixty-seven articles were identified for inclusion. OR were used in analysis of questions 2, 3, and 5 due to the case-control analytic strategy as biphasic and uniphasic anaphylaxis were analyzed by retrospective evaluation of therapies received before the outcome of interest. Conversely, question 4 was evaluated using the risk ratio, which is useful in the setting of a prospective analysis plan to evaluate differences in outcome between exposure and control. Of note, if the prevalence/incidence of the event is low, then the risk ratio and OR typically give very similar results. The Peto OR can be useful if there are no events or low number of events in arms evaluated, but was avoided in the topic area 2 analysis due to unbalanced arms that could lead to skewed findings using the Peto OR.¹⁹⁹

Topic area 2 included studies. The following studies were used in the analyses of questions 2 to 5:

Question 2: Alqurashi et al,⁴² Brady et al,¹⁷³ Brown et al,²¹ Calvani et al,¹⁷⁵ Douglas et al,¹⁷⁸ Ellis and Day,³⁹ Grunau et al,²⁰⁰ Guiot et al,²⁰¹ Inoue and Yamamoto,¹⁷⁹ Jirapongsanunuruk et al,¹⁸⁰ Kawano et al,²⁰² Ko et al,¹⁸¹ Lee et al,²⁰³ Lee and Greenes,¹⁴² Lee et al,¹⁸² Lertnawapan and Maek-a-nantawat,¹⁸³ Lin et al,²⁰⁴ Manuyakorn et al,¹⁸⁵ Mehr et al,¹⁸⁶ Michelson et al,¹⁶⁶ Oya et al,²⁰⁵ Poachanukoon and Paopairochanakorn,¹⁸⁹ Rohacek et al,⁴¹ Scranton et al,¹⁹⁰ Smit et al,¹⁹¹ Sricharoen et al,⁵⁵ Stark and Sullivan,³⁷ Vezir et al.¹⁹²
Question 3: Chang et al,²⁰⁶ Francis et al,²⁰⁷ Jerzak et al,²⁰⁸ Mach et al,²⁰⁹ Onetto et al,²¹⁰ Rougier,²¹¹ Seki et al,²¹² Shen et al,²¹³ Thompson et al,²¹⁴ Trudeau et al,²¹⁵ Weiss et al.¹⁹⁸

Question 4: Abe et al,²¹⁶ Katayama et al,²¹⁷ Kolbe et al,²¹⁸ Lee et al,²¹⁹ Park et al,²²⁰ Park et al.²²¹

Question 5: Augustsson et al,²²² Berchtold et al,²²³ Braaton et al,²²⁴ Brockow et al,²²⁵ Caron et al,²²⁶ Fan et al,²²⁷ Gold et al,²²⁸ Hejjaoui et al,²²⁹ Jacobstein et al,²³⁰ Jagdis et al,²³¹ Lorenz et al,²³² Mueller et al,²³³ Neilson et al,²³⁴; Portnoy et al,²³⁵ Reimers et al,²³⁶ Sanders et al,²³⁷ Schoning et al,²³⁸ Tankersley et al,²³⁹ Ohashi et al.⁴⁶

Key results. Question 2. As shown in Table IV and Fig 5, very low-certainty evidence suggests that glucocorticoids do not provide clear benefit in terms of reducing the risk for biphasic anaphylactic reactions (OR, 0.87; 95% CI, 0.74-1.02). Prolonged hospitalization and revisits were analyzed as surrogate markers in Michelson et al,¹⁶⁶ in which glucocorticoids were associated with decreased length of hospital stay but not with 3-day ED revisit among hospitalized children. However, this study was limited by the poor distinction between protracted or biphasic anaphylaxis, introducing possible classification bias. Meta-regression analyses were performed to address potential confounding by differential rates of epinephrine use, with the summary estimate adjusted by accounting for whether there were differences across studies with regard to the odds of the biphasic versus the uniphasic group also receiving epinephrine at baseline. In meta-regression analyses, epinephrine use accounted for about one-half of the between study variance, with moderate variance remaining after this correction ($\tau^2 = 0.4$).

Similar to findings regarding glucocorticoid use in anaphylaxis, antihistamines also did not provide benefit in reduction of biphasic reactions (for H1 antihistamines: OR, 0.71; 95% CI, 0.47-1.06; and for H2 antihistamines: OR, 1.21; 95% CI, 0.80-1.83) (Table IV and Fig 5). Additional analyses were performed excluding Mehr et al¹⁸⁶ and Lee et al¹⁸² to account for uncertainty in antihistamine preparations used without change in findings (for H1 antihistamine: OR, 0.69; 95% CI, 0.44-1.09). To address potential confounding by differential rates of epinephrine use, the summary estimate was adjusted by accounting for whether there were differences across studies with regard to the odds of the biphasic versus the uniphasic group also receiving epinephrine at baseline. In the meta-regression analysis, epinephrine use did not account for significant variation across studies. Kawano et al²⁰² reported findings of a retrospective cohort to evaluate the effect of antihistamine treatment to prevent

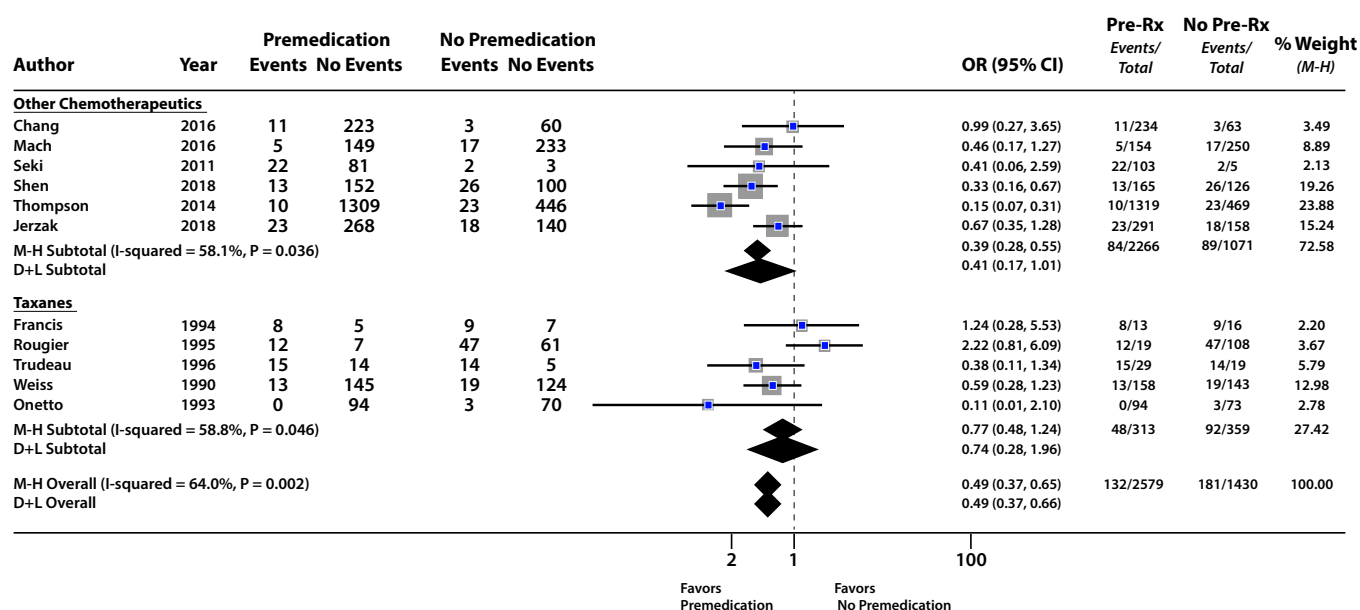


FIG 6. Should antihistamine and/or glucocorticoid premedication be used to prevent index hypersensitivity/infusion reactions to chemotherapy? Events are hypersensitivity or infusion-related reactions. Premedication is glucocorticoids and/or antihistamines.

TABLE VI. Question 4 GRADE summary of findings table: Should antihistamine and/or glucocorticoid premedication be used to prevent recurrent HSRs to RCM?

Prevent treatment harms to RCM.												
Certainty assessment							No. of patients		Effect		Certainty	Importance
No. of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Premedication	No premedication	Relative (95% CI)	Absolute (95% CI)		
Subsequent RCM reaction with or without premedication												
6	Observational studies	Serious*	Serious†	Not serious	Serious‡	None	523 of 4277 (12.2%)	1218 of 15,851 (7.7%)	RR 1.07 (0.67-1.71)	5 more per 1000 (from 25 fewer to 55 more)	⊕○○○ Very low	Important

Boldface indicates guideline group judgment in each domain.

RR, Risk ratio.

*Due to observations study design sources of bias could affect effect estimate.

†Significant heterogeneity among studies.

‡Several studies with wide ranging 95% CIs.

progression to anaphylaxis, so this study was excluded from the final analysis. However, the inclusion of Kawano et al²⁰² did result in a significant OR in favor of antihistamine use (OR, 0.65; 95% CI, 0.47-0.91). The significance of Kawano et al²⁰² is difficult to interpret because patients were selected using an ED diagnostic code of “allergic reaction” (code 995.3 in International Classification of Diseases, Ninth Revision) and patients receiving H1 antihistamines were more likely to receive epinephrine and glucocorticoids in their report. Similarly, Lin et al²⁰⁴ was excluded as the comparator in this analysis was an antihistamine, and Sricharoen et al⁵⁵ was excluded as all subjects received antihistamines.

Question 3. Premedication for chemotherapy was evaluated by outcome of HSR or infusion-related reaction (Table V and Fig 6). Specific agents evaluated included pegaspargase, docetaxel, carboplatin, oxaliplatin, and paclitaxel. Given heterogeneity of premedication, specific analysis of premedication variant strategies was not performed. Very low-certainty evidence suggests that glucocorticoid and/or antihistamine premedication

does provide benefit in terms of reducing the risk for hypersensitivity or infusion-related reactions in adults receiving chemotherapy who have not previously experienced a reaction to the drug when used in the context of a chemotherapy protocol (OR, 0.49; 95% CI, 0.37-0.66) (Table V and Fig 6). The test for heterogeneity yielded a statistically significant difference between studies ($P = .002$; $I^2 = 64.0\%$). Jung et al²⁴⁰ evaluated glucocorticoid premedication for rituximab in patients with B-cell malignancies, demonstrating a reduced rate of rituximab infusion-related reactions in patients pretreated with glucocorticoids (2.7%) compared with patients who did not receive premedication (13%) (OR, 0.183; 95% CI, 0.067-0.496; $P < .001$). Additional sensitivity analyses including the Jung et al²⁴⁰ analysis in the overall chemotherapy meta-analysis enhanced the benefit of chemotherapy premedication identified (OR, 0.45; 95% CI, 0.34-0.6).

Question 4. Very low-certainty evidence suggests that glucocorticoid and/or antihistamine premedication does not provide benefit in terms of reducing the risk for HSRs in patients

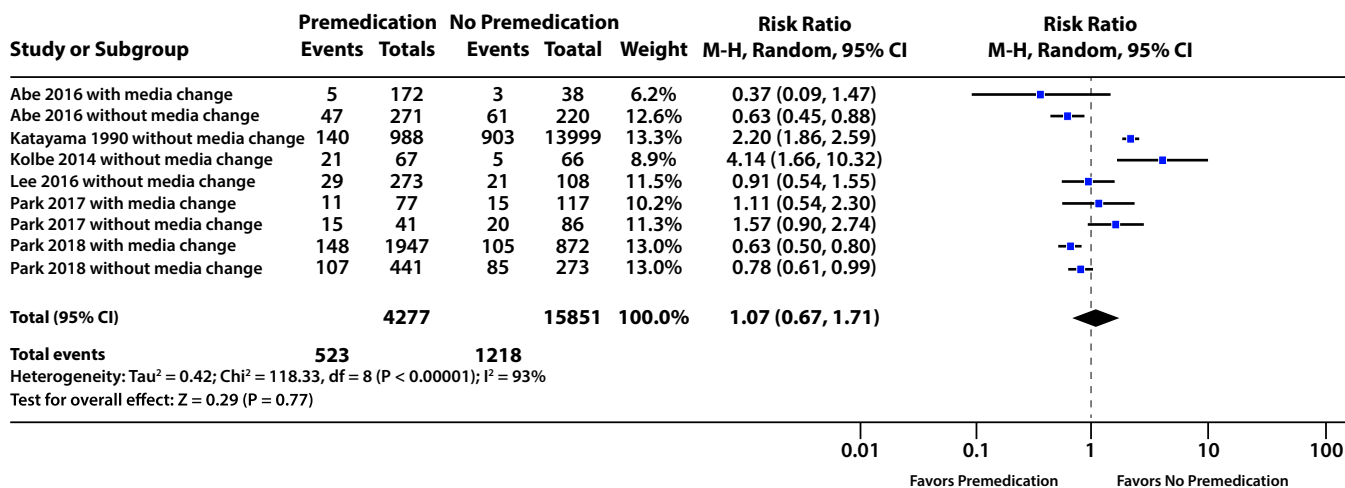


FIG 7. Should antihistamine and/or glucocorticoid premedication be used to prevent recurrent HSRs to RCM?

TABLE VII. Question 5 GRADE summary of findings table: Should antihistamine and/or glucocorticoid premedication be used to prevent HSRs to infliximab, allergen immunotherapy, or other agents?

Rate of investigator-defined allergic reactions												
No. of studies	Study design	Risk of bias	Certainty assessment				No. of patients		Effect		Certainty	Importance
			Inconsistency	Indirectness	Imprecision	Other considerations	Premedication	No premedication	Relative (95% CI)	Absolute (95% CI)		
19	Observational studies	Serious*	Serious†	Serious‡	Serious§	All plausible residual confounding would reduce the demonstrated effect	228 of 9473 (2.4%)	395 of 15922 (2.5%)	RR 0.74 (0.49-1.11)	6 fewer per 1000 (from 13 fewer to 3 more)	⊕○○○ Very low	Important

Boldface indicates guideline group judgment in each domain.

*Risk of bias across studies related to lack of blinding, lack of randomization, potential confounding by severity of presentation, practice variation.

†Significant heterogeneity across studies.

‡Significant degree of heterogeneity in outcomes reported.

§Several studies with wide ranging 95% CIs.

with prior RCM reactions (risk ratio, 1.07; 95% CI, 0.67-1.71) (Table VI and Fig 7). The test for heterogeneity yielded a statistically significant difference between studies ($P < .001$; $I^2 = 93\%$). Lasser et al²⁴¹ was excluded from the primary analysis because it was unclear which patients in this cohort who received nonionic contrast had experienced prior RCM HSRs; however, in sensitivity analyses including patients with overall hypersensitivity as well as more severe (grade II/III) reactions, premedication did not provide clear benefit (overall reactions: risk ratio, 0.97; 95% CI, 0.61-1.52; and grade II/III reactions: risk ratio, 1.00; 95% CI, 0.64-1.57). It is important to note that specific evaluation of patients with prior severe delayed onset allergic reactions for RCM is not well studied and was not addressed in the current analysis. Severe delayed RCM reactions have included Stevens-Johnson syndrome, toxic epidermal necrolysis, drug-related eosinophilia with systemic symptoms, and vasculitis—with fatalities reported.²⁴²⁻²⁵⁰ For instance, although iodixanol is a low-osmolar nonionic dimer, delayed T-cell-mediated reactions have been described.²⁴⁴ While skin testing with delayed readings at 48 and 72 hours may play a role in identifying non-cross-reactive agents,²⁴⁴ there remains uncertainty as to whether such an approach is necessary when compared with simply choosing a non-cross-reactive RCM for presumed

T-cell-mediated severe delayed onset reactions.¹⁷ Similarly, the necessity of other measures to prevent recurrent severe delayed reactions, which have included intravenous immunoglobulin, desensitization, and cyclosporine, is unknown.²⁵¹⁻²⁵³ A simple approach was recently proposed by Macy¹⁷ who reviewed RCM HSRs and described 4 non-cross-reacting RCM groups from the perspective of delayed-onset T-cell-mediated reactions (defined as groups A, B, C, and ungrouped). Group A RCM agents (which include the low-osmolar monomers iopamidol, iomeprol, ioversol, iothexol, and low-osmolar dimer iodixanol) were contrasted from group B (including the low-osmolar monomer iobitridol and low-osmolar dimer ioxaglate), group C (high-osmolar ionic monomer amidotrizoate/diatrizoate), and ungrouped agents (low-osmolar monomers iopromide, iopamidol, iothalamate). One management strategy suggested that glucocorticoid premedication begun 1 day before the procedure (and continued for 5 days) may have a role in severe delayed-onset reactions to group A RCM agents together with selection of a non-cross-reactive group (such as iopromide or iopamidol).¹⁷ The optimal approach to patients with delayed severe RCM reactions requires further study.

Question 5. Very low-certainty evidence suggests that glucocorticoid and/or antihistamine premedication does not

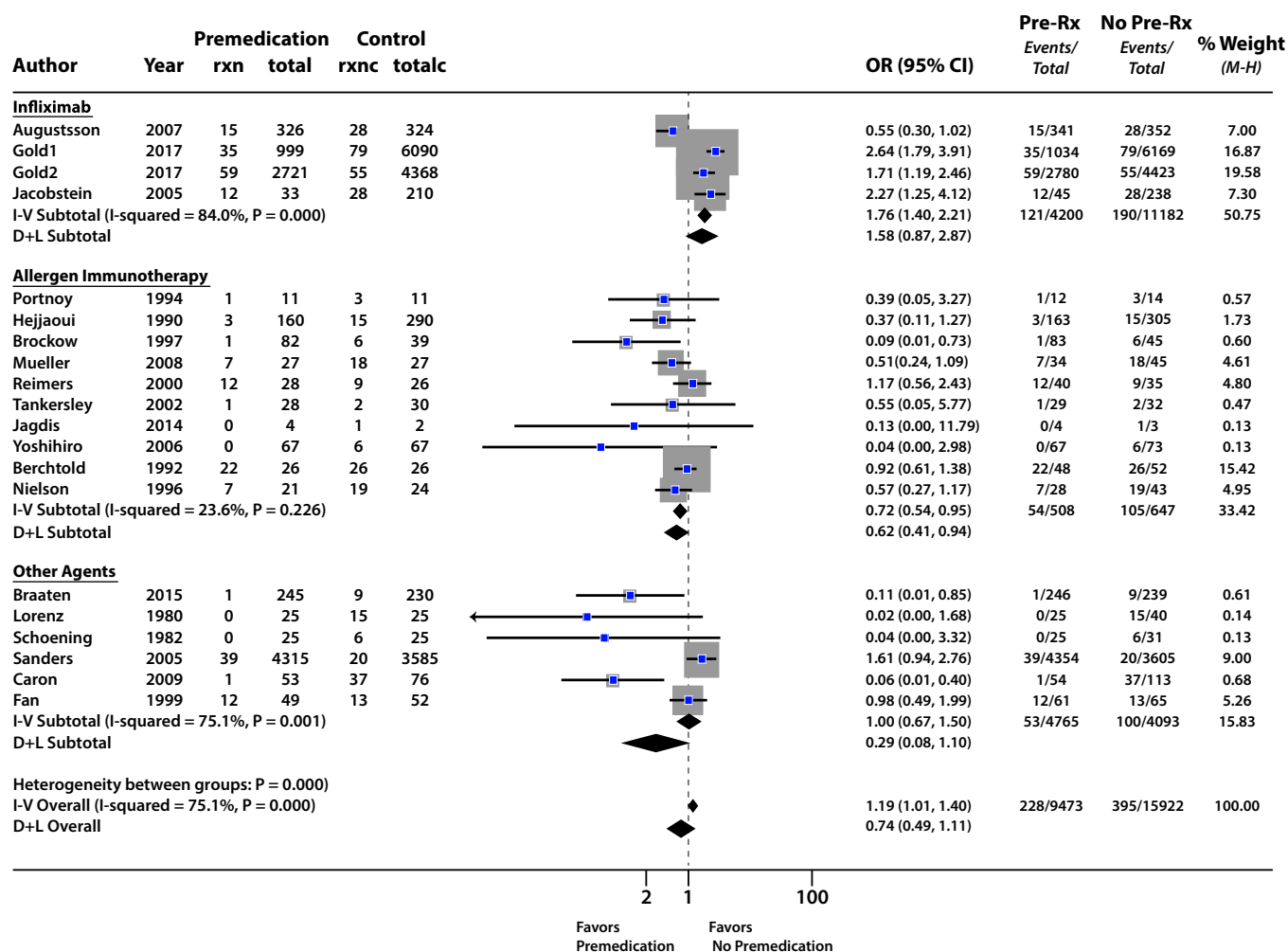


FIG 8. Should antihistamine and/or glucocorticoid premedication be used to prevent HSRs to infliximab, allergen immunotherapy, or other agents? *rxn*, Reaction with premedication; *rxnc*, reaction in controls; *totalc*, total for control.

provide benefit in terms of reducing the risk for HSRs in subjects receiving infliximab, allergen immunotherapy, or other (nonchemotherapy, non-RCM) medications (risk ratio, 0.74; 95% CI, 0.49-1.11) (Table VII and Fig 8). In contrast to infliximab, an analysis by Jung et al²⁴⁰ demonstrated glucocorticoid premedication was effective in preventing rituximab infusion reactions in the context of B-cell malignancies. Additionally, the subgroup analysis of allergen immunotherapy did demonstrate a significant benefit of premedication, driven largely by studies of premedication in accelerated allergen immunotherapy schedules, which present greater risks of anaphylaxis (risk ratio, 0.62; 95% CI, 0.41-0.94). This benefit may relate to a high baseline rate of systemic reactions. For example, Portnoy et al²³⁵ reported a double-blind placebo controlled trial of RIT in 22 allergic children 6 to 18 years of age. Systemic reactions (inclusive of isolated urticaria) were reported in 27% of subjects treated with H1 antagonists, H2 antagonists, and glucocorticoids compared with 73% of placebo subjects. One of 11 children experienced anaphylaxis in the treatment group compared with 3 of 11 in the placebo group. However, if additional consideration was given to patients receiving RIT who experienced either anaphylaxis or investigator-classified pulmonary symptoms

(wheezing, shortness of breath, or chest tightness), the difference between active treatment and placebo was 18% versus 45%, respectively.²³⁵ Additional sensitivity analysis performed using this modified definition of anaphylaxis from Portnoy et al²³⁵ did not significantly change results. Exclusion of the RIT patients from Portnoy et al²³⁵ and Hejjaoui et al²²⁹ resulted in an OR of 0.65 (95% CI, 0.41-1.04) for patients in the immunotherapy subgroup.

RECOMMENDATIONS

Question 1. What risk factors should clinicians take into consideration in determining the likelihood of biphasic anaphylaxis?

Recommendation 1. We suggest that a clinician incorporate severity of anaphylaxis presentation and/or the administration of >1 dose of epinephrine for the treatment of initial anaphylaxis as a guide to determining a patient's risk for developing biphasic anaphylaxis. Conditional recommendation. Certainty rating of evidence: very low.

Technical statement. The JTFPP findings suggest biphasic anaphylaxis is associated with a more severe initial presentation

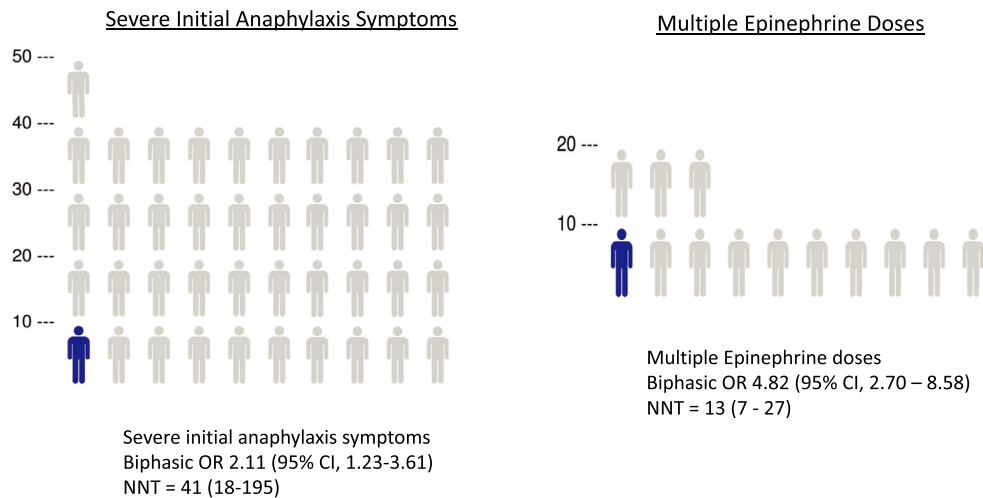


FIG 9. Extended observation to detect biphasic anaphylaxis: number needed to observe.

of anaphylaxis (OR, 2.11; 95% CI, 1.23-3.61) or repeated epinephrine doses (ie, >1 epinephrine dose) required with the initial presentation (OR, 4.82; 95% CI, 2.70-8.58). Additional risk factors identified included wide pulse pressure (OR, 2.11; 95% CI, 1.32-3.37), unknown anaphylaxis trigger (OR, 1.63; 95% CI, 1.14-2.33), cutaneous signs and symptoms (OR, 2.54; 95% CI, 1.25-5.15), and drug trigger in children (OR, 2.35; 95% CI, 1.16-4.76). While dyspnea on presentation was associated with a decreased risk for anaphylaxis, overall confidence in this estimate was low (OR, 0.6; 95% CI, 0.38-0.96).

Recommendation 2. We suggest in favor of extended clinical observation in a setting capable of managing anaphylaxis (to detect biphasic anaphylaxis) for patients with resolved severe anaphylaxis and/or the need for more than one dose of epinephrine. Strength of recommendation: conditional. Certainty of evidence: Very low.

Technical comment. At present, evidence is lacking to clearly demonstrate the period of universal extended observation that may be required or cost-effective in all patients with severe anaphylaxis or those who require multiple doses of epinephrine (Tables II and III). A recent meta-analysis of observation times suggested 1-hour observation was associated with a 95% NPV of biphasic anaphylaxis, while a 6-hour or longer observation period was associated with a 97.3% NPV of biphasic anaphylaxis occurring after discharge.⁵⁷ Based on this analysis, the incremental biphasic PEER between asymptomatic 1-hour and ≥6-hour observation is 2.3%. Therefore, the NNT with extended observation to be able to detect 1 episode of biphasic anaphylaxis before discharge (Fig 9) would be 41 (range, 18 to 195) for patients with a more severe initial presentation of anaphylaxis and 13 (range, 7 to 27) for patients with multiple epinephrine doses.¹⁹⁵ For patients at high risk for biphasic anaphylaxis or those with a higher risk of anaphylaxis fatality (eg, serious medical comorbidities), more prolonged monitoring can be cost-effective.⁵⁸ In a recent analysis, 6-hour observation was cost-effective if it was able to provide a high degree of protection against anaphylaxis fatality (24% fatality relative risk for extended vs 1-hour observation).⁵⁸ Patients with comorbidities such as severe respiratory or cardiac disease and corresponding higher risks for poor anaphylaxis outcomes may therefore benefit from more extended observation. Conversely, in patients presenting with nonsevere

anaphylaxis and promptly responding to a single dose of epinephrine without recurrence, evidence suggests that a 1-hour observation may be reasonable in the context of appropriate patient education.^{57,58} Such lower-risk patients would be characterized as having a very small risk of biphasic anaphylaxis (<5%) following discharge associated with a <50% fatality risk reduction from extended observation.⁵⁸ Therefore, the JTFPP suggests that in patients with a severe initial presentation of anaphylaxis (eg, those with hypotension, wide pulse pressures, multiple doses of epinephrine, or other markers of severity), extended observation should be considered following resolution of the index episodes without recurrence. At present, evidence is lacking to clearly demonstrate the exact period of universal extended observation that may be required or cost-effective in all patients with severe anaphylaxis or those who require multiple doses of epinephrine.^{36,58} In some circumstances a role may exist for shared decision-making tools around the duration of prolonged ED observation.

The JTFPP analysis found additional factors associated with risk of biphasic anaphylaxis that would be difficult to incorporate into clinical triage strategies, such as anaphylaxis caused by a drug trigger in children, anaphylaxis with cutaneous signs and symptoms, and use of glucocorticoids in children. Some of these associations may be confounded by anaphylaxis severity and practice variation, with very low certainty of evidence challenging the applicability of these factors to patient care until they can be further substantiated. For instance, it is highly unlikely that administration of >1 dose of epinephrine or glucocorticoids contributed to biphasic reactions, but very likely that these were indicative of a more significant anaphylactic reaction. It is possible that medication-induced anaphylaxis in children may be a risk factor for biphasic anaphylaxis, but it is not possible to determine whether this is due to having more severe anaphylaxis or whether medication, as a trigger, is an independent risk factor for biphasic anaphylaxis in children. In regard to the association of idiopathic anaphylaxis, follow-up for post-ED identification of a specific trigger was not explored; therefore, the significance of this factor is uncertain. While wide pulse pressures may be considered a marker for severe anaphylaxis, the clinician may also consider extended observation for patients with an unknown anaphylaxis trigger and children with a drug trigger.

TABLE VIII. Evidence to recommendations: Topic area 2

Evaluation and use of supplemental glucocorticoid and/or antihistamine premedication for anaphylaxis prevention		
Population:	Adults and children with anaphylaxis.	
Intervention:	Use of antihistamines and/or glucocorticoids to prevent anaphylactic reactions.	
Comparison:	Not using antihistamines and/or glucocorticoids for the purpose of preventing anaphylaxis.	
Main outcomes:	Prevention of anaphylaxis.	
Setting:	ED, outpatient, medical office, community.	
Perspective:	Clinicians and patients want to know whether anaphylaxis can be prevented with antihistamines and/or glucocorticoids.	
Background:	Clinicians frequently recommend antihistamines and/or glucocorticoids to prevent anaphylaxis. Premedication is often used for chemotherapy, monoclonal antibody infusions, and allergen immunotherapy. However, the benefit of antihistamines and/or glucocorticoids premedication for RCM, as well as each of these other settings, is uncertain. In addition, there is uncertainty whether antihistamines and/or glucocorticoids prevent biphasic anaphylaxis recurrence following resolved anaphylaxis of any cause.	
Conflict of interests:	None.	
Clinical statement		
Very low-certainty evidence suggests that treatment with glucocorticoids, antihistamines, or both as part of initial anaphylaxis management does not provide clear added benefit in preventing biphasic anaphylaxis in patients with resolved anaphylaxis. While a premedication strategy may provide benefit in patients receiving rush aeroallergen immunotherapy and patients receiving some forms of protocol chemotherapy, evidence is lacking to support clear benefit in patients receiving a infliximab without a prior history of anaphylaxis, or in patients with a history of anaphylaxis to RCM receiving an alternative low- or iso-osmolar nonionic RCM agent.		
Assessment		
Judgment	Research evidence	Additional considerations
Problem: Is the problem a priority?		
No	The lifetime prevalence of anaphylaxis is estimated between 1.6% and 5.1%, and biphasic anaphylaxis may occur in up to 20% of patients. ^{1,4} Medications are a leading trigger of anaphylaxis in adults. The prevalence of fatal anaphylaxis is between 0.47 to 0.69 per million persons and 0.25% to 0.33% of ED visits or hospitalizations. ^{9,29,31} Anaphylaxis prevention strategies have used antihistamines and glucocorticoids to prevent subsequent biphasic anaphylaxis in patients with resolved initial anaphylaxis, as well as premedication strategies in instances where the risk of anaphylaxis has been thought to be significant (chemotherapy, monoclonal therapy, RCM use, allergen immunotherapy, and others).	There is some uncertainty as to the exact rate of biphasic anaphylaxis and evidence regarding optimal treatment for biphasic anaphylaxis is scant. There is variation in the patient event rate of anaphylaxis in particular clinical settings.
Probably no		
Probably yes		
Yes		
Varies		
Do not know		
Desirable effects: How substantial are the desirable anticipated effects?		
Trivial	The JTFPP analysis did find a nonsignificant trend to prevention of biphasic anaphylaxis with glucocorticoids (OR, 0.87; 95% CI, 0.74-1.02) and H1 antihistamines (OR, 0.71; 95% CI, 0.47-1.06), but not for H2 antihistamines H2 antihistamines (OR, 1.21; 95% CI, 0.80-1.83).	Certainty of evidence is very low and findings are imprecise. However, it is possible that benefit could be evident in some circumstances. Based on the understanding of antihistamine and glucocorticoid mechanism of action, these therapies could decrease symptoms associated with anaphylaxis, such as urticaria. While this affect could confound the diagnosis of anaphylaxis, it may also provide some benefit in averting unnecessary care for patients who do not experience progression beyond urticaria as the only manifestation of an allergic response.
Small		
Moderate		
Large		
Varies		
Do not know	Premedication did show benefit with rush allergen immunotherapy, with a NNT of 19 (range, 12-119) at an anaphylaxis PEER of 14% from the immunotherapy analysis that included RIT. The JTFPP analysis also showed reduction in anaphylaxis and infusion reaction events with premedication for some chemotherapy agents (OR, 0.49; 95% CI, 0.37-0.66), but not infliximab (RR, 1.58; 95% CI, 0.87-2.87), or RCM (RR, 1.07; 95% CI, 0.67-1.71). However, under the best possible circumstances within these confidence limits, the NNT to prevent anaphylaxis by the administration of premedication would be 13 for chemotherapy and 385 for infliximab therapy. Within the confidence limits, in the setting of alternative low- or iso-osmolar RCM in patients with prior RCM reactions, the NNT would be 36 under the most optimistic scenario of premedication benefit.	
Undesirable effects: How substantial are the undesirable anticipated effects?		
Large	Glucocorticoids and first-generation antihistamines may have adverse effects, particularly in certain more vulnerable populations, which may include sedation and confusion, particularly in the elderly. ²⁵⁴⁻²⁵⁸ Side effects of these therapies may confound recognition, assessment, and/or treatment of	Additional medical complexity of these treatments may create obstacles to efficient health care delivery.
Moderate		
Small		
Trivial		

(Continued)

TABLE VIII. (Continued)

		Assessment
Judgment	Research evidence	Additional considerations
Varies	anaphylaxis. It is unlikely that antihistamines and glucocorticoids increase anaphylaxis risk; however, within the JTF analysis the precision of estimate included the possibility of increased biphasic anaphylaxis. This effect could be confounded by severity of anaphylaxis. Reliance on antihistamines could also result in delay in epinephrine use.	
Do not know		
Certainty of evidence (intentional vagueness): What is the overall certainty of the evidence of effects?		
Very low	Due to very low certainty of evidence and absence of a	The evidence base is of low certainty and a randomized
Low	randomized controlled trial to address this question, there	controlled trial in regard to premedication may be warranted.
Moderate	remains uncertainty and potential bias in the assessment of	
High	benefit or harms from glucocorticoids and/or antihistamines to	
No included studies	prevent anaphylaxis.	
Values (value judgments): Is there important uncertainty about or variability in how much people value the main outcomes?		
Important uncertainty or variability	With greater certainty of benefit, patients would likely accept a	Patients may choose to defer more complex treatment protocols
Possibly important uncertainty or variability	greater rate of adverse effects from glucocorticoids and/or antihistamines; however, with the degree of uncertainty identified in the JTFPP analysis, value judgments may be made by patients and providers in a more personalized context.	that involve glucocorticoids and/or antihistamines if the addition of these agents creates obstacles to care until there is greater certainty of benefit.
Probably no important uncertainty or variability	Patients with comorbidities such as diabetes and poorly controlled hypertension may choose to defer glucocorticoids or antihistamine therapy in some circumstances.	
No important uncertainty or variability		
Balance of effects (benefit-harm assessment): Does the balance between desirable and undesirable effects favor the intervention or the comparison?		
Favors the comparison	Sedation from first-generation antihistamines could be mitigated with the use of a second-generation antihistamine. In patients without comorbidities, the rare use of oral or intravenous glucocorticoids carries a low, overall risk, especially in comparison to anaphylaxis. While rare severe adverse events may occur from first-generation antihistamine or glucocorticoid (eg, fatal automobile accidents and aseptic necrosis of the hip), the likelihood of such events after single course of therapy would be very low. While under the best-case scenario, benefit from glucocorticoids and antihistamines could be evident with a NNT of 20 to 30 patients in some settings, all patients receiving therapy experience increased risk of adverse effects, medical complexity, and cost.	While this analysis is focused on anaphylaxis prevention, the greatest harm of glucocorticoids and/or antihistamines is the risk for delay in treatment with epinephrine.
Probably favors the comparison		
Does not favor either the intervention or the comparison		
Probably favors the intervention		
Favors the intervention		
Varies		
Do not know		
Resources required: How large are the resource requirements (costs)?		
Large costs	Costs on a societal level could be moderate, particularly if sedating antihistamines are used and lead to job-related opportunity costs or sedation-related traffic accidents. Indirect costs include time delays, opportunity costs, sedation, traffic accidents, management of hyperglycemia, and other adverse effects of therapy. However, in the best-case scenario costs of anaphylaxis could be prevented for every 20 to 30 patients treated in some settings.	If extended observation times are associated with additional treatment, or if parenteral treatments are administered, costs would be greater.
Moderate costs		
Negligible costs and savings		
Moderate savings		
Large savings		
Varies		
Do not know		
Certainty of evidence of required resources: What is the certainty of the evidence of resource requirements (costs)?		
Very low	There is uncertainty in the evidence of required resources as randomized controlled trials of glucocorticoid and antihistamine premedication are sparse. While treatment protocols of glucocorticoids and antihistamines to prevent biphasic anaphylaxis and prevention of monoclonal antibody anaphylaxis may vary, strategies for RCM premedication are more standardized. ¹⁷ Portnoy et al ²³⁵ began pretreatment 1 d prior to RIT.	There is some uncertainty as to whether more or fewer resources would be required for observation, given that the current use of antihistamines and glucocorticoids may provide a false sense of security that the patient has a significantly lower risk of anaphylaxis
Low		
Moderate		
High		
No included studies		
Cost effectiveness: Does the cost-effectiveness of the intervention favor the intervention or the comparison?		
Favors the comparison	If observation time is unaffected, there would be a minimal reduction in cost from omitting treatment with antihistamines and glucocorticoids to prevent biphasic anaphylaxis. However, if observation time was increased due to the withholding of these medications, there could be increased overall costs.	Cost-effectiveness would likely be sensitive to rates of anaphylaxis, hospitalization, and fatality risk reduction.
Probably favors the comparison		
Does not favor either the intervention		

(Continued)

TABLE VIII. (Continued)

Assessment		
Judgment	Research evidence	Additional considerations
or the comparison Probably favors the intervention Favors the intervention Varies Do not know No included studies	Lower costs would be expected with opportunity cost-savings from decreased medical complexity in premedication regimens; however, costs could be offset by increased rates of anaphylaxis. In the setting of RIT, costs of antihistamine and glucocorticoid premedication are small, and with benefit evident in at least 1 RCT the premedication approach is likely cost-effective. ²³⁵ In addition, 1 small study suggested benefit from antihistamine premedication before conventional immunotherapy. ⁴⁶	
Equity: What would be the impact on health equity?		
Reduced Probably reduced Probably no impact Probably increased Increased Varies Do not know	Increased medical complexity may increase disparities in health equity. In rural settings, access to 24-h pharmacies may limit immediate availability of antihistamine and glucocorticoid treatments if an outpatient course is prescribed following resolution of anaphylaxis. In addition, as the complexity of care increases by the use of premedication regimens, the degree to which delivery of care shifts from primary to subspecialty is uncertain. Patients with poor health literacy may be at risk for incorrect dosing of home regimens as preventative anaphylaxis strategies become more complicated.	Oral antihistamines and oral glucocorticoids are relatively inexpensive, so it is possible in some circumstances health equity impact could be minimal. However, if patients are treated for anaphylaxis at home for complete symptom resolution and further extended observation is driven by the practice of administering antihistamines and glucocorticoids, the effect on health equity could be more pronounced. As such, elimination of routine use of antihistamines and glucocorticoids to prevent biphasic anaphylaxis could improve health equity.
Acceptability and quality improvement opportunity: Is the intervention acceptable to key stakeholders?		
No Probably no Probably yes Yes Varies Do not know	Antihistamines and glucocorticoids are common medications used to treat and prevent allergic reactions. While these treatments should not interfere with prompt administration of epinephrine in anaphylaxis treatment, they are often administered as first-line drugs with a wait-and-see approach before epinephrine is administered. It has been shown that epinephrine is often omitted in the ED setting while antihistamines and glucocorticoids are administered for a diagnosis of anaphylaxis. Therefore, the administration of epinephrine for all patients with anaphylaxis and the withholding of antihistamines and corticosteroids for some patients will not be acceptable to all professional stakeholders. Many patients are very willing to take an antihistamine but delay self-administration of epinephrine even when they know they are having severe anaphylaxis. This guideline will likely do little to change patient behavior. Conveying the message to professionals and patients that these agents should be considered as adjunct therapies to decrease symptoms associated with anaphylaxis, such as urticaria, and not a primary treatment for anaphylaxis will require continued educational efforts. When antihistamines and corticosteroids are used with the intent of anaphylaxis prevention, evidence generally suggests that the likelihood of benefit is low and uncertain in most settings. However, as in situations of anaphylaxis treatment, antihistamines and corticosteroids may decrease risks of symptoms associated with anaphylaxis, such as urticaria. While the administration of these agents may delay recognition of anaphylaxis, they may also prevent unnecessary escalation of treatment for nonanaphylactic allergic symptoms. Evidence suggests benefit of corticosteroids and antihistamines in RIT to prevent anaphylaxis. Given that a similar mechanism of action by corticosteroids and antihistamines could also occur in anaphylaxis prevention in other situations, the beneficial use of these agents may be identified in future therapeutic trials. The NNT to prevent anaphylaxis will depend on the underlying patient expected event rate for anaphylaxis from a specific trigger.	The practice of treating patients experiencing anaphylaxis with antihistamines and glucocorticoids is fairly embedded into common practice styles. Stakeholders may weigh the risks of biphasic anaphylaxis more heavily than the risks of these medications and be uncomfortable with the risk benefit of denying adjunct treatment.
Feasibility: Is the intervention feasible to implement?		
No Probably no	Use of antihistamines and glucocorticoids by ED physicians to both treat and prevent anaphylaxis is widespread. The very	Additional high-certainty evidence is needed to better inform

(Continued)

TABLE VIII. (Continued)

Assessment		
Judgment	Research evidence	Additional considerations
Probably yes Yes Varies Do not know	low-certainty evidence from this meta-analysis and the current placement of these drugs as adjunctive agents (in addition to epinephrine) for the treatment of anaphylaxis makes practice change challenging. Likewise, office-based clinicians and patients are comfortable using an antihistamine for both the prevention and treatment of an allergic reactions. Given the evidence provided in this analysis, clinicians may consider withholding glucocorticoids prior to infliximab treatment and in patents with prior RCM anaphylaxis receiving an alternative low- or iso-osmolar agent. Patients receiving RIT may consider treatment with antihistamines and glucocorticoids While further study is needed, 1 study suggests possible benefit from antihistamine premedication before conventional aeroallergen immunotherapy. ⁴⁶	practice as to the role of antihistamines and glucocorticoids for the purpose of preventing anaphylaxis.
Intentional vagueness		
Yes	Due to low certainty of evidence and absence of a randomized controlled trials in most settings evaluated, there remains uncertainty in the role of antihistamines and glucocorticoids in the prevention of anaphylaxis.	Additional high-certainty evidence is needed to better inform practice.
Role of patient preference		
Probably yes	Patients may feel “safer” with the use of antihistamines and/or glucocorticoids, but this preference is likely to be highly influenced by counseling and education they receive from health care providers. The patient will need education and reeducation on the signs and symptoms of anaphylaxis and on the use of epinephrine as the only first-line medication for the treatment of anaphylaxis. Providers cannot allow the patient to “prefer” an antihistamine over epinephrine for the treatment of anaphylaxis. Patient preference may be a consideration in the use of antihistamines and glucocorticoids as second-line medications following epinephrine administration. Antihistamines and glucocorticoids may provide some role in treating the urticaria and pruritus occurring during anaphylaxis.	Shared decision making would be appropriate in some circumstances given the absence of clear benefit in prevention of anaphylaxis with antihistamines and glucocorticoids in many settings. Patient-preference sensitive care could address unwarranted practice variation to prevent biphasic anaphylaxis, monoclonal antibody anaphylaxis, and RCM anaphylaxis prevention.
Exclusions		
Yes	Given the low certainty of evidence, it is not possible to completely exclude subpopulations that may experience more pronounced benefit from a particular intervention to prevent anaphylaxis. The meta-analysis evaluated the role of antihistamine and/or glucocorticoid in prevention (not treatment) of anaphylaxis. In addition, children receiving chemotherapy, patients receiving chemotherapy desensitization, and patients with delayed RCM reactions were not included in the meta-analysis.	
Policy level		
No	We would not recommend policy-level interventions to either mandate or limit the use of supplemental therapy in anaphylaxis as the certainty of evidence relating to this question is very low.	

Boldface indicates guideline group judgment in each domain.

Incorporating cutaneous signs and symptoms into a clinical decision for extended observation may be limited by the common occurrence of cutaneous signs and symptoms in patients presenting with anaphylaxis. There was no signal that any medication other than epinephrine used for treatment of initial anaphylaxis reduced the risk of biphasic anaphylaxis. Notably, there does appear to be a trend to lower rates of biphasic reactions with earlier epinephrine administration following development of anaphylaxis. While early epinephrine in the setting of

anaphylaxis is important, evidence suggests preemptive epinephrine before symptom onset is generally not a cost-effective strategy.⁵⁴

Prompt and adequate treatment of anaphylaxis appears central to reducing biphasic anaphylaxis risk. The implications for the clinician, based on this systematic review and meta-analysis, is that the patient presenting with severe anaphylaxis and/or requiring more aggressive treatment (eg, >1 dose of epinephrine), following complete resolution of symptoms, may benefit from

longer observation time for a potential biphasic reaction. While the possibility of biphasic anaphylaxis should be emphasized in this higher-risk group, it is important to educate all patients on the chance of a biphasic reaction as well as avoiding known triggers, identifying symptoms of anaphylaxis, the use of auto-injector epinephrine for the treatment of anaphylaxis, and timely follow-up with an allergist.

Question 2. Should antihistamines or glucocorticoids be used to prevent biphasic anaphylaxis?

Recommendation. We suggest against administering glucocorticoids or antihistamines as an intervention to prevent biphasic anaphylaxis. **Strength of recommendation: conditional. Certainty of evidence: very low.**

Technical comment. As a secondary therapy, antihistamines and glucocorticoids may be considerations in anaphylaxis treatment.⁴⁵ In particular, antihistamines may treat urticaria and itching to improve comfort during anaphylaxis, but if used prior to epinephrine administration, they could lead to a delay in first-line treatment of anaphylaxis. The JTFPP analysis did not identify significant benefit in prevention of biphasic anaphylaxis from H1 antihistamines (OR, 0.71; 95% CI, 0.47-1.06), H2 antihistamines (OR, 1.21; 95% CI, 0.80-1.83), or glucocorticoids (OR, 0.87; 95% CI, 0.74-1.02). An interaction was identified between age and glucocorticoid use, with glucocorticoids actually increasing risk for biphasic anaphylaxis in children (OR, 1.55; 95% CI, 1.01-2.38); however, confounding effect of severity could not be excluded. Evaluation of the NNT of patients to potentially reduce biphasic anaphylaxis rates is useful.¹⁹⁵

At a biphasic anaphylaxis PEER of 5%, the NNT for H1 antihistamines is 72 to prevent 1 episode of biphasic anaphylaxis. At a biphasic anaphylaxis PEER of 20%, the NNT (to prevent 1 case of biphasic anaphylaxis) for H1 antihistamines is 20. However, neither of these values is certain, and confidence in the benefit of treatment is low, with an association of increased biphasic anaphylaxis rates within the confidence estimate.

At biphasic anaphylaxis PEERs of 5% and 20%, H2 antihistamine use is not associated with a decreased risk of biphasic anaphylaxis. However, the degree of certainty that H2 antihistamine therapy did not provide any possibility of benefit is uncertain.

At a biphasic anaphylaxis PEER of 5%, the NNT for glucocorticoids is 161 to prevent 1 case of biphasic anaphylaxis (and 47 at a biphasic anaphylaxis PEER of 20%). Again, neither of these values is certain, and confidence in the benefit of treatment is low, with an association of increased biphasic anaphylaxis rates within the confidence estimate.

Certainty of evidence is very low, and additional well-designed controlled trials are needed to further inform this practice (Tables VIII and IX). However, the JTFPP strongly recommends that secondary therapies never interfere with early epinephrine treatment, as this is the primary medication for the treatment of anaphylaxis.⁴⁵ The use of antihistamines may be associated with side effects that could confound assessment of anaphylaxis, such as altered level of consciousness with first-generation antihistamines. Harms from high-dose glucocorticoids may also outweigh benefits; however, due to the very low certainty of evidence (risk of bias, inconsistency, and imprecision), there

remains uncertainty in the assessment of benefit versus no benefit from supplemental therapies.

Question 3. Should antihistamine and/or glucocorticoid premedication be used to prevent index hypersensitivity/infusion reactions to chemotherapy?

Recommendation. We suggest in favor of administering glucocorticoids and/or antihistamines to prevent anaphylaxis or infusion-related reaction when indicated for specific agents in chemotherapy protocols. **Strength of recommendation: conditional. Certainty of evidence: very low.**

Technical comment. The JTFPP analysis did identify a significant change in rates of anaphylaxis and/or infusion reactions for some chemotherapy protocols. The use of premedication was associated with a decreased rate of HSRs for chemotherapy (OR, 0.49; 95% CI, 0.37-0.66). In contrast to chemotherapy premedication, benefit was not observed when using premedication to prevent anaphylaxis in the setting of infliximab therapy without prior reaction to the administered agent (risk ratio, 1.58; 95% CI, 0.87-2.87). We did not evaluate premedication in the context of desensitization to chemotherapy agents and to monoclonal antibodies. Furthermore, the use of premedication in patients who had previously experienced anaphylaxis from these agents was not evaluated.

At an anaphylaxis PEER of 12.9%, chemotherapy premedication is associated with a decreased risk of anaphylaxis. The NNT is 16 (range, 13-25).

At an anaphylaxis PEER of 2%, infliximab premedication is not associated with a decreased risk of anaphylaxis. However, the degree of certainty that therapy did not provide any possibility of benefit was very low. It is not possible to exclude some potential benefit from the use of glucocorticoids and/or antihistamines to prevent anaphylaxis, and additional well-designed controlled trials are needed to further inform this practice. A clinician may reasonably defer premedication use for the intention of preventing anaphylaxis. If standard practice dictates the use of premedication prior to the administration of infliximab, it would be reasonable to discontinue the premedication following tolerance of the first or second course of treatment.

Question 4. Should antihistamine and/or glucocorticoid premedication be used to prevent recurrent HSRs to RCM?

Recommendation. We suggest against routinely administering glucocorticoids and/or antihistamines to prevent anaphylaxis in patients with prior radiocontrast HSRs when readministration of a low- or iso-osmolar, nonionic RCM agent is required. **Strength of recommendation: conditional. Certainty of evidence: very low.**

Technical comment. The JTFPP analysis did not identify significant benefit from the use of premedication prior to the RCM to prevent anaphylaxis (risk ratio, 1.07; 95% CI, 0.67-1.71). The absence of benefit of premedication in patients with prior immediate HSRs to RCM who are receiving a different low- or iso-osmolar agent is consistent with prior literature; however, it is important to distinguish the immediate index reaction associated with RCM from a severe, delayed, cutaneous T-cell-mediated reaction, where premedication may add value to management.¹⁷

TABLE IX. Topic area 2 summary of judgments

				Judgment			
Problem is a priority	No	Probably no	Probably yes	Yes	Varies	Do not know	
Desirable effects	Trivial	Small	Moderate	Large	Varies	Do not know	
Undesirable effects	Large	Moderate	Small	Trivial	Varies	Do not know	
Certainty of evidence	Very low	Low	Moderate	High	No included studies		
Values	Important uncertainty or variability	Possibly important uncertainty or variability	Probably no important uncertainty or variability	No important uncertainty or variability			
Balance of effects, benefits, harms, and burdens	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	Do not know
Resources required	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	Varies	Do not know
Certainty of evidence of required resources	Very low	Low	Moderate	High	No included studies		
Cost effectiveness	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	No included studies
Equity	Reduced	Probably reduced	Probably no impact	Probably increased	Increased	Varies	Do not know
Acceptability	No	Probably no	Probably yes	Yes	Varies	Do not know	
Feasibility	No	Probably no	Probably yes	Yes	Varies	Do not know	

Boldface indicates guideline group judgment in each domain.

Risk of bias, inconsistency, imprecision, and indirectness attenuate the confidence in this guidance.

At a PEER of 8.7%, RCM premedication is not associated with a decreased risk of anaphylaxis. However, the degree of certainty that therapy did not provide any possibility of benefit is low.

Given the diversity of clinical circumstances evaluated and low confidence in the literature base, higher certainty evidence is needed to better inform practice, and future recommendations could potentially change as a result of new information (Tables VIII and IX).²⁵⁴⁻²⁵⁸ As such, clinicians may reasonably consider premedication in clinical circumstances associated with a high level of perceived risk of anaphylaxis or comorbidities associated with greater anaphylaxis fatality risk (such as underlying cardiovascular disease or use of beta-blockers, prior severe anaphylaxis), although evidence is lacking to clearly support this practice. Additional well-designed controlled trials are needed to further clarify the need for premedication prior to alternative low- or iso-osmolar RCM use in patients with prior anaphylaxis to prevent recurrence. This analysis evaluated patients with both mild and severe RCM reactions, but we were unable to stratify prophylaxis by severity of index reaction. Our analysis evaluated only low- and iso-osmolar nonionic radiocontrast agents and as such does not apply to patients receiving high-osmolar contrast agents for whom prophylaxis may be appropriate.²⁵⁹

Question 5. Should antihistamine and/or glucocorticoid premedication be used to prevent HSRs to allergen immunotherapy or other agents?

Recommendation. We suggest the administration of glucocorticoids and/or antihistamines as an intervention to prevent anaphylaxis in patients undergoing aeroallergen

RIT. Strength of recommendation: conditional. Certainty of evidence: very low.

Technical comment. Evidence suggests that in the setting of aeroallergen RIT, premedication may provide value in reducing systemic reactions and anaphylaxis (immunotherapy analysis including RIT: risk ratio, 0.62; 95% CI, 0.41-0.94). In the study by Portnoy et al,²³⁵ patients received H1 and H2 antagonists and oral glucocorticoids for 3 days, beginning 1 day before the 2-day RIT protocol. The evidence base for premedication before conventional aeroallergen immunotherapy is limited; however, a study by Ohashi et al⁴⁶ suggested some benefit with fexofenadine pretreatment 2 hours before conventional immunotherapy using cedar pollen or dust mite allergens. The evaluation of the NNT of patients to prevent 1 episode of anaphylaxis is useful.

The NNT to prevent 1 case of anaphylaxis with RIT premedication at a 4.5% rate of anaphylaxis is 58, based on the immunotherapy analysis including RIT studies. At a 9% rate of anaphylaxis, the NNT of premedication for RIT is 29. Assuming a patient expected anaphylaxis event rate of 14%, the premedication NNT is 19.

The JTFPP is unable to exclude the possibility that specific situations and subpopulations may exist where premedication could provide benefit to immunotherapy in those with concomitant risk factors (eg, in situations associated with higher rates of systemic reactions). Given the diversity of clinical circumstances evaluated and low confidence in the literature base, higher certainty evidence is needed to better inform practice, and future recommendations could potentially change as a result of new information. As such, clinicians may reasonably consider immunotherapy premedication in other clinical circumstances associated with a high level of perceived risk of anaphylaxis or comorbidities associated with greater anaphylaxis fatality risk

(such as underlying cardiovascular disease or use of beta-blockers), although high-certainty evidence is lacking to support this practice.

Additional good practice statements

GRADE provides a framework to evaluate evidence certainty and translate evidence to recommendations; however, some aspects of clinical practice are difficult to rigorously evaluate due to ethical and practical limitations. Despite these limitations, the JTFPP believes the following good practice statements are important and associated with optimal patient outcomes:

Good practice statement 1. Administer epinephrine as the first-line pharmacotherapy for uniphasic and/or biphasic anaphylaxis.

Good practice statement 2. Do not delay the administration of epinephrine for anaphylaxis, as doing so may be associated with higher morbidity and mortality.

Good practice statement 3. After diagnosis and treatment of anaphylaxis, all patients should be kept under observation in a setting capable of managing anaphylaxis until symptoms have fully resolved.

Good practice statement 4. All patients with anaphylaxis should receive education on anaphylaxis, including avoidance of identified triggers, presenting signs and symptoms, biphasic anaphylaxis, treatment with epinephrine, and the use of epinephrine auto-injectors, and they should be referred to an allergist. Of note, there may be some circumstances where self-injectable epinephrine is deferred (ie, resolved anaphylaxis and drug trigger with high likelihood of successful avoidance) and shared decision making may play a role in some circumstances.

LIMITATIONS

Unfortunately, the certainty of evidence around supplemental therapies in anaphylaxis management is very low. While early epinephrine is recommended by the JTFPP when anaphylaxis is recognized in any setting, whether clinicians should (or should not) also administer antihistamines and/or glucocorticoids is a question that has not been subjected to rigorous methodologic evaluation.

All patients with anaphylaxis should be educated regarding the risk for biphasic reactions, and self-injectable epinephrine should be available at discharge for prompt treatment if this occurs. Patients who experience greater severity of anaphylaxis are at greater risk for biphasic reaction, but the absolute risk of biphasic reactions in this population is less clear. While >1 dose of epinephrine was identified as a risk factor for biphasic anaphylaxis, we did not specifically evaluate this risk factor in the context of repeated subtherapeutic epinephrine dosing. The JTFPP recommends epinephrine be given promptly in appropriate doses when anaphylaxis is recognized. It is important to distinguish biphasic anaphylaxis (with an interval period of clear resolution) from protracted anaphylaxis. In circumstances where prescribed self-injectable epinephrine is not immediately available on discharge (eg, limited pharmacy hours or affordability), clinical judgment regarding risk of biphasic or recurrent anaphylaxis, access to subsequent emergency care, and shared decision making will be required to determine discharge decisions.

Our analysis is similar to results obtained by Ellis and Day³⁹ in which glucocorticoids demonstrated a nonsignificant inverse trend with biphasic anaphylaxis; however, caution is warranted in interpretation of these findings—particularly given the opposite association of glucocorticoids with biphasic anaphylaxis in children (which may be confounded by severity of index anaphylaxis and practice variation). Ultimately a randomized controlled trial of supplemental glucocorticoids and antihistamines in patients adequately treated with epinephrine with resolved anaphylaxis is needed to determine whether these agents prevent biphasic anaphylaxis.

We did not find clear evidence to support the role of glucocorticoids and/or antihistamines to prevent biphasic anaphylaxis. Clear evidence is also lacking to support a role for glucocorticoids and/or antihistamines in acute anaphylaxis, although the Cross-Canada Anaphylaxis registry recently suggested supplemental antihistamines may provide benefit when used with epinephrine.¹⁶⁴ In the same study,¹⁶⁴ supplemental use of glucocorticoids with epinephrine resulted in worse outcome.

The absence of benefit of premedication in patients with prior immediate HSRs to RCM who are receiving a different low- or iso-osmolar agent is consistent with prior literature;^{17,259,260} however, it is important to distinguish the immediate index reaction associated with RCM from a severe, delayed, cutaneous T-cell-mediated reaction, where premedication may add value to management. Patients receiving RCM may experience acute or delayed reactions.¹⁷ Four categories of reactions to RCM have been described: benign acute onset, anaphylaxis, benign delayed onset, and severe delayed onset.¹⁷ In a 2017 review²⁶¹ of 120,822 patients receiving low- or iso-osmolar agents (iopromide, iodixanol, iopamidol, ioversol, iobitridol, or iohexol), HSRs were reported in 0.4% with only 1.4% of these reactions described as severe. The JTFPP agrees with the suggestion that most individuals with acute RCM hypersensitivity can be effectively managed by selecting an alternative low- or iso-osmolar RCM without premedication;¹⁷ however, some controversy exists around the management of patients with prior RCM reactions.^{17,259,260,262} The American College of Radiology's *ACR Manual on Contrast Media Version 10.3*²⁶² emphasizes that no premedication strategy is a substitute for anaphylaxis preparedness, breakthrough reactions occur, and changing to an alternative low- or iso-osmolar contrast agent may provide a greater effect size than premedication alone. While premedication before high-osmolar agents has been shown to reduce immediate reactions of all severity in average-risk patients and mild immediate adverse effects in average-risk patients receiving low-osmolar agents, protection from premedication against moderate to severe reactions in high-risk patients receiving low-osmolar agents is unproven by high-certainty evidence, with estimates suggesting the NNT to prevent a fatal reaction in a high risk patient to be 50,000 (at a cost of \$131,211,400 per death prevented).^{259,262,263} The *ACR Manual*²⁶² suggests the utility of premedication in high-risk patients receiving low-osmolar contrast is uncertain and may be accompanied by direct and indirect harms, but that it may be considered in outpatients with prior allergic-like or unknown-type contrast reactions and in similar inpatients where the use of premedication does not adversely delay care or treatment decisions. The *ACR Manual*²⁶² also suggests that regardless of patient status, a history of a severe contrast reaction be considered a relative contraindication to the future use of the same class of media

and premedication be considered (if feasible) if there are no alternatives. High-quality studies are needed to better inform the practice of RCM premedication in high-risk patients, and future studies should distinguish among immediate and delayed, cutaneous and noncutaneous, mild and severe reactions and should stratify premedication by anaphylactic, hemodynamic, and chemotactic reaction types.

The role of glucocorticoid and/or antihistamine premedication in more high-risk settings (such as RIT) may be significant, and until additional evidence better informs practice, premedication may be appropriate in circumstances where a high risk of anaphylaxis exists. The lack of benefit from infliximab premedication in patients without prior infusion reactions is consistent with a recent meta-analysis.²⁶⁴

Large heterogeneity in analyses and limitations in study design attenuate the confidence in this evidence synthesis. We did not evaluate premedication in the context of desensitization to chemotherapy and monoclonal antibodies.²⁶⁵ The JTFPP continues to recommend prompt treatment of anaphylaxis with epinephrine and highlight that the addition of glucocorticoids and antihistamines should never delay or substitute for this primary management.

FUTURE DIRECTIONS

At present, high-certainty evidence is lacking to determine whether antihistamines and/or glucocorticoids provide benefit as supplemental therapies in anaphylaxis management in patients promptly and appropriately treated with epinephrine. In addition, it seems unlikely that antihistamine and/or glucocorticoid premedication is likely to offer clear benefit in the prevention of RCM anaphylaxis in patients with a history of immediate RCM hypersensitivity receiving an alternative low- or iso-osmolar RCM agent or in patients receiving infliximab who have not previously experienced an infliximab HSR. However, because the evidence synthesis contained in this practice parameter is derived from low-certainty, nonrandomized trials, additional research evaluating common practices in anaphylaxis treatment and prevention is urgently needed. Further studies are needed to evaluate the use of premedication in children receiving chemotherapy and the use of premedication in subjects undergoing chemotherapy desensitization. In some situations involving anaphylaxis prevention and management, shared decision making, taking into account patients' preferences and values, should be utilized, particularly when determining the length of medical observation following resolved anaphylaxis. In anaphylaxis, as in many other medical conditions, shared decision making, which entails patients (and their families) being fully informed of pros and cons of receiving a diagnostic or therapeutic intervention and participating in the medical decision making process, is appropriate in the context of desirable outcomes being closely balanced with undesirable outcomes, which in our guideline is reflected by the navigational signal to the clinician of a conditional (or "weak") recommendation.

CONCLUSIONS

Anaphylaxis is a multisystem allergic emergency. Early recognition and prompt administration of intramuscular epinephrine remain the cornerstone of management. Risk factors for biphasic reactions include severe anaphylaxis and/or the need for >1 dose of epinephrine. Additional biphasic anaphylaxis risk factors

include wide pulse pressures, unknown anaphylaxis trigger, cutaneous signs and symptoms, and drug trigger in children. Although treatment of anaphylaxis in the United States also traditionally has included use of antihistamines and glucocorticoids, data demonstrating the benefit of these additional approaches are very low certainty and when evaluated on the whole do not offer clear support for this practice to prevent biphasic anaphylaxis. Supplemental therapies such as glucocorticoids and antihistamines should never delay the rapid administration of epinephrine as soon as anaphylaxis is recognized. Consistent with the lack of clear benefit of antihistamines and/or glucocorticoids in prevention of biphasic anaphylaxis, current evidence is poor that routine use of these therapies prevents anaphylaxis in patients with a history of RCM HSRs (vs using a low- or iso-osmolar contrast without premedication, preferably an alternative agent) or in patients receiving infliximab without prior anaphylaxis; however, some circumstances do exist where premedication with antihistamines and/or glucocorticoids is warranted (eg, RIT and some forms of chemotherapy). As such, while prompt recognition and administration of epinephrine remains paramount in anaphylaxis management, clinical judgment is an irreplaceable key factor to optimize high-quality care.

REFERENCES

- Wood RA, Camargo CA Jr, Lieberman P, Sampson HA, Schwartz LB, Zitt M, et al. Anaphylaxis in America: the prevalence and characteristics of anaphylaxis in the United States. *J Allergy Clin Immunol* 2014;133:461-7.
- Buka RJ, Knibb RC, Crossman RJ, Melchior CL, Huissoon AP, Hackett S, et al. Anaphylaxis and clinical utility of real-world measurement of acute serum tryptase in UK emergency departments. *J Allergy Clin Immunol Pract* 2017;5:1280-7.e2.
- Loprinzi Brauer CE, Motosue MS, Li JT, Hagan JB, Bellolio MF, Lee S, et al. Prospective validation of the NIAID/FAAN criteria for emergency department diagnosis of anaphylaxis. *J Allergy Clin Immunol Pract* 2016;4:1220-6.
- Lieberman P, Camargo CA Jr, Bohlke K, Jick H, Miller RL, Sheikh A, et al. Epidemiology of anaphylaxis: findings of the American College of Allergy, Asthma and Immunology Epidemiology of Anaphylaxis Working Group. *Ann Allergy Asthma Immunol* 2006;97:596-602.
- Simons FE, Arduzzo LR, Bilo MB, Cardona V, Ebisawa M, El-Gamal YM, et al. International consensus on (ICON) anaphylaxis. *World Allergy Organ J* 2014;7:9.
- Jacobs TS, Greenhawt MJ, Hauswirth D, Mitchell L, Green TD. A survey study of index food-related allergic reactions and anaphylaxis management. *Pediatr Allergy Immunol* 2012;23:582-9.
- Clark S, Wei W, Rudders SA, Camargo CA Jr. Risk factors for severe anaphylaxis in patients receiving anaphylaxis treatment in US emergency departments and hospitals. *J Allergy Clin Immunol* 2014;134:1125-30.
- Jerschow E, Lin RY, Scaperotti MM, McGinn AP. Fatal anaphylaxis in the United States, 1999-2010: temporal patterns and demographic associations. *J Allergy Clin Immunol* 2014;134:1318-28.e7.
- Turner PJ, Gowland MH, Sharma V, Ierodiakonou D, Harper N, Garcez T, et al. Increase in anaphylaxis-related hospitalizations but no increase in fatalities: an analysis of United Kingdom national anaphylaxis data, 1992-2012. *J Allergy Clin Immunol* 2015;135:956-63.e1.
- Liew WK, Chiang WC, Goh AE, Lim HH, Chay OM, Chang S, et al. Paediatric anaphylaxis in a Singaporean children cohort: changing food allergy triggers over time. *Asia Pac Allergy* 2013;3:29-34.
- Grabenhenrich LB, Dolle S, Moneret-Vautrin A, Kohli A, Lange L, Spindler T, et al. Anaphylaxis in children and adolescents: the European Anaphylaxis Registry. *J Allergy Clin Immunol* 2016;137:1128-37.e1.
- Gonzalez-Estrada A, Silvers SK, Klein A, Zell K, Wang XF, Lang DM. Epidemiology of anaphylaxis at a tertiary care center: a report of 730 cases. *Ann Allergy Asthma Immunol* 2017;118:80-5.
- Carrard A, Rizzuti D, Sokollik C. Update on food allergy. *Allergy* 2015;70:1511-20.
- Gupta RS, Springston EE, Warrier MR, Smith B, Kumar R, Pongracic J, et al. The prevalence, severity, and distribution of childhood food allergy in the United States. *Pediatrics* 2011;128:e9-17.
- Gupta RS, Warren CM, Smith BM, Jiang J, Blumenstock JA, Davis MM, et al. Prevalence and severity of food allergies among US adults. *JAMA Netw Open* 2019;2:e185630.

16. World Allergy Organization. White Book on Allergy: Update 2013, Executive Summary. Milwaukee, WI: World Allergy Organization; 2013.
17. Macy EM. Current epidemiology and management of radiocontrast-associated acute- and delayed-onset hypersensitivity: a review of the literature. *Perm J* 2018;22:17-072.
18. Galli SJ, Tsai M. IgE and mast cells in allergic disease. *Nat Med* 2012;18:693-704.
19. Finkelman FD, Khodoun MV, Strait R. Human IgE-independent systemic anaphylaxis. *J Allergy Clin Immunol* 2016;137:1674-80.
20. Stone SF, Cotterell C, Isbister GK, Holdgate A, Brown SG. Emergency Department Anaphylaxis Investigators. Elevated serum cytokines during human anaphylaxis: identification of potential mediators of acute allergic reactions. *J Allergy Clin Immunol* 2009;124:786-92.e4.
21. Brown SG, Stone SF, Fatovich DM, Burrows SA, Holdgate A, Celenza A, et al. Anaphylaxis: clinical patterns, mediator release, and severity. *J Allergy Clin Immunol* 2013;132:1141-9.e5.
22. Sampson HA, Munoz-Furlong A, Campbell RL, Adkinson NF Jr, Bock SA, Brannum A, et al. Second symposium on the definition and management of anaphylaxis: summary report—Second National Institute of Allergy and Infectious Disease/Food Allergy and Anaphylaxis Network Symposium. *Ann Emerg Med* 2006;47:373-80.
23. Curtis C, Stukus D, Scherzer R. Epinephrine preparedness in pediatric patients with food allergy: an ideal time for change. *Ann Allergy Asthma Immunol* 2014;112:560-2.
24. Prince BT, Mikhail I, Stukus DR. Underuse of epinephrine for the treatment of anaphylaxis: missed opportunities. *J Asthma Allergy* 2018;11:143-51.
25. Robinson M, Greenhawt M, Stukus DR. Factors associated with epinephrine administration for anaphylaxis in children before arrival to the emergency department. *Ann Allergy Asthma Immunol* 2017;119:164-9.
26. Simons KJ, Simons FE. Epinephrine and its use in anaphylaxis: current issues. *Curr Opin Allergy Clin Immunol* 2010;10:354-61.
27. Kaliner M, Austen KF. Cyclic AMP, ATP, and reversed anaphylactic histamine release from rat mast cells. *J Immunol* 1974;112:664-74.
28. Liew WK, Williamson E, Tang ML. Anaphylaxis fatalities and admissions in Australia. *J Allergy Clin Immunol* 2009;123:434-42.
29. Castells M. An epidemiological approach to reducing the risk of fatal anaphylaxis. Totowa, NJ: Humana Press; 2011.
30. Lauritano EC, Novi A, Santoro MC, Casagrande I. Incidence, clinical features and management of acute allergic reactions: the experience of a single, Italian Emergency Department. *Eur Rev Med Pharmacol Sci* 2013;17(Suppl 1):39-44.
31. Ma L, Danoff TM, Borish L. Case fatality and population mortality associated with anaphylaxis in the United States. *J Allergy Clin Immunol* 2014;133:1075-83.
32. Church MK, Church DS. Pharmacology of antihistamines. *Indian J Dermatol* 2013;58:219-24.
33. Inagaki N, Miura T, Nagai H, Koda A. Inhibitory effects of glucocorticoids on increased vascular permeability caused by passive cutaneous anaphylaxis and some chemical mediators in rats. *Jpn J Pharmacol* 1988;46:189-92.
34. Choo KJ, Simons FE, Sheikh A. Glucocorticoids for the treatment of anaphylaxis. *Evid Based Child Health* 2013;8:1276-94.
35. Pourmand A, Robinson C, Syed W, Mazer-Amirshahi M. Biphasic anaphylaxis: a review of the literature and implications for emergency management. *Am J Emerg Med* 2018;36:1480-5.
36. Lieberman P. Biphasic anaphylactic reactions. *Ann Allergy Asthma Immunol* 2005;95:217-26.
37. Stark BJ, Sullivan TJ. Biphasic and protracted anaphylaxis. *J Allergy Clin Immunol* 1986;78:76-83.
38. Sampson HA, Mendelson L, Rosen JP. Fatal and near-fatal anaphylactic reactions to food in children and adolescents. *N Engl J Med* 1992;327:380-4.
39. Ellis AK, Day JH. Incidence and characteristics of biphasic anaphylaxis: a prospective evaluation of 103 patients. *Ann Allergy Asthma Immunol* 2007;98:64-9.
40. Grunau BE, Li J, Yi TW, Stenstrom R, Grafstein E, Wiens MO, et al. Incidence of clinically important biphasic reactions in emergency department patients with allergic reactions or anaphylaxis. *Ann Emerg Med* 2014;63:736-44.e2.
41. Rohacek M, Edenhofer H, Bircher A, Bingisser R. Biphasic anaphylactic reactions: occurrence and mortality. *Allergy* 2014;69:791-7.
42. Alqurashi W, Stiell I, Chan K, Neto G, Alsadoon A, Wells G. Epidemiology and clinical predictors of biphasic reactions in children with anaphylaxis. *Ann Allergy Asthma Immunol* 2015;115:217-23.e2.
43. Lee S, Bellolio MF, Hess EP, Erwin P, Murad MH, Campbell RL. Time of onset and predictors of biphasic anaphylactic reactions: a systematic review and meta-analysis. *J Allergy Clin Immunol Pract* 2015;3:408-16.e1.
44. Alqurashi W, Ellis AK. Do corticosteroids prevent biphasic anaphylaxis? *J Allergy Clin Immunol Pract* 2017;5:1194-205.
45. Campbell RL, Li JT, Nicklas RA, Sadosty AT. Emergency department diagnosis and treatment of anaphylaxis: a practice parameter. *Ann Allergy Asthma Immunol* 2014;113:599-608.
46. Ohashi Y, Nakai Y, Murata K. Effect of pretreatment with fexofenadine on the safety of immunotherapy in patients with allergic rhinitis. *Ann Allergy Asthma Immunol* 2006;96:600-5.
47. Klein JS, Yocum MW. Underreporting of anaphylaxis in a community emergency room. *J Allergy Clin Immunol* 1995;95:637-8.
48. Clark S, Long AA, Gaeta TJ, Camargo CA Jr. Multicenter study of emergency department visits for insect sting allergies. *J Allergy Clin Immunol* 2005;116:643-9.
49. Russell WS, Farrar JR, Nowak R, Hays DP, Schmitz N, Wood J, et al. Evaluating the management of anaphylaxis in US emergency departments: guidelines vs. practice. *World J Emerg Med* 2013;4:98-106.
50. Lieberman P, Nicklas RA, Randolph C, Oppenheimer J, Bernstein D, Bernstein J, et al. Anaphylaxis—a practice parameter update 2015. *Ann Allergy Asthma Immunol* 2015;115:341-84.
51. Simons FE, Ebisawa M, Sanchez-Borges M, Thong BY, Worm M, Tanno LK, et al. 2015 update of the evidence base: World Allergy Organization anaphylaxis guidelines. *World Allergy Organ J* 2015;8:32.
52. Turner PJ, DunnGalvin A, Hourihane JO. The emperor has no symptoms: the risks of a blanket approach to using epinephrine autoinjectors for all allergic reactions. *J Allergy Clin Immunol Pract* 2016;4:1143-6.
53. Shaker MS. An economic evaluation of prophylactic self-injectable epinephrine to prevent fatalities in children with mild venom anaphylaxis. *Ann Allergy Asthma Immunol* 2007;99:424-8.
54. Shaker M, Greenhawt M. The health and economic outcomes of peanut allergy management practices. *J Allergy Clin Immunol Pract* 2018;6:2073-80.
55. Sricharoen P, Sittichanbuncha Y, Wibulpolprasert A, Srabongkosh E, Sawanyawisuth K. What clinical factors are associated with biphasic anaphylaxis in Thai adult patients? *Asian Pac J Allergy Immunol* 2015;33:8-13.
56. Lee S, Bellolio MF, Hess EP, Campbell RL. Predictors of biphasic reactions in the emergency department for patients with anaphylaxis. *J Allergy Clin Immunol Pract* 2014;2:281-7.
57. Kim TH, Yoon SH, Hong H, Kang HR, Cho SH, Lee SY. Duration of observation for detecting a biphasic reaction in anaphylaxis: a meta-analysis. *Int Arch Allergy Immunol* 2019;179:31-6.
58. Shaker M, Wallace D, Golden DBK, Oppenheimer J, Greenhawt M. Simulation of health and economic benefits of extended observation of resolved anaphylaxis. *JAMA Netw Open* 2019;2:e1913951.
59. Lee S, Hess EP, Lohse C, Gilani W, Chamberlain AM, Campbell RL. Trends, characteristics, and incidence of anaphylaxis in 2001-2010: a population-based study. *J Allergy Clin Immunol* 2017;139:182-8.e2.
60. Worm M, Moneret-Vautrin A, Scherer K, Lang R, Fernandez-Rivas M, Cardona V, et al. First European data from the network of severe allergic reactions (NORA). *Allergy* 2014;69:1397-404.
61. Simons FE, Arduoso LR, Bilo MB, El-Gamal YM, Ledford DK, Ring J, et al. World Allergy Organization anaphylaxis guidelines: summary. *J Allergy Clin Immunol* 2011;127:587-93.e1-22.
62. Celikel S, Karakaya G, Yurtsever N, Sorkun K, Kalyoncu AF. Bee and bee products allergy in Turkish beekeepers: determination of risk factors for systemic reactions. *Allergol Immunopathol (Madr)* 2006;34:180-4.
63. Simons FE, Arduoso LR, Dimov V, Ebisawa M, El-Gamal YM, Lockey RF, et al. World Allergy Organization Anaphylaxis Guidelines: 2013 update of the evidence base. *Int Arch Allergy Immunol* 2013;162:193-204.
64. Faria E, Rodrigues-Cernadas J, Gaspar A, Botelho C, Castro E, Lopes A, et al. Drug-induced anaphylaxis survey in Portuguese Allergy Departments. *J Investig Allergol Clin Immunol* 2014;24:40-8.
65. Worm M, Eckermann O, Dolle S, Aberer W, Beyer K, Hawranek T, et al. Triggers and treatment of anaphylaxis: an analysis of 4,000 cases from Germany, Austria and Switzerland. *Dtsch Arztebl Int* 2014;111:367-75.
66. Decker WW, Campbell RL, Manivannan V, Luke A, St Sauver JL, Weaver A, et al. The etiology and incidence of anaphylaxis in Rochester, Minnesota: a report from the Rochester Epidemiology Project. *J Allergy Clin Immunol* 2008;122:1161-5.
67. Ross MP, Ferguson M, Street D, Klontz K, Schroeder T, Luccioli S. Analysis of food-allergic and anaphylactic events in the National Electronic Injury Surveillance System. *J Allergy Clin Immunol* 2008;121:166-71.
68. Allen KJ, Koplin JJ. The epidemiology of IgE-mediated food allergy and anaphylaxis. *Immunol Allergy Clin North Am* 2012;32:35-50.
69. Clark S, Bock SA, Gaeta TJ, Brenner BE, Cydulka RK, Camargo CA. Multi-center study of emergency department visits for food allergies. *J Allergy Clin Immunol* 2004;113:347-52.

70. Rudders SA, Banerji A, Vassallo MF, Clark S, Camargo CA Jr. Trends in pediatric emergency department visits for food-induced anaphylaxis. *J Allergy Clin Immunol* 2010;126:385-8.
71. Clark S, Camargo CA Jr. Epidemiology of anaphylaxis. *Immunol Allergy Clin North Am* 2007;27:145-63, v.
72. Harduar-Morano L, Simon MR, Watkins S, Blackmore C. A population-based epidemiologic study of emergency department visits for anaphylaxis in Florida. *J Allergy Clin Immunol* 2011;128:594-600.e1.
73. Alvarez-Perea A, Tomas-Perez M, Martinez-Lezcano P, Marco G, Perez D, Zurbeldia JM, et al. Anaphylaxis in adolescent/adult patients treated in the emergency department: differences between initial impressions and the definitive diagnosis. *J Investig Allergol Clin Immunol* 2015;25:288-94.
74. Webb LM, Lieberman P. Anaphylaxis: a review of 601 cases. *Ann Allergy Asthma Immunol* 2006;97:39-43.
75. Muraro A, Roberts G, Worm M, Bilo MB, Brockow K, Fernandez Rivas M, et al. Anaphylaxis: guidelines from the European Academy of Allergy and Clinical Immunology. *Allergy* 2014;69:1026-45.
76. Banerji A, Rudders S, Clark S, Wei W, Long AA, Camargo CA Jr. Retrospective study of drug-induced anaphylaxis treated in the emergency department or hospital: patient characteristics, management, and 1-year follow-up. *J Allergy Clin Immunol Pract* 2014;2:46-51.
77. Arroabarren E, Lasa EM, Olaciregui I, Sarasqueta C, Munoz JA, Perez-Yarza EG. Improving anaphylaxis management in a pediatric emergency department. *Pediatr Allergy Immunol* 2011;22:708-14.
78. Campbell RL, Luke A, Weaver AL, St Sauver JL, Bergstralh EJ, Li JT, et al. Prescriptions for self-injectable epinephrine and follow-up referral in emergency department patients presenting with anaphylaxis. *Ann Allergy Asthma Immunol* 2008;101:631-6.
79. Garvey LH, Belhage B, Kroigaard M, Husum B, Malling HJ, Mosbech H. Treatment with epinephrine (adrenaline) in suspected anaphylaxis during anesthesia in Denmark. *Anesthesiology* 2011;115:111-6.
80. Gelincik A, Demirturk M, Yilmaz E, Ertek B, Erdogdu D, Colakoglu B, et al. Anaphylaxis in a tertiary adult allergy clinic: a retrospective review of 516 patients. *Ann Allergy Asthma Immunol* 2013;110:96-100.
81. Grabenhenrich LB, Dolle S, Rueff F, Renaudin JM, Scherer K, Pfohler C, et al. Epinephrine in severe allergic reactions: the European Anaphylaxis Register. *J Allergy Clin Immunol Pract* 2018;6:1898-906.e1.
82. Mehl A, Wahn U, Niggemann B. Anaphylactic reactions in children—a questionnaire-based survey in Germany. *Allergy* 2005;60:1440-5.
83. Mostmans Y, Grosber M, Blykers M, Mols P, Naeije N, Gutermuth J. Adrenaline in anaphylaxis treatment and self-administration: experience from an inner city emergency department. *Allergy* 2017;72:492-7.
84. O'Keefe A, Clarke A, St Pierre Y, Mill J, Asai Y, Eisman H, et al. The risk of recurrent anaphylaxis. *J Pediatr* 2017;180:217-21.
85. Pourang D, Batech M, Sheikh J, Samant S, Kaplan M. Anaphylaxis in a health maintenance organization: International Classification of Diseases coding and epinephrine auto-injector prescribing. *Ann Allergy Asthma Immunol* 2017;118:186-90.e1.
86. Rueter K, Ta B, Bear N, Lucas M, Borland ML, Prescott SL. Increased use of adrenaline in the management of childhood anaphylaxis over the last decade. *J Allergy Clin Immunol Pract* 2018;6:1545-52.
87. Sidhu N, Jones S, Perry T, Thompson T, Storm E, Melguizo Castro MS, et al. Evaluation of anaphylaxis management in a pediatric emergency department. *Pediatr Emerg Care* 2016;32:508-13.
88. Wright CD, Longjohn M, Lieberman PL, Lieberman JA. An analysis of anaphylaxis cases at a single pediatric emergency department during a 1-year period. *Ann Allergy Asthma Immunol* 2017;118:461-4.
89. Helbling A, Hurni T, Mueller UR, Pichler WJ. Incidence of anaphylaxis with circulatory symptoms: a study over a 3-year period comprising 940,000 inhabitants of the Swiss Canton Bern. *Clin Exp Allergy* 2004;34:285-90.
90. Tanno LK, Bierrenbach AL, Simons FER, Cardona V, Thong BY-H, Molinari N, et al. Critical view of anaphylaxis epidemiology: open questions and new perspectives. *Allergy Asthma Clin Immunol* 2018;14:12.
91. Pumphrey RS. Lessons for management of anaphylaxis from a study of fatal reactions. *Clin Exp Allergy* 2000;30:1144-50.
92. Moneret-Vautrin DA, Morisset M, Flabbee J, Beaudouin E, Kanny G. Epidemiology of life-threatening and lethal anaphylaxis: a review. *Allergy* 2005;60:443-51.
93. Pichichero ME, Zagursky R. Penicillin and cephalosporin allergy. *Ann Allergy Asthma Immunol* 2014;112:404-12.
94. Pumphrey R. Anaphylaxis: can we tell who is at risk of a fatal reaction? *Curr Opin Allergy Clin Immunol* 2004;4:285-90.
95. Bock SA, Munoz-Furlong A, Sampson HA. Fatalities due to anaphylactic reactions to foods. *J Allergy Clin Immunol* 2001;107:191-3.
96. Yocum MW, Butterfield JH, Klein JS, Volcheck GW, Schroeder DR, Silverstein MD. Epidemiology of anaphylaxis in Olmsted County: a population-based study. *J Allergy Clin Immunol* 1999;104:452-6.
97. Sampson HA. Anaphylaxis and emergency treatment. *Pediatrics* 2003;111:1601-8.
98. Jackson KD, Howie LD, Akinbami LJ. Trends in allergic conditions among children: United States, 1997-2011. *NCHS Data Brief* 2013;(121):1-8.
99. Clark S, Espinola JA, Rudders SA, Banerji A, Camargo CA. Favorable trends in the frequency of U.S. emergency department visits for food allergy, 2001-2009. *Allergy Asthma Proc* 2013;34:439-45.
100. Parlaman JP, Oron AP, Usual NG, DeJong KN, Tieder JS. Emergency and hospital care for food-related anaphylaxis in children. *Hosp Pediatr* 2016;6:269-74.
101. Hess EP, Nestler DM. Transforming the emergency department observation unit: a look into the future. *Cardiol Clin* 2012;30:501-21.
102. Motosue MS, Bellolio MF, Van Houten HK, Shah ND, Campbell RL. National trends in emergency department visits and hospitalizations for food-induced anaphylaxis in US children. *Pediatr Allergy Immunol* 2018;29:538-44.
103. Bollinger ME, Dahlquist LM, Mudd K, Sonntag C, Dillinger L, McKenna K. The impact of food allergy on the daily activities of children and their families. *Ann Allergy Asthma Immunol* 2006;96:415-21.
104. Patel DA, Holdford DA, Edwards E, Carroll NV. Estimating the economic burden of food-induced allergic reactions and anaphylaxis in the United States. *J Allergy Clin Immunol* 2011;128:110-5.e5.
105. Sicherer SH, Forman JA, Noone SA. Use assessment of self-administered epinephrine among food-allergic children and pediatricians. *Pediatrics* 2000;105:359-62.
106. Shaker M, Kanaoka T, Feenan L, Greenhawt M. An economic evaluation of immediate vs non-immediate activation of emergency medical services after epinephrine use for peanut-induced anaphylaxis. *Ann Allergy Asthma Immunol* 2019;122:79-85.
107. Sousa-Pinto B, Fonseca JA, Gomes ER. Frequency of self-reported drug allergy: a systematic review and meta-analysis with meta-regression. *Ann Allergy Asthma Immunol* 2017;119:362-73.e2.
108. Harper NJN, Cook TM, Garcez T, Lucas DN, Thomas M, Kemp H, et al. Anaesthesia, surgery, and life-threatening allergic reactions: management and outcomes in the 6th National Audit Project (NAP6). *Br J Anaesth* 2018;121:172-88.
109. Golden DB, Demain J, Freeman T, Graft D, Tankersley M, Tracy J, et al. Stinging insect hypersensitivity: a practice parameter update 2016. *Ann Allergy Asthma Immunol* 2017;118:28-54.
110. Bilo MB, Bonifazi F. The natural history and epidemiology of insect venom allergy: clinical implications. *Clin Exp Allergy* 2009;39:1467-76.
111. Graft DF. Insect sting allergy. *Med Clin North Am* 2006;90:211-32.
112. Golden DB, Marsh DG, Kagey-Sobotka A, Freidhoff L, Szklo M, Valentine MD, et al. Epidemiology of insect venom sensitivity. *JAMA* 1989;262:240-4.
113. Hoffman DR. Fatal reactions to hymenoptera stings. *Allergy Asthma Proc* 2003;24:123-7.
114. Oude Elberink JN, van der Heide S, Guyatt GH, Dubois AE. Immunotherapy improves health-related quality of life of adult patients with dermal reactions following yellow jacket stings. *Clin Exp Allergy* 2009;39:883-9.
115. Oude Elberink JN, van der Heide S, Guyatt GH, Dubois AE. Analysis of the burden of treatment in patients receiving an EpiPen for yellow jacket anaphylaxis. *J Allergy Clin Immunol* 2006;118:699-704.
116. Oude Elberink JN, De Monchy JG, Van Der Heide S, Guyatt GH, Dubois AE. Venom immunotherapy improves health-related quality of life in patients allergic to yellow jacket venom. *J Allergy Clin Immunol* 2002;110:174-82.
117. de Groot H. Allergy to bumblebees. *Curr Opin Allergy Clin Immunol* 2006;6:294-7.
118. Reber LL, Hernandez JD, Galli SJ. The pathophysiology of anaphylaxis. *J Allergy Clin Immunol* 2017;140:335-48.
119. Francis A, Bosio E, Stone SF, Fatovich DM, Arendts G, Nagree Y, et al. Neutrophil activation during acute human anaphylaxis: analysis of MPO and sCD62L. *Clin Exp Allergy* 2017;47:361-70.
120. Castells M. Diagnosis and management of anaphylaxis in precision medicine. *J Allergy Clin Immunol* 2017;140:321-33.
121. Voehringer D. Protective and pathological roles of mast cells and basophils. *Nat Rev Immunol* 2013;13:362-75.
122. Kaliner M, Sigler R, Summers R, Shelhamer JH. Effects of infused histamine: analysis of the effects of H-1 and H-2 histamine receptor antagonists on cardiovascular and pulmonary responses. *J Allergy Clin Immunol* 1981;68:365-71.
123. Vigorito C, Russo P, Picotti GB, Chiariello M, Poto S, Marone G. Cardiovascular effects of histamine infusion in man. *J Cardiovasc Pharmacol* 1983;5:531-7.
124. Lin RY, Schwartz LB, Curry A, Pesola GR, Knight RJ, Lee HS, et al. Histamine and tryptase levels in patients with acute allergic reactions: an emergency department-based study. *J Allergy Clin Immunol* 2000;106:65-71.

125. Vadas P, Perelman B, Liss G. Platelet-activating factor, histamine, and tryptase levels in human anaphylaxis. *J Allergy Clin Immunol* 2013;131:144-9.
126. Laroche D, Gomis P, Gallimidi E, Malinovsky JM, Mertes PM. Diagnostic value of histamine and tryptase concentrations in severe anaphylaxis with shock or cardiac arrest during anesthesia. *Anesthesiology* 2014;121:272-9.
127. De Schryver S, Halbrich M, Clarke A, La Vieille S, Eisman H, Alizadehfarr R, et al. Tryptase levels in children presenting with anaphylaxis: temporal trends and associated factors. *J Allergy Clin Immunol* 2016;137:1138-42.
128. Dua S, Dowe J, Foley L, Islam S, King Y, Ewan P, et al. Diagnostic value of tryptase in food allergic reactions: a prospective study of 160 adult peanut challenges. *J Allergy Clin Immunol Pract* 2018;6:1692-8.e1.
129. Francis A, Fatovich DM, Arendts G, Macdonald SP, Bosio E, Nagree Y, et al. Serum mast cell tryptase measurements: sensitivity and specificity for a diagnosis of anaphylaxis in emergency department patients with shock or hypoxaemia. *Emerg Med Australas* 2018;30:366-74.
130. Grandel KE, Farr RS, Wanderer AA, Eisenstadt TC, Wasserman SI. Association of platelet-activating factor with primary acquired cold urticaria. *N Engl J Med* 1985;313:405-9.
131. Archer CB, Page CP, Paul W, Morley J, MacDonald DM. Inflammatory characteristics of platelet activating factor (PAF-acether) in human skin. *Br J Dermatol* 1984;110:45-50.
132. Krause K, Gimenez-Arnau A, Martinez-Escala E, Farre-Albadalejo M, Abajian M, Church MK, et al. Platelet-activating factor (PAF) induces wheal and flare skin reactions independent of mast cell degranulation. *Allergy* 2013;68:256-8.
133. Lai CK, Ollier S, Lau CK, Holgate ST. Effect of azelastine and ketotifen on the bronchial and skin responses to platelet-activating factor in humans. *Clin Exp Allergy* 1991;21:489-96.
134. Vadas P, Gold M, Perelman B, Liss GM, Lack G, Blyth T, et al. Platelet-activating factor, PAF acetylhydrolase, and severe anaphylaxis. *N Engl J Med* 2008;358:28-35.
135. Soter NA, Lewis RA, Corey EJ, Austen KF. Local effects of synthetic leukotrienes (LTC₄, LTD₄, LTE₄, and LTB₄) in human skin. *J Invest Dermatol* 1983;80:115-9.
136. Weiss JW, Drazen JM, Coles N, McFadden ER Jr, Weller PF, Corey EJ, et al. Bronchoconstrictor effects of leukotriene C in humans. *Science* 1982;216:196-8.
137. Weiss JW, Drazen JM, McFadden ER Jr, Weller P, Corey EJ, Lewis RA, et al. Airway constriction in normal humans produced by inhalation of leukotriene D: potency, time course, and effect of aspirin therapy. *JAMA* 1983;249:2814-7.
138. van der Linden PW, Hack CE, Kerckhaert JA, Struyvenberg A, van der Zwan JC. Preliminary report: complement activation in wasp-sting anaphylaxis. *Lancet* 1990;336:904-6.
139. Khodoun M, Strait R, Orekov T, Hogan S, Karasuyama H, Herbert DR, et al. Peanuts can contribute to anaphylactic shock by activating complement. *J Allergy Clin Immunol* 2009;123:342-51.
140. Fukuoka Y, Xia HZ, Sanchez-Munoz LB, Dellinger AL, Escibano L, Schwartz LB. Generation of anaphylatoxins by human beta-tryptase from C3, C4, and C5. *J Immunol* 2008;180:6307-16.
141. Smith PL, Kagey-Sobotka A, Bleecker ER, Traustman R, Kaplan AP, Gralnick H, et al. Physiologic manifestations of human anaphylaxis. *J Clin Invest* 1980;66:1072-80.
142. Lee JM, Greenes DS. Biphasic anaphylactic reactions in pediatrics. *Pediatrics* 2000;106:762-6.
143. Sicherer SH, Simons FER. Epinephrine for first-aid management of anaphylaxis. *Pediatrics* 2017;139:e20164006.
144. Lieberman P, Nicklas RA, Oppenheimer J, Kemp SF, Lang DM, Bernstein DI, et al. The diagnosis and management of anaphylaxis practice parameter: 2010 update. *J Allergy Clin Immunol* 2010;126:477-80.e1-42.
145. Simons FE, Roberts JR, Gu X, Simons KJ. Epinephrine absorption in children with a history of anaphylaxis. *J Allergy Clin Immunol* 1998;101:33-7.
146. Simons FE, Gu X, Simons KJ. Epinephrine absorption in adults: intramuscular versus subcutaneous injection. *J Allergy Clin Immunol* 2001;108:871-3.
147. Dreborg S, Kim L, Tsai G, Kim H. Epinephrine auto-injector needle lengths: can both subcutaneous and periosteal/intraosseous injection be avoided? *Ann Allergy Asthma Immunol* 2018;120:648-53.e1.
148. Lippert WC, Wall EJ. Optimal intramuscular needle-penetration depth. *Pediatrics* 2008;122:e556-63.
149. Manuyakorn W, Bamrunghachawkasem B, Ruangwattanapaisarn N, Kamchaisatian W, Benjapontitak S. Optimal needle length for epinephrine prefilled syringe in children. *Ann Allergy Asthma Immunol* 2017;118:740-1.e1.
150. Manuyakorn W, Bamrunghachawkasem B, Ruangwattanapaisarn N, Kamchaisatian W, Benjapontitak S. Needle length for epinephrine prefilled syringes in children and adolescents: is one inch needle appropriate? *Asian Pac J Allergy Immunol* 2018;36:113-9.
151. Rawas-Qalaji MM, Simons FE, Simons KJ. Sublingual epinephrine tablets versus intramuscular injection of epinephrine: dose equivalence for potential treatment of anaphylaxis. *J Allergy Clin Immunol* 2006;117:398-403.
152. Rawas-Qalaji M, Rachid O, Mendez BA, Losada A, Simons FE, Simons KJ. Adrenaline (epinephrine) microcrystal sublingual tablet formulation: enhanced absorption in a preclinical model. *J Pharm Pharmacol* 2015;67:20-5.
153. ARS Pharma. ARS Pharmaceuticals announces FDA fast track designation for ARS-1 intranasal epinephrine spray. News release. February 19, 2019. San Diego, CA: Pure Communications. Available at: <https://www.businesswire.com/news/home/20190219005141/en/ARS-Pharmaceuticals-Announces-FDA-Fast-Track-Designation>. Accessed February 20, 2019.
154. Srisawat C, Nakponetong K, Benjasupattananun P, Suratannon C, Wachirutmagur L, Boonchoo S, et al. A preliminary study of intranasal epinephrine administration as a potential route for anaphylaxis treatment. *Asian Pac J Allergy Immunol* 2016;34:38-43.
155. Campbell RL, Bellolio MF, Knutson BD, Bellamkonda VR, Fedko MG, Nestler DM, et al. Epinephrine in anaphylaxis: higher risk of cardiovascular complications and overdose after administration of intravenous bolus epinephrine compared with intramuscular epinephrine. *J Allergy Clin Immunol Pract* 2015;3:76-80.
156. Shaker M, Toy D, Lindholm C, Low J, Reigh E, Greenhawt M. Summary and simulation of reported adverse events from epinephrine autoinjectors and a review of the literature. *J Allergy Clin Immunol Pract* 2018;6:2143-5.e4.
157. Brown JC, Tuuri RE, Akhter S, Guerra LD, Goodman IS, Myers SR, et al. Lacerations and embedded needles caused by epinephrine autoinjector use in children. *Ann Emerg Med* 2016;67:307-15.e8.
158. Turner PJ, Jerschow E, Umasunthar T, Lin R, Campbell DE, Boyle RJ. Fatal anaphylaxis: mortality rate and risk factors. *J Allergy Clin Immunol Pract* 2017;5:1169-78.
159. Yu Y, Wang P, Bian L, Hong S. Rare death via histamine poisoning following crab consumption: a case report. *J Forensic Sci* 2018;63:980-2.
160. Nurmatov UB, Rhatigan E, Simons FE, Sheikh A. H2-antihistamines for the treatment of anaphylaxis with and without shock: a systematic review. *Ann Allergy Asthma Immunol* 2014;112:126-31.
161. Horak F, Stubner UP, Ziegelmayer R, Harris AG. Effect of desloratadine versus placebo on nasal airflow and subjective measures of nasal obstruction in subjects with grass pollen-induced allergic rhinitis in an allergen-exposure unit. *J Allergy Clin Immunol* 2002;109:956-61.
162. Derakhshandeh K, Mohebbi M. Oral bioavailability and pharmacokinetic study of cetirizine HCl in Iranian healthy volunteers. *Res Pharm Sci* 2009;4:113-21.
163. Pfizer. Zyrtec (cetirizine hydrochloride) tablets and syrup: for oral use. Prescribing information. 2002. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2002/19835s15,%2020346s81bl.pdf. Accessed May 11, 2019.
164. Gabrielli S, Clarke A, Morris J, Eisman H, Gravel J, Enarson P, et al. Evaluation of prehospital management in a Canadian emergency department anaphylaxis cohort. *J Allergy Clin Immunol Pract* 2019;7:2232-8.e3.
165. Liyanage CK, Galappaththy P, Seneviratne SL. Corticosteroids in management of anaphylaxis: a systematic review of evidence. *Eur Ann Allergy Clin Immunol* 2017;49:196-207.
166. Michelson KA, Monuteaux MC, Neuman MI. Glucocorticoids and hospital length of stay for children with anaphylaxis: a retrospective study. *J Pediatr* 2015;167:719-24.e1-3.
167. Croxtall JD, Choudhury Q, Flower RJ. Glucocorticoids act within minutes to inhibit recruitment of signalling factors to activated EGF receptors through a receptor-dependent, transcription-independent mechanism. *Br J Pharmacol* 2000;130:289-98.
168. Schardt C, Adams MB, Owens T, Keitz S, Fontelo P. Utilization of the PICO framework to improve searching PubMed for clinical questions. *BMC Med Inform Decis Mak* 2007;7:16.
169. Linstone HA, Turoff M. The Delphi method: techniques and applications. Reading, MA: Addison-Wesley, Advanced Book Program; 1975.
170. Dalkey N, Helmer O. An experimental application of the DELPHI method to the use of experts. *Manag Sci* 1963;9:458-67.
171. Schunemann H, Santesso N. How to GRADE the evidence: the Cochrane Collaboration. 2016. Available at: <http://training.cochrane.org/>. Accessed April 4, 2018.
172. Brown B. Delphi process: a methodology used for the elicitation of opinions of experts. Santa Monica, CA: Rand; 1968.
173. Brady WJ Jr, Lubner S, Carter CT, Guertler A, Lindbeck G. Multiphasic anaphylaxis: an uncommon event in the emergency department. *Acad Emerg Med* 1997;4:193-7.
174. Brazil E, MacNamara AF. "Not so immediate" hypersensitivity—the danger of biphasic anaphylactic reactions. *J Accid Emerg Med* 1998;15:252-3.

175. Calvani M, Cardinale F, Martelli A, Muraro A, Pucci N, Savino F, et al. Risk factors for severe pediatric food anaphylaxis in Italy. *Pediatr Allergy Immunol* 2011; 22:813-9.
176. Cianferoni A, Novembre E, Mugnaini L, Lombardi E, Bernardini R, Pucci N, et al. Clinical features of acute anaphylaxis in patients admitted to a university hospital: an 11-year retrospective review (1985-1996). *Ann Allergy Asthma Immunol* 2001;87:27-32.
177. Confino-Cohen R, Goldberg A. Allergen immunotherapy-induced biphasic systemic reactions: incidence, characteristics, and outcome: a prospective study. *Ann Allergy Asthma Immunol* 2010;104:73-8.
178. Douglas DM, Sukenick E, Andrade WP, Brown JS. Biphasic systemic anaphylaxis: an inpatient and outpatient study. *J Allergy Clin Immunol* 1994; 93:977-85.
179. Inoue N, Yamamoto A. Clinical evaluation of pediatric anaphylaxis and the necessity for multiple doses of epinephrine. *Asia Pac Allergy* 2013;3:106-14.
180. Jirapongsananuruk O, Bunsawansong W, Piyaphanee N, Visitsunthorn N, Thongkarm T, Vichyanond P. Features of patients with anaphylaxis admitted to a university hospital. *Ann Allergy Asthma Immunol* 2007;98:157-62.
181. Ko BS, Kim WY, Ryoo SM, Ahn S, Sohn CH, Seo DW, et al. Biphasic reactions in patients with anaphylaxis treated with corticosteroids. *Ann Allergy Asthma Immunol* 2015;115:312-6.
182. Lee J, Garrett JPD, Brown-Whitehorn T, Spergel JM. Biphasic reactions in children undergoing oral food challenges. *Allergy Asthma Proc* 2013;34:220-6.
183. Lertnawapan R, Maek-a-nantawat W. Anaphylaxis and biphasic phase in Thailand: 4-year observation. *Allergol Int* 2011;60:283-9.
184. Manivannan V, Hess EP, Bellamkonda VR, Nestler DM, Bellolio MF, Hagan JB, et al. A multifaceted intervention for patients with anaphylaxis increases epinephrine use in adult emergency department. *J Allergy Clin Immunol Pract* 2014;2: 294-9.e1.
185. Manuyakorn W, Benjaponpitak S, Kamchaisatian W, Vilaiyuk S, Sasisakulporn C, Jotikasthira W. Pediatric anaphylaxis: triggers, clinical features, and treatment in a tertiary-care hospital. *Asian Pac J Allergy Immunol* 2015;33:281-8.
186. Mehr S, Liew WK, Tey D, Tang MLK. Clinical predictors for biphasic reactions in children presenting with anaphylaxis. *Clin Exp Allergy* 2009;39: 1390-6.
187. Noone S, Ross J, Sampson HA, Wang J. Epinephrine use in positive oral food challenges performed as a screening test for food allergy therapy trials. *J Allergy Clin Immunol Pract* 2015;3:424-8.
188. Orhan F, Canitez Y, Bakirtas A, Yilmaz O, Boz AB, Can D, et al. Anaphylaxis in Turkish children: a multi-centre, retrospective, case study. *Clin Exp Allergy* 2011; 41:1767-76.
189. Poachanukoon O, Paopairochanakorn C. Incidence of anaphylaxis in the emergency department: a 1-year study in a university hospital. *Asian Pac J Allergy Immunol* 2006;24:111-6.
190. Scranton SE, Gonzalez EG, Waibel KH. Incidence and characteristics of biphasic reactions after allergen immunotherapy. *J Allergy Clin Immunol* 2009; 123:493-8.
191. Smit DV, Cameron PA, Rainer TH. Anaphylaxis presentations to an emergency department in Hong Kong: incidence and predictors of biphasic reactions. *J Emerg Med* 2005;28:381-8.
192. Vezir E, Erkocoglu M, Kaya A, Toyran M, Ozcan C, Akan A, et al. Characteristics of anaphylaxis in children referred to a tertiary care center. *Allergy Asthma Proc* 2013;34:239-46.
193. Yang MS, Lee SH, Kim TW, Kwon JW, Lee SM, Kim SH, et al. Epidemiologic and clinical features of anaphylaxis in Korea. *Ann Allergy Asthma Immunol* 2008;100:31-6.
194. Lee S, Peterson A, Lohse CM, Hess EP, Campbell RL. Derivation of a clinical decision rule to predict biphasic reactions in emergency department anaphylaxis patients. *Acad Emerg Med* 2017;24:S24.
195. Evidence-Based Medicine Toolbox. Odds ratio to NNT converter. Available at: <https://ebm-tools.knowledgetranslation.net/calculator/converter/>. Accessed June 8, 2019.
196. Blumenthal KG, Li Y, Banerji A, Yun BJ, Long AA, Walensky RP. The cost of penicillin allergy evaluation. *J Allergy Clin Immunol Pract* 2018;6: 1019-27.e2.
197. Yu YR, Abbas PI, Smith CM, Carberry KE, Ren H, Patel B, et al. Time-driven activity-based costing: a dynamic value assessment model in pediatric appendicitis. *J Pediatr Surg* 2017;52:1045-9.
198. Weiss RB, Donehower RC, Wiernik PH, Ohnuma T, Gralla RJ, Trump DL, et al. Hypersensitivity reactions from taxol. *J Clin Oncol* 1990;8:1263-8.
199. Cochrane.org. General methods for Cochrane Reviews: Peto odds ratio method. Available at: https://handbook-5-1.cochrane.org/chapter_9/9_4_4_2_peto_odds_ratio_method.htm. Accessed June 2, 2019.
200. Grunau BE, Wiens MO, Rowe BH, McKay R, Li J, Yi TW, et al. Emergency department corticosteroid use for allergy or anaphylaxis is not associated with decreased relapses. *Ann Emerg Med* 2015;66:381-9.
201. Guiot A, Ambroggio L, Parker M, Goodman MA, Perez Ramirez L, Lierl M, et al. Variation in the inpatient management of pediatric anaphylaxis. *Clin Pediatr (Phila)* 2017;56:1064-7.
202. Kawano T, Scheuermeyer FX, Gibo K, Stenstrom R, Rowe B, Grafstein E, et al. H1-antihistamines reduce progression to anaphylaxis among emergency department patients with allergic reactions. *Acad Emerg Med* 2017;24:733-41.
203. Lee S, Peterson A, Lohse CM, Hess EP, Campbell RL. Further evaluation of factors that may predict biphasic reactions in emergency department anaphylaxis patients. *J Allergy Clin Immunol Pract* 2017;5:1295-301.
204. Lin RY, Curry A, Pesola GR, Knight RJ, Lee HS, Bakalchuk L, et al. Improved outcomes in patients with acute allergic syndromes who are treated with combined H1 and H2 antagonists. *Ann Emerg Med* 2000;36:462-8.
205. Oya S, Nakamori T, Kinoshita H. Incidence and characteristics of biphasic and protracted anaphylaxis: evaluation of 114 inpatients. *Acute Med Surg* 2014;1:228-33.
206. Chang A, Kim M, Seyer M, Patel S. Allergic reactions associated with pegaspargase in adults. *Leuk Lymphoma* 2016;57:1665-8.
207. Francis PA, Rigas JR, Kris MG, Pisters KM, Orazem JP, Woolley KJ, et al. Phase II trial of docetaxel in patients with stage III and IV non-small-cell lung cancer. *J Clin Oncol* 1994;12:1232-7.
208. Jerzak KJ, Deghan Manshadi S, Ng P, Maganti M, McCuaig JM, Bulter M, et al. Prevention of carboplatin-induced hypersensitivity reactions in women with ovarian cancer. *J Oncol Pharm Pract* 2018;24:83-90.
209. Mach CM, Lapp EA, Weddle KJ, Hunter RJ, Burns KA, Parker C, et al. Adjunct histamine blockers as premedications to prevent carboplatin hypersensitivity reactions. *Pharmacotherapy* 2016;36:482-7.
210. Onetto N, Canetta R, Winograd B, Catane R, Dougan M, Grechko J, et al. Overview of Taxol safety. *J Natl Cancer Inst Monogr* 1993;15:131-9.
211. Rougier P. Docetaxel delivers new management opportunities for gastrointestinal carcinomas. *Anticancer Drugs* 1995;6(Suppl 4):25-9.
212. Seki K, Senzaki K, Tsuduki Y, Ioroi T, Fujii M, Yamauchi H, et al. Risk factors for oxaliplatin-induced hypersensitivity reactions in Japanese patients with advanced colorectal cancer. *Int J Med Sci* 2011;8:210-5.
213. Shen Y, Li C, Liu W, Mao W, Qian H, Wang H, et al. Clinical analysis of hypersensitivity reactions to oxaliplatin among colorectal cancer patients. *Oncol Res* 2018;26:801-7.
214. Thompson LM, Eckmann K, Boster BL, Hess KR, Michaud LB, Esteva FJ, et al. Incidence, risk factors, and management of infusion-related reactions in breast cancer patients receiving trastuzumab. *Oncologist* 2014;19:228-34.
215. Trudeau ME, Eisenhauer EA, Higgins BP, Letendre F, Lofters WS, Norris BD, et al. Docetaxel in patients with metastatic breast cancer: a phase II study of the National Cancer Institute of Canada-Clinical Trials Group. *J Clin Oncol* 1996;14:422-8.
216. Abe S, Fukuda H, Tobe K, Ibukuro K. Protective effect against repeat adverse reactions to iodinated contrast medium: premedication vs. changing the contrast medium. *Eur Radiol* 2016;26:2148-54.
217. Katayama H, Yamaguchi K, Kozuka T, Takashima T, Seez P, Matsuura K. Adverse reactions to ionic and nonionic contrast media: a report from the Japanese Committee on the Safety of Contrast Media. *Radiology* 1990;175:621-8.
218. Kolbe AB, Hartman RP, Hoskin TL, Carter RE, Maddox DE, Hunt CH, et al. Premedication of patients for prior urticarial reaction to iodinated contrast medium. *Abdom Imaging* 2014;39:432-7.
219. Lee SH, Park HW, Cho SH, Kim SS. The efficacy of single premedication with antihistamines for radiocontrast media hypersensitivity. *Asia Pac Allergy* 2016; 6:164-7.
220. Park HJ, Park JW, Yang MS, Kim MY, Kim SH, Jang GC, et al. Re-exposure to low osmolar iodinated contrast media in patients with prior moderate-to-severe hypersensitivity reactions: a multicentre retrospective cohort study. *Eur Radiol* 2017;27:2886-93.
221. Park SJ, Kang DY, Sohn KH, Yoon SH, Lee W, Choi YH, et al. Immediate mild reactions to CT with iodinated contrast media: strategy of contrast media readministration without corticosteroids. *Radiology* 2018;288:710-6.
222. Augustsson J, Eksborg S, Ernestam S, Gullstrom E, van Vollenhoven R. Low-dose glucocorticoid therapy decreases risk for treatment-limiting infusion reaction to infliximab in patients with rheumatoid arthritis. *Ann Rheum Dis* 2007;66:1462-6.
223. Berchtold E, Maibach R, Muller U. Reduction of side effects from rush-immunotherapy with honey bee venom by pretreatment with terfenadine. *Clin Exp Allergy* 1992;22:59-65.
224. Braaten K, Holcombe RF, Kim SS. Premedication with IV steroids effectively prevented anaphylactic reactions following ferumoxylol given as IV push in hematology and oncology patients. *Am J Hematol* 2015;90:E207.

225. Brockow K, Kiehn M, Riethmüller C, Vieluf D, Berger J, Ring J. Efficacy of antihistamine pretreatment in the prevention of adverse reactions to Hymenoptera immunotherapy: a prospective, randomized, placebo-controlled trial. *J Allergy Clin Immunol* 1997;100:458-63.
226. Caron EJ, Manock SR, Maudlin J, Koleski J, Theakston RD, Warrell DA, et al. Apparent marked reduction in early antivenom reactions compared to historical controls: was it prophylaxis or method of administration? *Toxicon* 2009;54:779-83.
227. Fan H, Marcopito L, Cardoso J, França F, Malaque C, Ferrari R, et al. Sequential randomised and double blind trial of promethazine prophylaxis against early anaphylactic reactions to antivenom for Bothrops snake bites. *BMJ* 1999;318:1451-2.
228. Gold SL, Cohen-Mekelburg S, Schneider Y, Shen N, Faggen A, Rupert A, et al. Premedication use in preventing acute infliximab infusion reactions in patients with inflammatory bowel disease: a single center cohort study. *Inflamm Bowel Dis* 2017;23:1882-9.
229. Hejjauji A, Dhivert H, Michel FB, Bousquet J. Immunotherapy with a standardized Dermatophagoides pteronyssinus extract. IV. Systemic reactions according to the immunotherapy schedule. *J Allergy Clin Immunol* 1990;85:473-9.
230. Jacobstein DA, Markowitz JE, Kirschner BS, Ferry G, Cohen SA, Gold BD, et al. Premedication and infusion reactions with infliximab: results from a pediatric inflammatory bowel disease consortium. *Inflamm Bowel Dis* 2005;11:442-6.
231. Jagdis A, Berlin N, Barron C, Giruparajah M, Leader N, MacLachlan S, et al. Effect of ketotifen premedication on adverse reactions during peanut oral immunotherapy. *Allergy Asthma Clin Immunol* 2014;10:36.
232. Lorenz W, Doenicke A, Schöning B, Mamorski J, Weber D, Hinterlang E, et al. H1 + H2-receptor antagonists for premedication in anaesthesia and surgery: a critical view based on randomized clinical trials with Haemaccel and various anti-allergic drugs. *Agents Actions* 1980;10:114-24.
233. Muller UR, Jutel M, Reimers A, Zumkehr J, Huber C, Kriegel C, et al. Clinical and immunologic effects of H1 antihistamine preventive medication during honeybee venom immunotherapy. *J Allergy Clin Immunol* 2008;122:1001-7.e4.
234. Nielsen L, Johnsen CR, Mosbech H, Poulsen LK, Malling HJ. Antihistamine premedication in specific cluster immunotherapy: a double-blind, placebo-controlled study. *J Allergy Clin Immunol* 1996;97:1207-13.
235. Portnoy J, Bagstad K, Kanarek H, Pacheco F, Hall B, Barnes C. Premedication reduces the incidence of systemic reactions during inhalant rush immunotherapy with mixtures of allergenic extracts. *Ann Allergy* 1994;73:409-18.
236. Reimers A, Hari Y, Müller U. Reduction of side-effects from ultrarush immunotherapy with honeybee venom by pretreatment with fexofenadine: a double-blind, placebo-controlled trial. *Allergy* 2000;55:484-8.
237. Sanders RP, Maddirala SD, Geiger TL, Pounds S, Sandlund JT, Ribeiro RC, et al. Premedication with acetaminophen or diphenhydramine for transfusion with leucoreduced blood products in children. *Br J Haematol* 2005;130:781-7.
238. Schöning B, Lorenz W, Doenicke A. Prophylaxis of anaphylactoid reactions to a polypeptid plasma substitute by H1- plus H2-receptor antagonists: synopsis of three randomized controlled trials. *Klin Wochenschr* 1982;60:1048-55.
239. Tankersley M, Walker R, Butler W, Hagan L, Napoli D, Freeman T. Safety and efficacy of an imported fire ant rush immunotherapy protocol with and without prophylactic treatment. *J Allergy Clin Immunol* 2002;109:556-62.
240. Jung JW, Kang HR, Lee SH, Cho SH. The incidence and risk factors of infusion-related reactions to rituximab for treating B cell malignancies in a single tertiary hospital. *Oncology* 2014;86:127-34.
241. Lasser EC, Berry CC, Mishkin MM, Williamson B, Zheutlin N, Silverman JM. Pretreatment with corticosteroids to prevent adverse reactions to nonionic contrast media. *AJR Am J Roentgenol* 1994;162:523-6.
242. Brockow K. Immediate and delayed reactions to radiocontrast media: is there an allergic mechanism? *Immunol Allergy Clin North Am* 2009;29:453-68.
243. Goodfellow T, Holdstock GE, Branton FJ, Bamforth J. Fatal acute vasculitis after high-dose urography with iohexol. *Br J Radiol* 1986;59:620-1.
244. Hasdenteufel F, Waton J, Cordebar V, Studer M, Collignon O, Luyasu S, et al. Delayed hypersensitivity reactions caused by iodixanol: an assessment of cross-reactivity in 22 patients. *J Allergy Clin Immunol* 2011;128:1356-7.
245. Laffitte E, Nenadov Beck M, Hofer M, Hohl D, Panizzon RG. Severe Stevens-Johnson syndrome induced by contrast medium iopentol (Imagopaque). *Br J Dermatol* 2004;150:376-8.
246. Miranda-Romero A, Sanchez-Sambucety P, Esquivias Gomez JJ, Martinez Fernandez M, Bajo del Pozo C, Aragonese Fraile H, et al. Vegetating iododerma with fatal outcome. *Dermatology* 1999;198:295-7.
247. Rosado A, Canto G, Veleiro B, Rodriguez J. Toxic epidermal necrolysis after repeated injections of iohexol. *AJR Am J Roentgenol* 2001;176:262-3.
248. Savill JS, Barrie R, Ghosh S, Muhlemann M, Dawson P, Pusey CD. Fatal Stevens-Johnson syndrome following urography with iopamidol in systemic lupus erythematosus. *Postgrad Med J* 1988;64:392-4.
249. Schmidt BJ, Foley WD, Bohorfoush AG. Toxic epidermal necrolysis related to oral administration of diluted diatrizoate meglumine and diatrizoate sodium. *AJR Am J Roentgenol* 1998;171:1215-6.
250. Vaillant L, Pengloan J, Blanchier D, De Muret A, Lorette G. Iododerma and acute respiratory distress with leucocytoclastic vasculitis following the intravenous injection of contrast medium. *Clin Exp Dermatol* 1990;15:232-3.
251. Al-Ahmad M, Bouza TR. Successful desensitization to radioccontrast media in two high-risk cardiac patients. *Ann Saudi Med* 2017;37:333-5.
252. Hebert AA, Bogle MA. Intravenous immunoglobulin prophylaxis for recurrent Stevens-Johnson syndrome. *J Am Acad Dermatol* 2004;50:286-8.
253. Romano A, Artesani MC, Andriolo M, Viola M, Pettinato R, Vecchioli-Scaldazza A. Effective prophylactic protocol in delayed hypersensitivity to contrast media: report of a case involving lymphocyte transformation studies with different compounds. *Radiology* 2002;225:466-70.
254. Turner C, Handford AD, Nicholson AN. Sedation and memory: studies with a histamine H-1 receptor antagonist. *J Psychopharmacol* 2006;20:506-17.
255. Bower EA, Moore JL, Moss M, Selby KA, Austin M, Meeves S. The effects of single-dose fexofenadine, diphenhydramine, and placebo on cognitive performance in flight personnel. *Aviat Space Environ Med* 2003;74:145-52.
256. Mansfield L, Mendoza C, Flores J, Meeves SG. Effects of fexofenadine, diphenhydramine, and placebo on performance of the test of variables of attention (TOVA). *Ann Allergy Asthma Immunol* 2003;90:554-9.
257. Witek TJ Jr, Canestrari DA, Miller RD, Yang JY, Riker DK. Characterization of daytime sleepiness and psychomotor performance following H1 receptor antagonists. *Ann Allergy Asthma Immunol* 1995;74:419-26.
258. Schroek JL, Ford J, Conway EL, Kurtzhals KE, Gee ME, Vollmer KA, et al. Review of safety and efficacy of sleep medicines in older adults. *Clin Ther* 2016;38:2340-72.
259. Davenport MS, Cohan RH. The evidence for and against corticosteroid prophylaxis in at-risk patients. *Radiol Clin North Am* 2017;55:413-21.
260. Mervak BM, Davenport MS, Ellis JH, Cohan RH. Rates of breakthrough reactions in inpatients at high risk receiving premedication before contrast-enhanced CT. *AJR Am J Roentgenol* 2015;205:77-84.
261. Li X, Liu H, Zhao L, Liu J, Cai L, Liu L, et al. Clinical observation of adverse drug reactions to non-ionic iodinated contrast media in population with underlying diseases and risk factors. *Br J Radiol* 2017;90:20160729.
262. ACR Committee on Drugs and Contrast Media. ACR manual on contrast media version 10.3. 2020. Available from: <https://www.acr.org/Clinical-Resources/Contrast-Manual>. Accessed October 10, 2019.
263. Davenport MS, Mervak BM, Ellis JH, Dillman JR, Dunnick NR, Cohan RH. Indirect cost and harm attributable to oral 13-hour inpatient corticosteroid prophylaxis before contrast-enhanced CT. *Radiology* 2016;279:492-501.
264. Fumery M, Tilmant M, Yzet C, Brazier F, Lureau J, Turpin J, et al. Premedication as primary prophylaxis does not influence the risk of acute infliximab infusion reactions in immune-mediated inflammatory diseases: a systematic review and meta-analysis. *Dig Liver Dis* 2019;51:484-8.
265. Sloane D, Govindarajulu U, Harrow-Mortelliti J, Barry W, Hsu FI, Hong D, et al. Safety, costs, and efficacy of rapid drug desensitizations to chemotherapy and monoclonal antibodies. *J Allergy Clin Immunol Pract* 2016;4:497-504.