Table of Contents

Policy overview and responsibility .............................................................. Page 2-3

Procedure guidelines for IV contrast .............................................................. Page 4

Point of care testing ..................................................................................... Page 5

Pre-medication policy for prior allergic like reactions to contrast media .................... Page 6

Pre-Medication Regimen .................................................................................. Page 7-9

Documentation of adverse events .................................................................. Page 10

Contrast reaction and adverse event radiologist coverage .................................. Page 11-12

Algorithm for recognition and response to contrast reaction .............................. Page 13

Management suggestions for major adverse events ......................................... Page 14-15

Dosing and contents of contrast reaction kits .................................................. Page 16

Protocol for Extravasated Contrast Material ................................................ Page 17

Contrast Extravasation Discharge Instructions ............................................. Page 18

Blood Transfusions and Radiology Contrast Administration .......................... Page 19

Policies specific to CT contrast media .......................................................... Page 20-31

Policies specific to MRI contrast media ........................................................ Page 32
I. Policy

To provide guidelines for the use of intravenous or oral, iodinated and gadolinium based contrast media, as well as the proper response of Radiology staff in the event of a contrast media event.

See policy I.21 for use of IV contrast on breast feeding patients.
See policy II.6 for Emergency Equipment and Contrast Reaction Kits

II. Responsibility

1. IV and oral contrast media agents are considered medications according to the Joint Commission and, therefore, all adherences to the Medication Management Standards and all applicable YNHH drug use policies apply.

2. The patient’s physician, PA, or APRN is responsible to order radiology exams, including those that require contrast media, either by written requisition or via computer order entry system. Inpatient and ED requests for contrast exams must include the patient’s pregnancy status and renal function as appropriate.

3. The radiologist has primary responsibility to review pertinent, available patient history, including eGFR levels, and the appropriateness of the request for contrast media, the dose, and the type of contrast administered prior to assigning imaging protocols.

4. Per YDR and DR administration, the responsibility to protocol CT exams with contrast is limited to radiology physicians and/or advanced practioners. For exams ordered with IV contrast, the patients’ eGFR should be ≥ 30. If the eGFR is < 30, should follow low eGFR workflow listed below.
   a. eGFR results for in-patient and ER patients should be within 48 hours. For out-patients, eGFR values are acceptable for up to 6 weeks before exam (the most recent Creatinine value can be used to compute the eGFR).

5. eGFR work flow for CT-
   If a CT study is ordered WITH contrast and eGFR is OVER 30, you can protocol it with IV contrast.

   If a CT is ordered WITH contrast and eGFR is BELOW 30 when patient arrives:
   a. Technologist will call the appropriate reading room to notify a radiologist. Radiologist then has to review the case and make a decision.
      i. Give contrast despite eGFR<30: A few studies have shown NO added risk of deterioration of renal function with IV contrast compared to matched controls regardless of renal function (2, 3, 5), however one study showed higher risk with eGFR <30 (1). If you have any doubt on best choice, discuss with ordering provider and document reasoning in your report.
      ii. Change CT to WITHOUT contrast: If clinical question can be answered sufficiently without IV contrast, document the following in your dictation. ie “Current study was initially ordered with IV contrast.
However the patient’s eGFR on “date X” was ‘X’. Thus, the exam was switched to without IV contrast to eliminate risk of renal injury.”

iii. **Exam should be canceled/re-scheduled:** If exam canceled, CSA (clinical scheduling assistant) will note the cancel reason as “lab function out of range” in the order history in EPIC.

b. Technologist should document in EPIC study notes the name of radiologist who made decision. If radiologist is ever unclear on what to do, they should discuss case with ordering provider.

If order is being CHANGED (to without contrast or canceled), then technologist will communicate the radiologist’s decision to CSA and ask CSA to contact the ordering physician’s office.

c. CSA, working from an approved script, will communicate the information to the ordering provider (or ordering providers staff) including the eGFR value and the radiologist’s recommendation for the patient’s imaging.

i. If the ordering provider does not agree with the radiologist’s decision, CSA will connect provider to radiologist for discussion. CSA will wait for further direction from the radiologist and/or technologist once that call is completed.

ii. If the ordering provider agrees with the radiologist’s decision, the CSA will edit exam order with ordering provider.

iii. IF CSA cannot get in touch with ordering physician (or surrogate), the radiologist’s decision will prevail. **It is crucial that all our reports have documentation for reasoning to give or withhold contrast for this reason.**

    o If the ordering provider agrees with the radiologist decision the CSA will-
        - If changing order to CT WITHOUT contrast:
            - EPIC Provider:
                - CSA will change the order in EPIC to a non-contrast exam and send the order via EPIC in-basket request for co-sign
                - CSA will track the order to ensure co-sign is received
            - Non-EPIC Provider:
                - CSA will change the order in EPIC to a non-contrast exam
                - CSA will request a new requisition from the ordering physician
                - CSA will track to ensure the new requisition is received
                - CSA will upload the new requisition into the Media Manager section of EPIC
                - Regardless of EPIC or non-EPIC provider, CSA will contact PFAS via PFASDRCHANGES@YNHH.ORG to alert the Pre-service team of the change in procedure code.
                - Pre-service team will address any issues with authorization
6. All personnel involved in the administration of contrast media are responsible to be aware of the steps that can be taken to anticipate a contrast reaction in order to try to prevent it, or if one occurs, recognize it and take appropriate measures. Contrast reactions may be dealt with by technologists, nurses, RA, radiologists, code-teams or a combination of the above. See Addendum I.15A Recognition and Response to a Contrast Reaction.

III. Procedure Guidelines for IV Contrast

1. Intravenous contrast will be injected through an intravenous line previously established by the nurse or technologist. See DR Policy 1.17: Medication Administration by Technologists in Diagnostic Radiology.

2. Prior to the administration of IV contrast, the patient’s history including medications, allergies, and questions screening for renal impairment will be reviewed by the technologist in the patient’s medical record, or obtained using the appropriate outpatient questionnaire, and subsequently scanned or entered into the medical record.

   a. If no contraindications to contrast are noted, the technologist proceeds with IV contrast administration as per protocol identified by the radiologist.

   b. If contraindications are noted, the case is referred to the radiologist for further consideration.

   c. An IV line will stay in place during the examination, should IV drug therapy be necessary.

   d. A physician must be readily available during the contrast examination.

   e. A contrast reaction kit and emergency equipment (including a code cart, if a hospital site), must be readily available.

   See Policy II.6 – Emergency Equipment & Supplies
IV. Point of Care Testing

A. Point-of-Care eGFR testing will be performed by the technologist/technologist aid or nursing as required for Outpatients (and rarely for in-patients), at the time of appointment. This test is inspected by the College of American Pathologists as part of the accreditation of the Department of Laboratory Medicine at Yale-New Haven Hospital. The meter will diagnose the quantitative measurement of creatinine in capillary, venous, and arterial whole blood and convert the creatinine value by means of standard algorithms into estimated glomerular filtration rate (eGFR) in order to evaluate renal function. The eGFR will be recorded in separate dedicated log as well as on the patients’ safety sheet.

B. Point of Care Meter:
Will be maintained by the MRI and CT Scan departments and a QA schedule will be strictly adhered to. Staff will be trained in the use of the meter during their orientation and reviewed for competency annuals. “Super users” will be assigned for training of staff members.

POINT-OF-CARE Renal Function Testing in Radiology
(Formerly Addendum I.15J)

C. MRI Patients:
- Please see MRI safety manual for full details.

D. CT Patients:
- Any outpatient that answers “Yes” to the contrast related questions on the CT Oral / IV Contrast Data Form will be given a Point-of-Care test to determine eGFR level if no eGFR/Cr value is available within 6 weeks.
- eGFR levels under 30 are referred to the radiologist as detailed in section 2.5.
Pre-medication policy for prior allergic like reactions to contrast media

<table>
<thead>
<tr>
<th>For Planned Administration of Contrast Agents:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous reaction to allergens (eg shellfish, peanuts, medications etc):</td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous reaction to <strong>same</strong> class of contrast agent going to be given:</td>
<td></td>
</tr>
<tr>
<td>Mild (Excluding hives/facial swelling/itching)</td>
<td>Moderate (Including hives/facial swelling/itching)</td>
</tr>
<tr>
<td>None</td>
<td>Pre-medicate and use different agent</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous reaction to <strong>different class</strong> of Contrast agent than type to be given.</td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

*Unless in the opinion of the responsible health care professional and supervising radiologist, the potential benefits outweigh the risks i.e. emergency situations. In these instances, specific indications and reason(s) for exception should be documented in the report.

Premedication with steroids and Benadryl is now recommended only for patients who have had a reaction to contrast of a similar class (iodinated agents used during CT are one class, gadolinium based agents used during MRI are separate class) to the one planned to be given.

Prophylaxis for those with reactions to other allergens is no longer necessary.

This policy decision is based on the following information:

- Current estimated reaction risk in the general population is about 0.6% (Wang et al.)
- Patients with a prior reaction to contrast are known to be at highest risk (3-11% reaction rate, with 2% breakthrough) (Mervak et al. Lasser et al) for repeat reaction.
- The rate of reaction to contrast agents for patients with prior anaphylaxis to substances other than contrast may be higher than the normal population, but not enough to warrant premedication.
- The current standard of care in the United States is to premedicate patients with steroids and Benadryl to decrease risk of repeat contrast reaction in patients who have had a reaction in the past to a similar class contrast agent.
**Reaction Definitions:**

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Nausea, Vomiting</td>
<td>-Rash, Hives</td>
<td>-Convulsions</td>
</tr>
<tr>
<td>-Cough</td>
<td>-Swelling: Eyes, Face</td>
<td>-Laryngeal Edema (severe or rapidly progressing)</td>
</tr>
<tr>
<td>-Warmth</td>
<td>-Tachycardia/Bradycardia</td>
<td>-Unresponsiveness</td>
</tr>
<tr>
<td>-Headache</td>
<td>-Hypertension</td>
<td>-Cardiopulmonary Arrest</td>
</tr>
<tr>
<td>-Dizziness</td>
<td>-Generalized or diffuse erythema</td>
<td>-Profound Hypotension</td>
</tr>
<tr>
<td>-Shaking</td>
<td>-Dyspnea</td>
<td>-Clinically Manifest Arrhythmias</td>
</tr>
<tr>
<td>-Altered Taste</td>
<td>-Bronchospasm, Wheezing</td>
<td></td>
</tr>
<tr>
<td>-Itching</td>
<td>-Laryngeal Edema</td>
<td></td>
</tr>
<tr>
<td>-Pallor</td>
<td>-Mild Hypotension</td>
<td></td>
</tr>
<tr>
<td>-Flushing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Nasal Stuffiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Anxiety</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**References:**


Lasser EC, Berry CC, Mishkin MM, Williamson B, Zheutlin N, Silverman JM. Pretreatment with corticosteroids to prevent adverse reactions to nonionic contrast media. AJR 1994


**Out-patient Adults:**

- 50mg Prednisone PO 13, 7 and 1 hour before the injection.
- 50mg Benadryl (Diphenhydramine) IV/PO within 1 hour of the injection.

**Adult in-patients and ED patients regime is:**

- 200mg Hydrocortisone IV 4 hours before injection.
- 50mg Benadryl (Diphenhydramine) IV/PO within 1 hour of the injection.

**Out-patient Pediatrics (For patients less than 50kg):**

- Prednisone 0.7 mg/kg (not to exceed 50mg) PO 13, 7 and 1 hour before the injection or Prednisolone 0.7mg/kg (not to exceed 50mg) PO 13, 7 and 1 hour before the injection.
• Benadryl (Diphenhydramine) 1mg/kg IV/PO (not to exceed 50mg) within 1 hour of the injection.

Pediatric in-patient and ED patients (for patients less than 50kg):

• Hydrocortisone 1mg/kg (not to exceed 200mg) IV 4 hours before injection.
• Benadryl (Diphenhydramine) 1 mg/kg IV/PO (not to exceed 50mg) within 1 hour of the injection.

Pre-Medication Regimen

Premedication order set is now available in EPIC
### CONTRAST REACTION

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Approx Cost</th>
<th>Dose</th>
<th>Route</th>
<th>Freq</th>
<th>Prof List</th>
<th>Rx Code</th>
<th>Phased Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contrast reaction pre-medication (cortisone/diphenhydramine)</td>
<td>MedMic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 loaded. No more to load.
V. Documentation of Adverse Events

1. If a contrast event occurs, the radiology nurse or technologist involved must document the details within the patient medical record (Epic). It will be the technologist or nurse’s responsibility to ensure that the individuals involved have included the following details:
   - Contrast agent/dose administered
   - Reaction signs/symptoms
   - Patient management, including drugs administered
   - Patient outcome
   - Provide discharge instructions sheet

2. Details concerning the administration of contrast and the adverse event must also be documented in the radiology report.

3. Nurses/Techs must also enter a report in RL solutions Event Reporting System.

4. At the radiologist’s discretion, the patient’s clinician will be notified verbally at the time of the event.
CT Contrast Reaction or urgent adverse patient event coverage*

### MONDAY - FRIDAY

<table>
<thead>
<tr>
<th>Patient Location</th>
<th>Day Shift (8am-5pm)</th>
<th>Evenings and night (5pm-8am)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SP2 (usually 7am-430pm)</td>
<td>Chest or Cardiac (S. Pavilion)</td>
<td>ED</td>
</tr>
<tr>
<td>Smilow (Open 7am-8pm)</td>
<td>If neuro case, neuro MR (Smilow)</td>
<td>Neuro</td>
</tr>
<tr>
<td>ED</td>
<td>Otherwise, body CT (Smilow)</td>
<td></td>
</tr>
<tr>
<td>Saint Raphael's (Open 24/7)</td>
<td>Body</td>
<td>ED</td>
</tr>
<tr>
<td>YNHH Nuc med PET/CT (open till 7pm)</td>
<td>Nuclear Medicine</td>
<td>Neuro (Smilow)</td>
</tr>
<tr>
<td>SRC Nuc Med PET/CT</td>
<td>Body</td>
<td>ED</td>
</tr>
</tbody>
</table>

### SATURDAY - SUNDAY

<table>
<thead>
<tr>
<th>Patient Location</th>
<th>Day Shift (8am-5pm)</th>
<th>Afternoon &amp; Nights (5pm-8am)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SP2</td>
<td>Chest if present. Otherwise ED</td>
<td>ED</td>
</tr>
<tr>
<td>Smilow (Open 8am-430pm)</td>
<td>If neuro case, neuro MR (Smilow)</td>
<td>Neuro (Smilow)</td>
</tr>
<tr>
<td>ED</td>
<td>Otherwise, body CT (Smilow)</td>
<td></td>
</tr>
<tr>
<td>Saint Raphael's (open 24/7)</td>
<td>ED</td>
<td>ED</td>
</tr>
</tbody>
</table>

*Non-urgent situations such as contrast extravasation, mild contrast side effects (nausea/vomiting), and falls will be handled by the supervising service during normal business hours.

<table>
<thead>
<tr>
<th>NEURO SMILOW-200-3181</th>
<th>PEDS-688-6184</th>
<th>ED YNHH-688-6180</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEURO FITKIN-688-4305</td>
<td>CHEST SP-688-8811</td>
<td>ED SRC-789-3929</td>
</tr>
<tr>
<td>BODY SMILOW-200-5734</td>
<td>CARDIAC -688-3570</td>
<td></td>
</tr>
<tr>
<td>BODY FITKIN-688-3171</td>
<td>SRC BODY-789-6092/3</td>
<td></td>
</tr>
<tr>
<td>BREAST-200-5229</td>
<td>SRC MRI-789-4126</td>
<td></td>
</tr>
</tbody>
</table>
Contrast Reaction or urgent adverse patient event coverage (non-urgent situations such as contrast extravasation, mild contrast side effects (nausea/vomiting), and falls will be handled by the supervising service during normal business hours)

### MONDAY - FRIDAY

<table>
<thead>
<tr>
<th>Patient Location</th>
<th>Day Shift (8am-5pm)</th>
<th>Evenings and night (5pm-8am)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitkin (Open 7am to 11pm)</td>
<td>If neuro case, neuro (Fitkin) Otherwise, body MR (Fitkin)</td>
<td>ED YNHH</td>
</tr>
<tr>
<td>Smilow 2 (Open 24/7)</td>
<td>If neuro case, neuro (Smilow) Otherwise, body CT (Smilow)</td>
<td>Neuro (Smilow)</td>
</tr>
<tr>
<td>Smilow 1 (Tue-7am to 7pm, M/W/Thu-7am-4:30pm, F-7am-3pm)</td>
<td>Breast</td>
<td>Closed now. When open ED</td>
</tr>
<tr>
<td>Pedi (Open 7am to 7pm)</td>
<td>Pediatrics</td>
<td>ED YNHH</td>
</tr>
<tr>
<td>Saint Raphael's (Open 24/7)</td>
<td>Neuro SRC, Body SRC, Chest SRC, MSK SRC</td>
<td>ED SRC</td>
</tr>
</tbody>
</table>

### SATURDAY - SUNDAY

<table>
<thead>
<tr>
<th>Patient Location</th>
<th>Day Shift (8am-5pm)</th>
<th>Afternoon &amp; Nights (5pm-8am)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smilow 2 (Open 24/7)</td>
<td>If neuro case, neuro (Smilow) Otherwise, body CT (Smilow)</td>
<td>Neuro (Smilow) if present. Otherwise ED</td>
</tr>
<tr>
<td>Smilow 1 (7am to 12pm Sat only)</td>
<td>Breast (if present) If breast not present- If neuro case, neuro (Smilow) All other cases Body CT (Smilow)</td>
<td>ED (7am-8am)</td>
</tr>
<tr>
<td>Fitkin (7:00am to 4pm Sat only)</td>
<td>If neuro case, neuro MR (Smilow) Otherwise, body CT (Smilow)</td>
<td>ED YNHH</td>
</tr>
<tr>
<td>Saint Raphael's (Open 24/7)</td>
<td>ED SRC</td>
<td>ED SRC</td>
</tr>
</tbody>
</table>

### Contacts

- **NEURO SMILLOW-200-3181**
- **PEDIATRICS-688-6184**
- **CHEST SRC- 789-3929**
- **NEURO FITKIN- 688-4305**
- **CARDIAC SP- 688-3570**
- **ED SRC-789-3929/789-6097**
- **BREAST-200-5229**
- **MSK SRC- 789-3704**
- **BODY MR FITKIN-688-3171**
- **BODY SRC-789-6092/3**
- **ED YNHH-688-6180**
- **BODY CT SMILLOW-200-5734**
- **NEURO SRC- 789-4126**
ALGORITHYM FOR RECOGNITION AND RESPONSE TO CONTRAST REACTION
(Formerly Addendum I.15A)

MAJOR REACTIONS

BREATHING PROBLEMS OR SHOCK

a) Coughing, Choking
b) Difficulty Breathing
c) Wheezing / Stridor
d) Facial / Neck Swelling
e) Cyanosis / Severe Diaphoresis
f) Unresponsive/hypotensive

NOTIFY RADIOLOGIST AND NURSING

1. Assess air way and lungs
2. Check vital signs - place on monitor
3. Check ability to swallow, patient color, quality of voice

IF PROBLEM- Call CODE

Within Hospital: Call 155 (Code Blue = Adults) (Code White = Pedi)
Outside New Haven: Call 9-911 (Local EMS)

MINOR REACTIONS/ PHYSIOLOGIC REACTIONS

• Nausea, vomiting
• Warmth
• Headache
• Dizziness
• Altered taste
• Pallor
• Flushing
• Chills
• Sweats
• Mild nasal stuffiness
• Anxiety

If Asymptomatic

1. Comfort and reassure patient
2. Observe – continue or complete exam
3. If no further problem, can discharge.

If no relief or symptoms persist

1. Maintain and secure IV access
2. Notify radiologist
MANAGEMENT SUGGESTIONS FOR MAJOR ADVERSE EVENTS

**ADULT:**

ASSESS AIRWAY, HR, BP, SPO₂, AUSCULTATE HEART AND LUNGS,
OBTAIN IV ACCESS, OXYGEN, MONITOR

**UNRESPONSIVE**

CALL CODE OR 911

PALKPLE PULSE? RESPIRATIONS?

YES

NO

**HYPOTENSIVE**

ELEVATE LEGS/NEGLIGENCE (10-15°)
OXYGEN AS NEEDED
SECURE AIRWAY

HEART RATE < 60 BPM?

YES

NO

**WHEEZING/BRONCHOSPAEM**

OXYGEN AS NEEDED
ELEVATE HEAD OF BED

**ALBUTEROL NEBULIZER OR INHALER**

STILL WHEEZING OR NO RESPONSE

**URTICARIA**

DIPHENHYDRAMINE (BENADRYL)
25-50mg (PO, IM, IV)

**ADULT- EpiPen (0.3mg)**

**FACIAL/LARYNGEAL EDMA**

OXEMET AS NEEDED
ELEVATE HEAD OF BED

**ADULT- EpiPen (0.3mg)**

**CALL CODE OR 911**

**USING THE EPIPEN**

1. Remove EpiPen from box

2. Pull blue safety release cap.

3. Press orange tip FIRMLY against outer thigh until it ‘clicks’. Hold for 3 seconds. DO NOT PLACE FINGERS OVER ORANGE TIP

**CODE TEAMS**

YNHH/Bridgeport/Greenwich: 155
L & M: 8888
Westerly: 222
## DOSING AND CONTENTS OF CONTRAST REACTIONS KITS

**References:**
ACR Committee on Drugs and Contrast Media. ACR Manual on Contrast Media

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albuterol MDI INHALER 90 mcg/actuation</strong></td>
<td>2 puffs (90mcg/puff) for a total of 180 mcg. May repeat up to 3 times every 20 minutes</td>
<td></td>
</tr>
<tr>
<td><strong>Albuterol Nebulizer 0.083% solution</strong></td>
<td>2.5 mg (3 mL) inhaled via a nebulizer over 5-15 minutes. May repeat as needed.</td>
<td></td>
</tr>
<tr>
<td><strong>Atropine 1mg/10mL SYRINGE</strong></td>
<td>0.5 mg IV -Administer slowly, followed by saline flush -May repeat every 3 – 5 minutes up to 3 mg total</td>
<td>Infants/Children: -MINIMUM single dose (for patients &gt;5 kg) = 0.1 mg -MAX single dose = 0.5 mg -MAX total dose = 1 mg Adolescents: -MAX single dose = 1 mg -MAX total dose = 3 mg</td>
</tr>
<tr>
<td><strong>Dextrose 50% 25g/50mL SYRINGE</strong></td>
<td>25g IV -Administer over 2 min 0.5 g/kg IV -Max single dose = 25g -Administer over 2 min</td>
<td></td>
</tr>
<tr>
<td><strong>Diphenhydramine 50mg VIAL</strong></td>
<td>25-50 mg IM or IV -Administer IV dose slowly over 1-2 min 1-2 mg/kg IM or IV -Administer IV dose slowly over 1-2 min</td>
<td></td>
</tr>
<tr>
<td><strong>Epinephrine auto-injector (Epi-pen®) ANAPHYLAXIS</strong></td>
<td>Hives, diffuse erythema, bronchospasm, laryngeal edema, hypotension: 0.3mg IM <strong>Use 0.3 mg auto-injector</strong></td>
<td>Anaphylaxis: 0.01 mg/kg IV (0.1 mL/kg of 1mg/10mL dilution) MAX individual dose: ( \leq 30 ) kg = 0.15 mg (1.5mL) ( &gt; 30 ) kg = 0.1 to 0.3 mg (1 mL to 3mL) -May repeat up to 1 mg total dose</td>
</tr>
<tr>
<td><strong>Epinephrine 1mg/10mL PREFILLED SYRINGE for IV administration (Anaphylaxis)</strong></td>
<td>Anaphylaxis (ONLY for very unstable patient: severe hypotension, tachycardia, severe airway edema) 0.1 to 0.3mg SLOW IV push (1 mL to 3mL of 1mg/10mL dilution) May repeat every 5 - 15 minutes as needed up to 1 mg</td>
<td></td>
</tr>
</tbody>
</table>
Loratadine (Claritin) | 10mg PO | 2-5 years: 5 mg PO  
≥6 years: 10 mg PO

Methylprednisolone | 125 mg VIAL  
administered over 3 minutes | 0.5-1 mg/kg IV push over 3 minutes  
-MAX dose = 125 mg

Sodium chloride 0.9% 500 mL | 1,000mL rapidly IV  
-MAX volume = 500 mL - 1,000 mL

**Protocol for Extravasated Contrast Material**
*(Formerly Addendum I.15C)*

Modified from the ACR Manual of Contrast Media Manual

**Background:**

Extravasated iodinated contrast media is hyperosmolar and toxic to the surrounding tissues. Most patients recover without sequelae but severe adverse events may occur. Extravasation produces an acute local inflammatory response that peaks at 24-48 hrs although ulceration and tissue necrosis may occur as early as 6 hours after the extravasation. Extravasation of a large volume of contrast material can produce a compartment syndrome.

**Evaluation and Treatment:**

- All patients in which an extravasation has occurred should be evaluated by a radiologist from the service that would be reading the exam.
- All outpatients should be monitored in the department for a minimum of 1 hour even if the patient is asymptomatic.
- Elevation of the extremity and a cold or warm compress should be applied to the site up to four times/day for 1-3 days (This decision is based on radiologist and patient preference)
- If the symptoms improve or the patient remains asymptomatic, they may be sent home but told to go immediately to an ER if symptoms deteriorate or if there are skin/neurologic changes (ulceration, blistering, change in sensation).
- If symptoms have not improved after 2 hours or skin/neurologic changes develop, the patient should be referred to the emergency room.
- For inpatients, the extremity should be elevated and a cold or warm compress should be applied (as above). Inpatients may be sent back to the floor but the house staff must be notified of the incident.
- A plastic surgical consult is frequently not necessary and a reliance of a volume threshold for surgical consultation is unreliable. In general, the need for surgical consultation should be made on the basis of the patient’s signs and symptoms.
  - An immediate plastic surgical consultation is indicated with the following:-
    - Increasing swelling/pain after 2-4 hours.
    - Altered tissue perfusion as evidenced by decreased capillary refill
    - Change in sensation of the affected limb
    - Skin ulceration or blistering.

**Documentation:**

- All extravasation events should be documented in the radiology report and the referring physician should be notified.
- The technologist is responsible to ensure that the extravasation incident is documented in Event Reporting system.
ACR Reference on Contrast Extravasations

“There is no clear consensus regarding effective treatment for contrast medium extravasation. Elevation of the affected extremity above the level of the heart to decrease capillary hydrostatic pressure and thereby promote resorption of extravasated fluid is recommended, but controlled studies demonstrating the efficacy of this treatment are lacking. There is no clear evidence favoring the use of either warm or cold compresses in cases of extravasation. As a result there are some radiologists who use warm compresses and some who use cold compresses. Those who have used cold have reported that it may be helpful for relieving pain at the injection site. Those who have used heat have found it helpful in improving absorption of the extravasation as well as in improving blood flow, particularly distal to the site”

Contrast Extravasation Discharge Instructions

(FORMERLY Addendum I.15C)

During your test today, you had intravenous contrast material extravasation. This means that some of the IV fluid or contrast material went into the tissues of your arm/hand. This may cause swelling and discomfort. The fluid will be absorbed by your tissues and any symptoms should go away.

The contrast material used was _____________________________

The approximate amount of extravasation was _______________________

Treatment:

• Try to keep the affected extremity elevated above the level of the heart as much as possible.
• You can apply either warm or cold compresses for 15 minutes a few times a day for 3 days or until the symptoms resolve.

Seek immediate medical attention if:

1. your swelling or pain do not improve
2. your skin blisters
3. there is increased firmness at the site
4. your arm or an area on your arm or hand becomes red
5. you experience a change in sensation of your hand or arm such as numbness and tingling

I have read and understand these instructions and received a copy.

Name of patient _____________________________________________

Signature of patient __________________________________________
Radiology Policy Regarding Simultaneous Infusion of Blood Products and Contrast Media

Blood transfusion and all blood related products including FFP, platelets and other cryoprecipitates play a vital role in patient care. Like drugs, these substances may also elicit allergic like reactions and immune responses that can potentially mimic reactions induced by IV injection of iodinated AND gadolinium based contrast media used during CT and MRI scans respectively. In conjunction with Yale/YNHH Transfusion Medicine Services, a joint agreement was made to limit CT and MRI scans WITH CONTRAST for patients actively receiving ANY blood product to STAT or LIFE-THREATING PRIORITY. For these studies, it is felt that the information provided by the rapid imaging outweighs any potential risk and/or uncertainty on which substance may have caused a reaction.

All other scans should be delayed until after the infusion is completed to avoid any misinterpretation of a contrast reaction from a blood product reaction and vice versa. These studies can be performed immediately after the infusion is complete if necessary".
Policies Specific to CT Contrast Media
I. Procedure Guidelines for Oral Contrast

1. All Patients
   a. Prior to the administration of oral contrast, the patient’s clinical history including medications, allergies and sensitivity and drugs, will be reviewed by the technologist in the patient’s medical record, or obtained using the appropriate outpatient questionnaire, and subsequently scanned into the RIS medical record.
   
   b. If no contraindications are noted, the technologist proceeds with oral contrast administration as per protocol identified by the radiologist.
   
   c. All patients routinely receive an iohexol (Omnipaque®) in H20 mixture, prepared according to the radiologist protocol, labeled with patient’s demographics, and provided to the patient or nurse with instructions for administration.
   
   d. If contraindications are noted, the request is referred to the radiologist for further consideration. An oral Barium Sulfate solution may be prescribed for patients allergic to iodinated contrast.
   
   e. A physician must be readily available during the contrast examination.
   
   f. A contrast reaction kit and emergency equipment (including a code cart, if a hospital site), must be readily available. See Policy II.6 – Emergency Equipment & Supplies

2. In-patients
   a. Labeled oral contrast will be delivered to the in-patient floor for administration to the patient by their nurse.

3. Adult ED Patients
   a. After the ED patient’s Pregnancy and eGFR test results are available (for select patients), the ED physician will order the contrast CT exam (Oral or IV) in the RIS, and include pertinent clinical history.
   
   b. CT exams requiring contrast will be reviewed and protocolled by radiology prior to dispensing and administering the contrast agent. The exception to this is for a “FULL Trauma” ED patient.
   
   c. If the study requires oral contrast it will be picked up in Radiology and given to the patient by ED nurse.
d. Patient imaging will begin approximately 45 minutes after the patient begins drinking it. Extended oral preparation may be prescribed by the radiologist at their discretion based on exam indication.

4. Pediatric ED Patients
   
a. After the contrast request has been reviewed by the radiologist, the appropriate dose will be determined.

b. Oral contrast will be dispensed to the pediatric ED for administration to the pediatric patient by their nurse.

c. The patient’s nurse will notify the ED radiology scheduler as the patient finishes drinking the oral contrast to coordinate exam timing.
CT Scan Oral Contrast
(FORMERLY Addendum I.15I)

25ml Omnipaque (Iohexol) in 900ml of Water

Patient Name: _______________________________
MRN: ___________________ Pt. Location ________
Date: ______________ Exp.Date/Time ____________
Start Oral: _____________ Finish _____________
Approx. Scan Time: ____________

Please instruct patient to drink contrast over the assigned hour. Please call 8-5639 if you have any questions or the patient cannot follow instruction, so we can expedite the procedure. If the start time is delayed please inform 85639. Inform the MD if the patient experiences any adverse events such as difficulty breathing or itching.

Rev 3/18/10

CT Scan Oral Contrast
Barium Sulfate Suspension (2.1%w/v, 2.0%w/w)

Patient Name: _______________________________
MRN: ___________________ Pt. Location ________
Date: ______________ Exp.Date/Time ____________
Start Oral: _____________ Finish _____________
Approx. Scan Time: ____________

Please instruct patient to drink contrast over the assigned hour. Please call 8-5639 if you have any questions or the patient cannot follow instruction, so we can expedite the procedure. If the start time is delayed please inform 85639. Inform the MD if the patient experiences any adverse events such as difficulty breathing or itching.

Rev 3/18/10
Metformin and Iodinated Contrast

Information for patients

This fact sheet provides instructions on how to take your oral diabetes medications containing Metformin after you receive iodinated contrast dye for a CT scan.

Diabetes medications that contain metformin include:

- Metformin (Glucophage/Glucophage XR, Glumetza, Riomet, Fortamet)
- Alogliptin/metformin (Kazano)
- Canagliflozin/metformin (Invokamet/Invokamet XR)
- Dapagliflozin/metformin (Xigduo XR)
- Empagliflozin/metformin (Synjardy/Synjardy XR)
- Ertugliflozin/metformin (Segluromet)
- Glipizide/metformin (Metaglip)
- Glyburide/metformin (Glucovan)
- Linagliptin/metformin (Jentadueto/Jentadueto XR)
- Pioglitazone/metformin (Actoplus Met/Actoplus Met XR)
- Repaglinide/metformin (Prandimet)
- Rosiglitazone/metformin (Avandamet)
- Saxagliptin/metformin (Kombiglyze XR)
- Sitagliptin/metformin (Janumet/Janumet XR)
- Vildagliptin/metformin (Eucreas)

Why should I be taking my metformin differently?

In rare instances, Metformin can cause a severe side effect called lactic acidosis. This may occur more frequently in patients with decreased kidney function. Decreased kidney function is apparent when your estimated glomerular filtration rate (eGFR) is less than 30 mL/min. Contrast dye can increase the chances of metformin causing lactic acidosis in patients with decreased kidney function.

What should I do?

If you have decreased kidney function (eGFR less than 30 mL/min):

- Stop taking metformin or metformin-containing products and contact your doctor within 48 hours before restarting.
- Bring this form with you to the doctor.

If you do not have decreased kidney function (eGFR 30 mL/min or greater):

- Continue taking metformin as originally prescribed.

Questions or concerns

If you have any questions or concerns, talk to your doctor or pharmacist.
Low-Osmolar Iodinated Contrast and Myasthenia Gravis

Low-osmolar iodinated contrast has been shown to have a weak association with exacerbation of Myasthenia Gravis-related symptoms, most commonly respiratory compromise. This association has been discussed with Yale Neurology who feel that the low risk does not merit screening patients for Myasthenia at this point. If a patient declares himself or herself as suffering from Myasthenia Gravis, our policy should be to reassure them that it is highly unlikely that any deterioration in symptoms will occur.
CT TECHNOLOGIST: Policy for Power Injection

** CVDs with TPN infusions cannot be used for contrast injection unless TPN has been disconnected and vigorously flushed by RN prior to exam, before patient leaves the floor.

** NOTE: No IV medication drips should be stopped or restarted without an RN’s help. Injector should not be used with any IV that has questionable patency. If in doubt, question the radiologist or the clinical team.

### CVD’s – Adult use

<table>
<thead>
<tr>
<th>Catheter</th>
<th>Used for CT Inject.</th>
<th>Lumen Size</th>
<th>Max Injection Rate</th>
<th>Max PSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power PICCS (Bard) or equivalent from other manufacturer</td>
<td>Yes</td>
<td></td>
<td>Check Hub</td>
<td>Check hub</td>
</tr>
<tr>
<td>Power Ports (Bard) or equivalent port from other manufacturer</td>
<td>Yes</td>
<td>6.5-10 French</td>
<td>5cc/sec.</td>
<td>300</td>
</tr>
<tr>
<td>Power Hickmann</td>
<td>Yes</td>
<td>Check Hub</td>
<td>Check hub</td>
<td></td>
</tr>
<tr>
<td>Non Power Injectable or unknown$^1$ ports</td>
<td>Yes</td>
<td>1 cc/ sec</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Micropuncture introducers placed by IR</td>
<td>Yes</td>
<td>5 French</td>
<td>5 cc</td>
<td>300</td>
</tr>
<tr>
<td>IV catheters in a foot vein</td>
<td>Yes</td>
<td>18g-22g IV access</td>
<td>1 cc/ sec</td>
<td>100</td>
</tr>
<tr>
<td>EJ or IJ – peripheral IV access</td>
<td>Yes</td>
<td>18g-22g IV access</td>
<td>2 cc/ sec$^2$</td>
<td>300</td>
</tr>
<tr>
<td><strong>Triple-Lumen (Arrow)</strong></td>
<td>Yes</td>
<td>16g=brown port - Use whenever possible 18g=blue port</td>
<td>1 cc/sec (unless higher rate listed on hub)</td>
<td>100 (lines that list higher injection rates at hub are usually OK to inject up to 300 psi)</td>
</tr>
<tr>
<td>Power Mid Lines</td>
<td>Yes</td>
<td>4/5 French</td>
<td>5 cc / sec</td>
<td>300</td>
</tr>
<tr>
<td>Quinton/ Non-Power Hickman/ Permacath</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non- Marked Piccs</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

$^1$ Review Epic (lines and drains section) to research if type of port is known. If unknown, and need to inject at higher rate can review chest x-ray or scout image with radiologist to see if port is labeled with “CT” icon denoting power injectable port.

$^2$ All attempts should be made to secure another site of access to allow for power injection, including PICC team consult. If there is no alternative IV access and the patient needs a STAT CTA for potentially life threatening indication, then attending radiologist supervising scan will need to approve study after discussion with attending clinician for patient. The radiologist will document approval in protocol and a clinical team LIP will accompany patient to CT scan in case of extravasation event in the neck. Technologist should not increase rate to beyond 4 cc/sec and 300 psi.
1.) Following Hand Hygiene Policy at all times: wash or Purell, don gloves, when completed remove gloves, then wash or Purell.

2.) RN must access and de-access all indwelling Ports – CVD lumen access may be performed by the CT technologist to inject contrast.

3.) Prior to use: All CVAD lines used for contrast with injector or hand injection must have a 15 sec. hub scrub with approved disinfectant and allowed to air dry (minimum 15 sec.). (All CVD’s must be checked for patency and blood return, using a 10 cc saline syringe with 3 cc removed. Flush line with 10 cc sterile saline after. A CVD should not be used without verification of blood return.

4.) CT Technologist should monitor injection site for the duration of injection when possible.

5.) The contrast for all CVD’s is Omnipaque 350. If prior contrast reaction to Omnipaque, alternative agent like Isovue 370 may be used)

---

**Script**

**Adult Power Hickman – In-Patients:** Call the floor to check IV status. If the RN states the patient has a Hickman two (2) questions need to be asked:

1.) Is the Hickman a **Power Hickman** (Needs to be labeled on the clamp with maximum injection rate, if not Is a P or an X seen within the line on the Chest X-Ray or is there documentation in EPIC.

2.) Has there been **TPN** running?
   a. If **Yes**: to flush vigorously now and Disconnect TPN and to clearly mark lumen used for TPN.
   b. Send patient with no meds running. (Open flush is allowed)
   c. Instruct RN that the patient will return **without** the catheter being flushed with heparin.
   d. If the TPN cannot be stopped and flushed before leaving the floor, the Hickman may not be used for the contrast injection.
   e. Follow 15 second hub scrub and allow to air dry (min. 15 seconds).
   f. Do not disconnect injector prior to exam completion or the hub scrub will need to be repeated.
   g. Maximum flow rate will be listed on the lumen clamp.

**Adult Power Hickman:** **Out- patient:** Follow 15 sec. hub scrub and allow to air dry (minimum 15 sec.) Maximum flow rate will be listed on the lumen clamp. Do not disconnect injector prior to exam completion or the hub scrub will need repeating. Call South Pavilion Core IR RN, Prep Hold RN, or RN in your respected area’s to flush heparin post injection per YNHH policy.

**Injection rate for use of PEDI Injector: Including foot veins**

<table>
<thead>
<tr>
<th>Lumen Size</th>
<th>Flow Rate</th>
<th>PSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>18g, 20g IV access</td>
<td>2 cc / sec</td>
<td>150</td>
</tr>
<tr>
<td>22 g IV access</td>
<td>2 cc / sec</td>
<td>150</td>
</tr>
<tr>
<td>24 g IV access</td>
<td>1.5 cc / sec</td>
<td>50</td>
</tr>
</tbody>
</table>

**Pedi- All Central Lines including Broviac: In-Patient patients:** Call the RN. Instruct RN to accompany the patient. Pedi RN will need to follow YNHH hub scrub policy. Pedi RN will hub scrub and access the pediatric patient’s **Central Line** and the technologist will connect the contrast. Omnipaque 350 may be injected @ 1 cc / sec. at 100 PSI. With the help of the CT Tech, the Pedi RN will disconnect the injector and follow YNHH heparin flush policy.

**Pedi Broviac:** **Outpatient:** Call Out Patient Pedi Nursing (follow same process as above)
WHAT TO DO WITH IV LINE AIR FILTER DEVICES BEFORE CT SCAN

!ALERT!

Attention all technologists who inject contrast. If you see a Pall Posidyne ELD filter or a Baxter INTERLINE System Extension Set (air eliminating filters) hooked up to a patient, please stop the line and let a nurse know before proceeding. These particular filters are used for patients with patent foramen ovale, as any air introduced into their body could result in a very serious reaction. They should NEVER be used with a power injector.

If you have any questions, please contact Dave Facchini:

david.facchini@ynhh.org
203-688-4367
CT Intraosseous Iodinated Contrast Injection Policy

IO lines may be used for power injection of iodinated contrast for CT

1. Flush IO line with 20cc IO saline. If IO line does not flush easily, do not use.

2. If Patient is unconscious, no analgesia is required. If patient is conscious and responsive to pain, IO 2% epinephrine free lidocaine should be administered just prior to contrast as per the protocol below:

ADULT:

- Prime EZ-Connect extension set with lidocaine *Note that the priming volume of the EZ-Connect is approximately 1.0ml.*
- Slowly infuse lidocaine 40 mg IO over 2 minutes.
- Allow lidocaine to dwell in IO space for 1 minute.
- Flush with 5 to 10 mLs of normal saline.
- Slowly administer and additional 20 mg of lidocaine IO over 1 minute.

Pediatric:

- Usual dose is 0.5mg/kg, not to exceed 40mg.
- Prime EZ-Connect extension set with lidocaine.
  *Note that the priming volume of the EZ-Connect is approximately 1.0ml.*
- Slowly infuse lidocaine over 2 minutes.
- Allow lidocaine to dwell in IO space for 1 minute.
- Flush with 2-5 mLs of normal saline.
- Slowly administer subsequent lidocaine (half the initial dose) IO over 1 minute.

3. Hook power injector tubing directly to IO line hub.

4. Inject contrast through IO line. No guidelines exist on rates for injection so use lowest injection rate possible (up to 5cc/sec) for the study and do not exceed 300 psi.

5. Disconnect power injector tubing from the IO line hub and flush the IO line with 20 cc IO saline.
Patients with a Single Kidney

It has been shown that there are no significant differences in the rate of AKI attributable to contrast enhanced CT in patients with a solitary kidney versus two kidneys. Therefore, patients with a solitary kidney should receive the same amount of IV contrast as those with two kidneys. This can be edited at the discretion of the supervising radiologist in patients with compromised renal function.

McDonald JS et al. Radiology 278;74-81:2016

Please follow the below link for a list of CT screening forms used by the department:

POLICIES SPECIFIC TO MRI CONTRAST MEDIA

All MRI polices have been moved, and are now centrally located within the YNHH MRI safety manual. Please click the below link to be routed to the manual:

https://ynhh.ellucid.com/documents/view/20133