

Clinical manifestations of acute contrast reaction

The most severe symptom predominates. If allergic-like and physiologic symptoms are mixed or cannot be determined (eg, cardiopulmonary collapse), reaction should be presumed allergic-like.

Mild, allergic-like

(self-limited, rarely requires treatment, may or may not recur)

- Transient urticaria, pruritis, or cutaneous edema
- Transient "itchy" throat, nasal congestion, sneezing, conjunctivitis, or rhinorrhea

Mild, physiologic

(self-limited, rarely requires treatment, dose dependent)

- Transient nausea, vomiting
- Transient mild hypertension
- Transient flushing, warmth, chills, metallic taste, or headache
- Vasovagal reaction (ie, hypotension and bradycardia) not requiring treatment

Moderate, allergic-like

(usually requires treatment, may progress to severe, may or may not recur)

- Urticaria, pruritis, cutaneous edema, or diffuse erythema requiring treatment
- Wheezing, bronchospasm, hoarseness, or throat tightness without hypoxia
- Facial edema without dyspnea

Moderate, physiologic

(usually requires treatment, may progress to severe, dose dependent)

- Nausea or vomiting requiring treatment
- Hypertension requiring treatment
- Chest pain
- Vasovagal reaction (ie, hypotension and bradycardia) requiring and responsive to treatment

Severe, allergic-like

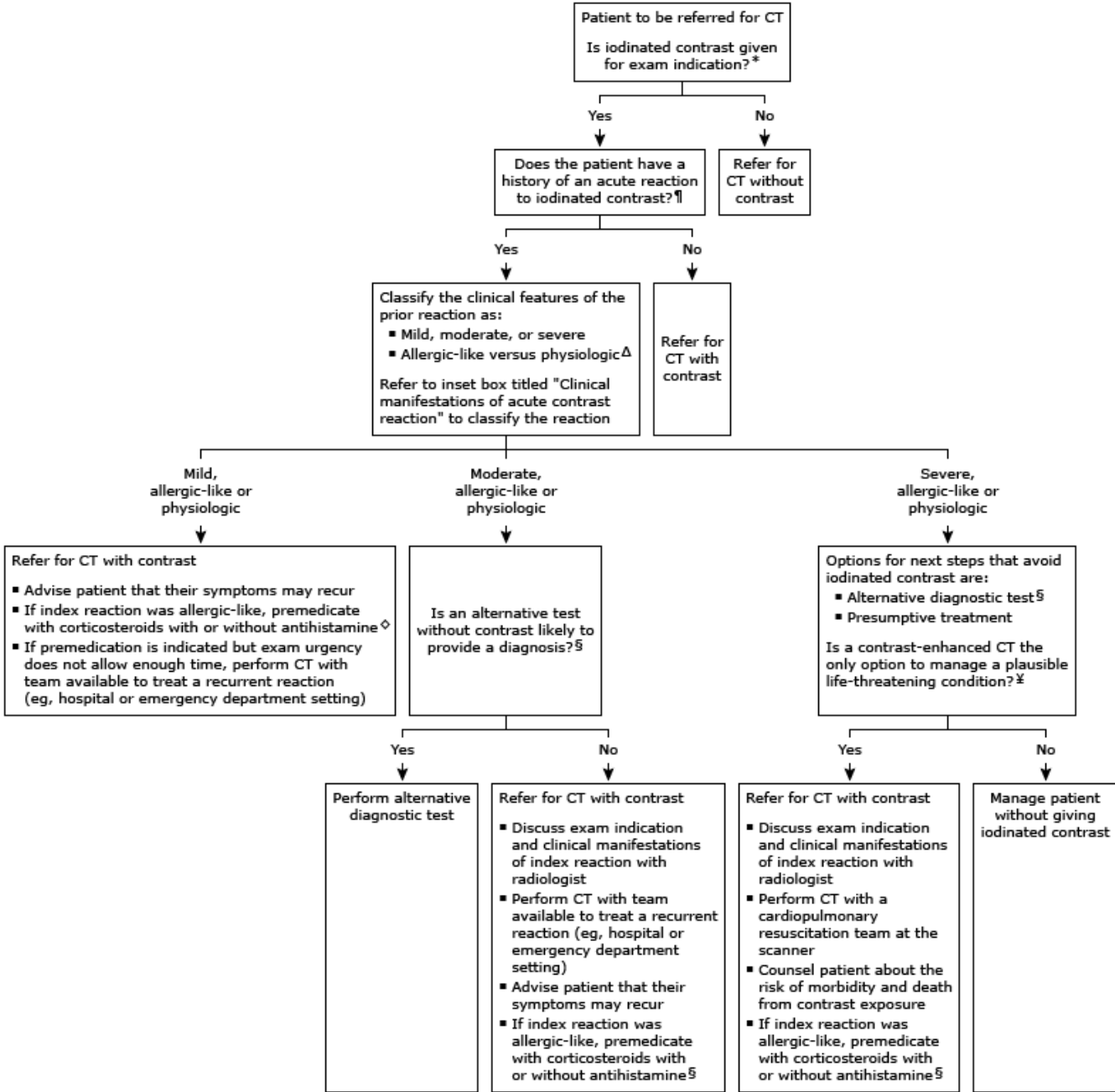
(life-threatening, associated with significant morbidity, may or may not recur)

- Diffuse cutaneous edema with dyspnea
- Diffuse erythema with hypotension
- Wheezing, bronchospasm, laryngeal spasm, or stridor with hypoxia
- Shock (hypotension and tachycardia)

Severe, physiologic

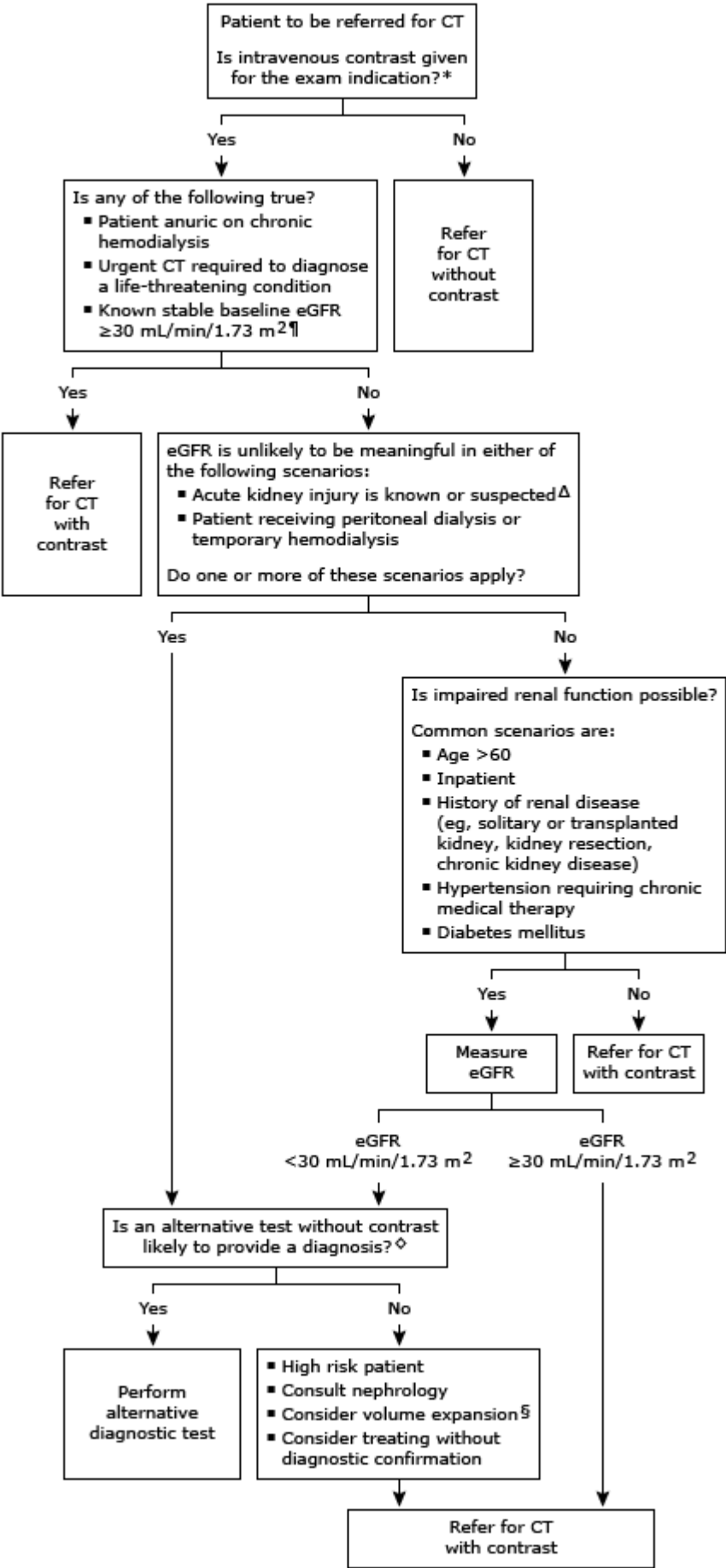
(life-threatening, associated with significant morbidity, dose dependent)

- Arrhythmia
- Hypertensive emergency
- Seizure
- Vasovagal reaction (ie, hypotension and bradycardia) resistant to treatment



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**Patient evaluation for contrast administration for
computed tomography: Concern for contrast
induced nephropathy**



Standards for patient preparation and indications for contrast vary somewhat with each practice. Provider should refer to institutional policies for detailed guidelines in patients likely to require an intervention.

CT: computed tomography; eGFR: estimated glomerular filtration rate.

* Refer to UpToDate topics or the American College of Radiology (ACR) Appropriateness Criteria for CT contrast recommendations based on a specific exam indication. Enteric (oral or rectal) contrast is not associated with renal injury.

¶ Medical judgment should be used to determine whether baseline renal function is likely stable. In general, eGFR within 30 days in an outpatient and two days in an inpatient is likely to reflect baseline renal function if the medical condition and treatments have not been changing in the interim.

Δ Examples are patients with sepsis, myocardial infarction, or large volume hemorrhage.

◇ Imaging alternatives are CT without contrast, ultrasound, magnetic resonance imaging, or nuclear scintigraphy. Discuss with a radiologist whether any of these are likely to provide a diagnosis.

§ No standard regimen has been described. Examples are 100 cc/hour, beginning 6 to 12 hours before and continuing 4 to 12 hours after the exam in inpatients, and 500 cc bolus over 30 minutes to one hour before and during the exam in outpatients.

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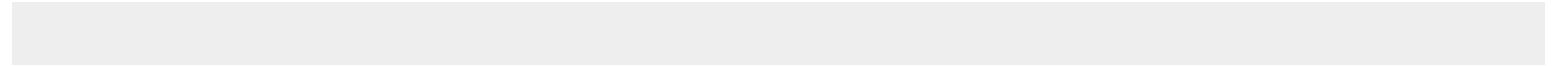
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Premedication prophylaxis for patients with previous acute reaction to iodinated contrast

Nonurgent oral premedication:
Glucocorticoid-preferred regimen:
Adult: Oral prednisone 50 mg at 13, 7, and 1 hour prior to contrast administration
Pediatric: Prednisone 0.5 to 0.7 mg/kg oral (maximum 50 mg per dose) at 13, 7, and 1 hour prior to contrast administration.
Glucocorticoid-alternate:
Adult: Methylprednisolone 32 mg IV at 12 and 2 hours prior to contrast administration.
Pediatric: Methylprednisolone 1 mg/kg IV (maximum 32 mg per dose) at 12 and 2 hours prior to contrast administration.
AND
H1 antihistamine:
Adult: Diphenhydramine 50 mg oral, IM, or IV 1 hour prior to contrast administration.
Pediatric: Diphenhydramine 1.25 mg/kg oral, IM, or IV (maximum 50 mg) 1 hour prior to contrast administration.
Urgent intravenous premedication (eg, inpatients, emergency department):*
Hydrocortisone 200 mg IV 5 hours and 1 hour prior to contrast administration and 50 mg IV diphenhydramine 1 hour prior to contrast administration.

IV: intravenously; IM: intramuscularly.

* Premedication regimens less than four to five hours in duration (oral or IV) have not been shown to be effective.

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