Anaphylaxis in infants: can recognition and management be improved?

F Estelle R Simons, MD, FRCP
Section of Allergy and Clinical Immunology, the Department of Pediatrics and Child Health and the Department of Immunology, Canadian Institutes of Health Research National Training Program in Allergy and Asthma, Faculty of Medicine, University of Manitoba, Winnipeg, Manitoba, Canada

The true rate of occurrence of anaphylaxis in infants, defined arbitrarily as age newborn to 2 years, inclusive, is unknown; however, most anaphylaxis case series and anaphylaxis epidemiologic studies in individuals of all ages include infants, some as young as 1 month of age. Fatalities in anaphylaxis, although rare in infancy, do occur, and even the first episode can be fatal.

CASE REPORT
A 9-month-old boy with a 2-week history of cough and wheeze suddenly developed choking, coughing, labored breathing, and apnea, followed by a respiratory arrest at home. He was resuscitated by his father and brought to a community hospital within 6 minutes. On arrival, he was afebrile, limp, and cyanotic, with decreased air entry, deep retractions, and generalized inspiratory and expiratory rhonchi. He had red, scaly areas of skin on his face, chest, and extremities, with superimposed raised red areas 0.5 to 1 cm in diameter on his face and chest. His weight was 9 kg; heart rate, 152/min; respiratory rate, 38/min; and blood pressure, 80/50 mmHg. He was given supplemental oxygen, intubated, ventilated, and transferred to a pediatric intensive care unit with the diagnosis of bronchiolitis, which was epidemic in the region at the time. Chest radiograph revealed minimal peribronchial thickening. The rapid antigen detection assay for respiratory syncytial virus was negative. He responded to albuterol and was extubated within 12 hours. In view of the atypical clinical picture for bronchiolitis and the rapid improvement, the diagnosis was reconsidered.

An allergy/immunology specialist was consulted, and additional history was obtained. The infant had been almost exclusively breast-fed since birth; however, on one occasion, he had developed generalized hives soon after ingesting a cow’s milk formula supplement. Minutes before his respiratory arrest, he had tasted ice cream for the first time. His eosinophil count was 1.08 × 10^9/L. Cow’s milk specific IgE was 3.6 kU/L. The allergist’s diagnoses were anaphylaxis to cow’s milk, asthma, and atopic dermatitis. Four weeks later, the skin prick test to cow’s milk was strongly positive (wheal 10 mm greater than control). Long-term risk reduction measures included initiated strict avoidance of cow’s milk and related products, and optimized asthma and atopic dermatitis management. An Anaphylaxis Emergency Action Plan was developed. An epinephrine autoinjector 0.15 mg was prescribed despite recognition that this dose was not ideal for a 9-kg infant. Education sessions were held with his parents.

WHAT TRIGGERS ANAPHYLAXIS IN INFANTS?
Food is the most common trigger of anaphylaxis in this age group through direct ingestion, breast milk, or accidental ingestion (eg, a crawling infant finds and tastes a food item); of note, skin contact with food or food-based skin care products or inhalation of aerosolized food particles potentially sensitizes an infant but seldom causes anaphylaxis. Caregivers may be unaware of the infant’s initial exposure to the food.

Correspondence: Prof FER Simons, e-mail: lmcniven@hsc.mb.ca.

Laboratory tests to support the clinical diagnosis of anaphylaxis are age-dependent (Table II). Anaphylaxis is episodic; subjectively, symptoms of anaphylaxis such as itching cannot be described by infants (Table I). Some signs of anaphylaxis such as urticaria pigmentosa/mastocytosis are likely to be important. Comorbidities in caregivers – for example, depression, asthma, and croup; and urticaria pigmentosa/mastocytosis are likely to be important.

Clinical risk factors and comorbid diseases that increase the risk of anaphylaxis and of fatality in anaphylaxis have not yet been optimally defined in infants. Atopy, common infant respiratory diseases such as bronchiolitis, asthma, and croup; and urticaria pigmentosa/mastocytosis are likely to be important. Comorbidities in caregivers – for example, depression, asthma, and croup; and urticaria pigmentosa/mastocytosis are likely to be important.

Laboratory tests to support the clinical diagnosis of anaphylaxis may or may not be helpful. Histamine levels need to be measured in a blood sample obtained within 1 hour of symptom onset. Total tryptase levels need to be measured in a sample obtained within 3 hours of symptom onset. Even if the sample is optimally timed, tryptase levels are seldom elevated in food-induced anaphylaxis. Moreover, if fatality occurs and an elevated postmortem tryptase level is found, interpretation can be difficult because elevated tryptase levels have also been reported in some infants with sudden infant death syndrome.

WHAT ARE THE BARRIERS TO OPTIMAL MANAGEMENT OF ANAPHYLAXIS IN INFANTS?
Acute management in health care settings
The universal principles of prevention, prompt diagnosis, rapid assessment (airway, breathing, circulation,
Table I. Symptoms and signs of anaphylaxis in infants*

<table>
<thead>
<tr>
<th>Anaphylaxis symptoms that infants cannot describe</th>
<th>Anaphylaxis signs that are potentially difficult to interpret in infants, and why</th>
<th>Anaphylaxis signs in infants: obvious but may be nonspecific</th>
</tr>
</thead>
<tbody>
<tr>
<td>General: feeling of warmth, weakness, anxiety, apprehension, impending doom</td>
<td>General: nonspecific behavioral changes such as persistent crying, fussing, irritability, fright</td>
<td>Skin/mucous membranes: rapid onset of hives (potentially difficult to discern in infants with acute atopic dermatitis; scratching and excoriations, as such, will be absent in young infants); angioedema (face, tongue, oropharynx)</td>
</tr>
<tr>
<td>Skin/mucous membranes: itching of lips, tongue, palate, uvula, ears, throat, nose, eyes, and so forth; mouth-tangling or metallic taste</td>
<td>Skin/mucous membranes: flushing (may also occur with fever, hyperthermia, or crying spells)</td>
<td>Respiratory: rapid onset of coughing, choking, stridor, wheezing, dyspnea, apnea, cyanosis</td>
</tr>
<tr>
<td>Respiratory: nasal congestion, throat tightness; chest tightness; shortness of breath</td>
<td>Respiratory: hoarseness, dysphonia (common after a crying spell); drooling, increased secretions (common in infants)</td>
<td>Gastrointestinal: sudden, profuse vomiting</td>
</tr>
<tr>
<td>Gastrointestinal: dysphagia, nausea, abdominal pain/cramping</td>
<td>Gastrointestinal: splitting up/regurgitation (common after feeds), loose stools (normal in infants, especially if breast-fed); colicky abdominal pain</td>
<td>Cardiovascular: weak pulse, arrhythmia, diaphoresis/sweating, pallor, collapse/unconsciousness</td>
</tr>
<tr>
<td>Cardiovascular: feeling faint, presyncope, dizziness, confusion, blurred vision, difficulty in hearing, palpitations</td>
<td>Cardiovascular: hypotension; measured with an appropriate size blood pressure cuff; low systolic blood pressure for infants is defined as less than 70 mmHg from age 1 month to 1 year, and less than (70 mmHg $1 + [2 \times \text{age in y}])$ in the first and second years of life; tachycardia, defined as greater than 120-130 beats per minute from the third month to second year of life inclusive; loss of bowel and bladder control (ubiquitous in infants)</td>
<td>Central nervous system: headache</td>
</tr>
<tr>
<td>Central nervous system: headache</td>
<td>Central nervous system: drowsiness, somnolence (common in infants after feeds)</td>
<td>Central nervous system: rapid onset of unresponsiveness, lethargy, or hypotonia; seizures</td>
</tr>
</tbody>
</table>

*More than 1 body system involved.

responsiveness, skin, and weight), and prompt treatment apply.¹ The evidence base for the treatment of anaphylaxis in infants is largely empirical. Epinephrine is the initial medication of first choice; however, the recommended initial dose of 0.01 mg/kg intramuscularly is based entirely on tradition, because no prospective epinephrine clinical pharmacology study has been conducted in infants with, or at risk of, anaphylaxis.¹² If intravenous epinephrine is needed, care should be taken to calculate the dose accurately, dilute the epinephrine solution accurately, and avoid an overly rapid infusion rate. If epinephrine overdose occurs, infants cannot report symptoms; signs include pallor, tremor, and pulmonary edema that, like anaphylaxis itself, may be manifest by cough and respiratory distress.¹³ In addition to epinephrine, supplemental oxygen should be given. The airway should be established and maintained. An intravenous line should be established. Continuous monitoring should be instituted. Additional medications should be administered as needed.¹

**Long-term risk reduction**
Assessment. Most episodes of anaphylaxis in infants are IgE-mediated. Sensitization to allergens – for example, to foods – can be determined by using skin prick tests or by quantitative measurement of allergen-specific IgE levels.⁶ Selection of allergens for testing should be based on the history. Positive skin tests have a different appearance in infants compared with older individuals. Like elevated allergen-specific IgE levels, they denote sensitization, but are not themselves diagnostic of anaphylaxis or any other allergic disease. In infants with food allergy, physician-monitored oral incremental challenges may be helpful if the diagnosis is in doubt or if there is minimal or no evidence of sensitization to the suspect allergen. A challenge is strictly contraindicated in an infant such as the one reported here, who has a strong clinical history of anaphylaxis and is highly sensitized to the suspect allergen.¹⁵

Equipping the infant's caregivers for management of anaphylaxis in the community. Risk reduction involves vigilant allergen avoidance, which can be stressful for families.¹³,¹⁶ Relevant comorbidities in the infant and the caregiver should be managed optimally. Caregivers should be equipped with injectable epinephrine for first aid treatment in the context of an Anaphylaxis Emergency Action Plan, which can be downloaded from www.aaaai.org and readily adapted for use in infants.¹³

**Epinephrine**
Most infants weigh less than 15 kg. No epinephrine autoinjector currently available provides a dose of <0.15 mg.¹⁵,¹⁷ Presenting a dilemma for physicians prescribing epinephrine autoinjectors for this vulnerable population (see Case Report). Although experienced pediatric nurses draw up and measure infant doses from an ampule of epinephrine rapidly and accu-
rately, caregivers without medical training find this extremely difficult to do.18

**H1-antihistamines**

In anaphylaxis, H1-antihistamines might relieve skin symptoms and signs but they do not relieve upper or lower airway obstruction or shock. They therefore are not drugs of choice, are not life-saving, and do not replace epinephrine.

The onset of action of orally administered H1-antihistamines takes at least 1 to 2 hours. First-generation H1-antihistamines in usual doses potentially cause sedation and unresponsiveness that can impede the recognition of anaphylaxis, and they can also lead to respiratory arrest in infants.19,20

**Medical identification**

At-risk infants who are in the care of a babysitter or other third party should be protected by wearing accurate medical identification,21 such as a T-shirt or Velcro patch on clothes (Velcro USA Inc, Manchester, NH) with a specific allergy alert message, for example, “Do not give cow’s milk to this baby.” Medical identification bracelets made of cloth are available for older infants.

Anaphylaxis education. Caregivers of infants report high anxiety levels with regard to taking responsibility for the recognition and management of an anaphylaxis episode, particularly the possibility of having to inject epinephrine.13,14 Individualized instruction and coaching help to diminish this anxiety.

**SUMMARY**

Anaphylaxis is likely underrecognized in infancy. Many episodes are ‘first’ episodes. Infants cannot report symptoms. Diagnosis therefore depends on a high index of suspicion and on physical signs. The differential diagnosis of anaphylaxis in infancy includes age-unique entities such as congenital or metabolic disorders, child abuse, Munchausen syndrome by proxy, and sudden infant death syndrome. Management is based on empirical evidence. A prospective systematic study of anaphylaxis in infancy is needed.

**Acknowledgement**

I gratefully acknowledge the assistance of Ms Lori McNiven.

This article was published in *Journal of Allergy and Clinical Immunology* 2007; vol 120, pp 537-540, Simons FER, Anaphylaxis in infants: can recognition and management be improved? Copyright American Academy of Allergy, Asthma & Immunology (2007). Reprinted with permission of the author and copyright holder.

**Declaration of conflict of interest**

The author declares no conflict of interest.

**REFERENCES**


