

Australian and New Zealand College of Anaesthetists (ANZCA)

Guidelines on the Perioperative Management of Patients with Suspected or Proven Hypersensitivity to Chlorhexidine

Background Paper

1. PURPOSE

The purpose of *PS60 Guidelines on the Perioperative Management of Patients with Suspected or Proven Hypersensitivity to Chlorhexidine* is to prevent recurrent inadvertent exposure and subsequent hypersensitivity reaction in these patients.

The ANZCA Anaesthetic Allergy Subcommittee was convened in 2012 and works closely with the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG). The subcommittee identified that as chlorhexidine was a very common hidden agent in the theatre environment and it has an increasing frequency of induced anaphylaxis, it warranted a policy in its own right. PS60 has been developed as 'Guidelines' with the long term goal of wide application and endorsement by relevant government bodies, medical colleges and professional associations

2. JUSTIFICATION

Chlorhexidine (1:6-Di-4'-Chlorophenyldiguanidohexane) is a broad spectrum antiseptic that is extensively used in healthcare environments. Its many applications in health care include well recognised inclusions in antiseptic solutions and gels for the disinfection of skin, but it is also in a large number of other products that may not be as well recognised. Chlorhexidine may be present in lubricants for indwelling urinary catheter insertion, impregnated into central venous catheters, dressings, surgical drapes and other medical devices. It is also widely available in the community in many presentations such as antiseptic hand rubs, mouthwashes, toothpastes and throat lozenges.

Recognition of the efficacy of chlorhexidine has seen its use dramatically increase within hospital environments and in the community in recent years. This has resulted in a problematic situation for those allergic to it. Ready identification of all products containing chlorhexidine is difficult with non-uniform standards of labelling. Frequent changes of products used by, and available to the practitioner, makes the task of avoiding the allergen during the patient's hospital stay particularly difficult. Utility of lists of chlorhexidine containing products are limited by the need for frequent updates to ensure inclusion of all products incorporating chlorhexidine.

In recent times there have been increasing reports of hypersensitivity to chlorhexidine, usually immediate type hypersensitivity (or anaphylaxis). When patients present to a healthcare facility with a history of confirmed or suspected hypersensitivity to chlorhexidine, there are no published guidelines detailing



mechanisms to prevent exposure of these patients to chlorhexidine products during their health care encounter.

3. REVIEW OF THE ISSUES CONCERNED

3.1 Increasing recognition of chlorhexidine as an allergen

Chlorhexidine was first developed for use in 1954 by Imperial Chemical Industries (ICI), Manchester, United Kingdom. The first report of cutaneous hypersensitivity was from Calnan in London in 1962¹. Further reports of anaphylaxis to chlorhexidine originated from Japan, by Okano² in 1983 and Nishioka³ in 1984.

The true incidence of anaphylaxis to chlorhexidine is not known and is almost impossible to calculate. Reasons for this include the absence of mandatory reporting of reactions and the inability to accurately ascertain the total number of exposures to chlorhexidine in all its forms. An additional confounder is that chlorhexidine anaphylaxis is thought to be under-recognised⁴.

Helping to conspire against identification as an allergen, chlorhexidine anaphylaxis is typically delayed when absorption occurs across skin or mucosa⁵, compared to the majority of perioperative antigens where anaphylaxis manifests within a few minutes of intravenous administration.

Whilst it appears that the incidence of anaphylaxis to chlorhexidine is low (due to the increasing denominator episodes of exposure), the numbers of patients experiencing adverse reactions appear to be increasing⁶. Many case reports and case series of chlorhexidine anaphylaxis are described in the literature⁷⁻⁵⁰.

A governmental warning was issued in Japan in 1984, prohibiting the use of chlorhexidine on mucosal membranes⁸. Warnings specific to hypersensitivity reactions from chlorhexidine impregnated central devices, such as central venous access devices (CVADs), have also been issued by the Food and Drug Administration⁵¹ in the United States of America and by the Therapeutic Goods Administration in Australia in 2012⁵².

Data from New Zealand Centres for Adverse Reaction Monitoring (CARM) shows 69 cases of anaphylaxis had been reported in New Zealand since 2000⁵³. The largest published case series is from Auckland where 26 cases of chlorhexidine hypersensitivity were diagnosed between 1998 and 2008⁷.

There is no centralised database in Australia for reporting chlorhexidine allergy. However, multiple testing centres affiliated with the Australian and New Zealand Anaesthetic Allergy Group are noting an increase in cases of chlorhexidine anaphylaxis diagnosed. One individual testing centre in Sydney, Australia has a case series of 29 cases of confirmed chlorhexidine anaphylaxis tested between 2007 and January 2015. At this centre chlorhexidine has risen to become the third most common allergen identified to cause perioperative anaphylaxis, after neuromuscular blockers and antibiotics⁵⁴.

A finding of additional concern is that multiple patients in this series had more than one episode of anaphylaxis caused by chlorhexidine as a result of failure to identify chlorhexidine as an antigen, or failure to recognise the presence of chlorhexidine in products found in the hospital environment. The findings

highlight the need for chlorhexidine-free management guidelines to protect these patients from iatrogenic injury.

3.2 Difficulty in identifying products containing chlorhexidine

Chlorhexidine is increasingly incorporated in antiseptic handrub solutions, gels, pastes, dressings and devices (including central venous catheters and drapes). As such, it is often seen as a hidden or “occult” antigen in the clinical environment. Furthermore, products purchased in hospitals for each application change in accordance with purchasing contracts and evolution of clinical guidelines, particularly infection control recommendations.

The inconsistent labelling of products that contain chlorhexidine also presents a barrier to successful avoidance of these products in allergic patients. There is no universal symbol to ensure it is simple to identify that a product contains chlorhexidine, such as there is for latex. Print outlining product composition is often small and not placed in a prominent or uniform position.

Registers of such products are not an easy solution, but are an important step in ensuring the safe management of chlorhexidine hypersensitive patients. They need to be individually prepared according to the clinical guidelines and purchasing practices in each hospital and frequently updated by each institution.

It is particularly important to understand that whilst a register of chlorhexidine containing products may help identify such products, absence of a product on the register is no guarantee that the product is chlorhexidine-free. A health worker must check every product they use on each occasion of use in patients who have a history to suggest chlorhexidine hypersensitivity to prevent exposure. This is time consuming and laborious but necessary to prevent inadvertent chlorhexidine exposure in allergic individuals.

3.3 Difficulty avoiding contact with chlorhexidine products once identified

During a hospital stay, an individual patient may transition through many departments of a hospital, such as emergency departments, operating theatres, intensive care units, general wards, and radiology. A system of labelling the patient and their immediate environment is necessary to achieve continuity of the knowledge of their allergy status as they progress through the system.

It is often worthwhile to develop a plan, ideally in the pre-admission setting, for anticipated medical procedures that may occur during the patient’s hospital stay. This plan can include perceived risks and alternative antiseptics/approaches to procedures. It is essential that non-chlorhexidine alternatives are maintained as standard stock in all clinical environments within hospitals to ensure safe care for these patients.

The patient must be educated regarding their chlorhexidine hypersensitivity and advised to notify each new staff member wherever possible.

Simple measures should be taken to isolate the patient from common forms of chlorhexidine exposure. For example, they should be housed in single rooms wherever possible, with all chlorhexidine products removed from the immediate environment and replaced with chlorhexidine-free alternatives.

4. SUMMARY

Chlorhexidine is an excellent antiseptic agent that may occasionally cause anaphylaxis. Though anaphylactic reactions to chlorhexidine are uncommon, it is an increasingly prevalent allergen in the perioperative setting.

Exposure to chlorhexidine in the clinical environment is routine. Avoidance of recurrent anaphylactic reactions must begin with the identification and substitution of all products containing chlorhexidine. Careful planning and implementation is required to prevent inadvertent exposure to chlorhexidine in the sensitised patient as they move throughout the hospital system.

RELATED ANZCA DOCUMENTS

PS60 Guidelines on the Perioperative Management of Patients with Suspected or Proven Hypersensitivity to Chlorhexidine

PS28 Guidelines on Infection Control in Anaesthesia

DOCUMENT DEVELOPMENT GROUP

The ANZCA Safety and Quality Committee acted as the document development group and delegated the task to the Anaesthetic Allergy Subcommittee as the expert panel.

EXPERT PANEL

Dr Michael Rose (Chair), FANZCA, Chair Anaesthetic Allergy Subcommittee and Australian and New Zealand Anaesthetic Allergy Group

Dr Helen Crilly, FANZCA, member Anaesthetic Allergy Subcommittee

Associate Professor David Scott, FANZCA, former Chair, Safety and Quality Committee

Dr Phillipa Hore, FANZCA, Chair, Safety and Quality Committee

Dr Beatrix Treuren, FANZCA, Deputy Chair, Anaesthetic Allergy Subcommittee

Dr Katherine Nicholls, Clinical Immunologist/Pathologist, member Anaesthetic Allergy Subcommittee

Dr Helen Kolawole, FANZCA, member Anaesthetic Allergy Subcommittee

Dr Karen Pedersen, FANZCA, member Anaesthetic Allergy Subcommittee

Dr Peter Roessler, FANZCA, Director of Professional Affairs (Professional Documents)

REFERENCES

1. Calnan, C. D. Contact Dermatitis from Drugs. *Proceedings of the Royal Society of Medicine* 1962; 55(1), 39–42.
2. Okano M, Nomura M, Okada N, Sato K, Tashiro M. Four cases presenting anaphylactic reactions due to topical application of Hibitane. *Skin Res* 1983; 25: 587 – 92
3. Nishioka, K., Doi, T. and Katayama, I. Histamine release in contact urticaria. *Contact Dermatitis*, 1984; 11: 191.
4. Krautheim AB, Jermann THM, Bircher AJ. Chlorhexidine anaphylaxis: case report and review of the literature. *Contact Dermatitis*. 2004; 50(3):113-116
5. Parkes W, Harper N, Herwadkar A, Pumphrey R. Anaphylaxis to the chlorhexidine component of Instillagel®: a case series. *Br J Anaesth* 2009;102:65-8.
6. Nakonechna A, Dore P, Dixon T, Khan S, Deacock S, et al. (2012) Immediate hypersensitivity to chlorhexidine is increasingly recognised in the United Kingdom. *Allergol Immunopathol (Madr)*. 2014; 42(1):44-9.
7. Wills A. Chlorhexidine anaphylaxis in Auckland. *Br J Anaesth*. 2009 May;102(5):722-3.
8. Okano M, Nomura M, Hata S, Okada N, Sato K, Kiyano Y et al. Anaphylactic symptoms due to chlorhexidine gluconate. *Arch Dermatol* 1989; 125:50-52.
9. Wicki J, Deluze C, Cirafici L, Desmeules J. Anaphylactic shock induced by intraurethral use of chlorhexidine. *Allergy* 1999; 54: 768-769.
10. Autegarden JE, Pecquet C, Huet S, Bayrou O, Leynadier F (1999) Anaphylactic shock after application of chlorhexidine to unbroken skin. *Contact Dermatitis* 1999; 40: 215.
11. Okano M, Masao N, Seiichiro H, Natsuko O. Anaphylactic symptoms due to chlorhexidine gluconat. *Arch Dermatol* 1989: 125: 50–52.
12. Okuda T, Funasaka M, Asimitsu M, Umeda T, Wakita K, Koga Y. Anaphylactic shock by ophthalmic wash solution containing chlorhexidine. *Masui* 1994: 43: 1352–1355.
13. Mitchell D J, Parker F C. Anaphylaxis following urethral catheterisation. *Br J Urol* 1993; 71: 613.
14. Cheung J, O’Leary JJ. Allergic reaction to chlorhexidine in an anaesthetised patient. *Anaesth Intensive Care* 1985: 13: 429–430
15. Khoo A, Oziemski P (2011) Chlorhexidine impregnated central venous catheter inducing an anaphylactic shock in the intensive care unit. *Heart Lung Circ* 2011; 20: 669-670.
16. Chisholm, D. G., Calder, I., Peterson, D., Powell, M., & Moul, P. Intranasal chlorhexidine resulting in anaphylactic circulatory arrest. *BMJ : British Medical Journal*, 1997;315(7111), 785.
17. Visser LE, Veeger JH, Roovers MH, Chan E, Stricker BH. Anaphylaxis caused by chlorhexidine following cystoscopy or urethral catheterization. *Ned Tijdschr Geneesk* 1994: 138: 778–780.
18. Russ B R, Maddern P J. Anaphylactic reaction to chlorhexidine in urinary catheter lubricant. *Anaesth Intensive Care* 1994: 22: 611–612.
19. Yong D, Parker F C, Foran S M. Severe allergic reactions and intra-urethral chlorhexidine gluconate. *Med J Aust* 162: 257–258.
20. Torricelli R, Wurthrich B. Life-threatening anaphylactic shock due to skin application of chlorhexidine. *Clin Exp Allergy* 1996: 26: 112.

21. Oda T, Hamasaki J, Kanda N, Mikami K. Anaphylactic shock induced by an antiseptic-coated central venous catheter. *Anesthesiology* 1997; 87: 1242–1244.
22. Snellman E, Rantanen T. Severe anaphylaxis after a chlorhexidine bath. *J Am Acad Dermatol* 1999; 40: 771–772.
23. Peutrell JM. Anaphylactoid reaction to topical chlorhexidine during anaesthesia. *Anaesthesia* 1992; 47: 1013.
24. Ohtoshi T, Yamauchi N, Tadokoro K, Miyachi S, Suzuki S, et al. IgE antibody-mediated shock reaction caused by topical application of chlorhexidine. *Clin Allergy* 1986; 16: 155-161.
25. Pham N H, Weiner J M, Reisner G S, Baldo B A. Anaphylaxis to chlorhexidine. Case report. Implication of immuno- globulin E antibodies and identification of an allergenic determinant. *Clin Exp Allergy* 2000; 30: 1001–1007.
26. Knight B A, Puy R, Douglass J, O'Hehir R E, Thien F. Chlorhexidine anaphylaxis: a case report and review of the literature. *Int Med J* 2001; 31: 436–437.
27. Garvey L H, Roed-Petersen J, Husum B. Anaphylactic reactions in anaesthetized patients – four cases of chlorhexidine allergy. *Acta Anaesthesiol Scand* 2001; 45: 1290–1294.
28. Thune P. Two patients with chlorhexidine allergy: Anaphylactic reactions and eczema. *Tidsskr Nor Laegeforen* 1998; 118: 3295–3296.
29. Evans P, Foxell R M. Chlorhexidine as a case of anaphylaxis (multiple letters). *Int J Obstet Anesth* 2002; 11: 145–146.
30. Pittaway A, Ford A, Wynne D, Davies L. Allergy to chlorhexidine-coated central venous catheters revisited (multiple letters). *Br J Anaesth* 2002; 88: 304–305.
31. Visser LE, Veeger JH, Roovers MH, Chan E, Stricker BH. Anaphylaxis caused by chlorhexidine following cystoscopy or urethral catheterization. *Ned Tijdschr Geneeskde* 1994; 138: 778–780.
32. Lockhart A S, Harle C C, Davies W. Anaphylactic reactions to chlorhexidine (multiple letters). *Br J Anaesth* 2001; 87: 940–941.
33. Bae, Y-J., Park, C. S., Lee, J. K., Jeong, E., Kim, T.-B., Cho, Y. S., & Moon, H.-B. (2008). A Case of Anaphylaxis to Chlorhexidine during Digital Rectal Examination. *Journal of Korean Medical Science*, 2008; 23(3), 526–528.
34. Stephens R, Mythen M, Kallis P et al. Two episodes of life- threatening anaphylaxis in the same patient to a chlorhexidine-sulphadiazine-coated central venous catheter. *Br J Anaesth* 2001; 87: 306–308.
35. Terazawa E, Shimonaka H, Nagase K, Masue T, Dohi S. Severe anaphylactic reaction due to chlorhexidine-impregnated central venous catheter. *Anesthesiology* 1998; 89: 1296–1298.
36. Porter B J, Acharya U, Ormerod A D, Herriot R. Latex/ chlorhexidine-induced anaphylaxis in pregnancy. *Allergy* 1998; 53: 455–457.
37. Chisholm D G, Calder I, Peterson D, Powell M. Intranasal chlorhexidine resulting in anaphylactic circulatory arrest. *BMJ* 1997; 315: 785.
38. Evans R J. Acute anaphylaxis due to topical chlorhexidine acetate. *BMJ* 1992; 304: 686.
39. Jee R, Nel L, Gnanakumaran G, Williams A, Eren E. Four cases of anaphylaxis to chlorhexidine impregnated central venous catheters: a case cluster or the tip of the iceberg? *British Journal of Anaesthesia* 2009; 103: 614–5.
40. Ferrarini A, Baggi M, Flückiger R, Bianchetti MG. Intraoperative anaphylaxis to a chlorhexidine polymer in childhood. *Paediatr Anaesth* 2006; 16: 705.

41. Beatty P, Kumar N, Ronald A. A complicated case of chlorhexidine-associated anaphylaxis. *Anaesthesia*, 2011, 66, 56–66.
42. Khan, R. A., Kazi, T., O'Donohoe, B. Near fatal intra-operative anaphylaxis to chlorhexidine—is it time to change practice? *BMJ Case Reports*, 2011, bcr0920092300.
43. Dyer, J. E., S. Nafie, J. K. Mellon, and M. A. Khan. "Anaphylactic reaction to intraurethral chlorhexidine: sensitisation following previous repeated uneventful administration." *Annals of the Royal College of Surgeons of England* 95, no. 6 (2013): 105E-106E.
44. Noel J, Temple A, Laycock GJ. A case report of anaphylaxis to chlorhexidine during urinary catheterisation. *Ann R Coll Surg Engl* 2012; 94: e159–e160.
45. Jayathillake A, Mason DF, Broome K. Allergy to chlorhexidine gluconate in urethral gel: report of four cases and review of the literature. *Urology*. 2003;61:837.
46. Ramselaar, C. G., Craenen, A. and Bijleveld, R. Th. Severe Allergic Reaction to an Intra-urethral Preparation Containing Chlorhexidine. *British Journal of Urology*, 1992; 70: 451–452.
47. Guleri A, Kumar A, Morgan RJM, Hartley M, Roberts DH. Anaphylaxis to Chlorhexidine-Coated Central Venous Catheters: A Case Series and Review of the Literature. *Surgical Infections* 2012, 13(3): 171-174.
48. Sijbesma T, Röckmann H, van der Weegen W. Severe anaphylactic reaction to chlorhexidine during total hip arthroplasty surgery. A case report. *Hip Int* 2011; 21: 630–632.
49. Beatty, P., Kumar, N., Ronald, A. A complicated case of chlorhexidine-associated anaphylaxis. *Anaesthesia* 2011; 66: 60–61.
50. Mushtaq, U., Tan, A., Tan, J.A. and Smith, W. Acute allergic reaction after intravenous saline injection: an unusual presentation of chlorhexidine allergy. *MJA Medical Journal of Australia*, 2014; 200(10): 599-600.
51. FDA Public Health Notice: Potential hypersensitivity reactions to chlorhexidine-impregnated medical devices. *US Food and drug Administration*. 1998
52. Anaphylaxis with chlorhexidine-impregnated central venous catheters. *Australian Prescriber* 2012; 35: 3.
53. Medsafe NZ. Chlorhexidine - Risk of Anaphylaxis. *Prescriber Update* 2013;34(2):22.
54. Royal North Shore Hospital Anaesthetic Allergy Clinic Database.

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the College's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the College website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and

practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated: 2015
Date of current document: September 2015

© Copyright 2015 – Australian and New Zealand College of Anaesthetists. All rights reserved.

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from ANZCA. Requests and inquiries concerning reproduction and rights should be addressed to the Chief Executive Officer, Australian and New Zealand College of Anaesthetists, 630 St Kilda Road, Melbourne, Victoria 3004, Australia. Website: www.anzca.edu.au email: ceoanzca@anzca.edu.au

ANZCA website: www.anzca.edu.au