**IV Contrast Allergy Premedication Guidelines**

The primary indication for premedication is for pre-treatment of patients considered at higher risk for an acute allergic-like reaction. While pre-medication may help reduce the risk of reactions, it has shown highest efficacy in patients with histories of minor reactions. Therefore, in patients with severe/anaphylactic reactions to contrast material, it may be advisable to consider non-contrast alternatives. Oral steroid premedication is preferred over IV premedication whenever possible. As a general rule, premedication regimens are ordered by the referring physician. Radiologists are available for physician consultation and regimen alteration when required. The emergent premedication regime is only recommended for patients who cannot wait for the 12-hour elective regimen and in whom other imaging strategies are not considered acceptable.

**Elective Premedication:**

a. Methylprednisolone (Medrol®) – 32 mg by mouth 12 hours and 2 hours before contrast media injection. [34].

   OR

b. Prednisone – 50 mg by mouth at 13 hours, 7 hours, and 1 hour before contrast media injection, plus Diphenhydramine (Benadryl®) – 50 mg intravenously, intramuscularly, or by mouth 1 hour before contrast medium [12].

   *NOTES: The first premedication regimen is preferred due to the logistics required for Benadryl administration. Benadryl may be added to the first regimen, but is not required.*

**Emergency Premedication:**

Methylprednisolone sodium succinate (Solu-Medrol®) 40 mg or hydrocortisone sodium succinate (Solu-Cortef®) 200 mg intravenously every 4 hours (q4h) until contrast study required plus diphenhydramine 50 mg IV 1 hour prior to contrast injection [35].

Note: It is preferred that steroids be given beginning at least 6 hours prior to the injection of contrast media.

**References**

ACR contrast manual, v10.2 2016