QUESTION

How do oncology nurses feel during a hypersensitivity reaction?

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"I can't breathe," she said.

I was working in an outpatient infusion center at the time of this event. We had a strong team, including nurses and advanced practice providers who would respond when called upon, but did not have a code team. If a patient was not stabilizing as a result of our interventions, we would call 911. My patient had completed a dose of oxaliplatin a few minutes ago, and now her 5-fluorouracil pump was programmed and ready for independent double verification from another nurse. Not expecting anaphylaxis after her drug was already finished, I rushed to respond quickly when she reacted to oxaliplatin. She was one of the rare individuals who reacted after her medication was completely done infusing. I hit the emergency light, and nurses rushed in; the emergency medical kit was opened, the pump was disconnected, and emergency medications were given via a newly started line of normal saline. I provided emotional support while pushing diphenhydramine, methylprednisolone, and famotidine. One nurse gave intramuscular epinephrine for the first time in her many years of nursing. Other nurses pitched in with oxygen and raced down the hall with the emergency cart. Additional doctors and pharmacists filled the room because this level of reaction required the urgent attention of the team. It was the end of the day, and the medical oncologist came quickly from three floors below, stepping away from his already full schedule. Our patient recovered, and we did not rechallenge her with chemotherapy this day because she had been given epinephrine.

I am a member of a large group of infusion nurses. In my current role as a nursing staff development coordinator, I provide nurses with annual emergency response training. We learn how to recognize reactions to various medications, from anaphylaxis to cytokine release syndrome. We also vigorously review our guidelines for handling infusion reactions and update them routinely with the most up-to-date evidence-based practice. In addition, our drug regimens display careful steps of what to do in the event of an unexpected reaction. However, no matter how thorough our training is, each emergency brings new challenges because every patient presents uniquely. Following such events, we try to have a postreaction huddle that day or the next to discuss what went well and opportunities to improve our process. On some occasions we have a formal discussion, and other times it is an in-the-moment conversation between nurses and other staff members reliving the event. The occasions when we call 911 are challenging. We are relieved to see the squad arrive and assume care but wonder how things go for the patient after they leave our floor. When we can stabilize and discharge the patient from our unit, we think about what will happen next time. Will the medication be changed to something else? Will a new drug work as well? Are we going to rechallenge with additional premedication? Will we titrate the current medication?

In one staff meeting, our mental health advanced practice RN asked if we could have any request granted for the day on our unit, what would it be? One of the first answers was no allergic reactions. Another was for every patient to have a complete response to their treatment. We have our hopes set high to see our patients have the absolute best possible outcomes. We prepare to respond quickly with expertise when the unexpected happens.

RESOURCES

- ***Annals of Oncology***
  Describes the European Society for Medical Oncology guidelines for management of infusion reactions
  https://doi.org/10.1093/annonc/mdx216
- ***Clinical Journal of Oncology Nursing***
  Reviews the symptoms of hypersensitivity reactions associated with oxaliplatin
  https://doi.org/10.1188/19.CJON.68-75
- ***World Allergy Organization Journal***
  Provides guidance on anaphylaxis management
  https://doi.org/10.1016/j.waojou.2020.100472

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