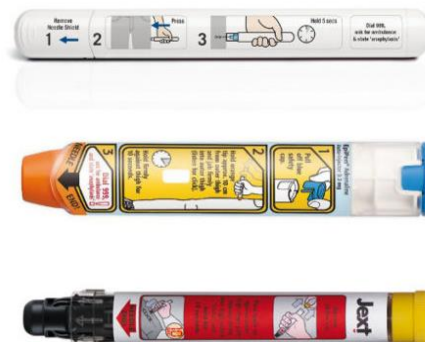


# Managing patients at risk of anaphylactic reactions

September 2020



Following a recent coroner's investigation into the death of a patient due to acute anaphylaxis a number of matters of concern have been raised. If not addressed these issues have the potential to cause future deaths. Prescribers are reminded of the following:-

- Prescribers should ensure that the appropriate strength of adrenaline auto-injector is prescribed taking into consideration patient age, weight and the manufacturers' recommendations.
- There should be clear documentation of the discussions around the advice and training provided as well as confirmation that the patient has understood all the information provided. *(Reinforcement of the advice provided and, the patient's understanding should be confirmed during medication reviews and if unusual ordering of medication is identified.)*
- Primary care clinicians must always confirm that the patient has had/or is still receiving specialist care. This should be re-confirmed when there is a transfer of care between services and when the patient is under transitional care services.

- The MHRA recommendation that patients should carry **2 adrenaline auto-injectors at all times** (this is particularly important for people who have allergic asthma because they are at increased risk of a severe anaphylactic reaction).
- Patients and their carers should be trained to use the particular auto-injector that they have been prescribed. **Training should be delivered if there is a change of auto-injector prescribed as administration technique varies between different brands.** Trainer devices are available for free from manufacturers' websites.

The MHRA has produced [Advice sheet to give to patients and carers](https://www.gov.uk/drug-safety-update/adrenaline-auto-injectors-updated-advice-after-european-review) which can be accessed via: <https://www.gov.uk/drug-safety-update/adrenaline-auto-injectors-updated-advice-after-european-review>.

This webpage also provides links to further patient information and training resources which have been produced by the manufacturers of Emerade<sup>®</sup>, Epipen<sup>®</sup> and Jext<sup>®</sup>.

- *Following the death of a patient due to acute anaphylaxis, prescribers are reminded of the MHRA recommendations around the prescribing of adrenaline auto-injectors to patients at risk of anaphylaxis.*
- *Further information can be accessed at: [Advice sheet to give to patients and carers](https://www.gov.uk/drug-safety-update/adrenaline-auto-injectors-updated-advice-after-european-review)*

For further information, please contact the Medicines Management Team on  
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