The use of contrast material is vital to the practice of radiology. A radiologist is expected to learn to use contrast material in a safe and effective manner. Contrast material is used to enhance the conspicuousness of lesions, various organs, tissues, and potential spaces. Special formulations and volumes of contrast are administered in various ways, depending on the clinical situations, as is outlined below. The radiologist must select the appropriate type, concentration, volume, and mode of delivery of contrast for each clinical setting. Certain types of contrast carry increased risk for patients, in certain clinical settings. The radiologist must weigh the risks and benefits of contrast administration and choose appropriately. Guidelines for various situations are outlined in the following sections.

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The use of contrast material is vital to the practice of radiology. A radiologist is expected to learn to use contrast material in a safe and effective manner. Contrast material is used to enhance the conspicuousness of lesions, various organs, tissues, and potential spaces. Special formulations and volumes of contrast are administered in various ways, depending on the clinical situations, as is outlined below. The radiologist must select the appropriate type, concentration, volume, and mode of delivery of contrast for each clinical setting. Certain types of contrast carry increased risk for patients, in certain clinical settings. The radiologist must weigh the risks and benefits of contrast administration and choose appropriately. Guidelines for various situations are outlined in the following sections.
1 GI FLUOROSCOPIC CONTRAST

There are two major techniques of fluoroscopic bowel opacification: single-contrast and double-contrast. In single-contrast studies, dilute contrast is used to distend the lumen. Lesions are then seen as profile abnormalities, or as filling defects with compression. The fluoroscope is set to a higher kilovoltage (110–120 kVp) than is used in double-contrast studies. In the latter, the mucosa is coated with thick barium contrast, and the lumen is distended with air. Lesions are coated, and good distention is vital. The fluoroscope is set to a relatively lower kilovoltage (90–100 kVp).

There are two major types of fluoroscopic bowel contrast: barium suspensions and water-soluble, iodine-containing contrast preparations. Barium preparations can be used with both single- and double-contrast techniques. Water-soluble contrast is used only with the single-contrast technique. If there is a risk of aspiration, barium is preferred, as water-soluble contrast is hyperosmolar and may cause alveolar edema. Alternatively, a low-osmolar nonionic water-soluble agent (such as Optiray 160® or Omnipaque 180®) could be considered if a risk of aspiration exists. If there is a risk of bowel perforation, water-soluble contrast is preferred, as barium extravasation is irritating and produces foreign body granulomata and subsequent adhesions.

Adult Esophagram/Upper GI

**Thick Barium (i.e., EZ Barium)**

The patient can only drink thick barium by cup, not through a straw. Thick barium is good for upright, double-contrast esophagus, stomach, and duodenal views.

**Thin Barium (i.e., Barospersse Barium)**

The patient can drink through a straw. It is good for prone right anterior oblique drinking esophagus images. It does not coat the esophagus as well as thick barium but has a faster small bowel transit time. Thin barium is useful for evaluation of the small bowel. For evaluation of the small bowel only, the radiologist may skip thick barium and go straight to thin to speed the transit of contrast through the small bowel. Owing to suboptimal coating with the thin barium, the stomach is less well assessed.

**Nonsterile Hypaque Iodinated Contrast**

A water-soluble contrast material that comes in a nonsterile powdered formulation. It is usually mixed with tap water at 20% for fluoroscopy, or 2% for CT and is adequate for single-contrast evaluation of the stomach, duodenum, or colon. This contrast is suboptimal for examination of the small bowel because the contrast is hyperosmolar, draws fluid into the bowel, and dilutes the column of contrast, making it difficult to see. It is often requested by surgeons to evaluate possible small bowel obstruction, as barium may get impacted and desiccated proximal to an obstruction and may spill into the peritoneum if surgery is necessary. As the contrast passes through the small bowel, however, the hyperosmolarity draws fluid into the bowel lumen, diluting the contrast material. This can make evaluation of distal small bowel obstructions extremely difficult, if not impossible.

**GastroView Iodinated Contrast**

A water-soluble contrast material that comes in comes in sterile, premixed bottles and is similar to 20% Hypaque.

**Esophotrast Barium or EZ Paste Barium**

Thick barium paste is used to evaluate the esophagus. Similar products are available from different manufacturers. One can mix this with applesauce or put it on graham crackers.

**Nonionic Iodinated Contrast (i.e., Omnipaque)**

This is a sterile, nonionic iodinated contrast. It is useful for initial swallows in a patient with a high likelihood of aspiration. If aspirated, it is slightly less damaging to lung tissue. A significant disadvantage is that it has a very bitter taste, and it may be necessary to instill this contrast through a tube placed in the esophagus.

**Pediatric Upper GI**

EZ Paque Barium or Nonsterile Nonionic Iodinated Contrast (25–30%) if barium is contraindicated.

**Be careful with Gastroview in children.** It is hyperosmolar and may lower intravascular volume by drawing fluid into bowel.

**Enteroclysis**

**i.e., Entero H Barium**

Micropulverized barium preparation, which coats well. It is washed through the small bowel with large volumes of methylcellulose or water.

**Double-Contrast Barium Enema**

**Polybar Barium**

Very thick barium preparation with good coating. However, slower moving column of contrast.

**AC® Barium**

Thinner barium preparation with poorer coating, but faster moving column.

**Example**

An example of a recipe for double-contrast barium enema is 50:50 Polybar/AC. If the patient is less mobile, the radiologist may want to go to 100% AC, to improve the barium flow.

**Single-Contrast Barium Enema**

Examples of recipes:

1 large can Hypaque®, mixed to 1200 mL, with water, or
4 bottles GastroView, mixed to 1200 mL with water.

Start with 1200 mL and make more if needed, for large-volume colons.
Rectum and Pelvic Floor Examination

*EZ Paste Barium*

Colostomy Study

100% AC Barium; give glucagon if appropriate.

2 BILIARY CONTRAST

I.e., Sterile Hypaque Iodine (Ionic) Contrast

This comes in sterile, premixed bottles at 60% and is useful for opacification of the biliary tree, sinus tracts, and gastro-

tomy tubes, during fluoroscopy. This contrast will be rapidly absorbed from most tissues, including the peritoneum and connective tissues, should it end up there.

3 BLADDER CONTRAST

I.e., Cysto-Conray®

This comes in sterile, 500-mL (adult) and 250-mL (pediatric) single-use bottles and is useful for cystograms and vesi-coureterograms (VCUGs).

4 INTRAVENOUS CONTRAST

Similar intravascular contrast agents are used for angiography, CT, and intravenous pyelography (IVP). All contain iodine, as the primary element for attenuating the x-ray beam. The older, less expensive contrast agents have iodine-containing molecules that are ionic. Most newer agents are nonionic. Use of nonionic agents is associated with fewer serious contrast reactions and fewer subjective complaints from patients about the injection. The newest agents, in addition to being nonionic, are also iso-osmolar to plasma. These seem to be the safest, best tolerated agents. Various formulations contain different concentrations of iodine. The radiologist can calculate the iodine content of different volumes of various agents. The radiologist should obtain consent from all patients before administration of contrast. When getting consent, one approach is to communicate to patients that “the administration of contrast is a safe and routine procedure. The benefits of using contrast, in general, clearly outweigh the risk. However, there is a small risk (1 in 50,000–100,000) of a life-threatening reaction.

A second important decision to consider is the volume of contrast to use. For older patients, smaller patients, and patients with renal disease, less contrast should be used. Under most none emergent situations, there is a limit to the amount of contrast used. For CT and IVP, this is generally a single dose per day. For angiography, administration of more contrast is acceptable.

A third important decision to make is the contrast flow rate. This may depend on the size of the needle, the size and strength of the vein that has been accessed, and the desired bolus rate. Higher flow rates are generally better, especially for CT, but be careful not to rupture veins and extravasate contrast. Angiographers must select volumes and flow rates to opacify fully the vessels that have been accessed.

Finally, there are several others factors to consider when administering contrast. One of the most significant complications of intravenous contrast administration is the subsequent development of contrast-induced nephropathy. Intravenous contrast should only be given within the set guidelines of the department. Examples of these of guidelines are described.

Examples of General Guidelines for Patients with Normal Renal Function

If recent creatinine is less than 1.5 mg/dL, then OK to give iv contrast.

If recent creatinine is between 1.5 and 2.0 mg/dL, then give iv contrast if it is necessary to answer the clinical question. You may decrease the volume of contrast administered, as well, from 100 to 75 or even 50 mL. Also, this type of patient may benefit from hydration before contrast infusion.

If recent creatinine is greater than 2.0–3.0 mg/dL, then get referring doctor involved in decision since the patient may get acute, irreversible renal failure and will need follow-up to assess renal function.

If recent creatinine is greater than 2.0–3.0 mg/dL, then don’t give iv contrast unless referring doctor insists (and preferably provides written documentation to that effect) This patient may need dialysis after contrast infusion.

Do not administer iv contrast with a concurrent chemotherapy or blood infusion, because is there is a reaction, there may be confusion as to whether the reaction was to the contrast, or the blood, or the chemotherapy agent.

General Rules for Patients with Decreased Renal Function

If recent creatinine is less than 1.7 mg/dL, then OK to give iv contrast.

If recent creatinine is between 1.7 and 2.0 mg/dL, then give iv contrast only if necessary to answer the clinical question.

If recent creatinine is greater than 2.0 mg/dL, then get referring doctor involved in decision and don’t give iv contrast unless referring doctor insists.

For a creatinine value to be relevant, it should be less than 2 months old.
Pay special attention to diabetics and other patients with medical renal disease, as well as older men with prostate problems.

If creatinine doubles over a month, renal function has decreased 50%.

If creatinine doubles over 24 h, renal function is essentially zero.

Don’t forget that thinner, older patients with poor muscle mass may have a relatively low baseline creatinine. For example, a rise in creatinine from 0.4 to 0.8 mg/dL in these patients may represent a 50% loss of function. A rise from 0.4 to 1.2 mg/dL may represent a 75% loss of function. Keep in mind that the creatinine level is an indirect indicator (albeit the most clinically relevant) of renal function.

If the patient has end-stage renal failure necessitating routine hemodialysis, contrast material does not usually cause difficulties as long as the patient undergoes dialysis promptly after the exam.

Glucophage®

There is no interaction between Glucophage and iv contrast. The problem is that if the patient develops renal failure acutely because of the contrast, toxic levels of Glucophage can quickly accumulate and result in a lethal lactic acidosis.

Have patient stop Glucophage for 48 h after iv contrast injection. If the patient is at high clinical risk for renal failure, he or she should have renal function checked prior to reinitiating the medication 48 h after the examination. If the patient notices no difference in the pattern of urine production and if the referring clinician agrees that no surveillance is necessary, the patient can subsequently resume oral hypoglycemics after 2 days.

Patients with a History of Contrast Reaction

Find out what type of reaction the patient experienced. Sometimes the patients confuse the feeling of warmth associated with an injection of contrast with a reaction.

For a history of serious iv contrast reaction such as bronchospasm and hypotension, and including hives, one must premedicate the patient with glucocorticoids prior to giving contrast.

Make sure the patient was premedicated appropriately.

Always administer nonionic iv contrast.

Example of Premedication for Prior Contrast Reaction

Prednisone 40 mg po
–Two doses: 12–18 h and 2 h before exam, or
–Three doses: 24, 12, and 2 h before exam.

Patients With Allergy

In patients with a history of asthma or chronic hives, consider using nonionic iv contrast.

Very Poor Cardiopulmonary Function

Such patients should get nonionic iv contrast. They are at increased risk of mortality, should the contrast trigger pulmonary edema.

A Breast Feeding Baby

Previously an absolute contraindication for iv contrast; now considered safe for mothers with breast feeding infants.

Sickle Cell Disease

If the patient is in acute crisis, don’t give iv contrast unless referring doctor insists, because of an increased risk of RBC sickling.

Patients not currently in crisis can receive iv contrast, at the discretion of the radiologist.

Multiple Myeloma

Absolute contraindication for iv contrast.

Possible Pheochromocytoma

Need α-blockers accessible prior to the administration of iv contrast.

The administration of contrast to these patients could potentially trigger a hypertensive crisis.

Summary of Contraindications for Contrast

Previous significant contrast reaction

History of anaphylaxis or nontrivial allergy to anything

Chronic urticaria or angioedema

Sickle cell anemia, multiple myeloma, asthma, or significant renal disease

Severe cardiac dysfunction or general debilitation.

Technique for Injection of Contrast

Check the creatinine. Obtain written, informed consent. Apply a tourniquet and gravity to distend veins. Select a contrast agent and draw up the desired volume. Select a type of needle (butterfly or angiocath) and a size (18–23 g). Connect the syringe to the needle, and expel all air from the system. Select a vein, and prep the overlying skin with an alcohol pad. Insert the needle into the vein, and tape down. For most injections done by hand, deliver the contrast as fast as you can push it through the needle while watching the vein for signs of extravasation. Palpate around the vein occasionally. A test injection with 10 mL of normal saline may be done before the injection of contrast material. Test injections are used in some institutions and may possibly reduce the incidence of contrast extravasation.
Table 1
Examples of Oral Contrast Protocols

<table>
<thead>
<tr>
<th>Area of interest</th>
<th>Contrast type/amount</th>
<th>Waiting time</th>
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<tbody>
<tr>
<td>Entire bowel</td>
<td>1 large cup (1000 mL) of oral contrast</td>
<td>2–3 h</td>
</tr>
<tr>
<td>Esophagus</td>
<td>2 teaspoons of esophageal paste contrast</td>
<td>Immediately</td>
</tr>
<tr>
<td>Pancreas</td>
<td>2 large cups of water</td>
<td>Immediately</td>
</tr>
<tr>
<td>Biliary system</td>
<td>2 large cups of water</td>
<td>Immediately</td>
</tr>
<tr>
<td>CT angiography</td>
<td>2 large cups of water</td>
<td>Immediately</td>
</tr>
<tr>
<td>Small bowel</td>
<td>1 cup (750 mL) of oral contrast</td>
<td>45–60 min</td>
</tr>
<tr>
<td>Terminal ileum</td>
<td>1 cup (750 mL) of oral contrast</td>
<td>90 min</td>
</tr>
<tr>
<td>Sigmoid colon</td>
<td>1 large cup (1000 mL) of iodinated oral contrast</td>
<td>2–3 h</td>
</tr>
<tr>
<td>Rectum</td>
<td>200–300 mL of contrast via rectal tube</td>
<td>Immediately</td>
</tr>
</tbody>
</table>
6 BLADDER CONTRAST FOR CT

Use diluted bladder contrast (i.e., Cysto-Conray) decreased in concentration to a 3% solution. Instill via Foley catheter via gravity. Can also use Hypaque-60 or Reno-M-60 diluted 1:10 with saline.

7 INTRATHECAL CONTRAST FOR CT

Nonionic, iodinated contrast is instilled intrathecally through a spinal needle prior to CT myelography. Examples of myelography preparations and volumes are as follows:

- 15 mL of Omnipaque 180
- 12 mL of Omnipaque 240
- 10 mL of Omnipaque 300

Ionic contrast is absolutely contraindicated, owing to the risk of seizures and other serious complications. Always double check the contrast administered intrathecally to make sure it is nonionic.

8 MR CONTRAST

Contrast material is also given for MR examinations. The vast majority of these agents contain gadolinium. The two major categories of MR contrast are the general purpose agents and the organ- or tissue-specific agents. The other categories, including oral MR contrast and the non-[1H] contrast agents, will not be addressed in this section.

**General Purpose Agents**

*Gadopentetate* (Gd-DTPA), *Magnevist®* (469 mg/mL)
- Standard dose: 0.1 mmol/kg or 0.2 mL/kg
- Dose range: 0.05–0.3 mmol/kg

*Gadoteridol* (Gd-HP-DO3A), *ProHance®* (279.3 mg/mL)
- Standard dose: 0.1 mmol/kg or 0.2 mL/kg
- Dose range: 0.05–0.3 mmol/kg

*Gadodiamide* (Gd-DTPA-BMA), Omniscan (287 mg/mL)
- Standard dose: 0.1 mmol/kg or 0.2 mL/kg
- Dose range: 0.05–0.3 mmol/kg

*Gadodiamide* (Gd-DTPA-BMA), Dotarem® (279.3 mg/mL)
- Standard dose: 0.1 mmol/kg or 0.2 mL/kg
- Dose range: 0.05–0.3 mmol/kg

*Gadobenate dimeglumine* (Gd-BOPTA), Multihance® (334 mg/mL)
- Standard dose: 0.05–0.1 mmol/kg or 0.1–0.2 mL/kg
- Dose range: 0.05–0.2 mmol/kg

Note: The hepatic uptake of Gd-BOPTA is 3–5%, and liver enhancement is noted up to 2 hours post injection. This gadolinium-based contrast is therefore useful as an extracellular agent in the first few minutes after injection as well as a hepatic agent when acquiring delayed images.

**Organ/Tissue-Specific Agents**

**T1 AGENTS**

*Gadobenate dimeglumine* (Gd-BOPTA), Multihance® (334 mg/mL)
- Standard dose: 0.05–0.1 mmol/kg or 0.1–0.2 mL/kg

**T2 AGENTS**

*Ferumoxides: AMI-25®, Feridex®, Endorem®* (mean particle size 150 nm)
- Standard dose: 10 mmol/kg or 11.2 mg of Fe/mL (and 61.3 mg of mannitol)
Contrast extravasation into the soft tissue surrounding the injection site is a relatively common complication of examinations involving iv contrast injection. The severity of this complication can range from trivial to limb-threatening. Examples of treatment for this untoward event are described.

- Minimal Extravasation
  > 5 mL
  No treatment or follow-up needed.

- Moderate Extravasation
  < 30 mL ionic or < 100 mL nonionic
  Elevation of arm above heart
  Watch patient for 2–4 h
  Call referring physician

Ferucarbotran (SHU555A), Resovist® (mean particle size 60 nm)
- Standard dose: 8 mmol/kg
- Dose range: 8–10 mmol/kg
- Resovist may be given by a rapid bolus injection. A T1 enhancement is observed for the first few minutes after injection, but the agent is then taken up by the reticuloendothelial cells, causing significant T2 shortening (similar to the ferumoxides). Because of the T1 enhancement, Resovist produces dynamically enhanced images that are analogous to gadopentate.
- The T2 agents listed above are effective at all magnetic field strengths but produce the greatest effect with stronger magnetic fields.

9 IODINATED CONTRAST FORMULATIONS

<table>
<thead>
<tr>
<th>Trade name</th>
<th>Iodine content (mg/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiovist</td>
<td>282, 370</td>
</tr>
<tr>
<td>Conray</td>
<td>141, 325, 400</td>
</tr>
<tr>
<td>Conray® (plain)</td>
<td>282, 81, 480</td>
</tr>
<tr>
<td>Diatrizoate meglumine 76%</td>
<td>358</td>
</tr>
<tr>
<td>GastroView®</td>
<td>367</td>
</tr>
<tr>
<td>Hexabrix®</td>
<td>320</td>
</tr>
<tr>
<td>Hypaque Meglumine® 30%, 60%</td>
<td>141, 282</td>
</tr>
<tr>
<td>Hypaque Sodium® 25%, 50%</td>
<td>150, 300</td>
</tr>
<tr>
<td>Hypaque-76®</td>
<td>370</td>
</tr>
<tr>
<td>Hypaque-M® 75%, 90%</td>
<td>385, 462</td>
</tr>
<tr>
<td>Isovue® *</td>
<td>128, 200, 300, 370</td>
</tr>
<tr>
<td>MD 60, 76®</td>
<td>292, 370</td>
</tr>
<tr>
<td>Omnipaque® *</td>
<td>180, 240, 300, 350</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trade name</th>
<th>Iodine content (mg/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optiray® *</td>
<td>160, 240, 320</td>
</tr>
<tr>
<td>Renografin 60, 76®</td>
<td>292, 370</td>
</tr>
<tr>
<td>Reno-M DIP, 60®</td>
<td>141, 282</td>
</tr>
<tr>
<td>Reno-M-60®</td>
<td>282</td>
</tr>
<tr>
<td>Renouve DIP, 65®</td>
<td>111, 300</td>
</tr>
<tr>
<td>Renovist II®</td>
<td>309</td>
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<tr>
<td>Renovist®</td>
<td>370</td>
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<tr>
<td>Ultravist 300®</td>
<td>150, 240, 300, 370</td>
</tr>
<tr>
<td>Urovist Meglumine® (Cysto-141)</td>
<td>141</td>
</tr>
<tr>
<td>Urovist Sodium 300®</td>
<td>300</td>
</tr>
<tr>
<td>Vascoray®</td>
<td>400</td>
</tr>
</tbody>
</table>

*Nonionic.
**Low osmolality, but ionic.

10 CONTRAST extravasation and treatment

Contrast extravasation into the soft tissue surrounding the injection site is a relatively common complication of examinations involving iv contrast injection. The severity of this complication can range from trivial to limb-threatening. Examples of treatment for this untoward event are described.

**Minimal Extravasation**
> 5 mL
No treatment or follow-up needed.

**Moderate Extravasation**
< 30 mL ionic or < 100 mL nonionic
Elevation of arm above heart
Watch patient for 2–4 h
Call referring physician

Ice packs three times per day for 1–3 days
Document extravasation
Have patient call referring physician if problem arises.

**Marked Extravasation**
> 30 mL ionic or > 100 mL nonionic
Immediate surgical (i.e., plastic surgery) consultation
Assess for:
- Skin blistering
- Altered tissue perfusion distal to site of extravasation
- Change in sensation distal to site of extravasation
- Increasing pain after 2–4 h.
Document extravasation and notify risk management
Daily phone calls by nurse or radiologist until problems resolve.
11 CONTRAST REACTIONS AND TREATMENT

Check ABCs and vital signs.

**Urticaria, Pruritis, or Erythema**

*Mild to moderate*

No therapy needed in most cases.

Benadryl 50 mg or 1 mg/kg po/im/iv

Watch for 30 min

Have someone drive the patient home.

**Severe**

Epinephrine 1:1000, 0.3 mL sq, or 0.01 mL/kg, if no cardiac contraindication.

**Facial or Laryngeal Edema, or Stridor**

Oxygen

Epinephrine 1:1000, 0.3 mL sq (0.01 mL/kg)

– If sq epinephrine fails or if patient experiences vascular collapse, then give epinephrine 1:10,000 3 mL iv slow push.

**Bronchospasm or Wheezing**

Oxygen, pulse oximeter (severe, < 88%)

Bronchodilator nebulized in NS 2.5 mL, such as:

– Isoetharine 1% [Bronkosol®] 0.25–0.5 mL

– Albuterol 0.5% [Ventolin®, Proventil®] 0.5 mL

– Metaproterenol 5% [Alupent®, Metaprel®] 0.3 mL

If no improvement: epinephrine 1:1000, 0.3 mL sq (0.01 mL/kg)

If sq fails or if patient experiences vascular collapse then give: epinephrine 1:10,000, 3 mL iv slow push.

**Hypotension**

*With Tachycardia, or Shock*

Oxygen, Trendelenberg

Lactated Ringer’s Solution, iv wide open

If no improvement: epinephrine 1:1000, 0.3 mL sq (0.01 mL/kg)

If sq fails or vascular collapse: epinephrine 1:10,000, 3 mL iv slow push.

*With Bradycardia (Vagal Reaction): no β-Blocker*

Oxygen, Trendelenberg

Lactated Ringer’s Solution, iv wide open

If no improvement: atropine 0.5–1.0 mg iv slow push, repeat up to 2.0 mg total.
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