

**Hospital Clinical Guidelines**  
**EVIDENCE TABLE**

**GUIDELINE TOPIC: Management of Latex Allergy**

Please record all references used in developing the clinical guideline. This form must be filled out electronically and emailed to [Jody.Smith@rch.org.au](mailto:Jody.Smith@rch.org.au)

NB: If you need assistance with completing this table, please contact Jody Smith on x 6956.

<b>Reference (include title, author, journal title, year of publication, volume and issue, pages)</b>	<b>Method</b>	<b>Evidence level (I-V)</b>	<b>Summary of recommendation from this reference (point form)</b>
Australasian society of clinical immunology and allergy (ascia) (2006)	Expert opinion	V	<ul style="list-style-type: none"> <li>• ASCIA is the peak professional body of Clinical Allergists and Immunologists in Australia and New Zealand.</li> <li>• ASCIA Education resources (AER) information bulletins are peer reviewed by ASCIA members and represent the available published literature at the time of review.</li> <li>• It is important to note that information contained in this bulletin is not intended to replace professional medical advice. Any questions regarding a medical diagnosis should be directed to a medical practitioner</li> </ul>
Association of Operating Room Nurse – Latex Guideline (2004)	Evidence Based Guidelines	V	<ul style="list-style-type: none"> <li>• The AORN guideline is based on research and expert opinion and may not apply to every individual and may require modification based on specific needs of a given patient, health care provider or situation.</li> </ul>
Young, M.A and Myers, M. (1997) Latex Allergy: Considerations of the Care of Paediatric Patients and Employee Safety. <i>Nursing Clinics of North America</i> p: 169-82.	Expert opinion	V	<ul style="list-style-type: none"> <li>• In the peri- operative arena, there is an increased risk for this allergy due to the mode and frequency of latex exposure.</li> <li>• Using a multidisciplinary team approach, nurses must institute policies and procedures for precautions to take with latex to ensure that patients and employees remain in a safe environment.</li> <li>• Through education, research and collaboration with industry and health care professionals, latex sensitization can be minimized, and latex allergic reactions avoided,</li> </ul>
Jackson, D. "Latex Allergy and anaphylaxis-what to do?" (1995) <i>Journal of intravenous Nursing</i> 18 33-52	Expert opinion	V	<ul style="list-style-type: none"> <li>• An overview of latex allergy, including methods for preventing reactions and reducing exposure to latex, is provided.</li> <li>• There is a strong need for more information on latex sensitivity, especially in the areas of epidemiology, product development, and effectiveness of procedures.</li> </ul>

<p>Robert, S. and Holzman, M.D (1997) "Clinical Management of Latex-Allergic Children" <i>anaesthesia Anal</i> (85) 529-33</p>	<p>Evidence obtained from case-series, either post-test or pre-test and post test.</p>	<p>IV</p>	<ul style="list-style-type: none"> <li>• For children who have had serious allergic reactions to latex, a latex-safe environment is effective in preventing preoperative anaphylaxis.</li> <li>• Latex allergic patients require the avoidance of latex products.</li> </ul>
<p>Department of Health New South Wales (2005) "Latex Allergy-policy frame work and Guidelines for prevention and management.</p>	<p>Evidence based Guideline</p>		<ul style="list-style-type: none"> <li>• The information contained in this guideline is believed to reflect best practice at the time of publication.</li> <li>• Where good evidence is not available the guideline offers current consensus based on expert opinion.</li> <li>• The guideline includes strategies for the identification and effective management of latex allergic health consumers in various clinical settings.</li> </ul>

Level of Evidence  
Clinical Guidelines  
Royal Children's Hospital

### The Hierarchy of Evidence

**The Hierarchy of evidence is based on the National Health and Medical Research Council (2000) and Oxford Centre for Evidence-based Medicine Levels of Evidence (May 2001)**

- I** Evidence obtained from a systematic review of all relevant randomised control trials.
- II** Evidence obtained from at least one properly designed randomised control trial.
- III-1** Evidence obtained from well-designed pseudo-randomised controlled trials (alternative allocation or some other method).
- III-2** Evidence obtained from comparative studies (including systematic reviews of such studies) with concurrent controls and allocation not randomised, cohort studies, case control studies, or interrupted time series with a control group.
- III-3** Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group.
- IV** Evidence obtained from case-series, either post-test or pre-test and post test.
- V** Expert opinion without critical appraisal, or based on physiology, bench research, or historically based clinical principles.

Clinical guidelines are based on reviews of the best available evidence. **Level 1 evidence represents the gold standard for intervention studies**; however it is not available for all areas of practice and for some guidelines it may be appropriate to utilise results from studies with lower levels of evidence. Some clinical guidelines may also be informed by experts in the field, locally (RCH) and internationally (Journal articles) (expert opinion) etc. This NHMRC Hierarchy can be used to grade evidence. Please record details on the evidence table and return to Clinical Quality and Safety (CQS) with guideline draft. The Evidence table can be filled out electronically or printed and used as a hard copy.

*Please contact Jody Smith Clinical Guideline and Path Coordinator on ext 6956 if you have any concerns or require assistance.*